AN EVALUATION OF HARINGEY CO-LOCATED WELFARE ADVICE SERVICES IN GENERAL PRACTICE SETTINGS

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An evaluation of Haringey co-located welfare advice services in general practice settings

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EXECUTIVE SUMMARY

OVERVIEW

This report documents the summative evaluation of Haringey co-located welfare advice services in healthcare settings, the ‘health hubs’. The evaluation used a mixed methods approach and was carried out between December 2015 and December 2016. To our knowledge this is the first methodologically robust controlled study of co-located welfare advice services in healthcare settings in the UK.

The evaluation assessed the impact of receiving advice on mental health and well-being, financial strain and help-seeking behaviours. It also furthers our understanding of how co-located advice services can support general practice work. Conclusions and recommendations from the evaluation pertain to service model delivery changes which are proposed will increase the effectiveness of service provision to meet desired outcomes.

BACKGROUND

Reciprocal links between social deprivation, mental and physical health are well documented (1). Those experiencing poor mental health are more likely to suffer social stressors such as indebtedness, unstable housing and difficulties in navigating the welfare benefit system. They are also more likely to have difficulties accessing support and advice for these and other welfare issues (2-5). The relationship between low income, unemployment and psychological distress may be partly mediated by exposure to stressors associated with living on low and unstable income, such as perceived financial strain. Financial strain has been found to predict both onset and duration of common mental disorders (6, 7); and, to predict future chronic physical illness (8, 9).

Austerity and welfare reform has led to cuts to a range of support services in the UK. Such changes are likely to exert additional strain on GPs, particularly those in deprived areas, and to exacerbate health inequalities among patients (10, 11). General Practitioners (GPs) are involved with a variety of social issues independent of direct clinical work (12).

Patient demand for such ‘non-health’ work has been identified as a contributing factor to increased general practice pressures (13-15). Individuals and practices in deprived areas are likely to face the greatest pressures linked to austerity and welfare reform, and to lack resources to cope (10).

In the context of ongoing welfare reforms, from 2013 Haringey Council piloted co-located welfare advice services in five healthcare settings in more deprived areas of the borough. Services ran weekly at the Laurels Healthy Living Centre, Tynemouth Road Medical Practice, Bounds Green Group Practice, Queenswood Medical Practice, and Broadwater Farm Health Centre.

The aims of the service were: to reduce symptoms of anxiety, depression and stress associated with adverse social circumstances; increase income; and increase the accessibility of advice. Aims for practices included: reduced GP consultations for social welfare/legal issues or for anxiety and stress linked to such issues; reduced practice time pressures (GPs and other practice staff); and, enhanced staff confidence in raising and addressing patient welfare issues.
STUDY DESIGN

The evaluation was carried out in collaboration with Haringey Citizens Advice (CA), and with the support of several local community-based organisations.

Qualitative interviews with 24 general practitioners (GPs), practice managers, reception staff and Citizens Advisers were conducted. Data were analysed using thematic analysis with a modified realist evaluation theoretical framework (16-18). Analyses aimed to develop a ‘programme theory’ linking co-located welfare advice activities to practice outcomes.

We identified key underlying mechanisms through which co-located welfare advice services could reduce strain on General Practice work. We also examined important influences on whether or not these mechanisms could impact upon General Practice outcomes. These include the actions stakeholders take (or do not take) in response to service provision, the way in which services are delivered, and pre-existing local and national contextual factors which promote the GP as the ‘go-to-location’.

The quantitative study included 278 individuals accessing the service across all sites between December 2015 and July 2016, and again 3 months later (the ‘advice group’). A comparison group (n=633) was recruited via 9 GP practices in Haringey and Camden without co-located services, via Homes for Haringey, and community sampling. The comparison group was propensity score weighted to adjust for measured differences between the two groups.

We compared changes in mental health (symptoms of common mental disorders, measured by the 12-item General Health Questionnaire (GHQ-12)) (19); well-being (measured with the Shortened Warwick and Edinburgh Mental Health Scale (SWEMWBS)) (20), and 3-month GP consultation frequency between the two groups. We also compared changes in financial strain; help-seeking for financial problems and for the health impact of such problems; and, self-reported improvements in social circumstances since receiving advice.

Lastly, we compared the costs of funding the service to the financial gains incurred by individuals receiving advice.

RESULTS

Qualitative findings

Supporting practices

Our findings suggest that the potential for co-located advice services to improve practice outcomes is under-recognised. This includes supporting general practice work, reducing practice pressures, and producing better outcomes for patients navigating the health-related welfare system.

Individuals access GP services for direct support (e.g., appointments for help navigating an aspect of the welfare system); and, indirect support (e.g., where ill health is triggered, maintained or exacerbated by underlying social situation(s)).

Appointments for direct support were perceived to increase waiting times and reduce capacity to support patients with medical needs. Supporting patients whose mental and/or physical health was affecting or affected by their social situation was perceived as an important part of their role, however, there was often frustration at their
inability to support patients with some of the ‘wider determinants’ of health.

Interviewees felt that the GP was perceived by patients and external agencies as the ‘go-to-location’. Factors promoting the view of the GP as ‘go-to-location’ included local area characteristics such as housing deprivation, language barriers and social isolation. Wider structural factors included the role of GP as coordinator and gateway to a range of social support services; and, cuts to other community services available as an alternative to patients.

We identified key barriers and enablers to these outcomes. Factors influencing service awareness were key facilitators and are amenable to change; they encouraged collaborative working, signposting, and change in patient help-seeking behaviour. Service promotion was associated with improved service awareness through proactive engagement, communication, regular reminders and feedback between advice staff, practice managers and funders. Other important facilitators were not limiting access to GP referral; offering booked appointments and advice on a broader range of issues responsive to local need. Key barriers included pre-existing socio-cultural and organisational rules and norms largely outside of the control of service implementers, which maintained perceptions of the GP as the ‘go-to-location’.

Quantitative findings

Who uses the service?

The welfare advice group were defined by very low incomes, being predominantly female and Black and Ethnic Minority (BAME), low educational attainment, and being outside of the labour force (mainly for long-term sickness/disability). Nearly three-quarters reported a long-term health condition, illness or disability – of which a third reported a long term mental health condition. Compared to individuals accessing all other Haringey Citizens Advice services, those accessing the health hubs were older and twice as likely to have a long term health condition.

Advice group participants were frequent attenders at their GP practice. The mean number of consultations reported in the past year was 13.1 (compared to 8.6 among controls).

Is co-location important?

In the light of two recent UK GP surveys, in which (particularly inner city) GPs reported patient health, GP workload and practice staff time demands had been adversely affected by greater patient financial hardship and changes to welfare provision; our findings suggest that the reductions in financial strain could reduce practice burden.

Our findings also suggested that co-location in health settings can target individuals less able to self-manage and/or more likely to turn to their GP for support. Specifically, nearly half of advice service users reported that had the service not been at the GP practice they would have gone to their GP for advice or would have not had sought advice at all. The vast majority of service users indicated a preference to access advice at their GP practice, most commonly for reasons linked to physical and psychological accessibility. Additionally, a large proportion had already spoken to their GP about the issue they were seeing the adviser about, most commonly
because it had been affecting their mental health or was otherwise health-related.

Impact of advice

Health hubs users reported that their financial circumstances were adversely affecting their wellbeing – nearly 70% identifying ‘problems sleeping’ and ‘stress’, just under half reporting ‘loss of confidence’ and ‘worsened physical health’, and a quarter reporting an impact on their ‘mental health’. At follow-up, the majority of advice group participants reported improvements in social circumstances and well-being as a result of receiving advice. Most commonly this included ‘reduced stress’, ‘increased income’, ‘improved housing circumstances’ and ‘increased confidence’.

Box 1 The impact of advice - key quantitative findings.

- The majority of advice group members reported improvements in circumstances as a result of receiving advice, particularly in stress, income, housing circumstances and confidence.

- There was an improvement in mental health (measured by GHQ-12) over time in both the advice and comparison groups. This improvement was greater among those receiving advice - there was a positive impact of receiving advice on mental health.
  - Overall there was a 43% bigger improvement among advice recipients than comparison group members though this was not statistically significant.
  - The impact of welfare advice on mental health was most pronounced, and statistically significant, among those experiencing a positive outcome of advice, females, and Black/Black British participants (55%, 63% and 91% bigger improvements respectively).

- There was a positive impact of advice on well-being among those who experienced a positive outcome from their advice session(s).
  - There was increase over time in well-being scores (measured by SWEMWBS) that was on average 1.29 points greater among the advice group relative to the comparison group.

- There was a reduction in the proportion of individuals reporting their financial situation as ‘difficult/very difficult’ over time among advice recipients, but not among comparison group members – there was a positive impact of advice on financial strain.
  - The reduction in financial strain was 58% bigger for advice group than comparison group members overall, 67% bigger among female advice recipients, and 70% among advice recipients with long-term conditions). These were all significant differences.

- There was no impact of advice on three-month consultation frequency.

- There was a positive impact of advice on reported use of credit card/overdraft if income did not cover costs.

- Advice group members became more likely to report not knowing where to seek advice for financial problems over time (relative to controls), comparison group members became more likely to report asking their GP for support (relative to advice group members).

- Advice group members received £15 per £1 invested by funders. This excludes non-directly financial gains.
**Controlled comparisons**

The proportion of individuals meeting criteria for a level of mental ill health that warrants further treatment (defined by a GHQ-12 score of 4 or more) declined in both the advice group and the comparison groups over time (representing an improvement in mental health). This was more pronounced among those receiving advice - there was a positive impact of receiving advice on mental health.

The improvement in mental health over time was 43% bigger in the advice group than in the comparison group overall. Among those who experienced a positive outcome of advice, the improvement was 55% greater; among females the improvement was 63% greater; and, among Black/Black British participants, the improvement was 91% greater among advice group members relative to that seen for controls. This difference reached statistical significance for females and Black/Black British participants.

Relative to controls, positive well-being scores improved significantly among advice recipients who were recorded with, or who self-reported improvements in housing, employment or income since receiving advice. In this group, there was increase over time in well-being scores (measured by SWEMWBS) that was on average 1.29 points greater among the advice group relative to the comparison group.

The strongest finding was for a significantly greater reduction in perceived financial strain among advice recipients relative to controls.

Further, our findings supported our hypothesis that any link between advice and improved mental health may be partly mediated by changes in financial strain for some individuals. Advice services needing to feedback to funders may consider monitoring changes in financial strain or perceived stress as more feasible and acceptable measures to collect on a routine basis from clients.

There was no evidence for any change in consultation frequency over the follow-up period. This was assessed for the three months prior and three months after seeking advice so findings should be taken with caution. Longer term follow-up for a subgroup of the advice and comparison groups is planned one year after the last person was recruited into the study (July 2017).

There was a significant reduction in the proportion of advice recipients reporting that they would use their credit card or overdraft if their income did not cover their costs, compared to controls.

Advice recipients were also less likely than controls to turn to their GP with the health impact of financial strains over time. However, there was also an increase in the proportion of recipients who reported not knowing where to turn to for support with financial issues over time. These findings may reflect concurrent changes in the way advice services were delivered in the area, with closures to high street services.

**Financial outcomes**

Between December 2015 and July 2016, £793,135 additional income was gained in total over all individuals who accessed the co-located advice service (averaging £2689 per capita). This compares to £1,805,706 for all other Citizens Advice clients during the study period (n=7760), corresponding to £232 per capita. Overall, 48% of enquiries at the health hubs result in a financial outcome, compared to 24% of enquiries at the wider CA projects. This is due to the broader range of advice issues covered at other CA projects, which
may not be directly financial-related (e.g., housing issues).

Cost effectiveness

Dividing income gain by cost of the service to funders over the eight month study recruitment period, translates to £15 income gain per £1 funder contribution. This excluded non-monetised benefits, e.g., from improvements in mental health, well-being and stress, thus underestimates the returns associated with co-located welfare advice services.

CONCLUSIONS

Co-locating welfare advice services in GP settings is an opportunity to support patients, particularly those living in deprived areas, at a location that they would normatively go to, to seek help. Co-located welfare advice can improve short term mental health, reduce financial strain and generate considerable returns for recipients. This is no small feat, given the extent of multiple-disadvantage experienced by those receiving advice. Further, the service delivers considerable returns, with £15 gained per individual for every £1 contributed by the Clinical Commissioning Group (CCG) during the study period. This is an underestimate and excludes social returns for advice clients.

It is likely that through Citizens Advice the impact of acutely stressful experiences are ameliorated – such as being faced with a cut in benefits, increase in costs, losing ones’ home or not being rehoused. However, it is also likely that many individuals continue to be at risk of further future acutely stressful experiences; e.g., uncertainty around changes to benefits entitlement and eligibility.

RECOMMENDATIONS

1. Target co-located advice services to support those who would benefit most and who would be most likely to turn to their GP for support with ‘non-health’ issues.

2. Proactively develop and maintain communication channels between practice managers, funders and advice staff to promote service awareness among staff. This includes opportunities for regular feedback, training/education, and frequent service reminders.

3. Integrate co-located advice services, ‘health hubs’ into practice teams; encourage mutual trust and respect of the skills offered by Citizens Advisers.

4. Increase the range of advice issues offered and be flexible to local need.

5. Promote co-located Citizens Advice services as an alternative patient pathway for direct support with health-related aspects of the welfare system.

6. Dedicate resources to encourage changes in help-seeking behaviours.
7. Formalise clear referral routes from frontline practice staff to appropriate Citizens Advice services.

8. Dedicate a proportion of health hubs sessions to booked appointments.

9. Adopt an approach to measuring the outcomes of welfare advice which is feasible and acceptable for advice services to routinely monitor, and which are proxy measures for improved mental health and well-being (e.g., perceived stress, financial strain).

INTRODUCTION

Individuals living in poor mental and physical health, those who are socially excluded and/or those living on a low income are at greater risk of social welfare problems; e.g., difficulties navigating access to the welfare benefit system; long-term indebtedness (3-5); and, adverse housing circumstances (2). They are also more likely to have difficulty accessing support and advice for such issues (21, 22).

Citizens Advice and other advice agencies have been providing outreach services in General Practice (GP) and other healthcare settings to increase accessibility. A 2008 review identified that welfare advice services provided within NHS healthcare settings were widespread in the UK - in 889 GP practices – though there had been an estimated 33% decline in GP linked services since 2005 due to unstable funding (23).

The potential benefit of such initiatives for both patients and practices have long been proposed, “General practitioners and community nurses are exceptionally well placed to detect those who are suffering genuine financial hardship but they are not well equipped to give advice about the complex system of state social security benefits. Imparting such advice in suitable cases, particularly where the lack of it is detrimental to health, might be regarded as a proper function of general practitioner and health centres” (24) (p.522).

General Practitioners (GPs) are involved with a variety of social issues independent of direct clinical work (12). Patient demand for such ‘non-health’ work has been identified as a contributing factor to increased general practice pressures (13-15).

Austerity and welfare reform has led to cuts to a range of support services in the UK. Such changes are likely to exert additional strain on GPs, particularly those in deprived areas, and to exacerbate health inequalities among patients (10, 11). Individuals and practices in deprived areas are likely to face the greatest pressures linked to austerity and welfare reform, and to lack resources to cope (10).

In 2014, two separate UK GP surveys found that the majority of GPs (particularly inner city) reported that patient health, GP workload and practice staff time demands had
all been adversely affected by greater patient financial hardship and changes to welfare provision (14, 15). These were reported to contribute to decreased time available for other patients’ health needs, as well as increased job stress and practice costs (25).

The rationale underlying co-located welfare advice in general practice (GP) settings is therefore threefold. First, there is a bidirectional link between health and adverse social circumstances. Those in poor health are more likely to experience worsening social situations (e.g. linked to employment, income and social relationships). In turn, such adversity precedes the onset of, and can both maintain and exacerbate existing poor health (1).

The second is location-based; individuals accessing their GP are often those who would benefit from welfare advice but do not/cannot access such advice. Prior research suggests that advice services located in GP practices are more accessible physically and psychologically for people experiencing health problems (21, 26-28).

Third, for various reasons patients often turn to GP staff for support with social welfare/legal needs, who are neither equipped nor able to support patients with such needs due to expertise and time constraints (14, 15, 24, 25).

The aims of co-locating welfare advice workers in general practice include both ‘patient outcomes’ and ‘practice outcomes’. Patient outcomes include reduction in symptoms of anxiety, depression and stress associated with adverse social circumstances; increased income; and increasing accessibility of advice. Practice outcomes include reduced GP consultations for social welfare/legal issues or for anxiety and stress linked to such issues; reduced practice time (GPs and other practice staff) pressures; and, enhanced staff confidence in raising and addressing patient welfare issues.

**EXISTING RESEARCH**

**PATIENT OUTCOMES**

Evaluations of the impact of these services have focused mainly on patient outcomes (29, 30) Previous work, including a formative evaluation of the Haringey service (31), has indicated that co-location increases access for those otherwise potentially unable or unwilling to seek advice (such as older and disabled people) and reduces stigma associated with advice receipt (26, 32-34).

