Recovery Alberta
MENTAL HEALTH AND ADDICTION SERVICES

Clinical Supervision and Practice Support Toolkit

July 2, 2026

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Contact

Provincial Practice Supports

Recovery Alberta: Mental Health and Addiction Services

Please send any comments and suggestions on this toolkit by email to AMH.Practicesupports@recoveryalberta.ca

https://www.albertahealthservices.ca/info/Page16083.aspx

For citation purposes, use the following format:

Recovery Alberta. (2026). *Clinical Supervision and Practice Support Toolkit.* Edmonton, AB: Provincial Practice Supports, Recovery Alberta.

Introduction

Disclaimer

The resources in this toolkit are provided as optional tools to support supervision and professional development. They are intended to guide meaningful conversations and reflection and may be used, adapted, or replaced with other approaches that best meet the needs of the supervisor and employee.

Any information documented using these tools is intended solely to support the supervisory process and is not intended to form part of the employee's official personnel or human resources record. Completed tools should not be submitted to Human Resources or retained in an employee file.

Purpose

The *Clinical Supervision and Practice Support Toolkit* offers healthcare providers guidance on the models, methods, and tools of clinical supervision to provide practice support to the Recovery Alberta: Mental Health and Addiction Services (Recovery Alberta) workforce. This toolkit is not meant to replace supervision standards for specific professions but is a resource for those who are already or considering becoming clinical supervisors in Recovery Alberta, and their supervisees.

How to Use This Toolkit

Supervisors, supervisees, and organizational leaders within Recovery Alberta can use this toolkit as a practical, adaptable resource to promote effective clinical supervision, foster professional growth, enhance care outcomes and align with the Canadian Centre for Substance Use and Addiction (CCSA) Workforce Competencies.

Some suggestions for making the most of the toolkit are:

1. **Getting Started**
   Understand what clinical supervision is and how this toolkit aligns with the CCSA Workforce Competencies.
2. **Navigate Through Toolkit**
   Locate specific topics such as supervision models, roles and responsibilities, or feedback strategies.
3. **Use the Tools and Templates**
   The Appendices contain sample forms, checklists, and planning templates organized by role: Supervisors (*Appendix 1*) and Supervisees *(Appendix 2*).
4. **Plan Supervision Collaboratively**
   Use the Supervisee Self-Assessment (*Appendix 2*) and Annual Supervision Plan (*Appendix 1*) to co-create a supervision plan tailored to individual and team needs.

5. **Apply into Practice**
   Employ the models, methods, and reflective tools during supervision sessions. Use the Feedback Checklist (*Appendix 1*) and Practice Reflection (*Appendix 2*) regularly.

6. **Review and Reflect**
   Encourage ongoing feedback and evaluation using the Supervision Feedback Form (*Appendix 2*) and Learning Plan (*Appendix 2*).

7. **Adapt as Needed**
   Modify tools and approaches to suit your clinical context, team structure, and professional discipline.

What is Clinical Supervision?

Clinical supervision

Clinical supervision is a working alliance and ongoing process between practitioners intended to enhance knowledge, skills, and clinical judgement; provide professional support and development; and improve client/patient outcomes (Rabie et al., 2023). Through clinical supervision, practitioners may reflect on their clinical practice and translate theory, models, principles, and values into technical and behavioural skill sets that can be utilized with individuals experiencing mental health and/or substance use disorders (Davys & Beddoe, 2020).

Practice Support

Within Recovery Alberta, clinical supervision is the primary pillar of practice support for mental health and addiction practitioners, who are responsible for providing recovery-oriented care to individuals receiving therapeutic services (Schriger et al., 2021). Clinical supervision helps integrate knowledge into practice, enhances practitioners' clinical skills, provides encouragement, and improves clinical outcomes. It is a critical way to bridge between classroom learning and practice across different work contexts, based on the trust and rapport established within the supervisor-supervisee alliance (Newman et al., 2023).

Other methods of practice support include mentorship, preceptorship, coaching, community of practice, training, and self-directed study. These will be further described later in this toolkit (Sahu et al., 2024).

Clinical Supervision versus Administrative Supervision

Within Recovery Alberta, clinical supervision may include regular supportive meetings focused on professional practice development and is distinct from administrative supervision, which involves performance evaluation and management of employees (Gardner et al., 2021). To ensure optimal accountability and risk management, both are needed. Ideally, the clinical and administrative supervision functions are performed by different people; however, in some circumstances (e.g., small working groups, remote locations, understaffed offices), both forms of supervision may be offered by the same person (Davys & Beddoe, 2020).

> **Administrative Supervision** involves recruitment, scheduling, quality improvement, quality assurance and performance management (Davys & Beddoe, 2020).
>
> > Examples: Care Manager, Unit Manager, Program Manager.
>
> **Clinical Supervision** focuses on healthcare providers' clinical judgment, and technical and behavioural competency development, including welcoming, engagement, screening, assessment, and intervention (Davys & Beddoe, 2020). Supervisors build a working alliance with supervisees to create a safe space for practice reflection and discussion about professional boundaries, caseload and interpersonal issues (McDonough et al., 2024).
>
> **Note:** Clinical supervision does not include performance evaluation or management.

Examples: Counselling Supervisor, Clinical Supervisor, Advanced Practice Role, Assistant Head Nurse, Clinical Nurse Educator or Specialist.

Interdisciplinary Supervision

Most mental health and addiction programs include a variety of health disciplines, such as nurses, psychologists, social workers, occupational therapists and addiction counsellors, known as interdisciplinary teams. Therefore, many healthcare providers are likely to be supervised by someone trained in another discipline, who has different education and experience (Schriger et al., 2021). There are benefits to interdisciplinary supervision, such as gaining another discipline's perspective on clinical care that is unencumbered by assumptions of one's profession and contributing to practice discussions that are potentially interesting and thought-provoking. However, for new staff trying to establish their professional identity and practice, it is recommended that novice clinicians also have access to supervision or support from their same discipline (Davys & Beddoe, 2020).

Culture and Supervision

Clinical supervision includes cultural considerations for the supervisors, the supervisees and the individuals to which they provide healthcare. Cultural competence has been championed in the past however this approach can foster assumptions or stereotypes about specific groups or cultures. Cultural competence assumes that specific knowledge about various cultures will improve care but fails to acknowledge intersectionality and individual identities .(Jones et al., 2021; Watkins et al., 2019).

Cultural awareness is an alternative approach and has been referred to by a variety of terms including cultural safety, cultural sensitivity and cultural humility. The goal is for the supervisor to be aware of their own beliefs, values and biases while being willing to learn about the impact of the supervisee's culture and beliefs on their life and work (Gatzunis et al., 2022).

