

**REFLECTIONS ON PRACTICE AND RECENT RESEARCH TO ENABLE FUTURE PRACTITIONERS TO LEARN ABOUT WORKING COLLABORATIVELY ACROSS DISCIPLINES TO BETTER HELP THE COMMUNITY**

**Dr Liz Curran, Australian National University, School of Legal Practice Associate Director,  
Centre for Profession, Education and Regulation in Law**

**ABSTRACT**

This article uses reflective practice and the author's recent research to explain why there is a need for such an approach to break down barriers between professionals to improve social justice and health outcomes for the community they will serve. This article is exploratory only and contains reflections on the author's research (including findings) and own experience in clinical teaching and some opportunities that could be explored to deepen student learning, understanding of the nature of problems, client contexts and holistic problem solving, especially skills in collaboration, interpersonal skills including working with other professions, problem solving, contexts that cause and exacerbate problems and interviewing skills. It suggests the idea for joint student learning across professional fields to enhance such skills and break down professional stereotypes and barriers as well as the development of an interdisciplinary student clinic as an important way of building better and more responsive future practitioners in health, law and allied health disciplines.

Key words: clinical legal education, interdisciplinary practice, social determinants of health, holistic services, access to justice.

**INTRODUCTION**

My recent research and practical experience as a clinical legal education supervising solicitor within a health service has led to the idea for the development of an interdisciplinary student clinic (IDSC) as an important way of building better and more responsive future practitioners in health, law and allied health disciplines. Such an idea is not new, but much of the literature examined looks at interdisciplinary clinics narrowly as lawyers and law students working in non-legal settings. My IDSC envisages law students in joint learning at undergraduate level with students undertaking courses in different fields such as doctors, nurses, psychology, law social worker, dentists, pharmacists and so on.

This article uses reflective practice and my recent research to explain why there is a need for such an approach to break down barriers between professionals to improve social justice and health outcomes for the community they will serve. This article is mainly based on

reflective practice in that it draws on my own practice experience as a clinical legal education supervisor, director of a legal practice that was co-located in a community health service, as a teacher of a practical legal training course of graduate lawyers seeking admission to practice, and on my own recent research findings and those in other jurisdictions which have reinforced my view. These will be briefly examined in this article.

This article is exploratory only and contains reflections on my own experience in clinical teaching and some opportunities that could be explored to deepen student learning, understanding of the nature of problems, client contexts and holistic problem solving especially skills in collaboration, interpersonal skills including working with other professions, problem solving, contexts that cause and exacerbate problems and interviewing skills. The aim of this IDSC and joint learning interdisciplinary program at university would be, in the first instance, to have joint learning opportunities in the early years of student courses, and then, if students elect to, an IDSC. The IDSC will assist students directly and the clinical supervisors and academic staff to teach context and skills in a framework where they can all gain an awareness of problems and the broader contexts not just limited to the legal dimensions that law students tend to be taught. This aligns with the recent research findings, discussed briefly in this article, on advice seeking behaviour of disadvantaged clients which suggests innovations are needed for more effective reach. The article finishes by flagging a new pilot IDSC I have been invited to advise on that is being established by Portsmouth University in the United Kingdom. Together with my cross-jurisdictional and cross-disciplinary colleagues, I intend to further explore this initiative in future articles which will scope, plan, operationalise and examine the impact of IDSC and interdisciplinary learning.

### **WHAT IS AN INTERDISCIPLINARY STUDENT CLINIC (IDSC)?**

Terms such as interdisciplinary, inter-professional, multi-professional, and multidisciplinary are often used interchangeably in the literature to refer to both different types of teams and different processes within them (Nancarrow et al, 2013).

The term interdisciplinary in the context of this article, is one more common in health, primary allied health and educational parlance, often in university settings, and has not been so common in legal language. I suggest that much can be learned from the use of such a term in legal circles and am keen to utilise it as a framework for this article and in future discussion (Maharg, 2007). IDSC, in this article, refers to the learning that emerges from interdisciplinary cross fertilisation and expanding opportunities. Such opportunities include giving advice in student clinics that look holistically at problems, rather than seeing problems in silos of law and health, seeing issues as contextual, overlapping and interconnected both in causes and solutions. It involves students jointly learning from different disciplines. In this case, it is applied within education and training pedagogies to

describe studies that use methods and insights of several established disciplines or traditional fields of study.

