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Readiness of Counselor Education and Supervision for Suicide Training: A CQR Study

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Abstract

The Counselor Education and Supervision professional community is responsible for providing training on suicide to Master's students in counseling. Elevated suicide rates and historically insufficient training along with updated practice, ethical, and accreditation standards necessitate changes to counselor preparation on suicide. Readiness assessment can support the CES community's aims to meet such standards. A Consensual Qualitative Research team utilized a community readiness framework to analyze interviews with fifteen educators, administrators, and supervisors in diverse CACREP-accredited programs. Readiness findings inform counselor preparation and policy at the course, program, state, and national level.

Keywords

suicide, counselor education, supervision, accreditation, crisis training

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Counseling is one of several occupations in which graduates may have received *pre-professional suicide training* (PPST), or preparation on suicide completed prior to offering professional services. The most recent U.S. Surgeon General's National Strategy for Suicide Prevention (U.S. Department of Health and Human Services [USHHS], 2012) contains an objective for graduate education in all health professions to adopt suicide training guidelines. Government agencies and nonprofits have called for improvements to PPST for many years (Schmitz et al., 2012; USHHS, 2012; U.S. Public Health Service, 1999). A large national taskforce (Suicide Prevention Resource Center [SPRC] and Suicide Prevention Action Network [SPAN] USA, 2010) once highlighted counseling as the first of eleven professional fields they evaluated to increase focus on suicide content when updating its training accreditation standards.

However, pre-professional suicide training in counseling programs remains lacking. A taskforce of the American Association of Suicidology (Schmitz et al., 2012) highlighted several gaps in PPST's existence, method, consistency, and specificity in counseling and other programs. Authors have echoed these gaps in PPST specific to counselor preparation (Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Wachter Morris & Barrio Minton, 2012), and called for the Counselor Education and Supervision (CES) field to change PPST so that future counselors can better address client suicide concerns. "Although many counselor education training programs incorporate a knowledge base of suicide theory and assessment in their curriculum, training is often inconsistent and randomly addressed" (Gibbons et al., 2009, p. 9). Results of a recent evaluation (Cureton et al., 2020) indicated that, although the CES field implements PPST, it is not fully prepared to sustain successful PPST based on gaps in knowledge among members of the field and a lack of resources, membership support, and leadership at multiple levels. We provide an overview of standards and guidelines that inform PPST, review research about gaps in counselor

PPST, then explain a framework for change and a research study which members of the CES field can use for change initiatives to improve PPST.

Literature Review

Standards and Guidelines

PPST in counselor preparation is informed by curricular, ethical, and practical standards and guidelines. The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) standards describe knowledge and skills that CITs must acquire. The 2009 CACREP standards marked an important transition as programs became explicitly accountable for covering suicide in core coursework and ensuring that students in almost all specializations demonstrate suicide risk assessment and management skills. The current 2016 CACREP standards (2015) include requirements that programs cover suicide prevention models, strategies, and risk assessment procedures in core curriculum. Counselors have an ethical obligation to practice within their scope of competence (American Counseling Association [ACA], 2014, C.2.a., p. 8). Counselor educators and supervisors have an ethical responsibility to "provide instruction based on current information and knowledge available in the profession" (ACA, 2014, F.7.b., p. 14) about suicide or other content.

Current information on suicide is available in practice and training guidelines. An American Association of Suicidology (AAS) taskforce (2004) defined seven domains of competencies: (a) attitudes and approach, (b) understanding suicide, (c) collecting assessment information, (d) formulating risk, (e) developing treatment and services plan, (f) managing care, and (g) understanding legal and regulatory issues. A workforce preparedness taskforce through the National Action Alliance for Suicide Prevention (2014) identified seven points on suicide training

structure and ten areas of content deemed "comprehensive to ensure a solid base foundation of knowledge necessary to serve individuals at suicide risk and their families" (p. 6).

Specific updates on counseling practice concerning suicide also appear in national guidelines (USHHS, 2012). Some examples include procedures for suicide assessment and intervention. To assess suicide risk, counselors should incorporate a standardized assessment instrument with clinical interviews (Bryan & Rudd, 2006). The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013a) contains revisions to suicide risk assessment items and an elaborated decision tree for suicidal ideation or behavior. During intervention, counselors should replace no-suicide contracts, which can actually pose more risk for client and counselor (Edwards & Sachmann, 2010; Lewis, 2007), with the use of safety planning (Stanley & Brown, 2012). These standards and guidelines inform counselors, interns, and counselors-in-training (CITs) and those who educate and supervise them.

Pre-professional Suicide Training

"[M]any CITs will encounter suicidal clients during their first clinical experiences, and there is a lack of preparation among CITs to respond to suicide despite CACREP requirements" (Shannonhouse et al., 2019, p. 141). Rogers et al. (2001) found that 30% of counselors had lost a client to suicide and 70% had a client who attempted. Over 90% of CITs reported having at least one client contemplate suicide in the past six months (Shannonhouse et al., 2019).

Lack of preparation among CITs concerns the inexistence, small amount, poor placement in programs' curricula; vagueness of training content; ineffectiveness of training methods; and inconsistency across programs. Not all CITs receive PPST (Hoffman et al., 2013; Lauka et al., 2014). Schmidt (2016) found that 86% (n=288) of a mixed sample of counselors, psychologists, social workers, and similar practitioners in school and clinical settings had a student or client

referred to them for being potentially suicidal; however only 52% (*n*=174) of the practitioners had received PPST on suicide assessment. Authors of a recent study (Elliott et al., 2019) with CITs in CACREP-accredited programs noted that "Many of the participants in this study were working with suicidal clients during their practicum field experiences—long before suicide was ever systematically addressed in their courses" (p. 3013). Counseling authors have provided informal suicide assessment interview tools such as SIMPLE STEPS (McGlothlin et al., 2016) and SHORES (Cureton & Fink, 2019), but CITs do not consistently learn about formal or standardized suicide assessment instruments (Neukrug et al., 2013; Springer et al., 2020), which the National Strategy refers to as "a useful component of a full evaluation" (USHHS, 2012, p. 56).

