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How Legal Problems Affect Health and the Role of Medical Legal Partnership in Canada

by

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Abstract

At the moment, there is little research involving the connection between legal issues and an individual's overall health. It makes sense that non-individual factors go into determining one's health, such as physical environment, housing, and education. These factors are typically referred to as the *Social Determinants of Health* (SDOH) (Mikkonen and Raphael 2012). However, at times, individuals experience issues that are legal in nature, which can in many ways affect one's health. It is this recognition that has sparked the creation of medical-legal partnerships throughout the United States, and more recently in Canada. The health benefits of medical-legal partnerships are well documented in the United States, and have created a network of medical-legal organizations, in addition to new practices in both legal and medical education (Theiss 2017; Tobin-Tyler 2011). This research explores the establishment of one of Canada's first Medical-Legal Partnerships (MLP) between The University of Calgary's Student Legal Assistance (SLA) and Calgary's downtown community health center (CUPS). This research explores how legal supports included alongside healthcare service provision can work to address structural inequalities that exist in our social environment and are created or exacerbated by one's "legal wellbeing". Interviews with healthcare and social service providers working alongside the CUPS and SLA MLP provides novel insight into the various ways legal issues can disrupt access to healthcare, interrupt health seeking behaviours, or create unique health crises all on their own. The idea behind this is to prove that legal wellbeing is a distinct social determinant of health. The following research aims to establish a foundation for the further development of Medical-Legal Partnership throughout Canada and challenges readers to ask, what does access to justice really look like?

Preface

This thesis is original, unpublished, independent work by the author, A.C van Olm. The reported interview data were covered by Ethics Certificate number REB19-1546, issued by the University of Calgary Conjoint Faculties Research Ethics Board for the project "A Qualitative Study of a Health Justice Partnership" approved on May 11th 2020.

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and complete my undergraduate degree, my graduate degree, and this research. At the same time, the experiences I have had from my interactions with patients and healthcare providers has shaped my research and will forever inspire my work.

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Dedication

In memory of my father Dr. John van Olm, whose approach to patient-centered care has always been my inspiration.

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Chapter 1: Introduction

There is a growing field of research involving the connection between legal issues and an individual's overall health. It is well established that factors such as physical environment, housing, and education are crucial to determining one's health such. These factors are typically referred to as the *Social Determinants of Health* (SDOH). This thesis considers legal access to legal support as a social determinant of health and legal care as a necessary adjunct to medical care. As we will explore, what it means to be 'legally well' can be complex. In some cases, one's legal wellbeing can be directly influenced by the legal issues someone experiences. In other cases, legal wellbeing can involve one's relationship with the law during probation or parole or managing a successful co-parenting arrangement. Because of the way these legal issues can impact other social determinants of health such as housing or employment, access to legal support can directly affect health. It is this idea has sparked the creation of Medical-legal Partnerships (MLP) throughout the United States, and more recently in Canada (Drozdzal et. al 2019). The creation of these partnerships aims to provide legal support that is not ancillary to medical support, but instead works in combination to treat health as an interdisciplinary project (Hughes 1995; Murphy et. al 2015; Tobin-Tyler 2011). In 2016 the University of Calgary's Student Legal Assistance (SLA) partnered with Calgary Urban Project Society (CUPS) to integrate legal services into a community health center. In Calgary, CUPS operates as a community health center that that offers primary care services and social support services for low-income Calgarians. The healthcare services available at CUPS include primary care facilities and a designated women's health clinic staffed with registered nurses and a rotation of family physicians. In the same location, CUPS provides a variety of additional social support services for low-income individuals including housing supports, early childhood and adult education, and

employment services. SLA on the other hand, is a student run legal clinic that serves low-income Calgarians with civil, criminal, and family legal matters. The MLP at CUPS is similar to those in the United States, and is based on a model of patient advocacy, or what has more recently been referred to in Canada as health justice (Tobin-Tyler 2011: Drozdzal et. al 2019).

Since 2014, I have worked part-time in the Rockyview General Hospital as a porter. Over the years, I was surprised to see how many complex factors were involved in a patient's healthcare experience. Often, the people I interact with are suffering from larger life issues that make their medical problems more challenging, some of which involve the justice system. At the same time, I began as a volunteer working during the summers as clinical support with the University of Calgary's Student Legal Assistance (SLA). During our day-to-day operations, we would carry out community outreach initiatives where students working with SLA would attend various outreach centers in Calgary. Generally, this was done at the Calgary Drop-In Center, The Calgary Dream center, and Alpha House. Each of these organizations serves to provide social support programs for Calgary's low-income community. Near the end of my volunteer position with SLA, our Executive Director at the time was interested in providing additional student outreach initiatives within the community. Influenced by my work with SLA, and my time as a hospital porter, I noticed there was an opportunity to provide patient advocacy within the Canadian healthcare system.

Over the course of the next year, I began researching how to implement student outreach alongside healthcare service provision. With the support of a student caseworker who understood the impact legal services could have in healthcare settings, we established Alberta's first health justice partnership with CUPS. The following year, I was invited to work in-house at CUPS as an intake liaison for SLA's health justice partnership in order to help the flow of potential

participants, while also working to establish a sense of organizational perpetuity to this newly developed program. Often this included taking notes for clients, organizing intakes for participants, and providing a presence within CUPS for SLA.

While we were working to establish this partnership, CUPS was undergoing a shift in their intake or triage procedures. In their new model, CUPS created a system where participants seeking assistance would complete a common intake procedure to identify which services might be of most use to them. Before the introduction of the common intake at CUPS, individuals would have to access different departments for different issues in a piecemeal fashion. The shift to a common intake ensured that individuals would be screened for every service that CUPS offers, including housing, identification, education, health, and now legal services. The establishment of the MLP with SLA meant that CUPS was now including legal needs assessments within their common intake procedure. When individuals expressed the need for legal service provision, intake staff at CUPS were able to refer participants to SLA directly. If student caseworkers from SLA were on-site, individuals could complete a legal intake and begin addressing their legal needs. If SLA was not on-site, individuals were referred to SLA at which point student caseworkers would schedule a time with participants to complete a legal intake at CUPS. In this model, law students from the University of Calgary would attend weekly intakes at CUPS to improve access to justice for many vulnerable and low-income Calgarians. Since 2016, SLA has been able to provide legal assistance to over 220 participants at CUPS and continues to have a consistent presence within the Calgary community.

In the United States, research shows that MLPs can improve access to legal services, improve patient health outcomes, reduce stress, and reduce health disparities (Hernandez 2016; Speldewinde 2015). The inclusion of legal support in healthcare is an emerging model in Canada

and differs from that in the United States. Primarily, this is because the American practice of MLPs includes instances of fully integrated MLP, which legal staff permanently on-site and fully integrated into the healthcare center (Tyler-Tobin 2011). Thus, researching Canadian MLPs can provide evidence in understanding how legal support can improve patient health within Canada's publicly funded healthcare system. The perspectives and experiences of service providers and clinicians will be vital in understanding the holistic effects that legal support can have on health and healthcare provision. This research therefore has the potential to benefit patients at a national scale and go on to change the current model of healthcare throughout Canada.

I. The Scope of Medical-legal Partnership

MLPs can be categorized into three distinct categories based on service provision. These models include: the general population model, the special populations model, and the alternative legal services model (Regenstein et. al 2018). The general population model is to be situated in general hospitals and aims serve the needs of a general low-income population. The special populations model tends to "focus services on an intentionally defined high need population" (Regenstein et. al 2018: 383). Importantly, the special populations model allows organizations that cater to specific populations an opportunity to provide legal services as part of their wraparound care provision. Examples of this include the MLP with Healthy Women, Healthy Babies, in Delaware that focuses its services on low-income pregnant and postpartum mothers (Regenstein et. al 2018). The alternative legal services model operates in areas with scarce staffing and scarce resource arrangements but provides a range of services that can range from telephone consulting for clients, to legal service providers that assist multiple healthcare institutions (Regenstein et. al 2018). Nonetheless, while MLPs can differ in their structure, their underlying rationale and goals remain the same. In each instance, MLPs have quickly become an

effective strategy in combating inequitable social problems that contribute to poor health outcomes and health disparities throughout the United States.

In the United States partnerships between lawyers and health professionals have been in existence since the late 1990's (Tyler-Tobin 2011). Initially, the establishment of the Medical-legal Partnership model was first developed at Boston Medical Center in 1993 when healthcare staff traced patterns of patient illness to moldy apartments where landlords refused to comply with sanitary code (Lawton 2014). Following the growth and success of Boston Medical Centers MLP, the proliferation of similar partnerships began to take hold in the United States. In 2006, the National Center for MLP (NCMLP) was established and seeks, "to improve the health and wellbeing of people and communities by leading health, public health, and legal sectors in an integrated upstream approach to combating health-harming social conditions" (Regenstein et. al 2018). Unsurprisingly, MLPs have been flourishing nation-wide in the United States and have recently become systematically incorporated throughout American healthcare settings. The National Center for MLP states that at the moment, "442 health organizations have developed MLPs in 48 states" (NCMLP 2017). However, the integration of legal services in healthcare settings is still relatively new. A 2016 analysis by the National Center for Medical-legal Partnerships indicates that, "approximately 41 percent of healthcare organizations indicate that their MLP has been active for more than five years, while 28 percent are three to five years old and 31 percent are two years old or less" (Regenstein, Trott, Williamson 2017: 8). In recent years, MLPs have become more prevalent in community health centers, Veteran's facilities, and home health organizations (Regenstein et. al 2018: 9). The increased implementation of MLPs within U.S healthcare settings over the years speaks to the true utility of the integration of legal services alongside healthcare provision.

In the United States, Federally Qualified Health Centers or FQHC's are, "community-based organizations that provide primary care and preventative care, including health, oral, and mental health/substance use services to persons of all ages, regardless of their ability to pay or their health insurance status" (Regenstein et. al; 2017: 8). Because of the well-suited nature of MLPs within these community health settings, FQHC's have become increasingly incentivized to implement MLPs for their patient population (Regenstein et. al 2017). This direct growth has led to increased funding and opportunities for MLPs to operate in different communities and diversify their service allocation (Sandel et. al 2010). At the same time, this has created opportunities for legal service providers with different organizational characteristics unique opportunities to provide services in spaces that best fit the needs of the population.

Another fundamental component of the MLP model involves having dedicated staffing from the legal services organization. Authors indicate that this piece is crucial for the success of both the partnership, and improving health outcomes for patients, as in house legal service providers can begin to identify patterns in the population they assist, and eventually become more perceptive to preventative, or acute legal interventions available for clients (Regenstein et. al 2018; Sandel et. al 2010). This increased interaction between healthcare staff and legal service providers helps to strengthen the partnership between legal and healthcare staff and bridge the knowledge gap between disciplines.

However, due to variations in community need, operational capacity, and finances not every MLP is structured the same. For instance, some MLPs are structured with a "lawyer in residence" approach, wherein, "the majority of partnerships, lawyers are available on site a few days per week, enabling them to respond quickly to patients needs and clinicians' questions" (Regenstein et. al 2018: 380). Other MLPs have lawyers provide routine drop-in services and

appointments as necessary for patients. The difference is both the level of integration from an organizational level and the level of legal integration into a patient's care plan. While the opportunity to have legal counsel fully integrated and on-site strictly dedicated to a healthcare center is an ideal scenario, MLPs have a spectrum of integrative variations with each still dedicated to the same goal of providing legal assistance to improve patient health.

Another key component of MLPs includes the implementation of a legal needs assessment strategy (Regenstein et. al 2018: 379). Early partnerships utilized legal needs screening through the I-HELP framework (Regenstein et. al 2018) which screens individuals for Income, Housing, Employment, Legal Status, and Personal and Family Stability, "to identify patient problems that are responsive to legal intervention" (Sandel et. al 2010: 1698). The I-HELP assessment tool allows practitioners to have more context about a patient's living conditions, which in turn can provide insight into an individual's legal and health needs (Sandel et. al 2010). Since the introduction of I-HELP, and its use among MLPs, organizations have started creating alternative legal needs screening tools, such as PRAPARE, and the CMS Core Health-Related Social Needs Screening Tool (Regenstein et. al 2018). These assessment tools are designed to help healthcare providers and their partners make more informed strategies that help to, "identify upstream socioeconomic drivers of poor outcomes and higher costs" (Regenstein et. al 2018). However, as we will explore, the complex way in which legal issues impact health means that quantitative 'measurement tools' cannot completely capture what it means to be legally unwell. Nonetheless, the development and utilization of novel screening mechanisms for MLP points to a step forward in acknowledging how legal factors can impact health. At times, agencies seeking to develop MLP may have pre-existing intake, triage, or screening practices, meaning legal needs assessment must be administered in different ways. Screening individuals for their health

harming legal needs is a cornerstone of the MLP model and indicates a crucial part of addressing social determinants of health, but requires stakeholders remain reflexive about how and in what context individuals are screened for health harming legal needs.

Finally, one of the most important characteristics of MLPs involves information sharing or a level of coordination between partners (Regenstein et. al 2018). After an individual has been screened for health harming legal needs they are triaged and referred for legal service (Regenstein et. al 2018; Sandel et. al 2010). For most partnerships, information sharing takes place between legal and healthcare providers, typically this involves referrals, consultations, legal information, or administrative questions and that may appear in different ways (Sandel et. al 2010). Additionally, legal service providers can provide healthcare staff with information and training about legal matters that their patients may experience during their care. In this instance, "lawyers help to train health staff so that they can better recognize when legal help is best deployed" (Regenstein et. al 2018: 380). Researchers argue that this approach "weaves early detection and responses to legal needs efficiently into clinical care so that needs can be addressed without an individual lawyer's intervention" (Sandel et. al 2010: 1699). Ideally then, principles of information sharing will help to reduce the knowledge gap between health and legal professionals. By including comprehensive training on legal issue spotting, MLPs are effectively implementing training that allows health care teams to identify and triage legal issues as part of a patient's healthcare plan. What makes this especially important is that the existing MLP between CUPS and SLA involves student caseworkers and collaboration with the University of Calgary. While the partnership between CUPS and SLA is not fully integrated, the opportunity to educate students in these settings creates a space for students and practitioners to build structural competencies through community engaged learning in clinical settings. Regardless of students'

future career aspirations, education in structural competencies can provide practitioners with a thorough understanding of how social and structural factors might affect potential clients (Tobin-Tyler 2011: 152).

II.Canadian Medical-legal Partnership

In recent years, Canada has started to see its own development of MLPs though it has only a handful of operational MLP defined services (Drozdzal et. al 2019). In 2009 Canada established the first MLP outside of the United States through Pro Bono Law Ontario's (PBLO) MLP for Children (PBLO 2009). Through this partnership, "a referral pathway was made for patients of low-income families with potential legal issues affecting their treatment" (Pai et. al 2010: 12A). In this particular model, "a qualified triage lawyer responded to referrals through private, confidential consultation, and free legal assistance was provided where required" (12A). The service structure provided by PBLO at SickKids Hospital were like the services offered by MLPs in the United States. The services provided were divided into 4 different areas including, brief service, legal advice, referral to an outside legal service, or information (Pai et. al 2010). A study of this partnership found "over a 6-month period, 169 consultations were made, for a total of 195 legal issues" (Pai et. al 2010: 12A). An analysis of these legal issues found "the commonly cited issue was family law including domestic violence and custody (22.1%; 43), immigration law (16.9%: 33), health insurance (10.3%: 20), and housing/tenancy (8.2%:16)" (Pai et. al, 2010: 12A). The study concluded that in addition, "a significant population of low-income families seek legal counsel over issues directly or indirectly affecting their children's health" (Pai et. al 2010: 12A). In turn, this MLP has been operational and continues to provide services to this date. This important study indicates an enormous first step for Canada in the effort to mitigate health

inequities through legal interventions that address social determinants of health. Surprisingly however, the development of such partnerships is not as commonplace as it appears to be in the United States.

Since 2009, partner organizations in Ontario started undertaking similar initiatives to implement medical-legal type services within their communities. In 2014, St. Michaels Academic Family Health Team launched their own Health Justice Partnership, which "aims to bridge the gap between social determinants of health knowledge and practice through a multi-partner medical-legal program informed by the MLP model" (Drozdzal et. al 2019: 246). This MLP was launched as a collective partnership between, St Michael's Academic Family Health Team, St Michael's Hospital, the ARCH Disability Law Centre, Aboriginal Legal Services of Toronto, HIV & AIDS Legal Clinic Ontario, and Neighbourhood Legal Services. The MLP is structured similarly to those in the Unites States and was launched initially with a legal need's assessment of patients of downtown Toronto's St. Michaels Hospital. Clinicians estimated that, "1,980 patients, representing more than half of the patients referred to social workers, had at least one legal issue". Interestingly, the structure of the MLP differs from American MLPs in that screening for legal needs are done by each patient's family physician, social worker, nurse, or other clinician. What distinguishes this MLP from its American counterparts, is that there is no standardized screening method for identifying an individual's potential health harming legal needs. Instead, clinicians and healthcare staff are given discretion on whether to advise patients for legal services. The MLP at St. Michaels Hospital offers a lawyer on-site who is generally assigned to an examination room, where patients can meet via drop-in or appointment-based meetings. The MLP initiative at St. Michaels Hospital has quickly become a multidisciplinary learning platform, that includes an "array of formal teaching sessions for clinic staff and family

medicine residents based at the clinics" (Drozdzal et. al 2019: 246). In this space, collaborators can work together to educate fellow staff members on the social determinants of health and improve access to justice. As we will explore, educational opportunities in these settings have several advantages. Since its creation, the MLP in Toronto stands as a very strong first step in the establishment of future programs that incorporate legal interventions in healthcare settings throughout Canada. Providing a context of existing health justice programs in Ontario demonstrates that similar partnerships could be implemented throughout Canada but require encouragement and support from community allies and agencies. With recent developments made to virtual and digital consultations with professionals, the credibility of online service provision is drastically improving. An embrace of virtual legal services could significantly contribute to the establishment of MLPs thorough Canada in a variety of different models including a uniquely digital platform for legal service provision.

