A map of the Greater Toronto Area (GTA) is the background of the page. The map is divided into numerous small, irregularly shaped regions, each filled with a different shade of orange or yellow. The colors range from light yellow to dark orange, suggesting a thematic map, possibly related to population density, economic activity, or administrative boundaries. The map shows the dense urban core of Toronto and the surrounding suburban and rural areas.

GTA Legal Clinics  
Transformation Project

# Vision Report

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# A: INTRODUCTION



Ontario's community legal clinics have been at the forefront of improving access to justice since they were first established just more than 40 years ago. In providing legal services to the poorest, legal clinics and their staff have improved access to the justice system. Through effective advocacy and in working on test cases, law-reform projects and community development, they have changed laws and communities so that individuals and groups have more meaningful and just communities in which to live, work and play. In virtually every area of clinic law, community legal clinics have made lasting differences for their clients' benefit.

They have done this by changing with the times. Clinics have grown from a handful of low-tech local offices in a few neighbourhoods to a systematic network of computerized clinics with expanded boundaries that serve large, complex communities in all areas of the province. Clinics have dealt with political adversity, poor pay for staff, diminished support from their funder, greater reporting requirements and inadequate resources. Despite a host of challenges and ever increasing poverty, clinics are still widely respected and treasured community assets. Clinics have attracted bright and committed young advocates and retained expert and respected older advocates; they are respected participants in the justice system who are routinely consulted on all manner of procedural and substantive legal issues. Clinic staff work together, rely on each other and are engaged at all levels, working on behalf of their clients and the community. Above all, clinics are rooted in the communities they serve.

Their work, however, is a work in progress. In the Greater Toronto Area (GTA), still far too many people face barriers in accessing the justice system and in realizing just outcomes when dealing with legal issues. The communities that clinics serve have been changing and shifting over the past 40 years. Poverty is more widespread than ever – its skin colour mostly not white – and is frequently compounded by poor health, especially poor mental health. Demand on and for clinic services has been increasing and becoming more and more complex. Clinics are facing inexorable challenges in meeting the needs of their clients. Demand is simply overwhelming the system and many clinics and staff members are becoming casework machines with increasingly narrow terms of service.

Moreover, these changes are taking place in a funding context that, while stable, has been flat-lined for almost 15 years. Since 2000, Legal Aid Ontario (LAO) has not provided funding for new general staff positions in its GTA clinics. During that same period, the number of households in the GTA living below the poverty line has more than doubled in York Region and Peel, and increased by 20% in Toronto. In addition, LAO has reduced access to legal-aid certificates generally, and stopped issuing any for civil matters (other than family, refugee, some immigration and mental-health cases), leaving community clinics as the only recourse for low-income people facing civil legal challenges.

While the need for additional funding for community legal clinics is more obvious than ever, the community legal clinics in the GTA acknowledged that it was not the only answer. They decided it was time to examine whether they could provide services to people living in poverty more effectively and more efficiently if they redefined how they do their work. While the clinics' desire for organizational change is primarily driven by the desire to serve their clients better – and to serve more of them – clinics also know that their clients want more uniform access to services, that their partners want greater collaboration and that their funders want them to be



administratively leaner. Clinics are feeling the pressure to change from all stakeholders, and it because these aspirations all have some resonance that they decided to undertake this Project.

Through earlier work the GTA clinics were aware of a number of systemic weaknesses in the way they were operating:

- Catchment areas vary widely in size and population without any clear underlying rationale, resulting in unequal service capacity and poor alignment between needs and resources.
- Catchment areas rarely reflect coherent service areas or geographically concentrated need.
- Services offered to clients are inconsistent from clinic to clinic.
- Internal capacity varies widely among clinics but all are too small to cope effectively with staffing and human-resource issues or partnership and volunteer development.
- Clinics operate as small, independent organizations without the capacity to develop administrative or technological systems that would allow them to work more efficiently to respond to client needs.
- While efficiencies could be realized by working together, there is no capacity to organize or co-ordinate the working together.
- The clinics wanted to explore whether:
  - » Community legal clinics could restructure in ways that would allow for more people living below the poverty line to access their services;
  - » Clinics could realize significant advantages in service delivery if they considered redrawing their catchment areas to better reflect client needs;
  - » Reorganized, larger clinics would be able to gain economies of scale that could increase front-line services, expand community engagement and improve support for clients.

The GTA clinics agreed to work together to study and consider, based on the evidence, what a transformed community legal clinic system could look like. The GTA Clinics Transformation Project is the result of their desire to find ways to provide enhanced services. This Vision Report completes the first phase of the Project.

What we have is a re-imagination of what the clinic system might look like in the years ahead. That is why this Report is called a Vision Report. It is the first step. Before we can change, we need to agree on the change we are making. If there is agreement, then the next step of planning how we get there can begin. And then, if we agree with the plan, we can commit to the task of implementing transformation.

The Vision for a new community legal clinic system in the GTA begins with clinic strengths. The Project was based on a belief that any clinic model developed must be community responsive, client-centered and governed by a community Board of Directors. We were also united in our commitment to ensuring that clinics must continue to offer a full range of community legal clinic services, including direct client services, law reform, public legal education and community development.

From the outset, we realized that we had to address the fact that the allocation of human resources among the clinics needed to address the changes that have occurred in regards to

the location of the GTA's low-income populations. We also recognized that to expand and enhance service delivery, and to leverage existing as well as any new resources, clinics needed to be larger.



Together (our Steering Committee was made of up staff and Board representatives from each of the 16 participating clinics), we developed a new model for our work. We worked hard in resisting the urge to jump to conclusions. Instead we patiently waded through qualitative and quantitative data, heard the summaries of what others had written on related subjects, and developed a set of principles that we felt were needed to guide our thinking and decision making.

Our conclusions are:

- Access to our services can be improved, and we can provide better services if we partner more with community agencies to provide services to our clients;
- We can do more for our clients if our staff work in teams and have backup support;
- We need to be better at co-ordinating clinic services and ensure that core client services are more uniformly available;
- We need to increase the number of staff who are primarily engaged in front-line services;
- To accomplish the necessary changes we need to return to a commitment to do more community development work;
- We need to be – and can be – more administratively efficient;
- We can increase the resources available to do our work by implementing these changes.

We realize these changes will take significant time, effort and commitment on the part of all participants; they are changes that matter, however, and it is important that clinics take the time to get them right. When this Project, started there was a lot of fear in the environment – fear that Legal Aid Ontario was interested in cutting clinic budgets, probably requiring layoffs and thereby constraining their capacity to serve clients. To move ahead it was essential that clinics' budgets not be cut and that they be able to reinvest savings in new services. The Project was able to negotiate an agreement with LAO that budgets would not be cut and that any savings realized through transformation would be reinvested in clinic services. With the cloud of budget cutbacks and staff layoffs lifted from the Project it was possible to move forward with defining the new Vision.

The community legal clinics of the GTA have changed drastically from what they were 30 and 40 years ago. We know that survival depends on adaptation. The Vision set out in this report aligns with the Strategic Plan developed by the Association of Community Legal Clinics of Ontario in 2012. We are building on our foundational strengths: our connection with our communities and our commitment to work with and on behalf of our clients.



## B: CHALLENGES

The GTA Clinics Transformation Project brought together clinics from across the GTA in a Steering Committee to identify the best way to help low-income resident access justice services.

As a first step in getting it right, we had to be willing to face what we are getting wrong. The Steering Committee did not shy away from reviewing the evidence and determining the challenges facing the clinic system.

### WHAT WE SAW

A demographic analysis of low-income populations showed changes that resulted in a poor correlation between clinic services and community needs. (For details on the research undertaken, please see Section F: Research.)

#### CLINICS ARE NOT WHERE THEY NEED TO BE, MAKING ACCESS HARDER

Demographic mapping showed low-income populations are not located near clinic offices. It also showed that clients tended to come from the areas closest to the offices, rather than the areas of greatest need. Physical proximity had a significant impact on access for high-needs communities, and the clinic system was not well designed to address this.

#### CLINICS SERVICES DO NOT MATCH COMMUNITY NEEDS

Demographic mapping also showed that low-income immigrants and people relying on Ontario Works, disability benefits and other income supports were all facing similar challenges. These maps also showed wide distribution of all of these needs but uneven distribution of services, with clinics in high immigrant neighbourhoods offering no immigration law.

#### “COMMUNITY CLINICS” ARE RARELY “NEIGHBOURHOOD CLINICS”

With 140 neighborhoods in Toronto, most of our 14 community clinics were bound to encompass far more than one neighbourhood. Even Kensington Bellwoods, an exceptionally small clinic, covers communities as diverse as Chinatown, the Annex, Little Italy and the towering waterfront condos. But most are much larger still, covering more than a dozen distinct communities housing hundreds of thousands of residents. This creates a need for most clinics to reflect a broad range of populations on their Boards, in their outreach and in their planning, something often strained by the limitations on outreach staff given high caseload volumes. It requires existing clinics to develop strategies that enable them to reach across wide geographies, which they consistently find a challenge using the current model.

### WHAT WE HEARD

Interviews and focus groups with hundreds of staff, clients, Board members and community partners showed more challenges facing clinics. (For details on the consultations undertaken, please see Section G: Consultation.)



## STAFF ARE OVERWHELMED AND UNDER-SUPPORTED



The number of files has grown and the pressure on staff is constant. Most staff work alone in a particular area of law and have no backup when they are sick, away or simply swamped. This affects staff and their clients.

## HOLISTIC SUPPORTS ARE NEEDED

Mental-health supports, social workers and housing workers are all components of ongoing client needs. Legal workers attempt amateur mental-health support in an effort to support clients through their legal struggles with mixed results. Few clinics have on-site capacity in these fields.

## PARTNERSHIPS ARE CRITICAL BUT UNDER-RESOURCED

Partners are critical to providing the supports that clients need. Community-service providers can offer the social, mental and other supports for legal clinic clients, but systematic partnerships are hard to sustain. Most clinics have too little administrative capacity and too little dedicated outreach capacity to support ongoing, systematic partnerships.

## COMMUNITY DEVELOPMENT AND PUBLIC LEGAL EDUCATION ARE GETTING SQUEEZED OUT

Virtually all clinics find it impossible to sustain their commitment to outreach, community development and public legal education. The pressure on files simply overwhelms staff.

## AREAS OF LAW ARE A PROBLEM

Clients need service in more areas of law, including employment law and immigration law, which are offered intermittently, and family, consumer and criminal law, which are virtually never available. Inconsistencies in the services mean people cannot access some areas of law depending on where they live.

## MOST CURRENT CLINIC CATCHMENTS ARE ALREADY TOO LARGE FOR “WALK-TO”

Clients and staff agree that transportation and access are a challenge. Most clinics see far less of the people in the most far-flung areas of their catchments than they do those who are close by. They note that when they change locations they lose clients from the old area and gain others from the new location. Some clinics have successfully tackled the problem with satellites, local access points and mobile services, but most struggle to engage their whole geography.

## THERE ARE NOT ENOUGH RESOURCES TO MEET THE NEED

Clinics are too small, too stretched and often too narrowly focused to meet the range of needs low-income people face. More resources and more capacity are needed.



## CLINIC LEGAL EDUCATION IS COMPLEX AND NEEDS CAREFUL ATTENTION

While many clinics work with students in many ways, a systematic clinic legal-education program is an important source of training for the next generation of clinic lawyers and poverty-law workers. Transitions can have an adverse impact on complex programs unless carefully planning with all partners is included.

## WHAT WE FOUND IN RESEARCH

A literature review of best practices in other jurisdictions, and learnings from experiments in poverty-law services in Canada and around the world, showed some clear patterns that drive success and failure.

### CLINICS DO BETTER WHEN THEY DRAW ON WELL-SUPPORTED RELATIONSHIPS

- The advantage that clinic models have over judicare models of service is the relationships that staff develop from working consistently in poverty law.
- Clinic staff have relationships with adjudicators and tribunal staff that help them negotiate better outcomes for clients, and do so more quickly.
- Clinic staff have relationships with other service providers that enable them to link clients to more holistic services.
- Clinic staff have relationships with other organizations that can help identify people with legal needs and link clinics to those clients.

Unfortunately, clinics are also often overwhelmed and, as a result, cannot commit the time and energy needed to sustain consistent relationships. Their partners find this a challenge.

### THERE IS MORE VOLUNTEER AND PRO BONO CAPACITY AVAILABLE THAN CLINICS HAVE USED

Many jurisdictions draw more extensively on pro bono lawyers, students and volunteers. Where they use that to enhance capacity, rather than displace core services, these models are successful. However, clinics need the internal capacity to recruit, train and support volunteers well if the standards of service, in the unique context of poverty law, are going to be maintained.

### A DIVERSITY OF COMMUNITY LEADERSHIP IS NECESSARY FOR RESPONSIVE SERVICE

Community governance brings many different voices to the leadership of the clinic system, helping clinics respond to the changing needs of clients in sensitive and appropriate ways. However, while Board members bring knowledge and awareness of their constituencies, they also need to draw on more than their personal experience to fully reflect the needs of the community. No Board can be so representative that all aspects of the community, large or small are reflected. This makes outreach, and staff-supported efforts to learn from the community, a key to success. Unfortunately, the pressures of casework frequently override the commitment to do community work. Consequently, clinics with little outreach capacity can find themselves less connected to the community than those that sustain systematic engagement.

## THERE IS DEMAND FOR MORE AREAS OF LAW



Research shows consistent demand for services in more areas of law. It also shows that certificates for legal aid in these areas are decreasingly effective as a tool to deliver service. Similarly, Duty Counsel who do not connect to a clinic provide less consistency of service for long-term cases. Diversification of areas for law in clinics is a growing need.

## SMALL STAFF TEAMS ARE A BARRIER TO EFFECTIVE MODELS OF SERVICE

Research points to the success of staffing models that are integrated and team-oriented. Integrated models make effective use of a wide variety of skills, allowing staff to draw on a range of knowledge, and can provide support to other team members on an ongoing basis. These teams can include lawyers, paralegals, pro bono lawyers, articling students and community organizers. Clinics that are too small to form teams are prevented from using this model.

## INCREASED SIZE ENABLED THE HAMILTON CLINIC TO IMPROVE SERVICES

The merger of three Hamilton clinics into one large clinic enabled the organization to expand outreach to new groups, create same-day advice service, deliver new areas of law, increase community engagement and significantly improve their volunteer co-ordination. All that added work was achieved while reducing, rather than increasing, staff stress.

# C: PRINCIPLES AND APPROACHES

The Project took on the task of reimagining the clinic system in a way that addressed the barriers clients face.

The effort to address those challenges drew on the experiences of clinic staff, clients, Boards and partners to develop a model that addresses the challenges we face.

To draw on best practices from around the world, the Project also reviewed literature on poverty law for examples of effective service and also for lessons on what to avoid. (For details on the literature review undertaken, please see Section H: Literature.)

## PRINCIPLES

To ensure that any solution reflected the fundamental priorities of the clinic system, principles were adopted to guide the choices being made. The Steering Committee adopted 30 principles that guide both the structure of new clinics and the policies under which they should operate. (For a detailed account of the principles and the research leading to their adoption, please see Section H: Guiding Principles.)

In summary, the principles offer the following guidance:



## CONNECTION TO THE COMMUNITY IS FUNDAMENTAL

New clinics should have community Boards, local accountability and a commitment to community development, outreach and public legal education.

## CLIENTS NEED INTEGRATED, CO-ORDINATED SERVICES

Seamless clinic law services are best, with multiple areas of law and access to advice in integrated clinic-law systems. They need multidisciplinary staff teams that provide holistic supports, either internally or in partnership with other services.

## ACCESS IMPROVEMENTS SHOULD BE DEVELOPED

Creating community access locations through partners should be part of a broader client-access strategy that includes multiple gateways to improve client access and efforts at harmonized intake.

## CLINICS NEED TO SUPPORT THEIR STAFF BETTER

Clinic staff need better backup. This includes working in teams and using volunteers, students and pro bono lawyers to add capacity. It also involves working collaboratively with partners to support clients, offering legal education to partner staff and engaging in joint outreach.

Office systems need to improve as well, including technology, human resources, communications and support, especially through transition periods.

## PARTNERSHIPS ARE IMPORTANT AND NEED RESOURCES

Clear relationships with community partners require time to create and sustain them. Proactive development and maintenance of partnerships, legal education for partners and their clients, active referrals, joint outreach and collaborating on access points all contribute to this.

## THE SYSTEM NEEDS TO DO MORE

Reinvestment is essential to the success of the clinic system. It allows for expansion of the areas of law, consistent service across common needs, and ongoing enhancements that reflect need. It enables clinics to support low-income communities that have unmet needs, and address areas that need law reform and where the clinic system can be an effective advocate

## CLINIC DESIGN CRITERIA SHOULD REFLECT THE CURRENT CONTEXT

In addition to creating flexible systems that have the right structure to support the operating principles and allow the right staff to do the right job, we recognize that some structural rules are worth following. Municipal boundaries matter and should be respected in creating new clinics. Resource allocation does not reflect population distribution and should.

# D: MODEL CLINIC



The Steering Committee jointly developed a Model Clinic organizational chart using an open discussion process, based on the principles they adopted.

For each aspect of the organizational chart, participants applied the learnings from the research and proposed to the group a structural element for the Model Clinic.

## THE MODEL

### GOVERNANCE

The Steering Committee generally agreed that there should be an **Executive Director** for the clinic.

The Steering Committee agreed that each clinic should maintain local control and community governance by having the ED report to a **community Board of directors**.

### AREAS OF LAW

The Steering Committee drew on the principle that there needed to be **expanded areas of law** that were available from all clinics. They agreed that there would be **four areas that all GTA clinics ought to provide**, with income supports, housing, immigration and employment law being the most likely candidates.

### ACCESS POINTS

The model depends on creating multiple points of access for service. The model calls on clinic staff and volunteers to be present, regularly, in all parts of the catchment, close to where clients live. This can only be achieved if clinics have the outreach capacity to identify issues and plan responses, the administrative capacity to connect to partners systematically, and the volunteer support to enable pro bono and student assistance to expand their reach.

### STAFF TEAMS

The Steering Committee drew on the principles related to staff support and team models to determine that **each area of law should be delivered by a team**. Without teams, all demand in a singular area, such as immigration, is expected to be met by one staff member without backup or support. In this model, each team is composed of two or more staff.

For co-ordination, the Steering Committee decided that each team should be supported by a **Team Leader** who will provide leadership, delegate tasks and participate in activities such as performance reviews, but who will not be a manager responsible for human-resource functions including hiring, firing or disciplinary measures. Each team should report to an Executive Director who can provide legal leadership to staff.



To design the individual teams, the Steering Committee drew on research on volumes of work in each area of law.

The Income Support Team is the largest due to the volume of demand in that area. Presently, income-support work, which includes ODSP work, accounts for more than 50% of GTA clinic file openings. An ODSP case-management system is recommended because it would increase the efficiency of the team by assigning case managers to carry out a high volume of routine, non-legal tasks that are typically required in the ODSP work. An effective case-management system should reduce the amount of time that high-priced legal staff are required, increasing capacity in other areas.

Housing files make up between 20% and 25% of casework. The Steering Committee created a **Housing Team** that reflects a caseload of 22% of casework staff.

The **Immigration Team and Workers' Rights Team** each account for 10% of the caseworkers, which represents an increase from the current volume of work done in those areas for most clinics. They have been expanded in an effort to respond to unmet need.

## OUTREACH

The Steering Committee decided on a significant increase in community workers by dedicating four workers to the **Community Outreach Team**. Community work is integral to clinic work but has suffered due to the immediate pressures of casework. Very few clinics in the current system have dedicated community workers, even though research shows this to be a best practice. Community workers in this model can function in their own team but also be connected to an area-of-law team. This will allow workers to acquire specialization and in-depth knowledge of issues that are important to their communities, and to inform the work of the area-of-law team.

## ADVICE

Research shows it is a best practice to embed advice staff into the clinic but still focus on the key skills that ensure effective service. This is reflected in the Model Clinic, with 25% of front legal staff assigned to this function, consistent with current volumes. As with community workers, advice staff can function as an **Advice Team** while being attached to an area of law. Specialization will enhance the ability to provide appropriate advice.

## ADMINISTRATION

The Steering Committee recognized the important role that administrative and support staff play in the effective delivery of community legal services. It is most efficient for legal staff to focus on casework rather than being tied up in administrative duties, which, while essential, can be time consuming. The Committee created an Administrative Team, sized to enable them to address this demand. The Steering Committee also recognized that maintaining formalized community partnerships and volunteer programs requires appropriate administrative supports, thus ensuring that the team accommodates some volunteer support and interagency communications. This team is also responsible for reception, intake and referrals. They are led by an Office Manager and include reception/human resource/referral staff and support staff, one of whom will provide backup for the Office Manager.



# PARTNERS



Supporting multidisciplinary holistic service is a principle of the transformation process, and so the process should protect and replicate, wherever possible, the innovations and best practices found in the current system. These include the student experiential learning program as well as the addition of municipally and federally funded social-service positions such as housing workers and social workers. The model chart captures this in the “**Other resources, partners, programs**” heading.

Some clinics, including Rexdale, bring **Duty Council** on site to provide legal support, and other clinics bring on site external staff, such as **Housing Staff** or **Mental-Health Staff**, to do issue-specific work. This is important to developing a multifaceted system that is responsive to multiple and complex client needs and is also reflected in the model organizational chart. Dedicated management time to support and develop partnerships enables the growth of these relationships, as do dedicated community-outreach staff and administrative supports.

# VOLUNTEERS

The principle calling for the new clinics to enhance, formalize and maintain mutually beneficial partnerships with **students and pro bono lawyers** requires commitments of staff time. These volunteers will help the clinics meet the needs of clients but will require staff time for recruitment, training and support. The Steering Committee relied on dedicated management time for the Executive Director and volunteer support time for the administrative staff to enable the increased use of volunteers.

# ENHANCED FRONT-LINE PRESENCE

By **reducing the number of clinics** and **consolidating administrative tasks**, this new model shifts more resources to the front lines. In this model, as much as **79% of staff are engaged in casework or community development**, a significant increase from the current models. This is possible because so much of the past administrative time was spent on redundant functions. With 17 clinics, 17 office managers and 17 receptionists repeated what was being done in adjoining clinics while 17 Executive Directors produced 17 funding applications and completed 17 financial reports from 17 bookkeepers and auditors. Similar economies can be found in the management of IT, phone systems and HR policies. Reducing redundant functions has a significant impact on service levels without affecting real administrative capacity.

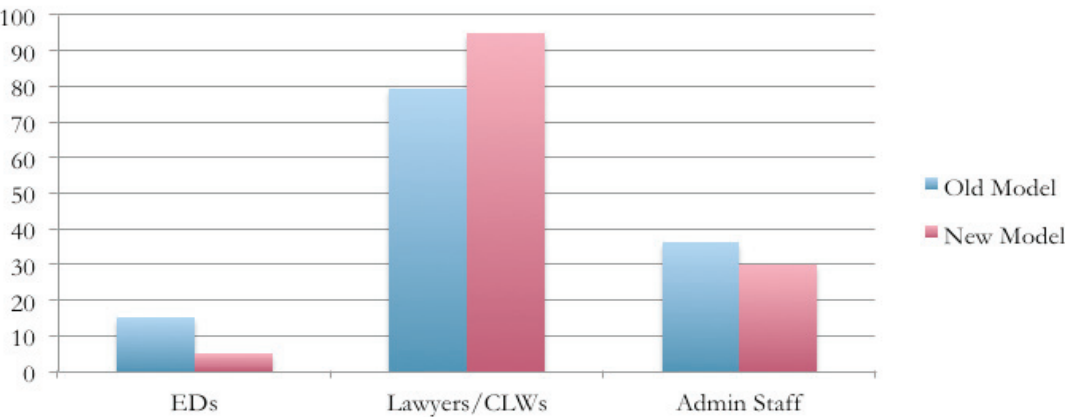


FIGURE 1: ORGANIZATIONAL CHART FOR THE MODEL CLINIC



## CLINICAL LEGAL EDUCATION

The Steering Committee also recognized the need for preserving a clinical legal-education program in the GTA. The clinic system benefits from having a program dedicated to the development of “next generation” clinic lawyers. The support of a university partnership also brings benefits to the clinic system: research and evaluation capacity, training capacity, support for law-reform initiatives, the potential for community/university partnerships, engagement of academics with Legal Aid Ontario and academic interest in the study of clinic services. All of these benefits make the university/clinic alliance an important one.

The practice of community lawyering holds that clinic services need to move beyond the provision of advice and representation to individuals and seek to enable social change. A clinical legal-education program therefore needs to be more than skills training. It must expose students to the theory and practice of lawyering for social change and include a managed approach to apportioning time between casework and community work, along with strategies for systemic reform. Part of this practice needs also to include research and writing looking at issues in securing justice for low-income individuals and disadvantaged communities, plus new strategies for advancements in social justice.

This requires supervision staff who engage students in critical questioning, guide reflection of their work and teach them the practice of working collaboratively with clients and colleagues. Therefore, caseloads must be limited to the capacity for responsible supervision.

The complexities of the relationship of the clinical legal-education program, the Intensive Program in Poverty Law at Parkdale and the transformed model of service delivery will need to be further explored as the future planning of the program involves significant operational detail. For the purposes of looking at resource allocation in this report, the clinical legal-education program has been allocated five staff that would be dedicated to student supervision and program support. The other staff that are required by the program also provide (with the students) general services in both client service and community-development work, so they have been included in the total allocation numbers.

## OTHER CENTRALIZED SERVICES

The Steering Committee also looked at other centralized service opportunities. A natural synergy is to look to the clinical legal-education program to provide training and supports to other clinics on incorporating law and paralegal students into their work on a volunteer work-experience basis. Another is to have a central repository for public legal education, so that basic information is standard through the GTA and available to clinics to customize for their particular communities. Training of pro bono volunteer staff can also happen centrally, or be resourced with centrally produced materials and curriculum. Finally, given the number of projects looking at the centralization of “back office” services in the clinic system, there seems to be potential for some administrative savings in this area, but the details of this are too dependent on other operational decisions. These services could include human-resource services, financial services and efficiencies of purchasing supplies and services.

## COLLABORATION AGREEMENT

A more critical part of the transformed Vision is the extent to which the new clinics will need to work together as a legal clinic system in order to maintain the important aspects of the

transformed model. Although there are instances of inter-clinic co-operation (the inter-clinic work groups are a prime example, along with a general willingness to take referrals) clinics in the GTA have not always worked together to ensure harmonization of policies and procedures. Collaboration around sharing knowledge and training can also be improved. The transformed system should build on the legacy of co-operation. We need to ensure harmonization of human-resource policies in order to maintain staff mobility between clinics, and maintain the agreed-upon standard legal services in order to ensure consistent levels of service throughout the GTA. As independent institutions with community governance, clinics will have the capacity to make their own choices about their programs and policies, but a voluntary inter-clinic agreement can augment the quality and consistency of the legal clinic system for clients, community partners and staff. It can also assist in coordinating efforts to produce shared strategies, ideas and materials and while minimizing the demand on staff.



## THE SIZE OF CLINICS

In facilitated large group discussions, the Steering Committee discussed which functions a Model Clinic should contain that would enable the transformed system to provide enhanced and accessible legal services. The organizational chart was built block by block and went through numerous revisions before the Steering Committee decided on the optimal chart as presented here.

The eventual size of the clinic was not pre-determined; it resulted from assembling a structure that would meet the required functions and principles outlined below.

In developing the model, the Steering Committee created two ODSP case management teams (with one case manager and two caseworkers each) and added two other income support staff for Ontario Works and other income-support work. As a result, the team was composed of eight staff: one team lead, two ODSP case managers and five caseworkers accounting for about 30% of all casework staff.

By extension, the Housing Team, which currently reflects 22% of casework staff time, would need one Team Leader and four caseworkers. Similarly, an Immigration Team and the Workers' Rights Team would each be composed of a team lead and one caseworker, reflecting that proportion of work. Advice makes up about 25% of all casework. As a result, the Steering Committee assigned four advice staff and an Advice Team lead. In an effort to expand the community-outreach work, the Steering Committee assigned four outreach workers to each Model Clinic. The Steering Committee assigned the Administrative Team an Office Manager, two reception/human resource/referral staff and three support staff, one of whom will provide backup for the Office Manager.

These decisions result in the organizational chart presented below. This iteration of the model produces a staff team of 33. While this reflects the choices made by the Steering Committee, this is not an inflexible template. There are a variety of modifications that could alter this number to some extent. Increase in focus on housing or employment law could expand those teams. The emergence of more routine aspects of housing law might argue for case management model in that field in the future. Significant improvements in technology might decrease the demand on the administrative team. Consequently, the 33-member staff team and the specifics of the organizational chart are informative a guide, not a strict rule.

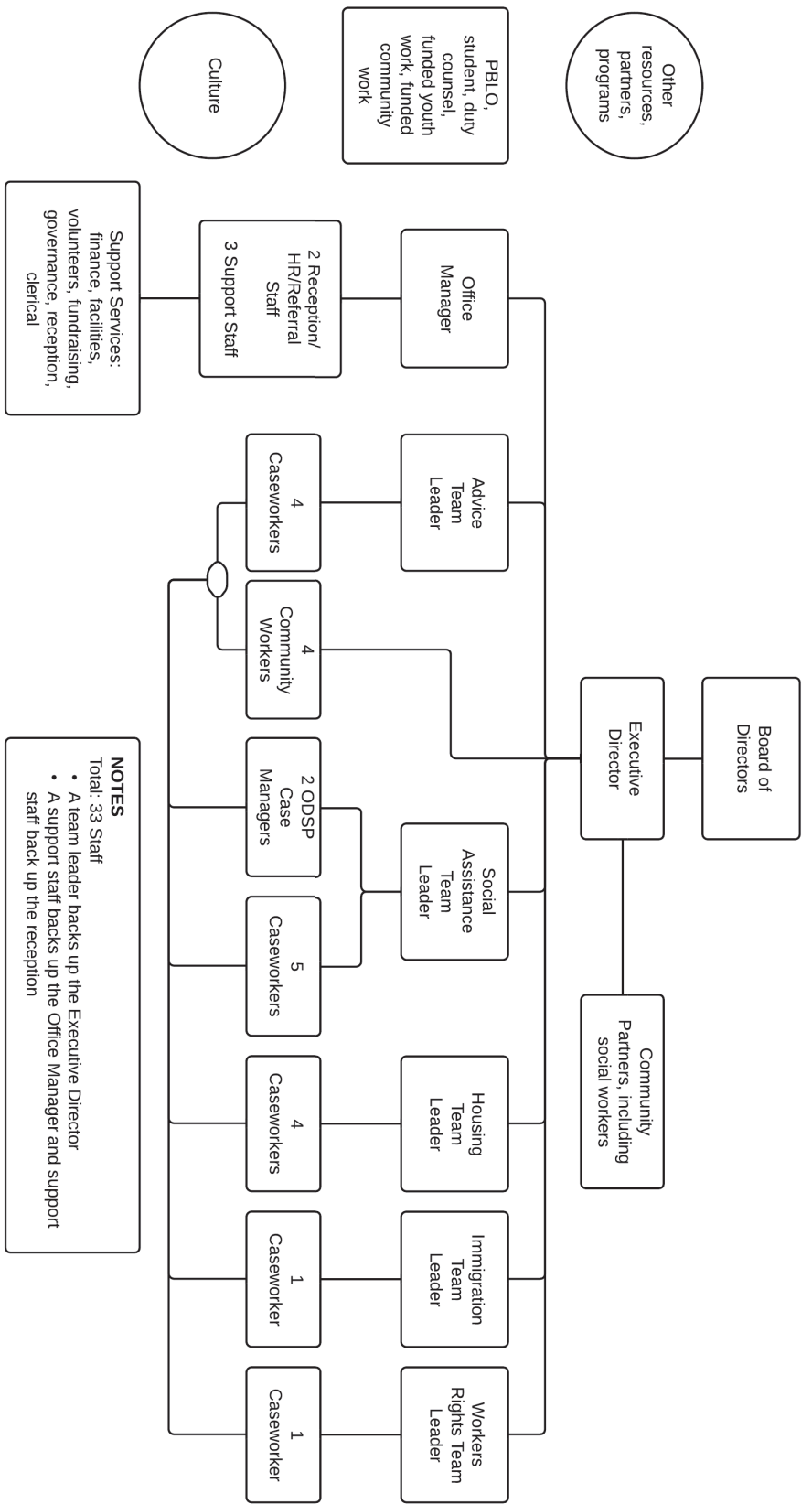


FIGURE 2: ORGANIZATIONAL CHART FOR THE MODEL CLINIC

## ALTERNATIVES TO THE MODEL CLINIC



Steering Committee members recognized that the 33-person clinic was significantly larger than standard clinics in the GTA, which caused some concern. However, it was also noted that the clinic most frequently given as an example of good practice was also, by far, the GTA's largest: Despite its unusually large size, Parkdale Community Legal Services was seen as neither excessive or bureaucratic, but rather capacious.

Nonetheless, recognizing that the 33-member clinic was not cast in stone, the Steering Committee reviewed alternatives to the model that reduced the staffing compliment.

### 26-PERSON CLINICS

One option is to reduce the team to 26 staff by proportionally reducing the largest teams. One way to reach that target is by taking:

- One staff from the Housing Team;
- One staff from the Advice Team;
- Two staff from the Income Support Team;
- Two staff from the Community Engagement Team;
- One staff from the Administrative Team

This produces an organizational chart such as the one below. It leaves ratios similar to the ones currently used but creates a smaller clinic overall; however, it moves all income support staff into the ODSP teams, which may put pressure on other areas of income support. It also slightly reduces the proportion of staff committed to advice by about 2%. It reduces community outreach staff more significantly (cutting the number to half the level in the pervious model), but still creates a higher proportion of outreach staff than now exists. By creating more clinics with more administrative needs, this model reduces the proportion of front-line staff to 77% from 79%.