The model I am advocating involves researchers, students, and teachers/clinical supervisors in the goals of connecting and integrating several academic schools of thought in joint skills development (e.g. skills including interviewing, interpersonal, problem solving, collaboration, holistic client care, problem identification and assessment and triage) and understandings of differing professional ethical responsibilities and roles of professions or technologies—along with their specific perspectives—in the pursuit of a common task. After skill attainments are put into practice, the idea is for student to provide an advice service with ‘real-clients’ or ‘simulated client situations’ to reach vulnerable/ disadvantaged clients in places and settings where the research suggests such clients, are most likely to turn for help (Buck, Tam and Fisher, 2007; Buck and Curran, 2009; Buck et al, 2010; Clarke and Forell 2007; Coumarelos et al, 2012; Curran, 2005; Mulherin and Coumarelos, 2007; Noone, 2012). As well as these skills, IDSC can also see students from different disciplines providing community education, professional development for practitioners about the different disciplines, and policy reform to address the structural inequities or poor policies or laws that can create or exacerbate problems (Curran, 2004, 2008; Curran, Dixon and Noone, 2005; Tobin-Tyler, 2012).

Xyrichis and Ream (2008) have noted that interdisciplinary health care teams face a set of challenges that are not necessarily encountered by other types of teams such as uni-disciplinary or non-health care teams. Lawyers also face challenges as they are not encouraged often at law school to learn how to work with other disciplines or recognise their value in solving a person’s problems that may have broader dimensions than just the legal problems. These challenges include the contentious nature of sharing professional roles and expertise, planning and decision-making, while delivering quality patient/client care within complex contexts (Nancarrow et al, 2013).

A recent action research study by Harris et al (2016) explores the complexity of inter-professional dynamics in primary health care settings in three jurisdictions, namely Australia, Canada and the United States. Harris et al note that such studies of the dynamic processes of teamwork and interdisciplinary practice have not been studied in depth in the literature and that their article seeks to explore this. They conclude that ‘interprofessional team based care’ has been demonstrated to improve quality of care outcomes in patients with chronic disease in primary care. The article notes that, based on their study, such interdisciplinary care, if done well, can improve client outcomes including health, the quality of care, lead to earlier interventions, and reduce duplication and hard navigability through improved co-ordination and referral and planning. Harris et al also note that interdisciplinary practice can lead to improved relationships, changes in practice and increased job satisfaction and greater opportunity for collaboration. The article notes that in Australia, for example, the role of effective triage and advocacy played by nurses had been

undervalued and under-explored and new opportunities can emerge. They suggest inter-practice communications and specific interventions thus enable greater opportunities for collaboration and improvement and role shifts and can reduce role confusion and tension in some practices between professionals. These are reasons I believe an IDSC and joint learning opportunities at university level are desirable, if not imperative, to better position future practitioners in law, health, allied health and social work and improve client care. Harris et al go into detail about the barriers and challenges of such practice and underline the importance of acknowledging that it takes, time, resources, thorough planning, space – both physical and in terms of creative responses – organisational buy-in, systems support, attitudes and cultures that are prepared to work differently, be flexible and adaptable and prepared-to-have-a-go leadership.

### **WHAT IS MEANT BY MULTIDISCIPLINARY PRACTICE?**

The term multidisciplinary practice (MDP) is one used in legal circles. It is often used to describe commercial models of practice where, for instance, lawyers work with accountants or financial advisers. MDP tends to be the term used in service delivery that is multidisciplinary. Given inherent conflicts in the role of a lawyer, their duties to the court and client and the differing ethical obligations in financial and corporate settings for accountant and others, MDP has had some criticism in this context and is often wound up with perceptions of lawyers including their role in medical negligence cases, commercial transactions for profit, which is unhelpful when one is trying to establish cross-professional relationship building. In my earlier writing and empirical study, I adopted the term MDP as it is commonly known in legal circles. However given the criticism and the many misunderstandings encountered that are emerging from such nomenclature, my journey has led me to adopt the term 'interdisciplinary' based on the literature in health and primary health spheres and the negativity and resistance that has been met using the term MDP. For clarity, therefore, some of my studies use the term MDP when they refer to service delivery as opposed to joint educational learning setting. Given the number of definitions in the literature and differing meanings ascribed to it, I define my use of MDP in the context of this article and my own research and evaluation context.

