
Geographies of Legal Resistance: Legal Clinic Struggles to Empower Marginalized Groups

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At the Limits of Law: Clinics as Sites of Legal Resistance

Ontario's first legal aid clinics were developed in the early 1970s by activists concerned about the marginalization of the poor within the legal system and the failure of the existing legal aid certificate program to meet the poverty law needs of groups such as tenants, welfare recipients, immigrants, injured workers, and persons with disabilities. Some of these activists were lawyers and law students; others were involved in low-income communities as social workers, community organizers, politicians, social housing advocates, and labor activists. Still others became involved in clinics as a result of their experiences of being marginalized within law, as low-income tenants, single mothers dependent on welfare, and injured or disabled workers dealing with unemployment and chronic poverty. Early struggles for clinics thus involved both professional advocacy and "grassroots" resistance to the exclusion and marginalization of poor people within law.¹

The 1960s saw growing dissatisfaction with and criticism of the province's certificate legal aid program, a program that provided low-income individuals with vouchers that could be exchanged for representation by a lawyer in criminal or family law cases, but that did not address growing needs for legal assistance in areas of poverty law such as disputes between landlords and tenants, social assistance recipients and state agencies, immigrants and immigration officials, and injured workers, compensation boards, and employers. As the welfare state expanded, the need for poverty law assistance became increasingly clear. In 1974, the Osler task force, struck to assess the existing legal aid system in the wake of these concerns, recommended the development of neighborhood law offices to complement the existing certificate legal aid program.² Support for such services grew during the 1970s as the first experimental clinics were established and as clinic advocates worked, through the clinics and Action on Legal Aid (the first umbrella organization of clinic activists), to secure ongoing funding and to shape the terms and conditions of that funding.

Geographically, clinic development was concentrated in Toronto during the 1970s. A number of factors help to account for this. It was

here that struggles for greater citizen involvement in planning and urban redevelopment took hold, reflecting the influence of “New Left” thinking about urban power and change in the 1960s and 1970s, the lingering “anti-establishment” sentiments of the 1960s, and citizen resistance to high-density redevelopment of inner- and central-city neighborhoods that threatened to displace the poor and working class (and even the middle class) through the destruction of affordable housing. Finding ways of making the legal system work for disempowered groups such as low-income tenants was integral to efforts to ensure that “ordinary” and disadvantaged citizens continued to have a place in the city and that urban change would not be dictated solely by the economic interests of powerful capitalists such as those heading the development industry. Redevelopment pressures were exacerbating Toronto’s “housing crisis” and displacing low-income residents from their homes and communities. Low-income tenants were mobilizing around issues of rent control and lack of tenant input in the operation of public housing projects, sometimes joining with low- and moderate-income homeowners to struggle for social housing alternatives that would preserve affordable housing and their communities. Cooperative housing projects, in which low-income residents collectively owned and managed their housing on a non-profit basis, often originated in situations where tenants were threatened with displacement by high-density redevelopment of a property and fought to remain “in place” by forming a tenants’ group and later a cooperative housing collective.³ In such cases, access to poverty law in the area of landlord-tenant legislation was vital and this helped fuel demands for alternative legal aid services from the 1970s on. As those living at the margins of urban life—the unemployed and working poor, welfare recipients, and low-income families threatened with eviction or displacement—mobilized to demand greater social justice in the city, the need and demand for poverty law services grew.

Toronto was also a site of emerging radicalism in professions such as law and social work during the 1970s. As what are often referred to as the “poor peoples” and “citizens” movements took hold and literatures on community organizing and advocacy grew, notions that professionals aligned with disadvantaged groups could contribute to social change became more influential. Professors and students from Osgoode Hall Law School began to critique the existing legal system, and established an early experimental legal aid clinic practicing poverty law in Toronto’s Parkdale neighborhood. Mary Jane Mossman, who articulated as a law student at the Parkdale Clinic and is now a professor at Osgoode, recalls how the availability of federal funds for community development projects

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poor, “[to] supply the economically weak with their undisputed right to good, competent legal services to be used in the exercise of their rights under the law.”⁶ Some clinics, notably Injured Workers’ Consultants (IWC), took direct action from outside existing relations in law in their struggles to empower low-income people. In IWC’s case, these actions included hiring injured workers rather than lawyers to represent other injured workers involved in compensation disputes and developing a working-class analysis of the regulatory process.⁷ Other early clinics, for instance Hamilton’s Dundurn clinic (established in 1972 by a coalition of church and community groups), sought not to directly empower the poor but to provide professional services that addressed local social problems, such as safety and poverty. In Hamilton, it has been McQuesten Community Legal Services, developed in the city’s working class east end, that has pursued education and organizing initiatives among groups such as tenants and single mothers.⁸ Clearly, then, the early clinics varied in their politics, aims, and practices, reflecting complex micro-geographic variations in the conditions in which they developed; social conditions and needs in the communities served, alliances with other groups and movements (e.g., in IWC’s case with left-wing labor), and leadership.

Creating resistance to the marginalization of the poor within the legal system and local neighborhoods was a difficult task, and became increasingly complicated and constrained by changes in the regulatory bodies and policies shaping the funding and delivery of legal assistance to the poor through community clinics. The early clinics, funded on an experimental basis by the federal government and charitable funding agencies, were relatively free of regulatory restrictions and able to pursue relatively radical agendas aimed at empowering poor communities through legal education and organizing, and developing collective management structures that would encourage broader visions of poverty law services and create opportunities for community involvement in the delivery of those services.

By the mid-1970s, experimental funding had been discontinued and Toronto’s clinics were threatened with closure. Clinic advocates, including Action on Legal Aid, appealed to the provincial government for long-term funding. The province responded with emergency funding in 1975 under the existing Legal Aid Act. This marked the beginning of a long-term regulatory relationship between local clinics, the governing body of the legal profession, and the provincial government—a relationship that changed over time as new regulatory policies and practices were developed, and as the politics of the regulatory agency and the clinic movement itself shifted away from radical visions of a decentralized legal clinic system dedicated to empowering the poor.

In 1976, the province, in consultation with the Law Society of Upper Canada, established a joint regulatory body to oversee the funding and activities of legal aid clinics. This body, the Clinical Funding Commit-

and the war on poverty in the United States influenced her views on law and social change:

I got involved in clinics when I was still a law student and that was late '60s, John Turner was Minister of Justice, Marc LaLonde was Minister of Health and Welfare. There was money flowing in all directions, for OFY, for LIP grants, you know all of that stuff Jean and Edgar Cahn were writing all their stuff on the war on poverty in the United States. Johnson had declared war on poverty. A law student in that environment, I think, essentially does believe that you can use law for social change. And certainly that was why I went to article at Parkdale.⁴

In short, Toronto, with intense redevelopment pressures, strong citizens' and poor peoples' groups lobbying for more inclusionary planning, high-density redevelopment, displacement and poverty, and advocates calling for greater social justice in cities and Canadian society, "new left" political leaders and an emerging radical base in the legal profession, was especially ripe for grassroots struggles for legal-aid clinics that would not just dispense services, but would take steps to empower the poor.

