REPRINTED FROM THE McCAMUS *(et. al.)* Review of 1997: available at

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CHAPTER 11: "POVERTY LAW" LEGAL AID SERVICES

In this chapter we discuss the issue of poverty legal aid services. Included in this chapter will be an analysis of the unique nature of poverty law needs and the context in which those needs are addressed currently. By necessity, much of this chapter analyses the role of community clinics. More specifically, this chapter contains a detailed discussion of the legislative mandate to deliver poverty law services, community governance, clinic accountability, the relationship of the community clinic system to the larger legal aid system, clinics' scope of services, and gaps in poverty law coverage. The final section of this chapter makes recommendations on each of these subjects.

THE NATURE OF POVERTY LAW AND THE NEED FOR POVERTY LAW SERVICES

The term poverty law describes the broad areas of law and legal needs which arise by virtue of an individual's or a group's poverty. As the Honourable Mr. Justice Osler noted in his 1974 Report of the Task Force on Legal Aid, "the poor have many problems peculiarly their own ... [The poor] are tenants not landlords, debtors not creditors, purchasers not vendors". In general, the legal needs of the poor have traditionally included housing law; income-maintenance law (including employment insurance, the Canada Pension Plan, welfare, family benefits, and workers' compensation); work-related issues (including employment standards, and occupational health and safety); and consumer and debt problems.

The interpretation of the complex and frequently changing statutory and regulatory schemes in these fields often requires legal assistance. For many reasons, poverty law cases do not fit into "traditional" legal models. Unlike much civil litigation, poverty law cases often involve what seems like very little money. Unlike criminal law cases, immediate loss of physical liberty is rarely a consequence of an unsuccessful poverty law proceeding. Unlike most "traditional" legal proceedings, most poverty law matters involve proceedings before government bureaucracies or administrative tribunals, not courts.

Despite these differences, poverty law matters are often of overwhelming significance to the individuals and groups affected. For example, despite the comparatively small sums involved in poverty law proceedings, those amounts can constitute a large proportion of a low-income person's earnings. The resolution of a poverty law issue may have serious consequences for the ability of persons to feed, clothe, and shelter themselves and their dependants. Indeed, for these reasons it is sometimes argued that poverty law legal aid services are of greater importance to the economically disadvantaged than are criminal or family law legal aid services. As the National Council of Welfare reports, most low-income people "have never been, and probably never will be, in trouble with the [criminal] law", whereas the network of civil laws governing most aspects of their everyday lives create a large (and largely unmet) need for legal advice and assistance.

Many poverty law clients also possess special characteristics which give rise to specific needs and demand specific responses. In the "traditional" practice of law, a client identifies his or her own legal need, brings a problem to the lawyer, and instructs the lawyer as to his or her wishes. By way of contrast, the economically disadvantaged often lack information about their rights and entitlements. They may also be unable to bring forward their legal claims because of the destabilization of their lives by abuse or homelessness, or because of their illiteracy, lack of education, the discrimination they suffer in their day-to-day lives, or the fact that they often do not speak English or French as a first language, if at all.

CONTEXT

In Ontario, poverty law legal aid has been delivered largely, although not exclusively, by community legal clinics. There are currently seventy such clinics in Ontario, serving more than one hundred communities. Within this number, there are two main categories of clinics: general clinics and specialty clinics. Fifty-six clinics are general-service clinics, offering services in core areas of poverty law practice. Depending on their location, general clinics may also offer services tailored to specific communities including Franco-Ontarians (e.g., Clinique juridique populaire de Prescott et Russell) and Aboriginal peoples (e.g., Keewaytinok Native Legal Services).

Fourteen clinics specialize in a particular area of law or in the legal needs of a specific client group. Examples of specialty clinics include the Advocacy Centre for the Elderly, the Advocacy Resource Centre for the Handicapped, Justice for Children and Youth, the Centre for Spanish-Speaking Peoples, Aboriginal Legal Services of Toronto, and the Canadian Environmental Law Association. Ontario also has three clinics that are affiliated with university law schools in the province: the Correctional Law Project (Queen's University), Legal Assistance of Windsor (University of Windsor), and Parkdale Community Legal Services (Osgoode Hall Law School). The Plan also funds six student legal aid societies, which are not formally considered part of the community clinic system.