Chapter 2: Literature Review

I. How the Social Becomes Biological:

The correlation between social conditions and health is a persistent finding in sociological and health research (Marmot and Wilkinson 2005; Schofield 2015). Social conditions are often understood as social determinants of health (SDOH), which includes social, economic, demographic, and behavioral risk factors (Prus 2011: 50), A central focus of the SDOH includes an individual's socioeconomic status (SES, "a composite measure that typically incorporates economic status, measures by income; social status, measured by education; and work status measure by occupation" (Adler, Boyce, Chesney, Cohen, Folkman, Kahn and Syme, 1994: 15). Thus, when assessing an individual's health, SES plays a critical role in determining the resources and supports available to promote health and helps to explain the pathways that ultimately lead to inequalities in health outcomes (Harvey, Hynes, and Pichora 2016). In fact, the World Health Organization outlines the SDOH as the conditions in which people are born, grow, live, work, and age (WHO 2018). Thus, conditions where individuals experience legal issues or engagement with the justice system should be included in the SDOH.

Perhaps one of the most elements of SES is income (Mikkonen and Raphael 2010). This is generally because income is essential in influencing ones living housing conditions, dietary needs, and psychosocial needs. In fact, "In Canada, income determines the quality of other social determinants of health" (Mikkonen and Raphael 2010: 12). Authors Mikkonen and Raphael argue that "income comes to be especially important in societies which provide fewer important services and benefits as a matter of right" (2010: 12). However, in many instances' income can affect health through resources that are not publicly funded, such as recreation. With this, Mikkonen and Raphael claim, "low income predisposes people to material and social deprivation

[…] the greater the deprivation, the less likely individuals and families are able to afford the basic prerequisites to health" (2010: 12). As a result of financial insecurity, many individuals can experience social exclusion, "making it harder to participate in cultural, educational, and recreational activities […] and lessens the ability to live a fulfilling day-to-day life" (Mikkonen and Raphael 2010: 12). inequalities individuals experience concerning socioeconomic status can go on a determine one's health status (Raphael 2004).

In addition, "public health experts agree that health inequities correlate strongly with, or are matched by, a combination of social inequalities" (Schofield 2015: 11). To change or address health disparities, it is first important to recognize the context of how disparities arise and assess how inequalities can impact one's health. The Whitehall Studies (Marmot et al. 1991) are among the most well-known studies to indicate that mortality rates among individuals differed based on social gradient or hierarchy. This issue presents a larger social problem as socioeconomic status is typically based on income, education, and occupation, meaning that these specific variables can play a determining role in an individual's health and health seeking behaviours (Schofield 2015; Siegrist and Marmot 2006).

In fact, "the social and economic structure of society, especially low income, income inequality, discrimination, and social exclusion are seen as the ultimate determinants, the 'causes of the causes,' of disease and death" (Deaton 2002: 14). Without social interventions in healthcare, individuals may receive physical care but will leave the health care system with the same social issues as before. These individuals then return when the conditions outside of the hospital force them into the health care system again. This creates a revolving door effect, by merely placing a Band-Aid on the individual's physical ailments and sending them back into the community. In the United States, MLPs have also begun to take on the role of identifying social

determinants of health patients may be affected by. Specifically, Theiss and Regenstein (2017) examine existing MLPs to understand how health providers can screen or assess patients for social determinants. Interestingly, the authors found that, "incorporating information about the social determinants of health into a patient care plan can translate to improved health outcomes" (Thiess and Regenstein 2017: 432). Additionally, the authors claim that "a patient's risk of disease may be predicted through an understanding of their background" (Theiss and Regenstein 2017: 432).

This research is also grounded on the notion that legal wellbeing should be included within the social determinants of health (SDOH). Literature suggests that in many ways one's ability to attain legal support is increasingly involved in shaping one's health (Dingake 2017; Tyler-Tobin 2011; Weintraub 2010). Thus, focusing on how legal issues or factors can influence an individual's health will serve as the theoretical foundation for this research. For every Canadian, the way law factors into our individual lives and communities can play an enormous role in the way that we go about our daily interactions, and the way that we structure our lives. In this sense, "law is one of the most important social determinants of health" (Tobin-Tyler 2011: 21). For this research, the idea of law as a social determinant of health can impact Canadians in four distinct ways; the first includes viewing law as an organizing structural body such as anti-smoking legislation, food and drug regulations, and healthcare policy. Generally, this could involve laws that impact public and population health. However, this also includes law as a structural force that impacts where and how people live, go to school, and earn a living. The second way to view law as a social determinant of health pertains to the way individuals engage with and experience legal matters in their personal and individual lives, such as civil litigation, child support matters, and criminal violations (Tobin-Tyler 2011). Law as a social determinant of health in this manner

also includes laws that are experienced differentially by communities, such as over policing in communities of colour. Because of this, "law influences a myriad of other social determinants, including education, income, housing, racial and ethnic disparities, nutrition, and access to health care" (Tyler-Tobin 2011: 21). Together these factors demonstrate the various ways in which law can impact individual and population health. Because on this, the development of MLPs is, "premised on the idea that bringing healthcare professionals and legal professionals together to address the social determinants of health not only addresses the immediate health concerns of patients through legal intervention but also changes systems – both within and outside the healthcare system – to improve the health of populations" (Tyler-Tobin 2011: 30). The underlying theoretical principle of this thesis is to further an understanding of the connections between social determinants, health disparities, and law.

In an older text, when MLPs were in their infancy, Zuckerman, Sandel, Lawton, and Morton (2008) describe how the creation of MLPs can transform healthcare. The study suggests that the presence of legal interventions can promote individual and population health. In this sense including legal services within a healthcare paradigm can address health upstream. Zuckerman et al. (2008) argue, "this strategy increases the likelihood that patients will receive the help they need before a deprivation of basic needs leads to a crisis" (2008: 1616). Medical-legal care provision has the possibility to not only address health harming legal needs retroactively, but also address concerns before they materialize.

Similarly, Dana Weintraub outlines her study which, "hypothesized that integration of legal services into pediatric settings would increase families' awareness of and access to legal and social services, decrease barriers to healthcare for children, and improve child health" (2010: 157). In the study, Weintraub identifies the socio-legal impact of poverty and how medical-legal

interventions can contribute to promote positive health outcomes. Weintraub argues, "healthcare providers are well-positioned and trained to identify salient social factors; however, they often lack the expertise to address these factors, particularly in the arena of poverty and health care disparities" (2010: 158). Although healthcare providers may be unable to address particular social determinants, Weintraub (2010) suggests that legal staff can take on these responsibilities to reduce health disparities. Specifically, "this pilot study suggests that the addition of a legal aid attorney to the medical team can increase access to legal and social services and decrease barriers to healthcare" (Weintraub 2010: 165). Thus, the need for and effectiveness of legal support alongside healthcare delivery can work to improve population health outcomes. Interestingly, almost half of the individuals in this study sought legal services related to health insurance. In Canada where healthcare is universal and publicly funded; individuals would not have this same demand, allowing legal service providers more time to focus on other substantive legal problems such as immigration matters, housing concerns, and family violence (Weintraub 2010). In addition, Weintraub found that, "the study demonstrated high participant satisfaction with integration of legal services in the clinical setting" (2010: 165). Although the idea of including legal services alongside healthcare may sound burdensome and awkward, patients indicate that a partnership like this can help to improve their overall experience. (Weintraub 2010). This example is only one of many pieces that provides an additional perspective from which law can be seen to influence the social determinants of health.

It can be difficult to conceptualize how specific social conditions manifest themselves in a patient's lived experience. Those familiar with the social determinants of health may be quick to understand the nuances of how the social becomes biological. But often, it remains difficult to

understand the relative disparity that may exist for a given social determinant, or rather how clinicians or healthcare staff could really do anything to alleviate or address these factors.

Efforts to implement 'structural competencies' among medical students has led researchers to develop structural vulnerability assessment methods that specifically seek to "help clinicians articulate and address the effects of detrimental social structures on patient care" (Bourgois et al. 2017: 2). Through their research, Bourgois et. al created a structural vulnerability tool as a method to "operationalize the concept of structural vulnerability by highlighting the pathways through which specific local hierarchies and broader sets of power relations may exacerbate an individual patient's health problems" (2017: 2). The applied and pragmatic approach to structural vulnerabilities taken by Bourgois et al. (2017) combined with an overarching social determinants of health framework provides clinicians with the ability to understand and operationalize how legal support can work to address the root causes of illness and health disparity.

Approaching health disparities from this perspective allows for a more intersectional understanding of an individual's social context as previously highlighted by Brown (2015). In their study, Bourgois et al. indicate that, "a patient's structural vulnerability is the outcome of a combination of socioeconomic and demographic attributes, in conjunction with assumed or attributed status" (2017: 2). Therefore, structural vulnerability is not only seen as certain social factors a patient experiences, but also includes how these factors are socially situated and may come with their own set of health disparities. For instance, certain social determinants may come with additional levels of vulnerability due to social perception, bias, or discrimination. In clinical practice Bourgois et al. (2017) argue that this can manifest itself in care provision through perceptions of health-related deservingness, normality, credibility, assumed intelligence, or imputed honesty (2017: 2) – all of which are factors that can create or exacerbate health

inequalities. At times, these factors can influence patient care provider interaction and influence an individual's willingness to seek care. For instance, if a patient is perceived as hostile from the perspective of care providers, this could alter or diminish the administration of care that a patient receives. Bourgois et al. (2017) argue that these clinical perceptions can create structural vulnerabilities for individuals, and by remaining vigilant and reflexive about the way clinical perceptions can impact care provision is essential for reducing health disparities. This is because, according to Bourgois et al., "structural vulnerability is produced by one's location in a hierarchical social order that is embedded in diverse networks of power relationships and effects" (2017: 3). Educating physicians and healthcare staff on structural competencies in this way allows for a more in-depth understanding of the social construction of structural vulnerability, including the contribution of one's own perceived bias in the administration of care. At the same time, conceptualizing structural vulnerabilities through this lens allows researchers to towards identifying the presentation of inequalities rooted socially and structurally within society while remaining reflexive about one's own positionality. Therefore, this text will aid in understanding how structural vulnerabilities impact care provision and patient health generally, but also how MLP can utilize these frameworks to reduce improve social determinants of health and reduce structural inequalities.

II. Structural 'Vulnerability'

Sometimes research involving health disparities can create narratives that further reify and, in some cases, produce additional structural inequalities. This is often due to differences in social positionality or standpoint between researchers, the research itself, and those who the research involves. In some cases, research involving service provision can create distinctions and

categorizations of people's social location (Brown 2015). I address this because the way 'vulnerability' has been used in social research can sometimes create divisions between individuals in our communities by ascribing generalizations or narratives developed in research. For this reason, the notion of vulnerability in social service provision is something that needs to be approached reflexively. Social research has started to address this idea by unpacking the idea of defining vulnerability and what this means for policy and practices aimed to help those that are considered 'vulnerable'. While the premise of community partnership for the sake of social justice and improved health outcomes can carry certain moral overtones, it remains important to be critical of what vulnerability truly means, how it has been defined, and how services and practices that are designed to support those that have been deemed 'vulnerable' are operationalized. Kate Brown (2015) discusses this idea and specifically focuses on understanding how, "vulnerability discourses frame relationships between state and citizen in ways that open up opportunities for enhanced support, but also form the intensification of social control" (174). The resulting discourses and ways vulnerability has been framed in social research has created what Brown (2015) describes as a "vulnerability zeitgeist" where certain research can become fixated on pathologizing vulnerability. Brown argues that certain "vulnerability rationales in social policy seem to undermine the structural accounts of disadvantages and 'rights-based' approaches to citizenship, advancing reconfigurations of welfare as a 'gift' rather than a 'right'" (2015: 189). Essentially, used without caution "vulnerability" creates a conceptual prism in which it is bound up with defenselessness, deservingness, and weakness (Brown 2015). In turn, the constructed vulnerability rationales tend to create even further reifications of disparity and inequality that end up creating forms of social control. Brown (2015) argues that this is generally because, "due to its strong links with ethics and morality, targeting or prioritising supposedly vulnerable people

for interventions or resources has a seductive veneer of fairness, deflecting attention from narrowing entitlement and wider social divisions of welfare and social control" (2015: 194). To combat this, Brown (2015) challenges readers to understand the social construction of vulnerability and focus more generally on the fundamental reorganization and redistribution of resources within society. Ultimately, Brown (2015) argues that "alongside effective theoretical approaches and ideas, transforming lived experiences of vulnerability requires addressing the steady advancement of punitive and exclusive regulatory mechanisms that increasingly bear down on those who face hardship" (195). Because of this, it is important to maintain focus on social and structural mechanisms that impede an individual's ability to access healthcare and how legal issues can work to perpetuate socially situated regulatory mechanisms. The ideas presented by Brown (2017) combined with the clinical tools, such as those presented by Bourgois et al. (2017) can help to identify how legal issues create structural inequalities that impact health.

III.The Nature of Service Provision for 'Vulnerable' Populations

Research done by Austin Sarat (1990) discusses the idea of a distinct legal consciousness among low-income individuals and welfare recipients. Sarat argues that the legal consciousness of this population, "is substantially different from other groups in society for whom law is a less immediate and visible presence. Law is, for people on welfare, repeatedly encountered in the most ordinary transactions and events of their lives" (1990: 344). Sarat (1990) highlights some of the interviews completed in the study and argues that this legal consciousness stems from the structural vulnerabilities associated with poverty or receiving welfare. Mainly, this is because for individuals on welfare or government assistance "law is immediate and powerful because being

on welfare means having a significant part of one's life organized by a regime of legal rules involved by officials to claim jurisdiction over choices and decisions which those not on welfare would regard as personal and private" (Sarat 1990: 344). Outlining the interactions between welfare bureaucracy and citizens is crucial for this work as it creates an opportunity to understand the way service provision is socially situated, constructed, and accessed. The ideas presented by Sarat (1990) are valuable in their understandings of underlying mechanisms of social control and more specifically what this means for individuals utilizing social services, including the experiences involved in seeking legal assistance.

By analyzing the experiences of those on welfare who are seeking legal services, Sarat (1990) finds that "power and domination are expressed in the legal consciousness of welfare [recipients] in temporal as well as spatial terms" (347). The spatial and temporal terms Sarat (1990) is referring to includes mainly the experience of welfare recipients in their search for legal services as they move from location to location seeking legal assistance, combined with the experience of retelling one's story resembling, "speaking into a void, of speech without response" (361). Sarat (1990) argues that this experience, combined with the "foreign terrain of the lawyer's office" creates a differential relationship of power and domination (347). Specifically, Sarat (1990) argues that individuals in their search for legal assistance are constantly "spatialized by having someone else's place triumph over their time" (Sarat 1990: 360).

Throughout this research, Sarat (1990) notes that the spatialization individuals endure and experience in their search for legal services within the welfare bureaucracy exists as a form of perverse social control and exists because of the bureaucratic fragmentation of available service provision. Similar to the themes introduced by Brown (2015), the social control mentioned here

by Sarat (1990) stems from the fact that, "the identity of welfare [recipients] is, in substantial part, legally constructed, and because the legal constitution of their subjectivity is visible in a way the legal constitution of the subjectivity of others is not" (Sarat 1990: 378). This means then, that the legal consciousness of welfare recipients is both embedded and perpetuated in the social world in which they exist. The social position and resulting experiences described by those interviewed by Sarat (1990) highlights how, "welfare [recipients] construct a consciousness of law on the basis of their daily deprivation, their experience of unequal, often demeaning treatment, and their search for tools with which to cope with an often-unresponsive welfare bureaucracy" (378). Together, these concepts help to outline how an individual's social location can work to influence service provision for low-income individuals and contextualize how mitigating the further fragmentation of legal service provision can help to address structural inequalities and work to improve patient health.

The themes covered by Sarat (1990) clearly outline the perspective of those seeking assistance within the bureaucracy of welfare. However, Sarat (1990) also notes how the spatialization and social control experienced by welfare recipients is a result of the bureaucratic fragmentation of service provision. Thus, the ideas presented by Sarat (1990) indicate a need to assess how structuring of the bureaucratic field can work to create systems of power and control. Authors Woolford and Curran (2013) study the bureaucratic field of non-profit social services in Canada and identify how current and emerging structures of social service provision can in fact create systems of power and inequality. Specifically, the authors critique how recent and emerging neoliberalization in the bureaucratic field of social service provision can create challenges and disparities in meeting their objectives. The authors point to entrepreneurial and managerial principles that are being utilized to address social problems as dangerous to the

structure of social support provision. Specifically, Woolford and Curran describe these dangers as the "marketization of non-profit and voluntary organizations in terms of lessening their contribution to deliberative democracy and the collective resolution of pressing social problems" (2013: 47). The authors outline how distinct neoliberal changes witnessed in the social service sector of the bureaucratic field have created a neoliberal disposition which, "contributes to the reproduction of a social service field increasingly disciplined to the tasks of finding funding, evaluation, and risk management" (Woolford and Curran 2013: 57). The result as pointed out by the authors is an emerging social service model that is itself complicit in producing and reproducing dominant power relations (Woolford and Curran 2013).

Woolford and Curran (2013) argue that critically reflexive frameworks present in Indigenous non-profit agencies can be especially helpful in understanding how to challenge and resist the neoliberal restructuring of the bureaucratic field. The authors argue that the reflexivity expressed during interviews with Indigenous non-profit service providers, "exposes how both welfare and neoliberal dispositions are complicit in reproducing a non-profit sector that affirms rather than challenges a social order still marred by colonial, economic, and gendered forms of domination" (59). The authors speak to the importance of reflexivity in coming to understand how problems that social services seek to solve are legitimately carried out. For Woolford and Curran (2013), reflexivity "is achieved when an actor moves beyond automatically exhibiting a feel for the game and instead reflects on existing social conditions and orients her or his practices in a more consciously strategic manner" (50). It is through these methods of reflexivity that the authors suggest social services can remain grounded to their original purpose and scope and resist the neoliberal restructuring of the bureaucratic field. Ultimately, Woolford and Curran find that, "instead of building networks with the world of business and transposing further elements

of the economic field into the non-profit sector, or adapting existing welfare practices to the neoliberal order, non-profit social service agencies need to network with activists and agents less encumbered by state funding, forming micro-publics in which alternative visions of social service can form" (2013: 60). The idea presented by Woolford and Curran (2013) will be especially helpful in analyzing how social context creates structural inequalities in both health and legal status. At the same time this text can provide an understanding of the way MLP can best support the needs of our community, while remaining reflexive about the ways in which existing social structures reify and produce social inequality.