Scenario: Indigenous Cultural Awareness

A staff member approaches a clinical supervisor with concerns about how to best support a client of indigenous descent. The clinician wonders if there are things they should or shouldn't be doing related to the client's cultural background. They also observe that the client is very engaged in treatment but sometimes misses appointments.

What can this supervisor suggest to the clinician in this situation?

- In the spirit of cultural safety and awareness, the supervisor can encourage the clinician to reflect on their own cultural beliefs and values as well as directly ask the client about their experience of culture, what practices are meaningful to them and how/if the client would like to incorporate those practices into their recovery plan.
- The clinician can ask the client if they are aware of supports such as the indigenous support line. If needed the clinician may review program resources, and local community support information with the client. https://www.albertahealthservices.ca/amh/Page16446.aspx

- The clinician can explore with the clients any barriers they may have to attend appointments consistently e.g. social determinants of health like transportation, childcare and finances.

At the next staff meeting the supervisor brings forward the need for culturally inclusive care, practices and programming as their urban addiction mental health clinic supports many clients of indigenous descent.

What could be some of their next steps?

- The supervisor can encourage staff to practice Allyship: https://insite.albertahealthservices.ca/main/assets/hr/tms-hr-ctc-being-an-ally-info-sheet.pdf
- The supervisor can provide resources for indigenous training to the clinicians such as My Learning Link courses and the Indigenous Health page on Insite. https://insite.albertahealthservices.ca/ihp/Page9219.aspx
- The manager could consult the Indigenous Wellness Core for direction on proper protocol for extending an invitation to partner with indigenous community members, listening to their stories and experience, and explore ideas for co-creating cultural practices at the clinic. https://insite.albertahealthservices.ca/scn/Page25806.aspx

Importance of Clinical Supervision

Benefits

Clinical supervision offers numerous benefits for both the supervisee and the supervisor. It can help to:

- **Increase Morale and Decrease Stress** - Support from clinical supervision can increase morale and self-esteem, mitigate exhaustion, burnout, and moral distress, and encourage self-awareness and self-expression (McDonough et al., 2024; Rabie et al., 2023).
- **Enhance Clinical Competency** - Clinical supervision can help practitioners deepen their clinical competency and expand their knowledge base and skills through reflection, feedback, and professional development (McDonough et al., 2024).
- **Develop Professional Identity** - Clinical supervision is a means by which healthcare providers can hone their professional identity. Academic learning is the foundation for competent practice and supervision can ensure supportive knowledge translation from student to novice to experienced practitioner (McDonough et al., 2024).
- **Enhance Knowledge of Self** - Clinical supervision can provide practice feedback that encourages self-review and reflection, allowing practitioners to discuss issues and identify ways to improve their practice (Newman et al., 2023; Rabie et al., 2023).
- **Help Mitigate Impacts of Isolation** - Clinical supervision can mitigate issues of professional or geographic isolation experienced in rural programs throughout Alberta. It can be helpful to optimize the use of technology to bridge the distance between

supervisors and supervisees (Gardner et al., 2021; McDonough et al., 2024).

Organizational Outcomes

Effective clinical supervision can result in several organizational outcomes:

- **Enhance safety and quality of care** - Supervision can increase satisfaction for individuals accessing mental health and addiction services through improved therapeutic alliance and overall quality of care received (McDonough et al., 2024; Rabie et al., 2023).
- **Improvement in client/patient outcomes** - Healthcare practitioners can refine their professional practice to enhance patient care.
- **Retain staff** - Clinical supervision is part of an organization's recruitment and retention strategy of highly qualified staff. It may serve as a protective factor to mitigate workplace and caseload issues. (McDonough et al., 2024; Newman et al., 2023).
- **Promotion of a culture of learning** - This can include ongoing professional development that aligns with best practices, standards, and competencies.

Challenges

There may be barriers to clinical supervision for the organization, supervisor, and supervisee that can impede implementation and effectiveness. The chart below outlines potential possible barriers and corresponding solutions.

Challenge	Causes of the challenge	Possible solutions
Lack of trained, experienced supervisors-Not enough supervisors in relation to number of staff (Davys & Beddoe, 2020)	• Supervision is underfunded • High education expectations for supervision positions • Limited number of professionals that meet education/experience requirements (Davys & Beddoe, 2020; Masamha et al., 2022; Newman et al., 2023)	• Advocate to increase awareness about the benefits of clinical supervision • Advocate to recognize experience as an asset to clinical supervision • Advocate for clinical supervision training in the organization (Bayley et al., 2022)
Lack of supervision guidelines and training – Limited availability of training or supervision for supervisors (Rabie et al., 2023)	• Limited awareness of the benefits of clinical supervision • Lack of funding (Davys & Beddoe, 2020)	• Advocate to increase awareness about the benefits of clinical supervision and need for training • Initiate or join clinical supervision communities of practice (Bayley et al., 2022)
Supervisor-supervisee ratio – If a supervisor has too many	• Lack of trained, experienced supervisors	• Use of group supervision where possible and appropriate

supervisees, they may only focus on administrative tasks and have little time for practice reflection (Davys & Beddoe, 2020; Masamha et al., 2022)	• Lack of funding (Davys & Beddoe, 2020)	• Advocate for the best use of clinical supervisor's skill set (i.e. Clinical support versus administrative support) (Gardner et al., 2021)
Lack of individual supervision - Group supervision is beneficial for all clinicians; however new staff also need individual supervision until their practice is established (Newman et al., 2023)	• Lack of competent trained, experienced supervisors • Lack of funding (Davys & Beddoe, 2020)	• Schedule individual supervision as per the developmental needs of the clinician i.e. New staff may be monthly and established staff may be quarterly • Provide frameworks and processes for staff to reflect and build awareness between supervision sessions (i.e.. Gibbs' Reflective Cycle, Supervisee Practice Reflection form in Appendix 2) (Davys & Beddoe, 2020; Feruza Masharipova, 2025; Gardner et al., 2021; Hamilton et al., 2024)
Inconsistent or infrequent supervision sessions (Newman et al., 2023b)	• Lack of management support to attend, lack of time to attend, supervisor is unavailable, off-site or has too many supervisees (Newman et al., 2023) • Staff reluctance or avoidance (Masamha et al., 2022a; Newman et al., 2023b)	• Schedule supervision as per the needs of the clinician i.e. New staff may be monthly and established staff may be quarterly • Conduct introductory sessions with staff to explain purpose of supervision and build rapport (Davys & Beddoe, 2020b; Gardner et al., 2021b; Hamilton et al., 2024)
Clinician reluctance to participate (Masamha et al., 2022; Newman et al., 2023)	• Uncertainty regarding rationale for supervision • Staff concerns about practice critique and performance management. • Lack of supervisory alliance resulting in staff feeling unsure of disclosing sensitive practice	• Conduct introductory sessions with staff to explain establish expectation of participation in supervision, explain its purpose of supervision and build rapport • Ask staff to assess their competency and reflect on their growth areas

