ATTACHMENT LG-2

This is the attachment marked "**LG-2**" referred to in the witness statement of Linda Sophie Gyorki dated 10 August 2015.

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Breaking down the silos:

Overcoming the Practical and Ethical Barriers of Integrating Legal Assistance into a Healthcare Setting

Report by Linda Gyorki

2013 Churchill Fellow

2013 CHURCHILL FELLOW

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Linda Gyorki

25 September 2014

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Thank you to Khoi Cao-Lam, the former Executive Officer of Inner Melbourne Community Legal (**IMCL**) for encouraging me to pursue the Churchill Fellowship and to expand IMCL's work in Advocacy-Health Alliances. Thank you also to Dr Nicole Bieske, the CEO of IMCL for her commitment to this work and for supporting me with this project as well as the Committee of Management of IMCL for encouraging me in this endeavour. A big thanks to the entire team at IMCL not only for their support but also for kindly increasing their workloads whilst I was on my Fellowship. For this, I thank Melanie Dye, Tanja Golding, Gabrielle McManus, Zoe Jones, Tenielle Hagland and Sarah Daniell. I am also grateful to Emily Clark (former Principal Lawyer) and Molly Williams. I am grateful to be able to work in an office with a dedicated and passionate team who work tirelessly to achieve positive outcomes for clients.

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Thank you to my parents, family and friends for their support and encouragement throughout the Fellowship.

Finally, thank you to my husband for his patience, support and guidance and for being a wonderful sounding board.

Executive Summary

There is a growing body of research to suggest that the health of individuals can suffer when they face legal problems. Further, Australian research has shown that individuals often seek legal advice from non-legal sources and frequently from health professionals. Accordingly, integrating legal services into a health-care setting not only provides a direct referral pathway for health professionals who treat patients with legal needs to refer patients to on-site legal services; it might also serve to bolster patients' attainment of better health outcomes.

However, there are practical and ethical barriers to integrating legal assistance into a health-care setting and to including lawyers on the "care team". Drawing on insights gained from several site visits to legal services that are engaging in multi-disciplinary work in the United States of America (**USA**), United Kingdom (**UK**) and Canada, this report aims to provide practical guidance to overcome these barriers. It is also intended to serve as a catalogue of examples of multi-disciplinary practice to be drawn upon by practitioners who aim to institute partnerships between health and legal service providers, or to integrate legal services in a multi-disciplinary setting.

This report considers a range of practical barriers which may arise during the implementation of this model of service delivery, including: building the capacity of health professionals to understand and identify the legal needs of patients; developing a direct referral pathway to an on-site legal service; engaging students and pro bono lawyers in the provision of services and addressing systemic legal issues that may arise.

Whilst provided in a unique setting, the legal services must still comply with the ethical obligations of the legal profession. This report also considers the ethical barriers that may arise through the integration of legal services in a health-care setting. In particular, the report considers how to ensure that health-care professionals understand the work of the legal service whilst still protecting the confidentiality of clients; safeguarding the security of legal documents as well as some of the issues surrounding the provision of secondary consultations.

Further, as the writer manages an Advocacy-Health Alliance between Inner Melbourne Community Legal and the Royal Women's Hospital aimed at addressing family violence, this report also considers the broader impact that integrated legal services can have on women.

With growing enthusiasm in Australia for the provision of unique models of legal service delivery, and for the approach of integrating legal assistance into health-care settings in particular, it is hoped that this report will act as a catalyst for the establishment of partnerships between legal services and health-care institutions in increasingly diverse contexts.

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Recommendations

The Churchill Fellowship highlighted several unique and innovative tools developed by organisations across several countries to integrate legal assistance into a health-care setting or to engage in multi-disciplinary practice. This report makes several recommendations which may assist in moving 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.

1. **Legal Needs Assessments.** Conduct a legal needs assessment prior to developing a partnership in order to ensure that the legal services proposed will meet the needs of the patient population. In order to meet patients' needs, lawyers may need to engage pro bono services or build their capacity in other areas of law.

2. **Become part of the care team.** Distinguish the legal service from an outreach clinic by incorporating it as part of the care team with a view to ensuring that lawyers become a sustainable part of the care team. This report provides some guidance on how this step can be taken.

3. **Nurture the Partnership.** Commit time to building and nurturing the partnership between the legal service and the health-care provider in order to bolster the sustainability of the model. This may include ensuring clear reporting guidelines and transparency about the partnership between the two organisations.

4. **Encourage the use of a legal screening tool.** There are several legal screening tools in existence. Encourage the use of legal screening tools amongst frontline health and social work professionals to enable them to better identify legal needs amongst the patient population and to refer accordingly.

5. **Secondary consultations.** Ensure that the legal service is available to provide legal information to health professionals and social welfare professionals that they can pass on to their patients. The benefits of providing this service include: building capacity amongst health professionals to identify and respond to legal needs and assisting health professionals to understand when a referral to a lawyer may be necessary.

6. **Reciprocal training.** Clear role delineation is critical to the success of this model. Training may be required to understand the different roles in the health-care setting. Further, one of the benefits of working in a multi-disciplinary setting is the opportunity to share expertise. Examples of areas in which lawyers can provide training to health and social welfare professionals include identifying legal needs and basic information that can be provided to patients who are experiencing legal needs. Examples of areas in which lawyers may benefit from training from their health and social welfare counterparts

include providing therapeutic practice, safety planning and understanding the health impacts of legal needs.

7. **Community legal education for patients.** On-site legal services do not need to be limited to the provision of legal advice. Patients may receive education sessions on a range of health and social issues in the hospital setting and integrated legal services provide an opportunity to deliver community legal education sessions to patients. For issues that commonly arise, consider running form-filling workshops on-site. Law students may be able to assist in the preparation and presentation of these sessions. Pro bono assistance may be sought from private lawyers to provide education sessions in specialised and technical areas of law, such as taxation law, for example.

8. **Feedback loop.** Ensure that the others in the care team understand the work of the legal service. Routinely seek informed consent from a client in order to provide feedback about their matter to the referring source, if it is in the client's best interests to do so. Seek consent from clients to provide de-identified case studies to the health-care team. Publicise and celebrate milestones such as successful case outcomes, the provision of advice to 100 clients on-site, the provision of assistance by 50 pro bono lawyers, etc.

9. **Telephone advice.** Consider complementing the on-site legal service with telephone advice to patients of the health-care provider in order to reach as many people as possible. Telephone advice may be more suitable for patients in an outpatient setting.

10. **Provide as broad and generalist legal services as possible to meet the needs of clients.** Wraparound care and avoiding the referral roundabout becomes easier if the on-site legal service is able to provide assistance in a broad range of areas of law.

11. **Engage law students and medical students.** Law students and medical students can be engaged at an early stage in their training to ensure that they have an understanding of the way in which legal assistance fits within the social model of health. Under supervision, students can be engaged in a number of ways including: conducting legal needs assessments, developing legal screening tools, taking instructions from patients/clients, developing and delivering community legal education sessions on-site, etc.

12. **Visibility.** Ensure that the legal service is present as part of the health-care team. This can be done by attending unit meetings, participating and presenting at grand rounds, presenting at professional development days, developing newsletters, engaging in social media, etc.

13. **Engage pro bono lawyers.** Engage pro bono lawyers to provide ongoing casework assistance and court representation for patients who the on-site lawyer cannot assist.

Consider engaging consultants who are specialists in the five key areas of law that arise in the health-care setting so that they can provide technical advice and assistance to pro bono lawyers.

14. **Evaluate the work.** There are several areas of this model of service delivery that require evaluation in Australia, including a longitudinal study to evaluate the health impacts of legal intervention, and evaluating the social and financial return on investment of integrating legal services into health-care settings.

Programme

Date	Location	Meeting
10-11 April 2014	Seattle, Washington, USA	• 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform.
14 April 2014	Durham, North Carolina, USA	• Madlyn Morreale, Supervising Attorney, MLP Program, Legal Aid of North Carolina • Meghan Melo, Attorney, Legal Aid of North Carolina • Sherry Everett, Attorney, Legal Aid of North Carolina • Professor Jane Wettach, Clinical Professor of Law and Director, Children's Law Clinic, Duke Law School
16 – 17 April 2014	Boston, Massachusetts, USA	• Associate Professor Megan Sandel, Associate Profesor of Paediatrics at Boston University School of Medicine and Medical Director of the National Center for Medical Legal Partnerships • Samantha Morton, Executive Director, MLP | Boston • JoHanna Flacks, Legal Director, MLP | Boston • Elizabeth Brusie, Staff Attorney, MLP | Boston • Deborah Durant, Staff Attorney, MLP | Boston • 7th Annual MLP | Boston pro bono breakfast
22-23 April 2014	Belleville, Ontario, Canada	• Site-visit of court house in Belleville • Deirdre McDade, Acting Executive Director, Community Advocacy & Legal Centre (**CALC**) • Gina Cockburn, Staff Lawyer, CALC • Sharon Powell, Community legal worker, CALC • Ruth James, Family Court Support Worker • Teresa Gauthier, Nurse Clinician for the Domestic Violence Sexual Assault Response Program
24 April 2014	Ottawa, Ontario, Canada	• Louise Toone, Executive Director, University of Ottawa Community Legal Clinic • Anna Colombo, Staff Lawyer, University of Ottawa Community Legal Clinic • Nathalie Champagne, District Area Director of Legal Aid Ontario for Eastern Ontario • Anne Scholberg, Director of Integrated Legal Services Office of Legal Aid Ontario

		• Jacques Chartrand, Lawyer-Director of West End Legal Services **(WELS)** • Laurie Joe, Staff Lawyer, WELS • Natalie Drolet, Lawyer, Connecting Ottawa
25 April – 2 May 2014	Toronto, Ontario, Canada	• Lee Ann Chapman, Lawyer, Pro Bono Law Ontario (**PBLO**) at SickKids • Dr Randi Zlotnik Shaul, Director of Bioethics, SickKids • Hannah Lee, Triage Lawyer, Holland Bloorview Rehabilitation Hospital • Yedida Zalik, Community Outreach Coordinator at ARCH Disability Law Centre • Dr Nav Persaud, Family Physician, St Michael's Hospital • Vinay Jain, Director of Legal Services, Unison Health & Community Services • Aissa Nauthoo, Legal Director, Centre Francophone de Toronto • Dr Robin Mason, Scientist at Women's College Research Institute and Assistant Professor of the Dalla Lana School of Public Health and the Department of Psychiatry, University of Toronto • Lynda Kosowan, Executive Director, Scarborough Women's Centre • Sheila MacDonald, Provincial Coordinator, Ontario Network of Sexual Assault and Domestic Violence Services • Susan Young, Executive Director, Ontario Association of Interval and Transition Houses • Amanda Dale, Executive Director, Barbra Schlifer Commemorative Clinic (**BSCC**) • Mary Lou Fassel, Legal Director, BSCC • Lynne Jenkins, Director of Counselling, BSCC • Deborah Sinclair, Social Worker, Consultant, Trainer and member of the Domestic Violence Death Review Committee • Tess Sheldon, PhD Candidate • Irene Gabinet, Transitional Housing and Support Program Coordinator, Woman Abuse Council of Toronto • Amy Wah, Staff Lawyer, HIV & AIDS Legal Clinic Ontario
6, 13, 14 May 2014	London, United Kingdom	• Julie Bishop, Executive Officer, Law Centres Network • Alan Clark, Manager, Springfield Advice & Law Centre • Janet Ragnaut, Housing Barrister, Springfield Advice & Law Centre • Mel Gonga, Senior Solicitor, Springfield Advice & Law Centre

		• Sharon Elliott, Solicitor and Deputy Head of Early Action, Community Links • Alicia Smith, Program Coordinator, Together for Families, LawWorks • Maddie Blackburn, PhD Candidate • Matthew Smerdon, Chief Executive, Legal Education Foundation • David Sampson, Deputy Director, Baring Foundation • James Kenrick, Advice Services Development Manager, Youth Access • Zoe Palmer, Manager and Senior Policy Officer, Women's Health and Equality Consortium • Emma Scott, Director, Rights of Women • Clare Laxton, Public Policy Manager, Women's Aid Federation • Ros Bragg, Director, Maternity Action
7 May 2014	Coventry, United Kingdom	• Elayne Hill, Solicitor, Coventry Law Centre
8-9 May 2014	Norwich, United Kingdom	• Gareth Thomas, Director, Clinical Legal Education, University of East Anglia Law School • Judi Lincoln, Advice and Volunteer Manager, Norfolk Community Law Service • Mandy Proctor, CEO, Leeway Domestic Violence and Abuse Services • Margaret Hill, Community Services Manager, Leeway Domestic Violence and Abuse Services
12 May 2014	Nottingham, United Kingdom	• Cheryl Weston, Manager, Nottingham Law Centre

Acronyms

AHA	Advocacy-Health Alliance (Australia)
BSCC	Barbra Schlifer Commemorative Clinic (Canada)
CABx	Citizens Advice Bureaux (United Kingdom)
CALC	Community Advocacy & Legal Centre (Canada)
CLC	Community Legal Centre (Australia)
DVDRC	The Domestic Violence Death Review Committee (Canada)
IMCL	Inner Melbourne Community Legal (Australia)
LANC	Legal Aid of North Carolina (USA)
LAO	Legal Aid Ontario (Canada)
LAW Survey	The Legal-Australia Wide Survey conducted in 2012
MLP	Medical-Legal Partnership
NHS	National Health Service (United Kingdom)
NLC	Nottingham Law Centre (United Kingdom)
PBLO at SickKids	Pro Bono Law Ontario at the Hospital for Sick Children (Canada)
The Women's	The Royal Women's Hospital (Australia)
QCCAV	Quinte Coordinating Committee Against Violence (Canada)
UEA	University of East Anglia (United Kingdom)
UK	United Kingdom
USA	United States of America
VSRFVD	The Victorian Systemic Review of Family Violence Deaths (Australia)
WELS	West End Legal Services (Canada)

INTRODUCTION

This report is based on two premises. Firstly, legal needs ought to be considered as one of the social determinants of individuals' health and wellbeing. Secondly, individuals often seek legal advice from non-legal sources and frequently from health professionals.[1] Accordingly, the provision of a direct referral pathway from health professionals to an on-site legal service has the capacity to improve health outcomes for disenfranchised individuals. However, shifting from the traditional model of providing legal services in a lawyer's office (or even on an outreach basis) towards integrating legal services within the health-care setting, which sees lawyers as part of the health-care team raises several practical and ethical barriers. Observing Medical-Legal Partnerships and other examples of multi-disciplinary practice in Canada, the USA and the UK has provided the writer with an opportunity to learn from examples abroad and to see how a shift towards a holistic model of service delivery which aims to provide wraparound care to clients might be achieved.

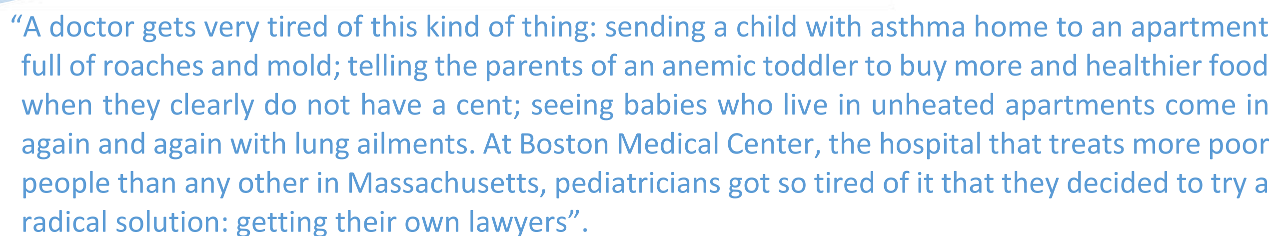
The impetus for undertaking the Fellowship was based on the writer's work in Victoria, Australia in managing an Advocacy-Health Alliance (**AHA**)[2] called "Acting on the Warning Signs", a partnership between Inner Melbourne Community Legal (**IMCL**) and the Royal Women's Hospital **(the Women's**). The focus of this report is to highlight methods to overcome the practical and ethical barriers inherent in integrating legal assistance into a health-care setting. Whilst there are some successful examples of Advocacy-Health Alliances in Australia, the model is relatively new in Australia. The Fellowship provided an opportunity to see how these barriers have been overcome abroad. In order to explore the practice of integrated service delivery, during the Fellowship, the writer visited several multi-disciplinary sites in health and other settings to observe unique models of legal service delivery. Whilst the focus of this report is to consider the integration of legal services into a health-care setting, important lessons have been learned from those engaging in multi-disciplinary practice. Accordingly, the report draws on and profiles the experiences and work of several organisations engaging in multi-disciplinary practice abroad.

Further, the legal service provided on-site at the Women's by IMCL is a generalist legal service and lawyers provide advice and casework assistance to clients for a range of legal issues, including family law, criminal law and civil law. However, the focus of the Acting on the Warning Signs project is to build the capacity of front-line health professionals to identify and respond to family violence and to refer patients to a range of on-site services (including the on-site legal service) with a view to providing a safe environment for women to access advice about their rights and entitlements. Accordingly, during the Fellowship, the writer visited several sites which are addressing violence against women in a multi-disciplinary way to glean insights in to this model of service delivery.

[1] Christine Coumarelos et al "Legal Australia-Wide Survey: Legal need in Australia" (Report, Law and Justice Foundation of New South Wales, August 2012) xvi-xvii.

[2] The terminology that is used in the USA for the integration of legal assistance into health-care settings is Medical-Legal Partnerships (**MLPs)**; whereas the Australian term for this model of service delivery is Advocacy-Health Alliances (**AHAs)**. Both terms will be used in this report depending on the jurisdiction discussed.

There are clear limits to this report. It is not intended to be a comprehensive analysis of AHAs, Medical-Legal Partnerships (**MLPs**) or multi-disciplinary practice. Rather, in drawing on examples from abroad as well as other resources; it is intended as a tool to provide practical guidance to integrate legal services in to a health-care setting and to provide a catalogue of examples to serve as inspiration for practitioners who aim to develop similar models of service delivery. Several other resources exist to guide the establishment of an MLP or an AHA.[3] As this model of integrated service delivery increases in popularity in Australia, it is hoped that this report can assist organisations to draw on the experiences of others in developing these partnerships.

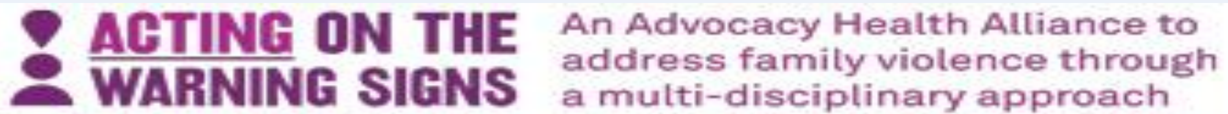


"A doctor gets very tired of this kind of thing: sending a child with asthma home to an apartment full of roaches and mold; telling the parents of an anemic toddler to buy more and healthier food when they clearly do not have a cent; seeing babies who live in unheated apartments come in again and again with lung ailments. At Boston Medical Center, the hospital that treats more poor people than any other in Massachusetts, pediatricians got so tired of it that they decided to try a radical solution: getting their own lawyers".

Goldberg, C, *New York Times,* 16 May, 2001.

[3] For information about the establishment of an MLP, see the website of the National Center for Medical-Legal Partnership based in the USA, The Medical-Legal Partnership Toolkit Phases I and II, *http://medical-legalpartnership.org/new-medical-legal-partnership-toolkit-available-free-download/*; Elizabeth Tobin Tyler et al (eds.), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011) and *The Journal of Legal Medicine* (2014) 35(1). A comprehensive literature review can be found on the website of the National Center for Medical-Legal Partnership at http://medical-legalpartnership.org/medical-legal-partnership-literature-review/. In an Australian context, see Peter Noble, 'Advocacy-Health Alliances – Better Health Through Medical-Legal Partnership', (Final Report, Clayton Utz Foundation Fellowship, August 2012) <http://lcclc.org.au/programs/advocacy-health-alliance/>.

CASE STUDY: ACTING ON THE WARNING SIGNS



Acting on the Warning Signs is an Advocacy-Health Alliance between the Royal Women's Hospital (**the Women's**) and Inner Melbourne Community Legal (**IMCL**) which aims to address family violence through a multi-disciplinary approach.

In 2009, IMCL commenced providing an ad-hoc legal service on-site at the Women's. In 2012, funding was received from the Legal Services Board Major Grants Programme to develop a more robust project which included a weekly on-site legal service, complemented by training of front-line health professionals to identify and respond appropriately to family violence. In 2013, further funding was received from the Legal Services Board Major Grants Programme to continue this work. As a result, the on-site presence of a lawyer has increased to three times each week and the provision of training to health professionals has continued. Since August 2012, over 130 instances of legal advice have been provided to patients on-site at the Women's.

Family violence was chosen as the focal topic for the Acting on the Warning Signs project because of its prevalence in Australia. In 2012, in Australia approximately 17% of women over the age of 18 had experienced violence by a partner since the age of 15.[4] Further, whilst often considered a social issue, a study by VicHealth has recognised that intimate partner violence has detrimental impacts on the health of Victorian women. The study shows that intimate partner violence is "the leading preventable contributor to death, disability and illness in Victorian women aged 15-44, being responsible for more of the disease burden than many well-known risk factors such as high blood pressure, smoking and obesity."[5]

The Women's is a large maternity hospital and pregnancy is a high-risk time for women experiencing or at risk of violence. Across many developed countries, between 4-9% of women are abused during their pregnancy and/or after the birth.[6] Accordingly, the provision of on-site legal services at the Women's provides patients with the opportunity to access information about their rights and entitlements in a safe environment. Based on studies in the USA which have found that the increased provision of legal services was one of three key factors

[4] Australian Bureau of Statistics, Personal Safety Survey – 4906.0 (Australian Bureau of Statistics), 2012.
[5] VicHealth, *The Health Costs of Violence: Measuring the Burden of Disease Caused by Intimate Partner Violence* (Victorian Health Promotion Foundation Revised ed. 2010) 10.
[6] Angela Taft, "Violence Against Women in Pregnancy and After Childbirth: Current Knowledge and Issues in Health Care Responses" (2002) Issues Paper 6 A*ustralian Domestic & Family Violence Clearinghouse* 17.

contributing to the decline of violence against women by their intimate partners; the Project aims to empower women through the provision of legal assistance.[7]

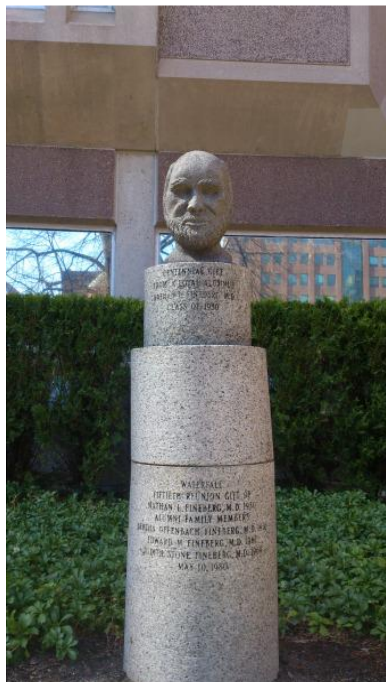
The training component of the Project recognises research which shows that disclosures of violence are often made to health professionals. Indeed, interviews with survivors of partner abuse have shown that health professionals are the major group to whom women want to disclose violence.[8] Accordingly, since December 2012, over 130 health professionals have received training at the Women's with the view to staff identifying signs of family violence, responding sensitively and providing appropriate referrals to women both on and off-site.