MDPs are where different professionals work together as a team for a client. The use of the term in legal circles in a context of commercial enterprises that blend lawyers and accountants or financial advisers and other settings has been criticised in literature on MDP as problematic ethically (Castles, 2008). This can be confusing as in many MDP the focus can be about profit and financial advantage and so this can complicate legal professional obligations around confidentiality and conduct, whereas the situation under discussion in this article is about disciplines working together to improve clients' health, social service and well-being in contexts where there are significant barriers to accessing legal help in

traditional legal settings, rather than for profit or competitive advantage. Traditional legal settings which are appointment based are predicated on clients and non-legal professionals being aware of the range of problems capable of having a legal solution and being able to navigate their way to and identify when they need legal help. This can be difficult where clients have barriers such as cost, poor information and/or experience social exclusion (Buck and Curran 2009; Clarke and Forell 2007; Coumarelos et al, 2012; Curran, 2005; Mulherin and Courmarelos, 2007).

Research suggests that skills of good client interviewing, triage, and peer-to-peer learning are skills that different professional disciplines can share even though their roles may differ (Curran and Foley, 2014; Harris et al, 2016; Tobin-Tyler, 2008,). New approaches to lawyering and health services provision are needed that work across silos to enable more seamless navigable service options for real-life clients of the clinic and new approaches in a work place (Harris et al, 2016). Pleasence et al (2014) highlight that vulnerable and disadvantaged clients are not gaining the legal help they need and are not seeking legal help and call for more integrated, connected service delivery.

#### **WHY AN IDSC?**

As noted above, this article and the suggestion for more IDSC as a model for enhancing the learning of skills in professional collaboration is informed by reflective practice on my experience of having run a clinical program with holistic client care in a co-located setting of a legal service within a community health setting (Curran 2005, 2008) in a one of the poorest postcodes in Australia (Noone 2009).

Leering (2014) provides a framework for why this practice experience has informed my conviction that IDSC are a critical advance in the delivery of clinical education and of enhancing skills in students.

*I became persuaded that habitual reflection would benefit legal practitioners at every stage of their development, from understanding better how to learn and function more effectively at law school so that our capacity to learn improves and our knowledge base increases, to encouraging self-directed learning, to enhancing learning from experience during the articling practicum and our early practice years. It also offered new ways to think about skill acquisition as, for example, information technology transforms our conception of legal practice, and we are called upon to be mentors, supervisors, managers, executive directors, and leaders in the course of our professional roles. It is clear that even as seasoned or expert legal professionals, we need to continually reassess and re-evaluate our professional calling and practice to provide better services, learn how to collaborate, take risks and to be prepared to*

*innovate* (Susskind 2008), and keep abreast of developments and new knowledge to increase access to justice.(p. 87-88)

This article is situated within a framework of reflective practice and seeks to suggest new possibilities to ‘*learn how to collaborate, take risks and to be prepared to innovate*’ emerging from my practical experience in seeking to reduce barriers to accessing justice. Practical experience as a clinical legal education supervising solicitor within a health service has led me to seek to progress ideas for the development of IDSC/multidisciplinary student clinics as an important way of building better and more responsive future practitioners in health, law and allied health disciplines. Other research has also shaped and informed this view (Hyams and Gertner, 2014; Tobin-Tyler, 2008).

From my experience and my own recent research, IDSC may be designed to explore more effective service delivery to the most vulnerable and which simultaneously might better build student skills and collaborative learning opportunities. This is based on my reflections on ten years of co-located service delivery, my involvement as a teacher of clinical legal education, my recent involvement in supporting start-up multi-disciplinary services, and my research findings (Curran, 2015, 2016; Noone, 2012; Noone and Digney, 2010).

#### **A ROLE FOR LEGAL SECONDARY CONSULTATIONS AND POLICY INPUT BASED ON CASEWORK TRENDS IN AN IDSC**

Previous clinical courses I developed enabled law students to engage with health and allied health professionals to support them in identifying and seeking systemic changes to poor health and social well-being client outcomes (Curran, 2004, 2008) by undertaking law reform projects. During these projects, students sought the views of health and allied health professionals and their experiences with disadvantaged clients of the co-located health service from where the clinical program operated.