Over the last few years, the concept of social accountability has made its way into the accreditation of medical education in order to establish and reinforce a level of social justice in healthcare provision. At the same time, this was done for medical education to make the responsibilities of practitioners more explicit to society and to provide evidence of their impact on public health (Boelen and Woollard 2009; Larkins et. al 2012). Because of changes in accreditation in medical education, medical schools may be required to account for the ways in which their graduates are used, and serve, their societies. In other words, accreditation in social accountability "should be reserved exclusively for institutions which are designed to make an impact on society" (Boelen and Woolard 2009, pg.889).

The World Health Assembly defined social accountability as, "the obligation of medical schools to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve" (WHA 1995). Ideally these health concerns are to be identified reflexively by governments, health care organizations, health care professionals, and the public (Boelen and Woollard 2009). The reflexivity here is important because, "the institution is likely to improve its effectiveness if it

works in partnership with other stakeholders in the system, namely, policy makes, health systems managers, health care professionals and civil society" (Boelen and Woolard 2009, pg. 889). The reason for introducing social accountability for MLPs is that legal education can benefit from similar principles given the impact legal issues can have socially and structurally in each individual's life. While accreditation in social accountability has not quite made its way into legal education, I believe there are certain frameworks and characteristics present in social accountability that can be utilized successfully in legal education. Boelen and Woolard introduce their CPU model for social accountability where, "the domain of *conceptualisation* involves the collaborative design of the kind of professional needed and the system that will utilise his or her skills. The domain of *production* involves the main components of training and learning. The domain of *usability* involves initiatives taken by the institution to ensure that its trained professionals are put to their highest and best use" (2009 pg. 890). For this research, frameworks of social accountability will be useful in understanding the utility of service provision for patients and participants, but also for understanding and maintaining a level of reflexivity required in successful medical-legal service provision (Boelen and Woolard 2009; Woolford and Curran 2013). At the same time, frameworks of social accountability will be useful in understanding how structural competencies developed through MLP service provision can help to improve patient and population health outcomes.

Chapter 3: Methods and Study Setting

I. Study Setting

In 2016, the establishment of the partnership between Student Legal Assistance (SLA) and Calgary Urban Project Society (CUPS) sought to replicate methods practiced by existing MLPs that were operating in the United States. At SLA, University of Calgary law students provide year-round legal information and representation in court to qualified Calgary and area residents (SLA 2019). To expand community outreach, SLA sought to partner with CUPS, a local community health center to integrate legal services in a healthcare setting.

CUPS, established in 1989, is a unique community institution in Calgary that provides consolidated services for low-income individuals and families. Specifically, "through integrated healthcare, education and housing, CUPS and its partners will assist adults and families in Calgary living with the adversity of poverty and traumatic events to become self-sufficient" (CUPS, 2020). This community health center provided an appropriate place to pilot the integration of legal services alongside other social services. In 2016, a Memorandum of Understanding was developed and law students at SLA began a pilot program by completing intakes at CUPS. Students at SLA would now rotate and provide weekly drop-in assistance at CUPS. The following summer, CUPS began implementing a common intake system for participants. Incoming participants would then be screened through a matrix that open ended in-depth questions about an individual's life and social context. Through the common intake system individuals are also screened for socio-legal needs. If participants express the need for legal support, intake staff can refer participants to SLA for an appointment or provide information regarding SLA's drop-in times. Currently, law students provide weekly drop-in services at CUPS and provide appointments as needed.

II. Methodology

This research has been completed through an *instrumental case study* of the MLP between CUPS and SLA. Specifically, the research here seeks to provide insight into the ways in which legal interventions can improve health and documenting how legal wellbeing is a distinct social determinant of health. Author Bruce Berg (2001) argues that "instrumental case studies provide insight into an issue or refines a theoretical explanation" (229). The intention behind this is to primarily understand how the social and structural inequalities presented in legal issues can impact health, and how MLP in general or how legal support paradigms can address these needs. The use of an instrumental case study is pragmatic because, "instrumental case studies often are investigated in depth, and all aspects and activities are detailed, but not simply to elaborate the case per-se. Instead, the intention is to assist the research to better understand some external theoretical question or problem" (Berg 2001: 229). It is through perspective that we can begin to unpack how processes within MLP can impact social support provision. Studies of this nature are limited in the field of MLPs, thus this research seeks to contribute to the current knowledge on the causal relationship between legal needs and health, while also providing insight on the impact of MLP on individual and population health.

For this reason, this research utilizes an explanatory case study design. This is primarily because explanatory case study design is, "useful when conducting causal studies […] particularly in complex studies of organizations or communities, one might desire to employ multivariate cases to examine a plurality of influences." (Berg 2001: 231). In this sense, proceeding with an explanatory case study allows for a critical analysis that seeks to explain the multiple variables and influences that exist within social support provision, legal service provision, and healthcare provision. Utilizing an explanatory case study design, the setting of the

case, “actually becomes of secondary importance” (Berg 2001: 229). In turn, the medical-legal partnership between CUPS and SLA, will act as, “a background against which the actual research interests play out” (Berg 2001: 229). The research interests here will include a more in-depth understanding on the impact legal issues have on one’s health and how legal intervention can improve health. Berg argues that “several pieces of information from the same case may be related to some theoretical proposition” (2001: 230). Therefore, the combination of interviews from service providers will present a better understanding of the legal issues influences health and work to create structural inequalities.

There are a few challenges associated with research design in explanatory case studies, specifically relating to objectivity and generalizability. For this reason, it will be crucial to, “articulate what areas have been investigated, and through what means” (Berg 2001: 232). For generalizability, it will be important to indicate how the MLP between CUPS and SLA is applicable for other organizations that may seek to promote health through legal support. The findings of this research can be used not only to understand Calgary’s MLP, but also provide a foundation that would be generalizable should other organizations develop MLP throughout Canada. As an organizational case study, this research will provide insight into the introduction and development of Canadian MLP. Although literature suggests explanatory case studies may be general in scope, “the results will be a thorough understanding about the how the agency operates, and how each subunit fits together and serves the objectives of the organization” (Berg 2001: 233). This study will examine whether provision of on-site legal services can help improve the medical needs of participants in community health centers. While there are nuanced approaches to identifying the different structures that exist within this partnership, one of the benefits of having an explanatory approach is that it allows for these themes to be assessed in

combination with my experiences working with student caseworkers at SLA, social support workers at CUPS, and as an intake liaison for the partnership between SLA and CUPS. The reason for qualitative data collection is to analyze and understand how of social support and care provision in our communities can benefit from the inclusion of legal support paradigms. Collection of this data can also help explain medical needs as they relate to an individual's legal and social circumstance.

It is important to note that the original structure of this research had to be adjusted in a few different ways. First, one of the original goals of this research was to capture law students' perspectives of the assistance provided between CUPS and SLA. However, due to complexities in fiduciary duty between student caseworkers and potential clients, including students became somewhat problematic as we did not want to compromise the legal service provision that student caseworkers could have or would have been providing to their clients. For this reason, this research focuses on the in-depth interviews with social service providers and physicians who have engaged with the MLP between CUPS and SLA and relies in part on my experience working alongside the development of this partnership.

This meant that we recruited service providers who had experience working with CUPS and SLA in addition to client's utilizing services between CUPS and SLA. As adjustments were made to the structure of the research project, the process was also affected by the emergence of COVID-19. This meant that now, instead of completing interviews on-site, we were to recruit individuals through email in accordance with purposive sampling techniques. All in all, we were able to complete 4 Interviews with 5 research participants who had contact with the medical and legal partnership between CUPS and SLA. This included social support staff from CUPS and local physicians.

While participants were originally included in our recruitment, it became increasingly difficult to contact individuals who had utilized services by CUPS and SLA during the first wave of the COVID-19 pandemic. I did call individuals who had agreed to participate in this research via contact with their caseworkers at CUPS, but these individuals did not return these calls.

The interview questions were constructed to gather a more in-depth understanding of how service providers experienced legal and health issues in their work, and how these issues were situated in our community for prospective clients (see Appendix). Each interview started by asking respondents to discuss their background and how their work related to this specific research. The interviews then proceeded by gathering detailed accounts of how service providers had come to understand the intersecting nature of health and legal problems, through their own experiences or through their work with patients, and through their experiences of navigating these systems. The interviews were semi-structured which allowed for a freer flowing conversation between me and participants. This also allowed for an opportunity to follow up on stories respondents had shared, and probe further into the experiences individuals had with participants or patients.

Interviews were all completed via Zoom due to the COVID-19 pandemic and were then transcribed some with help from digital transcription software, Sonix. To protect the identity of interviewees, names were anonymized and identifying features were redacted. Additionally, if individuals had shared stories about clients or patients that contained identifying information, this was also anonymized to preserve the confidentiality of patients and participants of CUPS. Together, the purpose of these interviews was to gather a more holistic understanding of how legal service provision can be included alongside healthcare, or how legal care can and should be included in healthcare provision. It is important to note that at CUPS, the term ‘participant’ or

'patient' is used for individuals accessing programming and can be interchangeably used with 'clients' for the sake of this research.

After interviews were completed, they were transcribed and imported into NVivo software to begin qualitative data analysis. Initially, analytical nodes were created so that research could be divided into specific themes for further analysis. This consisted of identifying similar themes that appeared in each respondent's interview, along with topics that are heavily discussed in existing literature, such as structural vulnerabilities and legal interventions (Bourgois et al. 2017; Tobin-Tyler 2011). From here, interviews were analyzed and coded according to themes. Once this was completed, I was presented with a substantial number of intersecting topics from each interview and began thematic analysis (Berg 2001). For instance, when individuals shared stories of their patients, these would be coded according to how service provision may be improved through MLP. When interviewees expressed certain legal interventions that could arise in a patient care plan, and these would be coded as "legal intervention" and some interviewees shared information regarding the intersection of health and legal issues which were coded as "structural vulnerabilities". Together, the quotations that have been captured from our interviews highlight the experiences of real-world service provision, and how the inclusion of legal expertise can support these processes.

It is important to note that MLPs are still in their infancy throughout Canada. For this reason, this research is mostly explanatory in nature and seeks to highlight the impact of legal services rendered alongside health supports, while also documenting how legal services could impact care provision and provide individuals with an alternative mechanism to address health.

Both SLA and CUPS are non-profit community driven institutions focused on securing the needs of low-income individuals. Current literature on this topic suggests that health and law can

be combined to provide patients and clients with improved health outcomes, while addressing multiple social determinants of health (Tobin-Tyler 2011). The result is a healthier community, with increased supports and reduced barriers to health and legal issues. The Canada Health Act argues that the function of Canadian healthcare is, "to protect, promote and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Canada Health Act, 1985). Arguably, access to legal support in a healthcare setting could improve a patient's sense of wellbeing, intersecting with this provision of the Act. This complementary interest justifies explanatory research into the potential benefit of the presence of legal support within hospitals and community health centers in Canada.

One of the larger and perhaps biggest limitations to this research is the fact that we have not been able to include perspectives and experiences from individuals utilizing MLP service provision. It is one thing to say that the development of MLP programs could support individuals who may need them, or could utilize them, but this becomes difficult without a subjective understanding of circumstance or how someone may have felt utilizing these services or what the experience of seeking legal assistance is like. For this reason, this research does not seek to impute the experience of those seeking legal assistance at any level, but rather seeks to provide a more detailed account of the processes and organization of health justice, and how MLP intervention can provide practical and concrete support in healthcare to promote health equity and reduce health disparity. Together, the following chapters will outline the nature of legal problems affecting people's health and the institutional and organizational processes that exist in health justice. Each chapter will discuss the nuances that exist within implementation. The chapters also contain subtopics which cover details of MLP, integration, and service provision.

The interviews contained here, in combination with my experience working alongside this partnership and acting as a liaison for SLA at CUPS will provide a thorough examination of the ways legal support can be included in healthcare provision and provide lasting outcomes for patients. Ideally, this work will provide other communities a reference point to improve healthcare service provision by including, integrating, and exploring legal support paradigms in healthcare.

Chapter 4: The Hidden Extent of Health Harming Legal Needs

As I began interviews for this project, I found myself eager to capture detailed accounts of the diversity of legal matters individuals were experiencing and how these different issues could impact health. Individuals have shared with me the different legal problems their clients typically deal with, and I am familiar with the various legal issues student caseworkers at SLA typically address. Generally, service provision is divided into three main areas of law including family, civil, and criminal matters. The legal problems individuals experience could range from support with parenting orders to addressing charges of assault or theft.

However, in trying to link or connect how various legal issues can contribute or affect someone's health I have also come across the assumption that the seriousness of a legal issue is proportional to the impact it will have on an individual's social determinants of health. While this is clearly the experience for many individuals who find themselves caught up in the legal system or are combating other structural vulnerabilities, less serious issues can also have a large impact. Exposing the substantial impact even 'trivial' legal issues can have in the daily lives of individuals shows just how easily legal problems can impact overall health. Through this research I have found, unsurprisingly, that overtly serious legal issues can in many ways impact individual health, but also that trivial or otherwise mundane legal issues can have the same effect on health seeking behaviour or access to healthcare.

The following chapter discusses the hidden extent of health harming legal needs and analyzes opportunities for medical-legal intervention. The first section of this chapter explores how even mundane legal issues can disproportionately affect health and analyzes remedies through medical-legal service provision. The second section of this chapter discusses MLP and criminal justice, while uncovering the complexities and inequalities present in the bureaucratic

organization of criminal justice. The third section of this chapter provides an analysis of the various legal issues individuals may experience between parking tickets and prison, this section highlights medical-legal interventions that may exist in civil, and family legal matters. Together this chapter aims to demonstrate how MLP can support individuals navigate legal problems that may affect one's health.

I. A Parking Ticket:

During my interview with respondent #1, a member of CUPS staff working as a registered social worker, it became clear that legal wellbeing was not directly proportional to health, but instead was a sort of threshold, that when combined with other social circumstances can create a uniquely personal medical-legal crisis. Respondent #1 shared one such instance:

> "Umm one of my tenants was really, when was that? Last year maybe, anyways one of my tenants was really sick, and he like almost died. Like his body was like shutting down, and he went into the hospital and his car was parked on the street, and then because it was parked on the street for so long, he couldn't get it to start or something happened with the door, and then street cleaners came along, and he couldn't move his car. So, he got a ticket, so from being released from the hospital almost dying and trying to get – his sister actually came from the states to help him because he couldn't figure anything out. To you know, getting like your medication in and your doctor's appointments and all these things set up to then, "oh now I have a ticket from street cleaning?" It was just like… plus an ambulance bill. It was like one thing on top of another." (R1)

Clearly, what is generally considered a simple civil legal issue – to be issued a parking ticket and given a fine, can impact individuals variously depending on their personal history and social position. This is not to say that health harming legal needs are exclusive to 'low-level' or 'trivial'

offences but shows rather that the need for such service integration is essential to achieve even a baseline of health equity. I followed up with respondent #1 about how working to resolve these tickets with the client has affected their understanding of the social determinants of health.

> "I think it just goes back to the stressors. So, like my tenant who had the parking ticket for not moving his vehicle, like he was dying – so like to have a 300-dollar ambulance bill and then this [parking ticket] on top of it. Like it is a process to get things written off and everything, but he was so grateful, and you could just see the weight lift off him when I said, "these tickets have been taken care of." Like he was just…like you don't have an extra 500 dollars when you are on Alberta Works making 700 a month. So, it was just huge, and just to not have another payment plan, or forget these different things. I know for him; it was like beyond huge relief for him." (R1)

The experience outlined by this respondent highlights a significant issue that could be remedied by services provided by SLA. While this individual's experience is unique, this example captures just how effective even minimal legal support can be to an individual's overall healthcare. While it might seem trivial to some, the stress associated with having to pay fines and understanding how to navigate the best way to address this can be involved and complex. For some, paying a fine means sacrificing scarce financial resources that could otherwise be spent on necessities for health promotion. One of my interviews was with a pair of employment and education directors at CUPS who work to help participants with employment or to further their careers through education. During this interview, respondents #2 and #3 discussed their work assisting CUPS clients who were seeking employment, and indicated that:

> "You've been working with that one lady. You know, I think her biggest barrier to employment was transportation. And she had so many tickets." (R2)

"Oh yes, that's a few actually." (R3)

"That's you know, when you're tired and just inability to be able to drive and find transport. Because she had so many tickets to deal with and it was like, how do we get this dealt with? What programs are available in terms of working with the justice system?" (R2)

In the end, these research participants discussed remedying the situation by applying for a small loans program called *Momentum* that respondent #2 describes as "a microloan that's provided to help with either finding employment or maintaining employment." The microloan described here is run through a Calgary based organization called *Momentum* which offers character-based microloans instead of asset-based loans (Momentum 2021). Generally, terms are decided based on individual need, and *Momentum* works together with the individual over the lifetime of the loan to ensure it can be paid while also contributing to classes on financial literacy (Momentum 2021). What I found particularly striking about this instance was the seemingly arbitrary nature in which individuals would be assessed on character and how this might perpetuate systems of power and control (Bourgois et al. 2017; Brown 2015; Sarat 1990). As I followed up on this case, respondent #3 recalled:

"It was something like she needs the car to be able to do [work as] a healthcare aide back and forth or something like that. And because of the tickets. This is like a very direct thing to her job, if she gets this [Momentum micro-loan], then she can have this in her field. But my understanding was they wouldn't just wipe out tickets willy-nilly unless it was directly connected with your line of work type thing." (R3)

While the opportunity for the individual mentioned above to receive a loan to pay off parking tickets is helpful, it has also created an additional complexity in the process of addressing something as basic as parking tickets. What respondent #3 discusses above is that normally

individuals in these circumstances would not be eligible for services offered by *Momentum* unless their ability to drive was connected to their ability to earn an income. In this example, not only was this individual experiencing the complexity of balancing health issues, fines, and employment, it turns out that the individual mentioned by respondent #3 needed to resolve her parking tickets to continue her work as a healthcare aide. Ultimately, what this meant was that in order to maintain employment this client was now required to take out a loan to pay off parking tickets. In the example presented earlier of the client who was in hospital and dealing with parking tickets, respondent #1 also mentioned that "just to not have another payment plan" was an important outcome of legal support from SLA. Analyzing this case along with the *Momentum* example described by respondents # 2 and # 3 indicate how sometimes, in the absence of legal supports one must take out a micro-loan or fear managing an additional 'payment plan' to remedy parking tickets. In either case, for low-income individuals, there can be more financial consequence to be issued a parking ticket than for those who are not low-income.

