

# Joining the dots

**2018 census of  
the Australian  
health justice  
landscape**

October 2019

# About Health Justice Australia

Health Justice Australia is a national charity and centre of excellence for health justice partnership. Health Justice Australia supports the expansion and effectiveness of health justice partnerships and works to change service systems to improve health and justice outcomes through:

- **Research:** Developing and translating knowledge that is valued by practitioners, researchers, policy-makers and funders
- **Practice:** Building the capability of health, legal and other practitioners to work collaboratively, including through brokering, mentoring and facilitating partnerships
- **Policy advocacy:** Working to reform policy settings, service design and funding, informed by the experience of people coming through health justice partnerships, and their practitioners.

## Authors

Suzie Forell, Research Director, and Marie Nagy, Researcher, Health Justice Australia

## Publisher

Health Justice Australia  
Level 5, 175 Liverpool St Sydney NSW 2000 Australia  
Phone: +61 2 8599 2183  
Email: [healthjustice@healthjustice.org.au](mailto:healthjustice@healthjustice.org.au)  
Website: [healthjustice.org.au](http://healthjustice.org.au)  
ISBN: 978-0-6483245-2-2

## Acknowledgments

Our thanks to the many practitioners who responded to the census and the services and partnerships they represent. It is their work that this report describes and their willingness to participate which contributes to our understanding of the landscape and how best to support it.

Thanks also to Dan Stubbs and Maie Gibney, Inner Melbourne Community Legal; Carol Quayle, Monash Health; and Marika Manioudakis, Eastern CLC, for their support including pilot testing the survey; and to Anne-Louise McCawley and the Health Justice Australia team for reviewing the report.

Report design: Anais Taylor

© Health Justice Australia, October 2019

Suggested citation: Forell, S, and Nagy, M (2019)  
*Joining the dots: 2018 census of the Australian health justice landscape*, Health Justice Australia, Sydney

# Contents

<b>Executive summary</b>	<b>6</b>
<b>Introduction</b>	<b>9</b>
<b>Methodology</b>	<b>10</b>
Respondents and response rate	10
How the legal and health service data are used in this report	10
<b>Services on the landscape</b>	<b>11</b>
Results	13
The growth of health justice services in Australia	13
The landscape across Australia	14
The service settings	16
The partners	18
People assisted	20
Legal issues addressed	23
Referrals between the health and legal partners	26
Type of legal assistance provided	27
Secondary consultation	28
Coordinated care	29
Cross-disciplinary training	30
Facilitating systems change	31
Activity to support partnering	32
Resourcing	34
Evaluation	38
<b>Implications and next steps</b>	<b>39</b>
<b>References</b>	<b>41</b>
<b>Appendix 1 Methodology</b>	<b>42</b>

## Shortened forms

ACCHO	Aboriginal Community Controlled Health Organisation
ACT	Australian Capital Territory
CALD	Culturally and linguistically diverse
CLC	Community Legal Centre
FDV	Family or domestic violence
HJA	Health Justice Australia
HJP	Health justice partnership
LGBTIQ+	Lesbian, gay, bisexual, transgender and gender diverse, intersex, queer plus
MOU	Memorandum of understanding
NDIS	National Disability Insurance Scheme
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
SA	South Australia
VIC	Victoria
WDO	Work and development order

# Glossary

<b>Care and protection (child protection)</b>	This refer to matters in which a human or community services department or child protection agency seeks to remove a child from their family due to a serious risk of or serious allegation of abuse or neglect.
<b>Health justice service</b>	Any service on the health justice landscape, including partnerships, outreach legal clinics, integrated services and service hubs. See <i>health justice landscape</i> .
<b>Health justice partnership</b>	Partnership between health services and legal services to embed legal help in healthcare services or teams.
<b>Health justice landscape</b>	The full spectrum of services that seek to provide legal assistance in healthcare settings, or with healthcare teams. Includes partnerships, outreach legal clinics, integrated services and service hubs.
<b>Integrated service</b>	Service in which a lawyer is employed by a health service as part of their healthcare team.
<b>Outreach service</b>	Lawyers attending health settings to provide a legal service or clinic but not considered to be part of the healthcare team.
<b>Service hub</b>	Place-based service hubs in which health, legal and other services work out of an accessible community setting (e.g. a housing estate).
<b>Secondary consultation</b>	Where health staff seek information from lawyers concerning a patient’s legal issue, or lawyers seek information from health staff concerning a client’s health issue.
<b>Warm referral</b>	Involves contacting another service on the client's behalf and may also involve providing a report or case history on the client for the service and/or attending the service with the client.
<b>Health partner/Legal partner</b>	We have used ‘partner’ to refer to each of the health and legal services that come together to provide a health justice service, regardless of where the service lies on the health justice landscape (and whether or not it would be considered a health justice partnership).

# Executive summary

## Health justice partnership: a response to complexity

Health justice partnerships are collaborations that embed legal help into healthcare settings, responding to legal and social problems that make or keep people unwell. This quiet revolution in service delivery is connecting health and legal care in the places that people are more likely to turn to for help, enabling service systems to better meet the complex and compounding issues facing many of the people they serve.

## Strong evidence drives collaboration

Since the World Health Organization's groundbreaking Commission on Social Determinants of Health (2008), the evidence has continued to grow about how social and environmental factors drive poor health. These factors include poor-quality housing, unstable or insecure work and family breakdown.

In 2012, a landmark study established that more than one-fifth of people in Australia experience three or more legal problems in a given year; and that vulnerability to legal need increases with deepening disadvantage. These legal issues may occur in clusters and many of them lead to illness. People often seek no advice for these problems but, when they do, they are less likely to seek help from a lawyer than another advisor such as a health professional.

Together, this evidence points to groups of people with intersecting health and legal issues who access health services with symptoms, but who do not seek out legal solutions. Health justice partnership responds to this evidence through collaboration to address the interconnected health and legal issues that can lead to and entrench disadvantage.

From the legal side, partnership offers the opportunity to reach and assist clients known to have unmet legal problems, but who do not access legal help in a timely way or at all. From the health side, partnership offers a broader range of tools beyond the medical to address factors which drive poor health (for a summary of this evidence see Forell & Boyd-Caine, 2018). For the people they serve, health justice partnership offers a more holistic approach to care.

## The census of the health justice landscape

Health Justice Australia (HJA) is the national centre of excellence in health justice partnership. Building upon HJA's first and foundational mapping of health justice services in 2017 (Forell, 2018), this 2018 census

describes the profile of the health justice landscape in Australia during the 2017-2018 financial year.

Data was received from legal partners in 73 health justice services and 25 of their health partners.

Responses from one-third of health partners in the 73 services reflects the primary role of the legal sector in driving health justice partnership in Australia, but also how this practice is evolving and HJA's emerging connection with health partners.

## A growing health justice landscape

Health, legal and community services come together in a variety of ways to provide legal help in healthcare settings. The 2018 census of the health justice landscape identified:

- health justice partnerships between different organisations;
- integrated services (where a lawyer is employed by a health service);
- outreach legal clinics; and
- legal help and healthcare as part of broader multi-agency service hubs.

Drawing upon both legal and health partner perspectives, the census reports activities of all services in Australia providing legal help in a healthcare setting or team: whether as legal outreach clinics, as integrated services, as service hubs or as health justice partnerships. Together these are described as 'health justice services' or a 'health justice landscape'.

The 73 services we report here, up from 48 health justice services reported in *Mapping a new path* (Forell, 2018), reflect both new services and higher participation in HJA's mapping work by existing services.

Fourteen health justice services commenced in the 2017 calendar year and eight in 2018.

## Reaching people with complex needs

The census indicates that services on the health justice landscape support people who are particularly vulnerable to multiple and intersecting problems.

Most health justice services targeted their support to particular communities or to address particular needs, including: family and domestic violence (15), mental health or addiction (12) and homelessness or other disadvantage (8). Eighteen services on the landscape reported working with Aboriginal and Torres Strait

Islander peoples, six with young people, four with older people, and one with the LGBTQI+ community.

However, the nature of complexity means that people with these problems are not only seen by specialist services. For instance, while only one in five health justice services specifically targeted family and domestic violence (FDV), people at risk of or experiencing family violence are seen in nearly 90% of all services on the landscape. More broadly, evidence indicates those experiencing FDV are 10 times more likely than others to experience a wide range of family, civil and criminal law issues and 16 times more likely than others to experience family law problems (Coumarelos, 2019).

Around one in six health justice services targeted support to those living with mental health conditions and/or addiction, yet more than four out of five indicated that at least 'some' of the people they served were experiencing mental health conditions and/or addiction. More than a quarter estimated that this applied to 'most' (>85%). All responding services indicated that at least 'some' of the people they saw were experiencing economic disadvantage, with nearly four out of five saying that this was the case for 'most' of their clients.

### Providing a range of help

Overall, the 'most common' legal issues reported to be dealt with in health justice services were: FDV and/or family law (a 'top three' issue for 62% of 65 respondents); fines and/or credit/debt (46%); housing/tenancy (31%); and care and protection (child protection) (31%). However, this varied between health justice services. FDV, family law, and care and protection were the issues most frequently reported as common in services targeting FDV. Fines, credit and debt were common among the 'top three' issues in services for young people, people who are homeless/in disadvantaged housing and those with mental health conditions and/or addiction, with housing problems also common.

The type of legal help provided includes advice, legal tasks (such as making phone calls on behalf of the client and drafting letters), casework and representation in court.

### Providing help in a range of health settings

Thirty-eight health justice services provided help in primary health settings, 30 in hospital settings and nine in community support settings, with some based in more than one type of setting. Of these, 17 health justice services were located in Aboriginal health or

community support settings, including 15 partnered with Aboriginal Community Controlled Health Organisations (ACCHOs).

In the vast majority of services, legal help is provided by community legal centres or legal aid commissions. One new partnership involves an Aboriginal legal service as the main legal partner in collaboration with an ACCHO. One longstanding partnership involves a private law firm in a hospital.

### Enabling a different way of working

Health justice partnerships break down siloed approaches to complex need by enabling:

- a greater range of strategies through the provision of legal help in healthcare settings
- more responsive client-centred service provision, including secondary consultation – whereby health staff can seek information from the lawyer concerning a patient legal issue, and vice versa
- coordinating cross-disciplinary care and strengthening practitioner capability through cross-disciplinary training.

### Driving systemic change

This new way of working is part of the systemic change being driven by health justice partnership. It is already resulting in:

- lawyers providing secondary consultations to health staff in 85%<sup>1</sup> of services. In two-thirds of services, health staff also provide secondary consultations to lawyers about health issues relevant to their clients.
- 70% of health justice services coordinating health and legal care for at least some patients/clients. In more than half of these the lawyer was included in clinical team discussions for at least some clients.
- 75% of health justice services' lawyers providing training to health staff, most commonly on particular topics such as family violence or how to spot legal issues. Training by health staff for legal staff was much less common.

While shared systemic advocacy has been central to the origin of the health justice partnership model, only a small proportion of more established health justice partnerships reported this activity over and above their direct one-on-one service delivery.

<sup>1</sup> Percentages and fractions are out of the number of respondents that provided an answer to each of the following questions, including 'don't know' as a possible response. There were 67 responses to this question.

## **Resourcing partnership**

To embed legal help into a healthcare team – moving beyond co-location to collaboration – requires a key ingredient: partnership. Partnership is a response to complexity and requires a range of processes, relationships and capabilities to work successfully towards shared goals, all of which require funding.

Currently, there is a much higher financial investment in health justice services by legal partners and the legal sector than health partners and the health sector. 60% of services indicated that their legal partner was their main source of funding in 2017-2018. The health service was the main funder for two services. Other funding sources were State/Territory and Commonwealth governments, philanthropy and the Victorian Legal Services Board Grants Program.

While reflecting the evolution of the health justice movement from the legal assistance sector, the reliance on legal sector funding is a concern for the future sustainability of health justice services, given the relative paucity of funding for public legal assistance (Productivity Commission, 2014).

To maintain this funding, legal services need to feel confident that investing in health justice partnership for those most difficult to reach and who require more support to effectively address legal issues is a sound use of scarce resources.

The current balance of funding may also indicate the need to identify HJPs as a compelling value proposition to health and government funders more broadly. Together these findings indicate the importance of identifying how legal help in health settings can improve patient outcomes and promote health service efficiencies. Supporting partnerships to identify and articulate their value is a continuing focus for HJA.



# Introduction

Health justice partnership (HJP) is a collaborative service model that embeds legal help in healthcare settings and teams. This practitioner-led innovation to address health-harming legal need has evolved into a movement attracting the interest of services, funders, researchers and policy makers across Australia. In 2016, Health Justice Australia (HJA) was established as a national centre of excellence for health justice partnership in response to this evolving movement.

In 2018, HJA published *Mapping a new path: the health justice landscape in Australia, 2017*, a first and foundational profile of the health justice landscape across Australia based on activity up to mid-2017 (Forell, 2018). Using that first survey as a pilot, we now report the findings of the 2018 census, covering services and activities on the health justice landscape in the 2017-2018 financial year.

