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Rapid Evidence Synthesis: Supporting people living with mental health problems to return to work or stay in work

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Rapid Evidence Synthesis:

Rapid Evidence Syntheses (RES) are produced by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration Greater Manchester (ARC-GM). The methods used are based on a framework set out in Norman et al. 2022 and previously registered on the Open Science Framework (OSF). [1,2]

RES use evidence synthesis approaches and draw on the GRADE Evidence to Decision framework[3] to provide rapid assessments of the existing evidence and its relevance to specific decision problems. In the first instance they focus on evidence from guidance and existing evidence syntheses. They are undertaken in a real-time context of decision-making around adoption of innovative health technologies and are designed to provide a "good-enough" answer to inform decision problems in a short timescale. RES methods are flexible and adaptive. They have evolved in response to user feedback and differ depending on the nature of the assessment undertaken.

RES are not intended to serve as a substitute for a systematic review or rapid review of evidence.

We welcome feedback and are particularly interested to hear how you have used this Rapid Evidence Synthesis.

Please send any queries or comments to:

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This work was undertaken by the National Institute for Health Research (NIHR) Applied Research Collaboration Greater Manchester (ARC-GM). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

[1] Norman, G. *Rapid evidence synthesis to support health system decision making. OSF registration.* 2020 [cited 2023]; Available from: osf.io/hsxk5

[2] Norman, G., et al., *Rapid Evidence Synthesis To Enable Innovation And Adoption in Health and Social Care.* Systematic Reviews, 2022. **11**: p. 250. https://doi.org/10.1186/s13643-022-02106-z

[3] Alonso-Coello, P., et al., *GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction.* BMJ, 2016. **353**: p. i2016.

1. Summary

There is moderate-certainty evidence that (augmented) supported employment is effective and cost effective in helping people with serious mental illness including schizophrenia to obtain and maintain employment. There is also moderate-certainty evidence that workplace interventions are effective and cost-effective in helping people with common mental disorders such as depression in reducing sick leave related to mental health and facilitating return to work. Evidence is less certain for other interventions such as psychotherapy interventions.

Qualitative evidence suggests that people with mental health value the meanings and benefits of obtaining and staying in employment and treat staying at paid work as a way to establish normal behaviour and mainstream life. To cope with re-employment, they may need to find their balance in new situations through learning new skills and competencies while receiving assistance. In this process and in returning to work, barriers and facilitators people experienced are generally related to organisational or environmental context, support, job characteristics, health symptoms and severity, personal characteristics. Qualitative evidence is largely from reviews of research with acceptable methodological quality.

(1) Effectiveness. There is evidence available from systematic reviews for a range of interventions and mental health conditions.

Mental illness in general. For helping unemployed people to **obtain employment**, there is moderate- or low-certainty evidence that supported employment is effective compared with psychiatric care alone. This relates particularly to augmented supported employment using symptom-related skills training, assertive community treatment, job-related skills training, and transitional employment. Individual placement and support and social skills training are also more effective compared with psychiatric care alone.

In terms of **maintaining employment**, people receiving (augmented) supported employment worked more weeks than those receiving transitional employment or prevocational training (moderate-certainty evidence). The evidence is less clear on use of work accommodation interventions, and computer-assisted cognitive remediation.

In terms of helping employees **return to work**, there is low-certainty evidence that employees with sick leave due to mental illness had fewer total sick leave days when using problem-solving treatment or cognitive behavioural therapy compared with control groups. The evidence is uncertain or limited on use of various return to work interventions in general, workplace interventions, return-to-work interventions that had work-focused problem-solving skills components, and interventions involving return-to-work coordinators.

***Schizophrenia*.** Evidence based on studies with some methodological limitations suggests that supported employment is effective for helping people with schizophrenia obtain and maintain employment, but it is unclear if augmented individual placement and support is better than standard individual placement and support in obtaining competitive employment.

***Common mental disorders such as depression, anxiety*.** There is high or moderate certainty evidence that a combination of a work-directed intervention and a clinical intervention probably help people return to work with shorter sickness absence and increase work functioning, though not retaining more people at work after one year or longer.

There is moderate-certainty evidence that workplace interventions, such as CBT-based and problem-focused return-to-work programmes, probably improve symptomology and improve occupational outcomes compared with others.

The evidence has some uncertainties in terms of impacts of psychological treatments on reducing sick leave and psychological symptoms for people with common mental disorders.

