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ARTICLES

THE COMMUNITY LEGAL CLINIC QUALITY ASSURANCE PROGRAM: AN INNOVATIVE EXPERIENCE IN QUALITY ASSURANCE IN LEGAL AID*

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The issue of quality in the provision of legal services to low income individuals has become an area of increasing concern and investigation in a number of different jurisdictions around the world. In Ontario, this issue has been addressed, at least in part, through the implementation of a formal quality assurance program providing for regular quality monitoring and control in the province's community legal clinic system. Anecdotal evidence indicates that the program, which has completed in-depth site visits at over one-third of the province's 70 community clinics, has had a beneficial effect on individual clinics and the clinic system as a whole in Ontario. There exists strong support for the quality assurance program among clinics and experience shows that clinics are implementing the program's recommendations as well as taking proactive steps to improve quality prior to formal reviews.

Despite this success, the program has been faced with many difficult issues since its inception. These issues include the appropriateness of client file reviews, the relationship of the quality assurance program to funding decisions, and the extent to which lawyers' work should be supervised within a clinic. Legal Aid Ontario, which has recently taken over responsibility of Ontario's legal aid plan from the Law Society of Upper Canada, has been given a specific mandate to implement a quality assurance program for the legal aid system as a whole and will be forced to address these same issues as it implements such a program.

I. INTRODUCTION

The issue of quality in the provision of legal services to low income individuals has become an area of increasing concern and investigation in a number of different jurisdictions around the world. In Canada, this concern for quality, or at least concerted efforts at measuring quality

* I would like to thank Tom Yeo for his excellent research assistance and all those who participated in this study, particularly John Swaigen and Mary McCormick.

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within the legal aid system, is very recent. Very little research has taken place in Canada with respect to assessing the quality of legal aid services being provided and no formal quality assurance program had been implemented providing for regular quality monitoring and control until the development of such a program within Ontario's community legal clinics.¹ This paper provides an overview of the development of that quality assurance program for the Ontario community clinic system and examines the experience and challenges that have confronted the program and may continue to confront the program as Ontario's legal aid system comes under a new governance structure.

A. OVERVIEW OF THE LEGAL AID SYSTEM IN ONTARIO AND COMMUNITY LEGAL CLINIC SYSTEM IN ONTARIO

The legal aid system in Ontario consists primarily of a certificate program, a community clinic program, and a relatively minor duty counsel program. Prior to 1 April 1999, the Ontario Legal Aid Plan (OLAP) was governed by the Law Society of Upper Canada, which had been granted the administrative authority to "establish and administer a legal aid plan."² Responsibility for performing the Law Society's oversight function rested with the Legal Aid Committee and the Clinic Funding Committee (CFC), both standing committees of the Law Society.³ The provincial government in Ontario provided open-ended funding for the certificate program until 1994 (when funding was capped), while the community clinic program had operated under fixed annual budget allocations since the program's inception.

The community clinic system consists of 70 clinics serving over 100 communities. The aim of the clinic system goes beyond the judicare system's focus on formal equality to justice and "stresses substantive

¹ As Alan Paterson and Avrom Sherr note, Canadian research on quality issues in legal aid has primarily focused on comparisons between staff and judicare models of service delivery, *infra* note 136. In her paper, S. Wain, "Quality Control and Performance Measures" in Ontario Legal Aid Review, *A Blueprint for Publicly Funded Legal Services* (Toronto: Queen's Printer, 1997) [hereinafter *Blueprint Report*], identifies the need for a comprehensive quality assurance program for legal aid services in Ontario. The *Blueprint Report*, *ibid* at 131, recommended that a major priority of a new legal aid regime should be the implementation of such a program.

² *Legal Aid Act*, R.S.O. 1990, c. L.9, s. 2.

³ The CFC was established in the late 1970s after a review of the administration of the recently funded clinics. The committee had both Law Society and government representatives, 40% of whom were required to have clinic experience.

social and economic equality between citizens.”⁴ The model defines legal needs more broadly by “emphasizing the potential role of legal services in the resolution of disputes between recipients and the machinery of the welfare state, and extending beyond the scope of services to include various methods of changing laws that affect the poor.”⁵ Most clinics are general service clinics that offer services in core areas of poverty law practice while specialty clinics specialize in a particular field of law or in the legal needs of a specific client group.⁶ Examples of specialty clinics include the Advocacy Centre for the Handicapped, the Advocacy Resource Centre for the Handicapped (ARCH), Advocacy Centre for the Elderly (ACE), Justice for Children and Youth, and the African Canadian Legal Clinic.

Clinics generally provide the following services:

1. summary advice and legal information within clinic areas of practice;
2. referrals to social service and community agencies, lawyers in private practice, and OLAP for certificates;
3. client representation before courts and administrative tribunals, including the Workplace Safety and Insurance Appeals Tribunal, the Social Assistance Review Board, the Ontario Human Rights Commission, and the Criminal Injuries Compensation Board;
4. public legal education, including seminars, workshops, presentations, and the production of pamphlets and videos in many languages;
5. law reform initiatives aimed at protecting and promoting the legal interests of the low-income community, including test-case litigation and appearances before municipal councils, legislative committees, and public commissions and inquiries; and
6. community development projects which assist clients to organize and to form self-help groups focused on low-income issues, including those affecting injured workers and tenant associations.⁷

Services are provided to clients based on both financial eligibility and coverage for the particular legal issue involved. Clinics employ three

⁴ F.H. Zemans & P.J. Monahan, *From Crisis to Reform: A New Legal Aid Plan for Ontario* (North York: York University Centre for Public Law and Public Policy, 1997) at 120.

⁵ Canadian Bar Association, National Legal Aid Liaison Committee *Legal Aid Delivery Models: A Discussion Paper* (Ottawa: Canadian Bar Association, 1987) at 118-119.

⁶ Zemans & Monahan, *supra* note 4 at 120. Some clinics do not employ CLWs and have chosen to only have lawyers and support staff.

⁷ *Ibid.* at 123.

types of service providers: staff lawyers, community legal workers (CLWs), and support staff. Community legal workers are similar in function to paralegals employed in private firms but also conduct the community education and organizing activities.⁸ As of July 1996, the CFC funded approximately 430 positions throughout the clinic system for an average of six positions per clinic. This total consisted of 174 lawyer positions, 113 CLWs, and 144.5 support staff.⁹

The administration of the clinic system is divided between the CFC and volunteer, elected boards of directors specific to each clinic.¹⁰ While the CFC is responsible for establishing policy and guidelines with respect to the funding of clinics and for administering the clinic funding program, the operational policy of each clinic is to be determined by the boards of directors.¹¹ Day-to-day management of each clinic is the responsibility of the clinic's Executive Director. Funding for individual clinics is provided through a "clinic certificate" which requires the clinic board to provide legal services and comply with general conditions in exchange for OLAP's agreement to provide funds. The Clinic Funding Office (CFO), headed by the Clinic Funding Manager (CFM), administers the overall system on behalf of the CFC. The CFO makes initial funding decisions but the final determination rests with the CFC.¹²

Based on the reported recommendations of the Ontario Legal Aid Review¹³ in 1997, the Ontario government introduced legislation, with the approval of the Law Society of Upper Canada, to remove the governance of legal aid from the Law Society and to place it in the hands of a newly established corporation called Legal Aid Ontario. The assets and liabilities of the Ontario Legal Aid Program were transferred to the new corporation on 1 April 1999. Legal Aid Ontario has been given broad powers to administer the legal aid program and relatively wide discretion to employ a variety of service delivery models in addition to existing models. Oversight of the clinic system is the responsibility of a special

⁸ *Ibid.* at 128.

⁹ *Ibid.*

¹⁰ *Ibid.* at 58.

¹¹ *Ibid.*

¹² R.R.O. 1990, Reg. 710, ss. 8-9.

¹³ In December 1996, the Attorney General of Ontario established the Ontario Legal Aid Review. The review, chaired by John D. McCamus, Professor of Law at Osgoode Hall Law School of York University, undertook a comprehensive analysis of the existing legal aid system in the province and reported its findings in August 1997. The report's 92 recommendations form the basis for Ontario's new legal aid regime that came into existence on 1 April 1999.

committee of the new corporation's board of directors having functions similar to the CFC. The corporation is also specifically required to "establish a quality assurance program to ensure that it is providing high quality legal aid services in a cost-effective and efficient manner."¹⁴ This responsibility for quality assurance also involves the Law Society, who will be responsible for reviewing the work of lawyers providing legal aid services.¹⁵

B. THE ORIGINS OF THE QUALITY ASSURANCE PROGRAM IN THE CLINIC SYSTEM

The conceptualization of a quality assurance program for Ontario community clinics began in the late 1980s. In February 1987, the Clinic Funding Committee adopted Clinic Performance Criteria. This policy summarized several years of consultations related to performance evaluation issues in clinics. At that time, the Clinic Performance Criteria outlined "carried general support from the system as being comprehensive, fair and with a good deal of rigour to allow for reasonably objective assessment of clinic and system behaviour."¹⁶ The Clinic Performance Criteria, which were developed in consultation with clinic representatives and which received the approval of the Ontario Association of Legal Clinics, were distributed to clinics in July 1988.¹⁷

At the time the Clinic Performance Criteria were developed, the clinics expressed some concern over the idea of a quality assurance program.¹⁸ These concerns, however, were not particularly strong given that the idea for a quality assurance program was in its conceptual stage. In addition, the program did not evolve past the development of quality criteria. The criteria, and the idea for a formal quality assurance program,

¹⁴ *Legal Aid Services Act*, 1998, S.O. 1998, c. 26, s. 92(1) [hereinafter *Legal Aid Services Act*].

¹⁵ *Ibid.* s. 92(8).

¹⁶ Clinic Funding Committee, *The Community Legal Clinic System of Ontario: Quality Assurance Program* (September 1996) [unpublished] at 23 [hereinafter *Program Description*].

¹⁷ *Ibid.* These criteria were distributed in July 1988 in a binder entitled *Materials for the Clinic Performance Evaluation Criteria*.

