The Unintended Benefits of Innovation:
The Legal Health Check-Up Revisited

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INTRODUCTION

The Legal Health Check-Up (LHC) attracted considerable attention among community legal clinics in Ontario beginning in 2013. The LHC began as a way for clinics to identify people experiencing legal and justice problems by partnering with various community groups to which people go for help with everyday problems. Using a questionnaire designed to draw out the legal aspects of everyday problems, community groups are able to exercise the gateway roles of problem spotting and referral by encouraging the people they assist to complete the check-up and contact the clinic for help with the legal aspects of their problems. The partnerships between these community groups and legal clinics enhanced the capacity of the clinics to reach into the community to identify unmet need that would otherwise remain hidden. This is because many people do not identify the legal aspects of problems they are experiencing or seek appropriate assistance.

This paper reviews the LHC experience in three community legal clinics in Southwestern Ontario since the two pilot projects were carried out between 2014 and 2016. These clinics indicated in an e-mail survey at the end of the phase 2 pilot study that they were continuing to actively promote the LHC within their communities. Other clinics have continued to respond to LHC forms submitted to them and may have more proactively used the LHC.

The LHC has continued to produce a flow of LHC forms identifying unmet need, although in smaller numbers than at the pilot stage. However, the three community legal clinics report that the experience of incorporating the LHC into their delivery models has had a broader, transformational effect on service delivery, changing their practice models toward a more holistic and integrated approach. Their experiences illustrate how innovation not only results from new ideas. A successful innovation may become an active change agent, creating new ways of doing things. This is an important way in which new ideas and practices are adopted at the service delivery level. This highlights the importance of providing sufficient funding to legal aid and private donor organizations with broad justice mandates to support innovation in community legal clinics.

THE LEGAL HEALTH CHECK-UP PILOT PROJECTS

The LHC was first piloted at Halton Community Legal Services (HCLS) in 2014-2015.[1] The LHC involved developing partnerships with service agencies and voluntary associations in the community where people would normally go to for

[1] Ab Currie, Extending the Reach of Legal Aid: Report on the Pilot Phase of the Legal Health Check-Up, Canadian Forum on Civil Justice, Toronto, 2015.

help with their everyday problems. Partnerships reflected the proposition that many of these everyday problems will have legal aspects.

HCLS developed an outreach tool called the "Legal Health Check-Up" (LHC). This was a paper or electronic form that asked questions to uncover everyday legal problems in areas such as housing, education, employment, income support and social and health support. The LHC form was provided to the partner organizations who were asked to administer it to the people that came to them for help.[2] As a result, the partner organizations were able to carry out the gateway roles of problem spotting and referral, identifying people with potential legal problems and referring them to HCLS for help with these legal problems. The partner organizations were "trusted intermediaries" with longstanding records of helping in the community. They were able to bridge the gap of mistrust that often exists between lawyers and disadvantaged people because people coming to them for help were more likely to seek help from HCLS because they were referred by someone they already trusted. [3]

The phase 1 pilot was highly successful. The LHC referrals substantially increased the number of intakes at HCLS by about one third. Following the initial pilot, a phase 2 pilot[4] was carried out with 12 other clinics in Southwest Ontario over a six-month period.[5] This phase was also successful. The 12 clinics developed partnerships with 125 community organizations and received more than 1,700 LHC referrals, although the majority of the referrals came from a small number of all intermediaries.

All intermediary groups that were approached to take part in both phases of the LHC project liked the concept. Most felt that it had the potential to improve their own service to clients and to improve the lives of their clients. However, the results of the research showed that there were problems. Among them were the following.

- intermediaries found the long-form LHC questionnaire too long and time consuming;[6]

[2] An electronic copy of the tool can be accessed here: https://www.legalhealthcheckup.ca/en/.

[3] Curran (2017, p. 51) describes this phenomenon as a "transferal of trust," where the trust the intermediary has in the community legal clinic based on positive past experiences "transfers" to their client.

[4] Ab Currie, Engaging the Power of Community to Expand Legal Services to Low-Income Canadians, Canadian Forum on Civil Justice, Toronto, 2017.

[5] The history of the pilot projects is actually slightly more complicated. HCLS ended its pilot project in January 2015 but the LHC continued. Three clinics, the Legal Clinic of Guelph and Wellington County, the Hamilton Community Legal Clinic and the Community Legal Clinic Brant, Haldimand and Norfolk developed LHC projects. The three early adopter clinics became part of the phase 2 pilot originally involving 13 clinics. Hamilton continued to accept LHC forms but dropped out of the phase 2 pilot, developing a very successful outreach project in which one- and half-day satellite clinics were developed with the original LSC partners plus several other community organizations. HCLS remained closely involved in the phase 2 pilot study assuming a coordinating role.

[6] The original long form Legal Health Check-Up asked about 6 problem areas, income, housing, education, employment, health and family & community services with a total of 60 separate questions. The mini LHC is a

- front line staff in some organizations said they were too busy to administer the LHC; and
- the LHC process sometimes duplicated and to a degree interfered with existing intake and other protocols.

Interviews with representatives of intermediary groups revealed that referrals to the community legal clinics were often made without completing an LHC questionnaire, although the referrals were prompted by it. This suggests that organizations would use the LHC without any formal arrangement after having developed some familiarity with the LHC.

Another unanticipated finding from the phase 2 research was that during the course of the pilot project, approximately 250 LHC referrals not connected with any of the partner intermediaries were submitted to the clinics. The LHC clearly diffused throughout the community beyond the initial formal partnerships between the participating clinics and community organizations. This suggests that the LHC was viewed by some in the community as a practical tool having value to them. The LHC had momentum in the community independent of the formal partnerships formed in the pilot project. Some individuals and organizations in the community learned about the LHC through the normal, diverse channels of communication in the community, saw the value in it and took it up.

