Measuring What Matters: Exploring Evaluation Frameworks for Justice & Health Partnerships

Background & Discussion Paper

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List of Acronyms

AAMC	American Association of Medical Colleges
AHA	Advocacy Health Alliances (Australia)
ASTI	Aboriginal and Strait Islanders (Australia)
BC	British Columbia
CALC	Community Advocacy & Legal Centre
CFCJ	Canadian Forum on Civil Justice
CHC	Community Health Centre
CLC	Community legal clinics (Ontario), community law centres (Australia)
CMA	Canadian Medical Association
CoP	Community of practice
FHT	Family Health Team
HCP	Healthcare provider
HHLN	Health-harming legal needs
HJA	Health Justice Australia
HJP	Health justice partnership, the Australian and UK term for JHP
JHP	Justice & Health Partnership, known in Australia as HJP, and the US as MLP
LAO	Legal Aid Ontario
LFO	Law Foundation of Ontario
LJFNSW	Law and Justice Foundation of New South Wales (Australia)
LSP	Legal service provider
MAG	Ministry of the Attorney General (Ontario)
MIEAC	Measuring Impact Expert Advisory Committee
MLP	Medical-legal partnership, the US term for JHP and HJP
MOU	Memorandum of Understanding
NCMLP	National Centre for Medical-Legal Partnerships (US)
NHS	National Health Service (UK)
OECD	Organization for Economic Cooperation & Development
PBO	Pro Bono Ontario
PHIR	Population Health Intervention Research
PHLR	Public Health Law Research
RCT	Randomized control trials
REB	Research Ethics Board
ROI	Return on investment
SDoH	Social determinants of health
SROI	Social return on investment
UCL	University College London (UK)
UK	United Kingdom
US	United States

Executive Summary

This background paper is intended to provoke discussion on how best to evaluate justice & health partnerships (JHPs) as they evolve in the Canadian context, specifically in the province of Ontario. We explore the imperatives for undertaking new research and building evaluation capacity, given the unique opportunities this innovative approach provides. JHPs are also known as "health justice partnerships," (HJPs) and medical-legal partnerships (MLPs), which are relatively new terms in the lexicon of access to justice innovations, and capture a movement that has been growing for several decades in Australia, the United Kingdom (UK) and United States (US), and more recently in Canada. The health justice approach is characterized by collaborations between legal and healthcare professionals designed to identify and ameliorate health-harming legal needs (HHLN) and improve outcomes for the people we serve. This paper outlines the intended and actual impacts of these partnerships by reporting on the results of our scoping review, and from systematic reviews originating in other countries. Intended long-term impacts of this approach include improved health – legal, financial, physical, emotional, social, and psychological – for individuals, and offers *value-added* benefits for service providers, institutions, and communities.

We report on approaches to evaluation and research that have been attempted or are being recommended across four countries – Australia, UK, US, and Canada, focusing on Ontario. The paper synthesizes promising practices from a literature search, jurisdictional scans, and key informant interviews with country experts. The appendices collect important resources for ease of future reference. We make interim recommendations for how small-scale HJPs might evaluate their work, and for building our evaluation capacity should more pilot funding become available to support the health justice approach. For evaluation research to be viable, we need adequate funding and appropriate evaluation and research expertise. We must learn from these novel health equity and access to justice initiatives, further document their impacts, and create explicit professional knowledge about how to work most effectively in this interdisciplinary space.

Given the very different contexts in which the health justice approach is being employed, we soon realized it would not be fruitful to propose a single approach to evaluation research and to measuring impact. This is because each partnership's intentions – the justification for starting one or expanding it – and the implicit *theory of change* and the assumptions that underlie how an initiative has been designed and implemented – can be quite diverse. Furthermore, evaluation approaches are influenced by the country and professional disciplinary context, and the interests of key stakeholders including government and/or funders. Given this complex reality, we felt it was most helpful to present our findings as a background paper. We want to scale up this approach, so it became important to contextualize how this health justice movement is developing in four countries, document who is leading it, and understand factors that may influence its growth. We discuss diverging and intersecting approaches to evaluation research – a bricolage of possibilities for further investigation, dialogue, discernment, and action. It was a challenging task to synthesize approaches to evaluation and research, and they continued to evolve since this paper was drafted in June 2021. To the extent possible given limited resources, we have updated it to March 2024. Next, we will produce topical briefing notes to disseminate its findings and make it more accessible.

Chapter One explains why we undertook this research, our intentions in publishing this paper, the process of creating it, and clarifies the purposes of evaluation, research, and evaluation research. We document the known impacts of the health justice approach summarizing systematic and scoping reviews. An overview of the content of the report, and its parameters follows, including emerging fields beyond the scope of our remit, but that hold promise for future efforts, such as public health law research, public health intervention research, health equity intervention research, and inclusion health research.

Chapter Two outlines the collaborative, iterative, and multi-disciplinary approach we took to our research, and some of our preliminary findings. We built our capacity for evaluation by engaging in dialogue across disciplinary perspectives. Chapter Three outlines the historic and current context for the health justice movement in Canada, Australia, UK, and US. Chapter Four explores research and evaluation approaches across these countries, and summarizes systematic and scoping review recommendations for improving research quality. We also review evolving approaches for measuring outcomes from access to justice initiatives, insights from the field of evaluation, identify pragmatic evaluation guides, and qualitative research approaches that show much promise. Chapter Five distills 22 themes from our study, and outlines promising practices for developing evaluation frameworks. Chapter Six sets out 10 potential next steps including opportunities to scale up partnerships in Ontario, share information, improve the discourse, create new professional knowledge, and build evaluation capacity.

Scaling up the health justice approach in Ontario will be supported by improving our capacity to evaluate these initiatives. Healthcare providers value evidence that establishes that efforts make a discernible difference. The impact of the approach must become more visible, and its role in ameliorating the social determinants of health, and building a healthy justice ecosystem better understood. Appropriate evaluation and research methodologies will depend on context, the change we seek to create through this work, including whether we want to build cross-disciplinary capacity to support better health by effectively collaborating. We need to build professional knowledge about what works, how it works, why it works, and for whom. We should build on the promising practices emerging in other countries who are further along in adopting this approach. Our recommendations, including those for evaluation capacity building in the legal sector, will be transferable to other types of access to justice initiatives.

Cross-disciplinary work is not without its tensions and struggles, with significant divergence of approaches and complexity born of different disciplinary capacities, predilections, and ways of understanding. Yet the health justice approach provides a rich opportunity for strengthening our capacity to serve vulnerable and disadvantaged communities given our shared commitments to goals of equity and justice. The funding for evaluation and research in the justice sector is scarce, unlike the health sector, so opportunities to collaborate with healthcare professionals are critical. Learning how to work effectively across the justice and healthcare sectors to improve access to justice and health equity is essential. We must maximize our learning from the research skills and evaluation expertise of healthcare providers. We hope that this report will seed much generative dialogue on the best way forward and sustainable action, evaluation, and research opportunities.

Chapter One: Introduction and Report Overview

Justice & health partnerships (JHPs) have emerged as a promising intervention for early resolution of problems arising from unmet civil legal needs and for helping to ameliorate health-harming problems (HHLN) with a legal component. In Ontario, JHPs are increasingly recognized as productively intervening to increase access to justice by working strategically with healthcare professionals (HCPs), acknowledging the role they play for their patients as "trusted intermediaries" with the justice system (Cohl et al., 2018). These initiatives, known in the US as medical-legal partnerships (MLPs), and health justice partnerships (HJPs) in Australia and the UK, include a wide range collaborations between legal and healthcare professionals designed to reduce the negative impact of justiciable problems. These multi-disciplinary approaches are increasingly recognized as an important strategy for intervening to improve health equity and protect human rights that are aligned with the social determinants of health (SDoH) (Curran, 2021; Genn, 2019; Keene et al., 2020; Schram et al., 2021; Teitelbaum & Lawton, 2017; Williams et al., 2008). Increasingly, law (Genn, 2019; Weber & Peppin, 2021; Williams & Hunt, 2019) and access to justice itself is being posited as a social or structural determinant of health (Jassar, 2021; Nobleman, 2014).

To date, developing these partnerships has primarily been a practitioner-led movement, working from the ground up, viewed with increasing interest by policy makers and governmental organizations (Genn, 2019; OECD, 2019, 2021a). The *health justice approach,* the term we will most often use here, is evolving rapidly: it is important to keep abreast of how people in other countries are advancing this approach because hosting organizations continue to experiment with new iterations. Tobin-Tyler et al. (2023) explained how this approach is proliferating internationally, particularly in the US, Australia, and UK. They outlined four assumptions common to these countries, although their context and approaches differ:

1. low-income and other marginalized groups experience worse health due to injustices that are both directly caused or exacerbated by and potentially remediable through law,
2. access to justice – especially through direct legal advice and support – is crucial for improving health and health equity,
3. because the same low-income and marginalized populations experiencing poor health also experience poor access to justice, formal partnerships among service providers working with these populations can facilitate both justice and better health equity, and
4. by collaborating health and legal service providers are in a unique position to identify the downstream health effects of law and policy failures (p. 333).

In our view, Canada is lagging behind in explicitly developing this approach.

This introductory chapter outlines our purpose for undertaking this research, our intentions for publishing this backgrounder, the process of producing it, and discusses evaluation research terms. It also reviews documented impacts of the health justice approach, previews the paper's content, and explains its parameters.

Purpose of the Research Study

We undertook the research for this "Justice & Health Partnerships: Measuring the Impact" project to understand more about the benefits of this approach for increasing access to justice for disadvantaged communities, and to distill promising practices for measuring impact. We wanted to identify evaluation strategies that could grow our professional knowledge about how best to implement JHPs. By exploring these three concerns, we hoped to gain new insights to contribute to the efficient and sustainable scaling up of this approach in Ontario. This would help Ontario's community legal clinics (CLCs) and others who are able to secure pilot or permanent funding to develop these collaborations. In our experience, this approach helps legal and healthcare professionals work together effectively to help people access justice and improve health outcomes. It provides a prototype for how service providers can act on health equity and equal justice imperatives, narrow justice gaps, and moderate adverse impacts of the social determinants of health especially for marginalized and vulnerable communities.

Purpose of Publishing the Research Report

This paper documents how the impact of these collaborations have been researched and measured, evaluation strategies, and lessons learned from existing evaluative efforts. Health justice evaluation research is a nascent and complex field, with strategies complicated by country context, yet enriched by differing disciplinary approaches, perspectives, and capacities. To respond to this challenge, Chapter Two documents how we carried out our multi-faceted study.

This backgrounder is intended to help legal and healthcare professionals and funders untangle the thinking and recent progress in this field of inquiry. We hope it will contribute to interdisciplinary discourse on promising practices for measuring impact and evaluating progress. Our expected audience includes those engaging in this work or who are interested in starting, funding, or researching these initiatives. It will be of particular interest to organizations and people interested in advancing health equity, and who want to improve the conditions into and under which people are born, grow, work and age as represented by the World Health Organization's SDoH (CCSD, 2008). HJPs hold much promise for producing better financial, legal, physical, and emotional health outcomes, particularly for vulnerable and marginalized communities.

Process of Producing the Research Report

Staff with the Community Advocacy & Legal Centre (CALC), partially funded by a Law Foundation of Ontario (LFO) Measuring Impact & Evaluating Progress grant, researched, and produced this report, and are solely responsible for its content. The research was overseen by an Expert Advisory Committee (MIEAC – see Appendix A). Members contributed so much to the learning process and helped guide how to best articulate and share findings. The Department of Family Medicine at Queen's University aided significantly by leading our preliminary scoping review of peer-reviewed literature on JHP impact (Jomaa et al., 2023).

Evaluation, Research, and Evaluation Research

In this paper, we often use the terms evaluation, research, and evaluation research interchangeably. Although some consider evaluation and research to have distinct meanings, in practice, the terms overlap. Generally, research is considered to contribute to knowledge that is generalizable. Evaluation, on the other hand, is usually understood as assessing a program or initiative against some criteria. Russ-Eft & Preskill (2001) noted that most conflate the two terms, but that research generally seeks conclusions and to develop new theories. Some consider evaluation to be a subset of research (Barnett & Camfield, 2016). It is also known as program evaluation, and is considered to be *applied* research, a field of social science research that evaluates the impact of social interventions (Babbie & Roberts, 2018). Barnett and Camfield (2016) observed that evaluation research is often conflated with policy research, implementation research, and operational research. Canadian and American professional evaluators have described program evaluation as systematically investigating the worth or merit of a program with many possible purposes to lead to improvements and/or accountability, and contributing to organizational or social value (Yarbrough et al., 2011). Under conditions of complexity, such as social innovation initiatives, Patton (2011), an advocate of utilization-focussed evaluation, recommended developmental evaluation. In our view, social innovation captures the phenomenon of the health justice movement, given its scope and diversity. In Chapter Four, we briefly delve further into applicable concepts and resources from the field of evaluation.

Our study revealed that more robust evaluations often include articulating a qualitative, quantitative, or mixed methods research methodology. Although comprehensively exploring research methodologies across the disciplines is beyond this report's scope, we document approaches from the social sciences and health for what they offer, as well as the field of evaluation. For evaluation research, it is important to "operationalize, observe, and recognize the presence or absence of what is under study" (Babbie & Benquisto, 2010, p. 362). Key to this endeavour is specifying anticipated outcomes, target population, understanding variables in the larger context, explaining interventions, operationalizing success or failure, and considering whether any standardized measures exist. Evaluation research designs can include qualitative studies, and experimental or quasi-experimental (such as time-series design, non-equivalent control groups, multiple time-series).

One of our first challenges was to understand how disciplines differ in how they describe, choose, use, and value research methodologies. According to Babbie and Benquisto (2010), the three most common purposes for social science research are to explore, describe, and explain. Within this research paradigm, Creswell (2013) characterized the five approaches to qualitative research inquiry and design as narrative, phenomenological, grounded theory, ethnographic and case study research. However, we learned that healthcare researchers tend to describe research methodologies as either experimental or observational and highly value experimental studies and randomized control trials (RCTs). As we reviewed studies and attempted to classify research methodologies, disciplinary differences made common understanding difficult.

Also, of note – using research methods as a component of evaluation frameworks means that research ethics should be considered. As we explore briefly in Chapter Four, the degree of

formality (and need for approval by a Research Ethics Board [REB]) often differs for program evaluation as compared to traditional research.

Imperatives for this Research Study

There were many imperatives for this study even before the global pandemic that has raised awareness anew about deleterious health and social inequities that proliferate injustice, and result in unequal access to justice. We identified five imperatives: first, as legal service providers (LSP) we must do more to understand evaluation and research and to strengthen our capacity to evaluate if we want to engage in these collaborations. Our 2019 mapping study of Ontario's JHPs revealed a nascent health justice movement. We learned that while a few partnerships had carried out some form of evaluation, our collective understanding of how to undertake quality evaluation research was very limited. It became clear we would benefit from understanding more about existing efforts in other countries.

Secondly, we concluded from our review of the health justice literature, our interviews with key informants, and CALC's own local experience developing JHPs that the opportunities to scale up this approach would increase substantially if we were able to measure progress and impact more effectively, efficiently, and sustainably. If the justice sector wants to work more strategically with the health sector towards mutually beneficial goals and improved outcomes for our shared patients/clients, legal professionals must become more proficient using the research approaches so valued by the healthcare professions. Evidence-based practice is a disciplinary norm in healthcare: we have much to learn from HCPs about how this evidence is gathered.

Thirdly, systematic and scoping reviews of existing research studies have confirmed the benefits of these partnerships and their impact. As discussed later, they have concluded that improving research rigor and undertaking more structured evaluations would be beneficial.

Fourthly, as a matter of professional responsibility HCPs are committed to – and want to act on – issues of health equity, principles that are informed by growing evidence that SDoH

> beget inequalities in health, and that this relationship is not always altered by improvements in health care. Although this policy is now a cornerstone of public health [in Canada], the disconnect between knowledge and its realization in medical practice represents a long-standing problem (Drozdal et al., 2019, p. 246).

JHPs are a seeding and breeding ground for unique interdisciplinary approaches that – if well planned, executed and understood – could help narrow the tragic gap caused by inequality and health inequities. Supporting HCPs in their professional mission by increasing the relevance and accessibility of legal help services that are responsive to the SDoH will mutually benefit legal professionals, legal aid funders and the people that they serve.

Finally, in access to justice work the field of evaluation research is underdeveloped. Taken as a whole, the justice sector is just beginning to explore how to effectively evaluate and measure the impact of different service solutions. The impact of the unmet legal needs of the public, in particular on vulnerable groups, reinforces historical disadvantage and inequality. Reports on the growing justice gap by the Canadian Bar Association (CBA, 2013) and the

national Action Committee on Access to Justice in Civil and Family Matters (2013) recommended a more empirical approach to questions of access to justice and evaluation. As a national research leader, the Canadian Forum on Civil Justice's (CFCJ) recent report on longitudinal research methodologies, RCTs, and quasi-experimental designs should be referred to alongside this report (Moore, 2020; Moore & Farrow, 2019). Later, we discuss Access to Justice B.C.'s work on an access to justice measurement framework. We also share insights from Australia's Law and Justice Foundation of New South Wales (LJFNSW), an early explorer of how to evaluate what works and legal help impacts. International outcome measurement discussions for access to justice and people-centred justice are also reviewed.

Our challenges in discerning how best to evaluate these interventions are not unique. Engaging in more systematic evaluation practices, and undertaking more sophisticated and rigorous research, as appropriate to context and funding, is a complex cross-disciplinary field of inquiry. Pleasence et al. (2014), authors of the influential international research synthesis *Reshaping Legal Assistance Services: Building on the Evidence Base,* noted:

> Fully establishing the impact of services and service change is complex and … requires resources and expertise that are not commonly available within legal assistance service agencies.… purposeful evaluation is also an integral part of service planning and management … Throughout the lifespan of a service there are different types of evaluation questions that can be asked (reflecting different purposes). … evaluations of what works may be specific not just to particular types of client, but also to particular forms of services or service environments (p. 175).

Sandefur and Burnett (2023) have written eloquently about the need to develop shared access to justice research frameworks to develop theoretical insights and actionable insights. They noted that we should be concerned about *effectiveness*, *sustainability*, and *scalability*. This background paper provides a practitioner-grounded and focussed contribution to this important dialogue.

Results of Systematic and Scoping Reviews: Distilling Impacts

To introduce the health justice approach, we report here on measurable impacts based on systematic and scoping reviews of reports and scholarly literature. In the health and biomedical sector, these types of reviews are highly regarded and well-established methods of summarizing quality research studies, although less well known in law. Forell & Gray (2009) described systematic reviews as a "methodology for selecting and synthesising the results of relevant research and evaluation studies in order to provide practitioners with practical information that is based on the best available research on a specific question" (p. 2). Eight reviews established the merits of the health justice approach and described their known impact. In Chapter Four we review their recommendations for improving the quality of research quality.

Jomaa et al. (2023)

We first describe the preliminary scoping review we undertook in 2019. We synthesized the findings of 30 studies from Australia, Canada, UK, and US (Jomaa et al., 2023). Many examined the impact of interventions on patients/clients, but several assessed changes in HCP

capacity to identify unmet needs related to the SDoH, or calculated the financial return on investment (ROI) for healthcare organisations. Partnerships addressed diverse legal needs including housing, utilities, income and food security, personal and/or family stability, health insurance, employment, education, immigration and legal status, powers of attorney and wills, and advice in criminal law matters. Evidence of benefits in multiple domains was found.

Three broad types of outcomes were identified: ***patient health status and healthcare utilizations***; ***justice, social, and economic outcomes***; and ***degree of health-justice integration***. For example, nine studies reported outcomes related to health and healthcare use including betterment of children's health. One showed improved diabetes management and three found reduced levels of lead in the blood following multi-disciplinary, complex interventions. In another study, asthma became better controlled following a legal intervention related to substandard housing. Three studies found positive impacts on mental health. A fourth recorded that mental illness symptoms were reduced and sustained at three and 12 months. Justice, social and economic outcomes included improving patient income and healthcare access, as well as impressive cost-benefit ratios and ROI for American hospitals (who are not publicly funded in the same ways as Canadian hospitals). Health-justice integration captured how healthcare and legal professionals collaborated to improve services. This included establishing formal partnerships, offering cross-disciplinary and often reciprocal learning and training opportunities to increase professional competence, improving legal literacy, and implementing screening tools.

Adams et al. (2006)

In a systematic review originating in the UK, Adams et al. (2006) synthesized the health, social and financial impacts of welfare rights advice delivered in healthcare settings arising from 54 UK studies and one US study. Most studies were considered "grey" literature (not peer-reviewed). They showed financial benefits. Although there was little evidence of measurable health or social benefit using quantitative methods and validated research instruments, this was "primarily due to lack of good quality evidence, rather than an absence of effect" (p. 1).

Analysis of the common themes arising from qualitative research elicited the following:

1. Delivering advice in healthcare settings, particularly primary care, legitimizes it, improves access, and decreases any stigma attached to attending…
2. Advice and financial benefits help elderly clients maintain independence…
3. Advice decreases worry and anxiety and improves mental health and quality of life irrespective of whether or not additional benefits received as a result…
4. Advice and increased benefits increases physical health…
5. Advice reduces use of health services…
6. Advice is seen as "expert" and therefore accurate. Service is professional… (p.23)

It was noted that benefits may only be temporary, and benefits of increased income can be offset by the impact of long-term illnesses on health.

Allmark et al. (2013)

Building on the Adams et al. review, Allmark et al. (2013) reviewed 87 UK studies to outline the potential causal pathways between advice interventions and health outcomes. To identify the types of interventions, they constructed a logic model. It included where the interventions occurred, who intervened, and plotted the anticipated ***primary*** (short term – direct result of the intervention), ***secondary*** (indirect), and ***tertiary*** (longer term) outcomes. For each outcome, the potential health, financial or non-financial benefits were described. The weight of the existing evidence for each outcome was represented on the logic model (see Appendix B).

Short term financial benefits included recovering unclaimed benefit income and managing debt, as well as non-financial benefits like free prescriptions, dental care, and other enhancements. There was self-reported evidence of health improvements, although validated research instruments were not often used. Some studies showed strong associations between financial capability and psychological well-being, as well as a "counselling effect" (positive impact of being listened to). Non-financial secondary outcomes included reducing social isolation, improving family and other relationships, and improved home environment. Of note, studies from the wider literature, for example, were used to link better housing with mental health improvements as well as physical health gains, suggesting that long-term health and well-being benefits could be plausibly attributed to the advice intervention. They cautioned on the use of RCTs for complex interventions, and preferred research design based on logic models:

> RCTs and other trial designs focus on input and output. This has been termed a 'black box' view of mechanisms. This often works well with closed systems, such as human bodies and drugs; however, it is problematic with open systems, such as societies. Logic models, in contrast, take a systems approach and are able to portray elements and relationships within a system. The model developed here identifies how the intermediate outcomes set in train by advice services can lead towards improved health… For example, there is evidence that financial benefits, such as disability allowance, added to non-financial benefits, such as disabled parking permits, improve people's mobility. From other sources, we know that improved mobility improves physical and mental health. Linking these factors in a model conceptually, we can describe the pathway from financial benefits to improved mobility and to a positive effect on well-being (cites omitted, p. 6).

Martinez et al. (2017)

Martinez et al. (2017) systematically reviewed available empirical evidence from 13 studies measuring the impact of US MLPs on patient welfare. They explored their potential to reduce health disparities for vulnerable populations and how they might address the needs of HIV-affected populations. Studies established a considerable scope of unmet legal needs, and noted successes in meeting many health and legal needs. Partnerships might be best customized to serve specific populations, given the diversity of possible interventions to meet their needs. Noting that there have been far fewer articles published about research, and far more that were descriptive rather than evaluative reports, they recommended future directions for research.

League et al. (2020)

To understand how US MLPs serving immigrant communities could assist immigrants, refugees, and asylum seekers, League et al. (2020) systematically reviewed the past decade's studies documenting impact. Complexity of partnerships and services provided varied widely.

> The overwhelming observation … is the significance of these partnerships to improve legal outcomes … positive legal outcomes are more likely when medical professionals contribute to legal proceedings … The legitimization of trauma and persecution through medical professionals in legal spaces may also be crucial for protecting the lives of migrants … the finding that people are more comfortable disclosing personal trauma and persecution to medical professionals rather than legal professionals … and that medical professionals can voice the realities that im/migrants have faced to legitimize their suffering in a system that is stacked against them (cites omitted, Discussion, para. 1).

"Bidirectional education exchanges" between legal and HCPs were found to be critical. For example, they raised awareness that re-traumatization can occur during legal interviews, which can make people less willing to pursue their rights. Trauma-informed training is needed to serve this population most helpfully, and community-centred and integrated care is an essential approach to serve this population's complex needs.

Beardon et al. (2021)

UK-based Beardon et al. (2021) ambitiously categorized intended impact and outcomes of HJPs in an international systematic scoping review of 118 studies originating from Australia, Canada, New Zealand, Ukraine, UK, and US. Eighty-seven were primary research studies, and 69 were published in peer-reviewed journals. The robustness of each study was evaluated using a customized quality assessment tool (see Appendix C). They found

> strong evidence for their effectiveness in resolving legal problems and thereby improving the socioeconomic circumstances of individuals, outcomes reported from all regions and service types. This demonstrates the important role of HJPs in addressing social determinants of health …. There was also strong evidence that HJPs improve access to legal assistance for patient groups that would otherwise not seek help for social welfare issues. HJPs therefore facilitate action on health and social inequalities by reaching those most likely to be affected by health harming legal need…. Overall, there was strong evidence among the studies (both quantitative and qualitative for improvements in mental health, particularly stress, depression, and anxiety (cites omitted, 2021, p. 7).

They produced a narrative synthesis of eight intended outcomes:

1. ***preventing health and legal problems*** (addressing SDoH, including access to food and utilities, social participation, access to health-related services, improvements in relationships, and in knowledge, empowerment, and confidence);
2. ***accessing legal assistance*** (including identifying problems with a legal component, helping people who might not otherwise have sought assistance, or increasing access for particular vulnerable groups, less stigmatizing and more trusted);

3. ***improving health*** (including improvements in mental health and well-being, reduced stress, reduced asthma, reduced need for medication, participation in activities of daily living);
4. ***resolving legal problems*** (including income-related, life event-related, housing and homelessness, education family, proactive planning for death or disability, access to healthcare [US]);
5. ***improving patient care*** (including addressing interconnected problems holistically, more patient-centred support tailored to need, improving continuity of support, increasing confidence and trust and strong doctor-patient relationships);
6. ***supporting healthcare services and providers*** (including reducing pressure on healthcare by facilitating hospital discharge and reducing time spent on non-medical issues, and in the US – generating significant sums for hospitals through healthcare reimbursements, HCPs reporting greater job satisfaction and ability to help);
7. ***addressing inequalities*** (not explicitly studied yet, but 15 studies mentioned it) Two studies had relevant outcomes, showing greater improvements (in income and mental health) for people with particular demographics (Black ethnicity and housebound people); and
8. ***catalyzing systemic change*** (including identifying discriminatory or harmful practices or population health risks, additional help for vulnerable groups, changes to legislation, and engaging in law reform activities).

Reece et al. (2022)

Reece et al.'s narrative systematic review was designed to build on Adams et al.'s (2006) work exploring the impact of UK welfare rights advice in healthcare settings. Data was extracted from 14 studies published between January 2010 to November 2020. Although noting concerns over the 'scientific' quality of some studies, they tracked improved financial security, and wider health and welfare benefits for both patients and the healthcare service. An average rate of return for social, economic, and environmental benefits of £27 per every £1 invested was calculated. Study findings were mapped against the Adams et al. program logic modelling.

Dowling et al. (2023)

Dowling et al. (2023) undertook a systematic review to ascertain the legal needs of US cancer patients and their outcomes after receiving MLP services. Three articles met the inclusion criteria, including two observational studies, and an RCT. Cancer patients had a high number of HHLN: one observational study documented reduced stress and better compliance with treatment, and another monetary benefits. The RCT's main measure was whether time to treatment decreased, showing no statistical difference with control groups, a rather odd way of measuring HJP impact, at least from a Canadian perspective.

These systematic and scoping reviews help us understand the impacts and the individual and systemic changes HJPs intended to manifest. Having a clear grasp of anticipated impacts, and the existing evidence establishing them will help design better interventions. Knowing what research has gone before, the gaps in evidence, and concerns about methodology helps focus evaluation and research efforts. If more HJPs are funded, there will be opportunities to evaluate effectiveness and impact using the promising practices that emerge from this study.

Overview of the Content of the Report

As this is a relatively new field of inquiry, we structured this report to take the reader through the process of our research journey and how our thinking evolved. Readers who are only interested in the emerging themes and findings from our research, the promising practices for Ontario's JHPs to consider, and next steps we recommend, should skip ahead to Chapters Five and Six. Readers who want to know more about our collaborative interdisciplinary learning journey, how health justice approach is evolving in four countries, and our deep dive into understanding evaluation research will find Chapters Two to Four useful.

Chapter Two sets out our research strategies, as well as what we learned from our inquiries. To set the context, Chapter Three explores how the health justice approach has evolved in Canada (with a focus on Ontario), Australia, UK, and the US. Chapter Four explores approaches to evaluation research, including jurisdictional scanning and recommendations for future research from key informants and the systematic and scoping reviews. It explores briefly access to justice outcome measurement, and reviews scholarly and pragmatic contributions to evaluation, and touches on qualitative inquiry including action research. To inform constructing evaluation frameworks for Ontario's JHPs, Chapter Five identifies the 22 themes arising from our study, and the need for further investigation, dialogue, experimentation, and funding. Chapter Six sets out potential next steps. Appendices collect important resources for future reference. The liberal use of appendices was essential: Time is scarce, and many HJPs do not have easy access to referenced academic literature, much of which exists behind paywalls.

It is hoped that empowered with the knowledge captured in this report, we can scale up this approach by useful evaluation practices that demonstrate impact. A range of evaluation and research methodologies will be appropriate. They will depend on available funding, context, the change we seek to create through our work, and whether we want to create professional knowledge about effective interdisciplinary collaborations. We need to build knowledge about what works, how it works, why it works, and for whom. It makes sense to build on promising practices from other countries that are further along than Canada in adopting this approach. Our recommendations, including for evaluation capacity building, may be transferable to other types of access to justice initiatives. We hope this background paper seeds much generative dialogue.

Parameters of this Background Paper

There are limits to what this report can accomplish. It is not intended as a treatise on evaluation or research methodologies, a comprehensive analysis of the state of the health justice approach internationally, or a "how-to" manual. However, Chapter Four reviews resources to help those beginning evaluation research.

As we reviewed the literature, we became aware of emerging research fields that may have something to offer, which we review briefly now. Within the scope of this project, it was not possible to explore the growing field of *public health law research* and the emerging field of *legal epidemiology* (Burris et al., 2020) although our concerns about knowledge generation align. As this field grows, this scholarship will have much to offer.

> Law is important to all facets of public health. Researchers, practitioners, policy makers, and advocates all have roles to play in designing, enforcing, monitoring, and evaluating the law. True integration requires good coordination of people doing different things in different disciplines, but it also requires adoption of shared methods, tools, and perspectives (Burris et al., 2016, p. 751).

Public health law research (PHLR) is "the scientific study of the relation of law and legal practices to population health" (Burris et al. 2010, p. 171). It uses "systematic methods within an explicit theoretical framework to collect and analyze data. PHLR seeks methodological rigor in all phases of research, from the careful articulation and operationalization of theory through thoughtful and innovative study design to analysis, interpretation, and dissemination" (p. 172). Swanson and Ibrahim (2011) elaborated on the use of causal diagrams in this context, a form of a program logic model, to support researching and evaluating the impact of laws.

An example of legal epidemiology was found in a protocol for a two-year study on the impact of MLPs (Muñoz-Laboy et al., 2019). Furthermore, as a harbinger of its future importance, the US Center for Disease Control (2019) has already developed competencies for legal epidemiologists, which suggests we should monitor these developments as we move forward. In the Canadian context, Pilliar (2023) has conceptualized *justice epidemiology* as an appropriate research strategy given the increasing focus internationally on the imperatives for person-centred access to justice.

Similarly, research approaches studying ground-breaking multi-component interventions to enhance *equity-oriented care* in primary healthcare settings for vulnerable communities show promise (Browne et al., 2015). Also, studies assessing *the impact of SDoH interventions on healthcare outcomes* also offer beneficial research methods (Gottlieb et al., 2017). However, health equity advocates have expressed concerns about the biomedical approach to research. Farrer et al. (2015) noted that scientific evidence, both quantitative and qualitative is required to sustain advocacy in health. It is problematic, given the complexity of SDoH interventions, that the existing hierarchy of evidence posits that RCTs are the gold standard, and puts less stock in qualitative research. RCTs may not always be the most effective method for understanding what works and why it works.

Furthermore, there will be much to be gained from studying more closely research methodologies (and the cautionary tales) from *population health intervention research* (PHIR). PHIR seeks to develop knowledge about the impact of interventions that ameliorate health risk factors or determinants as well as a knowledge base about *how* these problems can be addressed: Collecting studies about a particular strategy generates theories about how to achieve better public health (Petticrew, 2015). More rigorous research could be enabled by partnerships between healthcare delivery systems and academic researchers. For complex interventions, Rutter et al. (2017) cautioned that it is too narrow a focus to ask only *whether* an intervention fixes a problem. Researchers should instead focus on understanding what contributions are made by particular interventions. Tools designed to "answer questions about clinical interventions … grounded in linear models of cause and effect" (p. 2602) are too narrow an approach: a broader spectrum of research methods is required. Furthermore, a complex systems

approach to research would also allow for interventions to be modified and adapted as a result of what is learned.

Another field to monitor will be the emerging field of *inclusion health*. Luchenski et al. (2018) defined it as "a research, service and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and marginalised people in a community…. an emergent approach that aims to address health and social inequalities" (p. 266). In the UK context, this includes people who are homeless, Gypsies and travellers, prisoners, sex workers, vulnerable migrants, and those with substance use disorders. After conducting a major synthesis of the evidence of what works in inclusion health, Luchenski et al. convened a workshop in 2015 with marginalized individuals to help develop an agenda for future research and action: interestingly, an issue raised was the need for access to legal aid (p. 273). Future research was recommended to identify upstream interventions that could ameliorate the SDoH – including law, housing, training and education, and employment. (p. 274). In Ontario, assisting people to understand and enforce their rights related to housing, employment, training and education, constitute part of the poverty law services offered by a province-wide system of government-funded community legal clinics (CLCs). This research could contribute to drawing causal connections between providing legal assistance, ameliorating the intervening SDoH variable, and improving health.

Chapter Two: Carrying Out the Research Study - A Multi-faceted Learning Approach

In this chapter, we outline the deliberately collaborative, iterative, and multi-disciplinary approach we took to our research. We hoped to create actionable professional knowledge about how best to conduct research and evaluation contemporaneously with our inquiry. We wanted to build our capacity to evaluate and research these partnerships, to learn how to learn and engage in generative dialogue across disciplinary boundaries and perspectives. Through documenting our efforts, we wanted to generate a new cross-disciplinary discourse to guide future efforts. The approach we employed proved to be productive, although complex and time-consuming, but rich and rewarding. This research journey felt like a work-in-progress, an important strategy to harness interprofessional collaboration to improve justice and health outcomes.

We wanted to find answers to address a number of concerns. First, we wanted to understand more about JHPs in Ontario, as this fledgling movement had not been well documented. Secondly, we wanted to learn more about what made partnerships in Australia, Canada, UK, and US effective and impactful. Thirdly, we wanted to understand the different partnership typologies that were emerging: their differing intentions and theories of change would impact on their evaluation framework. Fourthly, and the main purpose of the research – how could this approach best be evaluated?

Given the breadth of our research questions, our approach became multi-dimensional. We elaborate below on the following tasks:

1. created an expert project Advisory Committee (MIEAC), where we shared what we knew about evaluation and research in our respective disciplines, investigated other options, and heard reports back from our members engaged in the following strategies;
2. conducted a mapping study of Ontario's justice & health partnerships,
3. collaborated with Queen's University Faculty of Medicine on a scoping review of the international literature on JHPs to understand the impact of this approach (Jomaa et al., 2023);
4. undertook jurisdictional scans of the four common law countries, by perusing the literature, including systematic and scoping reviews, and informally interviewed key informants in each country to understand how this approach had evolved, and how initiatives were evaluated;
5. reflected on the lessons learned over a five-year period as CALC developed and evaluated local JHPs employing differing research questions and data collection methods,
6. piloted constructing an evaluation framework with the staff involved in the first year of an LFO-funded small-scale JHP project in another county,
7. briefly surveyed key program evaluation and research resources including articles, guides, and books from respected scholars and non-profit organizations; and
8. received feedback on the final report draft from MIEAC members and key informants.

1. Measuring Impact Expert Advisory Committee (MIEAC)

Between September 2019 and November 2020, the cross-disciplinary MIEAC met virtually bi-monthly eight times. MIEAC members (see Appendix A for a list of members) brought significant relevant expertise to our discussions. This expertise included scholarly and

practice-based knowledge and skills in healthcare evaluation, legal and healthcare service delivery, JHP development, international development, epidemiological research, sociological research, international and Canadian legal needs research, action research, and access to justice. We report briefly on the results of our key investigations as appropriate.

Learning about evaluation and research from different disciplinary perspectives

MIEAC's volunteer experts shared their approaches to program evaluation, as well as their disciplinary research strategies. Understanding research from the perspective of a sociologist, an epidemiologist, a community-based healthcare centre, an access to justice think tank, and an international development perspective enriched our learning process. For those of us whose exposure to research methodologies has been limited to traditional legal approaches, Dr. Imaan Bayoumi's perspective as an epidemiologist on research credibility and validity was particularly illuminating (see Appendix D). It gave us much fodder for reflecting on how health justice approaches might be evaluated and researched within the healthcare discipline's evidence-based paradigm and the biomedical model.

Epidemiology

Epidemiology is the study of how the determinants of health-related states/events are distributed in specific populations, and how this information is applied to controlling health problems. A comparative approach between populations is used to plan and evaluate strategies to prevent illness or treat patients. Epidemiologists weigh the findings of research approaches from low to high credibility as follows: editorials and expert opinions, case series and case reports, case-control studies, cohort studies, RCTs, and systematic reviews.

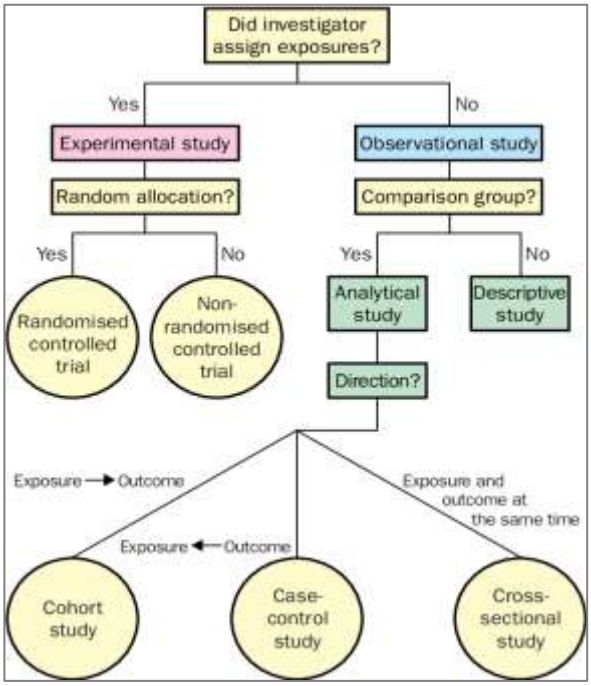

Figure 1: Algorithm for classification of types of clinical research.
Excerpted from Grimes & Schulz (2002)

Study designs are classified as either experimental or observational. Experimental studies include randomized and non-randomized control trials. Observational studies fall into three categories: cohort, case-control, and cross-sectional studies. Research studies are subject to much scrutiny: published guidelines are often used to assess the quality of health research. Study validity can be impacted by different biases – selection, recall, observation (Hawthorne effect), confirmation bias and publication. If we intended to attribute improved health outcomes to an HJP intervention, we concluded that the rigour of the study would be an important objective.

Experience-based Design: Ontario Local Health Integration Network (LHIN)

In the last few years, Ontario's Community Healthcare Centres (CHCs) have been mandated by the provincial government to improve their patient experience through *experience-based design*. This approach was developed by UK's Institute for Innovation and Improvement. This approach involves gathering experiences from patients and/or providers through in-depth interviewing, observations/group discussions, patient/caregiver emotional mapping. Exploring the patient/family experience, co-designing and measuring improvements are becoming part of CHCs' mandatory annual quality improvement plans. We should keep watch on this approach.

Quadruple and Quintuple Aim frameworks for evaluating healthcare initiatives

The impetus for the Quadruple Aim framework (see Appendix E) came from the Institute of Healthcare Improvement. Originally cast as the Triple Aim framework to optimize the performance of healthcare systems by focusing primarily on *improving population health*, with secondary goals of *enhancing patient experience*, and *reducing costs*, it was determined that this framework was leading to HCP burnout. This increased costs and impacted on the quality of care and patient health outcomes. So, a fourth aim was posited to capture the symbiotic relationship between patient and provider health. Assessing improvements to HCPs' work experience was recommended (Bodenheimer & Sinsky, 2014; Valaitis et al., 2020). We resonated with this fourth aim – *improving the work experience of the provider.* If implementing HJPs could make a bigger difference in patients' lives, and build capacity to meet complex patients' needs – could this then improve HCP professional well-being, sense of accomplishment, and help prevent burn out? A fifth aim was introduced recently, incorporating *health equity and the SDoH* to improve the performance of health systems (Itchhaporia, 2021). This fifth aim aligns very well with the intention of HJPs. These quadruple and quintuple aims are helpful for evaluating HJPs' impact.

Figure 2: Evolution to the Quintuple Aim
Itchhaporia, 2021, p. 2263

Access to Justice Triple Aim framework (Access to Justice B.C.)

An initiative based in British Columbia (BC) brought together experts to develop an evaluation framework for access to justice initiatives, which was highly influenced by the healthcare sector's Triple Aim Framework (see Appendix F) (Lowenberger et al., 2021). The three elements include *improving population access to justice*, *improving the user experience*, and considering *issues of costs* (costs of services to users or per capita, but also the social and economic cost of unresolved legal problems). Each element has multiple components. To help apply the framework, Access to Justice BC created a user's guide (Roberts & Dandurand, 2018). A framework like this provides a starting point for conversations about how to evaluate initiatives. Innovations should consider their impact on all three elements, similar initiatives should compare findings using common metrics, and measures should be monitored over time. Learning about the rationale behind this framework, we surmised it would be important to provide a menu of options for evaluating the health justice approach that innovators could choose from to decide how best to focus their evaluation research. It will be useful to update the framework to align with the evolution to quintuple aims for healthcare improvements.

Next steps

Our curiosity was piqued by how various ways of thinking about evaluation and research is dependent on the discipline: this led to a desire to expand our understanding of what might be valued when we work across disciplinary boundaries and the possible synergies that might be created by shared interests, goals, and new capacities created by this approach. We also wanted to incorporate the perspectives from sociology and international development, perspectives also represented on MIEAC. We decided to experiment with a concept mapping exercise to help us understand how we might integrate diverse perspectives to construct evaluation frameworks.

Concept mapping and developing a taxonomy of research terms

We used a modified form of concept mapping (Kane & Trochim, 2007) to identify key concepts important to each discipline and to key stakeholders, and began to explore the relationships between them. Although this highly interactive and synergistic exercise would have been more easily and efficiently conducted in-person and as a large group, the COVID-19 pandemic prevented in-person convening. Instead, we hosted small focus groups with MIEAC members allowing us to construct a large concept map (see an iteration of it in Appendix G).

