
Medical-legal partnerships: A new beginning to help Australian children in need

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Drawing on the strengths of both the medical and legal professions can reduce health inequities and preventable illnesses in children from vulnerable families. In response to frequent reports on high-risk injuries and illnesses in children from disadvantaged and isolated communities, the possibility of a multidisciplinary partnership, currently used throughout the United States of America, is explored. Given the limitations of each discipline on their own, the concept of medical-legal partnerships presents an innovative and strategic approach towards caring for Australia's most vulnerable. The development of this partnership will encourage and empower such groups to access fundamental legal and medical resources. The benefits and obstacles of such a partnership, together with social, economic and health data, are examined to reveal the urgent need to adopt a more meaningful approach towards family and paediatric health care. Finally, some of Australia's existing laws and practices are considered and brief recommendations are provided to initiate a proactive solution for the future.

INTRODUCTION

Medical and legal tensions about health care services, allocation of financial resources and legal support continue to require urgent review in Australia. The concept of medical-legal partnerships presents a new way in Australia of caring for the most disadvantaged sectors of our community. Empowering lower socio-economic groups and vulnerable communities by uniting the strengths of the two major professions will enable individuals and families to access fundamental legal and medical resources, help treat preventable illness and death, and meet basic needs. This article explores the possibilities of such a relationship, drawing on an existing United States model, and proposes that a similar partnership be established within Australia.

In response to an ever-increasing burden on the health of Australian families and children in disadvantaged sectors of our community, the authors consider the possibility of a multidisciplinary partnership that is currently being used in the United States to address similar problems. The article reveals how medicine and the law work effectively together to reduce preventable illness. Legislation offers protection to a certain degree but at times it has been shown to be reactive rather than a preventative regime. It is therefore important that we learn from the experiences of the models currently being used.

The concept of partnering lawyers with health care professionals arose in the early 1980s as a result of the AIDS epidemic in the United States.¹ A service dedicated to children, primarily from vulnerable communities, was then established by Dr Barry Zuckerman, leading paediatrician at Boston Medical Center, in 1993.² The primary objective of this partnership was to identify, and assist in

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¹ Lawton E, "Medical-legal Partnerships: From Surgery to Prevention?" (2007) *Management Information Exchange Journal* 37 at 38.

² By January 2009, 81 partnership sites had been established throughout the United States and Canada, with an additional 12-15 partnership sites in active development: Medical Legal Partnership for Children, *Medical-Legal Partnership Annual Site Survey* (2009) (MLP Site Survey), http://www.medical-legalpartnership.org/sites/default/files/page/2009_MLP_Site_Survey_Report.pdf viewed 18 June 2009.



addressing, the social contributors to illness, injury and malnutrition for vulnerable families.³ This also included consulting children who had suffered traumatic brain injuries from falls from apartment windows, burns from uncovered radiators and lacerations from unsafe play areas.⁴ It was the fact that children living in socio-economically disadvantaged communities experienced significantly increased risks to health that ultimately led to the development of the partnership.

The rationale behind a medical-legal partnership requires the application of many moral philosophies that have been discussed in bioethical debates. Moral theories explore how we should work out what would be the right or wrong thing to do and the various jurisprudential positions that might arise are briefly discussed. Issues such as autonomy, non-maleficence, beneficence and justice arise in these situations. For example, deontological theories centre on the rightness or wrongness of an action and are less concerned with the consequences arising from that action. Kantian theory argues that every person must be treated as an end and not as a means and respect for her or his individuality is important. From a utilitarian perspective, the morality of an action is the extent to which it promotes good consequences and therefore the maximisation of happiness. Rule utilitarians acknowledge that rules are important in identifying moral goals and prevent the majority from ignoring the rights of the minority.

Principles of justice are also a dominant theme in the medical-legal partnership. One of the purposes of a partnership is to give underprivileged and disadvantaged groups the same health care and legal services as everyone else and to ensure that our social system is able to give every person immediate and adequate access to medical treatment and legal redress. It therefore demands that resources are distributed fairly and equally. In contrast, economic theories espouse the maximisation of society's total wealth or economic efficiency. On the other hand, virtue ethics is dependent on working out what a virtuous person would do. Some characteristics of a virtuous person include honesty, kindness, justice and fairness. It can also be argued that virtuous people can also act wrongly despite having good intentions and virtuous attributes. An important aspect of these partnerships is therefore as an avenue to empower disadvantaged groups and not to take away their potential to be autonomous.

As discussed below, low-income families who have inadequate housing, who lack basic needs and who have little or no access to medical and legal services include many single parents, who will inevitably be women and young girls with children. Feminist theory is therefore critical to understanding how a medical-legal project could be transformative for those most in need. Feminists would argue that women, specifically socio-economically disadvantaged women, have been subordinated by men and that gender equality cannot be realised until there is also social change. Issues that are significant in this family dynamic include the extent to which females are affected by socio-economic disadvantage. Women are traditionally seen as the carers and as those who take on most, if not all, of the family caring. Full- and part-time work, childcare and childcare fees, sexual assault and even prostitution are some of the concerns. The role of the doctor here becomes important because women are not merely a collection of symptoms to be diagnosed and treated but require a fuller understanding of the social and political factors that impact upon them because of their gender. Access to legal services will empower women to overcome the oppression of social and economic disadvantage.