Clinics generally provide the following services:

- summary advice and legal information within clinic areas of practice;
- referrals to social service and community agencies, lawyers in private practice, and the Plan;
- client representation before courts and administrative tribunals, including Landlord and Tenant Court, the Workers' Compensation Appeals Tribunal, the Social Assistance Review Board, tribunals dealing with Canada Pension Plan and employment insurance matters, and the Criminal Injuries Compensation Board;
- public legal education, including seminars, workshops, presentations, and the production of pamphlets and videos in many languages;

- initiatives aimed at protecting and promoting the legal interests of the low-income community, including broad-based litigation; participation on government task forces and advisory bodies; and appearances before municipal councils, legislative committees, and public commissions and inquiries; and
- community projects which assist clients to form self-help groups focused on low-income issues.

In fiscal year 1996, clinics carried 37,097 files, provided summary advice in 147,636 matters, made approximately 70,000 referrals, conducted 2,055 public-information sessions (reaching more than 72,000 people), and presented 792 briefs or submissions. These statistics must be used cautiously, however, as it is more difficult to summarize clinic program services than certificate program services. Simple case totals may not reflect the relative complexity or impact of a single case. One clinic may be involved in several law-development initiatives, another in high-volume advisory services.

In fiscal year 1996, the clinic system cost a total of $32.5 million, just slightly more than 10 percent of the total legal aid budget of $315.6 million. Clinics have always operated under capped budgets, and their funding has been frozen since fiscal year 1993.

Clinics are not-for-profit corporations, managed by volunteer boards of directors who are responsible for clinic administration, personnel management (boards are the employers of the staff of each clinic), financial management, the determination of legal services to be provided (both the choice of areas of law to be dealt with and the methods or strategies to be used), and the evaluation of services. The day-to-day management of each clinic is the responsibility of the Executive Director (a member of the staff). As noted in chapter 3, clinics are staffed by lawyers, community legal workers, and administrative staff.

The practices of most geographically-based clinics are heavily weighted towards the areas of income maintenance, housing, and consumer problems-those areas of law which impact pervasively upon the lives of the economically disadvantaged. The practices of several clinics, the "specialty" clinics in particular, often address a range of other legal issues of particular significance to their communities. Individual case work is the predominant activity of most clinics.

As noted above, the Clinic Funding Committee (CFC) operates independently from the Legal Aid Committee, with a separate budget and separate administration. This framework was considered necessary to promote and protect the unique mandate of community legal clinics. The day-to-day carriage of CFC functions, including decisions in the first instance with respect to funding is undertaken by clinic funding staff (CFS). Appeals on initial funding decisions made by the CFS are to the CFC.

The CFC also provides services that directly support the work of clinics. The CFC funds regular regional training sessions and supports the work of interclinic committees designed to coordinate services in the fields of social assistance, housing, and workers' compensation law. The CFC also funds the Clinic Resource Office (CRO), a small office that provides clinics with legal research and strategic legal advice, produces and maintains a ìpoverty lawî data base of materials otherwise difficult to obtain, provides advisory support to interclinic committees, acts as a clearinghouse for the most recent information on relevant substantive law and clinic activities, and contributes to clinic training and continuing legal education.

Given the historic lack of private lawyers practising in the ìpoverty lawî, clinic lawyers and legal workers remain the most significant group of practitioners in Ontario with expertise in this area of law.

Over the two decades of their operation, some clinics have offered limited services in criminal law, family law, and other civil matters on an exceptional basis. However, such assistance has generally been provided only where clients have little access to other legal services, primarily in remote areas.

Several other jurisdictions deliver services using models similar to Ontario's community clinics, including British Columbia, Quebec, Australia, and England and Wales.