***Adjustment disorders*.** There is moderate-certainty evidence that CBT did not reduce time until partial or full return to work compared with no treatment. Problem solving interventions enhanced partial return to work at one-year follow-up compared with non-guideline based care in employees with adjustment disorders (moderate-certainty evidence).

Post-traumatic stress disorder. It is unclear if psychotherapy interventions are beneficial for helping people recover from post-traumatic stress disorder symptoms and return to work.

(2) Cost effectiveness. There is strong economic evidence favouring use of individual placement and support or (augmented) supported employment programmes for helping people with severe mental illness to obtain and retain employment.

There is high or moderate certainty evidence that workplace interventions including cognitive behavioural therapy, case management are probably cost-saving or cost-effective for treating people with depression. There is also moderate certainty evidence that regular and active involvement of occupational health professionals is probably cost-saving or cost-effective in reducing sick leave related to mental health and facilitating return to work.

(3) People's experience, barriers and facilitators. People with mental health value the meanings and benefits of obtaining and staying in employment and treat staying at paid work as a way to establish normal behaviour and mainstream life. To cope with re-employment, they may need to find their balance in new situations through learning new skills and competencies while receiving assistance.

Evidence from good-quality studies consistently suggests that key barriers and facilitators to obtaining and retaining employment, returning to work, and staying at work are related to: organisational or environmental context and leadership, the social and rehabilitation systems, social support at the workplace, job characteristics, health symptoms and severity, personal characteristics.

Key barriers identified for use of individual placement and support in Australia (known to be effective) include: a lack of understanding and training on the intervention for health professionals; strict implementation guidelines that are difficult to adhere to; difficulty with achieving intervention fidelity; and vocational rehabilitation not being acknowledged as a high priority and an integral part of an individual's recovery journey.

2. Methods

2.1 Description of the Intervention

People living with mental health conditions may experience problems in maintaining employment, returning to employment after time away from the labour market (due to their health or for other reasons), and in remaining at work and returning to work after sickness absence. This RES will consider interventions to support people with mental health conditions in their engagement with employment.

We use employment to mean having a paid job or active self-employment role and work to mean attendance at that job or role. Return to employment refers to taking up employment after a period of economic inactivity while return to work refers to returning from a period of sickness absence. Similarly remaining in employment refers to continuing to have a paid role while remaining at work refers to being able to attend a paid role (as opposed to being absent due to sickness).

Interventions may be used to help people with mental health conditions to stay in or return to work. Such interventions include but are not limited to (1) strategies targeting people not currently employed to return to employment, (2) strategies supporting employed workers to maintain a job, and (3) strategies improving the ability to remain at work (attendance) or return to work (from sickness absence) of those employed.

By helping people to return to employment or work or supporting job retention and attendance, such interventions are expected to improve work performance, reduce unemployment rates and socioeconomic inequalities and improve population health outcomes.

2.2 Search

We searched Medline (Ovid), PsycINFO and the Epistemonikos Database in November 2023. Our searches were based on the facets of return to work (or staying in work) and mental health. Search strategies are available upon request.

2.3 Key Questions

Q1. What is the evidence on the effectiveness and cost effectiveness of interventions for people living with mental health conditions in terms of work outcomes; in particular remaining in employment, returning to employment, returning to work and time away from work.

Q2. What is the evidence reported on the experience of those living with mental health conditions in coping with remaining in or returning to employment; returning to work and taking time away from work; and the barriers or facilitators towards employment retention or return and remaining at or

returning to work. We also considered participants' experiences of interventions aimed at supporting employment and the differential experience in this coping between those living with mental health conditions and the general population.

2.4 Inclusion Criteria

2.4.1 Participants

We included evidence on community-dwelling adults, regardless of their employment status, who live with mental health conditions. We consider mental health conditions to include any illness which is considered to be primarily mental rather than physical in nature.

We therefore included the broad diagnostic categories of depression, anxiety, bipolar mood disorder and schizophrenia but also illnesses such as eating disorders which have physical components. Diagnoses of personality disorders were also included because they share issues and treatment approaches with mental health conditions. We recognise that formal diagnoses may not always be clear or consistent and would consider people experiencing symptoms of mental ill health, whatever their diagnostic status (none, suspected, firm) and whatever the duration or severity of their condition (mild, moderate, severe).

