Speldewinde, CA and Parsons, I 2015, Medical-legal partnerships: the role of mental health providers and legal authorities in the development of a coordinated approach to supporting mental health clients' legal needs in regional and rural settings*, Rural and remote health*, vol. 15, no. 4, Article number: 3387, pp. 1-11.

Rural and Remote Health
MEDLINE listed
Impact factor 0.878
ISSN 1445-6354
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy

REVIEW ARTICLE

Medical-legal partnerships: the role of mental health providers and legal authorities in the development of a coordinated approach to supporting mental health clients' legal needs in regional and rural settings

CA Speldewinde, I Parsons

Centre for Rural Regional Law and Justice, School of Law, Deakin University, Waterfront Campus, Geelong, Victoria, Australia

Submitted: *24 November 2014;* ***Revised:*** *10 August 2015;* ***Accepted:*** *18 August 2015;* ***Published:*** *11 November 2015*

Speldewinde CA, Parsons I

Medical-legal partnerships: the role of mental health providers and legal authorities in the development of a coordinated approach to supporting mental health clients' legal needs in regional and rural settings
Rural and Remote Health **15: 3387. (Online) 2015**

Available: http://www.rrh.org.au

ABSTRACT

Introduction: Medical-legal partnerships (MLP) are a model in which medical and legal practitioners are co-located and work together to support the health and wellbeing of individuals by identifying and resolving legal issues that impact patients' health and wellbeing. The aim of this article is to analyse the benefits of this model, which has proliferated in the USA, and its applicability in the context of rural and remote Australia.

Methods: This review was undertaken with three research questions in mind: What is an MLP? Is service provision for individuals with mental health concerns being adequately addressed by current service models particularly in the rural context? Are MLPs a service delivery channel that would benefit individuals experiencing mental health issues?

Results: The combined searches from all EBSCO Host databases resulted in 462 citations. This search aggregated academic journals, newspapers, book reviews, magazines and trade publications. After several reviews 38 papers were selected for the final review based on their relevance to this review question: How do MLPs support mental health providers and legal service providers in the development of a coordinated approach to supporting mental health clients' legal needs in regional and rural Australia?

Conclusions: There is considerable merit in pursuing the development of MLPs in rural and remote Australia particularly as individuals living in rural and remote areas have far fewer opportunities to access support services than those people living in

regional and metropolitan locations. MLPS are important channels of service delivery to assist in early invention of legal problems that can exacerbate mental health problems.

Key words: Australia, coordinated approach, legal needs, medical-legal partnerships, mental health.

Introduction

In recent decades, a body of scholarly work has been devoted to considering individuals living with mental health issues in rural and regional Australian contexts. Consistently, this work confirms that a significant gap exists in the provision of services designed to support the people experiencing mental health concerns who reside away from the major metropolitan centres of the Australian coastal fringe. Where services do exist, it has been identified that individuals demonstrate a reticence to use those services. It has been confirmed that service provision is impacted by distance, irregular availability of mental health specialists working on a fly-in, fly-out basis and a disconnection between general medical services and mental health services. This article will consider the benefits of the medical-legal partnership (MLP) model, which has proliferated in the USA, and its applicability in the context of rural and remote Australia. It will demonstrate by outlining how this partnership model operates, that this form of partnership can fill a gap in provision of mental health services in contexts away from metropolitan areas. In conclusion, it will provide recommendations based upon the early work of an action research project in regional Australia as to the applicability of this model to the mental health sector.

Methods

This article describes a review of literature pertaining to MLPs that was conducted to develop an understanding of how the model functions and the potential for it to be rolled out across rural and remote Australia. The review was aimed with three research questions in mind: What is an MLP? Is service provision for individuals with mental health concerns being adequately addressed by current service models particularly in the rural context? Are MLPs a service delivery channel that would benefit individuals experiencing mental health issues? This review was conducted using A Measurement Tool to Assess Systematic Reviews (AMSTAR) guidelines as the framework in the development of this article and was initiated to understand the literature in support of an action research project that is investigating whether a dual-site rural and regional MLP can be established in the Barwon region of Victoria, Australia.

Inclusion and exclusion criteria

To be included in the review, literature had to be published in the English language, between the years 1993 and 2014. Literature focusing on MLPs was sourced from global sources and no exclusions in terms of regions or countries were applied. Only literature specific to rural mental health and that focused upon Australian contexts was used. Contrary to these search parameters, two papers are included in this literature prior to 1993. This occurred as these two papers were found as citations in a later paper, and these two papers, both by Bernstein, were deemed highly relevant.

