Clinics at the Crossroads:
The Future for Community Legal Clinics in Ontario

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The following presentation reflects the personal thoughts of its author based on discussions that have been ongoing within the ACLCO Executive over the past two years.
The ACLCO Executive is pleased to endorse this presentation.

History:

As you can tell from the title of my talk, I'm going to be looking at the future; where I see the clinic system will be going in the next few years. But, before we get there, I firmly believe that if you want to have some sense of the future, you need to both understand and learn from the past and the present.

In looking at the clinic system's past and present, what do we see?

In my opinion the most important thing that we see is that Ontario has the best community clinic system in the world. We don't need complex measurement tools to tell us that, and you certainly don't need to take *my* word for it. Every independent review and reviewer says it. We have the most comprehensive and most varied poverty law services. We spend the most money per capita on poverty law. Every external visitor who has ever compared Ontario's system to others says: "Ontario has the best community clinic system in the world"!

This is something of which we should be incredibly proud. Besides creating hockey players and producing maple syrup, Canada isn't recognized as a world leader in much of anything. But here in Ontario we are the best at providing poverty law services.

Although it is nice to recognize this (and we don't do that enough), it is also important that we recognize that this situation is not accidental. There are some very clear reasons why we are the world leaders in this field.

The first reason is the fundamental characteristics of our community clinic system. Although we sometimes take them for granted, the fundamental characteristics that form the bedrock of our clinic system are not replicated anywhere else. These fundamental characteristics are:

- Independence, marked by governance by locally elected independent boards of directors. This leads to community determination of poverty law services.
- Clinics that focus on what they were expressly created to do, which is to provide poverty law services (with the corollary that other services are provided, to a greater or lesser extent by other parts of legal aid).
- The provision of poverty law services through a comprehensive approach, including systemic responses such as: law reform, community organizing, test cases and public legal education.
- Core, presumptive funding, allowing clinics to engage in long range strategic planning and to make local service decisions based on client needs.
- And finally, a generally supportive funder, that respects these principles, supports clinics, and allocates a reasonable amount of its overall budget to poverty law services.

We should all understand that there is no other jurisdiction where these five fundamental characteristics all exist. So when we think about what makes our system so strong and unique, we should start with these bedrock characteristics.

But there is another important factor. And that is exemplified by all of you sitting here today, and many others who are not here. It is the dedication, the talent and the strength of the staff and boards in clinics right across this province. Clinic staff and board members have what a study, done by the eastern region calls, "a fire in the belly". We have a commitment that, to paraphrase MasterCard and the Beatles, "money can't buy". (Other organizations engage in all sorts of corporate gymnastics to attempt to *create* this type of commitment.) But in our clinics we have people who work here because we want to, and who give so much of ourselves to our work because who feel it is the right thing to do. This is another thing of which we should all be proud.

So this clinic model we have, populated by these dedicated staff and volunteers has created a tremendous resource for the low income population in Ontario. If you examine the history of progressive legislation in this province over the last 30 years, you will find key clinic involvement in virtually every instance. In the creation or preservation of progressive landlord and tenant legislation, social welfare legislation, worker's compensation, disability rights, human rights, etc., although none of these laws are perfect, Ontario's laws are often more progressive than many other jurisdictions in North America. And clinics have played an important role in this: whether in the courts, or educating our communities, or in the legislature, or on the streets.

And this work continues today. Clinics here in the southwest, and right across the province, are engaged in many important activities that have a significant impact on our clients' lives.