We also recognise that mental ill health may (and frequently does) occur alongside physical health conditions. In these cases we included interventions which are aimed at the mental health condition but not at the comorbid physical health condition per se, although this may have a causal role in mental ill health.

2.4.2 Interventions

We included evidence on interventions or, in the case of multicomponent interventions, any constituent components aimed at, supporting unemployed people with mental health conditions to be re-employed, supporting employed people to maintain a job, or improving the ability to remain at or return to work for those employed. Interventions which are aimed at supporting people with a range of medical conditions may also be relevant where targeted conditions include mental health conditions.

Interventions may be multi-component and/or multi-level and could include psychological components, such as cognitive behavioural therapy, psychotherapy, psychoeducation; coaching and practical or emotional support; elements such as practical adjustments to employment roles (e.g. reasonable adjustments for disability and other aspects such as flexible working practices); elements aimed at employers to help them manage working life for people with mental health conditions; and organisation-level policies.

We acknowledge the availability of general treatments such as antidepressants and cognitive behavioural therapy which aim at improving health outcomes rather than employment and work outcomes. General health benefits can lead to retention in or return to employment or work.

Employment and work outcomes however are not typically the primary target of such treatments. Where reported we considered them here although they are not the main focus of this RES and we did not have capacity to consider them systematically.

2.4.3 Comparators

We considered any comparator groups; we anticipate that these included no intervention, services as usual, and alternative interventions.

2.4.4 Outcomes

For Q1 we accepted and primarily focused on any outcome that could reflect returning to employment or work and remaining in employment or work concepts. These outcome measures include remaining in paid employment, returning to paid employment, long or short term sickness absence, and also cost outcomes such as out of work sickness benefits and in-work costs such as statutory and non-statutory sick pay. We considered cost-effectiveness outcomes (e.g. cost per quality adjusted life year (QALY); incremental cost effectiveness ratio (ICER)).

Where reported, we also considered outcome measures such as self-efficacy, health related outcomes such as recovery, remission and change in symptom scores, and quality of life.

For Q2 we considered participants' experience of coping with staying in employment and work or returning to employment or work and the related barriers and facilitators. Experience of interventions aimed at supporting employment was also considered. We planned to consider the differential experience between those living with poor mental health and the general population, however the evidence is unavailable.

2.4.5 Study design

We considered existing evidence syntheses including systematic reviews of primary studies of any design and overviews of systematic reviews in this area. We considered quantitative, qualitative and mixed methods reviews as appropriate to the question addressed. We used a broad definition of systematic reviews as having a systematic search and clear inclusion criteria.

Had we been unable to identify relevant evidence syntheses, we planned to consider primary studies, looking at the most robust primary study designs first. For Q1 these are randomised controlled trials (RCTs). For Q2 these are well conducted qualitative or mixed methods studies. Studies with less rigorous approaches were planned to be considered in the absence of more useful evidence.

3. Results

3.1 Results of search

We identified 642 records from database searches in terms of evidence synthesis publications. After study selection, we included 44 systematic reviews for Q1 and 6 reviews for Q2 in this RES. Because of the substantial review evidence available for both questions, we did not search for primary research. We have focused on the most recent and highest quality reviews (i.e. those with the most robust methodology).

3.2 The effectiveness and cost effectiveness evidence (Q1)

3.2.1 The effectiveness of interventions on work outcomes

***Mental illness in general*.**

- Vocational rehabilitation interventions for unemployed people to obtain employments

Eighteen systematic reviews report evidence on the effectiveness of vocational rehabilitation interventions on employment outcomes in unemployment adults with severe mental illness. Of these reviews, 12 involved various intervention types (1-12) whilst 6 focused on specific intervention types (13-18).

Of the 12 reviews including various interventions, Suijkerbuijk (2017) is a Cochrane Review and a network meta-analysis of 48 RCTs (8743 participants) that compared various types of interventions with comparators on employment outcomes.(6) This Cochrane Review considered a wide range of interventions and classified them into the following five high-level intervention groups: ***prevocational training programmes*** including job-related skills training, and symptom-related skills training (i.e. cognitive training, social skills training); ***transitional employment interventions*** including sheltered workshop, social enterprise, Clubhouse model; ***supported employment***; ***supported employment augmented with other specific interventions***; and ***psychiatric care only***. Compared with other systematic reviews, this Cochrane Review considered the widest range of intervention types and used network meta-analysis to simultaneously compare all included interventions for assessing which may be most effective. Cochrane reviews use rigourous review processes and are considered to represent gold standard evidence. We therefore focused on this Cochrane Review but we present evidence from other reviews where the Cochrane Review lacks relevant evidence on specific outcomes.

