The Impact of Advice for Health Services and Staff

It is evidence of the associations between social problems and morbidity which supports a broad approach to service provision in general practice.[42] Although the model of welfare rights advice based in primary care settings is now well established, provision remains patchy. An impact of this is that doctors and other health professionals are involved in the provision of advice about problems involving rights.[43] Exploring the social problems presented to GPs, Popay et al found that the types of problems raised were most commonly concerned with welfare benefits and housing, but GPs were most likely to refer to counselling services and to a lesser extent to generic advice services. In this study doctors reported finding it difficult to keep up to date with the availability of specialist support because of the transitory nature of some services.[44] Another study questioned the level of skills, awareness and training of health professionals to provide rights advice and advocated better measures to provide outreach advice, particularly on welfare rights, in order to promote both justice and health outcomes.[27]

Research has identified that the stress and anxiety associated with debt can affect health and can result in visits to a GP.[27] Drawing on this evidence, the London Health Forum highlighted that the resulting costs for the NHS could be significant, for example an hour of GP time costs approximately £160 in the city. The Forum has initiated a project to help ameliorate the health burden arising from the recession through early debt advice and other preventative measures.[45]

The impact of partnerships with advice agencies on the host services and staff has been assessed in several studies. Greasley and Small argued that advice located in primary care was particularly valuable for practices working in areas of high deprivation where a large number of consultations have an underlying psycho-socio-economic basis.[46] Advice work saved time and relieved the pressure on GPs and other primary health care staff in this setting. Other qualitative studies have identified outcomes including improved patient care at the same time as decreasing GP workload;[18] a trend towards a reduction of GP consultations and new drugs prescribed, particularly amongst people whose income increased;[32] and evidence of reduced drug-dependency.[37] Also health care staff have reported that advice can provide a referral pathway for patients who have social welfare issues allowing them to 'spend time more productively with patients'.[38] Approaches to design and implementation of financial inclusion initiative are discussed in more detail below in the section on Methods of Intervention.

Approaches to researching the health impacts of financial inclusion

Within the studies identified, the lack of clear results in terms of measurable impacts on health has been attributed, at least in part, to the methods used in some studies. Issues raised include sample size, attrition rates and the relatively short period of longitudinal studies (12 months at the longest from initial to final survey or interview). This section provides a summary of issues identified concerning the research methods used. Most studies included in this review contained some discussion about methods or research design, particularly in relation to three key areas: the relevance of standard instruments such as the SF36 and HADS to assess the impact of financial inclusion activities; the merits and demerits of control trials; and the role of qualitative and mixed-methods approaches.

Instruments to measure the impacts of financial inclusion

The only standard form that was used on more than two studies was the SF36 that was used in 5 studies using quantitative methods. The instruments identified in these studies are widely used to measure (self reported) health outcomes but, whilst these are well-established instruments for measuring health outcomes, they may not be appropriate for financial inclusion work. For example, Adams et al highlighted that general measures of health such as the SF36 "may not be able to pick up subtle changes in psychological and social aspects of health".[18]

Greasley used SF 36 and HADS and argued that, in the absence of a randomised control trial or legitimate comparison group, the health outcomes on these standardised questionnaires, coupled with patients' own accounts is perhaps the strongest evidence available to show that welfare advice can improve patients' health and quality of life.[34] However McIntosh et al identified a concern that some of the questions on the standard scales they used to assess health related outcomes: "may have been inappropriate for a study amongst older people and were not designed specifically for an older population".[39] They argued there is a need to look at alternative or additional measures relevant to an older population, such as maintenance of independent living. This lack of an existing ideal standard measure to assess the health, wellbeing and quality of life impacts of interventions may help to explain why so many different forms have been used in a small number of studies. It also suggests that more work is needed to develop measurements that are more suited to assessing financial inclusion interventions, addressing the situations of people who may be elderly or in poor health and reflecting a broader social agenda.

The relevance of (randomised) control trials

Few studies in this review involved the use of comparator or control groups and only two studies identified involved randomised control trials (RCTs), one of which was not completed because sample attrition was considered too great.[39,27] A key conclusion drawn by Adams et al was that RCTs should be used in future studies to gain a clearer understanding of the health impacts of advice.[18] There is a school of thought that advocates RCTs as the 'gold standard' in studies to assess the health impacts of an intervention. This is argued to be because they are regarded as the most reliable form of 'scientific evidence' since they eliminate spurious causality and bias. However, there are opposing views about the appropriateness of using RCTs as a method of assessing the impact of welfare rights advice on health, particularly where it could involve withholding information about legal rights and entitlements to benefits or income increases for the purposes of research.

