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Australian best practices—a comparison with the United Kingdom and the United States

Introduction

Efforts to develop clinical legal education in Australia, the United Kingdom (UK) and the United States of America (US) have gradually evidenced a common goal: to develop consciously the best practices of clinical legal education in each country. In doing so, there is an effort to provide clinicians with guidance to improve law student education in the essential lawyering skills and in their ability to analyse and critique the law and legal system. We use the term 'best practices' throughout this book to describe what experience and, to varying degrees depending on the country, research have shown to be the most effective practices, or approaches, to clinical legal education in the countries compared in this chapter. As noted in our Australian *Best Practices*, 'there will always be debate about what is "best"'.[1] In the UK, for example, clinical legal education practices are described as 'standards', though they do not serve a regulatory function. For comparison's sake, this chapter will refer to the UK 'standards' as 'best practices' or 'best practices standards'.

1 Adrian Evans, Anna Cody, Anna Copeland, Jeff Giddings, Mary Anne Noone, Simon Rice and Ebony Booth, *Best Practices: Australian Clinical Legal Education* (2013) Government of Australia, Office of Learning and Teaching, 7, accessible at perma.cc/2J6E-ZMQX. Accessed 19 August 2016.

While each country has a different system of legal education, and a different process for determining how a person qualifies for admission to practise law, the core pedagogy of clinical legal education in each country emphasises involving students in the work that lawyers perform in service to clients with legal problems. In a clinical course, 'clinic students confront the same types of issues they will confront after becoming full-fledged lawyers, [and] they do so under the supervision of faculty who engage the students in the process of critique, self-critique, and self-reflection'.[2] This pedagogy focuses on assisting students not just to learn how to learn from their experiences, but also to appreciate how that knowledge will assist them in their development as effective, ethical lawyers or other professionals, as well as to reflect on the role of law and the legal system in achieving justice.

In Australia, the UK and the US, clinical legal education principally developed as an emerging pedagogy in the 1960s and 1970s,[3] though, especially in the US, the origins of clinical legal education are much earlier.[4] In some jurisdictions, the focus of clinical legal education has been on client service and, in others, on legal education. However, both objectives are commonly recognised as important in all three countries. Other notable differences in clinical legal education among countries have included law reform *versus* client service in program goals, systemic advocacy *versus* individual advocacy in legal service delivery and, increasingly, the academic status of clinicians both within their individual law schools and the legal academies in their countries.

In this chapter, we compare the efforts in each country to establish best practices in clinical legal education, and the resulting best practices that were developed. We hope that the material in this chapter may aid clinicians in other countries as they consider whether to develop their own best practices in light of their cultures, legal institutions, and systems of legal education.

2 Peter A Joy, 'The Law School Clinic as a Model Ethical Law Office' (2003) 30 *William Mitchell Law Review* 35, 43.

3 See e.g. Jeff Giddings, *Promoting Justice Through Clinical Legal Education* (2013) Justice Press, 5–11 (cited hereafter as Giddings (2013)); William M Rees, 'Clinical Legal Education: An Analysis of the University of Kent Model' (1975) 9 *Law Teacher* 125, 125–26.

4 Giddings (2013), 5–8; and Chapter 2 of this book.

Why best practices?

The development of best practices reflects a level of maturity in clinical legal education, and represents an effort to move from the implicit and often anecdotal understanding concerning teaching and organising clinical legal education to a more systematic and explicit articulation of its effective qualities. By identifying and explicitly communicating educational practices and organisation of clinical legal education, best practices identify achievable goals and practices for individual clinicians, their clinical programs, and clinical legal education within each country. The articulation of best practices also supports the development of clinical legal education more broadly and documents existing good practices.

Best practices provide clinicians, law school deans, and other academic staff with criteria or guidelines for strengthening their clinical programs. Not only do best practices serve to enhance existing clinical programs, but they are also an important resource for law schools initiating such programs. In addition, for countries that have law school accreditation standards, such as the US,[5] best practices for clinical legal education can be influential. For example, efforts to identify best practices for clinical education in the US, especially in the areas of externships and status of clinical faculty, have had a beneficial effect on accreditation standards.[6]

Before best practices for clinical legal education can be developed in any country, there first needs to be a perceived need or benefit. In the US, where legal educators developed the first set of best practices (called 'guidelines for clinical legal education') in the late 1970s and early 1980s, the need was originally motivated by the growing importance of clinical legal education in legal education.[7] By the early 1990s, clinical faculty compiled data on reported practices of in-house clinics in areas such as student–faculty ratios, hiring criteria for clinicians, and structures for in-house clinics.[8] The more recent version of best practices for clinical legal

5 American Bar Association Section of Legal Education and Admissions to the Bar, *ABA 2016-2017 Standards and Rules of Procedure for Approval of Law Schools* (2016), at www.americanbar.org/groups/legal_education/resources/standards.html. Accessed 19 August 2016.

