CSIRO PUBLISHING
Practice & Innovation
www.publish.csiro.au/journals/py
Australian Journal of Primary Health, 2009, **15**, 203–211

Towards an integrated service response to the link between legal and health issues

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Abstract. International research that confirms links between health issues and legal needs and the prevalence of non-legal services as the first port of call for assistance with legal problems has reinvigorated interest in providing integrated legal and health services. This article details research that indicates experiencing 'justiciable events' (problems for which there is a potential legal remedy) leads to stress, anxiety and deterioration in physical or mental health problems. Health consequences are identified for those that do not obtain appropriate and timely legal assistance. People often experience clusters of legal and non-legal problems that require a range of responses. For those that seek assistance with their justiciable event, most seek this assistance from non-legal sources. Within the legal aid sector, these research findings are considered compelling reasons to integrate legal, health and welfare services. However, the co-ordination and collocation of legal and non-legal services (particularly for disadvantaged communities) is not a straightforward solution. Drawing on the experience of several examples of integrated approaches in legal, health and welfare service delivery including the longstanding arrangements between the West Heidelberg Community Legal Service, which is collocated with Banyule Community Health, a range of challenges facing those agencies wishing to develop relationships to provide integrated legal, health and welfare services are identified.

Introduction

International socio-legal research has confirmed links between legal and health needs, particularly for people with chronic illness and disability. It has highlighted the prevalence of non-legal services as the first port of call for assistance with legal problems. Within the legal aid sector, these research findings have prompted a renewed focus on integrating legal, health and welfare services. However, it is not apparent that this research has yet generated any interest within the Australian health and welfare sectors.

In this article I provide a brief overview of the research and some related social inclusion policy. I then detail an example of integrated legal services based at the long established West Heidelberg Community Legal Service (WHCLS), which is collocated with Banyule Community Health (BCH). Drawing on this experience and two other examples of innovative legal service delivery, a range of challenges in providing integrated legal, health and welfare services are identified.[1]

Even though the co-ordination and collocation of legal and non-legal services (particularly for disadvantaged communities) seems a straightforward solution, integrating services across sectors, government departments, organisational and professional boundaries is not a simple task.

Relevant research

Socio-legal research in the United Kingdom, New Zealand, Netherlands, Northern Ireland, Canada, Australia and Japan reveals that justiciable events (problems for which there is a potential legal remedy) are part of everyday life for a significant section of the population (Coumarelos *et al*. 2006; Currie 2007*b*). This body of research confirms the day to day experience of many workers in the field. People often experience problems in clusters, there can be a 'trigger' event that causes a cascading of events that leads to further problems, most people do not seek or receive legal advice and individuals suffer from 'referral fatigue'.

Level of legal need and social exclusion

Research seeking to measure unmet legal need in the 1970s and 1980s was subject to substantial criticism including that the approach limited assessing legal need to problems that respondents identified as legal and for which people seek advice from a lawyer (Curran and Noone 2007). In response, more recent research, pioneered by Genn (1999) shifted the

[1]Apart from the practical challenges discussed in this article the author acknowledges that the concept of integrated services warrants critical reflection, but that is not the focus of this article.

10.1071/PY09013 1448-7527/09/030203

focus of survey work to assessing legal need as 'problems that are legal in nature but for which a legal service is only one and perhaps not the best remedy for resolving it' (Currie 2007*a*).[2] Genn coined the term 'a justiciable event', defined as a matter experienced by a respondent which raised legal issues, whether or not it was recognised by the respondent as being 'legal' and whether or not any action taken by the respondent to deal with the event involved the use of any part of the civil justice system. (Genn 1999, p. 12).

The UK Legal Services Research Centre (LSRC) continued Genn's approach and surveyed over 5000 adults' experiences of justiciable events in 2001 and 2004. This and similar research in Canada, Netherlands, New Zealand and Australia reveals that justiciable events are part of everyday life for between one-third to one-half of the population. The events range across 'children, clinical negligence, consumer problems, mental health problems, discrimination, divorce, domestic violence, money or debt problems, rented housing, relationship background, owned housing, neighbours, unfair police treatment and welfare benefits' (Pleasence 2006).[3]

The research found that people with a long-term illness or disability, lone parents, people unemployed or on a low income, and people living in temporary accommodation are most likely to experience justiciable events. The researchers conclude that 'justiciable problems appear to be an integral aspect of patterns of disadvantage, alternatively described as social exclusion' (Pleasence 2006; Currie 2007*a*).

Connection to health

Health consequences have been identified for those that do not obtain appropriate and timely legal assistance with their justiciable event. The LSRC firmly posits there is a significant association between an individual's experience of justiciable problems and their health status. (Pleasence *et al*. 2004, p. 554). Experiencing justiciable events leads to stress, anxiety and deterioration in physical or mental health problems. Both the LSRC and NSW research found that people with a chronic illness or disability were particularly exposed and more likely to experience a wide range of legal problems (O'Grady *et al*. 2004; Coumarelos *et al*. 2006).

