Engaging the Power of Community to Expand Legal Services for Low-Income Ontarians

International Legal Aid Group Conference
Johannesburg 2017

Ab Currie, Ph.D.
Senior Research Fellow, Canadian Forum on Civil Justice
Research Consultant to the Legal Health Check-up Project

April 2017

Acknowledgements

This report was prepared by Dr. Albert Currie, Senior Research Fellow, Canadian Forum on Civil Justice. We are grateful to Legal Aid Ontario for funding the Legal Health Check-Up project and this research through its Fund to Strengthen Capacity of Community and Legal Clinics.

Project Team

Lead: Colleen Sym, Executive Director/Lawyer, Halton Community Legal Services
Consultant: Mike Balkwill, Balkwill and Associates
Researcher and Evaluator: Dr. Ab Currie, Canadian Forum on Civil Justice
Research Lawyer: Brandon Stewart, Halton Community Legal Services
Members: Halton Community Legal Services staff
Copy Editor and Layout: Eric Mills, Eric Mills Editing & Design
IT Consultants/Web design: The Dunham Group, www.thedunhamgroup.com

SUB-REGIONAL ADOPTERS

Community Legal Clinic, Brant Haldimand Norfolk, Ian Aitken, Executive Director
Hamilton Community Legal Clinic, Hugh Tye, Executive Director
Legal Clinic Guelph and Wellington County, Anthea Millikin, Executive Director
Chatham-Kent Legal Clinic Executive Director, Walter Van de Kleut
Waterloo Region Community Legal Services, Executive Director, Shannon Down
Neighbourhood Legal Services Inc. (London and Middlesex), Executive Director, Jeff Schlemmer
Elgin Oxford Legal Clinic, Executive Director, Ken Brooks
Community Legal Assistance Sarnia, Executive Director, Andrew Bolter
Justice Niagara, Micheal Foster (Jim Sykes during the research)
Huron-Perth Community Legal Clinic, Executive Director, Jamie Hildebrand
Windsor-Essex Bilingual Legal Clinic, Executive Director, Kevin Pinnsonneault
Legal Assistance of Windsor, Executive Director, Marion Overholt

We thank our partners for their participation and contributions to the Sub-Regional rollout phase of this project:

Table of Contents

Engaging the Power of Community to Expand Legal Services for Low-Income Ontarians

Executive Summary

The clinic–intermediary partnerships/legal health check-up is an approach to service delivery that recognizes the need to create a strong mechanism to achieve outreach and to provide holistic and integrated services to disadvantaged people. This is a response to a solid body of research, consistent with much clinical experience by practitioners, that there is a high prevalence of unmet legal need among the population, that people often do not recognize the legal issues embedded in the everyday problems they experience, that for this and other reasons they typically do not seek appropriate assistance with legal problems in a timely manner, and that people frequently experience clusters of inter-related legal and non-legal problems that are often difficult to deal with in isolation. These problems are part of the complex matrix of poverty; providing legal services in a way that responds to these aspects of legal problems can play a role in alleviating the conditions of disadvantaged people.

During the initial six-month implementation period of the Legal Health Check-up Project in Southwestern Ontario, 1700 individuals identified themselves as having everyday problems with probable legal aspects through the legal health check-up (LHC) process by 12 community legal clinics combined. This represents a substantial body of unmet need. About 45% of the 1700 individuals asked to be contacted by the clinic. Asking for help can be an acknowledgement of the seriousness of the problem they are facing. With respect to the 55% who did not ask for immediate help, we know that people are often not ready to ask about problems they are experiencing when first asked. Some people commented that they did not know they could get help of this sort from legal aid. Forty-six percent indicated they would like to receive public legal education (PLE) related to a problem they had identified on the LHC questionnaire, and 23% expressed an interest in attending group information sessions. The LHC clearly succeeded in identifying a substantial body of unmet need.

Overall, the clinics developed 125 partnerships with community organizations and service agencies in the Southwestern Ontario region. Ninety of these were active partnerships in which trusted intermediaries identified unmet need using the LHC questionnaire and referred people to the clinic. These partnerships represent 90 new pathways to legal help in the region through which people with unmet needs can find help from a community legal clinic. The 12 clinics developed partnerships with a further 35 community groups that did not complete any legal health check-ups. These organizations cited a variety of reasons for not completing any LHC forms, though some said they had referred some clients to legal aid clinics without using the LHC form. More than 200 people submitted LHC forms through a source other than one of the 125 groups with which the clinics had formal partnerships. This is a good indication of a considerable amount of diffusion of the LHC concept throughout the community beyond the formal clinic–intermediary partnerships within a relatively short period of time.

Most intermediary groups, both those that had produced LHC forms and those that did not, embraced the basic objectives of the legal health check-up. They felt that the LHC was a good idea, that it was aligned with the overall goals of the intermediary organization, that it was important to identify the needs of their clients, and that the LHC would benefit their clients. The majority of intermediaries that produced at least some LHC forms said they wanted to continue the relationship with the community legal clinic after the pilot period.

Clients who had completed a LHC questionnaire, were referred by one of the partner intermediaries, and had an intake appointment were generally positive about the LHC process. Based on a small sample of 23 clients, 65% said the LHC form was very easy to fill out, 60% said it was very helpful identifying problems, 48% said it had helped a great deal toward resolving the problem, 35% said they would probably have not gone to the clinic if they had not completed the LHC form, and 87% said they would go to the legal clinic with a future problem.

In view of the fact that the approximately six months covered by the research represents the early implementation phase of the project, the clinics substantially achieved the project objectives. Clinics were asked to indicate the level of priority they assigned to eight project objectives. The ranking of objectives by the clinics from greatest to least priority were 1) avoiding crises for clients, 2) identifying unmet need, 3) providing more holistic and integrated service, 4) achieving early intervention, 5) increasing service to underserved groups, 6) serving more people, 7) Increasing contact points in the community and 8) improving planning and co-ordination with community partners. Clinics were asked to assess the degree to which they had achieved the objectives, and these were ranked by level of achievement.

Avoiding crises for clients was the highest priority objective but, ranked fourth in terms of achievement, was relatively difficult to achieve. Identifying unmet need was the objective ranked overall as the second priority by the clinics but it was the priority for which the level of achievement was considered highest. The level of achievement was, overall, greater than its relative priority. This is no doubt attributable to the effectiveness of the legal health check-up tool as an instrument to identify unmet need. Providing holistic and integrated service to a greater extent was ranked third both as a priority and in terms of level of achievement. Clinics were already doing this to a degree, and the partnerships with community groups may have further enabled them to do so. Early intervention was ranked fourth in terms of priorities but sixth in level of achievement. Extending service to underserved groups was ranked fifth in level of priority and seventh in terms of achievement. Therefore, similar to avoiding crises for clients, clinics found both of these objectives difficult to achieve.

It is interesting that providing service to more people was not ranked high by clinics: sixth overall. In terms of level of achievement this objective was even lower, ranked eighth. Most clinics seemed to have formed the impression early on that the level of effort involved in developing partnerships, on the part of intermediaries as well as the clinics, ought to have been reflected in greater numbers of referrals. The relatively low number of intakes compared with the number of LHC forms completed or the number of requests for service was, for some, disappointing. However, building effective relationships with intermediaries takes time in order to determine what works well. The six-month period of the 12-clinic pilot was a period for relationship-building. Larger numbers of clients could be expected to follow a period of intensive relationship-building, determining what did not work well and what might

work better. This has been the experience elsewhere.

The two objectives that were ranked lowest in priority were providing more points of contact in the community, ranked seventh, and providing data for community-level planning, ranked eighth. In terms of achievement, both were ranked relative to their priority, fifth and second respectively.

Within the short implementation period, it is fair to conclude that the clinics made substantial progress in achieving objectives. Clearly there is work to be done on some objectives for which the priority did not match the level of achievement. However, the early phase of any innovation is characterized by learning, feedback and course correction.

The 12 clinics were asked if they felt the clinic–intermediary partnerships/legal health check-up was a better way to provide legal aid services. Nine responded; among them two said yes, five said partly and two said no. Clinics were evenly split when asked if they intended to continue with the LHC. Again, with nine clinics responding, two said they intended to continue in substantially the same manner as in the implementation period, three said they planned to continue with some aspects of the initial model and four said they did not plan to continue.

It can be fairly concluded that within the initial implementation period, the clinics have so far succeeded in achieving everything that could reasonably be expected. The basis of a strong community-based referral network has been established. Intermediaries identify with the global project objectives and, for the most part, wish to continue the partnerships. There has been some success by the clinics in achieving objectives and identifying what ones require more work. Part of the work with community partners will involve figuring out how to build collaborative relationships that will increase early intervention and avoid crises for people with legal problems. Clients that have gone through the intake process appear, on the whole, to be quite favourable toward the LHC form and the process they have experienced.

The 12 participating clinics have identified as community legal clinics for many years and have, in different ways, developed their own approaches to connect with community partners and meet the needs of the poor. They have accomplished this according to their resources, their concepts of legal aid, and their understandings of nature of legal services. The legal health check-up offers a good approach to service delivery. However, it also presents challenges to conventional ways of doing things on the local level, and to some orthodoxies in legal aid. Meeting some objectives like early intervention will be very challenging. Progress will require time. However, the clinics that are committed to taking up the challenge should be supported. The preliminary evidence presented in this report suggests that the legal health check-up is a promising approach that responds to important problems.

Introduction

This report examines the experience of 12 community legal clinics adapting an approach to service delivery, the legal health check-up (LHC), that was pioneered at Halton Community Legal Services (HCLS).[1] HCLS and the 12 clinics are all part of the province-wide Legal Aid Ontario community legal clinic system. The clinics are in the Southwestern Region of the province, generally west of Toronto.

Professor Louis Brown first proposed what he called legal health checks in 1974 by. Brown, who had written extensively about preventative law, saw that unrecognized legal problems among the public were an important rationale for legal health checks. "There is value in legal health checks whether or not legal problems have surfaced."[2]

The use of legal health checks has recently become popular. The American Bar Association has recommended using them.[3] In 2015 the Canadian Bar Association issued 14 legal health checks in connection with its equal justice initiative.[4] Both the ABA and the CBA initiatives are focused on lawyer use of legal health checks, without reference to poverty or disadvantaged populations.

In Australia, the Australian Productivity Commission recommended using legal health checks to identify and assist the complex needs of disadvantaged populations.[5] The recommendation endorsed a 2009 project by the Queensland Public Interest Law Clearing House (QPILCH) that had developed a legal health check-up for homeless people.[6] The development of legal health checks has continued since then in Australia. With the support of the federal government, QPILCH developed an on-line guide for community legal workers adopting a legal health check-up approach.[7] One evaluation in Australia documented partial success by five legal clinics in New South Wales using legal health check-ups for homeless populations.[8] The Australian literature refers to legal health check-ups as tools in developing pathways to legal health for disadvantaged people. A legal health pathway, an understanding between a community

---

1 A. Currie, *Extending the Reach of Legal Aid: Report on the Pilot Phase of the Legal Health Check-up Project*, Halton Community Legal Services, 2016.Accessed at https://www.legalhealthcheckup.ca/legalcheck/pdf/legal-health-check-up-pilot-evaluation

2 Louis M. Brown, *Manual for Periodic Legal Check-ups*, Prentice-Hall, New York: 1974.

3 American Bar Association, Commission on the Future of Legal Services, "Issues Paper Concerning Legal Checks", 2016

4 http://www.CBA.org/CBA/Equal justice/Resources/Legal Health Checks

5 Productivity Commission, *Access to Justice Arrangements*, Commonwealth of Australia, 2014, pp. 171 180, Section 5.4.

6 Queensland Public Interest Law Clearing House (QPILCH), http://naclc.org.au/cbpages/legal-health-check.php

7 "Legal health check on-line portal for community legal workers", Project Report, June 2015.

8 P. Novotra and B. Dougal, *Legal Health Check-up Evaluation Report, Pilot of law check-up tools in five homeless outreach clinics*, Legal Aid New South Wales, 2014.

organization and a legal clinic, can build a sustainable collaborative delivery model to identify legal needs and get people the help they need.[9] The pathways concept is a central element in the legal health check-up concept being developed by community legal clinics in Ontario.

In the most familiar form of a legal clinic's community partnership, a local legal clinic develops a problem-spotting and referral arrangement with a community health care provider. There are approximately 300 medical-legal partnerships in the United States.[10] These are generally considered effective at identifying legal problems related to medical issues.[11] Medical-legal partnerships have also been proven effective in Canada[12] and in Australia.[13] They have a strong theoretical and empirical basis. Research has shown that people frequently experience stress-related illness and other physical illness as a direct consequence of having a range of legal problems.[14] A clear and frequently used example is a landlord's failure to properly maintain an apartment, causing mould that adversely affects a tenant's health. The tenant may go to a doctor to deal with ill health related to exposure to mould. The doctor can treat the medical problem, but when the tenant goes back to the mould-producing environment the medical problem continues. The underlying problem is the proper maintenance of the building; the durable solution to the individual's health problem is legal, requiring the landlord to properly maintain the dwelling. The value of the medical-legal partnership is clear. However, community health clinics are only one among many possible community contacts.