6 See e.g. Peter A Joy, 'Evolution of ABA Standards Relating to Externships: Steps in the Right Direction?' (2004) 10 *Clinical Law Review* 681, 696–704; Peter A Joy and Robert R Kuehn, 'The Evolution of ABA Standards for Clinical Faculty' (2008) 75 *Tennessee Law Review* 183, 191–213.

7 Report of the Association of American Law Schools and American Bar Association Committee on Guidelines for Clinical Legal Education, *Guidelines for Clinical Legal Education* (1980), iii.

8 'Report of the Committee on the Future of the In-House Clinic' (1992) 42 *Journal of Legal Education* 508.

education in the US is the result of an effort that addresses best practices for all of legal education, and was motivated by the principle that US law schools could and should better prepare students for the practice of law. In the UK, which developed best practices first in 1995 and then revised them in 2007, the need was to provide guidance to those active in clinical legal education as well as to those setting up new clinical programs.[9] In Australia, the development of best practices responded to the need to integrate clinical legal education better into the academic focus of law schools, as well as to promote better unity between the academic and clinical dimensions of legal education.[10]

Comparing the scope of clinical best practices in Australia, the United Kingdom and the United States

The scope of best practices, and the nomenclature, differs in each country, in part due to the underlying need or motivation for identifying best practices. Our 2013 *Best Practices: Australian Clinical Legal Education* addresses clinical legal education through in-house live client clinics, external live client clinics ('agency clinics'), externships and clinical components of doctrinal law courses.[11] The 2007 UK *Model Standards for Live-Client Clinics* addresses live client clinical legal education that occurs in-house or through an external agency.[12] The 2007 version partially relied upon work published in 2004 by Richard Grimes and Hugh Brayne identifying and mapping best practices in clinical legal education through a project funded by the UK Centre for Legal Education.[13] The 2007 US *Best Practices for Legal Education* addresses all of legal education,[14]

9 Clinical Legal Education Organisation, *Model Standards for Live-Client Clinics* (2007), 3, at perma.cc/HR7Y-HSY5. Accessed 19 August 2016.

10 Adrian Evans and others, cited at footnote 1, 7.

11 Adrian Evans and others, cited at footnote 1, 7.

12 Clinical Legal Education Organisation, cited at footnote 9. For comparison's sake, our chapter uses the 2007 version of the CLEO *Model Standards for Live-Client Clinics* (updated from the 1995 version) because it represents the most current understanding of best practices for clinical legal education in the UK.

13 Richard Grimes and Hugh Brayne, *Mapping Best Practice in Clinical Legal Education* (2004), at perma.cc/ZM2T-NU6S. Accessed 31 January 2017.

14 Roy Stuckey and others, *Best Practices for Legal Education: A Vision and a Road Map* (2007) Clinical Legal Education Association.

devoting a chapter to 'Best Practices for Experiential Courses',[15] which include simulation courses, in-house live client clinics and externships, and another separate chapter to 'Best Practices for Assessing Student Learning'.[16] In our chapter, the comparisons of standards or best practices in each country will focus primarily on live client clinical legal education, in both in-house and external clinics or externships, because the live client element is the common denominator in those three models of clinical legal education.

An additional consideration for comparison's sake is the fact that in the US there are formal accreditation standards for law schools promulgated by the American Bar Association (ABA).[17] One standard and its interpretations address requirements for externships,[18] another standard defines a 'law clinic',[19] and another standard and its interpretations require that the terms and conditions of employment for full-time clinical faculty members be reasonably similar to those for other full-time academic faculty.[20] Because the ABA standards address conditions of employment for clinical faculty, the best practices in the US do not. The best practices in the US also do not include all of the requirements for externships found in the ABA standards, though they do cover many, and include some best practices for externships not in the ABA Standards.

15 Roy Stuckey and others, cited at footnote 14, Chapter Five: 'Best Practices for Experiential Courses', at 165–205. For comparison's sake, our chapter uses the experiential learning chapter from *Best Practices for Legal Education* because that chapter represents the most current understanding in the US concerning best practices for clinical legal education.

16 Roy Stuckey and others, cited at footnote 14, Chapter Seven: 'Best Practices for Assessing Student Learning', at 235–63.

17 American Bar Association Section of Legal Education and Admissions to the Bar, cited at footnote 5.

18 American Bar Association Section of Legal Education and Admissions to the Bar, cited at footnote 5, Standard 305 and Interpretations 305-1, 305-2, 305-3.

19 American Bar Association Section of Legal Education and Admissions to the Bar, cited at footnote 5, Standard 304.

20 American Bar Association Section of Legal Education and Admissions to the Bar, cited at footnote 5, Standard 405(c).

In Australia, the Council of Australian Law Deans (CALD) has adopted voluntary standards addressing matters related to the operation of law schools and law courses.[21] In Chapter 2, we provided an explanation of the regulation of law schools and the roles played by CALD and governmental regulatory bodies in Australia.