Search strategy

The search was structured around the key terms 'medical legal partnership', 'mental health', 'rural' and 'Australia' and variants of these. The search was directed toward ensuring that an understanding could be gained of what an MLP is, how MLPs could work in the mental health sector and to consider whether MLPs are an appropriate way of delivering better mental health support services in a rural context. Search limits were set to English-language publications between 1993 and onwards for 'medical legal partnership'

and refined further to 2000 and onwards for 'mental health', 'rural' and 'Australia'. The year 1993 was chosen for 'medical legal partnership' because this was when the first MLP, in Boston, Massachusetts, commenced operation. It is acknowledged that mental health literature started to appear in the Australian literature earlier than 2000; however, because the key theme of this article is MLPs and the mental health component complements the overarching themes of MLPs here, 2000 was chosen as it provided both a rounded historical and a current selection of relevant literature.

The search structure was broad: all EBSCO Host databases were used, slightly differently in each search depending on the limitations of the individual database. The search included Academic Search Complete, ERIC, Legal Source, MEDLINE, Newspaper Source Plus and PsycINFO databases. A Google Scholar search was also used. Where available, the status of publication was used as an inclusion criterion and in most cases EBSCO Host database identifies grey literature such as conference proceedings and theses.

Results

Search

The combined searches from all EBSCO Host databases resulted in 462 citations. This search aggregated academic journals, newspapers, book reviews, magazines and trade publications. After reviewing all titles and, when provided, associated abstracts, 267 articles were removed from the search due to duplication or as a result of the titles not indicating relevance to the aims of this review. Abstracts from the remaining 195 articles were read, resulting in the rejection of 85 articles. These articles were rejected as they did not fall within the criteria of MLPs, that is, they were partnerships but not between legal and medical practitioners. They considered partnerships, for example, between general practitioners and specialist medical services such as psychiatrists in rural settings. The remaining 110 full articles were read and 38 were selected for the final review based on their relevance to the following review question: How do MLPs support mental health providers and legal service providers in the development of a coordinated approach to supporting mental health clients' legal needs in regional and rural Australia?

What we discovered was that the MLP model is growing rapidly in the USA but there is very little in the way of scholarly literature on Australian examples. As will be discussed further, the literature found in the search clearly shows that, in the USA, benefits abound for patients who have access to MLPs. Applying the model in different medical contexts makes little difference to the success of the MLP – regardless of the medical context, be it general practice or more specific medical clinical operations such as mental health, patients who have access to the MLP exhibit improved health outcomes. The access to a legal professional, when many individuals with medical conditions either lack awareness of a legal issue or avoid a legal issue, makes a significant positive difference to health outcomes.

Discussion

Context of medical-legal partnerships in Australia and elsewhere

Medical-legal partnerships are joint ventures between lawyers and medical professionals. They entail a partnership arrangement integrating legal assistance into a medical setting whereby both partners seek to identify and resolve legal issues that impact patients' health and wellbeing. Typically, the types of legal support provided include civil problems such as issues pertaining to tenancy, income support, rights to education, divorce, guardianship and power of attorney[1-3].

An established network of MLPs operates in various guises in the USA. These MLPs operate in the context of general practice medicine and in more specific services such as those in the mental healthcare space, and they can incorporate psychiatrists, psychiatric nurses and social workers. Regardless of how an MLP operates, they can be observed engaging in three key activities: providing legal help in a

healthcare location, transforming the practices of legal and health institutions, and influencing policy change. It has been shown that many disadvantaged people are more likely to access the healthcare system than they are to access the existing legal systems. Providing legal support and services to those who are disadvantaged has been shown to significantly impact their health. There is the concomitant outcome of potential reductions in overall costs to the public health[4,5].