Justiciable events led to stress and anxiety (and a) deterioration in physical or mental health problems (Moorhead and Robinson 2006).[4] LSRC survey results indicate 16% of civil justice problems, like accidents, domestic violence, relationship breakdown, and poor quality housing lead to physical ill-health and 27% lead to stress-related illness (Pleasence *et al*. 2004). Significantly, Moorhead's research also found that accessing assistance to resolve problems, even if the problem was not resolved in the respondents favour, led to a reported reduction in stress levels and associated health problems (Moorhead and Robinson 2006).

Clusters of problems and response required

Individuals experiencing one justiciable event have an increased likelihood of experiencing further events. The survey results suggested that events often come in clusters and there can be a 'trigger' event that causes a cascading of events that leads to further problems (Pleasence *et al*. 2004; Coumarelos *et al*. 2006; Moorhead and Robinson 2006).

Moorhead was sceptical of the LSRC data, and conducted qualitative research that observed client interviews with a range of legal advice providers. His research reinforced the LSRC findings. He firmly concluded clients' problems are often multi-faceted, legal and non-legal, complex, interrelated and require more than simple narrow legal techniques for problem solving. In particular he recommended that disadvantaged clients would benefit from a degree of coordinated management because they tend to experience 'very complex clusters' of problems (Moorhead and Robinson 2006; Currie 2007*b*).

Advice seeking behaviour

Most people do not seek or receive legal advice about their justiciable event. An individual's advice seeking behaviour impacts on how and if legal problems are resolved. Of those people that seek assistance with their justiciable event, most seek this assistance from non-legal sources (O'Grady *et al*. 2004; Coumarelos *et al*. 2006; Clarke and Forell 2007). In the NSW study, help was sought in only 51% of legal events reported, and for those events in which people sought help only 12% sought assistance from lawyers. Understandably people sought assistance from services with which they were already in contact. Consequently, non-legal services are often the first point of contact for people with legal needs.

The NSW study also showed that 'people rarely seek assistance from more than one source for each legal issue', providing good argument to ensure that the 'door' that is approached is adequately resourced to assist in an appropriate and timely manner (Clarke and Forell 2007).

Relevant policy strategies

The reaction in the access to justice sector to this research has prompted renewed discussion about how and where best to provide appropriate and timely legal services to those seeking assistance. This parallels developments in other sectors like health and welfare that are also concerned about social exclusion and optimal service provision (Tieman *et al*. 2007; Biuso and Newton 2008; Swerissen 2008)[5]. However, there

[2]To date, there is no body of critique of this research. For an alternative approach to legal need see Curran and Noone (2007) and Noone and Curran (2008).

[3]The LSRC survey is now conducted on a continuing basis. For further details of surveys and related publications see website http://www.lsrc.org.uk/ (accessed 29 January 2009).

[4]This was recently confirmed in a Victorian study into the experience of those with debt who seek assistance from financial counsellors (Schetzer 2007).

[5]For example the Federal Government's GP Super Clinics http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinic-about (accessed 11 June 2009).

are no apparent moves to link legal, health and welfare policy initiatives despite the following policy strategies.

The current Australian Federal government acknowledges social exclusion as a national issue and a recent report listed the following policy approaches:

(1) enhancing the ability of services to address the multiple disadvantages that many of the socially excluded experience ('joined-up' services for 'joined-up' problems); and
(2) local co-ordination across government and non-government to achieve an integrated approach to social inclusion (Hayes *et al*. 2008, p. 16).

In Victoria, 'A fairer Victoria – creating opportunity and addressing disadvantage' is the state government's framework to address the 'causes and consequences of disadvantage' within Victoria. Within this framework there is recognition that addressing disadvantage involves improving access to justice, helping disadvantaged groups' access services and opportunities and localising service solutions (Victorian Government 2005).

At a direct service and community program level, 'joined-up' government policies feed strategies that promote integrated service delivery, collaborative service practice and partnerships that cross sectoral boundaries. Such strategies aim to put into practice 'joined up' policy to provide 'holistic' or 'seamless' service delivery They aim to be demand driven, to place a person's needs at the centre of service delivery, improve referral pathways and service access through service co-ordination (Saunders 2008).[6]

These recent public policy strategies into integrating human services have led to a focus on the necessary elements of integrated service or practice. Many terms are attached to inter-organisational attempts to work together such as integration, co-ordination, partnership, collaboration and multi-disciplinary practice (Tieman *et al*. 2007, p. 60). In human service organisations, these definitions are used to describe inter-organisational practices that attempt to achieve what has been described as 'collaborative advantage' when partnerships 'do tackle social issues that would otherwise fall between the gaps' (Huxham and Vangen 2005, p. 3).

