

Article

No Passport Required: Crossing Interdisciplinary Borders in an Australian Legal Clinic

Doris Bozin ¹, Allison Ballard ^{1,2,*} , Vicki de Prazer ³ and Jenny Weekes ³

¹ Faculty of Business, Government and Law, University of Canberra, 2617 Canberra, Australia; doris.bozin@canberra.edu.au

² Faculty of Business, Justice and Behavioural Science, Charles Sturt University, 2580 Goulburn, Australia

³ Medical and Counselling Centre, University of Canberra, 2167 Canberra, Australia; vicki.depraizer@canberra.edu.au (V.d.P.); jenny.weekes@canberra.edu.au (J.W.)

* Correspondence: aballard@csu.edu.au

Received: 14 June 2020; Accepted: 27 July 2020; Published: 29 July 2020



Abstract: How can disparate professions better collaborate in a legal clinic environment to improve the health and wellbeing, legal and social outcomes for patients/clients? In this paper, we explore how an intentional blurring of the boundaries between the health and legal professions in practice—between lawyers, general practitioners and psychologists, in particular—in the context of clinical legal education may result in better patient/client outcomes. We find that direct interdisciplinary professional referrals for patient/clients within a legal clinic environment can promote effective and timely therapeutic interventions for those with complex and interrelated legal and health problems. Drawing upon the literature around cross-disciplinary professional client referrals and two client case studies from a health–justice legal clinic environment in which doctors, psychologists and lawyers personally cross-refer patients with legal and health problems, we recommend some steps to break down the interdisciplinary borders so as to improve access to justice and health outcomes for vulnerable clients.

Keywords: interdisciplinary; professions; law; health; psychology; access to justice; vulnerable clients

1. Introduction

“First, treat no lawyers” is a maxim that might find favour with some physicians and psychologists, most notably those in North America. Such an idea reflects the deep and pervasive antipathy and distrust that sometimes exists between health and legal professionals within the United States, though not necessarily in other nations. A hostile interdisciplinary stance, where it does exist, may have significant negative consequences for patients and/or clients. Interprofessional rancour and competition may, for example, manifest in an unhelpful reluctance, or even a refusal, to treat those in need—particularly if there is some association with medical malpractice lawyers (Jacobson and Bloche 2005). As Jacobson et al. note, though, this issue of mutual professional distrust does not arise “over differences in core values but over different approaches for resolving the inevitable conflicts that arise” between the professions (Jacobson and Bloche 2005). Other factors which may contribute to a mutual aversion between lawyers and doctors in particular include fundamental misunderstandings of one another’s methods, values and roles; complex professional goals (such as safeguarding client autonomy and liberty versus patient care and protection); professional jargon; “arrogant and elitist attitudes”, and preconceived notions of distrust (Gyorki 2014). While not proposing that inter-professional antipathies, particularly between doctors and lawyers, is in any way universal or even the norm (and it certainly was not reflective of the situation experienced by the authors), it is worth considering how professional “ring-fencing” and/or role-based professional tensions, where they do exist and are unhelpful to achieving optimal outcomes for patients/clients, can be addressed and resolved through collaboration or other means.

In other words, how might interprofessional barriers be best broken down so that the vulnerable people served by the health and legal professions can cross interdisciplinary professional borders with ease?

In considering this question, in this paper, we first address the significant commonalities between the legal and health professions (with a particular focus on medical practitioners and psychologists) with a view to highlighting how these shared understandings can be mobilised through clinical legal education to support better outcomes for patients/clients. We then review a pilot health–justice legal advice clinic, a type of health–justice partnership, established at the University of Canberra, Australia, in mid-2017. We describe how the clinic worked in practice and address some of the professional and practice issues raised by its operation (for example, client confidentiality, consent and the importance of interprofessional trust) and outline how those concerns were managed. We also consider different approaches to interprofessional referrals and barriers to accessing legal services in Australia, before focusing on the hybrid referral system used by the health–justice legal advice clinic. Finally, we consider two client case examples before suggesting areas for future research directed towards ensuring that no passport is required when “crossing the borders” between a health service and a legal service.

2. Health and Law’s Professional Commonalities: More Open Doors Than Closed Borders

One way of demolishing the interdisciplinary barriers between the health and justice professions is through creating a reinvigorated interprofessional dialogue which emphasises the professions’ shared core values (e.g., respect for the individual and a commitment to reason-based decision-making, professional judgment, and experience) and mutual concerns for patient/client safety (Jacobson and Bloche 2005). Having constructive conversations between professionals about shared aspirations and professional responsibilities and obligations rather than maintaining a negative focus on professional divergence and dislike is—intuitively, at least—an approach which is more likely to generate better patient/client outcomes. While in Australia, the approach of lawyers is typically an adversarial one, this is not always the case, and, increasingly, alternative approaches to dispute resolution as well as ideas about therapeutic jurisprudence and restorative justice approaches are becoming more common across the legal profession, or certainly those parts of it with a greater social justice focus.

As will be only briefly touched on below, doctors, lawyers and psychologists are all bound by different ethical and professional standards which—in Australia, at least—share many commonalities, both in values and approach.

