

Mapping a new path

The health
justice
landscape in
Australia, 2017

About Health Justice Australia

Health Justice Australia is the national centre for health justice partnerships. We support the effectiveness and expansion of health justice partnerships in Australia through:

- Knowledge and its translation: developing evidence and translating that evidence into knowledge that is valued by practitioners, researchers, policy-makers and funders;
- Building capability: supporting practitioners to work collaboratively; and
- Driving systems change: connecting the experience of people coming through health justice partnerships, and their practitioners, with opportunities for lasting systems change through reforms to policy settings, service design and funding.

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ISBN: 978-0-6483245-0-8

Acknowledgments

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

The mapping survey was designed by Suzie Forell and Dr Hugh McDonald, Law and Justice Foundation of NSW, with input from Dr John Chan; Dr Virginia Lewis, Australian Institute for Primary Care & Ageing, Latrobe University; and Dr Ashley Schram, NHMRC Centre for Research Excellence in the Social Determinants of Health Equity, Australian National University. Our thanks for their work, together with thanks to Agape Lioulios, Eastern CLC, Federation of CLCs, National Association of CLCs and LawRight for their support, including pilot testing the survey.

We thank Dr Ashley Schram, Linda Gyorki, Peter Noble and Professor Dame Hazel Genn for peer reviewing this report.

Thanks also to Folk for their advice in the development of this report.

Report design: Sarah Hodges

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Suggested citation: Forell, S (2018) Mapping a new path: The health justice landscape, 2017, Health Justice Australia, Sydney

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Executive summary

Since the World Health Organization's groundbreaking Commission on Social Determinants of Health (2008), the evidence has continued to grow about how factors beyond the medical drive poor health outcomes for individuals and communities. These factors include poor-quality housing, unstable or insecure work and family breakdown. Meanwhile, in 2012 a landmark Australian study into legal need established that over one-fifth of people in Australia experience three or more legal problems in a given year, many of which cause illness. Many people seek no advice for these problems, but when they do, they are more likely to ask a non-legal advisor, such as a health professional, than a lawyer.

Taken together, the health and legal research points to common groups who are vulnerable to intersecting health and legal issues, but are more likely to turn to non-legal advisors, such as health professionals, than legal services for solutions.

Health justice partnerships respond to this evidence. In what has been a quiet revolution in service delivery, community lawyers have been collaborating with health services and their patients to address unmet, health-harming legal need. Since 2012 this revolution has grown from a handful of examples across the country to many. Now, through this report, we are able to identify the range of approaches, partnerships, settings and needs being met through health justice partnerships.

This report provides a first and foundational profile of the health justice landscape across Australia. It is based on information gathered in a 2017 survey, conducted by Health Justice Australia, of services across Australia that identify as health justice partnerships (hereafter, the services).

The survey illustrates a health justice landscape that has grown from seven services in 2014 to include now:

- up to 30 services operating in partnership, integrating a lawyer into the healthcare team in a health setting
- a further 18 services delivering a range of other service models such as: integrated services (health and legal services provided by one organisation); service hubs (health and legal services joined with other services in a community setting); outreach (with less intensive partnership arrangements and more autonomy than health justice partnerships); and student clinics (partnerships between law faculties and health agencies).

The services have been operating in almost every state and territory in Australia, however most are in Victoria and New South Wales. Across Australia, three-quarters of all services are in major cities.

Hospitals are the most common service setting, followed by community or public health service settings and Aboriginal medical or community services.

While some partnerships assist any patient of the health service, most focus on a particular client group: women facing domestic or family violence, Aboriginal and Torres Strait Islander peoples, people with mental health issues, older people at risk of elder abuse or young people. Services most commonly provide legal help for domestic and family violence and for family and civil law issues.

More than one in five respondents indicated that their partnership engaged in systemic advocacy.

Community legal centres were involved as legal partners in three-quarters of all partnerships and legal aid commissions in nearly three in ten. Public/not-for-profit hospitals and/or the area health services which administer them were partners in 28 services, community based health services in 14 services and Aboriginal community controlled health organisations in six.

A key feature of the landscape is the extent to which partners have supported each other with training and secondary consultation. More commonly, the help is provided by lawyers to their healthcare partners.

The shared goals of partnerships include: improving access to legal help, particularly to address health-harming legal need; the provision of holistic services; improved client health and wellbeing; and improved legal outcomes for clients/patients.

Half of all services were mostly funded by government sources. However this first survey did not explore how secure this funding was and services have reported to Health Justice Australia that they face very real challenges in sustaining their health justice partnerships due to short-term and uncertain funding.

This is one of three reports based on the mapping survey. The purpose of this first report is to provide a baseline picture of the health justice landscape, noting the range of services currently identifying as health justice partnerships. It provides foundational information to support planning, evaluation and the development of a best practice health justice partnership model, which is informed by the experience of practitioners and their partnerships.

The second, *Service models on the health justice landscape: A closer look at partnership*, is a discussion paper exploring what differentiates a health justice partnership from the other service models on the health justice landscape. This paper aims to develop clarity around the features of health justice partnerships as a specific service model. This understanding is critical to their effective evaluation.

A third report, *Building health justice partnerships: 3 key lessons from practitioners*, captures the experiences of health and legal practitioners in establishing partnerships between health and legal agencies to address health-harming legal need.

Collaboration in action

A case study of one health justice partnership

One of the health justice partnerships included in this report is between a local community legal centre and a major city hospital, and has been operating since 2015. Through this service, patients of the hospital are able to access a community lawyer to help find solutions to a range of legal problems that affect their health, such as mold in their public housing that causes respiratory illness or landlords refusing to install handrails so people with impaired mobility can continue living independently at home.

This health justice partnership provides help to people with a history of drug and alcohol abuse, poor mental health and family violence. For some people, these factors also mean their children have been removed from their care by child protection authorities.

When the lawyer first started working in this health justice partnership, she was seeing women at the end of their pregnancies who were facing the prospect of having their babies removed by child protection authorities. Many of these women had previously had children removed from their care, and the best support the lawyer could provide was to help these women attend the hearings that would review the removal of their babies, and try to keep the parents engaged in the system that, as far as they were concerned, was ripping their families apart.

Two years later, the lawyer in this health justice partnership is being introduced to women in the same situation, but much earlier in their pregnancies. Now, the lawyer is part of a coordinated healthcare team working with these women to help them understand why they need to attend an ante-natal program, or their partner should participate in a drug or alcohol course, to ensure they are well themselves and can provide a healthy and safe environment for their coming children.

Over this time, the hospital has seen a reduction in children being removed from their parents at birth. By including lawyers as part of healthcare teams, there is a possibility for early intervention and even prevention of harm in the lives of some of the most vulnerable women and their children.

The lawyer is part of a coordinated healthcare team working with [women at risk of having their children removed] ... to ensure they are well and can provide a healthy and safe environment for their coming children.

1. Introduction

Health justice partnerships (HJPs) are collaborations between health and legal services, bringing lawyers into healthcare settings to address health-harming legal need. From an innovation led by health and legal practitioners in particular communities, health justice partnerships have become a movement attracting interest from practitioners, researchers, policy-makers and funders. Yet there is no reliable data about the number, nature and scope of health justice partnerships across Australia. This report fills that gap, establishing a first and foundational profile of Australia's health justice landscape.

In response to this evolving movement, Health Justice Australia was established in 2016 as a national charity and centre of excellence for health justice partnerships. Based on a survey Health Justice Australia conducted in 2017, we have sought to identify what types of health and legal services work in partnership across Australia, who the partners are, and where partnerships are based. We have identified who these services support and what help they have provided. We have examined how agencies have partnered and learned about the difference they seek to make. Critically, this work defines a baseline from which we can track the growth, evolution and outcomes of services on the health justice landscape.

