Community Legal Clinics in Ontario

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Ontario has a system of fully funded yet independent network of community law clinics like those advocated in Rees’ paper. Professor Mossman explores the forces that led to the establishment of the community clinics, their relationships to the judicare system and the purposes behind the government’s assumption of responsibility for funding and defunding clinics: service to low income people, community involvement and representation and independence from funding sources. While Rees seems to suggest that government funded community clinics would automatically further these purposes, Mossman argues that scope of service, community involvement and funding decision processes must be structured very carefully in order to enhance clinics’ abilities to engage in meaningful representation, and warns that the early community clinic movement could be easily subverted by concentrating decision making control over clinics in the hands of the government, the law society, the clinic or even of other community groups.

Les Centres judiciaires communautaires en Ontario

L’Ontario possède un système de centres judiciaires communautaires, complètement financés mais indépendants, comme ceux préconisés dans l’essai de M. Rees. Le professeur Mossman explore les forces qui ont mené à l’établissement des centres communautaires, leur rapport avec le système d’aide judiciaire, et les buts sous-jacents à la décision gouvernementale de se charger de la responsabilité de financer (ou de cesser de financer) ces centres: service aux pauvres, participation et représentation de la communauté, indépendance à l’égard des sources de financement. Tandis que M. Rees semble suggérer que des centres communautaires financés par le gouvernement avanceraient forcément ces buts, M. Mossman prétend que l’étendue des services, la participation de la communauté et les procédés de décision quant au financement doivent être structurés avec grand soin pour augmenter les capacités des centres d’offrir une représentation efficace. Il avertit qu’à ses débuts le mouvement de centres communautaires pourrait facilement être perverti si le contrôle de leurs décisions était concentré entre les mains du gouvernement, de l’association des avocats, du personnel du centre ou même d’autres groupements communautaires.

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(1983), 3 Windsor Yearbook of Access to Justice 375
Introduction

"I would like to add significantly to the resources available to clinics . . . the clinics are in a position to take the law to those who need it most. It is almost trite to point out that a great many poor people have never been made aware of the right they enjoy under our laws . . . The clinics, located in, and run by, local communities, can reach out to advise people of their rights. They take the law to the people . . . In doing all of this, the clinics help convince the poor that they have a stake in this society."1

This 1982 statement by Ontario's Attorney-General is one of the positive statements that has been made about legal aid in Canada recently. While it is by no means Mr. McMurtry's first statement of support for the work of community clinics in Ontario, it is of special significance for two reasons. In the first place, it is a public statement of support for clinics in Ontario at a time when general policies of governmental restraint across Canada have resulted in significant, even fatal, cutbacks in legal aid programs.2 Secondly, the statement demonstrates support for increased resources for Ontario clinics at the very time when the Minister was deciding to offer only modest tariff increases to Ontario lawyers providing legal aid services under the complementary judicare program.3 The possibility that resources for community clinics would actually be increased in the face of governmental restraint, and the inevitable pressure to restrict expenditures, thus suggests a very high level of support by the Attorney-General for community clinics.

The value of the Minister's personal support for community clinics is substantial; indeed, on some occasions in the past, his personal support appears to have been critical to their survival.4 Clearly, the fact that the Ministry of the Attorney-General provides substantial funding for legal aid in Ontario, as well as his role under the Regulation in "designating" the funds for clinics out of the overall legal aid budget,5 place the Minister in

2 For example, Nova Scotia's legal aid budget was reduced by 25% for 1982-83; British Columbia was required to cut back by $1.3 million from a budget of $17.3 million and decided to institute a user fee and reduce the services provided; in Saskatchewan, certificates to the private bar were withheld for three months in 1982 to save costs; in Manitoba, by contrast, there was a small increase in the 1982-83 budget, but this followed several years of restraint. Survey Information, National Legal Aid Research Centre, Ottawa, November 1982; B.C. Legal Services Society Newsletter, October 1982.
3 In response to the Law Society's requested tariff increase of 30%, the Minister announced on January 15, 1983 a 5% increase retroactive to July 1982, with a further 5% increase effective July 1983. There had been no increase since 1979. Globe and Mail, January 15, 1982.
5 R.R.O. 1980, Reg. 578, s. 159.
an enviable position to nurture community clinics in accordance with his personal support for them. That the Minister's support is desirable seems self-evident; the real issue is whether it is, by itself, the explanation for the survival of Ontario clinics in the face of widespread restraint and cutbacks.

It has become clear in the early 1980's that many legal aid programs, established with idealism and great expectations in the 1960's and 1970's, have been all too easily eroded or destroyed as governmental restraint has become necessary in the face of an economic recession. For all practical purposes, legal aid has been regarded as just one more government program that is too expensive; there has been little or no recognition that legal services for the poor are any different from other social welfare programs. In this context, it is tempting to conclude that the reason that Ontario community clinics survive, even thrive, is the Minister's personal support for them. Such a conclusion, however, denies that the clinic movement has any inherent validity, for it assumes that their continued survival depends solely on his continued goodwill. More importantly, such a conclusion threatens the integrity of independent legal services; to say that legal services can be provided to the poor in Ontario only because, and so long as, the Minister supports the effort to do so by clinics, is to deny to clinics any capacity for independent legal representation of the poor. Even more significantly, it may also deny clinics capacity for any representation of the poor against, most frequently, the government whom the Attorney-General represents in law enforcement matters. The real issue is, therefore, whether Ontario clinics would have the capacity to provide independent legal services to the poor in the absence of Mr. McMurtry's personal support.

This paper is an exploration of the special nature of community clinics in Ontario. It asserts that Ontario clinics are unique in terms of their history, their structure, and their focus, and that no other system of clinics has such an inherent capacity to thrive independently of the Minister's personal support. Because of these special attributes, it also follows that no other clinic system has a greater opportunity to use its resources effectively to achieve the goal of equal justice for the poor. The challenge for Ontario clinics is to use their unique opportunity creatively and effectively toward achieving equal justice.6

II. In the Beginning: A Brief History

The history of community clinics in Ontario is not neat; like the clinic system itself, it is an amalgam of special

6 The phrase "equal justice" is taken from Cappelletti, Gordley and Johnson, Jr., Toward Equal Justice: A Comparative Study of Legal Aid in Modern Societies (Dobbs Ferry: 1975).
circumstances relating to particular times in particular communities. The history is also organic and still evolving, and underlies both the structure which has developed and the focus of clinic work. The history of the clinics is also part of the overall history of legal aid in Ontario; an understanding of clinics within the overall legal aid system in Ontario is fundamental to appreciating their significance, both past and present.

"Modern" legal aid programs in Canada developed only recently. The first such program was established in Ontario by the Legal Aid Act in 1966. Based on a report (the Joint Committee Report) recommending the establishment of a publicly-funded legal aid program to replace the services previously provided by lawyers on a charitable basis, the new legal aid plan demonstrated that: "... legal aid should form part of the administration of justice in its broadest sense. It is no longer a charity but a right." Recognition of this principle resulted in the implementation of legal aid programs in most of the Canadian provinces over the next few years.

The establishment of publicly-funded legal aid programs in Canada was a very significant development, and their impact on courts, lawyers, and clients cannot be over-estimated.