An external evaluation of the Project conducted by the University of Melbourne has found that "training significantly improved health professional's self-reported knowledge of family violence and the common presenting symptoms of family violence. There was also a significant improvement in their self-reported confidence in having sufficient knowledge and skills to respond to women experiencing family violence and to refer".[9] Further, the evaluation has found that "the co-location of a regular and consistent legal practitioner within social work appears to be the mechanism that led to increased awareness and accessibility for social workers to refer women to this service"[10] and that "seven of the eight women [who attended the IMCL outreach and were surveyed] believed that receiving legal advice had a positive impact upon their psychological and emotional health immediately during or after the consultation".[11]

[7] Amy Farmer & Jill Tiefenthaler, "Explaining the Recent Decline in Domestic Violence" (2003) 21(2) *Contemporary Economic Policy,* 158.
[8] Gwenneth Roberts, Kelsey Hegarty and Gene Feder (eds.), *Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence* (Churchill Livingstone Elsevier, 2006) 81.
[9] Kelsey Hegarty, Cathy Humphreys, Kirsty Forsdike, Kristin Diemer, Stuart Ross, "Acting on the Warning Signs Evaluation: Final Report" (University of Melbourne, August 2014), 2.
[10] Ibid 6.
[11] Ibid 64.

Chapter 1

Climbing the ladder: addressing legal needs as a component of health and wellbeing



This report is based on the premise that legal needs ought to be considered as one of the social determinants of individuals' health and wellbeing. Social determinants of health have been defined as "the set of conditions in which people are born, live, learn, work, play and age that affect their physical and mental well-being."[12] These determinants recognise that "the longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age."[13] Further, it is widely recognised that these determinants impact those of lower socio-economic status and that "people further down the social ladder usually run at least twice the risk of serious illness and premature death as those near the top" [14]. Indeed, in the USA, "the risk of dying before the age of 65 … is more than twice as likely for middle-income Americans as for those at the top of the income ladder [and] more than three times greater for those at the bottom than for those at the top".[15]

It is widely recognised that the foundations of health, as impacted upon by social determinants, are established in utero and during childhood. Adler and Stewart state:

> "[T]he ease or difficulty of practicing healthy behaviours is powerfully affected by our place on the ladder. Environments mold health habits. At each stage of life, from birth onward, the conditions we live in – the physical and social environments we encounter – constrain or expand the options available to us for improving our health and avoiding disease. Each step down the ladder provides fewer tools to help the individual engage in health-protecting behaviours….the rung we're on affects our health, and in turn our health affects our ability to reach higher rungs."[16]

In this light, the importance of providing wraparound care to people through a multi-disciplinary response that recognises the social determinants of health becomes apparent. So far as legal issues impact upon individuals' capacity to achieve or maintain health outcomes, legal services should form a component of this multi-disciplinary response. Accordingly, it is critical that we consider how lawyers and legal intervention can assist individuals to overcome those barriers to health and wellbeing which may be avoidable. More holistic models of care have the capacity to assist on an individual, organisational and broader policy level to address the impacts of legal issues. The following discussion further explores how legal needs may influence the health of individuals.

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[12] Daniel Atkins, Shannon Mace Heller, Elena DeBartolo and Megan Sandel "Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy" (2014) 35(1) *The Journal of Legal Medicine* 195, 196.

[13] Richard Wilkinson and Michael Marmot (eds) "Social Determinants of Health: The Solid Facts" (World Health Organisation Europe, 2nd ed, 2003) 10.

[14] Ibid.

[15] *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of* Health, World Health Organisation. 1 (2008), http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf in Atkins et al, above n12, 197.

[16] Nancy Adler et al., *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the US,* John D. and Catherine T McArthur Found. Res. Network on Socioeconomic Status and Health 1, 4 (2007), http://www.macses.ucsf.edu/downloads/Reaching_for_a_Healthier_life.pdf in Atkins et al above n12, 197.

1.1 ADVICE SEEKING BEHAVIOUR, LEGAL NEEDS AS A SOCIAL DETERMINANT OF HEALTH AND THE ARGUMENT FOR VIEWING LEGAL ASSISTANCE WITHIN THE SOCIAL MODEL OF HEALTH

> "Law is one of the most important social determinants of health. It helps establish the framework in which individuals and populations live, face disease and injury, and eventually die. By so doing, law influences myriad other social determinants, including education, income, housing, racial and ethnic disparities, nutrition and access to health care. In short, law is one factor that helps determine other social determinants".[17]

Law as a social determinant of health has been recognised in the Australian context with the findings of the Legal-Australia Wide (**LAW**) Survey conducted in 2012 which shows that legal problems often have negative impacts on many life circumstances including health, financial and social circumstances.[18] The LAW Survey found that in 19% of cases, legal problems caused physical ill health and that in 20% of cases, legal problems caused stress-related illness.[19] Further, the LAW Survey found that disadvantaged individuals "are particularly vulnerable to legal problems, including substantial and multiple legal problems".[20] Common problems faced by individuals in our society, including those concerning housing, relationships and employment are "frequently 'nested in legal rights and obligations'… the law thus provides a framework for the resolution of a broad range of problems central to individual and society welfare".[21]

There has been research in the USA about the way in which legal needs can impact on health. Lawton and Sandel provide a definition of legal needs as "an adverse social condition with a legal remedy – that is, an unmet basic need such as housing, food, or healthcare – that can be satisfied via the application of laws, regulations, and policies. Unmet legal needs, which can lead to poor health outcomes, are critical social determinants of health."[22] A national MLP survey was conducted by the National Center for Medical-Legal Partnerships in the USA in 2008 to determine the broad areas of social determinants that influence health. The five broad areas were labelled I-HELP and included: **I**ncome supports; **H**ousing and Utilities; **E**ducation and job training; **L**egal status/Immigration; and **P**ersonal and Family stability and safety.[23]

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[17] Wendy Parmet, Lauren Smith & Meredith Benedict, "Social Determinants, Health Disparities and the Role of Law" in Elizabeth Tobin Tyler et al (eds), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 21.
[18] Coumarelos et al, above n1.
[19] Ibid, xvi.
[20] Ibid, xiv.
[21] Christine Coumarelos, Pascoe Pleasence and Zhigang Wei, "Law and Disorders: Illness/Disability and the Experience of Everyday Problems Involving the Law" (Justice Issues Paper 17, Law and Justice Foundation of New South Wales, 2013).
[22] Ellen Lawton & Megan Sandel 'Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare through Medical-Legal Partnership', (2014) 35(1), *The Journal of Legal Medicine,* 29, 31-32.
[23] Elizabeth Tobin Tyler et al (eds.), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 73.

Lawton et al provide several examples of the ways in which social conditions which may be remedied by legal intervention can influence health, stating that "suboptimal urban housing conditions with high levels of mold, dust mites, and cockroach antigen have well-established links to poorer health outcomes in children with asthma. Substandard housing and homelessness also have been linked to higher rates of diarrheal illness, ear infections and lead poisoning. A troubling and widespread 'heat-or-eat' phenomenon, in which low-income children who live in cold climates experience impaired growth in the winter because family finances are diverted to heat the home, has been documented".[24] There was also a study conducted at St Luke's Roosevelt Hospital in 2006 which focused on asthma patients and in which LegalHealth researchers determined that those patients suffering from asthma who received legal interventions had "significant improvements in the severity of their condition, and fewer emergency room visits, than patients who did not receive legal assistance".[25] In 2007, LegalHealth conducted a survey focusing on cancer patients in which 83% of fifty-one clients who had cancer reported that legal assistance caused a "significant reduction in stress and 51 percent reported an improvement in their financial situation".[26]

The Robert Wood Johnson Foundation in the USA surveyed one-thousand physicians across the USA and found that "85% of physicians believe that 'unmet social needs are directly leading to worse health'…85% of physicians….believe patients' social needs are as important to address as their medical conditions …[and]…80% of physicians 'are not confident in their capacity to address their patients' social needs".[27] Accordingly, there is research to indicate that legal needs can impact on individuals' health and, by extension, legal needs ought to be recognised as social determinants of health.

Further, there is also research to show that health professionals are often consulted for legal issues. The LAW Survey found that individuals seek legal assistance from non-legal advisers in approximately 69.7% of cases and that in 27.2% of cases, respondents sought to resolve their legal issue by consulting health or welfare advisers.[28] Disadvantaged individuals are more likely to struggle with the problems they face and are less likely to take action in response to problems, thereby achieving poor outcomes.[29] Further, people often seek assistance from services with which they are already in contact and rarely from more than one source for each legal issue.[30] Accordingly, recognising that legal needs are a social determinant of health and that individuals frequently turn to health and welfare advisers for legal assistance; the natural extension is to

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[24] Ellen Lawton, et al, 'Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations' in Elizabeth Tobin Tyler et al (eds), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 81.
[25] R Retkin et al., "Medical-Legal Partnerships: A Key Strategy for Mitigating the Negative Health Impacts of the Recession", *Health* Law, 22 (2009): 31 in Parmet, Smith & Benedict above n.17, 26.
[26] Parmet, Smith & Benedict above n.17, 26.
[27] Atkins et al, above n12, 199.
[28] Coumarelos et al, above n1, 135.
[29] Ibid.
[30] Mary Anne Noone, "Towards an Integrated Service Response to the Link between Legal and Health Issues" (2009) 15 *Australian Journal of Primary Health*, 203.

respond to this research and to integrate legal service delivery into a health-care setting. This enables individuals to have a clear referral pathway for legal assistance in a health-care setting

Indeed, the Victorian legal needs survey notes that many individuals experience several connected legal and non-legal problems, and that to improve access to justice, a holistic and integrated approach is required.[31] The Victorian survey highlights that "a holistic approach to justice requires overcoming the fragmentation across legal and non-legal services…"[32]

> *"The world is full of examples in which health and law collide. A quick look at a local newspaper reveals some of the many connections between the health and legal sectors that permeate families and communities – the disabled veteran who needs a wheelchair ramp to get into his apartment building, the elderly woman who can no longer make healthcare decisions for herself, and the child exposed to environmental hazards in his community".*
>
> *Lawton, et al "Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership"* (2014) 35(1) *The Journal of Legal Medicine.*

Integrating legal services into a health-care setting provides greater opportunity for individuals to understand where legal advice can be sought and to enhance the capacity for individuals to seek legal advice.

Indeed, it can be difficult to know where to turn for legal advice. In the US, for example, there is "1 legal aid attorney for every 6,415 people living in poverty";[33] however, by comparison, "for every 429 people in the general population who are above the [Legal Services Corporation] poverty threshold", there is one private attorney.[34] Further, a legal needs assessment conducted at Boston Medical Center surveyed the parents/guardians of patients coming to the Paediatric Emergency Department for care in Autumn of 2007. 154 people completed the questionnaire and 39 completed an interview. The study found that nearly half of the families who participated received a letter threatening a utility shut-off; 25% of families used the stove to heat their home and 36% of families had to reduce the size of their meals or skip meals because of lack of money. [35] Further, families reported "that their issues had been a concern for them for at least six months" and 52% of the families who participated in this survey did not know where to go or who could help with this issue.[36] Another study of an MLP found that "85 percent of participating families who received legal services through their healthcare providers had not used legal resources before, and 78.8 percent were not aware of legal resources prior to MLP

[31] Christine Coumarelos et al, "Legal Australia-Wide Survey: Legal need in Victoria" (Report, Law and Justice Foundation of New South Wales, August 2012).
[32] Ibid, xxiv.
[33] James Teufel et al, "Rural Health Systems and Legal Care: Opportunities for Initiating and Maintaining Legal Care after the Patient Protection and Affordable Care Act" (2014) 35(1), *The Journal of legal Medicine,* 81, 96.
[34] Legal Services Corporation, "Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans (Updated Report, Legal Services Corporation, 2009) 1 in Atkins et al, above n12, 195.
[35] Megan Sandel et al, "The MLP Vital Sign: Assessing and Managing Legal Needs in the Healthcare Setting", (2014) 35(1), *The Journal of legal Medicine,* 41, 48.
[36] Ibid.

intervention".[37] Integrating legal assistance into a health-care setting provides a greater opportunity for individuals to seek legal assistance for issues that may be remedied by legal intervention.

Similarly, in the UK, trends relating to advice seeking behaviour have been recognised by the National Health Service (**NHS**). They have "commissioned advice agencies to provide advice in GP surgeries, as well as in hospital settings. Similarly, in Wales all seven Local Health Boards receive funding from the Welsh Government for funding generalist and welfare advice provision through GP surgeries and other health settings".[38] Citizens Advice Bureaux (**CABx**) have been placed in GP practices in the UK since the early 1990s and the results of a pilot, conducted in 1993, found that this practice was "an effective way of providing advice on life problems and securing proper payment of benefits, particularly to patients with health problems".[39] The research also found that these CABx outposts reached a different clientele to those who would otherwise seek advice from a CAB; that they were "more likely to be ill and that they were more likely to be entitled to welfare benefits that they were not receiving".[40] In 2005, it was reported that "CABx had provided advice in 751 GP surgeries and health centres, 62 general hospitals, 75 psychiatric hospitals and 165 mental health clinics" across the UK.[41] Of note, in 2013 in Derbyshire, 96 GP practices had CAB services which were funded out of the public health element of the NHS Primary Care Trust's budget.[42] The Marmot Review in the UK cites as one of the strategies for reducing health inequalities, the provision of CABx in GP practices.[43]

During a presentation given by the North Carolina Community Health Center Association at the MLP Summit in Seattle, it was emphasised that *"*leveraging the social determinants of health is "in the DNA" of community health centers*"*, that 52% of health center patients in North Carolina are uninsured and that 94% of them have incomes 200% below the federal poverty line. Data collected in 5 community health centers around North Carolina showed that 71% of all patient respondents reported experiencing at least one legal or resource need in the past year and nearly 80% of patients were very likely or somewhat likely to discuss legal/resource problems with their provider in the future. Further, 71% of staff said that they would screen and refer patients for free legal assistance if their health centre had an established referral programme.

Indeed, it can be said that addressing the legal needs that may impact on the health of individuals is in the DNA of community legal centres. By integrating legal services in to a health-care setting, individuals are provided with a greater opportunity to seek the assistance of community lawyers

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[37] Lawton, et al, above n.24, 80.
[38] The Low Commission, "Tackling the Advice Deficit: A Strategy for Access to Advice and Legal Support on Social Welfare Law in England and Wales" (2014), Annex 13, 1 <http://www.lowcommission.org.uk/Documents/Report-Annexes>.
[39] Paris JA, Player D, 'Citizens Advice in general practice', BMJ 1993; 306:1518 cited in The Low Commission, above n38*,* Annex 13.
[40] Jim AJ Paris and David Player, 'Citizens Advice in General Practice', (1993) 306 *BMJ* 1518 cited in The Low Commission, above n38, Annex 13, 2.
[41] The Low Commission, above n38, Annex 13, 4.
[42] Ibid.
[43] The Low Commission, above n38, Annex 13, 13.

and to seek remedies for their legal needs. As community legal centres and legal aid offices have always worked to empower the most disenfranchised, the natural progression is to enter the field of public health.

CASE STUDY: MEDICAL-LEGAL PARTNERSHIPS

The concept of Medical-Legal Partnerships (**MLPs**) is well-entrenched in the USA. MLPs exist in 262 healthcare institutions in 36 states in the USA.[44] "MLPs are located in a variety of healthcare settings, including hospitals, federally qualified health centers (FQHCs), medical schools, residency programs, and health-related social service agencies."[45] As outlined by Lawton, et al, "given the prevalence of legal needs among disadvantaged populations, targeted interventions to detect and address legal needs have emerged as an important component of local, state and national safety net programs."[46]

The first Medical-Legal Partnership was established at the Boston Medical Center in 1993 by Dr Barry Zuckerman, who stated: "as a pediatrician taking care of children in inner city Boston, it was upsetting for me to see children become sick and hospitalized for conditions that my children or children living in my neighborhood wouldn't suffer from. These included conditions related to inadequate food, to poor housing conditions, to utilities shut off, to violence in the community and other problems related to their social environment. I realized that there are a lot of protections and benefits that our public officials have put into policy and I thought the best way to address these problems was to hire a lawyer to see that the patient got help, to reduce unnecessary preventable illnesses."[47]

"MLP is premised on the idea that bringing health-care professionals and legal professionals together to address the social determinants of health not only addresses the immediate health concerns of patients through legal intervention but also changes systems – both within and outside the healthcare system – to improve the health of populations".[48] While MLPs share a common set of goals, each MLP is unique.

The three key components on which MLP are based are outlined by Lawton et al as follows:

> "1. The social, economic and political context in which people live has a fundamental impact on health;
> 2. These social determinants of health often manifest in the form of legal needs; and
> 3. Attorneys have the special tools and skills to address these needs."[49]

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[44] National Center for Medical-Legal Partnerships, <http://medical-legalpartnership.org/> as at 14 September 2014.
[45] Atkins et al, above n12, 200.
[46] Lawton, et al, above n.24, 72.
[47] Erin Marcus, "For the Sick and Poor, the Best Medicine May Be a Lawyer" (15 September 2010), *New American Media,* <http://newamericamedia.org/2010/09/is-there-a-lawyer-in-the-house.php>
[48] Parmet, Smith & Benedict above n.17, 30.
[49] Ellen Lawton and Elizabeth Tobin Tyler, "Optimizing the Health Impacts of Civil Legal Aid Interventions: The Public Health Framework of Medical-Legal Partnerships" (July 2013) 96, *Rhode Island Medical Journal*, 23, 23.

In the USA, access to the safety net and to medical care is a large component of the work of MLPs. "In some states, up to 50 percent of eligible people are not receiving food stamps due to complex application processes, burdensome documentation requirements, and other administrative and regulatory barriers."[50] This impacts on the health of many Americans and as Lawton et al highlight "health is undermined at both an individual and population level when people do not receive the benefits or protections that safety net laws and programs afford them, including a safer environment and better housing, nutrition and healthcare coverage." [51]

However, despite this, as outlined by Teufel et al, "although substantial research supports the impact of social determinants of health (**SDHs**), there are relatively few methods that address SDHs. MLPs are a research-supported method to address SDHs."[52] Lawton et al highlight that "several pilot studies show that people reported improved general health, less stress and feeling more empowered after MLP intervention."[53] Further, according to Lawton and Sandel, leaders in the field of MLP work, "MLP's future lies in its ability to reorient both the fields of law and medicine toward prevention of the social determinants of health".[54] The learnings of this work are transferable to the Australian context and are drawn on throughout this report.

CASE STUDY: NOTTINGHAM LAW CENTRE, ENGLAND[55]

Nottingham Law Centre provides free legal advice relating to debts, housing and welfare benefits in the City of Nottingham. "Services are particularly targeted towards disadvantaged and vulnerable sections of society whose access to legal advice is often limited or non-existent."[56] In 2012, Nottingham Law Centre secured £1,603,930 in welfare benefits for clients.

In 2010, the Law Centre conducted an evaluation of its work to determine how legal problems affect their clients and what effect the service that they provide has on the health, wellbeing, relationships and confidence of their clients. 12 clients were given a survey to fill out before and after seeing a lawyer and then interviewed. The clients required assistance with housing, debts and/or welfare benefits. The evaluation report shows that "all clients reported that their health had worsened since the problem started. This was a particular issue for the 8 clients who reported that their health was poor prior to the problem".[57] Further, the report states that "the

[50] Lawton et al., above n24, 72.
[51] Ibid.
[52] Teufel et al., above n33, 102. (Table 2: Diffusion of Innovation: Making a Case for Initiating MLPs in Rural Areas).
[53] Lawton, et al, above n24, 82.
[54] Ellen M Lawton & Megan Sandel, "Medical-Legal Partnerships: Collaborating to Transform Healthcare for Vulnerable Patients – A Symposium Introduction and Overview" (2014) 35(1), *The Journal of Legal Medicine,* 1, 6.
[55] Meeting at Nottingham Law Centre, 12 May 2014.
[56] ADP Consultancy – ASA Outcomes Pilot Report - Nottingham Law Centre Outcomes Report (on file with author).
[57] Ibid.

entire sample reported that the problem had contributed to a change in their mental and physical health to some degree”. [58]

However, several respondents reported improved health as a result of the legal intervention. One client reported that “her sleep had improved considerably…and her relationship with her children had dramatically improved [and]….she was better able to deal with housing officials ….” Her own confidence to be able to sort out problems had similarly increased. This client said: “I have realised that I should deal with problems earlier”. [59]

Comments from other clients following the intervention included: “I feel like I have a new life. I have turned a corner. I think my confidence has changed dramatically” and “I have got some order back to my life”. [60]

1.2 LEGAL NEEDS AND THEIR IMPACT ON MENTAL HEALTH

> “…there are strong links between people’s experience of rights problems and mental illness [and] these should be taken into account when designing services aimed at addressing the needs of users of such services.” [61]

People experiencing mental illness often grapple with significant legal problems. “The evidence to date suggests that psychiatric morbidity both follows on from and increases vulnerability to rights problems”.[62] People experiencing mental illness may grapple with the problems that they are experiencing given “…fear of disclosure, real and perceived communication problems and other capability issues”.[63] Further, “depression, agoraphobia or panic attacks can make even a short journey to an advice centre problematic.”[64] Key findings of the England and Welsh Civil and Social Justice Survey from 2006-2009 found that “the prevalence of welfare rights problems was found to increase with the level of psychiatric morbidity….among those with the maximum GHQ-12 score, indicating severe mental illness, no fewer than 83% reported welfare rights problems….the average number of problems per person was twice as high among ‘cases’ of mental ill health as among ‘non-cases’….[and] the likelihood of inaction by an individual in the face of welfare problems increased with the level of psychiatric morbidity”.[65] This emphasises the importance of integrating legal services for those experiencing mental illness with other support services.[66] Providing appropriate referral pathways to assist to alleviate these legal

[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] Nigel Balmer, Pascoe Pleasence & Alexy Buck, “Psychiatric Morbidity and People’s Experience of and Response to Social Problems Involving Rights” (November 2010) 18(6) *Health and Social Care in the Community* 596.
[62] Ibid.
[63] Ibid.
[64] Ibid.
[65] Michael Parsonage, “Welfare Advice for People Who Use Mental Health Services: Developing the Business Case” (Centre for Mental Health Report, December 2013), 8.
[66] Pascoe Pleasence & Nigel Balmer, “Mental Health and the Experience of Social Problems Involving Rights: Findings from the United Kingdom and New Zealand” (*March 2009*) 16(1), *Psychiatry, Psychology and the Law* 123-140.

issues can have flow-on effects for the health of those experiencing mental illness. Lewis argues that "not only is high quality welfare advice good for mental health service users, in the long run it could end up saving the NHS, and the country, money. More importantly, it increases options and gives practical solutions for dealing with the problem".[67]

A study based on the LAW Survey in Australia confirms the nexus between illness and disability and the increased experience of legal problems. "Compared to people with no illness/disability, those with combined mental and physical illness/disability of high severity were more than 10 times as likely to report legal problems and reporting levels were consistently higher across illness/disability types .... Not only do people with an illness/disability have high legal and health needs, but it is well documented that they can face a range of obstacles in accessing services."[68] Further, "people with a mental illness experience both individual and systemic barriers to accessing legal services" and can feel overwhelmed by their legal issues leading them to avoid addressing them.[69]

Many community legal centres across Victoria provide advice and assistance to clients with legal issues relating to debts and this is a common issue faced by those with mental illness. By integrating legal services with other multi-disciplinary service providers, it increases the likelihood that those with mental illness will have an opportunity to seek advice for legal issues relating to debt. It has been found that in the UK, at any one time, a quarter of adults will have a mental health problem[70] and a quarter of those with mental health problems are also in debt.[71] Further, half of people with debts have a mental health problem.[72] MIND, a mental health charity in the UK, has reported that "most people believed their debt had made their mental health worse and their mental health had made their debt worse".[73] Further, studies have found that people with debt problems are "twice as likely to subsequently develop major depression as those without debt problems and having a debt problem reduces the likelihood of recovery from depression."[74] Only approximately half of those with debt problems seek advice[75] yet a study has shown that in cases of debt, "contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable".[76]

[67] Martin Lewis (foreword) in Michael Parsonage above n.65, 3.
[68] Pascoe Pleasence, Zhigang Wei and Christine Coumarelos, "Law and Disorders: illness/disability and the response to everyday problems involving the law" (Report, Law and Justice Foundation, September 2013) 1.
[69] Karras, McCarron, Gray & Ardasinksi 2006, 93 in Pleasence et al above n68.
[70] NHSIC 2009 cited in The Low Commission, above n38, Annex 13, 3.
[71] Jenkins 2008 cited in The Low Commission, above n38, Annex 13, 3.
[72] NHSIC 2009 cited in The Low Commission, above n38, Annex 13, 3.
[73] The Low Commission, above n38, Annex 13, 1.
[74] P Skapinakis et al, "Socio-economic Position and Common Mental Health Disorders: Longitudinal Study in the General Population in the UK (2006) 158 *British Journal of Psychiatry* 848-849 cited in Parsonage above n65, 9.
[75] P Pleasence, A Buck and N Balmer "Causes of Action: Civil Law and Social Justice" (Legal Services Commission, 2004) cited in Parsonage above n65.
[76] K Williams & A Sansom, "Twelve months later: does advice help? The impact of debt advice: advice agency client study" (Ministry of Justice, 2007) cited in Parsonage, above n65.