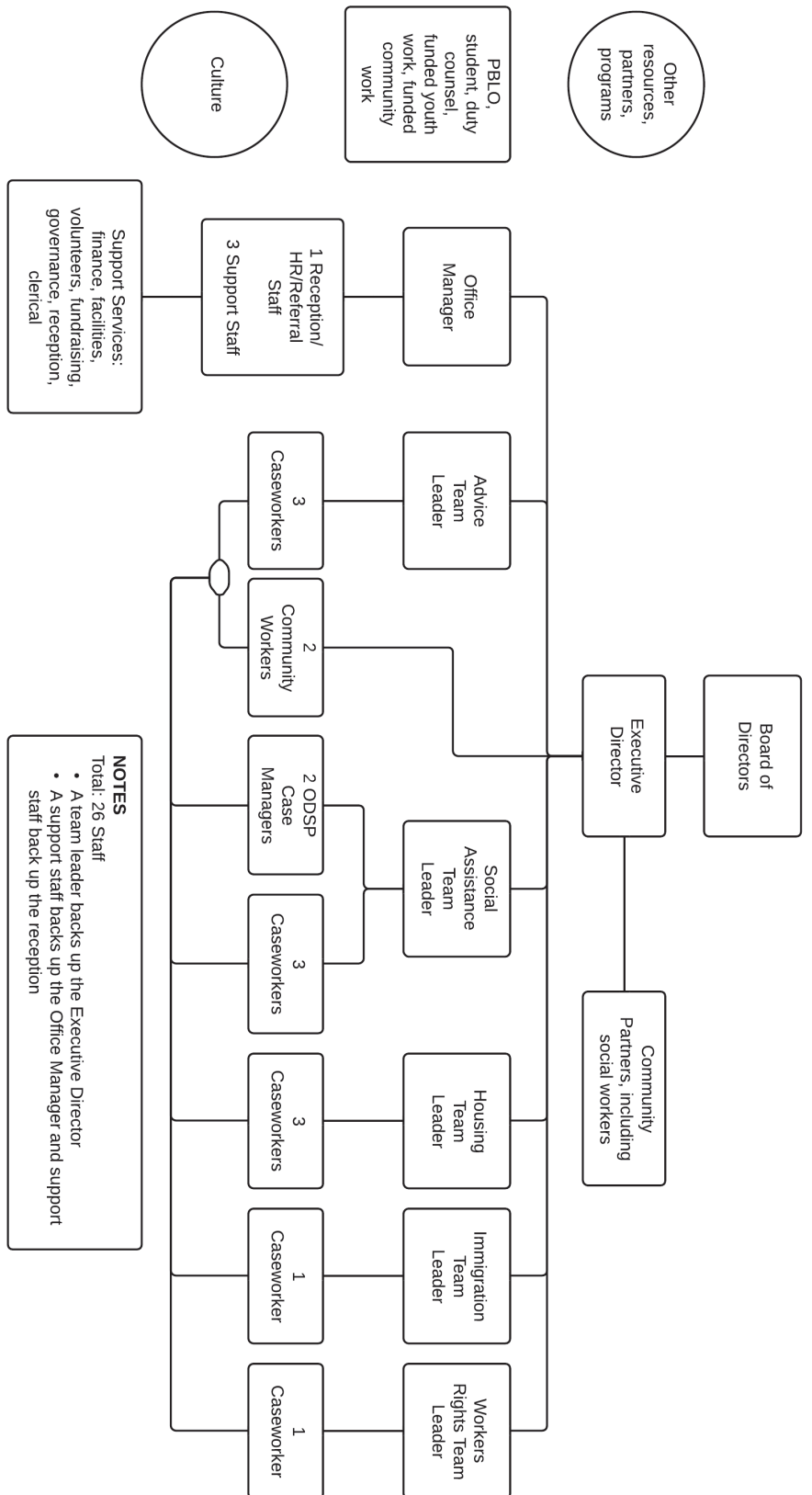


FIGURE 3: ORGANIZATIONAL CHART FOR A 26-PERSON CLINIC



## 21-PERSON CLINICS



Another option is to reduce the clinic to 21 staff by:

- Taking one staff from the Housing Team;
- Taking one staff from the Advice Team;
- Taking two staff from the Income Support Team;
- Taking three staff from the Community Engagement Team;
- Taking two staff from the Administrative Team;
- Removing the Workers' Rights Team;
- Reducing the immigration staff from a team of two to a single worker.

This takes the ratios of staff on each team well away from the current volumes of service but creates a smaller organization as shown in the chart below.

It eliminates the backup for immigration and eliminates employment law as a core area of service. It reduces community outreach to a level below the current volumes and moves all income-support staff into the ODSP teams, which may put pressure on other areas of income support. It also slightly reduces the proportion of staff committed to advice and community outreach by about 2%. This model reduces the proportion of front-line staff to 76% from 79%. This size represents a significant departure from the goals of the Model Clinic.

Further reductions in the staff sizes would result in the elimination of immigration services, as well as further departures from the commitments to community outreach, team models and the other principles driving the creation of the Model Clinic.

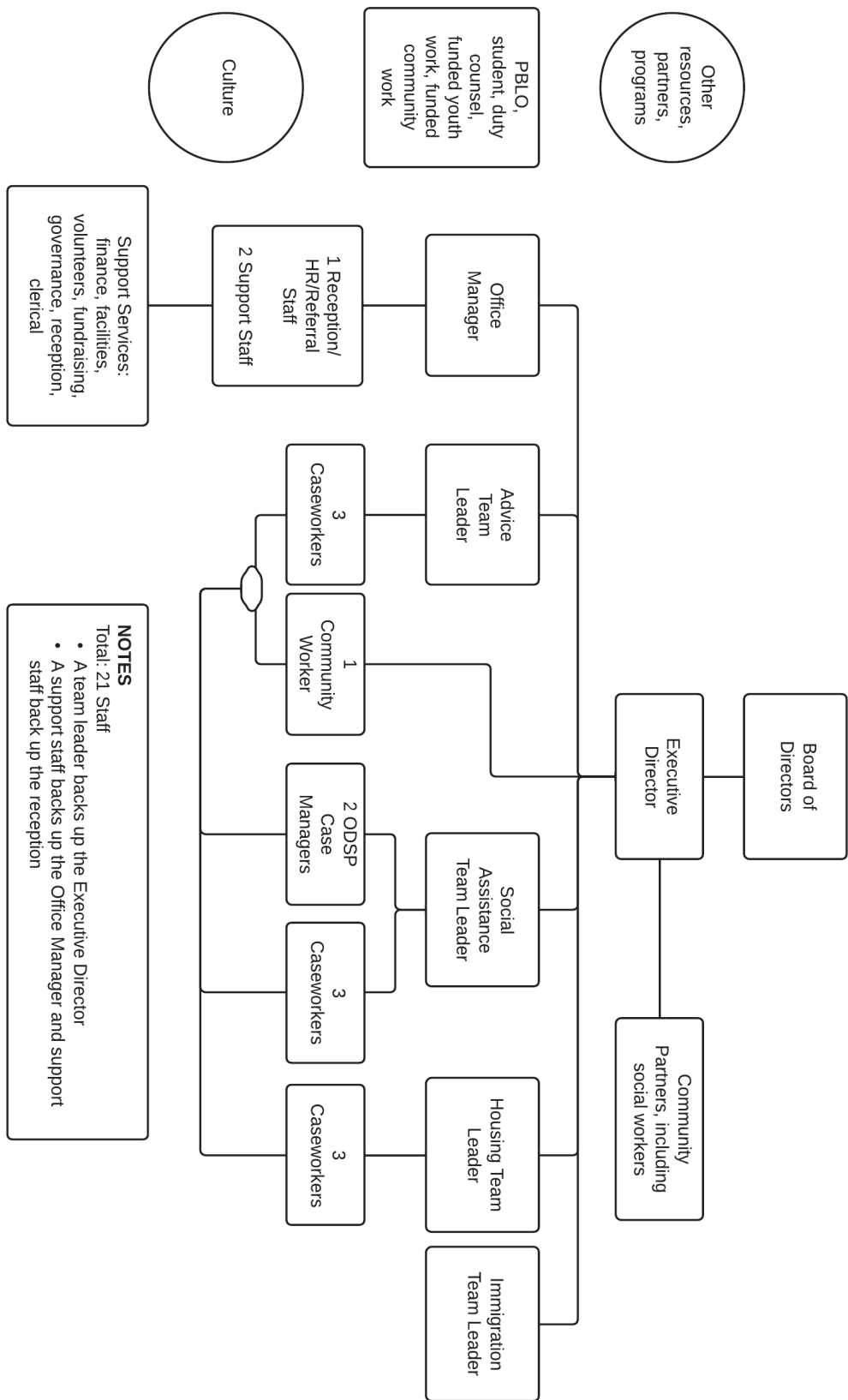


FIGURE 4: ORGANIZATIONAL CHART FOR A 21-PERSON CLINIC



## ALTERNATIVES TO THE MODEL CLINIC

The consultants analyzed and the Steering Committee considered other options for transforming the community legal clinics. The options considered fell into five categories and were rejected for the following reasons:

### HAVE CLINICS MOVE INTO MULTISERVICE HUBS

Service hubs have been popular for several years now, but as experience with them grows enthusiasm for this organization is waning. A critical issue for legal staff is that hours of operation are too restrictive and access to the facility is limited to set hours, preventing staff from working after-hours or on weekends. There is also some question as to whether there are real cost savings to be realized in occupying these facilities. While the square-foot requirements for a clinic may be less because it can share meeting rooms and other facilities, there is not enough experience to show that this results in significant real savings that can result in enhanced staffing. It is true that there may be benefit for clients in having easier access to other services that are also located in the hub; hubs cannot, however, provide the same service access to the clinic's clients who do not use the service hub.

The most important disadvantage of moving into a hub is that it does not provide the clinic with an opportunity of gaining economies of scale that would allow for additional investments in personnel. Nor is there any evidence to suggest that locating in a hub would allow a clinic to commit to increased staffing for dedicated community development or to be in a better position to train and/or enlist more volunteers. Opportunities for staff to work on teams or to have the back up they need would not be increased. Essentially, clinics would remain unchanged except for location and some increase in capacity to connect some clients to other services.

### HAVE CLINICS MERGE WITH OTHER COMMUNITY SERVICE ORGANIZATIONS

Again, there is some experience with this form of transformation. Presently, a number of clinics throughout the system are part of other service organizations. They fall into two categories: service organizations that are committed to serving a particular clientele (Centre for Spanish Speaking People and Centre de Francophone de Toronto) and those that are "secular" and deal with the general population within a particular locale (Unison Health and Community Services). While there has not been any formal evaluation of these experiences that we are aware of, it is worth noting that legal services have, in the past, elected to separate from multi-service organizations.

Much of the analysis regarding the merger of legal services with other service organizations is the same as moving the clinic into a service hub. Being part of a larger agency may well give a clinic's clients the benefit of having greater access to other services offered by that agency. The financial savings from such a relationship is limited, however, and does not create significant opportunities for the clinic to develop new or enhanced services. Even though a separate Executive Director is not required for the legal service, a director of legal services is required to essentially carry out many of the tasks an ED would. There is not much direct-service time to be gained by being integrated in this way.

The additional complication arising from a legal clinic being embedded in another organization is the loss of independence of the legal service. While other organizations can admittedly have



good community connections and foundations, and provide good complementary services, the fact of having to answer to non-lawyers for the work they do – and to be required to factor into their service-delivery decisions matters other than client requirements – is uncomfortable for most lawyers, community legal workers and paralegals. The fact that the legal-services division might not even have direct access to the Board of Directors of an organization (particularly in a larger organization) is problematic for most with a history of community legal clinic involvement.

#### HAVE SOME CLINICS MERGE WITH EACH OTHER THEREBY REDUCING THE NUMBER OF CLINICS BUT PRESERVING THEIR ESSENTIALLY LOCAL CHARACTER

Clinic mergers were rejected early in the process because they usually do not result in a significant change in culture and because they do not address the issue of needing to change clinic boundaries.

It became obvious later in the process that merging clinics also would not result in much transformation, though admittedly the more clinics that merged the greater the possibilities there were for transformation. If each clinic partnered with another, there would be seven clinics in Toronto, each with 13-15 staff. The administrative savings from this change would not be significant and the staffing complement would not be large enough to provide back up, to create service teams or to have a cadre of dedicated community development workers. If each clinic merged with two others, we would have five clinics in Toronto with each having a staff complement of about 20. This would certainly increase the administrative savings; however, the savings generated would still not be such that many new staff could be hired. More importantly, the staff complements would still not be large enough to realize the transformational objectives identified by the Steering Committee.

#### MERGE THE CLINICS THAT ARE RESPONSIBLE FOR SERVING THE AREA THAT ARE ASSIGNED TO THE NEW TRANSFORMED CLINICS

This option did not present many real advantages over the recommendation of the Steering Committee, although on its face it seemed simpler. The major shortcoming, as with all the “merger” options, is that it does not deal with the issue of resource re-allocation, even within the Toronto clinics. In addition, it does not really address the issue of where clinic catchment boundaries should be drawn.

#### LEAVE CLINICS AS THEY ARE AND JUST GET MORE MONEY FROM THE PROVINCE OR LAO TO FUND NEW POSITIONS WHEREVER THEY ARE NEEDED

There were some – though not very many – participants who advocated consistently for this position. While there was general agreement that additional funds are required for the system to effectively transform, a clear line was drawn between those who believed (1) all that was needed was more money, not transformation, and (2) those who believed that transformation would generate new resources internally and, in fact, might be used to lever new resources.

The important shortcoming of this option is that it fails to take into account that the large majority of staff in clinics, community partners and our funders (Legal Aid Ontario and the Ministry of the Attorney General) believe that some change is required if clinics are to continue to be effective for the next generation of those living in poverty in the GTA.

The Steering Committee reviewed these options but found none of them more effective as a solution to the challenges identified by staff, Boards and clients than the Model Clinic proposed here.



## E: CATCHMENTS

Clinic catchment areas need to be determined by client interests and operational requirements. The Steering Committee identified four important considerations in defining clinic catchment areas:

- Clinics should not straddle municipal boundaries.
- As much as possible, clusters of low-income population should be gathered into the same catchment areas (boundaries should dissect areas of high income rather than low income).
- Major transportation routes should facilitate access to clinic locations.
- They should be large enough to support a transformational clinic.

### SUBURBAN GTA

The first conclusion the Steering Committee came to in regard to catchment areas was that there should be one clinic in Peel and one clinic in York Region. An analysis of the low-income populations in York and Peel region showed that the low-income households in these regions would not, under any staff distribution model, have enough staff to create more than one clinic at or near the size of the model. Consequently, all models considered only one clinic in York and one in Peel-Dufferin, as shown in Figure 5.

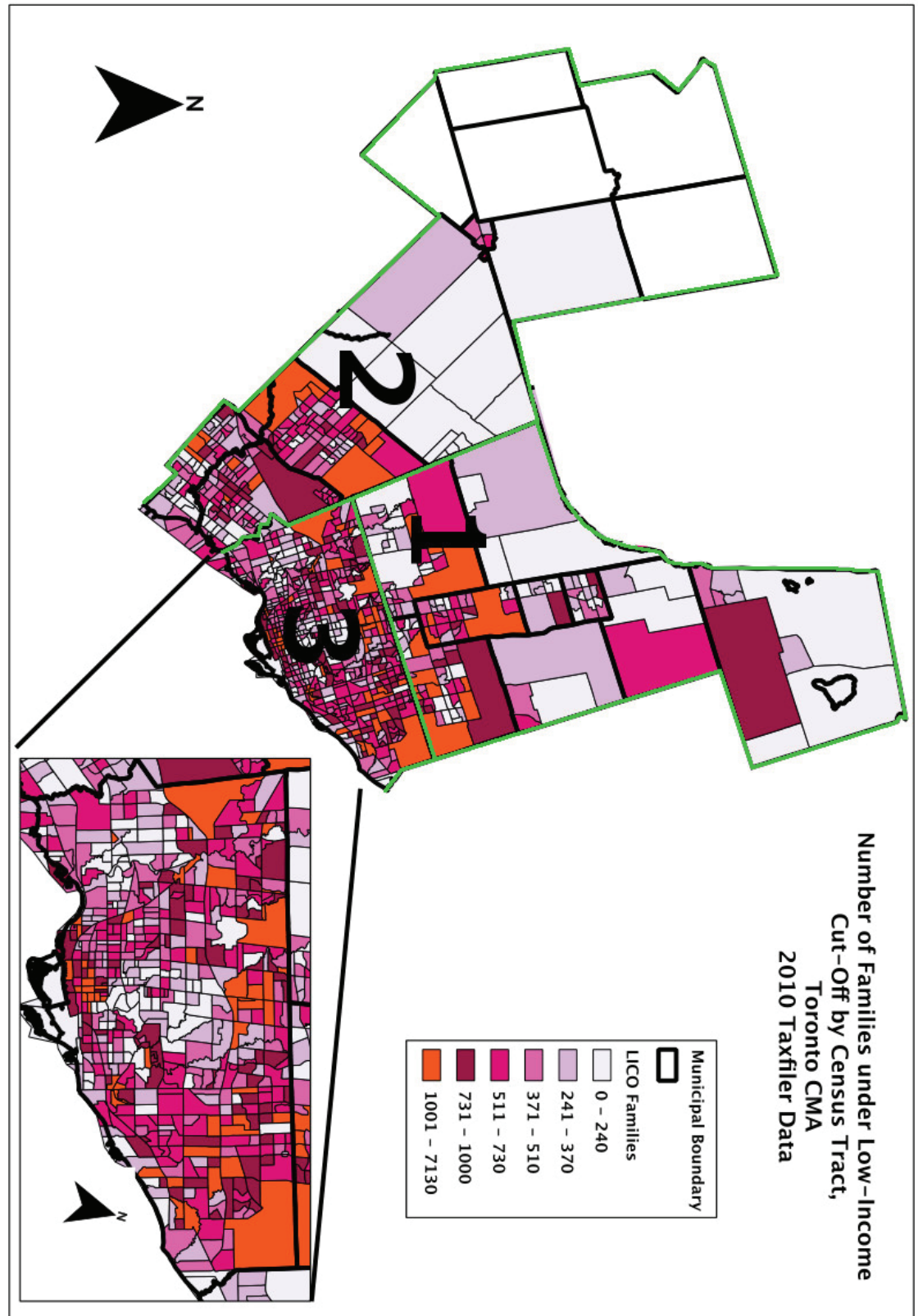


FIGURE 5: BOUNDARIES FOR A THREE-CLINIC MODEL IN THE GTA

## THE CITY OF TORONTO



Toronto was large enough to host more clinics in line with the size of the Model Clinic. Models were developed that included one clinic in Toronto as well as a two-clinic model, a three-clinic model and a four-clinic model. Creating more than three model clinics in Toronto would require an increase in the total staff complement.

### ONE CLINIC IN TORONTO

The single Toronto clinic model had advantages that were explored by the participating clinics. A single clinic lacks boundaries, allowing people to access justice where they wish, without constraint. Its size allows for some specialization. For example, unique areas of law could be practiced by one person in a very large clinic and accessible to all Toronto residents, without having as much impact on overall capacity as offering that area of law in three or four clinics. A very large clinic could also play a significant advocacy role, representing a very high proportion of the legal clinic system.

However, a single Toronto clinic would have a very large staff compliment, resulting in some diseconomies of scale. More middle management would be required to oversee a staff team of 80-100 people, reducing the front-line capacity. A very large clinic would also involve very large staff teams. The Model Clinic, scaled up to serve the whole City of Toronto, would have an income-security team of 20-25 staff, enough to create a risk of siloed work practices.

### TWO CLINICS IN TORONTO

The two-clinic model retained the challenges of the one-clinic model, with large teams and middle management, but sacrificed nearly all of the advantages of the one-clinic model, leaving little to recommend it as an option.

### THREE CLINICS IN TORONTO

With the current resources in Toronto (or approximately 104 staff), a 33-person clinic can only be created if there are three clinics or fewer in the city. Though back-office consolidation and other efficiencies may alter the demand on some functions (e.g. HR, payroll and other administrative work) those back-office staff would come from the existing 104 staff, making significant changes in size from those types of efficiencies impossible. Similarly, the gains from consolidating offices can produce some more staffing dollars but estimates put that increased staffing at approximately five staff for the GTA, an insufficient number for a major change in the number of 33-person clinics one can create in the GTA. A commitment to the 33-person clinic inextricably commits the model to three clinics in Toronto.

### FOUR CLINICS IN TORONTO

More clinics can be established with variation on the organizational model. A 26-person clinic allows for a four-clinic model, though some reductions in outreach and income-support teams result. Efficiencies that create one or two more positions in each clinic may be able to offset these smaller changes, however, a 26-person clinic cannot be stretched to create five or six clinics in Toronto.



## MORE THAN FOUR CLINICS IN TORONTO

Creating more than four clinics in Toronto requires significant departures for the model. Having five clinics in Toronto requires the creation of 21-person clinic; having six clinics requires a 16-person model. Clinics that size cannot create teams in four core areas of law, nor can they support the creation of more dedicated outreach staff or reduce the proportion of administrative work significantly.

## CREATING BOUNDARIES IN TORONTO

For new boundaries the Steering Committee chose not to merge existing clinics, but to develop new boundaries altogether. The boundaries of old clinics had already been shown to poorly correspond to the distribution of low-income households. They reflected historical events and patterns of early clinic development and bore little resemblance to current need.

The new boundary proposals were developed by assembling clusters of the census tracts where low-income households are found.

In keeping with the principle of creating access strategies, census tracts with high low-income populations that were close to each other, or that were linked by transit, were grouped together.

For each of these groupings, the number of LICO households was tabulated. Adjoining groupings were merged to produce staff teams similar to the size of the Model Clinic (approximately 33 staff).

## THE THREE-CLINIC MODEL FOR TORONTO

The three-clinic model was created by balancing the need for adjoining areas to be linked together, the need for clinics of similar sizes, and recognition of travel and transit patterns in the city. The contiguous clusters of low-income census tracts in the northwest quadrant of the city (north of Eglinton Avenue and west of Bayview Avenue) were an attractive option for the first clinic.

The southern clinic in Toronto could have a considerable east-west expanse due to the subway line running across the city, making a larger southern clinic easy to traverse for most clients. It incorporates Thorncliffe Park and Flemingdon as its north-east corner, as those communities are better linked by transit to the downtown than to the east end of the city.

The eastern clinic linked together the old city of Scarborough with the Don Mills/Fairview area in the east end of North York. This area is cut off from other low-income areas in North York by the affluent areas in the centre. The eastern portion of North York also shares demographic similarities with northwest Scarborough, making linkage more attractive, and the transit routes connect the two, through the east-west express bus routes that run through that part of the city.

While these boundaries are not fixed, they provide an overview of the size and geographic scale of the three-clinic model, and give a sense of the challenges in shaping the new clinics to reflect the principles adopted by the Steering Committee. These boundaries put about 30% of low-income households in the northwest and the eastern clinics, and about 40% in the southern clinic.



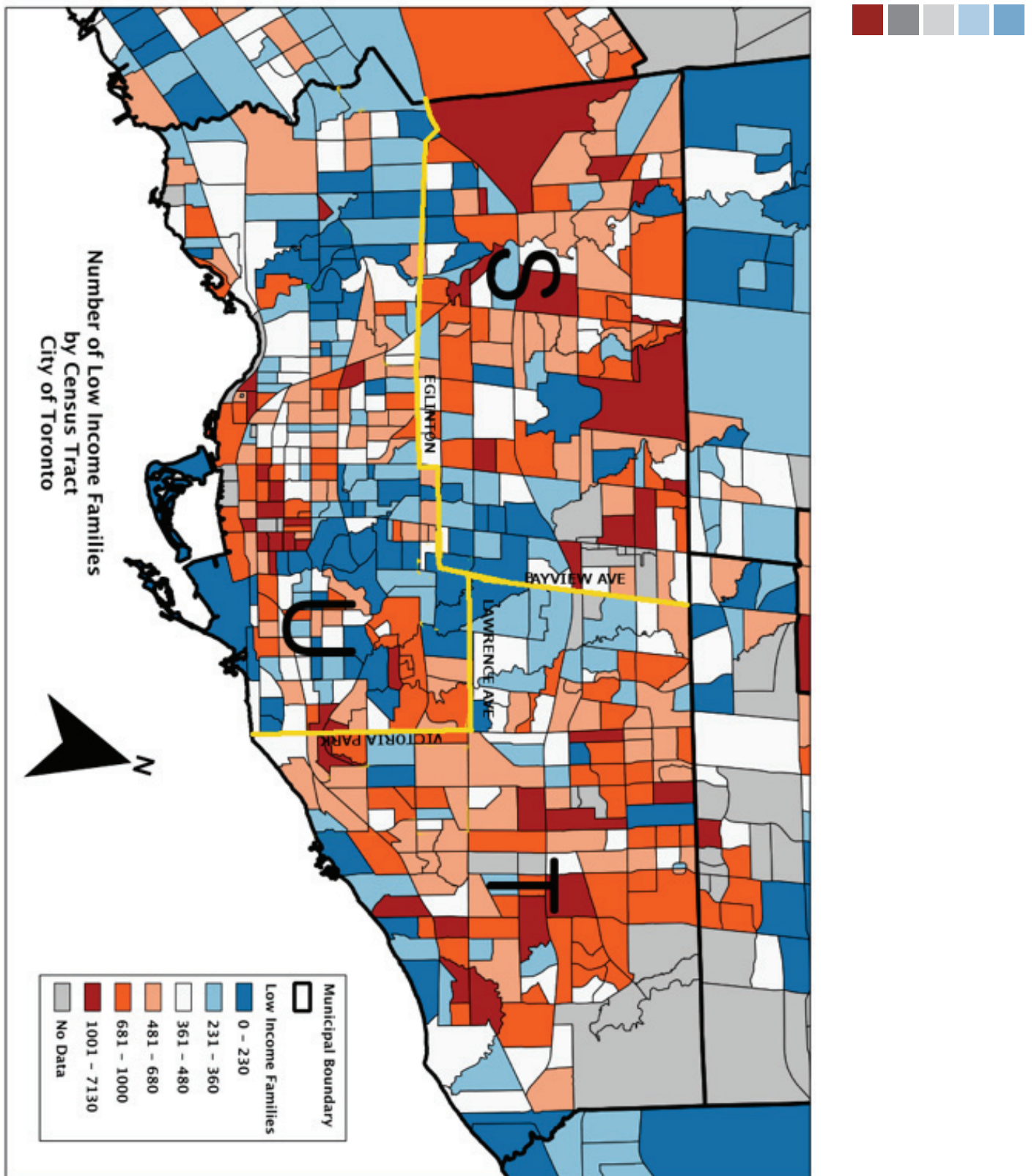


FIGURE 6: BOUNDARIES FOR A FOUR-CLINIC MODEL IN THE CITY OF TORONTO



## THE FOUR-CLINIC MODEL FOR TORONTO

The four-clinic model retains a similar northwest area but subdivides the southern clinic at the Don River and along Bayview. The Don is a natural divider in the city and the Bayview division follows a corridor of affluent neighborhoods through the centre of the city.

The eastern portion of the downtown clinic is linked with the southwestern area of Scarborough, up to the end of the most efficient rapid-transit routes through the area, which include the portion of the subway between the Don River and the subway terminus at Kennedy station, and the Eglinton and Lawrence bus routes, which are highly efficient through to Markham, where shifts in street patterns produce greater variation in routes.

While these boundaries are not fixed, they provide an overview of the size and geographic scale of the four-clinic model and give a sense of the challenges in shaping the new clinics to reflect the principles adopted by the Steering Committee. This model produces a range of clinic sizes, with about 25% of low-income households in the northeast and northwest clinics and 30% in the southwest clinic, but only 20% in the southeast clinic. Though there are some significant discrepancies in size, this model respects access issues better than other arrangements, keeping people who live close together or have access to connecting transit routes in the same clinics.

With 104 staff now working in clinics in Toronto, current staffing would allow for something similar to the 33-person clinic in the three-clinic model, but not the four-clinic model. The four-clinic model could only be achieved through a reduction to the 26-person clinic. A model allowing for five clinics in the GTA would require reduction of the organizations to at most 21 staff, which the Steering Committee did not view as achieving the goals of transformation.

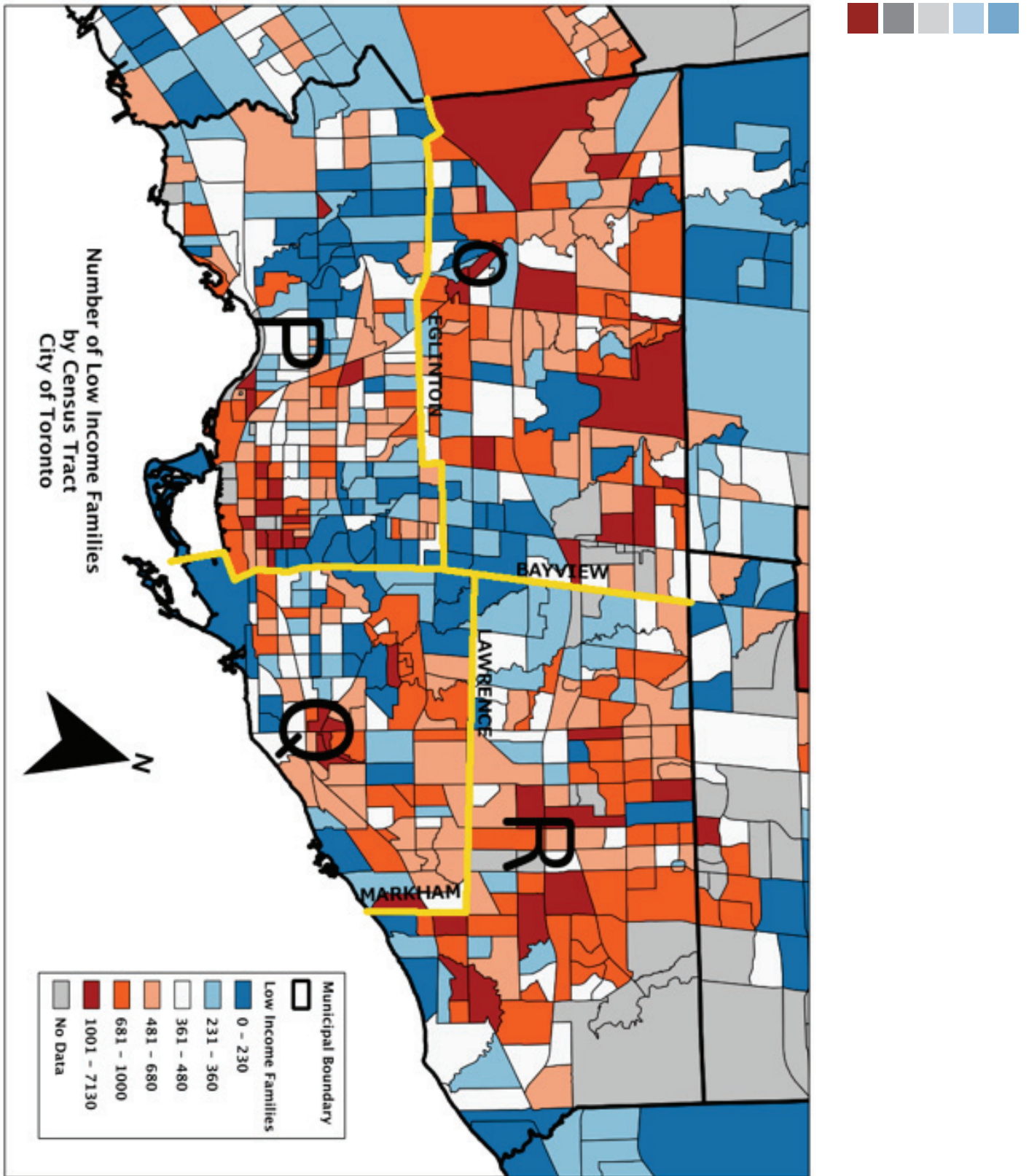


FIGURE 7: BOUNDARIES FOR A THREE-CLINIC MODEL IN THE CITY OF TORONTO BASED ON CLINIC MERGERS



## AMALGAMATIONS AS ALTERNATIVES

The Steering Committee explored alternative approaches to selecting catchment boundaries, including amalgamating existing clinics instead of creating entirely new boundaries. There are few options for amalgamating existing clinics to create new clinics of balanced sizes.

One option is a three-clinic model that merges Rexdale, Jane Finch and Downsview to make a northwest clinic; Scarborough, West Scarborough and Willowdale to make an east clinic; and the remainder combined to make a south-central clinic.

Unfortunately, this would leave the people in the north area of Flemington, most of west Toronto and the west area of Don Mills cut off from the community their clinic primarily serves, with long travel distances across poorly served transit routes to access the main office.

Another option is a four-clinic model where Rexdale, Jane Finch and Downsview make a northwest Clinic; Scarborough, West Scarborough and Willowdale make an east clinic; East Toronto, Kensington Bellwoods, Neighbourhood Legal and Flemingdon make a southeast clinic and Parkdale, South Etobicoke, West Toronto and Unison make a southwest clinic.

Unfortunately, this would leave the people in the north area of Flemington and the west area of Don Mills cut off from the community their clinic primarily serves, with long travel distances across poorly served transit routes to access the main office. It would also focus Kensington Bellwoods east, away from neighbouring clinics in the west downtown.

