

Mapping a new path



Service models on the health justice landscape

**A closer look at
partnership**



A discussion paper

November 2018

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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Executive summary

Since the World Health Organization's groundbreaking report from the Commission on Social Determinants of Health (2008), evidence has continued to grow regarding the importance of social and environmental factors in driving poor health outcomes for individuals and communities. These factors include poor-quality housing, unstable or insecure work, limited income and low social support.

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 are associated with increased risk of physical or mental 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 of people who are vulnerable to intersecting health and legal issues, but are more likely to turn to a non-legal advisor, such as a health professional, than a lawyer.

In response to this evidence, health and legal services have come together in a range of ways, including as health justice partnerships. Since 2012, this evolving practice has seen a growing number of service collaborations across Australia. However, Health Justice Australia's 2017 survey of services that identify as health justice partnerships revealed no single or unanimous understanding of what a health justice partnership is. On the contrary, it indicated a range of service models on the health justice landscape that, while all seeking to bridge the divide between health and legal silos, had some key points of difference.

Importantly, while research indicates the value of health and legal services collaborating to address unmet health harming legal need, we do not yet know what works best, for whom, in what circumstances and at what cost. This is a key agenda for Health Justice Australia. If we want to know and promote what works, we need to be clear about what the 'what' is: what makes a service a health justice partnership and what features are key to its effectiveness. This clarity of definition is important for planning, implementation, evaluation and improvement, in addition to explaining the rationale for policy and funding support.

The purpose of this discussion paper is to propose a definition of a health justice partnership and to identify key features of this model. The paper explores what takes a health justice partnership beyond standard services in terms of purpose, structure, activity and resourcing, and notes points of difference with other service models on the health justice landscape.

Broadly speaking we propose that **'health justice partnerships' are collaborations to embed legal help in healthcare services and teams**. While models vary and evolve over time, HJPs commonly work to improve health and wellbeing: for individuals, through direct service provision in places that they access; for people and communities vulnerable to complex need, by supporting integrated service responses and redesigning service systems around client needs and capability; and for vulnerable populations through advocacy for systemic change to policies which affect the social determinants of health.

For some on the health justice landscape, the health justice partnership features we outline will be reflected in their current service. Others may be working towards those features. For others again, the health justice partnership model proposed here may contrast with a model of service they are operating or that they aspire to. The choice of approach will depend upon the needs of clients or patients, the intent of the service and/or partners, and the resources and commitment available to develop the service model. As evidence becomes available, decisions will also be influenced by the relative cost and impact of each service model in each context. We hope the ideas we have set out in this paper provide a useful starting point for dialogue, as we move towards a shared understanding between practitioners, researchers, policy-makers and funders of what it means to be a health justice partnership.

Introduction

The innovation of health justice partnerships is collaboration that embeds legal help into healthcare services and teams. It is now a movement attracting interest from practitioners, researchers, policy-makers and funders. From the legal side, interest has centred on the capacity of HJPs to reach and appropriately assist people who are vulnerable to legal need, but unlikely to access legal services for those problems. From the health side, lawyers support patients who utilise health services and have injuries or conditions that may have an underlying legal dimension. Examples include stress arising from debt or loss of employment, or physical illness or injury arising from substandard housing or family violence.

Arising out of this practitioner-led innovation, Health Justice Australia was established in 2016 as a national charity and centre of excellence in health justice partnership (HJP). We aim to help people who are vulnerable to health-harming legal need by driving the effectiveness and expansion of HJPs. The evolving movement that Health Justice Australia supports has been informed by a history of outreach legal practice in Australia (see Pleasence et al, 2014; Forell & McDonald et al, 2013; Noone & Digney, 2010), together with the US movement of medical-legal partnerships (MLPs) (see Box 1; and also Noble, 2012; Gyorki, 2013). However, as also noted 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).

In 2017, Health Justice Australia conducted a survey to identify the ways that health and legal services across Australia were partnering to bring legal help into health settings. This work has been undertaken at a dynamic time when services are both starting up as and evolving into collaborations between health and legal agencies. Given the organic growth of these services, it is not surprising to find a range of different ideas about what constitutes an HJP. Some use HJP to describe any work involving health and legal services. Others use it to describe a particular service model, yet self-described HJPs may differ quite significantly from each other.

If we are to explore what works best to address unmet need, we need to know what the interventions are. Clarity of definition is important for planning, implementation, evaluation and the appropriate translation of the HJP model, in addition to explaining the rationale for policy and funding support. Therefore, the purpose of this discussion paper is to propose a clear definition of an HJP and to identify the features that make a service an HJP.

In identifying features that make up an HJP, we explore how HJPs differ from standard services, while also considering points of difference from other service models on the health justice landscape. We examine who HJPs serve and why, their service partners, their activities, their structure and resourcing. This is a foundational piece of work, so that when we evaluate the outcomes of services on the landscape, we understand how features of each model may contribute to the difference made. In a separate piece of work we will explore the outcomes that HJPs aim to achieve. Ultimately it will be outcomes that tell us which service models work best for whom, in what circumstances and at what cost.

We begin our discussion by recapping evidence which has informed the movement of legal services into healthcare spaces.

We cannot answer the question of ‘what works’ if we do not clearly understand what the ‘what’ – the strategy - actually is. And, of course, the question is not simply ‘what works?’ It is ‘what work’s best, for whom (these client groups), with what resources and in what circumstances’ (Forell & McDonald, 2017).

