CLINICAL SUPERVISION: AN OVERVIEW OF FUNCTIONS, PROCESSES AND METHODOLOGY

By
Thomas G. Durham, PhD
DISCLAIMER

The purpose of Clinical Supervision: An Overview of Functions, Processes and Methodology is to provide a compendium of material that offers a general overview of information pertaining to clinical supervision in the addiction treatment profession and for other mental health professionals. The materials contained herein are intended to compile an overview of research and provide a comprehensive knowledge base for clinicians who wish to expand their knowledge in clinical supervision. This manual is NOT all-inclusive or in sufficient detail to ensure success in certification/licensure exams but can be used as a resource to enhance overall understanding of clinical supervision in preparation for exams. As an adjunct to previously received didactic and experiential training in clinical supervision, this manual is also intended to assist the aspiring clinical supervisor in exploring concepts, theories, techniques and principles of this complex and dynamic undertaking.

Care has been taken to confirm the accuracy of the information presented and to describe generally accepted science. However, the author, NAADAC, editors and publishers are not responsible for errors or omissions or for any consequences from the application of the information presented in this manual and make no warranty, express or implied, with respect to the contents of this publication.

Published in 2019 by
NAADAC, the Association for Addiction Professionals
44 Canal Center Plaza, Suite 301, Alexandria, VA 22314

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Printed September 2019.
NAADAC, the Association for Addiction Professionals, understands the need for continuous education and strive to provide addiction-focused professionals the latest training to remain knowledgeable and pursue best practices for clients. The addiction profession is constantly changing to reflect new research and new understanding of the populations we serve. As a result, NAADAC is providing addiction professionals comprehensive education on clinical supervision.

This manual has been developed as a resource for addiction-focused professionals who work as clinical supervisors. Consistent clinical supervision has long been understood as a primary indicator of quality care. When professional helpers receive structured and consistent clinical supervision accuracy to regulations improves, patient satisfaction increases, quality and safety measures are more likely adhered to, and accountability becomes an expected norm.

This manual is intended to be a resource for professionals seeking to expand their knowledge of the functions, processes, methodology, and best practices in clinical supervision. The concept of clinical supervision will be defined, along with updated research on the effectiveness, methods, and techniques of clinical supervision specific to the addiction profession. Clinical Supervision strategy, structure, evidence-based models, and ethics will also be described.

Thomas G. Durham, PhD is the primary author of the Clinical Supervision Workbook. Many other writers and consultants volunteered their time and knowledge during the development of the training materials. NAADAC would like to extend its sincerest appreciation to the numerous contributors to this project: Thomas Durham, Michael DeMolina, Marty Harding, Sue Hoisington, Jim Holder, Donovan Kuehn, Rose Maire, Kaylene McElfresh, Richard Solly, Gerry Schmidt, Misti Storie, Jessica Gleason, Kristin Hamilton, Samson Teklemariam, Cynthia Moreno Tuohy and Mary Woods. This project could not have been completed without the many hours of brainstorming, researching, writing, reviewing and editing so this product could be a significant contribution to the addiction profession.

NAADAC’s Clinical Supervision: An Overview of Functions, Processes, and Methodology is only one of many planned educational projects geared at providing comprehensive and unbiased education to the addiction profession. NAADAC recognizes you have a choice in education providers, and we are delighted you have chosen to take part in this educational experience and build your toolbox of treatment resources. Thank you for your dedication to the addiction profession!

Together, we can and are making a difference!

Sincerely,

Diane Sevening, EdD, LAC, MAC
President
NAADAC, the Association for Addiction Professionals
NAADAC dedicates this manual to the late David J. Powell, PhD, whose model of clinical supervision has been held up as the quintessential road map for professionalism in supervisory practice. His supervision, mentorship and friendship to the primary author for nearly 30 years inspired the development of this manual. Thousands of addiction professionals have benefited from his expertise, leadership and guidance and have ultimately touched the lives of an inordinate amount of clientele during his professional career and beyond. It is our hope that, through this manual, the contributions of Dr. Powell will continue to enhance the motivation and professional growth of those who use it.

Sincerely,

Thomas G. Durham, PhD
Primary Author
Clinical Supervision: An Overview of Functions, Processes and Methodology
NAADAC, the Association for Addiction Professionals

Like many of us in the Addiction Profession, I consider the late David Powell the forefather of clinical supervision and have used his materials as a guideline light for decades. I was honored to work with Dr. Powell as a clinical supervisor in the US Navy Preceptorship Program, conducting trainings in China, and discussing the future landscape of addiction practice. His devotion to the addiction profession is something many of those who worked with him, including myself and the primary author of this manual, Thomas G. Durham, PhD, have worked to emulate. Thank you, Tom Durham, for your great work with this manual and your loyalty to David and the addiction profession. You have taken David Powell’s foundational work to a heightened level.