CURRENT LEGAL NEEDS

The determination of current legal needs in the field of poverty law is a complex undertaking. Unlike more "traditional" fields of legal practice, it is difficult to calculate current needs based only on measures such as expressed demand or numbers of unrepresented litigants. This is the case because many potential poverty law clients are either unaware of their rights or unable to act upon them.

In simple terms, it is clear that the need for core-area poverty law services is increasing. Unemployment and underemployment increase demand for both government benefit programs and poverty law services. Increases in the numbers of people living in poverty, such as sole-support families, the disabled, the elderly, and homeless persons, also increase demand for poverty law services, as do reductions in other community services which help the disadvantaged.

One obvious unmet legal need for poverty law services is demonstrated by the clinic system's lack of geographic coverage across the province. The original plan for the clinic system was to make general-service clinics available in all parts of the province. At present, however, much of the population of the province is without clinic services, including the communities of Lindsay, Guelph, Owen Sound, Brockville, Stratford, and Parry Sound.

Commentators have also noted increased requests for "traditional" legal aid services within community clinics, presumably because of the reduction in the number of certificates issued in these areas. Frederick Zemans and Patrick Monahan surveyed four clinics across the province and noted that many more requests for summary advice in family law have been recently been received by the clinics. Bogart and Meredith, in their study for the Review, found that many clinics are experiencing a significant increase in requests for assistance in family law matters from people who have either been denied a certificate or been discouraged from applying for one. Some clinics have responded by providing summary advice; others by creating self-help kits and pamphlets; and still others by conducting workshops with the assistance of the private bar.

As in other areas of legal aid services, the failure to provide poverty law legal aid services has costs. As the Advocacy Centre for the Elderly notes in its submission to the Review:

> ... if legal services are not available, the potential costs to the community are high as failure to resolve a problem dealing with basic rights may contribute to other problems, leading to a snowball effect, with additional human and financial costs for resolution or an escalation of dependency of that person on public systems".

DISCUSSION AND PROPOSAL

It is widely acknowledged that community legal clinics are best suited to deliver poverty law services. This conclusion has been confirmed by numerous independent studies on this subject, including the 1974 Osler Report; the 1978 Grange Report; the 1987 Canadian Bar Association report, Legal Aid Delivery Models: A Discussion Paper; the 1992 Review of Legal Aid Services in British Columbia; and the 1997 report by Osgoode Hall Law School Professors Frederick Zemans and Patrick Monahan, From Crisis to Reform: A New Legal Aid Plan for Ontario.

We have come to the same conclusion. Indeed, the community clinic model meets many of the goals we have identified for the larger legal aid system. The community clinic system can run on a capped budget; it works to understand and respond to individual and community needs; it utilizes lawyers, non-lawyers, public legal education initiatives, and other delivery systems in order to deliver services cost-effectively; it prioritizes needs and attempts to meet them strategically; it has developed linkages to nonlegal service providers; and it has recently adopted a quality-assurance program.

Subject to the discussion below, we have concluded that the community clinic model is the most appropriate to deliver poverty law services and that independent community governance is integral to that model. We strongly support the continuation and expansion of the current clinic system and propose only discrete reforms designed to make the current system function more effectively.

We believe that the clinic system should meet the same high standards we would require of the other components of the legal aid system. Our goal in this area is to propose reforms which will lead to an enhanced clinic system capable of delivering a wide range of accessible, cost-effective, high-quality services in furtherance of its mandate to providepoverty law services. In order to achieve this goal, the clinic system should improve its overall planning capacity and be able to be more fully coordinated with, and accountable within, the larger legal aid system. Clinics themselves should be governed by skilful, responsive, and responsible boards of directors who are well versed in the identification, prioritization, and meeting of local needs. In furtherance of these responsibilities, boards of directors should be assisted by a number of central supports. The proposals and recommendations that follow address each of these substantive issues.

We stress that our recommendations in this field must be supported by the adoption of our recommendations for criminal and family law legal aid services (in chapters 9 and 10) and by adequate funding for the system as a whole (in chapter 14). We strongly believe that the success of community clinics-and ultimately of the poverty law mandate itself-can be assured if low-income Ontarians have access to a broad range of high-quality criminal law and family law services provided by other parts of the legal aid system. In the absence of these services, there is likely to be considerable pressure on legal aid administrators and their funders to divert clinic funding to provide these services or to pressure clinics to provide them. The former would directly take resources from a key area of need; the latter would indirectly have the same effect-clinics would be overwhelmed by demand for these services, which, in turn, would threaten the provision of poverty law services at the local level.

