The attributes of health justice partnership: a conceptual framework

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Evidence in Partnership

Convened by Health Justice Australia, Evidence in Partnership (EiP) is a research collaboration building knowledge around the impact of health justice partnership.

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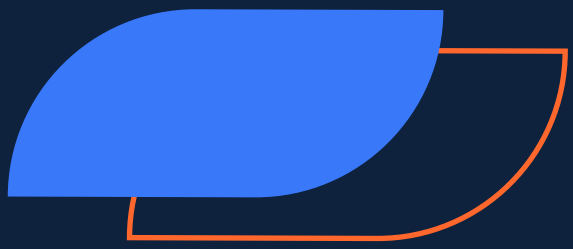


Abstract

Health justice partnership (HJP) is a model of service delivery designed to better reach and assist people and communities experiencing complex intersecting health, legal and social needs that impact upon their physical and mental health and wellbeing.

HJP integrates legal help into health and community services, recognising that those most likely to experience legal need and its impact are more likely to be in contact with these than legal services. Through partnership, HJPs build the capability of health and legal practitioners and capacity of the services in which they work to provide an accessible, 'person centred' and holistic response to complex need.

There are more than 140 HJPs in Australia. While there are common elements to these partnerships, there is also a lot of variation, to cater for different client groups, service contexts and service needs. But what is the 'secret sauce' for effective health justice partnership?

Based on an in-depth study across 11 HJPs, we identified twelve key attributes – or operational components – of HJP. These are attributes identified across the HJPs that we believe are critical to the effectiveness of partnership or integration more broadly. Together, the Attributes of HJP Framework (the Framework) describes what makes an HJP, what is needed for HJP and the shared work that HJP enables.

In the Framework, twelve attributes sit across five domains to describe: the service and context; partner alignment; the enabling environment; joint effort; and the service change enabled by HJP. We also identified how there is scope for variation between HJPs within each of these attributes – enabling HJP to remain a person centred, context specific response to complex need.

The purpose of this paper is to help understand what HJP is and what HJP requires to make a difference to the capability and capacity of practitioners and services and through this, to provide more holistic care to clients.

Introduction

Health justice partnership (HJP) is a model of service delivery that embeds legal assistance into services that support people's health and wellbeing, to assist people who may otherwise be facing barriers to accessing legal help directly. At the level of the individual, HJPs aim to effect change by addressing health-harming social needs that have legal solutions (thereafter referred to as legal needs). These can include issues related to housing, family relationships, employment, income and debt, disability, migration, and interaction with the justice system (Beck et al. 2012, Regenstein et al. 2018, Tobin-Tyler and Teitelbaum 2019). HJP provides 'joined-up care' that is person-centred and focused on addressing the social and legal determinants of health (Schram et al. 2021).

While the evidence for HJP's impact is growing, to date, much of it focuses on explicating the rationale for the HJP model, describing implementation, or reporting the outputs and outcomes of individual HJPs. (e.g. Beardon et al., 2021; First Step Legal, 2024). Less is documented about the core operational components of HJP and how they play out in practice. Similarly, much has been published on collaboration between different health, social care and community care professionals and services and far less on this kind of collaboration that also involves legal services and professionals. Building on work to fill this gap by Ries (2021) and Tobin-Tyler and Teitelbaum (2019), we present a framework of twelve foundational and functional attributes of HJP that we hypothesise constitute the 'secret sauce' of collaborative work between health, social or community and legal services and practitioners that may improve care, practitioner wellbeing, as well as health, wellbeing and justice outcomes for the people served by HJP.

The Attributes of HJP Framework (the Framework) builds on foundational work undertaken by HJA to understand the 'health justice landscape' in Australia (Forell, 2017; Forell & Boyd-Caine, 2018). This work was based on data collected via a nation-wide survey. It documented the variety of ways in which legal and health services worked together including their settings, client groups, activities, and funding. The Framework is the product of the scoping stage (study 1) of the Evidence in Partnership (EiP) project, currently underway as a collaboration between HJA and 11 HJPs in NSW and Victoria. More broadly, the EiP aims to assess the outcomes of HJP for clients and service providers and understand what works, for whom, in which contexts. Study 1 aims to identify the key attributes of HJP that both identify a service as an HJP and enable its effectiveness.

HJPs are thought to operate within three broad structural configurations i.e., referral only or 'outreach' (legal and health services do not coordinate care), 'partnered' or embedded (separate legal and health services collaborate to provide coordinated care beyond the initial referral), and integrated care (legal and health service collaborate to provide coordinated care as one organisation and are co-located) (Forell, 2017; Thorpe et al., 2017; Beardon & Genn, 2018; Regenstein et al., 2018; Ries, 2021). The findings presented in this document draw on and are most applicable to health, social or community and legal services that work together in a 'partnered'/ embedded or integrated model.

Aims

The study and resulting framework reported here aim to capture attributes that function as the 'active ingredients' (Schepman et al., 2015) of HJP. We hypothesise that these attributes contribute to effective collaboration between legal and health and/or social services, to improve care such that HJPs addresses the complexity of need experienced by individuals in their communities. As such, the Framework focuses on the interface between services and workers from different sectors (which in turn supports their interaction with clients). The attributes encompass those of inter*professional* and inter*organisational* relationships, while the arrangement of the domains from top to bottom is intended to reflect how components of HJP build on each other and are potentially shaped by different kinds of foundational attributes.

The Framework aims to function as a tool to guide the planning, implementation, assessment, evaluation of and research on HJPs by identifying:

- key attributes of HJP, that help define the service model and appear critical to its impact
- examples of variation between HJPs within attributes
- foundational and functional attributes and prompting investigation into how the former may inform the latter.

In the following section we present the Framework (Figure 1) and apply it to data collected as part of study 1 of the EiP project to describe each attribute and identify where there was commonality and variation among the sample of participating HJPs. At this scoping stage, we did not aim to objectively measure each attribute, rather our aim was to understand how each attribute manifested in the group of participating HJPs.

Methods

The Framework draws on 1) foundational work by HJA, 2) the literature on interprofessional and interorganisational partnership specific to HJP or Medico Legal Partnership (MLP) and multidisciplinary partnership in medical, allied health and social services (Ries, 2021; Corbin et al., 2018; Noone, 2009; Butt et al., 2008), 3) review of published evaluation reports (e.g. First Step Legal, 2024;nfs consulting, 2024) and 4) interviews with legal and healthcare practitioners.[1] We did not conduct a review of Memorandums of Understanding as part of this study.

Interviewees included 18 legal practitioners from all 11 HJPs participating in the study and 10 healthcare workers from 5 partnered healthcare services. Interviews were conducted with a range of legal and healthcare practitioners including team managers, frontline workers, both team managers and frontline workers (lawyers only), and monitoring and evaluation specialists. The 11 HJPs assisted clients with mental health concerns in mental health and/or alcohol and other drug settings, and general community health in tertiary hospitals, specialist hospitals, community health centres, specialist community health centres, and therapeutic communities.

The process of refining the Framework involved review by members of the EiP Advisory Committee and research team including a sensemaking session. Most EiP Advisory Committee members participated in an interview. The process of refining the Framework was also done in consultation with HJA colleagues who work closely with legal and health practitioners involved in HJP. More information about the methods and interviewees are included in Appendix 1 and 2 respectively.