For the individual who needed her car to work as a healthcare aide, not only were parking tickets impacting her own health status by disrupting her ability to work, but they were also disrupting opportunities of community care for those who would or could utilize her services. In this sense, the tickets issued to the individual above have gone on to cause more disruption than intended, anticipated, or recognized. This combined with the fact that involvement with the legal system can bring about primary and secondary stressors (Sugie and Turney 2017) is a reason why legal expertise should be integrated in healthcare settings. When questioned more about this example and whether legal care should be a part of healthcare, respondent #1 shared another example:

> "So, I know when I was in nurturing parent [parenting course provided by CUPS], there was a couple umm parents that would come in to nurturing parenting class and always get a parking ticket outside of CUPS. So then, because of SLA we were able to get things like written off for them. That was just such a relief, so they knew. And it held them back from coming to CUPS, like they got a ticket once and they're like "well I'm not going back there, I'm not taking transit I have a car." It just enforced that they could come, and it could still be their safe space." (R1)

Clearly then, there are people who might be seeking care or services provided by CUPS but could be deterred by the fear that they might receive another ticket or further ramifications from their unpaid tickets. While this may seem like an extreme reaction or response for receiving a ticket, the notion that people are avoiding positive health seeking behaviours due to a parking ticket or tickets in general means that the legal service provision can in fact change how certain individuals access healthcare. What struck me about the example of parking tickets, was seeing just how large of an impact something as simple as parking tickets could have on one's ability to receive and access healthcare. When individuals are avoiding social support services or avoiding accessing healthcare because of the fear of punishment, it means that legal issues can be a direct *threat* on one's health. In this example, not only were individuals avoiding positive health seeking behaviours for themselves by avoiding service provision at CUPS; the individuals who might have been avoiding going to CUPS due to parking tickets were in turn sacrificing their opportunities to attend parenting classes they had registered for at CUPS. Thus, the tickets given to these individuals not only affects those who receive the tickets but can have downstream effects on health seeking behaviours and access to healthcare. Together, these factors are all part of the social determinants of health and can create disruptions for vulnerable individuals who are

trying to improve different aspects of their health. I discussed ‘parking tickets’ with a community physician, respondent #5, who has extensive experience working with CUPS and Calgary’s low-income population.

> “I know for a lot of the individuals that we've had coming through CUPS; they've had issues with parking tickets and that caught me off guard, but that was a huge barrier for them accessing health services - parking tickets.” (Alex)
>
> “I feel like I'm not surprised. I mean, I most of my practice is outrageous. I don't actually work with people who? drive all that much, which is kind of a blessing. But it's more like the C-train ride and C-train ride without paying tickets. So, you see how it really impacts health seeking behavior because it plays in like you think you're going to get in trouble or somebody is going to realize that you owe or that you know, people not understanding confidentiality, especially in a population, is huge trust issues to begin with, trust and abandonment stuff.” (R5)

Or as respondent #5, added: “they just assume that everybody is watching them very carefully.” Not only can legal issues affect an individual’s health, but it can also affect access to healthcare, and health seeking behaviour. I followed up with respondent #1 about the impact even mundane issues such as parking tickets can have on people, as a registered social worker respondent #1 noted that:

> “They have other factors going that are going on in their life that are stressors to then having like this ticket that they can’t afford to pay is huge for them.” (R1)

Given the complexity of health, often there are multiple intersecting factors that contribute to an individual’s ability to maintain health or access healthcare. Upon completing these interviews, I was surprised to see just how large of an impact parking tickets had on health in general, but also

on how people might access health resources. For individuals who are low-income or struggling with other structural inequalities, the added complication of parking tickets becomes a punitive and exclusive regulatory mechanism (Brown 2015). Because of this, I found that the value of providing even minimal legal services, or even consultation with legal service providers could have far reaching implications for individual health, and perhaps even facilitate upstream access to healthcare. For example, during my interview with the education and employment directors for CUPS, respondent#2 discussed how the legal difficulties their clients faced impacted their health and wellbeing. In agreement with one another, respondent #2 stated that:

> "I think that one of the biggest things is it definitely impacts their mental health. When you're having to deal with a lot of these extra pieces, and you just feel like you can't get any further right? It's just such a major block, such a major barrier that you just, you just feel like it's an obstacle that impossible to overcome. And you just go, oh man, I can't get a job, I can't do this. I can't go to school, can't even get to the grocery store because I can't drive or whatever it may be." (R2)

As mentioned, engagement with the legal system through something even as simple as receiving parking ticket can create additional barriers for individuals struggling with health concerns. As a result, the combination of various vulnerabilities can make even "trivial" legal matters have disproportionally devastating consequences. In the example mentioned above, respondent #2 highlights just how broad the implications of a simple parking tickets could be and what this might mean for someone with limited finances and ongoing health problems. When issued a parking ticket, an individual is given an opportunity to contest or pay the fine. As mentioned however, the ability to explain personal circumstance or seek out services in the first place can be challenging (Sarat 1990). In these cases, MLP provides individuals with the opportunity to

access legal services alongside healthcare supports, such that ‘legal wellbeing’ becomes a factor integrated into one’s overall health.

II. Criminal Justice

For SLA, criminal legal matters are one of the main areas that student caseworkers focus their resources. SLA typically provides legal assistance for summary offenses, where the crown is not seeking jail time. This is because indictable offenses, where the crown is seeking jail time, are serious matters that are not primarily handled by students-at-law. However, there are still many instances where legal service provision, even done by student caseworkers, can impact an individual’s health during engagement with the criminal justice system. The criminal process can be long and involves multiple stakeholders and various levels of bureaucracy. This chapter outlines the different stages of criminal process and discusses the complex implications presented to health at each critical juncture. This process includes arrest and conviction, incarceration, probation, and finally life after engagement with the criminal justice system. During this research it has become clear that each step of the criminal justice process presents its own unique challenges to an individual’s overall health. The following section seeks to outline these complexities and highlight interventions for MLPs.

For some individuals one of the first steps in contact with criminal justice system includes arrest. Often, the experience of just engaging with police officers itself is traumatic and can be increasingly more traumatic when individuals are in mental or physical distress. In other scenarios interactions and previous lived experiences with police can alter the effect arrest might have on someone. However, this is only the start of how legal issues can begin to impact one’s health. After an individual has been arrested, they begin engaging in the bureaucracy of criminal

process. In such instances, Sugie and Turney argue that "the primary stressors of arrest may also lead to secondary stressors" (2017: 722). This could include anything from records gathered during arrest, witnesses to arrest, or prolonged contact with law enforcement during arrest. In each case, these processes themselves can create, "salient signals of criminality that may have detrimental consequences for employment, school, housing, and family relationships" (Sugie and Turney 2017: 722). These secondary stressors mentioned above can result in deleterious effects to health regarding one's social determinants of health and creates another mechanism by which individuals are both spatialized and surveilled (Sarat 1990; Sugie and Turney 2017). Aside from stressors mentioned above, the footprint of arrest can lead to secondary consequences that can disrupt one's health status, including disruptions to education, occupational status, and housing – all of which are primary indicators of the social determinants of health (Adler et al. 1994). I discussed the impact detention, arrest, or incarceration may have on patient health with respondent #5 who is a community outreach physician in Calgary and has experience working with CUPS patients. During our interview, respondent #5 stated:

> "Incarceration, even brief, can interrupt people's care, including medications like opioid replacement therapy, which can be really devastating for individuals that rely on that, like sort of daily dose of anything. I mean, if it's insulin that's true, too. Or, you know, some things have higher day to day impact. So, if you're incarcerated or held for any reason. That can be a huge issue both and the transition points going in and out of corrections can be a huge issue. So, it's hugely destabilizing." (R5)

Previously I discussed how the seriousness of legal matters is not proportional to the effect they may have on an individual's health, as even trivial legal issues can create devastating health consequences. The same is true of seemingly nonserious contact with the criminal justice system.

As mentioned above by respondent #5, even brief incarceration can impact an individual's health whether this includes opioid replacement therapy, insulin, or any other mental or physical health regimen individuals typically adhere to. It is also well documented that health services for those in prison are woefully inadequate and can work to further entrench health disparities among incarcerated individuals (Coughlin et al. 2016; Green and Kouyoumdijan 2016). I talked about the impact criminal legal matters could have on an individual's health with respondent #4, a psychiatrist who works extensively with individuals who are incarcerated in Alberta. Respondent #4 shared a story with me about a recent experience with a patient:

> "I had a guy recently who was actually a young engineer for [Calgary oil and gas company] and got addicted to opioids. [The company] terminated him right, and we argued that they couldn't terminate the guy at the time because he was impaired. And by their own policies and procedures, they were obligated to offer him treatment right then and there, through their EAP programs." (R4)

In this instance respondent #4 indicates that he was able to advocate to have this patient receive treatment from their employer through employee assistance programs (EAP). The EAP specifically focuses on free short-term counselling for personal or work-related problems as well as crisis counselling (EAP, 2020). In many cases, individuals struggling with substance misuse can benefit from the presence of legal support, as the nature of substance misuse can be problematic and cyclical without the right supports. I followed up with respondent #4 about this young patient to understand more about the circumstances involved in this case. Respondent #4 noted that:

> "He was using opiates, couldn't afford them, started doing burglaries, um so a couple of B and E's [Break and Enters] got caught, and lost his housing completely. Had no idea where

all his crap was. You know, so he got addicted and then [the company] fires him on the spot." (R4)

The difficulty for the patient mentioned above is interesting in that it really highlights how cyclical engagement with the criminal justice system can become. According to respondent #4 the health and legal issues began with opioid use, which then caused the individual to commit theft to finance substance use. In the end, the individual mentioned by respondent #4 was fired because of impairment at work, which in turn compromised his housing status. As a result, the individual in the case above would be facing multiple charges that could include theft from "break and enters" or possession of controlled substances – each of which carry their own specific legal intricacies and remedies. While people can each experience legal issues differently, this instance highlights how quickly social factors can accumulate and render someone trapped in a cyclical feedback loop within the justice system. This combined with the fact that the prospect of serving time in jail or serving time in general can perpetuate substance misuse (Hopley and Brunelle 2015) indicates the need for further analysis on the impact access to justice can have on one's health.

In some cases, there are alternatives measures in criminal justice for individuals struggling with mental health issues, substance use and other factors that might mitigate their legal culpability. Through my experience working with students at SLA, there are legal remedies available to people who meet the requirements of such mechanisms. For instance, Alberta currently has a service called the Provincial Mental Health Diversion Program (PMHDP) or MHD as it is more colloquially known. The goal of this program is to divert people who have been charged with minor criminal offences who have a suspected or diagnosed mental or concurrent disorder from the criminal justice system, and align these individuals with appropriate

mental health, treatment, or social supports in the community (PMHDP, 2020). Interestingly, typical charge types referred to MHD programs involve instances of theft under $5,000, mischief, or common assault. An extensive list can be found on Alberta Health Services mental health diversion information page, and they include the types of offenses committed by the person described by respondent #4. Given the medical expertise of individuals such as respondent #4 combined with an understanding of Mental Health Diversion programs available from caseworkers at SLA, individuals in these circumstances may be eligible for alternative sentencing measures that do not involve incarceration. However, for many individuals, this is not always the case.

As seen in the example above, the difficulties individuals experience in their everyday lives can be made more complicated when they are faced with indictment or already incarcerated. For those entering the Canadian penal system, health becomes even more complex due to the nature of institutionalization. In fact, research done by Kouyoumdjian, Schuler, Matheson, and Hwang, indicates that "Canadians in correctional facilities have poor health across a range of health status indicators, a finding that is consistent with international data on persons who experience imprisonment" (2016: 219). The health problems experienced by those who are incarcerated can continue after contact with criminal courts where individuals who have served time can experience subsequent, and continued health disparities (Kouyoumdjian et al. 2016). The authors go on further and indicate that, "improving the health of people who experience detention and incarceration is an important goal, and could lead to valuable secondary benefits for society, such as decreasing health care costs, improving health in the general population, improving public safety, and decreasing re-incarceration" (2016: 219).

The principle of including legal assistance alongside health does not limit itself explicitly to just criminal matters before and after sentencing. In many cases there are injustices that take place within our prison systems that can involve the conditions individuals are housed in, the way inmates are treated, and the way in which prisoner civil liberties and human rights are upheld. During my time spent with SLA it was rare that students dealt with individuals who had been incarcerated. In these circumstances, individuals would typically reach out to SLA via mail to begin correspondence. My understanding is that if these individuals met the financial eligibility guidelines of SLA, student caseworkers could begin initiating service provision. Generally, cases like these could involve appeals regarding the conditions individuals were being held in or situations that may be unjustly limiting civil liberties while in prison. These instances all involve *Habeus Corpus*, according to which "everyone has the right on arrest or detention to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful." (Parkes 2012: 351) Recent challenges to *Hebeus Corpus* rights allow for prisoners to invoke *Habeus Corpus* provisions in post-conviction circumstances. For instance, if an incarcerated individual is reprimanded for activities while in prison, they may be sanctioned or disciplined. Sometimes this means changing rooms, carrying extra side duties, or solitary confinement. In these instances, prisoners have an opportunity to invoke *Habeus Corpus* rights and appeal the lawfulness of these sanctions as they relate to an individual's detainment. In my experience, this is where SLA has come to provide services when individuals are incarcerated and seeking legal assistance. During our interview, respondent #4 shared an issue that would involve the *Habeus Corpus* rights:

> "Another issue that comes up inside jails, not common, but not infrequently actually, are issues around gender rights, particularly with trans individuals. These are tough issues, and

> they are not necessarily always done right. In some ways they arise more to the issue of human rights and what's appropriate. But there is some law that's been challenged around, you know, if I am a male to female, you know there's laws around strip searching that get violated. A lot of these individuals end up on mental health units even though they are not mentally ill. And jails will use the excuse that they're doing it because they have no place else to keep the person safe." (R4)

In examples like this, legal service provision such as those offered by SLA alongside healthcare expertise can work to bolster more equitable treatment – even during incarceration. For individuals dealing with instances outlined above, a patient's rights may be compromised while finding suitable accommodation. Through MLP, the perspective of healthcare staff can work to coordinate practices with legal supports. In the instance mentioned by respondent #4 above, gender can obviously have a significant impact on health status during incarceration. At times, uncovering health harming legal needs can work to facilitate care provision for individual offenders and patients. However, MLP can also work to address inequalities that are structured and rooted in administrative and bureaucratic processes. Respondent #4 highlights the opportunity for MLP to protect the individual rights of transgender individuals during incarceration, such as securing appropriate housing conditions. As respondent #4 indicates, there are also even larger human rights violations and social implications that exist in the administrative process of placing transgender individuals in mental health units. While this could in-fact be due to difficulties associated with offender accommodation, the health and social consequences that unfold because of inadequately addressing offender needs based on gender can have far reaching effects. This example highlights certain structural inequalities transgender people can experience within the justice system, but also points to disparities that exist and can

arise because of structural inequalities in the bureaucratic organization of criminal justice. Sometimes, physicians may be the most suitable individuals for deciding what measures should be taken to keep an individual 'safe' especially given how these complexities concern mental health and wellbeing. This combined with prisoners' *Habeus Corpus* rights means that coordinated legal services such as those provided by SLA can appeal unsuitable holding conditions that prisoners may be experiencing. Legal service provision in this way can ensure that an individual's social context does not have an unjust impact on health status.

Perhaps one of the most important things to consider from the perspective of incarceration is what happens to individuals after they have served their sentence. To adequately reintegrate into society requires that individuals maintain their health so that they can adhere to post sentencing guidelines and probationary measures and live life beyond incarceration. Obviously, it is also important to maintain a level of physical and mental health that provides individuals an ability to reintegrate with a reasonable level of self-regulation. Unfortunately, this can come with several its own challenges. For instance, respondent #4 notes that:

> "Once you wind up on probation or you're on parole, your life is hell. Right? Because if you want to go home and smoke a joint fine. If you want to stay out until 12 at night, fine. Right. But what happens is now you have a curfew; you can't use any drugs. You can't leave the house. You can't find a job. So that's the whole aspect of looking at it. And if you violate any of those things, you're back in jail." (R4)

For some, contact with the justice system can have a lasting impact on the way individuals engage with and are engaged by the world around them. As mentioned by respondent #4, when individuals have completed their sentence, they face additional punitive and exclusive regulatory mechanisms (Brown 2015) this time in the form of probation and parole. The result of this, as

noted by respondent #4, is it creates a system where individuals are monitored and observed through bureaucratic mechanisms of social control. As has been expressed through sociological literature and theory, the principle of surveillance can create an autonomous functioning of power (Foucault 1977). In contemporary society our legal system functions as an autonomous power to discipline and punish individuals for disobedience towards the law and socially constructed norms. In turn, practices of observation and assessment such as probation or parole work to create a relational and productive power that somewhat feeds off itself and in turn restricts an individual's relative agency. What this looks like in practice is outlined by Respondent #4, because "if you violate any of those things, you're back in jail". During my interview with respondent #4 we discussed this idea in more detail, where respondent #4 added that:

> "Everything goes smoothly until, you know, either you failed drug court because then you go back to jail, or you do some minor infraction or probation that you or I could do any time. Right? And then it becomes this vicious cycle. I see people who have had breaches, you know, for years. And I'm like, what was your original crime? It was eight years ago, and they keep breaching, you know, and when you look at it you know, what are they doing to breach? It's really not big things." (R4)

Respondent #4 makes an important note here, arguing that the autonomous functioning of power that results from surveillance for those on probation or parole is a threshold that seems inescapable. This is because, as mentioned by respondent #4, "you do some minor infraction that you or I could do at any time" and you are back in jail. What this really highlights is just how easily individuals can be caught in cyclical engagement within the justice system, if breaching the terms of probation and going back to jail is simple as missing curfew or jaywalking.