Mergers of existing catchments offer an alternative to creating new ones, but the difference is minor and, ultimately, unhelpful. An east-west boundary moves a single intersection from Bayview to Yonge and, in the process, disconnects low-income areas along Yonge from their nearest provider. A north-south boundary moves from Lawrence to the 401, but in the process cuts low-income areas just south of the highway from their closest provider. This alternative, though likely more familiar to participants, offers only minor changes, but each of them create circumstances that are disruptive to specific communities.



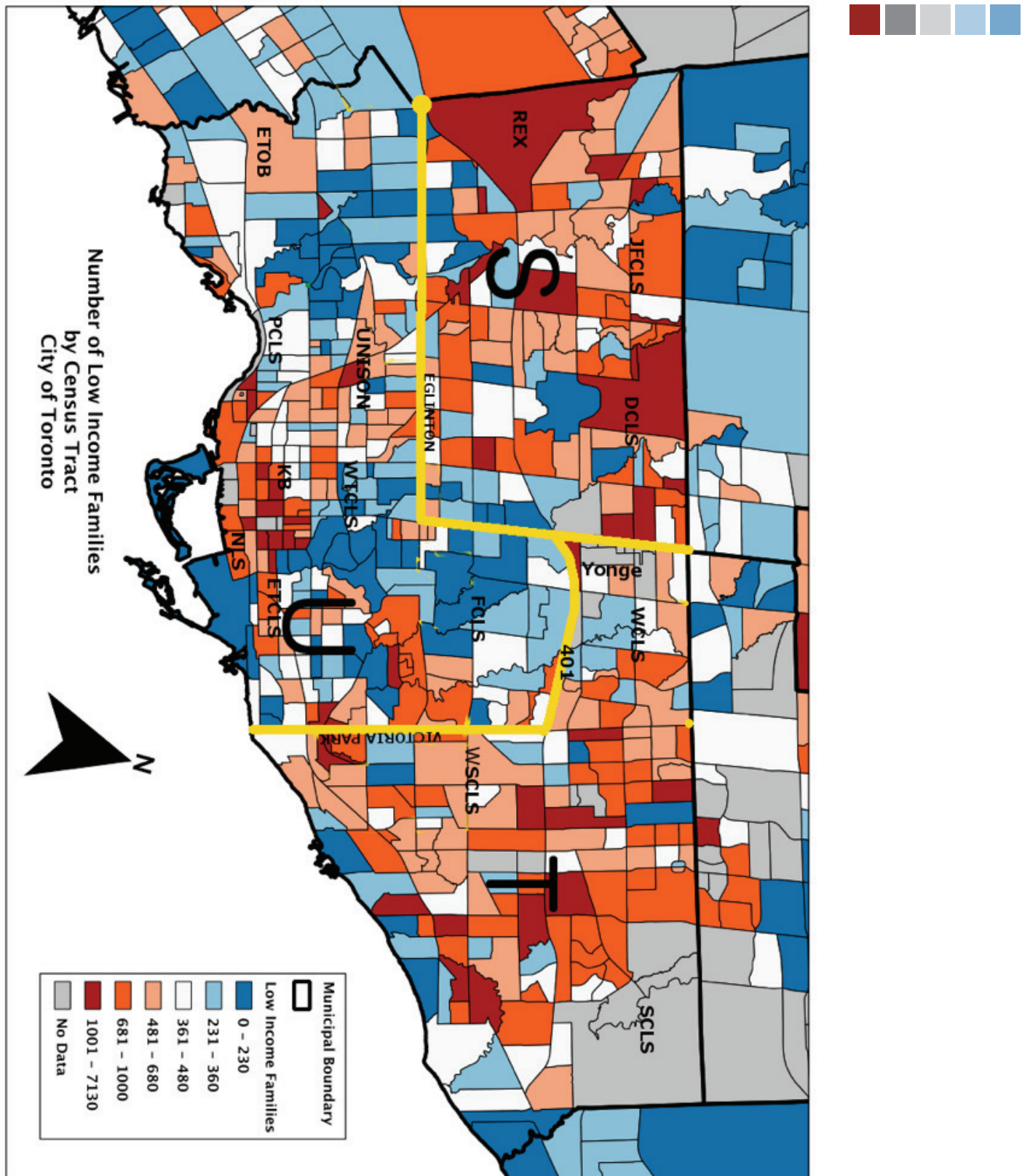


FIGURE 8: BOUNDARIES FOR A FOUR-CLINIC MODEL IN THE CITY OF TORONTO BASED ON CLINIC MERGERS

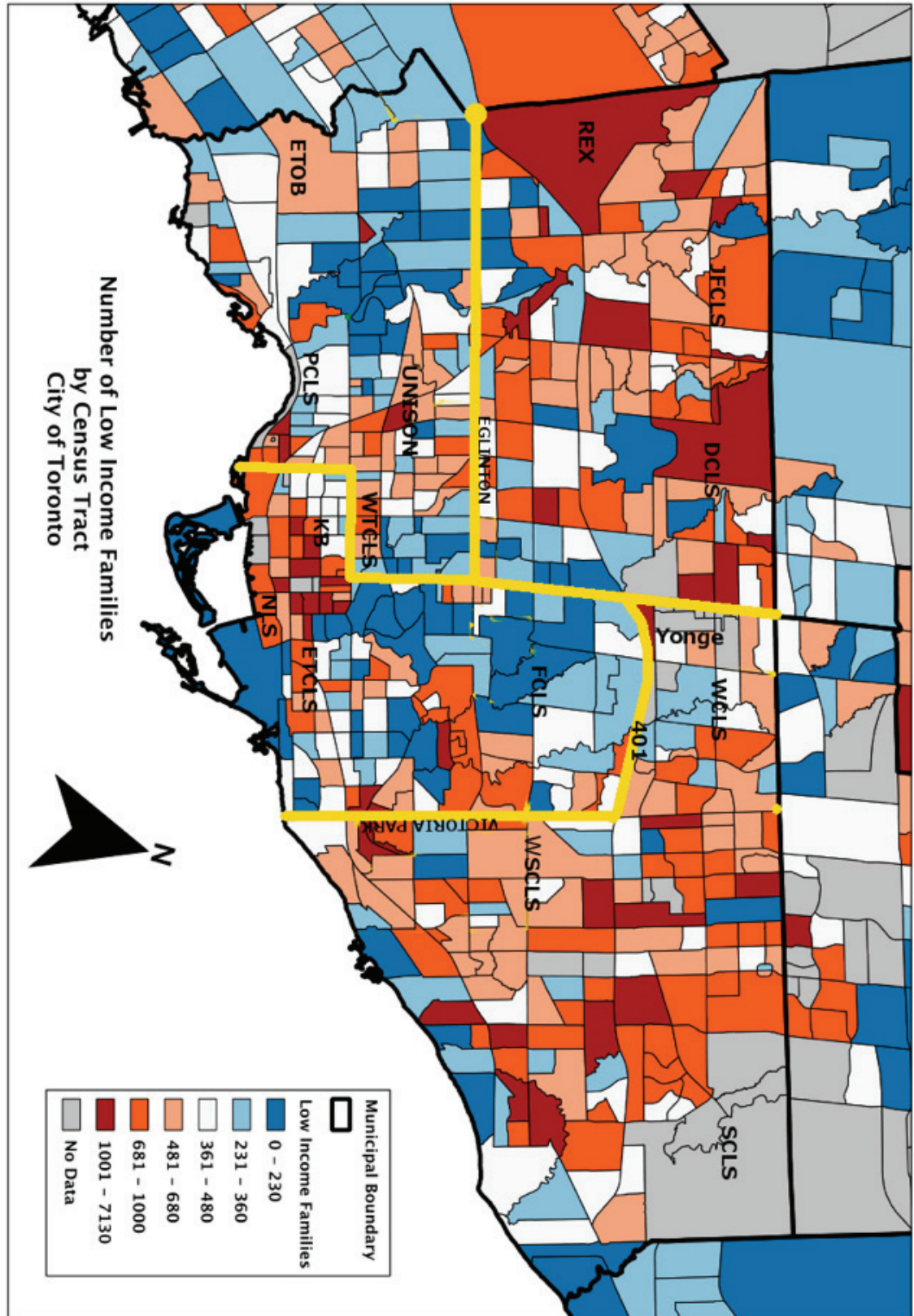


FIGURE 9: BOUNDARIES FOR A FOUR-CLINIC MODEL IN THE CITY OF TORONTO BASED ON CLINIC MERGERS

## “COMMUNITY” LEGAL CLINICS



This report recommends fewer, larger, legal clinics in the GTA. Will they still be “community” legal clinics?

“Community” in regards to community legal clinics means many different things. For a few it is serving a neighbourhood, for some it means serving an ethnic or racial community, and for still others it means helping the elderly, the disabled, injured workers, tenants or children. For virtually all geographically based clinics their “community” is a large territory made up of many communities. Only a few clinics, in the centre of Toronto, serve a very small area – and even those serve multiple neighbourhoods. Kensington Bellwoods CLS, a clinic serving an exceptionally small area, still covers communities as diverse as Chinatown, the Annex, Little Italy and the towering waterfront condos. There are 140 neighbourhoods in Toronto – it is not realistic to contemplate having a legal clinic to serve each neighbourhood. In short: All clinics with geographical catchment areas serve multiple “communities.”

Even within Toronto, most clinics serve large geographic areas – almost 100 square kilometres each for the Scarborough clinics. North Peel & Dufferin CLS covers an area of 2,400 sq. km., York Region more than 1700 sq. km., and Hamilton 1100 sq. km. And still we have no problem in calling these clinics “community” legal clinics.

Nor does the size of a legal clinic’s staff determine its “community” nature. The legal clinic in Hamilton has almost 30 staff; Parkdale has 20 staff plus 20 students. The Hamilton clinic has realized an increased ability to reach out to the communities it serves since the merger of the legal clinics there, including a robust outreach program to the First Nations communities, which was not possible pre-amalgamation. Legal clinics are currently hampered in their community outreach activities by their small size.

Though legal clinics have become very good at connecting with and serving multiple communities – this is one of the great strengths of the community legal clinic system → it remains an ongoing challenge for every clinic to find new and effective ways of reaching out to the members of their community regardless of how diverse or spread out that community may be.

Most legal clinic clients – within Toronto and elsewhere – cannot walk to their local legal clinic. That is the current reality. Our research has shown that by far most clients make initial contact with the clinic by telephone. The Transformation Project Vision recognizes the current reality and seeks to improve access for clients by providing more community access points outside of a legal clinic’s office. These will be developed in part through the dedicated community-development staff we are recommending. Fewer, larger legal clinics using community access points means greater ease of access for clients than currently available.

Just as with community legal clinics across the province, the transformed GTA clinics will be controlled by community Boards of Directors and will have strong connections with all of the communities that they serve. Community development, which is so critical for our legal clinics, will be enhanced in the new system. The “community” nature of legal clinics will not be diminished – it will be improved.



# F: THE PROCESS

## TERMS OF AGREEMENT

### MEMORANDUM OF UNDERSTANDING

The participating clinics signed a Memorandum of Understanding (MoU) agreeing to explore the challenges facing clinics and their possible resolutions. Clinics agreed that any decision made must adhere to and advance a set of core principles. These include that:

- Any clinic model developed must be community responsive, client-centered and governed by community Boards of Directors;
- There will be a continuation of a full range of community legal clinic services, including direct client services, law reform, public legal education and community development;
- The allocation of human resources among the clinics must recognize the changes that have occurred in areas of the GTA with low-income populations;
- There will be a commitment to expand and enhance service delivery and to leverage new resources (clinics need to be larger)<sup>1</sup>

By signing this MoU, clinics agreed to participate in the study process but did not commit to making any specific changes resulting from the study. The process would generate recommendations that would be reviewed by clinic Boards for discussion and decision, and at this time clinics could either sign on and commit to implementation or opt out of the process.

### DEMOCRATIC, COLLABORATIVE PROCESS

The process was designed to be collaborative, with continual stakeholder input, working toward a shared vision. To achieve this, a highly democratic decision-making structure was adopted. All participating clinics are represented on a Steering Committee, with two representatives nominated by their respective clinic. Staff and Board members were widely represented and every clinic was given one vote on the Committee, with two-thirds of all clinics required to approve any vote. This Committee is guided by a Terms of Reference that outlines their roles, responsibilities and methods for making decisions.<sup>2</sup> They are the decision-making body for the Project and meet regularly to discuss the research and its implications for developing a new model of service delivery. Decisions were made by consensus and, where consensus could not be reached, a vote that required a two-thirds majority of all clinics, and required votes from clinics representing the majority of low-income households in the GTA.

The Steering Committee members were also responsible for communications with stakeholders, including their Board of Directors, colleagues, clients and communities. They are the critical conduit in sharing information and participating in discussions with their stakeholders, gaining

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<sup>1</sup>See Appendix 1, v

<sup>2</sup>See Appendix 4, Steering Committee Terms of Reference.



input and bringing it back to feed into any decisions being made at the Steering Committee level. This allows for maximum transparency in the process and widespread input.



A Working Group was established, with seven clinic Executive Directors that represented a cross-section of clinic sizes, catchment areas, resources and geographic location in order to ensure balanced representation.<sup>3</sup> They managed the process, maintaining stakeholder relations, working toward achieving deliverables and bringing their recommendations to the Steering Committee. The Working Group has two co-chairs who had been seconded half-time to the project. The Working Group is guided by a Terms of Reference that outlines their roles and responsibilities.<sup>4</sup>

The Working Group meets regularly to discuss details and options at each step of the process, including approaches to transformation and consequences of possible recommendations. They compile information to present to the Steering Committee, providing discussion papers, briefing notes and PowerPoint presentations. Additionally, the Working Group prepared and presented an update memo at each Steering Committee meeting that outlined activities in which they had been involved, including discussions and negotiations with Legal Aid Ontario, presentations to external groups and any other involvement that has an impact on the Project. The Working Group co-chairs also meet regularly with Legal Aid Ontario representatives to keep them apprised of Project activities.

## COMMUNICATIONS

To create a transparent process with lots of communication, a multipronged Communications Plan was developed. The process was designed to be accessible to all stakeholders who should not only be aware of the Project, but also to be able to feed into the process and impact the recommendations. The process benefits from insights from all stakeholders based on their experiences, whether they are community board members, directors and staff, community partners or service users.

Project materials were designed to be accessible to various audiences. These include:

- Steering Committee meeting minutes that capture conversations and decision points made by that group, and can be used as tools to help the Steering Committee members inform their clinics and Boards about all developments.
- Regular newsletters that capture the process on a month-by-month basis for all stakeholders. Intermittent “Special Edition” newsletters are created to provide detailed updates on the Project and the research. “Special Edition” newsletters are distributed widely through clinic networks.
- A public website, [gtaclinics.ca](http://gtaclinics.ca), where all background materials and communications materials were posted and continually updated as the Project progressed. A “Frequently Asked Questions” page, as well as a “Contact Us” link, are available for anyone to ask questions or submit comments for consideration.

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<sup>3</sup>See Appendix 2 for a list of Working Group Members.

<sup>4</sup>See Appendix 3, Working Group Terms of Reference.



- A discussion board on the clinics' internal website, Knowledge Now, for clinic staff to have dialogue, post information and learn from each other about issues relevant to transformation.

In addition to communications materials, the Working Group made presentations about the project to stakeholders and held meetings to directly hear thoughts, concerns and ideas, including:

- Meetings with each participating clinic's Board, with presentations and discussion lasting up to two hours each, giving Board members an opportunity to gain further insight into the transformation process and offer input directly into the process.
- Four joint clinic staff meetings, which brought together staff from multiple clinics in half-day meetings and gave staff an opportunity to hear about the Project in detail, discuss issues and concerns and gather feedback. (Ease of travel and distance determined which clinics would participate together in the meetings; it was not a presupposition to restructuring clinics in the new system.)
- Town Hall meetings were offered to each clinic that wished to host one. While no clinics decided to organize Town Hall meetings prior to the release of the report, these meetings will be held once the draft of the report is made public, in order to enhance public awareness of the changes being proposed.

For each of these meetings, a presentation was developed that outlined the history of the Project, its structure and decision-making processes, as well as findings from the quantitative research, qualitative research and literature review.

The communications plan was a key component of the transformation process. It was designed to be responsive and accessible and to maximize the flow of communications with the various stakeholders. An open, transparent plan helped facilitate consensus.

## THE ROLE OF LEGAL AID ONTARIO

The funding for this Project was awarded by Legal Aid Ontario (LAO) to Flemingdon Community Legal Service.

In order to make certain that the process resulted in service improvements rather than simply cost savings, the GTA Legal Clinics Transformation Project also entered into a Framework Agreement with LAO that ensured:

- No clinic will have its budget cut while working on transformation;
- Once the process is complete, all the budgets of participating GTA clinics will be equal to their consolidated budgets prior to transformation;
- Cost savings realized through transformation will be reinvested into direct client service delivery and law-reform activities.

This agreement gave assurances to the participating clinics that LAO's intention was not to claw back on funding but rather maintain current levels of funding and use efficiencies from the transformation process to improve service delivery.

The Working Group co-chairs also met biweekly with LAO's Regional Vice President and staff to ensure that they were aware of the Project's process, discussions and decisions, and that the clinics were similarly aware of any concerns or expectations they had.

## RESEARCH



### METHODOLOGY

Extensive research had been conducted in the East End clinics research. That data was used in the GTA Clinics' Transformation Project and the approach used for further evidence gathering was modeled on it. In order to assess the context, needs and best practices on a broader level, a research phase was developed for the clinics in the GTA that had not participated in the previous study. It was structured in three parts.

### QUANTITATIVE DATA GATHERING AND ANALYSIS

Quantitative data was gathered and analyzed to consider demographic distribution and the concentrations of characteristics such as poverty, immigration and housing that might give rise to access to justice issues. Clinic data was also analyzed to determine patterns of service.

### QUALITATIVE DATA GATHERING AND ANALYSIS

Focus groups and interviews were held with staff, clients and community leaders to gain their insights and ideas for the transformation process.

### LITERATURE REVIEW

A literature review explored relevant articles and research on access to justice issues. In addition, participating clinics were invited to submit relevant material for the literature review.

### DISCUSSION PROCESSES

Each phase of the research was first discussed at the Working Group meetings and subsequently presented to the Steering Committee.

The quantitative data was discussed over the course of three months, using printed maps as a tool to facilitate dialogue. While clinic staff and their Boards are highly attuned to their respective catchment areas, the GTA-wide maps gave them information about the demographics and challenges in other neighbourhoods with which they may not have been familiar. Steering Committee members were able to learn from each other about the divergences within their catchments, in terms of the size of catchment, number of staff and the number of low-income families within that catchment.

The qualitative data was presented and discussed over the course of two months, using tools such as PowerPoint presentations, large group discussion questions and smaller breakout group discussions. Through these discussions, Steering Committee members were able to learn more about the challenges facing the clinic system as a whole, as well as challenges specific to individual clinics and some of the innovations adopted to address those challenges.

The literature review was presented and discussed over a one-month period and also used a PowerPoint presentation, large group discussions and smaller breakout group discussions. Steering Committee members were able to learn about national and international best practices for legal-service delivery that clinics across the globe have adopted to address similar challenges.



## G: QUANTITATIVE DATA

The quantitative research was designed to explore:

- The geographic distribution of the people that clinics serve;
- The distribution of populations with potential for legal issues;
- The geographic barriers to legal services.

The Working Group and Steering Committee discussed which data sets were most relevant to the research and selected some key data.

### DATA ON DEMOGRAPHICS

The Project used demographic analysis to identify areas where there may be high need for poverty law services. After careful review, the Steering Committee concluded that Statistics Canada's Low Income Cut Off (LICO) was the most appropriate measure to identify potential clients of poverty law services.<sup>5</sup>

For linguistic data, the 2011 census retained the questions from the long-form census, making it a reliable source of data. For income data, the most recent accurate data available was the 2010 tax filer data, which contained LICO statistics. For immigration patterns, the most recent reliable data was the 2006 long-form census.

The Working Group conducted a subsequent review to assess which was the better measure of likely demand for poverty law services: LICO households or individuals living below LICO. Analysis of case files showed that one-person households and multiperson households generated very similar numbers of cases per household. A five-person household, for example, did not produce five times as many landlord-tenant cases or immigration cases as a one-person household.

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<sup>5</sup>Demographic research was hampered by recent changes in data gathering by Statistics Canada. The elimination of the mandatory long-form census meant that many data sets used in previous research were no longer gathered in the census. While the National Household Survey gathered data on a broad range of demographics, it is a voluntary survey that shows significant skews in participation, making it unreliable for low-income populations and immigrant populations, many of whom were key subjects of the research. Consequently, the Working Group had to focus on other data sets for reliable data. The Working Group proposed a range of possible data to the Steering Committee as the basis for quantitative analysis. The Steering Committee struck a Quantitative Data Sub-Committee to review the options. The Committee reviewed the options and the data that emerged from the selected data sets. The Sub-Committee considered options for modeling poverty in the GTA, including the Low Income Measure (LIM), the Market Basket Measure (MBM) and the Low In

The Sub-Committee also reviewed options for presentation. They selected data mapping as the preferred way of reviewing data. The data was mapped out by census tract to visually assess where concentrations of issues may be found. The Sub-Committee requested specific maps, including:



- The number of LICO households;
- Immigration;
- Government transfers;
- Social housing;
- Languages other than English and French;
- Single-parent families;
- Average incomes.

## LICO MAPPING

Initial maps of LICO households showed that increasing concentrations of poverty has resulted in clear groupings of census tracts representing the highest numbers of low-income populations. Concentrations are clear in the southeast and northeast areas in York Region, in central Mississauga, Malton and Brampton, and in northwest, east and downtown Toronto. These patterns recur in several maps showing some consistent geographic areas of concentration for poverty law services.

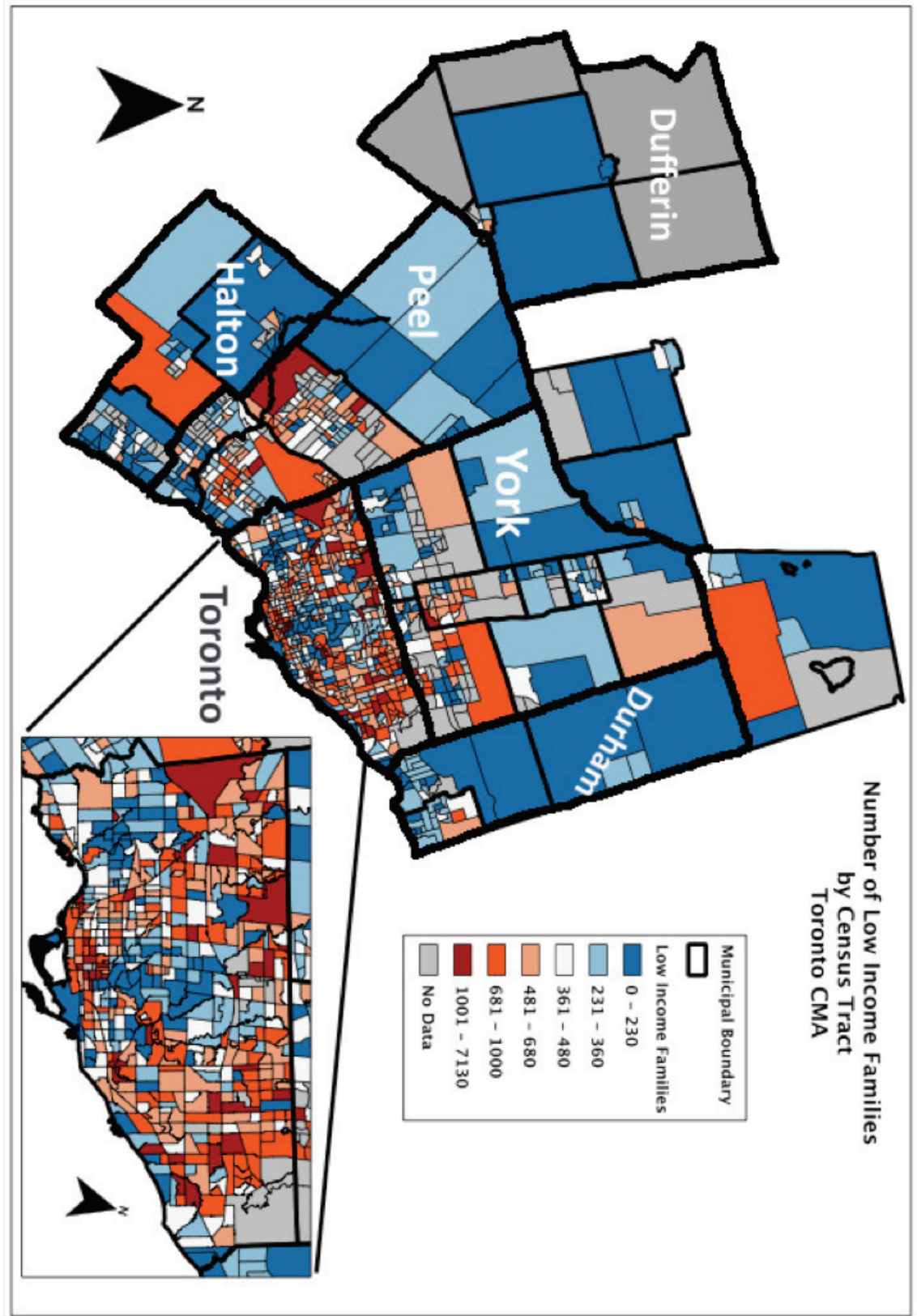


FIGURE 10



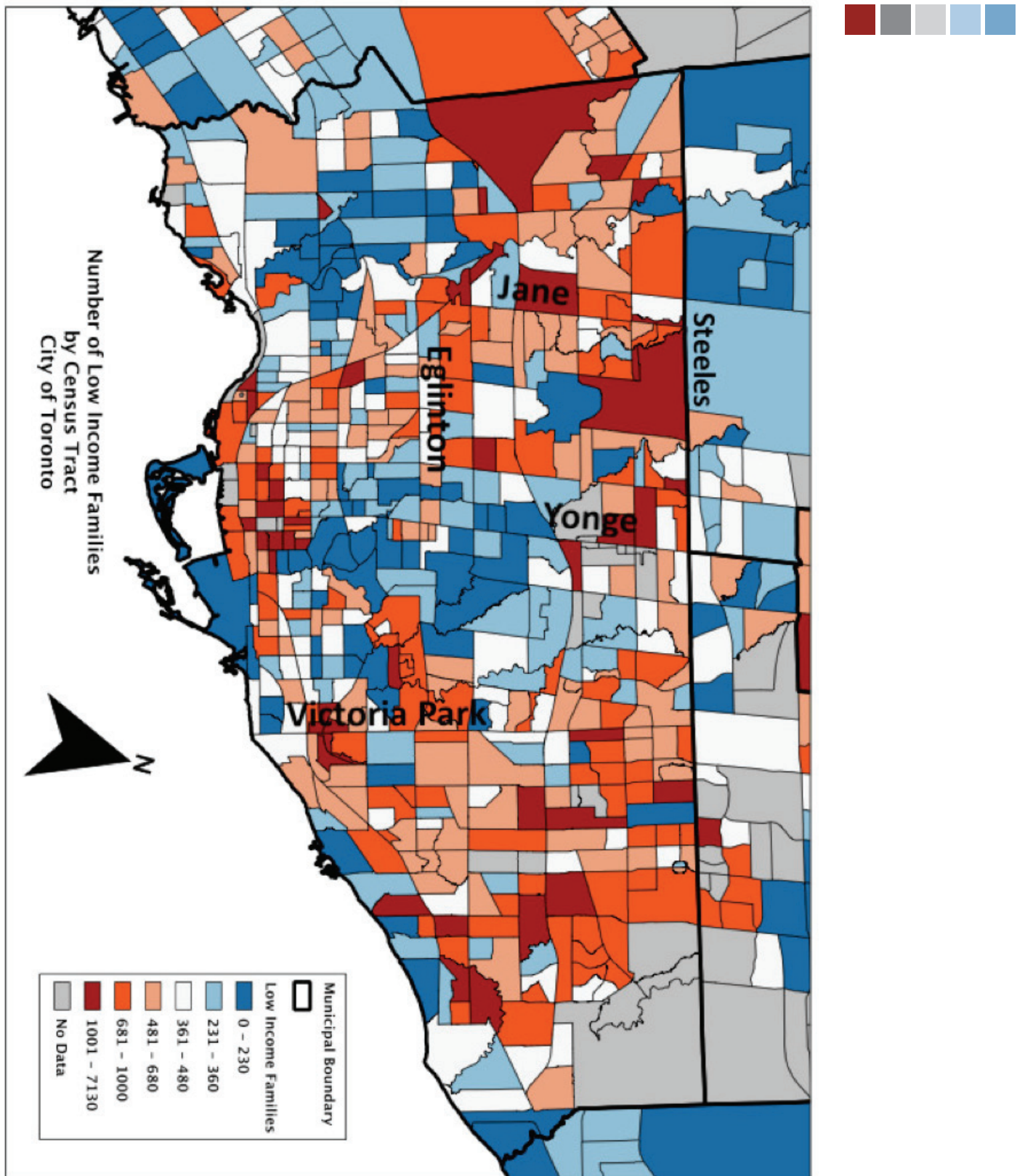


FIGURE 11



OTHER FACTORS

The Steering Committee reviewed maps of other factors affecting poverty law needs and found they showed similar geographic patterns. Concentrations of populations with characteristics likely to lead to poverty law needs clustered in similar locations as those living below the Low Income Cut Off. Concentrations are again clear in the southeast and northeast areas in York Region, in central Mississauga, Malton and Brampton, and in northwest, east and downtown Toronto.

