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NORTHERN REGION TRANSFORMATION PROJECT

Revised Final Needs Assessment – October 2015

Social Planning Council of Sudbury
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ACKNOWLEDGEMENTS

The Social Planning Council of Sudbury (SPCS) would like to extend its appreciation to the members of the Northern Region Transformation Working Group: Trudy McCormick; Jo-Anne Boulding; Sally Colquhoun, Michael Shain and Terry Copes. As well, we would like to recognize the invaluable assistance as provided by Jim Arenburg (Project Manager) and Erinne Wreggitt (Project Assistant). The SPCS would also like to thank the staff of the eleven (11) Northern community legal clinics for providing numerous documents and reports to the project team as well as Legal Aid Ontario (LAO) for funding the project. In addition, the project team would not have been able to organize and conduct focus groups with clients, community partners and clinic board members without the assistance of clinic staff. Your efforts made our jobs much easier and for that we are very thankful! We would also like to thank all of the focus group participants, key informants and survey respondents -- whether they were clients, community stakeholders, clinic staff, board members, or Legal Aid Ontario staff -- for taking time out of their busy schedules to meaningfully participate in the research process. Without the active engagement of all of the aforementioned individuals/groups, the project team would not have been able to produce this comprehensive needs assessment.

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CLIENT SUBMISSION

A female client who was unable to attend a client focus group made a hand written submission instead. Permission to reproduce the submission, excluding the client's name to preserve her anonymity, was obtained and is included below in full. It is important to note that this particular client - with her high literacy rate, long career in various government jobs and associated pension - is unlike the vast majority of CLC clients across the north – many of whom cannot read or write and for whom a pension will never be part of their financial reality.

"Work History: Department of National Defence (clerical position); Ontario Ministry of Natural Resources; Nipissing Board of Education (Clerical); Industry, Trade & Tourism, Manitoba (Computer Programmer); City of Winnipeg (clerical position). I am presently 62 years old and have been on ODSP since 2000. I am appalled at the way I have been treated -- by people who had no knowledge of my government background. I chose to stay quiet about it and have documented everything they have done since day one. Since I used and revealed this knowledge to the (local) ODSP office, they don't like me very much.

When I first needed help from the legal clinic … I was very ill, unable to work and I had just relocated back to my home town and I did not have my medical diagnosis (it was another 7 years before I got my diagnosis of bi-polar disorder). I desperately needed an advocate and assistance with the process of applying for disability. My lawyer from the legal clinic supported me in my endeavours. I was on many different medication trials and suffered from short term memory loss. (My lawyer) was like a rock in the storm. She made sense of the jumbled mess that was my life at that time. She was the entire and only reason I was able to be successful (in my ODSP application). She protected me and advocated on my behalf while I made my health a priority.

I didn't know ….3 years later that I would again need protection and legal advice. I was even fortunate enough to get the same lawyer. Being given incorrect information necessitated my next calls to the clinic... I was told I had to reapply for my CPP-D -- and if they turned me down, then ODSP would have to look at my eligibility for provincial assistance (threat). My window of opportunity for applying for CPP-D had long passed. And to qualify I would have to be able to prove I was disabled back to when I first applied. When the CPP hearing came about, I was too ill to attend but by then (my ODSP application) had been granted. My lawyer (from) the legal clinic told me the requests from ODSP were unreasonable and if they persisted she would definitely (write) a letter for me.

I was able to sleep again. ODSP backed off and quit badgering me about it. More incorrect information came my way -- I was told I had to "cash in my pension" (when I transferred the paperwork from Manitoba, to a (local) bank). The pension money was earned in Manitoba and must be governed by Manitoba Provincial Pension legislation. Had I not known to question this, my whole pension would have been forfeited. "Protection of Retirement Income" overrides all other legislation. Once again, thank god for the legal clinic

We need the community legal clinic … and all the services currently being provided … and more services covering different situations if possible. (The) legal clinic needs to be able to expand and grow to keep up with the huge demand for services. It would really help if the legal clinic could include litigating to protect estates and inheritances. Sometimes, the "watch dog" organizations like Human Rights and the Ombudsman's Office are inadequate for timely interventions in the case of bullying or discrimination. A "letter from a lawyer" usually has better results re: stopping the abuse and getting their attention. I am firm in my belief that the legal clinic is a "necessity". It is vital, crucial to protect vulnerable people from situations where otherwise, they would have no recourse. There are many people like myself (who) are vulnerable. We need the legal clinic... I have a nephew who has Asperger's Syndrome and I have watched him be segregated, bullied, and persecuted all his life. (Some people) desperately need access to legal services, protection and advocacy. It is also very important that legal clinic services are available in "remote" areas. I live (in a rural area). My lawyer travels to (the clinic's satellite office) and I was able to meet her there. Legal clinics need "sub" offices in various small towns … Providing services to remote areas is essential and could be expanded over time to reach more people."

Submitted on May 2015

EXECUTIVE SUMMARY

Starting with the recommendations, this report is divided into five main sections. The first section outlines five key regional recommendations including objectives, success measures and actions for each which Northern community legal clinics can engage in immediately (i.e. short term) and those which are considered to have longer timeframes.

The first recommendation, “Action to Break Regional ODSP Burden” reflects one of the key findings of the needs assessment – namely that ODSP casework on average constitutes 43% of Northern Community Legal Clinics (NCLCs) time and speaks to the necessity of NCLCs to work together to restore their capacity to function as general service clinics in poverty law. The second “LAO Actions/Practice to Facilitate Transformation” outlines a series of recommendations NCLCs will bring to LAO in order to help them function more effectively as individual clinics and on a regional basis. The third, “Establish Stronger Community Development Presence” recommends enhancing community development capacity at the local and regional levels by securing funding to support eleven new full time positions dedicated to community development in addition to one new full time community development regional coordinator position.

The fourth recommendation, “Create and Introduce a Collaborative Community Clinic Practice Model” will allow for the sharing of local clinic expertise in different areas of law regionally in both client service and community development as well as introduce and measure results of inter-clinic collaboration on back-office and non-legal functions. The fifth and final recommendation, “Expand Peer Support Model in Clinic Practice” speaks to the importance of supporting the development of collective self advocacy through dedicating resources to peer support development and mobilization. Finally, all of these recommendations are prefaced by two main overarching recommendations: to preserve the independence and autonomy of each of the eleven CLCs as the best way to maintain cost effective service delivery and maximum reach across the north and to preserve one-to-one and in person contact with clients.

The introduction section, which follows the recommendations, provides a provincial context by which the reader can begin to understand the poverty law landscape. Included in this section is a discussion of social and economic trends as well as reference to those most marginalized by low income (i.e. First Nation/Aboriginal; social assistance recipients and working poor populations). The author introduces literature on rural populations, including some of the challenges faced by those providing services, as well as those receiving services. The author sets out the background and history of this most recent re-structuring process, including providing a historic context within which poverty law services are situated.

The third section of the report, Literature & Best Practice Review, delves into rural and remote communities, including socio-economic and demographic characteristics; providing rural services delivery case studies (generic and those most directly speaking to the experience of rural legal services in other jurisdictions; etc.). The Literature & Best Practice Review section also talks about service delivery models, particularly urban-based models which have been applied to rural settings, including speaking to issues and challenges. In addition, the author speaks to issues associated with 'isolation' as it is defined in reference to metropolitan impact zones (MIZ). Finally, the author provides a synthesis of the characteristics of effective service delivery models for rural areas.

Following the Literature & Best Practice Review section, the author outlines the comprehensive research methodology that was undertaken to produce this needs assessment. This includes statistical data collection/analysis, data limitations, stakeholder data collection/analysis; census data (i.e. National Household Survey); provincial tax-filer data; provincial Ontario Works and Ontario Disability Support Program data; and Human Resources and Social Development data (i.e. social risk index data).

The last section of the report speaks to Capacity and Gaps (both regionally and locally). Within this section, the author identifies key external pressure points; complex systems, legal services gaps, cross-sectoral challenges in terms of case management and outreach and challenges associated with clinic mandates relating to community development, public legal education, and advocacy. Under regional capacity and gaps, the process by which a client currently navigates the poverty law system (intake and the spectrum of services including advice, referrals, brief services, representation and case closure is outlined. Right after the 'how the work gets done' section, the author introduces a number of innovative practices that are currently taking place across one or more of the eleven northern community legal clinics.

Moving from a regional analysis of capacity and gaps, the author speaks to local capacity and gaps. In order to situate a discussion of local capacity and gaps, the research team decided to present a visual picture of the 'supply' and 'demand' side of the poverty law landscape and service delivery environment. Infographics have been developed for each community legal clinic, based on their 2015/16 LAO funding applications as well as on other relevant indicators. For example, on the 'demand side', the infographic includes: (1) CLC catchment area's total population; (2) its size in square kilometres as compared to the square kilometers of the Greater Toronto Area (GTA) ; (3) the percentage of "all low income families and non-family persons" as captured by tax-filer data compared to the Low Income Measure (LIM) (4) a list of communities within the clinic's jurisdiction who report medium to high social risk indexes and who potentially could be considered as requiring poverty law services. On the 'supply side', the infographic includes: (1) the CLC's main offices and any satellite, branch or sub-office locations; (2) the CLC's 2015/16 estimated budget; (3) the CLC's

staffing complement in full time equivalents (FTEs); and finally (4) an estimated calculation of dollars available per low-income person annually within the service catchment area.

At the present time, the ability of community legal clinics to meet the needs of low-income individuals varies depending on the clinic in question. However, as this needs assessment demonstrates - overall demand for services significantly outstrips the supply of services – despite the best and often innovative efforts of clinics to do so. As a region an estimated average of $90.00 per low income person is available per year (not per visit) to ensure access to justice. Although the total population served by NCLCs is only 827,006 – it is vital to understand this population lives across 594,881 square kilometers – the equivalent of 84 Greater Toronto Area's (GTAs). Travel time and dollars associated with serving clients spread out over long distances, many of whom live in communities without road access and require expensive air travel to reach services is not factored into any of Legal Aid Ontario's budget allocations for northern clinics.

Some of the other recurring findings of the report include current tensions as perceived between community legal clinics and their funder. It was often noted that clinic staff and boards are so bogged down in paperwork /administration and day-to-day casework demands that there is little time left for community development, public legal education or law reform. Many key informants referenced increasing reporting obligations and oversight by LAO in the context of limited resources.

In terms of casework, an average of 43% of cases opened across northern Ontario in 2012/'13 were related to ODSP with most likely a significant number related to appeals of refusals of ODSP disability benefits. Overwhelmingly, clinics, clients and stakeholders referenced frustrations navigating this system, which will only intensify as the review process comes into effect. Clients accessing legal services in the north are increasingly marginalized by poverty, mental health, housing and transportation issues.

It should be noted that frustrations tended to focus on external systems rather than community legal clinics per se. This was particularly evident in the client survey results insofar as the overwhelming majority of clients who were surveyed expressed tremendous satisfaction with the services they receive from community legal clinics, with few indicating they had to wait for service. As important, clients referenced community legal staff as highly compassionate and competent and the clinic as a 'safe' and reliable place to go in order to get help (this perception was also reinforced by community partners).

For the most part, clients appear to be navigating the CLC process without having to wait lengthy periods of time which is in stark contrast to client experiences with the various tribunals and quasi-

judicial processes. For example, many key informants spoke of the challenges of working within the ODSP system, expressing frustration in the number of denials which are often reversed upon appeal; the pressure on government caseworkers to respond to unrealistic time frames (i.e. updating information on client applications, etc.) particularly when many clients lack phone service, are highly transient, and/or have literacy issues. A common theme that permeated the discussion on government tribunals and processes was the fact that increasing complexity is resulting in the need for intensive client supports which is taking time away from other important aspects of clinic law. Clinic staff, community partners and clients alike were often quick to note the waste of resources and illogical nature of government policies and/or tribunal processes.

Community legal clinics taking a lead role in building the case for policy changes at the provincial level (i.e. across various tribunals) was a recurring theme, with many key informants noting that northern clinics could more effectively advocate if they had the resources to work collectively.

Gaps in Legal Services

Many key informants noted the changing landscape of poverty law services -- particularly after the ODSP legislation was introduced -- when some legal services were 'dropped' in some locations, notably Workplace Safety Insurance Board cases, Employment Insurance and housing matters related to repairs and maintenance. There was general consensus that issues relating to housing (applications, maintenance/repairs), employment insurance (EI), criminal injuries compensation (CICB) and worker's safety insurance board (WSIB) cases, consumer advocacy, health care (competency) and small claims court issues are pressing needs that the NCLCs are not adequately resourced to be able to address.

Though family law services are not within the mandate of community legal clinics, CLC's are most often the first point of contact for those with family law issues, particularly those CLC's serving First Nation populations where there is no LAO service and/or where there are few family lawyers. For non-native clients, recurring themes included limited to non-existent services and the prohibitive cost of private lawyers for those who don't qualify for LAO service certificates. Clinics report 'revolving door' clients, many of whom are paying high rents/utilities with little to no money left over at the end of the month for food (leaving clients with no choice but to access food banks and other emergency services). Single households (including female-led households) can't make ends meet, end up in arrears, eventually getting evicted. In debt and owing money to landlords, they cannot qualify for social housing and end up in emergency shelters. More and more of these types of clients are finding themselves at the doors of community legal clinics, presenting with complex non-legal issues that are often beyond the capacity of clinics to address.

In areas where there are higher proportions of seniors, CPP, consumer advocacy, power of attorney, wills and health care (competency, substitute decision-making) were all identified as gaps. An aging population base highlights the growing demand for information and assistance with POAs, wills and capacity assessments. Across many clinic catchment areas reference was made to the lack of specialized professionals (including lawyers) and/or the high costs of assessments, which pose significant barriers for low-income individuals and families.

In catchment areas with high Aboriginal populations, differences were noted in terms of human rights issues, court processes, and challenges associated with not being able to access a full range of services including linguistic and culturally-appropriate legal services. It was also noted that Aboriginal experiences with mainstream agencies and court systems leave them fearful of accessing services (the perception for some is that clinics are 'government agencies' which makes outreach to First Nation communities in certain areas of the north more important).

Case Management, Outreach & Cross-Sectoral Collaboration

The concerns identified regarding the capacity to effectively case manage clients across community legal clinics and to a lesser extent, with external partners focused on the limitations of current databases, including slow/outdated IT software which is resulting in 'workarounds' (i.e. clinic staff referenced having to use their own laptops citing issues with LAO equipment). Clinic staff repeatedly reported being 'bounced out' of programs daily or having programs freeze on them, resulting in duplicated and/or quadrupled time investments.

Spending so much time navigating their own IT systems means legal clinics have less time for clients, outreach and community development work, although most partners indicated clinic staff often go above and beyond the call of duty to carry out this component of their mandate. In this light, it was often recognized that for clinics to effectively address the multitude of issues that clients bring to the table, staff need to have a background in community development/advocacy which is considered unique to the clinic law system. Giving a 'voice' to individuals with lived-experience and collectively advocating for policy change was often referenced by stakeholders and community partners as critical as was engaging community partners across sectors to impact systemic change.

A number of key informants who were interviewed made reference to the importance of ongoing opportunities to connect with partners which takes time. Other attributes noted by key informants were building trust, which is often predicated on getting to know staff through their presence in community. All of these factors were noted as being critical to strengthening partnerships and more effectively meeting client needs.

Creating more opportunities to engage non-legal partners was considered essential although legal services were not exempt from this recommendation. It was often noted that community legal clinics and LAO services could be better integrated and aligned in order to address what are considered to be significant gaps in the broader legal services landscape. As well, succession planning cannot be divorced from discussions around legal service gaps as most community partners referenced sustainability issues and the potential ramifications of clinic closures on their clients (this theme permeated key informant interviews and focus group discussions). Most northern clinics report little if any succession planning strategies given the difficulties of attracting lawyers, CLW's/paralegals and other professionals to work in the poverty law sector in northern Ontario.

Issues with Data & Technology

The needs assessment uncovered two very different pictures of poverty in northern Ontario. First and foremost, the level of poverty as reflected in tax-filer data differs significantly from that which is reported in Statistics Canada's National Household Survey. It is important to note that the former is mandatory while the NHS is a voluntary survey. The discrepancy between tax-filer data and NHS data was an issue for community legal clinics especially those reporting significant First Nation populations within their catchment area. NHS consistently under-reported levels of poverty, sometimes by as much as 200% which has implications from a service planning perspective depending on what dataset is utilized in decisions around allocating resources.
In addition to reporting higher levels of poverty than what is captured through the NHS, northern Ontario's huge geography, limited to non-existent transit programs and it's dispersed population base presents significant barriers which are currently not factored into LAO decision-making processes (i.e. very low population densities as experienced in rural/remote regions of northern Ontario translates into higher transportation costs which clients and clinics alike must absorb). Unfortunately, although technology can play a role in reaching low-income individuals living in more isolated areas of the north, the results of client surveys conducted across the 11 community legal clinics suggest as many as 40% -- 60% of clients don't have access to the internet, with 80% -- 100% of clients indicating they NEVER use the internet for legal information/advice.

The other data issue that was uncovered relates to the accuracy of data collected (for example, a number of clinics reported significant discrepancies between their data and the LAO-produced statistical reports; "referrals" were also considered to be an issue insofar as CMT can only capture one referral per client, however, most clinics indicate multiple referrals which go unreported).

In addition, the research team uncovered issues as it pertains to "outreach" (i.e. outreach includes community development, community organizing, public legal education, law reform and advocacy -- all of which are used interchangeably). The lack of standard definitions is problematic when it comes to inputting, tracking and analyzing data.

Creating more user-friendly computer systems and software, including supporting increased capacity to address IT issues at the clinic level is recommended i.e. providing training to staff so that they can resolve issues in a timely manner without having to rely so much on central support. Piloting texting options as an additional way for clients to access legal services appears viable given the trend towards increasing cell phone usage (i.e. pay-as-you-go plan with free texting). NCLCs should consider incorporating texting options within their service delivery continuum. Texting can be very cost-effective for clients and clinics alike. This is not to suggest that face-to-face interventions should be done away with, rather, that piloting a project that uses texting -- particularly with younger clientele -- could identify whether this mode of communication has sufficient merit to potentially expand to include more clinics (as appropriate).

Transforming Services

Clients, clinics and funders alike will benefit the most from a staged transformative process that supports clinics in immediately redirecting, as much as possible, current community development resources to dealing both locally and collectively with systemic issues interfering with their ability to provide the full gamut of services they are mandated to provide. Due in large part to systemic issues related to provincial policies, a steady increase in ODSP casework as well as the increasingly complex non legal issues clients are facing, clinic boards have found themselves having to decide between putting resources towards trying to meet the growing demand for client representation, advice and brief services or towards addressing the systemic issues driving the increase in demand for services. Understandably the majority have slowly pulled resources away from community development, law reform and public legal education to try and attend to these other more pressing demands. This “prioritization” of services however is not sustainable and is contributing (along with a host of other factors) to the weakening of one of the few remaining systems in Ontario that has the capacity – albeit currently under resourced – to address these complex systemic issues.

RECOMMENDATIONS - REGIONAL

Overarching Recommendations:

1. All Northern Community Legal Clinics (NCLC's) continue as independent and separate organizations within their current catchment areas and governed by independently elected volunteer boards of directors as the best way to maintain cost-effective service delivery and maximum reach across vast geographies and unique communities.
2. Preserve one-to-one and in person client interactions with NCLC staff.

A. Action to Break Regional ODSP Burden Immediate (June 2015) to Long Term (Mid-2018)

Important Note: The exact nature of ODSP casework across the 11 Northern Community Legal Clinics at this time is unknown. Appeals of refusal of ODSP disability benefits are suspected to be a significant part of this burden and therefore will probably be the focus of this recommendation.

Objectives:

a) Reduce the commitment of time and resources as a region to ODSP casework through the coordination of system wide advocacy and local organizing as appropriate.
b) Simplify the process in order for successful first time ODSP applications.

Success measure:

a) A sufficient reduction in ODSP caseload as a region.

A1. As much as possible, NCLCs direct their current community development resources as soon as possible to strategically focus on ODSP disability appeals advocacy – organizing both locally, regionally and provincially to address this systemic issue.

A2. NCLC's begin, as much as they are able individually, to develop short term strategic ODSP disability appeals advocacy plans with measurable indicators that include but are not limited to the following:

Immediate actions:

A3. Establish kits for CLCs, doctors and clients to properly fill out ODSP applications

A4. Educate the people who are doing medical reports on how to fill them out properly

A5. Utilize DAU staff to take a second look prior to hearing to prevent unnecessary hearings

A6. Argue at tribunal level for no review date if appropriate.

Short term actions:

A7. Get a better sense of the number of ODSP applications that are initially denied and then successfully appealed and the reasons why.

A8. Include non-legal crisis response agencies impacted by current ODSP polices/practices to address systemic ODSP issue

A9. NCLCs share with each other any helpful practices they are using to reduce ODSP caseloads.

A10. Community development education and training for all NCLC Boards to help NCLCs work toward greater emphasis on the community development component of their mandate.

A11. NCLCs work on hospitals standardizing their fees for hospital records

A12. Connect community development resources with on-going provincial resource groups and committees i.e. OPICCO, Steering Committee on Social Assistance, CRO etc.)

A13. Expand the ODSP Action Coalition into the North

A14. Educate DSSAB and social services about psych reports

A15. Encourage OW to have dedicated support person for ODSP applicants

A16. Train doctors/nurse practitioners to complete reports

B. LAO Actions / Practice to Facilitate Transformation Immediate (June 2015) to Short term (by March 31st 2016)

Objectives:

a) Develop standard practices for data collection and use

b) Provide funding and training support to NRTP implementation

c) Reduce administrative demands on local/regional clinic system

Success measures:

a) Consistent, comparable statistics across clinics

b) Reduction in time and resources for administrative activity

B1. It is recommended that NCLC's collectively make the following recommendations to their funder.

***** Recommendations #B2 to **#**B13 are relevant to LAO and ACLCO's current discussions about the allocation of new funds and therefore need to be made immediately. **Reduce Administrative Demands**

B2. Funding decisions impacting NCLCs be based on provincial tax-filer data (rather than census data which tends to be less accurate).

B3. LAO move to a three year funding cycle for clinics with funding applications due every third year

B4. LAO allow clinics to retain surplus funds to reinvest in clinic services locally and regionally.

B5. LAO turn over office leasing power to NCLCs with adequate resources.

B6. Pilot Projects (like the French Legal Advice Line Pilot) are an excellent way to test new programs however after a reasonable period of time (no more than three years) a decision must be made by LAO that if the initiative is to be made permanent, the associated staff position(s) also be made permanent to assist NCLCs in recruiting and retaining staff.

Statistics and Reporting

B7. LAO work closely with NCLC's to develop standard practices for capturing, inputting and reporting on data paying special attention to the following;

a) Separate out the statistics collected from satellite/ branch/sub offices from main offices to have a more complete picture of clinic outreach capacity and needs by community serviced.
b) Revisit the way in which "referrals" are captured. Currently referrals are only captured once whereas it is common practice for clinics to make multiple referrals over time with clients.
c) Revisit the way in which "outreach" is captured. "Outreach" currently is a category that includes community development, organizing, public legal education (PLE), law reform and advocacy. These aforementioned activities need to be broken out collected separately with standard definitions attached.
d) Finally, standard definitions concerning General Administration and Administrative Duties is needed.

Northern Considerations

B8. LAO include additional funding for transportation costs given northern Ontario's huge geography and dispersed and isolated population base.
B9. LAO restore and expand all language bonuses.
B10. LAO provide a housing and northern cost of living bonus for NCLCs operating in remote areas where housing is more expensive and/or not available.
B11. LAO pursue opportunities with local colleges, to offer paralegal training, including advocating for examinations in northern locales. This will assist in the recruitment and retention of community legal workers in northern legal clinics and enhance the opportunities available for them to become certified as paralegals.
B12. LAO provide one articling student for each NCLC in place of lottery system.
B13. LAO include funding to NCLCs for all non-salary associated costs associated with articling students.

Short term:

B14. LAO place Duty counsel services in NCLCs to better meet needs of shared clients allocating additional funds to NCLCs where needed to cover additional costs associated with this arrangement where appropriate.
B15. LAO ensure IT support to allow for intra-clinic and client communication.

C. Establish Stronger Community Development Presence Intermediate (March 31st 2016 –April 1st 2017)

Objectives:

a) Enhance the CD capacity at the local clinic level

b) Develop northern region CD capacity

c) Develop a coordinated local-regional CD strategy and plan for 2016-17

Success Measures:

a) Local budgets/staff time (allocated to CD) rise from 5%-10% to 15%-20% by 2016-17 fiscal year.
b) Two to three year NCLC Regional CD Strategy plan and compatible 11 local clinic CD strategies by Fall 2016.

As LAO increases opportunities for clinics to apply for funding available for "systemic advocacy" and to "support clinics working together to expand client services at the local, regional or provincial level" NCLCs apply for this funding to build upon the immediate recommendations outlined above in the following ways:

C1. Enhance community development capacity in each CLC catchment area by 1 Full Time Equivalent (FTE) position.

C2. Develop northern regional community development capacity by 1 FTE community development coordinator position who would:

1. Coordinate the ODSP advocacy (short term and longer terms plans) work with a primary focus on particular northern and regional issues and challenges.

C3. Update and expand current catalogue of funders to be shared with all NCLCs and their partners via CLEO-Net to expand access to alternate and matching funding sources.

Initial steps for implementation:

1. Build consensus among clinic boards to support community development priorities.

2. Create group to oversee work and work on this funding proposal.

3. Apply to LAO for joint funding for regional coordinator position

4. Create a template for clinics to use to apply for community development position at each clinic.

D. Create and Introduce a Collaborative Community Clinic Practice Model Immediate (June 2015) to Intermediate (March 2017)

Objectives:

a) Sustain proactive regional strategizing and planning arising from the NRTP.

b) Share local clinic expertise in different areas of law regionally in both client service and CD

c) Introduce and measure results of inter-clinic collaboration on back-office and non-legal functions.

d) Enhance both outreach and client service through building and mobilizing a network of "trusted intermediaries".

Success measures:

a) Clinics show increase in their local numbers served in different areas of law compared to 2010-2015 period.

b) More diversified source of referrals from 2015 in 2-5 yrs.

c) Cost-savings arising from shared administrative functions.

Immediate

D1. NCLC investigate the feasibility of sharing back office functions among more than one clinic with one clinic for example, being responsible for specific functions for the whole region or a cluster of clinics. Functions to be investigated include bookkeeping, payroll, major purchases/leases, phone systems, HR support and yearly audits and management practices.

D2. NCLCs examine tech support needed for collaborative practice i.e. sharing of case files and facilitating communication and collaboration between clinics and how to make better use of current resources.

D3. For joint planning purposes NCLCs develop ability to share NCLC statistics regionally.

D4. NCLCs pursue enhanced funding resources to support the coordination of the Northern Regional Training which is currently done by staff at the training host clinics.

D5. Examine options for a floater lawyer who can fill in for leaves, illness, extended vacation or litigation support.

D6. Recognizing the number of clients who rely on cell phone (pay-as-you-go plan with free texting options) explore the use of text communication as an additional way clients can communicate with NCLCs taking into consideration all client confidentiality and other security issues.

D7. NCLCs research collaborative community practice models.

D8. Develop a collaborative practice model where individual NCLCs who have expertise in specific areas of law provide legal services to other NCLCs who don't have that expertise but where there is a need. Manitoulin CLC and Lake Country CLC are already providing these services in the areas of WSIB and CICB respectively. This model would require hiring one FTE lawyer per area of law/clinic who would travel as needed. Employment Law and Seniors Law are two other areas of legal expertise in the north to be explored in this model.

E. Expand Peer Support Model in Clinic Practice Longer -Term (2-5 yrs.)

Objectives:

a. Define peer support model in terms of support for client legal service and supporting the development of collective self-advocacy

b. Dedicate resources to peer support development and mobilization (e.g. training and education)

c. Incorporate Peer Support into networks of non-legal agencies/organizations (trusted partners) who potential community legal clinic clients have contact with.

d. Support development of and maintain strong working relationship with mental health courts as a key component of a community support network for low income people.

Success measures:

a) Resource network of former clients (names/contact info.) to draw on for peer support.

b) Formation of new local self-advocacy groups

c) Cross-community connections of local self-advocacy groups resulting from coordinated clinic CD planning and training /education program

E1. Expand regional community development efforts to include other pressing systemic issues (like advocating for Affordable Housing, Injured Workers) as they relate to areas of clinic case work where demand can't be met. Of interest is Lake Country CLC's work with local bylaw offices to deal with landlord maintenance and repair issues.

E2. Continue efforts to provide culturally-appropriate programming/materials, hire FN case workers/ lawyers and recruit FN board members particularly in catchment areas with FN populations i.e. Algoma CLC, Elliot Lake and Northshore CLC, Kinna-aweya Legal Clinic, Northwest CLC, Sudbury CLC, Keewaytinok NLS and Clinique juridique Grand-Nord Clinic.

E3. NCLCs build strong partnerships with agencies/ organizations and groups who are working with marginalized clients to provide services to potential CLC clients where these potential clients feel most comfortable.

E4. Expand on Peer Support Model that is already in place in some NCLCs i.e. Injured Workers Group, Lake Country CLCs PROMPT group - whereby clients who are experiencing the same issues can be assisted by community members and/or alumni with their non-legal needs. Peer Support needs to be funded. Invite peer support group representatives to NRT to do training.

E5. More effectively work across the legal services landscape in northern Ontario by exploring opportunities to work together with NCLCS and other legal sharing information providers (Keewaytinok Native Legal Services and Clinique juridique Grand-Nord Clinic have expertise in this area).

E6. NCLC boards explore ways to make it easier to share clients cross-jurisdictionally (i.e. service agreements).

E7. It is recommended NCLCs develop (with guidance from LAO) a succession plan (retirements as well as sick leaves etc.) first for the north (individually and collectively) with measurable actions and timelines (articling students/LLPs).

E8. That NCLCs co-operate with Lakehead University Law School's Integrated Practice Program by taking on placement students on a regular basis.

E9. Collectively explore how to improve and enhance social media capacity.

RECOMMENDATIONS – LOCAL

For all NCLC's local recommendations concerning satellite offices, enhancing case work to include housing issues beyond evictions, WSIB, EI, CIBC etc. are to be considered **only** as additional resources become available and are secured and/or outcomes are achieved i.e. ODSP appeals reduced. The following recommendations are specific to the following NCLCs.

Algoma Community Legal Clinic

1. Consider revisiting satellite office location based on high SRI numbers for Dubreuilville, Garden River and Bruce Mines (Constance Lake FN also reports High SRI score) as resources become available.
2. It is recommended Algoma Board of Directors increase staff wellness supports.

Clinique juridique Grand-Nord Legal Clinic

1. Hearst and Cochrane report a SRI of 6 so providing a permanent satellite office in these locations is advisable as additional resources become available.

Elliot Lake and Northshore Community Legal Clinic

1. Board consider satellite presence in Blind River and Thessalon given their high SRI's (6-7) and to do outreach to First Nation communities located along the North Shore as additional resources become available.
2. Increase outreach efforts to low income populations residing in Elliot Lake (including but not limited to seniors).
3. Continue emphasis on consumer protection program (CAPP) and close working relationship with the Senior's Office is recommended. In addition, the clinic will be increasingly called on to field requests for assistance in the area of wills/estates, POA's and Health Care (i.e. competency assessments).

Keewaytinok Native Legal Clinic

1. Moosonee – the town in which Keewaytinok Native Legal Clinics is located - reports one of the highest SRI's (8) so it is expected demand for clinic services are expected to increase. If additional resources become available service in the Moose Factory satellite office should be

increased to full time from part-time as is increased outreach to the communities along the James Bay coast.

Kinna-aweya Legal Clinic

1. There are communities within the catchment area (many for whom statistical information is not available) who the clinic is already serving on a limited basis and who would benefit from additional services as resources become available i.e. Red Rock.

Lake Country Community Legal Clinic

1. The Town of Parry Sound reports a high SRI (8) so it is expected demand for clinic services will only increase. Emphasis should be placed on expanding to a full time satellite service in the town of Parry Sound as resources become available.

Manitoulin Community Legal Clinic

1. Aundeck-Omni-Kaning (AOK) and Wikwemikong both report high SRI (6), which means the clinic's main location (in the community of AOK) is appropriate. Outreach to Wikwemikong FN – as additional resources become available and only at the invitation of the FN - is recommended given its high social risk rating.
2. Extended clinic hours and physical accessible accommodations are recommended as additional resources become available.

Nipissing Community Legal Clinic

1. Continued efforts to provide outreach to low income populations in Mattawa (SRI 8) and West Nipissing District (5) is critical given their high SRI numbers as additional resources become available. North Bay also reported an SRI of 8 which is expected to lead to more demand for poverty law services well into the future.
2. Recommend Nipissing Board of Directors increase staff wellness supports.

Northwest Community Legal Clinic

1. Continued efforts to provide outreach to low income populations in Kenora given its high SRI (6) and other areas within the NWCLC catchment area reporting high social risk include Seine River and Manitou Rapids (6) as additional resources become available.

Sudbury Community Legal Clinic

1. Continue to provide services to low income populations in Greater Sudbury as well as expand outreach to Atikameksheng Anishnawbek (Whitefish Lake FN) (SRI 5) as additional resources become available.

Timmins-Temiskaming Community Legal Clinic

1. Continued efforts to provide services to low income populations in Kirkland Lake (SRI 6) and Latchford (SRI 5) is advised as additional resources become available.

INTRODUCTION

The Northern Region Transformation Project (NRTP) represents a commitment on the part of Northern Community Legal Clinics and Legal Aid Ontario (LAO) to enhance service capacity and pursue transformative action in the context of poverty law services. With a transformative agenda in mind, LAO requested its 76 community legal clinics -- including 11 clinics which provide services to low-income residents across northern Ontario -- to engage in a comprehensive needs assessment in order to inform next steps. In response to this request, The Northern Regional Transformation Project report provides a thorough analysis of the issues, challenges, existing capacity, and collaborative initiatives (with legal and non-legal partners) that currently reflects the poverty law landscape in northern Ontario.

The following section of the report provides the context within which poverty law services are situated, including a summary of socio-economic trends and in particular, the unique context in which northern community legal clinics find themselves. This section of the report also summarizes the current literature on rural poverty, addressing some of the issues in conceptualizing and reporting on the experience of individuals residing in rural and remote regions of Northern Ontario. Following this demographic summary, the introduction moves into the evolution of poverty law services in Ontario, highlighting the differences between community legal clinics and other legal aid service delivery methods. Legal Aid Ontario's re-structuring process is discussed in greater detail vis-à-vis three specific discussion papers which lay the groundwork for the comprehensive needs assessment and systems evaluation that is currently taking place.

Provincial Context

The legal and social context within which Legal Aid Ontario's re-structuring process taking place is defined by a number of key trends. The first of which is a provincial policy framework which

emphasizes 'doing more with less' (Hennessey & Stanford; 2013). Five years after the latest global recession, the provincial economy continues to lag along with the entrenchment of an austerity agenda vis-a-vs the Drummond Report which was released in January 2012. In an attempt to avoid what was considered to be an unmanageable deficit, the Drummond Report recommended the implementation of an austerity agenda with cuts to services and public sector funding (Hennessey & Stanford; 2013). The 2012 provincial budget cuts included cuts to Northern Ontario in the vicinity of $100 million dollars (The Report of The Ontario Common Front, Aug. 2012).

Rather than assisting in economic recovery, the focus on austerity has had serious unintended impacts which continue to be felt across both economic and social systems. Most particularly, the employment rate as of 2012 was 61%, down 2.5% from 63.5 in 2008 (Hennessey & Stanford; 2013). This represents a deficit of approximately 250,000 jobs, largely lost from the manufacturing and forestry/logging sector (the latter of which has particular relevance for the Northern economy). Alternately, what little job growth that has happened since 2009 has occurred within Ontario's sales and services sector, characterized as precarious, short-term, part-time and low paying.

A recent report indicates that between 2003 and 2011, the share of adult employees at minimum wage more than doubled, with single-parent families particularly hard hit -- a single parent with one child, working full time/full year for minimum wage earned less than the low income measure (after tax) threshold (even with benefits and transfers included) (Campaign 2000; 2013).

It is increasingly clear that poverty is becoming entrenched as reflected in a growing working poor population. As of October 2012, 1 in 5 unemployed Ontarians were receiving regular EI benefits, leaving the remainder turning to social assistance programs for relief (Hennessey & Stafford; 2013). In the past two decades, the number of individuals and particularly women who would qualify under the revised EI eligibility requirements has decreased significantly. Combined with the fact that women make up the majority of single parent families, this trend is concerning.

"In 2013, children (were) the single largest group accessing food banks in the province, comprising 35% of food bank users in Ontario." (Campaign 2000; 2013: p. 9). As reflected in most recent statistics on food bank usage, youth and seniors have also been hard-hit by the recent recession and austerity agenda. For example, youth report unemployment rates approaching 17%, while seniors are re-entering the labour force in record numbers, effectively filling entry-level positions traditionally held by youth (Hennessey & Stafford; 2013; Campaign 2001; 2013). Combined with sharply rising tuition fees and unprecedented student debt, youth entering today's labour force are at a distinct disadvantage. For those youth already at risk of falling through the cracks -- for example, youth aging out of the provincial child welfare system -- unemployment/underemployment rates are particularly high (Campaign 2000; 2013).

Understanding the impact of poverty as it relates to those who are most excluded from society speaks to the experience of First Nation and Aboriginal populations, as well as those individuals on social assistance. It is also important to note the impact of living in rural and remote settings, impacts which extend beyond mere income levels to encompass challenges associated with access to basic services. Notwithstanding the fact that First Nation communities in the north tend to be more 'isolated' than non-native communities, there are a number of northern census sub-divisions that are categorized as 'isolated', which speaks to the importance of factoring in distance/geography and remoteness in funding formulas. The next section of the report speaks to some of these issues, starting with the experience of First Nations and Aboriginal communities as it pertains to poverty and social exclusion.

Poverty and Aboriginal Communities

An Early Years report (2008) indicates that the poverty rate for Aboriginal children is double that of other Canadian children, with 1 in 4 children who live in First Nation communities living in poverty (Clark; 2008). Poverty within Aboriginal families can't be analyzed without reference to the impact of residential schooling and government policies relating to assimilation. Operating from 1849 to 1996, residential schools removed Aboriginal children from their homes, keeping them in institutions well into their teenage years. Children grew up without parental role models as is reflected in the results of a study done by the Chiefs of Ontario in which First Nations adults for whom the experience of their parents' and grandparents' attendance at residential schools in turn, was seen as negatively affecting the parenting they received as children (Best Start; 2012).

In addition to experiencing higher rates of poverty, on-reserve Aboriginals are significantly more likely to live in sub-standard housing, 22% compared to 2.5% of non-Aboriginal households. Poor housing leads to many health-related issues (physical and mental) and is one risk factor that has been identified as resulting in the high number of First Nations children having to go into care (Best Start; 2012). Aboriginal people are nine times more likely to end up in the criminal justice system, including Aboriginal women, whose children face higher risk for poverty and involvement in child protective services (Best Start; 2012).

As recently as 2010, on-reserve Aboriginal households were reporting median incomes slightly over $11,000, more than $6,000 less than their off-reserve Aboriginal household counterparts. Exacerbating the situation, in 2006, 38% of Aboriginal people in Ontario did not have a certificate, diploma or degree (Best Start; 2012).

Culturally-Appropriate Services

By virtue of its very significant First Nation population (across the north) and pockets of French speaking residents (Northeastern Ontario), the planning of services needs to incorporate linguistic as well as cultural differences. By far, Aboriginal individuals experience much higher levels of poverty as well as challenges in terms of being able to access culturally-appropriate services, although recent reports identify Francophone residents as reporting higher levels of poverty than English-speaking individuals living in Northeastern Ontario (Ontario Trillium Foundation, 2009). Whether they self identify as Aboriginal or Francophone, being able to access culturally-appropriate services is an issue, particularly for those residing in small, rural and remote communities of the north. As already mentioned, Francophone individuals residing in Northeastern Ontario tend to experience higher poverty levels than their English-speaking counterparts. However, combined neither report low income levels as significant as First Nation individuals (particularly those living on-reserve).

When thinking about poverty and social exclusion, it is important to note that certain marginalized populations experience significant and different needs that must be carefully considered in planning and implementing effective and culturally-safe services. Cultural safety is an evolving concept within the literature although its value is increasingly being recognized, most noticeably in the field of health, children's services, mental health, homelessness and corrections. A recent report on cultural safety as it pertains to Aboriginal homeless populations noted the following key characteristics of a culturally safe service:

- Respect and Trust;
- Awareness and Understanding of Aboriginal People;
- Non-judgemental;
- Access to Elders and Aboriginal Cultural Supports;
- Equality of Access to Services and Inclusion; and finally,
- Consistency of Services and Staff (Bird et. al, 2013)

For Aboriginal communities living and residing in Northern Ontario, the concept of culturally-safe programming is built around the following key elements: (1) being able to build a coordinated and integrated network of support programs for First Nations individuals/families accessing services; (2) utilizing a flexible approach that is tailored to specific cultural and social beliefs, including priorities as identified by First Nations clients; (3) employing Aboriginal workers who speak the language and understand cultural terms; and finally, (4) sensitivity to the impacts of severe funding issues as they pertain to First Nations populations living on reserve (Best Start; 2012). Emphasis

is placed on developing strong partnerships between Aboriginal and non-Aboriginal service providers -- including cross-cultural activities -- in an effort to increase awareness, shared understanding and an appreciation of the teachings, supports and strengths of First Nations communities (Best Start; 2012).

Social Assistance Recipients and Working Poor Populations

There is clear evidence that Ontario's working poor [3] population is burgeoning thanks to the proliferation of precarious, low paying jobs (with no pension or benefits). Alternately, pressures to reduce social and health care spending have had dire implications, particularly as they pertain to those with mental health and addictions issues (and those with other disabilities), individuals at risk of homelessness, social assistance recipients, unemployed workers not eligible for employment insurance, and certain racial groups (Aboriginals and Immigrants/Refugees). Many of the aforementioned individuals find themselves accessing the services of community legal clinics, who are as likely to refer these clients to other agencies citing mandate restrictions and/or human resource limitations.

Combined with more recent tightened employment insurance eligibility requirements, and cuts to social assistance in 1996, both systems have "failed to protect displaced Ontarians from the painful effects of the recession" (Hennessey & Stafford; 2013: p. 18). Furthermore, inflation has served to reduce the actual income of individuals or families receiving benefits -- which are already considered far below any measure of poverty or standard of adequacy (Campaign 2000; 2013). In 2011, four out of ten children living in low-income came from families where the breadwinner worked full time, full year (Campaign 2000; 2013).

The most recent setback to the working poor and social assistance recipients came in the form of funding cuts to the Community Start Up and Maintenance Benefit (CSUMB), "which provides a vital backstop to low-income families who encounter unexpected housing-related costs (including relocation costs); without this benefit, many of these families would face a significant risk of homelessness (with all its resulting personal, social and fiscal costs)" (Hennessey & Stafford; 2013: p. 28). The impacts of a substantially reduced emergency fund is reflected in the experience of one particular municipality (Kenora), where there was a 34% increase in evictions due to arrears. For twenty-one of these households, evictions were caused by the denial of access to discretionary or emergency housing benefits (i.e. CSUMB monies) (Campaign 2000; 2013).

Rural Poverty

Being able to assess the adequacy of poverty law services is contingent upon understanding the landscape (i.e. socio-economic; geographic; linguistic; cultural; etc.) as it pertains to current needs and expected demands. In general, "rural areas are sparsely populated areas outside of large urban centres that have defined social, economic and cultural traditions associated with their region or community" (Woods in Slaunwhite, 2009). A recent report produced by the Rural Ontario Institute analyzed Ontario census-subdivisions based on settlement size and degree of isolation. According to this report, most of Northern Ontario is considered to be isolated, including communities such as Dryden, Hearst, Kenora, Kirkland Lake, North Bay, Sault Ste. Marie, Timmins and Wawa. Over and above the reality of having to travel farther for services, applying an urban-based service delivery model -- designed to realize economic efficiencies and savings -- to rural settings fails to account for broader socio-economic impacts including but not limited to generally weaker economies; the north's reliance on resource extraction, recent job losses as well as losses associated with social capital and community cohesion (CMHA, 2009; Anderson, 2006; O'Leary, 2008).

Provincially, a recent report points to a number of challenges as it pertains to understanding the realities of working poor populations in rural areas. In addition to researchers creating their own definition of who should be captured by the term 'working poor', other challenges noted within the literature include the fact that more than 1 in 4 rural working poor individuals report not having access to a vehicle which negatively impacts on their ability to access services and/or obtain employment (Liau, 2006). This despite the fact that most definitions of rural poverty fail to take transportation issues into account.

Research to date suggests that living in a rural area "increases one's odds of living in poverty" (Liau; 2006: p. 4). As one theory of rural poverty, geographic disparities related to distance from market and dis-economies of scale produce weak economies characterized by few employment opportunities which results in the out-migration of working age individuals. When primary industries downsize (as has been the case in most rural regions of the province, including northern Ontario), the combined remoteness and resulting out-migration of youth in search of jobs, de-stabilize local economies further. In order to remain competitive, employers in rural regions are more likely to offer 'casual' work' (part-time and temporary employment) which results in lower wages and a lack of job security (Liau; 2006).

Not only are rural communities challenged to diversify their economies, research to date suggests that one out of two rural working poor live in unaffordable housing, spending more than 30% of their total income on housing. A 2009 Canadian Mortgage and Housing report identified youth,

single parents, the elderly and low-income families as facing significant challenges in terms of obtaining affordable housing in rural communities (Slaunwhite; Dec. 2009). All of these factors need to be considered in any attempt to re-configure service delivery mechanisms, particularly those relating to the provision of poverty law services in Northern Ontario.

BACKGROUND & HISTORY

Up until the mid-1960's individuals on limited incomes residing in Ontario who required legal services were dependent upon a pro bono system (i.e. lawyers taking cases for no fee), which failed to address broader issues of access and social justice. Beginning in the 1960's, the 'judicare program' enabled eligible low-income individuals to access legal 'certificates', effectively reimbursing private lawyers for their work (McMurtry, 2007). The 'judicare program' was based on the notion that "the best way of assisting the poor was to treat them exactly in the same way as one would treat those with funds" (McMurtry, 2007: p. 1).

It was recognized that more needed to be done to level the playing field as poor people differed significantly from their more affluent counterparts in terms of the need for legal services. There was recognition that poor people experienced discrimination and exclusion in areas relating to welfare/social assistance; tenancy and basic employment rights ... not typically the experience of richer clientele. In sharp contrast to their more affluent counterparts, poor people rarely saw themselves as having legal rights; furthermore, their circumstances required attention to the systems in which they were mired (McMurtry; 2007).

Within this framework the argument put forward was that "poor people and communities, traditionally disenfranchised on many levels, (need to) be involved in fashioning the responses to their legal problems, in a way that (is) not possible in the traditional one lawyer -- one client model" (McMurtry; 2007: p. 2). This view paralleled the social justice movement taking place in the 1960's, the end result being the "provision of legal services on the part of community agencies serving low-income individuals and groups, outside of the established legal aid scheme" (McMurtry; 2007: p. 2). By the mid 1970's a mix of delivery systems for legal services, including a fully staffed neighbourhood legal aid clinic model was implemented. Community agencies already providing some of these services to their low-income clientele were given funding to support their efforts, leading to an expanded community legal clinic system which continues to operate to this day.

A distinguishing feature of community legal clinics lies in its governance model (i.e. independently elected volunteer board of directors). The ability of community legal clinics to respond to client/community needs is an important by-product of a local governance structure. By identifying areas of greatest need, each community is able to "get the poverty law services that are most

critical to it, and at the time that they are needed" (McMurtry; 2007: p. 5). This independence from government is crucial considering the majority of poverty law issues directly relate to provincial policy and programming (for example, social assistance; social housing; etc.) (McMurtry; 2007).

By responding to the poverty law needs of its low-income population, Ontario and in particular, community legal clinics have "been instrumental in actually preserving the (legal aid) service in (Ontario). In other jurisdictions, where legal aid offices provide criminal and family law services, poverty law is either ignored or neglected (McMurtry, 2007).

The other major difference between community legal clinics and all other legal aid resources concerns the range of services provided. For example, while all other legal aid resources "are focussed on individual casework representation, clinic practice is far more varied, and includes: case files; referrals; legal advice/brief services; law reform files; community development files, and; public legal education materials "(McMurtry; 2007: p. 9).

The diverse nature of clinic work requires not only lawyers and those trained in legal administration, there is also need for community developers, community legal workers intake workers, policy analysts, social workers, etc. The balancing act required by community legal clinics to ensure attention to community needs requires clinic staff balance the demands of casework with broader community development and advocacy work. "It can be very tempting to allow casework pressures to overwhelm the other proactive and system forms of legal service ... but this would be an abdication of its mandate and underlying 'raison d'etre' (McMurtry; 2007: p. 10). Ensuring a percentage of time devoted to non-casework activities is vital from the standpoint of clinics being accountable to the communities they serve.

Poverty Law in Ontario

Under the Legal Aid Services Act, section 2, 'clinic law' is defined as an area of law which particularly affects low-income individuals or disadvantaged communities, including legal matters related to: a) housing and shelter, income maintenance, social assistance, and other similar government programs; and b) human rights, health, employment and education (McMurtry, 2007). However, this definition fails to take into account the differences that occur within and between communities (rural versus urban) as well as changing needs over time (McMurtry, 2007). A broader definition provided by McMurtry (2007) emphasizes legal areas that disproportionately impact low-income individuals/communities, including income maintenance, tenancy and employment rights. (The fact that criminal and family law areas are not included within the mandate of community legal clinics is no accident. The potential for a conflict of interest is considered too great (McMurtry; 2007).

Re-Structuring Legal Services

Legal Aid Ontario has been in the process of re-structuring its own internal operations as well as the operations of community legal clinics since 2009, a process that was driven by the most recent financial crisis and significantly reduced funding environment. In the process of re-configuring its own internal resources, LAO then turned its attention to community legal clinics, initiating conversations and producing documents which spoke to the need for transforming the CLC system.

Historical Context

Well before the 2008 financial crisis which was a catalyst for re-structured processes within LAO, there were important decisions that were made in the 1980's which have impacted the operation of community legal clinics. In particular, the decision to fund community legal clinics from a collective perspective, including a focus on 'economies of 'scale which has been perceived as failing to recognize each clinic as a separate entity. At the time the funder, which was the Law Society of Ontario structured community legal clinics such that support services such as IT, leasing, insurance, benefits and training dollars would all flow from a central office. Community legal clinics continue to operate for the most part, under this framework which is seen as promoting a 'weird dynamic' whereby CLC's are simultaneously independent/dependent on LAO ... they are "*inextricably linked with LAO and interact frequently around services ... which creates challenging dynamics*".

Role of Clinic Services Office

Up until 2000, LAO had a separate Clinic Services Office which employed 10 staff whose role was to monitor, fund and support community legal clinics. In the early 2000's, LAO closed its Clinic Services Office and created regional bodies whereby every region had its own Vice-President. Attached to each regional office is a clinic support position (CAPA) whose dual role includes supporting the regional VP as well as performing a support and liaison function to community legal clinics operating within its region. In the north, this position has witnessed a high degree of turnover which has left northern clinics without the necessary supports available to other clinics.

Discussions between LAO and the Association of Community Legal Clinics of Ontario

(ACLCO) around this most recent transformation process have been predicated on the need for clear accountabilities and relationships as they pertain to the following issues: LAO's role as both funder and a provider of services to clinics; a perceived lack of accountability on the part of clinics to meet performance standards as identified by LAO in exchange for funding; funding models, including challenges associated with the uptake of innovative/re-configured service delivery mechanisms; clarifying respective roles in determining local client need, including the role of clinic boards of directors; the role of ACLCO, which acts as an advocate voice for clinics and is perceived by LAO as discouraging collaboration and collective problem-solving; the need for

meaningful measures that speak to results and impacts on clients without being unduly burdensome; and finally, modernizing relationships between ACLCO, LAO, community legal clinics to ensure professionalism, transparency and accountability (LAO, July 2008).

Moving away from governance and financial matters, the third discussion paper (May 2012) focused on questions regarding long term structure and sustainability of clinic law services provincially, with the emphasis on clinics, Student Legal Aid Services Societies (SLASS's) and LAO working together to provide effective services to low-income populations (LAO, May 2012).

Reiterating basic themes such as expanded access to justice; client-focused and high quality services in the context of a transparent and cost-effective framework, LAO ends it discussion paper with a summary of ideas focused on "transforming legal, medical and social services" (p. 27) as it relates to needs assessments, outreach, legal intake, referrals, legal advice, back office functions, legal information, test cases, community development, public legal education, and institutional structure." Emphasis is placed on the clinic law delivery system focusing its attention on centralizing certain services (where it makes sense), determining the approximate mix of staff, identifying co-location opportunities and finally, understanding the changing nature of 'community' as it pertains to service delivery (LAO, May 2012).

Summary

To summarize, community legal clinics have a long and varied history in Ontario, with roots in the community agencies that served low-income populations. When legal aid replaced a pro-bono system with a "judicare" program and then began to provide funding for some poverty law services, this paved the way for the current community legal clinic system. A distinguishing feature of community legal clinics has been and continues to be their governance model (i.e. an independently elected board of directors) which remains accountable to the communities they serve. Community legal clinics also differ from other legal services in their ability to advocate for low-income Ontarians whose poverty law issues directly relate to provincial policy, including income maintenance, tenancy and employment rights. The diverse nature of clinic work requires not only lawyers and those trained in legal administration, there is need for community developers, CLWs, paralegals, intake workers, policy analysts and social workers.

In terms of re-structuring, LAO has evolved from a separate Clinic Services Office, which was replaced by a regional system in the early 2000's. The five regional offices have their own Vice Presidents, each reporting one support staff whose role is to be a liaison to community legal clinics operating within its region. The legal and social context within which LAO's re-structuring process is embedded is defined by a number of key trends. The first of which is 'austerity' and a provincial policy framework which emphasizes 'doing more with less'. Rather than assisting in economic

recovery, the austerity agenda has had serious unintended impacts which continue to be felt across both economic and social systems, essentially creating a burgeoning 'working poor' population (across urban and rural regions of the province). A number of key themes that relate directly to the provision of legal services to low-income populations in Northern Ontario including significant Aboriginal (28.8%) and Francophone (25.5%) **[01]** populations, not to mention an aging population base; and growing numbers of low-income and working poor populations, which are typically under-reported in rural regions (Liau; 2006; Annis & Patterson 2003; Halseth & Ryser 2010).

In the north, low income levels are found within First Nation communities, insofar as 1 in 4 First Nation children live in poverty, include the more than 22% of First Nation households that live in substandard housing. As well, Aboriginals are nine times more likely to end up in the criminal justice system, including experiencing systemic racism and social exclusion. When thinking about poverty and social exclusion, it is important to note that First Nation communities experience significant and different needs that must be carefully considered in planning and implementing services (i.e. culturally-appropriate services) -- this is also true for Francophone populations.

In addition to First Nation communities, trends which show rising rates of poverty among individual households, including elderly women should be of concern given the north's rapidly aging population base. As well, much lower levels of education as reported by northern residents (compared to their southern counterparts) should be a concern given the relationship between income and education (i.e. those with higher levels of education are more likely to report higher incomes).

Finally, considerations that speak directly to challenges associated with service delivery mechanisms include distance from urban centres and 'isolation'. In this respect, Northern Ontario is particularly challenged, requiring special acknowledgement of the impact of distance, geography and a dispersed population base from the perspective of service delivery costs and the need for satellite/branch/sub offices. The fact that most of northern Ontario is considered to be 'isolated' suggests the need to compensate for distance/geography in funding formulas. Many northern residents live in regions where there are limited and/or no legal services. Lessons from other jurisdictions, such as Quebec, should be incorporated into decision-making processes as it pertains to funding legal services in remote areas of the province. Quebec's Legal Aid Regulation makes provisions for remote regions (i.e. in terms of eligibility requirements, clients residing on or above the 51st parallel are allowed to report annual incomes 20% higher than residents in all other areas of the province).[1]

[1] approximate # derived from the following website: http://www.ofa.gov.on.ca/en/franco-stats.html

LITERATURE & BEST PRACTICE REVIEW

The following section provides a literature review of trends, issues/challenges as it pertains to delivering services to rural and remote populations, including identifying best practices provincially, nationally and internationally. The author draws from most recent literature on:

- rural and remote communities,
- health care integration,
- legal services to low-income populations, and
- services targeting certain hard-to-reach populations (such as indigenous communities and those with mental health and addiction issues).

A. Rural and Remote Communities -- Recurring Themes

A predominant theme that was identified in the literature concerns the lack of a standard definition of 'rural' which speaks to issues in measuring population health, not to mention identifying needs and gaps in order to plan more effectively (CMHA, 2009). Canada's national statistics agency, Statistics Canada defines rural as fewer than 1000 residents per square kilometer. The definition extends to census categories insofar as any community not labelled as a ‘census metropolitan area’ (CMA), a ‘census agglomeration’ (CA) or a small urban area is considered to be rural (Slaunwhite; 2009; Nuffield, 2003).

A recent report produced by the Rural Ontario Institute (2013) identifies the importance of distance from large urban centres and population densities as two of the most fundamental dimensions of rural places. For example, the Institute makes reference to a 'rural and small town' population (RST) which was estimated to be approximately 1.4 million in 2011. "The RST population is classified according to its 'metropolitan influence zone' (MIZ) where strong MIZ refers to communities where 30% or more commute to a CMA or CA (Rural Ontario Institute; 2013).

Demographic, Social & Economic Trends

Slack et. al. (2003) identify general trends which have changed the demographic, social and economic landscape in Ontario including an increasingly aging population base; the growth of single person households; and the increasing importance of immigration as a factor in population growth, particularly in large metropolitan cities.

In general, most recent data highlights a downward trend for rural communities in that, while the province's urban population grew by 15% between 2001 and 2011, its rural population declined by 7% (with differences amongst rural communities related to proximity to Metropolitan Influence

Zones (MIZ) (Moazzami; 2013). [2] Gradations of 'ruralness' (Mozzaami; 2013) also impact on education levels with educational achievement declining as "the distance between rural areas and population centres increases". [3]

Rural, remote and small town communities tend to face challenges in terms of their long term sustainability by virtue of their unique characteristics. For example, at-risk communities are defined by Slack et. al. as possessing several or all of the following characteristics: (1) generally smaller population bases; (2) physical isolation from urban centres; (3) weakened economies; (4) higher than average servicing costs; (5) declining rural service hinterlands (6) limited to no capital investment; (7) low levels of in-migration and (7) the presence of a large Aboriginal population (in certain regions). As a result of the interactions of the aforementioned factors, at risk communities tend to have fewer working age individuals -- reporting higher dependency ratios which speak to a community's economic vitality - with a larger proportion of children and seniors. Significantly, outmigration of young working adults translates into human capital deficits at a time when "most of the untapped resources in Ontario are located in rural areas" (Moazzami; 2013: 4).

abour Force Indicators

In terms of employment and occupation, it is often the case that small, rural, and remote communities are dependent on a few sectors and occupations. In addition, participation rates tend to be lower (particularly for women) while unemployment rates are higher (Slack et. al.; 2003). A recent study funded by the Strengthening Rural Canada initiative shows remote communities in Ontario as reporting participation rates 14% lower than their urban counterparts, with "unemployment rates in remote rural Ontario (averaging) 16.8% .... (and often reaching) as high as 66% in some Aboriginal communities" (Moazzami; 2011).

In general, differences between urban and rural and/or remote communities are often discussed in the context of diseconomies of scale and challenges associated with human capital (for example, access to a highly educated pool of workers) (Slack et. al; 2003; Moazzami; 2013). These differences have implications for the types of services needed, including the role that geography, population density, and market efficiencies play in the funding, delivery, and sustainability of services.

Rural Service Delivery -- Case Studies (Canada & United Kingdom)

It is important to note that rural communities are considered to be more than just service entities. For example, in contrast to their urban counterparts, residents living in rural communities are much more likely to report a strong a sense of community, including strong social bonds which are reinforced through daily interactions (Halseth & Ryser, 2006; Nuffield, 2003; Nyugen & Whetten,

[2] There is no consensus on the definition of 'rural'. Some researchers identify rural regions according to the percentage of population (50%) living in areas with a population density less than 150 persons/sq. kilometers (Slaunwhite; 2009). Statistics Canada refers to rural areas as any community outside of an urban centre.

[3] Working poor is defined by Social Development Canada as "those aged 18-64 who have worked for pay a minimum of 910 hours in the reference year, who are not full-time students, and whose family income falls below the LICO-IAT" (Liau; 2006: p. 20)

2003). The literature on rural legal services delivery out of the United Kingdom (UK), shows private bar rural solicitors as firmly 'embedded' in the communities in which they practice, reporting multiple roles (Franklin & Lee, 2007).

Embeddedness

In general, being well known and respected in their community was considered to be a key factor contributing to the success of rural solicitors; this success extended to being able to rely on word-of mouth advertising.

Thinning Out of Rural Services

The thinning out of rural services -- including legal services -- combined with an aging workforce, diseconomies of scale and the increasingly diverse nature of rural communities all pose challenges in terms of the sustainability of local service models. The literature out of the United Kingdom emphasizes the need for solicitors' to change their complacency and to become more proactive in reacting to these potential threats.

Continued access to legal services in rural areas will be challenged by shortages of lawyers, who are of retirement age and not expected to be replaced by young lawyers. "These trends are predicted to have a disproportionate impact on poor and marginalized people, given the active participation of rural, regional and remote lawyers in community-based legal aid and pro bono work" (Law Council of Australia, 2009).

In general, the literature out of the United States suggests approximately one-third of lawyers engage in pro bono and/or low bono work, with differences based on size of firm as well as urban/rural factors. It should be noted that while not in the same league of their urban counterparts, rural lawyers take on a fair proportion of pro bono work in the United States (Pruitt & Showman; 2014) which was a theme identified within the UK literature. Personal relationships are identified as being critical insofar as lawyers who 'knew' the person or organization referring a client were much more likely to take on the case (for limited or no fee) (Pruitt & Showman; 2014). The US literature also highlights the effectiveness of retaining urban lawyers given their preference for "providing pro bono beyond their usual geographic sphere" (Pruitt & Showman; 2014: 521). The potential role of non-legal community partners is highlighted by Pruitt & Showman (2014) as critical in promoting pro bono work among solo legal practitioners and in 'thickening' access to justice in general.

