Medical–legal partnerships: connecting services for people living with mental health concerns

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Abstract

Our paper will discuss an action research project currently underway in regional and rural Victoria which seeks to build a dual site Medical-Legal partnership (MLP). MLPs bring together medical practitioners and legal practitioners to provide an integrated service aimed at supporting the health and wellbeing of individuals. MLPs, conceptually, are in their infancy in the Australian context having been successfully operating in the United States since the early 1990s. Our research project focuses upon an MLP model which diverts from the norm focusing upon generalist health rather, is specifically directed towards supporting individuals living with mental health concerns in rural and regional Victoria. Empirical evidence will be drawn upon to demonstrate how a project such as ours can be commenced and it will deliver early findings into the success of integrated services and notions of co-locating services in the rural context. We aim to demonstrate the benefits of the MLP model in supporting the mental health needs of individuals living the rural Australian context.

Introduction

Medical-legal partnerships, is a partnership model that as the title suggests, brings together legal and medical practitioners to provide an integrated service. This service is aimed at supporting the health and wellbeing of individuals who may not generally have ready access to legal services. This is a partnership model that has been largely ignored in Australia despite its proliferation in the US**.** Our paper is effectively divided into three sections which consider the concept of medical-legal partnerships and the applicability of this partnership model to the mental health sector. Firstly, it provides a potted account of the history of Medical-Legal Partnerships or MLPs in US and in Australia. Secondly, we will discuss the benefits of MLPs in supporting the legal needs of individuals living with mental health concerns in the rural Australian context. The final section discusses the initial work associated with our action research project currently underway in regional Victoria which seeks to establish a dual site Medical-Legal Partnership. We will draw upon the ethnographic evidence from interviews and observations to demonstrate how a project such as ours can be commenced. To conclude, we will tie together our early findings and reflect upon notions of co-locating legal services with mental health providers who operate in the rural Australian context.

MLPs in Australia and the United States

In short, Medical-Legal Partnerships (MLPs) engage in three key activities: providing legal help in a healthcare location; transforming the practices of legal and health institutions; and influencing policy change. Yet, despite the benefits they provide to individuals, the MLP model is one which is in its infancy in Australia.[1] There is ample evidence from the United States of an established network of MLPs that have been operating in various guises for over twenty years.

The benefits of a collaborative approach between lawyers and health workers in the United States were described in the mid-1970s. Yet, despite these benefits becoming apparent, a formalised MLP structure and support network did not develop in the US until the early 1990s.[2, 3] This first formal MLP operation in the United States was commenced in 1993 at the Boston Medical Center as a co-located arrangement. With differing skill sets, medical and legal professionals sought to educate one another and address social determinants of health.[4,5] Aimed at addressing social factors affecting health that could be remedied through legal action, the Boston incarnation of the MLP model led legal workers to deal with issues including tenancy, income support, rights to education, divorce, guardianship and powers of attorney.[6] Furthermore, in addition to the benefit for clients, the Boston MLP provided benefits that extended beyond the provision of a legal service as it incorporated training for health practitioners, resulting in a model that offered both preventative health and preventative law. The health benefits associated with the MLP improved short and long term patient health as levels of stress were noticeably reduced as was improved patient adherence to required medical treatment.

MLPs spread to over 100 hospitals and 100 community health centres across the United States by 2010 and were present in over 500 health and legal institutions nationally by 2013.[7] There is not a 'one-size-fits-all' approach as the MLP model manifests itself in the health care sector in varying ways from specialised forms of medicine such as diabetes or mental health to more generalist medical service providers. To support the expansion of the network of MLPs across the United States, the National Center for Medical-Legal Partnerships was established as a guiding body for the establishment and ongoing function of MLPs. [4]