Findings from several research studies have demonstrated low levels of preparedness among counselors or CITs to address client suicide risk. Directors of counseling centers (Shaw, 2014) and counseling program graduates (Freadling & Foss-Kelly, 2014) indicated that CITs are underprepared for crisis intervention. A concerning 40% (*n*=135) of Schmidt's (2016) mixed practitioner sample reporting feeling somewhat or not at all prepared to conduct a suicide assessment and 19% (*n*=63) felt not very confident to work with a suicidal client or student. Only 45% of recent graduates deemed the counselor training they received on suicide assessment to be good or excellent (Wachter Morris & Barrio Minton, 2012). CITs and graduates desire more in-depth preparation on suicide and/or crisis topics, particularly related to in-session interventions and the hospitalization process (Cureton & Sheesley, 2017; Freadling & Foss-Kelly, 2014).

Research is mixed on the effectiveness of current PPST in counselor training programs. In a survey with recent graduates (Wachter Morris & Barrio Minton, 2012), satisfaction with crisis training correlated with crisis self-efficacy, and the amount of time that CITs spent in crisis training predicted crisis self-efficacy. Binkley and Leibert (2015) found that counseling practicum students

who completed suicide training in previous coursework had lower anxiety and higher confidence to counsel a suicidal client than those with no prior suicide training. However, practicum students who had only received suicide training outside of their coursework had higher confidence than those whose suicide training came from coursework alone.

Examinations of PPST's impact on skills are also mixed. Rigsbee and Goodrich (2019) found increased suicide intervention skills in CITs who completed an online suicide training, but the increase was not significantly higher than a control group who instead received multicultural counseling training. Shannonhouse et al. (2018; 2019) and Elston et al. (2020) found sustained skill improvement and application in CITs who completed a standardized suicide intervention training. Gallo et al. (2019) determined that a one-credit course for CITs on youth suicide prevention produced increases in suicide knowledge and suicide assessment and intervention self-efficacy. Although self-efficacy sustained at a three-month follow-up, it did not increase, despite CITs' opportunities to continue applying their recent training. The aforementioned trainings are offerings that may have associated costs to instructors and/or CITs.

A demonstrated gap remains in counselor PPST, with little literature to explain why. Based on their findings from a 21-year content analysis of suicide content in counseling journals, Gallo et al. (2019) identified the need for more research on PPST. Springer et al. (2020) recently specified the need for research involving interviews with faculty and site supervisors to gain their perspectives on PPST. Some discussions in counseling and social work literature have mentioned potential obstacles to improving PPST, such as: lack of knowledge among educators about how to provide suicide training (Ruth et al., 2012; Wachter Morris & Barrio Minton, 2012); a perception that current training is already adequate (House, 2003; Ruth et al., 2012); constraints in the curriculum (House, 2003; Ruth et al., 2012; Wozny, 2005); suicide stigma (Hoffman et al., 2013;

Ruth et al., 2012); and faculty's lack of knowledge about their program's training efforts (Barrio Minton & Pease-Carter, 2011). These contextual barriers may loom large in preventing effective PPST. But no researchers have previously engaged in a study of contextual concerns that might explain the remaining gaps in counselor PPST.

A Framework for Change

One framework for the study of contextual concerns is the Community Readiness Model (CRM; Oetting et al., 1995; Tri-Ethnic Center for Prevention Research [TCPR], 2014) which emphasizes community change through conceptualizing "the culture of a community, the existing resources, and the level of readiness" (Plested et al., 2009, p. 5). "Community readiness is the degree to which a community is willing and prepared to take action on an issue" (TCPR, 2014, p. 4). Philosophical foundations of CRM (Oetting et al., 1995) include the Transtheoretical Model of psychological or therapeutic change (Prochaska & DiClemente, 1983), diffusion of innovations (Rogers, 1962), and social and community action (Beal, 1964, and Warren, 1978, as cited in Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997). Whereas readiness for decision-making at the individual level is psychological, decision-making that characterizes community readiness occurs at the intergroup or inter-organizational level (Miller 1990 as cited in Donnermeyer et al., 1997). Thus, like individual readiness for therapeutic change (Prochaska & DiClemente, 1983), systemic readiness is considered a precursor to change, and communities and organizations who attempt change without first addressing readiness can experience failure (Armenakis, Harris, & Mossholder, 1993).

The CRM is a structured model with applications across health concerns. It contains six dimensions of readiness (Edwards et al., 2000) – Efforts, Knowledge of Efforts, Leadership, Climate, Knowledge about the issue, and Resources – and methodological guidance for seeking

information from community members. The first two steps are to define the community and the issue. The CES community includes those who provide education, supervision, and/or administration associated with counselor training and those who research and/or guide the efforts of the profession (e.g., editorial boards and accreditation bodies). CRM has often been applied to the issue of suicide; for example, a CRM assessment is a recommended step for suicide prevention in American Indian/Alaska Native communities (SPRC, n.d.).

A recent assessment (Cureton et al., 2020) revealed that CES's overall readiness to provide PPST was in the preplanning stage (4 out of 10) which indicates a sentiment in the field that PPST is important but CES members are unsure how to address it (TCPR, 2014). Results for specific dimensions ranged from 3 (out of 10) for Resources to provide PPST to 6 (out of 10) for readiness demonstrated by existing PPST efforts. It seems clear that CES is poised to improve its readiness to impact the problem of suicide via PPST. A deeper understanding of the willingness and preparedness in the CES field to do so could inform improvement initiatives.