Despite Noble's[4] indication that the MLP model in Australia is in its infancy, there has been a form of MLP operating in Australia since 1978. Noone[5] details the arrangement between the West Heidelberg Community Legal Centre and Banyule Community Health. Noone describes this as 'an interorganisational collaboration' in which the needs of the socially disadvantaged community are met by 'two different services with separate funding bodies.'[5] The two distinct bodies share their facilities and their expertise through organisational co-location, intermingling of organisational structure at board management level, a formal and informal process of cross-referral when opportunities are identified, the use of a common reception area, and attendance by legal staff engaged to work with other disciplines at health centre staff meetings. Other examples of multidisciplinary legal practices exist in the Australian community legal centre sector. This includes a working MLP model fashioned upon the established US model operating in regional Victoria under the auspices of the Loddon-Campaspe Community Legal Centre in a partnership arrangement with philanthropic donors[4,6].

Although descriptions of the benefits of a collaborative approach between lawyers and health workers in the USA were made in the mid-1970s[7,8], the origins of the MLP model did not occur there until the early 1990s. This model in the USA was first developed in 1993 at the Boston Medical Center[9]. This was a combination of medical and legal professionals with differing skill sets who sought to educate one another and treat social determinants of health[10]. This first MLP was directed at 'address[ing] social factors affecting health that could be remedied through legal action[11,12].' In short, the Boston MLP provided benefits that extended beyond the provision of a legal service to clients because it also incorporated training to health practitioners, resulting in a model that offered both preventative health and preventative law. It was also confirmed that the health benefits associated with the MLP improved short- and long-term patient health – levels of stress were noticeably reduced, as was patient adherence to required medical treatment[9-14].

Colvin et al[11] mention that, by 2010, the MLP 'model has spread to over 100 hospitals and 116 community health centres across the United States and by 2013 MLPs were present in over 500 health and legal institutions nationally[14].' The MLP model can manifest itself in varying ways from specialised forms of medicine such as diabetes or mental health to a holistic service encompassing legal and medical issues. To support the expansion of the network of MLPs across the USA, the National Center for Medical-Legal Partnerships was established as a guiding body for the establishment and ongoing function of MLPs[10].

Despite the proliferation of the MLP model in the USA, it is one that has not gained a foothold in the Australian context of healthcare delivery, aside from the relatively isolated examples already noted. Therefore, we seek to highlight within this literature review the potential for the replication of the MLP model in Australia and the application of the model in regional and rural Australia, drawing on the mental health context. Mental health issues of individuals living in the regional and rural Australian context are acknowledged in a corpus of literature as an indicator of the needs for greater availability of mental health services.

Service delivery for mental health problems in rural Australia

There exists a large body of literature considering the issues surrounding the treatment of individuals with mental health issues in regional and rural areas of Australia. Much of this literature highlights shortfalls in the treatment and support of individuals living with mental health issues. One of the earliest pieces of work in the review time period (2000

onwards) raised the significance of an issue that was 'a growing cause for concern[15].' Costs to the community associated with mental health problems at that time were burgeoning and, although being addressed in urban regions, rural mental health, particularly a rural mental health workforce, was critically underserved. Services described as 'fly-in, fly-out' were provided as a solution to the mental health patient living in the rural context, as were teleservices provided remotely[15]. Yet, at the start of the twenty-first century, the need for a strategy to address this issue was noted as being 'well overdue[15].'

Kelly et al identify that 'a minority of people with mental health problems seek and receive treatment, indicating a pressing need to improve the reach and appropriateness of mental health services. This is especially relevant for people living in rural and remote regions.'[16] A lack of professionals in regional Australian areas accompanies the lower rates of service use for problems associated with mental health. Kelly et al confirm that the services required to support mental health patients need to be reviewed and tailored to suit the varied locations of regional and rural Australia. Similarly, Allan confirms that individuals experiencing mental health issues living in regional Australia have to deal with issues of insufficient resourcing, inadequate access to services, health worker burnout and a health system that suffers from the cost of dealing with crisis rather than prevention[17]. It should be acknowledged that much of the literature here is of a historical nature. To consider more recent developments in the delivery of health services in a remote context, the potential for the MLP to become an element of e-health and telehealth initiatives in Australian rural and remote health delivery was considered[18]. Recent literature highlights a slow growth in the uptake of this new delivery channel and this lack of growth would only add a further level of complexity to establishing the MLP model, which has been ignored by Australian medical professionals until now. Across the research, the common themes exists that the strength of the MLP exists in its face-to-face functionality. Testing of the applicability of the model using video technology is a gap in the literature but one with the potential for exploration in the Australian context as this mode of communication gains popularity.