Postmodernism and poststructuralists also seek to address issues through diverse new perspectives more relevant to a contemporary and changing society.⁵ A postmodernist would argue that contemporary bioethics must take into account the biological aspects of medicine in conjunction with ethical and moral principles. The medical-legal partnership would be supported by this theory as it draws on the strengths of both the medical and legal professions to bring awareness to the social, cultural and moral milieu contributing to poor health, while equally focusing on the biological factors.

³ Zuckerman L, Lawton E and Morton S, "From Principle to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health" (2007) 92 *Archives of Diseases in Children* 100 at 100-101.

⁴ Lawton, n 1 at 37.

⁵ Kerridge I, Lowe M and McPhee J, *Ethics and Law for the Health Professions* (2nd ed, Federation Press, Sydney, 2005) p 26.



Some of these moral theories provide insight into the reasoning of how and why such a model is important in eliminating inequities within a social system and reducing hardship, injustice and illness in economically disadvantaged groups. As can be seen, several theories intersect and apply to make the moral force of such a partnership more meaningful.

THE MEDICAL-LEGAL PARTNERSHIP IN THE UNITED STATES

The benefits of medical-legal partnerships in the United States have enabled parents and doctors to focus on the medical needs of the child while lawyers provide advice and assistance on issues such as safe and affordable housing, education, immigration and legal issues surrounding health care.⁶ Moreover, it was found that access to community resources was more likely to be utilised and families would benefit from an integrated, preventative service in the one location – one that promotes health and wellbeing.⁷ As the health of socio-economically disadvantaged children cannot be improved by medical intervention alone, an important objective of an integrated approach is to effect social and political change by using the alliance of two powerful professions to assist the most vulnerable members of the community. Factors that have been essential to the medical-legal partnership have included weekly departmental meetings to discuss new and ongoing matters, the appointment of a medical director to the team, the development of plain language reference material for practitioners, implementing systemic reform and providing walk-in legal clinics at outpatient sites.⁸

Three core activities have been identified as essential in a medical-legal partnership.⁹ First, training for health care professionals includes analysing issues which impact primarily on disadvantaged families and neighbourhoods. This includes understanding children's basic needs and how those needs are negotiated within the legal system.¹⁰ Training frontline health care staff, legal partners, community partners and students is important to the effective adaptation and implementation of this relationship. In 2007, affiliated partnerships throughout the United States and Canada conducted almost 1,000 training sessions for health care and legal staff and evaluated a range of activities from the impact of advocacy training on physician and resident behaviour to the impact of legal intervention on health.¹¹

Training is essential to educate both medical and legal staff to collaborate effectively. It has been identified that professionals on both sides fail at times to appreciate and acknowledge the other when making decisions that have implications for their respective domains.¹² A number of factors contribute to this mutual aversion, eg preconceived notions of distrust between the professions arising from conflicts such as malpractice suits; a fundamental lack of understanding of one another's methods, values and roles; complicated professional jargon hindering open communication; arrogant and elitist attitudes; and interrelated but conflicting goals (these include lawyers safeguarding clients' autonomy and liberty while doctors protect and care for the health of patients).¹³ Hence these two professions can easily clash while pursuing what they believe to be the best interests of their mutual

⁶ Pilnik L, "Practicing Preventative Law: A Day in the Life of a Medical-Legal Partnership Attorney" (2008) 27 (1) *Child Law Practice* 14.

⁷ Lawton, n 1 at 39.

⁸ Tames P, Tremblay P, Wagner T, Lawton E and Smith L, "The Lawyer Is In: Why Some Doctors Are Prescribing Legal Remedies for Their Patients and How the Legal Profession Can Support This Effort" (2003) 12(2-3) *Boston University Public Interest Journal* 505 at 509.

⁹ Zuckerman, Lawton and Morton, n 3 at 101.

¹⁰ Zuckerman, Lawton and Morton, n 3 at 101.

¹¹ MLP Site Survey, n 2.

¹² Retkin R, Brandfield J, Lawton E, Zuckerman B and DeFrancesco D, "Lawyers and Doctors Working Together – A Formidable Team" (2007) 20(1) *Health Lawyer* 33.

¹³ Retkin et al, n 12.



patients/clients. However, it has been the experience of medical-legal partnership practitioners throughout the United States that these professional tensions are removed when patients and families' needs are placed first.¹⁴

Secondly, legal assistance to children and families in the clinical setting means that legal issues can be more effectively identified and addressed. During the referral process, practitioners can routinely screen for social and economic factors that impact on poor health. Once determined, a referral can then be made and legally assessed. When evaluating and treating sick children, health care professionals frequently identify how inadequate food, housing, safety, access to basic medications such as vaccines or other unmet basic needs contribute to preventable medical illness and poor child health. However, while child health professionals are often aware of the social context of the patients they serve, they generally do not have the knowledge, training, time or resources to effectively address non-clinical issues.¹⁵ The partnership therefore maximises child welfare and identifies breaches of legal rights that inevitably affect family and child health.

Thirdly, advocacy to effect policy change on a systemic level is undertaken by the partnerships to promote child health and wellbeing.¹⁶ To address policy issues, medical and legal partners in the United States have been engaged in numerous forms of advocacy, including testifying at legislative hearings, writing letters, convening meetings and negotiations with government offices and proposing reforms to rules and regulations.¹⁷

ISSUES ARISING FROM THE PARTNERSHIP

Set out below are some concerns that may arise as a result of a medical-legal partnership. These concerns, however, can be overcome with proper management and organisation.