Updated accreditation standards and guidelines underlie the need to change PPST for counselors. "Despite heeding previous calls and recommendations to prepare practitioners, more attention is needed to address previous and current identified [suicide] training deficiencies among practitioners" (Schmidt, 2016, p. 84). A community's readiness level informs targeted initiatives toward effective and sustainable change (Edwards et al., 2000). Therefore, a study of CES's readiness to provide PPST can help members of field meet ethical and accreditation obligations and update their education and supervision practices for successful and sustainable improvement to PPST. The following research question addressed the study's aim to determine how CES is ready regarding PPST: How do members of the Counselor Education and Supervision community describe its readiness to provide pre-professional suicide training?

Method

Consensual Qualitative Research (CQR) is a structured methodology for researching unexplored phenomena (Hill et al., 2005) and complex issues (Hill et al., 1997). CQR provides "a systematic way of examining the representativeness of results across cases through the process of reaching consensus among multiple researchers" (Wang, 2008, p. 275). The methodology supported trustworthiness and informed methods.

Trustworthiness

The research team used seven strategies which Merriam (2009) identified to maximize trustworthiness in a qualitative study. *Member checking* the researchers' understanding of the interview transcriptions allowed participants to clarify their intended meaning. The use of a research team supported *peer examination* of each other's work and the CQR steps for considering and discussing our biases initially and throughout (Williams & Hill, 2012) enhanced reflexivity. *Adequate engagement* occurred as all members of the research team participated in each step of the study, including reading and re-reading interview transcriptions, coding them in multiple ways, and referring to them during team discussions. Part of the analysis process involved identifying and discussing discrepant cases. An external auditor reviewed the *audit trail* and emerging findings multiple times and provided feedback. The following sections serve to demonstrate *reflexivity* and discuss *maximum variation* in the sample, and the manuscript represents an attempt to offer a *rich, thick description* of the context and findings.

Role of the Researchers

A team of three researchers and one auditor followed CQR methodology on team membership, development, and responsibilities (Vivino et al., 2012) and ways to address biases and expectations (Sim et al., 2012). Researcher notes during and after interviews (Burkard et al.,

2012) addressed such reflections. Discussion of our assumptions about suicide and PPST occurred at the onset and throughout data collection and analysis. Team members challenged each other's assumptions during consensus conversations as a process of collective bracketing.

Participant Recruitment

CQR developers (Hill et al., 2005, 1997) recommended the sample have some homogeneity, recent experience with the phenomenon, and result from some criterion-based sampling and randomization. The study's sample derived from the CACREP directory, program websites, and a random number generator to identify programs and individuals. Solicitation occurred through phone and email with a recruitment letter, demographic questionnaire, and informed consent document. Recruitment for site supervisors and adjunct instructors occurred thusly and via referrals. The sampling strategy also served to achieve maximum variation, which "allows for the possibility of a greater range of application by readers" (Merriam, 2009, p. 227).

Hill et al. (1997) established the ideal CQR sample size of 8 to 15. Table 1 displays information about the sample, which numbered 15 participants and was homogeneous: all were 1) professionals in the CES field, 2) affiliated with CACREP-accredited programs, and 3) had recent experience with the phenomenon, having provided PPST within the last year. The sample derived from distinct programs and represented: (a) all five regions of the Association for Counselor Education and Supervision; (b) all four CACREP program characteristics – public, private, multiple locations, and online; and (c) three types of participants –educators, administrators, and supervisors. Educators were full-time faculty members. Supervisors had primary roles as university or site supervisors. Program coordinators, practical training directors, and a department chair served as administrators in the sample.

Table 1

Participant Demographics by Type (N = 15)

Type	Case	Race/ Ethnicity	Gender	Setting	Respons.	Primary Role	Expert
Ed	1	Caucasian	M	University	T, S	FT faculty	No
Ed	4	N/A	F	University	T, S	FT faculty	No
Ed	6	Caucasian	F	University	T, S	FT faculty	No
Ed	9	Caucasian	F	University	T, S	FT faculty	No
Ed	10	Caucasian	F	University	T, S, A	FT faculty	No
Admin	2	White	F	University	T, S, A	FT faculty	No
Admin	3	White	M	University	T, S, A	FT faculty	No
Admin	5	Caucasian	F	University	T, S, A	Administrator	Yes
Admin	7	N/A	F	University	T, S, A	FT faculty	No
Admin	8	Caucasian	F	University	A	Administrator	Yes
Sup	11	Caucasian	F	Nonprofit	S, A	Site sup.	No
Sup	12	White	F	School	S	Site sup.	No
Sup	13	Caucasian	F	Nonprofit	S	Site sup.	No
Sup	14	Caucasian	F	Nonprofit	S	Site sup.	No
Sup	15	White	F	Private	T, S	Adjunct and site sup.	No

Note. N/A indicates a blank or irrelevant response; Respons. = Responsibilities; Admin = Administrator; Ed = Educator; Sup = Supervisor; T = Teach; S = Supervise; A = Administrate; Private = Private Practice

Variation also appeared in participants' practice, population, and research specialties. The demographic questionnaire did not address the specializations of the CACREP programs that participants were affiliated with, as most if not all were teaching, supervising, and/or administrating in multiple programs. However, participants identified their counseling and related professional specialties during the interviews: clinical mental health counseling; school

counseling; marriage, couples, and family counseling; addictions counseling; psychology; marriage and family therapy; and social work. They also mentioned having other research and practice specialties including: bullying; ethics; grief/loss; lesbian, gay, bisexual, and transgender clients; offenders and criminal justice; and spirituality. Two participants self-identified as experts by answering in the affirmative to a demographic survey question: "Do you have specialization or expertise in suicide and/or related education in counselor training? Such expertise may include delivering publications or presentations on counselor preparation related to suicide or crisis or receiving training to become a trainer for suicide education of counseling/clinical professionals."