This work has been undertaken at a dynamic time, when services are both starting up as and evolving into active partnerships between health and legal agencies to address health-harming legal need among a range of communities. Given the organic growth of these services, it is not surprising to find a range of different ideas about what constitutes an HJP. This report examines the findings of the mapping survey, taking at face value that a range of different services have identified themselves as health justice partnerships. But beyond mapping the landscape, this variance in service models raises key questions about what makes a service an HJP and how HJPs may differ from other equally valuable but different models of engagement between health and legal agencies. We explore these questions separately, in our forthcoming discussion paper, *Service models on the health justice landscape: A closer look at partnership*.

2. The evidence driving partnership

... 'a person's health is determined by a lot more than high-quality health care services and personal behavior; it's shaped by environment – where someone lives, works, plays and learns' (Williamson, Trott & Regenstein, 2018).

Since the World Health Organization's groundbreaking 2008 Commission on the Social Determinants of Health (CSDH, 2008), the evidence has continued to grow about how factors beyond the medical drive poor health outcomes for individuals and communities. These factors include poor-quality housing, unstable or insecure work and family breakdown (see also Marple, 2015, Williamson et al, 2018).

Meanwhile, in 2012 the landmark Legal Australia-Wide survey (LAW survey) established that over one-fifth of people in Australia experience three or more legal problems in a given year. Among these issues were housing and work related issues, money issues, and family breakdown: issues also noted in this and the broader legal needs research, for their reported impact on health, particularly stress-related and/or physical illness.

Critically, the evidence further indicates that many people seek no advice for these problems, but when they do, they are more likely to ask a non-legal advisor, including health professionals, than a lawyer (Coumarelos et al, 2012; see also Pleasence, Balmer & Buck, 2008).

Taken together, the health and legal evidence points to common client groups that are vulnerable to intersecting health and legal issues but who may come into contact with health services around their symptoms rather than with services that can offer legal solutions. The interconnected evidence base also notes the vulnerability of these same client groups to social and environmental factors which may be shaped by law and policy, which in turn may be influenced by systemic advocacy and law reform.

Health justice partnerships respond to this evidence, with an evolving movement of community lawyers collaborating with health services and their patients to address unmet, health-harming legal need. Some also have an eye to impact upon the social determinants of health more broadly.

However, as also observed in the US context, the movement is still young 'with much to learn as the field grows and matures' (Regenstein, Trott, & Williamson 2017 p.8). It is still too early in this movement to know what works best, for whom, in what circumstances and at what cost. This Report is a first step to identifying, profiling and understanding these efforts in Australia.

3. The survey methodology

In August 2017 Health Justice Australia sent a survey to all services in its network.¹ Initially responses were received from 39 services. After follow up and discussion with services, an additional nine responses were received, bringing the total to 48 respondents. Noting that the network was still building at the time the survey was distributed, we believe that virtually all HJPs that were operating in Australia in 2017 are included among the respondents to this survey.

However, survey respondents also included those involved in a number of other health justice service models. These included integrated services, outreach services, service hubs and student clinics (defined in Table 1, below).

In the absence of a shared understanding of what makes a health justice partnership, responses from a broad range of service types that have health and justice elements, or that specifically identify as an HJP, is not unexpected. However, not every example of these broader service types is included in the survey. Our report is limited to those organisations that identified themselves to Health Justice Australia as a health justice partnership by responding to our mapping survey.

Because the boundary between HJPs and other service models is yet to be clarified, and this broad view of the landscape will assist that process, all respondents are included in the data presented in this report.

...patients who are seen in clinical settings may well have problems in their everyday lives that may be causing or exacerbating their mental and physical ill health or may be getting in the way of their recovery. If we do not tackle these everyday 'practical health' issues then we are fighting the clinical fight with one hand tied behind our back (Marmot, in The Low Commission & Advice Service Alliance, 2015 p.7)

¹ At the point this survey was sent out, HJA's network was based on services describing themselves as health justice partnerships.

i. The limitations and future of this survey

This mapping survey has been a critical first step for Health Justice Australia in identifying the current scope and diversity of the network of health justice partnerships in Australia. As our first survey, this has proven to be a valuable pilot for any future data collection from the network. However it has also highlighted where we need to modify any future research to make it easier for respondents and more rigorous for analysis.

In particular, the following have a bearing on the results reported:

- A survey was sent to each partnership. Two-thirds of responses (31) were submitted by the legal partner only and one response was submitted by the health partner only, though it was evident in some of these responses that there had been discussion between the partners in completing the survey. One-quarter of responses (12) were submitted by the legal and health partner together.² The people completing the survey also varied, from the solicitor working in the HJP, to officers within either partner organisation. In some cases, the person responding to the survey was fairly new to their position. Therefore the accuracy of each answer (and corresponding data point) will vary with the level of knowledge of the respondent, particularly about their partner organisation or partner's perspective. Further, information is missing for some questions where respondents have indicated 'don't know'.
- It is evident from some of the responses that some questions asked in the survey were not clear or, in some cases, specific enough. This in turn undermined the utility of the data provided. Where we are not confident in the data collected, we do not report that data. Any limitations in the data reported below are discussed in the relevant section.

While these limitations are acknowledged, the data provided in this report also indicates the potential value of regular, consistent data collection from services over time. We intend for this to be the first of an annual collection of data on the health justice landscape in Australia, such that we can track changes and growth and provide regular detailed information back to services on that landscape and those interested in supporting and/or starting health justice partnerships.

² One survey was completed by an employee of the partnership and three respondents did not specify who completed the survey.

4. What services look like

i. Services on the landscape

One clear observation arising from the mapping exercise is the degree of variation between different services on the health justice landscape. As illustrated in the following sections, there is variation in service setting, partner types, clients assisted and the types of help provided. This is to be expected as the needs of clients vary, as does the infrastructure available in any given location to support these clients. The focus and expertise of partner agencies also vary and this too will influence the type and style of service that is developed. This variation is a strength of the health justice landscape as services can be developed to best meet the needs of particular client groups, with the resources and interest available to do so.

While there will always be some variation within a model of service (that is, different types of health justice partnerships), some of the variation we present here might indicate a different model of service altogether. While we explore these differences further in the forthcoming discussion paper *Service models on the health justice landscape: A closer look at partnership*, we have used the following broad descriptions as working definitions for this report.

