COMMENT

Legal Services for Mental Health Patients: Some Practical and Theoretical Observations on Canadian Developments

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Compared to United States developments, the growth of legal services for mental health patients in Commonwealth jurisdictions is closely tied to the evolution of state legal aid systems. This is illustrated by an examination of the emergence of patients' legal services in Canada where several different schemes have been established or attempted. The close association with state systems may lead to a number of problems. In particular, the domination of legal services by state legal aid systems that have an increasing "welfare state" function, may not be in the "best interests" of patients, who may be better served by partisan poverty law advocates. This is particularly pertinent in light of the conflict between the health and legal needs of patients and the "welfare state" function of the mental health system.

INTRODUCTION

The simultaneous growth of the mental health law and the legal aid/poverty law movements in the past 20 years has resulted in the gradual appearance of a variety of legal services for mental health patients in the United States, Canada, England and Australia. Growth has been particularly spectacular in the United States where a recent estimate suggests that approximately 139 legal advocacy systems are in operation. (Gordon 1981a).

In the United States, many of these services have evolved as either adjuncts to existing legal aid/poverty law agencies or through the expansion of civil rights organisations (*eg* the Mental Health Law Project). However, a major impetus appears to have come from: a) legal professional associations that fund various experiments (*eg* the American Bar Association); b) agencies established by the courts (*eg* the New York Mental Health Information Service); and c) agencies directed into existence by both court orders (*eg Davis v Baylor* (384 F Supp 1196 [1974]) and by

legislation (*eg Illinois Mental Health and Development Disabilities Code*: SB 250). In addition, the promise of substantial fiscal support resulting from President Carter's Commission on Mental Retardation has spurred the emergence of state-run advocacy systems.

This contrasts sharply with the situation prevailing in those Commonwealth jurisdictions where some forms of legal services for mental health patients exist (*ie* Canada, Australia and England). In those countries, the growth of legal services can be seen to be tied more closely to the evolution of legal aid structures. It has been argued elsewhere that

> . . . the development of legal aid systems has provided financial, organisational and conceptual support and direction (for patients' legal services) giving: i) an impetus to the few pre-existing but *ad hoc* legal services, notably those available through patients' organisations; ii) a selection of different legal service delivery modes; and iii) personnel interested in uncovering and answering the legal needs of disadvantaged groups such as mental health patients. (Gordon 1981b).

At the same time, such systems have also determined the emphasis, approach and, to some extent, the impact of existing services; notably the physical delivery mode, the delivery style, and the delivery objectives. State-run legal aid systems, which are affected by the prevailing policies of the government or legal profession, have provided a framework in relation to coverage, client eligibility and remuneration for legal workers. As such, they have also tended to restrain the work of legal services in both a procedural and an economic sense.

This is not to suggest that, in Commonwealth jurisdictions, legal aid systems have been the only source of impetus for mental patients' legal services. Indeed, in England, the dominant source of legal assistance has, since 1979, been in the hands of the Legal Department of the National Association for Mental Health (MIND), a division of an agency that has long acted as an independent "consumer group", for mental health patients. However, because of the procedures for funding legal representation this service is still tied to the English legal aid "system" with its attendant financial and organisational weaknesses (Gostin & Rassaby 1980). Similarly, in Canada, the Canadian Mental Health Association, another "consumer group" plays a significant role in providing, *inter alia*, patient representation before review boards, especially in Ontario. In addition, the National Legal Resource Service of the National Institute on Mental Retardation (established in 1978 at York University, Ontario) has been active in pursuing the interests of, in particular, the developmentally disabled. Notwithstanding the impact of these agencies, it is apparent that formal legal aid systems have been the principal driving force in developing patients' legal services. An examination of the emergence of such services, in Canada, should serve to establish this point and provide a review of developments in the area.

THE GROWTH OF PATIENTS' LEGAL SERVICES IN CANADA

In Canada, the early 1970s saw the emergence of legal service experiments in several provinces. Four distinct methods of delivery have now evolved from these initial schemes: the "store-front" law centre, the specialist advocacy centre, the duty

counsel system, and advice and referral schemes as adjuncts to a "judicare" system. Details of each method of delivery will be discussed briefly along with some other schemes that have been devised.