	experiences for fear of retribution (Masamha et al., 2022; Newman et al., 2023) • Viewing alternative forums such as shift handover, physicians rounds, education days, and team meetings as sufficient and satisfying ways of maintaining professional development (Masamha et al., 2022)	• Attempt to ensure separation of clinical and administrative supervision specifically related to performance management and/or any disciplinary actions • Offer supervision in a variety of settings and formats i.e. Observing sessions, virtual supervision, teaching moment at care conference, co-therapy, reviewing documents, short in-services… (Davys & Beddoe, 2020; Hamilton et al., 2024)
Balancing program requirements and professional best practice (Davys & Beddoe, 2020)	• Possible conflicts between organizational requirements and procedures and professional best practices (Davys & Beddoe, 2020)	• Acknowledge and address the areas of conflict between organizational requirements and best practice • Negotiate solutions with staff that balance organization requirements with best practice • Identify when organizational requirements are unrealistic or are counter to client care (Davys & Beddoe, 2020)

Scenario: Addressing Challenges

A clinical supervisor, who is relatively new to a team, notices that one of the experienced clinicians seems to avoid supervision meetings. The clinician has voiced that it “just takes time away from direct care” and that they are too busy to fit in supervision meetings. What strategies can this supervisor use to engage the clinician in supervision?

Strategies:

- Focus initially on building rapport and a discussion around how clinical supervision could be most supportive to the clinician
- Emphasize clinical support tasks versus administrative tasks, such as chart reviews, at first to reduce clinician reluctance to participate
- Be as flexible as possible in supervision methods, ad hoc supervision discussed below could be very effective for this clinician
- Offer opportunities for the clinician to act as a mentor or peer support to less experienced colleagues if appropriate

Models of Supervision

Functions of Supervision

There are a variety of supervision models and each includes one or more functions of Proctor's Supervision Alliance Model (Davys & Beddoe, 2020a):

1. **Normative** supervision ensures the service delivery quality through administrative tasks such as performance management and promoting standards of care. Clinical supervision includes supporting practice to meet standards of care but does not include performance management.

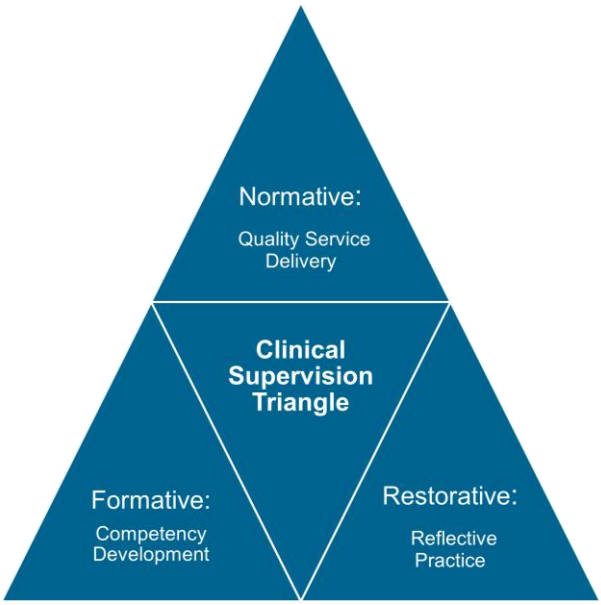
   Examples: chart audits, practice feedback, attending new hire interviews

2. **Formative** supervision facilitates professional development through the expansion of skills, knowledge, and competency.

   Examples*:* case consultations and training

3. **Restorative** supervision reflects on the healthcare providers' practice and promotes personal wellness and job satisfaction.

   Examples*:* individual supervision session and peer supervision



These functions form a triangle of priorities that need to be balanced within the supervisory working alliance. The most common tasks of supervisors are formative, which support competency development through case consultation, supervisory alliance and technical skill building (Rabie et al., 2023).

Developmental Models

Developmental models of supervision employ the formative function by collaboratively assessing healthcare providers' knowledge and experience and planning their learning and development needs. A beginner or novice provider may require more frequent support and guidance than a proficient or advanced practitioner (Gardner et al., 2021a)). It is important to consider that a supervisee at the advanced level may still require frequent supervision if they are learning a new intervention or modality.

For example, Stoltenberg and Delworth's Developmental Model (Davys & Beddoe, 2020) describes supervision at three stages:

Stage	Supervisee	Sessions	Supervisor
Beginner	May feel insecure	Frequent – monthly and as needed	Engaging Guiding

	Over/under confident	Structured Skill building Promote practice standards Individual supervision	Supportive Assessing Giving constructive feedback
Competent	Inconsistent confidence	Monthly Gaining skills Learning from mistakes Explores therapeutic alliance Group or Peer supervision	More connected relationally
Advanced	Confident	Quarterly Case consultation and reflection Group or peer supervision	Peer-to-Peer connection

Competency Models

A competency model can build on the developmental model's learning stage by identifying specific skill and knowledge needs through supervision and an individual learning plan. Competency-based feedback can facilitate reflection and self-evaluation during supervision conversations helping to develop crucial areas such as professional skills, attitudes, and values (Sahu et al., 2024).

Utilizing competencies can reduce 'rater bias' where a supervisor defaults to their personal and often idiosyncratic perception and opinion when observing and providing feedback. An example of rater bias is leniency error, where a supervisor may have an overly positive perception of a supervisee that may not match their actual clinical performance. A supervisor might also assume that an experienced clinician has advanced competencies when they may not. Supervisors would do best to anchor their feedback in nationally standardized technical and behavioural competencies, noticing the individual proficiency for each skill and targeting developing levels for learning plans and professional development (Sahu et al., 2024).

Recovery Alberta has adapted the Canadian Centre on Substance Use and Addiction's (CCSA) Workforce Competencies as their competency model to highlight the technical and behavioural skills required by healthcare providers working with individuals experiencing mental health and substance use concerns. CCSA has job-specific competency profiles, interview guides and performance evaluation tools that can aid supervisors of a multidisciplinary team with setting goals and creating corresponding supervision plans. Additionally, Recovery Alberta's Pathways to Excellence Framework and Learning Plan Guide and the Competency-Based Learning Plan Template are helpful for annual reviews and learning plan development.

