Shared Challenges and Collective Solutions:

Strengthening Canadian Psychology Training with Lessons Learned from Training Clinics

We would like to begin by acknowledging that we are located on unceded Indigenous lands. The Kanien’kehá:ka Nation is recognized as the custodians of the lands and waters on which we gather today. Tiohtià:ke/Montréal is historically known as a gathering place for many First Nations. Today, it is home to a diverse population of Indigenous and other peoples. We respect the continued connections with the past, present and future in our ongoing relationships with Indigenous and other peoples within and around the Montréal community.



- ***The Role of Training Clinics in the Psychology Discipline***
  Dr. Jill Robinson
  University of Victoria

- ***EDIA Training in Psychology***
  Drs. Shannon Johnson & Alissa Pencer
  Dalhousie University

- ***Professionalism as a Foundational Competency in Psychology Training***
  Dr. Marjorie Phillips
  University of Waterloo

- ***Balancing Autonomy and Structure in Clinical Supervision***
  Drs. Brae Anne McArthur and Kelly Hicks
  University of Calgary

Learning Objectives

Identify common challenges in training foundational competencies and how Canadian training clinic structures support development in assessment, intervention, professionalism, and readiness for practicum/residency.

Apply evidence-informed strategies to embed EDIA principles and professionalism in clinical training through didactics, reflection, and supervised practice.

Implement structured yet flexible supervision approaches (e.g., manuals, agreements) to strengthen consistency, trainee competence, and program cohesion.



Disclosures

We declare no conflicts of interest or content limitations.

The Role of Training Clinics in the Psychology Discipline

Dr. Jill Robinson, R. Psych.
Assistant Teaching Professor & Clinic Director
University of Victoria

Disclosures

I declare no conflicts of interest or content limitations, and I did not use AI in this presentation ☺

Learning Objectives

- Provide rationale/messaging to position training clinics as a community resource
- Describe variability in training clinics across Canada
- Present key data from the 2024 Canada-wide training clinic survey



Context and Problem

- The mental health sector has a significant shortage of appropriately trained health care providers (Endale et al., 2020)
- Notably, psychologist shortages exist across provinces (Moroz et al., 2020)
- Canadians face an uphill battle to access affordable and timely mental health care
- Simultaneously, Canadians face a family physician shortage (Moroz et al., 2020)
- The slow trickle of new practitioners into the field fails to keep pace with the increasing demand



Context and Problem



How do we increase the number of psychologists in Canada without sacrificing the necessary rigour and depth of training in the field?

Barring large injections of funds from provincial governments, one way to increase the reach of psychology into the community is through *adequately funded* and *fully operational* training clinics

A Partial Solution

The training clinic model serves two broad purposes:

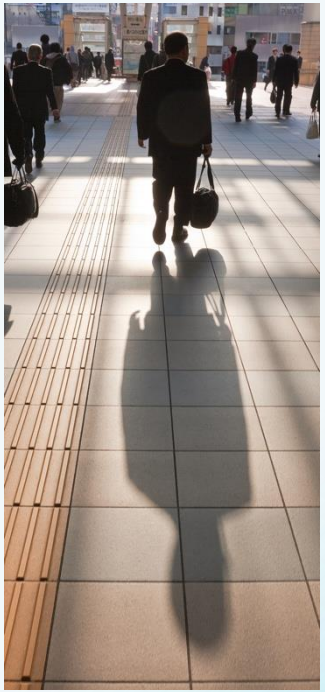
1. To train new cohorts of clinical and counselling psychologists
2. To provide accessible psychological services to community members

- Student training clinics reduce common barriers to care, increase system capacity, and provide supervised, experiential training



The Rationale

- **A psychology training clinic is a public service.**
- Public services address a specific need in the community and benefit the citizens of that community.
- Many training clinics must generate enough revenue to sustain or grow their operations; most public services in Canada are not required to do the same.
- Training clinics offer mental health services for the community and would benefit from funding structures similar to other public services Canada.



The Rationale



- Clients are drawn from campus and the surrounding community.
- Often serve populations who need access to low-cost/sliding scale psychological services.
- Training clinics decrease wait times by augmenting service capacity through supervised clinical training

The Data*: Clinic Information

- Support on average 1.7 professional psychology programs (range: 1 to 4)
- Train on average 65.8 graduate students (range: 31 to 200) per year
- An average of 10.9 clinical faculty (range: 2 to 25) supervise in the clinic, with an average ratio of 1 clinical faculty member to 10 students

- Most clinics have professional administrators (90%) and student support (58%)
- Fees for service: sliding scale (73.7%), fee without sliding scale (10.5%), entirely free services (15.8%)

- ***89.5% reported that their clinic could not self-sustain/generate revenue; 94.7% believed that it should not be self-sustaining***

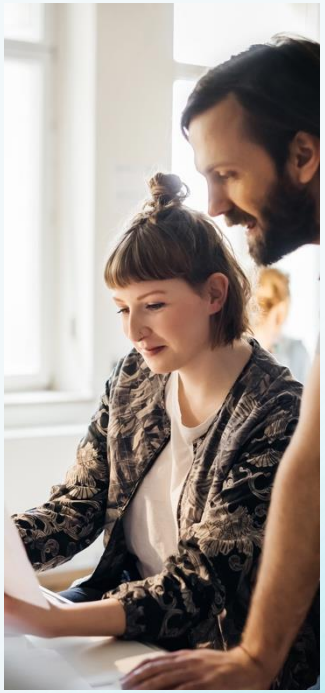
* Information drawn from a Canada-wide survey of psychology training clinics in 2024

The Data: Training Information

- Many first practica experiences are completed within the training clinic (88.9%)
- On average, 42% of clinical training in practicum occurred within the training clinic

Pedagogical importance of in-house training:

1. Facilitate intensive supervision and oversight
2. Support foundational standards of training
3. Increase initial skills in psychotherapy and assessment in an education-focused environment



Closing Thoughts



- The dual mandate of training clinics position them as essential components of academic training and provincial mental health services
- Clinics differ in the amount of administrative support they receive, the presence of additional paid/volunteer roles, and the number and types of programs, trainees, and clients they serve
- Clinic Directors reported that revenue-generation expectations conflict with best practice training standards

Closing Thoughts

To maintain high standards required by CPA, clinics require:

1. Stable, long-term funding
2. Expanded supervisory and administrative resources
3. Institutional recognition of clinics as a public service rather than revenue-generating entities

- Prioritizing these investments to expand service capacity and advance access to psychological care



Thank you!