Within this context, it is important to determine which administrative unit within a renewed legal aid authority will review clinic operations and determine their effectiveness. This unit-which will ultimately be charged with making decisions about the funding and de-funding of clinics, evaluating the performance of the clinics, and working to facilitate system linkages and supports-must have a thorough knowledge of clinics, their mandate, and the conditions necessary for their effective functioning. The need for expertise in this area suggests strongly the establishment of a separate unit that is linked to the central administration of any provincial legal aid authority. This subject is discussed later, in chapter 15, on governance.

That said, we have identified a number of issues which need to be addressed in the context of our analysis of the entire legal aid system in Ontario. These issues include:

- legislative mandate;
- community governance;
- accountability to the funder;
- the integration of community clinics into the larger legal aid system;
- clinics' scope of services, including whether they should provide assistance in family, criminal or immigration matters; and
- the completion of the community clinic system.

LEGISLATIVE MANDATE

At present, the *Legal Aid Act* does not specifically require the Plan either to fund clinics or to provide poverty law services. Rather, the legal authority to fund clinics and undertake such services resides in the Clinic Funding Regulation.

Given the central importance of these services to low-income Ontarians, we believe that the legal aid system should be statutorily mandated to provide poverty law services. The current Clinic Funding Regulation is sufficiently flexible to permit the recognition of diverse and changing poverty law needs. Subject to limited fine-tuning, the Regulation's language would appear to be an appropriate basis for a statutory poverty law mandate.

COMMUNITY GOVERNANCE

The issue of community governance is of fundamental importance to the mandate and operations of the community clinic system and the delivery of poverty law services. Besides having obvious implications for the legal and operational structure of community clinics, the resolution of the community governance issue has consequences for a series of related issues, including clinics' accountability to their funder, the mandate and role of the Clinic Funding Committee, regionalization, and the relationship of the clinic program to other legal aid services.

Community-elected boards have historically been important in ensuring independence from both the Plan and the provincial government; in assisting the clinic in identifying and prioritizing community needs; in ensuring accountability to their communities for the nature and quality of services provided; and, through their board members, in providing vital linkages to other community services.

Based upon our extensive consultations across the province and on our review of the dozens of submissions we have received on this topic, we are satisfied that community boards do and should continue to discharge these functions. We have concluded that there is a great deal of evidence that community boards ensure responsiveness to local community needs.

Information about the needs of the community and priorities within the community comes to boards through a variety of avenues: reviews of demand for services (statistics and staff analysis of trends); assessments of legislative or policy changes; consultations with community agencies; board members and staff; strategic planning sessions; client questionnaires; information and service requests from other agencies; assessments of community growth and demographics; consultation through special committees; and formal needs assessments of the community. The Advocacy Resource Centre for the Handicapped, for example, periodically surveys its membership "about the legal priorities of the constituencies each represents. Results are distributed and form the basis for discussion at 'priorities days' at which the membership meets and makes decisions which direct our work for the coming year".

Thus, community boards are able to fulfil many of the principles that we believe are important to the design of a governance regime: needs assessment, priority-setting, accountability, quality assurance, independence from government, innovation and experimentation, and cost-efficient delivery of services. As a result, we have concluded that independent community boards are an important component of the community-clinic model and are essential to the delivery of poverty law services in Ontario. Well-run independent community boards are an important bulwark protecting the independence of clinic operations and are an invaluable tool for identifying and prioritizing local needs within a capped budget.

Our consultations have revealed, however, that the current operation of some community boards could be improved. For example, many boards appeared to digress from their role as "governing" bodies into the day-to-day management of clinic operations. Some boards lack the detailed skills required to address the full range of clinic issues, be they strategic planning, personnel management, or financial policies. It is also apparent that some clinics are more successful than others in recruiting and involving the disadvantaged in community boards. This consideration is particularly important, given that low-income earners bring undeniable expertise to the work of a community legal clinic.