Professional, government and community support

First, existing partnerships across the United States have experienced challenges with evaluation, funding and sustainability, as well as substantive systemic concerns that required national or State-level solutions. Other challenges have included finding suitable clinical space to meet with clients, engaging hospital administration, developing and closing feedback loops with providers and performing outreach to more patients with legal needs.¹⁸

However, the ongoing support provided to these partnerships from all sectors of the community suggests that the concept has been embraced and encouraged. Over US\$8.5 million in cash funding have been provided to partnerships by the legal profession (including various legal services, State and local Bar foundations, law firms and law schools) as well as the medical profession (including hospitals, health centres, health foundations, health insurance companies and pharmaceutical companies). Within the community, individuals, fund-raising events and other corporations have also provided additional funding.¹⁹ Some legal aid programs have partnered with local clinics or hospitals to recoup money by securing health care benefits for eligible children and families, thereby accruing a benefit to the clinical setting. Some partnerships have also been able to receive direct funding from clinics and hospitals while offering their services onsite. Such a relationship has generated impressive cost/benefit data.²⁰

Issues of confidentiality

Another concern has been the issue of maintaining the confidentiality of information received from the patient. Supplying a medical-legal partnership with a patient's name and contact information and

¹⁴ Retkin et al, n 12 at 34.

¹⁵ Zuckerman, Lawton and Morton, n 3.

¹⁶ Zuckerman, Lawton and Morton, n 3.

¹⁷ MLP Site Survey, n 2.

¹⁸ MLP Site Survey, n 2.

¹⁹ MLP Site Survey, n 2.

²⁰ Lawton, n 1 at 41.



confirming the individual's status as a patient could constitute a disclosure of protected health information.²¹ To address issues of confidentiality under the United States model, the health care provider may require patients to sign a consent form prior to being referred. In addition, it is likely that medical-legal partnerships would be required to enter into a confidentiality agreement with their health care partners to establish the permitted and required use and disclosure of the information, the appropriate administrative, physical and technical safeguards to prevent its inappropriate use or disclosure and the reporting of any inappropriate use or disclosure.²² Similar measures would be undertaken in any Australian model to ensure that the integrity of patients' personal information is maintained.

Conflicts of interest

As with the case of other providers of legal services, there will inevitably be cases during which conflicts develop between family members (or between the client and legal representative) or where the client seeks assistance outside the scope of services agreed to. Issues such as domestic violence, suspicions or allegations of abuse or neglect further compound these challenges, as does working with children and young people whose status as minors requires special considerations. Partnerships need to remain conscious of the potential for such situations to develop.²³ In any circumstances of potential conflict, the partnership's lawyer will also liaise with the hospital's legal team to protect the institution from any possible liability. This is explored further below.

CURRENT SOCIAL AND HEALTH CONCERNS FOR AUSTRALIAN FAMILIES

Socio-economically disadvantaged

Inequalities or differences that are "unnecessary, avoidable, unfair and unjust" are found to be responsible for approximately 17% of the total disease burden in Australia.²⁴ Evidence highlights that children and adolescents from socio-economically disadvantaged families and Aboriginal and Torres Strait Islander communities experience poorer health than their less disadvantaged peers.²⁵ They experience a higher risk of preventable illness, injury, death and poorer education and social outcomes than other Australian children.²⁶ Indigenous children are twice as likely as other Australian children to be born with a low birth weight, to be hospitalised for chronic conditions and to die before the age of 20.²⁷ Homeless young people are also in the most disadvantaged group, experiencing the worst physical, emotional and social health outcomes.²⁸

The health of children from low-income families is critically influenced by the broader conditions of social and economic disadvantage. Children living in families without regular adequate income

²¹ The *Health Insurance Portability and Accountability Act 1996* (US) establishes the requirements regarding privacy and security of identifiable health information in the United States.

²² McDermott Will & Emery, LLP and the Medical-Legal Partnership for Children, *Introductory Frequently Asked Questions Regarding HIPAA, Privilege and Confidentiality in the Medical-legal Partnership Model* (2008), <http://www.medical-legalpartnership.org/resources/white-papers-and-reports> viewed 18 June 2009.

²³ McDermott Will & Emery, n 22.

²⁴ Royal Australian College of General Practitioners, *Guidelines for Preventive Activities in General Practice* (7th ed, 2009) p 3 (RACGP), http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/TheRedBook/redbook_7th_edition_May_2009.pdf viewed 18 June 2009.

²⁵ RACGP, n 24, p 3.

²⁶ Australian Institute of Health and Welfare, *Making Progress: The Health, Development and Wellbeing of Australia's Children and Young People* (AIHW, Canberra, 2008) p 2 (AIHW), <http://www.aihw.gov.au/publications/index.cfm/title/10653> viewed 18 June 2009.

²⁷ AIHW, n 26.