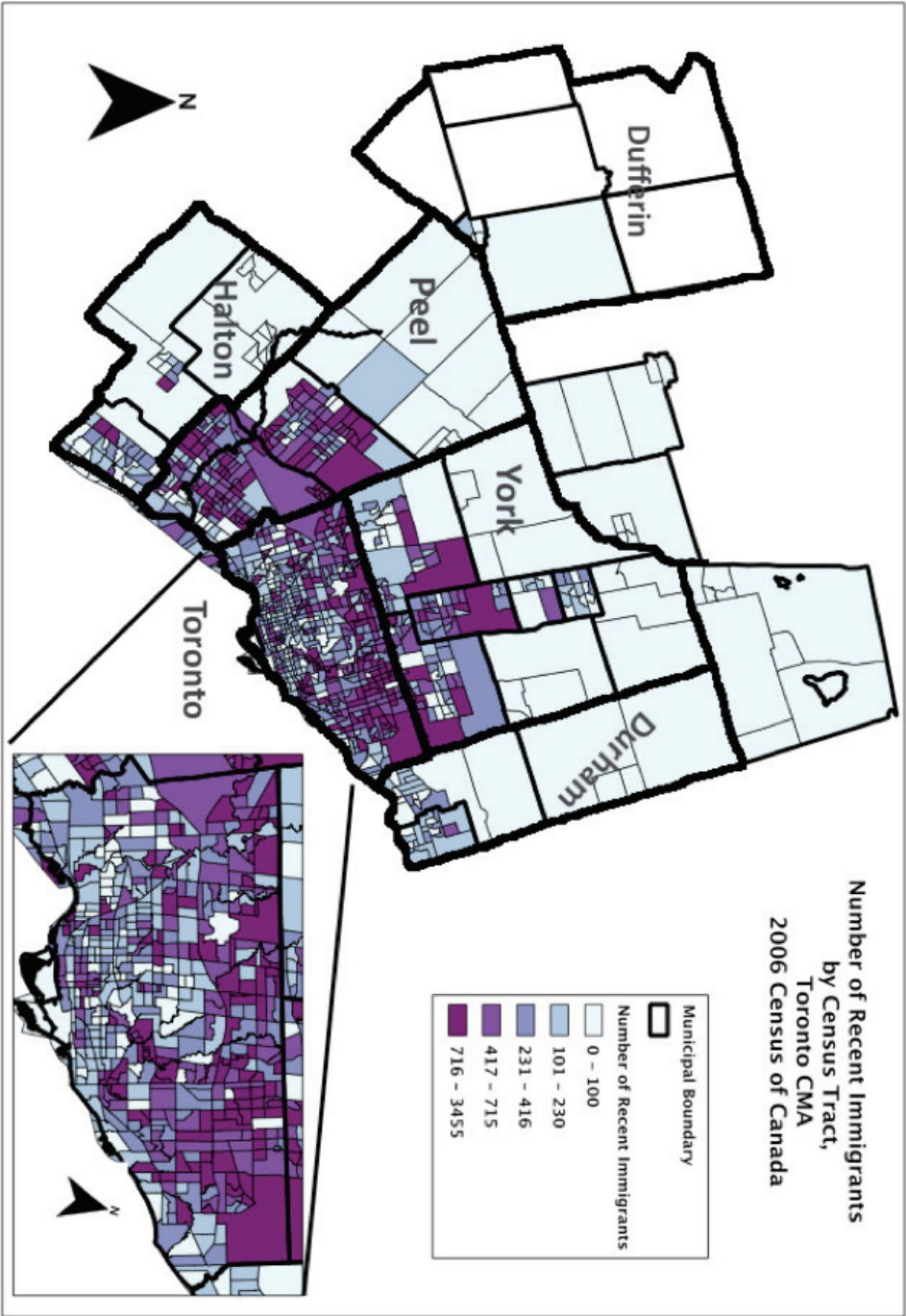


FIGURE 12



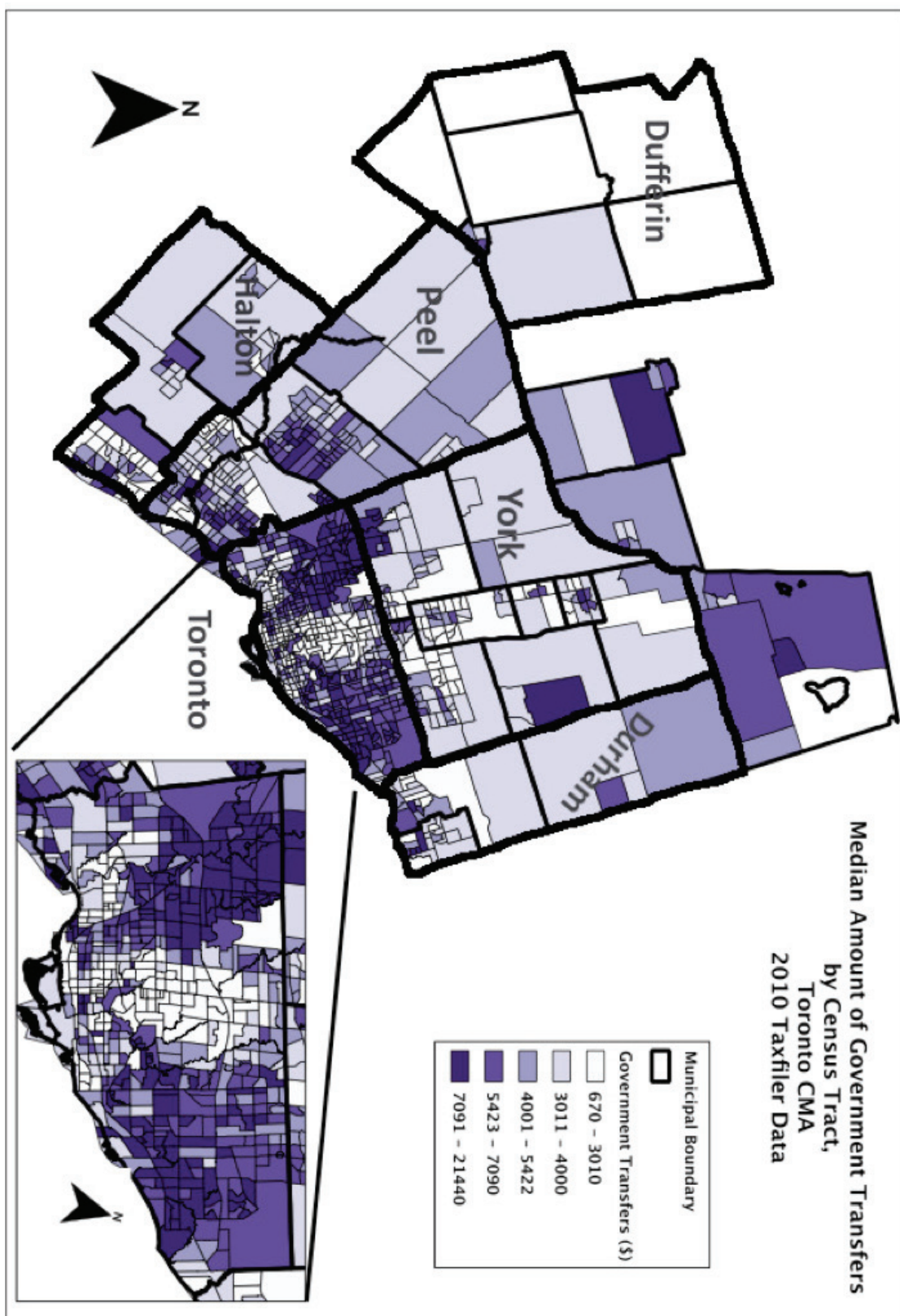


FIGURE 13

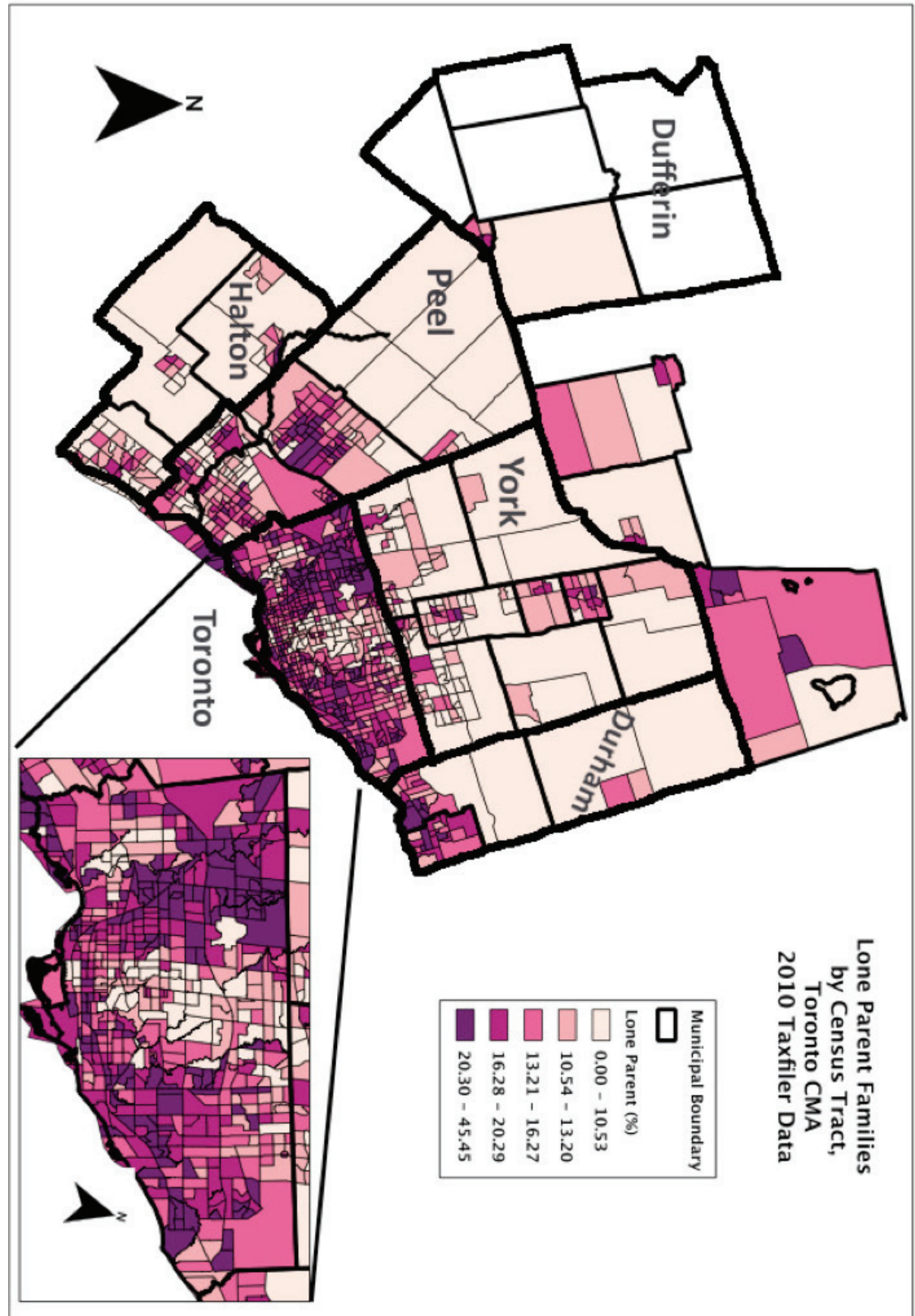


FIGURE 14

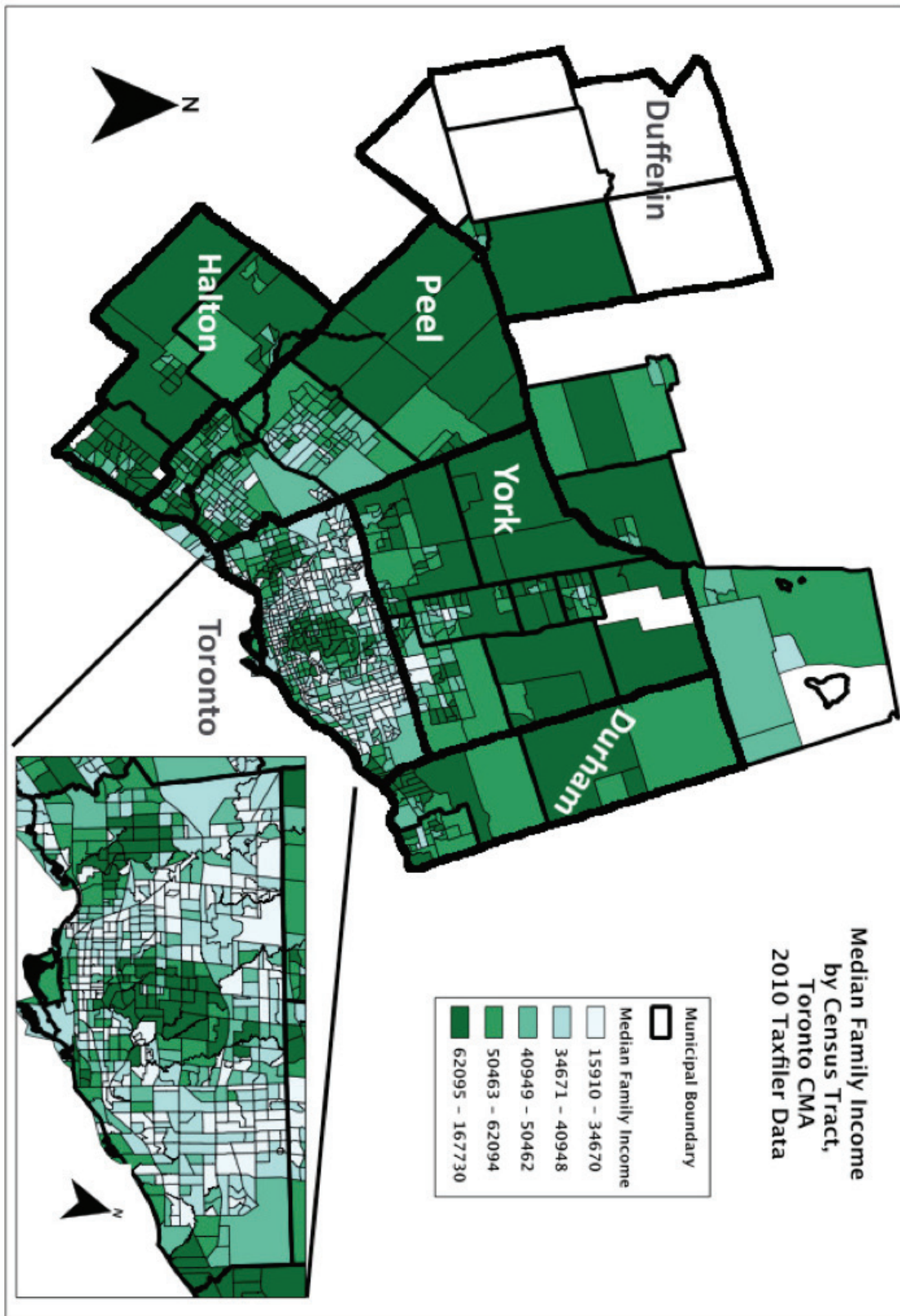


FIGURE 15





CORRELATIONS IN GEOGRAPHIC PATTERNS OF NEED

LICO data was overlaid with immigration and government transfer data to confirm the congruence of the geographic distribution of people facing those difference challenges.

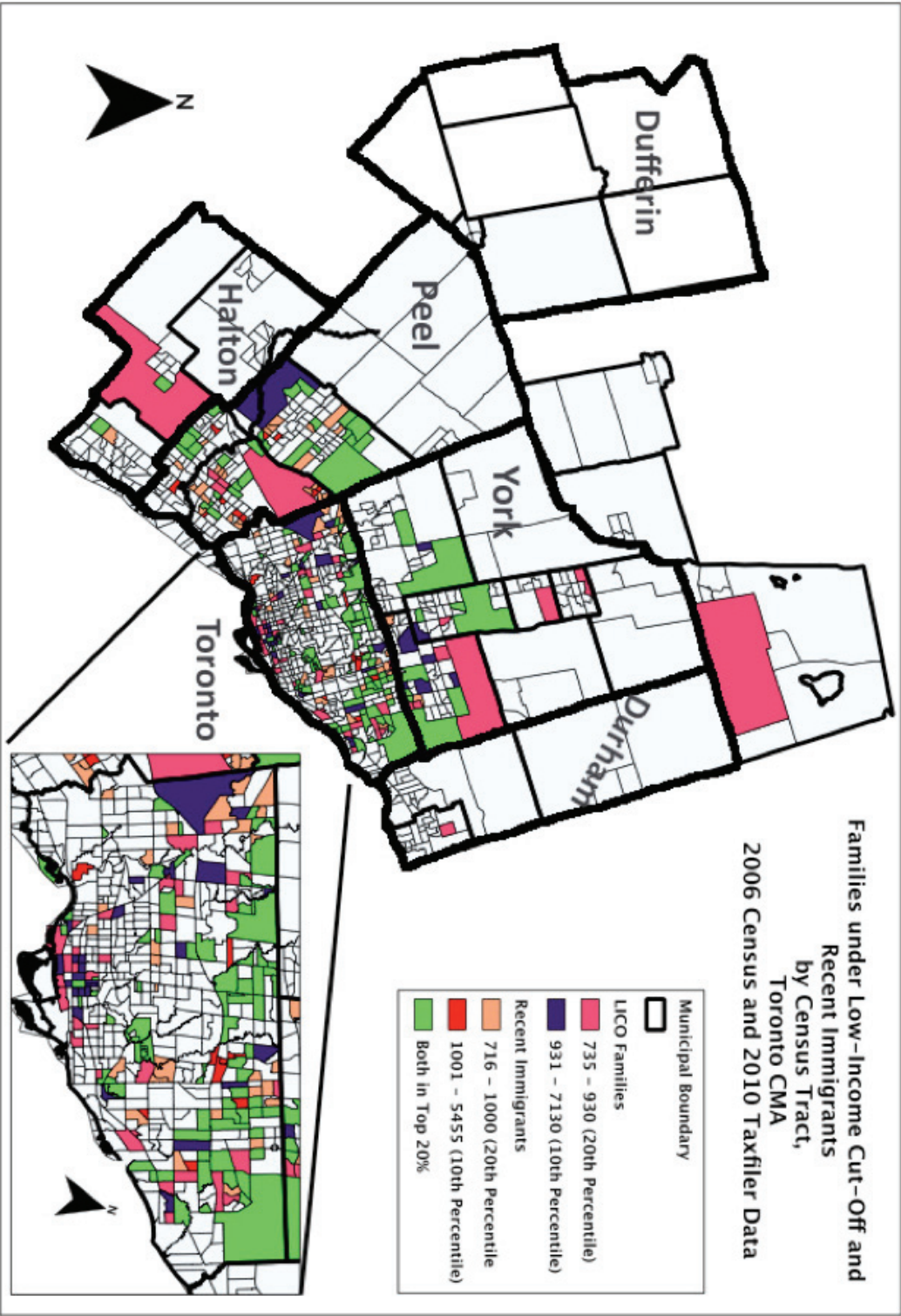


FIGURE 16

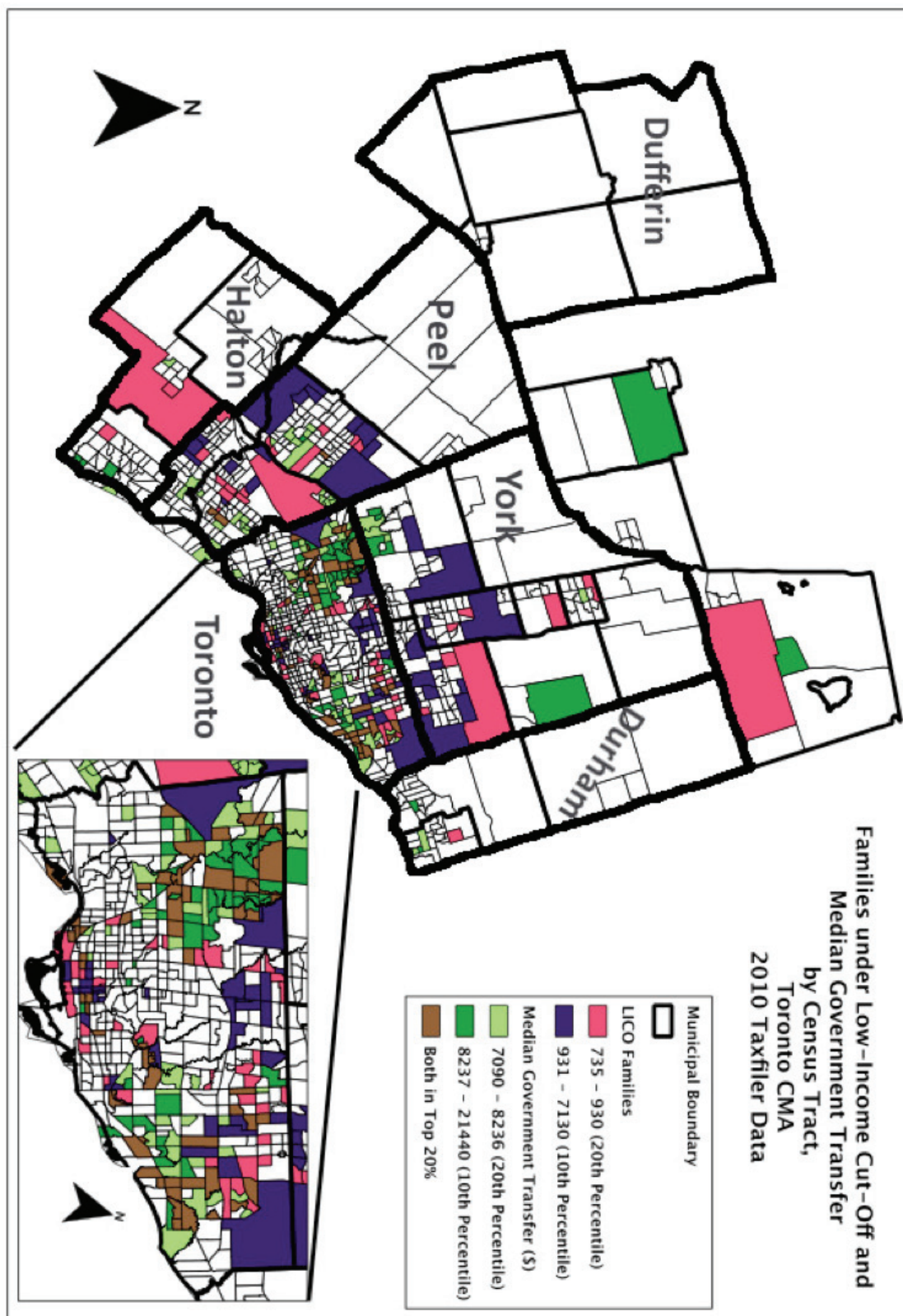


FIGURE 17



The consistent correspondence of areas where many people had incomes below LICO and the areas where people faced other challenges likely to produce legal needs confirmed the belief that the distribution of LICO households would be the best measure for where clinic demand was likely.

## MAPPING SERVICE USE SHOWS CURRENT ACCESS PROBLEMS

Patterns of service use were mapped using client data from the clinics. Client postal codes enable the mapping of their home addresses using the Forward Sortation Areas (or FSA, the first three digits of every postal code). Maps illustrating the volume of intake coming from each FSA indicated the geographic patterns of client intake. The maps, shown below, also include the site of the local clinic, using a green dot to show its location.

In most catchment areas, the highest volume of intake comes from the FSA surrounding the clinic itself. These maps clearly indicate that use of a community legal clinic is closely related to physical proximity. The data showed high volumes of intakes in areas where clinics had a physical presence. Often this at the office of the clinic but, as was the case in the Peel and York regions, clients can and do use a variety of satellite locations. Areas within the catchment area not immediately adjacent to the clinic office consistently showed far less clinic use. These patterns held even when the locations near the clinics did not correlate strongly with the clusters of low income, rates of immigration, receipt of government benefits, areas with high volumes of social housing, or other indicators of likely needs. The maps also showed lower use of clinic services in those areas of high need if they were located far from the clinic.

Public transit maps were also used to analyze access barriers. These maps showed very few points of overlap where rapid and frequent transit services went into or through those clustered areas of need, making access to existing clinic services located far from low-income areas a challenge.

These maps show that current use of poverty law services is driven strongly by proximity, resulting in areas of lower need that are close to clinics getting high volumes of services and areas of higher need that are far from clinics getting lower volumes.

Steering Committee members concluded that there will need to be improvements to current access strategies if clinics are going to enable people living in areas of high need that are far from existing clinic offices to connect with services. These access strategies should be a key part of any transformation plan. Clinic staff in York and Peel Regions, which have very large catchment areas, noted that they used satellite services hosted by partner agencies to reach people who lived far from the main office. They also noted that there were higher volumes of service use in the FSAs close to the satellites.

Clinic data also showed considerable variations in the amount of support available to clients in different clinics. Clinics in some parts of the GTA are able to provide more staff time per low-income resident than others due to the wide disparity in staffing. Figure 18 shows the considerable variation in staffing across clinics.

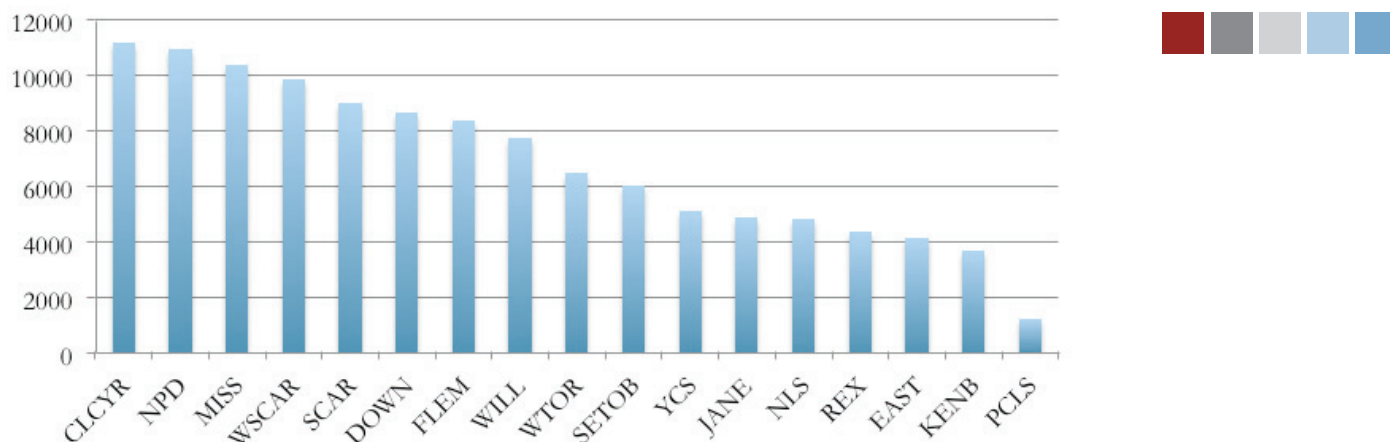


FIGURE 18: LICO POPULATION PER CLINIC STAFF MEMBER, LAO DATA, STATISTICS CANADA CENSUS DATA 2006

## SUMMARY

Demographic data was mapped and showed that there were distinct geographic clusters of needs that were likely to produce demand for poverty law services. Those clusters were most easily identified by mapping the number of households living under the Low Income Cut Off (LICO) in each census tract. Mapping patterns of clinic use showed that use is driven far more by proximity to the clinic than intensity of need. Areas with high volumes of needs far from clinics currently get less service than areas with lower levels of need closer to clinics. Access strategies would be needed to ensure that regardless of location, areas with high levels of need were able to have access to justice.



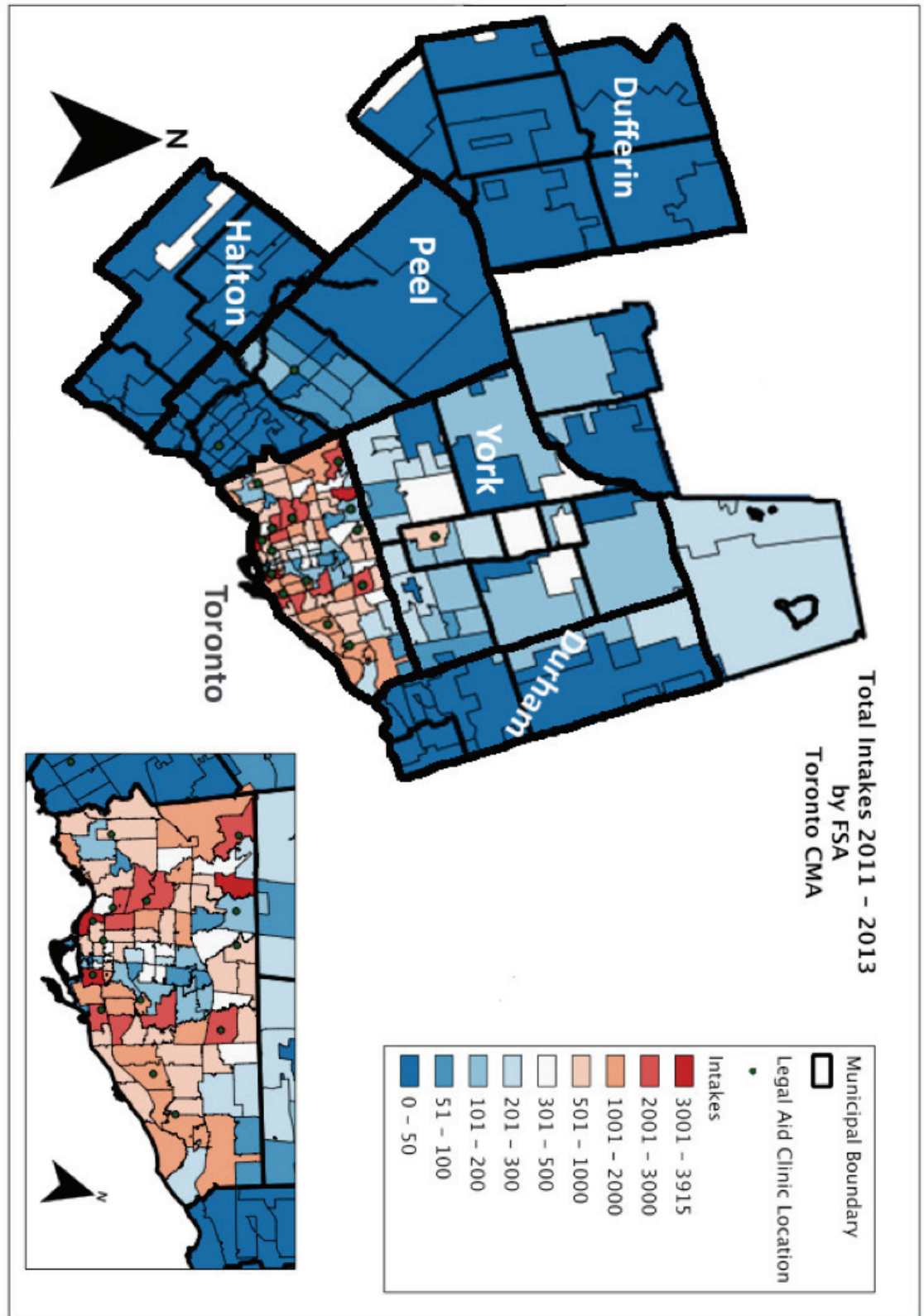


FIGURE 19



# H: CONSULTATION AND QUALITATIVE DATA



## METHODOLOGY

### FOCUS GROUPS

Focus groups were arranged with clinic clients from the participating legal clinics that were not included in the East End clinics research.<sup>6</sup> There were no clinic staff in attendance at these focus groups, with the exception of Parkdale Community Legal Services, where staff supported translation needs of their clients.

Each session began with an overview of the Project and introduction to the idea that clinics are considering changes to the community legal clinic system. Participants were ensured confidentiality of their responses and were given the option to not answer questions for any reason. The discussions were based on a consistent set of questions meant to draw out the clients' experiences of accessing services at community legal clinics, their needs and priorities in the future work of clinics, and their concerns about change.<sup>7</sup>

Focus group sizes varied but were generally held with groups of 10-12 participants. They each lasted two hours and were predominately carried out in English (translation was provided by clinics when required).

Focus groups were also held with staff teams in the participating legal clinics that were not included in the East End clinics research. An additional focus group at Parkdale Community Legal Services was held in order to accommodate academic staff and students who are part of the experiential learning program housed in Parkdale. There were no clinic directors at these focus groups.

Each discussion began with an overview of the Project. Generally, staff were aware that changes to the system were being considered; this time was also used as an opportunity to discuss their questions and concerns. Staff were ensured confidentiality of their responses and were given the option to not answer questions for any reason. The discussions were based on a consistent set of questions intended to draw out the experiences of staff in delivering services at community legal clinics, the needs and priorities of clients, emerging trends in the field and concerns about change.<sup>8</sup>

More than 200 staff and clients participated in focus groups in this phase of research, in addition to the more than 100 participants in the East End clinics research.

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<sup>6</sup> All groups were conducted with the exception of the one in West Toronto, which was unable to complete a client focus group.

<sup>7</sup> See Appendix 5 for the Client Focus Group Guide.

<sup>8</sup> See Appendix 6 for the Staff Focus Group Guide.



## KEY INFORMANT INTERVIEWS

One-to-one key informant interviews were conducted with clinic Executive Directors, Coordinators and the Academic Director to gain their insights both into the clinics in which they work and the system as a whole. They also talked about how the transformation process might affect the clinics. The interviews lasted between 45 and 60 minutes and used a structured set of questions that largely reflected the themes of the staff focus groups.<sup>9</sup>

Fifteen external partners were interviewed on a one-to-one basis, with the exception of Parkdale Community Legal Services, where two partners were interviewed together at their request. The interviewees were referred by the clinics and were a cross-section of community members, staff, directors of partner agencies and clinic Board members. The interviews were conducted in English. Discussions lasted on average 4 minutes and were based on a consistent set of questions meant to draw out their experiences of providing services in partnership with legal clinics, emerging trends in the field and concerns about change.<sup>10</sup>

More than 25 hours of interviews were conducted in this phase of the research in addition to the 20 hours of interviews conducted in the East End clinics research.

Detailed notes were taken during each focus group and interview to track discussions. Each data set was grouped according to the participants (Client Focus Group, Staff Focus Group, Director Key Informant Interviews, External Partners Key Informant Interviews and Student Learning Program). The data sets were imported into spreadsheets and coded for recurring themes and patterns. They were also analyzed for best practices that deviate from dominant themes but are areas in the clinic system that work well and could be incorporated into the new system.<sup>11</sup>

## FINDINGS

Focus groups and key informant interviews provided extensive insight into the workings of community legal clinics, including both the challenges and opportunities they confront.

### CLINICS ARE FACING SIGNIFICANT CHALLENGES SERVING INCREASINGLY COMPLEX NEEDS

The majority of clinic staff identified clients as facing multiple barriers. EDs, partner agencies and the clients themselves concurred. Clients come from diverse linguistic and cultural backgrounds, face severe crises and challenging life circumstances. Many are struggling with disabilities, especially mental health issues, and the severity of crises compounds these challenges.

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<sup>9</sup> See Appendix 7 for the Executive Director Key Informant Interview Guide.

<sup>10</sup> See Appendix 8 for the External Partners Key Informant Interview Guide.

<sup>11</sup> See Appendix 9 for the Qualitative Data Summaries.

## CLIENTS OFTEN HAVE MULTIPLE, INTERRELATED CASES DEMANDING TIME AND ATTENTION



Clients and staff both noted that the legal and non-legal issues they faced were multiple and generally compounding. Few clients present only a single legal challenge. Clients may be facing eviction because of a loss of benefits, or facing a loss of benefits because of a dispute over their immigration status. These are complicated by a variety of non-legal issues relating to crises and mental health issues in clients lives, most of which require skills and supports legal staff were not trained to provide. Clients often need counselling and mental health support to steer them through the difficult process ahead of them.

To support clients in these contexts, clinic staff must invest time and energy in gaining the trust of clients. Spending the time to listen and engage is, according to clinic staff, a key element in building the relationships that enable them to support their clients through difficult tasks. These relationships are valuable, as they enable clients to accept advice and gain confidence in the information provided.

## AREAS OF LAW ARE TOO NARROW FOR MANY CLIENTS

Clinic staff express widespread frustration at the pressures on staff time and the limitations on time with clients. This invariably result from growing workloads on increasingly complex cases with inflexible resources, as well as continuous pressure on client volumes and pace of service from their funder. EDs report negative impacts on the scope of work in this context.

***“A lot of people need help in the family law, labour and employment law issues, WSIB – we take in what we do and can, but refer a lot.”***

***–NPDCLS STAFF***

Fewer clinics are able to provide support for immigration and very few address employment law, EI, WSIB and other areas of law, despite demand for these services. Some smaller clinics were concerned about their ability to maintain the diversity of legal expertise required for the range of legal services clients needed.

## MANY WHO NEED ACCESS TO JUSTICE CAN'T ACCESS THE SERVICES THEY NEED

Clinic staff and EDs identified a wide range of people who need access to justice who cannot access the current clinic system. While telephone translation services have helped with linguistic barriers, language remains a hurdle for many. Many EDs, staff and Co-ordinators identified income criteria as an issue for many who need access to justice. Working poor families are simply not able to meet clinic requirements. Limitations on the areas of law provided by clinics add restrictions. Travel was also raised as a barrier.