Data Collection

Data collection began following approval from the university Institutional Review Board and research aligned with the ACA Code of Ethics (2014). Data collection consisted of a demographics survey, interviews, and member checks. The survey contained 11 questions: seven concerned basic contact and identity information and the remaining focused on professional roles and responsibilities and experience providing PPST. Interviews are the primary data source in CQR studies (Hill et al., 1997). The interview protocol was informed by recommendations for CQR (Burkard et al., 2012), the CRM framework (Plested et al., 2009; TCPR, 2014) and an evaluative pilot study (Cureton, n.d.). Semi-structured phone interviews contained 10 to 15 questions, each targeted to CRM readiness dimensions such as: "What is the attitude in CES about pre-professional suicide training?" and "How do CES members know or learn about suicide?" Interviews ranged from 45 minutes to 1.5 hours. Member checking occurred via email following preliminary analysis to address advice on CQR methods (Burkard et al., 2012; Hill et al., 2005). The email included (a) initial domains, (b) up to three clarification questions, and (c) an invitation for feedback and additional reflections.

Data Analysis

The analysis process involved three phases. Domains in CQR are groups of themes and core ideas are "summaries of the data that capture the essence of the participant's statement in fewer words" (Thompson et al., 2012, p. 111). Core ideas allow researchers to use consistent language and compare across cases, which included discrepant case analysis in this study. NVIVO version 11 was the software used to code the data.

Phase 1 – cases 1 through 3 – served to "further coalesce the team and to ensure that everyone is 'on the same page'" (Thompson et al., 2012, p. 112). All team members coded data into domains and identified core ideas. CQR methodology provides researchers the option to use a "start list" (Miles & Huberman, 1994 as cited in Hill et al. 2005) of domains, in this case the six readiness dimensions. Any additional domains were considered in consensus meetings. Phase 2 – cases 4 through 15 – used simplified analysis (Hill et al., 2005) to alleviate responsibilities while honoring the shared process of CQR. The first author developed core ideas, and all researchers independently coded and continued "to immerse themselves deeply in each case and helped edit the core ideas to make them as clear, accurate, and contextually based as possible" (Hill et al., 2005, p. 200). Consensus meetings spanned three cases at a time. Phase 3 involved cross-analysis or analyzing data at a "higher level of abstraction" (Hill et al., 2005, p. 200). These meetings focused on consensus regarding the category and subcategory structure for each domain and the placement of core ideas into the structure. This phase involved frequencies, or representative counts for categories across cases.

Results

The six domains represent CES's readiness to provide PPST: Efforts, Knowledge of Efforts, Leadership, Climate, Knowledge about Suicide, and Resources. No domains beyond these

six CRM readiness dimensions remained after team analysis. The current study was part of a larger study involving CRM scoring, which is reported elsewhere (Cureton et al., 2020).

Table 2

Domains, Categories, and Frequency Results by Domain

Domain	Category	Frequency
Efforts		
	Content	15
	Methods	15
	Format and schedule	15
	Target audience	15
	Responsible parties	12
	Longevity and existence	12
	Intentions	12
Knowledge of Efforts		
	Sources of information	15
	Knowledge of efforts varies	15
	Evaluation	15
	Positive appraisal	15
	Negative appraisal	12
Leadership		
	Active support	15
	Types of leaders	13
	Concern or priority	12
	Lacking support	9
	Awareness of leadership	9
Climate		
	Attitudinal climate	15
	Political climate	14
	Logistical climate	12
Knowledge of Suicide		
	Sources of knowledge	15
	Comprehensiveness and Content	15
Resources		
	Unavailable	14
	Available	13
	Conditional	12

Note. Categories appear in order of frequency.

Table 2 displays domains, categories, frequencies, and frequency labels as recommended by CQR methodologists (Ladany et al., 2012). Findings follow for categories that emerged at a

general frequency of 14 or 15 cases or typical frequency of 8 to 13 cases. We use pseudonyms throughout to provide representative quotes from our 15 CES members.

Efforts

The first domain is Efforts, or current programs or activities that address the issue (TCPR, 2014). These consisted of PPST provided by CES community members to CITs at any point in the Master's program (e.g., coursework, supervision, and extracurricular learning opportunities). Nearly all CES members cited risk assessment content (n = 14). The most cited method (n = 13) was professional practice in practicum and internship, and didactic suicide lectures arose in 12 of the interviews. Some participants described role-play methods situated in professional practice courses and in applied courses concerning counseling skills. Uniquely, Christine gives students a written assignment in which they provide a personal reaction to a case study and develop a script between counselor and client:

> I have them voice exactly in their own words what they would say. My hope is when that time comes that they will at least have a couple of words in their head so they can default into it, "Okay, this is what I need to do" kind of mode.

PPST efforts appear in a variety of formats and schedules. All participants mentioned PPST in Practica and/or Internship. Susan stated, "I always revisit it in Mental Health Prac because those students might not have seen it and/or heard it for three semesters. I want them before they go into the field to have it relatively fresh in their mind." Other typical formats include core courses on assessment, ethics, diagnosis, and crisis or trauma. Nine participants described in-person and online workshops. Three participants stated that PPST occurs via infusion, or integration throughout a student's training program. But four participants said PPST efforts last only one class session or lesson, and depicted them as detached from other training, calling them "segmented,"

"a one-time effort," "one and done," and "stand-alone." The most cited placement (n = 12) was what the research team termed "reactive supervision" in which PPST occurs after a supervisee alerts a supervisor about suicide issues that arose with a client.

The entire sample (n = 15) cited supervisees as a target audience for PPST and supervisors and educators as responsible parties. Students emerged as a party responsible for PPST when 10 participants described CITs' role to prompt PPST to occur. Sarah explained:

> It is a matter of teaching them to take accountability for their clients and make sure they are following the right order of things so they don't get themselves in trouble and lose their license before they even get a chance to practice much.

Some PPST efforts had only been in place for a year or less. However, others had existed for 10 years or longer. The primary intentions of efforts are to ensure that (a) CITs can smoothly and calmly recall information with clients and (b) programs are addressing counselors' legal and ethical issues concerning suicide. CES members who mentioned role plays explicitly described the intention as using practice to lessen CITs suicide assessment anxiety over time.

