Conceptualizing Interprofessional Working – When a Lawyer Joins the Healthcare Mix

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ABSTRACT

Research, policy and practice in the field of interprofessional collaboration have focused on how medical, nursing, allied health and social care practitioners work together to positively impact patient care. This paper extends conceptual thinking about interprofessional practice by focusing on lawyers as part of the interprofessional mix. This attention is prompted by medical-legal partnerships (MLPs), a service model by which lawyers join health care settings to assist patients with unmet, and often health-harming, legal needs. MLPs are present in around 450 hospitals and other health care sites across the United States and the model has spread to other countries, including Australia, the United Kingdom and Canada. However, enthusiasm for the MLP model is not yet matched by good evidence on how, when and for whom the model works. Interprofessional scholars contend that imprecise terminology and poor conceptualization of interprofessional arrangements hinder high-quality research and evaluation. In response to their critiques, this paper formulates a stepwise conceptual framework to guide the design, implementation and study of interprofessional arrangements that connect health, social care and legal practitioners. This framework draws on findings from national surveys of MLP initiatives in several countries and adapts several key conceptual frameworks that have been developed from systematic reviews of interprofessional working in primary health care. These conceptual frameworks are valuable because they promote clarity about different modes of interprofessional working and characterize the factors at macro (policy, funding), meso (organizational) and micro (practitioner, patient) levels that help or hinder professionals from different disciplines in working together. The paper considers factors at these three levels that require particular attention when lawyers join health care settings and proposes questions for future research in this emerging area.

KEYWORDS: Interprofessional collaboration; medical-legal partnership; conceptual framework; interorganizational collaboration

INTRODUCTION

Healthcare practice, policy and research have fixed on interprofessional collaboration as a means to improve service delivery with benefits for patients, practitioners and systems. In the first Cochrane Review on the topic, published in 2009, interprofessional collaboration was defined as "the process in which different professional groups work together to positively impact health care" (Zwarenstein et al., 2009). The dominant focus was on how medical, nursing and allied health professionals work together. In the 2017 update to the Cochrane Review, the definition of interprofessional collaboration was revised to recognize the involvement of social care practitioners and impacts beyond health care alone. The updated 2017 definition referred to "the process by which different health and social care professional groups work together to positively impact care" (Reeves et al., 2017). This paper focuses on the addition of legal expertise to interprofessional arrangements.

The medical-legal partnership (MLP) movement provides the motivation for this paper. MLPs – also known as health-justice partnerships (HJPs) – are a model by which lawyers are integrated into health care settings to assist people who may otherwise face barriers to accessing legal help. MLPs are premised on the fact that many people accessing health care services have unmet health-harming legal needs. Problems amenable to legal solutions may include matters related to housing, family relationships, employment, income support, disability services and immigration status (Tobin-Tyler and Teitelbaum, 2019). By connecting with patients in health care settings, lawyers can offer various forms of legal help, including information on legal rights, advice on legal options, preparation of legal documents, advocacy, and referrals for specialized or complex matters. These services are often provided at low or no cost for patients who meet financial eligibility criteria.

The MLP model originated in the United States in the 1990s (Sandel et al., 2010) and partnerships are now present in around 450 hospitals and other health care sites in nearly all states (National Center for Medical-Legal Partnership, 2019). The model has spread to other countries, including Australia (Forell, 2018), the United Kingdom (Beardon and Genn, 2018) and Canada (Drozdzal et al.,

2019). In this context of enthusiasm for connecting legal and health services, much of the literature on MLPs explicates the rationale for such partnerships (see eg, Beeson et al., 2013; Tobin-Tyler and Teitelbaum, 2019) and provides descriptive accounts of the development and implementation of specific partnerships (see eg Beardon et al., 2020; Benfer et al., 2018). However, a systematic review of MLP evaluation research concluded that publications advocating for connecting health and legal services "have considerably outpaced efforts to evaluate such models" (Martinez et al., 2017, p. 263).

As a consequence, there is little high-quality evidence to inform initiatives that connect legal, health and social care. Forell makes the stark observation: "It is still too early in this movement to know what works best, for whom, in what circumstances and at what cost" (Forell, 2018, p. 2). The results of observational studies provide a "promising initial evidence base" to support adding a lawyer to the interprofessional mix in health care settings (Gottlieb et al., 2017, p. 725) and there are increasing calls for rigorous empirical research. Benfer and colleagues have proposed an important set of questions that warrant investigation, including whether a lawyer's involvement in health care settings improves patient outcomes, influences doctors' practices, saves system resources, and enhances trust in the law and legal processes (Benfer et al., 2018, p. 607).

These questions call for expanding the concept of interprofessional working to consider how health, social care *and legal* professional groups work together to positively impact care, as well as *health and justice outcomes*. However, the lessons from research on interprofessional care stress the need for clarity about the ways in which different professionals interact in health settings and the core attributes of and influences on working arrangements. In a review of interprofessional interventions, Xyrichis et al concluded:

> … the interprofessional field remains poorly conceptualised in many empirical studies; with an ongoing terminological confusion about different kinds of interprofessional work activity such as collaboration, teamwork and coordination. This appears to be the key reason

> hindering and delaying our progress in understanding which kind of activity works better in which settings (Xyrichis, Andreas et al., 2018, p. 423).