The legal health check-up approach undertaken by the community legal clinics in Southwestern Ontario forms clinic–intermediary partnerships with a variety of community organizations and service providers, including health care providers. Community health services are only one of many kinds of community organizations to which people go for help with difficulties in their lives and through which hidden legal problems may be discovered. This multiple partnership approach places legal aid at the centre of a network of community legal services that can expand the reach of legal aid beyond the boundaries of its own limited resources and capacities.

---

[9] See "Tips to create a legal health check pathway" at Legalhealthcheck.org.au/legalhealthcheck/resources.html

[10] http://medical-legalpartnership.org

[11] Tishra Beeson, Brittany Dawn McAllister and Marsha Reganstein, *Making the case for medical-legal partnerships: A Review of the Evidence*, School of Public Health and Health Services, George Washington University, 2013.

[12] Lisa Turik and Michele Leering, *Justice and Health Partnerships Project Evaluation Report, Phase II*, Community Advocacy and Law Centre, 2016.

[13] Susan Ball and Cindy Wong with Dr. Liz Curran, *Health-Justice Partnership Development Report*, Victorian Legal Services Board, 2016.

[14] Ab Currie, "The Legal Problems of Everyday Life" in Rebecca L. Sandefur (ed.), *Sociology of Law, Crime and Deviance*, Volume 12, Access to Justice, Emerald, 2009 pp. 1 – 42.

Similar to the work being carried out in Australia, the legal health check-up (LHC) approach developed by Halton Community Legal Services and being adapted by the 12 community legal clinics is focused on extending service to the disadvantaged. The approach involves developing partnerships between the legal aid clinic and multiple community organizations and services. Partnering with community agencies with broadly similar objectives of helping people in poverty uses the resources extant in the community to extend the reach of legal aid. These collaborative partnerships are intended to magnify the limited resources of legal aid clinics that are small, or small relative to the task with which they are charged, to reach people in need of assistance whom the clinics could not reach on their own.

The problem this approach to service delivery is intended to address has long been familiar to service providers[15] and has, more recently, been described empirically in substantial detail by the contemporary body of legal problems research.[16] Research has systematically documented the very high prevalence of legal problems experienced by the public, especially among the poor. While people do indeed recognize they have a problem, they may lack the basic legal capability recognize the legal aspects of the problems they experience in everyday life and also lack the capacity to deal with them.[17] In qualitative research carried out in Ontario, service providers have said in their experience, people do not recognize they have a legal problem and often do not seek help until the situation is desperate.[18] There is general agreement in the legal problems research that the disadvantaged are more likely than the general population to experience inter-related clusters of multiple problems, both legal and non-legal.[19]

There is a point of view that the poor are not just like wealthier people with legal problems, except with less money. Constantly juggling problems and requirements in an environment of scarcity is at the root of the problem. Living a life defined by scarcity can lead to making trade-offs and short-term fixes for one problem that create longer-term disadvantages for others, thus perpetuating social disadvantage. A recent book relevant to the dynamics sustaining poverty by Mullainathan and Shafir argues that the stress involved in coping with money problems has a significant debilitating effect, reducing people's ability to cope with other issues

[15] David Wexler, has famously written: "the poor are always bumping into sharp legal things" in "Practising Law for Poor People", 79 *Yale Law Journal* 1049 (1970).

[16] By this I mean the body of research that began with the American Bar Association study, *The Legal Needs of the American Public* (1994) and the more influential *Paths of Justice: What People Do and Say about Going to Law* (1999) Followed by 25 major international studies and dozens of state-level studies in the U.S. In Canada see A. Currie, "The Legal Problems of Everyday Life".

[17] Recent Canadian research indicates that 64.9% of people who experienced an everyday legal problem did not recognize the legal implications, and 43.0% said they did not appreciate the seriousness of the problem. A. Currie; "Nudging the Paradigm Shift", *Canadian Forum on Civil Justice*, 2017.

[18] Michele Leering, *Paths to Justice: Navigating With the Wandering Lost*, Community Advocacy and Law Centre, 2011.

[19] Currie, "The Legal Problems of Everyday Life", op. cit.

and requirements in all areas of life.[20] Using their metaphor, stress reduces the "bandwidth" available to deal with other issues. Alleviating poverty has been a central goal of civil legal aid since the early days of the legal aid movement and the War on Poverty in the United States, and it remains a central objective. To effectively reduce poverty in peoples' lives, legal aid must develop delivery mechanisms that address these basic elements that affect the lives of the poor and how they respond to legal problems.

The high prevalence and the hidden nature of legal problems requires that legal service providers develop the capacity for outreach in order to identify the high prevalence of unmet legal need among people living in poverty.[21] Many activities such as the distribution of pamphlets or advertising in community newspapers may be considered forms of outreach. However, a main proposition underlying the LHC is that effective outreach aimed at disadvantaged people has to be a proactive process designed specifically to take account of the way in which disadvantaged people experience legal problems and the impediments in their lives that make seeking help less likely. This is not a process characterized by that iconic line from the movies: *build it and they will come*. Rather, it may be more aptly characterized: *go seek them out and they may come back with you*.

Legal service providers must also develop holistic and integrated services to deal with the multiple, interrelated legal and non-legal problems that appear in interconnected clusters. This is analogous to dealing with complex problems in many areas. The Canadian urban geographer Harvey Lithwick wrote that "*the* problem *of* cities is the interdependence of problems in cities."[22] It may be no less true of legal services that the problem of providing effective and durable solutions to the problems of the poor may be the Gordian knots of interdependent legal and non-legal problems that make them stubbornly resistant to effective and durable resolution.

There is a gap between identifying hidden legal problems and providing holistic and integrated service. Filling the gap requires building pathways to legal help. This is the core of the legal health check-up idea. The pathways are partnerships between the legal clinic and community groups along which people travel to obtain legal help. The community groups are trusted intermediaries between people needing legal help and the legal workers who can provide it. The intermediaries are voluntary associations and service agencies in the community to which people go to obtain assistance in a variety of areas. These can be employment services

[20] Sendhil Mullainathan and Eldar Shafir, *Scarcity: Why Having Too Little Means So Much*, Princeton University Press, 2013.

[21] Pascoe Pleasence and Nigel Balmer, *How People Resolve Legal Problems*, Legal Services Board, United Kingdom, May 2014.

[22] N. Harvey Lithwick, *Urban Canada: Problems and Prospects*, Research Monographs, Central Mortgage and Housing Corporation, Ottawa, 1971

agencies, multicultural services agencies, agencies providing assistance with housing problems, health care providers, church groups or a variety of government and voluntary associations providing service to people. They are places in the community where people will go to obtain assistance with everyday problems in their lives. The understanding central to the everyday legal problems approach is that legal problems are embedded in the everyday activities of life. These nodes in the community are therefore ideal places to identify the legal needs of their users or clients, people who would not otherwise recognize the legal aspects of those problems or seek help with them. The term "trusted" intermediaries if often used. To a greater or lesser extent, these are organizations or the people in them that disadvantaged people trust because they have a track record of trying to help. When a trusted intermediary says, "I think you may have a problem and you should go to see so-and-so at the legal clinic," the process of transferring that trust begins. If the assistance provided by the legal clinic is recognized as helpful by the client — if it meets the needs of the person as they see them — some of the barriers to access to justice are lowered.

The legal capability of the staff of intermediary community organizations to identify clients who may have legal problems is probably limited. Therefore, some form of legal health check tool is an essential part of the clinic–intermediary partnership approach, providing the staff with education about legal problems occurring in connection with everyday activities and a tool to identify problems. The LHC tool, which may take a variety of forms, provides an easy way to identify problems that occur in everyday life that require legal skills to make a clinical or legal assessment of the person's situation.

The legal health check-up tool is one important element creating the pathway to legal help. Taken together, the check-up tool and the legal clinic–intermediary partnership make up the legal health check-up (LHC) process. The original LHC tool used in the HCLS pilot project was a questionnaire that was written in plain language without reference to legal need and administered by intermediaries. It was then passed on as a referral to the legal clinic. It contained 62 questions covering six problem areas. This LHC tool is shown in Appendix One. An LHC tool can take a number of forms, including a truncated format that asks people about only broad problem areas.[23] As well, the LHC tool can serve purposes other than identification of individuals' legal needs. It can be used as a training tool for service providers in intermediary organizations, who might then make referrals without completing an LHC form. The important function of the LHC questionnaire of identifying hidden legal need is preserved so long as a questionnaire or assessment is completed for individuals at the clinic intake. An LHC questionnaire in any form is not a comprehensive assessment of legal and non-legal problems and legal need. It is the basis of a conversation with the individual client that occurs within a

[23] "Legal Health Check-up Resource", Legal Services Commission of South Australia, n.d. Accessed at http://www.lsc.sa.gov.au/ch_pages/new_release_lsc_legal_health_check.php

holistic intake process at the legal clinic in which clinic staff attempt to understand the complex life of the client, her problems and the assistance that can introduce greater stability into the person's life.

Building a pathway to legal help based on a clinic–intermediary partnership is a relationship-building exercise. The specific form of the relationship depends on the capacity and aspects of the service provided by the particular intermediary, and perhaps on idiosyncratic elements such as the commitment of individual staff. There is no template. The process of adapting the LHC initially developed, and that is still evolving, at HLSC is adaptive innovation. It was well understood at the outset of the expansion to the 12 clinics that each of the community legal clinics would adapt the Halton model, not adopt it as a template. The initial period of activity covered by this report is highly experimental. The adaptation process will have elements that are both common to all the clinics and unique to particular locations. There will be time for lessons learned about building pathways to legal help using the clinic–intermediary service delivery model. Conclusive judgements about successful outcomes will be premature.

Brief History and Context

The pilot phase of the Legal Health Check-up Project at Halton Community Legal Services (HCLS) and the subsequent expansion of the project to the 12 other clinics occurred as part of a Legal Aid Ontario Transformation Initiative that began in 2014. Under this program, clinics were challenged to develop service delivery approaches that were responsive to the needs of low-income Ontarians. The Transformation Agreement provided stable funding for a three-year period beginning in 2014 for clinics developing an innovative service delivery model. HCLS was able to draw upon some earlier work to put in place the legal health check-up very quickly at the beginning of the Transformation Initiative. The early success of the LHC at the Halton clinic encouraged other community legal clinics in the Southwestern Region to adopt the LHC Project. Twelve of the 16 clinics in the region adopted the legal health check-up. An organizational meeting involving all clinics was held in November 2015. Implementation began in most clinics in about February of 2016 with activities such as obtaining approval from boards of directors and recruiting community groups as trusted intermediaries. The adopting clinics began the operational phase of the projects in May or June of 2016, lasting approximately six months in the 12 clinics.

Six months allows little time for a new project to work out the unexpected problems that typically occur with a new program and to make adjustments to the unanticipated issues. This left no time for the projects to stabilize over a sufficient period of time for an outcome evaluation. Therefore, this assessment of the expansion of the LHC takes the form of a process evaluation or implementation study, but not a formal outcome evaluation.

The 12 participating clinics are located in cities between about 80 (Hamilton) and 370 kilometres (Windsor) west of Toronto. The clinics vary considerably in size, and serve areas that are quite different in terms of urban and demographic characteristics. Each clinic is autonomous, and while all are community clinics they may be organized quite differently with respect to service delivery. They provide services in different areas of civil law.

Table I: Participating Clinics

Clinic and web site	Location	Number of staff
Community Legal Clinic of Brant, Haldimand and Norfolk www.bhnlegalclinic.ca/	Brantford, Ontario	8
Chatham-Kent Legal Clinic www.cklc.ca/	Chatham, Ontario	4
Legal Clinic of Guelph and Wellington County www.gwlegalclinic.ca/	Guelph, Ontario	6
Hamilton Community Legal Clinic www.hamiltonjustice.ca/	Hamilton, Ontario	32
Waterloo Region Community Legal Services www.wrcls.ca/	Kitchener, Ontario	13
Neighbourhood Legal Services Inc. (London and Middlesex) http:www.facebook.com/neighbourhoodlegalservices/	London, Ontario	16
Elgin-Oxford Legal Clinic www.eloc.ca/	St. Thomas, Ontario	7
Community Legal Assistance Sarnia	Sarnia, Ontario	7
Justice Niagara	Welland, Ontario	11
Community Legal Aid Clinic	Windsor, Ontario	8
Huron-Perth Community Legal Clinic www.huronperthlegalclinic.ca/	Stratford, Ontario	5
Windsor-Essex Bilingual Legal Clinic www.blc-cjb.ca/	Windsor, Ontario	8

Methodology

This study draws upon several data sources. The research instruments are included in the appendices of this report. Between late August and mid-October 2016, telephone interviews were conducted with the executive director and staff responsible for the check-up project in each of the 12 adopting clinics. The purpose of the interviews was to familiarize the researcher with how the project was being implemented in each clinic. Interviews were very open-ended, allowing the clinic staff to describe aspects of the implementation, early successes, lessons learned and other information that could not have been anticipated, and asked in the form of structured questions. The interviews followed the same overall pattern but were not identical in content. However, these exploratory interviews provided a rich body of contextual

information for understanding the implementation of the LHC occurring somewhat differently in each clinic.

