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Justice in Health?

Studying the role of legal support in a culturally responsive mental health service in Australia

Stefanie Plage

Rebecca Olson

Nathalia Costa

Karime Mescouto

Sameera Suleman

Asma Zulfiqar

Jen Setchell

Rita Prasad-ildes

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The Australian Research Council Centre of Excellence
for Children and Families over the Life Course
Phone +61 7 3346 7477 **Email** lcc@uq.edu.au
lifecoursecentre.org.au

Research Summary

Why was the research done?

People who are culturally and racially marginalized (CARM) in Western, White normative and/or settler colonial societies confront a variety of built-in legal issues, for example related to immigration legal status, welfare, housing, employment, or family, that affect their mental health. Facing culturally unresponsive and complex health, legal and social care systems can delay or prevent accessing psychosocial supports to address such social drivers of poor mental health. This working paper draws on the evaluation of a culturally responsive mental health service with an embedded Health Justice Partnership (HJP) undertaken between August 2022 and November 2022 in Australia to reflect on the potential benefits and pitfalls of legal support in culturally responsive care.

What were the key findings?

Legal issues encountered by participants in our sample stemmed from financial difficulties (including debts), welfare access, family breakdown (including domestic and family violence), housing (including access and condition), and employment, migration and settlement troubles. While these legal problems often affect the lives of all people experiencing social disadvantage, people who are culturally and racially marginalized face additional complexities. Legal, welfare and health systems that are culturally unresponsive or fail to recognize the intersecting pathways to social exclusion present formidable challenges to addressing the social drivers of mental ill-health in this population.

What does this mean for policy and practice?

Health and social care integration is a perennial challenge for care practitioners siloed by funding streams and time-limited-service delivery. HJPs as a practice-led movement bringing together different sectors, disciplines and worldviews has the potential to create opportunities to address social determinants of ill-health. In the case of legal support for people who are culturally and racially marginalized, this movement needs to be guided by a combination of interdisciplinary frameworks including trauma-informed, strength-based, and person-centered approaches enabling culturally responsive care in which legal, peer and clinical staff need to be accommodated. Where such diverse practitioners collaborate as partners working towards a greater health equity through individual, meso-level and macro-level advocacy, HJPs represent an antidote to some effects of systemic exclusion.

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The authors

Stefanie Plage
The University of Queensland, School of Social Science
Email: s.plage@uq.edu.au

Rebecca Olson
The University of Queensland, School of Social Science
Email: r.olson@uq.edu.au

Nathalia Costa
The University of Queensland, Clinical Trial Capability Team
Email: n.cordeirodacosta@uq.edu.au

Karime Mescouto
The University of Queensland, RECOVER Injury Research Centre
The University of Queensland, School of Health and Rehabilitation Sciences
Email: k.mescouto@uq.edu.au

Sameera Suleman
World Wellness Group
The University of Queensland, School of Social Science
Email: sameera.suleman@worldwellnessgroup.org.au

Asma Zulfiqar
University of Melbourne, School of Social and Political Sciences
Email: a.zulfiqar@uq.edu.au

Jen Setchell
Institute for Urban Indigenous Health
The University of Queensland, School of Health and Rehabilitation Sciences
Email: jenny.setchell@iuih.org.au

Rita Prasad-ildes
World Wellness Group
Email: rita.prasad-ildes@worldwellnessgroup.org.au

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Abstract: People who are culturally and racially marginalized (CARM) in Western, White normative and/or settler colonial societies confront a variety of built-in legal issues, for example related to immigration legal status, welfare, housing, employment, or family, that affect their mental health. Facing culturally unresponsive and complex health, legal and social care systems can delay or prevent accessing psychosocial supports to address such social drivers of poor mental health. This article draws on the evaluation of a culturally responsive mental health service with an embedded Health Justice Partnership (HJP) undertaken between August 2022 and November 2022 in Australia to reflect on the potential benefits and pitfalls of legal support in culturally responsive care. HJPs are collaborations across law, health and social care professionals integrating legal support into health care to achieve more equitable health outcomes. Thinking conceptually with the social determinants of health and intersectionality in our thematic analyses of interviews with 16 service users and 37 service providers, we demonstrate why people with CARM backgrounds require tailored health and social care capable of addressing legal issues impacting their mental ill-health, how such care can eventuate across multiple social actors and organizations, and which culturally responsive principles underpin these cross-sectoral collaborations. We also offer some methodological reflections on studying these dynamics through culturally responsive qualitative research. Thus, we interrogate the dual capacity of health, legal and social care systems to capture people from CARM backgrounds in relations of care as well as oppression and discuss implications for culturally responsive HJP practice.

Keywords: Health Justice Partnerships; Culturally and Racially Marginalized; Australia; Mental Health; Culturally Responsive Qualitative Research

Introduction

Health Justice Partnerships (HJPs), called Medical-Legal Partnerships in the USA, are hailed as a way to achieve health outcomes through legal support (Curran 2017; Genn 2019; Martinez et al. 2017; Tobin-Tyler et al. 2023). In Australia, these partnerships are positioned as "pioneering collaborations between legal and healthcare professionals, strategically integrating legal assistance into healthcare services" to alleviate the inequitable conditions facing people experiencing socio-economic disadvantage (WWG & CLC 2024: 1; Lewis et al. 2018). HJPs occur in different ways, including co-located legal services in primary and tertiary health care settings (Beck et al. 2022; Burrows et al. 2011; Moffatt et al. 2004; Woodhead et al. 2017), through referrals (Close et al. 2021; Ollerenshaw & Camilleri 2017) and/or legal outreach services integrated with social care (Forrell & Gray 2009; Frost-Gaskin et al. 2003). Some models target specific subsets of the general population who are made marginalized in mainstream health and social care provision, including people seeking to access housing (Hernández 2016), young people in regional settings (Ollerenshaw & Camilleri 2017); people in palliative or end of life care (Close et al. 2021; Rodabaugh et al. 2010) or migrants and people from culturally and linguistically diverse (CALD)[1] communities (Fuller et al. 2020; Moffat & Mackintosh 2009).