1. Ethics was approved through South Western Sydney LHD (2024/ETH02493) and St Vincents' Hospital Melbourne (HREC 048/25)

Figure 1: Attributes of HJP

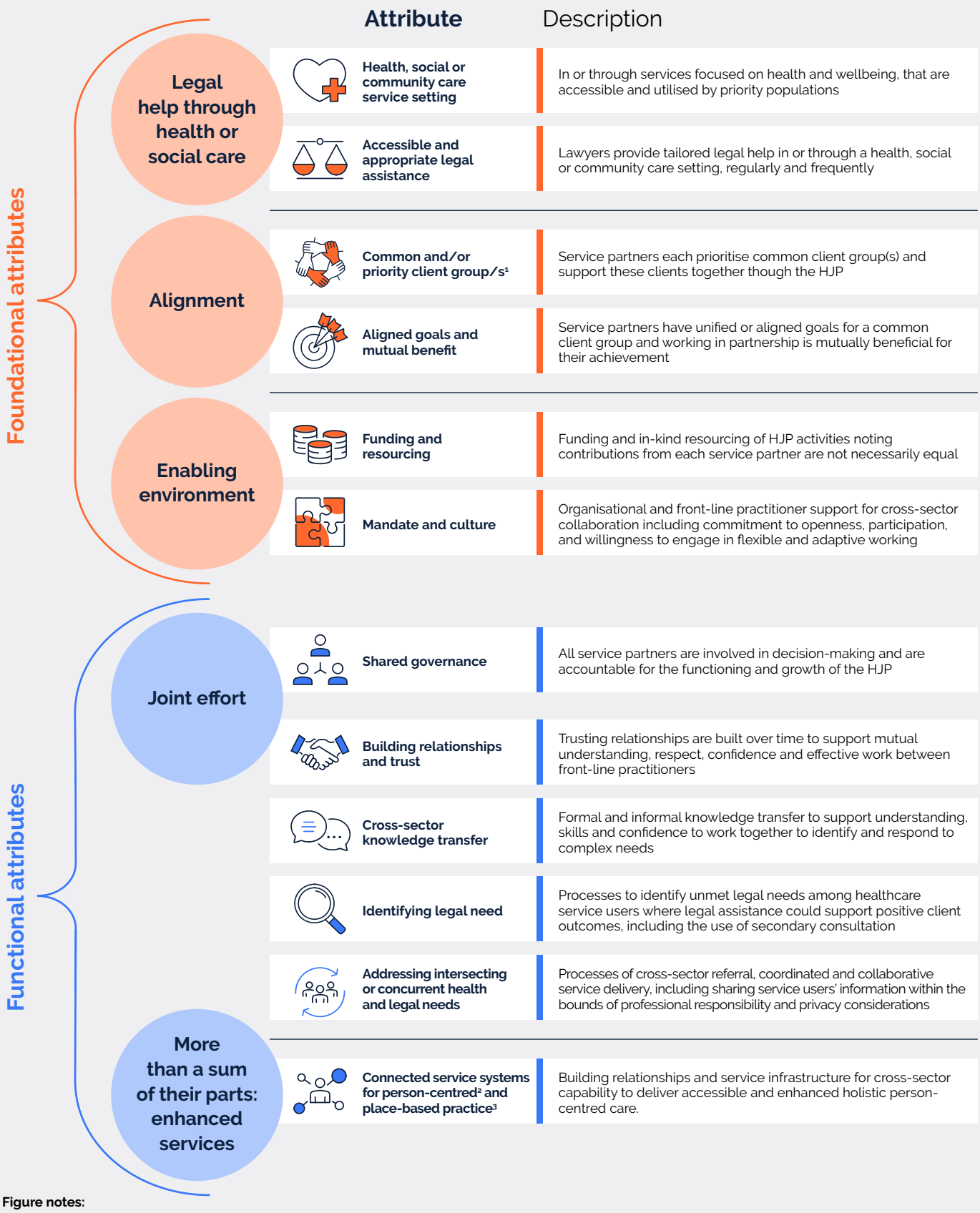


Figure notes:

1. HJP client groups typically consist of people with unmet legal needs that impact their health and wellbeing and who face multiple barriers to accessing and engaging with legal help. Barriers can include: limited financial resources; limited or fluctuating personal capability to act, resulting from issues including mental or physical health conditions that affect resilience, motivation and capacity; a limited understanding about legal issues, their seriousness or the opportunity for resolution; systemic inequities; a lack of guidance to and through legal pathways; and the high legal capability (skills, knowledge, trust, confidence) needed to access and use the legal system (Pleasence et al., 2014; Forell & Nagy, 2019)
2. Person-centred practice is defined for the purpose of this Framework as an approach to delivering services and care in an HJP in which the needs and priorities of the patient-client guide cross-sector processes, service delivery and decision making.
3. Place-based services are defined as services that are tailored and targeted to the specific circumstances of a community and place to respond to complex issues that are not well addressed with universal approaches. Place-based services also actively engage community members in service design. They are also outcomes focused and encourage flexibility in how outcomes are achieved.

Application of the Framework: commonality and variation within each attribute

Legal help through health or social care

Health, social or community care service setting

As a strategy to increase access to justice, lawyers who work in an HJP (thereafter 'HJP lawyers') take an outreach approach (Forell & Gray, 2009) and meet clients 'where they are'. This is one reason that public legal assistance services partner with health, social or community services to provide legal help in or through health care settings that people with unmet legal need may already be accessing. The healthcare settings of HJPs participating in the study are either public health services or not-for-profit organisations and serve lower income communities. They include: general community health centres (n=2), specialist community healthcare centres (n=3; mental health and AOD), tertiary hospital (n=1; all departments), targeted programs or specific departments within tertiary hospitals (n=5; mental health, AOD, homelessness), specialist hospital (all departments) (n=1, a dental hospital), and therapeutic communities (n=2; participative, residential or day program group based approach to mental illness and addiction). More broadly HJPs are also located in child and family hubs, community centres, housing services, among other health and social care settings (Forell & Nagy, 2019).

Among HJPs participating in the study, two HJPs are structurally integrated and co-located. They operate on the same premises, with one of these legal services auspiced by their healthcare partner, and the other set up by the healthcare partner as an ancillary service. The other legal services are based at a location different to the healthcare service, but the HJP lawyer/s spends time on-site at the healthcare service on a regular basis.

Accessible and appropriate legal assistance

HJP involves the provision of legal help in health, social and community care settings to increase the accessibility of legal assistance for people who are likely to experience legal issues and who face barriers to accessing legal help. These barriers may include difficulty navigating a complicated legal system, fear or distrust of lawyers or the law based on past negative experiences (Pleasence et al. 2014), and as noted by one of the HJP lawyers interviewed, managing symptoms of ongoing mental illness where attending to everyday activities is difficult and communication with professionals may be overwhelming and burdensome. Accessibility is increased by making lawyers available on a regular and frequent basis to assist clients attending the health, social or community service – what Tobin-Tyler and Teitelbaum refer to as 'lawyer in residence' (2019).

All legal services in the study of HJPs were Community Legal Centres (CLCs), which are independent not-for-profit community organisations that provide free legal services, especially to people experiencing social and economic disadvantage and/or domestic and family violence (Community Legal Centres Australia, 2022). More broadly, Legal Aid Commissions, Aboriginal and Torres Strait Islander Legal Services, and Family Violence Prevention Legal Services are or have been involved in HJPs with health, social or community services, in some cases with the pro bono support of private law firms (Forell & Nagy, 2019; Health Justice Australia, 2025).

It is also important that accessibility of lawyers informs the nature of the legal help itself; providing better access to justice depends on legal help that is accessible and appropriate, meaning it is tailored to the personal capabilities, behaviour, concerns and legal literacy of the individual in need of help (Pleasence et al., 2014).