Social, Health, Demographics -- Impacts on Service Delivery in Rural Settings

Using urban-based models to assess service delivery within rural context has several disadvantages which will be discussed below. By applying an urban lens to rural service delivery, Halseth & Ryser (2006) note that the unique needs and realities of rural areas are discounted. For

example, service closures and the centralization of services, designed to realize economic efficiencies and savings often have broad and far reaching effects, impacting a rural community's social and economic sustainability. When services are reduced in rural communities, the impact goes beyond issues of access and costs associated with traveling outside one's community; the impacts are also felt in terms of job losses (direct and indirect); losses associated with municipal taxes and assessments, as well as losses associated with social capital and community cohesion.

B. Challenges – Distance & Culturally Appropriate Services

The historic perception of rural communities as being homogenous and reporting an increased sense of wellbeing is challenged by a number of reports that show "people in rural communities (as reporting) poorer health status and greater needs for primary care, (albeit with limited) access (to) health care services" (Best Start; 2010; Anderson, 2006; CMHA, 2009). Included here would be the large number of Aboriginal individuals and communities who are seen to be particularly disadvantaged across social, economic and health-related fronts. In general, remote reserves are particularly challenged by a lack of and/or limited access to health and social services; distance from providers; and human resource challenges associated with recruiting and retaining staff (health, social, correctional, education, etc.) (Anderson; 2006; Nuffield, 2003).

Indigenous Populations - Emphasis on Youth

A review of youth justice literature highlights a disproportionate amount of research on Aboriginal communities located in rural and remote regions which show Indigenous youth as being overrepresented in the criminal justice system. Other key issues facing Indigenous youth as identified in the literature include cultural alienation and a general lack of resources to be able to respond to the specific needs of young people in Aboriginal communities (Nuffield; 2003)."Geography and distance, lack of familiarity with the workings of the criminal justice system, delays in the formal response to crime, leniency and/or inappropriateness of sentences, and a lack of human and other resources were consistently identified ... as the factors that most contributed to the ineffective delivery of criminal justice services to communities (James Bay, Quebec, Northwestern Ontario and Northern Saskatchewan)" (Nuffield; 2003: p. 2)

In terms of health status, geography and isolation tends to be associated with poorer health outcomes with the Aboriginal population considered to be one of the most marginalized (Anderson, 2006; CMHA, 2009; Nuffield, 2003; Mitton et. al, 2011; Neufeld, May 2014). Studies focusing on the needs of Indigenous populations and youth in rural/remote areas noted the correlation between suicidal ideation and stress as a key factor leading to youth suicide. The other important factor identified in the literature related to 'oppression', and in particular, the importance of dialogue around current forms of oppression rather than focusing solely on historic oppression (Mitton et. al, 2011; Nuffield, 2003).

The literature on Aboriginal communities (on and off-reserve) highlights the importance of age and culturally-appropriate programming as well as the need for investment in community (i.e. local staffing where possible to offset what is considered to be a transient service provider workforce) and community-based processes (Mitton et. al, 2011; Neufeld, May 2014; Nuffield, 2003).

Substance Abuse & Mental Health Issues

Not only do rural and remote areas face challenges in terms of accessing basic services across sectors (i.e. health and hospital-based services, including mental health/addictions programs, legal and social services), rural areas were more likely to report lower health status, higher mortality rates, and higher proportions of individuals with addictions to alcohol, and other substances (Mitton et al, 2011; CMHA; 2009).

Lack of affordable housing is a key theme identified in the literature on rural regions including Northern Ontario. Most recent reports from mental health service providers identify a five year wait list for supportive housing applicants with mental health and addictions issues (CMHA, 2009; Suter et.al. 2009; Suter, 2012). Unfortunately, the alternative for many is sub-standard housing, couch surfing or at the extreme end of the continuum, homelessness (CMHA, 2009; Suter et.al. 2009; Suter, 2012).

The lack of affordable housing means that rural residents are often reluctant to file complaints against their landlord "out of fear that the lack of anonymity characteristic of rural communities will cause the tenants to be blacklisted by all landlords in the area" (Pruit & Showman; 2014: p. 500).

Homeless populations and those at risk of losing their housing experience myriad social issues, including but not limited to substance and mental health issues. They often cycle in and out of hospital emergency departments as a result of their limited/lack of access to primary care. In Northern Ontario where there are fewer psychiatrists and family doctors, an additional concern relates to the tendency for doctors to screen out individuals living with mental illness and/or addictions who have complex health needs (CMHA, 2009). This has particular impacts for individuals having to navigate social assistance tribunals who require medical documentation in order to qualify for 'disability' benefits.

Service Delivery - Proximity to Metropolitan Influence Zones

Common themes that were identified in the literature on rural health delivery included: human resource issues; issues associated with coordinating services across sectors and jurisdictions (i.e. Aboriginal communities); and issues associated with geography (i.e. travelling long distances for services and the different impacts as experienced by communities depending on their proximity to urban centres) (Neufeld; May, 2014; CMHA, 2009; Slack et. al, 2003; Moazzani; 2013).

One Canadian study looked at non-urban census subdivisions located outside of the country's major cities and urban centres, including the impact of metropolitan influence zones -- measured

by the intensity of commuting patterns as reflective of the degree of economic integration with metropolitan (Census Metropolitan Area) and urban (Census Agglomerations) areas. This analysis identified areas that reported zero commuting to a CMA or CA as most 'isolated'. More specifically, isolated places were "defined as those in which commuting to work (or for services) to a metropolitan area is impractical or impossible because of long distances and high transportation costs" (Slack et. al; 2003: p. 12).

When one analyzed isolation based on settlement size (for example, those communities with a population of less than 1,000, most of Northern Ontario was considered to be 'isolated'. Within the category of 'small towns' (less than 10,000 population), communities such as Dryden, Hearst and Wawa were considered to be 'isolated'. For 'small cities' defined as having a population base between 10,000 and 30,000, Kenora and Kirkland Lake were defined as 'isolated'. Finally, for 'large cities', defined as having a population base between 30,000 and 100,000, North Bay, Sault Ste. Marie and Timmins were all considered to be 'isolated' (Slack et. al; 2003; p. 12). With the exception of Sudbury where there were no reported populations living in a census subdivision that is outside of a census metropolitan area, all other census divisions in northern Ontario - reported 100% of their population as residing in a census subdivision that is outside of a CMA (Rural Ontario Institute; June 2013). With its dispersed population base, and its many kilometres separating respective communities, Northern Ontario residents have to travel much farther in order to access needed services (CMHA, 2009; Anderson, 2006; O'Leary; 2008). This reality means that individuals living in the north often take on the financial costs associated with regionalized services (Anderson, 2006; CMHA, 2009).

C. Rural Communities -- Assets

In addition to reporting rich human and social capital, rural service providers are identified in the literature as better positioned to engage in collaborations -- within and across sectors-- than their urban counterparts. Some authors note the fact that in general, there are fewer power imbalances among rural service providers compared to service provider networks operating out of urban centres (Fleury, 2005). In addition, rural clients tend to report closer ties to their local service provider networks primarily because they don't have the luxury to be able to shop for services (Fleury, 2005).

Other key strengths that were associated with rural areas included: less bureaucracy and more independence in how things are done 'on-the-ground'; the sense that rural service providers feel they have a real impact and can affect positive change; and the satisfaction as expressed by rural service providers who note the advantages of being able to engage in a variety of work activities (Nuffield, 2003).

D. Characteristics of Effective Models for Rural Areas

1) Multiple Access Points/Services Continuum

Fleury (2005) lays out a model for rural mental health service delivery with multiple access points and multi-dimensional resources including community centres, community organizations, private medical clinics, and inter-sectoral resources such as police services and school boards. Gutierrez et. al. (2010) and Taylor (2001) note the importance of engaging 'anchor' institutions (such as schools, courts, and university medical departments) who work closely with allied health providers to provide a 'one-stop shop' for health care delivery in rural settings (Taylor et. al., 2001)

A review of the literature suggests that success on the integration front is contingent on the ability of all partners to recognize common problems of system functioning; the ability to share a common vision; and the political will to collaborate and acknowledge gains to be made from cooperation (Fleury; 2005; Taylor et al., 2001; Humphries & Wakerman; 2004). The Australian primary health care integration model stands out in the literature as providing services to rural communities through collaborative arrangements -- sometimes formal sometimes informal -- between various allied health providers who are co-located within their respective sites (Taylor et. al., 2001). The composition and staffing of 'teams' differ in terms of professions represented and roles performed, however, it is important to note that an extensive range of health and community services are provided at each of the sites (Taylor et. al., 2001).

2) Standardized Care through Multi-disciplinary Team

Fleury's (2005) integrated rural service delivery model includes a mobile team of mental health staff and a dedicated liaison officer/coordinator who works closely with all of the identified stakeholders to ensure coordination of services. All members are considered equal, with clear roles and responsibilities (Nyugen & Whetten, 2003; Fleury, 2005) and with sufficient resources to carry out their integration mandate.

The literature identifies the need for actors to see beyond what they perceive as a 'loss of power' and 'individual decision-making' to embrace communal goals. Some of the barriers to multi-disciplinary care as noted in the Australian experience include difficulties associated with establishing a common vision owing to the "mix of private and public (salaried) practitioners" (Taylor et. al., 2001; p. 309). From the perspective of effective on-the-ground activities supporting integrated efforts, the literature identifies the need for dedicated funding of coordinator positions. Over and above their administrative duties, coordinators are seen as critical in attending to various other aspects of a system's functioning such as facilitating relationships with relevant stakeholders (Nyugen & Whetten, 2003).

Ensuring that individuals hired to coordinate integration have: 1) diverse experience and understanding of system components and 2) are trusted by providers and clients alike is key (Nyugen & Whetten, 2003). This is particularly critical given the emphasis on relationship-building within and across system components (Nyugen & Whetten, 2003; Fleury, 2005, Ryan & Ray 2012).

3) Organizational Culture & Leadership

Effectively working across sectors to provide more integrated and comprehensive service delivery requires mutual respect and 'equal' relationships. At the same time that system players are challenged to level out the playing field and to treat each other as 'equals', the literature highlights the importance of 'leadership' and the need for visionary leaders. The literature suggests that as stakeholders take more ownership of integration efforts vis-a-vis their active involvement in the development of workplans, there is increased interest, motivation and trust as a result (Nyugen & Whetten, 2003). Ensuring adequate opportunities and resources for continuous learning builds capacity and understanding of the various roles of systems players.

4) Social Capital -- Partners

A review of the literature suggests that collaborations thrive within a culture of 'trust', characterized by high levels of commitment on the part of actors involved to work in a more integrated fashion (Fleury, 2005; Nyugen & Whetten, 2003; Pleasence et. al. 2014). However, the development of trust and/or social capital happens in stages, with more intensive and trusting relationships occurring over longer timeframes. For example, Pleasence et al point out that in their discussion of "joined-up" services there are methods of working together ranging from networking to coordinating to cooperating to collaborating to integrating (p. 71), noting that it takes more time and trust-building to move along the continuum at the cost of more organizational independence and autonomy. This is not to suggest in any way that "integration" of services or organizations as a whole is or should be the end goal. In fact, depending on the organizations involved and the nature of their services – cooperating and collaborating may be the most appropriate relationship.

5) Governance Structure/Regional Coalitions

The literature on integration notes the need for appropriate governance structures that promote coordination. (Nyugen & Whetten, 2003). Fleury (2005) identifies three levels of governance as it pertains to networks, all of which are inter-related and need to be managed:

- Strategic Level -- Ministry & Regional agencies and at the local level, upper management representatives;
- Tactical Level -- Program coordinators and division leads across participating organizations; and finally
- Operational Level -- Field staff across participating organizations

Integrated service networks require synchronized reforms targeting the three aforementioned levels of governance, with recognition that at the local level resource constraints can make network integration more difficult (Fleury, 2005). It is also recognized that network integration will look different depending on the setting (i.e. urban versus rural). The most important factor that Fleury underlines is "the importance of structuring ... networks to suit the context in which they are implemented ... (including) ... mobilizing health care staff according to functional/administrative,

clinical and physician-system integration types and strategic, tactical and operational governance levels" (Fleury; 2005: p. 9)

The literature notes certain advantages of working within rural settings including the fact that rural service providers are more likely to report multiple, professional and personal connections. It is often the case that rural stakeholders work together on an informal basis, utilizing formal memorandums of understanding when necessary (Taylor et. al., 2001 Fleury, 2005; Nyugen & Whetten, 2003). It is important to note that effective service delivery does not necessarily mean that all system functions need to be integrated. This is particularly true for rural areas where networks and collaborative activity are much more likely to flourish naturally (Fleury, 2005).

In terms of facilitators of integration, it is noteworthy that where there are policy directives from funders, collaborative actions were more likely to take root. In other words, where funding agents directed their respective organizations to network and to become better integrated there was greater commitment to follow through (Fleury; 2005).

6) Facilitators of Integration & Promising Practices

For the most part, the literature identifies the following factors as important facilitators of collaborations: co-located services; more time spent at rural service delivery sites; increasing understanding of each professional's role; and an ability to share clients (Taylor et. al., 2001). In addition, the Australian literature notes the importance of "community-controlled boards…" (Taylor et. al., 2001, p. 306). Such boards perform an oversight role at the local level, including promoting local solutions and encouraging local 'ownership' of the project, all of which were considered to be important elements to sustaining localized integrated service delivery (Taylor et. al, 2001).

In general, the literature on legal service delivery to low-income dispersed populations in Australia identified promising practices as follows: (1) regional coalitions with diverse representation, who come together to collaborate vis-a-vis 'steering committees'; (2) joint planning for improved referral mechanisms; (3) improved access to pro bono services and more effective planning of legal services (including community capacity-building); and (4) legal information and advice to community members, referred to as 'road shows' and targeting under-resourced areas (Forell et. al., 2009; McDonald et. al., 2014; Pleasence et. al, 2014; Ryan & Ray, 2012).

7) Bottom-up VS Top-down

Bottom-up planning and service delivery is a theme that is found in the literature, including an emphasis on service delivery mechanisms appropriate and flexible enough to meet the needs of the people they are serving (Anderson, 2006; Health Association Nova Scotia, 2013; Nuffield, 2003). As well, emphasis is placed on integrating and coordinating services in tandem with a community and/or region's socio-economic context (Anderson; 2006). In general, recommendations on how to better serve rural populations include the need for equitable and adequate funding; support for innovative programming leading to more effective/efficient services

which also build community capacity; and finally, investments in housing, transportation and community infrastructure (Anderson; 2006).

From the perspective of legal services to low income and marginalized populations, a number of best practices have been identified in the literature out of New South Wales including:

- ***Targeted Approach**, addressing unmet legal needs in a defined client group, community or place,*
- ***Actively engaging client groups/agencies,** coordinated across Legal Aid NSW practice areas*
- ***Client centered**, recognizing complex, legal/social needs including barriers to access*
- ***Consistency in service delivery**, with options for assistance between visits*
- ***Adequate resourcing for sustainability** within broader service frameworks,*
- ***Evaluation** to ensure the outreach is achieving its aims and complying with best practice.*

8) Client Focused

The literature review on integrated service delivery emphasizes the importance of meeting patient/client rather than provider needs and ensuring a system that is easy to navigate and which prioritizes patient engagement (Humphries & Wakerman; 2004). Harder to serve populations -- including communities in transition -- are particularly seen as beneficiaries of more integrated service delivery mechanisms. In this light, a number of authors note the importance of ensuring that case managers receive training to build capacity to better serve marginalized populations (i.e. training in mental health and addictions; culturally-safe services, etc. (Nyugen & Whetten, 2003).

Bringing services to clients, through outreach efforts and/or housing services in schools or community centres was further seen to be particularly beneficial in overcoming transportation and other challenges (Gutierrez et. al, March 2010; Anderson, 2006).

9) Funding Arrangements & Geographic Coverage

One of the themes identified in the literature concerns funding frameworks and the fact that per capita funding fails to take into account the higher costs associated with "providing services to areas with dispersed populations across a large geographic area" (CMHA; 2009: p. 6;). The Australian literature identifies a regional funding and service delivery model which is predicated on sufficient population thresholds to support an appropriate range of health and community services -- not so large as to jeopardize the ability to respond to local issues and needs but not so small as to not support an essential range of services (Humphries & Wakerman, 2004; Ryan & Ray; 2012).

A 'hub and spoke' model which is often referenced in the literature would be one such model (the hub and-spoke model is based on one or more regional authorities/agencies usually located in an urban area, extending outreach services to smaller communities within their catchment area

(Nyugen & Whetten, 2003; Neufeld, 2014). This model has shown success in Australia although it should be noted that many of the aforementioned characteristics of successful integration efforts were also present in the Australia case. (Taylor et. al, 2001).

10) Information Systems & Technology

Information and IT infrastructure were also noted as key components to an effective health service delivery model, especially for more rural and remote communities (Humphries & Wakerman, 2004) although there was recognition that "there (are) few (information) systems in place to support (a more integrated) approach" (Taylor et. al., 2001; p. 309). In particular, emphasis is placed on the need to develop overall information systems, including policies and integrated plans (Taylor et. al., 2001).

System-wide computerized information systems were often referenced in the literature on health and mental health care integration as the most effective way to enhance communication and information flows. Being able to develop software that offered electronic mail capability as well as enabling case management and clinical database integration was considered to be key to successful systems integration (Nyugen & Whetten, 2003). Funding coordinator positions to support and train staff and provider agencies on information systems, and enabling them to continuously contribute to the system`s improved functionality were also considered essential in terms of building ownership and continued use of these systems (Nyugen & Whetten, 2003).

From a technological standpoint, the literature identified the potential role of technology in expanding access to services (particularly follow-up care) -- virtual outreach programs (VOP) such as telehealth/telemedicine (in Ontario) were given as examples of IT platforms that can augment other delivery models (CMHA; 2009; Neufeld, 2014). Mitton et. al. (2011) noted that technology can play a role in more effectively reaching populations residing in rural/remote regions as long as the client is seen by a service provider at some point in time (Mitton et. al., March 2011). However, the literature also identified barriers that make the use of technology a challenge in rural and remote areas including the lack of existing infrastructure as well as limited bandwidth capacity (CMHA; 2009).In addition, there are issues associated with literacy/comprehension, the ability of clients who are in crisis to be able to navigate websites (including client comfort levels with these types of service delivery mechanisms). All of these issues are relevant for service delivery models developed to serve rural populations residing in rural areas of Northern Ontario.

Ongoing computer and network system support and training of staff and providers was also emphasized in the literature out of the United States. In the case of the HIV/AIDS case study, this role was provided by Agency Coordinators using various modes (on-site and telephone assistance). In addition to this support role, coordinators "developed computerized forms that automatically pulled information from ... databases, created a searchable website of information related to ... patient care and services, networked with agencies to encourage them to join the system, and developed informational databases (Nguyen & Whetten, 2003). These supports were

seen to be critical in reducing staff turnover, including playing an important role in fast-tracking new staff from the perspective of case management, knowledge of individual client needs, and facilitating a better understanding of what community resources were available (Nguyen & Whetten, 2003).

11) Performance Measures

The literature on integrated service delivery places importance on measuring outcomes at different levels and moving beyond a strictly cost-effective mode of thinking (for example, measuring care outcomes and linking this to quality improvement measures). In particular, emphasis is placed on developing performance measures which target the impact of services received (Anderson, 2006). In addition, a review of the literature identified the importance of implementing reward systems tied to measures which reinforce achievement of organizational priorities (Nyugen & Whetten, 2013).

In the New South Wales example, the impact of services received as a result of the Cooperative Legal Service Delivery Program was evaluated based in part, on the following indicators: (1) the experience of participating agencies; (2) the number and nature of referrals; and (3) the ability of legal and non-legal agencies to identify gaps and more effectively meet needs (Ryan and Ray, 2012). The following key highlights out of an evaluation of the New South Wales case studies were based on a review of 69 collaborative projects as developed and implemented in participating regions, including but not limited to 21 community legal education projects and 16 legal advice clinics targeted to specific populations (often referred to as 'pop-up' clinics which a mobile unit arranged weekly or monthly). The results of the 2012 independent evaluation showed:

- *Strong partner support noting the model's success improving access for disadvantaged populations*
- *Improved referral patterns/contact between agencies & increased access to information*
- *Increased awareness by legal/non-legal agencies of impact of laws on disadvantaged populations*
- *Better able to identify gaps (legal & related services) for disadvantaged populations*
- *Collaboration seen as giving some disadvantaged people legal assistance on specific issues. (Ryan and Ray, 2001*

In sum, most if not all of the characteristics of effective models for service delivery in northern, rural and remote communities as outlined in the literature and best practices are evident in NCLCs. Maintaining the independent and separate nature of CLCs across the north is the best service delivery model they could be using given the overall lack of regional social infrastructure across the north and clinic's limited budgets. In fact, it could be said that the NCLC system is able to perform as well as it does *because* of their volunteer governance model and bottom – up approach to service delivery since it lends itself so well to making the most of the assets that exists in northern, rural and remote environments namely rich human and social capital as expressed through stronger community ties and willingness to collaborate.

RESEARCH METHODOLOGY

Undertaking the Northern Region Transformation Project necessarily called for a comprehensive research design and methodology which included:

Confirmation of Research Design & Work Plan: project deliverables/timelines; communication protocols & working groups; clinic logistical supports; online portal for information exchange;

Statistical Data Collection/Analysis (ongoing):

- Developing a 'community profile' template (integration of primary and secondary data);
- Completion of 11 community profiles (including quantitative data for each community legal clinic catchment area);
- Revision of community profiles and quantitative data (based on feedback from the respective community legal clinics);
- Literature & Best Practice Review Stakeholder Data Collection/Analysis (ongoing):
- Develop lines of enquiry (client, clinic, stakeholder interviews and focus groups)
- Prepare and disseminate research tools (client & clinic surveys; client, community profile highlights;
- Key informant interviews (up to 5 per community legal clinic)
- 2-day on-site visit (identification of current/anticipated needs & existing community asset base)

Capacity & Gap Analysis (ongoing across 11 community legal clinics):

- Analysis of needs & existing clinic capacity data from surveys, interviews, focus groups & validated community profiles
- Map existing asset base related to low income legal service & advocacy needs;
- Create regional analysis on needs/resources/opportunities Research Integration (ongoing across 11 community legal clinics):
- Integrate findings into a comprehensive needs & resources analysis;
- Identify opportunities for transformative service delivery;
- Present and discuss preliminary report to Northern Transformation Working Group;

Design Workshop (1-day workshop with NRTP Steering Committee)

- Agree on decision-making process on options for transformative action
- Document workshop results

Final Report (incorporating design workshop results)

Project activity for the fall of 2014 focused on confirming the research design and work plan. Once agreement was reached, the statistical data collection and analysis piece began.

Statistical Data Collection /Analysis

This component of the research methodology focused on developing community profiles and quantitative data were being complied for each community legal clinic catchment area (utilizing data from Statistics Canada Census and National Household Survey; provincial tax-filer data; social risk index data from Human Resources Development Canada; and Ontario Works and Ontario Disability Support Program data. Once completed both the community profiles and quantitative data (excel spreadsheets) were uploaded to the consultants project portal for review, resulting in a number of revisions/corrections.

Data Limitations

Statistics Canada measures national trends across many different categories (i.e. population; language; culture; household characteristics; income; etc.). The accuracy of census data has been compromised insofar as the survey is now voluntary (whereas prior to 2011, the survey was mandatory). For northern communities, census data has been and continues to be plagued by issues associated with dispersed and small populations, including non-participation of First Nation communities. In particular, the north's huge geography and dispersed population base pose challenges as follows:

- It is more costly to collect data over a larger geography;
- Participation by First Nation communities has historically been low. In 2011, there were 20 First Nation communities who were "incompletely enumerated", all of whom were situated in Northern Ontario.[4]
- Below a certain population threshold, Statistics Canada suppresses data in order to maintain an individual's privacy. For example, in 2011, data at the census subdivision level (CSD)[5] was suppressed for approximately 46 CSD's located in Northern Ontario. The designated place suppression list impacted 8 Northern Ontario 'designated places'[6]. Finally, at the dissemination agglomeration level (DA), approximately 141 Northern Ontario DA's reported 'suppressed data'.[7]

The way that Statistics Canada addresses very low sample sizes is to use 0 or N/A to symbolize suppressed data. Statistics Canada provides the following threshold as it pertains to the standard practice of suppressing data – "the specified population size for all standard areas or aggregations of standard areas …. Is 40"[8] (in other words, where there are less than 40 individuals, data will be suppressed). For financial data the suppression threshold is higher i.e. 250. If one uses the example of the after-tax low income measure (LIM-AT), any and all standard areas reporting less than 250 people would show 0 or N/A, not because there are no incidents of LIM-AT but rather, to

4 https://www12.statcan.gc.ca/census-recensement/2011/ref/irr-app-ann-1-eng.cfm
5 https://www12.statcan.gc.ca/census-recensement/2011/ref/sup_CSD-SDR-eng.cfm#ON
6 https://www12.statcan.gc.ca/census-recensement/2011/ref/sup_DPL-LD-eng.cfm#ON
7 https://www12.statcan.gc.ca/census-recensement/2011/ref/sup_DA-AD-eng.cfm#ON
8 https://www12.statcan.gc.ca/census-recensement/2011/ref/DQ-QD/conf-eng.cfm

prevent potential identification of individuals/households falling within this category (i.e. breaching privacy issues). Thus, the 0 or N/A is interpreted at face value as meaning no individuals/households within the "standard area" report incomes falling below the low income measure (after-tax); rather than being interpreted as an unknown dataset by virtue of the fact that the data has been suppressed for that particular "standard area".

Northern Ontario also poses challenges in terms of data quality insofar as uneven participation rates make comparisons across census tracts virtually impossible. This is particularly the case for First Nation communities, but not exclusively given the voluntary nature of the census.

Further issues arise as a result of differences in the accuracy and quality of data depending on whether the data is obtained voluntarily (i.e. National Household Survey) or mandated (i.e. income tax filings). The biggest issue that has been cited with regards to the National Household Survey (NHS) is its voluntary nature which results in varying non-response rates across socio-economic status; cultural identify; and household status (to name but a few categories). For example, the NHS has been identified as more likely to be completed by higher educated individuals, two-person households and by older individuals. In contract, lone-parent and one-parent households, renters, Aboriginals, and lower socio-economic households are more likely to abstain from completing the NHS.[9] Not only are the NHS survey results seen as problematic in Ontario, B.C. also indicates issues related to accuracy of data, particularly for low-income populations.[10] [11]

In contrast, provincial tax-filer data offers information on income at lower levels of geography (i.e. census tract) as well as at the level of postal codes. Provincial tax-filer data is generated from individual tax files as provided by the Canada Revenue Agency -- files which are published annually and which report on income at the individual and census family level. Tax-filer data provides data as follows: single year, 5 year (0 – 24 years, 65+ years). A possible bias that has been attributed to tax-filer data is missing data from non-filers (i.e. individuals who don't file income tax returns). This contrasts with the bias attributed to NHS data which falls into the following two categories: 1) non-responses (i.e. individuals not completing the survey) and 2) over sampling (i.e. fewer respondents falling into lone-parent and/or single-person households as an example).[12]

Compared to provincial tax-filer data, the NHS is reported as being less accurate for lower levels of geography and small populations whereas provincial tax-filer data can be made available at both the postal and census geographic areas. Furthermore, the sense is that there is more incentive for individuals to respond honestly when filling out their taxes as compared to completing a voluntary survey (i.e. NHS).[13]

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[9] http://www.theglobeandmail.com/globe-debate/canadas-voluntary-census-is-worthless-heres-why/article14674558/

[10] http://still1in5.ca/wp-content/uploads/2014/11/DATA-SOURCES-AND-POVERTY-MEASURES-First-Call-2014-BC-Child-Poverty-Report-Card.pdf

[11] http://www.sprc.hamilton.on.ca/wp-content/uploads/2015/04/Profile-of-Hamiltons-Aboriginal-Residents.pdf

[12] http://communitydata.ca/sites/default/files/ccsd-cdp_roundtable-2014_deming.pdf

[13] http://communitydata.ca/sites/default/files/ccsd-cdp_roundtable-2014_deming.pdf

One other important caveat to include in this discussion is the fact that homeless individuals and families do now show up in census data or for that matter, tax-filer data. In the former case, census data is unable to capture homeless individuals/households because they have no fixed address. In the latter case, homeless individuals/household do not show up in tax-filer data because they tend not to file their taxes. It should be noted that in rural and remote communities, homelessness is often hidden and therefore under-estimated. In Greater Sudbury alone, approximately 1,420 individuals who were surveyed in conjunction with a Laurentian University study indicated they were homeless or at risk of being homeless (CGS; 2014). (Magnified across 10 Northern District Social Services Administration Board areas, the issue of homelessness is not insignificant.)[14] The closest proxy to homelessness -- as determined by Statistics Canada – is shelter usage as collected by the Homelessness Individuals and Families Information System initiative.[15] However, shelter usage is problematic in rural and remote areas of the north where shelters (and other crisis supports) are non-existent.

Literature and Best Practice Review

At the same time as the community profiles and quantitative data was being compiled and finalized, the research team conducted a literature and best practices review of community-based poverty law and health service models operating in other jurisdictions (with similar environmental conditions). The literature and best practice review focused on:

- Rural Communities (Economic, Social, Cultural, and Labour Force Indicators)
- Service Delivery to Rural and Remote Populations (Challenges)
- Rural Legal Service Delivery (Canada, Wales, Australia)
- Characteristics of Effective Service Delivery Models for Rural Areas

Setting the context vis-a-vis a literature and best practice review, the research team was then able to move to the next component of the research methodology: Stakeholder Data Collection/Analysis.

Note: The quantitative data sets for each of the NCLCs are available through a central drop box.

Stakeholder Data Collection/Analysis

The comprehensive needs assessment as implemented by the research team included key informant interviews of community legal clinic staff (and board members); interviews with external stakeholders and partners; and interviews with LAO stakeholders. In addition to key informant interviews across the 11 community legal clinic jurisdictions, the research team conducted focus

[14] http://www.hscorp.ca/wp-content/uploads/2012/09/Affordable-Housing-and-Homelessness-in-Northern-Ontario.pdf

[15] http://www.parl.gc.ca/Content/LOP/ResearchPublications/prb0830-e.htm

groups with clients, clinic staff, external partners and other key stakeholders (as identified by respective community legal clinics).

Key Informant Interviews

92 key informants were interviewed in the process of conducting the Northern Region Transformation Project (representing clients, community stakeholders and clinics -- i.e. staff, management and board members). The research team asked each community legal clinic to identify 4 -5 stakeholders to be interviewed. The following sectors were represented in the key informant interview process: food security; public health; MPP constituency offices; disabilities; shelters (generic &Women's shelters); faith community; Aboriginal organizations (mental health and addictions; health; police; education authorities; Chief & Council); seniors; police services; court administration; mental health/addictions; municipal government; provincial government (OW); violence against women; injured workers and HIV/Aids-serving organizations.

The project team developed three separate key informant templates to utilize as follows: (1) Executive Directors and Staff; (2) External Partners (Stakeholder) and (3) Legal Aid Ontario (regional and head office)

Questions targeting community clinic staff focused on:

- Clinic caseloads (i.e. the types of legal services provided as well as client profiles);
- Capacity in terms of meeting needs (present and future);
- Capacity to provide legal services based on their mandate;
- Resource intensive nature of caseload (i.e. straight forward vs. complex cases);
- Key partnerships (most helpful);
- Proportion of cases requiring external supports;
- Pressure points within clinics, including how to address; and finally,
- How to facilitate collaborations at the local, regional and provincial level.

Questions targeting external stakeholders focused on:

- Strength of relationships with community legal clinics, including how partners work with their respective CLCs;
- Partner understandings of clinic services, including the types of clients served;
- Partner understanding of CLC capacity to meet needs (present and future);
- Partner understanding of CLC capacity to fulfill its mandate, including identifying which legal areas might be easier to meet; and finally,

- How to facilitate collaborations at the local, regional and provincial level. The final key informant template that was developed for Legal Aid Ontario stakeholders focused on gathering information which would inform the project team as it pertained to:

1) Current and historic relationships with community legal clinics;
2) Challenges implementing system-wide changes within the CLC system;
3) Role of CLC in terms of community development;
4) Role of CLCs in terms of public legal education;
5) Role of IT in delivery of poverty law services, including advantages and disadvantages;
6) Role of performance measurement systems, including CLC capacity as it pertains to CIMS;
7) Identifying service delivery models which could be built on;
8) Identifying mechanisms, bodies, and or partnerships currently in place that could be built on; and finally,
9) Exploring what a successful transformation might look like for the north.

2 Day On-Site Community Visits

The research team spent two days at all of the eleven (11) community legal clinics between November 2014 and March 2015 to gather site-specific data and information (for example, each site hosted client, clinic and stakeholder focus groups). Where feasible, the research team visited satellite and/or branch/sub office sites in order to better understand the challenges clinics face in providing services to residents living in rural parts of their catchment area.

Focus Groups

Client focus groups were conducted in English and French (where appropriate). They usually were two hours in duration and participants were given honorariums to cover any transportation or child care costs incurred. Prior to each focus group the research team gave a brief introduction of the Northern Region Transformation Project; in addition, participants were asked to sign a consent form which would enable the team to tape the session for information purposes. In total approximately 33 focus groups were conducted with 248 individuals participating across diverse sectors.

Focus group questions probed for client experiences with the community legal clinic (how they had come to access services), including what legal and non-legal issues they were seeking assistance with. In addition, the researchers were interested in their perceptions on what services might be lacking (i.e. are there areas of the law that clinics need to be expanding on). Clients were asked about their usual method of accessing services (i.e. by telephone; on-site visits and/or face-to-face

communication; electronic methods/email, etc.) and their comfort levels accessing services through videoconferencing and/or through websites or 1-800 numbers. The researchers probed for any challenges that clients might have in accessing clinic and/or Legal Aid Ontario services across various mediums. Finally, clients were asked to identify organizations and/or services that they frequently access within their communities (i.e. government, nutrition, education, employment, health/mental health, social/recreational).

Stakeholder group questions probed for agency experiences with the community legal clinic:

identifying how they were involved with the legal clinic, including what legal issues their clients most often presented with. Participants were also asked about their understanding of the areas of law covered and the types of services offered by the community legal clinic. The researchers probed for stakeholder perceptions of which legal areas were most important from the perspective of greatest impact (client and community). They were also asked to identify obstacles in accessing legal services for clients and agencies alike (including areas of the law covered, clinic staffing and capacity, etc.). Stakeholders were asked to speak to the effectiveness of satellite/ branch offices (where appropriate) in meeting community needs and to identify other community resources that they typically refer clients to (probing for any issues that clients and/or stakeholders might face). Finally, participants were asked about their internet presence and practices; to what extent they use teleconferencing/videoconferencing and other technologies (probing for stakeholder perceptions on client comfort levels).

Surveys

The research team conducted client surveys (each CLC was given client surveys to disseminate to clients who were currently accessing services (or who were previous clients). Clients were able to complete surveys in their language of choice (i.e. English or French). Approximately 270 client surveys were completed. Client survey results reported on per clinic however are not statistically significant due to small sample sizes however are informative as individual cases. In addition to these surveys, each CLC was given a clinic survey to complete which probed for issues, challenges associated with human resources, ability to staff satellite and sub offices, technological capacity, current practices in terms of intake and the ways in which clinics were collaborating regionally.

Capacity & Gap Analysis - Regional & Local

Building on the site visits, the research team synthesized survey, interview and focus group data for the purposes of validating/modifying the community profiles for each clinic catchment area. In addition, the team utilized the above sources of data to compare the issues/needs identified against clinic capacity (locally and regionally). A summary analytic needs and resources report was produced for each catchment area which included current local/regional service delivery models.

Utilizing the diverse data sources (qualitative and quantitative), the research team essentially 'mapped' clinic-based and ancillary community assets supporting low income populations in each clinic catchment area, including technological capacity for service delivery. Finally, a comparative summary of needs, resources and capacities across the eleven (11) northern community legal clinic catchment areas was completed, with special emphasis on access issues and other barriers to services throughout the northern region as well as opportunities for service enhancements and sharing of resources.

Research Integration

In summary, the research integration piece represents a synthesis of all of the statistical and qualitative findings, including highlights from the perspective of needs, clinic capacity, assets (locally and regionally). The draft preliminary report includes potential transformative service delivery options and implications (locally and regionally) which will become the focus for the 'design workshop' in May 2015.

Design Workshop (May 2015)

The 1-day 'design workshop' with the Northern Region Steering Committee (members include all 11 Executive Directors and 1 Board member from each clinic) focused on the recommendations incorporated within the Preliminary Draft Report. The workshop entailed a facilitated process for decision-making and prioritization of the recommendations and included but was not limited to actions to break the ODSP burden to creating and introducing a collaborative community clinic practice model (see full set of recommendations, actions, timelines and priorities on pages 16-25). The direction of this facilitated process was set by first collectively affirming the following core principles and strategic goals.

Overarching Affirmation of Core Principles/Assets of the NCLC System

1. Separate, independent, autonomous organizations
2. Governed by community board within a defined geographic catchment area
3. Exercise a dual mandate of low income client legal service and community development and advocacy in poverty law
4. Reach deeply into the community to maximize client accessibility
5. Provide personal, one-to-one service to clients with legal issues
6. Connected to a larger community service/partnerships network.
7. Recognized as an essential individual and community resource for legal expertise in poverty law.

Strategic Goals of Recommendations

1. Preserve and enhance the core principles and strengths of community clinic law
2. Restore capacity to function as general service clinics in poverty law.
3. Establish the regional capacity to share resources and promote collaborative practice.
4. Strengthen the community development and collective advocacy role of clinics in their communities and in the northern region.

Final Revised Report (September 2015)

The design workshop results were incorporated into the Final Revised Report for submission to the Northern Region Transformation Project Steering Committee. This final revised report is accompanied by the following documents. 1. NRTP Clinic Survey Results 2. NRTP Client Survey Results 3. A Quantitative Data set for each NCLC catchment area.

CAPACITY AND GAPS ANALYSIS

It is important to situate a discussion of capacity and gaps within local and regional perspectives including: key pressure points (internal and external); poverty law areas that are predominating; legal system characteristics; cross-collaborations that are being initiated to better meet client needs including innovative practices; and finally, relationships with stakeholders (internal and external).

A. CAPACITY & GAPS - CONTEXT

Internal Pressure Points for CLC's

It was often noted that clinic staff are so bogged down in paperwork, administrative aspects of their jobs and casework that there is little time left for the important work of engaging community and proactively educating citizenry on their legal rights. Most key informants referenced increasing reporting obligations required by LAO and increasing oversight, in the context of decreasing resources (human and financial). There were also references to resources that were available to clinics in the past but which were scaled back (i.e. Northern Regional Training).

A number of key informants noted the all-consuming nature of the current transformation agenda, with some referencing the situational nature of LAO demands, going as far as to express skepticism and a certain degree of mistrust.

"LAO demands have monopolized staff time... exceedingly so … this seems to be situational as LAO looks for administrative savings. However, trying to squeeze savings out of the current service delivery model has institutional implications … (in terms of the endless stream of reports)… budget reviews, etc."

It was not unusual for clinic key informants, community stakeholders and clients to express fears associated with potential amalgamations and what they saw as a loss of services. A number of key informants spoke of the reality of living and working in the north, with miles and miles of bush between communities. Others spoke about burdensome administrative requirements that leave less time for client engagement.

"I wouldn't like to see (amalgamations) because people would have to travel even more than they do now. Clients don't get the services as is and it would be worse if the clinic were swallowed up (by Sudbury or Elliot Lake). Amalgamation works really well in downtown Toronto but not so much in Northern Ontario where you are separated by huge distances."

The most recent drive to secure administrative savings was also referenced as negatively impacting on clinic services, with clinics scaling back legal services, closing satellite operations and/or trying to find savings in other areas all the while operating on 'bare-bones' budgets.

"LAO keeps on adding layers and layers of bureaucracy that doesn't add to client services."

"There's always tensions and problems dealing with LAO … they micromanage what we do … saying we spend too much on administration but they keep increasing their administrative demands."

Several key informants reference a perceived 'adversarial' relationship between community legal clinics and LAO which was seen as deflecting attention away from client services. Being able to attract and retain the complement of staff, including the ability to attract young lawyers, CLW's and paralegals to work in the north is considered to be a significant issue in terms of succession planning. Heavy workloads, lower pay grades, and the realities of living and working in the north were often referenced by key informants. In terms of sustainability, the fact that many senior management, including lawyers working in clinic law settings are approaching retirement age in the next 5-10 years is a critical issue that requires attention. Northern clinics face unique issues in terms of being able to attract articling students, issues which are exacerbated by the current lottery system (for example, the limited number of articling students that can be funded under the current system, as well as limits to the number of times a clinic can access this resource). Southern clinics are at an advantage in this respect by virtue of the fact that law schools are all situated in the

south, with the exception of Lakehead University's new Law School. In this regard, LAO would be well served by expanding its articling program, including exploring partnerships with Lakehead's Law School (i.e. increasing funding for articling students to pursue placements in northern clinics, which would help address current human resource issues, not to mention very real issues around sustainability and succession planning).

A number of community legal clinics report significant workload issues as well as a general lack of workplace wellness which should be of concern given what are expected to be increased demands for services once income thresholds are raised. Time and time again, staff and clinic representatives referenced the number of 'sick leaves' as compromising the health of clinics in general, not to mention negatively impacting on clients in terms of reduced capacity. Sick leaves and staff vacancies directly impact on the ability of clinics to follow through on commitments:

"Staff are working on an initiative … where multiple (agencies) host a drop in for low-income or homeless individuals. Because one (clinic) staff member got sick, the clinic couldn't (attend as planned)."

"There is no workplace wellness whatsoever … (and) the nature of the work is tough … always hearing sad stories..."

"Staff are taking on multiple roles … it's a road to burnout. They are doing the work of three people..."

Providing poverty law services in the north means that community legal clinics by virtue of their mandate are serving the most marginalized in society. Clients with mental health and addiction histories; First Nation individuals negatively impacted by historic trauma and cultural assimilation; and individuals who are excluded from full participation in community (whether that be economic, social or cultural) are all recipients of clinic law services. Many clients present with social, health and economic issues beyond the ability of legal clinics to address (for example, illiteracy, HEP C/AIDS; homelessness; mental health and addictions). Having to address mental health issues among client populations was often referenced as the 'norm', requiring heavy investments of time and energy, including but not limited to proactive efforts in building relationships with mental health agencies and other non-profits who provide crisis supports. In addition, there was recognition that clients with mental health and other types of challenges require a different approach, one that is more personal and 'hands-on'- hence taking more time.

The following comments speak to some of the challenges clinics face in attempting to effectively serve these clients, noting the fact that for many marginalized individuals, community legal clinics

are their first point of contact (alternately, clients often referenced CLC's as being their 'last resort'). The nature and complexity of client issues pose unique challenges to community legal clinics insofar as individuals accessing their services may not have a home address, phone and/or the ability to function within the confines of the clinic service delivery environment (i.e. for example, many can't follow through on appointments or complete the required paperwork in a timely manner). A number of key informants spoke about the need for more flexibility (i.e. accepting clients who 'drop-in') which presents problems insofar as managing service delivery and human resources.

"Clients are often in crisis ... have multiple issues and no way of accessing services. It's not like they have fixed addresses and are able to drive to appointments. They have difficulty navigating systems without supports ... they are very vulnerable."

"(Our) clients are often in crisis ... social, economic, personal issues. They often lack capacity to understand decisions because of illiteracy ... (We) spend time building trust ... we don't rush people out the door".

The ability of clinics to provide services to residents in outlying communities was a theme that was referenced across focus groups (client, stakeholder) and to a certain extent, client surveys. The extent to which clinics were seen to be meeting needs varied, with clinic staff and board members more likely to indicate they were adequately meeting needs compared to the perceptions of clients and community stakeholders.

It should be noted that most community stakeholders and clients prefaced their comments with the phrase "I know that clinics are doing their best ... " , "the ability of clinics to meet needs of outlying communities depends on adequacy of their funding" or "this is not a reflection on the community legal clinic" but ....

"In the city itself I don't think people have a problem getting to the clinic but in places like Mattawa, etc. it is more of an issue. Nancy lives in Mattawa and the clinic has a satellite office ... I don't know if you could get people to come to the clinic if there was no satellite office."

"Wawa and White River are under-serviced, however, it's impossible to serve them being under-staffed."

"Rural areas need more attention … need more satellite offices and more outreach to smaller communities."

"They need more resources as we all do, to be able to meet the needs here because the demand is growing ... They are doing a great job! But they're being pulled every which way..."

"*If this clinic closed and people had to travel to Sudbury for services, it would be very bad! The staff should have more resources. Need more staff to make it work for the people of Manitoulin Island. This has no reflection on the (community legal clinic) but ... when you get Legal Aid lawyers they drag out the cases to use up all the money."*

"From what I know, the staff at (name of community legal clinic) never stop, but there is only so much to go around ..."

Call Centres vs Face to Face

Serving clients with complex needs automatically speaks to the trend for alternative service delivery mechanisms such as increased reliance on 1-800 call centres and websites. In the context of the NRTP, cautions were expressed about the effectiveness of 'call centre' services for individuals that are marginalized and who face many legal and social issues. Furthermore, clients typically accessing services of clinics and other community and/or government agencies are often in crisis mode which impacts on their ability to follow through across many areas of concern. They often don't have access to phones and/or have pay-as-you go phone plans which only allow them a certain number of minutes per month which has implications in terms of being put on 'hold'. These realities are captured in the following comments:

"People don't have internet or computers so it's hard for them to access these services. Some folks don't have phones or have pay as you go cell phone plans ... they can't use up all their minutes waiting to speak to someone."

"People don't have home phone lines anymore ... even if they have cell phones they can't afford to sit in the Q … that's 6 months of their phone funds."

"My clients are given the 1-800 # and they are sent on their way ... that's it!

For a lot of First Nation people ...you have to do that face-to-face time..."

These themes were also noted in the results of the client surveys insofar as 57% of clients indicated they used a telephone (landline) versus 38% who used cell phones. Less than 40% of

clients who responded to the survey indicated they used a computer (linked to the internet) on a daily basis with a number of clients indicating they either 'did not own a computer' (10%) and/or were 'not comfortable' using a computer. When you combine the number of respondents who indicated they 'never' looked on the internet for legal information and/or they did not own a computer, more than two-thirds of clients surveyed would not be in a position to access legal services on-line. In rural areas of the north, where internet access can be a problem, relying on an on-line service delivery medium can be problematic. Client survey results indicated that for those clients who reported access to the internet, most did not consider the internet a useful tool in accessing legal information (less than 23% of clients surveyed indicated that the internet was a good way to find legal information).

"*There is an avalanche of information that has to be sifted through ... can be overwhelming and confusing."*

A common theme that crossed the key informant interviews and focus groups (client, community stakeholder and clinic) was in reference to the appropriateness of call centre services in the context of clients in crisis who in addition to legal information, require assistance in terms of ancillary services and supports.

"This kind of service might work in downtown Toronto, but it doesn't work in (the) north especially for FN members who need to be able to see the person they are entrusting with personal information (life stories). People want to see an individual, not just a voiceless person on a phone."

Community stakeholders who participated in focus groups or who were interviewed referenced the experience of clients who they had recommended to various call centres. It was generally noted that call centres don't work well for clients, particularly First Nation clients and those with mental health, addictions and cognitive disabilities.

"*LAO's online lawyer referral service is a 'joke' ... I've heard nothing but complaints. They call ... expecting to get solid advice to their situation (but) because there is no follow up available locally, it doesn't go anywhere."*

"Phone calls and 1-800 numbers don't work for the people we serve ... people need that human touch especially if they are in crisis as a lot of our clients are. Folks are not computer literate and many clients we serve are not comfortable talking on the phone ... some have no phone access..."

"*People don't get access to legal certificates because they don't have the literacy to be able to navigate when they call the 1-800 number. They just hang up and don't get served.*"

External Pressure Points for CLC's

A significant pressure point that is located outside of the mandate of community legal clinics relates to family law and the reality that CLCs are increasingly picking up the slack in the context of decreased funding of family law services. Several key informants referenced LAO's retraction of certificate programs beginning in the mid 1990's, where there were significant funding cuts to family law services[1] (Mossman et. al., 2010). Many informants noted how this decision continues to negatively impact on community legal clinics. Although not within the mandate of community legal clinics, decreased funding of family law services and programs has meant that CLC's are the default for individuals looking for assistance in these types of matters. Recognizing the need for more supports in this area, combined with the fact that family law clients are often clients of CLC's, some see a role for CLC's to bridge this gap provided they have the resources to do so...

"(When) LAO began rationing legal services … CLC's fared ok … but family law got it in the teeth. (Family law clients are often CLC clients). Single moms (who) face issues relating to income (and) social housing. (CLC's have and continue to) house family law services ... Community legal clinics are not the answer to family law services..."

By far, family law (including child welfare issues for many First Nation populations) was seen as a huge pressure point for most community legal clinics, particularly those located in rural/remote areas of the North where LAO family law services are not present or very limited or where there are few family lawyers practicing. Recurring themes included limited to non-existent services, and the prohibitive cost of private lawyers for those who don't qualify for LAO certificates. It is often the case that CLC's are the first point of contact for clients with family law needs, with many clinics feeling they have a responsibility to offer brief services and/or summary advice (including housing family lawyers in clinic law settings as a way to meet increasing demand for service).

"In terms of Family Law Clinics (FLICs), Legal Aid clinics and dedicated duty counsel ... it's never enough. Most women we deal with don't qualify for legal aid."

"There are gaps in family law ... gaps in the certificate system ... also problems with legal aid certificates (being) taken out of the region by (external) lawyers that don't effectively represent clients."

"Child protection cases represent a big legal need ... especially parents who want to fight CAS applications. (There are) no children's lawyers (available in many areas of the north)..."

"FLIC's (are) strictly (for) information ... can't refer to local 'support....if a client is not eligible their only alternative is to hire a lawyer, which they can't afford. (They) end up representing themselves or go with a duty counsel (who doesn't know their case)."

Complex Systems

Many key informants spoke of the challenges of working within the ODSP system, expressing frustration in the number of denials which are often reversed upon appeal; the pressure on government caseworkers to respond to unrealistic time frames (i.e. updating information on client applications, etc.) particularly when many clients lack phone service, are highly transient, or who have literacy issues which impacts on their ability to understand and comprehend correspondence.

As previously indicated, clients typically are in crisis and unable to follow through on appointments or required paperwork; not to mention lacking the capacity to navigate processes under increasingly tight timelines. Recent changes to the Canada Pension Plan and Workplace Safety Insurance Board were noted by a number of key informants as creating real barriers for potential applicants. Some key informants noted the limited role that Worker Advisors can play (i.e. unable to advocate for their clients), including limited access to these kinds of supports depending on where you live in the north.

"For the first 15 yrs. the clinic did WSIB files but we stopped doing WSIB as a workload management decision a number of yrs. ago. There were other resources in the community for injured workers to get legal help, although that is not the case anymore."

Key informants referenced the fact that individuals served by community legal clinics often bring negative experiences with systems to the table. It was not unusual for informants to speak of fearful clients and clients who are 'intimidated' by the various systems they are forced to navigate. These sentiments are captured in the following comments:

"*Clients are very low-income often present with multiple complications including issues navigating the various systems & fears (associated with) these systems."*

"Lots of clients are frightened by the Social Benefit Tribunal process ... Their experience with the various systems (has been) negative and re-victimizing ... (The) tribunal process is lengthy and traumatic ... and it's getting worse, not better ..."

"SBT is the worst … I've had a few clients who reapply many times but many

"just give up" … It's intimidating for us professionals … imagine what it's like for the average person who doesn't have formal or family support."

A common theme that permeated the discussion on government tribunals and processes was the fact that increasing complexity is resulting in the need for intensive supports for clients navigating such systems, which is taking time away from other important aspects of clinic law. Key informants were often quick to note the waste of resources and illogical nature of government policies and/or tribunals, including the importance of clinic 'advocacy'.

"The main issues faced by the ... Community Legal Clinic (system) relates to the high number of refusals for qualification for ODSP ... without any rational explanation."

"Clients show up at hearings … unrepresented … and it's intimidating. I think the community legal clinic should get a lot of credit for … their support and advocacy. It's not even (just) about representing clients at a tribunal, it's about the clinic trying their best to make sure that it doesn't go that far to begin with."

"Disability issues are huge...the disability system is convoluted and illogical ... many of (my) patients have trouble understanding correspondence. If they didn't have the CLC to support them ... many would fall through the cracks. The tribunal system is ... overwhelming for doctors and patients."

"Injured workers are often denied basic settlements. WSIB changes parallel the kinds of issues (highlighted) in the New Veterans Charter. But injured workers are much worse off because (we) don't have the financial resources and/or supports to take the provincial government to court."

Clients and community stakeholders alike expressed frustration with complex paperwork, intimidating processes and the need for more supports for clinics to be able to address this growing problem. A number of partners referenced the fact that their local community legal clinic used to have various government forms on-site, including being funded to train community members to assist clients in completing paperwork -- through an LAO funded program-- but this is no longer the case.

"We used to … come to the clinic and get help filling out LAO applications. For the populations I serve they can't do this over the phone because they have limited understanding."

"Filling out forms is a big problem because our members don't know how to do this. We (band administrators) have to help them … we're not lawyers either."

In addition to challenges navigating the 'red tape', a common theme that was referenced in client and stakeholder focus groups concerned the government's agenda of 'gate-keeping', as perpetuating 'misinformation' and leaving clients in the dark as to their rights and entitlements:

"Gate-keeping processes are put in place … limit(ing) the number of people who can get through and get the service … that's being blunt. I've heard feedback from our withdrawal management staff (that) intake into the system and gate-keeping by gov't 1-800 numbers (is an important issue that) needs to be addressed. With the population we deal with … they are not in a state of mind to be able to use 1-800 numbers and they don't have support systems in place to help them."

"It's to keep people blind to exactly what they are entitled to... If you don't' know how can you squawk (argue)?"

Gaps in Legal Services

There was note of the changing landscape of poverty law services -- particularly after the ODSP legislation was introduced -- when some legal services were 'dropped' by many CLCs, notably Workplace Safety Insurance Board cases, Employment Insurance and housing matters related to repairs and maintenance. This has resulted in significant gaps which were acknowledged by a number of key informants. In particular, clients presenting with housing issues other than 'potential loss of tenancy' are of necessity reluctantly being turned away because of capacity issues.

There was general consensus that issues relating to employment insurance (EI), criminal injuries compensation (CICB) and worker's safety insurance board (WSIB) cases as well as consumer advocacy are pressing needs that cannot be addressed within the current clinic law system in Northern Ontario.

"(There are) quite a few gaps ... repair and harassment issues in housing.

Worker's Compensation ... consumer law, employment standards and CICB ...are areas where we don't currently provide services"

"Employment Law and human rights issues are not being addressed. Worker's compensation is (also) not being addressed ... if you have a small criminal matter, you have nowhere to go for help."

"Every day we get calls from people with maintenance and repair (issues)... We're not meeting the needs of people with employment issues..."

Region-specific gaps in legal services focused on issues relating to seniors (including CPP but also extending to consumer protection i.e. fraud and end of life issues such as power of attorney, wills and Health Care (competency). Focus group findings and the results of the client surveys reinforce the need for legal services to seniors (including those with cognitive, learning and developmental disabilities). Fully one quarter of clients who access clinic services reported needing help with CPP, debts, consumer problems, wills and power of attorney. Pay-day-loans and door-to-door energy retailers were common themes identified by community partners.

"We have 31 payday loan places operating out of Nipissing … they target the elderly."

"My mother signed up and it was a nightmare. They finally let her (out) of the contract (only because) I threatened (them) with legal action. If you start magnifying this scenario for an aging population base … (if you) don't have access to legal supports like the clinic, who's going to fight for them?" "(For) elderly people … Community Care Access Centre does assessments but if you don't' qualify you have to pay $1,500 … (it's) a big issue... people can't afford to pay this."

"Capacity issues and orders (that impact on elderly people and those with mental health issues) … (I'm) not sure how much assistance people are getting in fighting police powers (under the mental health act). There is a role for CLC's in helping people who get 'formed'."

In catchment areas with high Aboriginal populations, differences were noted in terms of access to services focused on human rights violations, issues associated with court processes (i.e. fly-in court proceedings which present logistical issues that impact on client ability to access duty counsel lawyers in a timely manner; being able to access the range of services available in most other jurisdictions of the province; and being able to access culturally-appropriate legal services).

It is notable that for a number of northern community legal clinics with significant First Nation caseloads, the configuration of legal services provided varied from that which was reported by other northern clinics, especially as it relates to First Nations sovereignty. Examples of differences include legal services whereby First Nation members are able to secure Identification

documentation as well as receiving support in terms of broader issues relating to Aboriginal identity and human rights.

"48% of our caseload (fits) the 'other' category ... Aboriginal rights ... we're often the first point of contact for First Nation people with legal problems."

"(We have a) large Aboriginal population ... many of whom should be on ODSP ... (but) are denied ... and never get past the next step."

"Legal clinics have ...a role to play in human rights work. Not just implementing current Human Rights code ... but building greater understanding..."

It is important to note that the provision of culturally-appropriate and safe legal services -- particularly for Aboriginal clients -- was seen as lacking in those parts of Northern Ontario where First Nation populations predominate (i.e. Cochrane District, especially for James Bay coastal communities, North Shore & Manitoulin Island). This does not take away from the importance of being able to provide culturally appropriate services to Aboriginal clients who present with legal problems in more urban areas of the north (such as Sudbury, Thunder Bay, Timmins, Sault Ste. Marie and North Bay).

Aboriginal issues were referenced by key informants, more or less, depending on the proportion of First Nation communities within the respective community legal clinic catchment areas. In general, the issues Indigenous populations face were considered to be quite different. However, it was not always clear the degree to which community legal clinics were seen as being positioned to be able to do this work as is reflected in the following comment:

"(In the Northeast, I'm) not sure that any of legal clinics are well positioned (to work with FN populations) except Moosonee (Keewaytinok CLC). (The issues) FN's face (are) not the same (as for) mainstream (populations). Clinics need to have Aboriginal workers/staff… (LAO) needs to invest in making services culturally safe."

There was a sense that the new funding being allocated to community legal clinics could potentially enable clinics to be able to work more collaboratively on a regional scale to better meet needs. This is considered to be particularly important given the changes to eligibility requirements which are expected to challenge clinics in terms of their ability to meet needs in legal areas not presently captured by clinic mandates.

"With the new funding .... (and new) eligibility guidelines ... (we may be able to) look at ways of meeting unmet areas ... on a regional basis."

"As (the eligibility threshold) increases there are going to be different legal needs …. (for example), there is going to be more employment related (legal) issues … employment insurance issues … "

It was clearly expressed by most northern community legal clinics that without additional resources and staffing, raising the income threshold is a moot point as most will not be in a position to expand on the services they offer. Many indicated they are just 'keeping their heads above water' as is. *"Increasing the threshold won't impact our disability caseload ... but it will increase our CPP-D caseload. We already turn people away with CPP issues ... we already turn people away for landlord & tenant stuff (repairs & maintenance issues). Regardless if they increase the threshold, if we don't get another staff member we can't serve more people. You can only work with what you have..."*

Case Management, Outreach & Cross-Sectoral Collaborations

The complexities and external supports needed in order to effectively meet the needs of clients accessing community legal clinic services inherently speaks to issues associated with capacity with respect to case management and the ability of staff to work in a more integrated fashion with their community partners (legal and on-legal). Some of the issues referenced by key informants included slow/outdated IT software which is resulting in 'workarounds' (i.e. clinic staff referenced having to use their own laptops citing issues with LAO equipment). Being able to interface with other databases was also noted as a concern, although issues were raised concerning privacy and confidentiality.

The ability to be more effective on this front was not lost on key informants, many of whom perceived improvements in case management processes as having significant benefits to clients. There were a number of key informants who spoke of the need to move forward in this respect, noting examples of effective case management models being implemented in other parts of the province (i.e. Belleville, Brant, Scarborough and Mississauga). LAO's Client Information Management System (CIMS) which is expected to be implemented by the fall of 2015 elicited mixed reactions insofar as being able to address all of the challenges that have been identified.

"(LAO's) upgrading (computers) but it's taking so long … We have Citrix which allows us to work off site (but) … I can't (access Citrix)... because (LAO) hasn't got the (upgrades) done. "

"Our computers are slow and we get very little training … In other areas of the province (they) have been able to go ahead with case management, disability support project … (they get the) data in an appropriate form… "

A number of community legal clinics indicate they proactively do outreach, whether that entails offering legal services out of satellite/branch or sub offices, including bringing services to clients who are housebound or homeless. (It should be noted that for some community legal clinics, attempts to find administrative savings have resulted in the closure of certain satellite/branch offices which has had negative impacts in terms of serving those living on the outer edge of their catchment areas).

It was often recognized that for clinics to effectively address the multitude of issues that clients bring to the table, staff need to have a skill set that is considered unique to the clinic law system. The make-up of community legal clinics was a common theme identified by key informants with many recognizing that in order to meet clinic mandates -- including providing effective services to clients -- community legal clinics need to have blended staffing. Emphasis was placed on the importance of community legal workers (who are trained in community development and public legal education) which was seen as contradicting LAO's current preoccupation with paralegals a trend which was seen as potentially undermining the clinic law system.

"It's important to have (mixed staffing) ...Clinics (need) a balance of paralegals/lawyers and community legal workers."

"LAO seems to be encouraging ... lawyers and paralegals. This is undermining the CD and PLE mandate of clinics. Lawyers and paralegals don't have the necessary skills to effectively work in community."