The LHC forms (questionnaires) completed by intermediaries were recorded electronically by each clinic, and transmitted to a consultant who compiled a database of all the information for each LHC form by clinic and separate intermediary group. These data include whether or not the form was abandoned before completion or contact was requested by the legal clinic. The LHC form also includes a small amount of biographical data on the individuals.

For each individual requesting contact from the clinic and for whom the clinic was able to contact and complete an intake, the clinic completed a caseworker form. The information on this form includes the problems identified at intake based on the everyday legal problems recorded on the LHC form, the service provided for each problem, whether a referral was made and to what organization, the involvement of the intermediary referring the client and an assessment of the presence of crisis. Seven of the 12 clinics provided caseworker data for 137 individual clients.

A questionnaire was administered to clinic staff covering various aspects of implementation, including how the LHC form was used in the intake process, an overall description of the clientele, difficulty contacting and following up with LHC clients, assessment of clients' experience, and an assessment of the extent to which the project was meeting expectations and objectives. The data were discussed at a learning lab held in late November 2016. This allowed additional comments from each clinic to be recorded. Nine of the 12 clinics submitted clinic questionnaires.

A questionnaire was administered to intermediaries through each of the clinics. One questionnaire was developed for intermediaries that did not produce any check-up questionnaires. A second questionnaire was developed for intermediaries that had produced at least some LHC forms. Because of limited research resources, the clinics agreed to administer the questionnaires to three intermediary groups, one that had produced no LHC forms, one that had produced a few forms and one that had produced most of the forms for that clinic. Interviews were carried out by telephone by the same member of the clinic staff. Six clinics responded to this request, providing a total of 15 completed questionnaires.

A questionnaire was administered by each clinic to clients who had received an intake interview and some service. The interviews were carried out by clinic staff. Six clinics provided a total of 23 client interviews.

The absence of data, in some cases from the majority of clinics, presents a potential bias from a methodological perspective. It is possible that only the clinics that are most committed to and

favourable toward the LHC Project provided data.[24] In research bias is a matter of reverse onus. If there is a reasonable apprehension of bias it is the responsibility of the researcher to make a good case to the contrary. This cannot be done in this study. It is, nonetheless, instructive to report and analyze the data that are available. However, in addition to the argument made earlier that the project is at too early a stage for an evaluation to be appropriate, it must be concluded that the data are probably too limited to support an evaluation. The data are sufficient to explore issues related to implementation but too weak to support conclusions.

Creating Clinic–Intermediary Partnerships and Identifying Legal Need

Building clinic–intermediary relationships with the legal health check-up tool as the mechanism to identify legal need creates the capacity for outreach by the clinics. In this way clinics are able to engage the resources of the community to identify people with unmet legal needs that, because of finite resources, they could not do themselves. The partnerships are pathways to legal help for individuals who are first identified by intermediaries and referred to partnering legal clinics.

The 12 clinics developed partnerships with a total of 125 intermediaries. These are 125 community organizations and service agencies, well known and actively serving disadvantaged people in their communities. These became points of contact in Southwestern Ontario for identifying unmet need. Each partnership forms the basis of a pathway to legal help.

During the six months from May to October 2016,[25] the intermediaries submitted 1700 LHC forms to the 12 clinics. This means that intermediaries identified a minimum of 1700 individuals experiencing problems that presented the possibility of unmet legal need. This is an underestimate. Some clinics referred people to the legal clinic without completing an LHC form. Also, as the Legal Health Check-up Projects became well known in the communities served by the Southwestern legal clinics, knowledge about them diffused to other organizations. A number of organizations other than the partner intermediaries began referring people to the legal health check-up web site and referring people to the legal clinic.

[24] Three clinics did not make time available for the in-depth interviews. Three did not complete the clinic questionnaire. Only seven of 12 clinics provided caseworker intake data. Seven clinics provided conducted interviews with intermediaries, and only five carried out interviews with clients.

[25] The length of the trial periods varied from one clinic to the next. Within clinics, not all intermediaries came on board at the same time. For purposes of presenting data in this section describing the activities of intermediaries, data cover the point at which each intermediary began until October 31, 2016. The performance of clinics and intermediaries are not being compared, so the variations underlying the data should make no difference for descriptive purposes.

A Profile of Everyday Problems

During the six-month period of the project, the 12 community legal clinics received a total of 1700 LHC forms. This represents 1700 individuals who identified one or more problems on the LHC form. Unlike the problem scenarios typically found in legal problems surveys, the problems on the legal health check-up form are not scenarios that have specific legal problems embedded in the wording. Rather, the specific items are of issues of a more general nature that are of concern to the individual. "Are you having trouble making ends meet?", the lead question in the income section of the LHC form, is an example. The LHC form primarily provides information about life problems that provide a basis for a conversation between the intake worker and the client that will establish specific legal and non-legal problems for which service can be provided. Therefore, it is not possible with any precision to identify the number problems from the LHC forms.[26] However, the data provide a wealth of information about the problems facing the people who submitted LHC forms,[27] and represent a virtual storehouse of incipient legal problems.

About 74% of individuals reported needing help either obtaining or maintaining various forms of social assistance. 60% said, in general, they were having trouble "making ends meet." The responses highlighted the struggle experienced by people meeting their basic needs.

- 36% reported that they relied on food banks.
- 40% said they were unable to meet their dietary needs.
- 33% said they had someone contacting them to pay outstanding bills.
- 43% said they could not afford transportation.

Almost half (47%) of all people completing an LHC form were living in rental accommodation. About 9% were living with family or friends, and a small number reported they were couch surfing, or living in their car or in a shelter. The following percentages characterize the housing experience of respondents.

- 24% of respondents said they had been late paying their rent during the last year and 13% were currently behind in their rent.
- 8% said they were at risk of being evicted and most (7.7%) had been served with eviction papers.
- 20% were behind in paying utility bills.

[26] In the Halton pilot study it was determined that the everyday problems and concerns identified on the LHC form corresponded well with clinically assessed legal problems. However, that empirical work was not carried out in this study.

[27] All percentages in the following section are based on a denominator of 1700.

- 14% had experienced an infestation of some kind.
- 14% reported outstanding repairs. Narrative comments included basement flooding involving sewage, electrical fires, ceiling leaks and missing carbon monoxide detectors.
- 12% said they had experienced discrimination by their landlord.

About 4% said that at some time in the past they had been denied a rental unit due to a disability, and 7% said they had been denied rental accommodation because they were on social assistance.

Access to education and educational programs presented as a problem for respondents. Nearly 26% of respondents reported needing help to access adult education classes or job training programs. And although only 14.5% of respondents reported worrying about their children's education, a mere 21.8% of respondents said that their children could participate in school activities.

The intersection of disability and employment was a prominent theme emerging from the data.

- About 39% of respondents reported having a disability that affected their ability to work.
- About 22% of respondents also expressed concern about telling their employer about any health problems.
- 13% of respondents indicated that their disability made it difficult to find work.

Nearly 23% of respondents reported being hurt at work. Almost 15% of respondents reported a fear of being fired, laid off or having their hours cut.

Almost 54% of respondents indicated that they had a family doctor. However, respondents reported issues with accessing the following health services and supports. This is significant because of the connection between ill health and legal problems.

- dental care (17%)
- mental health (11%)
- counselling (10%)
- glasses (10%)
- special diet (7%)

Nearly 41% of respondents also reported an inability to afford prescription medicines.

The narratives from the LHC form reveal that respondents and their families are experiencing financial difficulty when trying to access the above services. One respondent insightfully

observed that all problems begin with health problems and that a lack of proper health care has a "knock-on effect" that influences financial stability, financial independence and housing and food security.

Family law issues were not strongly reflected in the LHC data. However, social issues related to family life figured more prominently.

- About 12% of respondents reported going through a divorce or separation.
- 16% of respondents reported problems with child support, custody or access.

However, 20% of respondents reported at one time being in a relationship where they worried about their or their children's safety; 28% worried about being in a controlling relationship.

Responses to the questions concerning family and community support speak to the gap in affordable recreational activities for low- income individuals.

- About 33% of respondents reported not being able to afford to participate in community life.
- 30% of respondents reported that they or their children needed financial help to get involved in social, fitness or recreational programs.

The narratives reveal that respondents want to be more involved in community activities, such as recreational programs, but cannot afford to do so, or cannot access programs due to transportation issues.

Almost half, 45% of the 1700 individuals completing an LHC form indicated they wished to receive a follow-up call from a clinic. While the 1700 individuals represent a broad level of unmet need, the 45% (765 individuals) represents a more stringent indication of unmet need uncovered in the 6-month period.

A virtually equal proportion, 46%, indicated they would (or would also) like to receive public legal education (PLE) resources from the clinic. A smaller percentage, but still substantial at 23%, expressed an interest in attending a group PLE session. The most frequently requested topics were:

- family law
- housing and landlord-tenant rights
- employment law and wrongful dismissal
- Ontario Disability Support Program, and, more generally
- financial resources, supports to meet dental and dietary needs

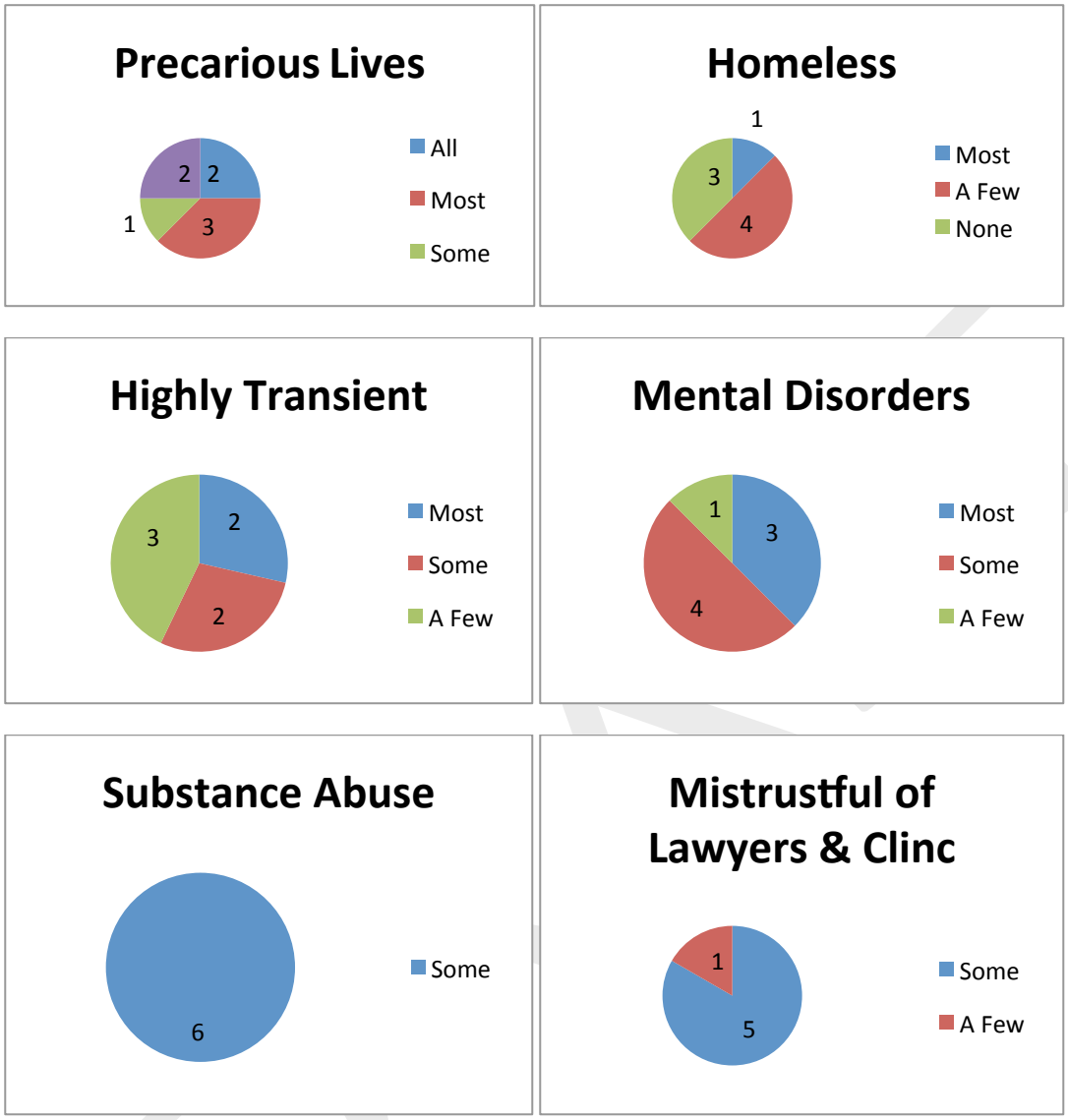
Related Non-Legal Problems

The research did not attempt to identify non-legal problems directly. The legal health check-up process is intended to identify hidden legal problems. It is well established in the literature that problems often co-exist in clusters of inter-related legal and non-legal problems. Clinics were asked to indicate the degree to which the LHC clientele corresponded to a series of characteristics that would predict multiple problems and barriers to accessing services. Five of nine clinics described the LHC clients as leading precarious lives. However, they did not tend to be homeless. Seven of the nine clinics said only a few or almost none of their clients were homeless or near homeless. Mental disorders were fairly common among this clientele. Three of the nine clinics said most of the clients experienced mental disorders, three said some and one clinic said a few. Six out of nine clinics said some of the LHC clientele experienced substance abuse. There were two "don't know" responses. Five of the nine clinics said some of the LHC clients appeared to be mistrustful of lawyers, one said a few and there were two responses of "don't know".