As we worked this through exercise over multiple meetings, we identified seven stakeholders: the user (patient/client), the health sector, the justice sector, researchers, evaluators, funders, and government and institutions. This exercise clarified what we have in common despite our disciplinary differences, and how we might work together more effectively. We mapped out the research cycle (see Figure 3) that would be part of the evaluation framework, and identified the different research terms used by our professions. We created a desired list of terms for a future taxonomy to build common language around evaluation research (see Appendix H). We hope this approach to improving our understanding of research terms, service delivery approaches, and desired or valued outcomes will help future evaluators work better across disciplinary boundaries, to meet the needs of different stakeholders.

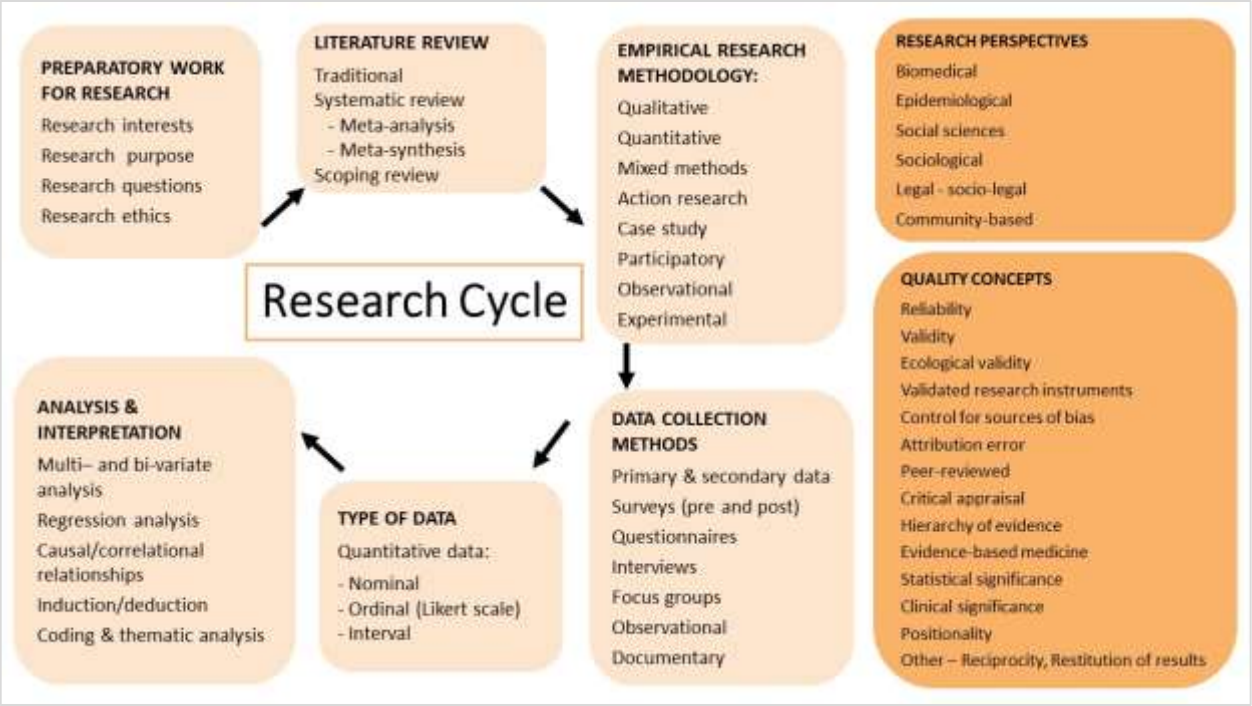

Figure 3: Research cycle from MIEAC concept mapping exercise

To find common interests, we also looked more closely at the justice and health service delivery approaches, the goals, and the desired outcomes for patients/clients. LSP providing poverty law services (the mandate of Ontario's CLCs) are aligned with HCPs seeking to improve their patient's health through SDoH interventions. Figures 4 and 5 capture the results.

Figure 4: Justice sector services, interests, outcomes, and common research approaches

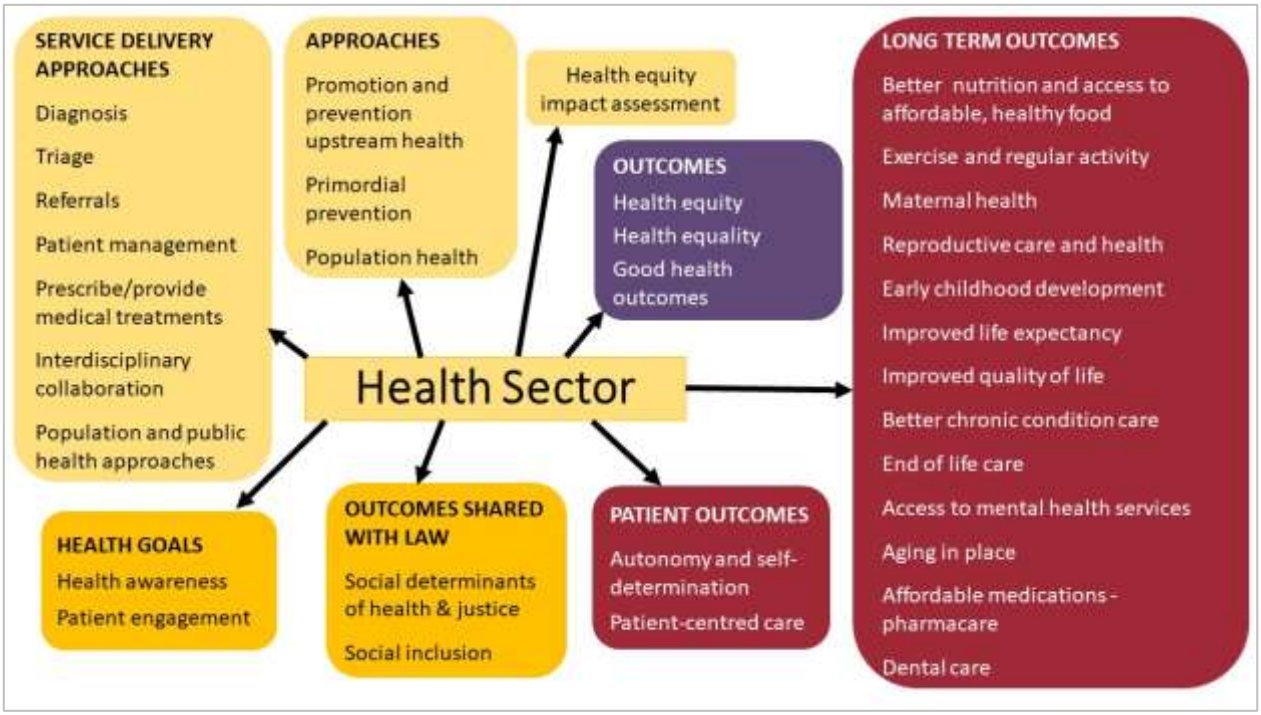

Figure 5: Health sector goals, approaches, services, outcomes, common research approaches.

It also became clear that funders, governments, and institutions have their own interests. A preliminary mapping of those interests is set out in Figure 6 below. This has implications for the results and impacts that they will want to see from evaluation and research. For a helpful discussion distinguishing the types of financial impacts, see Moore and Farrow (2019).

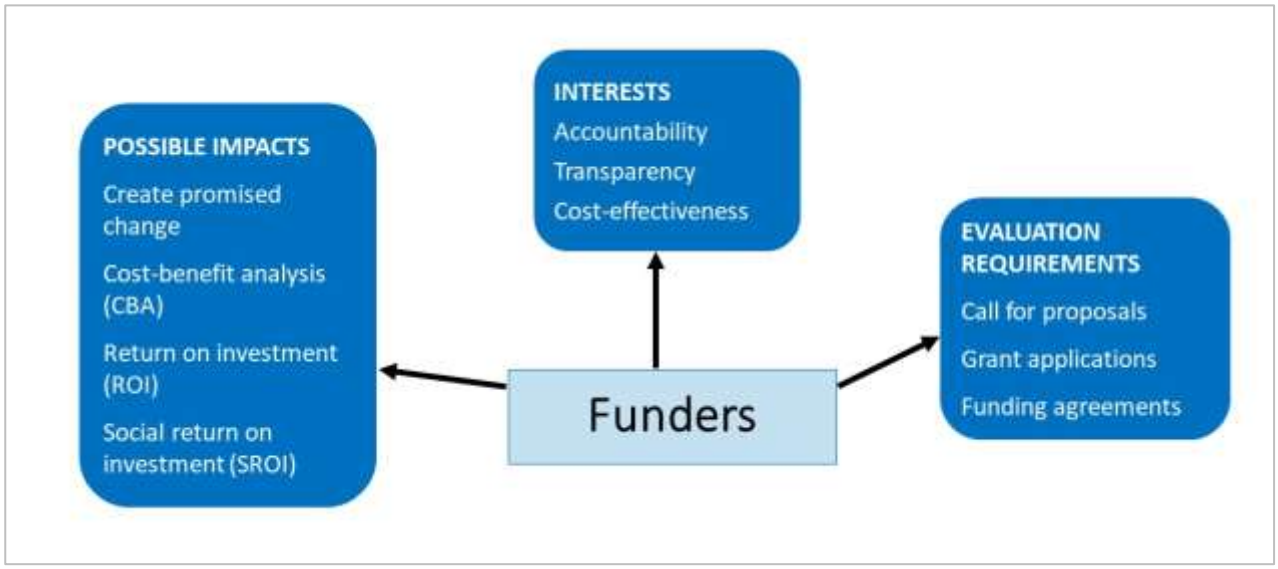

Figure 6: Funders – mapping their interests

Figure 7 captures our preliminary mapping to incorporate the presumed concerns of our clients/patients. This perspective would inform research questions designed to understand the impact on patients. This could include ensuring equal justice and human rights, and improving legal, financial, physical, emotional, and psychological health.

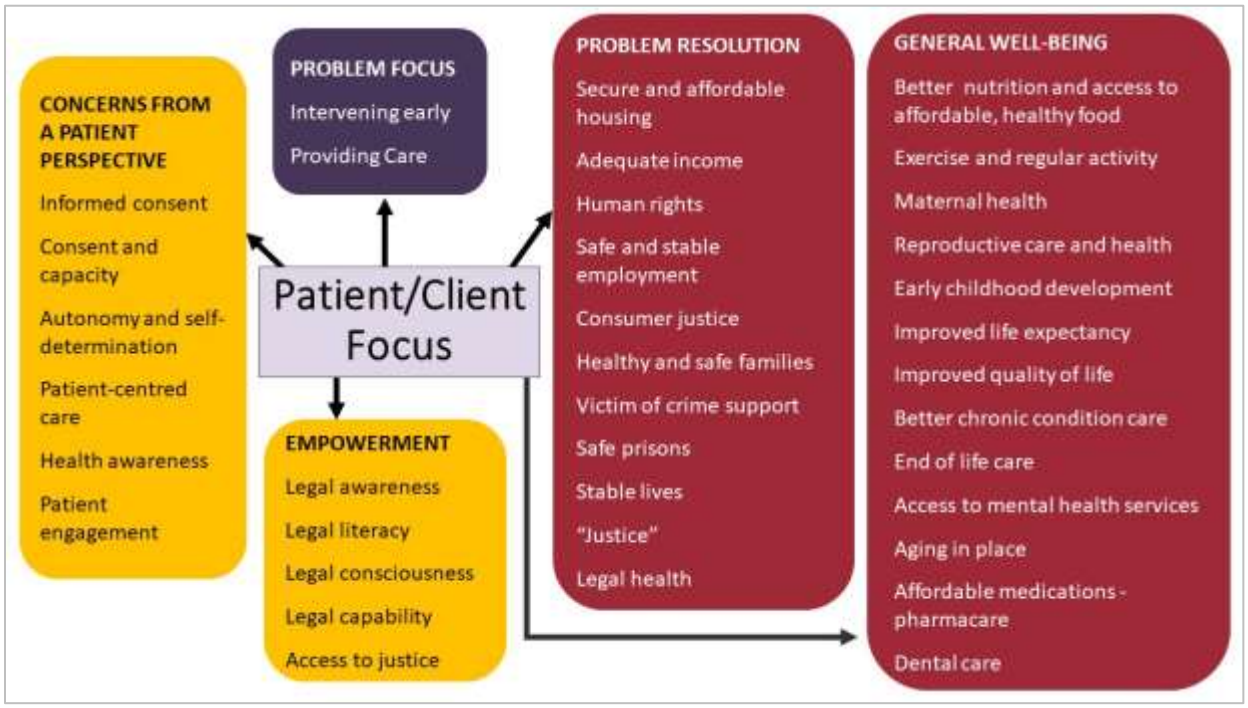

Figure 7: The client/patient interests, focus, and goals

In Figure 8, we turned our minds to what we knew of the approaches that evaluators might take to research effectiveness and impact and created a preliminary map. We explore what the evaluation sector might have to offer in Chapter Four.

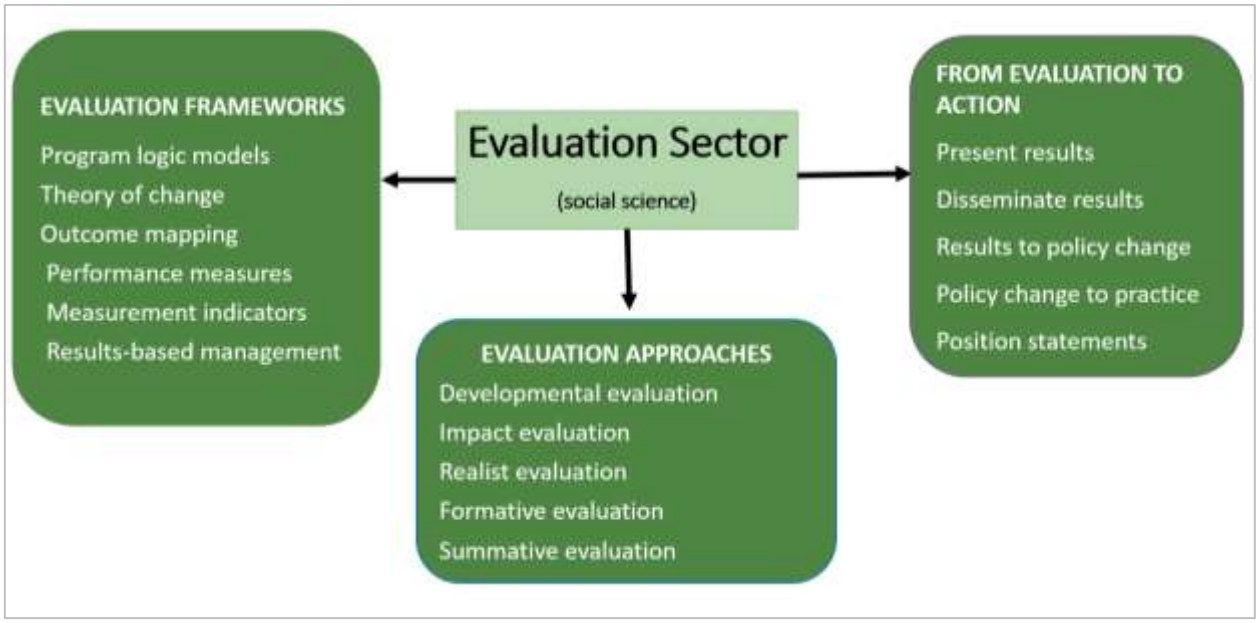

Figure 8: Evaluation Sector - mapping their approaches

Forthcoming research from St. Michael's Health Justice Program

Dr. Andrew Pinto, family physician, assistant professor and researcher with St. Michael's Academic Family Health Team (FHT) and founder of the Upstream Lab, presented to us about the evaluation of their Health Justice Program. What we learned is discussed in Chapter Four.

Provincial Justice & Health Partnerships' Community of Practice (CoP)

Since 2016, people involved in Ontario's JHPs, co-convened by CALC and Community Legal Education Ontario (CLEO) have met, now virtually and monthly, for knowledge-sharing and strategy development. In June 2019, HJA's Suzie Forell shared her insights with the CoP, and we also heard briefly from the UK's Dame Hazel Genn. We discussed the findings of the Ontario mapping study of JHPs, and the need for more evaluation research. We continue to work with CoP to build evaluation research capacity using this report.

2. Scoping Review of Justice & Health Partnership Literature

Dr. Bayoumi from Queen's University's Department of Family Medicine was the Lead Researcher for the 2019 scoping review, which followed strict research protocols to synthesize key studies of the effectiveness of HJPs (Jomaa et al., 2023). The research team included two Queen's medical students Danny Jomaa and Chalani Ranasinghe, Dalhousie law student Nicole Raymer, and Michele Leering. The research questions were:

1. Which HHLN are commonly addressed by HJPs and which populations are served?
2. What is known regarding the impacts of HJPs on patients and populations?
3. Which factors are associated with greater impacts of HJPs?

This study distilled measurable impacts and key partnership characteristics from the reported outcomes of evaluations of HJPs from peer-reviewed original research scholarship between 2000 and 2019 in countries that belong to the international Organization for Economic Cooperation and Development (OECD). Assisted by Queen's University medical and law libraries' reference librarians, 9,520 abstracts relevant to the search terms were retrieved from relevant databases and sorted in Covidence software, a citation management program. An in-depth review of title and abstracts by the research team, followed by a dual review for full-text screening, reduced the relevant articles to 30. The team then extracting article data into a comparative table, and analyzed it to identify themes and elicit findings.

Following the thematic analysis, we collaboratively drafted *Evaluating the Impact of Health Justice Partnerships: A Scoping Review* and submitted it for publication. Given our findings, we made a number of recommendations for future research and evaluation (see Chapter Four). Subsequently, Danny Jomaa prepared and presented a conference poster on the findings of the review at the prestigious North American Primary Care Research Group (NAPCRG) conference in November 2020 (see Appendix I).

The lessons learned from working on scoping review were many. The learning curve for the two non-medical researchers was steep, even though both had post-law school graduate

degrees and experience with mixed methods research. The initial research and record-keeping process was detailed, but well-managed. We learned to use Covidence software to manage more than 9,500 records. The terms medical researchers used were at times unfamiliar and even perplexing, requiring continual interrogation and extra research to understand them and statistical analysis. This reaffirmed that it would be important to develop a taxonomy of evaluation and research terms to support cross-disciplinary discourse, and to diversify the research skills taught to law students. We were particularly challenged to understand the significance of the statistics generated by quantitative studies, their weight and relevance. We learned from our colleagues how to chart effectively to distill and analyze study content, recording 'data' to answer different aspects of the research questions. Although the process of this detailed charting and co-authoring the article was very time consuming, it was ultimately worth the effort. The process viscerally brought home why this research strategy – producing systematic and scoping reviews – is so important in healthcare. We appreciated anew how much legal professionals have to learn about evidence-based practice, and conducting high quality qualitative and quantitative research.

Given this is a nascent field of investigation, with different countries using different terms to describe these partnerships, we discovered our search strategy failed to pick up UK studies which have not been described as JHPs or MLPs. For this study's purposes, this limitation was remedied by incorporating the findings of Beardon et al.'s (2021) robust systematic review which amply covered international developments and themes.

3. Jurisdictional Scans of Australia, Canada, UK, and US

We scanned four countries to ascertain how the health justice approach was evolving, and the state of evaluation and research efforts. This included informally interviewing key informants from each country (see Table 1) and searching the academic and grey literature (including websites and resources of national organizations supporting partnerships in Australia and US). How were useful evaluation frameworks constructed? What research questions were posed? What constituted credible research methodologies? And what methods were used to collect data?

Country	Name	Position/Organization
Australia	Suzie Forell	(then) Lead Researcher, HJA
Australia	Dr. Elizabeth Curran	(then) Honourary Associate Professor, Australian National University
UK	Sarah Beardon	(then) Doctoral candidate, UCL's Faculty of Law & Dept of Applied Health Research
US	Ellen Lawton	(now former) Executive Director, NCMLP

Table 1: Key informants for jurisdictional scans

We also mined the relevant proceedings of the 2017 UK workshop sponsored by Dr. Hazel Genn and the UCL's Access to Justice Centre, the 2019 HJA conference, and US NCMLP 2019 Summit. Given the more extensive US MLP history, our law student Nicole Raymer undertook a more conventional literature review (see Appendix J). We summarize the results of Raymer's jurisdictional scan in Chapter Three where we briefly outline the context, history, and nature of current partnerships, and in Chapter Four where we review four countries' prevalent and recommended approaches to evaluation and research.

4. Mapping Study (2019) of JHP Initiatives in Ontario

We also undertook primary empirical research to map Ontario's JHPs as of June 2019 using an on-line survey, followed by questions to clarify survey responses. The survey was based on precedents generously provided by HJA, and UCL's research study (Beardon & Genn, 2018). Research participants were recruited through Ontario's CLC list servs, LAO, JHP CoP, and the Access to Justice Research Network (AJRN). We also reached out to Pro Bono Ontario (PBO). We sought to document characteristics and the scope of existing partnerships, current evaluation and data gathering practices, and reported impacts. To supplement, we located Canadian scholarship and several formal evaluation reports.

We uncovered at least 33 partnerships with 11 hosts, most of whom were CLCs, with other hosts being PBO (six partnerships) and LAO (one partnership). The results of the mapping study are briefly explored in Chapters Three (nature of partnerships) and Four (research and evaluation approaches). We presented our preliminary research findings as part of a panel with HJA's Suzie Forell, and UCL's Dame Hazel Genn at the International Legal Aid Group (ILAG) 2019 conference and to LFO staff (see PowerPoint presentation).

5. Debriefing Lessons Learned from CALC's Early Local JHP Evaluation Efforts

Using an action research methodology, CALC began developing local JHPs as a service innovation in 2015, with funding from LAO for a small pilot project, as part of a rural justice initiative. We provide a brief overview of the pilot in Chapter Three, followed by our lessons learned in Chapter Four about evaluating projects without dedicated evaluation funding.

6. Piloted Program Logic Model as an Evaluation Framework with a New Partnership

We experimented with using program logic modelling to developing an evaluation framework during the first year of an LFO-funded rural and small urban JHP that was being developed in Peterborough County. Chapter Four sets out the lessons learned gleaned from debriefing this pilot exercise with the project lead and MIEAC.

7. Surveyed Resources and Literature in the Field of Evaluation Research

Given the justice sector's lack of knowledge about how to conduct evaluation research, the likelihood that there would be little funding available to undertake it, and limited interest to date by Canadian legal scholars in researching HJP approaches, we explored current practices in the field. Regrettably, our time and resource constraints prevented examining this field in depth, although we cite influential scholars, approaches, including action research in Chapter Four, and catalogued and annotated key resources including well-respected, freely available, and pragmatic step-by-step guides (see Appendix K).

8. Shared the Final Draft Report with MIEAC and Key Informants for Feedback

To respect the collaborative nature of the learning exercise, and to help us further process the research findings and how they would apply to Ontario's fledgling JHPs, we provided the

final draft of the paper to MIEAC's experts for review and comment in June 2021. Where possible, we provided our key informants with their country-relevant portion to ensure we had adequately captured developments in their jurisdiction. We also had unique opportunities to share and discuss the June 2021 draft with a Policy team at UK's Ministry of Justice who had been investigating similar issues, and the UK Open Innovation Team in 2023. We have incorporated feedback to the extent possible in this updated paper.

Chapter Summary

In this chapter, research strategies were outlined, and some preliminary findings were presented. Meeting with MIEAC, exploring various approaches, undertaking further research, and the process of synthesizing the research was an iterative 'jigsaw puzzle' exercise. Drafting this report helped piece together what was learned from each effort to understand better the nature of the approach, the disciplinary and country differences in interests, perspectives, and research methodologies, and to discern promising practices for the Ontario context.

We became aware of the methodological differences and similarities between how the legal profession, healthcare profession, evaluators, social scientists, and biomedical researchers undertake their work and their research. We became aware of what a disciplined research cycle could contribute to evaluating initiatives, and identified the need to develop a taxonomy of terms for research, and for access to justice and the health justice approach (see Appendix L). We considered where the health and justice sectors were aligned on shared goals, service delivery approaches, and desired outcomes. We began to think through the differing interests of clients and funders, and what that might imply for evaluation research. Exploring epidemiological approaches to research helped us to understand the biomedical model and how it contrasts with evolving socio-legal approaches.

With the help of medical researchers, we learned how to undertake a scoping review, the results of which are summarized in Chapters One and Four, and published it in 2023 (Jomaa et al.). We shared the preliminary findings from the jurisdictional scans, discussed the mapping study of Ontario's JHPs and the need to develop more systematic and sustainable evaluation practices for individual partnerships and across the fledgling Canadian health justice movement. And finally, after intensive research and drafting a report, MIEAC experts provided additional feedback, so that we could complete the collective learning process.

Chapter Three: Justice & Health Partnerships & The Evolving Health Justice Approach

In this chapter, we explore the nature and characteristics of the health justice approach and how the growing movements in Australia, Canada, UK, and US have evolved. It is not possible within the scope of this paper to present a comprehensive history of each country or to recognize all the people and organizations that have contributed to the evolution. Tobin-Tyler et al. (2023) provides an excellent introduction to advancements in Australia, UK, and US. Here, we offer a high-level scan of key developments in each country to contextualize evaluation strategies and interest in impact research. How the movement began and partnerships were funded are unique to each country. The contextual reality creates both challenges and opportunities for settling on promising practices for shared evaluation frameworks.

Given the different contexts, we soon realized it would not be fruitful to propose a single approach, because the intentions for each HJP – the justification for starting one or continuing it – as well as the implicit *theory of change* and assumptions underlying program design – can be quite diverse. Furthermore, evaluation is influenced by the context, and the interests of the key stakeholders including government and/or funders. As we discuss in Chapter Four, the interests of various stakeholders impacts decisions on why and how HJPs would be evaluated, what an evaluation would focus on, and the feasibility and risks to the research.

Before presenting the summaries of the jurisdictional scans, Table 2 captures at a glance some of the similarities and differences between the health justice approaches in the four countries.

Jurisdiction	Ontario, Canada	Australia	UK	US
Inception	2009, but with developments as early as 1980s with a co-located community legal and health clinics	2009, but with developments as early as 1978 with co-located legal and health clinic	2006 survey identified many initiatives, but with developments as early as 1990s with welfare rights advice outreach in doctors' surgeries (offices)	1993, Boston Medical Centre and Greater Boston Legal Services but with developments as early as 1960 and in 1980s with AIDs work.
Terms now used	Justice & health partnerships, health justice partnerships, health justice approach	Health justice partnership Health justice partnerships Health justice landscape	Health justice partnerships (still fairly new and most would not name as this) Health justice landscape	Medical legal partnerships Health justice approach
Current lead organization/Peak body	Informal, virtual community of practice in Ontario (founded 2016)	Health Justice Australia (founded 2016)	University College London Faculty of Law (Centre for Access to Justice)	National Center for Medical-Legal Partnerships (2006)
Funding for lead organization	No funding. In-kind contributions by CLCs and LAO	Yes, for 10 years. For sustainability, moving towards partial business-model funding	No. Affiliated with a university	Yes, but limited. A project in the Dept of Health Policy and Management & Milliken Institute School of Public Health at George Washington University
Estimated number of partnerships	33 with 11 hosts (2019) in one province (Ontario)	100 (2021), with most in 4 states (NT, Queensland, NSW, and Victoria) 105 (2022)	328 (Low Commission, 2014) 380 (Beardon & Genn, 2018)	450 (2019) in 49 states
Nature of partnerships	Very diverse, on a spectrum (see Figure 11)	Very diverse, five typologies identified	Very diverse, four typologies identified	Very diverse, at least three typologies identified

Jurisdiction	Ontario, Canada	Australia	UK	US
Sample of target populations	Vulnerable populations with poverty law issues Psychiatric survivors Mental health Children Rural & remote	Family and domestic violence Mental health and addiction Homeless Indigenous Young people Elderly Child welfare Debt	Patients in primary care Cancer patients HIV/Aids Elderly Frequent users Victims of domestic violence	Children & families Patients Family violence Veterans Homeless HIV/Aids Immigrants Rural & remote Cancer care Tribal communities
Service delivery approaches	Individual legal help (triage) Legal education sessions Secondary consultations Systemic advocacy	Individual legal help (triage) Legal education sessions Cross-disciplinary training Secondary consultations (reciprocal – legal & health) Systemic advocacy	Individual legal help Training sessions* Secondary consultations* Systemic advocacy* * = not in literature, not common, but emerging from Beardon's case studies	Individual legal help (triage) Curbside consult Legal education sessions Systemic advocacy
Emerging discourse	Legal literacy Legal capability Legal empowerment Legal health Health justice approach	Legal capability Legal empowerment Legal health Health justice landscape	Health justice landscape	Legal health Health justice approach Clinic-level solutions Policy-level solutions
Current influences	Access to justice Department of Justice Canada research (Currie) CFCJ research SDoH and health equity – interventions in primary care COVID-19	Access to justice LFJNSW legal needs research National Legal Assistance Partnership agreement Domestic violence Mental health COVID-19	Access to justice Genn Paths to justice Pleasence et al. research Social inclusion Cuts to legal aid (LASPO) Government White Paper (2021) & Integrated Care Systems UK Ministry of Justice Social prescribing COVID-19	Access to justice SDoH Academy American Bar Association American Medical Association Affordable Care Act Association of American Medical Colleges Healthy People 2020 Academc MLPs Kaiser Permanente
Defining the term	A wide range of collaborations between legal and healthcare professionals designed to reduce the negative impact of justiciable problems and health-harming legal needs (interim working definition) Formal or semi-formal partnerships with primary or secondary HCPs or hospitals that provide free legal information and advice to patients referred by HCPs or to HCPs themselves who are seeking information on behalf of a patient. (definition used for 2019 mapping study)	HJPs embed legal help into healthcare services and teams to improve health and well-being for: • Individuals through direct service provision in places they access • People and communities vulnerable to complex need, by integrating service responses and redesigning service systems around client needs and capacities • Vulnerable populations, through advocacy for systemic change to policies which affect the SDoH	These partnerships take a holistic approach in providing free legal advice in healthcare settings and aim to address the social determinants of ill health. (Intl Workshop, p.4) HJPs support collaborations between lawyers and health care workers to better identify and respond to the legal needs that undermine people's health (quoted from Australia (Intl Workshop, p. 32, Background paper) Socio-legal advice services within health settings (historically more broadly defined)	MLPs embed lawyers as specialists in healthcare settings.(NCMLP website)
Funding for partnerships	Legal service providers LAO Hospital Foundations LFO Municipalities Hospitals Pro bono	Legal service providers Legal Aid Commissions State & territory governments Law Foundations AU Attorney-General Health services	Highly varied	Legal service providers Healthcare organizations External grants Foundations/charities Pro bono

Table 2: High level comparison of the health justice movement in four jurisdictions

We start with our own jurisdiction – with a focus on Ontario since most of the developments to date has occurred in this province. We then explore Australia, the UK, and US.

Canada

Very little has been written about HJPs here. Yet, collaborations using a health justice approach date back to the 1980s, when an Ontario CLC was integrated into an HCP organization (now Unison Health & Community Services). In 2009, Pro Bono Ontario (PBO) was the first to formally bring the MLP model to Canada, as an intervention for children and their families at Sick Children's Hospital in Toronto (Jackson et al., 2012; Tepper et al., 2014). This early innovation has now expanded to four children's and two regular hospitals. A formative evaluation (Jackson et al., 2012) and a later comprehensive evaluation noted it was highly successful and effective (Focus Consultants, 2012). Families were in social and financial need, and children had serious health problems: The program addressed significant unmet needs. Legal staff had a good record of resolving clients' legal problems, with significant impacts for families. HCPs valued the program very highly, unanimously agreeing that stress on families was reduced.

Since these two early manifestations, other formal initiatives have emerged, many of which received funding for the first time during a three-year LAO Clinic Transformation initiative in 2014. Our 2019 mapping study, discussed below, identified 11 different hosts, with 33 different JHPs. We believe that many other CLCs work closely with HCPs but at the time of the 2019 survey would not have described their work as HJPs. That term has not been widely used until recently (Hay, 2018). We update our 2019 Ontario findings below with examples of initiatives that we would now identify as using this approach.

Preceding and contemporaneously with these developments, are related initiatives where HCPs intervene proactively on the SDoH. This included a series of articles by The Ontario Physicians Poverty Working Group in the *Ontario Medical Review* (Bloch et al., 2008; Dorman et al., 2013; Morris et al., 2013). The Canadian Medical Association (CMA) studied how to establish a role for doctors as active agents for change in health equity (2013). In 2015, to explain how the SDoH impact on patients' health, and how doctors might enact their *health advocate* role, the College of Family Physicians of Canada issued "Best Advice: Social Determinants of Health." For doctors, this health advocate role has articulated professional competencies. The report suggested that team-based care might include help from a legal aid professional. Other aligned interventions include implementing a poverty screening tool (Bloch, 2013; Centre for Effective Practice, 2016; Purkey et al., 2019), piloting an online tool to improve patient access to financial benefits (Aery et al., 2017), developing a standardized tool to collect SDoH data (Adekoya et al., 2023), and a tool to identify precarious employment (Ho et al., 2024). Others include employing a health promoter to improve patients' access to income security programs (Jones et al., 2017), creating a SDoH committee within an academic FHT (Pinto & Bloch, 2017), and integrating social justice advocacy into an FHT (Shoucri et al., 2021). Also training medical students on the SDoH (Pinto et al., 2018; Hassan et al., 2023) creates a framework for how HCPs can take action on the SDoH (Andermann, 2016), as is the growing *social prescribing* movement (Muhl et al., 2023).

Reports have identified HJPs as an example of working with *community justice help* and *trusted intermediaries* to help improve access to justice (Cohl et al., 2018; Mathews & Wiseman, 2021), and *multi-disciplinary problem solving* (Moore, 2022). Since the mapping study, the LFO funded several initiatives to develop HJPs under its Connecting Rural Region grant program, and CALC's Trusted Help project (co-hosted virtual forums and develops online learning sessions).

HJPs have emerged in other provinces including Alberta, Saskatchewan, Quebec, BC, and Nova Scotia. The Faculty of Law at the University of Calgary provided law students with a clinical learning placement at CUPS, a community-based organization that provides health, education and housing services to low-income Calgary residents (van Olm, 2021). CUPS students provide brief legal services and legal information. The College of Law and the College of Medicine at the University of Saskatchewan have been developing a community of interest to explore JHPs and sponsored events including a conference (CREATE Justice, 2018). Quebec's first MLP has existed at Montreal Children's Hospital since 2017, and Justice ProBono is also working with Médecins du Monde to answer questions from migrants with insecure status. In BC, the Legal Services Society supports two MLPs (Munro, 2012; Nobleman, 2014).There is also a Pro Bono initiative in Nova Scotia. The Family Legal Health Program offers free legal services to eligible families with a patient at IWK Health Centre and a legal need impacting their health. A hospital social worker identifies eligible patients, confirms eligibility to the Legal Information Society of Nova Scotia, who then refers them for pro bono services, if they do not qualify for legal aid.

2019 Ontario JHP Mapping Study

In June 2019 we completed a mapping study of Ontario's JHPs to understand more about how these partnerships were being developed and supported, evaluated, and their impacts. Here we present a high-level analysis of the nature of the partnerships, their activities, and their impact as reported by their hosts. Further details and statistics are summarized in a PowerPoint (Leering, 2019). We describe how these initiatives were being evaluated in Chapter Four.

The survey elicited responses from 11 hosts, with 33 partnerships identified. Nine hosts were CLCs (including one host with four clinics involved), the two others were PBO and LAO. HCPs included nine hospitals, nine CHCs, 10 FHTs, a nurse practitioner clinic, mental health association, and a doctor's office. In addition to the legal service providers that were hosts, others were involved including LAO staff, private bar lawyers offering pro bono legal help, and law students. At least three hosts also involved HCP student placements including social worker, nursing, and occupational therapy. Figure 9 sets out the timeline for JHP development.

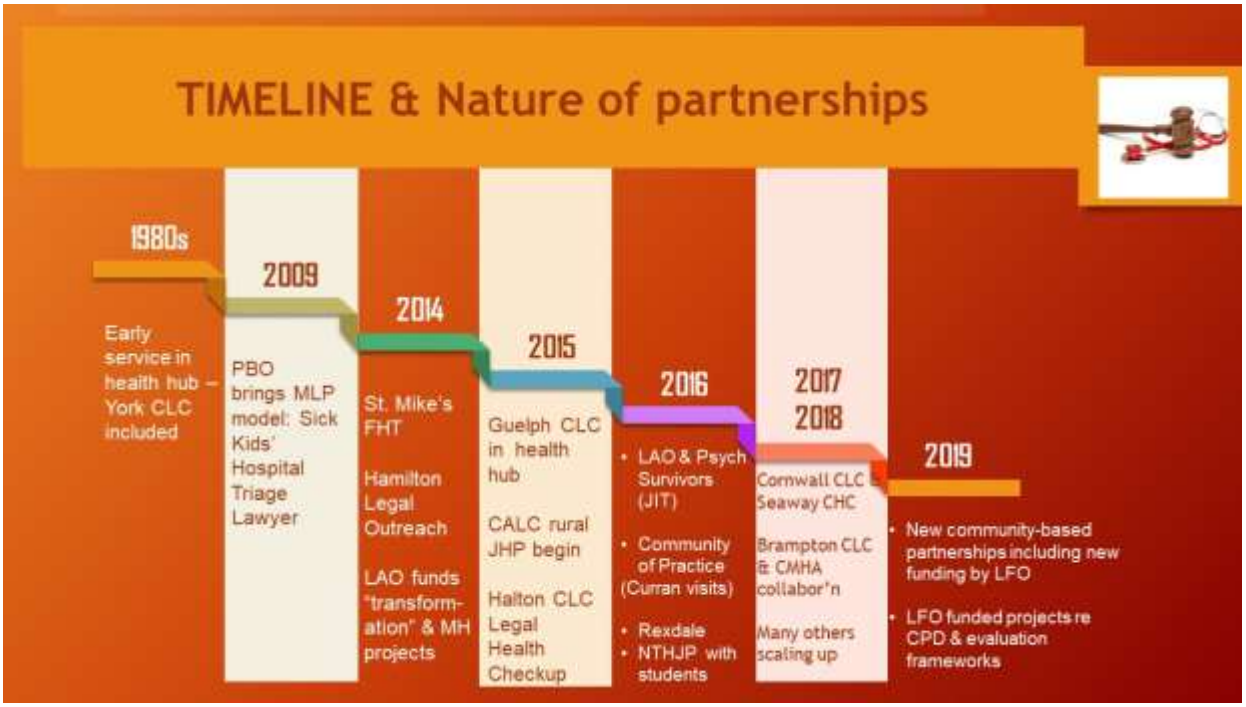

Figure 9: Historical timeline of JHP development in Ontario

Services were offered to people living on a low income and were sometimes targeted to particular populations including families with sick children, people with mental health challenges, street-involved and homeless clients with complex mental health and addictions issues, people living in rural areas, new immigrants, and clients with complex issues and chronic health conditions. Figure 10 sets out the kind of legal problems that were being seen.

Figure 10: Types of legal problems reported by 11 hosts identified through the mapping study

The degree of formality and the nature of the partnerships varied considerably. Figure 11 displays out a broad spectrum of possibilities for collaboration, with interventions varying in

their sophistication and degree of integration. Services characteristic in Ontario of the health justice approach begin in blue font to the right of the blue demarcation line. Four hosts reported formal Memorandums of Understanding (MOU) with all their HCPs, four reported that some had MOU, three reported they did not, and one noted it was not applicable. Four hosts met quarterly with HCPs to discuss their partnership, two reported ad hoc meetings depending on needs, one biannually, and three annually. During the start-up phase of a partnership, meetings are more frequent. Primary funding sources were LAO, with secondary funding sources being HCPs, LFO and municipal government. Few had core funding to support partnerships, several required project funding before the partnerships became sustainable within their legal service operations.

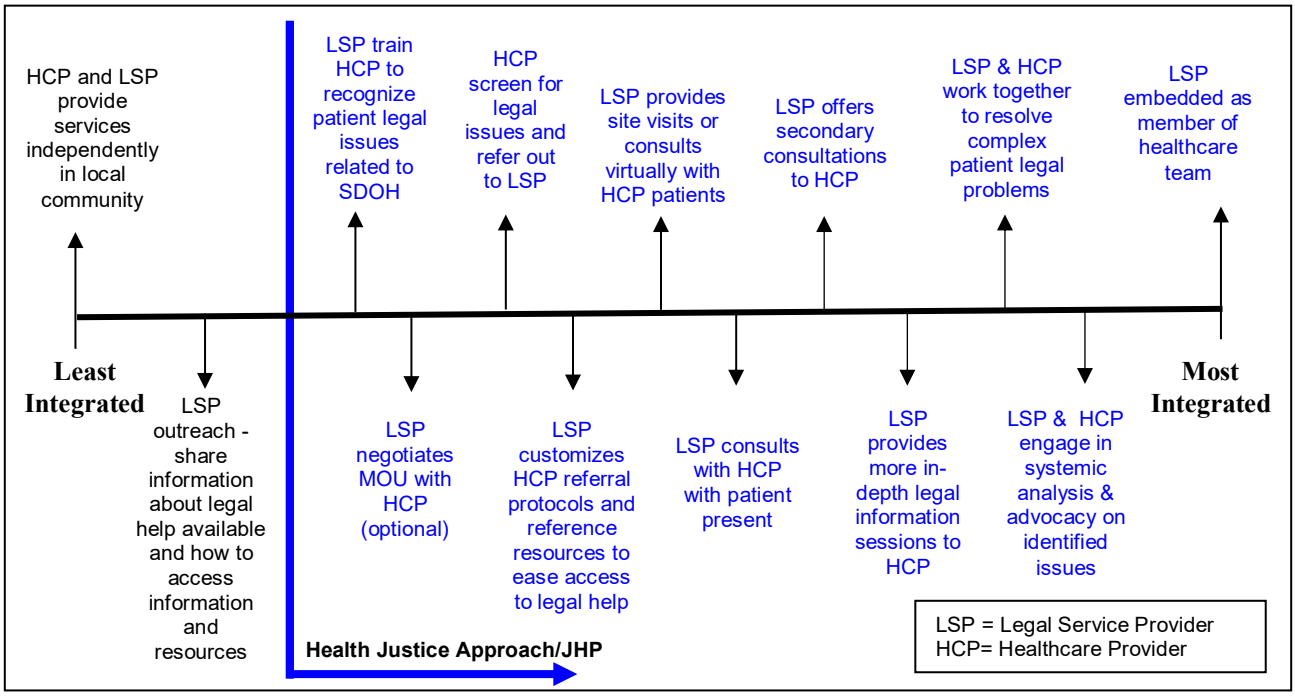

Figure 11: Spectrum of possible interventions of LSP in the health justice approach

Hosts reported, reported in order of strength of response, that the partnerships provided better opportunities to intervene early in justiciable problems, increased income security and housing (two of the SDOH), and improved the mental, emotional, and legal health of patients. Other benefits included greater employment stability, that their legal services had expanded to offer new kinds of legal help that patients required that they had not offered before, improved patient physical health, and that the legal literacy of HCPs had improved. Also, legal services were made more accessible and responsive to people's needs and enabled more holistic, client-focused services, and that healthcare and legal resources were used more cost-effectively. It was also noted that improved relationships with HCPs made communicating about legal entitlement and rights issues much easier and enabled joint systemic advocacy, and that higher quality medical reports were forthcoming when patients applied for income programs, or needed reports in legal proceedings. Participating in these partnerships also created new professional knowledge about how to screen for legal problems and better serve clients with complex needs.