²⁸ This includes malnutrition, chronic infections, sexually transmitted diseases, physical and sexual abuse and mental illness: AIHW, n 26, p 12; see also similar results in United States in Burg MA, "Health Problems of Sheltered Homeless Women and Their Dependent Children" (1994) 19(2) *Health & Social Work* 125.



have been shown to be at increased risk of poor health in both the short and long term.²⁹ Low socio-economic status, fear of homelessness, poor neighbourhoods and financial constraints have been found to contribute to housing stress, depression, anxiety and other preventable health issues,³⁰ such as asthma,³¹ diabetes,³² obesity, hunger and malnutrition,³³ and lack of access to adequate health care.³⁴ Moreover, the prevalence of asthma and poor health increases with increasing socio-economic disadvantage.³⁵ A total of 20% of Australian households with children under the age of 20 years are considered to be in the low-income quintile³⁶ and children born into socio-economically disadvantaged families are found to be more likely to die at an earlier age,³⁷ be exposed to environmental contaminants,³⁸ experience higher rates of infections, suffer physical and mental illness³⁹ and domestic abuse.⁴⁰ The increased likelihood of a child being injured or killed from potentially preventable causes, such as a house fire or assault, is also associated with single parenthood, young maternal age, poor housing, large family size and parental drug or alcohol abuse.⁴¹

Rapid economic growth has been accompanied by increasing financial constraints for many low-income and middle-income earners, even more with the recent economic decline. Housing is one of the most basic needs for families and adequate housing is essential for psychological and physical wellbeing. People are more likely to experience housing stress when they do not have access to housing of an adequate basic standard with reasonable access to work and community services at a cost which does not cause them substantial hardship.⁴² This issue now affects approximately 65% of lower-income private renters in Australia, a number which has increased rapidly over the past decade due to a fourfold increase in house prices⁴³ while rental vacancy rates have remained consistently low at 1% to 2.6% across Australia.⁴⁴ Families may be forced to reside in substandard housing as housing

²⁹ AIHW, n 26, p 10.

³⁰ Robinson E and Adams R, "Housing Stress and the Mental Health and Wellbeing of Families" (2008) 12 *Australian Family Relationships Clearinghouse Briefing* 4, <http://apo.org.au/research/housing-stress-and-mental-health-and-wellbeing-families> viewed 18 June 2009.

³¹ Burg, n 28.

³² Hearn L, Miller M and Cross D, "Engaging Primary Health Care Providers in the Promotion of Healthy Weight Among Young Children: Barriers and Enablers for Policy and Management" (2007) 13(2) *Australian Journal of Primary Health* 66; National Obesity Taskforce Secretariat, *Healthy Weight 2008: Australia's Future* (Department of Health and Ageing, 2003) p 2, [http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/healthy_weight08.pdf/\\$File/healthy_weight08.pdf](http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/healthy_weight08.pdf/$File/healthy_weight08.pdf) viewed 18 June 2009.

³³ Buckner JC, "Understanding the Impact of Homelessness on Children" (2008) 51(6) *American Behavioral Scientist* 721 at 731.

³⁴ Hearn, Miller and Cross, n 32 at 71.

³⁵ Australian Institute of Health and Welfare, *Asthma in Australia 2008* (AIHW, Canberra, 2008) p 41, http://www.asthmamonitoring.org/AinA08_html/Index.htm viewed 18 June 2009.

³⁶ AIHW, n 26, p 10.

³⁷ Australian Institute of Health and Welfare, *A Picture of Australia's Children* (AIHW, Canberra, 2005) p 14, <http://www.aihw.gov.au/publications/phe/apoac/apoac.pdf> viewed 18 June 2009.

³⁸ AIHW, n 26, p 7.

³⁹ AIHW, n 37, p 27; see generally RACGP, n 24, p 58.

⁴⁰ AIHW, n 37, p 59.

⁴¹ AIHW, n 37, p 54.

⁴² Robinson and Adams, n 30, p 1.

⁴³ Robinson and Adams, n 30, p 1.

⁴⁴ Robinson and Adams, n 30, p 2.



quality and suitability are compromised in order to keep costs down.⁴⁵ The quality of food, clothing, and children's access to school activities and adequate health care are also sacrificed to meet day-to-day living costs.⁴⁶

Women and young females

Approximately 20% of Australian children now live in single-parent families⁴⁷ and 43% of these children live in households that have income in the lowest quintile.⁴⁸ As mentioned, a high percentage of single parents with low socio-economic status and children are women and young females. In 2003, 72% of women in single-parent families where the youngest child was aged 0-2 years did not have employment. Employment among single mothers increased as the child's age increased; even so, 55% of women with children under 15 remained unemployed (compared to 41% of men in lone-parent families).⁴⁹ A total of 51% of all children in one-parent families did not live with an employed parent and indigenous children were 3.6 times more likely than other children to live in jobless families.⁵⁰ Family cohesion also rated higher in intact families than in single-parent or blended families.⁵¹

Aside from unstable housing arrangements, socio-economic disadvantage, violence and sexual abuse in childhood, poor school attendance and performance and a family history of teenage pregnancy are also factors thought to contribute to teenage motherhood.⁵² In 2005, 11,700 babies were born to teenage mothers. This results in a high risk of single parenthood, increased dependence on welfare support and interrupted education that can affect the health, education and economic futures of these children.⁵³ The indigenous teenage fertility rate is shown to be five times higher than the non-indigenous rate.⁵⁴ Moreover, as teenage mothers are more likely to delay having their pregnancy confirmed, and are also more likely to engage in risky behaviour (ie smoking and drinking alcohol during pregnancy), they face a higher risk of preterm delivery, low birth weight, complications and perinatal mortality.⁵⁵

Birth weight is considered an important indicator of the likelihood of good health and survival.⁵⁶ A higher rate of babies with low birth weight are born to single mothers, indigenous mothers and socio-economically disadvantaged families⁵⁷ as infants born in remote or disadvantaged areas are 30 to 40% more likely to be of low birth weight, whereas the incidence in the indigenous population is as much as 50% higher.⁵⁸ Babies born with a low birth weight (defined by the World Health Organisation as weighing less than 2,500 gm) are at a greater risk of experiencing poor health, neurological or physical complications, hospitalisation and death than other infants.⁵⁹ Approximately 6% of Australian babies are born with low birth weight and this may at times be attributed to risk factors such as a

⁴⁵ Robinson and Adams, n 30, p 2.

