GTA LEGAL CLINICS' TRANSFORMATION PROJECT

Monthly Newsletter **June 2014**

The Steering Committee has been discussing at length the implications that the research, the principles, and the decision points would have on developing a transformed model of poverty law service delivery. These served as guidelines for the choices people had to make about the future of clinics. Some principles were about what clinics would do, like increasing the areas of law clinics can offer. Others addressed how they do what they do, like having community work done by dedicated community workers. Still others were about who they work with, like establishing more stable partnerships with other service providers.

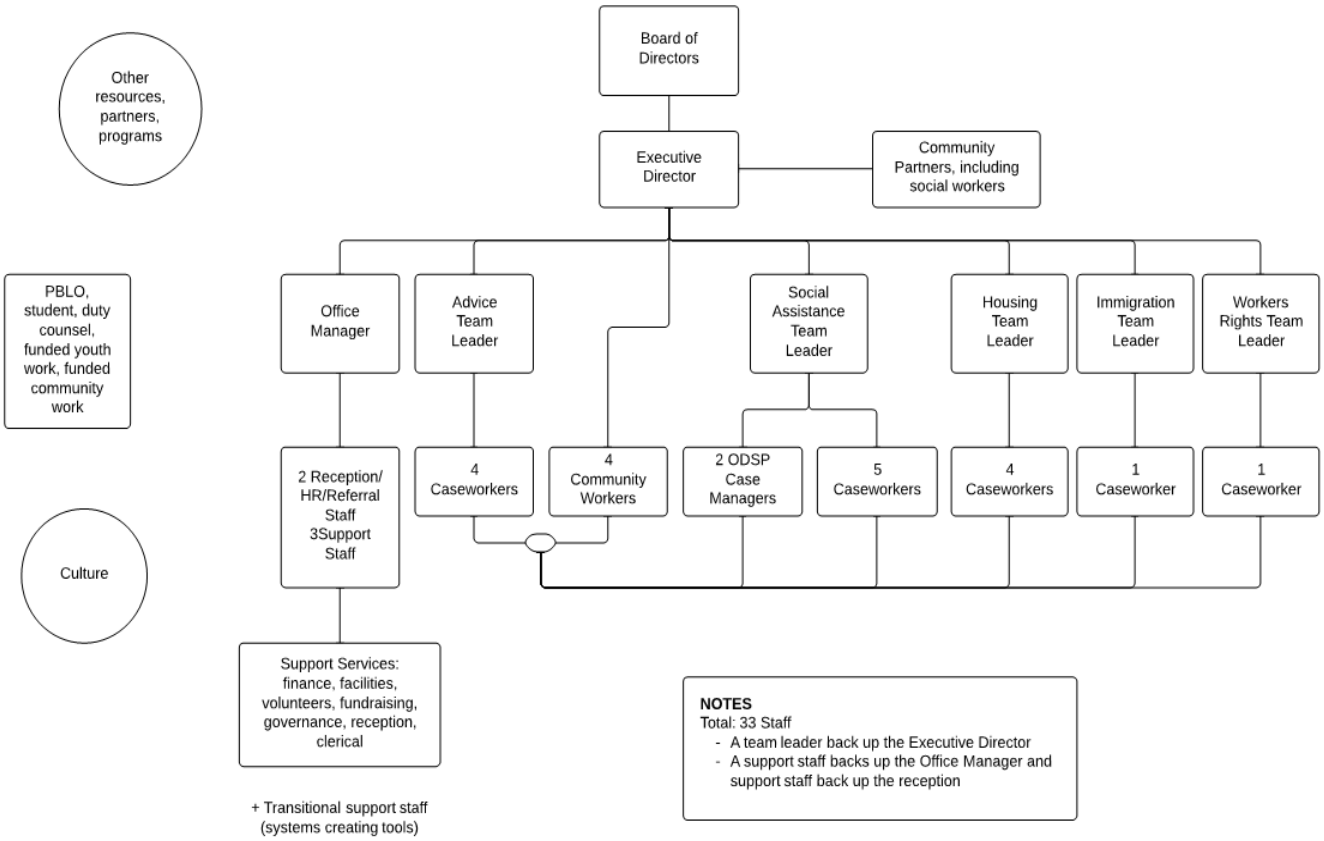
For a complete list of the principles and the evidence that supported them, please visit www.gtaclinics.ca.

