GTA Legal Clinics
Transformation Project

Vision Report

Executive Summary

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strategy & communications

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EXECUTIVE SUMMARY

WHERE WE HAVE COME FROM

PROCESS

The GTA Legal Clinics Transformation Project has created a Vision Report for the future of the GTA's geographically based community legal clinics. It recommends larger community clinics with resources re-aligned to match need and increase the capacity to generate enhanced services for clinic clients. The Project, made up of 16 community legal clinics across the GTA, was directed by a Steering Committee that included staff and Board members. The purpose of the Project, in line with the Association of Community Legal Clinics of Ontario's Strategic Plan, was to develop and recommend a new model for the GTA clinics that would increase access to justice for people living in poverty. If the vision is adopted and implemented, the clinic system in the GTA will look and operate very differently from the way it does today.

CONSIDERATIONS

It can also be destructive if it does not take into account the fundamental values that define and make the existing system work. The Steering Committee of the Project has worked hard to ensure the fundamental basis of community legal clinics is well recognized, understood and preserved in the Vision being articulated here. The new model reinforces clinic control by – and accountability to – the communities served. It also ensures attentiveness to the needs of their communities. The Steering Committee has made a point of ensuring that the community development work that set community legal clinics apart in the past will be re-invigorated if the new service model is implemented. It is a critical feature of the new model that more extensive resources will be committed to establishing stronger relationships between the legal clinic and community members and partners. The erosion of those connections in many of our communities – even more critical given the changing nature of our communities – was indeed a major concern when developing the new service model.

CHALLENGES

While clinics have provided effective legal services for decades, they find themselves facing big challenges, which the structure of the current system cannot help them address. Demand for clinic service has been growing in volume and complexity for many years; clinic catchment areas and resource allocations do not reflect the changed or changing needs of local communities, making it impossible for clinic staff to respond in adequate ways. Other legal-aid services have been cut back. Among clinic staff and Board members especially there is mounting realization that the status quo will not be able to successfully meet these challenges because:

- Legal clinics currently are too small to have any resiliency in staffing (when someone is sick, goes on leave, or just takes vacation, there are service impacts);
- We do not have the ability to respond to emerging issues and emergency situations;
- In making difficult choices about allocating our limited resources we have had to narrow the critical services we are able to offer;

- We struggle to maintain basic services, and have limited capacity to develop new, innovative projects.

PRINCIPLES

The participating clinics agreed the Transformation Project had to be guided by the principles that were set out in the Project's Memorandum of Understanding:

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

WHERE WE ARE GOING

IMPROVED SERVICE

Through an extensive year-long effort, the Project Steering Committee worked with many clinic staff members, Board members, clients, community partners, community supporters and other key stakeholders and Legal Aid Ontario to identify transformational principles for clinics and the work they do, identify the decisions that had to be made and develop a model for what the clinic system in the GTA could look like.

Acceptance of the Vision Report by the GTA clinics does not bind them to the changes recommended in the Report – it is an acceptance of the Vision that we wish to attain. Once there is agreement on the Vision a Transition Plan will be developed setting out what needs to be done to implement the Vision. It is at the stage of acceptance of the Transition Plan that a binding commitment to the recommendations will be required.

In addition to the principles in the Memorandum of Understanding, the Steering Committee identified principles to guide the building of a new service model. The legal services model that was developed has these broad objectives or aspirational characteristics:

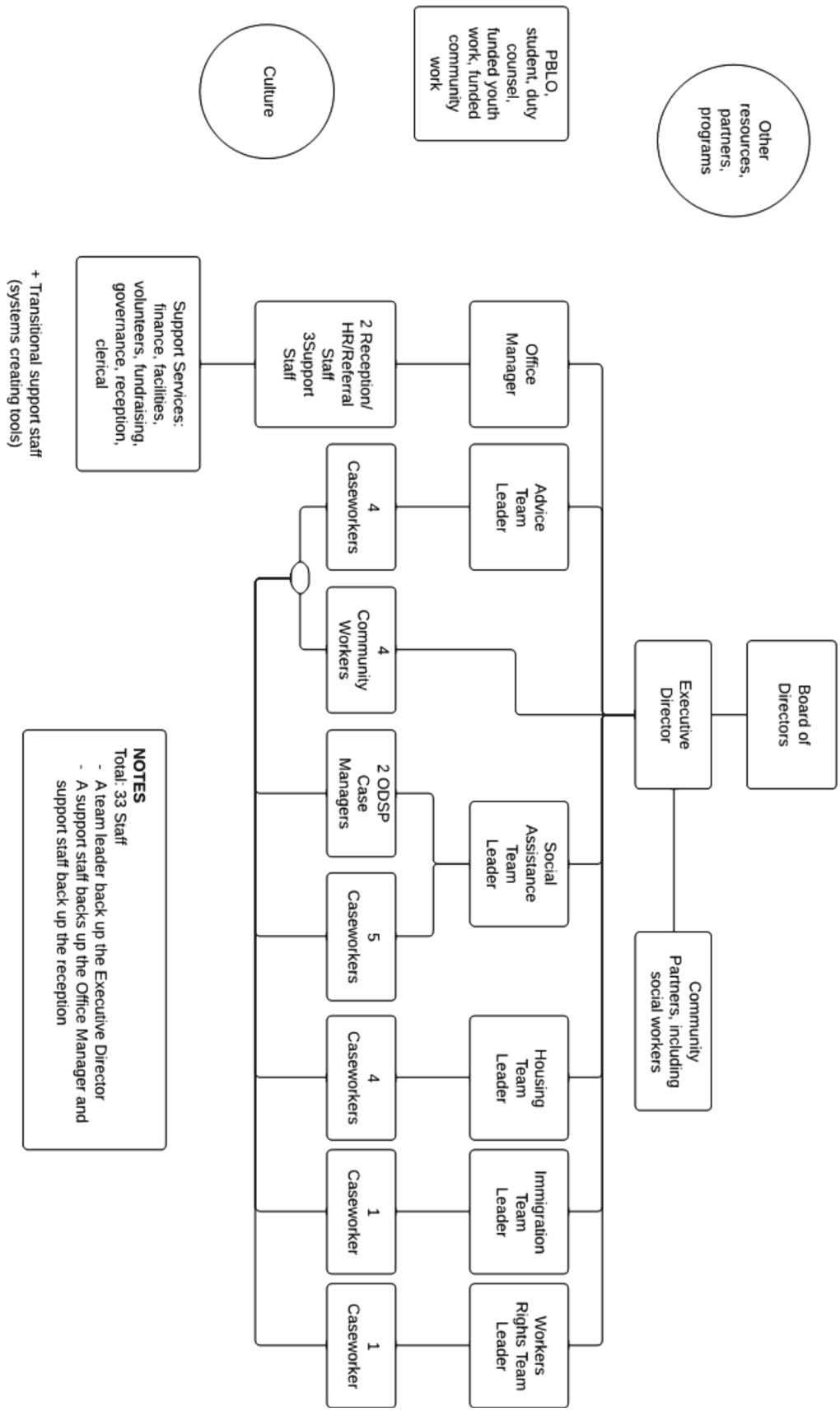
- **Puts more services on the front lines:** Our proposal would increase service delivery staffing (direct client service and community/systemic work) by 18%.
- **Increases community outreach and engagement:** Our proposed model doubles the number of community-development workers and ensures they spend their time in the community.
- **Supports staff better:** Our proposed model ensures backup for all staff positions and organizes staff in area of law teams.
- **Staff flexibility:** Larger clinics have the depth of staffing to re-deploy staff so that our services are more sustainable and we have the capacity to react to emerging issues.

- **Offers more consistent support to the people who need legal services:** We are proposing an agreement to make core services available consistently across the GTA.
- **Aligns resources with the people who need them:** Our proposal will allocate resources to the places where people have the greatest need.
- **Is more efficient:** Our clinics will use teams, case-management processes and specialization to ensure that the right person is doing the task.
- **Faster and better service:** Our clinics will employ dedicated advice staff.
- **Ensures efficiencies are not just cost-cutting measures but real service improvements:** The Project won a firm commitment from LAO that all savings would be reinvested into improving clinic services in the GTA.
- **Ensures people receive holistic supports:** The proposal links clinics to other community partners more effectively by using dedicated community-development workers to develop and maintain partnerships.
- **Improves access:** The proposal creates more access points in partnership with community agencies.
- **Maintains community control:** Community-based Boards will continue to set strategic directions for the new clinics.