Clinic supporters did not, of course, always agree on how empowerment could be achieved, or whether particular clinics were empowering the poor communities they served. In Toronto's Parkdale Clinic, established in 1971 for the dual purposes of delivering poverty law services and professional training of Osgoode Hall Law School students, there were ongoing disputes about whether the clinic was actually increasing the capacities of Parkdale residents to understand and take action on legal issues, or simply producing lawyers with experience in poverty law.⁵ While other neighborhood clinics did not have such a direct tension between serving a low-income community and serving the legal profession, other circumstances, such as geographic location, neighborhoods or communities of interest served, and responses to regulatory changes, influenced clinic leaders' positions on issues of empowerment. Neighbourhood Legal Services, for example, was established in 1973 in Toronto's Don District, a low-income area under intense redevelopment pressure and with a wide range of groups, such as low-income tenants, welfare recipients, and public housing tenants, struggling against exclusion from and/or marginalization within their community. From the outset, the clinic established a relatively radical course of action that included supporting grassroots struggles against redevelopment and displacement of low-income residents. By 1975, only two years after its establishment, Neighbourhood Legal Services had broadened its community development work to include redevelopment in the downtown core, issues facing injured workers, cooperative housing initiatives, conditions on "skid row," and welfare rights. The clinic's mission statement, which emphasized collective rights and action, reflected this commitment to empowering the

eration of legal clinics by local boards representing poor communities.¹¹ While this proposal was a reasonable one, and has formed the basis for the regulatory process during the 1980s and 1990s, it failed to anticipate how difficult it would be to achieve such a balance in practice: how, for example, changes in the politics of the CFC would alter conceptions of what clinic services were and were not legitimate, and of how clinics ought to be managed “in the public interest.” As central regulatory policies proliferated, from the 1980s on, and as the implementation of those policies passed into the hands of people less committed to radical empowerment of the poor within law and to a decentralized grassroots clinic system that could achieve this, control over clinic development and services became increasingly centralized within the CFC. This, in turn, set the stage for ongoing conflicts over whether the regulatory committee’s intervention in clinic development and services was undermining community board control of legal aid clinics. The “community control” issue has thus continued to haunt the regulatory process and to strain relations between clinic representatives, staff, and regulatory officials.

The scope of clinic efforts to empower poor communities was an early source of tension between activists and the committee; as cases such as the defunding of PAL indicated. Although the Law Society and attorney general representatives on the CFC were sympathetic to the radical aims of clinics, they expressed concerns about the possibility that some clinics might cross the “boundary” between legitimate legal services and social action. Early legal clinics were eager to test—if not transgress—those boundaries in order to promote social change through action on poverty law issues. While those involved in clinics often disagreed on how to challenge the marginalization of poor people within law and society, they also shared a sense that poverty law services could make a real and lasting difference in poor peoples’ lives and communities.

Early clinic board members and staff were thus likely to interpret central intervention in the development and delivery of clinic services, through funding and defunding decisions, as a significant threat to establishing a community-controlled clinic system capable of empowering poor communities within law and society. Committee officials and staff, on the other hand, were inclined to view central decisions on matters such as whether particular clinic services were legitimate in a more benign—if not paternalistic—way. At a time of significant opposition to clinics within the legal profession and government, including allegations that clinics were politically partisan and sites of opposition to the ruling conservative government, it was important “for the good of the clinics” in terms of public funding and support, that the committee discourage clinics from developing overtly radical and political agendas for social change and restrict their services to ones that could be justified as “legal.” This view was influential within the Attorney General’s department, which promoted expansion of the clinic system during the 1980s, despite lack of support

tee (CFC, later known as the Clinic Funding Committee), consisted of representatives of the provincial government's justice department (the Department of the Attorney General) and of the Law Society of Upper Canada (the professional society of the Ontario legal profession). In principle, this arrangement was intended to place the province in the arms-length position of funder, with the Law Society taking responsibility for the allocation of those funds to clinics. In practice, there is some evidence to suggest that the province has intervened more directly in regulatory policies and procedures. This includes appointing members to the committee with relatively conservative views of legitimate legal services and influencing policy decisions through informal contacts.⁹ Legal clinics did not have direct representation on the CFC, although one committee member was to have "some association" with clinics. Lack of formal representation made it difficult for clinic spokespersons to contest policy changes that threatened goals, such as community control of legal clinics. In addition, the CFC's mandate under provincial law was unclear; the 1976 regulation specified that clinics receiving funding should be independent and have a community base, and provided for services delivered by community legal workers and proactive or "preventative" law programs aimed at improving conditions of life in poor communities.¹⁰ How the committee was to evaluate clinics for funding, defunding, and performance assessment purposes remained unclear. This ambiguity contributed to difficulties in reconciling the committee's responsibility to account for the public funds received by legal-aid clinics with the goal of an independent, community-controlled, legal-clinic system. A related barrier to developing clinics that could empower the poor was that, in the absence of a clear legal definition of the CFC's mandate, the committee frequently changed the informal "rules" regarding clinic funding and services; increasing uncertainty about the types of clinics and service activities that would be supported and whether providing alternative services such as grassroots organizing would place their funding at risk. The controversial defunding of the People and Law Clinic (PAL) by the CFC, on the grounds that its proposed new commitment to social organizing and action "crossed the line" between legitimate legal services and political action, brought these issues to a head and helped to trigger a provincial Commission of Inquiry into the regulatory relationship between the CFC and legal aid clinics (known as the Grange inquiry).

The Grange Commission's report reaffirmed the principle of independent, community-controlled legal clinics and recognized the need for services that extended beyond traditional individual legal casework and promoted the collective legal welfare of low-income communities. It proposed a regulatory framework that defined the CFC's regulatory role as one of ensuring accountability in the expenditure of public funds, suggesting that this would allow a balance to be struck between the committee's responsibility to the public and the development and op-

legal services. What they perhaps did not anticipate was the extent to which the formal policies they helped to elaborate would, in less radical times, be deployed in ways that threatened grassroots control of clinic development and services. Because the 1980-82 committee supported the basic empowerment objectives of clinics, attempts were made to implement these policies in ways that respected the independence and autonomy of the community boards of clinics. So, for instance, officials would provide input to clinic deliberations on hiring new personnel but would leave the ultimate hiring decisions to the community board responsible for the clinic. Despite such measures, many clinic activists had a less benign or neutral view of the emerging formal regulatory process, viewing the barrage of formal policies and guidelines instituted during this period as significant threats to community control of legal aid clinics.

The composition and politics of the regulatory agency changed after 1982; in particular, support for grassroots control of clinics waned in practice as strict central regulation of the clinic system came to be seen as the primary means of ensuring that legal clinics delivered quality legal services to the poor. Quality services, in turn, were increasingly defined as the provision of routine legal services to poor individuals. Indeed, as the 1980s progressed, it became less common within both the CFC and clinic movement to regard legal clinics as alternative services aimed at empowering the poor, and more common to regard clinics as offices dispensing routine legal services to poor individuals. As one former CFC staffperson put it, legal clinics were frequently regarded as just "the same as the local welfare office."¹⁴

Centralized control of clinic development and services intensified after 1982, as clinics were forced to comply with existing policies and a growing array of new regulatory requirements on matters such as client eligibility, relations with employees, and the respective roles of paralegals (or community legal workers) and lawyers in the clinic system. Clinics that resisted were pressured into compliance. One clinic that wished to retain a collective management structure that conflicted with the regulatory agency's "independent clinic" model, for instance, was informed that additional funding for staff would be denied until it satisfied the model's requirements. When a clinic in Sudbury refused to put a lawyer in the position of executive director, on the grounds that an existing paralegal staffperson was qualified for the position, the clinic funding committee intervened and helped to replace board members who opposed compliance with this feature of the independent clinic model.¹⁵ Such drastic actions made it clear that the CFC was prepared to undermine the authority of community boards in order to achieve compliance with central policies and procedures.

