Readiness of Counselor Education and Supervision to Provide Master's-level Suicide Training

Jenny L. Cureton

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READINESS OF COUNSELOR EDUCATION AND SUPERVISION TO PROVIDE MASTER’S-LEVEL SUICIDE TRAINING

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

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Counselor Education and Supervision

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This Dissertation by: Jenny Cureton

Entitled: *Readiness of Counselor Education and Supervision to Provide Master’s-level Suicide Training*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Education and Behavioral Sciences in Department of Applied Psychology and Counselor Education, Program of Counselor Education and Supervision

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ABSTRACT


The Counselor Education and Supervision field serves to prepare counselors-in-training to practice counseling. The Council for the Accreditation of Counseling and Related Educational Programs includes suicide training in its standards for accredited counseling programs (2009, 2015). Counselor educators and supervisors have an obligation to use the latest knowledge in the counseling profession and their professional competence to provide counselor training on ethical practice (American Counseling Association, 2014) including suicide-related counseling situations.

The Counselor Education and Supervision field needs to change master’s-level suicide training. The field’s previous master’s-level suicide training appears lacking. Recent developments impact the field and master’s-level suicide training, including (a) the 2016 Council for the Accreditation of Counseling and Related Educational Programs Standards, (b) the 2014 American Counseling Association Code of Ethics, (c) the 5th edition of the Diagnostic and Statistic Manual of Mental Disorders, (d) suicide training guidelines and core competencies, and (e) advancements in research and policy.

The readiness of the Counselor Education and Supervision field is to provide master’s-level suicide training in the context of these recent developments was previously unknown. The Community Readiness Model provides a theoretical framework for
proactively assessing a community’s readiness to address an issue. The purposes of this study were (a) to assess the field’s stage of readiness to provide such training and (b) to identify themes of readiness pertaining to the field’s knowledge of suicide, leadership, training efforts, knowledge in the field about those efforts, climate, and resources.

The philosophical paradigm was a combination of social constructionism and post-positivism. The methodology for this study was Consensual Qualitative Research. Counselor educators, supervisors, and administrators (e.g., program coordinators, department chairs, and clinic directors) affiliated with accredited master’s programs in counseling shared their perspectives via semi-structured interviews on the readiness of the Counselor Education and Supervision field to provide master’s-level suicide training. A research team consisting of the primary researcher, two co-researchers, and an external auditor analyzed the data through analysis and cross-analysis of domains and core ideas.

The findings offer valuable information to the Counselor Education and Supervision field about its readiness to provide master’s-level suicide training. The field’s overall readiness to provide such training is preplanning: a score of 4 out of 9. Readiness for the six domains ranged from vague awareness regarding resources – a score of 3 out of 9 – to initiation regarding efforts – a score of 6 out of 9. Qualitative findings include six domains with three to seven categories within each domain. A relational model conveys the intersections of the domains. Logic models serve as tools to guide readiness improvement initiatives. Individual counselor educators and supervisors, accredited programs, and others in the Counselor Education and Supervision community will be able to use these findings to inform teaching and supervision efforts, accreditation implementation, program evaluation, and future research.
ACKNOWLEDGMENTS

I owe incredible gratitude to several guides, colleagues, family, and friends for supporting me during my PhD program. My advisor and chair, Dr. Elysia Clemens, fueled my passion for pedagogy and ignited my commitment to research. Her expertise and dedication to excellence combined with her matter-of-fact style was the perfect recipe for the mentorship I needed here. It is hard to imagine a better voice to have inside my head as I begin the tenure-track life.

I am grateful to Dr. Heather Helm for lending her knowledge and experience to this dissertation and to my growth as a Counselor Education and Supervision professional. Her abiding concern for the human relationship was an encouraging and important reminder of where I am from and where I seek to go in this work. She and Dr. Jeffrey Rings served as tremendous role models for supervision and supervision of supervision. Dr. Rings, thank you for your tireless work supporting me and all students with compassion and challenge. I appreciate Dr. Harvey Rude for serving on my committee. Your guidance and ideas were instructive from our very first meeting and I foresee their contribution to my future success for longer than you may imagine.

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comradery made it worth your generous gifts of time and effort. Janessa, our early and continuous bond during this PhD program have sustained me through some of the most challenging moments. For you, I am forever grateful. May the shenanigans continue!