The joint student law reform projects saw law students work collaboratively with health and allied health professionals to identify recurring trends/problems for their clients/patients. In their projects (assessed) law students made many recommendations, and some were adopted by decision-makers around family violence, human rights around pharmacotherapy for drug users and alternatives to and limitations of the courts (Curran, 2004). For example, the students’ policy reports saw them interview a range of professionals such as financial counsellors and gambling counsellors in producing reports on Youth Debt and Problem Gambling; and family counsellors and domestic violence and crisis workers for a report on family violence. These discussions by students with non-legal professionals broadened each report to consider the reasons behind the legal problems, their causes and solutions. The family violence report was used by government for the implementation of a specialist family violence court as recommended by the students and the other reports led to media coverage and a student appearing before a Parliamentary Inquiry into Gambling (Australian Broadcasting Corporation 2014; Curran 2004).

On reflection, if each student had come from a different discipline and written different chapters from their professional vantage point, working side by side and developing the framework of their law reform project, this might have led them to have deeper discussions and a sharing of perspectives offering considered and lateral solutions through the cross-fertilisation of ideas. The reports might have had greater depth and broader recommendations for improvement.

The benefits of students being exposed to different professionals in the law clinic saw them all working together to provide holistic client/patient care. The law clinic students gained referrals from health and allied health professionals which might otherwise not have occurred, leaving many clients' legal problems unresolved. This occurred largely through their clinical supervisor (often supported by the students) undertaking what are called Legal Secondary Consultations (LSC) and or by their own engagement with service personnel, often through joint student law reform projects (as discussed above), where they got to know non-legal professional staff in the MDP.

LSC are defined as where a lawyer offers a non-legal professional (such as a doctor, nurse, youth worker, social worker or financial counsellor) legal information or advice on legal processes for their client through the non-legal professional as an intermediary, or assists the professional in their role (such as what happens at court, and how to give evidence or structure reports for a court to provide the required considerations), or on their professional and ethical obligations, or guides the non-legal professional through tricky situations involving their client or their work for clients. It is 'secondary' in that the legal information is provided to the professional intermediary who is already supporting a client and then this intermediary uses this information to assist their client or patient, as a basis for a referral or to enable the professional to better support the client.

Students received referrals for their work in the clinic on behalf of clients from the relationships and linkages they and their clinical supervisor made with health and allied health professionals who might otherwise not have realised the scope of client problems that might have a legal solution (Genn, 1999). Such preparedness to refer clients often occurred through the LSC and/or by their engagement with service personnel, often via joint student law reform projects where they got to know non-legal professional staff in the MDP whom they would liaise with when developing their law reform and policy topics based on client work and trends emerging from such work.

LSC, systemic reform and social change that seeks to prevent problems, improve community outcomes or go to solve the core of problems or inequity will now be discussed.

In my view, the clinic was great but limited, as it was a 'law student clinic only setting' with the advantage of being in a MDP. It could have gone further had students and clinical supervisors in clinical settings come together to work from different interdisciplinary trainee practitioner spheres, thus complementing learning from each other's disciplines and

supporting advice for clients, mindful and learning about professional ethical boundaries and how to accommodate these through clear communication and protocol development, Such IDSC and undergraduate joint learning opportunities might have also broken down the different university school silos and built understandings and opportunities for research collaborations emerging from the clinic.

### **SCOPE FOR UNIVERSITY COLLABORATION ACROSS DISCIPLINES**

After some failed attempts at conversations to enable more cross disciplinary learning opportunities for students in the 2000s, it became clear to me that my efforts floundered because of academic funding conditions, regulatory and accountability settings and educational silos in Australia. Such initiatives were constrained and more facilitative cross disciplinary enterprises in course design so students from different schools (nursing, medicine, teaching, social work etc.) could be open to joint learning opportunities in the undergraduate courses and clinical opportunities for cross-fertilisation were difficult.