In addition to the information already provided about PBO's MLP that began in 2009 (see the updated description here), we describe several partnerships based on published information including the Health Justice Program at St. Michael's Hospital, the Northwest Toronto Health Justice Project, LAO's Embedded Lawyer Project, and CALC's JHP project. We then discuss other initiatives we would now describe as employing this approach. Chapter Four provides details about how Hamilton, Halton, and Guelph & Wellington CLCs employ the approach through the lens of their evaluation studies.

In 2014, four CLCs began collaborating with St. Michael's Academic FHT and Hospital to develop a Health Justice Program. Partnership phases included a needs assessment, a review of the literature, developing the model to pilot embedded legal service delivery, multidisciplinary learning opportunities including teaching sessions for medical staff and residents, public legal education sessions for the community, a "grand rounds" lecture, law student placements, and systemic and policy advocacy (Drozdal et al., 2019). This is the only partnership LAO funds officially in Ontario's CLCs: since 2019 it has continued to raise awareness of the intersection between poverty law issues and SDoH. The Health Justice Program's (2020) study of housing needs advocated for funding of legal aid as a medical need. More recently, they have led the production of the first Canadian textbook on the health justice approach. Their impressive advocacy for systemic policy changes was captured in the *Journal of Healthcare for the Poor and Underserved* (Shah et al., 2024).

The Northwest Toronto Health Justice Project was launched in 2016, with funding from LAO's Mental Health Strategy. It was a collaboration between the Rexdale Community Legal Clinic and Rexdale and Black Creek CHCs, William Osler Health System, Humber River Hospital, and Osgoode Hall Law School's CLASP student clinic. PBO provided help to develop it, and evaluated it. Over a two-year period, 276 clients increased their access to legal, health and social services, recovering approximately $98,000 in economic benefits, and tenancies were saved. HCPs' ability to identify legal components of patients' issues increased through legal training sessions. Six law students and an articling student were involved.

Since 2016, LAO has funded The Embedded Lawyer Project in a high needs area of Toronto in collaboration with a community mental health and justice agency, Sound Times, who provides administrative staff and office space. The LAO staff lawyer works with Sound Times clients, triaging for all their legal issues including criminal, family, and poverty law needs. Annual reports document the accomplishments of this innovative and unique approach to serving vulnerable clients with multiple and intersecting legal needs. For the 2022/23 reporting period, significant estimated savings for avoided court costs ($955,000) and shelter costs ($153,000) benefitted the provincial and municipal government (LAO, 2023). The lawyer served 245 clients, with eight evictions prevented, and three successful transfers to safer housing. Twenty people had their charges dismissed, others received summary legal advice and/or limited representation, and 23 were fast tracked to receive LAO certificates to retain private lawyers.

CALC's JHP initiative as a case study & scaling up efforts

In 2015, CALC staff began developing JHPs in our local communities of Hasting, Prince Edward, and Lennox & Addington counties in southeastern Ontario using an action research

methodology. Action research, as discussed in Chapter Four, is appropriate when there is a desire to improve practice or to create change within organizations or systems, and little understanding of an issue or how to approach a problem. Action research methods are very flexible, pragmatic, adaptable, and involve simple steps. We used a cyclical process of planning, implementing, observing, monitoring progress, collecting data, reflecting, evaluating, and revising how the project is implemented as we process the lessons learned (Leering, 2017).

Prior to beginning our health justice initiative officially, we researched US and Australian developments. With the help of a small seed grant from LAO through the Rural & Remote Boldness initiative, we launched the project. We used semi-structured interviews with local HCP organizations to assess the need for legal help, working with a small local Advisory Committee to design responsive approaches to meet the need. Since 2016, CALC has engaged nine different community HCP partners, six with formal MOUs. A dedicated web page, annual project reports, and the conference poster presented at the NCMLP 2019 Summit provide more detail (Turik, 2016, 2017, 2018, 2019). Several articles and reports describe the work (Cohl et al., 2018; Hay, 2018; Leering, 2017). Chapter Four reviews lessons learned from evaluating each phase.

To learn from and support others who were experimenting with this approach, in 2016 we formed a provincial JHP Community of Practice. It meets monthly, now virtually. In 2019/20, we collaborated with Peterborough and Northumberland CLCs who had received an LFO Connecting Rural Communities grant to scale up this approach in their adjoining counties with large rural populations. Additional initiatives have included helping to construct a Queen's University interdisciplinary course for rural professionals, hosting a law student research project, producing nursing student and medical resident workshops at Queen's, and hosting Queen's nursing and occupational therapy placements. Since 2019, CALC has also carried out the LFO-funded Trusted Help project, co-hosting health justice forums with CLCs in other communities to scale up the model, and developing on-line learning resources for HCPs. Later in 2024, a virtual hub, the Justice & Health Partnership Learning Centre, will launch.

Our action research in CALC's community, and our collaborations with other CLCs and HCPs revealed that there is more that LSPs need to know and do to engage more HCPs in this shared mission. We have much to learn from our healthcare colleagues about building our capacity to evaluate JHP impacts.

More and subsequent developments in Ontario

Other initiatives we would now describe as using this approach include the Canadian Environmental Law Association's (CELA) multi-disciplinary partnership working on the RentSafe Program, and the HIV& AIDs Community Legal Clinic Ontario's (HALCO) work in close partnership with many HCPs, particularly on systemic issues. Additionally, the Barbra Schlifer Commemorative Clinic also engages in this approach (Gyorki, 2014). Aligned developments would include four Justice Centres, initiated by an interdisciplinary, inter-ministerial collaboration led by the Ministry of the Attorney-General (MAG). These Justice Centres have a different focus than other health justice initiatives extant in Ontario in that they intend to "address the root causes of crime, break the cycle of offending, and improve community safety" (MAG, 2021) through bringing together health, mental health, addictions,

housing, and employment supports, as well as embedding connections to some CLCs like Justice for Children & Youth. Although it is not publicly available, MAG retained independent consultants to develop an evaluation strategy for these Justice Centres.

Since the 2019 study, colleagues, and JHP Community of Practice members shared other examples. Staff at North Peel & Dufferin Community Legal Services collaborate with the Dufferin Area FHT to improve patients' financial security. They developed a streamlined approach to help people receive provincial disability pensions more quickly. This has included LSPs and HCPs working together on patients' applications and any subsequent appeals of denials of the benefit, providing training, accessing digital copies of health records, and leveraging social work support. The number of disability appeals has been significantly reduced, with people successfully receiving benefits up to a year earlier than before this intervention. In another example, the Sudbury Community Legal Clinic has worked with the Northern Ontario Medical School to introduce first year medical students to the SDoH and justice through clinic placements. And yet another interesting example is the Niagara Community Legal Clinic's collaboration with HCPs to develop an integrated, coordinated regional mental healthcare strategy that strengthens the opportunities for early intervention and prevention.

Australia

Australian LSPs have been building their health justice approach for several decades. As early as 1975, initiatives were emerging that would later become known as HJPs. These are collaborations or co-locations that explore an integrated service response to the links between health and legal issues particularly for disadvantaged populations. Banyule Community Health Service's 1978 collaboration with the West Heidelberg Community Legal Service (and La Trobe University) is cited as an early example (Buck & Curran, 2009; Noble, 2012b; Noone, 2009). By 2007, researchers with the LJFNSW began documenting how unmet legal needs connects to adverse health impacts and theorized how important it was to provide holistic and coordinated responses to help disadvantaged populations receive timely help (Clarke & Forell, 2007).

Legal scholarship increasingly documented the need for vulnerable and marginalized communities to have *joined up* and *multidisciplinary* approaches to ensure social inclusion and human rights (Buck & Curran, 2009; Curran, 2008, 2021; Noone & Digney, 2010). The promise of MLPs was explored by Hum and Faulkner (2009), who were involved in a medical-legal network for children and advocated for a more meaningful approach toward family and paediatric care building on US examples. The breadth of the health justice approach increased when, for example, in 2009, an informal partnership between a CLC in Melbourne and Royal Women's College Hospital focused on domestic violence (Gyorki, 2014).

The health impacts of unresolved legal issues became even more apparent in the wake of the LJFNSW's first Legal Australia-wide Survey (Coumarelos et al., 2012). Health impacts, also documented by other studies, including from the UK and Canada, led to a consensus that legal assistance services for vulnerable and marginalized people should be *targeted*, *joined-up*, *timely*, and *appropriate*. (Pleasence et al., 2014). Pleasence et al.'s ground-breaking research synthesis *Reshaping Legal Assistance Services* aligned with growing interest in piloting the health justice approach by LSPs, led principally, but not exclusively, by Australia's CLCs.

Examples of early initiatives in the state of Victoria included a collaboration between LSPs and HCPs in a newly formed Neighbourhood Justice Centre (Noone, 2009). In 2012, the aforementioned voluntary partnership between Inner Melbourne Community Legal with Royal Women's College Hospital acquired funding for a pilot project (Gyorki, 2014). Around the same time an innovative partnership in Bendigo between another CLC and a CHC was funded (Noble, 2012a). After Peter Noble and Linda Gyorki were awarded prestigious research fellowships for international field research, they wrote comprehensive reports to document the benefits of this approach. They stressed the importance of scaling up what were then called Advocacy Health Alliances (AHA) (Noble, 2012a; Gyorki). Noble used the term AHA to capture the breadth of collaborations that would integrate legal help as an essential element of healthcare, anticipating a broader range of disciplines than in the US (2012b).

In 2012, following an AHA Symposium attended by 250 people, it was recommended a movement be built by funding pilot projects and a National AHA Network (Noble, 2012b). The AHA Network subsequently became the Health Justice Partnerships Network, hosted by Victoria's pro bono organization Justice Connect. In New South Wales, HJPs also began scaling up with 10 partnerships funded with more in the planning stage (Legal Aid New South Wales, 2016). Community of practices were formed in some states to support HJP development.

In a 2014 submission to the Australian Productivity Commission's investigation into access to justice, Noone and Noble described AHA as having three core components: providing legal assistance in a healthcare setting, transforming health and legal institutions and practice, and influencing policy change to improve the health and well-being of vulnerable populations through cross-disciplinary legal and health professional advocacy. One of the support network's early contribution was an HJP tool kit. Following on this, Health Justice Australia (HJA) was founded in 2016 as a national centre of excellence to support this innovation. HJA conducts research, develop practical resources, and engages in strategic advocacy. One of HJA's foci is to support partnerships to identify and articulate their value.

In 2017, 2018, and again in 2022, HJA conducted national surveys to identify how many of these partnerships were emerging and to map the service landscape (Forell, 2018; Forell & Boyd-Caine, 2018; Forell & Nagy, 2018; HJA, 2022). Using data from 73 health justice services (up from 48 in the 2017 pilot census), five different categories of partnerships were identified as set out in Table 3. Forell noted these were preliminary categories as partnership activity ebbs and flows, and where a service falls at any given point varies. No two HJPS were identical. In 2018, 30 of the services assisted in at least one hospital setting, and 38 in primary or community health services or support settings. Most common legal partners were CLCs, followed by Legal Aid Commissions, an Aboriginal and Torres Strait Islander Legal Service, a Family Law Prevention Legal Service, and a private law firm. Legal partners reported significant in-kind contributions for supervision, governance, and oversight. HCPs reported contributing in-kind physical space, admin support, staff training time, promotional time, and executive oversight. HJA's 2018 survey revealed that less than half of HJPs evaluated their initiative. Twenty-one (mostly embedded lawyer models) had been evaluated externally, and eight internally. By 2022, 105 partnerships were identified (HJA, 2022).

Category	Description
HJ Partnerships	Partnership (commonly between health services and legal services) to embed legal help in health care teams or services
Integrated services	Services in which a lawyer is employed by a health service, as part of their healthcare team (or a health professional employed by a legal service)
Outreach services	Lawyers attending health settings to provide a legal service or clinic but not considered to be part of the health care team
Service hubs	'Place-based' service hubs in which health, legal and other services work out of an accessible community setting (e.g., a housing estate)
Student clinics	Services where supervised law students provide legal help to patients in a health setting

Table 3: Categories of partnerships identified in Australia
(Forell & Boyd-Caine, 2018)

HJA has sponsored conferences, health justice conversations, an informative website, and many learning opportunities. Three particularly helpful resources are papers discussing service models (Forell & Boyd-Caine, 2018), *Secondary Consultation: A Discussion Paper* (Rajan et al., 2021), and *Building Blocks for Health Justice Partnership Development* (Turner, 2021). Resources are also provided to help practitioners, researchers, and policy makers and funders including a toolkit for forming partnerships, and a guide for reviewing partnerships. Recent influential HJA policy briefs include *Legal Help as Mental Health Care* (Nagy & Forell, 2020) - credited with realizing additional funding for HJPs, *Health Justice Partnership as a Response to Domestic and Family Violence* (Forell & Nagy, 2021), and connecting client well-being (Forell, 2021) and financial well-being to the impact of HJPs (Pitt, 2023). They work on numerous projects including creating HJPs in mental healthcare settings, beginning with a needs assessment process (Forell & O'Connor, 2024) and undertaking other research studies (Scott & Forell, 2024). Independent evaluators confirmed HJA's significant contributions to strengthening the health justice approach (SVA Consulting, 2020). At HJA's 2023 conference, the Australian government's Attorney-General extolled the benefits of HJPs.

Other developments

The Australian government has supported HJP development, including to tackle elder abuse. The government's approach to funding legal aid is reflected in the current National Legal Assistance Partnership Agreement. Section 67 specifically recommends the health justice approach, aligning it as an approach to ameliorating the impacts of domestic violence. To receive funding, states must include these as legal service priorities (Australian Government, 2021). In May 2021, the government made a further $17 million Australian dollars available to expand HJPs for intimate partner violence as well as for people with mental health issues (HJA, 2021).

HJPs are increasingly seen as a way to act on health equity concerns. Schram et al. (2021) proposed a sociolegal model of health, with law increasingly understood as a tool for health, influenced by the Lancet-O'Neill Institute Commission on Global Health & Law.

United Kingdom

For the past three decades in the UK, there have been numerous initiatives that we would now describe as exemplifying the health justice approach. This movement began with different

organizations providing welfare rights advice in doctors' surgeries. A multitude of studies, and four systematic reviews showed promising outcomes – increasing income security and providing additional health-related services (Adams et al., 2006; Allmark et al., 2013; Beardon et al., 2021; Reece et al., 2022). Even after devastating cuts to legal aid, the Low Commission identified a wide range of social welfare legal services functioning in healthcare settings (Parkinson & Buttrick, 2015). Social welfare legal problems in the UK include housing, benefits, consumer & debt, employment, immigration, elder and family law issues.

Concerns about the health impacts of unresolved justiciable problems has been growing for many years, following ground-breaking research linking these problems to ill-health based on the findings of a comprehensive legal needs survey (Pleasence et al., 2004). In 2015, an evidence review and mapping study for the Low Commission confirmed that "the right welfare advice in the right place provides real benefits for patient health, especially where advice services work directly with the NHS [National Health Services] and care providers … early and effective welfare advice provision reduces demand on the NHS" (Parkinson & Buttrick, 2015, p. 9).

In 2017, the UCL's Centre for Access to Justice sponsored an international workshop to explore how HJPs in the UK, Australia, and the US address HHLN and the SDoH. Attendees also considered how to develop an evidence-based policy agenda and robust research program for the role of HJPs in an evolving *social prescribing* initiative in UK healthcare (Woodhead, 2017). This resulted in a more concerted effort to explore the feasibility and value of establishing a national health justice strategy (Beardon & Genn, 2018, Genn & Beardon, 2021).

Following on the Low Commission and the Parkinson and Buttrick reports, UCL's Centre for Access to Justice undertook a mapping study, identifying more than 380 HJPs (Beardon & Genn, 2018). The most common organizations providing social welfare legal advice and help were Citizens Advice and MacMillan Cancer Support. However, a wide range of other organizations were also involved. The partnerships varied from local 'one-off' to country-wide initiatives, with 66% physically located in healthcare settings. Forty percent had only short-term funding (less than a year), making them quite precarious. Although there were many challenges for establishing HJPs, when they became effective, HCPs valued them highly. HJPs developed from the "bottom up" in their communities, resulting in diverse and innovative approaches. Beardon and Genn categorised the different types of partnerships and their level of sophistication and integration as set out in Table 4 below.

Nature of partnership	Description
Integrated	Social welfare legal advisors working within healthcare teams, or single services providing both healthcare and advice
Connected by direct links	Social welfare legal services connecting with healthcare via a direct route (by referral, co-location or both): the most common form of partnership
Connected by indirect links	Social welfare legal services connecting to healthcare via an intermediate service (a link worker, community navigator or similar model): the most common approach is social prescribing schemes which connect patients to a network of community services for non-clinical support
Performing a 'social prescribing' function	Social welfare legal services receiving referrals directly from healthcare, and also acting as coordinators to refer patients on for wider sources of support in the community

Table 4: Categories of social welfare legal services links with healthcare
(Excerpted from Beardon & Genn, 2018, Table 5)

For Beardon and Genn's (2018) study, 10 service providers were interviewed about their experiences in delivering health justice services. Challenges included scarce resources, inadequate space when co-located, excessive demand relative to legal service provider capacity, and short-term funding making it difficult to create sustainable partnerships. Working across disciplines was challenging – including a lack of understanding about how the legal service might best integrate with health services for patient benefit, cultural differences, and the slow pace of establishing trusted working relationships with so many competing priorities. To get more uptake, research is needed to establish patients' financial and health benefits. Partnerships benefitted from champions within the health service, from goodwill and commitment to shared goals, especially when a health need was addressed or healthcare pressures were reduced. Co-locations provided the best opportunities for relationship building and demonstrating the value of collaboration. Regular feedback and communication was seen as critical. Evaluation practices elicited from the survey are described in Chapter Four.

Beardon and Genn (2018) recommended creating a platform to share lessons' learned and promising practices. Furthermore, collaborations would benefit from a collective approach to evaluation. Additionally, HCPs' growing interest in offering *integrated care* and *social prescribing* (referring to appropriate community services to improve health and well-being) provide opportunities to broaden the reach of the health justice approach (Beardon, 2022b).

Genn (2019) has written comprehensively and persuasively about how access to justice can mitigate the SDoH. Genn noted that law may be one of the most important SDoH, drawing on more than 20 years of socio-legal research exploring unmet legal need, challenges people face resolving their legal problems, and her seminal study *Paths to Justice: What People Do and Think about Going to Law* (Genn & Beinart, 1999). "Understanding that legal problems create or exacerbate ill health and that ill health creates problems for which the law provides solutions, is a necessary step in understanding the links between law and health in the pursuit of improve public health and well-being" (Genn, p. 160). Her work has been very influential in advancing government and healthcare interest in HJPs. Figure 12 captures how legal interventions tackle the upstream causes of ill health. In her view, expanding the approach will transform how services are delivered and improve the health and well-being of people who are disadvantaged and vulnerable. Genn encouraged "transdisciplinary research collaboration to support cross-sector policy development and practice innovation" (p. 162).

Social Pathogen	Medical condition	Medical intervention	Legal remedy
Poor quality damp housing	Chronic asthma	Increase asthma medication dose and frequency, refer to specialist clinic	Compel landlord to comply with legal duty to provide healthy safe housing. Check income entitlements. Increase income to enable move to better accommodation
Employer illegally threatening with redundancy	Insomnia in pregnant woman	Sleep hygiene advice, hypnotic medications, referral to psychological therapies	Compel employer to comply with legal duty to protect employment of pregnant employees
Landlord threatening eviction	Suicidal ideation or deliberate self-harm	Mental health referral, safeguarding, emergency assessment, psychotropic medications	Prevent eviction and or compel local authority to provide housing assistance
Unsafe working conditions	Lower back pain	Analgesia, imaging investigations, surgical referral	Compel employer to modify working conditions or provide reasonable adjustments to accommodate
Insufficient income for healthy diet	Malnutrition, anaemia, iron deficiency	Supplemental nutrition milkshakes, iron supplements, Vitamin B12 and folate	Check income entitlements. Increase income by applying for unclaimed benefit. Appeal decision to deny or withdraw benefits.

Figure 12: Biomedical model and integrated service delivery model compared. (Genn, 2019, p. 181)

Developments in the UK since the harsh cuts to civil Legal Aid in 2013 now appear to be shifting in favour of exploring how HJPs might improve health, and thereby reduce healthcare costs. High level government discussions have been taking place. A new Law for Health stream was launched at UCL Health of the Public, which features HJP work. Beardon et al. (2020) explored how this approach can improve mental health. Since 2021, Law for Health has hosted numerous webinars and workshops, sharing insights from their research and Beardon's (2022a) doctoral research. Beardon (2022b) reported on her comparative case study of nine HJPs, how HJPs could be implemented successfully, and made recommendations about service design, collaborative working, sustainability, and national action. They continue to undertake new research, including a report on the current HJPs challenges after surveying 75 partnerships (Beardon et al., 2024). A website now supports HJPs, which includes advice for practitioners. After broad consultation, a pragmatic HJP implementation guide (Beardon, 2024) is available.

In 2019, the Ministry of Justice issued a Legal Support Action Plan, indicating an interest in quicker, easier, and more timely access to legal help (Ministry of Justice, 2019, 2020). The Ministry wanted to understand the health and well-being benefits of holistic legal support hubs. To that end, a process was designed for evaluating integrated advice hubs in primary healthcare settings (IFF Research and York Health Economics Consortium, 2023a/b) which is discussed further in Chapter Four. More recently, in 2024, an Open Government Team became very interested in the approach while preparing a policy brief for the Ministry of Justice's Review of Civil Legal Aid (Open Innovation Team, 2024).

United States

To understand how MLPs developed, we conducted a jurisdictional scan using peer-reviewed and grey literature. Appendix J links to the report distilling research and evaluation methods (up to 2020), including an analysis of 46 articles, NCMLP publications, and a key informant interview. Here, we review the history of MLPs, the current landscape, and resources.

According to Teitelbaum and Lawton (2017) collaborations between health and legal professionals occurred as far back as the 1960s, when a health centre in Mississippi hired a lawyer to address patients' food and housing issues. Hospitals and civil legal aid agencies worked closely during the 1980s AIDS epidemic to meet the end-of-life needs of patients with AIDS. The first official MLP was formed in 1993 between the Boston Medical Center and Greater Boston Legal Services to address poor housing conditions of children with asthma. After a *New York Times* article detailing the Boston MLP in 2001, partnerships began steadily developing across the US, with almost 75 created in the next five years. In 2006 the W.K. Kellogg and Robert Wood Johnson Foundations provided funding to create the NCMLP.

Originally located at the Boston Medical Center, in 2013 the NCMLP moved to the Milken Institute School of Public Health at George Washington University. The new location was intended to allow the NCMLP to connect with government agencies, new private partners, and expand MLP programs on the national level (Teitelbaum & Lawton, 2017). Shortly after this move, several researchers working at the NCMLP were involved with the Southern Illinois University and Southern Illinois Healthcare's Fifteenth Annual Health Policy Institute, "Medical-Legal Partnerships: Collaborating to Transform Healthcare for Vulnerable Patients" (Lawton & Sandel, 2014). This symposium brought together national leaders in medicine and law to present on and discuss the MLP model, including how MLPs interact with the *Patient Protection and Affordable Care Act*, could improve medical education, and address the SDoH.

Following the symposium, a special edition of the *Journal of Legal Medicine* focused exclusively on MLPs and summarized key symposium presentations (Lawton & Sandel, 2014). Articles addressed common hardships partnerships face, how to promote fuller integration with health settings (Sandel et al., 2014), the unique impacts MLPs have on healthcare education (Tobin-Tyler et al., 2014), and how MLPs could be used to establish higher standards of care (Hallarman et al., 2014). The special edition's ultimate goal was to "plant the seeds for the next decade during which MLP will help healthcare reach its true potential" (Lawton & Sandel, p. 6).

Increasingly, MLPs are seen as a "critical strategy to create a more equitable next era of health law" (Ahrens, 2022, p. 1). Cannon (2023) asserted that "health justice is not just healthcare justice; it is also economic justice, racial justice, housing justice, and other forms of justice that necessitate access to legal resources to address unmet legal needs that drive health inequity" (p. 75). Growing attention has been paid to how MLPs can effectively "teach" complex SDoH to medical residents (Welch et al., 2021), and better prepare law students for tackling 21st century issues (Rosen Valverde, 2018). In March 2023, several university law schools convened a forum for academic HJPs (62 US law schools are involved in them) to share promising practices, research, and potential interprofessional learning strategies, (Tobin-Tyler et al., 2023).

The NCMLP currently focuses its work in four areas: *transforming policy and practices* across sectors; *convening experts* to accelerate MLP growth; *building an evidence-base* for the MLP approach; and *promoting financial investments* in the approach. According to their website, there are currently over 450 partnerships, with MLPs present in almost every state. An environmental scan of MLPs in federally-funded health centres estimated 100 – 150 MLPs, and an additional 100 – 150 in the planning stages (Baños et al., 2023).The NCMLP now actively promotes partnerships as a tool to address patient's SDoH needs. The evidence base is growing: MLPs lead to improved health among people with chronic illnesses such as asthma (Klein et al., 2013), diabetes (Malik et al., 2018), and sickle cell disease (Pettignano et al., 2011). Patients receiving MLP services are more likely to take their medications as prescribed (Weintraub et al., 2010), and report less stress and improved mental health (Rosen Valverde et al., 2019; Ryan et al., 2012; Tsai et al., 2017). MLPs are reported to lead to more stable housing (Hernández, 2016) and financial benefits for patients (Klein et al., 2013; Pettignano et al., 2013; Taylor et al., 2015), and to greater cost reimbursements to HCPs (Rodabaugh et al., 2010). They help improve rural health systems by fostering intersectoral integration to benefit patients (Teufel et al., 2014).

The Robert Wood Johnson Foundation funded the NCMLP to conduct research on five partnerships from 2016-2020. The goals were to measure the financial and social impacts of MLP services on patients, describe the experiences and attitudes of involved patients and HCPs, and identify best practices for how MLPs operate in hospitals and healthcare settings (NCMLP, 2016). Materials produced included a White Paper on physicians' perceptions of the benefits of MLPs and a series of five case studies of how the lives of patents were improved by a specific partnership (Marple & Dexter, 2018a/b/c/d/e; Trott, Regenstein, et al., 2019). During this period, the NCMLP also developed the SDoH Academy, and offer virtual webinars and training materials to assist HCPs understand how MLPs can impact on the SDoH.

Ellen Lawton, former NCMLP Co-director suggested that LSPs now advance MLPs as a tool for health professionals for addressing SDoH (personal communication, August 5, 2020). In the early days of MLPs, several studies focused on the ROI for hospitals (Teufel et al., 2009, 2014), and Social Return on Investment (SROI, Goffinet et al., 2013). In addition to the obvious benefits for patients, another impetus for developing cross-disciplinary partnerships are the benefits that accrue to both health and legal service providers. For example, there is a growing body of evidence that HCPs who perceive they have increased clinical capacity to intervene on social and economic needs report higher job satisfaction (tied to ameliorating burnout) and perceive higher quality medical care (Pantell et al., 2019). Murillo et al. (2022) reported that pediatric providers became more effective in addressing HHLN related to the SDoH, empowered them to engage in systemic advocacy, and improved relationships to families.

Currently the NCMLP provides technical assistance and networking to support partnership growth in the US. They promote and contribute to materials from third parties that could assist partnerships, including data collection tools (surveys) from the Association of American Medical Colleges (AAMC), and the County Health Rankings. The County Health Rankings, a program of the University of Wisconsin Population Health Institute, provides communities with reliable evidence about strategies that improve health. They reviewed the current evidence available for MLPs and identified expected outcomes, potential beneficial outcomes, and effectiveness. They gave MLPs the evidence rating of "Some Evidence," deeming

that strategies with this rating are likely to work and have been tested multiple times with overall positive trends, but require further research to confirm their effects.

With a change in government, the NCMLP began to have access to greater support on a federal level – which had been a motive for relocating from Boston to Washington. Tobin-Tyler et al. (2023) reported that half of all MLPS receive some level of financial contribution from their healthcare partner. This has partly been enabled by the 2010 passage of the *Patient Protection and Affordable Care Act* which incentivized addressing upstream causes of poor health, and provided funding for attending to patients' non-medical needs. In 2014, the federal Health Resources and Services Administration was permitted to recognize and fund civil legal aid as an *enabling service* in health centres (Baños et al., 2023). The movement continues to expand: Cannon (2023) described President Biden's support for MLPs, noted recent federal legislation providing $2,000,000 in funding, and some states providing funding for MLPs. Other NCMLP developments of interest have included grant support for new MLPs and research on impact has been forthcoming through a new partnership with Kaiser Permanente intended to stabilize housing and prevent evictions. In July 2023, the NCMLP also launched a collaboration in 2023 with the Association of Clinicians for the Underserved to raise awareness of MLPs, develop a community of practice, and engage in advocacy through law and policy.

With 58 law schools participating in MLPs across the US, even more lawyers working in prestigious and powerful positions will have had experience with the MLP approach and can promote the movement. The influence of lawyers with this MLP experience appears to have led to the American Bar Association endorsing the approach, which parallels its endorsement by the American Medical Association (Healton et al., 2021).

The NCMLP recognizes there are many different partnership models. Table 5 outlines three partnership models from a webinar series about MLPs in health centres.

MLP Structure	Description
Referral Network	One or more medical partners agree to refer patients with potential legal issues to a participating legal partner. Medical partner gives legal partner's contact information to patient but does not directly communicate with legal partner on patient's behalf. Any personal health information (PHI) is transferred from medical partner to legal partner is requested by and transferred by patient. Legal partner does not communicate directly with medical partner.
Coordinating Staff	Medical partner and legal partner agree to form MLP with some staff designated to coordinate identification and referral of appropriate cases. Dedicated staff (e.g., social workers, care managers, paralegals) may be employed by either party but are typically located on-site at the medical partner. Dedicated staff may be responsible for obtaining consent to share PHI with legal partner and/or facilitating communication between the MLP partners.
One Organization	Medical partner and legal partner are both part of the same organization. Referrals are made either by the medical partner directly or by dedicated staff within the organization. The MLP partners may share information using a common internal information management system, though a firewall may be maintained between PHI and legal information in that system.

Table 5: Categories of different MLP structures.
(Slide 25, excerpted from Hamilton, 2021)

NCMLP also describes partnerships by their stage of development. In a toolkit for creating and supporting MLPs for veterans, as seen below in Figure 13, MLPs are portrayed as progressing through stages from exploratory, aspirational, operational to mature.

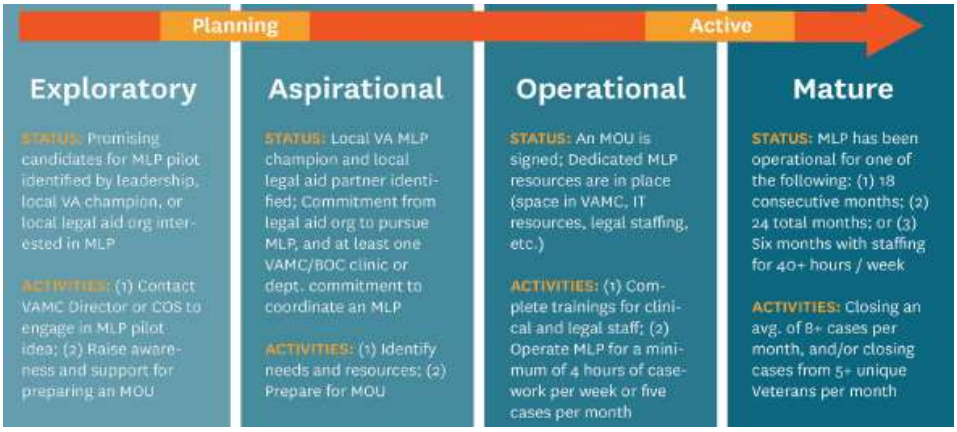

Figure 13: Stages of Veteran Affairs MLP Development
(Excerpted from Trott, Theiss, et al., 2019, Figure 1)

The NCMLP has twice supported researchers to conduct literature reviews evaluating MLPs. Both reviews included a literature matrix, describing and categorizing the documents reviewed. The original review completed by Beeson et al. (2013) identified three main themes: *financial impacts*, *impacts on patient health and well-being*, and *impacts on knowledge and training of health providers*. Murphy (2020) updated the literature review seven years later (2020). The updated review identified outcomes (as opposed to themes) in five different categories: *changes in the health and well-bring of patients*, *improved housing and utility stability among patients*, *improved access to financial resources among patients*, *improvements to health care systems and workforce*, and *improvements in policies, laws, and regulations*. These reviews demonstrated a shift to focusing on specific outcomes, and incorporating SDoH language into patient outcomes.

Readers wanting more information on the US will find the NCMLP website to be very useful. Key resources include:

- Social Determinants of Health Academy,
- 2020 Health-Center Based MLP Toolkit (Marple et al., 2020),
- 2019 Veterans Affairs MLP Readiness Guide (Trott, Theiss et al., 2019),
- Implementation Guidance and Suggested Measures for VA MLPs (Trott et al., 2021), and
- Association of American Medical Colleges Program Logic Model (AAMC, 2019a).

Since drafting this report in 2021, the volume of academic literature and published studies continues to grow. To name but a few, examples include introducing a legal health check-up in a school-based health centre for low-income adolescents (Kessler et al., 2021); a physician-public defender collaboration (Vanjani et al., 2020); examining MLPs as a *structural intervention* in HIV/AIDs treatment and conceptualizing a legal continuum of care (Martinez et al., 2022); integrating MLPs into trauma care (Hall et al., 2022) and perinatal care (Patchen et al., 2023); and, MLPs facilitating *cost of care conversations* (Edward et al., 2022). Welch et al.'s (2021) explored the effectiveness of teaching the SDoH to undergraduate and graduate medical students through MLPs and reported positive results. Alur et al. (2023) produced a scoping review on what MLPs can do for trauma patients, and Johnson et al. (2024) conducted a narrative review of peer-reviewed articles about US MLPs and their structure and impact.

Academic MLPs continue to develop their theory and practice of health justice partnerships which contributes significantly to the strength of the movement in the US (Bliss et al, 2012). These initiatives seed the ground for increasing sophistication and rigour, and nurture strong future leadership from law and medical students. A forum, convened by Yale Law School in early 2023, resulted in 19 powerful articles exploring the transformative potential of MLPs (Kraschel et al., 2023) published in a dedicated edition of the Journal of Law, Medicine & Ethics.

Chapter Summary

In this chapter, we shared what we learned about the evolving health justice approach in four countries. We described the results of our mapping study and literature review documenting Ontario's JHPs emergence, their characteristics and evaluations, and our context. We included a case study of CALC's local partnerships. We described current scaling up initiatives in Ontario.

We explored the research and practice innovations in Australia and how legal needs studies, a synthesis of international empirical research findings, and early experimental HJPs contributed to substantial scaling up of the model there. This has since attracted significant government and legal aid investment (particularly for domestic violence and mental health interventions). Since 2016 HJA has become a leader in building the movement, articulating its aims and impacts, researching impact, and preparing policy briefs to influence government.

Research and practice developments in the UK have also been inspiring, building on a long tradition of welfare rights advice in primary care settings, a seminal study on unmet legal needs, and evidence of the health impacts of unmet legal needs. Although slashed funding for legal aid in the past decade presents a major obstacle to scaling up the promising developments of the past, there is now a resurgence of interest in the (newly named) health justice approach because of concerns that have included social inclusion, social prescribing, and ameliorating the SDoH. Leadership by the UCL's Centre for Access to Justice, as well as research by the Low Commission, have encouraged the Ministry of Justice in England and Wales to look more closely at HJPs as a model for improving health, aligned with the goals of their government's Legal Support Action Plan.

The chapter concludes by discussing the MLP model which originated in the US. MLPs are promoted by strategic and influential leadership, with support from many credible organizations including the American Bar Association, American Medical Association, and the vibrant NCMLP's many research and awareness- and capacity-building activities. Moving from an earlier focus of ROI, and improving health outcomes for patients, MLPs intervening to ameliorate the SDoH has recently rapidly gathered traction across the US, supported by the NCMLP, with growing support from governments. The legal academic community has been a strong supporter of the MLP approach through hosting MLP student clinics, participating in research studies, and producing copious scholarship including in the fields of public health law, access to justice, and legal education, supporting and promoting the MLP approach.

Chapter Four: Approaches to Evaluation and Research

In this chapter we discuss the approaches to evaluation research arising from MIEAC's deliberations, the jurisdictional scans, the systematic and scoping reviews, insights gained from developments in access to justice outcome measurement, the field of evaluation, and qualitative research. A consensus has not yet emerged on how best to evaluate and measure as this field is still nascent. In Australia, UK, and US there is a great deal of interest in building knowledge of what works, for whom, how or why it seems to work, and at what cost. To contribute to international knowledge sharing, we wanted to document the different ways of approaching research and evaluation, and their genesis. Chapter Five then outlines possible emerging promising practices to inform evaluation frameworks in Ontario.

Canada: Approaches and Lessons Learned from Ontario, Canada

In this section, we summarize the approaches taken in Ontario as revealed by the mapping study, published reports, and peer-reviewed literature. We also debrief CALC's experience evaluating our JHP initiative, and report on the piloting of an evaluation framework.

Lessons learned from the mapping study (Leering, 2019)

The mapping study revealed that 10 of the 11 hosts evaluated their program in some way, with five retaining independent evaluators some time during in their program's development. For three, program logic models guided decisions about what to evaluate. Figure 14 outlines data collection methods. Data was collected by the hosts, although how much was collected and reported varied. Hosts were interested in learning how to do this more effectively and efficiently.

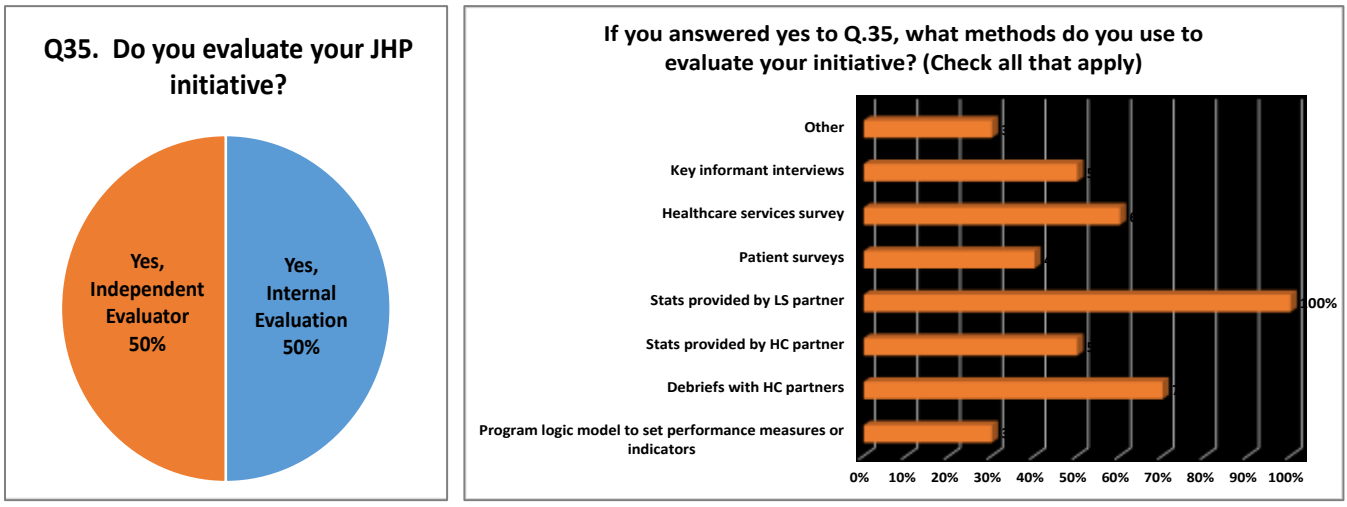

Figure 14: Data collection methods from Leering (2019) mapping study

We asked what challenges hosts faced in developing/sustaining partnerships. These included, in order of reported frequency, that all the legal needs could not be met, funding shortfalls (and project-based), HCP staff turnover, issues of patient confidentiality, and to a lesser extent, LSP staff turnover. Also identified were challenges getting other LAO-funded services (family,

criminal, immigration) to become part of the partnership offerings, cuts/changes to community services making it difficult to offer holistic services, and various reasons for loss of partners.

Lessons learned from published reports and peer-reviewed articles

Now we summarize the approaches some of Ontario's JHPs have taken as captured in published reports and peer-reviewed articles. Most studies used mixed research methods. For example, a formative evaluation of PBO's Sick Children's Hospital program (Jackson et al., 2012) collected data from legal case files and semi-structured interviews. Focus Consultants' (2012) undertook a thorough summative evaluation including a literature review, case file review, and surveys for HCPs, pro bono lawyers, and children's parents. Their report includes their data collection tools. Detailed findings are presented on client demographics, referral and service data, and legal problems and their resolution. Health problems are reported to the extent possible, using data from the triage lawyer's records, and assumptions based on which hospital department referred to the lawyer. Many other findings are reported on clinicians' and families' perceptions of the service, and recommendations for improving the service. The most frequent interventions benefiting families were reducing stress and improving their financial situation.

In 2018, the Rexdale Community Legal Clinic worked with PBO to design the evaluation of the Northwest Toronto Health Justice Program that included using a program logic model. Figure 15 captures the questions addressed by their evaluation. Data was collected by gathering details from legal case files about referral source, the type of legal problems and the services provided, and case outcomes. Client and clinician surveys and a key informant interview were conducted. Narrative case studies of typical client problems and resolutions were also gathered.

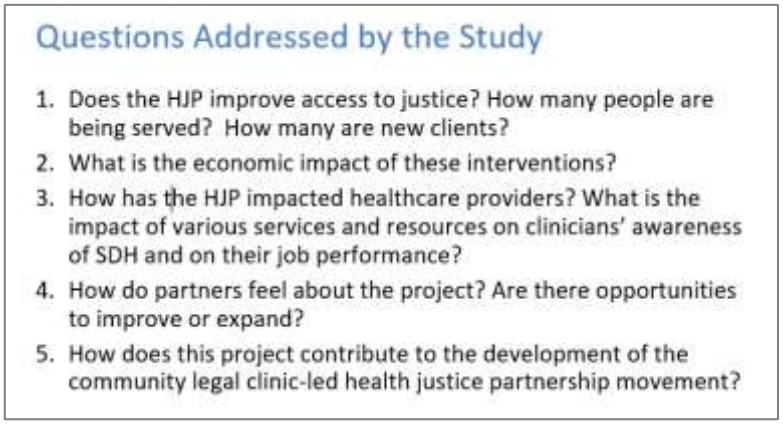

Figure 15: Questions from the Northwest Toronto Health Justice (Excerpted from Rexdale CLC, 2018)

The Hamilton Community Legal Clinic hosted a number of different HJPs partnerships including an academic FHT and a youth mental health crisis support centre. To evaluate their initiatives, they used an outcome evaluation to assess the extent to which the project had met its intended objectives, focussing on immediate, intermediate, and ultimate outcomes (Zarinpoush, 2006). Their evaluation framework also included developing a program logic model, and setting evaluation questions. Data was collected, and then analysed statistically and thematically with their project partners. In addition to using legal service data, surveys collected qualitative feedback from community partners and clients (Hamilton Community Legal Clinic, 2019). One

of the initiatives was also the subject of an "observational" research study by Agarwal et al. (2020). This study reported on the use of a screening tool, and booking of appointments for free legal advice. Demographic data was collected. The analysis revealed that all patients had at least one issue related to the SDoH and 84.2% had at least one legal need (with an average of 3.4 legal issues) identified by the screening tool. However, only 14.5% booked an appointment, and only 73.4% of those kept the appointment. Statistical tests were used to ascertain the likelihood that clients would keep their appointment, aided by the use of SPSS software. Agarwal et al. (2024) reported on a pre-post evaluation of this academic FHT that featured a weekly legal clinic.