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7 S.O. 1966, c. 80.
8 Report of the Joint Committee on Legal Aid, William B. Common, Q.C., Chairman (March 1965). Mr. Common was then Deputy Attorney-General for the Province of Ontario, and the Committee was composed of members of the Law Society of Upper Canada, appointed by the Treasurer, and members of the civil service of Ontario, appointed by the Attorney-General. See Joint Committee Report, 5.
9 Id., 97.
10 Newfoundland The Legal Aid Act (1976)
Nova Scotia Legal Aid Planning Act (1970)
The Legal Act (1977)
New Brunswick The Legal Aid Act (1972)
Quebec Loi de l'aide juridique (1972)
Manitoba Legal Aid Services Society of Manitoba Act (1972)
Saskatchewan Act to Amend the Legal Profession Act (1967)
The Community Legal Services (Saskatchewan) Act (1974)
British Columbia Court Rules of Practice Act (1968)
The Legal Services Commission Act (1975)
The Legal Services Society Act (1979)
Yukon Legal Aid Ordinance (1975)
N.W.T. Legal Services Ordinance (1979)

An Act passed for Prince Edward Island has not been proclaimed; in Alberta, the Legal Aid Society has been incorporated under the Societies Act and the plan functions as an agreement between the province and the Law Society. See Statistics Canada, Legal Aid, 1981 (Minister of Supply and Services Canada: 1981), 10-12.

More importantly, in a society committed to equality, the need for legal aid services is unquestioned.\(^{12}\) In the context of the Ontario Legal Aid Plan, the objective of equality in the administration of justice was clearly stated; it was intended that the same legal aid services be made available to the poor as were already being provided to fee-paying clients.\(^{13}\) With the benefit of hindsight, it is easy to appreciate that such a concept of "equal justice" was too narrow, and that the legal services which poor people most needed were those that responded to their problems, not to the problems of fee-paying clients. Gradually, it was recognized that the poor had legal problems quite different from those of the non-poor, and that Ontario's legal aid system, based on the norm of the fee-paying client, often did not provide appropriate assistance.\(^{14}\) In addition, the Plan's services were criticized because they were provided by the same private practice lawyers who worked on behalf of fee-paying clients. Of course, the use of the same lawyers to provide services to rich and poor alike arguably represented the epitome of equal opportunity — if but only if both groups of clients required the same services. As it became clear that lawyers acting for the poor needed to be familiar with poverty law, it also became clear that specialization was desirable and that salaried lawyers were needed because they could devote their energies solely to the legal needs of the poor.

At the same time that such issues were being discussed about the scope of the Plan's legal aid services and the appropriate means of providing them, concerns were also expressed about the legal profession's continued monopoly on decision making in the context of a publicly-funded program. While it might have been appropriate for the Law Society of Upper Canada to administer the earlier charitable legal aid program, it was suggested that the public who paid for the program, and the poor to whom it was directed, deserved some opportunity for input in decisions about legal aid services.\(^{15}\) These concerns

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\(^{12}\) In the first Annual Report of the OLAP, this principle was recognized; the Report stated: "There has always existed, even within the most enlightened society, a disparity between the availability of a lawyer to the well-to-do and to the indigent. . . . Ontario has now taken a giant stride to ensure that no one shall be denied the services or advice of a lawyer because of lack of money. . . ." Ontario Legal Aid Plan, The Law Society of Upper Canada, Annual Report 1968, 6.

\(^{13}\) Id.

\(^{14}\) See, for example, Taman, The Legal Services Controversy: An Examination of the Evidence (National Council of Welfare: 1971).

\(^{15}\) Significantly, the Joint Committee noted in 1965: "The almost unanimous view expressed to the Committee was that the administration should be the exclusive responsibility of the Law Society of Upper Canada. This partnership between the Provincial Government and the Law Society has existed for 14 years and there is no reason in the opinion of the Committee, for any change." See Joint Committee Report, 99.
must be understood in the context of scepticism whether lawyers could be trusted to act effectively in the public interest, and increasing concern about their monopoly on legal services. In several provinces which established legal aid programs after 1966, such arguments bolstered the desire for an independent corporation with a Board composed of some non-lawyer members. In Ontario, by contrast, the Legal Aid Act granted responsibility for the administration of legal aid to the Law Society of Upper Canada, the governing body of the Ontario legal profession.

The alleged deficiencies of the Ontario Plan were frequently debated in the late 1960's and early 1970's against the backdrop of the American legal services programs and President Johnson's War on Poverty, as well as the Canadian concept of "the just society". In a general way, the ideas about equality of opportunity were fuelled by a growing mistrust of professionals and their monopoly on information and skills to generate a desire for increased community or public participation in decision making and collective action. Notwithstanding that the Ontario Legal Aid Plan had signified a major societal change in attitude as recently as 1966, the currency of such ideas inevitably led to dissatisfaction with both the goals and the methods of the Plan.

Essentially, it was the critics of the Plan who initiated and established alternative legal aid services in response to "unmet needs"; and it is these services which formed the nucleus of the community clinic system now in place. For example, the need to provide assistance for specialized poverty law problems motivated (at least partly) the organization of Injured Workers' Consultants, a program in which injured workers themselves assisted others with compensation claims. The scarcity of lawyers who were familiar with compensation claims as well as the group's desire to engage in self-help, contributed to the creation of a "clinic" with no lawyer involvement at all, a model decidedly different from the Plan's legal aid services. Similarly, the need for help in a developing legal field contributed to the establishment of the Canadian Environmental Law Association; the "clinic" undertook litigation "in the public interest" and acted for client groups, activities which were not then recognized by the Plan as being needed legal services. At the same time, Parkdale Community

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16 For example, Saskatchewan, Manitoba and Quebec. See especially Larsen, "Seven Years with Legal Aid (1972-79) A Personal View of Some Events and Background Literature" (1981), 11 Man. L.J. 237.
17 Act, s. 2. The Law Society's power is "subject to the approval of the Attorney-General".
18 The early group apparently was funded by a Local Initiatives Program grant.
19 The original group also included a major research focus, the Canadian Environmental Law Research Foundation (CELA).
Community Legal Clinics in Ontario

Legal Services was established, using law students to provide legal services to the poor.\textsuperscript{20} Early on, Parkdale decided to confine its services to a defined geographical community and to limit its services to matters for which the Plan would not provide a certificate; a little later, Parkdale also began to set up structures for community input in decisions about the services it offered, thereby demonstrating a need for services other than those offered by the Plan.

All of these early clinics were established in response to "unmet legal needs", and to fill the "gaps" in the services available from the Plan. As is evident from the brief description above, however, early clinics were designed to meet a number of different objectives, using a variety of means. They did not follow any coherent plan or overall set of priorities for alternative legal services. Yet the ideas originally generated by the establishment of these and similar clinics have evolved as the articulated principles of existing community clinics in Ontario. In particular, the experiences of the early clinics identified two principles. One principle is the need to focus clinic services on the legal needs of the poor; in particular, the need to respond to the real needs of poor people, utilizing specialized personnel that includes both lawyers and community workers. The second principle is the need for community involvement in decision making, especially the need to involve the poor community and legal aid clinic clients in decisions about their legal aid services.