Among the HJPs participating in the study, there were various ways in which legal assistance was made accessible and *appropriate*. Within all the HJPs, lawyers were available on-site at the healthcare facility to meet with clients, however the number of days designated for this varied. At both of the structurally integrated HJPs where the partnering health and legal services were co-located, HJP lawyers were available for in-person scheduled and impromptu appointments in addition to addressing questions from healthcare staff (secondary consultations) 5 days per week, provided they were in the building and not, for example, at court. Among the other HJPs, time spent onsite by the lawyer ranged between 0.5 to 2 days per week. Spending 0.5 days onsite was attributed to limited space at the healthcare service. Legal assistance within most HJPs was delivered by one dedicated lawyer, with help from other lawyers at the CLC for instance to provide specialist assistance beyond the HJP lawyer's expertise. At one HJP a roster of three lawyers with different background specialities (family law, migration) worked across two healthcare sites. At one of the integrated HJPs, there were nine lawyers, albeit mostly working part-time. Lawyers spent less time onsite at the two therapeutic communities, only 1 day per fortnight or month, as these services are located at quite a distance from the CLCs.

In all cases, apart from the therapeutic communities, there was flexibility in when in-person meetings with clients could occur. If the day that the lawyer was onsite was not convenient for the client, the lawyer could arrange to meet them at a different time or at the CLC or at another location. The latter, however, did not occur very often. It should also be noted that the turnaround times from when lawyers received a referral to engaging with a client or the wait time after

booking an appointment were reported to be short – a week or less.

In addition to in-person availability, HJP lawyers reported being available to clients and healthcare staff over the phone or email on each of their working days, which was 5 days per week apart from those who worked part-time.

Flexibility and tailoring legal help to individual clients' needs was a key characteristic of the day-to-day work of the HJP lawyers. They recounted instances in which they met their clients when, where and for durations of time that were most convenient and comfortable for their client. It was not unusual for HJP lawyers to rearrange their schedule at the last minute to meet the needs of a new client or an existing client whose personal and social circumstances may change significantly and may necessitate the HJP lawyer to interact with services external to the HJP to assist their client. They were also contactable by any means that worked best for their client (e.g., call, email, text) and ensured that the way the law was explained was accessible. This often meant explaining issues as practically as possible and avoiding the use of legal terms and references.

It was explained that working in such a way was an expectation and essential to being able to properly and respectfully address the types of problems and complexity experienced by the groups of people HJPs aim to assist. Lawyers' understanding of and capacity to work with the impact of mental illness, addiction and trauma was also noted to support this type of responsive and appropriate care.

Alignment

Common and/or priority client group/s

HJP is a model for services from different sectors to support a common client group who are experiencing intersecting health, legal and social issues. Through HJPs, legal assistance may be available for all low-income patients of a healthcare service or users of a social or community service or targeted to people experiencing specific health or social issues (Ries, 2021). Services usually align to fill identified gaps or develop different areas of expertise to assist different priority groups. In the legal assistance sector, work to serve groups who experience the most complex need and greatest barriers to accessing help is referred to as 'targeted' (Pleasence et al., 2014). Intensive legal support is provided within very specific programs intended for those with greatest need. This is due largely to funding constraints in the legal assistance sector.

In the study cohort these programs included: AOD (n=3), AOD and mental health (n=1), mental health (n=4), community or mental health treatment orders (n=3)), women (n=1), homelessness (n=1), any patient of the health service (n=6). An HJP may have more than one target population.

Aligned goals and mutual benefit

For partnerships to work effectively, it is important that the partnering organisations and frontline workers have aligned goals and mutual benefits (Butt et al., 2008; Corbin et al., 2018; Nevstad et al., 2021). This is particularly important when the partnership exists between sectors such as health and law that operate within distinct bureaucratic systems, with different professional and ethical frameworks governing their operations and each with its own terminology and ways of working. Aligned goals and shared objectives help identify how these sectors can contribute their various expertise to address different aspects of the intersecting issues affecting the lives of their common clients.

All legal and health practitioners interviewed spoke with consensus about aiming to resolve complex situations and *"improving overall outcomes"* (HM01) for clients, meaning an improvement in life situation and wellbeing, not just clinical health or legal outcomes. They aimed to achieve this by addressing the underlying social determinants and psychosocial drivers of (ill)health and working toward longer term stability. One lawyer expressed that her ultimate aim was to *"put clients on a better path"* (LPM03) and others said that working as an HJP lawyer meant

> *"trying to address the broader context or issues that people are experiencing in life to create a situation where they don't find themselves here again"* (LM03) or *"…are confident to come back and get legal advice again"* (LM01)[2]. Health and legal partners were very much aligned in their goal of improving clients' wellbeing by holistically addressing the problems in their lives.

Notably, health and legal practitioners were also aligned in the importance they placed on reducing stress and anxiety as a first step toward client wellbeing. In all HJPs, whether they were targeted toward helping clients receiving mental health care or not, interviewees drew a strong association between the stress of psychosocial and legal problems and deteriorating mental health, which often impacted on emotional resilience, tolerance to life stressors, and a person being able or not to focus on mental health treatment and recovery. Legal and health practitioners agreed that for those experiencing psychosocial stressors leading to mental health problems, as well as for those experiencing ongoing symptoms of mental illness, symptoms were unlikely to improve if underlying stressors were not addressed.

> *…if a client is coming in, accessing mental health support, but their legal issue is what's driving their mental health deteriorating …being able to address that has an impact on mental health and well-being …. There are plenty of examples of that.* (HM01)

> *…we can't eliminate everything, but if we can reduce the level of psychosocial stresses for these mental health clients then it allows them to have more energy when they come into therapy… They can come in in a much calmer state and do more work with you in therapy room and you can see more progress.* (HC03)

Legal and healthcare workers were well aware of the intersecting nature of legal and health problems experienced by their clients. It follows that their accounts revealed significant mutual benefits to *"healthcare and legal working together to address the complexity of the presenting client"* (HM01). As in the quotes above, addressing psychosocial and legal issues made mental healthcare more effective. Conversely, when clients were quite unwell, it was also necessary for them to make progress with their treatment prior to being able to address their legal issues. The complexity of intersecting issues and symbiotic relationship between legal and health services throughout a client's recovery is exemplified in the quote below.

> *I'm thinking of a client who was homeless when he became an involuntary mental health [in] patient … He had a criminal matter, but he was originally too sick to even tell us what to do, to give his instructions about how to proceed. …so it just had to wait for him to stabilise. But part of what was stopping him from being stabilised was that he didn't have a home to go to. The social workers found him a Community Housing place that was going to have support, but he was so unwell because of the criminal charges, the worry of that, that he hadn't stabilised enough to go into housing. And the housing provider wanted to know what was going to happen with*

2. It was not uncommon for clients to experience legal issues again. For this reason, it was a goal of HJP lawyers to ensure that their clients felt empowered and confident enough to contact them for help in the future, to address issues as early as possible.

the criminal matters, because if he was going to go to jail, they weren't going to keep the house for him. So it was multi-way, we needed to deal with the criminal proceedings to have him less stressed, to get better, but then also deal with it in a way that meant he could go into the house with support, and it all did work out, but it took so many months because his recovery was so complicated and the recovery was intertwined with how he was processing the criminal charges and this possibility of 'maybe I have housing, maybe I don't'. (LM05)

Legal and health practitioners also recounted mutual benefit in overcoming bureaucratic issues associated with supporting clients in their recovery. For the lawyers interviewed for this study, working together with a client's healthcare provider/s meant that they were able to request medical information to support a client's legal matters in court or a tribunal, far quicker and without additional costs. Favourable legal outcomes then assist in reducing stress and progressing a client's stabilisation and long-term wellbeing, which, especially for young people, may include dismissal of charges and avoiding a criminal record.

