



Health Justice Partnerships in Social Prescribing International Workshop

Thursday 9 November 2017
Updated Background Materials

UCL Laws
in collaboration with



UCL FACULTY OF LAWS

UCL Laws has been a leading centre of legal education for almost 200 years. The Faculty continues to hold its historical reputation as a world-class institution for education and research. It consistently ranks among the top law faculties in the UK for research, teaching and student satisfaction. The Faculty has world-class scholars that range across the full spectrum of legal issues. This research often has a profound real world impact, reflected in its national and international influence on government policy, law and legal practice.



THE UCL CENTRE FOR ACCESS TO JUSTICE

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.



THE INTEGRATED LEGAL ADVICE CLINIC

The UCL integrated Legal Advice Clinic (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 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 of 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.

HEALTH JUSTICE PARTNERSHIPS IN SOCIAL PRESCRIBING INTERNATIONAL WORKSHOP

THURSDAY 9 NOVEMBER 2017

12:30 – 19:00

THE ATHENAEUM, PALL MALL, LONDON

It is increasingly accepted that a strategic approach to improving public health and well-being involves addressing the upstream causes of downstream health problems. Unresolved social welfare issues create and exacerbate mental and physical health problems. Health Justice Partnerships (HJP), in which access to free legal advice is provided in health settings, can help to tackle the social determinants of health through, for example, alleviating poverty, improving housing conditions, and securing stable employment. Although such initiatives have been developed internationally, they have been largely uncoordinated, sporadically funded, and poorly evaluated. This International Workshop brings together policy officials, health professionals, commissioners, research funders and health researchers to focus on developing the role of social welfare legal advice in social prescribing through HJPs.

The event will include two formal panel discussions; the first will give an overview of social prescribing developments and then look 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 will focus on advancing an evidence-based policy agenda around the role of HJPs in social prescribing. While there is a considerable amount of social prescribing activity in relation to social welfare issues, it is sporadic and uncoordinated and we lack evidence of efficacy and what models work best. The second panel will consider 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 background paper aims both to inform discussions at the workshop and to serve 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:

- What are Health Justice Partnerships?
- How do they work and what socio-legal 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?

PROGRAMME

12:30 - 13:30 Buffet Lunch

13:45 - 15:30 Session 1

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 Discussion 1: An international overview of Health Justice Partnerships

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)
- Steve Dubbins (Head of Impact, Macmillan Cancer Support)

15:30 - 15:45 Break

15:45 - 17:30 Session 2

Panel Discussion 2: Evidence and policy for Health Justice Partnerships

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)

18:00 - 19:00 Drinks and networking

BIOGRAPHICAL NOTES ON THE PANEL

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

Director (UCL Centre for Access to Justice)

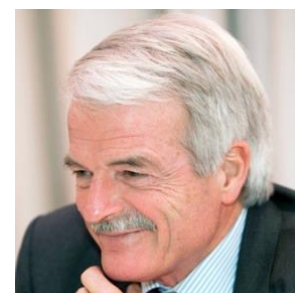
Dame Hazel Genn is Director of the UCL Centre for Access to Justice and was Dean of the UCL Faculty of Laws 2008-2017. Dame Hazel is a leading authority on access to civil and administrative justice. Her prize winning scholarship focuses on the experiences of ordinary people caught up in legal problems 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 VA/VISN 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.

