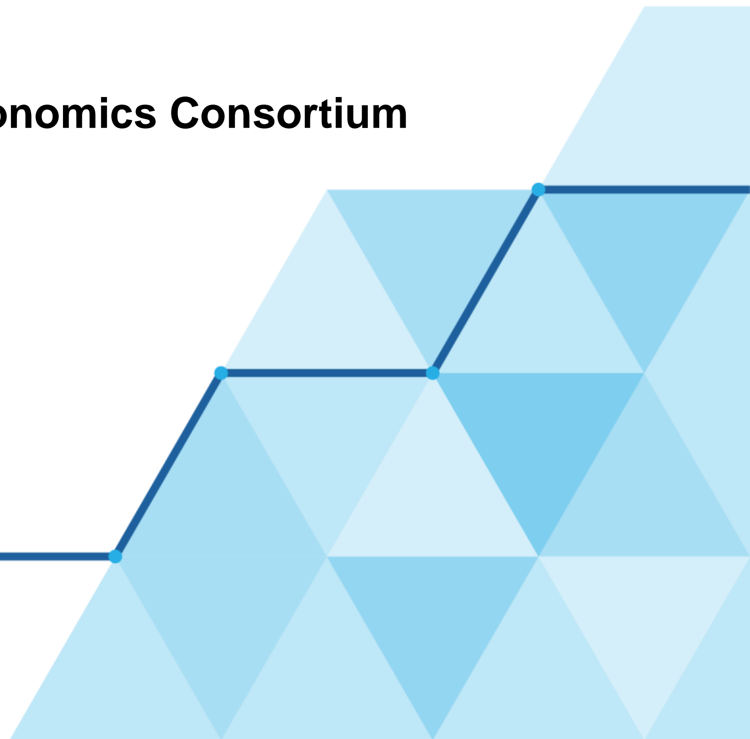
Ministry of Justice

Evaluation of Integrated Advice Hubs in Primary Healthcare Settings

Feasibility Study

IFF Research and York Health Economics Consortium



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IFF Research and York Health Economics Consortium

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1. Executive summary

1.1 Background

In 2019, the Ministry of Justice (MoJ) published the Legal Support Action Plan (the 'Action Plan'), which outlines the department's vision for legal support. As part of the Action Plan, the MoJ committed to test and evaluate the provision of holistic legal support hubs, to generate evidence on how this approach can more effectively support earlier resolution of a person's legal problems.

There are various initiatives underway across the country that creatively deliver legal support alongside other services, including legal advice delivered with healthcare, education and criminal justice services. The initial area of focus is co-located legal support services within primary healthcare settings (e.g., General Practice surgeries), referred to as 'Health-Justice Partnerships' (HJPs) as there are strong links between rights based[1] and health problems and how these issues can cluster. To this end, the MoJ has committed to collecting robust evidence on HJP models currently in use in England and Wales. The MoJ are looking to answer five key research questions.

The MoJ are looking to answer five key research questions:

- RQ1. To what extent does integrating advice in a healthcare setting result in legal problems being resolved earlier?
- RQ2. To what extent does integrating advice in a healthcare setting result in improved socio-economic outcomes for individuals?
- RQ3. To what extent does integrating advice in a healthcare setting result in improved health outcomes?

[1] Citizens have a range of rights, entitlements, and responsibilities, that are underpinned by law and policy. A 'rights-based problem' is a problem accessing, defending or enforcing these rights, entitlements and responsibilities. For example, someone may wish to appeal a decision about their benefit entitlement or take action to enforce an aspect of their tenancy agreement.

- RQ4. What models and types of advice are most effective in securing positive outcomes?
- RQ5. What are the challenges to setting up and delivering integrated services in healthcare settings?

As a first step in exploring how an evaluation could be conducted, IFF Research and the York Health and Economics Consortium (YHEC) were commissioned to conduct an initial feasibility study to ensure the most appropriate evaluation design within the time constraints (2 years and 3 months) and budgetary constraints of the project, involving clients, HJPs and wider stakeholders in the design of the evaluation to ensure that it is fit for purpose.

This report outlines the existing evidence base around HJPs, including how they have been evaluated across OECD countries. The report then presents findings from primary data collection to inform the recommended approach for the evaluation of HJPs in England and Wales. The content of this feasibility study provides valuable learnings on the nature of HJPs operating in England and Wales that can help to inform further evaluations. The Technical Appendix published alongside this report provides details of the types of methodological considerations needed to conduct a robust evaluation of HJPs.

1.2 Findings from the feasibility study

The feasibility study was carried out between January and March 2022 and involved: a targeted literature review of HJPs; depth interviews with six key stakeholders (including government officials, academics and strategic staff from the advice sector), 13 HJP leads (mostly CEOs of advice agencies) and seven HJP clients; the development of the existing HJP theory of change (ToC); and the development of an evaluation framework to map out how the ToC could be evidenced in a further evaluation.

Literature review

The purpose of the literature review was to gain a good understanding of the evidence base around HJPs, contribute to the ToC and to inform possible evaluation methods. A structured but pragmatic approach was taken, which updated a recent systemic scoping review by Beardon et al. published in 2021 [1]. The search strategy modelled the search

terms used by Beardon et al and included structured searches of academic literature and a review of grey literature from appropriate sources. 39 documents that report on evaluations or case studies of partnerships between healthcare and legal or rights advice services published from 2018 to current were selected and extracted. An additional 30 documents from the website searches were also selected and extracted.

The results of the literature review found many positive outcomes for co-located services. For example, Beardon et al [1] found strong evidence for improved socioeconomic circumstances of individuals, mental health, legal problems, and found evidence that HJPs may address inequalities. Reece et al [2] reported financial gains and increased financial security for individuals, plus a reduced burden on primary and secondary health care services. A service evaluation in Glasgow [3] found substantial financial gains for people obtaining money advice from a service embedded in a General Practice (GP) surgery.

The literature review also highlighted research gaps and challenges that may guide possible evaluation methods. There was a need identified for more high-quality studies in areas such as minority groups, inequalities, and how to target interventions. The variety of approaches taken and outcomes measured throughout the literature reflected a lack of a consistent outcome framework for evaluating these types of interventions. These are considerations that can inform how the evaluation progresses. The literature was also examined for specific themes of client drop-off, maximising recruitment, ethical considerations, professional development, translation services access for black and minority ethnic groups and disabled people.

Primary Research

As part of the feasibility study we conducted six key stakeholder interviews, 13 interviews with HJP leads and seven interviews with HJP clients. Alongside the literature review, these qualitative interviews helped inform the development of the ToC, provide insight to the nature of existing HJPs - enabling the development of the model structure detailed in Chapter 4, and ultimately provide pragmatic details on how HJPs operate which instructed the design of the proposed evaluation.

Interviews with key stakeholders

Stakeholders spoke positively about different types of models but suggested that physical co-location is the 'gold standard' approach, as it facilitates genuinely integrative and joined-up working, which positively impacts outcomes for users and the wider system. However, more evidence on the different models and associated outcomes was felt to be needed, alongside sharing examples of best practice. Views on the potential positive impact of a national agenda on HJPs were mixed, with some concerns about moving away from localised support and the uncertainty of priorities in an ever-changing political landscape.

Stakeholders were broadly positive about the evaluation's Theory of Change but suggested some changes, which we later incorporated and suggest exploring in the process evaluation interviews. The suggested changes include:

- the inclusion of community involvement as an 'input', because this was described as being a key factor of success in established HJPs e.g., the Bromley by Bow Centre; and,

- the inclusion of 'training for health professionals' as an input, because of the acknowledgement that successful HJPs require engagement from healthcare professionals, who are often time-poor and therefore need to feel confident about the potential benefits of HJPs to patients and the wider system.

HJP Leads

HJP leads described a range of different models with varying sources of funding (e.g., from Primary Care Networks or Local Authorities), referral systems (e.g., formal booking systems or informal signposting) and ways of delivering different types of advice (e.g., face-to-face/remotely and one-off advice/ongoing casework). These interviews helped to shape our understanding of the different types of HJP models, identify the feasibility of conducting research with users and identify the availability of hub-level data that could be shared for analysis. These insights contributed to the design of our suggested approach to the process and impact evaluations.

HJP clients

The seven clients interviewed as part of the feasibility study were experiencing a range of mental and physical health issues and sought legal advice for a number of reasons relating to finances (benefits and pensions), relationships or housing. Some clients were referred to the legal advice directly by a healthcare professional, such as a GP or nurse, whilst others were signposted to advice. In some cases, the legal advice was provided within the healthcare setting, which was felt by some to be advantageous due to ease of access. In other areas, the legal advice was provided at a central location or remotely due to the Covid-19 pandemic. Clients spoke positively about the referral experience and the provision of advice. In many cases, clients reported that their legal issues had been resolved and suggested a range of positive outcomes, including on their mental and physical health, finances or housing situation. In addition, some clients reported feeling more confident about knowing how to deal with a similar issue in the future and who to seek advice from. We suggest exploring these themes with a larger group of clients as part of the process evaluation, with some follow-up interviews to explore the potential longitudinal impacts of receiving support through an HJP.

Nature of the HJPs

The literature review alongside the depth interviews with stakeholders, HJP leads and HJP clients revealed that there are two main ways that the models of HJPs vary from one another; and consequently, that there are three main models of HJPs that should be included in the full evaluation.

The first way that HJPs vary is dependent on whether they are physically onsite or co-located at the healthcare setting (i.e., the GP practice contains a physical space on their premises for the advisor to meet with clients) or whether the clients must visit the advisor outside of the health care setting (either physically in an alternative location like the Citizens Advice office, or remotely via telephone or video conferencing).

The second way that HJPs vary is according to the referral process used to refer clients from the healthcare setting to the advice provider. At the more involved end of the spectrum is a referral process which is structured and uses a consultation booking system (using a process such as an online portal) with information about the client (such as the nature of their issue) shared between the health providers and advisors. The mid-tier

referral type occurs when healthcare providers use a consultation booking system to create advice appointments for clients, but the healthcare provider does not share information about the client with the advisors. The least involved referrals occur when the healthcare provider signposts to the patient that they should contact the advisors or when the client refers themselves to the advisor.

The decision to group HJPs into models based on their physical co-location and their referral process aligns with the main distinguishing factors identified in the definitions of HJPs, integrated services and co-located services used in the literature:

- **Health Justice Partnerships:** HJPs or Medical-Legal Partnerships (MLP) can be generally understood to include services in which legal and social services are provided in a healthcare setting. To note some definitions from included papers, an evaluation of MLPs in the US from Nerlinger et al (2021) [26] described MLPs as "a prime example of a health system–community partnership that incorporates legal assistance as an integral component of medical care." An Australian paper from Inner Melbourne Community Legal (2018) [19] evaluating HJPs in various Melbourne hospitals stated that "HJPs integrate legal assistance into a healthcare setting." Beardon et al [1] defined "health-justice partnership" broadly as the provision of legal assistance for social welfare issues in healthcare settings.
- *In this report we have adopted Beardon et al's broad definition of HJPs to refer to all models of health justice initiatives included in this study.*
- **Integrated services** (within the context of health justice initiatives): Integration of services can follow various models. A report on the health justice landscape in England and Wales noted that, rather than following a single model, most were unique local arrangements developed independently and could include co-located services, referral pathways and integrated multidisciplinary teams. The authors reported that the majority of legal services were co-located in healthcare settings (66%), and generally linked to health providers through a referral-based system (86%) (Beardon et al 2018) [12]. Similarly, a systematic review of MLPs serving immigrant communities in the United States (League et al, 2021 [9]) described various forms of integration, including: systems in which lawyers referred clients

to healthcare providers when needed; systems in which healthcare providers referred patients to lawyers when needed; integrated case-management systems; and systems in which medical and legal services were situated together.

- *The degree of integration between the services when the health partner refers the client to the justice partner has influenced how the HJPs included in this study have been allocated to a particular HJP model.*
- **Co-location** (within the context of health justice initiatives): Co-location refers to the physical presence of legal services within a healthcare setting. An international systematic review of HJPs defined co-location as health and legal services as these "being physically located together." (Beardon et al 2021) [1]. A report on the health justice landscape in England and Wales found that the most common healthcare settings in which service partnerships were found were GP practices (49%), followed by mental health services (34%) and hospitals (34%) (Beardon et al 2018) [12].
- *Co-location, or the lack of physical co-location, is the second distinguishing feature which how HJPs have been split into various models for this report.*

The three models of HJPs that we suggest including in the process evaluation are those where the health and justice arms are fairly integrated:

- Model one: A co-located HJP that uses a structured consultation booking system and shares information.
- Model two. A co-located HJP that uses a consultation booking system.
- Model three. A HJP that is not physically co-located but does use a structured consultation booking system and shares information.

Theory of change

A ToC is a visual representation that outlines the activities that a programme is going to undertake (e.g., delivering legal advice to clients in an HJP), the immediate results of the activities (e.g., clients receive appropriate advice/help for their problems), and the outcomes that lead or contribute to the longer-term impacts (e.g., this helps people tackle

their problems swiftly, which in turn helps prevent problem clustering and ultimately reduces demand on the formal justice system).

The MoJ's ToC for HJPs was developed as part of the feasibility study. The original ToC was refined by taking into account findings from the literature review, findings from interviews with hub leads (i.e., managers and CEOs of legal advice centres that work within primary health care setting/s) consultation with key MoJ policy makers and academics.

The ToC builds a shared understanding of what is being evaluated and what key outcomes should be measured. The ToC is the basis for the evaluation framework which maps out the research methods that should be used to evaluate HJPs, ultimately testing how the ToC plays out in the real world.

Evaluation framework

As set out in Chapter 8 the evaluation framework was developed to map out how each of the components detailed in the ToC can be evidenced through the proposed impact, process and economic evaluation set out in Chapters 5, 6 and 7 of this report. Relevant aspects of the evaluation framework are included in each of these methods sections to show how the proposed approach meets the research objectives.

1.3 Recommended evaluation approach

Taking the learnings from the feasibility study into account, as well as the time and budget constraints set by MoJ, IFF and YHEC recommend carrying out an evaluation with the three key strands of an impact evaluation, process evaluation and economic evaluation. Technical details on each strand including the rationale behind the methodological design, risks and limitations, quality assurance and ethical considerations are included in the Technical Appendix published alongside this Feasibility Study.

Impact evaluation

To robustly estimate the impact of HJPs on the speed of resolution of legal problems, better social-economic outcomes and improved health outcomes, it is proposed to carry out 'before' and 'after' surveys with HJP clients who have received legal advice and a

counterfactual comparison group[2] who, through screening, have been identified as also having a legal need. Propensity score matching (PSM) will then be used to match HJP clients with a comparator group to reduce the risk of selection bias.

Process evaluation

To explore the implementation and delivery of HJPs, including the challenges of setting up and delivering integrated health and justice services we recommend a detailed process evaluation, which would involve speaking in depth to all parties engaged with the HJPs.

To gain insight at a high level we suggest the evaluator conducts:

- Two to three depth interviews with **strategic staff** in umbrella body organisations (e.g., the central Citizens Advice office) and healthcare commissioners

Then within each of the three HJP models identified in Chapter 4 we suggest the evaluator conducts:

- Three depth interviews with **HJP leads or managers** (e.g., the local Citizens Advice CEO)
- Three mini-groups with four to five **frontline advisors** working in HJPs
- Five to six depth interviews with **healthcare professionals**
- 20 depth interviews with **HJP clients** soon after they have been had their first meeting with the advisor and then 10 follow up interviews with these participants six months after their first appointment (the smaller follow-up sample size accounts for the expected attrition between interviews).

Economic evaluation

The economic evaluation will support the process and impact evaluation by considering the financial and economic costs and benefits of the intervention. The evaluation will aim to quantify in economic terms:

[2] The counterfactual group is a group that have not received support from an HJP, and so act as a proxy for what would have happened to the HJP clients in the absence of the HJP support.

- Changes in resource use in the justice and health and social care systems, as well as any other relevant government departments;
- Impacts on individuals relating to improved access to justice and resulting health benefits;
- Wider societal benefits, such as the 'spill over' effects of the creation of additional employment or getting people back to work.

Incremental costs and outcomes of implementing interventions will be identified, measured and valued as part of the economic evaluation. A cost-benefit analysis (CBA) approach will be used that includes a comparison of interventions and consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary terms. This will allow for the costs and benefits relating to interventions to be appraised consistently with financial values attached to costs and benefits.

2. Introduction

2.1 Background and policy context

Context

A large proportion of English and Welsh citizens experience a need for legal or rights-based advice at some point. Recent research by the Legal Services Board and the Law Society[3] provided the largest ever survey of legal needs in England and Wales. It found that over six in ten (64%) adults had experienced a legal problem in the last four years and half (53%) had faced a contentious legal problem. Modelling suggested that those experiencing a contentious legal problem comprised 22% who had their legal needs met through gaining adequate professional help, and 31% of adults who had unmet legal need – because they did not get professional help, wanted more help or their issue took longer than two years to resolve.

The fact that legal rights-based problems and health problems can present together makes a case for the potential value of co-located advice. Research has also shown that people experiencing legal problems often approach friends and family first for help or turn to trusted members of the community such as GPs. GPs have also reported that they are increasingly seeing patients with unaddressed social welfare issues as a result of cuts to Legal Aid and reduced local authority resources[4].

HJPs

The idea of co-locating legal advice in healthcare settings is not new, and HJPs have been in existence since the late 1980s. Partnerships between social welfare, legal services and healthcare services aim to support individuals with issues affecting their physical and mental health, whilst assisting healthcare professionals in managing non-clinical demand. They seek to improve access to legal advice for people most in need and address underlying causes of ill health and inequalities.