Together, these instances show how incarceration or involvement with the criminal justice system at any level can continue to disrupt the lives of individuals and perpetuate structural inequalities and health disparities long after initial engagement. In my interview with respondent #4, we discussed life after prison and ideas of legal support for individuals who had completed their prison sentence.

> "When you go into jail, you lose all your benefits, right? So, if you have Blue Cross, it's cut off. If you have AISH, it's cut off until you get back out and then you have to reapply for all of those processes. Student legal doesn't have to necessarily be involved in those, but they it's helpful for them to be involved in the appeals so that they have an understanding of the process for, you know, because people get denied who had had it for years. And a lot of that's a crapshoot." (R4)

While the respondent above notes that legal caseworkers need not be explicitly involved in these matters, this is without question an area where legal support can have a large impact on someone's health status and contribute to reducing health disparities. As indicated by respondent #4, supporting individuals through the appropriate appeals process could determine whether someone obtains health-related benefits. At the same time, preventative safeguards like appealing loss of benefits can also work to prevent recidivism (Kouyoumdjian et. al 2016).

During the interview process I began to realize that access to justice can be a critical safeguard from health issues created and exacerbated by engagement with the criminal justice system. I began to understand how much of an impact any type of engagement with the criminal justice system could have on individuals and what this might mean for someone's acute and long-term health. It became clear that regardless of level of contact, engagement with the justice system can produce and perpetuate a variety of structural inequalities.

Recently, research has been done involving the lifecycle of Canadian criminal records and the effects this can have on offender rehabilitation. Kilgour (2013) documents how offenders' abilities to seal their previous criminal records "are shaped by the social norms and values embedded in public policy mandates, which ultimately appear to disrupt, rather than support, offenders' rehabilitation" (136). In Canada, the Canadian Police Information Center (CPIC) is responsible for gathering and consolidating offender information within its national database (Kilgour 2013). While this is obviously an important process in minimizing risk to the public and for the efficacy of policing in Canada, it also presents, "serious complications for those who have criminal records but must present a criminal background check for work, volunteering or education" (139). This can be problematic not just for individuals who have been incarcerated or convicted, but it is important to note that engagement with the criminal justice system that results in non-convictions and discharges can also result in a criminal record.

Instances of non-conviction includes any criminal charge that results in a legal decision other than "guilty" (RCMP, 2021). Examples of these decisions include, acquittals, withdrawn charges, stay of proceedings, peace bonds, and dismissed charges (Kilgour 2013). In each of the scenarios, even if an individual has not been convicted of a crime, "they are not automatically removed from an individual's criminal history either" (142). What this means then is individuals in these circumstances must appeal to the appropriate authorities to redact and remove their record of engagement and apply for file destruction. This added step creates problems, as individual might not know that digital or physical record exists or understand how to go about having it removed. The bureaucratic complexities as pointed out by Kilgour, "means that many people who have never actually been convicted of a criminal offence do have a criminal history, which is accessible nationwide through CPIC's central computer system, and do not take the

very achievable steps of removing such a record" (142). In addition to non-convictions, individuals might also receive discharge decisions for their original charges. In these cases, an individual would still have legal culpability, but no conviction. Here, individuals generally must adhere to specific provisions as outlined by the courts. Discharge types include conditional discharges, curative discharges, and absolute discharges (RCMP, 2021). In cases of curative discharges, individuals are typically required to appear for counseling for substance use as part of their discharge provisions, as generally curative discharges only relate to offenses involving substance misuse and legal culpability. In other cases, if an individual has received a conditional discharge, they may be required to complete community service or fulfill other prerequisite 'conditions' to be granted a discharge. In each case however, an individual's engagement with the criminal justice system is still documented in their criminal records. Even if someone has been granted an *absolute* discharge, it can still take up to one year to have this reflected on one's criminal record (Kilgour 2013).

In Canada, after an individual has been convicted of a crime, they may apply for a pardon or record suspension to clear their criminal history. Individuals seeking a pardon or record suspension may be eligible in different circumstances given the nature of the original crime. Typically, for individuals who have been convicted, pardons may be granted 5 or 10 years after sentencing has been completed depending on the nature of the original offence (Kilgour 2013). As outlined previously, individuals that may have received a non-conviction or discharge may apply for a record suspension through their local police authorities or at least initiate the bureaucratic process and await approval. The problem with this is that "because there is no established body to teach offenders about how the management of their criminal record by the Canadian government via CPIC is carried out, it is difficult for them to know how to access and

retrieve their record, let alone attempt to have it sealed, destroyed or purged according to what type of record they may have" (143). In each case, the complexities that exist in criminal record management or the bureaucratic processes that exist for individuals looking to move past their criminal history presents yet another obstacle in the rehabilitative process. This is because, as noted the impact of incarceration or even arrest can carry salient signs of criminality which go on to affect housing, employment, and education (Kilgour 2013; Sugie and Turney 2017). Regardless of the individual motives, the ability to seek a record suspension or pardon after incarceration, conviction, or even engagement with the justice system is an essential protection for one's health.

In some cases, the opportunity for someone to be granted a record suspension or pardon after engagement with the criminal justice system can provide opportunities to increase employability or further education and begin a new career. This is generally because, "obtaining employment is often an integral part of an offender's rehabilitation, as it enables them to gain confidence, personal fulfillment, and a source of income that lowers their risk of reoffending because they are able to provide for themselves" (Kilgour 2013, 145). In this sense, a record suspension or pardon can directly impact an individual's social determinants of health and provide financial stability. As mentioned, this is often because the ability to continue with life in an independent manner after incarceration provides sustainability and escape from structural vulnerabilities (Bourgois et al. 2017; Kilgour 2013; Sugie and Turney 2017). During my interview with respondents #2 and #3, who are education and employment coordinators at CUPS, we discussed how legal services can benefit individuals seeking employment after engagement with the criminal justice system.

> "So right now, for example, I work pretty closely with the John Howard Society because we do work with a lot of people that require, that are looking for pardons because it drastically increases their employability. And, you know, even when you're looking at it, education, you know, if you're going into university. And if you have to do a private thing, you know, you're doing social work or something, you have to do a practicum. You know, being able to have a clean record, you know, being able to have a pardon or have that stuff dealt with, you know, so that can have a child and youth clearance [to work with youth]. Right. Things like that. So, I think it's pretty massive, especially considering our area of work." (R2)

My conversation with respondent #2 reminded me of some of the questions people would ask me when I was part of the SLA program. While I was not able to provide details to individuals seeking assistance for record suspensions or pardons, I was surprised to see how many people approached me with questions about applying for a record suspension. For many, a pardon seemed like an opportunity to re-establish oneself and pursue new educational and employment goals and begin rehabilitation after engagement with the criminal justice system. I followed up with CUPS education and employment staff respondents #2 and #3 about the impact pardons or record suspensions could have for some of their clients:

> "And that's where those legal teams and legal systems come in and allow people to be able to move forward with their mental health with their you know, certain self-sustainment." (R2)

As we continued our conversation, respondent #3 noted that the ability to have a clean record and therefore have more option in relation to employment and education meant that some people would no longer have to work in trades or occupations that are dangerous to their health.

> "Some are working in, you know, other trades that are dangerous to their health." (R2)

"So, in a way, you think that maybe if they had the right legal support, it could put them in a job that kind of minimizes that risk in a way?" (Alex)

"Definitely kind of. If they're able to move away from that world. Yeah." (R2)

Clearly then, the presence of integrated legal support in healthcare settings can create a way for individuals to access secure employment opportunities after engagement with the criminal justice system. For individuals at CUPS, record suspensions and pardons are area of support that SLA can provide immediate consultation on. In each of these scenario's SLA can provide direct assistance, or at least help individuals navigate these processes so that they are more aware of the timelines and eligibility requirements of a applying for a record suspension (Kilgour 2013).

What is implied by our interviewee above is that in some instances, individuals may be involved in dangerous or sometimes unlawful employment practices to survive. This can include sex work, organized crime, or distribution of illicit substances. In each case, sometimes the very thing holding people from obtaining legal employment can be their past legal history, engagement with the justice system, or health issues involving substance misuse – and thus, the cycle continues. This can be especially problematic for individuals such as the patient mentioned above by respondent #4 who was fired due to their struggle with opioid use. It is these circumstances where legal support can be a crucial part of healthcare provision. Involvement with the criminal justice system can be prohibitive where it is not just a consequence of the legal actions themselves, but instead come as a compounding of intersecting social determinants and as we have seen, bureaucratic control that perpetuates structural inequalities (Brown 2015). For those individuals that are already on the verge of crisis, and are struggling in maintaining their psychosocial wellbeing, legal support can breakdown legal and bureaucratic barriers and support individuals in improving overall health.

III. Structural Inequalities Between Parking Tickets and Prison

Originally, the goal of establishing a partnership at CUPS was to provide another mechanism of community outreach for students at SLA while also implementing another way to improve access to justice for low-income Calgarians. During the initial pilot phase of this project, we would typically set up an area for students so that individuals at CUPS could drop-in as they saw fit and complete an intake at CUPS. In many cases, the legal services rendered by MLPs allow patients to address other structural or social needs that might be influencing their ability to maintain health and health seeking behaviours. However, there are many different instances between parking tickets and prison where MLP can help to reduce health disparities. This can include civil litigation, criminal proceedings, parenting orders, or immigration concerns. The following section explores a variety of other legal issues and uncovers the structural inequalities the exist within them and may be addressed through MLP.

Generally, the benefit of legal service provision integrated alongside healthcare or other social support programs enables individuals to address the legal barriers that might be impacting their health. During my time working with CUPS and SLA, one of the areas that SLA worked with quite frequently involved family legal matters. This would generally include students helping individuals address issues with child support, maintenance enforcement, or parenting orders. In each of these examples' SLA student caseworkers would provide direct assistance in navigating these issues for their clients and provide the appropriate information for clients when they are required to appear in court. During my interview with respondent #1, we discussed the impact family legal matters can have on single parents and children. As a registered social worker, respondent # 1 shared a scenario and found that:

> "Yeah, and like I know a lot of clients, like I, I'm always like you need to get a parenting order, you need to get maintenance like and one of my umm clients actually did, but then it's like, now she's at the point of, "oh he doesn't have a job, and he's hiding" how can they get money from him when he's hiding. So, it's even like, umm the next step after like it's so sporadic for when she actually gets paid by him. But I'm always like, "you need to get this set up in place, because you don't know what is going to happen, you need to protect yourself and your kids." (R1)

As respondent #1 outlines, sometimes the experience individuals have in working to navigate their own legal problems can be difficult and time consuming. Interestingly, our participant acknowledges how significant legal protections can be the to the family outlined above. The point here is that even initiating the process of family legal matters can be an important first step for legal security for the individual mentioned above by respondent #1. While respondent #1 acknowledges that it can be "so sporadic for when she actually gets paid by him," the point is that there may be legal mechanisms that can initiate the enforcement of orders or even situations where student caseworkers can begin to draft new or revise existing parenting orders. In this scenario, the added benefit of including legal services alongside a patient's potential care plan means that single parents can receive legal support to access income that might have otherwise been difficult or next to impossible to obtain. At the same time, legal support from student caseworkers can alleviate the stress of navigating the legal system as a single parent or understanding the complexities of court orders and bureaucratic processes. Without knowing the full circumstances of the individuals included in the example above, it is hard to say whether the individual would or could receive any of the finances owed. However, the principle remains that if legal support is activated, then an individual has gotten even one step closer to reducing the

stress and vulnerability associated with raising children on an uncertain income, and now has access to support systems that may lessen the burden of navigating the intricacies of family law.

For individuals who are low-income, legal issues can also present a threat to housing security which in turn can come with their own subsidiary costs to health. For this reason, stable and secure housing is a fundamental social determinant of one's health. Given the impact COVID-19 was having on individuals at the time of my interviews and what this meant for housing insecurity, displacement, and tenancy issues, I discussed how housing factors into the work of respondent #5 as a community physician. Respondent #5 said that:

> "So, the things about housing I think is really important to our, to the work. Tenants' rights, landlords' rights. Like can they do that? Like one of my patients got evicted at the beginning of COVID when there was a moratorium on evictions. What are my options? How do I advocate for that patient when evictions in general are big, right?" (R5)

The point raised by respondent #5 is interesting in that it highlights just how significant of an impact a patient's legal wellbeing can be for the administration of healthcare. In the example outlined by respondent #5 an individual might be seeking healthcare services but at the same time discovers they are going to be evicted. This creates a dual complexity, where the added stress and difficulty of being evicted, finding new housing, and moving can all affect health themselves, not to mention how these factors may influence why one was seeking healthcare services in the first place. This is where the right legal support and consultation can assist in both patient care and physician administration of care.

SLA provides direct legal support for rental and tenancy issues in Calgary. These issues could include landlords withholding damage deposits, tenants applying for rent abatement, tenants seeking damages for substandard housing requirements, or even evictions. These issues

all include SLA working through Alberta's Residential Tenancy Dispute Resolution Service (RTDRS) to facilitate the legal dispute process. In this process, student caseworkers work to efficiently navigate and resolve legal issues that individuals may not have known were available. While the support of students in the process is vital for the legal service provision, the bureaucratic process involved in these matters can be complicated enough to dissuade claimants or tenants from accessing services. The intricate nature of these processes themselves highlight a way in which bureaucratic processes can also produce and reproduce dominant power relations (Woolford and Curran 2013). In this sense, the complicated nature of bureaucratic process itself is a structural inequality, especially for individuals who are already struggling with health and legal concerns. During my interview with respondent #1, a registered social worker at CUPS, we discussed how complex bureaucratic processes could prevent or disrupt individuals from accessing healthcare or addressing legal concerns.

> "So then if you have somebody that's already been in trouble, who is scared of police, who had been in jail, who has all this different background and may not have the knowledge of like where to go, and doesn't have a computer, doesn't know how to look things up or to research things….They're going to be like, "well fuck this basically I'm done" like they're basically gonna write it off, like, there has been so many clients I have worked with that don't have proper ID so they don't actually know if they have had anything. And then, they just sit there and just, they could have a warrant out for their arrest and not even know, you know?" (R1)

Respondent #1 highlights how intersecting needs can compound and create devastating consequences. One of the key things respondent #1 points out is the structural inequalities that may be involved for individuals are looking to address legal concerns. Not only is the act of

seeking assistance in and of itself arduous, but the process of seeking legal support includes confronting the 'legal consciousness' one may have established from previous adverse experiences with the justice system (Sarat 1990). From here, individuals must research what it is they need to do, and how it needs to be done with what limited resources are available. As respondent # 1 mentions, this can be incredibly difficult for individuals without a computer or computer literacy. Obviously, this is exponentially more difficult when you do not have government ID that states who you are. This means another bureaucratic process is required even before you begin to address your legal matters. What respondent #1 really highlights in this example is how sometimes there may be legal issues someone could be experiencing that they might not even be aware of because they do not have government issued ID. This combined with the fact that individuals may be avoiding addressing such problems for fear of legal consequence or other stressors involved in dealing with these issues can disrupt health (Sugie and Turney 2017).

This reminded me of something that happened quite frequently with SLA when student caseworkers were first completing intakes at CUPS. For example, one afternoon an individual came in seeking assistance and as per regular protocol a student caseworker began to complete an intake documenting appropriate details of the individual's legal matters. Once the intake had been completed, students could search their client's name on Remote Courtroom Scheduling (RCS) to see if their client had any upcoming family, civil, or criminal appearances. When the SLA caseworker did this for the client, it turned out the individual was scheduled for an appearance that same day, in just a few hours. Because CUPS is located downtown and is blocks away from Calgary's courthouse, the student was able to attend court on the client's behalf and adjourn the matter to a later date now that their client had legal representation. This meant that

the individual that had completed an intake was able to avoid receiving a failure to appear (FTA) warrant for a court appearance they were not aware of or forgot existed. For individuals who might not have been able to remember or discover when their next appearance is and might not have been able to complete an intake, without legal help they might "write it off" and in turn, receive a warrant for FTA. Ultimately, something that initially seems innocuous and minimally burdensome such as a court appearance can be the start of a slippery slope for those combating structural vulnerabilities (Bourgois et al. 2017: Brown 2015). When issues begin to stack the outcomes can be exponential in terms of negative health outcomes, stress, and financial consequence. In these scenarios, the implementation of legal support can provide a necessary protection for individuals in a more accessible manner. During my interviews, I asked our participants whether they thought legal care should be part of healthcare, respondent # 3 noted that,

> "I think that's a great idea, that for people to have access to legal help, it would hugely impact peoples' mental and physical health. And a lot of people that we work with are dealing with legal issues that may be connected with all of that, might be connected with mental health and addictions and just the difficulty of poverty or living on the street and stuff like that. So, I think to have access to that is a huge impact on people's lives and how they grow, all of that." (R3)

As one would imagine, engagement with the justice system at any level can carry its own difficult set of circumstances that will be unique to everyone. When you combine these problems with financial insecurity, poverty, or ongoing mental or physical health issues one's circumstance can become increasingly more complex and difficult to navigate. The added benefit of including legal supports in these settings provides a new method for individuals to access

justice such that the locational and temporal spatialization of seeking legal assistance is reduced (Sarat 1990).

IV. Reducing Barriers to Access to Healthcare through Access to Justice

As we have discussed, an individual's social location and social environment can have a significant impact on the way one engages with the world around them. The subjective and relative nature of health also means that legal issues would impact everyone's health differently, and in different ways. At times, this may include legal issues that arise from substance use which in turn affect health or health issues that arise from threat or fear of eviction. Legal issues that arise in one's life can also create difficulties for individuals to access healthcare in the first place. In some cases, legal matters, "may directly affect a patient client's ability to access care, follow a care plan or meet legal deadlines, which can impact health outcomes and overall well-being" (Tobin Tyler 2011: 141). Because law and its operation are often embodied in a particular set of social and lived conditions (Sarat 1990) legal issues themselves can also affect how individuals access other social supports related to health such as housing and employment. As noted, this can become especially problematic when individuals have a criminal record and seeking employment. Therefore, promoting health equity and reducing health disparities through legal interventions requires a re-distribution of resources so that individuals all have equitable access to justice and in turn, healthcare (Brown 2015). The following section discusses how MLPs and access to justice can reduce barriers potential patients experience in accessing healthcare.