PARTICIPANTS LIST

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Table of Contents

PROGRAMME	4
BIOGRAPHICAL NOTES ON THE PANEL.....	5
PARTICIPANTS LIST	10
What are Health Justice Partnerships?	13
Why develop these partnerships?	13
How do they work and what socio-legal outcomes do they achieve?	16
Organisation	16
Population.....	16
Funding.....	16
Output.....	17
Financial outcomes.....	17
Other service outcomes	18
Barriers to partnership working	18
Can Health Justice Partnerships improve health and reduce service use?	20
What are the underlying theories?	20
Income, indebtedness, financial strain and health.....	20
Health impact of increased income	22
Reduced health service use	24
Theories linking socio-legal advice and health	24
Theories linking advice and reduced health service use	25
What evidence is there from evaluations of Health Justice Partnerships?	26
Recent developments: moving the evidence base forward.....	30
What are the gaps in the evidence base?	31
Appendix 1: The UCL integrated Legal Advice Clinic (iLAC) – A Health Justice Partnership	34
Appendix 2: Health research at the UCL iLAC	37
Appendix 3: Health justice partnerships national mapping study.....	37

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.*¹ (p.1)

HJPs have emerged - particularly in Australia - as links between lawyers and health professionals, the concept of supporting individuals in need of legal assistance through collaborations between health and socio-legal advice services has been previously developed elsewhere.

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 in health settings have mainly been provided by voluntary and community organisations such as Citizens Advice and condition-specific charities, such as Macmillan Cancer (see '

How do they work and what socio-legal outcomes do they achieve?')

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 similar²:

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 health 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 poverty³. Social justice research has shown a positive correlation between increasing numbers of socio-legal problems and poor health, particularly mental wellbeing^{4 5}. People vulnerable to social exclusion and those in ill health are also more likely to develop

¹ Health Justice Australia. *Our theory of change: how we achieve systemic improvements in health and justice through partnership*. Health Justice Australia, 2017.

² 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.

³ World Health Organisation. *Social Determinants of Health - The Solid Facts*. 2003

⁴ 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

⁵ 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

such problems⁶. 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 health⁷. 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;^{8 9 10} and, adverse housing circumstances.¹¹ They are also more likely to have difficulty accessing support and advice for such issues.¹² The rationale for linking advice and health services was recognised by Jarman¹³ 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:¹⁴

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 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)

⁶ Balmer N. English and Welsh Civil and Social Justice Panel Survey: Wave 2. Legal Services Commission; 2013

⁷ Genn H. Paths to Justice: What people do and think about going to law. Oxford: Hart Publishing; 1999

⁸ 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.

⁹ 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.

¹⁰ 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.

¹¹ 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.

¹² Finn D, Goodship J. *Take-up of benefits and poverty: an evidence and policy review*. Centre for Economic & Social Inclusion, 2014.

¹³ Jarman B (1985) Giving advice about welfare benefits in general practice. *BMJ*, 290: 522-524.

¹⁴ Parkinson A, Buttrick J. *The Role of Advice Services in Health Outcomes Evidence Review and Mapping Study*. Consilium Research and Consultancy, 2015.

Findings from social justice research carried out in the UK,^{15 16} and the US^{2 17}, 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.^{18 19 20 21}

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:²²

General practitioners (GPs) are involved with a variety of social issues independent of direct clinical work.²³ Patient demand for such “non-health” work has been identified as a contributing factor to increased general practice pressures.^{24 25 26} 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.^{27 28} 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 provision.²⁵ ²⁶These were reported to contribute to decreased time available for other patients' health needs, as well as increased job stress and practice costs.²⁹ (p.1794)

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 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.

¹⁸ 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.

¹⁹ Haigh T. *Tower Hamlets Health & Advice Links Project*. Social Action for Health, 2012.

²⁰ Greasley P, Small N. *Welfare advice in primary care*. University of Leeds, 2002.

²¹ Kite A. Citizens Advice in GP Surgeries: an investigation. PhD Thesis, 2014.

²² 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.

²³ 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.

²⁴ Baird B, Charles A, Honeyman M, Maguire D, Das P. (2016). *Understanding pressures in general practice*. London: The King's Fund.

²⁵ 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>

²⁶ 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>

²⁷ 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.

²⁸ 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.

²⁹ Citizens Advice. *A Very General Practice: How much time do GPs spend on issues other than health?* Citizens Advice, 2015.

How do they work and what socio-legal outcomes do they achieve?