A mapping study[5] by the UCL Centre for Access to Justice (2018) found a diverse range of activity across 383 different health and justice services. It found that the type of organisations offering legal advice in healthcare settings included charities, local authorities, health services, independent

[3] 'Legal Needs of Individuals in England and Wales: Summary report 2019/20' The Legal Services Board and the Law Society (Jan 2020)

[4] 'Healthy Legal Advice: Findings from an Opinion Poll of GPs' Legal Action Group (2014)

[5] 'The Health Justice Landscape in England & Wales: Social welfare legal services in health settings' S Beardon & H Glenn, UCL Centre for Access to Justice (2018)

organisations and partnerships of providers. The most common advice providers were the Citizens Advice Bureau (CAB) and Macmillan Cancer support. The arrangements for offering the advice were typically built independently through local relationships, leading to diverse and innovative examples. The settings where advice was delivered were most often GP practices (49%), followed by mental health services (34%) and hospitals (34%); but a wide range of other settings were represented including hospices, care homes and community health centres. Legal assistance ranged from first-line advice to in-depth casework, legal representation and consultancy; with support ranging from filling in application forms for benefits, representing people at tribunals, to taking direct action on behalf of individuals.

Potential benefits of co-locating legal and health support services

There is evidence to suggest that co-location has dual positive impacts on both the legal and the health outcomes for the individuals. Linking legal services to health settings can improve access for people who would not otherwise seek professional legal advice[6], thus leading to swifter resolution of their legal problem. In addition, various research studies have suggested mental health benefits to those receiving advice such as reducing financial strain, anxiety and stress[7,8.]Physical health benefits can be harder to demonstrate but some studies have shown positive links; for example a 2012 study suggested improvements to blood pressure, sleeping patterns and healthy behaviours, and reduced medication use and contact with primary healthcare[9].

A recent literature review (carried out by researchers at UCL and Kings College London, 2021)[10] synthesised the international evidence on the impact of HJPs (through a comprehensive search of the literature over the period 1995-2018). The review found, “strong evidence that health justice partnerships improve access to legal assistance for people at risk of social and health disadvantage; positively influence material and social circumstances through resolution of legal problems; and improve mental wellbeing”.

[6] ‘Citizens Advice in Primary Care: A Qualitative Study of the Views and Experiences of Service Users and Staff’ J Burrows and others, 125 Public Health (2011)

[7] ‘The Role of Advice Services in Health Outcomes’ A Parkinson & J Butterick, The Low Commission and Advice Services Alliance (2015)

[8] ‘Impact of Co-Located Welfare Advice in Healthcare Settings: Prospective Quasi-Experimental Controlled Study’ C Woodhead and others, 211 British Journal of Psychiatry (2017)

[9] ‘An Overview of Possible Links Between Advice and Health’ G Crofton-Martin (Citizens Advice Bureau, 2012)

[10] ‘International Evidence on the Impact of Health Justice Parterships: A systematic scoping review’ S Beardon, C Woodhead, S Cooper, E Ingram, H Glenn, R Raine (Public Health Reviews, April 2021).

Policy context

The MoJ Legal Support Action Plan[11] outlines a commitment to delivering smarter, better forms of legal support and initiatives. To achieve this, co-locating support services are identified as one strategy as part of a holistic approach.

As part of the Action Plan, the MoJ is committed to test and evaluate the provision of holistic legal support hubs, to collect more evidence on whether the models currently in use in the UK allow for earlier resolution of people's legal problems. Whilst the MoJ already believes the general case that early advice can lead to benefits for individuals and cost savings to the public sector, it is seeking more evidence on what works for whom and at what point.

Whilst the plan acknowledges that voluntary sector organisations are already delivering a range of advice, it is concerned that some people do not know where to seek support and may fall through the net since referrals into these initiatives is often reliant on local or personal relationships. Co-location may be a route to address this.

The broader context faced by the MoJ is described in its most recent Outcome Delivery Plan[12] where three over-arching strategic objectives are set out against the backdrop of recovering from the Covid-19 pandemic and resulting backlogs on the courts. The idea of holistic legal support hubs, co-located with other services plays into the third strategic objective which is around swifter access to justice, a stronger smarter courts and tribunal system and making sure the vulnerable are supported in the justice system. If co-located advice hubs can help to resolve people's legal problems earlier, then this should reduce the burden on the system with fewer cases needing to go to court or tribunal.

[11] 'Legal support: The Way Ahead. An action place to deliver better support to people experiencing legal problems' Ministry of Justice (Feb 2019)

[12] Ministry of Justice Outcome Delivery Plan 2021-22 (15th July 2021)

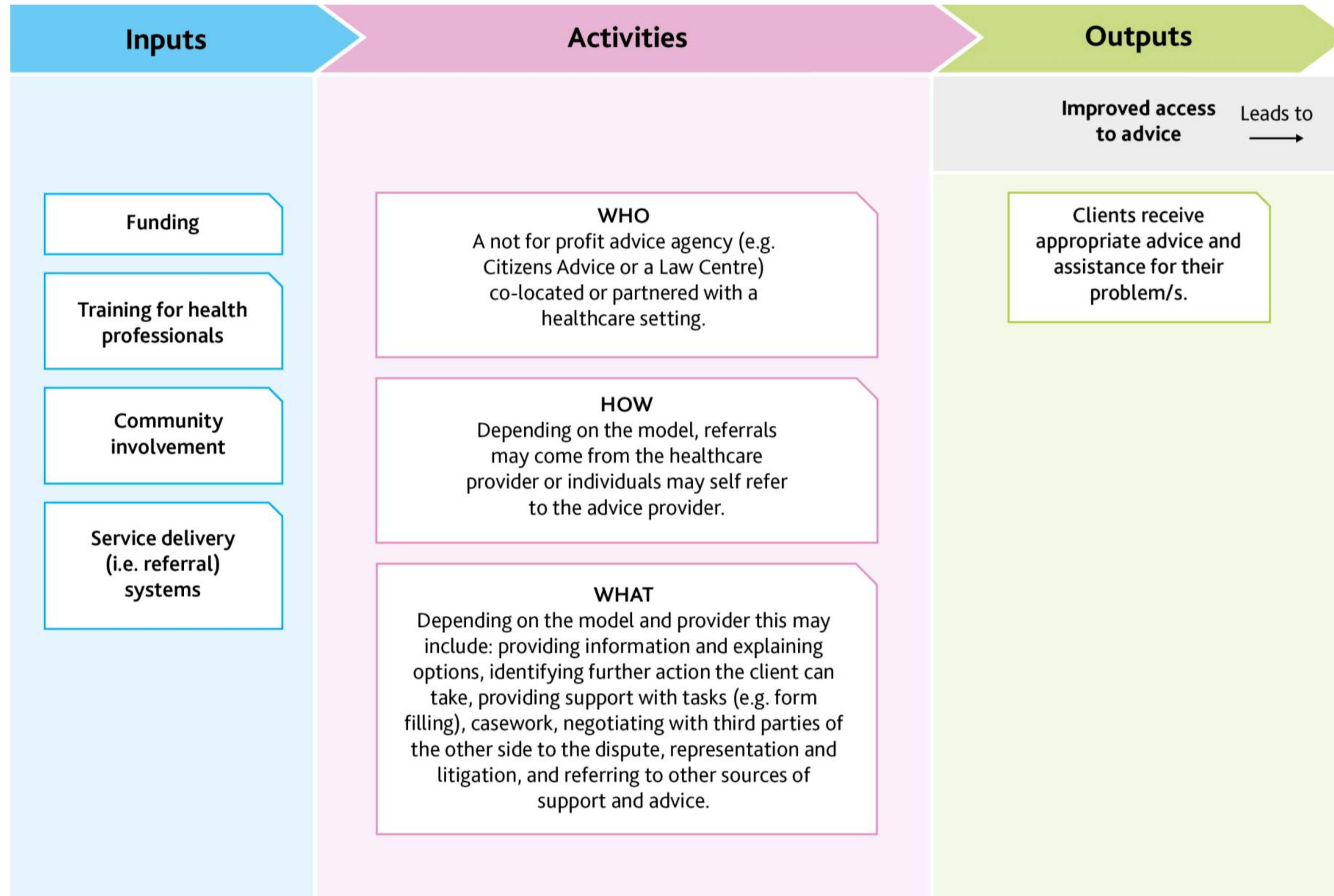
2.2 Theory of change for HJPs

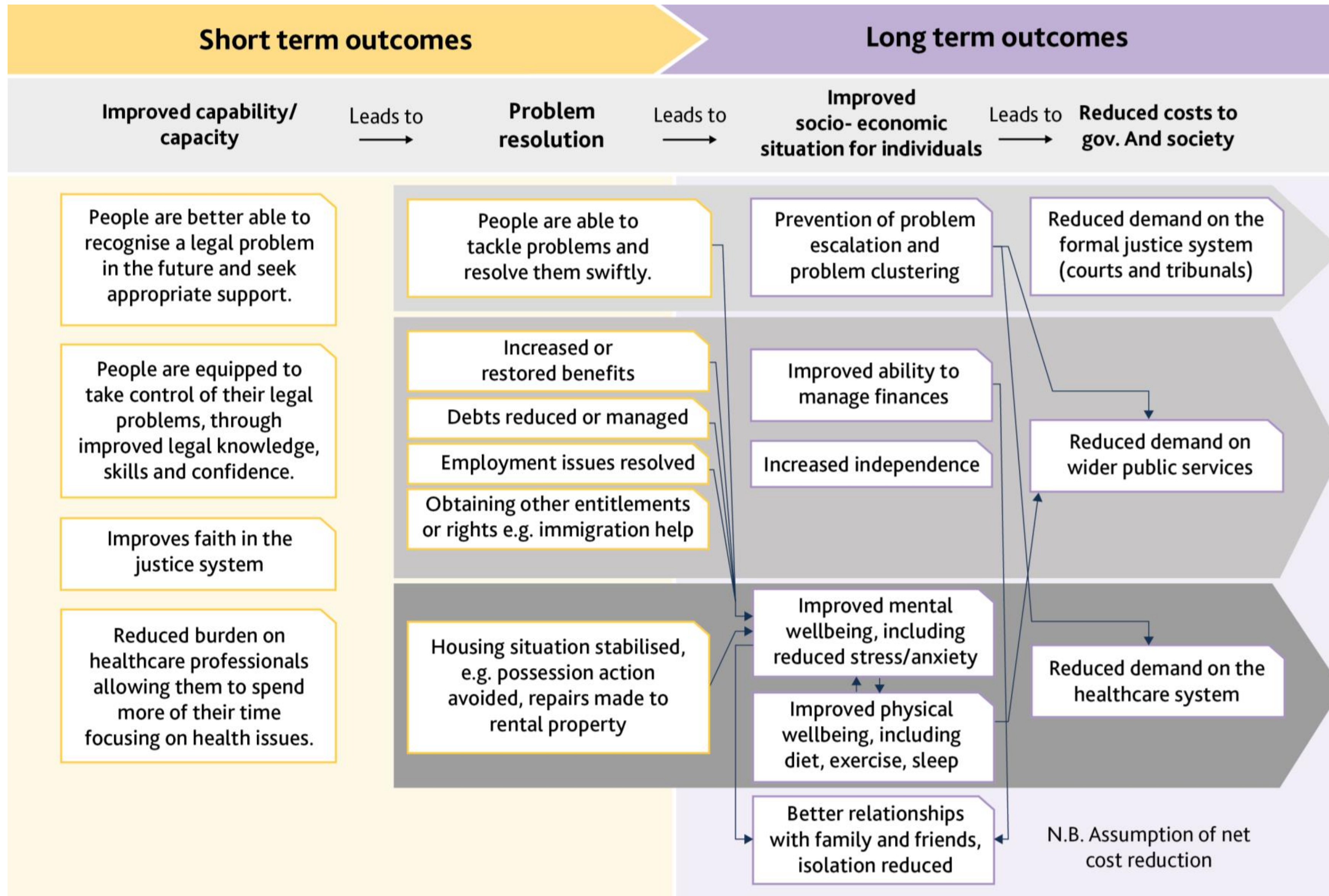
The ToC (presented in Figure 1) visually illustrates how the various inputs, activities and outputs which make up HJPs are expected to lead to the short-term outcomes and then longer-term outcomes of:

- reduced demand on the formal justice systems (courts and tribunals);
- reduced demand on wider public services; and
- reduced demand on the healthcare system.

To simplify the relationships between outcomes, blocks of colour/shading show where there are broad ‘leads to’ relationships, with smaller arrows showing where relationships cut across these broad categories. It is important to note that the ToC provides an overarching explanation of HJPs as a whole, but not all elements will apply to every HJP.

Figure 1: HJP theory of change




Short term outcomes
Long term outcomes
Improved capability/ capacity
Leads to
Problem resolution
Leads to
Improved socio- economic situation for individuals
Leads to
Reduced costs to gov. And society
People are better able to recognise a legal problem in the future and seek appropriate support.
People are equipped to take control of their legal problems, through improved legal knowledge, skills and confidence.
Improves faith in the justice system
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.
People are able to tackle problems and resolve them swiftly.
Increased or restored benefits
Debts reduced or managed
Employment issues resolved
Obtaining other entitlements or rights e.g. immigration help
Housing situation stabilised, e.g. possession action avoided, repairs made to rental property
Prevention of problem escalation and problem clustering
Improved ability to manage finances
Increased independence
Improved mental wellbeing, including reduced stress/anxiety
Improved physical wellbeing, including diet, exercise, sleep
Better relationships with family and friends, isolation reduced
Reduced demand on the formal justice system (courts and tribunals)
Reduced demand on wider public services
Reduced demand on the healthcare system
N.B. Assumption of net cost reduction

See Appendix A for a detailed explanation of the ToC including the context and problem statement as well as assumptions, risks and external influences (which are not included in the ToC for ease of presentation).

This ToC was developed as part of the feasibility study. It builds on the original MoJ ToC by taking into account findings from the literature review, findings from interviews with advice hub leads (i.e., managers and CEOs of legal advice centres that work within primary health care setting/s) consultation with key MoJ policy makers and academics.

As a whole, the ToC plays a crucial role in both the design of the evaluation and in the analysis and reporting of evaluation findings as it:

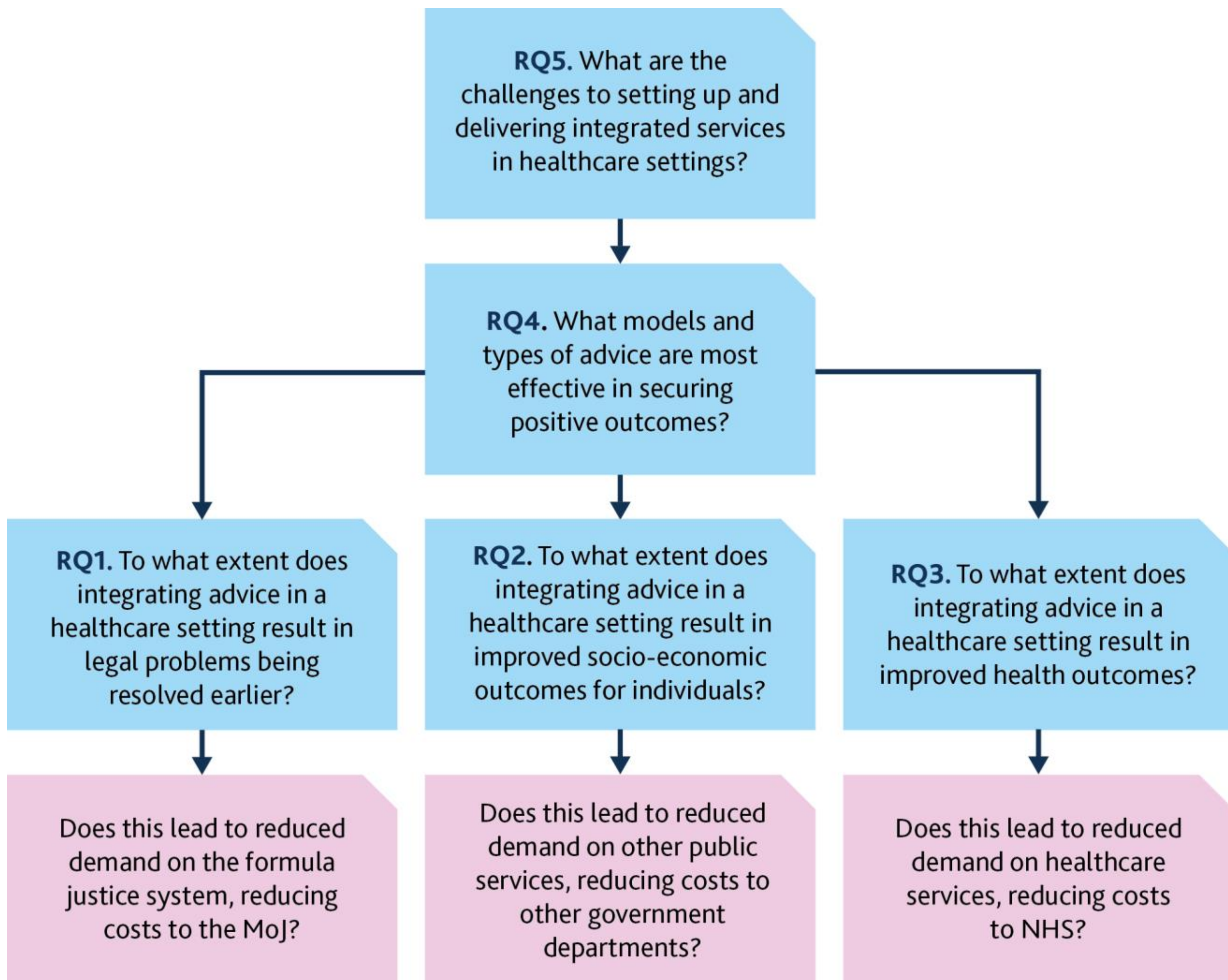
- builds a shared understanding of what is being evaluated and what key outcomes will be measured;
- shapes what will be explored through the evaluation in order to demonstrate the programme’s value; and
- supports interpretation of the evaluation findings.

The ToC should be reviewed and monitored throughout the evaluation and a final version, updated as necessary, incorporated into the final evaluation report.

3. Aims and objectives

As part of the Action Plan, the MoJ want to collect robust evidence, including quantitative evidence, on whether the HJP models currently in use in England and Wales mean that people with legal problems who otherwise would not have received legal support do so as a result of these HJPs and whether this leads to earlier resolution of people's legal problems. This evidence is needed to inform the MoJ's activity in this area. MoJ are looking to answer five key research questions, which are presented graphically in Figure 2[13].