The early clinics must also receive credit for the development of a third principle, that of clinic independence. As is apparent, all of the early legal aid clinics were established as alternatives to the government-funded legal aid Plan. On this basis, of course, they could be described as independent of the Plan in every respect. It is unclear to what extent they were also independent of their initial funding sources: the federal Department of Justice, LIP (Local Initiatives Program) grants, university funding and private foundation grants. Parkdale was even funded initially by the American Ford Foundation.\textsuperscript{21} However, while it may be that the early clinics were not independent of their initial funding sources, it is nonetheless clear that they operated independently of the Plan in their formative years. The Plan did not direct their activities and accepted no responsibility for them financially. Thus, the third principle which emerges from an assessment of the early experience of Ontario clinics is the independence of clinics from the Ontario Legal Aid Plan. The clinics received no direction

\textsuperscript{20} Parkdale opened in September 1971; it seems that both Injured Workers' Consultants (IWC) and CELA commenced at approximately the same time, or a little earlier. Further research on the early beginning of clinics is needed to be any more specific.

\textsuperscript{21} The Ford Foundation supported clinical legal education programs through Legal Education for Professional Responsibility (CLEPR.).
nor any financial support from the Plan. They were therefore fully autonomous alternate legal aid clinics, at least vis-à-vis the Plan.

Clinic independence from the Plan contributed to the intensity of the debate about legal aid services in Ontario in the early 1970's. As experience with the Plan increased, there were demands for new services, extended office hours and decentralized office locations (particularly in Metro Toronto). There were also demands for public participation and more appropriate delivery models. Eventually, a Task Force was established in January 1974 to examine and evaluate legal aid in Ontario. The Task Force’s Report (the Osler Report) later that year recommended a mixture of delivery systems (complementary models) for legal aid services, including in appropriate circumstances the staffed neighbourhood legal aid clinic. The Task Force also recommended the creation of an independent non-profit corporation, Legal Aid Ontario.

The conclusions of the Osler Task Force were regarded as official recognition of the validity of the early clinics' objections to the Plan. In a brief to the Ontario Government, the early clinics supported the Report’s recommendations and urged the creation of a new legal aid corporation in which neither the Law Society nor government representatives should have any special status. However, the brief is also important for identifying the fiscal dilemma then faced by the early clinics:

There are a number of community based groups that have been providing legal services on an experimental basis to people not normally reached by the private bar. The existence of these groups was a major impetus for setting up the Task Force, they served as the models for many of the Task Force recommendations, and the Report recommends that they be given support by Legal Aid. These groups are in urgent need of funds. Without further moneys almost all of them will fold by the end of the year [1976]. We urge the government and other funding sources to respond quickly, before it is too late. These groups form a solid foundation on which to build and develop community legal services. They must not be allowed to die.

22 The Plan responded to some of these demands, following the recommendation of the Community Legal Service Report (Law Society of Upper Canada: 1972).
24 Id., 25.
25 Id., 22-25.
27 Id., 10 (Recommendation 2).
The response was a decision that the Ontario Legal Aid Plan would fund community legal services projects and the proclamation of a new Regulation under the Legal Aid Act in January 1976, the clinical funding Regulation. This decision marked the end of one era and the beginning of another for community clinics. The Regulation authorized the Plan to provide funding to "independent community-based clinical delivery systems", but only "clinical delivery system" was defined in the Regulation. The reference to "independent" clinics was, moreover, puzzling; it is difficult to understand how the clinics were to remain "independent" of the Plan once the Plan assumed funding responsibilities — and the ambiguity of this reference has produced both immediate and lasting tensions within the clinic system.

The immediate concerns for clinic autonomy were evidenced in ongoing difficulties about the Plan's funding arrangements for them, and by different perceptions of such matters as the confidentiality of client files. In June 1978, the Attorney-General appointed Mr. Justice Grange to review the operation of the clinical funding Regulation and

...to have regard . . . to the need for independence of clinical delivery systems, funded under the Regulation, the need for accountability for the expenditure of public funds, the need to maintain good standards of service to the public, the need to deliver service at a reasonable cost to the taxpayer, and the need for orderly growth and development of the clinical portion of the Ontario Legal Aid Plan.

The Report of the Commission on Clinical Funding (the Grange Report) concluded that clinics funded by the Plan should have autonomy with respect to both policy and administration, "subject only to accountability for the public funds advanced and for the legal competence of the services rendered." In the words of the Report, the Plan may interfere

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28 Noticeably, the decision to fund clinics was not accompanied by any recommendation to establish an independent legal services corporation in Ontario.
29 O. Reg. 160/76.
30 Id., s. 147.
31 Id., s. 148; "Clinical delivery system" means any method for the delivery of legal or para-legal services to the public other than by way of fee for service, and includes preventive law programmes and educational and training programmes calculated to reduce the cost of delivering legal services.
32 A wide range of concerns was discussed at a meeting between members of the Clinical Funding Committee and clinic representatives in January 1978.
33 Report of the Commission on Clinical Funding, Mr. Justice Grange, Commissioner (October, 1978).
34 Letter of appointment to Mr. Justice Grange from the Honourable R. Roy McMurtry, Attorney-General (June 27, 1978), para. 4.
35 Grange Report, supra note 33, 22.
with the operation of clinics “only if [the Plan] can bring the interference within one or other of the public’s legitimate spheres of interest.”

In accordance with the Grange Report’s recommendations, a new clinic funding Regulation was proclaimed in June 1979, repealing and replacing the earlier one. The new Regulation again provided authority for the Plan to fund “independent” community organizations; once again, “independent” was not defined. The new Regulation also established a new structure for funding (and defunding) clinics, along with a new five-person Committee reporting directly to Convocation of the Law Society of Upper Canada and responsible for the administration of Ontario clinics.

In the years since 1979, the clinic system in Ontario has continued to grow and prosper. With the funding of a new clinic in Sioux Lookout in February 1983, the total number of clinics had reached 41, and the 1982-83 annual budget had grown to almost seven million dollars. More significantly, however, the uniqueness of their pattern of development has more clearly emerged; the combination of the focus of clinic work, the structures for decision making in the clinic system and the nature of community involvement in clinic legal services makes Ontario clinics uniquely capable of effective progress toward equal justice for the poor. To a great extent, the history of Ontario clinics as alternative legal aid services and the less receptive environment in Ontario (at least compared to some other Canadian provinces) has resulted in a community clinic system which has more inherent capacity to carry out its mandate than any others. Ironically, the apparent intransigence of the Law Society and the difficulties between clinics and the Plan seem to have produced a system of community clinics which is more effective than anywhere else. What follows is an analysis of why this is so, focusing on the three principles which have been identified: scope of clinic services, structures for decision making in the clinic system and community involvement in clinic legal services.

III. Ontario Clinics: Their Unique Characteristics

A. Scope of Clinic Services

The scope of services provided by Ontario clinics is the product of the history of legal aid in Ontario. The Ontario

36 Id.
38 Id., s. 148 (1)(a) and (2).
39 See Reg., ss. 151 and 152 (funding) and s. 155 (defunding).
40 See Reg., ss. 149 and 150.
41 For 1981-82, clinic expenditures were $5,469,935 out of a total of OLAP expenditures of $56,241,045. Ontario Legal Aid Plan, Annual Report 1982, 32.
Legal Aid Plan adopted the judicare delivery system, using private practice lawyers to provide legal aid services modelled on the services usually provided to fee-paying clients. Use of this model naturally resulted in the extension of legal aid services to those problems for which a fee-paying client would retain a lawyer: proceedings before the Supreme Court, or a county or district court or where a client was charged with an indictable offence. In other proceedings, the legal aid client could have representation only subject to the discretion of the area director of the Plan: proceedings in provincial court (family division), small claims court, boards and tribunals; where the client was charged with an offence which would be tried in a summary conviction proceeding (including a violation of a municipal bylaw); or in drawing documents, negotiating settlements, or giving advice “wherever the subject matter or nature thereof is properly or customarily within the scope of the professional duties of a barrister and solicitor.”