For a year following the phase 2 pilot project, the participating clinics and HCLS discussed how a version of the LHC based on the results of the two pilot studies might be implemented. This working group was facilitated by HCLS. The working group agreed that a mini-or short LHC form asking only about broad problem areas would be preferable to the original, longer form. It was agreed that stand-alone mini-LHC forms could be developed for other areas such as youth legal problems. Also, specific problem areas such as human trafficking should be added to the mini-LHC forms to meet community needs or service delivery priorities at individual clinics. The working group was a valuable forum, providing participants with a good way of simply finding out about developments in other clinics and for exchanging ideas.[7]

THE LEGAL HEALTH CHECK-UP SINCE THE PHASE 2 PILOT

The LHC has remained a strong part of the delivery models in the three clinics that indicated they have continued to actively promote it following the Phase 2 pilot. The two graphs below show the level of activity over a two-year period following the end of the phase 2 pilot in late 2016. Figure I shows the number of LHC forms

0ne-page card with only the 6 problem areas. These serve as starting points in a discussion exploring specific problems in an open format approach.

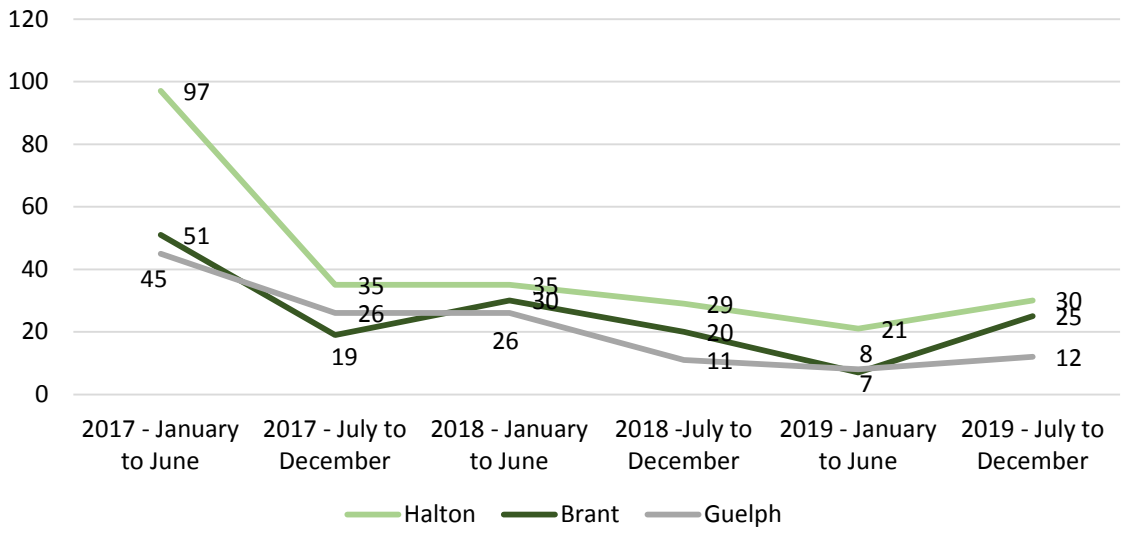
[7] Interview with the Executive Director of the Brant clinic, April 30, 2020

submitted to each of the three clinics in six-month intervals within this period. The 6-month intervals in the graph match the length of the phase 2 pilot study.

During the phase 2 pilot study, the Guelph clinic recorded 58 LHC forms and the Brant clinic reported 54 forms. These numbers are the benchmarks with which to compare the data in Figure 1. Halton did not participate in the phase 2 pilot since it had piloted the project and adopted the LHC into its service delivery approach the previous year. HCLS had carried out the first LHC pilot study the previous year. During that pilot study, 308 LHC forms were submitted to the Halton clinic, either directly from the 7 intermediary groups or on-line through the HCLS website.[8] This is an especially large number of LHC referrals. It may reflect the high degree of intensity with which intermediaries were encouraged to have the maximum number of their clients or constituents submit forms. The high level of effort that was invested in encouraging intermediaries to submit LHC forms may have produced a number that was possibly not sustainable over time under more normal circumstances.

In the 6-month period from January to June 2017, three years after the end of the phase 1 pilot in Halton and two years after the phase 2 pilot in which the Guelph and Brant clinics participated, Halton received 97 LHC forms. Brant received 51 forms compared with 54 forms during the pilot and Guelph received 45 forms compared with 51 forms during the pilot.