The most significant development of "store-front" law centres has been in British Columbia. In 1972, a loose amalgamation of interested parties, notably a psychiatric social worker, law students and lawyers involved in the then evolving legal aid movement, began a limited legal advocacy project in a large psychiatric hospital in Greater Vancouver. This scheme was expanded, under the auspices of the Vancouver Community Legal Assistance Society (VCLAS)[1] and with federal government support, into the Mental Patients' Advocate Project. The project operated from both "store-front" premises in the grounds of the hospital and from the inner suburban offices of VCLAS where patients on community release could obtain access to an advocate.

The project staff (two lawyers and a secretary) adopted a partisan advocacy approach to patient representation and offered the types of general services found in most conventional community law centres as well as specialist skills in mental health law matters. They undertook test cases and one class action. After a two year period, the project was assessed by the Department of Justice and although it was favourably evaluated, federal funding was withdrawn in September 1980. The provincial Mental patients' Association provided interim assistance but, in January 1981, the project had to suspend *full* operations. At present, the project secretary acts as a para-legal and the remaining lawyer is dividing his time between the hospital and the VCLAS office. To ease the workload, the project has had to be more selective in the type of work undertaken and many cases formerly handled by the project are referred to local practitioners under the "judicare" component of the provincial legal aid plan.

Attempts to provide similar services have occurred in other places. In Ontario, Toronto Community Legal Assistance Services (an agency established by the Faculty of Law, University of Toronto and funded by the Ontario legal aid plan) started a patients' legal service in 1974, in a major mental health centre. This scheme was designed as an annex to a conventional community law centre but ceased operations in 1980 due to a lack of support and conflicts between law centre and hospital staff. A similar, independent law centre opened in the York-Finch General Hospital in Toronto in 1974. However, this scheme concentrated only on conventional legal problems and excluded any legal issues pertaining to hospitalisation and treatment. Heralded as a laudable example of an inter-disciplinary approach to the needs of mental health patients (Monahan 1975), the scheme is still in operation, although in a severely restricted form. It now functions as a location for summary advice and assistance within the Ontario legal aid plan, rather than as an independent, community-based legal clinic.

Specialist advocacy centres are a more recent development than "store-front" law centres. The National Legal Resources Service of the National Institute on Mental Retardation is probably the leading example of this type of agency, particularly as it has had a number of successes in pursuing individual cases of injustice. In a similar vein, the Advocacy Resource Centre for the handicapped in Toronto is active in pursuing test cases, class actions and other reformative activities for a broad community of interest. Established in 1980 and funded by the Ontario legal aid plan,

this agency is sponsored by a coalition of consumer groups including mental patients' associations.

Apart from law centres and advocacy centres, a number of duty counsel schemes have also been established. In Ontario, duty counsel first appeared in fourteen provincial psychiatric hospitals in early 1975 and now attend on a regular basis to assist patients. Duty counsel are drawn from a volunteer panel of private practitioners working under the "judicare" component of the legal aid plan. In Manitoba, a similar duty counsel scheme also started in 1975. However, the lawyers are staff members of community legal services offices rather than private practitioners. Regular visits are made to three provincial institutions and counsel provide advice and assistance to any patient with a legal problem. A duty counsel scheme of a slightly different nature has also been in operation in British Columbia since 1974. The then provincial Legal *Aid* Society organised a patients' appointee project to assist those appearing before review panels established under the Mental Health Act. A panel of interested lawyers has been developed and, on receipt of a request from either a patient or a hospital social worker, the now Legal Services Society refer the matter to one of the practitioners. The cost of representation is borne by the provincial mental health authority.

In many respects, these duty counsel schemes act as advice and referral services, channelling applications for legal aid under the "judicare" component of provincial plans. However, because duty counsel schemes allow a patient at least some immediate access to a lawyer, they are to be distinguished from schemes that employ non-lawyer personnel to assist patients. An example of the latter can be found in Alberta where, in 1975, community legal aid interviewers were appointed to improve the level of access to the provincial "judicare" scheme. This system of "outreach" was designed to benefit all members of the community who were institutionalised or otherwise unable to obtain access to legal aid offices. In the specific context of mental health patients, a regular program of weekly visits to two provincial institutions has been established, complemented by advertising and the utilisation of ward social workers who act to channel clients as the need arises.