In contrast to the US, there is no overarching regulatory body for law schools in the UK, nor is there voluntary regulation similar to the CALD standards in Australia. As a result, one of the authors of the 2007 UK *Model Standards for Live-Client Clinics* refers to the document as largely consensual and 'a description of a range of good practices rather than necessarily best practices'.[22]

Process

Clinical researchers in each country employed different processes to study and obtain input to the development of best practices. While the processes differed, in each country the processes included efforts to solicit contributions from as many clinicians as possible so that the resulting best practices would serve the function of addressing important aspects of clinical legal education, utilising the lessons learned from clinicians with broad-ranging experiences. In each country, broad input was key to developing best practices that would reflect areas of consensus, as well as identify guidelines and practices for important issues facing clinicians where consensus had not yet formed. In Australia and the US, other legal educators not teaching clinical legal education provided additional input and perspectives.

The process of developing best practices in each country also involved research into the theoretical and practical dimensions of clinical legal education. The research component was very important in order for best practices to reflect something more than existing practices, especially where existing practices varied among clinicians and law schools. As a

21 Council of Australian Law Deans, *The CALD Standards for Australian Law Schools*, as adopted 17 November 2009 and amended to March 2013, available at perma.cc/FTX6-HGML. Accessed 19 August 2016. An introduction explaining the context for the CALD standards is available at perma.cc/C4ML-R2WS. Accessed 19 August 2016.

22 Email from Philip Plowden, Pro Vice-Chancellor, University of Derby, to Peter A Joy, Henry Hitchcock Professor of Law, Washington University School of Law (24 December 2013, 10:01:21 CST).

result, the best practices in each country also represent aspirational goals for clinicians, their law schools, and for clinical legal education in their countries. The balance of this section outlines the processes.

Australia

The development of best practices for clinical legal education in Australia has been distinct from the development of best practices in the UK and the US. The Office for Learning and Teaching (previously known as the Australian Learning and Teaching Council) funded this effort after a competitive grant process that required the project team to identify the project's rationale, methodology, and outcomes.[23] The grant process therefore required the project team to approach the development of best practices in a well-thought-out and systematic way. The grant also required periodic reports and a timetable for achieving various aspects of the project that served to keep the project focused and adhering to a schedule. The grant support provided funds for staff support and expenses related to the project.

The project team consisted of representatives from six law schools closely associated with experiential learning in law.[24] In addition to the project team there was both a national reference group and an international reference group that provided input throughout all phases of the project.[25] The project team investigated current practices in clinical programs throughout all of Australia and held workshops across Australia in order

23 After the grant award, the Australian Learning and Teaching Council was renamed the Office for Learning and Teaching, and information about the Office for Learning and Teaching is available on its website www.olt.gov.au/. Accessed 23 September 2014.

24 Members of the project team were Professor Adrian Evans, Monash University; Associate Professor Anna Cody, Director of Kingsford Legal Centre, University of New South Wales; Anna Copeland, Director of Clinical Legal Education Programs, Murdoch University; Professor Jeff Giddings, Director of Professionalism, Griffith University; Professor Mary Anne Noone, Coordinator, Clinical Legal Education and Public Interest Law Postgraduate Programs, La Trobe University; and Professor Simon Rice, ANU College of Law, The Australian National University.

25 Members of the national reference group were Professor Stephen Billet, Griffith University; Judith Dickson, Director, Practical Training, Leo Cussen Centre for Law; Professor David Dixon, Dean of Law, University of New South Wales; and Professor Sally Kift, Deputy Vice-Chancellor, James Cook University. Members of the international reference group were Professor Peter Joy, Washington University School of Law, US; Kevin Kerrigan, Executive Dean of the Faculty of Business and Law, University of Northumbria, UK; Professor Philip Plowden, Pro Vice-Chancellor, University of Derby, UK; and Professor Emeritus Roy Stuckey, University of South Carolina, US.

to understand the different approaches to clinical legal education and to identify effective practices. The project was a broad-based team effort that lasted 27 months.

The project team's methodology began with developing a single research instrument to survey Australian clinicians. Project team members interviewed clinicians and interested legal academics concerning the survey instrument, and utilised their input to refine the survey instrument. The project team next created a database of clinicians in Australia. Preliminary colloquia were held in some of the regions to introduce the survey instrument.

Once the survey instrument was finalised, the project team conducted interviews with clinicians and local stakeholders, principally in person but occasionally via telephone and webcam. Altogether, the project team interviewed representatives of 26 law schools over a 12-month period. The survey sought information on 'what are existing practices' and 'what should be best practices' for clinical legal education in Australia.

Using the responses from these surveys, as well as drafts of regional reports from participants at colloquia throughout Australia, the project team produced five Regional Reports identifying current practices in clinical legal education in 2011: one each for New South Wales and the Australian Capital Territory; Queensland and Northern New South Wales; South Australia; Western Australia and the Northern Territory; and Victoria and Tasmania.[26] Regional colloquia introduced key contributors to the initial findings of the Regional Reports. Before finalising the reports, the project team received feedback and evaluation from both the national and international reference groups.