⁴⁶ Hearn, Miller and Cross, n 32 at 71.

⁴⁷ AIHW, n 37, p 77.

⁴⁸ AIHW, n 37, p 80.

⁴⁹ AIHW, n 37, p 77.

⁵⁰ AIHW, n 26, p 9.

⁵¹ AIHW, n 37, p 79.

⁵² AIHW, n 26, p 15.

⁵³ AIHW, n 26, p 15.

⁵⁴ AIHW, n 26, p 15.

⁵⁵ AIHW, n 26, p 15.

⁵⁶ AIHW, n 26, p 16.

⁵⁷ AIHW, n 37, p 39; AIHW, n 26, p 16.

⁵⁸ AIHW, n 26, p 16.

⁵⁹ AIHW, n 37, p 37.



younger or older maternal age, smoking (prevalence of smoking decreases with higher socio-economic status)⁶⁰, alcohol and drug abuse and inadequate nutrition.

Homelessness

Although sometimes a temporary state, homelessness has also been found to significantly correlate with the risk of poor health in children. The current lack of adequate housing, locational disadvantage, unemployment, financial stress, discrimination, and personal problems such as mental illness, drug and alcohol addiction, domestic violence and family breakdown significantly contribute to homelessness.⁶¹ Research has indicated that children living in one-parent, step/blended or low-income families are more likely to experience mental health problems than other children.⁶² Families comprising a single mother with children are “the fastest growing subgroup of the homeless population”.⁶³ Of the families with children who attended a supported accommodation assistance agency in 2002-2003, 84% were single women with children, while 12% were couples and 4.4% were single men with children.⁶⁴

The indigenous Australian population is also over-represented with a higher rate of homelessness (22%) than other Australians.⁶⁵ In 2001, 10% of the homeless population in Australia were children under 12 years of age.⁶⁶ This proportion has increased by 22% and children and adolescents now account for one-third of the homeless population.⁶⁷ In 2002-2003, more than 23,600 children under five years of age accompanied a parent or guardian seeking supported accommodation assistance.⁶⁸ However, by 2006-2007, 69,100 accompanying children used supported accommodation services.⁶⁹ Tragically, this number will only continue to increase in the current economic climate.

The impact of homelessness further exacerbates the risk of poor health, education and social development. Homeless children have less access to education and health care, lower immunisation rates, poor nutrition, higher prevalence of disease, exposure to the elements and problems such as depression, low self-esteem and behavioural disturbances.⁷⁰ Further, a high proportion of these children may have already witnessed or experienced family violence and may be subjected to community violence. Such abuse and trauma adversely impact on children’s health and educational development and socio-economic attainment and increase the chance that they will become associated with violence and/or crime later in life.⁷¹

While it has been shown that good parenting with cognitive and emotional support can effectively reduce or eliminate environmental influences and raise resilient children,⁷² it is not enough to place responsibility on the parents alone; nor is it appropriate to lay blame. It is time for the government and the community to improve the living and health conditions of all Australians. When one considers the

⁶⁰ AIHW, n 37, p 41.

⁶¹ Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs, *Outcomes of the Public Consultation Process Homelessness Green Paper – Which Way Home: A New Approach to Homelessness* (2008), http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/greenpaper/Pages/outcome_green_paper.aspx viewed 16 January 2009.

⁶² AIHW, n 37, p 27.

⁶³ Burg, n 28 at 125.

⁶⁴ AIHW, n 37, p 61.

⁶⁵ AIHW, n 37, p 63.

⁶⁶ AIHW, n 37, p 61.

⁶⁷ AIHW, n 26, p 12.

⁶⁸ AIHW, n 37, p 61.

⁶⁹ AIHW, n 26, p 12.

⁷⁰ Burg, n 28 at 125; AIHW, n 37, p 61.

⁷¹ AIHW, n 37, pp 59-61, 70.

⁷² AIHW, n 37, p 89; Kroenke C, “Socioeconomic Status and Health: Youth Development and Neomaterialist and Psychosocial Mechanisms” (2008) 66 *Social Science of Medicine* 31 at 35.



stress inflicted on families by transitory living conditions, housing disruptions, domestic violence and extreme poverty, the burden may militate against the ordinary love and guidance a child may have otherwise received. As Kroenke⁷³ suggests, understanding how the independent effects of material and psychosocial influences interact with each other provides potential clues and opportunities for earlier and more effective intervention. “[O]nly when a homeless family has made tangible progress toward having basic needs met is there fertile ground for health care to become a priority in the lives of the family members.”⁷⁴

Obesity

Inadequate nutrition is also linked with obesity and the rates of overweight and obese people in Australia have almost doubled over the last two decades⁷⁵ and are estimated to be rising at a rate of 1% per annum.⁷⁶ The health and social costs of obesity and chronic disease are estimated to be as high as \$1.3 billion per year⁷⁷ with 58% of adult patients being seen by Australian general practitioners being overweight or obese.⁷⁸ Recent studies indicate that 6% of children aged two to four years are now obese and approximately 20 to 25% of school children are overweight with a quarter of this group obese.⁷⁹ A variety of factors are associated with the increase, such as a proliferation of highly refined and calorie-dense food choices, targeted marketing and ease of access, all of which contribute to children in families of highest social disadvantage being placed at even greater risk.⁸⁰