Box 1: Medical-legal partnerships (MLP)

The MLP movement in the United States has been a source of inspiration for the evolution of health justice partnerships in Australia. Medical-legal partnership refers to:

An approach to health that integrates the expertise of healthcare, public health and legal professionals and staff to address and prevent health-harming social and legal needs for patients, clinics and populations. By partnering together, healthcare, public health and legal institutions transform the healthcare system's response to social determinants of health (National Center for Medical-Legal Partnership 2015 p.2).

Common features and activities of MLPs are identified as:

- legal assistance to individual clients within healthcare settings
- transforming service systems through inter-disciplinary collaboration with lawyers on healthcare teams and cross-disciplinary training
- policy change, with legal and health professionals jointly advocating for policy and law reform to improve health and wellbeing (see Beeson, McAllister & Regenstein 2013, p 3-4).

As MLPs have developed in response to a very different social context to Australia, the model and its impact cannot necessarily be translated directly. However, the MLP model provides a guide to what may also be key features of health justice partnership on the Australian landscape (see Regenstein et al, 2017).

The evidence for health justice partnership

The movement towards health justice partnership is supported by evidence arising from both socio-legal and socio-epidemiological (public health) research, which coalesces around shared client groups, intersecting need and integrated service responses.

Research into legal needs and access to justice (see Pleasence and Balmer 2014, Pleasence et al 2014; Coumarelos et al, 2012) has identified that:

- Over one-fifth of people in Australia experience three or more legal problems in a given year. While common across the community, legal problems are particularly prevalent among people experiencing social disadvantage, particularly those with chronic ill-health or disability, single parents, the unemployed and people in disadvantaged housing.
- Legal problems have been found to cluster, for instance around family breakdown, money issues or poor-quality housing, and often coexist with 'everyday life' problems.
- Legal needs are reported to have adverse impacts, including income loss or financial strain, stress related illness and physical ill health.
- Those most vulnerable to legal need commonly face significant barriers to accessing legal help, including: not recognising that a problem has a legal solution; limited knowledge, skills and resources to respond to these problems; having other issues and priorities in their lives; concerns about the stress and possible repercussions of raising the issue; accessibility of services and cost.

With nearly half (47%) of those surveyed reporting that their legal problem led to a stress-related illness, loss of employment, or the need to relocate, this study reinforces the impact of justice issues on people's lives. (World Justice Project, 2018 p. 6)

- Nearly one in five Australians take no action for their legal problems. When they do seek advice, they are more likely to ask a non-legal advisor, such as a health professional, than a lawyer.
- Legal problems can both result from broader social problems and reinforce disadvantage.

A key rationale for legal services to provide assistance in healthcare settings is to better reach and assist those disproportionately burdened with legal need, but less likely to seek help directly from lawyers at all or in a timely way¹ (Pleasence et al, 2014; Forell & McDonald et al, 2013; Coumarelos et al 2012).

From the health side, the HJP movement responds to evidence that:

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

Indeed, it is broadly estimated that:

‘genes, biology, and health behaviors together account for about 25% of population health. Social determinants of health represent the remaining three categories of social environment, physical environment/total ecology, and health services/medical care’ (NCHHSTP Social Determinants of Health, 2018, drawing upon Tarlov, 1999).

Critically, these environmental and social factors particularly impact upon the health and wellbeing of the same vulnerable communities identified in the legal needs research (see Williamson et al 2018; Bachrach, Pfister, Wallis & Lipson, 2014; CSDH, 2008). Such factors include access to resources and services (e.g. income, safe and secure housing, education), personal safety (e.g. safety from violence) and stressors such as loss of employment and debt

A survey of GPs in the UK found that one in five consultations were for ‘non-medical’ issues, most commonly personal relationships, housing issues, employment related issues (including unemployment), welfare benefits and financial problems/debt (Caper & Plunkett, 2015).

...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, 2015 p.7)

(CSDH, 2008; see also Australian Institute of Health and Welfare, 2016 ch. 4). The

identified impact of unmet social needs more broadly includes more illness, shorter life expectancy and increased health-care spending (Bachrach et al, 2014, p.10; Australian Institute of Health and Welfare, 2016 ch. 4). Public health literature points to the key role of services and infrastructure beyond the health sector and importance of integrated approaches to address health and wellbeing (e.g. WHO, 2013).

Thus, people are coming into health services with problems which may have health symptoms but broader social causes

¹ Timeliness may refer to clients being able to access help early, before problems further compound and escalate and/or at a time when the client is motivated and can be supported to take action (Pleasence et al, 2014).

(Caper & Plunkett, 2015; Iacobucci 2014a & b; Popay, et al, 2007). Among these are issues that legal assistance services can address (Beardon & Genn, forthcoming; The Law Commission & Advice Service Alliance, 2015; Marple, 2015; Pleasence, Balmer & Buck, 2008).

Taken together, health and legal evidence points to common groups of people who:

- are vulnerable to complex life issues that have intersecting health and legal dimensions
- may not understand or respond to these problems as legal issues
- are less likely to have knowledge, skills, psychological readiness and resources to address these issues without support
- are more likely to seek help from people or services they know, commonly access and trust. Noting the nexus between chronic ill-health, disability and the experience of legal need, these places include health settings. However, depending on the client group, settings may also include welfare services, schools or local community centres
- may be driven to seek help or access services by crisis (medical, legal or otherwise)
- have health issues that are disproportionately affected by social and environmental factors, which are themselves shaped by law and policy
- will include some who are marginalised in their access to and uptake of any services.

The clients that HJPs seek to assist

A central rationale for health and legal services coming together is to assist shared client groups with problems that have both health and legal dimensions (Williamson et al, 2018; Bachrach et al, 2014; Beeson et al, 2013). The assumption is that health and legal strategies pursued in partnership will have better outcomes than standard services provided in health and legal silos.