Even setting aside the fact that lack of use of mainstream services is often the main reason for outreach based in health settings, others question the ethics and relevance of randomised studies and the use of control groups. Two of the co-authors in the Adams et al review were involved in a project to assess the feasibility and acceptability of a RCT of welfare rights advice and to identify appropriate health and social outcome measures in order to plan a definitive trial. MacIntosh et al sought to minimise the effect of loss of income by having a six month delay prior to the control group being assessed for benefit entitlement. They considered this would be a reasonable compromise "between impeding the receipt of benefit entitlements and allowing time for any health improvements to appear". However, the optimum time at which to measure any health benefits was unclear at the trial outset. They concluded that health improvements resulting from increased benefits may not be detectable after such a short time and identified that individuals in the control group did lose benefits as a result of this approach. While there is a methodological argument for delaying the welfare rights advice longer in the control group in a future trial, they recognised it is "ethically contentious, as it is hard to justify withholding an intervention that is known to be beneficial in financial terms". [39]

Abbott et al were criticised because they did not use a control trial. However, they identified the objections to RCTs as an approach for this type of study topic as including concerns about legal entitlements to welfare benefits and the fact that welfare benefits advice, in common with other financial inclusion interventions, is unlike medical treatments which are more commonly assessed using RCTs; and the resulting changes from advice or an increase in income have a value irrespective of any health effects, including the relief of poverty. For them it was:

> *"arguably unethical to deprive anyone, even temporarily, of money to which they are legally entitled, for the sake of an RCT when the presumed benefits to health are neither established (hence this study), nor the main outcome of the intervention. Observational studies have a valuable role to play when RCTs are not feasible."* [28]

Consistent with this view, Campbell et al considered that the use of a control group was not feasible for ethical, social and practical reasons. Although they acknowledged the need for cautious interpretation of findings, they highlighted that a qualitative study was conducted alongside the quantitative research and that supported their interpretation of health and non-health impacts to some extent.[24]

It is difficult to envisage conditions in which the ethical concerns raised here would not arise in research to assess the impact of advice for health, wellbeing and quality of life. Advice and financial inclusion interventions are first and foremost aimed at increasing income or sometimes reducing the cost paid by people on low incomes. While there is scope to assess the effects of such interventions on health, the need to reflect the social nature of the intervention should be prioritised:

> *"Social interventions differ from clinical and most complex public health interventions in that changes in health are often an indirect effect rather than a primary aim of the intervention. Investigation of indirect health effects often requires choices to be made between competing values, usually health and social justice, creating a moral problem. When, as in our study, the tangible social and economic gains generated by the social interventions outweigh the theoretical possibility of marginal health effects, the moral issues are clear."* [47]

Following Springett we would argue that appropriateness is intimately tied up with the nature of the object that is being evaluated.[48] The question of what is being evaluated has implications for the choice of what constitutes an appropriate framework for research and evaluation.

Qualitative and mixed methods studies

Mixed methods were the most common approach used in studies and those reporting concurrent qualitative and quantitative elements to studies highlighted the important contribution of qualitative research to extending understanding in what is a relatively new area of research for which the established measurement of health outcomes are less than ideal. For example, Moffatt et al highlighted how their qualitative study provided valuable information about outcome measures and helped with the overall interpretation of the concurrent pilot RCT. It enabled:

> *"participants to give an account of the various ways in which the intervention impacted on their lives, such as increased independence and improved quality of life, which were not explicitly measured in the pilot RCT and are challenging to capture quantitatively... The study also suggests that inclusion of a qualitative component will help to illuminate the process and outcome of a future trial."*[33]

Similarly Winder et al described the validity and reliability of their social services based study as being "supported and strengthened through feedback within and between concurrent studies" and that primary and secondary coders (with different professional backgrounds) came to a consensus on how themes were categorised and interpreted.[41] This approach is supported by Rogers et al who, in discussing the impact of urban regeneration on mental health, argue that:

> *"a combination of multi-level mode indicators and narrative accounts of individuals about mental health in the context of locality and personal changes are central for developing theories and methods appropriate for exploring the action and interaction of effects operating between structural and individual/agency levels.... Surveys which use subjective indicators of mental health and quality of life, together with qualitative research, which incorporates the narrative accounts of individuals about both the locality and personal circumstances implicated in mental health status, has the potential to assess and elaborate upon the way in which individuals perceive the effects of change.*[49]

Considered in this context, financial inclusion activity is a complex intervention and, whilst subject to more research than other areas, money advice is one aspect of potential financial inclusion activity whose effects do not necessarily follow the assumptions informing conventional assessment of health impacts. In the studies reviewed, there was some lack of satisfaction with standard measures to meet the needs of research in this relatively new field and debate around the relevance and ethics of randomisation and control trials. There were multi-disciplinary research teams in only a few of the projects identified, but where qualitative research was included in the methods used, the complexities have come through more clearly. At this early stage in a new field of research, there remains considerable scope to develop research projects from design through to analysis that reflect the complexities and multi-disciplinary nature of the issues involved.

Section 3: Models of intervention

This section draws out good practice lessons from the health-based literature to inform the development of future financial inclusion services.

Understanding the barriers or specific needs of different groups is central to effective service design.[10] When designing financial inclusion initiatives, "what helps one group of clients may not help another".[50] Research has established that advice is often needed at key transition points in people's lives such as the move into employment or job loss; when a relationship breaks down; or at the different stages in patient pathways, from diagnosis through to recovery. In addition, services need to consider how to design approaches that take account of the way that structural inequalities impact on specific groups.

