

# MEDICAL-LEGAL PARTNERSHIPS AND MENTAL HEALTH: QUALITATIVE EVIDENCE THAT INTEGRATING LEGAL SERVICES AND HEALTH CARE IMPROVES FAMILY WELL- BEING

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## INTRODUCTION

Populations—especially vulnerable ones—need more than just good medical care to be healthy. As a policy matter, this means that American health care will continue to underperform<sup>2</sup> and outspend other nations<sup>3</sup> unless we expand the current model to include innovations that address the social as well as medical determinants of health.<sup>4</sup>

There is no shortage of good ideas. Numerous delivery innovations have been implemented on a small scale to address patients' social risks such as food insecurity,<sup>5</sup> substandard housing,<sup>6</sup> and neighborhood violence.<sup>7</sup> However, these interventions have

<sup>2</sup> See World Health Organization, *World Health Organization's Ranking of the World's Health Systems*, PATIENT FACTOR, <http://thepatientfactor.com/canadian-health-care-information/world-health-organizations-ranking-of-the-worlds-health-systems/> (last visited July 8, 2017).

<sup>3</sup> OECD *Health Statistics 2016 Database*, ORG. ECON. CO-OPERATION & DEV., <http://www.oecd.org/els/health-systems/health-data.htm> (last visited July 8, 2017).

<sup>4</sup> See generally Elizabeth H. Bradley et al., *Health and Social Services Expenditures: Associations with Health Outcomes*, 20 *BMJ QUALITY & SAFETY* 1, 4 (2011).

<sup>5</sup> See, e.g., Anna P. Goddu et al., *Food Rx: A Community University Partnership to Prescribe Healthy Eating on the South Side of Chicago*, 43 *J. PREV. INTERV. COMMUNITY* 148 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4416784/>.

<sup>6</sup> James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 *AM. J. PUB. HEALTH* 758 (2002), <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.92.5.758>.

<sup>7</sup> Carnell Cooper, Dawn M. Eslinger & Paul D. Stolley, *Hospital-Based Violence Intervention Programs Work*, 61 *J. TRAUMA, INJURY, INFECTION & CRITICAL CARE* 534 (2006), [http://www.sdhppitt.com/uploads/1/5/3/6/15366632/cooper\\_violence\\_prevention\\_j\\_trauma\\_2006.pdf](http://www.sdhppitt.com/uploads/1/5/3/6/15366632/cooper_violence_prevention_j_trauma_2006.pdf).

difficulty expanding to a national scale despite evidence that some of them could significantly reduce health care costs and improve population-level health outcomes. Expansion is thwarted in part by the absence of evidence that these programs actually improve patient health and well-being, thus making sustainable financing to support long-term social interventions elusive.<sup>8</sup> This article adds qualitative evidence to the growing body of literature that one such intervention designed and shown to mitigate several social risks—the medical-legal partnership (MLP)—can improve patient mental health and family well-being. Specifically, the experiences reported by patients here confirm that one of the most important health outcomes associated with medical-legal partnership interventions is stress reduction.<sup>9</sup> Stress is clearly related to poor health outcomes.<sup>10</sup> This article contributes data gathered from interviews with seven MLP patients and their families, one year after they received MLP services. Little attention has been paid in the existing literature to collecting qualitative evidence of the mental health impact that MLPs can have. Although research has identified an association between unmet legal needs of low-income patients and their poor physical health, little is understood about how legal problems impact the mental health of patients' families.<sup>11</sup> This article begins to fill these voids.

The MLP is an innovative health care delivery model that integrates lawyers into the clinical setting to address legal problems that adversely affect vulnerable patients'.<sup>12</sup> Although approximately 300 MLPs operate nationwide in 155 hospitals, 139 health centers, and 34 health schools, the MLP intervention remains underutilized because broad payment mechanisms have not developed to finance

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<sup>8</sup> *Id.*; Bradley et al., *supra* note 4.

<sup>9</sup> Patti Neighmond, *People with Low Incomes Say They Pay a Price in Poor Health*, NAT'L PUB. RADIO (Mar. 2, 2015, 4:05 AM), <http://www.npr.org/sections/health-shots/2015/03/02/389347123/people-with-low-incomes-say-they-pay-a-price-in-poor-health>.

<sup>10</sup> David R. Williams et al., *Racial Differences in Physical and Mental Health: Socio-economic status, Stress, and Discrimination*, 2 J. HEALTH PSYCHOL. 335 (1997).

<sup>11</sup> *See, e.g.*, TISHRA BEESON ET AL., MAKING THE CASE FOR MEDICAL-LEGAL PARTNERSHIPS: A REVIEW OF THE EVIDENCE (Nat'l Ctr. for Med.-Legal Partnerships 2013), <http://medical-legal-partnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf>.

<sup>12</sup> *Id.*

non-medical services that demonstrably improve access to several social determinants of health.<sup>13</sup> This oversight is costly in light of national proliferation of the MLP model, and a significant body of research that provides a broad evidentiary base of the model's performance in a variety of clinical settings, patient populations, and geographic regions.<sup>14</sup> The MLP has yet to reach the vast majority of low income patients who could benefit from the intervention. In this article, several patient stories shed light on the real-life impact that MLPs have had beyond the return on investment numbers<sup>15</sup> and biomedical outcomes<sup>16</sup> reported to date.

This article presents data from interviews conducted, pursuant to Institutional Review Board Approval,<sup>17</sup> of seven families served by MLPs located in a mid-sized city in the western United States. The MLPs consisted of three safety-net health providers, volunteer private practice attorneys, and law student attorneys practicing under the supervision law faculty members and pro bono private practitioners, licensed and admitted to law practice. The entire project was made possible by the expert training and oversight provided by attorneys and staff from the state's Legal Services Corporation provider and generous funding from state-based, philanthropic foundations.

A year or more after each patient's legal case were concluded and closed, researchers conducted group interviews of patients and their families to explore the long-term impact MLPs may have had on the patients' lives. Researchers obtained patient consent to interview them, using a semi-structured questionnaire, presented to patients and any household members who also volunteered and consented to

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<sup>13</sup> MEGAN SANDEL, APPLYING THE MEDICAL-LEGAL PARTNERSHIP APPROACH TO POPULATION HEALTH, PAIN POINTS AND PAYMENT REFORM (Nat'l Ctr. for Med.-Legal Partnerships 2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/10/Applying-the-MLP-Approach-to-Population-Health-October-2016.pdf>.

<sup>14</sup> *Id.*

<sup>15</sup> See, e.g., James A. Teufel et al., *Rural Medical-Legal Partnership and Advocacy: A Three-Year Follow-Up Study*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 705 (2012).

<sup>16</sup> See, e.g., Robert Sege et al., *Medical-Legal Strategies to Improve Infant Health Care: A Randomized Trial*, 136 PEDIATRICS 97 (2015).

<sup>17</sup> Colorado Multiple Institutional Review Board, University of Colorado Denver-Anschutz Medical Campus, COMIRB Approval #14-1475.

be interviewed. Participants who completed the one-hour interview received a \$20 discount store gift card.

The themes that emerged are striking. First and foremost, with remarkable consistency across interviews, the data confirmed that unmet legal issues are the source of health-harming stress that compromises families' capacity to navigate their other health and social issues. Second, all the families interviewed in this study experienced some level of relief from stress and consequently improved social capacity, when they received assistance from their MLP attorneys, whether or not the legal issues they presented were entirely resolved. Third, the overwhelming majority of participants experienced positive resolution of their legal issues, and a year after the MLP intervention said they were experiencing a quality of life they deemed improved by the MLP intervention. Not all patients interviewed were satisfied with the MLP services they received. However, even those participants who did not have satisfactory resolution of all their legal issues, described significant and lasting improvements in their health, with particular focus on their emotional well-being that they associated with the MLP intervention.

This paper proceeds in four parts. Part I describes the MLP model, with a focus on its relationship to the social determinants of health. Part II explains how the social determinants of health affect population health outcomes. Part III presents the results of the patient and family interviews, to describe how MLPs in a large western city affected the social determinants of several vulnerable patients and their families. Part IV presents a discussion of the study results and outlines resulting policy implications.

