



Health Justice Partnerships in Social Prescribing International Workshop

Background Materials and Full Event Report
November 2017

UCL Laws
in collaboration with



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Located within the UCL Faculty of Laws, the Centre for Access to Justice combines the unique advantages of clinical legal education with the provision of pro bono legal advice to vulnerable communities, predominately in the areas of social welfare, employment and education law. UCL is unique in its incorporation of casework and social justice awareness into the law degree programmes we offer. Working in partnership with charity organisations and legal professionals, the Centre provides legal assistance to members of the local community while giving students an opportunity to gain hands on experience in meeting legal needs.



UCL CENTRE FOR
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THE INTEGRATED LEGAL ADVICE CLINIC

The UCL Integrated Legal Advice Clinic (UCL iLAC) launched in January 2016 at the Sir Ludwig Guttmann Health and Wellbeing Centre in Newham, one of England's most deprived boroughs. It provides advice, casework and representation across a range of legal issues,

with specialisms in welfare benefits, housing, community care and education law. The clinic receives referrals from practice GPs, as well as drop-ins from patients attending other clinics at the health centre. The UCL iLAC is staffed by UCL law students working under the supervision of experienced, qualified lawyers and advisers. Since its launch it has achieved many positive outcomes for members of the local community. Research is also being undertaken at the UCL iLAC, investigating the health impact of advice and the roles and value of health-justice partnerships.



THE LEGAL EDUCATION FOUNDATION

The Legal Education Foundation is a grant making trust that helps people better understand and use the law. We operate across three strategic objectives: increasing public understanding of the law and the capability to use it; improving the skills and knowledge of lawyers; and increasing access to employment in the profession. We do this so that those working in the law can be equipped to meet legal needs to the highest standard, and so that individuals and organisations with legal needs can learn about how to use the law to secure rights, fair treatment and protection. We place a particular emphasis on being evidence-led and on the role of digital technology and, more recently, have added policy and communications functions to the organisation.

The logo for The Legal Education Foundation, featuring the text 'The Legal Education Foundation' in white on a blue rectangular background.

The Foundation formerly operated as The College of Law, a law school delivering a full range of legal education courses to over 7,500 students a year. In 2012, the Governors of the College decided to sell off the education and training business and to use the funds generated by the sale to create a charitable foundation. We now distribute around £5million a year in grants. In 2014, the Foundation established the Justice First Fellowship – a scheme to provide fully-funded training contracts, pupillages and wider development opportunities for the next generation of specialist social welfare lawyers. In partnership with a growing number of host organisations and co-funders, over fifty Fellowships have now been funded across all four countries of the UK.

Under the objective to increase skills and knowledge of lawyers, we also support organisational development activities to strengthen legal services organisations. This includes practice management and leadership training, support for restructuring, improving IT infrastructure, developing collaborations and a wide programme of experiments developing new income streams for social welfare law. Under this work, the Foundation has supported work to expand partnerships with non-legal organisations, including in the health sector, hence our interest in today's workshop. Grants have included research led by Professor Dame Hazel Genn on the health outcomes of addressing social welfare legal needs, and supporting the development of exemplar social welfare advice services in healthcare settings.

We believe that resolving legal needs relating to areas such as income, debt, housing and employment are essential ingredients in providing support to people who are vulnerable. As Sir Michael Marmot put it in his foreword to a 2015 report on the role of advice services in health outcomes, 'Patients who are seen in clinical settings may well have problems in their everyday lives that may be causing or exacerbating their mental and physical ill health, or may be getting in the way of their recovery. If we do not tackle these everyday "practical health" issues, then we are fighting the clinical fight with one hand tied behind our back... what good does it do to treat people and send them back to the conditions that made them sick?' This underscores the urgency of finding ways to integrate and embed social welfare legal services in places where people most need them and at the earliest opportunity. The Foundation is committed to exploring this to find effective models in the health sphere that work for clinicians, for social welfare specialists and, most of all, for patients.

THE EVENT

On 9th November 2017 Professor Dame Hazel Genn, Director of the UCL Centre for Access to Justice, chaired an international workshop on health justice partnerships held in London. The workshop was the first meeting of its kind to bring together experts in the field from across the globe. This international involvement gave unique value to the event, providing insight to inform future directions for health justice partnerships in the UK. The workshop brought together leaders in the fields of both health and law to share experience, discuss challenges and consider ways forward.

The event included two formal panel discussions; the first gave an overview of social prescribing developments and then looked at the role of health justice partnerships in the UK, Australia and the US and their contribution to addressing underlying socio-legal causes of mental and physical health problems. The second panel focussed on advancing an evidence-based policy agenda around the role of health justice partnerships in social prescribing, considering what evidence is needed to support policy development, barriers to the collection of evidence, and how we can promote and fund a rigorous research programme.

THIS REPORT

This report presents the programme, speakers, presentations, discussions and feedback from the workshop. A background paper is appended, which informed the discussions at the workshop and served as a reference, linking to key literature in the field. Extracts and summaries from key articles, reports and research papers bearing on the following questions are included in the background paper:

- What are Health Justice Partnerships?
- How do they work and what outcomes do they achieve?
- Can Health Justice Partnerships improve health and reduce service use?
- What are the underlying theories of change?
- What evidence is there, and what are the knowledge gaps?

AUTHORSHIP

The discussions were transcribed by Jo Harwood for the Legal Education Foundation. The background paper was written by Dr Charlotte Woodhead.

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INTRODUCTION

Awareness of the impact of unresolved legal problems on health is growing. It is increasingly understood that many physical and mental health problems have an underlying socio-legal cause. Poverty, substandard living conditions, insecure employment and debt all have a direct impacts on health, as well as indirect impacts through denying citizens the capacity to make healthy lifestyle choices. It is against this background that health justice partnerships have been established.

Health justice partnerships embed free legal assistance in primary and acute healthcare settings with lawyers integrated into, or co-located with, the healthcare team providing free legal assistance to low income and vulnerable groups. Taking a holistic approach to healthcare, health justice partnerships aim to address the social determinants of health drawing in legal practitioners who have the training and skills needed to address social and economic issues that manifest as health-harming legal needs. Health justice partnerships build on citizens' trust in healthcare providers to deliver legal services that secure the protections and entitlements needed by low income and vulnerable patients such as improved housing conditions, welfare benefits, and secure and stable employment. Co-location of legal services increases access for those otherwise potentially unable or unwilling to seek legal

assistance and reduces the stigma associated with advice receipt. Health justice partnerships are a vehicle through which social welfare law can become part and parcel of the approach to improving the health of citizens.

Health justice partnerships now exist in the UK, US, Australia and Canada. The development of these partnerships in the UK has taken place at the grassroots level, which has, as a result, been largely uncoordinated and sporadically funded. Grassroots development has also meant that robust mechanisms for evaluating impact have not yet been established. This workshop brought together policy officials, health professionals, commissioners, research funders and health researchers to explore the desirability and feasibility of expanding the role played by health justice partnerships in the UK in tackling ill health. The broad aims of the workshop were to:

- Understand the role of health justice partnerships in social prescribing in the UK, Australia and the US and their contribution to addressing underlying social-legal causes of mental and physical ill health
- Advance an evidence-based policy agenda for the development of health justice partnerships in social prescribing and articulate standards for the design and conduct of evaluation research
- Increase understanding of the measures needed to advance practice in this field, including commissioning frameworks and the potential value of establishing a UK national centre for health justice partnerships.

Welcome and Introduction:

Professor Dame Hazel Genn DBE, QC (Hon), FBA (Director, UCL Centre for Access to Justice)

Opening address: Tackling social determinants of ill-health – the potential for incorporating legal advice into social prescribing

Professor Sir Malcolm Grant CBE (Chairman, NHS England)

Panel 1: An international overview of health justice partnerships

Focus: Philosophy, objectives and practice of health justice partnerships; Health justice partnership models; the range of current services, and the role of National centres in promoting effective practice; how HJPs fit with the social prescription agenda; lessons from international practice and the particular efficacy of HJPs in addressing the costliest conditions.

- Bev Taylor (Social Prescribing Development Manager, NHS England)
- Dr Tessa Boyd-Caine GAICD (CEO, Health Justice Australia (National centre for health justice partnerships))
- Ellen Lawton JD (Co-Principal Investigator, National centre for Medical Legal Partnership, George Washington University)
- Dr David Rosenthal (Assistant Professor of Medicine, Yale School of Medicine)
- Paul Sweeting (Specialist Support Adviser, Macmillan Cancer Support)

Panel 2: Evidence and Policy for health justice partnerships

Focus: What do we currently know? Strengths, weaknesses, gaps in the evidence, potential areas to focus on going forward. What type and quality of evidence is required to support policy development? Methodological and ethical challenges of measuring the health impacts of legal advice. What are the other tools and points of influence such as commissioning frameworks and devolution in light of the NHS Five Year Forward View and General Practice Forward View? What are the practical next steps for engaging these?

- Dr Arvind Madan (Director of Primary Care, NHS England)
- Professor Jonathan Montgomery (Chair, Health Research Authority)
- Professor Gwyn Bevan (Professor of Policy Analysis, London School of Economics & Political Science)
- Adam Clark (Strategy Manager, Norwich City Council)

BIOGRAPHICAL NOTES ON THE PANEL

Professor Dame Hazel Genn DBE, QC (Hon), FBA

Director (UCL Centre for Access to Justice)

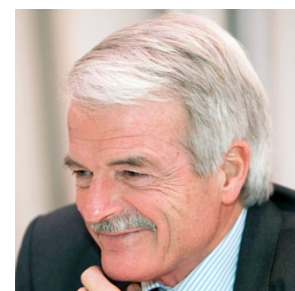
Dame Hazel Genn is Director of the UCL Centre for Access to Justice and was Dean of the UCL Faculty of Laws 2008-2017. Dame Hazel is a leading authority on access to civil and administrative justice. Her prize winning scholarship focuses on the experiences of ordinary people caught up in legal problems and the responsiveness of the justice system to the needs of citizens. She has conducted numerous empirical studies on public access to the justice system and has published widely in her specialist fields. In 2013 she established the UCL Faculty of Laws Centre for Access to Justice, and has recently developed its activities into an innovative health justice partnership with a GP practice in East London to deliver free legal advice to vulnerable patients within the practice.



Professor Sir Malcolm Grant CBE

Chair (NHS England)

Professor Sir Malcolm Grant served for ten years from 2003 as the President and Provost of UCL, and before then as Pro-Vice Chancellor of Cambridge. In 2011 he was appointed founding chairman of NHS England, which is currently his major role. He is a director of Genomics England Ltd.



He also an adviser on higher education to governments and universities, with current appointments in Russia, France, Hong Kong and the USA. He is Chancellor of the University of York, President of the Council for the Assistance of At-Risk Academics, a British Business Ambassador, a trustee of Somerset House and a Bencher of Middle Temple. He was born and educated in New Zealand and has been married for 43 years to Chris, a medical doctor, and they have three children and three grandchildren.

Professor Gwyn Bevan

Professor of Policy Analysis (London School of Economics & Political Science)

Gwyn Bevan is Professor of Policy Analysis in the Department of Management at the London School of Economics and Political Science. He has previously been head of that Department and, from 2000 to 2004, was seconded to the Commission for Health Improvement. Before joining LSE he worked for the National Coal Board, Warwick Business School, HM Treasury, the Medical Schools of St Thomas's Hospital and Bristol University, and an economic consultancy. He is



a member of England's Advisory Committee on Resource Allocation that advises the Secretary of State for Health on the formulas to be used in allocating resources for health care and public health. His current research includes: developing a method to enable stakeholders improve the value of health care in austerity, evaluations of the 'natural experiment' of outcomes of differences in policy that have developed between the different countries of the UK after devolution and identifying and reducing unwarranted variation in health care as a member of the Wennberg International Collaborative.

Dr Tessa Boyd-Caine GAICD

CEO (Health Justice Australia, National Centre for Health Justice Partnerships)

Tessa is the founding CEO of Health Justice Australia, established in 2016 as the national centre for health justice partnerships. She has worked in health, criminal justice and human rights organisations in Australia and internationally. She was previously Deputy CEO of the Australian Council of Social Service. Her report of her Fulbright Professional Scholarship in Nonprofit Leadership was published as *Lead or be left behind: Sustaining trust and confidence in Australia's charities*.



Her PhD on the detention and release of mentally disordered offenders from the London School of Economics was published as a book, *Protecting the Public? Detention and Release of Mentally Disordered Offenders* by Routledge in 2010. She is on the Board of Gondwana Choirs, the leader in Australian choral performance; and plays Ultimate Frisbee.

Adam Clark

Strategy Manager (Norwich City Council)

As Strategy Manager for Norwich City Council, Adam Clark leads on a range of initiatives, including financial inclusion, social prescribing and wider anti-poverty work, against a rapidly changing local government environment.



He left a financial services career in 2004 to join Toynbee Hall's financial inclusion team. Building on advice work with some of the most excluded communities in East London, he developed an array of projects, including research and policy to influence industry and government, co-production of good practice standards for the banking industry, and management of Transact, the national forum for financial inclusion.

After returning to his native Norfolk in 2010 he managed the Norfolk Community Advice Network, helping the local advice sector to collaborate, build effective referral pathways and navigate the reductions in legal aid, before joining the city council in 2014.

Steve Dubbins

Head of Impact (Macmillan Cancer Support)

Steve joined Macmillan in 2008. Prior to this he worked extensively in the advice sector in both operational and strategic roles around service design, delivery, and improvement.