Developing a Model of Community Legal Clinic Service Delivery

The first step to developing recommendations was to create a model organizational chart for a general service delivery community legal clinic. The Steering Committee used a collaborative process, involving all clinics in a group effort to co-design the best structure for a clinic. Steering Committee members identified the functions that would enable a clinic in the new system to achieve transformative elements, and together they assembled those elements to form the clinic model. The principles guiding this discussion included:

- a staffing structure based on a team model provides suitable backup support for staff;
- a staffing structure that is flexible enough to allow for the right staff for the right job;
- dedicated capacity for community work;
- expanding the areas of law;
- increasing the number of people served;
- administrative capacity to support formalized community partnerships that link people to a wider range of supports and access points;
- internal capacity to support sustainable and organized programs for volunteers, students and pro bono lawyers; and
- systematic improvement to intake, advice and referral processes at local clinics.

The Steering Committee built an organizational chart together box by box. They determined the core areas of law each clinic should provide, as well as the recommended size of each team that would provide it, based on the research. Initial discussions resulted in a large model clinic with significantly more core areas of law, and far more front-line workers and community workers than the clinics have now. The process resulted in a clinic of about 33 staff, though there is some flexibility in that number. The clinic was larger than most people expected but effort to reduce it size always took away from the goals and principles the Steering Committee was trying to meet. Clinics with fewer and smaller staff would require compromising on some transformation goals.



This model covers more areas of law than clinics are currently able to offer, adding employment law and ensuring immigration law is available everywhere. 79% of the staff in this model delivers front line services, increasing the current ratio significantly. Each area of law is led by a team lead who coordinates the team, as well as does case work. Every staff person, including administrative staff, community workers and caseworkers, have backup. The advice and community development staff each work as a team, but each staffer is also attached to an area of law so that they can gain specialized knowledge in that area. The model increases the support staff and administration capacity to recruit, train and manage more volunteers and increase the capacity for developing and maintaining formal partnerships.

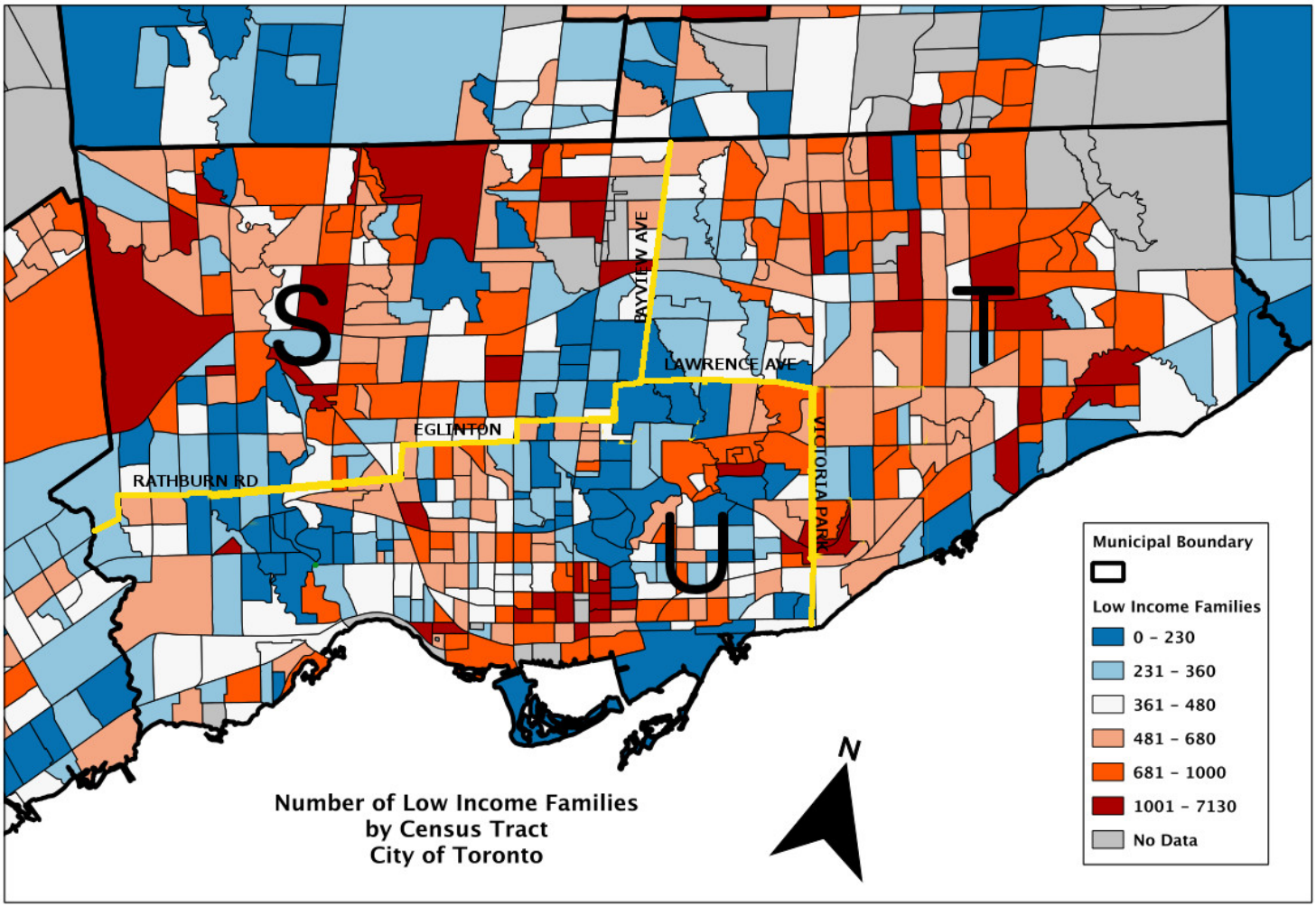
Implications for the Number of Clinics and Catchment Areas