¹⁸ Interview by F.H. Zemans with M. McCormick (Acting Quality Assurance Director), (10 February 1999). According to Judith Wahl (Executive Director of the Advocacy Centre for the Elderly), one of the primary concerns of clinics when the idea of quality assurance was first raised at a managerial meeting was that the model being considered was that used for quality assurance in nursing homes. Many clinics were concerned that such a model would be totally inappropriate to measure quality in a legal aid clinic. Interview by F.H. Zemans with J. Wahl (17 February 1999).

sat on the shelf for a number of years, seen as a “nice to do” project but not one that was a priority of the CFC or the clinics.

A quality assurance program for the clinic system was raised again in 1996 by the CFC. Several factors highlighted the need for such a program. The legal aid system in Ontario was facing significant financial pressures and it was expected that changes to the delivery of legal aid services would be forthcoming. In 1994, after dramatic escalations in the cost of the judicare side of the system, the province of Ontario imposed a cap on the funding of the certificate program, ending nearly 30 years of open-ended funding. While funding of the clinic system had always been capped, the total clinic budget had been frozen since 1993 and the possibility of serious cuts was feared.¹⁹ A comprehensive review of the delivery of legal aid services in Ontario was expected to develop changes to the legal aid system prior to the expiration of the Memorandum of Understanding (MOU) between the Law Society and the provincial government in March 1999. The CFC believed that “to support and defend the clinic system it is essential to be able to demonstrate in a tangible manner the quality of services provided by clinics.”²⁰

A second concern was that an increasing emphasis was being placed on quality assurance and accountability in other publicly-funded social programs. Several Ontario organizations were developing and implementing some form of quality assurance program, including hospitals, insurance clinics and many of the regulated health professions which were implementing accreditation systems to ensure continuing professional competency.²¹ The CFC was concerned that it was falling behind in its “ability to demonstrate the strengths of the clinic system.”²²

Additionally, there existed a perception that the legal services provided by the Legal Aid Plan, both by community clinics and the certificate program, were not of a high quality. While any evidence of quality problems was largely anecdotal, the perception was fairly widespread. With respect to the clinic system, the perception was that the clinics focused more on the quantity of clients they served rather than on the quality of the services provided.²³ A formal quality assurance program offered the opportunity to examine the accuracy of these perceptions and to improve the quality of the services provided by the clinics.

¹⁹ Letter from Paul Copeland (Chair, Clinic Funding Committee) to Chairpersons of Clinic Boards of Directors (22 November 1996).

²⁰ *Ibid.*

²¹ *Program Description*, *supra* note 16 at 2.

²² Copeland letter, *supra* note 19.

²³ S. Wain, *supra* note 1 at 616.

It was against this background that the CFC distributed the description of the proposed Quality Assurance Program (QAP) to clinics in September 1996 and recommended that implementation begin in late 1996 or early 1997.²⁴ The CFC emphasized that the QAP was:

1. to demonstrate the high quality of services delivered by the community clinic system; and
2. to continuously improve the quality of services delivered by community legal clinics.²⁵

It was also made clear by the CFC that the program was to be “a positive, remedial process and not a defunding procedure.”²⁶ However, this statement was accompanied by the caveat that “[w]e hope that defunding decisions will not be necessary in the future.”²⁷

II. THE COMMUNITY LEGAL CLINIC QUALITY ASSURANCE PROGRAM

A. THE DESIGN OF THE QUALITY ASSURANCE PROGRAM

In September 1996, the CFC distributed the Program Description of the QAP to all clinics. While the actual experience of the program has differed slightly from the Program Description, it is useful to examine the proposed design of the QAP.

The QAP identifies as its fundamental objective:

To allow for an ongoing, verifiable assessment of the quality of the operation of Community Legal Clinics.²⁸

Five major principles were identified as the foundation of the program:

1. The work produced by organizations is a function of five or six key work processes. By understanding the work processes and looking for opportunities to continually improve them, an organization can better fulfill its mandate.
2. Improvements should be continuous and incremental. A service organization improves quality by isolating opportunities for improvement, understanding their cause and then making amendments to improve the process producing those causes.

²⁴ *Program Description, supra* note 16.

²⁵ Copeland letter, *supra* note 19.

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ *Program Description, supra* note 16 at 5.

3. Customer expectations should be the general yardstick for improving work processes. Successful organizations listen, calibrate and respond to the needs of a variety of internal and external customers.
4. There is a need for statistical and evidence-based data to monitor variations in work processes and other factors such as customer expectations.
5. Existing expertise from within the system should be used to identify and solve problems.²⁹

These principles underlie the manner in which the CFC suggested that quality should be measured and improvements implemented. In addition, the QAP Description identified five principles related to how the program itself should be structured, implemented and managed:

1. Quality Assurance will focus on the operations of clinics including the quality of legal file management;
2. the QAP is meant to be supportive and facilitating;
3. the QAP staff will not make funding decisions;
4. the QAP builds upon current structures and information available in the Clinic System; and
5. the QAP will be adequately resourced.³⁰

It is worthwhile describing the original design of the QAP within the framework of these five principles:

1. QUALITY ASSURANCE WILL FOCUS ON THE OPERATIONS OF CLINICS INCLUDING THE QUALITY OF LEGAL FILE MANAGEMENT

Nine dimensions of quality formed the focus of the QAP:

1. Board Governance
2. Overall Management
3. Understanding the Community
4. Communications—External and Internal
5. Program Planning and Evaluation
6. Range of Services
7. Provision of Services
8. Service Delivery
9. Specialty Clinics

In each of these nine areas, the QAP employed Quality Assurance Criteria and Quality Assurance Indicators to assess the quality of services being provided by a clinic. A Quality Assurance Criterion is a standard that should be met in order to ensure that a particular work process is

²⁹ *Ibid.* at 2-3.

³⁰ *Ibid.* at 5.

functioning effectively. For each Quality Assurance Criterion, a number of Quality Assurance Indicators exist to assist a reviewer in determining whether the standard, or Criterion, is being met. For example, with regard to the quality dimension of "Understanding the Community," Quality Assurance Criterion 3.2 asks whether:

The Clinic regularly receives and evaluates feedback on how well it is meeting community needs and its clients' expectations from its many customer groups including the community, clients and the legal profession.³¹

The Indicators that a reviewer would find to suggest that the clinic is achieving this standard are that:

1. the clinic collects customer feedback;
2. the clinic is aware of other resources available in the community and has developed co-operative relationships;
3. contact with the local Bar is maintained;
4. clinic staff have personal contact with staff at local agencies; and
5. clinics with significant cultural, ethnic, or linguistic minorities have representatives of these minorities on the board.³²

A visit to the particular clinic being reviewed was the primary mechanism by which this information would be collected. Quality Assurance reviewers were expected to spend two days in the clinic conducting interviews, reviewing documents including procedures, operating manuals, and minutes of meetings, observing clinic operations and reviewing client files. Interviews were to be conducted with: the Executive Director of the clinic; the Board Chair and at least one other Board member; at least one staff lawyer, one community legal worker and one member of the support staff; and customers, including a client, representative of an external agency and member of the local Bar. A second source of information for the reviewer was to be centrally-produced data from the Clinic Funding Office, such as the most recent funding application for the clinic, an up-to-date list of board members and officers, the most recent audited financial statements, and any information provided to the CFC about individual complaints against the clinic.

One aspect of the site visit that posed the most concern to clinics (and, as will be discussed later in the paper, continues to pose concern), is the review of client files. In anticipation of this concern, the CFC in the Program Description stated that "[a]t this time, the review of client files is not intended to evaluate the quality of legal work performed or second

³¹ Quality Assurance Program, *Quality Assurance Manual: Part 1* (Revised: February 1998) [unpublished] at 52 [hereinafter *QAP Manual*].

³² *Ibid.* at 52-53.

guess the professional judgment of caseworkers.”³³ The reviews instead would focus on:

1. organization of the file
2. limitation periods
3. supervision and case consultation
4. case management procedures (where in place)
5. timeliness
6. communication with the client
7. egregious legal errors (not a review of caseworkers’ judgment but identification of any legal advice that is “simply wrong”).³⁴

Despite these assurances, many clinics expressed opposition to the review of client files when asked to comment on the Program Description. Concerns related to possible second-guessing of caseworkers’ professional judgment and also to the issue of solicitor-client privilege. In response, the CFC has noted that the review of client files was for the benefit of clients—its purpose was to ensure that low income people receive high quality legal services. Since the major work product of legal clinics is legal work, the CFC argued that there cannot be a valid assessment of clinics without reviewing the quality of legal work.³⁵

On the issue of solicitor-client privilege, the CFC proposed that all client retainers be revised to allow review of client files by QAP reviewers. Future clinic funding certificates would make it mandatory for clinics to include such a provision in their retainers.³⁶ In the meantime, the CFC suggested that the review of client files be conducted through discussions with caseworkers, by having the name of the client deleted from the file, or by contacting clients directly for permission to review their files.³⁷

2. THE QUALITY ASSURANCE PROGRAM IS MEANT TO BE SUPPORTIVE AND FACILITATING

The general view of quality assurance programs is that they can take one of two forms. They can serve as an enforcement mechanism to ensure that minimum standards are being met or they can be facilitative to encourage and assist quality improvements in the future. The CFC’s QAP emphasized that the program was to take the form of the latter, however,

³³ *Program Description*, *supra* note 16 at 18.

³⁴ *Ibid.* at 19.

³⁵ Copeland letter, *supra* note 19.

³⁶ *Program Description*, *supra* note 16 at 8.

³⁷ Copeland letter, *supra* note 19.

aspects of its use as a compliance mechanism were apparent and at least some clinics viewed the program as such.³⁸

In order to facilitate improvements, the program proposed to utilize a variety of tools. The first of these tools was to be the report and recommendations of the clinic reviewer. The report, to be provided to the Board and the Executive Director of the clinic, would evaluate the clinic as to its ability and potential to attain the required quality standards.³⁹ The report would include recommendations in areas where improvement was required to attain the quality standards.