Knowledge of Efforts

Knowledge of efforts focuses on the awareness among CES community members about any efforts that already exist to address an issue (TCPR, 2014). CES members particularly described their own PPST. Some knew what other educators, supervisors, or programs were providing; however, all participants indicated that this knowledge varies by individual, often because CES members lack knowledge beyond their role or area of expertise. Dillon explained, "It is very easy to get stuck in your own little slice of life," so CES members use professional conferences to overcome this. Nearly all of the sample (n = 13) named professional development (PD) as a source of information on others' PPST, such as conferences or trainings, and nine

participants also mentioned professional networking at events or "word of mouth" conversations with program/site or outside colleagues. Susan stated she attends suicide-related conference sessions to learn about suicide, but lamented:

> At every conference really it is a like-minded audience: people in the same room that have the same interests and passions. So obviously those of us in those sessions are very eager to train more, to teach our students more about assessing, but I don't know about the others who are not in that room with us.

One administrator noted that informal conversations around PPST occur more during program re-accreditation.

Nearly half of the CES members noted a lack of communication between university programs and practica/internship sites about PPST. Three educators said they did not know about site PPST and four site supervisors said the same about university PPST. Priscilla, a site supervisor, said "In all the conversations about suicide, no one [among interns] has ever said, 'Oh they've taught me about this already.' Or 'I took training on it.'" Site supervisor Dr. Smith expressed: "They've [university educators/administrators] never asked. I would say they have no idea at all of the actual level of training quality that their students are receiving in general, not just about suicide." Sarah summarized:

> It's like all of us assume that somebody else is doing that. They [program leaders] assume that the site supervisor is taking care of that. The site supervisor is assuming we are taking care of that. This professor is thinking, "Oh they are handling that in *Crisis and Trauma*." Yeah we are, but what about all the other courses?

Almost all participants (n = 13) were unaware of any evaluations of PPST. They offered numerous positive and negative appraisals by informally assessing the efforts during the research

interviews. Common positive comments were that PPST "raises students' awareness about suicide" and helps decrease discomfort (e.g., "practice saying the word"). They also praised the slow, thorough, and supportive nature of active and practical learning (i.e., role-plays and supervised practice). Negative appraisal concerned inadequacy of counselor preparation in general and lack of deliberate planning for PPST. The most cited weaknesses of PPST were (a) inconsistency, (b) poor timing and placement, (c) inapplicability, and (d) lack of breadth and depth. Carolyn said, "I too frequently hear students say, 'Gee that was never addressed until you talked to us about it.'" CES members attributed poor timing and placement of PPST to (a) too little time spent covering suicide in coursework, (b) not addressing suicide early enough in a course, and (c) lack of infusion throughout the counseling curriculum.

Leadership

The leadership domain in CRM represents concern about the issue and support from influential community members for efforts (TCPR, 2014), in this case leaders in CES for PPST. CES members most often identified leaders as program coordinators and other university/site administrators as well as leaders of counseling and suicide organizations, such as ACA and AAS. Participants also identified CACREP and published authors and presenters on suicide.

All of the CES members we interviewed were able to identify some type of active support for PPST from one or more of these types of leaders. Most mentioned support for suicide-related PD, although a few bemoaned the dwindling support for conference travel. Christine described the intentionality of regional conference leaders:

> I helped coordinate the [regional organization] conference and there was a conversation among conference coordinators and the organization's board that presentations that involve suicide or suicide training should be included. I saw a great representation of

accepted conference presentations related to suicide. So it is supported in that way.

Another element of active support for PPST from leaders was accreditation and ethical standards and site policies regarding suicide. Dillon asserted that these and policies from the ACA Ethics Board "communicate that it [suicide] is still a living issue in terms of what we talk about and that there needs to be active discussion about how to promote education best practices." Participants who are site supervisors cited their management's policies regarding client suicide screening and supervisee and client assignments as a source of active support for PPST at practicum and internship sites. The CES members indicated that though some leaders place a priority on PPST, support often seems attitudinal and intermittent as opposed to active and consistent. Henry explained of the CES field's leadership:

> We are getting the screen time that "This is an important issue! This is an important issue!" But then to actually dig in and say "What does that mean for us? How do we put feet on this for us and for our concentration?" that is when I give us a five [out of 10].

Susan described her department chair's reaction to PPST she provided:

> His mind is a constant spinning CACREP manual: "Where are we doing this and where are we doing that?" I feel like he's happy sometimes to check the box. Not that he just wants to get it done. He wants to know it is being done and I guess he was glad to see it was being done well.

Nine participants specified support they need and appealed to particular leaders to better prioritize PPST: mandates from training program administrators, state policymakers, and CACREP about suicide training for educators and supervisors. Dr. Smith asserted,

> There are no requirements. So are most people going to take that extra step when they're not required to? Probably not. And the poor students! Should they be left to the mercy of whatever supervisor feels like doing suicide training or not? That's not right.

Other requests were for program leaders to designate curricular placement of suicide content and work more on enhancing communication between instructors and site supervisors. Sarah explained, "There is a lack of investment in making sure that everybody is getting good and substantial training in it [suicide] rather than hit and miss sporadic. I think it's just kind of off their [program coordinators'] radar."

Climate

Climate is the context that sets the tone concerning the issue of focus and any efforts to address it (TPRC, 2014), i.e., CES's attitude toward suicide and support for PPST. Participants depicted a complex climate concerning attitudes, policies, and logistics. One attitude is that primary responsibility for PPST resides with supervisors and instructors of applied courses such as Practica and Internship. Another is that CES members who provide PPST must have expertise from practical experience with suicidal clients or research. Irving said, "People get their niches and I think they place suicide into more of the trauma response end of specializations. Then they say, 'Oh that's not my thing. I work over here.'" Participants explained the mindset among community members that CITs learn about suicide best via supervised practice. Lynn explained:

> I really do believe the application piece has to be done with clients. You just can't do it any other way. That's my responsibility. And it is a necessary part of the training. The schools can't do it and it is not their fault, so I don't criticize them for not doing it. It's just not their role. I don't do the initial education, which I am very grateful for actually. I think we [site supervisors] accept it as the cost of doing business: just part of my job.