Organisation

HJPs usually 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 health¹⁴ 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).¹⁴ Such a diversity has also been identified in the US³⁰ and Australia.³¹

Funding

The Low Commission's¹⁴ 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 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.³⁰

³⁰ National Center for Medical Legal Partnership. <http://medical-legalpartnership.org/fag/>

³¹ Health Justice Australia. <https://www.healthjustice.org.au/hjp/health-justice-partnerships-in-australia/>

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 2006³² 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.
- A 2008 survey of the extent and costs of GP-linked welfare advice provision across England³³ 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 £3,341.³⁴
- 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

³² 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.

³³ Bateman N. *Just what the doctor ordered: welfare benefits and advice and healthcare*. Age Concern England, 2008.

³⁴ Derbyshire Citizens Advice Bureaux. *Citizens Advice Bureaux in General Practice: Report 2011/12*. Derbyshire Citizens Advice Bureaux, 2012.

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.¹⁹
- An evaluation of GP-located welfare advice services in Haringey and Camden over 2015/16 reported average gains of £2689 per client.³⁵

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 local issue). Research of both general and health-linked advice services report a range of direct and indirect outcomes for clients, including: ^{2 35 36 37 38}

- 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.26 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.¹⁴ 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^{14 22}
- 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

³⁵ 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].

³⁶ 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.

³⁷ 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/>

³⁸ 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.

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.²²

- 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.²²
- Lack of belief, among some clinicians, that they have a role to play in supporting patients with such legal needs.¹⁴ 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.³⁹
- 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.²²

³⁹ Royal College of Psychiatrists. Debt and mental health:
http://www.rcpsych.ac.uk/pdf/factsheet_debtandmentalhealth.pdf

Summary

HJPs and similar models are collaborations between legal professionals, or 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.

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

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- 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.^{40 41} 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 applicants⁴² - but also to by-products of illness such as greater sick leave, greater risk of job loss, and physical limitations in ability^{43 44}
- 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 study⁴⁵ 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)⁴⁶ 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.⁴⁷ 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.^{46 48}

⁴⁰ Link BG, Phelan J (1995) Social conditions as fundamental causes of disease. *Journal of Health and Social Behaviour*, 1:80-94.

⁴¹ 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.

⁴² Han E, Norton EC, Stearns SC (2009) Weight and wages: fat versus lean paychecks. *Health Economics*, 1;18(5):535-48.

⁴³ 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

⁴⁴ 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

⁴⁵ Weich S, Lewis G (1998) Poverty, unemployment, and common mental disorders: population based cohort study. *BMJ*, 317: 115-119.

⁴⁶ 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.

⁴⁷ 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.

⁴⁸ 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.

- A longitudinal association has been reported⁴⁹ 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.⁵⁰
- 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 occurrences.⁵¹ 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 review⁵² 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.

⁴⁹ Taylor MP, Jenkins P, Stephen P, Sacker A (2011) Financial capability and psychological health. *Journal of Economic Psychology*, 32: 710-23.

⁵⁰ 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.

⁵¹ 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.

⁵² Cooper K, Stewart K. *Does money in adulthood affect adult outcomes?* Joseph Rowntree Foundation, 2015.

- 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

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.
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.

Adapted from Benzeval et al., (2014)⁵³ and Mackenbach, 2012⁴¹

⁵³ Benzeval M, Bond L, Campbell M, Egan M, Lorenc T, Petticrew M, Popham F. *Does money influence health?* Joseph Rowntree Foundation, 2014.

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.⁵⁴ 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.⁵⁵ 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)³⁸ 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.