Although not specifically evaluating the effectiveness and impact of specific JHPs, Currie evaluated the effectiveness of strategies aligned with the health justice approach (see Figure 11). This included a Legal Health Check-Up screening tool, service providers' use of *secondary consultations*, and a mobile van (Currie, n.d.a/b, 2017, 2018). These initiatives are led by Halton Community Legal Clinic and Legal Clinic of Guelph & Wellington Counties (this CLC is co-located with a CHC). The evaluations were formative, rather than summative outcome evaluations. The research approach appeared to be a case study research methodology that was exploratory and descriptive of the CLCs' initiatives, with mixed methods to collect data including surveys, interviews with staff and service providers , and reviews of CLC client case notes. The thorough description of 'cases' helps us understand how the initiative was implemented. The legal problems identified by the screening tool were analysed, and the nature of problems for which secondary consultations were being offered, and how they were perceived by HCPs and trusted intermediaries. The data collection instruments will be useful for other studies, especially those for the secondary consultation study (Currie, 2017). Although not specifically assessed, secondary consultation cost-effectiveness was apparent. For service providers having their clients complete the Check-Up was not sustainable, but secondary consultations were sustainable.

In September 2020, forthcoming evaluation research results from St. Michael's Health Justice Program were shared with MIEAC by Dr. Andrew Pinto, family physician, assistant professor, and researcher with the St. Michael's Academic FHT and founder of the Upstream Lab. The multi-pronged evaluation, funded by St. Mike's medical innovation fund, covered its first three years. They conducted a rigorous implementation evaluation, including analysing patient and health and service provider views and experiences. The research questions included how the partnership was implemented and how it evolved. What were the common legal issues identified and how were they addressed? Who was served? What were the experiences of the partnership for the stakeholders? How did the initiative impact on access to justice, and what were the legal and health outcomes? Three articles capturing study results are under peer-review. We are waiting for the findings to be published. The study methodology is described next.

A mixed methods research methodology used qualitative and quantitative approaches to answer the research questions. The patient's electronic medical record contained the form needed to refer patients to the initiative for help. With research ethics approval granted by the hospital, date was collected through a standard intake survey administered by the health justice team, and standard exit survey for every patient in the first three years, maintained in an ACCESS data base. The surveys captured patient demographics, identified issues, and patients' perceptions of whether the problem was resolved. Forty interviews gathered information from 20 patients, and

20 healthcare and legal service providers about how the program was implemented. There was also a short-term longitudinal study following 55 patients for four months.

Additionally, a case study methodology was used to describe and assess the systemic advocacy work undertaken by the team (linked with the hospital's SDoH Committee). Shah et al. (2024) developed a program logic model to guide the thematic and documentary analysis. They reviewed archival records of seven initiatives ranging from advocacy on income security programs, employment issues, citizenship, housing issues, Pharmacare, and supervised drug consumption sites. Key involved staff were interviewed by a study team member with a social work background. Outcomes included a reduction of medical reviews for income security applications, recommendations for changes to workplace laws were passed into law, and changes to citizenship legislation aligned with the submissions made to a government Standing Committee. For five initiatives, final outcomes are still outstanding. Shah et al. acknowledged that it was difficult to capture outcomes, given the length of time required to produce advocacy outcomes, and attribute causal relationships in such complicated and multi-faceted endeavours.

We briefly discussed with Dr. Pinto whether RCTs would be appropriate for measuring the impact of the health justice approach. We reviewed ethical reservations (comparing those with access to those who don't have it), the complicated tasks of controlling for all variables, and the viability of RCT for this type of complex intervention with complex outcomes. A "stepped-wedge" design might remedy some of the ethical concerns. A stepped-wedge design allows for a control and intervention group, where the time of when the intervention occurs is delayed for the randomized control group (Hemming & Taljaard, 2020).

Lessons learned from CALC case study

CALC, as part of our action research methodology, developed different evaluation questions for each phase of our JHP implementation as they had different goals. Table 6 below sets out the kinds of information we collected in each phase. Appendix M provides details of our evaluation framework. CALC staff benefited in 2016 from a workshop presented by Australia's Dr. Liz Curran. She recommended we choose measures that were relevant, realistic, useful, capable of improving practice, sustainable, and that could provide comparisons and contrasts. We were encouraged to measure what was readily measurable and within our capacity to collect, while staying away from measures that would be burdensome or expensive.

By the time we finished collecting data and evaluating the 2016/17 pilot we determined that it was challenging to measure whether our goals were being met directly with a metric: proxy measures and qualitative data were required. Much of the data had to be pulled manually which was highly inefficient. Our funder's new data management software made retrieving the needed information even more difficult. Also, much of the *value added* by the project was not captured at all. This included the interdisciplinary learning from nursing and occupational therapy student placements, the JHP Community of Practice, and the efforts we were making to share our knowledge and scale up the health justice approach in other communities.

Phase	Research need, approaches and data collection
2015: Pre-launch	Needs and capacity assessment of HCP organization Key informant semi-structured interviews Academic literature and reports Expert knowledge gleaned from HCP expertise on Advisory Committee
2016/17: Pilot	Whether early intervention was occurring Whether HCP secondary consultations occurring Whether ODSP disability appeals were being reduced Whether HCP legal literacy was increasing Developed "matrix of intervention" to assess stage of intervention across main legal issues Review of legal cases referred by HCPs to determine intervention timing Legal service data including number of client referrals and legal secondary consultations with HCPs (required tagging in statistical program) Metrics related to number of ODSP application appeals to determine whether they were being reduced by interventions with HCPs Pre- and post-legal literacy workshop evaluations
2017 - ongoing	Degree of participation by HCPs More limited data collection and data lost due to software and issues Number of referrals, originating location for referrals, number of legal literacy workshops and number of HCPs attending workshops
Summer 2017	Satisfaction with how partnerships were developing and ideas for improvement Partner survey using Survey Monkey Focus group
Fall 2017	Rationalizing evaluation efforts including data collection Piloted constructing a logic model to capture the complexity of the impact
Various time periods to support evaluation	Action research process Kept learning log/journal entries during project development Developed descriptive 'case studies' Wrote monthly project reports to monitor progress Prepared annual internal and external project reports Held annual collective debriefing meetings with HCPs

Table 6: Key data collection methods

In 2017, to capture the anticipated outcomes for the growing project and to rationalize the data we should continue to collect, CALC staff developed a program logic model to see if it could streamline our evaluations (Appendix N). We applied the logic modelling retroactively to each phase to see how well it might map onto the approaches we had intuitively taken to collect data. The logic models articulated project inputs, activities, anticipated outputs, and outcomes. The models also captured our underlying assumptions that action research and the SDoH were our theory of change. It became clear that this process could work effectively to capture all our intended outcomes, including value added, and refine research questions and appropriate measurement indicators. This led to better decisions on how and what data to collect sustainably.

Lessons learned from piloting the logic model with another project

Towards the end of the Peterborough and Northumberland's rural JHP project, we developed a program logic model to build the evaluation framework (see Appendix O). We also developed a template for deciding what data to collect (see Appendix P). We debriefed the experience with the project lead and MIEAC who agreed this process can be used successfully to plan and customize evaluations so they are responsive to the stage of a JHP's development, its context, and its intentions. The lesson learned was that logic modelling should be done at the outset, so that the right kinds of data can be efficiently collected from the beginning.

Australia: Approaches and Lessons Learned

Australian contributions to evaluation research in the context of access to justice have been rich and diverse. As a result, we widened the scope of our jurisdictional scan to include thoughtful considerations of evaluation research directions advanced by the Law and Justice Foundation of New South Wales (LJFNSW) in recent years. We also capture the results of the jurisdictional scan of HJP evaluation and research, based on reviewing and highlighting some existing evaluations that had been linked to the HJA website, and key informant interviews with HJA's Suzie Forell and then Australian National University's Dr. Liz Curran. We briefly review HJA's work on promising possibilities for evaluation and impact assessment.

Historical Influence of Law and Justice Foundation of New South Wales

Founded in 1967, the LJFNSW is a world leader in access to justice research. For the past 15+ years, they have been interested in assessing unmet legal needs, the impact of unmet needs, and what works to meet them. Important contributions to the discourse are summarized below.

Digiusto (2012) argued that research on effectiveness requires a causal link between an activity and an outcome, and research designs that can precisely measure and also isolate other variables that can influence outcomes. The concept of evidence-based practice aligns to this view, and very influential in the health sector. This, we have noted, has implications for the potential to scale up the health justice approach. Notably, in considering then recently developed American and British evaluation frameworks for legal service agencies, Digiusto cautioned that

> [t]he research investment involved in rigorously reporting … should not be underestimated. Apart from measurable aims and clear definitions, they require considerable resources, capacity, and the will to implement. Without these, appropriately designed outcomes-focused evaluation will rarely be possible" (p.4).

Digiusto's discussion is useful of when proxy measures are appropriate (a topic we need to explore more deeply), how legal assistance strategies and their potential outcomes are categorized, how to construct Goal Attainment Scaling with clients (a methodology with a 40-year history in health), useful client sample sizes, the need to watch for extraneous factors that contribute to outcomes in rigorous evaluations if looking for causal certainty, and quantitative and qualitative research methodologies. Researchers should consider these issues to ensure higher quality research design. Digiusto reviewed case study research and client satisfaction surveys for their evaluative aspects and limitations. Underlying assumptions of how a program is intended to operate, and its outcomes can be captured diagrammatically in program logic models

The importance of evaluating access to justice initiatives that are targeted, joined up, timely and appropriate for users' needs and capabilities was discussed in Pleasence et al. (2014). They stressed the value of monitoring and evaluation for establishing that services provided are effective, to develop best practices, and inform decisions about how services are provided. They cautioned that evaluating joined-up service approaches will be more difficult to undertake, given the nature of the "wicked" problems they often seek to tackle. Recommended approaches included a *network analysis* approach to evaluating partnerships as advanced by the Victorian Department of Development and Community Planning, or *assessing partnership work* using a

tool developed by the UK government (which appears to entail a more formative evaluation), and a *focus on user-experience*. Evaluations should be customized to the stage of partnership development because developing partnerships is not easy, and collaborations need time to grow. Given that intervening as early as possible is desirable for disadvantaged populations, they advised against relying unduly on *performance measures*, an approach that focuses on numbers, rather than complexity of services. They warned that "additional monitoring and evaluation must be balanced with the reality of an already stretched service environment and cannot be considered without appropriate skills and resourcing" (p.119).

Pleasence et al. (2014) noted that measuring the impact of services is a complex endeavour and yet critical for effective and efficient service delivery. Figure 16 below captures their evaluation model, identifying different purposes for evaluating, and different questions at each stage of development. However, all evaluative work is considered important for service planning and accountability: "Addressing 'what works' requires a multi-faceted, coordinated, and systematic approach to service monitoring and evaluation" (p. 175). Research strategies should draw upon the "rich and nuanced understanding of practitioners [or it] cannot accurately reflect the reality of service provision" (p. 176). They recommended reviewing research and evaluation efforts of other disciplines who provide service interventions to people with complex needs. They also noted the challenges of collecting and managing data, the need to develop research alliances to pool resources and learn from each other, and to consider retaining specialist evaluators to design complex studies.

Figure 16: Evaluation in a policy and operational context
Pleasence et al., 2014, p. 175

Forell and McDonald (2017) critiqued the quality of research the justice sector has historically produced. They also cautioned that funders' expectations for program evaluation rarely equates with the resources required to undertake it. "While there is widespread interest in 'what works' research and evaluation, understanding of what this requires in practice within the legal assistance context remains underappreciated and under-realised" (p. 1). They explained

why systematic reviews of research studies are so important in the health sector: this research methodology helps clarify what is known and what works. They identified serious challenges for evaluating legal assistance services given the lack of a centralized repository to easily locate studies, few exemplary ones, lack of comparators, limited justice sector expertise in empirical evaluation, and the dangers of relying on outdated administrative data management software to collect information.

Forell and McDonald (2017) explored the challenging and vexing task of identifying desired outcomes, whether they be for the client, the program, or organizational including adhering to 'access to justice principles' and the sustainability of the initiative, or broader system outcomes. They outlined a framework for evaluating "what works" and delineated factors to consider if the justice sector wants to learn from innovation by using a more structured, coordinated, and systematic approach. Cultivating the capacity for "evaluative thinking" at an individual and organizational level (see Figure 17 below) is crucial to engaging in a strategic learning. This suggests that a cultural shift will be required in the justice sector: to systematically engage in evaluative thinking, new professional competencies will be needed. Again, different stages of program development give rise to their own evaluative questions, requiring different data to be collected. A comprehensive evaluation at each stage is unrealistic. Embedded in the evaluative thinking cycle, is program logic modelling to articulate anticipated outcomes and the assumptions on which that logic depends. Evaluative thinking produces incremental, reflective learning and new knowledge of what works at each stage.

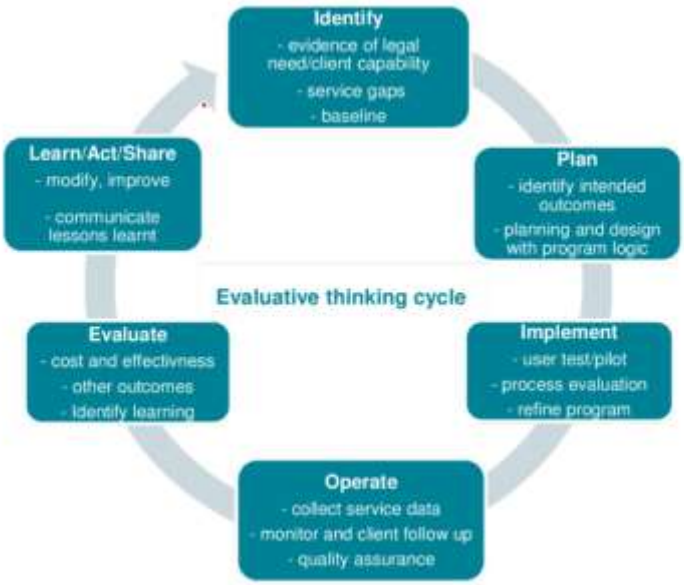

Figure 17: Evaluative thinking cycle
Forell & McDonald, 2017, p. 13

Also of interest, the LJFNSW developed indicators of the value of information and referral services (see Appendix Q) for an evaluation of Victoria Legal Aid's telephone advice services. The indicators also speak to issues of program quality and reach that could be useful for evaluating HJPs (Mirrlees-Black, 2020). The report's appendices include useful data collection instruments. Of note, although not specifically referring to this evaluation study, McDonald (2021) cautioned that the cost of collecting data routinely for telephone services could *double* the

cost per user, impacting on the sustainability of the service. Butler's (2022) rapid scoping review explored outcomes frameworks for legal assistance services. Although Butler noted that justice sector evaluation work continues to be its infancy, the review collects useful frameworks from Australian CLCs, UK Citizens Advice Bureaus, and the US Legal Aid Services Corporation. The LJFNSW recently launched a virtual Access to Justice Research Hub that will be providing more resources about access to justice evaluations over time.

Evolving approaches to HJP evaluation research

HJPs are being evaluated in different ways – funded by the Law Foundation of Victoria, Victoria Legal Aid, and the Australian government, amongst others, and some by pro bono researchers. Here we provide examples of interesting evaluation approaches taken by researchers and consultants, working from a list of evaluative reports that had been posted on the HJA website, and peer-reviewed literature. We also review HJA's approach and their efforts to create an overarching HJP theory of change. HJA also builds HJP evaluation capacity through a tool kit, and convening discussions and workshops.

Australian approaches to evaluation are diverse, and methods and findings are not consistently reported. Studies used a variety of research methodologies and data collection strategies. These ranged from collecting service data to show partnerships reached their intended audiences and that responsive legal services were provided – to more robust and sophisticated program level evaluations of multiple domestic violence intervention projects funded by the Australian Attorney General's Department (Social Compass, 2019). The Social Compass study provided two useful program logic model examples (Appendix R) and a table to guide evaluation planning containing criteria, possible evaluation questions, measurement indicators and data collection strategies (Appendix S), and their data collection tools.

Most evaluations used mixed methods to collect data. Program outputs and who is using the program are fairly consistently recorded. This may be because the initiatives are often funded as pilot or time-limited projects intending to reach particular high needs populations. Additional data is collected through surveys, interviews, focus groups, documentary reviews, and observation. Most studies obtained REB clearance.

Dr. Liz Curran was an early contributor to HJP evaluations, undertaking several as a pro bono consultant. In 2015, Bendigo's HJP sought to measure the extent to which program activities and outcomes demonstrated four proxy indicators for improving a client's SDoH and HCPs' professional capacity and practice (Curran, 2016). These proxies included *engagement* (clients/patients, staff, and organization), *capacity* (client, professional, staff and organization), *collaboration* (between clients, staff, and organizations; and *empowerment, advocacy, and voice* (clients/patients/professionals and staff and improved advocacy towards systemic change). Curran is particularly interested in studying the impact of secondary consultations (2017). In her view, effective human services evaluations should be relevant, realistic, useful, and capable of informing and improving practice. They must be sustainable, enable comparisons and contrasts, measure what is measurable, and what is in the service's ability to control, low burden and inexpensive – given the lack of evaluation funding available. The evaluation process can help

develop new approaches to legal practice. It is critical that new approaches not just be tried but that partners reflect critically about what is effective.

Curran has described her multi-method triangulated approach as including participatory evaluation, action research and continuous *reflective practice* (Curran, 2015, 2022, 2023, Curran & Taylor-Barnett, 2019). Curran recommended embedding evaluation at every stage of the partnerships, and ensuring it is inclusive of clients, community, staff, and key stakeholders (Curran, 2021). Tools to collect data have included feedback questionnaires (explicitly *not* client satisfaction surveys), surveys, a Collaborative Measurement Tool (modelled on the VicHealth Partnership tool), semi-structured interviews, guided professional journals, file reviews, debriefs, and focus groups. More recently, Reflective Practice Conversations, and Yarning Circles (with Aboriginal people) have been used to collect data (Curran, 2023). This study identified an additional key benchmark of *reach*, in addition to the prior four benchmarks, and suggested related indicators (pp. 31-32).This recent evaluative report documented work-in-progress recommendations for legal service interventions with the Aboriginal community.

Kalapac (2016) evaluated the quality of a domestic violence intervention designed to increase legal access and redress inequity for culturally and linguistically diverse (CALD) groups. Guided by the principles of collaboration, capacity building, engagement, equity, empowerment, and advocacy, a realist evaluation framework was chosen. This approach examines the nature of successful interventions and asks "under what contexts and for which groups [do] interventions work, and how?" (p. 35). This approach made sense because in the early stages of developing the partnership it is important to create new knowledge about how to work effectively together on the complex issue of family violence, and there was very limited literature to draw upon and few partnership examples to emulate. Kalapac described the distinct phases as forming the partnership, establishing the service, building capacity of the health sector to participate in legal services, providing a client-centred approach, and ultimate project outcomes. They used the VicHealth Partnership Checklist to assess the health of the partnership across seven aspects (see Appendix T).

The evaluation of the HJPs started by Inner Melbourne Community Legal (2018) considered four questions: What are patients' experiences of the onsite hospital clinic? To what extent have HJPs had an impact on the health and well-being of patients? To what extent have HJPs had an impact on the role of health professionals? To what extent has there been any policy, program or practice change as a result of the HJPs? A program logic model was developed (see Appendix U). Data was collected to measure stress levels using a standardized research instrument. Usefully, the report's appendices contain examples of other data collection tools. They recommended how the program might be enhanced. Future research should examine whether the service reduced the length of stay and readmissions, and the long-term cost effectiveness of co-location. An evaluation of an early stage of the initiative – the HCP training and referral pathways work (Forsdike et al., 2018), also usefully coupled its logic model with the associated evaluation strategies (see Appendix V).

Allison (2019) evaluated an Aboriginal HJP over an 18-month period using mixed methods to examine the impact on clients and stakeholders, whether resources were used effectively, and whether best practice principles for working with Aboriginal and Strait Islanders

(ASTI) were applied. Data collection methods included client files reviews, focus groups, observation, and attempting to collect information from an LSP's data base (it proved to be inadequate to the task). The report's appendices provide useful examples of interview and survey questions as well as other data collection instruments.

Ries (2021) provided another perspective for approaching evaluations. Described as the *science of interprofessional collaboration* in the healthcare sector, research on interprofessional collaboration is moving us to a "new era of health and social care" (Xyrichis, 2020, p. 3). Ries observed that this research is hindered by "imprecise terminology" and poorly conceptualized interprofessional arrangements (p. 1). To design, implement, evaluate HJPs, a "stepwise framework" (see Appendix W) was proposed. To improve professional practices and patient and system outcomes researchers studying interprofessional care and HJPs should connect.

Example of a useful Australian Government resource

The Productivity Commission Background Paper on the Indigenous Evaluation Strategy (2020a) provides useful resources for designing evaluations in any context (see Appendices X1 and X2). These include questions to consider when designing evaluations, and for deciding on the type of evaluation – which could include formative (process), summative (outcome, or impact), or economic evaluations. Their Guide is useful (Productivity Commission, 2020b). Figure 18 below replicates a figure from it, emphasizing the importance of embedding evaluation in all stages of program development, a recommendation that aligns with Curran (2021), Forell & McDonald (2017), and Pleasence et al. (2014).

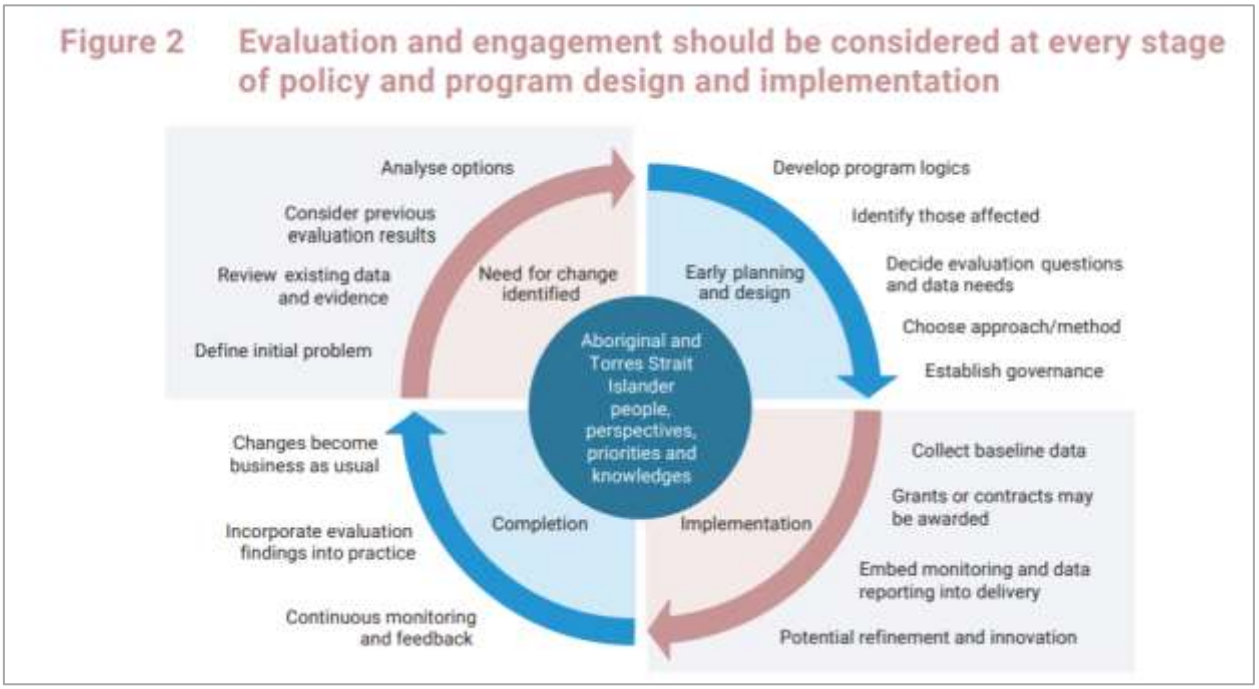

Figure 18: Embedding evaluation and engagement throughout program development
Australian Gov't Productivity Commission (2020b) *A guide to evaluation under the Indigenous evaluation strategy*, p.5, Figure 2

Health Justice Australia's approach

HJA provides pragmatic advice and support in designing evaluation processes as an essential building block for developing HJPs (Turner, 2021). Evaluations should inform decisions about whether to continue, expand, scale back, or try something new and to learn about or improve: to understand how the HJP works, the barriers and constraints to change, and the value of its work. Evaluations can create knowledge to share and build the evidence base, satisfy funders or help obtain future funding. HJA worked with the Centre for Social Impact (University of NSW) to improve the scope and quality of evaluations. They graphically represented the program logic and theory of change underlying the health justice approach (see Appendix Y). Table 7 summarizes measurement indicators related to each stakeholder or desired outcomes.

Focus of concern	Measurement indicators
Clients	**Short term** More appropriate and effective referrals More timely access to assistance (for clients with complex needs) Assistance that better reflects needs and circumstances **Medium term** More effective service responses to intersecting/complex issues Increased capability/empowerment to address health and legal issues **Long term** Health-harming legal needs are addressed
Improved well-being for clients	Community connectedness Health Achieving in life Safety Future security Standards of living Relationships
Communities	**Short term** Greater access to health and legal services that are accessible, safe, appropriate **Medium term** Increased confidence and empowerment to use legal and health systems **Long term** Increased use of health and legal services Fewer preventable legal and health issues Community well-being Change to the conditions that drive well-being
Health Justice partners	**Short term** Exposure to and learning from other professionals Improved capability to recognize and address health-harming legal needs Increased capacity and scope for collaboration **Long term** Improved job satisfaction and reduced burn out
Government/funders	**Short term** Improved advocacy for people with complex needs Increased capacity to respond appropriately to need **Medium term** Recognition of innovative response Evidence of what works More effective services are sustained through appropriate funding & resourcing **Long term** Cost-savings for the health/justice systems Effective response to wicked problems Better well-being for those with complex needs
Health justice practitioners	**Short term** Increased access to clients with complex needs Stronger referral pathways More effective service provision for clients with complex needs

Focus of concern	Measurement indicators
	Medium term Increased trust between practitioners Shared multi-disciplinary knowledge Increased capacity to address complex need **Long term** Improve multi-disciplinary knowledge of systemic issues More effective advocacy for change Reduced presentation of "crisis" problems

Table 7: Outcomes & Indicators from HJA Theory of Change

In more recent work, HJA has been supporting HJPs to evaluate partnerships in partnership.

In a workshop about evaluation at HJA's 2017 conference, Forell and Mirrlees-Black reviewed the challenges of defining/agreeing on success or failure. They noted that legal assistance is only one step in the process of resolving justice issues, discussed the optimism bias (assumption that a program works), and how to engage with and learn from failure. An HJA 2019 conference workshop considered how important Aboriginal perspectives on evaluation are: desired outcomes must be culturally informed. Williams (2018) described the "Ngaa-bi-nya," a program evaluation framework developed for ASTI. It includes evaluating across four domains– factors related to the *landscape*, *resources*, *ways of working*, and *learnings*. The Indigenous Evaluation Strategy Background Report also set out what to consider in evaluating Indigenous programs: context is critical, customization is necessary. ASTI perspectives, priorities and knowledge should be centred (Australian Government Productivity Commission, 2020a).

Key informant Suzie Forell stressed that building the value proposition for HJPs requires linking access to justice evidence with public health research findings to understand how legal help may connect to health outcomes. For example, linking how legal help maintains or retains housing, to research findings about how the quality and security of housing affects health (Forell, 2019). Reports should include adequate details about the 'active ingredients' of an intervention so these can be understood and compared. Furthermore, new directions for evaluation and impact measurement could include:

- Measuring the impact from the partnership work – how does each partner contribute to the other's goals? What is different about that they can achieve together rather than separately (with siloed delivery systems)? What is the impact on client well-being, service efficiency, client and service provide capability?
- Creating a new metric to assess improvements in client/patient well-being including validating a new measurement tool for this indicator
- Considering the impact of working in partnership on service provider well-being (including burnout)
- Understanding and measuring the impact of legal secondary consultations

Suzie Forell also noted that identifying what success means and who gets to name it is really important. Furthermore, HJPs are not just a legal assistance strategy but also a health and a social strategy to address complex need, or special needs such as domestic violence, as an example.

(Forell, 2019; personal communication, 02 December 2019, 19 October 2020, 20 April 2021, 25 June 2021, 24 August 2022, 05 March, 2024).

HJA is also working with public health researchers to explore legal services as a component of health care. Suzie Forell was an Associate Investigator on a major research project led by Murdoch Children's Research Institute to investigate integrated child and family service hubs as a response to the known impact of childhood adversity on children's lifelong mental health. Legal assistance was included in the two hubs. HJA is also convening a multi-site evaluation involving up to10 mental-health related HJPs served by seven legal services. Their approach in discussing the evaluations is to answer the question of "what's in it for health?" In other research HJA has: explored how HJPs engage with the financial counselling sector and contribute to financial well-being (Pitt, 2023); undertaken a qualitative study of a 30-year old partnership to explore what has contributed to its sustainability and to understand what 'good' looks like to client, health partners, and legal partners (Scott & Forell, 2024).

United Kingdom: Approaches and Lessons Learned

In this section we capture the approaches and lessons learned in the UK (principally England & Wales) considering the findings of the mapping study (Beardon & Genn, 2018) and other research, Parkinson and Buttrick's work, and the results of key informant Sarah Beardon's doctoral research (2022a). Developments with the Ministry of Justice commissioning a research and evaluation approach to evaluating HJPs are progressing and are reviewed briefly.

Mapping study: Current evaluation practices in the health justice landscape

The Health Justice Landscape in England and Wales report found that 60% of those responding to the survey undertook some form of evaluation or research, with 84% of those using data from service delivery such as statistics from doctors' records, client gains or the number of referrals (Beardon & Genn, 2018). Some used client surveys to track outcomes (including validated research instruments) or descriptive feedback including comments and interviews. The organizations measured a variety of outcomes including service processes (67%), health (63%) or legal outcomes (36%) or other (29%). Interviews with service providers clarified that more robust research was needed to demonstrate the impact of the service.

Evolving approaches to HJP research

Of the 60 UK studies that were included in Beardon et al.'s (2021) systematic scoping review, 11 were rated as "high" using a quality appraisal tool (Appendix C). These were examined more closely to ascertain their common features and what insights they might reveal for credible research and evaluation strategies. All were peer reviewed, and four were connected being preliminary, parallel, or pilot studies for an RCT involving older adults, where qualitative research was also been carried out (Mackintosh et al, 2006; Moffatt & Scrambler, 2008; Moffatt et al., 2004, 2006). Two of the articles captured quantitative and qualitative research on the same group of cancer patients (Moffatt et al., 2010, 2012). Two other articles were quantitative and qualitative studies within the same research study (Woodhead, Collins, et al., 2017; Woodhead, Khondoker et al., 2017). The remaining three studies featured different lead authors. The studies

ranged from 2003 to 2017, with the first was reported in 2003 and the last three in 2017. Two were experimental, one was quasi-experimental, and the rest were observational.

All the studies have interesting features to explore further. As an example, how can realist evaluations contribute to understanding how change is created by the health justice approach? This methodology was used in several earlier UK studies (Woodhead, Collins, et al., 2017). Also useful, as another example, were the techniques used to explain the nature of the intervention and the change that is sought and depict it visually. Figure 19 below from Moffatt et al. (2012) is an example of the perceived impact of welfare rights advice derived from a qualitative study, in a similar format to the logic models used in other studies.

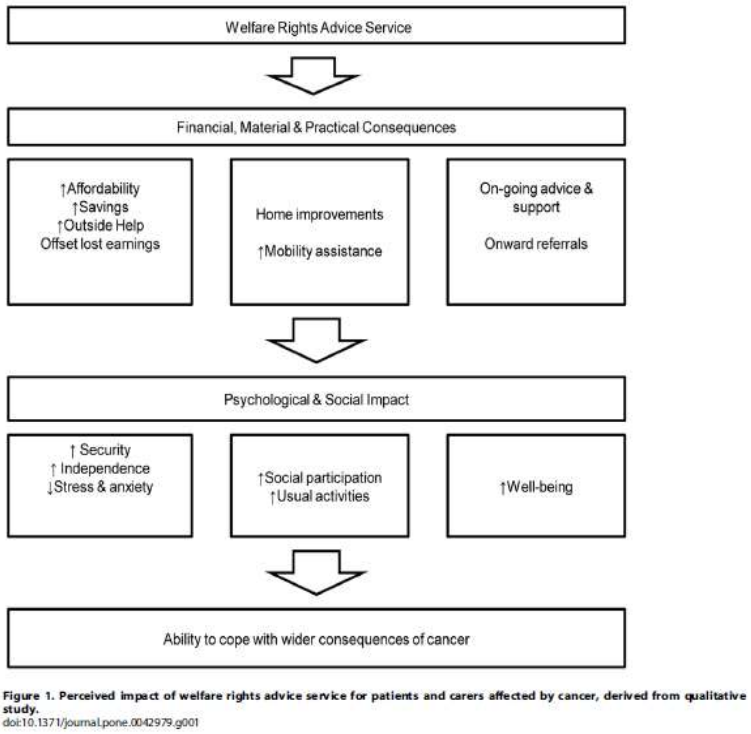

Figure 19: Perceived impact of welfare rights advice
From Moffatt et al. (2012)

Similarly, the intervention diagram and the conceptual map of intervention and potential outcomes by Gabbay et al. (2017) is a useful precedent. If it is envisioned that research studies of the calibre that Beardon et al. (2021) rated highly might take place in Ontario, a much closer study of the research questions, methodology, and data collection practices, the feasibility of the studies, and their findings will be important.

Parkinson and Buttrick (2015)

Following their review of evidence for the Low Commission and Advice Services Alliance, Parkinson and Buttrick (2015) recommended enhancing future research including:

- Undertake more empirical research with robust appropriate and credible approaches to measuring outcomes and impact of advice services.
- Design and deliver robust evaluative studies HCPs will need to provide considerable support including access to personal health records.
- Conduct studies that track clients' longer-term to monitor health impacts.
- Use standardized health measurement tools (although some reservations were expressed on whether they can capture subtle changes).
- Use qualitative research approaches that allow for a more nuanced examination of benefits that cannot be measured in quantitative studies like RCTs.
- Self-reported well-being and health are also important outcome measures. Evaluators and researchers need to develop a greater understanding of existing outcome frameworks used by the NHS and Public Health England that purport to measure these outcomes.
- Conduct cost-benefit analysis and effectiveness studies.
- Measure the impact on specific groups like migrants and asylum seekers.
- Explore the actual and perceived barriers to stronger partnerships between primary care professionals and advice services.

Genn (2019)

In her seminal article, Genn (2019) advocated for strengthening the evidence base. Legal service providers have much to learn from health researchers about measuring the impact and quality of services, choice of research methodology, design, and how to use and interpret data predictively.

> Robust outcomes-based research could support the development of HJPs and improve understanding of how accessing social welfare and familial rights and entitlements can mitigate health inequality. The extent health justice studies often have small sample sizes, inconsistent measurement tools and outcomes, insufficient follow up, and lack of a control or comparison to assess the counterfactual. There is also rather weak attention to how integrated services produce change, which groups are likely to benefit, which models are most cost-effective and the factors influencing implementation and outcomes (p. 35).

As part of this commitment to strengthening the evidence base, Genn and Beardon (2021) reported on an evaluation of UCL's first health justice clinic with the Liberty Bridge GP surgery. Subsequently, Genn was part of a research team conducting a rapid review of the health economics of HJPs (Granger et al., 2022). Identifying an evidence gap on the cost-effectiveness of these services, the team proposed an interdisciplinary research agenda for US and UK health economics and legal health-services researchers.

Beardon's doctoral research (2022)

Summarized in Chapter One, Beardon et al.'s (2021) systematic review provided much insight into the benefits of the health justice approach. Beardon (2022a, p. 59) noted that evaluation contributed to sustainability by demonstrating the project's value to funders and HCPs, ensuring quality standards were being met during implementation, and identifying how

the services could be improved to ensure the partnership was working effectively. However, providers found evaluation was challenging, given the commitment to research that is required. Beardon also studied the factors that might lead to these interdisciplinary partnerships being successfully implemented. Beardon (2022a) tested whether a theory derived from the emerging field of implementation science (General Implementation Theory) could help support their development, by undertaking a multiple case study of nine HJPs. Based on her doctoral research, Beardon (2022b) summarized her findings about how to implement HJPs effectively and made recommendations about service design, collaborative working, sustainability, and for national action initiatives to support the development of HJPs.

Ministry of Justice developments

The Ministry of Justice's recent work to implement the Legal Support Action Plan and test and evaluate the provision of holistic legal support hubs has led to their posing evaluation research questions. In preparation, following extensive research and consultation, the Ministry articulated an HJP Theory of Change/program logic model (IFF Research and York Health Economics Consortium, 2023a, pp. 73–84), and then posed five research questions:

To what extent does integrating advice in a healthcare setting result in:

1. legal problems being resolved earlier?
2. improved socio-economic outcomes to individuals?
3. improved health outcomes?
4. What models and types of advice are most effective in securing outcomes?
5. What are the challenges to setting up and delivering integrated services in healthcare settings? (p. 18)

The Ministry retained IFF Research and York Health Economics Consortium who have recommended an evaluation framework with three types of evaluation: impact, process, and economic. Details on how they intend to carry out each evaluation approach are found in their feasibility study (IFF Research and York Health Economics Consortium, 2023a). Although the research questions posed by the Ministry at first glance suggest a narrow focus on the type of outcomes will be evaluated, the feasibility study indicates a broad range will be assessed, informed by the Ministry's sophisticated Theory of Change. Because it is a complicated research project, it is impossible to summarize simply at this early stage. The feasibility study's complex evaluation framework should be reviewed very closely (pp. 56–65). Developments and lessons learned will need to be monitored. Up to 11 HJPs will participate in the research.

Other developments

Although we could not explore all the developments in legal empirical research on access to justice within the scope of this project, we wanted to recognize two issues of interest for future consideration identified by then UK researchers as these may impact on approaches that should be taken. This includes cautions for conducting RCTs in socio-legal settings (Pleasence, 2008). An RCT looking at impacts of the offer of debt advice in England and Wales, suffered from 'real world' challenges in longitudinal studies which included significant attrition of research

participants, preventing critical impact data from being collected: it highlighted the difficulties of using experimental methods for sensitive problems experienced by disadvantaged communities in a social setting (Pleasence & Balmer, 2007). A second issue is how to create standardized measures in empirical legal studies. Pleasence and Balmer (2019) explore what this will require from researchers in the context of developing a "general legal confidence scale" for *legal capability*. Legal capability is an important variable, and possible a confounding variable, given its importance to understanding problem-solving behaviour when legal issues are at play, and thereby relevant to the health justice approach. (Some of this work is now being carried out as part of the PULS study in Australia (Balmer et al., 2023, 2024.)

United States: Approaches and Lessons Learned

Medical-legal partnerships (MLPs) have been evaluated in many different ways: we explored this more deeply in the US jurisdictional scan (Raymer, 2021, see Appendix J). Raymer analyzed 46 studies, and outlined the type of partnership and intervention, the research questions, the research methodology and data collection methods, and key results. The peer-reviewed articles involved authors with backgrounds in medicine, law, public health, business, and social work, and were published primarily in health-focused academic journals. We present here the high-level results of the scan, and discuss examples of studies since 2021.

Peer-reviewed studies of partnerships were mostly quantitative (Losonczy et al., 2017), but also included qualitative (Mantel & Fowler, 2020) and mixed-methods (Tsai et al., 2017) research methodologies. Research questions varied in theme and included questions about health outcomes; a partnership's processes; the perceptions, or attitudes of people providing or receiving MLP services; financial outcomes; and access to justice outcomes. Nerlinger et al. (2021) provides a useful explanation of the AAMC initiative to develop a process for evaluating the efficacy of MLPs, and barriers to standardization. To support synthesis, Table 8 below compares the categories of outcomes we identified to those articulated by NCMLP's previous literature reviews, the AAMC, and domains of research from Lawrence et al. (2011). There were outcomes focused on patient health across all five sources. Improved medical institutions and financial outcomes were also common. Interestingly, only three specified outcomes connected to legal services or access to justice: the two most recent (Murphy, 2020; Raymer, 2021), and the oldest (Lawrence et al., 2011).

Four Research Domains (Lawrence et al., 2011)	NCMLP Literature Review Themes (Beeson et al., 2013)	AAMC Program Logic Model Outcomes (AAMC, 2019a)	NCMLP Literature Review Outcomes (Murphy, 2020)	US Jurisdictional Scan Identified Outcome Types (Raymer, 2021)
Improved health and well-being (direct and indirect patient benefits)	Impact on patient health and well-being	Patient and community health outcomes	Changes in the health and wellbeing of patients	Health outcomes
Improved medical homes and institutions (more efficient, cost-benefit analysis)	Financial impact	Patient and community health outcomes Health system savings	Improvements to healthcare systems and workforce	General process outcomes Healthcare provider financial outcomes

Four Research Domains (Lawrence et al., 2011)	NCMLP Literature Review Themes (Beeson et al., 2013)	AAMC Program Logic Model Outcomes (AAMC, 2019a)	NCMLP Literature Review Outcomes (Murphy, 2020)	US Jurisdictional Scan Identified Outcome Types (Raymer, 2021)
Improved clinical workforce skills (change in physicians serving, change in value of screening)	Impact on knowledge and training of health providers	Learner outcomes	Improvements to healthcare systems and workforce	Healthcare provider perceptions and attitudes
Improved provision of legal services (more cost efficient, reduce severe legal problems)			Systemic improvements in policies, laws, and regulations Improved patient housing and utility stability Improved patient access to financial resources	Access to justice outcomes Patient financial outcomes

Table 8: US jurisdictional scan – High-level outcome categories from US studies and reports

Study data was collected through case file reviews, access to already established service provider databases, surveys, and interviews. Several studies used validated research instruments, such as the Perceived Stress Scale (Rosen Valverde et al., 2019). Validated research instruments were endorsed in the grey literature, including Tobin-Tyler et al. (2011). Table 9 captures content from Lawrence et al. (2011) about validated research instruments and their appropriate uses.

Instrument	Outcome Measured	Authors
Perceived Stress Scale (PSS)	Stress	Sheldon Cohen, Tom Karmarck, Robin Mermelstein, "A Global Measure of Perceived Stress," *Journal of Health and Social Behavior*, 24, no. 4 (1983): 385-96.
Mastery Scale	Self-efficacy	Leonard I. Pearlin, Carmi Schooler, "The Structure of Coping," *Journal of Health and Social Behaviour,* 19, no. 1 (1978): 2-21.
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Physician communication with patient and guardian	Centers for Medicare & Medicaid Services (2020, July 16). *Consumer assessment of healthcare providers & systems (CAHPS).* https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS
Measure Yourself Concerns and Wellbeing (MYCaW)	Concerns in life	Charlotte Paterson, Kate Thomas, Andrew Manasse, et al., "Measure Yourself Concerns and Wellbeing (MYCaW): An Individualized Questionnaire for Evaluating Outcome in Cancer Support Care that Includes Complementary Therapies," *Complementary Therapies in Medicine,* 15, no. 1 (2007): 38-45. Elizabeth F. Juniper, "Can Quality of Life Be Quantified?" *Clinical & Experimental Allergy Reviews* 2, no. 2, (2002): 57-60.
Family Empowerment Scale (FES)	Family empowerment for families with children with disabilities	Paul E. Koren, Neal DeChillo, Barbara J. Friesen, "Measuring Empowerment in Families Whose Children Have Emotional Disabilities: A Brief Questionnaire," *Rehabilitative Psychology,* 37, no. 4 (1992): 305-21.
SF-12	Quality of Life	John E. Ware Jr., Mark Kosinski, Susan D. Keller, "A 12-item Short Form Health Survey: Construction of Scales and Preliminary Tests of Validity and Reliability," *Medical Care,* 34, no. 3 (1996): 220-33.