Clinics were given the opportunity to add other relevant characteristics of the LHC clientele. The following client characteristics that were volunteered responses by some clinics might also be considered as non-legal problems:

- low literacy (two clinics)
- low income
- mobility problems
- lack of transportation
- cultural differences

Figure I: Some Non-Legal Problems Experienced by LHC Clients



Clinics were asked about the level of difficulty in contacting LHC clients. Among eight clinics, one said it was fairly easy to contact clients, three said it was somewhat difficult, two said quite difficult and one said it was almost impossible. Four of the eight clinics said most clients provided cell or landline telephone numbers, two said some, and one did not know. Similarly, four clinics said most clients provided e-mail addresses, one said some, one said a few, and there were two “don’t know” responses.

Demographic Characteristics

People completing the LHC forms were fairly evenly distributed by age.

Table II: Individuals Completing LHC Forms by Age

Age Group	Number	Percent
Under 18	40	4.9%
18 to 24	104	12.8%
25 to 34	189	23.2%
35 to 44	165	20.3%
45 to 54	148	18.2%
55 to 64	118	14.4%
65 and older	51	6.2%
Total	**815**	**100.0%**

The majority were female.

Table III: Individuals Completing LHC Forms by Gender

Gender	Number	Percent
Male	352	37.1%
Female	581	61.2%
Transgendered	16	1.7%
Total	**949**	**100.0%**

The majority were unemployed.

Table IV: Individuals Completing LHC Forms by Employment Status

Employment Status	Number	Percent
Unemployed	557	66.3%
Employed part-time (1 job)	105	12.6%
Employed part-time (2 + jobs)	34	4.1%
Employed full-time	119	14.2%
Self-employed	24	2.8%
Total	**839**	**100.0%**

In terms of education, the largest percentage of people submitting LHC forms indicated they had less than high school, followed closely by people with some college or university.

Table V: Completing LHC Forms by Education

Education	Number	Percent
Less than high school	252	31.5%
High school graduate	196	24.6%
Some college or university	227	28.3%
University degree	125	15.6%
Total	**800**	**100.0%**

Finally, almost all people identified themselves as Canadian citizens.

Table VI: Citizenship and Immigration Status

Citizenship or Immigration Status	Number	Percent
Canadian citizen	694	87.7%
Permanent resident	79	9.9%
Refugee	8	1.1%
Without status	10	1.3%
Total	**791**	**100.0%**

Achieving outreach may also be viewed from a client perspective rather than overall numbers. On the client survey, people were asked three questions relevant to outreach. Did the legal health check-up help you identify legal problems? Would you have gone to the clinic when you did if you had not taken the legal health check-up? Would you return to the legal clinic to get help with a new problem? The responses are shown in Table VII.

Table VII: Client Perspectives on Outreach

	Did the legal health check-up help?		Would you have gone to the clinic?		Would you return with a new problem?	
	No.	%	No.	%	No.	%
Definitely	14	61.0%	10	43.6%	21	91.3%
Probably	3	13.0%	2	8.7%	2	8.7%
Maybe	1	4.3%	3	13.0%	--	--
Probably not	2	8.7%	5	21.7%	--	--
Definitely not	2	8.7%	3	13.0%	--	--
Not sure	1	4.3%	-	--	--	--
Total	**23**	**100.0%**	**23**	**100.0%**	**23**	**100.0%**

Almost 75% of clients who came to the clinic for a first intake appointment said the LHC was definitely or probably helpful assisting them in identifying problems. 43.6%, said they definitely or probably would not have gone to the clinic without having taken the LHC. Finally, 91.3% and 8.7% said they definitely or probably would go back to the clinic for help with a problem in the future. Although the number of respondents is small, these data clearly suggest that the legal health check-up process and, in particular, the LHC form provide an effective form of outreach.

Diffusion Throughout the Community

In addition to the 125 partner intermediaries, individuals completing LHC forms identified an additional 237 sources of LHC forms. This represents significant diffusion of the legal health check-up throughout the community beyond the formal partnership arrangements, representing unanticipated interest in and a positive judgement by the wider community about the legal health check-up idea. The actual references to sources of information about the LHC were often cryptic and difficult to identify precisely. An illustrative list of sources illustrating the breadth of the diffusion is as follows:

- friends and family members
- CLEO (Community Legal Education Ontario)
- CMHA (Canadian Mental Health Association)
- library
- cancer patient services

- family doctor
- Salvation Army
- Canada Employment and Learning Centre
- ARCH (disability law centre in Toronto)

On-Line and On-Paper Forms

Of the 1700 LHC forms completed by all 12 clinics during the pilot period, 54.6% (927) were completed on-line, 45.3% (771) were completed on paper and 0.1% (2) were completed by telephone. The majority being completed on-line suggests the possibility of enhancing the LHC through digital technology. One of the clinics indicating an intention to continue with the LHC approach suggested developing an *app* to encourage more people to complete the LHC questionnaire.

Identifying Need and Providing Service

Table VIII represents the flow of activity from problem identification to service provided up until the end of October 2016 by each of the 12 clinics. During the period between start-up and the end of October 2016, 2011 LHC forms including completed and abandoned forms, were submitted to the 12 clinics.[28]

Table VIII: Completed Legal Heath Check-Ups and Intakes

Clinic *	**Total no. of LHC forms**	**Completed LHC forms**		**Incomplete LHC forms**		**Requests for service**		**Intakes**	
		No.	% of total	No.	% of total	No.	% of completed	No.	% of requests
1	189	119	63.0%	70	37.0%	61	51.3%	31	50.8%
2	280	262	93.6%	18	6.4%	92	35.1%	31	33.7%
3	73	67	91.8%	6	8.2%	57	85.1%		
4	54	34	63.0%	20	37.0%	14	70.0%		
5	272	146	53.7%	126	46.3%	91	72.2%	14	15.4%
6	422	253	59.9%	169	40.1%	69	40.8%	13	18.8%

[28] The previous analysis was based on completed forms only to avoid problems with incomplete data. This table is constructed using both completed and abandoned forms to address attrition and completeness of forms. This accounts for the difference between the 1700 used in the analysis of problems above and the 2011 used in this table only.

7	127	116	91.3%	11	8.7%	59	50.9%		
8	110	71	64.5%	39	35.5%	31	43.7%		
9	235	209	88.9%	26	11.1%	88	42.1%		
10	66	25	37.9%	41	62.1%	14	56.0%	7	50.0%
11	58	40	70.0%	18	30.0%	23	57.5%		
12	125	89	71.2%	36	28.8%	68	76.4%	30	44.1%
Total	**2011**								

* Clinics corresponding to numbers:

1 = Community Legal Clinic Brant Haldimand Norfolk
2 = Chatham Kent Legal Clinic
3 = Windsor-Essex Bilingual Clinic
4 = Elgin Oxford Legal Clinic
5 = Legal Clinic of Guelph and Wellington County
6 = Hamilton Community Legal Clinic;
7 = Huron Perth Community Legal Clinic
8 = Justice Niagara
9 = Legal Services Windsor
10 = Neighbourhood Legal Services of London and Middlesex
11 = Community Legal Assistance Sarnia
12 = Waterloo Region Community Legal Services

Although the period of time varied slightly for each clinic because of different start-up dates, the approximate time period was six months. Several clinics expressed concern in the in-depth telephone interviews that the number of intakes was very low and that the results did not appear to justify the effort. That is a judgement that might be viewed as having been pre-mature. The time period covered by the data represents the early implementation stage of the project. Clinics had committed to a six-month period from May until the end of October. Generally, experience with experimental projects is that project development during the initial period may be a learning exercise during which progress is slow. It is a period of during which implementation monitoring should be carried out to identify early lessons learned and possible program modifications. Data from a roughly comparable project being developed by an Eastern Ontario community legal clinic illustrates the time that may be required to bring an experi-mental project from start-up to a stage close to maturity.

The Community Advocacy and Legal Centre (CALC) in Belleville has been developing partner-ships with six community health centres over approximately the past 18 months. This project is similar in broad terms to the Legal Health Check-up Projects under review here. CALC has chosen to work with community health centres as intermediary partners compared with the much larger range of intermediaries engaged by the Southwestern Region LHC Project. Second, the CALC project does not involve a legal health check-up tool, relying instead on direct referrals. However, the point has to do with the pace with which experimental projects may be expected to develop. The number of referrals from the six clinics[29] started very slowly, growing

[29] The CALC project began with more than six partner community health centres. Formal relationships were developed with six partners, although CALC continued to work with and receive referrals from the others.

dramatically with continued efforts by CALC to develop relationships with the six trusted intermediaries. During the six months prior to the formal start of the project, from July to December 2015, the six health clinics made an average of 2.5 referrals. During the six months between January and June 2016 the six community health centres made an average of 15 referrals.[30] As the project continued to mature, during the third six-month period, between July and December 2016, the six intermediaries made an average of 27 referrals.[31] CALC had been working with other community health centres early in the process but discontinued working with them when it became clear that effective partnerships would not be developed. This experience illustrates well the point that it is premature to judge the performance of the LHC Project on the basis of number of intakes during the first six months. In assessing its experience in the clinic questionnaire one of the clinics indicated that more time was required to develop relationships with the intermediary groups. This is the emphasis that ought to be placed on the LHC Project at this stage and the emphasis that should be the focus of this review.

Partnerships with Intermediaries

The data presented in Table IX (derived from Appendix One) show that some clinics engaged more intermediaries than others. The number of intermediaries per clinic ranged from 6 to 24. To a large extent legal aid clinics had prior connections with intermediary groups, often as members of community anti-poverty coalitions or as groups consulted periodically by the clinic about changing patterns of need in the community. The process of recruiting intermediaries was similar among clinics. A representative of the clinic visited each intermediary. The legal health check-up questionnaire in the booklet form was presented to the prospective intermediary group, along with a discussion of the basic objectives of the project. The process of recruiting intermediaries involved 12 clinics and more than 125 intermediary groups.[32]

[30] *Justice and Health Partnerships Project, Evaluation Report, Phase II*, Community Legal And Advocacy Centre, November 2016, p.5

[31] Data provided to the writer by CALC.

[32] Some prospective intermediary groups declined participation in the project.