Figure 2: Evaluation research questions



[13] References to co-location have been changed from the Invitation To Tender to integrated services, reflecting the fact that not all the models explored have advice services sharing physical space with healthcare services.

To answer these research questions, the MoJ is considering an evaluation covering four specific objectives:

- Objective one: To conduct a **feasibility study**, to design and agree the most appropriate methodology for an impact evaluation that can address RQ1, RQ2, RQ3, RQ4.
- Objective two: Explore **implementation and delivery** of co-located advice in primary healthcare settings (process evaluation, to address RQ5).
- Objective three: Collect evidence and conduct analysis to understand **any change in outcomes** and, if possible, to what extent are they attributable to the HJPs (impact evaluation, to address RQ1, RQ2, RQ3, RQ4).
- Objective four: Use the evidence related to the change in outcomes to determine the **financial and economic benefits**, including potential economic benefits to Government and wider society (economic evaluation, to address RQ1, RQ2, RQ3).

3.1 Approach to the feasibility study

HJPs are an interesting but complex area to evaluate. As a first step it is necessary to conduct a detailed feasibility study to scope out what evaluation design is possible within MoJ time and budgetary constraints, before committing to a full evaluation of HJPs in England and Wales. Together with MoJ, IFF Research and the YHEC undertook a targeted literature review, primary research and the development of an evaluation framework as part of the feasibility study.

Targeted literature to inform research design and inform the refinement of the ToC. The literature review sought to gain an in-depth understanding of the evidence base around HJPs, which research methods have been used to evaluate similar interventions in the past, synthesise what is known, and identify challenges to consider for the evaluation. The findings have contributed to the ToC and will be used in more detail going forward to inform possible economic evaluation methods. The literature review adopted a structured, transparent, repeatable but pragmatic approach. As well as carrying out structured

searches of academic literature, we also reviewed grey literature from appropriate sources such as the Social Care Institute for Excellence and the Joseph Rowntree Foundation.

Conducting primary research including interviews and consultations to further inform research design and refinement of the ToC. Interviews with key stakeholders, HJP leads (typically the CEOs or Managers of Citizen Advice Services) and HJP clients were carried out alongside a consultation workshop with key project contributors and stakeholders to inform the ToC and the proposed evaluation design.

Information gained from the literature review, interviews and consultations with key stakeholders was used to build upon the existing MoJ ToC. The information collected through these modes was triangulated to ensure the ToC accurately depicts the aims, processes, assumptions, outcomes and impacts for HJPs, and that it illustrates the mechanisms for change and how activities are translated into the intended impacts on clients/beneficiaries. Using an accurate ToC is crucial for ensuring that any proposed evaluation designs measure the right things, in the right way.

The primary research allowed the research team to develop a deeper understanding of the policy context around HJPs, which informed the ToC, and also to identify the information which was already being collected by HJPs and the gaps in this information which would need to be collected through further research in order to test how the ToC was playing out in the real world. Interviews with stakeholders, HJP leads and clients allowed the research team to assess: the willingness of HJPs to take part in the larger evaluation project; the type and quality of management information held by the HJPs – as well as their ability to share it; the number of new HJP clients that are moving through each hub; the background, initial set up process and operational structure of each HJP; the referral process from the health to the justice partners; the types of clients referred and the legal issues they have; expected outcomes from the HJP; and the initial views and perceptions of HJP clients after receiving advice.

The following primary research was conducted as part of the feasibility study:

- **Six stakeholder interviews** carried out between 4th and 24th February 2022. The stakeholder interviews provided a deeper understanding of the policy landscape and the rationale behind MoJ's interest in integrated advice hubs. These

stakeholders were a mix of government officials from MoJ, academics and strategic staff from the advice sector.

- **13 interviews with HJP leads** across England and Wales, between 28th January and 24th February 2022**.** Of the 13 interviews, nine were with advice hub CEOs, and the remaining four were with a development manager, funding project manager, income and inclusion manager and team leader. These interviews provided a detailed understanding of the operational model for each HJP as well as interrogated the existing data that is collected and held that may be of benefit to the evaluation.
- **Seven interviews with HJP clients** carried out between 16th and 23rd February 2022. These interviews ensured that the voice and concerns of HJP clients was heard and considered in the evaluation design and the development of the ToC.
- **An online workshop to refine the ToC with key project contributors** from MoJ, YHEC, IFF and Dr. Sarah Beardon (an expert on HJPs) was held on 10th March 2022. The workshop used the expert knowledge of the attendees and the findings from interviews and literature review to refine the ToC.

An evaluation framework, based on the ToC, was developed. The information from the ToC was carried forward into an evaluation framework which maps how each of the outcomes and impacts in the ToC can be evidenced, providing a proposed road map for a full evaluation of HJPs.

The full evaluation framework table is presented in Chapter 8, after the findings from the feasibility report have been presented and the discussion on best evaluation design in Chapters 5, 6 and 7. The evaluation framework maps the components of the ToC (the inputs, activities, outputs, outcomes and assumptions) and the indicators that they represent (i.e. the underlying question of each component) to the relevant data source (e.g. primary research or management information) that will be used to collect this information and the audience (e.g. HJP clients or HJP leads) of who can best provide that information. The evaluation framework highlights where it might not be possible to seek evidence over the timeframe available for the evaluation and also how benefits/impacts could be monetised.

The remainder of this report is split into two broad sections.

- The **findings from the feasibility study**; this section presents the literature review and the findings from the primary research; concluding with how these findings have informed our understanding of the nature of HJPs and how best they can be included in an evaluation.
- The **proposed approach for the evaluation**; this section outlines a possible approach to evaluating HJPs through an impact evaluation, process evaluation and an economic evaluation. This section concludes by presenting an evaluation framework demonstrating how each of the three research strands could be brought together to test the ToC.

4. Feasibility study findings

4.1 Literature review findings

The purpose of the literature review was to gain a good understanding of the evidence base around HJPs, which research methods have been used to evaluate similar interventions in the past, synthesise what is known, and identify challenges to consider for the evaluation. The findings have contributed to the ToC and will be used in more detail going forward, to inform possible evaluation methods. This chapter presents the key findings from the literature review. For more detail on the search methods used as well as a synopsis of each of the studies included in the review, please see Appendix B.

Search methods

This literature review builds on Beardon et al (2021) [1] systematic scoping review of international evidence on the impact of HJPs from January 1995 to 13 December 2018, using the same search terms and starting at the point in time that the Beardon et al searches finished in 2018 [12]. The search strategy for this literature review was structured and searched through academic literature and grey literature using the following conceptual structure:

- Health-justice partnerships OR (legal/rights advice AND healthcare settings).
- Searches were limited to English language publications with a publication date of 1 December 2018 (the cut-off date for Beardon et al (2021) to current date (up to 22 February 2022).

Full database search strategies are available on request and more detail on the search methods can be found in Appendix B.

Key findings

The following section summarises the types of studies included in the review, comments on the evaluation methods used and challenges identified in conducting a robust impact evaluation of HJPs.

Evaluation methods and content

Tables 1 and 2 show a summary of the study types included in the content review and the key aspects considered by the different types of study. The most relevant and robust studies were considered to be those where the service described was very similar to the HJP intervention, and the study methods did not display methodological limitations, such as low numbers where this was required by the study method, or lack of a comparator. There were two systematic reviews of evidence in addition to the Beardon et al 2021 systematic review [1], which were used as the basis for the literature searches. There was only one randomised control trial (RCT). The remainder of the studies in this category comprised a range of good quality case studies and service reviews/evaluations, adopting quasi-experimental and theory-based approaches designed to test whether an intervention led to expected outcomes. All the studies covered the topic of evaluation, with the majority including some of the evaluation outcomes of interest to this project i.e., individual health, legal/welfare outcomes for individuals, use of other services, and economic costs and benefits. Half of the studies focused specifically on primary care and three concerned services that were underpinned by partnership but were not co-located. Of the 21 records which were reporting on service interventions in non-UK countries, 14 were in the USA, five in Australia and one in Canada. This likely reflects the fact that the USA and Australia have established health justice networks.

Less relevant/robust studies were those where the intervention was similar, but not exactly the same as the HJPs that this project is focused on, such as patient navigators in an emergency department, or social prescribing with links to Primary Care Networks. This category also included studies where the intervention was very similar, but there were limitations to the study methods used. Further, methodological limitations were considered when assessing robustness. For example, trials with low participation numbers were considered less robust, as were studies with high rates of loss to follow-up in survey responses. Other considerations included the composition of control arms; in one study it was noted that the control arm was not randomised but composed of all patients who refused the legal services intervention (Malik, 2018) [38]. Studies were also considered less robust where there was limited reporting of the study methods or results. The majority were service evaluations and used case study, mixed methods and observational

approaches to assess the impact of the interventions described. Eight of these studies focused specifically on primary care.

Across all studies, a mixed methods approach was common, with both quantitative and qualitative methods used. Examples of quantitative measures were GP attendances, A&E attendance, value of benefits claimed, clients' health and wellbeing measures and quality of life scores. Examples of qualitative methods included GP/client surveys, interviews with staff and stakeholders. There was one example of focus group interviews.

Table 1: Study types included in the literature review

Study type	Most relevant & robust study design	Partly relevant and/or less robust study design
Systematic review.	3 [1], [2], [9]	-
RCT.	1 [7]	2 [23], [24]
Evidence/literature review.	1 [10]	3 [16], [17], [25]
Service review.	2 [11], [5]	-
Mixed methods evaluations (including observational studies).	1 [12]	9 [19], [20], [26], [47], [27], [28], [29], [30], [32], [34]
Case study.	3 [8], [6], [4]	5 [14], [15], [21], [35], [36]
Evaluation paper.	1 [3]	6 [13], [46], [18], [22], [33]
Record analysis.	-	1 [31]
TOTAL	**12**	**26**

Table 2: Content of studies summarised within the literature review

Study content	Most relevant & robust study design	Partly relevant and/or less robust study design
Primary care setting.	6 [1], [2], [3], [4], [8], [9]	8 [18], [22], [25], [28], [30], [31], [34], [36]
Secondary care setting.	3 [1], [2], [9]	8 [13], [46], [18], [19], [20], [25], [32], [33]
Other healthcare (mixed).	5 [1], [2], [5], [6], [9]	6 [13], [16], [25], [47], [29], [35]
Partnership but not co-located.	3 [1], [7], [9]	4 [13], [23], [24], [28]
Other setting.	3 [10], [11], [12]	7 [14], [15], [16], [17], [18], [21], [25]
UK based.	8 [1], [2], [3], [4], [8], [9], [11], [12]	9 [13], [14], [15], [16], [17], [18], [22], [24], [27]
Evaluation: content.	12 [1], [2], [3], [4], [5], [6], [7], [8], [9], [10], [11], [12]	22 [13], [46], [14], [16], [17], [18], [19], [20], [21], [22], [23], [24], [25], [47], [27], [28], [29], [30], [31], [32], [33], [34]
Evaluation: challenges/lessons.	9 [1], [2], [3], [4], [5], [7], [8], [10], [12]	11 [13], [46], [16], [17], [18], [19], [20], [22], [24], [26], [28]
Evaluation: economic.	8 [2], [3], [4], [5], [7], [8], [10], [12]	11 [13], [46], [16], [17], [19], [20], [21], [22], [24], [25], [47]
Outcomes: individual health.	9 [1], [2], [4], [5], [6], [7], [8], [10], [12]	15 [13], [46], [14], [16], [17], [18], [19], [20], [21], [22], [23], [24], [47], [27], [28]
Outcomes: individual legal/ welfare/ financial/ housing.	11 [1], [2], [3], [4], [5], [6], [7], [8], [9], [10], [12]	18 [13], [46], [14], [15], [16], [17], [18], [19], [20], [21], [22], [23], [24], [47], [30], [31], [32], [34]
Service use by patients.	10 [1], [2], [3], [4], [5], [6], [8], [10], [11], [12]	13 [13], [46], [16], [17], [18], [19], [20], [21], [22], [23], [24], [25], [47]
Knowledge sharing/joint working.	6 [5], [6], [8], [10], [11], [12]	11 [13], [46], [14], [16], [17], [18], [19], [21], [22], [29], [33]

Table 3: Summary of study methods and outcomes for most relevant/robust studies

Study Title	Study Method	Outcomes measured	Results
Beardon S, Woodhead C, Cooper S, Ingram E, Genn H, Raine R. International Evidence on the Impact of Health-Justice Partnerships: A Systematic Scoping Review. [1]	Systematic review.	Individual health outcomes. Service use by individuals – legal/ welfare/ financial/ housing.	Strong evidence HJPs improved socioeconomic circumstances, mental health, legal problems. Evidence that HJPs may address inequalities.
Reece S, Sheldon TA, Dickerson J, Pickett KE. A review of the effectiveness and experiences of welfare advice services co-located in health settings: A critical narrative systematic review. [2]	A narrative systematic review.	Individual health outcomes. Service use by individuals- legal/ welfare/ financial/ housing.	Evidence that access to co-located services improved knowledge about welfare rights, health and wellbeing, financial gains, financial security. Evidence that co-located welfare rights advice reduces the burden on primary and secondary health care services.

Study Title	Study Method	Outcomes measured	Results
Egan J, Robison O. Integrating money advice workers into primary care settings: An evaluation. [3]	Evaluation paper.	Service use by individuals- legal/ welfare/ financial/ housing.	Financial gains for individuals who engaged in the services. Individual's debt was identified and managed.
Begum T. Tower Hamlets: Co-located advice in primary care settings.[4]	Case study.	Individual health outcomes. Service use by individuals- legal/ welfare/ financial/ housing.	Advice services in GP settings improved accessibility- particularly for elderly and frail patients. Service prevented patient drop-off between referral and attendance. Reduction in non-clinical demands for GPs. Improved health outcomes for those using the service, e.g., reduced stress.
Allison F. Evaluation of the law right Wuchopperen health justice	Service review.	Individual health outcomes. Service use by individuals- legal/ welfare/ financial/ housing.	Clients identified that the legal clinic improved their wellbeing. Legal issues were addressed earlier and some legal issues were able to be averted

Study Title	Study Method	Outcomes measured	Results
partnership and law yarn. [5]		Knowledge sharing/joint working.	altogether, or prevented from escalating.
National Center for Medical-Legal Partnership. Complex Care and Medical-Legal Partnerships. [6]	Case study.	Individual health outcomes. Service use by individuals– legal/ welfare/ financial/ housing. Knowledge sharing/joint working.	When patients' legal needs were addressed the inpatient and emergency department use reduced and overall health costs reduced.
Haighton C, Moffatt S, Howel D, Steer M, Becker F, Bryant A, et al. Randomised controlled trial with economic and process evaluations of domiciliary welfare rights advice for socioeconomically disadvantaged older people recruited via primary health care (the Do-Well study). [7]	A randomised control trial (RCT).	Individual health outcomes. Service use by individuals- legal/ welfare/ financial/ housing.	Domiciliary welfare rights advice was more effective but more costly than usual care when it was delivered in the patients' homes. The study did not find a statically significant impact of the intervention on health outcomes or cost-effectiveness.

Study Title	Study Method	Outcomes measured	Results
Genn H, Beardon S. Law for health: Using free legal services to tackle the social determinants of health. [8]	Case study.	Individual health outcomes. Service use by individuals- legal/ welfare/ financial/ housing. Knowledge sharing/joint working.	Significant improvements to quality of life. An association found between legal problem resolution and significantly greater improvements in health and wellbeing scores (EQ-5D and SWEMWBS).
League A, Donato KM, Sheth N, Selden E, Patel S, Cooper LB, et al. A Systematic Review of Medical-Legal Partnerships Serving Immigrant Communities in the United States. [9]	Systematic review.	Individual legal/ welfare/ financial/ housing.	Successful partnerships are formed from sharing cultural competencies (the ability of staff to be respectful and understanding towards patients' beliefs, religion, and health needs) and from educational information. These factors can improve financial outcomes for migrants.
Murphy C. Making the case for medical-legal partnerships: An updated review of the evidence, 2013-2020. [10]	Evidence/literature review.	Individual health outcomes Service use by individuals- legal/ welfare/ financial/ housing. Knowledge sharing/joint working.	Positive improvements were reported across five key outcomes: 1) the health and wellbeing of patients; 2) housing and utility stability among patients; 3) access to financial resources among patients; 4) healthcare

Study Title	Study Method	Outcomes measured	Results
			systems and workforce; 5) policies, laws, and regulations.
Goodman J, Thomas S, Pointing E. How social welfare legal advice and social prescribing can work collaboratively in healthcare settings. [11]	Service review.	Service use by individuals. Knowledge sharing/joint working.	Funding should be targeted. Funding should supplement NHS England funding for link workers to enable social welfare legal advice services to meet demands.
Beardon S, Genn H. The health justice landscape in England & Wales: Social welfare legal services in health settings. [12]	Mixed methods evaluations (inc. observational studies).	Individual health outcomes. Service use by individuals- legal/ welfare/ financial/ housing. Knowledge sharing/joint working.	Issues addressed included welfare benefits, debt, and housing. The type of assistance provided ranged from first-line advice to in-depth casework. Funding of the services was reported as fragile and short-term, mostly coming from local authority and charity sources.

A number of challenges were identified when evaluating health-justice interventions, which are explained in more detail in Appendix B. These broad challenges are presented in Table 4 together with ways an evaluation could address each challenge.

Table 4: Primary evaluation challenges identified through the literature review

	Challenge identified	Solution/Mitigation
Recruiting and retaining representative participants	Difficulties recruiting study participants and retaining their involvement for follow-up was a recurring theme, particularly those with high-risk or vulnerable populations e.g., severe mental health issues and complex medical issues. As a result, studies often lacked statistical power due to small sample sizes. This is further exacerbated where expected effect sizes are small, hence requiring a large sample size to observe changes. Some studies only provided descriptive data and did not assess the impact of partnerships on solving legal issues or improving health outcomes. Recruiting a representative sample, including sufficient participants from ethnic minority groups can pose challenges of selection bias.	Incentives for both baseline and longitudinal interviews to aid recruitment and retention. Ethnicity data held so participation can be monitored. Robust sample sizes (200 at follow-up for hub and 400 for the counterfactual). Combine secondary and survey data to assess impact and cost-benefit. Service users will be asked to consent to their involvement in the user surveys.
Comparator group	Many of the studies did not include a comparator group. For the 11 studies which made reference to a comparator, this was typically a 'before and after' analysis. Only four of the studies compared outcomes with a control group, receiving 'usual care'. The lack of a comparator group presents particular challenges when attempting to distinguish and attribute the impact of the legal advice on health outcomes.	Counterfactual group to be included in evaluation design – see Impact Evaluation Chapter 5 for details. This includes the approach to identifying an appropriate and meaningful counterfactual group and the ethics of including a counterfactual group.