> *Competency development and annual learning plans are further discussed in the supervision planning section.*
>
> *Note: Mental health and addiction specific competency development can complement but not replace health professionals meeting their regulatory college continuing competency requirements.*

Reflective Models

Reflective models fulfill the restorative function of supervision by facilitating structured conversations that evaluate practice in a way that balances knowing one's strengths and areas for improvement. Reflection on practice involves inquiry and review of issues and concerns, allowing supervisees to proactively improve their knowledge and skills (Feruza Masharipova, 2025).

For example, the Gibbs' Reflective Learning Cycle includes six steps (Feruza Masharipova, 2025):

1. Describe – recall clinical situations objectively
2. Feelings – identify emotions about the situation
3. Evaluation – assess the situation for what worked and what did not
4. Analysis – review outcomes reflectively and critically
5. Conclusion – summarize learnings and notice what could change
6. Action Plan – set intentions and goals for future practice situations

The Gibbs' Reflective Learning Cycle can be used by the supervisee in between supervision sessions or completed together with the supervisor. It can be especially helpful for challenging situations or when learning a new skill or intervention.

> *A Supervisee Practice Reflection worksheet based on Gibbs' cycle is in Appendix 2.*

Roles and Responsibilities

Managers and Team Leaders

Managers and team leaders can support effective clinical supervision processes in the following ways (Schriger et al., 2021):

- Provide clear communication regarding the importance of clinical supervision
- Recruit, train, and develop clinical supervisors
- Designate a time for supervision to occur
- Ensure access to clinical supervision within staff work schedules
- Evaluate the process of clinical supervision in their workplace

Supervisee

The supervisees may have a variety of clinical backgrounds – nursing, occupational therapy, social work, counselling therapy, and psychology – that each have different views and experiences of supervision. Supervisors must relay role expectations at the commencement of

supervision sessions to ensure early mutual trust and understanding including clarity on what is required and what is desired from the supervision process.

Supervisees expectations are to:

- Actively participate in the process of clinical supervision
- Contribute to a constructive learning environment and working relationship
- Set goals for developing technical and behavioural competencies
- Advise supervisor of opportunities for observation of clinical activities
- Identify clinical situations for discussion (e.g. notes, recordings, questions)
- Reflect on their current practice (*see Appendix 2*)

Supervisor

Clinical supervisors' roles are diverse and varied. They may have competing priorities depending on the supervisee's caseload, rural or urban setting, and program and population needs. There are five main tasks for any supervisor (Davys & Beddoe, 2020; Sahu et al., 2024; Schriger et al., 2021):

1. **Facilitating knowledge translation and a culture of learning** by attentive listening, engagement, paraphrasing, and alliance building.

    Examples – observing a clinical session and new skill practice

2. **Providing feedback** through the use of open questions, reframing, and review of clinical outcomes. Identifying and address gaps in clinical practice, as well as system level gaps and risk management issues.

    Examples – Reviewing clinical documentation and written reports

3. **Presenting evidence-informed practice knowledge** to build understanding and assist problem solving by sharing research, policy, procedure, and practice expertise and experience. Contributing to the planning, implementation and evaluation of mental health treatment services.

    Examples – journal club, community of practice, networking with members of the interdisciplinary team, psychiatrists, and community partners in support of effective professional and collaborative practice

4. **Evoking personal and practice reflections** through sharing practice observations so that supervisees can gain awareness of ways and means to improve their behavioural or technical skills.

    Examples – Conducting team case consultations and offering support

5. **Specifying practice changes needed through** prescriptive direction. Specific practice suggestions may be less commonly used; however, they may be needed for any clinician learning a new skill or in a crisis situation where safety is at risk.

Examples – Close monitoring of practice changes (e.g. medication administration or electronic documentation), or providing guidance and direction in a timely manner to clinical staff with challenging and urgent cases

Supervisor Development

There is not one specific route to becoming a clinical supervisor. Supervisors often arise from within the team and are usually senior staff and viewed as informal leaders. The experience and qualifications required to be a clinical supervisor and provider of practice support is variable. No specific training is mandatory at this time, however there are identified pathways and developmental phases.

Three common pathways into the clinical supervisor role are:

1. **Task exposure** - refers to work experiences and activities that sparked an interest in supervision and pursuing a supervisor role. This is often a result of supervising students or serving in a temporary acting supervisory role.
2. **Supervision by 'happenstance' -** refers to an unplanned move to a supervisor role. Individuals who may have had no interest in a supervisory role may be placed in one due to circumstances at their workplace. This might include retirement or the sudden departure of a previous supervisor with no other candidates for the position (Schmidt & Kariuki, 2019).
3. **Deliberate decision** - refers to situations where the individual considered supervisory roles as an opportunity to create change and set that as a goal relatively early in their career (Schmidt & Kariuki, 2019).

Three developmental phases of supervision are:

Developmental Phase	Characteristics	The central question
1. Becoming a supervisor	More focus on role than process Hoping to impress and be effective Providing answers for supervisees Fixing	"Do they like me?"
2. Making connections	Adopting supervisory approach to best fit their own theoretical orientation and practice style Recognizing cultural differences Deepening skills Asking questions of supervisees	"Do they respect me and am I helpful?"
3. Integrating theory into practice to create change	Critical reflection on one's practice, Comfort with one's limits, Learning to trust one's judgment and practice wisdom Continuous innovation of their supervision skills and knowledge base	"Are they practicing ethically and are they learning?"

Adapted from (Davys & Beddoe, 2020)

Effective and ethical clinical supervision entails that clinical supervisors demonstrate current competency-based clinical skills and experience and also receive regular supervision and feedback. This may include a Community of Practice, specific training tailored to the practice area, and the development of a learning plan that focuses on building supervisory competencies (Davys & Beddoe, 2020).

Types of Supervision

There are several ways to conceptualize supervision; however, in terms of modes of delivery, there are two general types: individual supervision and group supervision.

Individual Supervision

Individual supervision is the cornerstone of professional development. It involves one-to-one time between professionals which may include discussing a case before a clinical session, leading or observing a live session, reviewing video or audiotape material, debriefing a counselling session, staging a role-play, and/or participating in a discussion about clinical work. Individual supervision is helpful for all clinicians, especially those who are relatively early in the development of their professional identity or those who would like to learn specific new skills. It provides ample opportunity for discussion and reflection, demonstration, and specific feedback (Davys & Beddoe, 2020).

Group Supervision

Group supervision occurs with a designated supervisor overseeing the professional development of a group of peers (Gardner et al., 2021). Supervision can shift from one individual to another in the group, or even to the group as a whole. It could include in-depth case reviews, clinical demonstrations, or discussions between practitioners and the supervisor (Davys & Beddoe, 2020). Group supervision is efficient, allowing supervisors to meet with multiple supervisees simultaneously and improving access for rural and remote programs. Additionally, group supervision offers learning opportunities that are unique to a group setting and enhances peer learning and support. Supervisees can benefit from more and varied case discussions and contribute to case discussions and ideas for technical strategies and approaches (Davys & Beddoe, 2020; Gardner et al., 2021).