Jill Robinson

jillrobinson@uvic.ca

Contributing authors: Jonathan Dubue, Mackenzie Dagenais, Shannon Gervan

Intentional strengthening of EDI competencies through Training Clinic experiences

Dr. Shannon Johnson and Dr. Alissa Pencer

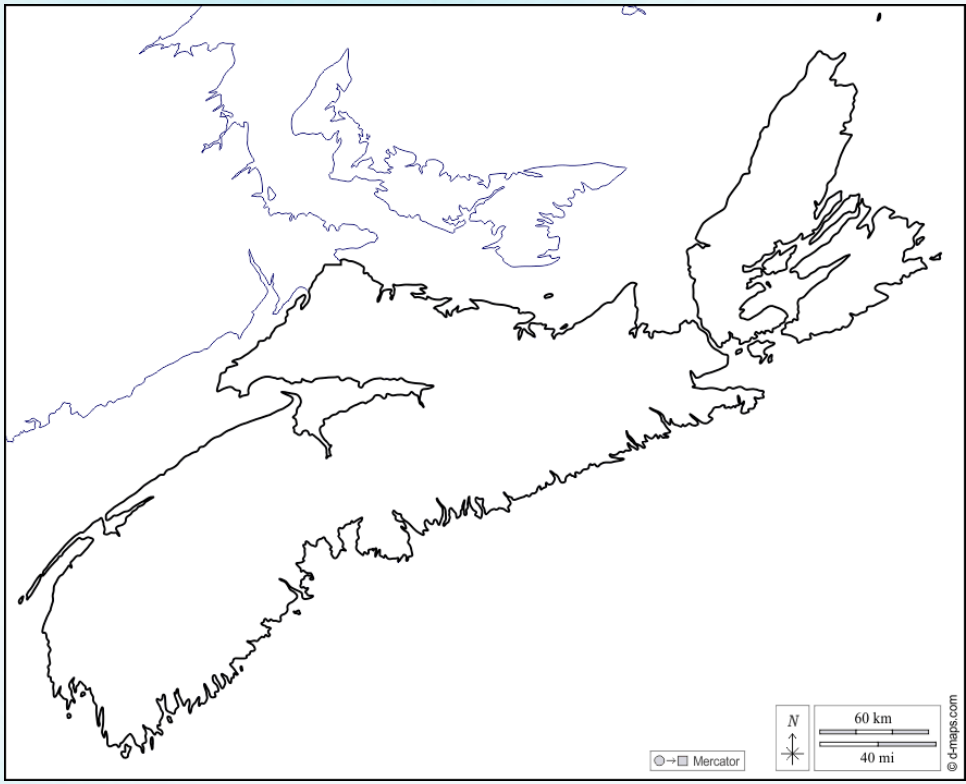
DALHOUSIE UNIVERSITY

CENTRE FOR PSYCHOLOGICAL HEALTH

Disclosures

We declare no conflicts of interest or content limitations and did not use AI in this presentation.

Land Acknowledgement



Learning Objectives



Generate new ideas and opportunities to strengthen EDI training within your training program

Provide **concrete examples** of curriculum and trainings that can be integrated into training clinic practica

Consider key **role of community-based connections and partnership**s for student and staff learning of EDI

*Why **intentionally strengthen*** EDI competencies within training clinics?

Much to learn/teach already

- integrating additional content based on new standards is critical AND challenging

May be '*difficult*' for instructors to integrate all relevant EDI content into existing courses

Integration of didactic and practical training enhances learning of EDI principles and practice

Key foundational competencies that influence all aspects of practice

Our Context

Provide free psychological services for **low-income clients**

Age 5 & up

Referrals only from **community partners** who support overlapping populations

Priority populations include those who identify as:

Indigenous

African Nova Scotian or Black

Newcomers/Refugees

2SLGBTQIA+

Children in care

Former children in care



Overview of current trainings and initiatives



Didactic
Course: Anti-Oppressive and Anti-racist Clinical Practice

On-site and virtual workshops

Community Partnerships & Community-Based Learning

Evaluation

Introduction to Anti-Oppressive and Anti-Racist Clinical Practice

Developed by Noor Sharif

Why?

- Some concepts not taught prior to first clinic practicum
- Review and repetition is helpful, particularly at key points in practical training
- Heavy emphasis on application
- May be used for remediation
- Self-guided & Asynchronous = resource students can use at any point

Roll out

- Reviewed by upper level students who provided feedback on all aspects of the course
- Specially asked at what points in practicum training each module would be most useful
- Required for all students starting in Winter 2027

Course outline

Module 1 – General Overview/concepts
Module 2 – AOP Basic Practice
Module 3 - CBT and AOP practice
Module 4 – Microaggressions
Module 5 – Depression and anxiety and systems
Module 6 – Racial trauma

12 – 18 hours total

Supervision opportunities:

Assignments for each Module (reflections, skill practice, case examples)

4 required video demonstrations of skills and concepts

Syllabus available for sharing

Didactic Training: Workshops

- Examples:
  - Psychological Assessment with Indigenous Peoples
  - Culturally Adapted CBT with 1) Black and 2) Indigenous Peoples
  - Working with Interpreters
  - Multicultural Foundations of Clinical Practice
  - Working with Refugees
  - 2SLGBTQIA+ 101 & Affirming Spaces

- Faculty, Students, Clinic Staff/Supervisors, and Community Partners attend



Community Organization Partnerships



- Working in community with community
- Historically marginalized groups
- Relationship building is key
    - Co-Directors of the training clinic, Clinical supervisors, Faculty, Social work team all involved.
- Consultation with community leaders

EDI and Community-Based Learning

- Mentorship and collaboration with social work team
  - Introduces interdisciplinary roles early in training
  - Anti-oppressive practice and social justice lens
- Rapport and relationship building with client, support person(s) AND community
- Flexibility of doing assessments and therapy in community
- These all TAKE TIME
- Prioritizing these as a valued and essential experience



Client Experience of Service Questionnaire

13.	I felt safe at this appointment	☐	☐	☐	☐
14.	I trust the people who saw me.	☐	☐	☐	☐
15.	I was asked about my race, culture (e.g., gender, 2SLGBTQIA+, religion, spirituality, language, age) or ethnic identity	☐	☐	☐	☐
16.	I was asked about cultural practices or spiritual beliefs that are important to me and/or my family	☐	☐	☐	☐
17.	I experienced racial or cultural harm at this appointment	☐	☐	☐	☐

ESQ is shared with all clients after initial appointment; includes specific questions about diversity

Quick check on students' progress with these competencies? Provides opportunities for conversation with student and supervisor, and student and client

Future Directions

- Communities of Practice
- Consultation Groups
- University Elder
- Further integration of coursework, asynchronous learning, workshops, training clinic practica, residency at Dalhousie



Challenge: Professionalism

Marjory Phillips, Ph.D., C.Psych
University of Waterloo

UNIVERSITY OF WATERLOO | centre for mental health research and treatment
PSYCHOLOGICAL SERVICES, TRAINING, & RESEARCH