The VicHealth 'partnership analysis tool' identifies four levels of partnership; networking, coordinating, cooperating and collaborating (VicHealth 2004). Scott (2005, p. 132) states that;

> '*collaboration means . . . the formal joining of structures and processes between organisations. It is part of a spectrum ranging from the informal to the formal, beginning with cooperation (as in informal information exchange), through coordination (as in the development of formal protocols) to collaboration and ultimately, integration, which involves the formation of new organisational structures*'.

In Victoria, this policy has been implemented in several strategies to address complex social problems through service integration. Within the justice portfolio, one example is the Neighbourhood Justice Centre that provides an integrated, local approach to access to justice within the context of a magistrate's court. Through this facility, court services, legal aid, mental health, drug, housing, employment services, financial counselling, personal and material support services are provided for the local community within the City of Yarra.[7]

Despite this and some similar therapeutic justice initiatives in the court system, there has been limited discussion in Australia of what 'joined-up' or integrated legal services for the poor and disadvantaged would entail (Curran 2007*a*).

Integrated legal services

The term 'integrated service' is not normally associated with the provision of legal services as lawyers working and sharing profits with non-lawyers has been prohibited by legislation.[8] Despite this, restriction on formal partnerships, Australian community legal centres (CLC) have always claimed to provide a 'holistic' service in recognition of the connection between socioeconomic and systemic factors and legal problems. For the past 30 years, CLC have valued working with non-legal, health and welfare workers in the resolution of clients' issues at both an individual and systemic level (Noone and Tomsen 2006). This multidisciplinary (or integrated) approach of Australian community legal centres has received little analysis to date but is now of renewed interest given the research findings discussed above.

For instance, the NSW research suggests that;

> '*to assist disadvantaged people to receive more appropriate and timely legal assistance . . . particularly (clients with) complex and interrelated legal and non-legal needs, a case managed, holistic or* '*coordinated response*' *was needed. This may involve a team of legal and non-legal services . . . [a]* '*service hub*' *or* '*one-stop-shop*' *where services are located near one another to improve client convenience and facilitate better referrals and coordination between the services*'. (Clarke and Forell 2007).

[6]For a summary of international and national experiences of joined up government see State Services Authority 2007. For a more critical assessment of 'joined up' policy approaches in Australia see Saunders (2008).

[7]This facility is modelled on a project in Redhook New York State, USA and North Liverpool UK. For more detail see http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/The+Justice+System/Neighbourhood+Justice/JUSTICE+-+Neighbourhood+Justice+-+Home (accessed 11 June 2009).

[8]However, recently commercial lawyers have called for a form of integrated service, multi-disciplinary partnerships (MDP). After heated debate within legal professional organisations both in Australia and internationally, a limited form of MDP is now allowed (Brustin 2002; Norwood and Paterson 2002; Dal Pont 2006, pp. 458–460; Castles 2008).

The UK research also concluded that clients with multiple events often need a more holistic service approach to effectively meet their intersecting legal and non-legal needs and that 'resolution to an individual's legal needs may often require the engagement of multiple funding streams outside of legal needs'. (Moorhead and Robinson 2006, p. 96).

In Australia, UK and USA several initiatives illustrate different approaches to providing integrated legal services to the poor and disadvantaged. One of the earliest Australian examples is that of West Heidelberg Community Legal Service (WHCLS) which is collocated with Banyule Community Health (BCH).

West Heidelberg Community Legal Centre and Banyule Community Health

West Heidelberg is an area of significant social disadvantage (Vinson 2004, 2007). Since 1978, WHCLS has been co-located within BCH. The centre was originally envisaged to provide preventive and diagnostic medical services and programs, stimulate community health welfare education programs, provide counselling and a location for community activities and groups and include 'a legal aid centre' (Noone 2007).

WHCLS remains a small organisation, currently employing one principal solicitor who provides legal casework and advice, a director, a project solicitor and two part-time legal secretaries. In partnership with LaTrobe University, it hosts a clinical legal education program for law students. WHCLS's Committee of Management includes a representative of BCH. The 'WHCLS Annual Report 2007–08' states the service 'gives priority to persons on low incomes who are marginalised or have difficulty navigating the legal system' and who are within their 'catchment area in order to encourage referral options and improved client outcomes'.

BCH's catchment is the local government area of Banyule, in which West Heidelberg is located. BCH's mission is to 'provide integrated quality health and community services that are accessible and responsive to the needs of our communities' (BCHS 2008). It employs over 140 staff, and its service delivery structure is now imbedded in the primary health care system providing a range of medical, dental, allied health and community services. An overwhelming number of its clients (90%) attend for an allied health, dental and/or medical service (10% attend for counselling/casework services) (BCHS 2008). In addition to direct service delivery, BCH runs several community groups focusing on health support and community participation including the Heidelberg West Neighbourhood Renewal project (BCHS 2008). The WHCLS is listed as a co located service on the BCH website and staff at WHCLS have access to the BCH email and intranet service.[9]

[9]http://www.bchs.org.au/ (accessed 9 February 2009).

