What works: Health and care interventions for supporting young people not in education, employment, or training (NEET)

Health Equity Evidence Centre

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EVIDENCE BRIEF

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Summary

Almost one million people aged 16-24 in the UK were not in education, employment, or training (NEET) between October and December 2025, equivalent to around one in eight young people. However, the nature of youth disengagement is changing. Almost 60% of young people who are NEET are now economically inactive rather than unemployed, and six in ten have never had a job.

Health has become increasingly prominent: 44% of young people who were NEET reported a work-limiting health condition in 2025, compared with 26% in 2015. There is an increasing recognition that helping young people into employment, education or training requires focused support from health and care services. This evidence brief examines what health and care services can do to prevent or reduce health-related disengagement from education, employment, and training.

The strongest evidence is for integrated supported employment, particularly Individual Placement and Support (IPS) for young people with mental health conditions, which improves entry into competitive employment. The evidence for education and sustained participation is less consistent. Importantly, the evidence challenges the assumption that young people must first recover clinically or become "work ready" before receiving support with education or employment, underscoring that health and participation goals can be addressed concurrently.

Other approaches – including multidisciplinary vocational rehabilitation, personalised navigation, psychological support, and therapeutic or community-based vocational rehabilitation – may contribute to addressing a range of health, functional, and social challenges affecting participation. However, the evidence for their influence on EET outcomes is less established.

We identify five evidence-informed principles that support young people who are NEET into employment.

1. Taking a life-course and transition-sensitive approach
2. Providing youth-responsive services with meaningful youth participation
3. Delivering integrated, multisectoral support
4. Addressing health and participation concurrently, rather than sequentially
5. Focusing on functioning, participation, and wellbeing, not symptoms alone

Current challenges

Between October and December 2025, nearly one million 16-24-year-olds in the UK were not in education, employment, or training (NEET). The nature of young people's disengagement from education and employment has changed substantially over the past decade. NEET is increasingly characterised by economic inactivity rather than unemployment: almost 60% of young people who are NEET are economically inactive, and six in ten have never been in employment, compared with four in ten two decades ago (1).

The health profile of young people who are NEET has also changed. The proportion of young people who are NEET reporting a work-limiting health condition increased from 26% in 2015 to 44% in 2025 (1). The commonest health condition of young people who are NEET is mental health problems (20%, 455,414 people), followed by learning difficulties including autism (12%, 315,248 people). There has been a particular rise in young people who are NEET with mental health conditions and learning difficulties (Figure 1).

Poor health is both an important predictor of vocational disengagement and part of a wider pattern of disadvantage associated with NEET (1). Across countries and settings, young people who are NEET report higher levels of mental ill health, psychological distress, and substance use when compared to their peers who are in education or employment (2–10). Conversely, studies of youth mental health services have found depression, functional impairment, and more severe or complex mental health needs to be associated with vocational disengagement (11–13).

Longitudinal evidence provides stronger support for poor health contributing to later disengagement than for a simple causal pathway in the opposite direction. Adolescent mental health and behavioural difficulties have been associated with

DEFINITIONS

NEET: Young people (aged 16 to 24), who are not in employment, education or training.

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.