Community Development, Public Legal Education and Advocacy

Before we speak to the issues, challenges and opportunities for community development, public law education and advocacy, it is important to note that these terms are not defined by LAO so there are differences in interpretation which are problematic. For example, 'community organizing', 'outreach, 'community development', 'public legal education 'and 'law reform' are all used interchangeably, despite the fact that they are distinct and separate terms with distinct and separate meanings.

For example, "community development" is defined as the process where community members come together to take collective action and generate solutions to community problems[16] (i.e.

16 http://www.peernetbc.com/what-is-community-development

relationship based social change), whereas "community organizing" is defined as the process of building power through involving a constituency in identifying problems they share and solutions to those problems (i.e. power-based social change).[17]

The former is predicated on the belief that positive change can happen through building strong, caring relationships while the latter is predicated on the belief that in order for positive change to occur on the ground, there must be a redistribution of power. "Advocacy" is defined as a political process by an individual or group which aims to influence decisions with political, economic and social systems and institutions.[18] Differing from advocacy, "law reform" refers to the process of examining existing laws, and advocating and implementing changes in the legal system, usually with the aim of enhancing justice or efficiency.[19]

"Outreach" tends to be defined according to service delivery: (i.e. providing services to populations who might not have access to those services). A key component of outreach is that the groups providing it are not stationary, but mobile. In addition to delivering services, outreach has an educational role (i.e. raising the level of awareness of existing services)[20].

Finally, "public legal education" (PLE) comprises a large range of activities intended to build public awareness and skills related to law and justice education[21]. PLE is not community development, community organizing, advocacy or outreach but is often a component of each of these services.

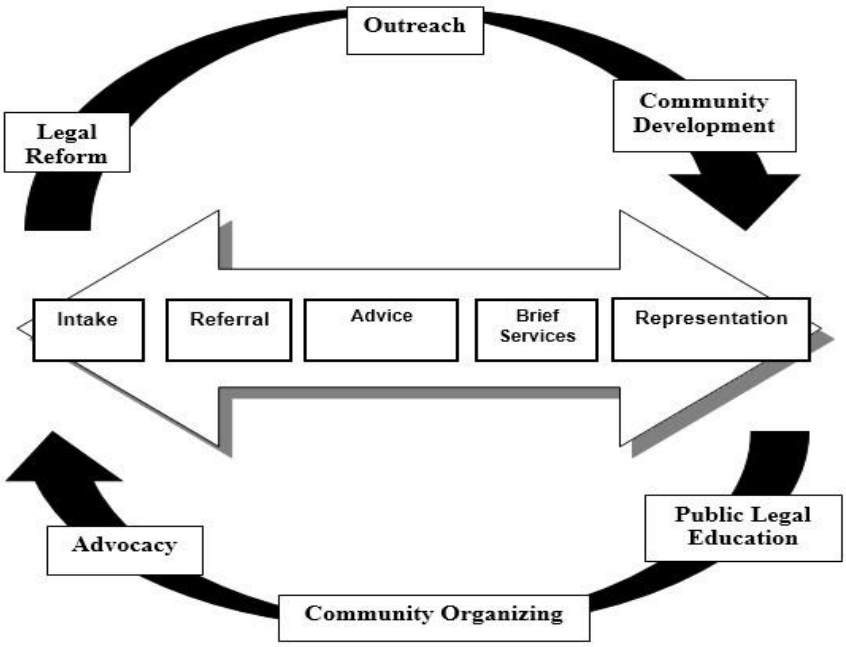
At the present time, LAO currently groups all of the aforementioned activities together under one section. (I.e. they are measured collectively under the category of "total outreach"). These kinds of inconsistencies are particularly concerning given the importance attached to statistics as driving decision-making processes around resource allocations. In addition, being able to plan for services is difficult in the context of such ambiguities. Being able to accurately capture community development activities versus outreach versus community organizing versus advocacy ... etc. must be predicated on clear and distinct categories. A service delivery continuum differs from the conceptualization of services as discrete entities and would address the difficulties in identifying where one activity ends and another one begins. To give a concrete example, say a client comes to a community legal clinic and receives a 'brief service'. They might learn more about their legal rights (which would be considered PLE), including being informed of a peer group (i.e. PROMPT or Speaker's School) and choose to participate (CD); they might also learn about and participate in organized events (which would be considered 'outreach'). As one can see, it becomes difficult to delineate where one type of service ends and where one type of service begins.

[17] http://comm-org.wisc.edu/papers97/beckwith.htm

[18] https://en.wikipedia.org/wiki/Advocacy
[19] https://en.wikipedia.org/wiki/Law_reform
[20] https://en.wikipedia.org/wiki/Outreach
[21] https://en.wikipedia.org/wiki/Legal_awareness

Using a different lens and way of understanding the aforementioned indicators as well as the other services CLC's provide (i.e. intake, referral, advice, brief services and representation) that uses the 'continuum of services" concept as being embedded within an on-going and cyclical process of outreach, community development, public legal education, community organizing, advocacy and legal reform is recommended.

Figure 1: Service Continuum and Community Development Process



At the present time, LAO collects and reports on community development, PLE and advocacy collectively. There is no question that all three represent important components of the clinic law system mandate, however, under the current reporting system one could make the argument that clinic work in these areas is not being captured. For the most part, community legal clinics take their responsibilities in this regard very seriously, noting the importance of proactively engaging the broader citizenry as it pertains to knowing their legal rights/responsibilities and organizing to exercise them. However, it should be noted that clinics are losing their CD capacity with many boards emphasizing casework as a priority. Some clinic staff also referenced boards as not necessarily being supportive of staff training in the area of community development.

"I would like to get trained in community development but I don't think our board would fund it..."

Clinics will continue to see their CD mandates erode unless efforts are made to keep these areas relevant and strong. The current NRTP uncovered issues with respect to the valuing of CD by LAO as well as by certain clinics who are having to cut back on the amount of CD work they engage in, in response to increasing caseloads:

“It shouldn't just be about the number of cases and summary advice... (it should be about) the quality of work we do in community ..."

"Overall (there is) very little organized advocacy … (within our) clinic and with other clinics organizations."

“LAO's performance measures don't capture the realities of community development work. They don’t realize that community development takes time. The skills required are under-valued...”

During the course of the NRTP stakeholders tended to reference community development and advocacy in the same sentence (including referencing community organizing and law reform).

"Legal clinics should be doing more CD. There are networks and community groups in North Bay trying to help folks who are marginalized... [an employee] sits on most of these … and that's huge. It's so important. The legal clinic is at many tables, hearing what's going on...”

"(The clinic) plays an integral role in coordinating a lot of public education and advocacy initiatives ... they are in the homeless shelter talking to staff about emerging issues ... their focus is very much on trying to make the various systems work."

"(We used) the community legal clinic for trailer park issues … landlord tried to charge us for water … and he was raising the rent. (We had) 23 out of 25 tenants sign a petition to seek legal advice … if it wasn't for the legal clinic we wouldn't have known about our rights … and we would be on the streets."

Despite their best efforts, it was noted by a number of community legal clinics that rising caseloads and decreased resources are hampering their efforts on this front. A 2012 survey of the 11 Northern Community Legal Clinics reports that upper level staff are predominately focused on casework to the exclusion of non-casework activity. For example, less than 5% of E.D.'s time targeted poverty law research, community development and public legal education collectively. This contrasts to the time Executive Directors spent on direct client casework (65%) and overseeing executive management activities (25%) (PC; Nov. 2012). Based on responses from the

11 Northern clinics, it is safe to say that while law reform, community development and public legal education are important components of community legal clinics' mandate, realistically, these areas suffer from a lack of attention/investment despite the best efforts of staff and management.

"On average, we get 20 walk-ins and 50 plus phone calls a day … we lack resources... (Clinic) work is impactful and important even though it isn't always recognized (by) our funders."

"The clinic isn't out in the community enough … I sit on John Howard Society board (and) other staff sit on other boards. There is a need for more teamwork and outreach … (connecting) with First Nation communities."

"Everybody wants you to do outreach but you have to have the capacity. When you promote your services your intake increases by 20% and you struggle to meet this need … it's got to be a supported endeavour."

It is noteworthy that many legal clinics continue to engage in community development not withstanding their caseload levels, which speaks to the passion and commitment of staff to go above and beyond the call of duty in an effort to make a lasting difference in their communities.

Seeking out community partners in order to address complex client issues and the need to sustain advocacy and law reform efforts was a strong theme that was referenced by clinics and community agencies. In general, community partners used the terms commitment, passion and strong sense of social justice when speaking of community legal clinic staff.

The unique role that community legal clinics could potentially play in terms of advocacy was referenced as important to sustain and support. A number of community legal clinics provide forums designed to give a 'voice' to individuals with lived-experience of poverty, extending invitations to community partners who share clientele and who often referenced the scarcity of opportunities to engage in collective action. Though not always reflected in LAO statistics, engaging community partners across sectors was emphasized as critical to more effectively serve clients and equally important, to support positive change at the policy level.

"(We need more) advocacy ... We work on social justice issues at the client level... but this never gets translated to higher, systemic level. We need more opportunities to be able to collectively advocate for systems change."

"(I) do a lot (in terms of) poverty awareness and working with provincial campaigns (i.e. Put Food in the Budget; Homelessness Strategies, etc.). (These) campaigns haven't really had other clinics involved.

(Community legal) clinics would have a stronger voice for advocacy if (they all) worked together … they would be better positioned to advocate on provincial level issues. If there's a way the funding structure could be enhanced so that they could hire 1 person to be the coordinator of that larger advocacy committee … advocacy would take on a whole new level."

In almost all instances, key informants who were community partners to the respective community legal clinics noted strong and effective partnerships. Many went on to say that clinics within their region were leading community-based responses to better address homelessness, mental health and addictions issues and food security issues. A number of northern clinics were seen as leading the way in this regard, modelling best practices on how to effectively engage and build strong partnerships in order to better serve clients:

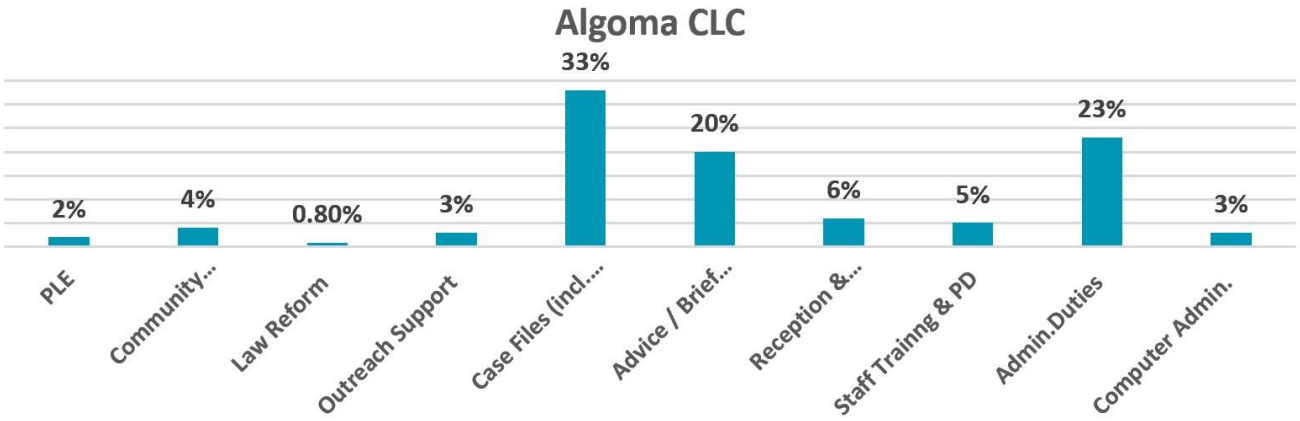
"The (clinic) has ... been recognized as a leader....however, capacity (is an issue) given rising caseloads and the undervaluing of community development in the eyes of their funder and (their) boards."

"(The clinic has) been in the community over 35 years …. (they`ve) developed these strong partnerships …"

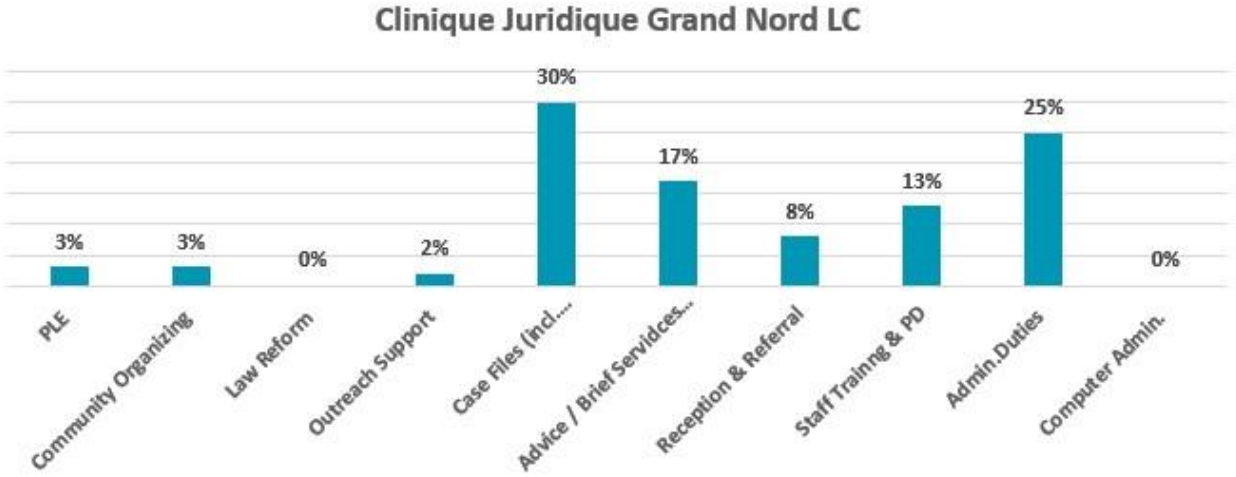
"The CLC was extremely helpful to family law staff who would not have known how to navigate (a local gov't housing department) process ..."

The following graphs and figures reinforce the trend that community legal clinics are overwhelmed with ODSP case files compared to the amount of time dedicated to community development, public legal education, law reform and outreach support (as reflected below in Figure 3: 2015/16 Funding Applications). For example, Figure 3 shows less than 10% of staff time is expected to be devoted to the four aforementioned areas. This contrasts sharply with anticipated staff time as reflected in case files, advice and brief service files (which range from 42% to 63% of staff time depending on the community legal clinic). Administrative Duties (i.e. budgets, completing LAO reports, ordering equipment, stationary etc.) are also capturing significant percentages of staff time (averaging 20% across all 11 CLC's). Based on an analysis of the 11 CLC funding applications, only one community legal clinic (Northwest) anticipates being able to distribute staff time more equitably across all of the categories (i.e. 25% of staff time is expected to be directed to community development, PLE, law reform and outreach support).

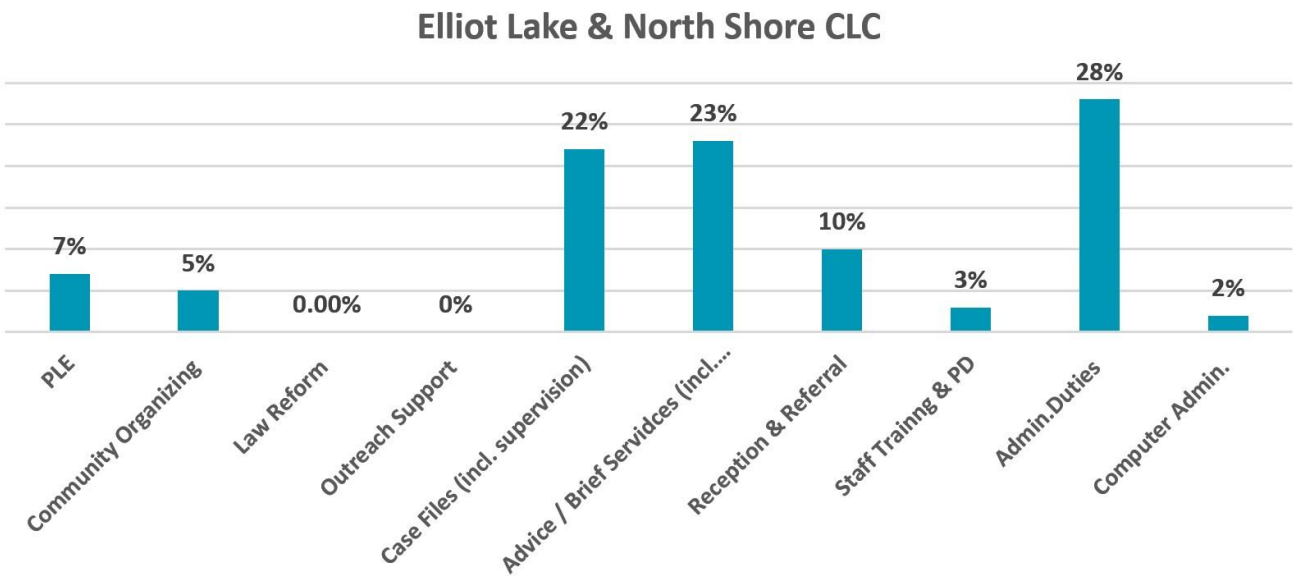
Figure 3: 15/16 Funding Applications by Clinic - Anticipated Staff Time



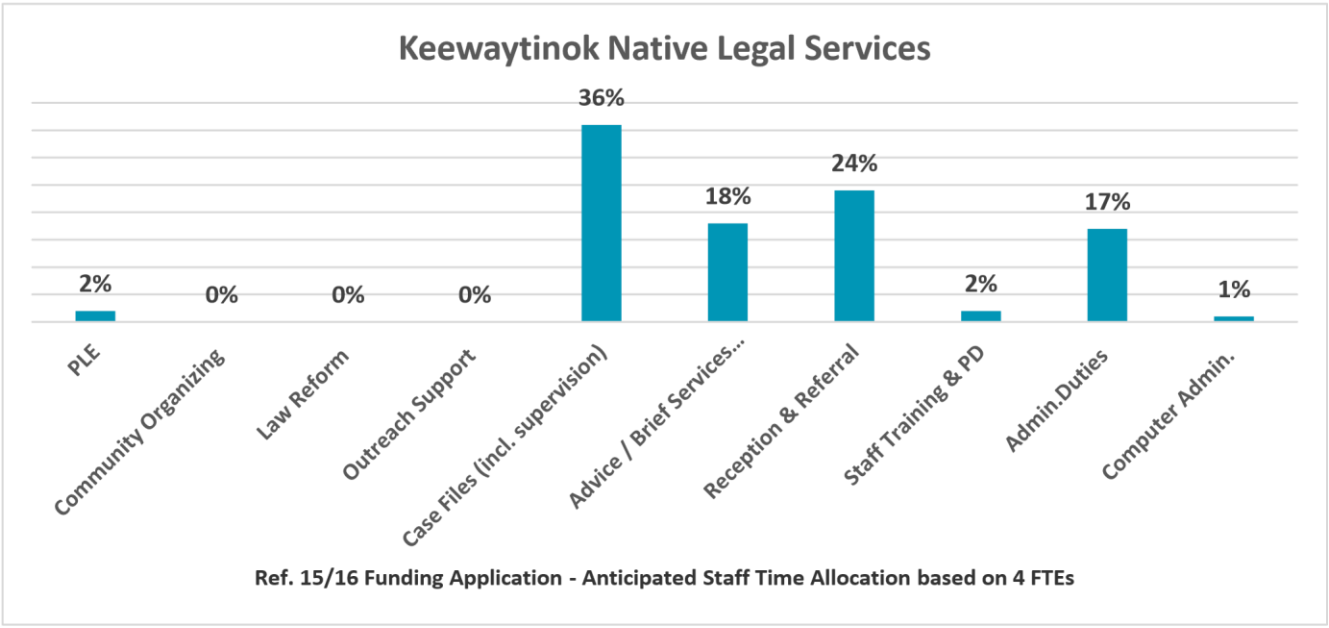
Ref. 15/16 LAO Funding Application - Anticipated Staff Allocation based on 6 FTEs



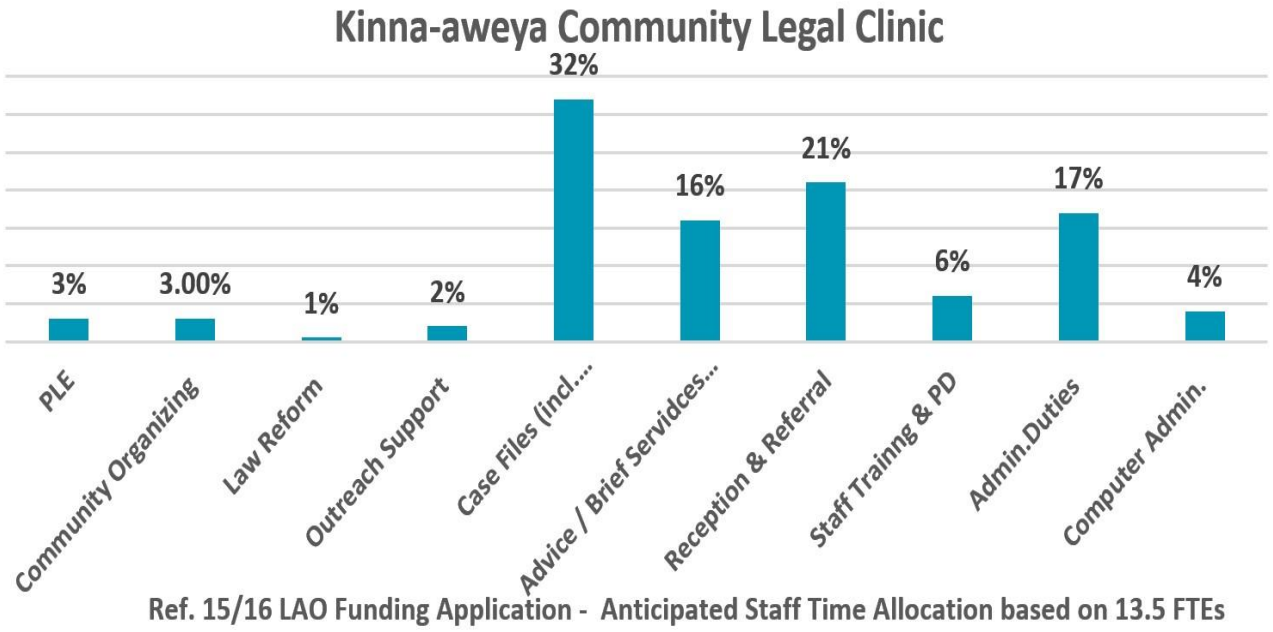
Ref. 15/16 LAO Funding App. -Anticipated Staff Time Allocation based on 4.5 FTEs



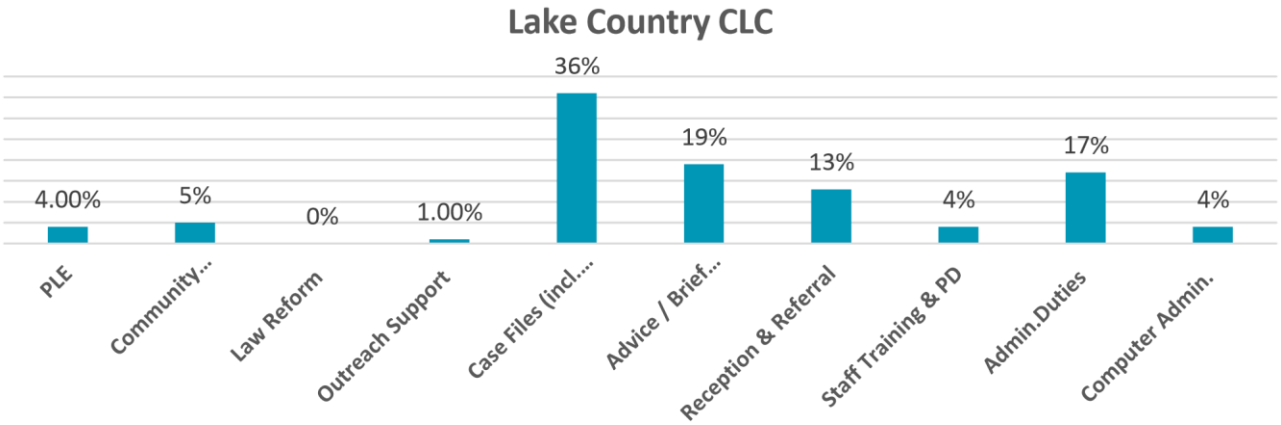
Ref. 15/16 LAO Funding Application - Anticipated Staff Time Allocation based on 3 FTEs



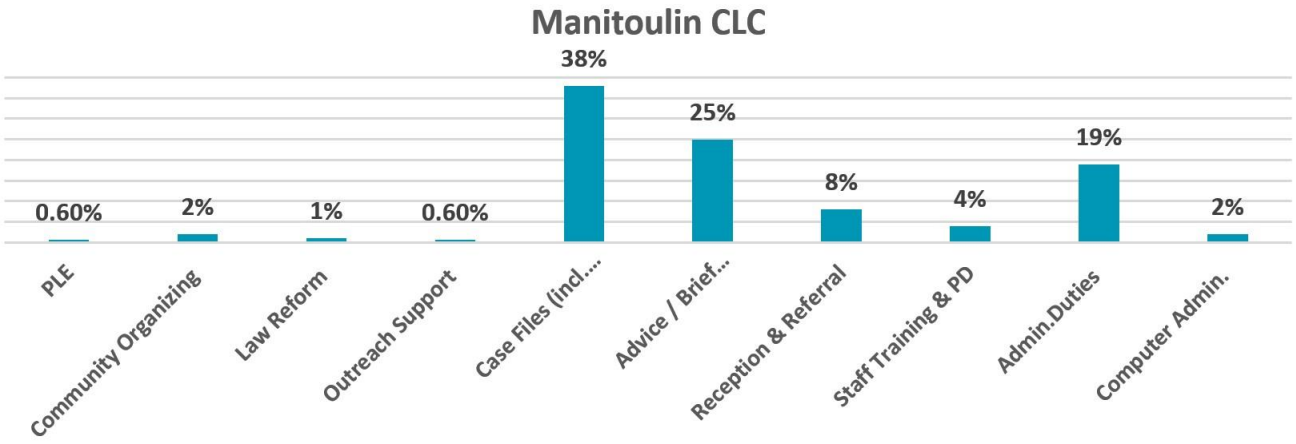
Ref. 15/16 Funding Application - Anticipated Staff Time Allocation based on 4 FTEs



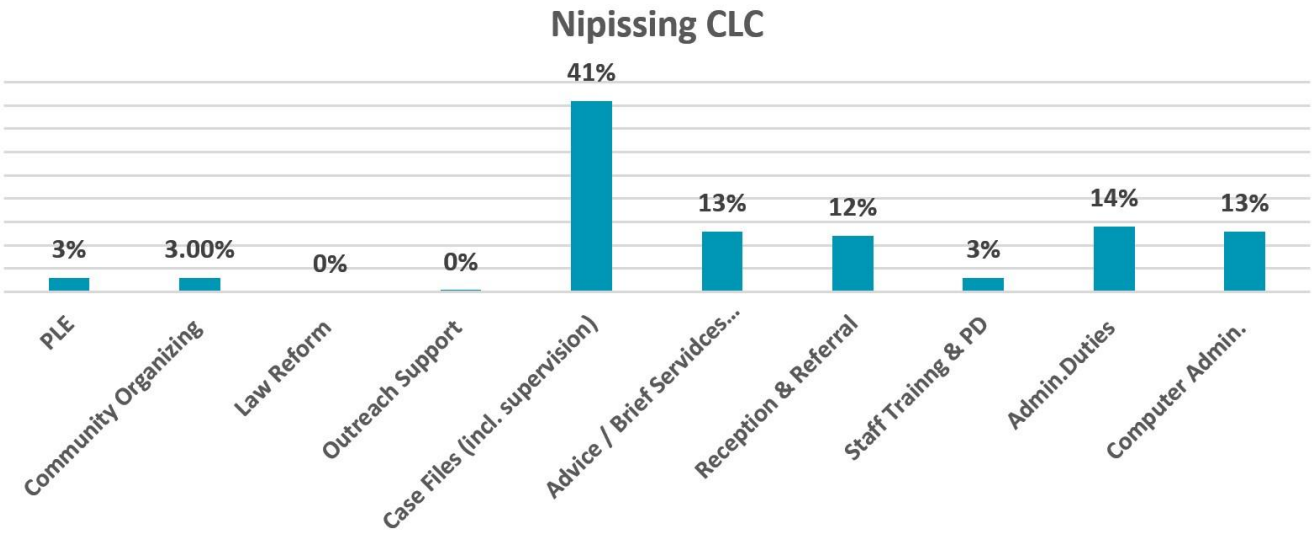
Ref. 15/16 LAO Funding Application - Anticipated Staff Time Allocation based on 13.5 FTEs



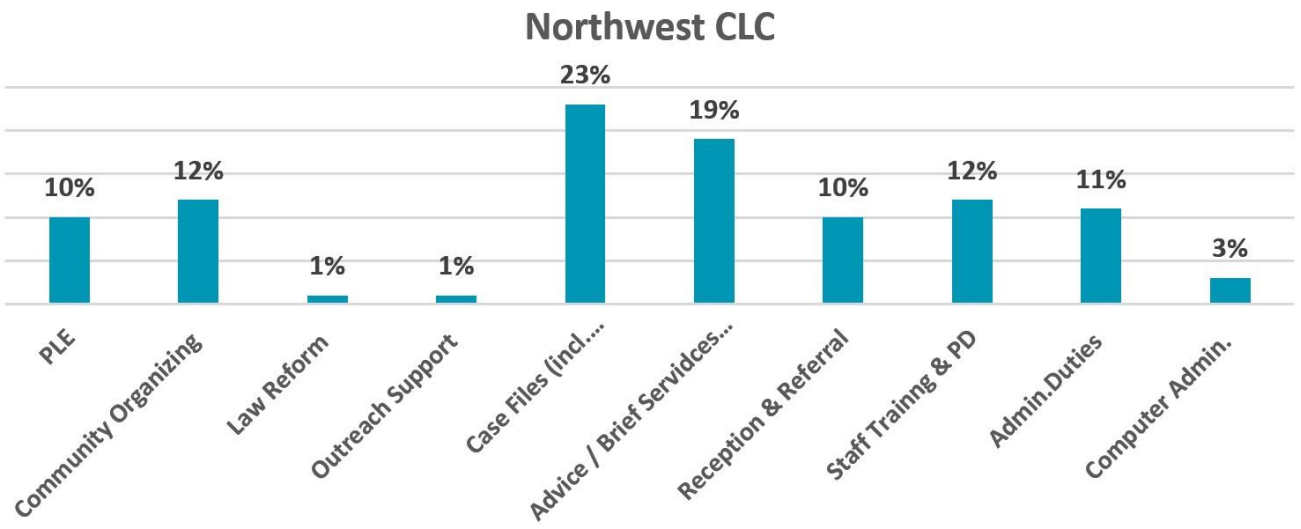
Ref. 15/16 Funding Application - Anticipated Staff Time Allocation Based on 6 FTEs



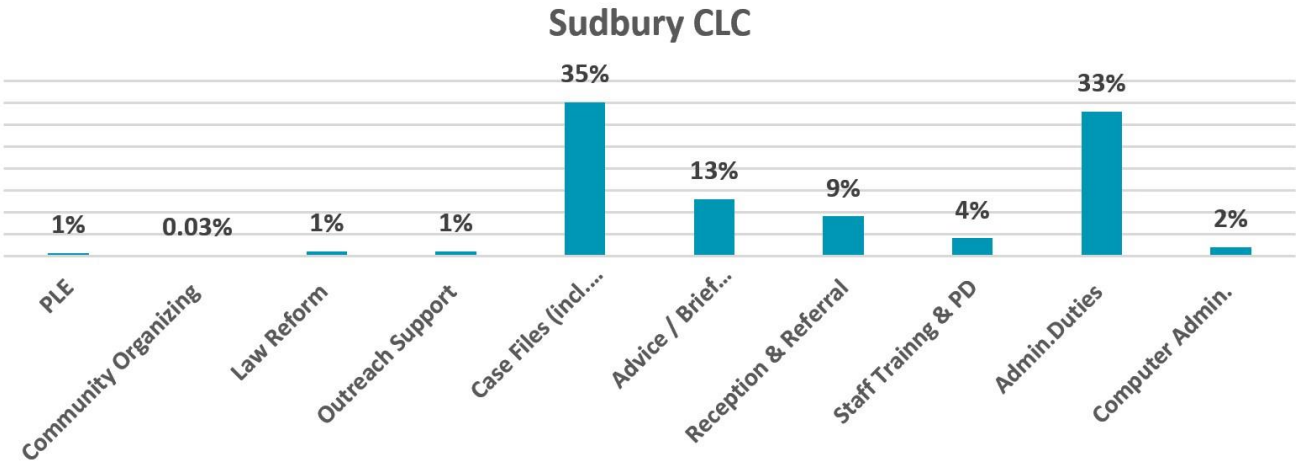
Ref. 15/16 LAO Funding Application - Anticipated Staff Time Allocation based on 3 FTEs



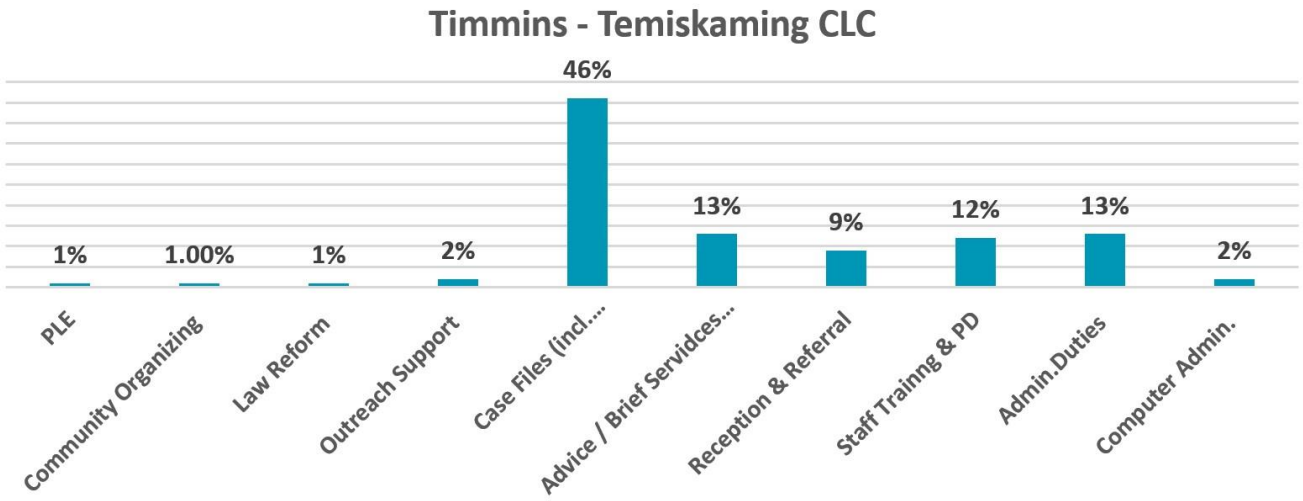
Ref. 15/16 LAO Funding Application - Anticipated Staff Time Allocation based on 5 FTEs



Ref. 15/16 LAO Funding App. - Anticipated Staff Time Allocation based on 10.3 FTEs



Ref. 15/16 LAO Funding App. - Staff Time Allocation based on 10 FTEs



Ref. 15/16 LAO Funding App. - Anticipated Staff Time Allocation based on 5 FTEs

Relationships – LAO Clinics, CLC's & External Non-Legal Agencies

A number of key informants who were interviewed made reference to the importance of ongoing opportunities to connect with partners which takes time. Other attributes noted by informants were building trust, which is often predicated on getting to know staff through their presence in community.
All of these factors were noted as being critical to strengthening partnerships.

"Having stable staffing has really helped in building strong relationships ... This is not typical of frontline providers in the non-profit/social services world. We have a lengthy and very good history with the CLC."

The ability to work collaboratively across community legal clinics hinges on human resource capacity in addition to identifying natural opportunities to scale up this type of sharing and relationship building. A number of opportunities were identified by key informants who were interviewed; most often in relation to Northern Regional Training, Community Legal Clinic E.D. meetings, Legal Aid Ontario Committee meetings, and cross-training workshops.

"More virtual study groups would be a benefit for community development and public legal education …."

"We work collaboratively at training sessions … I'd be open to sharing ideas … We do have a website however, there is no interactive capability."

"(In order to work more collaboratively across northern clinics), OPICCO (needs) to be funded, (we need a) northern coordinator position/support, (a) new statistics program and (LAO-funded) training."

There were a number of key informants who spoke about the benefits of working collaboratively with legal and non-legal service providers, including but not limited to collocating services where it makes sense. Caution was expressed when it comes to collocating CLCs with LAO offices for a number of reasons ranging from client safety (i.e. women survivors of violence would not be safe in a shared reception area); the potentially negative impacts on CLC's who share office space with LAO services where there are LAO office closures; the nature of the work -- in the case of potentially collocating services with LAO clinics, there were challenges associated with where offices would be situated (i.e. LAO clinics favour courthouse locations whereas community legal clinics are best situated within storefront locations embedded in the communities they serve). Cautions expressed in relation to LAO and CLC collocated services were not considered to be relevant in the context of non-legal service providers. In particular, a number of key informants noted the potential for co-located services with non-legal community agencies across many different sectors.

"Collocation with non-profits and community partners (offer) exciting possibilities. These agencies have same ethos ... the same philosophy around 'advocacy'.... (They tend to be) proactive. (The) Rexdale CLC clinic and Windsor bilingual clinics (are) good examples of collocated services that are working well."

"The Community Liaison Program (funded by the United Way SSM) is housed in the community legal clinic … (which is) an advantage. (My) clients have various legal issues … (so being collocated) is beneficial (in terms of) more collaborative working (relationships)."

Building on internal opportunities for more coordinated and integrated efforts amongst the 11 Northern community legal clinics, recent research conducted in conjunction with Phase 1 of the transformation project noted a high degree of reported inter-clinic activity in making case referrals and shared file transfer work (PC, Nov. 2012). In particular, three of the ten community legal clinics surveyed reported a high degree of consistency in reported case referrals between clinics. In terms of file sharing/file transfer work, while many relationships were reported, few instances of two-way file transfers were evident. This was also the case for continuing education and learning activities which merits further investigation. Finally, joint activity on law reform, community development/policy advocacy or public legal rights education was far less frequent, with only one

(1) northern community clinic reporting links to other community legal clinics in these activity areas (PC; Nov. 2012).
Particular advantages of collaborating with other northern community legal clinics, as noted by survey respondents included:

- the opportunity to share knowledge and expertise;
- coordinated efforts on common projects and issues; and
- a better understanding and appreciation among clinic staff, of the particular issues faced by clients residing in Northern Ontario (PC, Nov. 2012).

The ability of Northern community legal clinics to overcome jurisdictional barriers in order to better serve clients was noted as a particular strength. However, in most instances clinic policies and procedures need to be revisited in order to allow for this (i.e. one northern community legal clinic referenced the fact that they would have to get permission from their board to engage in cross jurisdictional file sharing).

Certain community legal clinic key informants spoke about the benefits of working with their counterparts across the north to better serve clients, particularly as it relates to WSIB, Criminal Injuries Compensation, ODSP and CPP. It is important to note that a number of key informants, including those speaking on behalf of LAO recognized the value of specialized expertise -- as found within CLC`s -- noting the above areas of law in addition to CLC`s with expertise in consumer, Aboriginal and human rights and disability law.

"LAO refer clients to CLC's based on specialty expertise. Manitoulin CLC's has specialized expertise in WSIB ... Elliot Lake CLC has expertise in seniors and consumer issues; Paul Lantz (Keewaytinok LC) has expertise in Treaty 9/First Nation issues ... and Sudbury CLC has expertise in ODSP cases...."

"(Being able to work more collaboratively requires a) dropping of jurisdictional silos. We dropped ours years ago. (There is no legislation preventing this from happening)... If we have the capacity to serve, we should be doing it."

"We're connected to different specialty clinics ... (through) the social assistance and community development list serve... (However), other than the Northern ED's Group and Office Manager's list serves ...legal clinics (aren't in a position to) collaborate in a technological way ..."

B. Capacity & Gaps – Regional

As part of the Northern Region Transformation Project, the Social Planning Council of Sudbury completed eleven community profiles which reflected in part, quantitative data collected from multiple sources including: Statistics Canada 2011 Census and National Household Survey data; 2012 taxfiler data[6]; ODSP and OW data. In addition, the research team utilized a social risk index -- developed by Human Resources Development Canada -- which represents a composite measure based on 8 Census and NHS variables.[7]

Utilizing all of the aforementioned data sources, the research team was able to identify variations across community legal clinic catchment areas. In particular, the social risk index (SRI) for each clinic catchment area was derived and then compared to the regional average as reported across the eleven (11) clinic catchment areas.

The Social Risk Index (SRI)

1. The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Stat Can NHS variables. The index is calculated by assigning one point when the community value exceeds the Ontario average. The SRI Index is used in this needs assessment as a tool to provide a means by which to compare clinic catchment areas well as provide an overall northern picture of social risk. Calculations for each clinic catchment area are based on calculations per census sub-divisions that are where appropriate weighted by population. The only exception to this is the "proportion of population who receive household income from government transfers" measure. This measure does not translate into number of people and therefore cannot be weighted by population. So in this case each catchment area's "proportion of population who receive household income from government transfers" is based on the average between each census sub-division for comparison sake.

2. Prevalence of low income

- Low income is associated with low-skilled jobs, high unemployment rates, unfavourable lifestyle and living conditions, and a greater prevalence of disability and health problems. It may also identify groups at risk for: marginalization, poor health status, malnutrition, poor housing conditions, learning problems in children, single parent families. People with low incomes have increased risk of illness and mortality as well higher levels of health service utilization.

3. Proportion of unemployed adults

- Unemployment is associated with low income and indicates socially disadvantaged status. It is associated with difficult living conditions, low socio-economic status, and health and social problems.

4. Proportion of adults with less than a high school education

• Studies have demonstrated a relationship between lower education and unskilled jobs, high unemployment, unfavourable living conditions, greater prevalence of disability and health problems, and potentially reduced access to health information.

5. Proportion of lone parent families

• Single parent families, especially those headed by females, may have reduced resources and access to health services.

6. Proportion of population that moved in the last year

• Mobility over one year is a measure of community transiency.

7. Proportion of population that identify as Aboriginal

• Health status characteristics and non-medical health determinants of Aboriginal people differ from the non-Aboriginal population, for example, infant mortality, unintentional injury deaths, suicides and smoking rates. Many reserves are in remote areas, and tend to be far from health services. This is useful information for planning population based services.

8. Proportion of population who receive household income from government transfers

• High proportion of income derived from government transfers may be a sign of lower socio-economic status, since the majority of these transfers are income supplements.

9. Proportion who rent their home

• Tenants are linked to mobility and stability, with tenants far more likely to undertake intra or inter-community movies compared to home owners. The differentiation between rental and owned housing can result in population sorting and consequent income segregation.

It is important to note that the average overall social risk for all the northern community legal clinic catchment areas falls within the medium 'risk' category with the following indicators being of particular concern in comparison to what is reported provincially:

- Northern clinic catchment areas report higher than average proportions of people that identify as Aboriginal (21% regionally versus 2% provincially);
- Northern clinic catchment areas report higher than average proportions of people that have low education (28% regionally versus 19% provincially);
- Northern clinic catchment areas report higher than average proportions of people that are unemployed (10% regionally versus 8% provincially; and finally,
- Northern clinic catchment areas report higher than average proportions of people receiving government transfers (23% regionally versus 12% provincially).
- In addition, northern clinic catchment areas report 31% tenants which is higher than reported for the province (28%).

Overall, the Northern clinic catchement area ranks a 5 on the Social Risk Index.

It is important to note that some clinic catchment areas reported higher proportions of their populations as having the greatest level of disadvantage or social risk. For example, the community legal clinic catchment areas of Keewaytinok (8), Nipissing (8) and Algoma (6) reported higher levels of social risk (on average). It is important to note that 5 community legal clinic catchment areas reported social risk indexes of 5 -- which falls within the medium to high risk category -- including a number of catchment areas that reported 'pockets' of high social risk as follows:

Census sub-divisions reporting an SRI of 8 included: Town of Parry Sound; North Bay; and Mattawa.

Medium to high social risk census sub-divisions (i.e. SRI of 6 - 7) included: Elliot Lake; Moosonee; Sault Ste. Marie; Kirkland Lake; Hearst; Thunder Bay; Kenora; Blind River; and Sudbury.[8] It is inferred that clinic catchment areas reporting higher social risk would most likely experience greater demand for legal and non-legal services (for example, Algoma and Nipissing catchment areas both of which are at the high end of the social risk index report higher demands for 'brief services' and/or 'advice' (respectively).

Figure 2: SRI Averages by Northern Clinic Catchment Areas

	Algoma	Clinique Grand Nord District	Elliot Lake North Shore Area	Keewaytinok	Kinna-aweya Area	Lake Country Area	Manitoulin Island	Nipissing District	North west Area	Sudbury District	Timmins - Temiskaming Area	Total Northern Profile	Ontario
Total Pop. (2011)	96,929	25,070	22,870	11,223	144,9093	105,285	13,048	90,217	46,515	182,745	79,582	817,982	
Social Risk Index	5	5	5	8	5	4	5	7	5	4	3	5	
Lone Parent Families	17%	13%	15%	34%	18%	13%	20%	17%	18%	16%	5%	17%	17%
Aboriginal Population	11%	11%	14%	80%	11%	6%	41%	10%	29%	9%	7%	21%	2%
Movers	10%	12%	11%	23%	11%	11%	10%	14%	11%	12%	10%	12%	12%
Tenants	29%	30%	35%	74%	26%	17%	14%	34%	23%	31%	28%	31%	28%
Low Education	21%	33%	25%	39%	22%	22%	27%	21%	24%	22%	27%	28%	19%
Unemployment rate	12%	9%	10%	9%	9%	9%	15%	9%	9%	8%	8%	10%	8%
Low Income (LIM-AT)	10%	13%	12%	29%	14%	12%	13%	15%	11%	13%	14%	14%	14%
Government Transfers	23%	24%	29%	15%	21%	19%	24%	21%	25%	17%	23%	22%	12%

LAO Statistics (2010 -- 2015): Categories of Service & Types of Cases

The following analysis is based on LAO statistics reported from 2010 to 2014/15 (including the 1st 3 quarters of 2014/15). The categories reported on include: (1) referrals; (2) brief services; (3) advice transactions; (4) total outreach and (5) cases opened. The following definitions are from the CMT Handbook -- 1998 -- Table of Contents and Definitions.

1. **Referrals** -- Referred from: captures where the client heard about the clinic; Referred to: captures referrals made by the clinic, advising the client to contact another resource for further assistance.

2. **Brief Services** -- Captures: (a) advice or assistance involving a significant amount of time (over one-half hour but less than 2 hours); or (b) some minimal advocacy undertaken (i.e. some telephone calls or a letter written on behalf of a client).

3. **Advice** -- Captures: where advice is given to the client by a caseworker with no follow-up (i.e. no extensive research, no letters written or phone calls made to third parties. There is no representation of the client, just advice provided to the client. Advice is usually expected to take a half-hour or less.

4. **Outreach** -- Captures any outreach efforts by the clinic, including talks given, yellow pages advertising, sign on the street, etc.

5. **Cases Open** -- A case file is client representation which goes beyond brief services. Where there is ongoing representation, or the assistance provided exceeds two hours, a case file should be opened (applying the eligibility guidelines).

There are a number of factors that impact on any/all of the aforementioned indicators including: clinic catchment size; satellite office (availability and number); availability of services which will vary depending on the setting (i.e. urban vs. rural/remote); clinic staffing levels (i.e. capacity) etc. Therefore while the following analysis highlights similarities and differences among and between the eleven community legal clinics, it represents one of many variables used in this report to better understand the poverty law service delivery environment.

Issues with Data

In the course of implementing the NRTP project the research team uncovered significant issues with data (as reported on by LAO through their CMT system). For example, there were inconsistencies noted in relation to the data provided for several community legal clinics as it pertained to 'referrals' and 'outreach".

"Outreach events tend to be under reported as some staff do not open files for them until they are about to close them. Thus, for a multi-year community development or law reform initiative, the number of sessions reported for 1 year could reflect several years' worth of meetings. Also, outreach stats (includes) training sessions attended by staff although it really is not outreach, the stats program treats them as such."

With so many errors and inconsistencies being reported, it is difficult not to call into question, the accuracy of the data which has implications in terms of decision-making as it relates to allocating funding. Other issues that were noted included timeframes (i.e. fiscal year vs. calendar year) and the cut-off points for data (in other words, in some cases it was not clear to the research team

whether the data being reported on was for a 12 month period or a 9 month period. Although the research team received clarification on these data issues, it became clear in the course of the NRTP project that LAO staff are not necessarily communicating with clinic staff around statistics and data issues (and vice versa). In this light, there were a number of community legal clinics who indicated they are collecting their own data in order to inform local planning and service delivery.

Another issue that was identified concerned how CMT captures data on referrals. Currently, clinics are only able to submit one referral per client which is problematic insofar as most clients need multiple referrals as they often present with 'clusters' of problem (i.e. legal, social, health, housing, etc.). The current performance measurement program needs to be revised accordingly given the fact that multiple referrals are the norm.

Finally, the fact that data for satellite/branch and or sub-offices is often not collected is problematic seeing as clinics have limited understanding of the types of legal issues, demographic characteristics and supports required for clients accessing services outside of main offices.

"(We have) no separate statistics for our satellite office."

In reviewing Legal Aid Ontario statistics for Northern Ontario between 2010/11 to the 1st 3 quarters of 2014/15 community legal clinics report the following transactions[9]. For example compared to the average reported for the north:

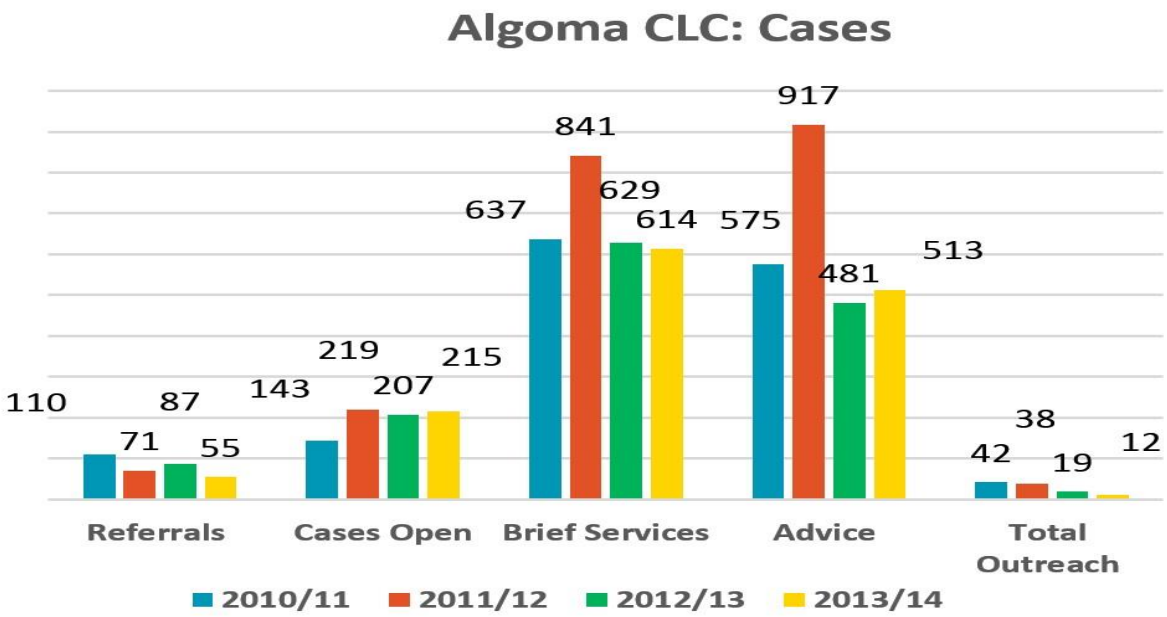
- Brief Services (average for all 11 CLC's = 314 per year) -- Northwest CLC, Algoma and Kinna-aweya stand out as reporting significantly higher than average number of 'brief services'. Elliot Lake also reports higher than average number of 'brief services'.
- Advice (average for all 11 CLC's = 897 per year) -- Kinna-aweya stands out at with Elliot Lake (1736) and Sudbury (1407) following, the Northwest CLC and Lake Country reporting higher than average number of 'advice' transactions.
- Referrals (average for all 11 CLC's = 435 per year) -- Sudbury CLC stands out at 2188. Kinna-awaya with approx.866 and with Elliot Lake next highest. Generally, referrals have decreased across all 11 community legal clinics since 2010 (with the exception of Algoma and Sudbury). (Referral data only reflect general trends as they are not accurate due to single counts).
- Total Outreach (average for all 11 CLC's is 44 per year) –Kinna-aweya stands out with 96 and Sudbury following at 48. Sudbury reports 'total outreach' numbers above the average with the remaining community legal clinics reporting outreach as ranging between 11- 43.

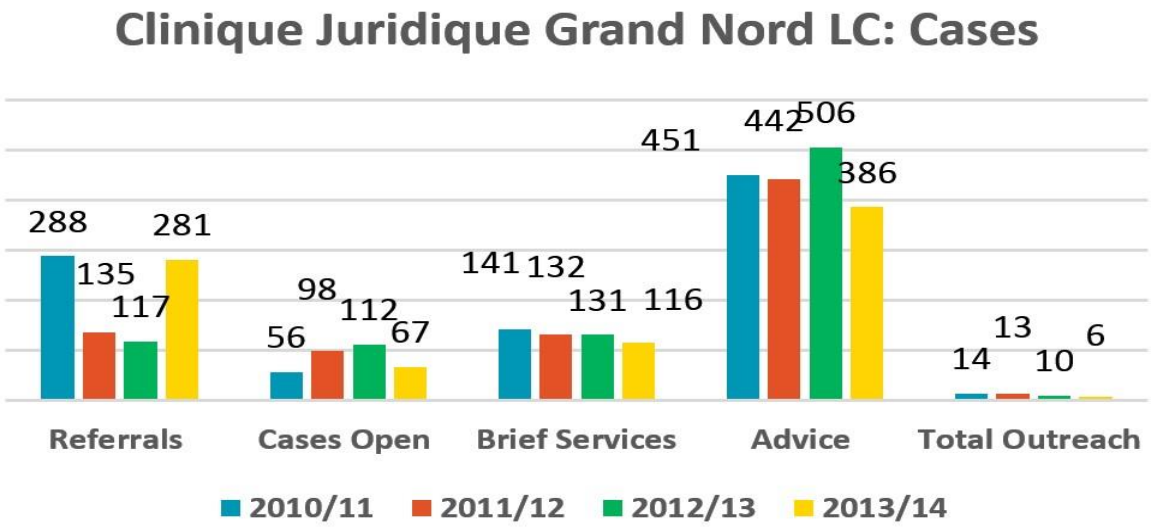
Generally, 'total outreach' has decreased since 2010 which might be related to the impact of LAO's administrative savings initiative which saw the closure of a number of satellite offices. This category also speaks to concerns that were expressed by stakeholders (clinic, client and

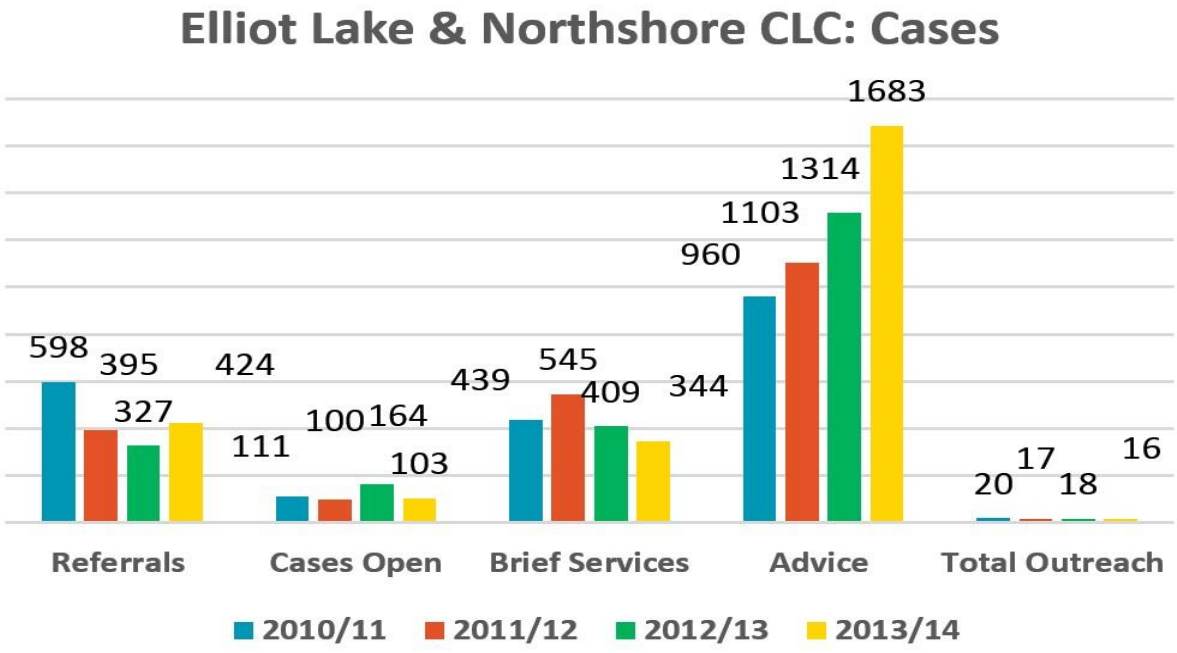
community) with respect to the ability of clinics to sustain partnerships (including the ability to engage in new partnerships) and fears about attracting more clients they are not able to serve.

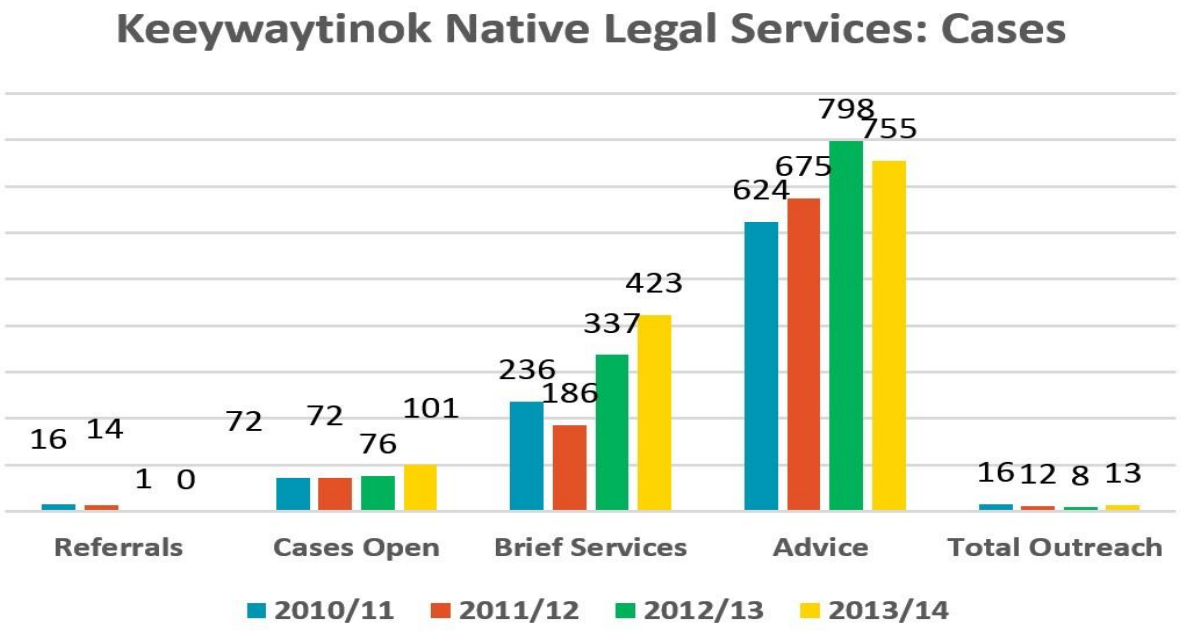
- Cases Opened (average for all 11 CLC's is 236 per year) -- Kinna-aweya stands out at 620 with Sudbury CLC with 419. Lake Country and Timmins-Temiskaming also reported higher than average 'cases opened'. Generally, the number of 'cases opened' across Northern community legal clinics has been on the decrease although statistics from the first three quarters of 2014/15 suggest an increase in the number of 'cases opened' for Algoma, Keewaytinok and Kinna-aweya.

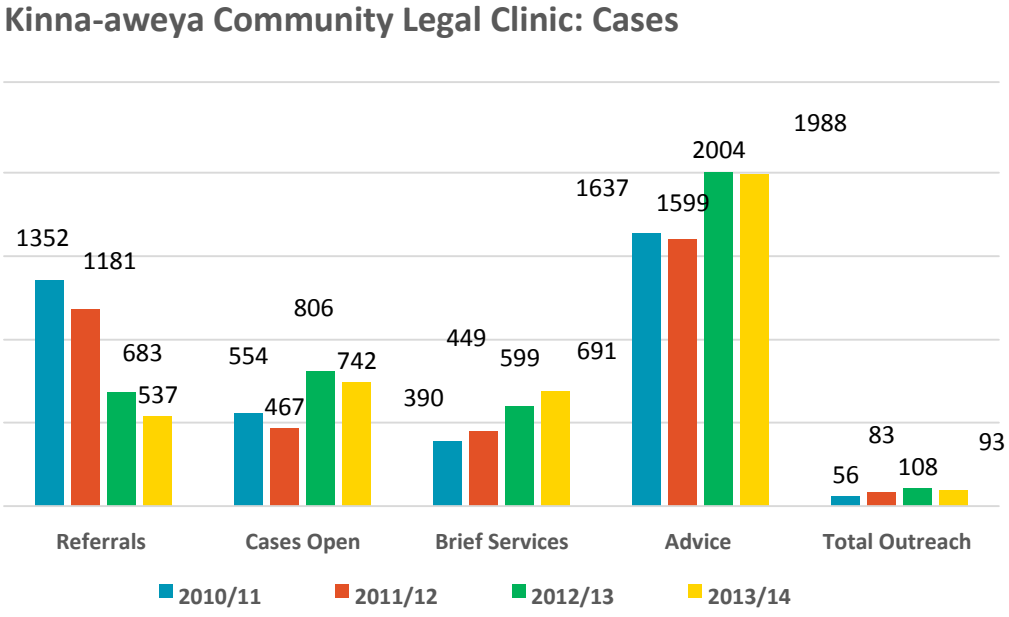
Figure 3: Northern Community Legal Clinic Cases 2010 – 2014 - LAO Stats.