Study design	Most of the study designs were observational, qualitative surveys or interviews, or descriptive. Comparing the effects of interventions across studies is challenging because of the heterogeneity between study designs, methodology, outcomes, legal intervention, and populations, all of which impact the interpretation of the findings. Furthermore, several reviews failed to report specific outcomes and the settings of the included studies.	Final report should provide details on specific outcomes observed and describe in detail how hub models worked.

Impacts of HJPs in existing evaluations

The Beardon et al review [1] found there was strong evidence that HJPs improved the socioeconomic circumstances of individuals, mental health (stress, depression, and anxiety), legal problems, and addressed the social determinants of health. Importantly, there was evidence to suggest HJPs may address inequalities by reaching people that are most likely to be affected by health-harming legal advice, but also those who may not otherwise seek legal assistance for social welfare issues.

This review found further evidence to support these findings. For example, a UK based systematic review by Reece et al [2] suggested that access to co-located services improves knowledge about welfare rights, health and wellbeing, financial gains, financial security, and also that co-located welfare rights advice reduces the burden on primary and secondary health care services. A service evaluation in Glasgow [3] found substantial financial gains for people obtaining money advice from a GP embedded service, and case study in Tower Hamlets [4] found GPs reported a reduction in non-clinical demands on their time. Evidence demonstrating a beneficial effect following support from an HJP is also available from overseas, including Australia [5] and the USA [6].

In the literature reviewed, the most common settings for welfare/legal advice to be provided were either primary care or in a hospital setting, with a selection of other settings such as community centres mentioned, particularly in the overseas literature. The literature emphasised that these partnerships increased the likelihood of people accessing legal

advice, particularly those on low incomes, most affected by health inequalities or health problems. This was due to the co-location of services making access to advice easier, increased awareness amongst health staff of the services available to refer to, and the availability of a free service (in countries where this would otherwise incur a charge). Some evaluations showed a positive contribution to patient care by managing health-harming needs through partnership. Some evaluations also reported benefits for health care professionals, improving their awareness and relationships with members of the wider multi-disciplinary team, and feelings of efficacy and empowerment.[14]

Not all of the evidence found positive outcomes, however. A UK based RCT [7] found limited evidence that a domiciliary welfare rights advice had a statistically significant effect on health related quality of life. Several studies highlighted the need for further high-quality studies in areas such as minority groups, inequalities, and how to target the intervention at those who are most likely to benefit. The ability to quantify benefits in a robust manner, and attribute them directly to the partnership intervention, was often noted as difficult due to the challenges mentioned above. Furthermore, the variety of approaches taken and outcomes measured reflects the fact that there is not a consistent outcome framework for evaluating these types of interventions.

Challenges associated with making HJPs accessible

The literature review found that HJPs encountered challenges with maintaining client engagement with their services, providing appropriate translation services, ensuring their services were accessible for those with a disability, reaching ethnic minority groups and providing training on the social determinants of health for healthcare professionals working within an HJP.

Maintaining client engagement in HJP services

13 papers included records describing factors that might have led to drop-off in client engagement with the services provided by HJPs. Practical or logistical issues and distrust

[14] While benefits for health care professionals were not felt central enough to the ToC to be included on the current version, these benefits will be listened out for when conducting the qualitative interviews with healthcare professionals as part of the process evaluation.

associated with cultural differences or previous negative experience with legal or government services were named as the key factors that lead to client drop-off.

Practical problems of engagement were widely reported. Time constraints and transport costs were noted in papers concerning a range of populations, including three concerning young people and their families, (Knowles 2018 [34]; Emengo 2020 [39]; Malik 2018 [38]), one concerning vulnerable patients during the pandemic (Elbogen 2021) [21], two concerning Australian aboriginal populations (Allison 2019 [5]; Day 2019 [46]), and a paper concerning socially vulnerable older adults (National Center for Medical-Legal Partnership, 2020) [6].

Another recurring factor was distrust associated with cultural differences or previous negative experience with legal or government services. This was noted in papers concerning vulnerable populations during the pandemic (Elbogen 2021) [21], papers concerning Australian aboriginal populations (Allison 2019 [5]; Day 2019 [46]), and a paper concerning women making use of a domestic violence unit (Social Compass 2019) [40]. Problems specific to vulnerable populations were noted by two Australian papers concerning onsite hospital legal services, which reported that the nature of these services meant that potential clients were often vulnerable and subject to emotional distress, and therefore more likely to disengage (Inner Melbourne Community Legal, 2018 [19]; Inner Melbourne Community Legal, 2018 [20]).

Three papers concerning community residents and primary care users described ways in which HJPs could remedy these factors. All three reported that the services had improved client access by providing avenues quickly and directly from healthcare workers to welfare advisers, reducing drop-off that might occur through complicated or slow referral pathways (Price 2021 [41]; Seymour 2021 [16]; Begum 2021 [4]).

Translation services

As some clients may be non-English speakers, access to using HJPs may be hampered where no translation services are provided. This was a relevant finding in the literature review, with 14 papers reported details on the need for translation services in HJPs.

Two papers reported that the services described suffered from unmet language needs which required further review (Goodman 2021 [11]; Murillo 2021 [33]). One pilot trial of

psychological intervention sessions for patients presenting to emergency departments in distress due to patients' financial, employment, housing or welfare difficulties, excluded participants who were not fluent in English, noting that translation services should be included in costings for a full trial (Barnes 2018 [24]). An observational study of a legal health clinic in Hamilton, Ontario noted that participants who did not speak English were required to bring their own translator (Agarwal 2020 [30]). One paper reported that the service being investigated advertised services with posters in six different languages, without specifying any other translation services (Drozdzal 2019) [42]. A systematic review of MLPs serving immigrants in the US found that 8 of 18 included studies reported on programs that offered direct translation services for clients (League 2021 [9]). Seven papers described services which provided translation and interpretation services due to their clients including migrant, indigenous or minority communities with language requirements (Price 2021 [41]; Bonuck 2020 [43]; Franco-Vasquez 2022 [44]; Fuller 2020 [37]; Shek 2019 [36]; Social Compass 2019 [40]; Allison 2019 [5]).

Services supporting disabled people.

There was some evidence from the review of the benefits of providing support for those with disabilities, in part to enable access to HJP services, but also because the advice provided to clients may be related to the disability issue experienced.

Five papers reported on disability requirements. One paper describing an MLP service for children with disabilities and their families reported that lawyers were provided with bi-directional training sessions on the needs of disabled clients (Bonuck, 2020 [43]). A review of legal services reported one study found that targeting housebound patients resulted in greater financial benefit for this group than for patients attending GP-based welfare rights advice sessions (Genn, 2021 [8]). Three Australian papers reported that the services concerned provided flexible and accessible services to reduce barriers for disabled clients (Price 2021 [41]; Inner Melbourne Community Legal, 2018 [20]; Allison 2019 [5]).

Professional development

The literature review found evidence that training of healthcare professionals in the social determinants of health has been recognised as a factor which can be helpful in these staff recognising a patient who may benefit from HJP type services.

25 papers discussed training of health professionals in an HJP setting. The training described was offered to all medical staff involved, including physicians and other health professionals. Training could take various forms, including group sessions, lectures and presentations, case-based learning, and webinars. It covered areas such as general understanding of the social determinants of health, awareness of existing legal services and how to refer patients. Other training included awareness of particular social issues – for example, two papers noted that physicians were trained in awareness of the signs of family or intimate partner violence in patients (Poleshuck, 2021 [45]; Inner Melbourne Community Legal, 2018 [19].). Two papers discussed the formal incorporation of educational content on the social determinants of health in health professional training. A paper describing the drafting of an evaluation tool for MLPs noted that education in the social determinants of health is increasingly integrated into undergraduate and postgraduate medical curricula and found that surveyed stakeholders from medical schools stressed that learning outcomes to measure education of medical staff should be linked to professional competencies (Nerlinger 2021 [26]). An evaluation of a pilot program for domestic violence units noted that services were working with medical professional bodies to have such training formally accredited, with the hope that this would ameliorate poor GP uptake due to their busy training schedules (Social compass, 2019 [40]).

Reaching black and minority ethnic groups

There was some evidence in the literature of the benefits of building on community connections and making services culturally appropriate, in order to improve access to HJP services.

Five papers discussed methods of improving outreach toward ethnic minority groups. Two papers noted that the MLP model itself could facilitate access. A British paper discussing the benefits of HJP for maternity services noted that Public Health England guidance on reducing inequalities for ethnic minority groups stresses cross-boundary working to address the interactions between social factors and health inequalities and observed that it is precisely this that HJP services aim to provide (Maternity Action, 2021 [19]). A Canadian paper describing that country's Health Justice Program and described HJP staff members' advocacy work in community workshops designed to increase individuals' knowledge of the available services (Drozdzal, 2019 [42]). Two Australian papers evaluating services for

aboriginal communities stressed that cultivating ties with aboriginal organisations and communities and employing aboriginal staff was vital to establishing trust and engagement with the services (Day 2019 [46]; Social Compass 2019 [40]). Another Australian paper evaluating an HJP in Wuchopperen, stressed that co-location of the legal clinic in a health service already thoroughly connected with the aboriginal community through aboriginal staff members facilitated greater participation (Allison, 2019 [5]). A common theme across these Australian papers that discussed aboriginal outreach was the importance of building trust through community connections, as these clients may have had previous negative experiences with legal services.

4.2 Nature of the HJPs

This chapter will introduce the 13 HJPs that were included in the feasibility study and their various operating models, before concluding with recommendations about which locations should be included in the evaluation.

HJPs in the feasibility study

In September 2021, MoJ asked for expressions of interest for taking part in an evaluation from a number of organisations that provide integrated health and justice services. These organisations included Citizens Advice, Law Centre Network and Advice UK.

MoJ received 58 responses. 15 of these advice hubs were delivering advice from a primary care setting and met the inclusion criteria of MoJ (including collecting a minimum set of data, having the capacity to facilitate the research and providing debt, housing and welfare advice at a minimum).

In January 2022, IFF Research invited the named contact, typically the CEO, at these 15 advice hubs to take part in an interview. The purpose of the interview was to better understand the operating models and the intended impacts of the advice hubs.

IFF Research conducted interviews with 13 of the 15 advice hubs. Of these advice hubs, 11 were Citizens Advice (CA), one was a Law Centre, and one was a housing association (under the umbrella of Advice UK). The two remaining advice hubs that met the criteria but did not take part in an interview (due to a lack of availability within the fieldwork period) were from CA.

Models of HJPs

As already mentioned in the executive summary, the literature review alongside the depth interviews with stakeholders, HJP leads and HJP clients revealed that there are two main ways that the models of HJPs vary from one another:

- Whether the legal advice hub is **co-located** onsite at the healthcare setting (i.e., the GP practice contains a physical space on their premises for the advisor to meet with clients). Alternatively, clients must visit the advisor outside the primary care setting, either at another location (such as the local Citizens Advice office) or remotely, by telephone or video conferencing. The literature review suggests that this is the key distinguishing factor.

- The nature of the **referral process** from the healthcare setting to the advisory team. The level of involvement from the healthcare provider in referring the client to the advice hub seems to sit along a spectrum and provides an indication of how integrated the health and justice partners are. (However, it is worth noting that HJPs tended to accept referrals from more than one of the routes outlined below):

- At the more involved end of the spectrum are the healthcare settings which have a *structured referral and consultation booking system*, so surgery staff (most commonly GPs but also nurses, receptionists and physios) can refer clients to the advice hub and/or create appointments for clients through a structured process such as an online portal which links the health and justice service providers. These healthcare providers also *share information* about the client (such as the nature of their issue) with the advice provider as part of the referral.

- The next type of referral occurs when healthcare providers use a *consultation booking system* to create appointments for the clients on behalf of the advice hub but do not share information on the client as part of the referral process. This process may be as simple as the GP or the GP receptionist maintaining a log of the healthcare patients who require advice and booking them an appointment with the advice provider.

- The less involved referrals occur when the healthcare provider or link worker assigned by the healthcare provider *signposts* to the patient that they should contact the advice provider, but there is no action taken by the healthcare provider or link worker to assist them with this.
- There are also client *self-referrals*. These seem to typically occur when clients reach out to the advisory organisation after seeing their support promoted via posters or leaflets at partner healthcare settings. This occurs in hubs with and without physical co-location.

Interviews with HJPs revealed different models, as shown below in Table 5.

Table 5: The primary HJP models

	Structured consultation booking system and/or shares information	Consultation booking system	Sign posting and/or self-referrals only
Co-located	4 advice hubs: • CA Dorset. • CA Warrington. • CA Solihull. • CA Blackpool.	4 advice hubs: • CA Milton Keynes. • CA NE Derbyshire. • CA Broxtowe. • Central England Law Centre.	N/a.
Not physically co-located	3 advice hubs: • CA Arun and Chichester. • CA Wandsworth. • CA County Durham.	N/a.	1 advice hub: • CA St Helens.

Two of the 13 hubs interviewed during the feasibility stage have been excluded from the remainder of the report, these are:

- **Melin Homes.** This organisation is a registered social landlord with the goal of sustaining tenancies. They are responsible for: supporting their tenants in the civil courts and during the tribunal process; protecting business income; and ensuring

the security of their tenants' homes is maintained. Melin Homes do have some links with mental health and older persons services, however the links are not formally established and Melin Homes are working to develop a stronger relationship with healthcare services. As it stands, the relationship with healthcare services is not sufficient to include them in this report or the wider evaluation.

- **CA St Helens**. This organisation has not been physically co-located in primary care settings since before the pandemic. They have no formal referral process in place, but as they previously had a physical presence in GP surgeries, health professionals are aware of them and signpost patients to their services. However, they do not have data on how many clients come to the service via the health-justice route, obstructing an effective evaluation of their hub.

Each of the main three models identified is described in further detail below. An example case study is provided for each model to give a deeper understanding.

Co-located HJPs with a structured referral/consultation booking system that may share information between the health and justice partners.

Model overview

The four advice hubs that fall into this category all have some legal support services physically co-located within healthcare settings. They also have a structured booking system for managing referrals and consultations with, in some cases, the capability for information sharing between the health and justice partners.

Location of support

The physical co-location of these advice hubs takes the form of a CA advisor holding regular sessions in the participating surgeries. These sessions are typically weekly (in one advice hub fortnightly) and used for pre-booked appointments with clients at the participating surgeries.

Referral process

There was some variation in the nature of the process by which clients were referred to justice support by healthcare partners. The approaches taken in this model included:

- GPs sharing a word document detailing the client's legal needs in an email to the CA, who then reached out to the client to arrange an appointment;
- An online platform that allowed a GP, nurse or receptionist to make a referral to the CA, from which an advisor would reach out to make an appointment with the client; and,
- In the case of two hubs, surgery staff (GPs, physios, receptionists) asking potential clients if they would like to receive legal support and then booking them an appointment with an advisor using the surgery's appointment booking system (self-referrals could also contact the surgery to arrange an appointment).

In the first two examples, the quantity of information and level of detail provided by GPs in the referral process could vary. All four advice hubs had the option to share information on the client within the referral process. Typically, this included the broad nature of their legal issue (e.g., housing, welfare, employment etc) however the level of other shared information varied between referrals depending on the needs of the case (as assessed by the referrer) and the wishes of the client.

Funding

Table 6 below outlines the funding sources for each of these advice hubs.

Table 6: Sources of funding for co-located advice hubs with structured referral/consultation booking systems and/or information sharing.

	Clinical Commissioning Groups	Primary Care Networks	Local Authority	Other
CA Dorset	✓			
CA Warrington	✓		✓	
CA Blackpool	✓	✓	✓	✓ DWP (The Money & Pensions Service).
CA Solihull		✓		

Table 7: Case Study - Citizens Advice Warrington.

A physically co-located advice hub with a structured referral/consultation booking system that may share information between the health and justice partners
This advice hub is based in Warrington and reaches between 500 and 600 clients via health referrals in a busy year. There are 18 participating GP surgeries in the project. The organisation is physically co-located in 10 surgeries, running in person two-hour advice sessions weekly. The other eight surgeries will refer patients to either the weekly sessions at one of the physically co-located surgeries or to the CA centre, located in Warrington city centre. Patients can be referred at the surgeries by a GP, nurse or receptionist via a secure electronic process. Patient consent is obtained and an appointment set up, with CA Warrington agreeing a time and date with the surgery. The referral form indicates the area of law that clients need advice on. The shared hubs and community outreach programme is funded by the local authority health budget. They are engaged strategically with local health and welfare boards and started the first GP outreach pilot in 1999.

Co-located with a consultation booking system.

Model overview

The three advice hubs that fall into this category all have some legal support services co-located within healthcare settings, alongside a booking system where healthcare professionals book clients in for a consultation with an advisor.

Location of support

As with the previous model, advisors have weekly sessions at participating surgeries, in which they support clients with their legal needs.

Referral process

In contrast to the previous model, referrals here involve booking clients an appointment with an advisor but do not involve information sharing or a structured referral. There is no formal handover process and advisors do not have knowledge of the issues clients are facing until they meet for their appointment.

Funding

Table 8 below outlines the funding sources for each of these hubs.

Table 8: Funding sources for co-located HJPs with a consultation booking system.

	Clinical Commissioning Groups	Primary Care Networks	Local Authority	Other
CA Derbyshire			✓	
CA Milton Keynes		✓	✓	
CA Broxtowe				✓ Boots; Henry Smith Foundation; CA funds.
Central England Law Centre			✓	

Table 9: Case Study - Central England Law Centre.