Professionalism as a Foundational Competency

- ✓ Self-reflection
- ✓ Time management and ability to meet professional deadlines
- ✓ Appropriate collegial communication
- ✓ Taking personal responsibility for professional work across settings and contexts
- ✓ Personal congruence between professional ethical values and behaviors
- ✓ Self-care and self-monitoring regarding fitness to practice

CPA Accreditation Standards, 2023

Challenges in Professionalism



Accountability

- ✓ Timeliness: documentation delays
- ✓ Tardiness / absenteeism: late for meetings, client sessions, frequent cancellations
- ✓ Lack of preparation: supervision, for client sessions
- ✓ Lack of adherence to administrative requirements: client file management, room bookings
- ✓ Comportment: adherence to dress code

Kaslow et al, 2018

Challenges in Professionalism



Communication

- ✓ Unreliable responding (failure to respond to emails in a timely manner)
- ✓ Not ensuring supervisors or admin staff are aware of changes in scheduling, updates to client service
- ✓ Non-disclosures of tricky situations in client sessions
- ✓ Difficulties in adjusting language and communication style to meet the needs of the audience
- ✓ Misuse of AI, social media, aps (without declaration)

DeJong, 2022; Kaslow et al, 2018; Hutman &Ellis, 2021

Challenges in Professionalis



Self-Reflection

- ✓ Lack of self-awareness, insight of impact on others
- ✓ Does not initiate requests for consultation, input
- ✓ Limited receptivity to receiving feedback from others
- ✓ Limited ability to learn from mistakes (unable or unwilling)
- ✓ Does not take responsibility for own actions

Trainees with lower competence and low insight may overestimate competence underreport to supervisor

Gonsalvez et al., 2023; Kaslow et al., 2018)

How to Address Problems with Professionalism



General Strategies

Communicate expectations clearly from the outset

- *Verbal*: Orientation sessions
- *Written*: Policy & procedure manuals, supervisory agreement

Reiterate expectations

- Post written procedures for common concerns (e.g., "Please remember to…")
- Track data and report on positive gains

How to Address Problems with Professionalism



For “mild” problems:

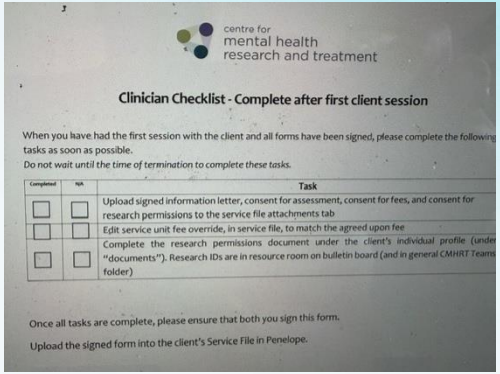
Provide clear and immediate feedback
Educate: Explain why this is a problem
Document your conversation

For “moderate” problems:

Consult with other supervisors (is there a pattern?)
Consult with the academic program DCT or practicum coordinator
Develop systems for tracking the behavior of concern
Continue to provide frequent informal and formal feedback

Kaslow et al., 2018

How to Address Problems with Professionalism



centre for
mental health
research and treatment

Clinician Checklist - Complete after first client session

When you have had the first session with the client and all forms have been signed, please complete the following tasks as soon as possible.

Do not wait until the time of termination to complete these tasks.

Completed	N/A	Task
☐	☐	Upload signed information letter, consent for assessment, consent for fees, and consent for research permissions to the service file attachments tab
☐	☐	Edit service unit fee override, in service file, to match the agreed upon fee
☐	☐	Complete the research permissions document under the client's individual profile (under "documents"). Research IDs are in resource room on bulletin board (and in general CMHRT Teams folder)

Once all tasks are complete, please ensure that both you sign this form.

Upload the signed form into the client's Service File in Penelope.

Accountability Example

Problem: Not recording consents in client file after 1st
Solution: Developed a first session checklist
Tracked compliance with checklist
Outcome: Checklist use improved compliance with procedures by 30% (from 77% completion of tasks to 100% completion, comparing new cases assigned in Winter 2026 to Spring 2026).

How to Address Problems with Professionalism



Communication Example

Problem: Student frequently neglects to inform setting (supervisor, admin staff) of clinical scheduling changes

Solution:
Education about why this is an issue
Develop a system to track problem

How to Address Problems with Professionalism



Self-Reflection Example

Problem: Over-confidence and high non-disclosures

Solutions:

Where possible, arrange to observe directly

Use video: first example that works well, then example of the issue (e.g. rupture with client, skill not working)

Educate about role of psychology on team, give feedback

Challenge:
Balancing Autonomy & Structure in Clinical Supervision

Kelly Hicks (she/her), Psy.D., R.Psych
Brae Anne McArthur (she/her), Ph.D., R.Psych
University of Calgary



UNIVERSITY OF CALGARY

Context

- Early career clinic directors noting variability in supervision practices
- **Importance** of autonomy and individualized supervisory style
- **Responsibility** to ensure evidence-based, culturally responsive, and ethically sound supervision practices
- **Assumptions** that supervisors are familiar with the specific program needs and the developmental expectations of the student clinicians
- **Structure** to open communication, empower the supervisor and the supervisee with consistent expectations, awareness, and understanding.

Case Vignette

A registered psychologist who recently started supervising in a community clinic values flexibility and prefers an informal supervision style. Over time, trainees supervised by this psychologist report uncertainty about clinic expectations, inconsistent feedback processes, and confusion about documentation standards compared to other supervisors at this setting.



Case Vignette

A newly licensed psychologist joins the clinic and begins supervising trainees for the first time. They are confident clinically but uncertain about supervisory expectations, evaluation processes, and how much guidance they should provide trainees.

Because each supervisor in the clinic tends to operate somewhat independently, the new supervisor receives mixed advice from colleagues about “how things are typically done.”

Challenge & Solution



How do we balance the autonomy of individual supervisor preferences while simultaneously ensuring evidence-based, culturally responsive, and ethically sound supervision practices?

Development of Supervision Toolkit documenting comprehensive strategies and resources that integrate structured guidance with flexibility for individualized supervisor approaches.

Challenge & Solution



How do we balance the autonomy of individual supervisor preferences while simultaneously ensuring evidence-based, culturally responsive, and ethically sound supervision practices?