Specifically, people from culturally and racially marginalized (CARM) communities living in Western, White normative and/or settler colonial societies experience structural and cultural barriers to psychosocial support aiming to improve their mental health (Costa et al. under review). Concurrently, they often confront many legal issues that may predate the experience of ill-health or emerge as a nearly inevitable result of social exclusion. Some such legal troubles

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[1] We acknowledge the critiques in regard to the 'culturally and linguistically diverse' (CALD) terminology and express our preference for the more recent term 'culturally and racially marginalized' (CARM). Throughout this article, we use CARM when we refer to our own research and CALD, if this was the heuristic used in the cited research or policy.

are specific to people from CARM communities who often have a migration background. For example, people may have ongoing commitments towards their families and communities overseas (Singh, Cabaal & Robertson 2010) or confront uncertainty regarding migration and settlement status (Zanchetta et al. 2021). Other legal issues reflect broader trends in the general population, including overwhelming consumer debts (Gabbay et al. 2017), domestic and family violence (DFV) (Maturi & Munro 2023), obligations in the local community (e.g., council fines) or difficulties accessing welfare entitlements (Greasley & Small 2005; Sherratt, Jones & Middleton 2000). Yet, for people who are culturally and racially marginalized, navigating legal, welfare and health systems can be challenging due to lack of cultural responsiveness in mainstream services (Balram et al. 2024; Mescouto et al. 2024). Unresolved legal issues while facing social and political marginalization can exacerbate existing mental ill-health; in turn, poor health presents a formidable barrier to resolving legal problems and prevent their escalation (Pleasence, Balmer & Buck 2008).

The Australian Bureau of Statistics (ABS 2023) estimated on 30 June 2023 that out of 26.6 million residents, 8.2 million were born overseas. In other words, just under one third of people residing in Australia are first generation migrants, with many more citing at least one parent born overseas. Yet, their experiences with seeking culturally responsive care are not well understood. In this context, we explore how legal support is delivered through an HJP embedded in a culturally responsive mental health service operated by a non-government organization catering to people from CARM communities in Southeast Queensland, Australia (see Olson et al. 2023). First, we aim to demonstrate the intersecting challenges experienced by people from CARM backgrounds at the nexus of legal, health and social care, why culturally responsive services are needed, and the opportunities and challenges to their implementation. Second, we aim to illustrate how culturally responsive research practice can produce knowledge for advocacy, sustainability, and improvement of HJPs for people who are culturally and racially marginalized.

We begin by reviewing the evidence on HJP outcomes for individuals, communities and health and social care systems. We then introduce the underpinnings of HJPs in fundamental cause theory (Cockerham 2021) and draw on the notion of intersectionality (Crenshaw 1989) to conceptually enrich our analysis. Then, we apply this theoretical lens to data produced through culturally responsive qualitative research for the purpose of evaluating the psychosocial support program. We comment on the potential pitfalls of health connecting with justice where current and historical elements of law contribute to marginalizing processes. In conclusion, we discuss implications for culturally responsive research and care, raising questions to feed into the research agenda on HJPs.

Towards integrating legal services into health and social care to address social determinants

HJPs are rooted in the public health movement addressing the social determinants of health. Reviews on the impact of these collaborations (Beardon et al. 2021; Martinez et al. 2017) found the emergent evidence base supports claims that HJPs are effective in identifying and resolving individuals' legal issues, in turn addressing the underlying social drivers of poor health. Notably, Beardon and colleagues (2017) identified strong evidence for better mental health outcomes after legal interventions. Rigorous evidence on other HJPs objectives, such as advocacy for systemic change, greater health equity, and better health services utilization on the population level was less conclusive. A rapid review on the economic impact of HJPs (Granger, Genn & Tudor Edwards 2022) similarly found that while financial returns for individuals supported with legal interventions were clearly documented, the cost-effectiveness and financial impacts of such interventions more broadly, or how they affected service use was not consistently reported on.

Further engaging with the current scholarship on HJPs, we found little reflection on the historical and contemporary contributions of intertwined social, health and law systems to marginalizing processes in settler and (post)colonial societies such as Australia (Staines 2023). This is an important area for study, given that individual-level legal support needs of people who are culturally and racially marginalized to some extent arise from system-level processes that constrain opportunities for good health, for example in access to 'universal' healthcare tied to migration status, or conditionality and exclusion from welfare entitlements.

There is also great variety in how HJPs are implemented. Legal services may be co-located, sought out via dedicated referral pathways, or integrated into multidisciplinary teams (Beardon et al. 2021). Martinez and colleagues (2017) noted that theoretical underpinnings of service development, implementation and evaluation are often not made explicit. Moreover, even though legal services are in some fashion tagged onto health care, many such interventions do not explicitly do so under the label HJP (Granger, Genn & Tudor Edwards 2022). How HJPs can be configured to be culturally responsive is even less clear. This has implications for how intersections between legal and medical care are understood and what kind of knowledge comes to bear within interdisciplinary practice. Below, we describe the conceptual approach we have chosen for the study of integrated services catering to people who are culturally and racially marginalized.