The integration of legal service provision alongside healthcare means that the complex care needs that people experience can be addressed in a more holistic manner. At times, however, as has been mentioned, one's legal status can provide a crucial determinant for engaging in health

seeking behaviour in the first place. For instance, Sugie and Turney (2017) note that, "because many convicted offenders are placed on probation, they may experience extended contact with the criminal justice system that leads to avoidance of surveilling institutions such as banks and hospitals" (2017: 722). Obviously, avoidance of hospitals has definite impacts to one's ability to seek the care they require if they are in physical destress, or perhaps require a physical assessment.

One of the most significant implications legal factors can have on an individual's health status involves the trauma that comes along with engagement in the justice system to any degree. As mentioned before, this can come through in the form of stress and result in the avoidance of surveilling institutions such as hospitals or courthouses (Sarat 1990; Sugie and Turney 2017). The avoidant behaviours noted here point to another way in which legal issues can disrupt continuity of care which in turn drastically impacts the way individuals remedy their own legal situations. Unfortunately, this can also come across in ways that greatly impact and influence health. As respondent #5, community physician in Calgary who has had extensive work with CUPS and community outreach, noted:

> "I would say that health seeking behavior is very much affected by a person's legal status. So, the best example I think of that is the undocumented refugee claimant who is fearful of being on the radar of government in any way. And so, if they especially if they don't know, they will just 100 percent assume that under the radar is always better and, in that regard, really will not seek care when they probably should because of that fear." (R5)

From this example, fear of contact with the criminal justice system can produce stressors that in turn aggravate an individual's general health and health seeking behaviours. Individuals who are unaware of their legal status or legal possible legal remedies may in fact be engaging in practices

that are detrimental to their health for fear of legal consequence. This is without a doubt one of the most salient areas of focus for MLPs and creates a prime example where the expertise of both legal and medical professionals can come together and provide cooperative practices and ensure that healthcare needs can be met, while at the same time addressing health harming legal needs. In our interviews, I asked participants if they could identify how legal support could improve patient health. As a registered social worker, respondent #1 suggested that:

> "If people were more educated and not scared, they would be more willing, to I don't know call the police or call the ambulance or kind of whatever. I know, I don't think this is a thing anymore, but people were like, after they got tickets on the C-train they were like scared of riding the C-train – so it's like how you get around or go see your friends or get out and do things when you don't have money to pay for a ticket and your already scared to get a ticket on the C-train." (R1)

Clearly, as suggested by respondent #1, the surveillance and autonomous functioning of power that is created through engagement with the justice system can work to prevent people from accessing both healthcare institutions and legal interventions. This means that providing legal services alongside healthcare essentially creates an interdisciplinary support paradigm that can provide individuals with a certain level of protection from the legal system but also within the legal system so that one can first begin to address pressing health needs without the fear of deleterious legal outcomes from seeking help. During our interview, respondent #5 mentioned:

> "That also applies to other marginalized groups or groups at higher risk of poor health outcomes anyways, such as like, well, drugs, people who use drugs is definitely a category. But also, women who have been sexually assaulted, for example, and I've seen that firsthand, where you know, fear of reporting or fear of seeking care or both." (R5)

As respondent #5 notes, the observational and productive powers that exist within the justice system can work to prevent individuals from seeking care for both medical and legal problems that may arise in one's life, which in turn can go on to exacerbate legal problems that prevent people from engaging in health seeking practices. What is important to note here is that implementing legal assistance alongside healthcare delivery creates an opportunity for patient care needs to be facilitated through one channel, or mechanism. The intersecting vulnerabilities people experience may not be completely rectified by addressing legal concerns, but it can allow people another avenue to improve social determinants of health that may have otherwise been preventing them from seeking treatment or will go on to cause them to return to the emergency room on a later date. Regarding these intersecting determinants of health, respondent #1 suggested:

> "And then yeah, the whole stress thing, like stress plays such an important part on our health, and it has such an impact that I think if we could even help relieve on piece of this stress – like their whole health becomes better, right. Like it is so interconnected." (R1)
>
> "Right, like as you mentioned things can compound. Like even for me in my own life I know things can compound quickly." (Alex)
>
> "Totally, I couldn't imagine. Like I know how I am when I am stressed or whatever, but then to have like a client who is, you know maybe in mental health or addictions, because if like they have mental health in it then it's like you said only going to compound and their mental health is going to spiral out of control or whatever right – it can lead to so many different things." (R1)

As mentioned by this respondent, including legal support within healthcare services can help to reduce stress for those that are experiencing multiple structural vulnerabilities (Bourgois et al

2017). The difficulty here is that legal problems can be complex and nuanced. Knowing how to approach these complexities is difficult even with the appropriate training and resources. For those without effective resources, issues can begin to "spiral" before they have even been addressed. Thus, in many circumstances one's social situation can affect how individuals access legal services and navigate barriers that arise. For instance, during my discussion with the employment and education facilitators at CUPS, respondent #2 outlined what this experience might be like for individuals with children:

> "People have, you know, kids. And when you're dealing with childcare, when you are low-income or having to find somebody to look after your kids, like if you don't have a lot of people that come to town, don't have any family here, don't know anybody, you know. And it's just the people within their building…. And it's like, you know, those people, you know, you wear out relationships quickly. If you if you're constantly asking for people to watch your kids, you can't go to your lawyer's appointment. Right?" (R2)

This point helps illustrate just how disruptive legal issues can be in someone's life. The added complexity of stress and finding childcare so that one can even leave the house to address legal matters creates an additional burden that is often difficult to manage. Not to mention, how adjusting child supervision can be seen as a way in which individuals become further spatialized in their search for legal assistance (Sarat 1990). This added to the fact that low-income individuals are dealing with limited financial resources can work to create friction with what limited social capital we all have, such as friendships. As a result of someone addressing their legal issues, childcare can fall on other members of the community and go on to strain vital interpersonal relationships. This can directly impact how individuals engage in health seeking behaviour, including their search for legal assistance.

In many ways the additional presence of legal service provision can facilitate preventative support that can combat certain difficulties that may arise during the administration of care for a patient. For instance, in our discussion with the community physician, who noted how crucial legal expertise can be in matters involving a patient's capacity or informed consent. Respondent #5 states that:

> "And like in a situation like that where somebody is saying, I'm going to address my charges, what can I do to help take me, you know, make sure that a person doesn't fall off in terms of their health plan, because I can be filling out a treatment form for them to go to that long term treatment center at the same time that they're saying we going to deal with my charges. And there's so much uncertainty around that. I don't know how to make a care plan for that person because I don't know what's going to happen to them." (R5)

As Respondent #5 mentions, the principle of implementing and adhering to a strict care plan can be difficult for care providers and patients if their future is uncertain due to complex legal factors. This can be due in part to incarceration, probation, or even familial intricacies that make care provision complex during engagement with the legal system. However, this example points out how access to justice can help improve access to healthcare, as individuals in this circumstance could rely on the added support of legal staff that are trained and knowledgeable in dealing with charges or legal complications. From here, legal support staff can help consult care providers on a long-term health plan for the individual in question. The collaborative nature of service provision provides a level of care that helps to reduce structural inequalities that affect health. For those who are seeking physical care, the added benefit of having integrated legal expertise means that they can begin identifying health harming legal needs that may not have known existed.

Chapter 5: The Institutional Process and Organization of Health Justice

The focus of this research is to uncover how medical-legal integration can work to improve patient health outcomes. While this project focuses generally on insights from the MLP established in 2016 by SLA and CUPS, the themes uncovered here may provide insight into how other communities and organizations can replicate and develop similar partnerships to incorporate legal service provision alongside healthcare. Additionally, the key takeaway form this work aims to reveal how legal barriers individuals face can create and perpetuate structural inequalities and affect health. Highlighting the organizational processes that exist in medical-legal service provision creates an opportunity to assess how bureaucratic processes that exist in legal endeavours may in fact contribute to structural inequalities, and how medical-legal intervention can work to improve access to healthcare and promote health seeking behavior. This chapter explores the process and organization of MLP in Canada and discusses how medical-legal service provision can be operationalized. The goal here is to outline how through MLP, legal issues can be addressed in healthcare settings, and why healthcare institutions provide a suitable place for such intervention and supports. This chapter discusses how the MLP between CUPS and SLA works to identify health harming legal needs while analysing what this means for service provision and patient health. The second section of this chapter explores the various nuances and complexities involved in integrating legal services in healthcare settings and explores how integration of legal services can be crucial for health equity. Finally, the third section of this chapter explores the illusion of access to justice in Canada, and how MLP can contribute to promoting health equity through access to justice. Together, this chapter aims to uncover the different structural and organizational aspects that exist in establishing and providing health justice.

I. Identifying Health Harming Legal Needs:

The partnership between SLA and CUPS came at a time when CUPS was introducing their new common intake system. The idea behind this was that individuals accessing services at CUPS would be screened for any services that may be applicable to them. This method meant that fragmentation between service provision could be reduced and that individuals could access multiple supports through CUPS at once. The introduction of SLA to CUPS meant that individuals could now access legal services in addition to housing, health, and educational supports. This meant that part of the new common intake system would include a legal needs assessment. The following section will discuss the process of identifying health harming legal needs while making distinct note of the reflexivity needed to properly integrate and administer services for individuals experiencing structural inequalities (Bourgois et al. 2017; Brown 2015; Sarat 1990; Woolford and Curran 2013).

For the MLP at CUPS, individuals are referred through the system once they have completed the CUPS common intake. This generally involves demographic questions, health questions, and questions that help outline an individual's broader social and health status. At this point, individuals with a need for legal support or assistance are referred internally by CUPS intake staff to different departments according to needs expressed by participants. If an individual expresses the need for legal assistance, the prospective clients' information is sent to SLA, where they are either picked up by a student caseworker, or if student caseworkers are scheduled for drop-in sessions that day or week, individuals can complete an intake at that time. Alternatively, if an individual is working with a specific CUPS support staff member and it becomes clear that there is a need for legal assistance, the CUPS support staff can refer their clients to SLA to initialize the intake process directly. How these individuals are referred and how issues are

identified by clients and staff is perhaps the most essential part of addressing concerns in the MLP model and providing the right supports (Brown 2015; Woolford and Curran 2013). By combining the expertise of staff members trained in identifying certain risk factors such as registered social workers and physicians, we can begin to allocate services appropriately. At the same time, when individuals are coming in to address their concerns, it is vital for intake staff to let individuals know that legal services and supports are available. In this sense, asking participants if they need legal assistance can initiate access to justice and connect them with SLA. By screening individuals through the CUPS common intake system, individuals are screened for all available services at CUPS. Questions around legal status generally involve asking participants whether they have any outstanding legal issues such as tickets, court orders, and warrants. Respondent #1 outlined the importance of this process:

> "Because if they are coming in for one thing, chances are there is going to be another service that we could refer them to. So, it captures their different sub-domains. So, there's like legal, and there is also like mental health, addictions, food, child development, and a couple other things obviously." (R1)

The sub-domains mentioned by this participant indicate the different areas that CUPS screens individuals for prior to service provision. Health issues that are exacerbated by legal conditions are also likely to be revealed during this process. It is for this reason that it is especially pragmatic to incorporate legal needs assessments in the initial stages of the intake process to identify whether a patient might be experiencing health-harming legal needs (Tobin-Tyler 2011). A benefit the CUPS common intake system is that questions with participants are open-ended and allow for more detail to be captured during an initial intake. In my experience working as a regular intake staff member for CUPS, intake staff are also able to probe further on specific

issues and how they relate to an individual's circumstance. For instance, if an individual mentions that they had engagement with the justice system 20 years ago, they may have now reached the temporal threshold to apply for and be granted a record suspension or pardon. For CUPS, screening individuals and gathering information about an individual's social circumstance can provide a comprehensive picture of overall wellbeing. In other cases, once an initial intake has been completed, caseworkers such as those working in CUPS housing programs, may have opportunities to follow up on these intake screening questions to monitor their client's wellbeing and in effect, their legal status. Respondent #1 mentions that by utilizing these screening questions,

> "With that, you get to like see what else they could use. So, like when I had a tenant, we do them every six months. So, if I have a tenant and you have a good relationship with them, they're going to open up to you." (R1)

This piece is essential to getting the most out of the MLP as it is sometimes difficult to understand or visualize the entirety of an individual's complex social history during an initial intake meeting. At the same time, it is crucial to receive at least *some* perspective on a client's legal wellbeing to ensure that proper care or access to justice is provided for everyone. In the case of CUPS, and most other healthcare institutions, individuals do not wish to be there, but are there seeking to address their concerns and most pressing needs. At CUPS this often includes discussing housing, employment, food insecurity, healthcare, and legal assistance. By capturing at least part of the picture, we can provide interdisciplinary solutions to an individual's most pressing needs and prioritize accordingly. At the very least, by completing a legal needs assessment alongside other structural vulnerabilities (Bourgois et al. 2017) we can begin to unpack how the issues an individual may be dealing with are more interconnected than

previously thought. The importance of screening measures is vital to the MLP model and allows for legal and health teams to come together and make informed decisions to best address any one need. Respondent #1 highlights the importance of such screening practices when addressing health, suggesting that,

> "Totally, and in our matrix, that's what it is. It is holistic, you are looking at every aspect of this person's life and then obviously the person that's asking the question knows kind of different resources to, "oh well did you know that we have SLA or that this community group does this… and go make a free lunch or meet people or whatever." (R1)

At times however, it is also important to consider the different factors that might contribute to an individual's willingness to discuss their legal status, or their legal wellbeing. Because involvement with the legal system is often highly stigmatized and dependent on the nature of an individual's legal scenario, it can be difficult to discuss (Sarat 1990). Other times, individuals may not be willing to share their legal background with intake staff so readily. For these reasons it is important to understand and keep focus on the organization of structural inequalities that individuals face in their search for legal assistance (Sarat 1990) but also to be careful in distinguishing how needs-based services are delivered to distinct populations to avoid creating further social divisions and mechanisms of social control (Brown 2015). The implementation of MLP provides an opportunity to reflexively assess and address inequalities patients and participants experience in their daily lives, while developing solutions with participants (Woolford and Curran 2013).

For instance, earlier I discussed the role SLA can provide participants in navigating the bureaucracy of RTDRS and how complicated this might be given someone's health status or level of computer literacy. I also discussed how engagement with the justice system can create

avoidance and result in warrants and deleterious health outcomes. By understanding and reflecting on these issues or by assessing the impact parking tickets can have during medical crisis, we can begin to identify and address the "punitive and regulatory mechanisms that increasingly bear down on those who face hardship" (Brown 2015). Therefore, while it is important to remain critical about the allocation of service provision, maintaining focus on the presence and emergence of structural inequalities creates a position to question the distribution of resources and opportunities across the whole of society (Brown 2015). Effective MLP creates an avenue to address and resolve inequalities as they are presented in more holistic and inclusive manner. For this reason, what it really means to identify health harming needs includes an in-depth understanding of structural vulnerability as rooted in social context and embedded in power relations (Bourgois et al. 2017; Brown 2015). During our interview, respondent #5 mentioned how multiple viewpoints on patient health can alter the epistemology of patient diagnoses. Specifically, we were discussing the importance of considering a patient's social determinants of health into their diagnosis or care plan. Because of this, respondent #5 suggests that interdisciplinary perspectives can change the one-dimensional nature of healthcare provision and asks:

> "Like how are we how are reviewing the patient? And I think that that does people harm. Right, because then that, combined with, the sole responsibility that's put on us, plus this expectation for perfection is like you can't make a mistake. It sets you up to, you know, and then and then you're supposed to be like team oriented as well. Like, it's it's a paradox. It puts people in these stressful situations where they start, I think, you know, faking it a little bit and like that it doesn't do the patient very well." (R5)

What Respondent #5 brings up is a very interesting and unique viewpoint in healthcare service provision. During our interview, we began discussing how an understanding of the social determinants of health would affect a patient care plan, or treatment. What respondent #5 shares is that assessing patient health without the use of social and structural context places an undue burden on physicians with the sole responsibility to identify and solve health needs as they have been embodied physically and biologically. The problem here, as mentioned by respondent #5 is this can result in physicians and care providers "faking it a little bit" just so the solution to individual health needs can have a biomedical resolution. In turn this can permeate through the healthcare system and affect the way patients receive healthcare services (Wade and Halligan 2004). The benefit of this coordinated effort between disciplines is that it creates opportunities to learn about the diversity of health needs and how social factors, including how structural vulnerabilities, are commonly expressed in people's lives (Bourgois et al. 2017). Thus, identifying health harming legal needs requires a reflexive approach to health by including the social and structural factors that contribute to an individual's health into a care plan (Brown 2015; Bourgois et al. 2017; Woolford and Curran 2013). One mechanism through which this can be done is MLPs. As we will see, the integration of legal support services alongside healthcare can create informed and reflexive approaches to identifying patient care needs while reducing social divisions and mechanisms of social control (Brown 2015).

II. Integrating Service Provision:

As has been noted, an essential piece of MLP service provision includes principles of integration. Being that MLPs exist differently according to community needs or available providers, there are varying degrees of MLP integration (Tobin-Tyler 2011). Since the MLP

between CUPS and SLA involves law students from the University of Calgary, there is a limit to the amount of integration available as caseworkers are still law students who volunteer to take on files with SLA outside of their educational requirements. This means that the MLP between CUPS and SLA is not fully integrated like examples in the United States, as mentioned earlier different models of MLP can be developed according to available resources or community needs. The following section outlines what integration of service provision in MLP can look like and how different levels of integration can provide various levels of legal support in our communities.