Another mindset within the CES community is that PPST should differ between CITs' concentrations, though several participants argued against the stance, as Henry did:

> If I'm doing my job right, we're all counselors. What better example to point to, sadly, than suicide? With suicide, I don't care where you are – addictions, career, school, clinical, whatever, it is something that transcends all. And for me, that is exciting. It sounds crazy to say that about suicide. But it is exciting because it points back to that vision of "Hey we're all counselors, let's lock this down. There is not room for excuses. Not room for not knowing."

The CES members we interviewed shared several positive attitudes in the field about the value and importance of PPST. They also vividly described negative views of PPST as "a necessary evil" that is "emotionally draining," and "takes up a lot of time and energy." They explained that some educators or supervisors dread or limit PPST because they see suicide as too advanced of a topic or too serious of a client issue, and they prefer to avoid student discomfort and negative course evaluations. Eleven participants attributed fearful attitudes to CITs that result in avoidance or overreaction by CITs which subsequently prompts the same response in many educators and supervisors. Participants identified compounding CIT factors: ignorance and misinformation about suicide and suicide issues in counseling, previous experience CITs may have with suicide, and their religious views on suicide. An educator from a counseling program at a faith-based institution explained that students who are more zealous in their faith prefer to pray the client through the suicidal ideation instead of engaging crisis response protocols.

Politics and logistics also set the tone for PPST in the CES community. Participants explained that suicide prevalence creates a perceived need for PPST. However, they named political obstacles such as disagreement about efforts and competing priorities for CES members,

CITs, and the broader community. Dillon stated, “I think one obstacle is the litigious nature of academia and the world in general. Our non-clinical non-counseling administrators have this more liability perspective as opposed to say an educational perspective if that makes sense.” Similarly, Irving attributed a liability “and emergency perspective” to “the agencies” where her students intern. CES members and other influences prioritize other issues over suicide. For example, a site supervisor shared that local counselors prioritize trauma and teen topics over suicide. Logistics involves practical obstacles that impact climate such as arranging PPST among busy CIT schedules, particularly when it impacts Practicum and Internship client schedules.

Knowledge about Suicide

Knowledge about Suicide concerns how much CES members know about suicide, the content of their suicide knowledge, and how they acquire suicide knowledge (TCPR, 2014). Twelve participants asserted that the comprehensiveness of suicide knowledge varies greatly among members of the CES field. Participants attributed more suicide knowledge to recent graduates and to CES members with more practical experience overall. Shawna said, “Some educators probably have more understanding than they wish they had, and others may not have had that much experience because for whatever reason they just never ran into it.” Similar to knowledge about efforts, CES members (n = 12) mentioned PD as a common source of suicide knowledge. They (n = 9) also said that many educators and supervisors use the PPST they had received when completing their own Master’s-level counseling training to inform the PPST they provide, although four participants stated that PPST was rare or nonexistent when they completed their graduate training. Only six participants named professional literature as a source of suicide knowledge for CES members.

Participants identified misconceptions and topics missing from CES community members' suicide knowledge: therapeutic relationship, risk assessment, interventions, prevalence, and conceptualization of suicide. Use of no-suicide contracts is an example of an intervention misconception. Christine said that a textbook she uses:

> has a recommendation to do a no-suicide contract. I just personally think it is ludicrous. …what's a piece of paper where they sign going to make that different? Maybe there is research to support that. I should look more into it because I don't know.

Other missing or inaccurate areas of suicide knowledge concerned non-suicidal self-injury, suicide statistics for children, and updated suicide terminology. Dr. Smith believes that Master's-level mental health training is generally inadequate and that this inadequacy, in combination with a lack of requirements that supervisors receive suicide training, creates a revolving pattern of subpar PPST in counselor preparation. She explained:

> I think the vast majority of people that are supervising the master's-level students are not exceptionally well-educated and trained themselves. …It's just that if you have also gone into a master's program that was not particularly competitive and you have not learned the stuff yourself, then how are you going to train at that higher level?

Resources

CRM identifies resources as the means available in the community such as money, time, people, and space to address the issue (TCPR, 2014). All but one participant (n = 14) struggled to name available resources for PPST and believed that existing resources were inaccessible for PPST. All but one participant named money as a resource that CES lacks for providing PPST, particularly as funding for external training workshops, payment for presenters, and reimbursement for CES members' PD on suicide and PPST. Time was also lacking, including time

for members to receive their own suicide training, to plan or coordinate PPST, and to devote to PPST in courses or across the curriculum.

Most of the participants (n = 13) were eventually able to name at least one resource that CES community members can access for PPST such as their existing salary, internal budgets and university- or district-level external budgets to pay CES members or speakers, and grants such as those from Substance Abuse and Mental Health Services Administration and Chi Sigma Iota. A third of the sample (n = 5) stated that time was available to CES members who wish to take off from work to receive their own suicide PD. Most participants (n = 12) noted that some resources are only available for PPST under certain conditions (e.g., travel reimbursement and project support only for research or scholarship and state funding earmarked for higher priority topics such as trauma and addictions).

Discussion

This study establishes a contextual picture surrounding pre-professional suicide training in counselor preparation: CES's readiness to address the issue of suicide via PPST. The study offers results from a cross-analysis of perspectives new in the PPST literature: educators, administrators, and site supervisors. Prior literature has elucidated gaps in PPST from CACREP-accredited programs (Cureton et al., 2020; Springer et al., 2020; Wachter Morris & Barrio Minton, 2012), and the findings from this study suggest a need for increased attention to boost readiness and improve PPST. We discuss the six readiness domains in interconnected groupings below, then highlight key opportunities to facilitate system-level change necessary to advance PPST.