Interrogating culturally responsive health, social and legal care through intersectionality

The most prevalent conceptual framework in the scholarship on HJPs draws on the social determinants of health literature (Genn 2019; McCabe & Kinney 2010). Popularized by Michael Marmot's famous call to investigate and address the "causes of the causes" for social gradients in health (2005: 1101), this approach is anchored in fundamental cause theory (Link & Phelan 1995; Phelan & Link 2013; Cockerham 2021). Fundamental cause theory queries why and how social structures promote good health for some, but not for others. Social categories are considered a fundamental cause for health outcomes under four conditions: First, the social category influences the experiences of multiple diseases. Second, the social category is exposed to diverse risks and pathways impacting disease outcomes. Third, the social category is characterized by differential opportunities to mitigate such risks through available resources. Fourth, the relationship of the social category with health outcomes is persistent, even though there might be advances in biomedical knowledge and practices (Cockerham 2021). Applying these criteria to people who are culturally and racially marginalized indicates the quality of CARM as a social category fundamentally affecting individual and community health.

We add the notion of intersectionality to approaching CARM as a social category that constitutes a fundamental cause in order to trouble the ‘straightforwardness’ with which HJPs address structural determinants of health. Continuing the philosophical trajectory of Black Feminist thought, Crenshaw (1989, 1991) distinguished three interrelated facets of intersectionality: structural, political, and representational (Carastathis 2014). Structural intersectionality captures how different social categories of exclusion in their simultaneity have the capacity to cause harm to a person. Political intersectionality attends to the consequences of denying this simultaneity resulting in seemingly contradictory and divisive agendas. Representational intersectionality is concerned with the social reproduction of difference through harmful tropes. Carastathis (2014: 307) notes, “intersectionality insists that multiple, co-constituting analytic categories are operative and equally salient in constructing institutionalized practices and lived experiences.” In this way, intersectionality contains the principles of simultaneity, complexity, irreducibility, and inclusivity. Accounting for only one form of oppression (e.g., based on gender) neglects the enmeshed nature of how marginalization manifests for the person who is at the center of multiple, interlocking normative grids.

Transferring the concept of intersectionality to the study of people who are culturally and racially marginalized requires deliberation and reflection. For instance, the acronym CARM itself seems to signal a multiplicity of categories drawn upon to explain oppression. A successor to the much-critiqued umbrella term culturally and linguistically diverse (CALD) (Lakin & Kane 2023; Maturi & Munro 2023), CARM makes explicit the weaponization of cultural and racialized subjectification in the perpetuation of social exclusion. At the same time, culture and race are themselves categories containing vastly different sets of experiences and can be drawn on for positive identification recognizing shared strengths and belonging.

We take a critical reflexive approach to intersectionality by tracing how legal, health and social care systems become entangled in the provision of psychosocial support for people who are culturally and racially marginalized. We explicitly acknowledge that these systems harbor multiple capacities; they have the capacity to extend relations of care at the same time as they might capture people in relations of oppression. This dual capacity of macro-level social forces affects the opportunities for people at their intersections to address mental ill-health. Drawing on intersectionality so understood, we move beyond the social determinants of health via better access to legal, health and social care systems to acknowledge that *more* is not necessarily better and draw conclusions for understanding HJPs uncritically as a vehicle for greater health equity.

Methods and Materials

We explore the perspectives of service providers and service users of a psychosocial support program that attends to legal issues through a culturally responsive HJPs.

Study design, setting, recruitment, and data collection

The data on which we base our analysis were produced in the context of a program evaluation of specialist psychosocial mental health support reviewed and approved by the University of

Queensland's Human Research Ethics Committee (2022/HE001102). Funded by Queensland Health, the evaluated program's overarching objective is to improve the social, emotional, mental and physical wellbeing of people from CALD [sic] backgrounds in Queensland, Australia. To that end, it provides multifaceted supports understanding mental health as embedded across and within multiple systems. Through the program, service users can access welfare and legal assistance by leveraging an HJP with a local community legal centre, or through referral pathways to specialist welfare, housing, employment or DFV services. Thus, supports available to service users are not limited to counselling, behavioural and wellness interventions, but also address social drivers of mental ill-health. The program seeks to be culturally responsive by offering to match service users and service providers appropriately to accommodate service users' needs and preferences. Services are provided primarily by staff with migration experience, including humanitarian migrants and asylum seekers. Multicultural peer support workers, who are often trained health and/or social work professionals support nearly all program activities.

We closely collaborated with key staff members at the organisation running the evaluated program to progress the research in a culturally responsive way. This included guidance in identifying and approaching prospective participants for recruitment. Prospective service provider participants and partner organisations were identified via a mapping exercise during a half-day workshop with the evaluated organisation. During this workshop we also developed a strategy to recruit service users employing a purposive sampling strategy (Daniel 2012). We aimed to arrive at a sample of diverse experiences with the program (i.e., in terms of length and types of supports) and demographic characteristics (e.g., legal migration status, country of origin and language). The final sample included 25 service providers affiliated with the evaluated organisation (internal), 12 service providers partnering with the evaluated organisation (external), and 16 service users.

All participants provided written informed consent prior to enrolment in the study. We undertook 39 semi-structured interviews employing three separate interview guides for these participant groups to explore experiences of delivering services, partnering with and receiving support from the evaluated program. Interviews took place between August 2022 and November 2022 in person, over telephone or via videoconference depending on participant preferences. Likewise, to accommodate organisational and individual schedules and priorities, we used a mix of group and individual interviews (Table 1). Interviews lasted between 16 and 83 minutes (average 45 minutes).