Figure I: Reported Number of LHC Forms:
6-Month Periods from 2017 to 2019



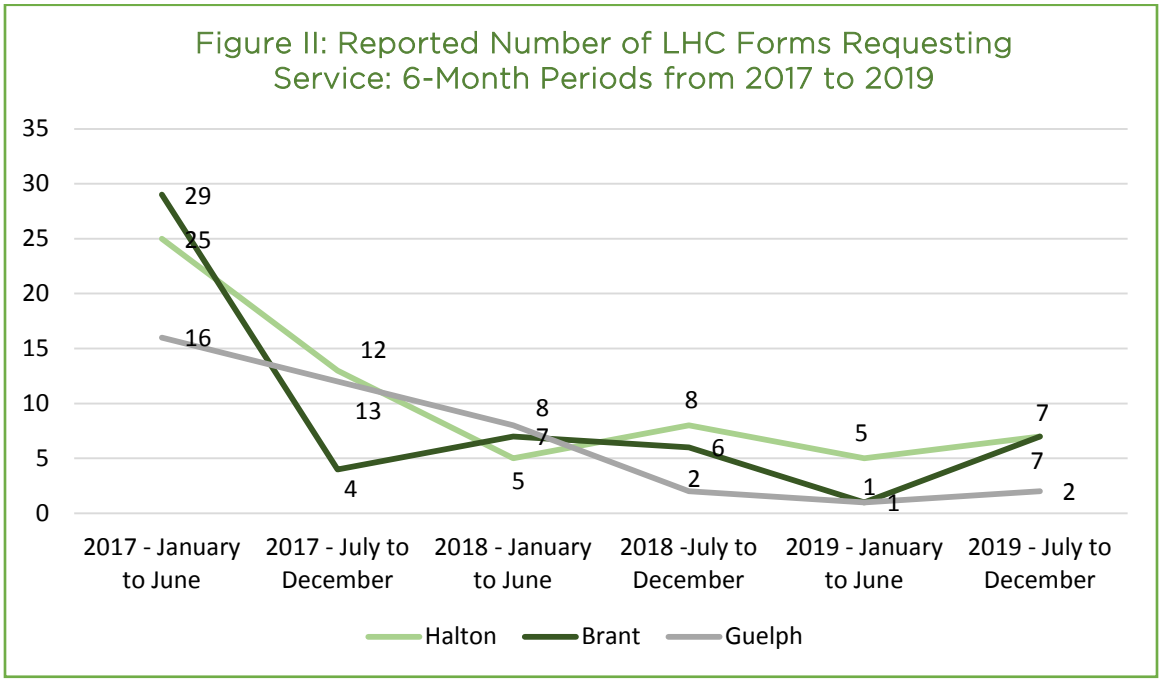
[8] The phase 1 pilot at HCLS was conducted between October 2014 and January 2015, ending when an initial target of 300 LHC forms had been received.

These numbers declined sharply in the last half of 2017 and more gradually up to the end of 2019. The reasons for the similar pattern for all three clinics are not clear. The pattern of decline is more evident when the 6-month numbers from Figure I are converted to annual figures.

Table I: Annual Number of Legal Health Check-Up Referrals			
	2017	2018	2019
Halton	132	64	51
Brant	64	50	33
Guelph	71	37	19

The numbers have declined, but nonetheless represent a substantial number of people submitting LHC forms to the clinics. This is, at minimum, a measure of the continued presence of the LHC in the three clinics' communities.

Not all LHC forms represent immediate requests for service. Figure II shows the number of requests for service associated with the LHC forms.



The requests for service are clearly lower than the number of LHC forms. However, people may delay contacting the clinics, resulting in an undercount of individuals requesting service based on the LHC forms. Acknowledging that an issue is a legal problem may be difficult. People may already be making attempts to resolve the

problem, or they may not yet be ready to tackle it. It is possible that people will initially indicate that they do not want to be contacted by the clinics until they have the motivation to tackle the problem.[9]

THE TRANSFORMATIVE EFFECT OF THE LEGAL HEALTH CHECK-UP

It would be incorrect to conclude that the decreased number of LHC forms at the three clinics represents a lack of success. The fact that the numbers have continued since the end of the pilot studies is an indication that the LHC has remained alive in the community and has some enduring value. More importantly, the LHC became a catalyst for a service delivery transformation at the three clinics. The transformation has moved the clinics away from a primarily transactional, case-based service to a more holistic, integrated, people-focused, community-oriented and trauma-informed service delivery model. The LHC has remained a component of the service delivery model in each of the clinics.

The history of the LHC in the three clinics illustrates how a transformation with its roots in socio-legal research takes place at the service delivery level. The transformative power of the LHC is partially rooted in the fact that the LHC form – as a problem identification and referral "tool" – was conceptually rich, built on the propositions, assumptions and empirical results of the contemporary body of legal problems research.[10] However, the transformations that took place were driven by each clinic's experience with the LHC.

[9] The LHC form includes an offer of service in which the person can ask to be contacted by the clinic. The reasons why people may not want a contact at the time they complete the LHC can be complex. In the phase 1 pilot people were asked why they did not want to be contacted. Some people indicated that they were not ready to talk to a legal advisor at that time.

[10] A large number of people in the population experience justice problems. These are everyday problems with legal aspects or problems with interconnected legal and non-legal aspects. Many people, especially the most disadvantaged, experience problem clusters, multiple inter-related problems that are made more complex and difficult to resolve because they are inter-connected. People may not understand these issues in legal terms; the problems are problems of everyday life and are implicitly understood that way by those experiencing them. People tend to take ordinary actions to deal with everyday problems. People with everyday justice problems often do not seek assistance from appropriate, authoritative sources for a variety of reasons such as thinking there is no help available for that sort of problem, not knowing where to go or what to do. However, people do go to a variety of service and voluntary organizations in the community that provide help with problems. These include government-funded organizations with professional or trained staff such as multicultural services agencies, employment assistance agencies and voluntary associations such as churches in which assistance is provided by volunteers.

FINDING THE "TAO" OF ACCESS TO JUSTICE

The following three sections describe the transformation in service delivery that was brought about in each of the three clinics. The transformation at each clinic is described in different terms to capture the unique ways in which community legal clinics develop different ways of connecting with the communities they serve, although around common themes and objectives. Each clinic, through the experience of carrying out LHC projects that were essentially similar, and through discussion among the clinics about different experiences and understandings, developed new and different ways of connecting with communities and of achieving access to justice.