Just a few examples:

- Over the last couple of years, ACTO (Advocacy Center for Tenants of Ontario), LCHIC (Legal Clinic Housing Issues Committee) and clinics throughout the system worked on a lobby effort to improve Ontario's landlord and tenant legislation. This coordinated law reform initiative, involving litigation, public legal education, legislative submissions and community organizing, led to the new *Residential Tenancies Act*, which remedied *some* of the more odious parts of the "tenant protection act": (including eliminating default eviction orders where tenants have not filed written disputes.)
- Both the North Peel and Dufferin, and Huron-Perth clinics have recently been successful at Divisional Court on important issues of tenants' rights, regarding damages for breach of the right to quiet enjoyment, and disputing rent increases based on an illegal rent.
- ISAC (Income Security Advocacy Center) and Campaign 2000 have worked together to develop a workshop that clinics and community groups can use to engage low-income people in discussions about Ontario's poverty reduction strategy and what they can do in their own communities to lobby the government and build public support for ending poverty. They will be working with local partners to put on the workshop in communities right across the province.
- The Windsor-Essex clinic has begun to offer services to local migrant workers in their community, providing help particularly with workplace safety and insurance board issues;
- The Chatham-Kent legal clinic has developed a set of precedent medical reports for physicians to use in disability cases that have had the impact of improving the success rate for clients in these cases, while saving the clinic disbursement funds. The clinic has shared these documents with other clinics.

Present:

So clinics in Ontario do tremendous work. Does this mean that we are perfect? Should we use our world leading status as an excuse to rest on our laurels?

I would love to say yes, so that we could get back to the buffet and to the dance floor. The problem is that despite our good works, the problems of our clients are not going away. We live in an economic system which, despite the ability to create massive wealth for the wealthiest, also tolerates and in fact creates enduring poverty and misery for the poorest and most vulnerable among us. These are our clients, our communities. And so despite our successes, we owe it to them to continue to improve on what we already have so that we can help them even more.

So, let's certainly talk about change and improvement. But any discussion about change and improvement of the clinic system must, in my opinion, *begin* with the recognition of the incredible effectiveness and efficiency of the clinics. To quote my colleague from England, Steven Hynes, "clinics in Ontario punch way above their weight". From the expenditure of a mere $56 million dollars, clinics provide a tremendous amount of service to the province of Ontario. We have this disproportionate impact for a variety of reasons:

- Clinics use graduated services, ranging from self help and summary advice to representation at the Supreme Court of Canada, depending on client need.
- Clinics work together provincially, regionally and locally to coordinate initiatives and share resources and knowledge.
- Central support services such as the CRO and training are provided to improve our effectiveness.
- Clinics work closely with local community partners to have the greatest impact in their communities.
- And locally, each clinic develops their own systems and techniques to stretch every penny out of the limited resources we have to provide our services.

Over the years, clinics have figured out so many ways to get the best bang for our limited buck.

But we are not perfect. We are very good, but we could always improve. Let me identify a few areas where I believe this could happen (and please recognize that these are not only my personal selections; rather clinic people across the province have been talking about the potential for improvement in these areas for years.)

1. Although clinics will never be able to help every person who is in need, it is unquestioned that we would like to be able to help *more* than we are helping now. Overall, clinics are not as accessible as we would like to be. And we are particularly not as accessible towards certain groups: those with physical or mental disabilities, those who don't speak English as their first language, and those who live in rural and remote areas. There are particular challenges involved in providing services to those groups. (Fortunately, the ACLCO and clinics are presently working with the Law Foundation who have initiated a project on accessibility issues.)
2. Clinics have very helpful resources to assist in providing traditional *casework* services to individual clients. The CRO (Clinic Resource Office), the barrister program, list serves, inter clinc study groups, etc., all help us have a tremendous impact in courts and tribunals. But we don't have the same type of supports in the provision of community development and other *systemic* work. Although this systemic work is as much a part of our

clinic mandate as the casework and in fact is the original *raison d'etre* of the community clinic model, as we all know, some clinics struggle in this area. As clinic groups like OPICO (Ontario Project for Inter-Clinic Organizing) correctly remind us, we need to do better in this area.