Peer Supervision

Peer Supervision in a group occurs without a designated leader. Professionals discuss practice topics to find solutions for their case management queries. They can form communities of practice where professionals who share a common background and similar practice area exchange information and experiences, thus learning from each other and facilitating personal and professional growth (Davys & Beddoe, 2020).

Ad Hoc Supervision

Ad Hoc Supervision is where practice support is provided spontaneously through day-to-day interactions. It may be supervisee-initiated case consultation or ethical consideration, or by way

of a supervisor's routine tasks, such as reviewing documentation and site visits. A flexible, approachable supervisor can make the most of these ad hoc learning moments (Ramani, 2015).

Supervision Methods

Supervision requires a variety of methods, techniques and tools to provide practice support for diverse clinical teams. Schriger (2021) delineates supervision methods into active and passive strategies. Despite active strategies being highly effective for knowledge translation and experiential learning, a supervisor may have limited capacity to utilize them if faced with high numbers of supervisees and involvement in administrative tasks (Schriger et al., 2021). Supervisors need to strive to be flexible, available, and approachable to maximize teachable moments within both scheduled and unplanned conversations with supervisees (Davys & Beddoe, 2020).

Active Strategies

Active strategies provide experiential learning and may be direct or indirect (Masamha et al., 2022; Schriger et al., 2021).

Direct methods pertain to clinical care, for example:

- Co-therapy – when a supervisor and supervisee work together with a client
- Live observation of the session and giving feedback – when the supervisor provides reflective and constructive feedback to improve the supervisee's practice
- Observation – when a supervisor observes the supervisee during a client session through a one-way mirror or via a virtual video meeting, such as Zoom or Microsoft Teams

Indirect methods occur before or after patient care, for example:

- Practice reflection – an individual supervision meeting to discuss a recent complex client (*see Appendix 2* for reflection template)
- Case consultation – when the supervisee requests scheduled or ad hoc meetings for discussion of a client's challenges, strength, and care plan (*see Appendix 1*)
- Role playing – an opportunity to practice a new approach through behavioural reversal
- Documentation review – audit and evaluation of documentation to align with program standards, best practices or implementation of electronic charting
- Review of session recordings – recordings can be shared according to program confidentiality protocols
- Setting learning goals – at the commencement of supervision and annually (*see Appendix* for samples)

Passive Strategies

Passive strategies are not skill-based but rather behavioural and relational soft skills, including supervisor modelling, giving and receiving feedback, openness, collaboration, and building alliance (Schriger et al., 2021). Examples include checking in with supervisees about how they

are coping, inquiring whether the supervision process is helpful, and requesting specific feedback regarding supervision regularly.

Supervision Working Alliance

Bordin (1983) proposes a Working Alliance Model of supervision characterized by collaboration and mutual agreement on goals, tasks, and bonds between the supervisor and supervisees (Bordin, 1983; Vail et al., 2021).

- **Goals** refer to mutually agreed-upon objectives for professional development to be supported by supervision.
- **Tasks** refer to the steps taken to reach the goals. For example, skill development, supervision meetings, reflective practice, and documentation review.
- **Bonds** refer to the ongoing maintenance of a supportive and trusting working alliance. Open communication is crucial including giving and receiving feedback as well as addressing parallel processes, transference, and countertransference.

Goals

Professional development goals can be collaboratively set and provide direction for supervision. Goals can be established through learning plans to support safe and ethical practice and competency development.

Supervision Planning

To get started in supervision, manager approval may be needed and a learning and supervision plan should be developed. At the first meeting, the clinical supervisor and supervisee can get to know each other and share their clinical training and experience. Further, they may clarify their expectations about the process, method, frequency, and content of clinical supervision. In future meetings, this can be formalized as a supervision plan. This is a critical step in developing a trusting and collaborative relationship between those involved in clinical supervision (Davys & Beddoe, 2020).

A sample Supervisee Self-Assessment for the First Meeting is in Appendix 1

Annual Learning Plan

Part of the supervision process provides practice support and promotes professional development. This can be accomplished by developing a learning plan *(see Appendix I)* that includes specific technical and behavioural competency improvement goals. Recovery Alberta has adopted the Canadian Centre Substance Use and Addiction's (CCSA) workforce competency tools as well as the CanMeds framework. Some options for developing a learning plan are:

- Review CCSA's Technical and Behavioural Competencies (Understanding the Competencies | Workforce) Competencies and the CanMeds roles (CanMEDS Framework). Consider areas of strength and opportunities for growth.

- ☐ Read to Pathways to Exellence Guide
- ☐ Fill out the Recovery Alberta Competency-Based Learning Plan to determine annual learning goals

Each healthcare provider will have varying levels of proficiency in each competency. Through annual assessment one can target key competencies for improvement and development. The technical and behavioural competencies are:

Technical Competencies:	**Behavioural Competencies:**
☐ Understanding Co-occurring Substance Use & Mental Health Concerns ☐ Understanding Mental Health ☐ Understanding Substance Use ☐ Accountability ☐ Collaborative Care Planning ☐ Community Development ☐ Counselling ☐ Family, Caregivers & Social Supports ☐ Group Facilitation ☐ Medications ☐ Outreach ☐ Prevention & Health Promotion ☐ Program Development, Implementation & Evaluation ☐ Record Keeping & Documentation ☐ Referral ☐ Risk Assessment & Crisis Intervention ☐ Screening & Assessment ☐ Trauma- and Violence-informed Care ☐ Treatment Planning	☐ Adaptability & Flexibility ☐ Analytical Thinking & Decision Making ☐ Collaboration and Network Building ☐ Continuous Learning ☐ Creativity and Innovation ☐ Culturally Competent & Equity-Informed Approach ☐ Developing Others ☐ Effective Communication ☐ Ethical Conduct & Professionalism ☐ Interpersonal Rapport ☐ Leadership ☐ Person-directed Care ☐ Planning & Organization ☐ Self-Care ☐ Self-Management & Self-Reflection ☐ Self-Motivation ☐ Teamwork

Competencies are reviewed and assessed individually according to the following levels of proficiency:

1. Foundational – basic knowledge and skill; practices with guidance
2. Developing – sound knowledge and skill; minimal guidance needed
3. Proficient – in-depth knowledge and skill; no guidance required
4. Advanced – expert knowledge and skill; expert and leads others

Note: that not all roles need proficiency in all competencies.

The Annual Supervision Plan *(see Appendix 1)* and a Competency-Based Learning Plan *(see Appendix 2)* will work together support the supervisee to identify the tasks required to achieve their professional development and practice goals.