Populations that are particularly at risk of poor health and justice outcomes include people living with disability or chronic health conditions, people experiencing domestic and family violence, people at risk of elder abuse, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities and people experiencing poverty. Noting that social and environmental factors (including legal issues) will also affect those who do not access any services, community-wide impact is likely to require more than individual assistance. Additional strategies may include service system redesign, and advocacy for policy change around factors which impact upon the social determinants of health (Bachrach et al, 2014; Gyorki, 2013; Noble, 2012; CSDH, 2008).

Early advocacy for HJPs framed the movement as a shift ‘...from the model of service delivery based upon the provision of outreach services to an integrated model of service delivery in a health-care setting’ (Gyorki, 2013, p.8; see also Noble, 2012). However, as noted in box 2, the mapping survey indicates that integration may take many forms and that there are several ways in which health and legal services are coming together.

Box 2: A health justice landscape

In August 2017 Health Justice Australia sent a survey to all services in its network to build a profile of HJPs in Australia. Information was gathered from the 48 responding services about their partners and partnering, their service settings and locations, the services they provide and the people they serve (See *Mapping a new path: The health justice landscape in Australia, 2017* for a copy of the survey and results).

A key observation from the survey was that, while all respondents identified as HJPs, health and legal services were coming together in a range of ways on the health justice landscape. While all services involved the provision of legal help in health or community settings, there were key elements of difference. Services differed in who they served (clients), their participants (services/professionals involved), intent (what they aim to achieve), activity (what they do) and structure (e.g. if and how they partner).

In exploring these differences, we identified five separate service models among the survey respondents: partnerships, integrated services, outreach, service hubs and student clinics. Had we looked more broadly, there may be an even greater variety of models.² Table 1 provides preliminary working definitions of these service models. We include them here to help identify similarities and differences as we explore the key features of an HJP.

Table 1: HJA 2017 mapping survey: ways that legal services are provided in health settings and teams

Model type	Broad description
Partnerships	Partnerships (commonly between health services and legal services) to embed legal help in healthcare teams or services.
Integrated services	Services in which a lawyer is employed by a health service, as part of their healthcare team (or a health professional employed by a legal service).
Outreach services	Lawyers attending health settings to provide a legal service or clinic but not considered to be part of the 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.

Models will vary for reasons ranging from the intent of the service, client need and preference, through to the resources and opportunities available to reach people with unmet need and/or to partner with others. Any judgement about the appropriateness of one model compared to another should be framed around the outcomes it achieves for client groups, taking into account the context and resources available to do so.

² These models are drawn from the survey and there may be others on the landscape. Internationally these include US Medical Legal Partnerships (see box 1), UK advice services in GP settings (see Beardon & Genn, forthcoming) and also in the UK, social prescribing initiatives (See <https://www.kingsfund.org.uk/publications/social-prescribing>).

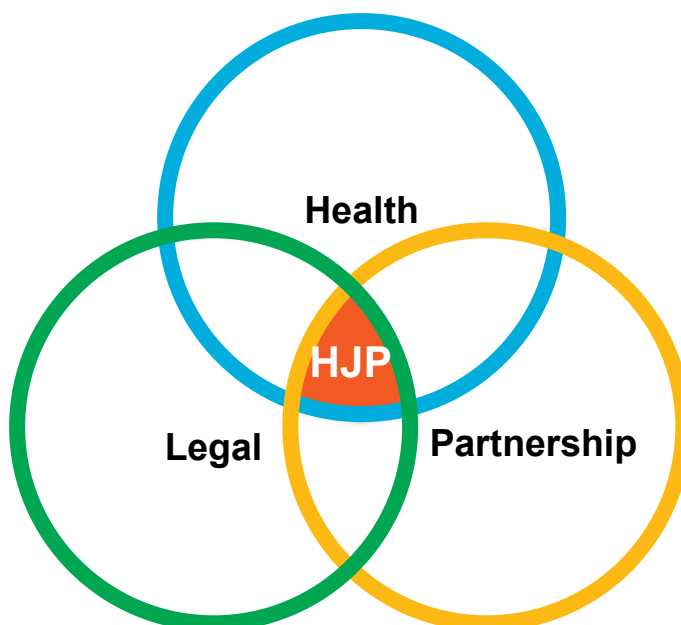
What is a health justice partnership?

The evidence outlined above identifies a complex range of inter-related problems facing vulnerable people and communities, including the barriers faced in addressing these issues. Structural and systemic factors also impact upon these problems and barriers, and it is around these individual and systemic challenges that we have framed our understanding of the potential value of health justice partnerships, compared to standard or siloed health and legal services.

In defining the challenges, the evidence also suggests possible solutions. It first suggests that complex problems might need complex solutions. Given the siloed reality of the current human services environment, one way for agencies to match this complexity is through cross-sector partnership. The evidence also suggests the value of strategies that can have a population-scale impact, for instance through the redesign of service systems, or through advocacy for change to the laws and policies that shape health and wellbeing. This allows for the impact of HJP activity to extend beyond service provision to individual clients.

Broadly speaking, we define HJPs as **partnerships to embed legal help into healthcare services and teams**. Importantly, the critical elements of this definition are not just embedded legal help in health services and teams, but also the partnership that enables this. Indeed, as we conceptualise the model, health justice partnerships sit at the nexus of the three domains: health, legal *and* partnership.

Figure 1: Where health justice partnerships sit on the health justice landscape



To understand why each of these elements is critical, we provide this fuller definition of HJPs:

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.