This is a cautionary observation for efforts to understand how models that integrate health, social and legal care can improve patient and population outcomes. Scholars in interprofessional care have proposed classification tools and conceptual frameworks to explicate different modes of interprofessional working, their attributes or characteristics, and the factors that support or hinder interprofessional arrangements. These conceptual analyses have not been extended to consider lawyers as participants in interprofessional arrangements.

Structure of the paper

The first section of this paper elaborates on the MLP model, discussing the rationale for involving lawyers in health care settings and the ways in which MLPs seek to effect change. This section presents key findings from recent surveys of MLPs in the US, Australia, and England and Wales, which reveal wide variation in how legal professionals connect with health services. Second, the paper considers several key conceptual models and frameworks that have been developed from systematic reviews of interprofessional working in health care, especially the primary care sector which focuses on "the provision of integrated, accessible healthcare services … in the context of family and community" (Donaldson et al., 1996, p. 31). These conceptual frameworks are valuable because they promote clarity about different modes of interprofessional working and articulate factors that help or hinder professionals from different disciplines in working together to improve care and outcomes. Interprofessional initiatives in health care are complex interventions and the "elements that function as the 'active ingredient' [to produce desired results] can be difficult to identify" (Schepman et al., 2015, p. 2). Conceptual frameworks support common language and understanding to inform the design, implementation and evaluation of new interprofessional arrangements. This paper proposes a stepwise framework to guide design, implementation, evaluation and research for initiatives that connect legal help to health services (see Appendix). It

also considers the factors at macro (policy, funding), meso (organizational) and micro (practitioner, patient) levels that impact interprofessional initiatives, including considerations that arise when lawyers join the interprofessional mix.

Lastly, the paper formulates areas for future research. A key message is that researchers and practitioners involved in initiatives that connect health, social and legal care do not have to re-invent the wheel; rather, they can learn from and extend the existing body of research on interprofessional care. It would be incongruous if the research on interprofessional care stayed siloed and was not applied to advance work on adding lawyers to health service settings.

ADDING LAWYERS TO HEALTH CARE SETTINGS

MLPs are a patient- and population-level intervention that aim to identify and respond to health-harming legal needs and ameliorate the underlying social and economic drivers of illness and disability (Shepherd and Wilson, 2018; Tobin-Tyler and Teitelbaum, 2019). MLPs fit within a spectrum of initiatives focused on patients' socio-economic vulnerabilities (Gottlieb et al., 2017). The concept of social prescribing has developed to refer to the practice of screening patients for needs arising from circumstances such as poverty, food insecurity, unstable housing and barriers to education and workforce participation, then connecting patients to relevant social and community services (Alderwick et al., 2018; Andermann, 2018; LaForge et al., 2018). MLPs aim to integrate lawyers into heath care settings to provide a level of joined-up care that may not be achieved simply by referring a patient to an external legal service provider.

Data on unmet legal needs provide evidence for the potential benefits of connecting lawyers to health service settings, especially for lower income populations. In the US, 71% of low income households have at least one civil legal problem (Legal Services Corporation, 2017). In Australia, 22% of the population experiences 85% of the legal problems; people with disabilities, those living on low income, and Indigenous people are disproportionately affected (Coumarelos et al., 2012). Over

three-quarters (77%) of patients accessing cancer services at an American urban safety-net hospital reported problems in areas such as income support and housing that could be remedied through legal interventions (Ko et al., 2016). Another study investigated civil legal service and MLPs for homeless populations (Tsai et al., 2017). More than 90% of the 48 service sites across the US reported that clients commonly had unresolved legal problems related to housing, employment, health insurance and disability benefits. Many people receive no or limited legal help for such issues (Martinez et al., 2017).

Through MLPs, legal assistance may be available for all low-income patients accessing a health service, or targeted to patients with specific conditions, such as cancer (see eg, Franco et al., 2013), HIV (Muñoz-Laboy et al., 2019) or critical illness (see eg, Eynon et al., 2019), or to age groups, such as socioeconomically vulnerable children (see eg, Klein et al., 2013) or older adults (see eg, Tobin-Tyler, 2019). MLPs may also feature interprofessional training for practitioners and advocacy for systemic legal and policy reforms to improve health equity (Genn, 2019; Scott, 2017).