As the CFC became more forceful in asserting central authority over clinic affairs, the facets of clinic organization and services subject to central regulation and intervention increased. From the mid-1980s,

for this within the conservative government, and reservations within the CFC itself. In deliberations over whether to discontinue funding for the PAL clinic, committee members expressed concern about PAL's plan to focus on "social development type services" and to move from providing direct legal services to "performing a social animation role." In a meeting between the CFC and PAL's board, one of the clinic's board members (a lawyer) even expressed concern at "the thought of PAL crossing the boundary between legal services and political organizing."¹² For many clinic activists the boundary at issue was a different one—that between central intervention and clinics that were independent of the regulatory agency and community-controlled.

The regulatory process that evolved during the 1980s and 1990s was an increasingly interventionist one. In the early 1980s, regulatory officials attempted to clarify and formalize the role of the CFC within the legal clinic system by introducing a series of new policies governing numerous aspects of clinic development and services. These included formal policies on reporting, hiring, conflict of interest guidelines (prohibiting clinic staff from serving on clinic boards), use of special terms and conditions in clinic funding certificates to enforce central policy, and enforcement of an "independent clinic" model. The latter required clinics to be run in a hierarchical fashion (headed by an executive director/lawyer who reported to the community board) and to sever formal ties with other community organizations. Of the various regulatory policies introduced during this period, it was the model that was especially unpopular with clinic activists, many of whom viewed its enforcement as direct intervention in internal clinic affairs and a barrier to working with other organizations to promote empowerment of the poor within law.¹³ Informal policies, such as discouraging applications for funding from new Toronto-based clinics and encouraging ones from clinics outside Toronto, also emerged.

The politics of the regulatory agency shifted in significant ways during the 1980s. From 1980 to 1982, the CFC and its staff were relatively supportive of the radical aims of the clinic movement, including the notion that legal clinics should be controlled by the poor communities they served. But these efforts to support community-controlled clinics took place in a relatively hostile political environment. Throughout the 1970s, fears that clinics would compete with lawyers in private practice fueled opposition from lawyers within the Law Society and local communities. By the 1980s, other sources of opposition had emerged, notably conservative members of provincial parliament who alleged that clinics were left-wing, politically partisan organizations. Such criticisms placed pressure on both the Attorney General and the Law Society to discourage clinic activities that could be construed as political rather than legal, and encouraged CFC members and staff to view the development of formal regulatory policies and procedures as serving the "best interests" of clinics by ensuring that they would be regarded as legitimate, quality

concentrate on poverty law issues affecting specific marginalized groups and to amass the knowledge and expertise needed to challenge existing law both provincially and nationally. All-purpose clinics, with mandates to serve all the poverty law needs of a given geographic neighborhood despite shortages of staff and funding, find it more difficult to engage in struggles of this social and geographic scope.

The changing geographies of the clinic system and movement have also influenced peoples' capacities to defend and promote a grassroots legal clinic system capable of empowering the poor. From the mid-1970s, informal policies favoring the development of new clinics outside Toronto have created a much more dispersed clinic system within the province. One consequence of this has been that new clinics, socially and geographically removed from early clinic radicalism in Toronto and with less experience of resistance to the erosion of community control through regulatory change, have tended to view clinics as offices dispensing routine professional services (like the local welfare office) rather than as sites of radical resistance and change within law, and to accept extensive state monitoring and intervention as the "way the system is."¹⁸

This "distancing" of newer clinics from the more radical roots of the clinic movement has been exacerbated in recent years by the demise of a provincial organization of clinics. From the mid-1970s until 1988, a provincial organization (i.e., Action on Legal Aid; from the early 1980s, the Ontario Association of Legal Clinics or OALC), whose activities included advocacy on behalf of clinics and resistance to the centralization of power within the clinic system, brought activists together around regulatory issues and provided an organizational base for collective resistance to the erosion of community board control of clinics. From the mid-1980s, the OALC, under pressure from the CFC to restrict its activities to the provision of technical and educational services to clinics and especially clinic lawyers, and also suffering from disputes over issues of organizational reform between clinic activists in different regions of the province, fought to retain both its funding and its role as a collective political voice for clinic activists. The clinic funding committee, anxious to increase the influence of lawyers within the clinic system (equated with quality legal services), refused to fund proposed OALC service projects that were judged to conflict with central policy, for example workshops to assist community legal workers in their community development and organizing initiatives. This, technically a "failure" to deliver services to clinics, and political disputes among clinics over the issue of how the OALC should be reformed, led to the defunding and demise of the provincial organization of clinics. Once again, there was a significant geography to this conflict. Toronto activists, many with experiences of the early radicalism of the clinic movement, promoted an inclusive organization that could advocate for clinic clients, staff, and boards and support collective resistance to policies that threatened community control and empower-

CFC policy decisions including requirements for greater supervision of community legal workers (CLWS) by lawyers, measures to increase representation of lawyers within the clinic system, and decisions against providing funding for the training and education of paralegals working in community clinics, had made it more difficult for community legal workers to use their skills to promote community development through legal clinics and, more likely, that they would be restricted to assisting with more traditional legal services. These regulatory outcomes, in combination with inaction on issues such as low wages for CLWS, have helped to marginalize paralegal workers and their community development skills within the clinic system. Other regulatory actions, such as refusing to fund salary and benefit increases negotiated through collective bargaining between clinic boards and their staff, have eroded board authority and community control of clinics. By 1988, central intervention in clinic affairs such as personnel had become so pervasive that four Toronto clinics challenged the status of community boards as employers in an appeal before the Ontario Labour Relations Board. Union representatives argued that state intervention was so extensive that the Ontario Legal Aid Plan (via its clinic funding committee) ought to be considered co-employer of clinic staff (i.e., with community boards.)¹⁶ The board ruled in favor of co-employer status, although its decision was overturned in a subsequent appeal.

There are significant geographic facets to these struggles over the regulation and control of Ontario's legal aid clinics. Different geographic visions of the clinic system have informed these struggles; radical visions of a decentralized and locally controlled clinic system on the part of some activists have clashed repeatedly with the centralized control and monitoring increasingly favored by the provincial regulatory committee. While the former aims to open up access to law, through education, organizing, and representation, the latter disciplines demands for local empowerment within law by centralizing power over clinic development and services and by restricting the capacity of poor communities to direct clinics through boards. The scope and geographic reach of clinic efforts to empower the poor have been constrained in significant ways by the regulatory policies of the state. Restrictions against formal ties with other community organizations, for example, have helped to discourage at least some clinics from solidarity and collective action with other groups working to educate and mobilize low-income citizens around issues such as poverty, welfare, and safety.¹⁷ Informal policies discouraging the development of new specialty legal clinics (that serve non-geographic constituencies or "communities of interest" such as the elderly and disabled) have restricted opportunities to expand the clinic system's capacities for law and social reform and limited the geographic reach of the clinic movement. Unlike all-purpose clinics, which now dominate the clinic system in Ontario, specialty clinics have been able to

neighborhood-based, all-purpose clinics. So, for example, ARCH has contributed expertise and staff to disability struggles waged in Ontario, in other regions of Canada, and at the national scale.