Co-located GP welfare advice services in the UK have been found to effective in increasing income and managing debts for those seeking advice, with one-off and ongoing financial gains ranging from over £1000 to over £3000 additional income per client; exceeding the costs of funding the service (23, 30, 31, 34).
The outcomes of advice are inconsistently reported, with missing data for many clients who are not able to be followed up by the advice service and for those whose outcomes were still pending at the time of the evaluation. Research exploring the impact of additional income has suggested that it tends to be spent on fuel, food, education, transport and recreation; and, that clients benefitted from increased social participation and better living standards (33, 35).

There is some evidence that co-located advice services improve mental well-being, but little or no evidence for improvements to physical health, which may be linked to limited follow-up periods (30, 35).

Qualitative studies generally report positive perceptions of improvements for client mental health and well-being, increased ability to manage finances, personal control, improved self-confidence and a reduction in anxiety and stress, improved social participation and improved family relationships (21, 26, 30, 32).

However, existing quantitative research has methodological limitations (30). Such studies have included small sample sizes, without a robust control or comparison group, and suffered from considerable attrition. This is due to difficulties in identifying and contacting a comparison group; difficulties in following up individuals who may lead chaotic lives and be hesitant to respond to contact attempts from unknown numbers; and, limited power of studies evaluating a small number of services.

Further, research which explores the underlying pathways linking advice and health outcomes is lacking (29, 36).

**PRACTICE OUTCOMES**

Qualitative studies reporting practice outcomes have identified a perceived reduction in practice staff workload, reduced time spent dealing with non-health issues (26, 27, 32, 37), and increased awareness about entitlements and sources of support among practice staff (26, 32, 38).

There is also weak quantitative evidence for a decline in consultation frequency following advice (38-41). Kraska et al. (38) attempted to quantify changes to health service use using data from the medical records of 148/250 patients referred to advisors within the study period six months prior to receiving advice and the following six months). The findings revealed statistically significant declines in GP appointments (though no significant difference in mental health related appointments), a 22% reduction in antidepressant prescription and a 42% reduction in hypnotic/anxiolytic prescriptions, which was statistically significant.

However, as with studies examining patient outcomes this study suffered from similar methodological limitations as described above including small sample sizes and a lack of robust control or comparison group (30).

**PROCESS**

The implementation of co-located welfare advice services differs across different projects in the UK. Derbyshire, Wales and Liverpool have particularly well developed systems of CA provision in GP practices, with services having been rolled out across the county of Derbyshire in almost all GP
practices, in practices covering all local authority areas in Wales, and more recently, in all of the 95 GP practices across Liverpool.

While services differ in the range of advice issues covered, the majority of issues dealt with by advice workers in GP surgeries are linked to health-related welfare benefits and to a lesser extent debt (34, 42). In general, referral to co-located advice could be from any general practice staff member, staff from another relevant agency, by self-referral or via a combination of these. Some services operate more formal eligibility criteria and referral processes. The service may be open to all patients registered at the host practice or those participating in the project; or, there may be screening to restrict eligibility such as to those with particular health conditions or of a certain age (34).

Previous evaluations provide limited process information on the nature of the service offered and on the characteristics of individuals receiving advice. Evaluations must be explicit about the aspect of the intervention they hypothesise to have an effect and who is most likely to benefit from services (43, 44). Another limitation of prior evaluations is lack of theoretical underpinning. Explicit assumptions about the nature of the problems targeted by co-located advice (“problem-theory”) and how the service might produce desired outcomes (“programme theory”) have not been made.

Moreover, there is no evidence available for providers of similar services to understand how benefits might occur or be promoted through co-location, or of which organisational, resource and activity factors influence outcomes. Understanding these issues could support stakeholders to improving existing, or develop future similar interventions (29, 45).

Lastly, prior evaluations of co-located welfare advice services took place before current and recent changes in the financial and welfare policy context. There is therefore a need to examine the implementation and effectiveness of such services today, and whether current models of service delivery are efficacious.

**NATIONAL AND LOCAL CONTEXT**

Any impact of welfare advice provision must take into consideration economic austerity measures and welfare reform in the wider context. The impact of such changes are expected to increase health inequalities overall, particularly in London (11).

Any financial gains associated with receiving co-located welfare advice may be balanced against health damaging effects of reductions in welfare spending overall and in the wider influences of the economic recession on employment and housing circumstances. While welfare reforms such as the introduction of Universal Credit aim to reduce complexity, many of the other elements of reform are likely to increase barriers to benefits uptake among entitled individuals and households. Recent and current reforms include:

- Transition from Incapacity Benefit to Employment Support Allowance,
entitlement to which will require a work capability assessment;

- Transition to Personal Independence Payment from Disability Living Allowance, involving tougher eligibility criteria and medical reassessments;

- Movement from council tax benefit to local council support which overall reduces financial support available for council tax;

- Introduction of the under-occupancy rules (the ‘bedroom tax’), which decreases housing benefits available to working age tenants who are identified as having a superfluous number of rooms; and,

- The ‘digital by default’ programme, which may reduce uptake among individuals unable to access such resources.

Moreover, increases in housing costs and changes to housing policy such as the move from social housing tenancies to ‘affordable rents’ are likely to compound problems for low income household, particularly in London (2).

Haringey encompasses high levels of deprivation. Although levels of deprivation vary across the borough, it has one of the highest proportion of low paid workers in London and in 2015 it was the 6th most deprived London borough. The influence of welfare reforms and austerity measures may therefore be particularly felt in Haringey, where 22,696 (20%) of Haringey households are affected by the cumulative impact of welfare reform (46).

Those living in the private rental sector, large and lone parent families, single, and in-work households have been disproportionately affected, while future welfare reforms are likely to affect out-of-work families. Moreover, nearly all households lack resources to cope with expected significant falls in income, with little or no savings (46).

Alongside wider implications of economic recession these changes mean that the demand for welfare advice is likely to rise in Haringey.
AIMS AND OBJECTIVES

The evaluation was designed to assess the following main questions relating to the receipt of co-located welfare advice:

Table 1 Primary and secondary evaluation questions

<table>
<thead>
<tr>
<th>Evaluation questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there any impact on:</td>
</tr>
<tr>
<td>➢ Patient mental health and well-being?</td>
</tr>
<tr>
<td>➢ GP consultation frequency?</td>
</tr>
<tr>
<td>➢ Perceived financial strain, confidence in managing financial problems and subjective empowerment?</td>
</tr>
<tr>
<td>➢ Knowledge/awareness of support services and future supporting seeking behaviours?</td>
</tr>
<tr>
<td>➢ How do practice and advice staff perceive the service, are there any barriers and facilitators to implementation?</td>
</tr>
<tr>
<td>➢ What factors are likely to influence the outcome of the primary questions?</td>
</tr>
</tbody>
</table>

METHODS

This study was carried out between December 2015 and December 2016. The evaluation used a quasi-experimental before-and-after design with an embedded qualitative study. To further inform the qualitative findings, data were collected from four practices in Camden which hosts a similar service but with differing implementation practices.

Box 2 Quasi-experimental study design

- Quasi-experimental designs include an intervention and a comparison group but individuals are not randomised into groups.
- Comparison group members are selected to be as similar as possible to those receiving advice (this is further enhanced through statistical approaches to analyses).
- This comparison helps us to understand what changes would have occurred over the study period anyway, without having received advice.
- This gives us confidence about whether changes observed among those receiving advice are likely to be as a result of receiving that advice.
**Service Description**

The characteristics of the co-located welfare advice services in the two localities are compared in Table 2. Co-located services in Haringey provide specialist casework advice on welfare benefits and debt (but will advocate on behalf of and signpost clients to other support services for other issues such as housing), offer a walk-in ‘first-come-first-served’ service and is open to all borough residents. Co-located services in Camden provide casework advice on a broader range of issues (e.g., housing, immigration and employment), offer booked appointments, and are only available to individuals registered with host practices.

**Table 2** Comparison of co-located welfare advice services offered in the two Localities

<table>
<thead>
<tr>
<th></th>
<th>Haringey</th>
<th>Camden</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of locations</strong></td>
<td>5 practices/health centres</td>
<td>12 practices</td>
</tr>
<tr>
<td><strong>Capacity</strong></td>
<td>Weekly sessions, 6 clients per session</td>
<td>Weekly/bi-weekly sessions, 6 clients per session</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>30 minutes/client</td>
<td>30 minutes/client</td>
</tr>
<tr>
<td><strong>Advice issues covered</strong></td>
<td>Specialist welfare benefits and debt including on-going casework</td>
<td>Wide range of issues including welfare benefits and debt, employment and housing (including on-going casework)</td>
</tr>
<tr>
<td><strong>Referral route</strong></td>
<td>GP referral/self-referral but predominantly self-referral</td>
<td>GP-referral/self-referral but predominantly GP-referral</td>
</tr>
<tr>
<td><strong>Access system</strong></td>
<td>Walk-in, first-come-first served</td>
<td>Timed appointments booked with GP reception</td>
</tr>
<tr>
<td><strong>Reach</strong></td>
<td>All borough residents regardless if/where registered with GP</td>
<td>Only patients registered at the host practice</td>
</tr>
</tbody>
</table>
QUALITATIVE STUDY METHODS

The qualitative study aimed to describe how social issues are perceived by primary care staff to contribute to increased practice pressures; develop an initial ‘programme theory’ for how the provision of co-located advice addresses this in relation to specific practice outcomes; and, identify barriers and facilitators to effective implementation.

A programme theory explains how an intervention is thought to contribute to a pathway of changes that produce the actual or desired impacts of the intervention. It also indicates other factors contributing to producing such impacts, such as the local and wider context. The practice outcomes investigated were:

1. Reduction in GP consultations for non-health issues or for anxiety and stress linked to non-health issues.
2. Reduced practice time (GPs and other practice staff) spent dealing with non-health issues.
3. Enhanced practice staff confidence in raising and addressing patient welfare issues.

RECRUITMENT

GPs, practice managers, GP receptionists and advice staff were invited to take part via e-mail/letter and through personal communication during the set up and running of the evaluation. Participation was open to staff from practices offering co-located advice in Haringey and Camden and those in the “comparison” arm of the wider evaluation from locality 1. Individuals were given an information sheet and signed a consent form prior to the interviews.

DATA COLLECTION

Semi-structured qualitative interviews were carried out by two members of the research team in person at a location of interviewee choice or by telephone. The topic guide built on existing literature and a formative evaluation of the Haringey service (31). It covered experiences, attitudes and expectations of the co-located advice service (see appendix p64). Interviews were audio-recorded and transcribed, removing identifiable information.

THEORETICAL FRAMEWORK

The mechanisms brought about by a programme are embedded within, but distinct from, pre-existing social (contextual) mechanisms. Pawson & Tilly (18) conceptualised mechanisms brought about by a programme as a combination of ‘resources’ (e.g., information, skills, support, materials) provided by the activity being evaluated and individuals’ ‘reasoning’ (e.g., attitudes, logic, beliefs) in response. However, it has been argued that the operationalisation of these ideas into the ‘context + mechanism = outcome’ (C+M=O) formula used as a guiding principle for Realist Evaluation is problematic in three main ways, which has led to difficulties in distinguishing context and mechanisms (16, 17, 47).

First, Porter (16) argues that the C+M=O formula moves away from the ‘realist’ idea that context encompasses pre-existing social mechanisms into which programmes are embedded and produces a categorical distinction between ‘context’ and ‘mechanism’. He suggests distinguishing ‘Contextual Mechanisms’ as the pre-existing social mechanisms within which (and as a result of) programmes are designed, from
‘Programme Mechanisms’ - the processes introduced which are designed to counteract the (contextual) status quo.

Second, there is a conflation of ‘resources’ and ‘reasoning’ within the term ‘mechanism’. Dalkin et al. (48) suggest this causes a tendency to emphasise either element while neglecting the other, and argue for a disaggregation of ‘mechanism’ into ‘resources’ and ‘reasoning’ to clarify interpretation. Porter goes further, saying that combining the two into a single term contradicts Pawson and Tilley’s (‘realist’) beliefs about the interdependence (but duality) of structure and agency - leading to an ‘elision of structure and agency’ (p.243). He instead proposes that human agency should be distinguished from the mechanisms brought about by a programme to acknowledge the role of interpretation and behaviour by human agents in bringing about change.

Third, and related, the notion of favourable contextual conditions ‘triggering’ mechanisms in order to produce outcomes is contested as undermining the role of human ‘volition’ (48) or ‘agency’ (16). While Dalkin et al. suggest considering ‘continuums of activation’ (p.5), Porter suggests removing ‘reasoning’ from the umbrella of ‘mechanism’, and explicitly including ‘Agency’ as an evaluation element in its own right. Agency refers to individual interpretations and responses to programme mechanisms. Taken together, Porter argues for a revised formula: Contextual Mechanisms + Programme Mechanisms + Agency = Outcome (p.247).

We use this approach to generate hypotheses about how co-located welfare advice is proposed to lead to outcomes (through which Programme Mechanisms). We explore how both individual responses to these (Agency) and pre-existing conditions (Contextual Mechanisms) influence the capacity for Programme Mechanisms to elicit change. It is hoped that future work may test and refine this initial programme theory in different situations.

DATA ANALYSIS

After familiarisation (listening to recorded interviews, reading and re-reading transcripts), interview transcripts were descriptively coded. Codes were discussed between two researchers and data were input into NVivo10 (49). Data were further coded using thematic analysis and reassessed for relevance to context, agency, programme mechanism and outcome-relevant concepts, providing a framework for further coding and data categorisation. The coding framework and analysis were agreed as consistent with the experiences of a member of the research team and CA volunteer, who supported quantitative data collection at the advice practices.
Table 3 Contextual Mechanisms, Programme Mechanisms, Agency - adapted from Porter (16)

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contextual Mechanism (CM)</strong></td>
<td>• Pre-existing socio-cultural and organisational situation (rules, norms, values and interrelationships) in which the co-located welfare advice service is embedded.</td>
</tr>
</tbody>
</table>
| **Programme Mechanism (PM)** | • Aspects or features of the service that are designed (or likely) to counterbalance the status quo within the prevailing context.  
• Transitive, influenced by social context and amenable to alteration by human action, thus also able to influence the social context they are embedded within.  
• May be latent. |
| **Agency (A)** | • Responses to or behavioural changes as a result of service provision which influence mechanisms and are relevant to the outcomes. |
| **Outcome** | • Consequences of the service being implemented.  
• These may be intended or desired as well as unintended or unanticipated influences of the service. |

QUANTITATIVE STUDY METHODS

RECRUITMENT

Advice group. All individuals aged 18+ years accessing co-located welfare advice services in eight sites during the recruitment period were eligible. Individuals were approached by the researcher after requesting to see an adviser or prior to a booked appointment. Individuals were informed about the study by the research team and given time to ask questions before deciding whether to participate. Those whose English was insufficient to understand the information sheet and consent form were excluded (3.2% of those approached). In line with recommendations from prior reviews of recruitment and retention among ‘hard to reach’ groups, (12, 13) individuals were offered £15 supermarket vouchers per survey.

Sample size

As advice group numbers were limited by available slots per session and duration of study period, we aimed to recruit a larger comparison group to increase the power of analyses. The sample size calculation was based on a: significance level of $\alpha=0.05$ (two tailed); allocation ratio of 1:2 (intervention:control); within GP practice intra-class correlation of 0.10 and a Variance Inflation Factor for adjusting for confounders of 1.33 (assuming a correlation of 0.5); (50, 51) and a retention rate of 75% (based on advice from an experienced contract research company). To detect a moderate effect size ($d$) of 0.4 (based on previous evaluation work in the field (30) with 90% power, we required a sample size of 816 (204:612 intervention: control). This sample size would also be more than sufficient to detect smaller effect sizes ($d=0.35$) with 80% power.

Comparison group. We identified individuals aged 18+ years from which to generate a propensity score weighted comparison group to reduce confounding due to differences between advice recipients and comparison group members linked to their likelihood of accessing co-located advice. The propensity score is an estimate of the probability that a given individual will receive co-located advice.
Calculation of the propensity score summarises a range of variables associated with receiving advice into a single probability value (Box 3). Weighting reduces bias by assigning more weight to comparison group members whose propensity scores were more similar to advice group members.

We contacted potentially eligible participants using three methods to reach similar individuals to those receiving advice. First, we identified nine local GP practices which were located in areas with similar levels of deprivation to host practices (measured by the 2015 Index of Multiple Deprivation (IMD 2015), but which did not host advice services. NHS Primary Care Research Support Service ran Practice list searches which stratified patients by age group, ethnicity and gender. They then randomly selected records within each strata such that those selected were representative of the profile of individuals who used the co-located advice service in the 12 months prior to study data collection (using data from the CA IT platform).