This new service model cannot be implemented through the existing clinics because they are too small to realize most of the transformational objectives. Simply making existing clinics bigger by adding new staff does not transform clinics and does not address many of the issues that were identified as problematic in the system: We just have bigger clinics and catchment areas would still be anachronistic. Moreover, with bigger clinics co-ordination amongst 16 clinics would become even more problematic than it is presently.

CLINIC STRUCTURE

Transformational clinics must incorporate the service model characteristics into their structure as well as into their operations. The Steering Committee matched the operating requirements with the transformational objectives and developed a clinic prototype. The prototype clinic has legal teams in each of four core areas of law, a consolidated advice team, enhanced and dedicated community outreach capacity and a viable administrative team capable of sustaining partnerships and a volunteer base. On the next page is the organizational chart that the Steering Committee developed for the clinic prototype. This prototype presents a 33-person clinic. Some variation on that size is possible; however, if the transformational objectives are to be realized, clinics would have to be roughly this large. Smaller clinics could still do good work, but they could not maintain the following: teams of workers in each core area, a team of dedicated community development workers that are attached to each of the core areas, a team of dedicated advice and referral workers and a commitment to have back up workers in every position.


Board of Directors
Executive Director
Community Partners, including social workers
Other resources, partners, programs
PBLO, student, duty counsel, funded youth work, funded community work
Culture
Office Manager
Advice Team Leader
Social Assistance Team Leader
Housing Team Leader
Immigration Team Leader
Workers Rights Team Leader
2 Reception/ HR/Referral Staff 3Support Staff
4 Caseworkers
4 Community Workers
2 ODSP Case Managers
5 Caseworkers
4 Caseworkers
1 Caseworker
1 Caseworker
Support Services: finance, facilities, volunteers, fundraising, governance, reception, clerical
+ Transitional support staff (systems creating tools)
NOTES
Total: 33 Staff
- A team leader back up the Executive Director
- A support staff backs up the Office Manager and support staff back up the reception

CATCHMENT AREAS

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

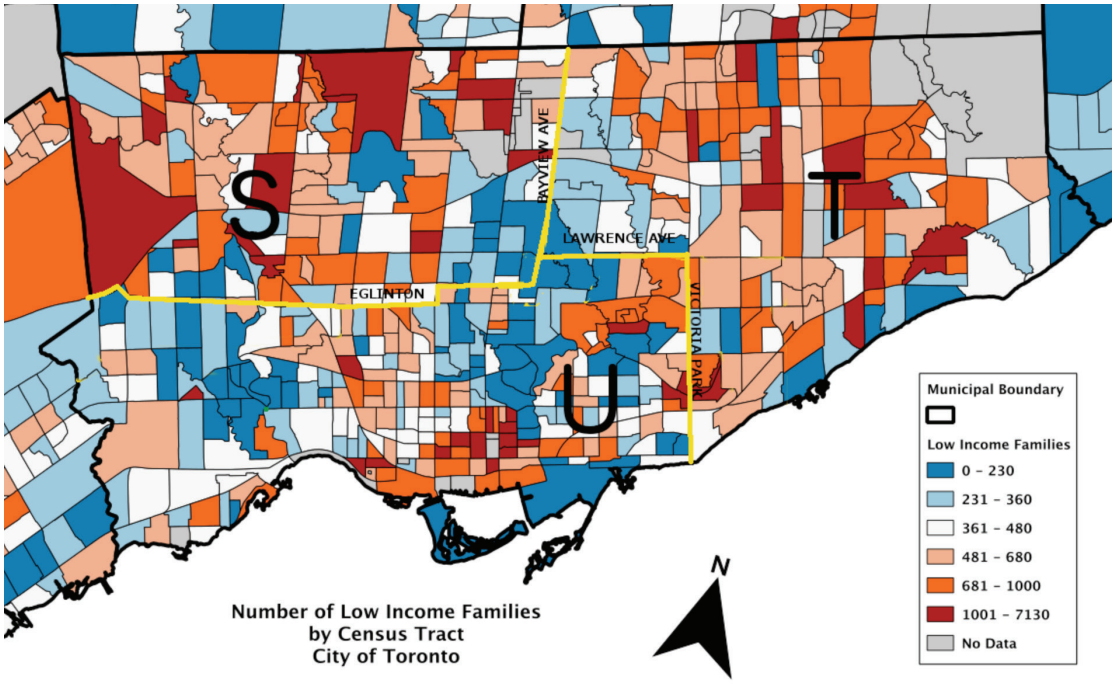
- Where possible clinics should not straddle municipal boundaries.
- As much as possible, clusters of low-income population should be gathered into the same catchment areas (boundaries should dissect areas of high income rather than low income).
- Major transportation routes should facilitate access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