Despite suggestions at the time, departments tended to be internally focussed and curriculum was perceived as too 'crowded', new ways of teaching were frowned upon (Enos and Kanter, 2002) and not seen as a priority. Clinics do exist in the United States, Australia and the United Kingdom that are delivering services on-site at health centres (Bliss, Caley and Pettignano, 2012) however most of these see law students as the key drivers delivering the advice service as a legal clinic (Hyams and Gertner, 2014) rather than being true IDSCs with, for example, students of nursing, dental care, pharmacy and social work delivering holistic services alongside law students as a team. Very few of these are interdisciplinary, in the sense that I am proposing, even though they sit in a health setting, they are still advice sessions provided by clinical law students, much like the model I worked with for ten years discussed earlier. The IDSC differs from these in the sense that the advice is from an array of students across different disciplines working together in an advice setting providing a holistic case managed service by students to clients/patients as a joint interdisciplinary clinic.<sup>1</sup>

My recent empirical research has reinvigorated my view that IDSC for all students to develop learning skills together first and then moving into an advice clinic setting once grounding is in place has a range of benefits, but clearly many challenges (Tobin-Tyler, 2008;

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<sup>1</sup> Hazel Genn is leading an evaluation of the University College London ('UCL') Advice Clinic. The UCL 'Integrated Legal Advice and Wellbeing Service' (iLAWS) centre offers free general advice and assistance for registered patients of the Liberty Bridge Road GP Practice in social welfare law issues. Based in the Guttman Health and Wellbeing Centre in Stratford, the clinic offers users of the Liberty Bridge Road General Practice free face-to-face general legal advice on all aspects of social welfare law including welfare benefits and housing. The UCL Legal Advice Clinic also provides the basis for a wide-ranging research agenda seeking answers to fundamental questions about the nature of legal needs and the links between legal and health problems, <<https://www.ucl.ac.uk/laws/accesstojustice/legal-advice> > accessed 30 August 2017 2017.



Trubek and Farnham, 2000). In recent times, I have been trying to open conversations to start cross disciplinary opportunities within the health and allied health schools at universities that might include justice perspectives and have only just started to make some small headway.

I have reflected on how much better these policy and law reform projects of my clinical students would have been if the law students could have worked on these projects with other students from different disciplines and therefore through different lenses and with ancillary learning outcomes around learning of different roles and perspectives. In my view, this would have seen them critically examine the siloed barriers to systemic improvements. Law students having to work with students of other disciplines to consider an array of perspectives on health, social, legal and economic aspects to client/patient lives would also have to navigate group dynamics and learn about different professional roles and perspectives which would situate them better once they become practitioners to enable joined up services and lateral solution and problem solving skills in collaboration with future colleagues (Harris et al, 2016). Such IDSC will require hard work and educators stepping outside of comfort zones and having to forge and sustain new relationships with other facilities. This will take time, effort, hard work and resourcing, but I believe it will lead to improved practice and better outcomes for students, clients, universities and communities.

### **EVIDENCE-BASED RESEARCH TO INFORM NEW WAYS OF TEACHING FUTURE PRACTITIONERS**

My empirical research, outlined below, reveals there may be a role for secondary consultation in IDSC to bridge professional understanding and confidence and capacity and to enable greater client/patient reach given resource constraints. Perhaps now, with this empirical evidence base, there might be greater preparedness to see justice included in other cross-disciplinary enterprises at universities?

The landscape has now changed given recent research (Allen Consulting Group, 2014; Australian Productivity Commission, 2014; Buck and Curran, 2009; Buck et al, 2010, Buck, Tam and Fisher, 2007, Clarke and Forell, 2007; Coumarelos et al, 2012; Curran, 2005, 2016; Mulherin and Coumarelos, 2007; Noone, 2012). We now know that people most in need of legal help are not accessing it with traditional approaches to lawyering (Pleasant et al, 2014) and that working alongside the patients'/clients' trusted health and allied health professionals may lead to better access to legal assistance.

Many studies and public inquiries also highlight there is also a need for new lawyering paradigms as the adversarial system fails certain groups in the population, particularly victims of crime, family violence (Australian Productivity Commission, 2014; Victorian Royal Commission of Inquiry into Family Violence, 2015), family law and youth. We see the

emergence of problem solving courts and therapeutic, restorative, conflict conferencing approaches (Burchardt, Le Grand and Piachaud, 2002) – for example, Aboriginal or Maori Courts, Youth Court, specialist mental health lists, neighbourhood justice centres and so on; calls for greater collaboration, mediation, negotiation, community development, integrated service delivery across legal and non-legal services (MDPs), professional and community empowerment.