In addition to the four specific categories discussed above, other schemes have been introduced to deal with the legal needs of patients. An "ombudsman" experiment was introduced to a hospital in Ontario but was phased out with the advent of the provincial duty counsel scheme in 1974. In British Columbia, the provincial Mental Patients' Association has recently organised a "courtworker" scheme designed to ensure that patients are properly assisted if and when they appear before the Vancouver Provincial Court (equivalent to an Australian Magistrates' Court) and the Legal Services Commission in Quebec, Newfoundland and Nova Scotia have set up various systems to advise patients of the availability of legal assistance, especially in relation to review tribunal hearings.

While special legal service facilities for patients have been developed by some provincial legal aid bodies, independent community law centres in Canada are also handling requests for assistance from patients as part of their general operations. The role played by Toronto Community Legal Assistance Services and the Vancouver Community Legal Assistance Society has already been discussed. It is also vital to acknowledge the work of agencies such as the Dalhousie Legal Aid Service in Halifax, Parkdale Community Legal Services in Toronto, Community

Legal Services in Fredericton, New Brunswick, Calgary Legal Guidance and the legal services established by the law schools associated with the major universities.

Although it is not possible to determine the extent to which such independent agencies provide assistance, it is clear that, in many cases, they bridge the gaps in coverage and eligibility created by the policies of provincial legal aid bodies, particularly in provinces such as New Brunswick that only have partial or otherwise inadequate legal aid plans. In addition, because of their policy of making their facilities easily accessible to disadvantaged people and providing specialisation through the practice of poverty law, independent legal services have attracted the attention of both mental health patients and those in a position to recognise the value of such services for patients (*eg* psychiatric social workers).

It is therefore apparent that the growth of legal aid systems has been the major impetus for mental patients' legal services in Canada. Indeed, there are inseparable links between the two groups in both an economic and an organisational sense.

SOME PRACTICAL AND THEORETICAL OBSERVATIONS

Aside from the many advances that have been made, the current position in Canada suggests some emerging problems in the relationship between legal aid systems and patients' legal services. Indeed, it is possible that the close ties with legal aid systems may have the effect of restraining, rather than encouraging, further growth. Several interlocking issues relate to this proposition and have practical significance for those seeking to establish legal services. They also introduce some theoretical considerations pertaining to the evolutionary patterns of legal aid in general and patients' legal services in particular.

The first issue is perhaps trite: state legal aid systems which have emerged to dominate and bureaucratise the delivery of legal aid are facing financial difficulty. Economic constraints affect eligibility and coverage policies as well as the availability of surplus funds for innovation and experimentation in areas such as mental health. Given that legal services for patients are late arrivals in the evolution of legal aid, they will probably suffer more from the effects of the fiscal drought. Linked to this are some more complex considerations.

There seems to be an increasing ideological demarcation between those managing state legal aid structures[2] and those involved in the practice of poverty law.[3] This suggested divorce has yet to be clearly delineated and analysed but it has a bearing on the future development of all legal aid facilities, including those for mental health patients. At this stage, a useful analytical approach would seem to be via the re-emerging interest in critical theories of the state and of the welfare state in particular (*eg* Gough 1979; Panitch 1979; Holloway & Picciotto 1978). In this respect, the notion of legal aid systems as an aspect of the welfare state is largely undeveloped, despite many intriguing linkages, and begs attention. For example, the financial drought mentioned above, can be usefully conceptualised in the context of O'Connor's notion of a fiscal crisis confronting the state as demands for and the costs of, legitimation mechanisms such as the welfare state, outstrip revenues (1973). Such a thesis obviously requires a meticulous and empirically founded examination. The intention here is simply to sketch an outline of potentially fruitful avenues of enquiry in the context of patients' legal services.

It seems that a "conservatisation" of the legal aid movement has emerged with the steady monopolisation of legal aid delivery by the state. The concept of "conservatisation" is employed here to encompass two interlocking processes applicable to the situation confronting many of the reformist movements that developed in the late 1960s and early 1970s. First, all radical organisations hold the potential to become conservative and find themselves subject to the criticism of emergent radical bodies: there is an air of structural inevitability about this process that speaks to the evolutionary patterns of any agency. However, this process may be "artificially" interrupted by state co-option of the radical organisation. In particular, and this has happened in relation to some civil rights agitators and other reformers in the United States (*eg* Platt 1979), radical leaders may be granted positions of responsibility within a state-organised body that takes over the services offered by the radical organisation. In this way, the state legitimates itself as well as the new agency. However, this agency no longer acts in the same way; it becomes a shadow of its former radicalism and seeks to *conserve* its sphere of influence within state-prescribed parameters, in its own self-interest.