On the basis of our review, we have identified several areas for improvement. In this discussion, we propose reforms which we believe will strengthen the existing community governance model.

Our first proposal reflects the need to improve training for all community clinic board members. Board training has always been considered a priority by administrators, board members, and clinic staff. In the new legal aid system we recommend, the unit of the legal aid authority responsible for clinics should make training a significant priority for all community boards.

The legal aid authority should retain responsibility for training in areas of concern to all clinics, such as issues relating to the delivery of services and personnel management. Individual boards themselves must assume responsibility for training on issues of local importance. Whether clinics choose to do this individually, regionally, or in conjunction with the boards of other community agencies would depend upon the size of the board, its training objectives, and the resources available to it.

Many boards have constituted "board development committees" in order to support ongoing board training. In order to be successful, board training must be accessible to people with a variety of educational backgrounds and should attempt to include cultural, race, and ethnic issues in order to ensure that needs can be properly understood and priorities can be set fairly.

In addition to assistance with training, there are other measures which could be put in place to improve board performance. In their recent Operational Review of the clinic system, Corlett and Associates found that board members were anxious to share information with one another-to learn best practices-but that there are few forums for accessing and sharing solutions. Corlett and Associates reported that "there are an astonishing number of creative solutions to common problems in the system...we are convinced that somewhere in the system a clinic has found a solution to every possible problem". As a result, the Operational Review argued strongly for the creation of additional infrastructures to support the work of the community boards, supports which could improve client services without threatening the independence of clinics.

We share this conclusion, and we recommend that the unit of the legal aid authority responsible for clinics develop systems of support for community boards, including assistance in the areas of fiscal management, labour relations, conflict resolution, and technical support. This unit must also facilitate the development of board "best practices", mentoring opportunities, access to experts, and improved communication among community boards.

ACCOUNTABILITY TO THE FUNDER

This topic is closely related to the next one-community clinic integration within the larger legal aid system.

It will be recalled that an integral component of the governance framework proposed in the Grange Report was the requirement that community clinics be accountable for the expenditure of public funds. The Clinic Funding Regulation was designed to assure autonomy and independence for the clinics in matters of policy and administration while preserving accountability for the expenditure of public funds.

Within the clinic system, accountability issues are sometimes controversial. Matters of financial accountability are relatively straightforward: the CFC currently requires and receives financial reports and financial audits. On the other hand, many clinics have historically objected to measures designed to analyze "operational" accountability (including quality of services, and responsiveness to communities). Despite these reservations, the clinic system has historically been much more proactive in assessing and monitoring the quality of legal aid services than other components of the legal aid system. For example, in 1987 the CFC developed Clinic Performance Evaluation Criteria. These criteria have recently been supplanted by a new clinic "Quality Assurance Program".

We recommend that the clinic's "Quality Assurance Program" be pursued vigorously. We also believe that the clinic system must continue its current efforts to regularize data collection across the province. We also recommend that individual clinics and the clinic system generally must significantly improve their ability to plan strategically. (This recommendation is discussed in more detail below.) These efforts will go a long way to continuing to assure the clinic system's accountability for the use of public funds.

COMMUNITY CLINIC INTEGRATION WITHIN THE LARGER LEGAL AID SYSTEM

In an era of capped funding, it is important to be able to coordinate all legal aid services in order to allocate resources in the most effective and efficient manner possible. During the era of open-ended funding of certificates, the need to coordinate services among clinics and/or between the clinic system and the rest of the legal aid system was comparatively limited. In the event of a "gap" in clinic coverage, an applicant could apply for a certificate and could, in many instances, receive legal aid assistance.

The question of clinic integration has two dimensions. The first is whether clinics effectively coordinate their services and resources among themselves. The second is whether clinic services and resources are effectively coordinated with other components of the legal aid system. Based upon our consultations across the province, we have concluded that clinic services and operations could be coordinated more effectively in both dimensions.