THE COMMUNITY LEGAL CLINIC OF BRANT HALDIMAND AND NORFOLK[11]

The Executive Director of the Brant clinic describes the pre-LHC character of the clinic as a publicly funded law firm, not much different from any private law firm. The majority of the clinic's work involved representation at landlord/tenant and employment tribunals, using legal means to resolve problems that had clear legal solutions. According to the Executive Director, the experience with the LHC has changed "the way lawyers at the clinic approach their work, how the clinic relates to clients and to the community…You can draw a straight line between the LHC and these changes." The LHC was the beginning of the clinic developing partnerships to identify people with unmet needs and the realization of the potential of developing community ties to a much greater extent.

The first step taken by the Brant clinic to develop a fully client-centered and community-focused service was to hire a community development officer, characterized by the Executive Director as an important staffing decision rather than hiring a lawyer. The community development worker was a person with extensive experience and ties to the community. The more collaborative connections with community organizations made by the community development specialist "changed the very nature of the clinic and how it connects with communities."

The following case provides an illustration of how a person with a legal need came to the attention of the clinic and the new approach for assisting the person. It is a paradigm case illustrating the nature of legal aid in Brant. The straight line referred to in the preceding paragraph was the realization based on the LHC experience that stronger connections with the community had to be developed, leading to the hiring of a community development officer and the collaborative partnerships for assisting clients represented by the example below.

[11] This section is based on an interview with the Executive Director of the clinic conducted on April 30, 2020

The community development specialist (C) was contacted by a nurse at the emergency department of a local hospital, where C had recently done a presentation about the Brant clinic. The presentation by C conveyed the proactive offer of help that the clinic is "not just a legal office; we try to solve problems." The nurse had observed an older man who was coming to the hospital every day. He had no medical issues, but simply had no other place to go. The nurse was concerned about the man, recognizing that he needed help, and contacted C at the community legal clinic in response to her outreach activity. This case would never have come to the attention of the clinic in the past, without the presence in the community that was being built through the clinic's community development strategy. A lawyer at the clinic (L) called the nurse and arranged for the man to talk to him on the phone when he next came to the hospital. The information that was initially revealed on the first call was that the man jointly owned a house with a relative, but was in fear of going there because the relative had told him to stay away. He was sleeping in his car. C and L arranged a conference call, involving the Ontario Provincial Police, the hospital, the Canadian Mental Health Association and the Ontario Housing Help Services to problem solve what was obviously a complex case.

This collaborative approach to problem solving revealed that the relative the man feared had previously asked the police to check the house out of concern for the safety of the man. The house was uninhabitable. The man was a hoarder. All utilities had been cut off because of non-payment of taxes and utility bills. Because the gentleman owned a house he would not normally have been eligible for housing assistance. However, given the unusual circumstances, the group worked out a way to provide the man with temporary accommodation and placed him on a priority list for assisted living. The law could not be applied because the circumstances did not fit, but a good and fair outcome was accomplished. Social justice was achieved.

The Brant clinic continues to do conventional legal work such as representation at tribunals. However, contacts often come through community partners. Assessments of client needs are filtered through the lens of client-centered holistic assessment to detect interconnected multiple problems and the individual's unique personal experience of the problem. This leads to integrated service through collaborative community partnerships. The service is trauma-informed and alert to individuals with complex problems. A new service, the legal secondary consultation (LSC),[12] followed naturally from the LHC. That aspect of the service delivery approach at Brant provides advice to service providers in community services and voluntary associations, assisting them to better help people who come to them for help.[13]

[12] In Brant legal secondary consultation is called the Agency Consultation Program. However, to be consistent with the other clinics LSC is used

[13] Ab Currie, Legal Secondary Consultation: How Legal Aid Can Support Communities and Expand Access to Justice, Canadian Forum on Civil Justice, March 2018.

HALTON COMMUNITY LEGAL SERVICE[14]

At HCLS, the LHC has become the basis for "a way of looking at things," guiding the development of a new infrastructure for providing service. The Executive Director expressed the service delivery approach of the clinic in the following way: "We come to you. We help you in a way that makes sense to you."[15] This is by no means new in the field of access to justice. It is similar to the *no wrong door, no wrong number* policy famously stated in an Australian access to justice policy report in 2009[16] and since widely borrowed as a no wrong door statement in a number of areas of public policy. Similar to the paradigm case illustration of the approach to service delivery at the Brant clinic, this draws access to *legal* justice closer to access to *social* justice.[17] It captures the essence of outreach; going out to the community to learn about the problems experienced by people and then partnering with that community to resolve problems. Importantly, it extends outreach by engaging the resources of the community to resolve legal problems by forming collaborative partnerships between the legal clinic and community organizations.

The Executive Director of HCLS said that because of the clinic's experience with the LHC "we have changed the infrastructure of the way we practice. This would not have happened without that (the LHC) experience." This service delivery infrastructure that has developed now includes, in addition to the LHC, a number of outreach components:

- HCLS has developed co-location relationships with several social services located in the larger building it currently occupies. This has produced a steady flow of referrals from these agencies.[18]
- The clinic has developed satellite intake locations at library branches, food banks and other places where people go for other purposes.
- The clinic has developed a community court outreach project.
- The clinic delivers PLE sessions to a large number of community groups.
- A major three-year PLE project is providing information to newcomers. This is an interactive form of PLE encouraging participants to talk about problems they are having in the area of law covered by the session, providing information about other community organizations where help is available and encouraging them to request assistance from the legal clinic.

[14] The following section is based on two telephone interviews with the Executive Director of HCLS, February 13 and March 8, 2020.

[15] Telephone Interview, March 8, 2020.

[16] A Strategic Framework for Access to Justice in the Federal Civil Justice System, Access to Justice Task Force, Attorney General's Department, 2009. Chapter 6.