Initially, the project envisioned the development of 'standards' for clinical legal education. The project team members utilised the information they gathered through the survey interviews and colloquia to develop an initial set of standards. These standards were circulated to an international audience at a joint conference of the Global Alliance for Justice Education (GAJE) and the *International Journal of Clinical Legal Education* in Valencia, Spain, in July 2011, and to a domestic audience at the Australian Clinical and Experiential Education Conference in September 2011. The conference workshops generated helpful feedback. After the

26 The Regional Reports are cited in Chapter 1 at footnote 6.

conference in Australia, the project team decided that characterising their recommendations as 'best practices' (rather than 'standards') was likely to be more productive and would better serve their acceptance by clinicians, law faculty, law deans, and others. Some thought 'standards' suggested a prescriptive approach.

The project team used material from the international and domestic conferences, as well as the reference groups, to develop best practices around the following seven themes: course design; law in context in a clinical setting; supervision; reflective student learning; assessment; staff; and infrastructure. Additional drafts of the best practices organised around these seven themes were presented to a stakeholder project workshop in December 2011, to CALD in July 2012, and to the Australasian Law Teachers Association (ALTA) Conference in July 2012.

The project team finalised the best practices in a document entitled *Best Practices: Australian Clinical Legal Education,* in September 2012, and presented the final version to CALD. CALD resolved unanimously to endorse the final version of the clinical best practices in November 2012.

United Kingdom

In the UK, the Clinical Legal Education Organisation (CLEO) developed an initial set of standards for live client clinics in 1995 at a time when some law schools were considering implementing clinical courses. Although CLEO refers to 'standards' rather than best practices, as noted at the start of this chapter, we will use the term 'best practices' or 'best practices standards' because they function as such.

CLEO's best practices standards resulted from the work of experienced clinicians who had identified good practices in developing clinical legal education in the UK. CLEO then adopted the best practices standards at its 1995 Plymouth Conference in the UK.[27]

Although active in the 1990s, CLEO then became dormant for a period of time.[28] However, it was revitalised and in 2006 it undertook to review and update its best practices to reflect developments due to the expansion

27 Richard Grimes and Hugh Brayne, cited at footnote 13, 78, Appendix 1.
28 Richard Grimes and Hugh Brayne, cited at footnote 13, 78.

of clinical legal education in the UK. The process involved discussion of revisions at CLEO meetings and the circulation of multiple drafts to CLEO members and others interested in clinical legal education.

Eventually, a general consensus was reached and CLEO adopted the *Model Standards for Live-Client Clinics* in 2007. These revised best practices standards state that they 'are intended to provide a benchmark for those active in or setting up clinics, and reflect the wide experience of those already running clinics both in the UK and abroad'.[29]

United States

In August 2001, the US Clinical Legal Education Association (CLEA) Board of Directors initiated the Best Practices Project. This followed a much earlier effort of a committee of the Association of American Law Schools (AALS) and the ABA that developed guidelines for clinical legal education published in 1980,[30] as well as another effort of an ABA taskforce that resulted in a report commonly known as the MacCrate Report,[31] which emphasised the important contribution of clinical legal education in teaching lawyering skills and professional values in law schools.

The CLEA Board appointed Professor Roy Stuckey to chair the project and created a steering committee consisting of 14 members representing a cross-section of clinical teachers and some interested non-clinical faculty. The steering committee determined the scope of their work.[32] Early in the project, the steering committee decided that the overall aim should be to focus on how law schools could and should better prepare students for the practice of law.

Better preparing students for the practice of law is extremely important in the US, because US law schools are professional schools, and graduation from an ABA-accredited law school enables graduates to sit for the bar in every US jurisdiction. As a result, almost all law school graduates take the bar examination and seek to be admitted to the practice of law.

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29 Clinical Legal Education Organisation, cited at footnote 9, 3.

30 Report of the Association of American Law Schools and American Bar Association Committee on Guidelines for Clinical Legal Education, cited at footnote 7.

31 Task Force on Law Schools and the Profession: Narrowing the Gap, American Bar Association Section of Legal Education and Admissions to the Bar, *Legal Education and Professional Development – An Educational Continuum* (1992).

32 Roy Stuckey and others, cited at footnote 14, ix–x.

Because the primary mission of every US law school is to prepare students for the practice of law and entrance into the legal profession, Professor Stuckey and the steering committee determined that focusing solely on best practices for clinical legal education would be insufficient to fulfil the overall project aim.

Professor Stuckey was the principal author, and much of the best practices for clinical legal education reflect his research into best practices for all aspects of legal education. The process of formulating the best practices involved several meetings of the steering committee and other faculty interested in the project throughout the different parts of the US in which drafts of the best practices were presented. Each new draft of the best practices was posted on a website, usually three times a year, and notices of the new drafts were distributed through various clinical and other law faculty listserves. This process spanned nearly six years. Literally hundreds of clinicians, legal educators and others provided suggestions and assisted with drafting what was eventually published as *Best Practices for Legal Education: A Vision and a Road Map*.[33] As the book containing the best practices was being finalised in 2007, CLEA appointed a Best Practices Implementation Committee to publicise the best practices and to encourage law schools to adopt them.