Sincerely,

Cynthia Moreno Tuohy, BSW, NCAC II, CDC III, SAP
Executive Director
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PREFACE
Clinical supervision is a mutual endeavor enhanced by a trusting bi-directional relationship that leads to professional development and enhanced client care through mentoring, guidance and clinical oversight. As a central learning experience, it becomes a process of conceptualized growth and, when effective, it involves much more than monitoring a counselor’s work.

Clinical supervision is emerging as a distinct professional specialty, yet most supervisors learn how to supervise based on their own experience as a supervisee. Though clinical supervision has long been practiced in the behavioral health professions, most research and training in this subspecialty has occurred during the last 30 years. Whereas counseling and psychotherapy have had the benefit of much research-based literature from which to draw, there has been a dearth of research on clinical supervision. Despite such scarcity, Bernard and Goodyear (2018), in their seminal text on clinical supervision, assert that all mental health professionals must acquire skills in clinical supervision since virtually all who make a career in counseling will eventually supervise others. NAADAC supports the assertion that all addiction professionals must acquire skills in clinical supervision since many who make a career in addiction specific counseling will be called upon to supervise others.

In today’s world of behavioral healthcare, programs, clinics, and counselors are held accountable in ways never before experienced. New demands for cost containment have resulted in our constant search for innovative ways to provide treatment and clinical supervision. We have been asked to provide treatment in less time with fewer resources and have begun to explore new technologies in pursuit of the most effective and efficient means of providing client care. For example, the use of technology is currently being explored and perfected as a means of reaching both clients and supervisees in remote or isolated areas (Barton, Roget, & Hartje, 2016). While the use of technology comes with many ethical questions relating to security and confidentiality, we must continue to explore all means of improving the effectiveness of our services while staying within the bounds of ethical practice.

Supervisors are tasked with carefully monitoring the services provided by counselors in an effort to seek assurance that service delivery maximizes each treatment opportunity. However, the downside of such monitoring presents a risk of minimizing the supervisory relationship and professional growth of the supervisee. In fact, limiting supervision to mere monitoring leaves the relationship perfunctory and hierarchical. The role of the supervisor must expand and many find themselves ill-equipped to deal with the many demands being placed on them.

For those benefitting from supervision, a significant learning experience can result – no matter where they lie on the continuum of professional development. As one strives for professional growth as a counselor, effective clinical supervision is a significant component of such progress. Such ongoing development, of course, is not only expected of entry-level counselors, but of advanced clinicians as well. Clinical supervision involves professional guidance from an experienced teacher or mentor who transmits knowledge to broaden the supervisee’s perspective. In fact, a major goal of supervision is to equip the counselor with the ability to “self-supervise.” This is not to say one will eventually continue without supervision, but it does support the goal that each counselor will gain confidence and a sense of
autonomy as a clinician, thus gaining an ability to choose an effective course of action that is consistent with his or her own judgement or inclination (Corey, Haynes, Moulton, & Muratori, 2010).

The knowledge that is transmitted in clinical supervision can be classified in two overlapping areas: research-based theory and the supervisor’s own knowledge-based skills. The latter involves the supervisor’s own acquired knowledge through his or her accumulated experience, training and supervision. However, how transmitted knowledge impacts a supervisee is also influenced by the supervisee’s own personality dynamics. This may include relational or interpersonal dynamics, level of self-confidence and degree of self-understanding (Bernard & Goodyear, 2018).

Supervision is complex. Not only does it involve a modicum of teaching through the relationship with an experienced clinician, it also brings all the dynamics of a patient into a relationship that has complexities of its own. The supervisory relationship also includes an evaluative role on the part of the supervisor. If the supervisor uses this role to hold power over the supervisee by infusing elements of contest, confrontation and challenge in the relationship, tension and mistrust will result. On the other hand, a supervisor who shows support, encouragement and collaboration will inevitably foster a collegial spirit, a high level of trust and a passion to grow and learn (Bernard & Goodyear, 2018; Corey et al., 2010).