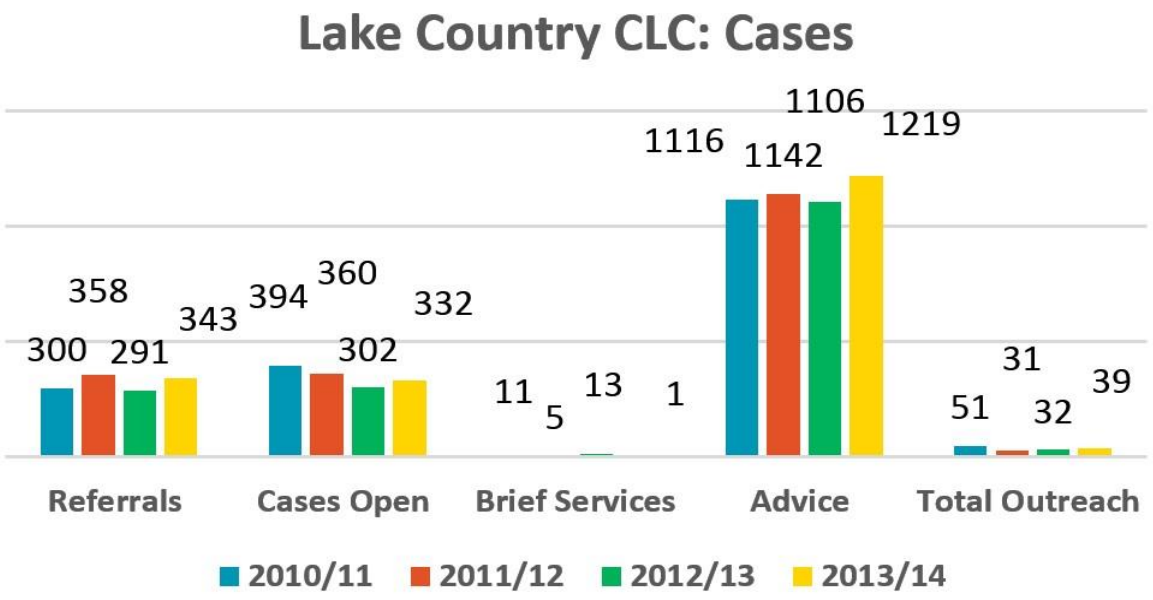


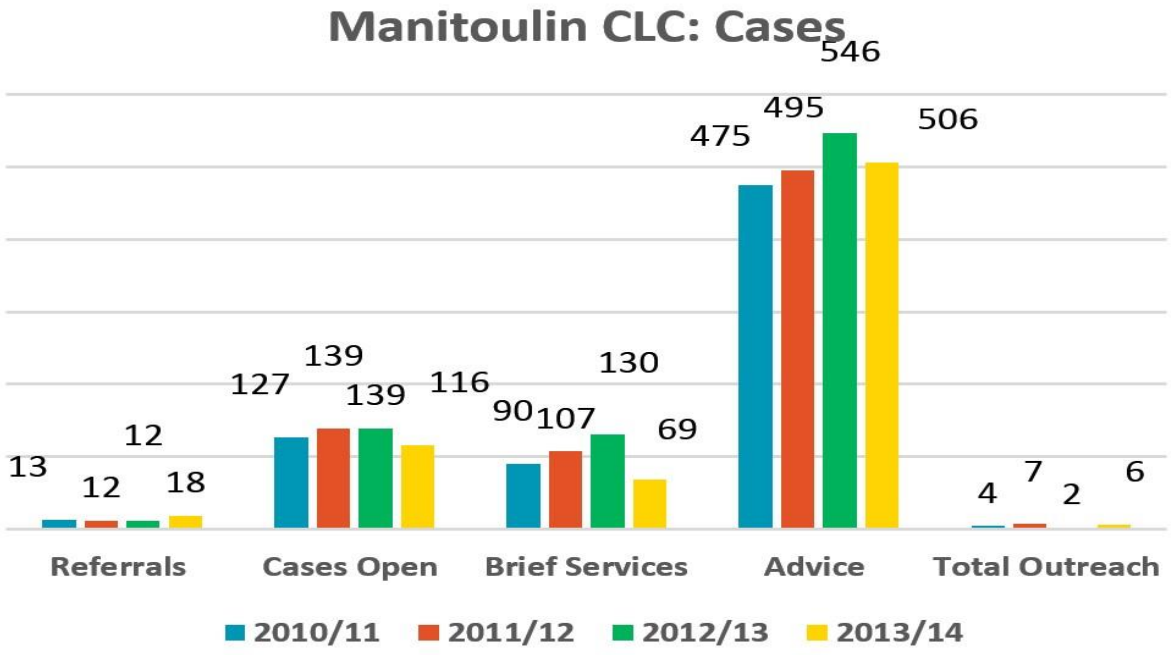

Clinique Juridique Grand Nord LC: Cases
288
135
117
281
56
98
112
67
141
132
131
116
451
442
506
386
14
13
10
6
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14

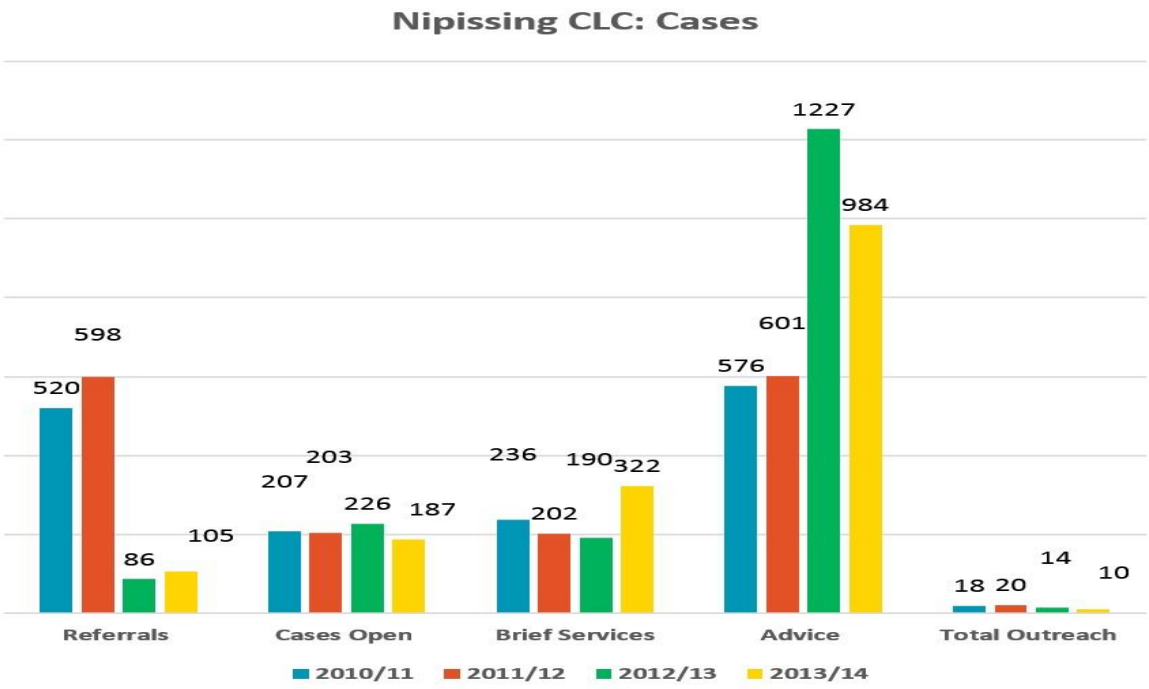

Elliot Lake & Northshore CLC: Cases
598
395
327
424
111
100
164
103
439
545
409
344
960
1103
1314
1683
20
17
18
16
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14

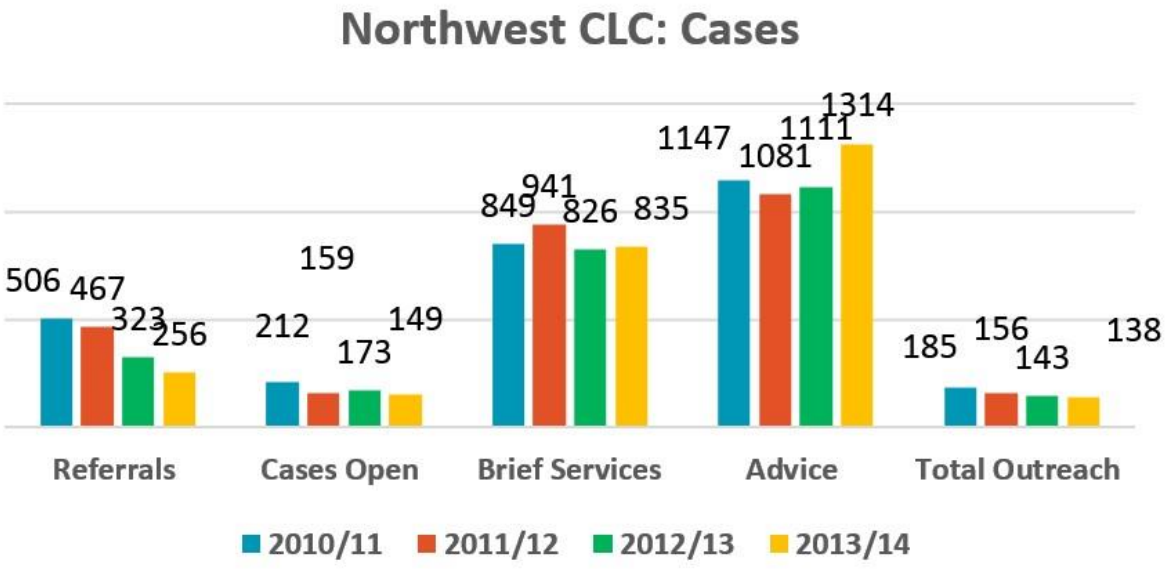

Keeywaytinok Native Legal Services: Cases
16
14
1
0
72
72
76
101
236
186
337
423
624
675
798
755
16
12
8
13
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14

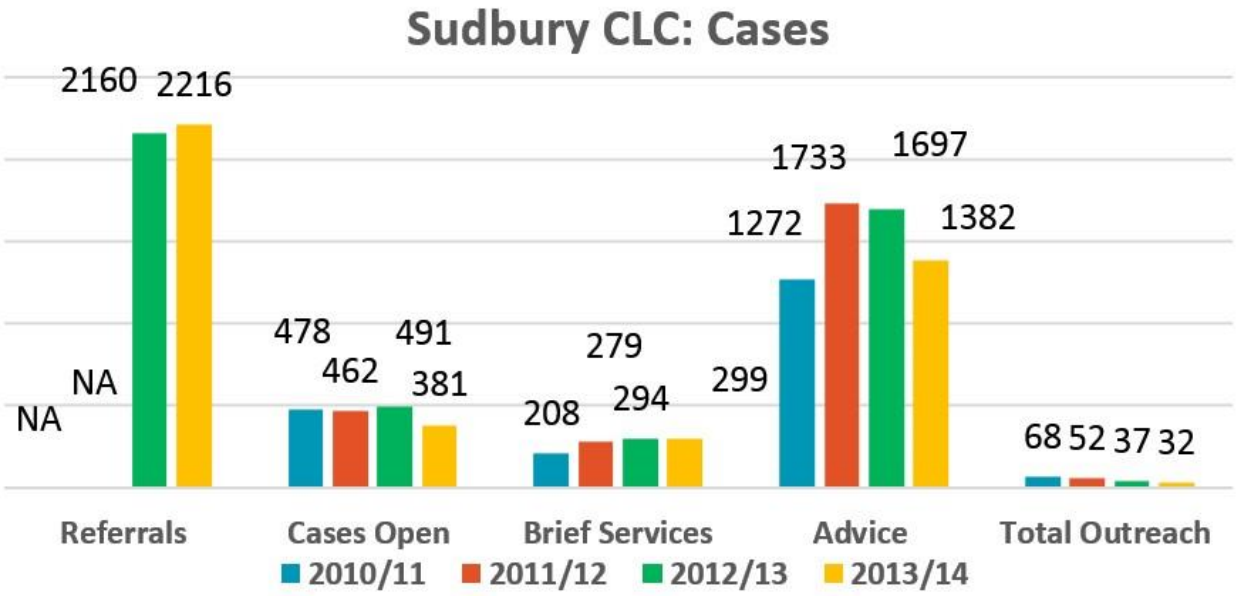

Kinna-aweya Community Legal Clinic: Cases
1352
1181
683
537
554
467
806
742
390
449
599
691
1637
1599
2004
1988
56
83
108
93
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14

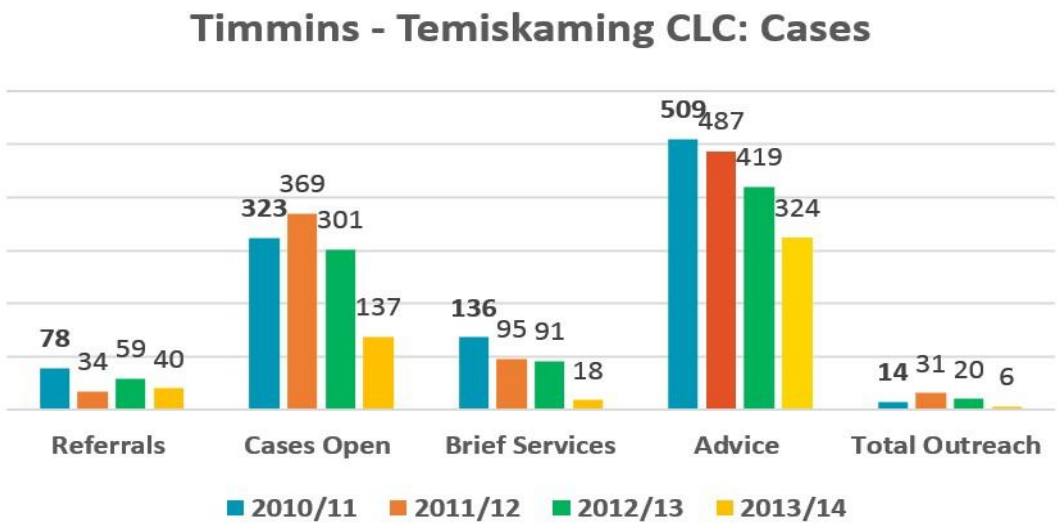

Lake Country CLC: Cases
300
358
291
343
394
360
302
332
11
5
13
1
1116
1142
1106
1219
51
31
32
39
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14


Manitoulin CLC: Cases
13
12
12
18
127
139
139
116
90
107
130
69
475
495
546
506
4
7
2
6
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14


Nipissing CLC: Cases
520
598
86
105
207
203
226
187
236
202
190
322
576
601
1227
984
18
20
14
10
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14


Northwest CLC: Cases
506
467
323
256
212
159
173
149
849
941
826
835
1147
1081
1111
1314
185
156
143
138
Referrals
Cases Open
Brief Services
Advice
Total Outreach
2010/11
2011/12
2012/13
2013/14





Capacity Issues

It is interesting to note the wide variations in capacity across the five specific types of services offered:

Brief Services

- Algoma and Elliot Lake CLC's which employ 6 and 3 Full-Time staff (respectively) report comparable numbers of client transactions as community legal clinics employing 10-13 FTE's

Advice

- Lake Country, Elliot Lake and Nipissing CLC's report some of the highest numbers of client interactions in this category based on their FTE staffing levels (5, 3, and 5 respectively) - compared to community legal clinic's with FTE's falling between 10 and 13.
- Once again, Keewaytinok reports proportionately higher numbers of advice' transactions (441 in 2013/14) in comparison to its total population (11,223).

Referrals

- Although the number of 'referrals' have decreased across the board (since 2010), in terms of capacity, Elliot Lake with its fewer FTE's (3) reports number of 'referrals' higher than community legal clinic's twice to three times its size.
- According to LAO statistics Sudbury CLC reported very low referrals. In a follow up conversation with the Executive Director, the research team revised these numbers accordingly (i.e. referrals reported between Jan. -- Oct. 2014 = 2216; referrals between Jan. -- Oct. 2013 = 2160).
- Manitoulin and Keewaytinok also report low referral numbers which most likely is a reflection of their rural/remoteness. It is generally the case that rural/remote areas lack much of the public infrastructure (i.e. services) that are available in urban areas (Slack et. al., 2001).
- Fewer services mean there are potentially fewer 'referrals'.
- Similarly, smaller community legal clinics might in fact be taking on clients without recourse to other services whose legal issues fall outside the clinic law system (which also might partially explain lower referral numbers).
- Once again, it is important to note that the current CMT program only captures 1 referral per client; however, in conversation with CLC's, they average 5 referrals per client (that means 4 of 5 referrals are not presently captured under the current system).

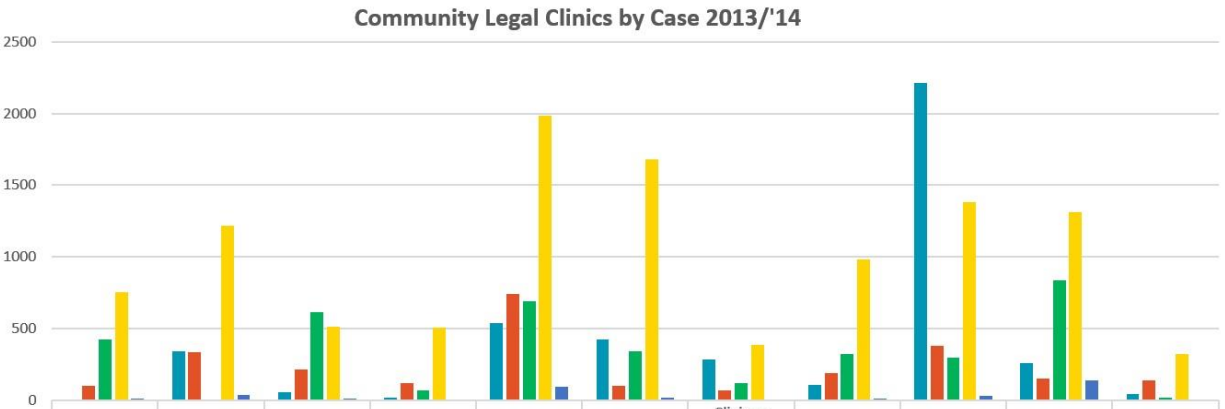
Total Outreach

- Kinna-aweya and the NWCLC report a lot of public legal education, law reform and community development activity.
- According to LAO statistics Sudbury CLC reported very low numbers for total outreach. In a follow-up conversation with the Executive Director, the research team revised these numbers accordingly.

- Algoma and Keewaytinok increased their 'total outreach' numbers. Keewaytinok's outreach numbers for the first three quarters of 2014/15 are particularly high given its smaller staffing complement.
- The Northwest CLC, Kinna-aweya and Lake Country all reported higher than average numbers of 'total outreach' transactions.
- There were wide variations reported among comparably sized clinics, particularly clinics reporting 10 or more FTE's, which appear to reflect inconsistent reporting practices.
- Once again, there are issues in the way clinics report on this type of data not to mention issues that relate to how the various categories are defined and measured (i.e. CD; community organizing; PLE; law reform; advocacy; outreach)

Cases Opened

- Based on the first three quarters of 2014/15, Timmins-Temiskaming has significantly exceeded its 2013/14 numbers in this area (which may be related to a recent mill closure in Iroquois Falls).
- Kinna-aweya, Sudbury, Lake Country, and Timmins-Temiskaming all report higher than average number of 'cases open'.



	Keeywaytinok NLS	Lake Country CLC	Algoma CLS	Manitoulin CLC	Kinna-awaya CLC	Eliott Lake & North Shore CLC	Clinique Juridique Grand Nord LC	Nipissing CLC	Sudbury CLC	NWCLC	Timmins - Temiskaming CLC
Referrals	0	343	55	18	537	424	281	105	2216	256	40
Cases Open	101	332	215	116	742	103	67	187	381	149	137
Brief Services	423	1	614	69	691	344	116	322	299	835	18
Advice	755	1219	513	506	1988	1683	386	984	1382	1314	324
Total Outreach	13	39	12	6	93	16	6	10	32	138	6

Types of Cases Opened

When one analyzes the types of cases community legal clinics opened in 2012/13 (see Figure 4) across the Northeast region, ODSP cases predominate. Cases opened only reflects new cases not on-going case work opened prior to these time periods. However, the graphs in Figure 4 provide insight into the trends occurring. Housing cases opened have remained stable at 16-18%. 11%-14% of cases fall within the 'other' category which merits further investigation. This might be a reflection of service requests across legal areas not typically seen by community legal clinics in the past.

Ontario Disability Support Program -- ODSP represents 50% of cases opened across the Northeast and 37% across the Northwest region (combined, they account for 43% of cases opened). Community Legal Clinics that report significantly higher ODSP cases opened -- compared to the regional average -- include: Algoma (70%); Nipissing (69%); Sudbury (57%) and Timmins Temiskaming (46%).

Housing Services **--** Housing issues represent 17% of cases opened across the Northeast and 16% of caseloads across the Northwest region. Community Legal Clinics that report significantly higher housing caseloads -- compared to the regional average --- include: Timmins-Temiskaming (36%); and to a lesser extent, Grand Nord (20%).

Ontario Works **--** OW represents 5% present of cases across the Northeast and 7% across the Northwest region. Community Legal Clinics that report significantly higher OW cases opened -- compared to the regional average (6%) -- include: Keewaytinok (17%); and Sudbury (10%).

Other Income Maintenance **--** Other income maintenance represents 10% across the Northeast and 7% across the Northwest region. Community Legal Clinics that report significantly higher Other Income Maintenance cases opened -- compared to the regional average (8.5%) include: Manitoulin (26%); Grand Nord (13%); Timmins-Temiskaming (13%); and Northwest CLC (12%).

'Other'-- 'Other' cases opened represents 10% across the Northeast and 11% across the Northwest region. Community Legal Clinics that report significantly higher 'Other' cases opened -- compared to the regional average (10.5%) include: Keewaytinok (39%); Manitoulin (33%); Elliot Lake (18%); and the Northwest CLC (17%).

Health Care -- Health Care represents 4% of cases opened across the Northeast and 0% across the Northwest region. Community Legal Clinics that report significantly higher health care cases -- compared to the regional average (2%) include: Elliot Lake (40%); Manitoulin (23%); and Keewaytinok (5%);

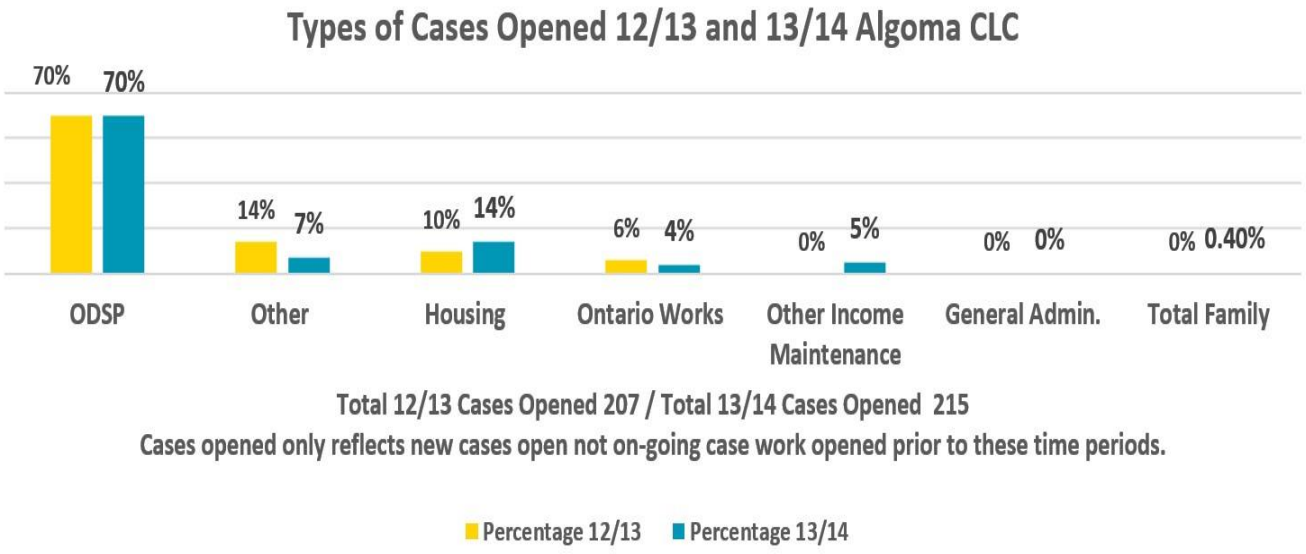
General Administration-- General Administration represents 0% of caseloads across the Northeast and 27% of caseloads across the Northwest region (averaging 14% across the north). Kinna-aweya

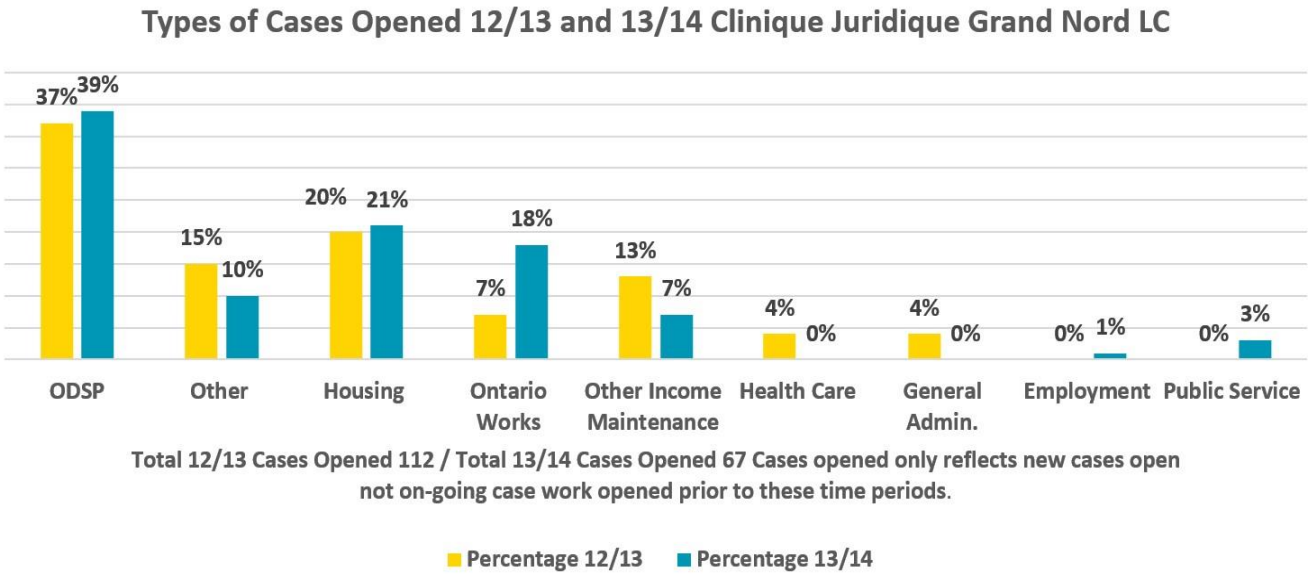
(31%) reports significantly higher general administration files than the regional average. It is assumed that Kinna-aweya high numbers of general administration cases reflects the number of ID clinics provided by the legal clinic (most recently, Kinna-aweya indicates cutting back on the number of ID clinics they provide because of capacity issues).

Although below the regional average, Keewaytinok (8%) Northwest Legal Clinic (8%); and to a lesser extent, Grand Nord (4%) and Sudbury (4%) report increasing percentages of general administration files.

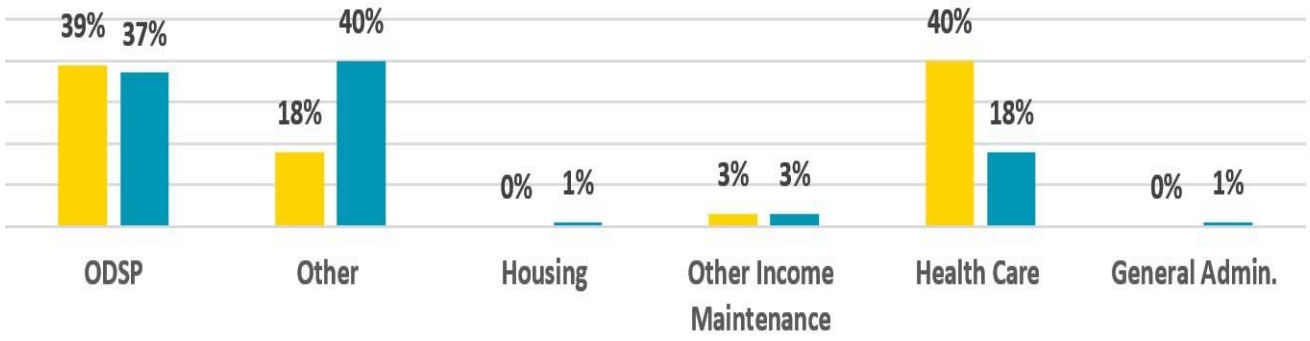
Human Rights & Aboriginal Rights -- Not surprisingly, Keewaytinok reported 20% of cases as falling within these two categories, with the Northwest CLC at 3%

Figure 4: Types of Cases Opened 12/13 and 13/14 by Clinic – LAO Stats.





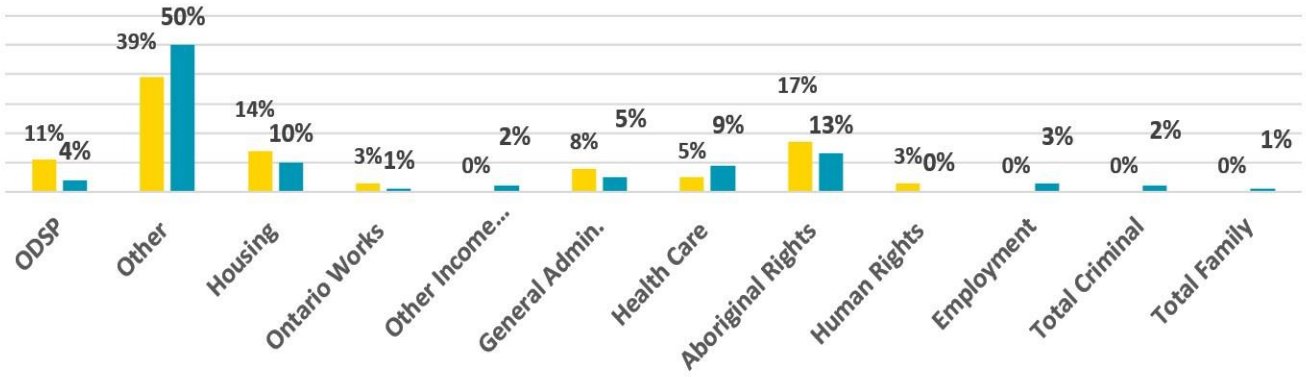
Types of Cases Opened 12/13 and 13/14 Elliot Lake & Northshore CLC



Total 12/13 Cases Opened 164 / Total 13/14 Cases Opened 103 Cases opened only reflects new cases open not on-going case work opened prior to these time periods.

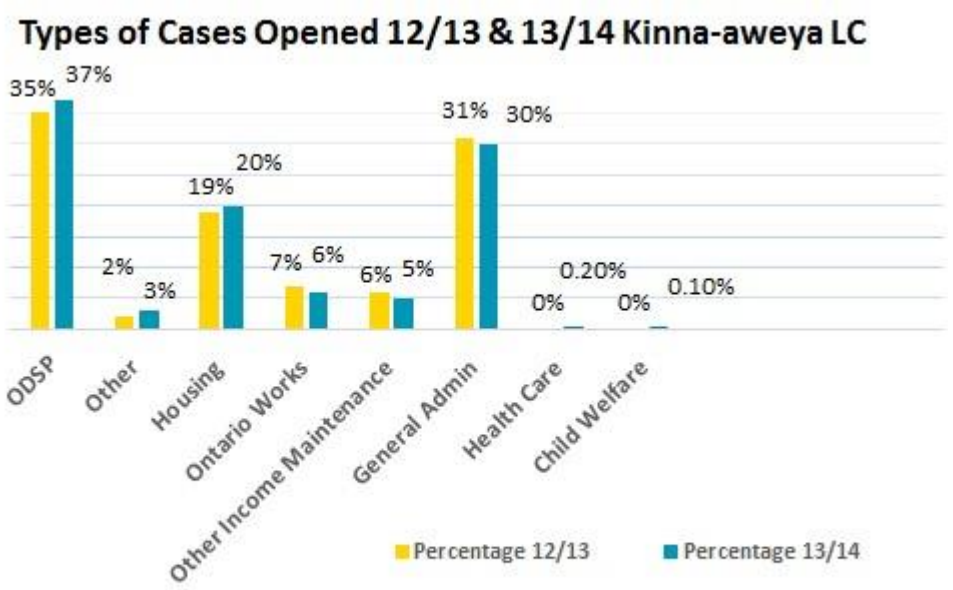
Percentage 12/13 Percentage 13/14

Types of Cases Opened 12/13 and 13/14 Keeywaytinok NLS

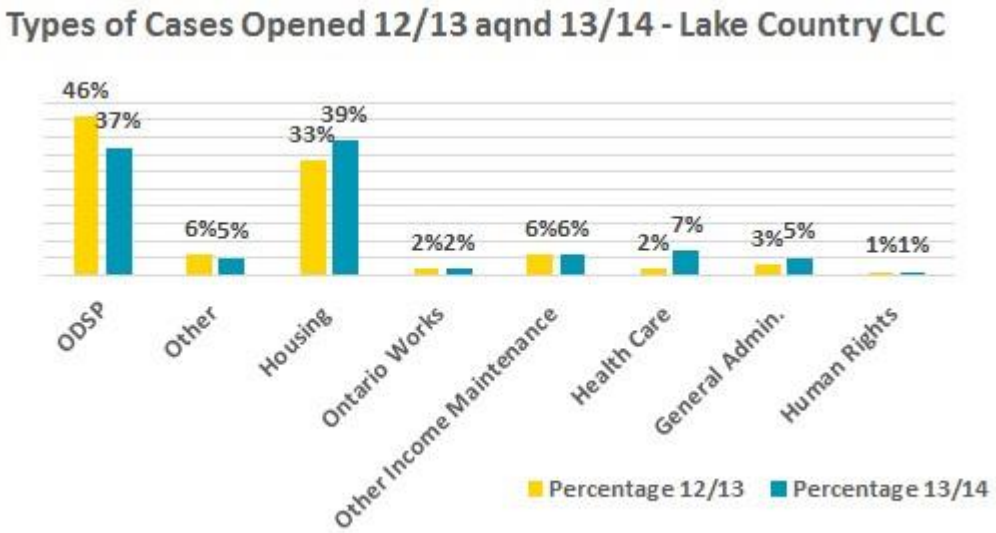


Total 12/13 Cases Opened 76 / Total 13/14 Cases Opened 101 Cases open only reflects new cases open not on-going case work opened prior to these time periods.

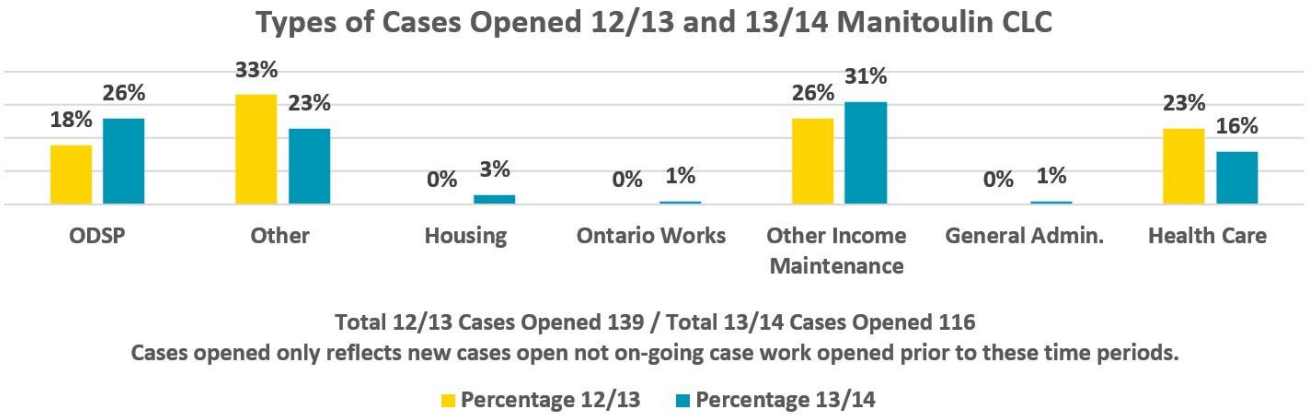
Percentage 12/13 Percentage 13/14

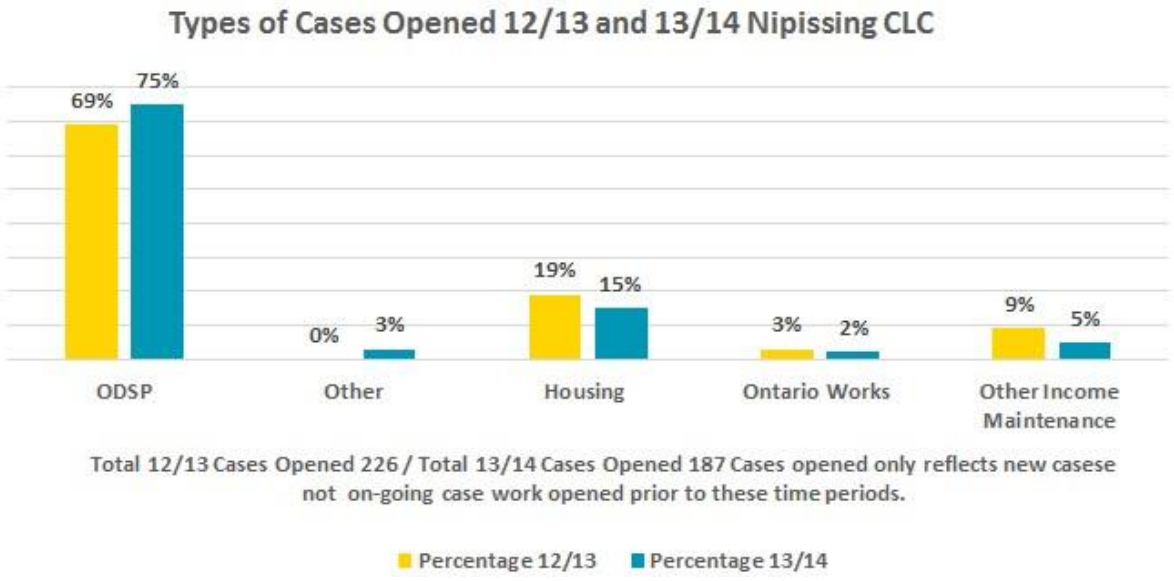


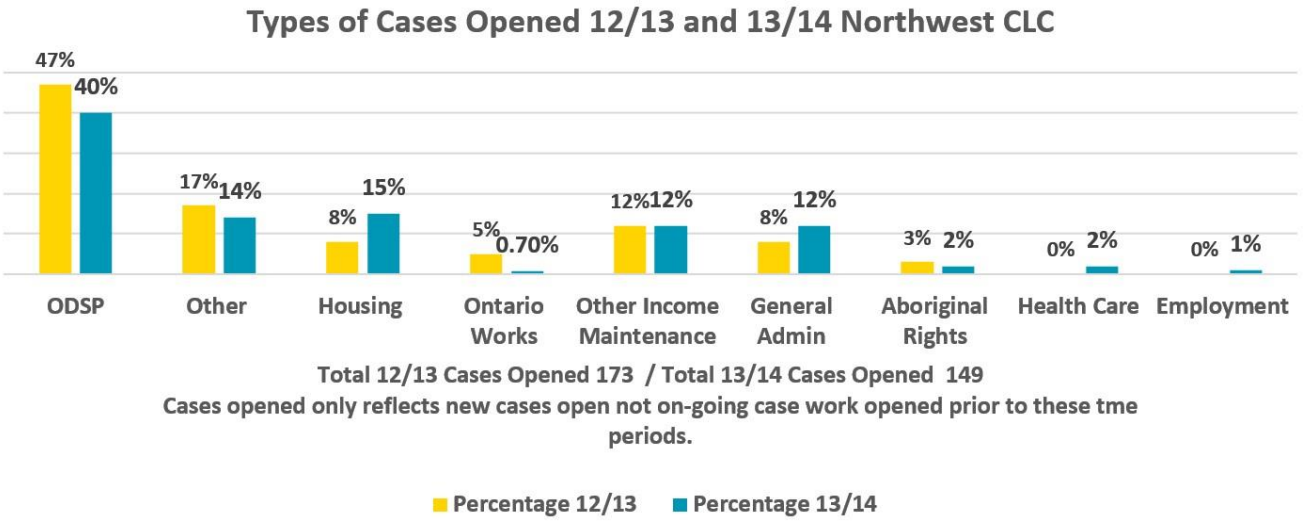
Total 12/13 Cases Opened 806 / Total 13/14 Cases Opened 742
Cases opened only reflects new cases open not on-going case work opened prior to these time periods.

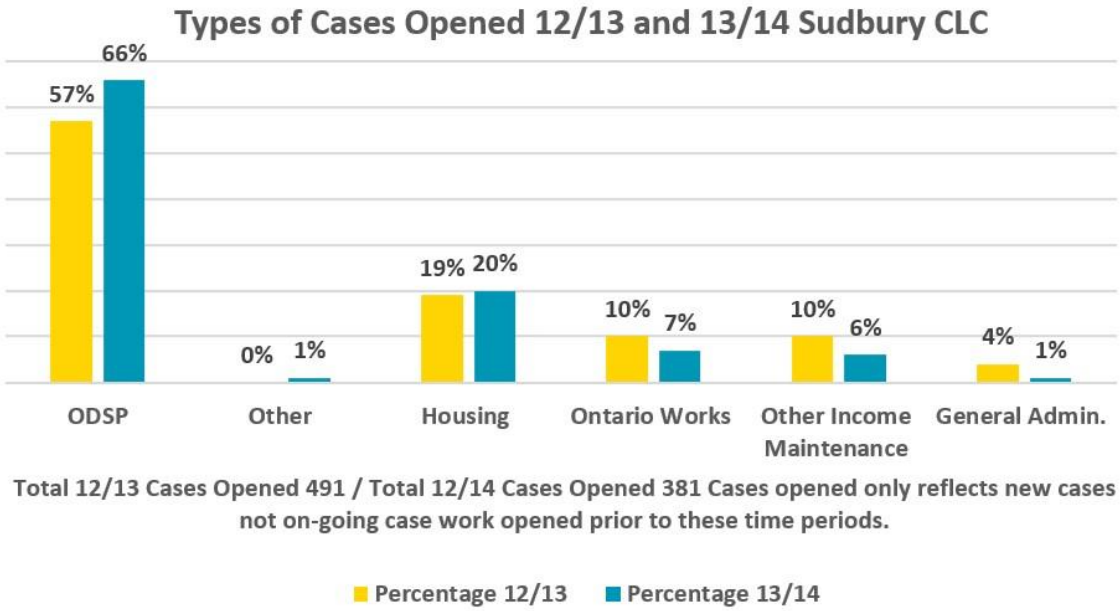


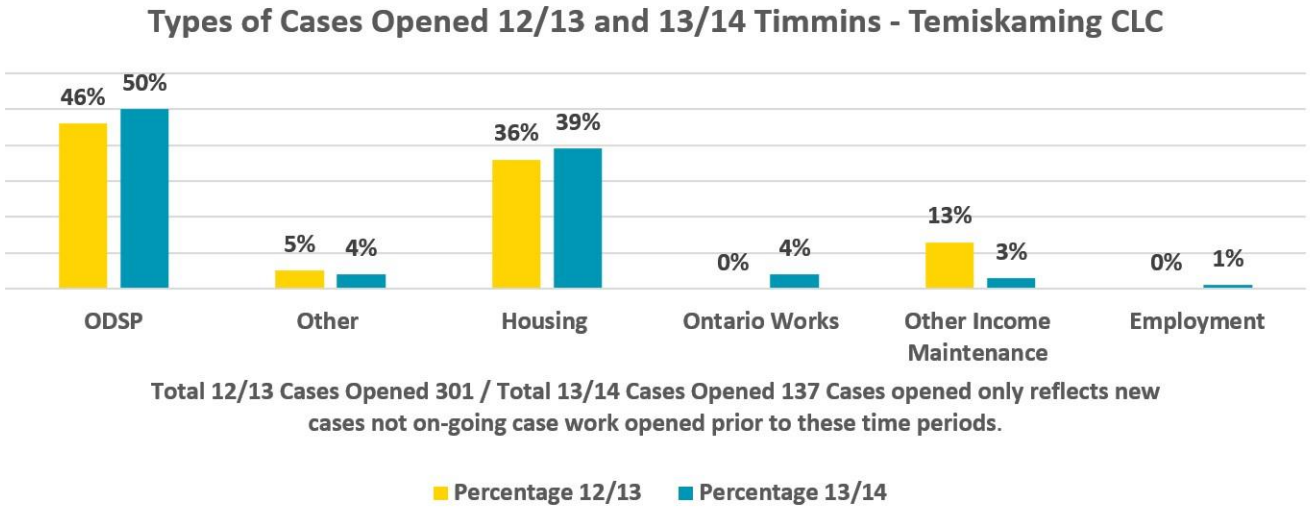
Total 12/13 Cases Opened 377 / Total 13/14 Cases Opened 329. Cases opened only reflects new cases not on-going case work opened prior to these time periods.


Types of Cases Opened 12/13 and 13/14 Manitoulin CLC
18%
26%
33%
23%
0%
3%
0%
1%
26%
31%
0%
1%
23%
16%
ODSP
Other
Housing
Ontario Works
Other Income Maintenance
General Admin.
Health Care
Total 12/13 Cases Opened 139 / Total 13/14 Cases Opened 116
Cases opened only reflects new cases open not on-going case work opened prior to these time periods.
Percentage 12/13
Percentage 13/14


Types of Cases Opened 12/13 and 13/14 Nipissing CLC
69%
75%
0%
3%
19%
15%
3%
2%
9%
5%
ODSP
Other
Housing
Ontario Works
Other Income Maintenance
Total 12/13 Cases Opened 226 / Total 13/14 Cases Opened 187 Cases opened only reflects new casese not on-going case work opened prior to these time periods.
Percentage 12/13
Percentage 13/14


Types of Cases Opened 12/13 and 13/14 Northwest CLC
47%
40%
17%
14%
8%
15%
5%
0.70%
12%
12%
8%
12%
3%
2%
0%
2%
0%
1%
ODSP
Other
Housing
Ontario Works
Other Income Maintenance
General Admin
Aboriginal Rights
Health Care
Employment
Total 12/13 Cases Opened 173 / Total 13/14 Cases Opened 149
Cases opened only reflects new cases open not on-going case work opened prior to these tme periods.
Percentage 12/13
Percentage 13/14


Types of Cases Opened 12/13 and 13/14 Sudbury CLC
57%
66%
0%
1%
19%
20%
10%
7%
10%
6%
4%
1%
ODSP
Other
Housing
Ontario Works
Other Income Maintenance
General Admin.
Total 12/13 Cases Opened 491 / Total 12/14 Cases Opened 381 Cases opened only reflects new cases not on-going case work opened prior to these time periods.
Percentage 12/13
Percentage 13/14



Analysis & Discussion

The disproportionate number of ODSP cases opened reported across the Northern clinic catchment area and the burden placed on four specific community legal clinics (Algoma, Nipissing, Sudbury and Timmins-Temiskaming) suggests the need for collective efforts targeting policy directives as it pertains to ODSP applications and appeals.

In addition, several northern community legal clinics are taking on increasing numbers of housing related cases -- particularly Timmins-Temiskaming and Grand Nord. Community Legal Clinics are increasingly being asked to assist clients with housing applications and repair/maintenance issues. At the present time, clinics are limited insofar as they are only able to address evictions issues.

Similarly to ODSP, the high numbers of housing-related cases calls for increased advocacy and strategies targeting policies/procedures of municipal housing departments (systems level) and by-law officers. The fact that Northern Ontario generally reports housing stock that is much older suggests that housing issues will continue to be a significant issue for low income populations typically served by community legal clinics.

Ontario works caseloads appear fairly stable across the north with the exception of Keewaytinok Legal Clinic catchment area which reports significantly higher levels of Ontario Works cases. The remote location, large geography and limited road access, combined with the catchment area's unique demographics (predominately Aboriginal population) should be factored into decisions around funding and resource allocations.

A number of community legal clinics report significant number of 'other income maintenance' cases opened (i.e. Manitoulin and to a lesser extent, Grand Nord; Timmins-Temiskaming; and the Northwest CLC). Other income maintenance includes but is not limited to WSIB, Canada Pension Plan (CPP) and Old Age Security (OAS). Given the most recent changes to CPP and Worker's Compensation, which have resulted in more complex and lengthy processes, it is expected that these types of cases will challenge community legal clinic capacity (similar to changes to ODSP in the early 2000's). It is important to consider the capacity of smaller community legal clinics to adequately meet needs (particularly as many of these clinics report higher a proportion of seniors, including a generally aging population base).

Also Manitoulin, Nipissing, Elliot Lake & North Shore, and Timmins-Temiskaming catchment areas are experiencing an in-migration of working poor, many of whom are seeking lower cost housing, are injured and/or travelling to the north for health-related reasons (i.e. recovery/addiction treatment services).

Community legal clinics across the north are increasingly reporting 'other' cases which includes consumer/debt; criminal injuries compensation, estates/wills, among other things, which suggests that clinics are increasingly being asked to serve diverse legal needs that are outside of their current ability to address.

How the Work Gets Done

The capacity of northern community legal clinics speaks to how the work gets done, starting from a client's first point of contact (i.e. intake) through to the point where the client's case is effectively closed. The following section speaks to the intake process from a regional perspective (across all 11 northern CLC's) with some local references (although it should be noted that a drilled down analysis of this process was beyond the scope of this project). Better understanding the processes in place for intake and how clients navigate their respective community legal clinics will illuminate potential issues and/or opportunities from the standpoint of human resources and logistics.

Regionally, community legal clinics did not report major differences in how clients accessed their services (i.e. 50% of clients use the telephone and 50% make in-person appointments). In terms of breakdown, clinic respondents indicated their top three legal services as follows: advice (56%); brief services (29%) and case files (23%). Some clinics indicated that by volume, advice and brief services represent the top two services, but by time, case files are very time consuming (one clinic indicated that they don't track the amount of time they spend on case files).

Four legal clinics interpreted the question as inquiring about the top two areas of the law their clinic captures. Responses based on this reading of the question indicate that ODSP, CPP and disability law predominate, with landlord/tenant, estate/wills and power of attorney also prominent.

Typically, community legal clinics across the north indicate housing (X7 responses); LAO (X4); mental health and addictions (X4); food banks (X3); access to government services, including Ontario Works and Member of Provincial Parliament (X3); health providers (X2); and private lawyers (X2) represent the most frequently requested supports as reported by clients. Slightly greater number of external supports are arranged during 'in-person' appointments (57%) compared to telephone exchanges between clinic staff and clients (42%).

Intake Process

Regionally, clinics were slightly more likely to indicate they are not limited in the number of intakes they can do in a day (X6 responses) compared to clinics who said they were 'limited' and/or 'sometimes limited' (X5 responses). The majority of clinics who responded to this question indicated that the intake process for branch offices was the same as for their main office. Those clinics who went on to elaborate indicated that:

- Intake is done by appointment only
- Administrative staff do the initial screening before turning the request for service over to the caseworker
- For satellites, clinics partner with local agencies in order to access fax machines (whereby retainers and signed authorizations are obtained, allowing clinic staff to open a new file

Though typically not viewed as 'intake', one clinic indicated that community development and public legal education 'files' are obtained in the following two ways: (1) the clinic has a working relationship with a particular agency and reaches out to them; and/or (2) an agency learns of the community legal clinic through word-of-mouth and makes a request for the clinic to do a presentation. Several clinics went on to emphasize the connection between public legal education and community development whereby knowledge of certain legal rights can result in mobilization around particular issues (i.e. Restorative Justice and Speaker's Schools were given as examples).

Limitations that were cited included specific 'intake days' (X4 responses) at main offices or satellite sites. Other limitations that were reported focus on challenges associated with staffing (i.e. when staff are on sick leave or on vacation, intakes are restricted). Technological limitations were also

noted (i.e. a limited number of phone lines means client calls go to voicemail -- it was noted that in most cases, voicemail messages are returned within one business day).

The overwhelming majority of clinics indicated that they involve community partners and organize for external supports on an 'as needed' basis, depending on the case. A number of clinics indicate that clients are provided with referrals/pamphlets at initial contact (which could be when the client first sees the caseworker or during the process of assisting the client over the phone). Only one clinic indicated that they rarely involve external partners at the time of intake, with referrals usually made during summary advice or brief services. External partners that were referenced by clinics include: homeless agencies; mental health and addictions services; OW offices; LAO clinics; private lawyers and MPP constituency offices.

Process by Which Files are Assigned

The community legal clinics reported variations in the way files are assigned with a number of clinics indicating Executive Directors' assign files to community legal workers (CLW's) or paralegals (depending on the area of expertise), with complex files assigned to lawyers. Generally, files are supervised by lawyers/Executive Directors' and in some clinics quarterly reviews of files are conducted. However, it was stated that in the case of ODSP, there can be delays in the assignment of files by several weeks.

Reference was made of the demands of clients who present with multiple issues (many of which are non-legal) and which tax the time and resources of clinic staff. On many occasions, clinic staff noted the importance of being present in the moment, so that clients could tell their stories in a safe/respectful environment. For many staff this means putting down their pens, turning away from their computers and giving their clients their full attention.

Overall, clients who were surveyed expressed tremendous satisfaction with the services they received from community legal clinics across the north, with few indicating they had to wait for service. This suggests that for the most part, clients appear to be navigating the CLC process without long wait times (this is in contrast to what clients are experiencing in the various tribunals and quasi-judicial processes). As important, clients referenced community legal staff as highly compassionate and as a 'safe' place to go in order to get help (this perception was also reinforced by community partners).

Innovative Practices

1. Non-Traditional Service Locations

The Northern Region Transformation Project uncovered a number of creative solutions in overcoming barriers to access for low-income residents of Northern Ontario. For example, one community legal clinic ensures that people living within its catchment area but who are in-between communities can access legal advice even if they are without transportation. In this case, a community legal worker who lives a number of miles from where the clinic is situated, essentially serves clients scattered across the clinic's catchment area by arranging to meet clients on her way home from work. This can only be done with the assistance of restaurant owners who provide confidential meeting spaces. This particular community legal worker makes stops along the way, meeting clients in their communities and effectively overcoming transportation and other barriers. In other clinics, lawyers and CLWs travel to client's homes, a practice which has all but disappeared in most client-service provider settings; in this respect, community legal clinics go over and above to effectively serve clients who face huge barriers and who would otherwise have few options in addressing their legal issues.

In First Nation communities located in and around Thunder Bay, CLW's were referenced as providing services out of their car (in the absence of a satellite office) which was seen to be particularly effective for individuals who don't generally adhere to appointments (for many reasons) and/or who have no phone or who may be transient or homeless. These kinds of innovative services were referenced time and time again in many of the smaller community legal clinics as well as those clinics serving First Nation communities.

2. Housing Family Law Services out of CLC's

Several community legal clinics located in small, northern communities allocate space for family law services (i.e. lawyer) who provides information and advice to those with family law issues. In regions of the north where access to Legal Aid family law services is limited or non-existent, or where clients must travel more than four hours (return trip) in order to access a family lawyer, this type of service is invaluable.

3. Excellence in Client Services

The Timmins-Timiskaming Community Legal Clinic has been known to travel to Toronto (bringing multiple special diet applications with them) so that clients don't have to wait that extra time in order for their application to be processed. A number of clients also referenced Timmins-Timiskaming clinic staff as giving them support and acknowledging them in community settings (which was very much appreciated by clients who are often excluded from everyday common courtesies).

4. Partnering with Community Agencies

A key informant from Grand Nord spoke about their relationship with a local food bank, which provides child care for parents/single mothers in order for them to attend appointments at the community legal clinic office. It is often the case that clients with children lack the financial resources to be able to pay for childcare and are reluctant to bring their children to legal appointments, so this type of services is invaluable in terms of removing barriers to access for single parent families.

Other essential services provided by clinics serving predominantly First Nation communities included staff providing translation services, often on their own time to Native Friendship Centres/Aboriginal organizations where there is need for oral or written translation (i.e. Cree). Though not officially recognized as a bilingual community legal clinic, Nipissing CLC provides French language services (to the degree that they are able) to clients living in a city that is predominantly English-speaking.

5. Providing Culturally Safe Services

Kinna-aweya and Keewaytinok Legal Services are demonstrating innovative service delivery insofar as Keewaytinok's office staff person speaks the local Cree dialect and Kinna-aweya intentionally recruits First Nation board members from the communities they serve in order to ensure that culturally- appropriate services are a priority. As well, Kinna-aweya weaves cultural Ojibway practices into their clinics "corporate" culture. It should be noted that Sudbury CLC also houses the French Legal Advice Line pilot project which provides much needed legal information (and access to a Francophone lawyer) to residents living throughout northern Ontario who live in communities without
French language clinic law services as well as those living in central and eastern Ontario. Also Elliot Lake and North Shore CLC and Clinique juridique Grand-Nord Clinic are designated under the French Services Act.

Similarly, Clinique juridique Grand-Nord Legal Clinic is in the process of developing a pilot project based on the Baamsedaa Program developed by Community Legal Assistance Sarnia. This will entail having an additional CLW (aboriginal) who will travel within the catchment area to provide legal services to aboriginal clients in Constance Lake, New-Post, Hornepayne, Hearst, Cochrane and Kapuskasing. Also over 800 evacuees due to flooding from Kashechwan are now located in Kapuskasing, with an estimated 500 planning to stay on a permanent basis.

Finally, at the Manitoulin Legal Clinic, the executive director has dedicated himself to serving members of local First Nations over the past 25 years establishing personal relationships with many of the members and local elders ensuring both aboriginal and nonaboriginal clients have services they can trust and be comfortable with.

6. Empowering Clients

The role of community legal clinics in building capacity in communities was a prominent theme within the Northern Region Transformation Project. Community development in its essence is about empowering individuals to better themselves (individually and/or collectively), recognizing the 'ripple effect' of these types of actions. Community legal clinics and their staff were often referenced as 'making a difference' in this respect. For example, in one remote First Nation community, a client of the community legal clinic indicated that her decision to return to school and upgrade her education was directly attributed to the support she received from a clinic staff member.

Other actions that support community capacity include facilitating support groups which help marginalized individuals feel less isolated, particularly where they are having to navigate various other quasi-judicial processes (i.e. SBT, LTB, WSIB). One cannot discount the role of community legal clinics in building capacity and supporting social change, one client at a time.

Several community legal clinics provide forums for low-income individuals to build confidence and leadership skills (i.e. Speakers School; PROMPT) which have ripple effects for participants and staff alike. Kinna-aweya's 'Speaker's School' is a 14 week program that is supported by the United Way and the City of Thunder Bay. Since its inception the program has produced more than 100 graduates, many of whom are women; including a number Aboriginal individuals who have transitioned into the workforce or gone on to further their education (i.e. enrolling in post-secondary programs).

Similarly, Lake Country's 'PROMPT' program which is a poverty action group, meets across diverse locations and is supported by the District Social Services Department. PROMPT is recognized as both a vehicle for clients to secure much needed support (from others who are experiencing the same types of issues), in addition to playing an important role in bringing a collective voice to advocate for systems change. Community partners across all northern community legal clinics were quick to reference the efforts of clinics in this regard (which are considered to be significant given current caseload demands). It was not unusual for community partners to reference clinics as leading community-based advocacy efforts.
Nipissing and Algoma Community Legal Clinics helped to mobilize trailer park residents in a collective effort to protect tenancies -- the clinics were successful in their efforts, serving to protect a number of low-income tenants from being evicted. These quasi 'class action' type cases are unique to the community legal clinic world, exemplifying community development and community organizing qualities and strengths.

In addition, Elliot Lake and North Shore CLC has implemented an effective Better Business-like Bureau (CAPP) that rates businesses based on feedback from consumers. This is an important database that can be referenced by residents when they are contemplating hiring a local business. In particular, it is critical for seniors who tend to be vulnerable to scams and frauds. This invaluable resource/database informs local citizens of what businesses to stay away from based on their

'rating'. Elliot Lake and North Shore CLC also provides an effective email service (Ask Alex) whereby citizens in both English and French can email their legal questions and have these questions answered by the clinic lawyer over a 24 hour period.

Community legal clinics are often seen as empowering individuals with lived experience insofar as many are recruited as board members. In this capacity they ground community legal boards in the day-to-day realities of low-income individuals and families, which ultimately assists boards in better serving the needs of marginalized populations within their catchment areas.

Finally, Algoma CLC provides and has provided for years Tele Typewriter TTY support to enable hearing and speech impaired clients to access services.

7. Building Community Capacity

A number of community legal clinics provide assistance to non-profit organizations, effectively helping to launch initiatives which builds capacity at the local level. Keewaytinok, Nipissing, Elliot Lake and North Shore community legal clinics were all referenced as providing invaluable support to non-profit organizations.

In addition a number of community legal clinics provide free tax clinics for low income individuals and students who are unable to pay (i.e. Northwest, Nipissing, Kinna-aweya). This enables them to access universal benefit programs which require income tax submissions in order to qualify (i.e. HST; Child Tax Benefit; etc.)