Perhaps because the latter activities were regarded as less important to fee-paying clients, the legislation denied these services “as of right” to legal aid clients in Ontario and made them subject to the area directors’ discretion. Regardless of the reason for the legislative choice, it affected the scope of services initially provided by the alternative legal aid clinics; essentially clinics focussed on the “gaps” in the Plan’s legal aid services, and provided “poverty law” services. In doing so, clinics transformed the concept of legal aid in Ontario; by focusing on the legal needs of the poor rather than on the existing needs of fee-paying clinics, clinics extended the full range of services needed by the poor in the justice system. From the early clinics’ perspective, if it was important to a welfare mother to pursue a claim before the Social Assistance Review Board, then legal aid representation should be available even if such services were not generally required by fee-paying clients. Furthermore, if a group of mothers on welfare wanted to submit a brief on retraining allowances to the Minister, legal aid representation should be available, just as fee-paying clients would obtain legal assistance in making briefs to government on matters of concern to them.

By 1978, the Grange Commission fully endorsed such clinic activities on behalf of the poor and the need for such activities has also been widely accepted in other jurisdictions, both in

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42 *Legal Aid Act*, R.S.O. 1980, c. 234, s. 12.
43 *Id.*, s. 13.
44 See *Grange Report*, supra note 33, 1-3 for a list of the “gaps” in the Plan’s services to which community clinics responded; in the words of the Report: “It was to plug these gaps that the clinical movement was born”. 
Canada and elsewhere. Yet the Ontario experience has special significance because it appears to be the only jurisdiction in which there are two completely separate specialized systems in place for delivering legal aid services. That is, while the judicare system operates to provide representation in court proceedings pursuant to the Legal Aid Act, the clinics provide legal advice and representation in matters for which certificates may not be granted. Even more significantly, community clinics have gradually directed attention to those legal problems for which certificates are almost never, or only infrequently, granted: welfare, rent review, workers’ compensation, unemployment insurance, some immigration and debtor problems, tenancy agreements, etc. On this basis, the clinics have become “specialists in poverty law” problems while the judicare program has continued to extend legal aid services to the poor on the same terms as it is available to fee-paying clients.

The clinics are staffed by lawyers and community legal workers whose interest, skills and training reflecting the clinics’ service priorities; the private bar, with interests, skills and training in traditional legal advocacy, provides legal representation in criminal, family and some civil matters to both legal aid and fee-paying clients.

The special significance of this functional division of roles in Ontario must be understood by contrast to clinic arrangements in other Canadian provinces in which the clinics conduct “intake” functions for the whole legal aid system, offer substantial legal aid advocacy before criminal and family courts and also make referrals to the private bar in the fee-for-service arrangement. In such cases, both clinic objectives and

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43 The legislation establishing other legal aid programs in Canada has recognized the need to respond to the specialized problems of the poor. For two examples, see the Quebec legislation supra note 10, s. 4, defining a right to legal aid of “an economically underprivileged person”, and the Manitoba experience referred to by Larsen, supra note 16.

46 The specialization “away from” routine representation by clinics in family law and criminal law matters has been noticeable in recent years (Clinic Funding Statistics: unpublished). However, university-based clinics, with a larger personnel than other community clinics, have continued to provide such representation. See Mossman, Report to the Legal Aid Committee and the Clinic Funding Committee on University Clinics (December 1981).

47 These arrangements exist, for example, in Nova Scotia, Quebec, Manitoba, Saskatchewan and British Columbia. There are a few “specialized” clinics in other provinces as well — two in Quebec, which are integrated with the provincial plan, fifteen in British Columbia which handle public information, referrals and tribunal matters and one in the N.W.T. None of these programs seems to operate with the same scope as is evident in Ontario. See Legal Aid, 1981, supra, note 10, 33-34 for information on “specialized” clinics, and 42 and 29 for patterns of legal clinics’ activities with respect to representation and referrals to the private bar. These patterns are generally confirmed by the Annual Reports of provincial legal aid schemes.
the functions of personnel are broad and complex. Moreover, it may be difficult to balance competing needs so as to find the necessary time and creativity to prepare a brief on behalf of welfare mothers, for example, and at the same time prepare for a criminal trial. By contrast, the Ontario clinics have an inherent capacity to focus on the specialized legal problems of the poor and to advocate purposefully on their behalf; the Ontario clinic system is an affirmative action program directed to achieving equal justice and capable of performing as a driving force on behalf of the poor. And Ontario clinics feel freer to specialize in the legal problems of the poor, knowing that other legal problems, for which traditional advocacy solutions are more appropriate, can be provided by the judicare program and by personnel who are appropriately trained to do so.\(^4^8\)

The division of functions between the clinic system and the judicare program in Ontario thus has immense potential for the objectives of clinics. In contrast to jurisdictions in which clinics have become the primary model for delivering legal aid services, the Ontario system permits a specialization of functions for clinics and private practice lawyers which is arguably more efficient. For clinics, however, the real significance is that specialization permits them to really take on the legal problems of the poor and become their effective advocates in the justice system. Ontario clinics need not be merely band-aids because the overall legal aid system permits, and even directs, them to focus their energies on systemic poverty law problems, leaving the representation of accused persons to the private bar.

The clearest evidence of the scope of services which clinics are intended to provide is found in the clinic funding Regulation under the *Legal Aid Act*, which provides that funding for clinics is based on the delivery of:

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\text{... legal and paralegal services or both, including activities reasonably designed to encourage access to such services or to further such services and services designed solely to promote the legal welfare of a community.}\]

Quite clearly, the Regulation endorses activities by clinics beyond traditional advocacy and authorizes clinics to engage in action on behalf of the clients to promote the legal welfare of

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48 This assertion is tempered by the problem of increasing needs and decreasing resources of the judicare program, particularly at present: "In Ontario, the demand for legal aid rose 21 per cent [a three-month period]", A.M. Lawson, Director of the OLAP: "There are more and more demands for aid from more and more people who can't afford anything else", James B. Chadwick, Chairman, Legal Aid Committee. See OLAP, *News Update* #10 (October 1982).

49 Reg., s. 148(s).
the poor. Since 1979, the clinic contract or certificate, which authorizes funding for each clinic, has also defined the scope of services in the same wording. Thus, both the clinic funding Regulation and the clinic certificate authorize clinics to undertake effective action on behalf of poor clients.