Features of WHCLS and BCH collaboration

The arrangement between the WHCLS and BCH can be viewed as an example of interorganisational collaboration; two different services with separate funding bodies, two separate boards of management who share facilities and expertise in order to meet the needs of a socially disadvantaged community. There is no formal agreement between the two organisations about service provision. The features of the approach adopted by the two, legally distinct, organisations WHCLS and BCH include:

- collocation of the organisations;
- crossover of board membership, including community members;
- use of a common reception area;
- maintenance of separate filing and administrative systems (to ensure the professional obligations of the lawyer/client relationship are meet);
- use of formal and informal referrals between staff of the two organisations;
- attendance by legal centre staff at larger health centre staff meetings; and
- employment of practitioners who are prepared and keen to work with other disciplines (Noone 2007).

To date, there has been only one documented study on the BCH integrated approach to services. The study focussed on how a financial counsellor and a problem gambling counsellor worked effectively together to provide the best service outcomes for their individual problem gambling clients. It identified the key elements as: location at the same site; willingness of staff to work together; professional experience of staff; understanding by the staff of the respective roles of different disciplines; clear and defined boundaries in casework; clear and prompt attention to referrals; and clear and frequent communication on cases (Pentland and Drosten 1996).

Referrals

Significantly, in relation to referrals, the counsellors considered that,

> '*the* '*success*' *of their work together has been influenced by being able to confidently and positively refer their clients to each other. . .it is essential that the referral process is clearly understood by both workers. It is fundamental to the effectiveness of service provision that each service has given an undertaking to respond quickly to referrals*' (Pentland and Drosten 1996, p. 59).

The anecdotal evidence about the current referral process between the staff of the two agencies is positive. The practices employed appear mutually beneficial and generally ensure that the client follows through on the referral and that the referral is an appropriate one. The collocation of the services is a critical feature enabling this to occur. Clients can be

personally escorted to the referral worker and introduced immediately. Clients do not usually recognise during the referral process that they are receiving services from different organisations. Most referrals from the BCH to WHCLS come from the financial counsellor, the doctors, social workers and drug and alcohol counsellors (Noone 2007).[10]

Advocacy and systemic work

The provision of integrated services at West Heidelberg not only focuses on individual services. There is significant potential in advocacy, policy and law reform work. Although law reform is a common feature amongst Australian Community Legal Centres, WHCLS's law reform work has an added dimension because of the contribution of BCH staff and through them local community members (Curran 2007*b*). In this way, the voice of the West Heidelberg community has been heard on a range of legal matters.[11] This capacity has been enhanced in recent years with law students participating in law reform projects arising from their casework. (Curran 2004). The capacity of 'social justice collaboratives' to be involved in systemic policy work has also been identified in the US and Canada (Trubek and Farnham 2000).

Further examples: legal workers in health agencies

In the UK, the relationship between justiciable events, ill-health and disability and poverty has supported the development of common policy objectives for both public health and civil justice. Several Community Legal Service Partnerships and Health Action Zones have worked together to integrate aspects of service delivery (Pleasence 2006, p. 175). As low income and poverty are recognised as key determinants of health, it is argued that,

> '*if new primary care organisations are to promote health and address health inequalities then a narrow concern with the presenting medical problems is not sufficient. In offering welfare advice services, they . . . [address] the wider health needs of their community which are fundamentally shaped by social and economic environmental factors*' (Greasley and Small 2005, p. 258).

Trials of placing welfare rights advisers in medical practices had the aim of ensuring people were receiving their maximum social security entitlements thus improving their income status. (Harding *et al*. 2002; Greasley and Small 2005) These trials indicate that 15% of medical consultations involved welfare rights issues, 50% of practitioners felt the welfare rights issues were urgent and 71% reported elements of mental health in their most recent cases where welfare was at issue (e.g. anxiety or emotional turmoil).

The research concluded that there were benefits of co-located services for patients, advisers and doctors. Patients found consultations with general practitioners were often pressured, and that the provision of other services in a comfortable environment went some way to resolving anxieties and sorting out problems, either before the doctors were seen or after referral by the doctor. The trust and confidence that patients had in the doctors reduced their anxiety in presenting to welfare advice that was located on site. The quality of the skills of the advice workers was strongly valued as patients could receive help in filling out forms and advocacy for appeal cases. The researchers concluded that primary care was ill-placed to tackle poverty in its entirety, but that the provision of welfare advice in general practice medical surgeries had the capacity to contribute to welfare take-up and other problems such as unfair dismissal (Sherr *et al*. 2002).