At Macmillan Steve initially worked in a service development team for two and half years before taking on the UK-wide role of Benefits Advice Programme Manager. Steve became Head of SES Programmes two years ago. In this role he has overseen the Local Authorities Partnership Programme, continued to lead the Benefits Advice Programme, and supported a number of projects and initiatives around analysis and performance.



In May 2017, Steve was appointed Head of Impact, responsible for the Portfolio of Interventions at Times of Need; and ensuring the impact of Macmillan's interventions for people living with cancer demonstrate strategic value; their impact is effective for people living with cancer, donors and system partners; and that Macmillan understands interventions (and their inter-relationship) in terms of cost, spend and effort.

Ellen Lawton JD

Co-Principal Investigator (National Centre for Medical Legal Partnership, George Washington University)

Ellen Lawton, JD is a Principal Investigator and Lead Research Scientist at the George Washington University where she leads the University's National Center for Medical-Legal Partnership in the Department of Health Policy and Management.

An expert in poverty law generally, Ms. Lawton is a lead editor of the 2011 textbook, [POVERTY, HEALTH & LAW: READINGS FROM MEDICAL-LEGAL PARTNERSHIP](#). Ms. Lawton is internationally recognized for her leadership in developing the medical-legal partnership approach, and has published an array of articles describing this work in both clinical and legal journals.



Ms. Lawton received the 2011 Innovations in Legal Services Award from the National Legal Aid and Defender Association, is chair of the board of directors at Health Imperatives and is a member of the board of directors of Community Resources for Justice. She also serves on the national advisory committee for the Primary Care Leadership Program.

Dr Arvind Madan

Director of Primary Care (NHS England)

Arvind Madan has been the Director of Primary Care and Deputy National Medical Director for NHS England since 2015, providing clinical leadership for the transformation of primary care. His main area of focus is delivery of the General Practice Forward View, which is a five year strategy to stabilize and transform primary care.



Arvind has been a GP for 20 years and remains a partner in the Hurley Group, a large multi-site general practice and urgent care provider. He retains a regular clinical commitment in general practice, urgent care and out-of-hours care, looking after patients in South and East London.

Arvind has a strong track record in using new technology and redesigned ways of working across care boundaries to improve outcomes. He is a member of the Kings Fund Advisory Board and has helped set up a Community Interest Company known as Healthy Minds, which runs peer mediation for children in 30 London schools.

Professor Jonathan Montgomery

Professor of Health Care Law (University College London)

Jonathan Montgomery is Professor of Health Care Law. He joined UCL in 2013. He was consulting editor for Volume 30(1) *Medical Professions of Halsbury's Laws of England* (5th ed 2011) and has been one of the General Editors of the *Butterworths Family Law Service* since 1996.



In addition to his academic work, he has undertaken a number of significant public service roles. These currently include Chair of the Health Research Authority (which protects and promotes the interests of participants, patients and the public in health research and aims to streamline its regulation). From 2012-2017 he was Chair of the Nuffield Council on Bioethics (the nearest the UK has to a national bioethics committee). He was a member of the panel of advisers to the Morecambe Bay Investigation, which reported in 2016.

Dr David Rosenthal

Assistant Professor of Medicine (Yale School of Medicine)

Dr. Rosenthal is a Primary Care Physician, Assistant Professor in the Section of General Internal Medicine at Yale Medical School, and the Medical Director of the Homeless Patient Aligned Care Team for VA Connecticut, a medical home model of care with specialized access for Veterans experiencing homelessness located in the Errera Community Care Center.



He helped plan and create the VACT HPACT clinic in 2012 including the physical build out, creation of processes, and staff hiring and training; development of daily huddle checklists and quality improvement initiatives, awarded VAVISN 1 Quality Improvement Award for Best Population Health Program, was awarded Best Clinical Innovation by Yale Department of Psychiatry, and was part of the CRRC team awarded large grant from Congress for large expansion to new clinical site in 2018 with expanded educational mission.

In August 2015, USICH officially recognized Connecticut as first state to functionally end chronic homelessness in Veterans, in January 2016, recognized as second state to functionally end homelessness in all Veterans. As of August 2017, VA Connecticut Homeless PACT was recognized as the #1 Top Performing H-PACT in Management of High-Utilizing Patients. For more information about the National Homeless PACT Program here featured on AHRQ website.

Bev Taylor

Social Prescribing Senior Choice Manager (NHS England)

Bev Taylor is Social Prescribing Senior Choice Manager for NHS England, where she is working to embed social prescribing across the NHS. Her back ground is working in the voluntary and community sector, supporting co-production at a local level, developing and delivering accredited leadership programmes across the North of England.



In recent years, Bev co-led Regional Voices, a national voluntary organisation working as a Strategic Partner to the Department of Health, Public Health England and NHS England. She lives in York and is based in Leeds.

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PART ONE: THE UK HEALTH CONTEXT AND AN INTERNATIONAL OVERVIEW OF HEALTH JUSTICE PARTNERSHIPS

1. Tackling the social determinants of ill health: the potential for incorporating legal advice into social prescribing – Professor Sir Malcolm Grant CBE (Chairman, NHS England)

There is a global problem in health. While major advances have been made in tackling communicable disease, health systems are struggling to respond to the rate of growth in non-communicable disease. In the UK, life expectancy has increased but so too has the number of people affected by ill health. In order to address the growing demand for healthcare, there needs to be greater investment in exploring the social determinants of health, such as stress and its causes.¹ It is no longer sustainable for the NHS to focus on fix and repair. There needs to be a major policy shift towards prevention, attuning the NHS budget towards tackling the causes of ill health. We are in the middle of the biggest movement in the world for taking a system of healthcare and turning it into a more integrated model.

The key questions are what interventions will reduce the burden of ill health in our population and how can these be funded. Health justice partnerships and social prescribing are mirroring this trajectory in NHS thinking, investing in early intervention to address the root causes of ill health. There are already a number of examples of successful practice in social prescribing in the UK. GP practices have been founded with social prescribing at their core, providing additional services such as co-located support services for children and adults with learning disabilities, along with social and teaching facilities. Within these models, the provision of medicine through prescription loses its dominance against the provision of other forms of support and advice. Collaborations between the arts and health are also emerging, such as physiotherapists choreographing dance classes to promote mobility.

While the merit of these social prescribing initiatives is clear, there remain major questions to be addressed about how these initiatives should be evaluated and their impact demonstrated.² We need to view the NHS not as a fragmented system but an integrated system that serves the population, measuring outcomes by impact on population rather than fix and repair. Evaluation is complex, however, not least as a result of the multiplicity of variables at play in each locality. But finding a robust framework for evaluation is crucial since any investment will come from the public purse. Careful thought needs to be directed, therefore, towards what health justice partnerships can most achieve as part of this movement, how the environmental impact on health can be most effectively alleviated and how impact can be demonstrated.

¹ On the social determinants of health, see for example the work of Professor Michael Marmot at UCL: <https://iris.ucl.ac.uk/iris/browse/profile?upi=MGMAR64>.

² On the limitations of the evidence base on social prescribing see for example: Centre for Reviews and Dissemination, *Evidence to Inform the Commissioning of Social Prescribing* (University of York, 2015).

2. The value of social prescribing – Bev Taylor (Social Prescribing Development Manager, NHS England)

Social prescribing holds the key to unlocking many of the solutions to the challenges currently facing the NHS by getting under the skin of health inequalities. And by investing in the prevention of ill health, pressure on general practice is in turn relieved by reducing demand. The law has a crucial role to play within social prescribing. Health justice partnerships also have an important role to play within the broader NHS programme of the personalisation of choice, which is shifting power from professionals to individuals. We need to build citizens' capacity to make positive choices about their health.

In thinking about the development of health justice partnerships, and social prescribing more generally, we have to be alert to the hierarchy of need. There are some basic needs – including safety, financial security and housing – which have to be addressed before any other initiatives can work. We also need to encourage people to be physically active, supporting them to manage their long-term conditions and maintain, or secure, employment. And people need to be connected, as well as having access to things that bring them joy.

Social prescribing is not a national initiative; it is a social movement. In developing health justice partnerships, and the social prescription model more broadly, it needs to be easy for GPs to connect with the movement. Social prescribing connector schemes are already emerging at the local level to fulfil this function. We need to grow these schemes and invest in capacity building of community organisations. We also need to map good practice in order to develop a more coherent movement at the national level,³ in addition to devising consistent measures for evaluating impact. Quality assurance is key too: there is a balance to be struck between encouraging creativity in devising innovative responses to ill health and ensuring that clinicians are assured of the standards of the community support services to which they refer patients.

3. International models: the National centre for health justice partnerships, Health Justice Australia – Dr Tessa Boyd-Caine GAICD (CEO, Health Justice Australia)

The health justice partnership movement in Australia gained momentum in 2012, led by community lawyers responding to national evidence on unmet legal need. This national research estimated that 8.5 million people in Australia experience a legal problem in a given year, approximately 3.7 million of whom experience 3 or more problems. It found that nearly one in five people across the community take no action for their legal problems; but those who do are more likely to ask a non-legal advisor, including health professionals, than a lawyer. Health justice partnerships were set up to respond to this unmet legal need and people's unwillingness to seek legal advice, building relationships between health and legal professionals in order to give people access to legal and social support within trusted health settings.

These partnerships now occupy a unique slice of the Australian health system, with over 30 partnerships across the country in hospital and community health settings, metropolitan

³ The UCL Centre for Access to Justice has been commissioned by the Legal Education Foundation to commence this work, mapping existing Health justice partnership services in England and Wales.

centres, regional communities and public, private and not for profit providers. These partnerships have focused on particular populations and areas of vulnerability. One of these areas has been intimate partner/family violence. The partnerships are working to increase access to legal advice for those affected by, or at risk of, intimate partner/family violence, as well as contributing to the system change agenda, providing advice to health professionals to better equip them to support those affected. Pioneering work into elder abuse has also been conducted, as well as attention being directed to the particular challenges facing migrant and asylum-seeking communities. And beyond this, an infrastructure has been built around civil legal needs (the quality of social housing, such as tackling mould, social security, credit and debt issues and some employment advice).

Health Justice Australia was established as a national centre of excellence in health justice partnerships in 2016 as a consequence of a growing demand to increase the role played by health justice partnerships in tackling ill health. It supports the expansion and effectiveness of health justice partnerships through a range of activities. It conducts research and is developing an evaluation framework for health justice partnerships, elevating the work taking place at the local level to the national level to build a national, and comparable, picture of impact. Health Justice Australia also provides support to practitioners working within this collaborative approach. Building these partnerships is not straightforward. We work to overcome the challenges to multi-disciplinary collaboration, addressing differences in professional dynamics, systems and funding streams, as well as the way in which professional expertise is valued and careers are tracked. It also connects the work of health justice partnerships, and the evidence on their effectiveness, with the policy conversation and system change agenda.

Key lessons from the Australian experience of developing health justice partnerships and establishing a National centre

- Moving beyond local initiatives without losing sight of the value of place-based approaches: One of the key challenges in expanding the health justice partnerships model is devising a strategy to move beyond community initiatives. It is not guaranteed that a partnership successful in one locality will enjoy similar success in another as a result of the multiplicity of variables at play. Population needs vary across localities, as does capacity to meet those needs. Overcoming these challenge is an important component of the work of Health Justice Australia.
- Overcoming a lack of legal awareness: There is a problem with translation. It is often not recognised that many of the problems people experience in their everyday lives have legal solutions. It is not obvious to non-lawyers, for example, that mould in rented accommodation causing respiratory problems is a legal problem with a legal solution. To make health justice partnerships work, investment is needed in engaging with professionals, administrators, funders and communities to increase awareness of the positive role the law can play in improving people's lives.
- Building trust in partnerships: For health justice partnerships to make a positive impact in practice, there has to be a willingness across different professions to work collaboratively and build trust. One of the challenges in Australia was a strong reticence to fund lawyers to spend time building relationships with health professionals, the feeling being that all investment of time should be in clients alone.

- Sustaining the movement: Secure funding is required to maintain the movement, which remains a challenge in the Australian context.
- Driving best practice within the service model: Practitioner-led innovation must be valued but the evidence base must also drive practitioners' own best practice to meet the needs of communities.
- Measuring impact: The question of how impact should be measured does not have a simple one-dimensional answer. Multiple methodologies are needed. Initiatives should serve communities but impact evaluation also needs to be connected to the broader policy and system agenda.

4. International models: integrated healthcare systems in the US – Dr David Rosenthal (Assistant Professor of Medicine, Yale School of Medicine & Medical Director, Homeless Patient Aligned Care Team for Veterans Association Connecticut)

In common with the UK, GPs in the US are under increasing strain in responding to the multiple medical and social needs of their patients. Many patients present with tri-morbidity, experiencing severe mental health problems, substance use disorder and chronic medical conditions, as well as facing problems with their housing. Integrated healthcare systems are being developed in the US in response to this problem. Bio-psycho-social co-located teams of medics, legal practitioners and social workers are being formed to help address the multiple causes of ill health. These teams are working to improve the lives of patients with complex needs but also to provide support to over-stretched GPs. Work is also being undertaken in ensuring patients have access to secure housing, recognising that housing often serves as a powerful stabilising force in patients' lives.