This full definition describes:

- the model (**partnerships** to embed **legal** help into **healthcare** services and teams),
- key activities (accessible direct service provision, integrated services through system redesign and systemic advocacy) and
- outcomes (improved health and wellbeing for clients, their communities and vulnerable populations).

The outcomes noted in the definition are high level and broadly expressed. In the future, Health Justice Australia will be working with our practitioner and researcher networks to develop an outcomes framework for health justice partnership.

Noting that no two HJPs will be identical, and indeed may change over time, we now explore features of health justice partnerships across the domains of health, legal (justice) and partnership.

Health

Health partners, services and settings

HJPs bring together health and legal support to address complex need. However, our mapping has indicated that across the health justice landscape, 'health' can refer to:

- service setting (hospitals, community health services, Aboriginal health services, forensic health settings, general practice, settings supporting the wellbeing of individuals), and/or
- organisational health partners (hospitals, area health services, health boards, community health services, general practice clinics, Aboriginal community controlled organisations), and/or
- health professionals (doctors, nurses, social and community workers, allied and public health staff).

Thus, while HJPs typically involve health partners, health practitioners and healthcare settings, an HJP could involve any one of the above. Included among Australian HJPs, for instance, are district nurses working in community settings, and maternal and child health nurses employed by local councils.

The rationale for placing services in health and community settings is that these are places more likely to be accessed by the client groups that legal services seek to assist. Clients of HJPs connect with legal services in a healthcare setting or through health practitioners because they:

- may seek help for a problem which is affecting their health (but that also has a legal dimension and solution)
- are connected with health services through crisis (e.g. injury, acute healthcare issues) or chronic illness (e.g., mental health, issues related to aging).

Box 3: Health ... and welfare?

A question arising is whether, for the purpose of defining service models, health services and settings should be drawn more broadly to also include welfare and community services that provide services to address wellbeing. For instance, is a legal outreach to a homelessness service a health justice partnership? What about a partnership between a school and a legal service?

The argument to think more broadly about health services and settings is informed by a preventive health perspective, which acknowledges the variety of community and welfare services that address the health harming issues facing individuals and the social determinants of health more broadly. By this argument, social or welfare services partnered with legal services may well be considered HJPs, particularly if they seek to address legal need that is harming health and wellbeing.

The proposed definition of an HJP does not detail the types of partner organisations (e.g. 'health' or 'legal') but broadly describes 'health services and teams' as the location of the legal help. This is based in evidence which points to the dual value of a health location for reaching clients with legal need, and the value of legal assistance as part of a healthcare strategy. However broadly this is interpreted, Health Justice Australia looks to support and learn from all forms of partnership and integration that bring legal help into healthcare services and team.

That noted, the question here is not one of value or relative impact but of definition, particularly for evaluation. We are seeking to define the features of a service model so we can identify what makes a difference. This involves being clear about who the partners are, where the services are located, what assistance they provide, what they aim to achieve and the resources they require, among the other features described below. With this clarity we can compare services and their outcomes. For this reason, it may be more helpful to describe other partnerships for what they are: for instance 'school justice partnerships' or 'community justice partnerships', noting similarities (and differences) in the service models and the outcomes each is trying to achieve.

Legal

Legal partners and legal help

All service models identified in the mapping survey provided legal help to individual clients. The legal help commonly involved a combination of: legal triage (identifying legal issues experienced by clients or patients) and referral; legal information; legal advice; legal tasks (also known as legal or minor assistance); and/or representation (which involves legal casework or in-court advocacy).³

However, services varied in the:

- type of legal issues addressed (family, civil, criminal or subsets/combinations of each of these)
- range of legal issues dealt with (e.g. single issue versus multiple issues)
- the level of legal help available (e.g. information, advice and referral only, or the capacity for more intensive support; one-off advice compared to ongoing assistance)
- service capacity to coordinate legal assistance with the healthcare provided
- the skills/experience of the lawyers involved
- client-facing hours.

A challenge for any legal assistance service in a constrained funding environment is the choice between intensive assistance for fewer clients with more complex needs and greater barriers to accessing services and less intensive assistance for a higher number and broader range of clients. HJPs are a service model to reach and assist clients with complex legal and other need. As such HJPs should have the capacity to provide the following.

- Legal assistance for the range of issues that clients in that particular setting are likely to face. These legal issues are likely to cross the legal specialties of family, civil or criminal law. However, in some settings, specific legal expertise may also be required, for instance the availability of family law or child protection expertise in an ante-natal setting. This assistance may be provided directly and/or by linking the client to further specialist support as required (Gyorki, 2013 p.9).
- Legal assistance beyond information, referral or advice. HJP lawyers should have the capacity to undertake legal tasks for clients (e.g. letter writing, negotiating with other parties) and advocacy or representation where required. Again, this assistance may be provided directly and/or by linking the client to further specialist support as required. Noting the needs that HJPs aim to address, a service that can only provide legal information, advice and a cold referral (e.g. a phone number of a legal service for instance) is less likely to be an HJP. However, a service that involves lawyers triaging and advising clients and then linking those clients directly with partnering legal services or firms may well be an HJP.

³ For definitions of legal service types see Australian Government Attorney-General's Department (Undated (c2015)). National Legal Assistance Data Standards Manual. Canberra.

- Ongoing legal assistance (beyond a single session) as required. An HJP should have the capacity, where needed, to take on a client for ongoing assistance in the form of representation, or if it is appropriate, to provide ongoing unbundled legal assistance or advice.⁴
- Legal assistance which is linked to or supports the healthcare plan for that client (see shared case management below).