# Methodology

The purpose of the 2018 census was to profile the health justice landscape in Australia during the 2017-2018 financial year and to provide consistent, comparable information about the range of services operating. Two separate survey instruments were used, one for legal partners and one for health partners. The surveys were sent to legal partner contacts with a request that they forward the health partner survey to their health partner contact. This was supplemented by broad communication about the surveys through the HJA network (e.g. Yammer page and other communications) and legal service peaks.

The rationale for using the legal partners as a key contact point for the survey is that the legal partner (e.g. the HJP solicitor or manager) is more commonly the one connected with HJA and the HJP network. They are also best able to identify the appropriate contact person in what are often larger health partner organisations. In future, HJA will aim to link directly with both health and legal partners to provide their input into the census.

Broadly, health and legal services were asked about:

- their organisation and their partners in the HJP
- service locations and settings
- clients targeted and assisted (legal partners)
- legal assistance provided
- partnership activities
- funding and resourcing for the service
- activity and outcomes data collected

The full methodology and limitations are detailed in Appendix 1. Survey instruments are available on the HJA website, [healthjustice.org.au](http://healthjustice.org.au).

## Respondents and response rate

This report is based on responses from legal partners involved in 73 services, and 25 health partners involved in 24 services. All services provided legal help in healthcare settings during the 2017-2018 financial year. Unless otherwise stated, data in this report relates to that timeframe.

We know of 10 outreach services (including four by one lawyer), one co-located health and legal service and

one integrated service (with the lawyer employed by the health service) that did not respond to the survey but were providing health justice services during the 2017-2018 financial year. There may be other legal outreach services in healthcare settings that HJA is not aware of. The response rate from all relevant services known to HJA was 86%. To the best of our knowledge, all Australian services that identified as health justice partnerships, and which saw clients during the 2017-2018 financial year, are included in the census.

## How the legal and health service data is used in this report

Due to the more complete dataset provided by the legal services (73 compared to 25 health service responses) we have used this as the core dataset. We have, however, checked these responses against the health service responses and reported the latter where possible and meaningful. Because of the lower response rate by health partners and the fact that, inevitably, more engaged partners will respond, the health partner responses cannot be seen as representative of the views or experiences of all health partners. Questions which were unique to health partners are reported separately.

Our primary reliance on legal partner responses skews reporting towards a legal service perspective on the data and landscape, and is a limitation of the study. However, it is also a reflection of the way that health justice partnership has evolved in Australia. The movement has been led primarily by the legal sector seeking to engage with the health sector, with HJA supporting and strengthening these cross-sector partnerships. The movement is yet to reach a place of equal engagement of health and legal partners across the landscape and the results of this census reflect that reality.

# Services on the landscape

The 2018 census of the health justice landscape gathered data from services that provided legal help in a healthcare setting or team during the 2017-2018 financial year. As was observed in our previous mapping of the landscape, these services come together in a range of ways: varying not only in the people they seek to help, the settings they work in and the help they provide, but also in how partners within the services connect and collaborate.

The census identified 73 partnerships, integrated services, outreach clinics and service hubs that provided legal advice and assistance in healthcare settings or teams during the 2017-2018 financial year. In this report we refer to these as 'health justice services' or together as the 'health justice landscape'.

In *Mapping a new path: the health justice landscape in Australia, 2017* (Forell, 2018) we identified different service models on this health justice landscape (Table 1). The rationale for identifying separate models was to

recognise that different ways of working may require different levels of resourcing and may have different potential outcomes. We were also keen to identify what it is that makes a 'health justice partnership'. As the discussion below indicates, however, the distinction between different models is not always clear in practice. Services vary for a range of reasons, not least the context in which they work. For some partners and in some settings, 'partnership' may not be the preferred or the most viable option.

We describe 'integrated services' as those in which the lawyer is employed by the health service, rather than separate health and legal services partnering to provide legal help in the health setting. 'Service hubs' identify place-based strategies where a range of agencies (e.g. health, legal, housing, family services) co-locate in an accessible location for clients. The location may not be a health setting but health teams are included among hub services.

Table 1: Service models on the health justice landscape

Model type	Broad description
<b>Health Justice Partnerships</b>	Partnerships between health services and legal services to embed legal help in healthcare services or teams.
<b>Integrated services</b>	Services in which a lawyer is employed by a health service, as part of their healthcare team.
<b>Outreach services</b>	Lawyers attending health settings to provide a legal service or clinic but not considered to be part of the healthcare team.
<b>Service hubs</b>	Place-based service hubs in which health, legal and other services work out of an accessible community setting (e.g. a housing estate).

Source: Adapted from Table 1 in *Mapping a new path: The health justice landscape in Australia, 2017* (Forell, 2018). Health and legal services may also work together in legal settings, such as courts and custodial settings. Such services are beyond the scope of the landscape as we are describing it here.

Broadly speaking, we identify ‘outreach services’ as legal clinics provided in health service settings, primarily as a strategy of the legal service to reach and assist clients with unmet legal needs and who do not otherwise access legal help. While they do support health service clients, lawyers are not embedded in the healthcare team.

HJA defines a ‘health justice partnership’ as partnership to embed legal help into healthcare services and teams to improve health and wellbeing (Box 1). Broadly, we understand HJP as a strategy to tackle the health, legal and other drivers of poor health at the individual level, by redesigning service systems and through policy change.

In this report we show that health justice services are working with clients who have complex and intersecting health, legal and other needs. The HJP model is premised on the understanding that it takes collaboration beyond simple co-location to address complexity, and to effect change for, but also beyond, the individual client.

A key finding from this census is that services do not neatly fit into categories of ‘outreach’ or ‘health justice partnership’. Rather, on the ground we see a continuum of practice.

In terms of the limited range of features identified in the census, at one end of the continuum are services that provide periodic legal help in healthcare settings with: no shared goals in a memorandum of understanding (MOU) between the health and legal services; no coordinated care between the health and legal service; and no training by legal staff for the health staff, or vice versa. There were only six such respondents in our survey.

At the other end of the scale we see partnerships which report: shared goals between the partners; coordinated healthcare and legal help around an individual as appropriate; interdisciplinary training; partners that meet frequently to manage and maintain the partnership; and a focus on shared systemic advocacy and/or systems change in addition to the client work (six partnerships).

Nearly two-thirds of respondents reported most, but not all, of these features. Further, the features and activities that they identified also varied. Some services provide interdisciplinary training and have capacity

#### Box 1: HJA definition of a health justice partnership

Health justice partnerships embed legal help into healthcare services and teams to improve health and wellbeing for:

- individuals, through direct service provision in places that they access
- people and communities vulnerable to complex need, by supporting integrated service responses and redesigning service systems around client needs and capability
- vulnerable populations, through advocacy for systemic change to policies which affect the social determinants of health (see Forell & Boyd-Caine, 2018).

for coordinated care, but not formally documented shared goals. Others have documented shared goals and perhaps lawyer training for health staff, but do not report other shared activities, such as coordinated care, health service training to the lawyers, and/or shared systemic advocacy. Some services that identify as outreach legal clinics – particularly those in remote locations – reported many features associated with HJP. While they may only be on-site fortnightly or less often (noting the small size of the host service), they do report cross-disciplinary training and coordinated care.

It is also clear from this and the last mapping survey, together with network feedback, that partnership activity ebbs and flows. At some times a partnership may look more like outreach, while at other times the collaborative practice is stronger. This variation across services, and within services over time, makes it challenging to neatly identify individual health justice services as either ‘health justice partnership’ or ‘legal outreach’. The census is therefore a valuable tool for identifying how services across the landscape may differ from each other and how each may change over time.

# Results

## The growth of health justice services in Australia

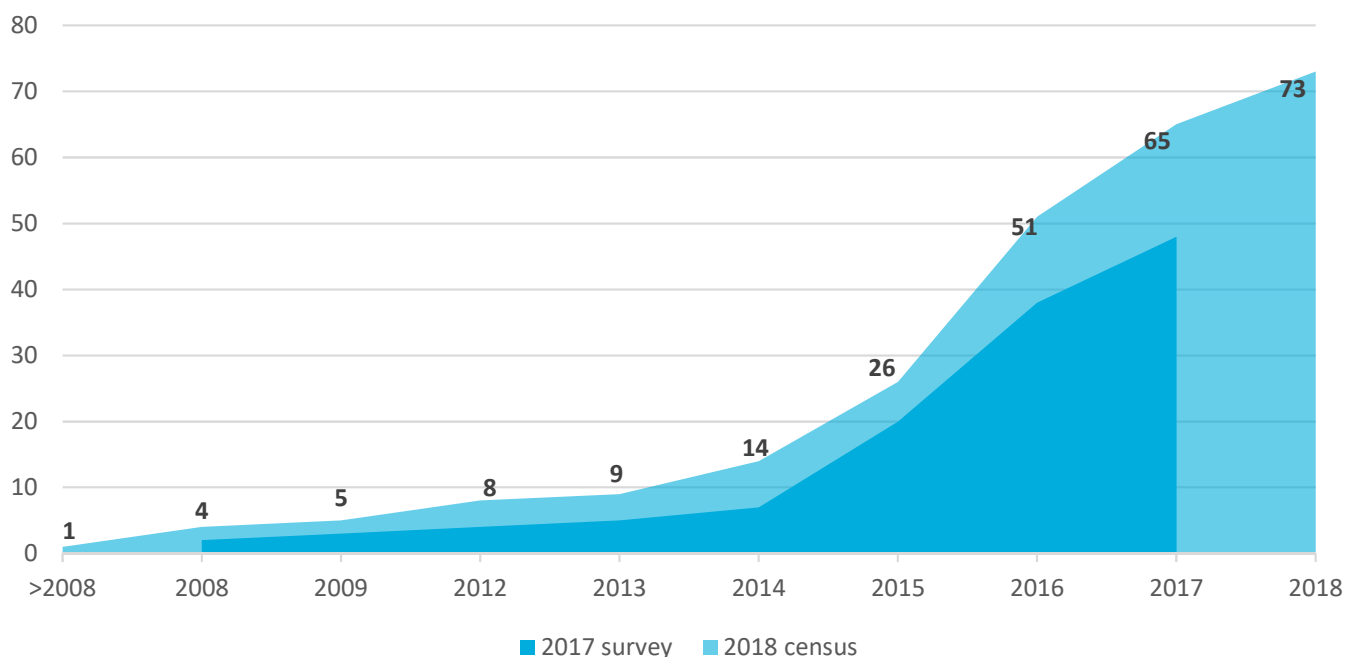
In this report we have identified 73 health justice services across the identified models (i.e. partnerships, outreach clinics, integrated services and service hubs). The vast majority were HJPs or legal outreach clinics. All of these services provided legal advice and assistance in healthcare settings or teams during the 2017-2018 financial year.

Respondents were asked in what year they commenced providing health justice services. Five respondents indicated that they had been providing legal services in the health setting for more than 10 years. Reflecting what was reported in 2017, most of the growth on the health justice landscape has been since 2014 (Figure 1).

A total of 14 health justice services were reported to have commenced in 2017 and eight in 2018.

The overall growth in the number of reported services here, compared to the 2017 mapping survey, reflects both additional services on the landscape and higher participation by existing health justice services in the 2018 census. In particular, these numbers include more services that operate as legal outreach clinics in health settings, but do not necessarily identify as HJPs.

Figure 1: Number of services on the health justice landscape 2008 – 2018



Source: HJA 2018 census, legal respondents. Count of health justice services (total N=73), displayed cumulatively, based on year of partnership commencement.

# The landscape across Australia

As was the case in 2017, the vast majority of HJPs and other services reported on the health justice landscape were in Victoria (Vic) and New South Wales (NSW) (Figure 2). There were 29 services reported in NSW and 28 in Vic (including one which crosses the NSW–Vic border). A higher proportion of NSW services were at the outreach end of the continuum, with more HJPs and integrated services reported in Vic. The two service hubs that responded were in NSW.

The rise in NSW from 15 health justice services in 2017 to 29 in 2018 is largely due to more comprehensive reporting by Legal Aid NSW of its wide network of health service-based outreach clinics and HJPs. The number of services reported in Vic has increased from 24 in 2017 to 28 in 2018, with the vast majority of these services being HJPs. In the Australian Capital Territory (ACT), a previous service is no longer operating, a new HJP has been established and three outreach services that were not reported in 2017 have been included. Tasmania was the only jurisdiction that did not have a health justice service operating in 2017-18.

Figure 2: The health justice landscape by state or territory



Source: HJA 2018 census, legal respondents. Count of health justice services (total N=73). One HJP works across the Vic–NSW border and is represented in Victoria.

## Partnerships in rural and remote locations

Four in 10 services on the health justice landscape are outside major cities. This may be seen as a relatively high proportion of health justice services reported in regional and remote areas compared to the Australian population distribution, and an increase since 2017. Contributing to this increase are new HJPs in the Northern Territory (NT) and the higher reporting of Legal Aid NSW remote area outreach clinics and partnerships, particularly as part of their program of civil law services for Aboriginal communities.