One of the challenges for GPs in supporting patients with complex needs is that their appointments are time limited. It is difficult for GPs to deal with the whole spectrum of patients' problems within the allocated appointment time. The significant benefit of co-location is that GPs can feel confident in asking their patients about their non-medical problems because they have somewhere on site to refer their patients for tailored support. And it is essential that GPs feel able to explore patients' multiple needs in this way because without this, the root causes of the problems go unaddressed. Addressing the root causes of patients' problems reduces their need for healthcare and improves their quality of life.

The problem in the US, again in common with the UK, is that while there is significant anecdotal evidence of the effectiveness of these health-justice collaborations, there is a lack of data. Practice clearly demonstrates the positive impact on health and quality of life of tackling legal problems. There is reason to feel confident that these collaborations can be as effective as medication in responding to ill health. The challenge now lies in gathering robust evidence to demonstrate this positive impact.

5. International models: the National centre for Medical Legal Partnership, USA – Ellen Lawton JD (Co-Principal Investigator, National centre for Medical Legal Partnership, George Washington University)

Medical Legal Partnership is the US equivalent to health justice partnerships. In many ways, the development of these partnerships in the US mirrors what is happening in the UK. The partnerships are emerging at the grassroots level, with 300 hospitals and community health centres now practising these partnerships. The partnerships are young, with around 30% less than five years old. The US remains, therefore, at the early stages of the transformation process towards embedding legal services as standard into the care of vulnerable populations.

One of the particular challenges in developing these Medical Legal Partnerships in the US has been that the health sector does not look to the legal sector as a vehicle for the solution of problems. Indeed, there is a mistrust of the legal profession within the healthcare profession, stemming from a perception that the law causes, rather than remedies, problems. The insularity of professions acts as a further barrier in building multi-disciplinary collaboration. But the legal profession has a crucial skill-set to bring to the table in supporting both vulnerable communities and the over-stretched healthcare profession. The problem stems from the legal profession having traditionally been ineffective in making its impact clear. The solution in overcoming this invisibility of impact lies with the legal profession to make clear the rate of need, how it responds to citizens' problems, how much investment of time this requires, how much it costs and what the outcomes are.

In common with the UK, the evidence base on the effectiveness of Medical Legal Partnerships in the US is small but it is growing. The evidence that exists shows the positive impact these partnerships are having in decreasing medical costs, increasing engagement and improving health outcomes. These partnerships are also offering a solution to the over-burdening of healthcare professionals. What is needed is to catalyse leadership to think about how to incorporate these partnerships at the local level, including through professional training and engagement, in order to cement them into medical practice. And these partnerships are already gaining traction. Piloting in healthcare systems across the US led the federal agency that funds community clinics to acknowledge that legal services form an important component of what vulnerable patients need in order to access primary care. Following this acknowledgment, there has been a 30% uptake across the country in health centres adopting these partnerships, which is paving the way for a period of more co-ordinated growth within the movement. Medical practitioners are increasingly recognising that they cannot perform their duty to their patients without access to legal services.

6. Taking a holistic approach to healthcare: supporting people affected by cancer in the UK – Paul Sweeting (Specialist Support Adviser, Macmillan Cancer Support)

One of the biggest concerns for cancer patients is their finances. Four out of five people diagnosed with cancer experience an average £570 monthly drop in income. In order to best support those diagnosed with cancer, Macmillan Cancer Support is investing in early intervention, partnering with 120 organisations, such as the Citizens' Advice Bureau, to provide a holistic care package to patients. This initiative is providing advice to patients on financial support entitlement, ensuring their access to the level of financial support to which they are entitled and supporting them with appeals where necessary. Where possible, advisers are co-located in the medical centre in which patients are receiving their treatment.

In Glasgow, the model has developed into one where patients have the option to opt-out of receiving legal advice, rather than having to opt-in.

The evaluation of this approach is ongoing but some clear benefits are emerging. Early intervention prevents financial and legal problems from spiralling out of control, which in turn is having a positive impact on health and well-being. Patients are also reporting that the non-medical support services are facilitating their ability to engage in treatment, and patients' ability to return to, or remain, in work is similarly being strengthened. Positive feedback is also being received from healthcare professionals. Rather than viewing this initiative as a burden, healthcare practitioners are welcoming it because it enables them to focus on patients' health, safe in the knowledge that there are professional advisers on hand to address patients' non-medical needs.

Reflections – key messages on taking health justice partnerships forward in the UK from the panel discussions and contributions to the debate from attendees

The potential for health justice partnerships to tackle the root causes of ill health and improve citizens' quality of life is clear, as is their value in reducing pressure on the health system by tackling demand. There are a number of examples of successful practice, which can be used to inform and grow the movement. In addition to the work taking place in England and Wales, and internationally in Australia and the US, work is ongoing in Scotland in embedding welfare rights advisors into GP services. There are around 50 GP practices across Scotland which now have embedded welfare rights advisors, with the aim being to increase this number to 150 by the end of next March through collaboration with the Citizens' Advice Bureau. The emphasis in Scotland has been on service redesign, rather than relying on additional funding. Formal evaluation has to date been light, since these developments have taken place organically, but the feedback is that the model in Scotland is working well, improving the health and well-being of citizens as well as providing support to GPs.

Expanding the role played by health justice partnerships in improving health and well-being in the UK will be a complex process, raising a number of operational challenges. The desirability and feasibility of establishing a UK National centre for health justice partnerships should be explored since this Centre could play an integral role in responding to these challenges and advancing the movement.

Challenges	Response/ways to overcome these challenges
<p>Scalability: There are already a number of examples of good practice. The question to be addressed is how we can learn from these examples in building the health justice partnership movement in a way which is sensitive to the multiplicity of different variables at play within different localities.</p>	<p>A National centre could act as the catalyst for growth in health justice partnerships, acting as a hub for sharing best practice, researching the most effective ways to scale existing practice and co-ordinating the movement.</p>

<p>Workability: It needs to be easy for GPs to make referrals to socio-legal support services so that health justice partnerships alleviate, rather than carry any risk of increasing, the pressure on GPs.</p>	<p>Health justice partnerships can reduce the pressure on GPs by equipping them with a range of support services to which they can refer their patients. A National centre could raise awareness of the value of these partnerships and co-ordinate the effort to connect GPs to them.</p>
<p>Raising legal consciousness and demonstrating legal impact: We need to build an evidence base which demonstrates the significant impact the law has on improving the quality of citizens' lives and find ways to disseminate this evidence. The language of law and justice is not common parlance within the health sector. There also remains a lack of awareness of health justice partnerships. Awareness of the role of the law needs to be raised within the medical profession to support health practitioners to become better versed in legal issues, which will in turn increase their confidence in making referrals to socio-legal services.</p>	<p>Optional joint courses are developing in the US that give medical trainees the opportunity to gain practical experience of the role the law can play in responding to ill health. To increase legal consciousness more fully within the medical profession, however, it is necessary to marry theory and practice, putting emphasis on the role of the law both within the formal curriculum and, crucially, also outside the university setting in clinical practice.</p> <p>There are already volunteer social prescribing champions within medical schools across England. If a move is made to make training on the role of the law a more formal part of the curriculum, there are questions to be asked about how this can be achieved and at what stage of medical training the legal training should be embedded.</p> <p>Furthermore, as has been the case in Australia, a National centre can build capability and legal consciousness within the medical profession by forging channels of communication and collaboration across professions.</p>
<p>Overcoming the barriers to effective collaborations: Investment is needed in forging links between the legal and health professions, overcoming professional insularity, building trust and cementing communication channels.</p>	<p>A National centre could fulfil this role, co-ordinating the multi-disciplinary approach and supporting practitioners working collaboratively.</p>
<p>Referral fatigue: There is a risk that people will experience referral fatigue in being signposted to too many different services.</p>	<p>Co-location can mitigate against referral fatigue by making it easy for people to access all the relevant support services in one place.</p>

Quality assurance, managing clinical risk, responsibility and liability:

Innovative approaches to tackling the social causes of ill health should be encouraged but GPs must be assured of the quality of the support services to which they are referring their patients. There are risks to GPs of making referrals to non-accredited services. This is currently acting as a barrier to engagement for some healthcare practitioners. A related point is that it needs to be considered where responsibility and liability will lie following patient disclosures.

These are issues which would have to be addressed in growing the health justice partnership movement, with **multi-disciplinary work and collaboration** required on how best to respond to these challenges.

PART TWO: EVALUATION, EVIDENCE AND POLICY FOR HEALTH JUSTICE PARTNERSHIPS

The existing evidence base on the effectiveness of health justice partnerships is limited, with numerous examples of successful practice but no consistent mechanism for collecting and evaluating evidence on a larger scale. Key questions which need to be addressed in taking health justice partnerships forward include:

- What evidence, and how much evidence, is required to demonstrate the effectiveness of these partnerships and support policy evidence?
- What are the methodological and ethical challenges of measuring the health impacts of legal advice?
- What tools can be developed to scale existing practice?

These questions are important, both in building best practice and in securing sustainable investment to fund the movement.

1. Scaling and evidencing social prescription in GP practice – Dr Arvind Madan (Director of Primary Care, NHS England)

Around 30-40% of conversations people have with their GPs concern issues which do not solely relate to healthcare. The General Practice Forward View is working to provide support for struggling practices, address problems in GP workloads, increase patient access to healthcare at evenings and weekends, grow a wider workforce, invest in technology and estates and drive a national development programme to speed up the transformation of services. The aim is for an extra £2.4 billion to be invested in general practice each year by 2021 in order to begin to reverse the historic underinvestment in general practice. As part of this vision, there is an increasing emphasis on the importance of multi-disciplinary working

and the sharing of best practice. Social prescribing will play a key role, making up one of the 10 High Impact Actions. Work is already underway in integrating social prescribing into medical practice, with one-stop social connector services making an important contribution to this work.

There are a number of challenges, however, in embedding social prescribing into GP practice. These include the complexity of the interface between health and social care systems and clinician confidence having, to date, been mixed, although confidence is growing. The lack of a robust evidence base on the effectiveness of social prescribing in tackling ill health also presents challenges. There is an argument that social prescribing is so intuitively correct it should be pushed forward without waiting for the evidence base to be established. But there is also an argument that the investment of public money mandates rigorous evidence, and there is a need for data in order to understand how to scale these partnerships and ensure quality.

The answer to these challenges of scaling and evidence is likely to lie in taking a mixed approach. There are already numerous examples of good practice, which can inform the blueprint for rolling out these partnerships on a larger scale. In Rotherham, for example, social prescribing is paying for itself, with a 28% reduction in the use of GP consultations and a 24% decrease in A&E use. The scaling of these partnerships must take place alongside investment in obtaining evidence on impact in order to justify the investment from the public purse.

2. Social prescribing to tackle serious welfare issues – Adam Clark (Strategy Manager, Norwich City Council)

Social prescribing forms a significant element of Norwich City Council's response to the city's serious welfare issues, particularly within the financial climate of limited Council resources. One third of children in Norwich are living in poverty, there is an 11-year gap in life expectancy between the poorest and wealthiest males and it is the second worst place in the country for social mobility. To respond to these issues, the Council has piloted new locality initiatives, including social prescribing within GP practices, to address the social determinants of ill health and well-being. These initiatives have primarily been focused on re-aligning existing services, rather than reliance on additional funding, with a particular emphasis on social welfare law. Support is also being provided in other areas such as digital inclusion.

Independent evaluation of these initiatives is ongoing. Comparative analysis is yet to be conducted but existing data based on presentations to GPs, feedback from health services and self-reported health and well-being outcomes (based on the Warwick-Edinburgh Wellbeing Scale) are positive. The interim six months evaluation found that while uptake is much lower than anticipated, there is a high participation rate of 86% once the GP referral has been made. Satisfaction rates are also high. Patients' needs, however, are complex, with 50% having been diagnosed with a mental health condition and 50% experiencing frequent loneliness. The initiative is struggling to meet the full set of patients' complex needs, which reflects in part the gaps in existing services, particularly in relation to mental health provision.

Further work is required on improving communication channels with GPs, using data more effectively to target services, broadening referral networks to include pharmacies, health visitors and children's centres as part of Social Prescribing Plus and providing more support

to existing initiatives. In scaling these social prescribing initiatives across the county, work is also required in overcoming the differences in perceptions across professions on the function of social prescribing and the need it is intended to address. Further evidence would be of significant benefit to the scaling process. This evidence does not have to be of a 'gold standard' but it must be sufficient to enable an understanding of what works and how services can be targeted more effectively, including where investments should be made to reduce demand. Social prescribing is not a silver bullet. It has to be targeted, evidenced and well-executed. If done well, however, it has a valuable role to play in tackling ill health and service demand.

3. Health justice partnerships, research ethics and evidence generation – Professor Jonathan Montgomery (Chair, Health Research Authority)

There are a number of research ethics and evidence generation challenges in increasing the role played by health justice partnerships in tackling ill health.