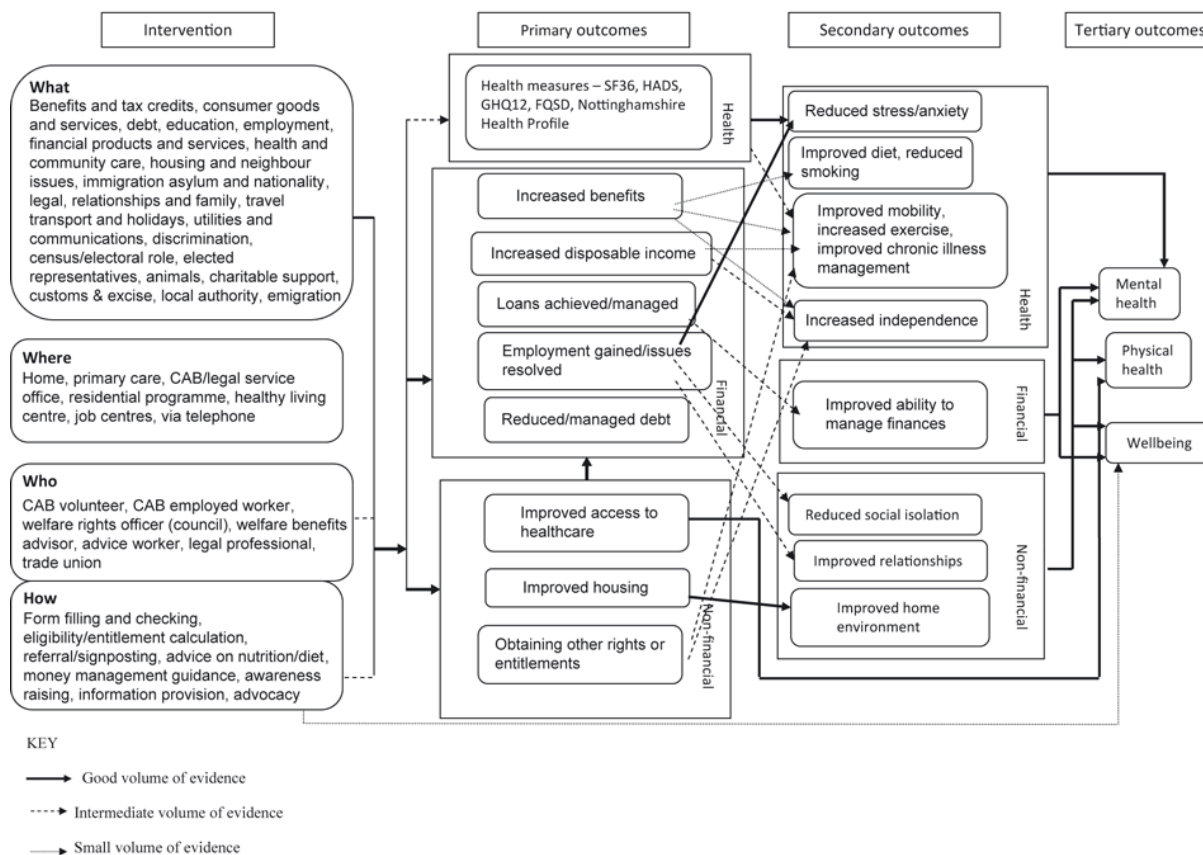
Work is currently being completed at Northumbria University³⁷, to build on this logic model and empirically test the proposed underlying mechanisms linking socio-legal advice and health, using a realist evaluation approach.⁵⁶ Initial findings indicate that the receipt of advice is linked with increases 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 individuals experience reduced stress and social isolation, and stressors are relieved which may otherwise precipitate or exacerbate existing mental health problems.

⁵⁴ 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.

⁵⁵ 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.

⁵⁶ 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.

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.²² 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 Figure 3.