Table 2: The health justice landscape by remoteness classification

State or territory	Major cities	Inner regional	Outer regional	Remote	Very remote
New South Wales	16	9	1	3	
Victoria	16	9	2		
NSW/VIC	1				
Queensland	5		2		
Australian Capital Territory	4				
Northern Territory			1	1	1
South Australia	1				
Western Australia	1				
<b>Total</b>	<b>44 (60%)</b>	<b>18 (25%)</b>	<b>6 (8%)</b>	<b>4 (6%)</b>	<b>1 (1%)</b>

Source: HJA 2018 census, legal respondents. Count of health justice services (total N=73). Classified according to the 2016 Remoteness Area Category Names for Australia, based on the postcode or region of the service. If services work in multiple locations which cross remote classifications, we have placed them in the more remote location.

# The service settings

Health justice services operate in a range of settings: hospitals; primary or community health services; and community support settings. They may operate across multiple sites of the same type (e.g. two hospitals) or different setting types (e.g. a hospital and a primary health service; an Aboriginal Community Controlled Health Organisation (ACCHO) and a specialist school).

As Figure 3 indicates, half (38) of the health justice services operated in one or more primary health setting. Of these, 15 were based in one or more Aboriginal health services, 13 of which were ACCHOs. The types of other primary health settings included community health services, mental health and alcohol and other drug services, maternal and child health services, allied health services, a youth health service and an LGBTQI+ (lesbian, gay, bisexual, transgender and gender diverse, queer, intersex plus) health service. Three respondents indicated the primary health setting was 'general practice' (but in each case as part of a community health centre).

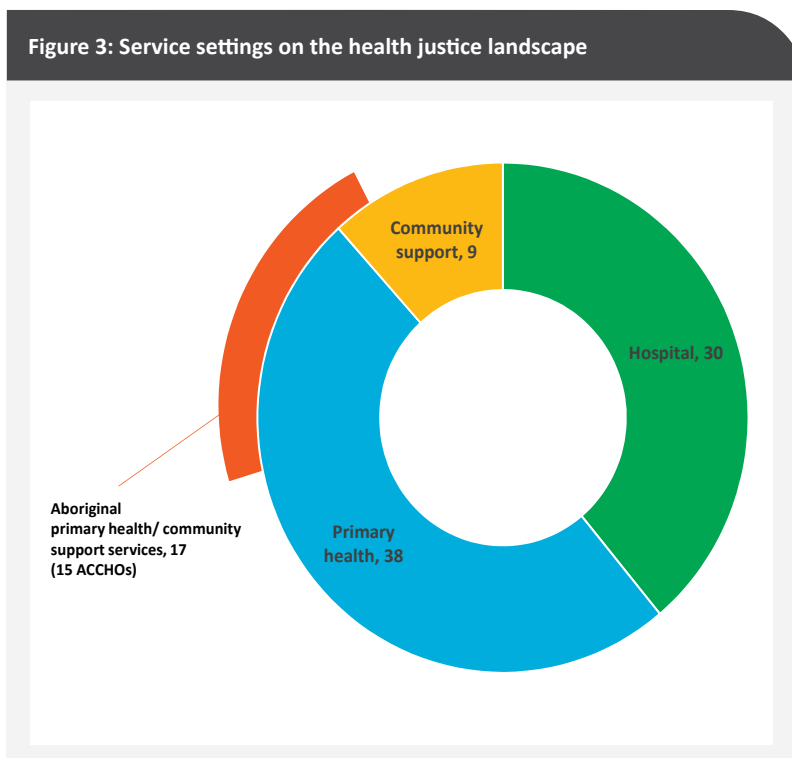
Thirty services provided assistance in at least one hospital setting.

Nine services operated in community support settings, including child and family services, a public housing setting, residential rehabilitation services, a suicide prevention service hub, general support services for people with mental health conditions and schools. Two community support settings support Aboriginal and Torres Strait Islander peoples specifically.

Two-thirds (49) of services operated at a single site, 17 operated at two sites and six at more than two sites (e.g. more than two hospital, community and/or community health service settings). Some community-based services do further outreach, for instance domiciliary and community nurses, who work out of a variety of locations (individual locations were not counted as separate settings).

Across the landscape, legal help was provided at more than 100 different health and community sites.

Figure 3: Service settings on the health justice landscape



Source: HJA 2018 census, legal respondents. Count of service setting types (total N=77), in N=72 health justice services. One respondent did not record any setting and was not included. Numbers add up to more than 72 as some services operate in more than one setting type.

Figure 3 shows the number of health justice services operating in each unique setting type. If a service is operating in a hospital and a primary health setting, both setting types are counted. If a service is in two hospitals only one setting type is counted. 13 of the 15 Aboriginal health settings were ACCHOs and one community support setting was run by an ACCHO. Another community support setting primarily supports Aboriginal and Torres Strait Islander peoples.



### **Health staff that lawyers connect with in hospitals**

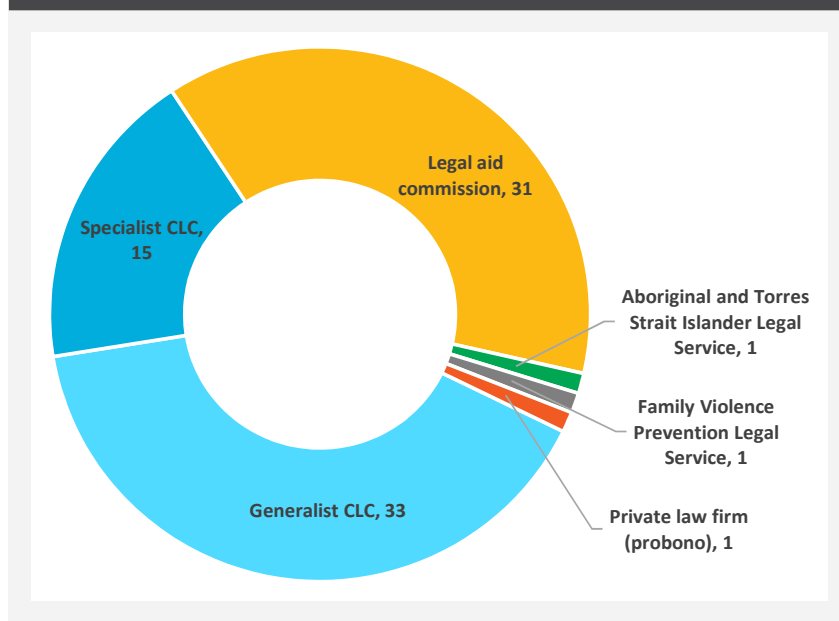
In hospital-based health justice services (N=30), six legal partner respondents said they most commonly liaised across the whole hospital. Noting they could provide multiple responses, nearly half said one of the units they most commonly liaised with was the social work department. Around one-third nominated maternity and a quarter nominated allied health. Six legal partners said the mental health unit was commonly worked with, two named oncology and one named the alcohol and other drug unit.

The small number of hospital respondents to the health survey indicated that their service worked across the whole hospital (7), one only with social work and two only with allied health.

# The partners

A diverse range of legal and health partners have come together across the landscape. Some partners (health or legal) are involved in more than one health justice service and some services involve more than one legal and/or more than one health partner.

Figure 4: Legal partners on the health justice landscape



Source: HJA 2018 Census, legal respondents. Count of legal partners (total N=82), in N=73 health justice services. Numbers add up to more than 73 as some services have more than one type of legal partner.

## Legal partners

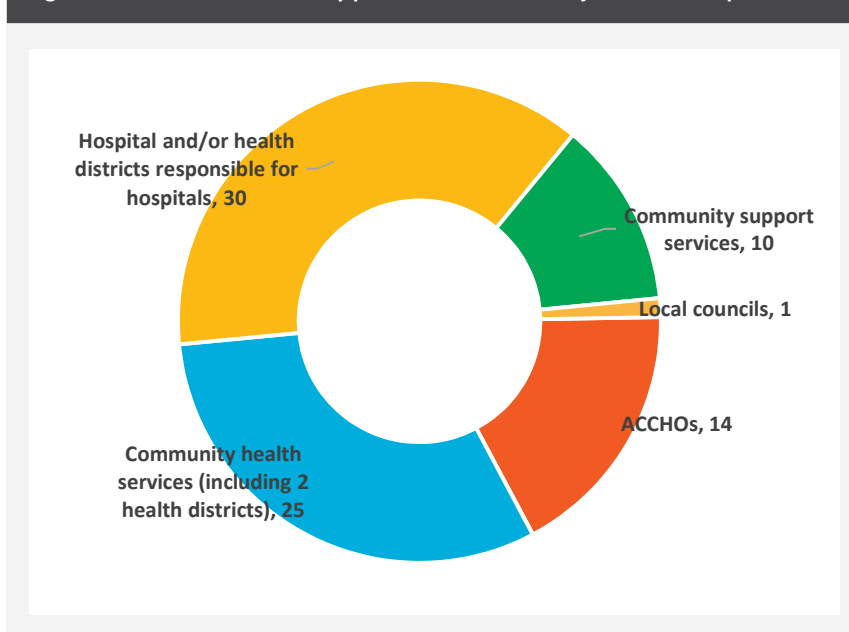
Australia-wide, generalist or specialist community legal centres (CLCs) were partners in two-thirds (66%) of services on the health justice landscape and legal aid commissions in 43%. However, proportions differ by state/territory. In Vic, NT, Qld and the ACT, most or all legal partners were CLCs, while a legal aid commission was the legal partner in most NSW services, one NT service and the SA service. The WA service involved the legal aid commission and two CLCs. In one partnership, the legal partner was a private legal firm providing pro bono legal assistance.

## Health partners

On the health side, state and territory differences make it more difficult to consistently classify services based on the information collected in the survey. However, in broad terms, the survey indicated that legal services have most commonly partnered with:

- hospitals (30 services). In 10 of these services, the administering health district or service was listed as a partner together with, or instead of, the hospital.
- Aboriginal Community Controlled Health Organisations (ACCHO) (14 services)
- other community health services (25 services). Administering health districts were listed as partners for four of these community health services, including two Aboriginal health units.
- community support services (a main partner in 10 services). Community support partners included: a department of family and community services, government family and child services, a university-supported service hub, education services, Aboriginal healing services, and alcohol and other drug rehabilitation services.

Figure 5: Health and community partners on the health justice landscape



Source: HJA 2018 census, legal respondents. In 73 health justice services counted in the census, the number of 'main' health and community partners was 78, reflecting that some services have more than one type of health or community partner.

In service hubs, we count the key health/community partners, but not every organisation providing assistance in the hub. Responses from legal respondents were checked against 25 health service respondents. As health administration structures vary from state to state, the term 'health district' is not applicable in all states and territories. Community support services include government community service and housing departments and non-government services.

## Other partners

In one of the service hubs on the landscape, the state family and community services, and housing departments were key partners, but there was a range of other partner services in the hub. In another, the main partner was a community support service, but again, a range of other government and non-government support agencies also provided services.

Evaluators were listed as partners by nine respondents.

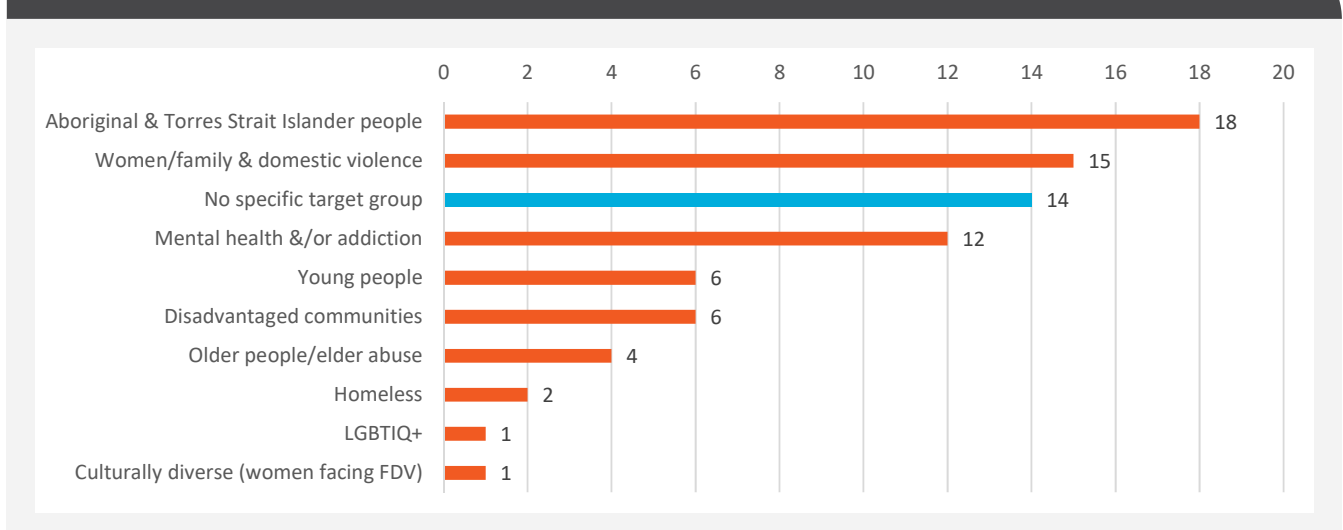
# People assisted

## Who are services targeting?

Just as the service settings vary across the health justice landscape, so too do the people or groups that services direct their assistance to. Just under one in five (14) health justice services targeted ‘the general community’, rather than a particular group or issue. Ten of these services were in public hospitals.