Obtaining paid (competitive) employment. Suijkerbuijk (2017) performed two network meta-analyses: one with high-level intervention groups, and the other with specific interventions. (6)

In the analysis with high-level intervention groups, augmented supported employment was the most effective in rates of people obtaining competitive employments versus psychiatric care only (RR 3.81, 95% CI 1.99 to 7.31; moderate-certainty evidence), followed by supported employment (RR 2.72, 95% CI 1.55 to 4.76; low-certainty evidence). There is no difference in competitive employment rate between the common comparator psychiatric care only and prevocational training (very low-certainty evidence), and transitional employment (low-certainty evidence); but the evidence has uncertainties.

In the network meta-analysis with specific interventions, compared with the common comparator psychiatric care only, augmented supported employment with symptom-related skills training showed the best results (RR 3.61, 95% CI 1.03 to 12.63). The other augmented supported employment interventions (augmentation using assertive community treatment, job-related skills training, transitional employment), social skills training and individual placement and support were also more effective than psychiatric care only. There is no difference between the common comparator psychiatric care and cognitive training, job-related skills training, sheltered workshops and Clubhouse. There is no certainty of evidence assessment result for this analysis.

Obtaining paid (non-competitive) employment. One small trial (n = 256) with some methodological limitations suggested that augmented supported employment was more effective than psychiatric care only (RR 44.69, 95% CI 6.25 to 319.49). Transitional employment appeared better than supported employment; benefits were consistently suggested by four trials (n = 587) with some methodological limitations. Evidence with some uncertainties suggests no difference between augmented supported employment and transitional employment, or between supported employment and psychiatric care.

Suijkerbuijk (2017) has limited and/or uncertain evidence on symptom scores and quality of life. (6) Here we supplement evidence using van Rijn (2016), a systematic review and meta-analysis of 16 RCTs and particularly focused on the evaluation of the effectiveness of using re-employment programmes in unemployed people on their functioning, mental health and quality of life.(11) Meta-analyses suggested that re-employment programmes had a modest positive effect on the quality of life. No difference was found in functioning and mental health outcomes. The evidence however has some uncertainties because more than half of the 16 studies had methodological limitations.

The evidence favouring the use of individual placement and support or (augmented) supported employment interventions as noted in Suijkerbuijk (2017) is consistent with another six systematic reviews that focused on individual placement and support/ supported employment interventions.(13-18)

- Vocational rehabilitation interventions for maintaining people in employment

Three systematic reviews present evidence in this area including one Cochrane Review involving various interventions(6) and the other two focusing on specific interventions.(19,20)

Suijkerbuijk (2017) present evidence on **various types of interventions** in the topic of **maintaining people in paid, competitive employment**.(6) Suijkerbuijk (2017) suggested that people receiving supported employment worked more weeks than those receiving transitional employment (MD 17.36, 95% CI 11.53 to 23.18) or prevocational training (MD 11.56, 95% CI 5.99 to 17.13). Those using augmented supported employment worked longer than those in supported employment (MD 10.09, 95% CI 0.32 to 19.85) and prevocational training (MD 22.79, 95% CI 15.96 to 29.62).

Zafar (2019) focused on use of **work accommodation interventions** for helping people with mental illness mitigate workplace limitations and maintain their employment.(20) They included 15 studies, and most of them suggested that work accommodations improved length of job tenure. However the evidence is uncertain as none of the included studies used an experimental design.

For **prevocational training programmes** for obtaining and maintaining employments, Chan (2015) reports a systematic review of nine trials (n = 740) published between 2005 and 2014, most of the nine trials had methodological limitations.(19) People receiving computer-assisted cognitive remediation showed 20% higher employment rate (95% CI 5% to 35%; n = 550), worked 19.5 days longer in a year (95% CI 2.5 to 36.6 days; n = 475), and earned US$959 more in total annual earnings (95% CI US$285 to US$1634) than those not receiving the treatment. The evidence however has some uncertainties due to methodological limitations identified, and inconsistency between studies included in analyses of the three outcomes.