The first conclusion the Steering Committee came to in regard to catchment areas was that there should be one clinic in Peel and one clinic in York Region. No more than one clinic in those areas can even be close to the transformational size.

In the City of Toronto, a three-clinic model appeared most promising, though a four-clinic model was also explored. The most obvious boundaries were:

- A north-south line along the Bayview Avenue corridor from Steeles Avenue south to Bloor Street.
- An east-west dividing line running along Eglinton and Lawrence Avenue from Scarborough to Mississauga.
- A boundary along Victoria Park separating the Scarborough area from the Downtown.

Alternate subdivisions of the southern part of the City were considered in a four clinic model.



Map of the 3 clinic model for Toronto

RESOURCE ALLOCATION

GTA clinics are currently funded for 135 full-time equivalents (FTE). Although allocating resources is more accurately the process of allocating budget dollars, the Steering Committee found it easier and more understandable to speak of resources as FTEs. The Peel clinics currently have 16 FTEs, York Region has 10 and the Toronto clinics have 109.

The Steering Committee recognizes the importance for clinics in general of the clinical legal education training program (CLETP) run jointly by Parkdale Community Legal Services and Osgoode Hall Law School. It also recognized that this program has staffing requirements beyond those a clinic would need without such a program. The Steering Committee agreed that 5 of the 109 Toronto clinic FTEs would be set aside and committed to the CLETP. Accordingly, the City of Toronto FTE figure used by the Steering Committee was 104.

The Steering Committee concluded that the most useful measure of poverty, and corresponding projected need for legal services, was the number of households living below the Low Income Cut Off (LICO), the poverty measure used by Statistics Canada. Other options were considered but the lack of universality of other data and the lack of specificity for other factors led the Steering Committee to rely on LICO households as the most reliable measure. It therefore accepted that resources should be allocated on the basis of LICO households in each catchment area.

It is widely recognized that both population growth and poverty growth in Peel and York Region has been dramatic. Despite this, clinic FTE allocations have not changed since 2000. Over the intervening 15 years the low-income population in those areas has more than doubled. As a result, the staff-to-LICO household ratios in the 416 area (Toronto) and the 905 (Peel and York Region) area are hugely disproportionate: an average of 1:3000 in the 416 area and more than double that in the 905 area. Notwithstanding the resourcing differential, Toronto's poverty numbers also continue to rise. Poverty is not leaving Toronto for the outer suburbs; it's growing everywhere though at a much higher percentage rate in the 905 area.

Based on the most recent data available (2010 tax filer data), the allocation of resources based on LICO households would be:

	2010 LICO HOUSEHOLDS	%	2010 STAFF ALLOCATION
YORK REGION	76,510	15%	20
DUFFERIN/PEEL	112,920	22%	29
TORONTO	315,280	63%	81
GTA	504,710	100%	130

The projected result is unsatisfactory from several perspectives:

- It would result in no clinics having full transformational capacity: York has only 20 staff, Peel would have 29; three Toronto clinics would total 81 and have almost no ability to create three clinics of the model size.
- It is highly unlikely that all the Toronto clinics would accept a proposal that saw a reduction in funding equivalent to 23 FTE for the 14 Toronto clinics

- Because poverty is still increasing in Toronto (in terms of gross numbers at an equal rate as it is in Peel and in York Region), there is no justification for reducing funding for staffing in these clinics. There is no ready explanation for why the Toronto clinics should be asked to fix a problem that is really one of underfunding by LAO.

CONCLUSION

The Steering Committee reached the following conclusions.

PRINCIPLES

The principles that guide the creation of new clinics include connection to the community, integrated service, better access for clients, better support for staff, increased service and stronger community partnerships as outlined in the Principles adopted by the Steering Committee.