The number of hours per week that a service operates will reflect a range of issues, including client need, host service hours, available resourcing and the like. While the number of client facing hours does not define a service as an HJP or otherwise, the hours (resourcing) staff have available to provide client services, support shared practice (e.g. training) and to sustain the partnership is likely to be critical to an effective HJP.

Box 4: Shared case management – lawyers as part of healthcare teams

Service models vary in the extent to which partners coordinate their services around the client. Some operate on the basis of one or more services co-locating in a health setting and each providing services to the client, but remaining largely independent of each other. Others coordinate their services across the partnership, such that the timing and impact of one service is considered relative to the other services (e.g. Pleasence et al, 2014 pp.106-107). For example, the health service might work with a client to stabilise their mental health issues before the legal service assists to secure a tenancy that the client is then more equipped to retain. Shared case management is an indication that lawyers are considered as part of the healthcare team, which has been argued to be a feature that differentiates HJPs from legal outreach clinics in health settings (Gyorki, 2013, p. 8). With shared case management comes the need for partners to address issues such as their respective professional rules and obligations (e.g. lawyer-client privilege and mandatory reporting requirements). Shared case management is also likely to be a feature of integrated services.

Expertise of legal professionals

To be most effective, HJP lawyers (or the other specialist advisors discussed below) will benefit from expertise beyond their usual specialisations in a particular area of law. Indeed a feature of legal practice in an HJP may be the skills and experience of lawyers in:

- being able to identify, effectively triage and/or provide assistance for issues that may cross the spectrum of legal need
- working effectively with vulnerable client groups that may have complex needs beyond the legal
- inter-disciplinary working in partnership with another sector’s organisation and their staff (see Forell, McDonald et al, 2013; Lawton & Tobin Tyler, 2013).

Clients with complex needs appreciate lawyers who are friendly, approachable, respectful and skilled at explaining legal issues in plain language. Legal advisers need the capacity to be able to appropriately refer clients for help with issues which are beyond the scope of the service. (Forell & Gray, 2009)

⁴ ‘Unbundled legal services’ commonly refer to those in which a represented client may undertake some of the tasks to reduce legal costs. In this context we are referring to ongoing assistance provided by a lawyer to a client, but where the client remains in control of their matter, rather than the lawyer acting for the client.

Just as health services can be broadly drawn to include those that address ‘wellbeing’, it could be argued that the ‘legal’ domain on the health justice landscape might include others in the ‘advice’ sector: financial counsellors, tenancy workers and the like. This is the broad view taken of health justice partnership in the UK where welfare advice services (which include legal advice) have been provided in various healthcare settings including general practice clinics (Beardon & Genn, forthcoming; the Low Commission & Advice Services Alliance, 2015). Most critical in our view is that the type and level of legal assistance provided in any setting is calibrated to the needs and capabilities of the people and communities served.

Student clinics and some outreach services use students, interns or junior volunteer and pro-bono lawyers within their service setting, supported by experienced supervising lawyers. Without appropriate training and support, junior practitioners may struggle to marshal the skills necessary to bridge the range and complexity of needs that HJPs have been designed to address. For this reason student clinics have been identified in this discussion as a separate service model.

Importantly, however, university-based cross-disciplinary training of health and law students to think and work beyond professional silos has been a key part of the MLP movement in the US and is gaining interest in Australia (see Bliss, Caley, and Pettignano, 2012; Pettignano, Bliss, McLaren & Caley, 2017). This is a broader strategy to support evolving practice on the health justice landscape.

Partnership

A defining feature of the HJP model is ‘partnership’, with collaboration through partnership across the health and legal silos the key point of difference between HJPs and standard services. However, the mapping survey revealed that the degree and way to which organisations and practitioners work together may also differentiate service models on the health justice landscape.

It is clear that single entity interventions, being too narrow in their approach and too restricted in their reach, are inadequate to tackle the complexity of many of the issues at hand. (Partnership Brokers Association, 2017)

HJP is a model which has active interdisciplinary partnership at its core. HJPs contrast to integrated services in which the lawyer is employed by the health service. They

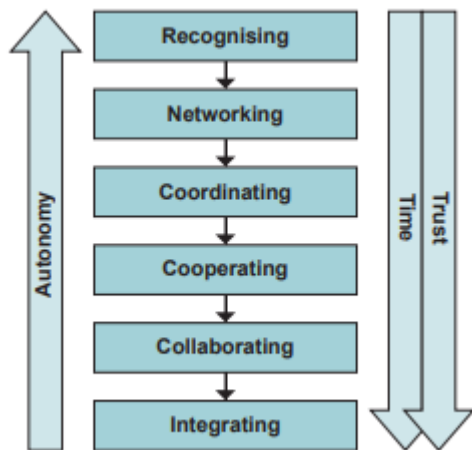
contrast to outreach services in the level of ‘partnering’ involved.

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)

‘Partnership’ is evident in the structure of the partnerships, their intent (shared by the partners) and their activities (e.g. shared case management, joint systemic advocacy). In terms of partnership, HJPs may differ from service hubs in their coordination around the clients and in their level of collective action towards the systemic factors affecting complex need.

This variety of partnering seen on the health justice landscape reflects what Pleasence et al (2014) have described as a ‘continuum of joined-up services’ (see Figure 3).

Figure 2: Continuum of joined-up legal and other services



... 'joined-up services' (legal/legal and legal/non-legal) that reflect the experience and needs of service users, are best positioned to address underlying and consequential issues (particularly where these are aspects of social disadvantage) and better yield whole-system policy objectives. (Pleasence et al, 2014 p.67).

