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# A review of the effectiveness and experiences of welfare advice services co-located in health settings: A critical narrative systematic review

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ABSTRACT

We conducted a narrative systematic review to assess the health, social and financial impacts of co-located welfare services in the UK and to explore the effectiveness of and facilitators and barriers to successful implementation of these services, in order to guide future policy and practice. We searched Medline, EMBASE and other literature sources, from January 2010 to November 2020, for literature examining the impact of co-located welfare services in the UK on any outcome. The review identified 14 studies employing a range of study designs, including: one non-randomised controlled trial; one pilot randomised controlled trial; one before-and-after-study; three qualitative studies; and eight case studies. A theory of change model, developed a priori, was used as an analytical framework against which to map the evidence on how the services work, why and for whom. All studies demonstrated improved financial security for participants, generating an average of £27 of social, economic and environmental return per £1 invested. Some studies reported improved mental health for individuals accessing services. Several studies attributed subjective improvements in physical health to the service addressing key social determinants of health. Benefits to the health service were also demonstrated through reduced workload for healthcare professionals. Key components of a successful service included co-production during service development and ongoing enhanced multi-disciplinary collaboration. Overall, this review demonstrates improved financial security for participants and for the first time models the wider health and welfare benefits for participants and for health service from these services. However, given the generally poor scientific quality of the studies, care must be taken in drawing firm conclusions. There remains a need for more high quality research, using experimental methods and larger sample sizes, to further build upon this evidence base and to measure the strength of the proposed theoretical pathways in this area.

## 1. Introduction

Early childhood deprivation is associated with significant negative physical, mental health and social outcomes that not only limit a child's development in the short-term but have long lasting effects into adulthood (Marmot et al., 2010; Wickham et al., 2016). In adulthood, links between financial insecurity, social deprivation and mental health are also well established (Marmot et al., 2010). Financial insecurity can precipitate and perpetuate mental health problems and has been found to be a predictor of chronic physical illness (Kahn and Pearlin, 2006; Georgiades et al., 2009; Alliance, 2015). Furthermore, individuals suffering with poor mental health associated with financial insecurity, worsened in recent years by austerity and then the Covid-19 pandemic, are more likely to face challenges in accessing the advice and support needed to address these welfare issues (Jenkins et al., 2009; Fitch et al., 2011; Dickerson et al., 2022). The Covid-19 pandemic and other austerity measures have created and exacerbated financial insecurity for many families, worsening existing inequalities (Dickerson et al., 2022).

The adverse effect of chronic financial insecurity on physical and mental health can be obviated if corrected early on (Kahn and Pearlin, 2006). However, there is evidence of unequal access to benefits in some communities in the United Kingdom (UK), and this has been found to be particularly pronounced in some ethnic minority groups (Prady et al., 2016).

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Various schemes have been put in place to improve uptake of benefits by co-locating welfare rights advice services within healthcare settings (Bateman, 2008, Krska et al., 2013; Woodhead et al., 2017). A systematic review of welfare rights advice delivered in healthcare settings found that there was evidence that this approach resulted in financial gains but at that time there was limited high quality evidence to suggest that this resulted in improved uptake or measurable health or social benefits (Adams et al., 2006). Allmark et al. developed a theory of change model, building upon this review with a synthesis of evidence published to 2010, to demonstrate the possible causal pathways linking co-located welfare services and health benefits (Allmark et al., 2013a, 2013b). However, there is little collective understanding of how best to implement these welfare services in a healthcare setting and how to target those most in need.

Since 2010 in the UK, significant reforms made to the social security system generated confusion for those already accessing benefits, as well as those possibly entitled to them. The Welfare Reform Act 2012 legislated for Universal Credit and Personal Independence Payments (Hobson, 2020). Further temporary and some more-permanent changes have been made in response to the 2020 coronavirus pandemic and continue to evolve over the course of the pandemic (Hobson, 2020).

In light of the changing situation in the UK, and the increased need for financial support for vulnerable groups in the recovery from the pandemic, this paper provides a timely update of the research evidence, building upon the results of the previous 2006 review and theory of change model published in 2013 (Adams et al., 2006; Allmark et al., 2013a, 2013b), in order to guide future policy and practice. We conducted a critical narrative systematic review to assess the health, social and financial impacts of welfare advice services co-located in healthcare settings and to explore the facilitators and barriers to successful implementation of these services to understand how to reach those populations most in need of this service, whilst representing value for money for commissioners and society.

## 2. Objectives

This review explores the effectiveness and experiences of welfare advice services co-located in a healthcare setting in the UK. The objectives are to:

1. Determine the evidence of effectiveness of welfare advice services co-located in a healthcare setting on health and social outcomes, using a meta-analysis where possible.
2. Assess the economic benefits of co-located welfare advice services from the perspective of the individual, the national health service (NHS), the commissioner and society.
3. Identify and explore the relationships between reported facilitators and barriers to implementation, to understand how and why particular barriers and/or enablers to implementation operate.

## 3. Methods

A critical narrative systematic review (Popay et al., 2006) was conducted, structured in accordance with recommendations from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Shamseer et al., 2015). Data extracted from the included studies were analysed using a critical narrative synthesis, adopting an evidence-led framework described by Rodgers et al. (Rodgers et al., 2009). This approach consists of four elements employed in an iterative manner to analyse the included studies: developing a theory of how the intervention works, why and for whom; developing a preliminary synthesis of findings of included studies; exploring relationships in the data; and assessing the robustness of the synthesis. This approach was chosen in anticipation of fewer empirical studies and a high volume of grey literature, based on the previously conducted systematic review and an initial scoping search.

## 4. Search strategy

A literature search was conducted for relevant published articles from the sources listed in Table 1. Search strategies were developed, built upon the previous systematic review in this area (Adams et al., 2006), separately for each of the academic databases, in order to match the appropriate indexing terms, see Appendix One. The search results were limited to those written in English with a publication date between January 1st, 2010 and November 30, 2020.

## 5. Inclusion and exclusion criteria

This systematic review includes studies which qualitatively or quantitatively examined the impact of welfare advice services delivered whilst physically co-located in a healthcare setting in the United Kingdom, on any outcome (including health, social, financial outcomes), published from January 2010 to November 2020.

Studies published outside the UK were excluded, given the significant variation in nature, provision and funding of both welfare services and healthcare settings. Studies published prior to 2010 were also excluded, owing to the significant reforms made to the social security system in the UK at this time. Moreover, studies examining the provision of specialist services (e.g. housing advice for homeless people) were excluded from the study, as these are not delivered as general welfare advice services by welfare advisors.

For the purposes of this review, healthcare settings are those defined as health care related buildings, where the primary purpose is to promote, restore or maintain health (World Health Organization, 2009). Welfare advice services are defined as the delivery of expert advice concerning general welfare rights and entitlement to and claims for welfare benefits.

## 6. Data extraction and record management

Following completion of the literature search, the results were exported to Covidence, a screening and data extraction software tool (Veritas Health Innovation). Screening was performed through a process

**Table 1**
Literature sources searched for studies of the health, social and financial effects of welfare services co-located in health settings.

| Electronic databased searched | Websites | Other sources |
|---|---|---|
| - Applied Social Sciences Index and Abstracts (ASSIA)<br>- Humanities Index<br>- Cumulated Index to Nursing and Allied Health Literature (CINAHL)<br>- Cochrane Database of Systematic Reviews<br>- EMBASE<br>- Health Management Information Consortium<br>- International Bibliography of the Social Sciences (IBSS)<br>- Medline<br>- NHS Economic Evaluation Database<br>- PAIS Index<br>- Psycinfo<br>- Science Citation Index<br>- Social Policy and Practice and Social Care Online<br>- Social Science Citation Index<br>- Social Services Abstracts<br>- Sociological Abstracts<br>- Taylor & Francis<br>- WorldCat<br>- Zetoc | - Age Concern www.ageconcern.org.uk<br>- Child Poverty Action Group www.cpag.org.uk<br>- Department of Health (UK) www.dh.gov.uk<br>- General Accounting Office (US) www.gao.gov<br>- Home Office (UK) www.homeoffice.gov.uk<br>- Joseph Rowntree Foundation www.jrf.org.uk<br>- MDRC www.mdrc.org<br>- National Audit Office (UK) www.nao.org.uk<br>- Office of Policy (US) www.ssa.gov/policy<br>- Office of the Deputy Prime Minister www.odpm.gov.uk<br>- Rightsnet www.rightsnet.org.uk<br>- Urban Institute www.urban.org | - Hand searching of key journals<br>- Google<br>- Google Scholar<br>- Reference list of included articles<br>- Author searches<br>- Conference publications<br>- Published policies<br>- Other relevant grey literature |

of marking records for inclusion based on the relevance of the title, followed by the abstract and full text. The accuracy of the selection was checked by a second reviewer who repeated the abstract and full text selection process independently with a random sample of 10% of excluded studies.