This manual provides a resource for addiction and other mental health professionals in clinical supervision, whether or not they are already functioning as supervisors. To that end, it provides a comprehensive knowledge base for clinicians who wish to expand their knowledge in clinical supervision. An as adjunct to previously received didactic and experiential training in clinical supervision, this manual is also intended to assist the aspiring clinical supervisor in exploring concepts, theories, techniques and principles of this complex and dynamic undertaking.
CHAPTER ONE
INTRODUCTION
Clinical supervision has become the primary means of training for addiction and mental health professionals. Most credentialing boards require several thousand hours of supervised work experience, whether part of a degree program or outside of an academic experience. For most addiction professionals, supervision and training occurs on-the-job. Although many receive such supervised training in an academic setting or field placement, most addiction professionals rely on the guidance of an experienced clinical supervisor in their development toward mastery as effective counselors (Campbell, 2006). If such guidance is lacking in supervisory expertise, counselors may struggle, experience unnecessary stress, or perhaps terminate their employment. Potentially talented counselors may be lost to the field; thus, contributing to staff turnover, a situation that many programs in the field are already experiencing.

**Primary Assumptions**

This training manual is based on eight primary assumptions that are discussed here. These assumptions form a philosophical foundation that are intertwined throughout the material presented in this document. They are as follows:

**Relational Dynamics** – The relationship between the supervisor and the supervisee becomes the foundation that all work in supervision is based on. A productive and positive supervisory relationship is supported by many as an essential component leading to effective counselor development and client care (Bernard & Goodyear, 2018; Corey, et al., 2010; Campbell, 2006). Like the clinical relationship, the power of the relationship is one of the most significant influential factors in supervision. A working alliance between supervisee and supervisor is crucial to the effectiveness of the relationship. Such alliance leads to a level of engagement that is necessary for a trusting bond marked by positive rapport and a mutual desire to work together. Therefore, taking time to cultivate the relationship while focusing on engagement becomes an initial step in developing a strong working alliance (Bernard & Goodyear, 2018; Campbell, 2006). As noted by Bernard and Goodyear (2018), “the supervisory relationship is the pillar that supports everything else about supervision” (p. 86).

Not unlike the clinical relationship where counselors explain to clients the process of therapy in order to reduce anxiety, it is essential that supervisors develop a successful relational experience. Supervisors must diligently build an understanding and concurrence with each supervisee with regards to expectations and professional developmental needs. In addition, supervisors can be instrumental in reducing anxiety and creating a safe environment to foster growth within the supervisory relationship (Campbell, 2006).

It is important that supervisors take time during the developmental stages of the supervisory relationship to establish the framework for supervision. As we will see later in Chapter Seven, taking a motivational interviewing approach in establishing the relationship can not only assist in laying the important foundation for supervision, but it enhances the potential to develop a positive working alliance by reducing anxiety, creating trust, and overcoming any initial resistance to supervision.
Direct Observation – Providing clinical supervision through direct observation (also known as “live supervision”) gives the supervisor a consistent and accurate picture of the counselor’s skill level while providing a forum for shaping skills through role modeling and on-the-spot input. Like a craftsman who guides an apprentice through demonstration and observation, the clinical supervisor is given an opportunity to foster an effective learning and growth experience for the counselor being observed.

Direct observation of a supervisee’s work has the potential of increasing the supervisory alliance, principally through a mentoring and supportive relationship. This occurs through an increased level of involvement, in particular when the observation is accomplished by way of the supervisor doing co-therapy with the supervisee. Since they are working together, with the opportunity for direct and immediate assistance (both during and after the session), there is great potential for reduced anxiety (about being observed) and an enhanced alliance between supervisee and supervisor (Bernard & Goodyear, 2018).

As noted by Powell (2004), direct observation has the potential to become the cornerstone of effective supervision of addiction and mental health professionals as it provides a consistent and accurate picture of the supervisee. Besides the potential of enhancing the supervisory alliance, being in the room with the counselor or observing through any of a variety of means, greatly enhances the fidelity of the information about the supervisee’s skill and knowledge level (Powell, 2004). Meeting with the supervisee after the session provides a rich opportunity to discuss the session, explore interventions made (by the supervisor as well as co-therapist), and discuss how working together was beneficial to the client.

Finally, direct observation can include demonstrations by the supervisor – especially during co-therapy with a client. Supervisors are able to constantly model professional behavior – in staff meetings, casual communications with clients and staff, and in clinical sessions. As a supervisor, you are constantly under the spotlight. Modeling and demonstrating clinical expertise is perhaps the most powerful and significant means of modeling therapeutic interventions and behavior. Demonstration by the supervisor, whether with a client or during a supervisory role play, can have a secondary benefit by reducing burnout, enhancing motivation, and providing additional support for all staff (Campbell, 2006). Direct observation will be explored further in Chapter Eight of the manual.