Within the clinic system itself, there are several structures or measures which serve to coordinate resources and services, including the Clinic Funding Committee and clinic funding staff; the Clinic

Resource Office; specialty clinics (including, but not limited to, Community Legal Education Ontario); regional and interclinic working groups; and a range of collective activities initiated by clinics themselves, including the recently founded Provincial Association of Community Legal Clinics.

These activities and programs are important in and of themselves, but more could be done. For example, many clinics coordinate many services among themselves only on a informal or an ad hoc basis. Our consultations confirmed Corlett and Associatesí earlier finding that many opportunities for sharing of resources and information are missed because of a lack of communication. More important, there is no regular process for setting strategic directions for the clinic system as a whole: even though many individual clinics have excellent strategic-planning processes, the overall system does not. In the past, geographic gaps in clinic coverage and limited resources have militated against individual clinics' seeing themselves as components of a larger system. In the future, we believe that much more effort would be appropriate in this area.

In a reformed legal aid system, it is clear that individual clinics, the clinic system, and the overall legal aid system should, and could, coordinate their services much better than at present. Our consultations revealed that Area Directors and clinic Executive Directors were often unaware of the specific activities of each other's organization. As a result, there was often distrust or misinformation about the other "side" of the legal aid system. At the level of provincial administration, many observers told us that the Legal Aid Committee and the Clinic Funding Committee could improve their communication and coordination of services significantly.

Until recently, there was not a pressing need to coordinate the services of the certificate program with those of the clinic program. As a result, each "side" of the legal aid system became somewhat isolated from the other over the course of time. We believe that that isolation must end if legal aid services are to be improved in Ontario. Indeed, many of our recommendations on the subject of legal aid governance, identification of client needs, priority-setting, and service-delivery innovations will significantly improve the coordination of clinic and non-clinic services.

We believe the coordination of services between clinics and the clinic system and the larger legal aid system would be significantly enhanced if individual clinics and the overall clinic system initiated a multiyear strategic-planning process. The purpose of this initiative would be to develop processes and programs that will enhance the ability of the clinic system to provide poverty law services. Necessary components of this strategic-planning initiative would be an assessment of the current and likely future demand for such services; an evaluation of the strengths and weakness of the system to meet that demand; the development of programs or strategies designed to create or improve the coordination of services and skills within the system; and the development of performance measures against which the achievement of those objectives can be assessed.

We would expect that the unit within the legal aid authority with responsibility for overseeing clinics would also be responsible for facilitating the overall strategic-planning process. In order to be effective, this process must involve both provincial and local representatives, clients, and non-legal community-based organizations. Representatives from local clinics and their communities must identify the legal needs of those communities, draw attention to innovative and effective measures to meet those needs, and identify areas where they need additional support. The Provincial Association of Community Legal Clinics should play a vital role in this process.

Combined with a similar exercise in the areas of criminal, family, and other civil matters, this process would go a long way to ensuring appropriate, needs-based, transparent decisions by the central funding authority by providing an ongoing basis for evaluating community needs and specific clinic funding requests. This process would also ensure clearer coordination between the clinic system and other components of a legal aid system. This process should also assist clinics within the same region, or providing the same types of services, to improve the horizontal integration of their services.

At a local level, this planning process should be undertaken by each individual clinic. The clinics which currently have excellent strategic-planning processes should be used as models for those clinics whose planning is less successful. This local process must be undertaken in conjunction with other legal aid service providers in the area. In the context of capped funding, the legal aid system must comprehensively identify local needs and coordinate services, as between alternative service providers. As a small step towards this goal, we recommend that the Executive Director of each clinic sit on local legal aid Area Committee, and that the local Area Director, or his or her designate, sit on the board of directors of the local clinic.

SCOPE OF SERVICES

The broad scope of services provided by community clinics corresponds to the multifaceted, needs-based, strategic, cost-effective services we envisage being utilized by a reformed legal aid plan. Indeed, we believe that such a broad scope of services is necessary for the system to operate effectively, as noted by the submission to the Review of the Advocacy Centre for the Elderly:

> [case representation] alone would not address the systemic issues that lead to the individual client problems. Without public legal education initiatives, more client services would be required. Without law reform activities, more money would be needed to respond to client needs that arise from the impact of legislation and policy which creates problems for many individuals. Without a comprehensive approach to these legal issues, demand for individual representation would likely increase.