Data were extracted using a structured, pre-piloted, proforma. Headings adapted from Popay et al. were used to structure the data extraction: setting, participants, aim, sampling and recruitment, method, analysis and results (Popay et al., 2006). The reference management software, EndNote, was used to store and manage the retrieved references.

## 7. Quality assessment

The quality of each study was assessed using tools from the Center for Evidence-Based Management (CEBMa) according to study design, including quantitative and qualitative designs (Center for Evidence-Based Management, 2014). The CEBMa does not include a tool for studies adopting a mixed methods design. For mixed methods studies only, the Mixed Methods Appraisal Tool (MMAT) was used to assess quality and risk of bias (Hong et al., 2018). Studies were assessed based on the clarity of the research question, eligibility criteria, study population and sample size, outcomes measured, and type of statistical analysis employed. After assessing their quality, studies were classified into three appraisal categories (high, medium and low) based on their internal validity indicated by the quality appraisal and risk of bias score.

Alongside a quality assessment, all studies were appraised using tools to evaluate the relevance and 'richness' of their findings. 'Richness' has been described as 'the extent to which study findings provide in-depth explanatory insights that are transferable to other settings' (Popay et al., 2006). The criteria for assessment of 'richness' taken from an approach by Higginbottom et al. (2020) are described in Table 2 (Higginbottom et al., 2013; Higginbottom et al., 2020).

## 8. Data synthesis

Data extracted from the included studies were analysed using a critical narrative synthesis, adopting an evidence-led framework described by Rodgers et al. (Rodgers et al., 2009). An overarching theory of change was developed a priori and used as an analytical framework against which to assess the evidence and explain how the intervention works, why and for whom. This was refined in light of the emerging findings from the narrative systematic review. The theory of change builds upon the model proposed by Allmark et al. to explore the mechanism through which services indirectly improve health and wellbeing through measures to address social determinants of health (Allmark et al., 2013a, 2013b). The model also explores how these services provide benefits to the health service and how these pathways work together to reduce health inequalities.

A textual description of all included and excluded studies was created alongside the quality assessment to generate summary measures that were used to form a cross-study analysis. An example one page systematic textual narrative summary can be found in Appendix X (Popay et al., 2006; Higginbottom et al., 2020).

Given the significant heterogeneity in methods across the included studies, and lack of formal statistical analysis, quantitative data are presented descriptively. The average estimates of effect across the studies are reported, alongside the median and range where appropriate, to give an indication of spread and variability of data.

Qualitative data were translated through a thematic analysis, chosen for its systematic and replicable approach to analysis based on explicit rules of coding (Stemler, 2000). The data were interrogated to explore relationships within and across the included studies. Factors were identified that might explain differences in direction and size of effect across the included studies or in the type of facilitators and/or barriers to successful implementation of co-located welfare rights advice interventions.

Heterogeneity between all studies was explored in consideration of study design, outcomes and study population. Given the complex nature of welfare rights advice interventions, it was difficult to anticipate the main sources of heterogeneity a priori. Where the main potential sources of variation could be identified, heterogeneity between effects were explored by means of subgroup analysis, based on the theory of change model about how the intervention works and for which groups. Where appropriate conceptual models and concept mapping were used to explore and highlight relationships between data.

## 9. Theory of change

Our theory of change proposes that the implementation of a welfare advice service in a healthcare setting results in cost savings to the NHS and social sector and ultimately reduces health inequalities, see Fig. 1.

There are several mechanisms through which welfare advice services co-located in a healthcare setting might operate to improve uptake of advice, compared to welfare advice services offered in a conventional setting, owing to the nature of its co-location. Being nested within a health setting, the services are considered more accessible and provide a greater degree of anonymity to individuals accessing them. Due to the connection between welfare advice services and health professionals, the services are perceived to be more trustworthy, less stigmatising and better able to identify and provide early intervention to those most in need of help. The services are thought to offer a more enhanced, specialist service, tailored to the needs of those specifically with long-term health and mental health conditions, with better follow up and continuity of care, compared to conventional services. Overall, welfare services co-located in a healthcare setting adopt a proportionate universalism approach, distributing resources to favour the disadvantaged, by increasing resources to meet the needs of some of society's most vulnerable people, enabling it to have a greater impact on health inequalities (Mayne, 2015).

Access to these services and take up of the welfare advice provided, improve financial security and stability for individuals through increased household income and support with debt relief. Improved financial literacy and an awareness of their welfare rights, help individuals feel more empowered and better able to manage their finances and improves their financial support seeking when they are in need of financial assistance in the future, instead of relying on overdrafts, credit cards and loans. This breaks the cycle of spiralling financial insecurity and ultimately reduces levels of poverty. These impacts on financial security improve physical health and wellbeing, through reduced levels of mental health and stress-related conditions.

Accessing co-located welfare services could also improve health and wellbeing through measures to address other social determinants of health more directly. The services provide advice and support to improve housing conditions, access to nutritional food and transport, reducing the risk of communicable disease transmission and improving physical health, as well as mental health and wellbeing. Services also

**Table 2**
Criteria for assessment of 'richness' (Higginbottom et al., 2013; Higginbottom et al., 2020).

| Assessment | Conceptual definition |
|---|---|
| Thick papers | Greater insights into outcomes of interest<br>Clear account of processes provided by which findings are produced<br>Clear description of analytical processes<br>Developed and plausible explanation presented |
| Thin papers | Limited insights provided<br>Lack a clear account of processes<br>Present and underdeveloped and weak interpretation of findings produced<br>Present a weak and underdeveloped interpretation of the analysis based on the data presented |

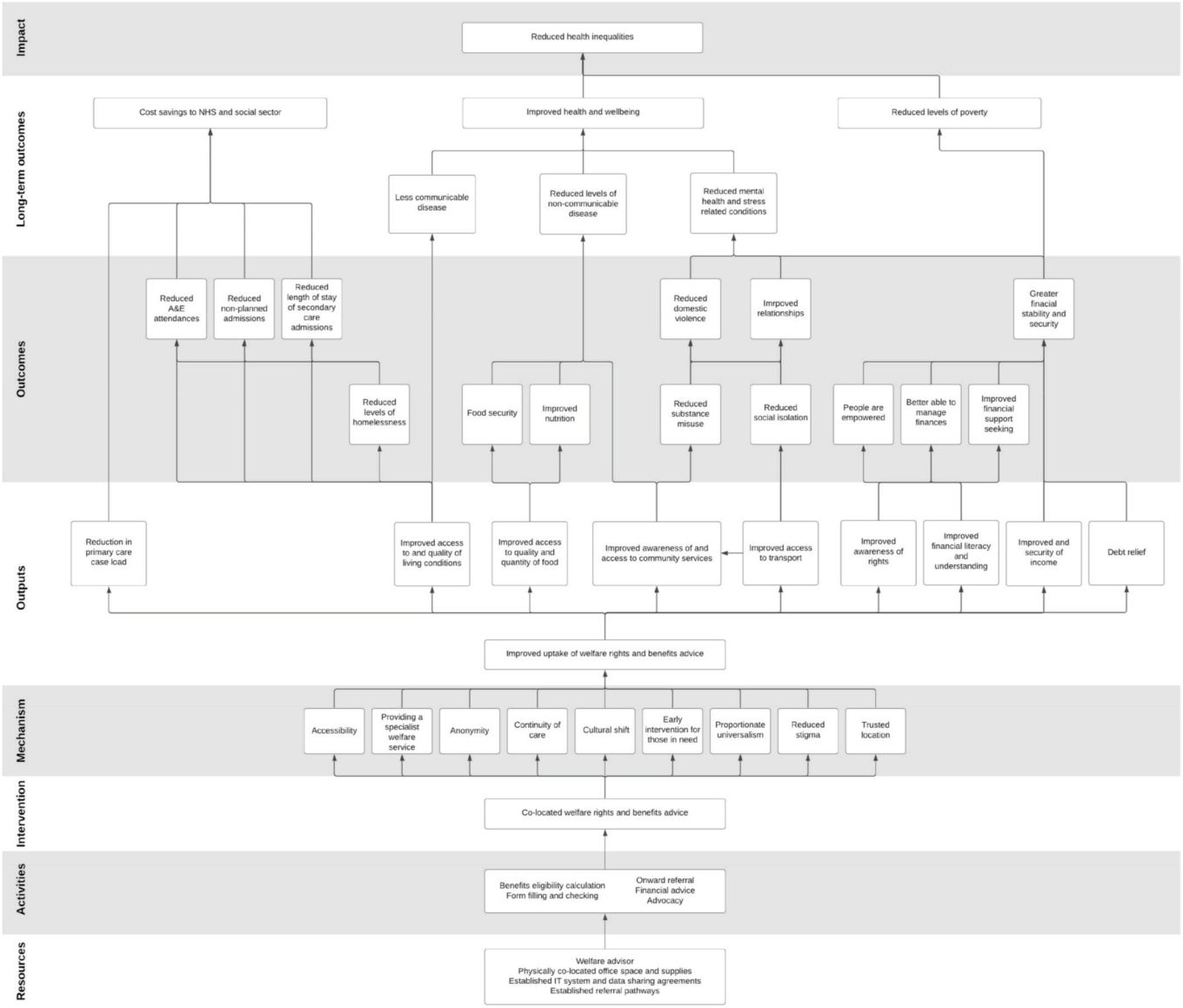


**Fig. 1.** Theory of change model of how the implementation of a welfare advice service in a healthcare setting can reduce NHS and social sector costs and ultimately reduce health inequalities.

raise awareness of and promote access to community services, improving and encouraging appropriate use of health services to improve health and wellbeing generally. This also reduces levels of substance misuse directly, improving personal relationships and reducing levels of domestic abuse, all improving health and wellbeing.