- (1) Funding streams: The funding of healthcare is complex, particularly in the light of, for example, the interface between health and social care funding. In addition, if the problems causing ill health stem from access to justice, there may be reason to question why the bill for health justice partnerships should fall on the health budget. Any investment from the health budget will have to be carefully and robustly justified.
- (2) Health data and privacy rules: Health data needs to be protected and there are issues surrounding split loyalties for healthcare professionals. While there may be little objection to referring a patient to legal support services, there are far thornier issues when it comes to data sharing in relation to areas such as immigration. Legal professional privilege has a stronger protection than medical confidentiality. These data and privacy challenges are not insurmountable but they demand careful thought. Ground rules will need to be worked through.
- (3) Health research: health justice partnerships raise potential conflicts of interest. GPs have a duty to represent their patients; researchers' primary objective is to obtain high quality data. In order to define what a proportionate ethics framework would look like in this area, there is a need for research and data on the potential pitfalls of these partnerships, as well as their benefits, so that the risks can be evaluated and managed. It would not be sufficient to categorise this work as service development and evaluation, rather than research, since this would represent under-regulation. The challenge is striking the right balance in the level of regulation required.
- (4) Evaluation tools: It is also clear that some form of common currency is needed in researching and evaluating these partnerships but we do not yet know what this should look like. A new research paradigm is required. There are challenges in defining intervention in a way which permits comparison. There are questions as to what comparisons should be being made and what kind of outcomes measures should be employed. And as part of this research and evaluation process, there needs to be engagement with participant groups in defining the outcome measures. These measures should be built from the bottom up, giving a voice to patients and ensuring that the measures are recognised by those served by these partnerships. This may mean some level of sacrifice in establishing comparative measures since a one-size-fits-all measure cannot be imposed from the top down.

- (5) Investment: Within stretched budgets, there is never ‘new’ money. Investment in health justice partnerships will always involve investment being taken away from another area. This again underscores the importance of investment in these partnerships being robustly justified. As part of this justification, we need to understand the cost of lack of access to justice and the financial value of the social capital of legal empowerment. Annualised budgets also raise challenges in relation to return on investment. A new research model is needed in order to respond to these challenges.

4. The challenge of evaluation – Professor Gwyn Bevan (Professor of Policy Analysis, London School of Economics and Political Science)

Our healthcare system is not sustainable unless we tackle non-communicable disease. Diabetes, for example, poses particular risks to the population’s health. The problem is that while awareness-raising initiatives on the importance of diet and exercise may seem appealing, these initiatives do little to decrease diabetes risk. The reason they are ineffective is because the broader structural problems that undermine health, such as poverty and inadequate housing or homelessness, must also be addressed if people are to be able to make positive health choices. Reliance on individual willpower is insufficient since people living in areas of deprivation often do not have the foundations in place to enable them to make positive choices. Research in Newham, for example, suggests that if 10,000 people at risk of developing diabetes are put through an information programme on the importance of diet and exercise, only around 40 of those people will be prevented from developing the condition. People living in poverty have to make hard decisions all the time. We need to ensure people have the mental ‘bandwidth’⁴ to be able to make healthy choices.

Health justice partnerships could, therefore, have a vital role to play in connecting health with legal advice to address the structural problems which undermine health. The complication, however, lies in finding a way to evaluate these partnerships. This task cannot be approached in the same way as a randomised control trial. Significant challenges also lie in overcoming the issue of intrinsic variability, finding a way to adapt a service working well in one area so that it can enjoy similar success in another.

Reflections – key messages on evaluation, evidence and policy for health justice partnerships from the panel discussions and comments from attendees

If it is felt that health justice partnerships are making a sufficiently powerful contribution to improving health and well-being to merit their expansion, it then needs to be determined where the responsibility lies in taking the movement forward, building on the successes at the local level to create a more cohesive movement. As part of this, there are important questions to be answered on where the funding responsibility should fall and how the impact of these partnerships should be evidenced and evaluated.

⁴ Reference to ‘bandwidth’ here comes from: S.Mullainathan & E.Shafir, *Scarcity: Why Having Too Little Means So Much* (Time Books, 2013). See: <https://scholar.harvard.edu/sendhil/scarcity>.

Funding the movement

The funding of health justice partnerships would require a flexible and strategic approach to investment, which sits uncomfortably with the existing NHS procurement model. There are also broader questions to be asked on where the responsibility for funding health justice partnerships should lie. There will be arguments on this which cut both ways. At a basic level, if the problems causing ill health are legal ones, it may be argued that responsibility should fall on the justice budget; but if the objective is to improve health, and the principal benefits accrue to health, there is an argument that responsibility should lie within the health budget. There is a need for communication and collaboration across sectors to explore this issue. It is also important to re-think how we determine and value investment, moving away from a fixation on departmental budgetary savings to a focus on the very real benefits which accrue from collaborative work across disciplines to improve the health and well-being of the population.

Evaluation and evidence

Assessing the strength of the existing evidence base: There is a debate to be had on whether the existing evidence base is sufficient to enable the scaling of these partnerships to be commenced, alongside further research and evaluation, or whether there is a need for more robust data to be procured as the first step before any further action can be taken.

Understanding what data is needed: It is clear that at least some further research is required to understand what works within existing initiatives but what 'what works' means is not uncontentious. There needs to be further conversation on what 'success' and 'impact' mean and what outcome measures would look like. There is a significant body of international evidence available on 'what works', which could inform this conversation. The What Works Centre for Wellbeing, for example, could be a useful resource.⁵

Measuring impact and determining outcome measures: There are different ways of measuring impact. Financial return on investment is one measure but thought needs to be given to how the less tangible impact on health and well-being can be assessed. Measuring impact is complex due to the inherent challenges that exist in determining attribution. The number of variables at play undermines the extent to which the specific impact of socio-legal interventions on health can be isolated.

Those served by these partnerships must also have a voice within the evaluation process. We are seeing a move away from the analysis of individual patient biometric care to a more holistic version of care focused on what matters to patients. But incorporating patient perspectives into evaluation is not straightforward. What matters to patients may not sit easily with the type of data required to influence policy and the system change agenda. Patient-based evaluation may also limit the extent to which a comparative approach can be taken since a one-size-fits-all measure cannot be imposed from the top down.

⁵ <https://www.whatworkswellbeing.org>.

It is also important to consider impact in relation to the broader community, as well as the individuals receiving support. The concept of 'community dividend' could be relevant, exploring the benefit of initiatives to the broader communities they serve. The work of the Revolving Doors Agency in its 'Rebalancing Act' project, which was supported by Public Health England and the Home Office, may prove a useful resource in thinking about funding and outcome measures.⁶

Mixed methodologies: In order to respond to the complex challenge of researching the impact of these partnerships, it is likely a mixed-methods approach will be required. The answer to how to evaluate these partnerships will not lie within one methodology. Different funding streams may also require different forms of evidence, which may mean a portfolio of evidence has to be produced to meet different funders' requirements.

Barriers to conducting social sciences research within healthcare settings and the need for a new research model: There are barriers to social sciences research being conducted in healthcare settings since socio-legal research does not fit neatly into the existing health research paradigm. The clinical trials template is inappropriate for exploring the impact of health justice partnerships. This is a major structural barrier which will need to be dismantled if these partnerships are going to be able to move forward. There are also significant data and privacy challenges to be worked through. The time taken to obtain ethics approval to conduct socio-legal research within health settings also presents challenges. A new research model is required but there are significant disadvantages to postponing the scaling of health justice partnerships until this new model has been nailed. There is a need to work on both concurrently, building the health justice partnership movement whilst also working to establish a new model.

Devising evaluation measures which remain sensitive to place-based differences: Too great a focus on cost and outcome measures can divert attention away from the differences that exist across localities. The challenge lies in devising evaluation measures which provide comparable data but without losing sight of place-based differences. Any national and regional standards devised must be capable of being flexed in response to the needs of different localities.

Demonstrating the positive impact of legal advice: The legal profession has not done well in assessing its own impact. While there are limitations to randomised control trials, there may still be value in establishing if any appetite exists for using quasi-experimental models/measures to garner data on the impact of legal advice. The cost of lack of access to justice, and the financial value of the social capital of legal empowerment, should be explored and quantified.

Proxy measures: There may be value in considering whether it is possible to identify a readily available measure which can be employed as a proxy for the range of benefits that follow.

The value of formative evaluation: It may be beneficial to integrate formative evaluation into the evaluative framework to enable lessons to be learnt, and improvements made, as the movement progresses.

⁶ <https://www.gov.uk/government/news/new-advice-on-reducing-health-inequalities-in-the-criminal-justice-system>.

Taking care to avoid over-promising on impact: Care is needed to avoid the impression that health justice partnerships are a panacea for all social welfare problems. People's lives remain hard, even once housing or debt issues are resolved, particularly in the light of low levels of welfare benefit provision. Providing support to a person at one stage in their life also acts as no guarantee for the lifetime resolution of problems. This is not to detract from the positive impact these partnerships make but rather to encourage careful thought about how impact is portrayed and evidence is disseminated.

Feedback forms were presented to participants at the event, in order to gather information and ideas with which to take the discussions forward. Answers to the questions are presented below verbatim:

1. What do you see as the key advantages of health-justice partnerships?

- Holistic needs assessment; appropriate skills set to meet need; reduced anxiety; priority need defined by client / patient.
- Critical to tackle determinants of health for people who need it the most.
- Connecting support services that address issues people face holistically. Thinking about how to embed within healthcare.
- Meeting the holistic needs of the most vulnerable citizens. Reducing demand on general practice.
- Effective way to address wider determinants of health through partnership work in primary care.
- Improved health outcomes!
- Puts 'wellbeing' in an overall sense ahead of reactive care.
- Improved health outcomes. Financial benefit to healthcare providers and individuals.
- To address non-medical social problems and relieve pressures on the system and improve health and wellbeing for individuals and communities. Multi-disciplinary cross-profession collaboration.
- They bring people greater advantages than simply improving health.
- Address the social determinants of health (individually).

2. Do you have any reservations about health-justice partnerships?

- No.
- Not particularly.
- Not about the principle – absolutely sound. Need to avoid this looking like yet another initiative – but explain how it is part of an integrated approach.
- No I can see the benefit – we just need to be transparent and honest about the likes of ethics.
- Funding means and staff skill mix.
- Support and supervision to the legal practitioners in a health setting.
- The definition – how understandable is it?
- My overall reservations around social prescribing remain the lack of evidence around direct financial benefits to local authorities.
- Cultural shift required in both professions. Would law firms be receptive to being in partnership with health? Might be best driven by university legal / law departments.
- The absence of funding to make them scalable.
- Uncertainties about their heterogeneity and effectiveness.

3. What do you think would be the benefits of developing health-justice partnerships more widely?

- More equitable access to necessary care.
- Would like to have partners who bring justice expertise to help us get 'top cover' to deal with some of the barriers we face in this field.
- Thinking about how people whose health is negatively impacted by social / environmental factors can access legal advice / support.
- Funding – annual returns on investment (for health).
- Reducing demand on social and health services – mapping need to resource more effectively.
- Early interventions lead to less use of services later.
- Improving primary care services.
- Involvement of colleagues beyond health (GPs) – police, ambulance, fire service, housing, social workers – who have contact with people in their homes.
- They would benefit people in important ways and ultimately decrease public spending.
- Benefits for individuals, health practitioners and 'social capital'.

4. What do you think would be the barriers to developing health-justice partnerships more widely?

- Awareness of health / social professionals to make referral. Opt-out may be better. Funding and sustainability.
- Dedicated time and resource to focus on facilitating this.
- Capacity to coordinate efforts and raising it up people's priority list.
- Awareness, education, case examples help.
- Structural barriers about funding streams.
- Culture.
- Who is paying for it? Will primary care providers / GPs invest in it?
- Overall, I think there is a lack of understanding among key decision makers about HJPs, as well as social prescription in general. There needs to be more direct engagement with political leadership at council level – they make the decisions!
- Funding, leadership.
- The absence of funding.
- Funding, evidence of effectiveness. Lack of cross-governmental working.

5. What in your view should be the next steps for health-justice partnerships in the UK?

- Collaboration, evaluated research using appropriate methods including client-defined impact. Pilots.

- Would suggest that could be amplified by connecting into national social prescribing steering group. Could consider developing the movement in the same way as the social prescribing movement.
- Linking it into existing networks, like social prescribing, rather than creating new ones.
- Work with London's prevention partnership board.
- Encourage local examples of good finance and highlight and publicise to encourage others.
- To more widely disseminate the idea or concept of health justice partnerships.
- Consider if there is a model that would evolve into a 'full-blown' partnership formally.
- Plan out some shared work with Local Government Association and London Councils.
- Get a national champion, e.g. Sally Davies, John Bell.
- Leadership from legal profession. Review of models. Evidence of effectiveness.

6. What is your most important take away message from today's workshop?

- Collaboration – lots of great ideas and experience which would generate excellent pilot work.
- Will think about the importance of measuring the value of collaboration.
- Contacts, links, understanding.
- The impact of health and justice partnership work each on the other.
- We need to measure and report!
- Primary care needs to change!
- This is well worth exploring further!
- How important this initiative is.

7. Is there any particular action that you will take as a result of today's workshop?

- I will be in touch with a number of participants and further discuss perspectives and opportunities for future collaboration.
- Follow up a conversation with Tessa about 'collaboration' as a process in this work that needs to be better understood. Suggest to committee to invite Hazel to join national social prescribing steering group.
- Follow up contacts.
- Invite legal partnerships to the table.
- Share my data more widely.
- Not sure. Maybe ask for a pilot approach to getting legal advisers / debt advice into our network of primary care centres.
- I will have a discussion or two with my superiors regarding next steps.
- Discuss it with government officials.
- To think about this as an evaluable intervention within a new cross UCL research bid (Good to have Hazel / Laws involved).

8. If there is anything you would like to contribute to the discussions that you did not have the opportunity to, please write this below:

- There is an inter-professional (health, legal, social) education programme as a key output to any LEF funded research around end of life care. I'm interested in discussing with other participants.
- Offer to follow up and discuss how we make this real in London.
- Learn from other sectors and how they measure.