The medical profession (anecdotally and assertedly) is obliged to “First, do no harm” (Mehrig 2014). Those who enter the practice of medicine promise to maintain the highest standards of personal integrity and competence and to have compassion for those in their care (Leaning 1997). The doctor–patient relationship is a partnership based on trust, mutual respect and collaboration (Australian Medical Association 2016). Lawyer–client relationships are analogous. Like doctors, legal practitioners are obliged to take oaths or affirmations of honour upon admission to professional practice. They must comply with a range of common law obligations and statutory rules of professional conduct. Fundamentally, lawyers must be of good fame and character and possess a commitment to integrity and protection of the public (Dal Pont 2010). Australian psychologists are similarly bound by a professional code of ethics and obliged to respect patient confidentiality (Australian Psychological Society 2007).

Arguably, then, the medical, legal and psychological professions share significant commonalities in terms of their professional relationships with those they serve and also the broader community (including as represented by the courts and/or professional regulatory bodies). All three professions, for example, have confidentiality obligations to individual patients/clients as part of their ethical framework (that is, they stand in a position of trust to their patients/clients) and must take responsibility for the quality of advice/care/interventions/representation/treatment provided to them. Of course, the professional obligations of these disciplines are not identical, but where tensions do arise on account of differing responsibilities, an interdisciplinary sharing of information and ongoing education

about potential areas of conflict would assist in smoothing and navigating the frontiers which separate these professions.

All doctors, lawyers and psychologists must generally place patient/client interests above their own and (generally) respect patient/client confidences. At times, however, the duties owed to society (or to the court, in the case of a lawyer) create potential role conflicts with respect to professional confidentiality obligations to patients/clients. All three professions may, for example, in the context of professional privilege/confidentiality, be privy to disclosures of a credible threat to harm another person. In the case of the lawyer–client relationship, however, the idea of “legal privilege” belongs to the client and could generally only be waived by them upon instruction, whereas statute law often requires the mandatory disclosure of certain things by doctors and psychologists but not by lawyers. For example, doctors, dentists, nurses, police, teachers and certain others (but not lawyers) are mandated reporters in suspected cases of child abuse or neglect under Section 356 of the *Children and Young People Act 2008* (ACT 2008). These differing circumstances clearly raise a potential conflict of interest between professionals who are working together.

Where lawyers perceive that such a threat is credible, they may disclose confidential information for the sole purpose of avoiding the probable commission of a “serious criminal offence” and/or disclose the threat and other relevant confidential details to the client’s doctor, the police and/or the person threatened ([Australian Solicitors Conduct Rules 2015](#)). Similarly, exceptions to the requirement for doctors to maintain patient confidentiality include where there is a serious risk of immediate harm to the patient or another person, where required by law, where part of approved research and where there are overwhelming societal interests ([Australian Medical Association 2016](#)). The disclosure obligations of psychologists in this context are similar to those of doctors ([Australian Psychological Society 2007](#)).

At the heart of these confined circumstances of permissible disclosure in breach of patient/client confidentiality obligations is the public interest—that is, serving public as opposed to private interests. Public interest embraces “standards of human conduct . . . tacitly accepted and acknowledged to be for the good order of society and for the well-being of its members. The interest is therefore the interest of the public as distinct from the interest of an individual or individuals . . . ” ([Kaye and Ormiston 1991](#)).

An ethos of public service sits at the core of professionalism for both health and legal practitioners. For some lawyers, providing pro bono legal services to vulnerable people to promote access to justice reflects their idea of professionalism ([Dal Pont 2010](#))—undertaking pro bono work is “a desirable, indeed a necessary part, of every solicitor’s practice” ([Adams 2000](#)). While the concept of pro bono service is perhaps not as normalised within the health professions, doctors and psychologists, like lawyers, regularly deal with those on the margin—the “poor, vulnerable, elderly, addicted, insane, imprisoned, unemployed, discriminated against, tortured, homeless . . . ” ([Nathanson 1997](#)). They know that these vulnerable people have higher rates of sickness and ill health and that access to the “goods and freedoms of society plays an important part” in how and whether an individual experiences a given illness and also whether or not the experience of that illness is particularly severe ([Leaning 1997](#)).

The significant commonalities outlined above, including shared ethics of care across the health and legal professions, underpin, at least in part, the emergence of health–justice partnerships both within and outside Australia. While still relatively novel in the Australian context, these sorts of professional interdisciplinary partnerships have become increasingly common ([Brown-Irava et al. 2017](#)). Health–justice legal clinics require health and legal professionals to work together as an interdisciplinary team, to develop positive working relationships and trust and to put the best interests of patient/clients ahead of their own. By doing so, the potential benefits for patients/clients (and society) by way of better health, wellbeing and social outcomes are significant.

Improved patient/client outcomes are possibly one of the best justifications for fostering greater cross-professional collaboration in a legal clinic context. In any case, professional antagonism in the context of clinical legal education within the health–justice partnership space would be untenable. Clearly, the best interests of the key stakeholders in legal clinic environments—the patients/clients,

the law students, the health and legal professionals, the clinic academics and the university—would not be well-served by interdisciplinary professional antagonism.

Doctors, lawyers and psychologists have much in common, including often sharing highly protective attitudes towards their patients/clients. It is these very commonalities, rather than any professional differences, that come to the fore and aid mutual cooperation in the best interests of shared patients/clients in the health–justice legal clinic setting.