Table 9: Examples of validated research instruments used in evaluation of MLPs
Modified from Table 18.3, Lawrence et al., 2011, p. 663

US stakeholders recommended further exploring the SDoH, and how legal contributions can impact health to a greater degree. Mantel and Fowler (2020) also recommended partnerships increase tracking of legal and health outcomes, suggesting partnerships should produce regular reports to support their value. Many authors encouraged more rigorous, empirical research studies to be conducted (Benfer et al., 2018; Mantel & Fowler, 2020; Martinez et al., 2017; Muñoz-Laboy et al., 2019; Teitelbaum & Lawton, 2017;). Benfer et al. called for strengthening understanding of how legal help impacts patient health, and the full value of legal services provided by legal partners. Benfer et al. reiterated the need for RCT to evaluate MLPs, but recognized ethical difficulties in withholding legal information or referrals from a control group. Views on how research should be conducted or which populations to focus on differed. The NCMLP is currently focused on promoting health-centered partnerships, and partnerships with Veteran Affairs organizations (Marple et al., 2020; Trott et al., 2021; Trott, Theiss, et al., 2019).

Lawrence et al. (2011) usefully proposed possible measurement indicators as set out in Table 10, with the metrics categorized into three broad areas – program performance, social and economic impact, and organizational health.

PROGRAM PERFORMANCE	
Advocacy capacity-building in healthcare partners	• Number of healthcare workers trained • Self-reported changes in knowledge, attitudes, and behaviours (currently documented via IRB-approved needs assessment studies) • Number of patients screened for unmet legal needs by providers; percentage of healthcare affiliates total patient population screened; percentage of healthcare affiliate provider panel engaged in screening • Number of provider-focused advocacy tools designed and deployed • Rate of provider utilization of MLP-designed advocacy tools (such as utility shut-off protection form letters, housing conditions advocacy letter templates), especially those integrated into the electronic medical record • Number of distinct providers making use of advocacy tools, including triage calls • Number of instances where MLP-supported (either through an advocacy tool or triage call) provider advocacy was successful on behalf of a patient (will require new record-keeping on the clinical side)
Legal assistance outputs (aggregated by subject matter)	• Percentage of legal matters favorably resolved • Percentage of legal matters with a neutral output • Percentage of legal matters unfavourably resolved
Legal assistance outcomes (examples)	• Monetary value of SNAP benefits secured for patient-clients • Number of housing units whose unhealthy conditions were eliminated, etc.
SOCIAL & ECONOMIC IMPACT	
Improved health outcomes	• Number of health problems eliminated (or severity thereof reduced) • Improved patient problem-solving, self-efficacy, self-mastery • Reduction in patient stress and/or anxiety • Number of health-promoting laws, policies, regulations, or practices successfully implements with MLP support; number of low-income people affected • Number of health-harming laws, policies, regulations, or practices successfully averted with MLP support; number of low-income people affected
Improved efficiency of healthcare delivery	• Reduced patient no-show rates • Improved treatment adherence among patients

Institutional return on investment	• Reduced in rate of individual hospital readmission • Timely discharge of inpatients (reduction in number of "stuck" patients) • Revenue generation (increased patient volume) due to increased efficiency of patient medical appointments • Improved reimbursement of healthcare services
ORGANIZATIONAL HEALTH	
Program capacity built	• Number of healthcare affiliates served • Number of new staff hires made • Number of new healthcare affiliates • Number of pro bono partnerships leveraged • Number of law school partnerships leveraged • Number of legal services organization partnerships leveraged • Number of student volunteers leveraged
Improved efficiency of healthcare delivery	• Number of healthcare affiliates making direct investment in services • Budget v. actuals

Table 10: Examples of MLPs target metrics from Poverty, Health and Law
Lawrence et al., 2011, p. 651, Table 18.2

The NCMLP publishes and collects tools for MLP evaluation. Their website includes a resources section with reports and case studies they authored, select peer-reviewed research on MLPs, tools to support partnership evaluations. They have published multiple toolkits for creating and supporting partnerships, some of which include suggested measurement indicators and evaluation criteria for monitoring MLP success (Marple et al., 2020; NCMLP, 2015; Trott, Theiss et al., 2019). A handbook outlines seven suggested performance measures that partnerships could use to evaluate their programs (Regenstein & Trott, 2016). Appendix J outlines these recommendation for performance measures and gathering data. The NCMLP also recommended a program logic model developed by the AAMC (2019) as a tool to help MLPs evaluate their partnerships with expected outcome categories seen above in Table 8. Currently, the NCMLP is encouraging evaluations to focus on health outcomes (Ellen Lawton, personal communication, August 5, 2020) and implied in their newest MLP toolkit (Marple et al., 2020).

Our jurisdictional scan revealed diversity in how MLPs are being evaluated. There is currently an emphasis on focusing on health outcomes in evaluating partnerships but recognition that there is not a single evaluation or research model that would apply to all. Since the scan, the US research continues to proliferate. Two examples include an RCT study comparing immediate referral to a wait-list control for referrals to an MLP with mixed results (Liaw et al., 2023), and a retrospective cohort study showing a 37.9% lower than median predicated hospitalization rate for children after a legal intervention was provided (Beck et al., 2022). Given the increasing number of studies, it is important to keep abreast of published literature for the lessons learned.

Convening an International Consortium on the Health Justice Approach

In May 2021, HJA convened a first meeting of advocates for the health justice approach from Australia, Canada, UK, and US. This followed on an international virtual panel at the OECD conference on people-centred justice in March 2021 that explored what law can learn from health (with representatives from the NCMLP, OECD and the World Health Organization). We discussed the possibilities for collaboration: a meeting in June 2021 focussed on evaluation

and research issues. Tobin-Tyler et al. (2023) subsequently produced an excellent article on developments in Australia, the US and UK. International collaboration to promote the health justice approach through sharing lessons learning, research agendas, and interprofessional training as examples, were thought to hold much promise. It will be very useful to monitor ongoing developments of this consortium.

Recommendations for Future Research Extracted from Systematic and Scoping Reviews

To develop evaluation research approaches, it was prudent to review and extract recommendations from the scoping and systematic reviews.

Jomaa et al. (2023)

Given existing research gaps, Jomaa et al. (2023) recommended the following:

- Studies should provide more detail about the nature of partnerships, how personnel are employed and how they operate to increase our understanding of what factors contribute to partnership success, and to allow for comparisons.
- Although abundant literature demonstrates the SDoH are associated with poor health outcomes, it will be beneficial to rigorously evaluate upstream cost-effective interventions.
- It would be useful to have larger scale studies to support wider population health effects.
- Longitudinal evaluations of the benefits provided by these partnerships, particularly if they expand to larger communities and populations, would be useful.
- It would be worth studying HJPs supporting patients who visit emergency departments rather than primary care, given the frequency at which high needs patients visit them.
- How can the data partnerships collect lead to identifying systemic issues and lead to public policy changes. Policy level surveillance and intervention would be a worthwhile addition.

Adams et al. (2006)

Adams et al. (2006) noted that although these initiatives are often required to evaluate their service as a condition of funding, both the resources and the skills to conduct evaluations are scarce. They noted favourably the use of various validated research instruments to measure outcomes in higher quality studies that included those set out in Figure 20:

- Short Form 36 (SF36, a general health scale)
- Hospital Anxiety and Depression Scale (HADS – questionnaire measuring anxiety or depression)
- Measure Yourself Medical Outcome Profile (MYMOP – patient generated well-being scale)
- Nottingham Health Profile (NHP – quality of life scale)
- Edinburgh Post-natal Depression Scale (p. 5).

Figure 20: Various validated research instruments to measure outcomes

They noted that additional research was not needed on financial impacts as this has already been well-established. Although several studies had used questionnaires where patients reported high levels of positive impact, they were not validated psychometrically. Further studies should:

- Identify who benefits the most to target interventions.
- Look at whether rights advice in social welfare settings does or does not have health and social effects. These studies should carefully consider what outcomes to measure. For example, SF36 may not pick up subtle changes in the psychological/social aspects of health.
- Improve their equality – they must be properly resourced by funders and undertaken by people with appropriate skills.
- Consider randomized and controlled research approaches, but longitudinal research could take years to show impacts.

Allmark et al. (2013)

To design evaluation frameworks, Allmark et al. (2013) observed these challenges should be considered when linking interventions to health benefits:

- Physical health benefits may take time to emerge and risk being unreported.
- Existing validated research tools may not be sufficiently sensitive to detect changes or may not measure the outcomes that are important.
- Demonstrating a positive impact on health may not be possible if the population served would be on a trajectory of health decline regardless of intervention.
- RCT and similar designs that anticipate simple inputs and outputs, and controlled variables (human bodies/drugs) may not be suitable for systems (society/laws) that are not "closed."
- Using a more systems-focused analysis, logic models can link conceptually the causal pathways that could lead to improved outcomes.
- An evidence-based logic model provides a helpful evaluation framework for both practitioners (for program design) and researchers (to test causal linkages).

Martinez et al (2017)

Martinez et al. (2017) noted we need more empirical evaluations that are rigorous and replicable to study the health impacts rather than the more frequently studied impact of unmet legal needs. However, they assessed that RCTs cause ethical issues.

> This design is particularly relevant where it is predicted that the intervention will do more good than harm and/or that the non-intervention would amount to doing harm, as in the case of MLPs; under such circumstances, it is considered unethical to utilize a parallel design in which only some participants receive an intervention (p. 270).

They recommended:

- more studies on the benefits of targeting programs to specific populations,
- a more theory-based approach to evaluations including applying the theory of "triadic influences" as well as the "theory of planned behaviour" to help design these partnerships

using participatory-based research approaches as part of the evaluation framework, and also encouraged the use of "causal diagrams" to understand and influence program design (but did not cite Allmark et al.'s (2013) article featuring this);
- large-scale prospective longitudinal studies, and
- considering "step-wedged" RCTs to evaluate efficacy.

In their view, vigorous research designs would include developing adequate scales and validated instruments although that they recognize that creating standardized instruments would be a complex endeavour due to the wide diversity of interventions and partnerships.

League et al. (2020)

League et al. (2020) noted that few partnerships serving immigrant communities had written up their lessons learned and best practices. They suggested it would be useful if studies:

- set out the duration of their collaboration and services,
- discuss the long-term legal and patient outcomes,
- report on the success or failure of clinical care,
- describe systems in place of support legal and medical needs,
- take ethnographic approaches to understand the complexities of projects that drive how projects are formed, implemented, organized, and their longevity, and
- fill the knowledge gaps – what and how many informal partnerships exist between smaller organizations doing similar health justice work.

Their review implicitly suggests that an added criteria for program evaluation for immigrant communities should be the structural and cultural competence of program staff, to assess whether there are institutional barriers to service, and whether staff should be trained in trauma-informed approaches. More scholarly publications on these partnerships would be beneficial.

The three more recent systematic reviews came to the following conclusions:

1. Beardon et al. (2021) recommended more robust study designs using comparator groups, and alternatives to RCTS such as natural experiments and existing data sources. Investigating the impact of HJPs in providing early access to health and legal services to foster prevention, how they improve patient engagement with their care and long-term trajectories, outcome variations across different social groups, and whether they improve how health services function would be useful.
2. Dowling et al. (2022) highlighted that more robust descriptions of how and what services are delivered would be helpful, better articulated theories of change, more consistently conceptualized outcomes, and developing well-validated screening tools with more precisely defined HHLN (to distinguish what can be served by a non-lawyer) . More longitudinal studies would be helpful, with more diverse cancer patients, Further, to build the evidence base there need to be more published studies: partnerships with researchers and evaluators would be helpful to build the field.
3. Reece et al. (2022) concluded, not surprisingly, that more empirical studies are needed of higher scientific quality, how best to help minority groups who are not well-represented in

the research to date, and to invest more funds in evaluation and appropriate skills to conduct more robust evaluations of how the services are implemented and their effectiveness.

Insights from Access to Justice Research: Developments in Outcome Measurement

Although it is beyond scope to report broadly on outcome measurement development from the field of access to justice research, it is prudent to cite some early work that explored outcome measurement and evaluation for justice interventions. This field should be monitored more closely for emerging insights that may support HJPs access to justice outcomes. This will be critical if these outcomes can be related to the SDoH: attaining positive justice outcomes may provide good proxy indicators for assuming improvements to health. Although ensuring good *legal health* as an outcome has not been explicitly explored, operationalizing this term, and developing it conceptually will be useful. Outcome measurement has become a subject of renewed interest because many influential organizations have been advocating for expanding existing measurement indicators to better monitor progress in civil justice to influence the United Nations Sustainable Development Goal 16.3 on access to justice.

Albiston and Sandefur cautioned that studies should consider a broad range of outcomes and impacts beyond those for specific individuals. "Civil justice research must step back from narrow definitions of effectiveness … and consider the broader, systemic effects of representation on individuals and those around them" (2013, p. 111). They explored RCT's limitations for legal interventions, offering the following critiques: findings may indicate whether representation statistically made a difference but cannot tell us why, factors related to how the client was represented are not usually understood (and can't be controlled for), and randomized design field studies are very different from experimental studies conducted in labs where extraneous factors can be controlled from influencing results. Furthermore, RCTs cannot capture the benefits that accrue elsewhere in the system, or to other parties – the value added – by the intervention, beyond the individual outcome. They argued that to arrive at better empirical measures, a more explicit theory on the meaning of effectiveness is needed.

A program evaluation framework for an access to justice initiative involving non-lawyers in New York City Courts identified three factors for measuring success, which included *appropriateness of the program*, *efficacy of the service offered*, and *sustainability* – which included quality, efficiency, and legitimacy (Sandefur & Clarke, 2015).

Udell and Widman (2018) created a guide to tracking outcome data for civil legal aid that recommended unlocking the potential of this data, finding solutions to the challenges of tracking outcomes, and preserving the integrity of outcomes data. They noted a shift in civil legal aid from reporting on "outputs" to "outcomes" the tracking of which will help better communicate the impact of legal aid. Tracking outcomes will incorporate the views of clients and service providers about what is successful. They expressed concern about attributing causality to legal interventions. Furthermore, they commented on relying on RCTs, despite recent interest because of their capacity to generate knowledge in medicine, noting they are not foolproof, and require replicable studies that ask the same questions repeatedly and control for the same variables.

> The time and place of the experiment, the distinctive population of clients, the unique skills of the providers, the characteristics of the decision-makers, and the nature of the services (if any) received by the control group are among the factors that may make it hard to generalize the findings from a single RCT to other setting at other times, in other places, in other cases, with different litigants, lawyers, decision-makers, etc. For these reasons, it may be important also to be able to replicate RCT findings before placing great reliance on the findings of a single study. Significantly, even when RCTs fail, they may still prove valuable because their failure often helps to illuminate important facts or other considerations that will increase the power of the experiments that follow (p. 37).

An OECD (2019a) paper on people-centred justice acknowledged the challenges of evaluating access to justice initiatives. These included that it is a new field, lacks common definitions, there are diverse ways of providing legal services, lacks a common framework for developing process and outcome indicators, cost of evaluation relative to the cost of delivering the program, and complexifying factors that have only recently been understood such as legal capability. Although recent efforts to develop a validated measurement tool for legal capability through a general legal confidence scale have shown promise, much more work remains to be done (Pleasence & Balmer, 2019, p.143). OECD recommended 10 criteria for developing, designing, delivering, and evaluating people-centred justice services. These include, as set out in Figure 21: evidence-based planning; accessibility; availability; prevention, proactivity, and timeliness; appropriateness and responsiveness; empowerment; equality and inclusion; outcome-focused and fairness; collaboration and integration; and effectiveness (p. 189).

Figure 21: Delivery and design criteria for people-centred legal and justice services
From OECD (2019a), p. 190

A report more closely examining approaches and indicators in access to justice metrics was commissioned by the Action Committee on Access to Justice in Civil and Family Matters (Calibrate, 2019). Although more applicable to measurement indicators at the country level, it is a good primer on for understanding and measuring justiciable problems, legal problem types, seriousness of the legal problem, problem resolving behaviours, how justiciable problems have been resolved, perceptions of outcome and process, and legal capability and empowerment.

Also of interest, was a report commissioned by the LFO for evaluating systemic advocacy on Ontario's CLCs. Smyth (2017) distinguished between formative evaluations, which are often *process* evaluations, and summative evaluations that are usually either *outcome* evaluations looking at the immediate effects of the program or *impact* evaluations that look more broadly at the longer-term effects of a program including direct or indirect benefits or consequences. Participatory, developmental and advocacy evaluations were discussed briefly and a framework for engaging in participatory evaluation is provided.

Insights from the Field of Program Evaluation

To supplement what we gleaned from HJP research reports and scholarly articles, we next explore insights gleaned from the field of evaluation, first identifying some of the more scholarly approaches and theories, followed by a summary of pragmatic guidance from evaluation guides and resources annotated in Appendix K. In the following section, brief but relevant insights from qualitative research methodologies are shared (including case study, and action research) that could inform approaches to evaluation design. Each of these enriches our understanding of appropriate approaches to apply in evaluation design. Of note, several of the pragmatic guides to program evaluation provide brief primers on qualitative and quantitative research, which will greatly assist staff tasked with evaluating an initiative internally.

A word of caution - the evolving nature of HCPs is that they can be complex interventions, depending on the type of change they seek to create. More sophisticated or integrated interdisciplinary partnerships require several phases of implementation. Process (formative), outcome, and impact evaluations (summative) would be important. From the Australian jurisdictional scan in Chapter 4, we learned that evaluating different phases of a program gives rise to different research questions, with different methodologies and data collection strategies. As set out below, developmental evaluations offer a more inclusive approach to understanding impact in complex innovations, like *collective impact* interventions.

Academic approaches to evaluation research

Patton (2015) described a typology of research purposes that included basic research, applied research, formative evaluation, summative evaluation, and action research (See Appendix AA). Basic research is assumed to create generalizable knowledge as an end in itself, and helps build theory, whereas applied research contributes to understanding and developing theories to solve human and societal problems. Patton (2011) differentiates usefully *formative*, *summative*, and *developmental* approaches. Formative evaluations help to improve an intervention and is focused on a specific program, hoping to be useful in the specific context studied. Summative evaluations help determine whether an intervention is effective or not, with

results hopefully generalizable to other programs. Developmental evaluations contribute to double loop learning and are very focused on being usable. Patton distinguished between initiatives that are *problem-focused* versus *values-focused* which also influence evaluation design. In his view, developmental evaluation is guided by, and shares inquiry techniques associated with reflective practice, action research, amongst others.

Also of interest is guidance on how to approach evaluation from researchers involved in Canadian collective impact projects. Collective impact, a term first coined by Kania and Kramer (2011), describes initiatives commonly understood to be multi-sectoral efforts to bring about community change using social innovation to solve *wicked* and intransigent problems. The health justice approach is aligned with this, which seeks to move beyond singular organizational approaches. In Table 11, Cabaj (2014) cited Patton's work to compare traditional evaluations to the complexity-based developmental evaluation more appropriate to collective impact work.

TABLE 1: COMPARING TRADITIONAL AND COMPLEXITY-BASED DEVELOPMENT EVALUATION

TRADITIONAL EVALUATIONS	COMPLEXITY-BASED, DEVELOPMENTAL EVALUATIONS
Render definitive judgments of success or failure.	Provide feedback, generate learnings, support direction or affirm changes in direction.
Measure success against pre-determined goals.	Develop new measures and monitoring mechanisms as goals emerge and evolve.
Position the evaluator outside to assure independence and objectivity.	Position evaluation as an internal, team function integrated into action and ongoing interpretive processes.
Design the evaluation based on linear cause-effect logic models.	Design the evaluation to capture system dynamics, interdependencies, and emergent interconnections.
Aim to produce generalizable findings across time and space.	Aim to produce context-specific understandings that inform ongoing innovation.
Accountability focused on and directed to external authorities and funders.	Accountability centered on the innovators' deep sense of fundamental values and commitments.
Accountability to control and locate blame for failures.	Learning to respond to lack of control and stay in touch with what's unfolding and thereby respond strategically.
Evaluator controls the evaluation and determines the design based on the evaluator's perspective on what is important.	Evaluator collaborates in the change effort to design a process that matches philosophically and organizationally.
Evaluation engenders fear of failure.	Evaluation supports hunger for learning.

Source: Patton, Michael Quinn (2006). Evaluation for the way we work. *Nonprofit Quarterly, 13*(1), 28–33.

Table 11: Comparing Traditional and Complexity-Based Development Evaluation

Cabaj set out five simple rules for evaluating collective impact initiatives:

Rule 1	Use evaluation to enable – rather than limit – strategic learning
Rule 2	Employ multiple designs for multiple users
Rule 3	Shared measurement, if necessary, but not necessarily shared measurement
Rule 4	Seek out intended and unintended outcomes
Rule 5	Seek out contribution – not attribution to community changes

Table 12: Five Simple Rules for Evaluating Collective Impact Initiatives
Excerpted from Cabaj (2014), pp 110-120.

Cabaj noted that RCTs are traditionally used to assess *attribution* but are not well-suited for complex interventions that involve multiple parties rather than a discrete intervention. By acknowledging that multiple factors are likely to have contributed, it might still be possible to assess an intervention's *relative* contribution. Cabaj observed favourably that Canada's Treasury Board's Centre of Excellence has encouraged theory-based approaches to evaluation using logic models to articulate anticipated causal linkages to desired outcomes, including the assumptions that underlie the mechanisms of change. "Theory-driven" approaches include "realist evaluation," an evaluation methodology described elsewhere in this report that is very focused on understanding the context that can enhance or detract from the desired results.

In the context of evaluating HCP professional educational programs, Haji et al. (2013) opined that evaluators need to move beyond whether a program worked, to establish how it worked, why it worked, and what else happened. This larger focus adds significantly to an evaluation's value: its usefulness is reduced if this is not accounted for. If evaluations focus too much on whether predicted outcomes are reached, they will not be able to explain how interventions and outcomes are related. In their view, to move beyond 'did it work,' "future evaluative efforts should incorporate …. not only programme *outcomes* but programme *processes* … an evaluation of programme theory … generate an emergent theory" (p. 349) and capture context. Choosing an evaluative approach "is not so much a treasure hunt for the 'perfect model' as it is a reflective exercise in which the evaluator recognises the inherent biases associated with his or her selection and decides on the most appropriate *combination* of available approaches" (p. 349). To evaluate complicated and complex interventions, it is essential to understand program theory: evaluations may require an evolving logic model (Rogers, 2008).

For Newcomer et al. (2004) an evaluation is only useful and worth its cost if it goes beyond assessing program results to identify ways that a program can be improved. Evaluations used only for external accountability that do not help improve programs are often not worth the cost. They recommended a systematic assessment of program results, and to the extent possible, systematic assessment of the extent to which the program caused those results. Articles in the *Handbook of Practical Program Evaluation* stressed the importance of evaluability assessments, program logic modelling, designing evaluations and data collection methods, and different methods of analysing data with an emphasis on quantitative approaches (Wholey et al., 2004).

Program evaluation standards have become more rigorous over the past decade. *Program Evaluation Standards: A Guide for Evaluators and Evaluation Users* is an important resource jointly developed by Canadian and American experts (Yarbrough et al., 2011). Evaluations should be adaptive, responsive, and mindfully used. Evaluation quality has five properties: utility, propriety, feasibility, accuracy, and accountability with standards specified for each. *Instrumental* evaluations are generally used to inform judgements about the worth or significance of a program, whereas *conceptual* or *enlightenment* evaluations are used to understand aspects of the phenomenon. Evaluation design is described as including naturalistic, experimental, quasi-experimental or mixed approaches. (In this context, naturalistic design would be "qualitative research.") Human rights and respect for participants and stakeholders means considering research ethics, which may require consulting with institutional research ethics boards. Increasingly, the process of an evaluation is used to "build internal evaluation capacity and

systematic evaluative inquiry as a regular mechanism" (p. 5). Building evaluative inquiry skills internally to a project or an organization benefits from participatory, collaborative, appreciative, and empowering approaches. Reflective practice is an important aspect of a developing an evaluator's professionalism and expertise.

Pragmatic approaches to program evaluation

For most small-scale HJPs sophisticated evaluations will not be possible. Yet evaluations are critical for new and ongoing initiatives, at the very least to ensure we learn from innovative approaches, and create new knowledge of what works, how and why it works, and for whom. Since we do not currently have a pragmatic evaluation resource manual specific to the health justice sector, there is much to be learned and adapted from existing guides created for non-profits and the health sector. Appendix K is an annotated collection of guides to evaluation. To be included here the resource needed to be freely available, useful, pragmatic, and professional. Most offer step-by-step guidance, stressing the importance of evaluation planning, including ensuring the feasibility of an assessment, articulating a logic model or theory of change, developing outcome measures, and designing evaluations. Evaluation capacity building, supporting evaluative thinking, and building learning organizations are often stressed.

Other useful resources come from international development programs. One such example is from the OECD, providing a high-level checklist to decide which aspect of an intervention is to be evaluated, with the criteria set out in Figure 22 below. The choice (and the related research question) will influence the design of the evaluation (OECD, 2021b).

Figure 22: OECD Criteria to be considered in designing an intervention
Excerpted from OECD website, https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

Insights from Qualitative Research Methodology

As we noted in Chapter One, comprehensively exploring research methodologies across the disciplines is beyond the scope of this report, but it is interesting to consider qualitative

approaches from the social sciences for the perspective they have to offer, to supplement biomedical research approaches often preferred in the health sector. Creswell (2013) characterized five approaches to qualitative research inquiry and design as narrative, phenomenological, grounded theory, ethnographic, and case study research. For our purposes, to understand more about HJPs, individual and multiple or collective case studies are most relevant.

Case study

According to Stake (2008), case studies "concentrate on experiential knowledge of the case and … optimizing understanding of the case requires meticulous attention to its activities" (p. 444). Stake (2006) classified case studies into three types, all of which were relevant to understanding HJPs: *intrinsic* – to understand a particular case; *instrumental* – to examine a particular case to gain insight into an issue or theory; or *collective* – to gain a larger sense of what was being studied. Yin (2014) described the case study approach as an opportunity "to shed empirical light on … theoretical concepts or principles" (p. 40). The case study approach may offer greater understanding in the early days of trying to understand the nature of a phenomenon. This methodology often borrows from phenomenological, grounded theory and ethnographic approaches. Exploratory case studies are often the first step in developing theories of why or how things work: it is important to understand the parameters of a phenomenon first, which can then be followed by correlational or experimental studies, as theorizing about causal linkages which then may be amenable to testing. A multiple-case study methodology can contribute greatly to understanding an intervention as it permits comparisons (Yin, 2014).

For example, a study looking at the impact of interventions to improve health equity (Browne et al., 2015) developed a mixed methods, multiple-case study design to examine the impact of their intervention on enhancing staff capacity, improving processes of care, polices and structures, and client outcome. It is "a comprehensive research strategy useful in exploring, describing, explaining, and evaluating causal links in real world interventions that are too complex to be assessed by survey or experimental strategies alone" (cites omitted, p. 7).

Action research

Action research is a research methodology that is often used to understand and create new knowledge about a problem or an approach. It is often use when improvements in practice or changes in organizations and systems are desired, but the 'problem' is not well understood. Described as largely an inductive research strategy, it

> results in a richer, deeper, and more multifaceted understanding of the issue being examined by the research, creating situated knowledge about the challenge being faced. It is ideally suited for supporting innovation in the access to justice sector because it encourages reflection and action in a cyclical process that incrementally and iteratively begins to change the situation while it is being researched (Leering, 2017, p. 209)

Action research uses a cyclical, iterative process, embedding evaluative questions as part of the design, planning, and implementation cycle. It is ideally suited for developing small scale JHPs. Qualitative date is often collected but quantitative data is also collected at different phases to answer emergent evaluative questions. Leering (2017) contextualized action research, citing

multiple action research scholars, and described simple steps for carrying out the research and can be referenced for further details. Coghlan (2001), and Kemmis (2010) are good references.

Research Ethics Considerations

Evaluation research must consider research ethics issues, either informally or formally depending on whether the purpose is *research* or *program evaluation*. In Canada, guidance is provided by the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans: TCPS2 (2022). Research is defined broadly as "an undertaking intended to extend knowledge through a disciplined inquiry or systematic investigation" (Tri-Council Research Agencies, 2022, p. 4). Three core ethical principles govern: respect for persons, concern for welfare, and justice. This translates into requiring informed consent, freely given without interference, that can be withdrawn at any time; protecting participants including by providing information on the risks and potential benefits related to their participation, minimizing risks and protecting their privacy; and treating people fairly and equitably, particularly protecting those that are vulnerable, and protecting participants from power imbalances. If associated with a university or a healthcare institution, formal research ethics boards (REBs) will vet applications. There are various options for community-based research ethics approval if needed. However, program evaluation activities are exempted under TCPS2 Article 2.5 if they are used exclusively for assessment, management, or improvement purposes. However, if the data collected for program evaluation purposes is later used for research, it may then require REB approval. A free online course is available to understand the research ethics requirements. Patient/client confidentiality requirements will also need to be met for both HCPs and LSPs, to comply with legal and professional responsibilities with appropriate consents, and data anonymized.

Chapter Summary

In this chapter, we delved into the different research and evaluation approaches that had been tried or are recommended in each country and gleaned from the scoping and systematic reviews. We shared insights from the emerging field of outcome measurement in access to justice, the fields of evaluation and qualitative research, and considered research ethics. In all countries, mapping studies are building our understanding of the nature of partnerships and growth of the movement. The findings also indicate that further expertise and resources are needed to build evaluation capacity, including evaluative thinking. From UK and Australian researchers, we are beginning to see interprofessional care scholarship influencing evaluation research. Recent interest in convening an international consortium to build the evaluation research capacity of the health justice approach will help to advance our knowledge of what works, for whom, and at what cost.

In Canada, JHP evaluation research is its infancy, even at an individual program level, as the health justice movement is still nascent. However, an early summative study of the impact of the first JHP was exemplary in its thoroughness, and forthcoming research on the impact of a newer partnership involving an FHT is similarly robust. Logic modelling has emerged as a critical aspect of evaluation and program design, including for CALC's local partnerships which were presented as a case study. Logic modelling was piloted with a new JHP to build an evaluation framework, and a sample template for collecting data was created.

Australia's rich and diverse contributions to evaluation research were charted through the work of the LJFNSW, evaluators, scholars, and HJA. Embedding evaluative research at each phase of a project is recommended to guide the choice of methodologies, from planning, to establishing, to monitoring implementation, through to evaluation, with different research questions posed. The importance of cultivating a capability for evaluative thinking was outlined. We provided noteworthy examples of evaluation research design, logic models, data collection tools and potential program outcomes from a range of sources, including the HJA's new "theory of change." It functions as a logic model to describe the many possible beneficial outcomes and impacts of the health justice approach. Newer impact considerations include how partnerships can contribute to the service goals of both legal and healthcare providers, the outcomes and impact of legal secondary consultations, as well as the need to develop new metrics to measure improvements in client and provider well-being. Incorporating Aboriginal perspectives and ways of knowing in evaluations was also a strong theme.

US approaches have been highly varied, with quantitative, qualitative, and mixed methods research approaches utilized by a wide range of researchers from medicine, public health, law, business, and social work. To support the US jurisdictional scan, Appendix J includes an analysis of 46 studies, their research questions, methodologies, and data collection practices. For future reference and synthesis, we explored outcome categories that might be expected from health justice interventions in the US, and measurement indicators to consider.

Systematic reviews of studies of HJPs have been popular in the UK, and increasingly, in the US, to which we added our study' scoping review. Systematic reviews have outlined the need for more robust, and different types of research, and to improve research reporting. A particularly important contribution was Allmark et al.'s (2013) systematic review and the logic model constructed to show the causal and evidentiary linkages between the legal intervention and primary, secondary, and tertiary outcomes. To add to the credibility of all studies, using validated research instruments to measure improvements to physical, emotional, and mental health as well as other constructs was identified as crucial. However, concerns were expressed about the sensitivity of some research instruments and their applicability to specific populations. Tensions between RCT/biomedical research approaches and more qualitative and exploratory research models are seen in Australia, UK, and US, adding to the opportunities to be creative in designing evaluation research, but adding to its complexity.

Finally, the chapter ends with a brief overview of emerging ideas about outcome measurement in access to justice, as this will need to be monitored. We then summarized insights from the field of program evaluation including scholarly contributions defining different types of evaluation including formative, summative and developmental. Practical resources to support evaluation are annotated in Appendix K. We reviewed qualitative research methodologies such as multiple (comparative) case studies to build a better understanding of what works, for whom, how or why it seems to work, and at what cost. Action research as a method that creates change while building understanding was discussed with its ability to build evaluative thinking, and as an engaged research approach for HJPs in the planning and implementation phases, in particular.

Chapter Five: Discussion: Promising Practices for Evaluating Progress and the Impact of These Partnerships

Here we discuss the themes from our research and their implications, emerging concerns and cautions, including promising practices for evaluating progress and the impact of HJPs in Canada, focused on Ontario. Although Ontario's health justice movement is nascent, our HJPs are Canadian leaders in experimenting with this innovation. Yet we are not on par with the increasingly sophisticated partnerships in Australia, UK, and US. We must be realistic and pragmatic about what evaluation research efforts here can accomplish in the short term, with so few dedicated resources to develop and maintain partnerships, only a small number of identified HJPs, little or no funding for program evaluation or robust research, with only slight academic and government interest. In the short term, evaluation efforts should be focused on ensuring that our HJPs are developing efficiently, strategically, and sustainably. The goal is to create and document new professional knowledge about how health justice approaches can be most effective. At the same time, it is imperative we take the longer-term view and begin to document *impact* to build the movement. Also, credible research studies could catalyse greater client/patient-centred professional practice in the health and justice sectors, improve service delivery, resolve HHLN earlier, and attract professional, government and funder support.

Opportunities to implement the health justice approach are more readily available in Ontario because there is already a non-profit legal services infrastructure to support these partnerships if there is the will and capacity to do so. *Poverty law* is a valued legal practice domain that is responsive to the SDoH, with *clinic law* services funded by LAO pursuant to its statutory mandate under the *Legal Aid Services Act*, S.O, 2020 c. 11. This mandate has created a progressive system with a 40-year history of establishing community-based legal clinics that is not shared by the other Canadian provinces and territories. Across Ontario, a network of more than 70 independent CLCs offers free poverty law legal services, and provides specialist legal services (lawyers, paralegals, and community legal workers) for vulnerable populations living on a low income. However, the scope of legal help would be considerably strengthened if LAO also committed their resources and staff to HJPs to provide access to family law help, a legal service s not within the mandate of CLCs. The Embedded Lawyer project is an excellent example of better alignment of LAO resources to the health justice approach.

Figure 23 captures the rationale for building a stronger evidence base and new cross-disciplinary professional knowledge about what works. At a **micro** level, evaluation research will ensure the viability, sustainability, and impact of our local HJP initiatives. At a **meso** level, to broaden access to this service innovation, we must strategically use the professional knowledge gained about how to implement these partnerships effectively and their documented impacts to encourage adoption of the health justice approach in other communities. We must build a stronger health justice movement, collaborating with HCPs to offer more people-centred services that respond to HHLN to support health equity and equal justice. For **macro**-level impact, we need to build the evidence base of how this approach creates positive change by ameliorating the SDoH in our Canadian context, and improves health and justice outcomes, particularly for vulnerable populations. Fortunately, research in other countries who are a decade or more ahead of us, has already created a strong evidence base. We must stay abreast of, learn from, and support these efforts in Australia, UK and the US.

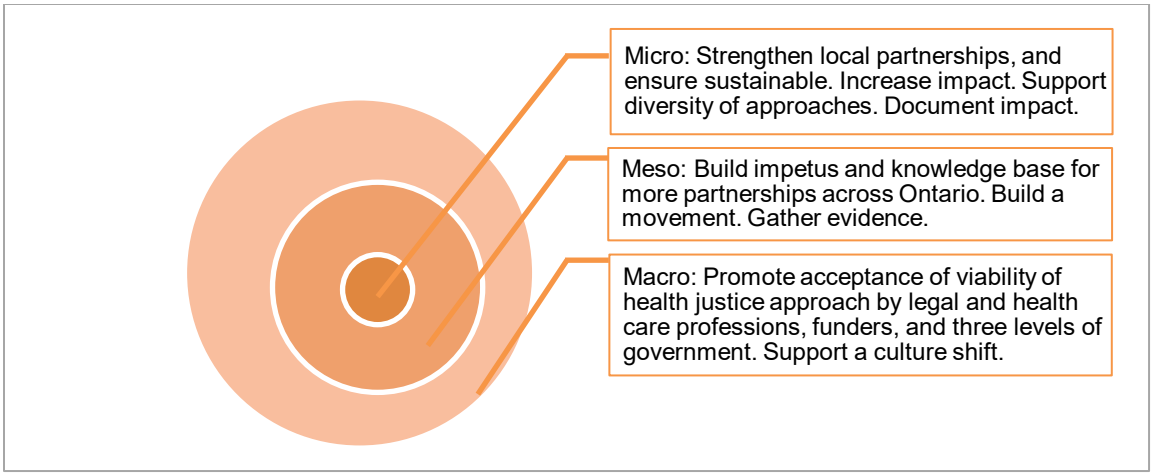

Figure 23: Pragmatic rationales for building a stronger evidence base on HJP practice and impact

This chapter is not intended as a "how to" manual. In Chapter Six, as a next step, we recommend evaluation capacity be built in the justice sector. This includes creating learning and professional development opportunities, and health justice specific evaluation resources – informed by this report and the templates and resources gathered here.

Opportunities to evaluate HJP work are abundant: we have defined this health justice approach broadly to be inclusive of varied interventions where legal professionals work with HCPs and/or their referred patients to improve legal literacy, legal health and empowerment, and to resolve HHLN. A spectrum of partnership activity characteristic of Ontario's HJPs was set out in Figure 11 (Chapter Three). Developing the capacity to evaluate the effectiveness of specific activities, and the strength of partnership and interdisciplinary approaches, and gathering evidence of outcomes and impact for clients and service providers, will all contribute to creating new knowledge about what works, for whom, and to develop practical theories of how and why it works. This includes how best to build awareness of remedies for HHLN and ameliorating the SDoH, intervening *upstream*, constructing simple referral pathways, and engaging in collaborative problem-solving for complex client/patient issues, in order to strengthen the robustness of the health justice approach.

It has been a complex and challenging task to synthesize evaluation and research strategies from different countries, disciplinary traditions and partnership interests. It also surfaced a conundrum. Analysing approaches in other countries, in particular the UK and US, revealed that producing empirical evidence of actual health impact is important, and even critical to finding more funding. This raised the question of whether – before we could reasonably expect HCPs or government ministries to adopt this innovative approach on a larger scale – we would have to 'prove,' with statistical significance, that legal interventions lead directly to improved physical health and well-being. Making these causal attributions seems a daunting, expensive, and unnecessary task. Yet, the hierarchy of evidence so valued by health professions was repeatedly reflected by recommendations for RCTs and longitudinal studies. There are serious questions about the wisdom of devoting significant resources to RCTs, or even their usefulness at this early stage of enacting the health justice approach. This was confirmed by the experience in published studies that used this approach. The research questions that would give rise to making RCTs the research methodology of choice, even setting aside ethical and logistical

concerns, would be very narrow ones. Additionally, given the complex nature of health justice interventions, it seems impossible, artificial, and possibly even counterproductive to attempt to control enough variables to be able to conduct RCTs.

Other questions surfaced: Is it sufficient to show that a legal intervention ameliorated an SDoH? This would then allow for a causal attribution or contribution, using existing studies, to link mitigated threats or improved determinants to better patient health outcomes. And given the evidence from legal needs studies of the impact of unmet legal needs on the health of research participants (Farrow et al., 2016), albeit self-reported – is it not enough that a timely legal intervention averted another crisis for people who live precarious lives on low or below poverty line incomes? Furthermore, often a longer-term desired HJP outcome is systematic analysis of the root causes of repeated problems in order to support systemic advocacy for legal and policy changes to ameliorate injustices. The possibilities for this type of impactful interdisciplinary collaboration, as a value-added aspect, given our shared interests in promoting equity and inclusion, provide a strong motivation and impetus for implementing the health justice approach.

We treat the conundrum as creative tension, and will not attempt to resolve it here. HJPs are a complex social and cross-disciplinary intervention in a real-world context that have the potential to function on so many levels to create change, including client/patient, practitioner, organizational, and systems levels, and where narrow approaches to evaluation or impact measurement seem almost counterproductive. At this stage, legal and healthcare practitioners are still building professional knowledge about how to work across disciplines to make client/patient care more effective, efficient, and impactful. The challenging conundrum of evidentiary "proof" of health benefit remains as we update this report. There is much fodder for critical reflection and generative dialogue on how to move forward as opportunities to engage in evaluation grow.

To support dialogue and help Ontario's HJPs design appropriate evaluation frameworks, we now turn to the 22 themes, including promising practices, distilled from our research. These are largely explained without citations as these are amply noted in preceding chapters. Before we begin, we reiterate that robust guidance for developing HJPs can be gleaned from lead organizations in Australia, UK, and the US. Additionally, practical and technical advice are available from colleagues in Ontario's JHP CoP, based on knowledge distilled from experience.

Themes and Promising Practices from the Research

1. Context matters

The **jurisdictional** context plays a role in deciding why or how partnerships should be evaluated as well as dictates whether funding could be available for sophisticated research endeavours. We have seen that in different countries, and at different points in time, the impetus for undertaking partnerships as well as research changes, including what types of outcomes are of interest and will be measured. In our Canadian context, we need to build an evidence base about impact to capture the attention of the justice sector, HCPs, healthcare institutions as well as funders, scholars, the professions, and all three levels of government – municipal, provincial, and federal. We must build our knowledge base on how to ensure the partnerships work productively.

The **disciplinary** context influences decisions on the type of research that will be undertaken, based on the disciplinary preferences for credible empirical research that is capable of producing valid results, beliefs about the hierarchy of evidence, and what constitutes (and whether it is necessary to engage in) evidence-based practice. The health disciplines have been more interested in quantitative research, influencing the methodology choice in many studies.

The context of a **partnership** also matters. Are the HCPs primary, secondary or tertiary care providers? What types of HCPs are involved? Are partnerships in urban, small urban, rural, or remote areas? What types of LSPs are involved? Are they poverty law service providers (CLCs), law students, criminal or family lawyers, or other legal professionals on a legally-aided or pro bono basis? Are universities or other research organizations available for support? All these factors influence program design and capacity. Most partnerships are uniquely constructed and responsive to many local factors. These factors also influence whether there is interest in conducting evaluation research and whether and what evaluation research expertise is available.

2. Is the purpose of the study intended to be evaluation, research, or evaluation research?

We learned that these three terms are often conflated, yet do not always mean the same thing. To conduct a credible evaluation, research strategies will be used to some extent. The purpose of the research matters a great deal. If a study is intended as *scientific*, to prove an hypothesis, rather than designed to understand, evaluate and improve a program, or to ensure accountability to funders, additional factors must be considered, including seeking research ethics approval. As we intended to focus on evaluation frameworks, we have largely explored evaluation research. However, another purpose was to report on how HJP impact has been measured, so we analysed methodologies used in more formal empirical research studies.

3. Research approaches and methodology choices matter

There is disciplinary tension around what research approaches and methodologies are considered to produce credible, reliable, and valid research findings for evaluating progress and measuring impact. It is important to step back to consider which approaches will be most appropriate to provide insight on the research questions. This will help to resolve the tension. We reported on different options informed by approaches used in the healthcare sector, and by social scientists, evaluators, and others. Experimental, quasi-experimental, or observational approaches are more common in the healthcare sector. Their observational approaches include the qualitative approaches to research valued in the social science sector. Two qualitative approaches we considered were case studies and action research. Approaches to evaluation discussed briefly were formative (process), summative (outcome or impact), developmental, participatory, and realist. Economic evaluations such as ROI, SROI, and cost-benefit analysis were also evident in the studies. Appendix X2 provides a table linking evaluation types, to the research questions they help answer, and the purposes the evaluations might serve. The pragmatic evaluation guides (Appendix K) can function as primers on research methodologies, explained in plain language.