## I. THE MLP MODEL

### A. Overview

Medical-legal partnerships help low income and underserved populations improve their health and health care by addressing legal issues that adversely affect the social determinants of health.<sup>18</sup> The MLP operates on three distinct levels. First, MLP attorneys work with

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<sup>18</sup> BEESON ET AL., *supra* note 11.

clinical providers to change traditional delivery systems so that health providers routinely screen patients to identify unmet legal needs that harm health. For example, MLP attorneys work to develop awareness and resources that enable clinicians to discover, during routine history and physical examinations, that a family living in a substandard apartment may be exposed to lead in paint, soil, or water at levels which violate federal safety standards.<sup>19</sup> Next, the MLP integrates lawyers as members of the health care delivery team to address legal problems collaboratively with providers. For example, physicians who discover families living in substandard conditions can refer patients to in-house attorneys to address the health hazards in their home. Third, MLP attorneys can work to change population-level policies. For example, MLP lawyers work together with providers to compile evidence that a community population may be exposed to health hazards; the MLP can use this evidence to support patients in negotiations, as well as in legislative, administrative, or judicial hearings. Despite the evidence that one in six people need legal care to be healthy,<sup>20</sup> most of the nation's 300 MLPs are unsustainably financed.<sup>21</sup>

The MLP model is founded on the evidence that 50% of the factors that influence health outcomes are social, economic, and environmental.<sup>22</sup> Further, where these non-medical factors are affected by income, housing, education, personal safety, and other

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<sup>19</sup> Andrew F. Beck et al., *Identifying and Treating Substandard Housing Cluster Using a Medical-Legal Partnership*, 130 PEDIATRICS 831 (2012), <http://pediatrics.aappublications.org/content/pediatrics/130/5/831.full.pdf>.

<sup>20</sup> *See 1 in 6 People Needs Legal Care to be Healthy*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/>; *see generally* Tina Rosenberg, *When Poverty Makes You Sick, a Lawyer Can Be the Cure*, N.Y. TIMES OPINIONATOR BLOG (July 17, 2014, 9:30 PM), <https://opinionator.blogs.nytimes.com/2014/07/17/when-poverty-makes-you-sick-a-lawyer-can-be-the-cure/>.

<sup>21</sup> Recently, the national center for MLPs issued a report that contained the qualitative responses of over 250 MLP respondents nationally. Among the reports for recommendations, the drafters explained the need to "grow, improve, and sustain MLPs by building out critical infrastructure elements like diverse and stable funding streams." MARSHA REGENSTEIN ET AL., *THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD 5* (Nat'l Ctr. for Med. Legal Partnerships 2016), <http://medical-legalpartnership.org/wp-content/uploads/2016/08/2015-MLP-Site-Survey-Report.pdf>.

<sup>22</sup> A. R. Tarlov, *Public Policy Frameworks for Improving Population Health*, 896 ANNALS N.Y. ACAD. SCIENCES 281 (1999).

legal problems associated with poor health, resolving these legal problems can improve health outcomes.<sup>23</sup> Most often those legal needs concern inequitable access to medical care, or problems with one of the social determinants of health.<sup>24</sup>

Dr. Barry Zuckerman is credited with founding the nation's first formal MLP at Boston Medical Children's Center in 1993,<sup>25</sup> however this entity was preceded by Dr. Jack Geiger who formed a precursor in 1967 to address food and housing insecurity in Mississippi.<sup>26</sup> Moreover, health care providers and civil legal aid attorneys collaborated early during the 1980s to combat the emerging HIV/AIDS crisis.<sup>27</sup> From their inception, MLP's have sought to present a new model of health care delivery by integrating three services into the clinical setting. First, MLP lawyers provide legal representation to address adverse social conditions for which there are legal remedies, and which have the potential to improve patient health. Examples include requiring landlords to remove lead paint toxins or mold, appealing wrongful public benefit terminations, and enforcing educational accommodations for disabled children. Second, MLPs transform health and legal institutional practices by training clinical providers to screen for and identify patients' social and legal needs during office visits. The idea is to identify these impactful non-medical needs while they may be addressed preventively in the same way that physicians seek to provide preventive rather than crisis medical care. Third, MLPs advocate for structural policy changes at an institutional, local, state, and federal level. MLP attorneys bring a "patient-to-policy" perspective, identifying needs in the communities

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<sup>23</sup> James Krieger, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447157/>.

<sup>24</sup> Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations*, 29 HEALTH AFF. 1697 (2010).

<sup>25</sup> Dana Weintraub et al., *Pilot Study of Medical-Legal Partnership to Address Social and Legal Needs of Patients*, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 157, <https://pdfs.semanticscholar.org/ba04/c9307a7e933c886f49f002b33d60af760ac7.pdf>.

<sup>26</sup> See Jack Geiger, MD, M.Sc., ScD., WE ARE PUB. HEALTH (Mar. 10, 2014), <http://wearepublichealthproject.org/interview/jack-geiger/>.

<sup>27</sup> Ellen Lawton, *A History of the Medical Legal Partnership Movement*, COMMUNITY HEALTH F., Fall/Winter 2014, at 12, <http://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-A-History-of-the-Medical-Legal-Partnership-Movement.pdf>.

they serve, and then they work to improve policies and laws that impact those communities and ultimately, the social determinants of individual and population health.

### B. Examples

Some MLPs serve the needs of a specific population group. For example, LegalHealth in New York City is an MLP that serves veterans.<sup>28</sup> This MLP partners with public hospitals to help veterans maintain stable housing, secure VA disability benefits, and gain access to mental health services that assist them in coping with trauma after battlefield service.<sup>29</sup> In Cincinnati, Ohio, another MLP focuses on children. This MLP, called Child HeLP, addresses substandard housing conditions that hinder children's recovery from asthma and other chronic conditions.<sup>30</sup> Child HeLP also provides legal representation in custody, family violence, special education, and public benefits cases that present upstream barriers to children's health and well-being. Some MLPs serve broad population groups, while others specialize in addressing a specific type of legal problem. The majority of MLPs serve children (59%), and a majority of those children belong to low-income households.<sup>31</sup> Three-quarters of the health organizations that partner with MLPs are located in underserved areas; in 2015, 84% had at least a quarter of their patients on Medicaid and 47% have an uninsured patient population. Several MLPs also serve the elderly, immigrants, Native Americans, or adult patients with complex co-morbidities who frequently use emergency medical and social services, and are sometimes called "high" or "super-utilizers."<sup>32</sup>

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<sup>28</sup> Jack Tsai et al., *Partnerships Between Health Care and Legal Providers in the Veterans Health Administration*, 68 *PSYCHIATRIC SERVS.* 321 (2017), <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201600486>.

<sup>29</sup> *Id.*

<sup>30</sup> Beck et al., *supra* note 19.

<sup>31</sup> Marsha Regenstien et al., *The State of the Medical-Legal Partnership Field: Findings from the 2015 National Center for Medical-Legal Partnership Surveys*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, Aug. 2016, at 7.

<sup>32</sup> See T. L. Johnson et al., *For Patients Who Use Large Amounts of Health Care Services, The Need is Intense Yet Temporary*, 8 *HEALTH AFF.* 1312, 1313-14 (2015).

A few MLPs are known for effective advocacy on a specific public health legal issue. The Health Justice Project (HJP) in Chicago is an example of an MLP effectively addressing population health policy.<sup>33</sup> HJP identified a population health problem based on the frequent reports of children with elevated blood lead levels in its affiliated clinics.<sup>34</sup> This MLP responded by working to require the Chicago Housing Authority to lower the threshold level of lead poisoning in children that would trigger a mandatory assessment of the need for abatement.<sup>35</sup> Moreover, this MLP partnered with legal aid groups, health experts, and providers to file a petition for rulemaking that resulted in the United States Department of Housing and Urban Development announcing amendments to improve protections for children in public housing under the “Lead Based Paint Poisoning Prevention in Certain Residential Structures” regulations.<sup>36</sup> In another case, MLP staff and health care providers responded to the high frequency of patients in their clinic experiencing utility shut-off notices. That MLP included a form letter in the health care center’s electronic medical records for clinicians to access, sign and submit efficiently. This MLP also testified before state regulators on the medical impact of utility cut-offs.<sup>37</sup> This effort resulted in change in regulations that reduced the need for chronic disease re-certification to prevent utility cut-offs and allowed nurses to sign cut-off appeal letters.<sup>38</sup>

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<sup>33</sup> Carla K. Johnson, *Chicago Medical Clinic Prescribes Legal Help for Housing*, ASSOCIATED PRESS (Dec. 26, 2015), <https://apnews.com/42a3508eddb749cba995ba27666cb5b6/chicago-medical-clinic-prescribes-legal-help-housing>.

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> See generally Letter from Lee Francis, President & CEO, Erie Family Health Ctr. et al., to Dep’t Hous. & Urban Dev. (Oct. 31, 2016), <http://nhlp.org/files/Erie%20Family%20Health%20Center.Health%20Justice%20Project.National%20Housing%20Law%20ProjectComments.pdf>; see also 24 C.F.R. 35.

<sup>37</sup> See *Changing the Law to Keep the Heat and Lights On*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP (Nov. 1, 2010), <http://medical-legalpartnership.org/utility-story/>.