Based on communication with primary care research colleagues, we anticipated a response rate of 10% and therefore identified 500-700 patients from each practice (5419 in total from the nine practices). Practices then securely uploaded these contact details to a secure print and mailing company which posted recruitment packs to the individuals identified.

We expected that those responding to the GP contact attempts may be different to advice group members. Therefore, we also worked with a local housing association to contact tenants similarly based on age group, gender and ethnicity (n=490). Lastly, to further target our sampling and to achieve the required sample size, we worked with community organisations to advertise the study locally, particularly among Black African and Black Caribbean individuals who were under-represented in the GP-based returns (Figure 1). No identifiable data were disclosed to the research team before individuals had provided informed consent.

**DATA COLLECTION**

We piloted the baseline survey with 40 CA clients to check for acceptability and understandability of all items, since we anticipated that English would not be a first language and/or that literacy levels may be low for some participants.

We collected baseline data from advice recipients using self-report questionnaires at the GP practices prior to their advice session and follow up data were collected three months later (see discussion for rationale). Those invited to participate in the comparison group were posted or hand delivered (community sampling) study information and surveys at baseline and follow up.

Recruitment packs included pre-paid return envelopes for the surveys. At baseline, a separate envelope addressed to a different location was provided for consent forms to ensure survey responses were not linked to personal information. Questionnaires took approximately 15 minutes to complete.

Anonymised data were also extracted from the CA IT platform on demographic characteristics for all individuals accessing co-located CA services in the area during the recruitment period to determine whether the study sample was reflective of co-located advice service users overall.

**Survey measures**

Measures included:
• Socio-economic and demographic characteristics;
• Mental health (12-item General Health Questionnaire, GHQ-12) (52) and well-being (Shortened Warwick-Edinburgh Mental Well-being Scale, SWEMWBS) (20);
• Knowledge of advice services and confidence in managing finances;
• Self-report primary care health service use;
• Coping and support seeking behaviours for financial difficulties and advice.

The follow up survey additionally asked about any changes since receiving advice (welfare advice group only); and, whether individuals had accessed any welfare advice services since completing the first survey. See Appendices, p.60 for more information on survey measures.

**DATA ANALYSIS**

Overall, quantitative analyses broadly aimed to:

a) Describe the welfare advice group at baseline, including: socio-demographics, health and wellbeing, consultation frequency, financial strain and help-seeking for health-related financial problems.
b) Compare the characteristics and advice issues of those seen at the health hubs to the wider Haringey Citizens Advice services.
c) Assess the impact of receiving welfare advice at the health hubs by comparing changes in mental health, well-being, financial strain, consultation frequency and help-seeking for health-related financial problems between baseline and follow-up among advice and comparison groups (see Box 3).

**Sub-group analyses**

To assess whether the impact of advice differed by key demographics and advice outcomes, we re-ran analyses for certain subgroups. Propensity scores were generated separately by gender, ethnicity and long-term conditions status. We also evaluated a subgroup of individuals were recorded with, or self-reported, improvements since receiving advice in income, housing or employment.

Further methodological details of the statistical analyses are included in the Appendices (p.61).

<table>
<thead>
<tr>
<th>Box 3 Propensity Score weighting</th>
</tr>
</thead>
</table>
| Since individuals were not randomly assigned to the advice or comparison group, there may be differences in the characteristics of the two groups linked to their likelihood of accessing the colocated advice service. These differences may also influence the outcome of interest, leading to ‘selection bias’.

- Matching each member of the advice group to one or more comparison individuals based on those characteristics linked to whether or not they received advice reduces this bias.

- Rather than matching on each individual characteristic separately, which limits the power of statistical analyses, analyses can be weighted by ‘propensity scores’.

- The **propensity score** is an estimate of the probability that a given individual will be in the advice group. Calculation of the propensity score summarises a range of variables associated with receiving advice into a single probability value.

- Comparison group members are assigned weights according to how similar their propensity scores are to advice group members. |
QUALITATIVE FINDINGS

22 interviews were conducted with 24 participants including practice staff, CA staff and funders from the two localities (Table 4).

Table 4 Characteristics of interview participants

<table>
<thead>
<tr>
<th>Sample characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>42</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>58</td>
</tr>
<tr>
<td><strong>Role</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner (GP)</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Reception staff</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Practice manager</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Advice staff</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Funder</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td><strong>Area</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locality 1</td>
<td>11</td>
<td>46</td>
</tr>
<tr>
<td>Locality 2</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td><strong>Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td>Comparison</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>n/a</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24</td>
<td>100</td>
</tr>
</tbody>
</table>

1 Refers to GPs, practice managers and reception staff only

THE IMPACT OF PATIENT ‘NON-HEALTH’ ISSUES ON GENERAL PRACTICES

The way in which participants described patient ‘non-health’ issues to influence practices is summarised in Table 5. Non-health issues were brought to GP consultations in two ways: for direct support (e.g., appointments for help navigating an aspect of the welfare system); and, indirect support (e.g., where ill health was triggered, maintained or exacerbated by underlying social situation(s)).

GPs and practice managers reported that appointments for direct support increased waiting times and reduced capacity to support patients with medical needs, often considering this outside their clinical role. In contrast they felt that supporting patients whose mental and/or physical health was affecting or affected by their social situation was part of their role. However, there was frustration or dissatisfaction at their inability to support patients with some of the ‘wider determinants’ of health.

Participants across all job roles identified the immediate cause of the problem to be the perception of the GP as the ‘go-to-location’. For indirect support, this perception was because of the inherent link between social circumstances and health. For direct support, it was linked to the GP role as advocate or gateway to social support and to the view of the GP practice as a trusted and familiar support service. Interviewees identified both local factors and the wider structural environment as promoting the view of the GP as ‘go-to-location’.

Local area characteristics included the extent of temporary or social housing in the area - increasing the proportion of patients requiring medical opinion letters; language barriers and social deprivation - reducing the level of confidence to self-manage or seek help elsewhere; and, social isolation due to limited social support networks. Wider structural factors included GP involvement in welfare system decision-making; GP role as coordinator and gateway to social support services; and, cuts to other community services.

The next section describes how (through which Programme Mechanisms) co-located welfare advice services could counteract the status quo described above to influence practice outcomes. Key Contextual Mechanisms, Agency and also implementation factors are described (Table 6 & Figure 1).
Table 5 Summary of how participants perceived patient ‘non-health’ issues to influence practice pressures, and underlying Contextual Mechanisms

<table>
<thead>
<tr>
<th>Non-health issues and practice work</th>
<th>Illustrative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demands on GP consultations and practice staff time linked to non-health issues:</td>
<td></td>
</tr>
<tr>
<td>- <strong>Direct support</strong> (e.g., appointments for help navigating the welfare system)</td>
<td>People come to us with an agenda regarding social issues for example, if they want rehousing [...] or if they want to appeal benefits decisions, they have been told doctors' letters would help them. And then there are also the social issues where people are suffering from stress from work or housing. [51, GP, locality 2, advice group]</td>
</tr>
<tr>
<td>- <strong>Indirect support</strong> (e.g., ill health triggered, maintained or exacerbated by underlying social situation(s))</td>
<td></td>
</tr>
<tr>
<td>Increased waiting times, reduced capacity to support medical needs</td>
<td></td>
</tr>
<tr>
<td>Lack of expertise and time to support wider determinants of health</td>
<td></td>
</tr>
<tr>
<td>Reduced staff job/role satisfaction</td>
<td></td>
</tr>
<tr>
<td><strong>GP perceived as ‘go-to location’</strong></td>
<td></td>
</tr>
<tr>
<td>Patients are using the GP as a way of accessing services outside of what a GP is required to do.</td>
<td>I do get a lot of patients saying that places like Housing Authority and Job Centre's actually do tell them to come back to see the GP to get things like letters. [13, GP, locality 1, comparison group]</td>
</tr>
<tr>
<td>So other than clinical assistance, they do want help with housing for example.</td>
<td></td>
</tr>
<tr>
<td><strong>Local area and population characteristics; e.g., access to housing, social isolation, language barriers, deprivation.</strong></td>
<td>There are lots of issues with the accommodation that patients are in and so a lot of consultations, even if it may not be the first thing that they present with, it is there in the background. [13, GP, locality 1, comparison group]</td>
</tr>
<tr>
<td>Wider structural-welfare related environment; e.g., cuts to local support services, involvement of GP/medical evidence in welfare system, changes to benefits system</td>
<td>They think the GP has more power, give a letter [...] [and] of course the reason they don’t go to CAB because most of the CAB offices are closed anyway. [159]</td>
</tr>
<tr>
<td>[Place] has a big turnover of patients...so patients do feel isolated because they are new to the area and don’t know what’s available to them. So yes they are going to come here because it’s the GP and the GP they assume has the answers to everything. [73, Practice manager, locality 1, advice group]</td>
<td></td>
</tr>
</tbody>
</table>
Figure 1 Illustration of the Programme Mechanisms (PM) through which co-located welfare advice services could influence practice outcomes (O). Key Contextual Mechanisms (CM), Agency (A) and programme implementation characteristics (I) acting as barriers and enablers.
Table 6 Contextual Mechanisms, Agency, and implementation factors influencing Programme Mechanisms and practice outcomes.

<table>
<thead>
<tr>
<th>Outcomes relevant to:</th>
<th>Key Programme Mechanisms</th>
<th>Key Agency factors</th>
<th>BARRIERS</th>
<th>ENABLERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing/diverting consultations away from GPs</td>
<td>Providing an alternative option for patients</td>
<td>Promoting service awareness</td>
<td>- Lack of service reminders and feedback (A)</td>
<td>Proactive engagement by Practice Managers, Citizens Advice and funders (A)</td>
</tr>
<tr>
<td>Reducing time spent on non-health issues</td>
<td>Providing a signposting option for staff</td>
<td>Signposting and service promotion</td>
<td>- High staff turnover (CM)</td>
<td>Regular feedback on activity (A)</td>
</tr>
<tr>
<td></td>
<td>Opportunities for informal/formal interaction</td>
<td>Engaging in collaborative work</td>
<td>- Large practice/numbers of staff (CM)</td>
<td>Regular service reminders (A)</td>
</tr>
<tr>
<td></td>
<td>Relieving bureaucratic pressure</td>
<td></td>
<td>- Physical separation of co-located services (e.g. on a different floor) (CM)</td>
<td>Staff education/training on support offered by advisers (A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Frequent turnover of services/short term commissioning (CM)</td>
<td>Advertising/marketing service within and outside of GP practices (A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Time constraints (CM)</td>
<td>Promotional support from funders (A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Practice staff view of social issues as extraneous to medical role (CM)</td>
<td>Time/duration of co-location (Implementation)</td>
</tr>
<tr>
<td></td>
<td>Providing an alternative option for patients</td>
<td>Patient consultation behaviour</td>
<td>- Complex and interlinked patient social/health issues (CM)</td>
<td>Socially aware GPs/acceptance of biopsychosocial model of health (CM)</td>
</tr>
<tr>
<td>Reducing/diverting consultations away from GPs</td>
<td>Providing a signposting option for staff</td>
<td>Signposting and service promotion</td>
<td>- Practice policy preventing appointment gatekeeping (CM)</td>
<td>Offering advice on a broad range of locally relevant welfare issues (Implementation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Referral by GP only or walk-in service open to any resident (Implementation)</td>
<td>Appointment gatekeeping (CM)</td>
</tr>
<tr>
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<td>- Perceptions of the GP as ‘go-to-location’ (CM)</td>
<td>Appointment booking/option for self-referral/referral by other practice staff (Implementation)</td>
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<td></td>
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<td></td>
<td>- Structural reliance on GP for medical evidence (CM)</td>
<td>Patient communication clarifying support available from GP vs advisers (A)</td>
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<td></td>
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<td>Facilitation of welfare system navigation (A)</td>
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PRACTICE OUTCOME 1: REDUCED GP CONSULTATIONS

A signposting option for staff and an alternative option for patients. Co-located welfare advice services could lead to a reduction in GP consultations directly linked to non-health issues (e.g. housing letters or benefits advice) through two Programme Mechanisms: ‘providing a signposting option for staff’, and ‘providing an alternative option for patients’ (Figure 1). These mechanisms depended on the Agency of both clinicians and practice staff actively signposting to the service; and/or, of patients in changing their consultation behaviour. Such Agency was in turn reliant on adequate service awareness (Figure 1 & Table 6). However, we found such awareness to be limited even within host practices:

I have no clue that exists and I don’t know how, what exactly they do. [159, GP, locality 2, advice group]

I can’t be sure what day is the walk-in, whether they do walk-in or whether it is all appointments. I can’t remember. [61, GP, locality 1, advice group]

Lack of service awareness was therefore a key barrier to a reduction in GP consultations directly linked to ‘non-health’ issues. Factors affecting service awareness are described in more detail below.

Implementation differences between the two localities were also important (Table 6 & Figure 1). For the Programme Mechanisms identified above to affect a reduction in GP consultations, referral by other practice staff and self-referral should be possible. Reception staff suggested that the potential for co-located advice services to immediately influence GP consultations depended on their capacity to gate-keep appointments. If gate-keeping was not possible, any immediate or future reduction in consultations directly linked to non-health issues would be wholly reliant on changes in patient behavior (Figure 1). Policies on enquiring about the appointment reason varied across practices (Contextual Mechanism):

We can just book them an appointment [with the adviser] and know that they’re going get the right advice and it frees up the doctor’s appointment. [60, Reception staff, locality 2, advice group]

Now the doctors are saying they don’t want us to ask the [appointment] reason so they [patients] could go in to the doctor for a completely inappropriate appointment. [37, Reception staff, locality 2, advice group]

In locality 1, individuals more commonly self-referred partly due to less awareness and signposting by practice staff. Further, locality 1 services were open to anyone in the area, often used as an ‘overspill’ from other CA services and therefore were not necessarily being accessed by the target patient group. Nonetheless, advice staff in both localities felt that the opportunity for patients to self-refer enhanced access and could enable the diversion of appointments through patient consultation behaviour change (Agency). As above and illustrated in Figure 1, this was dependent on the extent of service awareness among patients.

Other enablers to patient behavior change described by GPs and advice staff included service longevity and adviser continuity. This was particularly essential for patients.
experiencing mental health difficulties, for whom the GP may be a more familiar and trusted adviser:

There are some that are sort of so entrenched that they have to see a GP or someone. I think it’s going to take time for them to develop a relationship with someone (...) and if they feel that they can trust that person. I think part of it being in a GP surgery automatically they will (...) have a sense that it is a reputable place. [13, GP, locality 1, comparison group]

Addressing underlying issues. Interviewees also discussed whether co-located welfare advice services could reduce GP consultations indirectly linked to non-health issues, through the Programme Mechanism ‘addressing underlying issues’ (Figure 1). Most respondents acknowledged that where underlying social drivers affected patients’ health, health improvement would be unlikely through medical intervention alone. Many felt that receiving welfare advice could positively influence mental health:

I’ve got one patient who has depression (...) he’s on some benefits but he’s finding it very difficult to get by and he can barely buy enough food to eat, and he’s concerned about having his benefits taken away so he’s the sort of person who I think if he had some more help with his finances that might help relieve stress and therefore his mental state. [61, GP, locality 1, advice group]

Whilst practice managers, reception staff and advice staff felt that such health improvements would reduce need for consultations, some GPs were not convinced it would be sufficient to influence demand:

The problems are deeper and more engrained and often go hand in hand with other problems so that it might take the edge off things but I don’t think lead to a massive improvement in someone’s overall well-being. [98, GP, locality 2, advice group]

Maybe it reduces the referral to secondary care but (...) I can’t honestly say it reduces the appointments with us. I don’t think it largely does. I mean maybe prevents some follow ups. If they are getting good advice they won’t come back to us quite so often. [51, GP, locality 2 advice group]

PRACTICE OUTCOME 2: REDUCED PRACTICE TIME SPENT ON NON-HEALTH ISSUES

Co-locating advice services could reduce practice staff time spent on non-health issues within and outside of consultations; especially if linked to direct (e.g., form-filling) rather than indirect support (e.g., depression linked to debt). Time saved was more commonly identified by advice and reception staff, through the Programme Mechanism, ‘reducing bureaucratic pressure’ (Figure 1):

They can do that [appeal against ESA decision] with a doctor but that means (...) more admin time for the doctor to do something like that where she could be doing another thing for another patient. [37, Reception staff, locality 2, advice group]

Advice staff and funders reported that since welfare and health issues were so intertwined, the most efficient way to address them would be to work together. They suggested that co-location may save time by facilitating collaborative work (Agency), enabled by opportunities for interaction (Programme Mechanism) provided by co-location (Figure 1). Further, two GPs reported that closer working with advisers could reduce time collating unnecessary information for
external agencies and reducing repeat requests for information:

The number of times where patients have gone to appeal, we’ve got letters from a solicitor requesting medical information and (...) having feedback from [the advice service], would stop excessive amounts of unnecessary information being sent. [13, GP, locality 1, comparison group]

However, it was acknowledged that co-located advice services would not completely remove bureaucratic pressure for non-health issues:

Having a CAB wouldn’t necessarily reduce the workload considerably because (...) in order for us to do our work and get a successful outcome for the patient, they would need to be doing some work, so i.e. doing medical reports. [40, Advice staff, locality 2, comparison group]

While respondents often aspired to work collaboratively, interactions in both localities were limited and there were few real examples of collaborative working:

The best model would be an advisory service within the practice premises which liaises closely with the GPs (...) But as I say with the current pressures on GP’s I can’t see that close working together is practical in reality. [93, Practice manager, locality 1, comparison group]

Actions and behaviours which promoted service awareness (Agency) was also key to mechanisms involved in time-saving (Figure 1 & Table 6). For example, this GP was unaware of the service at their practice and reported spending long hours working on letters that the advisers could have helped with:

When we finish work [we] then have to sit until 8 o’clock, 9 o’clock to do letters for housing and councils and x, y, z, so if (...) we had a CAB advisor, instead of seeing a GP [they could] just go to this adviser. [159, GP, locality 2, advice group]

Since most of the pathways linking co-located advice services and practice outcomes were influenced by service awareness, we describe in further detail the barriers and enablers to awareness.