A physically co-located hub with a consultation booking system
This advice hub offers services across the West Midlands, with offices in Coventry and Birmingham. It has capacity to help around 6,000 people per year across both sites, helping around 4,500 in Coventry and around 1,500 in Birmingham. The organisation has a long-established relationship (12 years) with a specialist GP surgery in Coventry which works with people who are either sleeping rough or are in insecure housing. An advisor works from the centre one day a week. There is no formal referral process; the health centre arranges an appointment between the client and advice hub, or clients meet directly with the organisation on a drop-in basis. Little is known about the client beforehand, with details taken at the advice appointment. Funding is provided by Coventry City Council, but these funds cannot be used outside of Coventry. They also have regional contracts with smaller bodies to provide regional support outside of Coventry.

Not physically co-located with a structured referral/consultation booking system that may share information between the health and justice partners.

Model overview

The three advice hubs in this category had structured referral systems but did not have physical co-location.

Location of support

Two of the three partnerships provided support from a variety of locations including the CA centre and home visits, alongside remote support via email, telephone, letter or video call. The other advice hub exclusively provided a telephone-based service, with no face-to-face support.

Referral process

All partnerships had their own online portal or platform through which GPs, link workers or other health professionals could make referrals for legal support. Basic contact information (name, telephone, email address) and an outline of the issue was provided as standard, however the level of detail provided about the issue the client faced varied. After receiving a referral, an advisor would reach out to the client to offer support with their legal issue.

Funding

Table 10: Funding sources for HJPs without physical co-location that have a structured referral/consultation booking system that may share information between the health and justice partners.

	Care Commissioning Group	Primary Care Network	Local Authority	Other
CA Wandsworth	✓			
CA Arun & Chichester	✓	✓	✓	✓ The National Lottery; independent lenders.
CA County Durham			✓	

Table 11: Case Study – CA Durham

Not physically co-located with a structured referral/consultation booking system that may share information between the health and justice partners
This advice hub is based in Durham. The service, called "Healthier & Wealthier", is available for people registered as patients with GP practices anywhere in County Durham, and reaches up to 3,500 clients a year. Initially the hub was physically co-located in GP surgeries, with a team of 4 or 5 advisors covering about 20 surgeries on a rota. However, not all GPs were engaged at the time meaning referrals across the 20 surgeries varied. The service changed into a telephone-based service, making it available to every GP surgery in the county who actively refer in. Referrals into the service team are made exclusively by GP surgeries and attached professionals (community midwives, practice counsellors, etc). The organisation has a portal, secured to NHS standards, that the 170 partners in the network can refer patients into once they consent to GDPR and data-sharing, depending on the service required. GPs can also email or phone the organisation with some basic client details (name, contact number, what the problem is) and the organisation will contact the client. It is funded by the Public Health Department at the local council.

HJP models to include in the evaluation

All 11 HJPs outlined in this chapter would be of value to include in the evaluation. These HJPs offer a balanced representation of the three different models (including three or four HJPs of each model) and reasonable variation in the size of advice hubs within each of the three models.

However, it would also be reasonable (and more cost-effective) to include nine HJPs overall – three of each model. In this scenario, it is recommended that the following advice hubs are not included:

- **CA Solihull.** Of the four physically co-located advice hubs with a structured referral/consultation booking system that may share information between the health and justice partners, CA Solihull has a referral model and funding sources replicated in CA Blackpool (which was the largest of the advice hubs within this model) so its broad structures would still be covered within the evaluation.
- **CA Derbyshire.** Of the four physically co-located advice hubs that operate with a consultation booking system, CA Derbyshire had the least comprehensive data collection processes. Its funding sources and delivery model would still be represented by the other advice hubs within this model, ensuring a reasonable coverage of different advice hubs within this model is retained.

For further detail of these two options (including nine hubs or 11 hubs in the evaluation), see Chapter 2 of the accompanying Technical Appendix.

5. Recommended impact evaluation approach

This section outlines the recommended approach for the impact evaluation. Technical details on the methodological design and learnings from the feasibility study as well as the strengths and limitations of the suggested approach are included in the Technical Appendix accompanying this study.

The impact evaluation will aim to robustly estimate the impact of HJPs on the speed of resolution of legal problems (RQ1), better social-economic outcomes (RQ2) and improved health outcomes (RQ3). A summary of the recommended approach is set out in Table 12 below.

Table 12: Summary of the recommended approach to the impact evaluation.

Summary of the recommended approach to the impact evaluation

To answer RQ1, RQ2 and RQ3 the most robust evaluation option is to carry out 'before' and 'after' surveys with HJP clients who have received legal advice and a counterfactual comparison group who, through screening, have been identified as also having a legal need.

To achieve this within the time and budget restraints of the project we recommend the approach set out in the following table:

	'Before' survey	'After' survey – 3 months later
HJP clients	Sample size: 600. Online survey with opt in telephone option.	Sample size: 200. Online and telephone (proportions tbc depending on number of telephone numbers provided at baseline).
Counterfactual group	Sample Size: 1,200 Online.	Sample Size: 400. Online.

All surveys are likely to take around 15 minutes to complete (although may vary depending on the client and their issue), except the screening survey for the counterfactual group which will take around 5 minutes. These surveys will be piloted, to effectively target the data required and minimise burden on participants.

'Propensity score matching' (PSM) will be used to address the risk of selection bias, by finding a comparator group of cases with a similar likelihood of experiencing the same treatment, based on a number of observable covariates. For further detail, see Chapter 2 of the Technical Appendix.

The sample sizes in Table 12 were derived by weighing up the ideal sample sizes for identifying statically significant differences against the time and budget constraints of this project. While it would have been preferable to have 400 participants in each 'after' survey group, a full explanation of how these final sample sizes were decided is explained in the Technical Appendix.

'Before' or baseline data will be collected from HJP clients immediately after their first appointment with the advisor; the advisor will distribute the invitation to the online survey which also collects consent to recontact. The feasibility study revealed a relatively low level of footfall through the HJPs and assuming a one in three response rate it is anticipated that it will take the best part of one year to collect baseline responses from 600 HJP clients. While a larger HJP sample would be preferred, this is not achievable within the time constraints of the project. To ensure consistency between the two groups, the counterfactual group will be recruited on a rolling basis across the same time period that HJP clients are recruited. To reduce the bias due to confounding variables, the two groups will also be matched on several observed covariates (including protected characteristics and type of legal problem) using propensity score matching.

There are several potential risks to this approach. For example, the reliance on the goodwill of advice hubs to administer the survey link, the use of a primarily digital approach which is likely to have less reach among those not digitally literate, and the

difficulty in measuring and attributing outcomes, which is particularly difficult in this context given the complexity of some clients' issues. These risks will be mitigated by: reducing the burden on advice hubs as much as possible by including a re-contact question on the baseline survey ensuring they only need to administer the survey once; providing supporting resources that they can share with clients; continually reviewing the ToC throughout the evaluation; ensuring sufficient base sizes as far as possible; triangulating data across each of the evaluation strands; and being clear from the outset about any limitations of the approach. See the accompanying Technical Appendix section 2.5 for more information about potential risks and mitigations.

6. Recommended process evaluation approach

This section outlines the recommended approach to the process evaluation. The Technical Appendix accompanying this study includes a discussion of the potential limitations of the approach, as well as suggestions as to how to manage these limitations based on learnings from the feasibility study.

Objective two of the evaluation is to explore the implementation and delivery of HJPs. This objective will help to answer RQ5, which focuses on identifying the challenges of setting up and delivering integrated health and justice services. Objective one and RQ5 can be addressed through a detailed process evaluation, which would involve speaking in depth to all parties engaged with the HJPs. A summary of the recommended approach is set out in Table 13 below.

Table 13: Summary of the recommended approach to the process evaluation.

Summary of the recommended approach to the process evaluation
To answer RQ5 we propose carrying out a series of interviews with persons engaged with the HJPs within each of the three HJP models identified in Chapter 4. To gain insight at a high level we will conduct: • Two to three depth interviews with **strategic staff** in umbrella body organisations (e.g. the central Citizens Advice office) and healthcare commissioners. Then within each of the three HJP models identified in Chapter 4 we will conduct: • Three depth interviews with **HJP leads or managers** (e.g. the local Citizens Advice CEO). • Three mini-groups with four to five **frontline advisors** working in HJPs. • Five to six depth interviews with **healthcare professionals.**

- 20 depth interviews with **HJP clients** soon after they have had their first meeting with the advisor and then 10 follow up interviews with these participants six months after their first appointment (the smaller follow-up sample size accounts for the expected attrition between interviews).

The spread of interviews recommended above would allow the evaluator to explore any key differences between model types in terms of implementation, delivery and perceptions of impact. Engaging with a greater number of clients than those included in the feasibility study will enable the evaluator to gain a deeper understanding of how the different model types, and related referral processes, impacts user experience.

There are several potential risks to this approach relating to the retention of clients for follow-up interviews, difficulties engaging healthcare professionals as they are particularly time poor, or a reluctancy among advice hubs to take part. However, these risks will be mitigated by: providing sufficient incentives to encourage clients and healthcare professionals to take part; building on the good rapport built with advice hub leads during the feasibility study – where most hubs said they would participate in the process evaluation; and maintaining effective working relationships with advice hubs, for example being available to answer questions/concerns and minimising the burden on them will be crucial to continued engagement. See section 3.2 in the Technical Appendix for more information about potential risks and mitigations.

7. Recommended economic evaluation approach

This section outlines the recommended approach for the economic evaluation. The Technical Appendix accompanying this study provides an overview of the potential limitations of the approach, as well as suggestions as to how to manage these limitations based on learnings from the feasibility study.

Objective four of the evaluation is to explore the financial and economic benefits of HJPs. This objective will help to answer RQ1, RQ2 and RQ3, which considers the financial and economic costs and benefits of HJPs. Objective four and RQ1, RQ2 and RQ3 can be addressed through an economic evaluation, utilising a CBA approach. A summary of the recommended approach is set out in Table 14 below.

Table 14: Summary of the recommended approach to the economic evaluation.

Summary of the recommended approach to the economic evaluation
The economic evaluation will support the process and impact evaluation by considering the financial and economic costs and benefits of the intervention. The evaluation will aim to quantify in economic terms: changes in resource use in the justice and health and social care systems, as well as any other relevant government departments; impacts on individuals relating to improved access to justice and resulting health benefits; wider societal benefits, such as the ‘spill over’ effects of the creation of additional employment or getting people back to work. Incremental costs and outcomes of implementing interventions will be identified, measured and valued as part of the economic evaluation. A CBA approach will be used, that includes a comparison of interventions and consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary terms. This will allow for the costs and benefits relating to interventions to be appraised consistently with financial values attached to costs and benefits.

In the initial stages of the evaluation, an economic analysis protocol will be developed and agreed with the MoJ project team. The protocol will include a detailed data specification, to identify the nature and source of data on costs and benefits, for both the intervention groups and for any agreed comparator group(s), in order to address the questions posed. The economic evaluation will align closely with the process and impact evaluations to ensure that the appropriate metrics are measured in a consistent way. Any assumptions and uncertainties in the values obtained will be tested in sensitivity analysis and will be reported transparently within any outputs.

There are several potential risks to this approach relating to the availability and quality of data. The HJPs selected to take part in the economic evaluation should have access to primary care data systems and the evaluator should allow sufficient time to access the required data to avoid project delays. Only reputable sources of data should be used to perform the scenario analysis. In addition, if longer term outcomes are not measurable within the timeframe of the evaluation, the evaluator should seek links between short term measurable outcomes and longer term outcomes from available literature. See section 4.4 in the Technical Appendix for more information about potential risks and mitigations.

8. Evaluation framework

To conclude, the recommended approach to evaluate HJPs is to carry out a process evaluation, impact evaluation and economic evaluation, using primary data collection, analysis of secondary data, application of literature evidence and economic analysis. This will involve:

- A before and after survey from beneficiaries and a counterfactual group that is matched using propensity score matching;
- Case studies, including a series of in-depth interviews with strategic staff in umbrella organisations, HJP managers, frontline advisors, healthcare professionals and HJP clients; and
- A cost-benefit economic analysis which will quantify changes as a result of HJPs in economic terms.

Table 15 indicates how the three research elements will contribute to a detailed understanding of the current implementation, delivery and impact of the advice hubs. (Note that PE, IE and EE are used in the table below to refer to the process, impact and economic evaluations).

In terms of next steps, the evaluation framework below will provide a guide for the development of all research materials for the process, impact and economic evaluations. The evaluators will develop a topic guide and/or survey questions for each target audience using the relevant indicators as set out below. This framework will then be used as the overarching structure for all analysis and reporting, with the evaluators assessing the evidence to determine whether each component of the ToC can be evidenced.

Table 15: Evaluation framework for integrated HJPs.

ToC Component	Indicator	Data Source	Audience
Inputs			
Funding.	What are the current sources of funding?	PE & EE: Advice hub case studies.	Strategic staff. Advice hub leads. Advice hub leads
Service costs.	What are the costs of delivering the service?	PE & EE: Advice hub case studies. EE: Cost & resources survey.	Strategic staff. Advice hub leads. Advice hub leads
Training for health professionals.	Whether training is provided for health professionals.	PE & EE: Advice hub case studies.	Health professionals. Advice hub leads.
Training for health professionals.	Type of training provided	PE: Advice hub case studies.	Health professionals. Advice hub leads.
Community involvement.	Levels of awareness of the HJPs.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline.*
Community involvement.	Degree to which community has influence over the way the co-located advice hub operates.	PE: Advice hub case studies.	Advice hub clients. Advice hub leads. Frontline workers.
Service delivery (i.e. referral) systems	What methods of referral systems are used in each model of advice hub including technology/software used?	PE: Advice hub case studies.	Strategic staff. Health professionals. Frontline workers.

Service delivery (i.e. referral) systems	What resources are deployed within practices to implement new service/systems?	EE: Practice surveys.	GP practice staff.
Service delivery (i.e. referral) systems	What patient information is shared between the health and justice partners?	PE: Advice hub case studies.	Strategic staff. Health professionals. Frontline workers.
Activities			
Who: A not for profit advice agency (e.g., CA or a Law Centre) co-located or partnered with a healthcare setting.	Which advice agencies are delivering the legal advice service in the primary healthcare setting?	PE: Advice hub case studies.	Strategic staff.
How: Depending on the model, referrals may come from the healthcare provider or individuals may self-refer to the advice provider.	How is a client typically referred from the health to the justice partner? (incl. software/booking systems that are used). *Same as referral input.*	PE: Advice hub case studies.	Strategic staff. Advice hub leads. Health professionals. Frontline workers.
How: Depending on the model, referrals may come from the healthcare provider or individuals may self-refer to the advice provider.	What information about the patient is shared between the agencies, if any? *Same as referral input.*	PE: Advice hub case studies.	Strategic staff. Advice hub leads. Health professionals. Frontline workers.

What: Depending on the model and provider this may include: providing information and explaining options, identifying further action the client can take, providing support with tasks (e.g., form filling), casework, negotiating with third parties or the other side to the dispute, representation and litigation, and referring to other sources of support and advice.	Types of advice or assistance is offered to the client?	PE: Advice hub case studies. IE: Client survey.	Strategic staff. Advice hub leads. Frontline workers. Advice hub clients & comparison group. *Baseline & follow up.*
Outputs (improved access to advice			
Clients receive appropriate advice and assistance for their problem/s.	Type of assistance received/given. *Same as assistance activity.*	PE: Advice hub case studies.	Strategic staff. Frontline workers. Advice hub clients.
Clients receive appropriate advice and assistance for their problem/s.	Degree to which the advice was appropriate for the situation.	PE: Advice hub case studies. IE: Client survey.	Frontline workers. Advice hub clients. Advice hub clients & comparison group. *Baseline & follow up.*

Clients receive appropriate advice and assistance for their problem/s.	Actions taken from receiving advice.	IE: Client survey. PE: Advice hub case studies.	Advice hub clients & comparison group. *Baseline & follow up.*
Short-term Outcomes			
Improved capability/capacity			
People are equipped to take control of their legal problems, through improved legal knowledge, skills and confidence.	Client's level of legal knowledge, skills and confidence.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
People are better able to recognise a legal problem in the future and seek appropriate support.	Client's ability to identify a legal problem.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
People are better able to recognise a legal problem in the future and seek appropriate support.	Client's ability to seek appropriate advice for legal issues.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
Improves faith in the justice system.	Degree to which clients positively view the justice system and avenues for addressing legal needs.	PE: Advice hub case studies.	Advice hub client.
Reduced burden on healthcare professionals allowing them to spend more of their time	Reduced number of visits to healthcare professional.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*

focusing on health issues.			
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.	How does the use of advice hubs impact on healthcare professionals' ability to focus on medical issues?	PE: Advice hub case studies.	Health professionals.
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.	Does the use of advice hubs reduce time spent writing up referral notes etc?	PE & EE: Advice hub case studies.	Health professionals.
Problem resolution			
People are able to tackle problems and resolve them swiftly.	Clients are able to recognise when an issue is a legal issue.	IE: Client survey.	Advice hub clients & comparison group *Baseline & follow up*
People are able to tackle problems and resolve them swiftly.	Clients are able to resolve their legal issues promptly.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
Increased or restored benefits.	Clients have increased access to benefits.	IE: Client survey. PE: Advice hub case studies. EE: Advice hub data systems.	Advice hub clients & comparison group *Baseline & follow up* Advice hub clients, baseline and follow up.

Debts reduced or managed.	Clients have been able to reduce debt or restructure debt so that payments are more manageable.	IE: Client survey. EE: Advice hub data systems. PE: Advice hub case studies.	Advice hub clients & comparison group. *Baseline & follow up.* Frontline workers. Advice hub clients.
Employment issues resolved.	Client employment issues are resolved promptly.	IE: Client survey. EE: Advice hub data systems. PE: Advice hub case studies.	Advice hub clients & comparison group. *Baseline & follow up.* Frontline workers.
Obtaining other entitlements or rights e.g., immigration help.	Client is on track/has gained access to other entitlements.	IE: Client survey EE: Advice hub data systems. PE: Advice hub case studies.	Advice hub clients & comparison group. *Baseline & follow up.* Frontline workers.
Housing situation stabilised, e.g., possession action avoided, repairs made to rental property.	Client has remedied/is in the process of remedying their poor housing situation.	IE: Client survey. EE: Advice hub data systems. PE: Advice hub case studies.	Advice hub clients & comparison group. *Baseline & follow up.* Frontline workers.