[17] Rebecca L. Sandefur, Access to What?, Daedalus, the Journal of the American Academy of Arts and Sciences, 148 (1) Winter 2019

[18] In 2017 the clinic moved office from the small township of Georgetown to the much larger urban center of Oakville.

- LSC[19] is a major part of the HCLS delivery approach that grew out of the LHC. In the original LHC project, community organizations carried out the two basic functions of problem spotting and referral using the LSC questionnaire as a tool. The LSC project invites community organizations that assist clients or constituents to contact the clinic for a consultation in cases where they think a legal issue might be involved. This is a highly successful project that has attracted a wide variety of community organizations and has maintained a stable number of requests for consultations in the two years following the pilot study.

These projects grew out of the clinic's experience with the legal health check-up. They make up a tapestry of projects that grew organically from the understanding of justice needs that reflected the underlying principles and rationale of the LHC. They arise from a continuous process of engagement with the community in which the needs of the users or clients of their service are expressed by organizations through dialogue with the clinic and the clinic responds with service that matches the requirements of the organizations. They are products of the capacity and resources of the clinic and of the needs and the characteristics of the community. Importantly, this tapestry of service delivery approaches is a result of an organic process, from the directions that emerge from the ongoing strategic outreach, rather than an *a priori* empirical portrait of the nature and extent of unmet needs or legal problems drawn from a survey or some other quantitative data source.

INCREASE IN THE LEVEL OF SERVICE[20]

As changes in service delivery have occurred at HCLS, the number of people served has increased. These two measures indicate the substantial increase in the level of service provided by HCLS during the period following the LHC pilot. They provide evidence of the transformation in service delivery described by the Executive Director as having been inspired by the LHC. While not direct evidence of the effect of the LHC, they are highly consistent with that narrative.

The two graphs below show measures of the increased level of service at HCLS over the past 5 years. Figure III reveals a 690.9 % increase in the number of PLE sessions provided to the community, from 11 in 2015-16 to 87 in 2019-20.

[19] Ab Currie, Legal Secondary Consultation: How Legal Aid Can Support Communities and Expand Access to Justice, Canadian Forum on Civil Justice, Toronto, 2018

[20] A special thanks is owed to Giulia Reinhardt, the Executive Director at HCLS, for providing the data. The numbers could not be extracted from the province-wide case management system and were extracted from separate reports. These data were not available from the other two clinics.

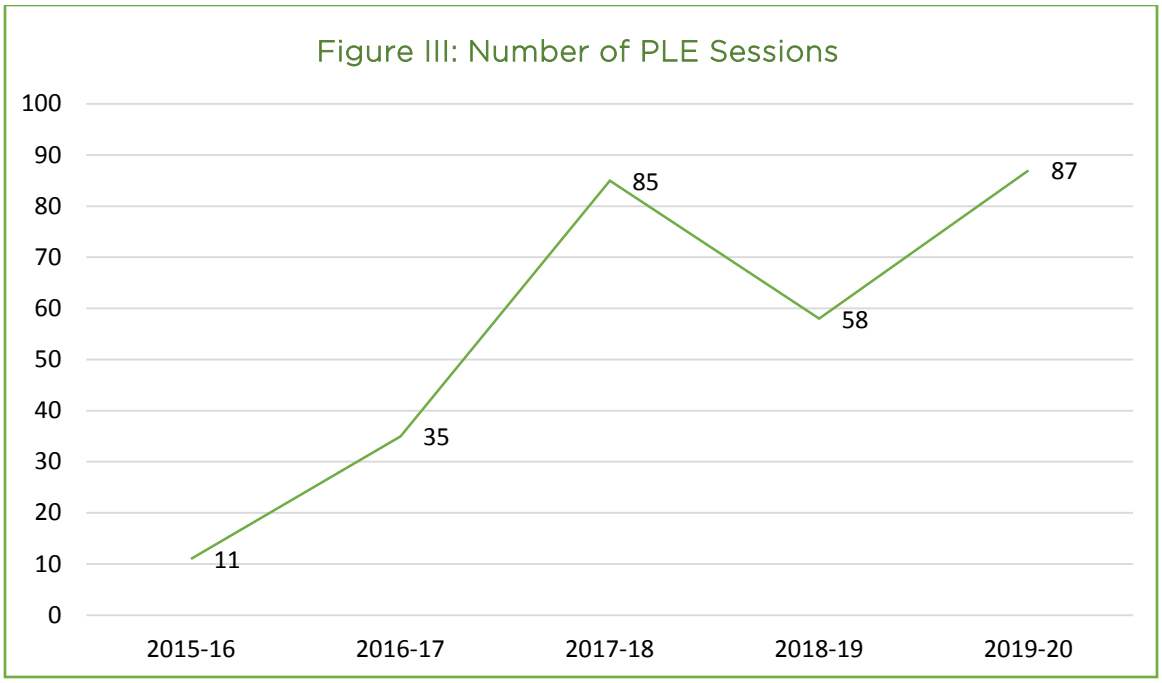
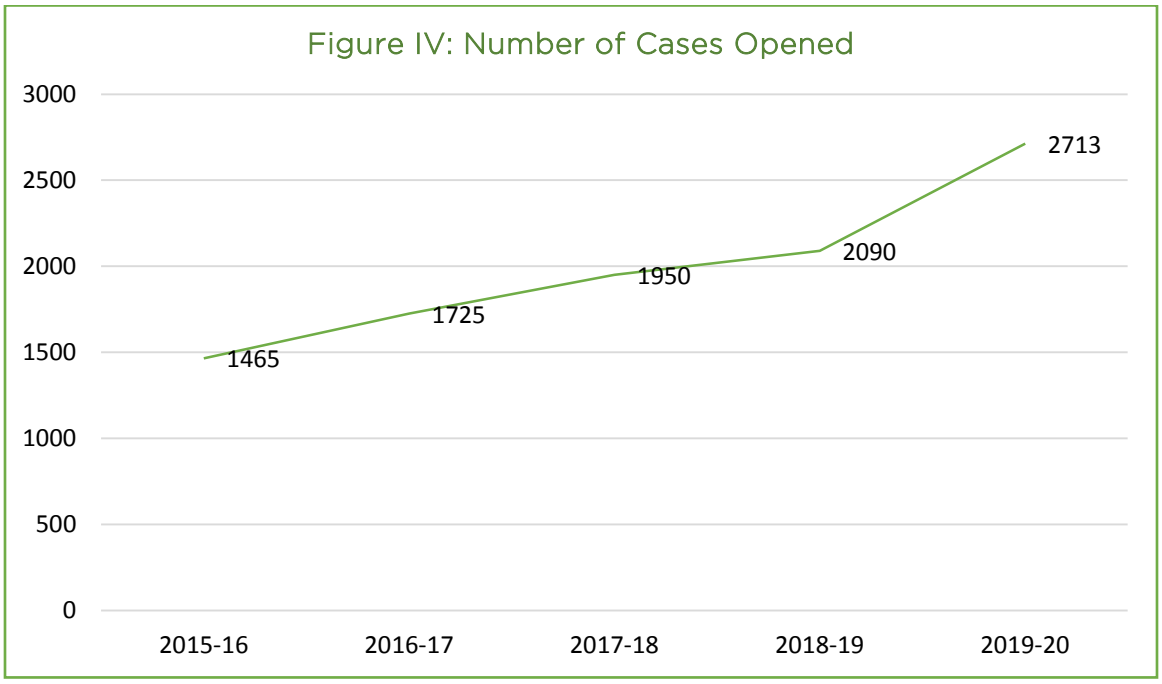