Another tool employed to facilitate quality improvement was the development of materials designed to assist clinics with improvements in various areas. If it was determined that a clinic was not meeting certain standards, recommendations by the reviewer could be accompanied with specific materials to assist the clinic in responding to the problem. Additionally, as reviewers visited more clinics, various best practices with regard to certain work processes could be identified and communicated system-wide to the clinics.

The use of peer mentors was also seen as important to the process of facilitating quality improvements. Peer mentors would be experienced Executive Directors/lawyers or have equivalent experience and they would assist clinics in developing programs for improvement. The CFC emphasized that their use should be viewed "as constructive, confidential and building upon the comments offered by the reviewer during the first visit."⁴⁰

A final tool available to the program was the use of special referrals. A special referral would occur when a reviewer suggested that a consultant with a particular area of expertise be brought in to assist the clinic. An example of this might be the use of a human resources consultant to assist with human resource record keeping issues. The QAP would maintain a list of such consultants and, if a problem were seen as systemic, could arrange for workshops to be provided to clinic management.⁴¹

³⁸ May Haslam (Board of Directors of Parkdale Community Legal Services Inc.) (30 October 1996) noted the different approaches which can be taken in implementing a quality assurance program and concluded that "[i]t would appear that the proposed QA Programme is a compliance review." Letter from M. Haslam (Board of Directors of Parkdale Community Legal Services Inc.) to P. Copeland (Chair of the Clinic Funding Committee (30 October 1996).

³⁹ *Program Description*, *supra* note 16 at 12.

⁴⁰ *Ibid.* at 21.

⁴¹ *Ibid.* at 22.

While these tools were meant to facilitate quality improvements in the clinic, the program design also possessed some elements of an enforcement mechanism. For each clinic, the Quality Assurance reviewer was to assign the clinic to one of three positions on a quality assurance continuum. Clinics assigned to Position 1 were achieving all or nearly all of the quality assurance standards and any quality improvements were minor and could be achieved within 3 months. Position 2 clinics were achieving most of the standards but some important areas had not received adequate attention with improvements likely taking up to six months. In Position 3 clinics, most of the standards were not being met and substantial effort was required before the clinic would be able to respond to the QAP in a way that serves its community's needs.

The significance of these "rankings" was that the clinic's position was to be reported to the Clinic Funding Manager. In addition, the Clinic Funding Manager was to receive a copy of the reviewer's full report for any Position 3 clinic and would also receive a copy of the report for any Position 2 clinic if that clinic had not made sufficient improvements within 6 months of the initial visit. Any ranking below Position 1 also entailed follow-up visits by the reviewer at regular intervals until the clinic had achieved Position 1 status. The fact that these rankings and, in some instances, reports would be provided to Clinic Funding staff implies that some element of minimum standard enforcement existed in the program, particularly when one considers the fact that such reports might then influence funding decisions.

3. THE QUALITY ASSURANCE PROGRAM STAFF WILL NOT MAKE FUNDING DECISIONS

The decision that AP staff would not be involved in funding decisions was an important principle in the design of the QAP, allaying clinic concerns that the program would be utilized as a defunding mechanism. The announcement of the QAP by the CFC was done at the same time that funding cuts to the clinic system were also being considered. Clinics, not unjustifiably, were clearly worried that quality reviews would be used to make funding decisions related to individual clinics.

The primary means by which the CFC hoped to achieve this goal was by separating the QAP from the Clinic Funding Office. The Quality Assurance staff would operate independently from the Clinic Funding staff and reviewers would restrict the content of their reports to the clinic's ability to respond to the standards and processes outlined in the criteria.⁴² The reviewer was not to make any recommendations regarding

⁴² *Ibid.* at 8.

funding of the clinic. This independence was to be further enhanced by having the Quality Assurance staff work at a location completely separate from the Clinic Funding Office.

Clinics, however, still had two concerns related to the structure of the program. First, despite the supposed independence of the Quality Assurance staff, the Quality Assurance Director was to report directly to the Clinic Funding Manager. Many clinics felt that if the program was to be truly independent, the Quality Assurance staff should not be Clinic Funding employees.⁴³ The CFC responded that:

This is an *employment* issue. The QA Program staff must be employed by an organization which can act as an employer. At this time, there is no feasible alternative employer. The issues of administration of the program and where reports are sent are quite separate from this employment issue. If QA Program staff were employed elsewhere, the issue of sending reports to CFS would still remain.⁴⁴ [emphasis in original]

It was felt that to overcome any difficulties in maintaining independence within this reporting relationship, it would be “preferable that the QAP Director benefit from the direction and policy advice of a Quality Assurance Steering Committee that would be comprised of members of the Clinic system.”⁴⁵

The second major concern of clinics was that even if the Quality Assurance staff did not themselves make funding decisions, their reviews had the potential to impact funding decisions. This concern related specifically to the procedure of ranking the clinics by position and the circumstances under which a copy of the report might be provided to Clinic Funding staff. The CFC acknowledged that this procedure had the potential to impact funding decisions. In response to clinics’ concerns that an appeal process be established for clinics which disagreed with a reviewer’s report, the CFC stated that:

The only “decision” made by [QAP] staff is what position a clinic is assessed at. The only consequence of the decision is whether a copy of the report goes to [clinic funding staff]. In most cases, there will be no further consequence. *If the report suggests to clinic funding staff that funding consequences should be considered*, then the clinic has the benefit of the full hearing and appeal process provided for in the Regulation and CFC policies.⁴⁶

⁴³ Copeland letter, *supra* note 19.

⁴⁴ *Ibid.* [emphasis added].

⁴⁵ *Program Description*, *supra* note 16 at 6. As of March 1999, this Steering Committee had not been constituted.

⁴⁶ Copeland Letter, *supra* note 19 [emphasis added].

Thus, while the CFC maintained that the primary objective of the QAP was not to use it as defunding tool, it left open the possibility that it could indirectly influence clinic funding decisions.

4. THE QUALITY ASSURANCE PROGRAM BUILDS UPON CURRENT STRUCTURES AND INFORMATION AVAILABLE IN THE CLINIC SYSTEM

In carrying out its quality reviews, the QAP was to utilize already existing information as much as possible. Reviewers would obtain centrally collected information on individual clinics (such as the information contained in the clinic's most recent funding application) prior to the clinic site visit. Once in the clinic for the site visit, the reviewer would focus on existing materials within the clinic, such as procedure manuals, Board minutes, completed client satisfaction surveys and client files. Additional information would be obtained by the reviewer through interviews with clinic stakeholders but the reviewer was not expected to generate a great deal of new information. For example, the reviewer did not have a mandate to conduct their own client satisfaction surveys.

5. THE QUALITY ASSURANCE PROGRAM WILL BE ADEQUATELY RESOURCED

The original Program Description did not specify how many reviewers would be employed by the program. The qualifications for a reviewer stated that they must be a lawyer with lengthy experience working in the clinic system, including experienced at the executive director or similar level.⁴⁷ The job description for the QAP Director stated that they should operate similarly to the executive director of a clinic and would be responsible for the development, implementation and maintenance of the program. This would include developing and refining a process for implementing the program, conducting site visits and developing a set of quality service best practices and indicators, a peer mentor network, and support materials for clinics with problems.⁴⁸

It was proposed that the program would be implemented in 3 stages over a two-year period. Six volunteer clinics would be reviewed during the first three months of the program. During the second phase of the program, ten volunteer clinics would be visited at the rate of one per week. The final phase would see the remaining 54 clinics in the system visited randomly until every clinic had been reviewed by the end of the

⁴⁷ *Program Description*, *supra* note 16 at 6.

⁴⁸ *Ibid.* at 6-7.

second year of the program. After that time, each clinic would be visited once every two years.

B. THE EXPERIENCE OF THE QUALITY ASSURANCE PROGRAM

Implementation of the QAP began in April 1997 with the hiring of John Swaigen as QAP Director. Mary McCormick was hired in September 1997 as the second Quality Assurance reviewer. Both individuals were lawyers with extensive experience inside, as well as outside, the clinic system and both had experience as clinic directors. Swaigen left the program in January 1999, at which time McCormick was appointed interim director of the program.

The first phase of the program proceeded with reviews of eleven volunteer clinics (more than the six clinics originally contemplated) between August and November 1997. This list of eleven provided a good sampling of clinics: clinics in Toronto, medium-sized cities, and small towns; a specialty clinic; and a bilingual clinic.⁴⁹

Prior to conducting the reviews of these clinics, the executive directors of the eleven clinics met with Swaigen and two consultants to the program for two days and were given an opportunity to comment on the quality criteria and indicators and on a Quality Assurance Manual, designed for clinics to prepare for the site visit. Changes to the program were made in response to these comments and utilized in Phase 1 of the program implementation.⁵⁰ Additional changes were made following completion of the review process for the volunteer clinics, again in consultation with the executive directors of those clinics which underwent review in Phase 1.⁵¹

Phase 2 was carried out from February to August 1998 and involved reviews of nine clinics, all selected alphabetically with the exception of one clinic which specifically requested inclusion.⁵² Site visits for these nine clinics were completed by June 1998 while report writing continued through July and August of that year.

For Phase 3, it was decided by the QAP and the Clinic Funding Manager that clinics should be reviewed at a lower frequency in order that other aspects of the program (such as the creation of benchmarks and best

⁴⁹ J. Swaigen, *Report on the Quality Assurance Program and Quality in the Ontario Legal Clinic System* (Toronto: Quality Assurance Program, 1999) [unpublished] at 3 [hereinafter *Director's Report*].

⁵⁰ *Ibid.*

⁵¹ *Ibid.* at 4.