Long-term Outcomes			
Improved socioeconomic situation for individuals			
Prevention of problem escalation and problem clustering.	Legal issue is dealt with more promptly than if no assistance was received through co-located advice hub.	IE: Client survey. EE: Advice hub data systems. PE: Advice hub case studies.	Advice hub clients. Baseline and comparison group – *follow up.* Frontline worker. Advice hub leads. Strategic staff.
Improved ability to manage finances.	Client is better able to manage personal finances.	IE: Client survey. EE: Advice hub data systems. PE: Advice hub case studies.	Advice hub clients & comparison group. *Baseline & follow up.* Frontline workers.
Increased independence.	Client feels that they have more autonomy and control over their own life.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
Improved mental wellbeing, including reduced stress/anxiety.	Client has improved mental wellbeing.	IE & EE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
Improved physical wellbeing, including diet, exercise, sleep.	Client has improved physical mental wellbeing.	IE & EE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
Better relationships with family and friends, isolation reduced.	Client feels that their interpersonal relationships have improved.	IE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*

Reduced costs to Government and society			
Reduced demand on the formal justice system (courts and tribunals).	Use of legal services for problems amenable to welfare advice.	EE: Advice hub data systems, literature evidence.	Legal services staff.
Reduced demand on wider public services.	Use of social care services.	EE: literature evidence and expert elicitation.	Social care staff.
Reduced demand on wider public services.	Increased productivity via changes in employment status.	Advice hub data systems, literature evidence.	Social care staff.
Reduced demand on the healthcare system.	Use of primary care services.	EE: Advice hub data systems. Practice surveys.	GP practices.
Reduced demand on the healthcare system.	Use of healthcare services for health-related problems.	EE: literature evidence and expert elicitation.	Health professionals GP practices.
Assumptions			
Working relationships - Healthcare and advice providers have strong, positive, collaborative working relationships, with clear processes for joint working and referrals.	Is the HJP positive and collaborative?	PE: Advice hub case studies	Advice hub leads. Frontline advisors. Health professionals.

Working relationships (as above)	Is there a clear process for referring clients between the health and justice partners? *Similar to referrals under inputs and activities.*	PE: Advice hub case studies	Advice hub leads. Frontline advisors. Health professionals.
Ease of use and access - The service is easy to use for patients and staff, so referrals are made and clients attend appointments. Clients can access these locations in the pandemic/post-pandemic world.	Referrals are made easily.	PE: Advice hub case studies.	Advice hub leads. Frontline advisors. Health professionals. Advice hub clients.
Ease of use and access	Proportion of missed appointments is low.	PE: Advice hub case studies.	Advice hub leads
Ease of use and access	Ease of accessing the advice hub.	PE: Advice hub case studies.	Advice hub clients.
Health professionals are able to identify when patients' issues have a legal dimension.	Ease with which health professional can identify legal issues when a client presents for a medical appointment.	PE: Advice hub case studies.	Health professionals. Frontline worker.
Clients act on the advice given – Clients have the confidence and motivation to enact a solution.	Following the first advice hub appointment, the client understands what steps need to be taken next.	IE. Client survey.	Client group. *Baseline.*
Clients act on the advice given	The client takes these steps within 6 months of their first advice session.	IE. Client survey.	Client group. *Follow up.*

9. Timeline

The timeline below provides an indication of how the impact, process and economic evaluations could proceed in 2023-2024.

Table 16: Indicative evaluation timeline.

	2022								2023												2024					
	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
Process Evaluation																										
Guide development/review		■	■																							
Recruitment & Fieldwork			■	■	■																					
Guide development/review for HJP clients and the follow-up with them				■	■							■	■													
Baseline & follow-up fieldwork with hub clients							■	■	■						■	■	■									
Impact Evaluation																										
Q'aire development & review		■	■																							
Baseline fieldwork					■	■	■	■	■	■	■	■	■	■	■	■										
Follow-up fieldwork									■	■	■	■	■	■	■	■	■	■	■							
Data coding and processing						■	■	■	■	■	■	■	■	■	■	■	■	■	■	■						
Data analysis																				■	■					
Economic Evaluation																										
Economic protocol		■	■	■																						
Economic analysis phase 1											■	■														
Economic analysis phase 2																					■	■				
Synthesis and reporting							■						■	■				■					■	■		
Reporting																										
Interim report 1						■	■																			
Interim report 2														■	■											
Interim report 3																			■	■						
Final report																							■	■	■	
Amends & signing off process																									■	■

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Appendix A: Theory of Change for HJPs

The ToC is a visual representation that outlines the activities that a programme is going to undertake, the immediate results of the activities, and the outcomes that lead or contribute to the longer-term impacts. It summarises the rationale for acting, sets out the inputs, activities, intended outcomes and impacts, and also shows the mechanisms by which change is intended to occur.

For the purposes of the HJPs within the scope of this evaluation, the ToC has five elements:

- The **inputs** and resources that are required to deliver the programme;
- The **activities** that are carried out with those resources;
- The **outputs** i.e. the immediate result of the activities;
- The **outcomes:** short and mid-term changes resulting from the activities; and
- The **impact** of the programme and the ultimate effects of the combined outcomes.

As a whole, the ToC plays a crucial role in both the design of the evaluation and in the analysis and reporting of evaluation findings:

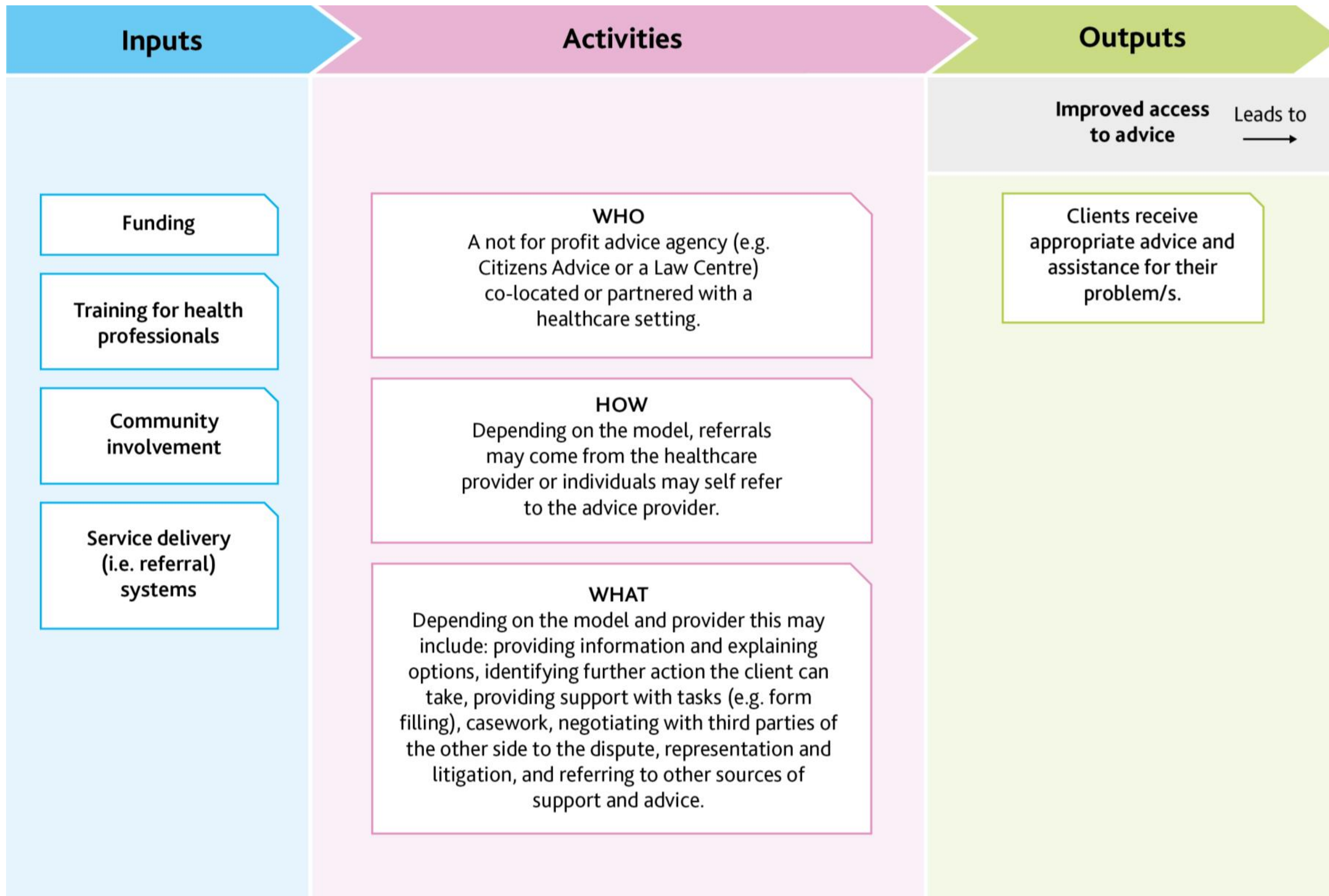
- It builds a shared understanding of what is being evaluated and what key outcomes will be measured;
- It shapes what will be explored through the evaluation in order to demonstrate the programme's value; and
- It supports interpretation of the evaluation findings.

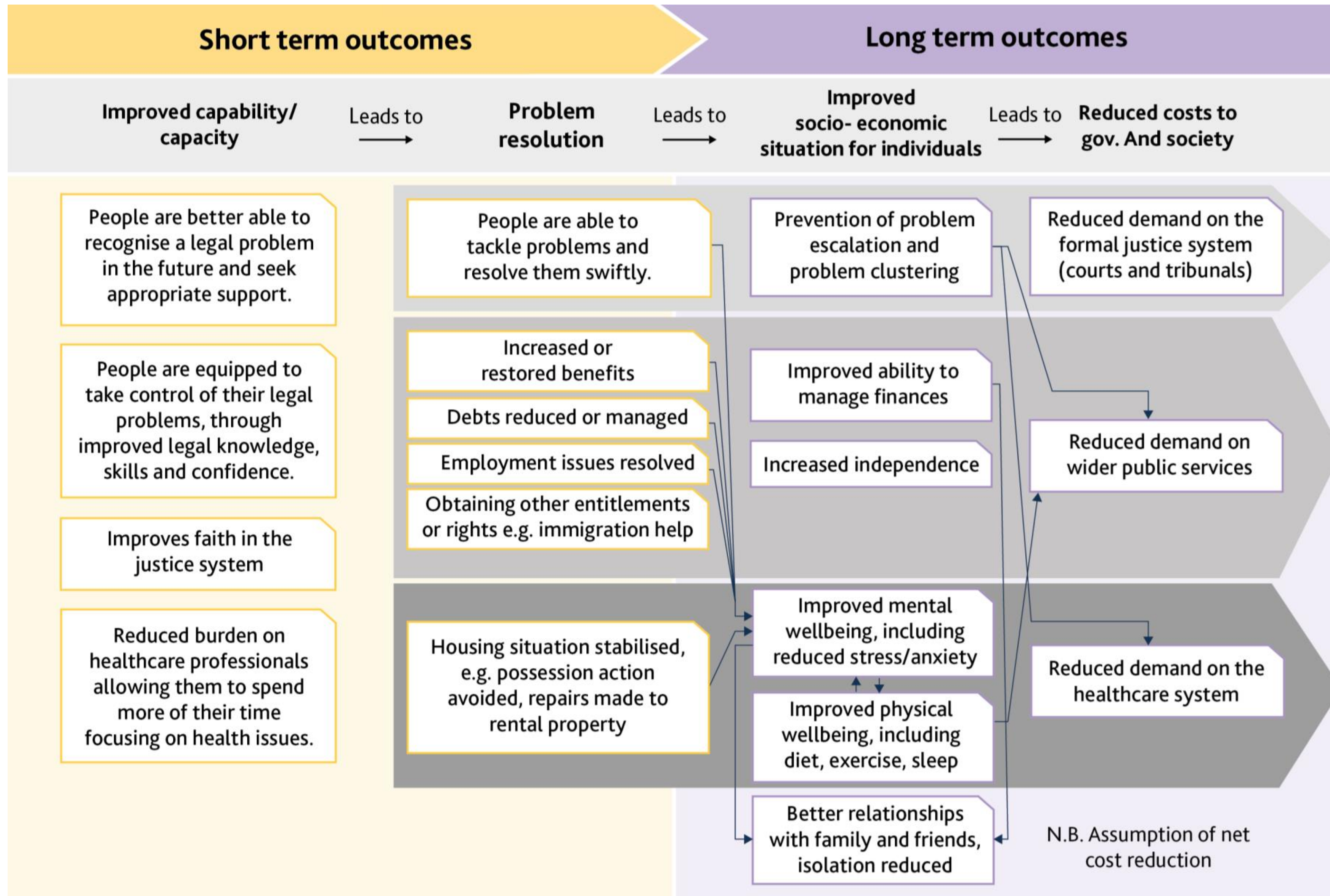
The ToC should be reviewed and monitored throughout the evaluation and a final version, updated as necessary, incorporated into the final evaluation report.

It is important to note that the ToC provides an overarching explanation of HJPs as a whole but not all elements will apply to every advice hub.

Figure 1 presents the ToC, with a more detailed narrative provided below, including the context and problem statement as well as assumptions, risks and external influences (which are not included in the ToC for ease of presentation). To simplify the relationships between outcomes, blocks of colour/shading show where there are broad 'leads to' relationships, with smaller arrows showing where relationships cut across these broad categories.

Figure 1: HJP theory of change.





Short term outcomes
Long term outcomes
Improved capability/ capacity
Leads to
Problem resolution
Leads to
Improved socio- economic situation for individuals
Leads to
Reduced costs to gov. And society
People are better able to recognise a legal problem in the future and seek appropriate support.
People are equipped to take control of their legal problems, through improved legal knowledge, skills and confidence.
Improves faith in the justice system
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.
People are able to tackle problems and resolve them swiftly.
Increased or restored benefits
Debts reduced or managed
Employment issues resolved
Obtaining other entitlements or rights e.g. immigration help
Housing situation stabilised, e.g. possession action avoided, repairs made to rental property
Prevention of problem escalation and problem clustering
Improved ability to manage finances
Increased independence
Improved mental wellbeing, including reduced stress/anxiety
Improved physical wellbeing, including diet, exercise, sleep
Better relationships with family and friends, isolation reduced
Reduced demand on the formal justice system (courts and tribunals)
Reduced demand on wider public services
Reduced demand on the healthcare system
N.B. Assumption of net cost reduction

Context and problem statement

Problem

Legal needs research shows that people experiencing justice problems often do not know that their issue has a legal dimension, perceiving these issues as 'life problems' or 'bad luck'. This means that many people do not immediately seek out professional legal support when experiencing a problem but go to their friends and family, or trusted members of their community or other professional services, such as their GP, particularly as these common but serious problems can have health harming impacts.

The link between justice and health problems is bi-directional. Legal needs can impact on social, and wider, determinants of health (e.g. housing and debt) and directly on health itself, whilst those with health problems are more likely to experience justice problems.

Individuals increasingly turning to support from GPs and healthcare professionals creates a strain on existing healthcare resources, and these professionals are often not equipped to deal with social welfare problems. This means that they are often unable to do more than to simply signpost patients who then may or may not seek help. If problems aren't resolved, they can escalate and cluster, leading to negative and costly outcomes for the individual, the justice system and wider society.

Hypothesis

It is hypothesised that if legal advice is partnered with a primary care health setting (which is familiar, trusted, discreet, confidential, less stigmatised, often less far to travel and somewhere people feel comfortable discussing anxieties), with formalised and appropriate referral mechanisms, then people will be supported with advice to resolve their issues earlier. These services will also reach people that would not otherwise have sought out legal support – particularly individuals from low income and disadvantaged groups or individuals that would like to protect their anonymity, as it can appear that clients are attending a regular GP visit. Further, referrals from a health professional can bear more weight with individuals who feel that they need more support in taking the first step to access legal advice.

Co-location and other integration between health and justice advice is expected to lead to reduced drop-off rates between services due to fewer referrals and resultant fatigue,

ultimately leading to increased engagement with advice services. Resolving issues earlier will avoid them compounding and escalating, avoiding a negative socio-economic outcome and improving health and wellbeing, reducing demand on healthcare and formal justice system providers.

Intervention
As stated in the introduction to this report, MoJ is committed to evaluating the provision of social welfare advice within primary healthcare settings. MoJ need to evidence whether the models currently in use in England and Wales allow more people to access legal support and/or allow for earlier resolution of people's legal problems. This will inform the MoJ's future activities in this area.

Assumptions
Underpinning the ToC are four key assumptions that will need to hold true in order for the outcomes and impacts shown in the ToC to occur. Understanding the assumptions supporting the programme's theory will provide greater understanding as to why an outcome may not have been achieved. The four key assumptions are that:

- Healthcare and advice providers have **strong, positive, collaborative working relationships,** with clear processes for referrals and administrative join-up.
- The service is **easy to use** for patients and staff, so referrals are made and clients attend appointments. As part of this, it is assumed that **clients can access these locations** in the pandemic/post-pandemic world.
- **Health professionals are able to identify** when patients' issues have a legal dimension.
- **Clients act on the advice given.** They have the confidence and motivation to enact a solution.

Inputs
The inputs column on the left-hand side of the ToC describes the resources – funding, policy and stakeholders - that are required to deliver the key activities of the HJPs and necessary to bring about the desired outcomes and impacts.

- **Funding**: At the moment, the funding of HJPs is localised and comes from a range of sources including from Local Authorities, charities, Clinical Commissioning Groups (CCGs), National Lottery funding, the DWP and the Money and Pensions Service (MaPS). This is important to consider as it may influence the type of services provided and types of data collected.

- **Training for health professionals**: Health professionals need to be trained to identify when an issue has a legal basis so that they can refer these clients on to receiving legal advice. This may range from formal training to less formal awareness-raising activities.

- **Community involvement**: Advice hubs need to ensure that people in the community are aware of the hubs and trust the organisations involved in order for them to use the service. Community involvement could entail working with local residents to explore what is important to them and designing services accordingly or training local residents to conduct primary research so that they have a stake in the service.