ARCH's story illustrates the importance of situating legal struggles within particular social and spatial contexts, within regulatory processes that have uneven outcomes, and conditions of struggle that vary over time and space. For one of the remarkable features of that story is how the clinic has been able to pursue an increasingly radical agenda of empowering the disabled to contest their marginalization within law and society, and to expand the geographic scope of its activities to national and even international scales, despite a regulatory regime established through the state and legal profession that has in many ways worked against such goals. Unlike many clinics, which have been disciplined and drawn into a more conservative, individual service-oriented clinic system and away from the radical goals of the early clinic movement, ARCH has evolved from a clinic providing legal services to disabled individuals to a clinic committed to the collective empowerment of the disabled through legal and political struggle.

Advocacy and Resource Centre for the Handicapped

Efforts to establish a specialty legal clinic for the disabled began in 1978. In October, a group of disabled consumer and voluntary agencies met in Toronto to discuss a proposal for a clinic such as ARCH. Matters discussed at this meeting included whether board membership should be restricted to persons with disabilities, what the key functions of the clinic would be, and how to secure funding from the Ontario Legal Aid Plan (OLAP). Harvey Savage, then assistant director of the plan, attended the meeting, and indicated that co-funding arrangements were preferred and that he would assist the organizers in seeking such funding from the federal Department of Justice. He suggested that the clinic begin as a pilot project serving the geographic area of metropolitan Toronto. And he stressed the importance of strong representation of the disabled on the clinic board. Groups participating in the meeting expressed support for a clinic that would act as a resource for individual advocacy, would intervene in special cases (such as those that constituted legal "test cases"), would monitor and advocate legislative change to promote and protect the rights of the disabled, and provide a mechanism and space for joint lobbying efforts with member groups.²¹ Although representatives of only eight groups attended this initial meeting, by June 1979 there were nineteen groups involved, representing a variety of physical and mental disabilities and service organizations.²²

The funding and policy practices of the CFC had significant impacts on ARCH's early development. Securing core (ongoing) funding for the clinic from the committee and its staff was particularly difficult in ARCH's

ment. Clinic activists outside Toronto were, in contrast, more willing to support proposals consistent with the regulatory agency's vision of an organization representing the lawyers heading clinics and geared to service rather than collective political goals.¹⁹

The tension between central control of clinic development and activities by the legal profession and state, and clinic autonomy and community-based control, has persisted into the 1990s. Willingness to resist policies that erode community control vary spatially, however. While the factors contributing to these variations are complex, they include the facts that many of the province's newer clinics lack experiences of grassroots radical opposition to prevailing relations within law, have developed at a time when a centralized regulatory regime was firmly in place, and that clinic activists have been gradually drawn into an "incorporated" system of justice in which legal aid tends to be viewed as a service to be dispensed to needy individuals by lawyers rather than a means of empowering the poor within the law. In such circumstances, the issue of who will control community legal clinics is less immediate and pressing. Clinics that retain a commitment in practice to radical goals of empowerment tend to either have board members or staff with direct experience and knowledge of how CFC interventions have threatened the capacity of community boards to control clinic affairs and to provide alternative community development services, and/or have developed under conditions encouraging more radical empowerment agendas (examples of the former include the Parkdale and IWC clinics, both located in Toronto, and Hamilton's McQuesten Legal Services with alliances in struggles such as the anti-poverty movement).

It is in this regulatory and geographic context that some legal clinics continue to struggle to bring poverty law and opportunities for collective legal resistance and empowerment to low-income neighborhoods and communities of interest such as the disabled. In the following section, I illustrate how the struggles of one such specialty clinic in Toronto—the Advocacy and Resource Centre for the Handicapped (ARCH)—have been shaped by how it has been politically and geographically situated within the regulatory process and clinic and disability movements.

Challenging Marginalization within the Law: ARCH

Specialty clinics, unlike most legal aid clinics, serve a particular community of interests rather than a specific geographic neighborhood. In Ontario, these constituencies include the elderly, the disabled, aboriginal peoples, tenants, injured workers, and environmentalists.²⁰ Focusing on the legal aid needs of specific marginalized groups allows specialty clinics to develop expertise in particular areas of poverty law and thus to influence poverty-law struggles on a wider geographic scale than

concerns about playing an overtly political role in the disability rights movement or even projecting images of such a role. In 1983, the clinic's executive director/lawyer expressed his unease with media perceptions that ARCH did or should provide leadership on disability issues: "... the press continues to identify and treat us like a lobbying organization—expecting us to take a stand on a broad range of issues. It can be anticipated that other more difficult requests will follow."²⁴

The issue of the terms on which OLAP would provide core funding to ARCH proved difficult to resolve. ARCH representatives protested the requirement that the clinic secure ongoing funding from sources other than OLAP. The board chair, for example, wrote to the clinic funding manager (in charge of staff advising and assisting the clinic funding committee) arguing that this unusual condition was "extremely onerous." However, regulatory officials and staff refused to change it.²⁵ In 1980, ARCH received core funding of \$80,000 but was advised that although \$40,000 in additional funds had been raised, the regulatory agency did not deem this as meeting the core funding requirement because the funding was not ongoing. ARCH tried to appeal both funding constraints and the co-funding condition in 1981. However, regulatory officials refused to grant an appeal hearing. Clinic representatives responded with anger and frustration, arguing that the regulatory agency's insistence on co-funding was discriminatory:

This Board unequivocally rejects the discriminatory proposition that ARCH be required to raise other source funds in order to subsidize the provision of direct legal services which are funded as of right by the Ontario Legal Aid Plan to other clinics, merely because ARCH serves the handicapped community.²⁶

Clinic representatives did win one important concession regarding funding during the early 1980s. This was that the clinic funding committee and staff would not direct how the clinic used its funding from non-OLAP sources.

Like other clinics, ARCH's activities were constrained from the outset by chronic underfunding. Clinic funding staff refused to provide badly needed funds for additional staff during the first three years of the clinic's operation, arguing that it was not clear that demands for clinic services would continue to be as high as they had been to date and that more time was needed to assess the effectiveness of those services. Regulatory officials and staff also refused to provide funding for the special services needed by the clinic's disabled clients, for example, signing services, braille paper, and library cassettes. Lack of funding had important consequences for ARCH's attempts to realize its key long-term goals of providing a legal resource for the disabled community in Ontario, and

case. This was because regulatory officials insisted on imposing a special condition on the clinic's funding; namely that ARCH secure a minimum of an additional \$40,000 in core funding in order to receive OLAP funds. It is not clear why co-funding was made a formal requirement in ARCH's case, since it had not been imposed on other specialty or all-purpose clinics. Also at this time, the agency had adopted an informal policy favoring funding of all-purpose rather than specialty clinics, a preference that ARCH supporters perceived during meetings with officials and staff who seemed to indicate that specialty clinics were "passe." It may be that the co-funding condition reflected the low priority given to specialty clinics at this time and/or was a way of ensuring that OLAP did not assume the full costs or risks of such projects.

Clinic services and management also were affected by the regulatory process in place by the late 1970s. ARCH's concerns to qualify for core funding seem to have taken priority over organizers' initial proposal that the clinic would focus on collective action to change the law. For when regulatory officials and staff expressed concerns that this might conflict with providing individual legal representation, ARCH organizers quickly revised the clinic proposal to make it clear that individual casework would provide the basis for the clinic's collective advocacy. As in the PAL case, it is clear that the CFC did not want ARCH to "cross the line" that the committee had drawn between legitimate legal services and political action to empower the poor.²³ As ARCH's supporters and staff later recognized, this shift in service emphases was a significant one. It meant that the clinic's staff and resources were largely consumed by the provision of legal assistance to individual clients during its first years of operation, that modest educational efforts were the only non-casework activities engaged in, and that longer-term law reform and organizing objectives were temporarily set aside. Although individual casework arguably helped to establish ARCH's credibility and reputation within government circles, and within the disabled and legal communities in the long run, the high demand for such services, regulatory emphasis on providing them, and limited staff and resources meant that more radical, collective, and coalitional strategies for promoting social change were placed on the "back burner" for several years. Like those at other clinics, ARCH organizers also bowed to pressures to ensure that the clinic conformed with the CFC's independent clinic model—although organizers considered placing a non-lawyer in the executive director's position, they decided against this when it was realized that this conflicted with the regulatory agency's "clinic model."