APPENDIX 1: BACKGROUND PAPER

WHAT ARE HEALTH JUSTICE PARTNERSHIPS?

Health Justice Partnerships (HJPs) are collaborations between legal and health professionals:

HJPs support collaborations between lawyers and health workers to better identify and respond to the legal needs that undermine people's health.⁷ (p.1)

The concept of supporting individuals in need of legal assistance through collaborations between health and socio-legal advice services has been developed in the US and Australia. The term 'Health Justice Partnership' is not commonly used in the UK (e.g., 'co-located welfare advice services') but initiatives providing socio-legal advice services within health settings have been in place, sporadically, since the early 1990's. In the UK, socio-legal advice services in health settings have mainly been provided by voluntary and community sector organisations such as Citizens Advice, and condition-specific charities such as Macmillan Cancer Support.

In the US, such collaborations are termed 'Medical-Legal Partnerships' (MLPs) and are more similar to the Australian model, but the core nature of and rationale behind such partnerships is similar⁸:

MLPs represent a multidisciplinary approach to address the social and legal problems that are intertwined with a patient's health through a mechanism that is accessible to the patient in a clinical setting. (p.1)

This synthesis focuses mainly (but not exclusively) on evidence from the UK and the terms 'Health Justice Partnership' and 'co-located welfare advice' are sometimes used interchangeably.

WHY DEVELOP THESE PARTNERSHIPS?

Social welfare problems are known to have a significant impact on physical health and mental wellbeing; this can occur both as direct consequences of the problem (such as poor living and working conditions), or through the many detrimental impacts of stress and poverty⁹. Social justice research has shown a positive correlation between increasing

⁷ Health Justice Australia. *Our theory of change: how we achieve systemic improvements in health and justice through partnership*. Health Justice Australia, 2017.

⁸ Beeson TI, McAllister BD, Regenstein M. *Making the case for medical-legal partnerships: A review of the evidence*. Washington, DC: The National Center for Medical-Legal Partnership, George Washington University, 2013.

⁹ World Health Organisation. *Social Determinants of Health - The Solid Facts*. 2003

numbers of socio-legal problems and poor health, particularly mental wellbeing^{10 11}. People vulnerable to social exclusion and those in ill health are also more likely to develop such problems¹². Social welfare problems tend to cluster, therefore individuals can develop multiple problems in their lives; dealing with these problems can have a damaging effect on health¹³. Therefore, early access to advice is essential in preventing a downward trajectory that can have a strong effect on health over time.

Collaborative models between legal professionals and welfare advice charities providing independent advice and advocacy for people are one approach to addressing health inequalities. For example, individuals living in poor mental and physical health, those who are socially excluded and/or are living on a low income are at greater risk of social welfare problems such as difficulties navigating access to the welfare benefit system; long-term indebtedness;^{14 15 16} and, adverse housing circumstances.¹⁷ They are also more likely to have difficulty accessing support and advice for such issues.¹⁸ The rationale for linking advice and health services was recognised by Jarman¹⁹ in 1985:

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

This insight has since been evidenced through research in both health and legal domains, as summarised in a recent review by the Low Commission:²⁰

There is mounting evidence of both the adverse health impact of social welfare legal problems and the beneficial health impact of receiving good advice. Many people presenting to health services are key target client groups for advice services and yet given the nature of their problems, it is clear from the evidence base that they have not accessed any advice services. There are many advice and legal support services across the country who have

¹⁰ Pleasence P, Balmer N, Buck A, O'Grady A, Genn H. Civil law problems and morbidity. *Journal of Epidemiology and Community Health*. 2004;58:552-7

¹¹ Balmer N, Pleasence P, Buck A. Psychiatric morbidity and people's experience of and response to social problems involving rights. *Health and Social Care in the Community*. 2010;18(6):588-97

¹² Balmer N. English and Welsh Civil and Social Justice Panel Survey: Wave 2. Legal Services Commission; 2013

¹³ Genn H. *Paths to Justice: What people do and think about going to law*. Oxford: Hart Publishing; 1999

¹⁴ Fitch C, Hamilton S, Bassett P, Davey R (2011) The relationship between personal debt and mental health: a systematic review. *Mental Health Review Journal*, 16: 153-66.

¹⁵ Balmer NJ, Pleasence P, Buck A (2010) Psychiatric morbidity and people's experience of and response to social problems involving rights. *Health and Social Care in the Community*, 18: 588-97.

¹⁶ Balmer N, Pleasence P, Buck A, Walker H (2005) Worried sick: the experience of debt problems and their relationship with health, illness and disability. *Social Policy and Society* 5(1), 39–51.

¹⁷ Tunstall R, Bevan M, Bradshaw J, Croucher K, Duffy S, Hunter C, et al. *The links between housing and poverty: an evidence review*. Joseph Rowntree Foundation, 2013.

¹⁸ Finn D, Goodship J. *Take-up of benefits and poverty: an evidence and policy review*. Centre for Economic & Social Inclusion, 2014.

¹⁹ Jarman B (1985) Giving advice about welfare benefits in general practice. *BMJ*, 290: 522-524.

²⁰ Parkinson A, Buttrick J. *The Role of Advice Services in Health Outcomes Evidence Review and Mapping Study*. Consilium Research and Consultancy, 2015.

recognised this issue and who are currently working in partnership with health services and/or operating in health settings, such as in GP surgeries and hospitals. (p.13)

Findings from social justice research carried out in the UK,^{21 22} and the US^{8 23}, illustrate that there is a positive correlation between poor health (particularly mental health) and increasing numbers of socio-legal problems. Evidence suggests that co-location of advice services increases access for those otherwise potentially unable or unwilling to seek advice (such as older and disabled people) and reduces stigma associated with advice receipt.^{24 25 26 27}

Finally, another less well recognised role of socio-legal advice in health settings is in supporting health professionals themselves. For example, in relation to general practice:²⁸

General practitioners (GPs) are involved with a variety of social issues independent of direct clinical work.²⁹ Patient demand for such “non-health” work has been identified as a contributing factor to increased general practice pressures.^{30 31 32} Austerity and welfare reform has led to cuts to a range of support services in the UK. Such changes are likely to exert additional strain on GPs, particularly those in deprived areas, and to exacerbate health inequalities.^{33 34} Two recent UK GP surveys found that the majority of GPs (particularly inner city GPs) reported that patient health, GP workload and practice staff time demands have been adversely affected by greater patient financial hardship and changes to welfare

²¹ Balmer NJ, Pleasence P, Buck A (2010) Psychiatric morbidity and people's experience of and response to social problems involving rights. *Health and Social Care in the Community*, 18: 588-97.

²² Balmer N, Pleasence P, Buck A, Walker H (2005) Worried sick: the experience of debt problems and their relationship with health, illness and disability. *Social Policy and Society*, 5(1), 39–51.

²³ Tobin-Tyler, E. Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health (2012) *Journal of Health & Biomedical Law*, 8: 211-247.

²⁴ Burrows J, Baxter S, Baird W, Hirst J, Goyder E (2011) Citizens advice in primary care: A qualitative study of the views and experiences of service users and staff. *Public Health*, 125: 704-10.

²⁵ Haigh T. *Tower Hamlets Health & Advice Links Project*. Social Action for Health, 2012.

²⁶ Greasley P, Small N. *Welfare advice in primary care*. University of Leeds, 2002.

²⁷ Kite A. *Citizens Advice in GP Surgeries: an investigation*. PhD Thesis, 2014.

²⁸ Woodhead C, Collins H, Lomas R, Raine R (2017) Co-located welfare advice in general practice: a realist qualitative study. *Health and Social Care in the Community*, 25, 1794–1804.

²⁹ Popay J, Kowarzik U, Mallinson S, Mackian S, Barker J. (2007) Social problems, primary care and pathways to help and support: Addressing health inequalities at the individual level. Part I: The GP perspective. *Journal of Epidemiology and Community Health*, 61(11), 966–971.

³⁰ Baird B, Charles A, Honeyman M, Maguire D, Das P. (2016). *Understanding pressures in general practice*. London: The King's Fund.

³¹ Iacobucci G. (2014a) GPs' workload climbs as government austerity agenda bites. *British Medical Journal*, g4300. Retrieved from: <http://www.bmj.com/content/349/bmj.g4300>

³² Iacobucci G. (2014b) GPs increasingly have to tackle patients' debt and housing problems. *British Medical Journal*, g4301. Retrieved from: <http://www.bmj.com/content/349/bmj.g4301>

³³ Bloomer E, Allen J, Donkin A, Findlay G, Gamsu M. (2012) *The impact of the economic downturn and policy changes on health inequalities in London*. London: UCL Institute of Health Equity.

³⁴ Deep End Report: GPs at the Deep End. *Improving partnership working between general practices and financial advice services in Glasgow: One year on*. Deep End Report 27, University of Glasgow, 2015.

provision.^{31 32} These were reported to contribute to decreased time available for other patients' health needs, as well as increased job stress and practice costs.³⁵ (p.1794)

HOW DO THEY WORK AND WHAT SOCIO-LEGAL OUTCOMES DO THEY ACHIEVE?

ORGANISATION

HJPs often involve the co-location of advice services in health settings. The mapping exercise carried out as part of the Low Commission report into advice and health²⁰ determined that the majority of services were co-located in or hosted by primary care health settings in general practice. Other services operate in secondary and tertiary health care systems such as within hospitals, specialist services for cancer and other long term conditions, and mental health services.

In general practice, individuals are often referred to the service by their GP or other health professionals or they may also self-refer. Services usually operate on a booked-appointment system, though some also offer walk-in in support. In other settings, advisers may form part of multi-disciplinary teams.

POPULATION

Services are targeted at a range of groups. In the UK, some areas (Liverpool, Derbyshire) have put co-located welfare advice services across the majority of their General Practices population-wide. In other areas, such as several London boroughs, services are targeted within more deprived localities. Other services aim to support more specific sub-groups, such as those with specific conditions in specialist services (e.g., cancer and mental health), groups defined by age (i.e., young people or older people), or demographic (e.g. women or children and families).²⁰ Such a diversity has also been identified in the US³⁶ and Australia.³⁷

FUNDING

The Low Commission's²⁰ mapping exercise of advice and health services revealed a range of funding sources and models in the UK:

Whilst difficult to ascertain funding sources in all cases without detailed consultation, most projects are either commissioned (e.g. through CCGs, public health or adult social care) or supported through one or more grants, with several examples developed as part of the work of the ASTF [Big Lottery - Advice Services Transition Funding] partnerships. It is apparent

³⁵ Citizens Advice. *A Very General Practice: How much time do GPs spend on issues other than health?* Citizens Advice, 2015.

³⁶ National Center for Medical Legal Partnership. <http://medical-legalpartnership.org/faq/>

³⁷ Health Justice Australia. <https://www.healthjustice.org.au/hjp/health-justice-partnerships-in-australia/>

that many of the examples have been delivered in some form for several years and have to some extent been reshaped to fit within the parameters and criteria of changing funding arrangements. A number of the projects have progressed from receiving funding from short-term grants to now being funded as part of mainstream provision. (p.58)

In the US, MLPs are funded through a mixture of: health community operational revenue; federal, state, local health and public health funding; academic research grants; managed care demonstration projects; federal and state legal aid appropriations and contracts; public interest legal fellowships; health and health care foundations; community and corporate foundations; and, social impact bonds.³⁶

OUTPUT

People seen by health service-linked legal or other welfare advisers are supported with range of socio-legal needs, including simple as well as more complex legal and other welfare issues. These include, for example:

- Supporting people to navigate the social-welfare system, including access to health-related benefits and appealing benefit decisions.
- Supporting people to manage their debts and advocating on their behalf with creditors.
- Advocating on people's behalf for suitable housing. This includes engaging with landlords to make housing repairs that improve health, such as treating mould or adding handrails; and, supporting people to make a case for access to social housing or for changing accommodation due to changes in health circumstances.
- Providing advice on legal and practical needs arising from illness such as wills, powers of attorney, and access to transport.

FINANCIAL OUTCOMES

In the UK, the most common issues dealt with by advice services located in health settings are access to health-related welfare benefits entitlements, appeals to benefit decisions and debt. Evaluations of services in the UK consistently report considerable financial gains to advice recipients, and that gains to advice clients substantially outweigh costs of providing services:

- The first systematic review of welfare rights provision in healthcare settings in 2006³⁸ reported a mean estimated gain of £1,026 per person, though due to a lack of available full financial data a precise estimate of gains was not possible.

³⁸ Adams J, White M, Moffatt S, Howel D, Mackintosh J (2006) A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings. *BMC Public Health*; 6: 81.