- **Service delivery i.e. referral systems**: There needs to be some form of agreed system/booking system set up for the hubs to function. The type of referral system used will have an impact on data availability for the evaluation, with some advice hubs collecting more data than others.

Activities

Activities will be carried out by a not-for-profit advice agency (e.g. CA or a Law Centre) co-located or partnered with a healthcare setting. Depending on the model, referrals may come from the healthcare provider or individuals may self-refer to the advice provider. The activities themselves also depend on the model and provider, and may include:

- Advisers providing information and explaining options to clients.

- Identifying further action the client can take.

- Providing support with tasks (e.g. form filling).

- Casework.

- Negotiating with third parties or the other side of the dispute.
- Representation and litigation.
- Referring to other sources of support and advice.

Outputs

The direct output of activities is intended to be **improved access to advice**, with clients receiving appropriate advice and assistance for their problem(s). There is an assumption here that the advice provided is additional to (or quicker/better than) what would have happened in the absence of the HJPs, including reaching individuals who would otherwise not have sought out legal support.

Short term outcomes

Receiving advice and assistance is anticipated to lead to the short-term outcome of **improved capability/capacity** of service clients, whereby:

- People are equipped to take control of their legal problems through improved legal knowledge, skills and confidence.
- People are better able to recognise a legal problem in the future and seek appropriate support, enabling them to identify needs which typically would not have been acknowledged.
- People have an improved faith in the justice system after experiencing that there is a system in place which can help them resolve their legal problems.
- The burden on healthcare professionals is reduced as they spend less time in appointments talking to patients about legal/social issues, allowing them to spend more time focusing on health issues. There may also be time saved trying to resolve legal/social issues outside appointments – both for healthcare professionals and other staff such as GP receptionists.

Improved capability and capacity is anticipated to lead to **problem resolution**, with clients able to tackle and resolve problems swiftly.

What the resolution of problems entails will vary depending on individuals' specific needs but key ways in which it is anticipated that problems will be resolved include:

- Increased or restored benefits.
- Debts reduced or managed.
- Employment issues resolved.
- Obtaining other entitlements or rights such as immigration help.
- Housing situation stabilised e.g., possession action avoided or repairs made to rental property..

Long-term impacts

Long-term impacts are the ultimate, high-level effects that the service is working towards. If clients experience improved capability/capacity and are able to resolve their problems as a result, this is anticipated to contribute to benefits for individuals, government and society.

Individuals are likely to experience an **improved socio-economic situation** via six key long-term impacts:

- Prevention of problem escalation and problem clustering.
- **Improved ability to manage finances**, enabling a better financial position and increased participation in society (due to more money to see friends and partake in leisure and social activities).
- **Increased independence**, defined as increased autonomy and ability to manage their lives with less support from the state or charities. It includes the ability to navigate their legal problems with less support than they otherwise would have needed.
- **Improved mental wellbeing**, including reduced stress and anxiety.
- **Improved physical wellbeing**, including better diet, more exercise and sleep.

Reduced stress often leads to reduced conflict within and beyond households and therefore **better relationships with family and friends.** Better relationships can in turn support increased independence and vice versa (e.g., greater financial independence might mean more money being spent on seeing friends and therefore **reduced isolation**). It is particularly worth noting how every type of problem resolution can lead to improved mental wellbeing, including reduced anxiety/stress, and that there is a bi-directional relationship between mental and physical wellbeing. These outcomes lie at the heart of the rationale for HJPs.

As individuals' socio-economic situations improve, this is likely to lead to reduced costs to government and society via three key long-term impacts:

- Through early resolution and the prevention of problems escalating and clustering, it is anticipated that fewer legal issues will need to go to court or tribunal resulting in **reduced demand on the formal justice system**.
- **Reduced demand on wider public services**, including social care, housing, welfare and benefits, local authorities and other dispute services such as Acas.
- Improved mental and physical wellbeing is anticipated to lead to **reduced demand on the healthcare system** in the form of fewer visits to GPs, less demand for community or specialist services, fewer prescriptions needed etc.

The ToC notes that there is an assumption of **net cost reduction**. This is to acknowledge that some of the ways in which problems can be resolved will cost the state money e.g., welfare benefits being restored or increased. It is anticipated that there will be a net cost reduction despite this, given that upstream preventative measures are typically more cost-effective than the interventions needed to solve problems once they have escalated (e.g., going to court).

While there is also the possibility that once people are better able to identify when they have a legal problem this actually increases demand on the formal justice system and wider services in some instances, again there is an assumption that this will not outweigh the benefits of early resolution across most cases. It should also be noted that even where wider services have more people contacting them, the contact made might be more

efficient because of the advice hub interaction beforehand meaning fewer referrals are made in error and individuals are better informed about what to expect from the service they contact.

Specific project risks and external influences

The HJPs and the proposed evaluation take place within a constantly evolving environment. As a result, changes to the evaluation are to be expected. The factors which might influence the advice hubs and the evaluation can be broadly split into specific project risks and external influences.

Specific project risks

- **Covid-19 impacts on access**, meaning that service usage is not high enough to achieve a large enough sample to produce statistically significant findings.
- The evaluation places an **additional strain on healthcare sites** during the pandemic.
- The evaluation places **additional strain on advice services** during the pandemic.
- There are no positive findings due to **measurement difficulties.** This could be detrimental to the advancement of HJPs. Tracking, measuring and attributing outcomes are particularly difficult in this context where clients have complex issues that can reoccur or repeat, meaning that their trajectory isn't linear, improvements may be marginal, and benefits are complex and diffused.

How these risks could be mitigated are included in the evaluation sections (chapters 5, 6 and 7).

External influences

- **Covid-19 impacts on healthcare**, including social distancing and more controlled access and remote consultations. This will impact footfall and how people interact with these services.

- **Covid-19 impacts on legal need and routes to resolution,** which has had a huge and constantly evolving impact on the social justice system, rights and entitlements and services that can be accessed for help.
- **Local needs and environment –** this may include system changes such as an increase in social prescribing, development of integrated care systems etc.
- **Wider funding and operational decisions** at the advice hubs, which can impact service delivery and data collection.
- **Government priorities**, HJPs are felt to fit within the current "levelling up" agenda and the NHS England and NHS Improvement strategy to reduce health inequalities (CORE20PLUS5).
- **Cost of living crisis**, likely to lead to more people needing help with legal issues.

Appendix B: Detailed results from the literature review

Search methods used for the literature review

A structured, transparent, repeatable but pragmatic approach was adopted, which included structured searches of academic literature, and review of grey literature from appropriate sources.

Beardon et al. (2021) carried out a systematic scoping review of international evidence on the impact of HJPs. This review considered both formally published and grey literature evidence, covering OECD countries from January 1995 to 13 December 2018. A targeted, pragmatic search was designed and carried out to identify new evidence reporting evaluations or case studies of partnerships between healthcare and legal or rights advice services published since the period covered by Beardon et al (2021), in order to maximise the utility of the time and resources available.

The search strategy was informed by that used by Beardon et al. (2021) and comprised the following conceptual structure:

- Health-justice partnerships OR (legal/rights advice AND healthcare settings)
- Searches were limited to English language publications with a publication date of 1 December 2018 (the cut-off date for Beardon et al (2021) to current date (up to 22 February 2022).

Full database search strategies are available on request. Website and web search engine searches were also targeted and pragmatic. Websites were browsed and/or searched with the most highly discriminating keywords from the database strategy, in order to identify potentially relevant documents published since 13 December 2018.

Resources searched and search results

The literature search was conducted in the databases and information resources shown in Table 17. This included databases of formally published evidence such as journal articles, as well as websites to capture grey literature.

Table 17: Databases and information sources searched for the literature review.

Resource	Interface
MEDLINE ALL.	OvidSP.
Social Policy and Practice.	OvidSP.
HMIC Health Management Information Consortium.	OvidSP.
APA PsycInfo.	OvidSP.
CINAHL Complete.	EBSCOHost
Age UK website.	https://www.ageuk.org.uk/
Centre for Mental Health website.	https://www.centreformentalhealth.org.uk/
Citizens Advice website.	https://www.citizensadvice.org.uk/
Health Justice Australia website.	https://www.healthjustice.org.au/
Justice website.	https://justice.org.uk/
Law and Justice Foundation website.	http://www.lawfoundation.net.au/
Law Centres Network website.	https://www.lawcentres.org.uk/
Legal Action Group website.	https://www.lag.org.uk/
Local Government Association website.	https://www.local.gov.uk/
Macmillan Cancer Support website.	https://www.macmillan.org.uk/
Maggie's website.	https://www.maggies.org/
Mind website.	https://www.mind.org.uk/
Ministry of Justice website.	https://www.gov.uk/government/organisations/ministry-of-justice

Money and Mental Health website.	https://www.moneyandmentalhealth.org/
National Center for Medical Legal Partnership website.	https://medical-legalpartnership.org/
National Institute for Health and Care Excellence (NICE) website.	https://www.nice.org.uk/
NHS England website.	https://www.england.nhs.uk/
Open Society Foundations website.	https://www.opensocietyfoundations.org/
Pathway website.	https://www.pathway.org.uk/
Release website.	https://www.release.org.uk/
Scottish Improvement Service website.	https://www.improvementservice.org.uk/
Shelter website.	https://www.shelter.org.uk/
Social Action for Health website.	https://www.safh.org.uk/
Social Care Institute for Excellence (SCIE) website.	https://www.scie.org.uk/
Social Prescribing Network website.	https://www.socialprescribingnetwork.com/
The Health Foundation website.	https://health.org.uk/
The King's Fund website.	https://www.kingsfund.org.uk/
The Legal Education Foundation website.	https://thelegaleducationfoundation.org/
Youth Access website.	https://www.youthaccess.org.uk/
UCL Centre for Access to Justice website.	https://www.ucl.ac.uk/access-to-justice/

The searches were conducted between 10 February 2022 and 22 February 2022. The database searches identified 3,882 records; an additional four records were identified via citation checking. After deduplication, 3,023 records remained for assessment. Records were rapidly assessed first at title and abstract, and then at full text by a single reviewer, using the inclusion/exclusion criteria shown in Table 18. Documents were selected and

extracted that report evaluations or case studies of partnerships between healthcare and legal or rights advice services published from 2018 to current. An additional 30 documents from the website searches were also selected and extracted. Following data extraction, these 69 records were further assessed for their particular relevance to the feasibility study and for robustness of methods.

Table 18: Study inclusion/exclusion criteria.

	Inclusion	Exclusion
Service definition.	Services providing legal assistance with social welfare issues in healthcare settings (direct physical or functional link between legal and healthcare service).	Areas of law other than social welfare. Information or advocacy services (not legal assistance). No direct links with healthcare.
Language.	Publications printed in English.	
Publication date.	Publication date of 1 December 2018 (the cut-off date for Beardon et al (2021) to current date (22 February 2022).	
Geographical location.	OECD countries.	
Research type.	Primary studies of any research design (both quantitative and qualitative), reviews and grey literature reports.	Publications not presenting empirical findings, publications presenting vignettes only.
Publication type.	Peer reviewed journal articles, reports, service evaluations.	Editorials, discussion papers, opinion pieces, letters and commentaries, conference abstracts.

Records were considered to be particularly relevant if the intervention featured an explicit partnership between healthcare and welfare/advice services, where the service described was very similar to the HJP intervention. If the intervention discussed links between health and welfare/advice services as part of a wider initiative (e.g., social prescribing), this was considered to be 'less relevant'. In the main, robust methods were classed as systematic reviews and RCTs, but also included a small number of well conducted evaluations using quasi-experimental methods, and service reviews or case studies using mixed methods.

The most robust studies were considered to be those where the study methods did not display methodological limitations, such as low numbers where this was required by the study method. On this basis, 12 records were considered to be relevant and well conducted studies. A further 26 were partly relevant and/or used less robust study methods. Methodological limitations were considered when assessing robustness. For example, trials with low participation numbers and were considered less robust, as were studies with high rates of loss to follow-up in survey responses. Other considerations included the composition of control arms; in one study it was noted that the control arm was not randomised but composed of all patients who refused the legal services intervention (Malik, 2018) [38]. Studies were also considered less robust where there was limited reporting of the study methods or results. The main themes are summarised in the next section.

Additional highly focused web searches using Google were also carried out to identify documents not captured by the resources above.

Detailed results

Most relevant and robust studies

A systematic scoping review by Beardon et al in 2021 [1] included evaluations of HJPs published between 1st January 1995 and 13th December 2018 in OECD countries. The study did not provide specific information about each HJP included but largely the co-located partnerships provided free legal advice in primary care or a hospital setting. The study found there was strong evidence that HJPs improved the socioeconomic circumstances of individuals, mental health (stress, depression, and anxiety), legal problems, and addressed the social determinants of health. Importantly, there was

evidence to suggest HJPs may address inequalities by improving access to legal assistance for people that are most likely to be affected by health-harming legal need, but also those who may not seek help for these issues. For example, one study included in the review found HJPs improved access to legal assistance for older people and people with mental health issues. Beardon et al's study highlighted that there is a need for more high-quality research on the impact on health inequalities, health service utilisation with a suitable comparator, prevention of health issues in the long term and other impacts for health services and patient care. Based on the evidence available, they could not generalise the impact of HJPs on individual health because a variety of methods, populations, and legal interventions were used in the 77 studies included in the review.

A 2021 report by Genn and Beardon [8] explored the experiences of clients and GPs in relation to a primary care-based legal advice clinic conducted at University College London (UCL). The main activity involved offering free community legal support which included casework and representation to address social welfare issues. The evaluation used surveys to gather information from the clients and the GPs involved. The research found there were significant improvements to quality of life, as reported in improvements in quality-of-life scores in the six months after the initial legal assistance. There was also an association found between legal problem resolution and significantly greater improvements in two of the health and wellbeing scores (EQ-5D and SWEMWBS) relating to outcomes such as pain, self-care, anxiety, and depression. Clients also had improved health where there had been positive progress with legal issues, specifically improvements in mental wellbeing. The GP interviews found that there was a positive contribution to patient care for managing patients' non-medical and health-harming needs through the partnership. General practitioners felt supported by the legal clinics, felt confident patients were receiving the right support, and believed co-location could improve attendance in primary care.

A narrative systematic review by Reece et al in 2022 [2] examined the impact of welfare advice services delivered, whilst physically co-located in a UK healthcare setting, on any outcome type (for example health, social, and financial). The review included 14 studies of co-located health and welfare advice partnerships, which were largely conducted by Citizens Advice. The review suggested that access to co-located services improved

knowledge about welfare rights, health and wellbeing, financial gains, financial security, and also that co-located welfare rights advice reduces the burden on primary and secondary health care services. The study highlighted future studies will need to address concerns that were identified in the review, such as recruiting a sufficient number of people from minority groups.

Another systematic review by League et al in 2021 [9] evaluated partnerships between health care providers and legal providers between 2010 and 2019 for immigrant and migrant communities in the United States. In total 18 studies were included in the qualitative synthesis and 11 studies included recommendations for forming a co-located partnership. The study found that successful partnerships are formed from sharing cultural competencies (the ability of staff to be respectful and understanding towards patients' beliefs, religion, and health needs) and from educational information, and that this can improve financial outcomes for migrants. The study did not report the specific outcomes and health care settings for the studies included in the review.

A literature review completed by Murphy [10] in 2020 was presented as a briefing paper providing an update to previous work focusing on medical-legal partnerships in the US. It focused on studies from January 2013 to August 2020. There were 70 articles found and an additional 13 observational studies, as well as supplementary relevant literature that had not been peer-reviewed. The literature included descriptive articles that outline the need for and approach of medical-legal partnerships, practice reports that take a case study approach to describe medical-legal partnerships in practice, and observational studies that seek to measure the impact of medical-legal partnerships. Positive improvements were reported across five key outcomes: 1) the health and wellbeing of patients; 2) housing and utility stability among patients; 3) access to financial resources among patients; 4) healthcare systems and workforce; 5) policies, laws, and regulations.

A UK RCT carried out by Haighton et al in 2019 [7] compared domiciliary welfare rights advice service offered to people in primary care in their own homes to usual care (i.e. GP and welfare rights services that are not co-located), and investigated the impact on health outcomes (including mental health, financial wellbeing, standard of living index, social support and participation, general health status, health related behaviours, mortality, financial status, and independence). The study's economic evaluation (within-trial cost–

consequences analysis) found that domiciliary welfare rights advice was more effective but more costly than usual care. The intervention cost an additional £17 (95% CI £15 to £19) because it was delivered in the patient's homes. The study did not find a statically significant impact of the intervention on health outcomes or cost-effectiveness. A potential reason for this is that attrition rates were high and those who remained in the study were healthier than those who had dropped out. There were few people in the study who were socioeconomically deprived and as a result, most participants were not eligible for welfare benefits. The study concluded that further research is needed to identify how to target the intervention at those who are most likely to benefit.

The evaluation paper by Egan and Robison [3] from 2019 focused on embedded advice workers in nine general practices in Glasgow, UK, operating in areas with higher than the Scottish average for deprivation. The comparative impact evaluation explored financial outcomes and the processes of setting up and delivering the project. It also examined the governance of the project and the potential learning that could be taken from the scheme. Over 12 months, the money advice service was able to provide £1.5 million worth of financial gains for people who engaged in the services and an additional £470.5k worth of debt was identified and managed. This gave a return on investment of £19.26 financial gain for every £1 invested or when debt is taken into account a ROI of £25.29. Around 30% of referrals did not engage with the service. The successful cases found that half of financial gains were for disability-related benefits, with other referrals covering homeless and housing issues, as well as mental health issues.

The National Center for Medical-Legal Partnership [6] created a blueprint for complex care based on case studies from the US. All four medical-legal partnered services had a specific interest in serving people with complex health needs. In the evaluation, outcomes from a one-year pilot study of high-need, high-use patients in a primary care, secondary care and home settings, at Lancaster General Health, provided results indicating that when patients' legal needs were addressed the inpatient and emergency department use reduced by 50% and overall health costs reduced by 45%. Another study showed a positive impact on mental health when free legal services were offered to 950 veterans. The report included a comparison to a similar high-intensity, team-based care management model that demonstrated a 37% reduction in unplanned hospital

readmissions among 149 high-cost, high-use Medicare beneficiaries in four states by addressing patients' social determinants of health and connecting them to relevant community-based services.