Service awareness. Barriers to service awareness included a lack of reminders and opportunities for dialogue about the service between advisers, GP practice staff and funders (Table 6). Despite co-location, respondents in both localities suggested frequent reminders were necessary given the number and unstable commissioning of other services (Contextual Mechanism):

Just as you’re starting to have an awareness of what’s out there, services move, close down, rebrand and change (...) and so it’s harder for us as health professionals to keep track of them all and it’s probably even harder for patients or members of the public. [32, GP, locality 2, advice group]

Practice managers were identified as key facilitators of service promotion; providing opportunities for advisers to feedback to practice staff (e.g., at team meetings), communicating with GPs directly, and advertising the service to patients (e.g., in waiting areas):

[At] one of our GPs there’s a new practice manager and all of a sudden that practice manager is doing other things to try and promote the service to patients (...) [if] they have a positive reaction to the service, then
that spreads to the doctors and to the receptionists. [40, Adviser, locality 2]

Partly due to the greater longevity of services, practice managers at locality 2 were perceived as more proactive than locality 1 managers and advisers distinguished ‘cooperative’ practices from others. Other influences on service promotion included the presence of “socially aware” GPs (Contextual Mechanism) and proactive engagement (Agency) by CA advisers (Table 6). Advisers stated that it was important to feedback to practices on their activity, but noted variability in assimilation:

I try and tell them, the Practice Managers, so that they’re aware that we’re producing results for their surgery (...) some of the surgeries are interested, others are not particularly bothered. [22, Adviser, locality 2]

The physical co-location of advice services encouraged staff awareness through the Programme Mechanism, ‘providing opportunities for formal and informal interactions’ (Figure 1):

They [advisers] can sometimes knock on our door and say, “we have got a person we are worried about, would you arrange to see them?” So it is very useful to have them situated here, definitely. We do invite them to our educational meetings once or twice a year and meet them in the coffee room quite informally. [51, GP, locality 2, advice group]

I think having a presence in an actual surgery or practice highlights that the service exists, so it’s more visible. [92, Funder, locality 2]

Certain practice characteristics impeded service awareness by minimising opportunities for interaction and advice staff proactive engagement (Contextual Mechanism). These included large list sizes, large numbers of front-line staff, high staff turnover, and locating advice services physically apart from the main surgery area (Table 6):

The doctors should know but we have a huge cohort of clinicians and because everyone works part-time we try to inform people through emails, GP education meetings (...) and also the trainers should tell their trainees. Whether that happens, I don’t know. [88, Practice manager, locality 2, advice group]

The extent of perceived funder support also varied by locality. If advisers struggled to feedback to practices, support from funders to promote the services to practices or provide a forum for formal feedback (Agency) was needed. Locality 2 advisers reported that funders engaged with regular feedback on service activity, identifying an ‘individual champion’. In contrast, locality 1 advisers perceived little funder support and few opportunities to promote or feedback on the service formally. Advisers from both areas thought that funders could do more:

I also think [in terms of] support we get from our funders (...) just in terms of promoting - they do bits and pieces behind the scenes - but I'd like to see them all sort of promoting, this as a service they are paying for...or certainly exerting some kind of influence on the doctors. [40, Adviser, locality 2]
QUANTITATIVE FINDINGS

STUDY SAMPLE AND RESPONSE RATE

During the baseline study period 598 contacts were recorded with the GP co-located welfare advice services at participating practices in Haringey and Camden, of which 404 were unique clients (347 in Haringey and 57 in Camden).

In Camden, the number of contacts recorded by the research team and study recruitment was constrained by delays in getting practice approval, large numbers of non-attenders at one participating practice, and the appointment booking system. There was often insufficient time to introduce individuals to the study beforehand as most individuals arrived just prior to their appointments.

Overall, 70.5% of unique clients completed the baseline survey (72.9% in Haringey). In Haringey, the most common reason for not participating was ‘trust’ (8.7%) and ‘other/unknown’ (8.7%). In Camden, the majority of non-participation was due to lack of time (29.8%), reflecting the difficulty of recruiting people with a timed appointment (Table 7).

<table>
<thead>
<tr>
<th>Table 7 Response rate for welfare advice group baseline survey in Haringey and Camden</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Total contacts¹</td>
</tr>
<tr>
<td>Unique clients</td>
</tr>
<tr>
<td>Completed</td>
</tr>
<tr>
<td>Refused</td>
</tr>
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<td>Language</td>
</tr>
<tr>
<td>No time</td>
</tr>
<tr>
<td>Trust</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

¹Some individuals accessed the service more than once during the study period.

THE WELFARE ADVICE GROUP AT BASELINE

Who accesses the service?

The study sample was reflective of all those accessing the Haringey health hubs during the study period in terms of ethnic group, age group, sex and health status (see Appendices, p.63).

The characteristics of the welfare advice sample are illustrated in Figure 3. The majority of participants (61.5%) were female; 74.3% were aged between 35-64 years; and the most commonly recorded ethnic groups were Black African/mixed White & Black African (25.3%) and White British (24.5%).
Most participants (45.9%) were outside of the labour force, predominantly long term sick or disabled; 15.8% were unpaid carers; over a third of participants reported no educational qualifications and a third had qualifications up to GCSE level.

Over 40% of the sample were living alone and identified as single; the majority (73.1%) were living in rented accommodation; and, over half reported their monthly household income as less than £550.

Most participants (73.5%) reported having a long term health condition, of which 72.5% identified a physical condition, 30.0% a mental health condition, and 24.0% a disability or impairment (a quarter of those with any long term condition or disability reported more than one type).

At baseline 78.9% of welfare advice group participants scored 4 or more on the 12-item General Health Questionnaire (GHQ-12), indicating they have or are at risk of developing symptoms of psychiatric ill health that are likely to require further treatment.

The mean wellbeing (SWEMWBS) score at baseline was 18.1 (Standard deviation (SD 5.2).

The mean reported number of GP practice appointments over the past 12 months was 13.1 (SD 12.8).

Comparison with other CA services

The characteristics, health status, advice type and advice offered to individuals accessing Haringey Citizens Advice services (excluding health hubs) and those accessing the health hubs are illustrated in the Appendices (p.63).

As with the health hubs, the majority of the wider CA clients were female and the distribution of ethnic groups were largely similar. Those accessing the wider CA services were younger, in particular including a greater proportion of 25-34 year olds.

Individuals seen at the health hubs were proportionately twice as likely to have a long term health condition, disability or impairment, than individuals seen at other CA services.

Nearly twice the proportion of individuals seen at the health hubs accessed the service for advice linked to welfare benefits and debt compared to those accessing other Citizens Advice services. A greater proportion of individuals seen at other Citizens Advice services, requested advice on employment, housing and immigration than those seen at the health hubs (Figure 2).
Figure 3 Baseline socio-demographic characteristics of welfare advice group sample

1Based on 278 baseline welfare advice group baseline surveys
Accessing the co-located advice service

As illustrated in Figure 4, welfare advice group participants had most commonly heard about the service through their GP or at the GP practice (41.2%), while a third of participants reported that they had been told about the service by Citizens Advice or other information and advice service.

A large majority of participants’ reported a preference to see the welfare adviser at a GP practice than somewhere else (92.9%).

The majority of individuals preferring to see an adviser at a GP practice stated this was because the service was easier to access (e.g. due to mobility problems of anxiety with travel), nearer home or more convenient (54.7%). The next most common reason was because the GP practice was a more familiar/known, safe or less anxiety-provoking environment (17.8%).

5-6% of respondents also mentioned that there was a greater chance of being seen there; that the advice or adviser was better at the GP-based welfare hubs; or, because their advice issue was linked to health or they believed the adviser may have access to their health records.

If the service had not been available at the practice, nearly a third of participants (31.5%) would not have sought advice at all, while 15.8% would have spoken to their GP/other health professional, or other practice staff.

A large proportion (39.0%) had already spoken to their GP about the issue they were going to see the adviser about that day. Of these, the majority said this was because the issue was affecting their mental health (29.5%) or was otherwise health-related (24.2%). Of the 61.0% who had not spoken to their GP about the issue they were seeing the adviser about that day, the majority (63.2%) said that it was because the issue was not relevant to their GP or was not health-related.

There were a significantly greater proportion of individuals meeting the criteria for GHQ caseness amongst those who had spoken to their GP about the issue they were seeing the adviser about, compared to those who had not (87.4% vs 73.4%, p=0.007). Similarly, a greater proportion of those who preferred to access advice at the GP practice met the criteria for GHQ-caseness than those who preferred to access advice elsewhere (79.8% vs 62.5%), though this was not statistically significant (p=0.101).
Figure 4 Accessing the co-located advice service

How did you hear about the service?

- 41% My GP/the GP practice
- 33% Word of mouth
- 16% CAB/Other information & advice service
- 10% Other

If the service was not here, where would you go?

- 55% Other information & advice service
- 30% Would not have sought advice/don’t know
- 15% GP/practice staff

Given the choice, would you rather see an adviser at a GP practice or somewhere else. Why?

- 93% More accessible/convenient
- 7% Familiar/safer environment
- 6.4% More chance of being seen
- 5.9% Adviser/advice is better
- 5.5% Will have access to health records
- 5.1% Trust GP, GP understands my problem
- 4.7% Would prefer to keep separate

---

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Baseline financial status and financial strain

68.5% of the welfare advice group reported finding their financial situation as ‘difficult’ or ‘very difficult’.

59.0% felt that they were financially worse off than the same time last year, while 39.0% and 30.2% felt that their current financial situation would remain the same or get worse respectively by the same time the following year.

58.4% reported at least one problem meeting housing-related payments in the past year.

Welfare advice group participants who reported a greater amount of financial distress (p<0.001), those with problems paying for housing in the past year (p=0.017) and those who were finding it more difficult to manage financially (<0.001), were at greater risk of reaching the threshold for GHQ-12 caseness.

Help-seeking for financial-related issues and impact on health

Among the welfare advice group, the top four strategies to manage if participants’ income did not cover their costs were to ‘cut back on spending’ (52.5%), ‘seek advice’ (48.2%), ‘borrow money/take out a loan’ (33.5%) and ‘miss payments’ (27.0%).

If participants’ had problems linked to being behind and unable to pay for something, or if they had questions about financial-related issues, they were most likely to report that they would talk to Citizens’ Advice or other information and advice service (70.1%). Nearly half reported that they would talk to friends or family (45.7%); and a fifth would talk to a GP or other health care professional (20.5%).

Participants reported that financial stresses and strains had impacted on their health and well-being. They most commonly identified ‘problems sleeping’ (67.3%), ‘stress’ (66.9%), ‘loss of confidence’ (48.6%), ‘physical health’ (44.2%) and ‘fear’ (38.9%) as being affected. Over a quarter (25.2%) reported that their financial worries had influenced their mental health.

When asked who they would talk to about those health and wellbeing issues that had been influenced by financial stresses and strains, participants most commonly identified ‘GP or other health care professional’ (52.9%), ‘Citizens Advice/other information and advice service’ (51.1%), and ‘friends or family’ (46.8%).
EVALUATING THE IMPACT OF CO-LOCATED WELFARE ADVICE

Generating a comparison group

Comparison group individuals who reported having accessed advice for financial and benefits-related issues since completing the first questionnaire were excluded from analyses (n=64). Propensity scores (indicating the probability of receiving co-located welfare advice) were estimated using logistic regression (see Appendix p.60 for more detail). Post-estimation analyses revealed overlap in the range of common support across the whole distribution of the propensity score (the extent to which the distribution of propensity scores in the advice and comparison groups overlapped). The sample was divided into six blocks of observations with similar propensity scores. The propensity score was balanced (no difference in mean propensity score) across advice and comparison groups within each block.

Within each block, t-tests indicated that the covariates were also balanced (the means were equal) across the two groups. The sample was then weighted using kernel weighting, such that comparison group individuals were assigned weights according to how close their propensity scores were to individuals in the advice group. Four individuals were dropped from the comparison group because they were outside the range of common support (propensity scores did not overlap with advice group participants). Estimates of the difference in differences between the two groups were made for key outcome variables (see Appendix p.61 for more detail on analytical methods). See Appendix p.64 for a comparison of baseline characteristics between advice and comparison groups following weighting.

Self-reported improvements since receiving advice

Advice group participants were asked at follow-up whether they felt there had been any improvements in a range of health and functioning domains since receiving advice at baseline. 64% of the welfare advice group reported at least one improvement since receiving advice. Of those reporting any improvements, the most commonly recorded were ‘improved stress’ (25.9%), ‘improved income’ (20.6%), ‘improved housing circumstances’ (17.7%), and ‘improved confidence’ (15.9%) (Figure 5).

In the following analyses, the interaction between group membership and time (before or after) illustrates whether the change in the outcome (or odds of an outcome if binary) before and after is different in the advice and comparison groups and is a measure of the effect of the advice service.
Estimating the impact of the service on outcomes

Primary outcome. The proportion of individuals scoring four or more on the GHQ-12 (GHQ ‘caseness’) reduced between baseline and follow-up in both groups, and to a greater extent among the advice group than controls. The reduction in odds of scoring 4 or more over time was 43% greater for advice group members than controls - though this did not reach statistical significance (Table 8).

The reduction in GHQ caseness over time was significantly greater for the advice group relative to controls among females (63% greater reduction in odds of scoring 4 or more over time) and, in particular, among Black/Black British participants (91% greater reduction). There was also a 55% larger reduction in odds of scoring 4 or more for those receiving a positive outcome for advice, though this did not quite reach statistical significance (p=0.055). Adjustments for financial strain reduced the strength of the interaction among females (ratio of Odds Ratios (rOR) 0.48, 95% CI: 0.24 to 0.97, p=0.040) but had no impact among Black/Black British participants (rOR 0.12, 95% CI: 0.04 to 0.38, p<0.001).

Other outcomes. We found no evidence for any difference in change in SWEMWBS well-being scores between the two groups (Table 8). In sub-group analyses, those who received a positive outcome from advice demonstrated significantly improved well-being scores relative to controls (Table 9); the increase in SWEMWBS scores were on average 1.29 points greater over time in the advice group.
compared to the comparison group. This was only partly accounted for by adjustment for financial strain (β coefficient 1.12, 95% CI: 0.04 to 2.20, p=0.042).

Advice group participants reported more frequent consultations than controls (12 month mean consultation frequency 13.1 (SD 12.8) vs 8.6 (SD 9.1)). Comparing consultations during the three months before and after baseline, there was no evidence for an impact of advice on consultations was found overall (Table 8), or for any of the subgroups (Table 10).

There was a significantly larger improvement in financial strain among the advice group relative to controls overall (p=0.005) (Table 8). There was a 58% bigger reduction in the odds of reporting financial circumstances as ‘difficult or very difficult’ among the advice group than among controls. Financial strain also improved significantly more for advice group recipients among females (67% greater improvement, p=0.011), those with long-term conditions (70% greater improvement p<0.001), and those with positive outcomes from advice (55% greater improvement, p=0.001) (Table 9).

There was a significant reduction in the proportion of individuals reporting that they would use their credit card or overdraft if their income did not cover their costs among the advice group (23.4% before vs 17.7% after), relative to an increase among controls (15.9% before vs 18.9% after; rOR 0.48, 95% CI: 0.26 to 0.90, p=0.021). The only difference in support seeking behaviours for financial-related problems was an increase in the proportion of advice group members who would not know who to go to for financial support (4.0% before to 7.4% after) relative to a reduction among controls (8.2% to 6.6%) (rOR 2.33, 95% CI: 1.14 to 4.76, p=0.021).