⁵² Eleven clinics were originally selected for review in Phase 2 but two had to be postponed for unforeseen circumstances and completed as part of Phase 3.

practices and the formation of a steering committee) could be developed.⁵³ It was also decided at that time that future clinics should be chosen for review on a lottery basis, rather than alphabetically. It had been observed in the earlier phases of the program that many clinics made significant improvements in their operations in preparation for the review. It was felt that clinics near the bottom of the alphabetical list might not have the incentive to make these improvements if they were safe in the knowledge that they would not face a review for another one or two years.⁵⁴

To date, 26 of the 70 clinics have been reviewed and 23 have received at least a draft report from the reviewers.⁵⁵

C. IMPACT ON CLINIC OPERATIONS

Due to the QAP's obligation to keep Quality Assurance reports confidential, actual reports on individual clinics were not available in the preparation of this paper. However, the executive directors of four clinics which had undergone Quality Assurance reviews were interviewed to gain some insight as to their experiences with the program.⁵⁶ While this did not necessarily constitute a representative sample of the clinics reviewed, the interviews did provide a better understanding of how the program functions at the site visit level and how individual clinics have responded to the review and recommendations. As well, some information on clinic experiences with the review process was available from a survey, conducted by the QAP, of the eleven Phase 1 clinics.⁵⁷

The QAP seemed to have an impact on the clinics even before the reviewer arrived for the site visit. Clinics tended to begin reviewing and revising their procedures and operations in preparation for the visit. The Board of Directors of at least one clinic was motivated by the impending review to look finally at a variety of issues related to the clinic's

⁵³ *Director's Report*, *supra* note 49 at 6.

⁵⁴ *Ibid.*

⁵⁵ M. McCormick Interview, *supra* note 18.

⁵⁶ Telephone interviews by F.H. Zemans with: D. Baker (Advocacy Resource Centre for the Handicapped) (16 February 1999); T. Hunter (Simcoe Legal Services Clinic) (16 February 1999); D. Balderston (Algoma Community Legal Clinic) (16 February 1999); and J. Wahl, *supra* note 18.

⁵⁷ See Quality Assurance Program, *Results of the Quality Assurance Program Questionnaire for Staff and Board Members: Phase 1* (August 1998) [unpublished] at 4 [hereinafter *QA Survey*]. Responses to the survey were completed by 63 of the 82 board and staff members who were interviewed during Phase 1 site visits. Responses were provided by 9 Executive Directors, 7 Board Chairs, 8 Board members, 14 lawyers, 8 CLWs, 5 office managers, 11 support staff, and one articling student.

operations that staff had been encouraging them to address for some time. Another clinic indicated that it spent considerable time preparing for the review. Board meetings and at least ten staff meetings were convened to review clinic operations in light of the quality standards.⁵⁸ Swaigen's *Report on the Quality Assurance Program and Quality in the Ontario Legal Clinic System* confirms that making improvements prior to the site visit was a common practice among clinics.⁵⁹

One area in which clinics seem to have responded on a system-wide basis is with regard to client satisfaction surveys. One of the indicators of the QAP is whether the clinic has a method of collecting customer feedback. Many clinics have responded by conducting surveys of former clients, often enlisting university students to assist in carrying out these surveys.⁶⁰ Where the surveys were completed before the site visit, they proved to be quite helpful for the reviewer.⁶¹ Otherwise, the reviewer's assessment of client satisfaction was primarily based upon only one or two interviews with clients selected by the clinic. It became a standard recommendation of the reviewer that these surveys should be used by clinics.⁶²

Clinics tended not to view the site visit process as particularly disruptive. While the presence of quality reviewers in a clinic must be inherently disruptive to some extent, two-thirds of respondents to the QAP's survey of Phase 1 clinics indicated that they felt the presence of the reviewer generally was not very "intrusive" and that the reviewer did not substantially "impede the work of the clinic unnecessarily" during the visit. No one responded that the reviewer was "very much" intrusive.⁶³ Actually, despite the fact that site visits generally took between three and six reviewer days (the latter being a three day visit by two reviewers), only 4 of 63 respondents felt that the site visit was too long and several clinics would have liked a longer visit.

One executive director acknowledged that he and the staff had some initial trepidation about the presence of the reviewer but that the reviewer was very "nurturing" throughout the entire process.⁶⁴ There was

⁵⁸ J. Wahl Interview, *supra* note 18.

⁵⁹ *Director's Report*, *supra* note 49 at 6.

⁶⁰ M. McCormick Interview, *supra* note 18.

⁶¹ Interview by F.H. Zemans with J. Swaigen (Former Quality Assurance Director), (15-16 February 1999).

⁶² *Ibid.*

⁶³ *QA Survey*, *supra* note 57 at 4.

⁶⁴ D. Balderston Interview, *supra* note 56.

overwhelming consensus from the clinics interviewed, and from those that responded to the Phase I survey, that the reviewers handled themselves in a very professional and non-threatening manner.⁶⁵

Following a site visit, clinics are provided draft copies of the reviewer's report and are provided with "an opportunity to question or challenge the accuracy of facts, the validity of findings, and the value or feasibility of recommendations."⁶⁶ Clinics usually required at least six weeks to respond to the report in order for the clinic's board of directors to meet and consider the report.⁶⁷ Swaigen noted, however, that where the report contains "controversial or unpalatable findings or recommendations," several months may be required for the clinic to prepare its response.⁶⁸ After receiving the clinic's response, the QAP makes the appropriate changes to the report and notes any comments or suggestions that it does not accept directly in the report. Of the eleven Phase I clinics, most felt that the clinics' responses to the draft report were appropriately addressed in the final reports.⁶⁹

Each clinic report has tended to include 60 to 80 recommendations for improvement. While this number is quite substantial, some of the recommendations made to date have involved minor procedural issues. For example, frequent recommendations have included stamping the clinic's name, address, and telephone number on all texts in the library and amending its bylaws to use gender-neutral language.⁷⁰ Other recommendations were more significant but would likely have to be implemented over a longer period of time. These recommendations included improving staff morale, recruiting more board members from the low-income community and improving communication between the clinic and the local Bar.

⁶⁵ *QA Survey*, *supra* note 57 at 3. Sixty-two of 63 survey respondents indicated that the reviewer(s) had conducted himself or herself in an appropriate, professional and non-threatening manner, while one person declined to respond to these particular questions.

⁶⁶ *Director's Report*, *supra* note 49 at 18.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *QA Survey*, *supra* note 57 at 5. Of the 40 respondents who indicated that they read the final report, 47.5% indicated that the clinic's response to the draft report was "very appropriately addressed" in the final report and a further 32.5% felt it was appropriately addressed.

⁷⁰ Quality Assurance Program, *Master List of Recommendations Made in the First 23 Draft Reports* (January 1999) [unpublished] at 7 and 17 [hereinafter *Master List of Recommendations*].

To date, the majority of recommendations have been related to specific procedures and policies within the clinic. These have included recommendations that:

1. time management systems (referred to as “tickler systems”) be changed to ensure compliance with Law Society guidelines;
2. amendments be made to clarify aspects of the clinic’s conflict of interest policy;
3. the clinic establish an outside work policy addressing issues that may arise out of outside work by staff members (e.g. conflicts of interest, use of clinic time and resources);
4. a performance evaluation policy be established requiring annual evaluation of all staff members, including the executive director;
5. the clinic produce an office procedures manual for each of its offices or various “station manuals” (addressing, for example, invoice control, office opening and closing procedures, recording of sick leave and other absences, etc.);
6. the clinic consider additional virus protection on its computers;
7. the clinic increase awareness of its complaints policy among clients and visitors by posting a notice in the waiting room and including a reference to the policy in the client’s retainer;
8. telephone access be improved by ensuring recorded messages are updated and that calls are answered or returned promptly;
9. the executive director establish a plan for supervising the work of all lawyers in the clinic, including periodic file reviews; and
10. written standards be prepared for maintaining files and managing cases.

It should be noted that, in many instances, while a recommendation may have addressed a particular issue-related procedure or policy, that should not suggest that that issue was itself a problem for the clinic. For example, the need to revise conflict of interest or outside work policies should not imply that conflict of interest or outside work by clinic staff was a problem in the clinic. It is simply an indication that the clinic’s written policy in those areas did not comply with the Quality Assurance standards.

Encouraging clinics to formalize their procedures and policies is something that can be viewed as one of the most significant contributions of the QAP. Swaigen suggests that there is a great deal of experience among people presently in the clinic system and many of the policies and procedures have been institutionalized to such an extent that they exist more in “peoples’ heads” than in written form.⁷¹ There is anecdotal evidence that these procedural recommendations are being implemented

⁷¹ J. Swaigen Interview, *supra* note 61.

by the clinics.⁷² However, recommendations dealing with issues such as staff morale or board representation are more complex issues that will likely take a longer period of time for clinics to address.

It was acknowledged by the QAP that some of the recommendations for improvement could only be implemented with additional resources.⁷³ An example of this was raised by an executive director who noted that some recommendations relating to clinic security were really dependent upon funding.⁷⁴ Similar recommendations dealt with improving physical access to the clinic.

In addition to commenting on problems that may exist in a clinic and making recommendations to address those problems, reports also document the clinic's strengths and practices where it performs well. This would seem to be an important aspect of the QAP. Reports have provided staff and boards of at least some clinics with a tremendous morale boost. As one executive director stated, after 10 to 15 years in a clinic one tends to think that the clinic is doing a good job but it is nice to have that confirmed.⁷⁵

Clinics also indicated other benefits from the review process. The reports have proved to be useful as a board orientation tool as well as in dealings with staff. One director indicated that the report has been important to legitimize concerns and issues when dealing with clinic staff.⁷⁶ The review was also described as a "self-reflection" process, forcing the clinic to thoroughly assess how well it was serving its clients.

III. ISSUES RELATED TO THE QUALITY ASSURANCE PROGRAM

A. CONFIDENTIALITY AND SEPARATION FROM FUNDING DECISIONS

1. ANALYSIS

The relationship of the QAP to the Clinic Funding Office has been, and continues to be, a major issue of concern for clinics. The manner in which the program has been carried out to date has provided even greater

⁷² *Ibid.* Interviews with Executive Directors of other clinics also support John Swaigen's conclusion that clinics are implementing many of the procedural recommendations.

⁷³ *Director's Report, supra* note 49 at 21.

⁷⁴ T. Hunter Interview, *supra* note 56.