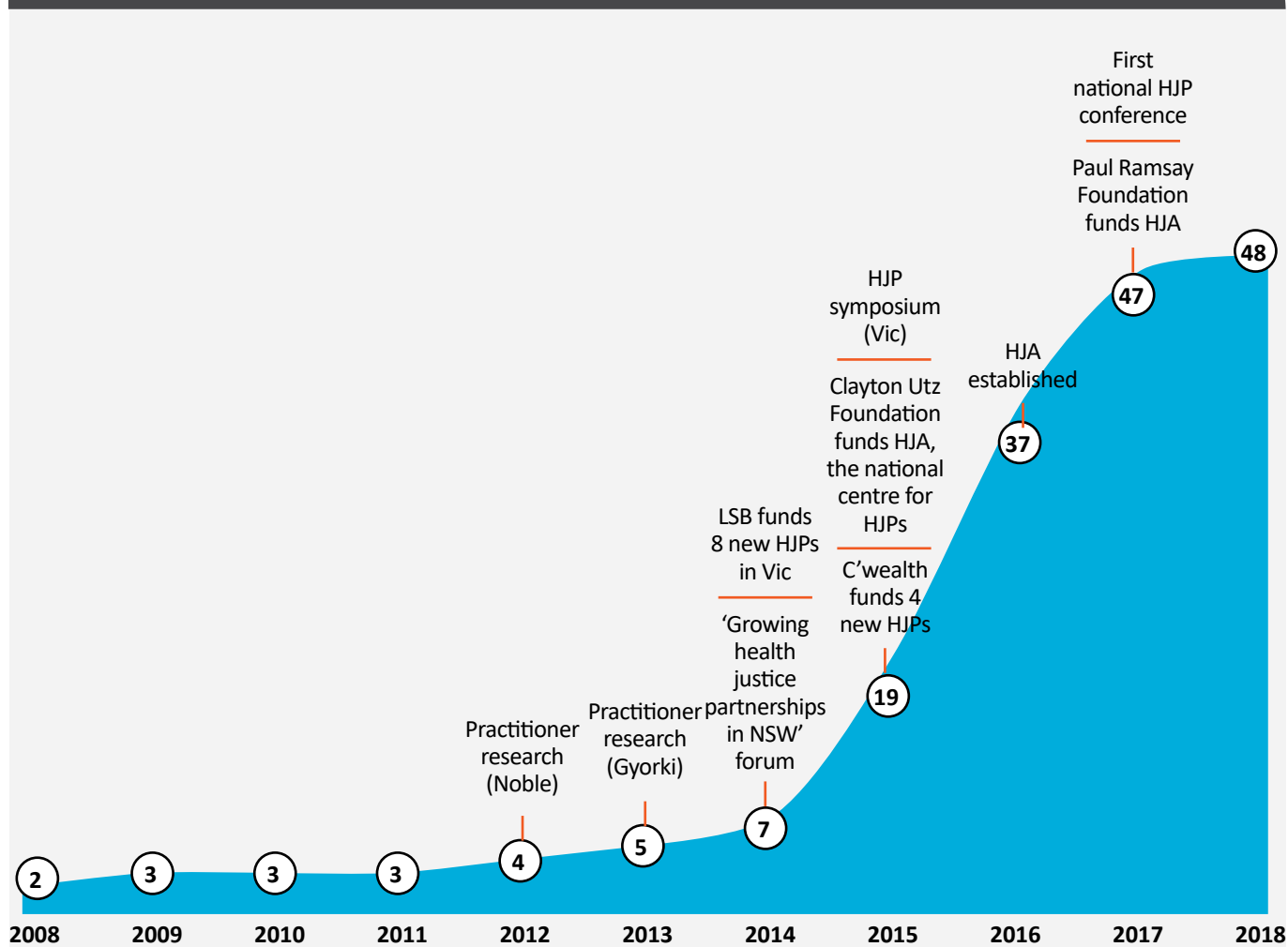
Table 1: Service models on the health justice landscape

Model type	Broad description
Partnerships	Partnerships between health services and legal services, to have a lawyer included as part of a health care team and with shared goals.
Integrated services	Services in which a lawyer is employed by a health service, as part of their health care team (or a health professional employed by a legal service).
Outreach services	Lawyers attending health settings to provide a legal service or clinic but not considered to be part of the healthcare team.
Service hubs	'Place-based' service hubs in which health, legal and other services work out of an accessible community setting (e.g. a housing estate).
Student clinics	Services in which law students are supervised to provide legal help to patients in the health setting.

ii. The growth of health justice in Australia

Respondents were asked what year they commenced providing services to patients/clients. Two respondents indicated that they had been providing legal assistance in a health or community setting for nearly 10 years (since 2008). In 2014 there were just seven services operating. Since then there has been significant growth in the number of services on the landscape, to 19 in 2015, 37 in 2016 and 47 by December 2017. One respondent commenced client services in January 2018.

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

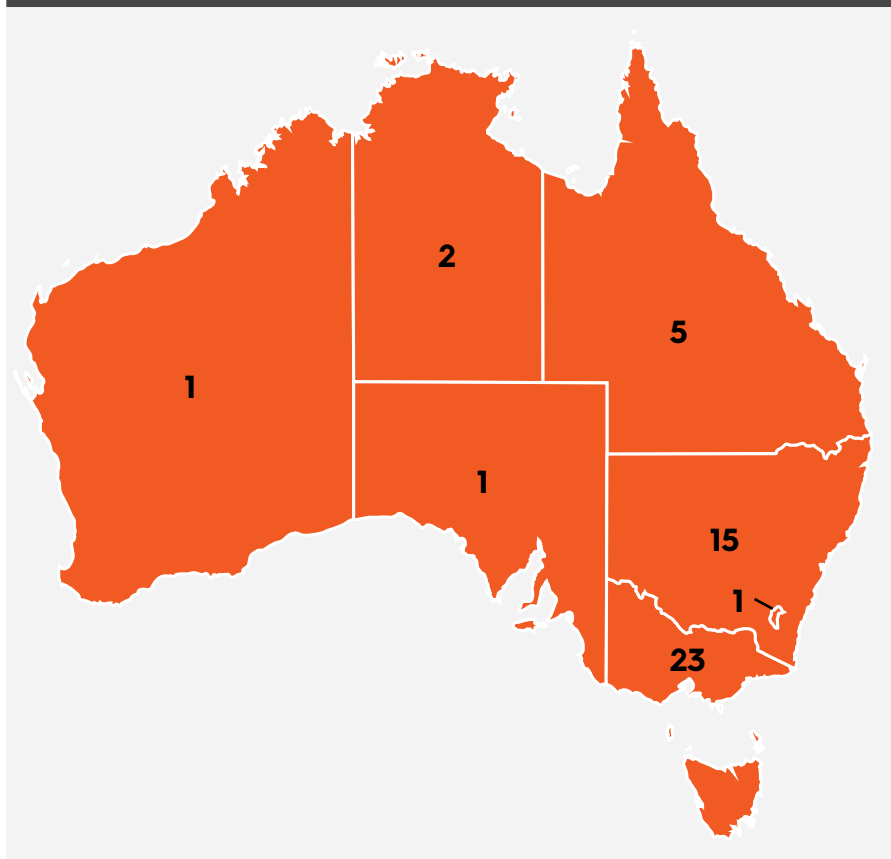


Source: HJA 2017 mapping survey. N=48 services.

iii. The landscape across Australia

Of the 48 services that responded to the survey, nearly half (23) were based in Victoria, and 15 in New South Wales. One New South Wales-based respondent provided services across the New South Wales–Victoria border. There were five respondents from Queensland and two in the Northern Territory, with one service each in Western Australia, the Australian Capital Territory and South Australia. As at December 2017, Tasmania was the only jurisdiction that had not established a health justice partnership or similar.

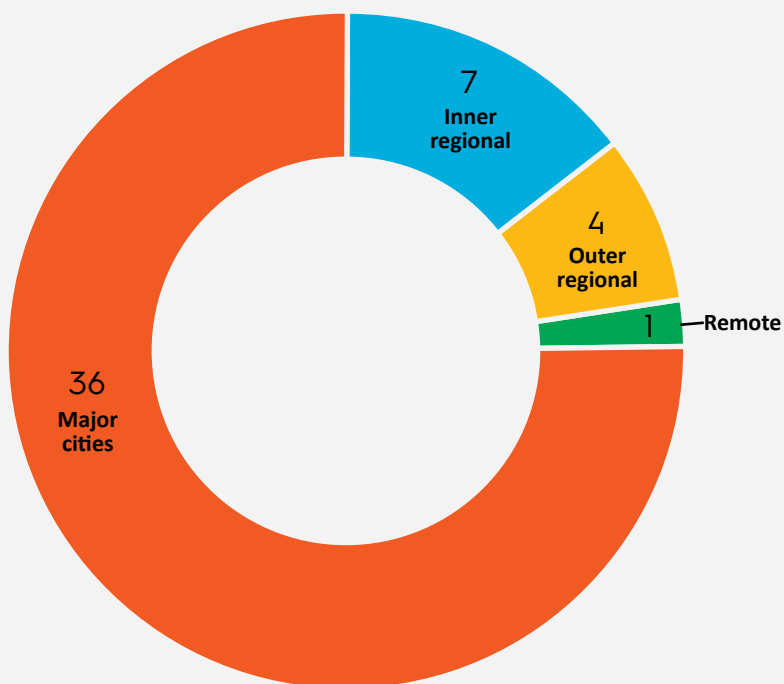
Figure 2: The health justice landscape by state or territory



Source: HJA 2017 mapping survey. N=48 services.