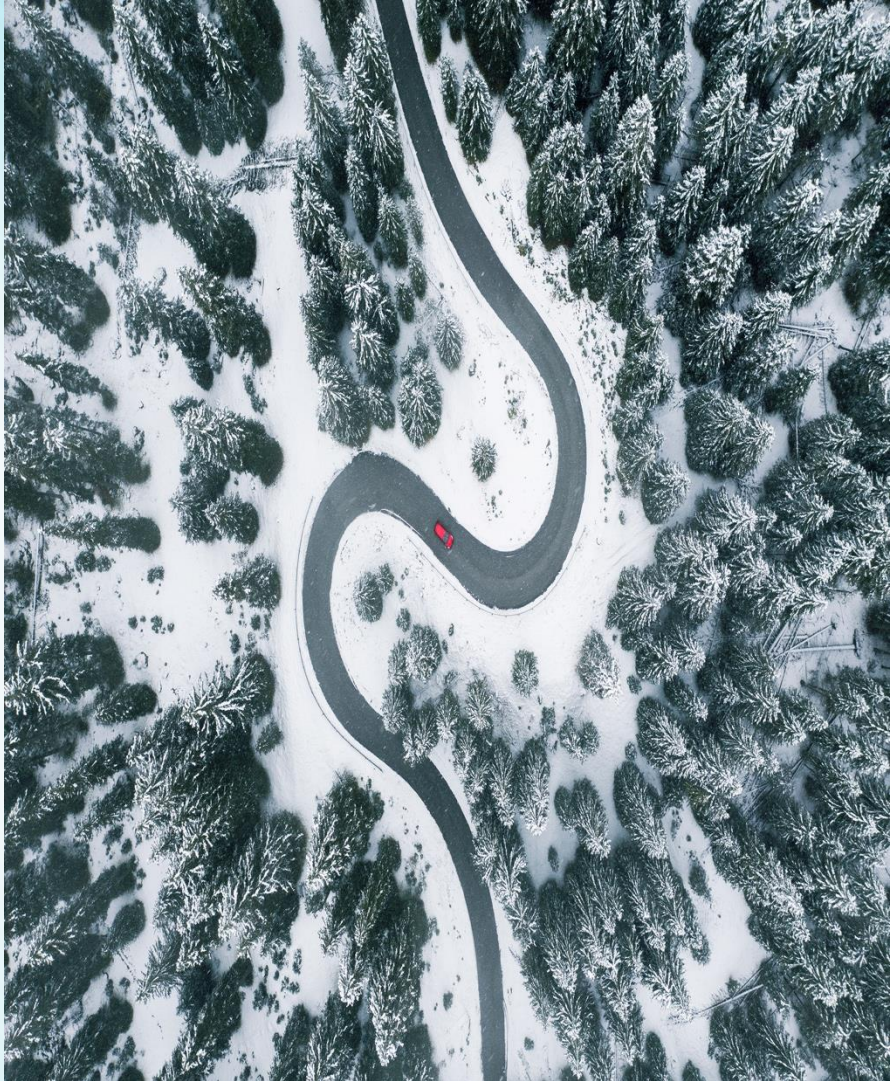
Development of Supervision Toolkit documenting comprehensive strategies and resources that integrate structured guidance with flexibility for individualized supervisor approaches.

Who this supports…

- Training Clinics
- Director of Practicum
- Residency Coordinator
- Director of Clinical Training

How we built this…

- Recognition of variability
- Clinic expectations
- Scoping Review
- Integration of existing resources



Scoping Review of Supervision in Psychology Training

Guidelines

- CPA, APA, NASP, ASPPB
- Common skills for supervisors/supervisees

Common Models/Theories

- Competency Based Supervision
- Developmental Stages Model
- Scientist Practitioner

Best Practices

- Supervisor competence
- Self-reflection
- Collaborative relationships
- Professional identity
- Student perspectives/satisfaction

Solution:

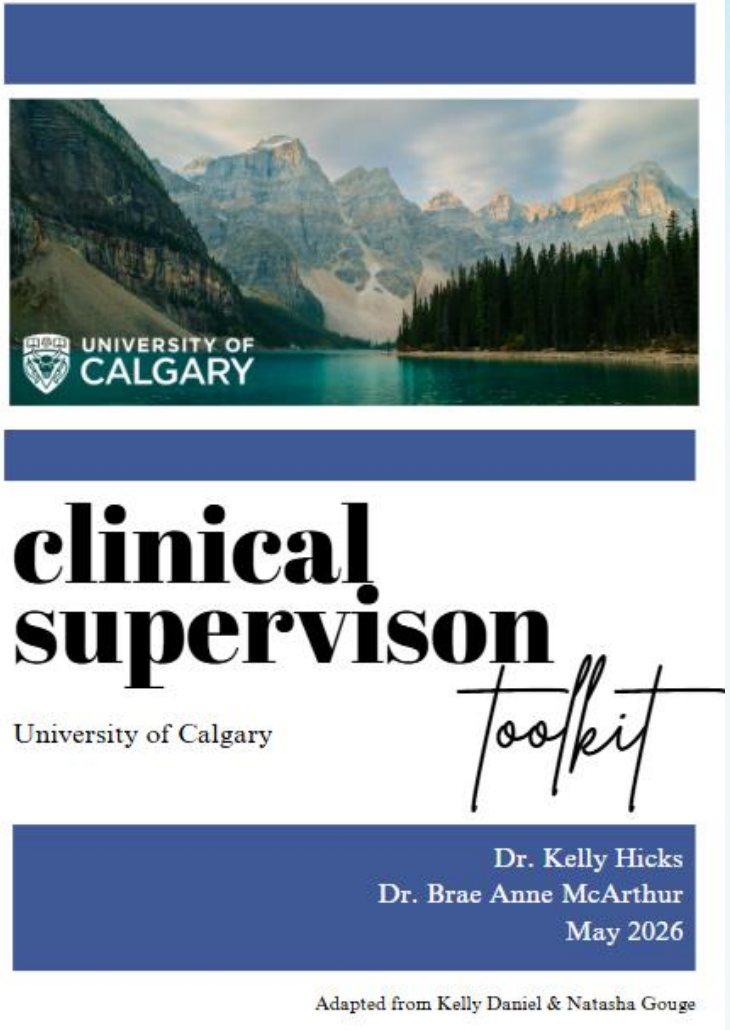

UNIVERSITY OF CALGARY
clinical supervison
toolkit
University of Calgary
Dr. Kelly Hicks
Dr. Brae Anne McArthur
May 2026
Adapted from Kelly Daniel & Natasha Gouge

table of contents

BUILDING EFFECTIVE SUPERVISION SPACES

Clinical supervision best practices

What is clinical supervision?
Types of supervision
The supervisory relationship
What is clinical supervision and what is it not
What makes supervision successful?
Components of effective supervision
Developmental model of clinical supervision
Seven eyes supervision model
Cultural competence in supervision
Benefits of clinical supervision

Clinical supervision at UofC

Supervision sequence at the UofC
Who should I go to for help?

Supervisor's role

Expectations of clinical supervisors
Supervision rules and contracts
Supervisor checklist

Student's role

Expectations of clinical supervisees
Effective utilization of clinical supervision
Barriers to engaging in clinical supervision
Preparing for supervision
Reflection in supervision
Skills for reflection
Models of reflection
Using Driscoll's model of self-reflection in supervision
Gibb's reflective cycle
Johns' model for structured reflection
TEAMS model of self-reflection

Appendix (also available as individual files on D2L)

Supervision contract examples
Peer supervision contract
Case presentation forms
Clinician self-assessment measures
Supervision evaluation forms
Supervision log examples

References

References and additional resources

Clinical Supervision Best Practices

What is clinical supervision

The Canadian Psychological Associa
recognizes supervision as a **specialized area of**
psychological activity that has its own foundation of
knowledge and skills that are enhance by education
and training.