It is somewhat surprising, given Australia's habit of adopting much that is American and the growth of MLPs in the United States, that until recently, MLPs have been absent from the context of Australian health care delivery. Despite the indication that the Medical-Legal Partnership model in Australia is in its infancy, [1] there had been a loose form of MLP operating in Melbourne since 1978 at the West Heidelberg Community Legal Centre and Banyule Community Health. This early partnership, differs from the US model in that it is not a true alliance arrangement. It is described as 'an interorganisational collaboration' in which the needs of the socially disadvantaged community are met by 'two different services with separate funding bodies.'[8] These two distinct bodies share their facilities and their expertise through organisational co-location. Intermingling of organisational structure at board management level occurs as well as a formal and informal process of cross-referral when opportunities are identified. A reception area which is common for both services is used, and legal staff attend health centre staff meetings. Other than the West Heidelberg example of MLPs in the Australian context, few other multi-disciplinary legal practices exist in the Australian Community Legal Centre sector. The one prominent current working model operating in the regional Victorian city of Bendigo is fashioned upon the established U.S. model under the auspices of the Loddon-Campaspe Community Legal Centre in a partnership arrangement with support from philanthropic donors.[1]

Benefits of an MLP in the mental health space

To the benefits of the MLP model for individuals with mental health concerns. For the client who has accessibility to the MLP space, research has shown that benefits abound. One particular study in Arizona has identified that patients with mental health related concerns, issues pertaining to perceived stress and wellbeing, benefit from the availability of legal services. This is particularly so for sufferers of high levels of stress.[9] When one considers social determinants of health such as work environment, legal concerns and housing then how psychological stress can impede upon social determinants of health, it is widely acknowledged that social disadvantage can leads to increased stress. It is well known that lifestyle choices such as unhealthy dietary patterns, sedentary behaviour and smoking leading to heart disease and cancer are all critical components which can be impacted upon by stress. Therefore, the subsequent reduction of stress can lead to improved health outcomes. Through the MLP, legal practitioners can support the reduction of psychological stress by being present and available to resolve issues like tenancy, fines, custodial orders, which can weigh upon an individual with mental health concerns and exacerbate the deterioration of one's mental health.[9] In a family advocacy program located within a health care provider of the University of Arizona, free legal services in the MLP context are provided to 'referred low-income patients'. This is complemented with legal advocacy training provided to medical residents to support referral generation. As one of the rare quantitative studies which consider stress and wellbeing and a patient's participation in an MLP model, confirmation of the benefit that an individual dealing with mental health issues can garner from involvement in the MLP model exists.[9] This research provides hard data as substantive evidence to support the development of the MLP model within the mental health sector.

As an example of how adaptations to the US model are experienced, it can be shown how cooperation between legal and mental health service provision is highly beneficial to individuals with mental health concerns. One example of the model takes it beyond the bricks and mortar of the health care clinic and involves mobility.[10] Known individuals with diagnosed mental health problems are registered and when domestic incidents occur, partners in the MLP attend the home or site where an incident is occurring. They work collaboratively to support this individual to deal with the incident then, on an ongoing basis to prevent further incidences occurring by remaining in contact with the individual. By taking the partnership to the individual rather than the individual needing to go to the service, which it has been acknowledged can be extremely uncomfortable for individuals dealing with mental health issues, the MLP aids in reducing the incidences of issues such as the perpetration of

violence, which in turn leads to legal action. It is a case of both mental health service providers and legal support networks collaborating to circumvent the incident caused by the mental health issue.

Not only are there benefits to those with mental health issues. Professionals working in the mental health sector gain improved understanding of how to identify and support their clients when a legal need arises. In one example, the blanket discontinuance of a government benefit was noticed by a care team specialising in helping mental illness patients.[11] The matter was raised with the state agency responsible for payment of the benefit by the care team. The care team did not achieve a satisfactory response from the agency. The matter was then taken by the care team of clinicians, a psychiatrist and care coordinators to the MLP. The MLP lawyer took up the matter, acted as the representative, and came up with a solution to overcome this issue leading to the reinstatement of the benefit or alternative means of funding being accessed. The care team was noted as saying that 'this was a problem that could only have been addressed by a medical-legal partnership.'[11] Through collaboration, an acceptable approach informed by medicine and law was found to address an issue at a systems level which then benefitted the mental health patient.