Table IX: Legal Health Check-up Forms Submitted by Intermediaries

Clinic	Number of intermediaries	Total number of LHC forms	Number of intermediaries producing no LHC forms	Number of intermediaries producing at Least 50% of all LHC forms
Brant	11	54	2	2 = 59.0%
		Simcoe Caring Cupboard = 20 forms		Ontario Works = 12 forms
Chatham-Kent	16	350	3	2 = 69.2%
		Ontario Works = 157 forms		Community Living Chatham-Kent = 63 forms
Windsor-Essex	6	34	1	2 = 85.3%
		Family Services of Windsor-Essex = 17 forms		Sexual Assault Crisis Centre = 12 forms
Elgin-Oxford	7	25	2	2 = 68.0%
				Central Community Health Centre, St. Thomas = 12 forms
				West Elgin Community Health Centre, West Lorne = 5 forms
Guelph	9	58	1	2 = 67.2%
				Guelph Community Health Centre = 23 forms
				Rural Wellington Community Team = 16 forms
Hamilton	14	211	1	2 = 63.9%
		McMaster Family Practise = 72 forms		Notre Dame House (youth hostel) = 63 forms
Huron-Perth	12	75	3	3 = 57.0%
		Clinton Family Health Team = 14 forms		Salvation Army Food bank = 18 forms
Justice Niagara	14	35	4	3 = 57.1%
				Port Cares = 9 forms Oak Centre = 6 forms
				Community Cares of St. Catharines and Thorold = 5 forms
Legal Assistance Windsor	15	202	3	3 = 63.4%
		Women's Enterprise Skills = 52 forms	YMCA = 42 forms	Drouillard Place = 34 forms
London & Middlesex	8	21	2	3 = 66.2%
		Community Employment Choices = 6 forms		Middlesex County Library = 4 forms
				Canadian Mental Health Association = 4 forms
Sarnia	24	41	18	1 = 63.4%
				Financial Fitness Centre = 26 forms
Waterloo	13	80	3	1 = 56.3%
				Two Rivers Family Health Team = 45 forms

With each clinic operating independently, there was some variation in the number and format of meetings in the recruitment phase. In the telephone interviews with executive directors and staff involved with the legal health check-up, questions were asked about the process of recruiting intermediaries. For the most part, clinics recruited organizations with which they had some prior relationship to participate in the LHC. The prior relationships typically involved membership on consultative community networks or, in some cases, direct periodic consultation between the legal clinic and the organization about poverty-related community needs and issues. In a smaller number of cases in which the legal clinic used the legal health check-up initiative to expand service to areas or groups that were not being well served, new groups were approached. This often involved expanding to address unmet need in rural areas or to Aboriginal people.

The community organizations and agencies that were approached to become part of the LHC Project were generally reported to have been enthusiastic about the concept. According to clinic staff, the managers of the organizations that were approached easily understood the concept of legal problems embedded in the ordinary day-to-day activities of people. They understood the concept of hidden need. They understood barriers to accessing legal and other services.

The basic strategy of developing clinic–intermediary partnerships as a means to build pathways to legal help was largely successful, viewed as a first step in a longer process. Although the numbers are quite uneven, most intermediary groups identified unmet need, measured in terms of producing LHC forms.[33] Including all clinics, 41 of the 125 intermediary groups did not produce any LHC forms. This means that 67.2% of all intermediaries identified unmet need to some degree. One clinic, Community Legal Assistance Sarnia, was an outlier with respect to the number of intermediaries, having recruited 24 intermediary groups. This is a far larger number than most others. Eighteen of the 24 intermediaries produced no LHC forms. If Sarnia is removed from the calculation, 77.2% of all intermediary groups identified people with unmet needs using the legal health check-up process. Most intermediaries produced a small number of LHC forms. For all clinics, between one and three intermediaries identified between 57.0% and 85.3% of the unmet need for the clinics, that is, produced 57.0% to 85.5% of all LHC forms.

It is to be expected that some intermediaries will produce more referrals than others. This may be due simply to the variety of types of organizations and consequently the different issues and problems that may arise with that diversity. However, by forming partnerships with a variety of community organizations and service agencies rather than focusing on a particular type such as in legal clinic–health care partnerships, this approach maximizes the potential to engage the

[33] The number of LHC forms as a measure underestimates the number of people with unmet legal needs identified because there were some referrals without LHC forms having been completed.

resources of the community more broadly. Six of the 24 high-producing intermediaries identified in Table IX are health care partners. Otherwise, these intermediaries represent a wide variety of types. The legal health check-up is a multiple pathway model for creating outreach and building pathways to legal help. Further, Table XI shows that different kinds or organizations are the highest producers of LHC forms among the 12 clinics, suggesting the value of engaging a variety of community partners.

The following section examines why some intermediaries were more productive in terms of producing LHC forms than others. This information will hopefully assist clinics to more effectively engage intermediaries and optimize this approach to building partnerships.

Clinics' Views on Intermediary Production of LHC Forms

In the clinic questionnaire, clinics were asked why they felt some intermediaries produced no forms or only a few, while some produced a relatively large number. Nine clinics responded to the questionnaire. Seven of the nine clinics indicated they had followed up with intermediaries after the partnership began to discuss possible problems. All responses presented below are based on the seven clinics that conducted follow-up meetings. The clinics were asked to provide up to three reasons why some intermediaries were producing few or no LHC forms. The three most frequently cited reasons were

- The intermediary organization lacks capacity (5).
- The LHC form is too long (3).
- The clients of these intermediaries are not interested in completing the forms (3).

Other single factors mentioned were:

- The intermediary feels they already know where to refer people with different problems.
- The LHC does not fit well into the organization's existing service.
- The LHC does not fit well with the organization's normal work process.
- Many clients have language barriers and completing the LHC with them is difficult.
- The organization does use the LHC form internally, but does not forward it on to the legal clinic with the referral.

Clinic respondents were also asked for reasons why a few intermediaries produced relatively large numbers of forms. In this case two observations stand out:

- The work of the clinic as represented in the LHC is closely linked to the work of the intermediary (5).

- Having dedicated staff at the intermediary organization was also mentioned (3).[34]

Other reasons given single mentions were:

- The organization does not have its own intake model, and therefore found it easier to integrate the LHC into its process.
- Having a strong presence at the intermediary location; a clinic staff member assists people with the LHC forms at the intermediaries' location.
- Clients of the intermediary were provided with bus tickets as an incentive.
- The intermediary fully understands the benefit of the LHC.
- The intermediary understands the commitment of Legal Aid Ontario to the project.

In connection to the last observation concerning commitment, one clinic indicated in the in-depth interviews that some prospective intermediaries had been reluctant to participate in the project because it was presented as a pilot project. The organizations were reluctant to make the commitment to become involved, possibly changing organizational practices, for a project that might be discontinued.

The Views of Intermediaries

A small sample of intermediaries was also asked about their experience participating in the LHC Project. Two questionnaires were used, one for intermediaries that produced no LHC forms and one for those producing at least some forms. In the sampling of those that produced at least some LHC forms, intermediaries producing a relatively small number of forms and the intermediaries who produced the largest number were distinguished and selected separately.

Intermediaries Producing No LHC Forms

The reasons why some intermediaries produced no LHC forms appears to rest on largely practical, idiosyncratic reasons relating to the particular intermediary organizations. The problem was not that the concept was not appealing. All five intermediaries within this group said when they first decided to participate in the project they felt it was a good idea, thought it would be a good approach to identifying unmet need, and thought it would benefit their clients. Four of the five intermediaries acknowledged a shared interest between the legal clinic and their organization and four out of five thought the information gained from the LHC form would be useful for their own planning. All of the five intermediaries that had produced no LHC forms said they understood the LHC concept, and all five said that legal problems experienced

[34] Having "an engaged staff person at the intermediary organization" was also mentioned by one clinic executive director in a separate e-mail communication.

by their clientele were a concern to them. Only one of the five organizations said the form was too long for their staff to deal with. Two of the five intermediaries said they had their own intake process that made the LHC questionnaire at least partly redundant.

Significantly, perhaps, a majority of this small sample (three of the five intermediaries) said the LHC form was too long for their clients. This echoes similar comments about the form made by respondents in other intermediary questionnaires, in the clinic questionnaire and in the in-depth interviews with clinic staff.

Comments to open-end questions provide insights into why these intermediaries did not produce LHC forms during the duration of the trial period:

- It was easier to refer without completing the questionnaire.
- People already know about services and sources of help.
- We did not use the questionnaire with new clients. We thought it would be would be too overwhelming. We only used it with existing clients.
- We were undergoing an accreditation process and a change of management.
- The LHC is a good idea but it did not meet the immediate needs of our clients.
- The questions are very general, [while] clients' problems are usually very specific.
- The existing relationship with the clinic resulted in making direct referrals rather than using the form.
- A shorter version of the questionnaire is needed.
- When clients come in [with problems] they are desperate.
- Clients don't want to go somewhere else. Most clients wanted to speak with an elder. They want an Aboriginal lawyer.

In four of the five cases, the intermediary said the clinic had contacted them early in the project to discuss any problems they were having with the LHC process. Contact and support by the clinic was apparently not a problem. However, the intermediary organizations were able to identify a number of reasons why the LHC process was not working. It might be concluded that although there was contact by the clinic, a more intensive working relationship between the clinic and intermediary partners would have identified the problems that were signaled by intermediaries as contributing to intermediaries producing no LHC forms. Some clinics attempted to form partnerships with a relatively large number of intermediaries. Developing relationships with the relatively large numbers of intermediaries may have required more resources than clinics anticipated. Working more intensively with fewer intermediaries at the outset and adding more intermediaries at a subsequent stage might have been a better strategy.

Intermediaries Producing Some Forms

Eleven interviews were carried out with intermediaries that provided clinics with at least some LHC forms. Six interviews were conducted with intermediaries that submitted a few forms to the clinics, and five with intermediaries that provided most of the forms to the clinics. The intention was that by comparing the two groups on questions such as why they participated in the project, how the forms were used, and what problems were encountered would provide some insights into why some intermediaries produced relatively large numbers of LHC forms. However, three of the six intermediaries producing a few LHC forms indicated they often made referrals without completing a form. All five of the high-volume intermediaries said they did this occasionally, but not often. This jeopardizes the reliability of responses to other questions and calls into question the reliability of distinguishing the two categories of intermediaries for purposes of this analysis. Because the numbers of completed questionnaires is so small, a shift due to referrals made without LHC forms could significantly alter the distributions of responses. In any case the differences between the "few" and "most" groups were not instructive. Therefore, this section will focus on responses to two questions only, and on comments made by respondents elaborating on those responses.

Intermediaries were asked if they wished to continue with the clinic–intermediary partnerships. Five of the six respondents providing a few LHC forms indicated they wished to continue the partnership. One said it did not wish to do so. Among the intermediaries providing the majority of LHC forms to their partner clinics, four out of five said they wished to continue the partnership, with one not answering. Overall, this indicates an overwhelming level of support for the LHC Project among the clinics that responded.

The respondents indicating they wished to continue with the project from both groups were asked about suggestions for improvement. Respondents from the "few" category of intermediaries said:

- a simpler questionnaire
- a shorter version of the questionnaire
- a shorter form
- a mobile app to make the process more efficient

Respondents representing intermediaries that had produced most of the LHC forms for the clinic suggested:

- a shorter form
- a simpler questionnaire

- [reduced] length of time it takes
- The length of the check-up is a detriment.
- Expand to rural areas.

The comments elaborating on another question, "Did you have problems adopting the Legal Health Check-up", are also instructive:

- The only problem was not having enough time.
- Not a problem when we used the two-page questionnaire.[35]
- Clients usually don't want to talk about other things.

The comment in the last bullet is similar to problems with the length of the questionnaire, but has implicit in it one reason why a long questionnaire is problematic. Clients are often focused on immediate problems and therefore a long questionnaire is unwelcome.

Responses to other questions and comments clearly suggest a recognition of the value of the legal health check-up by all intermediaries, regardless of the number of LHC forms produced. Respondents were asked for reasons at the outset of the project for their decision to participate as a partner with the clinic in their area. Among the clinics that had produced a few LHC forms, positive endorsements were unanimous. Six out of six intermediaries said they generally thought the concept was a good idea, said they thought it would be an effective way to identify needs, felt that the check-up would benefit their clients and thought the information would be useful for their own planning. Similarly, five out of five intermediaries that had provided the largest number of LHC forms to their partner clinics thought the LHC concept was a good one overall, thought it would be a good way to identify unmet need, and expected it would benefit their clients. Three of the five from this group of intermediaries anticipated the information from the LHC would be useful for their organizational planning.

Additional comments were

- We felt there was a gap and the legal health check-up could fill it.
- We had an idea that the problems faced by our clients were legal in nature.
- [The LHC] can keep people from falling through the cracks.

Turning to responses based on experience, intermediaries were asked if they thought the legal health check-up had benefited their clients. Among the intermediaries producing a few LHC forms, three said the process had benefited their clients very much, one respondent said a lot, one said not very much and one did not answer. Among the five intermediaries producing the

[35] One clinic adopted a two-page questionnaire during the project.

greatest number of forms for their partner clinic, one said it had benefited their clients very much, three said quite a lot and one responded some.

The comments elaborating on the closed responses were

- We are getting good feedback from clients.
- Another resource is useful; it is hard to get clients to follow up.
- Very useful related to ODSP [Ontario Disability Support Program]; it connects with physicians and caregivers, provides a plan and direction.
- Feedback from clients who didn't know problems had a legal remedy.
- Always urge clients to connect with [clinic name] if I thought it would help.

One comment seems slightly off the mark but, nonetheless, positive:

- Helped build a better relationship with the clinic; understand what they do.