In the context of arguably Australia's most rural state, with a high number of remote communities, Western Australia, those same issues identified by Judd and Humphreys[15] were also confirmed by Sweeney and Kisely[19]. They were further exacerbated by a disconnection between GP services and mental health. Exacerbating the issues for individuals with mental health conditions is a rural health system with barriers to collaboration, of which Sweeney and Kisely give an example. Issues with management, poor communication, difficulties in referral between services and cultural differences between services all led to client dissatisfaction. In particular, Sweeney and Kisely mention the relationships between GPs and mental health services in a regional setting in which 'confusion (existed) as to the exact role of mental health services, after-hours access, the provision of counselling to those in situational crisis, communication problems, differences in working practices and difficulties dealing with the stigma of mental illness in rural communities[19].' Again, remoteness has the ability to be reduced by telehealth services but no reported research into the capacity of co-located services using technology is available[20] .

The concerns surrounding service provision remain as a critical factor in providing adequate services to support individuals who are living in the rural context and have mental health problems. The role of GPs in attending to mental health patients, in particular for individuals experiencing depression, was further highlighted and issues surrounding the care of these patients were noted as health services needing to 'align themselves more closely' to ensure successful treatment of high-prevalence disorders such as depression[21]. Likewise, in addition to the health services themselves, broader issues around employment, education and training; housing and accommodation; transport; social inclusion; and mental health promotion remain key factors in facilitating support frameworks[22,23].

Lockhart[24] highlights the benefits of partnerships in supporting people in rural and remote Australia with mental illness but from the perspective of partnership between the GPs and community-based mental health workers. In 2006, when the article was published, Lockhart drew attention to the rural GP being the main point of treatment for mental illness to the extent that rural GPs managed similar or greater percentages of cases than urban GPs.

Medical-legal partnerships and mental health

The function of MLPs can vary and partnerships exist that function in the context of providers of mental health support and services[11]. The medical partners in an MLP with this mental health focus can be specialists such as psychologists, psychiatrists, mental health nurses and social workers. Colvin et al[11] draw upon the work of Cohen et al[10] to support this statement, yet a rigorous search of literature through internet searches using both Google Scholar and literature search engines such as EBSCO Host has uncovered little discussion on the partnerships that focus explicitly upon mental health. The benefits of the partnership between a mental health support service and law providers has been reviewed by Kisely et al with a conclusion that partnering mental health workers and police officers leads to an improvement in the treatment of people with mental illness[25]. This study evaluated a partnership in Nova Scotia in which a mobile crisis response service incorporated teams of mental health and plain clothes police professionals who would respond to severe and acute situations in the community. Kisely et al confirm that there has been limited formal evaluation or information on mobile services, a similar situation to the evaluation of MLPs with a mental health focus. This example of a partnership arrangement – although differing from those considered earlier in that this service is mobile – is evidence of the benefits of MLPs to individuals with mental health concerns. The benefits associated with collaboration are shown to lead to improved and more efficient treatment of mental health issues. It is crucial here to acknowledge that this is a different model – it is a partnership with police rather than with lawyers. This is highlighted to support the notion that partnership arrangements for mental health patients provide a clear benefit to treatment of mental illness.

The distinction between the mobile MLP model and one that is office-bound and sedentary has not yet translated to scholarly research. The search conducted as part of this review did not uncover literature that compares these two variants of MLP. Thus, the potential that exists for further study of the various MLP models such as those already considered here has not translated into a comparative analysis that can be used to identify strengths and weaknesses in each model. Issues such as continuity and awareness of service, costs to service providers and, ultimately, the benefit to the client are all areas of further study to determine the best form of the MLP model.

To the more conventional arrangement of a co-located MLP within the bricks-and-mortar building of a medical practice, the benefits of the MLP arrangement for people with mental health problems are most recently confirmed by Chaudary[26] and his experiences of Indiana's first community mental health centre. Chaudary indicates that the discontinuance of a service was noticed by a care team specialising in helping mental illness patients. The matter was raised with the appropriate state agency but the care team did not achieve a satisfactory response from the agency. The matter was then taken by the care team of clinicians, a psychiatrist and care coordinators to the MLP. The MLP lawyer then took up the matter, acted as the representative, and came up with a solution to overcome this issue. Chaudary states that 'this was a problem that could only have been addressed by a medical-legal partnership.' Through collaboration, an acceptable approach informed by medicine and law was found to address an issue at a systems level, which then benefited the mental health patient.