Ascertaining which research methodology is the most aligned to the research question suggests that relevant research expertise is available to inform the decision. Especially for

unfunded and small HJP evaluations, it is likely that outside resources will need to be leveraged in. Involving HCPs in designing evaluations, and leveraging in their expertise, will be critical.

4. Resources matter

Many researchers cautioned that undertaking rigorous evaluation research means that funders must provide **adequate funding** for evaluations. Inadequate funding limits what is possible. The cost of undertaking evaluation research must also be compared to the cost of delivering the services, as the cost can be equal to or greater than the cost of actually providing the service. It can also be burdensome for already overstretched service providers, impacting productivity. A frequent observation was that there have been few resources to develop HJPs to date and that funding for evaluations was often scarce or non-existent. Time and resource constraints can contribute to poor quality evaluations, which are a waste of resources.

Resources includes being able to recruit **appropriate professional expertise** to support evaluation. At the present time, the justice sector, and legal practitioners, are at a professional disadvantage. We usually need to leverage other professional expertise to carry out this research. Expertise may be available from HCPs who have developed it in their professional training, and for whom research is required competency. HCP organizations may also employ researchers and evaluators. Affiliated post-secondary institutions may have interested faculty or graduate students. Legal professionals need to become better informed about approaches to evaluation and research methodologies (hence the detail in this background paper). Complex evaluations will require specialized expertise. The literature and our MIEAC experience, revealed that partnering with university faculties significantly contributed to evaluation feasibility and research capacity, including access to funding grants for research more readily available to the health sector.

Another resource issue identified is the need for a **centralized repository** of evaluation and research studies to increase the ease of accessing and building on what has gone before. This would also support more standardized evaluations, measurement indicators, etc. The NCMLP and HJA are already taking steps in this direction, at least for studies in their own countries.

5. The purpose of the partnership matters

Clarity on the purpose of the HJP, and specifically the change that the partnership or activity seeks to create is absolutely essential for evaluation design. Working with the partners to be clear on the intended change is an important first step. Discussed below, the process of developing program logic models helps articulate that change, the assumptions that underlie the theory of change, and anticipated outcomes. Conceptualizing outcomes helps to determine possible measurement indicators, which then leads into evaluation design and the research cycle.

6. Stakeholders' interests matter

It became clear that we must consider the interests of stakeholders in both the service and the research. For example, if we wish to ensure a more client-centred service, we will want to capture the views and experiences of the **patients and clients**, and so may choose participatory research methodologies, or methods for gathering data that place their concerns at the centre.

Similarly, if the **legal or healthcare practitioner** views or expertise are valued, or we seek to build new knowledge amongst those involved in an HJP, we will use research approaches that are more inclusive and *reflective*, and support evaluative thinking and organizational learning.

Healthcare and legal professionals have many converging interests, including on shared outcomes, as set out in Figure 4 and Figure 5 in Chapter Two. These incentives will help focus evaluations on what matters to the partners, and the planning and reflective debriefing process will build professional knowledge, and increase the likelihood that data will be consistently collected. (If HJP service delivery partners are also the researchers, bias concerns may arise, which could be mitigated by data triangulation and data collection methods.)

Logistically, in partnership evaluations, **organizations** are stakeholders as they will devote resources to implementing the approach. It will be important to negotiate from the outset what evaluation research is desirable and how and when it will be carried out, including resource allocation. Data collection challenges existed in many research studies, some of which might have been ameliorated by better planning and research design.

Pragmatically, the **funder** may dictate what type of evaluation is required, and what outcomes need to be measured. It may be useful to evaluate beyond those requirements, based on the organizational or other stakeholder's interests if we want to build a stronger evidence base.

Indigenous interests and perspectives in evaluation and research merit special considerations as we learned in the Australian jurisdictional review. Appendix X1, provides an example of how these interests would be included in designing an evaluation.

7. Does independence of the evaluator or researcher matter?

The studies we reviewed most often engaged outside experts and consultants, sometimes pro bono. A benefit to retaining external evaluators is that the findings may be considered more credible, and less susceptible to bias. The downside is the loss to evaluation capacity building and organizational learning. Several studies involved HJP staff in designing and implementing the evaluation – a useful compromise. A caution – if a scientific research study is envisioned, with purposes beyond program evaluation, ensuring researchers' independence is important.

It will not be feasible for most small-scale HJPs to consider external evaluators. And it may not be necessary, depending on what is being evaluated. Program evaluation is critical, and must take place, regardless of whether an independent evaluator can be retained. Building evaluative thinking capacity internally in HJPs is essential. Notably, action research should include evaluative components. Developmental evaluations are inherently participatory, they build new knowledge about what works and strengthen evaluative thinking capacity.

8. Evaluation capacity building is critically important

To scale up the health justice approach, we must build evaluation capacity. Australian researchers identified the need to increase the legal sector's capacity for evaluative thinking (see Figure 17 in Chapter Four). Much can be learned from HCPs about how to evaluate, a capacity

embedded in their professional commitment to evidence-based practice. Resources in Appendix K distill pragmatic and well-structured advice and will build an internal evaluation capacity.

9. When designing a program, the findings of prior credible evaluation and research about what works matters

An essential factor in designing an HJP will be to understand not just what is needed but what has already been tried or is available to meet those needs, and what approaches might be successful. Undertaking this preliminary research is a component of evidence-based practice for HCPs, but much less so for LSPs. This paper, the systematic and scoping reviews, the US jurisdictional scan, and NCMLP literature reviews analyze approaches that have been tried before. These are an invaluable resource.

Regrettably, as a practical matter and constraint, it can be challenging for practitioners to have access to articles that are often behind paywalls. For ease of locating articles, the Reference list, includes hyperlinks to articles and reports, and the NCMLP collects relevant articles on their website.

10. The quality of evaluation research matters

Assessing the quality of research studies is important in healthcare: appraising studies is a technique employed when undertaking systematic reviews. Beardon et al.'s (2021) quality appraisal tool (Appendix C) can be used as a list of questions to consider when designing research strategies. However, this rigour may go beyond what can reasonably be expected from internal evaluations. It provides guidance on what should be contained in research reports, although may be more than desirable or necessary for less formal evaluations, as contrasted with published research studies intended for academic audiences. In summary, considerations include:

- engages with existing studies and research,
- clearly defines the purpose of the research,
- outlines the research questions,
- the study design is appropriate for the research questions,
- considers ethical issues,
- analyses data rigorously analysed and reaches valid conclusions,
- reporting is clear and comprehensive, and limitations or weaknesses are acknowledged, and
- findings contribute to knowledge or practice.

We can reasonably expect that as we produce more HJP evaluation reports, possibly framed as case studies, that it will be possible to engage in a multiple case study analysis. Additionally, a qualitative synthesis of the reports might be feasible, if they were of sufficiently high calibre.

11. Evaluations should be embedded at each stage of HJP development.

This theme came through strongly, particularly from Australia's access to justice researchers. Figures 16 and 18 (Chapter Four) set out four typical stages for developing programs and key research questions. Designing a responsive evaluation framework would

include updating the logic model for each stage, with research questions related to that stage's anticipated outcomes. A cautionary note was that a full-blown evaluation at every stage would not be sustainable.

In the early phases of a partnership, formative or process evaluation methods are appropriate to ensure that the initiative is being developed efficiently and correctly. This allows for mid-course corrections if that phase's intended outputs and expectations are not being met. It would be premature to be evaluating longer-term outcomes. Interprofessional care research may provide a critical lens against which to assess the factors influencing how a partnership is developing. Several researchers suggested partnership evaluation checklists (Appendix T).

12. Quality evaluation frameworks incorporate at least a basic 'research cycle'

We concluded, following MIEAC deliberations and our review of the literature, that an evaluation framework would incorporate, modified as appropriate, the components of a research cycle as set out in Figure 3 (Chapter Two). Modifications would be necessary based on the formality, comprehensiveness, and viability of the evaluation. Before incorporating the research cycle into the framework, developing a program logic model would be helpful.

13. Constructing a program logic model matters

Many of the studies and reports referred explicitly to the use of program logic models for various purposes, including designing evaluation frameworks. The process of logic modelling helps to design an HJP intervention, to surface assumptions about how it will work, and to support planning, implementing, and monitoring. Numerous examples are provided including Figure 19 (Chapter Four), or in Appendices B, N, O, R, and U, or theories of change like HJA's (Appendix Y). Logic modelling articulates the inputs, activities, expected outputs, and intended short-, medium-, and long-term outcomes, and surfaces the underlying assumptions.

The process for developing the program logic model for CALC's partnership was modified from a health professional workshop on evaluating an educational program intervention. It was subsequently piloted with a new HJP, as discussed in Chapter Four. The blank template provided in Appendix AA articulates all the usual aspects of program logic, differentiates between program development in the first phase, and program outcome and impact as the HJP matures, and includes a space to articulate assumptions that shape the design of the initiative, possible external influences, the context, and unintended or value-added impacts.

14. Articulating anticipated outcomes matters

An essential component of evaluation design is to articulate the anticipated outcomes, most easily documented in the program logic model. Outcomes (and their related measurement indicators) were articulated in many different ways in the publications, as were categorizations of the types of outcomes and impacts. The key consideration will be the answer to the question: "What is the change that you expect to create?" Further synthesising, streamlining, and rationalizing these categories in a customized evaluation framework will be highly beneficial. See, as examples, the systematic reviews categories (Chapter One), the Australian jurisdictional

scan in Appendices Q, S and HJA's efforts (Table 7) and Appendix Y, US efforts collated in Table 8 and access to justice outcome measurement themes (Chapter Four).

And a caution – there were concerns about obsessively focused on only measuring progress towards predicted outcomes, risking losing what else is generated – which we loosely termed the "value added." Health justice interventions are complex by their cross-disciplinary nature, and can produce unexpected beneficial outcomes. Conceptually these partnerships also fall into public health interventions, and social innovation and collective impact fields, where new approaches to research and evaluation that are more developmental and generative in nature and anticipate value-added contributions. As a pragmatic matter, and to compensate for this concern, the program logic template (Appendix AA), has a space to identify the value-added aspects of the HJP, outcomes (and outputs) that were not anticipated in program design.

15. Creating an evaluation research plan matters

It is important to clearly document the evaluation research plan. Describing the plan provides an historical record, increases the credibility of an evaluation report, and explains how the research was carried out will be essential if publishing a report in a peer-reviewed journal is anticipated. Practically speaking, documenting the plan is essential for HJPs where the roles and responsibilities for collecting data are going to be shared, expectations need to be delineated, and possibly even negotiated. There were many examples in the studies where data collection issues arose. Developing a plan systematically also functions as a way to ensure that the evaluation plan is feasible within the existing resources. Templates for designing plans are provided by several pragmatic evaluation guides (Appendix K).

16. Research questions matter

A key component to begin the evaluation research cycle is to pose clear research questions. The nature of the questions will help to determine the appropriate research methodology. Research questions and the resulting choice of research methodology from key US studies were charted (Appendix J) to aid designing evaluation frameworks. It will be useful to reference our scoping review (Jomaa et al., 2023), and Beardon et al.'s (2021) analysis of high-quality research studies. Unfortunately, not all studies set out their research questions clearly. It is important to specify the research questions in writing up an evaluation study.

17. Research ethics matter

Although the ethical standards for program evaluation are not as formal as for research as defined by the TCPS2 (2022) and discussed more thoroughly in Chapter Four, this issue must be considered. Several of the pragmatic evaluation guides annotated in Appendix K consider the obligations that are raised by research ethics.

18. Developing measurement indicators matters

Having specified anticipated outputs and outcomes in the logic model, and considered what your research questions are, a next step will be to develop corresponding measurement

indicators. These are likely unique to your HJP: several examples were provided including Table 7 (HJA), Table 8 (US jurisdictional scan), and Appendix Q (Victoria Legal Aid). New measures have been suggested for patient and service provider well-being.

Several authors mentioned the importance of using proxy measures when a desired outcome cannot be measured directly. How to decide on the validity of proxy measures needs further investigation, and was not sufficiently explored in any of the studies. Proxy measures are usually carefully designed, to ensure that they can consistently be measured at different points in time. A helpful discussion of proxy measures was created for the World Bank by Kusek and Rist (2004). (Constructing/using proxy measures has become increasingly popular in international forums, such as measuring progress towards United Nations' Sustainable Development Goals.)

19. Data collection practices matter

Once the research methodology is chosen, choosing appropriate methods to collect data is important. How data is collected, and preserved is a significant research ethics concern. The studies revealed a wide variety of methods including holding unstructured, semi-structured and structured interviews; using questionnaires and surveys (both pre- and post-intervention); observing in the field; and hosting focus groups. Other methods included special record keeping practices (sometimes with mixed success or lacking consistency, and ideas like professional journals); reflective practice conversations, reviewing health and legal file records and program documents; and retrieving statistics and other information from data management systems.

To collect useful data, terms must be properly operationalized. Furthermore, using validated research instruments is definitely a best (and not just a promising) practice that significantly increases the credibility of the findings. Examples of these instruments included Figure 20 and Table 9 (Chapter Four).

20. Keeping track of "value-added" by HJPs matters

We learned that highly structured evaluations that focus only on measuring anticipated outcomes, may fail to recognize all the benefits or impacts of the HJP. It is important to keep track of these unanticipated or value-added outcomes and document them so they can be included in the evaluation report. Qualitative data collection supports this. The program logic template provided (see Appendix AA) provides a space to note these value-added aspects.

21. Data analysis choices matter

Depending on whether quantitative or qualitative data is gathered, different methods for analysing the data will be appropriate. It is beyond scope to describe these, but how the data is analysed should always be described in the report. For example, when qualitative data was collected, a study should reference how that data was analyzed according to the best qualitative research practices (such as constant comparative, and disconfirming case methods). For large amounts of data, the capacity to use software to support analysis is essential. Researchers used qualitative data management software like NVIVO to simplify coding the data and identifying

relationships between the emerging themes. For quantitative data and statistical analysis, using SPSS and ANOVA software was often cited.

As a practical matter, we created a template in Appendix P to help make decisions about data collection for a small HJP evaluation, and populated it with some content that might be relevant. As a cautionary note, do not underestimate the time it will take to develop indicators, collect data, pilot test to make sure it is collectable, monitor that staff collect it, checking data reliability (defining the data to be collected, and operationalizing terms), and how long it will take to properly analyse it.

22. Professional reporting matters

Although report writing is very time consuming, it is essential to create a written record of the results of evaluative efforts. The more frequently we can document evaluations in professional reports the better, so findings can grow the evidence base. Pragmatic evaluation guides (Appendix K) provide sound advice on robust report writing. Promising reporting practices can also be gleaned from Beardon et al.'s (2021) quality appraisal tool (Appendix C).

Practically speaking, busy service providers will find it almost impossible to prepare formal reports without additional resources. Although this is discouraging, this is the very practical reality we face, and amply noted in the publications reviewed. On the positive side, the discipline and practice of writing reports functions to surface our tacit professional knowledge, enables knowledge-sharing, and helps us to better articulate what we are learning in this important cross-disciplinary work.

Chapter Six: Recommended Next Steps

This background paper records the benefits and impacts accruing from HJP activity in four countries. We reported briefly on our perceptions of how the health justice movement has developed historically and uniquely in those same four countries, and the current context that supports scaling up this innovative approach. It became clear that creating a lead organization to support and promote the health justice approach has been critical to building the movement in each country, as well as finding *champions*, and to engaging legal and healthcare professionals, including academic researchers in law and healthcare faculties, and governments.

To ascertain the research approaches that were employed in the past and recommended for the future, we analyzed evaluation reports and research studies. To support HJP evaluation, we identified 22 promising themes, practices, and steps to consider. Incorporating this strategic and evaluative thinking in our health justice work will strengthen our capacity to *measure what matters*, to conduct credible evaluation research, and to track and measure impact. We hope our findings will support efforts to scale up the health justice approach in Ontario. The promise and the accomplishments of HJPs for improving health equity and access to justice are becoming more widely appreciated, so publishing this updated background paper is timely. Furthermore, many of our findings and recommendations, particularly for building evaluation capacity in the justice sector, are transferable to other access to justice initiatives.

We have concluded that a range of evaluation approaches and research methodologies are appropriate. Choices will be guided on context, resources, and the change we seek to create through our initiatives. For HJPs, this process can include, amongst other goals, tracking the benefits accruing to individual patients/clients, service providers, and the sponsoring organizations; creating new professional knowledge about how to identify legal problems and provide more integrated or holistic services, especially for more complex patients/clients, and how to work more effectively collaborate across disciplines. Evaluation findings have the potential to help guide efforts not just on how to improve the services to individuals, but also how to provide impactful training to both legal and health care providers on the SDoH, health equity and access to justice issues. They contribute to our understanding of how interprofessional partnerships work best, and how to construct and nurture them most productively.

We identified challenges and concerns for engaging in evaluation research. We provided pragmatic advice, where possible, on how to avoid or overcome these, referring to both scholarly and practice literature on evaluation, and the evaluation experience of Ontario's HJPs. We documented the creative tension, particularly around the hierarchy of evidentiary value of research studies, noting significant trepidation about the value of RCTs in the complex and unique HJP environment. We explored approaches to evaluation research that may be more generative, meaning that they could produce more actionable professional knowledge, and support scaling up more effectively. As an example, HJPs are akin to social innovation, and would benefit from more holistic collective impact and developmental evaluation strategies. We gathered a plethora of resources for future study, dialogue, and use including charting aspects of research methodologies, samples of existing program logic models, and categorized outcomes and shared measurement indicators. These indicators include patient health and health care use; access to justice, social and economic benefits; and health-justice integration, amongst others.

Sharing this compilation is to support creating interdisciplinary professional knowledge about how to evaluate what works, how it works, why it works, for whom, and at what cost. We must continue to build on the promising practices emerging from the justice and health movements in the US, UK and Australia who are further along in explicitly recognizing and funding HJPs.

We now recommend next steps including opportunities to build awareness of the approach and evaluation capacity, and better document partnerships as case studies and undertaking evaluation research. Pragmatically speaking, Ontario's existing HJPs will need to leverage more resources to develop and maintain these initiatives, and to conduct more formal evaluations or engage in empirical research. We must be realistic about what we can accomplish with existing scarce resources, because extending legal services more formally to HJPs may compete with the urgency of our direct client work. Furthermore, the funding for evaluation and research in the justice sector is scarce, unlike the health sector, so finding opportunities to collaborate with our HCP partners will be critical. Publishing academic articles has become an important catalyst for creating change, fostering innovation, transmitting professional knowledge, and building interest in the health justice movement in other countries.

We recommend the 10 next steps:

1. Share this updated background paper with the provincial JHP Community of Practice, key stakeholders, interested researchers, and funders, Access to Justice Research Network (AJRN) and the International Development Research Centre (IDRC). We will make this report more publicly available by publishing it on CALC's website portal for Justice & Health Partners. We will also produce a series of short topical briefing notes to make the content of this paper more accessible and digestible to practitioners. We recommend developing a taxonomy of terms to build a common language and understanding of what health justice approach is about, and to support operationalizing important research terms for evaluation purposes (see Appendix L).

2. Convene opportunities for dialogue on evaluation research and the need to document the impact of this approach using this background paper. Work towards building a consensus on best evaluation practices for Ontario's existing HJPs, and what outcomes we wish to achieve and study. Consider whether more uniform approaches to collecting data on desired outcomes and would be timely, feasible, and sustainable. Explore how we could document HJPs consistently and professionally as descriptive case studies, pending further funding, interest, and opportunity to undertake evaluation research. In the interim, each HJP should be encouraged to collect and disseminate data on impact based on the applicable outcome categories identified by our research that align with their theory of change.

3. Meet with the LFO and LAO and other potential funders to discuss our findings and their implications for the future funding and evaluation of these initiatives.

4. Support the scaling up of HJPs and the health justice approach – to ensure that a critical mass of partnerships is created. This will supply more examples and case studies, and the opportunity to evaluate various approaches. Efforts could include sourcing funding for pilot projects, and reaching out to Ontario's Ministry of Health, the Ministry of the Attorney-

General, and the federal Department of Justice to communicate the value of this cross-disciplinary work. Sourcing funding and sponsorship to convene a provincial or national symposium about HJPs could also be very helpful for raising visibility with LSPs and HCPs and governments and for recruiting university law and health faculty academics and researchers to this work. An academic journal publishing a collection of articles arising from symposium presentations would be an excellent way to raise awareness, and credibility of the approach, as it has in the US.

5. Investigate the feasibility of funding for a provincial or national coordinating body with an expert advisory committee to champion the health justice approach. This body could support HJP development (including academic HJPs), provide seed grants and coaching, create a centralized repository for studies, and host the virtual Justice & Health Learning Centre. Having a central hub and staff would also make it easier to keep abreast of and liaise with colleagues internationally at HJA, NCMLP, and UCL, and support scaling up, evaluation capacity building, and research.

6. Find resources to build evaluation capacity, particularly for LSPs. This would include sharing this report, the future briefing notes, and convening conversations. Updating the 2019 mapping study of JHPs in Ontario would be timely. It would also be beneficial to operationalize terms related to health justice (see Appendix L for a preliminary list), and develop a taxonomy of research terms (see Appendix H for a preliminary list). It would be timely to develop experiential learning workshops to encourage evaluative thinking and action research approaches to build HJPs. To build capacity, an evaluation resource manual customized to these initiatives could be helpful, with practical tools to simplify evaluation planning, implementation, and reporting. (See Appendix BB for a sample Table of Contents.)

7. Maximize opportunities to learn about evaluation research from those involved in existing HJPs. Provide opportunities to build a shared discourse between legal service providers and HCPs about the health justice approach and evaluation research. Investigate possible interest in the professional evaluator community for supporting HJP future efforts, particularly evaluators with experience in developmental, collective impact, and realist evaluations.

8. Stay abreast of opportunities to convene an international community of practice on HJP evaluation and research. Continue to monitor developments in evaluation and the evolving health justice approach in Australia, UK, and US, and other Canadian provinces.

9. If opportunities become available, investigate the following in more depth: proxy measures, validated research instruments, realist evaluations, and evaluating professional education initiatives. It would be profitable to monitor developments in aligned research fields that were beyond our scope including Public Health Intervention Research, Public Health Law Research, inclusion health research, interprofessional collaboration, legal epidemiology, and emerging research approaches for measuring the effectiveness of health equity interventions.

10. Seek funding to customize an evaluation framework and implement a research study involving a cross-disciplinary team of legal and medical researchers when more formal and properly funded HJPs have been developed.

Although perhaps premature in the Canadian context, because HJPs are a relatively nascent approach, it would be useful to identify champions for more formal empirical research on the impact of these partnerships. We have well-established connections to the Canadian Forum on Civil Justice and have shared this paper with them. Engaging with health researchers who have been carrying out studies in other countries would also be prudent. It may be appropriate to reach out to research consortiums like the Institute for Clinical Evaluative Sciences (ICES), a not-for-profit research institute, that seeks to improve health and health care through research and analytics.

Early on in CALC's health justice work, we observed that HCPs are trained to work from an evidence-based perspective. Establishing the efficacy and effectiveness of particular interventions are foundational to how HCPs carry out their responsibilities, and an essential component of their professional reflective practice. Decisions about what interventions HCPs will support often need to be based on available persuasive evidence. Therefore, it is imperative that the work of Ontario's HJPs be better documented and articulated.

Regrettably, legal professionals are not yet usually trained to undertake empirical research, well-prepared for action research or reflective practice, or to approach designing and delivering services from an evidence-based perspective. Designing qualitative, quantitative, or mixed methods research strategies to study whether interventions are effective is unusual. To be realistic, lawyers in private practice could not afford it, and the non-profit legal services sector is too consumed by helping clients with precarious lives who are in crisis and challenged by systemic injustices to prioritize resources for evaluations. Furthermore, legal professionals are working within a justice system where accountability for effectiveness or efficiency has not often been required, or even questioned. These realities create systemic challenges to building evaluation capacity, but these can be overcome. Focusing our efforts on evaluating access to justice innovations that allow us to work with HCPs who have a different skill set and professional competencies shows much promise for supporting a cultural shift in the legal profession, and new legal professional competencies. Our experience with this study has provided new inspiration for understanding how we might better realize equal access to justice, and improve health equity, working in collaboration with HCPs on a shared mission.

Cross-disciplinary work is not without its tensions: there is a significant divergence of approaches and a complexity born of different disciplinary capacities and ways of understanding. The disciplinary divide and cultural differences are real, but these partnerships show that they are both surmountable, and in fact, transformative for the partners involved. Legal and healthcare providers working together to improve the legal, financial, and physical, emotional, and psychological health of the people they serve can provide renewed energy to their professional practices. They can provide rich opportunities to create change for individuals, vulnerable communities, and the public, as well as the potential to reduce healthcare costs. Interprofessional collaboration to explore and manifest the health justice approach provides a wealth of opportunities to create new professional competencies and practical knowledge, and systemic advocacy to better serve the needs of vulnerable and disadvantaged communities.

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Appendix A: Members of Measuring Impact Expert Advisory Committee (MIEAC)

Dr. Imaan Bayoumi	Queen's University Department of Family Medicine, and Centre for Studies in Primary Care
Dr. Ab Currie	Canadian Forum on Civil Justice
Adrian di Giovanni	International Development Research Centre
Yonit Furhman	Pro Bono Ontario, observer
Danny Jomaa	Queen's University School of Medicine student
Lynn Linton	Gateway Community Health Centre (CHC) Executive Director
Brea Lowenberger	Saskatchewan Access to Justice Coordinator
Julie Mathews	CLEO Executive Director/Lawyer
Nicole Raymer	Dalhousie University Faculty of Law student
Doug Surtees	University of Saskatchewan Professor of Law
Julia Swedak	Gateway CHC Director of Quality & Knowledge Management
Lisa Turik	CALC Project Lead on Trusted Help and Co-chair of the Justice & Health Partnerships Community of Practice

Appendix B: Logic Model Identifying Different Types of Interventions
Allmark et al. (2013)

https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2524.2012.01087.x, Figure 2, p. 61

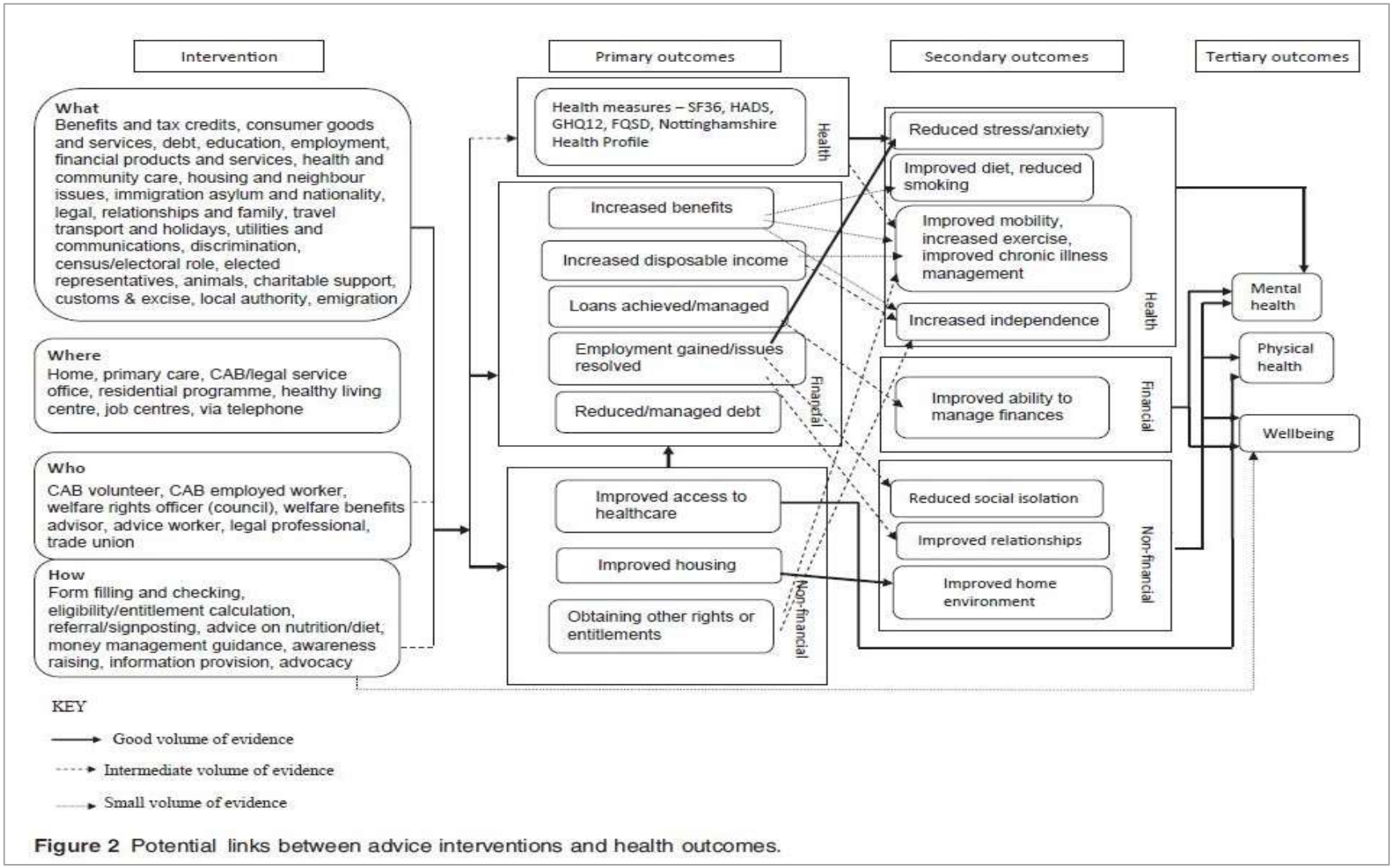


Figure 2 Potential links between advice interventions and health outcomes.

Appendix C: Customized Quality Appraisal Tool for HJP Research Studies

Beardon et al. (2021)

APPENDIX 2: QUALITY ASSESSMENT

Methods for development of quality assessment tool:

The quality assessment tool was developed for the body of literature gathered in this review, reporting on the delivery of HJPs. Existing tools could not easily or appropriately be applied, given the unique combination of disciplines and the diversity of research designs and literature types included. Quality assessment frameworks were reviewed to identify ratings of reporting that could be applied across the papers as a whole; these included frameworks from the medical, legal and interdisciplinary fields(Centre for Evidence Based Medicine, no date; Critical Appraisal Skills Programme, no date; UK Government, 2014; Jenkins, Partin and Wise, 2015; Belcher *et al.*, 2016; Mårtensson *et al.*, 2016; Van Gestel, Byland and Lienhard, 2018). Items from these checklists were first listed in full, and any that were too specific to a method or discipline were excluded. Remaining items were grouped according to similarity of meaning, and assessed as to how appropriately they could be applied to the included papers. This process of reduction resulted in a series of 16 statements relating to the following aspects of the papers: 'Context', 'Methods', 'Reporting', and 'Formal assessments'. Each criterion was rated using the following scores: 0 = 'No evidence', 1 = 'Some evidence', 2 = 'Good evidence'. Scores were then summed to give an overall value on the scale of 0 – 34. This was converted to a broader rating category: 0-10=Low, 11-20=Low/Medium, 21-30=Medium/High, 30+=High.

Table 1: Quality assessment tool developed

	Criteria	Meaning
Context	Engagement with existing evidence and theory	Adequately presents existing knowledge/ research evidence relevant to the context Demonstrates understanding of the relevant issues and sources Sets out hypotheses / theories of change
	Clear description of context/setting	A detailed description of the setting and context in which the service operates e.g. details of location, health service, legal service, target population, service aims
	Clear description of intervention	A detailed description of the activities of the service e.g. legal intervention, links with healthcare, operational details
Methods	Relevant research problem	Research problem is clearly stated and defined. Research problem is grounded in the context (including current debates, social context, knowledge gaps, theories). Practical applications of the research are considered.
	Clear definition of research aims/questions	Research aims and/or questions are clearly stated and defined. Research questions are related to the problem context.
	Appropriate study design/methodology	The processes of undertaking the research are clearly described. The study design is appropriate for addressing the research questions. The methods fit the purpose and are sufficient to generate the evidence required.
	Appropriate selection of data subjects/ sources	Selection of data subjects and/or sources is well described Sampling procedure is inclusive of all relevant participants / data sources
	Appropriate information gathering	Data collection procedures are clearly described Choice of outcome measures is fitting and sufficient Data collection is of sufficient duration and completeness
	Rigorous analysis	Analysis of study data is clearly and comprehensively explained Appropriate analysis methods are employed
	Use of theoretical foundation	The approach is informed by appropriate theories relevant to the context Theories are developed or examined
Reporting	Clear and comprehensive reporting	Results are clearly presented in full Language is clear, precise and understandable Report is well structured
	Critical evaluation	Information is critically evaluated Potential bias or confounding is discussed and taken account of if possible Alternative explanations are considered
	Critical reflection	Limitations of the research are discussed The role/standpoint of the researcher is disclosed and its impact considered Potential influence of context-specific cultural factors is considered
	Valid conclusions	Conclusions are linked to study's results and other existing evidence Interpretation is logical and transparent Argument is well-crafted
	Transferability	The research makes a significant contribution to knowledge or practice The application of the findings in other contexts is discussed (generalisability)
Formal assessments	Peer reviewed	The publication has undergone peer review
	Consideration of ethical issues	Ethical challenges are considered and responded to The research has undergone a process of ethical review

Appendix D: PowerPoint Backgrounder: How Epidemiologists Approach Research
Bayoumi (Presented at Internal MIEAC Meeting, June 25, 2020)

Notes on Epidemiology and Health Research Methods

Imaan Bayoumi MD, MSc, FCFP
Assistant Professor, Family Medicine

Queens University
Department of Family Medicine

What is epidemiology?

- Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems
- Epidemiological information is used to plan and evaluate strategies to prevent illness and as a guide to the management of patients in whom disease has already developed
- Relate to defined population
- Oriented to groups rather than individuals
- Conclusions based on comparisons

Study designs

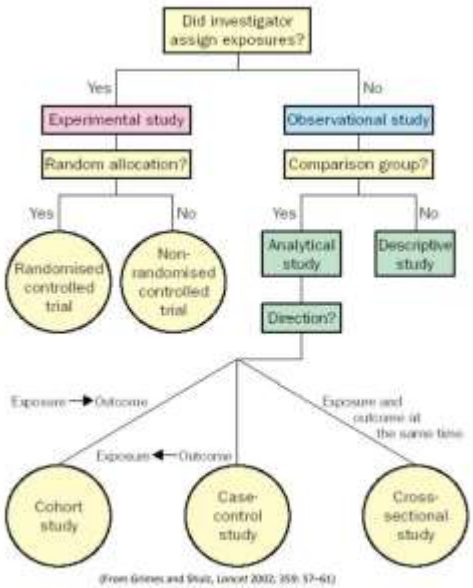
Cohort study

- Data are obtained from groups who have been exposed, or not exposed
- No allocation of exposure is made by the researcher.
- Best for study the effect of predictive risk factors on an outcome.

Case Control study

- Patients with a certain outcome or disease and an appropriate group of controls without the outcome or disease are selected (usually with careful consideration of appropriate choice of controls, matching, etc) and then information is obtained on whether the subjects have been exposed to the factor under investigation.

- Cross-sectional study
  - A study that examines the relationship between diseases (or other health-related characteristics) and other variables of interest as they exist in a defined population at one particular time (ie exposure and outcomes are both measured at the same time). Best for quantifying the prevalence of a disease or risk factor, and for quantifying the accuracy of a diagnostic test.



Common sources of Bias

- Selection bias
  - subjects studied are not representative of the target population
- Recall bias
- Observation bias (Hawthorne effect)
- Confirmation bias
- Publication bias

Guides for assessing the quality of health research

- CONSORT – RCTs
- STROBE – Observational studies
- PRISMA- Systematic Reviews
- GRADE – Clinical Practice Guidelines

STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
Methods		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(a) *Cohort study*—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants
		(b) *Cohort study*—For matched studies, give matching criteria and number of exposed and unexposed *Case-control study*—For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding
		(b) Describe any methods used to examine subgroups and interactions
		(c) Explain how missing data were addressed
		(d) *Cohort study*—If applicable, explain how loss to follow-up was addressed *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of

A word or two about outcomes

- Process vs Clinical outcomes
- Patient Reported Outcome Measures (PROMs)
  - Capture a person's perception of their health
  - Validated generic & disease specific tools eg Quality of life
  - Measure Symptoms; Distress/ Anxiety; Unmet need
- Patient Reported Experience Measures (PREMs)
  - Purpose: allows patients to provide direct feedback on their care to drive improvement in services.
  - Qualitative and quantitative approaches
  - Surveys: paper and electronic e.g. PETs
  - Focus Groups
  - Patient story/ journey
  - Observation

Community engaged/ Patient oriented research

- Community-based participatory research (CBPR) is a partnership approach to research that equitably involves community members, organizational representatives, researchers, and others in all aspects of the research process, with all partners in the process contributing expertise and sharing in the decision-making and ownership.
- I-CREATe – Innovations for Child and Family Resilience, Equity and Advocacy
- Patient oriented research aims to transform the role of patient from a passive receptor of services to a proactive partner who helps shape health research and, as a result, health care.