The chapter devoted to best practices for experiential courses relied on scholarship and teaching materials from more than 40 clinicians, as well as on the work of educational theorists and the results of surveys and clinical committee reports.[34] The chapter also drew on the work of a joint committee of the AALS and the ABA that published *Guidelines for Clinical Legal Education* in 1980.[35]

Reinforcing the work on best practices in the US was the publication in 2007 of a study by the Carnegie Foundation for the Advancement of Teaching that called for the 'integration of student learning of theoretical and practical legal knowledge and professional identity'.[36] The Carnegie Report observed: 'Clinics can be a key setting for integrating all the

33 Roy Stuckey and others, cited at footnote 14, ix–x.

34 Roy Stuckey and others, cited at footnote14, 165–205.

35 Report of the Association of American Law Schools and American Bar Association Committee on Guidelines for Clinical Legal Education, cited at footnote 7.

36 William M Sullivan, Anne Colby, Judith Welch Wegner, Lloyd Bond and Lee S Shulman, *Educating Lawyers: Preparation for the Profession of Law* (2007) Carnegie Foundation for the Advancement of Teaching, 3 (the Carnegie Report).

elements of legal education, as students draw on and develop their doctrinal reasoning, lawyering skills, and ethical engagement, extending to contextual issues such as the policy environment.'[37] The Carnegie Report's ultimate conclusion was that clinical legal education can and should play a key role in preparing students for the practice of law.[38]

Best Practices for Legal Education and the Carnegie Report have helped to shape thinking in the US about the development of legal education and the importance of clinical legal education. Since their publication, there has been an increased emphasis on clinical legal education at many law schools.[39]

Conclusion

Each country employed a different process for identifying best practices, although the goals in each country were largely the same—to identify existing practices that are generally accepted as preferable ways of organising and delivering clinical legal education. In Australia, the process was very structured and systematic, soliciting input not just from clinicians in Australia but from other legal educators in Australia and in other countries. The process for identifying best practices in the US was not as systematic as that in Australia, but was structured to provide an opportunity for as much input as possible from clinicians and other interested educators. It was also very research-based, drawing on scholarship and research into teaching and learning, empirical studies about negative effects of current legal educational practices on the emotional wellbeing of students, and was informed by the work of the Law Society of England and Wales in developing a new training framework for solicitors.[40] In contrast to both the processes in Australia and the US, the best practices standards developed in the UK were less informed by research into teaching and learning but, rather, reflected a consensus among UK clinicians concerning the best approaches for developing clinical legal education.

37 William M Sullivan and others, cited at footnote 36, 121.
38 William M Sullivan and others, cited at footnote 36, 197–98.
39 Mark Yates, 'The Carnegie Effect: Elevating Practical Training Over Liberal Education in Curricular Reform' (2011) 17 *Journal of the Writing Institute* 233, 233–34.
40 Roy Stuckey and others, cited at footnote 14, 1.

General scope of best practices: Live client clinics

The best practices developed in all three countries share a focus on best practices for live client clinics—that is, clinics in which students represent, or assist in the representation of, real clients with legal problems. The reason for this shared focus is not explained, though it may be because those involved in developing the best practices in each country had experience primarily in this form of clinical legal education. While the best practices share a particular focus on live client clinics, the general scope of each set of best practices varies from all of legal education in the US, to all of clinical legal education in Australia, to focusing solely on live client clinics in the UK.

The organisation of the best practices also differs. Australian best practices are organised around seven themes, with a short discussion of each theme followed by underlying principles and then best practices with illustrations. There is also a bibliography of books and articles for each theme. The UK best practices are organised around 24 standards with subsections, without a bibliography or references. The UK best practices standards do not prescribe learning outcomes or take a position on student assessment, but do provide appendices with an example of learning outcomes and the 'pros and cons' of assessing student performance. The US best practices identify a set of 10 best practices for all experiential courses (simulations, externships, and live client), eight best practices specific to in-house clinical courses, and 11 best practices for externships, as well as the underlying principles for the best practices.

The following table provides an overview of the general focus of each set of best practices relating primarily to live client clinics, whether in-house, external or externships. Where distinctions between best practices for in-house clinics and external clinics or externships are important, those distinctions are noted. The main themes are identified using the best practices headings in each country, though some paraphrasing is used when necessary.

To assist interpretation, the table uses the assigned numbering systems used in Australia and the UK, and lists the most equivalent US best practices, which rely on letters and numbers. In the US, those best practices for all experiential courses are labelled A.2.a–j; best practices for in-house live client clinics are labelled C.2.a–h; and best practices for externships are labelled D.2.a–k.