Note: Learning plans may be used for performance evaluation and management by managers; however, the purpose of learning plans within clinical supervision is for professional development only.

Tasks

Tasks refer to the steps taken to reach the goals. These may include, for example, specific skill development, supervision meetings, reflective practice, and documentation review.

An Annual Supervision Plan helps to identify the specific tasks and support required from the supervisor for the supervisee to achieve their annual learning goals. An annual plan for clinical supervision should include:

- **Frequency of supervision sessions:** Regular check-ins to assess progress and address any issues.
- **Professional Development:** Opportunities for training and skill enhancement.
- **Goal Setting**: Establishing and reviewing goals for supervisees
- **Feedback**: Opportunities for providing and receiving feedback

A log or alternate documentation of clinical supervision sessions is kept by both the supervisor and supervisee. This document should not include any client or patient identifying information.

Other considerations in developing an annual supervision plan include responsibilities regarding preparation for supervision sessions, managing confidentiality if recordings of sessions are used, and how the information gathered in clinical supervision sessions will be used.

A sample Annual Supervision Plan is in Appendix 1

A routine Clinical Supervision Meeting worksheet is in Appendix 1

Bonds

Bonds refer to the establishment and ongoing maintenance of a supportive and trusting working alliance between supervisor and supervisee (Bordin, 1983). Open communication is crucial, along with effective giving and receiving feedback, noticing boundary crossings, and addressing parallel process, transference, and countertransference (Davys & Beddoe, 2020).

Giving and Receiving Feedback

One of the most important skills for a supervisor is the art of giving and receiving feedback. Being able to give and receive feedback well ensures effective communication and creates a safe culture of learning and growth. Davys (2020) describes feedback as the “process of telling another individual how they are experienced”. When feedback is specific, balanced, structured, and part of routine supervision practice, it builds honesty and trust within the supervisory alliance. Feedback needs to be balanced: neither too positive, which can sound patronizing, nor too general, nor too negative, which can shame, harm, and humiliate. Preparation can aid feedback delivery by allowing time to consider key points (Davys & Beddoe, 2020).

Davys and Beddoe (2020) suggest the DESC mnemonic for preparing feedback:

- **Describe** the behaviour that requires change
- **Express** your issues or concerns with what you observed
- **Specify** the change in the behaviour that is required
- **Consequences** – explain the reason the behaviour needs attention, what will be different if the behaviour changes

Scenario: Giving Feedback

A supervisor is completing chart audits and has identified that one of their supervisees is not adequately documenting risk in their progress notes. How can the supervisor use the DESC script to provide feedback?

D- I have noticed that you often are not providing any details when documenting risk on your progress notes. I was wondering if you have had the opportunity to look at documentation examples or if you need additional resources about documenting risk.

E- I am concerned as this could result in you missing cues that an individual is at risk and it is required as best practice.

S- In future documentation, you will need to state level of risk and the reasons that support your assessment.

C- This will protect both you and the individual you are working with. It will also provide relevant information if other healthcare providers are involved in the person's care.

A sample Feedback Preparation Checklist is in Appendix 1.

By the same token, supervisors can model for their supervisees how to give and receive feedback well and demonstrate that honest communication strengthens bonds and promotes individual and relationship growth. Supervisors can solicit feedback using a formal questionnaire, several of which have been developed and evaluated for use within supervision relationships (Schweitzer & Witham, 2018). For example, the Supervisory Relationship Questionnaire (Palomo et al., 2010) has both a long form and a short form and could be used to generate conversations about the effectiveness of the supervisory relationship. Reviewing the questionnaire near the beginning of a supervisory relationship would serve as an invitation to supervisees to reflect on how they could benefit from the relationship itself to meet supervision needs; as well as set up the expectation that giving and receiving feedback is a reciprocal affair. Both supervisors and supervisees can expect to include giving and receiving feedback as part of their routine activities.

A sample Supervision Feedback form to be completed by the supervisee is in Appendix 2

Boundaries

Within a safe supervisory alliance, the supervisor can help address boundary challenges early by noticing when the supervisee's therapeutic rapport with, and thoughts and feelings about a client or patient are moving beyond professional norms. Boundary concerns may manifest as labeling an individual as special, keeping conversations private, spending extra time with the

person, or withholding interactions from coworkers including managers. The supervisor can proactively share their observations of potential boundary crossings and advise the supervisee on corrective action (Davys & Beddoe, 2020).

Transference, Countertransference and Parallel Process

Maintaining the supervision alliance bond includes noticing and addressing the largely unconscious relational dynamics of transference, countertransference, and parallel process that may interfere with the supervisor's effectiveness and impede the supervisee's professional growth (Davys & Beddoe, 2020).

> **Transference** occurs when a supervisee projects onto the supervisor the positive or negative responses, feelings, and attitudes they have experienced in a prior relationship.
>
> **Countertransference** is the reverse to transference. The supervisor reacts to the supervisee based on memories of another person. Noticing and then exploring these emotional reactions together provides rich information about the emotional life and relational dynamics not only of the person in therapy but also of the supervisor and supervisee. As such, this exploration has great potential to further build supervision alliance bonds. (Davys & Beddoe, 2020)
>
> **A parallel process** occurs when the supervision alliance mirrors the emotional dynamic of a therapeutic relationship that is being supervised. For example, supervisee who is trying to help a dismissive client may find themselves being dismissive of their supervisors feedback, advice, and input. Awareness of, and a willingness to address emotional reactions manifested in behavioural changes allow both supervisor and supervisee to address together challenging issues that may emerge in both the therapeutic and supervision relationships. (Davys & Beddoe, 2020).

Practice Tools

Throughout this toolkit there are worksheets and checklists mentioned that are available in the appendices. They are meant to guide and support clinical supervision and provide practice support as it applies to each program and clinical practice area.

Appendix 1: For Supervisors

- Annual Supervision Plan
- Clinical Supervision Meeting
- Feedback Preparation Checklist
- Case Consultation
- Therapy Observation Checklist

Appendix 2: For Supervisees

- Supervisee Self-Assessment for the First Meeting
- Supervisee Practice Reflection
- Supervision Feedback Form
- Competency-Based Learning Plan

A recommended comprehensive reference for clinical supervision is:

Davys, A., & Beddoe, L. (2020). *Best Practice in Professional Supervision, Second Edition: A Guide for the Helping Professions.* Jessica Kingsley Publishers

Additional Practice Supports

Clinical supervision is a central pillar of practice supports but other activities promote clinical development. Additional practice supports include a range of activities that educate, encourage, support, and develop practitioners to enhance their clinical knowledge, skills, and ultimately improving care outcomes (Davys & Beddoe, 2020; Sahu et al., 2024).