But what is a 'partnership'? Variation in connecting health, social care and legal expertise

Services that connect lawyers with health care settings take different forms. This variation is revealed in national surveys conducted in the US (Regenstein et al., 2018), Australia (Forell, 2018) and England and Wales (Beardon and Genn, 2018), as well as a recent interview study of 31 professionals working in MLPs across the US (Mantel and Fowler, 2020). The American survey covered 275 health care and 150 legal organizations and identified three models (Regenstein et al., 2018). According to this taxonomy, a **partnership** occurs when health and legal organizations form a relationship whereby the lawyer is considered part of a team for patient care and assistance. Notably, this model requires both inter*organizational* and inter*professional* relationships, an issue elaborated upon later. An **integrated service** occurs when a health organization employs a lawyer to be part of the patient care team; effective interprofessional working will be required in this model.

Outreach occurs when a lawyer from a legal organization visits the health care organization to see patients seeking legal help, but the lawyer is not considered part of the clinical team.

The Australian mapping review identified the same three models of partnership, integrated services and outreach, and added two additional models: **service hubs**, in which health, legal and other services operate from the same community location, such as a public housing estate; and **student clinics**, in which law students under supervision provide limited types of legal help in a health setting. The England and Wales report identified three approaches that connect legal and health services, with some variation in terminology compared to the American and Australian reports: **integration,** by which legal advisors join healthcare providers in multidisciplinary teams (which would encompass both partnerships and integrated services); **direct links**, by which legal advisors are co-located at health care sites, typically with formal referral pathways; and **indirect links** where an intermediary such as a social prescribing link worker connects a client to relevant services. The majority of services reported in the UK survey were co-located but operationally separate; those with close and ongoing partnership ties were rare (Beardon and Genn, 2018, p. 18). This paper focuses on **partnerships** and **integrated services,** as defined in the American and Australian work, as they involve a higher degree of interprofessional connection, compared to other models.

A set of defining features for partnerships

To support a consistent understanding, American authors have proposed eight core components that characterize a **partnership** between legal and health services: a formal agreement, such as a memorandum of understanding, between the legal and health organizations that sets out roles and responsibilities for matters such as staffing and patient privacy protections; a target population to be served by the partnership; a process to identify patients' socio-legal needs, such as the use of structured screening questionnaires to support triage and referrals; defined roles for core practitioners; presence of an on-site lawyer, which is described as a "signature characteristic" of a partnership (Regenstein et al., 2018, p. 380); training for health care staff on legal issues relevant to

their work and patient populations; information-sharing arrangements, especially to comply with privacy laws; and dedicated funding, often from multiple sources such as philanthropic grants and internal organizational funds (Tobin-Tyler and Teitelbaum, 2019). However, some of these components are under-realized in practice, such as inconsistent approaches to screening for legal needs (Theiss and Regenstein, 2017).

The Australian mapping also proposed several features that would distinguish a *partnership* from other ways of connecting health and legal services. Like the American list, it covers tangible and transactional activities, and also includes more intangible elements, such as a sense of common purpose among professionals and a shared commitment toward redesigning systems and advocating for system-level changes (Forell and Boyd-Caine, 2018, p. 11).

Once the nature of the interprofessional arrangement is characterized at the level of the service model (see Step 1, Appendix), a next step focuses on how practitioners from different disciplines actually work together, including how they distribute roles and responsibilities and their degree of integration and interdependence.

CONCEPTUALIZING INTERPROFESSIONAL CARE – Learning from healthcare literature

Health researchers have used systematic reviews to develop frameworks that conceptualize various aspects of interprofessional working, especially in primary care (see eg, Saint-Pierre et al., 2017; Schepman et al., 2015).These reviews found a lack of detail about the ways in which interprofessional contact and working occur: many studies fail to make clear "the mode of collaboration … in terms of how those involved collaborate in practice across disciplines and diagnoses" (Saint-Pierre et al., 2017, p. 132).

To support clear and consistent descriptors of different modes of interprofessional work, Xyrichis, Reeves and Zwarenstein (2018) critically reviewed empirical studies of interprofessional

interventions to elaborate on four categories: teamwork; collaboration; coordination; and networking (Reeves et al, 2010). These categories represent tighter to looser degrees of connection based on six dimensions of interprofessional characteristics. A *shared commitment* refers to the psychological attachment of practitioners to the interprofessional arrangement. A *shared team identity* refers to the meanings that practitioners attach to their team. *Team goals* refers to a clear expression of the purpose and aims of the team. *Roles and responsibilities* relate to the tasks or activities performed by practitioners, which may be differentiated by disciplinary boundaries. *Interdependence* refers to the extent to which the processes or outcomes of an interprofessional interaction depend on the decisions of all practitioners. *Integration* refers to the alignment of individuals' professional practices toward a process or outcome – such as discharge planning or improved care quality – to which practitioners contribute.

Xyrichis et al proposed a framework – the InterProfessional Activity Classification Tool (InterPACT) – to plot the level of each dimension in an interprofessional context, ranging from low to very high. According to this classification, **teamwork** involves a high degree of interdependence and a strong sense of shared identity, goals and responsibility among team members. **Collaboration** and **coordination** place less emphasis on shared identity and integration but still require clear goals and a degree of shared responsibility, which is higher in collaboration than in coordination. In coordination initiatives, case management responsibilities may be assigned to a particular role, which attenuates the need for sharing responsibility across multiple practitioners. Finally, **networking** involves the loosest form of interprofessional working, in some cases with minimal face-to-face contact and relying mostly on written communication. This work highlights that terms such as 'multidisciplinary team' and 'interprofessional collaboration' may be over-generalizations, just as the 'partnership' label is applied to widely varying initiatives that connect health and legal services.