3. Health–Justice Clinics: Interdisciplinary Collaboration Promotes Better Client Outcomes

Health–justice partnerships are diverse in design and come into existence for a range of different reasons. What they commonly recognise and try to remedy, though, is the inequitable access to justice experienced by vulnerable people. Disability and illness in particular are commonly associated with a person's increased vulnerability to significant (often unresolved) legal issues as well as an experience of disadvantage and social exclusion (Clarke and Forrell 2007). Furthermore, people who experience a legal problem (if they even recognise it as such) are more likely to consult a health professional rather than a lawyer (Clarke and Forrell 2007; Gyorki 2014). In about 50 per cent of cases, people with potential legal problems do not seek any assistance at all and so are at risk of falling through the cracks. The association between legal problems and chronic illness/disability is also often bi-directional; for example, “long-term incapacity can cause unemployment, family breakdown and debt problems” which can, in turn, cause or exacerbate existing psychological and/or physical illness (Clarke and Forrell 2007).

Given the combined impact of the failure to recognise and/or a reluctance to seek help for legal problems, a tendency to avoid lawyers and the probability that not addressing legal problems may cause or escalate health problems (and vice versa), a holistic approach is pragmatic. In other words, if health and legal practitioners work together to develop an all-inclusive picture of a person's health, social and legal problems, they will be better able to develop a comprehensive management plan for that person. Holistic or “wrap-around” patient/client care/intervention/treatment can be better facilitated by developing more positive, constructive and trusting interprofessional relationships as well as an enhanced capacity to cross-refer clients. A more integrated approach in turn offers the potential to achieve far better health and legal outcomes for vulnerable populations.

A Case Study: the University of Canberra Health–Justice Legal Advice Clinic

With the above issues in mind, in mid-2017, an informal arrangement between law academics from the University of Canberra School of Law and the University's Medical and Counselling Service saw the establishment of a pilot on-campus health–justice legal advice clinic (the Legal Clinic). There was little by way of preliminary formality, planning or political posturing in respect to the pilot clinic: the seeds were sown in late 2016/early 2017 over coffee conversations and a “handshake” agreement.

While, as will be discussed more below, many other health–justice clinics are planned with great precision and formal memorandums of understanding, here, the driving force was simply the desire of two legal academics to provide a genuine opportunity for practical legal experience for credit for later year law students. This was in response to law student feedback that there were insufficient opportunities for them to obtain practical legal experience.

For their part, the general practitioner head of the Medical & Counselling Service (the Health Service) and a staff psychologist recognised the need to offer their vulnerable patients a point of referral to address their legal issues. The parties agreed to establish a collaborative health–justice service to solve two problems: the anecdotal lack-of-legal-practice-opportunity-for-law-students-problem and the absence of a reliable (legal) referral point for the Health Service's patients.

The resulting (pro bono) Legal Clinic was auspiced by a private law firm (owned by one of the legal academics). The Legal Clinic accepted personal (direct) referrals for legal assistance from the health professionals at the Health Service. In turn, the Legal Clinic was also able to direct-refer distressed clients to the Health Service. The Health Service provided, at no cost, a dedicated on-campus

space (with an office, computer and single interview room) and private lawyers volunteered their time, energy and expertise to supervise law students who undertook legal cases and research work for the referred patients/clients. For the students, their clinical legal experience was also academically credited towards their law degree studies.

Once the parties agreed to run the pilot Legal Clinic, the law academics developed and conducted an orientation training session for the health professionals who would be referring patients to the Legal Clinic. The training covered the rationale for the Legal Clinic, the services it could provide, the way it would work and information on how to spot a legal issue and how to refer clients to the clinic. The latter in particular was important. While doctors, psychologists and other healthcare professionals may understand that their patient has a legal problem, they may not know where to refer the client for legal help or have any established links to legal service providers (or lawyers). In addition, for some, this type of referral or “assistance may be, or may be seen to be, beyond their role” (Clarke and Forrell 2007). By advising the health professionals about the type of service the Legal Clinic could provide, by putting “names to the faces” of the lawyers at the clinic, and, in particular, by having it located on-campus and geographically proximate to the Health Service, it was logistically (and emotionally) easier for the health professionals to refer their patients and to understand the benefits of doing so.

Other issues that needed to be addressed prior to the opening of the Legal Clinic included the appropriate management of patient/client confidentiality and consent issues. To this end, a patient/client referral form which included provisions for the patient/client’s consent for the referral was developed by the health and legal professionals. The form was signed by the patient and presented to the Legal Clinic during the patient/client’s first appointment.

The Legal Clinic operated one day each week, primarily through direct, personal referral from the health practitioners at the Health Service. It also saw clients on a “drop-in” basis, though this aspect of the service was not heavily promoted on campus.

Throughout all of this, possibly the most important aspect of the Legal Clinic was the relationship of trust and goodwill between the legal academics, the lawyers and the health professionals. Together they envisaged the possibility of running an on-campus health–justice legal advice clinic on a shoestring and through ongoing interdisciplinary collaboration, they made it work. The trust and goodwill between the health and legal professionals was present at the outset but it, and the partners’ personal and professional commitment to the service, also grew over time as positive outcomes were achieved for the referred patients/clients through effective team-work. Clear lines of communication and trust are two of the key components of successful health–justice partnerships (Ewais and Banks 2018; Curran 2016) and they featured strongly in the Legal Clinic.