In the USA there is a 'thriving multidisciplinary law firm' based at the Paediatrics Department of the Boston Medical Center. The Family Advocacy Program (FAP) began in 1993 and has grown to include 'three lawyers versed in multiple practice areas including family, education and immigration law. . .a network of advocacy resources. . .[and] systemic reform efforts related to recurrent problems faced by patient-families' (Tames *et al*. 2002). The rationale behind the FAP was the recognition and frustration of the paediatricians that they could not address the underlying causes of poor health in children. For example, unsafe housing conditions leading to lead paint poisoning, asthma and injury, lack of sustainable income affecting childhood nutrition, and poor access to educational and social services for children with special needs (Zuckerman *et al*. 2004; Tyler 2008).

The successful elements of this integrated approach are said to be: weekly walk-in legal clinics at outpatient sites; FAP staff participation in interdepartmental meetings; meaningful ongoing collaboration on individual family matters and systemic reform; addition of a medical director to the FAP team; the development of doctor-friendly advocacy materials and tools; and working as a team (Tames *et al*. 2002). The FAP approach has recently been endorsed with the allocation of funds to replicate the program across the United States (Tyler 2008).

Challenges of integrated service delivery approaches

The co-location of services, like West Heidelberg Community Legal Service and the Banyule Community Health Service does not mean, in itself, that the two services provide integrated services to their clients. Though the close proximity of services could be seen to be helpful to people using the service in terms of ease of access, there are many other influences affecting effective integrative service delivery between two organisations and across disciplines. These occur

[10]Currently a research project is obtaining both quantitative and qualitative material on this arrangement. This is funded by the Legal Service Board Victoria.
[11]The Annual Reports of the West Heidelberg Legal Service detail a range of examples.

at a sector/policy level through funding bodies, at an organisational level through management direction, at an inter-professional level through training and professional ethics, and at a personal level through workers' own beliefs and work practice.

Sector/policy level

The challenges of providing integrated services begin at the sector/policy level. For instance in Victoria the current policy directing Community Health Services has an 'overarching strategic imperative to strengthen Community Health Services in their provision of comprehensive primary health care system' (DHS 2004, p. 4) and the Primary Care Partnerships strategy has guided recent service and health promotion integration. This strategy assists 'providers to address the broad determinants of health and well being' and as such embraces a social model of health which is 'concerned with addressing the environmental determinants of health and well being as well as biological and medical factors' (DHS 2001, p. 10). The VicHealth document, 'Burden of disease due to health inequalities' (VicHealth 2008), states that unequal access to good housing, adequate income and healthy food lead to health inequalities and that low income and unemployment lead to social isolation and exclusion which effects health.

Yet, despite the body of socio-legal research that emphasises the connection between legal problems and health issues discussed above, there is no mention or apparent awareness of this link in these policies. Equally, community legal services and legal aid services are not present in any recent integrated health service initiatives in Victoria.

Research into effective collaboration between health zones in the UK established that cross sectoral local initiatives can lead to collaboration between organisations due to a shared purpose. However, these initiatives are often in competition with broader sector agendas (Fisher *et al*. 2007; Wyles 2007). Funding programs and the policy objectives of funding bodies have a direct impact on service delivery and the success of breaking down silos within and between service units.

Collaborative practice requires resources. A study on collaboration between child protection and mental health services identified that 'inadequate resources was the issue endorsed most strongly by respondents as a barrier to collaboration' (Darlington *et al*. 2005, p. 1094). Funding bodies that are supportive of integrated service practice as a means to achieving broader policy objectives need to allocate sufficient funds to enable appropriate allocation of staff resources.

A simple WHCLS example highlights the impact of external funding arrangements. It had been a common practice (when required) for the legal practitioner to request, on behalf of the client, a written report from the BCH doctor to present to a court or tribunal. This was produced at no cost to the legal service or the client. In recent times, BCH began to request payment for these reports. The rationale being that the doctors funding is based on provision of specific services, report writing is time consuming and not billable. Often the client was unable to pay. Clearly, in this instance, the funding imperatives for the medical practice inhibited a collaborative approach with the legal service.

If governments are seeking to encourage integrated services then some attention is required to the issues of infrastructure including funding accountabilities. Each funding source requires specific accountability measures and the challenge is to develop 'valid and reliable measures of success that hold across multiple partners [that can] identify optimal partnership working and evaluate outcomes'. (Balmer *et al*. 2005, p. 49). A further challenge is to document the efficiency of integrated services particularly in relation to administration and other infrastructure costs.

Organisational level

Funding at a policy or sector level also needs to be matched by a commitment at an organisational level to allocate resources to this task and to be willing to share resources. This necessitates a sharing of goals and visions and a high level of trust and mutual responsibility (Johnson *et al*. 2003*a*; Walker *et al*. 2007). As Johnson *et al*. (2003*b*) wrote in their research into partnerships working in local health Care Trusts in the UK,

> '*differences in political views and, therefore, in goals, fear of budgetary repercussions, differences in . . . work cultures, and in competing demands on already overworked staff, all worked against the development of the trust and stable working relationships needed to collaborate successfully*'.