Coumarelos et al[6] have made a clear connection between everyday problems that involve the law and long-term illness/disability, particularly mental illness, in the Australian context. They confirm the direct or proximal connection of health status to legal needs associated with housing issues to domestic violence and draw upon the Legal Australia-Wide

(LAW) survey authored by Coumarelos et al[27] to support their conclusions. They also make a case for the integration of services based upon data that indicates a need for more effective referral practices as well as the securing of early intervention in problems with the potential to exacerbate. Coumarelos et al make it clear that health inequalities are reduced when the availability of legal assistance is prevalent[6].

A study in Tucson, Arizona, of the application of the MLP model examined patients with mental health related concerns, issues pertaining to perceived stress and wellbeing and how the MLP delivers legal services to people with high levels of stress[28]. Confirmation of the social determinants of health incorporating work environment, legal concerns and housing and how psychological stress can impact these determinants have been considered along with social disadvantage. Lifestyle choices such as unhealthy dietary patterns, sedentary behaviour and smoking, which can lead to heart disease and cancer, are all critical components that can be impacted by stress and the subsequent reduction of stress can then lead to improved health outcomes. Ryan et al highlight these issues, then describe how legal practitioners placed within an MLP can support the reduction of psychological stress[28]. In a family advocacy program located within the University of Arizona, free legal services are provided to 'referred low-income patients'. This is complemented with legal advocacy training provided to medical residents to support referral generation. As one of the rare quantitative studies that considers stress and wellbeing and a patient's participation in an MLP model, this article provides confirmation of the benefit that an individual with mental health issues can garner from involvement in the MLP model. This work provides substantive evidence to support the development of the MLP model within the mental health sector.

Documented accounts of medical-legal partnership models

This article seeks to confirm the current shortfall in scholarship pertaining to the impact of MLPs with a mental health focus while reviewing the literature that considers MLPs. Much of the documentary evidence and illustrative material relating to the MLP model provides accounts of how legal issues impact the health of individuals in low socio-economic situations. Zelhof and Fulton[1] provide an account of the operation of an MLP with a mental health focus. Mobilization for Youth Legal Services commenced by providing outpatient MLP services in the mid-1980s in New York with funding from the city's Department of Health and Mental Hygiene. The MLP aimed to deal with civil legal problems that affect a patient's mental health and with issues of homelessness, which negatively impact individuals with mental health issues. This is not a service that acts in a representative capacity around involuntary treatment and detention matters; it is a service 'dedicated to simultaneously servicing both legal and treatment needs' in outpatient mental health program or temporary hospital situations[1]. In a society in which 25% of adult Americans suffer from a mental disorder in a given year, destabilisation associated with legal issues can have a significant impact on individuals living with mental health issues[1]. Meeting the needs and mitigating external stressors are the impacts that an MLP with a mental health focus can provide to clients. It is the MLP that can play a role as part of an interdisciplinary approach to supporting mental health clients and this is supported by the work that Mobilization for Youth Legal Services has been shown to undertake for its clients.

The provision to use law students is an element of the MLP model that is building momentum as a method of providing clinical legal experience to budding lawyers[29,30]. Wettach provides an example of a functioning Tennessee MLP that utilises law students and gives them 'an opportunity to work directly with other professionals' from disciplines outside of the law[29]. In addition to the obvious benefit of building expertise in applying legal knowledge in a client-based situation, Wettach also considers the communication and presentation skills along with the interdisciplinary focus derived from working within a medical centre as being clear benefits to the law student. From the mental health client perspective, like many scholars reporting on the benefit to the MLP, Wettach views the learning derived by the lawyer as being beneficial to the client, allowing the lawyer to gain a

clearer understanding of the issues associated with mental health. Wettach highlights the ideal nature of law school clinical programs as MLP partners: 'student participants can both contribute greatly to and benefit tremendously from the relationship.' Despite the potential for a law student to lack 'on-the-ground' practical and clinical experience due to a lack of contact opportunities with clients, Wettach raises no concerns in her article about the lack of practical experience of a law student detracting from the quality of advice or support provided to the client.