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)

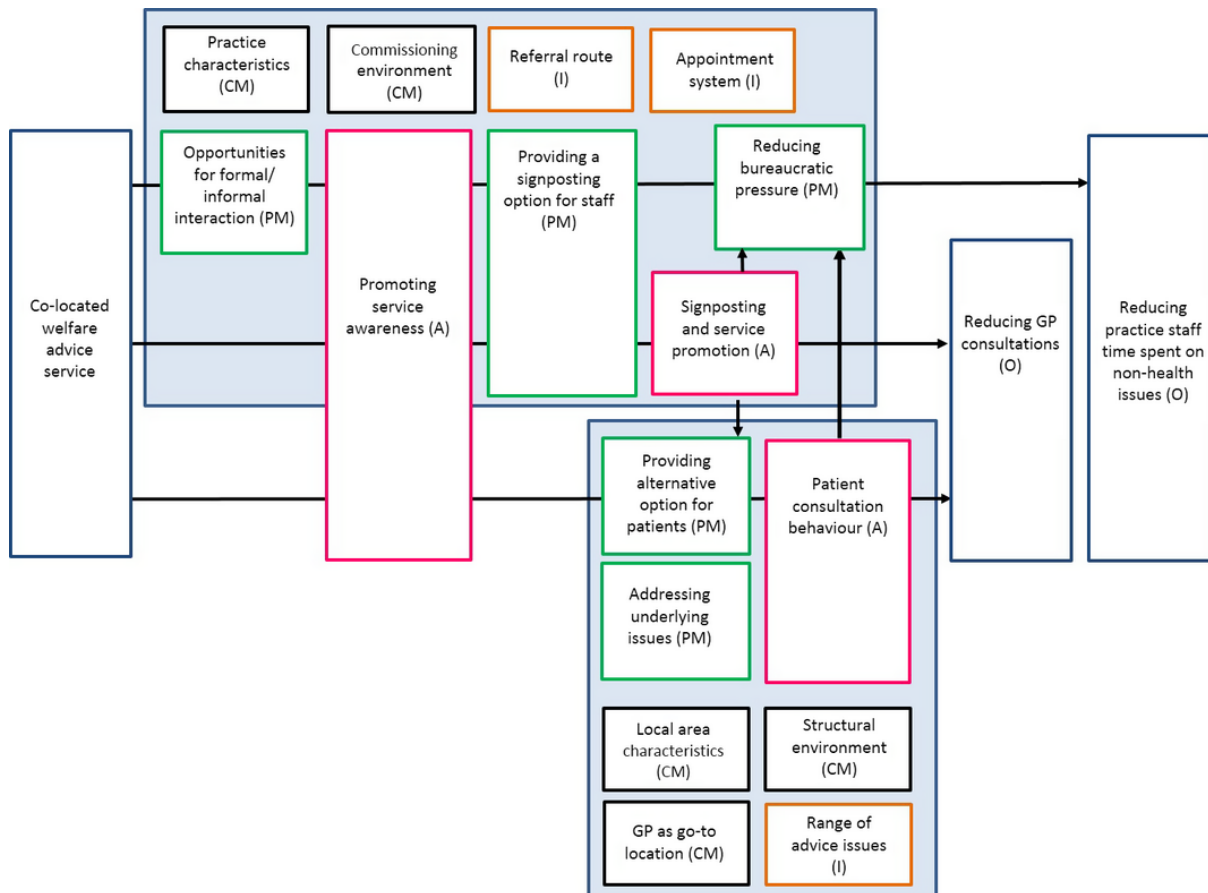


FIGURE 1 Illustration of the Programme Mechanisms (PM) through which co-located welfare advice services could influence practice outcomes (O). Key Contextual Mechanisms (CM), Agency (A) and programme implementation characteristics (I) acting as barriers and enablers are also shown. [Colour figure can 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) ⁵⁷	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) ³²	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 • Need for larger studies with longer follow up times, use of randomised and controlled approaches and more specific measures of health
Wiggan & Talbot (2006) ⁵⁸	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	<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.

⁵⁷ Greasley P, Small N. *Welfare advice in primary care*. Leeds: University of Leeds, 2002.