CUPS is a unique facility in that there are many departments focused on addressing different aspects of an individual's social determinants of health. These different departments provide an ideal place to understand how the flow of such legal integration and partnership can work in accordance with other social support mechanisms. As noted, one of the key elements in MLP is the ability for service provision to be included alongside healthcare or social support provision. When asked about the integration of legal and healthcare services, respondent #3 found that:

> "The one thing that I really like about CUPS is that, you know, somebody can come in and they can have access to a health center. They can have access to family services, they can have access to counselling. They can have access to legal aid, to housing, to you know everything. And. And having that one stop shop. Yeah, of wraparound care and integrated care is really huge. Because then, you're not having to send clients all over the place" (R3)

For instance, if one department uncovers legal issues for a particular process, then they themselves can activate legal services on behalf of their client. For example, a social worker helping a prospective client find employment may identify the need for and importance of legal

intervention, such as a pardon, before other staff. The nature of health and intersecting social conditions means interdisciplinary support can work more efficiently to understand and address health concerns as they arise. I discussed this idea with respondent #5 who found that as a community outreach physician:

> "I mean I think the more complex the social and medical environment is, whether you are looking at an individual patient, or like the community or a population level. The more interdisciplinary the care team needs to be." (R5)

As suggested by respondent #5 above, it is not just the legal service provider or healthcare service provider that can identify structural vulnerability or health harming legal needs (Tobin-Tyler 2011). The benefit here of integrated service provision includes an opportunity for staff to uncover problems or inertia in processes that may have legal remedies. While discussing the integration of legal service provision, I asked interviewees what improvements could be made to the SLA partnership at CUPS. Respondent #1 said:

> "We could definitely have someone [from SLA] come on in zoom or come into our resource rooms and talk about it. We can have you come in and kind of do a meet and greet kind of thing, so that you can answer questions. Because sometimes some of the questions that are asked like we can't necessarily answer. Umm, I know there is a lot, and I don't know if you guys do this, umm I know we have a lot of issues like kind of around parenting orders and kind of getting those things set up. And like maintenance forms and stuff even kind of like an education kind of like around that, umm and I think that even just maybe reminding staff. I know it's on our programming calendar for CUPS, but maybe just needs to be reminded like internally – "hey we have this going on, on Mondays, make sure you refer your clients in

kind of thing. Or you refer them in, and this is what they offer, this is what they can help your clients with." (R1)

During our interviews, some of the participants noted that the benefit of having MLP integration was the immediacy of consultation for legal service provision with clients. For healthcare providers, having the opportunity to consult legal expertise was also crucial in the field, or on-site in hospitals or care centers. Either way, effective MLP also relies on a certain level of integrated service provision. Generally, this is to avoid the current fragmentation of social support services and combat the disparities that arise due to the divisions between available supports (Sarat 1990; Woolford and Curran 2013). This is relevant for our research, because it exposes a moment where the integration of legal services alongside healthcare can work to improve health outcomes for individuals, but also creates a space for educating service providers and staff. During our interview with Respondent #5, I followed up with them and asked:

"I've been hearing a lot of commentary on how a big piece of this medical-legal partnership can just be or can also include the students teaching the healthcare staff and teaching the people at CUPS or in that health care organization how to navigate the legal system, so they don't have to deal with that burden." (Alex)

"Exactly. Like if some like somebody somebody's lawyer comes to me and says, 'OK, this is exactly what I need from you' I'm super happy to do that. Right. Like, I it's like, OK, it gives me that. But I don't necessarily know to initiate that *Gladue* letter for somebody or like an advocacy letter for somebody or it just is kind of like you fly by the seat of your pants." (R5).

While the efforts done by our interviewees to implement health justice is admirable, there is most definitely a better approach than 'flying by the seat of your pants' when it comes to health justice and establishing equitable health outcomes. For individuals seeking care, being able to access

services in a ‘one-stop-shop’ fashion is especially pragmatic considering the multidimensional way legal factors can impact health (Tobin Tyler 2011). For instance, during our interview with CUPS staff, respondents #2 mentioned,

> “When you say, oh, OK, well, I'm going to set up this ad with these people for you. But you're going to have to get over to the far side of town. Right. It's like, OK, well, you're dealing with people who don't have transportation, don't have access transportation, probably. It took a serious amount of mental just to actually get into your building in the first place. And now you're sending them somewhere else.” (R2)

One of the initial difficulties with legal service provision at SLA is that it is located on the University of Calgary campus, and many times the only way individuals could access services provided by SLA was by taking public transit to the city’s Northwest, and then navigate the inner workings of the university campus. In addition, individuals frequently have work or other obligations that might make attending an intake session difficult. For this reason, SLA offers evening intakes on campus so that individuals can access legal services beyond traditional business hours. This is an important aspect of access to justice, as it allows an opportunity for individuals who may be working or have complicated schedules to seek legal assistance. In fact, during my walks home in the evening from campus, I have encountered individuals that have come off transit and are looking for SLA. Luckily, I was able to point them in the right direction. However, the fact remains that for some individuals access to justice can even include this piece as well – navigating a university campus at 8pm. Therefore, one of the crucial incentives behind the CUPS and SLA partnership was to provide a level of integrated service, such that individuals could receive on-site legal assistance that would eliminate the extra distance and spatialization of the already fragmented social support system (Sarat 1990). Because CUPS is located in

Calgary's downtown core next to the central c-train line, individuals would no longer have to traverse the city for legal assistance. Additionally, because individuals may already be familiar with CUPS or utilize other services at CUPS they were now able to access legal services in a familiar and trustworthy space. This piece was vital for the success of the MLP at CUPS, and I believe will be essential for the success of future MLPs in Canada. I discussed the idea of integrated service provision during my interview with CUPS education and employment director Respondent #2 who said:

> "Whereas a place like CUPS in you know, where you go, OK, you know, hey, we need to talk about this piece. You know, you've got some warrants or something and we need to deal with that. Well, you know what? I'm just going to walk you down the hallway and let's go meet this team, you know, I'm just gonna walk you down the hallway and introduce each of those people, you know, just so that there's that warm handoff." (R2)

The principle noted here as the "warm handoff" is vital to the success to service implementation in MLP. This adds a level of coordination between care staff, while also having the added benefit of legal service providers in-house or available for quick consultation. Granted the service provided by SLA at CUPS is not full time, but the fact that there is continuity within the programming ensures that individuals can access legal services when they are needed at consistent times. This creates another level of wraparound care for patients that might otherwise be unavailable or underutilized. Without this form of integrated service provision, the onus rests solely on the individuals with legal problems to address them in an effective manner, which often comes with its own embodied difficulties (Sarat 1990; Woolford and Curran 2013). For instance, respondent #2 found:

> "You know, twice I was able to say, oh, you know what, the legal teams here. Let's walk. You just walk down the hallway. Let's get on the list and let's introduce you to these people. And so, it's just the ability, to instead of just saying, you know, here, I'm going to send you over to this side of town, there's no guarantee they're going to go…" (R2)

A similar idea is presented by Sarat (1990) in presenting the various experiences of individuals and their search for legal assistance. One of the reasons that integrated service provision is so important, is that it helps to reduce the institutionalization and hopelessness involvement with the justice system can create. The problem here is that previous experiences with the justice system can create discouragement as suggested by our respondent above. This is because when services are locationally fragmented, it also takes time to seek out the services themselves, all of which can be made more difficult depending on the availability of resources. As mentioned by Sarat (1990) the fragmentation of service provision contributes to the way individuals become locationally and temporally spatialized in their search for legal assistance. I discussed this idea with respondent #2, who found that:

> "It makes me think of the fact that a lot of people that feel like they've been defeated over and over and over again, if there's any kind of…one more barrier or one more step that seems, you know, any amount of discouragement, then that could just knock the whole thing down….whereas if you are there present and you have that warm handoff, it makes things, you know, you're already connected, you're on to the next step and you're motivated to keep going. Whereas the other way, if you feel that there's all this is too hard, this is just you know, they just make it too difficult for me to actually get any help. And I've heard people say that to me before as well, accessing programs that, you know, someone just gave up one

on one thing or another because they just felt it was it was too many steps, and it was too difficult." (R2)

For people who take public transport, this might mean transferring stations, increased wait times, or walking when transit routes are unavailable. This means that for potential clients, having to venture across the city to access services is how the search for legal assistance can involve, "a recurring drama in which they wait to speak only to be unheard, then find another place to wait and engage in yet another ritualistic telling" (Sarat 1990: 360). It is both this travel and continued waiting that contributes to the experience of being spatialized and intensifies structural vulnerability (Bourgois et al. 2017; Brown 2015; Woolford and Curran 2013). This in turn works to privilege spatial relationships and works to create systems of power and inequity (de Certeau 1987). This means that integrated service provision can work to disrupt spatial privileges and provide an additional mechanism to improve access to healthcare. Without the integration of legal services, individuals are venturing across the city enduring the repeated drama that their story might go unheard, yet again (Sarat 1990). I discussed what legally integrated services can look like between care providers and patients with respondent #5:

"It's like integrated right into the team or the patient's medical home. That that role, especially for people who are. You know, at high, high risk of a bad health outcome and low capacity because, you know, they're preoccupied with survival, it's not because they're dumb or they don't have other, you know, other resources." (R5)

"But those resources are being spent on survival. And so, who has time to go down to Legal Aid and find out if the police stomping on your foot was OK or not? You just carry on. You might tell your doctor because you've got a broken foot. Yeah, or maybe not. Right. Because you've also got some tickets." (R5)

In many cases, as has been pointed out by the respondents, care providers and social support workers are also taking on this added role of legal counsel for their patients when they begin to realize that their patient or client's biggest hurdle in improving their health is due to complex legal problems. By taking on this role, care providers are essentially acknowledging how seriously legal factors might be affecting their patients' health and helping to give "recipients a name, an identity, a way of being heard; it ends the frustrating experience of speaking into a void and of going unnoticed" (Sarat 1990: 363). We discussed this aspect of health justice with respondent #5 who noted that:

> "So, I spend a lot of time, like looking for people by the mustard seed (Calgary homelessness organization) and like saying to patients that they like, you know, the cops broke my leg or something where like the most common one is like handcuff injuries. Right. Or like shoulder brachial plexus like shoulder stuff. Right from them. And I say to my patients like, yeah, you know that I believe you because people often don't, for whatever reason. I think these days maybe that's changing a bit like the police brutality or excessive force is being taken a lot more seriously than it ever has before." (R5)

The experience outlined above by respondent #5 highlights how certain legal issues can express themselves in one of many ways during a clinician's administration of care. While these are important details for a physician to note for a medical assessment, collaboration with a legal representative could work to document and address instances of police brutality or violations of civil liberties. By implementing legal services in settings like these, or alongside care providers, the barriers individuals experience in accessing legal care can be reduced, such that the prolonged search for legal assistance is eliminated, and the "physical embodiment of waiting" (Sarat 1990: 360) is at the very least reduced.

By including a model of service provision that eliminates the need to seek out additional disjointed services provides a point of contact that pushes back on the fragmentation experienced in social service provision (Brown 2015; Sarat 1990; Woolford and Curran 2013). Something special that I have noticed within each of my interviews, is that each interviewee has expressed in their own way how they have sought out medical-legal interventions for their patients to improve health outcomes. In each case, this is typically beyond what is considered part of one's job, specialization, or occupational requirement. For example, respondent #1 discussed her continued advocacy for a client to obtain a parenting order, saying, "I'm always like you need to get a parenting order, you need to get maintenance." Respondent #2 said, "I work pretty closely with the John Howard Society because we do work with a lot of people that require that are looking for pardons because it drastically increases their employability". Respondent #3 stated, "I had a call yesterday about people looking for free legal advice, and it looks like that. What was it called? The lawyer referral program had been discontinued, but it sounds like legal guidance does the 30 free minutes on the phone, I was just communicating with them just on behalf of a client, just to kind of liaise." Respondent #4 said, in relation to his patient who was fired due to opioid impairment, "Now, because I spent an inordinate amount of time basically saying, "look, you know, he's impaired. He should be going to treatment, given the chance to get off opiates." And they eventually they eventually reneged and offered took him back and off for treatment." Respondent #5 noted, "I went to the border with somebody who was about to be extradited, for example…. I was like 'over my dead body your extraditing this guy, like, you can't'."

In each of these instances, our interviewees are carrying out health justice *by themselves* on behalf of their clients in the absence of fully integrated legal supports. While this is without

question a great aspect of the care providers within our community, the complexities that exist in legal matters can more efficiently and suitably be dealt with by qualified legal service providers. The problem here is that the MLP between CUPS and SLA is not fully integrated. This means that at times, legal services are provided in an ad-hoc or non-systematic manner. The result here unfortunately can be a continued fragmentation of service provision. As we will see, this fragmentation can also be the result of divisions between disciplines in higher education that restrict interdisciplinary collaboration.

What the respondents point to above is that there is a definitive need for integrated legal support, in varying circumstances and settings. The benefit here is that by further understanding the needs of service providers and the community creates space for improvements to be made. At the same time, I believe this also points to the notion of access to justice in Canada. When care providers and social support staff are taking on the role of legal service provider the resources care providers spend on confronting legal barriers takes away from their opportunity to aid in areas where their expertise could be more impactful. Having a care provider take on the role of legal counsel indicates how inaccessible justice in Canada really is. While this can be a drawback to the level of integration available between student legal clinics and healthcare institutions, as we will discuss, the presence of students creates its own unique benefits for MLP service provision. MLPs provide the perfect opportunity for interdisciplinary teams to foster greater social accountability within their communities through community engaged learning. While interviewing respondents, I realized that principles of social accountability were already being carried out, but also that respondents themselves had realized how MLP could improve and build on social accountability from clinical and educational standpoints respondent #5 mentioned that:

> "So that would be another thing that I would say is really interesting, like community court, drug court, those kinds of things, like we need to understand that better. And I think that we need to get out of our hierarchical and sort of like who's caring for the patient, what impacts health like and see the relevance. Like see each other's relevance and how can we work together to make health better for our patients and clients." (R5)

As mentioned above by respondent #5, the ability for physicians and care providers to understand health needs from different perspectives creates an opportunity to provide relevant health supports for patients (Tobin-Tyler 2011). Not only does this work to provide a holistic approach to service provision, but for physicians and legal service providers, but it is reflexive in that it creates an opportunity to learn about the nuances of each other's professional roles and how they might be relevant to their own clinical practice. The opportunity for students to learn in this capacity provides a more complete and socially accountable approach to health service provision and in turn population health.

Because MLP is based on the notion of understanding health in the social context of a patient or client's life (Tobin Tyler 2011) cultural competency is essential to ensure effective service provision. MLP helps establish cultural and structural competencies, "by creating an expectation that those operating within professional environments are conscious of social context and cultural differences, professionals come to understand that differences can lead individuals to alternative interpretations of situations and conclusions based on the same set of facts" (Tobin Tyler 2011: 152). We discussed the importance of understanding a patient's social environment in administration of care with respondent #5, who stated that:

> "Like when I, when I talk about *Gladue Reports*, for example, like with my colleagues. I don't think any I don't think any of the colleagues that I have that I sit there with at CUPS,

> with people who are, you know, probably the most concentrated number of care providers in our in our community anyways that are looking after a high percentage of indigenous patient's rights. And most of the time, they have no idea what I'm talking about." (R5)

A *Gladue Report* is part of a sentencing provision that provides Aboriginal offenders consideration that the court must consider when assessing a case as per s.718.2(e) of the *Criminal Code*. Under this provision, the courts would receive a *Gladue Report* that would include the unique circumstances of the individual involved, this was to ensure that systemic factors and pertinent background information would be included in sentencing judgements within the courts. The purpose of including *Gladue Reports* for Aboriginal offenders was intended to combat the finding that racism and systemic discrimination are a reality for Aboriginal offenders (Pfefferle 2008).

While the implications and efficacy of *Gladue Reports* are still contested within the courts and in legal scholarship, what remains important is respondent #5 identifying and acknowledging the importance of such sentencing provisions and how this could also affect healthcare provision. Respondent #5 also makes note how colleagues from CUPS may not even know what a Gladue Report is, or its significance. This is important for our research, because it exposes a moment where the integration of legal services alongside healthcare can work to improve health outcomes for individuals, but also for communities. One of the benefits of MLP regardless of the level of integration is that legal assistance is framed as a health need which can shift the discourse of wrongdoing, or a breach of social conditions present in legal problems to that of a needs-based solution presented from a health perspective. Not only is this a benefit for patients and participants, but this is also beneficial for service providers and institutions. This is because, "working closely with an attorney, physicians, nurses, and other members of the

healthcare team can gain insight into the law, policies and regulations that affect patient health and well-being" (Sandel, Keller, Lawton, Ta, Kapple 2011: 594). When framed as a co-determinant of health, legal problems can be addressed in a more productive manner that helps to resolve many of the underlying issues that may have led individuals to engage with the justice system. Medical-legal service provision creates an opportunity to reorganize and redistribute resources within society and work to eliminate the exclusive regulatory mechanisms (Brown 2015; Bourgois et al. 2013; Woolford and Curran 2013). Whether this comes in the form of implementing trauma informed practices or providing expertise on *Gladue Reports,* collaboration through MLP provides a reflexively novel way to address health equity and health disparity.

III. "Magic"

While conducting interviews, there were obviously a few moments and stories that really stood out to me as indicating the need for a legal support system for patients in need. Unfortunately, the instances captured through interviews here, and arguably anywhere, only shed partial light on the legal issues individuals confront in their daily lives. For each of us, we have had some sort of relationship with the law or legal world, whether this includes parking tickets, driving through a Checkstop, or having friends and family who have had shared stories of their interaction with the law. In each instance individuals develop and carry with them a socially constructed consciousness about the law, and how it exists and has existed in their own world. Sarat (1990) discusses this idea but focuses on a distinct legal consciousness present among welfare recipients. However, during my time spent working closely with SLA, CUPS, and everything in between, I believe there is also a general consciousness about the way legal services are provided and how legal support is perceived. This section discusses the perception

of ‘magic’ within legal service provision and highlights how this contributes to the structural inequalities associated with access to justice.