Vingilis and Fuhrmann confirm that the concept of using student law services to support people with serious mental illness is not new[30]. Their article, which focuses solely upon the role that law students can play in community legal services, although not an example of an MLP, confirms that law students can be equipped to support people with mental illness. This leads to the potential to co-locate law students within a functioning MLP. They mention that 'the hospital can provide a more secure setting to both the persons with SMI [severe mental illness] and the law students because of the support of hospital staff and familiar surroundings, as compared to an unfamiliar legal clinic.' This notion of co-location to support the mental health patient is not explicitly defined as an MLP in this article, yet it fits the MLP model convincingly.

Away from the mental health MLP model, Barratt Marshall describes the operation of the MLP model in Philadelphia and how one MLP is supporting the medical and legal rights of the lesbian, gay, bisexual and transgender community[13]. This MLP is identified as a service that co-locates services to provide greater access to resources that address wellness issues. Further documented accounts reinforce MLPs, which have a more generalist health focus, as services that are interdisciplinary, provide a complete method for attending to patient welfare and lead to solutions to patient-related problems not necessarily able to be handled by healthcare workers. Examples include issues with private health insurance providers and government benefits[31-33], personal safety[31] and housing and tenancy[33,34].

Challenges

Most recently it has been confirmed that significant challenges are being experienced by justice and health agencies as a result of the increasing number of individuals living with mental illness. The response and management of the needs of individuals with mental illness are not being satisfactorily responded to due to a lack of capacity[35].

Coumarelos et al have identified the overwhelming need for integrative models such as the MLP model based upon the varying types of legal problems and forms of illness/disability that exist in Australia[6]. This assertion is made from the perspective of 'both (sides of the) justice and health equality perspectives.' Boumil et al[36] have identified some issues pertaining to the ethics and professional duty that could arise in the MLP model.

Despite the praise being heaped upon the MLP model, there are sceptics who raise concerns over the sharing of confidential client information. For the MLP model to succeed, communication between the medical and legal teams is required. The 'novel legal and ethical concerns' associated with a model in which issues can range from difficulty in identifying who an MLP client is to 'seemingly inconsistent obligations of service providers[36].' According to Boumil et al, ensuring that ethical boundaries are not crossed means that all professional parties involved in the MLP must ensure 'that MLP staff communicate with the patients at every stage of the intervention. Indeed, MLPs must engage in explicit discussion with the patient even prior to the initial referral to the advocacy staff[36].' Issues relating to consent must be dealt with clearly and incorporated into any referral process instigated by the MLP. How communication is undertaken to ensure confidentiality is also paramount, as is confidentiality itself. Boumil et al conclude by stating that 'as long as critical professional obligations are recognized and care is taken to preserve the ethical boundaries of all professionals on the MLP team, physicians, lawyers, and social workers can collaborate without posing undue risk to each other's ethical commitments or compromising each other's professional duties or patient care[36].'

Challenges also exist with funding, sourcing staff and continuity of staff. Almost all of the literature considered in this article alludes to successes but there has been little mention of funding for partnerships. This raises the challenge of what occurs when funding is exhausted. When funding is made available, be it in the form of government or philanthropic funding such as in the Loddon-Campaspe MLP[4], and the funding ends, does this end the partnership? There is no evidence in the literature of failed partnerships. Sourcing suitably trained legal and medical staff willing to partake in the partnership can become an issue. It is apparent from the literature discussed here that legal partner sources are diverse. Student lawyers, pro-bono lawyers or salaried lawyers are all in evidence as members of the partnership. The challenge exists to gain a better understanding of who is best placed to act as the legal partner in an MLP.

Recommendations

A growing network of MLPs have clearly taken hold across the landscape of service provision in the USA for individuals who deal with mental health issues. The literature demonstrates that MLPs in the USA help people with mental health problems to deal with legal issues before they have an even greater impact upon their lives. For example, by dealing with an issue such as non-payment of rent, which could cause a tenant eviction, the additional stress that this can create for a person with mental health problems can be alleviated.