Broadly reflecting the population distribution in Australia³, three-quarters (75%) of all respondent services were located in ‘major cities’.⁴ Seven (15%) services were located in inner regional areas, all in NSW and Victoria. Of the four outer regional services, two were in Queensland and one each was in Victoria and the Northern Territory. The one remote-area service was also in the Northern Territory.

Figure 3: The health justice landscape by geographic classification



Source: HJA 2017 mapping survey. N=48 services.

Note: Classified according to [ASGC Remoteness Areas \(2006\)](#), based on the postcode of the service.

³ To place this figure in context, in 2017, an estimated 71.8% of the Australian population lived in ‘major cities’. However, this varied by state with an estimated 77.9% of Victorians and 75.3% of New South Wales residents living in major cities (Australian Bureau of Statistics, 2018).

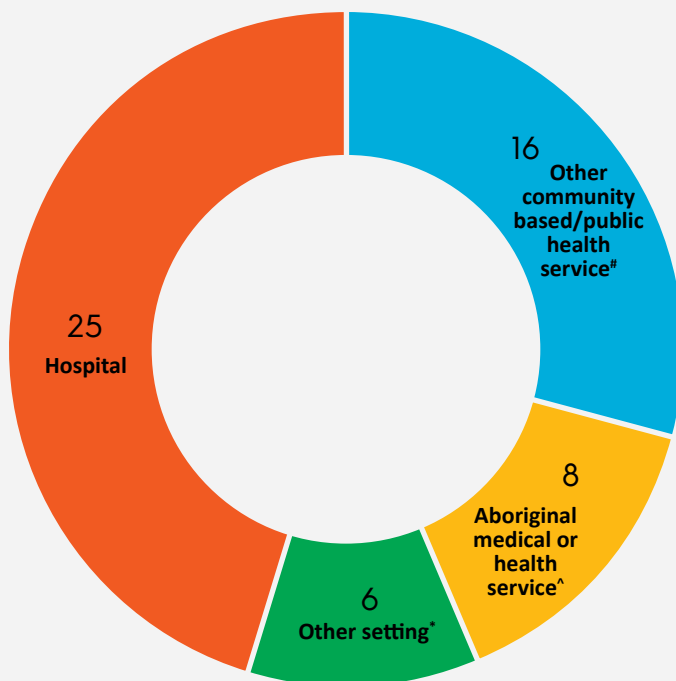
⁴ As defined by the ASGC Remoteness Areas (2006).

iv. Service settings

Health and legal services have come together to support clients in a range of service settings. The 48 respondents to this survey reported activity in 55 service settings – with some partnerships running services in two or three locations. The most common service settings across the health justice landscape were hospitals (45% of all settings), all but one of which were public or not for profit hospitals. Respondents indicated a further 16 legal services in community based or public health services; another eight in Aboriginal medical or health services; and six more in other community settings.

The services (which included health/wellbeing and legal assistance) in community settings included a ‘hub’ service in a housing estate, outreach to community-based services and a partnership on site at a university.

Figure 4: Service settings across the health justice landscape



Source: HJA 2017 mapping survey. All service settings listed in the survey (N=55 settings for 48 services).

Notes:

* 'Other setting' includes a housing estate, community services and a university.

^ In addition to an Aboriginal health service, one respondent also provides legal assistance in a further two community settings.

Includes general community health, mental health and maternal health. One service also provides home visits, and another is based in a GP clinic run by a community health organisation.

v. The people partnerships aim to assist

Just as the service settings varied across the health justice landscape, so too did the client groups that services aim to assist.

Around one-third of respondents indicated that they support 'any patient of the health service' and identified the health service (hospital or community health setting) as available to all members of the local community. Commonly these were hospitals or health services in geographic areas accessible to people in need of legal help (that is, with high legal need and fewer resources to address that need).

Other services targeted specific client groups and/or legal issues. Some services were placed in client-specific 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.

Client groups specifically targeted by these services included:

- Women facing domestic or family violence (10 respondents, which reflected one in five respondents)
- Aboriginal and Torres Strait Islander peoples (8 respondents)
- People living with mental health issues and/or alcohol and other drug issues (7)
- Older people, focused on elder abuse (4)
- Young people (1)

One service targeted people experiencing mortgage hardship and another focused on people experiencing housing/tenancy problems. Two services noted that they assist health staff as well as patients.

vi. Legal assistance provided

While only 10 respondents indicated that their service targeted women facing domestic or family violence, 88% (42) of respondents said that their service assists with domestic or family violence-related legal issues.

Just over three-quarters of respondents (37) also indicated that they assist with family law issues, but it is not clear from the results how commonly this reflected specialist family law assistance over and above the family violence work. This is an issue that can be more carefully explored in future surveys.

More than half of the respondents said that their service assisted with:

- Housing and tenancy
- Credit/debt
- Fines
- Government/social security
- Consumer issues

Other legal issues that services said they could assist with included: discrimination; issues related to elder abuse; employment, crime, health (including mental health), immigration, guardianship, and child protection.

Of interest, all but two respondents indicated that they addressed legal issues across two or more of the broad categories of civil, crime and family law. The two indicated they provided civil law services only, though civil law itself covers a wide range of legal problem types. This broad approach may reflect holistic responses to complex need, particularly around domestic and family violence and elder abuse.

Given the usual specialisation of legal practice, it would be useful to explore further the level of legal assistance that these services can provide for each type of legal issue. While this first mapping survey was not sensitive enough to provide such detail, in general all the services provided at least legal advice and referral. The vast majority (45) provided 'legal assistance', such as letter writing and negotiating; and the same number indicated that they provided community legal information to clients.

Two-thirds (34) of the respondents indicated that their service provided advocacy (in a court or tribunal) or representation to clients. Another nine services were able to refer clients to their partner organisation for advocacy/representation. Five services did not list advocacy/representation as a form of legal assistance they provide. Future surveys could more fully explore when and for what types of matters frontline services link back to their parent service (e.g. legal aid commissions), pro-bono partners or others to provide representation where required.

Looking forward, it would be valuable to collate data from across the landscape on the profile of clients actually assisted by services, together with the legal issues they face, the help they receive for each of these problem types; and the outcomes achieved. This will provide a much more nuanced understanding of the types of problems arising for different clients in different settings – and how these are addressed. Client views on the types of support and assistance they require should also inform the development of the model.

vii. Hours the service is open or accessible to clients

Respondents were asked about the number of hours per week their service was open or accessible to clients. Noting that a small number of respondents provide services in more than one location, we report below the total number of client-facing hours for the service as a whole.