4. Patient/Client Referrals: A Patchwork Quilt of Warm and Cold Spots

Perhaps one of the most important aspects of the collaboration between legal and health professionals in the context of clinical legal education through health–justice partnerships is having a good referral system. Legal (or law) clinics, including health–justice clinics or partnerships, are typically cooperative ventures between different service providers and stakeholders including law faculties, health services, legal aid/community legal service providers, private lawyers and/or firms and law students, so having pre-determined and productive ways of referring patients/clients is clearly a crucial element in the success of such ventures. Sometimes legal clinics operate within an existing medical or health service (for example, the Health Advocacy Clinic at the Mater Young Adult Health Centre in Brisbane, Queensland, and the Loddon Campaspe Community Legal Centre–Bendigo Community Health Service partnership in Bendigo, Victoria). In such cases, referrals would be internal to the organisation and so perhaps more straightforward. Ideally, in all cases, though, even those referred within an organisation, patients/clients would be direct-referred within or between services so as to provide holistic wrap-around client services in the hope of achieving better client outcomes. Clients may, for example, be referred to legal clinics by health and medical practitioners for information, support, advice and a for a range of legal services, including mediation and dispute resolution. Clients

may also be referred (or referred back) to medical practitioners and psychologists by law clinics. Regardless of the direction of referral, the aim of referring clients is to “deliver high-quality, timely, safe and ethical services” to the client (Australian Attorney-General’s Department n.d.). As Gyorki suggests, integrating legal services into a healthcare 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 (Gyorki 2014).

Establishing clear and effective referral pathways to the legal service, including on-site legal clinics, is critical. This may mean assuming responsibility for making appointments with the other service provider and also clarifying whether clients can book their own legal assistance appointments (Gyorki 2014). It may also require determining (ideally in consultation with the patient/client) the amount of their private information that may be shared with the other service as well, of course, as obtaining the patient/client’s consent to the sharing of that information. Referral processes should be determined by client needs, service arrangements and the capacity of the referring and receiving services (Australian Attorney-General’s Department n.d.). As seen in Table 1 below, each of the different types of client referrals has advantages and disadvantages. Patient/client referrals can occur by telephone, letter, email, website or other forms of written communication or via face-to-face handovers, or some combination of these or other approaches. Referrals may be active and warm or facilitated and cold, or some amalgam of these approaches (Australian Attorney-General’s Department n.d.). Where feasible, facilitated, warm and/or active referral processes are preferable in light of the aim of creating holistic wrap-around services, particularly for those clients who are likely to experience any difficulties in accessing the other service without overt assistance.

Table 1 below is adapted from the table in the Australian Attorney-General’s Department (n.d.) referral guidelines for the Family Relationship Centre and the Family Relationship Advice Line and incorporates referral information gleaned from the “Breaking down the silos: Overcoming the Practical and Ethical Barriers of Integrating Legal Assistance into a Healthcare Setting” report (Gyorki 2014).

Table 1. Advantages and Disadvantages of Different Types of Referral.

| Possible Term | Characteristics | Possible Advantages/Disadvantages | Referral Pathways |
|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Passive Referral | The client is given contact information for appropriate service(s) and is left to make her/his own contact at a time that best suits the client. | This process gives responsibility to the client to take action on their own behalf. However, there is a greater likelihood that the referral will not be taken up. | Patient/client contacts legal service provider by phone call, fax, email or by drop-in to make an appointment. |
| Facilitated Referral | The client is helped to access the other service; for example, the referring organisation makes an appointment with the other service on the client’s behalf, asks the other service to make contact with the client/s or a caller is transferred to the other service. | The other service is made aware of the client, and the client is helped to access that other service. The client may need to wait for a response from the other service. | With the patient/client’s consent, the medical service provider contacts the legal service provider by phone call, fax, email or by dropping-in to make an appointment for the patient/client. |

Table 1. Cont.

| Possible Term | Characteristics | Possible Advantages/Disadvantages | Referral Pathways |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Active Referral | The referring organisation, with the client's consent, provides the organisation to which it is referring the client with information that it has collected about the client or with its professional assessment of the client's needs. | The client does not need to repeat all of their story and the agency to which the client is referred has relevant information about the client. However, there is a risk that the information is communicated out of context and therefore misinterpreted by the service which is receiving the referral, especially if not done as a "warm" referral (see below). | With the patient/client's consent, the medical service provider contacts the legal service provider by phone call, fax, email or by dropping-in to make an appointment for the patient/client. |
| Cold Referral | The client is transferred to another service, without any immediate communication between the Centre or Advice Line and the other services—for example, by putting the client into a call centre queue. | The other service may be unaware of the nature of the call or of any information or services that have already been provided. The client may be frustrated that they have to re-tell their story or may not communicate their needs in a way that allows the other service to see why the client has been referred. | Medical service provider transfers the potential patient and/or client calling in to another service. |
| Warm Referral | A "live" three-way conversation in the presence of the client (whether face to face or by telephone) in which the referring organisation introduces the client, explains what has already been done to assist the client and why the client is being referred. | This provides an open and transparent process in which information can be exchanged between the Centre, the client and the other service. Issues can be clarified immediately. The client does not need to repeat all of their story. The process relies on someone being available at the other service at the time the client is to be referred. | Medical service provider contacts the legal service provider by phone call, fax or email while with the patient/client, or by dropping-in with the patient/client to the legal service provider to either make an appointment for the patient/client or to sit in on the interview with the patient/client's consent. |

4.1. What We Did

Using the framework provided in Table 1 above, the referral approach adopted by the Legal Clinic was an amalgam of the warm, facilitated and active referral approaches. Referrals were patient-centred and individualised to the client in question, acknowledging that there is really no one-size-fits-all approach.