Comparison of general themes of best practices for live client clinics

Australia	United Kingdom	United States
Course Design		
1. Specify learning objectives 2. Design curriculum to achieve learning outcomes 3. Live client experience follows observation and simulation 4. Students develop reflective practice 5. Classroom component 6. Clinical component reflects course objectives 7. The nature of work to be conducted by an agency clinic and externships is to be negotiated to address priorities of both the agency and the law school and to support the course objectives 8. Simulations are used to prepare students for clinical experience 9. Students read relevant academic and practice materials 10. Student selection is consistent with university policy 11. Supervisor has discretion in casework selection consistent with learning outcomes (in agency clinic course to agency's right to choose cases and projects, preference should be given to matters addressing learning objectives) 12. Clinical course requires student engagement over sustained period of time 13. Clinical courses run over a semester to give students necessary time to reflect on their experience 14. Clinical course design has regard to best practices in regard to Law in Context, Supervision, Reflective Learning, Assessment, Staff, and Infrastructure 15. Periodic review of law school curriculum should include a review of all clinical courses	1. Educational Objectives 1.1 The substantive law and legal process 1.2 Professional responsibility and ethics 1.3 Legal and transferrable skills 1.4 The role of law and justice in society 21. Training 21.1 Minimum – build to live client clinic through training 21.1.1 That supports the general educational aims of the program and is appropriate to the stage of development 21.2 Recommended – structure training to be case focused and use clinical manuals 21.2.1 Appendix A – Learning Outcomes (examples)	A. Experiential Courses Generally 2. Best Practices for Experiential Courses, Generally a. Provide students with clear and explicit statements about learning objectives and assessment criteria b. Focus on educational objectives that can be achieved most effectively and efficiently through experiential education – includes helping students appreciate their ethical obligations – includes helping students how to learn from experience c. Meet the needs and interests of students d. Grant appropriate credit e. Record student performances i. Give students repeated opportunities to perform tasks if achieving proficiency is an objective C. In-House Clinical Courses 2. Best Practices for In-House Clinical Courses a. Use in-house clinical courses to achieve clearly articulated educational goals more suited to those goals than other methods of instruction – this includes emphasis on the importance of seeking justice and providing access to justice, fostering respect for the rule of law, the essentiality of integrity and truthfulness, the need to deal sensitively and effectively with diverse clients and colleagues b. Be a model of law office management d. Approve student work in advance and observe or record student performances f. Have a classroom component D. Externships

Australia	United Kingdom	United States
		2. Best Practices for Externship Courses a. Use externship courses to achieve clearly articulated educational goals more effectively and efficiently than other methods of instruction could b. Involve faculty enough to ensure achievement of educational objectives d. Establish standards to assure that work assigned to students will help achieve educational objectives f. Consider students' needs and preferences when placing students h. Approve student work in advance and observe or record student performances i. Ensure that students are prepared to meet obligations j. Give students opportunities to interact with externship faculty and other students
Law in Context in a Clinical Setting		
1. Case work selection preference to students analysing context of law's operation (in agency clinic subject to agency's right to choose cases and projects preference is given to matters that best enable students to critically analyse the context of law's operation) 2. Client-focused approach to skills training includes cultural awareness 3. Students responsible for work with clients 4. Instructors engage students in structured analysis of their experiences 5. Supervision draws out law-in-context dimensions of client interactions 6. Classes include examination of broader context of law and the legal system 7. Readings encourage broad, critical analysis of law in context 8. Assessment includes assessing students' ability to reflect on how law operates from a range of perspectives and their own role in the legal system	12. Integration – Structure clinical program so that it enables students to better understand concepts and principles of law in the context in which they operate – Clinics should be integrated with the rest of the curriculum – The role of law and justice in society should be a course objective	C. In-House Clinical Courses 2. Best Practices for In-House Clinical Courses c. Provide malpractice insurance e. Balance student autonomy with client protection h. Respond to the legal needs of the community

Australia	United Kingdom	United States
Supervision		
1. Supervisors are able teachers and practitioners 2. Clinic designed to advance clients' interests while supporting students' education 3. Students are prepared and trained for work 4. All supervisors are trained (in agency clinics and externships, training is provided by the law school in conjunction with agency) 5. Law schools effectively support supervisors (in agency clinics and externships, supervisor training includes provision of feedback to students) 6. Supervisors are accessible to deal with unexpected events (externship supervision agreements include regular meetings involving clinical academic) 7. Supervisors provide constructive feedback to students in a timely manner	2. Supervision 2.1 Use competent and experienced supervisors 2.2 Adhere to special qualification and registrations necessary for practice areas 2.3 Designate one or more persons as director(s) of clinic 2.4 Solicitors should be well qualified 2.5–2.7 Supervision has to be adequate at all times, includes law office management	2. Best Practices for Experiential Courses, Generally f. Train those who give feedback to employ best practices j. Enhance effectiveness of faculty in experiential courses, includes using qualified faculty and assigning reasonable workloads D. Externships 2. Best Practices for Externship Courses c. Establish criteria for approval of sites and supervisors e. Establish standards to assure that field supervisors will help achieve educational objectives
Reflective Student Learning		
1. Course is structured to emphasise reflective learning 2. Course provides students a framework for reflecting on experience 3. Clinical legal education pedagogy involves planning, reflection (self-critique and feedback), and planning next step 4. Prompt feedback 5. Reflective learning builds on students prior learning 6. Reflection is assessed	20. Student Activity 20.1 Minimum 20.1.1 Orientation to clinic operating practices 20.1.3 Weekly meetings with supervisors 20.2 Recommended 20.2.1 Keep record of each student's expectations and performance to enhance formative feedback through feedback 20.2.3 Encourage group work 20.2.5 Structure work so students assume responsibility	2. Best Practices for Experiential Courses, Generally g. Train students to receive feedback h. Help students identify and plan how to achieve individually important learning goals