Source: Pleasence et al, 2014 p.71

Health and legal services form partnerships to improve client and community reach and outcomes through 'joined-up' service delivery. Additional benefits for partner organisations may include supporting staff to do their work more effectively and to access new professional knowledge, skills and networks through interdisciplinary work and professional development. However, increased connectedness and the opportunities that may bring needs to be balanced with the reduction in partner autonomy (within the context of the partnership) and an increase in required time, resources and trust.

Further, joined-up services '...are generally set against a backdrop of very limited resources and significant capacity constraints' (Pleasence et al 2014, p.69). Therefore the degree of partnership that can be sustained will be affected by a range of factors, including the willingness of services to actively partner, their shared intent and their relative resource capacity. It may well be the case that, in some service contexts, a partnership model is not the most appropriate or feasible option.⁵

Below we discuss the characteristics of partnership that we are seeing in Australian HJPs and which may be key to the impact of HJPs. However we also note that effective partnership takes time, commitment, energy and resources to build and to sustain. Partnerships will differ from each other, have strengths and weaknesses and may ebb and flow in cohesion and effectiveness over time.

Shared purpose

Shared purpose is an indicator that services are operating in genuine partnership and a factor considered in the literature on partnership as critical to success:

Partners should be aligned around a purpose they all explicitly share. Such alignment will underpin and drive the partnering endeavour forward, create energy and engagement and foster the emergence of collective intelligence. At the same time, partners should be clear and explicit on the

⁵ In their article *To partner or not to partner* Prescott and Stibbe say that intending partners should ask five questions. Paraphrased, these are: 1) is partnering going to create significantly more value than created by the input resources applied apart? 2) Are the partners likely to be able to work together? 3) Are the risks (of all kinds) of engaging in the partnership sufficiently low or can they be reasonably mitigated? 4) Is there sufficient capacity and appetite to collaborate, both within your own organisation and (as far as you can tell) within partner organisations? 5) Are sufficient resources (financial and otherwise) available to support your organisation's participation and allow you to commit fully? <http://www.effectivepartnering.org/blog/partner-not-partner/>

benefit to their own organisations of involvement in the partnering endeavour. (Promoting Effective Partnering, 'Mutual benefits aligned purpose')

The shared goals of the partnership should support each organisation's broader goals. For instance, the goals of legal assistance services often centre around improving access to justice for clients by providing legal assistance; and around increasing the capability of individuals and services to respond to legal problems (e.g. Planigale and Thwaites 2017). The goals of the health agencies generally include a focus on delivering better health outcomes for clients (e.g. cohealth Strategic Plan, 2015-2018).

Generally speaking, the goals of an HJP are likely to recognise the interconnectedness of health and legal issues and aim to integrate their shared expertise to address those issues. Indeed, in the broadest sense, health and legal services are united in their intent to improve the lives of their clients. Partnerships may also have goals relating to sustaining the partnership itself. These are discussed below.

A focus on health-harming legal need and the social determinants of health

HJPs typically have shared goals around impact on the health-harming needs of their clients and communities. In addition to improved outcomes for individuals through direct service provision, an HJP may more broadly aim to:

- support and/or improve service practice and staff expertise (see reciprocal training below)
- influence law and policies that in turn shape the social and environmental factors that may impact disproportionately on the client groups they serve – that is, social determinants of health (see systems change and systemic advocacy).

Shared goals and shared commitment may be outlined in an MOU or other documentation, but more importantly, are reflected in activity, structures and relationships built to reach those goals.

Shared activity

As discussed, a primary activity of HJPs is to provide legal help, which may include help that is coordinated with the health assistance to support clients (e.g. as shared case management). Other indications of partnership around client needs include cross referral, secondary consultations, reciprocal training and shared systemic advocacy.

Cross referral

An indicator of an active relationship between partners is client referral – particularly warm referral – between the host health service and the HJP.⁶ With legal services placed in health settings, we would expect to see formal referral processes from health staff to legal staff. However, the mapping survey indicated that in many services there are also referrals back from the legal staff to health staff. While formal referral processes are indicative of partnership structure, the uptake of these processes, together with the amount of informal referral either way, speaks to the strength of that partnership.

⁶ Warm referral (also known in the US as 'warm hand off') involves contacting another service on the client's behalf and may also involve writing a report or case history on the client for the legal service and/or attending the service with the client. A cold referral, by contrast involves providing the contact details of a legal service to a client, for them to follow up independently.

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. This is a narrower definition than that provided by Curran (2017 p.48) which points to the broader range of services a lawyer may provide a health colleague in a partnership context, including advice on the health worker's ethical obligations or how to give evidence or structure reports for court.

Secondary consultations reflect a high degree of collaboration, indicating trust between the partners, together with a degree of understanding about the framework in which the other partner operates [that is, recognising obligations around mandatory reporting (health services) and confidentiality/privilege (legal services)]. Noting these professional obligations, lawyers may limit secondary consultation to the provision of 'information' about a mutual clients' legal issues rather than 'legal advice', which is provided only directly to a client (see Lewis, 2016).

Secondary consultations are considered to be a feature of health justice partnerships (Gyorki, 2013 p.8) and may be a key point of difference between this and other service models.

Reciprocal/interdisciplinary training

For health and legal services to work together around a common client group, staff will need to know, at a minimum, what types of issues can be referred to the partner and how to make that referral. The type and extent of reciprocal or interdisciplinary training required will reflect the scope of service provision, shared activity and/or partnership involved in each service model.