<sup>38</sup> See *id.*

### C. MLP Populations

The need for MLP representation is particularly acute among the poor, not only because this population experiences a greater burden of social, environmental, and health problems, but because low-income Americans have inferior access to legal services than the wealthy enjoy. This lack of access is often called the “justice gap” – a term that describes the difference between legal needs and legal services available.<sup>39</sup> Studies show that between 70% and 90% of the legal needs related to housing, family, and consumer issues that low-income families face go unaddressed. Moreover, un-represented litigants who proceed in court by representing themselves in civil matters suffer much worse outcomes than those with legal representation.<sup>40</sup> The underlying concept that drives the MLP model is that vulnerable patients require access to lawyers in order to enforce and advocate for laws that will protect their access to the social determinants of health and thereby equip them to better address poor health conditions.<sup>41</sup>

## II. HOW MLP INTERVENTIONS EQUALIZE ACCESS TO THE SOCIAL DETERMINANTS OF HEALTH<sup>42</sup>

### A. Overview

Social determinants are the economic and social conditions that shape individual and population health. Social scientists recognize

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<sup>39</sup> Rebecca Buckwalter-Poza, *Making Justice Equal*, CTR. FOR AM. PROGRESS (Dec 8, 2016, 9:03 AM), <https://www.americanprogress.org/issues/criminal-justice/reports/2016/12/08/294479/making-justice-equal/>.

<sup>40</sup> Russell Engler, *Connecting Self-Representation to Civil Gideon: What Existing Data Reveal About When Counsel is Most Needed*, 37 *FORDHAM URB. L.J.* 35, 39 (2009).

<sup>41</sup> BEESON ET AL., *supra* note 11.

<sup>42</sup> This section was first published in a white paper written by the author. DAYNA B. MATTHEW ET AL., *THE LAW AS HEALER: HOW PAYING FOR MEDICAL LEGAL PARTNERSHIPS SAVES LIVES AND MONEY* (Ctr. for Health P. at Brookings 2017).

five factors that may contribute to health outcomes.<sup>43</sup> These social factors include the social environment (e.g. income, gender, disability, and race discrimination), the physical environment (neighborhood and living conditions), and access to health care. They have at least as strong an association with poor health outcomes as genetics, biology, or effects of individual behaviors related to diet, smoking, exercise, or alcohol consumption.<sup>44</sup> Therefore, policy interventions that address the social determinants of health are essential to improving population health.

The World Health Organization (WHO) compiled the first comprehensive evidence of the association between social determinants and population health in 1998 based on clear evidence of the inverse relationship between socioeconomic status and poor health.<sup>45</sup> The evidentiary basis for the association WHO spotlighted can be traced to “The Whitehall Studies,” a pair of analyses from the UK that identified an inverse relationship between the social status of British civil servants, and their relative risk of morbidity and mortality.<sup>46</sup> The Whitehall studies compiled over fifteen years of longitudinal data for a cohort of over 10,000 study participants.<sup>47</sup> The data showed that most diseases, coupled with shorter life expectancy, occur more commonly further down the social ladder, less commonly in the middle-class, and least among upper class populations.<sup>48</sup> This relationship, called the “social gradient,” reflects the fact that people with lower socioeconomic status (SES) bear at least twice the risk of

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<sup>43</sup> Laura McGovern et al., *The Relative Contribution of Multiple Determinants to Health Outcomes. Researchers Continue to Study the Many Interconnected Factors that Affect People's Health*, HEALTH AFF. (Aug. 21, 2014), [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_123.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf).

<sup>44</sup> C. Forchuk et al., *Social Determinants of Health: Housing and Income*, 18 HEALTHCARE Q. 27, 27 (2016); see Harry J. Heiman & Samantha Artiga, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. (Nov. 4, 2015), <http://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

<sup>45</sup> See generally WORLD HEALTH ORG., *SOCIAL DETERMINANTS OF HEALTH: THE SOLID FACTS* (R. Wilkinson & M. Marmot eds., 2nd ed. 2003).

<sup>46</sup> Michael Marmot & Eric Brunner, *Cohort Profile: The Whitehall II Study*, 34 INT'L J. EPIDEMIOLOGY 251, 251 (2005).

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

shorter life expectancy and disease morbidity than people with higher SES. The major contribution of the Whitehall studies was to confirm that psychosocial conditions at work, home, and in communities account for the social gradient.<sup>49</sup>

## B. Evidence Linking Social Determinants, Law, and Health

More recently, researchers have attempted to identify causal mechanisms that link specific social determinants to poor health outcomes. Several studies have linked infant mortality and poverty,<sup>50</sup> as well as mental health and more specifically income inequality with health disparities.<sup>51</sup> Other researchers have identified poor housing conditions,<sup>52</sup> stressful work environment,<sup>53</sup> and educational disparities<sup>54</sup> as social mechanisms that have a deleterious impact on health. Importantly, health behaviors such as smoking, alcohol consumption and drug use have been associated with poor social conditions such as low income<sup>55</sup> and low educational attainment.<sup>56</sup>

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<sup>49</sup> *Id.*

<sup>50</sup> Jeanne Brooks-Gunn & Greg J. Duncan, *The Effects of Poverty of Children*, 7 CHILD. & POVERTY 55, 57 (1997).

<sup>51</sup> David R. Williams et al., *Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination*, 2 J. HEALTH PSYCHOL. 335 (1997); see also Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099, 1102.

<sup>52</sup> James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758, 758 (2002).

<sup>53</sup> See *How Does Employment, or Unemployment Affect Health?*, ROBERT WOOD JOHNSON FOUND., <http://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health.html> (last updated Mar. 2013); see generally J. Siegrist, *Adverse health Effects of High-Effort/Low-Reward Conditions*, 1 J. OCCUPATIONAL HEALTH PSYCHOL. 27 (1996).

<sup>54</sup> Emily B. Zimmerman et al., *Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives*, AGENCY FOR HEALTHCARE RES. & QUALITY (2014), <https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html>.

<sup>55</sup> Smoking prevalence of blue collar workers is double that of white collar workers. This difference may be explained by the additional psychological stressors low income brings. See Glorian Sorensen et al., *Reducing Social Disparities in Tobacco Use: A Social-Contextual Model for Reducing Tobacco Use Among Blue-Collar Workers*, 94 AM. J. PUB. HEALTH 230, 230 (2004); see also Elizabeth M. Barbeau, *Working Class Matters: Socioeconomic Disadvantages, Race/Ethnicity, Gender, and Smoking in NHIS 2000*, 94 AM. J. PUB. HEALTH 269, 269 (2004).

<sup>56</sup> Antti Latvala et al., *Drinking, Smoking, and Educational Achievement: Cross-Lagged Associations*

The causal relationship between these social risks is a matter of debate. However, the association between social risks and inferior health outcomes has been quantified by some researchers who purport to show these risks are a mechanism by which health inequities occur.<sup>57</sup>

Estimating the contribution of a social risk factor to particular health outcomes is complex. Disease and injury may be linked to multiple potential causal factors. Measuring the impact of social determinants is further complicated by confounding differences in populations being compared, the importance of intergenerational or life-course perspectives, data availability, and the timing of impacts and outcomes measured. Vulnerable patient populations may not readily present themselves for data collection for several reasons, including historically informed distrust of medical researchers. Also, causality is bi-directional: While social risk factors can cause poor health, poor health can lead to lower income and educational attainment.

Despite these challenges, several researchers have estimated relative contributions of social risk factors to morbidity and mortality. For example, researchers David Cutler and Adriana Lleras-Muney estimated that a year of education raises earnings by approximately 10% in the United States, reduces the risk of heart disease by 2.16 percentage points, reduces the risk of diabetes by 1.3 percentage points, and increases life expectancy by 0.18 years using a 3% discount rate.<sup>58</sup> Sandro Galea and colleagues estimate that, in 2000, approximately 245,000 U.S. deaths were attributable to low education, 176,000 to racial segregation, 162,000 to low social support, 133,000 to individual-level poverty, 119,000 to income inequality, and 39,000 to area-level poverty.<sup>59</sup> While the methods to accurately quantify the impact of each social determinant on adverse health

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*from Adolescence to Adulthood*, 137 DRUG ALCOHOL DEPENDENCE 106 (2014).

<sup>57</sup> Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 1995 J. HEALTH & SOC. BEHAV. 80, <https://www.jstor.org/stable/pdf/2626958.pdf?refreqid=excelsior:fb8cd04bab9a87b81ea927d7830ca35a>.

<sup>58</sup> David M. Cutler & Adriana Lleras-Muney, *Education and Health: Evaluating Theories and Evidence* 2-5 (Nat'l Bureau of Econ. Research, Working Paper No. 12352, 2006).

<sup>59</sup> Sandro Galea et al., *Estimated Deaths Attributable to Social Factors in the United States*, 8 AM. J. PUB. HEALTH 1456, 1456 (2011).

outcomes are still evolving, MLPs have been shown to improve the association between each of these upstream social determinants, and downstream patient health outcomes.