Political resistance to legal clinics, in particular within the legal profession and government, and related views within the attorney general's department and CFC that clinics had to avoid activities that could be seen as "political and partisan," contributed to clinic organizers' and staff

There were significant changes, social and spatial, in how ARCH was situated within disability struggles from the mid-1980s to the 1990s. Until the mid-1980s, pressures to deliver legal assistance to individuals, driven by the needs of the disabled as well as the state's regulatory regime, helped to restrict ARCH's activities to individual casework and modest educational efforts. Chronic underfunding and the regulatory agency's co-funding requirement meant that volunteers and staff were constantly scrambling to secure new funding sources (often through short-term grants), that new initiatives could only be launched once such funding was secured, and that even then there were no guarantees that projects would be able to continue for any length of time. Lack of funds also restricted the geographic scope of ARCH's services and activities in its early years, in particular, by creating strong disincentives to take on legal casework outside Toronto (e.g., lack of funds for travel expenses). Under these circumstances, clinic supporters and staff tended to concentrate on delivering "quality services" to disabled individuals, rather than launching major law-reform initiatives or supporting collective acts of resistance by persons with disabilities. Legal resistance to the marginalization of the disabled within the law and society was, in this sense, largely "contained" within the existing legal system and the regulatory regime governing clinic development and services. ARCH gained legitimacy within the clinic and legal systems by satisfying the regulatory requirements of the latter and sharing expertise with professionals in the former (e.g., judges who increasingly called on ARCH staff for legal advice). By defending individual disabled persons' rights to "normal" access to "typical" legal services, ARCH had gained credibility as a poverty law service with a largely "liberal" political agenda.

From the mid-1980s onward, ARCH's politics and tactics began to shift away from this "incorporated liberal agenda" and toward a more radical politics aimed at empowering the disabled within the law and society. One of the reasons this shift seems especially remarkable is that it was at odds with the general trend toward more "incorporated justice" evident within the clinic system as a whole. It also reminds us that radical resistance is neither inevitably absorbed or contained by "the system" nor precluded by apparently non-radical political beginnings.

A number of factors made this shift in political direction possible. ARCH fundraising campaigns were becoming increasingly successful. This success reflected, in part, the facts that ARCH was the first legal resource of its kind to develop in Canada and that awareness of disability issues on the part of Canadian governments and citizens was growing in response to the disability movement during the 1980s. As a result of grants from a variety of sources, including the Donner and Trillium foundations, Metropolitan Toronto Social Services, and the City of Toronto, ARCH was able to launch law reform and education efforts including assisting in the development of an advocacy program for disabled persons living

contesting the limits of law through test cases and collective education and organizing. For example, the clinic's board was forced to adopt a policy that restricted the geographic scope of its service and organizing activities, namely, that of avoiding taking on legal cases outside metropolitan Toronto (even test cases), because it did not have access to funds for travel expenses. Fundraising became a pressing priority for clinic board members and staff, both because the clinic lacked the funds to meet client demand and needs, and because the regulatory agency insisted on a co-funding arrangement. Thus a lot of time and energy was spent trying to secure additional funds (e.g., through multiple grant applications, instituting membership fees, starting a voluntary donation program based on member groups' abilities to pay, a largely unsuccessful campaign for support from corporations, and approaching the Attorney General for funding for special services). Still, as the clinic board's president observed in late 1982, demand continued to outpace clinic resources:

The demand for ARCH's services, from the day we have opened, has exceeded our limited capacity. The demand has shown no signs of slackening since then, and we know there are many handicapped people who require legal assistance. It should be noted that ARCH still has a policy of not advertising its services, to produce this demand.²⁷

Despite these constraints, the clinic had accomplished a great deal since its establishment in 1979. A successful national conference on Disability and Law had been organized with funding from the Department of Justice, the clinic was recognized for excellent work on individual legal cases (including an increasing number from outside of Toronto), and it was engaged in a variety of legal-education efforts. The latter ranged from providing legal advice to judges and others in the legal profession, to conducting seminars on the human-rights code for groups such as employees of the Ontario Human Rights Commission, and acting as a catalyst for and providing input to the province-wide study of disabled persons' access to law and legal services conducted by Judge Abella.²⁸ Clearly, ARCH had started to challenge the legal system and poverty law services to recognize the rights and address the needs of persons with disabilities. What was still unclear was the politics that would guide this challenge. In 1980, ARCH representatives had characterized the clinic's primary objective as creating access to law within the existing legal and poverty-law services systems. This objective was rooted in a commitment to "normalization" of the disabled and was understood to mean creating environments in which the disabled would—as far as possible—have access to "typical" legal services. Whether "typical" would eventually be broadened to include services working to radically empower the disabled remained to be seen.

It is clear that by 1985, clinic activists and staff were no longer content with the political status quo, for they endorsed a revised set of objectives for ARCH that committed the clinic to working toward empowerment and social change. It was agreed that the clinic would move away from provision of direct legal representation in favor of test cases, more legal education, helping to develop lay advocacy systems, and legal work that would help to entrench the rights of the disabled under the Charter of Rights and Freedoms. The clinic's early objective of "normalization" within the legal system—that is ensuring that all disabled persons had access to "typical" legal services—was displaced by more radical and ambitious objectives. It was agreed unanimously, "That ARCH's Purpose be to assist in realizing the full social participation of the disabled community in society;" and, "That ARCH's Goal be to ensure that the legal needs and issues concerning persons with mental and physical disabilities are addressed and met thereby assisting in the process of complete social integration."³⁰

The clinic's commitment to empowering the disabled and supporting collective action deepened as the 1980s progressed. In October 1987, clinic activists approved new objectives explicitly aimed at empowering the poor in and against law. These included:

To enhance the understanding of how social change can occur by educating disabled people about the potential benefits and limitations of engaging in test case litigation and other mechanisms for achieving social change; To work as legal counsel to coalitions of organizations representing disabled people. To contribute to the positive image of disabled people by cooperating with the media (with the consent of clients) in presenting disabled people asserting their rights.³¹

Other objectives included promoting ongoing consultation with the disabled community to ensure that ARCH's litigation strategy was meeting the needs of the disabled, and to achieve the empowerment of disabled people through legal assistance, and monitoring and reporting on legislative, regulatory, administrative, and judicial changes affecting persons with disabilities.³²

The political organization of the clinic itself provided both opportunities for and challenges to implementing an increasingly "empowerment-oriented" agenda of legal and social change. The clinic's management, by a board that consisted of representatives from organizations of the disabled, was unique within the clinic system and oriented toward collective, coalitional strategies. Activists were aware, however, that this same structure also, at least potentially, served to "distance" clinic staff and volunteers from the disabled community they served. Not only did the board consist of other representatives of the disabled community—

in institutions, developing educational packages concerned with issues such as abuse of persons with disabilities, and delving into new areas of poverty law such as the rights of persons with HIV/AIDS. Non-OLAP funding sources gave the clinic greater independence from regulatory policies than most clinics enjoyed, allowing ARCH to complement legal casework (increasingly “test case”) with law reform and organizing initiatives. As funding and staff levels grew, the geographic reach of ARCH’s activities extended to the provincial and national scales (for example, through work on lay advocacy for disabled people in institutions, the accessibility of legal services for the disabled in Ontario, and legal work on charter rights cases).