Targeting groups

Income is a key predictor of financial exclusion - vulnerability to financial exclusion is related to both long-term and temporary low incomes, and to facing major unexpected expenses.[10,51] Different vulnerabilities can create barriers to financial inclusion which interact with low income. What follows is a summary of those studies which have targeted an intervention to meet the needs of specific groups:

- **Older people**: It has been recognised since the early 1990s, that providing benefits advice services for older people in a health-care setting, usually a primary health-care centre, can be highly effective and beneficial. Reasons identified within the literature have included: many older people have regular contact with primary care and clinics and health centres can be less stigmatising than benefits offices.[30] Key features of income maximisation services for older people have involved: the active creation of contacts with older people to alert them to their entitlements; pro-active offers of advice to people who are retired and particularly those in poor health, with a disability or in a caring role; and active assistance with the process of claiming.

- **Ethnic minority groups:** The review identified one project which successfully reached this target group while others have reflected on the barriers to access for this group including lack of bi-lingual staff and promotional materials.[39] The Health Plus Project employed 6 advice workers in General Practices throughout the Bradford City Primary Care Trust (PCT) area.[34] Most of the advice workers were from ethnic minority origins and able to provide a bi-lingual service, whilst two advice workers could access interpreters. Income generation through benefit claims was only one aspect of this project and other forms of advice and assistance (e.g. disability aids & adaptations, home care, housing, immigration) were equally important for patients. The majority of patients referred to the service were female (61%) and most were of south Asian origin. The authors suggested that the high proportion of Asian service users may reflect a greater need for help with understanding and completing welfare benefit letters and forms.

- **Gender:** Although the studies included in this review often reported on the numbers of men and women accessing projects there was no gendered analysis of the impact of services or health outcomes. There is increasing recognition among health policy-makers and service planners that gender is a central determinant of health status.[52] A number of studies have explored the way men and women tend to use health and other public services differently. However, in the area of health and over-indebtedness, gendered analysis is lacking and there is potential for future research in this area.

- **Families and Children:** Families with young children are particularly vulnerable to poverty. However, no studies were identified that had families with children as their main focus. The recent announcement of a 'Healthier Wealthier Children Families Financial Inclusion Project' across NHSGGC is a welcome development in this regard. This 15 month project will target pregnant women and families with young children who are at risk of poverty. It will aim to develop expertise to address child poverty through a partnership model providing income maximisation advice and developing a strategic approach to linking the provision with health and other services.[53]

Interventions targeted at patient groups

Health-based financial inclusion initiatives should be flexible, taking account of the needs of patients with acute conditions and provided at different stages in the patient pathway of longer term conditions. Acute, short-term episodes of ill health have a similar relationship to financial exclusion as many other dramatic shocks in people's lives and poorer people are less likely to have a cushion to manage this kind of crisis.[54] Here, early access to advice on benefits and action to prevent debts getting out of control during the period of illness are priorities. Different support may be needed for people with chronic health conditions: for example, where they limit ability to work, people can be denied financial goods and services as they move onto long-term low incomes.

- **Cancer patients, their families and carers**: In parts of the UK including some areas in Scotland, Macmillan Cancer Support has established partnerships with local money advice services to improve access to specialist advice and address the stress and anxiety associated with money worries which often arise following diagnosis for example, due to a drop in income or increased costs associated with managing their cancer. The service is delivered in places that are convenient to the clients and their families including in their own home, in hospitals and other health settings. [55,56]

    - In England and Wales Macmillan Cancer Support have funded CABs to provide specialist advice to people affected by cancer. Between January 2007 and June 2009, 51 bureaux provided a Macmillan partnership service.[55] They helped nearly 15,000 clients. The majority (54%) accessed the service via either an outreach service, home visit or at the hospital.

    - Within Glasgow, Macmillan Benefits Service was established in 2008. This is a four year partnership between Macmillan Cancer Support, Glasgow City Council and NHS Greater Glasgow & Clyde. The service has a Glasgow-wide remit to accept referrals from anyone with a cancer-specific diagnosis and their families or carers in the local authority area. It offers a home visiting service and advisers also visit customers in hospitals and hospices if necessary. The project accepts referrals from a wide range of sources including: hospitals, hospices, health centres, and social work, family and friends and self referrals.

- **People with mental health problems and their carers:** People with mental health problems are vulnerable to financial exclusion and problem debt. In Britain they are nearly three times more likely to report debt compared with individuals without similar conditions.[57] The Manchester Mental Health Welfare Rights Service and the GAMH financial inclusion development project are two good examples of services designed to meets the needs of this group.[58] Evaluation of these projects has found that what works is:

    - Advice sessions delivered from places people with severe mental health problems go to and are comfortable in, such as day treatment centres, where user groups have drop-ins, or via home-visits if required.

    - Staff who are expert in benefits and advice and knowledgeable about a range of medications and mental health conditions.

    - Some service users require the support of their key worker or CPN to attend appointments. GAMH operates a supported referral service which puts the person referred to a money advice agency at the centre of the process. It ensures the person referred is provided with support from a worker who is experienced in supporting people with mental health problems before, during and after the referral to the money advice agency. The service also provides mental health first aid training to money advisers.