8. Facilitating Self-Help Groups in Rural Areas

Yet another example of effective community development is embodied in the story of an injured worker, who with the support of the Manitoulin Community Legal Clinic, went on to mobilize injured workers in and around Manitoulin Island and the North Shore in order to advocate against Worker's Compensation policy changes. This group continues to meet and provide education to the public on various topics that impact on low-income populations (i.e. mental health, PTSD). This worker's group is currently in conversations with injured workers in northern cities like Sudbury, Thunder Bay and North Bay in an effort to bring their message to others who are facing challenges navigating the Worker's Compensation system.

9. Facilitating Solutions to Local Issues

Many community legal clinics were noted for their ability to address gaps in non-legal services. For example, Algoma Community Legal Clinic's advocacy and community development efforts resulted in the creation of social housing cooperatives in the 1980's which continue to operate and serve the needs of those with housing issues in Algoma district. Kinna-aweya clinic holds regular ID Banks in recognition that Aboriginal individuals (as non-native individuals) often lack the documentation needed in order to access social benefit programs (i.e. OW/ODSP, etc.). The Northwest and Algoma community legal clinics are meeting increased demands from individuals needing specialized documentation in order to successfully cross the Canada/USA border.

In remote regions of the north, First Nation individuals accessing the services of Keewaytinok are increasingly needing help in the area of provincial offences (i.e. First Nation members come down to Moosonee from remote reserves without proper driver's licences and/or insurance, neither of which is enforceable on reserves). Fines can amount to $5,000 with First Nation individuals facing charges under the Provincial Offences Court. Unfortunately, LAO services do not extend to these types of offences so for First Nation individuals migrating south, without the services of Keewaytinok, many First Nation individuals would be without legal recourse.

In Algoma, the community legal clinic successfully re-negotiated fees associated with obtaining medical records for the hospital. Similarly, the Northwest CLC was able to partner with the Metis Nation of Ontario to bridge gaps in terms of client access to psychiatrists, which allowed them to secure medical reports in support of client ODSP applications. Through some ingenious legwork, the clinic was able to engage in conversations with their regional MNO branch and was able to successfully connect clients who needed this type of specialized service.

10. Building on Inter-Clinic Expertise

Not only are community legal clinics building capacity within their own communities, positively impacting on low-income populations, but increasingly they are exploring ways to better serve their clients through inter-clinic resource sharing. For example, certain clinics possess expertise in areas of the law such that other clinics refer cases outside of their jurisdiction in order for their clients to be best served. Sudbury (Employment Law) and Lake Country (CICB) are examples of this type of specialized expertise which was recognized across key informant interviews, focus groups and surveys.

Currently, Elliot Lake and North Shore CLC is exploring a partnership with the Advocacy Centre for the Elderly (ACE) – a specialty clinic in Toronto – to establish an on-going presence in the north that would serve to provide resources, support and assistance for legal issues relating to the elderly. In this way, through the Elliot Lake and North Shore CLC partnership with ACE, northern expertise with legal issues related to the elderly will be further enhanced. The Manitoulin CLC is interested in extending their expertise in WSIB Law and working with injured workers cross regionally. Similarly, Clinique juridique Grand-Nord Clinic is interested in extending their legal expertise in provincial offences and French language services regionally.

Finally, there has been excellent participation and sharing of expertise, perspectives and resources by many different people across the North over the years in provincial study groups, training, leadership and participation i.e. ACLCO, specialty clinic boards, interclinic working groups, PLAC etc.

11. Site-Specific Practices

Other innovative practices include programs uniquely developed to address the specific legal needs within communities (i.e. seniors and those needing assistance with provincial offences), including developing user-friendly clinic manuals designed to assist smaller sized clinics across

relevant areas (i.e. governance, policy development, etc.); learning modules that are designed with literacy levels in mind; and email services that effectively reach those who are house bound).

12. Collocated Services and/or Clustering

Other ways that community legal clinics are innovating to better meet the needs of their local communities include collocating with appropriate service providers. For example, the Elliot Lake and North Shore clinic is collocated with a number of health/mental health agencies. Algoma CLC shares space with a Human Rights Legal Support Centre and houses United Way's Community Liaison Program and the Kenora branch of the NWCLC shares space with the LAO office. Manitoulin CLC has been exploring opportunities to collocate with a local Family Health Team; and Sudbury CLC is to a certain extent, collocated with the LAO office, reporting mutually beneficial opportunities associated with shared training (i.e. articling students) and resources. The Sudbury CLC is exploring a shared space facility that is currently in the planning stages and represents a joint venture of the Sudbury United Way and the University of Sudbury. The shared space project would bring together a number of community organizations and services under one roof.

Some community stakeholders and clinic staff who were interviewed noted the effectiveness of community legal clinics in the context of broader community partnerships, including partnerships with non-legal organizations in an effort to more effectively serve low-income clients.

Ancillary resources that present opportunities for effective service delivery include collocated models and/or networks that are reflected in the following six community legal clinic settings: Elliot Lake and North Shore; Sudbury; Algoma; Nipissing, Lake Country and Kinna-aweya.

For example, to the extent that Elliot Lake and North Shore CLC is located in the same building as a number of health/mental health and addictions and counselling agencies, it facilitates what the literature refers to as a 'warm hand-off' (whereby clients are personally escorted to the referral agency, emphasizing the importance of that personal touch). 'Warm hand-offs'' and personally accompanying clients to various referral services was referenced by many community legal clinics as a best practice.

In terms of other types of collaborative initiatives and client-friendly services, the Sudbury CLC is located next to the LAO office, sharing professional development and advice when it comes to family law issues in particular. It was recognized by several key informants that being in close proximity to each other helps to address some of the gaps as it pertains to areas of the law outside the mandate of community legal clinics to address (i.e. family law).

Algoma community legal clinic shares space with two outreach workers (United Way Homelessness Program) as well as with the Human Rights Centre (which targets legal issues affecting First Nation individuals/communities as well as mainstream individuals). The resulting exchanges (formal and informal) build social capital and help to bridge gaps in services. In a catchment area with a significant First Nation population, collocated services help bridge the gap between mainstream service providers and First Nation clients.

Though not necessarily co located with another service provider, Kinna-aweya, Nipissing and Lake Country clinics reflect an effective networking model which outreaches to a number of crisis support agencies, all of whom know each other well and have built high levels of trust and social capital which enables them to more effectively address the complex needs of their clients. There are many factors underlying the development of such comprehensive networks including but not limited to staff capacity (and skill sets); being able to access additional funding to support this level of partner engagement, as well as prioritizing a 'client-centred' approach to service delivery.

As previously indicated, both Kinna's Speaker's School and Lake Country's PROMPT program exemplify what is possible when clinics have the capacity to engage community partners. This in turn, builds social capital which benefits the community in multiple ways by bringing clients, agencies advocating for marginalized individuals and the general public together to effect positive change.

Nipissing clinic works closely with the city's diverse counselling, mental health and addictions sector to raise awareness of issues relating to disability and ODSP systems, building cross-sectoral bridges to more effectively meet needs. In addition, the clinic is working with Ontario Works and District Social Services Administration Board staff to address various systemic issues.

Having provided a summary of how clients typically navigate the clinic law system (regionally) as well as speaking to innovative practices that are happening on-the-ground across most if not all of the eleven community legal clinics, the next section of the report speaks to local capacity and gaps, including introducing an infographic that reports on a number of key components of community legal clinics. This is followed by a summary of key themes as reported on by clients who completed surveys, as well as information distilled in the key informant interviews, focus group data and community legal clinic surveys.

Approximately 270 client’s surveys were completed by clients, with 92 key informant interviews and 33 focus groups conducted by the research team (across all 11 community legal clinics). Caution should be used when interpreting the results of the client survey per clinic given the small sample size as well as the fact that clients were pre-selected by clinics --i.e. the client survey is not a random sample). It is assumed that higher functioning clients were more likely to complete surveys.

C. Capacity and Gaps - Local

In order to situate a discussion of local capacity and gaps, the research team decided to present a visual picture 'demand' side of the poverty law landscape and service delivery environment. Infographics were developed for each community legal clinic, based on their funding applications

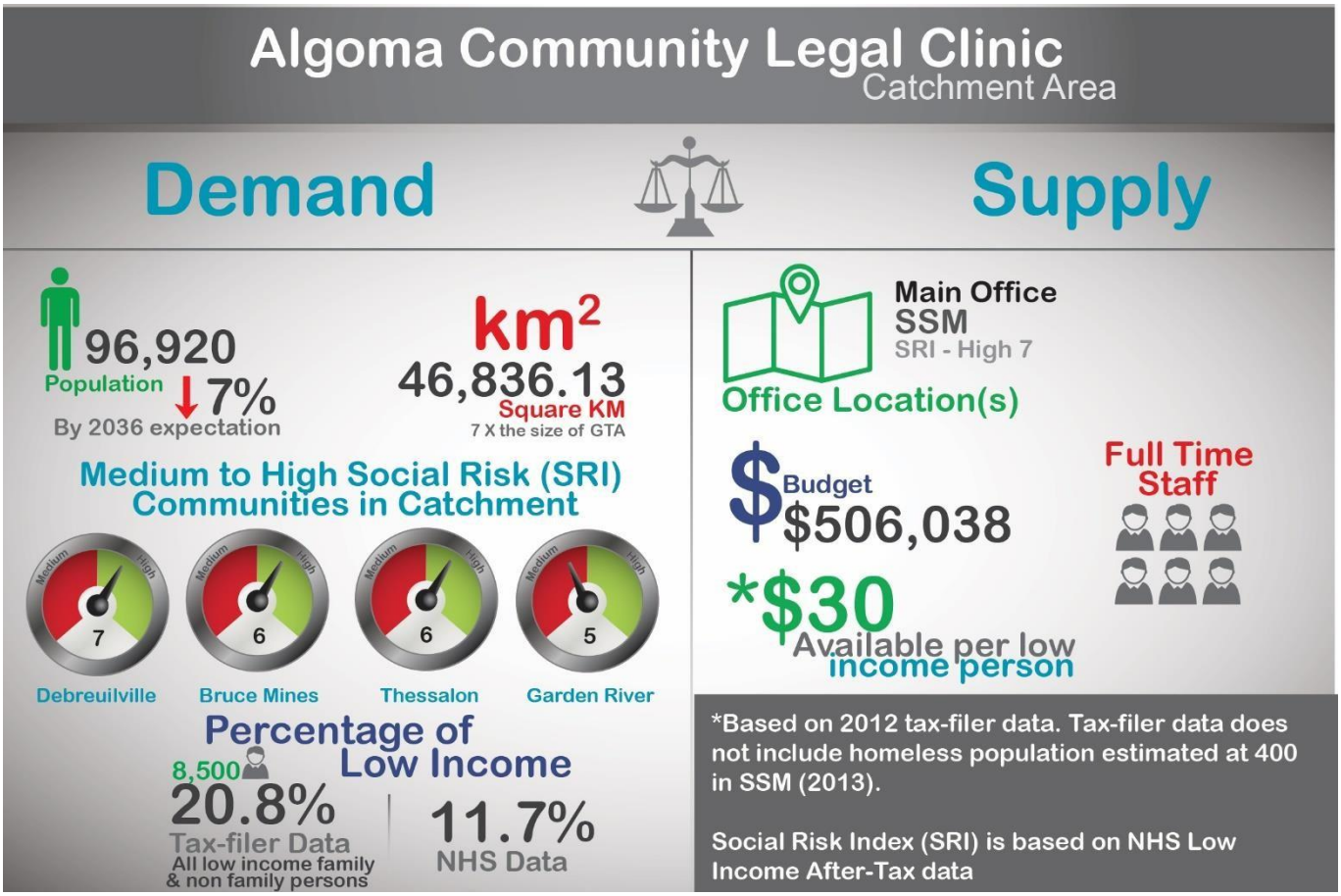
as well as on relevant other indicators. For example, on the 'demand side', the infographic includes: (1) CLC catchment area's total population; (2) its size in square kilometres; (3) the percentage of low income residents within its catchment areas; and (4) a list of communities within the clinic's jurisdiction who report medium to high social risk indexes and who potentially, could be considered as requiring poverty law services. On the 'supply side', the infographic includes: (1) the CLC's main offices and any satellite, branch or sub-offices; (2) the CLC's 2015/16 budget (not including pilot project salaries or disbursements) (3) the CLC's staffing complement; and finally (4) ***** a calculation of dollars available annually per low-income person within its service catchment area.

In order to capture an accurate regional picture of the poverty law landscape (including the clinic service delivery environment), all of the relevant information displayed in the infographics has been added together - creating a regional average (see below). At the present time, the ability of community legal clinics to meet the needs of low-income individuals varies depending on the clinic in question. However, overall demand for services significantly outstrips the supply of services – despite the best and often innovative efforts of clinics to do so. As a region an estimated average of $90.00 per low income person is available per year (not per visit) to ensure access to justice. Although the total regional population is only 827,006 – it is vital to understand this population lives across 594,881 square kilometers – the equivalent of 84 Greater Toronto Areas (GTA's). Travel time and dollars associated with servicing clients over long distances, bad roads, ice roads and rivers is not factored into any of the budget allocations for northern clinics.

- The total regional population = 827,006
- Estimated population for 2036 = 827,006
- Total square kilometres = 594,881 (84 X GTA)
- Total est. 15/16 Budget (excludes project $ and disbursements) = $8,144,789
- Total FTE's (no pilot or project staff included) = 70.5
- Average $ per low-income individual available per year = $90.00

*****Calculation is derived by determining number of "All Low Income Family and Non Family Persons" from 2012 tax-filer data. Divide the 15/16 estimated clinic budget (taken from all NCLC Funding Applications) by "All Low Income Family and Non Family Persons" and then divide by two to get an estimate of dollars annually available per low income adult. Note: this calculation does not take into account discrepancies between clinics due to years of experience among staff members or differing proportions of lawyers/CLWs per clinic.

1. Algoma Community Legal Clinic



Clients accessing services from Algoma Community Legal Clinic tended to be English-speaking and female. In terms of marital status, almost all reported either single, divorced, separated or widowed status (only two clients reported being married or in a common-law relationship). Based on these responses it can be inferred that the majority of clients reside in single-person households which tend to be more vulnerable to financial stresses, including job losses or economic downturns (compared to two-person households). The type of legal assistance required by clients surveyed overwhelmingly focused on 'legal representation' (86%), and to a lesser extent, advice (71%), legal information (50%) and assistance with forms (50%).

Legal issues cited by Algoma clients who were surveyed tended to be in relation to 'access to social benefits' (57%) as well as 'housing issues' (36%) and to a far lesser extent, criminal/family law (14%), CICB (7%), and CPP (7%).

As with most other northern community legal clinics and in line with the results of client surveys, Algoma CLC spend a disproportionate time on ODSP cases, 80% of which are successful upon appeal (approximately two thirds of clients indicated they required clinic services relating to 'access to social benefits'), with 21% of clients indicating they relied on government pensions (very few clients reported that they were unemployed).

Concerns expressed with respect to ODSP included the complex nature of the disability system, which is expected to worsen given the most recent decision to review ODSP caseloads provincially (which is expected to significantly add to clinic staff workloads).

Algoma was one of several community legal clinics where safety concerns were referenced -- by community stakeholders and clinic representatives. The challenges of navigating the ODSP system (denial; multiple appeals, etc.) was seen as placing staff safety at risk by exacerbating stress levels among client populations already noted as suffering from mental health issues (this is not to be interpreted as a 'judgement' but rather, as a statement of fact). There were fears expressed that clients might inadvertently lash out at staff (this was also an issue for Nipissing, particularly in the context of satellite offices where 1 staff typically works in isolation).

Frustrations with the various provincial/federal tribunals was a common theme across northern clinics (including Algoma clients, as reflected in the following comment: the CLC "*helped with ... (my) application process for CPP ... over and over and over as the government of Canada has no idea what the reality of poverty is.*"

Other issues cited by Algoma stakeholders as it pertains to the disability system concerned adjudicator's decisions with respect to medical documentation accompanying ODSP applications (i.e. adjudicators not accepting specialist reports, etc.). The cost and/or ability of clients to secure medical reports was also seen as creating issues for clinic staff insofar as clients who don't have medical documentation or who can't afford to pay for such reports may not be able to access representation. This trend which was referenced in other community legal clinics noted the fact that clinics are being forced to decide on the merits of ODSP cases before they get to the tribunal stage (i.e. clients with strong cases and with a good chance of winning their appeals are being chosen over clients whose cases are less solid, oftentimes clients who are without medical reports). A number of clinics reported utilizing this criteria to determine which cases they would take, only because they lack capacity to serve all clients asking for assistance with ODSP appeals. Clinics also have limited resources to purchase medical reports.

The other poverty law areas Algoma CLC reported include landlord/tenant, criminal/family, CICB and CPP cases. Clients who completed surveys tended to support this finding insofar as 36% of clients referenced housing issues, 14% referenced issues with family law matters and 7% referenced CICB and CPP matters. Gaps as identified by staff and community partners extend to human rights issues (particularly given the large number of First Nation communities in and around SSM), access to family law services, the growing complexity of clients (with mental health, literacy and housing issues) and other landlord/tenants issues (such as repairs and maintenance). With 5 year wait lists for social housing, homelessness is considered to be a significant issue as are legal issues associated with working poor populations (i.e. employment standards; consumer contracts and payday loan and money mart operations). Income support for seniors was also perceived as a growing need given Algoma's aging population.

The ability to engage in community development work given high caseloads and a dispersed population base -- including high proportion of Aboriginal communities -- was considered to be a challenge with the recognition that even if the clinic could raise public awareness of the services provided, most people wouldn't qualify for their services.

Transportation and distance to services were also major themes in the client surveys with 53% reporting this as a barrier and issues relating to client ability to understand and respond to government requests for information. It was not unusual for clients to report *"(not) being able to comprehend and understand information".*

Over and above these challenges, clients who completed surveys overwhelmingly expressed high satisfaction with the types of services provided by Algoma CLC. Client experiences accessing clinic services tended to be very favourable, with few reporting they had to 'jump through hoops and/or repeat their story'. The majority of clients felt that they 'received the help they needed and that their opinions were heard', with very few clients indicating they had to wait for services. As important, the majority of clients indicated they felt the Algoma CLC staff were compassionate and empathetic in their interaction with clients.

In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly social services as well as mental health supports) not to mention providing clients with practical supports such as bus passes, etc... Overall, clinic staff were seen as responsive to client requests, including taking on advocacy roles when needed: *(The clinic) updated (me) with how my case was going."; "The legal clinic dealt with the situation."*

There was recognition of Algoma's long history in community development particularly in the area of non-profit housing (facilitating the establishment of housing cooperatives in Sault Ste. Marie) although many stakeholders questioned the capacity of current staff to be able to proactively

engage in outreach efforts. The ability to continue this important work and to mentor other clinics wanting to build capacity in this way was seen as compromised by caseload demands which are perceived as 'burning out staff'. Community stakeholders were more likely to reference vacancies, sick leaves and a generally overworked staff which had broader impacts insofar as clinic staff being able to follow through on community partnerships/commitments, etc.). Many referenced staff as working unpaid overtime to keep up, including volunteering to assist clients outside of office hours.

The presence of the Human Resource Centre -- which is located in the same office as the legal clinic and which focuses on human rights issues (primarily affecting First Nation individuals although not exclusively) -- was often referenced as providing opportunities for collaborative efforts to better meet the needs of Algoma's Aboriginal population (which is significant). Pressure points identified by community stakeholders reiterated themes identified by clinic staff including: LAO administrative demands with respect to re-structuring; pressures to do away with autonomous boards; and the perceived undervaluing of community development work by LAO.

Partners tended to view the needs assessment as an opportunity for LAO and community legal clinics to revisit the way in which they work. For example, although technology was not considered to be effective for clients, the perception was that LAO and the Algoma clinic could utilize IT platforms to save on meetings, etc. (for example, using Google Hangout or videoconferencing instead of having LAO staff fly north or clinic staff fly south for the purposes of meetings, etc.) Travel savings could then be re-allocated to client services.

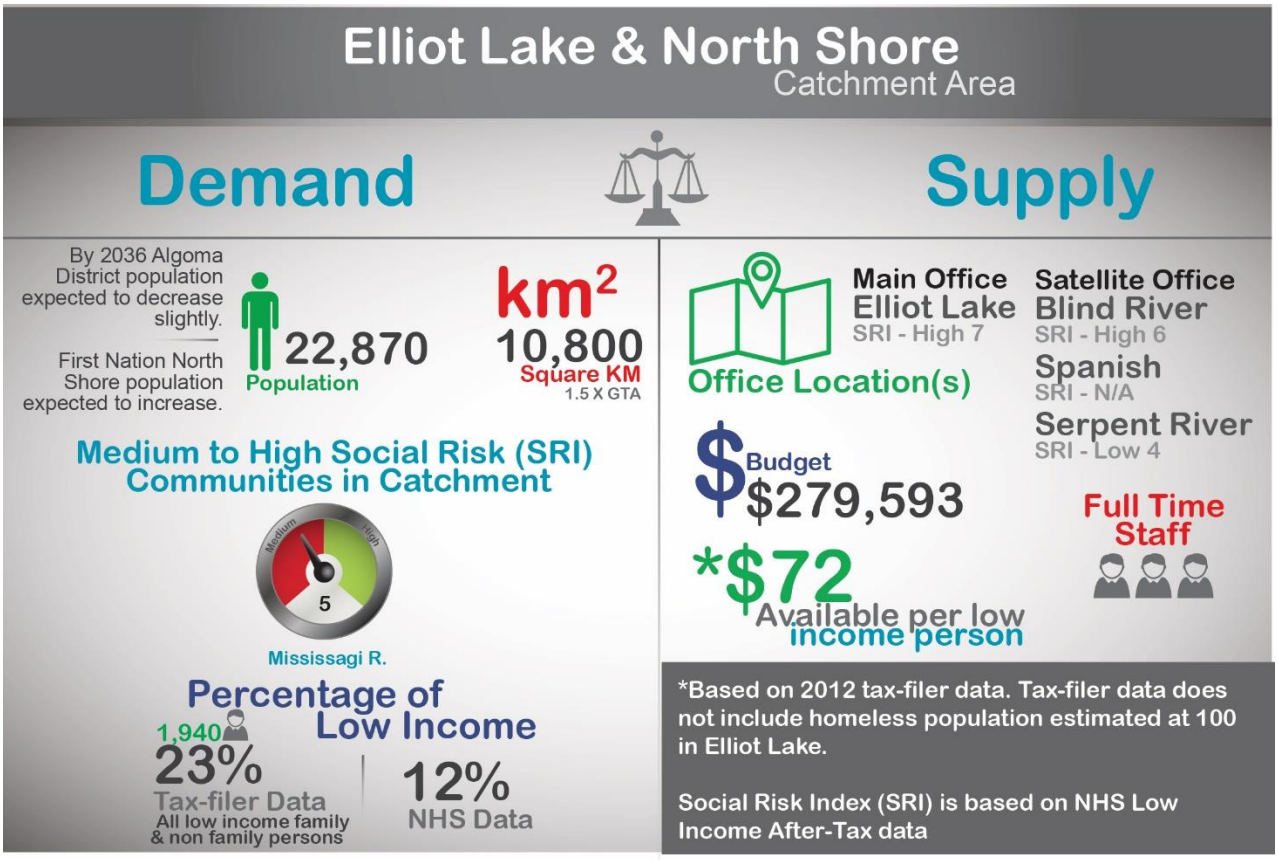
In contrast, there was consensus that the trend towards call centres and websites in place of traditional service delivery mechanisms for low income clients was considered to be ineffective and inappropriate.

Similar to a number of other northern clinics surveyed, Algoma stakeholders expressed tremendous frustration with having to 'workaround' LAO computer equipment and software, referencing inefficiencies that add to workload. Lawyers, CLW/paralegals identified having to re-enter case notes multiple times as well as being kicked out of the system for every document they print. These additional pressures, added to the very high caseloads are leading to 'burn-out' and 'sick leaves' (a theme which resonated with a number of northern community legal clinics).

Transportation and geography were seen to be significant barriers to both clients and clinics alike, impacting on the costs of service delivery and speaking to the importance of satellite services. A number of clients also referenced issues with current hours of operation, suggesting the clinic consider more flexible hours (including being open during the evening); these types of

recommendations have human resource implications which also speaks to funding levels. Raising awareness about clinic services was also a key theme that was identified across many if not all key informant interviews and focus groups. Using IT (teleconference; virtual study groups, enhanced NRT) for the purposes of CD and PLE was referenced as an opportunity to build staff capacity across northern clinics.

2. Elliot Lake and North Shore Community Legal Clinic



The fact that Elliot Lake & North Shore CLC reports a much older demographic might explain to a certain extent, the reliance on landlines (telephone) as opposed to cell phones (fewer than 30% reported access to a cell phone) although more than half of clients indicated they are hooked up to a computer (66%). This still leaves approximately 35% of clients accessing clinic services as being 'without a computer' which has implications in terms of receiving services via the internet (i.e. websites). Interestingly enough, approximately half of all clients who were surveyed indicated they NEVER use the internet as a source of legal information, with the majority (98%) preferring face-to face interactions (although at least 30% of clients indicated they would be open to telephone exchanges with clinic staff). The majority of clients who were surveyed did not believe the internet was a good way to get legal information even if they reported good computer skills, or were able to navigate websites.

Barriers to service that were reported by clients included (in order of importance): fees (one third of clients referenced not being able to afford private legal services). Interestingly enough, transportation/distance to services was not considered to be an issue. Community stakeholders indicated that because social housing units are located in Elliot Lake and because the public transit bus delivers individuals' right to the door of the clinic, transportation is not so much of an issue. However, it should be noted that almost all focus group participants were from Elliot Lake (no participants indicated being from any outlying areas i.e. Blind River, Serpent River, etc.). Clients who responded to the survey generally did not indicate various other barriers to service (which contrasted significantly from most other community legal clinic client survey responses).

In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly social and health services) not to mention providing clients with practical supports such as bus passes, etc. The clinic was also reported as helping clients to access 'housing' supports and food banks within the community.

The clinic reports caseloads primarily focused on CPP, consumer fraud, wills and Power of Attorney (POA's) which differs significantly from most of the other northern CLC's who indicate OW/ODSP and landlord/tenant cases as representing a disproportionate percentage of their overall caseload. This finding is supported by the results of client surveys insofar as CPP issues accounted for 13% of client responses. In comparison, access to social benefits captured 8% of client responses with criminal/family law, consumer debts and housing the next highest (combined they represented 12% of client responses). (9 out of 24 clients provided responses to this question; it could be assumed that clients who chose not to respond to this question may have had other non-legal issues that they were accessing clinic services for).

Housing issues, including reference to bad landlords which appear to be more prevalent in other northern regions were less likely to be cited as issues in Elliot Lake (most likely this is due to the fact that the City's Retirement Living Program is for all intents and purposes the most significant 'landlord'). The city's strategy to attract more seniors however, will have implications in terms of the types of legal services needed in the future. Some clients alluded to this in their comments: *"Even though I own my own home, I'm on subsidized pension (and) wish I could get some services that I can't afford to pay for (i.e. wills).* This latter comment should be of concern given Elliot's Lake's aging population based as well as its status as a Retirement Living Community.

Seniors on fixed incomes predominate in the clinic's catchment area and there appears to be a growing working poor population located in the city of Elliot Lake. The local economy supports minimum wage jobs and as previously indicated, the city is aggressively marketing Elliot Lake as a

desired place in which to retire (which accounts for its significantly older population base). This transition to a retirement living community has been ongoing since the early 1990's when Elliot Lake's uranium mining industry disappeared, resulting in major job losses and an out-migration of working age residents.

The legal needs of lower income residents, as partially reflected in responses to the client survey indicate that individuals tend to want assistance with 'legal information' (71%) and 'forms' (58%) and to a far lesser extent, someone to 'represent' them (29%). The fact that significantly fewer clients of the clinic require 'representation' tends to reinforce clinic perceptions that seniors accessing services require time, attention, and a certain degree of 'hand-holding', including having the clinic advocate on their behalf (outside of tribunal or quasi-judicial settings). Key informant interviews and focus group discussions tended to reinforce the clinic's role in assisting seniors in consumer fraud cases, and to a far lesser extent, helping clients navigate the kinds of legal systems other clinics referenced (i.e. SBT; LTB; WSIB; etc.). Some clients referenced needing assistance with contractors, noting the importance of being able to contact the clinic when they need help ... "*it's important just knowing that the clinic is here when needed".* A number of clients indicated they needed advice across many legal areas, including but not limited to assistance in the area of non-profit incorporation and charitable status, as reflected in the following comments:*"(The clinic) helped with family law, (with) my mother and father's wills and several times as part of a non-profit organization …(providing) invaluable support for the community".* Although not as prominent, clients did reference accessing family law services which are technically not within the mandate of CLC's to provide: *I needed help with family law but this is not in their legal area"; "I've paid alimony for 15 years (even though my ex) is on an old age pension. (I will be taking my CPP) in April (2015) ... (My ex) will be making a larger income than me, but I still have to pay her!"*

The ELNSCLC engages in a number of outreach efforts designed to raise community awareness, primarily in the area of consumer fraud. For example, its Clinic Assistance to Promote & Protect (CAPP) program includes a database on local businesses that informs citizens of businesses to stay away from. Stakeholders also referenced workshops which raised awareness about the importance of wills and POA's. Not surprisingly, partnerships tended to revolve around the CAPP program in terms of working closely with the Senior's Information Officer (funded by the Ontario Provincial Police) as well as with Family Health Teams and mental health and social services by virtue of the clinic being located in the same building as most of the aforementioned services.

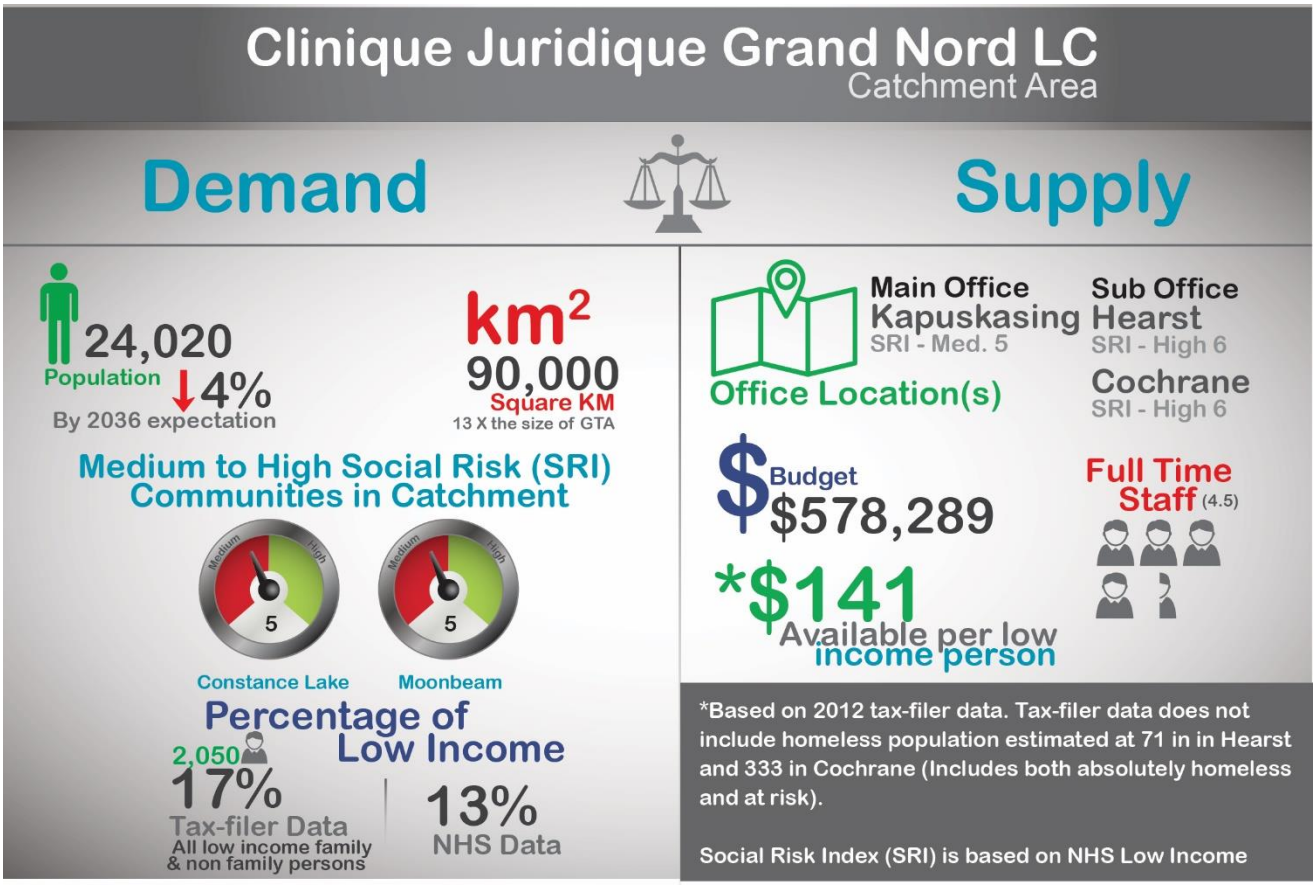
As a result of Elliot Lake's burgeoning seniors population it is expected that low-income seniors will continue to represent the bulk of the clinic's caseload moving forward. In conjunction with the clinic's existing consumer fraud program (CAPP) which targets seniors (particularly women), it is expected that an aging population will increasingly require assistance in terms of health care (i.e.

capacity/competency assessments) which will challenge a number of northern community legal clinics given the cost and lack of services in this regard.

A number of written comments provided by clients alluded to the clinic's work in the area of protecting seniors from consumer fraud as well as informing seniors of end of life issues: *"Workshops presented by Mr. Bondy (were) very informative on various subjects"; "You and the Law is an excellent program; "Love the public education workshops ... very informative".*

In general, client experiences accessing clinic services was overwhelmingly positive, with few reporting they had to 'jump through hoops and/or repeat their story'. Most clients felt that they had received the help they needed and that their opinions were heard, with few clients indicating they had to wait for services. Community legal clinic staff were often noted for their compassion, empathy and overall, for their good quality service: *"Keep up the great work!"*

3. Clinique Juridique Grand Nord Legal Clinic



In terms of ODSP, OW and LTB cases, a theme which runs across almost all northern legal clinics concerns the high success rates on appeal. However, there is the sense among community partners that the clinic is 'putting out fires' and expending a majority of its energy on casework files which leaves less time for the kind of community development work it is known for. The type of legal assistance required by clients surveyed overwhelmingly focused on 'legal information' (85%), 'advice' (95%), 'representation' (85%) and 'assistance with forms' (66%). A number of clients who were surveyed referenced issues associated with understanding documents and forms, citing literacy issues: *"(I need help) understanding information given to me."* Clients often reported needing assistance in understanding documentation and being able to navigate the various government process.

Key themes running through the key informant interviews, focus groups and client surveys suggest a predominance of ODSP, landlord/tenant and CPP cases. For example, 52% of client issues fell within the 'access to social benefits' category, with 24% being captured under 'Canada Pension Plan'. Housing issues and provincial offences were the next highest category (14% respectively), followed by criminal/family law (10%) and consumer debts (5%). The written comments provided

by clients who were surveyed tended to reference issues with ODSP, CPP-D and consumer debt, and the importance of having a driver's licence (for employment, etc.): *"I live outside of town ... I need my driver's licence ... the clinic helped me keep my driver's licence."* In this light, almost half of clients surveyed reported transportation and/or distance as a significant barrier to service, followed closely by fees (40%).

The catchment area that Grand Nord serves is characterized by acute housing shortages, high cost of rental accommodation and high utilities or energy costs. These factors leave individuals vulnerable to sub-standard housing and fearful of losing their tenancies; this means they are less likely to report repair/maintenance issues, including any type of harassment or discrimination on the part of their landlord.

Particular trends that might increase the numbers of Aboriginal individuals seeking assistance from the community legal clinic includes the yearly migration of First Nation individuals from Kashechewan to Kapuskasing in response to their communities' flooding issues. This trend highlights both capacity issues and logistical challenges (i.e. serving transient Aboriginal clients in their own language). It should be noted that Grand Nord's main office is located in Kapuskasing which is home to a significant Aboriginal and Francophone population base. It is generally the case that both Francophone and Aboriginal clients are perceived as not being well served by the current service delivery framework (at least in terms of being able to access a range of legal services in Cree/Ojicree or French). Being able to provide culturally-appropriate services was seen as a significant challenge for clinic staff, with Grand Nord acknowledging outreach to First Nation populations as a priority in their strategic plan.

Gaps in legal services most often referenced family law issues (including children's lawyers) and criminal law -- putting pressure on Grand Nord to provide some type of assistance as a result of decreased LAO certificates being issued and the prohibitive cost of hiring private lawyers. Other legal gaps that were referenced included consumer issues (debt), WSIB, employment standards and CICB cases. With respect to criminal law, a concern that was raised by several stakeholders related to the pressure placed on those facing lesser charges to 'plead out' without fully understanding the ramifications of their actions.

There was consensus that the trend towards call centres and websites in place of traditional service delivery mechanisms for low income clients was considered to be ineffective and inappropriate (by Grand Nord clients and community partners alike). For example, even though clients tended to report having access to landlines and/or cell phones (pay-as-you go with free texting options), fully one third of clients did not have computer access and those with cell phones would not have the capacity to wait in the 'q' for service through a call centre. In addition, there

were some clients who had neither phone service or computer access: *"(I have) no phone or internet."*

Along these same lines, more than two-thirds of all clients who were surveyed indicated they NEVER use the internet as a source of legal information, with the majority (100%) preferring face-to-face interactions. It should be noted that at least 25% of clients indicated they would be open to telephone exchanges (i.e. speaking with clinic staff over the telephone which should not be confused with 'call centre operations'). The majority of clients who were surveyed did not believe the internet was a good source of legal information.

Like many community legal clinics, IT challenges were noted internally as an issue for staff (i.e. Citrix, CMT, etc.) as well as in relation to client services (i.e. the appropriateness of asking low-income clients to access call centres for service).

In general, stakeholders referenced the increasing challenges associated with the use of technology for tribunals (SBT and LTB) which was seen as negatively impacting clients (i.e. comfort levels; access to justice, etc.). There were issues noted in terms of clients -- many of which are disabled -- having to sit in front of a screen without moving for hours as well as clients being unable to have a support person accompany them because of space limitations. In general, the lack of counselling services for clients was considered to be a challenge, particularly for clients going through tribunal systems who require extra supports.

In contrast to client experiences navigating the various tribunal systems, clients were overwhelmingly satisfied with the services they received from their local community legal clinic. For example, few clients who were surveyed reported they had to 'jump through hoops and/or repeat their story' with the majority of clients indicating they 'received the help they needed and that their opinions were heard'. Clients were slightly less likely to report they were served in a timely manner (which most likely speaks to internal capacity issues). A majority of clients reported that clinic staff understood what it was like to live in poverty and were compassionate, empathetic and professional: *"(I received) A++ (service)."*

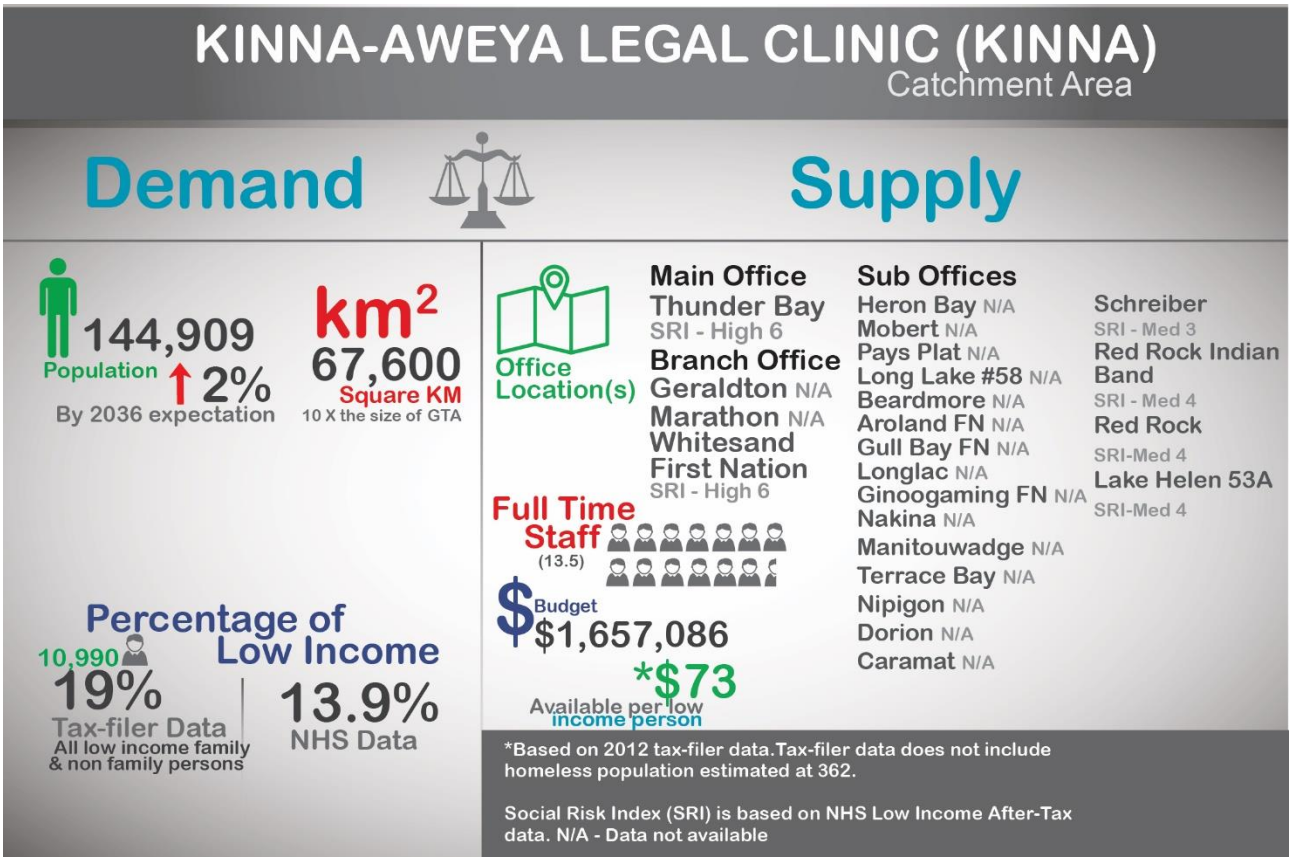
In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly social as well as health/mental health services) not to mention providing clients with practical supports such as bus passes, etc. This was reflected in client survey results insofar as anywhere between 40% to 60% of clients reported they looked to the community legal clinic for assistance with service referrals. Grand Nord clients who completed surveys also identified needing assistance in terms of mediation services.

Partnerships with food banks and agencies mandated to provide crisis supports (Violence Against Women; mental health; etc.) were most often noted. The Cochrane Native Friendship Centre was cited as a real asset and strong community partner, providing support in the way of family court worker, abuse prevention and counselling programs.

Increasing and more complex caseloads ('clusters' of social and legal issues, including high illiteracy rates) were seen as presenting unique challenges for clinic staff and community partners. In addition, mental health challenges were cited in the context of transportation issues. Stakeholders spoke of the clinic serving those with mental health and addiction issues who have to travel significant distances to access the district's only methadone program.

Most community partners who participated in the NRTP project identified the need for Grand Nord to work at a systems level, addressing OW/ODSP and landlord/tenant policies and practices. It was often recognized that Grand Nord has a lot of clout which is increasingly needed in regards to the tribunal system. It was noted that ODSP adjudicators often refuse to accept medical reports submitted in defence of ODSP applications (Nurse Practitioners who are authorized to sign off on medical reports are often challenged by ODSP adjudicators as not sufficiently qualified). With a shortage of family physicians, this internal ODSP policy means applications and appeals processes experience significant delays.

4. Kinna-aweya Community Legal Clinic



There was consensus that the trend towards call centres and websites in place of traditional service delivery mechanisms for low income clients was considered to be ineffective and inappropriate. For example, even though clients tended to report having access to landlines and/or cell phones (pay as you go with free texting options), fully two thirds of clients did not have computer access (*"I don't have a computer" (X3)* and those with cell phones would not have the capacity to wait in the 'q' for service through a call centre. In addition, there were some clients who did not have phones or who indicated they were not comfortable using methods of communication other than face-to-face interactions (*"I'm illiterate and do not know how to use a computer"; "the internet is not specific enough … "*).

Along these same lines, slightly less than two-thirds of clients who were surveyed indicated they NEVER use the internet as a source of legal information, with the majority preferring face-to-face interactions. The majority of clients who were surveyed did not believe the internet was a good way to get legal information, citing lack of internet access as well as issues with literacy and comprehension.

Similarly to clients accessing services from a number of other northern community legal clinics, Kinna-aweya clients were significantly more likely to report transportation/distance to services (74%) as a barrier. Other barriers to services as noted by clients included: clinic hours (13%); and no services (13%). A number of clients cited issues associated with communication/comprehension and literacy (13%); mental health issues (6%) and not knowing where to go for help (6%):*"I suffer from social anxiety and have mental health issues"; "(I have) reading/literacy issues (and) no phone: I have difficulty remembering appointments because of a brain injury."*

It was not uncommon for staff to cite more than 500 pieces of identification as having been issued since 2012, with staff having to scale back on the number of ID clinics they host because of capacity issues. Community partners also referred to increased pressures on the clinic to meet this growing demand given the fact that most provincial programs require ID (including schools who require birth certificates for registering students). First Nation individuals were often noted as disproportionately more likely to seek assistance with documentation. Stakeholders and clinic staff alike noted the potential role of Service Canada in fulfilling this function given the fact that First Nation band members are under the Federal Government's purview.

Written comments provided by clients focused on family law issues and eligibility issues (LAO certificates) including an increased number of clients who needed assistance navigating tribunals: *"I dealt with a divorce in the past few years. I represented myself as I could not afford a lawyer. I applied for legal aid and was denied three times. I am illiterate and the process was stressful." "I needed someone to represent me on my appeals to the SBT (Social Benefit Tribunal)."*

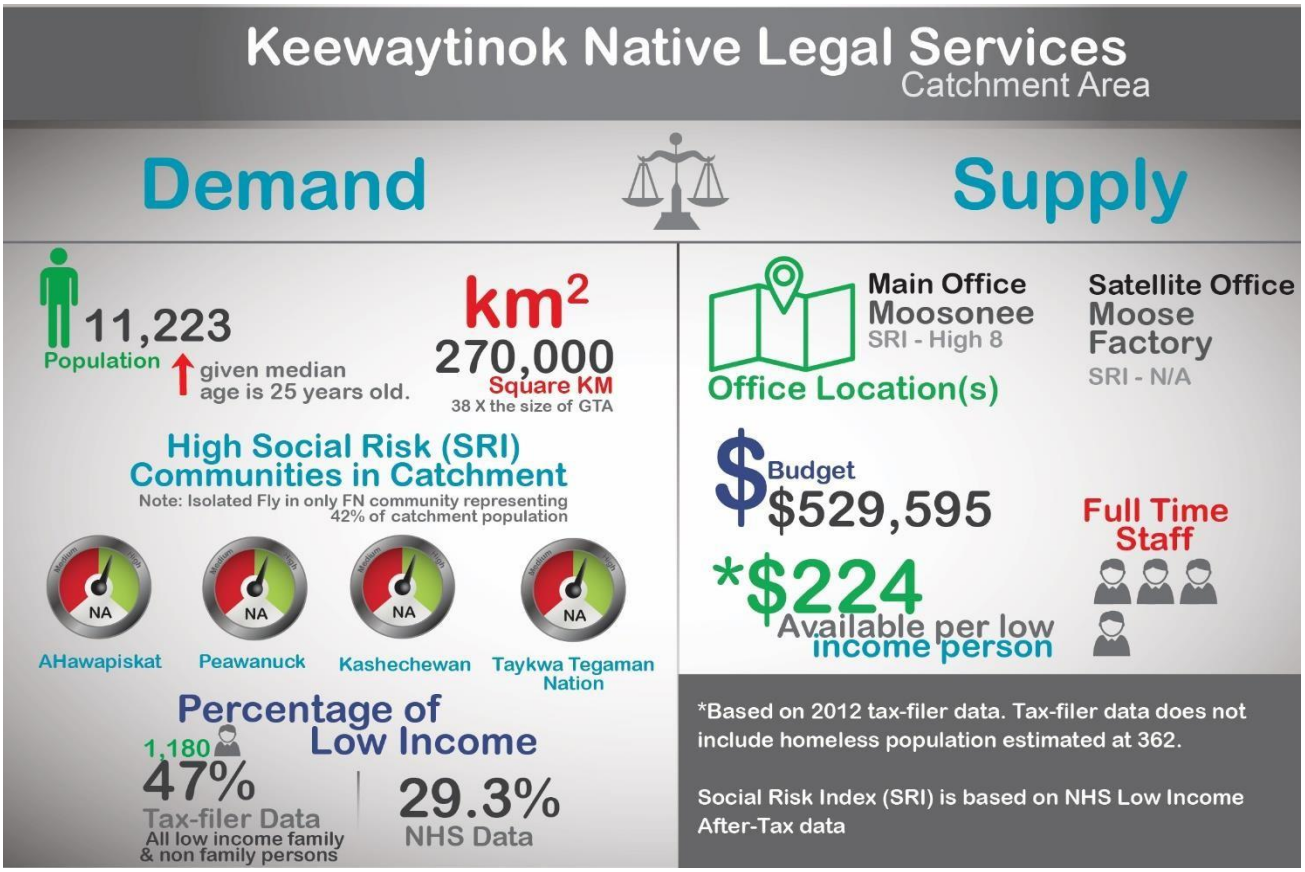
Client experiences accessing clinic services tended to be highly favourable, with few reporting they had to 'jump through hoops and/or repeat their story'; the majority of clients felt that they 'received the help they needed and that their opinions were heard. Most clients who were surveyed reported they received services in a timely manner. Clients also referenced the fact that Kinna-aweya provided them with practical assistance (such as bus passes, vouchers, etc.). At least 39% of clients indicated they received this kind of assistance from the community legal clinic: *"The clinic gave me a bus ticket and food"; "They helped with my taxes, photocopying, faxes, etc."*

Finally, a majority of clients reported that clinic staff understood what it was like to live in poverty and were compassionate, empathetic and professional. Clients who were surveyed provided a significant number of additional comments to that effect: *"(The clinic) made me feel better that I did not have to deal with problems alone..."*

Another theme identified that resonated across other northern clinics was the need to limit intakes and/or cap the number of cases staff take on (in some cases due to sick leaves, etc.). High burn-out rates were reported in the context of very low staff turnover which was also a common theme for northern clinics: staff tend to be in their positions for 15-25 years which was seen as both positive and negative (positive from the perspective of building strong and lasting relationships with community partners but negative insofar as clinic work is emotionally draining and therefore staff can burn-out).

Being able to access paralegal training was also an issue identified by stakeholders, with individuals having to travel to southern Ontario in order to access programs and to write their final exams. This issue impacts on the sustainability of community legal clinics insofar as individuals born and educated in the south are less likely to be attracted to Northern Ontario (versus Northern residents who have the opportunity to do their legal training closer to home).

5. Keewaytinok Native Legal Services



Keewaytinok clients tended to be younger males (i.e. 73% were younger than 45 years, with 40% younger than 35), and were equally likely to speak English as they were Cree (all fifteen clients who completed the surveys self-identified as Aboriginal). In contrast to other northern community legal clinics, far fewer clients reported being single, divorced, separated or widowed and by inference were less likely to reside in single-person households. (It should be noted that First Nation communities in Northern Ontario report significant challenges in terms of housing--including over-crowding and substandard housing conditions – so one cannot correlate marital status with assumptions around household composition since First Nation families often live together across generations (by choice or necessity). Also, First Nation individuals tend to not be able to get legally divorced due to access and cost.

As previously indicated, the client population tends to be much younger with only 20% of clients reporting they were over the age of 46. Furthermore, fewer than half of clients surveyed indicated they required assistance in the way of 'legal information' (33%) with approximately 66% of clients

indicating they needed 'advice' and help with 'forms' (respectively). To a far lesser extent, clients reported needing 'legal representation' (29%), with no clients indicating a need for mediation services or service referrals. The fact that clients indicate not needing legal representation might be a reflection of cultural fears around navigating mainstream court systems and legal services in general (a theme that was referenced by a number of stakeholders).

The types of issues faced by community legal clinics operating in remote locations with large Aboriginal populations were quite different, with ODSP and housing issues representing less than one-third of Keewaytinok's caseload. Client survey results tended to support this finding, to the extent that no clients indicated ODSP as their source of income, with 40% and 20% (respectively) reporting employment and unemployment. To a far lesser extent, clients reported being full-time students, Ontario Works recipients or CPP recipients. This is not to say there is less of a need for advocacy around ODSP issues. In fact, it points to how much more difficult it is for this population to access ODSP income supports.

According to the clients who were surveyed, the most frequently reported legal service accessed by clients was criminal injuries compensation (CICB) which accounted for 43% of responses, followed by criminal/family (13%), consumer debt (13%), CPP (13%) and to a far lesser extent access to social benefits (OW/ODSP) (5%). Other issues that were referenced by clients included employment issues (13%), Old Age Security, human rights issues and help with forms or letters: "*(The) clinic wrote letters on my behalf ... helping explain the legal jargon"; "(The clinic helped me with) employer problems ... (including) a debt of $16,000 to Revenue Canada."*.

The high number of CICB cases most likely captures First Nation individuals negatively impacted by historic trauma and cultural assimilation and who are entitled to compensation as a result of their experiences in residential schools. For those going through the CICB process, a theme that permeated key informant interviews and focus groups concerned the general lack of support that is available for First Nation clients, including severe shortages of counselling services and culturally appropriate supports. It is important to note that the provision of culturally-appropriate and safe legal services -- for Aboriginal clients -- was noted by certain NRTP key informants as being inadequate, particularly in those parts of Northern Ontario where First Nation populations predominate (i.e. along the James Bay coast). This necessarily results in community legal clinics becoming the default for counselling and support services directed at survivors of residential schooling (including their family members).

Similarly to other northern legal clinics but on a much larger scale, Keewaytinok indicated providing family and criminal law type services which represents as much as one-fifth of their caseloads; client survey results also show Keewaytinok as unique to the extent to which they are providing such services (which is outside of their mandate). As the first point of contact for many individuals

and given its remote location and fewer ancillary resources (legal and non-legal) the community legal clinic finds itself providing summary advice, brief services, etc. to clients with family and criminal law needs. Family law challenges that were cited include the lack of family lawyers; the decreasing number of LAO certificates available (referencing LAO's restrictive income threshold) as well as the difficulties First Nation individuals face when navigating the criminal court system.

Lack of affordable housing and sub-standard housing (as a result of First Nations not being adequately funded to address chronic housing issues on reserve) is reflected in the growing number of housing-related cases the clinic is taking on. The public housing units in Moosonee were reported as becoming more restrictive which is resulting in more evictions. Where the housing authority used to allow individuals 12 - 18 months to address arrears, this practice is no longer in effect. As a result more individuals are being evicted and finding themselves without housing. In addition to assisting with legal needs, the clinic was noted for their ability to link clients to agencies in the community (particularly housing, food, social and health services) not to mention providing clients with practical supports such as bus passes, etc. At least 50% of clients indicated they received this kind of assistance from the community legal clinic. (The clinic was also referenced as assisting clients who needed translation services.) Language, literacy issues and difficulties comprehending forms and navigating processes were all referenced as challenges faced by clients.

Transportation issues, cost of living and remoteness are huge barriers that were referenced as not being recognized within the current funding framework (i.e. the cost of servicing fly-in First Nation reserves). Other issues that were noted relate more directly to disability processes and target the lack of family doctors, including a severe shortage of psychiatrists (1 psychiatrist services the entire Cochrane District). Clinic staff use ice roads in winter to get to remote communities to provide outreach. In summer months, they travel by helicopter and water taxis which can be expensive. These kinds of realities were reiterated by clients who responded to the survey. For example, transportation/distance to services was reported as a challenge by almost half of clients surveyed, with literacy/comprehension issues and fees capturing 36% of responses. To a lesser extent, clients also referenced clinics hours of operation as a potential barrier to service.

Though not particularly unique to northern community legal clinics, the fact that Keewaytinok serves a predominantly First Nation population was perceived as a challenge in terms of potential conflicts of interest (similar to other small community legal clinics operating in Northern Ontario). In cases where there is a conflict the legal clinic has to refer clients to Timmins-Temiskaming and/or Grand Nord (neither of which are accessible by car and are much further away).

Approximately two-thirds of clients accessing services from Keewaytinok reported access to landlines (telephone) with no clients indicating they possessed cell phones. Given the remoteness

of its catchment area the lack of cell phones should not come as a surprise, however, it is significantly different from what is reported by clients across most other northern community legal clinics.

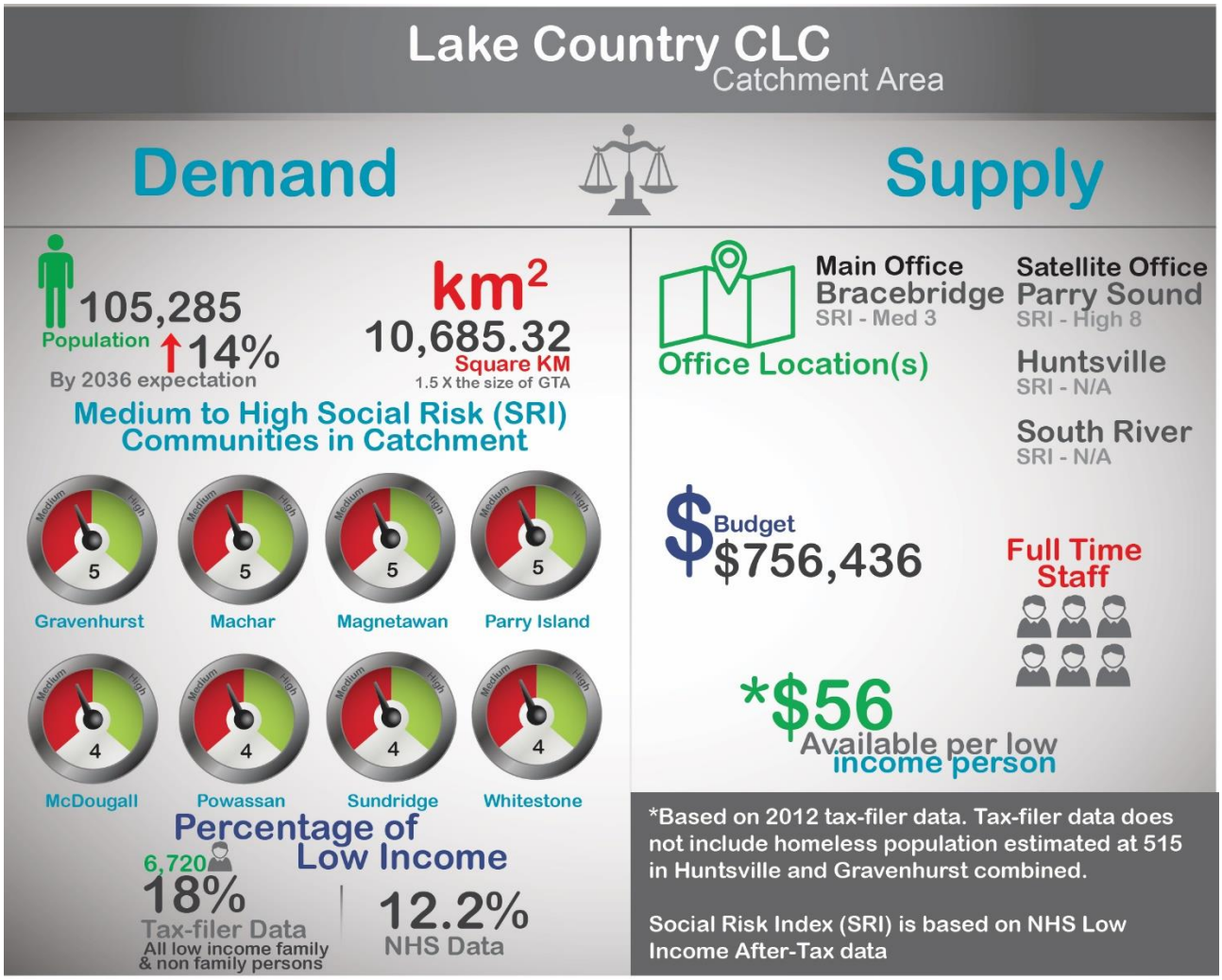
Surprisingly enough, 80% of Keewaytinok clients who were surveyed reported they have a home computer with internet access, the highest reported for clients who responded to surveys across the eleven community legal clinics. This corresponds to the reference to Facebook as an effective mode of communicating with clients as reported by clinic staff, community partners and clients alike.

Despite the high percentage of Keewaytinok clients who have access to the internet, there are still a number of clients (20%) who are 'without a computer', including one-third of clients who report being without a telephone. Similarly to clients accessing services across almost all of the northern community legal clinics, more than two-thirds of all Keewaytinok clients who were surveyed indicated they NEVER use the internet as a source of legal information, with the majority (100%) preferring face-to-face communications. This is particularly important in the context of cultural differences with many stakeholders referencing the importance of personal interactions with First Nation clients.

Despite the identified barriers to service (which include transportation/distance, literacy, language and fees), clients who were surveyed reported very high satisfaction levels with their community legal clinic. Very few if any clients reported they had to 'jump through hoops and/or repeat their story', with most indicating they 'received the help they needed and that their opinions were heard'. Clients were only slightly less likely to report they were served in a timely manner (which most likely speaks to internal capacity issues). A majority of clients reported that clinic staff understood what it was like to live in poverty and were compassionate, empathetic and professional in their interactions with clients.