All other services targeted specific populations and/or legal issues. Some clinics/services were located in specialised health settings, such as a women’s hospital, a mental health service or an Aboriginal medical service. In other cases, target clients were identified within a more general health setting such as a hospital.

Figure 6: People and issues targeted by health justice services



Source: HJA 2018 census, legal respondents. Count of health justice service targets (total N=79) in N=73 health justice services. Numbers add up to more than 73 as some services targeted more than one client group or a sub group (e.g. homeless youth). Where two groups were specified, the service was counted in each group.

Noting these groups are not mutually exclusive, health justice services targeted:

- Aboriginal and Torres Strait Islander peoples (18 services, 25%)
- women and/or people experiencing family or domestic violence (FDV) (15, 21%)
- people living with mental health conditions and/or addiction (12, 16%)
- young people (6)

- disadvantaged communities including those in social housing or experiencing financial stress (6)
- older people, focused on elder abuse (4).

Some health justice services targeted a more specific population, such as homeless youth, women from culturally and linguistically diverse backgrounds facing FDV, Aboriginal and Torres Strait Islander young people, or Aboriginal peoples accessing alcohol and other drug rehabilitation services.

### Who are services seeing?

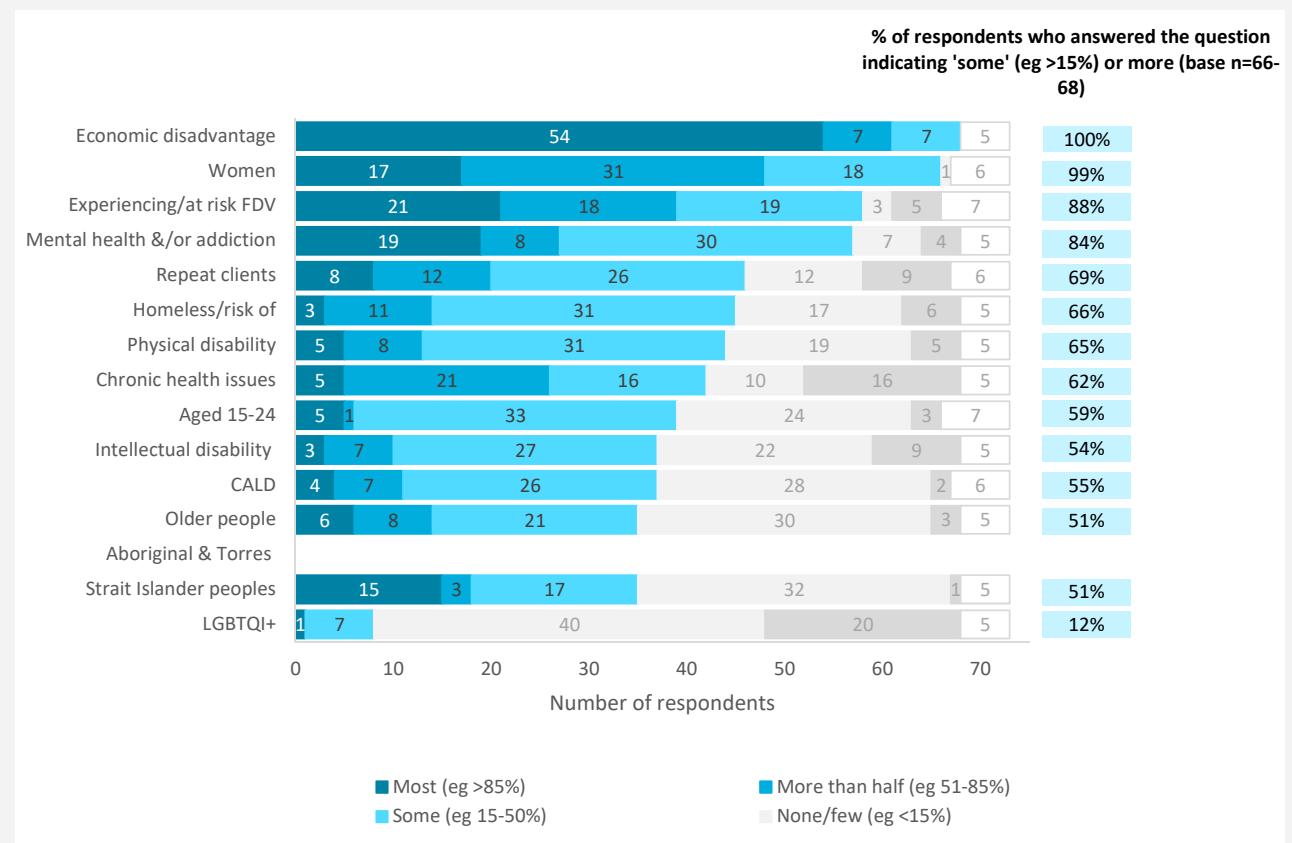
In addition to asking which groups are targeted by health justice services, we asked who lawyers actually assisted. Based on legal respondent estimates (N=66–68) and noting that some clients may face compounding issues:

- all respondents indicated that at least ‘some’ clients (e.g. >15%) were experiencing economic disadvantage, with nearly 80% indicating that ‘most’ (e.g. >85%) of their clients were facing economic disadvantage
- 88% indicated that at least ‘some’ of their clients were experiencing, or at risk of, FDV, with around one-third indicating this applied to ‘most’ of their clients

- 84% indicated that at least ‘some’ clients were experiencing mental health conditions and/or addiction. Nineteen legal respondents (28%) indicated that ‘most’ of their clients were experiencing these issues.

While this reflects lawyer assessment only, it aligns with the information from health service respondents, for whom mental health/addiction was the most commonly noted health issue faced by patients referred to the HJP (see Box 2). This client profile is consistent with the intent of partner legal services to reach and assist those who are experiencing vulnerability, who are likely to have unmet legal need and who likely would otherwise not access legal services.

Figure 7: People and issues seen by health justice services



Source: HJA 2018 census, legal respondents. Count of health justice services (total N=73). Respondents were asked to estimate, from their observations, the frequency with which the service served people having these features, in categories ranging from “None/few (e.g. <15%)” to “Most (e.g. >85%)”.

The 17 health justice services providing assistance in Aboriginal health settings (most commonly run by ACCHOs) primarily support Aboriginal clients. In addition, of the 50 services that did not specifically direct their services towards Aboriginal and Torres Strait Islander peoples, 17 estimated at least 'some' (>15%) of their clients identified as Aboriginal or Torres Strait Islander.

As suggested by the overall figures, women and other clients at risk of, or experiencing, FDV were commonly seen, even in services that did not specifically target FDV.

Of the 52 respondents whose health justice service did not target FDV (e.g. were generalist or supporting other target groups), nearly 85% (44) identified that at least 'some' of their clients were experiencing/at risk of FDV. Of the remaining eight services, just three indicated that 'none/few' of those they assisted were experiencing or at risk of FDV, with the other five responding that they didn't know.

Similarly, people requiring assistance with mental health conditions or addiction were seen well beyond targeted services. Of the 57 services that answered the question and were generalist or targeted towards other groups, four out of five (46) estimated at least 'some' of those they assisted were experiencing mental health conditions and/or addiction, with only seven reporting the incidence to be 'none/few'.

Respondents in 28 (42%) services estimated they saw no or few people from culturally and linguistically diverse (CALD) backgrounds in their service. These 28 included most that targeted Aboriginal and Torres Strait Islander people. Four health justice services indicated that most of their clients were from CALD backgrounds.

One service exclusively works with LGBTQI+ communities. The vast majority of services said they did not know how many of their clients were LGBTQI+, or that 'none/few' were, which we take to reflect that people did not disclose this information to service providers and/or services did not ask or collect that data.

Health service respondents were asked about the profile of patients seen in the health setting where the health justice service was located. With responses from 22 or 23 health partners for each question:

- 18 indicated that more than half of the patients in the setting were experiencing economic disadvantage (the remaining 4 respondents said they did not know)
- 10 indicated more than half the patients were experiencing mental health conditions and/or addiction (5 said 'some', 7 did not know)
- 10 indicated more than half the patients were experiencing chronic health conditions (5 said 'some', 6 did not know)
- 8 indicated more than half the patients were experiencing FDV (6 said 'some', 7 did not know)
- 15 said that more than half the patients seen were 'repeat users' of the health service (2 said some, 4 did not know).

Of note, the majority of these health service respondents said that 'most' (n=13), 'more than half' (3) or 'some' (2) of their patients would 'benefit from assistance by a lawyer'. One said their patients would not benefit from assistance by a lawyer, while the remaining six said they 'did not know'.

#### Box 2: Health issues facing clients referred to the HJP

Eighteen health partners described the types of health issues facing clients referred to their health justice service. The most common health issues reported (by setting type) were:

- mental health and/or alcohol and other drug issues (12 respondents: 6 in primary health, 3 hospital, 2 community, 1 ACCHO).
- injury (7: 6 hospitals, 1 primary health)
- chronic disease/illness (6: 2 ACCHOs, 2 primary health, 2 community)
- pregnancy or baby health (6: 4 hospital, 1 ACCHO, 1 primary health).

Other issues less commonly reported were: end-of-life care; homelessness and other social support needs; podiatry; and sexual health issues. Given the small number of health partner respondents, these figures are not representative of health issues faced by HJP clients across the landscape.

# Legal issues addressed

The census asked legal partners to list the three most common issues that they saw in their health justice service. Legal responses were received from 65 of the 73 health justice services, with most of the missing data pertaining to outreach legal services. Looking across all health justice services, the legal issues most commonly listed in the ‘top three’ issues seen were:

- FDV and/or family law (a top three issue for 40 of the 65 respondents, 62%)
- Fines and/or credit/debt (30 respondents, 46%)
- Housing/tenancy (20 respondents, 31%)
- Care and protection (20 respondents, 31%).

**Table 3: Most common legal issues dealt with by health justice services**

Legal issues	Number of services for which issue is among the most common	% of 65 services
<b>Family and domestic violence and/or family law</b>	40	62%
<b>FDV</b>	33	51%
<b>Family law</b>	28	43%
<b>Credit/debt and/or fines</b>	30	46%
<b>Fines</b>	20	31%
<b>Credit/debt</b>	19	29%
<b>Housing/tenancy</b>	20	31%
<b>Care and protection (child protection)</b>	20	31%
<b>End of life planning (power of attorney, wills), enduring guardianship</b>	9	14%
<b>Consumer</b>	9	14%

*Source: HJA 2018 census, legal respondents. Count of health justice services (total N=65). No response for 8 services. Respondents were asked to report, in open text, the ‘three most common types of legal issues’ seen by the HJP lawyers. Figures represent the number of services that included the issue in their ‘top three’ and add up to more than 65 because each service reported up to three issues.*

However, the most common issues identified vary with the specific needs targeted by the health justice service. As might be expected, all services targeted to women and/or those experiencing FDV listed FDV as a top three issue. The other most common issues were family law, and care and protection. Of note, 10 out of 13 services serving the general community also listed FDV and/or family law as a top three issue, and five indicated fines or debt as a top three issue. Equally, FDV and family law were issues commonly addressed by services targeting elder abuse.

By way of contrast, more than four out of five services targeted either to young people or to people living

with mental health conditions and addiction listed fines or debt as a top three issue. Housing was a top three issue for most services supporting those experiencing disadvantage/homelessness and half of the services supporting people experiencing mental health conditions and/or addiction.

For services supporting Aboriginal and Torres Strait Islander peoples, a wider range of top three issues was reported, most commonly FDV/family law, fines/money issues, care and protection and housing.