Finally, improved access to welfare services may also provide benefits to the NHS. Improved uptake of welfare advice services lead to a reduction in primary care appointments and improved use of secondary health services, particularly mental health services, resulting in significant cost savings for the NHS and freeing up the resources needed to address those most in need.

## 10. Results

The search identified 7998 potentially eligible records through bibliographic database searches and an additional 15 from reference and citation searching. Upon removal of duplicates and exclusion after title and abstract review, 138 articles were left for full text review. A total of 14 studies were included in the final review, see Fig. 2. A description of each included study is outlined in Table 3. Superscript references in the text will be used to refer to the relevant included studies, numbered according to their place in Table 3.

## 11. Study characteristics

Of the 14 studies included in this review, half were published in peer-reviewed journals,[1,8-12,14] six studies were published as reports,[2-3,5-7,13] and one was published as a thesis abstract.[4] The included studies were published between 2010 and 2020, nine prior to 2015.[1,3-8,13-14] They employed a range of designs: one non-randomised controlled trial,[11] one pilot randomised controlled trial which was terminated as a result of low recruitment,[10] one before-and-after-study,[8] three qualitative studies,[4,12,14] and eight descriptive case studies.[1-3,5,6-7,9,13] The evidence from this review has been mapped onto the theory of change model (Fig. 3), demonstrating the spread of evidence across the model; highlighting areas with a greater evidence base and areas where evidence is limited or lacking.

The welfare advice services evaluated in the reviewed studies all provided general welfare rights advice for adults aged 18 years and over, 11 were for the general population and three provided services

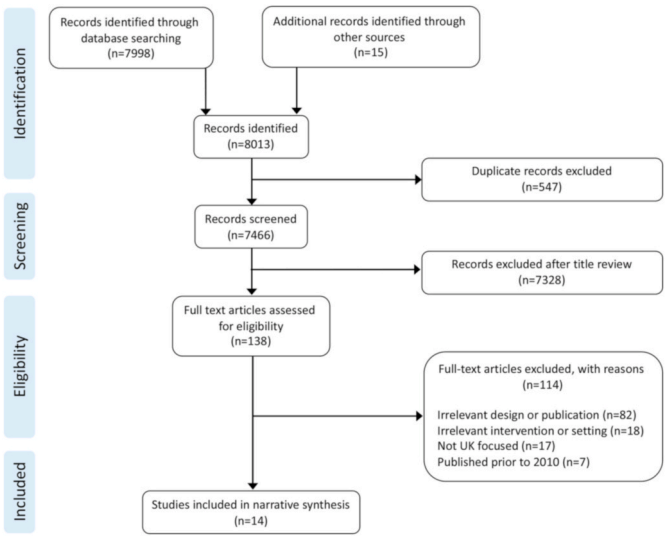


**Fig. 2.** The PRISMA flow chart of the final selection process.

specifically for: adults with cancer;[1] mental health problems;[13] or mothers and their families[6-7]. Nine of the evaluated services were co-located in general practice,[2-5,8,10-12,14] while three were co-located in secondary care in mental health,[13] oncology[1] and intensive care[9] settings. Two linked studies evaluated services co-located across maternal and child health community and secondary care settings.[6-7] Welfare advice services co-located in a primary care setting usually provided advice and support to the general practice patient list, although some offered this more generally to the local population, not limited to those registered with the practice. Access to welfare services was largely appointment based and accessed through referral by a general practitioner. However, some patients could self-refer. Two providers offered a drop-in service.

The co-located welfare advice services were largely provided by the Citizen's Advice Bureau (n = 9) including all of those co-located in general practice in England.[3-5,8,10-14] For services based in Scotland (n = 3), the services were provided by Money Advice Workers[6-7] or welfare advisors accredited under the Scottish National Standards for Information and Advice Providers.[2] The co-located oncology welfare advice was provided by Macmillan Cancer Support[1] and the welfare advice service co-located in intensive care was provided by trained legal advisors.[9]

The majority of reviewed studies reported the effects of the intervention on health[1-3,5-6,8-12,14] (n = 11) and social outcomes[1,3,6,9,11-14] (n = 8) for the participants. Three papers[8,10,11] utilised quantitative methods and eight papers[1-3,5-6,12-14] used forms of qualitative methods to explore physical and mental health outcomes. Social outcomes included improved access to housing, employment and education opportunities and improved relationships. Seven papers[1,3,6,9,12-14] utilised qualitative methods and one paper[11] used forms of quantitative methods to explore physical and mental health outcomes. Three studies reported predominately on the impact of the intervention on mental health outcomes.[8,10,13] Six of the studies evaluated the impact of the intervention on health services, in particular its effect on prescribing, service use and staff workload.[2,5,8,11-14]

Seven studies incorporated an economic evaluation, six reporting from the perspective of the welfare advice recipient,[1-3,6-7,11,13] and two used a Social Return on Investment (SROI) approach,[2-3] which has a broader (e.g. social, economic and environmental) concept of resulting value (Nicholls et al., 2012). Six of the included studies included a review of the effectiveness of the implementation of the co-located welfare advice services.[2,6-7,9-10,12] Nearly half of the reviewed studies explored participant experience of the intervention. Recipients of welfare advice were most commonly studied (n = 7),[1-2,4-5,9,10,14] alongside healthcare professionals working in the setting (n = 6).[1-2,5,8-9,14] Two studies examined the experiences of welfare advisors delivering the intervention.[1-2]

The quality of over half of the papers was assessed as high (n = 5) [1,10-12,14] or medium (n = 3).[4,6,8] These better quality studies used robust approaches and made attempts to adjust for observed confounders. The quality of the remaining six studies was assessed as low, owing to a lack of reporting of their methodological and analytical approaches.[2-3,5,7,9,13] The majority of reviewed studies were assessed as being of high relevance to the review objectives[2-12,14] (n = 12), with two studies being assessed with medium relevance.[1,13] Half of the included studies were assessed as thick on the 'richness' of their findings.[1,4,6,10-12,14] Studies of high or medium quality were also usually found to be thick on the assessment of the 'richness' of their findings. No studies were rejected on the basis of their quality, relevance or richness of their findings.

## 12. Study findings

### 12.1. Baseline characteristics

The baseline characteristics of participants were similar across the four studies where they were reported (Table 4). They were more likely to be female, with an average age of 46 years. Few individuals under the age of 24 years sought access to welfare services. Details regarding the ethnicity of participants were reported in limited detail across four of the included studies; the majority of participants accessing welfare services described their ethnicity as white (74%).

### 12.2. Financial impacts

The theory of change model (Fig. 1) proposes that access to co-located welfare advice services and improved welfare leads to greater financial stability, through improved income, support with debt relief and greater financial literacy and an awareness of welfare rights. Greater financial stability was supported by the studies included in this review. All studies included in this review highlighted that there were improvements in financial outcomes for individuals who access co-located welfare advice services. This was reported by participants, healthcare professionals and welfare advisors alike. Improved and greater stability of household income came from backdated payments from unclaimed benefits and regular gains in household monthly income, through successful applications for eligible benefits.[3,5-7,9-11,13-14] Many participants also reported receiving debt advice or support in reducing their levels of debt following access to welfare services in the included studies.[6,9-10,13-14]

Several studies reported that participants felt that their knowledge about financial issues, the law and their rights had improved as a result of having access to a welfare advisor.[1,3-4,6-7,9,10,13] They felt better able to deal with current and potential future welfare problems. Even participants who only received advice but did not gain financially reported feeling that their confidence in managing finances had increased. Studies report that those who accessed welfare services were also more likely to know where and how to access advice in the future, should they need it.[11-12] They also reported knowing how to avoid financial support-seeking behaviours that are detrimental to financial security, such as using credit cards and overdrafts.