The patient/client's individual diagnoses, the type(s) of legal problem(s) and the seriousness (or not) of the client's matter/circumstances were key influencers in deciding which referral type was appropriate in a given case. Typically, though, after a health practitioner obtained patient consent for a referral to the Legal Clinic, they would either make an appointment by telephone or in person or, alternatively, if it was a clinic day, accompany the person to the Legal Clinic and do a face-to-face hand-over.

Sometimes, the client would ask the health practitioner to also act as a support person during the legal interview. Occasionally, too, the lawyers would refer clients to, or "back to", to the Health Service, particularly if the lawyer was concerned about the client's mental health and well-being. In general,

this sort of tactic is not uncommon in Australian legal practice—Australian employment and personal injury lawyers may advise their clients to establish a dedicated professional relationship with a general practitioner and may also suggest that the client obtain a doctor’s referral for a government-funded “mental health plan”. This strategy is particularly useful for sexual harassment and discrimination matters, employment disputes and worker’s compensation claims where clients may be traumatised and in significant emotional distress. As observed by prominent Australian employment lawyer, Josh Bornstein, in 2018, in response to a question from ABC presenter Virginia Trioli, about a (sexual) harassment case (emphasis added):

By the time a woman comes to see me about me a sexual harassment case, the first thing I’m always prepared for is that her *health will be severely compromised* and in fact this is an issue for people who have traumatic experiences at work and there are a hell of a lot of them. We spend more time at work than we do at home and so the whole gamut of human experience and drama occurs at work, but a woman who has suffered sexual harassment who’s got to the point of booking to see me will be very, very distressed and traumatised. It’s only a matter of degree so I *spend ten minutes giving medical advice even though I’m a lawyer, and making sure that if they haven’t already got a GP and a least a referral to a psychologist* [they get one]. The other thing about the journey is, the journey can be over in three months and usually no one knows about it. It’s on under the radar. If I have someone coming to see me about sexual harassment in a law firm and I press send on a letter of demand, for example in the legal industry, I can then set the clock and I will be like lightning. And cases like that are over reasonably quickly and with confidentiality. So, in one sense that’s a good thing for women and women in that situation often want confidentiality, so it’s very complex. My first duty is to advance what they want. *On the other hand, this is going on all the time and no one knows about it and this doesn’t assist the broader policy issues* (ABC Television 2018).

Every client and every patient is different. Consequently, an individualised and flexible approach to client care by both health and legal professionals is likely to achieve better outcomes. The health professionals involved in the pilot Legal Clinic reported that their engagement with the lawyers and the services that they provided had improved their own ability to further assist their patients. In their patients, they observed both a positive shift in thinking and added insights into their problems from a legal perspective. These positive changes in the patient, in turn, assisted the health professionals working with them to better compartmentalise and address the patient’s various health, legal and other issues (Weekes 2019).

4.2. Barriers to Accessing Legal Services in Australia

Clients may experience a range of barriers in accessing different services, including legal advice and assistance services. Obstacles to service access may include things like a lack of information about available services, a lack of services generally (e.g., interpreter services), a lack of anonymity (this is particularly problematic in rural and regional areas where there are fewer lawyers), a lack of capacity/interest in taking up the referral, a lack of access to childcare arrangements (when visiting a lawyer), no or reduced access to transport (particularly for elderly or disabled clients), long waiting lists, costs, cultural and/or language barriers, difficulties in contacting clients (e.g., lack of phone services) and family relationships (Australian Attorney-General’s Department n.d.).

In particular, many women who have experienced family or domestic violence do not follow through with general practitioner referrals to other services. However, where a patient does accept a referral, factors that make it easier for them to access the other service include offering to make or making the appointment, providing written information about the appointment (including the time, location and directions to the appointment and the name of the person to be seen) and also telling the client about referral pathways to safety and healing, the specialised service to which they are being referred and what might be expected from it (Royal Australian College of General Practitioners 2014).

So, while there may be many “practical and ethical barriers” to client referral, to integrating legal assistance into a healthcare setting and to including lawyers on the “care team”, these can, as

discussed below, be addressed through proper planning. Clearly, where a health practitioner is able to contribute to providing a wrap-around service for a client by referring directly to a legal service, and/or by accompanying the client to the legal service, systemic barriers may be broken down. In such a context, the client is likely to feel more supported and to have more faith in the legal practitioner. This is likely to be, at least in part, because they trust the health professional who has facilitated the interaction and who has, by implication, therefore also demonstrated some degree of trust in the lawyer (Allinson and Chaar 2016).

4.3. *The Benefits of Building “a Circle of Trust”*

The factors that promote trust between patients and health professionals include competence, social/communication skills, honesty, confidentiality, caring and demonstrating respect for the patient (Allinson and Chaar 2016). As mentioned above, direct referrals by a trusted health professional to a lawyer may sow the seed of establishing a similar confidence in the lawyer or practice to whom a patient is referred. Clearly, the skills and attitudes of key staff are also crucial to effective client referrals. Successful referrals require empathy, respect for the client, cultural sensitivity, comprehension of levels of client distress and non-judgmental attitudes. Referring staff also need to possess the knowledge, capacity and skills to support their clients to access other services, including being able to negotiate ways to overcome any possible barriers to service access (Australian Attorney-General’s Department n.d.).