The specialized function of Ontario clinics and their clear mandate to advocate for equal justice for the poor make them unique as legal aid clinics. They are also somewhat unique because the scope of services they offer was not actively designed, but rather grew out of the desire to respond to unmet needs of the judicare system. To say that legal aid services now provided by clinics and the judicare program are complementary is not, however, to suggest that they are without tension. Particularly because of increasing needs and decreasing resources, the judicare program in Ontario may now be in some jeopardy. For this reason (among others), there have been suggestions that some of the services now provided by the judicare program might better be transferred to clinics and that the intake work of area legal aid offices could also be done by clinics. While such proposals may appear superficially attractive, they present a real threat — to the poor — of a loss of legal aid services specializing in poverty law and advocating, in the broadest sense of the word, on behalf of the poor community. The danger for Ontario clinics is that by acquiring the workload of the judicare program, they will inevitably fall prey to the problems of multi-purpose clinics for which there is ample evidence in other jurisdictions. This conclusion does not mean that a clinic system might not be an appropriate means of providing some services now delivered by the judicare program in Ontario, but it does mean that there are serious, even tragic, disadvantages to utilizing the existing community clinic system to deliver judicare services. To do so would mean that the poor would lose their advocates for systemic change in Ontario’s justice system.

B. Structures for Decision Making in the Clinic System

Decision making about Ontario clinics, like the scope of their services, reflects the history of their development and the critical importance of clinic independence, which is so characteristic of their early beginnings. The concept of independence from the Plan is one which endorses full clinic

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50 Clinic certificate 1982-83, clause I; this clause is not included in the certificates of three university-based clinics which have no community board.

51 Concerns have been expressed by the Director of OLAP and the chairperson of the Legal Aid Committee, supra, note 48. In addition, Ontario lawyers who participate in judicare services scheduled protest “study days” in early 1983. The Ontario judicare situation is not unlike that in other provinces, see supra, note 2.
independence, subject only to interference by the Plan in the public interest with respect to accountability for public funds and competence of services. While either of these grounds for interference could limit clinic independence significantly, it is of importance to note that the Grange Report clearly placed the burden of demonstrating grounds for such interference on the Plan.\textsuperscript{52}

Notwithstanding the traditional idea of clinic independence from the Plan, the concept of clinic independence is of utmost significance in connection with the quality of legal aid services they provide. Independence in legal decision making is fundamental to a democratic society, as reflected in the need for a independent judiciary; equally important is the need for independence in legal advocacy and representation.\textsuperscript{53} Indeed, the crisis in legal services in the twentieth century results from the need to preserve such independence in legal representation in the face of massive government funding for legal services: to what extent is the public’s democratic right to political accountability for government expenditures to be tempered by the legal aid client’s right to traditional independent representation; and if there is to be some democratic accountability for legal aid expenditures, will not this mean that justice for legal aid clients will inevitably be second class?

The need for independence for legal aid services is not an academic issue. To the extent that clinics are successful advocates on behalf of the poor, they may become targets for defunding by government, acting in accordance with the democratic will of the majority. Even if legal services are less successful (and therefore perhaps less visible targets for budget cuts), they may be defunded pursuant to general government priorities on the basis that the priorities of the majority must prevail. In this way, protection for minority rights seems always to be eroded when government funding is provided because of the democratic need to take account of majority will. The evidence of this dilemma has been all too apparent in decisions of government, both in Canada and elsewhere, to cut back funding for legal aid services in recent years.\textsuperscript{54}

To some extent, the dilemma created by public funding for legal services — the tension between democratic decision making by government on the one hand and legal protection for minorities on the other — has remained essentially unresolved. The special contribution of Ontario clinics is their development of a process for making funding decisions for legal aid services which separates, as much as possible, the need for accountability for public funds from the need for independent legal representation. An assessment of this process requires a

\textsuperscript{52} Grange Report, supra note 33, 21-22.

\textsuperscript{53} This concept is more fully explored in Ellis, supra, note 4, 5-9.

\textsuperscript{54} For a good example, see Larsen, supra, note 16.
review of the definition of clinic services, the composition of the funding body and the process for funding and defunding of clinics in Ontario.

In the first place, the definition of services is contained in both the Regulation under the Legal Aid Act and in the contract with each clinic. Subject to this definition, a clinic has authority to provide legal aid services within the limits of the law and the rules of professional conduct. This authority includes challenges to government administration, the Law Society and the Ontario Legal Aid Plan. Interestingly, nothing in the definition of clinic legal services precludes clinics from undertaking work for which the judicare program provides a certificate, although clinics must provide services "on a basis other than fee-for-service." The complementary nature of the services provided by clinics and judicare thus results from historical and functional demands rather than from administrative fiat, and it is now well recognized that a clinic client who chooses to appeal a case may continue to retain a clinic employee even when a certificate would issue.

Notwithstanding the importance of the broad scope of clinic services, however, it is clear that clinic independence depends much more critically on the process for making funding decisions, since a negative funding decision for a clinic would completely shatter any potential for independent legal representation; more subtly, perhaps funding decisions may also influence the type or extent of legal representation that is actually provided by clinics. For both these reasons, the funding process is a critical element in determining whether independent legal representation is possible.

The key element in the process for decision making about Ontario clinics and the one which most affects the quality of their independent services, is the composition of the funding body. The funding body must be as independent as possible from any controlling influence. Ontario clinics are funded by the Clinic Funding Committee, an appointed body of five persons established by the Regulation. The Law Society, which has administrative responsibility for the Plan, appoints three persons to the CFC, and the provincial Attorney-General appoints the other two. However, one of the members appointed both by the Law Society and by the Attorney-General must, pursuant to the Regulation, be a person "associated with a clinic." The CFC is entirely

55 Reg., s. 148(2).
56 Id.
58 Reg., s. 149.
59 Reg., s. 149(3).
60 Id.
61 Id.
62 Reg., s. 149(4).
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separate from the Legal Aid Committee; while the latter Committee has general responsibility for the Plan as a Committee of the Law Society, the CFC has responsibility under the Regulation for the overall administration of clinic funding. Because the Law Society has overall responsibility for the Plan, the CFC reports directly to Convocation of the Law Society. However, there can be no appeal from any funding decision of the CFC (other than perhaps by way of judicial review).

The composition of the Committee ensures that its decision making about community clinics takes account of relevant interests, but that there is no single controlling influence. The funder (the Attorney-General), the administrator (the Law Society) and the clinics are all represented among the appointees. The independence of the Committee is also protected. It is protected from the Attorney-General because he may appoint only two of the five members, and one of the two must be a person with previous “clinic association.” It is protected from the Law Society because, although it may appoint three members, one must also be a person with previous clinic association. It is protected from the Plan and the Legal Aid Committee because the CFC reports directly to Convocation (and not through the Legal Aid Committee). And it is protected from Convocation because there is no appeal from a funding decision of the CFC. The CFC’s independence in decision making is also enhanced because it acts as an appellate tribunal for clinics on funding decisions made by the Committee’s staff, and is thus also independent of the initial funding decision making. The Committee’s objectivity, in addition to its composition, ensures further protection in decision making about clinic funding. Thus, while individual members of the Committee may advance their own interests very strongly, the Committee’s decision must in all cases represent at least a partial consensus from among the CFC’s members, whose interests are often competing ones. This need for an alliance provides a measure of protection for the independence of clinic legal services which, while it is less than complete, is certainly more substantial than would be possible if funding decisions could be made by the Attorney-General, acting alone for example.