⁵⁸ 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.

	well as the role of advice services in improving health.	<ul style="list-style-type: none">• Increases in income from welfare rights interventions associated with significant improvements in mental health but the evidence for physical health was more limited.
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Table 1: Continued

Review	Method and coverage	Main findings and conclusions
CLAHRC-South Yorkshire (2012) ⁵⁹	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.
Low Commission (2015) ¹⁴	Rapid evidence review of evaluations of health-linked advice services in primary, secondary and tertiary care	<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.

⁵⁹ Collaborations for Leadership in Applied Health Research & Care – South Yorkshire. *The health effects of welfare rights advice and welfare benefits: a critical review*, 2012.

Recent developments: moving the evidence base forward

A prospective quasi-experimental study of the impact of welfare advice in general practice³⁵

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 people⁶⁰

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 health⁵⁶

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 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)³² and the 2015 Low Commission¹⁴ 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;^{35 60} 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

⁶⁰ 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.

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.⁶¹ 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.
- 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.⁶² 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?’⁶³ 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.² 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.

⁶¹ 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.

⁶² Parsonage M. *Welfare advice for people that use mental health services: developing the business case*. Centre for mental health, 2013.

⁶³ 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.

- 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.

Appendix 1: The UCL integrated Legal Advice Clinic (iLAC) – A Health Justice Partnership

ABOUT THE SERVICE

The UCL integrated Legal Advice Clinic (iLAC) is an example of a health justice partnership and is based in the Guttman Health and Wellbeing Centre in Stratford (East London). It offers users of the Liberty Bridge Road General Practice free face-to-face general legal advice on all aspects of social welfare law including specialist advice and casework on welfare benefits, housing, community care and education.

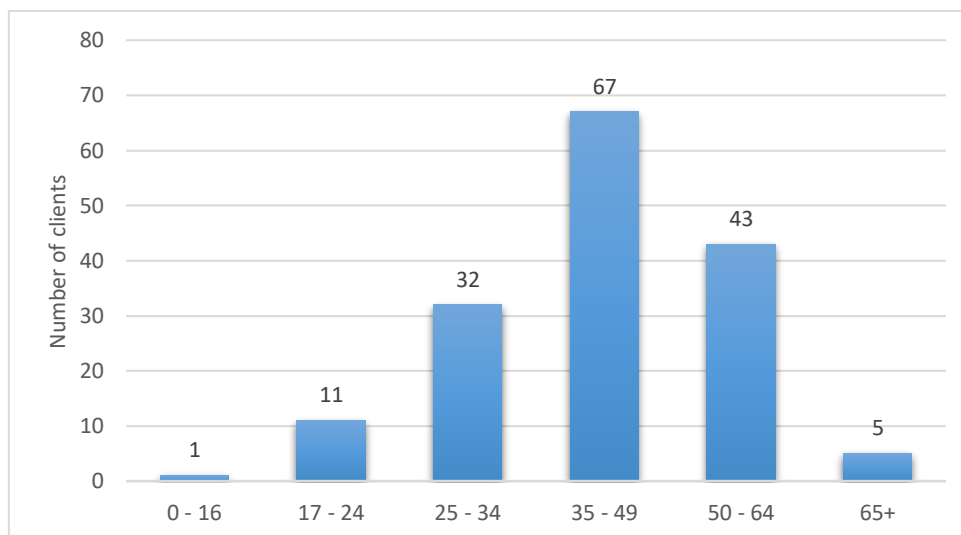
Staffed by UCL law students working under the close supervision of qualified lawyers and advisers, the service provides a valuable and much needed service to members of the local community.

Building on the Faculty of Laws' world-leading access to justice research, the UCL iLAC will also provide the basis for a wide-ranging research agenda seeking answers to fundamental questions about the nature of legal needs, the links between legal and health problems, and the benefits of early legal advice.