One of the big benefits of working in HJP is that it's much easier for lawyers to access health information, for them to support applications, like for NDIS and for waiving debt, fines and things like that. If you don't have that relationship, then sometimes it costs a lot of money to get health information. (LP05)

There are opportunities for us to rely on those health professionals to produce evidence that's going to be helpful to our client's legal scenario. So often times, in a criminal matter …any kind of health reports that describe the person's diagnosis, treatment and engagement with services is going to be helpful to the outcome in the Criminal Court. (LM04)

Enabling environment

Funding and resourcing

As a targeted and relatively intensive service for clients with complex needs, HJPs need specific resourcing in addition to the core (non-HJP) work of the CLC and healthcare service. Although both partners provide financial and/or in-kind resources to the functioning of an HJP, these contributions can look quite different, reflecting what each is best placed to provide.

In the study sample, the legal service partners provided lawyers who were funded to do the legal work arising from the HJP through one or a combination of federal and state government funding sources including the then National Legal Assistance Partnership (NLAP) mental health stream funding, the Victorian Legal Services Board and Commissioner (VLSB+C), and the NSW State Attorney General through the Community Legal Centres Program Critical Gaps. Some HJPs drew on NLAP 'core' funding which funded the work of the CLCs to fund their HJP. One of the legal services also received philanthropic funding, which until recently, when they received NLAP funding for the first time, had supported their work entirely. Importantly, funding for HJP did not come with restrictions or prescriptions on how collaborative work was to be conducted, which provided scope for flexibility described in the next section. However, legal practitioners noted the insecurity of short-term funding impacted HJP lawyers' job security and HJP sustainability. The legal partners also provided legal education for healthcare workers and formal referral processes, e.g. referral forms.

While none of the healthcare partners in the sample currently provided funding for the HJP, they provided resources such as referral pathways (between clients lawyers may otherwise not reach and the legal service); appropriate workspace for the lawyer to meet with clients onsite; healthcare service email addresses for the HJP lawyer/s; time in health staff meetings for legal education; the time of managerial staff to attend steering committee and other leadership meetings; and healthcare service staff induction and training for HJP lawyers in health issues such as specific mental health disorders and information about clinical practices.

Historically, one of the health partners in the sample funded the HJP lawyer for a period. More broadly in Australia currently, Health Justice Australia is aware of funding of HJP by the health sector only in Western Australia and the Northern Territory.

Mandate and culture

As indicated above, there are considerable mutual benefits to working in cross-sector collaboration for both legal and health services and practitioners. However, forming, working in and sustaining partnership is difficult to realise without the organisational support and commitment of each partner service including levels of management and practitioners. Such support varies significantly between health and social care sectors and the community legal sector.

Particularly within mental health and AOD services, collaborative, multi-disciplinary teamwork is the norm. It is a way of working that utilises diverse skills and knowledge in response to an understanding that drivers of poor health outcomes and health inequity include factors outside of the health sector. This is reflected in established frameworks and concepts such as the psychosocial model of health (Wade & Halligan, 2017), the recovery orientated approach (Australian Health Ministers' Advisory Council, 2013), the social determinants of health (Kirkbride et al., 2024), and person-centred care (Edvardsson, 2015; Ekman et al., 2021). These frameworks establish that drivers of health and recovery are multi-dimensional and differ between individuals. HJP fits well within this established way of working as a form of multi-disciplinary teamwork that extends to include a professional from a sector other than health to become an inter-disciplinary or 'inter-professional' collaboration (Ries, 2021).

Responding to access to justice evidence that highlights which community groups disproportionally experience unmet legal need (e.g. Coumarelos et al., 2012), there are specific examples of inter-disciplinary initiatives, including HJP, within the legal assistance sector. For instance, all the HJPs in the sample were initiated by the legal partner. There is recognition within the public legal assistance sector (e.g. Federation of Community Legal Centres Victoria, 2023), supported by access to justice research (Noone, 2009; Pleasence et al., 2014), that collaborative and innovative service delivery is necessary to achieve strategic goals of increasing access to justice, and the capacity of legal services to provide quality services that advance social justice. Choosing to operate within a partnership model, however, remains at the discretion (and initiative) of individual legal and healthcare services. Of the eight CLCs participating in the EiP, two worked only within a partnership model, meaning they only accepted clients who had been referred to them by one of their health or social care partners; and six of the eight CLCs operated in more than one HJP.

Essential to working in collaborative partnership are flexibility and adaptiveness in response to the processes and structures of the partner service (Butt et al., 2008; Corbin et al., 2018). Underpinning this is awareness, appreciation of, and willingness to engage with those from different disciplines and sectors. Analysis of the interviews conducted with both health and legal practitioners suggests a culture of openness, engagement and flexibility at each HJP. There was a distinct commitment to working in partnership with a different sector. Further discussion and analysis also suggested that cultures of openness and engagement *enabled* the work of partnership, as it 'authorised' key processes and activities of cross-sector partnership that may not be considered appropriate or necessary in regular practice, particularly in non-HJP legal assistance services. These processes and activities included the time lawyers were able to spend with clients on matters and the range of assistance provided; data and information sharing; communication, compromise and negotiation in response to different professional obligations; negotiation of bureaucratic processes and timelines; and learning and adopting terms used by a partner sector. Specific activities will be described in more detail in the next section. Below is an example of

how a partnered health and legal service (integrated) worked together in ways that involved bi-directional sharing of client information and negotiation of legal procedures and timelines toward aligned goals.

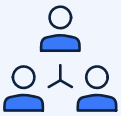
> *…there's a push and pull within any HJP but particularly ours because it's a proactive rather than responsive, reactive partnership. We have the person's clinical outcome front of mind and what's best case for their clinical care, and that can take longer than the justice system is prepared to be patient for. So, to negotiate therapeutic adjournments to give a depth of understanding to the court, the legal service to advocate for our clients, to give them a better chance of sustaining agency throughout their interaction [with the justice system], rather than to be beholden to orders, giving them a chance to actually have agency in achieving better mental health and reduction in recidivism.* (HC01)

In the sample HJPs, apart from when the legal and health services were co-located, the HJP lawyer/s entered the workspaces of the health service. It is important to note that in these cases it was usually the work of the lawyer/s that was most significantly shaped and adapted in response to the ways of working of their health partner. For instance, HJP lawyers described being guided by the preferences of healthcare workers regarding how referrals were sent to them and how and when healthcare workers could contact them for secondary consultation. Healthcare workers recounted being able to work with HJPs lawyers to decide on when legal help would be appropriate for a patient, and what *"best outcomes"* (HC01) look like, particularly for individuals interacting with the justice system. Some lawyers noted that this flexibility and adaptability was paramount to the success of the model.

Appreciation for lawyers' willingness to work in ways that responded to times and ways in which the healthcare teams needed them was expressed by several healthcare workers who, reflecting on past experiences, said the partnership would not work otherwise. Being flexible, adaptive and open to compromise based on how healthcare workers operate was also a way in which lawyers sought to demonstrate the benefits of partnering to healthcare workers, which included making their work easier. To that end, lawyers did not want to burden healthcare workers with rigid referral and secondary consultation procedures. Significantly, such a responsive and adaptive way of working contrasts with the way of working among other lawyers e.g. duty lawyers whose work activities are more restricted and defined. The capacity for flexibility and *"shape shifting"* (LMP04) on an organisational level was also important, for example when staff turnover at a partnered healthcare service was high and induction and legal education sessions had to be repeated at times and frequencies that had not been planned in advance.