The CFC’s composition does not, however, provide the only protection for independent legal services in community clinics. A further element of this protection is found in the annual process of obtaining funds for clinics. The CFC is responsible

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62 Reg., s. 149(7) and s. 150(1)(a).
63 Reg., s. 153(2).
64 Reg., s. 152(5).
65 There is no authority on this point, but the CFC has chosen to operate since 1979 as if its proceedings were subject to judicial review.
66 Reg., s. 152.
for determining the needs of community clinics and defining an annual budget request; the CFC’s request is included in the overall request made by the Law Society on behalf of the Plan. Once the amount of the overall budget for the Plan has been determined, however, the Attorney-General is required by the Regulation to designate the amount to be allocated for community clinics. In the result, the clinic budget forms part of the Law Society’s annual request for funds for legal aid services, for which the Society has both a statutory and a professional responsibility. Because the Attorney-General designates the amount for clinics out of the overall amount allocated to legal aid, the CFC has the benefit of substantiating its request on two separate occasions. It is at least arguable that this process contributes further to the independence of clinic legal services because two different decisions are required. More significantly, however, independence is achieved because neither the Law Society’s request nor the Minister’s designation can affect the allocation for any individual clinic; such a decision is made by the Committee’s staff, subject to the provisions for appealing to the CFC. Thus, for example, a clinic which successfully filed a private prosecution against a Cabinet Minister on behalf of a client, or a clinic which successfully challenged the denial of a legal aid certificate to a client, cannot be adversely affected either by the Law Society’s request or by the Attorney-General’s designation. And, in the absence of an appropriate alliance between CFC members, and excluding clinic appointees, it could not be adversely affected by an appeal to the CFC. In the absence of an appeal, the clinic’s budget needs must be determined by the Committee’s staff in accordance with the Grange Report’s direction that clinics should be independent, subject only to interference from the Plan in the public interest to protect accountability for public funds and competence of services. So long as clinic activities meet the definition of activities provided in the Regulation, their independence, subject to the Grange Report’s limits, can be reasonably assured by the funding process.

Similarly, there is some protection for independent clinic services in the defunding process. Because initial decisions are

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67 Reg., s. 158. The Grange Report, supra note 33, recommended that: “. . . the role of the Committee should not be a political one. Its task . . . is to estimate the need and then if the funds are inadequate for that need, to establish priorities among the applicants. It may be that political considerations will affect the allotment. I cannot see why it should affect the request; the amount requested should represent the amount genuinely considered by the Committee to correspond with the need.”

68 Legal Aid Act, s. 6.

69 Reg., s. 159.

70 Legal Aid Act, s. 2.

71 Reg., s. 151.

72 Reg., s. 152.

73 Grange Report, supra note 33.
made by the Committee's staff, the CFC is able to act as an impartial appellate tribunal; in some cases, a clinic has a right of appeal, while in other, the clinic must seek leave to appeal to the CFC. And while the CFC may decide to defund a clinic other than during the funding process, it may do so only when the CFC makes a finding that the clinic "has failed to abide by or has contravened" a condition of its certificate. Moreover, the Regulation requires that

the Committee shall not make a finding . . . unless it has given notice of the proposal to the clinic, together with written reasons, and has provided to the clinic an opportunity to be heard by the Committee. These defunding procedures, coupled with the Committee's composition and the possibility that the CFC's decisions may be subject to scrutiny by way of judicial review add to the measure of protection for independent legal services provided by clinics.

The structure for decision making in the Ontario clinic system cannot, by itself, fully guarantee independent legal services in clinics. The structure described, however, provides a greater chance for achieving independence than a system in which one person makes funding decisions; the consequences of adverse decisions or compromised services is all too evident in other jurisdictions when a change in the incumbent of the Attorney-General's portfolio has occurred. What is asserted here, and all that is asserted, is that a broadly-based and balanced process for decision making may provide greater long term protection for a clinic system than one champion. Clearly, to have a strong and independent clinic system which is championed by the Attorney-General is advantageous, but to rely on a champion alone is to put legal aid services in great jeopardy.

It must, of course, be noted that the Ontario system is complicated, much more complicated than a structure involving only one decision maker. The issue, however, is whether its complexity is too great in light of its objective: the independence of publicly-funded clinic legal aid services. In the interests of equal justice, a structure which substantially achieves independent legal representation for the poor, notwithstanding the need to account for public funds and provide competent services, should not be rejected on account of complexity, at least in the absence of any compelling alternative.

C. Community Involvement in Clinic Legal Services

The significance of community involvement in Ontario clinics is difficult to measure. The difficulty stems from the

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74 See Reg. s. 152 and s. 148(1)(f).
75 Reg., s. 155(1).
76 Reg., s. 155(3).
elusiveness of the concept of community and the different meanings assigned to it in different contexts. For example, while Ontario clinics were established outside the framework of the Ontario Legal Aid Plan and the Law Society, and therefore outside the governing body of the legal profession, there were several individual lawyers who actively participated in creating the early clinics. On this basis, the community cannot be defined as necessarily excluding lawyers. What is clear in retrospect, however, is that the absence of a concrete idea of community did not impede the activities of people (including some lawyers) whose commitment to providing a needed service resulted in the creation of the early clinics.

The idea of community involvement in legal aid services was generated by both the developments in the United States, where the Economic Opportunity Act of 1964 included a requirement of maximum feasible participation by affected residents,\(^{77}\) and by prevailing political philosophy of the early 1970's in Canada, where funding for community action projects, including LIP and OFY (Opportunities for Youth) was created. There was a dominant sense of optimism that the community could and should be involved in its own development with respect to legal services as well as other services. This philosophy was also consistent with the view (repeatedly expressed by proponents of early clinics) that the transformation of legal services from charity provided by the legal profession to a right funded by the public purse required representation of a broader range of interests in decision making about such services. Arguably, clients who received services, government which allocated funds, and the tax paying public deserved to be involved, in addition to lawyers, in decisions about publicly-funded legal aid services. In Ontario, the intransigence of the Law Society on the issue of such shared control, even after the Osler Task Force Report, once again emphasized the significant differences between the clinics and the Society's judicare program.

Even within the clinic system, however, the concept of community was ill-defined. In some cases, the community meant the people actively involved in the clinic; in other cases, it meant the target group for whom the clinic services were designed, even though no structure existed by which the target group could influence clinic priorities. In a few cases, where early clinics developed geographical boundaries and limited services to residents within the boundaries, it was possible to organize a meeting and elect a community board.\(^{78}\) This arrangement was not widespread, and clinics which had boards

\(^{77}\) For a provoking discussion of the background to this provision, see Larsen, \textit{supra}, note 16; the United States experience was also influenced by E. & J. Cahn, "The War on Poverty: A Civilian Perspective" (1964), \textit{73 Yale L.J.} 1317.

\(^{78}\) An early example was Parkdale Community Legal Services.
sometimes included among the board’s members only appointed persons and staff members employed at the clinic. In general, the community involvement in the early clinics was uneven, reflecting much of the strength of grassroots development as well as its lack of overall structure.