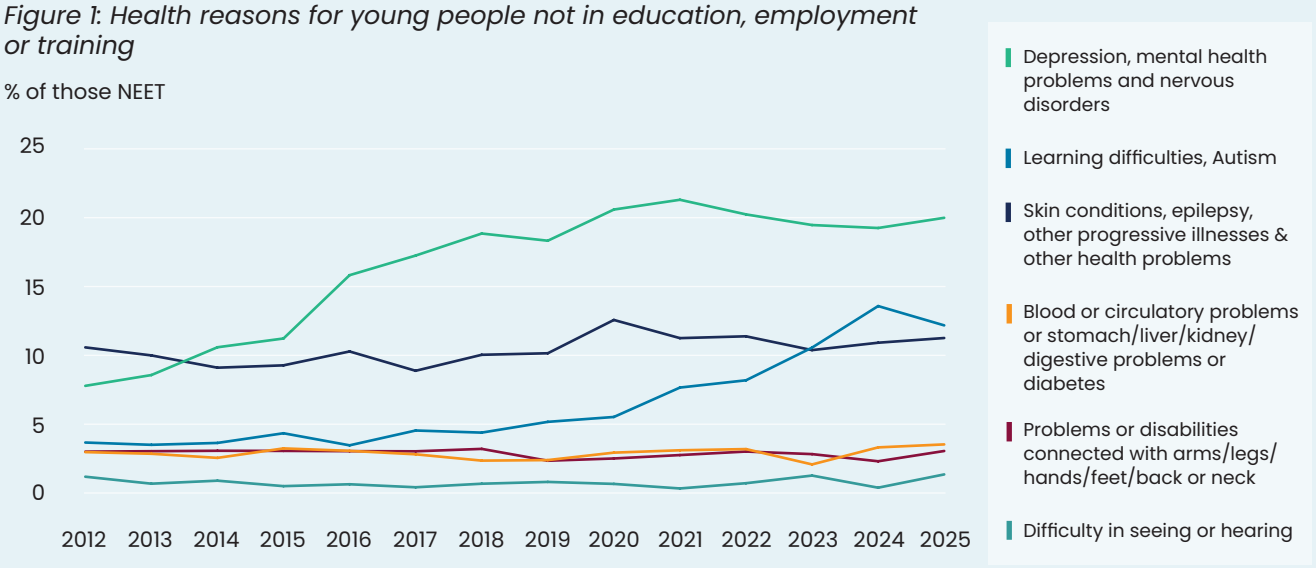
Unemployment: People without a job, who have been actively seeking work in the past four weeks and are available to start work in the next two weeks. Or people out of work who have found a job and are waiting to start it in the next two weeks.

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 weeks.

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

Source: Office for National Statistics

Figure 1: Health reasons for young people not in education, employment or training



Source: Department for Education and Department for Work and Pensions (2026). NEET age 16 to 24: 2025. Annual Population Survey, England.

subsequent NEET status and poorer educational and employment outcomes (14–17). Among help-seeking young adults, the course of depression and functional disability has similarly been associated with subsequent NEET status (18). A systematic review and meta-analysis concluded that mental health problems and substance use are associated with NEET status, with longitudinal evidence more consistently supporting mental ill health preceding NEET than NEET causing subsequent mental ill health (19). Longitudinal studies indicate that periods of disengagement can coexist with, and potentially contribute to, continuing mental health and socioeconomic disadvantage into early adulthood (20,21).

Importantly, these relationships are also unequal. Studies identify differences according to socioeconomic circumstances, educational attainment, family and childhood circumstances, health and disability, and other forms of disadvantage (22–27). In the UK, disabled young people are substantially more likely to be NEET than their non-disabled peers, while young people from lower-income backgrounds, facing educational or family challenges, or living in deprived areas are more likely to be NEET than their peers (1,23,28,29). Thus, NEET should be understood as a status that can arise through different pathways, rather than a single health or employment problem.

National and local policymakers are increasingly recognising that supporting young people into employment, education or training requires a joined-up approach across the labour market, education and health. Here we examine health and care interventions which prevent or reduce health-related disengagement from education, employment and training.

Summary of evidence

Overall, the evidence was considered across two complementary bodies of literature: direct evidence on interventions for young people who were NEET or vocationally disengaged, and broader evidence on health and care interventions supporting young people with health conditions which reported outcomes on employment or education. Evidence relating specifically to neurodiversity, work, and health in the wider population is synthesised in a separate complementary evidence brief.

We identified 181 potentially relevant studies and evidence sources through Health Equity Evidence Centre work and health living evidence maps, Google Scholar, snowball searching, and grey literature searches. Of this, we prioritised 58 studies that were the most relevant to understanding how health and care interventions might support young people's participation in education, employment, or training. The Living Evidence Maps provided the direct evidence relating to NEET within their scope, while supplementary searches were used to identify a broader body of relevant health-adjacent literature examining EET outcomes among young people.