- Vocational rehabilitation interventions for helping employees **return to work**

Five reviews report evidence on interventions that aimed to help employed people to return to work including: one involving various intervention types,(21) and four focusing on specific interventions.(22-25)

Munoz-Murillo (2018) is a systematic review of RCTs and non-RCTs and aimed to assess the effectiveness of **various interventions** used in the professional (re)integration of people with mental disorders in European countries. (21) Of the 18 included studies, 11 focused on return-to-work interventions. Munoz-Murillo (2018) suggested the effectiveness of return to work interventions remains unclear as the 11 studies showed inconsistent results.

van Vilsteren (2015) is a Cochrane Review focusing on **workplace interventions** that aimed to help employees return to work from sick leave due to various types of health conditions including mental illness.(25) This review defined workplace interventions as those focusing on changes in the workplace or equipment, work design and organisation (including working relationships), working conditions or work environment, and occupational (case) management with active stakeholder involvement of (at least) the worker and the employer. The evidence is very low certainty because of issues with study quality and small sample sizes, and the authors were unsure of the true effects of the interventions. Although there were statistically significant benefits of workplace interventions in the studies of employees with mental illness compared with usual care for the outcome of first return to work (HR 2.64, 95% CI 1.41 to 4.95) significant difference was not found for lasting return

to work (HR 0.79, 95% CI 0.54 to 1.17) or cumulative duration of sickness absence within 12 months (MD -8.42 days, 95% CI -35.99 to 19.16).

Two reviews focused on use of **prevocational training programmes** for helping return to work.(22,23) Doki (2015) included ten RCTs (n = 1554) that compared **problem-solving treatment or cognitive behavioural therapy** with control groups in employees with sick leave due to mental illness.(23) Its data analysis suggested that interventions may have significantly fewer total sick leave days than the control group (mean difference −6.64 days, 95 % CI −12.68 to −0.59; low certainty evidence).

Dewa (2015) focused on return-to-work intervention that had work-focused **problem-solving skills** components.(22) They included six RCTs investigating eligible interventions for employees with medically certified sickness absences due to mental disorders, of which two were rated as high quality, two as moderate quality and two as low quality. Dewa (2015) reported variations of effects in return-to-work rates among the studies and concluded that there is limited evidence that interventions with work-related problem-solving skills are effective in return-to-work outcomes.

MacEachen (2020) focused on the impacts of involving **return-to-work coordinators** when dealing with people with common mental illness on the outcomes of return to work.(24) This review suggested that return to work interventions involving a coordinator may result in delayed time to return to work compared with control groups, and may not increase return to work rate or worker's self-efficacy for return to work. The evidence is limited and uncertain as the evidence is from only four quantitative studies including only one small RCT.

***Schizophrenia*.**

Four systematic reviews summarised evidence on vocational rehabilitation interventions for helping people with schizophrenia to obtain and maintain employment including: three involving various intervention types(26-28), and the fourth focusing on a specific intervention (29).

Of the three reviews including various interventions, we focus on the latest review in this RES. Abidin (2021) included 24 RCTs that used five types of programmes of supported employment, integrated supported employment, vocational rehabilitation, cognitive intervention and virtual reality-based vocational training.(26) Included studies largely suggested that integrated supported employment was the most effective for helping obtain and maintain employment (in terms of employment rates, job tenures and the length of working). However, evidence on non-vocational outcomes (psychological outcomes and self-esteem) is mixed and unclear. Nine of the 24 included RCTs had methodological limitations.

One systematic review focused on use of augmented individual placement and support for helping people with schizophrenia to obtain competitive employment(29). The review included 12 RCTs but found no clear difference between augmented and standard individual placement and support in obtaining competitive employment (RR 1.37, 95% CI 0.97 to 1.95). The evidence has some uncertainties as at least five of the 12 trials had substantive methodological limitations.

***Common mental disorders such as depression, anxiety*.**

Six systematic reviews summarised evidence on vocational rehabilitation interventions for helping people with common mental disorders such as depression, anxiety to return to work, of which four reviews, including a Cochrane review, included various interventions (30-33), and two focused on specific intervention types(34,35).