By 1976, when funding for clinics by the Plan commenced, the concept of community was identified at least clearly enough to be included in the definition of funding in the Regulation; it referred to “independent community-based clinical delivery systems”.\(^7\) Given the variation in the nature and extent of community involvement in clinics at that time, it is hardly surprising that the definition could do no more than refer to a clinic’s community base. However, the definition at least identified the focus of the clinic, clearly differentiating it from the Law Society or the Plan. By 1979, the definition in the Regulation was altered, and a clinic was defined as an independent community organization.\(^8\) From a community base, clinics had developed into community organizations. Moreover, on the basis of the *Grange Report*’s recommendation, community was defined to include a geographical community, persons who have a community of interest, and the general public.\(^9\)

The change in the wording of the 1979 Regulation produced little immediate effect on the existing clinics. From 1979, however, the newly-appointed CFC and its staff consistently used the terms of the clinic certificate to influence clinic structures and to strengthen the role of community-elected boards. Early on, the certificate included a clause requiring a clinic to have a Board of Directors “including some persons representative of the community served by the clinic”, and later certificates required the adoption of constitutions for clinics and the establishment of procedures for matters such as complaints about clinic services.\(^10\) All of these measures were justified in accordance with the *Grange Report*’s proviso that the Plan could interfere in the public interest to ensure either accountability for public funds or competence of services. From the Plan’s perspective, it was not possible to demonstrate accountability for increasingly large amount of public funds for clinics in the absence of some structure for decision making which met minimum standards of accountability.

In the clinic context, few actions by the Plan have produced such grave misunderstanding as the efforts to implement minimum standards of accountable decision making. On the part of clinics, every new requirement was seen as an interference with autonomy and an attempt by Plan administrators to impose their ideas on an unwilling

\(^7\) O. Reg. 160/76, s. 147.
\(^8\) Reg., s. 148(1)(a).
\(^9\) Reg., s. 148(1)(d).
\(^10\) Clinic certificates 1981-82 and 1982-83.
community. From the Plan’s perspective, the possibility of sustained growth in the number of clinics, and continued capacity for effective legal challenges, both depended on the demonstration of public accountability, in the financial arrangements of clinics and in their decision making. There can be no doubt to anyone who has ever experienced it that the strength of commitment of community clinic boards has often substantially increased because they have felt (rightly or not) threatened by a loss of control to a “Toronto bureaucrat”.

The most significant aspect of the Grange Report’s limits on clinic independence, however, is that they leave community boards with full responsibility for the selection of legal services. With respect to the choice of areas of legal problems and the deployment of staff resources to respond to such needs, the clinic board is fully in charge, subject only to the board definition of legal services in the Regulation. In practice, this means that a clinic board may determine that it will make unemployment a priority problem because unemployment is a chronic problem in the community. This might mean, for example, a direction to staff to challenge every unemployment entitlement decision for a defined period, to write and submit a brief to the legislature based on the problems experienced by clinic clients who are unemployed and to hold meetings with unemployed persons interested in self help and mutual support. Notwithstanding the Grange Report’s limits on clinic independence, the capacity of a clinic board to identify a community problem and marshall its resources “to promote the legal welfare” of the poor community is limited only by its imagination.

The potential for a clinic board to utilize effectively the resources entrusted to it underlines the need for accountability in the process by which its decisions are made. If a board does identify a problem, prioritize its needs, marshall its resources and take on all opponents on behalf of the poor, it will, in any such process, need to ensure that its decision is “legitimate” — both because the clinic may deny services to other potential clients in order to undertake a major effort on behalf of the unemployed and because the clinic will undoubtedly be challenged by those who its efforts adversely affect, such as government. A decision made by a community board, elected in accordance with procedures in a written constitution and with a mandate under a Regulation to “promote the welfare” of the poor, cannot be effectively challenged; by contrast, a group which is self appointed and without minimum procedures for fair decision making has much less credibility when it responds to a client who has been denied service or to an outraged bureaucrat. Thus, the efficacy of community control of

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83 A recurring theme in appeals by clinics to the CFC, at least with respect to terms and conditions of the clinic certificate, has been the interference by the Committee’s staff in the autonomy of clinics.
effective legal services depends on the legitimacy of its process for making decisions, but the substantive choice about the allocation of its resources remains, subject to the Regulation, completely within the control of a community board.

The need to legitimate controversial decisions by community boards about the use of scarce resources in providing legal aid services motivated the Plan to request appropriate decision making structures. Because each clinic board is the product of its own community, reflecting its own concerns and goals, the Plan's requirements were proposed as minimum standards only; there is no requirement of uniformity.

Indeed, the absence of uniformity is the strength of the community clinics in Ontario. If each clinic board can reflect the special concerns and priorities of its poor community, it will, of necessity, become the advocate for those people. Through natural links with other people and groups in its own community, and across Ontario, such a clinic board has a significant capacity to influence policies affecting its own clients as well as others with similar problems throughout the province. A clinic's activities can identify legal reform which is needed and can greatly assist in the process of achieving it. In the long term, this means that clinics become valuable, even indispensable, tools for achieving equal justice for the poor. As such, community support for and involvement in clinics will make it difficult or even impossible for their funding to be drastically reduced.

Even if the protections in the Regulation and the certificate for the services provided were removed, and even if some of the protections of the funding process were eroded, the Ontario clinics could nonetheless retain some capacity for independent legal representation by means of their political strength, dependent entirely on the support of the community. In this light, community involvement — especially involvement which is both meaningful and accountable — is more than an interesting ideal; it is the most vital element in the unique characteristics of Ontario clinics.

IV Ontario Clinics in the 1980s — An Assessment*

The preceding analysis of the history of clinics in Ontario, and of the characteristics which make them uniquely capable of surviving in the face of economic recession, is intended as an assessment of the inherent strength of the clinic system in Ontario. In my view, there are significant differences between the Ontario clinic system and clinics which have developed in other jurisdictions. Although this analysis has shown the inherent strength of Ontario clinics and their unique capacity for survival, it would be wrong to conclude that they are

* From May 1979 to September 1983, I was Clinic Funding Manager of the Ontario Legal Aid Plan and on leave from Osgoode Hall Law School.
invulnerable. Indeed, by demonstrating the careful balance which has been achieved in the Ontario clinic system, this analysis also points to the delicacy of the balance which must be maintained. In my opinion, community clinics in Ontario have the capacity to meet the legal services crises of the 1980’s, just as they have done in the preceding decades, but the emerging issues require an appreciation of community clinics and their potential on the part of government, the legal profession and clinics.

A. Renewing the Service Mandate: Clinics and the Legal Profession

In this analysis, I have tried to show that the history of Ontario clinics has resulted in a Regulation which defines a broad scope of services; indeed, I have suggested that the Regulation provides a mandate for Ontario clinics to take on the systemic legal problems of the poor rather than to be limited to merely ad hoc remedies. A service mandate direct to promoting “the legal welfare of a community” presents both an opportunity and a challenge to eliminate inequality in the justice system.

In relation to the service mandate, there are important choices presently facing Ontario clinics. In the first place, individual clinics must define more systematically the scope of services they want to provide. Too frequently, clinics in Ontario have simply responded to the service needs which have “walked in the front door”; such a passive response approach inevitably means that other legal needs, perhaps more compelling because less often recognized, are not met at all. Moreover, the case-by-case approach, by itself, may frequently do little or nothing to promote the legal welfare of the poor. Thus, while there is a basic clinic responsibility to get involved in the day-to-day legal problems faced by the poor, clinic boards must also systematically assess the nature of the services they provide in terms of the real problems of their low-income community. In addition, both clinic boards and staff must continually reassess the strategies they use to most effectively promote the legal welfare of the community. Moreover, in the context of a clinic system with inherent capacity to achieve so much effective equality for the poor, and taking account of the scarce resources available, clinics as a group may need to begin defining the limits of community control when a board is unwilling to define a service mandate for its community which goes beyond the band aid ad hoc approach.