Controls became proportionately more likely to talk to their GP for the health impact of financial strains over time (43.9% before and 53.7% after). In contrast, there was no change among the advice group (54.8% vs 55.1%), generating a significant group x time interaction (rOR 0.56, 95% CI: 0.36 to 0.89, p=0.015). However, there was also a significantly greater increase in the proportion of advice group members who did not know where they would seek help for the health impact of financial issues (2.4% and 7.4%) relative to controls (9.9% and 3.4%) (rOR 8.8, 95% CI: 1.56 to 49.27, p=0.014).

Financial outcomes

Financial outcomes over the study period are shown in Table 10. Between December 2015 and July 2016, £793,135 additional income was gained in total over all 295 individuals who accessed the co-located advice service (averaging £2689 per client). This compares to £1,805,706 for all other CA clients during the study period (n=7760), corresponding to £232 per client overall. These income gains were not shared over all clients as some received one off advice or were enquiring about non-(directly) financial related issues.

Such non-income related enquiries are proportionately more common for the wider CA projects as they cover a broader range of issues (employment, housing and immigration). Further, some individuals had more than one financial outcome over the study period (e.g., where debts were rescheduled and they received help successfully applying for welfare benefits).
Cost : consequences

While a detailed cost-benefits calculation was not possible, a crude measure of cost : consequences was made by dividing the total income gain by the cost of the service to the Clinical Commissioning Group (CCG). Over the financial year 2015/2016, the CCG contributed £79,000 to the health hubs (£52,667 for eight months). For the funding as a fraction of the study period (eight months), this corresponds to £15 gained per individual for every £1 contributed by the CCG.

This calculation is a crude estimate and does not include any social value gains.
Table 8 Before-and-after comparison of primary outcomes among those receiving co-located welfare advice and propensity score weighted controls. Percentages (%), means and standard deviations (SD), ratio of odds ratios (rOR), β coefficients and 95% confidence intervals (CI) are shown.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Baseline</th>
<th>Follow-up</th>
<th>Interaction group x time (rOR/ β coefficient, 95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advice</td>
<td>Comparison</td>
<td>Advice</td>
<td>Comparison</td>
</tr>
<tr>
<td>Common mental disorder¹ (%)</td>
<td>79.5</td>
<td>68.6</td>
<td>62.6</td>
<td>56.5</td>
</tr>
<tr>
<td>Well-being² (mean, SD)</td>
<td>18.1 (5.2)</td>
<td>18.7 (5.0)</td>
<td>18.0 (5.5)</td>
<td>19.7 (4.4)</td>
</tr>
<tr>
<td>Consultation frequency³ (mean, SD)</td>
<td>4.1 (3.8)</td>
<td>2.7 (3.1)</td>
<td>4.0 (3.6)</td>
<td>2.5 (2.5)</td>
</tr>
<tr>
<td>Financial strain⁴ (%)</td>
<td>66.9</td>
<td>39.9</td>
<td>58.6</td>
<td>43.2</td>
</tr>
</tbody>
</table>

¹Measured with 12-item General Health Questionnaire, scores 4+ identified as cases (logistic regression, rOR). ²Measured with Shortened Warwick and Edinburgh Mental Well-being Score (linear regression, β coefficient). ³Self-reported GP appointments in the last three months (Poisson regression, β coefficient). ⁴Indicates those reporting finding their financial situation as ‘difficult’ or ‘very difficult’ (logistic regression, rOR).
Table 9 Sub-group analyses estimating the impact of co-located welfare advice receipt relative to propensity score weighted controls. Ratios of odds ratios (rOR), β coefficients, 95% confidence intervals (CI) and p-values are shown.

<table>
<thead>
<tr>
<th>Common mental disorder&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Well-being&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Consultation frequency&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Financial strain&lt;sup&gt;4&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Interaction group x time (rOR, 95% CI)</td>
<td>p</td>
<td>Interaction group x time (β coefficient, 95% CI)</td>
<td>p</td>
</tr>
<tr>
<td>-----------------------------------</td>
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<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
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<tr>
<td>Female (n=595)</td>
<td>0.37 (0.20 to 0.70)</td>
<td>0.002</td>
<td>0.26 (-0.52 to 1.05)</td>
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<tr>
<td>Male (n=316)</td>
<td>1.15 (0.29 to 4.51)</td>
<td>0.843</td>
<td>0.27 (-1.16 to 1.70)</td>
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<td><strong>Ethnicity</strong></td>
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</tr>
<tr>
<td>White (n=466)</td>
<td>0.69 (0.33 to 1.46)</td>
<td>0.331</td>
<td>0.02 (-1.59 to 1.63)</td>
</tr>
<tr>
<td>Black/Black British (n=252)</td>
<td>0.09 (0.03 to 0.28)</td>
<td>&lt;0.001</td>
<td>-0.21 (-1.44 to 1.03)</td>
</tr>
<tr>
<td>Other (n=176)</td>
<td>0.83 (0.13 to 5.20)</td>
<td>0.845</td>
<td>0.69 (-1.03 to 2.42)</td>
</tr>
<tr>
<td><strong>Long-term conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n=438)</td>
<td>0.41 (0.15 to 1.13)</td>
<td>0.085</td>
<td>-0.24 (-1.03 to 0.56)</td>
</tr>
<tr>
<td>No (n=468)</td>
<td>0.71 (0.31 to 1.64)</td>
<td>0.429</td>
<td>1.15 (-1.17 to 2.46)</td>
</tr>
<tr>
<td><strong>Advice outcome</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (n=708)</td>
<td>0.45 (0.20 to 1.02)</td>
<td>0.055</td>
<td>1.29 (0.25 to 2.32)</td>
</tr>
<tr>
<td>No (n=816)</td>
<td>0.64 (0.39 to 1.03)</td>
<td>0.063</td>
<td>-0.52 (-1.44 to 0.41)</td>
</tr>
</tbody>
</table>

1 Measured with 12-item General Health Questionnaire, scores 4+ identified as cases (logistic regression, rOR). 2 Measured with Shortened Warwick and Edinburgh Mental Well-being Score (linear regression, β coefficient). 3 Self-reported GP appointments in the last three months (Poisson regression, β coefficient). 4 Indicates those reporting finding their financial situation as ‘difficult’ or ‘very difficult’ (logistic regression, rOR).
### Table 10: Financial outcomes for all co-located welfare advice ('health hub') clients and all other Haringey CA clients during the study period (Dec 2015 to Jul 2016)

<table>
<thead>
<tr>
<th></th>
<th>Benefits &amp; tax credits (£)</th>
<th>Debt (£)</th>
<th>Employment (£)</th>
<th>Housing (£)</th>
<th>Other (£)</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health hub clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income gain</td>
<td>703,803</td>
<td>10,208</td>
<td>0</td>
<td>0</td>
<td>450</td>
<td>714,461</td>
</tr>
<tr>
<td>Re-imbursements, services,</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>loans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debts written off</td>
<td>0</td>
<td>77,731</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>77,731</td>
</tr>
<tr>
<td>Repayments rescheduled</td>
<td>0</td>
<td>943</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>943</td>
</tr>
<tr>
<td>Total</td>
<td>703,803</td>
<td>88,882</td>
<td>0</td>
<td>0</td>
<td>450</td>
<td><strong>793,135</strong></td>
</tr>
<tr>
<td><strong>All other CA clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income gain</td>
<td>1,223,435</td>
<td>33,325</td>
<td>28,246</td>
<td>0</td>
<td>7,143</td>
<td>1,292,150</td>
</tr>
<tr>
<td>Re-imbursements, services,</td>
<td>0</td>
<td>130</td>
<td>0</td>
<td>1,850</td>
<td>0</td>
<td>1,980</td>
</tr>
<tr>
<td>loans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debts written off</td>
<td>0</td>
<td>510,633</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>510,633</td>
</tr>
<tr>
<td>Repayments rescheduled</td>
<td>0</td>
<td>943</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>943</td>
</tr>
<tr>
<td>Total</td>
<td>1,223,435</td>
<td>545,032</td>
<td>28,246</td>
<td>1,850</td>
<td>7,143</td>
<td><strong>1,805,706</strong></td>
</tr>
</tbody>
</table>
DISCUSSION

SUMMARY

To our knowledge, this is the first controlled prospective summative evaluation of co-located welfare advice services in healthcare settings. A mixed methods approach enabled us to look more in-depth at not just whether the service was effective in influencing outcomes, but how – and under which circumstances.

The qualitative evaluation focused on revealing how co-located welfare advice services could support practices with patients presenting either for direct support navigating an aspect of the welfare system, or indirectly for health/mental health issues with underlying social drivers.

We described how social issues are perceived by primary care staff to contribute to increased practice pressures including demand for GP consultations and practice staff time spent dealing with ‘non-health’ issues. We identified key implementation, Agency and Context-related barriers and enablers to the capacity for co-located welfare advice services to influence outcomes.

Our quantitative findings revealed that the provision of co-located advice led to significant improvements in mental health and well-being. Specifically, symptoms of common mental disorder (defined by a GHQ-12 score of four or more) improved amongst female and Black/Black British advice group recipients; and, those with a positive advice outcome also reported improvements in well-being (SWEMWBS).

The strongest evidence was for a significantly greater reduction in perceived financial strain among advice group members relative to controls. This is reflected in an average financial gain of £2689 per capita among advice recipients.

Relative to controls, advice recipients also reported enhanced coping strategies for dealing with financial strains; however, they were also more likely to report not knowing where to go to for support with financial strain or the health impact of such strains over time. We did not find any difference in self-reported (three month) consultation frequency.

Below we discuss the findings in more detail, strengths and limitations of the evaluation, and recommendations.

EXPLANATIONS FOR THE FINDINGS AND COMPARISON WITH LITERATURE

Mental health and well-being

In line with theories linking low income to poor mental health, via exposure to perceived stress associated with economic strains (53), we hypothesised that changes in financial strain may underlie any improvements to mental health and well-being. This hypothesis was partially borne out by our results. Thus, financial strain was strongly associated with symptoms of common mental disorder and well-being, and there was a significant decrease in financial strain among advice recipients.

Adjustments for financial strain reduced significant group x time interaction effect sizes where these sub-groups experienced a
significant reduction in financial strain relative to controls (females, those experiencing positive outcomes of advice). However, financial strain was not significantly improved among Black/Black/African advice recipients, suggesting there may be another underlying mechanism between receipt of advice and improved symptoms of common mental disorder in this group.

A more generalised measure of perceived stress may be a useful gauge of the impact of advice which leads to other non-directly financial outcomes (e.g. improvement in housing circumstances or reduced fear). Perceived financial strain and perceived stress may be better measures for advice services to routinely monitor the health impact of advice, where detailed questions about mental health may be deemed inappropriate for advisers or advice clients.

Reduction in indebtedness may also underlie changes in mental health and well-being. We found a significant reduction in reported use of a credit card or overdraft among advice group members if their income did not cover their costs, relative to an increase among controls. This may be linked to debt management outcomes of advice and/or to information provided about budgeting and debt management. Such a reduction is important since use of both credit cards and unauthorised overdrafts incur high interest rates, further increasing the likelihood of indebtedness, which is prospectively associated with poor mental health (3).

Our reported financial gains per capita are in line with those previously reported (30). We found that for every £1 invested by funders, £15 was gained per client. Previous research with CA clients indicates that additional income is spent on fuel, transport, food and clothing children (32, 54). This suggests that the impact of advice is not limited to a reduction in financial strain but directly influences a range of wider determinants of health. Moreover, these returns are likely underestimates since they do not include social gains from non-directly monetised outcomes. For example, improved housing, avoiding repossession, avoiding court, employment support. Farr et al. (55) estimated that the total social return on investment was between £33 and £50 for CA clients, per £1 spent by funders.

**Financial support-seeking**

Our findings that (in contrast to advice service users) individuals in the comparison group were more likely to talk to their GP about health or functioning impacts of financial strain, and less likely to seek advice from the welfare agencies if they were unable to meet payments over time, could be related to concurrent closures of local high street CA services during the study period. The proportion of advice group members not knowing where to see help for financial issues or the health effect of such issues increased over time relative to controls. This may also be linked to such closures, since a considerable proportion had been signposted to the co-located service from high street CA services.

**Consultation frequency**

Patients in more deprived areas have higher rates of consultations associated with psychological difficulties linked to problems such as financial hardship. We therefore hypothesised that the intervention would reduce consultation rates. Although validity of self-reported health care use has been found to be fair; (56) it is possible that the lack of self-reported reduction in appointments was secondary to recall bias. This is particularly in
view of previous research (38) which found small reductions in GP consultation frequency and antidepressant prescription among individuals six months before and after receiving co-located welfare advice. However, it should also be noted that this was a small, uncontrolled study, precluding causal inference.

**Impact on GP non-health workload**

In the light of two recent UK GP surveys (14, 15, 25) in which (particularly inner city) GPs reported patient health, GP workload and practice staff time demands had been adversely affected by greater patient financial hardship and changes to welfare provision; our findings suggest that the reductions in financial strain could reduce practice burden. Furthermore, our findings suggest that co-location in health settings can target individuals less able to self-manage and/or more likely to turn to their GP for support.

Specifically, nearly half of advice service users reported that had the service not been at the GP practice they would have gone to their GP for advice or would have not had sought advice at all. The vast majority of service users indicated a preference to access advice at their GP practice, most commonly for reasons linked to physical and psychological accessibility. Additionally, a large proportion had already spoken to their GP about the issue they were seeing the adviser about, most commonly because it had been affecting their mental health or was otherwise health-related.

**Model of service delivery**

Our qualitative findings suggest that co-located welfare advice services have the potential to reduce pressures on general practice. However, co-location alone is unlikely to ‘trigger’ the necessary Programme Mechanisms linking advice services to practice outcomes. We identified key implementation, Agency and Contextual mechanism-related barriers and enablers to the capacity for co-located welfare advice services to influence outcomes.

Individual and organisational actions and behaviours influencing service awareness (Agency) were key facilitators and are amenable to change; they encouraged collaborative working, signposting, and change in patient help-seeking behaviour. Service promotion was associated with improved service awareness through proactive engagement, communication, regular reminders and feedback between advice staff, practice managers and funders.

Other important facilitators were not limiting access to GP referral; and, offering booked appointments and advice on a broader range of issues responsive to local need (implementation characteristics). Key barriers included pre-existing socio-cultural and organisational rules and norms largely outside of the control of service implementers, which maintained perceptions of the GP as the ‘go-to-location’.

Difficulties in making co-location work in primary care have been identified by previous research examining other forms of ‘integrating’ services through co-location. For example, Lawn et al. (57) state, “coordination and collaboration do not happen on their own, that co-location is not just about the bricks and mortar. It is also about strategies to bring people together in a meaningful way.” (p8).

Many of the barriers to co-location acting as a facilitator to integrated working identified here were recognised in a systematic review of joint working (58), such as a lack of formal
or informal regular and frequent communication. In addition, they highlighted the need for mutual trust and GP respect for the skills and contribution of other partners; sufficient administrative support; supervision and training; feedback about referrals; and, clear lines of responsibility.

As described by our interviewees, allowing sufficient time for co-location to have its desired effects has previously been acknowledged as important (58, 59).

**Strengths and limitations of the study**

A major strength of our research is the use of a robust comparator group allowing us, for the first time in this field to infer causality, rather than only correlation. Second, unlike previous research in this field (60, 61) our study was sufficiently powered to detect significant differences over time between advice and comparison groups. Third, we achieved similar or higher follow up rates than have previously been reported (36, 60, 62) which further increases our ability to have confidence in our results. Fourth, we were able to demonstrate that changes in perceived financial strain may be one important underlying pathway linking advice to mental health. This may be a useful proxy measure for advice services in demonstrating their value to funders. Fifth, by collecting data on health outcomes, service use and financial benefits accrued, we are able to provide data of direct value to commissioners, enabling them to make informed decisions about resource allocation across disparate services.

This was a multi-site than single case study which increases the external validity of our results. However, the sites examined were in London and served areas with high levels of multiple social disadvantage. Whilst the services examined are likely to be similar to other inner metropolitan areas, other urban and rural populations have differing socio-demographic population profiles and welfare needs. However, co-located services provided in less urban UK locations also report that welfare benefits and debt are the main issues presented and the income gain per capita is in line with these other services (42, 63). This suggests that our results are likely to be generalisable to other settings but this does require empirical testing.

We acknowledge that some sub-group analyses may have had limited power to detect small effect sizes, we therefore limited analyses to key sub-groups (e.g. by gender and ethnicity) which we identified a priori on the basis of utility for commissioners of these services.

We measured follow up at three months for three reasons. First, to increase confidence in a direct association between advice receipt and changes in mental health, particularly in a multimorbid and deprived population in which other factors could influence the outcome and override the benefits of welfare advice. Second, to minimise attrition, which is often a limitation of research with socio-economically disadvantaged groups, limiting statistical power and increasing the risk of bias (64-66). Third, this decision was based on data provided by the CA indicating mean time to resolution of issues as three months.