Secondly, radical organisations are now facing the rise of the "New Right", itself a radical but non-reformist (*viz* conservative) ideology spurred by the fiscal and legitimation crises confronting capitalist states (*Crime and Social Justice* 1981). Conservative forces are manufacturing a new "consensus" and are employing, *inter alia*, an ideology of law and order to undermine those radical agencies that have wrested reforms aimed at shifting power in society. As Nader (1981) has recently noted, public interest law is under threat as a consequence of this type of development. This form of conservatism is effective where radical organisations relinquish their position in the face of opposition, where funding is withdrawn as a result of state fiscal policies, or where (as noted above) the state takes over in the interests of "rationalising" the "welfare" services formerly provided by a radical body.

In the specific context of legal aid delivery, part of this process involves an increasing rejection of more activist approaches to legal aid delivery — as exemplified by poverty law practice — on the basis that they are "unrealistic", "ineffective" and/or "impractical". This is in part due to the perceived, although questionable, "failure" of the legal aid/poverty law pioneers to create certain reforms in social, political, economic and legal structures; reforms that were rather poorly defined at the outset. With the perceived "failure" and associated disillusionment there has been an element of surrender to a legal aid titan controlled by interests that may not find the more challenging theory and practice of poverty law especially comfortable.

Although the reasons may be subject to debate, it is clear that the theoretical foundations of poverty law, which underlie Charles Reich's exposition of the notion of "new property" (1964) are somewhat distant from the operational policies of contemporary, state legal aid systems. Reich's description of the growth of government largesse as a function of its increasing interventionist role in the economic realm,[4] helps to place the disadvantaged — who receive "income" from government in the form of benefits — in the same legal and economic context as the multitude of enterprises who also receive "income" by way of government contracts, subsidies and franchises. In this situation, poverty law, but more

particularly its sub-specialisation, social welfare law, can be seen as an activity that provides the disadvantaged with a mechanism for protecting their interests (or property) just as other, more monolithic and powerful bodies, have legal mechanisms that protect and assist their interests in their economic relationship with government. In this context, the key word is *activity*. Poverty law in its ideal and often applied form is a proactive enterprise embodying a form of partisan advocacy that incorporates an aggressive assertion of needs and "property rights". As such, and given its relative youth, a purely reactive stance or a pure concern with matching the power of social control systems, notably the criminal justice, family law and mental health systems, is insufficient. Given that the first two systems and, to a modest extent, the third system are a major focus of state legal aid structures (particularly by way of duty counsel schemes), the essentially passive and reactive nature of these bodies is illuminated. In effect, legal aid systems are becoming an agency of the welfare state; that is, structure designed to mediate social crises arising from economic fluctuations, in the interests of the prevailing economic order (monopoly capitalism) and to thereby help legitimate that order. In this sense, legal aid is a social control system rather than a mechanism for advancing the interests of the disadvantaged by challenging the state and effecting relevant reforms. Indeed, it may no longer be appropriate to refer to "legal aid" and "poverty law" in the same breath.

Where substantial links are forged between state legal aid systems and, for example, legal services for patients, the former enjoy not only economic but also ideological hegemony over the latter. Often supported by "evaluation research", legal aid delivery priorities are determined *and* legitimated in accordance with policy-makers' ideas of what "unmet legal need" is, where it is to be found, and how it is to be answered. Given the process of "conservatisation" and the suggested "welfare state" function of legal aid, these perceptions may not incorporate support for the types of objectives associated with activist groups, even though some of their delivery methods (*eg* "store-front" offices) may be used. In this situation, the need for patients' legal services may be by-passed or, where services are developed, they may be strictly limited to carbon copies of facilities provided for the disadvantaged in their confrontations with other social control systems.

It might be argued that so long as patients are given access to some legal resources it matters not who organises and directs the enterprise. This proposition has appeal, especially given the extent of unmet need that exists. However, an acceptance of this approach must be viewed with caution, especially in light of the wide spectrum of patients' needs.