Clinical supervision is an **intervention provided by**
more senior member of a profession to a more jun
member. This relationship enhances the superv
professional functioning and monitors the qu
services offered to clients (Bernard & Goody
2004, p. 8).

The CPA has guidelines that demonstrat
principles of the Canadian Code of Eth
Psychologists may be applied to super

Principle 1: Respect for the Dignity of P
Principle 2: Responsible Caring
Principle 3: Integrity in Relationship
Principle 4: Responsibility to Socie

Click HERE to access CPA
supervision.

Types of supervision

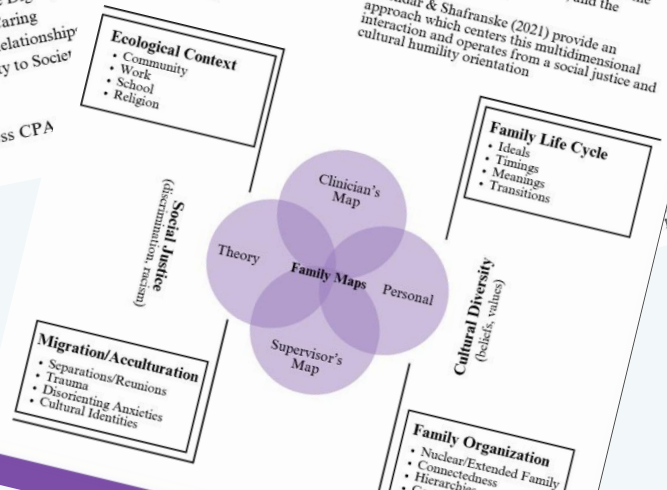
- All practicum students ate
assigned faculty clinical supervis
- Supervisors are assigned on a semester basis
- Individual supervision should include detailed review of ass
video review using the IVS system, and conceptualization and inte
support. Detailed student and supervisor expectations for individual
vision are provided below and on subsequent pages
roup supervision weeks or summer therapy practicum, group
typically takes place in lieu of individual supervision

Cultural competence in supervision

Multidimensional Ecological Comparative Approach (MECA)

Culture is complex and multidimensional. We all exist in our own cultural niche (map). So do our clients. In supervision, we must consider the interaction between the cultural niches of the client, therapist, and supervisor, and the treatment we provide.

Falendar & Shafranske (2021) provide an approach which centers this multidimensional interaction and operates from a social justice and cultural humility orientation



Peer supervision

- Offered to all new practicum clinicians weekly during their first semester in the UofC
- Provided by an advanced graduate student who has successfully completed the *Models of Clinical Supervision* course
- Peer supervision is supervised by a licensed clinical faculty member, often the practicum supervisor for the semester in occurs

icipate in
on with an
or
rvision is
ate clinic
e direct
sor assigned for
vision
ot attend individual
uring the weeks they
p supervision. This
dividual supervisor a
dmin time to review
take reports, and video
p supervision is also
monly offered for the summer
erapy practicum during the
tudent's second summer in the
program

Development model

Model of Clinical Supervision highlights three
ent based on the constructs of awareness,

ian Development

Awareness | Motivation | Autonomy

Level 2 | Level 3

Motivati
Fluct

Components of effective supervision

(health & care professions council 2020)



Clinical Supervision at U of C

Supervision sequence at the UofC

Reflects a typical sequence with practic… …ting in fall of year 1

1	**Adult Assessment** Fall Y1	Group supervis… Individual sup… as needed
	Child Assessment Winter Y1	Group supervision … Individual supervision with a senior… as needed
	Assessment Practicum Summer Y1	Weekly individual or group supervision
2	**Adult Therapy** Fall Y2	Weekly group supervision with a psychologist Weekly individual supervision with a senior student
	Child Therapy Winter Y2	Weekly group supervision with a psychologist Weekly individual supervision with a senior student
3	**Practicum I** Fall-Spring Y3	Weekly individual or group supervision
4	**Practicum II** Fall-Spring Y4	Weekly individual or group supervision
5	**Practicum III** Summer Y4	Weekly individual or group supervision

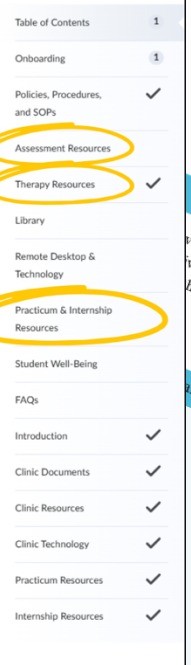
DON'T FORGET ABOUT YOUR OTHER RESOURCES!

D2L

= self-help

Resources for therapy, assessment, and practicum placements





Who should I go to for help?

These lists are not exhaustive or mutually exclusive, but should assist in general/flexible guidance



…risk assessment, assessment questionnaires)
…and how-to guides
…amples of assessment reports, progress notes, intake reports
• Orientation and refresher materials

Clinical Supervisor

- Crisis situations*
- Difficult moments in session
- Diagnostic questions
- Conceptualization questions
- Transference
- Countertransference
- Support & process
- Treatment planning
- Professional development

Peer Supervisor

- Documentation questions
- Policy questions
- Logistical support
- Reflection of faculty supervision
- Difficult moments in session
- Transference/Countertransference questions
- Diagnostic & conceptualization
- Accountability



Clinic Director

…vel issues (e.g., Titanium, IVS)
…ve concerns or problems
…h UofC staff, supervisors, clinicians, patients, and/or processes

…alling Tree if your Clinical Supervisor is unavailable

Supervisor's Role

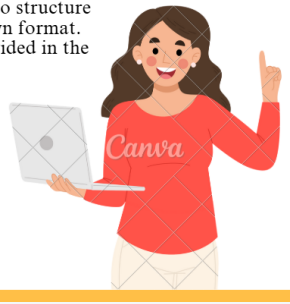
Supervisor checklist

- [ ] Did I enable the supervisee to describe their experience?
- [ ] Did I affirm and support the supervisee?
- [ ] Did I enable the supervisee to reflect on their experience?
- [ ] Did I share knowledge/information as appropriate
- [ ] Did I listen more than I spoke?
- [ ] Did I use questions to enable the supervisee to describe, reflect, and seek conclusions?
- [ ] Did I try to understand how the supervisee feeling?
- [ ] Did I maintain appropriate focus?
- [ ] Did I seek feedback from the supervise
- [ ] What do I need to take to my own s

Expectations of clinical supervisors

Essential Expectations

- Provide individual 1:1 weekly supervision to all assigned supervisees and their caseloads, except during group supervision weeks
- Provide on-call crisis supervision for all supervisees during UofC operation hours
- Review and sign clinical documentation including Titanium progress notes, intake reports, diagnostic evaluations (if indicated)
- Review recorded psychotherapy sessions using the IVS recording software
- Maintain knowledge of student's active caseloads inlcuding ensuring administrative tasks are complete (e.g., is client up to date on payment)
- Supervisors maintain autonomy to structure individual supervision to their own format. Some supervision guides are provided in the appendix to aid in development.
- If consistent problems arise in individual supervision, the superviser is encouraged to consult with the Clinic Director or Practicum Coordinator



Supervision rules and contracts

Supervision ground rules can help create a productive space where supervisees feel safe. Ground rules are particularly helpful for group supervision where the safety, perspectives, and practice of many supervisees must be protected.