An example of integrated service delivery assisting those experiencing mental illness is the Citizens Advice Bureau in Sheffield, profiled in a report by Parsonage.[77] This service is providing both a social and financial return on investment to the community that it serves. The service supports people with severe mental illness throughout the city, most of whom are patients of the Sheffield Health and Social Care NHS Foundation Trust. The Service in Sheffield assists approximately 600 people each year and just under half of those who are assisted by the Service are inpatients, the remainder living in the community.[78] A report shows that this “welfare advice generates cost savings in a number of ways” including reductions in inpatient lengths of stay, prevention of homelessness and prevention of relapse.[79] Indeed, “because the costs of severe mental illness including relapse are so high relative to the costs of welfare advice, only a small number of successful interventions are needed for an advice service to generate sufficient savings to be good value for money.” [80]

It is also important to note that young people who are experiencing mental illness may be particularly vulnerable to legal needs. Youth Access in England has found that “young people’s problems rarely develop in isolation” and that for example, mental ill-health is often coupled with homelessness, money and employment problems and that “the propensity for problems to co-occur seems to be greater in youth than at other life stages.”[81] Because of this, “young people often need help to address a range of inter-related personal, practical, emotional, health, social welfare and legal needs simultaneously” yet they are often the least likely to seek assistance.[82] A study has found that two-thirds of young people with housing and money problems had mental illness and that 45% of them reported their health suffering. However, “after receiving advice, 64% of them reported improvements in their levels of stress, 34% in their general health and 42% in their housing situation”.[83] Youth Access has been working in this field for some time with a view to integrating social welfare advice with mental health services aimed at assisting young people. The *Making Tracks Project* worked in three areas to develop better partnerships between GPs, primary care trusts and young people’s information, advice and counselling services. An external evaluation of this work found “consistent improvements across all three pilot sites in young people’s social, mental and physical health after receiving services”.[84] The recognition that “part of the package needs to be advice” was made clear to the writer during a meeting with Youth Access in London. Indeed, Youth Access has assisted young people to draft their own manifesto in which they state:

> “We need more mental health and drug services that are just for young people and are delivered alongside advice services … young people often find it difficult

[77] Parsonage above, n65.
[78] Ibid 15.
[79] Ibid 31.
[80] Ibid.
[81] Youth Access, “Making Integration a Reality: Part 2: Developing Effective Holistic Services for Young People in Transition” (Commissioning Briefing, March 2014), 5.
[82] Ibid.
[83] Ibid.
[84] The Low Commission, above n38, Annex 13, 10.

to get advice. At least 1 million young people are left to cope with their problems unassisted each year…it is hard to find out about your rights – we don't always know we have rights we might be able to use".

CASE STUDY: SPRINGFIELD ADVICE & LAW CENTRE AT SPRINGFIELD UNIVERSITY HOSPITAL, LONDON, ENGLAND[85]

Established in 1982 and based at Springfield Hospital, Springfield Advice & Law Centre (**the Law Centre)** is an example of a legal advice service integrated into a hospital setting. The Law Centre provides specialist advice, casework and representation in housing, debt, welfare benefits, community care and mental health to patients, relatives and carers of the South West London and St George's Mental Health Trust. They also provide general advice and referral in other areas of law including wills, probate, enduring powers of attorney and court of protection issues. The Law Centre also provides services for young people with mental health problems under the age of 21.

The hospital trust provides mental health services across five south west London boroughs (Wandsworth, Merton, Sutton, Kingston and Richmond) which service around 1 million people and all of these people are within the catchment area of the law centre.

The Law Centre has two Caseworkers and three Lawyers on the staff as well as a Manager. It provides a daily drop-in clinic from 10am-1pm and pre-booked appointments from 2pm-4pm. It also runs several outreach clinics at other mental health organisations in the community, including the Jubilee Centre, Imagine, Focus 4-1 and at Wilson Hospital, all services aimed at assisting mental health outpatients.

The Law Centre works closely with mental health professionals employed by the mental health trust and prides itself on a "partnership" approach to help resolve legal problems and deal with

[85] Meeting at Springfield Advice and Law Centre on 14 May 2014.

the "human side of community legal work".[86] Patients are either referred by hospital staff or they self-refer. Hospital staff also call staff of the Law Centre to confer with them about legal issues. Alan Clark, Manager said that "Clients say they often feel intimated going to other services. At Springfield, the Law Centre aims to provide a safe and supportive environment without any stigma and to provide legal assistance as close as possible to where people are already accessing services". [87] The Law Centre also provides education sessions to community agencies on mental health matters and periodically talks to hospital staff about their services.

The Law Centre encourages the support of family and friends of patients and aims to provide solutions to clients' legal problems which also aids their recovery. Further, former clients of the Law Centre often return to the law centre as volunteers to transition back in to employment. Alan Clark highlights that "It's about comfortably getting people back into the workforce. It's a user-led organisation and we listen to users".

1.3 LEGAL NEEDS AND THEIR IMPACT ON WOMEN EXPERIENCING VIOLENCE

Violence against women is a key issue impacting the health and wellbeing of women. Violence Against Women can be defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private

[86] Meeting with Alan Clark, Manager, Springfield Advice and Law Centre, 14 May 2014.
[87] Ibid.

life".[88] The health impacts of violence against women are significant and detrimental. A report by VicHealth, mentioned above, has found that intimate partner violence "is the leading preventable contributor to death, disability and illness in Victorian women aged 15-44 […and is…] responsible for more of the disease burden [for Victorian women aged between 15-44] than many well-known risk factors such as high blood pressure, smoking and obesity."[89] In the USA, intimate partner violence "is the leading cause of nonfatal injury to women"[90] and in 2003, the Centers for Disease Control and Prevention in the USA estimated that the cost of intimate partner violence to the "health and mental health systems exceeded $4.1 billion per year."[91] Further, a report by the Department of Health in the UK, highlights that "the health and social costs and consequences of domestic violence are extensive and serious enough to constitute a major public health issue".[92]

A report by the Women's Health and Equality Consortium in England has highlighted that women and girls face different risks to their health than men.[93] This is exacerbated by gender inequality and by the gendered nature of violence against women. "Sexual and domestic violence and abuse puts women and girls' lives at risk and can have serious consequences on their health and wellbeing".[94] In addition to the physical injuries often sustained by women during violent incidents, "many chronic physical conditions have been linked to [intimate partner violence]. Pain and somatic complaints are particularly prevalent among abused or formerly abused women, who report high levels of headaches and neck pain, digestive disorders, pelvic pain, and overall low self-report of health-related qualify of life." [95] "Gender based-violence is both a cause and a consequence of HIV."[96] Further, research has shown that children who have been exposed to intimate partner violence "have a twofold greater risk of developing asthma than children who are not exposed."[97]

Further, the risk of poverty is greater amongst women than men and women are likely to "suffer recurrent and longer spells of poverty…which negatively impacts their physical and mental health".[98] In addition, "92% of homeless women [in the US] have experienced 'severe physical or sexual abuse at some point in their lives'"[99]

[88] *Declaration on the Elimination of Violence Against Women* (A/RES/48/104), Article 1.
[89] VicHealth, above n5, 10.
[90] Betsy M Groves, Lisa Pilnik, Elizabeth Tobin Tyler, Jane Liebschutz and Megan Bair-Merritt, "Personal Safety: Addressing Interpersonal and Family Violence in the Health and Legal Systems" in Elizabeth Tobin Tyler et al (eds), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 349.
[91] Ibid 347.
[92] Department of Health, "On the State of the Public Health" (Health and Domestic Violence: A life issue, 1997).
[93] Women's Health & Equality Consortium, "Better Health for Women: How to Incorporate Women's Health Needs into Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies" (January 2013), <www.whec.org.uk>, Annex A, 17.
[94] Ibid 17.
[95] Groves et al, above n90, 349.
[96] Women's Health & Equality Consortium, above n93, 17.
[97] Groves et al, above n90, 364.
[98] Women's Health & Equality Consortium, above n93, 16.
[99] Groves et al, above n90, 356.

The use of health-care services increases with intimate partner violence.[100] Interviews with survivors of partner abuse in Australia have shown that health professionals are the major group to whom women want to disclose violence[101] and an Australian study shows that "a full-time primary care clinician is probably seeing at least one currently abused woman each week, although she may not be presenting with obvious signs or symptoms".[102] Further, studies in the USA have found that increased provision of legal services was one of three key factors contributing to the decline of violence against women by their intimate partners.[103] Indeed, women who are experiencing violence may be exposed to a range of legal issues. In the UK, a survey of justiciable problems was conducted and found that 337 (6%) (of 5,611 adult respondents) reported "one or more family justiciable problems in the preceding 3.5 years" with 88 of those reporting domestic violence.[104] Further, family violence can also trigger other legal issues[105] and women experiencing violence may have a clustering of legal issues, including issues relating to debts, housing and employment.

Indeed, Pleasence et al have stated that:

> "those most affected by such problems experience them, not in isolation, but in combination, and at the heart of the experience of multiple problems we repeatedly find domestic violence. Our findings expose a deeply troubled subgroup within the population where family problems are played out against a background of violent behaviour. A great challenge for those providing family advice and support services is, therefore, to utilise resources to enable those at high risk of experiencing multiple family problems to avoid doing so, and to enable those who have already found themselves faced with a cluster of problems to move on from them."[106]

Women experiencing violence may face several barriers to accessing the legal system. Women who are chronically abused may not have the liberty to contact a lawyer and if they do, there may be a fear that they may not be believed. Therefore, recognising that women experiencing violence often disclose to health professionals and that women experiencing violence often have a clustering of legal needs, by providing legal services on-site in a health-care setting, women are provided with an opportunity to seek information and advice about their rights and entitlements in a safe environment.

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[100] Ibid, 349.
[101] Roberts et al, above n8, 81.
[102] Kelsey Hegarty, "Measuring a Multidimensional Definition of Domestic Violence: Prevalence of Partner Abuse in Women Attending General Practice" (Unpublished doctoral thesis: University of Queensland, 1999) in above n8, 36.
[103] Farmer & Tiefenthaler, above n7*,* 158.
[104] Pascoe Pleasence, Nigel Balmer, Alexy Buck, Aoife O'Grady, Mavis Maclean and Hazel Genn, "Family Problems – What Happens and to Whom – Findings from the LSRC Survey of Justiciable Problems" (1 July 2003) *Family Law* 497.
[105] Coumarelos et al above n1, 167.
[106] Pleasence et al above n.104.

CASE STUDY: BARBRA SCHLIFER COMMEMORATIVE CLINIC, TORONTO, CANADA[107]

The Barbra Schlifer Commemorative Clinic, established in 1985, is a multi-disciplinary service that offers legal assistance in family law, immigration and criminal law as well as counselling and language interpretation to women who have experienced violence. The Clinic also advocates for law reform and social changes that benefit women. The Clinic assists women experiencing a range of forms of violence, including women subjected to human trafficking, forced marriage and family violence. The Clinic also works in close collaboration with several hospitals including the Women's College Hospital and has an extern program for law students from the University of Toronto.

The social work team and the legal team at the Clinic have open discussions about the best approach for women. Social workers and lawyers hold "common practice meetings" in which all staff across the departments are present to discuss the cases of clients that they assist. Further, the language interpretation services are also available to assist women accessing external services for issues relating to violence and appointments must be booked by a service provider on a woman's behalf.

The number of women assisted by the Clinic has increased significantly in recent years, with 3500 women assisted in 2010 and 5123 women assisted in 2013. "The clinic…was designed to be a unique model of service delivery…it was a multi-disciplinary service that combined counselling and legal services so that we could take a more holistic approach to addressing multiple legal and non-legal needs that survivors of violence have…", explained Amanda Dale, Executive Director "there is a significant shift towards a more holistic approach…an integrated response can become life changing".

[107] Meeting at Barbra Schlifer Commemorative Clinic, 2 May 2014.

CHAPTER 2

JUMPING HURDLES:

OVERCOMING THE PRACTICAL BARRIERS OF INTEGRATING LEGAL ASSISTANCE INTO A HEALTHCARE SETTING

> "We need to create a culture of cooperation and coordination between health, social care, public health, other local services and the third sector. Working in silos is no longer acceptable".[108]

Recognising the research related to advice seeking behaviour and the impact of legal needs on health, it is apparent that integrated legal services must become part of this culture of cooperation and coordination. However, combining law with other professions can bring with it practical and ethical barriers. This chapter outlines some of the practical barriers that may arise in integrating legal assistance into health-care settings.

2.1 INTEGRATED MODELS OF SERVICE DELIVERY OR OUTREACH CLINICS

This report aims to support the integration of legal services in to health-care settings as well as hospitals and other multi-disciplinary environments. Integration is distinct from the provision of an off-site outreach clinic. Off-site outreach involves a lawyer attending a multi-disciplinary site and seeing clients of that organisation. This is distinguished from an integrated model of service delivery whereby the lawyer becomes part of the care team that delivers services to patients.

During the MLP Summit in Seattle, a presentation was given by the MLP of Southern Illinois that showed the continuum between coordination, co-location and integration. Coordinated service delivery was defined as separate systems, some communication about patients/clients and a limited understanding of others' roles. By contrast, integration was defined as the ability to "communicate frequently in person, [become a] collaborative member of [the] care team, discuss overall strategy and specific patient/client issues, actively seek system solutions together and roles and cultures blend at system, team and individual levels".[109] By its nature, this model of service delivery will require a significant amount of communication between partners in order for the legal partner to become part of the fabric of the healthcare setting.

The National Center for Medical-Legal Partnership is a "parent organisation" to MLP programs around the USA, supporting the expansion of this work, providing assistance and guidance to budding MLPs and providing examples of best practice.[110] The National Center argues that most successful MLPs have incorporated a few key ingredients into their programs, including:

- health and legal partners planning together from the embryonic stages of the program, to implementation and expansion;
- constant communication between partner organisations whilst respecting the confidentiality of clients/patients;
- evaluation and metrics to promote sustainability and awareness of the work;
- on-site legal assistance in which a lawyer is part of the clinical team;

[108] The Rt. Hon. Jeremy Hunt MP, Secretary of State for Health and Norman Lamb MP, Minister of State for Care and Support, Foreword to "Integrated Care and Support: Our Shared Commitment" cited in Youth Access, "Making Integration a Reality: Part 1: Joining up the Commissioning of Young People's Services across Health, Social Care, Housing and Youth Services" (Commissioning Briefing, March 2014), 1.
[109] Diane Land, Medical-Legal Partnership of Southern Illinois, Presentation at 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform, 10-11 April 2014 (Seattle, USA)
[110] Lawton, et al, above n24, 89.

- starting small and ensuring that priorities between the partner organisations are aligned. This may include focusing on a single legal issue area in which the legal team has the most expertise. However, the National Center has indicated that successful MLPs align health priorities with legal priorities;
- Improving internal and external systems that can impact patients on a broader level.[111]

Pro Bono Law Ontario at the Hospital for Sick Children in Toronto, Canada, (**PBLO at SickKids**) is a key example of a model of integrated service delivery which aims to provide advice in an environment that is safe for children, young people and their families. An external evaluation report conducted about the PBLO at SickKids states that "clinicians were virtually unanimous in asserting that the on-site location was essential to the success of the model".[112] However, in addition to a lawyer being on-site in the social work department at SickKids four days a week, the lawyer also sits on several hospital committees, provides training to hospital staff and meets with every fourth year social paediatric student, as well as incoming residents to explain the nature of the programme to ensure full integration. A significant number of the intakes are through secondary consultations with staff at the Hospital who then convey the information to patient families. [113]

Further, there is an integrated example of an MLP aimed at addressing the legal needs of low-income children and their families living in Georgia, called HeLP.[114] HeLP has three partners including Emory University School of Medicine, Children's Georgia State University College of Law and Atlanta Legal Aid Society.[115] "All three partners contribute full-time-equivalent professional services to HeLP's operations".[116] The Hospital also provides funding for a 0.1 FTE position to have a Children's Medical Director for the Project.[117] In addition to providing on-site legal assistance, five subcommittees of an Advisory Council have been established to provide education programs to hospital staff and other interested groups; raise funds for HeLP; provide pro bono legal services for those that HeLP is unable to assist; produce scholarship and other written materials; assist with the evaluation of the project and enhance public awareness of the HeLP Project.[118] Pettignano et al state that "through the delivery of public health legal services, socioeconomic barriers to health are reduced, improving, in HeLP's experience, the health and well-being of children".[119]

[111] Ibid 90-91.
[112] Focus Consultants, "PBLO at SickKids: A Phase II Evaluation of the Medical-Legal Partnership between Pro Bono Law Ontario and SickKids Hospital, Toronto, Final Report" (17 February 2012), ix.
[113] Meeting with Lee Ann Chapman at PBLO at SickKids, 29 May 2014, Toronto, Canada.
[114] Robert Pettignano, Lisa Bliss and Sylvia Caley, "The Health Law Partnership: A Medical-Legal Partnership Strategically Designed to Provide a Coordinated Approach to Public Health Legal Services, Education, Advocacy, Evaluation, Research, and Scholarship" (2014) 35(1), *The Journal of Legal Medicine,* 57, 63.
[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Ibid.
[119] Ibid, 79.

Further, in the UK, there are several examples of integrated service delivery aimed at assisting young people. Young people can be particularly vulnerable to social welfare problems and their issues often cluster with other issues. "Reflecting the complexity of the adolescent transition, young people's social welfare problems rarely develop in isolation from inter-connected practical, emotional and personal issues" thus necessitating an integrated response from services.[120] In England, several youth agencies provide advice alongside other interventions such as counselling, advocacy and health clinics. 188 youth presenting for social welfare advice were surveyed in youth advice settings across 16 sites, operated by 14 different organisations throughout England and Wales. "70% of clients felt that advice resulted in improvements in stress and or their health in general".[121] The findings "demonstrate the benefits to mental health of social welfare advice provided in young person-friendly settings and the importance of an advice model that acknowledges and responds to young people's significant emotional and mental health needs".[122] The findings of the research state that "youth information, advice and counselling services offer a proven integrated model in which advice is provided alongside a range of complementary services. It cannot be assumed that other models of advice provision to young people would achieve similar results."[123] Indeed, as indicated by Youth Access, "co-ordinated early intervention during adolescence and young adulthood has the potential to prevent multiple problems, improve young people's long-term outcomes and save the public purse vast sums of money."[124]

CASE STUDY: PRO BONO LAW ONTARIO AND SICKKIDS, TORONTO, CANADA[125]

Established in 2009, the Medical-Legal Partnership between Pro Bono Law Ontario (**PBLO**) and The Hospital for Sick Children (**SickKids**) sees a lawyer in the social work department of the hospital four days per week. Following in its wake, Children's Hospital of Eastern Ontario, London Children's Hospital and Holland Bloorview Rehabilitation Hospital in Canada have established similar models.

PBLO is a "charitable organisation with a mandate to improve access to justice by creating and facilitating opportunities for lawyers to provide pro bono legal services to low-income Ontarians as well as the community organisations that serve them."[126] SickKids is a major paediatric centre for the Greater Toronto area as well as a teaching hospital for the University of Toronto. The aim of the MLP between these two organisations is to "help low-income patients and families deal with legal challenges that impact the patient's health and/or the family's capacity to care for

[120] James Kenrick, "The Advice Needs of Young People – Key Research Evidence on Young People's Needs for Advice on Social Welfare Issues" (Research Briefing, Youth Access, July 2009).
[121] Youth Access, "Youth Advice: a Mental Health Intervention? Summary of a Research Study on the Mental Health Benefits and Cost-Effectiveness of Youth Advice Services" (Research Briefing, November 2012).
[122] Ibid.
[123] Ibid.
[124] Youth Access, above n108.
[125] Meeting at PBLO at SickKids, 29 April 2014.
[126] Focus Consultants, above n112 vi.

their sick child".[127] Lee Ann Chapman, the on-site lawyer, explains that the MLP assists with "anything that impacts the child's health directly or indirectly … we do think of ourselves as part of the healthcare team".