Discussed so far are attributes we consider to be foundational to the establishment and development of an HJP, and we have provided insight into how they vary among the HJPs participating in the EiP project. The following section describes different ways of working together – the 'functional' attributes – that constitute the practice of 'joint effort' in collaborative partnerships between legal, health and social care services and practitioners. Here also, we provide examples of variation among these HJPs. A managing lawyer who was involved in the development of the HJP in which she worked emphasised that it is up to the individual CLC to design their own approach to working in collaboration. This is reflective of the 'place-based' nature of HJPs and suggests the practice of partnering will be different in each HJP. Although not expanded upon in this document, the examples of variation below are thus reflective of different foundational specificities of attributes such as target client group profile/s, healthcare setting/s, and culture.

Joint effort



Shared governance

Governance approaches within individual HJPs have not received a lot of attention in the literature on HJP or MLP. However, commitment from all partnered services to have the joint opportunity to reflect on the functioning of the HJP and have input into decision-making is crucial for sustaining and developing a partnered service delivery model.

One of the legal professionals interviewed captured the importance of a steering committee when she said, *"…they're really important, sort of the crux of the mechanism that keeps the partnerships on track."* (ME02)

Legal practitioners from each HJP were asked about governance. They each described an approach to the governance of their HJP, but these ranged from established steering committees to ad hoc meetings.

At seven HJPs, there was a steering committee which included members of senior level management from both the legal and healthcare services and HJP lawyers; they did not however always include front-line healthcare workers who referred to the HJP lawyer. Two of these HJPs, which were associated with the same legal service, also included a lived experience representative in a capacity in which the consumer representative felt most comfortable. Five of these steering committees met regularly throughout the year (e.g. quarterly) and two had not met for a considerable amount of time. They were seen as important forums in which changes and developments could be made to the HJP. They also provided the opportunity to update senior level management on the workings of the HJP and highlight its achievements with data and case studies. Including senior management was important for encouraging buy-in from management, especially if the HJP's setting was a large tertiary hospital with many active programs and initiatives, but it was sometimes difficult to maintain their engagement with the steering committee. Staff turnover at large hospitals also affected the stability of steering committees.

The two steering committees mentioned above that had not met for some time (associated with two HJPs from one CLC) did not mean that there was not any governance oversight; the HJP lawyers and managers of the various social work teams they worked with meet regularly (monthly) to discuss any staff changes, legal education needs for staff, and any issues with the referral process. The meetings were described as short and sharp but a good opportunity to discuss any practical issues with the day-to-day functioning of the partnerships. In another HJP, also operating out of a major tertiary hospital, similar regular monthly meetings were held between the two HJP lawyers and a manager within the clinical team with which they worked. They also discussed how things were going, any trends, referral outcomes and any difficulties. In yet another HJP, within a large community health centre, it was primarily the managing HJP lawyer and a program manager from the healthcare service who had formed the strategic governance level thus far. Despite staff willingness to form an operational committee, they had found

it difficult to meet on a regular basis and to include a regular group of team leaders from each of the programs at the healthcare service due to staff turnover and a restructure at the healthcare service.

The two HJPs that operated within a structurally integrated model did not have separate steering committees. Instead, at one of them, information regarding the HJP would be reported to the board of the integrated service. At the other, the principal lawyer was included in management level meetings of the community healthcare centre in which the legal service was embedded, to contribute to the planning of programs when discrete opportunities or needs arose.

Building relationships and trust

Trusting relationships are essential to working in partnership (Nevstad et al., 2021), particularly when the partnership involves working alongside practitioners of a discipline and sector in which one is not trained and may not initially be familiar with. In HJP, among healthcare workers, this may also involve overcoming unease, scepticism or misconceptions about lawyers or the law and their usefulness for improving wellbeing (Forell & O'Connor, 2024).

The central role of trust in lawyers in the care and emotional logics behind decisions to refer patients to a HJP lawyer cannot be understated. The process of 'transfer of trust' is an established principle of multidisciplinary teamwork (Forell & Gray 2009; Clarke et al., 2012; Cohl et al., 2018) and was articulated by many of the healthcare workers *and* lawyers interviewed. A psychiatric nurse and clinical lead at a HJP that supports clients who often experience multiple intersecting challenges said that his trust in the HJP lawyer comes from being confident that they understand the complexities of the work of supporting people who live with multiple points of disadvantage that contribute to the legal problems they face. A healthcare team leader at the same HJP further captured 'transfer of trust' in the following way:

> *When you work with people …you get quite protective of your clients because you see the effort and you see the struggle for them. We work with a lot of people that have had really poor histories in terms of their interactions with either the health system or the justice system or just anybody in any sort of like professional role. …So, it is really beneficial that we know the lawyers, we know they're going to treat our clients with dignity and respect and they're going to approach situations with compassion and understanding…* (HM03)

This suggests that in addition to being confident that the lawyer's knowledge and understanding of care aligned with their own, healthcare workers also sought familiarity with the lawyer and a sense of their approach to *providing* care.

The HJP lawyers interviewed paid considerable attention to building relationships between themselves and healthcare workers by being present, available, approachable and flexible to build the trust necessary for referrals to occur. In response, healthcare workers appreciated feeling confident in approaching the lawyers to seek advice and ask questions even if they thought they might seem

incredibly basic to lawyers. By far however, it was working in the same spaces that was highlighted by both lawyers and healthcare workers as a vital determinant of getting to know each other, forming relationships and building trust.

> *…if the lawyer is off site …you don't have that relationship with them, so it's a little bit different … We have a relationship with [HJP lawyer], who's here because we see each other in meetings, we see each other in the hallway, we share food, snacks …all of that I think really makes it more organic and more fluid. And just easier.* (HC03)

One lawyer working in a tertiary hospital setting recalled initially feeling apprehensive about the possibility of being accepted by health staff, but now feels like an integral part of the clinical team rather than an external resource and puts this down in large part to working in the same space. Both lawyers and healthcare workers emphasised the importance of opportunities for informal relationship building by way of impromptu conversations in the hallway or waiting in line for a coffee at the clinic café. In HJPs where there seemed to be the most collegiality between healthcare workers and lawyers and sense of being in the same team, building relationships was closely associated with sharing mealtimes; *"we work together and eat together"* (HC01).

Within HJPs in large tertiary hospitals, where the lawyer was embedded within a clinical team, HJP lawyers recounted a formalised process of initiating relationships. This was done by way of an induction process including introduction of the lawyer to all members of the clinical team, and inclusion of the lawyer as a 'contingent worker' or unpaid member of staff with access permissions and a health service email address.

As indicated so far, HJPs require and deepen intentional relationships between services and practitioners from different fields of expertise, knowledge and practice. In the section below we discuss the importance of building cross-sector knowledge, which is both underpinned by and enhanced by the building of trusting relationships.

Cross-sector knowledge transfer

This section highlights the importance of deepening knowledge about one's partnered sector and practitioners. Key cross-sector knowledge includes the nature of problems the partnered sector and practitioners typically address, the approaches they use to do so, unique sector processes and practices, terminology, and professional obligations. Increasing knowledge about the legal sector and the work of community lawyers is especially important among healthcare workers, to develop sensitivity to legal problems their clients may face and confidence to take action, including making referrals to lawyers (Forell & O'Connor, 2024).