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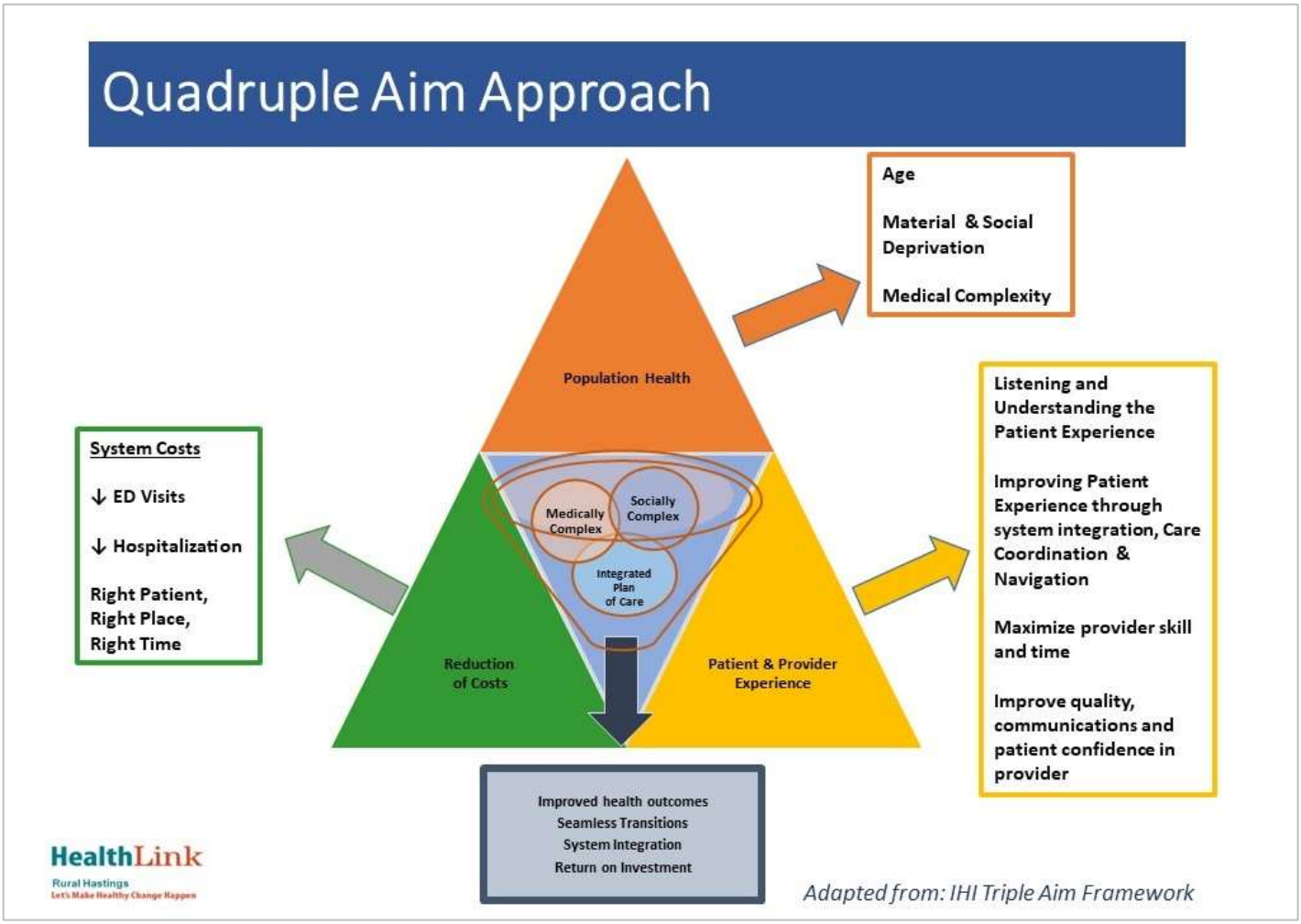
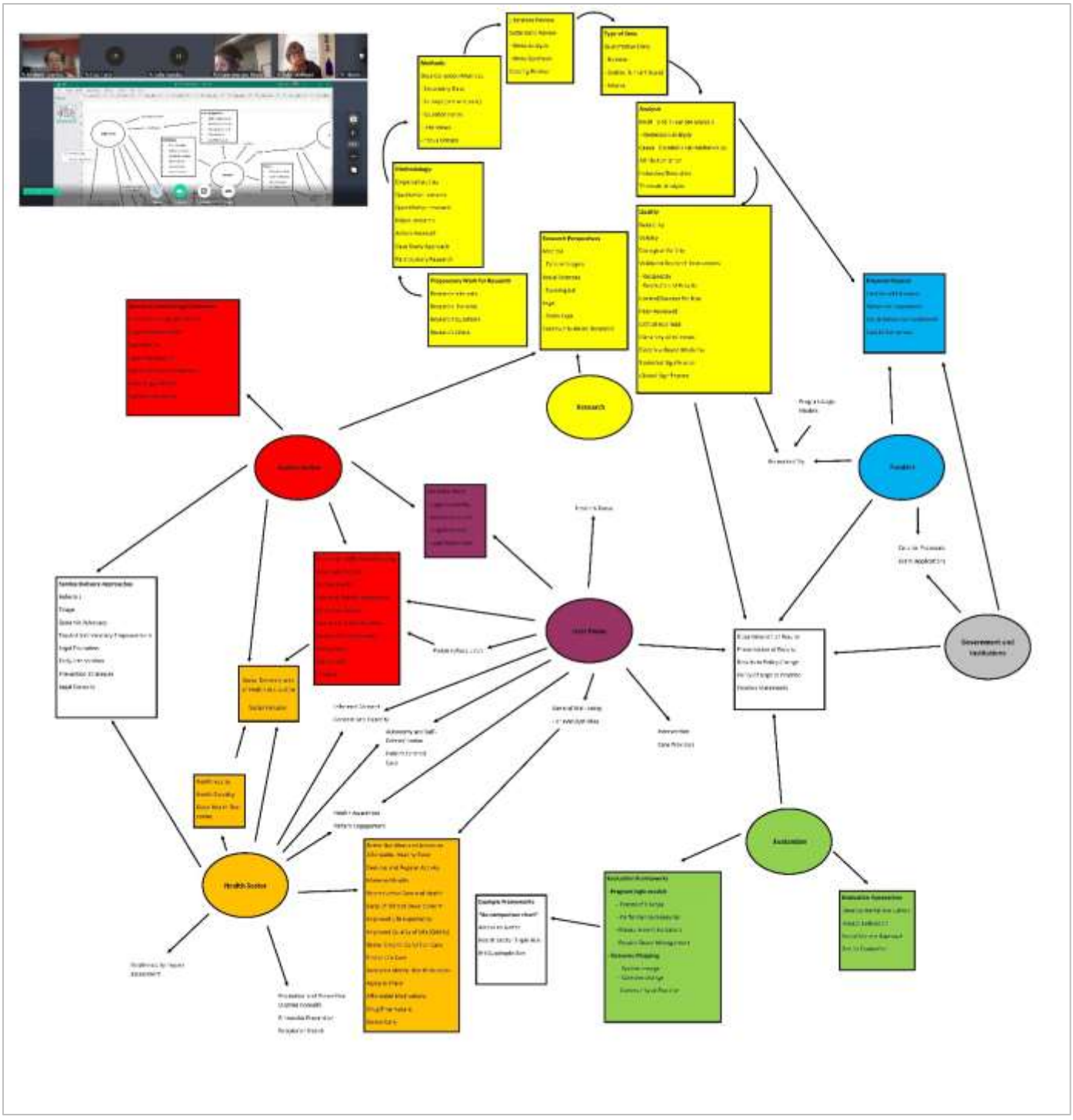
Appendix E: Quadruple Aim Framework
Gateway CHC



Appendix F: Triple Aim Framework
Access to Justice B.C. (2019)

Table 1 - Access to Justice Measurement Framework - Summary		
Elements	Dimensions	Components
Improving Population Access to Justice	**Prevalence of legal needs/problems**	• Prevalence of legal problems in the population • Prevalence of unaddressed legal needs in the population • Public legal awareness
	Response to legal needs	• People's choice of path to justice • Legal information and education needs • Legal advice needs • Need for legal representation and other legal assistance • Need for consensual dispute resolution process
	Fair and equitable access to justice	• Accessibility of justice system for British Columbians • Including geographical access, accessibility for Indigenous people, accessibility for people with mental illness, and accessibility for immigrants and refugees • Financial access to justice system • Timeliness of access to justice system
	Social and economic impact of access to justice	• Social policy objectives • Protection of people's rights • Public confidence in the justice system • Public confidence in social institutions • Gender equality • Justice for Indigenous people • Social & economic costs and benefits of access to justice
Improving User Experience of Access to Justice	**User experience of obstacles to access to justice**	• Obstacles to access (distances, technology, affordability) • Eligibility to services • Affordability of services • Delays in accessing justice services and their impact
	Quality of user experience of the justice system	• Quality of legal information and education • Trust and confidence in legal information • User empowerment • Quality of referral services • Quality of legal advice • Quality of legal assistance and representation • Experience of self-represented litigants • Quality of consensual dispute resolution processes
	Effectiveness of justice system in addressing user legal problems	• Effective resolution of legal problems • Mitigated impact of legal problems • Prevention of legal problems • Prevention of conflicts • Unmet legal needs and their consequences • Limits to the assistance received
	Appropriateness of the justice process	• Fairness, equity and impartiality of the process • Cultural appropriateness • Voice and participation
	Justice outcomes for the users	• Outcomes of the justice process • User satisfaction with outcomes of justice process • Compliance with court orders, judgments, and mediated agreements • Post-resolution support • User enhanced legal awareness • Enhanced legal capability
Improving Costs	**Per-capita costs of services**	• Per capita costs of services • Impact on new initiatives on per-capita costs
	Per-user costs of services	• Per user costs by type of services • Impact of new initiatives on per-user costs
	Other costs	• Social and economic costs of unresolved legal problems • Impact of unresolved problems on costs in other sectors

Appendix G: MIEAC Concept Mapping Exercise: A Work-in-progress - Early example of concept mapping exercise (Summer 2020)



Appendix H: Draft recommended list of terms and concepts related to research & evaluation frameworks

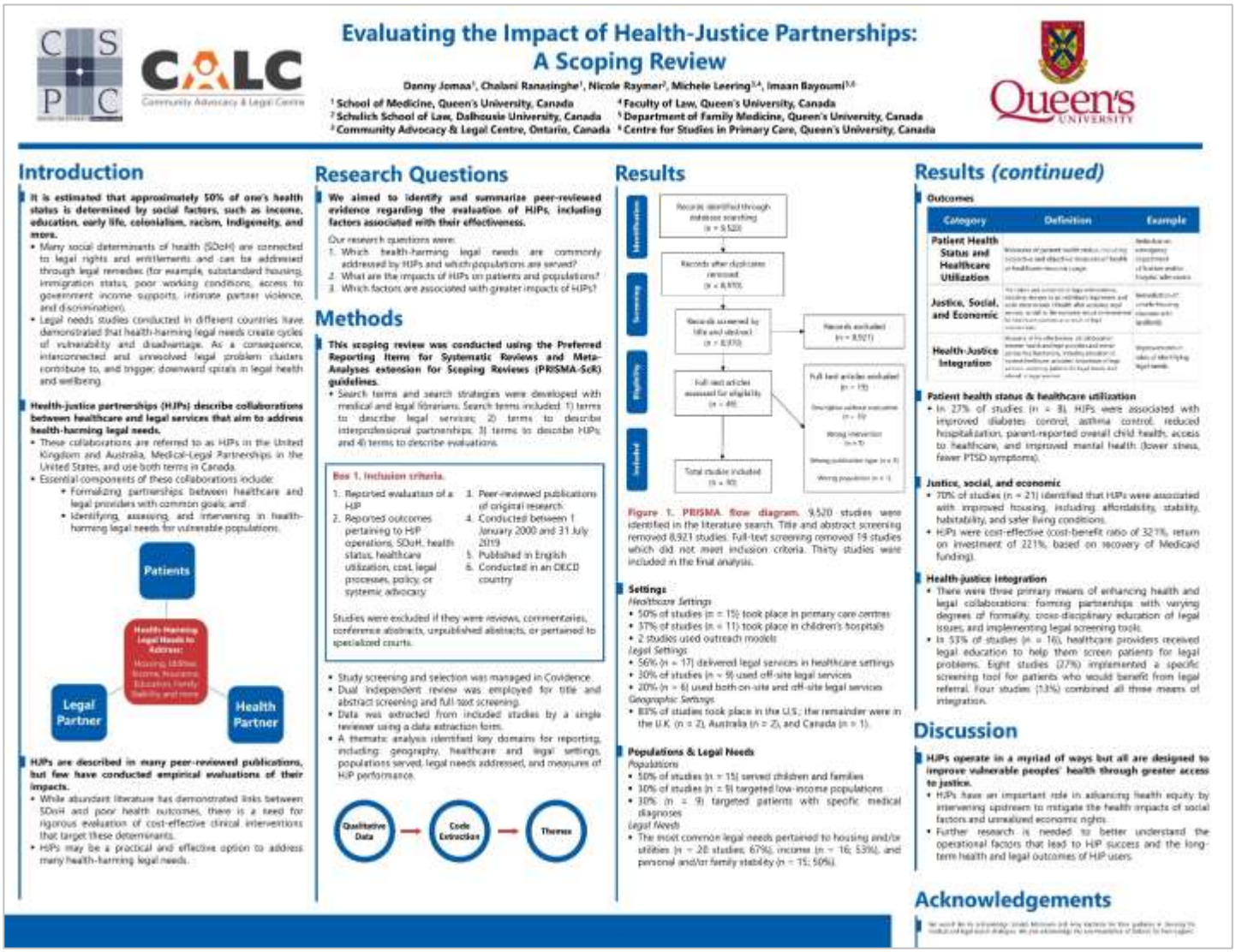
Due to the lack of training in law on research and evaluation, a taxonomy of terms related to research and evaluation should be developed for the proposed evaluation manual. Below is a draft list. A useful resource would be:

OECD-DAC. (2002). *Glossary of key terms in evaluation and results-based management.* ALNAP. https://www.alnap.org/help-library/glossary-of-key-terms-in-evaluation-and-results-based-management

Accountability	Inputs	Quintuple Aim framework
Action research	Interviews	Realist evaluation
Analysis – multivariate	Measurement indicators	Recall bias
Analysis – univariate	Mixed method designs	Reciprocity
Attribution error	NVivo Software	Regression analysis
Bias	Observation bias	Reliability
Case control study	Observational data	Research ethics
Case study	Observational research	Research methodology
Causal inferences	Operationalization (of concepts/terms)	Research methods
Chi square	Outcomes	Research purpose
Clinical outcomes	Outcome evaluation	Research questions
Cohort study	Outcome mapping	Return on investment (ROI)
Confirmation bias	Outputs	Sampling
Cost-benefit analysis	Participatory Research	Scoping review
Credibility	Patient/Caregiver Emotional Mapping	Social return on investment
Cross-sectional study	Patient Reported Experience Measures (PREMs)	Social sciences
Developmental evaluation	Patient Reported Outcome Measures (PROMs)	SPSS
Diagnosis	Performance measures	Statistical significance
Documentary review	Process outcomes	Step-wedged randomized control trial
Epidemiological	Process evaluation	STROBE statement
Evaluation	Program evaluation	Summative evaluation
Evidence-based medicine	Program logic model	Surveys (pre- and post)
Experienced-based design methodology	Proxy indicators	Systematic review
Experimental research	Publication bias	Theory of Change
Focus groups	Quadruple Aim framework	Transparency
Formative evaluation	Qualitative data analysis software (QDAS)	Triangulation
Hawthorne effect	Qualitative research	Triple Aim Framework
Impact evaluation	Quality improvement	Validated research instruments
Informed consent	Quantitative research	Validity
Inova	Questionnaires	Validity, ecological

Appendix I: Conference Poster – Scoping Review for North American Primary Care Research Group Conference (November 20, 2020)
Jomaa et al (2020, November)

NAPCRG Poster Presentation on Scoping Review by Queen's Department of Family Medicine
Conference: https://napcrg.org/conferences/2003/sessions/1885
Poster: https://communitylegalcentre.ca/tcodownloads/napcrg-2020-conf-scoping-review-poster/



Appendix J: American Jurisdictional Scan: Medical-legal Partnerships & Evaluation
Raymer (2021)

Full report at: https://communitylegalcentre.ca/tcodownloads/MIEP-US-jurisdictional-scan-2021

Introduction Excerpted From the Report:

This jurisdictional scan was undertaken as part of the Measuring Impacts & Evaluating Progress (MIEP) project with funding from the Law Foundation of Ontario. It addresses how medical-legal partnerships (MLPs) in the United States (US) evaluate their work, how and what kind of research has been conducted on their effectiveness, and what kind of outcomes or impacts have been documented. This scan describes and analyzes the peer-reviewed academic and grey literature about MLPs until 2020, including documents available from the National Center for Medical-Legal Partnership (NCMLP) and data from a key informant interview. The NCMLP supports existing partnerships and encourages new partnerships in the US. Founded in 2006, and housed at the Boston Medical Centre, it relocated to Washington, D.C., in 2013 and is now a project of the Department of Health Policy and Management at the Milken Institute School of Public Health at George Washington University.

The primary research question for this jurisdictional scan was: "How are American medical-legal partnerships and their programs/projects being evaluated?" To answer this question, we wanted to understand what type of partnerships existed, what types of initiatives or interventions were being evaluated or researched, who was undertaking the research, what research questions were being asked, and what evaluation frameworks or research methodologies were being used. Related to this we wanted to understand what type of data was being collected and how it was being collected, and what lessons were learned for future studies. We were also interested in whether literature was peer-reviewed, and if so, where it was published. We also wanted to learn more about what experts and researchers involved with the NCMLP or other organizations thought promising evaluation or research practices should be.

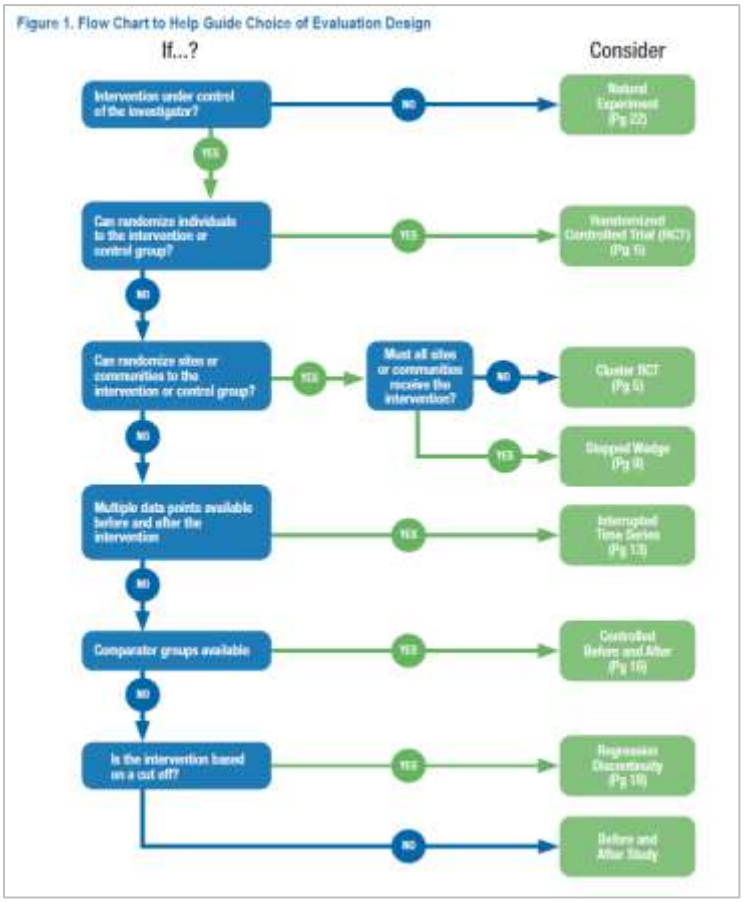
The answers to the primary and related questions and factors we gleaned from our review helped us to identify promising practices for evaluating these partnerships. This in turn will help us to consider what types of evaluation frameworks and research approaches might best benefit the fledgling but growing justice & health partnership movement in Ontario.

We first explain how we identified and collected relevant literature and data. Secondly, we explore what we learned when we analyzed the literature and interview data. This includes exploring how the research and evaluation approaches evolved, what other useful approaches have been recommended, and the evolving understanding of the multi-faceted nature of outcomes from these partnerships.

Appendix K: Annotated Bibliography of Useful Resources for Evaluators
(Leering & Raymer, 2021)

1. **Academy Health. (2017).** ***Evaluating complex health interventions: A guide to rigorous research designs.***
   https://academyhealth.org/sites/default/files/AH_Evaluation_Guide_FINAL.pdf

This guide provides a good explanation of different evaluation designs. It differentiates clearly between experimental/randomized, quasi-experimental, and observational study designs, providing examples of each. It has a short but useful glossary that quickly describes key terms. A notable contribution is a flowchart to help guide evaluation design choices, seen excerpted below (p. 4). The guide outlines the pros and cons of the different study design choices well.



Academy Health's flowchart to help investigators choose an evaluation design (2017, p. 4).

2. **Center for Community Health and Development at the University of Kansas. (n.d.)** ***Chapter 36: Introduction to evaluation*****. Community Tool Box**. https://ctb.ku.edu/en/table-of-contents/evaluate/evaluation

An online toolbox that provides many tips and tools for people working in community programs, including tools for evaluation. This chapter includes six sections, with an introductory section dedicated to planning evaluation and describing programs. Section 3 provides useful

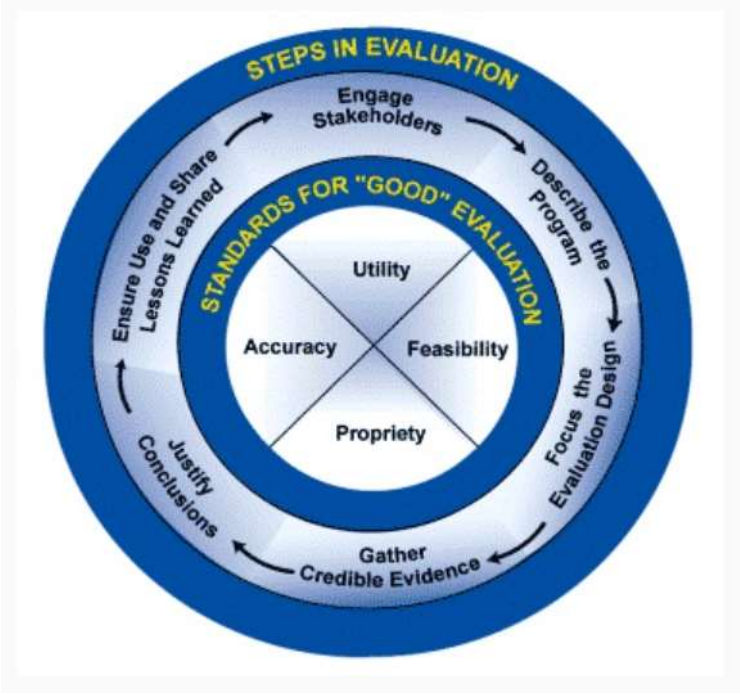
information in determining and understanding the interests of community leaders, evaluators, and funders. They also provide links to many other online and print evaluation resources. Each section has a checklist, example, tools and PowerPoint to facilitate understanding of the topic.

3. **Gamble, J.A.A. (2008). *A developmental evaluation primer*. Canada: The J.W. McConnell Family Foundation**. https://mcconnellfoundation.ca/wp-content/uploads/2017/07/A-Developmental-Evaluation-Primer-EN.pdf

This manual introduces and explains developmental evaluation. It contributes a good plain language description of developmental evaluation and addresses common myths and concerns well. It also identifies what programs are best suited to using developmental evaluation, and provides examples of organizations who have used it well.

4. **National Center for Chronic Disease Prevention and Health Promotion. (2011). *Developing an effective evaluation plan: Setting the course for effective program evaluation*. Centers for Disease Control and Prevention.** https://www.cdc.gov/obesity/downloads/cdc-evaluation-workbook-508.pdf

This guide endorses provides a six-step framework to guide evaluations, seen below. The steps are explored individually, breaking down the process clearly. It also articulates four standards for "good" evaluations and explains them. Useful in this manual are the planning documents and worksheets. As well as the checklist for ensuring effective evaluation reports.



CDC's Framework for program evaluation framework excerpted from National Center for Chronic Disease Prevention and Health Promotion, 2011 (page 5).

5. **Raine, R., Fitzpatrick, R., Barratt, H., Bevan, G., Black, N., Boaden, R., Bower, P., Campbell, M., Denis, J.L., Devers, K., Dixon-Woods, M., Fallowfield, L., Forder, J., Foy, R., Freemantle, N., Fulop, N.J., Gibbons, E., Gillies, C., Goulding, L., … Zwarenstein, M. (2016). Challenges, solutions, and future directions in the evaluation of service innovations in health care and public health.** ***Health Services and Delivery Research, 4*****(16), ISSN 2050-4349**. https://doi.org/10.3310/hsdr04160. https://www.ncbi.nlm.nih.gov/books/NBK361182/pdf/Bookshelf_NBK361182.pdf

This is a collection of individual essays on different evaluation topics or methods. The essays are mostly theoretical and some of the language is highly technical, but Essay 2 provides a good exploration of randomized control trials for complex interventions, including choosing study design and pragmatic issues. Essay 4 provides useful information on patient-reported outcomes measures, including common challenges. The exploration of different methodologies in Essay 6 is thorough, and Essay 7 contributes valuable information on contextual issues and qualitative research.

6. **Rural Health Information Hub. (n.d.)** ***Module 5: Evaluation considerations for social determinants of health programs***. https://www.ruralhealthinfo.org/toolkits/sdoh/5/evaluation

This website provides numerous evaluation toolkits, including a toolkit specific to evaluating social determinants of health programs. This toolkit makes several important points, including that to plan a program evaluation, there needs to be a rational for how the program will achieve desired outcomes. They endorse the development of logic models or theories of change to identify measurable results. They also suggest measuring return on investment to help funders and other stakeholders see financial value in investing in the social determinants of health. Community-based participatory research is promoted as a way to amplify the voices of residents not usually included in the traditional research process. Finally, they recommend tailoring evaluation strategies to promote ownership of data, consent, and accuracy of vulnerable populations historically harms by unethical research practices.

7. **Snelling, S., & Meserve, A. (2016).** ***Evaluating health promotion programs: introductory workbook*****. Public Health Ontario. Queen's Printer for Ontario**. https://www.publichealthontario.ca/-/media/documents/E/2016/evaluating-hp-programs-workbook.pdf?la=en

This workbook provides a 10-step program evaluation framework. This clearly identifies each of the steps, why they are important, and how to facilitate them. Each step also includes reflection questions, a summary, and a worksheet. Particularly useful are steps 7 – 9 on collecting data, processing data and analyzing results, and interpreting and disseminating the results. A good discussion on the ethical considerations in Step 7: Collect Data is notable.

8. **Tewolde, H., & McKeown, J. (2018).** ***HEQCO's program evaluation manual – For programs related to access and retention*****. Higher Education Quality Council of Ontario**. https://heqco.ca/pub/heqcos-program-evaluation-manual-for-programs-related-to-access-and-retention/

This manual offers a good overview of practical considerations for developing evaluations. It provides great pragmatic advice. While focused on evaluating programs to enhance student participation, the manual is broad enough to guide evaluations beyond their target programs. It provides good information for establishing the purpose and scope of evaluations. The manual is especially great for its focus on issues of sampling, quantitative data analysis, and research ethics. An example of this is the comparison of information gathering techniques, seen below (p. 20).

Table 2: Comparison of Techniques for Gathering Information from People

Description	Pros	Cons
Close-ended Surveys Collects info from large groups about topics that are neither complex nor sensitive using clearly defined questions and predetermined answers	• High reliability • Efficient data collection • Simple data analysis • Low cost	• Difficult to construct • Self-report can cause bias • Impersonal and lacking context • Limited validity • Not suitable for complex or sensitive topics
Open-ended Surveys[13] Collects info from moderately sized groups prompting open responses to clearly defined questions on topics that can be somewhat complex or sensitive	• Moderate validity • Efficient data collection • Moderate cost	• Difficult to construct • Self-report can cause bias • Impersonal • Difficult data analysis • Limited reliability
Interviews Collects rich contextual or behavioural info about feelings and/or opinions from a small sample of knowledgeable people	• Produces rich data • Allows interpersonal contact • High validity • Suitable for complex/sensitive and high-status respondents	• Requires trained interviewers • Lengthy data collection • Difficult data analysis • Limited reliability • High cost
Focus Groups Collects relatively non-sensitive info from groups of 8–12 people when group interactions can be harnessed to stimulate rich responses	• Produces rich data • Allows interpersonal contact • High validity • Moderately efficient data collection • Moderate cost	• Requires trained interviewers • Difficult data analysis • Limited reliability
Observation Collects data on a wide range of behaviours to learn about issues that program staff or participants may be unaware of, or unable or unwilling to discuss	• Produces direct and holistic data about behaviours • Provides good sense of context to evaluator • Occurs in natural, unstructured settings	• Requires trained observers • Potential for biased data (e.g., wary participants, selective perception) • Difficult data analysis • Limited reliability • High cost

Source: Adapted from National Science Foundation, 2002; Baker, n.d.

9. **W.K. Kellogg Foundation. (2017). *The step-by-step guide to evaluation*. W.K. Kellogg Foundation**. https://www.wkkf.org/resource-directory/resources/2017/11/the-step-by-step-guide-to-evaluation--how-to-become-savvy-evaluation-consumers

Notable contributions are the descriptions of different types of evaluation, as well as the contribution of evaluative thinking (and a learning organization focus) to program evaluation. Offers step-by-step de-mystification guide to designing and carrying out evaluations

supplemented by their 2006 *Logic Model Development Guide*. Highly useful is its plain language description of data collection methods – including quantitative, qualitative and mixed method approaches, and how to analyse and interpret the data. This guide pays particular attention to community and stakeholder engagement, racial equity and the importance of culture in evaluation.

10. **W.K. Kellogg Foundation. (2006). *Logic model development guide.* W.K. Kellogg Foundation**. https://www.aacu.org/sites/default/files/LogicModel.pdf

This guide provides a good description on what a program logic model is, how they can lead to successful program evaluations, the different types of logic models, and how to develop a program logic model for your program. The first three chapters focus on the benefits of models and how to develop basic models, with Chapter 4 going in-depth on how the logic model can be used in evaluation. The guide provides useful templates, checklists, and exercises to walk through logic models from inception to practice.

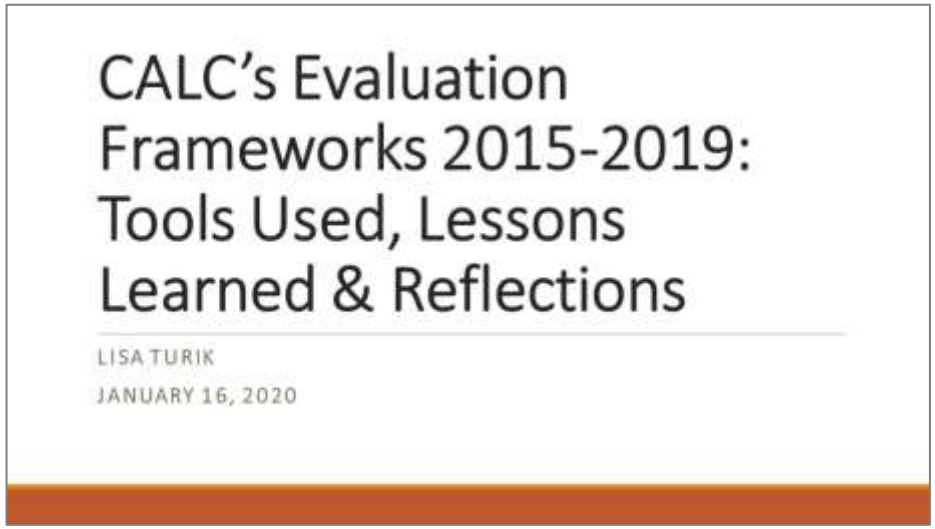
11. **Zarinpoush, F. (2006). *Project evaluation guide for non-profit evaluations: Fundamental methods and steps for conducting program evaluation*. Imagine Canada**. http://sectorsource.ca/sites/default/files/resources/files/projectguide_final.pdf

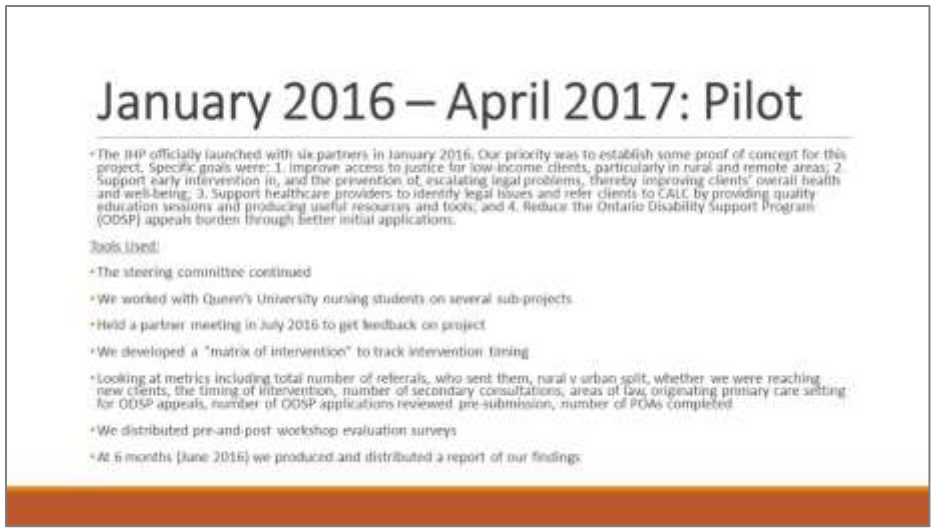
Another step-by-step guide with useful materials on how to create an evaluation plan, and how to monitor program activity. Contains a useful glossary of research and evaluation terms. The template for choosing data collection methods to respond to research questions is also useful. Practical tips on how to conduct interviews, hold focus groups, and design survey are helpful also.

Appendix L: Taxonomy of Health Justice Related Terms

Access to justice	Medical-legal partnerships
Civil legal needs	Patient-centred care
Cold referral	Paths to justice
Early intervention	People-centred justice
Health equity	Preventative care
Health-harming legal needs	Public legal education
Health justice approaches	Referral fatigue
Health justice landscape	Reflective practice
Health justice partnership	Screening tools
Holistic	Secondary consultations
Holistic defence	Signposting
Hot referral	Social determinants of health
I-HELP categories	Structural determinants of health
Interprofessional care	Structural determinants of mental health
Justice & health partnership	Systemic advocacy
Justice ecosystem	Triage
Law reform	Trusted intermediaries
Legal capability	Warm referral
Legal care	
Legal consciousness	
Legal empowerment	
Legal health	
Legal health check-up	
Legal information	
Legal literacy	
Legal needs assessment	
Legal representation	

Appendix M: Summary of CALC's Evaluation Framework 2015-2019
Turik, L. (2020)
https://communitylegalcentre.ca/tcodownloads/calc-evaluation-frameworks-2015-2019-and-lessons-learned/





January 2016 – April 2017: Pilot

What We Learned

- None of the goal statements could really be accessed directly. They all required proxy measures
- Evaluation was laborious as many of the metrics we were using had to be manually pulled
- Things were happening that couldn't really be captured by data alone
- Possible consistency or bias issues with timing of intervention, even relying on the "matrix of intervention", since project lead was reviewing and coding these

What We Would Change

- Going forward it would be impossible to continue the same level of data collection and reporting - just too much staff time was required. On top of that a new case management computer program (CIMS) in May 2017 would make it impossible to get even the data we had been able to extract easily from the old system
- We wanted to incorporate qualitative measures

May 2017 – Ongoing: CIMS

- New case management software rolled out in May 2017 and proves to be an ongoing challenge.

Tools Used:

- Limited metrics: number of referrals, originating location for referrals, number of workshops and number of healthcare providers in attendance

What We Learned

- CIMS is an ongoing challenge.
- Legal clinics use CIMS very differently from one another.

What We Would Change

- Since "throw it out the window" sadly isn't an option... we have gradually been able to find some strategies that work. We need to have conversations with other clinics running JHPs about how they are collecting information in CIMS so that eventually stats could be compared

Summer 2017: Partner Survey

- We wanted to get some data on the partner perspective to the project. Specifically we wanted to know – did they feel the project supported them to make referrals? Were they satisfied with learning opportunities and CALC supports? Did the project help to build confidence identifying legal issues? Overall did they feel the JHP was helpful to them, and helpful to their patients?

Tools Used:

- Survey Monkey – anonymous response
- Focus Group – partner meeting in September 2017

What We Learned

- This worked pretty well to get the big picture, gave us the information we were looking for, but some comments were confusing and there was no easy way to follow up since survey was anonymous
- The response rate was decent overall, but with some glitches, for ex one organization did not respond at all

What We Would Change

- Could consider some key informant interviews in addition to the survey

Fall 2017 - Ongoing: Logic Model

- Our efforts to capture the bigger picture of what this project was doing and search for something to help guide our thoughts about evaluation led us to creation of a logic model. It has been revised several times as the project has progressed (most recently Sept 2019)

Tools Used:

- Logic model

What We Learned

- Through creation of the logic model we began to see there was even more going on with this project than we realized.
- We started to feel strongly that we needed to get some dedicated funding in place to work on evaluation frameworks for these kinds of projects– and we needed expert help
- Logic models are useful tools but can be daunting for lawyers (and others!) who've never worked with them before – having one done as a model or working with people who have experience can help

Summer 2019: Mapping Study

- We wanted to better understand the landscape of JHPs in Ontario

Tools Used:

- Survey Monkey
- Key Informant Interviews

What We Learned

- The combination of survey monkey and key informant interviews worked well to give a sense of the number and scope of projects in Ontario

June 2019 – June 2020: LFO Project

- In late 2018 the Law Foundation of Ontario put out a granting call for applications dedicated to evaluation – this seemed the perfect opportunity and just what we'd been looking for to build out our evaluation of the project. We applied and were successful with a project to create evaluation methodologies and resources for justice & health partnerships

Tools Used:

- Interdisciplinary Advisory Committee / learning from each other
- Scoping review
- Key international informant interviews
- US MLP evaluation frameworks review
- Taxonomy of terms

What We Learned & What We Would Change

- Stay tuned!

Other Evaluation Strategies

Tools Used:

- Learning log
- Guided professional journal entries
- Case studies
- Monthly "action plan" reports to our Board
- Yearly internal project reports
- Yearly annual report to the public
- Yearly meeting with all partners, more frequent debriefing with individual partners

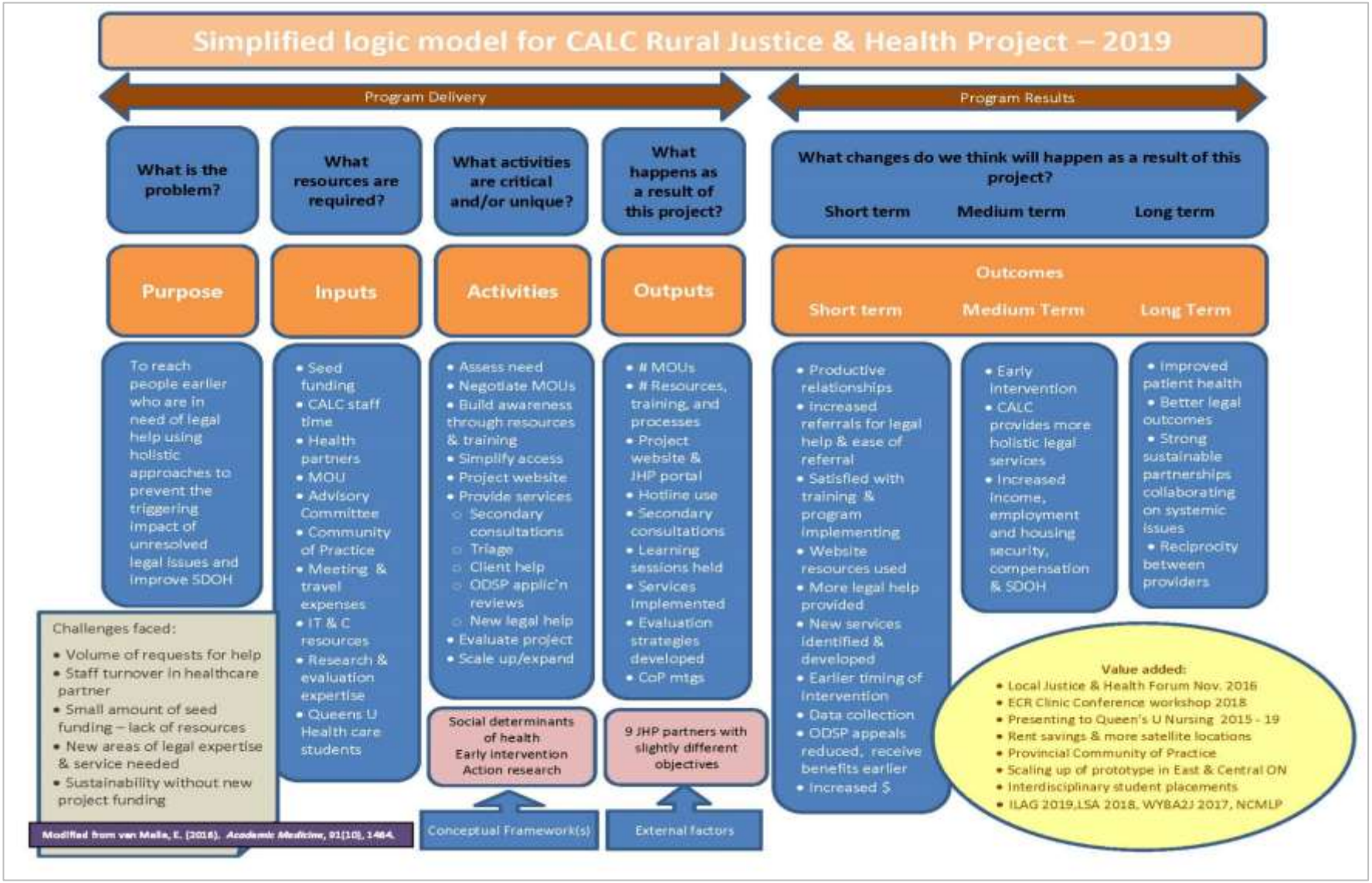
What We Learned & What We Would Change

- As the project has developed there has been a sprawl – both in terms of what we are doing and what we are measuring, tracking, evaluating. It may be time for some streamlining.

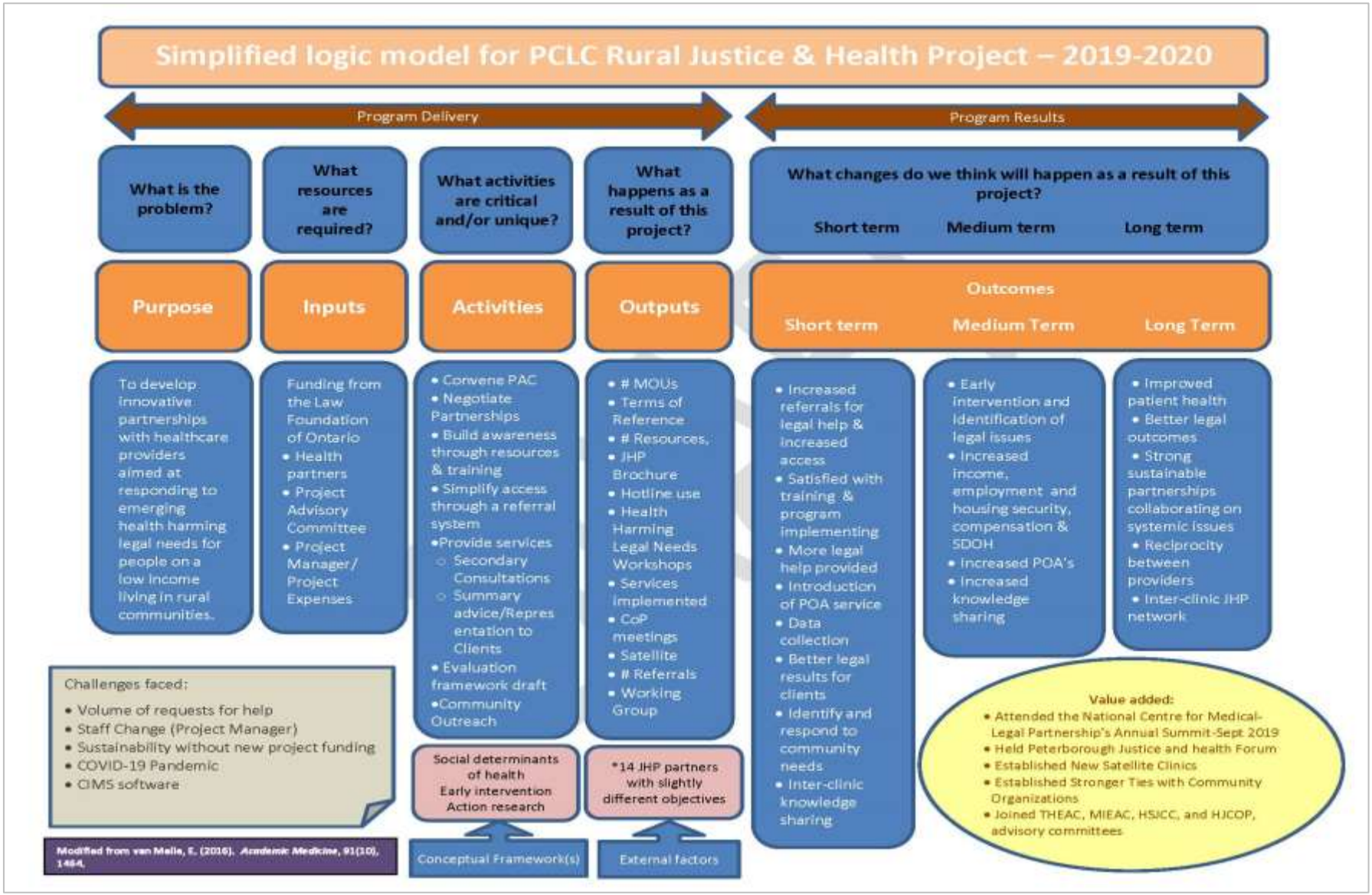
Reflections & Questions

- Trying to evaluate this project has been an exercise in how much we can do with very scarce resources - in terms of money, knowledge, and time
  - Since CIMS, even collecting basic metrics like "number of referrals" feels unreliable, onerous and unsustainable at times (and we are very resourceful and experienced!)
  - Many legal clinics in Ontario have even fewer resources than CALC – we are seeing the "solution" for some with JHPs is not to do any evaluation.
  - If we are to spread this movement, then question becomes how to get buy-in for these projects, especially around evaluation? How to get data that can be contrasted and compared?
- We have been experimenting with a number of approaches but it's still hard to get at the overall impact of these projects – on access to justice, improved health/well-being

Appendix N: CALC's Local JHP Program Logic Models (2019)



Appendix O: Proposed Program Logic Model Piloted for CR Rural Grant to PCLC
(CALC, 2020)



Appendix P: Proposed Interim Template to Analyze Data Collection Strategies
(CALC, 2020)

SAMPLE JHP Interim Working Template – Measurement Indicators – Discern/record data collection decisions – Draft – May 2021
(Working from Piloting PCLC's Draft Logic Model: **Short term Outcomes**) Key: HCP = health care provider; LSP = Legal service provider

Program results - Outcome or output to be measured	Measurement indicator	Preliminary concern	Data collection source	Alternative source	Data collection method or tool	Challenges anticipated	Possible new questions or concerns arising	Other
Increase in client referrals for legal help from HCP (& increased access to LSP – see "more legal help" provided below for this aspect)	Number of referrals	Pre-project baseline is needed NB. Pre-project source of referrals must be tracked	Statistics program that can record where people are referred from to generate reports	EXCEL chart	Service records must be tagged as referred by HCP Run statistical report on appropriate fields pre and post	Stats program may need to be modified to collect data. Staff members must enter data consistently	Query if multiple HCP and whether should distinguish? Do all clients referred by HCP, actually follow-up on HCP referrals? If this is an implementation concern will need to collect data from HCP, and compare	Do we have any concerns with knowing what type of client? See example below re rural/urban split if this is a project objective.
Increase in HCP referrals for legal help (secondary consultations)	Number of referrals	Pre-project baseline is needed	Statistics program	EXCEL chart	Service records must be tagged with HCP Run statistical report on appropriate fields	Same as above	Are there different kinds of secondary consultations? With client, without client? If this is of interest, will need to decide how to monitor. More complicated analysis will be required	
Possible enhancement given project funding for rural A2J: Reach more rural residents than had previously. Referrals received are proportionate to percentages of urban/rural people in catchment area	Whether client resides in urban or rural area	Need to know and/or define catchment area's urban/rural split Pre-project baseline is needed	Statistics program	EXCEL CHART	Service records must be tagged with urban/rural or other appropriate field that would identify as rural or urban	Same as above Query whether existing mandatory field such as postal code can distinguish rural from urban to avoid additional tagging	Additional record-keeping task introduces risk of incomplete data	
More legal help provided (What legal services were requested and received)	Legal service provided	Pre-project baseline is needed Also pre-project case selection criteria/service menu	Statistics program LSP Policy documents	EXCEL CHART	Generate report from tagged client data records with fields for service type and area of law Compare pre and post	Analysing this data efficiently	Are we able to meet new needs? Are we turning people away because we don't offer this help? Do we need to inform HCP to refer consistently with our case selection policy OR do we want to be responsive to new needs - will we have to modify case selection policy? Offer new legal services	May impact on future LSP service provision if want to be responsive to unmet need