- A 2008 survey of the extent and costs of GP-linked welfare advice provision across England³⁹ indicated that these cost approximately £5.8 million annually, compared to an estimated £43.7 million accrued in additional benefits in a single year (£1,549 per client). This was considered a likely underestimate due to lack of available follow-up financial information.
- Derbyshire, Wales and Liverpool have the most developed, sustained and wide-spread systems of socio-legal advice provision (by Citizens Advice) in GP practices in England. In Derbyshire, the number of clients seen annually rose from 18,589 in 2009 to 30,528 in 2012/2013. Financial gains to clients rose from £4,545,623 to £9,024,744 per year while the amount of debt rescheduled or managed reduced from over £7.5 million to just over £6 million during the same period. Between 2009 and 2013, cost per client of providing the service dropped from £187 to £123 and estimated annual cost to commissioners remained fairly constant, dropping from £790,000 in 2009/10 to £767,377 in 2012/13. In Derbyshire, the average financial gain per client was £3,341.⁴⁰
- In the first six months of the Liverpool Advice on Prescription Project, £1.8 million of debt was managed and nearly £3.5 million income gained for clients from (£1,144 per client) 3057 enquiries, though these gains were expected to rise over time as the project become more widely utilised.
- In 2011/12, the Tower Hamlets Health & Advice Links project, which covers 24 General Practices, generated over £4.5 million in additional income from 1178 clients (over £3,800 per client), of which over half was generated through health-related welfare benefits.²⁵
- An evaluation of GP-located welfare advice services in Haringey and Camden over 2015/16 reported average gains of £2689 per client.⁴¹

OTHER SERVICE OUTCOMES

While financial gain from a mixture of increased income (e.g., from health-related benefits), rescheduled debts, one off payments, or written off debts is the most commonly recorded outcome from health-linked socio-legal advice services, other outcomes are also achieved for clients. The nature of socio-legal outcomes vary across services supporting different population groups and in different local areas (e.g., where access to housing is a pressing

³⁹ Bateman N. *Just what the doctor ordered: welfare benefits and advice and healthcare*. Age Concern England, 2008.

⁴⁰ Derbyshire Citizens Advice Bureaux. *Citizens Advice Bureaux in General Practice: Report 2011/12*. Derbyshire Citizens Advice Bureaux, 2012.

⁴¹ Woodhead C, Khondoker M, Lomas R, Raine R (2017) The impact of welfare advice in general practice: a prospective controlled quasi-experimental study. *British Journal of Psychiatry* [In press].

local issue). Research of both general and health-linked advice services report a range of direct and indirect outcomes for clients, including: ^{8 41 42 43 44}

- Improved housing conditions
- Improved relationships
- Increased/improved sleep
- Gained employment or volunteering opportunities
- Safety from domestic violence
- Increased confidence
- Reduced stress
- Improved mental health and well-being (see p.46 for evidence of health impact).

BARRIERS TO PARTNERSHIP WORKING

While partnerships between health and legal or welfare services aim to support patients and can help ease burden on services links to demand for non-clinical need, anecdotal and research evidence suggests there can be challenges in securing buy-in and participation of health professionals.²⁰ Even when services are directly commissioned by Clinical Commissioning Groups (CCGs), or public health, it can take several years for services to 'bed in' and clinicians to start meaningfully engaging with and referring to legal or advice partners. Several factors influence this:

- Lack of proactive promotion of services by funders, central government, health organisations and professional membership bodies^{20 28}
- Lack of promotion of the service by practice managers. Research suggests this is likely to vary across practices, with more supporting practice managers supporting dissemination to clinicians and other allied health professionals, reception staff and patients. Promotion activities include advertising (websites, GP rolling screens), providing opportunities for feedback and engagement with advisers at team meetings and regular staff reminders.²⁸
- Difficulties for clinicians in retaining the broad range of available services in-house and locally to support patients outside of direct medical care. This is influenced by a commissioning environment with frequent, short pilots of services, transient funding and insufficient time permitted to demonstrate significant effects to health or service use costs. Awareness is also influenced by the size of the practice, numbers and turnover rate of staff.²⁸

⁴² Farr M, Cressey P, Milner S, Abercrombie N, Jaynes B. *Proving the value of advice: A study of the impact of Citizens' Advice Bureau services*. University of Bath, 2014.

⁴³ Dalkin S, Lhussier M, Forster N, Hodgson P, Carr S. Exploring the impact of Citizens Advice activities on health. <http://sphr.nihr.ac.uk/research/public-health-practice-evaluation/>

⁴⁴ Allmark P, Baxter S, Goyder E, Guillaume L, Crofton-Martin G (2013) Assessing the health benefits of advice services: using research evidence and logic model methods to explore complex pathways. *Health and Social Care in the Community*, 21: 59-68.

- Lack of belief, among some clinicians, that they have a role to play in supporting patients with such legal needs.²⁰ Insufficient training in how to address welfare related issues within a consultation may also affect their confidence in raising such issues. Resources such as those produced by the Royal College of Psychiatrists to support practitioners to address debt problems among patients are an example of ways to overcome this.⁴⁵
- Lack of understanding about exactly what such services can do to help patients (and clinicians or other practice staff), and lack of feedback about the outcomes of such advice.²⁸

Summary

HJPs and similar models are collaborations between legal professionals, or social welfare advice services and health services. Legal assistance or independent advice may be provided by lawyers and/or by trained professionals in the voluntary and community sector. These alliances rely on a broad range of (often transient) funding sources. Such collaborations have been in place for some time in the UK but due to unstable funding, coverage has often been patchy and short term. The rationale underlying HJPs is threefold:

1. There is a bi-directional link between health and adverse social circumstances. Those in poor health are more likely to experience worsening social situations (e.g., linked to employment, income and social relationships). In turn, such adversity precedes the onset of, and can both maintain and exacerbate existing poor health.
2. Those who would benefit from socio-legal advice often do not or cannot access such advice. Prior research suggests that socio-legal services located in GP practices are more accessible physically and psychologically for people experiencing health problems.
3. For various reasons patients often turn to trusted health professionals for support with socio-legal needs, who are neither equipped nor able to provide such support due to lack of expertise and time constraints.

Direct outcomes for clients are often financial, though significant proportions of advice recipients experience other improvements such as in housing and employment opportunities. As such models directly influence the social determinants of health. In the face of increased pressures on health professionals due to greater financial hardship and changes to welfare entitlements, co-located socio-legal services also have the potential to support health services.

There may be barriers to successful partnership working that take time to overcome, proactive engagement by advisers, funders and practice staff is needed.

⁴⁵ Royal College of Psychiatrists. Debt and mental health:
http://www.rcpsych.ac.uk/pdf/factsheet_debtandmentalhealth.pdf

CAN HEALTH JUSTICE PARTNERSHIPS IMPROVE HEALTH AND REDUCE SERVICE USE?

This section focuses on the theoretical and empirical evidence base linking the work undertaken by HJPs and other health service-related socio-legal advice services, to improved health outcomes for clients. Given that the most commonly reported direct outputs from health-linked socio-legal services are financial, theoretical pathways linking low income and indebtedness to health outcomes are first considered alongside wider research evidence for a health impact of increases in income and reduced debt.

WHAT ARE THE UNDERLYING THEORIES?

INCOME, INDEBTEDNESS, FINANCIAL STRAIN AND HEALTH

- Theoretical approaches linking income and health in a causal association reflect wider theories concerning the relationship between socioeconomic status and health; those most relevant to the current intervention include material, psychosocial, behavioural and personality characteristics

Box 1: Summary of theorised pathways linking income and health

- These theoretical pathways are not mutually exclusive, are likely to interact, and to operate in different ways for different individuals in varying temporal, social and geographical contexts. For instance, material pathways linking income to health might depend on other resources available to individuals - their knowledge, skills, prestige, social contacts and personality traits.^{46 47} These resources evolve from multiple contextual factors throughout childhood and adulthood and can be intergenerational.
- The relationship between health and financial/social circumstances can be bidirectional - poor health may itself limit income by restricting people's ability to access employment and, in particular, stable secure employment. This may be related to biases in the labour market – for instance, unfair recruitment disadvantaging obese applicants⁴⁸ - but also to by-products of illness such as greater sick leave, greater risk of job loss, and physical limitations in ability^{49 50}

⁴⁶ Link BG, Phelan J (1995) Social conditions as fundamental causes of disease. *Journal of Health and Social Behaviour*, 1:80-94.

⁴⁷ Mackenbach JP (2012) The persistence of health inequalities in modern welfare states: the explanation of a paradox. *Social Science & Medicine*, 31; 75(4):761-769.

⁴⁸ Han E, Norton EC, Stearns SC (2009) Weight and wages: fat versus lean paychecks. *Health Economics*, 1;18(5):535-48.

⁴⁹ Stronks K, van de Mheen H, van den Bos J, Mackenbach JP (1997a) 'The interrelationship between income, health and employment status'. *International Journal of Epidemiology*, 26(3):592-600

⁵⁰ Martikainen P, Adda J, Ferrie JE, Davey Smith G, Marmot M (2003) 'Effects of income and wealth on GHQ depression and poor self rated health in white collar women and men in the Whitehall II study'. *Journal of Epidemiology and Community Health*, 57(9): 718-23

- Several studies indicate that the relationship between income and other dimensions of socio-economic status such as unemployment and health – particularly mental health – may be accounted for by debt and/or financial strain. A UK prospective cohort study⁵¹ found that while poverty and unemployment were associated with the persistence of episodes of common mental disorder, they were not associated with its onset – rather, perceived financial strain was associated with both onset and maintenance of the disorder. Similarly, Jenkins et al. (2008)⁵² found that the income-mental health relationship was mediated by debt.
- A review of longitudinal studies assessing the role of debt on mental health found evidence that indebtedness and increases in debt levels were prospectively associated with poor mental health.⁵³ For example, people with debt problems are more likely to be identified with depression in future and the more debts people have, the greater their likelihood of later mental health problems.^{52 54}
- A longitudinal association has been reported⁵⁵ between financial capability (including perceived financial strain, problems borrowing or saving, problems paying bills, and having to cut spending to pay bills financial capability) and symptoms of common mental disorder, life satisfaction and health problems associated with anxiety and depression; and, that changes in financial capability are associated with changes in mental health. Importantly, they also found that the impact of financial incapability exacerbates the adverse impact of other circumstances such as unemployment or relationship breakdown, while the impact of financial incapability on mental health is reduced among those in those in good general health.
- Financial strain is also a risk factor for physical health and mortality, though the underlying mechanisms are unclear. In a study of Swedish women, even after adjusting for a wide range of socio-economic indicators, psychosocial factors, health behaviours and physical measures, the experience of financial strain over the previous year was significantly associated with an increased risk of recurrent cardiac events.⁵⁶
- Other work suggests that the long term experience of financial strain over a lifetime is linked with self-reported chronic conditions, physical symptoms and perceived general health, even after controlling for current financial circumstances and that persistent financial strain is more strongly associated with ill health in later life than episodic

⁵¹ Weich S, Lewis G (1998) Poverty, unemployment, and common mental disorders: population based cohort study. *BMJ*, 317: 115-119.

⁵² Jenkins R, Bhugra D, Bebbington P, Brugha T, Farrell M, Coid J, Fryers T, Weich S, Singleton N, Meltzer H (2008) Debt, income and mental disorder in the general population. *Psychological Medicine*, 38(10):1485-93.

⁵³ Fitch C, Hamilton S, Bassett P, Davey R (2011) The relationship between personal debt and mental health: a systematic review. *Mental Health Review Journal*, 16: 153-66.

⁵⁴ Skapinakis P, Weich S, Araya R (2006) Socio-economic position and common mental disorders: Longitudinal study in the general population in the UK. *British Journal of Psychiatry*, 189: 109-117.

⁵⁵ Taylor MP, Jenkins P, Stephen P, Sacker A (2011) Financial capability and psychological health. *Journal of Economic Psychology*, 32: 710-23.

⁵⁶ Georgiades A, Janszky I, Blom M, László KD, Ahnve S (2009) Financial strain predicts recurrent events among women with coronary artery disease. *International Journal of Cardiology*, 26;135(2):175-83.

occurrences.⁵⁷ This suggests that reducing financial strain may have less impact on physical health among those for whom this has been a life-long situation.

HEALTH IMPACT OF INCREASED INCOME

- A systematic review⁵⁸ of research assessing causal associations between increases in adulthood income and adult health found strong evidence that additional financial resources reduce symptoms of common mental health problems (such as anxiety and depression) and increase subjective feelings of happiness. This effect was greater among low-income households. In contrast, there were more mixed conclusions for a causal association between additional income, health behaviours and physical health.
- When the increase was related to social reforms, there was some evidence of a reduction in harmful health behaviours such as smoking.
- In relation to physical health measures – obesity, mortality and morbidity – there were also mixed findings, with many studies finding a positive impact on mental health but no impact on physical conditions. The reasons for these mixed findings are likely to at least partly reflect the methodological and theoretical limitations of the studies included in the reviews; the findings did not reflect the impact of long-term inter-household income differences and, given the above discussion of pathways linking income and health, are likely to reflect the narrow focus on income.
- While marginal increases in adult income may positively influence mental health because of immediate alleviation of some of the psychosocial stressors linked with psychological ill health, differences in physical health are likely arise from a multitude of interacting circumstances that are related to, but not sufficiently accounted for by income.

Box 1: Summary of theorised pathways linking income and health

Adapted from Benzeval et al., (2014)⁵⁹ and Mackenbach, 2012⁴⁷

Material

Higher income increases people's potential to afford to live in healthy housing and healthy environments, to work in health promoting job conditions, to buy healthy food and better healthcare, and to participate in health promoting social activities.

⁵⁷ Kahn JR, Pearlin LI (2006) Financial Strain over the Life Course and Health among Older Adults. *Journal of Health and Social Behavior*, 47(1):17-31.

⁵⁸ Cooper K, Stewart K. *Does money in adulthood affect adult outcomes?* Joseph Rowntree Foundation, 2015.

⁵⁹ Benzeval M, Bond L, Campbell M, Egan M, Lorenc T, Petticrew M, Popham F. *Does money influence health?* Joseph Rowntree Foundation, 2014.