A number of clients indicated they had accessed the community legal clinic before and/or had taken part in clinic-sponsored workshops; career fairs or Annual General Meetings: *"I was a previous client" (X2); "(The) housing workshop (and) AGM were very helpful".* For those who provided additional comments, the sense was that clients benefit a great deal from the community legal clinic and that services provided by Keewaytinok are essential: *"Keep up the great work ... great staff!"*

6. Lake Country Community Legal Clinic



The type of legal assistance required by clients surveyed overwhelmingly focused on 'legal information', 'advice' and 'assistance with forms' (100% response rate) followed closely by 'representation' (80%). 70% of clients who were surveyed also indicated 'mediation' services would be of assistance to them. The following written comments captures some of these sentiments: *"(The clinic) represents me with the landlord tenant tribunal"; "(Having) someone in your corner who knows the law (and can) explain options..."*

Barriers to service that were reported by Lake Country clients included (in order of importance): transportation/distance to services (60%), no services (25%); clinic hours (15%); and issues related to communication (i.e. comprehension, literacy) (15%). A number of client comments touched on mental health issues and difficulties understanding legalese: *"(I have a) disability ...*

agoraphobia (which makes it) hard to leave my house"; "(I have) reading problems ..."; (It's hard to understand the) legal jargon...." ; "*I only have grade 5 and have a hard time reading and understanding forms and letters."*

Similar to a number of other northern CLC's (i.e. Kinna-aweya and Manitoulin), Lake Country clients who responded to the survey were more likely to cite transportation and distance as barriers to services. This theme resonated with community partners and clinic staff who noted challenges serving a dispersed population base (many noted the importance of expanding services out of Parry Sound and South River satellite offices, both of which were considered to be higher needs communities).

Other issues that emerged included the need to work around client realities -- in practice, most stakeholders referenced the need to allow for 'drop-in's, recognizing that clients face significant challenges (logistical and otherwise) which makes it difficult for them to follow through on appointments. This was a theme that crossed many other northern community legal clinics (as well as non-legal service providers).

Being able to contact clients was a potential challenge for service providers which speaks to issues associated with client access to landlines, cellphones and internet service. Similarly to other northern clinics, clients who completed surveys tended to report access to landlines (80%) and to a lesser extent, cellphones (55%) as well as internet access (65%). This still leaves approximately 35% of clients as being without computer access which has implications in terms of receiving services through the internet (i.e. websites). As well, fully two-thirds of clients surveyed indicated they NEVER use the internet as a source of legal information reporting low comfort levels: *"I would rather talk to someone"; "(It's) always better to sit down and talk to a lawyer."*

As with the majority of community legal clinics, caseloads resolve around OW/ODSP and landlord tenant issues. These themes were reiterated in the client surveyed insofar as clients tended to report disability (55%) and OW (30%) as their main source of income. Legal issues cited by clients tended to be in relation to 'access to social benefits'(65%); 'housing issues' (40%); consumer debt (10%); criminal/family law and CPP (5% respectively). Written comments as provided by clients noted issues with landlords, harassment and human rights issues: *"(I am in a) rent dispute with my landlord -- low income rental unit"; "(I've had to deal with) harassment from (my) landlord for 11 years"; "(I need help with) human rights issues (and) community development ... public legal education."*

Clients were more likely to report mental health issues, homelessness, high illiteracy, and 'clusters' of other issues which were seen to be exacerbated by a complex and intimidating tribunal systems.

For example, the SBT, ODSP and other systems were often referenced by clients, community partners and clinic staff as challenging to navigate for clients without formal or informal supports. Increasingly, clinic staff and other community partners are having to take on this role, a role for which they feel particularly ill-equipped.

Medical documentation was often referenced as presenting challenges given the lack of family doctors and/or the reluctance of some medical professionals to sign off on disability applications. The disability system in general was seen as problematic (i.e. tight timelines for appeals present challenges in terms of tracking clients that tend to be transient, including those who have no and/or limited access to phones). Housing and energy costs were referenced as high considering the lack of industry/economy. There were references made to the hidden homeless problem and the lack of good and sustainable jobs which results in high numbers of working poor.

Very strong partnerships that were noted for Lake Country CLC included: Ontario Works, Violence Against Women agencies, as well as a multitude of other non-profits (Parkinson's, Elder Abuse Committees, etc.). Lake Country was seen as doing vital outreach and community development work, with many stakeholders referencing the PROMPT program which gives a 'voice' to low income individuals and clients.

Client experiences accessing clinic services tended to be very favourable, with few clients reporting they had to 'jump through hoops and/or repeat their story'. The majority of clients felt that they 'received the help they needed and that their opinions were heard', with very few clients indicating they had to wait for services. As important, the majority of clients felt Lake Country staff were compassionate and empathetic in their interaction with clients. Clients who were surveyed provided a significant number of additional comments to that effect: *"(I'm) glad the clinic is here as I wouldn't have known what to do"; "My case worker did a great job representing me"; "Without your services I wouldn't have made it ..."*

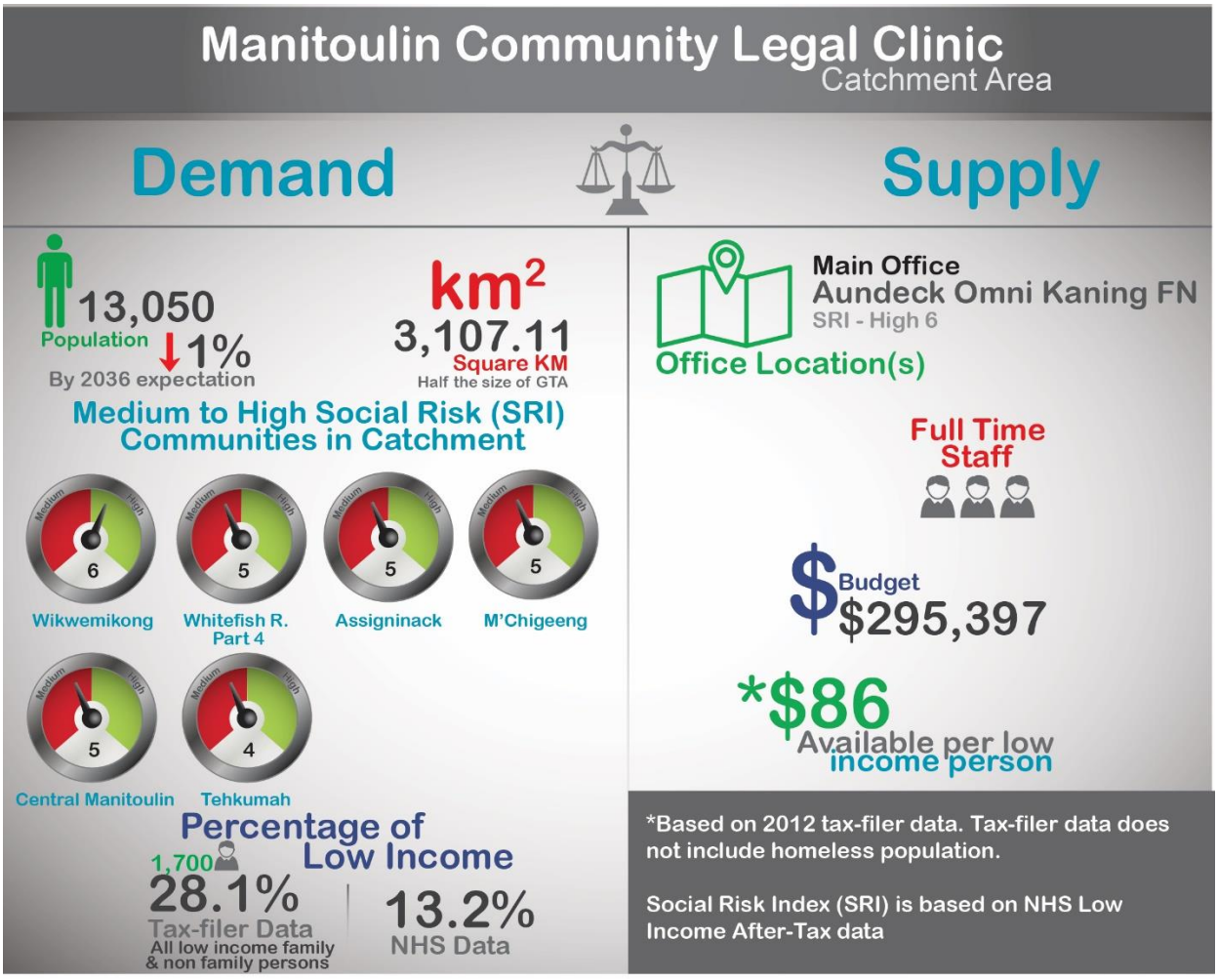
In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly social service agencies, although clients also indicated assistance in the area of referrals to housing services, food banks, employment and mental health services). In addition to service referrals, more than half of clients surveyed reported they had been linked to other people in the community who could understand what they were experiencing. Lake Country was also referenced by approximately 40% of clients as providing them with practical assistance (i.e. bus passes, vouchers, etc.).

Legal gaps that were identified by stakeholders included: legal services for working poor populations (including consumer debt and pay day loan operations); services to those with family

law issues (including women survivors of violence needing assistance with criminal injuries compensation); and seniors issues (CPP/OAS/POA's; competency assessments). Many referenced the need for more public legal education, including building current capacity to engage in outreach and community development. A number of stakeholders referenced the importance of personal relationships (with clinic staff, government agencies (i.e. OW/ODSP case workers) and community partners, all of which allow for more effective service integration (including resolving issues before they escalate).

Lake Country clinic stakeholders spoke of strong partnerships with a number of specialty clinics and resources, including OPICCO (which is seen as a potential resource which could assist in building community development capacity within community legal clinics). Lake Country is one of three community legal clinics that provide forums for clients to come together for the purposes of empowerment and systems change (i.e. PROMPT). The ability of Lake Country to engage in community development, however, was seen as a 'catch-22 insofar as limited capacity to meet what are considered to be increasing demands for services (this theme resonated across a number of clinics).

7. Manitoulin Community Legal Clinic



Client surveys received from Manitoulin CLC reflect a predominantly older clientele (80% of clients were over the age of 46, with a significant number over the age of 65). Primarily English-speaking, approximately one-quarter of client respondents self-identified as Aboriginal. Clients were equally likely to be male/female, and slightly less likely to be married or in a common-law relationship (44%) – combined, single, divorced, separated and/or widowed clients accounted for 54% of responses. Therefore, approximately 54% of clients who were surveyed could be categorized as residing in single-person households which has implications in terms of their vulnerability to financial stresses (i.e. not being in a position to share housing costs, etc.).

The high cost of rental housing, acute shortages, and sub-standard housing were all trends that were reported in Manitoulin (similar to other CLC's). One trend that was reported by Manitoulin and which was found in Nipissing, Elliot Lake & North Shore and Timmins-Temiskaming community legal clinics concerns the 'migration' of low income individuals from Southern Ontario in

search of cheap housing, and a slower pace of life. This trend was noted as impacting legal clinics and community partners. Stakeholders tended to relay the same story: individuals would migrate north in search of low-cost housing or mental health and addictions services; with no family or support systems in place they often find themselves in need of crisis assistance (i.e. mental health; housing; legal services).

Differing from most other northern clinics (with the possible exception of Lake Country), Manitoulin was also seen as experiencing fluctuations in population (it's not uncommon for Manitoulin to witness a doubling of its population in summer months (due to an influx of tourists) which taxes emergency health, mental health and social services infrastructure.

The perception that low-income populations and those on social assistance are moving to Manitoulin for cheaper housing might explain the high proportion of ODSP, CPP, and WSIB caseloads as reported by the community legal clinic. This is supported by the client survey results insofar as clients tended to report a reliance on ODSP as their main source of income (49%); Canada Pension (28%); with clients indicating the legal clinic helped them access social benefits (28%), including helping them navigate Worker's Compensation and CPP (28% and 21% respectively).

Changes to the WSIB system were often referenced by stakeholders as negatively impacting injured workers, resulting in denials and multiple appeals, which negatively impact on clinic staff. The various tribunals were referenced as overly complex, overwhelming and lengthy for clients, clinic staff and medical professionals. The sense was that adjudicators often don't accept anything less than a psychiatrist's report (which creates challenges when there is only one psychiatrist serving Manitoulin Island).

This theme ran through the client surveys insofar as few clients reported accessing the community legal clinic for housing-related issues (although it should be noted that where housing is in short supply (as it is for Manitoulin Island), individuals often will live in sub-standard conditions, not reporting issues to landlords for fear of losing their tenancy). In comparison to most other northern legal clinics, the Manitoulin clinic reported fewer housing cases; however, a common theme that emerged from stakeholder interviews and focus groups concerned the high cost of housing, including but not limited to the exorbitant cost of hydro/heating). The fact that the Island reports old housing stock was seen to be a concern moving forward.

Family/Criminal law issues were reported by 14% of client respondents as was consumer law/debt (9%), employment insurance (9%) and criminal injuries (9%). Other legal issues that were mentioned by clients concerned power of attorney; wills/estates; and unemployment insurance: *"I*

used clinic services for my father's estate (will)"; "(I'm) fighting for fair and just compensation for a work place injury ... (I've been) unfairly denied benefits and treatment."; "The clinic helped me with parental leave income..."

The type of legal assistance required by clients surveyed overwhelmingly focused on 'legal information', 'advice' and 'assistance with forms' (93% response rate) and to a far lesser extent, 'legal representation' (37%). The fact that fewer clients desired legal 'representation' services was similar to clients who responded to surveys in Elliot Lake & North Shore CLC as well as Keewaytinok.

The biggest barrier to service reported by clients included distance and transportation issues (74%). Although transportation and distance was a widely cited barrier across all community legal clinic catchment areas, the extent to which Manitoulin clients referenced this as a barrier suggests that the geography and dispersed population base is a particular challenge for clients. For example, approximately 16% of clients indicated they live more than 2 hours away from the community legal clinic (return trip) with 19% indicating they live at least two hours away.

In addition to transportation, Manitoulin Island is seen as being home to individuals with lower levels of education, literacy and fewer prospects for good jobs (i.e. working poor population). This theme permeated key informant interviews and focus group discussions. All of these issues were cited by community stakeholders as leaving more residents vulnerable to low income.

In all other areas, clients from Manitoulin indicated similar barriers as clients elsewhere in the north: no services available (12%); clinic hours of operation (7%); accessibility issues (4.6%); and issues associated with mental health (3%). Some of the written comments provided by clients reflect these issues: *"The clinic is not wheelchair accessible"; "(There is) no wheelchair ramp"; "(In terms of) transportation, (I) have back, neck and knee problems (and a) fused right ankle... (it's) hard to drive any distance ..."* Differing from the themes reported across most other northern legal clinic catchment areas, access to primary health care wasn't referenced as a significant issue for Manitoulin clients who were surveyed. In contrast, access to specialized care (particularly mental health services such as psychiatrists) was considered to be a significant issue for residents of Manitoulin Island.

Legal gaps that were referenced included: family law services (particularly the lack of family lawyers taking LAO certificates); and the large number of First Nation residents who though eligible for ODSP are unable to successfully navigate the disability system. A number of issues raised in relation to various government processes (including LAO) was the perception that the various government systems are designed to keep people in the 'dark' about their rights/entitlements. This

perception extended to call centre type services offered by LAO which were seen as inappropriate for the client population it is targeting.

Community stakeholders often referenced the challenges associated with helping their clients navigate the various systems; stakeholders expressed frustration that community legal clinics don't receive support from LAO in order to assist clients in completing various applications (i.e. ODSP in particular). For example, the 1-800 number was not considered to be effective for the client populations being targeted by community stakeholders who participated in focus groups (i.e. mental health and addiction populations; senior populations with Alzheimers'; and physically, cognitively or developmentally-delayed populations). Stakeholders referenced how they would bring clients to the community legal clinic and have the clinic assist clients in completing forms -- many referenced an LAO-funded program in the 1990's that used to recruit lay persons and train them to assist clients in this way.

Similar to other community legal clinics, clients tended to report access to landlines (telephone) (84%) and to a far lesser extent cell phones (35%). Approximately 40% of clients who were surveyed reported they have internet access; of these clients, slightly less than half indicated they NEVER use the internet as a source of legal information, with 28% indicating they use the internet on an occasional basis. The majority of clients who were surveyed did not believe the internet was a good way to get legal information citing lack of internet access, including not being able to understand the information available. *"(It) seems like you can't always get a definitive answer." "Sometimes it leads to more questions... I use the internet mostly for email, online banking, Kijijii, job search and Facebook*." In contrast, the vast majority of clients (95%) preferred face-to-face interactions.

Similar to other smaller northern clinics, it was often expressed that clinic presence in small communities is critical given transportation/geography and the realities of being more isolated in general. This is particularly true for clients who are in 'crisis', which means they have more difficulty accessing resources/services that require them to travel -- especially when public transit is lacking, which is the case for Manitoulin Island. There was the sense that people are falling through the cracks because they don't have the financial resources to be able to get to the services they need. Emphasis was placed on integrating services insofar as exploring opportunities to co-locate various services where it makes sense.

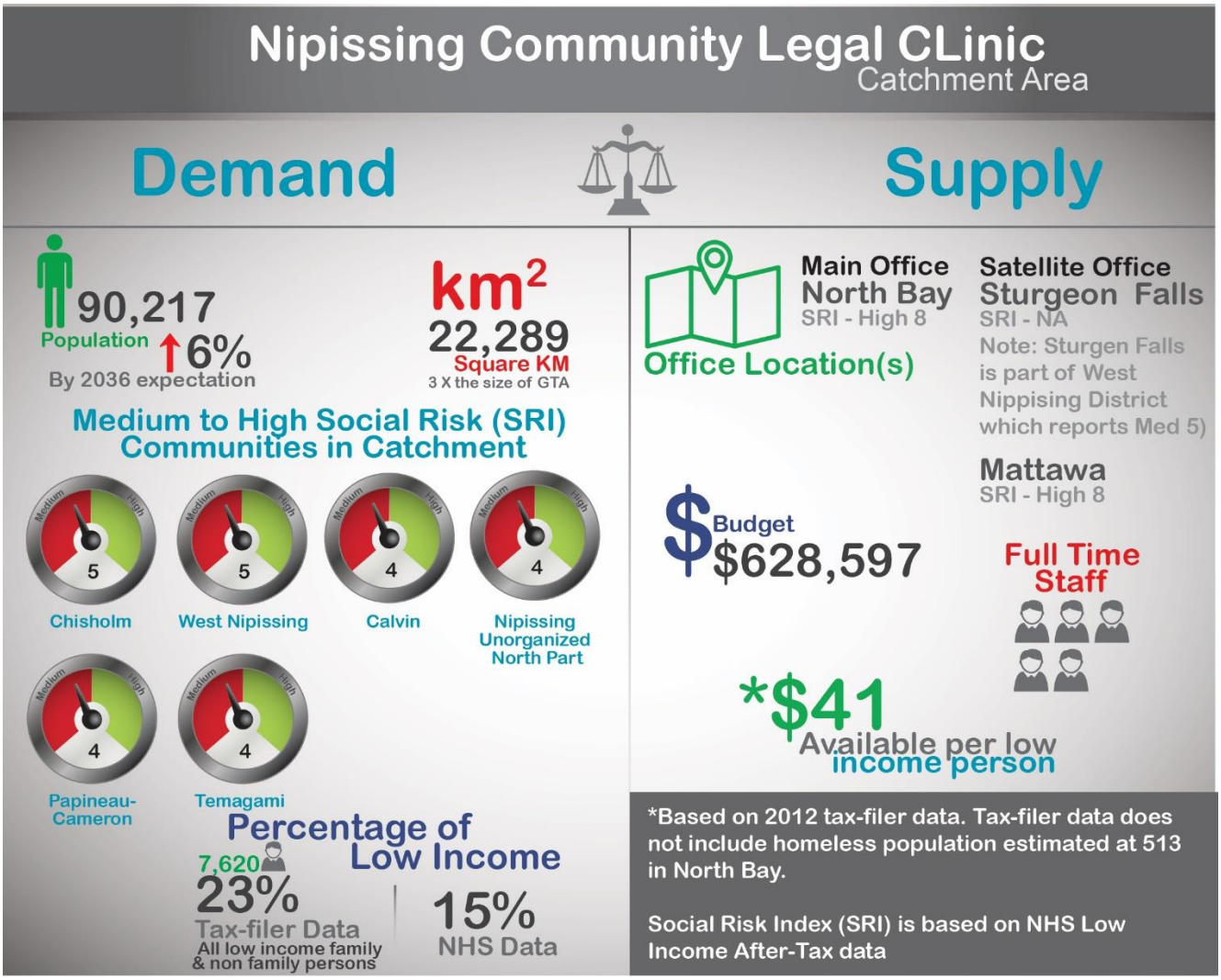
Client experiences accessing clinic services were overwhelmingly positive, with almost no clients reporting they had to 'jump through hoops and/or repeat their story'. The vast majority of clients felt that they 'received the help they needed and that their opinions were heard', with very few clients indicating they had to wait for services. As important, fully 93% of clients who were surveyed indicated they felt that Manitoulin Community Legal Clinic staff were compassionate and

empathetic in their interactions with clients. A significant number of clients provided comments praising clinic staff for the quality of services received: *"(They) provided guidance, assistance, (and) legal representation for (my) disability claim. I was represented at the tribunal by Mr. Shain."*

In addition to assisting with legal needs, the Manitoulin clinic was seen as linking clients to agencies in the community (particularly social, mental health and primary health services) not to mention providing clients with practical supports such as bus passes, etc. Of the clients who were surveyed, 74% indicated they were assisted in non-legal issues they were facing. For example, the clinic was also reported as helping client's access 'housing' supports and food banks within the community as well as providing a forum for clients to mobilize: *"The clinic helped found (the) Manitoulin and North Shore Injured Worker's group. Clinic is always willing to give practical help. I needed help with housing issues -- others need help with first and last month's rent."*

Partnerships that were noted included: DSSAB (OW); Manitoulin Family Resources; First Nation communities; North Shore/Manitoulin Island Injured Worker's Group (supported by the CLC for the purposes of collective support and advocacy); and Family Health Teams.

8. Nipissing Community Legal Clinic



Clients receiving services from Nipissing CLC who were surveyed tended to be significantly younger (more than 70% of clients were under the age of 46 years; 26% were under 35). Clients tended to be evenly distributed across male/females categories, with the majority reporting English as their primary language; slightly more than one-quarter of clients self-identified as Aboriginal.

Nipissing clients who completed surveys were much more likely to report being single, divorced or separated (combined they accounted for 70% of client responses) – joining Kinna-aweya and Lake Country as one of the highest percentages reported across all northern CLC's. This means that approximately 70% of clients who were surveyed could be categorized as residing in single-person households which has implications in terms of their vulnerability to financial stresses (i.e. not being in a position to share housing costs, etc.).

Not unlike other community legal clinic clients, Nipissing clients who completed surveys overwhelmingly reported their main source of income as Ontario Works (43%) and ODSP (43%) with '13% of clients indicating they were unemployed. This corresponds with the vast majority of clients who reported legal issues relating to 'access to social benefits' (83%) and CPP (10%). Housing (7%); Worker's Compensation and criminal injuries were the remaining categories that were referenced by clients. Other legal issues that were mentioned by clients concerned ODSP overpayment issues (7%).

Similar to other northern community legal clinics (i.e. Manitoulin; Elliot Lake and North Shore; and Timmins-Temiskaming) low income individuals are perceived as being encouraged to move north in search of low cost housing and better quality of health services (for example, North Bay is known for its extensive mental health and addictions infrastructure and services). North Bay's history as a regional psychiatric centre, combined with the in-migration of working poor individuals may be contributing to a disproportionately higher ODSP caseload as reported for the district. In addition, North Bay houses a number of aftercare and addictions treatment centres and services, all of which serve to attract individuals with mental health, addictions, and disability issues to the city. (This is also true for the Elliot Lake and North Shore CLC, the Northwest CLC and the Sudbury CLC).

Barriers to service that were reported by clients include (in order of importance): distance and transportation issues (33%) and 'no services' (17%). Clients from Nipissing indicate similar barriers as clients from other catchment areas as follows: clinic hours of operation (4%); accessibility issues (including lack of phone; literacy issues; etc.) (7%); and issues associated with mental health (4%) as partially reflected in the following comments : "*I have health issues and suffer from anxiety, depression and alcoholism"; "Sometimes in the past (I've) had no phone"; "I go to the clinic's satellite office in Sturgeon Falls ... I have a hard time just to move in the mornings..."*

As with other community legal clinics, OW/ODSP and landlord tenant issues predominate with system-navigation challenges resonating with staff, clients and community partners who were interviewed or who participated in focus groups. In particular, stakeholders referenced the fact that only one psychiatrist provides community-based services (out of a total of 25 psychiatrists operating out of North Bay's Regional Health Centre). This has implications from the perspective of access to medical documentation in support of disability applications. Similar to other legal clinics, Nipissing stakeholders also noted issues with forms (complexity; clients not understanding correspondence; clients not able to complete applications without assistance and support, etc.).

As with other legal clinics, family law is considered to be a big gap with the Nipissing clinic often being the first point of contact for those with these types of legal issues. Not being able to access LAO certificates because of very low income thresholds and service provider and client frustrations with LAO's 1-800 number were often referenced. Service providers indicated many of their clients have 'pay-as-you-go' cell phone plans with unlimited texting which means they can't afford to sit in the 'q' and wait for assistance (there were also issues with 'after-hour' services of call centres). Issues with the 1-800 call centre resonated across all northern community legal clinics.

Clients accessing services through the Nipissing Community Legal Clinic were more likely than those accessing services from most other northern clinics, to report higher cellphone access (67%) compared to landlines (57%). Approximately two-thirds of clients also reported access to the internet although this still leaves one-third of clients without access to the internet which has implications from the perspective of offering services vis-à-vis websites, etc. A further two-thirds of clients who were surveyed indicated they NEVER use the internet as a source of legal information, with slightly more than half of clients indicating they did not believe the internet was a good way to get legal information. The results of the client survey overwhelmingly favoured more of a personal interaction between clients and clinic staff (i.e. face-to-face communication).

Legal gaps that were identified by service providers included issues with MAG's 'form 13' which entitles victims of abuse to two hours of free legal advice from a lawyer (unfortunately, lawyers are required to take a course in Toronto in order to qualify and few are willing to do this, leaving victims of violence without access to this program locally and/or on long wait lists). Generally, the LAO certificate program was seen as 'overburdened'. Other issues with LAO certificates focused on the 'quality' of services provided and the lack of French speaking lawyers serving Nipissing district. Other legal gaps that were referenced by community stakeholders concerned the growing demand for competency assessments and substitute decision-making. Both cost and quality of assessments were noted as issues, including few qualified professionals available locally to meet this growing need.

Being able to serve a dispersed population base was seen as a challenge, with community stakeholders often noting the importance of satellite offices. Being able to adequately staff existing satellite operations was highlighted as an issue by clinic staff, community partners and clients alike. This is particularly relevant in light of transportation issues (disproportionately impacting rural residents). Some clinic staff referenced security issues (i.e. working alone), especially in light of clients who are denied disability benefits and who might engage in desperate measures. This issue was referenced in other clinics insofar as staff feel as if they are a 'lightning rod' for government policies (i.e. ODSP denials, unwarranted cut-offs, etc.).

Other challenges that were identified related to the high cost of housing and sub-standard housing which often means clients are forced to rent in high crime areas of the city (i.e. illicit drug use; prostitution; etc.). As with many other northern clinics, social housing wait lists are long which results in the under-reporting of housing issues (i.e. clients fearful of losing their tenancy put up with harassment and sub-standard conditions). Service providers referenced clients waiting as long as ten years for a placement in social housing units, with women survivors of violence (who receive priority status) often waiting more than 1 year for social housing. The lack of emergency funds and repair programs (i.e. formerly CHIPI and the Residential Repair Assistance Program) were seen as putting even more pressure on those who rely on social assistance as well as working poor populations to be able to maintain their housing.

Community partners, clients and clinic staff all referenced the various tribunals as complex, intimidating and illogical in their decision-making processes (including the high number of denials which are reversed on appeal). Once again, this was a theme that resonated across all northern community legal clinics (made worse by the most recent provincial review of ODSP case files and the new ODSP computer system).

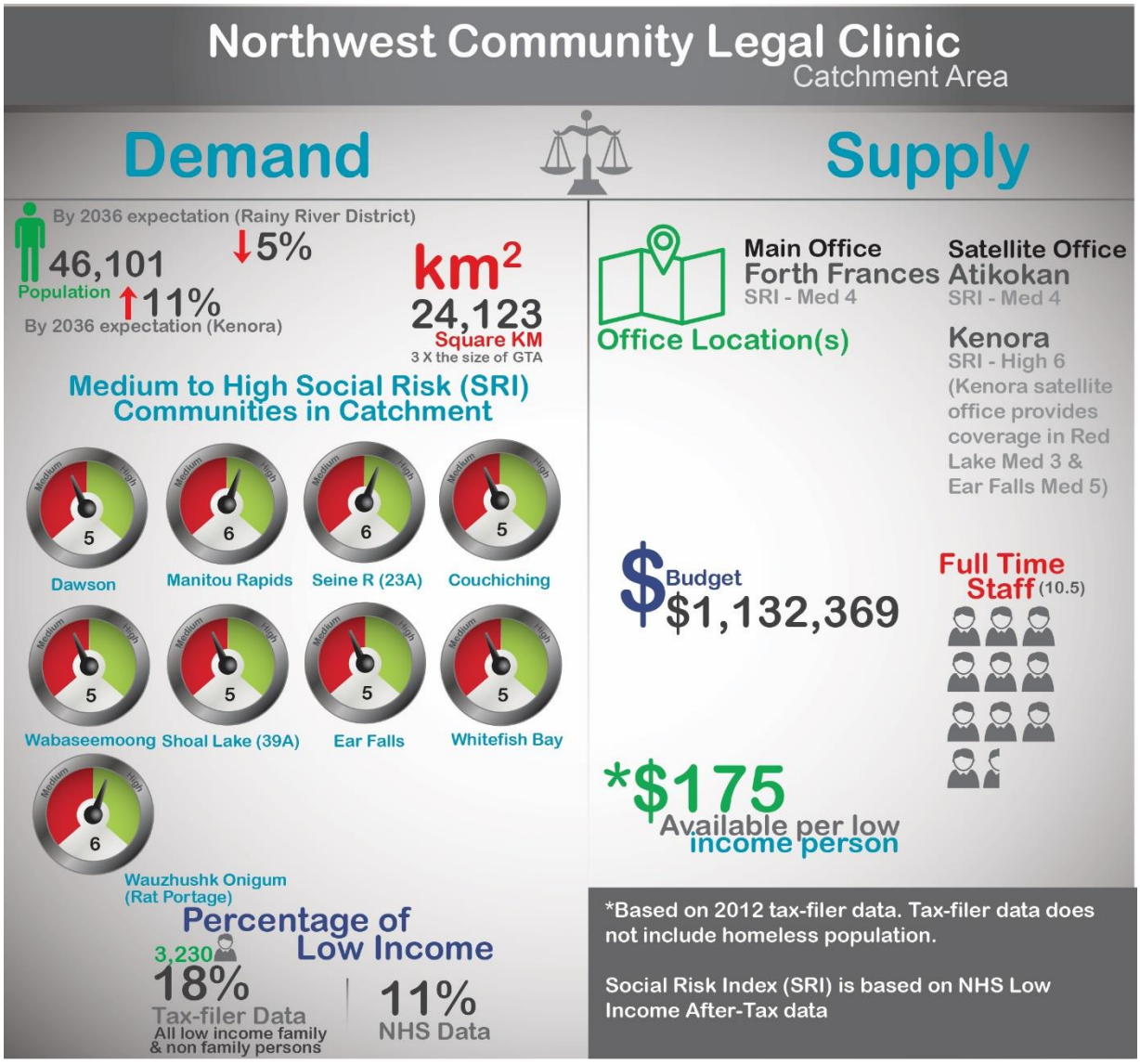
Clients and community partners often referenced the clinic as a safe place for clients and an important community resource. Client experiences accessing clinic services were overwhelmingly positive, with almost no clients reporting they had to 'jump through hoops and/or repeat their story'. The vast majority of clients felt that they 'received the help they needed, and their opinions were heard', with very few indicating they had to wait for services. As important, 93% of clients surveyed indicated they felt Nipissing Community Legal Clinic staff were compassionate and empathetic in their interactions with clients: *"I felt that the worker put herself in my shoes".*

A significant number of clients provided comments praising clinic staff for the quality of services received: *"Even after the decision, the clinic made sure I understood what to expect and what the decision meant. I felt assured that the clinic was there to help me if required;" "Services were great ... professional, understanding and both sympathetic and empathetic."*

In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly social, mental health and primary health services) not to mention providing clients with practical supports such as bus passes, etc. Of the clients who were surveyed, 74% indicated they were assisted by the clinic in addressing other, non-legal issues they were facing. The clinic was also reported as helping client's access 'housing' supports and food banks within the community including providing a safe and welcoming environment for clients: *The services were great and I would recommend the clinic to anyone who might need their help."*

The clinic's presence within many community-based coalitions and working groups was referenced, noting their strong commitment to community development and advocacy (on behalf of clients as well as at a higher systems level). The importance of maintaining the clinic and engaging in 'succession planning' were also noted as key. The clinic was seen to have a role in cross-community advocacy, including being seen as ideally placed to pull the kind of information together (i.e. ODSP success rates upon appeals, etc.) that could effectively lead to changes in provincial policies/practices. A number of community partners and clients spoke of the need for community legal clinics to "put pressure on decision-makers" (including local agencies where appropriate).

9. Northwest Community Legal Clinic



Client surveys received from the Northwest CLC reflect a slightly younger clientele (for example, 64% of clients accessing services were under the age of 46 years. There were slightly more male clients who completed surveys compared to their female counterparts (61% vs. 39% respectively). Almost half of all clients who were surveyed self-identified as being Aboriginal (although the majority of clients including those reporting Aboriginal status reported English as their primary language).

While a number of other CLC's reported disproportionately higher numbers of single-person households (based on client responses to questions about their marital status), the Northwest CLC

reported the highest number of single-person households (82%) based on client survey results. This has implications in terms of vulnerability to financial stresses and the potential for clients needing the services of community legal clinics.

Covering a vast geography, the clinic offers services out of four sites: Kenora, Fort Frances, Rainy River and Atikokan. Depending on the community in question, different issues emerged. For example, Kenora has a high percentage of First Nation individuals, including individuals who fly-in from remote reserves in the district. Kenora also reports more clients with mental health and addiction issues most likely a result of Kenora's status as a regional psychiatric facility (Kenora is also home to a detox program). First Nation clients accessing services from the Kenora branch office were often seen as needing assistance in terms of Aboriginal issues, status registration and documentation (SIN, birth certificates, etc.) as well as with criminal injuries compensation (as a result of residential schooling cases).

The Atikokan branch office tends to serve clients with WSIB, ODSP and housing issues. The local economy is beginning to recovery after more than a decade of downsizing in the forestry sector (since 2000, a number of mills were closed resulting in significant job losses). However, on the social housing front Atikokan is challenged by housing that is in serious disrepair, which has implications in terms of wait lists for social housing (it should be noted that housing issues tend not to be as significant in Atikokan as they are for Kenora and Fort Frances residents). In addition, key informants and focus group participants tended to highlight Fort Frances as challenged by the high cost of utilities. Reference was also made of the LAO clinic in Fort Frances which was closed in 2010; a number of stakeholders indicated that this loss has resulted in serious gaps in terms of access to family/criminal law matters.

As with all other northern community legal clinics, the Northwest CLC deals with OW, ODSP and landlord tenant issues. This finding was reinforced by client survey data which shows clients as heavily dependent on disability pensions (61%) and to a lesser extent, Ontario Works (18%). 11% of clients indicated they were unemployed with 4% of clients reporting they had full-time employment.

Legal issues cited by clients tended to be in relation to 'access to social benefits' (64%) and housing (32%). In terms of housing issues, crisis supports that used to be in place such as the CHIPI program (covering first and last month's rent) is no longer available, forcing more individuals into homelessness and by default into the poverty law system.CPP (25%); family law (21%); consumer debt (11%); criminal injuries (7%) and worker's compensation (4%) were the remaining categories that were referenced by clients.

Written comments provided by client's referenced wills/estates, family law and CIBC issues, and issues associated with administration/documentation: *"I'm having trouble seeing my kids ... having a hard time in the trial court ... not having rights as a tenant"; "Residential school issues...."; "(I have an) American social security number and American disability application".*

The type of legal assistance required by NWCLC clients who were surveyed favoured 'legal information' (86%), followed closely by 'advice' and 'assistance with forms' (78%). 39% of clients indicated service referrals would be beneficial with 32% indicating an interest in 'mediation' services.

Barriers to service that were reported by clients included (in order of importance): distance and transportation issues (53%), particularly in the context of communities dispersed across a large geography along what is considered to be a very dangerous highway. Northwest CLC was one five CLC's --Manitoulin; Kinna-aweya, Keewaytinok and Lake Country-- where clients reported transportation/distance as a significant barrier to service (as reflected in the following written comments): *"(I face) transportation issues if the service is out of town because I have no vehicle"; "Winter travel (is an issue)".*

Clients needing psychiatric services (including medical documents to support ODSP applications) have to travel to Kenora which is a challenge that is only expected to worsen considering the large numbers of individuals with mental health and addiction issues living in the NWCLC catchment area. It should be noted that many Northwestern Ontario residents travel to Manitoba to access mental health, addictions, and health services from Winnipeg Health Sciences Centres (Winnipeg is a 3 hour drive from Kenora, one-way).

In all other areas, clients from the Northwest CLC indicated similar barriers as follows: clinic hours of operation (7%); and accessibility issues (including literacy) (4%): *"My biggest barrier is my knee, sometimes walking or standing is not possible"; "(I need help) filling out the paperwork (for) ODSP."* Similarly to other community legal clinics, clients accessing services from the Northwest Community Legal Clinic reported access to a landline (phone) (68%) and to a lesser extent a cell phone (43%).

Approximately 43% of clients surveyed reported they have a home computer with internet access.

This still leaves 57% of clients accessing clinic services as being 'without a computer', which has implications in terms of receiving services via the internet (i.e. websites). Approximately one-half of clients who were surveyed indicated they NEVER use the internet as a source of legal information, with 32% indicating they use the internet on an occasional basis. The majority of clients who were surveyed did not believe the internet was a good way to get legal information citing lack of internet

access, as well as referencing low comfort levels: *"I don't know how to use a computer"; "(Using the internet for legal information is) ... not for me because I couldn't understand it."*

Client experiences accessing clinic services were overwhelmingly positive, with almost no clients reporting they had to 'jump through hoops and/or repeat their story'. The vast majority of clients felt that they 'received the help they needed and that their opinions were heard', with very few clients indicating they had to wait for services. As important, the majority of clients who were surveyed indicated they felt that the Northwest Community Legal Clinic staff were compassionate and empathetic... A significant number of written comments praised clinic staff for the quality of services received: *"Not only do I feel every effort is being made on my behalf, but I generally get to communicate with my (clinic worker) faster than I would expect and they have always seemed to have genuine concern for my situation."*

In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly in the area of mental health (CMHA) housing, and food (Salvation Army). Other service referrals that were noted included employment/education services, social services as well as referrals to mental health and primary health services. In addition, clinic staff were noted for providing practical assistance such as bus passes, etc. Of the clients who were surveyed, the majority indicated they were assisted by the clinic in addressing other, non-legal issues they were facing.

Areas where clinic staff were seen as crossing jurisdictional issues in terms of First

Nations (FN) communities included: when FN band members are 'banned' from their home reserves (fly-in) and find themselves stranded and needing legal assistance; when criminal injuries compensation cases end up on the clinic's doorstop as a result of perceived inadequacies with private lawyers who have been hired to represent FN clients; the legal clinic assists FN clients

in navigating OW issues with their local bands; and the clinic intercedes with human rights and Aboriginal rights (i.e. they refer cases to Indian and Northern Affairs Canada and the Federal Human Rights Board and the Federal Labour Board).

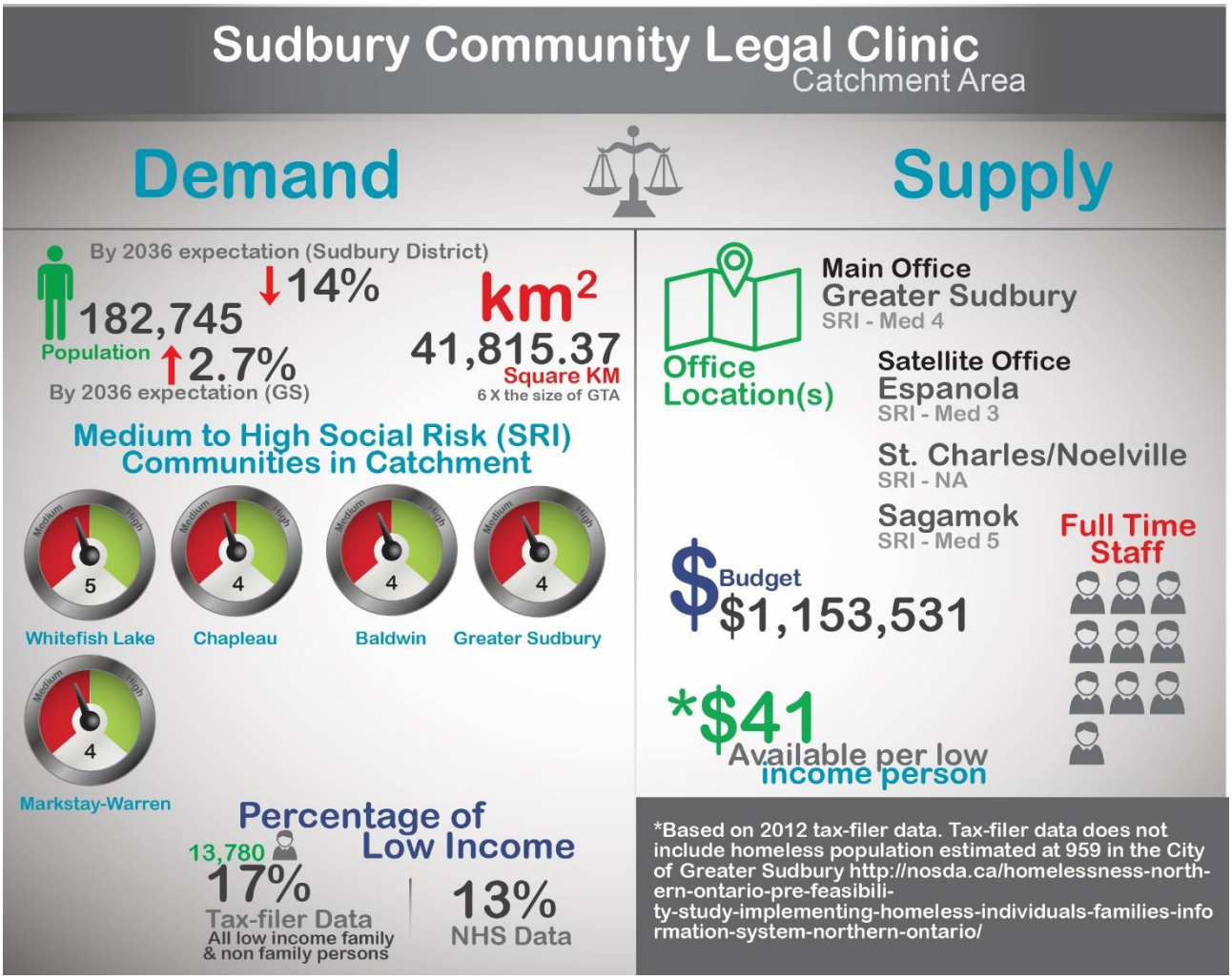
Gaps most often referenced by clients, community partners and clinic staff included housing and homelessness issues; family law; worker's compensation; estate/wills and human rights issues.

A number of community partners referenced the clinic's strong presence on housing/homelessness and mental health tables and taskforces (i.e. Kenora Substance Abuse and Mental Health Taskforce; the OPP Pillar's Taskforce, Inclusive Community Project). The NWCLC was referenced as taking a lead role in coordinating services to vulnerable populations, including working with local

agencies to get a community wellness project off the ground. A number of key informants noted the clinics outreach, public education and advocacy initiatives (i.e. going into public housing units to talk with single moms about landlord/tenant issues). In addition, reference was made to the clinic's work with Kenora Association for Community Living in overturning a provincial policy which reduced payments to ODSP clients based on their housing situations (i.e. that clients were considered to be in room and board situations if they shared a home with someone else).

"The community legal clinic is very much a part of the fabric of Kenora … the city and its people. (We) cross paths with all of the staff on a regular basis".

10. Sudbury Community Legal Clinic



Client surveys received from the Sudbury CLC reflect a slightly older clientele (for example, 63% of clients accessing services were older than 46 years; 37% were younger). There were slightly more female clients who completed surveys compared to their male counterparts. More than two-thirds of clients surveyed reported English as their first language with 17% of clients self-identifying as Aboriginal (though English speaking).

Similarly to the Northwest CLC, clients who were surveyed in relation to the Sudbury CLC were much more likely to report being single, divorced or separated (73%) and therefore, could be construed as residing in single-person households which has implications in terms of their vulnerability to financial stresses.

Not unlike other community legal clinic clients, Sudbury CLC clients who completed surveys reported their main source of income as disability and Ontario Works (33% and 30% respectively) and to a far lesser extent, CPP (3%). 17% of clients indicated they were unemployed with 16% of clients reporting they had full-time or part-time employment. Similarly, the legal issues as identified by clients tended to focus on 'access to social benefits' (57%) and CPP (20%). Housing (20%); family law (6%); consumer debt (6%); criminal injuries (3%) and worker's compensation (3%) were the remaining categories that were referenced by clients.

Other legal issues that were mentioned by clients could be categorized as administration, paperwork and/or documentation (i.e. clients needing help with forms), issues associated with ODSP, human rights and housing issues: *"ODSP ... I needed help with OW caseworker ... landlord issues"; "Human Rights Commission". "The clinic helped fight a rent increase".*

These themes resonated with key informant interviews and focus group discussions insofar as ODSP, landlord/tenant caseloads are seen to dominate staff time with tribunal work and appeals taking up a disproportionate amount of time, energy and resources of staff. Appeals and complex government processes were also noted as overwhelming and re-victimizing the most marginalized of clients (those who are homeless, with mental health and addiction issues, etc.).

In general, and not unlike most other northern community legal clinics, a common theme referenced by stakeholders focused on the disability system which is seen as being punitive, traumatic and intimidating (i.e. as getting worse not better). Community partners and clients often noted the important role clinics could play in collective advocacy, focusing on systems-level change (i.e. common themes that were identified included the need to use 'clout' in order to change policy/practices of municipal housing authorities, and various government departments and processes (including OW,ODSP, SBT, LTB, CPP and WSIB).

Gaps in legal services that were identified included legal services targeting working poor populations (employment insurance, etc.) and housing issues (repair and maintenance). Stakeholders went on to speak about particular populations that are not presently being served (including seniors, students and the working poor). Seniors issues tended to focus on substitute decision-making and POA; student issues were referenced in terms of housing; and working poor issues tended to be in relation to employment insurance, etc.

As with other northern clinic catchment areas, emphasis was placed on assisting clients complete applications given increasingly more complex requirements; it was often recognized that clients of community legal clinics face issues including but not limited to mental health, literacy, low-income, all of which can make it difficult for clients to be able to follow through on government requests. A number of clients referenced issues understanding government forms "*(I) need someone to help with forms".* In addition, clients often referenced poor mental health and significant physical health barriers :*(My) body was in pain so it was affecting my energy levels and mobility ... " I use a cane"; (I) cannot walk long distances".* Clinic hours were referenced by a number of clients as a barrier :*"(Clinic should be) open more hours at night".*

The Sudbury CLC was seen as spending a disproportionate amount of time on ODSP cases (i.e. helping clients' complete forms, representing clients on appeals, etc.). Stakeholders also referenced issues with the local housing authority and the need for strategic interventions and sensitivity-training for housing authority staff although it was noted that relationships have improved such that the clinic was able to refer clients who require assistance with ID (i.e. birth certificates, etc.) to the local Ontario Works office.

Specific challenges that were identified in terms of outreach and service delivery focused on limited capacity to serve outlying communities (i.e. Chapleau; and more rural areas areas in the Sudbury district) and the need for staff to be able to balance 'drop-ins' (versus scheduled appointments which aren't considered amenable to the populations the clinic is serving). There was consensus that the clinic is unable to engage in CD work because of very high casework demands. Community development work though referenced as critical for the SCLC to be engaged in was often seen as challenging given the current caseloads (i.e. ODSP, LTB, SBT). Strong partnerships that were noted tended to focus on agencies that serve homeless individuals, those with mental health and addictions issues, HIV/AIDS-serving, Aboriginal as well as Francophone-serving organizations, government (i.e. OW), non-profits (Social Planning Council of Sudbury) and educational institutions (i.e. Northern Ontario School of Medicine).

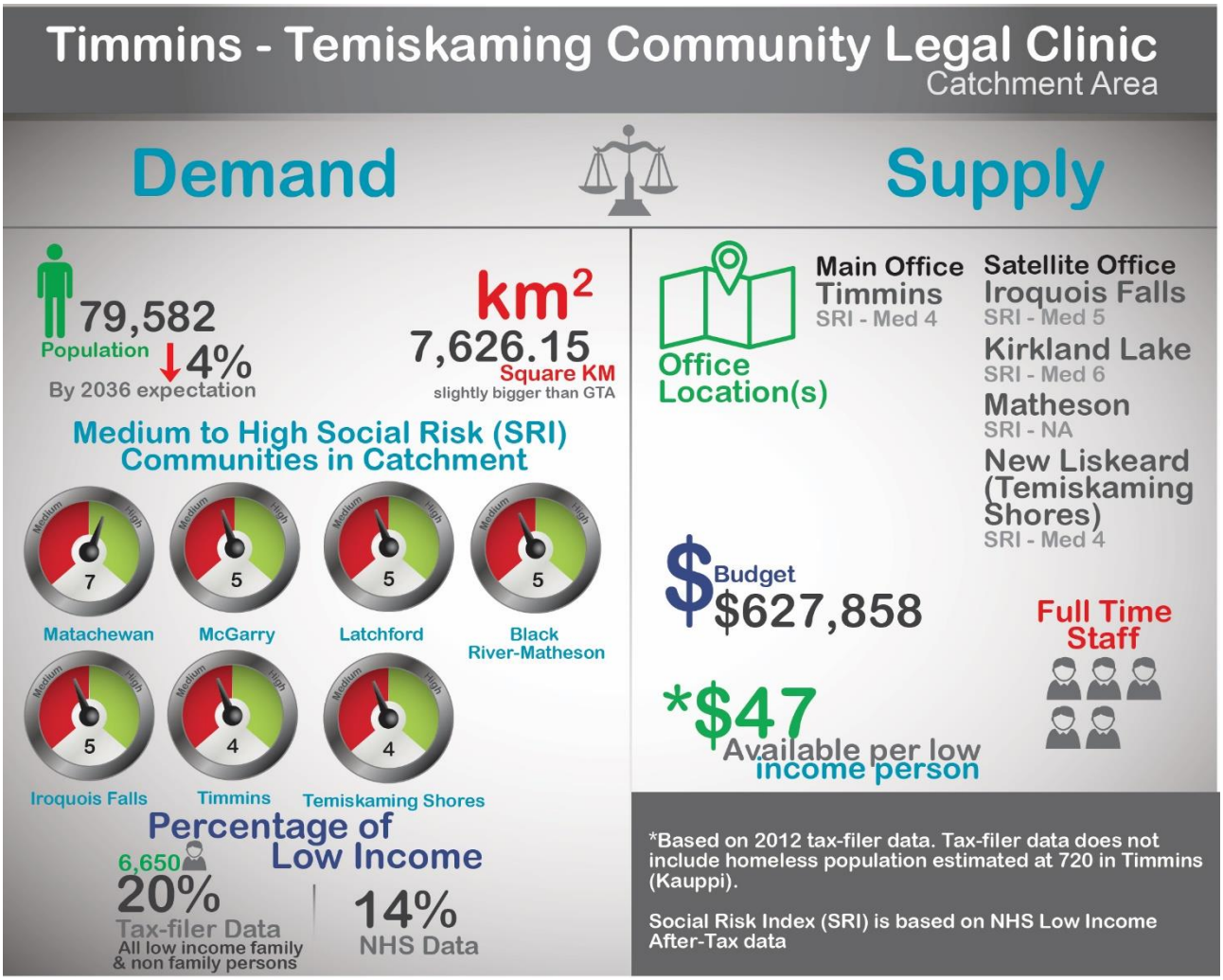
Clients, clinic staff and community stakeholders all referenced challenges insofar as availability of specialists in signing off on disability applications (including the ability of medical doctors to complete forms accurately).

Similarly to other community legal clinics, clients accessing services from the Sudbury Community Legal Clinic predominantly reported access to landline phones (67%) followed closely by cell phones (57%). (Clinics report clients as increasingly moving to cell phones and particularly, pay-as-you go plans with free texting options). It should be noted that Sudbury CLC houses the French Legal Advice Line which is available free of charge, to French speaking clients across the north and in parts of central Ontario.

Of the 47% of clients surveyed who reported internet access, slightly more than half indicated they NEVER use the internet as a source of legal information, with a number of clients citing issues with the Lawyer Help Phone line: *"Lawyers are not taking cases from other cities although they are the only specialists in that field and the law society referred me to them."* In general, the majority of clients who were surveyed did not believe the internet was a good way to get legal information. The vast majority of clients (100%) prefer face-to-face interactions.

The type of legal assistance required by clients surveyed overwhelmingly focused on 'legal representation' (80%) and 'legal information' (83%), 'advice' (77%) and 'assistance with forms' (71%). 40% of clients also indicated 'mediation' services would be of assistance as would service referrals (37%). In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly in the area of housing and food). Other service referrals that were noted by clients included: social services as well as referrals to mental health and primary health services. As well, clinic staff were noted for providing practical assistance such as bus passes, etc. Of the clients who were surveyed, the majority indicated they were assisted by the clinic in addressing other, non-legal issues they were facing: "*(The clinic) helped get a food allowance for my diabetes".*

11. Timmins-Temiskaming Community Legal Clinic



Client surveys received from the Timmins-Temiskaming CLC reflected a slightly younger clientele (for example, 53% of clients accessing services were younger than 46 years (47% were older). Female and male clients tended to be equally represented, with one client reporting 'transgender'. Most clients reported English as their primary language with 20% of clients self-identifying as Aboriginal.

Similarly to other CLC's, clients accessing services from the Timmins-Temiskaming CLC were much more likely to report being single, divorced or separated (67% combined); this means that 67% of clients can be construed as residing in single-person households which has implications in terms of their vulnerability to financial stresses. Not unlike other community legal clinic clients, Timmins-Temiskaming CLC clients who completed surveys reported their main source of income

as Ontario Works and disability (40% and 20% respectively) and to a far lesser extent, CPP (7%). 13% of clients indicated they had full-time or part-time employment, 7% of clients reporting being unemployed and 7% reported student status.

Legal issues cited tended to be in relation to 'access to social benefits' (33%); housing (27%); CPP (7%); family law (7%); consumer debt (7%); and criminal injuries (7%). Other legal needs that were mentioned by clients included needing help with forms, not qualifying for LAO certificates, and needing help finding affordable housing: *"Family law matters... custody and support. Support was too high and I did not qualify for a Legal Aid certificate ... "; "There is a lack of affordable housing in my community ... landlords can charge an exorbitant rent for basic or sub-par accommodation."*

Client survey results reinforce staff and community partner perceptions that the community legal clinic deals predominantly with OW/ODSP and landlord/tenant cases. Similarly to other community legal clinics, Timmins-Temiskaming reports a success rate approaching 65% for ODSP appeals. CICB and CPP caseloads were also seen as significant in terms of requiring a lot of staff time and attention (once again, 7% of clients who responded to the survey indicated needing clinic support for CICB and CPP applications). Supporting clients through the various tribunals was considered to be a big challenge. As far as gaps in services, most noted issues with family law, the lack of assistance in consumer/debt and small claims court processes, all of which are increasing in demand. These gaps were also referenced by clients completing surveys.

As with Grand Nord, Timmins-Temiskaming also deals with the annual migration of First Nation individuals from Kashechewan who are forced out of their communities because of spring flooding issues, which presents challenges given the housing shortages experienced in Cochrane District and the clinic's limited capacity to provide culturally-appropriate services. Notwithstanding this influx of Aboriginal persons, the clinic catchment areas per se report high proportions of Aboriginal individuals. In addition, Timmins-Temiskaming CLC reports a significant Francophone population with unique service needs.

Clinic and community partner respondents tended to reference LAO administrative demands (i.e. micro-managing) as taking away from client services, including preoccupying staff and board time/attention. This theme predominated across all northern community legal clinics.
Similarly to what is being experienced across Manitoulin, Nipissing, and Elliot Lake and North Shore community legal clinic catchment areas, Timmins-Temiskaming also reports the influx of low income populations to parts of their service area (i.e. Kirkland Lake) in search of lower housing costs and lower cost of living. As a result, clinic staff report serving clients with complex issues including those with mental health and addiction issues as well as low-income and precariously housed individuals who generally don't or can't follow through on appointments.

The lack of family doctors and challenges in securing medical documentation in support of ODSP applications were also noted by stakeholders. The ability to navigate disability forms and documents was referenced as a challenge for clients, medical practitioners and clinic staff (similar to what has been reported for most other northern community legal clinics).

Clients and community stakeholders reported a lack of awareness in terms of the range of legal services offered by the TTCLC particularly in outlying areas. Clinic stakeholders who were interviewed noted the difficulties in attracting board members from outlying communities. In general, it was suggested that the clinic should do more outreach with services providers and the general public.

Similar to other northern community legal clinics, family law was referenced as a gap despite the existence of a Family Court Resource Program (pilot) that offers information, support, accompaniment and access to duty counsel services for women involved in the family court process. The LAO certificate program was also referenced as problematic in terms of the 'quality legal advice' provided. Despite all of these identified challenges, client experiences accessing clinic services were positive, with almost no clients reporting they had to 'jump through hoops and/or repeat their story'; the vast majority of clients felt that they 'received the help they needed and that their opinions were heard' with very few clients indicating they had to wait for services. As important, the majority of clients who were surveyed indicated they felt that the Timmins-Temiskaming Community Legal Clinic staff were compassionate and empathetic in their interactions with clients. A number of clients provided comments praising clinic staff for the quality of services received: *"They make it easy to explain problems and give you time to discuss everything"; "They did not back down dealing with the collection agency ... I was trying to get my telephone bill reduced".*

In addition to assisting with legal needs, the clinic was seen as linking clients to agencies in the community (particularly in the area of housing and food). Other service referrals noted included social services as well as referrals to mental health and primary health services.

Appendix

1) Community Profiles
a. Algoma CLC
b. Elliot Lake and North Shore Community Legal Clinic (ELNSCLC)
c. Clinique Juridique Grand - Nord Clinic
d. Kinna-aweya Legal Clinic
e. Keewaytinok Native Legal Clinic
f. Lake Country CLC
g. Manitoulin CLC
h. Nipissing CLC
i. Northwest CLC
j. Sudbury CLC
k. Timmins-Temiskaming CLC

2) References

Note: Community Profiles and Data Sets for each NCLC can be found at: https://goo.gl/CbkF4L

Appendix A

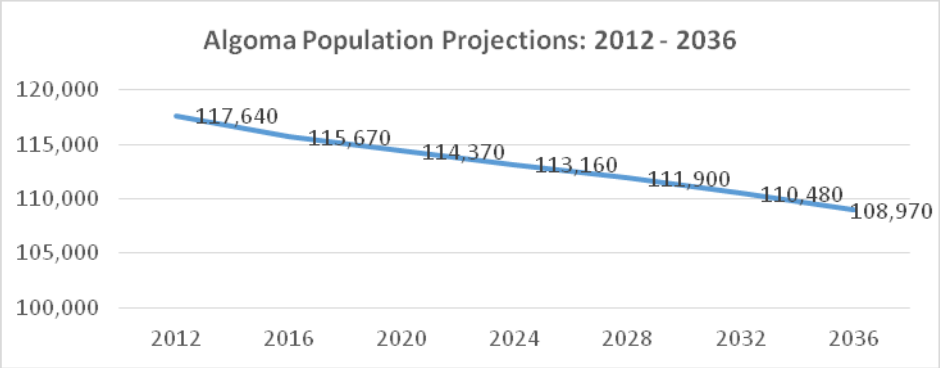
Community Profiles

ALGOMA COMMUNITY LEGAL CLINIC

Population Profile

The catchment area of the Algoma Community Legal Clinic includes the majority of the Algoma District and a very small portion of the Cochrane District. The main clinic office is located in Sault Ste. Marie (S.S.M).

There are 24 census sub-divisions in the catchment area with total population of approximately 96,920 people (2011 Census). The largest census sub-division is Sault Ste. Marie (75,141) and the smallest is the Gros Cap 49 Reservation (68). Of the 24 census sub-divisions, 6 are First Nation Reservations. The population in the Algoma District is expected to *decrease* by 7.4% by 2036 (see chart below).



The chart below indicates the census sub-divisions experiencing the greatest population changes.

Census Sub-division	2011 Total Population	Population change % (2006 to 2011)
Gros Cap 49	68	25.9
Garden River	1107	12.4

Hilton	261	7.4
Johnson	750	7.0
Wawa	2975	-7.1
Jocelyn	237	-14.4
Hilton Beach	145	-15.7
Dubreuilville	636	-17.9
White River	607	-27.8

The population in this catchment area is older than average, with a median age of 48.0 years old (versus 40.4 years old in the province) and 84.8% of the population is 15 years of age or older.

Language characteristics:

The majority of the population's mother tongue is English (86.2%). Approximately 8% of the population's mother tongue is a language other than English, French or an Aboriginal language, and a small proportion (5%) report French as their mother tongue.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Algoma Community Legal Clinic Area: Overall social risk for this catchment area is high (5). These risk factors include a higher than average proportion of: Lone Parent families; Low Education; Unemployment; Government Transfers; Aboriginal Identity; and Tenants.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Lone Parents	17.4	16.7
Low Education	21.3	18.7
Unemployment rate	10	8.3

Government transfer payments	22.6	12.3
Aboriginal Identity	10.8	2.3
Tenants	28.8	28.4
Movers	10.0	11.6
Low Income (LIM AT)	11.7	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is 20.8% of all families and non-family people (which differs considerably from the NHS Low Income After-Tax measure of 11.7%). This means there were 8,500 people and/or families living in low income. The median income for these low-income families and non-family persons was $13,113. There were 3,175 individuals without income. 1,960 (43.8%) lone-parent families, 4,130 (26.4%) of children under 18 and 1,020 (6.1%) of those 65 years and older were living in low-income. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[22] and for Ontario Disability Support Program[23] in the Algoma District was 795 (OW) and 1,561 (ODSP), and 2,003 (OW) and 3,947 (ODSP) in Sault Ste. Marie.