The primary role of the on-site lawyer includes consultations with clinicians and families that may result in information or advice passed to a clinician; a brief service and/or advice to the parent/patient and/or referral of the case to a pro bono lawyer or another organisation. The MLP has established a direct referral pathway to three Toronto law firms who provide assistance on a pro bono basis.[128] The on-site lawyer also provides training to clinicians at the hospital by attending academic rounds and engaging with clinicians to assist them to identify legal issues.[129] The lawyer is also involved in law reform and addressing systemic issues that arise in the hospital, including broad-based advocacy around laws and policies that impact the clients. The lawyer has established and chaired a committee called the Systemic Issues Working Group which aims to address systemic issues that may arise. The committee includes social workers, nurses, doctors, fellows and residents as well as external lawyers and members of the Office of the Provincial Advocate for Children and Youth.[130] The working group is now a collaboration between all the PBLO Children's Hospital Programs and healthcare lawyers from a major Toronto law firm.[131]

Further, PBLO at SickKids is accredited as a leading healthcare practice in Canada because of the innovation of the on-site legal clinic as well as the impact on family centred care. Lee Ann Chapman explains that "they were the first hospital in Canada and the only one for years to have the on-site programme. It's not a surprise that it started here. It's very child and family-centred. It's a wrap around service. This [expansion of the model] was the next logical step… the success rates are incredibly high…the family satisfaction rates are incredibly high".[132]

Indeed, an evaluation of this MLP considered the cases of 463 clients between September 2010 and September 2011. The evaluation highlights that the respondents were largely those of "modest means and family circumstances" whose vulnerability was increased in the face of additional health and/or legal problems.[133] Referrals were received from a broad range of departments within the hospital. 99 of the clients were referred to a pro bono lawyer and 235 referrals were made to organisations other than the pro bono lawyer (including 94 to Legal Aid and 74 to the private bar).[134] 80% of the cases involved one legal problem and 20% involved two or more problems. The top six legal issues were immigration/refugee law, family law, education, employment law, health law and issues of capacity or consent.[135]

[127] Ibid.
[128] McMillan LLP; Torkin Manes LLP; Bellissimo Law Group
[129] Focus Consultants, above n112 vi.
[130] Focus Consultants, above n112 vi.
[131] Borden Ladner Gervais LLP
[132] Meeting with Lee Ann Chapman at PBLO at SickKids, Toronto, Canada, 29 April 2014.
[133] Focus Consultants, above n112, 52.
[134] Focus Consultants, above n112 viii.
[135] Ibid.

The evaluation has shown that this model is addressing research relating to advice seeking behaviour. The evaluation asked parents whether "they or anyone else in the family had tried to get help for any of their legal concerns before they went to the lawyer's office at SickKids. None of them had done so."[136] The evaluation highlights that "the impact of legal problems was felt most strongly in two areas of parents' lives: first, the level of stress and worry they were experiencing and, secondly, in their financial situation."[137] Approximately half of the respondents "estimated a moderate to significant improvement in regard to the child's health or in their (the parents') ability to help maintain the child's treatment".[138]

Almost all the respondents acknowledged that they had received several services from this project, including information from a clinician who had consulted the on-site lawyer, advice from the on-site lawyer as well as in some cases, advice and assistance from organisations to which they had been referred.[139] The findings of the evaluation were that "the project works extremely well in a clinical setting at the hospital and enjoys the full confidence of hospital clinicians; [the project] has steadily enlarged its service capacity, [the project]….has created significant positive impacts for families…and that the project…was addressing significant unmet needs". [140]

Window in front of the Hospital for Sick Kids, Toronto

CASE STUDY: UNISON HEALTH & COMMUNITY SERVICES, TORONTO, CANADA[141]

"At Unison, we believe in a client-centred, multi-disciplinary approach to primary health care. This means that our clients are at the centre of any planning and decision-making about their treatment and/or care"[142]

A remarkable example of integrated service delivery can be seen at Unison Health & Community Services in Toronto. Formed in 2010 by a merger between two community organisations with over 30 years' experience serving the community, Unison Health & Community Services is a not-for-profit community based organisation. Unison expands across 5 sites and employs 240 staff offering a wide range of free, confidential and non-judgmental services to people of all ages,

[136] Ibid, x.
[137] Ibid.
[138] Ibid, xi.
[139] Ibid.
[140] Ibid.
[141] Meeting at Unison Health & Community Services on 28 April 2014.
[142] Unison Health & Community Services - Welcome Booklet.

cultures and backgrounds. Services include health care, counselling and case management, legal advice, housing assistance, health promotion and community action programs as well as a diabetes education centre, anonymous HIV testing, dental clinics, adult protective services, art therapy classes and pathways to education to improve school attendance and academic achievement.[143] The services are complemented by a food bank in the basement which service providers can access on behalf of their clients who are struggling to make ends meet.

All new primary health-care clients of Unison must attend an information session either in a group and/or with an individual provider. Several appointments are then available to clients of Unison. Home visits are also provided in some cases to clients of Unison and doctors are on-call for urgent medical problems after-hours. Unison also covers the cost of all care provided including many of the fees charged by specialists, emergency departments and pathology labs.[144]

The Legal Clinic at Unison is funded by Legal Aid Ontario and lawyers are employed by Unison. The legal team includes lawyers, community legal workers and support staff. Clients can either access the legal clinic as a patient of Unison or can access the legal clinic independently of other services. If the client identifies a legal problem when they see the receptionist, then they are referred directly to the legal clinic (without going through the orientation). Legal services include summary legal advice, legal representation, community legal education, law reform, community outreach and community development. Legal assistance is provided in a range of areas.

Vinay Jain, Director of Legal Services has said that "the ultimate goal is to have a seamless service which is at one end of the spectrum. The other end of the spectrum is completely independent services. We're somewhere in between. We're always looking for a way to get further over [to the other end of the spectrum]….There's a lot that's done informally…quite often, it works best when people walk down the hall and ask a question and then we're able to assist the client…someone's door is usually open here…then we're able to assist them and provide some information or if necessary set up a further appointment."

CASE STUDY: COMMUNITY LINKS, LONDON, ENGLAND[145]

David Cameron, the British Prime Minister has called it "one of Britain's most inspiring community organisations".[146] Established in 1973, Community Links is a charity organisation based in East London that runs a wide range of community projects for over 16,000 people each year.[147] At the outset, Community Links was established to ameliorate the social exclusion felt by many in the community, particularly those residing in high-rise social housing in the East end. Since then, it has grown to become a community hub based on the one-stop shop model including youth organisations, community development, healthcare prevention and national

[143] Ibid.
[144] Ibid.
[145] Meeting at Community Links, London on 14 May 2014.
[146] Website of Community Links, <www.community-links.org>
[147] Ibid.

work programs.[148] For approximately twenty years, legal advice has been one component of the service provided to those in the community. Every Monday to Friday, there is an open door advice service based on a first-come, first served basis. Clients are triaged by an advisor and if specialist legal advice is required, the client is referred to the on-site legal centre. Sharon Elliott, Manager and Solicitor, explained that most days from half past seven in the morning, people are queuing for advice.[149]

Community Links is in the process of evaluating their service and every client who accesses the on-site legal service is given a survey. Six months after completing the survey, clients will be called to determine whether their health has improved and whether they feel more connected to the community.

In 2004, Community Links expanded its scope and now also provides outreach services in "everyday community settings" such as GP surgeries, schools and community centres.[150] Advice sessions are run on a weekly or fortnightly basis and training sessions are offered to staff at community venues to enable them to give basic information to patients and to signpost issues. The evaluation of these services reports that "the experience of the Newham GP advice project … found that people who may not normally seek advice are much more likely to do so when it is 'prescribed' by their doctor and they have the opportunity to see an adviser in their local surgery."[151] The evaluation found that "over 1800 clients received free, independent, quality assured advice" and 65% of these clients were from an ethnic minority.[152] Further, the cost-benefit of this model of service delivery was highlighted in the evaluation which showed that "the outreach cost £267,247 [and] the service cost per client was £147. Extra benefits identified for clients were worth over £1.7 million per annum [and] an average of £978 per client, per annum in increased income".[153]

2.2 NEEDS ASSESSMENTS

One of the first steps in developing a successful AHA or legal outreach clinic is to conduct a legal needs assessment at the host site to ensure that the service provided is targeted and appropriate. This will help determine the legal and health service providers in the area as well as the scope of needs among patients accessing the services.

The National Center for Medical-Legal Partnership based in the USA has developed a Medical-Legal Partnership Toolkit which encourages all MLPs to conduct a legal needs assessment. It suggests identifying and defining the target population that the MLP seeks to service and

[148] Meeting with Sharon Elliott, Community Links, London, England, 14 May 2014.
[149] Ibid.
[150] Kirsty Collander Brown, "Community Outreach Advice Service: Project Evaluation for Community Links and West Ham and Plaistow New Deal for Communities" (August 2006).
[151] Ibid.
[152] Ibid.
[153] Ibid.

recommends framing the target population within a health context.[154] It also suggests conducting interviews with local healthcare stakeholders and encourages those seeking to establish a partnership to go through its I-HELP tool and to note the relevant rates of need for the target population.[155]

The I-HELP tool, below, is a guide to assist in determining legal needs, as follows[156]:

- **I**ncome supports/Insurance (food stamps, disability, benefits, cash assistance, health insurance)
- **H**ousing and Utilities (eviction, housing conditions, housing vouchers, utility shut off)
- **E**ducation/Employment (accommodation for disease and disability in education and employment settings)
- **L**egal status (criminal background issues, consumer law status, military discharge status, immigration status)
- **P**ersonal and family stability (domestic violence, guardianship, child support, advanced directives, estate planning).

The I-HELP tool has an emphasis on health insurance due to a lack of universal health cover in the USA which sees, for example, 24% of people in Texas being uninsured, 20% of those in Georgia, Louisiana and South Carolina being uninsured and a national average of 16% of people being uninsured.[157] Whilst this issue is less relevant to an Australian context, the tool provides a solid basis for the development of a needs assessment.

Similar needs assessments have been conducted in Toronto, Canada. St Michael's Hospital and ARCH Disability Law Centre in Toronto are in the process of establishing an MLP aimed at assisting those on a low-income in Toronto's inner city. Prior to commencing service provision, a legal needs assessment was conducted. Two doctors from St Michael's Hospital (one of whom has degrees in both law and medicine) went through 200 referrals to determine what fraction of patients might require legal assistance. The needs assessment showed that well over half of the patients considered had more than one legal issue and based on the results, it was decided to house the MLP in the family practice unit of the Hospital. Dr Nav Persaud, one of the doctors who conducted the legal needs assessment, stated, "I think every patient who is referred to this service will represent systemic issues….there are daily frustrations for medical practitioners and this [MLP] will impact patients profoundly". [158]

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[154] National Center for Medical-Legal Partnership, "The Medical-Legal Partnership Toolkit. Phase 1: Laying the Groundwork." February 2014, <*http://medical-legalpartnership.org/new-medical-legal-partnership-toolkit-available-free-download/*>
[155] Ibid.
[156] Ibid.
[157] Emily W. Parento & Lawrence O. Gostin, "Better Health but Less Justice: Widening Health Disparities After National Federation of Independent Business v Sebelius", 27 *Notre Dame L.J. Ethics & Pub. Pol'y* 481, 483 (2013) in Joel Teitelbaum, "Obligation and Opportunity: Medical-Legal Partnership in the Age of Health Reform" *The Journal of Legal Medicine* (2014) 35(1) 17.
[158] Meeting with Dr Nav Persaud from St Michael's Hospital & Yedida Zalik from ARCH Disability Law Centre, Toronto, 30 April 2014.

2.3 LEGAL SCREENING TOOLS

Many individuals experiencing legal issues, may not readily recognise that they are in fact facing legal issues. A low-income patient may, for example, turn to their clinician and comment that they have significant debt issues. However, this in and of itself may not prompt the clinician to refer the patient to a lawyer. Further, the parents of a child who is experiencing asthmatic symptoms as a result of living in mouldy accommodation may not automatically identify this as a legal issue and may not consider seeking the assistance of a lawyer. Yet, in both cases, legal intervention may be critical. In the case of an asthmatic child, "no matter how capable and compassionate the physician is, the child's health has a much greater chance of improving by the addition of a legal intervention that removes the root cause of the problem".[159]

One of the key aims of integrating legal assistance into healthcare settings is ensuring that clients do not need to explicitly identify themselves as in need of legal assistance. Instead, "the healthcare team helps them identify their legal needs and can address such needs as part of routine care."[160] Accordingly, by encouraging health professionals to identify legal issues and provide referrals to an on-site legal clinic, an opportunity is provided to identify an issue and respond appropriately. Professor Wettach from Duke Law School has emphasised that attorneys should be considered "subspecialists that can remedy some of the non-medical obstacles that affect child health".[161]

However, health-care professionals traditionally are not equipped to screen for legal needs. Accordingly, several examples of MLPs and multidisciplinary models have developed legal screening tools to facilitate this process. The aim of a legal screening tool is to identify legal needs not to pass the responsibility of responding to the legal need to health-care professionals. It is intended to act as a catalyst for referrals to the on-site legal service. "Social screening tools have been developed to aid providers in helping patients to identify any unmet social needs that may have legal consequences down the line".[162] Some models have adopted a formal approach to screening for legal needs whereas others are based on a more ad-hoc approach. The I-HELP tool referred to above is a screening tool commonly used by MLPs in the USA.

PBLO at SickKids in Toronto, Canada worked with the Social Paediatric Department and the Social Work Department to develop a screening tool, called the "poverty tool" which is used by family practitioners and paediatricians. Lawyer, Lee Ann Chapman has said that "the idea is that you would ask families as part of the social history…if the child's at school, are they getting enough to eat, do they feel safe at school and do they have a place to live. Those are basic questions every paediatrician needs to ask in order to address the social determinants of health".[163] In an

[159] Diane M Goffinet, James A Teufel, Diane Land, Andrew Weaver, "Medical-Legal Partnerships in the Age of the Affordable Care Act", *Clearinghouse Review* 47, 269.
[160] Sandel et al, above n35, 50.
[161] Meeting with Professor Jane Wettach and Madlyn Morreale, Durham, North Carolina, USA, 14 April 2014.
[162] Sandel et al, above n35, 51.
[163] Meeting with Lee Ann Chapman at PBLO at SickKids, Toronto, Canada, 29 May 2014.

evaluation conducted of the MLP at SickKids, 90% of clinicians expressed confidence in their ability to identify that a family at SickKids had a potential legal problem that could be addressed by PBLO.[164]

NC Children's Hospital in Chapel Hill, in partnership with Legal Aid North Carolina, has incorporated an MLP into its broader efforts aimed at reducing paediatric readmissions. As part of the discharge planning and follow up protocol, hospital staff screen patients and their families for a range of medical, social and/or legal issues and then make referrals to Legal Aid of North Carolina or other hospital or community resources.[165]

At Child HeLP in Cincinnati, families are requested to fill out a one page questionnaire that relates to social risk or school related issues when they bring their child in for a well-child visit. A medical assistant then enters that information in to the electronic medical record.[166] Further, Arkansas Children's Hospital is profiled in the Journal of Legal Medicine as an example of an organisation that screens for unmet needs at the start of visits. At check-in, patients are provided with a form to complete which is then reviewed by the resident. If the patient has responded positively to any questions, the resident asks a specific set of follow up questions. Depending on responses, some patients are given an information sheet outlining how to access a specific referral whereas others are provided with a warm referral to the MLP. The screening tool has also been designed to follow up on patients who have responded positively to an unmet legal need at the outset.[167]

In order to address unmet legal needs, the Community Advocacy & Legal Centre (**CALC**) in Belleville, Canada has introduced the concept of the "trusted intermediary". A "trusted intermediary" helps bridge the gap between legal need and the legal system. CALC emphasised that some bridge this gap voluntarily because they are a "good neighbour, friend, hairstylist or confidante [whereas] others play that role because they are in a helping profession – a nurse, social worker, clergy, doctor, librarian", etc.[168] CALC has created a type of 'legal health checklist' which can be used by these 'trusted intermediaries' to determine whether there is a legal need and to allow for appropriate referrals. Such checklists provide an opportunity for 'trusted intermediaries' to screen for legal needs and refer accordingly, assisting in preventing legal needs from requiring intensive interventions and also reducing the cost to society.

CASE STUDY: CENTRE FRANCOPHONE DE TORONTO, CANADA[169]

The Centre Francophone de Toronto (CFT) is another extraordinary example of a not-for-profit, one-stop shop model in Toronto. In promoting the health and wellbeing of the Francophone

[164] Focus Consultants, above n112, 37.
[165] Meeting with Professor Jane Wettach and Madlyn Morreale, Durham, North Carolina, USA, 14 April 2014.
[166] "Break out session 23: Developing best in class MLPs through population based learning networks", 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform, 10-11 April 2014 (Seattle, USA)
[167] Sandel et al above n35, 52.
[168] Bafflegab, semi-annual newsletter of the Community Advocacy & Legal Centre, Fall 2013, 22(2).
[169] Meeting at Centre Francophone de Toronto, Canada 2 May 2014.

community in Toronto, it provides legal assistance co-located with a range of other services, including healthcare, children and family services, newcomer services and employment assistance.[170]

All service providers who assist a client at their first visit to the CFT must complete a "global evaluation form" which determines the needs of the client. Aissa Nauthoo, Legal Director of CFT says: "….we sit down during the intake and we go through the client's needs at the very beginning…this applies to all the caseworkers….the idea is to just take responsibility for all the needs of the client".[171] The global evaluation form explains to clients that CFT aims to improve their wellbeing by providing services in an interdisciplinary setting. The global evaluation determines the needs of the clients by asking questions about physical health, access to justice, primary health, mental health, employment, housing and personal security, social aspects (including isolation, status, etc) and child development.[172] Aissa Nauthoo stated that "the fact that we have all these programmes in place really makes our job much easier – much, much easier. Like I said we don't have to play the role of the social worker like many, many other legal clinics have to, we just concentrate on the legal aspects."[173]

Clients are given the option of signing a confidentiality waiver so that organisations within CFT can discuss the needs of the client in a multi-disciplinary context. Further, with the client's consent, the global evaluation form is then faxed to the relevant services throughout the building along with an internal referral form in order to bring about a more holistic model of care for clients. The referral form requests that the person to whom the referral is made contact the referrer within 30 days to provide feedback about the case. Aissa Nauthoo has said: "we strongly believe in … a holistic and comprehensive approach to providing services…we strongly believe that obtaining legal services are part of the social determinants of health".[174]

[170] Website of Centre Francophone de Toronto, <http://www.centrefranco.org/en/cft/centre-francophone-de-toronto/>
[171] Meeting with Aissa Nauthoo, Centre Francophone de Toronto, Toronto, Canada, 2 May 2014.
[172] Ibid. Note that the global evaluation form is in French and the list is the author's translation of the French form.
[173] Meeting with Aissa Nauthoo, Centre Francophone de Toronto, Toronto, Canada, 2 May 2014.
[174] Ibid.

2.4 REFERRAL PATHWAYS

In developing a multi-disciplinary model of service delivery, it is critical to establish clear and effective referral pathways to the on-site legal service. Further, the legal service must be clear as to who is responsible for making appointments, the method in which referrals can be made and whether only clinicians or other providers can make appointments or whether service users themselves can book in for legal assistance. Several different referral pathways are available including email, fax, phone calls or possibly even referrals through the electronic medical record. Ensuring the clarity of this process is fundamental to bringing about a successful partnership. Benfer highlights that the "referral systems designate how partners will: (1) introduce patients to MLP partners for assistance; and (2) communicate the health-related legal and social needs of patients to partners."[175] Associate Professor Sandel highlighted the importance of this process stating that "most physicians/clinicians operate in a busy environment so it's important to have ease of referrals".[176] Integrating the referral into the electronic medical record provides great visibility to the project, allows for data collection and therefore evaluation to be easier and it shows greater integration.[177] Ensuring seamless referrals allows the referral to the legal service to become a part of routine practice much like a referral to a specialist.

The referral pathway at MLP | Boston invites clinicians and allied healthcare staff from partner hospitals to call or email the MLP directly with a question or a potential referral.[178] Unison Health & Community Services in Toronto has tried a number of different referral pathways. It started by accepting email referrals and then moved to paper-based referrals, however, it has found that the optimal referral pathway is to allow clinicians or other service providers as well as clients themselves to book in automatically. If a client or another service provider calls or attends the legal service, they are automatically transferred to the legal receptionist who conducts an intake and books them in to the service.

At PBLO at SickKids in Toronto, a clinician (a social worker, nurse or doctor, or other allied healthcare professionals) is the intermediary that brings the patient to the attention of the lawyer, either by phone or in person. The patients cannot drop in to see the lawyer as there needs to be a process in place in order to ensure that the client is indeed a patient of the Hospital or a family member of a patient and that the legal issue is one that "has an impact that can be reasonably connected to the child's health or ability of the parents to care for the child".[179] As it is a free service there is also financial criteria (the cut off is approximately three times higher than provincial legal aid programs thereby ensuring access by low and moderate income families). The lawyer at SickKids is often asked to join meetings held between patients and their social workers and a referral is made during the course of the consultation. The majority of referrals come from the social work department. "Approximately 75%-80% of referrals come

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[175] Emily A Benfer, "Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education", *The Journal of Legal Medicine* (2014) 35(1) 113, 126.
[176] Meeting with Associate Professor Megan Sandel, Boston, Massachusetts, USA, 16 April 2014.
[177] Benfer, above n175, 126.
[178] Meeting with MLP | Boston, Boston, Massachusetts, USA, 16 April 2014.
[179] Focus Consultants, above n112, 37.

through social work", says Lee Ann Chapman, the on-site lawyer, "I really have to be available whenever…the patients may only be here for a day…or they may be outpatients and may only come for one day a month…90% of the time I don't have appointments ahead of time….it's about when it's convenient for the patients".[180]

Based on the model at the Hospital for SickKids, PBLO at Holland Bloorview Rehabilitation Hospital in Toronto has adopted a similar approach. The triage lawyer there frequently sits in on client interviews with social workers, thereby developing a rapport with the client. She then has an opportunity to discuss the issues in a consultation with the client. "It's very client-centred", says Hannah Lee, triage lawyer at Holland Bloorview Rehabilitation Hospital, "clients and families are involved in every step".[181] PBLO at Holland Bloorview Rehabilitation Hospital complements its on-site presence with information sessions to parents and clinicians. This raises the profile of the service, creates links with the patients and encourages referrals.[182]

Springfield Advice and Law Centre based at Springfield University Hospital in London is listed on the internal telephone directory at the Hospital thereby facilitating referrals which can be made by simply calling an extension. The referral pathway is reciprocal with the law centre referring cases back to the Hospital as well.[183]

Further, as mentioned above, the Community Advocacy & Legal Centre in Belleville, Canada aims to train "trusted intermediaries" in the community to facilitate referrals to the legal centre. "Intermediaries are a presence in local communities making early intervention more likely…working with intermediaries makes a holistic, integrated and 'joined up' approach more likely as paths to justice become less daunting, more usable and visible by people". [184] CALC provides training to encourage trusted intermediaries to 'spot or red flag' legal issues, understand the legal services available and to make appropriate referrals.[185]

The messaging and communication around the on-site service is also critical to opening up referral pathways. Associate Professor Sandel emphasised the importance of framing the discourse within a medical framework, suggesting code cards for legal referrals and considering developing a clinical practice guideline for the MLP, framing the MLP as quality improvement or incorporating clinical champions into the model.[186]

Further, raising visibility for the service within the partner organisation is critical. Several services advertise in the host organisation's newsletter. MLP | Boston sends out quarterly newsletters, including case studies with de-identified success stories, staff updates and other information that may influence referrals. The newsletters also include toolkits and fact sheets for hospital staff.