⁷⁵ J. Wahl Interview, *supra* note 18.

⁷⁶ *Ibid.*

confidentiality of reports and information than originally contemplated by the Program Description. No ranking took place of clinics on a Position 1, 2 or 3 basis and consequently the Clinic Funding Office did not receive reports or any information based on a clinic's ranking on this spectrum. Swaigen commented that he found no practical means of implementing such a classification system.⁷⁷ Such a system was described as requiring "a complex method for comparing clinics with each other that would involve manipulating a large number of variables and would involve a high level of subjectivity."⁷⁸

Instead, three circumstances have been identified where problems related to a clinic should be provided to the Clinic Funding Manager. These are where:

1. There is an outright refusal by the clinic to cooperate.
2. The situation at the clinic constitutes an immediate threat to the integrity of the clinic system.
3. The QAP Director sets a timeframe for resolution of a clinic's problems and improvement is not made by the date set by the QAP Director.⁷⁹

In the third case, the problem would only be reported to the Clinic Funding Manager after a final report had been issued to the clinic and the clinic had had a reasonable period of time to address the problem. Prior to this, the clinic would have been made aware of any problems in the draft report and of the possibility that failure to address the issues could result in it being reported to the Clinic Funding Manager. Thus, a clinic has the opportunity at the draft report stage to dispute the existence or seriousness of the problem or the appropriateness of the recommendation.⁸⁰ In order to preserve confidentiality, the QAP could not comment on whether any of these "mandatory recommendations" had been issued or whether any had been reported to the Clinic Funding Office.

The operations of the QAP and the Clinic Funding Office have been described as being separated by a "Chinese Wall."⁸¹ Originally, the QAP was located in a completely separate office but it now is situated down the hall from the Clinic Funding Office. However, to ensure the confidentiality of clinic reports, the QAP has its own locked premises and separate computer network.

⁷⁷ *Director's Report, supra* note 49 at 19.

⁷⁸ *Ibid.*

⁷⁹ *Ibid.* at 20.

⁸⁰ *Ibid.*

⁸¹ Interview by F.H. Zemans with S. Thomas (Clinic Funding staff) (26 January 1999).

Swaigen believes that there is evidence that these policies are working well. As indications of this, he points to the fact that clinics feel that reports and recommendations are fair and useful. He also reports that clinics are responding to the program by making the required quality improvements both before and after site reviews.⁸² Clinicians interviewed for this paper also expressed their opinion that a great deal of the program's success to date can be attributed to the independence of the reviewers.

Despite this, there are some obvious tensions that seem to be inherent in the structure of the relationship between the QAP and the Clinic Funding Office. The fact that the Quality Assurance Director reports directly to the Clinic Funding Manager and has no access to the CFC, other than through the Clinic Funding Manager, raises considerable concern amongst the clinics; the QAP has, itself, expressed concerns about the reporting relationship. There are two major concerns related to this reporting relationship.

The first of these concerns relates to overlap in the mandates of the two offices. This overlap arises from the QAP's mandate to develop and communicate best practices and also to prepare support materials for the use of clinics. At the same time, the Clinic Funding Office is responsible for recommending policies and certificate conditions to the CFC. As Swaigen notes, "the program's unique vantage point sometime[s] provides it with a different perspective on what constitutes a best practice from that of the Clinic Funding Office."⁸³ He adds that:

If the [Quality Assurance] Director is not free to express ideas that may conflict with those of the Clinic Funding staff or communicate with clinics without the prior consent of the Clinic Funding Manager then there is no real separation in relation to these functions.⁸⁴

Swaigen's report indicates that at least three discussion papers have been prepared by the QAP related to best practices or policies for the clinics. Two of these three papers were not distributed to clinics at the request of the Clinic Funding Manager,⁸⁵ indicating that this issue of responsibility for clinic policies and practices does present operational difficulties for the program. The possibility of the two mandates conflicting can also be seen at the individual clinic report level. One clinic indicated that a particular organizational structure that it had in place had

⁸² *Director's Report*, *supra* note 49 at 9.

⁸³ *Ibid.* at 11.

⁸⁴ *Ibid.*

⁸⁵ *Ibid.* at 4.

always been discouraged by the Clinic Funding Office and described as “inappropriate.” The clinic’s report, however, validated the fact that the structure was working very well in that particular clinic.

The second issue relates to the ability of the QAP to deal with matters arising out of the relationship between the clinics and the Clinic Funding Office. The QAP identified specific problems in some clinics that were directly related to their relationship with the Clinic Funding Office. A frequent concern raised by clinics was the poor quality of communications which they had with the Clinic Funding Office. This is a problem that had been previously documented by the *Corlett Report* in 1993 and described as the “black-hole syndrome”—clinics not getting responses from the Clinic Funding Office to queries they might have on various issues.⁸⁶ Reviewers found that this complaint continued to exist among the clinics.⁸⁷ Swaigen also identified as problems both a lack of consultation with clinics before policies were adopted by the Clinic Funding Office and feelings of mutual mistrust between the parties.

Swaigen believes that these problems contribute to unequal resources within the clinic system. Reviewers found that, in some instances, clinics desired certain resources that either they were unaware were available to them or other clinics had. Thus, some of the quality problems identified by reviewers could have been corrected with additional resources some clinics were apparently unaware were available in the system. For example, Swaigen points out that some clinics needed additional storage for closed files but had not requested funds for outside storage in the belief that funds were not available. Yet other clinics had, in fact, obtained funds for the same purpose.⁸⁸

The current structure, however, makes it difficult for Quality Assurance staff to identify these problems within clinics that may be attributable to systemic problems arising out of the Clinic Funding Office. As Swaigen asks rhetorically:

[U]nder the current reporting structure can a QA Director who wants to keep his or her job report honestly on problems to clinics meeting quality objectives that arise from the way the CFO deals with clinics?⁸⁹

⁸⁶ Clinic Funding Committee, *Corlett Report*.

⁸⁷ *Director's Report*, *supra* note 49 at 22.

⁸⁸ *Ibid.* at 24.

⁸⁹ *Ibid.* at 11.

2. RECOMMENDATION

Any quality assurance program implemented or continued under Legal Aid Ontario should ensure that the program reports go to the corporation's committee governing clinics, rather than the committee's staff office. This is clearly the approach advocated by the clinic directors interviewed for this paper; it is also the approach that seems to be suggested by the Director's Report. This structure would help to guarantee the independence of the review process, something that was critical to the acceptance and success of the program to date but which has only been achieved with much difficulty. It could also provide a mechanism for the independent quality assurance review of the clinic committee's staff office. As well, such an approach could help to deal with the issue of responsibility for best practices. As Swaigen suggests:

If the Clinic Funding Manager and the QA Director were required to coordinate their efforts and could submit any irreconcilable differences of opinion to the governing body for resolution overlap and duplication could be avoided.⁹⁰

The Director's Report did attempt to address some of the quality concerns related to the Clinic Funding Office, suggesting that certain policies need to be updated or developed and that improved support should be provided to clinics in areas such as information technology and human resources.⁹¹ These comments were not the product of a formal quality assurance review of the Clinic Funding Office. However, Swaigen suggests that "many of the quality criteria and indicators used by the QA Program could be adapted to evaluate the effectiveness of the CFO and its governance by the CFC."⁹²

Confidentiality of reports should also be maintained under the new regime, except in those extreme instances where disclosure to the funder is required to maintain the integrity of the system. The confidentiality of reports has been a central concern for clinics. While some may argue that confidential quality reviews do little to improve the accountability of the clinic system, the present confidentiality requirements seem to have contributed to the program's success. Clinic staff appear to have been very forthcoming with Quality Assurance reviewers, safe in the knowledge that the review was designed to assist the clinic rather than the funder. Future reviewers could be faced with reluctant clinic staff if funding consequences were linked to quality assurance reviews. Clinics

⁹⁰ *Ibid.* at 11.

⁹¹ *Ibid.* at 25-31.

⁹² *Ibid.* at 25.

might also tend to become more focused on satisfying the demands and wishes of the funder rather than making innovative attempts at improving quality on an ongoing basis.

B. CLIENT FILE REVIEW AND SUPERVISION OF LAWYER'S WORK

Two major issues raised by the QAP that have not abated since its inception relate to the extent to which the work of lawyers should be subject to review. As discussed earlier, the first of these issues concerns whether Quality Assurance reviewers should be permitted to review client files of lawyers working within the clinic system. The second issue relates to the extent to which the work of lawyers in a clinic should be supervised by other lawyers in that clinic.

1. CLIENT FILE REVIEW BY QUALITY ASSURANCE REVIEWERS

(a) *Analysis*

Opposition to the review of client files by QAP reviewers has been based on two grounds. The first concern is a concern by the clinics to preserve solicitor-client privilege. In the reviews that have been completed to date, this concern has been dealt with in one of two ways. In most instances, a retainer system was established between the clinic and the QAP staff whereby the clinic was, in fact, "retaining" the reviewer. The second approach, which was insisted upon by some clinics, required client consent to be provided before the reviewer was allowed to examine the file. One clinic which had obtained clients' consents indicated that only one client refused and that refusal was likely due to the presence of extensive medical records in the file.⁹³ This approach is to some extent an "honour system" because it trusts that the staff member, with the knowledge of which files are to be reviewed during the site visit, will not "clean-up" the file in anticipation of the review.⁹⁴ The reviewers did not view this possibility as a significant problem that in any way affected the integrity of the process.⁹⁵ It should also be noted that the program originally contemplated changes being made to the clinic's funding certificate which would require retainers to include a provision allowing access to the file for quality assurance reviews. To date, this change has not been implemented by the CFC.

⁹³ J. Wahl Interview, *supra* note 18.

⁹⁴ J. Swaigen Interview, *supra* note 61.

⁹⁵ *Ibid.*

The review of client files by Quality Assurance staff has also been objected to on the basis that the Law Society “has the sole obligation and authority to determine issues of competence or professional misconduct within the legal community.”⁹⁶ Curiously, this argument has been advanced more vigorously from those outside the clinic system than from those within it.