Table 1 - Data Collection and Sample

n=53	Service Providers (internal)		Service Providers (external)		Service Users	
Individual Interviews	6	n=6	8	n=8	14	n=14
Group Interviews	6	n=19	2	n=4	1	n=2
All interviews	12	**n=25**	12	**n=12**	15	**n=16**

Reflexivity in culturally responsive qualitative research

As Authors, we represent diverse cultural ties and nationalities. As academics affiliated with a large higher education institution, most of us have migration backgrounds. Some hold more than one citizenship and live and work as non-native speakers in an English-speaking country. We recognize, how our experiences are marked by the privilege afforded by our roles as academic researchers and migrant settlers on unceded Indigenous lands. From this position, we appreciate the heterogeneity among people and communities subsumed under terms such as CALD and CARM. We also represent diversity in terms of disciplinary backgrounds, including sociology, social work, and physiotherapy. We see this as a strength we bring to culturally responsive qualitative research (Jordan & Hall 2023), as we are engaged in ongoing dialogue, stretching the epistemological and ontological boundaries of our respective disciplines.

We sought to maintain culturally responsive qualitative research practice at every stage of the study, including data collection. For example, to facilitate interviews in service users' preferred language, we utilised a telephone-based professional interpreting service during 8 service user interviews. A further 3 service user interviews relied on the evaluated organisation's peer support workers to facilitate the interview in a language other than English. These included the following languages: Spanish, Turkish, Vietnamese, Arabic, Indonesian, Amharic, Farsi, and Tamil.

Reflection on our research practice sensitised us to issues that might unfold in health and social care. For example, often there was little time to brief interpreters regarding the relational nature of a research interview. At times, long participant answers were condensed into a concise response. In turn, prompts and follow-up questions asked by the interviewer to delve into greater depth were sometimes translated to simply repeat the original question. We also observed that while participants preferred to express their views in their first language, they were often capable users of English, and some shared their frustration with interpreters after the interview. Interpreters also articulated frustration with interview settings, for example, the presence of young children, friends and family audible over the phone line. On one occasion, a member of the research team conducted an interview in Spanish due technical difficulties with phone interpretation. Conducting an interview in a language that while fluent, was unfamiliar to the interviewer deepened reflections on the role of language in culturally responsive research practice. While errors of expression were a source of embarrassment for the interviewer, the participant responded with patience and support. We interpret this as accidental opportunity for reciprocity in the research, highlighting the relational nature of knowledge production in which language is just one of many factors.

To stay true to our intention to conduct the research in a culturally responsive fashion, we persisted in allowing for the messiness of everyday life to be reflected in these interviews. We had to accommodate participants' caring commitments in the research setting to prevent their exclusion, even if it meant that participants were also attending to their children while sharing their insights. Often service users were more concerned about feeling at ease than about privacy and invited trusted others, including peer support workers to be present. Rather than a challenge to the rigour of the evaluation as we had feared, we found this to be an invaluable asset which provided us the opportunity to observe the relationship between service providers and service users during interviews, while also enhancing a sense of safety for these participants during the research process.

Data analysis

We audio recorded all interviews with permission from participants. The interviews were professionally transcribed and deidentified for analysis. To make sense of the data we employed theory-driven thematic analysis, as we elaborate below (Braun & Clarke 2022). The analytical process unfolded iteratively supported by NVivo software and collaboratively in dialogue with key stakeholders affiliated with the organisation operating the evaluated program (National Health and Medical Research Council 2018). As part of culturally responsive qualitative research practice, this included two half day workshops, in which we presented tentative findings, gathered stakeholder perspectives that further enriched or prompted revisions to these insights, and also provided opportunities to reflect on implications for practice and policy. Subsequently, a number of these stakeholders also contributed to reporting (see Costa et al. under review; Mescouto et al. 2024), including the present paper.

The analytical process followed principles of thematic analysis compatible with culturally responsive qualitative research, including attention to the subjective position of the researchers, their active role in constructing codes to arrive at themes, and making explicit the theoretical assumptions on which the analyses are based (Braun & Clarke 2022). These theoretical underpinnings in the first instance derived from fundamental cause theory positioning CARM as a social category. After familiarization with the interview transcripts, annotation, and memoing, we engaged in analytical discussions across the research team.

The role of legal support as part of psychosocial care towards improved mental health for people from CARM communities was not initially of interest to the study. However, as the data analysis progressed the salience of addressing legal issues at the intersection of health and social care became apparent, particularly given the active HJP involved in service delivery at the evaluated program. Consequently, this subtheme was elevated to a key analytical focus prompting us to revisit the dataset as a whole through the conceptual lens of intersectionality (Crenshaw 1989) complementing the social determinants of health perspective. In the section that follows, we present findings on the role of legal support in delivering psychosocial services to people from CARM communities as part of addressing their mental health needs. All quotes are deidentified using pseudonyms and state the role of the participant as either internal service provider, external service provider or service user.

Results

First, we describe the variety and complexity of legal issues service providers and service users encounter and how they affect opportunities for good health. Second, we provide insights into how care coordination with practitioners providing legal support takes place. Third, we identify the service principles and values that inform these practices and tie these insights together within the intersectionality framework.

Structural intersectionality: Legal troubles? Health troubles? Or both?