[180] Meeting with Lee Ann Chapman at PBLO at SickKids, Toronto, Canada, 29 May 2014.
[181] Meeting with Hannah Lee at Holland Bloorview Rehabilitation Hospital, Toronto, Canada, 25 April 2014.
[182] Meeting with Hannah Lee at Holland Bloorview Rehabilitation Hospital, Toronto, Canada, 25 April 2014.
[183] Meeting with Alan Clark, Springfield Law Centre, London, England, 14 May 2014.
[184] Meeting at the Community Advocacy & Legal Centre, Belleville, Canada, 23 April 2014. Powerpoint presentation by Community Advocacy & Legal Centre, "Expanding access to justice by partnering with trusted intermediaries".
[185] Ibid.
[186] Meeting with Associate Professor Megan Sandel, Boston, Massachusetts, USA, 16 April 2014.

MLP | Boston has also developed pocket-sized fact sheets for clinicians and allied health-care staff to keep in their pockets and refer to as necessary.[187]

At Unison Health & Community Services in Toronto, the legal centre is advertised in the welcome booklet that is provided to all new patients. The legal centre is also mentioned on the TV screens in the waiting areas throughout the service. Further, at each staff orientation, a representative from the legal service attends and explains the services that are available.[188]

CASE STUDY: COVENTRY LAW CENTRE[189]

With thirty-eight staff who assist 6000 clients each year, Coventry Law Centre is the largest law centre in the UK. Coventry Law Centre is co-located with an organisation aimed at addressing homelessness and assists clients in a broad range of areas of law.

The *Troubled Families Project* is one of several projects run by Coventry Law Centre, all of which are aimed at linking people in to advice services. Coventry City Council's Troubled Families team has been joined by a specialist advice worker from Coventry Law Centre. Anyone who receives a social service intervention from Coventry City Council's Troubled Families team is now automatically offered a referral to an advice worker from Coventry Law Centre, regardless of whether a legal need is identified. Clients are then given the option of attending the office of Coventry Law Centre or receiving a home visit whereby an advisor or paralegals from Coventry Law Centre provide them with information and advice. Clients are clearly told that anything they tell Coventry Law Centre is confidential unless they consent to the law centre communicating with the Troubled Families team and client consent is sought to discuss their matters with their social workers. The aim of the project is to try and look at the whole picture. "It's reasonably seamless for the client…" says Elayne Hill, a solicitor at Coventry Law Centre, "we are a bolt on service for [social services]…they don't give us that family's name without that family's consent…we go in because sometimes if we can solve somebody's debt problems, welfare benefits, their housing problems, that actually might take some of the tension out of the household. It's a new way of trying to assist a family rather than things being done in isolation…we're looking at potential legal issues…because some people may not know they've got legal needs. They may not know they're not on the right benefits, they may be ignoring all the debt collectors or they're overcrowded and they're entitled to a larger house."[190]

Coventry Law Centre has another project aimed at assisting undocumented migrants under the age of 30 link in with services. The project provides front-line legal assistance to clients and also provides training to other organisations, particularly healthcare providers in Coventry as to the entitlements of young, undocumented migrants and how to make a referral to Coventry Law

[187] Meeting with MLP | Boston, Boston, Massachusetts, USA, 16 April 2014.
[188] Meeting with Vinay Jain, Unison Health & Community Services, Toronto, Canada, 28 April 2014.
[189] Meeting at Coventry Law Centre, 7 May 2014.
[190] Meeting with Elayne Hill, Coventry Law Centre, Coventry, England, 7 May 2014.

Centre. Elayne Hill describes one client who was assisted by this project, "we had one young girl who was found sleeping near the railway with her 18 month old child. She was undocumented. Since becoming part of the project, she and her child have got regularised status and she has connected in with local services such as mums and toddlers groups…health professionals….[and]… housing providers…she's now living in a home, providing for her child and there's a support network around her…without the project, at some point she would have been picked up either by the police or social services, that child could have gone into social care….that one case alone…justifies the existence of the project and by having legal alongside [other services] we were able to say 'you can get recognised status' so actually we've kept that family together...none of the other [support services] would have been any good if she had been put on a plane and deported."[191]

Coventry Law Centre is also a member of Advice Services Coventry, a website which aims to ensure that people are referred to the appropriate service. This means that if a client walks in to any of the member organisations of Advice Services Coventry, a referral can be entered on the website and the client can be advised that the appropriate service will contact them. This programme aims to ensure that people do not fall through the gaps by being physically referred from one service to another. Instead, the referrals are facilitated through a website. Elayne Hill highlighted that it was set up because "people fall through the gaps then they just give up….it was a way of really making the client journey a little bit smoother and in theory they could walk into any advice agency in Coventry".

CASE STUDY: NOTTINGHAM LAW CENTRE'S GP PROJECT[192]

Nottingham Law Centre (**NLC**) recently ran a one-year pilot project with a consortium of local General Practitioners, enabling doctors with patients presenting with depression, anxiety and other health issues to refer to the NLC. Clients would be contacted within 48 hours of a referral being made and in the majority of cases, a generalist advisor from the NLC would provide a home-visit to the client to assist with their legal needs. If specialist assistance was required, clients would be referred back to a specialist adviser at the NLC. The project had several aims including the promotion of "patient self-care and management".[193]

An overview of the project explains that "it has been estimated that 15% of GP consultations involve welfare rights issues, and that in approximately 70% of these there is also a mental health element to the consultation"[194] and that "there is evidence that a general practice setting is an acceptable venue for the provision of welfare advice".[195] Further, the overview states that "the

[191] Ibid.
[192] Meeting with Nottingham Law Centre on 12 May 2014.
[193] ADP Consultancy, above n56.
[194] Nottingham Law Centre's GP Project Service Specification (on file with author, provided at site visit).
[195] Ibid.

confidential and non-stigmatising nature of General Practice are important features that promote access".[196]

Indeed, anecdotally, Cheryl Weston, the manager of NLC explained that they had noticed that many of the clients that were seen through this project would not otherwise have attended a legal service and some expressed that they did not know that a service such as NLC existed.[197] "Even after the first interview quite often there was a huge difference", explained Cheryl Weston from NLC, "people…say I feel so different, I feel as if I've been listened to, I feel as if I was turning into this angry person that I didn't like and for the first time I feel that somebody has recognised that it's a problem and is going to deal with it for me".

From the perspective of the GPs involved in the project, there was also a significant impact. Cheryl Weston explained that some of the GPs "…really connected with the fact that advice could make a difference and it might reduce the need for prescriptions, the need for appointments and it might help them in their work".[198] Cheryl Weston explained that it's necessary for people "….to see the link between advice and health and see that…having advice on welfare benefits and debt and housing can have a knock on benefit on somebody's health…it's getting them to see it as a referral pathway, as opposed to the traditional medical model of treatment, that there are socio-economic issues that can be tackled by someone here". Upon a case being closed, client consent is sought to write to the GP explaining the outcome of the case. Cheryl Weston, Manager of Nottingham Law Centre explained that "we round out the picture and it's not just left down to them thinking, 'I wonder what happened'… it's nice for the GPs to find out what happened at the end of the case".

[196] Ibid.
[197] Meeting with Cheryl Weston, Nottingham Law Centre, Nottingham, England, 12 May 2014.
[198] Meeting with Cheryl Weston, Nottingham Law Centre, Nottingham, England, 12 May 2014.

CASE STUDY: LEGAL AID ONTARIO, OTTAWA, CANADA[199]

Legal Aid Ontario recognised that many of their clients were experiencing a clustering of legal needs. The development of an integrated legal services office is a new approach to providing a more holistic level of service delivery. Recognising that people don't often turn to lawyers for legal advice, Legal Aid Ontario endeavours to reach out to the community and provide outreach services within Aboriginal Health Centres and other community agencies. Legal Aid Ontario also has a social worker on staff to provide services to its clients. Anne Scholberg, the Director of Integrated Legal Services at Legal Aid Ontario highlighted the importance of providing wrap around care: "someone might lose their housing because their child has gone into care for some time and then they can't get their child back because they've lost their housing. We try to help with related problems that can assist the client as a whole".

2.5 SECONDARY CONSULTATIONS AS A MEANS OF PRACTISING PREVENTATIVE LAW

> "MLP brings legal assistance to the client, rather than waiting for the client to seek help, often when it is too late. By training frontline clinicians to detect unmet legal needs that are impacting patients' health – no matter how severe – MLP promotes the early identification of legal needs and allows for timely preventive legal intervention".[200]

One of the aims of an integrated model of service delivery is for the on-site lawyer to become part of the care team and to be called upon to provide secondary consultations to colleagues in the health-sector. Secondary consultations include the provision of legal information by the legal service to the health-care providers. Whilst the health-care providers cannot provide legal advice to their patients, legal information may provide sufficient information to the patient to resolve the issue. One of the benefits of integrated service delivery is the opportunity to focus on preventative law and therefore by providing secondary consultations to colleagues in the health sector, the on-site lawyer can intervene in legal issues before they become larger issues that may require court intervention or a more adversarial approach. In order to provide a breadth of

[199] Meeting at Legal Aid Ontario, 24 April 2014
[200] Lawton et al, above n24.

secondary consultations, it is recommended that the on-site lawyer provide a generalist service and not limit the legal assistance provided to one area of law.

Several of the sites that were visited during the Fellowship provided secondary consultations to health professionals and other front-line service providers. MLP | Boston provides an example of a model of service delivery based on preventative law by emphasising the importance of secondary consultations. Samantha Morton, Executive Officer of MLP | Boston has stated that "in their most sophisticated iteration, medical-legal partnership programs even anticipate and avert patients' legal risks before they convert into legal and health crises".[201] "Preventing law theory invites consideration of whether MLP presents an opportunity for patients to have access to a 'primary care legal advocate' dedicated to primary prevention of health-harming legal problems". [202] A meeting with Megan Sandel, Associate Professor of Pediatrics at the Boston University School of Medicine and the Medical Director of the National Center for Medical-Legal Partnerships emphasised the importance of secondary consultations and likened the process to that between a general practitioner and a specialist. "A rapid response to a question from a clinician is very helpful. For example, if a doctor sees someone with a heart murmur, they page the on-call cardiologist and together they develop a plan on the phone and the doctor can assist the patient, having consulted with the cardiologist", explained A/Prof Sandel. In order for this process to work seamlessly, there must be a lawyer on-call and there needs to be an answer in "real-time".[203] This process also builds the capacity of front-line health professionals to identify legal needs with the hope that the health-professional will not need to call on the second or third occasion. The health professional will also be equipped to provide information to the patient and to explain that if the information does not resolve the legal issue, that patient should book in to see the on-site lawyer.

This model of preventative law is also practised by the Community Advocacy & Legal Centre (**CALC**) in Canada who has a lawyer available each day to provide secondary consultations to health professionals. "We try to bill it as preventative health-care", says Deirdre McDade, Acting Executive Director. CALC complements these secondary consultations by providing training to health professionals. The MLP for Children in Durham in North Carolina also places significant emphasis on secondary consultations or "curbside consultations", receiving calls from hospital or clinic staff who have queries relating to patients. The legal service at Centre Francophone de Toronto in Canada which is integrated with a number of other services receives phone calls from doctors and nurses "on a daily basis".[204] Further, Springfield Advice & Law Centre which is based at Springfield University Hospital in England receives daily queries from clinicians from the hospital.[205]

[201] Samantha Morton, "Child Advocacy: Good Medicine for Special Needs Kids" (August 2013), <learnnow.org>.
[202] Samantha Morton, "From Practice to Theory: Medical-Legal Partnership enters its Third Decade" (31 January 2013), <healthlawreporter.bbablogs.org>.
[203] Meeting with Associate Professor Megan Sandel, Boston, Massachusetts, USA, 16 April 2014.
[204] Meeting with Aissa Nauthoo, Centre Francophone de Toronto, Toronto, Canada, 2 May 2014.
[205] Meeting with Alan Clark, Springfield Advice & Law Centre, London, England, 14 May 2014.

West End Legal Services (**WELS**) in Ottawa, Canada is located near a community health centre. The legal clinic provides consultations about vulnerable clients to health/medical practitioners as well as social support and community agencies dealing with disability, housing and immigration issues. Training is also provided to medical and agency staff to recognise issues in these areas and refer them to the legal clinic for assistance. The referral process is mutually complementary in that if one agency cannot be of service a referral will be made to another service.[206]

PBLO at SickKids in Toronto, Canada also supports the provision of secondary consultations. On-site lawyer, Lee Ann Chapman explains: “about two-thirds of the consults…I never see the family. It will just be done through the social worker or other clinician because the family is out of town or the family has issues and it will be worked through the social worker and sometimes it doesn’t require them to see me…sometimes the family doesn’t want to see a lawyer…I’m enabling the clinicians to provide legal information”. Ms Chapman often provides secondary consultations to queries from clinicians enabling them to provide the legal information to the patient. In some cases, the patient may not want to see a lawyer because, for example, they may not have legal migration status in Canada and the thought of seeing a lawyer may scare them.[207]

Forty clinicians were surveyed as part of an external evaluation conducted at SickKids in Toronto, Canada. 75% of the respondents were social workers, 15% were nurses and 10% were doctors. 46% of clinicians estimated that their consultations with the on-site lawyer were conducted by telephone rather than in person. Further, social workers and nurses expressed “strong confidence (ratings of 6.1 and 6.0 respectively on a 7-point scale, where 1=not confident at all, 7=very confident) in their ability to identify that a family had a potential legal problem (doctors’ mean rating was 3.8)”.[208] 60% of clinicians felt that the on-site legal service was the first time that patients had identified their legal problems and sought assistance and a further 30% felt that this was sometimes the case.[209] Finally, “clinicians’ average rating of the degree to which the program helps reduce the stress of the child’s health problems on the family was 6.5 on a 7-point scale (where 1=hasn’t reduced the stress at all and 7=has reduced the stress a great deal)”.[210]

[206] Meeting at West End Legal Services, Ottawa, Canada, 24 April 2014.
[207] Meeting with Lee Ann Chapman, PBLO at SickKids, Toronto, Canada, 29 May 2014.
[208] Focus Consultants, above n112.
[209] Ibid.
[210] Ibid.

CASE STUDY: MLP | BOSTON, BOSTON, USA[211]

MLP | Boston is the founding site of the national medical-legal partnerships and has several medical partners, including Boston Children's Hospital, Boston Medical Center, Dana-Farber Cancer Institute, Good Samaritan Medical Center and Saint Anne's Hospital. It also partners with 20 law firms and in-house pro bono partners.

MLP | Boston aims to provide "direct, proactive legal assistance to low-income, medically vulnerable people across the age and disease continuum". It receives funding from a number of different sources. It employs an Executive Director, three full-time legal staff and a quality manager.

MLP | Boston has adopted a model which includes an attorney who liaises with health-care staff at Boston Children's Hospital who have identified a patient's possible legal need. The dedicated attorney trains the healthcare team members, responds to "legal triage" consults when clinicians believe a patient has a legal risk or problem, and connects some patients with free legal representation. The attorney spends one full day each week onsite at Boston Children's Hospital to reinforce her integration into the hospital. Her focus is to practice preventive law and she is available to answer questions in-person, by phone or by e-mail to staff at the Boston Children's Hospital thereby assisting her to identify and address legal needs amongst the patient population.

MLP | Boston considers an attendance with a lawyer as the "last port of call". They aim to up-skill front-line professional staff to assist with the issue. The on-site lawyer at Boston Medical Center sits in on weekly clinical case reviews and helps to identify legal issues.

"In 2013, MLP | Boston trained 455 front-line health care staff on how best to screen for and respond to patients' health-harming legal needs; responded to 476 "legal triage" consults from providers and staff on behalf of vulnerable patients; comprehensively evaluated the legal needs of 78 patient-families; facilitated provision of intensive legal advice and assistance to patients regarding 150 acute legal needs."[212]

CASE STUDY: CONNECTING OTTAWA, CANADA[213]

The Connecting Ottawa project is a three-year pilot project funded as an Access to Justice Initiative of the Law Foundation of Ontario.[214] Natalie Drolet, Lawyer at Connecting Ottawa highlights that the project "encourages a holistic approach for delivering access to justice and recognises that legal problems are often part of a larger constellation".[215] The project recognises the complexity of advice-seeking behaviour and aims to improve access to justice for people who are not proficient in English or French or who face communication challenges as the result of a

[211] Meeting at MLP | Boston, 16 April 2014.
[212] Medical-Legal Partnership | Boston: An Overview, April 2014.
[213] Meeting with Connecting Ottawa, 24 April 2014.
[214] Website of Connecting Ottawa, <www.connectingottawa.com>
[215] Meeting with Natalie Drolet, Connecting Ottawa, Ottawa, Canada, 24 April 2014.

disability or sensory impairment. The work of Connecting Ottawa is guided by the research of Karen Cohl and George Thomson who advocated for “a consortium of local legal and non-legal organisations and provincial bodies to develop strategies to improve linguistic access to information and services, working together as a coherent system within the region”.[216] Connecting Ottawa tries to improve the system through collaboration, by acting on the basis that “every door is the right door to services”.[217]

Connecting Ottawa operates out of a community centre and is staffed by a lawyer and a social worker who are available to consult with front-line workers in their forty-four partner organisations. If necessary, they are able to reach out for further assistance or referrals to one of their partner organisations which include community services, health centres, immigration services, interpretation and translation services, legal services and services for disabled persons. It is not intended that Connecting Ottawa provides front-line service delivery to clients. Connecting Ottawa has developed a pool of trained volunteer ‘facilitators’ who support clients with follow up. Connecting Ottawa also hosts public legal education courses for service providers and communities including an annual conference that advocates for resource sharing. Connecting Ottawa has also developed web resources to assist people to link in with legal services. Finally, Connecting Ottawa also provides subsidies to enable interpretation services.

2.6 RECIPROCAL TRAINING

Several legal centres in the USA, Canada and the UK provide training to health professionals to ensure that they are able to identify legal needs and to refer appropriately when legal needs arise. Benfer suggests that “the topics should be developed in conjunction with the needs of health service providers, thereby increasing the utility of presentations and communication between parties”.[218] Further, Benfer suggests that in order to promote teamwork and sustainability “health service providers participate in legal and/or social work case rounds, and legal partners participate in medical precepting to provide insight into the effects of a prospective client’s health condition”.[219]

Training is entrenched in the role of the on-site lawyer at PBLO at SickKids in Toronto, Canada. An external evaluation report relating to this MLP states that “the triage lawyer engages with hospital clinicians (social workers, nurses and doctors) through rounds to identify legal issues that impact patient health or a family’s capacity to manage their child’s care. The triage lawyer estimates that this comprises 20% of her activity.”[220] The on-site lawyer regularly attends teaching rounds, including grand rounds, primarily social work rounds and bioethics rounds. At the outset, the on-site lawyer used the opportunity of presenting at grand rounds to talk about

[216] For the research of Karen Cohl and George Thomson, see *Connecting across Language and Distance (2008)* http://www.lawfoundation.on.ca/wp-content/uploads/The-Connecting-Report.pdf.
[217] Website of Connecting Ottawa, <www.connectingottawa.com>, Meeting with Natalie Drolet, Connecting Ottawa, 24 April 2014.
[218] Benfer E, above n175, 130.
[219] Benfer E, above n175, 130.
[220] Focus Consultants, above n112, ix.

the on-site legal service that was available for patients. However, as the service is now well-integrated in to the hospital, the rounds are an opportunity to provide training and education on a variety of topics. Further, the on-site lawyer has addressed a Conference for the Paediatric Association of Ontario as the keynote speaker. The on-site lawyer also conducts rounds for all incoming medical residents and sits on several hospital committees. Often in collaboration with social workers, the on-site lawyer also provides workshops to patient families on relevant topics, including bullying and special education. These workshops often take place in the evenings and on weekends to maximise the number of participants. Pro bono partner lawyers have also offered their services to provide legal education sessions to patients on topics including taxation law, employment law, immigration law and family law. Further, the on-site lawyer ensures that social workers are kept abreast of legislative reform that may impact on their work by sending out three consecutive e-mails to all social workers. The first e-mail generally announces the legislative amendment including a hyperlink to the amendment. The second e-mail provides a summary of the amendment in dot-point form and the third e-mail is a reminder about the amendment, any new processes that need to be in place and the impacts of the amendment.

The legal team at Centre Francophone de Toronto (CFT) in Canada also assists clinicians by providing prompts to enable them to identify legal issues. CFT has a staff of approximately 100 who meet on a monthly basis. The legal team raises key legal issues at these meetings and if necessary, they hold workshops for teams.[221]

The CALC in Belleville, Canada runs a programme called *'Expanding access to justice by trusted intermediaries'.* Lawyers from CALC go out in to communities and train trusted intermediaries, including health and social welfare professionals encouraging them to "spot" or "red-flag" legal issues. "What we find in poverty law is that this is very important", explained Deirdre McDade, Acting Executive Director.[222] At Unison Health & Community Services in Canada, all new staff are required to attend an orientation to all the services provided on-site and this provides an opportunity for the legal team to provide information about their service as well as indicators of legal needs to consider.[223]

The HIV & AIDS Legal Clinic Ontario (HALCO) provides training to health care professionals throughout Ontario, including Public Health staff, nurses, HIV specialists and primary care physicians, who request it. Amy Wah, staff lawyer at HALCO explains, "our office has done some really good work reaching out to all the public health units in Ontario….We're always offering to give talks about our clinic and our services to any organisation in Ontario…..and often the medical professionals are interested in that…because…they are the first people to talk to the patient … about these life problems….it really is an important site of contact." [224] Further, the Springfield Advice & Law Centre in England provided feedback to the Royal College of Psychiatrists and Money Advice Trust on use of the Debt & Mental Health Evidence Form. Periodically, staff from

[221] Meeting with Aissa Nauthoo, Centre Francophone de Toronto, Toronto, Canada, 2 May 2014.
[222] Meeting with Deirdre McDade, Acting Executive Director, Community Advocacy & Legal Centre, Belleville, Canada, 23 April 2014.
[223] Meeting with Vinay Jain, Unison Health & Community Services, Toronto, Canada, 28 April 2014.
[224] Meeting with HIV & AIDS Legal Clinic Ontario at the Barbra Schliffer Commemorative Clinic, Toronto, Canada, 2 May 2014.

the Springfield Advice & Law Centre also talk to hospital staff to advertise their services and encourage the identification of legal issues.[225]

The Coventry Law Centre in England provides training to local General Practitioners on topics including the provision of relevant evidence in domestic violence cases. "…Unfortunately for patients or potential clients, it all depends who your GP is as to whether you're going to get the support or not. Because of course, domestic violence isn't just coming in with a broken arm, it's so many other things. It can be financial abuse, which can be traumatising. It's about helping doctors get to grips with that", explains Elayne Hill, Solicitor at Coventry Law Centre.[226] Further, recognising that changes are often made to social welfare laws, Coventry Law Centre aims to keep local agencies abreast of these developments. Coventry Law Centre has set up a legal advice hotline and provided several training sessions to agencies about the circumstances in which it is legal to cut welfare benefits to an individual.