Law interacts with the social determinants of health in at least two important ways. First, formal laws “on the books” help structure and perpetuate the social conditions that we described as social determinants.<sup>60</sup> Second, the ways these formal laws are actually implemented “on the streets” result in law acting as a mechanism or mediator through which social structures are transformed into levels and distributions of health.<sup>61</sup> To the extent that low-income patients are unable to enforce the law “on the books” to fully access their rights to equal access to decent housing, fair employment, safe environments, food security, health benefits, and other social determinant of health, then their unmet legal needs operate as barriers to good health outcomes.<sup>62</sup> The MLP model integrates legal assistance as a vital component of patient care for low-income families, directly addressing unmet legal needs, and thus both roles that law plays in contributing to health outcomes. In short, MLPs establish a core partnership between health care and legal teams that are uniquely positioned to address patients’ social and legal needs in a clinical setting thereby improving these patients’ full access to the social determinates that affect their health outcomes. The acronym, “I-HELP” is used by the National Center of Medical Legal Partnerships to describe each of the legal issues related to the social determinants of health that MLPs can handle.<sup>63</sup> The next section summarizes MLP impacts on each of these legal issues.

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<sup>60</sup> Scott Burris, *Law in a Social Determinants Strategy: A Public Health Law Research Perspective*, 126 PUB. HEALTH REP. 22 (2011).

<sup>61</sup> *Id.*

<sup>62</sup> Elizabeth T. Tyler, *Aligning Public Health, Health Care, Law and Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health* 8 J. HEALTH & BIOMEDICAL L. 211 (2012).

<sup>63</sup> The MLP acronym for this list of legal issues MLPs address is “I-HELP.” *How Civil Legal Aid Helps Health Care Address SDOH*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>.

### 1. *Income*

Economic hardship adversely affects health. Moreover, the health effects of economic insecurity are mediated by economic policies.<sup>64</sup> Factors that contribute to economic insecurity include unemployment, working conditions at an undesirable job, income loss due to structural economic changes, and wage rates that result in being unable to pay one's bills. These economic risk factors are associated strongly with adverse mental health outcomes. Moreover, low-income people who experience economic insecurity are more likely to have high blood pressure, high cholesterol, diabetes, and obesity.<sup>65</sup>

### 2. *Housing*

Housing is an important direct and indirect determinant of health that MLPs address. Numerous studies associate poor housing conditions with a broad range of health problems such as asthma, lead poisoning, developmental delays, heart disease, and neurological disorders.<sup>66</sup> More than one researcher has called the state of inadequate housing in poor American communities a "public health crisis."<sup>67</sup>

Laws that regulate these housing safety and sanitation issues tend to be under-enforced in low-income communities.<sup>68</sup> For example, the data describing prevalent housing problems cited here prevails despite the fact that all states except Arkansas have

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<sup>64</sup> Ralph Catalano, *The Health Effects of Economic Insecurity*, 81 AM. J. PUB. HEALTH 1148, 1148 (1991).

<sup>65</sup> Sy Mukherjee, *Four Ways That Poverty Hurts Americans' Long-Term Health*, THINK PROGRESS (July 30, 2013), <https://thinkprogress.org/four-ways-that-poverty-hurts-americans-long-term-health-b5dac184fdf9>.

<sup>66</sup> Matthew Desmond & Monica Bell, *Housing, Poverty, and the Law*, 11 ANN. REV. L. & SOC. SCI. 15, 20 (2015).

<sup>67</sup> See Samiya A. Bashir, *Home is Where the Harm is: Inadequate Housing as a Public Health Crisis*, 92 AM. J. PUB. HEALTH 733 (2002).

<sup>68</sup> See Elizabeth T. Tyler, *When Are Laws Strictly Enforced? Criminal Justice, Housing Quality, and Public Health*, HEALTH AFF. (Nov. 5, 2015), <http://healthaffairs.org/blog/2015/11/05/when-are-laws-strictly-enforced-criminal-justice-housing-quality-and-public-health/>.

legislatively recognized that an implied warranty of habitability protects tenants.<sup>69</sup> Some scholars have argued that improving building code enforcement will increase the cost of housing and harm poor tenants,<sup>70</sup> however, the empirical evidence for this position is weak.<sup>71</sup> In contrast, substantial evidence shows that legal representation improves housing code enforcement,<sup>72</sup> and further that code enforcement can improve health. The majority of tenants in housing courts nationally do not have legal representation, while most landlords have attorneys.<sup>73</sup>

Residential segregation remains a fundamental cause of racial disparities in health and represents an opportunity for MLP intervention.<sup>74</sup> Segregation refers to the geographical separation of people, primarily related to discrimination rather than to personal preferences, based on ethnicity or race. Residential segregation is detrimental to health outcomes for minority populations.<sup>75</sup> This is because when black and Latino populations live in segregated neighborhoods, they are isolated from the resources white

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<sup>69</sup> Ashley E. Bachelder et al., *Health Complaints Associated with Poor Rental Housing Conditions in Arkansas: The Only State Without a Landlord's Implied Warranty of Habitability*, 4 FRONTIERS PUB. HEALTH 263 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5120100/>.

<sup>70</sup> See generally Neil K. Komesar, *Return to Slumville: A Critique of the Ackerman Analysis of Housing Code Enforcement and the Poor*, 82 YALE L. J. 82 1175, 1186 (1973).

<sup>71</sup> Michael A. Brower, *The "Backlash" of the Implied Warranty of Habitability: Theory vs. Analysis*, 60 DEPAUL L. REV. 849, 885 (2011).

<sup>72</sup> Pamala C. Ortiz, *How a Civil Right to Counsel Can Help Dismantle Concentrated Poverty in America's Inner Cities*, 25 STAN. L. & POL'Y. REV. 163, 185 (explaining that the majority of tenants in housing courts nationally do not have legal representation, while most landlords have attorneys). Tenants' vulnerability in housing court is exacerbated by the fact that as a group, unrepresented tenants are most often poor, female, and members of racial or ethnic minority groups. However, substantial evidence shows that when lawyers are present, tenants fare better in housing cases, with some reporting tenants are as much as nineteen times as likely to win if they are represented by counsel, in comparison to unrepresented tenants. Moreover, other studies show that represented tenants obtain more favorable settlements, fewer defaults, and more trial victories. *Id.*

<sup>73</sup> Russell Engler, *Connecting Self-Representation to Civil Gideon: What Existing Data Reveal About When Counsel is Most Needed*, 37 FORDHAM URB. L.J. 38, 46-47 (2009).

<sup>74</sup> David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 404 (2011).

<sup>75</sup> Joseph J. Sudano et al., *Neighborhood Racial Residential Segregation and Changes in Health or Death Among Older Adults*, 19 HEALTH PLACE 80, 81 (2013).

populations can access to protect and improve their health. Residential segregation relegates black and Latino populations to areas of lower quality housing, schools, food, employment, and recreational spaces as well as increased exposure to violence, environmental hazards, and disparate law enforcement practices.<sup>76</sup> Residential segregation is also associated with inferior access to health care providers and access to lower quality providers such as pharmacies with lower-quality inventories, clinicians with inferior training and experience, and hospitals with worse outcomes, older physical plants, and less medical equipment.<sup>77</sup> Higher rates of racial segregation are associated with higher rates of adult and infant mortality,<sup>78</sup> coronary heart disease,<sup>79</sup> infectious disease such as tuberculosis,<sup>80</sup> and poorer mental health,<sup>81</sup> even when researchers control for poverty rates. Residential segregation is also associated with higher homicide rates, one of the key drivers of the gap in black-white life expectancy.<sup>82</sup>

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<sup>76</sup> See, e.g., Michael R. Smith & Matthew Petrocelli, *Racial Profiling? A Multivariate Analysis of Police Traffic Stop Data*, 4 POLICE Q. 4 (2001); Steven J. Briggs & Kelsey A. Keimig, *The Impact of Police Deployment on Racial Disparities in Discretionary Searches*, 7 RACE & JUST. 256 (2016).

<sup>77</sup> See Jonathan Skinner et al., *Mortality After Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, 112 CIRCULATION 2634, 2635 (2005); see also Peter B. Bach et al., *Primary Care Physicians Who Treat Blacks and Whites*, 351 NEW ENG. J. MEDICINE 575, 579 (2004); see also Darrell J. Gaskin et al., *Residential Segregation and Disparities in Health Care Services Utilization*, 69 MED. CARE RES REV. 158 (2012).

<sup>78</sup> See Thomas A. LaVeist, *Segregation, Poverty, and Empowerment: Health Consequences for African Americans*, 71 MILBANK Q. 41, 41, 45-46 (1993); see generally Thomas A. LaViest, *Racial Segregation and Longevity Among African Americans: An Individual-Level Analysis*, 38 HEALTH SERV. RES. 1719 (2003).

<sup>79</sup> See Ana V. Diez Roux et al., *Neighborhood of Residence and Incidence of Coronary Heart Disease*, 345 NEW ENG. J. MEDICINE 99, 103 (2001); see also Jing Fang et al., *Residential Segregation and Mortality in New York City*, 47 SOC. SCI. MED. 469, 476 (1993).