While many institutions and disciplines have, over the years, become siloed into their own way of thinking, practices and procedures for each discipline have become farther and farther removed from one another. I believe in part this is to do with the increasing specializations of disciplines or fields of study and the hierarchical structure of higher learning (Bressler and Persico 2016). I have also come to believe that this siloed effect could also be the result of self-regulated professions that govern entry through the use of gatekeepers and other mechanisms. The resulting fragmentation can be, in part, economically motivated due to professions trying to stake their claim to ensure that their space at the heuristic ‘table’ is reserved while using academia to secure market share (Kahn 2011). What this does is create a fragmentation of clinical service provision and leaves substantial gaps for individuals seeking services (Sarat 1990). What I have come to find is that access to justice, or finding solutions to legal problems, is in reality a very difficult thing to achieve. But why?

When I first submitted a proposal for SLA caseworkers to provide integrated service provision at CUPS, the idea behind this was to find another avenue to provide outreach for those who may need legal assistance. Granted, the service provision typically covered by SLA is for individuals who meet financial eligibility guidelines such that they are living at or below the poverty line. But in terms of legal support or access to justice, this is it. For those living under the poverty line, it is either Student Legal Assistance, Calgary Legal Guidance, or Legal Aid. Each of which serve and support low-income populations. But at the end of the day this is it. What happens when you are slightly above the financial eligibility guidelines? Where do you receive services? Do you?

What this project really seeks to do, is reduce the complexity of access to justice by incorporating legal 'wellbeing' as another determining factor in one's health. Ideally, this research also seeks to demonstrate how one's legal condition can and, in many ways, does impact health (Tobin-Tyler 2011). I believe that framing legal wellbeing as a determinant of health will also alter the social consciousness that exists around legal service provision and access to justice. This idea became clear to me during my first interview. During our interview, respondent #1 was expressing just how important the legal support provided by SLA was for their client. This was regarding the individual who had been hospitalized and had their car impounded due to accumulated parking tickets. What struck me specifically was how respondent #1 described this service provision:

> "So, we referred him to SLA, and yeah you guys worked your magic and yeah it was gone" (R1)

The truth is -- and I can speak to this because on many occasions I have accompanied student caseworkers and dealt with instances very similar to this -- it is not magic, and it is not overtly complex. At the end of the day, it is privilege. It is support from another person who has some, even if not complete, knowledge of the justice system, who can act in good faith on behalf of another individual and advocate for them. But for those on the outside of law, especially those in need of services, law "is an already entered space, an enclosure seen from the inside, an enclosure whose imperative power whose 'supposed to'(s)' is clothed in the categories and abstractions of rules" (Sarat 1990: 345). Keeping this in mind, I followed up with respondent #1 about the complexities of the legal system, who found that:

> "Even going in and knowing where to go is so confusing in our courthouse, like knowing where to go and who to talk to for a ticket, and parenting or whatever the case is it is just confusing." (R1)

I think this piece more than anything, speaks to the actual threshold of access to justice in Canada. Before my experience working with SLA, when I received a parking ticket, I would simply pay it in order to avoid the difficulty of attending court and advocating for myself. This wasn't because I was incapable of doing so, but more because it seemed like the process was so complex that it maybe wasn't worth the time or stress for me to fight it. Instead, I would just pay. This is part of my privilege.

However, for many, this is not the case. For individuals that do not understand the complexity of the legal system, or do not have the finances to "pay the fee", navigating the legal system can be overwhelming and burdensome. It is for this reason that legal services should not be siloed to exist into its own realm, where the onus is placed on the individual to cross the city for access to fragmented service provision, support, or care (Sarat 1990). Instead, by shifting focus and acknowledging the legal status or legal wellbeing can be a determinant of health will change the way we view legal support and the justice system in general.

Interestingly, the complexities expressed by respondent #1 is a sentiment that seems to be all too common about legal support. Admittedly, the legal system is complex, just as diagnosing health problems are complex. However, within the legal system, individuals are left to their own devices, entering, and engaging with a system they have little to no familiarity with (Sarat 1990). During our interview I asked respondent #1 about the complexity of navigating our justice system, and how this might affect access to justice for low-income individuals, as a registered social worker respondent #1 responded by suggesting that:

> "I feel like they [legal services], they are not delivered to like low-income people. They're like to the middle class and higher, higher class people I know. I've had, I was actually fighting Sun wing, so the like airline… and I had to like go and like, deal with them, and I like call Calgary Legal [CLG] and I'm like, "I don't know what to do, like can you lead me..." like I had no idea of how to like start the process." (R1)

I have made the case that legal "wellbeing" should be considered a social determinant of health. As has been suggested by participants, many of the legal issues individuals have been experiencing complicate or exacerbate pre-existing health conditions and, in some cases, these legal issues can build and create additional health concerns. This can in turn, change or diminish one's health seeking behaviours while at the same time work to further entrench health disparities. If, or when we are sick, we seek assistance from medical or healthcare professionals. We attend triage and get diagnosed for various health concerns and are ideally given the appropriate services that are required to ensure that our health concerns can be or eventually are addressed.

However, when one becomes legally 'ill' or has existing legal 'ailments' the mechanisms in place to ensure that one receives appropriate care are almost non-existent. While the mechanisms exist for those who have finances to fund legal endeavours, or access to resources that would enable one to address these problems independently, each of these are very privileged avenues to treat one's own legal 'health' and in many cases is limited to very few people. This problem becomes even more dire when individuals are low-income or are dealing with multiple intersecting health problems. Then, the principle of access to justice no longer becomes just about 'accessing' anything, it becomes a scenario where individuals play catch up with a system that is rigged against them (Sarat 1990). Considering this, I asked individuals during our

interviews how they felt legal services were delivered to low-income individuals. During my interview with the education and employment directors at CUPS, respondent #2 noted that:

> "It's tough because people associate legal services with high cost and so they're afraid to create legal services with them. They'll see the word legal, and they'll associate it with law. And then also they associated with police and get scared off. Right. Or they get they've been screwed by lawyers in the past or whatever it may be at court, you know. So, I think people are a little nervous, a little gun shy. And they see it as expensive service, something that's unattainable for them." (R2)

In turn, medical-legal partnership creates an opportunity for capacity building in healthcare. This is done both through medical and legal education, and through community engaged learning with students, clinical practitioners, and consultation with community members. The development of MLP provides a space for each community stakeholder to learn and adapt to community-based problems and help shape health outcomes. MLP in turn facilitates an educational opportunity where, "the varying perspectives and approaches to problem solving that are illuminated by multiple disciplines in the classroom widens the lens of all participating students" (Tobin Tyler 2011: 117). Students from all parts of the healthcare team can come together and collaborate on shared goals for positive health outcomes – whatever that may include. During my interview with respondent #5, a community physician, I asked:

> "Now you mentioned kind of improving the idea of capacity building in this space. I was wondering maybe if you could kind of kind of explain how you can see that happening with medical-legal partnership?" (Alex)

> "Ok, so imagine a table that is that has medical and legal representatives there, like including the students that, and everybody who's sort of involved. You've got somebody from justice, somebody from CPS, clinical people." (R5)
>
> "So that table needs to work together to come up with solutions. Police, for example, don't understand that there are medical things that we can do to de-escalate a meth psychosis. And so that conversation…. like, what would you do in this situation? I don't know. What would you do in this situation? OK, well, this is what I can offer, and this is what I can offer. And it's like this exchange, we could actually solve this. We could come way closer to a place where, you know, police are not responding to every mental health crisis around which they shouldn't be." (R5)

The complexity of our social landscape makes health a unique condition for everyone. At the same time, this can change based on individual lived experience, background, or social position. In terms of capacity building in healthcare, I believe that the establishment of MLPs can help demonstrate ways that we can rethink and revolutionize healthcare practices and prove that care provision extends beyond addressing physical and mental health needs in a piecemeal fashion. At the same time, MLP provides an opportunity where, "infusing skills in collaboration and interdisciplinary problem solving early in professional training will produce more thoughtful and effective practitioners and policy makers who understand the connections between social conditions, the law and health" (Tobin Tyler 2011: 121). The heuristic device presented by respondent #5 above is a perfect example of how collaborative practices can create effective outcomes in healthcare organization and process.

Chapter 6: Conclusion

After seeing the development of this program, I have noticed that not only is the MLP at CUPS a way for implementing a new form of access to justice within Calgary, but access to justice can and in many ways does promote health equity. While service provision for legal matters in and of themselves do not always directly impact patient health, the integration of legal services alongside healthcare provides patients with the opportunity to seek out remedies for other issues they may not have known to be available to them. At times this can be because, the law as experienced by low-income and marginalized communities is "grounded in realities of a society in which race, wealth and power matter, and law is neither more nor less useful because it does not transcend the world as they know it (Sarat 1990: 359)." This means that improving population health and individual health requires an assessment of the various factors that contribute to one's life and social circumstance.

In Canada, this involves understanding the social environment in which these issues develop and understanding how the social determinants of health can create inequalities throughout our population (Bourgois et al. 2017; Brown 2015). As I have noted, providing appropriate health justice requires a vigilant reflexivity between community and care providers, and requires that partnerships, service providers, and policy makers maintain focus on the socially structured inequalities that lead people to utilize such services in the first place (Brown 2015; Woolford and Curran 2013). This is primarily because of the way law and health are embedded in social context and social location (Sarat 1990; Tobin-Tyler 2011). Therefore, the future development of MLP requires that stakeholders remain reflexive about patient and population needs, while maintaining focus on the structural inequalities present in our communities (Brown 2015). Through this research it has become clear that MLP has the

potential to provide space for this reflexivity. During my time working with SLA and CUPS, I found that there are particular legal issues that are well suited for MLP. As mentioned, this would include civil issues such as parking tickets and fines. At the same time, I found that family legal matters would be especially well-suited in MLP service provision as these issues are prevalent in our communities and could contribute to improving efficiency of the family court system. Finally, I think general consultation and basic legal information can be one of the most influential services that MLPs can provide. Sometimes this can be as simple as directing someone how to attend court, and in other cases it could mean completing and entire intake. The actual presence of legal support in these settings is what I think is most vital for the proliferation of MLP in Canada. The ability to provide basic consultation and information is what also makes MLP so well suited and mutually beneficial for service provision to be completed by students with oversight from practicing lawyers. I believe the presence and inclusion of students in this space is vital for improving access to justice and further proliferation of MLPs in Canada. I also believe the opportunity for students to learn in these settings is a novel way MLP can affect population health more generally. Let me explain.

In recent years medical education has seen a considerable investment into implementing methods and strategies of social accountability. Social accountability in this sense involves, "the obligation of medical schools to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve" (Boelen 1995). An important aspect defined through the research of social accountability in medical practice involves a certain level of community feedback and critical reflexivity (Woolford and Curran 2013). The idea behind this is that education, research, and service activities would meet the priority health needs of the public, which would be jointly

defined by government agencies, the healthcare system, and the public (Boelen et. al 2012; Woolford and Curran 2013). Given how much of an impact legal factors can have on the lives of those in our community, I believe legal education would benefit by adhering to similar principles. In fact, I believe some of these principles are already being activated through engagement in MLP.

Part of what makes a medical education socially accountable is having students learn how social factors can contribute to an individual's health status. Typically, this includes curricula involving the social determinants of health, but can also include instances of community placement, and courses based on community engagement (Lamus, Jaimes Serrano 2011). Not only does this add a level of structural competency to medical education, but it provides students with an understanding of how different individuals may exist within the healthcare system. In medical education, extensive research has shown the effects of community engaged learning in clinical practice, including the returns such programs have back on the communities they serve and future careers of students (Boelen et al. 2016; Howe and Ives 2001; Reeve et al. 2017). In this instance, MLP provides legal students with an opportunity to develop interprofessional collaborative practices. As found in medical education research, community engaged learning provides students with an increased awareness of community health needs, a greater understanding of the social determinants of health, and a greater appreciation of the health advocate role (Essa-Hadad, Murdoch-Eaton, Rudolf 2015). Having interdisciplinary perspectives present through the healthcare process can improve the way health systems respond to healthcare needs, while also providing more appropriate and reflexive service provision to patients through the administration of care. What makes this especially critical, is that while MLPs are still quite rare in Canada, the model between SLA and CUPS provides an excellent way to establish social

accountability in legal education and practice. For law students at the University of Calgary this MLP provides students with experience and a more in-depth understanding of how legal factors can contribute to health disparities, while at the same time providing community outreach.

The benefit here for students, is that the community engaged learning done through MLP can provide a more holistic understanding of how individuals in our community are impacted by structural vulnerabilities and how this relates to the social determinants of health (Bourgois et al. 2017; Stettin, Black, Edwards, Schaeffer, Blue 2019). This in turn can provide students with an opportunity to develop cultural and structural competencies. At the same time, it has been found that "attorneys who engage in MLP are able to reframe their work in terms of patient health and well-being and can better understand the connections between policies and health outcomes" (Sandel, Keller, Lawton, Ta, Kapple 2011: 594). The partnership role that exists within a MLP allows for a certain reflexivity between service providers and the community which is essential for social accountability (Boelen et. al 2012). The result of this is students who take lessons from their experiences in MLP forward with them into their careers which permeates through the community. For this reason, the integration of legal services in healthcare settings provides students and care providers with a more comprehensive understanding of how to best serve their community's needs, while also providing possibilities to improve population health through health justice.

One of the most interesting things I have come to learn from my time in my working with SLA was just how important law students and students in general were for this process. When this partnership began, the costs associated were low for both the University and for CUPS, but the impact seemed to be very high. What was especially helpful about student led service provision was that there were continuously new and incoming students with various levels of

interest for the work done by SLA at CUPS. This meant that current and incoming students were getting hands on experience that was directly tied into their education while building employable skills for their future careers. Aside from additional C-train tickets, service provision done by students helped keep the costs for most parties involved remain low or next to zero. Because of this, I feel there are also certain opportunities for interdisciplinary collaboration where students from other faculties can gain applied experience and operationalize their education through MLP. At the moment, students in faculties everywhere are hard pressed to gain practical experience in real world applications. Interdisciplinary partnership such as MLP provides many opportunities for interdisciplinary collaboration while allowing students the possibility of studying, working, and learning in these spaces. I believe that MLP is just the first step for improving interdisciplinary learning and developing interprofessional collaboration in higher education. Finally, due to proliferation of online video conferencing in the workplace, I believe there are significant opportunities for MLP to expand service provision and improve the efficiency of the Canadian justice system through digital consultation. The opportunity for clinicians and clients to meet without being face-to-face can change the spatialization people experience in their search for legal assistance (Sarat 1990). At the same time, digital platforms can provide an ideal space for individuals to provide basic legal information and educational services for clinicians and the public.

By including legal assistance alongside healthcare, we can begin to provide another mechanism for reducing social inequality, or at the very least, provide an alternative advocacy paradigm for individuals who could utilize such service provision. It is important to note that for those already accessing social services, “continuous, regular contact does not mean that they are included, or can establish themselves, as full participants in the construction of legal meanings or

in the practices through which power is exercised and domination maintained" (Sarat 1990: 377). For this reason, service provision needs to remain reflexive and critical about the different mechanisms of social control that can create and exacerbate structural inequalities (Brown 2015). At the same time, including legal assistance alongside healthcare services can reduce the fragmentation of social support services and provide a new mechanism by which individuals can access support to address legal concerns. Framing legal needs as healthcare needs and integrating legal services into healthcare settings can begin to alter the social privilege of law which can engage a "consciousness of resistance in which recipients assert themselves and demand recognition of their personal identities and their human needs" (Sarat 1990: 344). Through MLP we can also begin to reorganize and redistribute access to justice within our society and thus transform experiences of vulnerability by addressing the exclusive regulatory mechanisms that disrupt access to healthcare (Brown 2015).

One of the most important things I have come to understand about access to justice through my research involves the concept of agency and the opportunities individuals may have that would allow them the *opportunity* to access justice. I believe there is a common misconception surrounding the idea of access to justice that revolves around the adage of "if you build it, they will come." While this idea may hold true in many circumstances, throughout this research I have found that this could not be farther away from what it really means to improve access to justice. This is because, as we have found above, access to justice sometimes means having to take transit to a legal clinic at 8pm on a weekday, or maybe it means that you must find accommodation for your children so you can make your lawyer's meeting, and in other cases it might mean you have to avoid taking transit because you already have too many tickets. Either way just because there is access, doesn't mean it's accessible. The beauty of medical-legal

partnership then, is that access is tied directly and synonymously with healthcare such that both services are accessible under the same diagnostic paradigm. Through further development and implementation of MLP, access to justice can be as simple as going to the hospital or going to see your family doctor. Therefore, by acknowledging how significantly legal issues can impact one's health is the first step to further development and proliferation of MLP in Canada. Including legal supports alongside healthcare provision means that the temporal and locational spatialization of seeking legal assistance (Sarat 1990) is integrated directly into our communities' most robust social support network – the Canadian healthcare system. Doing so changes how individuals can access legal support, and it means access to justice becomes a lot more accessible.

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Appendix

Interview Guide for CUPS Staff:

Much of the interview will be handled as a conversation, which moves back and forth between topics and reveals naturally occurring concerns, meanings and actions. Generic prompts will be used to elicit examples and stories (such as: "can you give an example?" "How did that happen?")

Can you please tell me about your experience and role at CUPS?

Prompts for following specific information if not spontaneously included in narrative:

- What is the mission of CUPS?
- Can you tell me about the clients that CUPS serves?
- How did you come to work at CUPs in this role?

Do you think legal care should be a part of healthcare?

Prompts for following specific information if not spontaneously included in narrative:

- Are there any experiences you've had while working here that you think really capture the importance of providing legal services in a healthcare setting?
- How do you think that legal issues can affect an individual's health?
- What are your perceptions of the way legal services are delivered to low-income individuals?

Please tell me about your experience working with SLA and CUPS.

Prompts for following specific information if not spontaneously included in narrative:

- What has been your involvement with the SLA program at CUPS?
- How do you think participants at CUPS perceive the support of the legal assistance program?
- How has the CUPS/SLA partnership contributed to your understanding of the social determinants of health?
- In what ways do you think the partnership between CUPS and SLA could be improved?
- Can you identify any specific ways that legal support can improve health?
- Can you identify any other interventions that can improve access to justice?