### Assistance provided for different types of legal issues

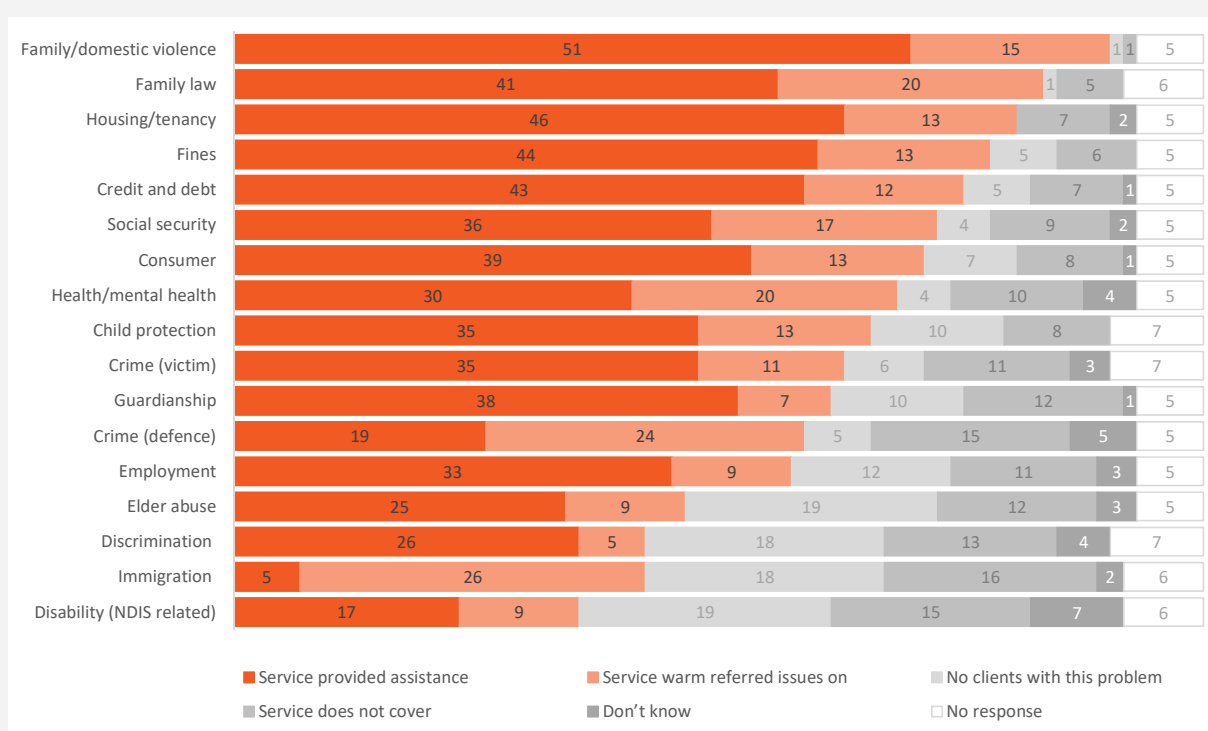
While the reported ‘top three’ issues give an indication of the matters that services commonly dealt with, we were also interested in the range of issues encountered and the type of help provided. Respondents were asked to indicate whether they had directly assisted or provided a warm referral for clients with a list of legal problem types. Options were also provided to indicate that the issue was out of scope for the health justice service or that it did not see any clients with the issues. Figure 8 shows the prevalence of different types of legal issues seen in health justice services and whether these issues were dealt with by health justice lawyers or warm referred.

As well as being one of the most common issues dealt with by many health justice services (Table 3), family and domestic violence was the legal issue seen by the highest number of services across the landscape. Almost all respondents who answered this question indicated that their service had assisted with FDV. In

around three-quarters of these services, assistance was provided directly by health justice lawyers (‘in-house’) and in the remainder, clients were warm-referred for legal help. Just one service reported not assisting any clients with FDV, while another said that it was out their service’s scope. Family law issues were also very common, though a little more likely to be warm referred to the legal partner’s agency or another legal service, or considered out of scope.

Figure 8 also indicates the issues least likely to be seen and/or dealt with in a health justice service: namely immigration (in-house assistance by five services and warm referral by 26 others); NDIS (National Disability Insurance Scheme) matters (in-house assistance by 17 services and warm referral by 9 others); and criminal law defence work (19 services). Beyond the list provided, ‘other’ legal issues nominated by respondents included motor vehicle accidents, insurance or workplace injury compensation, administration of wills and disputes arising, police complaints and stolen wages.

Figure 8: Health justice services’ assistance with specific legal issue types



Source: HJA 2018 census, legal respondents. Count of health justice services (n=73).



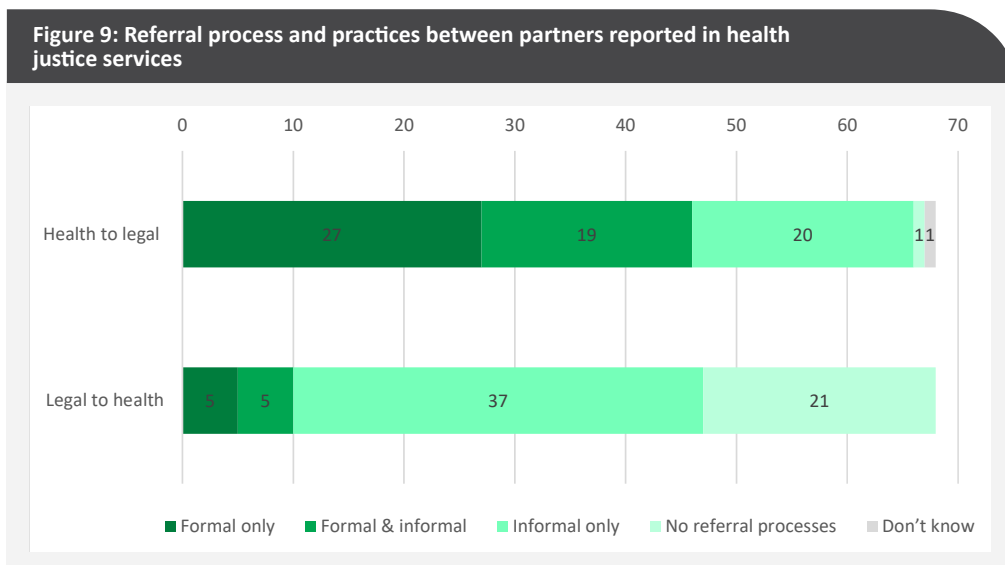
As with the 'top three' reported issues, the range of problems seen in different health justice services varied with the services' focus. Comparing services targeting different issues and people:

- In all services targeting FDV, FDV issues were dealt with directly by the health justice lawyers. In services that did not specifically target FDV, 70% dealt with FDV issues in-house, while 27% warm referred these matters to other legal services.
- In terms of the range of issues addressed, services targeting FDV focused on family and domestic violence, family law, and care and protection (child protection). These services also commonly dealt with immigration issues, but generally by way of warm referral. Less than half of these services said they had provided assistance or warm referral for issues such as employment, guardianship, crime (victim or defence), health/mental health or disability, elder abuse, discrimination, social security or housing.
- By way of contrast, most services supporting Aboriginal and Torres Strait Islander peoples provided legal assistance or warm referral for nearly all the listed legal issues, though fewer of these services dealt with immigration and elder abuse issues.
- Services targeting the needs of people experiencing mental health conditions and/or addiction also dealt with a wide range of legal issues. In particular, most assisted with or warm referred criminal defence matters (9 of 10 that responded) and discrimination matters (8 of 11). In contrast, criminal defence matters and discrimination were less commonly dealt with in generalist health justice services (5 of 12 and 4 of 12 respectively).

# Referrals between the health and legal partners

One indicator of an active relationship between partners is the level and type of client referral between the partner organisations. A referral may involve a health provider identifying that their patient has a legal problem, speaking with a patient/client about the fact that available legal help might assist, and booking them in or bringing them to the legal service available on site.

With health justice services providing legal help in the health setting, we see more formal and informal referral processes to legal help than from the lawyers back to the health provider (Figure 9). As indicated by the boxed quote opposite, the appropriate mix of formal or informal referrals is context specific.



Source: HJA 2018 census, data combined from 68 legal respondents and 23 health respondents. Count of health justice services (N=68). No response for 5 services.

## Health to legal

Based on data combined from both the legal and health partner surveys, 46 services (68%) reported formal referral processes from the health staff to the legal staff: of these, 19 also reported informal processes. A further 20 indicated informal but no formal referral processes. One respondent indicated that clients called the service directly and did not report a referral process.

## Legal to health

Only 10 services indicated that there were formal referral processes from the legal staff back to the host health service, five of which also had informal processes. More commonly the referral processes from the lawyer back to the health service were only informal (37 or 54% of services), while 31% indicated no referral procedures at all.

# Type of legal assistance provided

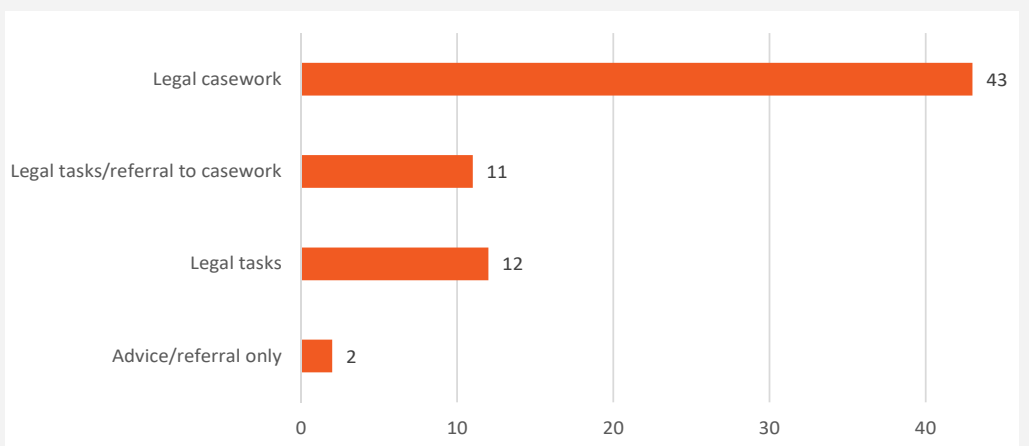
Generally speaking, the more complex the legal issue or intersecting set of issues that a person faces, and/or the lower a person’s legal capability to address the issue, the more intensive the support required to resolve a legal issue (McDonald & Wei, 2015; Pleasence et al, 2014). Data provided above about the profiles of clients and the range of legal issues seen in health justice services indicates the need for a range of legal service options (advice through to casework) that can be appropriately tailored to each client and their circumstances.

Figure 10 indicates the most intensive form of assistance that legal respondents say they can provide in their health justice service. All indicated that their health justice service could provide legal advice, with all but

two saying they could undertake ‘legal tasks’ (e.g. writing letters or making phonecalls for clients). Just under two-thirds (43) said they were able to provide casework/representation services and 11 more could undertake legal tasks and provide warm referrals to casework. To place this in context, much of the legal assistance provided by community legal centres more generally is in the form of legal information and resources, community legal education, legal advice and referrals, and minor assistance (e.g., Cameron, 2017 pp. 37-38; Productivity Commission, 2014, Chapter 5 and p. 671).

The relative intensity of assistance provided through health justice services reflects the complex and compounding health and legal needs of the people they serve.

Figure 10: The most intensive level of legal assistance reported in health justice services



Source: HJA 2018 census, legal respondents. Count of health justice services (N=68). No response for 5 services.

**The HJP with [the health service] is very informal. My experience as an Aboriginal person and with my dealings with a lot of Aboriginal organisations is that arrangements are informal and based on relationships between staff. Also strictly speaking I see the relationship not so much as an HJP but more as providing an accessible legal clinic to the ... community as well as the [health service] staff referring clients to me. – Legal partner**

## Secondary consultation

In the context of health justice services, secondary consultation is when a lawyer provides information to a health professional about a legal issue facing a patient/client, or when a health professional provides information to a lawyer about a health issue facing a person they are assisting. Secondary consultation is particularly useful when a health professional is not sure if the issue their patient faces is a legal issue or where the patient is not ready to speak directly to a lawyer about an issue. For lawyers, secondary consultations with health professionals may provide greater insight into how a client's health issues may be impacting upon their legal issues and their current capability to address these issues. Secondary consultation is of interest as it may speak to a relationship between partner services, including the familiarity of the knowledge, skills and expertise each partner can provide.

With responses for 67 health justice services, 85% (57) said that legal practitioners provided secondary consultations to partner health professionals, seven said they did not and three did not know. Two-thirds (45) reported that health professionals provided secondary consultations to the legal practitioners, one-quarter (17) said they did not and five did not know.

Among the health partner respondents we saw slightly higher reporting of secondary consultation in each direction. However, this smaller group of respondents may represent a more engaged subset of health partners, relative to others on the landscape.