A potential disadvantage of this short follow up period is that we under-reported the benefits of welfare advice. This is suggested by the data we extracted from the CA IT platform which demonstrated that some individuals receive several episodes of advice over a period longer than three months. This indicates that we may have collected outcome data for individuals in whom issues of concern are not fully resolved or for whom benefits of
advice receipt may accumulate over a longer period.

Previous research found that long term exposure to financial strain is associated with subsequent chronic conditions, physical symptoms and poorer perceived general health, even after controlling for current financial circumstances, and that persistent financial strain is more strongly associated with ill health in later life than episodic occurrences (9). It is possible that any impact of reduced financial strain on mental health and well-being may take longer to fully emerge. Further, the impact of any acute reduction in financial strain may be muted among those who have been chronically exposed to such stressors. After receiving advice, the impact of acutely stressful experiences may be ameliorated; however, many individuals may continue to be at risk of further future adversity.

Another limitation was the crude approach to assessing return on investment. Our Cost-Consequences Analysis excluded non-monetised benefits, e.g., from improvements in mental health, well-being and stress, thus underestimating the value of co-located welfare advice services. Previous uncontrolled research (67) estimated the cost effectiveness of welfare advice for young people using published algorithms to convert changes in GHQ-12 scores, stress, and housing circumstances into Quality Adjusted Life Years (QALY) gained. They concluded that advice provision was cost effective on the basis of either mental health or housing circumstances, without including any other benefits of advice.

We used the GHQ-12 as it is brief, simple and easy to complete and more parsimonious with other elements of the surveys. The proportion of advice group members meeting the criteria for common mental disorder symptoms likely to warrant further treatment was very high (~80%), likely linked to the prevalence of long term conditions in this group (68). This may limit the capacity to demonstrate changes in mental health associated with advice.

CONCLUSIONS & RECOMMENDATIONS

We conclude that co-located welfare advice can improve short term mental health, reduce financial strain and generate considerable returns for recipients.

Co-locating welfare advice services in GP settings is an opportunity to support patients, particularly those living in deprived areas, at a location they would normatively go to, to seek help. Further, it may be expected that co-locating services should make it easier for GPs to refer patients to appropriate support.

Co-location of welfare advice has the potential to help practices support patients with social issues but not if co-location is limited to a physical sharing of space. Coordinated working requires individual and organisational effort, and strategic support. Since many of the facilitators to mechanisms linking co-located advice and practice outcomes, including diverting consultation time away from GPs and reducing practice staff time spent dealing with non-health issues, the majority of the following recommendations pertain to implementable service model delivery changes.

1. Target co-located advice services to support those who would benefit most and who would be most likely to turn to their GP for support with ‘non-health’ issues.

Encouraging self-management is a core aim for wider IAG services. However, for vulnerable residents, those otherwise unable to advocate for themselves, and those who
would otherwise to go to their GP for support, more targeted services are necessary for them to be able to access support and advice linked to social and welfare issues. Those in poor physical and mental health are both at greater risk of social welfare issues and more likely to have difficulty accessing support and advice for such issues. A large proportion of health hubs users in the current study indicated they would not have sought advice had the service not been there and the majority of those reporting a preference to see an adviser at a GP practice sited physical and psychological reasons. By co-locating advisers in health settings, it increases physical and psychological accessibility for this group.

2. **Proactively develop and maintain communication channels between practice managers, funders and advice staff to promote service awareness among staff.** This includes opportunities for regular feedback, training/education, and frequent service reminders, and may be facilitated by the provision of information ‘navigators’.

For co-located advice services to impact practice outcomes and to reach patients who would most benefit from co-located services, it is critical that more work is done on service promotion. Information ‘navigators’ provided through the IAG contract could support this element and be a huge benefit of transferring the health hubs to IAG work.

Proactive engagement by both Citizens Advice workers and practice managers is also necessary to accommodate this. Engagement with practice managers has been limited, negatively influencing service awareness and restricting many of the pathways linking co-located advice services to practice and patient outcomes.

Examples of communication channels include periodic briefings to practice staff, regular feedback meetings with service funders, training opportunities for practice staff, and regular and sustained service reminders. Should the health hub work be transferred to IAG, dedicated ‘information navigators’ would be able to facilitate this process to minimise additional burden on practice staff and advisers.

IAG navigators would also help bridge contextual barriers identified in the qualitative evaluation. For instance, in practices with a high number or turnover of staff, large practices, practices where the advice service is located physically apart from main GP receptions, navigators could be deployed to assist with promotion and enhanced services.

3. **Integrate co-located advice services, ‘health hubs’ into practice teams, encourage mutual trust and respect of the skills offered by Citizens Advisers.**

The Citizens Advisers located in the health hubs offer a discrete service within the wider Citizens Advice environment. They are trained specialist legal advisers with expertise in and experience of supporting individuals with health-related welfare benefit and debt issues. They are trained in mental health first aid and have developed considerable experience in supporting patients experiencing mental health issues to navigate the welfare system. Yet, advice staff often felt they were viewed as ‘outsiders’ in the practice setting, perceived as an optional ‘add-on’ rather than as integral to the range of services offered. This limited both will and opportunity to proactively engage with practices.

It was important for practice staff to prioritise medical need and to increase the availability of appointments for medical need. However, despite the potential for co-located advice services to support practice work, and divert ‘non-health’ work, the interviews revealed that the service was seldom used or viewed in
this way. Furthermore, there was little understanding or communication about the range of ways the service could support both practices and patients.

4. Increase the range of advice issues offered and be flexible to local need.

GPs and other practice staff interviewed frequently perceived themselves to be the ‘go-to-location’ for many social-related issues. They described housing as a key local issue underpinning demand for support from practitioners and requests for housing medical support letters were a considerable source of additional time burden.

While the bidirectional relationship between housing and health was acknowledged and legitimised, there was also a concern that patients believed medical evidence would strengthen their case for housing, re-housing, or housing improvements for an individual or family. The Housing for Health NHS Alliance states that, ‘most housing organisations no longer require letters from GPs about their patients’ health to substantiate an application for housing or rehousing’, with self-assessment protocols being increasingly common [http://www.nhsalliance.org/housing-for-health/](http://www.nhsalliance.org/housing-for-health/). However, patients under housing stress and those who are less able to advocate for themselves for mental health, health, literacy and/or language-related reasons are likely to continue to turn to the GP.

Citizens Advice workers located in GP practices are well placed to intervene with those patients who turn to the GP with these issues, and offer a signposting option for practice staff receiving requests for housing support. For future GP co-located work, Haringey Citizens Advice plan to increase the provision of advice given, in particular housing and employment. They could support patients with applications for housing/re-

housing, medical self-assessment, advocate for patients to the Council, Housing Associations and private landlords, and provide a bridge to other housing support services.

Encouraging service awareness among both staff and patients is essential for such a service to reduce practice staff burden.

5. Promote co-located Citizens Advice services as an alternative patient pathway for direct support with health-related aspects of the welfare system.

Individuals asking for support from their practice for a welfare benefit or housing-related issue may be better supported by a Citizens Advice worker alone, or in conjunction with information from their GP. Diverting consultations and reducing demand on practice staff time is a key element of the advice work able to be delivered by Citizens Advice. For example, draft letters for housing and benefits-related issues could be prepared by advisers in collaboration with individuals and left for GPs to approve and sign. This would save GP time drafting letters, release appointments for medical reasons, and minimise the chances of patients being ‘bounced back’ by increasing the relevance of information made available to external agencies.

Promoting service awareness among practitioners, practice managers and reception/administrative staff is vital for the service to be a signposting option and for patient consultation behaviour change. This includes proactive efforts to increase awareness about the range and nature of issues Citizens Advice workers can support patients and practices with.

6. Dedicate resources to encourage change in help-seeking behaviours.

Increasing service awareness among individuals in the target group who would not
otherwise seek advice or know where to get it would increase the proportion of people seen at the hubs who may benefit most.

This includes promoting sources of support for self-management and providing timely information about co-located advice services to GP patients. One approach may be to ask patients for a reason for their appointment at the time of booking. However, practice policies vary on permitting this, it would not divert people booking online, and individuals may prefer not to disclose such information to reception staff. Instead, automated verbal information could be given about the service when calling to book an appointment. GP website information, signs and posters in waiting rooms, radio or social media messages may also be useful.

Continuity of advisers at the health hubs is important to building trust and familiarity among both patients and staff.

7. Formalise clear referral routes from frontline practice staff to appropriate Citizens Advice services.

Clearer referral routes from receptions at GPs and practitioners to IAG services would promote service awareness, encourage staff to direct patients to appropriate services and patient behaviour change. GP staff interviewed in the current study were often unaware of or not confident about signposting to external support services; for example, due to frequent changes in the services available, or lack of understanding about how Citizens Advice could help.

Reception staff often felt that being able to direct patients to the co-located advice services was useful for them and enabled them to free up GP appointments. A more formalised direct referral pathway available to all practice staff and other allied health professionals, with clearly defined referral criteria and information on what services are available could be developed bespoke to each practice location.

8. Dedicate a proportion of health hubs sessions to booked appointments.

The current service model reduces the capacity for the health hubs to be a source of support patients less able to self-manage and to support practices with work that patients bring to them. Offering walk-in services not limited to GP referral increases accessibility and removes the requirement for an initial GP appointment to access services. However, this meant that capacity was often blocked up by individuals who had been diverted from high street services.

Further, some individuals, such as those experiencing symptoms of mental ill health and/or those on certain medications, may find it more difficult to wait in a busy waiting room for long periods of time and/or to reach the surgery early enough to make it on to the waiting list. Retaining slots for booked appointments would also enable clinicians and other practice staff to refer patients to a specific, timed appointment in-house.

9. Adopt an approach to measuring the outcomes of welfare advice which is feasible and acceptable for advice services to routinely monitor, and which are proxy measures for improved mental health and well-being (e.g., perceived stress, financial strain).

Routinely monitoring the impact of welfare advice on health and mental health outcomes to feed back to funders is likely to be an unrealistic expectation. Many individuals are seen only once by advisers, and indeed this is a positive aim of the service to encourage self-management in future. Even if individuals are seen multiple times or are supported by in-depth casework, following them up to assess outcomes is very resource intensive and likely to achieve low response rates.
Asking individuals accessing the service about their mental health in detail may be perceived as intrusive and advisers may not feel comfortable doing so. Considering short term markers or mediators of the relationship between social/financial problems and psychological distress may be more appropriate. For example, questions about financial strain, financial capability or even perceived stress and problems sleeping.
CA  
Citizens Advice (formerly Citizens Advice Bureaux).

GHQ-12  
12-item General Health Questionnaire, used to measure symptoms of psychological distress. Scores of 4 or more indicate a level of symptoms likely to need further treatment.

COST : CONSEQUENCES  
Crude measure of return on investment, calculated by dividing the cost of the service to funders, to financial gains to welfare advice clients. This under-estimates returns as excludes non-directly monetised outcomes such as avoiding repossession, improvements to housing circumstances, and reduced stress etc.

PROPENSITY SCORE  
Estimated probability of receiving intervention

STATA  
Statistical software package.

SWEMWBS  
Shortened Warwick and Edinburgh Mental Wellbeing Scale, used to measure subjective well-being. Greater scores indicate more positive well-being.

FINANCIAL STRAIN  
Subjective measure of financial strains assessed with the item, ‘how are you managing your finances these days?’ Possible responses are: ‘living comfortably, doing alright, just about managing, finding it difficult, finding it very difficult.’

ODDS RATIO (OR)  
Compares the odds of experiencing an outcome in the intervention group, to the odds of experiencing the outcome in the comparison group. An OR of 1 indicates no difference between the groups. If <1, the intervention group is less likely to experience the outcome than the comparison group; if >1, more likely.

RATIO OF ODDS RATIOS (rOR)  
A measure of the effect of receiving welfare advice on a binary outcome. Compares the odds ratio of an outcome by time in the advice group to the odds ratio of an outcome by time comparison group.

\[
\frac{odds \ of \ outcome \ in \ advice \ group @ followup}{odds \ of \ outcome \ in \ advice \ group @ baseline} \\
\frac{odds \ of \ outcome \ in \ comparison \ group @ followup}{odds \ of \ outcome \ in \ comparison \ group @ baseline}
\]

In other words, if the odds of experiencing an outcome were lower at follow-up than they were at baseline for the advice group (e.g., if there was an improvement in mental health over time) – how does this change compare to that seen in the comparison group? If rOR=1 there was no evidence for any impact of receiving advice – both groups experienced the same change in the odds of experiencing an outcome. If rOR<1 there was evidence for a positive impact of advice – e.g., the improvement over time (reduced odds of experiencing mental ill health) among the advice group was larger than the improvement over time among the comparison group. If rOR>1 there was evidence for a negative impact of advice – e.g., the improvement over time (reduced odds of experiencing mental ill health) among the advice group was not as big as the improvement over time among the comparison group.
REFERENCES


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79. Leuven E, Sianesi B. PSMATCH2: Stata module to perform full Mahalanobis and propensity score matching, common support graphing, and covariate imbalance testing. Statistical Software Components, 2015.

SURVEY MEASURES

Primary outcome

Common mental disorder. The 12-item General Health Questionnaire (GHQ-12) is a widely used screen for commonly occurring symptoms of mental distress, encompassing comorbid symptoms of anxiety and depression. (19) The GHQ-12 has been validated against standardised clinical interviews and is considered as a unidimensional construct. (69) Each item has four response categories on a Likert scale ranging from ‘not at all’ to ‘much more than usual’. The commonly used ‘GHQ-method’ of scoring (19) was used (‘rather more’ or ‘much more’ than usual =1, ‘not at all’ or ‘no more than usual’= 0). Scores were summed and range from 0 to 12, a score of 4 or more (GHQ ‘caseness’) indicated a level of symptoms likely to need further treatment. Standard procedure is to count missing items as low scores, those responding to fewer than four GHQ items were coded as missing.

Other outcomes

Well-being The 7-item Shortened Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) (20) evaluates various aspects of positive mental health over the past fortnight, requesting the level of agreement with statements such as, ‘I’ve been feeling optimistic about the future’. Responses are measured on a five-point scale ranging from ‘none of the time’ to ‘all of the time’. Scores are summed and used as a continuous variable; greater scores indicate more positive well-being. Scores range from 7 to 35 and are transformed to a total score according to an established conversion table. (70) In line with previous approaches (68) those who answered 3 or more items were included, and the average score of non-missing items was imputed for remaining items.

Consultation frequency. We asked individuals to report how many GP appointments they had had over the past 12 months (baseline only), and over the past three months (at follow up).

Financial strain. Perceived financial strain was measured with an item used in large UK household panel surveys (71) ‘How would you say you were managing your finances these days?’ Response options were on an ordinal scale from ‘living comfortably’ to ‘finding it very difficult’.

We examined coping and support seeking for financial pressures at baseline and follow-up using items adapted from the OECD Measuring Financial Literacy Questionnaire (72) and the English and Welsh Civil and Social Justice Survey (73). Participants were asked what they would do (e.g., ‘use credit card/overdraft’, ‘sell something’) and who they would go to (e.g., GP/health care professional or friends/family), if their income did not cover their costs. Questions about whether and how financial stressors affected them (e.g., physical health, mental health) were asked before enquiring who they would go to for support with these experiences. The follow up survey also asked about any changes since receiving advice (welfare advice group only); and about access to welfare advice services since baseline.

Propensity score covariates

Independent variables to be included in the model were identified a priori and measured at baseline (Table 1). This included the following categorical variables: age group, gender, ethnic group, marital status, employment status, educational attainment, household
composition, housing tenure, monthly household income, long-term health conditions status and financial capability. Financial capability was assessed with four items indicating problems meeting housing-related payments in the last year, taken from the British Household Panel Survey. (74) We summed the number of problems and created a binary variable (0/ 1+ problems).

Accessing the advice service

To explore further the utility of co-locating advice services, the surveys included questions about how they had heard about the service (e.g., GP/health professional, word of mouth); preferred location of welfare advice (GP or elsewhere); and, whether they had spoken to their GP about the issue they were seeing the adviser about (yes/no). Open ended questions explored reasons for the latter two items, responses were thematically coded for analyses.

Cost-consequences analysis

Cost-consequences analysis is a ‘course-grain estimate of return on investment’ used when there is incomplete data available to carry out a full financial analysis. (75) We divided the total financial gain for all individuals accessing the co-located advice services (including income gain and debt managed) using data from the CA IT platform, by the cost of the service to funders over the eight month study period.

DATA ANALYSIS METHODOLOGY

All analyses were carried out using STATA v.14. (76) Univariate descriptive analyses were carried out to examine baseline characteristics. Propensity scores were calculated with logit regression, with advice group membership as the dependent variable. (77, 78) The sample was divided into blocks of observations with similar propensity scores, t-tests were run to check for propensity score balance across each group within each block, and for covariates within each block across the two groups. Data were then kernel weighted (79) and post-estimation analyses assessed the extent to which the distribution of propensity scores in the advice and comparison groups overlapped (‘common support’), those outside the common support were excluded. Data were not imputed as missing propensity score covariate data were low (5.27%) and loss to follow-up was not associated with primary outcomes.