The intermediaries were also asked if the LHC process had helped the intermediary organization better assist their own clients. Among the six intermediaries providing only a few LHC forms to clinics, two responded very much, one said some, two said not very much and one said not at all. In contrast, among the five intermediaries that had produced the largest number of LHC forms, four said quite a lot and one said some. This is a more positive response overall compared with the "few" LHC forms group of intermediaries, suggesting that establishing an identity of interest between the intermediary and the clinic and, on a practical level, embedding the activities of the clinic in the activities the intermediary are factors that may produce an effective partnership.

Volunteered comments related to this question were

- The legal health check-up gave clients what they needed in the moment and made follow-up easier.
- The greatest benefit is an on-going relationship with a community resource.
- Clients are often in crisis mode. [This is] a good way to get proactive information.

Clients' Experience and Outcomes

Twenty-three client surveys were carried out by five clinics. These were all people who had received some service. Among this group, 83% were over 35 years of age, 78% were female and 74% were born in Canada. Further, 83% of the 23 respondents lived in rented apartments of houses. One person reported himself as being homeless, one reported living with parents, one in a rooming house, and one in his own house.

Data from the client questionnaire are complementary to this profile. The nine clinics were asked to characterize the clients referred from intermediaries through the LHC process. Eight clinics said only a few (four) or almost none (three) were homeless. One clinic said most were homeless and one didn't answer. Two clinics described all of the LHC clients as living precarious lives, three clinics said most of the LHC clients, one said some and two clinics said a few clients lived precarious lives, with one response of "no answer". Two clinics said most of the clientele were highly transient and two said some of them. Three clinics said a few LHC clients were highly transient and two registered responses of "don't know". Three of the nine clinics said most of the clients appeared to have mental disorders, while four clinics said some may have had mental disorders. One clinic said it believed a few of its clients had mental disorders, and there was one response of "no answer". Six of the nine clinics said that some of their clients had substance abuse issues. Three clinics said they did not know. Five of nine clinics said the LHC clients seemed mistrustful of lawyers. One clinic said a few were mistrustful and three clinics did not know.

Clinics were asked if there were characteristics of the LHC clientele other than those on the list of characteristics provided in the client questionnaire. The clientele was characterized by respondents from the clinics as having

- a disability that affects their ability to work
- low literacy (two responses)
- transportation problems
- cultural differences

As well, relating to the behaviour of clients:

- will respond when ready
- do not return calls

The data from the caseworker (intake) forms provide the most reliable profile of problem types. Overall, seven clinics provided intake data for 137 individuals. Forty-six provided data on problem type. About 35% (16) were housing problems of various types. The 21 other problem types included: family (4), ODSP (4), debt (3), employment insurance (3), criminal matters (3), Ontario Works program (2), income (2), immigration (2) and one each of human rights, education benefits and a social insurance number issue.

The client questionnaire, which gathered data directly from clients, provided 15 problems types, six of which (40%) were housing problems. Other problems described in the client questionnaires were harassment, mental health support, separation agreement, child support,

family law, workplace harassment, ODSP, traffic offences and Canada Pension Plan Disability support.

Based on 79 of the 137 cases in the caseworker intake data, the level of service received by about half of individuals was a referral, 50.6% (40). Summary advice was provided to 39.3% of clients (31) in the caseworker data. Five clients, 6.3%, received brief service, such as a letter, a telephone call to an agency involved in the problem or filling out an application form for assistance. Three clients received representation, 3.8%.[36]

Seven clinics provided 98 records on number of problems in the caseworker data or intake data.

Table X: Number of Problems Reported for Clients

Number of problems reported	Number of individuals	Percentage of individuals
1	22	22.4%
2	26	26.5%
3	19	19.5%
4	16	16.3%
5	10	10.2%
6	4	4.1%
7	1	1.0%
Total	**98**	**100.0%**

Multiple problems are prevalent. 51.1% of respondents experienced three or more problems. The range of average number of problems varied rather widely from 1.4 per individual to 3.2 across the seven clinics.

Data on level of crisis was also collected in the caseworker survey. Of the 136 intake cases, 50 (36.8%) were considered by intake workers to have been in some level of crisis. Intake workers assessed 23 of the 50 (48.0%) intakes as having been in actual and immediate crisis.[37] Twenty-seven cases, 54.0% of intakes, were assessed as being in emergent crisis.

[36] All cases in which representation was provided were reported by one clinic.

[37] 17 of the 23 crisis-designated cases were reported by one clinic. This suggests the need for a more consistent methodology for assessing level of crisis.

The problems reported in the intake or caseworker database tended to longstanding issues. The seven clinics reported length of time since the problem first emerged for 84 intakes, selecting one problem for each intake. Most problems had begun a year or more before the client asked for help. Slightly more than one third, 36.9% (31), of the problems had begun one year or more ago. Further, 28.6% (24) of the problems assessed had begun between six months and a year ago.

Table XI: Time Since First Occurrence of the Problem

Length of time since initial occurrence	Number	Percent
Less than 1 month	7	8.3%
1 to 3 months	9	10.7%
3 to 6 months	13	15.5%
6 to 12 months	24	28.6%
1 year or more	31	36.9%
Total	**84**	**100.0%**

It appears that the Legal Health Check-up Project is encountering clients in crisis and with longstanding problems. Therefore, at the early stages the project, clinics are not achieving objectives of early intervention and avoiding crises. This is clearly a problem to be addressed. In narrative comments, both clinics and intermediaries noted that clients not only often appear in crisis mode, but are sometimes reluctant to deal with problems other than the one of immediate concern to them.

Most intake clients, 11 out of 23 respondents (48%), said they learned about the legal health check-up through an intermediary group. Six people (26%) identified the legal clinic as the place where they had learned about the LHC. Friends or family (three), a paper advertisement (one) and not sure (two) were other responses. Eleven people (48%) filled out the form on-line, compared with 12 people (52%) who completed the form on paper.

The majority of people, 15 out of 23 (65%) said the LHC form was very easy to fill out. Five people (22%) said it was somewhat easy. Only one respondent said it was difficult to complete the form and two were not sure. This stands in contrast with the comments from intermediaries and clinics. Eight of the 23 respondents (35%) in the client questionnaire said they had assistance completing the form. Most, 15 (65%), had no assistance. The 11 respondents who had assistance completing the form were asked if they think they would have completed the form without help. Four of the 11 people (36%) said they definitely would have completed

the form without help. One respondent said probably, one said maybe, one said probably not, and two were not sure.

Turning to outcomes, the 23 respondents were asked if they thought the LHC form was helpful in identifying the problems they were experiencing. Fourteen of 23 respondents, about 60%, said it was definitely helpful. Three respondents said it was probably helpful, two were not sure, two said probably not and two said it was definitely not helpful. Respondents provided a few volunteered comments about problems with the LHC questionnaire:

- Questions hard to understand.
- Too many questions (2).
- The questions didn't relate to my problems (2).
- English is not my first language.

The LHC questionnaire and process appear to have provided the basis for holistic intake from the clients' perspectives. When asked if the clinic asked about other problem they might be experiencing, 20 out of 23 (87%) intake respondents said yes. Asked if they were able to tell the intake worker everything they wanted about their problems, nine out of 23 (39%) respondents said completely and a further 11 (48%) said mostly. Three respondents said this had not been the case.

Respondents were asked if the clinic had helped solve the problem.[38] Eleven of the 23 intake respondents (48%) said "a great deal". Seven respondents (30%) said "some", one respondent said not very much, one said not at all and three were not sure.

Respondents were about evenly split when asked if they would have gone to the clinic without the LHC process. Three said they would definitely not have gone without the LHC, and another five said probably not — together 35%. On the other hand, seven respondents said they would definitely have gone to the clinic without the LHC, and a further three said they probably would have gone without the LHC form and process. Taken together, these responses equal about 43%. Somewhat less than a quarter, five respondents (22%), said they might have gone in the absence of the LHC process. However, 20 out of the 23 respondents (87%) said they would go back to the clinic with a future problem. Three respondents (13%) said they would probably go back to the clinic. It is not possible to link the likelihood of going to the clinic with future problems to the experience of the LHC process, except to observe that all respondents were part of the LHC process.

[38] Implied in this question is "using the LHC form and process".

Achievement of Objectives by Clinics

The objectives clinics attempted to achieve in the project, the extent to which they met their objectives, whether they plan to continue with the approach in some form, and what changes experience has taught them should be made are central questions in this study. As was discussed in the introduction, the innovation model employed as the legal health check-up moved out from the Halton experiment to the 12 Southwestern Region clinics was adaptation rather than replication. Clinics were encouraged to develop the clinic–intermediary partnership/legal health check-up model in ways that were best suited to the characteristic their service delivery environments, to the resources available within their clinics and in a way that reflected their own ideas about how to implement the main features of the legal health check-up,. Although the LHC approach has characteristic elements that represent broad objectives, clinics were free to set their own priorities with respect to objectives or to adopt their own.[39]

Figure II (below) presents data showing how the nine clinics responding to the clinic survey prioritized eight objectives of the LHC model. Figure III shows the extent to which clinics reported having achieved these objectives. The results presented in the two figures will be discussed together. The objectives and achievements are ranked by visual inspection, counting the number of times clinics ranked the objective as high, medium, low or not an objective, and similarly the number of clinics indicating they had achieved the objective completely or mostly, partly, not very much or not at all. Because this approach to ranking is somewhat subjective, numerical scores were also created as described in the footnote.[40]

Avoiding crises in the lives of clients dealing with legal problems was the highest-priority objective for largest number of clinics. Eight clinics ranked this objective as a high priority and one ranked it as medium priority. However, in terms of meeting this objective, avoiding crises for clients ranked fourth overall. Only two clinics indicated they had completely or substantially achieved this objective. Two indicated they had partly met this objective, three said not very much, and two clinics said they had not achieved this objective at all.[41] Clinics were asked to

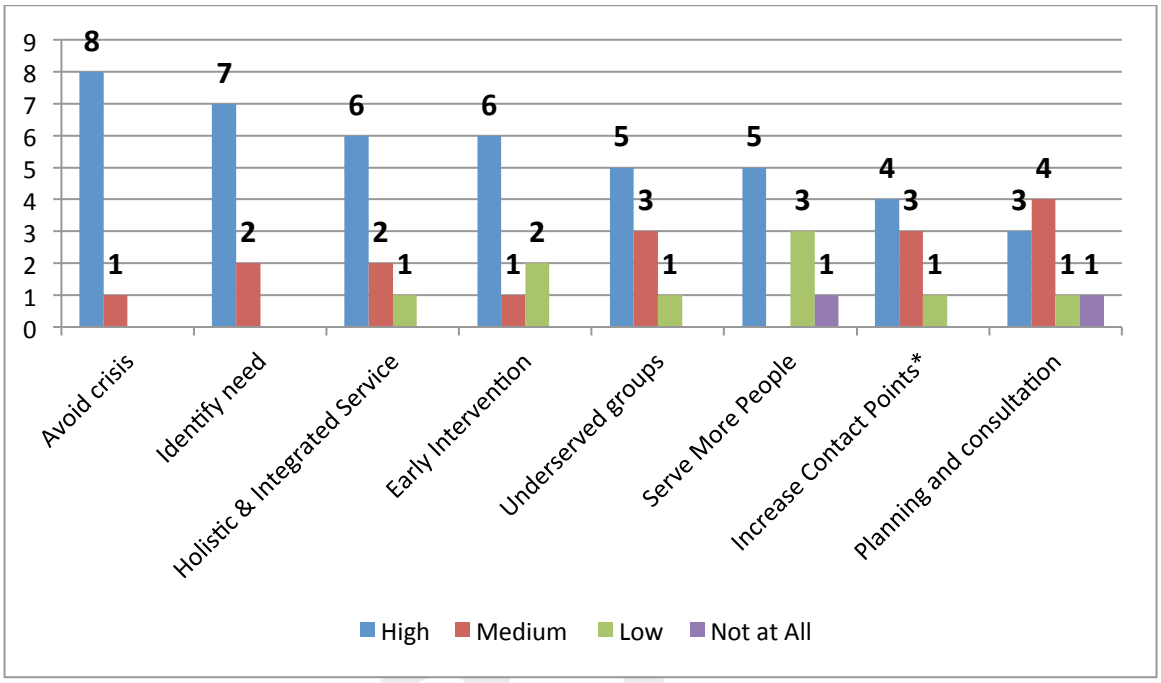
[39] Two clinics expressed project objectives other than the eight included in the clinic questionnaire. One clinic with ties to a university student legal aid clinic indicated that using the legal health check-up process to train students was a high priority objective that had been achieved completely. Another clinic indicated that building relationships with community organizations was a high priority that was mostly achieved.