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

Census Sub-division	*Social Risk Score*	*Lone Parent Families*	*Low Education*	*Unemployment*	*Gov't Transfer Pymts*	*Aboriginal Identity*	*Mover*	*Tenant*	*Low Income LIMAT*
Dubreuilville	7	10.5	43.2	10.7	26.0	11.1	16.0	31.0	22.0
S.S.M.	7	18.9	20.2	10.5	18.0	9.2		30.3	14.2
Bruce Mines	6		27.9	11.4	33.2	10.1	17.4		16.5
Thessalon	6	17.8	30.5	16.0	25.2	15.8			20.1
Garden River	5	38.7	39.5	12.6	29.7	92.9			

[22] Ontario Works includes Temporary Care Assistance
[23] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

Housing

The total number of private households in the Algoma District is 41,690 (Census 2011). The Ontario Non-Profit Housing Association (ONPHA) 2013 survey identified the District of Sault Ste. Marie Social Services Administration Board as reporting 1,125 applicants for social housing, with an average wait time of 2.29 years (ONPHA).

Transportation

The City of Sault Ste. Marie has multiple transportation services, including public transit, parabus services for those with physical disabilities, and a community bus designed for seniors and persons with special needs but is available to anyone in the community.

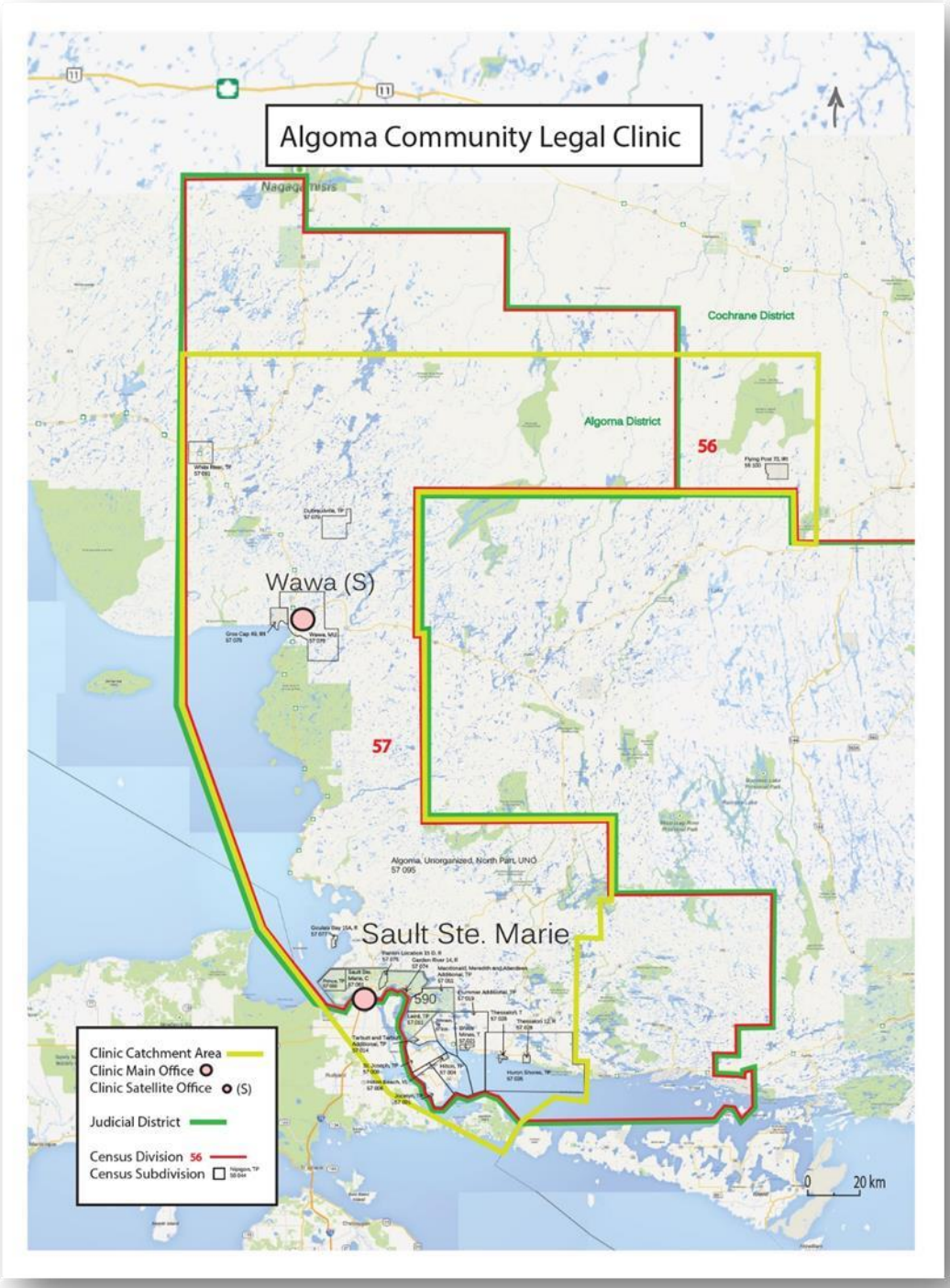
Greyhound bus services are available via Hwy 17 to Wawa and White River, as well as to Bruce Mines and Thessalon. For more remote areas, there is also Algoma Central Railway passenger service that goes to Dubreuilville.

Technological Infrastructure

The Lady Dunn Health Centre is located in Wawa, and there are hospitals in Thessalon, Richards Landing and Sault Ste. Marie. The Ontario Telemedicine Network (OTN) is available in the Algoma District and provides access to specialized medical care using video conferencing and other telediagnostic equipment.

Sault College and Algoma University are located in Sault Ste. Marie, and Confederation College is located in Wawa. Adult education is also available to the Algoma District through the North Algoma Literacy Coalition, which offers training support to adults who are pursuing employment, high school credits, post-secondary or apprenticeship. Contact North provides distance education to the Algoma District and has online learning centers that are equipped with audio/video/web conferencing, computer workstations and high speed Internet (where available) in Thessalon, Richards Landing, Sault Ste. Marie, Wawa, and White River.

There is cell service in the majority of the District, however there are areas along Hwy 17 that appear to be without cell service. Based on Roger's Cellular coverage maps, there is also no service in the townships of Jocelyn and Laird or in the First Nation community of Gros Cap 49.


Algoma Community Legal Clinic
Cochrane District
Algoma District
56
Wawa (S)
57
Algoma, Unorganized, North Part, UNO
57 095
Sault Ste. Marie
590
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
0 20 km

ELLIOT LAKE & NORTH SHORE LEGAL CLINIC

Population Profile

The catchment area of the Elliot Lake & North Shore Legal Clinic (ELNSCLC) comprises Iron Bridge (to the west), Elliot Lake (to the north) as well as Massey, Walford/Walford Station, Spanish Sables, and certain First Nation Reserves located along the North Shore of Lake Huron. The main clinic office is located in Elliot Lake, with satellite offices in Blind River, Spanish and Serpent River.

There are 8 census sub-divisions in the ELNSCLC catchment area with a total population of approximately 22,870 people (2011 Census). The largest is Elliot Lake (11,348) and the smallest is the Serpent River # 7 Indian Reserve (373). Of the 10 census sub-divisions, 3 are First Nation Reservations.

Unfortunately, population projections are not available at a sub-district level, and so what is provided below is a best estimate based on a number of independent reports. For example, a 2009 report by dMA Planning & Management Services projects that by 2020, Elliot Lake's population could be as high as 15,000 (using 2011 population census data, this would represent a growth rate of about 3,652 or 24%). However, looking at census data (1996 - 2011), after reporting a population of 13,588 in 1996, Elliot Lake has experienced a downward trend (from 11,956 in 2001 to 11,348 in 2011). Algoma District Services Administration Board in its housing report (2014) projects a slightly decreasing population base over the next twenty years. In contrast, First Nation communities along the North Shore are increasing in population which is a trend that is expected to continue for the foreseeable future.

The chart below indicates where there have been population changes for census sub-divisions within the Elliot Lake and North Shore Legal Clinic catchment area.

Census Sub-division	2011 Total Population	Population change % (2006 to 2011)
Serpent River	383	9.7
The North Shore	509	-7.3
Blind River	3549	-6.1
Mississagi River	509	-5.6
Spanish	696	-4.4
Algoma Unorg. North Part	5,518	-3.5
Elliot Lake	11,348	-1.7

The population in this catchment area is older than average, with a median age of 46.2 years old (versus 40.4 years old in the province) and 82.9% of the population is 15 years of age or older.

Language characteristics:

The majority of the population's mother tongue is English (79.2%) with 12.8% of residents reporting French as their mother tongue. Another 4.7% report a mother tongue other than English, French or Aboriginal and a very small proportion (1.2%) report an Aboriginal language as their mother tongue.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Elliot Lake & North Shore Community Legal Clinic Area: Overall social risk for this catchment area is medium (5). These risk factors include a higher than average proportion of: Low Education; Unemployment; Government Transfers; Aboriginal Identity and Tenants.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Lone Parents	15	16.7
Low Education	25	18.7
Unemployment rate	10	8.3
Government transfer payments	28.7	12.3
Aboriginal Identity	14	2.3
Tenants	35	28.4
Movers	11.3	11.6
Low Income (LIM AT)	12	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is 23.0% of all families and non-family people (which differs considerably from the NHS Low Income

After-Tax measure of 12%). This means there were 1,940 people and/or families living in low income. The median income for these low-income families and non-family persons was $15,630. There were 605 individuals without income. 370 (45.6%) lone-parent families, 840 (34.5%) of children under 18 and 350 (7.0%) of those 65 years and older were living in low-income. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[24] and for Ontario Disability Support Program[25] in the Algoma District was 795 (OW) and 1,561 (ODSP).

Social Risk in Census Sub-divisions

The census sub-divisions at high to medium risk for which data is available include:

Census Sud-division	Social Risk Score	Lone Parent Families	Low Education	Unemployment	Government Transfer Paymts.	Aboriginal Identity	Movers	Low Income LIMAT	Tenants
Elliot Lake	7		25	17	33	7	12		40
Blind River	6		23	11	20	11	13	20	
Mississagi River	5	43	32	11	25	92		17	
Serpent River 7	4	33	36		32	93			

Housing

The total number of private households in the Elliot Lake and North Shore Community Legal catchment area is approximately 7,560. As of December 31st, 2013 there were 724 applicants on the Algoma District Service Board's social housing wait list (ONPHA; 2014). There are two women's shelters that provide emergency housing services -- Mississauga Women's Shelter in the vicinity Blind River and Maplegate House for Women in Elliot Lake. There are no publicly-funded shelters available for men however, there is a privately run facility with limited capacity that operates out of Elliot Lake (Farley, July 2013). In general, there is little data on the incidence of homelessness in the Algoma District. Residents can access emergency facilities and treatment centres located in First Nation communities with the condition that they participate in Aboriginal cultural activities (Farley, July 2013).

Algoma District Social Services Administration Board recently produced a housing and homelessness plan (Farley, July 2013) outlining the housing needs for the District over the next ten years. Housing plans have also been produced for the Sudbury-Manitoulin and the Parry Sound DSSAB's. These latter two reports identify common risk factors for homelessness, including households spending more than 30% of their income on shelter costs; families living in low-income; food bank usage; and households accessing energy assistance.

Moreover both the Sudbury-Manitoulin and Parry Sound DSSAB housing reports go on to say that in rural areas, housing stability can also be compromised by lower wages, fewer job opportunities,

[24] Ontario Works includes Temporary Care Assistance
[25] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

and fewer social and informational resources. Poor transit services and social isolation can also make it difficult to access information and support when needed.

There is also a number of other circumstances that can contribute to a particular person or household becoming homeless. This can include addictions, mental illness, physical illness or disability, family violence, discrimination, unemployment, family breakdown, eviction, natural disaster, house fires, and deinstitutionalization.

These circumstances are often compounded by factors specific to the North, such as: high unemployment and seasonal unemployment; extremely low vacancy rates; distinct First Nations issues like inter-generational patterns of substance use, violence and generalized instability within the community linked to historical experiences with residential schools; high and rising energy costs relative to other parts of the province, and increasing property taxes, all of which especially impact people on fixed incomes, particularly senior-led households.

Transportation

Elliot Lake has a public transit system which operates from Monday to Saturday as well as a handi transit and specialized transit systems. The latter transportation system is administered through the Huron Lodge Assisted Living services and is funded by the City of Elliot Lake and the Ministry of Health. In addition, there are taxi services available.

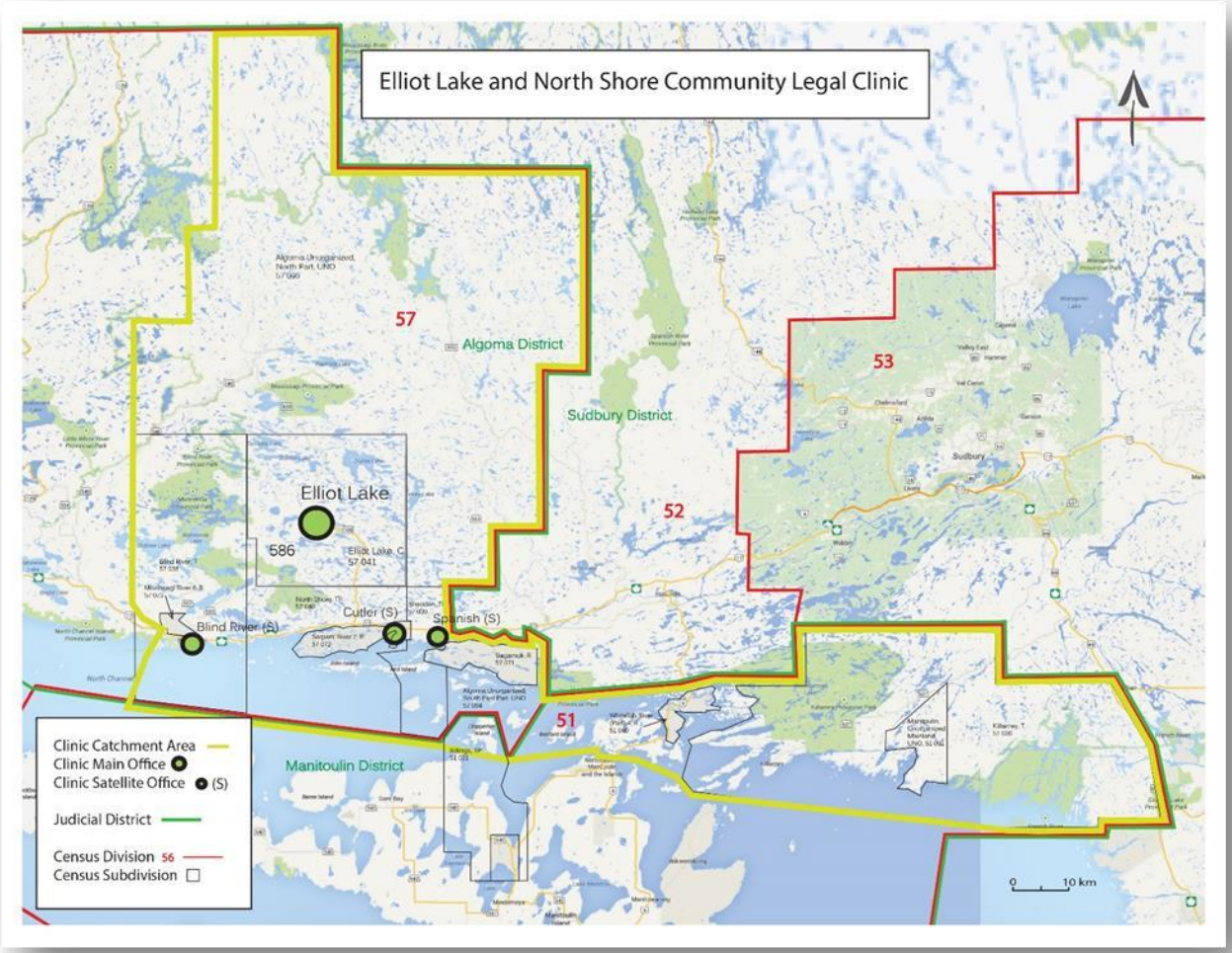
Technological Infrastructure

There are 2 hospitals in this catchment area including the Blind River District Health Centre (a satellite of the Sault Hospital) and St. Joseph's General Hospital in Elliot Lake. The Ontario Telemedicine Network (OTN) is available at 4 sites in the Elliot Lake and North Shore Community Legal Clinic catchment area. Algoma Public Health (Elliot Lake and Blind River satellite sites), Blind River District Health Centre and St. Joseph's General Hospital provide access to specialized medical care using video conferencing and other tele-diagnostic equipment.

Contact North has 4 online learning centers located in Massey, Sagamok First Nation, Serpent River First Nation and Spanish that are equipped with distance education technologies such as audio conferencing, videoconferencing, web conferencing, computer workstations and high-speed internet (where available)**.** Sault College and College Boreal both have satellite campuses out of Elliot Lake. There is cell service is available for most of the Elliott Lake and North Shore areas

REFERENCES:

Farley, Toni & Associates. July 2013. *Appendix 1: The Housing Analysis Report.* Prepared for the Algoma District Services Administration Board. Housing and Homelessness Plan – Draft dmA Planning & Management Services. February 2009. *Parks, Recreation, Arts and Culture Master Plan. Final Report.* Multi-Use Complex Feasibility Study Final Report -- Feb. 2009. Prepared for the City of Elliot Lake.

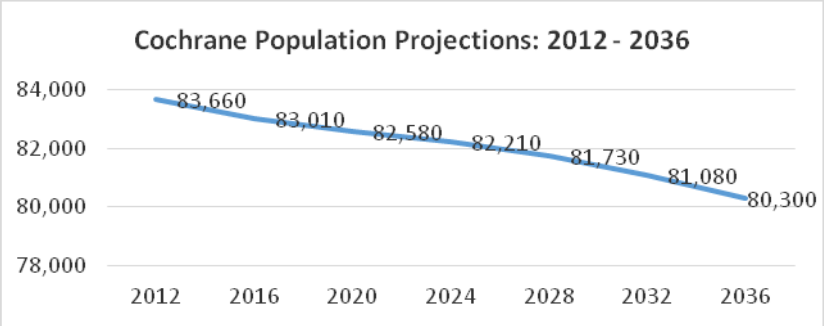

Elliot Lake and North Shore Community Legal Clinic
57
Algoma District
53
Sudbury District
Elliot Lake
586
52
Blind River (S)
Cutler (S)
Spanish (S)
51
Manitoulin District
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
0 10 km

CLINIQUE JURIDIQUE COMMUNAUTAIRE GRAND-NORD

Population Profile

The catchment area of the Clinique juridique Grand-Nord is located predominately in the District of Cochrane and a small unorganized area in the Algoma District. The main clinic office is located in Kapuskasing and there are satellite offices in the communities of Hearst and Cochrane.

There are 10 census sub-divisions in the catchment area with a total approximate population of 25,070 (2011 Census). The Cochrane District's population is expected to decrease by 4.0% from 2012 to 2036 (see chart below). Please note that the city of Timmins is included in the Cochrane District's population projection – but Timmins is not a part of this clinics catchment area (which explains the difference between the catchment area's population size and the Cochrane Districts population projections).



The chart below indicates the census sub-divisions experiencing the greatest population changes.

Census sub-division	2011 Total Population	Population change % (2006 to 2011)
Opasatika	214	-23.6
Moonbeam	1,101	-15.2
Hornepayne	1,050	-13.2
Val Rita-Harty	817	-13.0
Mattice-Val Côté	686	-11.1
Hearst	5,090	-9.4

The population in this catchment area is older than average, with a median age of 46.6 years old (versus 40.4 years old in the province) and 84.6% of the population is 15 years of age or older.

Language Characteristics

The majority of the population's mother tongue is French (64.7%). The 32% of the population who indicated their mother tongue is English primarily live in Hornepayne, Constance Lake and Cochrane. A small proportion indicated Aboriginal languages as their mother tongue (1.2%) and also reside in Constance Lake and Cochrane.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (no high school diploma, certificate or degree); Lone parent status; Mobility (movers in the past year); Tenancy; Aboriginal identity; and Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Clinique juridique Grand-Nord Area: Overall social risk for this catchment area is medium (5). These risk factors include a higher than average proportion of: Low Education; Unemployment; Government Transfers; Tenants; and Aboriginal Identity.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Low Education	33.1	18.7
Unemployment rate	9	8.3
Government transfer payments	23.8	12.3
Tenants	29.9	28.4
Aboriginal Identity	10.7	2.3
Movers	11.5	11.6
Lone Parents	12.7	16.7
Low Income (LIM AT)	13	13.9

Based on 2012 tax-filer data, the **prevalence of low-income** before tax for this catchment area is 17.0% (2050) of all families and non-family people (which differs considerably from the NHS Low Income After-Tax measure of 13%). On average, these low-income families and non-family person median income was $16,261. There were 920 individuals without income. 450 (37%) lone-parent families, 1,150 (22%) of children under 18 and 380 (8%) of those 65 years and older were living in

low-income. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[26] and for Ontario Disability Support Program[27]in the Cochrane District was 1,140 (OW) and 3,172 (ODSP).

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

Census Sub-division	Social Risk Score	Low Education	Unem-ploy-ment	Gov't Transfer Pymts	Tenant	Aboriginal Identity	Mover	Lone Parent Families	Low Income LIMAT
Constance Lake	6	69.1	26.5	46.4	33.3	100.0		36.1	
Cochrane	6	33.2	8.7	20.2		19.8	14.4		17.2
Hearst	6	31.9	10.0	19.1	44.0	4.0			16.1
Kapuskasing	5	30.0		17.9	33.8	6.3	11.9		
Moonbeam	5	34.7	24.0	23.9		4.2	19.9		
Mattice-Val Côté	3	49.5		23.2		9.0			

Housing

The total number of private dwelling in the catchment area of Clinique juridique Grand-Nord was 10 550 (2011 Census). The Ontario Non-Profit Housing Association (ONPHA) survey reports that in 2013, there were 1,586 households on a wait list for rent-geared-to-income (RGI) housing in the Cochrane District. The average wait time was 1.95 years.

The Cochrane District Social Services Administration Board created a 10-year housing plan that sets out a framework for communities within the Cochrane District in order to address ongoing housing needs. The priority issues that were identified were a need to increase the available private and public residences for seniors as well as supports and social programming. A need for personal support workers and a lack of transitional housing including a crisis centre for emergency housing situations. A great need for more varied housing stock to accommodate larger families and the need to address the very long social housing wait lists.

As part of a 5-year funded research project by Social Justice and Policy at Laurentian University (Kauppi, 2014) exploring issues of poverty, homelessness and migration, the Poverty, Homelessness and migration (PHM) study conducted a homelessness prevalence count in North Eastern Ontario. A part of the findings were reported for the communities of Hearst, Cochrane and Moosonee (this last community, belonging to the catchment area of Keewaytinok Native Legal Services Clinic). Nevertheless the count characterizes the nature of the homelessness population in the Northern communities. The count found that there were 71 individuals at risk of homeless or individuals experiencing absolute homelessness in Hearst and a much higher number in the

[26] Ontario Works includes Temporary Care Assistance
[27] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

community of Cochrane where 333 individuals were counted to be at risk of homeless or experiencing absolute homelessness. The findings from the three communities combined, Hearst, Cochrane and Moosonee are as follows: 13% were absolutely homeless and 87% were at risk of homelessness, a further 47% were children or adolescents under the age of 18 and 32% were women. The majority of people experiencing homelessness were women and children or youth.

Transportation

In the catchment area of the Clinique juridique Grand-Nord, there is a passenger bus service available along Hwy. 11 daily in each direction. Ontario Northland Bus runs from the South to the community of Cochrane and has flag stops at most of the catchment communities with the exception of Constance Lake. There is no other public transit service available in any of the communities. The only other ground transportation that is available in the larger of the communities is private taxi service which is not affordable for anyone living on a fixed income.

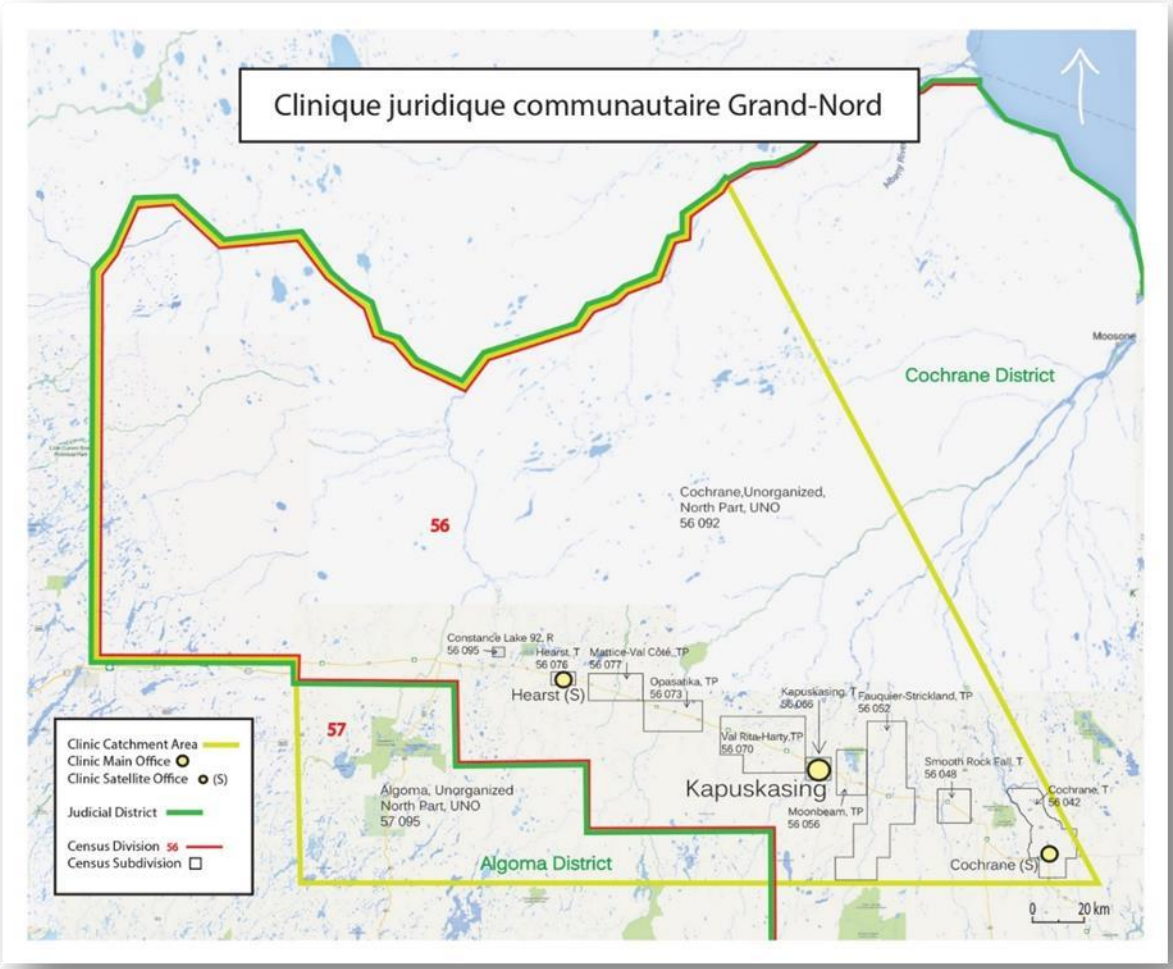
Technological Infrastructure

There are couple of adult education centres available in both official languages in the larger communities including Hearst, Smooth Rock Falls and Kapuskasing. Additionally there is a presence of post-secondary education including l'Université de Hearst, Collège Boréal and Northern College and well as Contact North and Niska Career Academy. The institutions make use of a combination of audio-conference, videoconference, and e-learning technologies to make educational programs and courses accessible.

There are 4 hospitals in the catchment area including Cochrane, Smooth Rock Falls, Hearst and

Kapuskasing. The Porcupine Health Unit is also present in Smooth Rock Falls, Cochrane, Hearst and Kapuskasing. In Fauquier-Strickland there is a primary health centre. The Ontario Telemedicine Network (OTN) is available in this catchment area and provides access to specialized medical care using video conferencing and other tele-diagnostic equipment. There is also a detox centre in Smooth Rock Falls that is sponsored by the hospital.

Cellular services are available in all of the 10 census sub-divisions along Hwy. 11 for the catchment area of the Clinique juridique Grand-Nord. There is also a full range of high-speed internet, phone services, cable television and radio in each of the areas. However, high speed internet is not available in all rural communities. Some still only have dial-up capabilities, or very slow high speed connections through satellite by either xplornet or local service providers (Hearst and Kapuskasing area).


Clinique juridique communautaire Grand-Nord
Cochrane District
Moosone
Cochrane,Unorganized,
North Part, UNO
56 092
56
57
Constance Lake 92, R
56 095
Hearst, T
56 076
Mattice-Val Côté, TP
56 077
Hearst (S)
Opasatika, TP
56 073
Kapuskasing, T
56 066
Fauquier-Strickland, TP
56 052
Val Rita-Harty, TP
56 070
Kapuskasing
Smooth Rock Fall, T
56 048
Cochrane, T
56 042
Moonbeam, TP
56 056
Cochrane (S)
Algoma, Unorganized
North Part, UNO
57 095
Algoma District
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
0
20 km

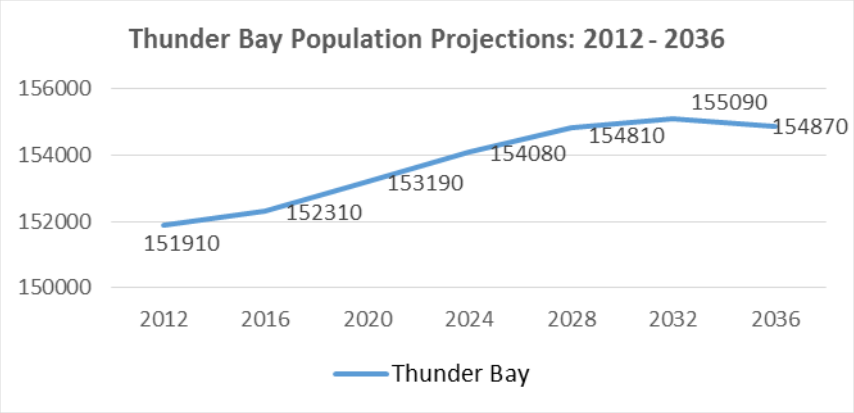
KINNA-AWEYA LEGAL CLINIC

Population Profile

The catchment area of the Kinna-aweya Legal Clinic includes the Thunder Bay District. The main office is located in Thunder Bay, and branch offices are located in Greenstone and Marathon.

There are 21 census sub-divisions in the catchment area with a total population of approximately 144,909 people (2011 Census). Of these census sub-divisions, 11 are First Nation. The largest census sub-division is the city of Thunder Bay (108,359) and the smallest is the Pays Plat 51 Reservation (75).

The population in the Thunder Bay District is expected to increase by approximately 2% between 2012 - 2036 (see chart below).



Approximately 11 census sub-divisions have 400 or less people. The chart below reports upon the census sub-divisions with more than 400 people, and are experiencing the greatest population changes.

Census Sub-division	2011 Total Population	Population change % (2006 to 2011)
Schreiber	1,126	25.0
Shuniah	2,737	6.0
Marathon	3,353	-13.2
Red Rock	942	-11.4

Thunder Bay Unorg.	5,909	-10.3
Terrace Bay	1,471	-9.5
Neebing	1,986	-9.1
Manitouwadge	2,105	-8.5

The population in this catchment area is slightly older, with a median age of 41.4 years old (versus 40.4 years old in the province) and 85.1% of the population is 15 years of age or older.

Language characteristics:

The majority of the population's mother tongue is English (85.1%). Approximately 4% reported French as their mother tongue with 1% reporting an Aboriginal language. 10% indicated their mother tongue is a language other than English, French or Aboriginal.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in the Kinna-aweya Community Legal Clinic Area: Overall social risk for this catchment area is medium (5). These risk factors include a higher than average proportion of: Low Education; Unemployment; Government Transfers; Aboriginal Identity and Lone Parents.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Low Education	22	16
Unemployment rate	9	8.3
Government transfer payments	21	12.3
Aboriginal Identity	11	2.3
Lone Parents	18	16.7
Tenants	26	28.4
Movers	11	11.6
Low Income (LIM AT)	13.9	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is 18.8% of all families and non-family people (which is significantly higher than the NHS Low Income After-Tax measure of 13.9%). This means there were 10,990 people and/or families living in low income. The median income for these low-income families and non-family persons was $15,278. There were 4,860 individuals without income. 2,480 (39%) lone-parent families, 5,930 (25.1%) of children under 18 and 1,280 (5.8%) of those 65 years and older were living in low-income. MCSS reports that the average monthly caseload in 2013/14 for Ontario Works[28] and Ontario Disability Support Program[29] in the Thunder Bay District was 2,632 (OW) and 5,834 (ODSP).

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

[28] Ontario Works includes Temporary Care Assistance
[29] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

Census Sub-division	Social Risk Score	Lone Parent Families	Low Education	Unemploy-ment	Gov't Transfer Pymts	Aboriginal Identity	Mover	Tenant	Low Income LIMAT
Thunder Bay	6	19.7	21.8		16.3	9.5		30.3	15.0
Whitesand	6	33.3	80.6	15.4	57.6	98.1		76.5	
Fort William #52	5	41.2	38.7	14.7	29.0	84.9			
Lake Helen #53	5	29.4	43.2	12.0	29.6	86.9			
Conmee	4		30.6	8.8	15.5	20.6			
Greenstone	4		30.3	13.0	18.7	28.2			
Red Rock	4		22.4	17.5	21.9	18.5			
Thunder Bay Unorganized	4		24.7	12.8	18.4	7.4			

Housing

The total number of private households in this catchment area is 64,505 (Census 2011). The Ontario Non-Profit Housing Association (ONPHA) survey reports that the Thunder Bay district had 1,185 households waiting for rent-geared-to-income (RGI) housing in 2013. The average wait time was 1.13 years.

A most recent report addressing housing and homelessness issues in the District of Thunder Bay -- "*Under One Roof: A Housing and Homelessness Plan (2014 -2024)"* -- identifies common risk factors for homelessness, including households spending more than 30% of their income on shelter costs; families living in low-income; food bank usage; and households accessing energy assistance. Moreover the report goes on to say that in rural areas, housing stability can also be compromised by lower wages, fewer job opportunities, and fewer social and informational resources. Poor transit services and social isolation can also make it difficult to access information and support when needed.

The Thunder Bay DSSAB's report "*Under One Roof: Housing and Homelessness Plan*" reports that the district has 6 emergency shelters, serving men, women, youth and/or victims of domestic violence.

Transportation

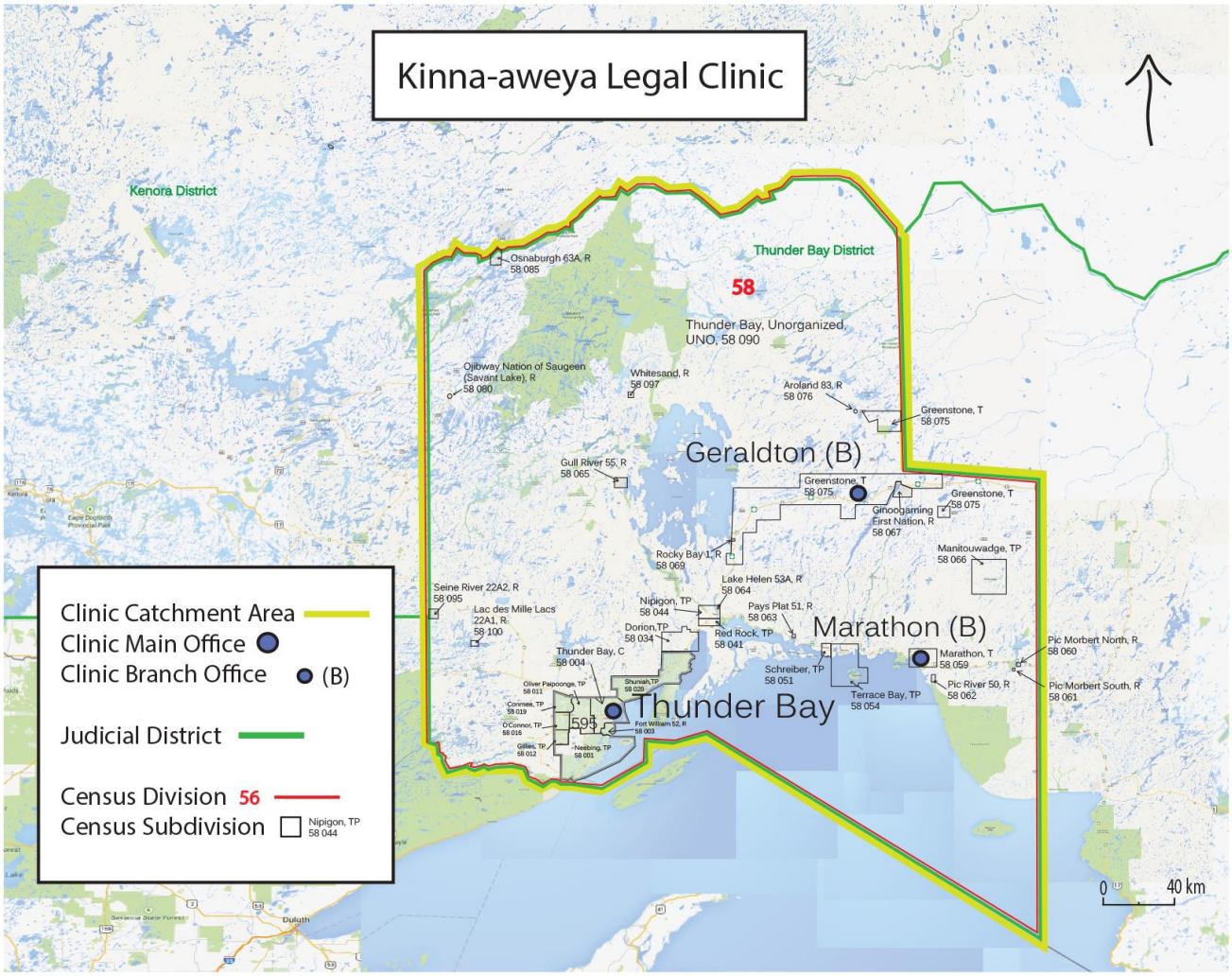
The city of Thunder Bay has public transit serving the city. In addition, Greyhound services the communities of Nipigon, Marathon, Manitouwadge, Greenstone (municipality of) and Thunder Bay. The Canadian Red Cross operates the "Seniors Transportation Program" in the District of Thunder Bay which is available to seniors and wheelchair passengers that do not have access to their own vehicle or public transportation.

Technological Infrastructure

The Thunder Bay Regional Health Sciences Centre shares the delivery of healthcare with other hospitals in the District, servicing the communities of Manitouwadge, Marathon, Schreiber, Terrace Bay, Nipigon, and Greenstone. In addition, the Anishnawbe Mushkiki Aboriginal Health Centre is located in Thunder Bay. NorWest Community Health Centre in Thunder Bay also offers Mobile Health Services to communities in the District of Thunder Bay. The Ontario Telemedicine Network (OTN) is available in the Thunder Bay district and provides access to specialized medical care using video conferencing and other tele-diagnostic equipment.

Confederation College campuses are located in Greenstone and Marathon with the college's main site located in Thunder Bay. Thunder Bay is also home to Lakehead University. Contact North provides distance education to the district of Thunder Bay and has online learning centers that are equipped with audio/video/web conferencing, computer workstations and high speed Internet (where available) in Thunder Bay, Nipigon, Red Rock, Rocky Bay First Nation, Pic River First Nation, Terrace Bay, Schreiber, Marathon, Pic Morbert First Nation, Greenstone and Manitouwadge.

There is sporadic cell service in the Thunder Bay District. Cell service mostly exists in and around the communities along Hwy 11 and Hwy 17, including Red Rock, Nipigon, Dorion, Thunder Bay, Greenstone, Manitouwadge, Marathon, Terrace Bay, and Pic Morbert.


Kinna-aweya Legal Clinic
Kenora District
Thunder Bay District
58
Osnaburgh 63A, R
58 085
Thunder Bay, Unorganized, UNO, 58 090
Ojibway Nation of Saugeen (Savant Lake), R
58 080
Whitesand, R
58 097
Aroland 83, R
58 076
Greenstone, T
58 075
Geraldton (B)
Gull River 55, R
58 065
Greenstone, T
58 075
Greenstone, T
58 075
Ginoogaming First Nation, R
58 067
Manitouwadge, TP
58 066
Rocky Bay 1, R
58 069
Lake Helen 53A, R
58 064
Seine River 22A2, R
58 095
Lac des Mille Lacs 22A1, R
58 100
Nipigon, TP
58 044
Pays Plat 51, R
58 063
Marathon (B)
Dorion,TP
58 034
Red Rock, TP
58 041
Thunder Bay, C
58 004
Marathon, T
58 059
Pic Morbert North, R
58 060
Schreiber, TP
58 051
Terrace Bay, TP
58 054
Pic River 50, R
58 062
Pic Morbert South, R
58 061
Thunder Bay
595
Clinic Catchment Area
Clinic Main Office
Clinic Branch Office (B)
Judicial District
Census Division 56
Census Subdivision
Nipigon, TP
58 044
0
40 km

KEEWAYTINOK NATIVE LEGAL SERVICES

Population Profile

The catchment area of Keewaytinok Native Legal Services includes a satellite office in Moose Factory, although the clinic also provides limited outreach service to Fort Albany. Other communities within the catchment area include Peawanuck, Attawapiskat, Kashechewan, Fort Albany, and Takywa Tagamou Nation, all of which are First Nations. These clients are generally served remotely by telephone, fax and internet.

There are 7 census sub-divisions in this catchment area with a total population of approximately

11,223 people (HPRT 2013 Moose Factory Community Profile). It is important to note that Statistics Canada census data traditionally has been challenged by incomplete enumeration, a common problem in remote communities and communities with a high number of Indigenous peoples. As a result, we have chosen to utilize other more accurate sources. The largest census sub-division is the Town of Moosonee (3,500) and the smallest is Taykwa Tagamou Nation (123).

Unfortunately population projections are not available for this area. Although census data report most of the aforementioned census sub-divisions as decreasing in population, local sources of information suggest otherwise.

Census sub-division	2013 Total Population
Fort Albany	1,100 est.
Moosonee	3,500 est.
Taykwa Tagamou Nation	123 est.
Peawanuck	300 est.
Moose Factory	2,700 est.
Attawapiskat	1,800 est.
Kashechewan	1,700 est.

The population in this catchment area is much younger than average, with a median age of 25.5 years old (versus 40.4 years old in the province) and 71.5% of the population is 15 years of age or older according to 2011 census data. However, as a result of incomplete enumeration, the percentage of the population over the age of 15 may be higher than thought. For example, more than one-third of Attawapiskat First Nation band members who still live in their home community are under the age of

19 and three quarters are under the age of 35 (December 10, 2010)[30]

[30] Goyette, Linda. December 10th, 2010. *Attawapiskat: The State of First Nations Education in Canada.*

Language Characteristics

Most of this population is of Indigenous heritage, with 69.2% of the Town of Moosonee identifying as Aboriginal (First Nations, Inuit, Métis) and the remaining communities serviced being First Nations (Census 2011).

While the majority of the population's mother tongue is English, a large proportion (23%) report an Aboriginal language as their mother tongue. There are very few (less than 1%) reporting French.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (no high school diploma, certificate or degree); Lone parent status; Mobility (movers in the past year); Tenancy; Aboriginal identity; and Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in the Keewaytinok Native Legal Services Clinic area: The only census sub-division that had enough data to report upon the social risk is Moosonee, with a Social Risk score of (8). This is the highest possible score and reflects a higher than average risk for every variable.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Low Education	38.4	18.7
Unemployment rate	9.0	8.3
Government transfer payments	14.9	12.3
Tenants	75.7	28.4
Aboriginal Identity	79.3	2.3
Movers	23.6	11.6
Lone Parents	34	16.7
Low Income (LIM AT)	29.3	13.9

Based on 2012 tax-filer data, the **prevalence of low-income** before tax for this catchment area is

Canadian Geographic. Retrieved 2011-12-03. source: http://www.canadiangeographic.ca/magazine/dec10/attawapiskat.asp

47% of all families and non-family people (which is significantly higher than the NHS Low Income After-Tax measure of 29.3%). On average, these low-income families and non-family person median income was $16,000. There were 105 individuals without income. 540 (68%) lone-parent families, 1,880 (58%) of children under 18 and 140 (36%) of those 65 years and older were living in low income. Over half of the population in Attawapiskat and Kashechewan live in low-income. In July 2014, there were 200 people receiving Ontario Works and 14 people receiving Ontario Disability Support Pension.

Housing

The availability of data on housing in Moosonee is very limited. The total number of occupied private dwellings is 1,115 homes. In 2012, The Centre for Research in Social Justice and Policy at Laurentian University conducted a period prevalence count of individuals facing homelessness or near homelessness in Moosonee (Kauppi, 2014). The data showed that there are 362 unduplicated cases (including children) of homelessness. A majority of homeless people were women or children/youth.

Transportation

There is no public transit available in the Town of Moosonee. Water taxi, helicopter (both very expensive) and ice road (depending on time of the year) connect Moosonee to Moose Factory.

For travel to and from Moosonee from Timmins, Air Creebec, and Thunder Airlines provide flights from Moosonee Airport. The Polar Bear Express (Ontario Northland Train) provides rail service between Moosonee and Cochrane from Monday to Friday.

Daily air travel to Moosonee, Fort Albany, Kashechewan and Attawapiskat (and less frequently

Peawanuck is accessible through Attawapiskat airport year-round. However, it is cheaper to fly to Europe than these small communities. The airport is equipped with a gravel runway and receives flights from Thunder Airlines, Wabusk Air and Air Creebec. During the winter months, winter roads are constructed to connect Attawapiskat to other coastal towns on the James Bay Coast, including Kashechewan, Fort Albany, Moosonee and Moose Factory. During the period when the winter road is open, taxi service may be available to shuttle community members between communities.

Technological Infrastructure

Health services across the catchment area serviced by Keewaytinok Native Legal Services is offered by the Weeneebayko Area Health Authority (WAHA). WAHA is responsible for providing comprehensive health services along the James Bay and Hudson Bay coastal regions, servicing six communities: Moose Factory, Fort Albany, Attawapiskat, Moosonee, Kashechewan and Peawanuck. The Ontario Telemedicine Network (OTN) utilizes videoconferencing to service communities within the Keewaytinok Native Legal Services catchment area. These communities include Moosonee, Moose Factory, Fort Albany, Attawapiskat, Kashechewan, and Peawanuck.

Videoconferencing capabilities are also possible in some communities within the catchment area of the Keewaytinok Native Legal Services catchment area as other sectors are currently utilizing videoconferencing for service delivery. Contact North has three online learning centres located within this region, namely in Moosonee, Moose Factory and Attawapiskat. Each online learning centre is equipped with distance education technologies such as audio conferencing, videoconferencing, web conferencing, computer workstations and internet. This organization does offer conferencing solutions for companies and not-for profit organizations.

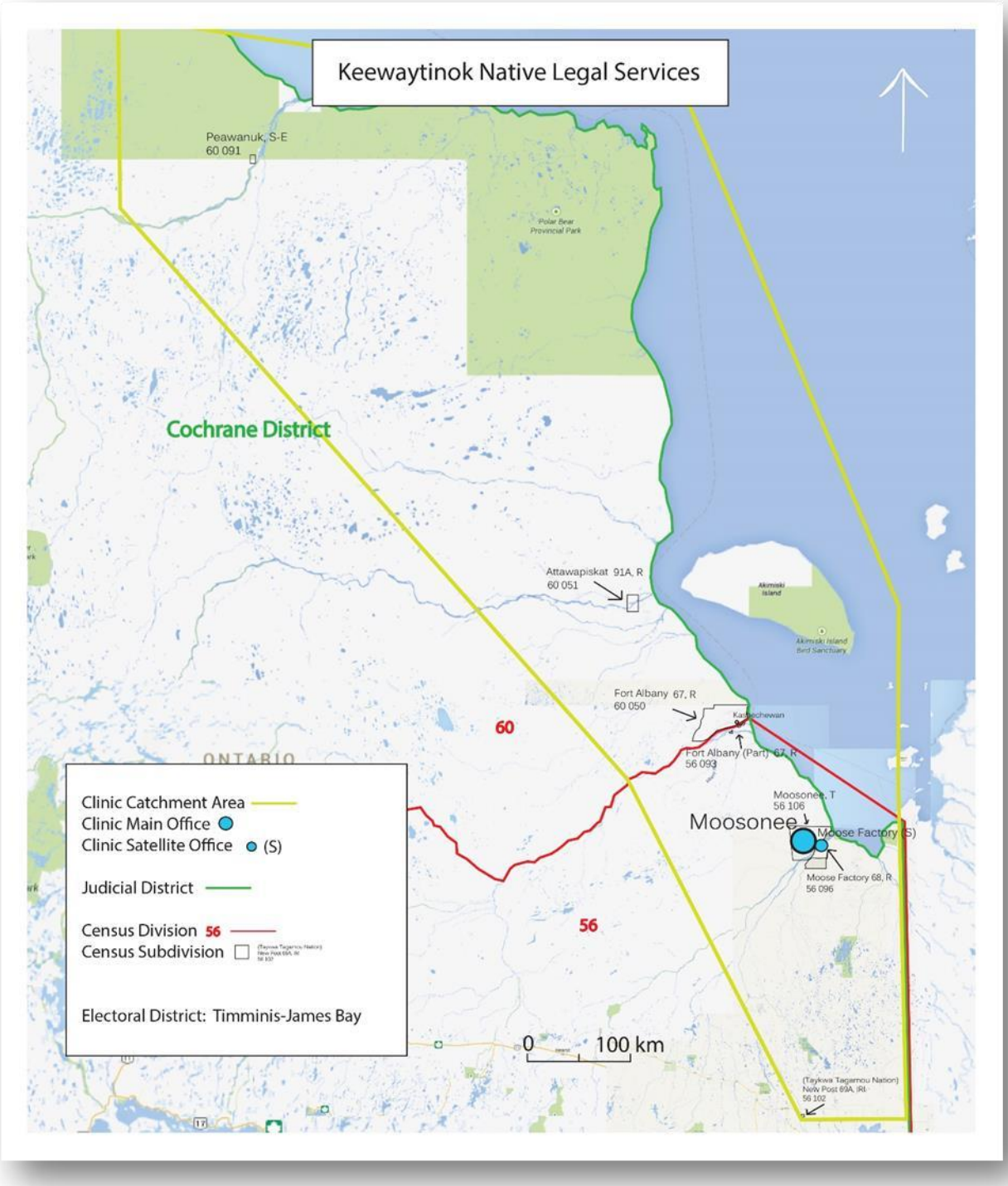
Cellular service is provided by Ontera in Moosonee and Moose Factory (starting summer 2015) and fibre optic cable. It sells internet services to Mocreebec which operates a cable service in Moosonee and Moose Factory (in partnership with the Moose Cree First Nation. It also provides connectivity to the Western James Bay Telecom Network which provides internet services in coastal communities.
Cell service is also available in Attawapiskat.

Northern College maintains a campus in Moosonee and provides distance education to various other communities within the catchment area of Keewaytinok Native Legal Services.

REFERENCES:

HPRT 2013 Moose Factory Community Health Profile Page. source:

http://www.healthforceontario.ca/UserFiles/file/Floating/Program/HPRT/moosefactory-en.pdf

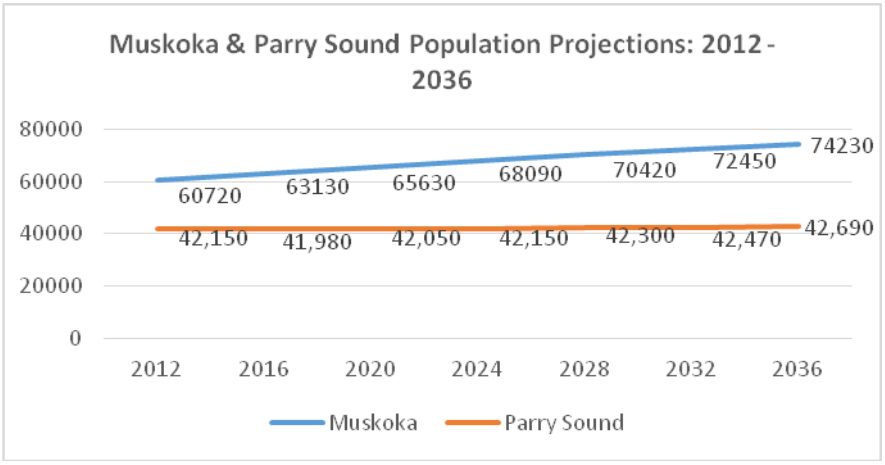

Keewaytinok Native Legal Services
Peawanuk, S-E
60 091
Polar Bear Provincial Park
Cochrane District
Attawapiskat 91A, R
60 051
Akimiski Island
Akimiski Island Bird Sanctuary
Fort Albany 67, R
60 050
Kashechewan
Fort Albany (Part) 67, R
56 093
60
ONTARIO
Moosonee, T
56 106
Moosonee
Moose Factory (S)
Moose Factory 68, R
56 096
56
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
Electoral District: Timminis-James Bay
0 100 km
(Taykwa Tagamou Nation)
New Post 69A, IR
56 102

LAKE COUNTRY COMMUNITY LEGAL CLINIC

Population Profile

The catchment area of the Lake Country Community Legal Clinic includes Muskoka and Parry Sound districts. The main clinic office is located in Bracebridge, with satellite offices in Huntsville and the Town of Parry Sound and South River.

There are 39 census sub-divisions in the catchment area with a total population of approximately 105,285 people (2011 Census). The largest census sub-division is Huntsville (19,056) and the smallest is the Henvey Inlet # 2 Reservation (28). Of the 39 census sub-divisions, 7 are First Nation Reservations. The population projections expect the population to increase from 102, 870 in 2012 to 116,920 in 2036 (an increase of approximately 14%). It should be noted that communities in the Parry Sound District are expected to remain stable whereas communities in Muskoka District are expected to increase by 13,500.



However, by census sub-division, the chart below indicates where there have been population changes.

Census Sub-division	2011 Total Population	Population change % (2006 to 2011)
Henvey Inlet # 2	28	86.7
French River 13	113	38.4
Parry Island	419	19.7
Perry	2,317	15.3
Shawanaga 17	213	10.4
Town of Parry Sound	6,191	6.4

Seguin	3,988	-6.7
Lake of Bays	3,284	-8.0
Parry Sound Unorg. NE	217	-8.1
Georgian Bay	2,124	-9.2
Whitestone	918	-10.0

The population in this catchment area is older than average, with a median age of 49.2 years old (versus 40.4 years old in the province) and 85.9% of the population is 15 years of age or older.

Language Characteristics

The majority of the population's mother tongue is English (89.7%). A very small proportion (1.3%) of the population's mother tongue is French with an even smaller proportion (1.1%) captured under Aboriginal. Another 5.1% report a mother tongue other than English, French or Aboriginal.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Lake Country Legal Clinic Area: Overall social risk for this catchment area is medium (4). These risk factors include a higher than average proportion of: Low Education; Unemployment; Government Transfers; and Aboriginal Identity.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Lone Parents	12.9	16.7
Low Education	21.8	18.7
Unemployment rate	9.2	8.3
Government transfer payments	19.2	12.3
Aboriginal Identity	5.5	2.3
Tenants	17.3	28.4

Movers	10.8	11.6
Low Income (LIM AT)	12	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is18% of all families and non-family people (which differs considerably from the NHS Low Income After-Tax measure of 12%). This means there were 6,720 people and/or families living in low income. The median income for these low-income families and non-family persons was $15,727. There were 1,785 individuals without income. 1,220 (38.0%) lone-parent families, 3,310 (24.0%) of children under 18 and 1,300 (7.2%) of those 65 years and older were living in low-income. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[31] and for Ontario Disability Support Program[32] in the Muskoka District was 1,017 (OW) and 1,661 (ODSP), and 790 (OW) and 1,419 (ODSP) in the Parry Sound District.

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

Census Sub-division	*Social Risk Score*	*Lone Parent*	*Low Education*	*Unemploy-ment*	*Gov't Transfer Pymts*	*Aboriginal Identity*	*Tenant*	*Mover*	*Low Income LIMAT*
Parry Sound	8	22.1	29.7	11.1	21.5	6.7	41.7	16.8	15.6
Gravenhurst	5		22.9		20.2	2.6		13.6	17.0
Machar	5		22.2	11.1	19.8	3.3			14.1
Magnetawan	5		25.9	13.6	23.6	4.7			14.8
Parry Island	5	36.4	33.3	23.3	25.5	84.3			
McDougall	4		19.1	11.7	14.0	5.5			
Powassan	4		29.3	10.6	20.5	3.2			
Sundridge	4		30.6	23.8	21.1			21.6	
Whitestone	4		20.4	14.5	25.7				22.4

[31] Ontario Works includes Temporary Care Assistance
[32] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

Housing

The total number of private households in the Lake Country Community Legal Clinic catchment area is 32,565. Since the clinic catchment area cover two districts -- the District of Parry Sound and the District of Muskoka -- the information provided below is separated out accordingly. In terms of the wait list for rent-geared-to-income housing (i.e. social housing), Muskoka District reported 650 households as of December 31st, 2013, with an average wait time of 4 years. During this same time period, the District of Parry Sound reported 413 applicants on their social housing wait list with average wait times approaching 4 years (ONPHA).

District of Muskoka:

As of December, 2014 there were 653 applicants for social housing, with an average wait time ranging from 3-5 years (personal conversation, Madeleine Bergin, Mgr. Housing Services, Muskoka DSSAB). There are two women's shelters operated by Muskoka Women's Advocacy group -- Muskoka Interval House in Bracebridge and Chrysalis in Huntsville -- targeting women escaping domestic violence. In addition, the District of Muskoka funds 3-bedroom transition unit operated by the Salvation Army, with the Bracebridge unit reporting full occupancy in 2013.

Parry Sound District:

As of December 31st, 2013, there were 418 applicants for social housing, with an average wait time ranging from 2-3 years (ONPHA). There are two women's shelters operated by the Parry Sound District Social Services Board, ESPRIT PLACE Family Resource Centre, located in the Town of Parry Sound. As well, there is a Transitional Housing Support Program and Community Outreach program which operates out of the Town of Parry Sound and South River.

The 2013 ten-year " Housing and Homelessness Plan" that has been produced for the Parry Sound District Services Board Catchment Area identifies common risk factors for homelessness, including households spending more than 30% of their income on shelter costs; families living in low-income; food bank usage; and households accessing energy assistance. Moreover the report goes on to say that in rural areas, housing stability can also be compromised by lower wages, fewer job opportunities, and fewer social and informational resources. Poor transit services and social isolation can also make it difficult to access information and support when needed.

There is also a number of other circumstances that can contribute to a particular person or household becoming homeless. This can include addictions, mental illness, physical illness or disability, family violence, discrimination, unemployment, family breakdown, eviction, natural disaster, house fires, and deinstitutionalization.

These circumstances are often compounded by factors specific to the North, such as: high unemployment and seasonal unemployment; extremely low vacancy rates; distinct First Nations issues like inter-generational patterns of substance use, violence and generalized instability within the community linked to historical experiences with residential schools; high and rising energy costs relative to other parts of the province, and increasing property taxes, all of which especially impact people on fixed incomes, particularly senior-led households.

Transportation

Other than the Parry Sound Public Transportation program and the Huntsville Public Transit Service that operate within the towns of Parry Sound and Huntsville (respectively), there is no land-based transportation systems serving outlying areas of these two districts. There are taxi services available.

PROMPT and other local agencies were successful in advocating for a “Corridor 11 Bus” that travels form Huntsville to Barrie. This bus has been in operation for about a year since the Ontario Northland service was cancelled. This bus will stop at any community and/or point along its route and is a testament to the value of local organizing.

Technological Infrastructure

There are a total of 3 hospitals in the Lake Country Community Legal Clinic catchment area, with locations in Huntsville, Bracebridge and the Town of Parry Sound. The Ontario Telemedicine Network (OTN) is available in the Parry Sound and Muskoka Districts, providing access to specialized medical care using video conferencing and other tele-diagnostic equipment.