At the same time, ARCH’s efforts to promote awareness of and action on disability issues were starting to pay off. In 1983, for example, clinic representatives helped to convince the Attorney General to launch a public inquiry into the accessibility of legal services for the disabled. ARCH worked closely with the Abella inquiry and, in 1984, the government invited the clinic to assist in implementing its recommendations. This prompted the CFC, in turn, to offer substantial increases in the core funding through OLAP (\$100,000), in exchange for ARCH’s assistance in implementing the inquiry’s recommendations within the clinic system. Clinic activists, concerned that OLAP’s support for action on disability issues might extend only to ARCH and one or two other clinics, used this opportunity to encourage the CFC to provide funding to clinics throughout the system to ensure that they had staff with experience and expertise in disability issues.

While these conditions made it possible for clinic board members and staff to pursue a more radical law reform, education, and organizing agenda, and to expand the geographic scope of ARCH’s activities, such shifts would not have occurred without the long-standing ideological commitment of ARCH supporters and staff to radical strategies of empowerment, and their growing dissatisfaction with the gap between dreams of a clinic that supported coalitional struggles against oppression and the realities of incorporated poverty-law services. Clinic leaders recognized that while ARCH had become successful within the regulatory constraints of the clinic system, it was not yet a radical site of struggle and empowerment within law that could help to unsettle and change prevailing relations of power that marginalized the disabled within law, society, and space:

ARCH in the first five years has evolved into a successful and complacent entity—and the board reflects this—the question is does the board want to sit back and rest a bit or resist that temptation and focus on a theme or rally cry. For example: What do we want: ACCESSIBILITY, when do we want it: NOW and muster all of ARCH’s energies as well as all ARCH’s member organizations²⁹

clinic leaders to strengthening the power of the disability movement was expressed in various practical ways, including a 1991-92 program to provide small grants to self-help disability groups to assist them in running their organizations more effectively. The empowerment objectives of this program were clear: "Through this grant we hope to encourage people to become involved in the disability movement, to develop structures so they can grow and take on new responsibilities."³⁵ The preoccupation with individual legal assistance that characterized the clinic in its early days had been replaced by more inclusive processes and spaces of resistance in which political empowerment was viewed as a crucial precondition for effective resistance to prevailing relations within law. New and revised clinic objectives in 1991 acknowledged that legal casework alone was insufficient to ensure the inclusion of persons with disabilities in Canadian society and emphasized ARCH's role in encouraging the disabled to explore complementary political avenues of change. ARCH's education initiatives would no longer, for example, only alert disabled persons to the benefits and limitations of test case litigation as an avenue of social change but would also seek to educate activists about "other resources for action, and developing strategies for law reform in order to achieve social change."³⁶

As in the past, ARCH remained committed to reaching out to persons with disabilities not associated with disability organizations by providing rights information. However, this information was no longer restricted to legal issues of rights. It now included discussion of effective political avenues of law reform. To help strengthen the disability movement's capacities to contest the law, the clinic would encourage a wider range of disability organizations to respond to legal rights issues and would encourage organizations such as unions to become involved in disability issues in alliance with disability organizations. ARCH would also seek to empower disability activists by helping them develop their own legal expertise and initiatives. Two key new objectives were, thus, to "Enhance the ability of member organizations to undertake actions which previously have been seen as ARCH's sole responsibility," and "to increase the involvement of non-member organizations in ARCH's work."³⁷

With the election of an NDP government in Ontario in 1990, ARCH was able to forge ahead with its law-reform agenda. Clinic staff served as legal counsel to Disabled People for Employment Equity, which was working with other coalitions to press for strong and effective provincial equity legislation. The provincial Employment Equity Act that resulted from such efforts was a short-lived victory, however, as it was subsequently dismantled by the conservative government elected in 1995 on the official but erroneous grounds that the act instituted a quota system for advancing equity in the workplace (i.e., a system requiring that a certain proportion of employees be members of underrepresented groups). Similarly, ARCH's victory in getting the NDP government to set

representatives whose “first loyalty” was to their own particular organizations—but with constituents scattered across regions and even provinces, clinic activists could not monitor developments within their community in the close way that neighborhood clinics could. As a 1985 brief noted, ARCH volunteers and staff could not sit in a local donut shop and hear community issues being discussed.³³

ARCH responded to this challenge in a number of ways, including substituting task forces for committees to make member involvement more attractive and focused (e.g., of limited duration and with a specific goal) and holding periodic policy and litigation strategy retreats. Special projects, that included working with the deaf community and AIDS victims, have broadened the types of disabled clients the clinic is in contact with. Educational and informational outreach, through the clinic’s newsletters, national conferences, and speaking engagements, for example, have also brought clinic staff into contact with members of the disabled community.

ARCH’s law reform and organizing efforts became increasingly national in scope as the 1980s progressed. Specialization in legal “test” cases, including litigation based on constitutional rights under the national Charter of Rights and Freedoms, allowed the clinic to play a leadership role in law reform; a role that was complemented by initiatives to mobilize organizations around issues of disability and law. In 1987, for instance, ARCH worked with several national disability organizations to establish the Canadian Disability Rights Council (a body that promotes litigation advancing the rights of disabled persons under the Charter and constitution). In 1988, clinic representatives helped to promote the development of self-advocacy systems for the disabled in institutions at the national and international scales by discussing the clinic’s experiences in helping to develop pilot self-advocacy programs in selected Ontario institutions and publicizing the positive difference self-advocacy was making in disabled peoples’ lives.³⁴ Following passage of the Americans with Disabilities Act (ADA) in 1990, discussions began within ARCH about political strategies for promoting a similar act in the Canadian context. Clinic activists recognized that the success of struggles for a Canadian act depended on building the political power of the disability movement by strengthening the input of the disabled within federal decisionmaking, building more effective coalitions between disability organizations, securing permanent funding for disability groups, and ensuring that disability organizations had ongoing and effective input into ARCH’s law reform and organizing efforts.

In general, the 1990s saw this emphasis on building the legal and political capacities of the disability movement increase. Disability and equity issues were clearly on the political agenda in 1990, as indicated by historic events such as the passage of the ADA and the election of Ontario’s first New Democratic Party (NDP) government. The commitment of

the clinic funding committee for its funding than most clinics. This gave ARCH the opportunity to explore ways of complementing its legal work with strategies for building the disability movement itself.