Raising Counselor Self-Efficacy – An effective clinical supervisory working alliance has the potential of raising self-efficacy among counselors, not only for those at the entry level but for those who may become discouraged, experience self-doubt or burnout at any level of professional growth. Described as an individual’s belief about his or her level of capability to produce a desired level of performance, self-efficacy is domain-specific (Bernard & Goodyear, 2018). Thus, when we speak of self-efficacy in the domain of counseling, we are referring to one’s level of belief in his or her capability as a professional counselor.

Clinical supervisors play a significant role in influencing counselor self-efficacy. Most supervisees have a strong need to feel (and appear) competent. Thus, the supervisory alliance and the methods and techniques used to offer input to counselors on their work are crucial to the success of raising counselor self-efficacy. As we will see in Chapter Four of this manual, there are several developmental models that demonstrate an oscillation in one’s level of self-efficacy as one moves through his or her developmental stages of growth (Bernard & Goodyear, 2018; Stoltenberg & McNeill, 2010; Powell, 2004). In Chapter Six we explore specific means of performing formative evaluations for supervisees. This will include not only the provision of effective feedback, but also the introduction of concepts known as feed up and feed forward that, along with taking a motivational interviewing approach, can be quite powerful in enhancing counselor self-efficacy (Fisher & Frey, 2007).

Solution- and Strength-Based Supervision – As a narrative approach to supervision, solution-focused supervision is a strength-based attitude that emphasizes the creation of a reality constructed within one’s contextual environment. Grounded on the assumption that people can construct pathways to success, this approach focuses on creating visions of what is possible while acknowledging the supervisee’s strengths. Following the philosophy of Steve deShazer’s solution-focused therapy, this supervisory approach encourages the creation of solutions without dwelling on the “problem” (deShazer, 1994). Bernard and Goodyear (2018) provide an overview of solution-focused supervision that includes identifying positive goals for the supervisee, exploring exceptions to difficulties
and challenges, and processing positive changes that occur between supervisory sessions for both the supervisee and his/her client.

Solution- and strength-based supervision also follows Powell’s philosophy that supervisees find their own solutions while under the tutelage and guidance of a mentor (Powell, 2004). Solution-focused supervision emphasizes that when supervisors dwell too much on the struggles a supervisee may be having, solutions can be overlooked. By searching for exceptions to what the supervisee may be struggling with, the focus shifts from the problem to the solution.

**Individualized, Needs-Based Model** – As with the therapeutic approach with clients, understanding individual needs is an essential element in clinical supervision. Since a major component of supervision is the promotion of supervisee growth and development, a needs-assessment, primarily based on the supervisee’s self-assessment, is a key factor in this effort. Self-discovery and self-exploration by the supervisee lead to empowerment, thus enabling the supervisee to monitor his/her own performance (Corey et al., 2010). This self-discovery can be encouraged and monitored by the supervisor who, through this process, gains awareness of the individualized needs of the supervisee.

An individualized supervisory model also requires a collaborative process. Through this collaboration, the supervisee participates in goal development, methods of supervision and how evaluation is achieved. This attitude can lead to a strong supervisory alliance marked by trust, honesty, and respect – all significant components of an individualized approach to supervision (Corey et al., 2010).

Finally, a needs-based approach is dependent on the counselor’s developmental needs. By adhering to a developmental model of supervision, the supervisor assesses where the supervisee is on a developmental spectrum and forms a relational approach based on the counselor’s place on that continuum. One particular model, the Integrated Developmental Model (IDM) of supervision, will be explored further in Chapter Four of this manual. As one of the more widely used models, the IDM is both descriptive and prescriptive in its overview of supervisor interventions at various stages of professional development of counselors (Bernard & Goodyear, 2018). IDM is a four-stage model that includes three overriding structures (self and other awareness, motivation, and autonomy) providing markers for each of the four stages of counselor development (Stoltenberg & McNeill, 2010).

**Didactic Teaching** – Effective clinical supervision occurs in a learner-based relationship that includes teaching skills through an individualized training plan. Direct observation, as described above and detailed further in Chapter Eight of this manual, provides a first-hand view of the supervisee’s skill level, thus informing the supervisor of training needs in supervision. These needs thus are addressed through a tutorial relationship where the supervisor plays the role of instructor. Powell (2004) emphasized the tutorial role in his definition of supervision, noting also that, in this role, the supervisor addresses the specific training needs of each individual under the supervisor’s tutelage.