Intervention approaches

The evidence includes a diverse range of approaches through which health and care services may support young people whose health affects their participation in employment, education, or training. We grouped the interventions into five broad categories according to their primary intervention approach and intended pathway to participation. These categories overlap, and some interventions contain components relevant to more than one intervention approach.

The main distinction lies in where each approach intervenes in the pathway between health and participation. Integrated supported employment and education, including Individual Placement and Support (IPS), embeds vocational support within healthcare and addresses health and EET concurrently; whereas multidisciplinary vocational rehabilitation focuses more explicitly on the functional consequences of physical or mental health conditions on an individual's work or education. Personalised navigation and reintegration support coordinates access to services where multiple health, social, and practical barriers interact, usually provided by a case manager or coordinator to help an individual navigate services. Psychological and therapeutic approaches primarily focus on supporting individual mental health and wellbeing where it may constrain participation in work or education, while therapeutic and community-based rehabilitation uses meaningful activity and supportive environments, such as structured group-based and community activities, as a bridge towards wider participation.

Table 1: Summary of intervention approaches, related outcomes, and evidence base.

Intervention approach	What does it involve?	Population/need	Work / EET findings	Health / wider findings	Overall evidence picture
1. Integrated supported employment and education	Employment/education support integrated with mental health treatment, often using IPS; rapid job search, individualised support, benefits advice, employer engagement, and ongoing support	Primarily young people with serious mental illness/early psychosis; some emerging evidence for anxiety/depression and broader youth mental-health populations	Most consistent positive evidence for competitive employment; some evidence for increased time worked. Education findings less consistent	Primarily vocational studies; some studies examine mental health and functioning	**Strongest and most consistent intervention evidence,** particularly for employment among young people with serious mental illness
2. Multidisciplinary vocational rehabilitation	Health/rehabilitation care combined with vocational assessment, coaching, work-related problem solving, and support navigating workplace barriers	Young people with chronic physical or mental health conditions affecting work participation	Mixed. Some models show vocational gains; At Work did not outperform usual care	May improve self-efficacy, functioning or work-related capability	**Mixed evidence,** but potentially important for young people needing health and vocational support simultaneously
3. Personalised navigation and reintegration support	Individualised support addressing health, social, and vocational barriers together, often involving case management, navigation, or coordinated services	Young people with multiple health/social barriers, including substance use and mental ill-health	Some promising employment/ reintegration findings, but generally weaker designs	Improvements reported in wellbeing, work ability, engagement, and related outcomes	**Promising but limited evidence**, particularly for complex needs
4. Psychological and therapeutic approaches supporting participation	Psychological treatment or therapeutic activity intended to improve health, functioning, and capacity for participation	NEET young people experiencing psychological distress, social withdrawal, or other mental-health barriers	Work/EET outcomes often absent or insufficiently measured	More consistent improvements in distress, wellbeing, emotional regulation, or functioning	**Some evidence of health benefit, but little evidence that health improvement translates into EET**
5. Therapeutic and community-based vocational rehabilitation	Meaningful activity in supportive settings combined with therapeutic, social, and/or vocational development	Young people experiencing health, wellbeing, and social barriers to participation	Limited direct causal evidence for EET outcomes	Qualitative/observational evidence suggests confidence, social connection, wellbeing, and readiness may improve	**Useful mechanism and implementation evidence, but effectiveness remains uncertain**

1. Integrated supported employment and education

Integrated supported employment approaches address health and vocational participation concurrently, rather than treating employment as something to consider only after clinical recovery. The most established model in the evidence is Individual Placement and Support (IPS), which integrates employment specialists within mental health services and combines rapid job search with individualised support, employer engagement, and ongoing assistance once a person enters work.