5. Confidentiality and Protocols

As Gyorki notes, providing direct referral pathways from health professionals to on-site legal services such as the Legal Clinic has the capacity to significantly improve health outcomes for disenfranchised individuals (Gyorki 2014). However, moving away from traditional legal service models in a lawyer’s office and integrating legal services within a healthcare setting where lawyers are part of the healthcare team also presents a number of practical professional and ethical difficulties (Gyorki 2014).

As Benfer notes, both lawyers and law students working in health–justice partnerships must be particularly cognisant of client confidentiality and ethical obligations as well as the need to protect lawyer–client privilege and privileged work product (Benfer 2014). Both the legal and health partners must also be aware of their different professional reporting, information-sharing, privacy, insurance and statutory obligations and take deliberate steps to comply with what is required so as to avoid liability and breach (Benfer 2014).

Consequently, it is necessary to develop clear protocols between the referring and receiving service providers. These could be in the form of “memoranda of agreement” or other forms of formal agreement, which outline the relationships and delineate the roles and responsibilities of the collaborating partners (Australian Attorney-General’s Department n.d.). In addition, arranging education for the different partners on rules and ethical policies, preparing agreements on emergency care in the event of injury, having information-sharing policies and holding current professional and regulatory accreditation and approvals are necessary (Benfer 2014). Where confidential information is to be shared between health service and legal service providers, formal agreements are essential and any policies, arrangements and/or agreements made between the parties should be periodically reviewed and modified as appropriate (Benfer 2014).

What We Did

The legal and health professionals and the students involved in the Legal Clinic worked collaboratively to ensure that the best interests of the client were the paramount concern. The overall aim of the clinic was to work collaboratively to achieve better health, wellbeing, legal and social outcomes for the patients/clients. As alluded to above, the arrangements between the health and

legal professionals consisted of a range of formal and informal processes, which included establishing proper and ethical referral protocols and procedures.

If a client agreed to a referral to the Legal Clinic, for example, they were asked to sign a confidential consent form (which was able to be individualised and adapted). It included details such as their personal particulars (name, address, contact details), an overview of the patient/client's concerns, the details of the treating/referring health practitioner and patient/client name, signature and date block.

The arrangements between the legal and health professionals were premised on the following:

- Each professional's understanding of their ethical obligations to individual patients/clients in line with their own discipline's ethical framework and the appropriate sharing of these obligations with the other discipline professions as required (as discussed during the preliminary training session);
- The professionals working together as an interdisciplinary team to develop and maintain positive working relationships and open channels of communication with each other and to put the patient/client's best interests ahead of their own;
- Establishing and continuously building inter-professional trust and respect through regular formal and informal meetings to provide feedback and resolve any problems arising;
- Being committed to providing a holistic wrap-around patient/client service directed towards achieving better patient/client outcomes. Regardless of the direction of referral, the aim of referring clients is to "deliver high-quality, timely, safe and ethical services" to the client.
- Administratively, the Health Service was responsible for the following:
 - Obtaining the patient's consent to be referred to the Legal Clinic;
 - Making an appointment with the Legal Clinic for the patient by telephone or in person, and/or alternatively, on occasion, escorting the patient to the Legal Clinic and (at times) attending the interview with them in a support capacity;
 - Providing (where possible) a personal hand-over of the patient/client to the Legal Clinic.

In addition to consulting the client and providing legal advice and assistance and forward referral if necessary, the Legal Clinic was responsible for drafting ethical referral protocols and procedures, including basic client consent forms (which were individualised and adapted in light of a client's personal characteristics, vulnerabilities and diagnoses). The Legal Clinic was also responsible for maintaining client records on behalf of the auspicing law firm.

6. Case Studies from the Legal Clinic

The following two client case studies highlight the benefits of providing a holistic wrap-around client service in the Legal Clinic.

6.1. Case Example One

A patient/client with significant mental health issues was facing a number of criminal charges interstate. On account of those issues, the patient/client had been unable to attend court interstate for over a year, but a further court date was pending. The Health Service "warm-referred" the client to the Legal Clinic. On initial consultation, the client was reluctant to do anything to address the criminal charges issue. With the consent of the patient/client, the lawyer asked the health professional to attend the next interview as a support person. The lawyer then explained to both the possible consequences of not dealing appropriately with the criminal charges and the upcoming court attendance. Ultimately, the patient/client, after encouragement from the health professional, gave instructions to the lawyer to address the criminal charges. After significant work by the lawyers and the law students, the Court agreed to dismiss the charges against the client. The health professional subsequently advised the lawyers that the patient/client "was in a much better place psychologically as a result of the criminal charges being dismissed".