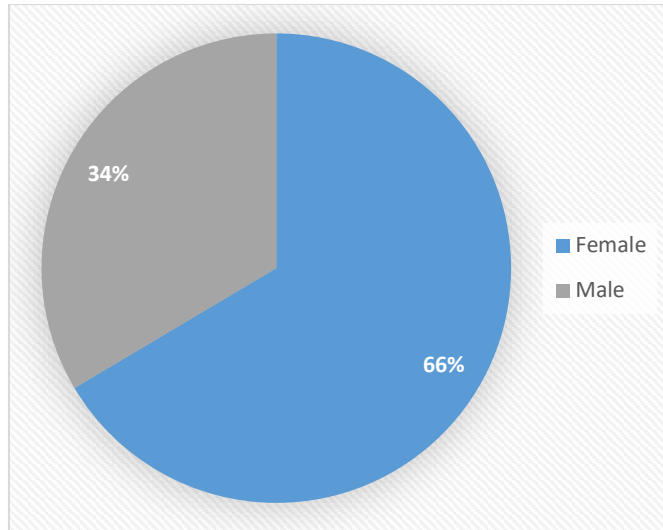
CLIENT CHARACTERISTICS

The following data show the characteristics of clients attending the UCL iLAC clinic to date (January 2016 - September 2017).

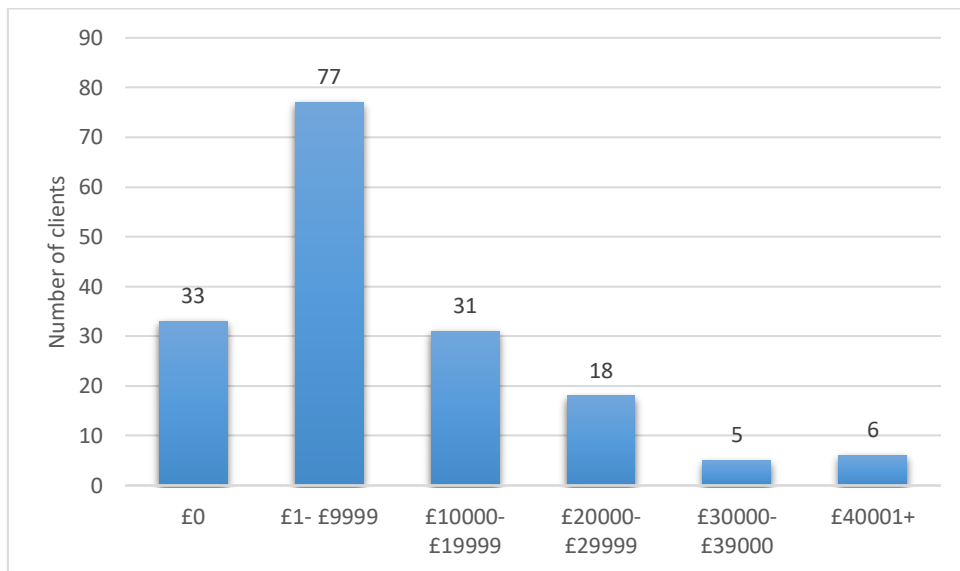
Age range:



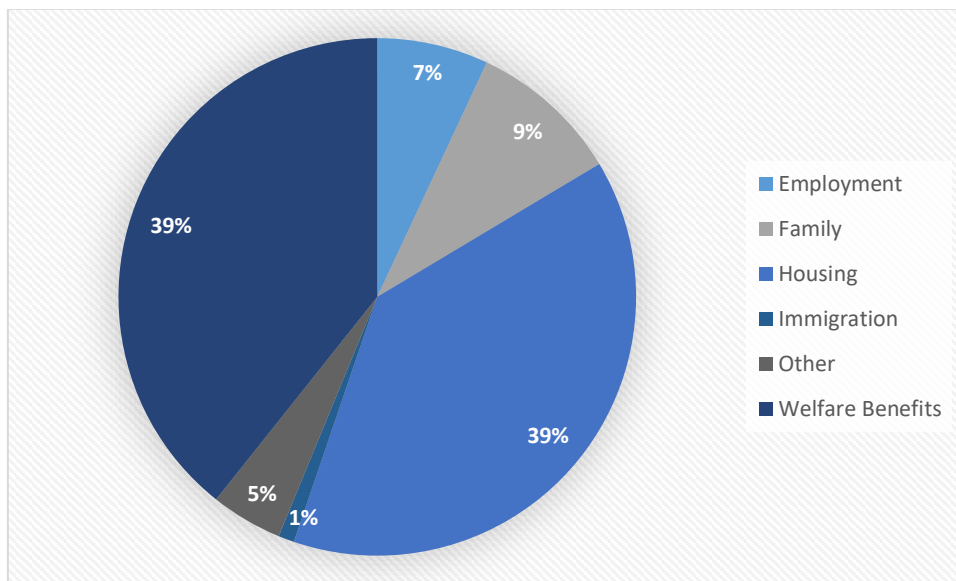
Gender:



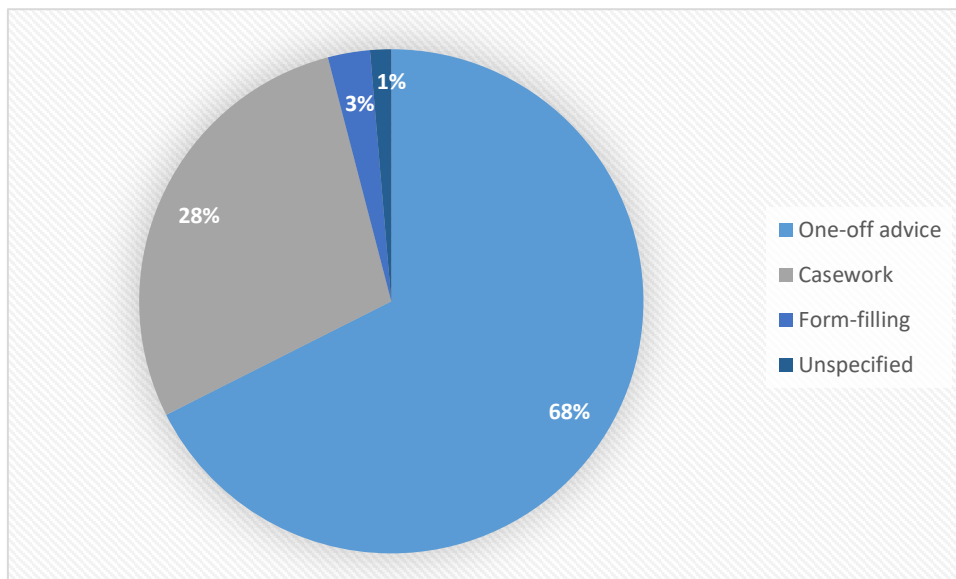
Income band:



Legal problem types:



Type of advice given:



Appendix 2: Health research at the UCL iLAC

ABOUT THE PROJECT

Research is being undertaken at the UCL integrated Legal Advice Clinic to investigate how the provision of free legal advice in a primary care setting is associated with the health and wellbeing of individuals who use the service.

Specifically, the project is looking at the following aspects:

- The burden of ill health (both mental and physical) among those seeking legal advice at the clinic, and how this is related to their legal problems.
- Whether health status (both mental and physical) changes in the months following the receipt of legal advice.
- How health-related behaviours (such as smoking and drinking) may be related to having a civil legal problem, and whether these behaviours change following the receipt of legal advice.
- Whether receiving legal advice affects how often patients use the GP.
- Clients' perspectives on tackling legal problems in a primary healthcare setting.
- Perspectives of GP practice staff on co-located legal advice services and how this can contribute to professional practice.

The research involves running quantitative surveys using validated health measures and following clients' progress over time. One-to-one in-depth interviews are also being conducted with clients and medical staff to gather qualitative evidence. Recruitment and data collection for both surveys and interviews are ongoing.

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