Efforts, Knowledge of Efforts, and Resources

Results indicate that CES has provided PPST efforts for several years, particularly covering suicide risk assessment via roleplays in skills-based courses and/or lectures. CES does not appear

to consistently utilize the infusion approach for PPST. Students carry responsibility in and beyond applied coursework to broach the topic of suicide with their superiors. Counselor educators and supervisors' primary goal for PPST is to ensure CITs and graduates can later calmly recall informal suicide assessment protocols and legal or ethical concerns.

The current findings indicate that little to no evaluation occurs to determine whether or not this goal is attained in short-term or sustained success. Members of the CES field operate in silos (i.e., their own courses/programs, settings, and areas of expertise) that limit their knowledge of PPST efforts beyond their own – a finding that supports existing literature (Barrio Minton & Pease-Carter, 2011; Ruth et al., 2012). Some use professional conferences and networking to overcome that barrier. Results indicate that PPST's positive attributes such as awareness-raising and learning via active practice are balanced with negative attributes and barriers to providing PPST. Negative attributes of inconsistency, poor timing/placement, and inapplicability or cursory content echo the existing mental health literature (Freadling & Foss-Kelly, 2014; Schmidt, 2016; Springer et al., 2020) as does limited time in the curriculum and in educators', supervisors', and CITs' lives to devote to PPST (House, 2003; Ruth et al., 2012; Wozny, 2005).

Results suggest that practical necessities available to CES members for PPST are lacking. This lack is consistent with studies with other mental health providers (Hung et al., 2012; Ruth et al., 2012) and points to the need for readiness-informed improvement initiatives. Another novel focus of the current findings was CES's limited money both for PD and workshop presenters to deliver PPST. Some CES members appear to have access to budgets, grants, and time off for PPST-related initiatives particularly if they are engaging in related research/scholarship or combining suicide study with another topic of concern.

Climate, Leadership, and Knowledge of Suicide

Themes that emerged in the Climate domain represent additional obstacles for PPST consistent with previous mental health literature (Hoffman et al., 2013; Ruth et al., 2012) such as suicide stigma, limited mindsets, and competing priorities. The current study's findings extended obstacles to include CES members, CITs, and the broader community. Like educators in psychology (Liebling-Boccio & Jennings, 2013) and social work (Ruth et al., 2012), CES members seem to agree that PPST is crucial, but disagree about the need to improve PPST. Mindsets that 1) only certain CES members (i.e., Practicum and Internship instructors and site supervisors with longstanding practical expertise in suicide) should provide PPST and that 2) PPST should differ greatly between counseling concentrations, appear to limit PPST. An overall negative and fearful view on suicide and PPST also prohibits improvements.

The current findings indicate that CES leaders acknowledge a need for PPST and provide some support, but do not attempt to improve or evaluate efforts. Leadership support remains needed to ensure PPST comprehensiveness and consistency within and between counselor training programs (Freadling & Foss-Kelly, 2014; Gibbons et al., 2009; Hoffman et al., 2013). Wachter Morris and Barrio Minton (2012) observed that CES programs who fail to methodically address crisis preparation leave decisions to individual instructors. This study's findings illustrate CES members' desire for more direction and support from program and site leaders, CACREP, and policy leaders, particularly to fill knowledge gaps among educators and supervisors (i.e., mandating suicide-related PD and establishing tighter communications between university and site representatives) and to prioritize PPST via decisions and policies (i.e., about placement in the curriculum and procedures for involving interns in suicide cases).

The current study's results provide some empirical information to confirm authors' previous commentary that CES members may lack knowledge about crisis and related education (Dupre et al., 2014; Wachter Morris & Barrio Minton, 2012) and suggest that this gap in educators' and supervisors' knowledge may be partly to blame for graduates' and CITs' criticisms of PPST efforts (Freadling & Foss-Kelly, 2014). The current findings display CES's knowledge about suicide as basic, lacking in comprehensiveness, and highly variable from member to member. Some members of the field who are considered experts on the topic of suicide based on their research or practical experience may have more knowledge of suicide. Participants named several areas of suicide misconceptions or missing knowledge among CES members. The most common sources of CES members' suicide knowledge were PD (i.e., conferences and trainings) and the PPST they received in graduate school. This raises concerns, considering the limitations on PD support and the history of inadequate PPST in counseling and other professions. Professional literature may serve to provide updated suicide knowledge to CES members, but less than half of the sample named literature as a source used (*n*=6; 40%).

Future Directions

Implications

Numerous implications emerge from this study on readiness as context for counselor PPST. Findings have implications for various leaders as well as for counselor educators and supervisors and for CITs. The AAS Task Force (Schmitz et al., 2012) pointed out the systemic ethical issue wherein mental health training programs continue to graduate practitioners to serve clients despite being inadequately prepared to address suicide. The findings of this study support their recommendations to include suicide training in accreditation standards for graduate programs and healthcare organizations, state licensing requirements, and related legislation. It appears from these

findings that CES members may welcome such regulations. CES leaders in professional organization positions and university and site administrators can provide informed guidance to CES members on advocacy to accreditation/licensing boards and to legislators regarding suicide training for direct providers and those who supervise and teach them.

Along with field leaders, university and site administrators can work to devote funding to PD and specifically to teaching-related endeavors so that suicide training for educators, supervisors, and CITs can become more available. The current study serves to amplify calls from Gallo et al. (2019) and others for CES authors to conduct and publish more suicide literature in general, and the current findings demonstrate the particular need for suicide literature beyond suicide risk assessment and legal/ethical concerns. CES authors and presenters should highlight suicide literature on missing/inaccurate information such as the therapeutic relationship and conceptualization of suicide, diverse interventions, prevalence particularly in youth, differences and overlap between suicide and non-suicidal self-injury, and updated terminology. That said, the fact that CES members may not be accessing literature to inform their suicide knowledge and the PPST they provide may be a bid for these CES thought leaders to deliver more accessible PD aimed at educators and supervisors.