Supervision contracts can also be useful in outlining the expectations for supervisors and supervisees. Please see example supervision contracts located in the Appendix.

Example Group Rules

- Confidentiality
- Refrain from talking over others
- Respect colleagues and differences of opinions
- Listen when others are speaking
- Have a good sense of humor
- Challenge others respectfully
- Be aware of others - try not to dominate the space
- Maintain awareness of time
- Allow people to own their own experience
- Be responsible for your actions
- Step outside of the supervision room if needed

Student's Role

Expectations of clinical supervisees

- As a trainee, you are practicing under your supervisor's license. You must adhere to their instruction and clinical decision-making. **When in doubt, contact your licensed clinical supervisor.**
- Supervisees should **PREPARE** for supervision and engage in open reflection and dialogue with supervisor. Supervision will not be effective if prepared.
- Supervisees are
  - These clip **improvem**
    - Clips clien
  - Focusin will lin
    - F fe
  - It is that to th
  - Diffe supe sup Ple

Barriers to engaging clinical supervision

- I like things the way they are
- I don't want to dwell on the things that have gone wrong
- I don't want to hear about eveyone else's problems
- I'm a professional, feelings don't come into it

adapted from the Helen & Douglas House Clinical Supervision Toolkit (2014)

Effective utilization of clinical supervision

Engaging in supervision is not only an ethical mandate for trainee clinicians, it is also the space where you will develop the necessary skills to enter the profession and engage in independent practice. It is an *essential* part of your clinical training and should be regarded as such.

Preparation

Effective supervision requires preparation. Preparation often includes watching recorded tape, developing hypotheses, and generating questions for the supervision session.

Reflection

Effective supervision requires self-reflection. Reflection includes an active evaluation of your actions, feelings, and thoughts as they relate to your clinical practice and interaction with patients.

Growth mindset

Effective supervision helps you grow. It is a space for you to grow. It is supervision more than anything is a space for you to grow. It is to make mistakes as a trainee clinician. The goal of supervision is to grow from mistakes and requires effort from you to reflect, change based on experiences.

gness

on requires willingness to actively engage. uncomfortable and vulnerable. Willingness to lean nd vulnerability will make supervision more in strong clinical skills and training.

tion

onship. working relationship between two supervision) and requires flexibility from both.

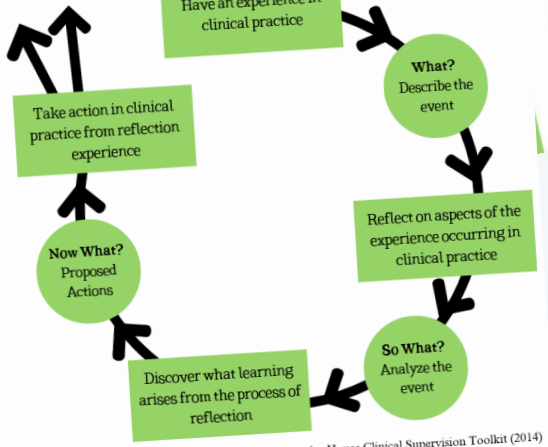
Models of Reflection

Engaging in self-reflection and reflection of clinical practice creates a supervision environment that is productive and growth-oriented

There are several models that help cultivate reflection in the supervision environment:

Driscoll's Model of Reflection

What? So What? Now What?



adapted from the Helen & Douglas House Clinical Supervision Toolkit (2014)

Ask yourself

Why do I feel the need to protect myself from clinical supervision?

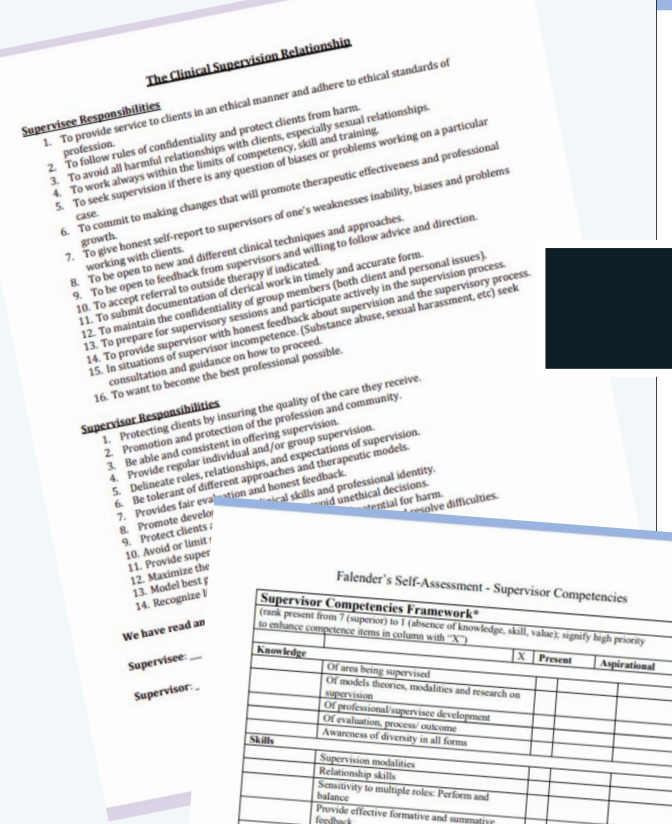
Preparing for supervision

Why should I prepare?