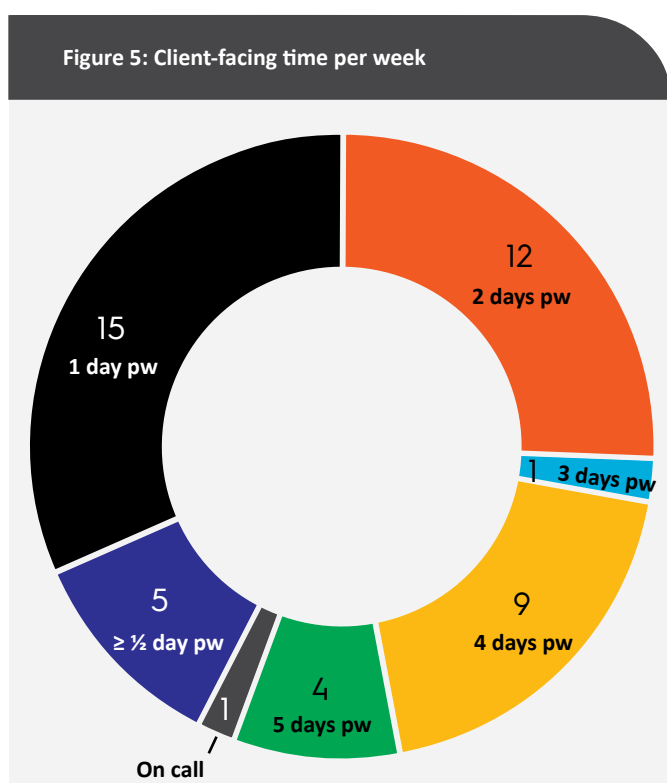
Again, we see diversity across the health justice landscape. Three respondents indicated that their services were open to clients less than half a day a week (including those which may provide services less than weekly). Thirteen services were reported to be at least 4 days a week.

Most commonly, respondents indicated they were open to clients or patients in the health or community setting for at least half a day, one to two days per week. One respondent service takes bookings for clients in the health setting for the lawyer to meet with the client in that setting. As the lawyer is otherwise off-site, this is described in Figure 5 as 'on call'.

Importantly, services on the health justice landscape involve hours invested well beyond client-facing hours. Lawyer and/or health partner time will also be spent:

- undertaking legal work on behalf of individual clients
- undertaking systemic advocacy
- providing training or other support to the partner organisation (e.g. lawyers training health staff about how to identify legal issues and refer clients)
- building or sustaining the partnership (e.g. meetings, planning, evaluation activity, informal liaison)

Future surveys may track this additional time investment.



Source: HJA 2017 mapping survey. N=47 services. 1 response missing

Notes:

Where services have more than one location, the number of hours are combined.

Specific hours have been grouped into days, with less than half a day being 3.5 hours a week or less. 1 day is from 3.5 to 7 hours, 2 days is from 8 hours to 14 hours, 3 days is from 15 to 21 hours, and so on.

viii. Systemic advocacy

On the health justice landscape, systemic advocacy involves identifying how law, policy or practice is systematically affecting client groups – as evidenced by the experience of clients and patients being seen in the services – and using that information to influence change to those laws, policies or practices. The health justice partnership model aims to amplify the impact of advocacy through the shared voices of health and legal partners and their clients. Systemic advocacy is a strategy to elevate the impact of HJPs beyond the health-harming legal needs of individual clients, to address factors that may affect health and wellbeing more broadly (Gyorki, 2013).

Respondents were asked whether systemic advocacy was engaged in by their respective partner organisations or their partnership. Eleven of the 48 respondents indicated that their partnership was involved in systemic advocacy while 15 specifically indicated that their partnership did not undertake systemic advocacy. Eight respondents did not know or did not answer the question, while others pointed to advocacy work undertaken by one or both of their partners, though not within the partnership itself.

ix. Training

A key feature of a health justice partnership is the work undertaken to build the capacity of partner staff to effectively work together to support their common clients or patients. Such training includes:

- education for health staff about the legal assistance available to their patients and how to refer patients to the service (45 services)
- education for health staff about how to identify a health-harming legal issue facing their patient (44 services)
- education for legal staff about the services provided by the health service (28 services) or the types of health issues facing clients (13 services)

Overall, nearly all of the respondents indicated that training had been provided by the legal staff to health staff about legal issues and/or the services provided onsite by the legal partner. Moreover, six out of 10 (29 services) indicated that training had been provided by the health staff to the lawyers.

What is not clear is the specific content of the training and in how many cases it was an ongoing program. This will be followed up in future surveys.

While not quantified in this survey, some HJPs reported providing community legal education sessions to clients or communities. Again, this could be explored in future.

[We run] training sessions on how the legal partner works, and how the health partner works, so that all staff at both partner services have a good understanding of how to work together. (Legal partner, NSW)

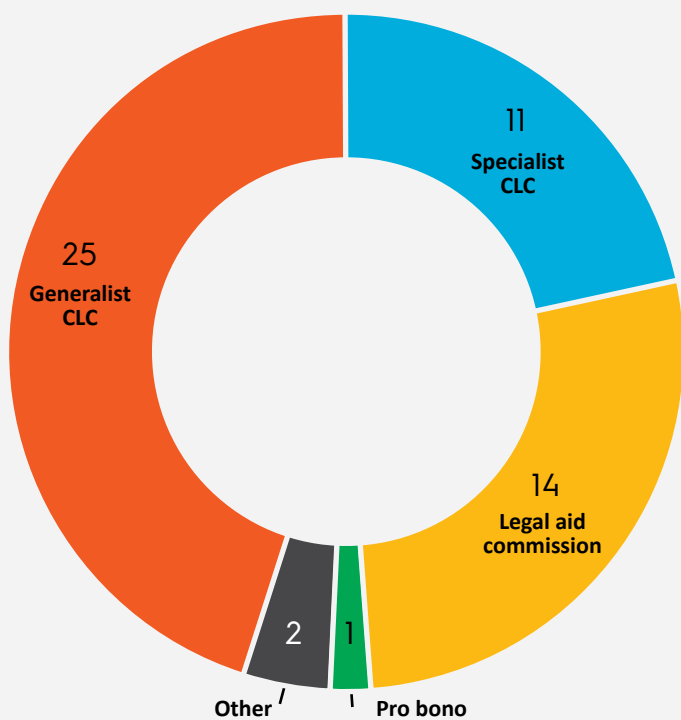
x. The partners

A diverse range of legal and health partners have come together across the landscape. Some legal and health partners were involved in more than one partnership; and some partnerships involve more than one legal and/or more than one health partner.

Australia-wide, generalist or specialist community legal centres (CLCs) were partners in three-quarters of services on the health justice landscape, and legal aid commissions in nearly 30% of all services. However, patterns in growth have varied across the country. For example, growth in Victoria and Queensland has been largely driven by the CLC sector; while in New South Wales interest has been shared by both CLCs and the legal aid commission.

A small number of services involved pro bono legal partners providing frontline legal support or, more recently, non-legal organisations employing lawyers. Figure 6 does not illustrate the extent of pro bono support that may have been provided through CLC-staffed services. In all services, except the one integrated service (included as 'other' on Figure 6), the lawyer placed in the health or community setting is employed or supervised by a legal partner.

Figure 6: Legal partners on the health justice landscape



Source: HJA 2017 mapping survey. N= 53 partners in 48 services.