### 12.3. Health and social impacts

The theory of change model proposes that a welfare advice service co-located in a health setting improves health and wellbeing through three mechanisms: reduced mental health and stress-related conditions; reduced levels of non-communicable disease; and less communicable disease. Improved physical health, or the perception of such, was reported as a positive outcome in most studies included in this review by participants, healthcare professionals and welfare advisors alike.[1-3,5-6,8-14]

**Table 3**
Characteristics and narrative description of included studies in the narrative systematic review.

| | Study | Aim of study | Study population& setting | Intervention | Study design | Outcomes measured | Main findings |
|---|---|---|---|---|---|---|---|
| 1 | Moffatt et al. (2012) | To explore what impacts welfare rights advice services have on the quality of life and wellbeing of people with cancer? | Adults with cancer; Secondary care; oncology | Macmillan Cancer Support appointed three experienced welfare rights advisors to provide a dedicated welfare service for people with cancer and their carers. | Mixed methods; case report | User experience; provider experience; healthcare professional experience; financial impact | -1174 clients advised<br>-Welfare benefit claims resulted in a median increase in weekly income of £70.30<br>-Service lessened financial impact of cancer and associated stress and anxiety<br>-Facilitated independence and capacity to engage in daily activities, with overall improvement in wellbeing and quality of life |
| 2 | The Money Advice Service (2018) | To evaluate the welfare advice service provided in GP practices in the area. | Adults; primary care | Provision of a full welfare rights advice service at GP practices by welfare advisors. | Mixed methods; case report | User experience; provider experience; healthcare professional experience; social return on investment (SROI); factors facilitating successful implementation; barriers to implementation. | -Every £1 invested in the co-location service generated £39 in social and economic benefits<br>-Service reduced anxiety and stress associated with financial insecurity, leading to improved health and wellbeing<br>-Co-located services were better able to target priority groups and those experiencing health inequalities with early intervention<br>-Services reduced general practice workload, improving practice efficiency and job satisfaction<br>-Care needs to be given to the practicalities of the service, including adequate office space and implementing a referral pathway and data sharing protocols |
| 3 | Hirst and Minter (2014) | To evaluate the welfare advice service provided in GP practices in the area. | Adults; primary care | Provision of Citizens Advice Bureau sessions in GP practices. | Mixed methods; case report | User experience; financial impact; SROI | -The service achieved financial gains of £10,569,083 overall and managed £4,524,309 of debt in one year<br>-Every £1 invested generated an additional £12.53 for clients and managed £2.34 of debt<br>-Services improved security of income and overall health and wellbeing |
| 4 | Kite (2014) | To investigate how delivering advice in a GP setting contributes towards the accessibility of advice and the empowerment of advice clients. | Adults; primary care | Provision of Citizens Advice Bureau sessions in GP practices. | Qualitative; surveys; 412 surveys completed | User experience | -Improved control of problem (80%)<br>-Improved understanding of the law and their rights (75%)<br>-Able to enforce their rights (66%)<br>-Feel able to have a say in the decisions that affect them (65%)<br>-Better able to deal with similar problems in the future (64%)<br>-Improve control over life (59%)<br>-Able to influence officials/people in authority (38%) |
| 5 | Adderley and Russell (2012) | To evaluate the welfare advice service provided in GP practices in the area. | Adults; primary care | Provision of Citizens Advice Bureau sessions in GP practices. | Mixed methods; case report | User experience; provider experience; healthcare professional experience. | -2163 clients supported<br>-Clients reported: reduced levels of anxiety and/or depression (76%); reduced anti-depressant use (31%); supported resumption of day to day activities (85%); improved their general situation (7%); and reduced GP appointments (7%).<br>-GP's reported: reduced amount of medication (8%); reduced numbers of referrals to other specialist mental health services (85%); and reduced numbers of GP appointments (43%).<br>-Practice managers reported a reduction in GP appointments (22%). |

(*continued on next page*)

**Table 3** (*continued*)

| | Study | Aim of study | Study population& setting | Intervention | Study design | Outcomes measured | Main findings |
|---|---|---|---|---|---|---|---|
| 6 | Naven et al. (2012) | To evaluate the Healthier, Wealthier Children project. | Pregnant women, families with children under five years and families with additional support needs; community and secondary care settings | Provision of welfare rights advice services in GP and maternal and child health settings by Money Advice Workers. | Mixed methods; case report | User experience; provider experience; healthcare professional experience; financial impact; factors facilitating successful implementation; barriers to implementation. | -2516 clients supported<br>-Average annual client gain of £3404<br>-Clients reported a reduction in stress, improved mood and an increased sense of self-worth and security<br>-Strategies to actively encourage collaboration between health professionals and welfare advisors were key to successful implementation and delivery<br>-Challenges to successful implementation included navigating existing NHS information sharing and data protection protocols and ensuring adequate welfare advice staff representation on strategic groups |
| 7 | Naven and Egan (2013) | To evaluate the Healthier, Wealthier Children project. | Pregnant women, families with children under five years and families with additional support needs; community and secondary care settings | Provision of welfare rights advice services in GP and maternal and child health settings by Money Advice Workers. | Mixed methods; case report | Financial impact; factors facilitating successful implementation; barriers to implementation. | -360 clients supported<br>-The total financial gains from this project amounted to £2,323,484<br>-Flexibility in models of delivery e.g. telephone triage increased client engagement and staff satisfaction<br>-Challenges with identifying appropriate outcomes to measure and demonstrate effect |
| 8 | Krska et al. (2013) | This study aims to: determine staff perceptions on the impact of the advice service on general practice workload; to quantify the frequency of mental health issues among patients referred to the service; and to measure any impact of the service on appointments, referrals and prescribing for mental health. | Adults; primary care | Provision of Citizens Advice Bureau sessions in GP practices. | Quantitative; before and after study | User experience; provider experience; healthcare professional experience; mental health; health and social care utilisation. | -148 clients supported<br>-Qualitative interviews conducted with GPs (n = 4), practice managers (n = 9) and welfare advisors (n = 6)<br>-GP appointments reduced from an average of 4.90 appointments per patient to 4.26 per patient (P = 0.017)<br>-Prescriptions for hypnotics and anxiolytics reduced by 42% (P = 0.016)<br>-Non-significant reductions in nurse appointments (1.50–1.35 per patient) and prescriptions for antidepressants (1.20–0.96)<br>-No change in appointments or referrals for mental health problems |
| 9 | Eynon et al. (2020) | A retrospective analysis of the service over a | Adults; secondary care; general | Provision of a legal service, | Mixed methods; case report | Provider experience; healthcare professional experience; financial impact. | -551 clients advised<br>-Addressing complex social issues reduced levels of stress and improved wellbeing<br>-Access to service reduced costs of healthcare and improved access to preventative |

(*continued on next page*)