<sup>80</sup> See Dolores Acevedo-Garcia, *Zip Code Level Risk Factors for Tuberculosis: Neighborhood Environment and Residential Segregation in New Jersey, 1985-1992*, 91 AM. J. PUB. HEALTH 734, 737, 739 (2001); see also D. Acevedo-Garcia, *Residential Segregation and the Epidemiology of Infectious Diseases*, 51 SOC. SCI. & MED. 1143, 1157 (2000).

<sup>81</sup> See Carol S. Aneshensel & Clea A. Sucoff, *The Neighborhood Context of Adolescent Mental Health*, 37 J. HEALTH & SOC. BEHAV. 293, 307 (1996).

<sup>82</sup> GREGORY ACS ET AL., *THE COST OF SEGREGATION* (Urban Institute 2017), [http://www.urban.org/sites/default/files/publication/89201/the\\_cost\\_of\\_segregation.pdf](http://www.urban.org/sites/default/files/publication/89201/the_cost_of_segregation.pdf).

Affordable housing improves MLP clients' health by alleviating crowding, freeing financial resources to pay for health care and food, limiting exposure to environmental toxins. Also, increasing patients' household stability is associated with improved mental health.<sup>83</sup> A significant body of research supports these associations between affordable housing and health.<sup>84</sup>

Adults living in unaffordable housing are more likely to say their health is fair or poor compared to similar people living in affordable housing.<sup>85</sup> Cost-burdened adults or adults facing foreclosure are less likely to fill prescriptions and adhere to health treatments.<sup>86</sup> Frequent moves are associated with higher rates of behavioral and mental health issues among children.<sup>87</sup> Increases in housing costs have been associated positively with increased food insecurity among children.<sup>88</sup> Seniors are more likely to have depression, and adolescents are more likely to have anxiety and aggression when access to affordable housing is limited. Children with unstable housing are more likely to use emergency department services; children who are moved around more have lower weight for their age, and adolescents are more likely to use drugs.<sup>89</sup> The U.S.

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<sup>83</sup> Nabihah Maqbool et al., *The Impacts of Affordable Housing on Health: A Research Summary*, INSIGHTS FROM HOUSING POL'Y RES., Apr. 2015, at 3 [http://www.housingpartners.com/assets/creating\\_change/http\\_\\_app.bronto.pdf](http://www.housingpartners.com/assets/creating_change/http__app.bronto.pdf).

<sup>84</sup> Susan C. Saegert et al., *Healthy Housing: A Structured Review of Published Evaluations of U.S. Interventions to Improve Health by modifying Housing in the United States, 1990–2001*, 93 AM. J. PUB. HEALTH 1471 (2003).

<sup>85</sup> *Id.*

<sup>86</sup> Janet Currie & Erdal Tekin, *Is There a Link Between Foreclosure and Health?*, 7 AM. ECON. J. 63 (2015), [https://www.princeton.edu/~jcurrie/publications/Foreclosure\\_Health\\_Jan\\_2014.pdf](https://www.princeton.edu/~jcurrie/publications/Foreclosure_Health_Jan_2014.pdf).

<sup>87</sup> See *Safe, Stable Homes Lead to Healthier Children and Families for Baltimore*, CHILD. HEALTHWATCH, Oct. 2012, at 1, [http://www.childrenshealthwatch.org/wp-content/uploads/MDHousing\\_brief\\_October2012.pdf](http://www.childrenshealthwatch.org/wp-content/uploads/MDHousing_brief_October2012.pdf); see also *LIHEAP Stabilizes Fam. Housing & Protects Children's Health*, CHILD. HEALTHWATCH, Feb. 2011, at 1, [http://neada.org/wp-content/uploads/2013/02/childrens\\_healthenergy\\_brief\\_feb11.pdf](http://neada.org/wp-content/uploads/2013/02/childrens_healthenergy_brief_feb11.pdf).

<sup>88</sup> Jason M. Fletcher et al., *Assessing the Effect of Changes in Housing Costs on Food Insecurity*, 15 J. CHILD. & POVERTY 79, 79–93; Sharon I. Kirkpatrick & Valerie Tarasuk, *Housing Circumstances Are Associated with Household Food Access Among Low-Income Urban Families*, 88 J. URB. HEALTH 284, 289, 291 (2011).

<sup>89</sup> Maqbool et al., *supra* note 83.

Department of Housing and Urban Development estimates that in 2015, approximately 500,000 people were unsheltered homeless.<sup>90</sup>

### 3. *Employment*

MLPs seek to improve patients' health by addressing legal issues that pertain to loss of employment, employment conditions, or employment discrimination. Several studies have shown that being employed has a positive protective effect on mental health.<sup>91</sup> While, having a steady job provides income to buy healthy food, obtain health care, and access other determinants of health, low-income populations are often vulnerable to health harming working conditions, or can be subjected to unfair labor practices. The Robert Wood Johnson foundation classifies 10.5 million Americans as "working poor," a status associated with health risks due to workplace injuries or depression.<sup>92</sup> Moreover, unemployment is a health hazard. People who are unemployed are 54% more likely than those continuously employed to have poor health.<sup>93</sup> They are 83% more likely to develop stress-related conditions such as stroke, heart attack, heart disease, arthritis, or depression.<sup>94</sup> At the same time, people who are frequently absent from work due to illness are more likely to lose their jobs.

### 4. *Legal Status*

The three legal status issues that MLPs typically address relate to citizenship, marital status, and discrimination due to minority status. Conflict and uncertainty with respect to each of these issues are associated with negative health outcomes.

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<sup>90</sup> See THE STATE OF HOMELESSNESS IN AMERICA 2015 (Nat'l Alliance to End Homelessness 2015), <http://endhomelessness.org/wp-content/uploads/2015/04/2015-state-of-homelessness.pdf>.

<sup>91</sup> Maaiké van der Noordt, *Health Effects of Employment: A Systematic Review of Prospective Studies*, 71 OCCUPATIONAL & ENVTL. MED. 730 (2014).

<sup>92</sup> ROBERT WOOD JOHNSON FOUND., *supra* note 53.

<sup>93</sup> *Employment*, COUNTY HEALTH RANKINGS & ROADMAPS, <http://www.countyhealthrankings.org/our-approach/health-factors/employment> (last visited July 9, 2017).

<sup>94</sup> WEBER-MORGAN HEALTH DEP'T, COMMUNITY HEALTH ASSESSMENT 97, [http://www.webermorganhealth.org/about/documents/WMHD\\_CHA.pdf](http://www.webermorganhealth.org/about/documents/WMHD_CHA.pdf).

As a vulnerable population, immigrants to the U.S. have an intersectional group of potential issues that limit access to healthcare: socioeconomic background, immigration status, English proficiency, federal and state laws regarding publicly funded healthcare, residential area limitations, and feelings of stigma or marginalization.<sup>95</sup> Compared to the U.S.-born population, immigrants are 2.5 times less likely to have insurance.<sup>96</sup> They also use healthcare services less frequently and receive lower-quality care.<sup>97</sup> Additionally, immigrants face language barriers, receive fewer preventative services, and are more likely to not understand the directions for prescriptions and follow-up appointments. Over 20% of non-English speaking patients altogether avoid seeking medical help because of language barriers.<sup>98</sup> MLP attorneys can help resolve immigration status, clear criminal or credit histories, and assist with asylum applications, therefore allowing immigrants consistent access to care and potential benefits.<sup>99</sup>

Studies show that legal representation improves outcomes in family law cases.<sup>100</sup> Maccoby and Mnookin found that parents were more likely to request and receive joint legal custody when both

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<sup>95</sup> Sergio Cristancho et al., *Listening to Rural Hispanic Immigrants in the Midwest: A Community-Based Participatory Assessment of Major Barriers to Health Care Access and Use*, 18 QUALITATIVE HEALTH RES. 633 (2008); see also Rayden Llano, *Immigrants and Barriers to Healthcare: Comparing Policies in the United States and the United Kingdom*, STAN. J. PUB. HEALTH (June 1, 2011), <https://web.stanford.edu/group/sjph/cgi-bin/sjphsite/immigrants-and-barriers-to-healthcare-comparing-policies-in-the-united-states-and-the-united-kingdom/>.

<sup>96</sup> *Immigrants in the United States: A Profile of Americas Foreign-Born Population*, CTR. FOR IMMIGR. STUD., <http://cis.org/node/3876> (last visited July 9, 2017).

<sup>97</sup> Kathryn P. Derose et al., *Definitions & Determinants: Immigrants and Health Care: Sources of Vulnerability*, 26 HEALTH AFF. 1258, 1262 (2007).

<sup>98</sup> Amanda Machado, *Why Many Latinos Dread going to the Doctor*, ATLANTIC (May 7, 2014), <https://www.theatlantic.com/health/archive/2014/05/why-many-latinos-dread-going-to-the-doctor/361547/>.