Estimating the impact of advice. The effect of the intervention (receiving advice) was estimated by comparing the before-after change in the intervention group to that in the comparison group. This can be done conveniently by including an interaction term between group and time (before-after indicator) in the statistical model.

To account for clustering within individuals and GP practices, data were analysed using mixed effects multi-level longitudinal regression methods. (80) All analyses specified robust standard errors, were weighted using the kernel weights generated, and additionally adjusted for indicators of missingness on propensity score covariates and loss to follow-up (educational attainment, household composition, household income, ethnicity). Logistic models were used for binary outcomes, interaction coefficients were exponentiated and expressed as ratios of odds ratios (rOR) with 95% confidence intervals (CI). For count outcomes we used Poisson models. Coefficients were expressed as percentage change in scores [1-exp(β3)], with 95% CIs. For continuous outcomes we used linear regression models with the interaction
coefficients indicating the difference between the changes in outcome score by group.

We re-ran analyses for the main outcomes, generating separate propensity scores for specific subgroups: gender (male/female); ethnicity (White, Black/Black British and other); long-term conditions status; and, whether or not individuals were recorded with, or self-reported, improvements since receiving advice in income, housing or employment. For the main outcomes, additional adjustments were made for financial strain for significant models.

**Missing data**

72% of the welfare advice group and 84% of the comparison group were retained in the study between baseline and follow-up. Data were analysed assuming missing at random (MAR). To assess this assumption, a binary variable was created to indicate missingness on any variable used to develop the propensity score and missingness due to loss to follow up. Logistic regressions with the missingness binary variable as the dependent variable were then run including key socio-economic covariates as independent variables. We identified several covariates that predicted missingness in propensity score variables (household income and ethnicity) and loss to follow-up (household composition and educational attainment), and were therefore satisfied that data were MAR.

Missing data were not imputed. This was because the proportion of missing data among propensity score covariates was low (5.27%) and because loss to follow-up was not associated with any of the primary outcomes. Further, considerable additional statistical complexity would have been required to combine a propensity score matching approach with multiple imputation. Multiple imputation involves the estimation of two sources of variance (within and between imputed datasets), and does not account for variance associated with the propensity score estimate. Full analyses would have to be run on each imputed dataset and then the findings combined, factoring in each source of variance in addition to clustering. The added value of such an approach was considered negligible.
### COMPARISONS WITH OTHER CITIZENS ADVICE CLIENTS

**Table 11** Comparison of sex, age, ethnicity and health status recorded during the study period among clients seen at the Haringey Citizens Advice (CA) (excluding health hubs), CA-recorded health hub clients and evaluation study sample during the study period (December 2015 – July 2016).

*Numbers do not add up to totals due to missing data

<table>
<thead>
<tr>
<th></th>
<th>All CA clients (excl. health hubs) (n=7760)</th>
<th>CA-recorded health hubs clients (n=295)</th>
<th>Welfare advice: study group (n=278)</th>
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63
Figure 6 Advice and comparison group sample flow chart

Advice group
- N=295 contacts with advice recipients
- N=17 declined to participate
- N=278 advice group sample

Comparison group
- N=5973 comparison recruitment packs sent/given out (5419 GP, 490 Housing association, 64 community)
- N=633 baseline questionnaires returned
- N=6 received welfare benefits/debt advice between baseline and follow up
- N=4 propensity scores outside range of common support
- N=623 comparison group sample
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<th>Comparison (n=623) (%)</th>
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</table>
EXAMPLE GP TOPIC GUIDE

1. Can you tell me a bit about your experiences of social issues (such as problems with benefits, debts, housing, employment or other similar things) among your patients?
   
   Probe: how does this manifest in consultations?
   
   Probe: in your view, do patients experience health problems linked to underlying social issues?

2. What tools, if any, do you feel you have available to address issues like these?
3. In your own words could you describe how you see your role in relation to patient social issues?
   
   Probe: is this shared by your colleagues, do you think?

4. Can you describe your experiences with the Citizens Advice service at this practice?
   
   Probe: Do you signpost patients to see the advice service here? Why/why not?

5. Could you tell me about any interaction you have with the adviser, if any?
   
   Probe: Are there any ways you feel this could be improved at all?

6. Do you think patients might go to see the adviser instead of you/another GP? Why? Why not?
7. Do you think it has the potential to reduce the number of non-clinical appointments? Why? Why not?
8. Are there any other ways that having an advice service might influence the practice in your view?
9. Do you get any feedback from patients or colleagues about the service?
   
   Probe: Are there any ways you feel this could be improved at all?

10. Is there anything you would do to change or improve the way the service is run at your practice?
11. Any other comments?
SURVEY QUESTIONNAIRES

Advice group baseline survey

HOW TO COMPLETE THE SURVEY

BEFORE YOU FILL IN YOUR SURVEY PLEASE READ THE INFORMATION BELOW
All the questions require 'tick box' responses.
Please read each question carefully and put an \( \checkmark \) in the box which comes closest to your views, checking you have answered all questions.
In most cases you will only have to tick one box but please read the questions carefully as sometimes you will need to tick more than one box.
Answer the next question unless asked otherwise.
Some questions include an ‘other’ option. If you would like to include an answer other than one of those listed within the question, please tick the ‘other’ box and write in your answer in the space provided.
Once you have finished please take a minute to check you have answered all the questions that you should have answered.
This questionnaire consists of 8 pages and should take no longer than 15 minutes to complete. Thank you in advance for your time.
When complete, please put your survey into the provided pre-paid envelope marked ‘SURVEY’ and return to Ipsos MORI. You do not need to add a stamp.
The enclosed consent form should also be completed. Please place your completed form into the provided pre-paid envelope marked ‘CONSENT’ and return to UCL. You do not need to add a stamp.

Section 1: About you

Q1 Are you?
PLEASE \( \times \) ONE BOX ONLY

- Male
- Female
- Other/prefer not to say

Q2 How old are you? (years)
PLEASE \( \times \) ONE BOX ONLY

- 16-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75+

Q4 Are you...
PLEASE \( \times \) ONE BOX ONLY

- Single (never married/in civil partnership)
- Married/in civil partnership
- Divorced/dissolved civil partnership/separated
- Widowed/surviving civil partner
- Living as married
Q3 What is your ethnic group?

CHOOSE ONE SECTION FROM A TO E, THEN TICK × ONE BOX TO BEST DESCRIBE YOUR ETHNIC GROUP OR BACKGROUND.

A - White
- English / Welsh / Scottish / Northern Irish / British
- Irish
- Gypsy or Irish Traveller
- Any other White background

B - Mixed / multiple ethnic groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed / multiple ethnic

C - Asian / Asian British
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

D - Black / African / Caribbean / Black British
- African
- Caribbean
- Any other Black / African / Caribbean background

E - Other ethnic group
- Arab
- Any other ethnic group

Q5 Are you...?

PLEASE × ONE BOX ONLY

- Unemployed – seeking work
- Unemployed – not seeking work
- Working full time (30+ hours)
- Working part time (9-29 hours)
- Retired
- Carer (children or elderly/disabled person)
- Student/volunteer
- Disabled or long term sick
- Other

Q6 Which of the following best describes your household?

PLEASE × ONE BOX ONLY

- I live alone without children
- I am a lone parent
- I live with my partner/spouse without child/children
- I live with my partner/spouse with child/children
- I live with other adults who are unrelated to me
- I live with family member(s)

Q7 Which of the following applies to your household monthly income?

PLEASE × ONE BOX ONLY

- Up to £399 per month
- £400-£549 per month
- £550-£799 per month
- £800-£999 per month
- £1,000-£1,499 per month
- £1,500-£1,999 per month
- Over £2,000 per month
Q8  What is the highest educational or school qualification you have?  
PLEASE × ONE BOX ONLY

- None
- Higher educational qualification below degree level
- Up to GCSE or O-level, or equivalent (e.g., high school diploma)
- Higher degree or above
- Up to A-level or equivalent (e.g. advanced placement qualification)

Q9  Which of the following best describes your accommodation?  
PLEASE × ONE BOX ONLY

- Owned outright
- Rented
- Owned/being bought on mortgage
- Rent free
- Shared ownership
- Other

Q10 How many times have you visited your doctor’s surgery for an appointment in the last year?  
PLEASE WRITE IN BOX OPPOSITE

Times

Q11 And in the last three months?  
PLEASE WRITE IN BOX OPPOSITE

Times

Q12 Do you have a long-standing (lasting/likely to last a year or more) physical or mental impairment, illness or disability)?  
PLEASE × ONE BOX ONLY

- Yes
- No

Q13 If yes, is this:  
PLEASE × ALL THAT APPLY

- A disability/impairment
- Long term mental health condition
- Long term physical health condition

Q14 Do you give unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction?  
PLEASE × ONE BOX ONLY

- Yes
- No

Section 2: Your welfare advice service

Q15 How did you hear about the advice service at this GP practice?  
PLEASE × ONE BOX ONLY

- My GP/the GP practice
- Citizens Advice Bureaux/other information & advice service
If this advice service was not available at this GP practice, where would you go?
PLEASE × ALL THAT APPLY

- My GP/other healthcare professional
- Would not have sought advice
- GP receptionist/other GP staff
- Don’t know
- Other information & advice service
- Other

If you had the choice, would you rather see a welfare adviser at a GP practice or somewhere else?
PLEASE × ONE BOX ONLY

- GP practice
- Somewhere else

Why? Please state a reason
PLEASE WRITE IN BELOW

Have you spoken to your doctor about any of the issues you are seeing the adviser about today?
PLEASE × ONE BOX ONLY

- Yes
- No

Why?
PLEASE WRITE IN BELOW

Section 3: Your finances

How would you say you are doing financially compared to a year ago?
PLEASE × ONE BOX ONLY

- Better off
- About the same
- Worse off

Looking ahead, how do you think you will be financially in a year from now?
PLEASE × ONE BOX ONLY
Q23
How would you say you are managing your finances these days?
PLEASE × ONE BOX ONLY
- Better off
- About the same
- Worse off
- Living comfortably
- Finding it difficult
- Doing alright
- Finding it very difficult
- Just about getting by

Q24
Many people these days are finding it difficult to keep up with their housing payments. In the last 12 months have you:
PLEASE × ALL THAT APPLY
- Had difficulties paying for your accommodation?
- Had to borrow to meet housing payments?
- Had to make cutbacks to meet housing payments?
- Been more than two months behind with your rent/mortgage?
- None of these

Q25
What would you do if your income did not cover your costs?
PLEASE × ALL THAT APPLY
- Draw money from savings
- Borrow money/take out loan
- Use credit card/overdraft
- Miss payments
- Sell something
- Do nothing
- Cut back on spending
- Seek advice
- Work extra hours
- Other

Q27
If you ever had a problem linked to being behind and unable to pay, for example:
- Credit or store cards, or Hire Purchase/credit purchases
- Personal loans/owed money
- Utility bills (e.g. electricity) or TV licence, or council tax/income tax
- Court fines
- Other payments
- Or in terms of your entitlement to/how any of these were being dealt with:
- Welfare benefits or tax credits
- State pension/Pension credits
- Student loans or grants
What would you do?
PLEASE × ALL THAT APPLY
- Do nothing
- No one to talk to about these issues
- Talk to GP/other health professional
- Talk to Citizens Advice/other adviser
- Talk to faith leader or other member of religious organisation
- Other
- Talk to friends or family
- Don’t know
Please rate each question on the scales below by choosing the number that most reflects how you feel today
PLEASE × ONE BOX ONLY

How would you rate your level of financial strain today?
- Overwhelming
- No strain

How satisfied are you with your present financial situation?
- Dissatisfied
- Satisfied

How do you feel about your current financial situation?
- Overwhelmed
- Comfortable

How often are you concerned or worried about being able to meet usual monthly living expenses?
- All the time
- Never

How confident are you that you could find the money to pay for a financial emergency that costs about £500?
- No confidence
- High confidence

How often are you unable to socialise (e.g. go out for dinner or a drink, go to the cinema or something else) because you cannot afford to?
- All the time
- Never

How often do you find yourself only just about getting by?
- All the time
- Never
How much of a worry are your household finances in general?

Overwhelming 1 2 3 4 5 6 7 8 9 10 Not at all

Q28 If you have had any of the financial issues listed above (or similar), did you experience any of the following as a result?
PLEASE × ALL THAT APPLY
- Physical ill health
- Stress related ill health
- Other mental ill health
- Drinking more alcohol
- Using drugs
- Loss of confidence
- Fear
- Problems sleeping
- None of these

Q29 If you were to experience any of the above issues (e.g. ill health, loss of confidence etc.) as a result of your financial situation or benefits, what would you do?
PLEASE × ALL THAT APPLY
- Do nothing
- Talk to GP/other health professional
- Talk to faith leader or other member of religious organisation
- Talk to friends or family
- No one to talk to about these issues
- Talk to Citizens Advice/other adviser
- Other
- Don’t know

Section 4: Your wellbeing

Q30 Last, here are some questions about your thoughts and feelings recently. Have you recently...
PLEASE × ONE BOX ONLY FOR EACH STATEMENT

a) Been able to concentrate on whatever you’re doing?
- Better than usual
- Less than usual
- Much less than usual
- Same as usual

b) Lost much sleep over worry?
- Not at all
- Rather more than usual
- Much more than usual
- No more than usual

c) Felt that you were playing a useful part in things?

b) Been able to enjoy your normal day-to-day activities?
- More so than usual
- Less so than usual
- Same as usual

h) Been able to face up to problems?
- More so than usual
- Less so than usual
- Same as usual

i) Been feeling unhappy or depressed?
More so than usual
Less so than usual
Much less than usual
Same as usual
Not at all
Rather more than usual
Much more than usual
No more than usual

Felt capable of making decisions about things?
More so than usual
Less so than usual
Much less than usual
Same as usual
Not at all
Rather more than usual
Much more than usual
No more than usual

Felt constantly under strain?
Not at all
Rather more than usual
Much more than usual
No more than usual

Felt you couldn’t overcome your difficulties?
Not at all
Rather more than usual
Much more than usual
No more than usual

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience for each statement over the past two weeks.

a) I’ve been feeling optimistic about the future
b) I’ve been feeling useful
c) I’ve been feeling relaxed
d) I’ve been dealing with my problems well
e) I’ve been thinking clearly
f) I’ve been feeling close to people
g) I’ve been able to make my mind up about things

Thank you for taking part in the study. Please return your completed questionnaire according to the instructions on the first page of this questionnaire.
Baseline comparison group survey

**HOW TO COMPLETE THE SURVEY**

BEFORE YOU FILL IN YOUR SURVEY PLEASE READ THE INFORMATION BELOW
All the questions require ‘tick box’ responses.
Please read each question carefully and put an ✗ in the box which comes closest to your views, checking you have answered all questions.
In most cases you will only have to tick one box but please read the questions carefully as sometimes you will need to tick more than one box.
Answer the next question unless asked otherwise.
Some questions include an ‘other’ option. If you would like to include an answer other than one of those listed within the question, please tick the ‘other’ box and write in your answer in the space provided.
Once you have finished please take a minute to check you have answered all the questions that you should have answered.
This questionnaire consists of 8 pages and should take no longer than 15 minutes to complete. Thank you in advance for your time.
When complete, please put your survey into the provided pre-paid envelope with ‘SURVEY’ marked on the back and return to Ipsos MORI. **You do not need to add a stamp.**
The enclosed consent form should also be completed. Please place your completed form into the provided pre-paid envelope with ‘CONSENT’ marked on the back and return to UCL. **You do not need to add a stamp.**

**Section 1: About you**

**Q1** Are you?
PLEASE ✗ ONE BOX ONLY

- ☐ Male
- ☐ Other/prefer not to say
- ☐ Female

**Q2** How old are you? (years)
PLEASE ✗ ONE BOX ONLY

- ☐ 16-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75+

BARCODE PLACEMENT ONLY. DO NOT PRINT.

**Q3** What is your ethnic group?
CHOOSE ONE SECTION FROM A TO E, THEN TICK ✗ ONE BOX TO BEST DESCRIBE YOUR ETHNIC GROUP OR BACKGROUND.