Preparation is important because:

- It enables the reflective process to begin prior to supervision, promoting the best use of time
- It helps supervision become more powerful in relation to the outcome possibilities and depth of reflection
- It increases the likelihood of supervision feeling useful and worthwhile so it improves motivation
- It models and communicates a high level of commitment

Appendix



The Clinical Supervision Relationship

Supervisee Responsibilities

1. To provide service to clients in an ethical manner and adhere to ethical standards of profession.
2. To follow rules of confidentiality and protect clients from harm.
3. To avoid all harmful relationships with clients, especially sexual relationships.
4. To work always within the limits of competency, skill and training.
5. To seek supervision if there is any question of biases or problems working on a particular case.
6. To commit to making changes that will promote therapeutic effectiveness and professional growth.
7. To give honest self-report to supervisors of one's weaknesses inability, biases and problems working with clients.
8. To be open to new and different clinical techniques and approaches.
9. To be open to feedback from supervisors and willing to follow advice and direction.
10. To accept referral to outside therapy if indicated.
11. To submit documentation of clerical work in timely and accurate form.
12. To maintain the confidentiality of group members (both client and personal issues).
13. To prepare for supervisory sessions and participate actively in the supervision process.
14. To provide supervisor with honest feedback about supervision and the supervisory process.
15. In situations of supervisor incompetence. (Substance abuse, sexual harassment, etc) seek consultation and guidance on how to proceed.
16. To want to become the best professional possible.

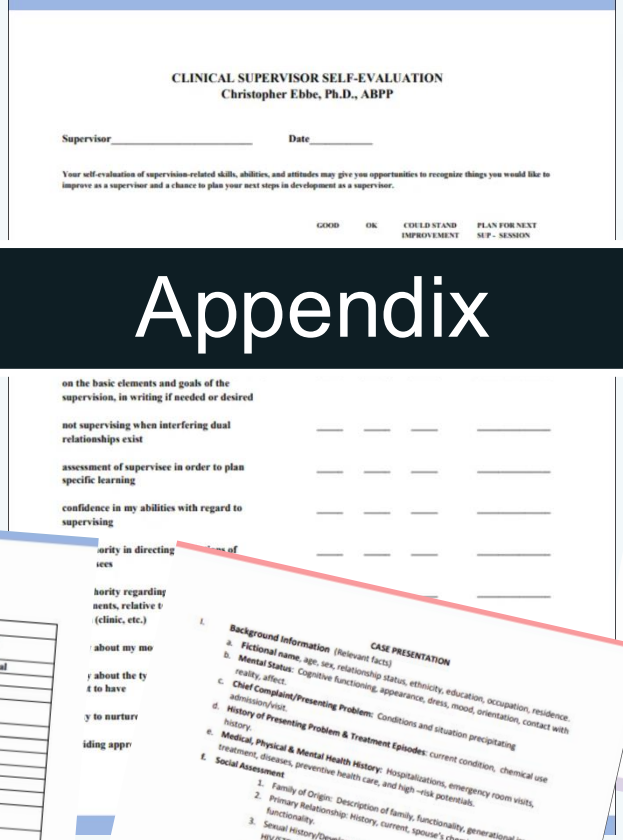
Supervisor Responsibilities

1. Protecting clients by insuring the quality of the care they receive.
2. Promotion and protection of the profession and community.
3. Be able and consistent in offering supervision.
4. Provide regular individual and/or group supervision.
5. Delineate roles, relationships, and expectations of supervision.
6. Be tolerant of different approaches and therapeutic models.
7. Provides fair eva… and honest feedback.
8. Promote develor… al skills and professional identity.
9. Protect clients … oid unethical decisions.
10. Avoid or limit … ential for harm.
11. Provide super… resolve difficulties.
12. Maximize the
13. Model best p
14. Recognize l

We have read an

Supervisee: ___

Supervisor: _

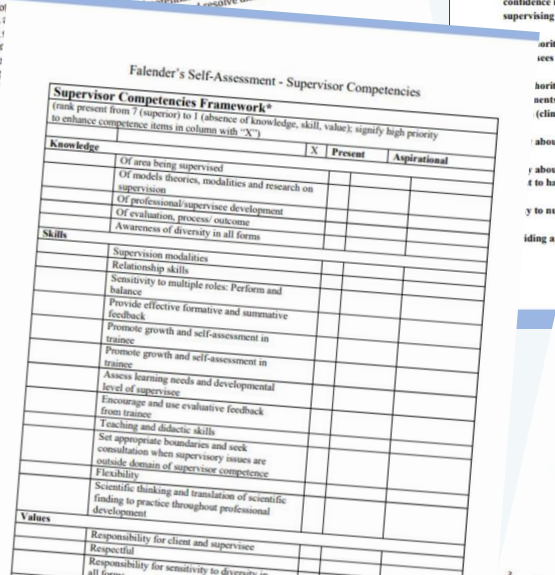


CLINICAL SUPERVISOR SELF-EVALUATION
Christopher Ebbe, Ph.D., ABPP

Supervisor_____ Date_____

Your self-evaluation of supervision-related skills, abilities, and attitudes may give you opportunities to recognize things you would like to improve as a supervisor and a chance to plan your next steps in development as a supervisor.

	GOOD	OK	COULD STAND IMPROVEMENT	PLAN FOR NEXT SUP. - SESSION
on the basic elements and goals of the supervision, in writing if needed or desired				
not supervising when interfering dual relationships exist				
assessment of supervisee in order to plan specific learning				
confidence in my abilities with regard to supervising				
…ority in directing …ees				
…hority regarding …nents, relative t… (clinic, etc.)				
…about my mo…				
…about the ty… t to have				
…y to nurtur…				
…iding appr…				



Falender's Self-Assessment - Supervisor Competencies

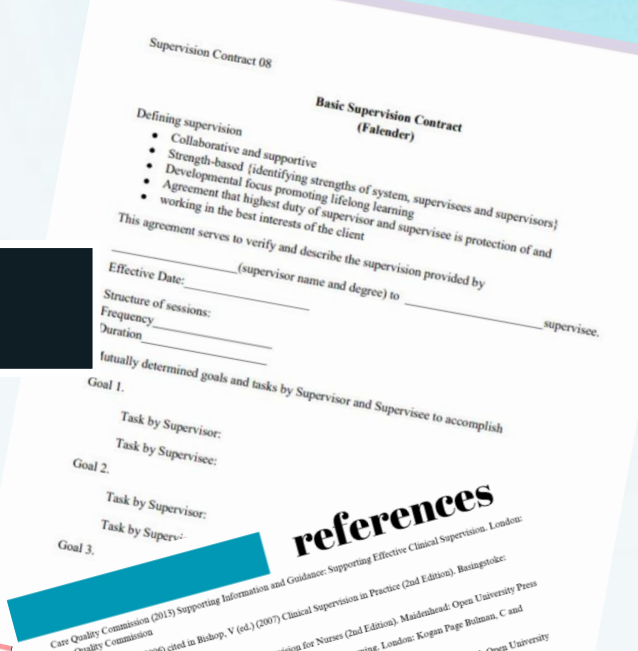
Supervisor Competencies Framework*

(rank present from 7 (superior) to 1 (absence of knowledge, skill, value); signify high priority to enhance competence items in column with "X")