**...health worker has secondary consult with me, if appropriate health worker arranges client appointment, after client appointment I meet with health worker to arrange any necessary services or to get further information. I keep health worker in the loop and use them as the main contact point for the client. I use health worker to arrange further client appointments where necessary and appropriate. – Legal partner**

# Coordinated care

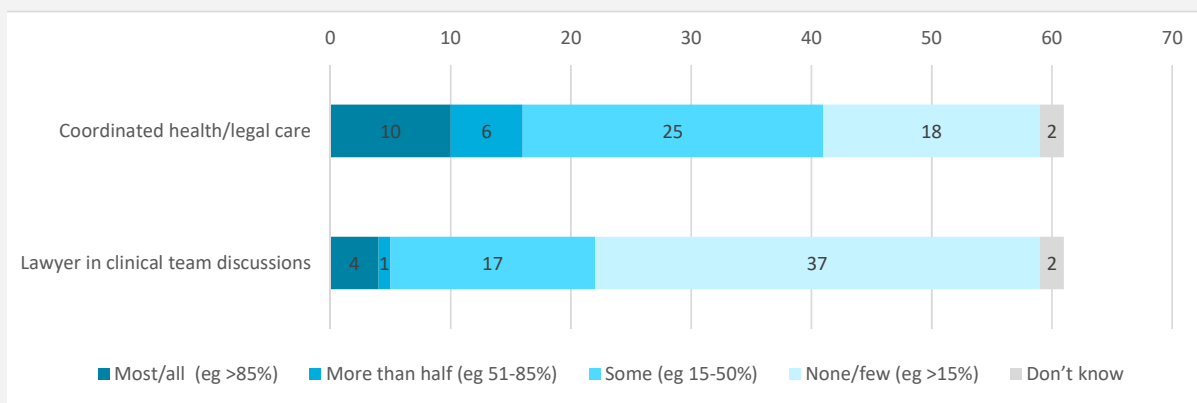
One indication of collaboration beyond the co-location of health and legal services is the capacity to coordinate legal assistance with the healthcare provided to a patient/client. Again, coordinated care is a possibility arising from the relationship between partners, and the familiarity of knowledge, skills and expertise each can provide in relation to the support of shared clients/patients.

Respondents were asked to estimate for what proportion of clients they ‘coordinated the legal assistance of a client with the healthcare provided to that client’. As indicated by Figure 11, of the 61 services

responding to this question, 70% (41) indicated they coordinated care for at least some (more than 15%) clients. Of these, six services indicated that they did this for more than half of their clients and 10 indicated that they coordinated care for most clients.

Fewer services reported having the lawyer participate in clinical team discussions, with 61% of respondents indicating that this occurred for none or very few of the clients. Twenty-two respondents indicated that health justice lawyers were included in team discussions for at least some clients.

Figure 11: Coordination and communication activity reported in health justice services



Source: HJA 2018 census, legal respondents. Count of health justice services (N=61). No response for 12 services.

Services were also asked if they shared the support of patients/clients in some other way. Noting that some people may have used this field to further explain the ‘coordinated care’ they provide, comments included:

*Ongoing communication, sharing tasks, providing regular updates, sometimes joint meetings.*  
(legal partner)

*The mental health clinician focused on the mental health concerns whilst the lawyer addressed the legal issues that were impacting upon the person.*  
(health partner)

*My role, legal case manager, is responsible for liaising between clinical and legal teams and the care provided by both for clients.* (legal partner)

*With client’s consent, discussion with health worker.*  
(legal partner)

*Where an urgent restraining order is required the HJP solicitor is able to coordinate with the health service to ensure that we are able to gauge physical health and mental health concerns so as there is minimised health risk to the patient while going through the application process. We also work closely with the legal service for women who are at risk of having a child taken into care and protection.*  
(health partner)

*Service provider generally sits in on legal advice, with client’s consent. Service provider provides information on therapeutic situation of the client and assists with support and referral.* (legal partner).

# Cross-disciplinary training

Another key feature of a health justice partnership is cross-disciplinary training: to build the capacity of partner staff to effectively work together to identify, refer and support their common patients/clients.

Training across the health justice landscape takes many forms, from discrete formal sessions to information provided more informally, such as in:

*'...regular social work meeting attendance, to advise of referral method and remind people of the service.'  
– health service respondent)*

## Legal to health partner training

Fifty health justice services (75% of those who responded to the question) indicated that the legal practitioners provided training to their health partners during the 2017-2018 financial year, while 14 (21%) said they did not. Topics most commonly covered included:

- FDV (including legal processes) (22 respondents)
- how to spot a legal issue/conduct a legal health check (19)
- about the HJP or legal service and how to refer (16)
- fines, debt/consumer issues and in NSW, Work and development orders (WDOs) (10)
- family law (6).

Other topics included care and protection, elder abuse, power of attorney and guardianship, how to work with lawyers and information sharing. One service provided training about the NDIS. The provision of training to health staff is a common feature of HJPs but is also undertaken by a number of outreach legal clinics. Seven

health partner respondents described training provided to them about court processes, the legal system and legal remedies, including WDOs.

## Health to legal partner training

Only nine legal partner respondents (and six health partner respondents) reported that health staff provided training to the HJP lawyers during the 2017-2018 financial year. Training for lawyers by health professionals most commonly covered issues including working with clients with complex needs, including dementia, living with trauma and substance abuse.

While limited to a few services, the census indicated training for lawyers by health staff was provided in a range of settings, including large hospitals, large community-based networks, small health services targeting specific client groups and a community service hub.

## Community legal education

More than half (37) of the legal partner respondents indicated that their health justice service provided community legal education, services or practitioners outside the host service. The most common topics were:

- FDV and/or family law (11)
- civil law issues (e.g. housing, employment, social security), and/or consumer issues (11)
- information about the HJP and referral process (10 respondents)
- fines and debt (7)
- elder abuse, power of attorney, guardianship, wills (7).

**'Elder abuse, how to best discuss a referral to a lawyer with patients/clients to engage them in the process, legal areas the HJP can assist with, information about these legal areas and how the HJP can help patients/clients with these areas (e.g. what lawyer might do and what the process and outcome may be), ethical/confidential obligations of HJP lawyer, documentation of role, process of secondary consultations'  
–Health partner, describing training provided by their HJP lawyer**

# Facilitating systems change

Health justice partnership can itself be understood as a change in the way health and legal services work together to address complex or intersecting need. Partnerships may in turn promote broader systems change, within and beyond their partnering agencies. We asked legal and health respondents if their 'HJP/partnership [had] facilitated change to the way that the health or legal services address client needs' (systems change) in the reporting period. Of the 66 responding legal partners, 30% (20) indicated that their partnerships had facilitated systems change, while 56% (37) services said they had not. Nine legal partner respondents said they did not know.

Of interest, 15 of the 25 health respondents indicated their partnership had facilitated change in the way that the health or legal services address client needs. In eight of these partnerships, the legal partner indicated that HJP/partnership had not facilitated systems change or that they did not know if it had.

The apparent difference in view between health and legal partners may in part reflect the differences in the way the question was interpreted by respondents. It may be that, when considering 'systems change', legal partners were not considering their partnering work as change, or were focusing on changes that the HJP is making beyond the fact of partnering itself.

By way of contrast, health partners may be seeing the fact of their partnering to provide legal help to their patients – the additional activities and resource this represents – as a systemic change in their service environment. Those activities include the two-way secondary consultations, cross-disciplinary training, established and warm referral pathways and coordinated care, all reported above. As the data above indicates, these are practices we are seeing – to greater and lesser degrees – across the health justice landscape.

## Systemic advocacy

Policy advocacy and law reform work (systemic advocacy) are core to the work of community legal services (NACLC, 2018 p. 12). On the health justice landscape, systemic advocacy may involve identifying how law, policy or practice is systematically affecting the health and wellbeing of people and communities, then using that information to influence change to those laws, policies or practices. The health justice partnership model aims to amplify the impact of policy advocacy through the shared voices of health and legal partners (Gyorki, 2013). However, this census indicates that partnership activity around systemic advocacy is not common.

Twelve legal respondents (18% of those who answered this question) indicated that they had undertaken policy advocacy or law reform activities as a partnership during the 2017-2018 financial year, over and above any advocacy work undertaken by the individual partner organisations. Forty-five (69%) indicated they had not done so and nine did not know.

Thus, while systemic advocacy is part of the potential for HJPs – and a key aspect of the medical legal partnership model in the United States – this appears still to be developing as a standard feature of services on the Australian health justice landscape. However, based on HJA interactions with partnerships during the reporting period, we are aware of the enthusiasm for this work among existing and emerging HJPs.

# Activity to support partnering

All services on the health justice landscape provide legal help in healthcare settings. Moving beyond co-location to collaboration, embedding legal help into a healthcare team requires the key ingredient of partnership.

Partnership is complex, requiring a range of processes, relationships and capabilities to work successfully towards shared goals (HJA, 2019). Here we report a subset of activities and structures relevant to partnership that were explored in this census. As a census is not a tool to determine the strength or health of partnership approaches, Health Justice Australia is developing appropriate methods to support partners to assess and respond to the health of their partnerships.

## Documenting the relationship

More than three-quarters (50) of the 66 legal respondents who answered this question indicated that they had an MOU with their partner organisation, while one integrated service indicated that this was not applicable. In the previous mapping survey, two-thirds of respondents (31 of 47) indicated that their partners had signed a formal MOU for their service.

The fact of an MOU does not necessarily indicate partnership. However, there may be key content which supports (and points to) partnership, such as the articulation of shared purpose or goals, and clarification of roles and responsibilities.

More than 70% of legal respondents (46) said that the roles and responsibilities of each partner were outlined in an MOU or other documentation, while nearly one-quarter (15 services) indicated that roles and responsibilities were not formally documented.

The vast majority of responding health partners reported that they had an MOU with the legal partner.

## Shared goals

Partnership literature points to a shared vision and sense of purpose as key when building and maintaining an effective partnership (Promoting effective partnering, n.d.; HJA, 2019; Forell & Boyd-Caine, 2018). The census asked if the service or partnership had shared goals articulated in their MOU or in other documentation. One third of legal partner respondents (22) indicated that their partnership had shared goals documented, while half (32) said they did not. For

one integrated service this was not applicable and 11 indicated that they did not know.

Among the 25 health partner respondents, six agreed with their legal partner that they had shared goals. Another seven health partners indicated that they had shared goals, when their legal partner responded differently, saying they did not. The remaining responses matched those of their legal partner in saying the service did not have shared goals or they did not know if it had.

While we only have data from both partners in one-third of partnerships, the level of discrepancy between health and legal responses and, 'don't know' responses about shared goals is notable. This may reflect the fact that a census is a blunt instrument for assessing shared goals, as it can't identify how alive these goals may be in practice, beyond the written record.

The results do, however, point to the further support that HJA could provide partners on the landscape: to support partners to develop a shared sense of purpose and goals, to communicate these goals and to revisit and amend them as required.

The shared goals articulated by 27 health justice services can be grouped as following:

- improved access to legal help for clients with unmet/health-harming legal need, particularly vulnerable client groups (12)
- increased capacity of health service staff to identify and refer legal issues facing patients (12 partnerships)
- improved client health and wellbeing (9)
- holistic/integrated care for clients; improved/integrated service model for clients with complex needs/to demonstrate the model (5)
- increased capacity of legal service staff to identify and refer legal issues facing patients (5)
- improved engagement with clients/community to understand complex needs (4).



## Ongoing communication

Clear communication processes are foundational for effective partnering (HJA, 2019).

In addition to the activities listed above, respondents were asked how often their partnership met in 2017-2018 to discuss 'HJP activities, progress, the health of the partnership, and/or strategic direction'.

Of the 64 legal respondents that answered this question, 19% (12) said they met every 4-6 weeks, 19% said quarterly, with nearly half meeting at least two to three times during the year. Thirteen services said they met 'as required' or informally. A further nine services met once in the 12-month period.

Nine legal respondents, all working in outreach legal clinics, said their partnership did not meet to discuss activities, progress, the health or the strategic direction of their health justice service during the year.

In 10 cases where responses were received from health and legal partners of the same health justice service, their answers were the same. In the remainder, partners' responses differed to varying degrees (e.g. quarterly compared to six weekly; quarterly or annually compared to informally; monthly compared to 2-3 times per year; monthly compared to don't know).

### Box 3: Examples of HJP goals

*Objectives of the HJP: Patient support - integrated legal support for patients in health setting, doing all things they are reasonably able to ensure appropriate referral, to help address the social determinants of health, increase the well-being of patients and addressing and case-managing their issues holistically. Staff Support: After family and friends, women experiencing family violence are most likely to disclose family violence to a health professional. [Partner services] will work together to better support the hospital's medical and allied health staff who are assisting patients experiencing family violence by onsite legal presence, developing and improving screening, identification and referral in relation to family violence, developing and delivering accredited training to staff in relation to family violence.*  
– Legal partner (hospital partnership).