In Australia, there is a need for the integrative model described in this article, which mirrors that of the USA, to fill a gap in service provision for individuals living with mental health concerns. This is particularly pertinent to rural and remote Australian contexts, where services are even less available, and more dislocated from one another than in the cities. In regional and rural settings, mental health and legal professionals working cooperatively have a better capacity to deliver more positive outcomes for communities. Attracting students who are working towards qualifications in legal and mental health practice to rural and remote areas and facilitating their cooperative work with each other through the MLP model is important for the sustenance of those communities as they bring in fresh approaches to dealing with mental health problems. The cost reductions in overheads associated with co-location are a concomitant operational benefit that can be shared. Most importantly, the improved welfare of patients and the benefits to professional staff, which have been proven to be delivered by a functioning MLP model, need to be recognised by state and federal governments. An awareness campaign directed at lifting the understanding of government ministers with portfolio responsibilities for rurality, health and law is required. This is particularly so to complement integrated care initiatives being rolled out across rural sites such as Western Health Care (New South Wales) and the GP Tasmania network[37]. As an overall recommendation, state and federal governments need to gain an awareness of the MLP model and examine ways in which it can support the proliferation of MLPs into the rural and remote context.

Conclusions

This review article has discussed and analysed current and significant research about the role of MLPs and mental health in relation to the establishment of these types of facilities in rural Australia. It has explained what the MLP model is and how it operates in both general health and mental health settings. The literature relating to mental health issues experienced by individuals living in the rural context was briefly explored to provide a context for this issue and why it is important, particularly highlighting the lack of access to mental health services in these communities. The history of the limited MLPs in Australia was considered and was supported by a brief account of how MLPs have developed in the USA. This discussion highlighted the importance of MLPs in assisting to alleviate mental health issues through the opportunities they provide for early intervention and addressing legal problems that may be detrimental to mental health. MLPs provide a means of breaking that destructive cycle. Recommendations for the development of MLPs within the mental health sector were put forth and challenges identified. The significance of MLPs in developing stronger solutions to support people with mental health conditions is

crucial, and developing partnerships to enhance these needs should be considered a priority by those involved in this field of research in Australia.

References

1. Zelhof J, Fulton SJ. MFY Legal Services' mental health-legal partnership. *Journal of Poverty Law and Policy* 2011; **44:** 535-544.

2. Atkins D, Heller SM, DeBartolo E, Sandel M. 2014 Medical-Legal Partnership and Healthy Start: integrating civil legal aid services into public health advocacy, *Journal of Legal Medicine* 2014; **35(1):** 195-209.

3. Lawton EM, Sandel M. Investing in legal prevention: connecting access to civil justice and healthcare through medical-legal partnership., *Journal of Legal Medicine* 2014; **35(1):** 29-39.

4. Noble P. *Advocacy-health alliances: better health through medical-legal partnership*. Bendigo, Vic: Advocacy Health Alliance, 2012.

5. Noone MA. Integrated legal services: lessons from West Heidelberg CLS. *Alternative Law Journal* 2012; **37:** 26-30.

6. Coumarelos C, Pleasence P, Wei Z. Law and disorders: illness/disability and the experience of everyday problems involving the law. *Updating Justice* 2013; **22:** 1-3.

7. Bernstein BE. Lawyer and social worker as collaborators in the medical setting. *Health &Social Work* 1977; **2:** 147-155.

8. Bernstein BE. Lawyer and social worker as an interdisciplinary team. *Social Casework* 1980; **61:** 416-422.

9. Zuckerman B, Sandel M, Lawton E, Morton S. Medical-legal partnerships: transforming health care *Lancet* 2008; **372**: 1615-1617.

10. Cohen E, Fullerton DF, Retkin R, Weintraub D, Tames P, Brandfield J, et al. Medical-legal partnership: collaborating with lawyers to identify and address health disparities. *Journal of General Internal Medicine* 2010; **25(2):** 136-139.

11. Colvin JD, Nelson B, Cronin B. Integrating social workers into medical-legal partnerships: comprehensive problem solving for patients. *Social Work* 2011; **57(4):** 333-341.

12. McCabe HA, Kinney ED. Medical legal partnerships: a key strategy for addressing social determinants of health. *Journal of General Internal Medicine* 2010; **25(2):** 200-201.

13. Barratt Marshall R. Medical/legal partnerships: a holistic approach to health and well-being. *Philadelphia Gay News* 2012; **31:** 13.

14. Lawton E, Tyler ET. Optimizing the health impacts of civil legal aid interventions: the public health framework of medical-legal partnerships. *Rhode Island Medical Journal* 2013; **July**: 23-26.

15. Judd FK, Humphreys JS. Mental health issues for rural and remote Australia. *Australian Journal of Rural Health* 2001; **9:** 254-258.