<sup>99</sup> MARSHA REGENSTEIN ET AL., *MEDICAL-LEGAL PARTNERSHIP AND HEALTH CENTERS: ADDRESSING PATIENTS' HEALTH-HARMING CIVIL LEGAL NEEDS AS PART OF PRIMARY CARE 3* (Nat'l Ctr. for Med. Legal Partnership 2015), <http://medical-legalpartnership.org/wp-content/uploads/2015/08/Medical-Legal-Partnership-and-Health-Centers.pdf>.

<sup>100</sup> Emily Taylor Poppe & Jeffery J. Rachlinski, *Do Lawyers Matter?: The Effect of Legal Representation in Civil Disputes*, 43 PEPP. L. REV. 881, 922 (2016), <http://digitalcommons.pepperdine.edu/plr/vol43/iss4/1>.

parties were represented.<sup>101</sup> Legal representation also correlated with improved financial awards in domestic law cases. Women have greater odds of receiving alimony when represented in divorce proceedings than when unrepresented.<sup>102</sup> MLP attorneys have represented clients in immigration hearings, a setting in which traditional legal aid offices cannot practice; the MLP can address a range of health-related immigration issues ranging from advocacy for victims of human trafficking, obtaining work permits, and helping individuals and families eligible for status adjustments that can lead not only to citizenship, but also to the freedom to seek regular access to preventive care.

### 5. *Personal Safety*

Abuse causes both immediate and long-term injuries and health conditions, including anxiety and post-traumatic stress disorder, which may require long-term mental health care. Interpersonal violence (IPV) constrains employment opportunity. Victims of IPV are often fired as a result of their abuse—between 21% and 60% lose their jobs from reasons stemming from the abuse, including time off from work to obtain medical, legal, or counseling services.<sup>103</sup> Low income women who experienced IPV had 30% lower odds of maintaining a thirty-hour work week for six or more months when compared to women who did not experience violence.<sup>104</sup>

IPV is associated with homelessness and housing instability, both of which are risk factors for poor health outcomes. Between 22% and 57% of all homeless women report IPV as the immediate cause of their homelessness.<sup>105</sup> However, it is not only the poor who suffer the health impacts of IPV. Affluent victims of abuse lose access to finances. Having an attorney substantially increases the chance of

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<sup>101</sup> Jane C. Murphy, *Engaging with the State: The Growing Reliance on Lawyers and Judges to Protect Battered Women*, 11 J. GENDER, SOC. POL. & LAW 499, 521 (2003).

<sup>102</sup> Poppe & Rachlinski, *supra* note 100, at 923.

<sup>103</sup> Emily F. Rothman et al., *How Employment Helps Female Victims of Intimate Partner Violence: A Qualitative Study*, 12 J. OCCUPATIONAL HEALTH PSYCHOL. 136, 136 (2007).

<sup>104</sup> *Id.*

<sup>105</sup> *Domestic Violence and Homelessness: Statistics (2016)*, FAM. & YOUTH SERVS. BUREAU (June 24, 2016), <https://www.acf.hhs.gov/fysb/resource/dv-homelessness-stats-2016>.

receiving a protection order against a violent partner. One study showed that 83% of women seeking protection from domestic violence successfully got a protective order, while only 32% of unrepresented women succeeded.<sup>106</sup> MLPs have helped IPV victims receive cash assistance, food stamps, change their welfare benefits, and negotiate child support arrangements.<sup>107</sup>

### III. THE EVIDENCE: MLPs POSITIVELY IMPACT PATIENTS, FAMILIES, AND HEALTH

Researchers have identified the relationship between unmet legal needs and poor health in low-income populations.<sup>108</sup> Moreover, evidence has also shown that a patient's unmet legal needs can affect the well-being of an entire family unit. For example, a parent's inability to resolve legal issues may threaten the health and stability of children in the household.<sup>109</sup> Estimates of the percentage of low-income, community health center patients who have unmet legal needs range from 50% to 85%—between 10 million and 17 million patients.<sup>110</sup> The objectives of this study were to understand the nature of the health problems caused by unmet legal needs and to explore the impact the MLP intervention might have on those health issues through interviews with patients who had experience with MLP programs and their families.

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<sup>106</sup> Murphy, *supra* note 101, at 511-12.

<sup>107</sup> Dayna B. Matthew, *The Law as Healer: How Paying for Medical Legal Partnerships Saves Lives and Money*, CTR. FOR HEALTH P. BROOKINGS (Jan. 30, 2017), <https://www.brookings.edu/research/the-law-as-healer-how-paying-for-medical-legal-partnerships-saves-lives-and-money/>.

<sup>108</sup> Peter Shin et al., *Medical-Legal Partnerships: Addressing Legal Needs of Health Center Patients* 10 (Geiger Gibson/RCHN Community Health Foundation Research Collaborative policy research brief 18, 2010), [http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1006&context=sphhs\\_policy\\_ggrchn](http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1006&context=sphhs_policy_ggrchn).

<sup>109</sup> Vivek S. Sankaran & Martha L. Raimon, *Case Closed: Addressing Unmet Legal Needs and Stabilizing Families*, U. MICH. CTR. STUDY SOC. POL. 2 (May 4, 2010), <http://repository.law.umich.edu/cgi/viewcontent.cgi?article=1085&context=other>.

<sup>110</sup> JOEL TEITELBAUM ET AL., *MEDICAL-LEGAL PARTNERSHIP FUNDAMENTALS & STRATEGIES* (Nat'l Ctr. for Med. Legal Partnership 2016), [https://www.americanbar.org/content/dam/aba/directories/pro\\_bono\\_clearinghouse/ejc\\_2016\\_148.authcheckdam.pdf](https://www.americanbar.org/content/dam/aba/directories/pro_bono_clearinghouse/ejc_2016_148.authcheckdam.pdf).

### **A. Study Participants: Medical Legal Partnership Patients and Families**

In 2009, a university-based children's hospital in the Western United States, partnered with the state's Legal Services Corporation (LSC) legal aid provider to form the state's first MLP. For four years, this MLP provided legal services to patients at the children's hospital and ultimately closed in the fifth year for lack of funding. In 2012, two attorneys co-founded an MLP incubator, named after the state, called the "Colorado Health Equity Project (CHEP)." CHEP formed three more smaller MLPs in its first year of operation, using volunteer and student attorneys from the state law school.<sup>111</sup> Law school students and students from the state's public health school collaborated to work with pro bono private attorneys as well as the LCS lawyers in serving poor patients at the children's hospital, and at two other clinical sites. MLPs formed at the safety net hospital clinic specializing in refugee health, and at a federally qualified health center. During its first year of operation, the law-school based MLP provided legal representation to eight families,<sup>112</sup> introduced training to frontline providers in two safety-net health clinics, and provided public policy advocacy on six legislative initiatives during the state's legislative session. The remaining seven consented to interviews along with members of their immediate household and interviews were conducted in accordance with approved IRB protocol.

### **B. Methods**

The eight MLP patients were invited to participate in a one-hour interview with their families to discuss their experience with the MLP. Seven patients agreed to participate and consented using an IRB-approved informed consent form. Six of the patients who consented also brought family members to participate in the interview so that a total of seventeen individuals were interviewed for this study. Each participant received a \$20 Target gift card at the

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<sup>111</sup> For more information about the Colorado Health Equity Project, see *Colorado Health Equity Project*, UNIV. COLO. DENVER, <http://chep.colorado.edu/> (last visited July 31, 2017).

<sup>112</sup> One family was lost to follow-up.

conclusion of the interviews. Patients were offered the option of conducting interviews in Spanish or English, and the option to meet for the interview at the clinic where they received care, or in their homes. Three patients elected to be interviewed in Spanish, and all opted to be interviewed at home. Trained interviewers used a semi-structured patient interview guideline containing a series of questions designed to uncover the legal problem faced by the patient before the MLP intervention. The Guideline then presented semi-structured questions to explore the ways patients' legal problems may have affected the patient or members of the patient's household. For example, researchers inquired how the patient's legal issues, and later the MLP, affected work, finances, accommodation/where the client lived, family relationships and health. Interview transcripts were translated, coded, and transcribed before being provided to the author for coding and analysis in order to protect privacy and confidentiality, and to ensure that the author, a supervising attorney in the CHEP, did not participate in or influence interviews.

### C. Findings

In each of the interviews, the CHEP patient faced multiple legal challenges prior to the MLP intervention. Table 1 summarizes the family structure, legal, mental health and physical health problems patients and their families identified, and the legal outcome of the MLP intervention.