Of course, ARCH's privileged position within the clinic system did not shelter it entirely from the regulatory policies of the state and legal profession. The 1992 funding cutbacks, for example, threatened to terminate an innovative HIV/AIDS project that had widened ARCH's constituency (it was ultimately funded through the attorney general). A project concerned with the abuse of persons with disabilities was discontinued in the same year as resources were allocated elsewhere. An operational review of the clinic system conducted during the early 1990s, in response to ongoing conflicts over the balance of power between the state's regulatory agency and clinic boards, encouraged ARCH and other clinics to struggle to reaffirm and protect the principle of community-controlled legal aid services. ARCH, as a member of the Metropolitan Toronto Association of Legal Clinics (MTALC, which was established in 1992 as a regional association of clinics), was also critical of the absence of an appeal process independent of the clinic funding committee and its staff, and of conflicts between the CFC's roles as supporter and funder of clinics (e.g., its ability to restrict clinic activities through terms and conditions of funding certificates).⁴⁰

Like other clinics in the province, ARCH activists have been frustrated by the absence of a collective political voice in the regulatory process. With the demise of the OALC in 1988,⁴¹ organizing among clinics fractured along regional and political lines; regional associations of clinics were formed and the associations differed often dramatically in their philosophies and goals. A key and long-standing geographic division between Toronto and non-Toronto clinics, the former carrying on traditions of radical grassroots organizing and community development pioneered by early clinics in the city and the latter tending to varying degrees toward relatively incorporated politics of individual service provision, was thus reaffirmed. Hopes that the operational review of the clinic system conducted in the early and mid-1990s might address clinic desires for greater involvement and say in the regulatory process were dashed when the review report recommended a system of representation in which only people appointed by CFC staff would have input.⁴² ARCH joined the MTALC, when it formed in 1992, but clinic activists noted that the bias in membership towards all-purpose neighborhood clinics meant that the particular issues facing specialty clinics were often neglected. A 1993 memo from the clinic's executive director to board members explained the organizational and political differences that set specialty clinics apart from all-purpose clinics:

Specialty clinics are defined by the communities they serve (normally provincial in their mandate) ... they tend to emphasize test cases and law reform ... they develop specialized legal resources, try to

up the Ontario Advocacy Commission, responsible for establishing a self-advocacy system for disabled persons in institutions, turned into defeat when the Harris Conservatives subsequently eliminated that body. Other law reform initiatives launched by ARCH during the early 1990s included submission of a report on systemic discrimination against the disabled to the Human Rights Code Review Task Force, a report on initiatives for the employment of the severely disabled endorsed by both the Disabled Persons for Employment Equity and Employment Equity Alliance, establishment of a coalition working to end discrimination against the disabled by insurance companies, work with the Canadian Disability Rights Council and Coalition of Provincial Organizations of the Handicapped to increase disabled persons' access to benefits under the Canada Pension Plan, preparation of a report for a federal government committee on strategies for developing a comprehensive disability compensation plan in Canada, participation in an inter-clinic working group concerned with support housing, involvement in coalitions pressing for more accessible public transportation, assisting in the establishment of an Ontario Health Consumer Coalition, and advocacy of an Ontarians with Disabilities Act. In fact, and in marked contrast to the clinic's early days, there were few facets of disabled peoples' lives left untouched by ARCH's law reform efforts during the early 1990s.³⁸ ARCH also continued to promote disabled persons' rights within the legal system by, for example, presenting arguments regarding the duty to accommodate disabled employees in test cases before the Ontario Supreme Court.³⁹

How was ARCH able to chart a relatively radical course of action during the 1990s, when most other clinics were swept up in an increasingly conservative regulatory process that encouraged them to dispense legal services to poor individuals but not to promote social change? One factor was its development as a specialty clinic. Unlike other collective-action-oriented specialty clinics such as PAL, ARCH restricted its early activities to the legal services sanctioned by the state's regulatory agency and was able to build its reputation as a provider of quality legal services to the disabled within the clinic system, legal profession, and government in this way. Although regulatory officials and staff actively (albeit informally) discouraged the establishment of new specialty clinics during the 1980s, ARCH's success in providing legal services to the disabled and the evident ongoing demand and need for such services within the clinic and legal system, as well as the clinic's prominent role as a legal resource for legal professionals and government, helped to secure ARCH's place within the clinic system from the points of view of both the clinic funding committee and Ontario Attorney General. In 1992, when the first-ever funding cuts to the clinic system resulted in fears of clinic closures, ARCH representatives were thus reassured that the cutbacks "would not harm a hair on ARCH's head." Another factor that allowed the clinic to move toward a more radical empowerment agenda was the fact that it was less dependent upon

as I indicate below.

One of the important lessons to be drawn from this account is that while grassroots organizations may share common goals and experiences, they are also situated in distinctive ways within processes and spaces of regulation and resistance. This “situatedness,” in turn, makes a difference in how struggles to empower marginalized groups unfold. ARCH, developed after central regulation through the state and legal profession had already commenced, did not initially struggle against regulatory pressures to deliver individual legal services and to limit law reform and organizing initiatives. As the first clinic of its kind and without first-hand experience of the erosion of grassroots control through central intervention, the immediate priority for ARCH’s leaders and member organizations was to secure funding and a place within the existing clinic system. In the clinic’s early days, struggles with the CFC were limited to disputes over specific conditions of funding deemed discriminatory and/or onerous, such as the unusual condition of matching core funding, and CFC refusal to provide badly needed funds for the special needs of disabled clients.

In strategic terms, then, ARCH was situated within the clinic system in a very different way than early Toronto clinics, such as IWC, which had developed as experimental grassroots organizations with an openly radical commitment to empowering the poor within law and society. For IWC, a clinic developed by and for injured workers and dedicated to empowering workers to assert and advance their collective rights through their own legal knowledge and expertise, so that they could collectively challenge compensation law as a site of oppression and injustice within the state, regulatory requirements that undercut injured workers’ control of the clinic directly threatened the alternative poverty law championed by its supporters and staff. Experiences of both regulatory pressures to limit their role in educating and mobilizing injured workers and of the marginalization of workers within compensation law and society generally (e.g., through unemployment, inadequate rehabilitation, and poverty) had taught IWC activists to respond to growing central intervention in clinic affairs with determined and sustained opposition.

ARCH’s development was also shaped in distinctive ways by the regulatory process itself. As indicated above, activists objected to the regulatory agency’s special requirement that the clinic secure additional funding from non-OLAP sources since this departed from regulatory relations with other legal clinics. Ironically, however, this requirement, which forced ARCH to develop an ongoing and relatively successful fundraising strategy, ultimately gave the clinic a greater degree of freedom to engage in alternative forms of legal resistance than most clinics have enjoyed. With multiple funding sources, the clinic could satisfy CFC performance requirements, which stipulated a high volume of individual legal assistance and casework, and draw on funds from alternate sources to build and augment its education and organizing activities. As clinic

involve other clinics in work on behalf of client constituencies, relate closely to the private bar ... they have special resources issues e.g., disbursements on test cases, expensive libraries, attempts to retain specialized expertise ... specialty clinics have unique concerns about clinic funding regulations (e.g., board composition, involvement in law reform...).⁴³

Political fragmentation, exclusion from the regulatory process and lack of a collective political presence at the provincial scale continue to be pressing issues for Ontario's clinics. ARCH has continued to be active in the MTALC, although it has considered the possibility of establishing a provincial association of specialty clinics (the latter was rejected in 1993 as too elitist and as a project that would absorb too many of ARCH's resources).

Despite such challenges, ARCH remains a significant example of the kinds of differences specialty clinics can make in the position of marginalized groups in and against the law. By 1994, ARCH could boast 52 member organizations and an impressive record of responding to disabled peoples' concerns through test-case litigation and law reform. Since then, it has continued to press for legal changes that will empower disabled women and men within the law—including work on employment equity issues, responding to cutbacks and changes in social assistance for persons with disabilities, and ongoing efforts to force the Ontario Conservative Government to pass an Ontarians with Disabilities Act that will protect and advance disabled peoples' rights. With its strong commitment to social change and empowerment, ARCH will continue to play a key leadership role in such struggles and, perhaps most importantly, in the collective project of building disabled peoples' capacities to contest their oppression within the law and society not only within local spaces of everyday life, such as their neighborhood legal clinic, but also at national and even global scales.