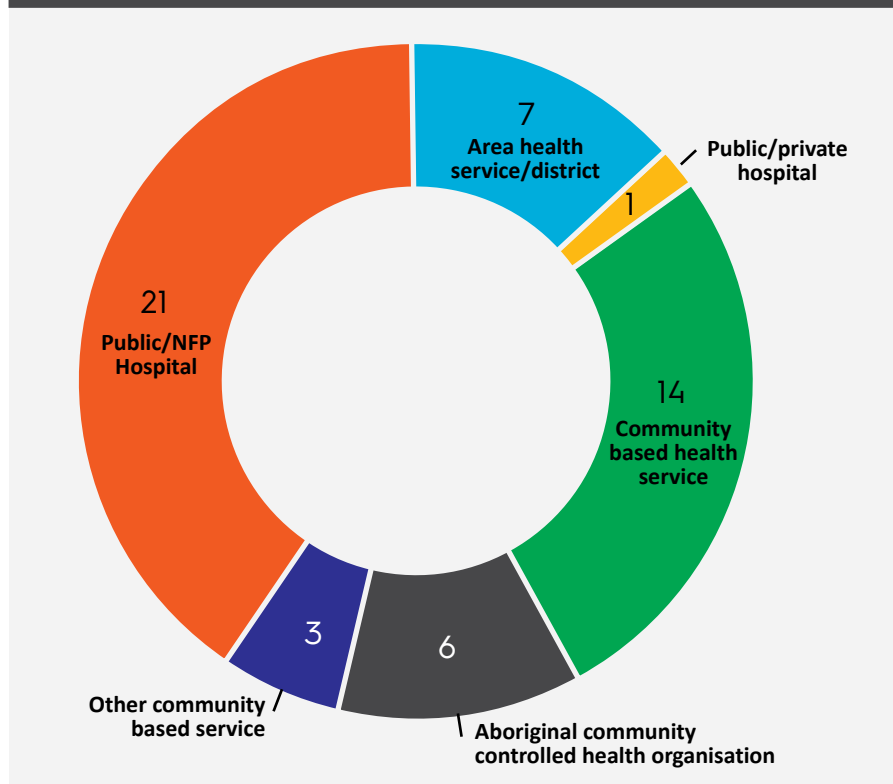
Other: a lawyer employed in a health service, a university clinic

Note: Numbers add up to more than 48 as some services have more than one type of legal partner.

On the health side, state and territory differences make it more difficult to accurately 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 major public or not-for-profit hospitals (to provide 21 services), and/or the administrative health districts or services that administer these hospitals, as well as other health services in their districts (7 services). Community based health services are partners in 14 services and six partnerships include an Aboriginal community controlled health organisation (ACCHO) as a partner.

Future surveys will explore more closely the types of legal and health organisations involved in these partnerships.

Figure 7: Health partners on the health justice landscape



Source: HJA 2017 mapping survey. N= 52 partners in 48 services.

Notes: Numbers add up to more than 48 as some services have more than one type of health/community partner. As health administration structures vary from state to state 'area health service/district' is not applicable in all states and territories.

5. What partnership looks like

One purpose of the mapping survey has been to identify indicators of active and effective partnering between health and legal agencies. Elements of active or effective partnering include co-creation, mutual engagement, capacity creation, common goals and collaboration towards those goals. (For more, see [Promoting Effective Partnering](#).)

Here we report some preliminary indicators of partnership, based on the information available from the survey. Again, future work may refine this set of indicators.

**If we truly want to work in partnership,
if we truly want those partnerships to
increase our effectiveness, to improve
outcomes for the people we support, then
we need to be willing to give up some of
our self-valued expertise, to make room
for other experts. We need to share our
knowledge; we need to share our power.
(Boyd-Caine, 2018)**

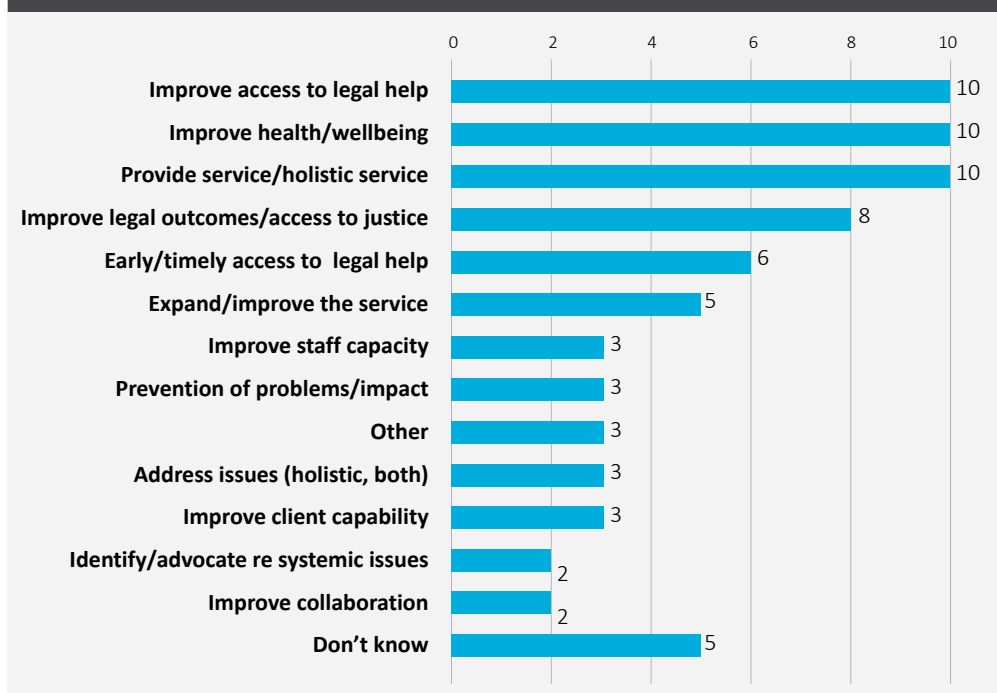
i. Shared goals

Respondents were asked about:

- legal partner goals or outcomes for the service
- health partner goals or outcomes for the service
- shared goals or outcomes

Generally speaking the shared goals outlined were the same as or combined the goals of each of the health and legal partners. Noting this, the most common shared goals (as categorised by us) were: improved access to legal help for the patient/client groups served; improved health and wellbeing by addressing health-harming legal need; and the provision of holistic or integrated services.

Figure 9: Goals or outcomes shared by the partners



Source: HJA 2017 mapping survey. N= 46. No response from two respondents.

Note: the one response indicating 'no shared goals or outcomes' had common outcomes expressed for each of the health and legal partners.

ii. Partnerships based on an MOU

Nearly two-thirds of respondents to this question (30 of 46) indicated that their partners had signed a formal memorandum of understanding (MOU) for their service. A further 13 respondents indicated that there was either an informal agreement between the partners or indicated that the service was a 'joint project of two (or more) organisations'.

The report *Building health justice partnerships: 3 key lessons from practitioners* provides insight into the work involved in forming a partnership and reaching agreement on an MOU.

Without an MOU it is easy for misunderstandings to arise between partners about their respective responsibilities. (HJA, 2018)