EXISTING AUSTRALIAN LAWS AND PRACTICES

Royal Australian College of General Practitioners

Australia’s leading professional organisation for the safety and quality of general practice – the Royal Australian College of General Practitioners (RACGP) – recognises the importance of preventative care in today’s climate and that health practitioners are in the ideal position to screen and enhance preventive care approaches.⁸¹ This unique vantage point allows health care professionals to see not just the medical crisis but also the “social” crisis facing families, such as eviction, domestic violence, poor access to education or lack of income support.⁸² The RACGP recommends screening and providing counselling advice, including accident/injury prevention for infants through to adolescents.⁸³ As patients view their health practitioners as “a credible source of preventive advice”, they are receptive to advice about how to reduce or avoid illness and injury.⁸⁴ There are, however, inherent difficulties in combating large-scale issues at a practitioner-client level⁸⁵ which is why the need for coordinated multi-sector partnerships is increasing and why primary care providers are being called

⁷³ Kroenke, n 72 at 37.

⁷⁴ Burg, n 28.

⁷⁵ National Obesity Taskforce Secretariat, n 32, p 2.

⁷⁶ AIHW, n 37, p 44.

⁷⁷ National Obesity Taskforce Secretariat, n 32, p 2.

⁷⁸ Britt H, Miller GC, Charles J, Bayram C, Pan Y, Henderson J, Valenti L, O’Halloran J, Harrison C and Fahrudin S, “General Practice Activity in Australia 2006-07” (2008) *General Practice Series* 21.

⁷⁹ Department of Family and Community Services, *Longitudinal Study of Australian Children* (2005); Vaska VL and Volkmer R, “Increasing Prevalence of Obesity in South Australian 4-Year Olds: 1995-2002” (2004) 40 *Journal of Pediatric Child Health* 353; RACGP, n 24, p 12.

⁸⁰ RACGP, n 24, pp 17-19; Parsons TJ, Power C, Logan S and Summerbell CD, “Childhood Predictors of Adult Obesity: A Systematic Review” (1999) *International Journal of Obesity Related Metabolic Disorders* 23 (Suppl 8) S1-S107, <http://www.ncbi.nlm.nih.gov/pubmed/10641588> viewed 18 June 2009 (abstract).

⁸¹ RACGP, n 24.

⁸² Lawton, n 1 at 37.

⁸³ RACGP, n 24, pp 17-21.

⁸⁴ RACGP, n 24, p 4.

⁸⁵ Robinson and Adams, n 30, p 7.



upon to play a more active role in screening and prevention.⁸⁶ Just as the medical profession advocates preventive health care, so too can the legal profession advance a preventive legal strategy to address the social and economic problems of clients, especially from low-income and other disadvantaged communities, thereby improving their health and wellbeing.⁸⁷

National Obesity Taskforce

For a long time, considerable emphasis had been placed primarily on schools as playing a key role in the development and wellbeing of children and young people. By school age, however, as Hearn, Miller and Cross point out, lifestyle and food preferences have generally become well established, being most strongly influenced by the family and social environment.⁸⁸ Moreover, having such a narrow emphasis resulted in the most disadvantaged communities continuing to be overlooked, as children in these communities are the less likely to attend school regularly or have access to adequate schooling.

In 2003, the National Obesity Taskforce was established to combat the rising incidence of obesity in Australia. It was not enough to continue to leave the responsibility with schools and the taskforce's National Action Agenda extended responsibility across various primary care groups, stressing that organisations and groups should strive to implement strategies and actions that are evidence-based, with emphasis placed on partnerships across all of Australia.⁸⁹ New knowledge should be generated through innovation, research and evaluation⁹⁰ and special attention should be given to the context and challenges facing young Australians.⁹¹ As part of the guiding principles, the National Obesity Taskforce noted that actions should concentrate on solutions rather than problems, be long term and sustainable and help those most in need to close the gap of health inequality.⁹²

Privacy Act

In Australia, privacy is fundamental in delivering quality health care. In a 2004 submission to the Office of the Privacy Commissioner, the Department of Health and Ageing acknowledged the deeply personal nature of an individual's health information. Without an assurance that health information will remain confidential, people may be reluctant to obtain health care, thus placing in jeopardy their own health, as well as the health of others.⁹³ The *Privacy Act 1988* (Cth) directly imposes a duty of confidentiality.⁹⁴ Organisations (and individuals) must not use or disclose personal information for a secondary purpose unless the person concerned consents, expressly or by implication; disclosure is necessary to an individual's life, health or safety; disclosure is necessary to avert a serious threat to public health or public safety; or the disclosure is required by law.⁹⁵ In all Australian States,⁹⁶ medical practitioners and some health professionals (nurses, psychiatrists, counsellors) must report any reasonable suspicions or allegations of children being abused or neglected and children may be

⁸⁶ Hearn, Miller and Cross, n 32 at 69.

⁸⁷ *American Bar Association Resolution in Support of Medical-Legal Partnership* (2007), <http://www.medical-legalpartnership.org/about-us/pro-bono-partners/american-bar-association> viewed 18 June 2009.

⁸⁸ Hearn, Miller and Cross, n 32 at 67.

⁸⁹ National Obesity Taskforce Secretariat, n 32, p 4.

⁹⁰ National Obesity Taskforce Secretariat, n 32, p 6.