    - It can take several appointments for an adviser to make a needs assessment or fill forms with some clients. This may be because it takes longer for the client to build trust with the adviser, necessary to apply for key benefits such as DLA or because they have to go into hospital.

    - Continuity in the service provision is crucial for this client group because some can find it difficult or distressing to access advice and tell their stories to strangers.

    - Continuity of support through the process of admission to and discharge from hospital

- **People affected by stroke**: A financial inclusion service was established in November 2008 by NHSGGC to meet the financial needs of people affected by stroke.[29] Key lessons from the evaluation of this service include the need for advice at each stage of the stroke pathway including early intervention; continuity of adviser on discharge; and holistic support covering all aspects of money advice. Unfortunately the service evaluation only focused on the money advice and income maximisation activity and lessons were not drawn on the impact or uptake of financial capability. Despite these problems with the evaluation of this, the project has a patient-centred model which aims to provide a flexible package of support and the approach to consultation and design of this service can inform the development of provision for other groups.

Screening or referral?

The research indicates that, whilst some projects are based on multiple referral routes (e.g. self-referral, GPs, nurses, social worker or carers), others have managed projects through tighter referral or screening arrangements to target specific groups or situations. A clear lesson from projects which have focused on access to advice through GP surgeries has been that this is an effective way for services to reach groups who are less likely to use mainstream services. [59,12] However, some studies have cautioned that the primary beneficiaries of this approach tend to be older people, more than other groups at risk of exclusion and considered hard to reach, including younger families[60]. Also the level of uptake is dependent on the attitude of practice staff towards the service, their knowledge of the service, and general promotion of the service. [34,23] Popay (2007) argued that the reason that at least some GPs do not respond to patients' social problems are likely to be complex,[44] but research suggests that they include patients' reluctance to disclose social problems and GPs reluctance to probe for these. [61,62,63]

The most successful services tend to be where other health workers are fully supportive of the initiatives and the welfare rights advisors are an integral part of the health unit (e.g. GP practice), with other health care staff aware of appropriate clients to refer on to them. Where advice workers are more marginalised, due to location (lack of space) and/or lack of interest from healthcare staff the literature suggests the impact was less.[20]

Hoskins et al (2005) evaluated a 15 month project where community nurses used pre-screening forms in the course of their normal daily work to screen their older clients' Attendance Allowance status. The authors argue that the pre-screening intervention overcomes the barrier of some clients' reluctance to disclose personal information and share health concerns, due to the therapeutic nature of the nurse/client relationship.[14] Toeg et al have highlighted the challenges of this approach arguing that screening requires specialist benefit knowledge, as well as an awareness of statutory and voluntary services. He noted the educational potential that can stem from such a project in relation to all members of the primary health care team, as well as medical students and general practice registrars.[64]

Managing referrals and expectations

Whilst it is vitally important that people in need of support are assisted in identifying sources of accredited advice, it is inherent in this that once directed they are actually able to access that advice: i.e. receive a consultation within a timely period. If the number of referrals increases as a direct result of the establishment of a referral mechanism, it is imperative that the resources available to service this increase in demand are identified and released.[27]

Developing Services

Training needs

Advice work in primary care and other health settings, compared to generic advice work, may require relatively longer sessions and longer-term involvement with patients to address complex problems and deal with follow-up work. To support service users with a range of complex health needs, one evaluation identified that money advisers established links with mental health organisations and accessed ‘mental health first aid’ training[10]. Fitch has recommended that health staff should receive training on how to talk with patients about debt; knowing how to refer to, and support, debt advisers; but without being expected to become ‘debt experts’ themselves.[5] The Royal College of Psychiatrists, with the input of a range of other organisations, has developed a guide to help health and social care workers support people with debt and mental health problems.[65]

It is important to provide training for health staff about appropriate referrals. Referrers need to be aware of the range of assistance provided in order to avoid inappropriate referrals and ensure use of the service.[19] A recurrent issue identified concerns health staff attitudes presenting a barrier to advice. In one study health professionals characterised claimants as ‘scroungers’ and a nurse assumed that a patient did not need DLA because he/she belonged to an ethnic minority that “looks after their own”,[21] pointing to the need for equalities and diversity training to tackle barriers to referrals.

Advertising and promotion

To encourage engagement in any initiative, primary care staff and other groups of referrers in a number of projects have highlighted the need for feedback about referrals.[15,10] Whilst it was appreciated that advice issues are confidential, feedback about the number of patients seen and general outcomes is important.