The more vexing question on this subject is whether or not clinics should be required, or allowed, to deliver criminal law or family law services. In the historical evolution of the legal aid plan, areas of practice were divided between judicare and the community clinics. The certificate system provided criminal, family, immigration and refugee law services; the clinic system provided poverty law services.

Our survey of clinic activities reveals that this traditional "division of labour" largely remains to this day. We say "largely" because it is also clear that some clinics provide limited services in all of these areas.

Clinic statistics show that the vast majority of criminal and family law service is in the nature of summary advice. In 1996, clinics provided summary advice in 10,139 family law cases (representing less that seven percent of clinic "summaries"). In the same year, clinics opened 196 family law files (representing fewer than one percent of total new files). These family law files were concentrated in a few clinics: Justice for Children and Youth, Keewaytinok, Willowdale and East Toronto. In 1996, criminal "summaries" represented 2.86 percent of the annual total. Most of this advice was provided by clinics primarily serving Aboriginal populations: Aboriginal Legal Services of Toronto, Kenora, Keewaytinok, Manitoulin, and also Justice for Children and Youth. Not including statistics from the Correctional Law Project, which serves only those incarcerated, clinics opened 165 criminal law files in 1996. These files again were concentrated in a few clinics: Justice for Children and Youth, Keewaytinok, and Kenora. The statistics show greater clinic involvement in immigration law, with 822 files in 1996. Here, too, the work is relatively concentrated; most clinics do not provide immigration and refugee law services, some clinics provide a small amount, and a small number of clinics provide substantial services. The Clinic Funding Committee submission to the Review concludes that, "services in family, criminal, and general civil are generally provided only where clients have little access to other legal services, primarily in remote areas, such as along the James Bay coast".

Some clinics also address systemic criminal and family law issues. For example, several clinics have begun to provide victim-witness supports to abused women, and in this role have worked actively to improve the criminal justice system's response to wife abuse (for example, working with local Crowns to provide information about conditions for bail releases). Others have undertaken significant systemic work around policing and its impact upon the populations they serve: the homeless, youth, blacks, psychiatric survivors. Some clinics, particularly since the recent reduction in certificates, have begun to provide an increasing number of services in the family law area: at least one clinic has created a family law duty counsel clinic; others have begun to provide informational sessions on family law.

With these statistics in mind, it is possible to imagine a limited role for clinics in the delivery of criminal, family, or immigration and refugee law services, particularly at the informational or systemic level, should an individual community board conclude that these services represent an area of community need.

There are, however, many reasons why clinics should not assume a significant role in direct client representation in criminal and family law matters: If clinics were required to provide these services, community governance would be threatened. It is difficult to see a role for a community board in cases pitting one community member against another, or possibly against a segment of the community. There can also be either a conflict of interest or serious practical difficulties if the clinic is the only legal resource available to advise both accused and victim, to advise both "sides" in a custody case, or to act for a community member who then becomes witness to another matter where another community member would like representation. Finally, we are concerned about a clinic's ability to supervise, establish priorities for, and assure the quality of criminal, family, and refugee law services when that represents only a limited part of that clinic's otherwise specialized mandate.

We have concluded that general-service clinics should, as a general rule, not have a mandate to provide direct case representation in criminal, family, or immigration and refugee law matters: Clinics should, however, be allowed to provide other kinds of services in these areas, where such services are consistent with their poverty law mandate and appropriate safeguards are in place to ensure that these services do not overwhelm the clinic's poverty law services. Some clinics could deliver limited case-representation services in exceptional circumstances (such as geographic remoteness and/or lack of other available service providers) if such services are assessed as a community priority. Specialty clinics could and should provide services (including case representation) in these areas if such services would support their focus on systemic issues or would support their client community.