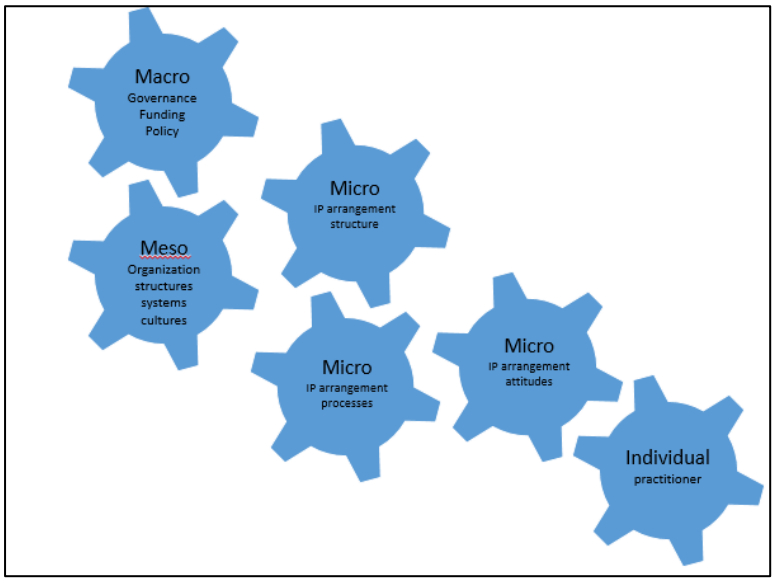
The InterPACT is a useful tool to inform the design, implementation and evaluation of initiatives that connect health, social and legal care (see Step 2, Appendix). When planning for lawyers to join health settings, particularly through partnerships or integrated service models, the tool could help front-line practitioners and service managers to clarify their preferences for interprofessional working and, in turn, the resources and capabilities needed to support them. It is important to note that having a lower level of intensity on dimensions of the InterPACT scale should not be viewed negatively; the goal should be to match the level of intensity with that required to meet the needs of the target patient population, within organizational and community contexts. Reeves and colleagues have explained that interprofessional working "should not be regarded as moving along a single, linear, hierarchical spectrum from weak to strong; rather … a more nuanced conceptualisation [matches] design [to] clinical purpose(s) in order to serve the local needs of patients" (Reeves et al., 2018, p. 2). In some circumstances, supporting effective networking between legal and health professionals may be sufficient, rather than dedicating the time, funding and other resources needed to establish a genuine teamwork model (or worse, setting expectations for team-based work but not supporting the conditions necessary for teams to function properly).

Clear characterization of the types and dimensions of interprofessional working will support higher quality research and evaluation to answer the key questions of what works, under what circumstances and for whom. For example, practitioners working in interprofessional arrangements can reflect on the six dimensions – shared identity, integration of practices, and so on – to determine where they currently sit and whether adjustments are needed to achieve desired outcomes. The InterPACT tool itself can be reviewed and refined over time; Xyrichis and colleagues offered the "tool not as a finished product, but as an initial conceptual basis from which research, practice and educational advancements in our field can be made" (Xyrichis, Andreas et al., 2018, p. 423).

Factors that Influence Interprofessional Working

The preceding discussion stressed the need for clarity about the nature and constituent elements of the arrangements that connect health, social and legal care. A next step is to consider the multiple factors that influence the effectiveness of interprofessional arrangements. Mulvale and colleagues identified statistically significant factors associated with effective interprofessional primary care teams (Mulvale et al., 2016). They developed a conceptual 'Gears model' to illustrate that interprofessional working is a dynamic process that can be helped or hindered by multiple drivers operating at various levels. The macro level includes system governance, funding, practitioner regulation and professional education. Meso level factors include structures, systems and cultures within organizations. At the micro level, the structure and processes of particular interprofessional arrangements are key. At the level of the practitioner, relevant factors include individuals' views about interprofessional working and their level of experience and confidence in their professional role. This model is instructive when considering new or additional factors that are relevant when legal organizations and practitioners are added to the mix.

Figure 1. A Gears Model – Factors that influence interprofessional working



[Modified from Mulvale et al., 2016]

Mulvale et al's analysis revealed that most research in primary care has focused on the structures, processes and attitudes at a micro level that influence interprofessional working, aspects that are also reflected in InterPACT. They concluded that available evidence identifies facilitators such as shared goals, champions and supportive practitioners within the interprofessional arrangement, open processes for communication, problem solving and decision-making, and feelings of commitment and belonging among practitioners. Similar factors were also emphasized in a systematic review of interprofessional primary care initiatives in Australia, Canada, the UK and New Zealand (Wranik et al., 2019).