We sought to gain an understanding of the most pressing concerns that the service users and service providers encountered during service delivery. We asked service providers what support needs they addressed commonly, and likewise we prompted service users to tell us what they wanted support for. Even though not explicitly phrased in terms of legal needs, responses to our questions revealed a gamut of legal issues entwined with mental and physical health. This service provider shared:

> Immigration matters. That might really change everything for them, especially if they have a partner that's going to be deported soon and they're not going to have that partner there. So it's like, "Okay, I'm going to be a single parent for a very long time. … Do I stay here with my kids … or do I go back home with my partner?" (Lucia, internal service provider)

This service provider also discussed how migration and settlement not only affected opportunities for family unity, but impacted how families navigated domestic violence (DV) and separation:

> A lot of our client is a combination of DV support that they need and often DV related to family law. … sometime it's housing is another one, financial support, relationship conflict that's impacting families and client wellbeing. … our client also got a lot of issues with immigration, because sometimes they come as refugees or they got married to someone here and then the relationship ends. (Margo, internal service provider)

The precarity of settlement status highlights the additional and intersecting forms of marginalisation. These both affected male and female service users facing the dissolution of relationships:

> I was also worried about my visa and [support worker] said to me, "… we're supporting you. On top of that, the government's not going to get rid of you tomorrow just because your ex wants to cancel your visa." …. I didn't know what to do, I didn't know anything

> about the legal side of things or the emotional side of things, I didn't know how to ask for help or how to deal with the psychologist. (Manuel, service user)

> I never been educated, not in my language and not in English. I've been here since mid, early '80 and I learn English through my cleaning job, through mixing with people, through all that, without any schooling or certificate. (Eva, service user)

These participants articulated a heightened sense of intersecting vulnerabilities after separating from their partners. While financial constraints, loss of income, and housing insecurity as the result of separation are common for many people, especially women (Kuskoff et al. 2024), these participants confronted the prospect of having to navigate systems that they felt ill-equipped for, putting them at risk of being taken advantage of or even having to leave behind the country they had come to call home. What is more, participants explicitly connected these legal issues with their experiences of ill-health, indicating the salience of structural intersectionality. These discussions revealed additional complexities people from CARM communities need to resolve:

> I had some mental and emotional health problems because of my financial difficulties. … I had a problem with a lady and then [support worker] helped me to find a lawyer to just settle the problem with that lady, … I have lots of debts. … I have done citizenship test twice, and I couldn't pass. … If I'm not in the pass [next time], bye-bye. (Azar, service user)

> my workplace, they terminate for me because they have bullying, harassment. … they're treating me very badly. … at one time I tried to suicide … I'm thinking badly and then I don't know where I go, what I do. I don't know because I don't have a money to find a legal way or whatever. That why I'm fairly upset. And then I'm still refugee. (Thani, service user)

These participants shared experiences that were overwhelming for them. Coping with a toxic workplace is difficult enough, yet even harder when there is no legal remedy at one's disposal. In Australia, a recent report found that it is virtually impossible for migrant workers to hold their employers accountable to contractual obligations, including basic entitlements to pay (Hemingway et al. 2024). Taking legal action against workplace bullying carries not only costs but also risks that can jeopardise one's future opportunities to reside in Australia.

We also note the financial burden participants consistently talked about across the sample. Australia is currently experiencing unprecedented housing and cost of living crises that particularly impact people who already socially and economically disadvantaged (Plage et al. 2024). However, people from CARM backgrounds are doubly affected by these crises as their entitlements and access to welfare supports are comparatively constrained. This includes access to the tax-funded universal health care system, Medicare, and benefits for unemployment and disability. Even people who are eligible to these entitlements in alignment with their settlement status, might still miss out because of overly convoluted application processes (Balram et al. 2024). Seeking welfare advice, legal representation or resolutions taking judicial pathways requires savviness, resources and patience, which may deter people from CARM communities disproportionately, exacerbating their ill-health. Many service users and service providers recounted how free legal support made available through the evaluated organisation not only helped with navigating the complexities of rights and obligations, but also significantly improved their health:

> [Support worker] assisted with some of understanding the court processes and how it all works and basically gave me some reassurance. … I was in a depressive and isolation mode where I had no one, nothing, and these ladies actually gave me a very good insight in what I needed to do. Because I was also hospitalised. … It was a long and stressful

> process, especially the court proceeding [for my children from the separation]. (Elif, service user)

> when I'm manic I couldn't control financially, which is one of my bipolar symptoms. … my debt's there. So once it's all cleared out, I felt very emotionally light and more hopeful in my life. … My short-term goal is more getting healthier mentally and physically. And my midterm goal is finding a place to live through the government housing, as well as finding a job. … at least I have a hope now. Just couple of months before I had no hope, so hopeless and so worthless. You know? (Bridget, service user)

The quotes above reveal the diversity of legal issues faced by people from a CARM background and how these issues affect their health. While things like migration and settlement are distinct to their experiences, troubles with housing, employment and family are more universal. However, as we have shown, while commonplace, intersecting trajectories of marginalisation compound vulnerabilities. Simultaneous and complex experiences of cultural and racial marginalization are not reducible to being either a migrant, a disenfranchised worker, a person with mental ill-health or disability but can only be addressed comprehensively. This calls for care coordination across multiple service providers located in different organisations across government and non-government sectors. Below we elaborate on the integration of legal support into health and social care in this context.

Health and social care coordination for CARM involving Health Justice Partnerships

How HJPs are enacted across multiple sectors, organisations and individuals has significant flow on effects for experiences with services and service user outcomes. There are various models according to which legal support features within health and social care. While some are implemented through flexible (and somewhat ephemeral) referral pathways, other proponents call for paralegals or lawyers firmly integrated in a co-located model of primary health care.