We focus on the Cochrane Review in this RES as it is the most recent and included the largest number of RCTs and the widest range of intervention types.(32) It suggests that, compared with other interventions, a combination of a work-directed intervention and a clinical intervention probably shortens the length of sickness absence in days (moderate-certainty evidence), but the combined intervention does not result in more people being at work after one year or longer follow-up (high-certainty evidence). The combined intervention may improve depressive symptoms (low-certainty evidence) and probably slightly increases work functioning within one year (moderate-certainty evidence). Specific work-directed interventions may not be more effective than usual work-directed care alone in terms of reducing sickness absence, reducing risks of being off work, improving depressive symptoms, and improving work functioning (low-certainty evidence). Psychological interventions may reduce the number of sickness absence days compared with usual care (low-certainty evidence). Interventions to improve clinical care probably lead to lower sickness absence and lower levels of depression than usual care (moderate-certainty evidence).

Salomonsson (2018) is a systematic review of 45 RCTs that evaluated the effects of **psychological treatments** on reducing sick leave and psychological symptoms for people with common mental disorders (CMDs; i.e. depression, anxiety, stress or insomnia) or non-patients with symptoms of CMDs and at risk for sick leave (35). The data analyses presented showed a small but significant effect on both sick leave and symptoms in people using **psychological treatments** compared with those using usual care. The evidence may have some uncertainties as 76% of the included studies were judged as having some methodological limitations.

Joyce (2016) presents evidence on **workplace interventions** that aimed to rehabilitate employees with depression, anxiety or both (34). Interventions with a specific focus on work, such as exposure therapy and CBT-based and problem-focused return-to-work programmes, probably improve symptomology and improve occupational outcomes (moderate-certainty evidence) compared with others.

***Adjustment disorders*.**

Arends (2012) reports a Cochrane Review that included nine RCTs (n = 1546) evaluating the effectiveness of ten psychological interventions and one combined intervention in facilitating return to work of employees with adjustment disorders compared to no or other treatments (36). Arends (2012) found that CBT did not significantly reduce time until partial return to work (moderate-certainty evidence) or time to full return to work (low-certainty evidence) compared with no treatment. Problem solving interventions significantly enhanced partial return to work at one-year follow-up compared with non-guideline based care but did not significantly enhance time to full return to work at one-year follow-up (moderate-certainty evidence).

***Post-traumatic stress disorder*.**

Two systematic reviews summarise evidence on interventions for helping return to work in employees with post-traumatic stress disorder.(37,38) We focus on the latest review in this RES (38).

The review included 15 studies and suggested that psychotherapy interventions are beneficial for helping people recover from post-traumatic stress disorder symptoms and return to work. In studies that reported on work status, return to work rates increased over time and were generally between 58% and 80% across follow-up time points. However the evidence has uncertainties as most of the included studies (13/15; 87%) were non-RCTs, thus having methodological limitations in evaluating interventional effectiveness.

3.2.2 The cost effectiveness of using interventions

Six systematic reviews present cost effectiveness evidence by different types of vocational rehabilitation interventions (39-44).

Two reviews focused on **supported employment interventions**.(43,44) We focus on Park (2022) in this RES as Zheng (2022) targeted severe mental illness,(44) Park (2022) covered a wider range of mental disorders,(43) and both reviews report consistent evidence. Park (2022) included 54 economic studies, mostly from high-income countries (31% in the UK). This suggests the evidence may be generally applicable to the UK context. Overall, Park suggested a strong economic case for the implementation of individual placement and support/ supported employment programmes, including individual placement and support interventions that was augmented with cognitive remediation and cognitive behavioural therapy.

de Oliveira (2020) reports a systematic review of economic analysis studies that included **workplace interventions targeting mental health and substance use disorders in the workplace**.(39) de Oliveira (2020) included 56 studies, largely cost-benefit analysis, with most interventions targeting multiple mental health disorders, depression, or smoking. We focus on mental health evidence in this RES. de Oliveira found moderate-certainty cost-effectiveness evidence favouring the use of cognitive behavioural therapy and workplace interventions including care management to treat depression in workers. There is also high certainty evidence that regular and active involvement of occupational health professionals is cost-saving and cost-effective in reducing sick leave related to mental health and in encouraging return to work.

Three reviews focused on return-to-work interventions for mental illness related sickness absences (40-42), and we present the review with comprehensive evidence for the widest range of interventions. Gaillard (2020) reviewed 11 economic studies of interventions targeting to improve employees' mental health, prevent common mental disorders or promote return-to-work after an absence due to mental illness.(41) Of the 11 studies, nine evaluated interventions aiming at reducing time to return to work or at preventing recurrent sickness absence after return to work. Gaillard suggested there was moderate-certainty evidence of positive economic results for return to work

interventions from the employer's and societal perspectives. All of the 11 studies were from high-income countries, with eight from Netherlands but none from UK.