6.2. Case Example Two

A patient with significant work-related spinal injuries, psychological distress, constant pain and a lack of financial resources was warm-referred to the Legal Clinic by the Health Service. Although the client had already retained a private lawyer in relation to a negligence claim against the client's employer, there had, from the client's perspective, been a significant delay in resolving the dispute and there were, on the face of it, a number of outstanding legal issues that the law firm had not addressed. These included the question of outstanding monies owed by the employer, a possible victim of crime application and housing issues. There are a number of possible explanations for these "omissions" by the retained lawyer including that lawyers may have been "siloe" by specialising in certain areas of law, such as personal injury or negligence, rather than considering a broader spectrum of social justice issues such as helping the client to secure government housing. In this case, for example, the low level of prescribed fees for making a victim of crime application in the relevant jurisdiction, as per Section 12(2) of the Australian Capital Territory's *Victims of Crime (Financial Assistance) Regulation 2016 (ACT 2016)*, offered little financial incentive for the retained private lawyers to undertake the work. The (pro bono) clinic lawyer, with the assistance of the health professional, identified all the relevant issues that were negatively impacting the client's ability to fully recover their health and to become financially and physically independent. After consulting the retained lawyer and requesting that they "accelerate" their assistance to the client, the Legal Clinic assisted the patient/client to recover the monies owed and to ensure access to disability-appropriate accommodation. The health professionals anecdotally reported to the lawyers that there had been an improvement in the client's health and psychological status after the Legal Clinic's intervention.

7. Conclusions: Lessons Learned—The Way Forward

While there is clearly more work to be done to optimise the scope and practice of legal clinics, such as the one described in this article, as well as to define the types of services that such clinics offer to clients, the pilot clinic's reported patient/client outcomes, as exemplified by the two case studies above, were positive. Two of the key components in this particular legal clinic's success were, firstly, in the view of the authors, the referral system adopted by the health and legal professionals. Secondly, the shared aspirations and the ongoing mutual relationships of trust, confidence and friendship fostered by all parties were pivotal. However, as the reported positive outcomes largely rely on informal feedback from the participating lawyers and health professionals and a brief on-line survey of the law students who worked in the clinic, a more formal mechanism of assessing patient/client outcomes, determining the appropriateness of the referral systems used in such environments and assessing the real benefits to law students is needed. This offers significant scope for future research.

In addition, as the pilot clinic was operated by an informal agreement between the legal academics, the auspicing law firm and the Health Service, the authors agreed that more attention needed to be given to this issue in future iterations of the clinic. The informal agreement underpinning the operation of the pilot clinic was a "handshake" deal based on a shared goal of improving outcomes for patients/clients while also providing practical legal experience for law students. Despite this informality, arrangements were nevertheless put in place to safely share patient/client information and to include, as necessary, and with the client's consent, the referring health professional as a "support person" in the Legal Clinic's client interviews. The rationale for having health professionals attend the Legal Clinic patient/client interviews was to ensure that they gained a better understanding of the legal parameters and complexities of their patient's situation. This arrangement also avoided the need for the health professional to take their own notes of the interview, therefore avoiding their inclusion of these records in any subpoenas of patient records. To facilitate this arrangement, as well as the referral itself, prior to being referred, patient/clients were asked to sign a confidential consent form which allowed the lawyers and health professionals to share any patient/client information that was relevant for legal purposes. While all patients/clients did sign the consent form, it was also made clear

to them that should they not wish to sign the consent form, they would still be able to access the Legal Clinic and its free legal services.

In moving forward, the authors considered that formalising the original “handshake” arrangement with a comprehensive written memorandum of understanding around the objectives, roles, responsibilities and records management obligations of the different parties and professional disciplines participating in the clinic was important. Commentary on these developments and what was done as the pilot Legal Clinic entered the next stage of its genesis are, however, outside the scope of this article, which focuses on the establishment and operation of the pilot clinic.

While the pilot clinic ran successfully on a shoestring and without any funding from the university (apart from the provision of an on-campus space in which to house the clinic and interview clients), securing ongoing funding for the clinic and also ensuring its continuing independence moving forward were both considered to be imperative (and beneficial) attributes. The legal and health professionals who designed, established and operated the clinic contributed their ideas and labour on a voluntary and pro bono basis and brought significant goodwill to their efforts on the clinic’s behalf. This approach of course reflects a volunteer and public service ethos that is also very much part of the Australian community and the professions. However, in order to promote sustainability, to provide a dedicated workspace and to offer greater numbers of law students the opportunity to obtain on-campus legal practice experience, some degree of funding would likely be necessary.

Although this pilot Legal Clinic focused on a particular alliance between legal and health professionals, many other professional alliances are possible and could offer many potential benefits, including by “future-proofing” the students of a range of different disciplines. For example, work-integrated learning and working agreements/alliances between lawyers and accountants, lawyers and economists, lawyers and engineers and engineers and architects, to name just a few, could capitalize on the similar skills needed by each, as well as exploring the value of the different insights to practice to be gained from working more closely across professional disciplines. This area is ripe for both creative practical applications and future research.

The success of the pilot Legal Clinic suggests that achieving positive client outcomes in respect legal, health and social concerns will be facilitated through providing supportive, professional and compliant interdisciplinary referrals. Integral to this is developing and maintaining the relationship of trust and respect between the different professions. Where this works well, as it did with the pilot health–justice legal advice clinic, no passport is required to cross the border from one professional disciplinary practice to the next.

Author Contributions: Conceptualization, D.B. and A.B.; Project administration, V.d.P. and J.W.; Resources, V.d.P. and J.W.; Writing—original draft, D.B. and A.B.; Writing—review & editing, D.B. and A.B. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Conflicts of Interest: The authors declare no conflict of interest.