**Table 1. Summary of patient family composition<sup>113</sup> and un-met medical and legal problems before MLP Intervention**

Family Composition	Legal Issues	Physical Health Issues	Mental Health Issues	Other Issues	Legal Outcome
M/F/AS	<b>Housing:</b> Bed bug, roach, and pest infested home (professional exterminator)	Family deferring treatment for all conditions: Leg	Stress Lack of sleep Helplessness Heart-brokenness Sense of	Lack of basic necessities: clothing, kitchen and household items	<b>Housing:</b> Terminated Lease, Relocated  <b>Income:</b>

<sup>113</sup> M - mother; F - father; AS - adult son; AD - adult daughter; S - minor son; D - minor daughter

	<p>declared the trailer uninhabitable)</p> <p><b>Income:</b> Medicaid and food stamps terminated thus family deferring medical care</p>	<p>amputation (F) Cancer (F)</p> <p>Epilepsy (M) Tumors on feet (M) Stomach ulcers (M) Obesity/Unhealthy weight (M/F)</p> <p>Undiagnosed head injury (AS)</p>	isolation	<p>Personal burden placed of medical caring for her husband alone</p>	<p>Medicaid and food stamps re-instated <b>Income:</b> SSI rating and hearing for AS</p>
M/F/D	<p><b>Personal Status</b> Father and children refused to honor court ordered visitation after parental rights terminated</p>	Drug use	<p>Stress: conflict with current husband</p> <p>Powerlessness: Ex-husband made her feel powerless</p> <p>Fear: ex-husband could leave the country with their children, never see them again</p>		<p><b>Personal Status:</b> Visitation plan negotiated and begun but terminated after several visits</p>
M/AD	<p><b>Housing:</b> FEMA funds to replace flood-damaged, molded roof</p> <p><b>Income:</b> Apply for Social Security Disability</p> <p><b>Income:</b> Need for probate assistance after mother's</p>	COPD (oxygen dependent)	Stress over living situation and probate matter	Homelessness (living in car)	<p><b>Housing:</b> FEMA funds obtained and roof repaired. Clean up completed and client housed <b>Income:</b> Unresolved</p>

	death				
M/F/AD	<p><b>Legal Status:</b> Family seeking political asylum</p> <p><b>Employment:</b> Work permit renewal</p>	Trauma	<p>Anxiety Nervousness Insecurity Fear of removal Depression</p>	<p>Disruption to work due to work-permit renewal process</p> <p>Unable to work to obtain basic life necessities while waiting for asylum case</p>	<p><b>Legal Status:</b> Temporarily resolved</p>
M/F/S	<p><b>Legal Status:</b> Parents undocumented</p> <p><b>Housing:</b> Wrongful eviction.</p> <p><b>Housing:</b> S required room for medical equipment but landlord refused</p> <p><b>Employment:</b> F working but sometimes not paid for day labor because of legal status</p>	<p>Congenital tracheal defect; unable to grow or develop normally until surgery at age 3</p>	<p>Stress: Over loss income while caring for son; over son's health;</p> <p>Stress: Inadequate housing and income</p> <p>Fear: Eviction and/or removal</p>	<p>Mother unable to work due to care required for son</p>	<p><b>Legal Status:</b> Unresolved</p> <p><b>Housing:</b> Eviction stopped</p> <p><b>Housing:</b> Relocated to larger apartment</p> <p><b>Employment:</b> Unresolved</p>

M	<b>Income:</b> Disability claim denied	Back injury due to accident at work and recovery from surgery  Depression, helped by medication	Stress: Lack of income and pain from injury	Financial burden on family, living with sister and with mother.	<b>Employment:</b> Workers Comp settlement awarded
M/S	<b>Legal Status:</b> M undocumented and deferring treatment for hyperthyroidism  <b>Income:</b> Unable to work due to legal status	Hyperthyroidism (M)	Stress: Financial instability  Fatigued: Due to untreated chronic health condition	Medication: Could not afford thyroid medication due to unstable employment	<b>Legal Status:</b> M status regularized  <b>Income:</b> M employed due to adjusted legal status. Treatment resumed for M chronic illness

Although each case presented unique challenges and complex layers, three common themes emerged. First, each respondent family identified a clear relationship between the legal issues with which they grappled, and adverse health impacts connected to their inability to resolve or even address those issues alone. Second, the most consistently identified health impact that participants identified was that having unmet legal needs led to stress that adversely affected their mental health and well-being. Without exception, each group interviewed named stress as one of the most significant impacts they experienced from having legal problems they had no way to resolve. Each family interviewed experienced some type of mental health issue associated with this stress, most often described as fatigue or depression, related to the un-addressed legal problems. Third, even respondents who were not completely satisfied with their legal outcomes, clearly experienced relief from stress that led to an improvement in their life circumstances because they had help addressing their legal problems through the MLP intervention. Importantly, each family revealed that the lower stress levels associated with having legal assistance continued to improve their lives, a year following their work with MLP attorneys.

### *1. Stress—The Underappreciated Health Impacts of Unmet Legal Needs*

The most dramatic health finding from this study relates to the prevalence and severity of mental health impacts that unmet legal needs have upon low-income families. Without exception, every patient interviewed, and virtually every family participant identified stress—most without being prompted by a question—as an adverse health impact caused by the inability to address their legal needs. In most cases, the stress was accompanied by a physical diagnosis or manifestation that could not be described as mild or minor. For example, one family seeking political asylum had been exposed to physical and psychological trauma in their home country which could account for some of their susceptibility to mental health issues that surfaced during the interview. However, the adult members of this family identified the complexity and uncertainty of the asylum process as a causal factor of the anxiety and depression diagnoses each had received. Moreover, members of this family had to interrupt their interview in order to regain composure emotionally, because of the stress due to their unresolved legal issues. Similarly, another family that had lived for some years in sub-standard, bug infested housing explained that every member of the household had given up accessing health care, seldom left their home, and had irregular sleeping and eating patterns as a result of the discouragement they felt from their legal circumstances.

The CHEP client who sought visitation with her children admitted she was combative and uncooperative with family members and even with her own legal counsel at the outset of the representation due to the stress and powerlessness she felt over her legal problem. A year later when she was interviewed for this study, her demeanor was notably more conciliatory even though the visitation plan had not wholly met her original goals for reunification. She saw the fact that her MLP attorneys were able to give her a chance to resolve the legal barriers as an important reason her stress decreased, despite the fact that the intervention did not meet all her expectations. Finally, another client who remained hostile and angry after the MLP case ended, cited the fact that the MLP was not able to address all the legal issues she faced. This patient was homeless and living in her car when the MLP began

working with her. By obtaining FEMA funds, arranging a roof repair, and cleaning debris from the yard and house, the student attorneys helped facilitate housing. Yet, the MLP did not undertake and therefore did not resolve the large probate issue she faced. This omission continued to produce anger and stress in her life.

Importantly, participants explained that they experienced a reduction in their stress levels simply from having help from an MLP attorney, notwithstanding the legal outcome. One participant said that while the positive result from going to court on her case was responsible for reducing her stress “big time,” she also indicated that even before the outcome, just having an attorney give attention to her case reduced her stress.

Respondent: *It was very stressful. At the time, I was taking depression pills. . . . They helped me out a lot, they did. They were really good. . . . At the time, I was like so depressed and so stressed out because I was never getting any communication with the disability. I was like “oh my God, what’s going on here?” So, when they started helping me out, just in a few months that they helped me out with, I mean that was so stress free.*

Interviewer: When they started helping you did you feel like your stress was reduced?

Respondent: *Oh, yeah. . . .*

Interviewer: So, would you say that um [sic] that lawyer’s interaction with you – the communications – did that reduce the stress itself?

Respondent: *Yeah it did. It sure did. Cause he was always – we were always in communication. If he didn’t call, I would call. If I didn’t call, he would call me. We were like on top of things communicating. . . . That was just really helpful. . . . [Working with the MLP] really gave me positive . . . perspective. It felt like ah - the world just got off of my back. It rolled off. And it felt – so – cause I felt like everything was just bringing me down. Felt heavy. And so that was quite a lift up.*

This patient indicated the MLP was part of the reason she no longer takes medication to control depression.

A consistent theme in the interviews was that stress associated with unmet legal needs affected the entire family, not just the patient who had the legal problem. For example, housing and income problems spilled over to cause mental health issues for the adult children in one participant’s household.

Respondent: *The homelessness was almost unbearable because there was no place for me, because I had special needs as a disabled person who's oxygen dependent. It's very difficult to go even to a shelter because there was no way that I could set up my oxygen tank and stuff. Then you have to begin earlier than you'd like, so it left me with living in my car. . . . I had no income. I couldn't work. I was borrowing money, and not paying anything. Therefore, I had bills that probably didn't get paid because they just accumulated. . . . Of course, it took a lot of emotional toll on my son and my daughter. They all have also been diagnosed with PTSD or PTS, whatever that is. We're all suffering from it. Of course, some of us are handling it better than others.*

Some participants were able to explain that their unmet legal needs also imposed a financial and systemic cost even beyond their immediate family.