The second issue facing clinics is the need to define the limits of the service mandate set out in the Regulation, particularly when clinics are actively providing legal services in addition to case-by-case services for clients. In his letter of December 16,
the newly-appointed chairperson of the Clinic Funding Committee endorsed the enthusiasm of the *Grange Report* for a full range of clinic legal services on behalf of the poor. He also expressed the CFC’s concern about the consequences of “political activities by clinics”. The issues raised by the Chairman’s letter are critical for the future of Ontario clinics because they may affect their ability to “promote the legal welfare” of the low-income community. It is essential, first of all, to understand that the service mandate of clinics (promoting the legal welfare of the community) both permits, and indeed requires, clinics to advocate on behalf of the poor in a partisan, and not a neutral, manner. To the extent, therefore, that the chairperson has suggested that clinics “must always be non-partisan”, his statement is not consistent with the service mandate of the Regulation. On the other hand, to the extent that his letter suggests a lack of authority in the Regulation for “the possible promotion of any political party when clinic employees are speaking to tenants about rent review”, the Chairman’s analysis may be more accurate. There is a difference between partisan advocacy on behalf of the poor and partisan political activities; the former is clearly part of the service mandate of Ontario clinics while the latter probably are not. The crucial point is that clinics must themselves define the limit, perhaps in consultation with the CFC, in order to ensure that the limits of the service mandate are not exceeded, but, more importantly, that they are fulfilled. In the context of any such discussion, it will also be of critical importance to understand the boundary between clinic advocacy on behalf of the poor (pursuant to the Regulation) and the strategies which may be necessary to obtain ongoing funding for clinics. To the extent that the chairperson’s letter may appear to suggest that ongoing funding for clinics depends on some restraint in their wholehearted promotion of the legal welfare of the poor community, his assertions cannot be accepted.

Finally, the service mandate of clinics requires an appreciation of their role in the context of the Plan’s judicare program. To the extent that the judicare program presently faces some jeopardy (for a variety of reasons), the service mandate of clinics may also be affected; notwithstanding their separate structures for delivering legal aid services, clinics and the judicare program are mutually dependent. And although it may be appropriate to consider the efficacy of delivering judicare services by salaried staff, it is critical to understand that the service mandate of community clinics cannot be adapted to the provision of simultaneous judicare services without losing the essence of their present service mandate. The

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85 Letter from Roger D. Yachetti, Q.C., chairperson of the Clinic Funding Committee to the Chairpersons of Boards of Directors and Deans of Law Faculties, December 16, 1982.
86 *News Update, supra*, note 48.
issue is not the appropriate delivery system but the scope of services to be offered. In this respect, both clinics and judicare lawyers have a mutual interest in an acceptable resolution of the judicare dilemma. In addition, both clinics, and other members of the legal profession have a mutual interest in ensuring the equal justice for the poor which community clinics have a mandate to achieve.

B. Maintaining Independent Legal Service: Clinics and the Government

In this analysis, I have also tried to demonstrate the critical importance of independent legal services provided by clinics and the delicate nature of the structure developed to achieve this objective. I have also noted the additional advantages accruing to clinics through the Minister's personal support for their activities. Ironically, it is the Minister's unqualified support for clinics which has, in recent months, resulted in a weakening of the structures designed to protect clinic independence. Notwithstanding his good intentions, the Minister's actions require careful scrutiny in the interest of the continued capacity for independent clinics to promote the legal welfare of the poor.

As has been demonstrated, the independence of clinics depends substantially on the existence of a CFC which is free from any controlling influence in its decision making. The Minister's decision in early 1982\(^8\) to appoint two of his senior officials to vacant positions on the CFC signified both his personal support for clinics and his concern to ensure that clinic interests received due attention in his Ministry. Unfortunately, his choice also undermined the delicate balance earlier achieved by the CFC, thereby creating a possibility of more overt governmental intervention in the activities of clinics and their advocacy on behalf of the poor. That the Minister's appointees were persons with some experience in legal aid matters and a sincere commitment to clinics is beside the point; their positions placed them, inevitably, in a conflict of interest on any issue where independent legal representation of the poor was inconsistent with governmental (and Ministerial) policies. Moreover, since this potential conflict of interest problem could be identified in advance, it seems that the Minister's

\(^8\) The Minister had been requested to make an appointment to replace Brian Bellmore, who had earlier resigned; in February 1982, he announced the appointment of J. Douglas Ewart, Director, Policy Development Department, to replace Mr. Bellmore. At the same time, the Minister announced the appointment of Glenn Carter, General Manager (Programs and Administration Division) to replace an existing member of the CFC, Michael Fitzpatrick (Director of Courts Administration). The Minister confirmed that Mr. Ewart, who had worked as a student at Parkdale Community Legal Services in 1971, was a person with "previous clinic association".
choice must have been made only because he was unable to find any equally suitable appointees who were not employees of his Ministry; particularly with respect to the appointee "with previous clinic association", it is unfortunate that the Minister's choice creates an inevitable conflict between the need to protect independence of clinic legal services and the obligation to defend Ministry policy about legal aid services. And it is essential to recognize that these concerns are live issues, particularly taking into account the need to resolve existing problems with the judicare services. The possibility that community clinics might be expected to undertake the delivery of judicare services clearly demonstrates the conflict between the clinics' interest in continued specialization in poverty law problems to promote the legal welfare of the poor and the Ministry's interest in cost-effective delivery of high volume legal aid services. Because two members of the CFC could not vote independently on any such proposal, there must be serious concern about the integrity of CFC decision making, and its continued role in preserving independent legal services for the poor. In this context, the Minister's personal support for clinics and his expressed desire to increase their resources requires very careful assessment.

C. Achieving Equal Justice: Clinics and their Communities

The requirement in the 1979 Regulation for a clinic to be a community organization reflects the significance of the concept of community in Ontario clinics. As I have suggested, the recognition of the community's importance to successful clinic action on behalf of the poor has steadily increased, particularly since 1979. Moreover, as has been shown, it is the community which offers the final link in the structures for achieving independent legal representation in the face of substantial public funding for legal aid services.

In this context, Ontario clinics must also be confident that their community organizations are scrupulously independent of other community groups, particularly in relation to decision making procedures and financial arrangements. It is critical to the credibility of successful advocacy on behalf of the poor that a community clinic be, and be seen to be, independent. In this way, independence from government is complemented by independence from other community groups. Notwithstanding that many clinics have evolved out of other community groups, the success of a clinic's advocacy, as well as its credibility as an independent legal service, depend on its scrupulous independence from other community groups. In recent months, the recognition of MTLS's (Metropolitan Tenants Association) need to make decisions about priorities for its legal service,88

88 See Report: Independent Community Clinics and Other Community Organizations — a Report to the CFC on MTLS and the FMTA (August 1982); the Report was substantially accepted by MTLS and recently approved by the CFC.
independently of the Federation of Metro Tenants, has signalled a recognition of the importance of this principle and of the coming of age of community clinics in Ontario.

The concept of the community is a vital part of Ontario clinics: the community includes the many people over many years who have made their contribution to the growth and success of clinics, as well as the people to whom clinics, in many different ways, have provided assistance. As I have suggested, the Ontario clinics have a unique opportunity to fulfill the promise of legal aid services. The challenge for Ontario's community clinics is the responsibility of achieving equal justice by and for their community: the poor.