Across the literature the need for advertising and promotion of services was highlighted as an important issue. Advertisements and promotion should be visible in ‘outreach’ locations where people might be seeking help, using a service or just looking for information (e.g. Jobcentre, childcare services, libraries, GP surgeries).[27] In one study surgeries with printed information available rated the adequacy of advice services more highly.[66]

Partnership working

Good practice in delivering financial inclusion interventions in health-settings has been achieved through partnership working with local specialist advice agencies. Although research has identified that complex partnerships can limit the effectiveness of short-term projects,[10] Partnerships with specialist money advice services, as well as services that are specialist in supporting groups, have been identified as effective ways to develop advice and outreach sessions and other activities that improve access to advice. For example, the Glasgow

Association for Mental Health has implemented a strategy to tackle financial exclusion and improve access to advice for people with mental health problems that involves partnership working with money advice agencies across the city, service users and carers and it is currently developing stonger links with NHSGGC.[23]

Section 4: Conclusions and Recommendations

Conclusions

Addressing the health benefits of financial inclusion remains a complex area of intervention and research. As a very new discipline, financial inclusion and the approaches involved within it are constantly changing and developing and there remains considerable scope for further project development and research. Although this review has had financial inclusion as its focus, income maximisation work remains the central concern of most of the research identified. However, financial inclusion is not only about access to benefits and income maximisation but also debt advice, financial awareness and financial capability (how people use financial services, how they budget and pay for their bills and how they plan for the future). A growing number of health-based initiatives aiming to tackle the wider issue of financial exclusion are operating within NHSGGC and nationally, and the picture is moving fast.

Whether or not projects have involved some targeting, for example towards older people, there is limited evidence of analysis of the different situations of different groups or the impacts for groups within the target population, for example on the basis of gender, ethnic origin, disability or learning difficulties. Strategies that work for one group or situation can inform work with other groups but may not always be effective. Research and evaluation need to go beyond recording the characteristics of service users and explore different needs, impacts and outcomes of advice. However, this work should also be informed by a growing body of research on effective practice in financial inclusion work.

Investment in financial inclusion is relatively recent within the NHS, so many initiatives remain at the early stages or are short-term, and few have been evaluated for their impact on health. This presents opportunities for future evaluation and research to explore the health impacts of these approaches. There are gaps in the groups that have been targeted in initiatives and limited analysis of outcomes or analysis other than for whole populations, for example on the basis of gender. The research shows that services are effective at reaching older people, for whom primary care is a trusted source of support. While this is likely to remain important, there is less evidence of services targeting other groups at risk of exclusion, including families with children. However, a new NHSGGC project targeting this group will be well placed to contribute to building understanding of the benefits of income maximisation work in a health setting for a key group that is vulnerable to poverty.

The mental health benefits of financial inclusion activity are important in their own right and the area in which qualitative and quantitative research has shown some clear benefits. However, the wider effects of addressing the stress and anxiety of debt and low income should be explored. For example, the Mental Health Foundation has highlighted that people with anxiety disorders are at greater risk of developing a number of different physical health conditions, including coronary heart disease[67]. Regardless of the causal pathways between debt and mental ill health, the link is evident and important, particularly in view of the growing problem of personal over-indebtedness in recent years.

The review has also identified opportunities to further develop existing approaches to tackling financial exclusion. For example, in addition to welfare rights and debt advice, other linked areas of policy and practice have the potential to be considered in integrated approaches to financial inclusion because they are strongly linked to the issues of poverty and ill-health. Addressing fuel poverty is one area that has been highlighted. Prevention of homelessness and eviction and re-housing of homeless individuals is another area in which the right advice and support is essential to addressing the situation of people who are likely to have health and/ or addiction issues.

These wider issues also serve to highlight the need for a broader agenda in research that takes more account of the complexities of people's lives. The review raised questions about whether enough account has been taken of the effects for different groups of people and different health circumstances (for example acute and chronic health conditions, mental health problems). There is some agreement that, in order to gain a better understanding of the impact on health, more sensitive measures need to be developed and studies need to be longer term than the one year that most studies have lasted in the past.

Adams et al concluded from their review that there is little need to conduct additional work to determine whether welfare rights advice has a financial effect but there was "little evidence either that welfare rights advice in healthcare settings does or does not have health and social effects, and this remains an intervention with theoretical potential to improve health".[18] We would re-emphasise the issues identified with the lack of sensitivity of standard self-report health outcome tools in the field of advice and financial inclusion impacts on health. More importantly, however, there is a need to illuminate further the evidence from quantitative research and from a body of qualitative research which supports the positive effects of benefits advice on mental health and socio-economic wellbeing. The significance of this evidence has been underplayed.

Evidence of effective practice exists, but this would benefit from further development. In particular, advice needs, like health needs, are often not static and some flexibility in service design may be needed to respond to changing needs. For example, someone diagnosed with a condition involving long-term management or a long period of recovery may have particular and different advice needs at the point of diagnosis, when entering or leaving hospital as an in-patient and during periods of recovery or deteriorating health. Such an approach would be consistent with the aim of holistic provision and the aims of providing seamless services and the use of the pathways approach. Training and information sharing are necessary components for ensuring that health and financial inclusion professionals have the right levels of awareness and expertise for the work they do.

Financial inclusion is an area of mutual concern for local government and health services and has much potential to contribute to better understanding of how services can help to reduce health inequalities. This potential also extends to addressing any unintended consequences of the way services currently work.

Recommendations: Research

Recommendation 1: More research is needed to broaden understanding of the extent to which financial exclusion and inclusion are affected by factors such as gender, family circumstances, age, ethnicity or disability and their relationship to the impacts of financial inclusion initiatives for health, wellbeing and quality of life for different groups within target populations.