STRUCTURE

New, larger clinics should be established based on the Model Clinic structure, as outlined in the Model Clinic Organizational Chart. Structure features include:

- Four teams in four areas of law (income supports, housing, immigration and employment);
- A consolidated advice team;
- A larger outreach team;
- Adequate administrative supports capable of supporting volunteers and partnerships;
- A relatively flat management structure.

CATCHMENTS AREAS

One clinic should be established in York Region, and one in Peel Region. Toronto should have a much smaller number of clinics than present to enable clinics large enough to accommodate the principles and the Model Clinic design. Catchments should reflect the Principles, respecting municipal boundaries and linking contiguous areas of low incomes similar to those shown in the maps adopted by the Steering Committee.

RESOURCE ALLOCATION

Resources should be allocated according to the distribution of households living under the Low Income Cut Off (LICO).

These allocations should be updated when the process is implemented using the then more current 2016 census data.

Allocations using current resources would significantly diminish Toronto's capacity to serve its growing low-income populations. As much as there is justification for increasing resources to the 905 area, there is no justification for reducing the resources of the 416 area, so additional funding needs to be obtained before these recommendations can be implemented.

OTHER OPTIONS CONSIDERED

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

1. **Have clinics move into multi-service hubs.**

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

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

2. **Have clinics merge with other community service organizations.**

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

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

The additional complication arising from a legal clinic being embedded in another organization is the loss of independence of the legal service. While other organizations can admittedly have good community connections and foundations, and provide good complementary services, the fact of having to answer to non-lawyers for the work they do – and to be required to factor into

their service-delivery decisions matters other than client requirements – is uncomfortable for most lawyers, community legal workers and paralegals. The fact that the legal-services division might not even have direct access to the Board of Directors of an organization (particularly in a larger organization), is problematic for most with a history of community legal clinic involvement.

3. **Have some clinics merge with each other, thereby reducing the number of clinics.**

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

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

4. **Merge the clinics that are responsible for serving the areas that are assigned to the new transformed clinics.**

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

5. **Leave clinics as they are and just get more money from the Province or LAO to fund new positions wherever they are needed.**

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

The important shortcoming of this option is that it fails to take into account that the large majority of staff in clinics, community partners and our funders (LAO and MAG) believe that some change is required if clinics are to continue to be effective for the next generation of those living in poverty in the GTA. It must be acknowledged that there is little support for the status quo.

FUTURE CHANGE

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

HOW DID WE GET HERE?

The Project used an evidence-based approach that allowed the Steering Committee to consider data and avoid any pre-determined conclusion. In the course of a substantial research phase, the Steering Committee looked at:

- Quantitative data, including census data and clinic service statistics;
- Qualitative data, including interviews and focus groups with staff, community, Boards and clients;
- Best practices in literature on access to justice.

This approach allowed for thoughtful review of needs, challenges, gaps and best practices in various jurisdictions as the basis for developing a model.

After the research was completed, the Steering Committee began the process of developing a service model that can best serve clinic clients.

QUANTITATIVE DATA

The quantitative data collection phase gathered information on demand for services, types of services provided, staffing complements and where clients live. This phase also included a demographic scan, which mapped and analyzed where people on low incomes live, where people with other indicators of legal need live, where clients live and where clinics are located.

The data showed some high concentrations of low-income populations in particular areas. It also showed a high correlation between areas of concentrated low-income population and other indicators of need: concentration of recent immigrants and refugees, of households dependent on public income supports and of the location of social housing units.

Also of note was geographic concentration of clinic clients in close proximity to the clinic's location. Clusters of low-income residents that reflected other need indicators but were not as proximate to the clinic's office showed a lower usage rate than similar clusters closer to the clinic location. In other words, there was a high correlation between clinic usage and geographical proximity. Clearly proximity is an important factor to access.

Major transportation route maps were overlaid onto demographic maps and showed that very few connect to high concentrations of low-income communities or to clinics, which also suggests poor transportation services may be a barrier to access.