In an HJP that aims to have impact beyond individual clients, staff may require training to:

- more fully understand the needs and capability of their patients/clients beyond their own expertise
- work effectively in partnership to address those needs through direct service provision
- work effectively in partnership to affect systems change (see Gyorki, 2013 pp. 8-9, National Centre for MLPs, 2015).

Systemic advocacy and systems change

Systemic advocacy is a strategy to elevate impact beyond the health-harming legal needs of individuals, by addressing factors that may affect health and wellbeing more broadly.

Systemic advocacy involves identifying how law, policy or practice is systematically affecting population 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. Systemic advocacy is a core activity of many legal assistance services, including those that partner with health services.⁷ In *The Change Toolkit* the Victorian Federation of CLCs notes:

Many successful law reform efforts are the result of work undertaken by a coalition of organisations. Forming an alliance with others will allow you to scale your efforts and will also allow you to draw on

⁷ See the Victorian Federation of CLCs systemic advocacy too, [The change toolkit](#). See also Warner, B. (2014). Maximising value through strategic advocacy. [UCL International Conference on Access to Justice and Legal Services](#). London, Victoria Legal Aid.

a broader range of skills and resources. It also shows that the issue is something that many feel strongly about. (Vic Federation of CLCs, ch. 2, p. 3)

A key opportunity for HJPs is the amplification of advocacy and its impact through the shared voices of health and legal partners (the partnership) and their clients/communities. This has been articulated clearly in the US MLP model, which informed the evolution of HJPs in Australia:

although direct legal assistance and institutional change can improve the health and well-being of hundreds of individuals and families who are cared for in health settings with MLPs, the true power of the MLP model lies in its potential to influence populations via broad-scale policy change. MLPs strive to enact multilevel policy change by leveraging healthcare and legal expertise to improve local, state and federal laws and regulations that impact the health and well-being of vulnerable populations. (Lawton, Sandel et al. 2011)

The potential to create change at the local level, for instance in the settings in which they operate, is another key opportunity for health justice partnership impact beyond the lives of individual clients. System impacts at this level might include changes to policies or procedures that, having been established to meet a particular professional need, inadvertently causing harm or creating barriers to clients of the HJP. Examples here might include the process for obtaining medical reports as part of an application for social security payments; or reports by allied health professionals to support applications for minor modifications to housing for someone with a mobility impairment.

Partnership structure, resources and contribution

In addition to a shared commitment, intent and activities, partnerships are indicated by structures and resources to support collaborative practice. Well-functioning partnerships demonstrate a genuine commitment of each partner to work collaboratively, with this collaboration supported by active leadership within each partner organisation. The ability of project partners to come together (formally through regular governance committee meetings and informally through project partner interactions) to reflect on and coordinate the partnership and its activities is another enabling feature of effective partnership. At the staff level, the tasks and time required for partnering activity needs to be recognised in relevant position descriptions, beyond direct service provision.

While there is no one-size-fits all approach to working in partnership, the Partnership Brokers Association (PBA) suggest all partnerships should be considered good enough to do what is required; fit for purpose given the context; and they must add value to each partner's respective work (PBA training session attended by HJA personnel).

MOUs

The mapping survey indicated that two-thirds of respondent services had a formal memorandum of understanding (MOU) for their partnership. However the existence of an MOU did not differentiate one service model from another. While there were outreach services, service hubs and HJPs with MOUs, the same service models also reported operating without any MOU.

It may be that the content of the MOU speaks more to the nature of the relationship between services than the fact of the MOU. For instance, an MOU for an outreach clinic may address practical issues such as the provision of the space, services provided and processes such as the host service booking in clients (Forell, McDonald et al. 2013).

Health Justice Australia's [MOU resource kit](#) suggests that an MOU for an HJP should include agreed positions on a range of elements including the shared intent and values of the services; information sharing arrangements; the contribution of each partner; the role of the coordinating officers; governance structure and responsibilities for policies and protocol development; and dispute resolution. The *Building effective health justice partnerships* report highlights the investment of time and resources required to develop the understandings that may be articulated in MOUs.

[It requires] long lead times to implement the process and navigate ongoing large organisational processes (HJA, 2018 Legal partner, hospital setting)

Just as an MOU does not necessarily signify an HJP, the lack of an MOU does not imply a service is not an HJP. Partnership practitioners have suggested that the spirit or culture of a partnership is determined far more by the ongoing and evolving relationship between those partners than by the way it is documented (ref- MOU Resource kit). That noted, a document that outlines how the partners aim to work together to achieve their shared goal is noted as a useful tool for well-functioning partnerships.

Resourcing/mutual contribution

Another factor critical to effective and sustained partnership is shared commitment and contribution. Contributions may be financial, professional skills or knowledge based, relational – with other professional networks or with clients, educational, infrastructure based, or some other in-kind support. While the contributions made may not be the same from each partner, one indicator offered in the literature on effective partnering is that 'partners are satisfied with the quality and quantity of the contributions of the other partners'.⁸ The NCMLP's report, *The State of the Medical-Legal Partnership Field*, notes that, in the US context '...legal organisations are more likely than healthcare organisations to report a budget for MLP activities', a situation that appears to be mirrored in Australia. However, they note 'one of the funding streams that demonstrates commitment to MLP as a critical part of healthcare operations is the operating budget' (Regenstein et al, 2016, p.19).

Other factors relevant to health justice partnerships

The features identified above are not exhaustive, and there will be others, particularly as the health justice partnership movement learns and evolves. These may include:

- legal triage practices, including the use of screening tools by services to identify legal need
- community legal education for clients or patients
- community/client engagement and leadership
- data collection and/or data sharing between partners.