A - White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish

C - Asian / Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
Gypsy or Irish Traveller
Any other White background

B - Mixed / multiple ethnic groups
White and Black Caribbean
White and Black African
White and Asian
Any other Mixed / multiple ethnic background

D - Black / African / Caribbean / Black British background
African
Caribbean
Any other Black / African / Caribbean background

E - Other ethnic group
Arab
Any other ethnic group

Q4 Are you...
PLEASE × ONE BOX ONLY
Single (never married/in civil partnership)
Married/in civil partnership
Divorced/dissolved civil partnership/separated
Widowed/surviving civil partner
Living as married

Q5 Are you...?
PLEASE × ONE BOX ONLY
Unemployed – seeking work
Unemployed – not seeking work
Working full time (30+ hours)
Working part time (9-29 hours)
Retired
Carer (children or elderly/disabled person)
Student/volunteer
Disabled or long term sick
Other

Q6 Which of the following best describes your household?
PLEASE × ONE BOX ONLY
I live alone without children
I am a lone parent
I live with my partner/spouse without child/children
I live with my partner/spouse with child/children
I live with other adults who are unrelated to me
I live with family member(s)

Q7 Which of the following applies to your household monthly income?
PLEASE × ONE BOX ONLY
Up to £399 per month
£400-£549 per month
£550-£799 per month
£1,000-£1,499 per month
£1,500-£1,999 per month
Over £2,000 per month
£800-£999 per month

Q8 What is the highest educational or school qualification you have?
PLEASE × ONE BOX ONLY

- None
- Higher educational qualification below degree level
- Up to GCSE or O-level, or equivalent (e.g., high school diploma)
- Higher degree or above
- Up to A-level or equivalent (e.g., advanced placement qualification)

Q9 Which of the following best describes your accommodation?
PLEASE × ONE BOX ONLY

- Owned outright
- Rented
- Owned/being bought on mortgage
- Rent free
- Shared ownership
- Other

Q10 How many times have you visited your doctor’s surgery for an appointment in the last year?
PLEASE WRITE IN BOX OPPOSITE

Times

Q11 And in the last three months?
PLEASE WRITE IN BOX OPPOSITE

Times

Q12 Do you have a long-standing (lasting/likely to last a year or more) physical or mental impairment, illness or disability)?
PLEASE × ONE BOX ONLY

- Yes
- No

Q13 If yes, is this:
PLEASE × ALL THAT APPLY

- A disability/impairment
- Long term physical health condition
- Long term mental health condition

Q14 Do you give unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction?
PLEASE × ONE BOX ONLY

- Yes
- No

Section 2: Your finances

Q15 Have you ever received advice about your personal or household finances or benefits from any of the services below?
PLEASE × ALL THAT APPLY

- Citizens Advice Bureaux (NOT at a GP surgery)
- Other advice service
Citizens Advice Bureaux (at a GP surgery other than my own)  None
Citizens Advice Bureaux (at my own GP surgery)

Q16 Was this in the last three years (since 2012/13)?
PLEASE × ONE BOX ONLY
☐ Yes ☐ No

Q17 How would you say you are doing financially compared to a year ago?
PLEASE × ONE BOX ONLY
☐ Better off ☐ Worse off ☐ About the same

Q18 Are you currently receiving any of the below?
PLEASE × ALL THAT APPLY
☐ Unemployment-related benefits/National Insurance Credits
☐ Child benefit
☐ Income support
☐ Tax credits, e.g. Child Tax Credit
☐ Sick/disability/incapacity benefit
☐ Housing/Council tax benefit
☐ Any pension
☐ Any other benefits

Q19 Many people these days are finding it difficult to keep up with their housing payments. In the last 12 months have you:
PLEASE × ALL THAT APPLY
☐ Had difficulties paying for your accommodation?
☐ Had to make cutbacks to meet housing payments?
☐ Had to borrow to meet housing payments?
☐ Been more than two months behind with your rent/mortgage?

Q20 How would you say you are managing your finances these days?
PLEASE × ONE BOX ONLY
☐ Living comfortably ☐ Finding it difficult
☐ Doing alright ☐ Finding it very difficult
☐ Just about getting by

Q21 Looking ahead, how do you think you will be financially in a year from now?
PLEASE × ONE BOX ONLY
☐ Better off ☐ About the same
☐ Worse off

Q22 What would you do if your income did not cover your costs?
PLEASE × ALL THAT APPLY
☐ Draw money from savings ☐ Borrow money/take out loan
☐ Use credit card/overdraft ☐ Miss payments
☐ Sell something ☐ Do nothing
☐ Cut back on spending ☐ Seek advice
Q23

Please rate each question on the scales below by ticking the number that most reflects how you feel today.

PLEASE × ONE BOX ONLY

How would you rate your level of financial strain today?

Overwhelming 1 2 3 4 5 6 7 8 9 10  No strain

How satisfied are you with your present financial situation?

Dissatisfied 1 2 3 4 5 6 7 8 9 10  Satisfied

How do you feel about your current financial situation?

Overwhelmed 1 2 3 4 5 6 7 8 9 10  Comfortable

How often are you concerned or worried about being able to meet usual monthly living expenses?

All the time 1 2 3 4 5 6 7 8 9 10  Never

How confident are you that you could find the money to pay for a financial emergency that costs about £500?

No confidence 1 2 3 4 5 6 7 8 9 10  High confidence

How often are you unable to socialise (e.g. go out for dinner or a drink, go to the cinema or something else) because you cannot afford to?

All the time 1 2 3 4 5 6 7 8 9 10  Never

How often do you find yourself only just about getting by?

All the time 1 2 3 4 5 6 7 8 9 10  Never

How much of a worry are your household finances in general?
Overwhelming 1 2 3 4 5 6 7 8 9 10 Not at all

Q24 If you ever had a problem linked to being behind and unable to pay, for example:
- Credit or store cards, or Hire Purchase/credit purchases
- Personal loans/owed money
- Utility bills (e.g. electricity) or TV licence, or council tax/income tax
- Court fines
- Other payments

Or in relation to your entitlement to, or with the way in which any of the following were being dealt with:
- Welfare benefits or tax credits
- State pension/Pension credits
- Student loans or grants

What would you do?
PLEASE × ALL THAT APPLY
- Do nothing
- No one to talk to about these issues
- Talk to GP/other health professional
- Talk to Citizens Advice/other adviser
- Talk to faith leader or other member of religious organisation
- Other
- Talk to friends or family
- Don’t know

Q25 If you have had any of the financial issues listed above (or similar), did you experience any of the following as a result? PLEASE × ALL THAT APPLY
- Physical ill health
- Loss of confidence
- Stress related ill health
- Fear
- Other mental ill health
- Problems sleeping
- Drinking more alcohol
- None of these
- Using drugs
- None of these

Q26 If you were to experience any of the above issues (e.g. ill health, loss of confidence etc.) as a result of your financial situation or benefits, what would you do? PLEASE × ALL THAT APPLY
- Do nothing
- No one to talk to about these issues
- Talk to GP/other health professional
- Talk to Citizens Advice/other adviser
- Talk to faith leader or other member of religious organisation
- Other
- Talk to friends or family
- Don’t know

Section 3: Your wellbeing

Q27 Last, here are some questions about your thoughts and feelings recently. Have you recently...
PLEASE × ONE BOX ONLY FOR EACH STATEMENT

a) Been able to concentrate on whatever you’re doing?

b) Been able to enjoy your normal day-to-day activities?
Q28 Below are some statements about feelings and thoughts. Please tick the box that best describes your experience for each statement over the past two weeks.

PLEASE × ONE BOX ONLY FOR EACH ROW

<table>
<thead>
<tr>
<th>a)</th>
<th>I’ve been feeling optimistic about the future</th>
<th>None of the time (1)</th>
<th>Rarely (2)</th>
<th>Some of the time (3)</th>
<th>Often (4)</th>
<th>All of the time (5)</th>
</tr>
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<tbody>
<tr>
<td>b)</td>
<td>Lost much sleep over worry?</td>
<td>Not at all</td>
<td>More so than usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
<td>Same as usual</td>
</tr>
<tr>
<td>h)</td>
<td>Been able to face up to problems?</td>
<td>Not at all</td>
<td>More so than usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
<td>Same as usual</td>
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<tr>
<td>c)</td>
<td>Felt that you were playing a useful part in things?</td>
<td>More so than usual</td>
<td>Not at all</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
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<tr>
<td>i)</td>
<td>Been feeling unhappy or depressed?</td>
<td>More so than usual</td>
<td>Not at all</td>
<td>Rather more than usual</td>
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<td>d)</td>
<td>Felt capable of making decisions about things?</td>
<td>More so than usual</td>
<td>Not at all</td>
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<td>j)</td>
<td>Been losing confidence in yourself?</td>
<td>Not at all</td>
<td>More so than usual</td>
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<td>e)</td>
<td>Felt constantly under strain?</td>
<td>Not at all</td>
<td>More so than usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
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<tr>
<td>k)</td>
<td>Been thinking of yourself as a worthless person?</td>
<td>More so than usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
<td>Same as usual</td>
<td></td>
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<tr>
<td>f)</td>
<td>Felt you couldn’t overcome your difficulties?</td>
<td>Not at all</td>
<td>More so than usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
<td>Same as usual</td>
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<tr>
<td>l)</td>
<td>Been feeling reasonably happy, all things considered?</td>
<td>More so than usual</td>
<td>Less so than usual</td>
<td>Much less than usual</td>
<td>Same as usual</td>
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b) I’ve been feeling useful

c) I’ve been feeling relaxed

d) I’ve been dealing with my problems well

e) I’ve been thinking clearly

f) I’ve been feeling close to people

g) I’ve been able to make my mind up about things

Thank you for taking part in the study. Please return your completed questionnaire according to the instructions on the first page of this questionnaire.

Both groups follow up survey

HOW TO COMPLETE THE SURVEY

BEFORE YOU FILL IN YOUR SURVEY PLEASE READ THE INFORMATION BELOW

All the questions require ‘tick box’ responses.

Please read each question carefully and put an X in the box which comes closest to your views, checking you have answered all questions.

In most cases you will only have to tick one box but please read the questions carefully as sometimes you will need to tick more than one box.

Answer the next question unless asked otherwise.

Some questions include an ‘other’ option. If you would like to include an answer other than one of those listed within the question, please tick the ‘other’ box and write in your answer in the space provided.

Once you have finished please take a minute to check you have answered all the questions that you should have answered.

This questionnaire consists of 8 pages and should take no longer than 10 minutes to complete. Thank you in advance for your time.

When complete, please put your survey into the provided pre-paid envelope marked ‘SURVEY’ and return to Ipsos MORI. You do not need to add a stamp.

Section 1: About you

Q1 Are you...?

PLEASE ✗ ONE BOX ONLY

✓ Unemployed – seeking work
✓ Unemployed – not seeking work
✓ Working full time (30+ hours)
✓ Working part time (9-29 hours)
✓ Retired
✓ Carer (children or elderly/disabled person)
✓ Student/volunteer
✓ Disabled or long term sick
✓ Other

Q2 How many times have you visited your doctor’s surgery since completing the first survey (3-4 months ago)?

PLEASE WRITE IN BOX OPPOSITE

Times

Section 2: Your finances
Q3 Which of the following applies to your household monthly income?

PLEASE × ONE BOX ONLY

☑️ Up to £399 per month
☒️ £1,000-£1,499 per month
☒️ £1,000-£1,499 per month
☒️ £1,400-£1,999 per month
☒️ Over £2,000 per month

Q4 How would you say you are managing your finances these days?

PLEASE × ONE BOX ONLY

☑️ Living comfortably
☒️ Finding it difficult
☒️ Finding it very difficult
☒️ Just about getting by

Q5 Looking ahead, how do you think you will be financially in a year from now?

PLEASE × ONE BOX ONLY

☑️ Better off
☒️ Worse off
☒️ About the same

Q6 Have you received advice about your personal or household finances or benefits from any of the services below since completing the first survey (3-4 months ago)?

PLEASE × ALL THAT APPLY

☑️ Citizens Advice Bureaux (NOT at a GP surgery)
☒️ Citizens Advice Bureaux (at a GP surgery other than my own)
☒️ Citizens Advice Bureaux (at my own GP surgery)
☒️ Other Information & advice service
☒️ None

Q7 What would you do if your income did not cover your costs?

PLEASE × ALL THAT APPLY

☑️ Draw money from savings
☒️ Borrow money/take out loan
☑️ Use credit card/overdraft
☒️ Miss payments
☑️ Sell something
☒️ Do nothing
☑️ Cut back on spending
☒️ Seek advice
☑️ Work extra hours
☒️ Other

Q8 Please rate each question on the scales below by choosing the number that most reflects how you feel today

PLEASE × ONE BOX ONLY

How would you rate your level of financial strain today?

Overwhelming 1 2 3 4 5 6 7 8 9 10 No strain

How satisfied are you with your present financial situation?
How do you feel about your current financial situation?

**Dissatisfied**  
1 2 3 4 5 6 7 8 9 10 **Satisfied**

How often are you concerned or worried about being able to meet usual monthly living expenses?

**Overwhelmed**  
1 2 3 4 5 6 7 8 9 10 **Comfortable**

How confident are you that you could find the money to pay for a financial emergency that costs about £500?

**No confidence**  
1 2 3 4 5 6 7 8 9 10 **High confidence**

How often are you unable to socialise (e.g. go out for dinner or a drink, go to the cinema or something else) because you cannot afford to?

**All the time**  
1 2 3 4 5 6 7 8 9 10 **Never**

How often do you find yourself only just about getting by?

**All the time**  
1 2 3 4 5 6 7 8 9 10 **Never**

How much of a worry are your household finances in general?

**Overwhelming**  
1 2 3 4 5 6 7 8 9 10 **Not at all**

If you ever had a problem linked to being behind and unable to pay, for example:
Credit or store cards, or Hire Purchase/credit purchases
- Personal loans/owed money
- Utility bills (e.g. electricity) or TV licence, or council tax/income tax
- Court fines
- Other payments

Or in terms of your entitlement to/how any of the following were being dealt with:
- Welfare benefits or tax credits
- State pension/Pension credits
- Student loans or grants

What would you do?
PLEASE × ALL THAT APPLY
☑ Do nothing ☐ No one to talk to about these issues
☐ Talk to GP/other health professional ☐ Talk to Citizens Advice/other adviser
☐ Talk to faith leader or other member of religious organisation ☐ Other
☐ Talk to friends or family ☐ Don’t know

Q10 Some people experience one or more of the issues below linked to problems with money or benefits:
- Physical ill health
- Stress-related ill health
- Other mental ill health
- Drinking more alcohol
- Using drugs
- Loss of confidence
- Fear
- Problems sleeping

If you did experience any of the issues above as a result of your financial situation or benefits, what would you do?
PLEASE × ALL THAT APPLY
☑ Do nothing ☒ No one to talk to about these issues
☒ Talk to GP/other health professional ☒ Talk to Citizens Advice/other adviser
☒ Talk to faith leader or other member of religious organisation ☒ Other
☒ Talk to friends or family ☒ Don’t know

Q11 If you have talked to Citizens Advice or another information & advice service since completing the first survey (3-4 months ago), did it lead to any of these improvements?
PLEASE × ALL THAT APPLY
☑ Physical health ☐ Income
☑ Levels of stress ☐ Confidence
☑ Relationships ☐ Involvement in community
☑ Housing circumstances ☐ None of these
☑ Employment circumstances ☐ Not applicable
Section 4: Your wellbeing

Q12 Last, here are some questions about your thoughts and feelings recently. Have you recently...
PLEASE × ONE BOX ONLY FOR EACH STATEMENT

a) Been able to concentrate on whatever you’re doing?
   Better than usual
   Less than usual
   Much less than usual
   Same as usual

b) Lost much sleep over worry?
   Not at all
   Rather more than usual
   Much more than usual
   Not at all


c) Felt that you were playing a useful part in things?
   More so than usual
   Less so than usual
   Much less than usual
   Same as usual

d) Felt capable of making decisions about things?
   More so than usual
   Less so than usual
   Much less than usual
   Same as usual

e) Felt constantly under strain?
   Not at all
   Rather more than usual
   Much more than usual
   No more than usual

f) Felt you couldn’t overcome your difficulties?
   Not at all
   Rather more than usual
   Much more than usual
   No more than usual

g) Been able to enjoy your normal day-to-day activities?
   More so than usual
   Less so than usual
   Much less than usual
   Same as usual

h) Been able to face up to problems?
   More so than usual
   Less so than usual
   Much less than usual
   Same as usual

i) Been feeling unhappy or depressed?
   Not at all
   Less so than usual
   Rather more than usual
   Much more than usual
   No more than usual

j) Been losing confidence in yourself?
   Not at all
   Rather more than usual
   Much more than usual
   No more than usual

k) Been thinking of yourself as a worthless person?
   Not at all
   Rather more than usual
   Much more than usual
   No more than usual

l) Been feeling reasonably happy, all things considered?
   More so than usual
   Less so than usual
   Much less than usual
   Same as usual
Below are some statements about feelings and thoughts. Please tick the box that best describes your experience for each statement over the past two weeks.

PLEASE * ONE BOX ONLY FOR EACH ROW

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<td>d) I've been dealing with my problems well</td>
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<td>e) I've been thinking clearly</td>
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<td>f) I've been feeling close to people</td>
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<td>g) I've been able to make my mind up about things</td>
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Thank you for taking part in the study. Please return your completed questionnaire according to the instructions on the first page of this questionnaire.