In the long run, we believe that these issues will be of decreasing importance to most clinics. Our recommendations on the subject of criminal, family, and immigration and refugee law legal aid services, if properly implemented, should address the most pressing legal needs in these areas.

COMPLETION OF THE COMMUNITY CLINIC SYSTEM

Earlier, we identified several "gaps" in the distribution of general-service clinics in Ontario. Despite the clinic system's proven success in addressing poverty law needs, many communities in the province simply have no access to community clinics, and those which do have clinics generally require additional resources to meet present demand. This situation contradicts the principle that a full range of legal aid services should be accessible to all Ontarians. It is simply unfair that some Ontarians should have access to this important service while others do not. Consequently, we recommend that the authority governing a reformed legal aid system in Ontario should make the completion of the geographic coverage of general-service clinics across the province a key priority.

In addition to general-service clinics, we believe that there are many reasons to expand the specialty-clinic system. The success of specialty clinics such as the Advocacy Resource Centre for the Handicapped, the Advocacy Centre for the Elderly, and Community Legal Education Ontario, to name but a few, have proven their ability to deliver high-quality, cost-effective services for their target populations.

Although the potential range of specialty clinics is quite broad, we have identified one such clinic which we believe should receive consideration-a specialty clinic to provide comprehensive legal services for Aboriginals living in urban areas and on nearby reserves. As outlined in the background paper prepared for the Review by Jonathan Rudin, a form of specialty clinic (potentially called "Aboriginal Legal Services Centres") would be well-suited to provide this particularly vulnerable population with accessible, community-based, flexible, high-quality, and multifaceted legal services. These Centres could be integrated with local Aboriginal Friendship Centres. If appropriate, consideration should be given to developing this model in northern Ontario also.

As part of its strategic-planning process, we recommend that the legal aid authority consult with current clinics, community groups, service providers and interested individuals in order to determine which specialty clinics should be introduced and the process by which to introduce them.

RECOMMENDATIONS

1. A revised *Legal Aid Act* should include an explicit mandate to provide "poverty law" services.

2. The community clinic model should be retained as the primary means of delivering "poverty law" services in the province.

3. The independent community board of directors model for individual clinics should be retained.

4. The legal aid authority should make training of community-clinic board members a high priority.

5. The unit of the legal aid authority responsible for clinics should develop infrastructures designed to support community boards, including assistance in the areas of fiscal management, labour relations, conflict resolution, and technical support. This unit should facilitate the development of board "best practices", mentoring opportunities, access to experts, and improved communication between community boards.

6. The clinic system's "Quality Assurance Program" should be pursued vigorously. The clinic system should continue its current efforts to regularize data collection across the province.

7. Individual clinics and the overall clinic system should initiate a multiyear strategic-planning process. This process should include an assessment of the current and likely future demand for "poverty" law services; an evaluation of the strengths and weaknesses of the system to meet that demand; the development of programs or strategies designed to create or improve the coordination of services and skills within the system; and the development of performance measures against which the achievement of those objectives can be assessed.

8. The Executive Director of each individual clinic should sit on the Area Committee of the administrative unit of the legal aid authority in his or her area. The Area Director, or his or her designate, of each administrative area within the legal aid authority should be a member of the board of directors of the clinic in his or her area.

9. As a general rule, the general service clinics should not have a mandate to provide direct case representation in criminal, family, or immigration and refugee law matters. However,

(i) such clinics should be allowed to provide other kinds of services in these areas where such services are consistent with their "poverty law" mandate and appropriate safeguards are in place to ensure that these services do not overwhelm the clinic's "poverty law" services, and

(ii) they should be allowed to deliver limited case-representation services in exceptional circumstances (including geographic remoteness and/or lack of other available service providers) if such services are assessed as a community priority.

10. Specialty clinics could and should provide services (including case representation) in these areas if such services would support their focus on systemic issues or would support their client community.

11. The legal aid authority should make the completion of the geographic coverage of the general service clinic system a key priority. The legal aid authority should consult with current clinics, community groups, service providers, and interested individuals in order to determine the need for any new specialty clinics.