In 2021, Goodman et al. [11] produced a review of social welfare legal advice services, establishing the different kinds of collaboration, as well as examining the different ways to fund, refer, data share and establish working protocols. The methodology included interviews with clinicians, link workers, welfare advisors, project managers, commissioners and representative bodies. Snowball sampling was used, and in total 20 were interviews conducted. The findings included a review of the benefits and drawbacks of different kinds of arrangements offering legal advice. Among these were the varying referral pathways, either from GP to social prescriber to welfare adviser or from GP to welfare adviser to social prescriber. In the former, a noted drawback was that the clients most in need of support were those most likely to drop out with each added referral stage between the GP and a welfare adviser. In the latter, in the event that a social prescriber would be the most useful service, an additional step in the form of a first referral to a welfare adviser could lead those most in need of support to drop out of the service. A further referral pathway model described was the integration of the social prescribing and welfare advice services into a single service to which GPs could refer. However, while this reduces the number of referral points, there was concern that combining two services into one might leave both with the resources of a single service, effectively doubling the workload and reducing the quality. Further, while the benefits of co-location were described, the authors noted that social prescribers found meetings outside the healthcare setting important to glean wider information about each client's circumstances and needs. Overall, the importance of training and good working relationships was highlighted to ameliorate drawbacks associated with service integration. Key messages from the report included that funding should be targeted and should supplement NHS England funding for link workers to enable social welfare legal advice services to meet demand.

A case study by Begum [4] focused on co-located advice in primary care settings in Tower Hamlets, UK. The report provides information on the service that has been providing social welfare advice to GP patients in the borough since 2004, and contains details from an evaluation of the service which covered a range of impacts on staff and patients. Advisors

reported being able to work more effectively and efficiently than when they had been delivering advice in other settings, partly due to being able to access medical records. Patients found that the advice services in GP settings improved accessibility, which was particularly beneficial for elderly and frail patients. The service also prevented patient drop-off between referral and attendance. Moreover, it showed that GPs in practices with the advice services experienced a reduction in non-clinical demands, as well as feeling more positive about the quality and efficiency of consultations. Both GPs and patients felt there were improved health outcomes for those using the service, such as a reported reduction in stress.

An evaluation by Allison [5] from 2019 focused on the Wuchopperen Health Service Health Justice Partnership in Australia that served Aboriginal and Torres Strait Islander communities in particular. The evaluation examined an 18-month period of the service, collecting and analysing data from clients and staff. The main activity was a clinic where legal partners provide civil and family law legal information, advice and casework. The evaluation found that clients identified that the legal clinic improved their wellbeing, by reducing stress and anxiety caused by legal issues. The partnered legal clinic also found that legal issues were being addressed earlier than if the individuals had been expected to present to a stand-alone legal clinic. Some legal issues were able to be averted altogether, or prevented from escalating to a more serious, complex level. Outcomes from staff showed that they felt the social determinants of health were being tackled, plus health issues were addressed more often because people were coming back to the health service for legal assistance therefore drop off was reduced. Finally, a key result from the evaluation was the focus on trust that was critical for outreach, clients came to the legal service that was co-located because they trusted healthcare professionals. The evaluation did not have a comparator.

A review in 2018 by Beardon and Genn [12] mapped services across England and Wales, finding a total of 380 social welfare legal services. The key service aims included handling issues of physical and mental health, assisting healthcare professionals to manage non-clinical demand and addressing a range of other health-related needs. The most common issues addressed were welfare benefits, debt, and housing. The type of assistance provided ranged from first-line advice to in-depth casework. Funding of the services was

reported as fragile and short-term, mostly coming from local authority and charity sources. The review suggested that the move towards integrated care could be a potential opportunity for a wider development of partnerships between social welfare legal services and healthcare services.

Partly relevant or less robust studies

The following studies were less relevant to the review because the evidence was less robust or the services described were variations on the service model of interest.

An evaluation by the Administrative Justice Council [13] in 2021 examined the medical-legal partnerships of four UK-based hospital trusts: Great Ormond Street Hospital, Springfield Hospital, Royal Brompton Hospital and Harefield Hospital, and South London and Maudsley NHS Foundation Trust. The main activity reported was 10 interviews were conducted with participants from these services. There were six key messages identified as outcomes of the research: 1) by providing integrated social welfare services, this can enable patients to leave hospital once medically advised; 2) co-location enables a holistic approach to patient's welfare. The patient's physical and mental health improves by dealing with all the presenting issues at the earliest opportunity; 3) for the social welfare advice to work well in a hospital setting there needs to be good communication between the various teams; 4) co-location leads to a system of knowledge sharing between clinicians and advice workers whereby clinicians become better able to spot issues presenting in patients requiring advice; 5) for services to continue, there needs to be support and buy in from all staff members; 6) the value of advice provision within hospitals can be observed as a benefit to all types of hospitals and patients.

In 2019, Day and Moensted [46] evaluated an Australian service between Redfern Legal Centre and Sydney Local Health District. The main activities of the HJP were employing a solicitor at the hospital twice per week to provide legal assistance to the clients and training hospital staff to identify legal issues. The service was found to be providing non-judgemental compassionate care in a flexible, accessible manner to promote good outcomes for vulnerable clients and encourage equity in terms of access to legal services for this population. There were, however, limitations to the review such as limited information in terms of type and breadth of information available on the clients, large

amounts of missing data and difficulty in evaluation due to the complexity and diversity of the cases.

A 2021 case study by Hutchinson [14] examined social prescribing link worker services in Barking and Dagenham. Social prescribing link workers acted as ‘relationships managers’, each allocated to one primary care network to link with clinical services. Moreover, they worked closely with the Homes and Money Hub (HaMH) within the local authority to support residents with issues related to housing and money. The link workers and the HaMH could also refer individuals onto Citizens Advice Barking and Dagenham for complex benefit appeals and housing cases, and immigration cases that HaMH do not cover. The results from the evaluation found successfully sustained tenancies, improved financial stability and maximised income for service clients. The case study was fairly short and lacked detail, acting as an overview of the service rather than an in-depth evaluation.

A case study by Seymour [15] from 2021 reviewed the activities in North Islington Primary Care Network, UK. The network worked with Help on Your Doorstep (HOYD), a charity undertaking outreach and resident engagement, to improve access to social welfare services and social welfare advice for local residents. The partnership with the North Islington Primary Care Network employs link workers with a social welfare advice specialism. This means that HOYD can refer clients to social welfare services and have the provision to follow up afterwards to ensure issues are resolved. Although the case study lacked data, there were positive outcomes and feedback from patients who accessed the services. The service reported funding issues as the reason for not having a more comprehensive evaluation available.

Maternity Action [16], [17], [18] published evaluation briefings and a review of evidence on HJPs with a view to scoping out the potential for integrating their advice service into healthcare settings. The evaluation drew upon case studies which found evidence for improved outcomes covering health and wellbeing. The main activity by Maternity Action is a free, specialist information service specifically targeting pregnant women and vulnerable pregnant women who are migrants.

An evaluation from 2018 of hospital partnerships by Inner Melbourne Community Legal [19] interviewed patients and staff involved in the Royal Children’s Hospital, the Royal

Melbourne Hospital and the Royal Women's Hospital. The evaluation included a survey of 80 patients who had accessed legal services through the hospitals. 82.5% of 80 patients surveyed had never seen a lawyer about their legal issues before and 40% of patients said that they would not have seen a lawyer if there had not been a free and onsite legal clinic. 74% of patients surveyed felt that the legal issue had a negative impact on their health and wellbeing and 59% of patients surveyed thought that the legal advice had a positive impact on their health and wellbeing. The evaluation had several limitations, including the presence of a volunteer bias, as data collection did not provide a sample that was representative of all patients and staff, and issues with patients not completing the follow up survey.

A second evaluation by Inner Melbourne Community Legal [21] from 2018 focused on the Royal Melbourne Hospital partnership in particular. The main activity was an onsite legal clinic providing free legal services to patients through a referral system. 95% patients found it easier to see a lawyer, due to the location and time and day of the appointments and 48% of patients reported that they felt the legal advice would probably have a positive impact on their health and wellbeing. A further interview with four social workers found that the partnership allowed them to have better knowledge, capacity, and support, as well as feeling more confident dealing with legal issues. Additional outcomes included that there could be faster, safer, and more successful discharges. There were some issues with the evaluation as the most vulnerable patients were not asked to participate as it was not deemed appropriate. Those who required an interpreter were also not asked to participate. Patient medical and legal records were not shared which reduced the scope of outcomes.

A slideshow presentation from 2021 by Elbogen et al. [21] detailed two case studies from the USA which considered how to address financial and legal problems to improve the mental health of adults and children during the Covid-19 pandemic. The first explored the links between mental health and socioeconomic issues, finding that bringing civil legal aid services into healthcare settings could lead to cost savings. The average amount of time to resolve a legal issue was 5.4 hours, at an average cost of $50-$70 an hour and $270-$405 per legal issue addressed. This was compared to the average annual direct costs to provide healthcare to a person who is chronically homeless, has severe mental illness or both, which ranges from $10,000-$60,000. Secondly, a service called Mental Health

Advocacy Program for Kids aimed to improve health and increase educational success of children with unmet mental health needs. Attorneys provided free legal representation to low-income families and advocated for access to mental health services for children. The evaluation showed improved school attendance, decreased use of emergency mental health services by children, decreased inpatient hospitalisations of children, improved mental health of children and caregivers, and decreased rate of family conflict.

A 2019 slideshow presentation by Allman [22] presented the evaluation of the Suffolk Community Foundation's work to extend the reach of Citizens Advice Ipswich to deliver a pilot working with 13 GP surgeries across Ipswich. There was a reported potential reach of around 250,000 people. The main activity of the Connect for Health programme was to resolve or reduce legal welfare needs that impacted negatively on health and wellbeing through face-to-face advice services. The evaluation found that on average clients had 68% fewer appointments compared to the six months prior to advice. GPs recognised the benefits of increased advice provision in health, and that there is evidence of the impact of advice on health-related outcomes. Further details on the evaluation methodology were not available.

A 2020 RCT by Bovell-Ammon et al in the USA [23] examined the impact of an intervention that addressed housing instability in people who are homeless or had with complex health needs. The intervention was a partnership between legal services providing assistance with housing applications and legal support, and health-care providers providing a letter of medical need and requests for housing or other health services when required. The study suggested that after six months the intervention improved child health status, and parental anxiety and depression, compared to the control group. The study found no significant differences in outcomes in the homeless participants, however the study was limited by a small sample size and the inability to separate out the impact of legal advice on health outcomes.

Another UK RCT by Barnes et al in 2018 [24] evaluated a community support team intervention which assisted vulnerable individuals with accessing relevant support and managing their financial problems. The intervention group was compared to people receiving one session with the support team and referrals to other support services. The study found the main benefits reported in the qualitative interviews were improvements in

financial situations. The study had problems retaining and recruiting people into the study but based on the evidence gathered, concluded the intervention was low cost and feasible.

A 2019 review by Mekdes et al [25] summarised the Commonwealth Fund's assessments of evidence on interventions to address health-related social needs for people who are considered ‘high-need’ (for example, uninsured people) in the USA. The study found that providing legal assistance to at-risk people can reduce readmissions, emergency department visits, hospitalisations, and reduce costs. The quality of evidence included in this review was low-quality, as most study designs were case studies apart from one RCT.

Nerlinger et al in 2021 [26] developed a logic model and a potential evaluation tool using three different medical legal partnerships. The study highlights three main long- and short-term outcomes for medical legal partnerships: learner outcomes (this refers to the outcomes of staff trained in the partnership, such as engagement with their training and improved identification of the social determinants of health), patient and community health outcomes, and health system savings. The paper does not show the application of the tool on a ‘real’ medical legal partnership.

A mixed method evaluation carried out by Berg et al in 2022 [47], in the USA, described a partnership between a public health care system and legal advice, and investigated whether high-risk individuals’ situations improved after referral from healthcare to legal services. Of the 23 people interviewed, 57% reported a resolution to the financial barrier to health care after intervention. The study concluded that there was an association between legal services and self-reported improvements to health. However, the study did not include a comparator and the sample size was small.

A UK realist mixed method evaluation by Dalkin et al in 2019 [27] examined three projects, one of which involved GPs referring patients with multiple and complex issues (including severe mental health problems and welfare issues) to the local Citizen’s Advice service. The study found improvements to well-being and stress after advice had been given to people using the service. Only one project is relevant to this review but the impact of this project is unclear because all three projects were analysed together.

A pilot before and after study by Rosen in 2019 [28] examined the impact of a partnership between free legal advice with healthcare on parental stress, for low-income children with

disabilities and their families. The study measured stress using the Perceived Stress Scale (PSS-10) questionnaire, which asks participants how often they felt a certain way - for example, how often they have felt upset, with high scores indicating higher levels of stress. The study found that retaining people in the study was an issue but reported an average reduction of 2.5 in PSS-10 stress scores. One third of participants reported an increase in stress after intervention. The interpretation of this finding is limited by the lack of comparator, and the small number of people who completed the study (40% of people completed both pre- and post-intervention questionnaires).

A before and after study, in Australia, carried out by Lewis et al in 2020 [29] evaluated health care professionals' opinions on an HJP, in which older people in community health services were referred to a lawyer if abuse was suspected. The study found that health care professionals reported that older people do have legal issues but they were not confident in identifying abuse and referring to a lawyer. The impact of legal advice is unclear in this case because fewer health care professionals completed the survey after the lawyer was introduced to patients.

Agarwal et al in 2020 [30] carried out an observational study of a legal health clinic partnership between primary care and legal aid clinics in Canada. The study provided a description of the demographics of people using this clinic. The study found that people at high risk of financial issues (for example, people who do not have citizenship or housing) and ethnic minorities were more likely to attend the legal clinics. The study concluded that the legal health clinic partnership helped to fulfil unmet legal needs of people in primary care.

Lawton et al in 2020 [31] carried out an analysis of records from a single United States paediatric primary health care and legal advice partnership. The study found that within the clinic where 74 people received services from Medical-Legal-Psychology Partnerships, 50% of referrals were for educational achievement, and the remaining were for public benefits issues, or family disputes. The study did not measure the impact of the clinic on any outcomes of interest (e.g., the success in solving legal issues or improving health outcomes).

Keene et al in 2020 [32] carried out qualitative interviews of the experiences of patients in a medical legal partnership in the USA. The study suggested that medical legal partnerships can identify legal needs, improve awareness in people who would not have sought legal advice, improve access to legal services, support relationships between clients and lawyers, and address affordability concerns.

An evaluation by Murillo et al in 2021 [33] assessed the experiences of the providers using qualitative interviews within the same medical legal partnership as Keene et al [32]. The study found that providers reported improved awareness and ability to address social health determinants and health harming legal needs and improved providers' advocacy and relationships with patients.

A 2018 qualitative study by Knowles et al [34] examined a food insecurity screening and referral program at three paediatric primary care clinics in the USA, using focus group interviews. The study found mixed evidence for the effectiveness of the program. The study found that the main concern was that many people who screened positive for referral were not eligible for additional help.

A case study by Salter in 2021 [35] examined the organisation of a partnership between legal services and an emergency care provider for low-income hospital populations in the United States. The study found that the following were essential components to the partnership: onsite legal services, assignment of an administrative partner from the health care team to the legal partner, and a committee of staff from a variety of backgrounds to oversee efficient day to day running of services such as data collection and referrals. The partnership also led to medical and legal staff sharing ideas to address social determinants that most often effect people in their services.

Another USA case study carried out by Shek et al in 2019 [36] evaluated and described the organisation of a medical legal partnership in Hawaii. The study suggested that it is important the intervention begins with the doctor introducing the lawyer face to face, at the point legal aid is needed. In order for the system to work for the individuals who are often most affected, the intervention needs to be community lead and inclusive (for example, individuals should be offered an interpreter).

Appendix C: Glossary of technical terms

Table 19: Glossary of technical terms

Term	Definition
Confounding variables.	A confounding variable is a variable that hasn't been accounted for, that can suggest there is correlation when there isn't or introduce bias.
Cost-benefit analysis.	Cost-benefit analysis is a comparison of interventions and their consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary terms. This approach allows costs and benefits to be appraised consistently.
Counterfactual group.	The counterfactual group acts a proxy for what would have happened to beneficiaries in the absence of the intervention, in order to estimate the impact of a specific intervention.
Covariates.	Covariates are characteristics of the participants in an experiment (e.g. demographics). If you collect data on covariates before you run an experiment, you can use that data to see how the intervention affects different populations.
Grey literature.	Grey literature is material which hasn't been subject to a formal peer-reviewed academic publication process. Examples might include reports, conference proceedings, dissertations, theses, presentations, evaluations, government publications and policy papers.
Propensity score matching.	Propensity score matching is a quasi-experimental method in which the researcher uses statistical techniques to construct an artificial control group by matching the intervention unit with a control group unit of similar characteristics. For further detail please see Appendix B.
Quasi-experimental design.	Quasi-experimental design attempts to establish cause-and-effect without using random assignment. Quasi-experimental designs encompass a broad range of techniques that are frequently used when it is not feasible or ethical to conduct a randomised control trial.

Randomised Control Trial.	A randomised control trial is a study in which people are randomly assigned to two (or more) groups to test a specific intervention. One group receives the intervention, the other has an alternative or no intervention at all.
Sample size	A sample size is a part of the population chosen for a survey or experiment. The sample size is important for any study which seeks to make inferences about a population based on the sample. In practice, the sample size is commonly determined based on the cost, time or ability to collect data, as well as the need for it to offer sufficient statistical power.
Sensitivity analysis.	Sensitivity analysis is an assessment of the sensitivity of a model to its modelling assumptions. It seeks to learn how sensitive the model outputs are to changes in inputs and how that sensitivity might affect overall findings.
Statistical power.	Statistical power is the likelihood of a statistical test detecting an effect when there actually is one. High power in a study indicates a large chance of detecting a true effect. Low power means there is a small chance of detecting a true effect or that the results are likely to be distorted by random and systematic error.
Theory of Change.	A theory of change is a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context.