Mentorship	Support offered by an experienced professional who is nurturing and guiding the less experienced professional. e.g. new staff with senior staff
Champion	A person who supports and promotes a new initiative or change. e.g. electronic chart implementation
Preceptorship	Clinical teaching roles that are used to support the transition of students or new graduates into the clinical environment
Communities of Practice	Groups of like-minded individuals who routinely meeting virtually or in-person to share strategies and insights
Coaching	A teaching process where a person gets support while learning a specific skill or specialty from an individual who has more expertise or experience
Shadowing	An opportunity to observe the work of a more experienced practitioner by a new or less experienced practitioner
Peer Consultation	Two or more practitioners come together to share information, discuss cases, seek feedback and receive support in a non-hierarchical format
Buddy System	Two people work together to monitor and help each other by sharing their time, abilities, knowledge and skills
Self-directed Study	Learning that is directed or conducted by oneself. e.g. reading journal articles, or taking online course
Conferences	An in-person or virtual gathering of people that facilitates knowledge transfer around a theme or series of topics
Training	In-person or virtual delivery of evidence-informed knowledge and skills.

Summary

Clinical supervision and practice support are essential to ensuring quality service delivery, ongoing competency development and evidence-informed reflective practice. This toolkit provides practical guidance on supervision including models, worksheets, and checklists to build knowledge and understanding of effective clinical supervision for Recovery Alberta's diverse workforce of mental health and addiction healthcare providers.

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Appendix 1: For Supervisors

Note on Toolkit Tools and Templates

The tools and templates in the appendices are samples only, and may be modified to support your use. Fillable versions are available as separate documents to support practical use. These can be completed digitally or printed for use in supervision planning and reflection.

To access fillable versions of the appendices, please access the PACES webpage.

Annual Supervision Plan

Review the completed Recovery Alberta Competency-based Learning Plan together.

Annual Learning Goals
1.
2.
3.

Annual Learning Actions
1.
2.
3.

Supervisor support required for each goal/action (if applicable)
1.
2.
3.

Frequency of supervision sessions, location, day, and time (supervisor to send calendar invites):

Preferred supervision method

- ☐ Direct observation
- ☐ Clinical feedback
- ☐ Reflection and discussion session
- ☐ Group supervision
- ☐ Case consultation
- ☐ Documentation audits

Special interests (therapy modalities, populations, groups, etc):

Comments:

Clinical Supervision Meeting

Caseload Review		
Quarterly Summary		
Inflow - New Clients	# Transfers:	
	# Request for Provider:	
	# New from Walk-In/Access:	
Outflow – Closures	# Met treatment goals:	
	# Lost to follow up:	
	# Transfer to internal AMH:	
File Audit Results		
Strengths: **Areas of Improvement:**		

Case consultation (brief description of situation, discussion, and plan)

Review annual learning plan goals, progress, and actions required.

Supervisee follow-up required (follow up, discharges, pursuing education opportunities):

Supervisor follow-up required (provide resources, assist with referrals/transfers, follow up):

Date and time of next supervision meeting: _____

Feedback Preparation Checklist

Checklist before you give feedback (Yes/No):

- ☐ Do you think they are aware of their behaviour?

- Do you think they are mainly responsible for the behaviour? (are others involved)
- Do you think they are open to receiving feedback?
- Is this feedback related to past practice or behaviour?
- Are you prepared to give feedback? (see steps below)

Preparing Feedback:

- Describe the specific actions you want to identify and their effects on others
- List detailed examples of these actions and their effects on others
- Identify and describe suggested actions to improve or change their behaviour

Last minute checklist:

- Is it clear? What is the feedback and why do you want to give it
- Is it owned? Stick to your perception of the behaviour by using 'I' statements
- Is it balanced? Give a range of feedback – correcting, reflective, affirming
- Is it specific? Accurately describe the behaviour and situation

Delivering Feedback:

- Describe the behaviour you want changed
- Express your concern (feelings)
- Specify the change in behaviour you want
- Consequences – explain the reason you want the change

Adapted from Davys and Beddoe, 2020

Case Consultation: Supervisor Guiding Questions

Assessment
What do you want help with?

Plan of action
What is your assessment and/or treatment plan?
What is your approach in managing this person/situation?
Any considerations to follow this plan?

Administrative
What administrative requirements are there?
Documentation, notification etc

Theory and practice
What theoretical approaches are guiding you?
Do you have the skills and knowledge to implement this approach?

Reflection on self and therapeutic relationship
Are you noticing any feelings or thoughts working with this person?
If so, how are these thoughts and/or feelings impacting on your work with them?

Person factors
What are the individual's strengths and abilities that you can bring forward for them?
What resources are there within the person's community?

Supervisory relationship
Are there parallel processes occurring?
Is what is being brought to supervision mirroring what is happening for the clinician and/or supervisor? How does this impact your work?
Does anything else need to happen either outside or inside the session to manage the working alliance?

Evaluation
What is helpful and unhelpful in this discussion?
What else is needed?
Is there anything that needs to be discussed that isn't being addressed?

Adapted from Clinical Supervision Services © 2016 www.clinicalsupervisionservices.com.au

Therapy Observation

How did the clinician begin the session?

What information did the clinician gather?

How did the person react to the questions asked?

What did the clinician do (verbally and nonverbally) to encourage the client to continue talking?

If the client wandered off-topic, how did the clinician draw him/her back to the topic?

How did the clinician demonstrate empathy for the client?

Did the clinician demonstrate evidence-informed strategies, techniques, approaches?

What strengths, talents, abilities do the therapist recognize and encourage with the person?

What goals and action plans were discussed?

How did the clinician end the interview?

Did she/he summarize information, discuss what would happen next?

Appendix 2: For Supervisees

Supervisee Self-Assessment for the First Meeting

Initial meeting checklist:

- ☐ Review supervisee's educational background, past clinical experience
- ☐ Review supervisor's educational background, experience, and approach
- ☐ Review program requirements and processes
- ☐ Review regulatory and ethical guidelines per professional college
- ☐ Internal supervisors who will be supervising the performance of a restricted activity must be authorized to perform that activity.
- ☐ Supervisor approved for time allocated within their AHS role to provide supervision.
- ☐ Supervisee approved for time allocated within their AHS role to receive supervision.