In such environments, integrated service practice relies on commitment to shared goals, communication and strong leadership (Johnson *et al*. 2003*b*, p. 80).

Collaborative practice involves the investment of scarce resources and energy in developing and maintaining relationships with other organisations (Scott 2005). There needs to be recognition that 'turf issues' may occur and cultural understandings of each organisation need to be developed within each organisation. Upper management involvement is critical in ensuring this occurs (Johnson *et al*. 2003*b*).

For instance, at WHCLS, the CEO of BCH is a member of the Management Committee and until recently, two community members of the WHCLS Management Committee were also on the BCH Board. The inclusion of accommodation for WHCLS in a new BCH building, with minimal cost to the legal service, is also a strong endorsement by the Board of BCH and the management of the provision of integrated services to the local community. At the opening of the new building at West Heidelberg in 2007, the CEO of BCH reiterated the commitment to integrated health and welfare services as well as high quality and low cost services; accessibility; encouragement of community participation and working closely with other agencies.

Professional level

Professional boundaries and training can be another major barrier to effective collaboration. Differences in styles of communication and decision making, 'models of understanding, about roles, identities, status and power and about information sharing' can lead to conflict and misunderstanding in achieving collaborative practice. (Robinson and Cottrell 2005; Scott 2005) Enablers of inter-professional collaboration include not only enhancing coordination structurally, but also establishing a culture of 'commitment' at a strategic and operational level to overcome professionally differentiated attitudes (Robinson and Cottrell 2005, p. 558).

Similarly, Darlington *et al*. (2005) wrote that 'professional identities are very important to workers so it is important to reduc(e) the extent of otherness', and for professionals to gain understandings of other professions ethics and boundaries. This is particularly important for integrated legal service delivery due to the specific nature of lawyer and client confidentiality. This issue and other ethical issues are often raised as hurdles to integrated legal services. However, the models described above provide examples of how these ethical and professional issues can be addressed (Norwood and Paterson 2002; Tames *et al*. 2002; Anderson *et al*. 2007; Castles 2008; Curran 2008).

Personal level

In the gambling project referred to above, the counsellors shared an interest in working with problem gamblers and a willingness to work together as a starting point. The success of the relationship owed much to the counsellors consciously putting 'a priority on building their professional relationship and engagement in joint casework' (Pentland and Drosten 1996, p. 58). This preparedness of the staff involved, to recognise and utilise the professional expertise of other disciplines, was seen as critical. Related to the willingness to work together is the need for an understanding of the different roles of each discipline. The gambling study noted that this includes an appreciation of,

> '*the philosophy and principles of the work area and of the individual worker; what each profession can and cannot do with and for clients; and styles of working with clients and within the team. As part of building their professional relationship, it has been important for the counsellors to learn about each other's work and to develop an understanding of each others practice*' (Pentland and Drosten 1996, p. 59).

It is generally accepted that the nature of relationships and good communication are critical to successful collaboration and integrated services. Bringing together professionals who are predisposed to work with others to address complex and multifaceted issues is the first step. Then the task is to build processes and trust, enable ongoing communication and have continued cooperation and coordination (Trubek and Farnham 2000, p. 258; Norwood and Paterson 2002, p. 357; Tyler 2008).

However, it must be recognised that the skills set required to facilitate good communication with a range of other workers may not be those characteristic of clinically trained health, welfare or legal workers (Walker *et al.* 2007, p. 20). There needs to be management support for an integrated approach which ensures workers are given appropriate induction, training and support (Tyler 2008). To enhance communication between the disciplines, both formal and informal mechanisms need to be established.[12]

Conclusion

Recent international and Australian empirical research into access to justice and legal needs reveals strong links between an individual's health and welfare and their involvement in legal matters. Additionally, research in New South Wales has identified that only 12% of people, who sought advice about a legal problem, did so from a lawyer or law related agency. Most people seek assistance about their legal problems from non-legal service delivery agencies with which they have already had some contact.

In response to these research findings and in order to improve the health and justice outcomes for the community, exploration and investment in developing service delivery models that bring together legal, health and welfare sectors is warranted. In this task, the experience of existing models of legal services working together with health and welfare services, like the WHCLS and BCH relationship, provides some useful insights into what facilitates and impedes integrated services.

Conflicts of interest

The author is the La Trobe University representative on the Management Committee of the West Heidelberg Community Legal Centre.

Acknowledgements

Special thanks to Kate Digney for research assistance and to the Legal Services Board Victoria for research funding. Thanks also to the two reviewers of this article for their thoughtful and detailed comments.

References

Anderson A, Barenberg L, Buck A, Walker H (2007) Professional ethics in interdisciplinary collaborates: zeal, paternalism and mandated reporting. *Clinical Law Review* **13**, 659.