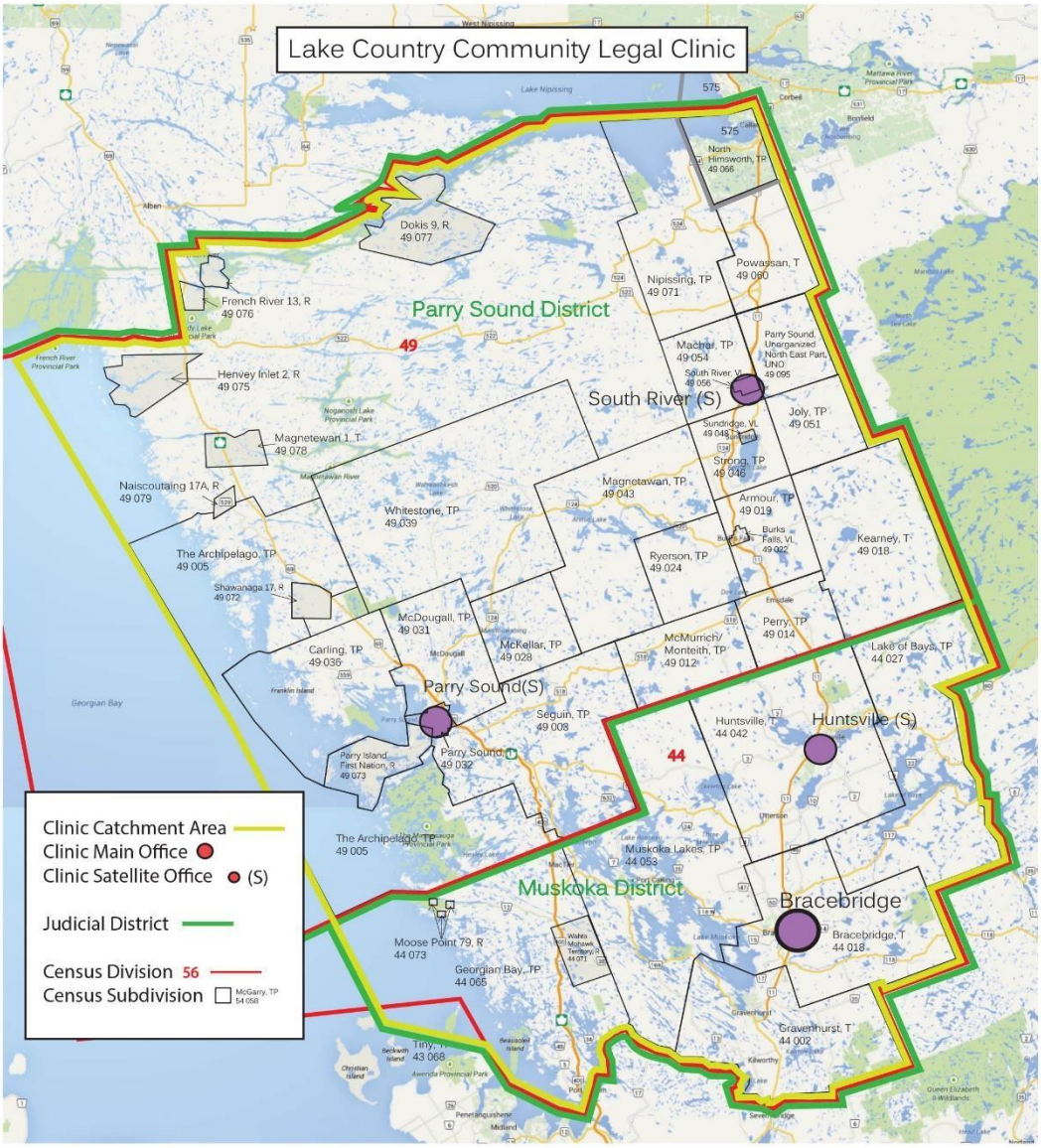
Contact North has 4 online learning centers located in Parry Sound, South River, Magnetawan First Nation and Wasauksing First Nation that are equipped with distance education technologies such as audio conferencing, videoconferencing, web conferencing, computer workstations and high-speed internet (where available)**.**

There are a number of post-secondary campus sites including:

- Canadore Campus -- Parry Sound
- Nipissing University -- Bracebridge
- Georgian College -- Bracebridge

- Willis College of Business, Health & Technology -- Bracebridge
- University of Waterloo Summit Centre for the Environment -- Huntsville
- Northern Ontario School of Medicine (to be housed in the Summit Centre) -- Huntsville

There is cell service for most of the district of Muskoka and to a lesser extent, the district of Parry Sound with Rogers wireless towers in Huntsville and Bracebridge.

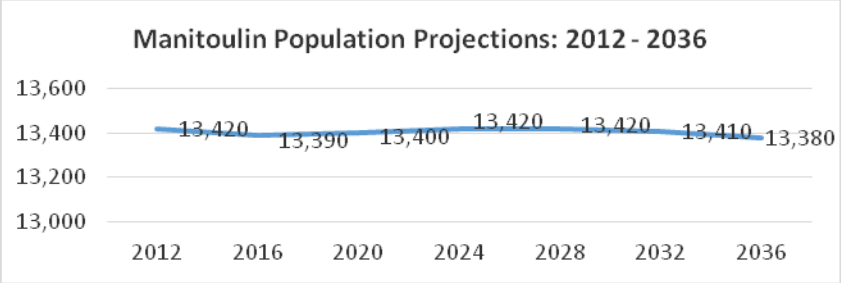


MANITOULIN LEGAL CLINIC

Population Profile

The catchment area of the Manitoulin Legal Clinic is the Manitoulin District. The main clinic office is located just outside of Little Current (in Aundeck-Omni Kaning), and there are no satellite offices.

There are 16 census sub-divisions in the catchment area with a total population of approximately 13,050 people (2011 Census). The largest census sub-division is Northeastern Manitoulin and Islands (2,706) and the smallest is the Zhiibaahaasing Reservation (55). Of the 16 census subdivisions, 7 are First Nation Reservations. The population projections expect the population to remain stable at approximately 13,400 from 2012 to 2036 (less than 1% change).



However, by census sub-division, the chart below indicates where there have been population changes.

Census Sub-division	2011 Total Population	Population change % (2006 to 2011)
Whitefish River FN	487	28.5
M'Chigeeng	897	17.1
Gordon/Barrie Island	526	14.6
Sheshegwaning	118	10.3
Wikwemikong (unceded)	2592	8.6
Burpee and Mills	308	-6.4
Billings	506	-6.1
Gore Bay	850	-8.0
Manitoulin Unorg West Part	160	-27.9

The population in this catchment area is older than average, with a median age of 46.6 years old (versus 40.4 years old in the province) and 82.4% of the population is 15 years of age or older. However, on average the First Nation communities have a much younger median age, of 32.1 years of age.

Language characteristics:

The majority of the population's mother tongue is English (85.5%). Approximately 10% of the population's mother tongue is an Aboriginal language, and a small proportion (3%) is French.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Manitoulin Legal Clinic Area: Overall social risk for this catchment area is medium (5). These risk factors include a higher than average proportion of: Lone Parent families; Low Education; Unemployment; Government Transfers; and Aboriginal Identity.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Lone Parents	20.2	16.7
Low Education	26.5	18.7
Unemployment rate	15	8.3
Government transfer payments	24.3	12.3
Aboriginal Identity	41.0	2.3
Tenants	13.9	28.4
Movers	10.3	11.6
Low Income (LIM AT)	13.2	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is 28.1% of all families and non-family people (which differs considerably from the NHS Low Income After-Tax measure of 13.2%). This means there were 1,710 people and/or families living in low

income. The median income for these low-income families and non-family persons was $15,660. There were 515 individuals without income. 490 (54.4%) lone-parent families, 1,110 (39.5%) of children under 18 and 340 (11.8%) of those 65 years and older were living in low-income. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[33] and for Ontario Disability Support Program[34] in the Sudbury-Manitoulin District was 467 (OW) and 998 (ODSP). Please note that this data reflects both the Manitoulin and Sudbury Districts.

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

Census Sub-division	Social Risk Score	Lone Parent Families	Low Education	Unemployment	Gov't Transfer Pymts	Aboriginal Identity	Movers	Low Income LIMAT
Wikwemikong	6	47.1	38.8	18.5	35.6	98.8	16.6	
Sucker Creek	6	33.3	35.1	22.2	30.0	91.9	19.6	
Assiginack	5		26.9	21.2	25.3	17.0		27.1
M'Chigeeng	5	36.0	30.4	20.5	31.6	93.9		
Whitefish River	5	24.1	32.4	13.6	29.8	88.8		
Central Manitoulin	4		20.9	11.7	25.7	4.9		
Tehkummah	4		37.0	30.6	33.9	4.9		

Housing

The total number of private households in the Manitoulin District is 5,550. As of September 30, 2014 there were 93 applicants for social housing, with an average wait time of 2.28 years (MSDSSAB, ONPHA). Other than the Haven House (Manitoulin Family Resources) for women escaping domestic violence, there are no shelters or data available on the incidence of homelessness in the Manitoulin District.

However, the 2014 "Moving Forward: A Plan to Address Housing and Homelessness within the Manitoulin-Sudbury District Services Board Catchment Area over the Next 10 Years" report identifies common risk factors for homelessness, including households spending more than 30% of their income on shelter costs; families living in low-income; food bank usage; and households accessing energy assistance.

[33] Ontario Works includes Temporary Care Assistance
[34] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

Moreover the report goes on to say that in rural areas, housing stability can also be compromised by lower wages, fewer job opportunities, and fewer social and informational resources. Poor transit services and social isolation can also make it difficult to access information and support when needed.

There is also a number of other circumstances that can contribute to a particular person or household becoming homeless. This can include addictions, mental illness, physical illness or disability, family violence, discrimination, unemployment, family breakdown, eviction, natural disaster, house fires, and deinstitutionalization.

These circumstances are often compounded by factors specific to the North, such as: high unemployment and seasonal unemployment; extremely low vacancy rates; distinct First Nations issues like inter-generational patterns of substance use, violence and generalized instability within the community linked to historical experiences with residential schools; high and rising energy costs relative to other parts of the province, and increasing property taxes, all of which especially impact people on fixed incomes, particularly senior-led households.

Transportation

There is no land-based public transportation to or around the Manitoulin District. The MSDSSAB operates a van program for OW and ODSP recipients living on Manitoulin Island who need to access education/employment services in Little Current and Espanola. In addition, many of the larger First Nation reserves have vans that they use for transporting band members to medical appointments. There are taxi services available. There is also the Chi-Cheemaun ferry which operates during the summer months (May to October) and provides ferry transport between Tobermory and South Bay Mouth.

Technological Infrastructure

There are 2 hospitals in this catchment area, located in Little Current and Mindemoya. The Ontario Telemedicine Network (OTN) is available in the Manitoulin District and provides access to specialized medical care using video conferencing and other tele-diagnostic equipment.

Contact North has 3 online learning centers located in Gore Bay, Wikwemikong, and M'Chigeeng that are equipped with distance education technologies such as audio conferencing, videoconferencing, web conferencing, computer workstations and high-speed internet (where available). Cambrian College is located in Little Current.

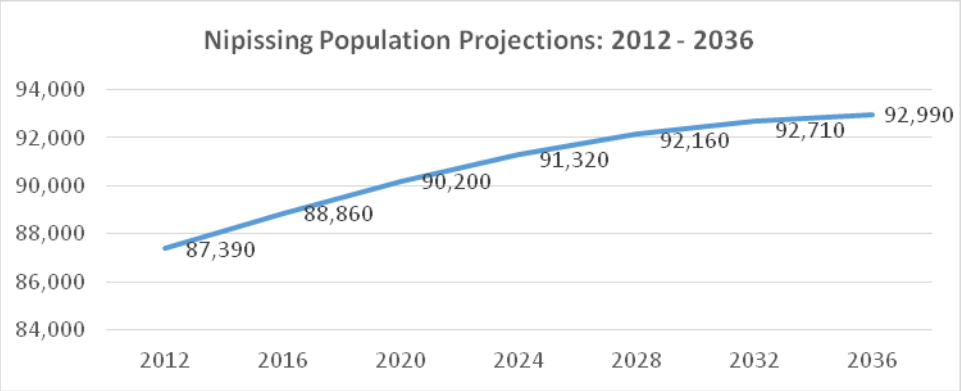
There is cell service on most of the Island, including new towers in Wood Lake, Manitowaning, Little Current, Sheguiandah, South Baymouth, Billings and Mindemoya. However, not all areas of the Island have service, such as the West End of Manitoulin.

NIPSSING COMMUNITY LEGAL CLINIC

Population Profile

The catchment area of the Nipissing Community Legal Clinic extends north to Temagami, east to Mattawa, south to the Township of Papineau-Cameron and west to Sturgeon Falls. The main clinic office is located in North Bay, with satellite offices in Sturgeon Falls and Mattawa.

There are 14 census sub-divisions in the catchment area with a total population of approximately 90,217 people (2011 Census). The largest census sub-division is the City of North Bay (53,651) and the smallest is Nipissing Unorganized South Part (80). Of the 14 census sub-divisions, 2 are First Nation (Nipissing #10 and Bear Island). The Nipissing District's population is expected to *increase* by 6%, from 87,390 in 2012 to 92,990 in 2036 (see chart below).



By census sub-division, the chart below indicates where there have been population changes.

Census sub-division	2011 Total Population	Population change % (2006 to 2011)
Nipissing Unorg. South Part	80	18.0
Mattawan	162	10.2
East Ferris	4512	6.7
West Nipissing	14,149	5.5
Sturgeon Falls	6672	4.5
Chilsholm	1263	-4.2
Calvin	568	-6.6
Papineau-Cameron	978	-7.6
Temagami	840	-12.0

The population in this catchment area is older than average, with a median age of 46.8 years old (versus 40.4 years old in the province) and 85.1% of the population is 15 years of age or older.

Language Characteristics

The majority of the population's mother tongue is English (68.9%). A smaller proportion (27.4%) of the population's mother tongue is French, followed by the very small proportion (0.3%) of residents who report Aboriginal language as their mother tongue. Another 3% report a mother tongue other than English, French or Aboriginal.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Nipissing Community Legal Clinic Area: Overall social risk for this catchment area is high (8). These risk factors include a higher than average proportion of: Lone Parents; Low Education; Unemployment; Government Transfers; Aboriginal Identity; Tenancy; Low Income and Movers.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Lone Parents	17.0	16.7
Low Education	21.1	18.7
Unemployment rate	9	8.3
Government transfer payments	21.0	12.3
Aboriginal Identity	9.7	2.3
Tenants	33.9	28.4
Movers	13.9	11.6
Low Income (LIM AT)	15	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is

23% of all families and non-family people (which differs considerably from the NHS Low Income AfterTax measure of 15%). This means there were 7,620 people and/or families living in low income.
The median income for these low-income families and non-family persons was $16,172. There were 2,785 individuals without income. 1,620 (44.6%) lone-parent families, 3,600 (26.9%) of children under 18 and 1,130 (8.8%) of those 65 years and older were living in low-income. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[35] and Ontario Disability Support Program[36] in the Nipissing District was 2,104 (OW) and 4,196 (ODSP).

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

Census Sub-division	Social Risk Score	Lone Parent Families	Low Education	Unemploy-ment	Gov't Transfer Pymts	Aboriginal Identity	Tenant	Mover	Low Income LIMAT
North Bay	8	19.1	19.0	8.6	16.4	8.0	39.5	15.5	15.5
Mattawa	8	18.2	30.5	18.1	31.2	23.5	34.1	19.4	30.2
Chisholm	5		34.8	10.3	27.0	12.6		12.3	
West Nipissing	5		27.0	8.8	23.3	13.4			18.6
Calvin	4			12.5	16.6	28.1	31.1		
Nipissing Unorg.	4		27.7	10.7	19.0	6.8			
Papineau-Cameron	4		26.2	14.1	24.5	21.1			
Temagami	4		19.6	23.9	19.7	9.3			

Housing

The total number of private households in the Nipissing Community Legal Clinic catchment area is 26,240. In 2013, 1,068 households were waiting for social housing in the District with an average wait time of 1.49 years (ONPHA). There are six emergency shelters operating in the Nipissing CLC catchment area, three of which are located in North Bay: North Bay Crisis Centre; Nipissing Transition House; and Salvation Army Family Services. In addition, there are two women's shelters

[35] Ontario Works includes Temporary Care Assistance
[36] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

associated with Family Resource Centres in Sturgeon Falls and Mattawa, and one women's shelter attached to Nipissing 10 First Nation (Ojibway Women's Lodge).

As a part of its comprehensive housing plan, the Nipissing DSSAB produced "Literature Review: 10 Year Housing and Homelessness Plan Sub Report # 1 which identifies common risk factors for homelessness, including households spending more than 30% of their income on shelter costs; families living in low-income; food bank usage; and households accessing energy assistance.

Moreover the report goes on to say that in rural areas, housing stability can also be compromised by lower wages, fewer job opportunities, and fewer social and informational resources. Poor transit services and social isolation can also make it difficult to access information and support when needed.

There is also a number of other circumstances that can contribute to a particular person or household becoming homeless. This can include addictions, mental illness, physical illness or disability, family violence, discrimination, unemployment, family breakdown, eviction, natural disaster, house fires, and deinstitutionalization.

These circumstances are often compounded by factors specific to the North, such as: high unemployment and seasonal unemployment; extremely low vacancy rates; distinct First Nations issues like inter-generational patterns of substance use, violence and generalized instability within the community linked to historical experiences with residential schools; high and rising energy costs relative to other parts of the province, and increasing property taxes, all of which especially impact people on fixed incomes, particularly senior-led households.

Transportation

The only public transportation system that is available in the Nipissing District serves the City of North Bay although there are issues with respect to the availability of public transit services on the outskirts of the city. In addition, there are taxi services available.

Technological Infrastructure

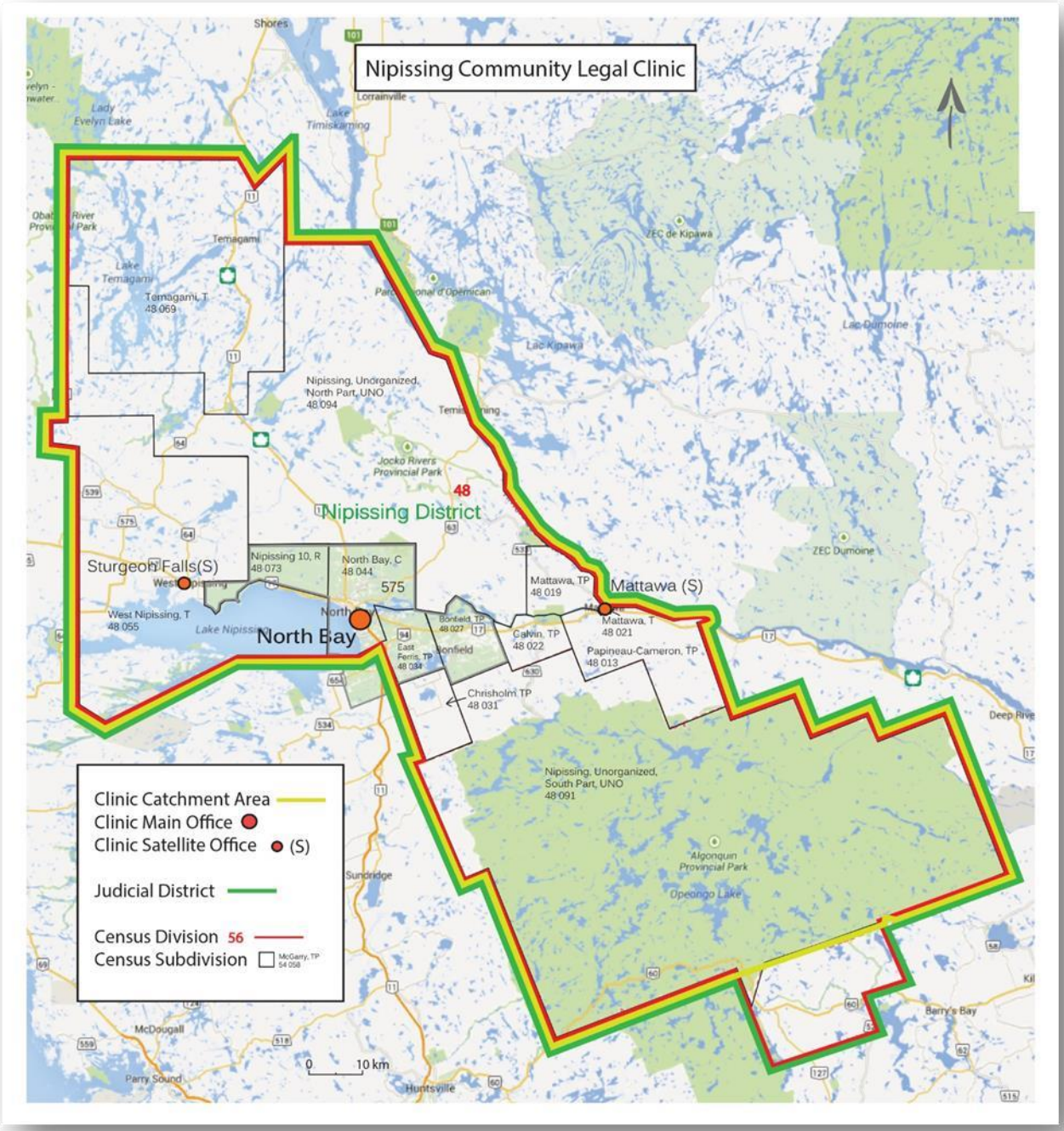
There are three hospitals in the Nipissing Community Legal Clinic catchment area: North Bay

Regional Health Centre, West Nipissing General Hospital (Sturgeon Falls) and Mattawa General Hospital. The Ontario Telemedicine Network (OTN) is available in all of the aforementioned hospitals, providing access to specialized medical care using video conferencing and other tele-diagnostic equipment. Other access sites for OTN videoconferencing include: North Bay and District Association of Community Living; North Bay/Parry Sound District Health Unit; and the Northeast Mental Health Centre -- North Bay.

Contact North has 3 online learning centers located in North Bay, Sturgeon Falls and Mattawa that are equipped with distance education technologies such as audio conferencing, videoconferencing, web conferencing, computer workstations and high-speed internet (where available)**.**

The City of North Bay is home to Nipissing University and Canadore College. North Bay is also home to CTS Career College that provides post-secondary courses in health and sciences; business; law & justice; and technology. In addition, the Union of Ontario Indians operates the Anishinabek Educational Institute (with a campus in Nipissing District (North Bay). The Institute offers a wide range of post-secondary courses to Aboriginal students.

There is cell service for most of the Nipissing district although some more rural and remote areas of the district experience reception issues.


Nipissing Community Legal Clinic
Nipissing District
48
Sturgeon Falls(S)
North Bay
Mattawa (S)
Nipissing 10, R
48 073
North Bay, C
48 044
575
Mattawa, TP
48 019
Mattawa, T
48 021
Calvin, TP
48 022
Papineau-Cameron, TP
48 013
Chisholm TP
48 031
Nipissing, Unorganized,
North Part, UNO
48 094
Nipissing, Unorganized,
South Part, UNO
48 091
Temagami, T
48 069
West Nipissing, T
48 055
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
0 10 km

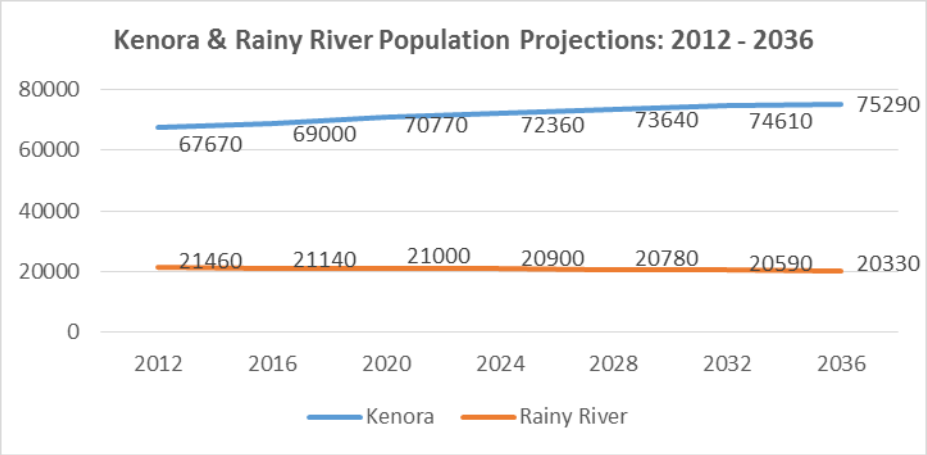
NORTHWEST COMMUNITY LEGAL CLINIC

Population Profile

The catchment area of the Northwest Community Legal Clinic (NWCLC) is the Rainy River District and a small portion of the Kenora District. The main clinic office is located in Fort Frances with branch offices in Kenora and Atikokan. The Kenora branch office offers sub-monthly coverage to residents of Red Lake and Ear Falls.

There are 45 census sub-divisions in the NWCLC catchment area with a total population of 46,104 people (2011 Census). The largest is the city of Kenora (15,348) and the seconds largest is Fort Frances (7,952). It is important to note that 22 census sub-divisions report populations less than 400, all within First Nation Reservations.

From 2012 to 2036, the population in the Kenora district is expected to increase by 11% while the population in the Rainy River district is expected to decrease by 5% (see chart below).



Excluding those census sub-divisions with less than 400 population, the chart below indicates where there have been population changes.

Census Sub-division	2011 Total Population	Population change % (2006 to 2011)
Couchiching	796	15.2
Whitefish Bay (32A)	670	8.0
Sioux Narrows-Nestor Falls	720	7.1

Wabaseemoong (White Dog)	832	5.9
City of Kenora	15348	1.1
Red Lake	4366	-3.5
Machin	935	-4.4
Ear Falls	1202	-16.0

It should be noted that 16 First Nation reported population increases ranging from 5% to 37% between 2006 -2011, with one reserve reporting a 115% increase in population.

The population in the NWCLC catchment area is much younger than average, with a median age of 27.6 years (versus 40.4 years in the province) and 78.8% of the population is 15 years of age or older. It should be noted that First Nations, with their booming child and youth populations are serving to keep the median age for the region well below the provincial median age.

Language Characteristics

The majority of the population's mother tongue is English (86.9%). Approximately 4% of the population's mother tongue is an Aboriginal language, and a small proportion (2.1%) is French. About 4% of the population reports a mother tongue other than English, French or Aboriginal.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (less than high school); Lone parent status; Movers; Tenancy; Aboriginal identity; Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Northwest Community Legal Clinic Area: Overall social risk for this catchment area is medium (5). These risk factors include a higher than average proportion of: Lone Parent families; Low Education; Unemployment; Government Transfers; and Aboriginal Identity.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Lone Parents	18.4	16.7
Low Education	24.1	18.7
Unemployment rate	9	8.3
Government transfer payments	25	12.3
Aboriginal Identity	29.4	2.3
Tenants	22.8	28.4
Movers	10.7	11.6
Low Income (LIM AT)	11	13.9

Based on tax-filer data (2012), the **prevalence of low-income** before tax for this catchment area is 18% of all families and non-family people (which differs considerably from the NHS Low Income AfterTax measure of 11%). This means there were 3,210 people and/or families living in low income. The median income for these low-income families and non-family persons was $15,751. There were 1,260 individuals without income. 850 (43%) lone-parent families, 2,130 (25%) of children under 18 and 520 (8%) of those 65 years and older were living in low-income. MCSS reports that in 2013/14 the average monthly caseload for Ontario Works[37] and Ontario Disability Support Program[38] was 603 (OW) and 1,164 (ODSP) in the Kenora district and 239 (OW) and 472 (ODSP) in the Rainy River district.

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

[37] Ontario Works includes Temporary Care Assistance
[38] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

Census Sub-division	Social Risk Score	Lone Parent Families	Low Education	Unemploy-ment	Gov't Transfer Pymts	Aboriginal Identity	Tenant	Mover	Low Income LIM AT
Kenora	6	18.3	22.0		14.3	18.0	28.6	11.8	
Kenora First Nation	6	38.1	55.6	16.0	28.6	96.2		15.8	
Manitou Rapids	6	43.8	44.1	16.7	32.0	100		13.3	
Seine River (23A)	6	38.5	58.7	13.9	44.4	98.2		14.8	
Couchiching	5	37.2	34.8	10.8	25.8	95.0			
Dawson	5		40.4	16.4	26.0	4.9			25.9
Shoal Lake (39A)	5	45.0	52.2	24.1	33.9	97.4			
Ear Falls	5		22.2		20.8	17.3		18.1	14.7

Housing

The total number of private households in the Northwest Community Legal Clinic catchment area is 18,020. As of December 31st, 2013 there were 373 and 79 applicants on the Kenora district and Rainy River district's social housing wait list (respectively). From 2012 - 2013, Kenora reported a 4% increase in its social housing waitlist whereas Rainy River reported a 30% decrease (ONPHA). Average wait times are not available for Kenora district while Rainy River district reports an average wait time of 1.7 years.

There are five (5) women's shelters operating within the Kenora and Rainy River districts: Saakaate House (City of Kenora); New Starts for Women Inc. (Red Lake); Rainy River District Shelter of Hope (Atikokan);Dryden's Hoshizaki House and Sioux Lookout's First Steps. NWCLC's catchment area also includes two emergency shelters operating out of Red Lake and the City of Kenora that are offer services to men. It should be noted that the shelter in Kenora is 'dry' (KDSB; 2014).

Two recent reports addressing housing and homelessness issues in the Kenora and Rainy River

Districts identify common risk factors for homelessness, including households spending more than 30% of their income on shelter costs; families living in low-income; food bank usage; and households accessing energy assistance.

In rural areas, housing stability can also be compromised by lower wages, fewer job opportunities, and fewer social and informational resources. Poor transit services and social isolation can also make it difficult to access information and support when needed.

There is also a number of other circumstances that can contribute to a particular person or household becoming homeless. This can include addictions, mental illness, physical illness or disability, family violence, discrimination, unemployment, family breakdown, eviction, natural disaster, house fires, and deinstitutionalization. These circumstances are often compounded by factors specific to the North, such as: high unemployment and seasonal unemployment; extremely low vacancy rates; distinct First Nations issues like inter-generational patterns of substance use, violence and generalized instability within the community linked to historical experiences with residential schools; high and rising energy costs relative to other parts of the province, and increasing property taxes, all of which especially impact people on fixed incomes, particularly senior-led households.

Transportation

There is only 1 public transportation service available out of the city of Kenora. Otherwise, there is no land-based public transportation serving the Kenora and Rainy River districts. There are taxi services available.

Technological Infrastructure

There are eight (8) hospitals and/or health centres which offer emergency medical care in the Kenora and Rainy River districts, five (5) of which are located within the NWCLC catchment area: Lake of the Woods District Hospital (city of Kenora); Rainy River Health Centre (Rainy River); La Verendry Hospital (Fort Frances); Atikokan Hospital (Atikokan); and Emo Health Centre (Emo). Most of the aforementioned hospitals/health centres offer Ontario Telemedicine Network (OTN) services and provide access to specialized medical care using video conferencing and other tele-diagnostic equipment.

Contact North has fully-serviced online learning centers in the clinic catchment area as follows: Atikokan; Balmertown; Ear Falls; Emo; Fort Frances; city of Kenora; Rainy River; and Red Lake all offer on-line learning services. Each of these communities are equipped with distance education

technologies such as audio conferencing, videoconferencing, web conferencing, computer workstations and high-speed internet (where available)**.**

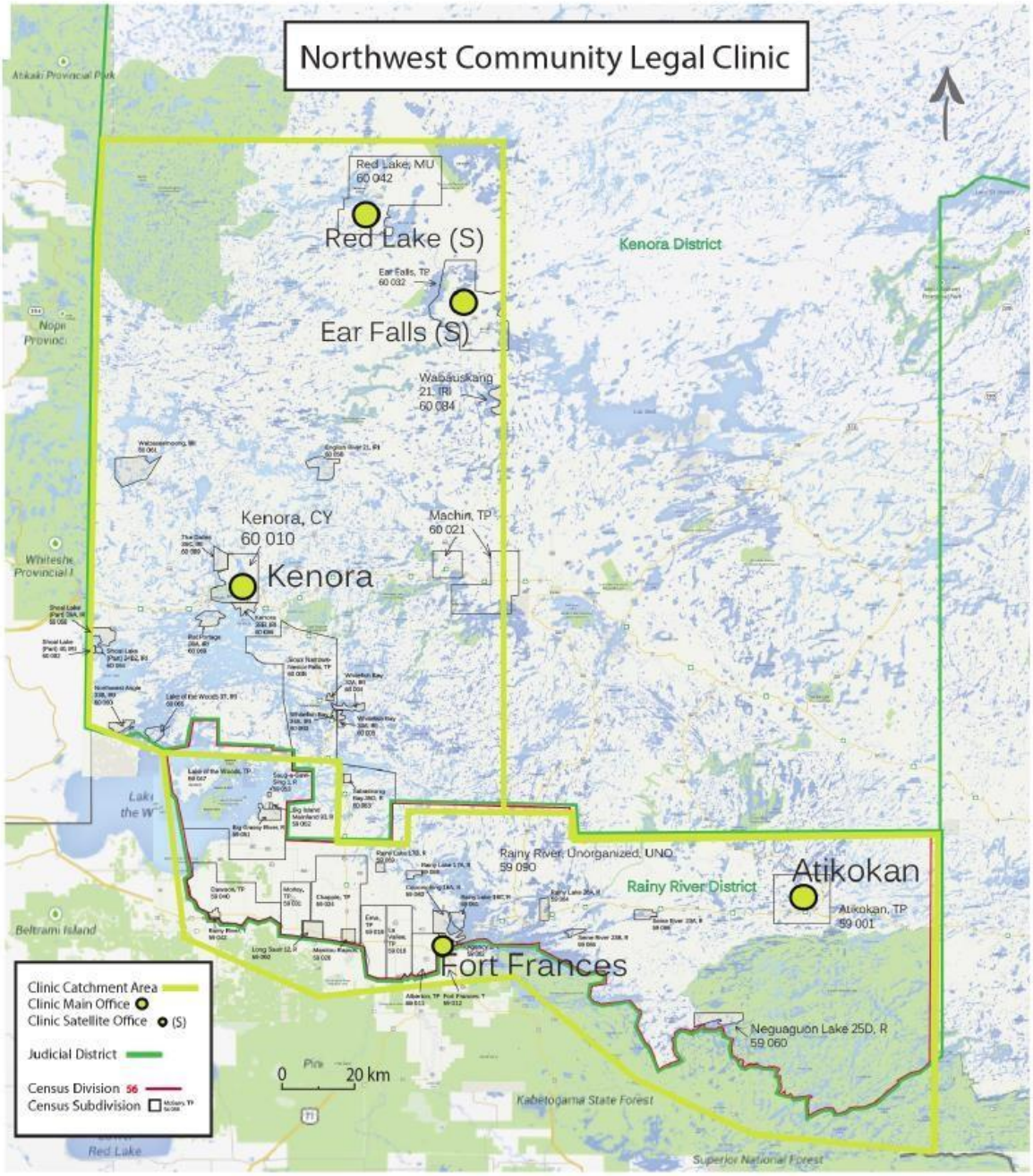
Post-secondary opportunities offered to communities within the NWCLC catchment include satellite campuses of Confederation College located in Kenora (city), Red Lake and Fort Frances (Confederation College is based out of Thunder Bay). Seven Generations also has two campuses in the NWCLC catchment area.

There is cell service available in and around Kenora (city), Rainy River, Fort Frances, Red Lake, and Ear Falls. The degree to which one can access cell service in some of the more remote communities in the districts varies.

REFERENCES

Kenora District Services Board. 2014. *A Place for Everyone -- Kenora District Services Board Ten Year Housing and Homelessness Plan (2014 - 2024).*

Rainy River District Social Service Administration Board. 2014. *10-Year Housing and Homelessness Plan -- 2014 -- 2024*. Prepared by OrgCode Consulting Inc.


Northwest Community Legal Clinic
Red Lake, MU
60 042
Red Lake (S)
Kenora District
Ear Falls, TP
60 032
Ear Falls (S)
Wabasuskang
21, IR
60 084
Kenora, CY
60 010
Kenora
Machin, TP
60 021
Rainy River, Unorganized, UNO
59 090
Rainy River District
Atikokan
Atikokan, TP
59 001
Fort Frances
Neguaguon Lake 25D, R
59 060
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
0
20 km
Kabetogama State Forest
Superior National Forest
Red Lake

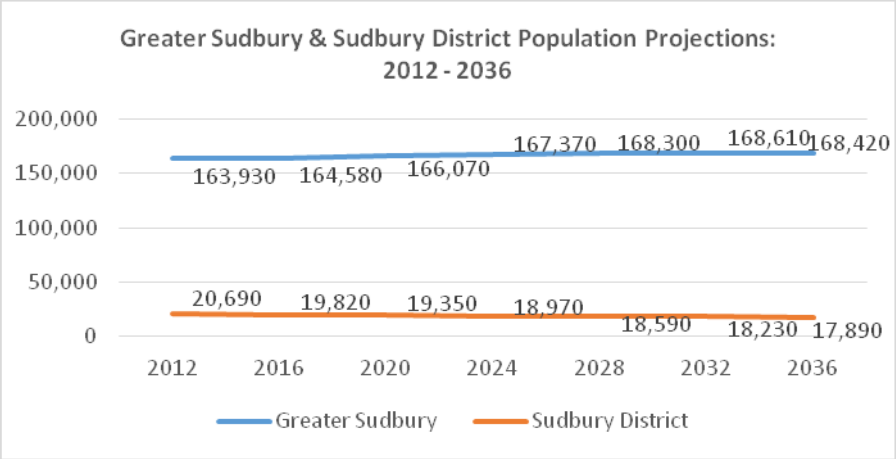
SUDBURY COMMUNITY LEGAL CLINIC

Population Profile

The catchment area of the Sudbury Community Legal Clinic includes the City of Greater Sudbury and the Sudbury District. The main clinic office is located in Greater Sudbury with satellite offices operating out of the communities of Espanola and St. Charles/Noelville and a sub office in Sagamok FN.

There are 19 census sub-divisions in the catchment area with a total population of approximately

182,745 people (2011 Census). The City of Greater Sudbury's population is expected to *increase* by 2.7%, while the population in the Sudbury District is expected to *decrease* by 13.5% (see chart below).



The chart below indicates the census sub-divisions experiencing the greatest population changes.

Census sub-division	2011 Total Population	Population change % (2006 to 2011)
French River FN	137	38.4
Whitefish Lake FN	394	12.9
St.Charles	1,282	10.6
Markstay-Warren	2,297	-7.2
French River	2,442	-8.2
Chapleau	2,116	-10.1
Chapleau 75 FN	79	-14.1

The population in this catchment area is older than average, with a median age of 46.2 years old (versus 40.4 years old in the province) and 81.1% of the population is 15 years of age or older.

Language Characteristics

While the majority of the population's mother tongue is English (66%), this catchment area has a large Francophone population, with 27.2% of the population's mother tongue being French. The highest proportions of Francophones can be found in French River (48.3%), St-Charles (47.2%), Chapleau (39.4%), Markstay-Warren (35.8%), Sudbury North Unorganized (31.6%) and Greater Sudbury (27.4%). Less than 1% indicated their mother tongue is an Aboriginal language, and 6.1% indicated non-Aboriginal languages as their mother tongue.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (no high school diploma, certificate or degree); Lone parent status; Mobility (movers in the past year); Tenancy; Aboriginal identity; and Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in Sudbury Legal Clinic Area: Overall social risk for this catchment area is medium (4). These risk factors include a higher than average proportion of: Low Education; Government Transfers; Tenants; and Aboriginal Identity.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Low Education	21.6	18.7
Unemployment rate	8	8
Government transfer payments	17.0	12.3
Tenants	31.2	28.4
Aboriginal Identity	9.2	2.3
Movers	12	12
Lone Parents	16.2	16.7
Low Income (LIM AT)	13	13.9

Based on tax-filer data, the **prevalence of low-income** before tax for this catchment area is 17.0% (13,780) of all families and non-family people (which differs considerably from the NHS Low Income After-Tax measure of 13%). On average, these low-income families and non-family person median income was $15,479. There were 5,985 individuals without income. 3,040 (37%) of lone-parent families, 6,450 (19%) of children under 18 and 1,570 (6%) of those 65 years and older were living in low-income. MCSS reports that the average monthly caseload in 2013/14 for Ontario Works[39] and Ontario Disability Support Program[40] in Greater Sudbury was 3,214 (OW) and 6,078 (ODSP) and in the Manitoulin-Sudbury Districts it was 467 (OW) and 998 (ODSP). Please note that this number reflects both the district of Sudbury and the district of Manitoulin.

Based on Census data, the **proportion of lone-parent** families for this catchment area is lower (16.2%) than the provincial average of 16.7%. High proportions are found in the First Nation communities of: Duck Lake Reserve (60%), French River Reserve (42.9%); Whitefish Lake First Nation (30.4%),Wahnapitei First Nation (28.6%) and Sagamok FN (35%).

Social Risk in Census Sub-divisions

The census sub-divisions of medium risk for which data is available include:

Census Sud-division	Social Risk Score	Low Education	Unemployemnt	Government Transfer Paymts.	Tenants	Aboriginal Identity	Movers	Lone Parent Families
Sagamok FN	5	46	31	42	14	99	7	35
Whitefish Lake FN	5	38	18	22		91		
Chapleau	4	29	17	16		10		
Baldwin	4	43	9	30		6		
Greater Sudbury	5	21		15	32	8		17
Markstay-Warren	4	27		21		12	13	
Espanola	3	24		17		10		

Housing

The total number of private households in the catchment area of the Sudbury Legal Clinic is 72,265 (Census 2011). The Manitoulin-Sudbury DSSAB reports that by July 2014, there were 287

[39] Ontario Works includes Temporary Care Assistance
[40] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

applicants for social housing in the Sudbury District. The Ontario Non-Profit Housing Association (ONPHA) survey reports that in 2013, there were 1,021 households on a wait list for rent-geared-to-income (RGI) housing in the City of Greater Sudbury. The average wait time was 1.14 years.

While obtaining data on homelessness or near-homelessness is difficult, the Poverty, Homelessness and Migration study conducted a homelessness prevalence count in North Eastern Ontario, and found that in 2009 there were 462 unique cases of homelessness in Greater Sudbury. The Greater Sudbury Report Card on Homelessness indicates that 959 people used an emergency shelter in 2013.

Transportation

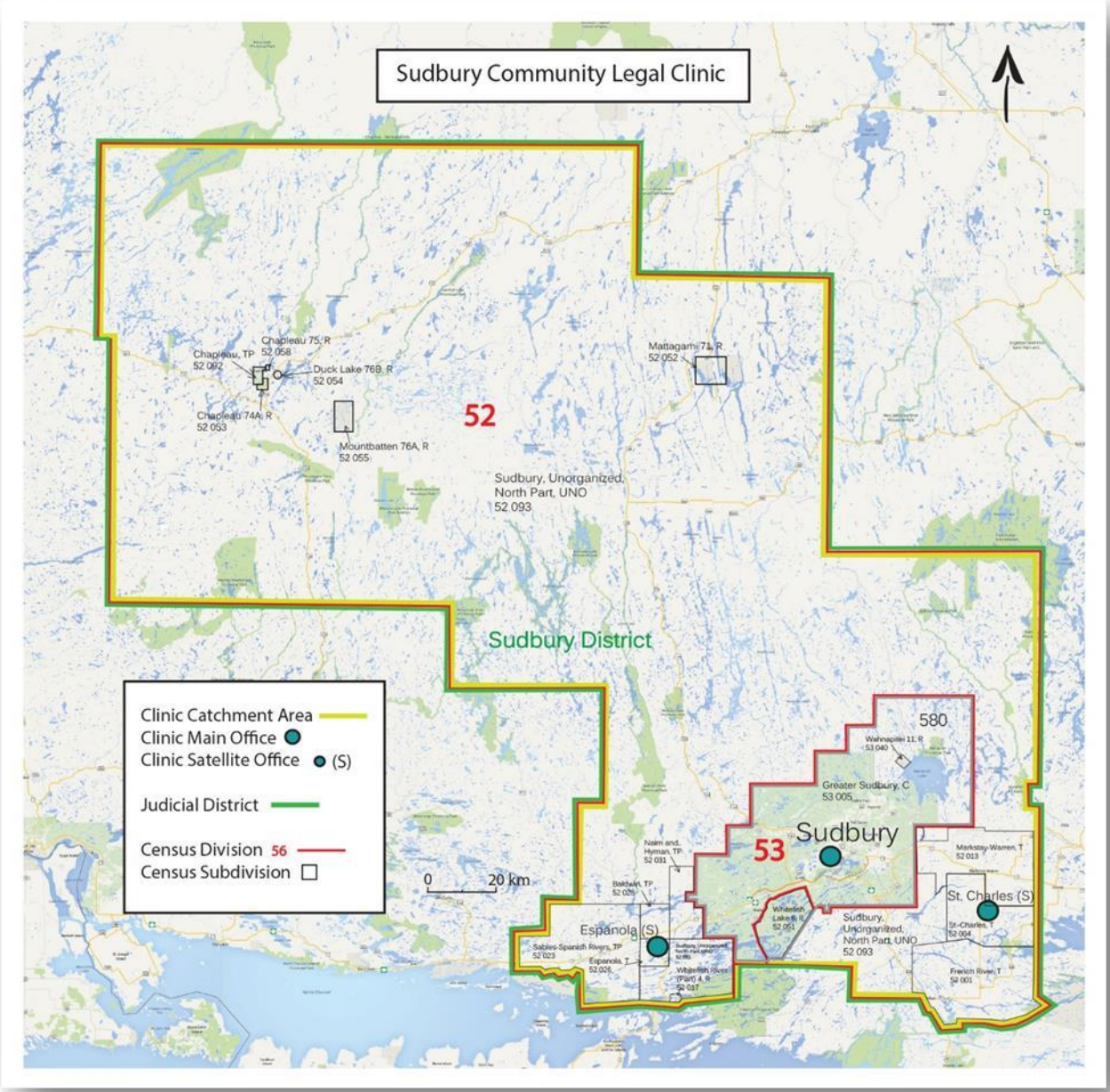
Greater Sudbury Transit serves the entire city of Greater Sudbury on a daily basis. The Township of Chapleau provides a safe and reliable bus transportation service for anyone in the community requesting transportation within the Township boundaries. The bus is equipped with 12 seats and 2 wheelchair spaces. The service provides door-to-door pickup and drop-off, assistance to get on and off the bus, if required, and wheelchair accessibility.

Greyhound Bus travels to Espanola and the Espanola Care Van provides public transportation for residents aged 55 and over and residents with disabilities. The Care Van is available Monday to Friday at a rate of $2.50 per trip. Ontario Northland serves many northern communities including Markstay-Warren and the French River area.

Technological Infrastructure

There are numerous avenues for post-secondary and/or distance education through Contact North, which serves Greater Sudbury, Chapleau, Espanola, St.Charles and Noelville. Cambrian College is located in Espanola and Greater Sudbury. College Boreal and Laurentian University are located in Greater Sudbury.

There are hospitals or health centers in this catchment area that are found in Greater Sudbury, Espanola and Chapleau. The Ontario Telemedicine Network (OTN) is available in this catchment area and provides access to specialized medical care using video conferencing and other tele-diagnostic equipment. Cellular service is available in these communities as well as a full range of internet and phone services.

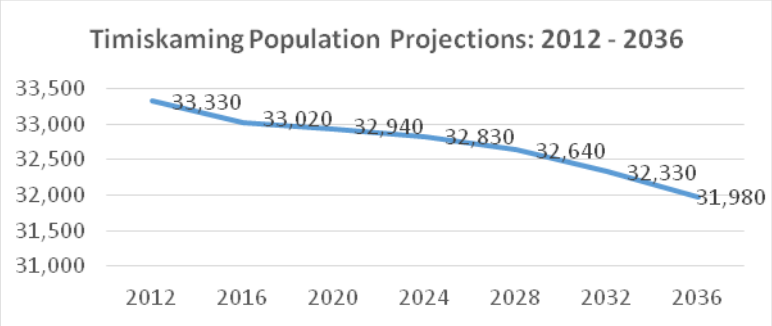

Sudbury Community Legal Clinic
Chapleau 75, R
52 058
Chapleau, TP
52 092
Duck Lake 76B, R
52 054
Chapleau 74A, R
52 053
Mountbatten 76A, R
52 055
Mattagami 71, R
52 052
52
Sudbury, Unorganized,
North Part, UNO
52 093
Sudbury District
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
0 20 km
580
Wahnapitei 11, R
53 040
Greater Sudbury, C
53 005
53
Sudbury
Naim and Hyman, TP
52 031
Baldwin, TP
52 025
Markstay-Warren, T
52 013
St. Charles (S)
St-Charles, T
52 004
Whitefish Lake 6, R
52 051
Sudbury, Unorganized,
North Part, UNO
52 093
Espanola (S)
Sables-Spanish Rivers, TP
52 023
Espanola, T
52 026
Whitefish River (Part) 4, R
52 037
French River, T
52 001

TIMMINS-TEMISKAMING COMMUNITY LEGAL CLINIC

Population Profile

The catchment area of the Timmins-Temiskaming Community Legal Clinic spans both the Cochrane District and the Timiskaming District. The main clinic office is located in Timmins with satellite offices located in Iroquois Falls, Kirkland Lake, Matheson and New Liskeard.

There are 28 census sub-divisions in the catchment area with a total approximate population of 79,582 (2011 Census). The size of communities in this area varies greatly, from 124 inhabitants in the Township of Gauthier to 43,165 in the City of Timmins. The Timiskaming District's population is expected to decrease by 4% from 2012 to 2036 (see chart below).



The chart below indicates the census sub-divisions experiencing the greatest population changes.

Census sub-division	2011 Total Population	Population change % (2006 to 2011)
Matachewan Township	268	-28.5
McGarry	595	-11.7
Black River-Matheson	2410	-8.0
Kerns	359	10.5
Abitibi	126	10.5
Coleman	597	10.6
Matachewan FN	83	15.3

The population in this catchment area is older than average, with a median age of 46.8 years old (versus 40.4 years old in the province) and 84.5% of the population is 15 years of age or older.

Language Characteristics

While the majority of the population's mother tongue is English (62.6%), there is a large Francophone population with a third (33.1%) reporting French as their mother tongue. Another 5% report a mother tongue other than English, French or Aboriginal, and a very small proportion (0.5%) report an Aboriginal language. The census sub-divisions with large Francophone populations (over a third) include Iroquois Falls, Timmins, McGarry, Armstrong, Harley, Casey, and Harris.

Social Risk Index

The Social Risk Index is a composite measure of the socio-economic risk in communities. The index was developed by Human Resources Development Canada and is composed of 8 Census and NHS variables, including: Low income; Unemployment; Low education (no high school diploma, certificate or degree); Lone parent status; Mobility (movers in the past year); Tenancy; Aboriginal identity; and Government transfer payments. The index is calculated by assigning one point when the community value exceeds the Ontario average. Low risk is a score of 0-2; medium risk is a score of 3-5; and high risk is a score of 6-8.

Social Risk in the Timmins-Temiskaming Community Legal Clinic area: Overall social risk for this catchment area is medium (3). Risk factors include a higher than average proportion of: Low Education; Government Transfers; and Aboriginal Identity.

Social Risk Variable	Clinic Catchment (%)	Province (%)
Low Education	27.4	18.7
Unemployment rate	8	8
Government transfer payments	23.2	12.3
Tenants	27.6	28.4
Aboriginal Identity	7.3	2.3

Movers	10.3	11.6
Lone Parents	5.3	16.7
Low Income (LIM AT)	14	14

Based on 2012 tax-filer data, the **prevalence of low-income** before tax for this catchment area is 20% (6,650) of all families and non-family people (which is slightly higher than the NHS Low Income After Tax measure of 14%). On average, these low-income families and non-family person median income was $15,911. There were 2,520 individuals without income. 1,440 (41%) lone-parent families, 3,330 (23%) of children under 18 and 1,140 (10%) of those 65 years and older were living in low income. Approximately half of those living in low-income live in Timmins. MCSS reports that the monthly average caseload in 2013/2014 for Ontario Works[41] and for Ontario Disability Support Program[42] in the Timiskaming District was 592 (OW) and 1,447 (ODSP).

Social Risk in Census Sub-divisions

The census sub-divisions of high to medium risk for which data is available include:

Census Sub-division	*Social Risk Score*	*Low Education*	*Unemploy-ment*	*Gov't Transfer Pymts*	*Tenant*	*Aboriginal Identity*	*Mover*	*Lone Parent Families*	*Low Income LIMAT*
Matachewan (Township)	7	37.5	22.2	32.3		26.4	15.4	23.5	24.1
Kirkland Lake	6	26.0		19.1	33.0	5.2		19.9	21.0
McGarry	5	33.9	15.4	33.5			14.7		21.7
Latchford	5	69.0	10.0	48.7		19.5			32.9
Black River-Matheson	5	27.3	15.6	18.3		7.9			19.0
Iroquois Falls	5	31.7	8.6	18.0		12.7	11.8		
Timmins	4	26.8		14.4	29.7	8.0			
Temiskaming Shores	4	27.4	11.9	19.9		3.8			

Housing

[41] Ontario Works includes Temporary Care Assistance
[42] Ontario Disability Support Program includes Assistance for Children with Severe Disabilities

The total number of private dwellings in the catchment area is 33,705 (2011 Census).The catchment area of the Timmins-Temiskaming Community Legal Clinic spans the service areas of both the Cochrane District Social Services Administration Board and the District of Temiskaming Social Services Administration Board.

According to the 10-year housing plan produced by the District of Temiskaming Social Services Administration Board, the total number of eligible applicants on the waitlist for social housing has increased significantly over the past five years from 118 applicants in 2008, to 533 applicants in December 2012. The DTSSAB reports that the number of new applications received has remained consistent with an average of 314 new applications per year. The average wait time is 1.54 years.

The Cochrane District Social Services Administration Board created a 10-year housing plan that sets out a framework for communities within the Cochrane District in order to address ongoing housing needs. The goal of the study was to assess current and future housing needs, develop objectives and targets, and describe how the progress towards meeting the objectives and targets will be measured. The population in the Cochrane District is ageing, which is putting pressure on the support services associated with care for seniors.

Further, as part of a 5-year funded research project exploring issues of poverty, homelessness and migration, the Poverty, Homelessness and Migration (PHM) study conducted a homelessness prevalence count for Timmins in 2011. The count was done during a specific one week period in January 2011 and counted individuals at risk of homelessness or individuals experiencing absolute homelessness. A total of 720 individuals were identified as being homeless, including 257 infants, children and adolescents under the age of 15. Further, Aboriginal peoples represented 39% of homeless individuals identified in the PHM study.

In addition, a quarter of those who were absolutely homeless indicated they did not receive any government benefits. Those not accessing government benefits also reported that they had no income, had some employment income, or were receiving some financial support from family members or a private pension. Many problems with income security programs were also reported, specifically pertaining to Ontario Disability Support Program and Ontario Works. Approximately 27% of respondents identified problems with income security programs as being directly linked to homelessness. This was indicated by all participants identified as being absolutely homeless in the PHM study.

A majority (75%) of absolutely homeless people who participated in the study reported they had not been referred to other services.

Transportation

Passenger bus service is available within the catchment area of the Timmins-Temiskaming Community Legal Clinic catchment area. Ontario Northland Bus provides limited service between Timmins and New Liskeard, four buses daily in each direction. This does provide some capacity for transportation between larger centres and for those communities located along Hwy 11. However, smaller communities located further away from the main highway receive few if any transportation services.

Looking at transit services, there is public transit available in Timmins and New Liskeard. The clinic office in Timmins is located in the downtown core and is very close to the transit centre, which services the communities of Timmins, South Porcupine and Schumacher. Further, the community legal clinic offers some clinic hours in New Liskeard based on staff availability and client requests. This outreach service operates out of a temporary location provided by the local Chamber of Commerce.

Other communities within the catchment area, for example Iroquois Falls and Kirkland Lake, have limited transit available to individuals with disabilities or seniors. The availability and range of services is quite limited and often reserved for medical appointments as they are funded through health agencies like Temiskaming Home Support.

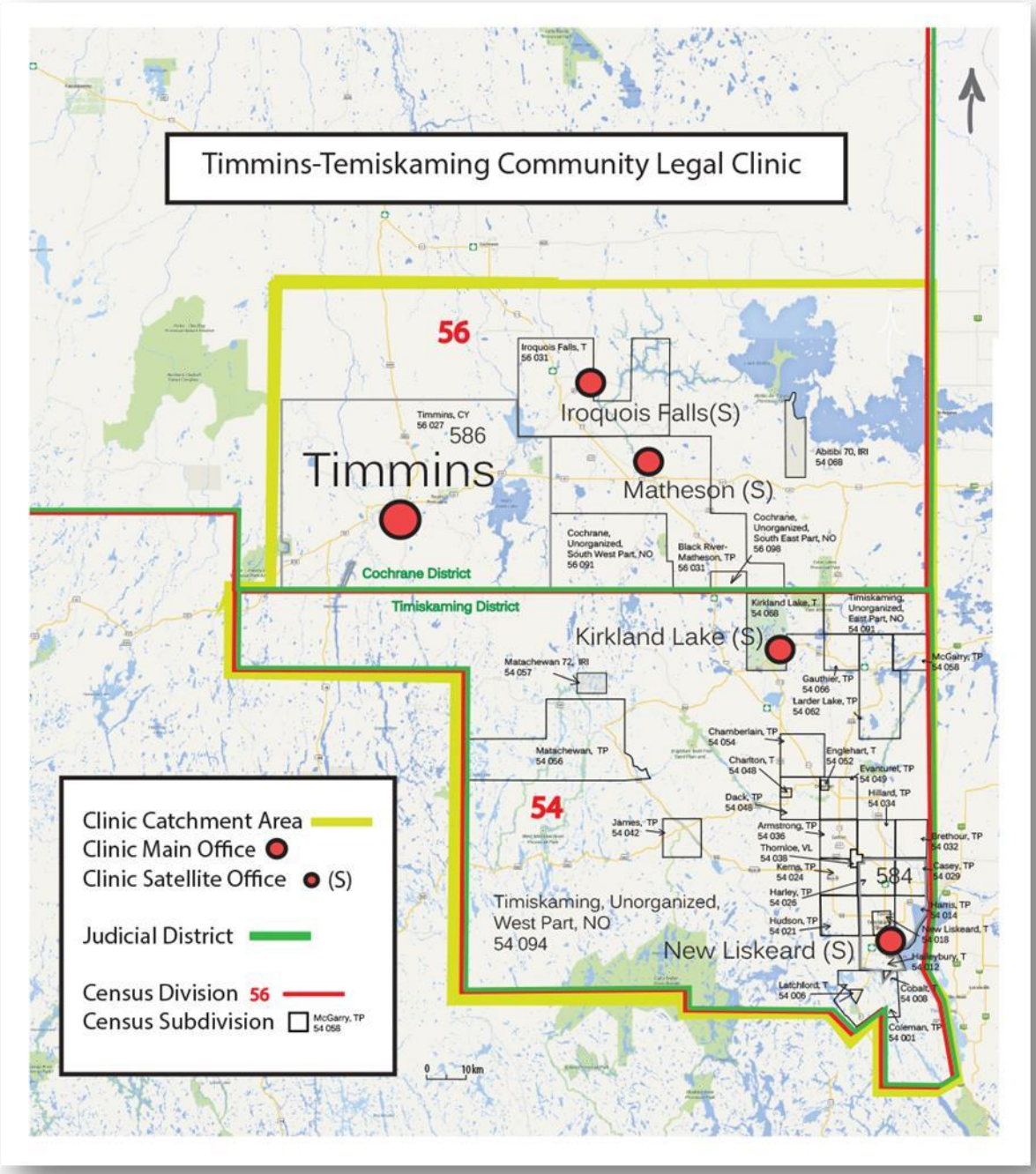
Technological Infrastructure

There is a strong post-secondary education presence within the catchment area of the TimminsTemiskaming Community Legal Clinic. Northern College operates campuses in Timmins, Haileybury and Kirkland Lake. Algoma University offers courses in Timmins via videoconference and in person. There are also French-language educational opportunities, with l'Université de Hearst and Collège Boréal offering courses in Timmins, as well as Collège Boréal offering additional courses in Temiskaming. Of note is that the campuses in Timmins of each post-secondary educational institution are very new, having been constructed within the last 10 years and maintain the most up-to-date technological tools available to students, including but not limited to equipped laboratories, computer laboratories, libraries and videoconferencing capabilities.

Health services across the catchment area varies, with the larger urban centres like Timmins and New Liskeard offering a larger gamut of services, while smaller communities continue to face the challenges of rural health service delivery. The Ontario Telemedicine Network (OTN) is present in all hospitals in this catchment area and provides access to specialized medical care using video

conferencing and other tele-diagnostic equipment. There are a total of 6 hospitals in this area, each equipped with OTN capabilities. The hospitals are Anson General Hospital (Iroquois Falls), Bingham Memorial Hospital (Matheson), Englehart and District Hospital (Engelhard), Kirkland and District Hospital (Kirkland Lake), Temiskaming Hospital (New Liskeard), Timmins and District Hospital (Timmins).

Cellular service (4G HSPA) is available on the main highways and in most rural areas through a variety of providers including Bell, Telus, Rogers, and Koodoo. Fibre optic cable is currently available only in Cobalt, Temiskaming Shores (New Liskeard, Haileybury and Dymond Township) and Timmins, with high speed internet available in selected areas. Primus offers dial up internet service in most rural areas in the catchment area of the Timmins-Temiskaming Legal Clinic.


Timmins-Temiskaming Community Legal Clinic
56
Iroquois Falls, T
56 031
Iroquois Falls(S)
Timmins, CY
56 027
586
Timmins
Matheson (S)
Abitibi 70, IRI
54 068
Cochrane, Unorganized, South West Part, NO
56 091
Black River-Matheson, TP
56 031
Cochrane, Unorganized, South East Part, NO
56 098
Cochrane District
Timiskaming District
Kirkland Lake, T
54 088
Timiskaming, Unorganized, East Part, NO
54 091
Kirkland Lake (S)
Matachewan 72, IRI
54 057
McGarry, TP
54 058
Gauthier, TP
54 066
Larder Lake, TP
54 062
Chamberlain, TP
54 054
Matachewan, TP
54 056
Englehart, T
54 052
Charlton, T
54 048
Evanturel, TP
54 049
Dack, TP
54 045
Hilliard, TP
54 034
54
James, TP
54 042
Armstrong, TP
54 036
Thornloe, VL
54 038
Earlton, TP
54 032
Casey, TP
54 029
Kerns, TP
54 024
584
Harley, TP
54 026
Timiskaming, Unorganized, West Part, NO
54 094
Hudson, TP
54 021
Harris, TP
54 014
New Liskeard, T
54 018
New Liskeard (S)
Haileybury, T
54 012
Latchford, T
54 006
Cobalt, T
54 008
Coleman, TP
54 001
Clinic Catchment Area
Clinic Main Office
Clinic Satellite Office (S)
Judicial District
Census Division 56
Census Subdivision
McGarry, TP
54 058
0
10km

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