Mulvale et al found there has been less investigation of macro and meso level factors, with governance, organizational culture and information systems identified as relevant factors. Legislative frameworks to support interprofessional arrangements have received some attention (Girard, 2019; Lahey and Fierlbeck, 2016) There has, however, been little examination of how interactions across the various levels and their relative impacts influence interprofessional working. Additionally, research on effective interprofessional working structures and processes are "an intermediary result that may or may not be linked to end results such as the improved health of the patient, greater efficiency or reduced costs, or improved quality of care" (Mulvale et al., 2016, p. 4). The gaps in evidence on health outcomes were also highlighted in a recent review by Wranik et al (2019). However, these authors found "strong quantitative evidence that the addition of new providers and new models of care is associated with increases in the provision of recommended tests and preventive services, and a decrease in the use of hospitals" (Wranik et al., 2019, p. 10). While primary care initiatives often involve new or expanded roles for nurses (Contandriopoulos et al., 2018), Wranik et al's finding provides further rationale for providing access to legal help in order to prevent the prolongation and escalation of health-harming legal needs. This point leads to the question – What difference does a lawyer make? – which has implications for the conceptualization of interprofessional working and also for a future research agenda.

INTERPROFESSIONAL CARE – WHAT DIFFERENCE DOES A LAWYER MAKE?

This final section considers two aspects of the question "What difference does a lawyer make?" It discusses how the involvement of lawyers in health settings raises additional considerations, with attention to macro, meso, micro and individual levels. A revised Gears model is proposed (see Step 3, Appendix), along with research questions to investigate the impact of adding lawyers to the interprofessional mix, both for how care processes work and for patient and population outcomes.

Macro and meso level factors

As noted above, macro and meso level factors, and their interactions with factors at other levels, have attracted less investigation in interprofessional care research. Barriers and enablers at these levels have heightened importance for genuine partnerships between health and legal services, which demand both interprofessional and inter*organizational* relationships. Useful lessons can be taken from Karam and colleagues' systematic review that identifies similarities and differences of, and features needed to support, interprofessional and interorganizational collaboration (Karam et al., 2018). A high level of regular, open and reciprocal communication was identified as core to effective connections between organizations. Communication is the means to establish trust, identify and agree on shared goals and clarify roles of the organizations and professionals who will work together in an interprofessional arrangement. For successful connections between organizations, Karam et al underscored the need for formalizing the arrangement through written policies and procedures and the need for clear roles for the professionals from different organizations. In contrast, interprofessional working that involves different health care disciplines within the same organization may involve deliberate role blurring.

Karam et al caution that achieving effective work arrangements between organizations is more challenging than establishing interprofessional work within a single organization. They suggest that professionals employed within the same organization stand a better chance of developing:

> a certain cohesion due to physical proximity, informal communication, and a common organizational culture. In interorganizational collaboration, on the other hand, this sense of belonging is less easily achieved, especially given differences between corporate cultures and their models of governance, as well as issues relating to geographical distance, the multitude of processes, and formal paths of communication (Karam et al., 2018, p. 80).

These observations highlight areas for investigation in partnerships between health and legal service providers, including strategies that can effectively bridge professionals from different organizational and practice cultures. A recent interview study of 31 professionals working in US medical-legal partnerships provides some insights, for example, highlighting the vital role of a clinical leader in the health organization to champion the addition of a lawyer for holistic patient care (Mantel and Fowler, 2020). The experiences and impacts of bringing legal help into different types of health settings is an important area to explore. In Australia, public and not-for-profit hospitals are the most common service setting for partnerships, followed by community based or public health services (Forell, 2018). In England and Wales, nearly half (49%) of legal services were connected to general practice clinics, with around one-third of services connected to hospitals, mental health centres or community health centres (Beardon and Genn, 2018).

The impact of differing legal and ethical responsibilities on communication and information-sharing must also be considered. For example, lawyers' duty of confidentiality to their clients is central to the trust relationship and the basis for solicitor-client privilege, a legal rule that protects communications from disclosure without client consent. In contrast, healthcare professionals are typically mandatory reporters under statutory regimes covering matters such as public health and protection of children and vulnerable adults (Mantel and Knake, 2018). Awareness of these different roles is important in sharing patient information across legal and health organizational and professional boundaries. Privacy concerns and methods for permissible sharing of patient

information to enable effective partnerships cut across individual, organizational and governance levels (Mantel and Fowler, 2020).

Funding is also a crucial macro and meso level consideration. Partnerships require dedicated funding, ideally with contributions from each partnering organization. The surveys on medical-legal partnerships in the US, Australia and the UK report that legal organizations provide the larger share of funding, including through the provision of low- or no-cost legal help. American commentators caution that "this marriage of convenience can only go so far" (Regenstein et al., 2018, p. 384) and that increased financing from health sectors is needed. Moreover, new initiatives may be funded on a pilot basis, leaving partnering organizations and professionals uncertain as to whether "fragile" funding (Beardon and Genn, 2018) will be sustained to support ongoing work, longer-term evaluations and scaling up of effective models (Shaw et al., 2018). In this financial context, evidence is needed that demonstrates the returns on investing in health system capacity to meet the complex needs of disadvantaged patients (Pantell et al., 2019).