**Table 3** (*continued*)

| | Study | Aim of study | Study population& setting | Intervention | Study design | Outcomes measured | Main findings |
|---|---|---|---|---|---|---|---|
| | | period of 11 years was undertaken to look at the range of legal advice sought. | | including welfare rights advice, for inpatients in critical care or for those who have suffered trauma. | | | healthcare<br>-Co-located services were better able to target priority groups with earlier intervention |
| 10 | Gabbay et al. (2017) | The aim of the pilot trial was to test the procedures, recruitment processes and operational strategies that were planned for use in the main trial, evaluating the effectiveness of debt counselling for primary care. | Adults; primary care | Provision of debt counselling and advice by Citizens Advice Bureau. | Quantitative; randomised controlled trial | User experience; mental health; physical health; health and social care utilisation | -Total of 61 participants (32 intervention, 29 control) were randomised<br>-Qualitative interviews were conducted with 23 participants and 11 GPs and welfare advisors<br>-Beck Depression Inventory-II scores fall from 29 [36.6 mean] (7.9 SD) to 24 [29.0] (11.3) at 4 months in the control group. In the intervention group fall from 32 [33.9] (8.4) at baselines to 28 [25.7] (9.9) at 4 month follow-up.<br>-Beck Anxiety Inventory scores fall from 27 [28.2 mean] (13.0 SD) to 23 [22.4] (11.8) at 4 months in the control group. In the intervention group fall from 31 [25.4] (13.3) at baselines to 26 [24.9] (14.0) at 4 month follow-up.<br>-Mean quality of life scores rose by 8.8 versus 3.3 in the intervention group to give a higher mean score at 4 months<br>-Participants identifyied two main benefits of advice: first, support in engaging with a range of agencies about debt issues and, second, identifying sources of additional financial support<br>-Services should provide more opportunity for informal collaboration between health and welfare services to achieve successful implementation |
| 11 | Woodhead et al. (2017) | To examine the impact and cost-consequences of co-located benefits and debt advice on mental health and service use in primary care. | Adults; primary care | Provision of Citizens Advice Bureau sessions in GP practices. | Quantitative; quasi-experimental controlled trial; odds ratios, economic analysis | Financial impact; mental health; health and social care utilisation; return on commissioner investment. | -278 participants, 623 controls<br>-Per capita, advice recipients received £15 per £1 of funder investment<br>-Common mental health disorders reduced among women (rOR = 0.37, 95% CI 0.20–0.70) and Black advice recipients (rOR = 0.09, 95% CI 0.03–0.28) relative to controls<br>-Individuals whose advice resulted in positive outcomes demonstrated improved well-being scores (β co-efficient 1.29, 95% 0.25–2.32)<br>-Reductions in financial strain (rOR = 0.42, 95% CI 0.23–0.77) but no change in 3-month consultation rate were found |
| 12 | Woodhead et al. (2017) | To develop an initial programme theory for how the provision of co-located advice supports specific general practice outcomes, and to identify salient barriers and enabling factors. | Adults; primary care | Provision of Citizens Advice Bureau sessions in GP practices. | Qualitative; semi-structured interviews | User experience. | -24 semi-structured interviews conducted with GPs (n = 9), reception staff (n = 4), practice manager (n = 3), welfare advisors (n = 6) and service funders (n = 2)<br>-Participants noted a reduction in GP consultations and practice time spent on non-health issues following access to the service<br>-Facilitating implementation factors were not limiting access to GP referral and offering booked appointments and advice on a broader range of issues responsive to local need<br>-Key barriers included pre-existing sociocultural and organisational rules and norms, which maintained perceptions of the GP as the "go-to-location" |
| 13 | Parsonage (2013) | To report the financial | Adults with mental | Provision of Citizens | | Financial impact. | -622 clients supported<br>-Clients increased their income by £4274 per annum on average |

(*continued on next page*)

**Table 3** (*continued*)

| Study | Aim of study | Study population& setting | Intervention | Study design | Outcomes measured | Main findings |
|---|---|---|---|---|---|---|
| | impact of the Citizens Advice Bureau service in a secondary care mental health service. | health conditions; secondary care; mental health. | Advice Bureau sessions in secondary care mental health services. | Mixed methods; case report | | -Services generated cost savings in three ways: reduction in inpatient lengths of stay; prevention of homelessness; and prevention of relapse of severe mental illnesses. |
| 14 Burrows (2011) | To examine the views and experiences of staff and users of Citizens Advice Bureau (CAB) services located in general practice, and to identify key factors perceived as contributing to the intervention effectiveness. | Adults; primary care. | Provision of Citizens Advice Bureau sessions in general practice. | Qualitative; semi-structured interviews. | User experience; provider experience; healthcare professional experience. | -Ten general practice staff and welfare advisors, and 12 service users interviewed<br>-Co-located advice was found to have financial benefits and was perceived by participants to offer health<br>-Demonstration of measurable health improvement and wellbeing presented challenges |

"Most respondents [medical professionals and welfare advisors] acknowledged that where underlying social drivers affected patients' health, health improvement would be unlikely through medical intervention alone."

Study 12

Several studies reported that participants and welfare advisors felt that access to co-located welfare services led to improvements in mental health and overall feelings of wellbeing, thus achieving a greater quality of life.[1-3,5-14]

For most included studies, impacts on mental health were explored using qualitative methodology, with two studies conducting a robust qualitative analysis using a thematic analysis[12,14] and one using frequency counts of commonly reported outcomes.[4] Two studies measured mental health and wellbeing outcomes using validated tools, comparing self-reported changes to mental health between an intervention and control group.[10-11] These studies demonstrated improvements to mental health and wellbeing outcomes following intervention compared to controls. One study[10] presented descriptive statistics owing to lack of statistical power and the second study[11] presented outcomes as odds ratios, finding that mental health and wellbeing outcomes only improved significantly for recipients who were female or belonged to black ethnic groups. A meta-analysis for mental health and wellbeing outcomes was not possible due to heterogeneity in outcome measures utilised.

Where reported in included studies, improved mental health and wellbeing were attributed largely to reductions in levels of stress, by way of: improved income; [3,5-7,9-11,13-14] debt relief;[6,9-10,13-14] and support with managing bills and finances.[6-7,9]

"[CAB] was invaluable. I'd have killed somebody, or killed myself if I hadn't got it sorted out because it was just going downhill."

Study 14

Three studies of varying quality assessment (low medium and high respectively) found that many of their participants reported a feeling of self-worth and security following use of the services.[4,6,11] Two studies of medium and high quality assessment, found that there were fewer accounts of suicidal ideations and reduced need for medication as a result of improved mental health.[5,8] One high quality study found statistically significant reductions in prescriptions for anxiolytics and hypnotics (42% reduction ($P = 0.016$)) during the six months after referral to the service compared with the six months before and a non-significant reduction in nurse appointments (from 1.50 to 1.34 per participant), suggestive of improved mental health outcomes for participants accessing co-located services.[8] However, this study found no change in appointments or referrals for mental health conditions. Where measured objectively, through access to GP consultation records and as a self-reported measure, there was a 27% average reduction in antidepressant prescribing (range 22–31%) following receipt of co-located welfare advice.[5,8] One medium quality study[5] used simple frequency counts of self-reported outcomes to collect this data and a second before and after study[8] accessed GP records to measure frequency of GP consultations in the six months before and after intervention. Both studies presented their results descriptively owing to a lack of statistical power.

Further improvements in mental health were reported by two studies, of medium and high quality.[6,14] Some participants felt that they were able to talk to family and friends after receiving welfare rights advice and this had improved close relationships, resulted in fewer arguments in the household and significantly less stress within relationships. One low quality study found there was evidence to suggest that access to welfare rights advice helped to remove some participants from situations where they were living with abusive partners.[13] This was not described in significant detail but involved re-housing participants away from their abusive relationships and securing their financial situation.

One high quality study included in the review demonstrated that


**Fig. 3.** Map of the narrative systematic review evidence against the theory of change model.

participants who accessed welfare services also reported reduced substance misuse.[12] This was facilitated by an improved access to primary care, mental health and community drug and alcohol services. Where housing conditions were poor, some participants reported reduced drug and alcohol use following access to the welfare service through improved housing conditions and thus breaking the cycle of the resumption of alcohol and substance misuse.[12]

Two high quality studies highlighted that some general practitioners were more sceptical about the long-term improvements to mental health owing to an improved financial situation.[8,12] They felt that the issue of poor mental health and financial insecurity and instability were multifactorial, each contributing to the other, and solving the issue of poor mental health with a short-term improvement in financial security would not be sufficient to solve the problem. This was also reported by some participants who still felt that they had significant money worries to contend with or who were still worried about the future.[8,12]

Several studies attributed improvements to physical health from addressing other social determinants of health.[1-3,5-6,8-9,11-14] For all included studies, impacts on physical health was explored using qualitative methodology, with two studies conducting a robust qualitative analysis using a thematic analysis.[12,14] No studies measured physical health using validated tools. Three high quality studies found that access to co-located welfare rights advice improved engagement with other community health services and thus improved compliances with treatment plans, particularly for chronic, complex disease management.[1,9,14] Two studies, of medium and high quality, found that participants reported overall improved levels of nutrition and greater food security through improved income and access to alternative food sources, such as food banks.[6,14] Several studies reported improved housing conditions for participants through assistance with housing applications and grants by welfare advisors.[1,3,6,9,11,13]

### 12.4. Health service benefits

Finally, the theory of change model also suggests that access to co-located welfare rights advice and improved welfare can benefit the NHS through reduced primary and secondary care caseload, resulting in cost savings for the NHS and freeing up the resources required for those most in need.