1

SAMPLE JHP Interim Working Template – Measurement Indicators – Discern/record data collection decisions – Draft – May 2021

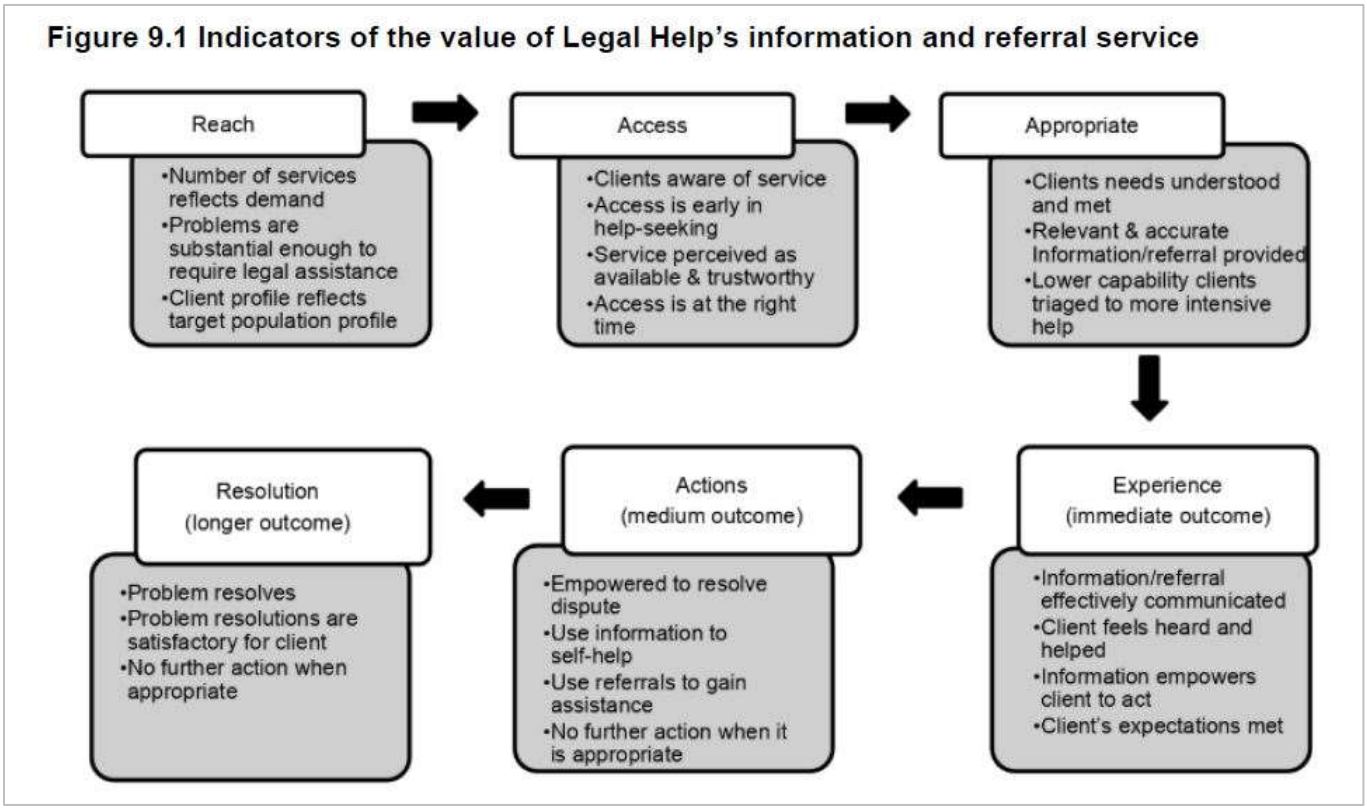
(Working from Piloting PCLC's Draft Logic Model: **Short term Outcomes**) Key: HCP = health care provider; LSP = Legal service provider

Program results - Outcome or output to be measured	Measurement indicator	Preliminary concern	Data collection source	Alternative source	Data collection method or tool	Challenges anticipated	Possible new questions or concerns arising	Other
HCP satisfied with training and implementing of program	Level of HCP satisfaction	Must negotiate with HCP in advance how this will be monitored Operationalize "satisfaction"	MOU records program offerings MOU documents how program will be evaluated Create surveys or interview scripts to monitor satisfaction.	Meeting notes of discussions Email or other correspondence	Record keeping in Project Lead log Use software such as Survey Monkey to collect survey data. Schedule interviews (create notes/transcripts for analysis)	Consider issues of informed consent when collecting data. Consider how to ensure clear and honest communication. Time to analyse data.	Is satisfaction the right measure? Should we be concerned about whether the training is effective? For example, should we consider pre- and post survey of training participants? For program implementation, should we be instead concerned that we are modifying to improve results as we go?	Consider re-wording this outcome to be more specific. Consider training separately from program implementation.
Earlier timing of intervention	Timing of intervention	Operationalize the term "early intervention" for each possible legal issue Decide how to tag record for whether meets "early" criteria	Statistics program Client file record	EXCEL chart	Tag record in statistics program Generate report from appropriate fields	Accurate and consistent record-keeping by all staff (may need to spot check a certain number to ensure adequate)	"Earlier" timing is misleading a the true concern would be that the intervention is "early" in a problem's development to avoid, where possible, more serious adverse or spiralling consequences.	Consider re-wording this outcome to be more specific to the desired change that is envisioned
Sample MEDIUM Term outcome: Increased income, employment, and housing security and compensation (areas of law related to SDOH)	Amount of compensation generated Type of security that resulted from intervention. Query if intervention was only information or advice vs. representation – can results be attributed or even monitored (would have to follow-up to record)	Ensure client confidentiality Need for enhanced record-keeping on client case results (change in practice) Will need to operationalize "security" types (i.e. retained housing)	Statistics program Client file record	EXCEL chart	Create new fields to capture this data in stats program Generate report	Same as above Decide on how economic results will be quantified (i.e. if receive disability pension, what calculation is used?)	Impact of a multitude of possible intervening factors may need to be considered that impact on and distort results Collecting this data for information or advice services only may be cost-prohibitive	

Appendix Q: Value Indicators - Telephone Legal Information Services for Victoria Legal Aid
Mirrlees-Black (2020)

Figure 9.1: Indicators of the Value for Legal Help's Information and Referral Service (LJFNSW, 2020, p. 98)

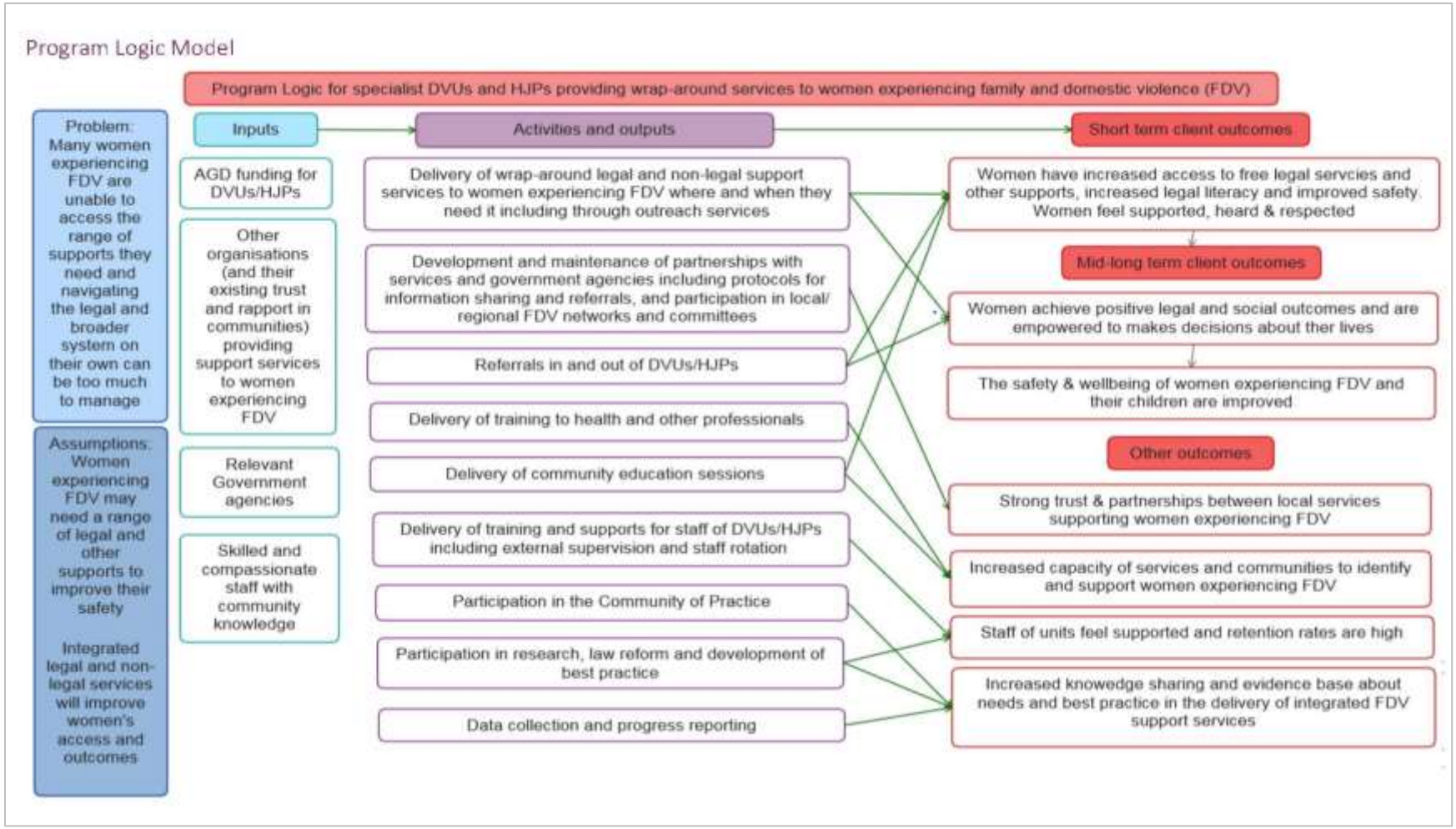
http://www.lawfoundation.net.au/ljf/site/articleIDs/6893EB76A34C4F158525856D0028BFFC/$file/Law%20Informed%20-%20Final.pdf



Appendix R: Program Logic Model for Evaluating for Australian DV HJPs
Social Compass (2019)

Evaluation of the Pilot Program of Specialist Domestic Violence Units and Health Justice Partnerships Established Under the Women's Safety Package, p. 47

https://www.ag.gov.au/sites/default/files/2020-03/final-report-evaluation-of-the-dvus-and-hjps.pdf



Appendix S: Possible Evaluation Criteria, Questions and Indicators

Social Compass (2019)

Social Compass (2019), Appendix A, Possible evaluation criteria, questions and indicators, pp. 51-52

Criteria	Evaluation question	Indicators
Enables legal and non-legal benefits for women accessing the services	To what extent are women accessing DVUs/HJPs experiencing legal and non-legal outcomes?	• Outcomes identified by clients • Outcomes identified by managers, staff of DVUs/HJPs. Staff of partner organisations • Legal and non-legal services delivered
Access: Reaching women most in need	To what extent are DVUs/HJPs accessing women most in need?	• Client demographics • Perspectives of managers and staff of DVUs/HJPs and partner organisations
Builds strong collaborative partnerships in the delivery of wrap-around services	To what extent are DVUs/HJPs building strong collaborative partnerships in the delivery of wrap-around services? To what extent are DVU/HJP staff collaborating internally in the delivery of wrap-around services?	• Referrals to and from other services and agencies • Development and utilisation of protocols for client referrals, risk assessment and information sharing • MoUs with hospitals and other relevant services • Perspectives of managers and staff of DVUs/HJPs and partner organisations • Perspectives of clients
Enables outcomes for other stakeholders supporting women experiencing FDV	To what extent are DVUs/HJPs enabling other outcomes?	• Increase in capacity of staff in health settings to identify, refer and support women experiencing FDV • Perspectives of managers and staff of DVUs/HJPs and partner organisations • Delivery of community education sessions • Participation in the community of practice • Participation in local and regional FDV networks and reference groups • Participation in research and law reform work
Supports staff to deal with the difficult nature of the work	To what extent are staff supported to deal with the difficult nature of the work?	• Staff support activities provided • Role rotation to allow time away from frontline client services • Perspectives of managers and staff of DVUs/HJPs
Innovates strategies to overcome barriers to service delivery and client access	To what extent are DVUs/HJPs innovating local strategies to overcome barriers?	• Barriers identified • Implemented strategies • Perspectives of managers and staff of DVUs/HJPs and partner organisations
A community of practice approach identifies best practice in the delivery of FDV services	To what extent is the community of practice informing DVU/HJP service delivery?	• Participation in CoP • Perspectives of participants
Prioritises safety	To what extent are DVUs/HJPs prioritising women's safety?	• Safety plans developed • Risk assessments • Other safety strategies in place
Tailors services to the needs and capacity of clients	To what extent are DVUs/HJPs tailoring services to the needs and capacity of clients?	• Outreach services provided • Length of appointments • Perspectives of clients • Perspectives of managers and staff of DVUs/HJPs and partner organisations
Provides flexible services to respond to local community needs and gaps in services	To what extent are DVUs/HJPS providing flexible services to respond to local community needs and gaps in services?	• Consultation with other services in design of unit • Outreach services provided • Perspectives of clients • Perspectives of managers and staff of DVUs/HJPs and partner organisations
Delivers trauma-informed services	To what extent are DVUs/HJPs delivering trauma informed services?	• Trauma-informed training delivered • Perspectives of clients • Perspectives of managers and staff of DVUs/HJPs and partner organisations
Delivers culturally appropriate services	To what extent are DVUs/HJPs delivering culturally appropriate services?	• Use of interpreters • CALD and Indigenous staff • Perspectives of clients • Perspectives of managers and staff of DVUs/HJPs and partner organisations
Skilled, experienced, compassionate staff	To what extent are DVUs/HJPs employing skilled, experienced and compassionate staff?	• Training delivered to staff • Perspectives of clients • Perspectives of managers and staff of DVUs/HJPs and partner organisations

Appendix T: Partnership Checklist (Australia)
VicHealth (2011)
https://www.vichealth.vic.gov.au/search/the-partnerships-analysis-tool

VicHealth

vichealth.vic.gov.au

The checklist

Rate your level of agreement with each of the statements below, with 1 indicating strong disagreement and 5 indicating strong agreement. The scores will be totalled automatically. To save your checklist, select 'File'/'Save As'/'PDF'. You can then name your checklist and email it to your partner organisations as an attachment.

	1 Strongly disagree	2 Disagree	3 Not sure	4 Agree	5 Strongly agree	
1. Determining the need for the partnership						
There is a perceived need for the partnership in terms of areas of common interest and complementary capacity.	O	O	O	O	O	
There is a clear goal for the partnership.	O	O	O	O	O	
There is a shared understanding of, and commitment to, this goal among all potential partners.	O	O	O	O	O	
The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal.	O	O	O	O	O	
The perceived benefits of the partnership outweigh the perceived costs.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0
2. Choosing partners						
The partners share common ideologies, interests and approaches.	O	O	O	O	O	
The partners see their core business as partially interdependent.	O	O	O	O	O	
There is a history of good relations between the partners.	O	O	O	O	O	
The partnership brings added prestige to the partners individually as well as collectively.	O	O	O	O	O	
There is enough variety among members to have a comprehensive understanding of the issues being addressed.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0
3. Making sure partnerships work						
The managers in each organisation (or division) support the partnership.	O	O	O	O	O	
Partners have the necessary skills for collaborative action.	O	O	O	O	O	
There are strategies to enhance the skills of the partnership through increasing the membership or workforce development.	O	O	O	O	O	
The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners.	O	O	O	O	O	
The administrative, communication and decision-making structure of the partnership is as simple as possible.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0
4. Planning collaborative action						
All partners are involved in planning and setting priorities for collaborative action.	O	O	O	O	O	
Partners have the task of communicating and promoting the partnership in their own organisations.	O	O	O	O	O	
Some staff have roles that cross the traditional boundaries that exist between agencies or divisions in the partnership.	O	O	O	O	O	
The lines of communication, roles and expectations of partners are clear.	O	O	O	O	O	
There is a participatory decision-making system that is accountable, responsive and inclusive.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0

	1 Strongly disagree	2 Disagree	3 Not sure	4 Agree	5 Strongly agree	
5. Implementing collaborative action						
Processes that are common across agencies have been standardised (e.g. referral protocols, service standards, data collection and reporting mechanisms).	O	O	O	O	O	
There is an investment in the partnership of time, personnel, materials or facilities.	O	O	O	O	O	
Collaborative action by staff and reciprocity between agencies is rewarded by management.	O	O	O	O	O	
The action is adding value (rather than duplicating services) for the community, clients or agencies involved in the partnership.	O	O	O	O	O	
There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0
6. Minimising the barriers to partnerships						
Differences in organisational priorities, goals and tasks have been addressed.	O	O	O	O	O	
There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership.	O	O	O	O	O	
There are formal structures for sharing information and resolving demarcation disputes.	O	O	O	O	O	
There are informal ways of achieving this.	O	O	O	O	O	
There are strategies to ensure alternative views are expressed within the partnership.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0
7. Reflecting on and continuing the partnership						
There are processes for recognising and celebrating collective achievements and/or individual contributions.	O	O	O	O	O	
The partnership can demonstrate or document the outcomes of its collective work.	O	O	O	O	O	
There is a clear need for and commitment to continuing the collaboration in the medium term.	O	O	O	O	O	
There are resources available from either internal or external sources to continue the partnership.	O	O	O	O	O	
There is a way of reviewing the range of partners and bringing in new members or removing some.	O	O	O	O	O	SUBTOTAL
SUBTOTAL						0

Aggregate score	**TOTAL**
1. Determining the need for the partnership	0
2. Choosing partners	0
3. Making sure partnerships work	0
4. Planning collaborative action	0
5. Implementing collaborative action	0
6. Minimising the barriers to partnerships	0
7. Reflecting on and continuing the partnership	0
TOTAL	0

Checklist score

35–84 The whole idea of a partnership should be rigorously questioned.

85–126 The partnership is moving in the right direction but it will need more attention if it is going to be really successful.

127–175 A partnership based on genuine collaboration has been established. The challenge is to maintain its impetus and build on the current success.

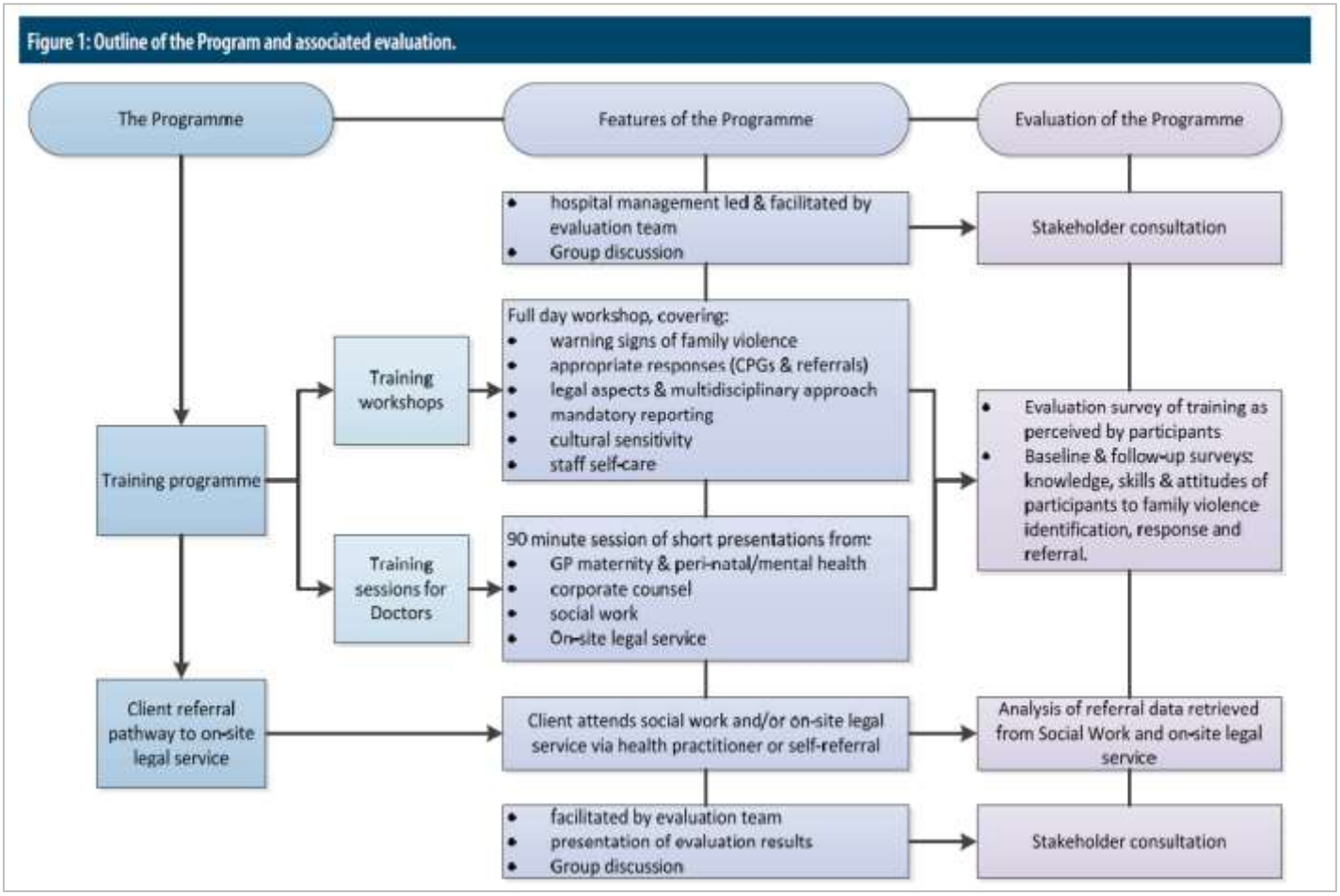
Appendix U: Program Logic Model for Partners in Care Evaluation
IMCL report (2018)

https://imcl.org.au/assets/downloads/IMCL_report_FA_web.pdf), p.17

Appendix V: Outline of the HJP Program and associated evaluation
Forsdike et al. (2018)

Figure 1 from *An Australian hospital's training program and referral pathway within a multi-disciplinary health-justice partnership addressing family violence*, Australian and New Zealand Journal of Public Health 42 (16), p.286, November 2017.

https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12743



Appendix W: Conceptualizing HJP Interprofessional Working (Stepwise conceptual framework)

Ries (2021)

APPENDIX

Adding a Lawyer to the Interprofessional Mix: A Conceptual Framework

Health, social care and legal professional groups work together to positively impact care, as well as health and justice outcomes.

This Appendix provides a stepwise conceptual framework to guide design, implementation, evaluation and research. **Step 1** involves determining the nature of the interprofessional arrangement at the level of the service model. **Step 2** involves ***zooming in*** to characterize the dimensions of interprofessional activity and how they connect practitioners from different disciplines. **Step 3** involves ***zooming out*** to consider the factors across macro, meso and micro levels that influence interprofessional arrangements.

STEP 1: What is nature of the arrangement that connects health, social and legal care?

What is the nature of the service model?

- ❑ A healthcare organization and a legal organization form a relationship where a lawyer is considered part of the team for patient care and assistance → **partnership**
  - This involves both interorganizational and interprofessional relationships (considered at Step 2)
  - Components to clarify the partnership relationship:
    - Prepare a formal agreement (memorandum of understanding) with roles and responsibilities of partnering organizations
    - Define the target patient population
    - Determine a process to identify patients' legal needs
    - Define practitioner roles
    - Provide for on-site lawyer
    - Deliver practitioner training
    - Establish information sharing arrangements
    - Ensure dedicated funding for the arrangement
- ❑ Lawyer is employed by a health organization → **integrated service**
  This involves interprofessional relationships (considered at Step 2)
- ❑ Lawyer from legal organization visits clients in health care setting but is not considered part of care team → **outreach**
- ❑ Legal service operates from a healthcare site, but is operationally separate → **co-located service**
- ❑ Health, legal and other services operate from the same community location (eg, housing estate), but are operationally separate → **service hub**

Note: Students from various disciplines, including medicine, nursing, allied health, social work and law, may be supervised in practical training in any of the above models. However, interprofessional education initiatives, such as student-led clinics, are not the focus of this framework.

[Sources: Regenstein et al., 2018; Forell and Boyd-Caine, 2018; Beardon and Genn, 2018]

Step 2 – Zooming In: How do practitioners work together?

The dimensions of interprofessional activity

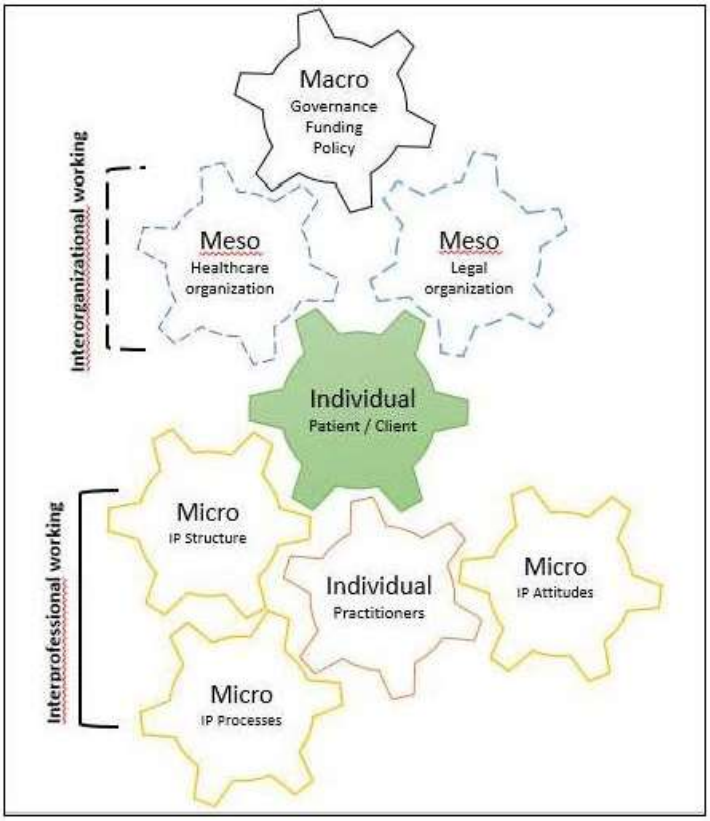
Simplified Inter Professional Activity Classification Tool

• indicates level of intensity

Dimensions / Activity type	Shared commitment	Shared identity	Clear team goals	Clear roles and responsibilities	Interdependence among practitioners	Integration of work practices
Teamwork	••••	••••	••••	••••	••••	••••
Collaboration	••••	•••	•••	•••	•••	•••
Coordination	•••	•••	•••	••	••	••
Networking	••	••	••	•	•	•

[Modified from Xyrichis et al., 2018] The authors identified sub-types within collaboration and coordination that are not included here.]

Step 3 – Zooming Out: Factors that Influence Interprofessional arrangements



[The Gears model is adapted from Mulvale et al., 2016]

Note: This conceptual framework can be applied as a stepwise, cyclical process. After working through the three steps, users can cycle back to Step 1 to re-consider the choice of service model.

Appendix X1: Questions for Planning Stage of an Evaluation
Australian Government Productivity Commission (2020a)

Table 1, p. 22, Questions to consider at the planning stage of an evaluation
https://www.pc.gov.au/inquiries/completed/indigenous-evaluation/strategy/indigenous-evaluation-background.pdf

Table 1 **Questions to consider at the planning stage of an evaluation**

The main steps in evaluation	*Questions to consider*
Define the policy objectives and outcomes to identify what to evaluate	What is the program logic or theory of change? Is the program logic clear on how the program outcomes are expected to be achieved and how these are linked to higher-level outcomes? Do the intended outcomes align to those identified by Aboriginal and Torres Strait Islander people and other stakeholders?
Identify and engage with those who will be affected by the policy or program	Who will be affected by the policy or program? (This should include those involved in delivering the initiative, users/recipients, others affected by the policy or program, and those interested in the evaluation results.) What is the likely impact on Aboriginal and Torres Strait Islander people or communities?
Identify the evaluation questions	What do policy makers and those affected by the policy or program need to know? (Have evaluation questions been decided on with Aboriginal and Torres Strait Islander people and other main users of the evaluation results?)
Select an evaluation approach and method(s)	What approaches and methods will answer each of the evaluation questions (will they require a formative, process, impact evaluation, or some combination)? Have the approaches and methods been decided on with those affected by the policy or program? Have contextual factors that are likely to influence outcomes been identified?
Identify data requirements (quality evaluations require good data)	What data are required? What is already being collected/available? What processes need to be put in place to allow the data to be collected? (If undertaking an impact evaluation, how will baselines be collected and when will impact be measured?) Are the data or the collection methods used responsive to the needs, rights and cultural safety of Aboriginal and Torres Strait Islander people?
Identify ethics requirements	What ethics processes are required? Has time been allowed for ethics processes?
Identify resource and governance needs	What level of resourcing is required for the evaluation? Does the evaluation plan allow sufficient time and resources to engage meaningfully with Aboriginal and Torres Strait Islander people at each stage of the evaluation? What governance arrangements (a steering group or peer review) will need to be put in place? What quality control processes will there be?
Conduct the evaluation	Will the evaluation be conducted internally or be externally commissioned? Who will be responsible for tendering, project management and quality assurance? Will the evaluation best be co-designed or Indigenous-led?
Use and disseminate the evaluation findings	What will the findings be used for? How will the findings be shared and disseminated? Will it be necessary to present the findings in different formats for different users? What approaches will be used to ensure information is considered during relevant policy decision making?

22 INDIGENOUS EVALUATION STRATEGY
BACKGROUND PAPER

Appendix X2: Criteria for Deciding on Evaluation Type
Australian Government Productivity Commission (2020a)

Table 2, p. 27, What type of evaluation? It will depend on the purpose and the questions you want answered
https://www.pc.gov.au/inquiries/completed/indigenous-evaluation/strategy/indigenous-evaluation-background.pdf

Table 2 **What type of evaluation? It will depend on the purpose and the questions you want answered**

Evaluation type	*Questions*	*Purpose*
Formative or process evaluations — these evaluations are undertaken early in the development or implementation of a policy or program.	How is the policy or program delivered? Is the program being delivered as intended? Is the policy or program appropriately targeted? How effective has implementation been so far? What are the policy or program's strengths and weaknesses? Can the policy or program be improved to achieve better outcomes?	These evaluations help to better understand the mechanisms at play in successful and less successful policies and programs. They can help shape a policy or program to perform better. The evaluation can assist in improving an initiative as it is rolled out and can provide a baseline for future evaluations.
Summative, outcome or impact evaluations — these evaluations judge the overall merit, worth and impact of a policy or program.	What difference did the policy or program make? Has the policy or program achieved its objectives? Does the evidence support the theory? Has the policy improved outcomes? If so, by how much? Did the policy affect groups of users differently?	These evaluations are undertaken for lesson-learning (they can be used to inform decisions about whether to expand, cease, replicate or scale up a program) and accountability.
Economic evaluations — these evaluations assess the net benefit of a policy or program.	Do the benefits justify the costs, or was it worth it? Are there alternative approaches that would result in lower costs for the same benefits?	These evaluations quantify the value of policies and programs and can be used to compare options. They are undertaken for accountability and resource allocation decisions.

Are some approaches more or less suited?

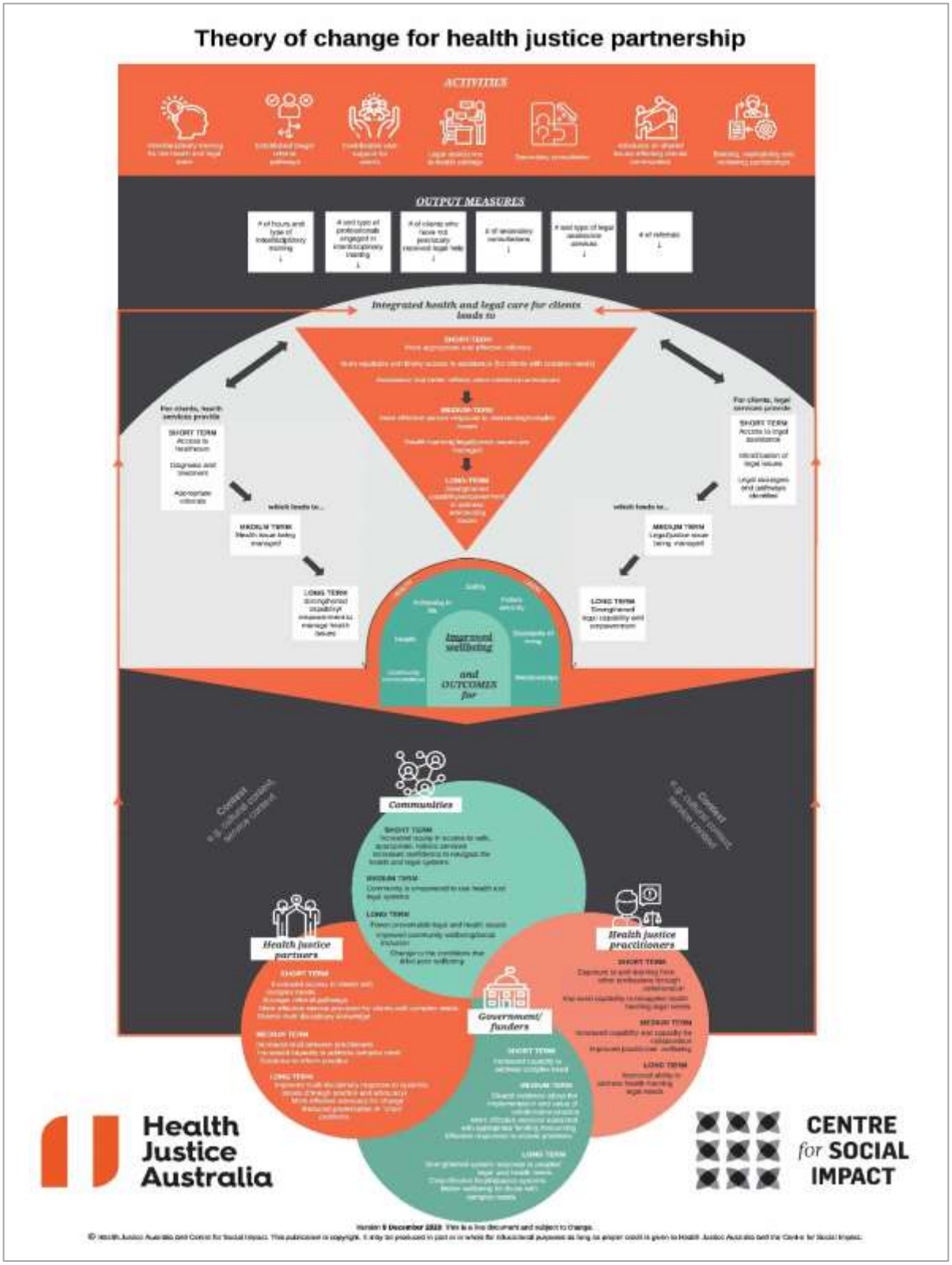
Some participants suggested that certain approaches to impact evaluation, including experimental approaches such as randomised controlled trials (RCTs), were less suited to understanding policy and program impact for Aboriginal and Torres Strait Islander communities.

What makes RCTs different to other evaluation approaches is a randomly assigned control group that allows evaluators to compare the effectiveness of a policy or program against what would have happened had they not changed anything. RCTs are used extensively in areas of medical, health and other scientific research, where treatments are homogenous and defined, and where the nature of experiments are largely under the control of researchers. They are used less in evaluation where policies and programs are designed to deal with multiple and complex issues and where change is expected to occur in the long term.

OVERVIEW 27

Appendix Y: HJA & Centre for Social Impact's Theory of Change for HJPs

https://healthjustice.org.au/resource/toolkit/health-justice-partnership-theory-of-change/



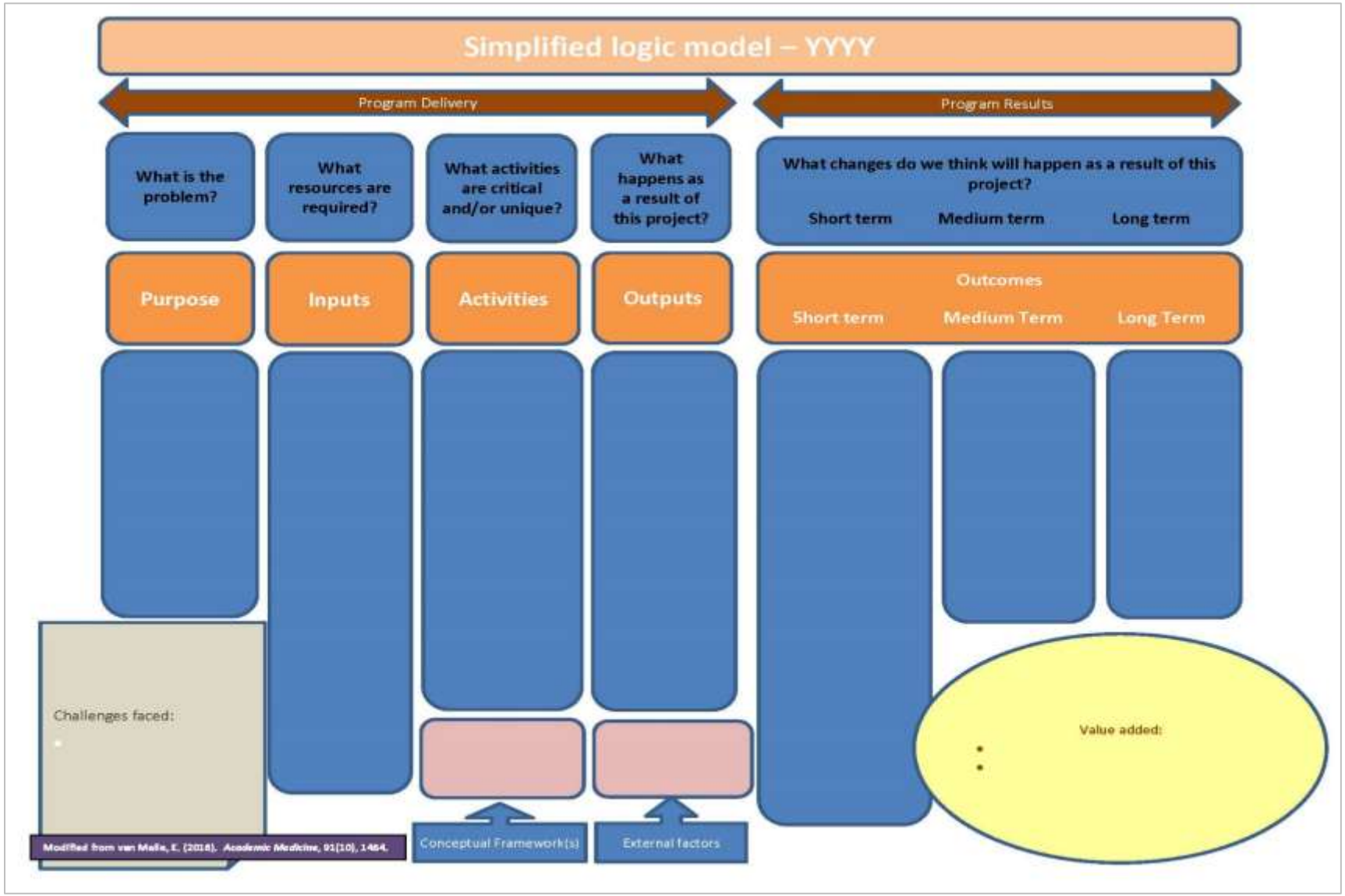
Appendix Z: A Typology of Research Purposes
Patton (2015)

Exhibit 5.1, *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.)

EXHIBIT 5.1 A Typology of Research Purposes

TYPES OF RESEARCH	PURPOSE	FOCUS OF RESEARCH	DESIRED RESULTS	DESIRED LEVEL OF GENERALIZATION	KEY ASSUMPTIONS	PUBLICATION MODE	STANDARD FOR JUDGING
Basic research	Knowledge as an end in itself; discover truth	Questions deemed important by one's discipline or personal intellectual interest	Contribution to theory	Across time and space (ideal)	The world is patterned; those patterns are knowable and explainable.	Major refereed scholarly journals in one's discipline; scholarly books	Rigor of research; universality and verifiability of theory
Applied research	Understand the nature and sources of human and societal problems	Questions deemed important by society	Contributions to theories that can be used to formulate problem-solving programs and interventions	Within as general a time and space as possible, but clearly limited application context	Human and societal problems can be understood and solved with knowledge.	Specialized academic journals, applied research journals within disciplines, interdisciplinary problem-focused journals	Rigor and theoretical insight into the problem
Summative evaluation	Determine the effectiveness of human interventions and actions (programs, policies, personnel, products)	Goals of the intervention	Judgments and generalizations about effective types of interventions and the conditions under which those efforts are effective	All interventions with similar goals	What works in one place under specified conditions should work elsewhere.	Evaluation reports for program funders and policymakers, specialized journals	Generalizability to future efforts and to other programs and policy issues
Formative evaluation	Improve an intervention: a program, policy, organization, or product	Strengths and weaknesses of the specific program, policy, product, or personnel being studied	Recommendations for improvements	Limited to the specific setting studied	People can and will use information to improve what they're doing.	Oral briefings; conferences; internal reports; limited circulation to similar programs, other evaluators	Usefulness to and actual use by intended users in the setting studied
Action research	Solve problems in a program, organization, or community	Organization and community problems	Immediate action; solving problems as quickly as possible	Here and now	People in a setting can solve problems by studying themselves.	Interpersonal interactions among research participants; informal unpublished material	Feelings about the process among research participants; feasibility of the solution generated

Appendix AA: Blank Program Logic Model Template for Ontario's HJPs
Sample 1



Sample 2

Simplified logic model – YYYY

PROGRAM DELIVERY				PROGRAM RESULTS		
What is the problem?	What resources are required?	What activities are critical and/or unique?	What happens as a result of this project?	What changes do we think will happen as a result of this project?		
Purpose	Inputs	Activities	Outputs	Outcomes		
				Short Term	Medium Term	Long Term

Challenges Faced	Conceptual Framework(s)	External Factors	Value Added
•			•
•			•
•			•
•			•
•			•

Appendix BB: Sample Table of Contents for an Evaluation Resource Manual

MIEP Phase II (if funded)

Proposed resources for Evaluating Justice & Health Partnerships

Draft Contents

- Acknowledgements
- Purpose of the manual/resources & Overview
- Classifying types of justice & health partnerships
- Understanding shared and differing interests in program outcomes (funders, health care providers, legal service providers, clients/patients)
- Understanding different approaches to evaluation and impact measurement
- Learning from best practices from other jurisdictions
- Proposed evaluation frameworks for justice & health partnerships
- Collaborating to undertake evaluation and impact studies
- Developing an evaluation plan and a budget
- Constructing program logic models to guide evaluation (what is the change you seek to create?)
- Developing research questions
- Articulating research methodology, data collection methods, analysing and interpreting data
- Ensuring appropriate staff competencies and training for undertaking evaluative research
- Complying with research ethics concerns and guidelines
- Implementing evaluation and research methods
- Writing a research report
- Other useful resources to reference
- Conclusion

Reference List

Appendices:

- Concept Map
- Taxonomy of terms
- Sources for validated research instruments

Templates:

- Program logic model template
- Work sheet for developing measurement approaches/data collection
- Work plan template for carrying out evaluation and research
- Sample letter of information for research or evaluation participants
- Sample Informed Consent letter
- Sample information-sharing agreement