Conclusions: Learning From Clinic Struggles

This paper has examined some of the ways in which legal aid clinics in Ontario have struggled to empower groups, such as the disabled and injured workers, who exist at the margins of power in law and society. And it has looked at how the struggles of a particular specialty legal clinic—ARCH—have been situated within a specific socio-spatial context of regulation and resistance, within specific experiences of the regulatory process and its consequences, and particular geographies of clinic development, regulation, and politics. Such situated geographies of legal resistance can help us to understand the uneven development and outcomes of grassroots struggles to empower marginalized groups,

from the local to the national is compelling testimony to the determination of clinic activists not only to change laws that disadvantage poor clients, but to contribute to grassroots challenges to social injustice in and beyond the legal system.

Perhaps the most important lesson is a practical and political one. This is that there are always ways of resisting, disrupting, and sometimes even “working around” the most entrenched and oppressive regulatory regimes. New ways of contesting oppression, for example, through developing collectively controlled community legal clinics, help to create fissures or subversive spaces within legal and political processes that can be used to advance the rights and well-being of marginalized groups. The way in which organizations engage in these “spaces of opportunity” and the differences collective action makes will vary, reflecting differences in how activists are socially and spatially situated within processes of regulation and resistance. It is in this geographically uneven way that grassroots struggles through legal clinics are opening up spaces of resistance within Canadian law and society.

What changes in the clinic system and its politics would allow clinic activists to advance their empowerment objectives? ARCH’s experience suggests that multiple funding sources can help to ease regulatory restrictions on clinic activities, in ARCH’s case giving the clinic greater freedom from the CFC’s centralized regulatory regime. Organizations such as unions and housing cooperatives that make use of clinic expertise could help to provide such funding, as could campaigns for support from charitable and corporate donors (although ARCH’s experience suggests that corporations are not necessarily sympathetic to the need for community legal aid clinics). Overcoming regional divisions in the politics of the clinic movement could also be an important step forward, allowing clinics to lobby for less restrictive regulation at the provincial scale. This would require efforts to forge a common vision of what the clinic system can and should be; whether it is just another “welfare” service or a vehicle for progressive legal and social change. I’ve argued in this paper that diverse experiences of being situated within the clinic movement and regulatory process have contributed to such divisions; however, sharing those diverse experiences with the common objective of creating a more grassroots and empowering clinic system could help to counter this. Perhaps the most important challenge is to continue to defend and advocate community control and community development work, and to convince newer clinics that real change in poor peoples’ lives requires a devolution of power over legal knowledge and resources into the hands of marginalized groups. This would require considerable “soul searching” within the clinic movement with regard to what sorts of services lead to real change and which tend to reinforce existing distributions of power. Leaders within clinics such as ARCH can play an important role in encouraging other clinic activists to reassess their services and to reimagine

staff's expertise in disability and law grew, and as education and lobbying efforts encouraged other legal clinics to assist disabled clients, ARCH was able to adopt a test-case litigation strategy aimed at changing the law, and to mobilize disability activists around collective initiatives such as the ongoing struggle for an Ontarians with Disabilities Act. ARCH activists were thus able to become increasingly committed in practice to radical goals of empowerment within law and society; a political shift at odds with trends toward more conservative, service-oriented poverty law within the clinic system.

ARCH's story also illustrates how important specific socio-spatial networks of political alliances are in shaping the capacities of grassroots organizations to contest the marginalization of poor people within law and society. The unique composition of ARCH's board, a coalition of disability activists and organizations that expanded numerically and geographically over time, not only helped to position the clinic within the wider coalitional politics of the disability movement, but also encouraged clinic leaders to respond to increased radicalism and commitment to social change among disability activists. Unlike neighborhood clinics that had severed political alliances with local grassroots organizations under pressure from the CFC to conform to the "independent clinic model," ARCH was in a position to grow and change with the disability movement—to develop law reform and organizing initiatives consistent with the empowerment objectives and increasingly national and international geographic scope of disability rights struggles.

What is harder to convey is the dedication and determination that informs clinic struggles to empower those at the margins of law and society, whatever the outcomes of those struggles are.

Clinics like ARCH and IWC not only work on a daily basis to help inform, assist, and mobilize people with little, if any, power within the legal system, they do so under especially difficult circumstances. Inside and outside legal channels, they must struggle against powerful opponents such as government agencies and business lobbies whose resources vastly outweigh their own. They must do so under conditions of high need and demand for services and with severely overworked and often underpaid staff. And they must contend with a funding and regulatory process that too often seems to oppose radical goals of legal clinics and poverty-law services collectively run by and for marginalized communities.

The fact that, despite such difficult conditions of struggle, specialty clinics like ARCH have helped to reform prevailing relations in law and the state and to empower marginalized groups at geographic scales ranging

Geographers have made substantial contributions to the study of laws and justice in recent decades.³ These studies have contributed to the legal/politics/culture interface by focusing on a variety of issues, including judicial culture and climate, sentencing variations, court administration and reorganization, race and justice, water and environmental law, and redistricting and reapportionment. Political geographers, in much of their work, acknowledge the importance of place, region, and political cultures, in particular citing the pioneering work of Elazar on the evolution and persistence of regional political cultures and "ethnic geology."⁴ These political cultures are based on historical migration streams, settlement patterns, and religious preferences. An understanding of regional variations in legal cultures is also derived from political scientists studying legislative innovations, state court citations and networks, and regionalism.

Innovative States, Court Prestige, and Regionalism

The impacts of different political cultures are evident in the legal culture of different states and regions and in innovations appearing in state judicial systems. "Prestige" states are those judiciaries that are innovative and influential. This idea was recognized as early as 1936, when Mott studied "indicators of judicial reputation" of state supreme courts.⁵ He sought to measure how state courts are ranked using a variety of measures, including a survey of law professors, state cases used in law classes and books, prestige rankings, and citations. An additional measure was the number of state cases cited with approval by the U.S. Supreme Court for 1900, 1915, and 1929.⁶ Massachusetts, New York, Illinois, and California were accorded the highest reputations. Walker studied the speed and patterns of diffusion of eighty-eight legislative innovations prior to 1965.⁷ He identified "innovative" or "pioneering" states as those whose legislative decisions influenced the adoption of similar legislation in surrounding states. California, New York, Massachusetts, and Michigan were identified as innovative states. Each of these "ha[d] a group of followers, usually within their own region of the country."⁸

Subsequent to Mott's and Walker's pioneering efforts, other political scientists have looked at state court standing or prestige, innovation, regionalism, and judicial communication. Merryman looked at why California's state supreme court was a "factor of authority" nationwide in decisions of other courts.⁹ Shapiro looked at tort organization in fifty-two appellate courts and concluded they basically operate independently, but arrive at similar policies. He wrote that these courts "constantly cite each other as persuasive or illustrative or worthy of consideration in making their own [decisions]."¹⁰

Canon and Baum studied the innovativeness
Stanley D. Brunn is Professor in the Department of Geography at the University of Kentucky in Lexington; Fred M. Shelley is Professor in the Department of Geography at Southwest Texas State University in San Marcos; Gerald R. Webster is Professor in the Department of Geography at the University of Alabama in Tuscaloosa; and Wael M. Ahmed is a recent graduate of the University of Kentucky College of Law in Lexington. *Historical Geography*, Volume 28 (2000): 134-55.