		X	Present	Aspirational
Knowledge				
	Of area being supervised			
	Of models theories, modalities and research on supervision			
	Of professional/supervisee development			
	Of evaluation, process/ outcome			
	Awareness of diversity in all forms			
Skills				
	Supervision modalities			
	Relationship skills			
	Sensitivity to multiple roles: Perform and balance			
	Provide effective formative and summative feedback			
	Promote growth and self-assessment in trainee			
	Promote growth and self-assessment in trainee			
	Assess learning needs and developmental level of supervisee			
	Encourage and use evaluative feedback from trainee			
	Teaching and didactic skills			
	Set appropriate boundaries and seek consultation when supervisory issues are outside domain of supervisor competence			
	Flexibility			
	Scientific thinking and translation of scientific finding to practice throughout professional development			
Values				
	Responsibility for client and supervisee			
	Respectful			
	Responsibility for sensitivity to diversity in all forms			

CASE PRESENTATION

I.
- **Background Information** (Relevant facts)
  - a. **Fictional name**, age, sex, relationship status, ethnicity, education, occupation, residence.
  - b. **Mental Status**: Cognitive functioning, appearance, dress, mood, orientation, contact with reality, affect.
  - c. **Chief Complaint/Presenting Problem**: Conditions and situation precipitating admission/visit.
  - d. **History of Presenting Problem & Treatment Episodes**: current condition, chemical use history.
  - e. **Medical, Physical & Mental Health History**: Hospitalizations, emergency room visits, treatment, diseases, preventive health care, and high –risk potentials.
  - f. **Social Assessment**
    1. Family of Origin: Description of family, functionality, generational issues.
    2. Primary Relationship: History, current, spouse's chemical use and functionality.
    3. Sexual history/Development: Development, preference, abused or abuser, HIV/STD risk.
    4. Trauma and Losses: Emotional, physical, and other.
    5. Social/Peer Relations: Support network, degree of social involvement and skills.
    6. Religion/Spiritual Orientation: Attitude, involvement, attendance, values, beliefs.
    7. Financial status: Problems, impact of chemical use and socioeconomic status.
  - g. **Legal Problems**: History, current status and pending charges.
  - h. **Vocation and/or Education**: Problems, performance, attitudes and plans.
  - i. **Collateral Information**: information from sources other than the client and past treatment records.
- 2. **Diagnosis and Treatment**
  - a. **Assessment and Diagnosis**: Summarize assessment and substantiate your diagnosis.
  - b. **Treatment Planning**: Describe the plan and course of treatment. Describe how treatment plan will address the client's motivation for treatment, strengths, weaknesses, and culture. How was the
  - c. **Terminat…** treatment plan?



Supervision Contract 08

Basic Supervision Contract
(Falender)

Defining supervision
- Collaborative and supportive
- Strength-based {identifying strengths of system, supervisees and supervisors}
- Developmental focus promoting lifelong learning
- Agreement that highest duty of supervisor and supervisee is protection of and working in the best interests of the client

This agreement serves to verify and describe the supervision provided by _____(supervisor name and degree) to _____supervisee.

Effective Date:_____

Structure of sessions:

Frequency_____

Duration_____

Mutually determined goals and tasks by Supervisor and Supervisee to accomplish

Goal 1.

Task by Supervisor:

Task by Supervisee:

Goal 2.

Task by Supervisor:

Task by Supervi…

Goal 3.

references

Care Quality Commission (2013) Supporting Information and Guidance: Supporting Effective Clinical Supervision. London: Care Quality Commission

Bishop and Sweeney, (2006) cited in Bishop, V (ed.) (2007) Clinical Supervision in Practice (2nd Edition). Basingstoke: Palgrave-Macmillan

Bond, M and Holland, S. (2010) Skills of Clinical Supervision for Nurses (2nd Edition). Maidenhead: Open University Press

Bond, Keough and Walker (1985) Reflection: Turning Experience Into Learning. London: Kogan Page Bolman, C and Shultz, S (eds), (2004) Reflective Practice in Nursing (3rd Edition). Oxford: Blackwell

Cassedy, P (2010) First Steps in Clinical Supervision – A Guide for Healthcare Professionals. Maidenhead: Open University Press

Falender, C. A., & Shafranske, E. P. (2021). Clinical supervision: A competency-based approach (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000241-000

Schön, D (1991) The Reflective Practitioner: How Professionals Think in Action. Surrey: Ashgate Butterworth, T (1992) cited in Bond, M and Holland, S (1998) Clinical Supervision for Nurses.

Department of Health (1993) NHS Management Executive: A Vision for the Future. The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care. London: Stationery Office

Driscoll, J. (2007) Practising Clinical Supervision (2nd Edition). Edinburgh: Bailliere-Tindall

Gibbs, G. (1998) Learning by Doing: A Guide to Teaching and Learning Methods. Oxford: Further Education Unit, Oxford Polytechnic

Guidelines for Clinical Supervision in Health Service Psychology. (2015). The American Psychologist, 70(1), 33–46. https://doi.org/10.1037/a0038112.

Hawkins, P and Shohet, R (2012) Supervision in the Helping Professions (4th Edition) Maidenhead: Open University Press

Hawkins, P and Shohet, R (1989) Supervision in the Helping Professions (1st Edition). Maidenhead: Open University Press

Johns, C (2007) Towards Easing Suffering Through Reflection. Journal of Holistic Nursing Vol. 25, No. 3 204-211

Johns, C. (2013) Becoming a Reflective Practitioner (4th Edition). Oxford: Wiley-Blackwell

Milton Keynes: Open University Press

McNeill, B., Inman, A. G., & Talbot, J. M. (2016). The integrative developmental model of supervision. American

Psychological Association.

Standards Council (2008) The Code – Standards of Conduct, Performance and Ethics to Nurses and Midwives

…ctice in accountability, cited in M Marlien and M Payne (eds) Enabling …

…Education and Training in Youth and Community Work …

…London: Sage

…supervision in the

Case Vignette

A registered psychologist who recently started supervising in a community clinic values flexibility and prefers an informal supervision style. Over time, trainees supervised by this psychologist report uncertainty about clinic expectations, inconsistent feedback processes, and confusion about documentation standards compared to other supervisors at this setting.

A newly licensed psychologist joins the clinic and begins supervising trainees for the first time. They are confident clinically but uncertain about supervisory expectations, evaluation processes, and how much guidance they should provide trainees.

Because each supervisor in the clinic tends to operate somewhat independently, the new supervisor receives mixed advice from colleagues about “how things are typically done.”

Thank You

Kelly Hicks
kelly.hicks@ucalgary.ca

Brae Anne McArthur
braeanne.mcarthur@ucalgary.ca

Questions?



Presentation Slides

Jill Robinson
jillrobinson@uvic.ca

Alissa Pencer
alissa.pencer@dal.ca

Shannon Johnson
Shannon.johnson@dal.ca

Marjory Phillips
marjory.phillips@uwaterloo.ca

Kelly Hicks
kelly.hicks@ucalgary.ca

Brae Anne McArthur
braeanne.mcarthur@ucalgary.ca