Across systematic reviews of vocational interventions for young people with mental health conditions, IPS has produced the most consistent evidence of improved competitive employment (30–33). The evidence is strongest among young people experiencing serious mental illness or early psychosis, while also highlighting considerable variation in how employment outcomes were defined and measured (34). More recent evidence suggests that IPS can also be implemented in routine mental health services. Bond et al (35) followed young adults aged 16-24 receiving IPS in public mental health services and found that 45.9% obtained competitive employment or a paid internship during the first year, while 12.6% achieved new education outcomes.

Evidence from Norway also suggests that IPS can operate across health and welfare systems. For instance, Brinchmann et al (36) examined implementation among young adults receiving temporary health-related welfare benefits and found an increase in employment following implementation, with effects increasing over three years. The model has also been adapted to young people's wider vocational trajectories. Ellison et al (37) incorporated supported education, near-age peer mentoring, career development, and benefits counselling within an IPS-informed programme for emerging adults with serious mental health conditions. Simmons et al (38) similarly combined IPS with vocational peer work within integrated youth mental health services for young people aged 15-25.

Overall, this literature provides the strongest evidence in the review that employment support integrated with healthcare can improve employment outcomes, particularly among young people receiving mental healthcare. Evidence for education and long-term participation remains limited.

2. Multidisciplinary vocational rehabilitation

Multidisciplinary vocational rehabilitation similarly brings health and employment support together but focuses more explicitly on the functional consequences of a health condition and the barriers these create for participation. Interventions can combine health or psychological support with vocational assessment, skills development, work preparation, and individualised support towards employment.

Evidence for this approach is more heterogeneous than for IPS. Reviews of NEET interventions identify multicomponent approaches combining vocational support with health, psychological, educational, or social components, but substantial variation in intervention design and outcome measurement makes it difficult to determine which components are responsible for effects (30,31,39). For example, Crespo-Andrade et al (40) evaluated a multicomponent programme for marginalised unemployed young people in Latin America that combined support across several domains and reported improvements in emotional and cognitive outcomes. Overall, the evidence supports addressing multiple barriers to participation but provides less certainty about the effectiveness of a distinct multidisciplinary vocational rehabilitation model.

3. Personalised navigation and reintegration support

A third group of interventions responds to vocational disengagement as the result of multiple interacting health, social, and practical barriers that may not be amenable to a single clinical or employment intervention. These approaches tend to provide flexible, individualised support that helps young people navigate services, address barriers and reconnect with employment, education, and other forms of participation. For example, in the COPE programme evaluated by Bertotti et al (41), support was deliberately flexible and community-based, with practitioners responding to young people's wider circumstances over delivering a narrowly clinical intervention. Qualitative findings emphasised emotional support, trust, and flexibility alongside opportunities to build confidence, develop skills, and become more active.

Similarly, De Lannoy et al (42) evaluated a holistic coaching and referral programme designed to

improve wellbeing and employability among young people who were NEET. These approaches reflect a broader theme in the intervention literature: programmes appear more responsive to heterogeneous NEET populations when support is tailored to individual circumstances and can connect young people with different forms of provision (39). However, evidence for navigation and reintegration remains limited, particularly in comparison with supported employment. The available studies are more useful for understanding how personalised and coordinated support might operate than for establishing comparative effectiveness.

4. Psychological and therapeutic approaches supporting participation

Some interventions focus primarily on the health and psychological barriers associated with vocational disengagement, rather than providing direct employment support. These include psychotherapy, mindfulness, and psychological skills programmes delivered to young people who are NEET or experiencing substantial barriers to participation.

For example, Lee et al (43) evaluated a home visitation programme for socially withdrawn young people, while Roemer et al (44) examined a mindfulness-based intervention for young unemployed adults within a residential youth development programme and measured psychological distress, wellbeing, and mindfulness. Anestis et al (45) evaluated Dialectical Behaviour Therapy skills training among at-risk young men in a residential programme, and Buckman et al (46) examined psychological therapy outcomes among young adults who were NEET. Other included studies have evaluated multicomponent interventions targeting psychological and social functioning among marginalised or socially withdrawn young people (40,47–49).