The size of the proposed model clinic, which would have approximately 33 staff, has implications for the number of clinics that the new system can have and their catchment areas. It would make more than one clinic in York Region or Peel Region impossible. It would make it difficult to spread the 104 staff currently working in the City of Toronto over more than 3 clinics. Having four clinics, for example, requires the model to be trimmed to at most 26 staff per clinic.

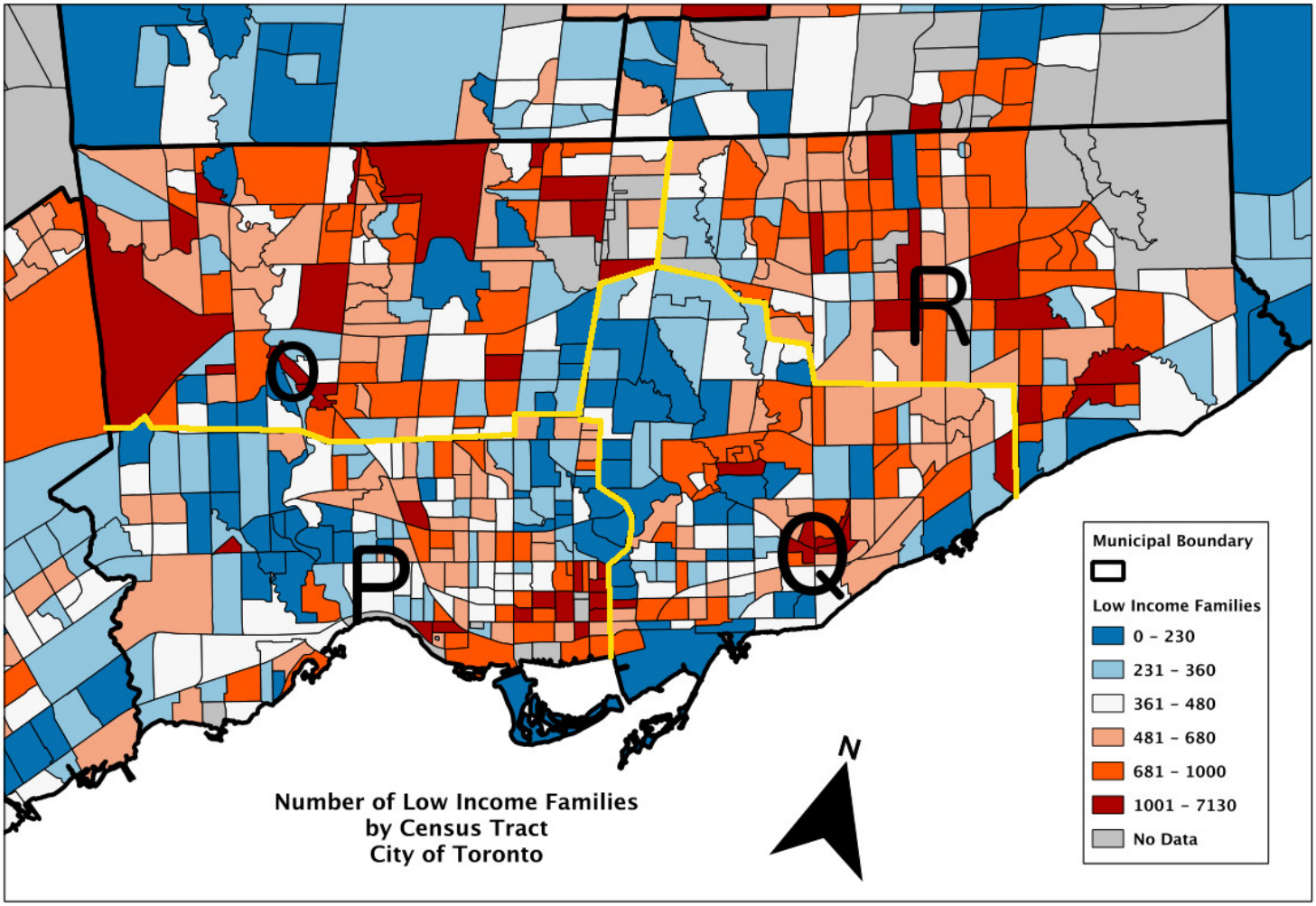
The Steering Committee explored different catchment area options, grouping together areas with low-income populations and using higher income areas as borders between catchments; they also made sure access to clinics was enhanced by public transit routes.

