



## Health Justice Partnerships in Social Prescribing International Workshop

Athenaeum Club, London

9 November 2017

### Introduction

Awareness of the impact of unresolved legal problems on health is growing. It is increasingly understood that many underlying physical and mental health problems have a socio-legal cause. Poverty, substandard living conditions, insecure employment and debt all have a direct impact on health, as well as having a more indirect impact in denying citizens the capacity to make healthy lifestyle choices. It is against this background that Health Justice Partnerships have been established. These partnerships take a holistic approach in providing free legal advice in healthcare settings and aim to address the social determinants of ill health through, for example, alleviating poverty, improving housing conditions and securing stable employment. They are the vehicle through which welfare law becomes part and parcel of the approach to improving the health of citizens.

Health Justice Partnerships now exist in the UK, US and Australia. But 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**; and
- 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**.

This report summaries the key messages from the workshop. Part One provides an overview of the current UK health context and the different models of Health Justice Partnerships that exist internationally, exploring the philosophy behind these partnerships, their operation in practice and the role a National Centre can play in building the movement and promoting effective practice. It also considers some of the operational challenges that exist in developing the Health Justice Partnerships movement. Part Two gives an overview of the debates on how these partnerships can be developed, evaluated and sustained, exploring the methodological and ethical challenges that exist in measuring the health impacts of legal advice.

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

### **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.<sup>1</sup> 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.<sup>2</sup> We need to view the NHS not as a fragmented system but an integrated system that serves the

---

<sup>1</sup> 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>.

<sup>2</sup> 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).

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.

### **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,<sup>3</sup> 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.

### **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 evidence

---

<sup>3</sup> 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.

found that of Australia's population of around 24 million, 8.5 million people will experience three or more legal problems in a given year, half of whom will seek no legal support to address those problems. The 50% who seek advice are much more likely to raise those problems in a trusted environment, such as a health setting, than they are to go to 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 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).

The National Centre for Health Justice Partnerships was established in 2016 as a consequence of a growing demand to increase the role played by Health Justice Partnerships in tackling ill health. The Centre is taking the lead in developing these partnerships to better respond to the reality of people's needs. It conducts research and evaluates the effectiveness of 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. The Centre also provides support to practitioners working within this collaborative approach. Building these partnerships is not straightforward. The Centre works 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 the National Centre.

- **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.

**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.

**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.

### **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><b>Scalability:</b> 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 <b>National Centre</b> 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><b>Workability:</b> 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 <b>National Centre</b> could raise awareness of the value of these partnerships and co-ordinate the effort to connect GPs to them.</p>
<p><b>Raising legal consciousness and demonstrating legal impact:</b> 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 <b>joint courses</b> 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 <b>marry theory and practice</b>, putting emphasis on the role of the law both within the <b>formal curriculum</b> and, crucially, also outside the university setting in <b>clinical practice</b>.</p> <p>There are already <b>volunteer social prescribing champions</b> 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>

	Furthermore, as has been the case in Australia, a <b>National Centre</b> can build capability and legal consciousness within the medical profession by forging channels of communication and collaboration across professions.
<b>Overcoming the barriers to effective collaborations:</b> Investment is needed in forging links between the legal and health professions, overcoming professional insularity, building trust and cementing communication channels.	A <b>National Centre</b> could fulfil this role, co-ordinating the multi-disciplinary approach and supporting practitioners working collaboratively.
<b>Referral fatigue:</b> There is a risk that people will experience referral fatigue in being signposted to too many different services.	<b>Co-location</b> can mitigate against referral fatigue by making it easy for people to access all the relevant support services in one place.
<b>Quality assurance, managing clinical risk, responsibility and liability:</b> 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 <b>multi-disciplinary work and collaboration</b> 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.

### **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.

## 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.

## 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 outcome 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.

**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'<sup>4</sup> 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.

#### **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-

---

<sup>4</sup> 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>.

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.<sup>5</sup>

**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.

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.<sup>6</sup>

---

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

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

---

**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.

**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.

---