Supervisee reflection questions:

1. Consider your current knowledge and skills and identify your strengths in mental health and addiction clinical practice:

2. Which skills would you like to develop or improve:

3. What knowledge or approach would you like to add to your practice:

4. Identify self-care practices you employ at work and outside of work:

5. What is your experience of supervision in the past? What expectations or hopes do you have for future clinical supervision? Any preferred methods e.g. direct observation, chart audits, written feedback

Next meeting: Complete the AMH competency-based learning plan and review with supervisor

Follow up meeting (date)_____

- ☐ Discuss reflection questions

- ☐ Review AMH competency-based learning plan
- ☐ Develop supervision plan

Supervisee Practice Reflection

Based on Gibbs' Reflective Learning Cycle and adapted from Feruza Masharipova, 2025

Description: Recounting the experience • What happened and who was involved • When and where did this occur
Feelings: Capture your emotional response • Positive emotions • Negative emotions
Evaluation: Assess the good and bad • What worked well and what didn't • What were the positive impacts and the negative consequences
Analysis: Interpret the experience • Explain why things unfolded as they did • Draw on relevant literature and professional knowledge
Conclusion: Final reflection • What you could have done differently • What you've learned from the experience
Action Plan: Develop a plan • What would I do if a similar situation arises in the future

Supervision Feedback Form

Please provide feedback about your experience with supervision.	SA Strongly Agree A Agree N Neutral D Disagree SD Strongly Disagree				
	SA	**A**	**N**	**D**	**SD**
I felt welcomed by the supervisor					
The supervisor treated me with respect					
The frequency of scheduled supervision is adequate					
I am involved in setting the agenda for individual supervision sessions					
Supervision has helped me maintain my professional practice					
The supervisor supported my ability to manage stress					
The supervisor supported my ongoing professional development					
After a supervision individual session, I have a better understanding of using therapeutic approaches when working with individuals					
The supervisor is available when I need support					
The supervisor welcomed constructive feedback about their supervisor style					
The clinical supervision I received was helpful Please provide examples:					
Support from the supervisor has facilitated my growth in technical and behavioural competencies (Refer to Canadian Centre on Substance Use and Addiction's (CCSA) Workforce Competencies) Please provide examples:					

What recommendations do you have to improve future clinical supervision?

Any further comments that might be helpful for planning supervision?

Recovery Alberta Competency-Based Learning Plan

This Learning Plan template is designed to guide your professional development over the coming year. It includes sections for self-assessment, goal setting, and planning of learning activities. Use this template to reflect on your current competencies, set SMART goals, and outline the steps you will take to achieve them.

Unlike general organizational learning plans used for annual performance development—which focus on job-specific goals and HR metrics such as training hours completed, performance review scores, or compliance with mandatory courses, this learning plan template emphasizes technical skill-building, professional identity formation, and interprofessional excellence. It aligns with national frameworks and is intended to complement—not replace—existing performance development processes.

See the document titled Pathways to Excellence: A Competency-Based Professional Development Framework & Learning Plan Guide for more information on how to use this learning plan.

1. Employee/Participant Information

Field	Details
Date Created	
Review Date	

2. Self-Assessment

Use this section to reflect on your current strengths and areas for development.

a. Strengths and Key Competencies

What skills, knowledge, qualities, or achievements do you feel most confident about in your current role?

b. Areas for Growth

Where would you like to improve or gain new knowledge or skills?

c. Career Aspirations

What are your short and long-term career goals?

d. Learning Preferences

How do you prefer to learn (e.g., hands-on, coaching, online, self-study)?

3. Skills and Competencies to Develop

Recovery Alberta supports competency development through two complementary frameworks:

- CCSA Competency Framework: Provides a detailed guide to technical and behavioural skills essential for recovery-oriented care.
- CanMEDS Framework: Defines seven professional roles that support holistic development across disciplines, including communication, collaboration, leadership, and advocacy.

Regulated health professionals (e.g., physicians, nurses, psychologists, social workers) align their learning objectives with their regulatory college and Standards of Practice. They may use the CCSA framework to target specific competencies and the CanMEDS roles to support broader professional growth.

Non-regulated health professionals (e.g., addiction counsellors, recovery coaches, peer support workers) are encouraged to use the CCSA framework to guide their development and may reference CanMEDS roles to strengthen interprofessional skills and values.

Together, these frameworks support:

- Technical skill development

- Professional identity formation
- Interdisciplinary collaboration

CCSA Competencies

Technical Competencies	Behavioural Competencies
Understanding Co-occurring Substance Use and Mental Health Concerns	Adaptability and Flexibility
Understanding Mental Health	Analytical Thinking and Decision Making
Understanding Substance Use	Collaboration and Network Building
Accountability	Continuous Learning
Collaborative Care Planning	Creativity and Innovation
Community Development	Culturally Competent and Equity-Informed Approach
Counselling	Developing Others
Families, Caregivers and Social Supports	Effective Communication
Group Facilitation	Ethical Conduct and Professionalism
Medications	Interpersonal Rapport
Outreach	Leadership
Prevention and Health Promotion	Person-Centred Care
Program Development, Implementation & Evaluation	Planning and Organizing
Record Keeping and Documentation	Self Care
Referral	Self-Management
Risk Assessment and Crisis Intervention	Self-Motivation
Screening and Assessment	Teamwork and Cooperation
Trauma and Violence-Informed Care	
Treatment Planning	

The CanMEDS Roles:

1. **Medical Expert:** Apply medical knowledge and clinical skills to deliver high-quality patient care.
2. **Communicator:** Communicate clearly, compassionately, and respectfully to support shared decision-making.
3. **Collaborator:** Work effectively within interprofessional teams to ensure coordinated, safe care.

4. **Leader:** Drive positive change and manage resources to improve healthcare systems.
5. **Health Advocate:** Address health inequities and support patients and communities in achieving better health.
6. **Scholar:** Commit to lifelong learning, teaching, and applying evidence-based practices.
7. **Professional:** Uphold ethical standards, integrity, and accountability in all professional actions.

Review the CCSA technical and behavioural competencies and/or the CanMEDS roles to assess your required, current, and/or desired level of proficiency from foundational to advanced.

1 - Foundational 2 - Developing 3 - Proficient 4 – Advanced.

Skill/Competency/CanMeds Professional Role	Current Proficiency	Desired Proficiency	Priority (High/Med/Low)

4. Learning Activities

Note: Professional development activities may be influenced by financial and operational considerations. Staff are encouraged to collaborate with leadership to identify meaningful learning opportunities and explore available supports.

Skill/Competency/CanMeds Professional Role/Growth Area	Goal	Activity Type (Course, Workshop, Coaching, On-the-Job)	Provider/Resource	Timeframe	Status	Notes

5. Application and Practice Plan

Skill/Concept	How It Will Be Applied	Setting/Project	Timeline

6. Measurement and Evaluation

SMART Goal	Success Indicator(s)	Method of Evaluation (e.g., feedback, performance review)	Review Date

7. Progress Review & Reflections

Use this section during regular check-ins to review and update your plan.

Date	Reflections / Notes	Adjustments Needed