Many studies, utilising qualitative methodology, reported that GPs and other administrative staff found co-located services to be time saving for doctors and administrative staff alike. Services reduced practice staff time spent on non-health issues both inside and outside of consultations, where this linked to direct rather than indirect support, such as reducing bureaucratic pressure involved with form-filling, rather than addressing problems such as depression linked to debt. .[2-3,5-8,11-12,14]

However, the studies included in this review suggested that there was a mixed experience of whether co-located welfare advice services reduced contact time with healthcare professionals. These studies were

**Table 4**
Baseline characteristics of participants across included studies.

| | Average | Number of studies |
|---|---|---|
| **GENDER** | | |
| Male | 44% | 4[1,10-11,13] |
| Female | 56% | 4[1,10-11,13] |
| **AGE** | | |
| 17–24 years | 9% | 4[8–9,11,13] |
| 25–34 years | 11% | 4[8–9,11,13] |
| 35–44 years | 16% | 4[8–9,11,13] |
| 45–54 years | 22% | 4[8–9,11,13] |
| 55–64 years | 21% | 4[8–9,11,13] |
| 65 + years | 18% | 4[8–9,11,13] |
| Mean age | 46 years | 4[8–9,11,13] |
| **ETHNICITY** | | |
| BME communities | 20% | 4[6–7,11,13] |
| White | 74% | 4[6–7,10-11] |
| Not-specified | 6% | 4[6–7,10-11] |
| **HOUSEHOLD INCOME** | | |
| Income (<£4800 per annum[a]) | 51% | 2[11,13] |
| Income (£4800-£12,000 per annum[a]) | 37% | 2[11,13] |
| Income (>£12,000 per annum) | 12% | 2[11,13] |
| **RELATIONSHIP STATUS** | | |
| Co-habiting | 38% | 3[1,10,13] |
| Single | 51% | 5[1,10-11,13] |
| Other | 11% | 2[1,10] |
| **EMPLOYMENT STATUS** | | |
| Employed | 19% | 2[1,11] |
| Not working due to long term illness or disability | 42% | 2[4,10] |
| Looking after the home | 3% | 2[1,10] |
| Unemployed | 18% | 4[1,4,10-11] |
| Retired | 18% | 4[1,4,10-11] |

[a] The threshold for claiming universal credit for single people over the age of 25 years old is £4800. The threshold for joint claimants of universal credit for people over the age of 25 years old is £4800–12000. Correct as of August 22, 2021.

limited to a primary care setting. Where explored qualitatively, two studies, of medium and high quality, found that patients reported a reduced need for repeat GP appointments following access to co-located welfare rights advice.[5,12] In two high quality qualitative studies, they found that there was a difference in experience of the services and its perceived effect on consultation rate by GPs.[12,14] Some GP's felt that the service had no impact upon their consultation frequency and in fact felt that it was their role to consider and to support patients with their social problems where they impacted upon health, despite others stating this was outside their clinical role and feeling unqualified to address them directly.[12] Some participants reported booking additional GP appointments, where they might not have done otherwise, because they were in the building seeing the welfare advisor.[14] Others report perceiving the welfare service as 'an extra' rather than instead of consulting their GP.[12,14]

Where measured objectively, through access to GP consultation records and as a self-reported measure, there was a 7% average (range 0–13%) reduction in GP attendance following receipt of co-located welfare advice.[5,8,11] One high quality paper reported a 13.1% reduction in GP attendance ($P = 0.017$) for advice recipients in the six months after being in receipt of the intervention, compared to the six months prior, using a before and after study design.[8] However one high quality paper found no difference in GP consultation rate in the three months following receipt of the intervention compared to a control group, using a quasi-experimental study design. One high quality paper using a before and after design found there was no difference in referrals to mental health services in a six month period before and after benefitting from co-located welfare rights advice.[8]

Several studies found that there was a high sense of achievement reported by healthcare professionals who engaged with co-located with welfare rights advice services.[2,6-8,12] In one medium and two high quality studies, many reported a frustration with their inability to support patients with wider determinants of health and being able to refer into a service providing this support gave the health professionals a feeling of satisfaction. [7-8,12] Two low and one medium study reported that healthcare professionals referring into the service felt that their own financial literacy had improved as a result of their interaction with the co-located service, though there was no description of how this idea was explored with these healthcare professionals.[2,6,13]

### 12.5. Co-located services as a specialist service

The theory of change model suggests that there are several mechanisms through which welfare advice services co-located in a healthcare setting can increase uptake of advice and ultimately improve welfare, compared to services offered in conventional settings, due to its location. This element was not a specific research question explored by the studies included in this review. However, qualitative exploration of the impact of co-located services on participants, healthcare professionals and welfare advisors generated findings that contribute to this theory.

Some of the included studies found that welfare advisors felt that co-located services gave a greater sense of confidentiality and trust to participants, which was reflected by the views of participants in these studies.[2,6-7,9,10,12-14] Some studies, including several of high quality, reported that provision of welfare services co-located within a healthcare setting were also more able to target and reach some of the most vulnerable people.[1-2,6-9] The authors identified that health services and healthcare professionals often have a unique access to vulnerable individuals and can strengthen the identification of need for advice among these groups, thereby mitigating poverty and reducing health inequalities.

### 12.6. Economic evaluation

Nine studies provided financial data for 14,468 participants who

**Table 5**
Economic evaluation of co-located welfare services.

| | Total | Average | Median | Range | Number of papers |
|---|---|---|---|---|---|
| **SERVICE USE:** | | | | | |
| Participants supported | 14,468 | 1608 | 622 | 19–6785 | 9[1,3,5-7,9-11,13] |
| Number of contacts | 23,070 | 7690 | 1231 | 28–21811 | 3[1,3,10] |
| Number of issues resolved | 30,347 | 15,174 | – | 1725–28622 | 2[3,13] |
| Average number of contacts per client | – | 4 | 3 | 1–8 | 4[1,3,10,13] |
| Average number of issues per client | – | 4 | – | 3–4 | 2[3,13] |
| **SERVICE COST:** | | | | | |
| Cost of service (per annum) | – | £660,324 | £843,597 | £79,000–1,058,375 | 3[3,6,11] |
| Cost of service (per person) | – | £272 | £272 | £124-421 | 4[3,6,11,13] |
| **FINANCIAL GAINS:** | | | | | |
| Participant financial gains (per person) | – | £1840 | £1394 | £776–3656 | 6[1,3,6-7,11,13] |
| Average income increase (per annum) | – | £2757 | £3046 | £963–4274 | 6[1,3,6-7,11,13] |
| Debt managed (per annum) | £4,653,309 | £2,326,655 | – | £129,000–4,524,309 | 2[3,9] |
| Social return on investment (per £1 spent) | – | £27 | – | £15–39.00 | 2[2,11] |

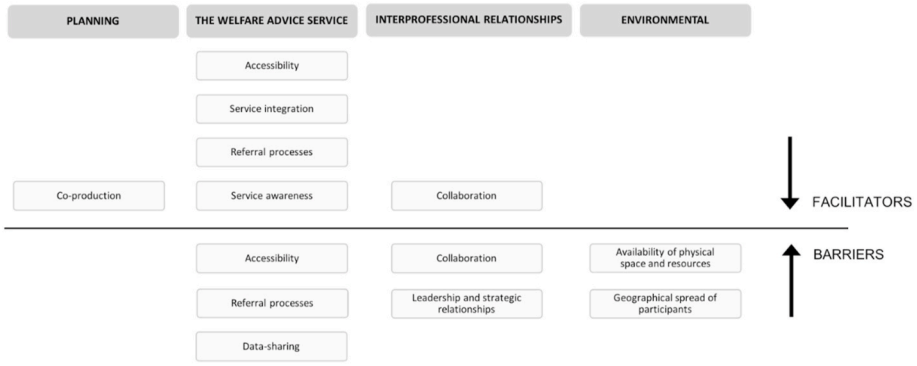


**Fig. 4.** Factors affecting the successful co-location of a welfare advice service in a health setting.

accessed and were supported by the welfare rights advice services.[1,3,5-7,9-11,13] Some studies reported details on the costs of the service provided to commissioners and the financial gains for the participants, NHS and wider society (Table 5). [1,3,5-7,9-11,13]

Participants in receipt of general welfare rights advice had on average four contacts[1,3,10,13] and four issues resolved per participant.[3,13] Where reported, the majority of participants accessing the services received support on more than one issue.[3,13]

The average cost of this service per study to commissioners was £660,324 per annum, ranging from £79,000 to £1,058,375 per study.[3,6,11] The average cost per client was £272 (£124–421).[3,6,11,13] More established services were found to cost less owing to less funding being required for set up costs and efficiency savings.[2,6]

Financial gains ranged from one-off payments, owing to unpaid or incorrectly allocated benefits, to improvements in annual household income, as a result of successful claims for entitled benefits. Participants gained £1840 on average in one off payments and also benefitted from an average increase of £2757 in household income per annum across studies.[1,3,6-7,11,13]

Two services provided across three of the studies generated on average £27 of social, economic and environmental return per £1 invested. Both studies reported a positive return on investment that ranged from £15 to £39 return on investment per £1 invested.[2,11]

### *12.7. Service implementation*

Many of the studies described some of the factors they considered to have facilitated and/or hindered the successful implementation of a welfare advice service in a healthcare setting. Fig. 4 provides an overview of these factors, which are summarised in Table 3. Co-production of the services, effective communication, collaboration and integration and simple referral pathways, were some of the more recurring themes identified.