Australia	United Kingdom	United States
Assessment		
1. Assessment is aligned with learning outcomes 2. Formal assessment uses publicised criteria and combined with informal feedback 3. Summative and formative assessment are used 4. Assessment is graded or assessed on a pass/fail basis 5. In externships 'Learning Contracts' or some other mechanism are used to ensure shared understanding of learning outcomes and assessment among the agency, the students, and the law school 6. Clinical assessment practices are criteria-referenced and in accord with law school policies 7. Clinics incorporate mid-semester review 8. Clinical assessments are not subject to large class algorithms 9. Clinical supervisors consult with each other in assessing the same students	10. Learning Outcomes – Identify learning outcomes appropriate for the academic level of the student 11. Assessment – Explicitly takes no position on assessment noting that some live client clinics do not use assessment Appendix B – Assessment (pros and cons of assessing student performance)	[Chapter Seven of *Best Practices* focuses on assessing student learning] – Effective assessment exhibits qualities of validity, reliability, and fairness 1. Be clear about goals of each assessment 2. Assess whether students learn what is taught (validity) 3. Conduct criteria-referenced assessments, not norm-referenced (reliability) 4. Use assessments to inform students of their level of professional development 5. Be sure assessment is feasible 6. Use multiple methods of assessing student learning 7. Distinguish between formative and summative assessment 8. Conduct formative assessments throughout the term

Australia	United Kingdom	United States
Staff		
1. Clinical supervisors have status consistent with their positions (in agency clinics a clinical supervisor/teacher with academic status has overall responsibility for the course) 2. Clinical staff (supervisors and professional staff) are appointed with comparable terms and conditions of employment as law school peers (agency clinic supervisors receive appropriate training) 3. Workload allocation and research expectations recognise actual hours spent in clinical supervision 4. Clinical supervisors have discretion as to student loads depending on the number and complexity of files 5. Clinical supervisors with academic positions requiring research and publication should have student ratios adjusted 6. The university should support clinical academics' scholarship to the same degree as non-clinical academic staff 7. Appointment criteria for clinical supervisors includes practice experience 9. The law school should encourage suitable academic staff to rotate into clinics as clinical supervisors	15. Supervision and Staffing 15.1 Minimum 15.1.1 No more than 12 students in teams of two per supervisor 15.1.2 At least two supervisors per clinic 15.1.3 Supervisor available at all times clinic is open 15.1.4–6 Describes supervision 15.1.7–12 Describes supervisory practices and staffing 15.2 Recommended 15.2.1 Dedicated administrative/clerical staff 15.2.2 Describes client appointment process 23. Management 23.1 Minimum 23.1.1 Clinic supervisors have overall management authority 23.1.2 Supervisors report to director or person with overall responsibility 23.1.3 Management ensures students meet stated learning outcomes 23.2 Recommended 23.2.1 Use a clinic advisory committee that includes members of the bar and public	C. In-House Clinical Courses 2. Best Practices for In-House Clinical Courses g. Provide adequate facilities, equipment and staffing [The issue of status for clinical faculty is addressed by the ABA.][a]

Australia	United Kingdom	United States
Infrastructure		
1. Insurance 2. Policies for ethical and fiduciary obligations to clients 3. Written policies for supervision, assessment, and conflicts of interest (memorandum of understanding with agency clinics and externships) 4. Access to university library 5. Access to university IT services 6. Sufficient staffing for casework 7. Compliance with all health and safety requirements 8. University support for replacing clinicians on leave	Infrastructure Standards 3. Stationery and Publicity 4. Basic Client Care 5. Insurance 6. Confidentiality 7. Ethics 8. A Professional Standard of Service 9. Conflict of Interest 13. General Representation 14. Operational Practice 16. Maintenance of Files and Records 17. Premises 18. Equipment 19. Funding 22. Referrals to Other Agencies 24. Review of Clinical Procedures	C. In-House Clinical Courses 2. Best Practices for In-House Clinical Courses b. Be a model of law office management c. Provide malpractice insurance g. Provide adequate facilities, equipment and staffing D. Externship Courses 2. Best Practices for Externship Courses g. Provide malpractice insurance k. Ensure that adequate facilities, equipment, and staffing exist

[a] ABA Standard 405 and its Interpretations define the professional environment in the law school, and Standard 405 provides: 'A law school shall afford to full-time clinical faculty members a form of security of position reasonably similar to tenure, and non-compensatory perquisites reasonably similar to those provided other full-time faculty members.' American Bar Association Section of Legal Education and Admissions to the Bar, cited at footnote 5. Information about status, staffing, student–faculty ratios, and other aspects of supervision and staffing of in-house clinics and externships in the US is collected and made available by the Center for the Study of Applied Legal Education (CSALE) through surveys and reports published every three years. The most recent data and reports are available at www.csale.org/. Accessed 19 August 2016.