Education policy is another important macro level consideration. Universities and other training bodies will need to provide interprofessional study and work opportunities to connect students across various disciplines, including medicine, nursing, allied health, social work and law (Sklar, 2016; Tobin-Tyler and Teitelbaum, 2016). Education and training should support the characteristics and capabilities that future practitioners will need for interprofessional work, including "openness, respect, and readiness to value different contributions … the ability to cope with change, reciprocity, and reflexivity" (Karam et al., 2018, p. 79).

Micro level of interprofessional work

Structures and processes for interprofessional working have been the topic of most health care studies, providing evidence to inform the design and implementation of multidisciplinary care initiatives. Adding a lawyer to the mix will add further considerations, especially to take account of new activities, such as interprofessonal training on legal issues, and to clarify roles and

responsibilities for screening, referrals, communication flows and follow-up concerning health-harming legal needs. For example, within a local context, which practitioner is best placed to screen, triage and refer patients in relation to social and legal risks – a nurse, a social worker? Will screening target specific issues, such as assessing for elder abuse among older patients (Ries and Mansfield, 2018), or cover a broader range of issues, such as the "I-HELP" questionnaire that asks about income and insurance, housing and utilities, education and employment, legal status and personal stability (National Center for Medical-Legal Partnership, 2015)? When and how will information collected through screening be used and acted upon, and what role will patient preferences have in such decisions (Alderwick and Gottlieb, 2019)? Continuity of care must also be considered, especially for hospital-based services where patients with identified legal needs can be lost to follow-up once discharged.

The emerging literature on integrating social risk screening in healthcare settings raises cautions (Fichtenberg et al., 2019). Screening patients for social problems has resource and system implications. As Runyan states: "no one is arguing the connection between social factors and poor health [but is] this really [the responsibility] of an undeniably overworked and underfunded primary care system. Not to mention the legitimate concerns about what to do, how to do it, and who pays for the time required once social needs are identified" (Runyan, 2018, p. 550). The "medicalization" of socio-economic problems by putting social and legal care into healthcare settings has a downside to the extent that it reinforces "practices that apply bandaids to the root causes of health-endangering poverty" (Shepherd and Wilson, 2018, p. 563). Scarce resources may be directed to acute problems while the structural determinants of inequity are further entrenched (Chokshi, 2018). Additionally, Alderwick and Gottlieb worry about the "risk of medicalizing socioeconomic hardship and alienating the community-based organizations that health care systems depend on to deliver social services" (Alderwick and Gottlieb, 2019, p. 7).

Adding the knowledge and skills of lawyers to the interprofessional mix may alleviate these concerns by strengthening, not alienating, connections and capacity across health, social and legal care sectors. This potential is a hypothesis to be tested, especially to investigate the macro, meso and micro level factors that enable multi-sector initiatives to mature and achieve systemic changes "to build healthier, more equitable communities" (Siegel et al., 2018, p. 30). The capacity of medical-legal partnerships to effect broader organizational and community changes is underexplored (Anderson-Carpenter et al., 2013). To date, evaluations of arrangements that add lawyers to the interprofessional mix have focused on process measures, such as the number of patients screened for legal issues, the number of referrals to an on-site lawyer and the types of legal services provided. Less is known about how access to legal help affects patient, population and system outcomes. There is a need for conceptual clarity about the nature and types of interprofessional working to underpin research that advances knowledge in this field.

The individual patient/client

Being patient- or person-centered is a key component of quality care, however these terms are understood in varying ways (Håkansson Eklund et al., 2019; Langberg et al., 2019), and few studies on interprofessional primary care have collected data directly from patients about their experiences or satisfaction (Morgan et al., 2020). In developing the Gears model, Mulvale et al depicted patient needs and preferences as a factor that determines whether single-profession or interprofessional care is appropriate. However, the studies that informed that model did not elaborate on the role of patients as participants or decision-makers within the interprofessional care context. Subsequent research has explored how patient-centered care is delivered (or not) in interprofessional arrangements, suggesting that different professional cultures and the contingencies of specific working relationships influence the degree to which patients are considered at the center of their own care (Sidani et al., 2018). In theory, integrating lawyers into health settings aligns with the

holistic, collaborative and responsive elements of patient-centered care (Sidani and Fox, 2014), however its operationalization is an area for investigation.