Psychosocial stress	Stress associated with low income e.g. indebtedness and financial strain, and/or to perceptions of relative inequality has a causal influence on health. Pathways from stress to health include various psychological (e.g. reduced self-efficacy and self-esteem, reduced access to emotional social support); biological (e.g. stress hormones, autonomic dysregulation); and, behavioural (e.g. health behaviours, coping strategies) mechanisms.
Behavioural	Low income is associated with health risk behaviours (e.g. greater alcohol use, smoking, unhealthy diet, less exercise) and with lower uptake of health education messages, preventative services and some health monitoring services. This may be linked to stress (e.g. self-medication), lower future expectations (and differences in prioritisation of risks), and lower uptake of health promoting activities that signify social status.
Personality	Variability in personality characteristics – including IQ as well as personality traits such as conscientiousness, neuroticism, agreeableness, extraversion and openness - can affect health via several proposed pathways associated with income. For example, via greater educational attainment and therefore employment opportunities and adult income; greater uptake and assimilation of health education messages and thus healthier behaviours; greater ability to communicate effectively with health professionals; and a lower likelihood of psychological ill health.
Biological	Whichever pathway(s) considered, for health to be affected by income there must be an influence on biological factors to cause ill-health. While the biological processes underlying behavioural explanations such as smoking, diet and exercise need scarce elaboration, the biological impact of psychosocial effects is less widely understood. Much evidence that exposure to stress – especially the chronic, cumulative types of exposure that may signify the realities for many individuals and households experiencing persistence low income – adversely influences health via increases in production of stress hormones and autonomic dysregulation. This directly influences health, for example by raising blood pressure, impacting insulin resistance and increasing susceptibility to infection.

REDUCED HEALTH SERVICE USE

In order to understand how such an intervention might influence health service use, it is important to consider the literature linking socioeconomic status and health service use.

- Relevant to the current intervention, is that GPs have been estimated to spend 80% of their time on 20% of their patients.⁶⁰ When exploring reasons for those 'frequent attenders' – those that take up the greatest proportion of GP time – evidence from systematic reviews suggest that physical and psychiatric illness, emotional distress, social problems, medically unexplained symptoms, health anxiety and poor perceptions of health are all significant predictors.
- There is limited evidence that interventions targeting these frequent attenders actually influence consultation rates; however, these have focused on attending to undiagnosed psychiatric disorder among frequent attenders.⁶¹ The impact on attendance of interventions which aim to alleviate social problems is not known.
- As patients in more deprived areas have higher rates of consultations associated with psychosocial problems – psychological difficulties linked with problems such as financial hardship, debt and relationship breakup, initiatives which may reduce some of those psychosocial stressors may have the potential to impact consultation rates.

THEORIES LINKING SOCIO-LEGAL ADVICE AND HEALTH

Allmark et al. (2013)⁴⁴ carried out a systematic review of the literature to construct a conceptual 'logic model' linking advice provision to health outcomes. This review generated a visual depiction of hypothesised links between advice and health outcomes, mapping chains of causal pathways between the outcomes of advice (such as improved housing, or reduced debt), and intermediate (such as reduced anxiety, stress, or social isolation) to longer term health impacts (improvements to mental and physical health) (see Figure 2). These illustrate a broader range of pathways than the income/financial strain mechanisms identified above, reflecting the range of ways in which socio-legal advice may influence health.

Work is currently being completed at Northumbria University⁴³, to build on this logic model and empirically test the proposed underlying mechanisms linking socio-legal advice and health, using a realist evaluation approach.⁶² Initial findings indicate that the receipt of advice is linked with increases in resources available to people. These serve as 'stop-gaps', immediately relieving acutely stressful and disadvantageous experiences such as providing food-bank vouchers, and avoiding homelessness. Support received also addresses underlying social issues on a longer term basis, helping individuals achieve solutions to financial, housing, employment and interpersonal problems. Through providing this support

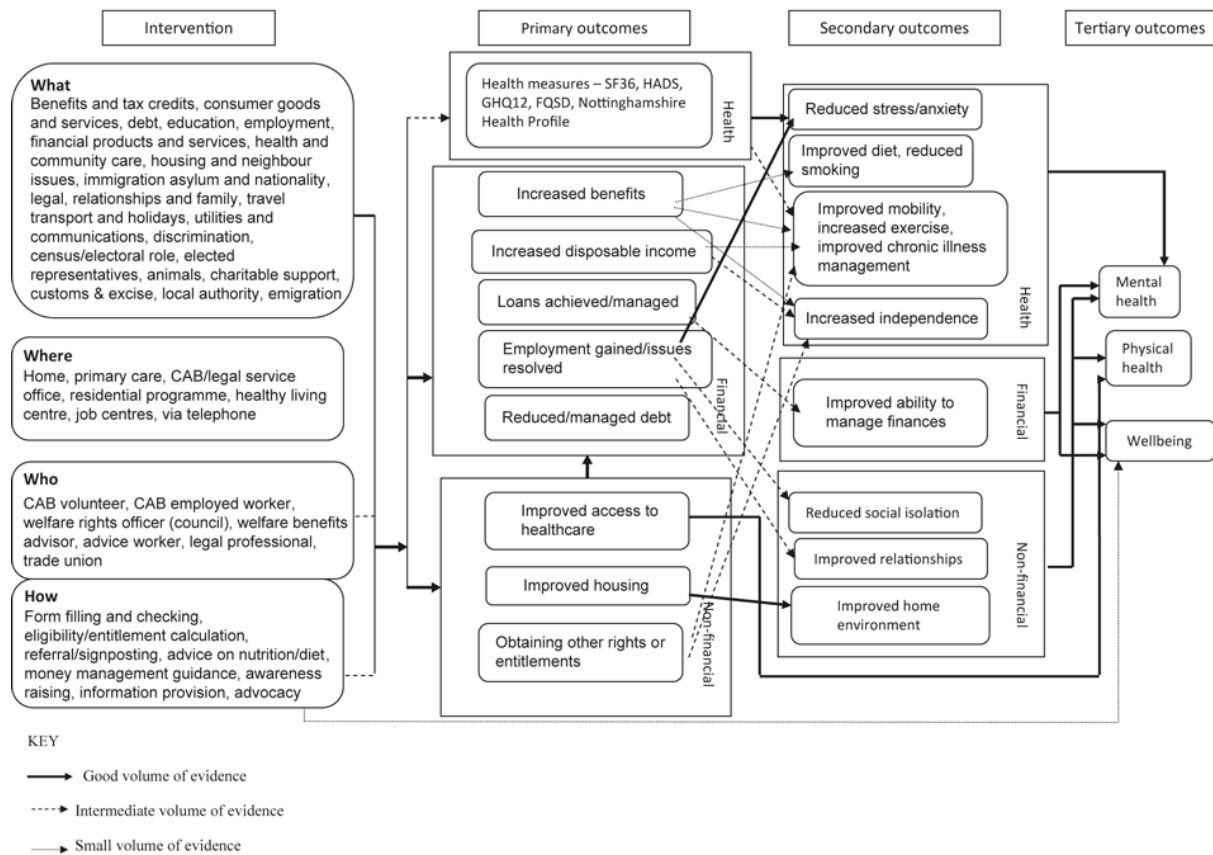
⁶⁰ Neal RD, Heywood PL, Morley S, Clayden AD, Dowell AC (1998) Frequency of patients' consulting in general practice and workload generated by frequent attenders: comparisons between practices. *British Journal of General Practice*, 48(426):895-8.

⁶¹ Smits FT, Brouwer HJ, ter Riet G, van Weert HC (2009) Epidemiology of frequent attenders: a 3-year historic cohort study comparing attendance, morbidity and prescriptions of one-year and persistent frequent attenders. *BMC Public Health*, 24;9(1):36.

⁶² Forster N, Dalkin SM, Lhussier M, Hodgson P, Carr SM (2016) Exposing the impact of Citizens Advice Bureau services on health: a realist evaluation protocol. *BMJ Open*, 6(1):e009887.

individuals experience reduced stress and social isolation, and stressors are relieved which may otherwise precipitate or exacerbate existing mental health problems.

Figure 2: Theoretical framework linking advice interventions and health outcomes (Source: Allmark et al., 2013)



THEORIES LINKING ADVICE AND REDUCED HEALTH SERVICE USE

Recent research examined the links between co-locating advice services and reduced general practice workload/pressures, and reduced GP consultations for socio-legal issues.²⁸ Five mechanisms were identified through which co-located advice could influence a reduction in consultations linked to social (non-clinical) issues, and reduced practice staff time pressures. These include:

- Addressing underlying social issues that would not be managed through medical intervention but may be adversely affecting health, and which may be barriers to engaging in clinical/self-management for health conditions.
- Providing practices with a signposting option for staff who lack time and appropriate expertise.

- Providing an alternative option for patients to access support, reaching people who would otherwise turn to a health professional, who would not usually seek advice, or who would not be able to seek advice elsewhere (e.g. due to physical or psychological barriers).
- Reducing bureaucratic pressures such as minimising requests for support with health-related benefits and other form filling, housing letters, advocacy work etc.
- Providing opportunities for collaborative work, closer working enabled by co-location could reduce time collating unnecessary information for external agencies and reduce repeat requests for information.

The potential for these mechanisms to influence health service use was reliant on adequate service awareness, which was often lacking amongst health staff – despite co-location. Factors influencing service awareness and the likelihood of observing reductions in health service use are illustrated in **Error! Reference source not found.**

Figure 3: Linking co-location of socio-legal advice to outcomes for general practices using a modified realist evaluation approach (Source: Woodhead et al., 2017)

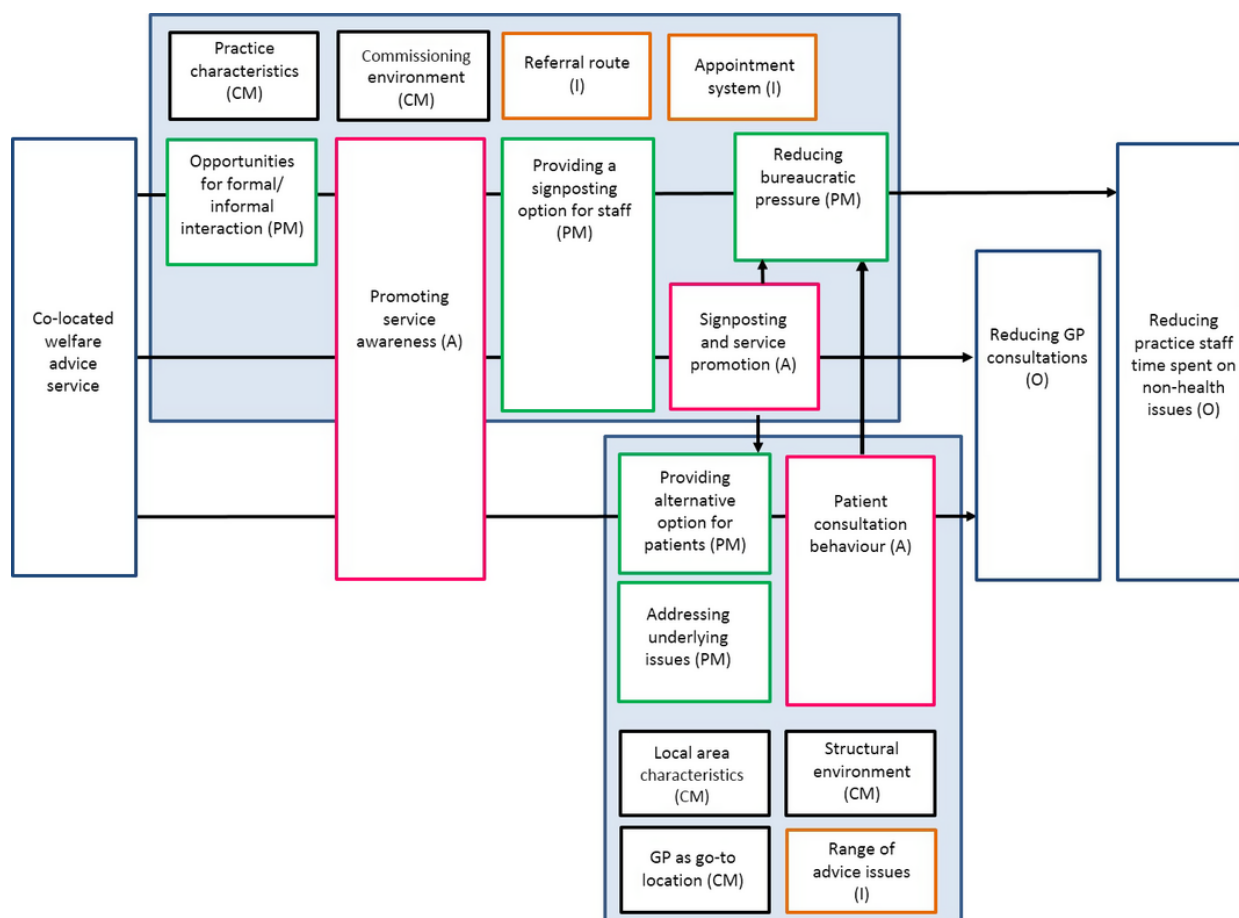


FIGURE 1 Illustration of the Programme Mechanisms (PM) through which co-located welfare advice services could influence practice outcomes (O). Key Contextual Mechanisms (CM), Agency (A) and programme implementation characteristics (I) acting as barriers and enablers are also shown. [Colour figure can be viewed at wileyonlinelibrary.com]

WHAT EVIDENCE IS THERE FROM EVALUATIONS OF HEALTH JUSTICE PARTNERSHIPS?