The Steering Committee looked at four different configurations of catchments and number of clinics. In each, the outer suburbs had a clinic with Peel region reaching the model size clinic and York region well below the model size clinic.

A three-clinic model in Toronto works best with a North West clinic, a Scarborough/Don Mills clinic, separated by affluent areas in central North York, and a South clinic that runs along the subway line, as shown.



The Steering Committee also looked at other model and options, including a four-clinic model in Toronto that divided the South Clinic along the Don River, and put some of South West Scarborough with the new South East clinic.



With some exceptions, the Steering Committee favoured a three-clinic model because it is within this model that most of the transformational elements are realized.

Resourcing Clinics

The Steering Committee has also explored various tools for allocating resources to these new clinics, and determining about how many staff they would have.

The Steering Committee looked at basing staffing on current demand but this was not recommended because current usage favours clinics that are more resourced than others, and both are unreliable in predicting any latent or future changes in demand.

The Steering Committee looked at basing staffing on how many households are under Statistics Canada's "Low Income Cut Off" (LICO), indicting the number of people living in poverty in the catchment area. People living in poverty don't necessarily need poverty law services but LICO is a common measure of probable needs, it is readily available, and a strong predictor of other demand factors. The income of a LICO household is higher than clinic service financial eligibility requirements, however, research showed that areas with high LICO populations are also the areas with the most very low income people (under $10,000 per year) and the most immigration and welfare reliance.

Poverty has grown since staffing allocations were last made in 2000. Poverty in Toronto has increased steadily but it has skyrocketed in the 905 area. As a result, the need for staff in the 905 now far outstrips resources, even more than it has in Toronto. To equitably redistribute resources across the GTA, downtown Toronto would have to transfer some of its resources to the inner suburbs and a significant amount to the outer suburbs. Exacerbating this issue is that the fact that the GTA is significantly more under-resourced than any other region in the province. It is unclear who ought to fill the gap created by increasing under-funding of the clinic system. Does LAO fill that gap by injecting more resources into the system, or should Toronto by redeploying existing resources?

The Steering Committee has decided to recommend that while they have been able to collectively determine a vision for transformed legal clinic services, the vision cannot be implemented without new resources from LAO.

Updated Timeline

The Vision Report will be released in July 2014 offering recommendations from the Steering Committee to Boards of all clinics on the future model of poverty law service delivery.

Endorsing the Vision Report means boards are adopting these ideas in principle, they are not yet binding their organizations to that vision. The next phase will be the development of a report that will consider a more detailed level discussion of implementation, including staffing implications. Only after they have seen the implication of the transition plan will Boards be asked to make a firm commitment to the transformation process.

Clinics will be provided with tools and information to support discussions with staff, boards and communities. This will include a discussion guide, a Q&A, a report summary and a short, simple guide to the process and its recommendations for the general public.

The timeline of the project has been extended to allow the boards to have adequate time to consider the report and seek community input through town halls. They will now have until October 2014 to provide feedback and endorsement for the report.