iii. Referrals between the health and legal partners

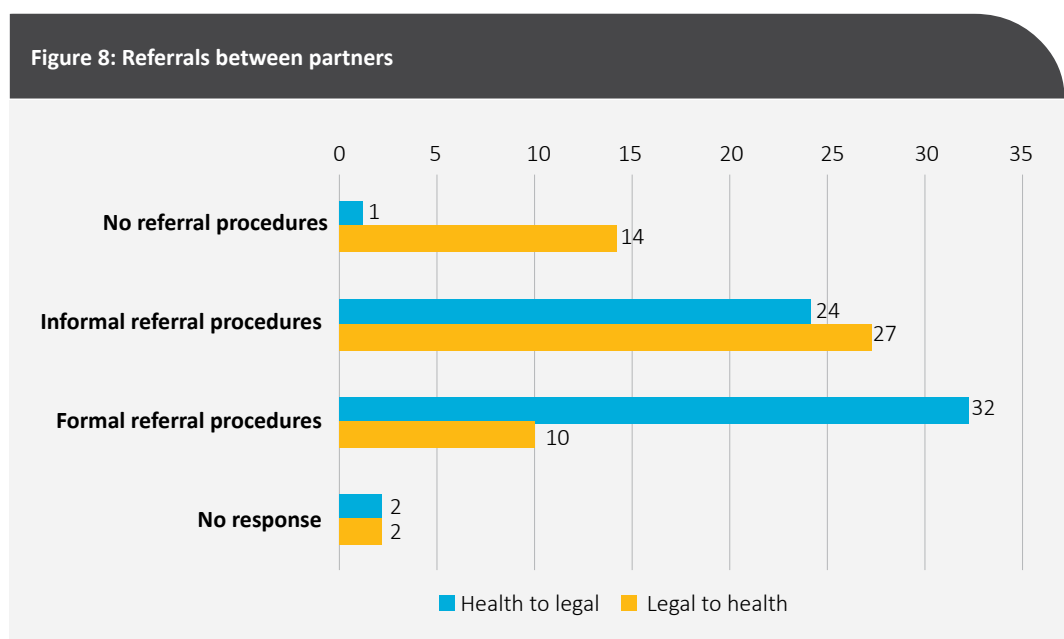
One indicator of an active relationship between partners may be the level and type of client referral between the two organisations. An example of such a referral is a health provider identifying that their client has a legal problem and booking them in or bringing them to the legal service available on site.

Given the placement of legal services in a health setting, we would expect to see at least informal referral of clients from the health staff to the legal staff, and more of a focus on formal processes in this direction.

This is reflected in the data. Two-thirds of the services reported formal referral processes from health staff to legal staff. Half of the services reported informal referral procedures in addition to or instead of formal referral processes. There was no reported referral process in place for one service and two respondents did not know.

More than one in five respondents indicated that there were formal referral processes from the legal staff back to the health staff and nearly 30% indicated no referral procedures at all. Broadly speaking, this may reflect the nature of the service models involved, where legal clients are already in, and are drawn from, the health setting. What is striking in the data is the fact that more than half of the respondents reported informal referrals from legal staff back to the health staff. This may be an indication as to the strength of partnership with two-way communication to address the needs of the client.

Of course, it would be helpful to have more information about the nature of these referrals. When are they part of shared case management and when are they steps in a pathway to additional assistance? Do they involve feedback to the referrer about the progress of the client’s matter? What circumstances best facilitate referrals. These types of questions could be considered in future surveys.



Source: HJA 2017 mapping survey. N= 46. No response from two respondents.

iv. Secondary consultation

In addition to training, education and referral, respondents reported health and legal staff supporting each other and their clients with secondary consultations. In the mapping survey secondary consultation was defined as ‘advice to a legal professional about the health needs of a particular patient’ or ‘advice to a health professional about the legal needs of a particular patient’.

More than three-quarters of respondents (36) said that legal service staff provided secondary consultations to health professionals in the service setting, while 34 reported that health professionals provided secondary consultations to the lawyers. We did not explore in this survey how formal or informal these secondary consultations were.

v. Ongoing communication

Respondents were asked whether they have communication or shared practices between their partners. They were able to indicate whether they do any or all of the following:

- operate in parallel, supporting a common client group
- have regular informal communication about the partnership
- have regular (at least quarterly) formal communication about the partnership
- share case management of individual clients through the partnership

While five respondents did not respond, four respondents indicated that they worked in parallel but had no formal or informal communication or shared case management. This would suggest fairly low engagement between the partners. Conversely, six respondents indicated they undertook shared case management, (with or without formal/informal communication)⁵.

Of the remaining respondents:

- eight reported formal but not informal communication between the partners
- 11 reported informal but not formal communication
- 14 reported both formal and informal communication

At times, when the hospital has been under periods of great stress ..., it has made it harder to stay in touch with the health partner staff as they were facing so many other pressures. We needed to take more responsibility for communication (Legal partner, NSW)

⁵ There are key challenges services need to address in shared case management, including safeguarding client confidentiality and privileged communication with their lawyers (Noble, 2012; Gyorki, 2013). Lawyers equally must be aware of mandatory reporting requirements placed on their health colleagues.

vi. Integration

Respondents were asked where they would rate their partnership on a scale of integration. While two respondents did not answer the question, 22 of the remaining 46 respondents (48%) described their partnership as 'collaboration', the highest level of integration or partnership on the scale. Another 12 defined their partnership as 'coordination'.

This scale and its terms are defined here, from the lowest level of integration or partnership to the highest.

No awareness: We are not aware of the approach taken by our partner workers in the other organisation.

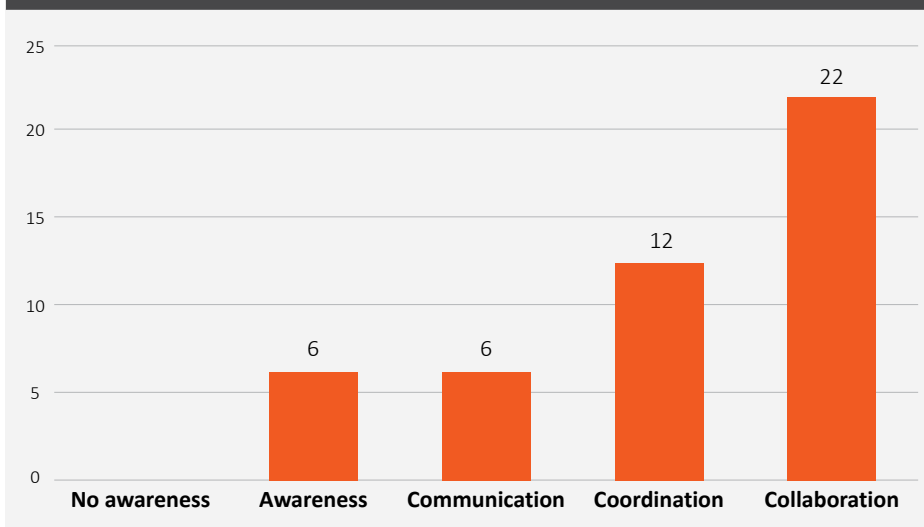
Awareness: We are aware of the approach taken by our partner workers in the other organisation, but organise our own activities solely on the basis of our own objectives, materials and resources.

Communication: We actively share information (formally or informally) with our partner workers in the other organisation.

Coordination: We work together by modifying program planning and delivery to take into account methods, materials and timing of our partners in the other organisation.

Collaboration: We jointly plan and deliver key aspects of our program with the other organisation with the aim of an integrated approach.

Figure 10: Where respondents rated themselves on the partnership spectrum



Source: HJA 2017 mapping survey. N= 46. No response from two respondents

vii. Funding source

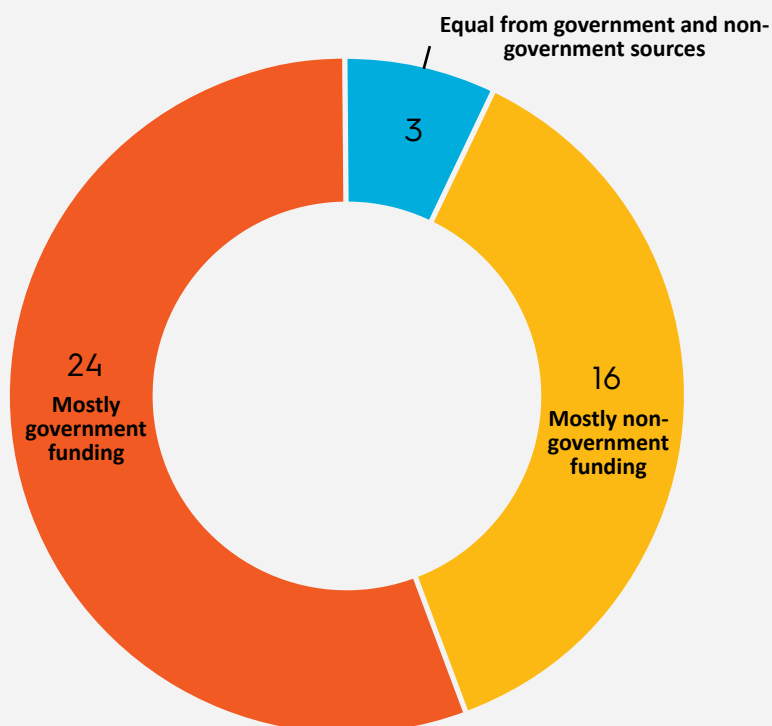
Respondents were asked to indicate, in broad terms, how they were funded. While some respondents indicated changes in funding over time, half (24) indicated that most of their funding came from government. This includes partnerships for which the cost is absorbed by the legal service provider as well as grants of funding to establish a health justice partnership.