## CLIENTS RARELY FIND CLINICS THROUGH ON-STREET PRESENCE

Though perennially seen as a key ingredient of access, on-street visibility is not often identified by clients as a method for finding or accessing services. Many clients learned of the clinic through word of mouth, generally through a family member, friend, or neighbour. Clients were also referred to clinic services by other service providers or by their ODSP, OW or housing offices.

## MOST CURRENT CLINICS CAN'T OFFER "WALK TO" NEIGHBOURHOOD-STYLE SERVICE

With the exception of a few downtown Toronto clinics, most clinics are already much too large to allow most clients to walk to the clinic or access the office in their own neighbourhood. Clinics often have no physical presence in parts of their catchment area and report lower participation from those areas. Clinics that have moved report significant shifts in their client base unless efforts to re-establish a physical presence in the old location are made.

***"I don't walk in, I'm too far, their catchment is large so imagine lots don't walk in. I get lots done over phone. Not terribly accessible."***

***—SOUTH ETOBICOKE CLIENT***

## SOME CLINICS ALREADY ADDRESS DISTANCE WITH OTHER ACCESS STRATEGIES

Because most current clinic catchments cover large areas, and clients from distant areas of the catchment have difficulty accessing the clinics, some clinics are already working on methods to offset the burden that travel places on clients. Transit fare is often mentioned as a necessary support. Some clinics find their legal staff have to travel to their clients.

Some clinics create satellite locations or access points in partnership with specific agencies or organizations designed to meet a specific population with clearly identified legal needs. Clinics that have used this model find it effective if there is a coherent strategy around the satellite that reflects a clear target audience with identified legal needs. Satellite locations that have incorporated some triage by the host organization have been particularly effective. Less formal "drop-in" satellite efforts receive mixed reviews, often reaching ineligible clients or clients with legal needs within the scope of clinic services.

## THOUGH WALK-IN SERVICE HAS APPEAL, CLIENTS RELY PRIMARILY ON PHONE ACCESS

Although the ability to walk into an office is important to clients, most clients reach the clinic by phone before ever visiting the office. There was a high comfort level reported with the current phone system in place, which was characterized by a personalized, human element. Clients reported that clinic staff frequently answered their phones, including clinic directors and lawyers, who gave their direct extensions to clients. When clients had to leave a message, they reported that all staff returned calls in a very timely way, usually within 24 hours, and no client reported having to leave more than one voice message. It was also important to clients that clinic staff were knowledgeable and could give relevant information to them over the

phone. The prominence of phone contact persists, even though some clinics currently insist on face-to-face intake and some clients find the cost of phone time an issue.



***“I started off with a phone call, then I went in personally to the clinic, and then I’d switch back and forth mostly with phone calls, only went in when it was essential.”***

**–KENSINGTON BELLWOODS CLIENT**

Live engagement is usually relied on for any review of documents. Live contact is preferred by many as a method of building trust and for navigating complex discussions. Little use is made of current electronic methods such as Skype and video calls, and even email and web use are fairly uncommon. The diversity of gateways to contact, intake and service reflect the diversity and uniqueness of clients and their needs and are likely a long-term feature of clinic life.

***“I use email, and sometimes even texting, with one of the workers here.”***

**–PARKDALE CLIENT**

#### PHYSICAL PRESENCE IS STILL IMPORTANT

Despite the infrequent reliance on on-street presence, many clients felt that having the option to walk into a community-based clinic or satellite location was important. Clients reported a high comfort level with this option of service delivery, though few used it.

Having a walk-in option was particularly important to clients with language barriers, who reported that it was easier to access translation. It was also important to clients with mental health issues, who stated that, in general, they were able to gain a better understanding of their situations through human contact.

Partners express support for visible physical presence and believe that any changes to the legal clinic system needs to take into consideration what access will look like for clients facing multiple barriers.

#### PHYSICAL DISTANCE REQUIRES PROACTIVE ACCESS STRATEGIES

Clinics that had moved in the past found that sustaining relationships requires access strategies to be more proactive. Clients value comfort and familiarity of current clinic locations, and resist having to navigate unfamiliar transit routes, roads and offices. It is necessary to be conscious of clients’ needs when considering relocating services.

***“We lost a lot of people when we moved. We use satellites and move to them. We use newsletters, communications, phone calls to ensure that we try to keep in touch with people who otherwise wouldn’t hear about it.”***

**–DOWNSVIEW STAFF**



For clients, physical access included being near good transit, as well as having parking spaces for those who drove. Other clients reported positive experiences connecting with the legal services through a satellite location for intake, but many still needed to travel to the main clinic location for follow-up service.

#### WELCOMING ENVIRONMENTS HELP CLIENTS CONNECT

Clients reported that the relationship they have developed with legal clinic staff has been overwhelmingly positive and exceeded many service delivery expectations. The current phone system was characterized by a personalized, human element, with a high degree of responsiveness. Walk-in engagement was also positive for clients, who were greeted well and served fairly promptly.

Client experiences with other systems, including immigration, health care, social services and housing, were described in negative ways, with clients reporting being turned away for services again and again. At the legal clinic, clients describe being treated with respect, which included many cases where staff took the time to understand all aspects of the client's situation, dealing with the legal matters where they could, and making sure to refer clients appropriately.

#### PARTNERS CAN HELP CONNECT CLINICS TO CLIENTS

Many clinics see a significant number of cases from partner agencies or from agencies that serve similar clients such as OW, ODSP and social housing providers.

Clinics also find partner agencies advantageous in obtaining new information about client populations and client needs, and identifying emerging trends. These relationships offer access to client populations that may need service, information or support. Legal education efforts are often delivered through these relationships, as are satellite and outreach activities.

#### PARTNERSHIPS PROVIDE CLINICS WITH A RANGE OF OTHER BENEFITS

Many people in need of supports are unable to get service from community legal clinics, either because of income eligibility criteria or because they seek services that clinics currently do not provide. Most clinics engage in an extensive range of referral processes. However, clinics have few mechanisms for testing the success of the referrals they make. They get little feedback from the other agencies they refer to and rely on negative long-term feedback from clients as one of the few tools to track the currency and effectiveness of referral processes.

#### CLINICS CAN PROVIDE PARTNERS WITH MORE THAN JUST REFERRALS

Partners refer clients to the clinic when a legal issue is disclosed. In some cases, partners will telephone the clinic for brief advice related to a client issue. Partners also host clinic public education sessions on-site in regards to relevant community issues, such as immigration, housing or ODSP. Clinics find this is a good method for building trust with clients, and provides some level of preventative measure.

In some cases, legal staff also provide education sessions for community partner organization staff, which has been helpful in triaging clients to appropriate services. Partners value this support and would welcome its expansion.

## CLINICS HAVE TOO FEW STRONG FORMAL RELATIONSHIPS WITH PARTNERS



Most clinics have some relationships with organizations or agencies in their area. However, those links are rarely robust partnerships and often rely on personal connections between staff at the two agencies or informal connections built up over time. Staff turnover creates a significant loss in many interagency relationships. Few institutional mechanisms exist to re-establish strong links to compensate for staff turnover.

***“In general, legal clinics are very isolated; they talk to other legal clinics but not so much with other organizations.”***

**–UNISON PARTNER**

While clinics placed high value on partnerships, few were able to dedicate the staff time, in outreach or administration, to systematically pursue or maintain them.

Overwhelmingly, partners would like to see more formalized relationships developed through the transformation process with community legal clinics. These could take the form of satellite clinics hosted within existing community-based agencies, increased and ongoing training for community agency staff on legal issues, referrals based on circle of care so that clients do not have to repeat their story over again to different staff, and built-in quality assurance measures, all of which are important components of these partnerships.

## MANY OPTIONS FOR PARTNERSHIP EXIST

In addition to offering referrals and delivering intermittent services on-site, clinics can enter into many forms of partnerships. Some clinics enter into close relationships with specific partners whose clients have persistent legal issues, jointly strategizing on priorities, law reform issues, outreach and promotion. Others provide partner organizations with training programs to develop greater expertise in legal issues. This, in turn, helps partner organizations provide clients with the appropriate advice and guidance — helping them avoid legal complications and ensuring they know their rights — and helps staff identify real legal needs for referral when they arise.

Clients like the idea of clinics being close to other necessary services. Proximity to other services made them aware that those services existed. Partners shared their clients’ fondness for joint or close locations.

## PROXIMITY AND SHARED CLIENTS FACILITATE RELATIONSHIPS

Many clinics maintain their strongest relationships with organizations that share catchments and overlap in target populations. Often, proximity to partner organizations helps facilitate ease of access for clients, who can address several support needs in a single visit, avoiding transit time and cost barriers. Similarly, clinics with nearby partners found it easier to manage some referrals and support requests. Sending a client across the street or across the hall, or asking a colleague from another agency for advice or assistance based on relationships of very frequent interaction, were valued by clinics with nearby partner agencies.



## CO-LOCATION IS A MIXED BLESSING

Though there are significant benefits to proximity, full co-location has challenges. Clinics already located in hubs and integrated facilities expressed consistent frustration over loss of control of hours and access. Staff found that opening and closing times, weekend and after-hours access, intake procedures and reporting structures all became more complicated and less responsive to the needs and priorities of the clinic in joint arrangements. Some called the arrangements “administrative nightmares” and expressed enthusiasm for undoing the joint structures.

They also expressed some concern about loss of identifiable presences. Some felt that they lost priority in driving the location of the clinic by committing to a shared facility and were concerned that their current location was not the most appropriate for their client population.

***“We don’t have keys, can’t control when we can stay in the building ... have to manage it somehow. I meet with people minutes before a hearing. If people work until 5 and we close at 4:30 how do we help them?”***

***-CLINIC STAFF***

## STAFFING STRUCTURES LEAVE STAFF UNDER PRESSURE

Clinic staff and EDs noted that the unmanageable volume of demand placed constant pressure on staff, and expressed concern about the never-ending torrent of case files. They felt that the unrelenting pressure threatened scope, quality and attention to detail.

***“That’s a problem when staff go away, they don’t overlap.”***

***-KENSINGTON BELLWOODS CLIENT***

Pressure from funders to report high client volumes overlooked the intensity and the complexity of cases, and staff felt this as pressure to turn over cases faster, despite the challenges in doing so. Virtually all clinics identify increasing front-line staffing as their number one priority when addressing difficulties in both volume and internal flexibility.

***“It’s like the work builds up while you’re gone, but you do need the break. It’s tough.”***

***-WEST TORONTO STAFF***

## TEAMS HELP MITIGATE PRESSURE

Staff in larger clinics often have systems to support each other in areas of law during periods of high pressure, or during leaves and holidays. These clinics create teams, operating in an area of law, that work together to map out plans and distribute workloads as well as share information and expertise. Staff in small clinics can sometimes cover for each other but often express frustration at the inability of the system to provide support when they are overrun or away. Clinics that have built strong teams, where numbers and circumstances permit it, have had positive responses from EDs and staff.



## SOME CLINICS DRAW ON OTHER AREAS OF THE BAR TO HELP



Some clinics have ensured regular visits from LAO Duty Counsel staff, allowing for family law and employment law services to be available on-site. Others have sought support from the private bar, engaging lawyers with expertise in other areas of law on a pro bono basis to participate in the work of the clinic. Use of articling students, volunteer law students and students from other programs such as paralegal and social work has been increasing. Formal procedures for orienting and training volunteers are important for the success of these tools.

## COMMUNITY KNOWLEDGE IS IMPORTANT

Centralized services, such as intake phone systems or centralized advice clinics, were poorly received by all groups. Staff anticipated poor appreciation of local circumstances and poor awareness of constantly changing referral contexts, resulting in poor performance. Clients wanted systems that were integrated into the local service network. Staff also expressed concern that intake had to be informed by the pattern of needs and issues emerging in the cases being pursued by the clinic.

***“Relationships need to be maintained. Like CHCs, clinics should do more preventative care before getting to crisis management. Having someone with local knowledge is important and saves time.”***

***-SOUTH ETOBICOKE PARTNER***

## INTEGRATION IS IMPORTANT TO CLINIC SUCCESS

When exploring potential new models of clinics, clients and staff expressed anxiety about the fragmentation of services and the possibility of clients having to go to one clinic to get advice, or service in one area of law, and then having to travel to another clinic in a different location to receive more intensive or different legal assistance. Staff and clients noted that many issues are interrelated, so accessing different services through different clinics would prevent holistic support.

While fragmentation was unattractive, some specialization, such as an advice hotline, was popular with clients if it was to be integrated into the current system rather than disconnected from their local clinic.

## OUTREACH AND COMMUNITY DEVELOPMENT ARE NEEDED

One area of clinic work that has faced particular pressure is community development and outreach. Most clinics express frustration at the pressure on organizing time that is created by the endless flood of casework. Some clinics have made outreach and engagement a key piece of work for a particular staff person, which increases focus on that element of the work. While helpful, most clinics find this approach does not fully offset the pressure of urgent case files and that the time they intend to dedicate to outreach is still often encroached upon. Some clinics hire staff through programs offered by the City, such as Investing in Our Communities, who dedicate their time to outreach and community development. Clinics have also set minimum



allocations of time to community work, requiring those responsible for community work to dedicate a specific number of hours per week to that work, regardless of competing pressures. Other clinics have dedicated specific staff to exclusively working in communities, ensuring that they aren't faced with competition from case files. Again, the allocation of dedicated outreach staff depends on a staff complement large enough to allocate resources to that function.

***“When I started, I was drawn by meaningful issues and opportunities for law reform and PLEs. We’re so busy with casework that we just don’t have time to do these things. We’re cognizant of the numbers, which is what LAO seems to care about. The community work is sacrificed.”***

***-WEST TORONTO STAFF***

Public legal education is a type of outreach that most clinics conduct; it helps with outreach to the agencies that sponsor the public legal education activity and provides information to client groups. Active practices work toward innovating public legal education delivery in order to deal with language-access issues. Other clinics have further developed this model to offer programs such as “tenant schools” or letter-writing workshops, in which clients learn skills to build capacity and empower them to take action on their own. Still other clinics have use organizing models that support clients to come together and take action on their own to deal with specific issues (such as bad landlords or repair issues within a building). These models also provide input on law reform, legislation advocacy or more general issues such as poverty reduction.

***“You are limited. You could get 10 requests for outreach but you can’t do them all. We do maybe one a month.”***

***-REXDALE STAFF***

***“When I started, I was told about 20% of my time would go to organizing. But honestly haven’t had much opportunity to do organizing because demand for file work is so great.”***

***-UNISON STAFF***

#### CLINICS ALSO FACE SOME UNNECESSARY BARRIERS TO MEETING DEMANDS

Overly detailed reporting requirements and poorly considered targets create pressure on clinics that make it hard to meet the full scope of client needs. EDs and staff continue to explore and discuss intake systems, seeking the most effective mechanisms.

Clinics often face challenges in how their workplaces are set up. Many identified the shortage of space overall, and in particular private meeting or office space where confidential client meetings can take place.

Clinics widely criticized their IT infrastructure, expressing concern about everything from internet access to telephone lines to digital document management. Systems that support success are simply not in place and technology is woefully out of date and riddled with impractical constraints.



Many clinics also identified a need for staff or support systems that helped with clients' non-legal needs. Social workers or mental health workers were often identified as valuable additions to the team.

Clinics are often frustrated with the many constraints that prevent the outreach, public legal education and community development work they see as central to their mandates. Many are also frustrated by the minimal amount of law reform work that time allows.

## LEGAL EDUCATION SHOULD BE PLANNED CAREFULLY

In addition to appreciating the extra capacity that students can bring to delivering legal service to clients, clinics recognize the important role they play in training clinic workers for the future. Most clinics in the GTA use students in some way:

- They have one or more articling students (both paid and volunteer).
- They hire summer students through government career experience programs.
- They use law students during the school year and also in the summer when they are seeking volunteer work experience.
- They use students from practicum programs, such as paralegal, community services and social work.
- They use non-law students, from college programs, training schools and high schools, who are seeking volunteer hours or experience. The Intensive Program in Poverty Law at Parkdale has also long served as a training ground for future clinic lawyers.

Students who receive the opportunity to work in clinics identify the practical learning opportunity as invaluable and generally have good experiences. The advantage of the clinic experience is that students are able to see the practice of law not in its abstract logical framework but in a social context that reminds them what law is for, as well as how it works. Given the traditional model of legal education, it is not surprising that students find they learn little about poverty law in their academic training, and are excited and exhilarated to see another side of law than that practised in large firms. Seeing the law deployed to serve vulnerable people is only part of the benefit. Seeing legal practices shaped by real practical needs in the day-to-day lives of clients and seeing law reform priorities set in contexts of the real crises that plague the most marginalized people provides a transformative experience that, for many, places law in a new perspective. Alumni from clinical experiences say that these learning opportunities provided different viewpoints and sometimes a different direction to the rest of their legal careers.

The academic programs that send students for practicum, work and volunteer experiences have additional concerns that students receive an experience that is supportive and well supervised, as well as reflective of their particular programs and academic work. Clinics that try to incorporate students into their service delivery have concerns that they lack the resources and experience to provide the kind of framework for the experience that the academic programs would like to see. Both sides see this as an issue to be bridged as the interest in experiential learning increases.



Some clinics – such as Parkdale, with a formal program providing student training – have found that the goal of positive experiential learning requires specific approaches to legal education. Locking students in a room to plough through an overload of case files won't achieve it; nor will restricting students to basic tasks. Exposing students to community development and outreach work, the creation of law reform projects and the real challenges of supporting clients are critical elements of success. However, giving students a free hand in addressing complex and thorny issues for clients will also prove unsuccessful. Students and teachers have both found there is a need for a direct supportive relationship between students and their teachers to guide them through the challenges they are facing. Consequently, a strict limit on the volume of work is needed to ensure time for reflection, learning, and effective practice by new learners. Time is also a critical feature, as acclimatizing to new ideas, processes and procedures, as well as new communities, takes time. Allowing acclimatization to happen over an extended period of time is a valuable component of successful pedagogy. Students identify a six-month period as an ideal, if not always practically achievable, window.

## CONCLUSION

These divergent practices among clinics offer “natural experiments” in clinic development that provide insight into best practices and future models. Incorporating them into the considerations of the future shape and structure of clinics gives perspective that goes beyond the common practice and enriches the discussion.

## LITERATURE REVIEW

The first phase of the literature review, conducted for the East End study, searched for peer-reviewed articles as well as grey literature on poverty law services, and was drawn from academic databases and online sources. The second phase of the literature review included an open call to clinics and stakeholders, including Legal Aid Ontario, to provide the Working Group with articles related to poverty law service delivery.

The articles were then culled to remove duplicates and to look for national and international best practices of service delivery, as well as lessons learned from restructures in other relevant sectors, including children's services, community health, non-profit and the poverty law sector. These articles were then divided into two categories: Elements of Effective Clinics and Structures and Transitions.<sup>12</sup>

## ELEMENTS OF EFFECTIVE CLINICS

### CLINICS ARE A HIGHLY EFFECTIVE MODEL OF SERVICE

Much research has been done that compares the value of the judicare model with the clinic model (Buckley, 2000; Currie, 2000). Data not only showed that the clinic staff model was more economically effective, but research also described the reasons for it, most notably that staff lawyers are more time efficient because they maintain relationships that make them more

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<sup>12</sup>See Appendix 10 for the Bibliography.

likely to negotiate effective resolutions earlier in the legal proceedings and are better than the private bar at making deals, pleading cases and negotiating (Buckley, 2000).



## MULTIDISCIPLINARY, HOLISTIC SERVICES ARE MOST EFFECTIVE

Clinics in various jurisdictions use integrated and multidisciplinary approaches to service delivery that include legal as well as non-legal assistance (Long and Beveridge, 2004). For example, British Columbia integrated intake and referrals in partnerships with community agencies and community health centres (Buckley, 2000). In some cases, lawyers are fully integrated into community-based agencies and, in others, clinics are part of a formalized network of agencies (Foster and Glick, 2007). The literature asked questions about the idea of “community,” which may not always be related to geography. Common experiences can also unify and create communities.

Where satellites have been used with success they have offered advice to clinics, visibility in communities and accessibility through use of paralegals and volunteers. In South Africa, for example, towns will have a main legal clinic hub staffed with lawyers, while volunteers are deployed to satellite offices in more remote villages (Long and Beveridge, 2004).

## FORMALIZED PARTNERSHIPS IMPROVE SUPPORT

Efforts to make relationships systematic and strong were valued by partners. More intensive training in partner organizations is best coupled with a commitment to quality referrals that connect clients to specific people and specific services in other organizations, preferably through a harmonized intake. These types of relationships also usually ensure follow-up to confirm that the connection was made successfully. Joint efforts and outreach, organization and mobilization deepen these relationships and the effectiveness of the work (Eagly, 1998; Forster & Glick, 2007; Leask, 1985; Long & Beveridge, 2004; Moore, 2003; Newman, 2007; Trubek, 1998). Opportunities for successful collaboration are often lost due to the informality of relationships and inconsistent communication between partners (Ministry of the Attorney General, 1997).

## VOLUNTEERS, STUDENTS AND PRO BONO SUPPORT INCREASE CAPACITY

Many models successfully integrated pro bono and student lawyers. Australia, for example, has a 4:1 volunteer-to-staff ratio, Washington has pro bono involvement at all 41 of their clinics, and New Mexico has a state-wide Volunteer Attorney Program (Long & Beveridge, 2004; Marks, 2013). In the United States, two thirds of lawyers offer pro bono service and most firms offer 3-5% of staff time for pro bono work (Houseman, 2007), with similar findings in Victoria, B.C. (Giddings & Noone, 2004).

There are limits to the reliance on volunteer services, and the literature cautioned that pro bono lawyers cannot successfully replace a base of paid staff or government funding. Where students are involved, their caseloads must be managed so that they do not lose time for education and reflection (Brodie, 2006; Long & Beveridge, 2004). In order to develop and maintain successful volunteer and community partnerships, there needs to be clarity around roles, responsibilities and appropriate administrative capacity to support the partnership.



## COMMUNITY LEADERSHIP IS NECESSARY FOR RESPONSIVE SERVICE

The community governance model is universally recognized as a central tenet of the clinic system, and the literature suggests that community leadership ensures that clinics respond to the changing needs of clients in sensitive and appropriate ways (McMurtry, MAG, Mosher, Abramowitz, Brodie, Leask, Newman). It was found that while Board members bring knowledge and awareness of their constituencies, they benefit greatly from training in governance and representative functions.

## OUTREACH, COMMUNITY DEVELOPMENT AND PUBLIC LEGAL EDUCATION ARE A CRITICAL COMPONENT

Outreach and community work are also found to be valuable drivers of service priorities, and some authors go further, stating that community development and mobilization are key to success. Some authors maintain a “two-way street” approach, with lawyers learning from the community and the community drawing on legal expertise to develop strategies for access to justice (Alfieri, 2005; Alvarez, 2007; Cook, 2006; Eagly, 1998; Wexler, 1970). However, it was found in the literature that pressures of casework very frequently override the commitment to do community work; authors stress the need to avoid this trade-off and ensure follow-through on outreach (Ministry of the Attorney General, 1997; Trubek, 1998).

Research also showed that integration of all aspects of service delivery was vital to clinic work. From outreach, advice, law reform and casework, the various interactions inform each other in a systematic way to access justice (Buckley, 2000; Currie, 2000).

## THERE IS DEMAND FOR MORE AREAS OF LAW, BUT CONSTRAINTS AS WELL

Some of the literature explored the areas of law offered by clinics, and there was a debate regarding broadening the scope of law to include family, civil, employment and criminal. Certificates for services in these areas are decreasingly effective, as they provide low pay and few lawyers accept them (Buckley, 2000). This trend has progressively increased the reliance on Duty Counsel. While Duty Counsel has been a valuable assistance to those who do not connect to a clinic or a lawyer prior to a hearing, there is no consistency of service and there is a disconnect from other more long-term supports – for instance, the continuity of representation or the ability to forward complex cases to senior lawyers (Buckley, 2000; Currie, 2000; Ministry of the Attorney General, 1997).

## INTEGRATED, TEAM-BASED STAFFING MODELS ARE HELPFUL

Authors point to the success of staffing models that are integrated and team-oriented. Integrated models make effective use of a wide variety of skills, allowing staff to draw on a range of skills and knowledge, and can provide support to other team members on an ongoing basis. These teams can include lawyers, paralegals, pro bono lawyers and articling students, and may also include social workers, interpreters, health care workers and community organizers. Teams are generally led by a key lawyer who plays a supervisory role (Leask, 1985; Long and Beveridge, 2004; Martin, 2001).



## ACCESS THROUGH TECHNOLOGY IS A BENEFIT



In addition to in-person services, the literature explored the use of different technologies that have been implemented with the intention of increasing access to services. The technology most often debated was the use of a hotline, which some literature found could be helpful in providing brief service and referrals, but only where the operators were familiar with local resources, connected to a broader infrastructure and well-trained in various areas of law (Moore, 2003). The case study of British Columbia, where resources were moved to a hotline, found that the increase in volume was offset by a decrease in service delivery because of the lack of local knowledge, time limits per case, poor infrastructure and no clinic system to deal with clients when the hotline fails (Long and Beveridge, 2004).

Further innovations examined included touch-screen kiosks for information, video conferencing for remote access, websites and multilingual videos, as well as the transfer to electronic files (Houseman, 2005; Marks, 2013; Minnesota Legal Services Planning Commission Drafting Committee, 2004-2005; Zehren, 2013).

## STRUCTURES AND TRANSITIONS

The second component of the literature review looked at pragmatic ways organizations have realigned their services. There is a range of ways that organizations restructure, and while the language used to describe these efforts varied, the processes and outcomes were usually the same. Partnership options included different degrees to which agencies can choose to collaborate or integrate some or all of their programming and/or administration (California Health Care Foundation, 2009; La Piana & Kohm, 2003).

## KEYS TO SUCCESS

While there is no set path to successful restructuring, there are similar key factors in setting the stage for those outcomes:

- Organizations need to consider whether they are generally prepared in terms of leadership, resources, governance and processes.
- Open and transparent communication and engagement with all stakeholders, including boards, staff, clients, partners and communities, must be continuous and transparent, with a focus on building trust.
- Communication should also flow both ways to ensure input from the stakeholders to the decision makers.
- Strong leaders who put the vision of the new entity first.
- Engagement with all stakeholders.
- A clear plan that outlines defined goals, timelines and benchmarks.

A number of articles also mentioned that where a positive pre-merger relationship existed, the merger was found more likely to succeed (California Health Care Foundation, 2009; Ministry of Children and Youth Services, 2012; Owen et al., 2012; Reed, 2009).



## CHALLENGES

Authors catalogued challenges to change that organizations may face, including:

- Emotional ties (Blumberg, 2009; La Piana & Kohm, 2003).
- Staff, Board and community reticence about any form of change. Fear of job loss and takeovers can exacerbate the situation. Even where there are well-intentioned agreements, trust between all parties needs to be built (Blumberg, 2009).
- Underestimating the importance of organizational culture (Blumberg, 2009).
- Underestimating costs, and the complexity of the process (Reed, 2009).
- A perceived lack of choice, lack of clarity about the rationale and lack of understanding about the benefits and what the restructuring actually entails, resulting in fear, resentment or resistance (Blumberg, 2009; La Piana & Kohm, 2003; Ministry of Children and Youth Services, 2012).

## KEEPING EYES ON THE PRIZE

Some organizations found that keeping the mission in focus was a way to remind stakeholders why the process is happening and about the problems it was designed to solve or the benefits it was designed to confer.

Leaders who were strong, had vision and believed fully in the mission helped keep people focused on the goal, not on the frustrations inherent in the change process.

## INCLUSION MATTERS

Using a collaborative approach, and including as many people as possible, helped to gain trust and buy-in. Participants should also be involved in celebrating those changes and successes post-merger (Dallhoff and Bugg, 2009).

To achieve this, any realignment process needs a robust, multipronged communications strategy, including:

- Providing information to help manage expectations and alleviate fears and misunderstandings (Owen et al., 2012).
- Listening. While it is important to get the message out, it is equally important to hear feedback and incorporate it into the planning.
- A business plan that clearly outlines an execution strategy with deliverables, timelines and who is responsible for what actions (Dallhoff and Bugg, 2009).
- Ongoing monitoring and evaluations (Ministry of Children and Youth Services, 2012).

# I: GUIDING PRINCIPLES



The Steering Committee drew on the quantitative data, qualitative data, literature review and their own experience to identify key learnings from the research. The Steering Committee distilled these into a set of principles. The later decisions of the Steering Committee were informed by the following 30 Principles.

## PRINCIPLES GUIDE STRUCTURE BUT ALSO GUIDE OPERATION

The principles provide a valuable guide to clinic design. Setting out clear priorities helps us avoid recreating existing structures out of habit or familiarity and encourages clear thinking about the structures that best serve clients.

But the principles are also a guide to practice. They lay out key operating strategies that clinics should adopt, in addition to offering guidance on structure. The importance of connecting to communities is useful in planning a clinic but just as useful in managing it. The need to use added access points to connect to clients tells us something about how we can design future clinics, but also tells us what we need to do when we are operating them. The importance of supporting staff by working in teams is a structural innovation, but also an operating priority.

These principles form a key component of the Transformation. By applying them in the day-to-day work of the clinics, new clinics can enhance services, improve access, improve staff capacity and enrich their partnerships. These improvements can occur independent of changes in clinic structures. However, structures created to accommodate those principles will better support their implementation. Structures that allow for the administrative time to build partnerships and support volunteers will have more success in those areas than clinics that lack those structural changes.

The Steering Committee drew on the research to develop each of the principles. For each principle the supporting research is noted in the accompanying footnote. The principles have been grouped thematically to link related ideas.

## CONNECTION TO THE COMMUNITY IS FUNDAMENTAL

### COMMUNITY BOARDS AND LOCAL ACCOUNTABILITY ARE IMPORTANT

The community governance model is a central tenet of the community legal clinic system. Community leadership ensures that the clinics respond to the changing needs of clients in sensitive and appropriate ways, and it is vital to the success of the community clinic model.<sup>13</sup>

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<sup>13</sup>The literature strongly supported the community governance model as a mechanism for ensuring responsiveness to communities. All current clinics use this model, and qualitative data and Steering Committee input also showed strong support for local governance.



## WE NEED COMMITMENT TO COMMUNITY DEVELOPMENT

Community development is fundamental to the model. It increases responsiveness to local needs and enhances accountability to the community. This work often suffers from the demands of legal casework. Clinics tend to work in silos and outreach efforts could be co-ordinated better with partners and across clinics. Through the transformation process, levels of resources allocated to these activities should increase.<sup>14</sup>

## WE NEED COMMITMENT TO PUBLIC LEGAL EDUCATION

Public legal education is fundamental to the model. It also increases capacity in a local community to respond to legal issues. This work often suffers from the demands of legal casework. Clinics tend to work in silos and legal education efforts could be co-ordinated better with partners and across clinics. Through the transformation process, levels of resources allocated to these activities should increase.<sup>15</sup>

## CLINICS NEED THE ABILITY TO ADJUST TO CHANGING NEEDS

### FLEXIBILITY HELPS

Service delivery methodologies are always a work in progress. They need to be continuously adjusted to meet changing needs and to improve quality. As a result, the authority to change service delivery processes must remain within a legal clinic so that changes can be quickly implemented. Any changes must be responsive to local needs. If there are too many layers of bureaucracy, legal clinics will lose the flexibility that they need.<sup>16</sup>

### RIGHT STAFF FOR THE RIGHT JOB

Staffing models need to have built-in flexibility to ensure that staff are able to respond to changing and complex client needs in the most effective way possible, assigning the person with the right skill set and experience to each task.<sup>17</sup>

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<sup>14</sup>The qualitative data, input from the Steering Committee and the literature all confirm the importance of community development to clinic work. The qualitative data and Steering Committee input strongly supports the need to do more in this area and indicate that outreach enhances responsiveness to community needs. The literature suggests different models for community-development work, such as having dedicated staff to do outreach, community development and public legal education work or, alternatively, dedicating a percentage of staff time to this area. Qualitative data also indicates that more cross-clinic co-ordination would be helpful and more efficient.

<sup>15</sup>The qualitative data, input from the Steering Committee and the literature all confirm the importance of PLE to clinic work. Although it would be helpful to have dedicated staff doing this work in conjunction with the legal staff, there are pros and cons to various staffing models for community-development staff. Clinics tend to work in silos, with multiple clinics working on the same issues without co-ordinated efforts, and this sometimes results in duplication of PLE and outreach efforts. This work could be more focused instead of being diffused across many clinics with better outcomes and fewer human-resource investments.

<sup>16</sup>Both the qualitative data and input from the Steering Committee pointed to the need to be responsive to local needs as well as the importance of non-bureaucratic systems that are simple to navigate for clients with complex needs. The literature spoke to the importance of local control and connectedness to communities.

<sup>17</sup>Qualitative data and Steering Committee conversations support these staffing models and the literature underscores the importance of appropriate assignment in areas such as intake.

## CLIENTS NEED INTEGRATED, CO-ORDINATED SERVICES



### SEAMLESS CLINIC LAW SERVICES ARE BEST

We want to provide seamless clinic law service to clients. We want to provide for the client's needs, from referral to advice to assistance to representation (and be able to send the client back and forth between levels of service) without having to send the client elsewhere. It is preferable to keep it all within one organization.<sup>18</sup>

### ACCESS TO ADVICE IS BEST IN INTEGRATED CLINIC LAW SYSTEMS

Clients want to be able to access advice quickly. The more steps there are (phone calls, referrals follow-up, etc.) between initial contact and provision of advice, the less likely it is that the client will be effectively served. It is helpful to have advice staff who are available to provide service on initial contact, but that advice has to be provided by qualified, experienced staff.<sup>19</sup>

### MULTIDISCIPLINARY STAFF TEAMS PROVIDE HOLISTIC SUPPORTS

Legal clinics could benefit from having access to a larger range of staff, not just lawyers, community legal workers and support staff. Clients often need non-legal assistance to go with the legal assistance. Other professions, such as social workers, social service workers and mental health workers could assist in the work of legal clinics. This could be done through staffing of clinics or by collaboration with other agencies.<sup>20</sup>

## ACCESS IMPROVEMENTS SHOULD BE DEVELOPED

### CREATE COMMUNITY ACCESS LOCATIONS THROUGH PARTNERS IMPROVE ACCESS

Walk-in access does not necessarily have to be at the clinic office; it can be at the office of a community partner where a structured, collaborative agreement is in place.<sup>21</sup>

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<sup>18</sup>The qualitative data and Steering Committee input shows support for seamless service provision for clients and the literature supports single institutions delivering integrated legal services.