[40] By assigning scores: high priority = 1, medium = 2, low = 3 and not a priority = 4, a summary score can be created by multiplying each score by the number of clinics receiving it, summing the products and dividing by the nine clinics. In this case the scores sum to 10 (eight scores of 1 and one score of 2). The overall priority ranking for all clinics for avoiding crisis is 10 ÷ 9 = 1.1. (One is the highest score.) The scale may be more intuitive if the highest number represents the highest priority. This is accomplished by computing the reciprocal of each score (e.g. 1 ÷ 1.).

[41] Similarly, average scores can be created for the degree to which clinics said they had achieved this objective by summing the scores and dividing by the nine clinics. Achievement scores were assigned as completely or substantially achieved = 1, partly = 2, not very much = 3 and not at all = 4. In this case the scores sum to 23 with

comment on why they had not achieved the various objectives. Only one clinic commented on the difficulty in achieving this objective, suggesting it was difficult to achieve because clients frequently declined appointments when contacted after having requested contact from the clinic on the legal health check-up form.

Figure II: Objectives and Their Level of Priority



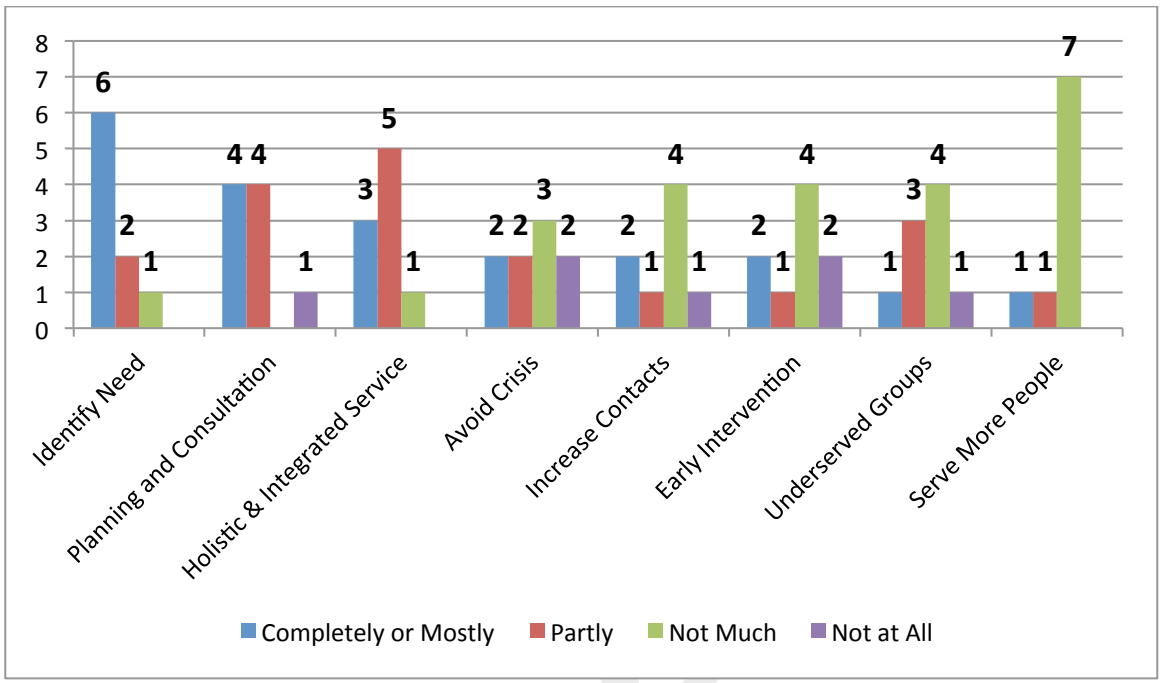
*One "don't know" response for "increase contact points."

Identifying unmet need was the second-highest priority objective for clinics. Seven clinics ranked this objective as a high priority and two a medium priority. Six clinics reported that this objective had been completely or substantially met, two said the objective had been partially met, and one clinic indicated that identifying need had to a large extent had not been met. In terms of achievement this objective ranks highest overall. This is probably what one would have expected. The legal health check-up form is specifically designed to identify everyday legal problems and hidden or unmet legal need. Two clinics commented on problems achieving this objective. One response focused on the low number of legal health check-up forms submitted by many intermediaries, suggesting that more time for building relationships with inter-mediaries was required so more LHC forms would reliably and consistently be completed. Also focusing on completion of the LHC forms, a second clinic suggested that more time to build

an average score of 2.6: (two scores of 1, two scores of 2, four scores of 3 and one score of 4 (23 ÷ 9 = 2.6). Reciprocals were calculated for each score to assign the highest score to the highest level of achievement (e.g. 1 ÷2.6 = 0.39).

trust with individuals might result in a greater number of people coming forward to reveal problems.

Figure III: Achievement of Objectives



The objective ranked third overall as a priority among the nine clinics completing the questionnaire was providing service that is more holistic and integrated. Six clinics said it was a high priority, two said it was a medium priority, and one said it was a low priority. For this objective, the gap between level of priority and level of achievement is substantial. Three clinics said they had completely or substantially achieved this objective. Five clinics indicated they had partly met this objective, and one indicated the objective had largely not been met. Three clinics commented on the difficulty in achieving this objective. Two said they already provided a high degree of holistic and integrated service. One clinic commented that the difficulty contacting clients limited their ability to provide a holistic and integrated service. More time was needed to build relationships with intermediaries so more LHC forms would reliably and consistently be completed. Also focusing on completion of the LHC forms, a second clinic suggested that more time to build trust with individuals might result in a greater number of people coming forward to reveal problems.

Early intervention was the fourth-priority objective overall. Six clinics indicated this objective was a high priority, two said it was a medium priority, and one indicated it was a low priority. In terms of achievement of objectives, early intervention ranked sixth overall. This was a high priority for two clinics, medium for one clinic, a low priority for four clinics, and not a priority at

all for one clinic. People declining appointments and people not seeking assistance until a crisis have evolved were reasons for the difficulty achieving the early intervention objective.

Reaching underserved groups was the fifth-greatest priority overall, with five clinics indicating it was a high priority. Three clinics said serving more groups was a medium priority, and one indicated it was a low priority. In terms of achievement this objective ranked seventh overall. One clinic rated its achievement on this priority as high, three said it was medium, four said low, and one said not at all. Three clinics commented that they were already providing service to a number of under-served groups making the achievement reaching more such groups very difficult. One clinic said that the under-served groups were especially difficult to reach.

The sixth-ranked priority was serving more people. This is interesting because the second-highest priority was identifying legal need, and one might have thought that serving more people would be closely related to identifying need. In the in-depth interviews conducted early in the project, some clinics expressed concerns about their capacity to handle increased numbers of clients. This concern seems to have worked to downplay serving more people as an objective in favour of early intervention and avoiding crises. In terms of achievement, this objective ranked eighth overall. Only one clinic indicated that this objective had been completely or substantially achieved. One said this objective had been partly achieved, and seven said it had not been achieved at all. Clinics suggested a variety of reasons why serving more people was a difficult objective to achieve. These included: people not keeping appointments; most intakes were existing or repeat clients; a general lack of response to the outreach effort, that is, few LHC forms were completed (two clinics); not enough resources to properly administer the LHC tool; and at this early stage the focus was on relationship-building rather than on increased numbers of clients (one clinic).

Providing more contact points in the community was ranked as the seventh-most important priority overall. The low ranking is probably because all clinics felt they had already successfully built a network among organizations within their communities, having traditionally done so as community clinics in order to monitor needs and participate with organizations in initiatives to alleviate poverty in their communities. Four clinics said it was nonetheless a high priority to increase their existing network of contacts, three said it was a medium priority, and one said it was a low priority. In terms of achievement, this objective ranked higher than its priority ranking, fifth overall. Four clinics said this objective had been completely or mostly achieved, four said it had been partly achieved, and one clinic indicated it had not been achieved at all. Four clinics provided comments on the difficulty meeting this objective. Four clinics indicated they already had extensive contact points in the community. One clinic said more time was required to develop relationships with new organizations so they would be solid community contacts.

Finally, using the data on the prevalence of legal problems from the legal health check-up tool for planning was the lowest-priority objective. Three clinics indicated it was a high priority, four ranked it as a medium priority, one ranked it as low, and one said it was not a priority all. However, when asked about achievement, four said this objective had been completely or mostly been achieved, and four said it had partly been achieved. The clinic indicating this objective was not a priority at all also said it had not been achieved at all. One clinic commented on the clinic questionnaire that existing resources were too limited to use the data for planning and to support community-wide consultation. In the in-depth interview, one clinic indicated that was the main reason why it was interested in participating in the LHC Project.

One clinic provided narrative comments on the main difficulties encountered during the implementation of the project without reference to specific objectives. None of the clients referred through the LHC process presented at the crisis stage at this clinic. In the experience of this clinic, clients often forgot that they had completed a LHC form with the intermediary. Having forgotten or having only a vague memory of completing the LHC form, people tended to be suspicious of the follow-up call. Thus there was no trust established between the client and the clinic, and this was not mediated by the manner in which the LHC process unfolded with the intermediary group. Finally, and overall, it was very difficult to contact people who had requested a follow-up by clinic intake on the LHC form.

Table XII summarizes the rank ordering of the overall level of priority for objectives and the degree to which the objectives were achieved. The rank order of priorities based on a visual assessment is shown in the second column. The priority score calculated as described in footnote 40 are shown in the second column. Note that there is a lack of correspondence between the visual ranking and the scores for the last three objectives. The visual rank order of degree of achievement is shown in the fourth column, matched with the priority of objectives rather than ranked from one to six. An achievement score is shown in the fifth column, calculated as explained in footnote 40. The sixth column shows the gap between priority and achievement according to visual inspection. This is done by subtracting the level of priority expressed as the place in the rank order, number 1 for avoiding crises, from the place of avoid crises in the rank order of degree of achievement, number 4. The gap is −3.

Table XII: Rank Order of Priority and Degree of Achievement for Objectives

Objectives	Rank order of priority	Priority score	Correspond-ing rank of achievement	Achieve-ment score	Gap between rankings	Numerical gap between scores
Avoid crises	1	0.91	4	0.39	−3	−0.52
Identify unmet need	2	0.83	1	0.71	+1	−0.12
Provide holistic and integrated service	3	0.71	3	0.56	0	−0.15
Early intervention	4	0.63	6	0.37	−2	−0.26
Extend service to underserved groups	5	0.62	7	0.39	−2	−0.23
Provide service to more people	6	0.50	8	0.37	−2	−0.13
Establish more contact points in the community	7	0.62	5	0.40	+2	−0.22
Data for community-level planning	8	0.56	2	0.56	+6	0.0

All of the objectives have a degree of importance that should not be ignored. Referring back to Figure III, six objectives were identified as high priorities by between eight and five of the nine clinics responding to the clinic survey. These were avoiding crises, identifying need, holistic and integrated service, early intervention, extending service to under-served groups, and serving more people. Increasing points of contact in the community and using the problems data for planning and community consultation were identified as high priority objectives by four and three clinics, respectively. However, they are not insignificant in terms of the objectives clinics attached to the project.

Four objectives are deserving of attention because of the gap between the level of priority and the extent to which the objective was achieved. Ranking the overall level of priority of the objectives and comparing this with the rank order of the degree to which the objectives were achieved, avoiding crises for clients, providing early intervention, extending service to under-served groups, and providing service to more people are all higher in terms of priority than the degree to which they were achieved. For example, avoiding crises was ranked as a high priority by eight clinics. This places avoiding crises as the most important objective overall. However,

only four clinics said that objective had been completely or mostly achieved. In terms of achievement, this places avoiding crises in fourth place. The priority-versus-achievement gap is −3. Achievement is three places lower in terms of rank order than priority. Similarly, there is a priority versus achievement gap of −2 for early intervention, extending service to under-served groups and providing service to more people.

Focusing first on the number of people served, in the in-depth interviews a number of clinics expressed dissatisfaction with the small number of intakes relative to the number of LHC forms completed. Table VIII shows the attrition from forms completed to intake. In the comments concerning the difficulty encountered in achieving objectives, several clinics referred to lack of uptake, too few LHC forms completed, and not as many people completing the forma as expected. Two clinics commented that "more time was needed to develop relationships between intermediary groups and clinics" and "needed more time for relationship-building and educating intermediaries. It may be that the expectation, and thus the high priority placed on, serving more people was premature — perhaps a case of placing the cart before the horse. Relationship-building, building the pathways to legal help along the intermediary–clinic relationships seems clearly prior in time to a large flow of clients. How many clients that might be expected is certainly unknowable *a priori*. Building a triangle of trust between clinic, intermediary and people; developing a identity of purpose and shared goals between the clinic and each intermediary; developing an understanding on the part of the intermediary about how legal problems and everyday problems of life dealt with by that organization intersect, developing an understanding of the clientele, the barriers to accessibility they may experience and thus how the pathways to legal help will have to be constructed are all things that have to be learned in the relationship-building process. Data drawn from comparable projects is rare. However, the limited experience available based on empirical data suggests that the numbers of people served will increase with time and sustained effort.