Figure IV shows the overall increase in cases opened over the same 5-year period. The number of cases opened increased from 1,465 in 2015-2016 to 2,713 in 2019-2020, an 85.2% increase.



THE LEGAL CLINIC OF GUELPH AND WELLINGTON COUNTY[21]

Similar to the Halton and Brant clinics, the LHC has transformed the way in which the Guelph clinic works with clients. Since the phase 2 pilot study, the clinic has remained in contact with the original intermediary groups involved in the pilot and has expanded the range of contacts with community organizations. The clinic is located in the Guelph Community Health Centre, co-located with several other community services, enabling referrals and integrated services.

In 2019, Guelph developed a highly successful pilot project to increase access to legal aid services to rural Wellington County.[22] For a period of 6 months, the van made one-day visits in 12 communities throughout rural Wellington County. The van was parked in a place in each community in a conspicuous location intended to attract people by displaying highly visible signage advertising free legal help. One of the main features of the project was the holistic style of contact with people approaching the van that was explicitly modeled on the LHC. People visiting the van to discuss a problem were asked about other issues with which they felt they might need help. This follows the lesson learned in both the phase 1 and 2 pilots that the LHC form is the starting point of a conversation with a client and it can serve as the foundation of holistic intake. During the course of the pilot project, a strong network of referrals to and from community groups was developed. These networks of referral provided integrated service based on relationships with a range of community partners.

LSC was also adopted as an element of the service delivery approach, in parallel with similar projects in the Halton and Brant clinics and, as in those clinics, it developed out of the experience with the LHC. The LHC was built on connections with community partners to carry out problem spotting and referrals. LSC provides advice to community partners, providing them with advice that will enable them to better assist people who come to them for help. As in Halton and the Brant clinic, the Guelph clinic has similarly developed a more holistic, integrated, client-centered, community-focused and trauma informed way of assisting clients. A direct line can be drawn from the LHC to LSC, and to mobile service delivery to rural areas. The LHC continues as a distinct part of the service delivery approach at the Guelph clinic.

[21] The information in this section is based on a telephone interview with the Executive Director of the Legal Clinic of Guelph and Wellington County on March 8, 2020.

[22] Ab Currie, Someone Out There Helping: Final Report of the WellComS Mobile Van Project, Canadian Forum on Civil Justice, Toronto, 2019.

THE CONTINUED ROLE OF THE LEGAL HEALTH CHECK-UP

The LHC continues to play a significant role as a component of the overall service delivery models at the three clinics. As well, the LHC has the potential to generate increased numbers of referrals, although its contribution to a stronger community development approach to community legal service is important in itself.

THE LEGAL HEALTH CHECK-UP AS A "CALLING CARD"

The numbers of referrals generated by the LHC appear to be lower than the pilot project levels in all three clinics. While the numbers may accurately represent the number of LHC forms that are submitted and that can be counted, it is possible that the numbers are underestimates of the full impact of the LHC. The phase 2 pilot study showed that community organizations were sometimes referring people to the clinics without completing the LHC, although the referral came as a result of the use and influence of the LHC in the organization. However, the LHC appears to play an important role in the on-going outreach strategy carried out by the clinics. The LHC can serve as the clinic's "calling card." At PLE sessions or public information sessions at which participants are informed about the approach taken by the clinic and the services provided, the LHC may be a good tool to serve as a basis for explaining the everyday legal problems concept, the holistic approach taken by the clinic and the proactive offer of service.