3. As I mentioned earlier, clinic boards of directors contain some of the most dedicated and passionate volunteers you could hope for. I have been humbled by the dedication to community clinics I have witnessed in some of the board members I have met. Some clinic boards are incredibly strong and are able to strategically plan and act as the local governors and stewards of poverty law services that they must be. At the same time, some clinic boards struggle with this. Some clinics have difficulty attracting talented board members and some clinics face difficulty in supporting them. There is room for improvement across the system in this area.
4. Some of the best lawyers I have ever met are executive directors in the clinic system. If I needed legal assistance, I would be privileged to have them represent me. But, some of these executive directors will be the first people to tell you that they were never trained to manage a complex workplace. In my opinion, the job of executive director in a community clinic is one of the most challenging jobs that exists; you must be a lawyer who represents clients, you must be a personnel manager, you must administer an office and a budget, and you must support a volunteer board of directors. In many larger organizations each of these tasks is handled by a different person who is expert in that one field. In clinics it is usually one person who has the ultimate responsibility for all of it. But, clinic executive directors don't receive training at law school in strategic planning, or human resources, or fiscal management, or board recruitment and support. And although some have picked it up quite magnificently, others understandably struggle with *some* aspects of the job. We must find a way to assist those who are struggling.
5. We must also find a better way to share the information and knowledge that exists in the clinic system. Our colleague, Kevin Smith at Parkdale often says, "there does not exist a single problem confronting a clinic that some other clinic hasn't already dealt with". I think he is right. We are pretty good at sharing our substantive legal information, but not as well in other areas such as management and administration. The problem is that too often we are each left to figure out the solution on our own, sometimes reinventing the wheel 80 times over. We must find better ways to share the tremendous wealth of knowledge that exists in our 80 clinics.
6. And connected with sharing this wealth of clinic knowledge, and in fact connected with all of these areas of potential improvement, we should work on our methods of peer support. Other systems have developed ways for organizations and their associations to help and support each other. Mentoring, peer support, secondments, staff exchanges, etc.: these are ways

the clinics could learn from each other and help each other improve. (It is my hope that, in the future, the ACLCO will be able to provide assistance and leadership in each of these areas.)

These are some of the biggest challenges facing clinics today. In my opinion, if we made advances in these six areas, we could significantly strengthen our system and improve the impact we have on our communities. Fortunately there is work being done on some of these challenges, but not enough and not quickly enough. In the future, the ACLCO would like to work with the clinic system, and with Legal Aid Ontario, on tackling these issues. We have some ideas and we know that there are many more creative ideas in the clinic system and we would like to create proper forums to develop the solutions.

Allow me to make a brief comment about money. It is undeniable that more money would help solve some of these problems. It is also undeniable that, considering the need, there is nowhere near enough money being spent on poverty law services in Ontario. The demand for our services is insatiable and it is depressing and demoralizing to all of us to have to turn away or provide only limited services to so many. It is also undeniable that the government has the resources to meet these needs, but chooses to spend most of it in other places: in other areas of the justice sector, such as high profile prosecutions of alleged terrorists and gang members, or on significant salary increases for crown lawyers, judges and tribunal members.

Because of this, the ACLCO has placed obtaining increased funding for the clinic system at the top of its list of priorities. Last year, leading up to the provincial budget, we led an intense and coordinated public lobby campaign to increase the legal aid budget. Many of you took part in that campaign, and I thank you for that effort. And it brought some success, leading to the first increase in core legal aid funding in 10 years. But that is not enough. And for that reason, last month, the ACLCO met with the new attorney general, the Honourable Chris Bentley, a former board member of the London legal clinic, and reminded him of the unarguable need for additional resources. The ACLCO will continue to pressure governments of all levels, and Legal Aid Ontario, for increased funding for community clinics.

But, between us, we need to be realistic as well. Ontario is presently the second highest per capita spender on legal aid in the world, after the UK. Ontario is the highest per capita spender on *community clinics* in the world.

It would be wonderful if we could double or triple the community clinic budget next year. But, as we constantly push for increased resources, we must understand

that the government is just as aware of the facts and figures as we are. They know how much other jurisdictions spend on legal aid and on poverty law.

In a perfect world, clinics would have as many resources as every government lawyer and downtown law firm we have to face in court. But in a perfect world, my kids' history teacher and Tom Cruise would swap salaries; in a perfect world our clients would be running corporations and making government decisions while Stephen Harper and Conrad Black would be living in social housing on welfare payments and engaging in workfare programs. In a perfect world Hamilton and London would have NHL franchises and Gary Bettman would be running stock car races in Atlanta and Carolina. Obviously this isn't a perfect world. So as we fight tirelessly for additional legal aid funding, we need to recognize that we can't wait for the pot of gold to move forward.