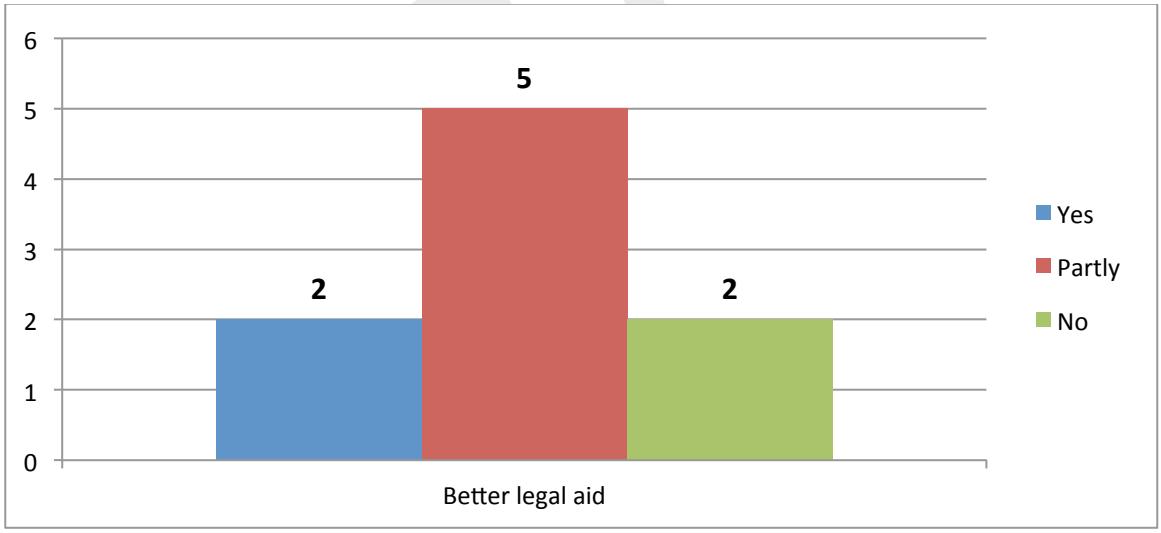
The relative lack of success in extending service to under-served groups indicates that to an even greater extent a very intensive process of building the clinic–intermediary relationships may be required. The prospective client populations were new, as were the intermediary organizations that would have formed the conduit to the clinic. Learning how to make the LHC process work given the nature of the individuals and of the organizations would have been especially critical.

The relative lack of success in achieving two related objectives, avoiding crises and early intervention, may be attributable to the nature of the client population. The clinics that commented on problems achieving these objectives said people tend not to come for assistance until a problem has come to the crisis stage. This may be typical of people whose lives are defined by scarcity experiencing more needs and problems than resources to deal with them.

Life is a common set of trade-offs, and dealing with problems in a preventative manner without help is a luxury people can rarely afford.[42] This is a pattern rooted in the lives of the poor, and expecting people to change without regard to the context of lives of poverty is probably unrealistic. Like the other objectives, avoiding crises and early intervention may be of necessity longer-term goals that involve building trust with individuals and building their basic legal capability. This requires a form of legal service in which lawyers and legal workers become involved in the complexity of people's lives, building trust with them over a period of time and increasing the extent to which they will "get in touch" when a problem is emerging. It is transformative for the legal service. For the individuals being helped, it is transformative because it attempts to change the basic patterns of their lives from reaction to prevention. For individuals this might occur over a span of time encompassing several visits to the clinic by an individual with encouragement from the clinic staff to come in for help or advice. The introduction of a tool to help identify problems is only the starting point of this process of relationship-building and establishing trust.

One the basis of this experience, seven of the eight clinics submitting a clinic questionnaire concluded that overall the intermediary–clinic LHC approach is a better way to deliver legal aid. The two clinics in which staff felt it was not a better approach to legal aid said the approach was too time-consuming.

Figure IV: LHC: A Better Approach to Legal Aid

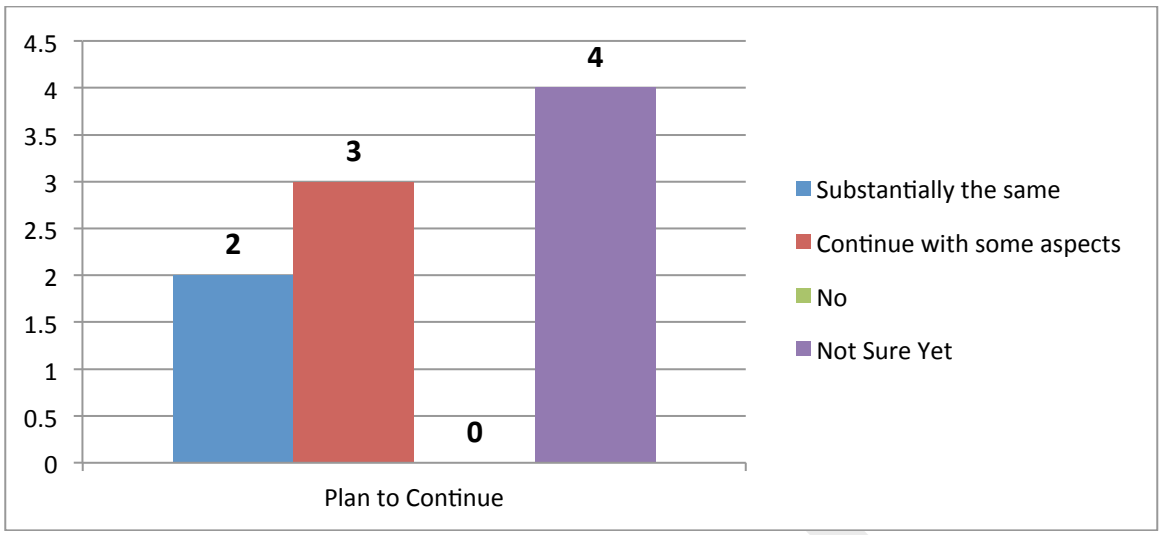


When asked about intentions to continue with this approach, integrating it into their established approach to service delivery, four clinics were unsure. Nonetheless, based on the

[42] *Scarcity: Why Having So Little Can Mean So Much,* op. cit.

pilot experience, five of the nine clinics indicated they would continue with this approach, substantially or in some aspects.

Figure V: Plan to Continue



Conclusions

Acknowledging the incomplete data and the fact that the 12 clinics have gone through only the initial phase of implementing the legal health check-up, it can be concluded that the initial experience is largely positive. During the first six months of the project, the clinics established 125 partnerships providing the basis for pathways to legal help in Southwestern Ontario. Ninety of these produced referrals with legal health check-up forms. The 90 intermediaries produced 1700 completed LHC forms. The 90 intermediaries that produced some forms identified an average of 18.9 people per intermediary with potential legal problems. Approximately 765 (45%) of the total of 1700 individuals who completed an LHC form requested contact from a clinic. This represents an average of 8.5 people per intermediary requesting service. Only six clinics provided intake data, so it is impossible to precisely calculate the average number of actual referrals per intermediary. Six clinics recorded 188 intakes. Extrapolating from the clinics that reported the number of intakes, an estimated 376 intakes might have been made to all clinics. Based on that number, each of the 90 intermediaries produced an estimated average of 4.2 intakes.

The cost to legal aid of this increase in access to justice was not great. Seven clinics reported that they spent only a few thousand dollars on printing and other operating costs. In addition, clinics expended some internal resources that were not measured. Two clinics spent approximately $30,000 for additional dedicated staff either to develop the LHC or to replace the designated LHC specialist. No attempt was made to record the resources expended by

intermediaries. However, it is clear that the intermediaries contribute considerable in-kind resources in terms of staff and other costs to the partnership arrangements. This is a major feature of the clinic–intermediary partnerships model, engaging the community and leveraging the considerable resources extant within service agencies and community organizations to extend the reach of legal aid and expand access to justice. It is a model that is fuelled less by money than by a commitment to common objectives among legal aid providers and community organizations. Those objectives in broad strokes are alleviating poverty, increasing social justice and expanding access to civil justice. The money and other resources expended by legal aid building the clinic–intermediary partnerships/legal health check-up model are probably more than matched by the resources contributed by the intermediary partners and, over time as the approach matures, would yield a handsome return in greater access to justice.

The clinics that provided data substantially achieved their priority objectives. During this early period, avoiding crises for people with legal problems, achieving early intervention, extending service to underserved groups and serving more people were the objectives for which the level of priority was not matched by the level of attainment. These are the objectives for which more effective strategies must be developed or the feasibility of objectives reconsidered. This is what one would expect in the initial phase of a project and represents progress in implementing a version of the LHC concept that meets the needs extant in their community, reflects the capacity of the clinic and represents the clinic's priorities.

The legal health check-up is viewed favourably overall among the intermediaries who chose to partner with legal clinics. All intermediary groups were positive about the main objectives of the legal health check-up. Most intermediaries that had participated in the project by producing at least some LHC forms indicated they wished to continue with the partnerships.

Clinics were about evenly split with respect to continuing with the check-up project. About half said they planned to continue with the project, either largely in its present form or with some changes. The remaining half were uncertain about continuing. None of the clinics that provided data had decided not to continue when the clinic questionnaire was completed.

Importantly, a significant proportion of LHC clients were positive about the service they had received. Many said it helped them identify problems and gave them voice in telling the service provider everything about their circumstances they wanted to reveal. The vast majority said they would definitely come back to the clinic with a problem in the future.

Another positive aspect about the LHC Project is the apparent diffusion of the LHC beyond partner intermediaries throughout the larger community. More than 200 people submitting LHC forms indicated they had been informed about the check-up by an organization or an individual other than one of the 125 partner intermediaries.

A problem frequently identified as an impediment to implementing the project was the basic LHC form or questionnaire, often cited by clinics and intermediaries as being too long or not addressing the immediate needs or problems of clients. A few clients said the form didn't address their immediate problems. Identifying hidden need in the form of unrecognized legal problems, problems for which people feel there is no legal solution or possibly nothing that can be done at all, is central to the legal health check-up. Clearly a shorter form would be beneficial. However, the legal health check-up is a process and the check-up questionnaire is a tool that is a part of the larger process. So long as the broader exploration of clients' problems occurs at some point, possibly at clinic intake, the nature and the role of the LHC form in the overall process is flexible. Some intermediaries at least occasionally make referrals without completing an LHC form.

Early on in the project some clinics expressed disappointment at the low number of clients served relative to the number of people identified with legal problems. A frequent concern was whether the level of effort implementing the project was worth the meagre output of clients served. It is important to recognize that the early phase in implementing this project is largely one of relationship-building. Relationship-building is labour intensive. Relationships take time to evolve. Some clinics arranged partnerships with relatively large numbers of intermediary groups within a short period of time. Most of the intermediary partners developed by clinics for purposes of the LHC were existing contacts that may have existed for years for other on-going purposes. This may have had the unanticipated effect of obscuring the particular aspects of the relationships required to make the legal health check-up work, perhaps uniquely with individual clinics. The clinic–intermediary partnerships are pathways to legal help that are built on the unique features of the intermediary involved in the relationship. These features can be structural in terms of the organization of the intermediary organization or the physical location of the intermediary group in relation to the clinic. They can be idiosyncratic with respect to particular people involved in either the clinic or the intermediary. In retrospect, it might have been more productive to have concentrated on developing relationships with a small number of intermediaries, allowing for more intensive collaborative working relationships to develop.

With respect to numbers of clients, it is probably premature to be too concerned about numbers of clients served. It can be expected that numbers of people served will increase over time as the project matures. It might be expected that success at early intervention and crisis management (if not avoidance) may improve as well.

There are good indications that the legal health check-up is a sound approach to more effectively meeting the legal needs of the broad legal aid clientele. There is a sufficient body of experience and lessons learned to rethink what has been accomplished and to move forward. The difficulties in establishing clinic–intermediary relationships and the barriers constraining

individuals from coming forward to ask for help are not the only obstacles to be overcome. Longstanding clinic approaches, conventional professional practice, embedded concepts defining the services that ought to be provided by legal aid lawyers and, further, how deeply lawyers should be become involved in the lives of clients are all issues that must be placed under scrutiny. What is most important is not to allow orthodoxy to stand in the way of creativity and innovation. It is too early to say that the legal health check-up involves too much effort for the return in better service. The initial phase of an experimental project always presents the opportunity for questioning basic assumptions and rethinking approaches.