When given an explanation of the nature of HCLS' service during the phase 1 pilot, a key informant from one of the intermediary groups, *Voices for Change*, an organization of people with lived experience of poverty, responded: you must be "a different kind of lawyer."[23] In general, the LHC seemed to represent a view that is different from the image of the lawyer in popular culture. Based on the *Voices for Change* interview in the phase 1 pilot, an understanding of the overall approach represented by the LHC was a starting point for building a sense of trust between disadvantaged communities and lawyers. The interview suggested that disadvantaged people mistrust social service bureaucracies that are perceived to have treated them unfairly, applying rules that do little to improve their situation. Lawyers may be included along with all authority figures in that circle of mistrust. When asked about people not asking for assistance from the clinic even though she or he had problems, one of the respondents from *Voices for Change* talked about a respondent who feared revealing her situation to a lawyer. She had included some misrepresentations on the application for disability support and feared that if a lawyer found out he would pass on the information about her indiscretion to social services. A discussion of the LHC with community groups can

[23] See footnote 21.

be the framework for engaging and educating the community and building a sense of trust.

COULD THE NUMBERS OF THE LEGAL HEALTH CHECK-UP REFERRALS BE INCREASED?

The initial objective of the LHC was to identify people with undisclosed or unrecognized legal problems in the community and have these people referred to community legal clinics for assistance. The decline in the number of referrals based on LHC forms in all three clinics leads to a consideration of whether the number of LHC referrals could be increased. However, the data for HCLS show that the number of referrals to the clinic has increased substantially over the past five years, even though the number of LHC referrals has decreased.

A specific focus on increasing LHC referrals may not be as important given the broader transformation that developed from the LHC and of which the LHC remains a part. This said, it might be possible to adopt a dual focus for the LHC, concentrating on a smaller number of organizations while, at the same time, retaining the focus on community-wide diffusion. The results of the phase 2 research showed that in every participating clinic at least 60% of all LHC forms were submitted by only two or three intermediaries. One strategy for re-focusing the LHC would be to carefully select a small number of intermediaries, taking care to adjust the LHC process so it is a good fit with the objectives, capacity and organizational processes in the intermediary organizations. As an approach to identifying a broader segment of community needs, the success of this strategy would depend on whether a few organizations could be recruited that serve relatively large numbers of diverse, disadvantaged groups and whether they could be recruited as partners. This could be done while, at the same time, retaining the more community-wide "calling card" emphasis.

It might be possible to use social media to disseminate the LHC more broadly throughout the community. With active promotion by the three clinics, the LHC has circulated within the community for years following the end of the pilot studies. When both phase 1 and 2 pilots were being developed, all partner community organizations indicated that they saw value in the concept and felt that it would improve their ability to better serve their own clients. It is not surprising that the LHC concept diffused throughout the community during the phase 2 pilot. This leaves open the possibility that a mini-LHC might be a good outreach tool. This could serve as a tool to partner with particular organizations, as was the case with the original approach, and also to engage organizations and individuals in the community as a whole. Social media could be instrumental in reintroducing the LHC into the community.

In the two pilot projects, LHC forms could be accessed and submitted electronically on the clinics' websites. Extending the use of social media such as

Facebook, Twitter and Instagram could potentially reach thousands of individuals and dozens of community organizations, spreading information about the LHC widely throughout the community. Occasional Instagram posts could be used to highlight examples of people being assisted. A limitation to this strategy would be that some disadvantaged groups may not have access to adequate bandwidth or regular access to social media. However, leveraging digital platforms as part of the continued use of the LHC may complement broader technological initiatives that will be made by clinics and community partners, such as in response to the COVID-19 health crisis.[24]

A good illustration of the effective use of social media in disseminating information about the availability of legal help throughout the community may be found in the recent mobile legal services project developed by the Guelph clinic.[25] At the beginning of the project about 2% of visitors to the van said they learned about it through social media. By the end of the project, this percentage had increased to almost 35%.

During the pilot projects, the clinics were able to absorb the increased number of LHC referrals from intermediaries without substantial increases in resources, although some clinics altered their internal processes or hired additional staff to deal with the increased numbers of referrals generated by the LHC. A social media-driven approach to the LHC would potentially reach broader segments of the community and would almost certainly produce even greater stresses on small clinics that are typical of the Ontario community clinic system. Greater strains would be placed on intake and on assessment and service delivery by lawyers and community legal workers. It would be necessary to develop referral networks to deal with the wide range of problems that would emerge from an open-ended proactive offer of service. Most legal clinics provide service in only a small number of areas of law. Collaborative arrangements among clinics to provide service in different areas might be desirable, using Skype and the electronic transfer of documents to make shared services more efficient and overcome the barriers of time and distance for individuals. Additional resources would be necessary, but the possible benefits in improved access may be great for a relatively small increase in resources.

[24] For example, HCLS is currently offering PLE sessions using the Zoom platform due to the COVID-19 health crisis. An electronic version of the LHC could be incorporated into these sessions or made available through social media.

[25] Ab Currie, Someone Out There Helping: Final Report of the WellCoMs Mobile Van Project, Canadian Forum on Civil Justice, Toronto 2019 and Ab Currie, Max Leighton and Roseanne Vandermeer, Discovering the Power of Social Media in the Guelph in the Guelph Mobile Legal Service Project, SLAW, November 29, 2019.

PARADIGM SHIFT AND INNOVATION IN SERVICE DELIVERY

The way in which the LHC led to fundamental changes in service delivery in Halton, Brant and Guelph is an illustration of how the paradigm shift in access to justice that has achieved hegemony in the field occurs at the level of service delivery. The paradigm shift began with Hazel Genn's landmark *Paths to Justice* study[26] and was also influenced by the earlier American Bar Association research on the legal and civil justice needs of the American public.[27] The results of this research set in motion the shift toward understanding legal problems from the point of view of the people experiencing them, rather than through the perspective of the formal justice system, placing an emphasis on outreach and client-centered and community-focused approaches to service delivery.