Sixteen respondents said that most of their funding came from non-government sources. These include philanthropic funding and grants from statutory funding bodies such as the Victorian Legal Services Board.

Three respondents indicated funding from government and non-government sources, while five respondents did not know or did not respond.

A key issue to track in future is the sustainability of funding, as we aim to move services on the landscape from pilots to sustainable services. This is certainly a key concern of services as reported in *Building health justice partnerships: 3 key lessons from practitioners*. This tracking should also take account of the amount of unfunded work that is undertaken to support the partnership and its practice.

Figure 11: Funding across the health justice landscape



Source: HJA 2017 mapping survey. N= 43. No response from five respondents.

6. Conclusion

Health Justice Australia was established in response to the growing interest in health justice partnership as a model to prevent legal problems becoming health problems. The data in this report, drawn from our first survey of services within this movement, show the significant growth in health justice partnerships in recent years. These data also show the breadth and diversity of service models, partners, settings and target populations, across an even broader range of service models on the health justice landscape.

The report has explored some of the features of partnership. It shows there are services on the landscape with MOUs and referral protocols. There are services with strong informal relations as well as formal partnership structures. There are partners that support each other with training and secondary consultation; and partners that have shared goals in common, centred around the needs of their clients. The survey indicates both government and non-government funding sources but funding is not secure, particularly where it is project or pilot based (as highlighted in the report *Building health justice partnerships: 3 key lessons from practitioners*, also based on this mapping work). The sustainability of partnerships moving forward is a key issue.

The survey results have highlighted the value of collecting data to understand the landscape and to add definition to the models within it. Individual services can place themselves on this landscape and consider specific similarities and differences. However, the range of features discussed in this first mapping report is limited to the questions asked in the 2017 survey. There are of course other features and factors relevant to services on the health justice landscape that were not included in this first survey, but could be explored in future. In addition to specific suggestions made in each of the sections above, these might include:

- triage practices and the use of screening tools by services to identify legal need
- community legal education for clients or patients, or other community/client engagement
- service location or catchment area, mapped against indicators of legal need, high health need or social disadvantage more broadly⁶
- the capacity of services to meet demand
- data collection and/or data/information sharing between partners

Equally, the survey process has also identified how we could improve the data collection – to make it easier for services to participate, while improving the quality and value of information collected, potentially on an annual basis. The aim of ongoing data collection would be to chart and support the development of services on the health justice landscape. Through this research we hope to develop more detailed analysis about this innovative service model: its implementation and its impact in different service settings, for different client groups and in addressing critical issues, such as domestic and family violence, child protection and elder abuse.

In the meantime, the findings of this report will inform immediate priorities including:

- the funding and policy settings that can enable further exploration of partnership-based service models
- a clearer appreciation of different service models on the health justice landscape
- planning and evaluation and the development of a best practice HJP model, which draws upon the experience of practitioners and their partnerships
- tools for practitioners such as a template theory of change/program logic, an outcomes framework and measurement tools

⁶ These include the Law and Justice Foundation's Need for Legal Assistance Services (NLAS) capability indicator (Law and Justice Foundation of NSW, 2018) and the Australian Bureau of Statistics' Socio-Economic Indexes for Areas (SEIFA).

Appendix

2017 survey questions

1. What is the name of your Health Justice Partnership?
2. What is the name of your health partner?
3. What type of health service would best describe your health partner?
4. What is the name of your legal partner?
5. What type of legal service would best describe your legal partner?
6. Are there additional members of your partnership?
7. What year did you begin developing your partnership?
8. What year did your partnership commence delivering services?

Services delivered by your HJP

9. What is the service setting for your HJP?
10. What geographic area/s are covered by your HJP? (ie the catchment you service)
11. What is the post code of your HJP?
12. Why did you choose this community or setting for your HJP?

People using your HJP

13. Who can access your HJP?
14. Are people accessing your HJP from a particular gender?
15. Are people accessing your HJP from a particular age group?
16. Are people accessing your HJP from a particular culture or ethnicity?
17. Are your patients/clients repeat users of your HJP?
18. How many instances of service does your HJP provide per year? (ie not individual clients seen; include secondary consultations if you have these)

Activities of your HJP

19. What types of health services does your HJP provide to patients?
20. Of the types of health service provided by your health partner to patients, which are the most common? (please specify up to 3 or 'don't know')
21. What types of legal matters does your HJP help clients with?
22. If 'Civil Law (general)' was selected, which types of civil law matters?
23. What types of legal assistance does your HJP provide to clients?
24. Of the types of legal assistance your HJP provides to clients, which are the most common? (please specify up to 3 or 'don't know')
25. What types of assistance or support are provided by health staff to the legal partner/staff?
26. What types of assistance or support are provided by legal staff to the health partner/staff?
27. Does your HJP conduct systemic advocacy (ie building on individual patient/client work to address related legislative, policy or systemic factors)?
28. Are there any further features of your HJP that you have not already described?

Resources and infrastructure of your HJP

29. How many hours per week is your HJP open or accessible to patients/clients? (in the last financial year; estimate if you don't know)
30. How many staff hours (full time equivalent) per week are allocated to your HJP? (in the last financial year; estimate if you don't know or enter 0 if doesn't apply)
31. What is the annual operating budget for your HJP? (in the last financial year; estimate if you don't know or enter 0 if none)
32. Where is the majority of your HJP funding from?
33. What are your plans to grow the HJP in the next 3 years?

Key features of your partnership

34. Is your partnership formalised?
35. Does your HJP have referral procedures from your health partner to your legal partner?
36. Does your HJP have referral procedures from your legal partner to your health partner?
37. Does your HJP have communication or shared practices between your partners?
38. Which of the following best describes the level of integration between the partners in your HJP? [listed with descriptions were Awareness, Communication, Coordination, Collaboration, No awareness and Don't know]

Objectives of your HJP

39. Does your HJP have shared goals or outcomes it would like to achieve?
40. Does the health partner of your HJP have clear goals or outcomes it would like to achieve through the HJP?
41. Does the legal partner of your HJP have clear goals or outcomes it would like to achieve through the HJP?
42. How do you measure the impact or outcomes of your HJP? (eg defined metrics, internal evaluation, external evaluation, no set approach)

Lessons learned from your HJP

43. From the health partners' perspective, what has worked well in setting up and running your HJP?
44. From the legal partners' perspective, what has worked well in setting up and running your HJP?
45. From the health partners' perspective, what challenges have you faced in setting up and running your HJP?
46. From the legal partners' perspective, what challenges have you faced in setting up and running your HJP?
47. What would you do differently in setting up and running your HJP?
48. Which of the following activities would you find most useful from Health Justice Australia?
49. Who has completed this survey?

For further information about the survey, please contact Health Justice Australia.

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