Either approach is centred on primary health care as the focal point for legal support. As this service provider reasoned:

> primary healthcare is just such an *entry point* for the multicultural population, not just for mental health, for so many issues.… [evaluated program] transitioned into a psychosocial support *front door*.… this nexus between people's sense of health and wellbeing in terms of their mental health, and other social determinant-related issues… a nexus between workplace injuries, people not knowing their workplace rights, being on temporary visas and how that's all playing on people's physical and mental health, and the need for an *entry line* like this being so important to at least *hold* people while they're trying to work through those issues in the absence of culturally aware and responsive services in their locality. (Terrie, internal service provider – italics added for emphasis)

In this service provider account, primary health care is represented as 'entry point', 'front door' or 'entry line' for issues that go beyond the remit of biomedical approaches to health and are explicitly located within a social determinants of health framework. This poses challenges for clinical service providers who are not prepared to address these social determinants effectively on their own. We note a 'holding' approach expressed here; medical treatments are administered to alleviate and manage suffering in the meantime such drivers are identified and worked on. Yet, as this service provider explained separating out intertwined legal and health issues is difficult:

> Look at our health justice stuff, right? So a person who's got a chronic health condition and is experiencing DV or something like that, you've got your health professionals going, "Well, that's a legal problem," and then you've got the lawyers saying, "Well, that's a health issue." (Charlie, internal service provider)

Being aware that the clinical service cannot resolve the ‘causes of the causes’ that drive poor mental and physical health (e.g., DV, settlement or housing), clinical service providers sought to mitigate detrimental health effects within their scope of practice. This placed them in a difficult position where they constantly had to manage expectations, while sustaining relationships of trust with service users. For instance, one of the clinical service providers we interviewed, shared how a service user came to believe she had clout with immigration officials after initiating a phone call with them on the service user’s behalf. Balancing these expectations with the realities of government procedure was a common challenge for care coordination that within the service team was tackled by calling on multicultural peer support workers and specialist services. These service users noted:

> I find it very difficult to submit things from the hospital concerning our status here in Australia … [support worker] was the one who tries to help us in our papers, in submitting to the immigrations and telling them of the problem that we went through and faced. Yeah, and she was there. And she passed us to their legal advisor, who’s been helping us till now. It’s a blessing to us. (Dewil, service user)

> I have an intellectual disability. And you would appreciate that intellectual disability has a very impact on my life and the way I process things. Where, in this timeframe, [support worker] did an exceptional job of understanding me and taking me to the right services, like NDIS. (Elif, service user)

> On that first call I had a panic attack and didn’t know what to do with her and I felt like I was in a hole, there was nothing beneath me, and I felt all alone. And [support worker] told me many times that I’m not alone. … [support worker] also found for me that phone number, 1800RESPECT, for me to call, for them to then guide me. (Manuel, service user)

This team-based approach internal to the organization and linked in with external health justice partners provides some relief for clinical primary health care staff, while also providing support to service users beyond the clinical care. Given the intersecting forms of marginalisation faced by many of the service users, this was crucial to provide care capable of improving their mental and physical health. This approach addressed the psychosocial issues causing feelings of extreme isolation, confusion or even panic, that exceed the expertise and scope of practice of health professionals. As this clinical service provider explained:

> patients who have come either by boat or also by plane …, from offshore community detention and onshore community detention, released into their community with little to no financial or social support … [They need] medication and payment assistance, food, food assistance, radiology/pathology payment assistance, yeah, and also linking in with trying to find them housing and sometimes case management … our colleagues … work with us closely and we try and identify that gap while we are serving them from a mental health perspective. (Maxi, internal service provider)

A service provider partnering with the evaluated organisation clarified:

> we're a small team who assists vulnerable clients to navigate through … legal processes. … [Evaluated organisation] may contact us seeking legal assistance for one of their clients and that's generally how we receive referrals … I've also referred a client to the service for counselling supports. … it's an informal partnership. (Jane, external service provider)

Importantly, we locate these practices of integrating legal support, access to legal representation, welfare advice and logistical support within practices of care. The multipronged approach ensured that service users were not simply put *on hold* but *were held* while working towards addressing the psychosocial drivers of their mental health problems. Service users' distress was often acute at point of contact with the services. Rather than applying a demedicalized understanding of social issues to focus exclusively on the social determinants of ill health (e.g., migration, DV, finance, welfare), we demonstrate that indeed clinical and non-clinical services working across paradigms were needed to respond comprehensively to service users' needs. Below we explore the principles underpinning this integration of services to provide culturally responsive care.

Principles for culturally responsive care

So far, we have primarily focused on how the evaluated program pursued individual health and justice outcomes through care coordination with internal and external specialist services. Here, we tease out underlying principles that inform care coordination and cut across different societal impact levels. Advocating on behalf of service users for system transformation was considered core business. These service providers explained:

> that non-clinical aspect of [our team] is core to what we do. So, we're not having structured, like [our other team], that kind of more psychological, psychotherapies, CBT stuff, but we're very much non-clinical, looking at the whole person to de-stigmatise what our culture puts onto CALD communities as mental ill health. (Charlie, internal service provider)

> we become aware that the lawyer was not even using the interpreter much. They were texting to each other, emailing, and the person doesn't speak English, so she has to translate on her phone…. if we got our lawyers or whatever, then it much easier. You book the appointment, the client come back, explain everything, and then they get ready for the court… we also have our interpreters on a phone we can use on call. And then we have extra [multicultural peer support workers] who provide a cultural and the language to support. (Margo, internal service provider)