QUALITATIVE DATA

The qualitative data collection consisted of dozens of focus groups and key informant interviews. In every clinic in the GTA, one focus group was conducted with staff and another with clients. One-on-one interviews were conducted with each clinic director and two Board members or

community partners. This phase was focused on drawing out needs, priorities, experiences of what is working well, where barriers and challenges exist, and hopes and concerns for transformation.

Consistent themes emerged through the analysis, including:

- Clients have multiple, complex and cascading needs;
- Clients are seeking services in more areas of law, and staff want to provide that;
- Multiple gateways to service (walk-in, telephone, internet) enhance access;
- Partnerships help with making appropriate referrals and connecting to communities;
- Consistent work with the same tribunals can allow for more rapid and effective negotiations;
- Students and other volunteers can be a valued part of clinics but most clinics lack capacity to support them;
- There are many people who cannot access clinic services (barriers include transportation, language, mental health issues, financial eligibility excludes working poor) or cannot get the full scope of service they seek;
- Community development work, public legal education and law reform activities often suffer due to the immediate pressures of casework; and
- Clinics have poor IT infrastructure and in some cases inadequate workspaces.

Again, the Steering Committee discussed in detail the learnings from the qualitative data and used this in subsequent discussions to develop principles.

BEST PRACTICES

The final research phase was a literature review that looked at elements of national and international best practices for organizations seeking to enhance access to justice. The literature showed community clinics in other places found different ways to provide services to clients with complex needs:

- They use multi-disciplinary supports, whether on-site or through partnerships.
- They use satellite locations, sometimes staffed with students and pro bono lawyers, to be close and accessible to their clients.
- They use students, volunteers, and pro bono lawyers but recognize that they can't replace the core base of paid staff.
- Community Boards are critical. They provide strategic governance ensuring clinics respond to community needs but need support and can't be the only source of community input. They need the assistance from staff who engage in outreach and track community needs.
- They work with community partners to help them be able to effectively identify legal issues and to make appropriate referrals to legal clinics.
- They ensure that community work gets the attention it needs by allocating dedicated resources to outreach efforts.
- Where telephone service is used, it needs to be staffed by well-trained personnel who are knowledgeable in community resources.

- They embed services, including advice, in a clinic system that can take on cases when it goes beyond brief service and advice.

This information was also reviewed by the Steering Committee to help them develop a model for a more effective clinic system.

To read the research in more depth, please visit www.gtaclinics.ca.

DEVELOPING PRINCIPLES

The Steering Committee used this information to create 30 principles to shape the process. These served as guidelines for the choices people had to make about the future of clinics. Some principles were about what clinics would do, such as increasing the areas of law that clinics can offer. Others addressed how clinics do what they do, such as having community work done by dedicated community workers. Still others were about whom clinics work with, such as establishing more stable partnerships with other service providers.

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

DEVELOPING A MODEL OF COMMUNITY LEGAL CLINIC SERVICE DELIVERY

The first step to developing recommendations was to create a model organizational chart for a general service-delivery community legal clinic. The Steering Committee used a collaborative process involving all clinics in a group effort to design the best structure. Steering Committee members identified the functions and capacity a clinic would need to satisfy the principles established, and together they assembled the elements of a Model Clinic. The principles guiding this discussion included:

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

The Steering Committee built an organizational chart, identifying the core areas of law each clinic should provide. As well, based on the research, it recommended a size for each team that would provide the area of law service. The process produced a Model Clinic with core areas of law teams in income maintenance, housing, immigration and workers' rights, and with more front-line workers and community development workers than the clinics have now. The clinic was projected to require 33 staff members. While the 33-member clinic is not inflexible as a model, efforts to reduce its size always took away from the principles the Steering Committee

was trying to meet. Clinics with fewer staff would require compromising on transformation goals such as increased outreach or working in teams.

This model covers more areas of law than clinics are currently able to offer, adding employment law and ensuring immigration law is available everywhere. Seventy-nine per cent of the staff in this model delivers front-line services, significantly increasing front-line service staff from the current practice. Each area of law is led by a team leader who coordinates the team, in addition to doing casework. Every staff person, including administrative staff, community workers and caseworkers, have backup. The advice and community-development staff each work as a team, but each staffer is also attached to an area of law so that they can gain specialized knowledge in that area. Finally, through the support and administrative team, the model increases the administrative capacity to recruit, train and manage more volunteers and increases the capacity for developing and maintaining formal partnerships.