The debate has surfaced in relation to the legislation that transfers the administration of legal aid from the Law Society to Legal Aid Ontario. The original draft of this legislation provided for the establishment of a quality assurance program and allowed the new corporation to conduct quality assurance audits, including client file reviews, of any provider of legal aid services. At the request of the Law Society, however, the language of the section has now been qualified to provide that:

s. 92(8): The Corporation shall not itself conduct quality assurance audits of *lawyers* who provide legal aid services but shall direct the Law Society to conduct those quality assurance audits.⁹⁷

The justification offered by the Law Society for this amendment was that the quality assurance program originally contemplated by the legislation:

could lead to a situation in which both the Society and the Corporation would review the competence of a particular lawyer. In this event, the situation could well result in a duplication of efforts and conflicting decisions between the two bodies. Duplication and conflict of this kind would put legal aid lawyers in an impossible predicament: should they follow the dictates of the Society or of the Corporation? Moreover, such duplication could well be seen as a waste of public funds.⁹⁸

This, however, is a weak argument for removing an issue as important as quality from the mandate of the new legal aid corporation. First, it is difficult to envision a situation where the requirements of the Law Society and the Corporation would differ. The goal of the new legal aid corporation’s quality assurance program is to ensure that it is providing “high quality legal services in a cost-effective and efficient manner”⁹⁹ However, as Wain points out:

⁹⁶ Law Society of Upper Canada, *The Law Society of Upper Canada’s Submission to the Standing Committee on the Administration of Justice* (19 November 1998) [unpublished] at 6 [hereinafter *Law Society’s Submission*].

⁹⁷ *Legal Aid Services Act*, *supra* note 14 [emphasis added].

⁹⁸ *Law Society’s Submission*, *supra* note 96 at 6.

⁹⁹ *Legal Aid Services Act*, *supra* note 14 at s. 92(1).

The complaints and discipline system established by the Law Society is not primarily aimed at ensuring the delivery of high quality services to the public on an ongoing basis: it is instead a reactive system which responds to individual transgressions of professional ethics—failing to file required forms, misappropriation of client funds, practising without a licence, and so on...In addition, the complaints and discipline process does not deal with client complaints related to simple negligence unless the lawyer's conduct constitutes a disciplinable offence.¹⁰⁰

The legal aid corporation would presumably be concerned with ensuring quality services well beyond the minimum thresholds set by the Law Society. It is impossible to imagine a situation where a lawyer would be placed in an "impossible predicament" because the Corporation's definition of "high quality legal services" was in conflict with the ethical standards of the Law Society.

Secondly, even if some duplication of the two organizations' mandates did exist, it is unclear how the Law Society's solution would reduce costs of the program. In effect, parallel quality assurance regimes have now been created, particularly in the clinic system. The legal aid corporation will still be responsible for the review of all service providers who are not lawyers. Thus, the corporation will have to carry out reviews of clinics much in the same way that the QAP is currently operating, focusing on issues such as the overall operation of the clinic, its board, its internal procedures and policies, *etc.* However, client file reviews at these same clinics will have to be carried out by a separate body, the Law Society, which will then be reimbursed by the Corporation. It seems that much greater efficiencies could be achieved by the same body conducting both aspects of the review.

As well, in discussing the role of the Law Society in the efficient governance of a legal aid system, the report of the Ontario Legal Aid Review questioned the appropriateness of the Law Society overseeing a quality assurance program:

It is less obvious that the Law Society is well positioned to undertake programs of quality assurance. It might be difficult for the Law Society to undertake quality-assurance programs specifically targeted on legal aid service delivery. In any event, it would appear that comprehensive initiatives of this kind have not been undertaken over the years.¹⁰¹

The new corporation does have the ability to delegate to the Law Society its power to conduct quality assurance audits on service providers

¹⁰⁰ *Supra* note 1 at 616.

¹⁰¹ Ontario, *Report of the Ontario Legal Aid Review: A Blueprint for Publicly Funded Legal Services*, vol. 1 (Toronto: Queen's Printer, 1997) at 247.

who are not lawyers, including clinics.¹⁰² While such a delegation would reduce the duplication associated with having two different entities carrying out quality assurance reviews, it would effectively place the responsibility in the hands of an organization that has little experience and seemingly little interest in monitoring the quality of services provided by persons other than its own members. The Law Society does not appear to be well positioned to undertake this additional responsibility. Interestingly, the only members of Convocation, the Law Society's governing body, who opposed the amendment returning responsibility for quality assurance audits to the Law Society, were those members who had experience within the clinic system.¹⁰³

It should also be noted that section 92(12) of the *Legal Aid Services Act* requires the Law Society to report on the outcomes of the audits that it conducts:

The Law Society shall report to the Corporation on the quality assurance audits conducted by it, as directed or delegated by the Corporation and in accordance with the regulations, and shall include in its reports the information required by the direction, delegation or regulations, whether or not such information is governed by the rules of solicitor-client confidentiality, but shall not disclose any information that is subject to solicitor-client privilege.¹⁰⁴

This section provides the corporation with the authority to determine the issues and information which the Law Society should be examining when it conducts its quality assurance audits of lawyers. Presumably, these directions from the corporation would take the Law Society beyond its traditional approach of ensuring minimum levels of professional competence to examine quality assurance issues.

(b) *Recommendation*

It is important that Legal Aid Ontario implements its own quality assurance program for the clinic system rather than delegate this responsibility to the Law Society. Although it may result in some duplication of clinic review efforts, the Law Society is not well positioned to carry out this responsibility. The quality of legal work done by lawyers within a clinic must be fit within the context of the overall operations of that clinic. To reach a true assessment of whether the system is "providing high quality legal aid services in a cost-effective and efficient manner"

¹⁰² *Legal Aid Services Act*, supra note 14, s. 92(9).

¹⁰³ Interview with D. Millar (Chair of the Clinic Funding Committee), (18 February 1999).

¹⁰⁴ *Legal Aid Services Act*, supra note 14.

both organizations must work closely together to ensure that reviews of clinics and their staff are done in a harmonized rather than piecemeal manner. In order to harmonize the efforts of the both review processes, Legal Aid Ontario should utilize its ability to direct and coordinate the reviews of lawyers carried out by the Law Society.

2. SUPERVISION OF LAWYERS' WORK WITHIN A CLINIC

(a) *Analysis*

One of the most significant issues that has been raised through the QAP is the question of the supervision of lawyers within a clinic. Quality Criterion 7.3 states:

Supervision procedures are appropriate for the needs of the clinic and are applied to all legal services provided.¹⁰⁵

One of the indicators that a Quality Assurance reviewer should look at to assess whether a clinic is achieving this standard is whether:

All caseworkers (including all lawyers) have regular file reviews of all open files with a lawyer. This includes a system for periodically reviewing the files of the executive director.¹⁰⁶

This indicator created sufficient controversy within the clinic system that it led to the development of a discussion paper on the issue of supervision and eventually a new policy from the CFC.

Concern from the clinics on this issue is twofold. First, they believe that "it is wrong in principle to require more supervision of lawyers in clinics than is required for lawyers in private practice."¹⁰⁷ This objection appears based on a belief that freedom from supervision is inherent in the notion of a profession and that how lawyers meet the standards imposed by the Law Society should be left to the lawyers themselves, with enforcement done by the Law Society using a case-by-case, complaint-driven process.¹⁰⁸ If one considers the situation of a lawyer in a firm or other organization (as opposed to a sole practitioner) the issue of supervision is a private matter left entirely to the employer or other partners. In that sense, clinics argue that the manner in which staff

¹⁰⁵ *QAP Manual*, *supra* note 31 at 78.

¹⁰⁶ *Ibid.*

¹⁰⁷ Quality Assurance Program, *Supervising Lawyers' Work: What is an Appropriate Practice for Clinics?* (Discussion Paper, 1998) [unpublished] at 2 [hereinafter *Supervision Discussion Paper*].

¹⁰⁸ *Ibid.* at 5-6.

lawyers' work is supervised should be an issue left to the individual clinic.

The QAP has rejected this ground of opposition to regular supervision of lawyers' work within a clinic for many of the same reasons that it feels a general quality assurance program is needed for the clinics. Its discussion paper on the issue notes that the Law Society's traditional approach to ensuring quality legal services (complaint-based and market-driven) does not work well in the context of providing legal services to low-income individuals. Since clinic clients are often unsophisticated users of legal services, they "may require greater protection from incompetence or inattention than clients of the private bar."¹⁰⁹ The QAP further notes that since the clinic system is supported by public funds, the funder should have the right to ensure that this money is being spent wisely and that clinic clients are receiving quality legal services in return.¹¹⁰

The second concern raised by clinics which oppose a regular system of lawyer supervision, is that the process would be too time-consuming and simply not practical within a clinic. The discussion paper notes that greater supervision will increase workload in two ways. First, time taken in supervising is time that is not available for client representation (the paper concedes that clinics are already having difficulty serving all clients who require their services and are being forced to delay service or turn away meritorious cases because of the clinic's heavy workload).¹¹¹ Secondly, supervision in the form of file review requires lawyers subject to supervision to spend more time documenting what they have done for clients. The discussion paper rejects both of these arguments, emphasizing that any program of supervision can be designed to minimize the amount of time required.¹¹² It also suggests that improved file documentation will provide time savings by ensuring efficient management of files, including the ability of other caseworkers to readily refer to the contents of the file.¹¹³

Drawing on the position of the American Bar Association in its publication *Standards for Providers of Civil Legal Services to the Poor*, the QAP recommended in its discussion paper on supervision that the CFC require that clinics ensure supervision of lawyers' files, including files of senior and experienced lawyers and executive directors. The

¹⁰⁹ *Ibid.* at 7.

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.* at 7-8.

¹¹² *Ibid.* at 8.