Recommendation 2: Financial inclusion is a complex intervention. There is a great deal of good work being done that is not necessarily providing the depth of research and evaluation that is still required. There is considerable potential for financial inclusion initiatives to contribute to an agenda for improving health. However, for its contribution to be understood better and the social impacts of financial inclusion taken into account more fully, there is a need for:

- Multi-disciplinary research involving people with expertise in both health and financial inclusion

- Mixed-method approaches to research that draw upon the experiences of individuals to develop more effective methods for assessing the impact of financial inclusion interventions in relation to health, wellbeing and quality of life. Such work should build upon, but not rely on, existing standard health outcome measures such as the Short Forms that have been identified as insufficient for financial inclusion initiatives and for research with some groups of people, including older people

- Longitudinal research is needed, particularly for improving knowledge about the impacts of financial inclusion interventions for physical health and condition management. Ideally this needs to go well beyond the one year research period of most existing studies

Recommendation 3: Further research is needed on the links between debt and mental health, particularly to increase understanding of the ways in which financial inclusion activities can alleviate mental health issues and the potential for such interventions to contribute to reducing the physical health risks associated with poor mental health.

Recommendations: Practice

Recommendation 4: Monitoring of the characteristics of people using financial inclusion services should be kept under review to ensure that it can reflect both project and wider policy priorities. For example, monitoring should include family situation / relationship status, having dependent children and caring roles in addition to the social characteristics that tend to be recorded more routinely.

Recommendation 5: Evaluation and development of financial inclusion projects and services should take account of the effectiveness of services at reaching different groups, including within target populations. For example, do services targeting older people effectively meet the needs of both women and men?

Recommendation 6: Existing research and evaluation reports provide practical guidance on improving access to advice for people in a wide range of situations and this body of work can do much to inform development and review of projects and services, including adapting existing effective practice to improve service access for other vulnerable or disadvantaged groups.

Recommendation 7: Projects and services should be developed in a way that recognises the importance of responding to changing needs over time. This is consistent with holistic service provision and the pathway of care approach.

Recommendation 8: In view of the importance of a warm home, particularly for young and older people, NHSGGC should consider how addressing fuel poverty can be incorporated within its approach to financial inclusion. Linked to this, housing circumstances, particularly the risk of or actual homelessness, are potentially important areas for advice and support, particularly given that people in this situation are likely to have health or addiction issues. .

Recommendation 9: The wider issues of fuel poverty and homelessness highlight that there may be a need for wider links, for example with services addressing advice on homelessness and benefits, including CABs and Shelter, in a broad agenda to tackle financial exclusion.

Recommendation 10: Partnership working needs to include key health and financial service providers, but also service users and carers and the services that support them can provide valuable inputs to project development (for example, key workers). This could include development of alternative approaches to delivering financial inclusion advice, such as peer advice and support. In some circumstances, the input of other service providers may be important, such as housing providers and domestic fuel suppliers.

Recommendation 11: Training, awareness raising and capacity building should be kept under review to take forward financial inclusion work. This is likely to involve different training need for different groups and services, for example:

- For mainstream financial inclusion services training may need an emphasis on health needs and their impact on access to services and financial inclusion, with additional training where necessary, such as mental health first aid for money advisers
- For health service staff training should raise awareness of general rights and entitlements and the specific or general sources of help, including encouragement towards referral rather than seeking to gain detailed knowledge of benefits or other financial inclusion interventions

- For all groups, equality and diversity training may be important, particularly in projects involving screening of potential clients for financial inclusion interventions

NHSGGC Financial Inclusion Group will consider which recommendations can be taken forward through its review of its action plan for 2010/11 and which are longer term. There are opportunities for many of the recommendations to inform planning and service provision (e.g. Children & Families Project, Mental Health services, Long Term Conditions, Older People); development of guidance (e.g standards group; training initiatives) and monitoring (e.g. health benefits research group; policy framework indicators).

Appendix 1: Search Strategy and Analysis

To ensure that the relevant evidence was gathered within the timescale, we undertook an approach that is in accordance with some of the best practices involved in Rapid Evidence Assessment (REA). This approach ensures that rigorous and transparent search and analysis procedures produce a valid, robust and reliable analysis of the field. It also draws out lessons for future research and practice.

The key principles and steps in the REA method which can be applied in this project include the following:

- Developing an informed and systematic search strategy using electronic and print sources to ensure comprehensiveness within the constraints of the timetable
- Establishing explicit inclusion criteria for identifying relevant sources
- Assessing the relevance of identified articles in accordance with a standardised protocol
- Critically appraising evidence gathered to sift out studies of poor quality in accordance with explicit and transparent criteria
- Collating descriptive and analytical outlines of the selected evidence in a systematic and standardised format
- Providing an accessible and coherent narrative overview of the evidence and conclusions which follows logically from the analysis process

This appendix reports on the key elements in relation to the three key stages of this review which include the following:

- Stage 1: Data Search
- Stage 2: Data Analysis

Stage 1 – Data Search

The first stage initially involved clarifying the parameters and relevant search criteria to guide the literature review and evidence gathering processes. The agreed set and range of search terms is presented in Table A1 below. These keywords were identified based on understanding of the theory, research and debates in the area, and specified in advance to ensure that the search process and criteria for including and selecting studies is explicit and defendable.