⁹¹ National Obesity Taskforce Secretariat, n 32, p 4.

⁹² National Obesity Taskforce Secretariat, n 32, p 4. See also AIHW, n 26, p 7: the Council of Australian Governments has "committed to halving the mortality gap for Indigenous children under five within a decade. Improvements in Indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services, and integrated child and family services".

⁹³ Australian Government Department of Health and Ageing, *Submission to the Office of the Privacy Commissioner Review of the Private Sector Provisions of the Privacy Act 1988* (December 2004), <http://www.austlii.edu.au/au/other/alrc/publications/issues/31/8.html> viewed 18 June 2009.

⁹⁴ *Privacy Act 1988* (Cth), Sch 3, NPP 2.1 and s 14, IPP 11.

⁹⁵ *Privacy Act 1988* (Cth), Sch 3, NPP 2.1.

⁹⁶ For example, in Victoria under the *Children, Youth and Families Act 2005* (Vic), ss 182, 184.



detained for observation, assessment or treatment without parental consent. Protection from any legal consequences is provided to informants.⁹⁷ The current version of the Australian Medical Association's *Code of Ethics* (2004) also acknowledges that it may be permissible for a doctor to disclose personal information about a patient where there is "a serious risk to the patient or another person ... [or] overwhelming societal interests".⁹⁸

While noting the benefits of much of this type of regulation, caution must be exercised to implement it strictly in the context of disadvantaged communities where issues of economics, job opportunities and structural and social disadvantage primarily cause strain and hardship for families. Cultural tensions may also conflict with opposing views of how best to raise children and what is viewed as in their interest by taking children away from their families. This may be a dangerous road to take, as we have already seen the impact of this on Aboriginal communities in the past.

Child Wellbeing and Safety Act 2005 (Vic)

The intention of the Victorian Parliament that "all children should be given the opportunity to reach their full potential and participate in society irrespective of their family circumstances and background" is an unmistakably fundamental principle of the *Child Wellbeing and Safety Act 2005* (Vic).⁹⁹

Section 5 of the *Child Wellbeing and Safety Act* aims to encourage the development of services for children and families to readily identify and provide interventions to remove causes of possible harm and strengthen the support available to children as early as possible in life.¹⁰⁰ Section 5(2) of the Act provides that children and families in communities or population groups that are known to have the greatest need should be given the highest priority in the making available of appropriate and sufficient levels of assistance.¹⁰¹

Charter of Human Rights and Responsibilities Act 2006 (Vic)

The recent enactment of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) has brought Australia closer to attaining a written document to formalise human rights. How this Act is ultimately interpreted is yet to be seen. The purpose of the Act is to recognise that all people are free and equal in dignity and rights. It recognises the importance of human rights in a democratic and inclusive society and that they are applicable to all people without discrimination.¹⁰² Several of the rights that have been expressed in international covenants have been repeated in the Charter, such as recognising the right to equality before the law,¹⁰³ life,¹⁰⁴ and protection of families and children.¹⁰⁵

United Nations Convention on the Rights of the Child

As of December 2008, 193 countries had become signatories to the *United Nations Convention on the Rights of the Child* (CRC). Only the United States and Somalia have not signed the CRC. Although Australia ratified the Convention in December 1990, it has yet to be incorporated into Australian law. However, the Human Rights and Equal Opportunity Commissioner has the role of monitoring Australia's compliance.¹⁰⁶ Compliance with the CRC is also monitored by the Committee on the

⁹⁷ Skene L. *Law and Medical Practice: Rights, Duties, Claims and Defences* (3rd ed, Lexis Nexis, Sydney, 2008) p 148.

⁹⁸ Australian Medical Association, *Code of Ethics* (2004) at [1.1(1)].

⁹⁹ *Child Wellbeing and Safety Act 2005* (Vic), s 5.

¹⁰⁰ *Child Wellbeing and Safety Act 2005* (Vic), s 5(2)(a).

¹⁰¹ *Child Wellbeing and Safety Act 2005* (Vic), s 5(2)(b).

¹⁰² *Charter of Human Rights and Responsibilities Act 2006* (Vic), Preamble. Special recognition has been given to Aboriginal people in Victoria.

¹⁰³ *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 8.

¹⁰⁴ *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 9.

¹⁰⁵ *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 17.

¹⁰⁶ See http://www.hreoc.gov.au/human_rights/children/index.html viewed 31 December 2008.



Rights of the Child based in Geneva and governments must report every five years to the Committee on what they are doing to provide children with their rights under the Convention.

There are 54 Articles. Some of the key provisions are:

- all rights apply to all children without exception or discrimination of any kind;¹⁰⁷
- the best interests of the child must be a primary consideration in all actions concerning children;¹⁰⁸ and
- states have an obligation to ensure as much as possible every child's survival and development.¹⁰⁹

RECOMMENDATIONS

Variants in health disparities cannot be explained by socio-economic factors alone. However, it is clear from the above research that people living in socio-economically disadvantaged families or communities experience far greater risks to health than those higher on the socio-economic scale. What follows therefore are some suggested reforms and recommendations that could assist in changing the way disadvantaged groups receive and access medical and legal assistance which addresses some of the concerns about access to formal justice.

Crisis services

Crisis services are in need of urgent reform and financial backing for effective prevention and support models. Such services include income support, employment, education and training, health, justice, aged care and migrant settlement services. These mainstream services have in many instances failed to respond adequately to the level of need.¹¹⁰ Services and service providers need to involve the individual at the process and development stage in order to recognise their respective needs and become more client-centred. This will produce more effective and equitable outcomes.