Respondent: *[Homelessness] kept me from being able to keep my illness in control. It costs more money to keep me in the hospital more. I think I was in the hospital probably four, five times, in a six-month period. They weren't short stays. They were seven, ten, fifteen days that kind of stuff. That's how ill I became. Actually, to be honest, it was life threatening.*

The evidence from these interviews helps to described not only the extent of the human burden that unmet legal needs can impose, but also the shared community burden these needs represent overall.

## ***2. MLPs Can Have a Lasting Impact to Reduce Stress and Improve Well-Being***

Importantly, when legal issues were resolved, whether positively or negatively, participants indicated a dramatic improvement in their mental health. One participant came to the MLP seeking to regain custody of her children after her parental rights had been terminated. The MLP did not achieve this outcome. However, with the help of an experienced supervising attorney who dedicated her family law expertise pro bono, student attorneys were able to enforce court visitation orders. They did this, in part, by developing and implementing a family reunification plan with a family counselor who also donated her time and expertise to the project. The outcome was remarkable. At the outset, the hostility and anger among family members prevented even supervised visits. But a year after the MLP relationship ended, the patient explained how the opportunity to see and talk to her children was sufficient to change their long-term relationship.

Interviewer: One thing we're trying to learn is just how those [custody] problems are affecting your life? What was it like before you got that help?

Respondent: *It was way worse. . . . It was way worse. . . . I couldn't do it because I felt like I was under my ex's control. If I did this he would take them away. He would have that power over me but once I got that help from my husband here and [MLP program], it all changed. I have more confidence now. . . . I've learned a lot about the law and how to go about the situations and stuff and what to file. I've learned a lot. . . . How they work with the parenting plan. . . . They taught me how to actually set up a parenting plan and stuff like that, even though it never went my way because I haven't been there.*

This patient explained that though she did not achieve custody, the ability to go to court and require visitation with her children gave her an opportunity to explain her side of the story that had led to the family separation. This opportunity, she explained, was an important outcome of the MLP interaction.

Respondent: *I felt like my kids were being told things that were lies. When we were going through therapy together, they learned some things that weren't true that I tell them the truth. I was honest with them. I didn't lie to them. If they asked me, "mom, why did you get rid of my brother," I straight up told them the truth about it because I had to give up two children. That was because when I was a baby I was actually on drugs and I had to give up that child. . . . I had to tell them the truth.*

Interviewer: It sounds like this has been a pretty difficult process to navigate all this.

Respondent: *Oh yeah. It's been difficult . . . . Before [attorney's name] help in that, I'd been dealing with it since 2010. . . I feel a little relieved and now that the kids know somewhat of the truth . . . .*

This participant continued to explain that in addition to the relief she felt from having the opportunity to speak with her children during the MLP intervention, her own mental health, as well as her relationship with all of her children has improved. Even though the older children remain in their father's custody, the participant has a relationship with them she did not have before working with MLP attorneys. Moreover, she explains she has also improved relationship with her current husband and two younger children.

Interviewer: Did you feel like it stressed you out at all when you [feared not seeing the children]?

Respondent: *Oh yeah. It did. It still does a little but not as much. It affected my relationship with my current husband. We would at the end of the day argue because I was upset.*

Interviewer: Do you feel like that part's been able to get better since all this has been resolved?

Respondent: *Oh yeah. Now that I'm able to concentrate for stabilizing for these two [younger children], knowing that the other three are in good hands and they're not leaving the country. I talk to them on the phone every once in a while or if they need something I send them stuff. . . . I feel like I've been maintaining [stability] more because the least I can do is talk on the phone with them and text message. We Facebook and we do all that. We never used to do that. I think we're doing a good progress. I think after a while they're going to want to come over. They actually see their sisters every so often.*

This family's story suggests that legal representation helps more than just the immediate patient, and can last well beyond the conclusion of the legal case. Perhaps the most telling change in this client's story, is the hope she has for the future, now that she has reestablished some family stability. In her words,

Respondent: *Before I felt like giving up and going back to drugs and everything but not anymore. I've got too much to live for. . . .*

In many cases, MLP attorneys could not solve all of the clients' legal problems, and the intervention lasted only for the time needed to resolve specific legal issues undertaken in the legal representation. Several study participants felt this was a shortcoming. Participants explained the MLP intervention should have lasted longer, or should have offered more comprehensive legal services. In the case of this same participant, she explained:

Respondent: *It was helpful. I's [sic] just I think the communication between everybody, especially the students that were supposed to be working with more . . . I love [supervising attorney]. She helped out a lot but I think they should have been involved a little bit more so they can learn. . . . They needed more help to continue a little longer.*

These shortcomings persisted even in the case where an MLP intervention was able to make a dramatic difference with one legal issue, but not with all. For example, MLP attorneys helped one participant, who was an oxygen dependent COPD patient, transition from being homeless and living in her car, to having a stable home

she owned and occupied a year after the MLP ended. Yet, from the outset, the MLP attorneys could not represent this client in the probate and will contest issues she faced. These issues were outside the scope of the MLP's representation. But they are unmet legal needs that remain central to this participant's life.

Interviewer: What we're going to talk about now is how the medical-legal partnership helped with any of these problems to the extent that it did help. The first question is what . . . were they able to do for you?

Respondent: *Like I said they got me the . . . cut a little bit of the [red] tape and got me my FEMA right away. There was nothing else that they could help me with. . . . They were only able to work on my case for four weeks or something like that, because they graduated, and then that was the end of it. They didn't really even get into my issues because they weren't there long enough to do anything . . . .*

Interviewer: How do you think that working with the medical-legal partnership . . . How do you think it affected your life?

Respondent: *For that moment, I felt relief, that I wasn't in it by myself, so it helped with that way . . . I really don't think that they should dabble in people's legal affairs or their whatever unless they're willing to follow it through.*

This participant was willing to admit that the MLP got her back into her home, helped repair her home, and thus reduced her stress level. But she clearly felt abandoned by the end of the program when her other legal problems persisted.

#### IV. DISCUSSION AND POLICY IMPLICATIONS

Although a strong consensus has developed around the understanding that improving population health outcomes will require significant increases in spending on social care, evidence is still emerging to show how and to what extent mitigating social risks can improve health. Therefore, payers have yet to embrace reimbursement for addressing the social determinants of health.<sup>114</sup>

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<sup>114</sup> See Institute of Medicine, *Paying for Population Health Improvement: An Overview, in FINANCING POPULATION HEALTH IMPROVEMENT: WORKSHOP SUMMARY* (Nat'l Acad. Press 2015), <https://www.ncbi.nlm.nih.gov/books/NBK284858/>.

Even interventions, such as the Medical Legal Partnership model which has been shown to positively impact patient health outcomes, have not yet been fully reimbursed by payers or included broadly in providers' operating expense budgets. Insufficient attention has been given to shifting health care dollars in the system from end user payment for health care services to upstream etiologies for addressing poor health. Upstream services are largely focused on social care and services. This study adds additional evidence to support the case for financing social interventions to achieve long term health and cost improvements.

Two observations about the legal issues in this study are noteworthy. First, the type and frequency of legal problems participants in this study experienced mirrored the national data. Income and housing problems are the legal concerns that most often represent barriers to healthy living for low income families both nationally and in this study. Half of the families in this study had at least one housing or income issue that required legal representation to resolve, and in two of three cases where housing was an issue, the family also had a legal problem related to income. At the same time, MLPs have a track record of effectively resolving these issues for patients and their families. In this study, housing problems were among the most severe legal issues raised, and in each case, the MLP teams were able to resolve housing problems favorably for patients. This outcome is especially significant given the shortage of affordable housing that low income families face. The legal representation participant families received allowed included steps that attorneys are uniquely positioned to undertake such as initiating condemnation proceedings, appealing wrongful benefit terminations, assembling evidence and arguing for a disability rating, and communicating a willingness to take a landlord to court. These measures influenced the speed and quality of dispositions achieved. Second, where legal status issues could be addressed, the resolution dramatically improved the entire family's financial and health prospects. Regularizing legal status changed access to health care for the chronically ill patient participant, facilitated employment, and dramatically reduced stress. In contrast, the patients and family members for whom the MLP could not improve legal status, or could not get help with other legal issues, continued to experience adverse

physical and mental health consequences. Importantly, these consequences reverberated throughout families and even to communities beyond the family.

## CONCLUSION

The case is emerging to support sustained financing that addresses not only biomedical needs, but the social determinants that importantly influence population health. One important, but understudied mechanism by which the social determinants adversely influence health is related to the impact that stress has on patients who are exposed to significant social risks. Medical-legal partnerships have been shown to improve patient access to income, public benefits, education, decent housing, and personal safety. However, this study adds depth to that evidence, by increasing the understanding of the prevalence, severity, and breadth of the costly burden that that stress and mental health problems associated with unmet legal needs can impose on patients, families, and society. This contribution is particularly significant as the evidence that stress adversely affects health. The link between MLP interventions and stress relief warrants further study to strengthen the evidence that payers may rely upon to sustainably finance this and other social interventions as an approach to improve population health.