Across this literature, psychological distress, wellbeing, emotional regulation, and functioning are more consistently measured than subsequent employment or education. A rapid evidence review commissioned by Public Health Wales (50) similarly found some evidence of improvements in mental and emotional health and wellbeing, but highlighted the limited quality of the underlying evidence and inconsistent measurement of EET outcomes. These interventions therefore provide evidence about addressing health-related barriers associated with NEET, but considerably less evidence that improvements in health alone produce sustained vocational re-engagement.

5. Therapeutic and community-based vocational rehabilitation

Finally, some approaches use meaningful activity and supportive environments themselves as part of the pathway towards vocational participation. Rather than moving immediately into formal job search, young people participate in structured activities through which they can rebuild routines, relationships, confidence, and practical or social skills (51–55).

For example, Ørjasæter (51) examined art-based vocational support for emerging adults who were NEET, with participants and staff emphasising individually tailored support, supportive relationships, peer interaction, and an appropriate balance between demands and support. Grow2Grow combined mental health and vocational support through horticultural activity outside conventional clinical settings (56), while Down to Earth used sustainable construction activities with disadvantaged and hard-to-reach groups and examined mental health and social connection (27). Similarly, Kendall and Maujean (52) evaluated an equine-assisted psychological intervention for disengaged young people.

These studies suggest several plausible pathways through which structured community activity might support movement towards participation, including improvements in confidence, social connection, wellbeing, skills, and engagement. However, the evidence for subsequent entry into or sustained participation in EET is considerably less developed. These outcomes should therefore be understood as potential mechanisms or intermediate outcomes, rather than evidence that community-based therapeutic activity itself improves EET participation.

Evidence-informed principles for supporting young people into employment, education and training (EET)

Several common principles emerge across the studies. These principles describe how health and care services might organise support around young people's participation in education and employment, rather than specifying a single intervention that should be implemented for all young people who are NEET.

1. Taking a life-course and transition-sensitive approach
2. Providing youth-responsive services with meaningful youth participation
3. Delivering integrated, multisectoral support
4. Addressing health and participation concurrently, rather than sequentially
5. Focusing on functioning, participation and wellbeing, not symptoms alone

Principle 1: Taking a life-course and transition-sensitive approach

Support for education and employment should reflect the distinctive developmental stage of adolescence and emerging adulthood, rather than simply adapting adult employment programmes for younger populations. Young people's vocational trajectories are rarely linear: education, training, first employment, changes in career aspirations, periods of ill health, and transitions between services may occur concurrently. This means that preventing long-term disengagement requires attention both to early intervention and to continuity through transitions.

The wider evidence supports taking a longitudinal view of these trajectories. Mental health and behavioural difficulties during adolescence are associated with subsequent NEET status and poorer education and employment outcomes (14–17,37), while studies of young people receiving mental healthcare similarly show that health, functioning, education, and employment can change together over time (18). Intervention reviews also highlight the importance of approaches that accommodate both education and employment during this developmental period rather than treating employment as the only vocational outcome (30,31).

Overall, a life-course perspective suggests looking beyond whether a young person enters employment at a single time point towards whether services support participation across changing educational, employment, and health circumstances.

Principle 2: Providing youth-responsive services with meaningful youth participation

Services should be responsive to young people's developmental stage, circumstances, priorities, and changing education and employment goals. This may require provision that differs from conventional adult employment support, including greater attention to education, emerging vocational goals, social relationships, and the wider circumstances influencing participation. Across the intervention literature, personalised and flexible approaches recur in programmes working with heterogeneous groups of young people who are NEET or experiencing health-related barriers to participation (37–39,42,51,57).

Youth-responsive provision should be distinguished from youth participation in service design. The former adapts support around the circumstances of young people (54,55,57,58); the latter involves young people themselves in shaping what support looks like and how decisions are made (59–61). A systematic review of theories, models, and frameworks for youth engagement in health research found that meaningful engagement encompasses questions of power and decision-making, process, impact, and equity (62). Equity-focused frameworks particularly emphasised young people's perspectives and local knowledge alongside attention to social determinants and structural conditions.