Co-production of the welfare advice service within the healthcare setting at the planning stages was seen as an essential factor for the successful implementation of the service.[6-7,13] Involvement of both healthcare professionals and welfare advisors was found to be important, in order to raise awareness of the service amongst healthcare professions and thus improve appropriate referral rates.[6-7,13] Several studies also reported the importance of higher level strategic buy-in to facilitate effective leadership and strategic working relationships.[6-7] Co-production was felt to promote a more sustainable approach and built trust between the NHS and welfare services.

Most studies reported the importance of effective collaboration, communication and integration of the services.[2,6-7,9-10,12-13] Some welfare advisors reported organisational barriers with NHS information sharing protocols which made referral processes more challenging and caused unnecessary delays.[6] The quality of working relationships among project staff was also an important contributory factor in achieving successful implementation.[6,7,10,12] Where working relationships were nurtured and created a welcoming, close and trusted relationship, the integrated services thrived. Welfare advice staff felt more integrated within the team when they shared physical space and resources with the healthcare staff, helping them to feel a part of the team.[8,12]

> "*Co-ordination 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.*"
>
> Study 11

Simple referral pathways with clear associated documentation for professionals and participants improved referrals into the service. [2,5,7,10,14] The most common form of referral was directly by healthcare professionals, who are considered to know their patients well and are best able to identify need .[2,5,7,10,14] Referral by healthcare professionals legitimised the need for the services and helped to convey a sense of trust in the welfare service. [2,10,14] The option to self-refer was available in most services though it was not the most commonly accessed route.[12-14]

Finally, across many of the included studies, there was a strong sense that shared values (co-production, collaboration, communication, confidentiality, flexibility, holistic care and trust) between all involved with the services was important for a successful and effective service. .[2,6-7,9,10,12-14]

## 13. Discussion

### *13.1. Summary of key findings*

This systematic narrative synthesis review considers 14 research studies exploring the integration of welfare services within various healthcare settings. Most of the studies were qualitative and before and after studies, with only one study demonstrating causal evidence supporting the links between improved mental health and use of co-located welfare services.[11]

This review overall demonstrated clear financial gains and improved financial security for participants, which reinforces previous findings (Adams et al., 2006). The reviewed studies suggest that access to co-located services improved knowledge about financial issues, the law and welfare rights. This knowledge could empower individuals, enabling them to better manage their finances and to improve future financial support seeking, breaking the cycle of spiralling financial insecurity and ultimately reducing levels of poverty.

Co-located welfare advice was reported to both directly and indirectly improve health and wellbeing through action on key social determinants of health. The review also found some evidence to suggest that co-located welfare rights advice reduces the workload for primary and secondary care services, resulting in cost savings for the NHS. If demonstrable by further high-quality studies, this could suggest that co-located services are able to improve the availability of resources required for those most in need.

This review suggests that co-located services generated these outcomes through provision of a greater sense of confidentiality and trust to participants and were better able to target and reach some of the most vulnerable people. These mechanisms were not explored as primary outcomes for the studies included in the review and have not yet been formally studied.

Importantly, several studies highlighted challenges in conducting evaluations of welfare services of relevance to future studies conducted in this area. Many struggled to recruit sufficient participants or were unable to follow-up sufficient numbers to achieve reasonable statistical power. Several studies reported challenges in identifying suitable effectiveness and implementation outcome measures, resulting in significant heterogeneity in reported outcomes across the included studies. The challenge of recruiting minority groups into the study was also raised as a particular concern in many studies.

### 13.2. Limitations

This review includes a wide range of studies utilising a variety of methodological approaches, statistical techniques and outcome measures. A large proportion of the studies included in this review were grey literature, not published in peer reviewed journals. Quality assessment of these studies was challenging as the methodological approaches were not well described. Although many of the included studies were found to be of limited scientific quality, it was felt that it was important to include these studies in the review, as they often included legitimate data on financial outcomes and population coverage of the services and ensured the review was representative of the available evidence base. However, as grey literature is not well indexed, it is also difficult to be sure that all available evidence has been accessed, despite the systematic approach to the search strategy.

The significant heterogeneity in the research methodology and outcome measures prevented robust comparison of effect between studies. Each study which evaluated changes in mood used a different measure of depression, levels of anxiety or measure of wellbeing. There is also a lack of statistical analyses of outcomes presented from service evaluations with the majority reporting simple descriptive measures. Therefore, it was inappropriate to perform formal meta-analysis and our interpretations and conclusions are drawn from a narrative review.

Finally, this review is limited to studies conducted in the United Kingdom given that health and welfare systems are country specific with significant variation existing between countries, therefore the results may not be generalisable internationally. However, some conclusions may be applicable, such as how the co-located services are implemented and evaluated.

### 13.3. Findings in context

Since the UK Coalition Government's first Budget in 2010, significant reforms have been made to the UK's social security system. The introduction of the Welfare Reform Act 2012 legislated for Universal Credit and Personal Independence Payment and led to one of the most radical transformations of the UK welfare system (Hobson, 2020). Further temporary and some more-permanent changes have been made in response to the 2020 coronavirus pandemic and continue to evolve over the course of the pandemic (Hobson, 2020). For individuals this means that their benefits entitlement may have changed over time, in addition to the way in which they access them. The changing landscape of the social security system can generate confusion for those already accessing benefits, as well as those who may be entitled to them.

The introduction of Universal Credit has since been the subject of a great deal of controversy in the UK. There are concerns that the policy has led to several negative impacts for individuals dependent on welfare payments, increasing the risk of poverty disproportionately for the poorest and widening inequalities. Several studies report worsening financial security, increased food insecurity and worsening poverty (Cheetham et al., 2019; Craig and Katikireddi, 2020, Wickham et al., 2020). Furthermore, the policy has been linked with poor mental health, with participants of some studies having considered suicide (Wickham et al., 2020), and exacerbation of long-term health conditions (Cheetham et al., 2019).

The COVID-19 pandemic has created or further worsened financial difficulties and insecurity for the most vulnerable in society and additional temporary and some more-permanent changes have been made in response to the pandemic and will continue to evolve over the course of the pandemic. During this time, access to financial support services and packages from the government has also been challenging for many families (Islam et al., 2020). For the most vulnerable groups, such as refugees and asylum seekers, face-to-face access to organisations for support with welfare and housing has been curtailed, which is how these services would normally be accessed (Dickerson et al., 2020). There have been major changes in the delivery and practice of health services and the voluntary and community sector since the onset of the pandemic. The move to remote and distanced working for many, particularly within primary care, will impact upon the delivery and accessibility of co-located services moving forward. There have been some studies conducted to evaluate the provision of welfare rights advice services with functional links rather than physical co-location to general practice that could be considered in light of this (Haighton et al., 2012).

### 13.4. Areas for future research

This review builds upon the previous body of evidence provided by the systematic review published by Adams et al. (Adams et al., 2006). Together we find that co-located welfare rights advice improved financial security and in our review we find some but limited convincing evidence of measurable health or social benefits - one experimental study with adequate power reporting short-term improvements in mental health and wellbeing, reduced financial strain and considerable financial returns compared to control groups.[11] Qualitative methods have largely been favoured to explore the effects of co-located services on health and wellbeing and there remains a lack of causal evidence of changes to health and wellbeing. Given reductions in funding, evidencing about the cost-effectiveness of these interventions will help protect them from cuts to services in the future.

Future research in this area needs to be sufficiently powered with a robust comparator group to build upon the theoretical models proposed in this review. This review highlights the need for future research to utilise common health outcome measures that can enable comparisons to be made across the literature and for economic evaluations incorporating both a patient and a health services perspective. In order to draw firm conclusions about the links between the provision of welfare advice and improvements in health and wellbeing and reducing health inequalities, research needs sufficient resources to follow-up patients over the short, medium and long term.

Research so far has a significant under-representation of ethnic minority groups, despite them being amongst those with the greatest need. Further research needs to be conducted to ensure co-located services are best able to reach those most in need and to explore the health and social impacts of the services for these groups.

Most of the studies in our review examined welfare services co-located in a primary care setting, which is perhaps reflective of the more established relationship between welfare service providers and primary care providers. However, this may also reflect a lack of formal evaluations conducted in a secondary care setting and research should be planned to ensure it reflects the scope of available services.

Future research should consider the capacity of the voluntary and community sectors to provide welfare services in the context of an evolving pandemic and in the future recovery from the pandemic, when the strains in the health sector make addressing the facilitators to co-working more challenging.

## 14. Conclusion

This review contributes to the growing body of evidence that welfare rights advice co-located in a healthcare setting can improve health and wellbeing and provides cost savings to the NHS, freeing up resources for those most in need. This review also examines how the literature builds the evidence base to support the proposed theoretical pathways through which the co-located services operate to reduce health inequalities.