In the Australian context, despite the lack of MLP history and as an incentive to establish MLPs, a connection can be made between everyday problems which involve the law and long-term illness/disability, particularly mental illness.[12] The direct or proximal connection of health status to legal needs associated with items from housing issues to domestic violence is made in the 2012 Legal Australia-Wide (or LAW) survey.[13] Through the conclusions in the LAW survey, a case can be made for the integration of services and the instigation of the MLP model. The LAW survey data indicates the need for far more effective referral practices between service providers and lawyers. What better way for those referral practices to improve than through the collocation of services and people and the adoption of the MLP. Health and legal practitioners are working in the same space, interacting professionally and socially, leading to working collaboratively to support their patients' needs in a holistic manner. The MLP model works in opposition to mental health services and legal services that are disparate. The securing of early intervention in problems as they are identified by both sides to the partnership, problems which left unaddressed will potentially exacerbate can be addressed by having a lawyer in the building in which a mental health service provider operates. From the body of existing research, not only can mental health needs be supported through the service provision an MLP can provide, but it is safe to say that health inequalities can be reduced when the availability and support of the MLP is prevalent.

Our work: building an MLP

So, with that background in mind and research showing that many disadvantaged people are more likely to access the healthcare system than they are to access the existing legal systems, our work is aimed at establishing an MLP. The project commenced in September 2014 through approaches to local mental health care providers and legal practitioners. We are working to support the notion that providing legal support and services to those who are disadvantaged, significantly impacts in a positive way upon the health of those disadvantaged people. There is of course the concomitant outcome of potential reductions in overall costs to the public health system.[1, 8]

Ours is a Centre focused upon enhancing access to improved justice systems and services for rural and regional Australians. We are based in Geelong as part of Deakin University's School of Law. We were fortunate to secure a small funding grant to develop an action research project across two sites in the Barwon region of South Western Victoria. We were required to locate one of these sites in a rural township and chose to place the other in a more metropolitan setting. We determined that a site would be chosen with population of less than 10,000 but it would need to be a large town that also serviced smaller outlying rural townships. Why? Because it is a simple case of capacity and ensuring that we could attract a legal service and enough of a potential client base to make it attractive to potential MLP participants. We chose the rural township of Colac, located approximately 150 kilometres from Melbourne. Colac has a population of around 10,000. The other site was to be located in the major regional city of Geelong.

Our funding was simply available to cover the costs associated with employing a Research Fellow to facilitate the research components of the project and no funding was available to employ staff working in the MLP or to fund infrastructure. Unlike the Bendigo MLP and other recently announced MLPs in

Victoria which have the benefit of philanthropic or government support, we are reliant upon drawing on existing infrastructure and sources to make ours work.

It is a given that there are mental health providers doing outstanding work for their clients based in regional towns. So, to build this MLP from the ground up, we approached different legal and mental health providers in the region. Before we commenced the visits to the mental health providers, we steeled ourselves for objections and a lack of interest, particularly as there was no funding available yet, from the mental health sector we were met with enthusiasm. We visited most of the providers of services in the mental health space in the Geelong region to scope out what they think would function well in their space. In terms of mental health providers we found that all were represented in Geelong and some provided services in smaller regional centres such as Colac. It became apparent that to use one mental health service provider across both sites would be beneficial to expediting getting the project off the ground. We asked a series of questions to determine what a service provider provided and if the MLP concept was feasible. We were always met with enthusiasm and an attitude of build it and we will come.

We then set about gaining an understanding of how best to bring in the other side to the partnership, the legal sector. Again, we prepared ourselves for a lukewarm reception as, here is a service provider that is seen as under resourced and extremely busy and we had no funding to take a lawyer away from a legal practice and employ them in an MLP.

The first hurdle we were initially faced with came in a question of where the legal practitioners would be sourced from. As a university, we have a student cohort willing to gain experience in providing a triage type legal service. Of course though, a law student cannot step into the role of giving legal advice. With cap in hand, we approached our own School of Law. We were asked two critical questions which, without significant funding, would be obstacles to the success of the project: who will act as a supervisor and who will bear any cost involved in supervising the student? Despite there being examples from the US[14, 15] where law students are effectively utilised in the MLP arrangement as the first point of call when a legal need is identified, the lack of funding to allow these costs to be covered proved an obstacle we have not been able to overcome as yet. We have initially moved away from this as a viable option although using law students in voluntary capacity has not been discounted once the MLP is functional.