Although CACREP was an early adopter of suicide-specific standards (SPRC and SPAN USA, 2010) by adding them to the 2009 Standards (CACREP, 2009), Elliott et al. (2019) pointed out the potentially backwards movement from 2009 Standards, which included suicide in standards for competency and knowledge, to the 2016 Standards (CACREP, 2015) which no longer explicitly address suicide in competency standards. In creating future standards changes, CACREP leaders may consider reinstating suicide specificity into standards and/or providing definitions for terms like *crisis* as they do for *multicultural* and others in the glossary.

Program leaders such as coordinators, department chairs, and site internship directors can use this study as a prompt to undergo systematic planning and evaluation of current and improved PPST. Given findings concerning silos within programs, practicum/internship sites, and the CES field overall, inclusive workgroups at multiple levels may be most informative and successful, along with surveys of students, graduates, and supervisors. Aims can target existing recommendations for suicide training such as using both passive and active learning strategies (Cureton & Sheesley, 2017; Gallo, Doumas, et al., 2019), covering suicide comprehensively (AAS, 2004; Cureton et al., 2020), and maximizing a standalone course and/or infusion (Cureton & Sheesley, 2017; Gallo et al., 2019; Wachter Morris & Barrio Minton, 2012).

Another group implicated in these findings is counselor educators and supervisors. Educators and supervisors must seek the latest knowledge about suicide to meet ethical obligations for continuing education and training (ACA, 2014). The findings underscore the responsibility of these CES members to update their own knowledge as well as their curriculum and other preparation. They should be encouraged to consult with and invite colleagues with suicide expertise into their planning and delivery and to ask for and share updated suicide literature recommendations, particularly those that transcend the singular topic of suicide risk assessment. Additionally, the findings pose an invitation to educators and supervisors to proactively face their own and CITs' challenging feelings about suicide. This may happen through self-reflection and therapeutic processes to address suicide countertransference (e.g., Cureton & Clemens, 2015), humanistic pedagogy to address CITs' apprehension about suicide (Guillot Miller et al., 2013), and/or by acknowledging strengths-based resiliency in suicide protective factors (e.g., Cureton & Fink, 2019). Additional climate shifts may occur for those who apply suggestions from CRM authors to hold media and prevention events to address suicide stigma (TCPR, 2014). Such

awareness events can benefit CES members, CITs, and local communities to improve community climate, and knowledge about suicide and suicide prevention efforts.

Finally, the study has implications for CITs. Just as CES members need to welcome the uncertainty and anxiety surrounding the topic of suicide (Cureton & Sheesley, 2017), so can CITs toward themselves, their peers, and their instructors and supervisors. CITs may embrace and demand in-depth coverage and varied training methods on the important topic of suicide. Students and interns can understand the value of providing feedback about the PPST they receive (or do not receive), ideally in non-threatening spaces and venues created by educators and supervisors including for clarity, coverage of specific subtopics, and recommendations for updated PD.

Limitations

Some study limitations exist primarily related to design. The focus on members who directly provide and/or impact PPST resulted in a defined community (i.e., educational, supervisory, and administration professionals affiliated with master's programs), which excluded CITs from the sample. Future readiness applications may be expanded to CITs and/or graduates. Despite the alignment with recommendations for CQR studies (Hill & Williams, 2012) to use of criterion sampling with some element of randomization, the sample was entirely White and 13.33% male. This is not representative of CACREP full-time faculty members which are 71.38% Caucasian/White and 37.71% male (CACREP, 2018). Self-selection into the study may also have biased the results. Intentionally targeting recruitment and sampling toward more representative samples is important for future counselor preparation research on the topic of suicide. A limitation related to analysis was use of the option in Consensual Qualitative Research of "shortcutting the process" in Phase 2. Though we ensured "all members of the team remain close to the data and

reach consensus on the content of each core idea" (Thompson et al., 2012, p. 115-6), this necessarily restricted the amount of independent analysis.

Future Research

The findings prompt future research related to PPST in CES, particularly evaluative studies. Several directions emerge for research related to climate, leadership, and resources. The findings revealed a sharp distinction between positive and negative attitudes toward PPST, and the issue of priorities arose within more than domain. Leadership and policy studies involving CES leaders and policymakers could inform advocacy efforts. More research seems needed on financial and other resources available and applicable for PPST. Future studies could serve to explore the readiness of specific programs to provide PPST. Finally, although generalizability is not the aim of qualitative research, development and use of a community readiness survey and/or other quantitative instrumentation and design is an interesting area of future research on CES' readiness to address suicide and other crucial counselor preparation topics.

Conclusion

The current research was a qualitative study on the CES field's readiness to change PPST which incorporated an established readiness model as the study's framework. Understanding the readiness of the CES field to provide PPST is a crucial and timely endeavor. Developments in the aforementioned standards and guidelines serve to steer the work of counselors, educators, supervisors, and others. However, readiness to implement changes to PPST that align with these developments was unknown. The Community Readiness Model (CRM) was developed to stop the trend of inconsistent and unsuccessful prevention efforts (Edwards et al., 2000). This study's integration of the CRM framework and CQR methodology produced results that serve as a groundwork for change. Programs initiated PPST efforts, likely in response to CACREP (2009)

Standards, but may have proceeded before the field was ready to sustain successful change. Efforts have positive attributes, but several weaknesses maintain inadequacy of PPST. Consistency is lacking in efforts, knowledge of efforts, and knowledge about suicide. Increased efforts, ongoing leadership support, and growing suicide knowledge provide an opportunity to provide and evaluate PPST further. This manuscript can inform initiatives to improve counselor preparation on suicide.

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