Training programs

In the United States training programs, medical-legal partnership trainers provide the frontline health care providers with information on how to look for the unmet basic needs and how to refer to the partnership lawyer. It has been identified that the best way to manage this burden is through short, regular training that advises doctors how to screen and refer. This has included a clearly defined and efficient referral process and open lines of communication between medical and legal staff so that protocols can be adjusted as they go along. Moreover, having a doctor involved in crafting the training and protocols is essential to ensure it will translate back into the clinical setting. It is important that the legal team adapts its practice to the clinical setting and how doctors work best. For example, at many hospitals, lawyers carry hospital pagers so the clinical staff can access them for referrals in the same way they would access a different medical specialist.¹¹¹

Many United States lawyers who participate in medical-legal partnerships also lead training sessions for medical residents and other health professionals about major issues that may impact on health such as housing, where mould, lead paint and other substandard living conditions cause serious health risks and problems for children.¹¹²

In practice, re-educating practitioners removes the focus from placing blame on parents to proactive identification of, and intervention in, the areas in which health care and legal service providers can support families to provide children with quality care in all aspects of their lives, fostering opportunity for them to achieve their potential. Mandatory reporting requirements, eg, may

¹⁰⁷ *United Nations Convention on the Rights of the Child*, Art 2.

¹⁰⁸ *United Nations Convention on the Rights of the Child*, Art 3.

¹⁰⁹ *United Nations Convention on the Rights of the Child*, Art 6.

¹¹⁰ Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs, n 61.

¹¹¹ Personal advice from MLP member of Boston dated 9 September 2008.

¹¹² Pilnik, n 6 at 15.



conflict with each of the profession's obligations and objectives. All States in the United States¹¹³ and Australia have mandatory reporting requirements in cases of child abuse, neglect and other health or safety concerns regarding children. Partnership teams often include licensed professionals who are under an obligation to report. However, although rules of professional conduct dictate when lawyers may report, lawyers are generally not considered to be mandatory reporters. Where a conflict arises in this situation, parties involved will need to consider whether to limit the mandated reporter's exposure to confidential or privileged information and whether clients and their representatives should be informed of such team members' reporting obligations.¹¹⁴ Caution must therefore be taken to ensure a balanced and equitable approach to complying with the law while understanding the social and economic factors that may impact upon these difficult issues.

The professions, governments and community alike must ensure that the critical period of neurological, physical and emotional development in children and young people is supported regardless of social, cultural or economic status.

Prevention and promotion

Prevention and health promotion in Australia have historically been under-supported within Australia's health care budget.¹¹⁵ As Harper and Oldenburg indicate:

Challenging environments and competing interests are common in healthcare decision-making where budget holders attempt to weigh the ethical, effectiveness, efficiency and equity implications (and tradeoffs) of resourcing decisions.¹¹⁶

Medical-legal partnerships provide an equitable, efficient and effective method of delivering preventative care and promoting the health and wellbeing of all Australian children.

Social workers

Australian social work has much to offer in a medical-legal partnership project. Given its multiple roles and identities, there is an opportunity to ease caseloads and promote efficiency. Factors such as the direction for these roles, how and which knowledge is utilised, how power and authority are distributed and what meaning is accorded to social justice are at the centre of continuing debate.¹¹⁷

CONCLUSION

It is hoped this article will serve to generate more rigorous pursuit of effective measures to enhance the wellbeing of children and encourage continuous development of interdisciplinary professional partnerships. Not only does the potential exist to assist many children and families, but many disadvantaged groups can benefit through collaborative opportunities. Australia's ageing and indigenous populations, socially and economically disadvantaged communities, chronically ill patients, and refugees and asylum seekers all could benefit from having access to the combined knowledge and expertise of professions working in collaboration.

It is important to understand the value of training and re-educating staff for this project to reflect diversity in culture, ethnicity, race, class, sexuality and age. Legal and medical theories, together with the work of other disciplines such as sociology, economics and politics, must continue to influence the

¹¹³ As well as the District of Columbia, the Commonwealth of Puerto Rico, the United States Territories of American Samoa, Guam, Northern Mariana Islands and the Virgin Islands have statutes identifying persons who are required to report child maltreatment under specific circumstances. See Child Welfare Information Gateway, *Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws* (2008), http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm viewed 18 June 2009.

¹¹⁴ Child Welfare Information Gateway, n 113.

¹¹⁵ Harper T and Oldenburg B, *Call for a National Charter for Health, Issues Paper* (2009) p 5, <http://www.vichealth.vic.gov.au/~media/ResourceCentre/PublicationsandResources/General/National%20charter%20for%20health1.ashx> viewed 18 June 2009.

¹¹⁶ Harper and Oldenburg, n 115, p 9.

¹¹⁷ Napier L and George J, "Changing Social Work Education in Australia" (2001) 20(1) *Social Work* 75 at 85-86. The authors proposed restructuring the design and content of the social work degree at the University of Sydney to reflect change and diversity in Australian society.



context for analysis, discussion and collaboration. Access to health and legal services must be more than merely formal justice. Legislative and practical policies urgently require review to address social and economic concerns impacting on families, women and children and to ensure that such policies are in line with the international obligations that Australia has undertaken. Distribution of resources, government and public funding and political policies must remain high on the agenda if change is to become possible and lasting.