Balmer N, Pleasence P, Buck A, Walker H (2005) Worried sick: the experience of debt problems and their relationship with health, illness and disability. *Social Policy and Society* **5**(1), 39–51.

BCHS (2008) '2008 Quality of care and annual report.' (Banyule Community Health Service: Melbourne)

[12]Students working in a clinical environment that utilises an integrated approach can evaluate the merits of an integrated approach as well as identify and develop relevant skills.

Biuso C, Newton B (2008) Supporting quality care in general practice: the collaboratives approach. *Australian Journal of Primary Health* **14**(2), 46–52.

Brustin SL (2002) Legal services provision through multidisciplinary practie – encouraging holistic advocacy while protecting ethical interests. *University of Colorado Law Review* **73**, 787.

Castles M (2008) Possibilities for multidisciplinary collaboration in clinical practice: practical ethical implications for lawyers and clients. *Monash University Law Review* **34**(1), 116–146.

Clarke S, Forell S (2007) 'Pathways to justice: the role of non-legal services. Justice issues.' (Law and Justice Foundation of NSW: Sydney)

Coumarelos C, Zhigang W, *et al*. (2006) 'Justice made to measure: NSW legal needs survey in disadvantaged areas. Access to justice and legal needs.' (Law and Justice Foundation of NSW: Sydney)

Curran L (2004) Responsive law reform initiatives by students on clinical placement at LaTrobe. *The Flinders Journal of Law Reform* **7**(1), 287–301.

Curran L (2007*a*) 'Ensuring justice and enhancing human rights: a report on improving legal aid service delivery to reach vulnerable and disadvantage people.' (La Trobe University: Melbourne)

Curran L (2007*b*) 'Making the legal system more responsive to community: a report on the impact of Victorian Community Legal Centre (CLC) law reform initiatives.' (West Heidelberg Community Legal Service: West Heidelberg, Vic.)

Curran L (2008) Relieving some of the legal burdens on clients: legal aid services working alongside psychologists and other health and social service professionals. *The Australian Community Psychologist* **20**(1), 47–56.

Curran L, Noone MA (2007) The challenge of defining unmet legal need. *Journal of Law and Social Policy* **21**(1), 63–89.

Currie A (2007*a*) 'The legal problems of everyday life. International Legal Aid Group Conference. Legal aid: a new beginning?' (Univeristy of Strathclyde: Antwerp, Belguim)

Currie A (2007*b*) Civil justice problems and the disability and health status of Canadians. *Journal of Law and Social Policy* **21**, 71.

Dal Pont G (2006) 'Lawyers professional responsibility.' (Thomson LawBook Co.: Pyrmont, NSW)

Darlington Y, Feeney JA, Rixon K (2005) Interagency collaboration between child protection and mental health services: practices, attitudes and barriers. *Child Abuse & Neglect* **29**, 1085–1098. doi: 10.1016/j.chiabu.2005.04.005

DHS (2001) 'Primary care partnerships: better access to dervices – a policy and operational framework.' (Victorian Government Printer: Melbourne)

DHS (2004) 'Community health services – creating a healthier Victoria.' (Victorian Government Printer: Melbourne)

Fisher C, Hunt L, Adamsam R, Thurston WE (2007) 'Health's a difficult beast': the interrelationships between domestic violence, women's health and the health sector: an Australian case study. *Social Science & Medicine* **65**(8), 1742–1750. doi: 10.1016/j.socscimed.2007.05.047

Genn H (1999) 'Paths to justice: what people do and think about going to law.' (Hart Publishing: Oxford)

Greasley P, Small N (2005) Providing welfare advice in general practice: referrals, issues and outcomes. *Health & Social Care in the Community* **13**(3), 249–258. doi: 10.1111/j.1365-2524.2005.00557.x

Harding R, Sherr L, Singh S, Sherr A, Moorhead R (2002) Evaluation of welfare rights advice in primary care: the general practice perspective. *Health & Social Care in the Community* **10**(6), 417–422. doi: 10.1046/j.1365-2524.2002.00393.x

Hayes A, Grey M, *et al*. (2008) 'Social inclusion. Origins, concepts and key themes.' (Commonwealth of Australia: Canberra)

Huxham C, Vangen S (2005) 'Managing to collaborate: the theory and practice of collaborative advantage.' (Routledge: London)

Johnson LJ, Zorn D, *et al*. (2003*a*) Stakeholder's views of factors that impact successful interagency collaboration. *Exceptional Children* **69**(2).