### **WHY MY EMPIRICAL RESEARCH SUGGESTS IDSC AND JOINT STUDENT LEARNING ARE CRITICAL IF FUTURE PRACTITIONERS ARE TO BE ABLE TO BE EFFECTIVE**

In one longitudinal study in Bendigo in rural Victoria, it was shown that, because of an MDP (called Health Justice Partnerships (HJPs) as they situate a community lawyer in a health and allied health setting) clients' knowledge and confidence in engaging with the HJP increased by 90.9 per cent. Of the clients interviewed, 91 per cent indicated that they would not have seen a lawyer with their legal problem/s if they had not been connected to the community lawyer through the health or allied health worker from the HJP (Curran, 2016; Curran et al, 2016).

Prior to HJPs, 40 per cent of clients interviewed were deterred from seeking legal help due to poor experiences with lawyers or the legal system. Clients who have multiple and complex problems reported that they were previously anxious and frightened, as they did not know their rights. This impacted on their Social Determinant of Health ('SDH'). The intervention of the Bendigo HJP is reported as having a positive impact on clients' SDH and offering 'hope', as they now have someone to negotiate on their behalf, who knows their legal position. This allows clients to 'know where they stand'.

There were also positive responses from health staff. Levels of trust between health professionals and patients, responsiveness, and engagement all increased by 87.5 per cent. Clients in HJPs are getting 'better help' and there is a 'positive impact': for example, no drug relapse, reduced stress, and reductions in suicidal ideation have been reported. Such reports are consistent with findings in the United States on the impact of HJPs (Lawton and Sandel, 2014; Pettignano, Bliss and Caley, 2014; Roberts and Currie, 2012; Lawton and Tobin-Tyler, 2013). There are few peer reviewed or evaluation reports on the impact of LSC, a gap which I seek to address. For this reason, I have included it in my measurements to gauge its impact and have written elsewhere about it in more detail (Curran, 2017 forthcoming).

The Bendigo quantitative data (Curran, 2016) on LSC revealed:

Health/allied health professional participants 81.9 per cent strongly agree and 18.2 per cent agree there is 'huge value' to them in LSC (100 per cent positive view on its value) (Curran, 2016).

An extract from the qualitative data highlights numerous data revealing the benefits of LSC:

*Secondary consults and an open door attitude helps me make effective referrals. If I'm unsure about a particular referral I ask [Lawyer] if referral is appropriate etc. – [Lawyer] then does a conflict check. Open door is important as I already have a relationship with the client. When I refer to [Lawyer], the client feels confident that I'm referring to a lawyer of the service. Our clients already have lots of barriers to seeking assistance. Clients come here for many different reasons.'* (Interview with nurse, Curran, 2016)

Although a small project, the Bendigo study revealed data from the longitudinal study over three years showing that LSC can break down poor stereotypes of lawyers and build professional trust. Once non-legal professionals found that trust they were more ready to refer their vulnerable clients thus enabling the lawyers in the HJP to reach clients who would otherwise not seek legal help (estimated to be 86 per cent of vulnerable and disadvantaged clients in the Australia-wide Law Survey, Coumarelos et al, 2012).

The data extracted from surveys and interviews with clients and non-legal and legal professionals revealed that LSC's were often used by non-lawyers to test out whether the lawyer was approachable and understanding and, if this was the case, they would then be prepared to refer their vulnerable client as they felt they had a duty of care. 41 per cent of clients and 75 per cent of non-legal professionals reported they had poor previous experiences of lawyers and/or the legal system prior to their contact with the HJP. This is consistent with the findings of Sandefur (2014) in the United States.

The Bendigo participants noted that were it not for the intervention of the HJP they would not have referred/or sought help for the legal problem/s at hand. LSC's were a critical way of breaking down silos, building trust and reaching clients. At times clients/patients were not ready to see the lawyer due to being overwhelmed or reticent and so the non-legal professional could use the LSC to assist the client/patient in such circumstances. Staff also noted that having the LSC at hand meant that they felt their decision making improved and that they felt more confident to assist clients in navigating the legal system. They also reported that not only did the clients' stress/anxiety levels reduce from the HJP intervention but also noted their own stress levels were also improved though the knowledge that they could easily ask a lawyer for quick and timely help.