Each clinic in the transformed system will maintain community governance structures and operate independently. A collaborative agreement between the clinics will determine how they work together, and community Boards and local clinic management will maintain the authority to shift resources internally to be able to respond to community needs as they see fit.

IMPLICATIONS FOR THE NUMBER OF CLINICS AND CATCHMENT AREAS

The size of the proposed Model Clinic, approximately 33 staff, has implications for the number of clinics that the new system can have and their catchment areas. It would make more than one clinic in York Region or Peel impossible. It would make it difficult to spread the 104 staff currently working in the City of Toronto over more than three clinics.

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

The Steering Committee looked at four different configurations of catchments and number of clinics. In each, Peel had a clinic approaching the Model Clinic size and York Region's clinic was well below the Model Clinic size.

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

The Steering Committee also looked at versions that used existing clinic boundaries and amalgamated them to compose new catchments. It looked at cutting down the clinic staff size to create more clinics. None of these approaches produced better options in terms of realizing the most transformational objectives. Clinics with fewer than the 26-33 staff invariably sacrificed key components such as staff teams, dedicated community-development workers and covering all the core areas of law. Using existing boundaries preserved the disjuncture between existing boundaries and the distribution of low-income populations. On reviewing these alternatives the Steering Committee reaffirmed its support for the three-clinic model in Toronto and a single clinic in each of Peel and York Region.

RESOURCING CLINICS

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

The Steering Committee considered basing staffing on current demand but this was rejected because current usage favours clinics that are more resourced than others, and is unreliable in predicting either latent demand or future changes in demand.

The Steering Committee looked at basing resourcing on how many households are under Statistics Canada's Low Income Cut Off (LICO), indicating the number of people living in poverty in the catchment area. People living in poverty do not necessarily need poverty-law services, but LICO is a common measure of probable needs, readily available and a strong predictor of other demand factors. The income of a LICO household is higher than the financial eligibility guidelines for clinic service; however, research showed that areas with high LICO populations are also the areas with the most very low-income people (less than $10,000 per year), the most recent immigrants and the most welfare-reliant households.

Poverty has grown since new staffing allocations were last made in 2000. Poverty in Toronto has increased steadily but it has skyrocketed in the 905 area. As a result, the need for staff in the 905 now far outstrips resources, even more than in Toronto. To equitably redistribute existing resources across the GTA, some staff working downtown Toronto would have to move to the inner suburbs and a significant number to the outer suburbs. Exacerbating this issue is that the fact that in the GTA, ratios of staff to below LICO households are significantly higher than those in the rest of the Province, meaning that, relatively speaking, GTA clinics are significantly more under-resourced than any other region in the Province. It was accepted by the Steering Committee that the Project was not responsible for filling in the gap created by ongoing and increasing under-funding of the clinic system, particularly in the GTA and especially in the 905 area, by Legal Aid Ontario, the Ministry of the Attorney General and the Province of Ontario.

The Steering Committee has decided to recommend that the GTA legal clinics should transform along the lines of the Vision they have developed and as is set out in the Report; at the same time, it acknowledges that the Vision cannot be implemented without new resources from LAO.

UPDATED TIMELINE

The Vision Report is offering recommendations from the Steering Committee to Boards of all participating clinics on the future model for the delivery of poverty law services in the GTA. The Steering Committee is asking clinics to endorse the Vision it is putting forward.

Endorsing the Vision Report means that Boards are supporting the Vision, but they are not yet binding their organizations to it. The next phase will be the development of an implementation plan that will consider, among other issues, staffing implications. Only after they have seen the Transition Plan will Boards be asked to make a firm commitment to the implementation of the Transformation Vision.

The Steering Committee has accepted the suggestion that clinics need more time to consider this Report. Notwithstanding that the substance of the Report has been known for some time, and that the Steering Committee's materials have been accessible online for a long time, Board members on the Steering Committee expressed the view that more time was needed to review

the proposal. It is understood that substantive discussion of an important issue will remain somewhat abstract until a concrete proposal is presented.

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

The timeline of the Project has been extended to allow the Boards to have adequate time to consider the report and seek community input through town hall meetings. Feedback is expected throughout the fall of 2014, with a final decisions on the Vision anticipated before year-end.

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