The limited research that has been undertaken shows that patients' needs are broad and complex (*eg* Brakel 1978; Dickey & Remington 1976). Because of the close relationship between poverty, mental ill-health and institutionalisation, patients' legal services are inevitably tied to the basic elements of poverty law and social welfare law but with an obvious concentration on mental health law issues. The three areas have a marked mutuality and, in some cases, this has found a concrete base. Legal services, such as the Riverview project in British Columbia, approximate in delivery method, philosophy and objectives the types of model poverty law practice that have been attempted or proposed in some jurisdictions (Bothmann and Gordon 1979). In this respect, they are similar to community law

centres, as the client group is both a geographical community (the residents of an institution) and a community of interest (clients of the mental health system). As such, the work of these patients' legal services tends to highlight the importance of full-time, partisan advocacy on behalf of the client *group* as well as *individual* clients.

Further, patients' needs are directly related to the inadequacies and injustices of prevailing mental health systems: in particular, the often Draconian nature of involuntary commitment and continued detention procedures. It is therefore necessary to find ways of generating substantial reform in a state-run system. Using, or relying upon, another state-run system to do this may be of questionable value, particularly as the patterns of ideological and organisational domination have a pervasive and mutually supportive quality. Clearly, the mental health system is as much part of the welfare state as is legal aid. In this respect, they perhaps share the same social control function and cannot be relied upon to act other than in the collective interests of their mutual enterprise. To some extent, this is supported by two interlocking issues: the actual operations of duty counsel schemes in the mental health context; and the conflict between the health and legal needs of patients.

(1) From what is known of patients' legal services that are directly associated with state legal aid systems (*ie* duty counsel schemes) it is clear that they do not take an activist approach to delivering legal services. In the main they are only marginally concerned with the interests of mental health patients as a group. They are essentially reactive and mediatory. Their impact, particularly given the need for reformative activities, is therefore questionable and can be aligned with "welfare state" goals.

However, with reforms occurring in mental health legislation (*eg* the establishment of review boards and the extension of patients' rights) and the increasing recognition by Canadian courts that mental health review boards have a duty to act fairly [*eg Re Abel et al v Penetanquishene Mental Health Centre* (1979) 46 CCC (2d) 342 (Ont Div Crt); *Martineau v Matsqui Institution Disciplinary Board* (1980) 50 CCC (2d) 353 (SC Can); *Re Abel et al and Advisory Review Board* (1981) 56 CCC (2nd) 153 (Ont C A)], it might appear that the role of the partisan advocate/legal service is given support. Legal need that can only be answered by legal services, in an adversarial context, is in effect being created by legislators and courts. For example, legislation in one Canadian province (Quebec) already requires that institutions notify the local legal aid agency of all involuntary commitments and forthcoming review hearings so that the agency can directly canvass the needs of individual patients. In addition, informal arrangements have been established in other provincies (*eg* Nova Scotia) so that notification occurs without legislative compulsion. These developments perhaps serve to counter the suggestion that *any* form of partisan advocacy is avoided. However, there are two problems that highlight the continued dominance of a "welfare state" function:

a) Advocacy is encouraged in only one area of legal need — representation before review hearings. As such, these types of developments do not necessarily encourage partisan advocacy in its broadest sense; *viz* actively seeking system reform through legal or other action.

b) As state legal aid systems are invariably involved in providing representation, any advocacy appears in the duty counsel form. Even if it were possible to bracket the problem of ideological domination, much depends on the quality of representation and on the economic and organisation supports that are provided.

Additionally, and perhaps more importantly, duty counsel schemes have a restraining effect on the creation of alternatives. Their presence serves to deflect efforts away from encouraging the development of activist and partisan advocacy by creating the impression that unmet need is being effectively answered. Thus they tend to diffuse the demand for legal services, at the same time avoiding conflict with another titan — the mental health professions. This problem is connected to the next issue for duty counsel schemes can be seen as a product of a conflict between patients (and their representatives) and the mental health system.

(2) In the mental health law context, the recognition of a conflict between the health and legal needs of patients is central to understanding patterns of development. Indeed, where organisations have become involved in pursuing patients' interests there is evidence of internecine warfare between two professional groups — lawyers and mental health personnel — and their associated perceptions of what is in a patient's "best interests". In this respect there is a clash of ideologies.

Lawyers tend to argue that civil rights needs — notably the right to liberty — should dominate all other considerations and that mental health systems should be adapted to acknowledge this priority. On the other hand, mental health professionals allocate priority to health needs arguing that patients have a right to mental health without which "liberty" is meaningless. Both seem to agree that conventional legal needs should be answered, particularly where they are related to restoring and maintaining health.