⁸ See: <http://www.effectivepartnering.org/factor/collaboration-communication/mutual-engagement/>

Conclusion

Health justice partnership is a service model developed to address the compounding impact of intersecting legal and health issues on people and communities. This paper has explored the features that takes HJPs beyond standard services to address those complex needs. To add further definition, we have also considered how HJPs differ from other service models on the health justice landscape.

The purpose of identifying specific features of HJPs is to help us better link the resources we invest and the activities and strategies we implement to the outcomes we hope to achieve. This is the foundation for testing how well different models may improve outcomes for people vulnerable to health-harming legal need and impact on the social determinants of health more broadly; and at what cost.

Broadly speaking we have defined HJPs as partnerships to embed legal help in healthcare services and teams. The critical features of this definition are 'embedded legal help', 'healthcare services and teams' and 'partnership'. HJPs have elements of each of these. However, HJPs will come together in various ways, between different types of organisations, to provide legal assistance in a variety of settings. The clients they assist will also vary. The need is not for all HJPs to be the same, but for each to be clear about what they are, who they serve, what they seek to achieve and how they intend to do it. The features outlined here may help reach that clarity.

For some services on the health justice landscape, the features we have outlined will be reflected in their existing service. Others may be working towards those features. For others again, health justice partnerships may contrast to a model of service they are operating already or that they aspire to. The choice of model should be determined by the needs of clients served, the intent of the service and/or partners and the resources and commitment available to develop the service model. As evidence becomes available, decisions should also be influenced by the relative cost and impact of each service model in each context.

This paper is intended to provide a starting point for discussion, as we move towards a shared understanding with practitioners, researchers, policy-makers and funders of what makes a health justice partnership. It is a definition framed around the need health justice partnership aims to address and the value it intends to bring, based on current available evidence. It is a model which will evolve in response to further evidence arising. By articulating the model we hope to facilitate that shared learning.

Appendix 1: Summary of HJP features

An HJP is a partnership to embed legal help into healthcare teams and services. While the types of services that identify as an HJP will vary considerably, Table A1 describes common features across a range of domains (as discussed in the paper).

Based on the evidence presented, we propose that HJPs have features listed below, with the purple italicised features indicating more established/resourced practice.

Table A1: Features of HJPs by domain

DOMAIN	FEATURES OF HJPS (<i>features of more established practice in italics</i>)
Aim/target clients	
Target clients	<ul style="list-style-type: none"> While HJPs often target specific client groups, the HJP model is designed to assist clients/patients with unmet legal need and who face particular barriers to seeking (timely) legal help directly from legal services
Rationale for HJP	<ul style="list-style-type: none"> To improve legal and/or health outcomes for the target clients To reduce the health-harming impact of legal problems on target clients and communities <i>To support/improve/ change service systems (including professional knowledge and practice)</i> <i>To address the social determinants of health</i>
Health	
Service setting	<ul style="list-style-type: none"> Health settings and/or
Partner types	<ul style="list-style-type: none"> Health services partnered with legal services (see partnering, below) and/or
Practitioners	<ul style="list-style-type: none"> Health professionals partnered with legal practitioners
Legal	
Legal issues addressed	<ul style="list-style-type: none"> Capacity to assist and/or triage the range of issues (criminal, civil, family) that face the target client group May focus on legal issues relevant to presenting health issues
Legal assistance provided	<ul style="list-style-type: none"> Appropriate to the needs and capability of the target client group. Generally, the capacity to provide assistance, beyond a single advice session. <i>Capacity to carry a file (provide representation)</i>
Shared case management/lawyer on healthcare team	<ul style="list-style-type: none"> Coordination of support for client by partner services (informal or formal). Scope for more structured shared case management where required <i>The lawyer is considered part of the healthcare team.</i>
Specialist skills (lawyers)	<ul style="list-style-type: none"> To assist with the legal issues identified To work appropriately and effectively with the client group To work effectively with health professionals to support clients To work with the health organisation to sustain the partnership
Partnership activity	
Secondary consultation	<ul style="list-style-type: none"> Lawyers provide secondary consultations <i>Health staff provide secondary consultations</i>
Systemic advocacy	<ul style="list-style-type: none"> Undertaken by one/both partner organisations <i>Undertaken by both partners together as the HJP</i>
Reciprocal/ Interdisciplinary training	<ul style="list-style-type: none"> Training provided, at least initially, for health staff e.g., on role and parameters of legal assistance and how to refer clients. Training for legal staff by health service e.g., on how health service operates and health issues facing client groups <i>Ongoing program of reciprocal/interdisciplinary training (formal and informal)</i>
Referral	<ul style="list-style-type: none"> HJP takes referrals for legal help from health service (and potentially others)

	<ul style="list-style-type: none"> • Health service takes referrals from the HJP lawyers
Partnership structure	
Shared goals	<ul style="list-style-type: none"> • The HJP has shared goals, which have been discussed and are understood by the partners • <i>The HJP has shared goals, which are documented and communicated, with regular monitoring and review processes in place</i>
Structures for mutual engagement	<ul style="list-style-type: none"> • Processes and structures are established collaboratively to support ongoing interactions between partners, including collaborative management of the HJP. (Examples include shared goals, shared activities and mutual support, formal documentation and ongoing formal and informal communication.)
Resourcing/contribution	<ul style="list-style-type: none"> • Some contribution from each partner (which may include staffing, infrastructure, resources, training, professional knowledge or skills, client or partner relationships etc) • <i>Each partner's contribution to the HJP is clearly documented (formally or informally) and is considered appropriate.</i>

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