> *…strengthening the capacity of the services to address social determinants of health and tackle issues like housing and debt, unemployment … increased knowledge of the [health] workers around legal issues, access to services, so just making it a lot easier through our model for clients to be able to access the legal services.* (HM01)

Formalised methods of building knowledge and awareness of legal issues, processes, and available legal services among partnered healthcare service staff at most HJPs included short legal training sessions delivered by HJP lawyers at health staff meetings and dedicated legal education sessions. The legal education sessions cover specific legal issues relevant to the health service including changes to the law or what the legal service can help with more generally. Some healthcare workers said that insights gained from this kind of legal education, particularly regarding the kind of issues the lawyers could help with beyond criminal issues, was paramount to being able to identify everyday problems experienced by clients such as debt as 'legal issues' with legal solutions and advocate on the client's behalf for their resolution.

> *I think it's really important when the lawyers come and talk to us as a team, that's a very important source of information because when they share scenarios or examples of people and problems they can help and provide some assistance with it's always a prompter. If as a worker, I'm not prompted to understand the array of situations that that they can assist with then I may not be prompted to hear that in somebody's story. So, for example a mother might be talking to me about her older child who was driving her vehicle and racking up all of these fines. It was actually only when we were doing a bit of a discussion around family and budgets and things like that, that she said, "oh, you know, and I don't know what to do about these fines."* (HC04)

Some HJP lawyers created 'legal health check' or legal needs assessment tools for healthcare staff. At one community health centre they became posters that healthcare staff put on the wall in their consulting rooms and at another it was a resource that could be accessed by healthcare staff on the centre's intranet.

One HJP was in the process of organising formalised bi-directional transfer of knowledge by implementing 'shadowing' of healthcare staff by legal staff and vice versa so that practitioners could become more familiar with the day-to-day workings of the partnered service. It was only at two HJPs that legal practitioner interviewees recalled that HJP lawyers had received educational sessions about the social determinants of health from practitioners at the partnered or integrated healthcare service and information sessions on what certain teams within the service did and how the lawyers could collaborate with them. Some lawyers said that they had received, or it was planned for them to receive trauma-informed practice training. One managing lawyer also mentioned receiving violence prevention training from the partnered mental healthcare service. For the most part though, the lawyers absorbed knowledge about health conditions and their causes, treatments, the functioning of health services and the health system, that was relevant to their clients through listening to their stories and being aware of what kind of treatment they were receiving (this information also came from healthcare workers e.g., through the referral process), through regular attendance at multi-disciplinary case conferencing meetings, and informal conversations with healthcare and social work colleagues.

When asked, all HJP lawyers said that they would welcome training from healthcare and social work professionals, particularly training specific to mental healthcare to complement what they had learnt informally through working closely with clients receiving mental health treatment. One HJP lawyer who had previously worked as a mental health professional said that the knowledge gained from that helped her to know which topics could potentially make a client uncomfortable (such as when a client is recounting experiences of as past trauma), how to create a safe space for the client to discuss their concerns, and to know when it was appropriate to end a conversation if a client was experiencing increased agitation or frustration.

Healthcare workers recalled many instances and the enormous value of the informal learning that occurs through working closely alongside a lawyer in the day-to-day work of an HJP. This kind of knowledge transfer was noted by all legal and healthcare workers as fundamental to the functioning of an HJP. Secondary consultations[3] were highlighted as a key mechanism for this kind of knowledge transfer, particularly to identify legal issues (for more information about secondary consultations see Rajan et al., 2021).

> *…just clicking that that is a legal need is important. …for us, secondary consults are absolutely critical. They're one of the most important tools that we use as part of our health justice partnership to build that legal capability in our partners; to help them understand how to identify legal need."* (ME02)

In contrast to many other referral pathways within healthcare, there aren't specific criteria for making a referral to the HJP lawyer. As such, secondary consultations made up an important part of the process of making a referral. If a healthcare worker had not made a referral for a particular issue before (or was not sure if there was a legal issue) it was common for them to enquire with the lawyer first to see if in fact the lawyer could address the issue, and it was worth making the referral. Most lawyers said that they encouraged referrals no matter what the problems were as they would refer the client to another trusted lawyer or service if they could not help themselves. As such, the issue of 'dead end' referrals was not mentioned as a problem. There was not an indication in the interviews with healthcare workers or lawyers that this process of checking deterred healthcare workers from making referrals or seeking initial advice from the lawyer.

Interviews also revealed the value of knowledge gained by health and social care workers from their HJP lawyer about how to navigate government services and legal systems, handle quasi-legal issues, and most effectively advocate for their clients. This made them more confident and certain in their work, knowing that they had addressed and explored all available options for their clients. By working alongside their HJP lawyer, mental health and social care workers also gained understanding of legal terminology and when help from their HJP lawyer would allow them to powerfully advocate for clients who faced issues related to housing maintenance, expensive and inappropriately charged hospital bills (at another healthcare service), and instances of over-policing and the criminalisation of mental health.

> *[we'll seek advice from the lawyer] if we're meeting all those barriers and we're not quite sure how to navigate something. If we're needing understanding of terminology. If we feel as though it might have more power to have legal input for a person. … it helps my team to feel empowered to go that extra step and push harder, advocate in a different way.* (HM05)

Previously they had felt far more limited in their ability to address the psychosocial determinants of health for their clients.

> *…when we didn't have this partnership …we were doing all this work ourselves and it was so hard trying to navigate and figure it out, trying to call Legal Aid for advice and they can't give you anything …it was just so hard to get any information or understanding about what you were trying to do. So, you're just out there flailing around drowning. So, I think it [HJP] has empowered clinicians a lot. And given them a lot of knowledge on how to support their consumers.* (HM05)

3. Not all healthcare practitioners used the term 'secondary consultations' but all interacted with their HJP lawyer in this way when needing to seek advice.

In another example, in a long established HJP, a healthcare manager explained that beyond being able to access legal help to advocate for a client, they had come to understand enough to appreciate when a legal approach may or may not be the best approach based on an individual's circumstances.

> *I think one of the greatest advantages is the multidisciplinary knowledge. Working alongside each other, I think it goes both ways. We learn so much about how other disciplines work, how the lawyers might approach something, but equally I guess you also come to know that they have a way of working in the legal space and we have a way that we work in the health space… with housing issues, when you go down a legal tenancy route, it ends up in VCAT and it can be quite a traumatic experience. It gets the outcomes, but sometimes in some situations, taking a more negotiating route with a landlord can sometimes get results too. It's just a slightly different way of trying to support the client. …it's that learning back and forth, when to proceed and when not. And I think the fact that we work alongside each other has helped us know actually maybe we need to take a different approach, maybe we need legal to help with this one and legal saying maybe we need the health worker to help more with this one.* (HM02)

Identifying legal need

Although other researchers have placed ways of identifying patients' legal need in the formative stages of an HJP (e.g., Ries, 2021), our research shows that they need to develop over time, as the legal and health practitioners and services get to know each other, which approaches work best, and what is feasible within the partnership. It is also of course necessary for healthcare workers to build the knowledge and skills to identify that their patient may have legal issues. Identification of legal need by HJPs involved in the study was primarily undertaken by healthcare workers and, to a lesser extent, lawyers.