References

- ABC Television. 2018. *Q&A Special: #MeToo*. ABC Television Australia. Available online: <https://www.abc.net.au/qanda/qa-metoo-special/10649600> (accessed on 14 June 2020).
- ACT. 2008. *Children and Young People Act 2008*. Canberra: ACT.
- ACT. 2016. *Victims of Crime (Financial Assistance) Regulation 2016*. Canberra: ACT.
- Adams, Justice. 2000. *Goldsmith v Villaneuva*, [2000] NSWSC 1181 at [17] per Adams J.
- Allinson, Maria, and Betty Char. 2016. How to Build and Maintain Trust with Patients. Pharmacy Learning Centre. Available online: <https://www.pharmaceutical-journal.com/eye-care/how-to-build-and-maintain-trust-with-patients/20201862.article?firstPass=false> (accessed on 14 June 2020).
- Australian Attorney-General’s Department Referral Guidelines. n.d. Available online: <https://www.ag.gov.au/FamiliesAndMarriage/Families/FamilyRelationshipServices/Documents/Referral%20Guidelines.doc> (accessed on 28 July 2020).

- Australian Medical Association. 2016. Available online: <https://ama.com.au/media/new-code-ethics-doctors#:~:text=%E2%80%9CThe%20AMA%20textquoterights%20Code%20of%20Ethics,patients%2C%20colleagues%2C%20and%20society> (accessed on 14 June 2020).
- Australian Psychological Society. 2007. Code of Ethics (in Australia) for Psychologists. Available online: <https://www.psychology.org.au/getmedia/d873e0db-7490-46de-bb57-c31bb1553025/APS-Code-of-Ethics.pdf> (accessed on 14 June 2020).
- Australian Solicitors Conduct Rules. 2015. *Solicitors Conduct Rules 2015*. Available online: https://www.lawcouncil.asn.au/files/web-pdf/Aus_Solicitors_Conduct_Rules.pdf (accessed on 14 June 2020).
- Benfer, Emily A. 2014. Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education. *The Journal of Legal Medicine* 35: 1130148. [CrossRef] [PubMed]
- Brown-Irava, Cheryl, El-Chami Miriam, and Wong Francisca. 2017. UC Health-Justice Clinic: Law students tackle the intricate interplay of legal and health issues. *Ethos* 245: 36–40.
- Clarke, Sophie, and Suzie Forrell. 2007. Pathways to justice: The role of non-legal services. *Justice Issues*. Available online: [http://www.lawfoundation.net.au/ljf/site/articleIDs/B0B818584C14F361CA257306000716A2/\\$file/pathways_to_justice.pdf](http://www.lawfoundation.net.au/ljf/site/articleIDs/B0B818584C14F361CA257306000716A2/$file/pathways_to_justice.pdf) (accessed on 14 June 2020).
- Curran, Elizabeth. 2016. *Research and Evaluation Report for the Bendigo Health–Justice Partnership: A Partnership between Loddon Campaspe Community Legal Centre and Bendigo Community Health Services*. Canberra: International Centre for the Profession, Education and Regulation in Law (PEARL), ANU.
- Dal Pont, Gino E. 2010. *Lawyers and Professional Responsibility*, 4th ed. Sydney: Lawbook Co.
- Ewais, Tatjana, and Cate Banks. 2018. Health and justice partnerships for young adults—When health and law unite in care. *Health Education Journal* 77: 656–66. [CrossRef]
- Gyorki, Linda. 2014. *Breaking Down the Silos: Overcoming the Practical and Ethical Barriers of Integrating Legal Assistance into a HealthCare Setting*. Churchill Fellowship Report. Melbourne: Inner City Melbourne Community Legal.
- Jacobson, Peter D., and M. Gregg Bloche. 2005. Improving Relations between Attorneys and Physicians. *Journal of the American Medical Association* 294: 2083–85. [CrossRef] [PubMed]
- Kaye, Fullagar, and J. J. Ormiston. 1991. *Director of Public Prosecutions v Smith*. [1991] 1 VR 63; Appeal Division of the Supreme Court of Victoria (at 75). Victorian Reports. Melbourne. Available online: <https://victorianreports.com.au/judgment/1991-1-VR-63> (accessed on 14 June 2020).
- Leaning, Jennifer. 1997. Human Rights and Medical Education: Why Every Medical Student Should Learn the Universal Declaration of Human Rights. *British Medical Journal* 315: 1390–91. [CrossRef] [PubMed]
- Mehrig, Sigrid. 2014. *First Do No Harm: Medical Ethics in International Humanitarian Law*. International Humanitarian Law Series; Leiden: Koninklijke Brill NV, vol. 44.
- Nathanson, Vivienne. 1997. Humanitarian Action: The Duty of All Doctors: Humanitarian Issues, Large and Small, Are All around Us. *British Medical Journal* 315: 1389–90. [CrossRef] [PubMed]
- Royal Australian College of General Practitioners. 2014. *Abuse and Violence: Working with Our Patients in General Practice*, 4th ed. East Melbourne: The Royal Australian College of General Practitioners, Available online: <https://www.racgp.org.au/getattachment/4e803844-24c6-4c89-8f81-0f20c454bb31/Abuse-and-violence-Working-with-our-patients-in-general-practice-br-White-Book.aspx> (accessed on 14 June 2020).
- Weekes, Jenny. 2019. Self-reported insights and anecdotal evidence as noted by the fourth, general practitioner author.