Paradigm shifts occur first in the world of scientific research.[28] In T.S. Kuhn's formulation, the initial seminal research spawns a period of ordinary scientific research confirming and elaborating on the insights of the seminal research, building a body of knowledge different from conventional ways of understanding. As the body of research becomes more widely known and accepted, results of the research gradually work their way from the world of science into the worlds of policy and program development.[29]

Although it had become well-established in the policy development literature,[30] the paradigm shift became concrete in the form of an innovation in service delivery at HCLS in 2013 with the LHC. The LHC became an integral part of the service delivery approach at each of the three clinics. In a manner parallel to the way in which an initial discovery leads to a period of ordinary research in the world of science, the adoption of the LHC led to a series of changes that transformed service delivery at the clinics. The LHC remains an important part of their service delivery approaches. More importantly, however, the LHC led to stronger connections with the community, different ways for lawyers to carry out their work and it shaped the way in which other specific outreach initiatives are developed.

[26] Hazel Genn, Paths to Justice: What People Do and Think About Going to Law, Hart Publishing, Oxford, 1999.

[27] Consortium on Legal Services and the Public, Agenda for Access: The American People and Civil Justice, Final Report on the Implications of the Comprehensive Legal Needs Study, American Bar Association, Chicago, 1996; Consortium on Legal Services and the Public, Legal Needs and Civil Justice: A Survey of Americans, Major Findings of the Comprehensive Legal Needs Study, American Bar Association, Chicago, 1994.

[28] Thomas S. Kuhn, The Structure of Scientific Revolutions, University of Chicago Press, Chicago, 1962.

[29] Legal Needs Surveys and Access to Justice, OECD/Open Society Foundations, OECD Publishing, Paris, 2019, p. 37

[30] A Strategic Framework for Access to Justice in the Federal Civil Justice System, Access to Justice Task Force, Attorney General's Department, 2009. Chapter 6.

CONCLUDING REMARKS

The LHC experience at the three clinics illustrates how the impact of a good innovation can have a multiplier effect, leading to other changes in service delivery that can be as fundamental, and perhaps broader in reach than the initial project. The initial LHC innovation had incorporated findings from a rich and extensive body of research, giving the LHC the benefit of a solid conceptual framework. Also, and equally important, the extensive discussion and exchange of ideas that were part of the collaborative process among a number of clinics that developed and implemented the LHC was a very positive process. The LHC projects being carried out in individual clinics benefited from shared ideas, experiences and lessons learned from different contexts. There are important differences among community legal clinics in Ontario because of long-standing and deep connections with quite different communities. The clinics involved in the LHC initiative were all community legal clinics, however, and the collaboration that occurred throughout the pilots furnished a wealth of both shared and diverse experience. The LHC experience in different clinics highlights the LHC's high degree of adaptability to different service delivery environments.

There is an important lesson for funders of access to justice innovations in this revisiting of the LHC. The benefits of a good innovation can have multiplier effects that go much beyond the initial objectives of a particular project. Similar to the pattern followed by paradigm shifts in the world of science in which the initial research is likely to produce a body of research that elaborates on the original discovery, a keystone innovation in the world of service delivery can produce multiplier effects that can transform the way service is delivered. This process is made up of unanticipated changes that are often the unique products of the connections between the clinic and the community. Although the ideas and program developments that emerged from the LHC were unanticipated in the beginning, they were well planned and carefully implemented to fit the unique circumstances created by the features of each community in that time and place and the capacity and resources of each clinic.

Success is not final, and failure is not fatal.[31] Innovation is a continuous process that can reach beyond its original objectives. Years after the initial pilot studies and after the funding has ended, the LHC continues to pay dividends and expand access to justice. There is a strong message for funders of legal services in this experience. Fund innovation and fund it generously enough so that the potential of innovative projects to produce multiplier effects and unanticipated benefits is not limited by the perennial constraint in legal aid of doing more with less, or with

[31] "Success is not final, failure is not fatal, it is the courage to continue that counts" is an admonition often attributed to Winston Churchill. According to the Churchill scholar Richard Layworth, Churchill never said this. Richard Layworth is a writer and historian, Senior Fellow and Hillsdale College, Churchill Project; see richardlayworth.com/success

not enough. Encourage collaboration among legal service providers trying the same innovation in different ways that fit their unique circumstances. Collaboration creates an innovation space that is more than the sum of its parts and more than the creativity of clinics working in isolation. Stay in for the long haul with continuing support.

This paper does not present a comprehensive update of the LHC since it was first piloted. The extent to which the LHC has continued in other clinics besides the three highlighted here was not examined. As well, the LHC can take forms other than the approach developed in the community legal clinic context. For example, private law firms could send annual legal health checks to their clients, inviting them for a consultation. This review is primarily an assessment of how the LHC, as an example of a good innovation, had a multiplier effect in the three clinics, changing the way service is now provided and extending access to justice to encompass more holistic forms. Some changes that encourage the expansion of access to justice are ordinarily made on a system-wide basis and are top down. Higher financial eligibility cut-offs or increases in per capita funding are examples. However, the most fundamental changes in service delivery happen at the ground level and come from the bottom up; those that result in more holistic, integrated, people-centered, community-focused and trauma informed service. These broader impacts of particular innovative projects can extend beyond an arbitrary project date, taking shape in ways that could not likely be anticipated at the outset of a project. Innovation should be understood in that way, managed and funded accordingly.