This distinction is relevant to NEET because young people's experiences can identify barriers and priorities that may not be captured through clinical or employability measures alone. Qualitative evidence from vocational support similarly highlights the importance young people place on individually tailored provision, supportive relationships, peer interaction, and an appropriate balance between support and challenge (51). Meaningful youth participation may therefore help services identify barriers,

define relevant outcomes, and design provision that better reflects how young people experience health, education, and employment.

Principle 3: Deliver integrated, multisectoral support

Health-related vocational disengagement often cuts across the responsibilities of healthcare, education, employment, and welfare services, such that support may be weakened when young people are expected to navigate these systems independently. The evidence includes several approaches in which health and vocational expertise are brought together around the young person rather than provided sequentially or in isolation.

IPS provides the clearest example of this integration. Brinchmann et al (36) examined cross-sector implementation involving mental health services and the Norwegian Labour and Welfare Administration among young adults receiving temporary health-related welfare benefits, finding increased employment following implementation. Bond et al (32) similarly examined IPS delivered within routine public mental health services for young adults, demonstrating how vocational support can be incorporated into existing mental healthcare. Beyond IPS, holistic and personalised approaches combine or coordinate support across health, social, educational, and employment-related needs (39,42).

Taken together, these studies suggest that integration is better understood as a function than a single organisational model: the relevant services and expertise will vary according to young people's needs, but health and participation goals should not be addressed in disconnected systems.

Principle 4: Address health and participation concurrently, rather than sequentially

The strongest intervention evidence challenges a sequential approach in which young people are expected to first achieve clinical recovery or become "work ready" before support with education or employment begins. Instead, health treatment and vocational support can be delivered concurrently, allowing education or employment goals to be addressed as part of care rather than deferred until treatment has ended.

This principle is central to IPS, where employment support is integrated with mental health treatment rather than preceded by prolonged pre-vocational preparation. Systematic reviews and randomised studies of interventions for young people with mental health conditions consistently identify IPS as one of the better-supported approaches for improving competitive employment (30,31,63,64). Evidence from routine implementation similarly demonstrates that vocational support can be delivered within or alongside mental health services (32,36).

Nevertheless, concurrent support should not be interpreted as employment-first support for everyone. Some young people may require more gradual or intensive health, social, or rehabilitative support. The broader implication is that services should avoid creating an unnecessary sequential pathway in which vocational aspirations are automatically deferred because a young person is receiving treatment.

Principle 5: Focus on functioning, participation, and wellbeing, not symptoms alone

Health outcomes and vocational outcomes should not be treated as interchangeable. Improving symptoms, psychological wellbeing, or functioning may be valuable outcomes in themselves, but does not demonstrate that a young person has entered or sustained participation in EET. Conversely, obtaining employment does not by itself establish that health, functioning, or longer-term participation has improved.

This distinction is visible across the intervention evidence. Psychological and therapeutic interventions have reported improvements in outcomes such as distress, emotional regulation, wellbeing, and functioning without consistently establishing subsequent EET participation (40,43–45,50). Conversely, supported employment studies primarily demonstrate vocational outcomes, while providing less evidence about longer-term health and participation (31,32). The evidence therefore does not support assuming that improvement in one domain necessarily produces improvement in the other.

Where supporting EET is an intended goal of health and care, health, functioning, and participation should therefore be considered and measured as related but distinct outcomes, including whether participation can be sustained over time.

What works: key recommendations

Based on the evidence, we have the following recommendations. GRADE certainty reflects the strength of evidence behind each recommendation, not necessarily the likelihood of effectiveness or policy priority.