16. Kelly BJ, Stain HJ, Coleman C, Perkins D, Fragar L, Fuller J, et al. Mental health and well-being within rural communities: the Australian Rural Mental Health Study. *Australian Journal of Rural Health* 2010; **18:** 16-24.

17. Allan J. Determinants of mental health and well-being in rural communities: do we understand enough to influence planning and policy? *Australian Journal of Rural Health* 2010; **18:** 3-4.

18. Jang-Jaccard J, Nepal S, Alem L, Li J. Barriers for delivering telehealth in Rural Australia: a review based on Australian trials and studies. *Telemedicine &e-Health* 2014; **20(5):** 496-504.

19. Sweeney P, Kisely S. Barriers to managing mental health in Western Australia. *Australian Journal of Rural Health* 2003; **11:** 205-210.

20. Oliver-Baxter J, Brown L, Bywood P. *Integrated care: what policies support and influence integration in health care in Australia?* PHCRIS policy issue review. Adelaide: Primary Health Care Research & Information Service, 2013.

21. Wright MJ, Harmon KD, Bowman JA, Lewin TJ, Carr VJ. Caring for depressed patients in rural communities: general practitioners' attitudes, needs and relationships with mental health services. *Australian Journal of Rural Health* 2005; **13**: 21-27.

22. Turpin M, Bartlett H, Kavanagh D, Gallois C. Mental health issues and resources in rural and regional communities: an exploration of perceptions of service providers. *Australian Journal of Rural Health* 2007; **15:** 131-136.

23. Fragar L, Stain HJ, Perkins D, Kelly B, Fuller J, Coleman C, et al. Distress among rural residents: does employment and occupation make a difference? *Australian Journal of Rural Health* 2010; **18:** 25-31.

24. Lockhart C. Collaboration and referral practices of general practitioners and community mental health workers in rural and remote Australia. *Australian Journal of Rural Health* 2006; **14:** 29-32.

25. Kisely S, Campbell LA, Peddle S, Hare S, Pyche M, Spicer D, et al. A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *Canadian Journal of Psychiatry* 2010; **55:** 662-668.

26. Chaudary J. *Transforming systems for people with developmental disabilities: a patients-to-policy story*. (Online) 2014. Available: http://medical-legalpartnership.blogspot.com.au/2014/10/transforming-systems-for-people-with.html (Accessed 30 March 2015).

27. Coumarelos C, Macourt D, People J, MacDonald HM, Wei Z, Iriana R, et al. *Legal Australia-Wide Survey: legal need in Australia*. Sydney, NSW: Law and Justice Foundation of NSW, 2012.

28. Ryan AM, Kutob RM, Suther E, Hansen M, Sandel M. Pilot study of impact of medical-legal partnership services on patients' perceived stress and wellbeing. *Journal of Health Care for the Poor and Underserved* 2012; **23:** 1536-1546.

29. Wettach JR. The law school clinic as a partner in a medical-legal partnership. *Tennessee Law Review* 2008; **75:** 305-313.

30. Vingilis E, Fuhrmann B. The development and introduction of an in-patient student law services for persons with serious mental illness: a case study. *Administration and Policy in Mental Health and Mental Health Services Research* 2007; **34(5):** 470-478.

31. Bliss LR, Caley S, Pettignano R. Bridging the quality gap with medical-legal partnerships. *Physician Executive Journal* 2013; **May/June**: 44-49.

32. Odendahl M. Case illustrates the value of legal-medical partnership. *Indiana Lawyer* 2013; **28 Aug–10 Sept:** 5.

33. Rodabaugh KJ, Hammond M, Myszka D, Sandel M. A medical-legal partnership as a component of a palliative care model. *Journal of Palliative Medicine* 2010; **13:** 15-18.

34. Odendahl M. Representing the most vulnerable. *Indiana Lawyer* 2012; **28 Sept–11 Oct:** 3.

35. Victorian Auditor General. *Mental health strategies for the justice system*. Victorian Government Printer, 2014.

36. Boumil MM, Freitas DF, Freitas CF. Multidisciplinary representation of patients: the potential for ethical issues and professional duty conflicts in the medical-legal partnership model. *Journal of Health Care Law and Policy* 2010; **13:** 107-138.

37. NSW Health. *Integrated Care Strategy 2014–2017 info summary*. (Online) 2014. Available: http://www.health.nsw.gov.au/integratedcare/Documents/integrated-care-info-summary.pdf (Accessed 11 June 2015).