In a further Australian study in 2016, the Consumer Action Law Centre (CALC) conducted an online survey and focus group with non-lawyers using their 'worker support line' for LSC. These responses indicated the value of CALC's LSC, its reach and importance in reaching clients who might otherwise not find their way to a lawyer through traditional means but gain legal help through either building capacity of the non-legal professional LSC or through a referral following it. The data so far also suggests that an LSC goes beyond one client and is used to assist other clients, thus extending the reach of CALC (Willcox, Williams and

Curran, 2016). My other recent studies are measuring the extended reach to clients downstream of LSC.

In a further report by the Victorian Legal Services Board (LSB) and Commissioner (Curran et al, 2016) the following commonalities were found amongst the eight LSB-funded HJPs:

- HJPs do not work effectively unless they are designed and have input from all those who deliver the services and also have a client/patient perspective on what the barriers are and how to engage.
- HJPs take time and relationships of trust can be fragile.
- Common language between professionals that is clear and transparent is essential, professional roles need to be worked through and understood especially different ethical codes.
- Processes to maintain confidentiality, such as issues around information technology, need to be established but difficulties can be overcome through good communication and collaborative practice among the different professions.

This last point has also been noted in other studies on HJPs and the ability for professional differences that inhibit communication and create barriers to seamless service delivery and holistic client care to be overcome. The different professionals tend to focus on case managing the client and the outcomes to be achieved rather than their professional differences and find 'work arounds' to enable the problem at hand to be resolved (Curran, 2017 forthcoming; Gyorki, 2013; Noble, 2012; Tobin-Tyler, 2008).

#### **WHY THERE IS A NEED FOR SUCH AN APPROACH TO BREAK DOWN BARRIERS BETWEEN PROFESSIONALS TO IMPROVE SOCIAL JUSTICE AND HEALTH OUTCOMES**

New approaches to lawyering and health services provision are needed that work across silos to enable more seamless navigable service options for real-life clients. This cannot be assumed to be automatic on becoming a practitioner but rather ought to be examined earlier and throughout legal education. This will better prepare future practitioners as well as enabling an improved understanding of professional roles and preventing professional stereotypes from developing that can impede understanding and collaborative skills ought to be developed. Such legal education can include:

- teach early on before professional divides emerge and professional cultures become engrained
- learn about different professional roles and how they can complement each other
- share what is effective, and
- develop skills in working together.

Good client interviewing, triage, and peer-to-peer learning are skills that different professional disciplines can share even though their roles may differ. Developing and exploring and extracting good practice from across the health, social and legal spheres can enhance student growth and skills, and help break down professional stereotypes and professional cultural barriers early and would also see clinical supervisors and academics from different disciplines working together in course design and supervision, thus breaking down some of the university barriers discussed earlier (St Joan, 2001).

### **THE IMPETUS FOR INTERDISCIPLINARY LEARNING AND INTERDISCIPLINARY STUDENT CLINICS (IDSCs)**

This evidence-based research highlights how professionals who work together across different disciplines can enhance connections, referral pathways, access to legal advice and information and can extend trust and relationships which facilitate referral and engagement. There are now compelling empirical reasons for getting students earlier in their careers, and before they get set in their ways, to think about how other professionals have different things to offer and that collaboration is appropriate in many situations, and to encourage them to think laterally and holistically about their clients, mindful of different roles and expertise, and better aware of them.

I believe that earlier education, as would-be practitioners study at university might lead to better understandings and improved practice. IDSC and increased interdisciplinary learning opportunities could start in initial years of undergraduate university or the Juris Doctor (or JD) with joint learning opportunities in ethics, interviewing, triage, advocacy (in the broadest sense including with decision-makers in matters of housing, social support and so on, not just representation in court), multiple problem identification and context of clients.