MLP | Boston in the USA also provides several training sessions to partner organisations. These sessions include assisting front-line service providers to identify legal needs as well as sessions on legal topics of relevance to providers, such as writing letters in support of legal matters.[227] Training can also be complemented by the creation of forms or pro forma letters for front-line staff. For example, MLP | Boston has developed a form letter for use by physicians when chronically ill patients receive letters threatening utilities shut off.

Community Links in London, England has developed a model of training "advice champions". Lawyers from Community Links provide training at local organisations relating to the identification and assistance of clients who are experiencing debt issues. This includes training about basic money advice, welfare reform and social welfare benefits. Advice champions then assist clients to navigate the system and provide information and referrals as appropriate.

The Journal of Legal Medicine profiles the HeLP Medical-Legal Partnership in Atlanta, Georgia outlining that "in 2010 alone, HeLP provided 400 continuing education units to social workers within the children's system".[228] These sessions are "intended to target socioeconomic barriers that affect health and to educate the audience about the broad array of poverty-based legal issues referred to HeLP".[229] This form of training enables health-care providers to identify legal issues and to refer accordingly.

Further, multi-disciplinary training is also provided at the Barbra Schlifer Commemorative Clinic in Toronto where the Director of Counselling conducts training for lawyers and law students to ensure that they have an understanding of how trauma can affect the interaction of a client with their legal team.[230]

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[225] Meeting with Alan Clark, Springfield Law Centre, London, England, 14 May 2014.
[226] Meeting with Elayne Hill, Coventry Law Centre, Coventry, England, 7 May 2014.
[227] Meeting with MLP | Boston, Boston, Massachusetts, USA, 16 April 2014.
[228] Pettignano et al, above n114, 72.
[229] Ibid.
[230] Meeting at the Barbra Schlifer Commemorative Clinic, Toronto, Canada, 2 May 2014.

CASE STUDY: RIGHTS OF WOMEN, LONDON, ENGLAND[231]

Rights of Women is a charity organisation in the UK which works towards attaining "justice and equality by informing, educating and empowering women on their legal rights".[232] Established in the 1970s, Rights of Women complements legal advice and information with training courses, seminars, workshops and conferences. Emma Scott, Director explained that "up-skilling professionals is key to our work".[233] Recently, Rights of Women has developed a project aimed at assisting women who are migrants or asylum seekers to the UK by increasing the capacity of front-line service providers to give information relating to migration law. With legal aid funding reduced for cases relating to migration law, Rights of Women hopes that by providing training and technical support to independent domestic violence advocates, independent sexual violence advocates, women's organisation workers, refugee workers and crisis workers, more women will be made aware of their rights and entitlements in relation to migration law.[234]

2.7 ENGAGING STUDENTS TO MAXIMISE IMPACT

Many examples of legal services integrated into healthcare settings engage university students to maximise the impact of service delivery whilst at the same time training future service providers. During the Fellowship, several examples of students participating in the provision of services under supervision were observed and the observations were not limited to student clinics that had established partnerships with MLPs.

Tyler et al highlight that "inter-professional MLP education in which medical students learn alongside law students and are taught by lawyers offers a unique opportunity to not only develop medical students' understanding of how unmet legal needs are, themselves, social determinants of health but also provides a rich training ground to practice inter-professional, team-based problem solving".[235] Across the US, there are several courses which combine law students and medical students as part of the MLP model.[236] Several of these clinics focus on a specific legal topic to enable the students to learn a discrete area, such as threats to shut off utility services.[237]

In the USA, there are twenty-six medical schools associated with MLPs.[238] Further, according to Tyler et al, "in addition to medical schools offering MLP-focused curricula, some have begun experimenting with ways to offer medical students experiential learning opportunities, working on-site at MLPs through clerkship and clinical rotations…most typically, these have been designed in conjunction with an MLP law school clinical program…[and] provide an excellent

[231] Meeting at Rights of Women, 14 May 2014.
[232] Rights of Women, <http://www.rightsofwomen.org.uk/>
[233] Meeting with Emma Scott, Rights of Women, London, England, 14 May 2014.
[234] Ibid.
[235] Elizabeth Tobin Tyler, Lauren Taylor Anderson, Leah Rappaport, Anuj Kumar Shah, Deborah Edberg and Edward G Paul, "Medical-Legal Partnership in Medical Education: Pathways and Opportunities" (2014) 35(1), *The Journal of legal Medicine* 149, 163.
[236] Meeting with Associate Professor Megan Sandel, Boston, Massachusetts, USA, 16 April 2014.
[237] Ibid.
[238] Tyler et al. above n235, 164.

opportunity to train law and medical students together in the MLP model".[239] The aim of these programmes is not to provide medical students with an extensive understanding of the law, but rather to allow medical students to understand the role that the law plays in the lives of their patient.[240]

The HeLP clinic in Georgia, USA, profiled in the Journal of Legal Medicine, serves as "a hub for interprofessional education in Atlanta".[241] Pediatric residents from Emory School of Medicine attend the HeLP clinic case rounds and physicians seeking a masters degree in bioethics from Emory University also attend the HeLP Clinic which serves as a practicum placement for them.[242] Benfer highlights that "the most successful MLPs have the support and investment of the university graduate school leadership, and development offices. These MLPs have dedicated faculty – in full-time, salaried positions – administering and teaching in the MLP".[243] Further, the Health Justice Project in the USA, founded by Professor Benfer is a Medical-Legal Partnership clinic between Loyola University Chicago School of Law and Erie Family Health Center. Students of law, social work, public health and medicine enrol to participate in this clinic.[244] "Between January of 2010 and April of 2013, 106 students of law, medicine, social work and public health participated in the Health Justice Project. These students collaborated with diverse partners to address the health-related legal and social issues for more than 120 patients. As a result, students obtained more than $600,000 in medical debt forgiveness for patients and $550,000 in Medicaid reimbursement to Erie Family Health Center. Under the supervision of attorneys, students worked on 149 disability related cases and appealed improper disability benefit denials by the Social Security Administration, resulting in a 100% success rate in all cases with an appealable issue and nearly $200,000 in disability benefits. Students also worked on 205 housing cases".[245]

At PBLO at SickKids in Toronto, Canada supervised by the on-site lawyer, pro bono law students have worked at clinics for patient families to assist them to fill out documents, including drug benefits, and social welfare applications.[246] In Durham, North Carolina in the USA as part of their formal training, paediatric residents at Duke Medical School engage in a "Community Paediatrics and Advocacy" rotation that includes the MLP for Children. By undertaking this rotation, they are provided an opportunity to learn about community issues that relate to paediatric practice. A part of this rotation includes training by the two legal partners in the MLP, Legal Aid North Carolina and Duke Children's Law Clinic, about the MLP that they operate in Durham and about key legal issues that arise in this context.[247]

[239] Ibid 165.
[240] Ibid 167.
[241] Pettignano et al, above n114, 70.
[242] Ibid.
[243] Benfer E, above n175, 124.
[244] Website of Loyola University Chicago, <http://luc.edu/law/centers/healthlaw/hjp/index.html>
[245] Ibid, 147.
[246] Meeting with Lee Ann Chapman at PBLO at SickKids, 29 May 2014, Toronto, Canada.
[247] Meeting with stakeholders from the MLP in Durham, North Carolina, 14 April 2014.

Shade Tree Clinic in Tennessee in the USA is a free health-care clinic which has been run by students of Vanderbilt University since 2004.[248] It recently partnered with the Legal Aid Society to offer the clinic's patients free legal services. Its website quotes second-year medical student and the student medical director of the clinic "at first, we identified potential legal issues and referred them to the Legal Aid Society. It quickly became clear that we needed to enhance our partnership and bring the legal services into the clinic. Now, we are truly partners in providing health care."[249] An attorney attends the clinic on a regular basis and provides advice to patients.[250] Further, the attorney works closely with Vanderbilt law students.[251] Legal Aid society attorney and legal director of the MLP Chay Sengkhounmany stated, "Vanderbilt University medical students, social work and law students all work together to identify and evaluate medical and legal issues, and these students deserve a lot of credit for helping to make this an especially valuable partnership…they understand that this partnership is not just about making referrals to Legal Aid Society. They have made legal assistance not only a part of the services provided to their patients, but also a part of their training."[252]

CASE STUDY: MLP FOR CHILDREN, DURHAM, NORTH CAROLINA, USA[253]

Legal Aid of North Carolina, in partnership with other legal service providers and their health counterparts across the State are working to improve access to justice for low-income and at-risk patients in North Carolina. Legal Aid of North Carolina (**LANC**) has established an innovative, state-wide, MLP program that provides training to staff at several health centres and hospitals and includes an expedited referral protocol, on-site presence of legal staff, and the capacity for legal staff to meet with MLP patient/clients in a variety of community settings. In several locations, MLPs in LANC's network also include other legal partners.

In Durham, North Carolina, Duke Children's Law Clinic run out of Duke Law School, also takes referrals from the MLP in discrete areas of law. Under supervision, law students are allocated these files, their work giving them credit towards their degree.

The files that are referred to Duke University Law School form part of the Children's Law Clinic at the Law School. In return for undertaking 125 hours of clinic work per semester, students receive course credit. The course is run by Professor Jane Wettach, Professor of Law as well as a part-time lawyer and accommodates approximately 10 students per semester. The students have carriage of files, which includes taking instructions and giving advice under supervision. The law school at Duke University has been purpose-built with video cameras in interview rooms so that supervising lawyers can observe the students giving advice and intervene, as and when necessary. The law clinic has carriage of approximately 30 cases at any one time and students

[248] Website of the Shade Tree Clinic, <https://shadetreeclinic.org/index.php>
[249] Website of the Shade Tree Clinic, "Press Release: Legal Aid Society brings legal assistance to patients at Vanderbilt's free medical clinic" (July 2012) <https://shadetreeclinic.org/index.php>.
[250] Ibid.
[251] Ibid.
[252] Ibid.
[253] Meeting with MLP for Children, Durham, North Carolina on 14 April 2014.

are required to work approximately 10-12 hours per week on their files. The course focuses on cases that benefit the well-being of children, particularly special education, school discipline and supplemental security income cases. The MLP for children in Durham is one source of referrals to the clinic.

CASE STUDY: UNIVERSITY OF EAST ANGLIA LAW CLINIC AND NORFOLK COMMUNITY LAW SERVICE, NORWICH, ENGLAND[254]

Earlham Hall, a 16th century manor house which houses the University of East Anglia Law School (credits: www.uea.ac.uk).

The University of East Anglia (**UEA**) Law School in Norwich seeks to provide law students with a range of practical legal skills by giving them the opportunity to volunteer for a range of organisations throughout Norwich. Of 600 law students, 175 of them are involved in the legal education programme. In the 2012/2013 year, 1,081 pro bono hours were logged by students and 89% of students rated the programme as positive overall.

Awarded the LawWorks "Best Partnership in Pro Bono award" in June 2014, UEA Law Clinic has developed a partnership with the local community legal centre, Norfolk Community Law Service (**NCLS**) which enables law students to volunteer at NCLS and gain valuable skills. Gareth Thomas, Director of Clinical Legal Education at the University of East Anglia's Law School explained that "it's a win-win for everyone. The community legal centre gets the support of students as well as funding, the law school gets a clinical programme and the students get practical experience".[255] NCLS receives a minimum of 35 students per annum and the students must be in second year or higher.

Law students are allocated to teams within the law centre with one student being appointed team leader. One of the student teams focuses on family violence and has developed a partnership with domestic abuse charity, Leeway. Independent Domestic Violence Advocates (IDVAs) from Leeway provide placements for students at court hearings.

[254] Meeting at University of East Anglia Law Clinic, Norwich, England, 9 May 2014.
[255] Ibid.

The referral pathway for clients to access NCLS for legal issues related to family violence is often through Leeway's on-site presence at two local hospitals. Leeway places IDVAs full-time on-site at two local hospitals. The IDVAs provide assistance and support to victims/survivors of family violence and when legal issues arise, they make a referral to NCLS. These clients are then assisted by a team at NCLS which includes a law student, a lawyer, a housing worker and a support worker.

Some of the students at NCLS are also asked to provide legal education to high school students about their rights and responsibilities. "There's a very high proportion of kids in Norwich who leave school at age 16", explained Gareth Thomas, "so in addition to legal education, the students are also encouraged to talk about how much fun it is to be a student." [256]

CASE STUDY: UNIVERSITY OF OTTAWA LAW CLINIC, CANADA[257]

Established forty years ago, the University of Ottawa Law Clinic, funded by Legal Aid Ontario and the Faculty of Law of the University of Ottawa, is a community legal clinic which operates on the grounds of the University. The clinic employs four lawyers who are funded to train students and to serve low-income clients. Fifty students rotate through the clinic each academic year, receiving credit towards their degree for their work at the Clinic. From September until April, the students attend the clinic on a part-time basis and during the Summer semester, the students are there on a full-time basis. Students have carriage of the client files and the main role of the lawyer is to meet with students on a weekly basis to discuss the files and their strategic direction. The students take instructions from clients and advise clients that they will return to them within 48 hours with advice. The students then prepare a prospective advice memo which they discuss with one of the staff lawyers prior to the student then providing the advice to the client. After the initial meeting with the client, the students are responsible for all tasks, from drafting demand letters and pleadings to conducting trials During the Summer semester, each student has carriage of 10-15 files and the summer students stay on during semester to provide a mentoring role to the next round of students.

The lawyers also provide practical training to students on topics including legal drafting, interviewing, oral advocacy and file management. A psychologist attends the clinic and provides training to the students about mental health. Further, the students themselves go out in to the community and provide approximately 100 community legal education sessions per year at a range of different community organisations.

Louise Toone, Executive Director, explained that "the students can take more time with the clients so they feel that they're being listened to. The lawyer-client relationship is able to develop and that's probably the best thing about the work done by students. The students love it. It`s a great opportunity for them to get hands-on experience. Many tell us it's their best course. We

[256] Meeting at University of East Anglia Law Clinic, Norwich, England, 9 May 2014.
[257] Meeting at University of Ottawa Law Clinic, Ottawa, Canada, 24 April 2014.

do surveys of the clients on a regular basis and they're always overwhelmingly positive and [they make] comments like: 'you're going to be a great lawyer'..."[258]

2.8 ENGAGING PRO BONO SUPPORT FROM LAW FIRMS

If an organisation is in the fortunate position to receive the provision of pro bono support from law firms, this is an effective way to maximise the scope and impact of multi-disciplinary work. By engaging with a broad spectrum of pro bono support, it is possible to see more clients and to broaden the areas of practice in which clients are assisted. There are several creative ways to maximise the scope of pro bono support available to integrated legal service delivery.

PBLO at SickKids in Toronto, Canada engages a number of pro bono lawyers to assist with their work. On-site lawyer, Lee Ann Chapman has said "the engagement from pro bono firms has been tremendous …. pro bono has allowed us to do virtually anything that's not a conflict with the hospital…." When pro bono assistance is required, upon determining that there is no conflict of interest, the on-site lawyer sends out a basic fact scenario to two or more firms. The firm that is able to take on the case then receives a more detailed fact scenario. Meetings between clients and pro bono lawyers take place either at the hospital or at the law firm. "The results have been terrific", says Lee Ann Chapman "I have not yet had a case for which I couldn't find a pro bono lawyer". [259] The amount of time that pro bono lawyers provide to SickKids varies on a case-by-case basis.

Lee Ann Chapman provided several successful examples of pro bono involvement.

> "We had a lawyer who spent well over 150 hours on a case where provincial health-care had refused funding for oncology services for a very specific cell transplant that was only available at a New York Hospital….this was the last hope for this child who had recurring cancer….the provincial health team wouldn't fund it because it was experimental….the lawyer worked very closely with the oncologist … they won which was fantastic for both the child and the family who would have been financially devastated without the help of the lawyer…"[260]

> "We had a mother where the father had attempted to murder her. When he was released from prison he had a no contact order….but nevertheless he fraudulently claimed her and the children as dependents for tax purposes and she suddenly got a bill for $10,000 from Revenue Canada …. This totally impacted her ability to care for her child financially and emotionally…one of our pro bono partner tax lawyers met with her in the Hospital....she was extremely compassionate. These two had this amazing connection that continued on….she would send her children

[258] Ibid.
[259] Meeting at PBLO at SickKids, Toronto, Canada.
[260] Ibid.

> clothes…wonderful personal experiences can result for the family and the pro bono lawyer as a result of the connections." [261]

PBLO at Holland Bloorview Rehabilitation Hospital also in Toronto, Canada is based on a similar model to that at the Hospital for SickKids. The on-site lawyer resolves most cases on the spot through the provision of legal information, advice or referrals however for more complex cases, referrals are made to pro bono lawyers. On-site lawyer, Hannah Lee explained that the Project aims to "bridge the justice gap….Gowlings and Bellissimo Law Group provide pro bono legal services that are invaluable in bridging this gap. The response has been overwhelmingly positive …. it is a win-win situation for families and lawyers with both expressing deep appreciation for having participated in this program".

The Massachusetts Bar Association and the Medical-Legal Partnership Massachusetts network in the USA have created the "MBA Pro Bono Prescription". This initiative joins pro bono lawyers and doctors to "promote the health and well-being of low-income patients through legal advocacy".[262] Further, MLP | Boston has a well-refined practice of engagement with pro bono lawyers. Lawyers at MLP | Boston are often supported by pro bono lawyers who take carriage of files and assist the lawyers with their files. MLP | Boston has also engaged "pro bono consultants" to assist in their pro bono work. These consultants are leaders in the areas of housing law, education law, disability law and immigration law. When a referral is made to a pro bono partner, the lawyer from MLP | Boston prepares a memo for a lawyer including a summary of the case as well as the name and contact number of the relevant consultant. The pro bono lawyer can contact the consultant for advice and assistance, as and when necessary.

An initiative called "count me in" through the local Durham County Bar Association has helped Legal Aid North Carolina in the USA develop several unique models for engaging pro bono lawyers. For example, Legal Aid North Carolina offers a two-day training course relating to family law which private lawyers can attend at a subsidised rate, receiving credit towards their continuing professional education requirements. They have also implemented the "adopt-a-day" model in which pro bono lawyers run a clinic and cases that come through that clinic are then "adopted" by the volunteer lawyers and their respective firms. Once a month, family lawyers run a clinic at Legal Aid North Carolina to assist those who want to file for a divorce. Approximately 60 participants attend the clinic each month. While these pro bono outreach efforts are not particularly targeted to assist patients referred through Legal Aid of North Carolina's Medical-Legal Partnership program, they offer an important resource that expands the capacity of LANC's local office staff to address the needs of their community. [263]

Community Links in London, England receives 35% of its funding from corporate support. It also receives significant pro bono assistance from lawyers with pro bono lawyers running a free employment law service and another firm running a welfare benefits service.

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[261] Ibid.
[262] Website of the Massachusetts Bar Association, http://www.massbar.org/for-the-public/public-information/mba-pro-bono-prescription,
[263] Meeting with stakeholders from the MLP in Durham, North Carolina, USA, 14 April 2014.

The Journal of Legal Medicine also profiles the HeLP MLP's robust pro bono practice in Atlanta, Georgia, USA. Whilst the majority of patients are assisted by HeLP attorneys, if the client has a legal issue beyond the scope of the issues handled by HeLP or their geographic location is a barrier, cases are referred to volunteer attorneys or other appropriate community legal resources.[264] "Many volunteer attorneys use the hospital-based HeLP offices to meet with clients. In 2012, 44 cases were handled by volunteers". [265] Further, HeLP staff inform the State Bar of Georgia of the amount of pro bono work provided and this work is registered, with the individual practitioner receiving a certificate. Further, if a lawyer takes three cases or more in a calendar year, they receive a voucher valued at $150 which goes towards continuing legal education.[266]

2.9 ADDRESSING SYSTEMIC ISSUES

Throughout the course of the Fellowship, it became apparent that multi-disciplinary practice provides a valuable opportunity to identify and address systemic legal issues that may be impacting communities and that may not have been identified in the absence of an integrated model of service delivery. Benfer states that "the development of policy to address the root causes of poor health among patients is a crucial component of any MLP. Because effective policy is preventative in nature and involves the input of multiple disciplines, it is an ideal complement to the interprofessional and wide-reaching nature of an MLP".[267] This is further reiterated by Lawton, et al who state that:

> "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".[268]

Each week at MLP | Boston in the USA, the three attorneys meet to discuss systemic issues or trends that have arisen in referrals that week. For example, there was increasing recognition at MLP | Boston that many patients were having their utilities shut off. To remedy this trend, attorneys trained healthcare providers as to how to screen at-risk patients and write protection letters to prevent their utilities being switched off. Health care providers subsequently wrote letters protecting 193 families. Following this, attorneys opened a new legal clinic at the hospital to assist those families

[264] Pettignano et al, above n114, 65.
[265] Ibid.
[266] Ibid.
[267] Benfer E, above n175, 144.
[268] Lawton E et al, above n24, 76.

who were referred for advice if their utilities were shut off. Subsequently, the MLP was able to create 350% more letters helping 676 families. This not only broadened the scope of assistance but also saved clinic time.[269]

Further, at PBLO at SickKids in Toronto, equally important to the individual cases are the systemic issues that arise. On-site lawyer Lee Ann Chapman explains, "We've had a couple of test cases come out of the programme with results that impact the broader population, along with our individual representation, systemic advocacy has been incredibly important. It's a huge part of what we do now." PBLO at SickKids developed the "Systemic Issues Working Group" at the hospital early on when they realised there were many legal issues impacting multiple patient families. The group commenced by meeting on an ad-hoc basis and then began to meet on a monthly basis. The group includes social workers, nurses, doctors, fellows and residents, some external lawyers, and members of the office of the Provincial Advocate for Children and Youth. The Group has written letters to Ministers seeking reform and prepared formal submissions to Government. Broad-based advocacy through the Systemic Issues Working Group is estimated to be approximately 20% of the on-site lawyer's time. The onsite Advocacy Committee is now headed by SickKids' own Advocacy and Policy Director. However, there is also an off-site systemic working group which meets quarterly with representatives from the other Children's Hospital projects. The Committee's advocacy work "is directed at overarching issues, laws, policies and structures that impact the children and families whom she services."[270]

On-site lawyer Lee Ann Chapman explained:

> "Sometimes it is a question of making submissions on proposed legislation, or pointing out policies that negatively impact our patient population. However, where we think there's something that needs to be challenged in the courts; we put out a call to see if we can find a lawyer who can run a test case. One example of successful systemic advocacy was a policy that did not allow students to attend school in the hospital while maintaining a place in their home school. For students on dialysis or receiving chemotherapy for example, it meant that they had to

[269] "MLP | Boston Patients-to-Policy story" (Presentation by the National Center for Medical-Legal partnership and the Milken Institute School of Public Health at the George Washington University), 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform, 10-11 April 2014 (Seattle, USA)
[270] Focus Consultants, above n112.

choose to attend school in the Hospital 2 or 3 days a week or their home school the other 2 days. We challenged this as discriminatory and the policy was changed so they had the same access to full time education as other students. On days when they are in the hospital receiving treatment they can attend school and when they are at home and feel well enough they can attend their home school. It was not only important to help them maintain academic standards, but it also allowed for as normal as possible social contacts".