The configuration of which health and allied health workers identified potential legal issues differed among the HJPs. At some, especially larger community health centres with multiple programs, the lawyers relied on a wide range of healthcare workers from GPs to mental health professionals to social workers and family violence counsellors to refer clients. In others such as large tertiary hospitals, social workers made most of the referrals. In at least three HJPs – in two tertiary and one smaller specialist hospital – medical healthcare staff alerted social workers to potential legal issues, the social workers investigated the situation further and then made referrals to the HJP lawyer. As mentioned in the section above, in some HJPs the lawyers had developed a legal needs assessment tool and made it available to all healthcare staff. Despite the presence of such a tool (and legal education sessions) it wasn't always used and some lawyers noted difficulty in getting medically focused healthcare staff to adequately assess for legal need and refer. They suggested that GPs, and even more so specialist clinicians, did not have sufficient time with each patient to ask about potential legal problems in addition to addressing health problems. Other HJP lawyers cited high healthcare staff

turnover as a reason for inadequate referrals. At one of the structurally integrated HJPs and at the therapeutic communities, a legal health check had been incorporated as a routine part of the intake process that was conducted by health and allied health staff.

Within the HJPs, identification of potential legal need was done predominantly by allied healthcare workers including social workers, outreach workers or other healthcare staff whose roles included assessment of and addressing a client's psychosocial environment.

At two HJPs, the lawyers reported that posters advertising their service and contact details (one also included a photo of the lawyer) were displayed at the healthcare service. This made it possible for clients to self-identify that they had legal issues and refer themselves or mention the problem to their healthcare or allied health worker who would then refer them.

In some HJPs, the lawyer would, on a regular (weekly or fortnightly) or ad hoc basis, join multidisciplinary or case conferencing meetings in which the team discussed each of the patients within their care. This gave these lawyers the opportunity to identify unmet legal need more directly. The lawyer usually situated themselves in the background and listened for situations for which they could offer legal help. They either raised it in the meeting or approached the clinician individually afterwards depending on the legal issue. One of the HJP lawyers conceptualised this process as a safety net for any legal issues that may have been missed.

> *So it's an extra level to make sure that nothing has been missed …the Care Coordinator might be talking about something and it might be that you know the client is stressed because they just received a letter from the Minister of Immigration about their visa and then I will pipe up and be like, sounds like a legal issue, send that to me.* (LP04)

One legal professional also described a process of *"meerkat lawyering"* (ME02), in which lawyers spent time at a partnered social service, not to join formal meetings but to help staff identify legal issues or identify them themselves by engaging with the work of the social service.

As noted in the previous section, secondary consultations were important cross-sector interactions through which healthcare workers could build knowledge to identify legal issues, know which legal issues the HJP lawyer could address and which legal issues would need external legal help, and how to go about engaging that help. In HJPs where there was only one lawyer taking referrals from all departments of a tertiary hospital or health district, the lawyer did not have the capacity to develop relationships with all of the healthcare staff who contacted them, so secondary consultations were an opportunity for the lawyer to share more general legal information, not relating to specific patients, verbally and/or in written form (e.g. pamphlets) to be passed onto the patient.

Addressing intersecting or concurrent health and legal needs

In this section we build on trusting relationships, cross-sector knowledge, and activity to identify legal issues to discuss the various ways in which practitioners work together to address intersecting or concurrent legal and health problems.

As with activities to identify legal need, activity to address intersecting or concurrent health and legal needs in HJP that become routine or expected develop organically as the practitioners and services get to know each other and how they work together best. For instance, the most effective referral pathways may result from relationships built with particular healthcare staff: *"…once [social worker] came on board, we were able to cement that referral pathway"* (LPM03).

After secondary consultations to determine whether a legal issue is present and whether the HJP lawyer can address it, cross-sector referrals are at the functional heart of HJP. As discussed in the Enabling Environment domain (Figure 1), what was most convenient for the healthcare workers' and lawyers' flexibility in response to observing how healthcare staff worked and interacted with clients determined how referrals were made. Several HJPs had a referral form, but it was usually completed by the lawyer based on information from the healthcare service after a healthcare worker had contacted them by email or phone or they had had an in-person conversation. Other HJPs did not use a specific referral form and instead received emails from healthcare workers containing the necessary initial patient information.

Legal and health staff relayed the importance of 'warm referrals,' a process in which the referring healthcare worker makes an appointment for their client and/or introduces their client to the lawyer, or also sits in on their first meeting, or part of it (Taylor & Minkovitz, 2021). In this study health and legal practitioners described various kinds of warm referral; healthcare practitioners were attentive to making their client feel as comfortable with the process as possible and would act as their client wanted. Most HJP lawyers also said that they made every effort to meet their clients in person, especially in their first interaction with them.

Most health and legal workers described that relevant information about the patient's situation was, with the informed permission of the client, shared with the lawyer in the process of referral, such that the lawyer could begin to understand the client's life situation in order to contextualise their legal issue/s. This was particularly important when it was not appropriate or necessary for the client to repeat their story that they had already told their healthcare or social worker.

In collaborative models of HJP (Himmelman, 2002), supporting clients extends beyond referral. Although all HJPs in the sample could be considered as working in collaborative partnership to some extent, how legal and health workers worked together to address the needs of shared clients differed. This may be dependent upon characteristics of the client cohort, healthcare setting, and the nature of the legal issue and work required.

It should also be noted that in approximately half of HJPs in the sample, not all clients referred to the lawyer needed ongoing care from the health service. Ongoing care coordination seemed to occur for clients with complex life situations and who required more intensive support to address multiple issues,

ensure access to necessary services *and* when the health and legal services were configured together and had adequate resources to work in this way e.g. with the help of dedicated case managers.
A legal practitioner from a HJP that delivered a highly collaborative service to support clients requiring a high level of support described activity to address intersecting health and legal need in the following way:

> *…it's not just a referral pathway, it is the case conferencing and it is taking the time to not just update the clinician on the matter, but collaborate with the clinician so that we're managing the therapeutic timeline and the legal timeline and you know that's such a big and yet kind of second aspect to the role …it is so important.* (LPM04)

The following paragraphs reflect aspects of this kind of joint activity at different HJPs. It is important to note, however, that not all partnered services (participating in the study or not) work in such close collaboration, or depending on the needs of the client cohort and the particular legal issues, it may not be necessary to do so for all clients.

In initial or ongoing (if desired by the client) joint meetings with the lawyer, healthcare staff and/or case managers were there to support the client and did not engage in the conversation or take any notes. Healthcare staff most commonly joined lawyer-client meetings at the request of the client, as healthcare workers respected the need for confidentiality in these meetings. It could also be the case that the healthcare worker sat in on these meetings to support clients in feeling more comfortable and able to communicate effectively with the lawyer. In some cases, social work staff and case managers also accompanied clients to court appearances. Staff at two HJPs also described conducting joint home visits to elderly clients or in situations where the person's housing was a problem and they needed to assess it for repairs or maintenance.

Staff at only one (structurally integrated) HJP explicitly described a process of collaborative treatment planning and review of treatment plans at weekly meetings between health and legal staff. At other HJPs, at which health and legal practitioners also worked closely, the process of collaboratively working toward aligned goals for clients occurred on a case-by-case basis that involved health and legal practitioners requesting necessary information from each other and keeping each other up to date with relevant developments. Again, information exchange is undertaken within the parameters of each profession's obligations.

Navigating client information barriers is a central issue when working in interdisciplinary teams, and arguably more so in cross-disciplinary teams involving legal and health services where client-lawyer privilege and the lower threshold of mandatory reporting among healthcare and social workers need to be respected. At one HJP, consenting to the sharing of information between health and legal practitioners was a condition of receiving treatment within the HJP program – capturing how important the sharing of information is to supporting patients in partnership. At all HJPs, only information relevant and necessary to the effective coordination of legal help and healthcare was shared.