When lawyers join health service settings, several factors warrant positioning patients/clients with a more central and distinct status. The first factor is **patient consent.** In countries where MLPs have developed, it is a core principle of law that a competent patient has a right to consent to or refuse treatment (Fernandez Lynch et al., 2018; Godlee, 2015); consenting to the involvement of a lawyer is a logical extension of this right, especially since patients do not (yet) expect to see lawyers in healthcare settings. Fostering a therapeutic alliance between practitioners and patients is an important component of person-centered care (Langberg et al., 2019) and it must be clear that the lawyer's role is to advise and support patients in relation to their legal rights and options, but not to coerce them into steps they do not wish to pursue. Identifying socio-legal risks or problems is just a first step; determining the need for legal help depends on the patient's priorities and preferences (Alderwick and Gottlieb, 2019).

Deficiencies in consent processes are acknowledged in healthcare literature (Fernandez Lynch et al., 2018). Within interprofessional care contexts, variable practices exist for seeking client consent for actions such as discussion of their case in multidisciplinary team meetings (Rankin et al., 2018). A hypothesis worth exploring is whether the inclusion of lawyers in health settings may, over time, strengthen consent processes. For example, training and interactions with an on-site lawyer may heighten health professionals' awareness of the need to follow legal rules. If health care providers participate in explicit consent discussions, such as around sharing of patient information in interprofessional arrangements, this may influence the attitudes and processes of other team members.

A second factor relates to the opportunity to support individuals' **legal capability**, which refers to personal attributes such as knowledge, skills, self-efficacy and other resources that are necessary to recognize, respond to and resolve legal problems (McDonald and Wei, 2016, p. 2; Pleasence and Balmer, 2019). Screening for unmet legal needs and legal help delivered within health settings may strengthen clients' recognition of problems as matters amenable to legal intervention. This assistance may also build patients' understanding of connections between health, social and legal problems. Parallels may be drawn with strategies that aim to improve patients' capabilities as self-managers of chronic health conditions (Rees and Williams, 2009). Recognizing patients as experts in their "experience, feelings, fears, hopes, and desires" (Kennedy, 2003, p. 1276) extends to legal matters - the client knows their life and the resolution of problems that would be meaningful for them. Supporting disease management capability and legal capability raises similar questions, such as which patients are best suited to be self-managers and when professional support is vital to improving patients' circumstances.

A third factor is that populations served by MLPs will typically have **complex circumstances**, often experiencing multiple health, socio-economic and legal challenges. It is important to consider whether and how the characteristics of the target population may impact the success of interprofessional arrangements. A review of interprofessional primary care found that services that targeted older adults had fewer positive significant outcomes and suggested that the complex needs of some older patients may hinder interprofessional work or make it more difficult to establish effects on outcomes (Schepman et al., 2015). An in-progress systematic review on the impacts of interprofessional care interventions on patient-reported experiences and outcomes (Kaiser et al., 2018) will provide helpful insights. Another example is a randomised controlled trial currently underway to examine "legally-enhanced patient navigation" in an American MLP targeted at low-income cancer patients (Ko et al., 2019).

CONCLUSION

The past decade has seen considerable growth in scholarship in the interprofessional field, with a maturing of "interprofessional science" (Xyrichis, 2020). Yet research lags behind in investigating initiatives that connect legal professionals with health settings to positively impact care, as well as health and justice outcomes. To advance rigorous research, there is a need for clear and consistent terminology to define the types, core attributes of and influences on these interprofessional arrangements. Conceptual tools proposed by interprofessional care scholars, such as the InterPACT and the Gears model, provide a valuable starting point and have been adapted here in a framework to guide design, implementation, evaluation and research. This framework is provisional and should be refined as research progresses.

This paper concludes with a call to join up research agendas. To date, there is little connection between scholarship on medical-legal partnerships and on interprofessional care, however, as demonstrated here, there is much to learn in connecting these fields. With a burgeoning emphasis on more rigorous research in relation to MLPs, it is an opportune time to bring together research disciplines, as well as policymakers and other stakeholders, with shared interests in improving practices, systems and outcomes across the health-justice spectrum.

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APPENDIX

Adding a Lawyer to the Interprofessional Mix: A Conceptual Framework

Health, social care and legal professional groups work together
to positively impact care, as well as health and justice outcomes.

This Appendix provides a stepwise conceptual framework to guide design, implementation, evaluation and research. **Step 1** involves determining the nature of the interprofessional arrangement at the level of the service model. **Step 2** involves ***zooming in*** to characterize the dimensions of interprofessional activity and how they connect practitioners from different disciplines. **Step 3** involves ***zooming out*** to consider the factors across macro, meso and micro levels that influence interprofessional arrangements.

STEP 1: What is nature of the arrangement that connects health, social and legal care?

What is the nature of the service model?