A whole-of-hospital approach is adopted at PBLO at SickKids to address systemic issues. Lee-Ann Chapman, on-site lawyer highlighted the importance of this hospital-wide approach, stating:

> "Every 5 years, the government is mandated to review the *Child and Family Services Act* which is the child welfare law … and I asked for submissions from across the hospital…. I invited people to come to a meeting to talk about the legislation and the policies….People had terrific ideas about the shortfalls, the gaps in child welfare law and so we made submissions to the child welfare review and several of the submissions that we made were adopted and it was clear that we had an impact....it's very rewarding when you can see that difference proactive collaboration can make on changing the way we provide services to children.[271]

The Centre Francophone de Toronto (CFT), Canada also addresses systemic issues that arise. Following legislative changes affecting access to healthcare for refugee claimants, the legal service at the CFT prepared a simple step-by-step document to demystify the process for health professionals. Further, all patients who were refugee claimants and who were referred to a medical specialist were provided with a copy of the document to provide to their specialists. This meant that the legislative amendment was more broadly understood and patients were provided the best possible opportunity to receive healthcare. The Fellowship highlighted that this model of service delivery has the scope to bring about broader, systemic change.

2.10 RETURN ON INVESTMENT

Whilst there is undoubtedly a significant social return on investment from integrating legal services into a healthcare setting, there may also be a significant financial return on investment. In Camden, New Jersey, one percent of patients account for a third of the city's medical costs. [272] If even a fraction of the reason for this intensive use of the medical system is caused by underlying social determinants of health, arguably legal intervention has a role to play in reducing this cost. In an Australian setting, a recent study shows that community legal centres have a cost benefit ratio of 1:18 signifying a benefit to society that is eighteen times the cost.[273] The integration of legal services into health-care settings offers the potential for community legal

[271] Meeting at PBLO at SickKids, Toronto, Canada, 29 May 2014.
[272] Atul Gawande, "The Hot Spotters: Can we Lower Medical Costs by Giving the Neediest Patients Better Care", *The New Yorker* (24 January 2011).
[273] Stubbs J & Associates, "Economic Cost Benefit Analysis of Community Legal Centres" (June 2012).

centres to increase the scope of service provision on a larger scale whilst retaining the relatively flexible structure of a community legal centre and therefore to provide a significant financial return on investment.

In the USA, the financial return on investment of MLPs has been significant. Whilst the *Affordable Care Act* in the USA will increase the number of Americans who have health coverage, the lack of universal health coverage means that the financial return on investment for MLPs in the USA cannot be immediately translated to other jurisdictions which do have universal health care. Nonetheless, the significance of the financial return on investment in the USA shows the merit of integration. "For example the city of New York's MLP, LegalHealth, demonstrates improved patient satisfaction and an ROI [return on investment] to the healthcare institution of three dollars for every dollar invested into the MLP."[274] Further, "in the ten years since its inception, more than 2,141 cases have been referred to the Medical Legal Partnership of Southern Illinois (MLPSI)."[275] MLPSI has demonstrated a significant financial return on investment. "…approximately $6 million in patient medical debt has been relieved, and SIH (South Illinois Healthcare) has been reimbursed about $1.3 million for services rendered due to MLPSI efforts. The estimated return on investment directly to SIH is greater than 200% and the overall social return on investment exceeded 1100%."[276]

Further, it has been shown that "for every $1 North Carolina spends on legal services, nearly $10 flows into the economy."[277] A report outlining the financial return on investment of Civil Legal Services in North Carolina in 2012 outlines the following:

> "A study from the Centers for Disease Control and Prevention found that women who were the victims of physical assault in the past 12 months experienced an average of 3.4 separate assaults. Victims were injured in 41.5% of assaults, and 28.1% of those received some form of medical care. On average, the cost of medical and mental health services per physical assault was $816 when the study was authored in 2003, a cost of more than $1,000 dollars today. In addition to the productivity loss of victims, other potential costs include the cost of sheltering victims and families and the use of police and law enforcement resources in response to continued violence. If legal representation prevents one assault in half of the cases where domestic violence protective orders were obtained, the annual savings from the prevention of domestic violence by calculating the avoided medical costs alone is $1,004,963.44."[278]

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[274] Atkins et al, above n12, 200-201.
[275] Teufel et al, above n33, 105, footnote 129.
[276] Ibid.
[277] M Irvine "A 108% Return on Investment: The economic impact to the State of North Carolina of Civil Legal Services in 2012" (Center for Poverty, Work and Opportunity and NC Equal Access to Justice Commission, January 2014).
[278] Ibid.

Further, there are several examples of Citizens Advice Bureaux (**CABx**) co-located with GP practices in the UK. The Low Commission Report finds that funding for the provision of CABx in England has come from either the public health part of the NHS Primary Care Trust budget or from the core NHS Primary Care Trust budget. "Relatively few GP practices have funded provision from their GP commissioning budgets, but GPs have agreed to advice workers being based in their surgeries and have usually provided accommodation for the service free of charge. Despite some GPs' initial ambivalence about doing this, those who have the service value it highly and view their advice service as integral to the work of the primary healthcare team."[279] The Low Commission Report highlights the positive impact of CABx, highlighting that "an average of 25 per cent of patients using primary care services have had their income increased through the advice they have been given…the CABx in GP surgeries are reaching a new and, in the main, more deprived audience".[280]

Provision of integrated advice or legal services in a mental health setting also has the capacity to achieve both a social and a financial return on investment for patients experiencing mental illness. Parsonage highlights the work of the Sheffield Mental Health Citizens Advice Bureau which is based on the grounds of a hospital and supports approximately 600 people per annum with severe mental illness. The average cost of advice is approximately £260 per client compared to the national average cost of psychiatric hospital inpatient care which is around £330 per day.[281] Over half of the patients live in the community and the remainder are inpatients. Parsonage argues that the high costs of mental health "imply that interventions that reduce the severity of illness or prevent its deterioration may be able to generate significant savings. However, one clear conclusion from the analysis to date is that only a small number of successful interventions are needed for an advice service to generate sufficient savings to be good value for money – this is because the costs of severe mental illness are so high relative to the costs of the advice."[282] Parsonage states that "because the costs of advice are very low relative to the costs of health and social care for people with severe mental illness, only small savings in proportionate terms are needed for an advice service to represent good value for money".[283]

As argued by Atkins et al, "the MLP model not only transforms the way in which poverty law services are conceptualised but can also expand the types of funding sources…through partnership with a healthcare entity or health-related social-service organisation, poverty law providers can expand their service capacity, redefine the value of their work, and increase the likelihood of sustainability".[284]

[279] The Low Commission, above n38, Annex 13, 7.
[280] Ibid.
[281] Parsonage M, above n65, 27.
[282] Ibid.
[283] Ibid.
[284] Atkins et al, above n12, 207.

It is therefore important to note that several examples of integrated legal service delivery seek funding from the health-care providers in which the legal service is based. For example, in order for a healthcare institution to partner with MLP | Boston, it must:[285]

1. "commit to a financial contribution;
2. make the following resources/infrastructure available:
    - Designation of in-kind healthcare team directors (e.g. physician, nurse, social worker)
    - Access to interpreter, translation, social work, domestic violence and IT support services
    - Private space for on-site MLP activities (e.g. intake interviews, trainings) with necessary IT features
    - Periodic integration of other key leadership (QI, communications, development) in project"

2.11 THE IMPORTANCE OF EVALUATION

"In health-care, data is king. If you can't measure it, it doesn't exist".[286] Lawrence, et al highlight that:

> "What is unique to the MLP model is the fusion of the medical and legal disciplines, among others. These disciplines have distinct approaches to research and evaluation and have traditionally asked different questions about impact. For example, lawyers tend to focus on the outcome of a legal case, whereas healthcare providers tend to focus on improved health in an individual patient or patient population."

It is beyond the scope of this report to consider evaluation metrics and evaluation methodologies. However, the importance of evaluating the integration of legal assistance into a health-care setting cannot be understated and the institution of a robust evaluation which evaluates the health impacts of legal intervention is one of the recommendations of this report. Common evaluation metrics are in the process of being developed by the National Center for Medical-Legal Partnership in the USA and there is a comprehensive literature review on the website of the National Center for Medical-Legal Partnership.[287] Although there are several robust examples of evaluations conducted on MLPs and other models of multidisciplinary practice, this report adopts the views of Atkins et al insofar as they state the need for "longitudinal data showing the impact of MLP services over time on factors such as health, birth

[285] "B23: Developing best in-class MLPs through population-based learning networks", 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform, 10-11 April 2014 (Seattle, USA).
[286] Presentation by The Advisory Board Company, "Develop a best in class Medical-Legal Partnership: Strategies for Optimising Pediatric-Based MLP Models", 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform, 10-11 April 2014 (Seattle, USA).
[287] Website of the National Center for Medical-Legal Partnership, <http://medical-legalpartnership.org/>

outcomes, mortality, emergency room utilisation, treatment compliance and absenteeism to provide even more compelling evidence on MLP efficacy."[288]

[288] Atkins et al, above n12, 208.

CHAPTER 3

THINKING CREATIVELY WHILST STAYING WITHIN THE SQUARE:

OVERCOMING THE ETHICAL BARRIERS OF INTEGRATING LEGAL ASSISTANCE INTO A HEALTHCARE SETTING

Bringing together different professions with different cultural and ethical norms involves several challenges. Hum & Faulkner outline this tension as follows:

> "A number of factors contribute to this mutual aversion, e.g. preconceived notions of distrust between the professions arising from conflict such as malpractice suits; a fundamental lack of understanding of one another's methods, values and roles; complicated professional jargon hindering open communication; arrogant and elitist attitudes; and interrelated but conflicting goals (these include lawyers safeguarding clients' autonomy and liberty while doctors protect and care for the health of patients). Hence these two professions can easily clash while pursuing what they believe to be in the best interests of their mutual patients/clients."[289]

Further, in a report by Noble, Associate Professor Sandel highlighted that:

> "[I]n a lot of ways there are ethical issues, whether it be around case-sharing for instance. It's accepted in the medical profession that when I make a referral to a specialist the specialist tells me what happened because we're all with the same healthcare team. Whereas the legal profession is almost like once you take on the legal-attorney client privilege you don't want to tell anybody anything because everything becomes privileged. And so I do think that that is inherent to MLP and has to be worked out on every MLP level and some have done it better than others."[290]

Benfer highlights that:

> "Lawyers and law students in MLPs must be aware of how their participation affects their obligation to maintain client confidentiality, safeguard attorney-client privilege and protect privileged work product. Partners must also be cognisant of differences in professional reporting obligations and the effect on their work in the MLP. In addition, work of an MLP must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which governs use and disclosure of protected health information. It is incumbent on partners to take deliberate steps to comply with professional obligations as well as statutory requirements to avoid liability and breach. This may include: training partners on rules and ethical policies; an agreement on emergency care in the event of injury; agreement on an information-sharing policy; up-to-date liability insurance, as well as accreditation and approvals required by pertinent regulatory agencies; an

[289] F Hum & J Faulkner, "Medical-Legal Partnerships: A new beginning to help Australian children in need" (2009) 17 *Journal of Law and Medicine*, 105.

[290] Peter Noble, "Advocacy-Health Alliances – Better Health Through Medical-Legal Partnership", (Final Report, Clayton Utz Foundation Fellowship, August 2012) <http://lcclc.org.au/programs/advocacy-health-alliance/>

> indemnification policy; and an agreement to not represent parties in actions directly adverse to another partner".[291]

Accordingly, as outlined above, several ethical issues arise in integrating legal services into a health-care setting and this report aims to provide suggestions for overcoming some of these barriers so as to engage efficiently in holistic and multi-disciplinary practice. The number of barriers considered in this report is by no means comprehensive. A key barrier to integration is a mistrust amongst health professionals that an on-site lawyer will make the pathway to bringing a medical negligence claim more seamless for patients. In practice, the writer has not heard of an example of an on-site lawyer giving legal advice in a case of alleged medical negligence. To do so would clearly bring the lawyer's interests in the furtherance of the partnership with the health-care provider in conflict with his/her duty to the client and a referral would clearly be necessary in such cases. This must be made abundantly clear at the first meeting with the health-care site to ease any tension and mistrust between the two potential partners. Suggestions for integrating legal assistance into health-care settings whilst complying with ethical considerations such as confidentiality will be considered in this chapter.

3.1 CONFIDENTIALITY AND THE FEEDBACK LOOP

Medical professionals often work in a collaborative and open way within the care team, sharing ideas and practices in forums such as rounds and unit meetings. This creates a tension when a lawyer seeks to join the care team and raises the question of whether lawyers can be part of the care team, and indeed whether their confidentiality obligations to their clients allow them to join the care team

Zuckerman et al in the USA highlight this tension stating that there:

> "...is the perception, on the part of the hospital or legal aid staff members, that the collaboration poses a conflict of interest, creates an ethical dilemma, or somehow violates the patient's right to confidentiality. Although it is essential to explore and reinforce the separate obligations of each institution to the patient-family, the ethical and confidentiality issues can be resolved with a clear understanding of the role of the on-site lawyer and regular consultation with the bar association guidelines devised for this purpose."[292]

Galowitz et al also from the USA highlight that the ability of participants in an MLP to collaborate and communicate is critical to the MLP process. However, "from the moment a healthcare provider identifies a patient's potential need for legal assistance, the treating provider and any involved MLP legal staff must engage in the delicate balancing act of promoting the success of

[291] Benfer E, above n175, 127.
[292] Barry Zuckerman et al, "Why Pediatricians Need Lawyers to Keep Children healthy" (1 July 2004) *Pediatrics* 114(1).

the MLP relationship while preserving the protections and rights of the patient."[293] Galowitz et al highlight that "physicians in an MLP must recognise that the open communication they enjoy with their medical colleagues cannot exist to the same degree with their legal partners. Providers must recognise that they cannot routinely receive or release communication with the legal team as if they were a medical entity. That is, in most instances, the attorney will not be considered as part of the medical team and will need specific, explicit consent for communication. Developing appropriate releases of information between the medical and legal teams and establishing clear protocols for all forms of communication is crucial to avoiding misunderstandings and maximising communication opportunities".[294]

Elayne Hill of the Coventry Law Centre in England explained that "lawyers do have a different standard of…client confidentiality and I think sometimes it's hard for people who aren't lawyers to really understand the code that we're bound by".[295] It is critical that the different approaches to confidentiality and what can and cannot be disclosed are considered at the outset. "It is important that these issues are unearthed, discussed and addressed before the formal initiation of the collaboration".[296] The differing obligations relating to mandatory reporting should also be made clear. All participants should be transparent about their obligations and consideration should be given to providing training on the differing obligations. Further, consideration should be given to outlining these issues in the Memorandum of Understanding developed with the partner organisation.

In order to demystify the role of the legal service and to build an understanding of the importance of its work, it is important for the health-care practitioners to understand outcomes that it has achieved. However, communication between a client and their lawyer is confidential and accordingly, providing this feedback is not straightforward. It is recommended that informed consent should routinely be sought to provide feedback to the referring source, and if it in the best interests of the client to do so, to provide information to the referring source as to whether the referral was acted upon and if possible, the outcome of the referral. It is recommended that a client provide fully voluntary, informed consent in writing and that they should also be made aware of their right of revocation.

Galowitz et al suggest that "the retainer that the client signs should include provisions that describe the unique parts of the multidisciplinary practice, as well as a separate release that allows the lawyer to talk with non-lawyers about relevant parts of the case; the lawyer should advise the client that physicians and other professionals are mandated reporters and may have a statutory duty to report if the client gives consent to share information".[297]

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[293] Paula Galowitz, Jerome Tichner, Paul Tremblay and Steven Blatt, "Ethical issues in Medical-Legal Partnership" in Elizabeth Tobin Tyler et al (eds), *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, 2011), 158.
[294] Ibid, 169.
[295] Meeting with Elayne Hill, Coventry Law Centre, Coventry, England, 7 May 2014.
[296] Ibid, 162.
[297] Ibid, 182.

Pettignano et al profile the work of HeLP in Atlanta in the USA in the Journal of Legal Medicine and state that:

> "in the ongoing effort to encourage referrals, HeLP staff continue to learn the critical role feedback plays in the healthcare delivery system. HeLP attorneys require direct consent from clients to share information with health provider colleagues. The attorneys make every effort to obtain this consent in each case and to communicate pertinent information to the providers. HeLP also incorporates language imprinted at the very top of the new client intake sheet that is read to each client. This paragraph explains that the project is interdisciplinary and that physicians and students in medicine, public health, social work, and other disciplines – in addition to law – attend and participate in case acceptance meetings. Each new client is asked to give permission to present his or her case to the interdisciplinary team during case acceptance and to inform the referring provider that the client contacted HeLP. If a client refuses, the case is not discussed at interdisciplinary case acceptance and the referrer is not alerted….despite these efforts to provide feedback, HeLP's healthcare partners continue to request more feedback. In an effort to increase awareness of attorney's special duty to protect confidences, a segment of every educational presentation to hospital personnel covers confidentiality concerns. HeLP attorneys, in collaboration with health providers, continue to seek new, appropriate mechanisms for providing feedback".[298]

Benfer provides an example of the Health Justice Project in the Journal of Legal Medicine. That project has a systematised approach to providing feedback, in which "a consultation report is sent anytime there is an action taken on a case. The report may notify the healthcare provider that the patient has been contacted, what action has been taken, and whether the legal or social work team is engaged in ongoing representation of the patient". The report forms part of the electronic medical record and the healthcare provider is required to read the notes before taking further action on a client's case.[299] Benfer highlights that "this ensures delivery of information, prompts the provider to speak with the patient about identified health-related legal and social issues, and creates a record of the action and health outcomes in the EMR [Electronic Medical Record]."[300]

MLP | Boston provides feedback to referring health professionals by recording information as authorised by patient-clients on a pro-forma sheet in which they tick the relevant box as to the nature of their assistance. This sheet then becomes part of the medical record. The options include whether or not MLP is assisting the patient and the legal matter with which assistance is provided. At the North Carolina Children's Hospital MLP in Chapel Hill, North Carolina, the primary MLP lawyer completed extensive training relating to patient confidentiality and research

[298] Pettignano et al above n114, 67.
[299] Benfer E, above n175, 131.
[300] Ibid.

ethics and attends unit meetings about services for complex care patients. However, once a patient is referred to the MLP, the legal staff only discloses information about a shared patient/client's legal matter when the patient/client has authorised such disclosure.

At SickKids in Toronto, the lawyers are not considered to be part of the circle of care for the purposes of privacy. However, the social workers are part of the circle of care and attend clinical rounds at the hospital during which patients' files are discussed. The on-site lawyer spends significant time with the social work department and is confident that they will identify relevant legal needs. Similarly the patients and/or their families have solicitor-client privilege when consulting the on-site or pro bono lawyers. They can however waive privilege if they choose and consent to the release of information back to the clinician. In many cases this information can aid the clinician in providing on-going care, for example in cases where immigration status is an issue, or where drug benefits are being challenged.

At the Centre Francophone de Toronto (**CFT**) in Canada, consent is sought from clients by the legal team to share information with other professionals on-site. Referrals to other professionals within the CFT are prepared with the consent of the client. Provided consent is obtained, the person who receives the referral writes some notes on the referral as to whether they are opening the file and the work that they will be able to do to assist the client and they then send it back to the referrer. Further, one caseworker from each of the discrete services at CFT, including a community legal worker, attends the monthly, multi-disciplinary team meetings. Cases are discussed and it is determined how the different professionals can work together. Aissa Nauthoo, Director of Legal Services highlights that "there is a confidentiality policy that we have and a form that we ask clients to sign. It's thoroughly understood that any information that's shared would have to be pertinent to the matter that's at issue. It's not as if we're going to have full access to the medical file or the doctor would have full access to the legal file, but we would share information that is only pertinent to the problem that we're discussing…. obviously care is taken that we conform to the legislative requirements."[301] Unison Health & Community Services in Toronto communicates about cases when client consent is obtained and when it is necessary to do so. Although there is no formal feedback loop, with client consent, Unison Health & Community Services profiles client success stories throughout the organisation.

At the Springfield Advice & Law Centre in London, all clients are asked to fill out a third party authority form to provide feedback. The form lists a number of support staff and clients can cross out those with whom they would prefer that there be no communication. It is at the client's discretion to cross out all the names if they so choose. This authority is valid unless and until the client revokes it. At Community Links in London, client consent is routinely sought to send a letter to the referring source to explain the assistance provided.

Coventry Law Centre runs a successful 'Troubled Families Project'. Elayne Hill explained that all clients are asked by social workers "…first of all whether they want a Law Centre worker to come

[301] Meeting with Aissa Nauthoo, Centre Francophone de Toronto, Toronto, Canada, 2 May 2014.

and assess them for any legal needs, and obviously it's not compulsory, so they can refuse."[302] If clients agree that someone from Coventry Law Centre can visit them, the lawyer seeks consent to talk to their social worker about their case. The first duty is to the client in respect of confidentiality and this is made clear to clients. The majority of clients agree to this disclosure.

Client consent should also be obtained to profile de-identified client stories to create a greater understanding of the work done by the on-site lawyer. Benfer highlights the importance of sharing information and successes which "keeps all partners up-to-date on the achievements of the MLP, while also encouraging greater participation and engagement in the partnership."[303] Benfer notes that highlights can be delivered in "weekly email blasts, advocacy materials, blog posts, outcome charts, or a newsletter among other formats".[304]

CASE STUDY: LAWWORKS, LONDON, ENGLAND[305]

LawWorks is a clearinghouse which facilitates pro bono legal assistance for individuals and communities in England and Wales who are unable to access legal services. In partnership with Together for Short Lives, LawWorks has developed Together for Families which aims to assist children and young people with life-limiting or life-threatening conditions and their families by providing non-legal advocacy on issues relating to their health. Families are often referred by hospice workers or social workers and families themselves can contact Together for Families for assistance. The programme matches the family with a pro bono lawyer to advocate on their behalf although the advocacy that is provided is of a non-legal nature. Some advocates work with the families for days, others remain linked in with the families for months. However, the advocates rarely actually meet the families. They usually provide the assistance remotely by phone or email.

[302] Meeting at Coventry Law Centre,
[303] Benfer E, above n175, 132.
[304] Ibid.
[305] Meeting with LawWorks on 13 May 2014.

3.2 DOCUMENT SECURITY

Despite the open and public environment of many health-care settings, it is critical to ensure that the confidentiality of the files and documentation of clients is maintained and that the files are stored securely.

Unison Health and Community Services in Toronto has a legal service on-site. The records are kept completely separate to health records of patients. Health professionals cannot access legal records and lawyers cannot access medical records. Whilst all client files are kept on-site, they are only accessible by the legal clinic and IT services.

At SickKids in Toronto, to ensure privacy, client files are kept in a filing cabinet in the on-site lawyer's office. The door to the office and the filing cabinet are both locked and the on-site lawyer has the only key. As previously noted, the on-site lawyer does not have access to any medical records.

At Springfield Advice & Law Centre based at Springfield University Hospital in London, files are kept in the offices of the Law Centre with only lawyers having access and the Law Centre has its own network, distinct from the Hospital network. Lawyers always get the client's consent to seek access to medical records and an arrangement with the Hospital has ensured that clinicians do not charge clients of the Legal Centre for providing reports or medical records.