Observations from comparing best practices

The comparison of best practices for clinical legal education in Australia, the UK and the US demonstrates points of unity and divergence that reflect, in part, the differing motivations to create best practices in each country. All three sets of best practices address issues of importance to designing and delivering effective clinical legal education. All three explicitly reflect a commitment to educating students to become effective, ethical practitioners. In addition, each set of best practices involves differing levels of input from clinicians not directly involved in the drafting, and therefore reflects different approaches to addressing the issues identified.

The best practices standards in the UK are explicitly characterised as setting forth 'a minimum requirement, and one that might be exceeded where resourcing and pedagogic aims permit'.[41] Given the underlying motivation to provide guidance to new clinical programs as well as to reflect extant good practices, the best practices standards take a very nuts and bolts approach to what is minimally necessary to structure live client clinical legal education, focusing solely on live client clinics.

In contrast to the UK best practices standards, the best practices in Australia are explicitly characterised as reflecting 'what should be' best practices based both on empirical research into existing practices and engagement with relevant literature.[42] While some of the best practices reflect basic requirements for clinical legal education, many of the best practices go much further and are aspirational in terms of defining the elements of effective, excellent clinical legal education. The best practices in Australia look at wholly law school–funded in-house live client clinics, in-house live client clinics with some external funding, external live client clinics ('agency clinics'), externships, and clinical components, such as simulations of legal practice activities, in other courses.

In contrast to the best practices in both Australia and the UK, the US best practices that focus on clinical legal education are part of the larger project to define best practices for legal education as a whole. Like the best practices in Australia, the US best practices address all forms of live client clinics, externships, and simulation courses or course components. In addition, the US best practices also look at all other aspects of the law school curriculum and include non-clinical legal education courses. Given the broader scope of the US project, many of the best practices for clinical legal education are not as detailed or specific as those in Australia, and they do not focus on as many aspects of clinical legal education as the best practices in either Australia or the UK. The resulting document is large and reflects 'a thoughtful and deliberate search for ways to improve legal education that are consistent with sound educational theories and

41 Clinical Legal Education Organisation, cited at footnote 9, 3.
42 Adrian Evans and others, cited at footnote 1, 7.

practices'.[43] The resulting set of best practices includes some 'proposals call[ing] for significant changes in the content and organization of the law school curriculum and the attitudes and practices of law teachers'.[44]

Conclusion

Each set of best practices serves as an important resource for clinicians in each of the countries where they were created. The best practices reflect a common understanding in each country about the practices that best develop and deliver effective clinical legal education. Clinicians should compare their own practices with the best practices. Then they should decide whether and how to use their country's best practices to improve their clinical course, discuss with colleagues changes to the clinical program, and discuss with members of their law school's administration changes that may require institutional support.

Despite the different aims or purposes for best practices for clinical legal education in Australia, the UK and the US, the best practices from these three countries have many points of agreement on what is important to delivering effective clinical legal education. These points of agreement represent a shared understanding of important aspects of clinical legal education that transcends the system of legal education in each country. In this regard, the best practices from these three countries may serve as useful resources for clinicians in other countries as they structure their own clinical programs. In particular, the UK best practices standards address issues important to creating new live client clinics, and the Australian best practices address in some detail course design, law in context in a clinical setting, supervision, reflective student learning, assessment, staff and infrastructure for different forms of live client clinics, externships, and clinical components in other courses. In contrast, the US best practices primarily address issues of the curriculum in general, and are important for clinicians in countries in which law schools are primarily focused on preparing students for the practice of law because nearly all law school graduates are admitted to practise law. The US best practices also serve as a useful resource for clinicians in any country interested in structuring law school curricula to prepare students better for the practice of law.

43 Roy Stuckey and others, cited at footnote 13, 4. At present, clinical legal education in the US is sponsoring an effort to develop a companion book to *Best Practices for Legal Education*.

44 Roy Stuckey and others, cited at footnote 13, 4.

In other chapters in this book, we have addressed in depth many of the issues identified in the best practices from these three countries, including course design, supervision, reflective practice, law in context and assessment. In additional chapters, we have examined related issues such as costs and resources, non-traditional clients, and other issues of justice in clinics. These chapters are very important to understanding both the practical and theoretical underpinnings of creating best practices for clinical legal education.

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