The following points provide an overview of the data search:

- *Searches of electronic databases:* the main source of information on social policy and related research are bibliographic databases - collections of document summaries, usually with abstracts and some subject indexing based on a consistent coding procedure. The nature of coding and classification of content is often specific to each database and so the keywords in table A1 were used to search the thesaurus of each of the following databases:

Table A1: Search Terms

	AND		AND		AND	
Banking		Inclusion		Health		Evaluation
OR		OR		OR		OR
Credit		Exclusion		Mental health		Study
OR		OR		OR		OR
Debt		Poverty		Primary care		Pilot
OR				OR		OR
Money				GP (General Practitioners)		Research
OR				OR		OR
Money advice				Social work		Outcome
OR				OR		OR
Over-indebtedness				Hospitals		Impact
OR				OR		OR
Saving (s)				Nurse		Result
OR						OR
Income maximisation						Effect
OR						OR
Welfare benefits						Satisfaction
OR						OR
Insurance						Cost
OR						OR
Debt advice						Benefit
OR						OR
Affordable credit						Review
OR						
Loans						
OR						
Financial services						
OR						
Credit Union						
OR						
CDFI						
OR						
Unbanked						
OR						
Financial						
OR						
Bank account						

- ABI/ Inform
- Applied Social Science Index and Abstracts (ASSIA)
- Cambridge Scientific Abstracts: Worldwide Political Science Abstracts
- Cumulated Index to Nursing and Allied Health Literature (CINAHL)
- Education Resources Information Centre (ERIC)
- EconLit
- International Bibliography of the Social Sciences
- Planex
- Psych Info

- Social Services Abstracts
- Sociology Abstracts
- Medline
- Web of Knowledge

The search strings used to search each database along with a record of the number of 'hits' are included in this document in table A2 below.

A. *Hand searches of specific journals*: the electronic contents pages of Health and Social Care in the Community (Volumes 6–12, 1999–2009), BMC Public Health (Volumes 1-9, 2001-2009) and the Journal of Social Policy (volumes 28–38, 1999– 2009) were scanned to identify relevant publications. These journals were chosen because of their relevance to the subject area and the perception that substantial relevant work had been published in them.

B. *Searches of internet search engine*: searches were made of the internet search engine Google http://www.google.com and Google Scholar http://scholar.google.co.uk/ using the keywords in Table A2. The first 100 results returned by each search strategy were scanned for relevance and those judged to be potentially relevant followed up.

C. *Suggestions from experts and those working in the field*: 'Experts' – identified as such either by frequent publication in the area, or through personal contacts of the research team – were contacted directly and asked for help with identifying relevant literature or providing further contacts. Relevant reports were picked up from e-bulletins from a range of relevant organisations including Social Policy Digest, Transact and The Information Hub.

D. *Local monitoring and evaluation reports and reviews:* In addition to the review, the researchers have undertaken analysis of local monitoring and evaluation reports and reviews conducted by other health services across the UK. The commissioners have provided the research team with a number of relevant documents for this stage of the process.

Table A2: Database Searches

Database	Search string	Hits	relevant
CINAHL	(MH "Mental Health") or (MH "Physicians, Family") or (MH "Practitioner's Office") or (MH "Hospitals, Community") or (MH "Hospitals, Pediatric") or (MH "Hospitals, Psychiatric") or (MH "Hospitals, Special") or (MH "Hospitals, Public") AND (MH "Debt, Financial") or (MH "Bankruptcy") or (MH "Economic and Social Security") or (MH "Insurance") or (MH "Counselors") or (MH "Banks") or (MH "Credit") or (MH "Income (Omaha)")	86	2
PLANEX	("welfare benefits advice" or "banking" or "debt" or "money advice" or "unbanked" or "income maximisation" or "savings") AND ("health" or "mental health")	100	37
ERIC	Mental-Health.DE. OR Mental-Health.DE. OR Health-Needs.DE. OR Health-Promotion.DE. OR Public-Health.DE. OR Health-Personnel.DE. OR Community-Health-Services.DE. OR Mental-Health-Workers.DE.) AND (Debt-Financial OR Banking.W..DE. OR Credit-Finance)	13	0
Psychinfo	DE=("banking" or "financial strain" or "social security") and ("poverty"	101	16