- ❑ A healthcare organization and a legal organization form a relationship where a lawyer is considered part of the team for patient care and assistance ➔ **partnership**
  - ○ This involves both interorganizational and interprofessional relationships (considered at Step 2)
  - ○ Components to clarify the partnership relationship:
    - Prepare a formal agreement (memorandum of understanding) with roles and responsibilities of partnering organizations
    - Define the target patient population
    - Determine a process to identify patients' legal needs
    - Define practitioner roles
    - Provide for on-site lawyer
    - Deliver practitioner training
    - Establish information sharing arrangements
    - Ensure dedicated funding for the arrangement

- ❑ Lawyer is employed by a health organization ➔ **integrated service**
  This involves interprofessional relationships (considered at Step 2)

- ❑ Lawyer from legal organization visits clients in health care setting but is not considered part of care team ➔ **outreach**

- ❑ Legal service operates from a healthcare site, but is operationally separate ➔ **co-located service**

- ❑ Health, legal and other services operate from the same community location (eg, housing estate), but are operationally separate ➔ **service hub**

Note: Students from various disciplines, including medicine, nursing, allied health, social work and law, may be supervised in practical training in any of the above models. However, interprofessional education initiatives, such as student-led clinics, are not the focus of this framework.

[Sources: Regenstein et al., 2018; Forell and Boyd-Caine, 2018; Beardon and Genn, 2018]

Step 2 – Zooming In: How do practitioners work together?

The dimensions of interprofessional activity

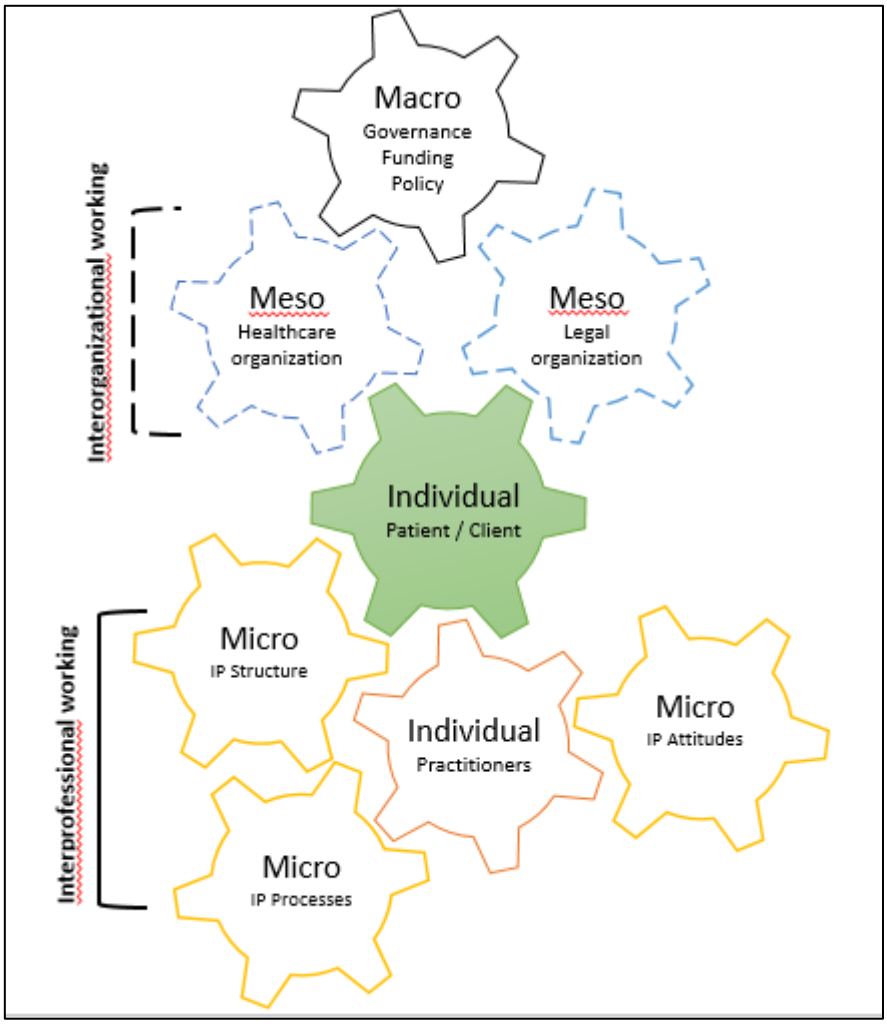
Simplified InterProfessional Activity Classification Tool

♦ indicates level of intensity

Dimensions / Activity type	Shared commitment	Shared identity	Clear team goals	Clear roles and responsibilities	Interdependence among practitioners	Integration of work practices
Teamwork	♦♦♦♦	♦♦♦♦	♦♦♦♦	♦♦♦♦	♦♦♦♦	♦♦♦♦
Collaboration	♦♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦♦
Coordination	♦♦♦	♦♦♦	♦♦♦	♦♦	♦♦	♦♦
Networking	♦♦	♦♦	♦♦	♦	♦	♦

[Modified from Xyrichis et al., 2018] The authors identified sub-types within collaboration and coordination that are not included here.]

Step 3 – Zooming Out: Factors that influence interprofessional arrangements



[The Gears model is adapted from Mulvale et al., 2016]

Note: This conceptual framework can be applied as a stepwise, cyclical process. After working through the three steps, users can cycle back to Step 1 to re-consider the choice of service model.