In later years, having developed these joint learning skills in the earlier years of their degree, law and health or welfare students, as they advance, could move onto to an IDSC, later in their degrees with offerings of advanced clinical opportunities in and advice service offering health and legal advice in community and health services to people that the research shows do not access services through traditional means. At the joint advice clinics, students (under joint clinical law and health supervision) would also be offering joint advice to professionals and client/patients, from different fields with student practitioners. A greater focus on communication and interpersonal skills would improve legal education too, as it is largely taught by case law and statute with minimal actual client-centred and problem solving practice that other professionals are exposed to in the undergraduate training (Enos and Kanter, 2002). In my experience, based on reflective practice in teaching junior graduate lawyers and in supervising and mentoring them in early years of practice, it comes as a shock to many law graduates when they are faced with their first client interview and realise that real-life clients do not fit within tight legal categories and that clients can be stressed, ill-informed and have multiple and complex issues.

The IDSC could also provide community education across legal and health fields conducted by the students jointly, community development and professional development for professionals about problem identification, LSC and possible holistic solutions where students work on research and policy projects jointly incorporating health, justice and social work paradigms, working on system projects emerging from the clinical advice giving and multidisciplinary discussions. This student work might also feed into student and academic clinical health and social research incorporating, but not dominated by, justice issues and intersecting with health, justice and social contexts and the broader causes and solutions would emerge.

There is a need for such an approach that goes beyond a law student clinic. My dream is to see an interdisciplinary clinic for different fields of professional training at graduate and undergraduate level to break down barriers between professionals to improve social justice and health outcomes. In this model, mindful of professional ethical boundaries and under ID supervision, students of different fields would learn to work collaboratively to deliver holistic client care and reach those currently excluded and learn through working with different disciplines different and more efficient and effective ways of assisting clients that break down existing silos that have developed over time by professionals having little exposure to different ways of working (Tobin-Tyler, 2008).

Reflection on my practical experience as a clinical legal education supervising solicitor within a health service has led to the idea for the development of IDSC/multidisciplinary student clinic as an important way of building better and more responsive future practitioners in health, law and allied health disciplines.

### **A NEW CLINIC?**

I delivered a workshop in August 2016 at Portsmouth University in the United Kingdom on Multidisciplinary service practice and my research and findings on HJP. Emerging from this workshop, discussion participants decided to initiate a student/clinician and academic IDSC at Portsmouth University. I have been appointed advisor (pro bono) on the establishment of this IDSC and on its evaluation. We are working together on such a model as a pilot, initially with the schools of law and nursing, but with expressed interest into the future of schools of pharmacy, dentistry and social work at Portsmouth University. A joint further collaborative conference paper and journal article on this pilot is in progress.

It is hoped this pilot IDSC will develop and explore taking good practice from across the health, social and legal spheres to enhance student growth and skills. The upcoming papers will also discuss how interdisciplinary learning and advice clinics in university courses can occur with respect for differing ethical boundaries and duties through clarity, effective communication and transparency and can enhance student ethical awareness. The

development of an IDSC will be an important way of building better and more responsive future practitioners in health, law and allied health disciplines.

Clinical supervisors can work across professional boundaries facilitating student learning so they can do the same with IDSC, as well as fostering 'peer-to-peer learning'.

The assessment framework for the IDSC will utilise my previous experience as a clinical supervisor and include students working together on community and professional development and separately on a joint project which will emerge out of their course experience and a 'guided reflective professional journal' which will be graded against key assessment criteria set by the supervisors and teachers liaising on key skills and attributes required from different disciplines. These criteria will be made available to students in a clear and transparent way. In addition, teaching pedagogy for different disciplines will also inform the development of course and curriculum to enable learning using the best from different disciplines.

Engaging students earlier in their careers in interdisciplinary practice before they get set in their ways and exposing them to thinking about how other professionals have different things to offer and that collaboration is appropriate in many situations. Encouraging them to think laterally and holistically about their clients and be mindful of different roles and expertise, engage in reflective practice as an integrated part of their learning and providing research and policy opportunities will also help to make them better aware of barriers to access to justice.

My work as a former director of a human rights agency and leader in an advocacy team of a humanitarian agency with work in Asia, India and Africa, identified a shortage of legal assistance services. There might also be a role for IDSC and MDP services in these countries too, situating them in the existing services, for example, in maternal and child health clinics in remote villages. Hopefully the empirical research and this article will inspire other start-ups on IDSC elsewhere.

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