And move forward on making these improvements we must, because our work is too important, and our clients' predicament too dire to sit on our laurels.

One area where things are likely to change in the near future is the clinics' relationship to our funder. Legal Aid Ontario is working on a discussion paper that will examine the relationship between LAO, clinics, and the ACLCO. Although we haven't seen that paper, discussions between the ACLCO and senior staff at LAO have given us some sense of what type of changes may be proposed.

One likely area is in the provision of central support services to clinics. (Here I am talking about things like: research, policy support, learning and training, IT purchasing and maintenance, benefits and insurance, etc.) It is not that LAO sees these services as unimportant, or that there is no value in providing them centrally, but there are some at LAO who question why *LAO* is providing some of these services to clinics. We are told that LAO needs to focus solely on its core role, which is being a funder. We are told that it, "muddies the waters" to be a funder to clinics on one hand and a support service provider to clinics on the other.

And although I do not see this as a straightforward issue, and I can see big advantages in LAO continuing to do more than just *fund* clinics, my personal feeling is that I can also understand some of these concerns. It is a simple fact that LAO's role as a support service provider to clinics is virtually unique in the world of funder – fundee relationships. Most funders have very little interaction with their fundees and provide limited, if any, supports to them. We all know that there are many stresses in the clinic - LAO relationship. It certainly appears that there are more stresses and flashpoints in the LAO - clinic relationship than exists in traditional funder - fundee relationships. It is hard not to think that some of these stresses arise because of the mixed relationship that clinics and LAO have.

And it is undeniable that an inappropriate amount of *everyone's* time is spent on managing this relationship.

It may be time to re-examine the LAO - clinic relationship: time to find a way of maintaining the parts that work, but changing the ones that don't. It's time we moved beyond the dispiriting disputes and skirmishes on which we waste far too much time. Perhaps it is time for LAO to take a step back and give clinics the freedom to manage our own system. And perhaps it is time for clinics to stop blaming LAO for every problem and take over responsibility for our own system. Whereas once upon a time I was reluctant to consider these changes, my own thinking on this has changed over the last few years; personally, I think it is time to move in this direction.

Our model allocates to our funder the primary role in many areas of central support for clinics. This is a model that has grown over time, without much thought or analysis. Perhaps it is time to consider a future where clinics collectively take over responsibility for things such as:

- Learning and training of clinic staff and boards;
- Poverty law research;
- Support for community development and law reform;
- Systemic needs assessment and strategic planning;
- Policy analysis and development;
- Quality improvement, peer mentoring and support throughout the clinic system; and
- Possibly, even some technical supports such as benefits and insurance administration, or IT supports.

LAO's discussion paper will likely propose changes to aspects of the LAO - clinic relationship. Clinics will need to consider these issues. The ACLCO will facilitate a clinic-wide discussion of these issues, and attempt to develop a systemic response. If deemed appropriate and necessary by our membership, the ACLCO could play an enhanced role in supporting clinics in the future.

A discussion of these issues will be the focus of the ACLCO's AGM next month and will continue for many months after that.

Change:

Now a few words about change: it is quite likely that we will be looking at potential changes to the clinic system in the next year or so. Change is not something clinics fear. My experience is that clinics are incredibly dynamic

and flexible, partly due to our relatively small size and the important characteristic of local control. Change is no stranger to clinics.

For example, when I began working in the clinic system (back when the dinosaurs walked), there was not much social assistance casework being done. But things have certainly changed. Over time there was a growing demonization of and a crackdown on welfare recipients. Laws were changed that made it harder for people to access and retain benefits to which they were entitled. So clinics changed and responded to this need.

Another example: when I began in the clinic system we used Dictaphones and legal pads and pencils (okay, so I still use a pencil). But things changed. We got a deal on Lanier-Harris "computers", and then we got fax machines. And finally, five years after everyone else, we got real computers. Now, if I don't receive 137 emails in one day, I know that the IT system is down. We've changed to incorporate technology to help us do more work.