In this somewhat confusing situation, legal aid policy-makers who do recognise that patients have unmet needs have a range of choices. They may opt to support schemes that embody aggressive, partisan advocacy (such as the Riverview project), or they may prefer alternatives. They may select a more mediatory approach and sponsor, for example, hospital "ombudsmen". These schemes limit conflict between mental health professionals and patients' advocates, but by restraining the latter rather than exploring and establishing a genuine compromise. However, as the former seem to have a more powerful voice in the determination of priorities it follows that their interests and their perceptions of what is in patients' "best interests" will dominate legal aid policy decisions. This is clearly evident in the tendency for state legal aid systems to encourage and support non-adversary legal services.

Certainly, the forms of negotiation rather than confrontation that are an implicit tactic in duty counsel and similar schemes recognise that litigation is not always the best way of answering the needs of patients. This is not denied by partisan advocates. However, to be just, any negotiation must proceed with a balance of power between those in conflict. It is this essential element that has been historically denied to patients,through the doctrine of *parens patriae*, and it is still largely absent in most jurisdictions. As a consequence, any mediatory approach to legal service delivery, at this time, necessarily commences with an inbuilt disadvantage.

Once equity in the relationship between patients and mental health professionals (and institutions) is created and assured — the task of the partisan advocate — it may be possible to consider less adversarial approaches. However, where patients' legal services are controlled by state legal aid systems, the likelihood of this occurring is reduced. Indeed, those legal services that are established by such systems tend, at best, to take non-existent power as given and then proceed to "represent" the interests of their clients. This seems to invite less than impressive results unless the "welfare state" function is seen as being of paramount importance.

Despite the emerging problems that have been outlined, the process of providing patients' legal services is showing some signs of continued growth. While litigation has not had the spectacular results attributed to United States mental health advocates, the gains that have been made in the context of legislative reform are encouraging. Patients' rights are being accepted as legitimate and there is at least a recognition of the necessity to find a compromise between the health needs, the civil rights needs and the conventional legal needs of patients. However, this progress may be stunted by the economic and, perhaps more importantly, the ideological, domination of legal services by state legal aid systems that are bonded to mental health systems by their mutual "welfare state" function. In this respect, the growth and current status of patients' legal services, in Canada, should serve to both encourage and caution practitioners in other jurisdictions.

Rather than automatically turning to state legal aid systems in the expectation that they will produce the necessary infrastructure for the growth of patients' legal services, it may be wiser to consider alternatives. In this sense, it may be necessary to re-examine the "private" realm. Joining the personnel of patients' associations and independent law centres with concerned mental health professionals may, in the long run, be in the "best interests" of patients.

With due diligence, funding and facilities may be obtained from several sources — law foundations, philanthropic trusts, university law schools and patients' organisations. Support from these quarters assures some measure of financial (and therefore ideological) autonomy and may allow members of the client group, who seem perfectly able to take part in the management of their own agency, to dictate service objectives. In this way, legal services will avoid external domination and be free to set their own priorities and goals, one of which is generating much needed reform in mental health systems. In addition, this process may effectively resolve the enduring conflict between the health needs and legal needs of patients — one which is currently being settled in favour of psychiatric perceptions of what is in a patient's "best interests". A principal objective of all legal services for the disadvantaged has always been the establishment of power for the client group. In the mental health context, this is clearly the power to determine what needs are and the individual circumstances under which either health, civil rights or conventional legal needs shall take priority. However comfortable the relationship may appear to be, association with state legal aid systems may not be helpful in the pursuit of this important goal.

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Endnotes

1. The Society is an independent public interest/poverty law agency. It specialises in test case litigation and supervises a network of law student clinics throughout the Greater Vancouver area.
2. State legal aid structures include not only legal aid schemes organised by provincial governments, but also those organised by provincial law societies. In this sense, the "state" is conceived as an "institution" with broad parameters.
3. Poverty law is seen as a category of aggressive, partisan action for a specific client group, as well as a category of legal specialisation. In Canadian jurisdictions, it is most clearly associated with the independent community law centres.
4. In this context, Reich's thesis can be tied to contemporary debates in the development of critical theories of the state, especially that surrounding the "relative autonomy" of the state.

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