<sup>19</sup>Qualitative data and the literature support this approach. While there is some attraction to having a centralized advice service, that would conflict with the "seamless service" principle. Legal clinic services are on a continuum (advice, assistance, full representation) and clients will need to be passed from advice staff to caseworkers (and sometimes back again to advice or referral staff). This would be difficult with a stand-alone advice service. Another problem with centralized advice is the administrative overhead involved with a shared service.

<sup>20</sup>Qualitative data and Steering Committee conversations support that clients have multiple needs and that staff teams need to draw on more diverse skills. The literature review supports the multidisciplinary team model or strong relationships with non-legal service providers.

<sup>21</sup>The qualitative data and Steering Committee input support community access locations. The literature supports this as well and provides overviews of best practices in various jurisdictions. The qualitative data and literature also support the use of partners to create satellite locations and drawing on partners to shape and recruit for those services. At the same time, a legal clinic needs to ensure that its clinic identity does not become conflated with the community partner's identity in order to avoid confusion and misrepresentation. It is important to balance client convenience with resource allocation. Travel time is required to go to an access point and a sufficient volume of client appointments is needed to make this worthwhile. Initial advice or intake can often be done by telephone, while in-person appointments can be booked at the access point. Access points work most effectively if the legal clinic sends someone (not necessarily a caseworker) to do in-person intake on a regular basis (to build a presence at the location) and other appointments are made on an as-needed basis. Agency staff can do basic information gathering for the legal clinic on an ongoing basis, possibly using A2J software.



## CLINICS NEED A CLIENT-ACCESS STRATEGY

Access to clinics is affected by physical proximity to an access point. Legal clinics should be located where there is good access for low-income populations. That can include either being located near those populations or near transit so that clients from all over the catchment area can get to the legal clinic.

Community access points should be used to allow easy physical contact with clients across the catchment area so that clients do not need to travel long distances. The boundaries should be along the natural dividing lines between clusters of low-income populations.<sup>22</sup>

## MULTIPLE GATEWAYS IMPROVE CLIENT ACCESS

We should be providing a variety of access methods. Different clients have different preferences and need different types of interfaces. Clients should be able to access clinic services in person, by telephone, by email, through a web page and through community partners providing community access locations.<sup>23</sup>

## HARMONIZED INTAKE BEARS CONSIDERATION

Clients should not have to repeat their story. They need a simplified intake process that can be shared (with their permission) with other agencies.<sup>24</sup>

# CLINICS NEED TO SUPPORT THEIR STAFF BETTER

## STAFF NEED BETTER BACKUP

Currently, clinics have great difficulty dealing with the consequences of staff being away on leave, being ill or feeling overwhelmed. This is a source of stress for staff and can cause service delivery challenges. Clinics would benefit from greater flexibility in deploying someone to deal with these issues who are familiar with the same area of law to cover the work if a staff person is away.<sup>25</sup>

## SPECIALIZATION AND TEAMS SUPPORT EFFECTIVE DELIVERY

Staff who specialize in an area of law deliver higher quality service and more efficient service. Legal clinics can also provide better service if staff are working in teams, sharing information and covering for each other as needed. Given that clients' problems often cut across areas of law, staff need to be aware of other areas of law (apart from their specialty) and need fast access to staff on other teams. Professional development needs suggest that opportunities to

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<sup>22</sup>Quantitative and qualitative data shows that low-income populations are not as well served when they live far away from the location of a clinic access point. The quantitative data also shows that in most areas of the GTA, good transit does not run through low-income communities, limiting access to other locations. Quantitative data and Steering Committee input support the need for community access points, proximity to transit and dividing lines that are based on the areas where few low-income residents live.

<sup>23</sup>Data gathered supports multiple gateways available for clients to access services.

<sup>24</sup>Qualitative data and Steering Committee input support clinics offering a harmonized intake model.

<sup>25</sup>This need is highlighted in the qualitative data as well as from input at the Steering Committee level. The literature review also speaks to the need for team coverage.



work outside the area of specialization at times would be desirable, as would the ability to incorporate rotational staffing models.<sup>26</sup>



## USE OF VOLUNTEERS, STUDENTS AND PRO BONO CAN ADD CAPACITY

Clinics can increase their capacity by making more use of volunteers, including community Board members and students. There is also great potential for more use of pro bono lawyers. Currently, clinics are not able to establish sustainable, organized programs with proper recruitment and training, as they do not have the staff time available to devote to this. There may be some advantage to creating a system of centralized training for volunteers, Board members and students working in clinics across the GTA, with a focus on maintaining the degree of quality work. However, these assets do not work if they are used to displace the core team of legal supports in clinics. In addition, we must exercise caution in the use of unpaid labour and make investments, such as mentoring, to enhance the quality of work and serve as a return for their contributions.<sup>27</sup>

## LEGAL EDUCATION REQUIRES A THOUGHTFUL APPROACH

Legal education is currently done on a large scale by Parkdale Community Legal Services, but is carried out in other ways at most legal clinics and is a valuable part of the clinic system. It not only nurtures future clinic lawyers but also provides a base of understanding and support for clinic law throughout the legal system. Students are able to see the practice of law not in its abstract logical framework, but in a social context that reminds them what law is for, as well as how it works. Transformation of the GTA legal clinics should include a clinical law component.<sup>28</sup>

## TECHNOLOGY NEEDS TO IMPROVE

Good technology could let clinics work better, and today's legal clinics are frustrated with the limited technology and support provided. Most clinics are unable to dedicate more resources (particularly human resources) to effective use of technology.<sup>29</sup>

## HUMAN RESOURCES SYSTEMS CAN BE CHALLENGING AND COULD IMPROVE

Clinics face human resource challenges. The small size of clinics also puts a lot of pressure on staff as they try to adapt to changes, such as staff going on leave or a new legal issue suddenly arising in the community. There is also little room for advancement in today's legal clinics, as there is little variety in the positions available.<sup>30</sup>

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<sup>26</sup>The qualitative data and the literature support the model of working in teams. Input at the Steering Committee supports specialization and predominant specialization in the ways noted above, but allowing for variety in legal work was required for challenge and professional development. It also supports a rotational staffing model so that staff have the opportunity to practise various areas of law.

<sup>27</sup>The literature supports partnerships with volunteers, students and pro bono services and offers many cross-jurisdictional models that significantly increase capacity. It indicates, however, that pro bono lawyers cannot successfully replace a base

<sup>28</sup>Qualitative data show that most clinics in the GTA use students in some way and that these are invaluable opportunities.

<sup>29</sup>Qualitative data and input from the Steering Committee point clearly to the need for better clinic IT systems; literature provides models on uses of various technologies, which will need further discussion and decision.

<sup>30</sup>The qualitative data and Steering Committee input support the need to alleviate some of this pressure and to have staff teams of a size that allows greater flexibility.



## SUPPORT STAFF AND BOARDS THROUGH TRANSITION

Changes in the workplace can be challenging for staff and they require extra support through transition phases. Included in this is the need for continual open and transparent communication. Giving time for staff to get to know their new work environments, roles and organizational cultures is important. Community Boards will also need similar supports.<sup>31</sup>

## PARTNERSHIPS ARE IMPORTANT AND NEED RESOURCES

### CLEAR RELATIONSHIPS WITH COMMUNITY PARTNERS IS AN ASSET

Clinics benefit greatly from collaboration with community partners. However, these are too often informal and specific to individuals within the legal clinic. Clinics would benefit from having more formal relationships with other community agencies. With appropriate support and training, partners can assist in early identification of issues, preventative advice and shared outreach efforts.<sup>32</sup>

### ACTIVE REFERRALS PRODUCE BETTER OUTCOMES

The success rate for clients is greatly improved with active referrals (for example, calling and making an appointment at another agency) and follow-up with clients. An up-to-date referral database is also important. Providing good referrals is a specialized service. We should move beyond seeing this as an administrative job (answering the phone) and train referral specialists. While economies of scale might suggest that a central intake/referral service would be best, this could decrease the quality of referrals due to lack of local knowledge (particularly across municipal boundaries).<sup>33</sup>

## THE SYSTEM NEEDS TO DO MORE

### REINVESTMENT IS ESSENTIAL

Savings created through efficiencies should be invested in enhanced services and more effective working environments.<sup>34</sup>

### AREAS OF LAW SHOULD REFLECT COMMON NEEDS

Partners and the general public are confused by the fact that access to a particular type of legal problem depends on where you reside. Good service delivery supports the idea of some

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<sup>31</sup>The literature states that the need for open and transparent communication cannot be underestimated, and that the process needs to allow adequate time to develop new organizational cultures for both staff and Boards. Discussions with staff, Boards and Steering Committee members also support this.

<sup>32</sup>The data supports formalized community partnerships. According to the literature, it is helpful to train partners to identify legal issues and provide limited advice oriented around issue identification and prevention.

<sup>33</sup>The literature supports active referral processes and the need for locally aware referral staff; the qualitative data indicate the need for well-informed local referral staff.

<sup>34</sup>The qualitative data and input from the Steering Committee support the need to enhance resources in order to provide more effective services in communities of need, while the agreement with Legal Aid Ontario provides for reinvestment, maintaining at least the same amount of funding.

coherence in the basic core list of areas of law that all GTA legal clinics address. Though needs may be different in other parts of the province, GTA clinics ought to offer some consistency in their communities. Each clinic must, nonetheless, decide how much of its resources it devotes to any particular area and what additional areas of law its client population may need.<sup>35</sup>



## EXPANDED AREAS OF LAW ARE NEEDED

Many low-income individuals need services that are not offered by clinics. Immigration law, employment law and family law are widely sought. Legal aid certificates are not meeting the needs of these populations.<sup>36</sup>

## NEED FOR ONGOING ENHANCEMENTS THAT REFLECT NEED

Currently, there is such great demand for clinic service that staff cannot meet all those in need. With transformed services reaching more people, this demand will grow. Resources and service enhancements will need to grow at least at the same rate in order to maintain current levels of service provision.<sup>37</sup>

## UNMET NEEDS EXIST FOR MANY LOW-INCOME RESIDENTS

There are a very large number of people living on low incomes who are denied access to justice because they are above the income guidelines. This creates an echelon of unserved, low-income residents, predominately the working poor.<sup>38</sup>

## WE NEED COMMITMENT TO LAW REFORM

Law reform is fundamental to the model. This work often suffers from the demands of direct client service. Through the transformation process, levels of resources allocated to these activities should increase.<sup>39</sup>

## CLINIC SYSTEM WILL BENEFIT IF IT IS AN EFFECTIVE ADVOCATE

The system as a whole will be a more effective advocate and have a stronger impact with co-ordinated efforts.<sup>40</sup>

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<sup>35</sup>The qualitative data and Steering Committee input support clinics offering core services.

<sup>36</sup>Qualitative data show that many clients seek services from legal clinics that fall outside of their scope of law, but that in many cases, the issues are interconnected. The literature and qualitative data support integrated services across many areas of law but give mixed guidance on whether to expand of law but give mixed guidance on whether to expand services to include family, criminal and consumer law.

<sup>37</sup>Data collected supports the need for resource enhancements to be able to provide adequate services.

<sup>38</sup>Qualitative data and literature support that this is a barrier to accessing justice.

<sup>39</sup>The qualitative data, input from the Steering Committee and the literature confirm the importance of law reform. The qualitative data and Steering Committee input support the need to do more in this area and indicate that this is a key part of responding to community needs. Qualitative data also indicates that more cross-clinic co-ordination would be helpful and more efficient.

<sup>40</sup>Input at the Steering Committee supports this.



## CLINIC DESIGN CRITERIA SHOULD REFLECT THE CURRENT CONTEXT

### MUNICIPAL BOUNDARIES MATTER

It is generally preferable for a clinic's catchment area to not cross a municipal boundary. A clinic serving more than one municipality has to develop relations with multiple government offices (notably Ontario Works and Housing) and community agencies. It multiplies the contacts a clinic must maintain. Clinic staff must also be familiar with local bylaws and procedures for more than one municipality. Clinics with stronger relations with their counterparts increase their ability to work more effectively. Catchment areas that match those of key partners enable clinics to work with the same partners more frequently, deepening relationships.<sup>41</sup>

### RESOURCE ALLOCATION DOES NOT REFLECT POPULATION DISTRIBUTION

The current allocation of personnel resources does not match the distribution of low-income people in the GTA. To illustrate, the current ratio of funded staff to low-income population in the GTA ranges from 1:1,500 to 1:16,500. The average is about 1:8,500. Resource allocation, however, is not this simple and will take into consideration a multitude of factors.<sup>42</sup>

## J: RESOURCE ALLOCATION

To determine how resources should be distributed among new clinics, the quantitative data was reviewed. Previous analysis had indicated (as outlined in the chapter on quantitative data) that LICO households were the best metric for identifying potential clients. A further review of that analysis was conducted.

### RESOURCE ALLOCATION MEASURES

Other demand indicators were developed, but each had significant flaws.

#### SERVICE VOLUMES

One option was to allocate resources based on current service volumes. Areas with high numbers of current clients in them could be allocated more resources to reflect their high level of existing demand. This, however, favoured already better-resourced areas that can manage higher volumes of service.

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<sup>41</sup>Qualitative data supports local partnership development through frequent engagement. The literature and qualitative data agree that longstanding relationships with adjudicating bodies facilitate effective settlements.

<sup>42</sup>Quantitative data shows concentrations of population in need in some areas with smaller clinic staff teams.

## OTHER INDICATORS OF NEED



Another option is to identify factors likely to produce demand for legal clinic services and assign resources accordingly. The number of tenants in an area, for example, could predict landlord/tenant legal service demands, but many tenants are not living on low incomes. The number of units of public and assisted housing could predict low-income tenant demand, but some areas of the GTA, most notably York Region, have little low-cost rental housing despite rising poverty rates, making that situation particularly challenging and impossible to identify through this metric. The number of OW cases and ODSP appeals were considered but, once again, variations in municipal policy distort the correlation between need and caseloads, applications and appeals.

## POPULATION PROJECTIONS

Another option was to allocate resources according to LICO but to make projections about future growth, so that rapidly growing areas of the GTA would not always be “playing catch-up”. While updating numbers was agreed to as a preferred way to ensure responsiveness to changing context, the Steering Committee was not comfortable projecting growth but preferred to update allocations at the time of the release of the 2016 census, which will be published in 2017.

## THE LOW INCOME CUT OFF

After careful reconsideration of options, the Steering Committee returned to exploring the Low Income Cut Off as the basis for resource allocation. LICO household is a readily available indicator of poverty. However, it is not an absolute predictor of demand. It is a higher cut-off than the eligibility criteria currently applied to legal aid services. It also reflects only poverty and no other factors, resulting in the need for legal interventions such as immigration or reliance on income supports.

Analysis of LICO, however, showed little difference between the geographic distribution of LICO households and more discretely defined client communities of need.

An analysis of the distribution of population at income levels below LICO showed little variation in geographic distribution. The table below shows that regardless of the level of income selected, the distribution of low incomes is consistent across the GTA geography, with little variation between LICO households living with under \$20,000 per year and households living with under \$10,000 per year. Consequently, using LICO offers a reliable indicator of where potential legal clinic clients are living.

Proportion of GTA Population at Specific Income Levels			
Statistics Canada, 2001 Census			
HOUSEHOLD INCOME	LICO	UNDER 20K	UNDER 10K
YORK	8.70%	8.80%	8.20%
PEEL	15.50%	12.40%	12.80%
TORONTO	75.80%	78.80%	79.00%
TOTAL	100.00%	100.00%	100.00%

FIGURE 20



A similar analysis of need was reviewed from earlier mapping efforts.

LICO households were mapped against other need indicators, such as immigration, showing little geographic variation between the concentrations of LICO households and the areas of highest immigration.

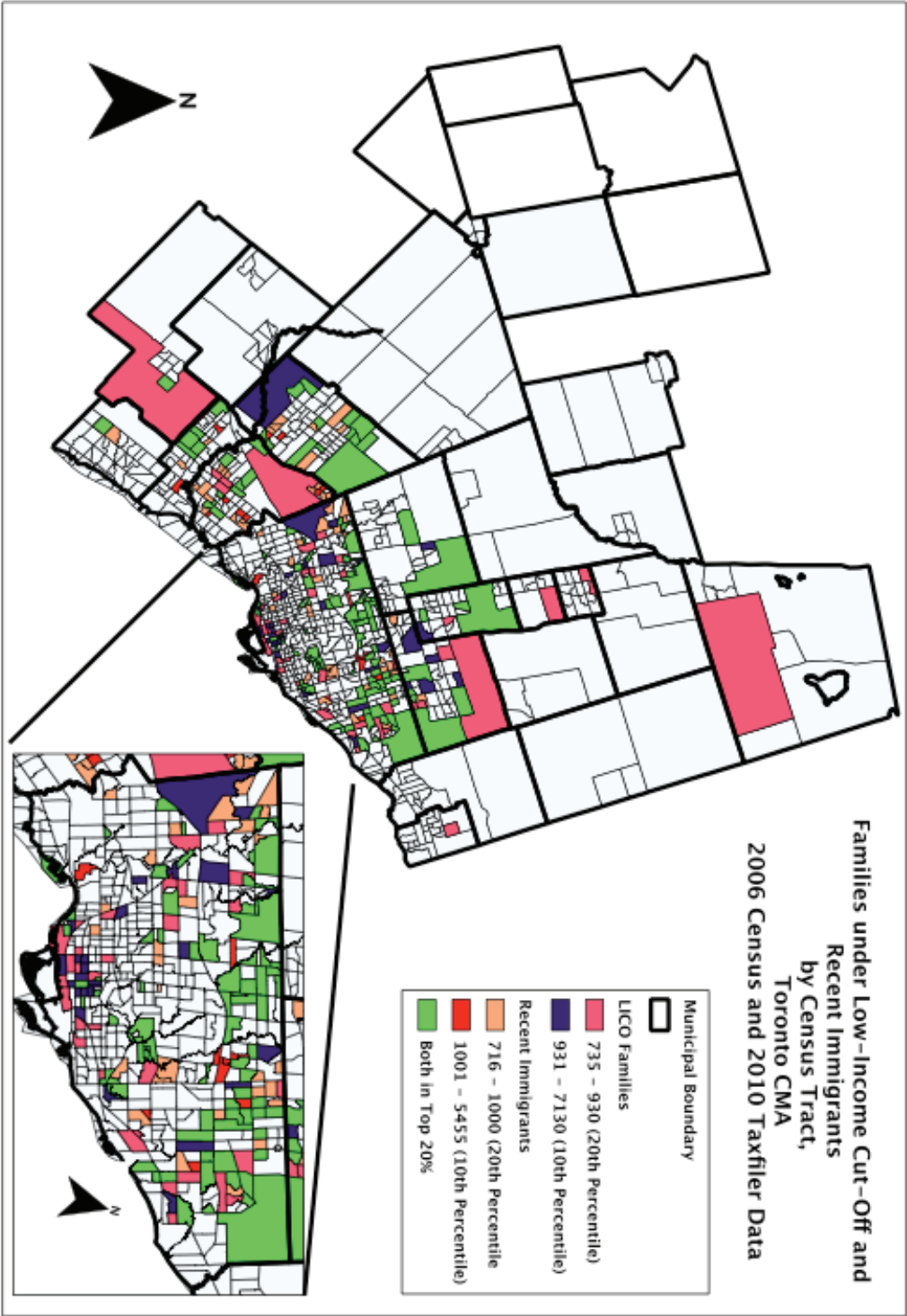


FIGURE 21



## ALLOCATING RESOURCES



### LICO HOUSEHOLD DISTRIBUTION IMPACTS

Tax filer data from 2010 was used to determine the distribution of LICO households across the GTA. The Steering Committee was provided with the resource allocation that would result from distributing resources proportionally based on that data. Resource allocating, for ease of comprehension, was expressed in terms of number of staff, though allocation in practice would use financial resources. Figure 22 shows how areas of the GTA were assigned the share of existing GTA clinic staff that reflected their proportion of low-income households.

The 2010 LICO household distribution showed that 15.2% of households were in York Region, 22.4% were in Peel region and 62.5% were in the City of Toronto. Staffing based on those percentages would place 20 of the GTA's existing 130 staff in York Region, 29 in Peel Region and 81 in the City of Toronto.

	LICO HOUSEHOLDS IN 2010	PERCENTAGE OF LICO HOUSEHOLDS	STAFF ALLOCATION BASED ON LICO HOUSEHOLDS	CURRENT ALLOCATION	CHANGE
YORK	76,510	15.16%	20 Staff	10 Staff	10
DUFFERIN/PEEL	112,920	22.37%	29 Staff	16 Staff	13
TORONTO	315,280	62.47%	81 Staff	104 Staff	-23
<b>TOTAL</b>	<b>504,710</b>	<b>100%</b>	<b>130 Staff</b>	<b>130 Staff</b>	<b>0</b>

FIGURE 22

These allocations produced a staff-to-client ratio of approximately one staff for every 3,800 LICO households. These allocations reflected the distribution of low-income households accurately but were a source of concern. They constituted a very large redistribution of staff from the City of Toronto to the outer suburbs. Currently, 104 staff work in Toronto clinics (in addition to approximately five staff who support the clinic education program at Parkdale Community Legal Services). The new distribution would constitute a net loss of 23 staff, almost a quarter of the staff in Toronto.

This very substantial loss of resources in Toronto would occur despite the fact that the number of people living below LICO in Toronto has actually risen over the last 20 years. The reallocation is not caused by a decline in poverty in Toronto – but rather a very rapid growth in poverty in the outer suburbs has lowered Toronto's proportion of a now much larger number of low-income households in the GTA.

### RISING POVERTY IN THE 905

Over the past 20 years, low-income populations in York and Peel have grown at an alarming pace. As the table below shows, though Toronto's low-income population grew by 51,000 between 2001 and 2010, York's grew by 46,000 (two and a half times its 2001 numbers) and Peel's by 59,000 (more than doubling its 2001 numbers). Since no resources were invested in York and Peel during these periods of unprecedented growth, their staff-to-client ratios became very unbalanced. As a result, redistribution within the GTA draws considerable resources out



of Toronto, despite Toronto's high and rising needs, due to the relative pace of growth. It is reasonable to assume that these trends will continue. York Region's very rapid growth and Peel's still healthy growth rate will continue to justify increasing shares of staff. York Region's low-income population will likely grow enough to justify about 26 staff over the next decade, and Peel's will rise enough to justify 28. During that time Toronto would still face staff reductions, to only 76 staff, despite a gradual growth in poverty,

	2001 LICO	% OF TOTAL 2001 LICO	STAFF ALLOCATION BASED ON LICO	2010 LICO	% OF TOTAL 2010 LICO	STAFF ALLOCATION BASED ON LICO
YORK	30,215	8.7%	11	76,510	15.16%	20
DUFFERIN/PEEL	54,110	15.5%	20	112,920	22.37%	29
TORONTO	264,375	75.8%	99	315,280	62.47%	81
<b>TOTAL</b>	<b>348,700</b>	<b>100.0%</b>	<b>130</b>	<b>504,710</b>	<b>100%</b>	<b>130</b>

FIGURE 23

## EQUITABLE RESOURCES

Given that Toronto's needs have not been reduced, one might argue that their resources should not be cut. To avoid cutting resources in Toronto and maintain staffing at 104, and at the same time ensuring a balance of resources between Toronto and the suburbs, new resources would have to be added to the clinics in the 905 areas code. To bring 905 clinics to parity with Toronto's staffing ratios would require about 36 more staff in York and Peel regions to address the exceptional growth within those communities.

	2010 LICO HOUSEHOLDS	% OF TOTAL 2010 LICO HOUSEHOLDS	STAFF ALLOCATION BASED ON LICO HOUSEHOLDS AT CURRENT TORONTO STAFFING RATIOS
YORK	76510	15.16%	25
DUFFERIN/PEEL	112,920	22.37%	37
TORONTO	315,280	62.47%	104
<b>TOTAL</b>	<b>504,710</b>	<b>100%</b>	<b>166</b>

FIGURE 24

Considerably more staff would be required in the suburban clinics and in the Toronto clinics if the GTA were resourced as other Southern Ontario clinics are resourced. Currently, Northern clinics are allocated additional resources to address the very large distance they have to brave to reach clients in very remote and inaccessible areas. However, Southern Ontario clinics vary less in their challenges. While some rural clinics are larger, urban clinics are more linguistically diverse and face higher rates of homelessness and other challenges. Despite that, clinics in the GTA are allocated far fewer staff per low-income household than the rest of the province.

Figure 25 shows that if GTA clinics were resourced in the way other clinics in Southern Ontario are, the equitable distribution of resources would not depend on drawing resources out of Toronto but simply investing in Toronto and the suburban GTA in ways that correspond to the model used in other area.

	LICO HOUSEHOLDS IN 2010	CURRENT ALLOCATION	STAFF TO POPULATION RATIO	STAFF ENTITLEMENT ON "OTHER ONTARIO" RATIOS
YORK	76,510	10	7,651	31
DUFFERIN/PEEL	112,920	16	7,058	45
TORONTO	315,280	104	3,032	127
GTA	504,710	130	3,882	203
905	189,430	26	7,286	76
OTHER ONTARIO	495,270	199	2,489	199

FIGURE 25

## AN IMPASSE

Though the Steering Committee has established principles for transformation, adopted a model for transformed clinics, determined a set of catchment areas that reflect a reasonable distribution of services and created a model for allocating resources, it recognizes that this Vision of transformed services cannot be implemented without new resources from Legal Aid Ontario.

## K: CONCLUSION

Clinics across the GTA have been working together for the last year to find different ways to provide better legal services to people living on low incomes.

Every clinic was encouraged to participate, and every clinic had a vote on the Steering Committee, which was composed of two representatives from each of the clinics.

The Project took a close look at the people who need legal services, where they live and the issues they face, and made practical, client-centered plans about how to support them better. The Project also engaged clients, staff and community members in dozens of focus groups and interviews with hundreds of participants. It also drew on the experiences of legal clinics and other service providers from around the world.

Looking at best practices, and guided by a set of shared principles, the Steering Committee developed a new model of service delivery that:

- Puts more services on the front lines, with fewer clinics reducing administrative demand, allowing 79% of staff to focus on casework or community outreach, an 18% increase.
- Increases community outreach and engagement, doubling the number of outreach workers and ensuring they spend their time in the community.
- Supports staff better, creating teams so that staff do not work in silos and have backup when they are overwhelmed with work or away.
- Staff flexibility: Larger clinics have the depth of staffing to re-deploy staff so that our services are more sustainable and we have the capacity to react to emerging issues.



- Offers more consistent support to the people who need legal services, ensuring that core areas of legal needs, such as immigration and employment law, are covered where they weren't before.
- Aligns resources with the people who need them, ensuring resources are allocated to the places where people have the greatest need.
- Is more efficient with teams that are set up to help ensure the best service as effectively as possible.
- Faster and better service: Our clinics will employ dedicated advice staff.
- Ensures efficiencies were not just cost-cutting measures but real service improvements, with a firm commitment from the Province to reinvest all savings into improving services in the GTA.
- Ensures people got holistic supports with links clinics to other community partners more effectively.
- Improves access, creating more access points in partnership with community agencies.
- Maintains community control, continuing to rely on community-based Boards to set the direction.

That model has four components: Principles, Structure, Catchment Areas and Resource Allocation.

## PRINCIPLES

The principles that guide the creation of new clinics include:

### CONNECTION TO THE COMMUNITY IS FUNDAMENTAL

With community Boards and local accountability and a commitment to community development

### CLIENTS NEED INTEGRATED, CO-ORDINATED SERVICES

Offering a full range of services in multiple areas of law in integrated clinics, connected to multidisciplinary staff teams providing holistic supports, internally or in partnership

### ACCESS IMPROVEMENTS SHOULD BE DEVELOPED

Creating community access locations through partners to improve access with multiple gateways to service

### CLINICS NEED TO SUPPORT THEIR STAFF BETTER

With better backup and teams, as well as support from volunteers, students, pro bono lawyers and collaborative partners, and improved office systems, IT and human resources

## PARTNERSHIPS ARE IMPORTANT AND NEED RESOURCES



Including relationships with community partners, proactive development and maintenance of partnerships, legal education for partners and their clients, active referrals, joint outreach and collaborating on access points

## THE SYSTEM NEEDS TO DO MORE

With reinvestment in the clinic system, expansion of the areas of law, consistent service across common needs and ongoing enhancements to address unmet needs

## CLINIC DESIGN CRITERIA SHOULD REFLECT THE CURRENT CONTEXT

In addition to creating flexible systems that have the right structure to support the operating principles and allow the right staff to do the right job; some structural rules are worth following, including respecting municipal boundaries and resource allocation that reflects population distribution

## STRUCTURE

New clinics will be based on the Model Clinic structure, as outlined in the diagram below, with:

- Four teams dedicated to four areas of law;
- A consolidated advice team;
- A larger outreach team;
- Adequate administrative supports capable of managing the offices but also supporting volunteers;
- Administrative capacity capable of partnership development and managing multisite access.

This model produces a clinic of 33 staff, though modifications to the model could alter that to some extent, producing staff teams as low as 26. However, changes that bring the staff size much lower sacrifice key components of the model.

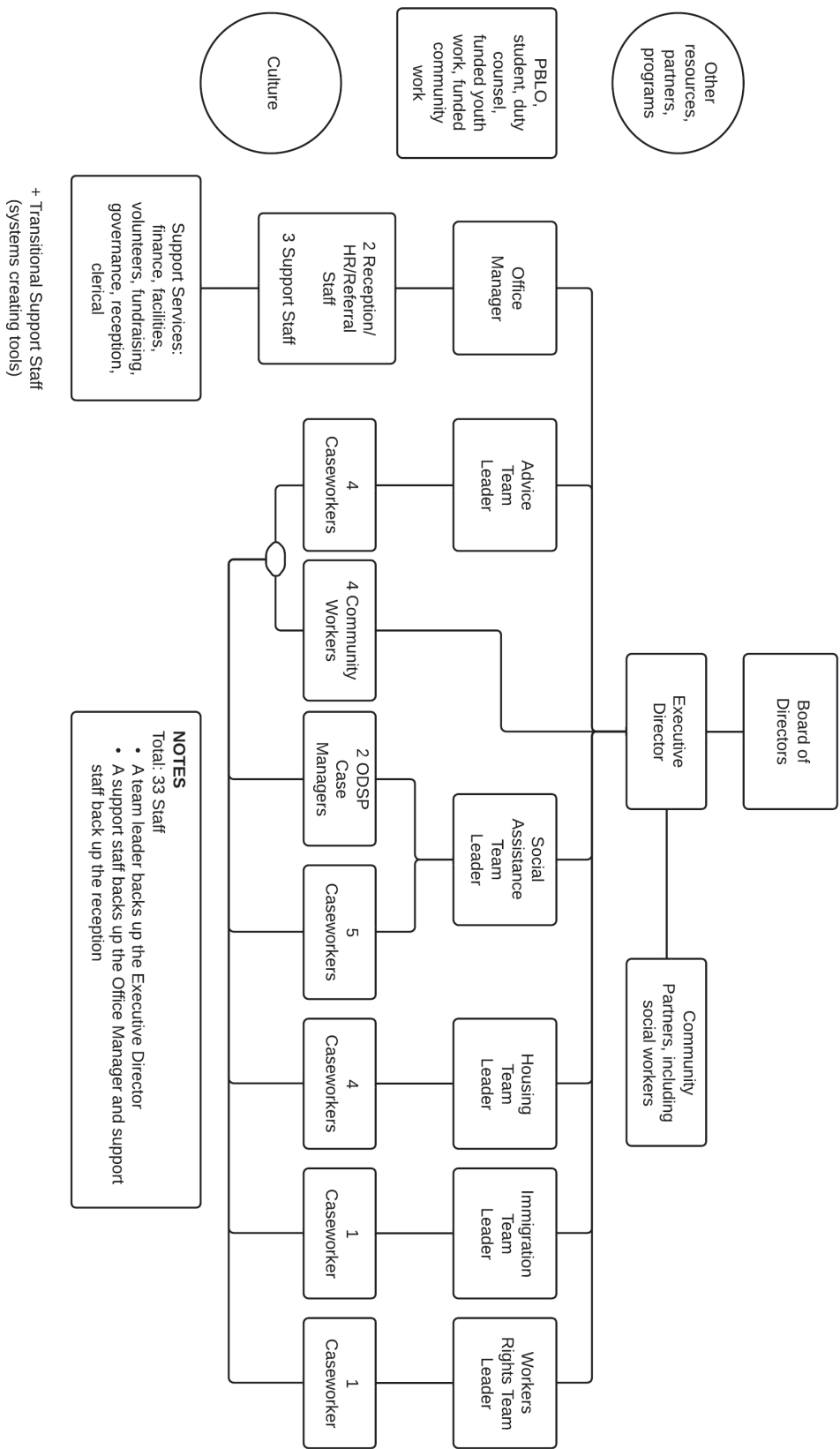


FIGURE 26



## CATCHMENTS AREAS



To ensure that most clinics have a staff team large enough to use the model structure, the Steering Committee adopted the three-clinic model based on new boundaries. Amalgamating existing clinics tied the outcome to boundaries that did not reflect the actual distribution of the low-income residents. A four-clinic model made it impossible to have clinics larger than about 25 staff. The Steering Committee adopted the following map as the most appropriate boundaries for clinics.