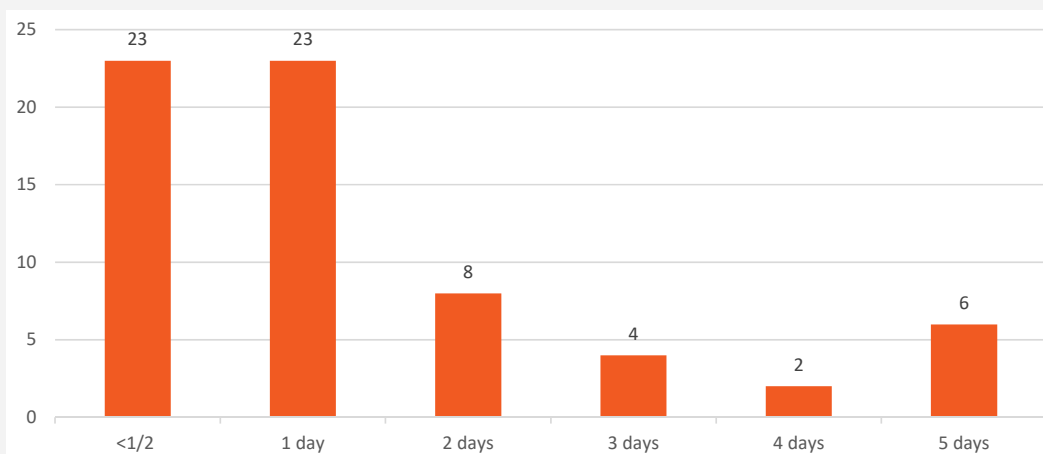
*To improve the number of women referred to the partnership for legal advice following a family violence incident. To educate all staff regarding legal matters, and to build confidence in staff to assess and refer women to the [partnership]*  
– Health partner (community health partnership).

# Resourcing

## Hours the service is open and accessible to clients

The census explored how many hours per week legal assistance was made available in the health setting. Noting that some health justice services operate in multiple locations, we report below the total number of lawyers' client-facing hours for the health justice service as a whole.

Figure 12: Client-facing days per week (up to and including) for health justice services



Source: HJA 2018 census, legal respondents. Count of health justice services (N=66). No response for 7 services. Where services have more than one location, the number of hours are combined. The hours per week are up to and including the number of days per week specified.

Over one-third (23) of legal respondents said their service was open to clients for up to half a day a week (Figure 12). Three added that clients could contact them by phone outside of these hours. Among those providing assistance for up to half a day a week are legal clinics which were on site at the health service fortnightly or monthly; and, in two cases, every 6–8 weeks, so the figure provided by respondents reflects an on-average calculation.

A further third (23) of health justice services were on site at the health location for half to a full day each week and the remaining 20 were available for two or more days a week.

As indicated below, health justice partners invest hours well beyond client-facing hours.

### Legal partner staff hours allocated to the HJP

Data was collected about the number of staff hours per week that legal partners contribute to the health justice service, including:

- time spent on face-to-face legal help and associated legal work for those clients
- providing training or other support to the partner organisation (e.g. lawyers training health staff about how to identify legal issues and refer clients) and community legal education
- building or maintaining the partnership (e.g. meetings, planning, evaluation activity, informal liaison, governance etc)
- administration
- undertaking systemic advocacy (although this to a lesser extent, according to the census).

Data was collected for paid lawyers, para-legals, community engagement workers, social workers, supervisors, administrative staff, any voluntary staff and 'others' engaged by the legal partner.

Sixty legal partner respondents provided information about staff hours per week allocated to the health justice service. Overall, these legal partners provided a median of 13.25 staff hours per week, 7.75 of which were lawyer hours. Based on the data collected, two-thirds of the investment from legal partners is in lawyer and paralegal time (noting this includes time spent on training and partnership work), with the remainder spent on administration, supervision and management, and in a small proportion of services, on community engagement.

Turning to lawyer hours:

- one quarter (16) of these services reported 30 minutes per week (calculated from two hours per month) to 3.75 lawyer hours per week
- 14 reported 4–7.75 hours per week
- 10 reported 8–15.5 hours per week
- 19 reported 16–45 hours per week.
- One service recorded 114 hours lawyer per week, reflecting three FTE lawyers.

The census indicates that, on average, these 60 services contributed a total of 1,578 hours per week through their health justice service, including 940 of lawyer hours.

### Health partner staff hours

The number of health partner staff hours were not specifically examined in this census and cannot be quantified. However, information on the non-financial contributions of the health partners (see Table 5, below), together with responses to other questions, indicates that health staff time is spent:

- making and supporting referrals to the lawyer
- in secondary consultations with the lawyer about patient needs
- coordinating care
- participating in (and, to a lesser extent, providing) HJP training
- building and maintaining the partnership and
- managing governance and administration related to the HJP.

**Funding sources**

Critical to the sustainability of health justice services is their funding. Respondents were asked to indicate the main and supporting sources of funding for their service during the 2017-2018 financial year. Four out of five (81%) services that could provide this information indicated that their main funder provided 75–100% of the funding for their health justice service. Therefore, we first report main funders (see Figure 13). For the 66 services for which we have data, nearly 60% (38) indicated that the legal partner was their main funding source. In nearly all cases, it was provided from core funding as staff time. Of note, legal outreach services are included in these legal partner-funded services. Two partnerships indicated the health partner as their main funding source. One was funded as a project within the health service’s budget while the other drew upon the partner’s core funding.

The Commonwealth Government was reported as the main funder of seven services, all under the Women’s Safety Package, though these include four provided by the same legal partner in partnership with different hospitals. All partnerships reporting a state or territory government as the main funder were in Victoria (through the Department of Justice, Victoria Legal Aid

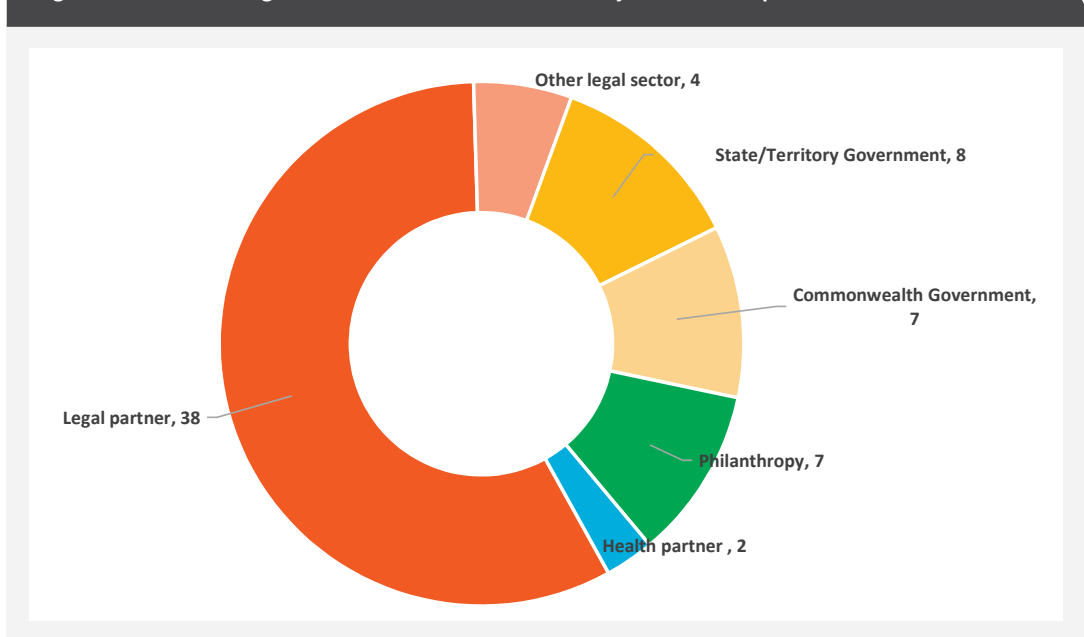
and/or the Department of Health and Human Services), though a NSW HJP also received considerable (but not the most) funding from NSW Department of Family and Community Services (Table 4). ‘Other legal sector’ funding in this financial year was all from the Victorian Legal Services Board Grants Program.

Table 4 indicates the main funding source and ‘additional funding sources’.

The heavy reliance on legal services as the main source of funding may flag a concern for the future sustainability of health justice services, given the relative paucity of funding for public legal assistance (Productivity Commission, 2014). Thinking more broadly, while HJP is a key strategy used by legal assistance services to reach priority clients and provide timely, appropriate and integrated services, their work also supports the health and wellbeing of clients and thereby, the work of their partner organisations.

A priority for HJA is to demonstrate the unique value of legal help in health settings to patients/clients, to health service capacity and to service efficiency and effectiveness in order to identify HJPs as a compelling value proposition to health and government funders.

**Figure 13: Main funding sources for services on the health justice landscape**



Source: HJA 2018 census, legal respondents. Count of health justice services (N=66). No response for 7 services.

Table 4: Main and supplementary sources of funding for health justice services

Funder type	Main funding source (N=66)	Additional funding source (N=27)	Total
Legal partner	38	8	46
State/Territory Government	8	14	22
Philanthropy	7	3	10
Commonwealth Government	7	1	8
Other legal sector	4	5	9
Health partner	2	5	7

Source: HJA 2018 census, legal respondents. Count of health justice services (N=66) reporting a 'main funding source'. No response for 7 services. 27 health justice services named at least one additional funder, with a total of 36 additional funding sources identified.

### Length of funding

Services were asked to indicate the date from which they received their main funding; and the date to which they are currently funded. Forty services did not respond to this question. The majority of the non-responding services were funded from their legal or health service's core funding. This may be ongoing funding or subject to the priorities of the funding agency.

Noting the very low response rate (which means that this information is not representative of all partnerships), the reported current funding periods ranged from nine months to 4.3 years.

All but two services that provided a start date for their funding also provided an end date. Of the 33 respondents that answered this question, 23 indicated that they were funded to a date before 30 June 2019, including five that provided a 2018 date and 15 who provided the 30 June 2019 date. A further three listed a date in the second half of 2019 and seven listed a date in 2020 or 2021.

### Non-financial contributions

Partners contribute to their health justice service in a range of ways beyond the financial. Table 5 describes contributions reported by health and legal partners that responded to this question.

In addition to lawyer time and direct financial contributions, legal partners supervise HJP lawyers, take referrals from the service for additional legal work and provide executive governance and oversight.

Health partners reported providing physical space for the lawyers to work, administrative support, executive oversight and the provision of time for staff training. Nine health partners indicated that they helped in communicating the availability of the health justice service.

Table 5: Non-financial contributions by partners, reported by health justice services

Non-financial contributions - legal partners		N=54
Supervision of HJP lawyers		39
Accepting referrals from HJP		39
Executive oversight/governance		32
Community legal education (by staff outside HJP)		21
Other: Admin/data entry		2
Other: Lawyer time in test case		1
Non-financial contributions – health partners		N=22
Office space		20
Administrative support		15
Executive oversight/governance		12
Staff hours in training		11
Communications/marketing		9

Source: HJA 2018 census, legal and health respondents. Count of health justice services receiving each type of non-financial contribution. N=54 legal partner responses (No response for 19 services). N=22 health partner responses (No response for 3 services). Each partner may provide more than one type of non-financial contribution.

# Evaluation

As an evolving service model, there is much to be learned about the implementation of health justice initiatives and the value and impact of embedding legal help in healthcare settings. One way to capture lessons learned is through evaluation. To understand the current environment, the census asked about evaluation work to date.

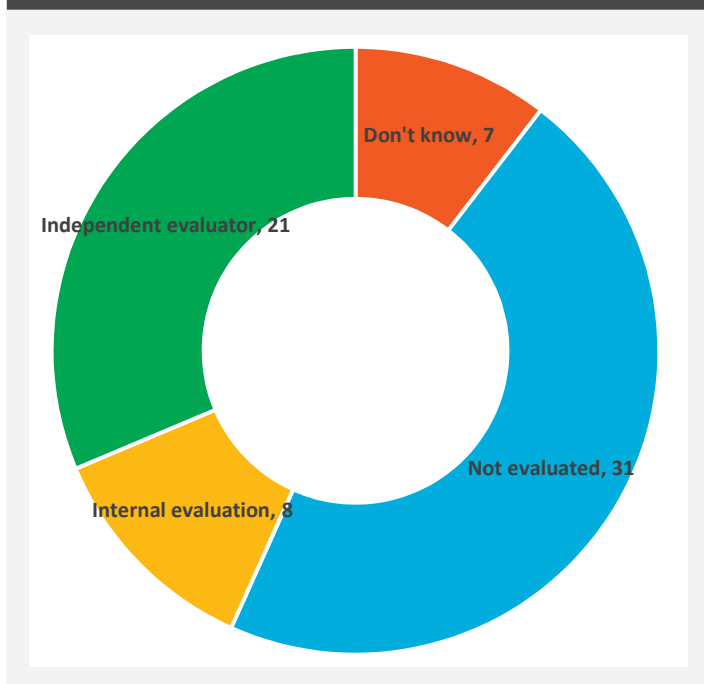
As indicated on Figure 14, less than half (44%) of the 65 legal respondents who answered this question indicated that their health justice services had been evaluated: 21 had been independently evaluated and another eight had been evaluated internally. The 31 who indicated their service had not been evaluated and the seven that did not know tended to be services funded by the legal partner from core funding; most commonly these were outreach services in health settings rather than more embedded HJPs.

The information gathered here on evaluation activity supplements HJA's review of what is known about the impact of health justice partnership in Australia and

internationally. Like the review, the census identifies pockets of comprehensive evaluation activity across the landscape, particularly around a small number of well-established HJPs. The Australian evaluation reports to date offer key insights into the challenges, value and opportunities of partnerships, and how they work to address complex need. As yet, and due to collection challenges, there is little reported data about how the impact of health justice services on client and service outcomes compare to other service strategies.