3.3 Evidence on people's experience and barriers or facilitators (Q2)

Six systematic reviews report evidence on the experience of those living with mental health conditions in coping with remaining in or returning to employment, and evidence on the related barriers or facilitators (45-50).

3.3.1 Experience in coping with remaining in or returning to employment.

Fossey (2010) reports a qualitative meta-synthesis of 20 studies on the experiences and views of people with mental illness in finding and keeping employment in integrated workplaces.(46) Four themes were identified: (1) employment has varied meanings, benefits, and drawbacks to weigh up; (2) strategies for maintaining employment and mental health are important and both require ongoing, active self-management; (3) diverse supports within and beyond the workplace are helpful; and (4) systemic issues add to the employment barriers.

3.3.2 Barriers or facilitators to multiple aspects of employment and work.

Barriers and facilitators to obtaining and maintaining employment. Kinn (2014) conducted a meta-synthesis of 16 qualitative studies (602 participants) and explored how people with psychiatric disabilities experienced facilitators of and barriers to participation in paid work in transitional, supported, and open employment settings (47). Kinn (2014) identified five facilitators and barriers to obtaining employment: fighting inertia (the longer they remained out of the work, the more difficult it became to return to it); taking control (including being aware of their own blind spots and triggers and making positive life-style changes); encouraging peers; disruptions related to the illness; lack of opportunities and supports. There are also five facilitators and barriers to maintaining in employment: going mainstream (paid work identified as a source of motivation, building daily routines, increasing autonomy, financial rewards, a passage to mainstream life, and as a way to establish normal behaviour); social cohesion (e.g. shaping a new identity or relationship in work community); clarity in role and responsibilities; environmental factors; managing self-disclosure. Kinn concluded that, to obtain and maintain employment, people with psychiatric disabilities may need to find and maintain their balance in new situations through a combination of learning new skills and competencies while receiving assistance from supporters.

Barriers and facilitators to returning to work. Andersen (2012) synthesised eight qualitative studies of medium or high quality, using meta-ethnographic methods, to explore which facilitators and barriers employees with common mental disorders experience in returning to work and how they perceived the process of returning to work (45). When returning to work, employees with common mental disorders experienced barriers and facilitators related to their own personality, social support at the workplace, and the social and rehabilitation systems. Employees found it difficult to decide when they were ready to resume work. After return to work, they experienced difficulties of implementing planned return to work solutions at the workplace due to individual factors such as

perfectionism, a high sense of responsibility, and low self-efficacy and work-related factors such as lack of social support and organisational structures complicating the implementation of work accommodations and gradual return to work.

Barriers and facilitators to work participation including stay at work and work performance.
Thisted (2020) reports an integrative review including 12 quantitative studies, three qualitative studies and two mixed methods studies, all being considered to be of acceptable methodological quality by the review authors (49). Thisted aimed to synthesise evidence on barriers and facilitators to work participation in employees with depression from the perspectives of employees, co-workers and employers. Six themes identified are: (1) sufficient treatment from health professionals promotes work participation, (2) open-mindedness and support at work promote work participation, (3) inadequate collaboration between rehabilitation stakeholders hinders work participation, (4) depression severity and reactions to symptoms influence work participation, (5) to stay at work, go on sick leave or return to work is influenced by personal characteristics and (6) occupational factors including job tasks and demands influence work participation.

van Hees (2021) is a realist review and aimed to understand mechanisms and contextual factors that can promote work participation in people with common mental health problems (50). Relevant themes identified include: (1) organisational climate and leadership, (2) social support, (3) perceived job characteristics, (4) coping styles, (5) health symptoms and severity, (6) personal characteristics, and (7) features of interventions.

3.3.3 Experience in using employment supporting interventions

Focusing on an Australian context, Mallick (2022) reviewed both quantitative and qualitative studies (n = 12) and presented evidence on barriers to the implementation of individual placement and support programmes in adults with serious persistent mental illness (48). Key barriers to individual placement and support use include: a lack of understanding, education, and training on the intervention implementation for mental health staff and disability employment services providers; strict implementation guidelines that are difficult to adhere to; difficulty with achieving intervention fidelity, thus impacting the financial viability of the intervention; and vocational rehabilitation not being acknowledged as a high priority and an integral part of an individual's recovery journey.

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