These accounts demonstrate how people from CARM communities are stigmatised and disadvantaged in the legal system, even when they have access to legal representation. Not only, does the integrated HJP consistently offer interpreters, it also brings peer support workers into the process. This highlights, that while language and interpretation is important, it is only a first step in providing culturally responsive care. When it comes to legal issues, with their own lexicon and logic, this can have profound consequences for the lives of the people who experience them. The service provider goes on to narrate:

> A couple were separated, but they didn't understand the reason why they need to leave each other. Whatever's happened, … neighbours called the police, police came, handcuffed the man, took him away, left the lady, nobody provide any interpreter or any legal support, so they never knew they are entitled to go and to defend. Now they have a DVO [domestic violence order] for five years, and yet nobody explained to them of their right, their responsibilities. (Margo, service provider)

Outcomes of bystander intervention are highly context dependent (Kuskoff & Parsell 2024). We do not claim to know what occurred to trigger the neighbour's call to the police and neither do we subscribe to any justifications of DFV within cultural frames of reference (Maturi & Munro 2023). What we note in this account is the absence of culturally responsive follow-up care, including support to the couple that would empower them to understand their legal rights and options. Another service provider partnering with the evaluated organisation comments:

> a lot of the mainstream services, the people don't identify as CALD themselves, so they don't have that understanding of the issues that present in those communities, that are often very unique in those communities. So first, I think it's important to have workers that are CALD. (Jane, external service provider)

Employing interpreter services in combination with peer support workers was a key principle of service delivery that informed practices of care to mitigate the harms and risks of intersecting marginalisations. The evaluated program actively encouraged their partners to adopt similar approaches in a strategic initiative towards system improvement, yet always centred on the whole person they are supporting. These service users shared:

> it's holistic to me, because it touches my health, it touches the legal part of our stay here, and it also touches our family as a whole, because it helps my son, and it also meet my physical needs because it organised food from [charity] to help me. And also, they organise a place for me to stay. (Dewil, service user)

> each person is different. My circumstances were I was having a baby and it was financial, but other people will have other issues…. there is a group of professionals that follow ethical rules and they're responsible and that they follow up and they're able to provide assistance depending on the situation that you find yourself. (Marta, service user)

These service users felt understood and supported across aspects of their lives that went well beyond the clinical remit, but accommodated and addressed the challenges they encountered in their everyday lives. The integration of legal support into relations of health and social care was instrumental in that respect. However, relations of care need time to be nurtured and to cultivate feelings of welcomeness (Plage et al. 2023). This service user reflects:

> sometimes I'm not answering [support worker's] phone, which is very rude, but I really, really didn't want to talk to anyone at that time. Then [support worker] leaving the voice message or text message, like it's okay, she can understand, and some encouraging words and rescheduling…. they fully understood my sickness…. they're very friendly, they're very caring, and they really giving attention on my own interest…. I feel like, oh, someone got my back. (Bridget, service user)

In addition to the key principles of making service users feel welcome, centring on their personal support needs to provide trauma-informed care and drawing on the cultural expertise of peer support workers, we also found that service providers sought to practice a strength-based approach in the social work tradition (Brun & Rapp 2001):

> something a client can do on their own, we'll let them, and we watch them do it. And other things they need support with, or they need link with other service providers to help them manage those things. So, we will tell them where to go, sometimes we just link them ourself, and we will advocate for them …. it's not about us just working with them, it's about them working with us.… They're just not part of the problem but they're also part of the solution. (Lucia, internal service provider)

However, this approach to care sits uneasily within the convoluted, fragmented, and programmatic nature of the larger health and social care system. As this service provider notes:

> Wherever you go, there's a visa restriction.… people are on this kind of merry-go-round of in and out of the system. That's not serving them. And that's not unique to people from CALD backgrounds, but it has an extra layer of complexity because of the lack of cultural understanding … there's a lot of health injustice that people experience on their pathways.… whether it's in employment, whether it's discrimination, whether it's oversees qualification, lack of recognition. (Terrie, internal service provider)

> the philosophy of [evaluated organisation] is about, we don't turn people back to say, "No, we don't." We just try and help in another way. It's a duty now, as we're trying to do our best. (Charlie, internal service provider)

These service providers articulated a strong commitment to supporting service users through a low-threshold, accessible service model. This was partially grounded in their understanding that many of the service users had few other options to find support that would take intersecting marginalisation into account and offer culturally responsive care that would also address the impact of injustice on their health. Yet, service providers are embedded into this landscape as they attempt to work with service users and advocate on their behalf. This service provider remembers one service user:

> I tried to explain to him, “We are not the system. We are basically advocating on your behalf. Our role is this.” He was so caught up, system-dependent, the [police], the housing, horrific injuries. We understand that, but I had to make a clear decision, “We cannot work with you. We won’t help you. We cannot. Especially if you consider us to be the system that’s damaging you, we don’t want to damage you more than what you’re gone through.” And he agreed. … doesn’t happen quite often, but it does happen. (Maxi, internal service provider)

Service providers at times confront limitations in their capacity to support service users when their previous experiences with government systems have irrevocably – and understandably - eroded their trust in health and social care. HJPs pursue objectives on various levels, including the pursuit of individual health outcomes, civil society reform towards greater accessibility for socially disadvantaged populations and macro-level advocacy for more just societies. While principles of person-centred care acknowledged the often-traumatic experiences that service users had in their lives and how they affected their capacity to engage in care, we see here the dual capacity of interlinked systems to occasion culturally responsive care *and* to further cultural and racial oppression. Operating within system constraints sits in tension with the larger HJP vision to transform health and social care towards greater equity, or may even work to inadvertently (re)produce some of these injustices.