Johnson P, Wistow G, Schulz R, Hardy B (2003*b*) Interagency and interprofessional collaboration in community care: the interdependence of structures and values. *Journal of Interprofessional Care* **17**(1), 70–83. doi: 10.1080/1356182021000044166

Moorhead R, Robinson M (2006) 'A trouble shared – legal problems clusters in solicitor's and advice agencies.' (Cardiff University Matrix Research and Consultancy, Cardiff Law School: London)

Noone MA (2007) 'They all come in one door. The transformative potential of an integrated service model; a study of the West Heidelberg Community Legal Service. Transforming lives: law and social process.' (Eds P Pleasence, A Buck, N Balmer) (The Stationery Office: London)

Noone MA, Curran L (2008) Access to justice: a new approach using human rights standards. *International Journal of the Legal Profession* **15**(3), 195–229.

Noone MA, Tomsen S (2006) 'Lawyers in conflict: Australian lawyers and legal aid.' (Federation Press: Sydney)

Norwood M, Paterson A (2002) Problem solving in a multidisciplinary environment? Must ethics get in the way of holistic service? *Clinical Law Review* **9**, 377.

O'Grady A, Pleasence P, Balmer NJ, Buck A, Genn H (2004) Disability, social exclusion and the consequential experience of justiciable problems. *Disability & Society* **19**(3), 259–272. doi: 10.1080/0968759042000204158

Pentland J, Drosten P (1996) Financial counselling and problem gambling counselling: exploration of a service model. *Australian Journal of Primary Health – Interchange* **2**(2), 54–62.

Pleasence P (2006) 'Causes of action: civil law and social justice.' (The Stationary Office: London)

Pleasence P, Balmer N, Buck A, O'Grady A, Genn H (2004) Multiple justiciable problems: common clusters and their social and demographic indicators. *Journal of Empirical Legal Studies* **1**(2), 301–329. doi: 10.1111/j.1740-1461.2004.00009.x

Robinson M, Cottrell D (2005) Health professionals in multi-disciplinary and multi-agency teams: changing professional practice. *Journal of Interprofessional Care* **19**(6), 547–560. doi: 10.1080/13561820500396960

Saunders P (2008) Social exclusion: challenges for research and implications for policy. *Economic and Labour Relations Review* **19**(1), 73–91.

Schetzer L (2007) 'Drowning in debt.' (Department of Justice: Melbourne)

Scott D (2005) Inter-organisational collaboration in family-centred practice: a framework for analysis and action. *Australian Social Work* **58**(2), 132–141. doi: 10.1111/j.1447-0748.2005.00198.x

Sherr L, Sherr A, *et al*. (2002) 'A stitch in time – accessing and funding welfare rights through health service primary care.' (London Department of Primary Care and Population Sciences, Institute of Advanced Legal Studies, School Medicine, University of London: London)

Swerissen H (2008) Hints for reforming primary and community care in Australia. *Australian Journal of Primary Health* **14**(3), 68–75.

Tames P, Tremblay P, *et al*. (2002) The lawyer is in. Why some doctors are prescribing legal remedies for their patients, and how the legal profession can support this effort. *The Boston University Public Interest Law Journal* **12**, 505–527.

Tieman J, Mitchell G, *et al*. (2007) Integration, coordination and multidisciplinary care: what can these approaches offer to Australian primary health care? *Australian Journal of Primary Health* **13**(2), 56–65.

Trubek L, Farnham J (2000) Social justice collaboratives: multidisciplinary practices for people. *Clinical Law Review* **7**, 227.

Tyler ET (2008) Allies not adversaries: teaching collaboration to the next generation of doctors and lawyers to address social inequality. *Journal of Health Care Law & Policy* **11**, 249.

VicHealth (2004) 'The partnership analysis tool.' (Victorian Health Promotion Foundation, DHS: Melbourne)

VicHealth (2008) 'Burden of disease due to health inequalities – research summary.' (VicHealth: Carlton) Available at http://www.vichealth.vic.gov.au/Resource-Centre/Publications-and-Resources/Health-Inequalities/Research-Summary-Burden-of-disease-due-to-health-inequalities.aspx [Verified 30 July 2009]

Victorian Government (2005) 'A fairer Victoria: creating opportunity and addressing disadvantage.' (Department of Premier Cabinet, State of Victoria: Melbourne)

Vinson T (2004) 'Community adversity and resilience: the distribution of social disadvantage in Victoria and New South Wales and the mediating role of social cohesion.' (Jesuit Social Services: Melbourne)

Vinson T (2007) 'Dropping off the edge: the distribution of disadvantage in Australia.' (Jesuit Social Services and Catholic Social Services Australia: Melbourne)

Walker R, Pietsch J, *et al*. (2007) Partnership management: working across organisational boundaries. *Australian Journal of Primary Health* **13**(3), 9–16.

Wyles P (2007) Success with wraparound: a collaborative, individualised, integrated and strength-based model. *Youth Studies Australia* **28**(4), 45–53.

Zuckerman B, Sandel M, Smith L, Lawton E (2004) Why pediatricians need lawyers to keep children healthy. *Pediatrics* **114**(1), 224–228. doi: 10.1542/peds.114.1.224