The research evidence is presented in two sections. The first summarises findings from previous reviews of the impact of socio-legal advice in healthcare settings, synthesising evidence from the past 25 years (see Table 1). The second updates these reviews with findings from recent studies completed since the last available review.

Table 1: Summary of reviews of socio-legal advice in healthcare settings

Review	Method and coverage	Main findings and conclusions
Greasley & Small (2002) ⁶³	Narrative review of evidence pertaining to welfare rights advice provision in healthcare settings with a focus on the types of problems raised and advice received, income gains, impact on health outcomes of clients, impact of interventions on use of health services, and the benefits of such interventions from the primary care perspective.	<ul style="list-style-type: none"> • (Methodologically weak) evidence for improvements to health and quality of life for those who receive advice. • (Methodologically weak) evidence for a reduction in health service resource use including consultations and prescriptions. • Healthcare based welfare advice interventions facilitates access for those otherwise potentially unable or unwilling to seek advice. • Stigma associated with advice receipt is reduced. • Knowledge about welfare services and benefits is improved among both patients and health workers. • The presence of advisors is a useful resource for GPs dealing with health related benefits claims.
Adams et al., (2006) ³⁸	Systematic review of both published and unpublished literature, of the impact of welfare rights provision in healthcare settings focusing on evidence for health, social and financial benefits for welfare advice clients.	<ul style="list-style-type: none"> • Clients routinely gained financially from the advice, with a mean estimated gain of £1,026 per person – though due to a lack of available full financial data a precise estimate of gains was not possible. • Of the studies that included a control or comparison group, measures of health were restricted to self-reported generalised health assessments and any significant differences reflected improvements in social or psychological health, rather than physical health. • Qualitative studies generally reported positive perceptions of the intervention and perceptions of improvements for client mental health and well-being among clients, practice staff and welfare advisors. • Evaluations were methodologically weak with small sample sizes and short follow-up periods • Need for greater understanding of who is most likely to benefit

⁶³ Greasley P, Small N. *Welfare advice in primary care*. Leeds: University of Leeds, 2002.

		<ul style="list-style-type: none"> • Need for larger studies with longer follow up times, use of randomised and controlled approaches and more specific measures of health
Wiggan & Talbot (2006) ⁶⁴	Narrative review of published and unpublished literature but with a wider scope to encompass a broader range of issues linking benefits and health such as current non-uptake of entitlements and potential economic benefits for the local community, as well as the role of advice services in improving health.	<ul style="list-style-type: none"> • Provision of welfare services in health settings increased uptake of entitlements, particularly among older people and disabled people, with resulting increases in income for those involved. • Extra financial resources tended to be spent on fuel, food, education, transport and recreation; and, that clients benefitted from increased social participation and better living standards. • The most effective services were typically those where healthcare workers were in support of the provision of advice services and had a good awareness of which clients should be referred to the service. • Increases in income from welfare rights interventions associated with significant improvements in mental health but the evidence for physical health was more limited.
CLAHRC-South Yorkshire (2012) ⁶⁵	Critical review of the literature published between 2006 and 2010	<ul style="list-style-type: none"> • Strong evidence of financial gain for those receiving advice. • Some evidence for improvements in mental health but only weak evidence for physical health improvements. • The small number of additional quantitative studies in the period 2006 to 2010 had small sample sizes and poor response rates. • Short to medium term physical health gains are unlikely to be apparent but that other markers of change may be more revelatory. • Recommended that evaluations must be explicit about the aspect of the intervention they hypothesise to have an effect – whether that is the receipt of advice, the financial gain itself – or other benefits, such as new employment.

⁶⁴ Wiggan J, Talbot C. *The benefits of welfare rights advice: a review of the literature*. Commissioned by the National Association of Welfare Rights Advisors, 2006.

⁶⁵ Collaborations for Leadership in Applied Health Research & Care – South Yorkshire. *The health effects of welfare rights advice and welfare benefits: a critical review*, 2012.

<p>Low Commission (2015)²⁰</p>	<p>Rapid evidence review of evaluations of health-linked advice services in primary, secondary and tertiary care</p>	<ul style="list-style-type: none"> • Considerable variation in the methodological robustness of the research, with inconsistent use of measurement tools and outcomes considered. • A lack of longitudinal assessment of outcomes and a lack of studies with control or comparison groups. • Absence of high quality studies demonstrating statistically significant impact on health of advice services. • Nonetheless, available studies present evidence of positive impact of advice services in improving health including reduced stress and anxiety, better sleeping patterns, reversal of weight loss, changes in medication, reduced contact with the primary care team, reduction or cessation of smoking, and improved diet and physical activity. • Less evidence is available demonstrating actual cost or efficiency savings; studies that have included such information have mainly inferred or assumed that such savings will be delivered.
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A PROSPECTIVE QUASI-EXPERIMENTAL STUDY OF THE IMPACT OF WELFARE ADVICE IN GENERAL PRACTICE⁴¹

A prospective, controlled quasi-experimental study with an embedded qualitative component was carried out by researchers at CLAHRC North Thames, UCL, between December 2015 and December 2016. The study covered eight intervention and nine comparator sites across North Thames. Before-and-after quantitative data were collected from individuals accessing welfare advice services co-located in general practice and a propensity score weighted comparison group via self-report questionnaires. Analyses compared change in several outcomes among the two groups. 285 and 633 individuals were recruited into advice and comparison groups respectively at baseline, of which 72% and 84% were retained at 3 month follow-up. Key findings are shown in Box 2.

Box 2: Key findings from a prospective quasi-experimental controlled study

- **The majority of advice group members reported improvements in circumstances as a result of receiving advice, particularly in stress, income, housing circumstances and confidence.**
- **There was greater improvement in symptoms of common mental disorder over time in the advice group - there was a positive impact of receiving advice on mental health.**
 - Overall there was a 43% bigger improvement among advice recipients than comparison group members though this was not statistically significant.
 - The impact of welfare advice on mental health was most pronounced, and statistically significant, among those experiencing a positive outcome of advice, females, and Black/Black British participants (55%, 63% and 91% bigger improvements respectively).
- **There was a positive impact of advice on well-being among those who experienced a positive outcome from their advice session(s).**
 - There was increase over time in well-being scores (measured by SWEMWBS) that was on average 1.29 points greater among the advice group relative to the comparison group.
- **There was a reduction in the proportion of individuals reporting their financial situation as 'difficult/very difficult' over time among advice recipients, but not among comparison group members – there was a positive impact of advice on financial strain.**
 - The reduction in financial strain was 58% bigger for advice group than comparison group members overall, 67% bigger among female advice recipients, and 70%

among advice recipients with long-term conditions). These were all significant differences.

- **There was no impact of advice on three-month consultation frequency.**
- **There was a positive impact of advice on reported use of credit card/overdraft if income did not cover costs.**
- **Advice group members became more likely to report not knowing where to seek advice for financial problems over time (relative to controls), comparison group members became more likely to report asking their GP for support (relative to advice group members).**
- **Advice group members received £15 per £1 invested by funders. This excludes non-directly financial gains.**

THE DO-WELL STUDY: EVALUATING THE EFFECTS ON HEALTH AND WELLBEING OF A WELFARE RIGHTS ADVICE SERVICE PROVIDED BY SOCIAL SERVICES DEPARTMENTS IN NORTH-EAST ENGLAND FOR LOW INCOME OLDER PEOPLE⁶⁶

Older people in poor health are more likely to need extra money, aids and adaptations to allow them to stay in their homes and remain in good health, yet many do not claim the benefits to which they are entitled. This UK study was a randomised controlled trial which evaluated the effects on health and wellbeing of a welfare rights advice service provided by social services departments in north-east England for low income older people, who were identified from general practices. 755 older people were randomly assigned to either of two groups. The first received an appointment with a welfare rights advisor in their own home, for a full benefit assessment and help with claiming benefits and other entitlements. Advisors kept in touch with them until they no longer needed help. The second group received exactly the same help and advice 24 months later and receive usual care in the meantime. Older people in both groups were interviewed at the outset and were interviewed again after 24 months to find out whether the service was beneficial and acceptable, and cost effective. The study was completed in 2015 and results are expected to be published in 2017.

UNDERSTANDING THE LINKS BETWEEN ADVICE AND HEALTH⁶²

Direct evidence for the impact of advice services on lifestyle behaviour and physical health is currently not well established. There is a need for greater empirical testing of theories around the specific mechanisms through which advice services and associated financial or non-financial benefits may generate health improvements. This UK study was a realist

⁶⁶ Haighton C, Moffatt S, Howel D, McColl E, Milne E, Deverill M, Rubin G, Aspray T, White M (2012) The Do-Well study: protocol for a randomised controlled trial, economic and qualitative process evaluations of domiciliary welfare rights advice for socio-economically disadvantaged older people recruited via primary health care. *BMC Public Health*, 28;12(1):382.

evaluation, operationalised in five phases: building the explanatory framework; refining the explanatory framework; testing the explanatory framework through empirical data (mixed methods); development of a bespoke data recording template to capture longer term impact; and verification of findings with a range of Citizens Advice services. This research aimed to build, refine and test an explanatory framework about how advice services can be optimally implemented to achieve health improvement. The study was completed in 2016 and results will be published in 2017.

WHAT ARE THE GAPS IN THE EVIDENCE BASE?

This section summarises identified gaps in the literature from previous reviews and emerging from the current paper. To some extent, the nature of and salience given to particular evidence gaps vary depending on who is funding the service, how they fit into broader commissioning and policy agendas, and available resources to support such initiatives.

- Both Adams et al. (2006)³⁸ and the 2015 Low Commission²⁰ report identified major gaps as a lack of controlled and longitudinal studies evaluating the outcomes and impacts of advice services in health settings. These issues have begun to be addressed by more recent studies; ^{41 66} nonetheless, longer term benefits of advice provision and legal assistance may take several years to emerge fully and may accumulate over multiple support episodes for clients over time. Such longer term outcomes are difficult to capture in most time-limited evaluations, and the complexity of people's lives – often experiencing multiple disadvantage – may make it difficult to attribute changes in the longer term to specific advice episodes or outcomes.
- There is little robust economic analysis of actual cost-benefits and efficiencies delivered for health services. Many studies report financial gains for clients that far outweigh costs to funders, but these exclude other non-directly financial gains that may or may not be monetised (e.g., quality of life, improved housing circumstances, avoided repossession or court fines, safety from domestic violence), and are thus underestimates of true benefits. Moreover, due to the lack of routine recording of contact with socio-legal services in patient medical records (i.e., structured 'read-coding' in the UK) – it is difficult to evaluate the impact of advice receipt on health service use. To our knowledge only one study has tested changes in objective measures of service use following receipt of co-located welfare advice.⁶⁷ The findings revealed significant before-and-after reductions in GP and nurse consultations, antidepressant and anti-anxiolytic medication prescription; however, as there was no control or comparison group the possibility that such a reduction represents 'regression to the mean' cannot be ruled out.

⁶⁷ Krska J, Palmer S, Dalzell-Brown A, Nicholl P (2013) Evaluation of welfare advice in primary care: effect on practice workload and prescribing for mental health. *Primary Health Care Research & Development*, 2013; 14: 307-314.

- Another gap is whether there are certain groups whose outcomes or health service use may be more likely to be positively influenced by the receipt of legal advice services in healthcare settings. For example, specialist welfare advice for people in contact with secondary mental health services has been proposed to reduce inpatient lengths of stay, prevent relapse and avoid homelessness, though this has not been empirically tested.⁶⁸ Also, older people with limited mobility may be better supported by legal assistance attached to social care services or which provide domiciliary services. Evaluations taking a realist perspective may better address the question of ‘what works, for whom and in what circumstances?’⁶⁹ This would enable funders to better adapt and target services to optimise outcomes for individuals and health services.
- An evidence review of Medical-Legal Partnerships also identified several gaps in the literature.⁸ This included a lack of clarity on the process of legal needs assessment, and the tools or instruments used to assess legal needs in clinical settings. Given the number of MLPs in the US, the authors identified the potential for best-practice and information sharing across services in relation to the assessment of legal needs, capacity assessment, and linking with integrated legal services, perhaps via a standardised legal needs assessment tool in clinical settings. They also identified that consensus about what constitutes a legal need, and specifying a threshold for referral to legal services may be helpful to MLPs as they look to improve their services and enhance their capacity to meet patients’ needs.
- The authors identified a lack of evaluation of the quality of MLPs, lack of common measures or metrics of quality, outcomes, or care processes. They suggested that a common set of metrics for MLP service quality would guide both partners in addressing patients’ health and legal needs and provide a benchmark for evaluation of quality and outcomes at individual, system, and policy levels.
- Little information is available about whether MLPs referenced any intended or achieved impact at the policy and regulatory level, including improvements in policies, laws, and regulations that affect vulnerable populations – for example identifying unmet need for the purposes of achieving policy change.
- Finally, linked to the point above about understanding what works, for whom and in what circumstances, the authors state that as increasing numbers of collaborations emerge, there is a need to develop empirical evidence to support the expansion of the model and to understand the components that contribute to its success.

⁶⁸ Parsonage M. *Welfare advice for people that use mental health services: developing the business case*. Centre for mental health, 2013.

⁶⁹ Pawson R, Tilley N. *An Introduction to Scientific Realist Evaluation*. In: Chelimsky ESW (Ed.). *Evaluation for the 21st century: A handbook*. SAGE Publications Ltd, 1997. p. 405-18.

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