In all HJPs client information was shared only with the consent of an individual client. Initially clients consented to the healthcare workers contacting the lawyer, and then the lawyer would ask the client for consent to share necessary information with the healthcare team. The lawyers assessed risk on a case-by-case basis and usually the legal issues at hand did not warrant a hard separation, where they could not share any information regarding the client's

legal situation with the healthcare workers at all. In most situations, clients welcomed the sharing of legal information between the people who were caring for them. Less frequently, some clients did not want healthcare staff or the service to know anything about their legal situation. In all HJPs including those working within an integrated and co-located model, legal and health administrative data were kept completely separate; health and legal workers did not have access to each other's IT systems. Further, at integrated and co-located HJPs, each service had its own reception area, offices, and phone system.

Upon client consent, a major benefit of HJP is the ability of lawyers to obtain health information and documentation to support submissions, for example to waive fines or debts, and for lawyers and healthcare workers to work together to complete forms and submissions to the NDIS or to request a mental health diversionary order in a criminal matter. Obtaining the necessary documents to support submissions to a court or public service from health facilities other than a HJP partnered health service, particularly private healthcare services, can be very costly and take extended periods of time.

> *One of the huge benefits of the HJP is that we're actively interacting with the person while they are a current public health patient, because usually if that person's been discharged, if that person's under the care of a private psychiatrist or psychologist, the reports that you need to get to satisfy the court that, "yes, this the person was under this cognitive disability and this is the appropriate treatment plan," that can cost like $2000 upwards. So if we've got a person who is on Centrelink or otherwise of low income because they've lost their job or whatever, and you get them while they're an inpatient and have that public health treatment team, we've worked with them so much, they're usually willing to do the reports for free for the person.* (LM05)

Within HJPs where the health, social and legal practitioners worked in close collaboration around individual clients, healthcare and social work practitioners articulated a 'divide and conquer' approach in how they worked together with their HJP lawyer to effectively and efficiently address the complex needs of their clients.

> *…because of the partnership, I will be the one who's collecting the information, as in support documents, she [HJP lawyer] will have to deal with the court and legal representation and correspondence, so it's kind of like we divide and conquer. … There's a lot of preparation before filing a review or filing a report or for a court case or charges or things like that. There's just a lot of information collection. … I spend a lot of time, I will review the patient's file and find out relevant information and send it to [the lawyer], and then she contacts relevant agencies like Victoria Police to request let's say documents or evidence and things like that.* (HC06)

> *…if somebody has a legal issue and they are also involved with the legal service, they've obviously got case managers as well. So it becomes a bit of a negotiation, a nice negotiation between us and them around 'you do this work, we'll do this work'. There's kind of a, probably a bit of a divide and conquer approach, that can be super helpful because quite often the people that end up coming to us and that we support have at least as long as my left arm of stuff that's not going right. That they need support fixing or figuring out or whatever and so being able to kind of divvy up those things can be quite helpful.* (HM03)

More than a sum of their parts: enhanced services

Connected service systems for placed-based and person-centred practice

In this document we have outlined and elaborated upon attributes that both help define HJP and which are key to the establishment and functioning of the model. To illustrate these, we have drawn examples from HJPs which are embedded/'partnered' or integrated in structure, and largely collaborative in practice. The attributes also capture the required capacities (aspects of an enabling environment) and capabilities (knowledge, skills, confidence) of legal, health, and social work practitioners to work in cross-sector partnership and deliver enhanced services for clients who require additional support to address intersecting or concurrent health and legal needs.

Where practitioners are involved in this kind of cross-sector partnership, they are also engaged in processes of building new cross-sector system infrastructure for effective knowledge transfer and coordinated person-centred care while respecting the unique obligations of each sector. By being able to respond to the needs of their client cohorts, the HJPs participating in this study are building community informed, place specific cross-sector systems of service delivery. Cross-sector infrastructure also assists in increasing resistance to well-known partnership vulnerabilities, such as periods of high staff turnover, and paucity of dedicated funding for cross-sector initiatives, by solidifying replicable operational process and identifying and leveraging cross-sector funding opportunities respectively.

Conclusion

Health justice partnership is a model of care that brings together services and expertise from across health, social and legal sectors, to better address the range of issues that can collectively impact people's health and wellbeing. HJP aims to improve access to legal help for people who otherwise face barriers to that access. It aims to improve client legal, health and wellbeing outcomes. It aims to build the capability of services and practitioners to do this work well.

The purpose of this paper is to help understand what HJP is and what HJP requires to make a difference to the capability and capacity of practitioners and services and, through this, to provide more holistic care to clients.

This paper has drawn upon Study 1 of the EiP project, working with 9 community legal centres running 11 HJPs in NSW and Victoria. The EiP is exploring the impact of HJP for services, practitioners and clients. The purpose of this paper has been to outline the attributes of HJP: what defines this way of working and what is needed to work this way.

We have identified 12 attributes and argued that each of these is essential to HJP. We have provided examples of how these attributes appear across a sample of HJPs. In doing so we have also identified different ways that HJPs reflect each attribute. For instance, while all the HJPs provide legal help in a health care setting to identified and shared client groups, the specific settings, the type of legal help they provide and the client groups they prioritise varied. The work of the HJPs was enabled by shared governance and resourcing, but the mechanisms for these also differed. The paper also illustrates the context-specific ways in which HJPs work collaboratively around the needs of their shared clients. While these attributes help define the model, this scope for variation within the attributes is key to HJP as a person-centred, cross-sector service model that can respond to local and individual need and operational context.

Planned studies in the EiP project next aim to explore how these attributes, and variation within the attributes identified here, may contribute to outcomes for clients, practitioners and partnering legal services.

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Appendix 1: Methods

Interviews

Semi-structured interviews were conducted by one HJA researcher who is trained and experienced in qualitative research methods. The interviews were informed by flexible topic guides developed by the HJA research team based on the key areas of enquiry. Topics explored in interviews with legal practitioners were types of legal staff working within the HJP, their scope of legal work, overview of HJP clients, operation and functioning of the HJP, resourcing and funding for the HJP, and outcomes of HJP. Interviews with healthcare workers included types of healthcare staff involved with the HJP, operation and functioning of the HJP, resourcing and funding for the HJP, value of the HJP for healthcare, and outcomes of HJP.

As is appropriate for qualitative research, analysis was conducted iteratively and informed the focus of ongoing data collection. Interview summaries were written by the interviewer after each interview. These summaries formed the basis for the research team's discussions and initial analyses. A thematic coding framework was developed and used for coding the interview data. Members of the HJP Advisory Committee were invited to participate in two sensemaking sessions, one to discuss preliminary findings and another to discuss initial write up of the findings. The Advisory Committee were also invited to review, edit, and provide feedback on two drafts of the Framework.

Appendix 2: Interviewees

Characteristics of interviewees

Lawyers (n=18)		No. (%)
Sex	Female	16 (89)
	Male	2 (11)
Lawyer roles	Managing lawyers	5 (28)
	'Front-line' HJP lawyers	7 (39)
	Managing and 'front-line' HJP lawyers	4 (22)
	Monitoring and evaluation specialists	2 (11)
State	NSW	6 (33)
	VIC	12 (67)
Healthcare workers (n=11)		
Sex	Female	10 (91)
	Male	1 (9)
Healthcare professionals	Clinical nurse consultant/mental health nurse	2 (18)
	Psychologist	1 (9)
	Mental health social worker	2 (18)
	Managers/Team leaders (Mental health)	4 (36)
	Managers/Team leaders (Community health)	2 (18)
State	NSW	4 (36)
	VIC	7 (64)

Evidence in Partnership

Health Justice Australia