This review demonstrates that co-located welfare advice services generate significant financial gains for participants and for the first time proposes the wider welfare benefits to participants, by addressing social determinants of health. Given the high number of included studies of low scientific quality, the interpretations and conclusions drawn upon in this review are considered subjective. There remains a need for high quality research in this area to further build upon this theory and to measure the strength of these pathways over time. Further work is also needed on how deliver a service that best meet the needs of minority groups who are under-represented in existing research.

Given the complexity of the UK welfare system and the ongoing and disproportionate impacts of austerity, and current evidence of widening inequalities, welfare services could be key to efforts to mitigate the impact of these wider policy impacts.

Finally, although performing some sort of evaluation of welfare services is often a requirement of funding, additional resources to support such evaluations is limited. Those commissioning and implementing welfare services co-located in healthcare settings should consider investing additional funds and securing the appropriate skills to conduct a robust evaluation of service implementation and effectiveness, guided by the findings of this review.

## Credit author statement

**Sian Reece**: Conceptualisation, Methodology, Validation, Formal Analysis, Investigation, Writing – Original Draft, Visualisation. **Trevor Sheldon**: Conceptualisation, Methodology, Validation, Writing – Review & Editing, Supervision. **Josie Dickerson**: Conceptualisation, Methodology, Validation, Writing – Review & Editing, Supervision. **Kate Pickett**: Conceptualisation, Methodology, Validation, Writing – Review & Editing, Supervision.

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## Appendix one. example search strategy

Search strategy for Medline via Ovid using keywords.

| Concept | Search terms |
|---|---|
| Social rights advice | *1. ((welfare adj3 (advice or advis$ or counsel$)) or (welfare adj2 right$) or (welfare adj2 (assess$ or eligible$ or entitle$)) or (welfare adj2 (benefit$ or claim$ or unclaim$)) or (welfare adj2 consultant$) or (welfare adj2 (eligib$ or entitle$))).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*2. ((benefit$ adj2 (claim$ or unclaim$)) or (benefit$ adj2 (eligib$ or entitle$))).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*3. (underclaim$ or under-claim$ or ((debt$ or money) adj3 (advice or advis$ or counsel$))).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*4. (citizen$ advice or (CABHO or (CAB adj (advice or advis$ or staff or health outreach)))).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*5. (((improv$ or increas$ or maximis$ or assist$ or help$ or support$) adj3 (access$ or uptake or apply$ or application$) adj3 welfare) or ((improv$ or increas$ or maximis$ or assist$ or help$ or support$) adj3 (access$ or uptake or apply$ or application$) adj3 benefit$) or (income security adj3 (intervention$ or program$ or promotion$))).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*6. ((housing adj3 (advice or advis$ or counsel$)) or (homeless$ adj3 (advice or advis$ or counsel$)) or (housing adj3 (advice or advis$ or counsel$))).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*7. ((employment adj3 (advice or advis$ or counsel$)) or (employment adj2 right$)).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*8. ((immigration adj3 (advice or advis$ or counsel$)) or (immigration adj2 right$)).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*9. ((family adj3 (advice or advis$ or counsel$)) or (family adj2 right$)).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*10. Social Welfare/11. Social Security/12. Public Assistance/13. Counselling/14.1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13* |
| Healthcare setting | *15. (NHS or health service$ or healthcare or health-care or health care or medical service$ or medical care or (patient$ adj2 care) or (patient$ adj2 health) or (care adj3 delivery) or care pathway$).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*16. (primary care or primary healthcare or primary health or general practice$ or family practice$).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*17. (secondary care or secondary healthcare or secondary health or hospital$).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*18. (emergency care or urgent care or hospice$).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*19. Social prescribe$.mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*20. (health center or health center or medical center or medical center).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*21. ((matern$ adj3 care) or (matern$ adj3 service) or (midwi$ adj3 care) or (midwi$ adj services)).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt*<br>*22.15 or 16 or 17 or 18 or 19 or 20 or 21* |
| Restricted to UK studies | *23. Exp Great Britain/24. (national health service* or nhs*).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt] (gb or britain$ or british$ or uk or uk or united kingdom$ or england$ or english$ or northern ireland$ or northern irish$ or scotland$ or scottish$ or wales or welsh$)*<br>*25.23 or 24* |
| Excluding animal studies | *26. (animal or animals or rat or rats or mouse or mice or rodent or rodents or swine or porcine or murine or sheep or lamb or lambs or ewe or ewes or pig or pigs or piglet or piglets or sow or sows or rabbit or rabbits or cat or cats or kitten or kittens or dog or dogs or puppy or puppies or monkey or monkeys or horse or horses or racehorse or donkey or donkeys or elephant or elephants or foal or foals or equine or dairy or cow or cows or bovine or calf or calves or cattle or heifer or heifers or hamster or* |

(continued on next page)

(*continued*)

| Concept | Search terms |
|---|---|
| | *hamsters or chicken or chickens or chick or chicks or hen or hens or poultry or broiler or broilers or livestock or wildlife or panda or pandas or buffalo$ or baboon$ or penguin$).mp. [mp = ti, ab, hw, tn, ot, dm, mf, dv, kw, fx, dq, nm, kf, ox, px, rx, an, ui, sy, pt]*<br>*27. Exp animals/not humans/28.25 or 26*<br>*29.14 and 22 and 25*<br>*30.29 not 28* |

## Appendix two. data extraction proforma

| DATA EXTRACTION PROFORMA |
|---|
| STUDY DETAILS |
| Author |
| Title |
| Publication Type |
| Study funding sources |
| Possible conflicts of interest for study authors |
| AIM |
| Aim of study |
| Research questions |
| SAMPLING AND RECRUITMENT |
| SETTING: |
| Health setting |
| Nature of co-location |
| Nature of welfare service provider |
| Welfare assistance provided |
| Length of appointment |
| Follow up arrangements |
| Aims and objectives of service |
| Funding and costs of service |
| Governance arrangements |
| METHOD |
| Design methodology |
| Method of recruitment of participants |
| PARTICIPANTS |
| Population description |
| Inclusion criteria |
| Exclusion criteria |
| Incentives offered |
| ANALYSIS |
| Data analysis |
| RESULTS |
| Total number of participants |
| EFFECTIVENESS |
| Reported health outcomes |
| Reported social outcomes |
| Reported financial outcomes (from participant perspective) |
| Reported financial outcomes (from a commissioner perspective) |
| Reported financial outcomes (from healthcare perspective) |
| Reported impacts on healthcare provider |
| IMPLEMENTATION |
| Factors facilitating implementation |
| Barriers to implementation |

## Appendix three. example of a textual summary

REFERENCE

Charlotte W, et al. Co-located welfare advice in general practice: a realist qualitative study. Health Soc. Care Community. 2017;25(6):1794-1804.

SETTING.

The study was conducted in two urban primary care general practices in England.

INTERVENTION.

The provision of co-located welfare rights advice services varied across locality. Co-located services in locality 1 provided specialist casework advice on welfare benefits and debt. They offered a walk-in "first-come-first-served" service that was open to all residents. In locality 2, the co-located welfare service offered booked appointments and casework advice on a broader range of issues e.g. housing and employment.

AIM OF STUDY.

To develop an initial programme theory for how the provision of co-located advice supports specific practice outcomes, and to identify salient barriers and enabling factors.

SAMPLING AND RECRUITMENT.

GPs, practice managers, GP receptionists and advice staff from intervention practices in both localities invited to participate. Sampling aimed to include representatives from each job role as well as from both the advice and comparison groups. Further sampling also aimed to include a greater

number of GPs.

STUDY DESIGN.

Twenty-four semi-structured interviews were conducted with general practice staff, advice staff and service funders between January and July 2016. This study is nested within a mixed-methods evaluation described elsewhere.[50] Interviews were chosen rather than focus groups both due to practical difficulties of bringing together practitioners at the same time and to enable individuals in different roles within the same practices to speak freely.

DATA ANALYSIS.

Data were thematically analysed and a modified Realist Evaluation approach informed the topic guide, thematic analysis and interpretation. The topic guide was built on a formative evaluation covering experiences, attitudes and expectations of the co-located advice service.

RESULTS.

Two outcomes are described linked to participant accounts of the impact of such non-health work on practices: reduction of GP consultations linked to non-health issues and reduced practice time spent on non-health issues. It was found that individual responses and actions influencing service awareness were key facilitators to each of the practice outcomes, including proactive engagement, communication, regular reminders and feedback between advice staff, practice managers and funders. Facilitating implementation factors were not limiting access to GP referral and offering booked appointments and advice on a broader range of issues responsive to local need. Key barriers included pre-existing sociocultural and organisational rules and norms largely outside of the control of service implementers, which maintained perceptions of the GP as the "go-to location".

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