¹¹³ *Ibid.*

discussion paper further recommended that this supervision include file reviews done on regular intervals, varying with the expertise, training, experience and past performance of the caseworker. The program of supervision would commence with a complete review of each worker's files and the supervisor would then make a judgment as to the frequency at which future reviews should be carried out for that particular worker. The paper suggested that supervision duties could be divided among clinic lawyers to reduce the time demands which would be placed on any one individual. It was also suggested that the files of executive directors should be reviewed by a senior staff lawyer within the clinic or an executive director or senior lawyer from another clinic (provided that appropriate mechanisms are put in place to ensure confidentiality).¹¹⁴

To emphasize the importance of supervision and file review within the clinic system, the discussion paper noted the experience of Rural Legal Services of Tennessee:

Since Rural Legal Services of Tennessee began serving clients in 1978, the most effective measure taken to improve the quality and volume of representation has been to conduct complete, periodic reviews of each attorney's and paralegal's open case files. This system has virtually eliminated inactive cases, reduced delay in case handling, improved documentation and file maintenance, improved communication among offices, improved the planning and preparation legal workers apply to their cases, and, in general, reduced the anxiety legal workers feel about their caseloads.¹¹⁵

Subsequent to the release of the QAP's discussion paper, the CFC adopted a Clinic Supervision of Legal Aid Services Policy. The key elements of the policy are that:

1. All advice and brief services provided to clients by non-lawyers shall be reviewed promptly by a lawyer, preferably on the same day but at least within 7 days.¹¹⁶ Community legal workers shall have file reviews at least every two months while other caseworkers (including law students and articling students) shall have file reviews at least every month, in accordance with their individual supervision plans.¹¹⁷
2. The executive director shall review on a random spot check basis the advice and brief services provided by other lawyers at least

¹¹⁴ *Ibid.* at 15.

¹¹⁵ N.G. McBride, "Improving Quality Representation: Complete, Periodic Reviews of Open Cases" (1987) 21:3 Clearinghouse Review at 254-257.

¹¹⁶ Clinic Funding Committee, Draft Clinic Supervision of Legal Aid Services Policy (1999) s. 3.1 [hereinafter Supervision Policy].

¹¹⁷ *Ibid.* at ss. 7.2 and 7.3.

every four months, in accordance with their supervision plan.¹¹⁸
 A minimum of five records for each lawyer shall be checked.¹¹⁹

3. The executive director shall assess the experience, knowledge, skill and performance of each caseworker and develop and maintain a current written supervision plan for each caseworker, in consultation with the caseworker and his or her supervisor.¹²⁰
 The plan must involve the review of open files, including the physical inspection of at least those files selected on a random basis.¹²¹
4. A supervisor will be assigned to each caseworker to carry out the file reviews. In addition, the executive director shall review at least 3 randomly selected closed files of every caseworker a minimum of once every six months.¹²²
5. The supervisor shall authorize the opening and closing of each file for every caseworker who is not a lawyer or CLW and for every lawyer and CLW with less than two years' experience.¹²³
6. The supervision plan must achieve the following goals:¹²⁴
 - (a) Caseworkers are sufficiently knowledgeable about the areas of law in which they are practising and are providing high quality legal services.
 - (b) File work is satisfactory or any deficiencies are noted in the supervisor's records, along with the supervisor's comments and recommendations for remedying the deficiencies.
 - (c) A series of file management requirements set out in an appendix to the policy are met. Examples of these requirements include that there are copies of all correspondence on file, there is a memo to file on every telephone call, interview and other written communication and that the file has proceeded at a reasonable pace without lengthy delays due to the caseworker.¹²⁵

The policy does not deal with the more difficult issue of the supervision of executive directors, instead noting that "that supervision

¹¹⁸ *Ibid.* at s. 7.1.

¹¹⁹ *Ibid.* at s. 3.2.

¹²⁰ *Ibid.* at s. 4.1.

¹²¹ *Ibid.* at ss. 4.2, 4.3.

¹²² *Ibid.* at ss. 4.4, 4.5.

¹²³ *Ibid.* at ss. 8.1, 8.2.

¹²⁴ *Ibid.* at s. 6.1.

¹²⁵ *Ibid.* at Appendix B.

issue is left to be addressed as a component of the QA program, or by way of [Legal Aid Ontario] standards or policies."¹²⁶

The primary concern expressed by the clinics which were interviewed for this paper with respect to supervision was that the suggested formal supervision procedure required too much of clinic staff's time.¹²⁷ While one executive director admitted that supervision through file review has helped to standardize the work done in his clinic, he noted that the process has been very time-consuming and that the wide-spread opinion among executive directors is that clinics will not be able to handle as large a caseload with the proposed supervision requirements.¹²⁸ Another executive director echoed the belief that the process was too time-consuming, noting that the clinic has tried to implement an effective supervision process which is not quite as rigorous or formal as that suggested by the QAP. This particular process consisted of Monday morning meetings of all clinic lawyers. Each week a different lawyer has been expected to go through his or her caseload and discuss what was being done on each case. When the Quality Assurance reviewer noted that this was not sufficient supervision, the clinic took further steps to ensure one-on-one review of each other's files in the clinic. For example, three lawyers responsible for summary intakes will review each other's files while the executive director and another lawyer will each review the other's files. While this seems like a practical solution to ensure an effective level of supervision within the clinic, it is unclear whether such a procedure will satisfy the requirements of the new CFC policy.

(b) Recommendation

It is important that supervision procedures be put in place in clinics, but these procedures should not be too rigidly imposed on clinics. Clinics should be free to implement procedures that take into account the practical realities of the clinic environment. If clinics can demonstrate to QAP reviewers that the systems they have in place are adequate to ensure that a sufficiently high-quality of legal services are being provided, then those supervision procedures should be adequate. A formal supervision procedure imposed by the funder leads to a situation where QAP

¹²⁶ *Ibid.*

¹²⁷ The Executive Directors which were interviewed were responding to the QAP's discussion paper on supervision and recommendations on supervision that had been provided to the individual clinics through the clinic review process. The Executive Directors were not yet aware of the CFC's new policy.

¹²⁸ T. Hunter Interview, *supra* note 56.

reviewers are ensuring compliance with minimum standards rather than making a practical assessment of whether the clinic is achieving its goals.

C. ENFORCEMENT OR FACILITATIVE FOCUS OF QUALITY ASSURANCE

1. ANALYSIS

The focus of the QAP to date has been on facilitating quality improvements in clinics rather than enforcing minimum standards. This approach has contributed to the acceptance of the program by clinics. Clinics have responded positively to the reviews and, at least in some instances, have used the process as a self-reflection exercise. Some clinics have even requested that reviewers look at certain files in order to obtain feedback.

2. RECOMMENDATION

The present system seems to have encouraged quality improvement in the clinic system. To sustain this improvement, a facilitative approach should be continued. Some measure of enforcement is important, particularly in instances where the credibility of the clinic system is at stake, but it should not be the focus of a quality assurance program within the clinic system. The program should continue to strive for ongoing quality improvements and, to this end, should supplement its review efforts with the development of best practices and other resources to assist clinics.

D. SUSTAINABILITY OF THE PRESENT PROGRAM

1. ANALYSIS

Clearly, the QAP has been a more labour-intensive process than originally contemplated by the Program Description. While reviews were originally planned for each clinic every two years, the program has only managed to review 26 of the 70 clinics in the first 18 months of its existence. Even accounting for the growing pains that might be expected with a new program, it is unlikely that the time needed to complete reviews will substantially decrease in the future. McCormick and Swaigen both indicated that quality criteria will evolve over time and that different things are likely to be looked at in subsequent visits to the same clinics (rather than just confirming that things have not changed substantially since the last visit).¹²⁹ In addition, if the program intends to place an even greater focus on developing best practices and system-wide reporting,

¹²⁹ M. McCormick Interview, *supra* note 18 and J. Swaigen Interview, *supra* note 61.

further time pressures will be placed on the site visit and report writing functions of program staff.

As Swaigen suggests, decisions will have to be made as to:

[W]hether to take longer than two years to carry out clinic reviews with existing resources, employ additional reviewers, or dilute the quality of the product by speeding up and shortening reviews and reports...In my opinion, at this time the clinic system will obtain greater value from the QA Program if it continues to do reviews in depth rather than perfunctory ones and spend much of its time producing best practices and support materials, as well as assisting with training, and carrying out similar functions, than if it is focusing all its energies on individual clinic reviews.¹³⁰

The quantity of resources available for an ongoing QAP under the new legal aid regime is uncertain. Given that Legal Aid Ontario has a specific mandate to implement a quality assurance program, resources will have to be committed to the program. However, one would anticipate that those resources would not allow for the employment of more than two or three reviewers of the experience and calibre of Swaigen and McCormick.

The clinic experience of the reviewers has been cited as a critical factor in the QAP's success and acceptance by clinics. It is important that clinic reviews continue to be headed up by reviewers with experience in the clinic system. There is no reason, however, that these efforts cannot be assisted by more junior reviewers. McCormick concedes that on some of the more "mechanical" aspects of the client file review, a well-trained non-lawyer could carry out the work.¹³¹ Collecting and reviewing policies and procedures could be done by such a junior reviewer while interviews and discussions with clinic boards and staff could be conducted by the more senior reviewer, preferably a lawyer with clinic experience.

The concern with the use of non-lawyers, such as CLWs or paralegals, is that their use might shift the focus of the QAP to enforcement of minimum standards (*i.e.* standards that can be easily and uniformly applied to clinics). The danger expressed by one executive director is that such an approach might overlook and eventually discourage innovation in clinics.¹³² This is a valid concern. If the QAP is to take a facilitative approach to its task, the ultimate responsibility for site visits and reports must rest with reviewers who have experience working in the clinic system. It will ensure acceptance of the program by the clinics and it will

¹³⁰ *Director's Report, supra* note 49 at 13.

¹³¹ M. McCormick Interview, *supra* note 18. Ms. McCormick maintains that legal expertise is preferable for file reviews.

¹³² T. Hunter Interview, *supra* note 56.

result in clinic reviews that have a more well-rounded assessment of the strengths and weaknesses of the clinics. However, greater use can be made of non-lawyers in an assisting role to alleviate some of the time pressures faced by reviewers.