Recommendation	Target audience	GRADE certainty
Integrate national health, education and employment policy focused on sustained participation	National government	⊕⊕⊕◯ Moderate
Focus on sustained participation and minimising dropout at the transition out of full-time education as the main objective and measured outcome, rather than job entry	National government, Integrated Care Boards and local authorities	⊕⊕⊕◯ Moderate
Ensure that adult services are adapted for young people through co-design, particularly with those who are currently underserved	National government, Integrated Care Boards and local authorities	⊕⊕⊕◯ Moderate
Where possible, offer health and employment support concurrently through integrated, multidisciplinary services	Integrated Care Boards, Health and care organisations, such as general practice and mental health services	⊕⊕⊕◯ Moderate
Prioritise Individual Placement and Support for young people with serious mental health conditions	Integrated Care Boards	⊕⊕⊕◯ Moderate
Consider targeting multidisciplinary rehabilitation and navigation for those needing support with physical health conditions or with particularly complex social needs	Integrated Care Boards	⊕⊕◯◯ Low
Include discussions of education, training and employment goals routinely as part of health and care contact	Health and care organisations, such as general practice and mental health services	⊕⊕⊕◯ Moderate
Focus on functional goals, alongside symptoms, in health and care services supporting young people who are NEET	Health and care organisations, such as general practice and mental health services	⊕⊕⊕◯ Moderate
Agree individual support plans for transitions between adolescent and adult services	Health and care organisations, such as general practice and mental health services	⊕⊕◯◯ Low
Consider community-based therapeutic activities for young people who are NEET focused on bridging to work, especially when immediate employment is not appropriate	Integrated Care Boards and local authorities	⊕⊕◯◯ Low
More evidence is required on how the effectiveness of services varies across key population groups, such as gender, ethnicity, disability and health conditions	Research funders and commissioners of service evaluations	Not applicable

Note: GRADE ratings reflect certainty of evidence, not priority for policy implementation. Evidence from larger, more robust studies is generally graded higher, while smaller studies or evidence requiring transferability judgements is graded lower. A low GRADE rating does not indicate low importance; some interventions with lower-certainty evidence may still have substantial population impact.

Limitations

The evidence base has several important limitations. First, the literature was heterogeneous in populations, interventions, settings, and outcomes, making direct comparison between approaches difficult. Employment outcomes were considerably more commonly reported than health outcomes, and relatively few studies examined education, training, sustained participation, or the relationship between changes in health and changes in EET participation. The strongest intervention evidence was also concentrated in particular clinical populations, especially young people with serious mental illness or early psychosis. Evidence was more limited for other health conditions and for interventions aimed at preventing disengagement before a young person becomes NEET. These limitations are reflected in the GRADE certainty assessments, particularly through indirectness and imprecision.

Second, there was limited evidence from an equity perspective. Although wider research indicates that the risk of becoming NEET is socially patterned, the intervention literature rarely examined whether access, engagement, effectiveness, or sustained outcomes differed by socioeconomic circumstances, ethnicity, disability, migration status, gender, or other dimensions of inequality.

Much of the stronger effectiveness evidence also concerned young people already engaged with specialist health services, providing less insight into young people who do not meet service thresholds or experience barriers to accessing care. The absence of differential-effect evidence limits conclusions about whether interventions that are effective overall also reduce, maintain, or widen inequalities in EET participation.

Finally, NEET remains a relatively new framing within health and care research. Relevant interventions have often been described using other concepts, including vocational rehabilitation, supported employment, work participation, occupational functioning, and return to work, rather than NEET terminology. This creates challenges for identifying and defining the evidence base and means that relevant studies may not be readily captured through NEET-focused searches alone. At the same time, growing policy and research attention to health-related economic inactivity among young people means this is a rapidly developing field. The findings of this brief should therefore be understood as a current synthesis of an emerging evidence base, which is likely to expand as more research explicitly examines health, NEET, and participation in education and employment together.

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 have shown that the structures and systems within society lead to health inequalities. We believe that only by tackling the unequal distribution of the social determinants of health can we achieve health equity, and that the benefits of healthcare should reach the most marginalised in society.

About this Evidence Brief

This work was developed collaboratively with NHS England, with funding provided by NHS England. The Health Equity Evidence Centre retained full independence in the production of all academic outputs.

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