Discussion

Better integration of health and social care is increasingly hailed as a means to promote health equity, yet its potential to enhance culturally responsive care is not well understood. HJPs are proposed as a way forward to attend to legal needs within clinical settings and beyond. While available evidence on the positive impact of HJPs for people experiencing social exclusion is encouraging, such emerging interprofessional and multidisciplinary models of ‘doing health’ alongside ‘doing justice’ call for culturally responsive qualitative research to produce knowledge on the opportunities and challenges for culturally and racially marginalized people. We complemented the dominant approach to HJPs within the social determinants of health framework to experiment with theoretical offerings from applying an intersectionality lens. Drawing on data produced as part of the evaluation of a culturally responsive psychosocial support service for people from CARM communities in Southeast Queensland, including interviews with service users, service providers and external partners, we discuss findings in terms of opportunities, limitations, and challenges to advance justice in health through culturally responsive qualitive research.

First, we situate our findings and their interpretations vis-à-vis the extant scholarship on HJPs. Genn (2019) notes the diversity of legal issues that are encountered by marginalised people on the one hand, and the range of models with which HJPs are practised to address them on the other hand. Legal issues range from financial difficulties (including debts), welfare access, family breakdown (including DFV), housing (including access and condition), employment, migration and settlement, and criminal justice contact. While there is often overlap between these legal problems in the lives of people experiencing social disadvantage, nonetheless varying vectors of marginalisation result in distinct sets of challenges. CARM populations are a case in point, as their opportunities for good health and legal resolution face further complexities. Not only do they additionally need to contend with migration and settlement law, but they also face the challenge of navigating health and social care systems that are configured along White and European values and norms (Mescouto et al. 2024). In other words, marginalisation along racial, ethnic and cultural logics intersects with social exclusion based in classed and gendered categories. This intersection of marginalisation requires targeted and nuanced HJP responses capable of promoting greater health equity for people from CARM communities by removing and mitigating obstacles such as linguistic and cultural discrimination, system complexity and producing culturally responsive health and social care services integrating legal support. The findings from this study demonstrate that limiting HJPs to establishing referral pathways to specialist services, for example to address DFV are more likely to succeed if service providers have established and trusting relationships and are willing and resourced to collaborate closely for often extended periods of time.

Culturally responsive service delivery for people from CARM communities needs to draw from multiple frameworks, cutting across strength-based, person-centred and trauma-informed approaches to care. In this way, we argue for making sense of HJPs in terms of an extension of the care paradigm eventuating in legal support beyond the social determinants of health. We also argue for greater engagement with the role of social work in the implementation of HJPs. Most service provider participants in this study were neither trained paralegals or lawyers nor health care professionals, but qualified social workers or human services professionals, often working as multicultural peer support workers, who also brought in their own lived experience to addressing the socio-legal troubles service users face. While it is beyond the scope of the present manuscript to provide an in-depth analysis of the benefits and limitations of peer support within culturally responsive health and social care integration, we argue that culturally responsive care leveraging peer support work is a meaningful addition to the frameworks listed above to attend to the intersection of racial, classed, and gendered marginalisation. Future research would do well to flesh out the contributions of peer social workers from CARM communities within specialist HJPs.

The latter is crucial, specifically with respect to the cultural frames of reference to make sense of what is to be considered a health or legal issue. For example, we heard claims from participants, that victim-survivors of DFV sometimes did not self-identify as experiencing DFV (Maturi & Munro 2023 presenting a critique). Interventionist approaches imposing a Western understanding of and response to DFV might put victim-survivors at risk of housing instability, ostracization from community, or having children removed from their families (Kuskoff et al. 2023). In turn, dismissing DFV when it occurs with reference to cultural idiosyncrasies expresses "an essentialist view of culture" that risks the health and lives of those who are subjected to it (Maturi & Munro 2023: 151). It invites both relegation (i.e., downplaying importance) and delegation (i.e., to community leaders, peer support workers) of the problem of DFV. HJPs supporting culturally and marginalized individuals, families, and communities, need to navigate such perceptions to address DFV in a culturally responsive manner.

Finally, our findings also raise questions regarding the HJPs' capacity for systemic transformation given their embeddedness in the service landscape. Many of the issues the HJPs sought to resolve through legal support and advocacy on behalf of service users, stem from fundamentally unjust legal, health and social care systems in the first place. Consequently, while practicing in line with the principles outlined here and cutting across social work, health care and social justice frameworks, is hoped to lead to greater permeation of integrated legal, health and social care across the government and non-government sectors, a much more radical transformation is needed to remove drivers of mental ill-health.

Conclusion

Health and social care integration is a perennial challenge for care practitioners siloed by funding streams and time-limited-service delivery. HJPs as a practice-led movement bringing together different sectors, disciplines and worldviews represent a point of departure to enhance capacities to address social determinants of health. This study interrogated the praxis of HJP work in the context of culturally and racially marginalized people's mental ill-health employing intersectionality as a conceptual tool to makes sense of this phenomenon. In this way, we contribute to the emerging evidence base on the impact of HJPs by teasing out nuances in their implementation. HJPs are predicated on lasting relations between service users and partners inflected by commitments to care and social justice. Configurations of HJPs need to account for the specific needs and preferences of the populations they serve. In the case of legal support for people who are culturally and racially marginalized, this needs to be guided by a combination of interdisciplinary frameworks including trauma-informed, strength-based, and person-centered approaches enabling culturally responsive care in which legal, peer support and clinical staff need to be accommodated. Where such diverse practitioners collaborate as partners working towards a greater health equity through individual, meso-level and macro-level advocacy, HJPs represent an antidote to some effects of intersecting marginalizations.

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