Clinics are, and should be, open to change. But we are also realistic. We know that not all change is inherently good. In fact, history has shown us that some change can be horrendously bad.

Sometimes those changes can be direct assaults, like when British Columbia eliminated its entire community clinic system (33 clinics) in one politically motivated stroke of the pen. But sometimes changes that are instituted with ostensibly good motivations can also lead to terrible results:

- In Australia, the federal funder felt that it needed better and easier-to-handle measurement tools for their legal clinics. So they developed and imposed on their clinics simple tools that measured how many cases clinics did, their won-lost ratio, and the amount of money they won in each case. The most immediate change that resulted from this was that many clinics began *creaming* the easiest-to-win and quickest-to-resolve cases, and stopped taking the more complex cases and more needy clients. These most vulnerable people were left to fend for themselves.
- In England, the central funder, bowing to the competitive efficiency of the marketplace and because they wanted to have a say in what poverty law services were provided by the independent clinics, began to offer funding for specific poverty law services to the top bidder. This change has led to clinics in the UK spending most of their time filling out funding applications and in doing the work for which funding is available, rather than the work that their community needs. It also has forced clinics there to cut back on their non-casework activities to be able to better compete for these block funding grants against private law firms, paralegals, citizen advice bureaus and even against

other clinics. It has become much harder to find people to sit on clinic boards because many poverty law service delivery decisions are now steered centrally by the funder.

So, although change can be good, and although we welcome changes that will bring improvements to the practice of poverty law in Ontario, we recognize that not *all* change is inherently good. The challenge is to get it right, and I would suggest that this is not too difficult. Together, clinics and our funder, LAO simply need to:

1. Identify what the *real* problems are;
2. Work *together* on solutions to those problems;
3. Ensure that in making positive changes we do not destroy the fundamental strengths that make our clinic system so good today. The fundamental strengths are those to which I referred to at the beginning of this talk (local independence, focus on poverty law, broad array of services, core funding, supportive funder); and
4. Preserve our history of bringing in change in a gradual, evolutionary way, so as to avoid the dislocation and destruction that usually accompanies "radical restructuring".

Although it should not be too difficult to get this right, the reality is, based on what has happened in other jurisdictions; it is apparently also not too difficult to get it terribly wrong. That is why it is fundamental that clinics, the ACLCO, and LAO must work collaboratively on any changes to our system.

Conclusion:

Although I have spoken today about what I think the future *may* look like, the reality is that none of us can read the future. There are simply too many variables and too many surprises we can't control. In fact, I can only make one promise to you about the future.

That is that as long as *I* am involved with Ontario's community clinic system I will fight to preserve and strengthen it. I believe our clinic system is a sacred trust. It is a rare example of when society actually "got it right" and hasn't screwed it up yet. People in the clinic system have fought hard to ensure that our system is still strong. In my years as a clinic board member, a clinic staff person and more recently with the ACLCO, I have had the privilege of working with many of these people.

Unfortunately, some of these people are no longer with us. One I need to make reference to is Stephen Little, former board chair of the Waterloo clinic and for

many years the dedicated co-chair of the ACLCO. Stephen gave countless volunteer hours to ensure both that his Waterloo clinic was meeting the needs of its community, and that the broader clinic system was strong and able to withstand challenges.

We owe it to those, like Stephen, who have fought for our clinic system, and to our clients who so depend on it, to never be sanguine about what we have. Sometimes I think it is a miracle that our clinic system has survived this long. We need to be vigilant and to understand that the fundamentals of the community clinic model in Ontario need to be protected to ensure that we do not suffer the same fate suffered by other clinic systems around the world. We owe it to them not only to fight to preserve our model, but to do everything we can to strengthen and expand it.

We need to be ready to move forward and make changes that improve our services, while ensuring that we preserve the fundamentals that are the bedrock of our model.

And I have no doubt that working together this is precisely what we will do.

Thank you all very much for listening to me today and for the work that you do every day.