Finally, at Community Links in London, the advice team is downstairs in a separate area to which only they have access and all client files and networks are totally separate.

3.3 SECONDARY CONSULTATIONS

As a number of MLP lawyers provide secondary consultations to health professionals discussed in chapter 2 above, there is concern about non-lawyers giving legal advice. It is critical that non-lawyers do not give legal advice and that this is made clear through training. Possible remedies to this may include training and education and the development of flyers that can be distributed by clinicians on areas of law that commonly arise amongst the patient population.

3.4 THIRD PARTIES ATTENDING CLIENT CONSULTATIONS

In multi-disciplinary settings, social workers, case workers or other professionals may wish to sit in on consultations with lawyers. This can raise issues as to whether or not legal professional privilege can be retained if, for example, notes are taken and placed on the medical record. It is recommended that informed consent is obtained from the client without the third party in the room to ensure that the client understands the implications, if any, of a third party sitting in for the consultation.

Tyler at al from the USA explain that:

> "collaborating professionals need to take great care to ensure that an individual's attorney-client privilege does not become waived because of the presence of an unnecessary person during a communication involving a member of the legal team. The professionals must remain attentive to the nature of the conversations and the participants. Collaborating medical and legal teams must establish strict protocols including shadow files and firewalls to protect records of legal communications from becoming part of the medical records".[306]

Further, Galowitz et al also from the USA highlight that:

> "…healthcare providers who participate in meetings with a patient and the patient's MLP lawyer may jeopardise the privileged nature of the conversation if the healthcare provider is viewed as an independent third party not involved in the legal representation of the client. Many state courts take the position that the presence of independent third parties during an otherwise privileged conversation between lawyer and client acts as a waiver of the attorney-client privilege. As a result, healthcare providers should generally not participate in attorney-client meetings. If the MLP lawyer, the client and the healthcare provider want the healthcare provider to play a more active role, MLP legal staff could request that the healthcare provider actively participate as a member of the client's legal team at least during the course of the meeting. This could be memorialised through the use of a form developed by the MLP legal staff discussing the role of the healthcare provider with the legal team. For example, the form could indicate that the healthcare provider could be present to help the lawyers identify what health conditions could be exacerbated by social issues (e.g. poor living conditions, lack of utilities). Establishing such a relationship would also help protect healthcare provider notes regarding a patient's legal issues that are included in the patient's medical records from being subject to subpoena. Even where a healthcare provider agrees to act as part of the MLP's legal team, MLPs should still be cautious about including healthcare providers in any conversations or meetings with clients, unless the client has given informed consent to waive the privilege. The impact of a healthcare provider's presence in this context when there has not been informed consent by the client has not been tested in the courts and could pose a serious risk of waiver of the attorney-client privilege. Healthcare providers and MLP lawyers should anticipate that due to the fact that the patient is pursuing legal remedies, medical records of the patient will likely be subpoenaed. Consequently, healthcare providers involved in the MLP model should segregate any legal information obtained regarding a patient from the remainder of the

[306] Galowitz et al, above n293, 173.

patient's medical records so that such information could be easily redacted if appropriate and necessary".[307]

At MLP | Boston, if a client attends an appointment with the social worker, the lawyer seeks basic instructions and subsequently, the advice is often provided to the client by phone following the consultation. This assists in retaining legal professional privilege for the client. However, if the client requests it, the presence of the social worker may be beneficial in order to provide support to the client. At the Community Advocacy and Legal Centre (**CALC**) in Belleville, service providers/trusted intermediaries sometimes sit in on appointments with clients. However, before they do so, the lawyer talks to the client first and seeks informed consent for this to occur.

At PBLO at SickKids in Toronto, to further ensure families understand their privacy rights, parents or patients who ask to attend legal meetings with both the lawyer and clinician are advised prior to the appointment about the possible implications for solicitor/client privilege and it is ensured that clients are providing informed consent. If there are concerns about abuse or violence, the on-site lawyer does not see the patient with a social worker present unless the patient/family member insists.

3.5 SPECIALISED HOSPITALS

There may be conflicts between the practice of the medical centre or hospital and the work of the lawyers in specialty medical centres. For example, psychiatric facilities which treat patients on involuntary treatment orders may consider legal advice by on-site lawyers to patients relating to contesting those orders to be a perceived conflict and an external referral may be necessary. Further, children's hospitals in which the hospital is providing family-centred care may be concerned about appearing to take sides for one parent over another in a legal dispute. Indeed, "family-centred care ethos endeavours to ensure each family member's wishes are taken into account in order to come to some kind of shared position. However, can the law sensibly account for the notion of the family in this way? Is there a legal position for the family as a whole, such that it can represent an impersonal and coherent point of view, abstracted from the individual opinions and rights of each of its constituent members?"[308]

Dr Randi Zlotnik Shaul, Director of the Bioethics Department at SickKids in Toronto explained that in a paediatric hospital "the fiduciary relationship is between the health care provider and the patient (the child). Yet, how to operationalize that in practice can be challenging depending on the hospital's model of family-centred care. When the interests of the child and the interests of the family are not consistent, this is particularly difficult. With the MLP, it can become complicated determining who is the client".[309] At PBLO at Sick Kids, the on-site lawyer does not provide representation in any case where there is a potential conflict with the Hospital or

[307] Ibid, 166.
[308] Lee Ann Chapman "Accounting for the Family in Law: An Impartial but not Impersonal Point of View" in R Zlotnik Shaul (ed.), *Paediatric Patient and Family-Centred Care: Ethical and Legal Issues* (International Library of Ethics, Law and the new Medicine) 57, 99.
[309] Meeting with Dr Randi Zlotnik-Shaul, SickKids, Toronto, Canada, 29 May 2014.

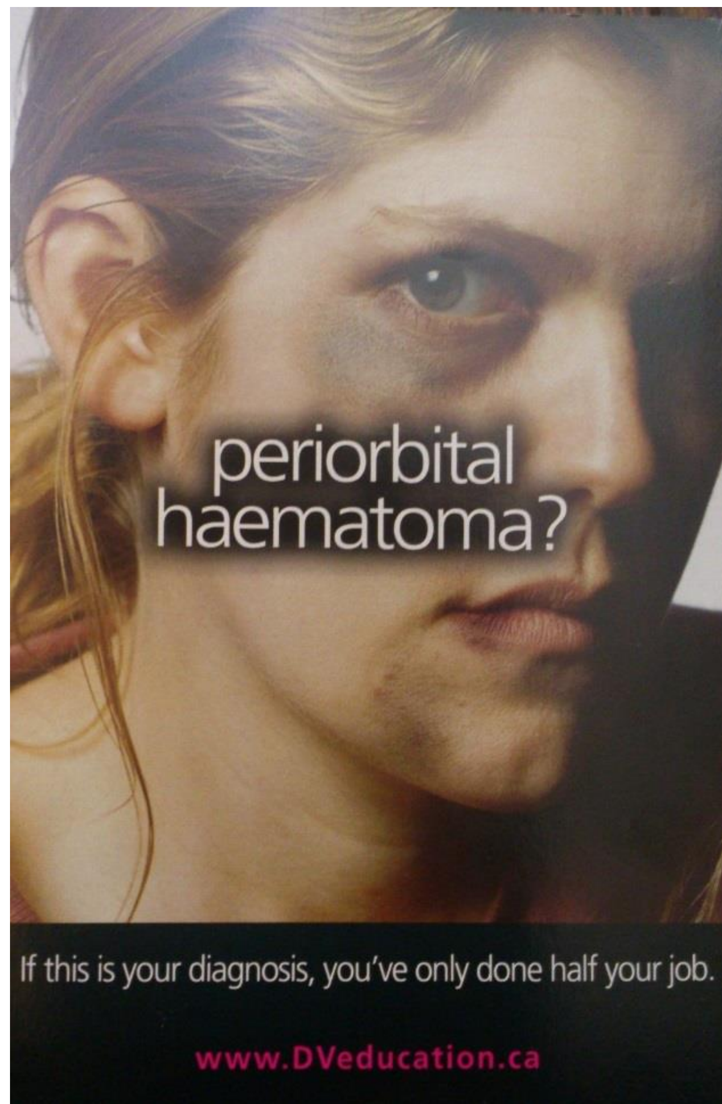
Hospital Staff (such as potential medical malpractice) those cases are referred to the in hospital Child and Family Relations Department, and if requested to outside lawyers. In addition, in cases in which one parent would be in dispute with another parent, for example family law matters such as custody disputes (except where there is a clear case of family violence), only general legal information and referrals to outside legal services are provided.

Examples have been provided above of some ethical barriers to consider in integrating legal assistance into a health-care setting. It is hoped that this provides a framework to think creatively in the provision of legal services whilst still complying with professional obligations.

CHAPTER 4

FOCUSING IN ON WOMEN'S HEALTH:

THE IMPACT OF INTEGRATED LEGAL SERVICES ON WOMEN



4.1 INTEGRATED LEGAL SERVICES AIMED AT ASSISTING WOMEN EXPERIENCING VIOLENCE

Violence against women continues to be a major health, legal, social and economic issue for the community and multi-disciplinary practice has the capacity to assist a significant number of victims/survivors of violence. In 2012 in Australia, approximately 17% of women over the age of 18 had experienced violence by a partner since the age of 15.[310] Further, violence against women and their children was estimated to cost the Australian economy $13.6 billion in 2008-2009.[311] The cost of violence against women and girls to the NHS in England is approximately £1.2 billion per year.[312]

As discussed in Chapter 1 (above), the effects of violence against women are multifaceted and may include detrimental health impacts as well as social exclusion, economic hardship, and homelessness. Further, women experiencing violence often disclose to health professionals[313] and often have a clustering of legal needs. Research shows that family violence significantly impacts pregnant women. Across many developed countries, between 4-9% of women are abused during their pregnancy and/or after the birth.[314] Recognising that women often disclose violence to health professionals and that pregnancy and illness may be one of the rare occasions when chronically abused women are permitted to go to a doctor, integrating legal assistance in a multi-disciplinary setting provides an environment where women can access information about their rights and entitlements and see a lawyer without having to risk contacting or attending a legal service. By providing a direct referral pathway from a health professional to legal and other services, there is the capacity to provide significant assistance to women.

The Victorian Systemic Review of Family Violence Deaths (**VSRFVD**) was established in 2009 to assist Victorian coroners investigating family violence related deaths involving children and adults. Its first report came out in 2012 and stated that:

> "a number of individuals known to the victim appeared to have wanted to offer further assistance and support, but did not due to a range of reasons. These included fear of the perpetrator; lack of recognition of the signs of escalating violence; lack of awareness as to the range of legal and community services that could provide assistance; a reluctance to get involved in family disputes; and hesitation about contacting police or other services. Witness statements also revealed that individuals were not always clear about the range of behaviours that comprised family violence, particularly in connection to non-physical forms of abuse."[315]

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[310] ABS, above n4.
[311] The National Centre to Reduce Violence Against women and their children, "Time for Action: The National Council's Plan to Reduce Violence against Women and their Children, 2009-2021" (March 2009), <http://www.ofw.fahcsia.gov.au/reducing_violence/national_plan/index.htm>
[312] Women's Health & Equality Consortium, above n93.
[313] Hegarty, KL, above n102.
[314] Taft A, above n6.
[315] Domestic Violence Death Review Committee, "Report of the Victorian Systemic Review of Family Violence Deaths" (Annual Report, 2012) 43.

In Canada, the Domestic Violence Death Review Committee (**DVDRC**) was established over ten years ago and in a recent report, it highlights the importance of multi-disciplinary practice, stating: "The first 10 years of the DVDRC has demonstrated that positive change is possible and that with a collaborative and multi-disciplinary effort we can continue to learn from the past in order to make Ontario a healthier and safer place in the future".[316] Deborah Sinclair, a member of the DVDRC explained that "everything that's written in our reports from day one has always been about trying to break the siloes down and trying to find out where the breaks in the chain are and trying to integrate law, mental health, hospitals, child welfare…"[317]

In order to provide a multi-disciplinary model of care for women experiencing violence, it is critical that the frontline health professionals to whom disclosures of violence occur are provided with adequate and appropriate skills to identify violence, respond to disclosures and refer appropriately. There are several key examples of training modules both in Australia and abroad which have been developed to build the capacity of front-line health and welfare professionals to identify and respond to violence. One example is "DV in Clinical Settings", developed by Dr Robin Mason (Scientist at WCRI and Assistant Professor at the Dalla Lana School of Public Health and the Department of Psychiatry, University of Toronto). Dr Robin Mason explained to the writer that DV in Clinical Settings is an evidence-based, competency-driven program comprised of seventeen different, interactive modules with three different focal areas including emergency, family practice and perinatal issues.[318] The modules were developed by a panel of experts including physicians, nurses, social workers and researchers and are available free of charge (www.DVeducation.ca). The training "covers basic to advanced competencies and everything from acute injuries to more subtle indicators".[319] The training also includes legal components such as mandatory reporting and documentation. All staff at the Hospital are expected to complete at least three modules. Over 5,000 people have visited the site which in addition to DV in Clinical Settings also houses two additional curricula. One focused on the connections between domestic violence, mental health and substance use problems called Making Connections, the other, Responding to Disclosures of Past Sexual Assault. "Making Connections is designed to enhance the knowledge, skills and practices of those who work with patients or clients who have experienced domestic violence, or abuse".[320] The website is complemented by a text manual and videos on appropriate responses. The online training is also complemented by a day-long on-site workshop and 800 people have attended these workshops. "This evidence-based, competency-driven program emphasises the ways in which women' really experience each of these complex problems - that is, often at the same time," explains Dr Mason. The third module, whilst still in development, focuses on helping frontline practitioners and allied health professionals recognize indicators of a past sexual assault and feel competent in responding to disclosures.

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[316] Office of the Chief Coroner for Ontario, "Domestic Violence Death Review Committee" (Annual Report, 2012) 39.
[317] Meeting with Deborah Sinclair at the Barbra Schliffer Commemorative Clinic, Toronto, Canada, 2 May 2014.
[318] DV Education website, <www.DVeducation.ca>
[319] Ibid.
[320] Ibid.

Sign in the court house at Belleville, Ontario, Canada

Further, it was noted during the Fellowship that several organisations which engage in multi-disciplinary practice also focus on women experiencing violence. For example the Centre Francophone Toronto provides legal education sessions at women's shelters. The Community Advocacy & Legal Centre in Canada belongs to the Quinte Coordinating Committee Against Violence (**QCCAV**). QCCAV brings together a number of different community agencies and aims to "coordinate a community-wide response aimed at eradicating violence through education and advocacy for effective intervention and therapeutic services in the Quinte area."[321] Based on the concept of 'no wrong door', the QCCAV includes members from a range of different organisations including the police, centres against sexual assault, womens' shelters, support services, welfare organisations, victims services, anger management services, legal services and others. The Committee promotes education and importantly, encourages active engagement amongst community organisations to ensure a coordinated approach. This committee also provides a forum for information sharing. On a larger scale, *Building a Bigger Wave* is the Ontario Network for Violence Against Women Coordinating Committees.[322] Building a Bigger Wave connects a number of organisations addressing violence against women in Ontario. Further, the Barbra Schlifer Commemorative Clinic profiled above is also an extraordinary example of a multi-disciplinary model aimed at addressing violence against women.

CASE STUDY: SCARBOROUGH WOMEN'S CENTRE, CANADA[323]

Scarborough Women's Centre was established in 1982 in response to the changing face of the community. Its mandate was to identify the needs of women (especially newcomers and women marginalised by poverty and abuse), to provide information to women about services available, and support the development of appropriate services.

One of its projects in the late 1980s involved working with municipal authorities including police and transit authorities to improve women's safety on transit as many women were not participating actively in the community because of fear. Over time, Scarborough Women's Centre has grown to include mentoring and tutoring programs, courses and workshops, formal

[321] Website of the Quinte Coordinating Committee, <http://www.qccav.ca/>
[322] Website of Building a Bigger Wave, <http://buildingabiggerwave.org/>
[323] Meeting with Lynda Kosowan of Scarborough Women's Centre on 30 April 2014.

counselling, outreach to young women, and outreach to women with disabilities. Its focus is on facilitating the empowerment of women to move towards economic and emotional independence, free of violence and abuse. [324]

More recently, Scarborough Women's Centre and a continuum of community and institutional partners including legal aid, police, hospital, shelter, community service, victim witness assistance, family services and others began to work towards the establishment of an access centre enabling women experiencing abuse and violence to go to one spot and access a continuum of services. As Scarborough is a large, suburban community that can take more than two hours to cross for one appointment, the relevant stakeholders mapped the various places that a woman would have to visit to access services to assist them and it was decided to develop this one-stop access model.

With client consent, the partners will work together and share client information in order to reduce the woman's need to repeat her story multiple times. It is at the discretion of the woman as to who is provided with her information. By providing one-stop access particularly for the initial triage and assessment phase, it is hoped that the woman will be more successful in her efforts to get the information and supports that she needs to leave an abusive situation in a safe, strategic way and to not be overwhelmed or exhausted by the process. Whilst the partnership and funding are being established, the access centre is operating for four hours per week. [325]

CASE STUDY: LEEWAY, NORWICH, ENGLAND[326]

Domestic Abuse charity, Leeway, has developed a partnership with the Norfolk Community legal Service.[327] Leeway provides on-sites services at two hospitals in the Accident & Emergency Department every weekday from 9am-5pm. Funded through a local initiative in Norfolk and based in the social work departments of the Hospitals, the Independent Domestic Violence Advocates (IDVAs) from leeway are on-site to provide independent, confidential assistance to women. IDVAs assist women with safety planning and housing issues and make referrals, as appropriate. The on-site presence at the hospital is complemented by training to hospital staff about domestic violence. Leeway is in the process of expanding this service to 170 GP surgeries in the area. Leeway also employs IDVAs based within the police stations and courts across the County of Norfolk.

[324] Ibid.
[325] Ibid.
[326] Meeting with Leeway, 10 May 2014.
[327] See Case Study: University of East Anglia Law Clinic and Norfolk Community Law Service for more information.

4.2 MEDICAL-LEGAL PARTNERSHIPS IN A MATERNAL-HEALTH SETTING

Recognising that pregnancy is a high-risk time for women experiencing violence, it is critical to consider that wrap-around care can be important for child and maternal health outcomes. "The causal connection between maternal stress and low birth weight and preterm birth is well-documented in the scientific literature".[328] Accordingly, the existence of Medical-Legal Partnerships in maternal health settings have the capacity to positively influence birth outcomes for women. One example bears this out. Delaware in the USA had the sixth highest infant mortality rate in the USA with 8.55 infant deaths per 1,000 live births between 2003 and 2007.[329] A pilot study was conducted of Medical-Legal Partnerships in Delaware which aimed to provide assistance to low-income, high-risk pregnant women.

Of 137 people in the study, almost one-fifth of those who had children had experienced concerns regarding domestic violence, two-thirds raised concerns finding affordable childcare and more than two-thirds had concerns about their children relating both to education and safety. Further, less than ten percent of those in the study had ever discussed their concerns with a lawyer.[330]

The study used a control group and an intervention group in order to evaluate the results.[331] The control group consisted of 50 people all of whom were provided with a toll-free legal aid helpline number. Of the 50 in the control group, 40 participants had no further contact and 7 participants called the legal aid helpline. Of the 7 who called the legal aid helpline, 1 was referred to another service, 1 received advice from the hotline attorney, 1 decided to handle the matter on her own, 2 failed to follow up and 2 were turned away as they did not have legal issues that were within the scope of the hotline (although 1 did receive community education materials).[332] The intervention group also consisted of 50 people who received direct access to the HEAL team advocate on-site. 65 cases were opened, 19 clients had multiple legal issues and 18 clients did not maintain contact for long enough in order to receive advice.[333]

The results "suggest that providing MLP services to high-risk pregnant women correlates with improved self-reported health and wellbeing".[334] Notably, the study found that "the analysed MLP participants reported an improvement in mental and physical wellbeing as well as a low level of perceived stress before and after receiving MLP services – with the exception of General Health, which features a slight decrease in average score between the two surveys….the improvement in average score in many of the subscales was not statistically significant".[335] The report finds that having a lawyer on the medical team can "promote health, prevent disease and

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[328] Atkins, D et al, Medical-Legal Partnership Pilot Project, Pilot Period: April 1, 2013- September 30, 2013, Community Legal Aid Society Inc.'s Final Report to the Delaware Healthy Mother and Infants Consortium (on file with author)

[329] Population Reference Bureau, analysis of data from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Causes of Death Public Use Files: VitalStats http://www.cdc.gov/nchs/vitalstats.htm presented at the 2014 Medical-Legal Partnership Summit: MLP in the Era of Health Reform, 10-11 April 2014 (Seattle, USA).

[330] Atkins, D et al, above n327.

[331] The study used a number of validated tools including the PROMIS short form v1.1 global health scale and the Perceived Stress Scale-4 in Atkins, D et al above n327.

[332] Ibid.

[333] Ibid.

[334] Ibid.

[335] Ibid.

address barriers to the effective care and management of illness". [336] Further, the study finds that the provision of MLP services to high-risk pregnant women "correlates with improved maternal health and well-being".[337] Accordingly, the merit of providing legal assistance in a maternal health setting has the capacity to assist a large number of women.

CASE STUDY: MATERNITY ACTION, ENGLAND

Maternity Action, an organisation in London, England provides expert advice and information on maternity and parental rights at work. Each month, 27,000 copies of their information sheets are downloaded from their website.[338] Further, Maternity Action opened a telephone advice service in May 2011 which whilst answering an average of 42 calls each week, was still receiving 21 times the number of calls to which they could respond with their current staff.[339]

Maternity Action also coordinates the alliance against pregnancy discrimination at work which includes a network of voluntary organisations, law firms and unions working towards addressing this issue.[340]

Maternity Action provides assistance to women seeking asylum who are provided with housing on a 'no choice' basis as this results in pregnant women being moved away from their ordinary health services and social networks at short notice, resulting in a harsh impact on their health and wellbeing.[341] Maternity Action also provides training to midwives on improving care for refugee and asylum seeker women.[342]

[336] Ibid.
[337] Ibid.
[338] Maternity Action, Annual Review (2011-2012).
[339] Ibid.
[340] Ibid.
[341] Ibid.
[342] Ibid.

CONCLUSION

Breaking down the professional silos between health, social and legal professionals has the capacity to provide greater access to justice as well as better health outcomes for individuals. The case studies discussed in the report and consideration of models of multi-disciplinary practice abroad highlight the importance of tailoring unique models of service delivery in order to create seamless pathways for disenfranchised individuals to access justice.

Whilst there are some barriers to integrating legal services into a multi-disciplinary setting, these barriers are undoubtedly surmountable. Drawing on expertise from abroad, it is hoped that this report has provided practical guidance to those considering developing a model which includes integrated service delivery.

Importantly, open and transparent communication between partner organisations as well as institutional relationship building will bolster the sustainability of the model. This requires time, commitment and creativity.

It is hoped that this report will nourish further thought and research in this area in Australia and that it inspires the development of many more examples of integrated legal service delivery in order to realise fairer and healthier outcomes for individuals in our community.

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