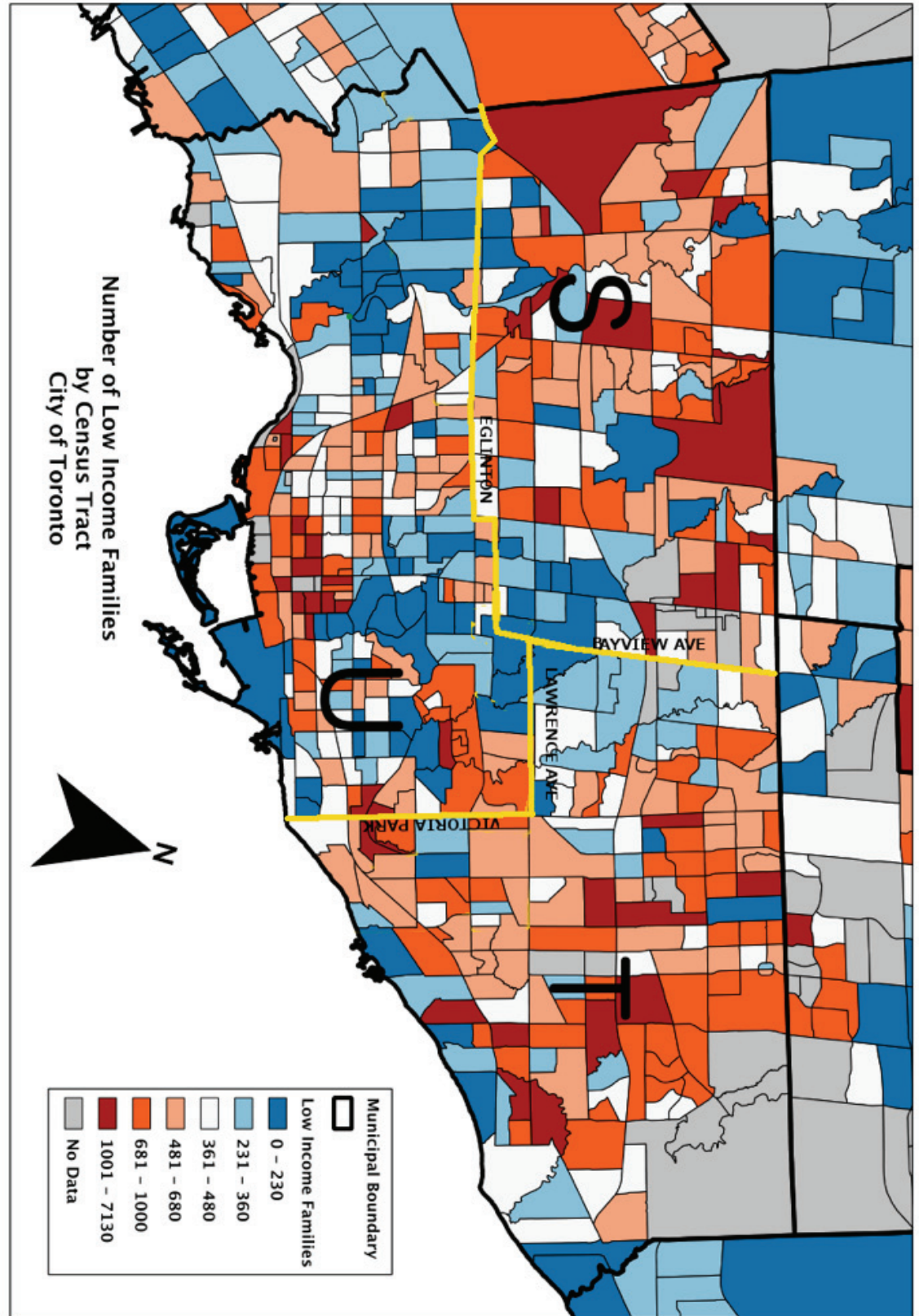


FIGURE 27

## RESOURCE ALLOCATION



Based on the research, the Steering Committee agreed to allocate resources based on the distribution of households living under the Low Income Cut Off (LICO). The Steering Committees estimates of that allocation show rapid growth in demand in the suburban municipalities in the GTA, so these allocations should be updated when the process is implemented using more current 2016 census data.

Unfortunately, the long-standing underfunding of the clinic system across the GTA, in absolute terms but also relative to the rest of the Province, has created a resource shortage, making reallocation challenging. Furthermore, the failure of the funding system to address exponential growth in poverty in the suburban municipalities over the last 20 years makes it impossible for the underfunded Toronto clinics to provide the resources necessary for the fast-growing suburban clinics to catch up from decades of neglect.

Consequently, resource allocation cannot proceed and the implementation of the transformation Vision will have to wait for appropriate resourcing to occur.

## FUTURE CHANGE

The GTA Clinics Transformation Project has completed its visioning stage with a coherent strategy for change. The process must address the need for resources to determine if it can proceed.



# APPENDICES

## APPENDIX 1: MEMORANDUM OF UNDERSTANDING

The GTA Legal Clinics Transformation Project intends to develop a model for re-structuring the delivery of services by geographically based general service community legal clinics in the Greater Toronto Area (the GTA Region as defined by Legal Aid Ontario). The GTA Transformation Project arose from a study done for the East End Toronto legal clinics which recommended re-structuring of the delivery of clinic law services and provided some principles to guide that re-structuring. After that report was issued, the East End Toronto clinics proposed that this should be a GTA-wide project and the Toronto Legal Clinic Managers Group agreed.

The study, along with other sources, identified the following weaknesses with the current structure of the geographically based community legal clinics in the GTA:

- The allocation of human resources among clinics does not recognize the changes that have occurred in the location of the GTA's low income population;
- Clinic catchment areas are not aligned with the needs of today's GTA and do not serve our clients in the best possible way.
- As small organizations, clinics are not able to develop administrative or technological systems to work more efficiently and thereby increase their service capacity in response to increasing demands; and,
- There is inconsistency in the range of services provided by Clinics which results in unequal access to services across the GTA.

The Transformation Project recognizes it is integrally related to the implementation of the Strategic Plan developed by the Association of Community Legal Clinics of Ontario, in particular, this commitment in the Plan:

We will collaborate to expand client and community access to poverty law services to address challenges such as changing demographics and the racialization of poverty, evolving service needs, and limited resources.

The Transformation Project is guided by the following principles:

- Any Clinic model developed must be community responsive and client-centered and governed by community Boards of Directors.
- There will be a continuation of a full range of community legal clinic services, including direct client services, law reform, public legal education and community development.
- The allocation of human resources among the clinics must recognize the changes which have occurred in location of the GTA low income populations.
- To expand and enhance service delivery and to leverage new resources, clinics need to be larger.

The Project is a joint endeavour of participating GTA clinics to determine the best model for replacing the existing geographically based general service community clinics with a smaller number of larger ones. The intent is to treat the GTA as a blank slate and envision what would be the best way to deliver clinic services to clients.



The Project will not determine operational issues, such as intake systems and service delivery models: those will be for the new clinics to decide upon.

The specific outcome of the Project will be to develop a model proposing:

- how many geographically based, general service community legal clinics there should be in the GTA;
- what their catchment areas should be;
- what principles should be used to allocate human resources among the newly established clinics; and
- an appropriate transition plan that identifies the critical transitional steps and issues, including governance issues.

By signing this Memorandum of Understanding (MOU), a clinic provides a serious expression of interest in the Project and support for its intended objective. At the end of the Project a report will be produced with recommendations and clinics will then need to indicate whether or not they support those recommendations. Signing the MOU does not commit a clinic to supporting the final report as the final recommendations are unknown and will evolve throughout the process.

The Transformation Project will be governed by a Steering Committee made up of one representative from each participating clinic. It is important to have a consistent representative, one who will serve as a liaison between the board of directors of the clinic and the Steering Committee.

The Toronto Legal Clinics Managers Group has struck a Working Group of eight Executive Directors to manage the project as directed by the Steering Committee:

- Marjorie Hiley (Flemingdon Community Legal Services)
- Jack de Klerk (Neighbourhood Legal Services)
- Christie McQuarrie (West Scarborough Community Legal Services)
- Stewart Cruikshank (East Toronto Community Legal Services)
- Jack Fleming (North Peel & Dufferin Community Legal Services)
- Jayne Mallin (Rexdale Community Legal services)
- Julius Mlynarski (South Etobicoke Community Legal Services)
- Nancy Henderson (Parkdale Community Legal Services)

Marjorie Hiley and Jack de Klerk were chosen to act as co-chairs of the Working Group.

The Project will apply for funding to hire consultants to work on various aspects of the project, including demographic analysis and community consultations. Ultimately, with the assistance of the consultants, the Steering Committee will produce a report which the clinics will be asked to endorse.



We support the GTA Legal Clinics Transformation Project:

Clinic: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Position: \_\_\_\_\_

Our designated representative is: \_\_\_\_\_

## APPENDIX 2: LIST OF WORKING GROUP MEMBERS

- Christie McQuarrie, Executive Director, West Scarborough Community Legal Services, mcquarrc@lao.on.ca
- Jack De Klerk, Executive Director, Neighbourhood Legal Services, deklerkj@lao.on.ca
- Jack Fleming, Executive Director, North Peel and Dufferin Community Legal Services, flemingj@lao.on.ca
- Julius Mlynarski, Executive Director, South Etobicoke Community Legal Services, mlynarsj@lao.on.ca
- Marjorie Hiley, Executive Director, Flemingdon Community Legal Services, hileym@lao.on.ca
- Nancy Henderson, Executive Director, Parkdale Community Legal Services, hendern@lao.on.ca
- Stewart Cruikshank, Executive Director, East Toronto Community Legal Services, cruikshs@lao.on.ca

## APPENDIX 3: WORKING GROUP TERMS OF REFERENCE

### COMPOSITION

- The Working Group was appointed by the Toronto Legal Clinic Management Group and formalized in the GTA Legal Clinics Transformation Project Memorandum of Understanding (the MoU) and the GTA Legal Clinics Transformation Project funding agreement.

### ROLE

- To work with the consultant(s)/project manager to achieve project deliverables.
- To bring forth recommendations on key decision items for Steering Committee review and approval.
- To address items as assigned by the Steering Committee.



## TERM

- Duration of the GTA Legal Clinics Transformation Project.

## MINUTES

- The Working Group will keep minutes recording discussion items and decisions.

## APPENDIX 4: STEERING COMMITTEE TERMS OF REFERENCE

### BACKGROUND

- The GTA Legal Clinics Transformation Project is a project of the GTA community legal clinics. It is informed by the experience of staff and boards and the January 2013 report “Refining the delivery of client-centred poverty law.”
- The Project will be a consideration of a new and better system for delivering a full range of clinic law services in the GTA which meet client and community needs and improve access to justice.
- The deliverables for this project are to determine the following elements of the transformation process:
  - » Optimal clinic structure in the GTA region
  - » Appropriate service areas and number of Clinics in the GTA
  - » Process for determining staffing levels
  - » Transition plan
- A Working Group was convened out of the Toronto Legal Clinic Management Group and its membership consolidated in the Memorandum of Understanding (“the MoU”) for the GTA Clinics Transformation Project and the GTA Legal Clinics Transformation Project funding agreement. The Steering Committee was convened from the participating clinics.
- Participating community legal clinics in the GTA Legal Clinics Transformation Project are those which have signed the Memorandum of Understanding.

### ROLE OF STEERING COMMITTEE/STEERING COMMITTEE MEMBERS

- To serve as decision-making body for the design of the new model and transition plan.
- To ensure effective communications with and participation of all participating clinics’ boards of directors, members, staff and community partners.
- To liaise with the Working Group on their activities, processes, structure and membership.
- To bring the final report and recommendations to each participating clinic for board review and decision-making.





## COMPOSITION

- Each participating community legal clinic will appoint a consistent representative (i.e. attends all meetings) authorized by their clinic. There is one vote per clinic, to be exercised by this representative.
- A secondary representative may attend from each clinic. A mix of Board and staff is encouraged. If the regular representative is unable to attend, the secondary representative may cast the clinic's vote.

## SUB-COMMITTEES

- The Steering Committee may appoint sub-committees to address specific topics. Sub-committees will bring recommendations to the Steering Committee for review and decision-making.

## TERM

- Duration of the GTA Clinics Transformation Project.

## DECISION-MAKING

- Each clinic will have one vote. The voting representative on the steering committee must be authorized to make decisions on behalf of the clinic.
- Decision-making will be by consensus where possible, and, if consensus is blocked twice, by simple majority vote (see consensus process notes at the end of this document).

## QUORUM

- 50% of clinics that have signed the Memorandum of Understanding for the GTA Clinics Transformation Project.<sup>1</sup>

## MEETING FREQUENCY

- Monthly with additional meetings as determined by the Steering Committee or at the request of the Working Group.

## CHAIR

- The Working Group will appoint an interim chair for the first meeting. The chair's role for this meeting will be to manage the agenda, and to lead a process to review, amend as necessary and adopt Steering Committee Terms of Reference.
- The Steering Committee will appoint co-chairs at the end of the initial meeting. All subsequent meetings will be chaired by the appointed member(s).

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<sup>1</sup>In the case of an odd number of participating clinics the 50% will be rounded up to the next whole number, e.g. For 17 clinics quorum will be 9 (8.5 rounded up to 9).

- The primary functions of the co-chairs will be:
  - » To prepare Steering Committee meeting agendas;
  - » To liaise with the Working Group;
  - » To manage Steering Committee discussion and decision-making, and
  - » To ensure that all elements of these Terms of Reference are applied to Steering Committee process and decision-making.



## MINUTES

- To be kept for all meetings, distributed in draft and reviewed, amended as necessary and formally adopted at the next meeting.

## CONSENSUS PROCESS

- An issue is discussed and a recommendation is made. Everyone who wishes to speak to the issue has the opportunity for input. The chair then repeats the motion/recommendation and asks if the meeting has reached consensus. Silence means consent and the motion/recommendation is approved. However, members have three ways to state their response to a call for consensus from the chair:
  1. **“I have reservations.”** This means that you are not certain that it’s the right decision but you can live with it. Consensus is reached. Your reservations/concerns can be noted so that your position is clear for the record.
  2. **“I stand aside.”** This means that you don’t think it’s the right decision, but you won’t stop it from going ahead. Again, consensus is reached.
  3. **“I block this.”** Finally, you can stop consensus from being reached by saying “I block this.” In this case consensus is not reached and the item is re-opened for further discussion.
- After a second round of discussion and call for consensus, if consensus is not reached, the motion reverts to a simple majority vote.

## APPENDIX 5: CLIENT FOCUS GROUP GUIDE

### INTRODUCTION

Legal clinics across the GTA, including \_\_\_\_\_ have come together to explore various options and approaches to more effectively and efficiently to meet the needs of residents that are on financially eligible under Legal Aid guidelines.

We work for an organization called Public Interest and will be facilitating all of the sessions with legal clinic clients and other residents for each of the participating legal clinics. We are talking to a number of individuals through interviews with organizations and agencies, to better understand the poverty law needs of residents. We are exploring the potential and possibility of how clinic service delivery could be adapted to effectively and efficiently meet the needs of clients and potential clients like yourselves.



Your input is a very important part of this process.

During the session we will refer to the term poverty law a lot. This term is meant to represent access to justice civil law services including Housing problems, tenant rights, Employment Insurance, Welfare/ Ontario Works, Ontario Disability Support Program, Canada Pension Disability and Workers Compensation (excluding family and criminal law) for low and no income residents.

Everything that you say here today will be kept confidential. No persons will be mentioned by name in the results or report and information will be presented to the legal clinics in group form at all times.

We are taking notes to make sure that we are capturing your thoughts and discussions accurately; however, these notes will only be viewed by Public Interest staff.

Please keep in mind that there are no right or wrong answers. We are interested in hearing about your experiences. We understand that there are many different and valuable experiences in this room. Not everyone's experiences and not everyone's opinions will be the same, but all of them are important to our work. Because of this, we ask that everyone be respectful of other opinions and allow each other to speak. I also ask that anything that is shared in this room remains here and isn't repeated elsewhere. I may also ask if you would like the opportunity to speak if you haven't done so already, and I may skip over you if you have spoken often, but there are others who want to speak.

The discussion today will take about 2 hours. For the sake of time, I may interrupt you or ask you to wrap up so that everyone has the opportunity to speak. And in order to hear all perspectives, I may ask people who haven't spoken to offer their ideas.

Does this sound okay to everyone?

## GO AROUND

Please introduce yourself, where you live and what legal clinic you've used before.

1. What legal issues are you or your family and friends, and people in your community most concerned about?

*Prompt for:*

- » OW/ODSP
- » Landlord/Tenant
- » Employment
- » Immigration
- » Affidavits
- » Family
- » Criminal

2. Which of these issues have you been able to get help for from a legal clinic?

3. What level of support have you been able to get?



*Prompt for*

- » Information on phone
- » Appointment with lawyer/CLW
- » Forms filled/signed
- » Non-legal support
- » Other

4. How effective was the support that you received?

- » What did you like about the support you received?
- » What happened when you found out you weren't eligible for their support? (referral to agency/other clinic, lawyer, nothing)

5. What issues was the legal clinic not able to meet?

6. What do you expect from a legal clinic? How do they meet your expectations?

7. How do you find out about the legal services and supports available to you and your friends/neighbours/family?

*Prompt for*

- » Word of mouth
- » Referral from other agency
- » Storefront sign

8. How do you currently access services from the legal clinic?

*Prompt for*

- » Phone
- » Website
- » In-person
- » Workshops/PLE

a. Which method do you prefer best?

b. How effective have you found each of them to be?

9. What are some of the challenges and barriers you have in accessing legal clinic services?

10. What can the legal clinic do to help overcome some of these barriers?

- » A number of legal clinics across Canada, the US and UK have explored different service delivery models and structures for providing law services that we want to explore with you.



11. How important is the location of the legal clinic for you?
  - a. If the legal clinic were to move, what kind of impact would it have on you?
  - b. Would the location be more attractive if the legal clinic were to move closer to other programs and services?
  - c. Would the location be more attractive if the legal clinic shared physical space with other programs and services like a CHC or Hub?
  - d. Are there any programs and services that would be problematic? What would they look like?
12. What impact could non-legal staff have on the way you experience support from legal clinics? What type of support would be most attractive?
13. What benefits or challenges would the following have for you in accessing legal services?
  - a. Telephone hotline
  - b. Enhanced website
  - c. Advice clinics
  - d. Specialized clinics

#### CONCLUSION (5 MIN)

That's all of the questions that we have. Is there anything that you would like to say, feel that we've missed, or wish that we had asked you about?

**Thank you for your time and feedback today!**

## APPENDIX 6: CLINIC STAFF FOCUS GROUP GUIDE

### INTRODUCTION

As you know, the legal clinics across the GTA, including your own, have come together to explore various options and approaches to build a new and better system for delivering a full range of poverty law services in the GTA that meets client and community needs and which seeks the most effective and efficient means of delivering clinic law services.

We work for Public Interest and will be facilitating all of the sessions like these for all of the clinics participating in the GTA Legal Clinics Transformation Project. We are holding a series of discussion groups like these for your clients as well, as well as a number of individual interviews with organizations and agencies that serve them, to better understand the poverty law needs of residents in your catchments.

Your input is a very important part of this process.

During the session we will refer to the term poverty law a lot. This term is meant to represent access to justice civil law services including housing problems, tenant rights, Employment Insurance, Welfare/ Ontario Works, Ontario Disability Support Program, Canada Pension Disability and Workers Compensation (excluding family and criminal law) for low and no income residents.



Everything that you say here today will be kept confidential. No persons will be mentioned by name in the results or report and information will be presented in group form at all times.



We are taking notes to make sure that we are capturing your thoughts and discussions accurately; however, these notes will only be viewed by the Working Group of the GTA Transformation Project and Public Interest staff.

Please keep in mind that there are no right or wrong answers. We are interested in hearing about your experiences. We understand that there are many different and valuable experiences in this room. Not everyone's experiences and not everyone's opinions will be the same, but all of them are important to our work. Because of this, we ask that everyone be respectful of other opinions and allow each other to speak. I also ask that anything that is shared in this room remains here and isn't repeated elsewhere. I may also ask if you would like the opportunity to speak if you haven't done so already, and I may skip over you if you have spoken often, but there are others who want to speak.

The discussion today will take about 2 hours. For the sake of time, I may interrupt you or ask you to wrap up so that everyone has the opportunity to speak. And in order to hear all perspectives, I may ask people who haven't spoken to offer their ideas.

Does this sound okay to everyone?

#### GO AROUND (5 MIN)

Please introduce yourself and let us know what work you do in the clinic and your involvement with poverty law issues.

#### QUESTIONS

1. Who does your Clinic serve and how have the demographics of your clients changed over the last five years?
2. Based on your experience working with low-income individuals and communities, what poverty law issues are your clients most concerned about? What issues do they seek assistance for?
  - a. OW/ODSP
  - b. Tenancy
  - c. Immigration
  - d. Employment
  - e. Other
3. What proportion of your clients have just one case in their file?
4. What law issues is your Clinic unable to meet? What are the barriers to addressing them?
5. How are clients currently accessing services – phone, in person, workshops – and to what degree do they rely on one method of interaction over the other? What is the impact on service delivery?



6. What are some of the barriers that clients face in accessing services? What can the Clinic do to help overcome some of these barriers?
7. In your experience, what service expectations do your clients have of your Clinic? Walk to clinic, be seen within a specific time frame, language supports What is the impact on service delivery?
8. What of these expectations are you able to meet and not meet? What are the barriers to addressing them?
9. Who would you say is facing the greatest challenges to accessing support from your Clinic?
10. What are the successful ways that the Clinic is able to address clients' challenges and barriers to accessing services?
11. What happens to your cases when you are on vacation or sick? How much of an impact does that have?
12. Where is there room for improvement and what would they look like? Staffing, location, services, partnerships
13. How would you describe the culture of the Clinic?
14. What does your Clinic do well and are there areas for improvement?
15. From your experience, what are the main issues facing your Clinic at this time and what are the barriers to addressing them?
16. Are there any structural or organizational issues that create barriers for clients to access services? How can these be overcome?
  - » A number of Clinics across Canada, the US and UK have explored different service delivery models and structures for providing poverty law services that we wanted to explore with you.
17. How important is the location of Clinic to your clients? What impact could a location change have for them?
  - a. Would the location be more attractive if it was closer to other programs and services they would use?
  - b. Would the location be more attractive if it were co-located with other programs and services like a community health centre or community hub?
  - c. Are there any co-location situations that would be problematic? What would they look like?
18. What impact could non-legal staff have on the Clinic and service delivery? Do you see a role for staff outside of the legal field? What type of support would be most attractive?
19. What impact would a new location have on yourselves as staff of the Clinic? Would the location be more attractive if it was closer to other programs and services that you could refer clients to?

20. What benefits and challenges would the following provide to Clinics?

- a. Poverty law telephone hotline
- b. Brief service or advice clinics
- c. Specialized clinics
- d. Would there need to be any guidelines/limitations to making it work?



#### CONCLUSION (5 MIN)

That's all of the questions that we have. Is there anything that you would like to say, feel that we've missed, or wish that we had asked you about?

Thank you for your time and feedback today. We are holding a series of discussion groups like these for your clients as well, as well as a number of individual interviews with organizations and agencies that serve them, to better understand the poverty law needs of residents in your catchments. We'll also be exploring more operational aspects of your clinics and will be incorporating your feedback, plus those of other stakeholders as we explore the possibility of how clinic service delivery could be adapted to effectively and efficiently meet the needs of your clients.

**Thank you!**

## APPENDIX 7: EXECUTIVE DIRECTOR KEY INFORMANT INTERVIEW GUIDE

### UNDERSTANDING CLIENTS AND THE COMMUNITY

1. Who does your clinic currently serve? Have you seen changes in who you're serving over the last 5 years? 1 year?
2. How is your clinic dealing with the changing demographics of your catchment area?
3. From your perspective, what are the major issues facing people in your catchment area? How is your clinic able to address these issues?
4. Are there client needs that your clinic is unable to meet? What are they and what are the barriers to addressing them?
5. Who would you say is facing the greatest challenges to accessing support from your clinic?
6. Do you have any formal or informal partnerships with other organizations? If yes, who are they and what is the nature of your partnership?
7. What role do you see partnerships with other organizations playing in the future of your clinic?



## GENERAL ORGANIZATION

8. How long has your clinic been operating?
9. What is the mission and focus of your legal clinic? How does it differ from others in this initiative? Across Toronto?
10. What is your role in your clinic? How has your role changed since you started?
11. What is the staffing complement in your clinic? What gaps have you identified that impact service provision?
12. How would you describe the culture of your clinic?
13. What does your clinic do well? What are the aspects of your clinic that are not working as well?
14. Are there services that you would like to see your clinic provide? What are they and have you taken any steps towards implementation?
15. From your perspective, what are the main issues facing your clinic at this time? What are the barriers to addressing these issues?
16. What major issues should be considered during the planning and implementation of this process?

## PROCESS

17. What made you think it would be useful for your clinic to participate in this process?
18. What external elements are influencing this process and need to be considered?
19. What would constitute success for this initiative? What purpose does this process serve?
20. What do you hope this process does not do? What are the possible bad outcomes or bad processes that should be avoided?
21. What would constitute success for LAO? What would be seen as a failure by LAO?
22. What would constitute success for your clinic?
  - a. What are the particular challenges/issues that you hope this process will address? What are the challenges that are important to address, but can't be addressed with this process?
  - b. What are the opportunities you hope to secure with this process? What are the opportunities that can't be secured with this process?
  - c. What would you and your staff see as signs that this process has been a bad choice?
23. We have the capacity do a limited number of key informant interviews and focus groups. Who are the key people/groups that you feel must be included?

## APPENDIX 8: EXTERNAL PARTNERS KEY INFORMANT INTERVIEW GUIDE



1. Tell me a bit about your organization, your catchment and your communities (the people in this area that you represent/serve/belong to a community with) – demographic breakdown, languages, ages, employment, geographic clusters.
2. What are your community's needs and how have they changed in the last 5 years?
3. For these populations, what types of services exist to support them?
4. Are there gaps in services to respond to your clients' needs? What is needed to fill these gaps? (Are there specific underserved populations, whether in or outside your scope of service?)
5. How does your community interact with the local community legal clinic? (programs, services, outreach etc.)
  - a. How could the local CLC improve their relationship with your organization to provide better services for residents?
6. In your opinion, what does the CLC do well? What can it do to improve?
7. In your opinion, what are the benefits of having a legal clinic in the community?
8. What would be the impact on the community if the clinic were to relocate outside of the community?
  - a. In your opinion, if this were to occur, what types of supports or accommodations would be needed to ensure the service delivery remains accessible for clients?
9. What would be the impact on the community if the clinic were to become a specialized clinic that focused on a particular issue – e.g. ODSP, tenants' rights...
  - a. In your opinion, if this were to occur, what types of supports or accommodations would be needed to ensure the full range of CLC service delivery remains accessible for clients?
10. In your experience, what can the CLC do to:
  - a. Reach more residents
  - b. Provide services that reflect the needs of the community
  - c. Provide greater, quality service for clients
  - d. Work better with other organizations in the area
11. Do you have any other feedback that could inform this process and the CLC's service delivery in the community?
12. Any other comments?



## APPENDIX 9: QUALITATIVE DATA SUMMARIES AND SUPPLEMENTARY REPORT

### CLIENT FOCUS GROUP SUMMARIES

This summary is based on nine focus group that Public Interest held clinic clients from the following legal clinics: Downsview Community Legal Services, Jane and Finch Community Legal Services, Kensington Bellwoods Community Legal Services, North Peel and Dufferin Community Legal Services, Parkdale Community Legal Services, Rexdale Community Legal Clinic, South Etobicoke Community Legal Services, Unison Health & Community Services, and Community Legal Clinic of York Region . Groups were carried out in several languages but predominately in English. Discussions lasted 2 hours and were based on a consistent set of questions oriented around drawing out the experiences of clients with accessing services at community legal clinics, their needs and priorities in the future work of clinics and their concerns about change.

#### *CLIENTS ARE FACING MULTIPLE CHALLENGES*

Focus group participants came from diverse socio-cultural, low-income backgrounds and faced multiple barriers to accessing services. Many clients reported struggling with mental health issues including depression, isolation, and anxiety. They described themselves as feeling lost, not knowing where to go for help or what help they could ask for. Many were in crisis by the time they reached the clinic; they reported struggling with high levels of stress, anxiety, and even suicide.

Newcomer and immigrant clients reported facing barriers to settlement regardless of whether they were newly arrived to Canada or here for many years. They reported language and not knowing Canadian systems as barriers to accessing services. They were concerned about sponsorship and family reunification issues, as well as trying to navigate the complex immigration system.

Many clients faced physical challenges and mobility issues. Clients reported suffering from ailments and deteriorating health conditions, personal and workplace injuries, as well as mobility issues.

Seniors also made up a sizeable proportion of clients, some of whom were caring for children with disabilities, as did single mothers.

Clients reported that in all cases, the issues they faced were multiple and generally compounding.

#### *CLIENTS SEEK AS BROAD SCOPE OF SERVICE*

Clients sought a broad range of legal services from the clinic system. Many clients reported accessing services for ODSP appeals and Landlord and Tenant issues. CPP and WSIB were among other issues clients sought helping for, as well as immigration and employment.

Clients also reported seeking services in areas of law not covered by the legal clinic system. These included criminal and civil matters, as well as family law, including domestic violence.





Given the barriers that clients face, discovering that clinic services existed was an issue. Many clients learned of the clinic through word of mouth, generally through a family member, friend, or neighbour who had accessed the services before and had good experiences. They shared this with clients and encouraged them to seek help at the clinic. In the same manner, clients reported that they also tell people in need about the clinic and that assistance can be found there.

Clients were also referred to clinic services by their ODSP or OW offices. Some clients reported that in their ODSP rejection letter that outlines the appeals process, seeking help at a community legal clinic was listed as an option of where to find assistance.

On a much less frequent basis, clients reported searching online where they found clinic contact information. As well, clients were referred to legal clinics by their city councillor and MPP office, a social worker through the Toronto District School Board, and a doctor. One client learned of the clinic because it was located in the same building as her husband's ESL class.

#### ACCESSING SERVICES

Though on-street visibility is not often identified by clients as a method for finding or accessing services, many clients felt that having the option to walk into a community-based clinic or satellite location was important, whether they were seeking initial consultation or advice, completing an intake, or for any follow-up concerns. Clients reported a high comfort level with this method of service delivery. In their experience, wait times were low. In cases where staff was busy, they still reported a high quality of service including a friendly greeting, being asked to wait, and told that staff will be with them shortly. Having a walk-in option was particularly important to clients with language barriers, who reported that it was easier to access translation. It was also important to clients with mental health issues, who stated that in general, they were able to gain a better understanding of their situations through human contact. Only one client stated that they did not want to risk spending a token to travel and not receive service, though this had not been the standard experience.

Although the ability to walk into an office is important to clients, many also reported calling the clinic first to get an appointment. There was a high comfort level reported with the current phone system in place, which was characterized by a personalized, human element. Clients reported that clinic staff frequently answered their phones, including clinic directors and lawyers, who gave their direct extensions to clients. Where clients had to leave a message, they reported that all staff returned calls in a very timely way, usually within 24 hours, and no client reported having to leave more than one voice message. It was also important to clients that clinic staff were knowledgeable and could give relevant information to them over the phone.

The location of the clinic was a key factor in accessibility of services for clients, with community-based locations being reported as extremely important. This included being near good transit, as well as having parking spaces for those who drove. Clients who lived in more remote areas outside of the city reported connecting with the legal services through a satellite location for intake, but that they still had to travel to the main clinic location for full service. This would have been a barrier had they not had access to a car.



Overall, the vast majority of clients reported being satisfied with the current location of their clinic, and any discussion of moving out of the current community location raised concerns. Clients stated that there is comfort in familiarity of clinic location. Having to navigate unfamiliar transit routes, roads, and office buildings was pointed out as sources of increased anxiety and barriers to accessing services.

#### *PARTNERSHIPS MATTER*

Clients reported that the relationship they have developed with legal clinic staff has been overwhelmingly positive and exceeded many service delivery expectations. Client experiences with other systems, including immigration, health care, social services and housing, were described in negative ways, with clients reporting being turned away for services again and again. At the legal clinic, clients describe being treated with respect, which included many cases where staff took the time to understand all aspects of the client's situation, dealing with the legal matters where they could, and making sure to refer clients appropriately in other areas.

Clients reported that staff knew who they were when they telephoned in, and most importantly was the fact that clients did not have to repeat their story over again. The only incidence where this occurred was in relation to student turnover. Clients stated that by the time they developed a relationship with the student, their placement was over and a new student was assigned to their file.

Virtually all clients reported having a relationship with the legal staff that is based on trust and mutual respect. The relationship frequently was described as ongoing, with clients reporting that legal clinics were often the first place they turned to when a concern arose, legal or otherwise. Clients described a feeling of being 'at home' in their legal clinic, and in some cases, felt as if their lawyer was their similar to family or a friend.