Such assistance from CLWs or paralegals could also assist in the development of best practices, support materials and training. These are all important aspects of the QAP that Swaigen is correct in asserting should not be neglected in favour of more frequent clinic reviews. If the system is to be supportive and facilitative, the QAP must assist clinics in making ongoing improvements, rather than just identifying what improvements need to be made.

2. RECOMMENDATION

With limited resources, a balance must be struck between the various aspects of the QAP. The depth and quality of clinic reviews should not be compromised by increasing the frequency of reviews. Comprehensive reviews on a three to four year cycle should be sufficient to ensure the QAP is carrying out its mandate. The composition of QAP staff should be broadened, however, to include more junior reviewers, such as CLWs or paralegals, to assist two or three lawyers with experience in the clinic system, serving as senior reviewers.

IV. CONCLUSION: IS IT WORKING?

A. IMPROVEMENTS IN THE OPERATION OF CLINICS

The clinic system's QAP is the first attempt in Ontario to monitor the quality of legal aid services on a continuous, ongoing basis. From the anecdotal evidence available, it is a fair conclusion that the program to date has had a beneficial effect on individual clinics and the clinic system as a whole in Ontario. Though there are some serious issues that must be resolved in the future, particularly as management of legal aid is transferred to Legal Aid Ontario, the clinics have nevertheless responded positively to the program. As the Quality Assurance Sub-committee of the Association of Community Legal Clinics of Ontario (ACLCO) recently advised the Transitional Board of the Ontario Legal Aid Plan, "there is strong support for quality assurance in the clinic system and...the current program has been very positively received and accepted."¹³³

¹³³ Letter of D. Balderston (Chair of the Quality Assurance Sub-Committee of the Association of Community Legal Clinics of Ontario) to Legal Aid Ontario, Transitional Board (20 January 1999).

Much of the program's initial success can be attributed to the people involved in its initial implementation. John Swaigen and Mary McCormick succeeded in implementing the program in a sufficiently flexible manner to address the needs and trepidations of the clinics without compromising the integrity of the exercise. By making the review process transparent for the individual clinics and making the implementation process transparent for the system as a whole, the QAP staff have been ensured the trust and respect of the clinics. This was further enhanced by the program's commitment to preserving confidentiality with respect to the Clinic Funding Office. With clinics obviously concerned about the potential for funding decisions to be linked to quality assurance reviews, the Quality Assurance staff worked within the existing employment relationship between itself and the Clinic Funding Office while maintaining a fair degree of separation and independence.

The Quality Assurance staff has also helped to maintain the program as a supportive and facilitative endeavour and not as an enforcement mechanism. Clinics appear to have responded to the program by taking not only reactive, but proactive steps as well to ensure compliance with quality assurance criteria. Given the structure of the program and the comments received from clinics, this response to recommendations from the Quality Assurance staff appears motivated by a legitimate concern for quality improvement within the clinic rather than fear of potential funding consequences if recommendations are not implemented.

Four benefits of the QAP are apparent from the first two years of its existence:

1. *It has facilitated operational improvements in individual clinics.* The program has helped clinics to identify aspects of clinic operations and procedures that require improvement and has helped them to identify methods to implement these improvements. It has helped some clinics to formalize policies and procedures that previously may not have been in place or may simply have been institutionalized by long-time staff members.
2. *It has provided a morale boost to at least some clinics.* Executive directors indicated that the reviewer's report provided a morale boost for clinic staff by noting areas in which the clinic excelled. Executive directors and staff often saw the reviewer's comments as validation of the good work that the clinic had been doing. Such a morale boost has been particularly important at a time when the clinic system has been under increasing financial pressures and clinic staff have been faced with wage freezes.

3. *It has empowered boards of directors.* The quality assurance review has been identified by clinics as a powerful tool for their boards of directors. The review has been cited as a useful self-reflection exercise for boards, as well as staff. Boards appear to have been active in overseeing improvements in clinic operations both before and after the formal review and report by Quality Assurance staff. Reports, which present a fairly detailed examination of the clinic's day-to-day operations, can also serve as helpful educational tools for board members, providing them with a better understanding of the clinic's functioning.
4. *It has improved the amount of client feedback.* Quality Assurance staff have noted the increased emphasis that clinics have placed on soliciting client feedback. A number of clinics have been conducting formal surveys of clients designed to measure the level of satisfaction with the clinic's services. In addition, Quality Assurance reviews have included limited interviews with clients and other stakeholders within the community, providing the clinic with feedback as to how well the clinic is perceived to be carrying its mandate within the community.

B. INCREASED ACCOUNTABILITY

The QAP has also improved the accountability of individual clinics and of the community clinic system as a whole. The need for improved accountability was cited as one of the primary motives behind the QAP.¹³⁴ At least one executive director clearly felt that a greater degree of accountability needed to be built into the overall clinic system and that the QAP has been a positive step in that direction.¹³⁵ However, while the separation between the Clinic Funding Office and the QAP has helped to ensure the acceptance of the program by clinics, one may argue that it has also limited the degree to which clinics may be held accountable if their reviews identify problems. The concern to ensure "value for money," identified by Paterson and Sherr as the popular perspective from which quality has been defined in most jurisdictions,¹³⁶ is perhaps not addressed in a system where the results of quality assurance audits are confidential and are only provided to the funder in extreme circumstances.

¹³⁴ For a discussion of the motives behind the QAP, see section I.B. above "The Origins of the Quality Assurance Program in the Clinic system."

¹³⁵ D. Baker Interview, *supra* note 56. David Baker noted that he had been critical of the CFC in the past for not having done more audits of clinics.

¹³⁶ A.A. Patterson and A. Sherr, "Quality Legal Services: The Dog That Did Not Bark" in Regan et. al., *The Transformation of Legal Aid: Comparative and Historical Studies* (Oxford: Oxford University Press, 1999).

Swaigen's report has provided a certain level of accountability for the clinic system, as has the publication of the comprehensive list of recommendations made to clinics. While Swaigen's report focused on issues related to the design and implementation of the QAP itself, it did take the opportunity to comment on the "Strengths and Weaknesses of the Clinic System."¹³⁷ This report was provided to the CFC, providing the committee with at least a general assessment of the overall quality of services being provided within the clinic system. The master list of recommendations made to the clinics also identified recurring areas where improvements were required in clinics. In his report, Swaigen concludes that:

The biggest barrier to improving quality in the clinic system is the lack of resources for clinics. Without more resources, it will be difficult for clinics to identify emerging legal needs or meet them. Nevertheless, my contact with the clinic system convinces me that the public is getting very good value for its money.¹³⁸

The report identifies areas commonly needing improvement in clinics. These include: time management systems that do not comply with Law Society guidelines; inconsistent file management procedures; wide disparities in walk-in and telephone access between clinics; and poor staff relations in some clinics.¹³⁹ The report also noted that some clinics serving large geographic areas have difficulty reaching out or providing services to clients outside the city or town in which the clinic is located.¹⁴⁰

Swaigen notes that there are systemic barriers directly related to the CFO and the CFC that impair clinics' ability to achieve quality criteria. These barriers include poor communications and mutual mistrust between the CFO and clinics, a lack of consultation with clinics before decisions are made and unequal access to resources.¹⁴¹ Although Swaigen chose to comment on these issues in his report, it remains difficult for the QAP to address these issues given that it does not have a formal mandate or mechanism to review the functions of the CFO or CFC. Both the CFO and CFC play vital roles in the overall functioning of the clinic system and therefore should be a factor in assessing whether the public is receiving "value for money."

¹³⁷ *Director's Report, supra* note 49 at 20-22.

¹³⁸ *Ibid.* at 31.

¹³⁹ *Ibid.* at 21-22.

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.* at 22-25.

It appears that the QAP has had a strong impact in improving accountability at the community level. Each clinic's board of directors, which is responsible for the operational policy of the clinic, is provided with a copy of the clinic's report. By providing clinic boards with an independent assessment of the clinic's operations, accountability of clinic staff to the board of directors, comprised of volunteer members from the community, has been enhanced. Anecdotal evidence suggests that clinic boards are using the quality assurance reviews as important tools in carrying out their responsibility of ensuring that the clinic is serving the needs of the community. Further, as discussed previously, the QAP has increased clinic efforts at soliciting client feedback. With clinics beginning to implement fairly sophisticated methods of collecting this feedback, improved responsiveness to community and client needs should result.

There is also no evidence that confidentiality must be compromised in order to achieve some form of public accountability. The present approach has clearly empowered clinic boards of directors and has forced clinics to improve attempts at assessing community and client needs. The CFC also appears to be satisfied with the current approach. Derry Millar, Chair of the CFC, noted that he would rather see system-wide reports and best practices rather than assessments or rankings of individual clinics.¹⁴²

C. CONCLUSION

The QAP has been successful in achieving results at the individual clinic level. In individual clinics the program has: facilitated operational improvements; provided a morale boost to some clinic staff; empowered boards of directors; and improved client feedback. Accountability of clinics to their communities has been enhanced as clinics have been forced to begin soliciting client feedback and clinic boards have been provided with independent assessments of the clinics' operations. This enhanced accountability at the individual clinic level cannot but help improve accountability of the clinic system as a whole.

Clearly, more system-wide reporting would improve accountability of the clinic system as a whole. Although Swaigen's report did make a limited assessment of the overall clinic system, a quality assurance program in the future should focus more on this type of reporting. Individual clinic accountability will likely be adequately addressed through the present process of reviews and reporting but an overall assessment of the entire clinic system on a regular basis will be required for Legal Aid Ontario to carry out its obligation of ensuring "that it is

¹⁴² D. Millar Interview, *supra* note 103.

providing high quality legal aid services in a cost-effective and efficient manner.”¹⁴³ However, without a regular means of evaluating *all* aspects of the community clinic system, there will remain a lack of accountability for the system as a whole. The CFO and CFC must subject themselves to similar periodic and independent evaluations in order to achieve the QAP’s objective of improving the accountability of Ontario’s system of community legal clinics to the public.

¹⁴³ *Legal Aid Services Act*, *supra* note 14 at s. 92(1).