	or "social equality") and ("mental health" or "primary health care" or "social casework" or "therapeutic processes" or "well being")		
ABI/ Inform	"banking" or "debt" or "unbanked" or "credit" or "savings" or "money advice" or "welfare benefits advice" or "income maximisation") AND ("health" or "mental health" or "social work") AND ("inclusion" or "exclusion" or "poverty" or "income inequality") AND ("evaluation" or "study" or "pilot" or "research" or "outcome" or "impact" or "result" or "effect" or "satisfaction" or "cost" or "benefit" or "review") AND PDN(>1/1/1990) AND NOT AT(book review) AND NOT (fiscal) *Database*: ABI/INFORM Global *Limit results to*: full text *Look for terms in*: Citation and abstract. *Publication type*: All publication types	212	1
Econlit	DE=("banking" or "money" or "savings and loan" or "personal finance d140") AND ("inegalitarianism" or "inequality" or "poverty" or "welfare and poverty general i300")AND("health" or "hospitalization or hospitalisation" or "social welfare function" or "social welfare programs or social welfare programmes")	221	3
Social Services Abstract	DE= ("banking" or "credit" or "debts" or "finance" or "information and referral services") AND ("deprivation" or "disadvantaged" or "low income areas" or "low income groups" or "poverty" or "social inequality" or "welfare dependency") AND ("social work" or "stress" or "well being" or "practitioner patient relationship" or "health" or "mental health")	65	16
Sociology Abstracts	DE= ("banking" or "credit" or "debts" or "finance" or "information and referral services") AND ("deprivation" or "disadvantaged" or "low income areas" or "low income groups" or "poverty" or "social inequality" or "welfare dependency") AND ("social work" or "stress" or "well being" or "practitioner patient relationship" or "health" or "mental health")	108	29
Medline	DE=("banking" or "credit" or "debts" or "information and referral services" or "financing personal economics") and ("social work" or "stress" or "well being" or "practitioner patient relationship" or "health" or "mental health") and ("deprivation" or "disadvantaged" or "low income areas" or "low income groups" or "poverty" or "social inequality" or "welfare dependency")	27	1
Applied Social Science Index and Abstracts (ASSIA)	(DE=("bankruptcy" or "benefits" or "consumer debts" or "financial institutions" or "financial services" or "personal debts")) and(DE=("community health" or "general practice" or "health" or "mental health" or "primary health care" or "public health" or "social work"))	141	14
Cambridge Scientific Abstracts: Worldwide Political Science Abstracts	(DE=("debts" or "banking" or "bankruptcy" or "budgets" or "consumer law" or "credit" or "finance" or "financial support" or "income" or "insurance" or "loans" or "money" or "saving" or "welfare recipients")) and(DE=("health professions" or "community mental health" or "health care services" or "mental health" or "mental health services" or "mental illness" or "public health" or "social services" or "stress"))	482	1
IBIS	financial inclusion or debt or banking or credit or "personal finance") and (health or "social work" or nursing or "primary health care"	24	6
Web of Knowledge	Title=(DEBT OR FINANCE OR CREDIT OR UNBANKED OR INCOME OR INDEBTEDNESS) AND Title=(HEALTH or mental health)	152 1	3

E. *Searches of specific websites*: the websites of a number of specific organisations that sponsor and conduct financial inclusion and social policy research are being searched on an ongoing basis and include:

- Government (UK)
- HM Treasury
- Cabinet Office
- Ministry of Justice/Department for Constitutional Affairs
- Department for Work and Pensions
- Department of Health
- Department for Business, Innovation and Skills
- Communities and Local Government
- Legal Services Commission/Legal Services Research Centre
- Scottish Executive
- Welsh Assembly
- Other bodies
    - NHS Health Scotland
    - Financial Services Consumer Panel
    - Financial Services Authority
    - Joseph Rowntree Foundation
    - Runnymede Trust
    - Institute for Fiscal Studies
    - Centre for Research on Social Policy
    - New Policy Institute
    - Friends Provident Foundation
    - Citizens Advice
    - Money Advice Trust – Information Hub
    - Sainsbury Centre for Mental Health
    - Mind
    - Macmillan Cancer Support

- Academic
    - ESRC
    - Personal Finance Research Centre
    - Research Unit for Financial Inclusion

F. *Reference lists from relevant studies*: the reference lists of all studies assessed to be relevant were scanned to identify other relevant work, as were the reference lists of previous reviews in this area.

Stage 2 – Data Analysis

To ensure consistency in analysis, each source identified and judged relevant in the literature search was reviewed using an analytical template covering:

- Nature of the study, article or report: e.g. original quantitative, qualitative or mixed-method research; policy commentary; theoretical analysis; research summary, etc.
- Specific subject/topic; aims of the study
- Relevance to and implications for health impact of financial inclusion activity and/ or practice in health services
- Further sources of information or reading identified

The evaluation of the quality of research studies and validity of evidence has been informed by our existing analytic expertise and familiarity with professional standards. For example, the Social Policy Association published a framework applicable to assessments of quantitative research studies, which included the following appraisal criteria (Becker et al., 2006):

- Validity: correspondence between data and conceptualisation; fitness for purpose of the research method
- Reliability: robustness of research instruments and consistency of observations
- Replicability: explicitness and transparency of method, likelihood of generating similar results
- Generaliseability: application of findings to wider cases or population

Following the appraisal of relevance and quality, the selected studies were analysed systematically in relation to content. A code list of emerging themes from studies was generated and iteratively revised in the light of new sources and results. The analysis has identified any recurring issues and findings from the literature (e.g. the frequency of particular outcomes or associations), and comment on these in terms of the relative strength of evidence and quality of the studies reporting these conclusions.

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