#### *SUGGESTIONS FOR CHANGE*

Although clients liked the idea of using the phone to call in to make appointments or seek very brief advice, overwhelmingly clients thought that a hotline would not enhance services. Based on personal experiences with other hotlines, clients felt a legal hotline would cause confusion, and be riddled with long wait times and multiple transfers. Clients were concerned that they would not be able to understand information accurately, that they would have to repeat their stories many times over to different operators, and that these would be stressors would be compounded if language and/or mental health were issues. The service would also lose the very important human element that currently characterized the legal clinic system. Overall, clients felt that a legal hotline would not enhance legal service accessibility, but rather would serve to increase their stress and anxiety levels and put up more barriers to accessing justice.

Some clients thought that a hotline could have advantages if it was introduced in addition to current services. Clients stated that they may use it for information or brief advice. Isolated individuals reported that it could be helpful to connect with services over the phone. Still, the human element is essential to clients, who stated that the hotline would only work if there were knowledgeable and friendly staff that answered and who could respond appropriately to an array of questions.

With similar concern, clients felt that accessing services through a website would not seek to enhance service provision in and of itself. Many clients reported being computer illiterate, and having very limited or no access to computers and internet service. In particular, seniors, and seniors with English language barriers reported overwhelmingly not having access to such technology. Concerns around privacy were raised, that clients did not feel comfortable entering personal information into a computer and that this would add another barrier to accessing service. Few clients reported accessing legal information online, and none of the clients reported that they would prefer it over face-to-face meetings.



A major part of the service that clients sought was in filling out forms and having the system, and what to expect during the legal process explained to them step-by-step. Many clients questioned how effectively this service could be provided over the phone or online. Overall, clients were wary of these suggestions and felt that they would further exacerbate systemic barriers to legal services.

#### *MOVING CLOSER TO OTHER SERVICES OR CO-LOCATING*

Clients expressed appreciation for clinics being close to other necessary services, and where this was already the case, clients found it aided them to follow through on accessing referrals. Proximity to other services made them aware that those services existed. Indeed, one of the barriers that clients spoke of was that they did not know what services exist and what issues they can ask for help for. It was for these reasons that clients whose clinic was already located closely to other services did not want their clinics to move, whereas clinics that were not near these other services, clients were open to a move that would put them closer.

Benefits of co-locating with other services, according to clients, could again include learning about what services existed and facilitate easier access to those services. Some relevant services that clients would like to see housed with legal clinics included counselors and social workers, an ODSP or OW office, housing help, and health care services. Clients did caution that this type of structure could be too big, too institutionalized, and too 'noisy'. They worried about losing the personalized and individualized approach to service delivery.

#### *ADVICE CLINICS AND SPECIALTY CLINICS*

Clients saw the advantage of adding advice or specialty clinics to the current legal clinic system, but felt that if their current community legal clinics were removed and replaced with specialty or advice clinics, that these would not enhance service delivery. Clients expressed anxiety with the fragmentation of services, and with having to go to one clinic to get advice, then having to travel to another clinic in another location to receive further legal assistance. As well, clients expressed concerns that since many issues are interrelated, then accessing services through specialty clinics would, again, require travel to different clinics to deal with the various issues. Instead of specialty clinics, clients suggested that lawyers and Community Legal Workers with specialized knowledge in different areas of law could work together within the same clinic.



## CLINIC STAFF FOCUS GROUP SUMMARIES

This summary is based on 12 focus group that Public Interest held clinic staff from the following legal clinics: Downsview Community Legal Services, Jane and Finch Community Legal Services, Kensington Bellwoods Community Legal Services, North Peel and Dufferin Community Legal Services, Parkdale Community Legal Services (including a focus group with clinic staff and one with academic staff and students), Rexdale Community Legal Clinic, South Etobicoke Community Legal Services, West Toronto Community Legal Services, Unison Health & Community Services, and Community Legal Clinic of York Region. Groups were carried out in English. Discussions lasted 2 hours and were based on a consistent set of questions oriented around drawing out the experiences of staff in delivering services at community legal clinics, the needs and priorities of clients, emerging trends in the field and their concerns about change.

Clinics overwhelmingly identify people facing multiple barriers as the core of their client groups. Every clinic mentioned the in the number of growth of clients confronting mental health challenges, adding complexity and new skill demands to the work of representation. Racially and ethnically diverse clients also makeup a significant proportion of clients, including immigrants, facing challenges navigating new systems and people of colour confronting the challenges associated with race. Isolated seniors and single parents were also mentioned. These characteristics describe clientele that face complex barriers that involve challenges that go well outside the legal challenges they face. Clinic staff noted the growing demands that result from the complexity of the circumstances of their clients and the increasing proportion of work that involved skills other than legal skills.

### *CLIENTS SEEK A BROAD SCOPE OF SERVICE*

Clinic staff identified significant demand in the major areas of clinic law. Virtually every clinic noted demands around immigrations and access to government benefits, regardless of whether or not the clinic offered those eservices. Many clinics face considerable demands around landlord and tenant law, again addressed to clinics that offer these programs and those that don't. Similarly, most clinics face demand for family law, though it falls outside the clinics' mandates, and many face demands for supports around criminal law and employment law. Clinics noted that the scope of services offered did not cover the range frequently requested by clients.

### *CLIENTS PRESENT COMPLEX CASES*

Few clients present with only a single legal challenge. Clients may be facing eviction because of a loss of benefits, or facing a loss of benefits because of a dispute over their immigration status. But clinics almost universally indicated that the vast majority of their clients have had multiple cases on their files.

### *CLIENTS NEED COMPLEX SUPPORTS*

Clinic staff describe clients as almost invariably in difficult circumstances facing short timelines and few options. Clients arrive in clinics seeking urgent aid with little clarity about the challenges they face and the real choices available to them. Clients are frequently in crisis and in need of emotional support. Many need counseling and mental health support to steer them through the difficult process ahead of them.

## COMPLEX CLIENTS NEED TIME



Clinic staff must invest time and energy in gaining the trust of clients. Spending the time to listen and engage is, according to clinic staff, a key element in building the relationship that enable them to support their clients through difficult tasks. These relationships are valuable to the ability to enable clients to accept advice and having confidence in the information provided. These result in longstanding commitments, and expectations, on the part of the client. Clinic staff express widespread frustration at the pressures on staff time, the limitations on time with clients that invariably result from growing workloads on increasingly complex cases with inflexible resources, and continuous pressure on client volumes and pace of service.

## TRUST AND FLEXIBILITY CONNECT CLIENTS TO CLINICS

The trust clinic staff engender is also a key part of generating the word of mouth that informs future clients that the clinic is an appropriate place to seek the legal help they need. Clients often come looking not for a clinic but for a specific staff person, regardless of the staffers expertise in the field, and are sometimes difficult to re-route to more appropriate supports.

## PEOPLE COME TO CLINICS THROUGH EVERY AVAILABLE GATEWAY

Though most clients connect to GTA clinics initially by phone, there are a wide variety of paths to service and all service paths offer specific benefits. Connection to the clinic by phone is widespread and clearly the most common first point of contact. Some clinics, however, prefer initial contact be live, one-on-one connections, while, conversely, others forbid it. Many clinics do initial intake over the phone but others insist on face-to-face intake procedures. Some clinics do extensive work on the phone and others indicate considerable difficulty with phone connections. Phone time is sometimes costly to clients and often they are difficult to reach by phone, however when it works, phones offer faster and less onerous connection opportunities for many. Live engagement is usually relied on for any review of documents. Live contact is preferred by many as a method of trust building and for navigating complex discussions. Little use is made of current electronic methods such as Skype and video calls and even email and web use are fairly uncommon. The diversity of gateways to contact, intake and service reflect the diversity and uniqueness of clients and their needs and are likely a long term feature of clinic life.

## TRAVEL IS A BARRIER FOR CLIENTS

Clinics identify travel as a major concern for many clients. Clients struggle with the cost and time requirements of travel, which, in some areas of the GTA, can result in a day-long commitment and an investment of more than a full day's food budget. Clinics expressed concern about being co-located far from the clients who rely on them. Clinics with no physical presence in parts of their catchment areas report lower participation from those areas and those that have moved report significant shifts in their client base resulting from the move unless substantial efforts to re-establish a physical presence in the old location are made.

Maintaining direct contact often relies on efforts to offset the burden travel places on clients. Transit fare is often mentioned as a necessary support. Many clinics provide satellite locations to facilitate easier physical access. Formal satellite locations are largely created in partnership with



specific agencies or organizations designed to meet a specific population with clearly identified legal needs. Some clinics offer mobile service, bringing lawyers to the homes or gathering places of clients on an as-needed basis. Less formal “drop in” satellite efforts receive mixed reviews, often reaching ineligible clients or clients with legal needs within the scope of clinic services.

#### *WHERE CLINICS CAN'T SERVE, THEY REFER*

Many people in need of supports are unable to get service from community legal clinics either because of income eligibility criteria or because they seek services clinics currently don't provide. Most clinics engage in extensive range of referral processes, generally referred to other service providers, usually in the area. However, clinics have few mechanisms for testing the success of the referrals they make. They get little feedback from the other agencies they referred to and rely on negative long term feedback from clients as one of the few tools to track the currency and effectiveness of referral processes.

#### *PARTNERSHIPS PROVIDE A RANGE OF OTHER BENEFITS*

Many clinics see a significant number of cases from partner agencies or from agencies that serve similar clients such as OW, ODSP and social housing providers.

Clinics also find partner agencies advantageous in obtaining new information about client populations and client needs and identifying emerging trends. These relationships offer access to client populations that may need service, information or support. Legal education efforts are often delivered through these relationships as are satellite and outreach activities.

#### *RELATIONSHIPS ARE ALSO HELPFUL WITH GOVERNMENT BODIES*

Developing relationships with staff of government bodies is also highly valued. Established connections with public housing staff, ODSP and OW staff and staff in courts and tribunals creates relationships of confidence and sometimes trust that allows for more rapid and effective negotiation and the ability to reach agreements without the cost and effort of formal hearings.

#### *FEW STRONG FORMAL RELATIONSHIPS WITH PARTNERS*

Most clinics have some relationships with organizations or agencies that they refer to frequently and some links between the clinic and those agencies. However, those links are rarely robust partnerships and often rely on personal connections between staff at the two agencies or informal connections built up over time, and far less often on any formal arrangement between the agencies. Staff stability plays a large role in the strength to those partnerships, with staff turnover creating a significant loss in many interagency relationships. Few institutional mechanisms exist to re-establish strong links to compensate for staff turnover.

#### *OUTREACH AND LEGAL EDUCATION HELP BUILD RELATIONSHIPS*

Clinics indicate that outreach efforts, as well as providing legal education seminars to staff and clients of nearby agencies are useful tools in building relationships with agencies and communities. Interagency relationships rely on reciprocal support and education is a key part of what clinics can



contribute. Clinics often identify the volume of outreach and Public Legal Education as two of the areas of work that have suffered under the time pressures imposed by case files, undermining the ability to build and sustain relationships with partners and communities.



#### *PROXIMITY AND SHARED CLIENTS FACILITATE RELATIONSHIPS*

Many clinics maintain their strongest relationships with organizations share catchments and overlap in target populations. Often proximity to partner organizations helps facilitate ease of access for clients, who can address several support needs in a single visit, avoiding transit time and costs barriers. Similarly, clinics with nearby partners found it easier to manage some referrals and support requests. Sending a client across the street or across the hall, or asking a colleague from another agency for advice or assistance based on relationships of very frequent interaction were valued by clinics with nearby partner agencies.

#### *COLLOCATION IS A MIXED BLESSING*

Though there are significant benefits to proximity, full co-location has challenges. Clinics already located in hubs and integrated facilities expressed consistent frustration over loss of control of hours and access. They also expressed some concern about loss of identifiable presences. Some felt that they lost priority in driving the location of the clinic by committing to a shared facility and were concerned that their current location was not the most appropriate for their client population.

#### *MANY WHO NEED ACCESS TO JUSTICE CAN'T ACCESS CLINICS*

Clinic staff identified a wide range of people who need access to justice who cannot access the current clinic system. While telephone translation services have helped with linguistic barriers language remains a hurdle for many. Travel is a challenge for all but the smallest clinics in downtown Toronto. Many who face insurmountable economic barriers to the justice system nonetheless fail to meet financial criteria for service. Many who meet financial criteria need service not offered by the clinic in their area. Those who seek services related to family law, including women escaping violence and seniors experiencing abuse, as well as those seeking assistance with employment law, including workers denied wages owed or those facing harassment or abuse in the workplace, have very few options for access. Even those seeking relatively common community legal clinic supports such as immigration law are all too frequently confronted with a local clinic that has not included that area of law in their scope of service. The narrowness of the range of services offered and inconsistency across clinics makes it difficult for clients to know what services to expect from the legal clinic “system”, and excludes a startling share of those in need of access to justice.

#### *CLIENTS OFTEN CAN'T GET THE DEGREE OF SUPPORT THEY SEEK*

Clinic staff routinely described clients who struggled with the limitation of the system. Many clients seek immediate service and full representation and are frustrated to learn that the constrained resources and optimal allocation staff time limit the service they can receive to advice, information or support, and that the pressure on staff often mean waits, limitations on discussion time and other restrictions that make the navigation of the system stressful for clients.



#### *STAFFING IS A CHALLENGE*

The volume of staff available, relative to the demands in the community, mean constant pressure on staff. Clinics express concern about the never-ending torrent of case files that threaten scope, quality and attention to detail. Pressure on client volumes overlook the intensity of cases and the complexity of work and staff experience this as pressure to turnover cases faster despite the challenges in doing so. Virtually all clinics identify an increasing front-line staffing as their number one priority addressing difficulties in both volume and internal flexibility. Staff in larger clinics often have systems to support each other in areas of law during periods of high pressure, or during leaves and holidays. Staff in small clinics can sometimes cover for each other but often express frustration with the inability of the system to provide support when they are overrun or away.

#### *CLINICS ARE EAGER TO DO MORE IN THE FACE OF HIGH NEED*

Clinic staff identified a range of activities and services that they believe should be a key part of their work but are squeezed out limited staffing and the time pressures of case files and client volumes.

First and foremost clinics sought time to do more education, outreach and community development. Most clinics felt they needed to do more in this area but few were able to free up the resources from case files and other pressures to consistently reach out and engage their communities.

Clinics expressed interest in increasing professional development as well, feeling the pressure of workloads limited time to gain new skills and information.

#### *CLINIC STAFF SEE A NEED TO CHANGE THEIR WORKPLACES*

Clinics often faced challenges in how their workplaces are set up. Many identified the shortage of space overall and in particular private meeting or office space where confidential client meetings can take place.

Clinics expressed concern about how accessible their space might be for clients, both in proximity to their homes and in access to transit.

Clinics widely criticized their IT infrastructure, expressing concern about everything from internet access to telephone lines to digital document management. Systems that support success are simply not in place and technology is woefully out of date and riddled with impractical constraints.

Many clinics also identified a need for staff or other supports that helped with clients' non-legal needs. A social worker or mental health worker were often identified as a valuable addition to the team.

#### *FRAGMENTATION IS UNHELPFUL*

When considering options for clinic structures, staff consistently opposed various forms of specialization or fragmentation of clinics. Clinics also emphasized the importance of connection to community in the design of clinic structures.

Centralized intake phone systems were unpopular. Staff anticipated poor appreciation of local circumstances and issues and poor awareness of constantly changing referral contexts resulting in poor performance. Staff also expressed concern that intake had to be informed by the pattern of needs and issues emerging in the cases being pursued by the clinic.



Specialized advice and brief service clinics were similarly criticized, with staff noting the often blurry line between advice, brief service and emerging cases at the intake stage and the redundancy that would result in the fragmentation of clinics into different service types.

## ED AND COORDINATOR INTERVIEWS

Executive Directors and Coordinators were interviewed one-on-one to gain their insights both into the clinics they work in and the system as a whole. They also talked about how the transformation process might affect the clinics. EDs were interviewed for between 45 and 60 minutes using a structured set of questions that largely reflected the themes of the staff focus groups.

Clinic leaders shared many of the ideas and concerns of the staff. Little variation existed on the subject of priorities, pressures, issues, client populations, current needs, and barriers to success. However, some key themes were strongly emphasized and those are outlined here.

### *CLINICS SERVE COMPLEX CLIENTS WITH COMPLEX NEEDS*

EDs and Coordinators clearly identified a wide range of clients and a constantly changing set of needs and characteristics. Though clients were by and large from the catchment area, they were not evenly distributed in it, with patterns changing as locations changed. EDs noted divergent needs in urban settings compared to rural area that exist in the GTA. Some EDs noted the rise in mental health issues they deal with. All underscored diversity as a key characteristic of client populations and most stressed language issues as a key factor in serving them.

Clients face a complex array of needs. Many come for income supports and housing services. Fewer clinics are able to provide support around immigration and very few address employment law, EI and WSIB, family law and criminal law though these areas are often categories of need for clients.

### *CLIENTS FACE BARRIERS TO SERVICE*

Many EDs and Coordinators identified income criteria as an issue for many who need access to justice. Working poor families are simply not able to meet clinic requirements. Travel was also raised as a barrier. Clinic leaders noted consistently that resource strains and work volumes also put pressure on their work, making it hard to offer the full range of services and supports they would like and hard to focus as much on each client. Some smaller clinics were concerned about their ability to maintain the diversity of legal expertise that they needed for the range of legal services clients needed. Many clients also had non-legal needs that required attention that the clinic was poorly situated to provide but created barriers to successfully supporting the client.



#### *PARTNERSHIPS WERE VALUABLE BUT OFTEN INFORMAL*

Clinics relied heavily on referrals to provide support to clients, and often received referrals from local agencies. . Many of those referrals involved local area partners. While clinic EDs and Coordinators placed high value on partnerships, few were able to systematically pursue or maintain them, and many were simply informal arrangements evolved over years of work. Clinics were clear that partnerships should be viewed as functional arrangements, and that some partnership arrangements could be more trouble than benefit. Partnering should be a thoughtful and purposeful plan not simply a mantra or fad.

#### *CLINICS TEAM UP TO FOCUS ON CARE FOR CLIENTS*

Clinics tend to build strong teams where numbers and circumstances permit it. EDs, like staff, value the work of teams and the inter-supportive roles of staff. That is difficult in many circumstances. High volumes and intensive case file demands make it difficult to provide the scope and intensity of support that would be ideal. Triage and efforts to stretch staff and time are endemic. Efforts to create new funding sources, including health, housing and federal sources, have helped in some circumstances but are far from adequate. Efforts to bridge travel problems by creating satellites have been helpful primarily when done in partnership with agencies serving similar clients and designed around meeting specific needs. EDs vary, as clinic staff do, in their emphasis on reaching clients by phone.

#### *CLINICS FACE BARRIERS TO MEETING DEMANDS*

High volumes, sometimes niggling interventions from LAO, intensive client needs, all create pressure on clinics that make it hard to meet the full scope of client needs. Poor IT infrastructure and phone systems add to these barriers. EDs continue to explore and discuss intake systems seeking the most effective mechanisms. The time needed to develop new partnerships, shore up existing ones and create accessible satellites is rarely available, creating barriers to strategies that could enhance service.

Clinics are often frustrated with the many constraints that prevent the outreach, public legal education and community development work they see as central to their mandates. Many are also frustrated by the minimal amount of law reform work that time allows.

#### *EDS SEE TRANSFORMATION AS POTENTIALLY BENEFICIAL – BUT ALSO RISKY*

With many structural issues affecting clinics, many EDs see opportunity in the transformation process. The ability to create new structures that address the barriers described above offer some hope, but not without risks. Avoiding job loss is a common priority. EDs and Coordinators place high priority on maintain strong relationships with communities and seeks structures that support that characteristic of clinics. EDs and Coordinators share a desire to see a consensual process that creates a viable distribution of resources, a strong relationship with clients and communities and enables them to address the scope of client needs they are now struggling to meet.

## EXTERNAL PARTNER KEY INFORMANT INTERVIEWS SUMMARY



This summary is based on fourteen key informant interviews. Interviewees were referred by the Executive Directors of the following legal clinics: Downsview Community Legal Services, Jane and Finch Community Legal Services, Kensington Bellwoods Community Legal Services, North Peel and Dufferin Community Legal Services, Parkdale Community Legal Services, Rexdale Community Legal Clinic, South Etobicoke Community Legal Services, West Toronto Community Legal Services and Community Legal Clinic of York Region. The interviewees are a cross-section of community members, staff and directors of partner agencies, as well as clinic board members. The interviews were conducted in English. Discussions lasted on average 45 minutes and were based on a consistent set of questions oriented around drawing out their experiences of providing services in partnership with legal clinics, emerging trends in the field, and their concerns about change.

### *LIKE CLINICS, PARTNERS SERVE COMPLEX CLIENTS WITH COMPLEX PROBLEMS*

Partner agency clients overlap with clinic clients due to their experiences within various systems including healthcare, immigration, housing, employment, and social services, often times requiring legal supports to navigate these systems. All partners identified that their clients face multiple barriers in accessing systems and supports, and all partners noted that increases in clients with complex issues related to mental health result in increased demands for holistic services.

Clients come from diverse cultural, ethnic, and linguistic backgrounds, many of whom are facing immigration issues and systemic barriers associated with language and race. Youth programming, increasing seniors population, women experiencing violence, clients facing homelessness, and clients reintegrating into the community after incarceration are some of the other areas of partners work in.

### *LIKE CLINICS, PARTNERS NEED TO SHARE THE LOAD*

Clients seek services in all major areas including health, housing, employment, social services, counseling, as well as recreation. Partner agencies provide direct services in these areas, but are unable to meet the volume of need. Where they can, they refer out to other community-based organizations that are accessible and of relevance to client needs. However, all partners were still able to identify major gaps in service provision, in particular in the areas of counseling and mental health, programming for youth and seniors, access to affordable housing and employment opportunities.

### *RELATIONSHIPS WITH PARTNERS ARE PRODUCTIVE BUT HAVE ROOM TO EVOLVE TO SOMETHING FULLER*

Partners interact with their local community legal clinic in a variety of ways. Most frequently, clients are referred to the clinic when a legal issue is disclosed through counseling. In some cases, partners will telephone the clinic for brief advice related to a client issue. These relationships are often individual and developed over time.

Partners also host clinic public education sessions on-site in regards to current relevant community issues, such as immigration, housing, or ODSP. This was reported as a good method



for building trust with clients, as well as providing some level of preventative measure. In some cases, legal staff also provide education sessions for community partner organization staff, which has been helpful in triaging clients to appropriate services. In some cases, for example with the recent changes to immigration law, legal staff trained community partners in how to fill out forms as well as the new deadlines, to assist clients to navigate the system in an effective and timely way. Concerns from partners was in relation to the quality control of such staff trainings, and a more formalized partnership with regular on-going community meetings was recommended as a way to ensure information was current, relevant, and appropriate.

Overwhelmingly, partners would like to see more formalized relationships developed through the transformation process with community legal clinics. These could take the form of satellite clinics hosted within existing community based agencies, increased and on-going trainings for community agency staff on legal issues, referrals based on circle of care where clients do not have to repeat their story over again to different staff, and built-in quality assurance measures are important components of these partnerships. The ability for legal clinic staff to provide mobile services was seen as an important feature to consider, as this method of service delivery has been successful in their previous experience.

#### *LOCATION MATTERS TO COMMUNITIES*

Community-based clinic and program locations are key to building trust with clients, developing networks, and learning about what is important to those who live in that community. Partners are concerned with access to clinic services and believe that any changes to the legal clinic system needs to take into consideration what access will look like for clients facing multiple barriers, whether it's mobility issues, language, transportation, or mental health issues. Partners consistently felt that co-locating or being near other community services will enhance access for clients.

Partners with experience in short distance relocations expressed that clients struggled with the move even if the distance was not that great. In one case challenges that arose due to relocation directly influenced the decision to move again nearer to the old location. This experience reinforces the need to be cautious of client requirements when thinking of relocating services.

#### *TRANSFORMATION OFFERS OPPORTUNITIES AND RISKS*

Although partners expressed that current relationships with community clinics and legal staff are positive, partners are also excited about the possibility of new systems of governance, structures, and service delivery latent in the idea of transformation. Partners felt clinics must remain accessible and community-based, drawing on local knowledge, and include a robust and formalized partnership with other service delivery agencies working in neighbourhoods. Partners are open to hosting satellites, working in new ways, professional development for their staff to work more effectively to meet needs of their clients. Reform must also look at eligibility requirements, which currently leave out many working poor.

#### *SPECIALTY CLINICS*

There was mixed response to the idea of their local clinic becoming a specialty clinic. Concern was raised that specialty clinics will not meet the diverse needs of clients. Mechanisms must be put in place to ensure that clinic capabilities reflect community needs and are flexible enough to shift areas of service to meet changes in demand.



Community members felt that, regardless of other changes, clinics needed to do more outreach to communities by engaging CLWs to focus on this work.

Priority was placed on being visible in the communities, but also on being more mobile, enabling clinics, regardless of their size, to meet people where they are at. Clinics should work with partners to conduct community and client needs assessments so that services are relevant and reflect community needs. More could be done to build on community partner relations, including hosting satellites, using partner resources such as translation, transportation, office space and possibly administrative supports.

## SUPPLEMENTARY REPORT ON QUALITATIVE FINDINGS

The report on qualitative findings outlined the overall trends and patterns in input from front line and management staff, clients and partners. These patterns, however, mask significant differences in the work of clinics, including informative approaches and best practices worth highlighting in the analysis.

### ADDRESSING PROXIMITY ISSUES

One area where clinics have adopted varied and effective strategies relates to the proximity of services. While a very small number of clinics work in areas that are compact enough to allow clients to walk there, most cover large areas, and find that clients from distant areas of the catchment have difficulty accessing the clinics. Several clinics have adopted satellite locations as a solution to that problem, having considerable success making their services available to clients who live far from their head office. These satellites are largely located at sites operated by service partners, often with those who provide related services like immigration services, but also at sites that draw eligible clients for unrelated reasons, such as food banks. Clinics that have used this model find it effective if and only if there is a coherent strategy around the satellite, reflecting a clear target audience with identified legal needs. Satellite locations that have incorporated some triage by the host organization have been particularly effective.

Not all clients facing proximity issues are distributed densely enough to support a satellite location. Several clinics have recognized the need for mobile services, sending legal staff to the homes, workplaces or gathering places of a single client to ensure that client has access to justice.

In other cases, rather than seeking a site close to the client population, some clinics have adopted a “transit centered” strategy, placing access points by transit hubs that better enable clients to reach them from other areas of the catchment.

### STAFFING

The challenge of staffing to meet the overwhelming demand is widely felt by clinics. The sheer volume of demand, combined with demands that exceed the scope of clinic services and put added pressure on individuals with expertise in high-demand areas of law, create considerable pressure that clinics have addressed in a variety of ways.

Some clinics have adopted team or group approaches to areas of law. To alleviate the pressure on individuals, teams operating in an area of law work together to map out plans and distribute





workloads as well as sharing information and expertise. Obviously this strategy is primarily pursued by clinics with larger staff complements as many clinics have too few staff to form multiple staff teams in specific areas of law. However, where a team approach has been pursued, it is a highly valued aspect of the clinic structure.

Clinics have taken several approaches to addressing the demand for services that fall outside those provided in the clinic system. Some have sought and obtained external funding to hire staff to deliver primarily non-legal services such as mental health supports, social work supports and housing help services. Others have sought funding for staff to deliver legal services outside the scope of clinic law. Youth justice workers at clinics have, for example, supported clients in need of criminal law services. However, when addressing the need for legal services outside the scope of the system, clinics have more often created partnerships with other areas of the bar. Some have co-located their services with LAO Duty Counsel staff, allowing for family law and employment law services to be available on-site. Others have sought support from the private bar, engaging lawyers with expertise in other areas of law on a pro bono basis to participate in the work of the clinic.

Engaging non-clinic legal staff has also helped some clinics deal with the volume of work. Use of pro bono lawyers is still low, but use of articling students, volunteer law students, and students from other programs such as paralegal and social work has been increasing. A challenge to this use is the available supervision for clinic volunteers. Some clinics have formal procedures for orienting and training volunteers, while others have adopted technologies (such as the Clinic IP supported interview products) that support accurate work and allow for easier supervision. Clinics recognize that it is important that student volunteers in particular should not be seen as exploitable free labour or as qualified staff, but also acknowledge the limited resources to invest in supervision. Ideally, student engagement happens in an environment of supervision and training to achieve both quality service for clients and an effective learning environment for students.

Clinics also address barriers to meeting the demands on scope of service by sharing services across catchment areas. Some clinics have referral agreements allowing a clinic lacking staff in a particular area of law to refer cases to the neighbouring catchment to be addressed by a clinic with more capacity in that area. Clinics also develop unique areas of expertise and offer that expertise in a “catchment-less” format, welcoming clients from across the City for services in that specific area of law or specialty within an area of law.

#### *OUTREACH AND COMMUNITY DEVELOPMENT*

One area of clinic work that has faced particular pressure is community development and outreach work. Most clinics express frustration with the pressure on organizing time that is created by the endless flood of casework. Some clinics have made outreach and engagement a key piece of work for a particular staff person, which increases focus on that element of the work. While helpful, most clinics find this approach does not fully offset the pressure of urgent case files, and that time they intend to dedicate to outreach is still often encroached on. Some clinics hire staff through programs offered by the city, like Investing in Our Communities, who dedicate their time to outreach and community development. Clinics have also set minimum allocations of time to community work, requiring those responsible for community work to dedicate a specific number of hours per week to that work, regardless of competing pressures. Other clinics have dedicated specific staff to exclusively working in communities, ensuring that

they aren't faced with competition from case files. Again, the allocation of dedicated outreach staff depends on a staff complement large enough to allocate resources to that function.



Public legal education is a type of outreach that most clinics conduct. It helps with outreaching to the agencies that sponsor the public legal education activity as well as providing information to client groups. Active practices work towards innovating public legal education delivery in order to deal with language access issues. Other clinics have further developed this model to offer programs such as “tenant schools” or “letter writing workshops” in which clients learn skills to build capacity and empower them to take action on their own. Still other clinics have worked with organizing models that support clients to come together and take action on their own to deal with specific issues such as bad landlords or repair issues within a building, or providing input on law reform or legislation advocacy, or on more general issues such as poverty reduction.

#### *RELATIONSHIPS WITH OTHER NON-LEGAL SERVICES*

Clinics have a wide range of strategies for working with non-legal service organizations. Some operate in hubs, sharing space with organizations who serve clients with similar needs. Others operate in consolidated organizations, embedding legal services in a broader service offering that includes health and social services. Others, as noted above, develop relationships that enable them to offer services at the partner location on a regular basis and often to benefit from triage done by the partner organization prior to meeting with the client.

Sharing space, however, is not the only innovation in partnership. Some clinics enter into close relationships with specific partners whose clients have persistent legal issues, jointly strategizing on priorities, law reform issues, outreach and promotion. Others provide partner organizations with training programs to develop greater expertise in legal issues. This, in turn, helps partner organizations provide clients with the appropriate advice and guidance, helping them avoid legal complications, ensuring they know their rights, and helping staff identify real legal needs for referral when they arise.

#### *LEGAL EDUCATION*

In addition to appreciating the extra capacity that students can bring to delivering legal service to clients, clinics recognize the important role they play in training clinic workers for the future. Most clinics in the GTA use students in some way: they have one or more articling students (both paid and volunteer); they hire summer students through government career experience programs; they use law students during the school year and the summer who are seeking volunteer work experience; they use students from practicum programs such as paralegal, community services, and social work; they use non-law students, from college programs, training schools, and high schools, that are seeking volunteer hours or experience. The Intensive Program in Poverty Law at Parkdale has also long served as a training ground for future clinic lawyers.

Students who receive the opportunity to work in clinics identify the practical learning opportunity as invaluable and generally have good experiences. The advantage of the clinic experience is that students are able to see the practice of law not in its abstract logical framework but in a social context that reminds them what law is for, as well as how it works. Given the traditional model of legal education, it is not surprising that students find they learn little about poverty law in their academic training, and are excited and exhilarated to see another side of law than that practiced in large firms. Seeing the law deployed to serve vulnerable people is only part



of the benefit: seeing legal practices shaped by real practical needs in the day-to-day lives of clients and seeing law reform priorities set in contexts of the real crises that plague the most marginalized people provides a transformative experience that places law in a new perspective for many. Alumni from clinical experiences describe the experience as one that provides a different viewpoint, and sometimes a different direction to the rest of their legal careers.

The academic programs that send students for practicum, work, and volunteer experiences have additional concerns that students receive an experience that is both supportive and well-supervised, as well as being reflective and contextual to their particular programs and academic work. Clinics that try to incorporate students into their service delivery have concerns that they lack the resources and experience to provide the kind of framework for the experience that the academic programs would like to see. Both sides see this as an issue to be bridged as the interest in experiential learning increases.

Clinics, like Parkdale, with a formal program providing student training have found the goal of a positive experiential learning experience requires specific approaches to legal education. Locking students in a room to plough through an overload of case files won't achieve it; nor will restricting students to basic tasks. Exposing students to community development and outreach work, the creation of law reform projects, and the real challenges of supporting clients are critical elements of success. However, giving students a free hand in addressing complex and thorny issues for clients will also prove unsuccessful. Students and teachers have both found there is a need for a direct supportive relationship between students and their teachers to guide them through the challenges they are facing and a strict limitation on the volume of work to ensure time for reflection, learning and effective practice by new learners. Time is also a critical feature as acclimatizing to new ideas, processes and procedures, as well as new communities, takes time. Allowing acclimatization to happen over an extended period of time is a valuable component of successful pedagogy. Students identify a 6-month period as an ideal, if not always practically achievable window.

#### *CONCLUSION*

These divergent practices among clinics offer “natural experiments” in clinic development that provide insight into best practices and future models.

Incorporating them into the considerations of the future shape and structure of clinics gives perspective that goes beyond the common practice and enriches the discussion.

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