To provide a baseline and to understand the potential for shared evaluation and analysis across the network of health justice services, the census also explored the activities and outcomes that partners record about their health justice work and how they record this information. This information will support the work HJA is doing with services to develop an outcomes framework for health justice partnership.

Figure 14: Evaluation of health justice partnerships and services



Source: HJA 2018 census, legal respondents. Count of health justice services (N=65). No response for 8 services.

# Implications and next steps

This census of the health justice landscape in Australia in the 2017-2018 financial year, describes a network of 73 services from remote Northern Territory and far North Queensland, to inner-city and suburban areas of Melbourne, Sydney, Canberra, Perth, Adelaide and Brisbane. Health justice services are also found in regional and rural locations in the Eastern states. The increase in survey participants between the 2017 and 2018 surveys reflects both new services on the landscape and broader engagement with HJA and the network of health justice partnerships and services.

The 2018 census was open to all services in Australia providing legal help in a healthcare setting or team: whether as legal outreach clinics, as integrated services, as service hubs or as health justice partnerships. As a result, the census records the activities of a wide range of services. However, it is evident that, even among those that identify as HJPs, there is variation in the way the partners come together, and the type and level of activity involved. This variation is inevitable and is most likely to remain a feature of the landscape. It is therefore important to understand the key features of each service, how they change over time and how they compare to each other. Our census is key to this work, as the only national, routine collection of data across services and partnerships on the landscape.

The 2018 census indicates that health justice services are reaching and assisting people with complex and intersecting needs, and with less resources to address those needs. Specifically, the census found services were assisting clients experiencing economic disadvantage, FDV and mental health conditions and/or addiction, whether or not the services were specifically targeting support to issues or client groups.

However, this census did not examine whether, if not for the health justice services, these clients would have received legal help in a timely way or at all. This is a question to be explored in evaluation work.

Nevertheless, the results do indicate that health justice services are well placed to respond to the complex need identified. Firstly, nearly all services were able to provide practical legal assistance (beyond just information and advice). Secondly, most services were

able to provide direct assistance or warm referral for a wide range of legal issues (though we note services targeting FDV tended to focus more on the immediate issues of family violence, family law and care and protection over other legal issues such as housing and employment, which may also arise). Thirdly, where health justice services provide more connected and coordinated support, this is likely to enable a more appropriate response to that complexity than health, legal and other services delivered separately.

In addition to information about the partners involved, the people assisted and the services provided, the census provides insight into how service systems change when health and legal services come together around complex need. It points to secondary consultations, cross disciplinary training and moves towards coordinated care.

Equally, however, the census also indicates areas of practice for which further support could be provided by HJA and by partner organisations to develop and embed collaborative work where appropriate. Specific examples include:

- mentoring and support for effective partnering between health, legal and other partners: to establish partnerships that are driven by a shared sense of purpose and shared goals, to monitor their ongoing 'health', to maintain and evolve partnerships longer term or, when and if the time is right, to move on from partnership altogether
- specific training and resources to build the capacity of health and legal staff to work together around the complex need with health and legal dimensions, including FDV and mental health
- support for partners to develop a shared sense of purpose and goals together, to communicate these goals and to revisit and amend them as required
- tools to support the health and wellbeing of health and legal staff working with complex need and trauma, including FDV
- training materials that might be delivered by health partners, for instance, about how various

mental health and other cognitive issues may impact upon someone's capacity to engage with their legal issues

- support for partners to engage in shared systemic advocacy around laws, policies, regulations or practices which affect the health of client groups and communities
- supporting health justice services to connect with each other in a peer network that facilitates shared learning and innovation.

Another key observation from this census is that there is more work to do to secure interest and investment in health justice partnership from a broader group of stakeholders, and ongoing funding from existing funders. A key next step is to identify the effectiveness of HJP as a strategy to address complex and otherwise unmet need, and to articulate clearly what 'effectiveness' looks like for whom.

As a national centre of excellence, HJA aims to build an evidence base around the value and impact of HJP. We work with partners to articulate, identify and communicate the unique value and impact added by health and legal services coming together in partnership. Specifically, we have commenced work with services towards a core set of shared measurable outcomes for HJPs, expressed in language and with data that resonates with key stakeholders. This work will support HJPs to evaluate their own services, but equally build capacity to share learning across the network and to pool data and insights from individual services to better understand this work in various settings. We believe the potential to tell the story of HJP collectively, with consistent and high quality measures and tools, is key to better informed practice, policy and systems change.



# References

## References

- Cameron, A (2017) [Review of NSW Community Legal Centre Services](#), NSW Department of Justice, Sydney.
- Clarke, S & Forell, S (2007) [Pathways to justice: the role of non-legal services](#), Justice issues paper 1, Law and Justice Foundation of NSW, Sydney.
- Coumarelos, C (2019) [Quantifying the legal and broader life impacts of domestic and family violence](#), Justice issues paper 32, Law and Justice Foundation of NSW, Sydney.
- Forell, S (2018) [Mapping a new path: The health justice landscape, 2017](#), Health Justice Australia, Sydney.
- Forell, S, and Boyd-Caine, T (2018) [Service models on the health justice landscape: a closer look at partnership](#), Health Justice Australia, Sydney.
- Forsdike, K, Humphreys, C, Diemer, K, Ross, S, Gyorki, L, Maher, H, Vye, P, Llewelyn, F & Hegarty, K (2018) [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 vol. 42(3), pp. 284-290.
- Gyorki, L (2013) [Breaking down the silos: Overcoming the Practical and Ethical Barriers of Integrating Legal Assistance into a Healthcare Setting](#), Winston Churchill Memorial Trust of Australia & Inner Melbourne Legal Centre, Melbourne.
- Health Justice Australia (2019) [Maintaining effective HJPs: Reviewing the way you partner](#), Sydney.
- Karras, M, McCarron, E, Gray, A & Ardasinski, S (2006) [On the edge of justice: the legal needs of people with a mental illness in NSW](#), Law and Justice Foundation of NSW, Sydney.
- McDonald, HM & Wei, Z (2015) [How people solve legal problems: level of disadvantage and legal capability](#), Justice issues paper 23, Law and Justice Foundation of NSW, Sydney.
- National Association of Community Legal Centres (2018) [National Census of Community Legal Centres, 2017 National Report](#), Sydney.
- Pleasence, P, Coumarelos, C, Forell, S & McDonald, H (2014) [Reshaping legal assistance services: building on the evidence base](#), Law and Justice Foundation of NSW, Sydney.
- Productivity Commission (2014) [Access to Justice Arrangements](#), Inquiry Report No. 72, Canberra.
- Promoting Effective Partnering, [Mutual Benefits and Aligned Purpose](#) webpage, last accessed October 2019.

# Appendix 1

# Methodology

The 2018 census of the health justice landscape is broadly based on the 2017 survey reported in Mapping a new path. However, for this census:

- separate surveys were designed for each of the legal and health partners, rather than a single survey for the partners to complete together
- some questions have been replaced and many other questions have been amended.

The revised survey was then piloted with a small number of health and legal services and further refined based on feedback provided. In late October 2018, a 'legal partner' survey was sent to the legal partner of every service on the health justice landscape known to Health Justice Australia. This included:

- all respondents to the 2017 survey
- any services known to be missing from the 2017 survey
- all services and partnerships which had commenced since the 2017 survey

Legal respondents were then asked to forward a link to a separate 'health partner survey' to their health partner.

The rationale for using the legal partners as a key contact point for the survey reflects the history of the HJP movement in Australia, which has been driven by the legal assistance sector. To date, legal partners (e.g. the HJP solicitor or manager) tend to be more likely to be the key contact point for and person connected with HJA and the HJP practitioner network. It is also they who are best able to identify the appropriate contact person in their health partner organisation. The movement is yet to reach a place of equal engagement of health and legal partners across the landscape.

Notifications were also sent through CLCs Australia (then the National Association of CLCs) and to legal aid commissions around the country, through the HJA newsletter and to the HJP practitioner network on HJA's Yammer platform. Any service providing legal help in a healthcare setting was invited to participate in the census. While this approach meant that we received responses from services that self-describe as 'outreach' as well as 'health justice partnerships', we have taken an inclusive rather than an exclusive approach to understanding the health justice landscape.

Health and legal partners were asked about:

- their organisation and their partners in the HJP
- service locations and settings
- partnership activities (e.g. secondary consultations, referral practices, inter-disciplinary training, systemic advocacy/other work, collaborative practice and governance activity)
- funding and resourcing for the service, including partner contributions
- activity and outcomes data collected by their respective services.

Legal partners were also asked about:

- client group(s) targeted and seen by the lawyers
- areas of law covered by the HJP and legal assistance provided
- evaluation activity to date.

Additional information gathered in the health partner survey included:

- areas of the hospital (where relevant) from which patients are referred
- demographic profile of patients supported by the host health service
- types of health issues faced by clients referred to the HJP.

The survey instruments are available on the HJA website.

Given the existence of some common questions across the two surveys, we noted some cases in which the health and legal partners of the same service had a different response to the same question. For instance, one partner indicated that there were secondary consultations, while the other did not.

We have checked with services on some of these details, but in a small number of cases we have considered which partner may be better placed to answer the question (e.g. taken the health service response about a health service process which is being discussed, such as referral from health to legal services). This is indicated in the text.

## Limitations

The aim of the census is to profile services on the health justice landscape: where they are, who they assist, the help they provide, the partners involved, funding, governance and the difference they seek to make. Due to the importance of partnership as a feature of HJPs, the survey also examines activities and features relevant to the relationship between partners. However the type and amount of information that can be collected in survey format from busy practitioners is necessarily limited. For this reason, the survey only looks at some of the structures and activities we may expect to see in a partnership and cannot, on its own, speak to the health or strength of the partnership. A partnership may be undertaking relevant activities, but facing other challenges which affect its capacity. Similarly, there may be relational factors which bind a partnership and enable it to undertake its activities which we do not identify in the survey.

As with any survey of this type, the accuracy of responses – and therefore the data reported - is dependent upon the knowledge and understanding of the person responding to the survey. Respondents may also interpret questions differently. We saw this when cross-checking responses from the health and legal partners of the same HJP.

Each survey took up to 35 minutes to complete, a particular challenge for services running a number of HJPs. As a result, some surveys were incomplete.

## Legal service response rate and respondents

Responses were received from 77 legal service providers. Two were excluded from the analysis as their partnerships did not see clients in the 2017-2018 financial year. Both had operated prior to June 2017 and expect to be operating again. Because this analysis reports on partnerships providing legal advice and assistance in healthcare settings, another partnership which provides community legal education only (no legal advice or assistance) in an educational setting was also excluded from the analysis. This leaves a total of 73 legal service respondents.

We know of 10 outreach services (including one lawyer at 4 settings), one co-located health and legal service, and one integrated service (with the lawyer employed by the health service) that did not respond to the survey. There may be other legal outreach services in healthcare

settings that we are not aware of. The response rate from all relevant services known to HJA was 86%.

None of the known non-responding services identify as health justice partnerships. For this reason we believe that all health justice partnerships in Australia that were seeing clients during the 2017-2018 financial year are included in the census.

Nearly 70% (51) of the legal service responses were completed by the HJP lawyer, four of which were also the HJP manager. A further 18 responses (25%) were completed by the manager responsible for the HJP or the Principal Solicitor of the legal service (2 responses). Two responses were completed by a social worker/case manager working within the HJP. The types of responding legal services are detailed under 'legal partners' in the results section.

## Health service response rate and respondents

Responses were received from 26 health service partners, with engagement in the survey from health service partners around Australia. One health partner was responding about an HJP that did not see clients during the reporting period and this has been removed from the analysis.

Two responses concern a single HJP, where there is one legal partner but three separate health/community partners. We therefore have a total of 25 health service responses concerning 24, or one-third, of the 73 services on the health justice landscape.

The 25 health service respondents included: 10 hospital partners; 11 community health services, including three Aboriginal community controlled health organisations, two mental health services, maternal and child health and an LGBTQI+ service; and three community support services, including an alcohol and other drug rehabilitation service. Health service responses cannot be considered representative of all health services on the landscape, as they are likely to be from services which are more engaged with the partnership.

Responding on behalf of health services were team leaders/program managers (12), agency managers/CEOs (7) and social workers (6). Most were involved in coordinating the partnership from the health service's point of view or governance (14), or working with the HJP, booking appointments or making referrals (5).

**P** +61 2 8599 2183  
**E** [healthjustice@healthjustice.org.au](mailto:healthjustice@healthjustice.org.au)  
**W** [www.healthjustice.org.au](http://www.healthjustice.org.au)

Health Justice Australia is a charity registered with the Australian Charities and Not-for-profits Commission. Health Justice Australia is endorsed as a public benevolent institution and has deductible gift recipient status (generally, donations of \$2 or more are tax deductible, depending on your taxation circumstances).

Health Justice Australia ABN 55 613 990 186