That successful channel of legal advice came from the Community Legal Sector. We also approached Legal Aid who were receptive to the notion but their initial service in providing legal advice and help is limited to phone based interactions, as well as some representation work on involuntary treatment matters and some criminal matters. This did not fit into the scope of what we are looking to achieve. We were advised that any face-to-face representation work conducted by Legal Aid only occurs after the initial telephone contact made by a potential client. We were left wondering would a person suffering a mental illness be comfortable dealing with a lawyer over the phone and, our aim was to deliver a service that supported the identification of a legal need by a mental health specialist. In short, if a person experiencing mental health concerns has legal needs that are either known or unknown, could these needs be effectively uncovered over the phone.

We approached a local Community Legal Centre who were receptive to the notion of co-locating their service. They had attempted a similar arrangements on an ad-hoc basis in the past. This Legal Centre had placed a lawyer at an outreach service which had been somewhat effective. But these earlier attempts to build partnerships were not a true partnership where the lawyer and the health worker would work co-operatively to meet a client's needs. Rather, what had happened was a lawyer would simply use an office space in the building. No referral networks were fostered, little promotion on the part of the health service provider occurred. The CLC were enthusiastic and it came down to them managing their staff to ensure that a representative would be available.

Findings

In mid-April, after five months of negotiations and scoping out of the project, we saw the first of weekly visits by a Community Legal Centre lawyer into a local mental health support service, commence. These visits begun at the Geelong site and involved a lawyer simply interacting at a lunch at a drop-in centre. The intent is for the lawyer to simply make themselves known and to engage with the service

users. One of the key points that we were told during our discussions with mental health providers is that the legal presence needs to be informal. Having a lawyer with a suit and tie, an authoritarian figure, would not work. The lawyer needed to set the client at ease by integrating themselves into the group, being part of the group and building trust with the potential client base. We had hoped to be able to provide findings of how these initial interactions had been received but the time aspects of submitting this paper meant we were unable to include these findings here.

So to the near future. By June we plan to commence trialling an MLP in Colac. This is our rural element to the project. Anecdotal evidence indicates that Colac will provide us with sufficient client base upon which to trial the MLP arrangement in a rural site. We believe this is critical as rural townships, acknowledged across much academic research as critical sites where mental health needs are not adequately be addressed due to lack of services, can be effective sites where MLPs are based. Even in the US, MLPs are generally based in cities and smaller sites are neglected. We were strategic in choosing both Pathways and the local CLC as they have existing arrangements in Colac. We view the Geelong site as critical to get the project up and running and to support both sides to the partnership to overcome any issues in the operation. Once an effective working relationship is operating, we will replicate it in Colac. We are hoping we can support Pathways and Barwon CLC to establish a cohesive operation based around the MLP model. Currently both service Colac but there is no connection between either of the services. This is an opportunity which lends itself to establishing an MLP within an existing partnership rather than bringing in new partners in Colac or other rural townships.

With regards to the future of MLPs in Australia, our work allows us to consider alternatives which we hope to explore once our dual partnerships are operating. We intend reviewing what sustainability looks like for MLPs that currently funded such as the Loddon Campaspe example or similar projects recently funded by the Legal Service Board. Also, can law students or private lawyers be used on a pro-bono basis in an Australian MLP? And finally, is this a model which in Australia, is reliant upon Community Legal Centres if funding is not available? In establishing a successful MLP, we needed to find a legal partner willing to co-locate a lawyer into a mental health service provider. As we are attempting to do this across two sites, one rural and the other regional, we decided that having partners represented in both Colac and Geelong would provide us with an easier option than trying to do this with four disparate organisations. We have been fortunate to find a CLC which is keen to extend its operation and reach out to the community and a group of service providers in the mental space who are passionate and see this model as beneficial to their clients. In addition, as advocates for the MLP model and its introduction in rural Australia, we have shown that MLPs can be constructed without funding to support any of the partners to the MLP. If the US experience is replicable in Australia, the demonstrable benefit of establishing MLPs in Australia will flow onto professionals working in the mental health space, individuals who are supported by those professionals and to our legal sector as they can gain a better understanding of how to work with clients who suffer mental health issues.

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Presenter

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