In the role of teacher, the supervisor also may assign specific tasks such as a literature search or readings on a specific topic and may provide didactic training on specific skills or other relevant topics (Corey, et al., 2010). In this didactic role, the supervisor provides a forum to ensure that supervisees develop competencies while bolstering these skills through supervised application with clients (Bernard & Goodyear, 2018). Thus, a primary role of the supervisor is to transform principles into practical skills (Powell, 2004). Such transformation occurs via the sharing of knowledge, skills and expertise by the supervisor in his or her tutorial role. As Powell (2004) pointed out, most supervisees enter the supervisory relationship with a degree of “empathy, genuineness, concreteness, and potency” (p.10) and many also lack the grounding needed to identify what is being done in counseling and to accurately conceptualize the individualized treatment needs of clients. This is most commonly the case with entry level counselors. However, supervisees at all levels benefit from didactic teaching when the supervisor has a sound understanding of each supervisee’s unique training needs.

**Ethical Grounding** - Clinical supervisors face ethical dilemmas in their supervisory roles and must remain alert to such dilemmas and be readily available to provide guidance and support to supervisees. It is incumbent on supervisors to provide such guidance as a means of assisting supervisees to be aware of ethical challenges as they occur and mentor them in developing a framework of ethical decision-making. Of course, underlying this obligation
is the overarching expectation that supervisors are knowledgeable and skilled in the practice of clinical supervision - this too is an ethical responsibility of the supervisor (Durham, 2017). The obligation for supervisors to receive training in clinical supervision is addressed in the NAADAC/NCC AP Code of Ethics: “Addiction Professionals shall complete training specific to clinical supervision prior to offering or providing clinical supervision to students or other professionals” (NAADAC, 2016, Principle VII-2). Without such training, supervisors may lack the skills necessary to ensure ethical guidance of their supervisees while monitoring the ethical performance of counselors. Such lack of training may put one at risk for being vicariously liable for the actions of supervisees (Corey, Corey, & Corey, 2018).

For many clinicians, confidentiality is a topic that initially comes to mind when counselor ethics are explored. This is the area, noted by Bernard and Goodyear (2018) as being most frequently identified by clinicians as ethically problematic. Confidentiality is specifically covered under Principle II in the NAADAC/NCC AP Code of Ethics (2016) and will be discussed more thoroughly in Chapter Five of this manual. Supervisors are encouraged to become familiar with the 28 items listed under the NAADAC/NCC AP Code as well as the Code of Federal Regulations (42 C.F.R. Part 2), the Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (HITECH). As will be explored more thoroughly in Chapter Five, HITECH widens the scope of privacy and security protection under HIPAA regarding the protection of confidential information that is transmitted via digital technology (Rousmaniere, Abbass, & Frederickson, 2014).

As mentioned previously, a goal of supervision is that the supervisee reaches a point of autonomy where he or she is making accurate and effective decisions regarding client care. When a counselor has reached this level of growth, he or she will likely have also developed the ability to “think ethically” (Durham, 2017).

**Outcome-Oriented Supervision** - When focusing on the primary purposes of clinical supervision, Bernard and Goodyear (2018) discuss two central purposes: Fostering the supervisee’s professional development; and monitoring client care. Depending on the situation, one may take precedence over the other. For example, in an academic-based field placement fostering professional development may have greater emphasis in supervision. However, in most cases, there is a mutual relationship between these two factors as they can have a bi-directional influence on each other. Of course, the “bottom line” is successful care and effective long-term recovery for the client. However, this begs the question: How can data show that supervision leads to effective client care? A thorough literature search will show the existence of research on the impact of supervision, but not surprisingly, such data is scarce. Bernard and Goodyear (2018) cite several such studies but note that there are both skeptics and advocates of what gets labeled evidence-based supervision. Also emphasized is the fact that the degree of change experienced by a client in therapy that can be attributed to clinical supervision has been one of the most difficult factors to empirically measure (Bernard & Goodyear, 2018). One difficulty in verifying supervision as being evidence-based is the fact that so many different factors are involved in what impacts treatment. We can say that good supervision leads to improved client care and effective client recovery, but it is only one of many dynamics that impact client recovery.

In their text on a proposed model of supervision, Rousmaniere, Goodyear, Miller, and Wampold (2016) acknowledge the need for “rigorous empirical testing” (p. 14) on clinical training and supervision. They propose a model of supervision and training that includes ongoing evaluation of clinical supervision with regards to its impact on client outcome and to that end supervisees receive continuous performance feedback throughout their career – no matter how advanced one is in their career path. They point out the fact that many clinicians stop getting this kind of supervision after being granted licensure. Another point argued by Rousmaniere, Goodyear, Miller, and Wampold (2016) is that the field must take a stance of empirical skepticism toward the effectiveness of all methods of clinical training. Also noted is that much of the supervisory practices currently used in the field are those traditionally passed down and assumed to be effective, yet with no empirical data to provide support.