There a number of academic and professional colleagues and friends who deserve recognition. Dr. Diane Stutey, your steadfast friendship and advice have been irreplaceable. I thank you and Dr. Kylie Rogalla and Dr. David Johns for opening your homes to me for helpful counsel and laughter. Dr. Hannah Kreider, I feel certain our souls have conversed brilliantly over tea on some other plane just as they have here. Thank you for sharing in my empathy. A special thanks to Kyle Lucas, a wonderful study partner and boss. Two very important people helped me become the counselor I am and encouraged me to continue to explore our field: Chuck Dunning and Vanden Thong. I am grateful I continue to receive the warm care and emotional intelligence you both exude.

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Mom and Dad, who few know as Drs. Judy and Bob Cureton, your constant and unconditional love has sustained me and our family through joyous and troubled times. It is you who taught me to greet death and hardship just like anything else: with grace, gratitude, and an open mind. To my grandparents, who believed in my personal, academic, and professional potential and privileged me with the means to pursue such dreams. And especially for Granddaddy: this is for you.

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<td>ACA</td>
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<td>ACES</td>
<td>Association for Counselor Education and Supervision</td>
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<tr>
<td>CACREP</td>
<td>Council for Accreditation of Counseling and Related Educational Programs</td>
</tr>
<tr>
<td>CIT</td>
<td>Counselor-in-training</td>
</tr>
<tr>
<td>CES</td>
<td>Counselor Education and Supervision</td>
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<tr>
<td>CWPTF</td>
<td>Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention</td>
</tr>
<tr>
<td>KOE</td>
<td>Knowledge of efforts</td>
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<td>KOS</td>
<td>Knowledge of suicide</td>
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<tr>
<td>MLST</td>
<td>Master’s-level suicide training</td>
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<tr>
<td>NAASP</td>
<td>National Action Alliance for Suicide Prevention</td>
</tr>
<tr>
<td>SPRC</td>
<td>Suicide Prevention Resource Center</td>
</tr>
<tr>
<td>TECPR</td>
<td>Tri-Ethnic Center for Prevention Research</td>
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<tr>
<td>USDHHSOSG</td>
<td>U.S. Department of Health and Human Services Office of the Surgeon General</td>
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CHAPTER I

INTRODUCTION

Historically, counselor educators and supervisors have inadequately prepared counselors-in-training to address suicide in counseling (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). The previous accreditation standards for counseling programs (Council for Accreditation of Counseling and Related Educational Programs, 2009) marked an important transition as accredited programs became explicitly accountable for covering suicide in core coursework. The current 2016 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2015) include suicide prevention models and strategies and suicide risk assessment in core curriculum requirements. These accreditation standards and the American Counseling Association Code of Ethics (2014) provide agreed-upon professional standards for training and practice specific to suicide. Master’s-level suicide training has not consistently met the needs and expectations of students, employers, and the broader community (Freadling & Foss-Kelly, 2014; Schmitz et al., 2012; Shaw, 2014). The evidence that master’s-level suicide training is not occurring in a systematic manner suggests a need for change (Hoffman, Osborn, & West, 2013).
Guidelines for adequate suicide training are established (American Association of Suicidology, 2004; National Action Alliance for Suicide Prevention: Clinical Workforce Preparedness Task Force, 2014). Counselor educators and supervisors have failed to consistently and adequately provide master’s-level suicide training (Barrio Minton & Pease-Carter, 2011; Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Lauka, McCarthy, & Carter, 2014; Neukrug et al., 2013; Raper, 2010; Shaw, 2014; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). Accreditation standards, and ethical standards, and the needs and expectations of students, employers, and the broader community offer a foundation for change to master’s-level suicide training. Counselor educators and supervisors can attend to developments within and beyond the field that have occurred since 2009 and apply these advancements to informing master’s-level suicide training. An assessment of the field’s readiness is a proactive step to inform new and ongoing efforts. Assessing readiness for change includes identification of the qualities of a system that assist or obstruct sustainable change (Armenakis, Harris, & Mossholder, 1993; Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Holt, Armenakis, Feild, & Harris, 2007). Understanding the readiness of the Counselor Education and Supervision field to provide master’s-level suicide training should highlight areas the field needs to address in order to successfully improve master’s-level suicide training.

**Need for Change**

Counselor Education and Supervision is among the fields that need to improve pre-professional suicide training (Schmitz et al., 2012; U.S. Department of Health and Human Services Office of the Surgeon General, and National Action Alliance for Suicide
Prevention [USHHSOSG and NAASP, 2012]. “The evidence clearly suggests that there has been a negligible progress in improving the competence of mental health professionals in evaluating, managing, and treating suicidal patients” (Schmitz et al., 2012, p. 296). Calls to improve pre-professional suicide training across mental health fields span the last few decades (USHHSOSG and NAASP, 2012; U.S. Public Health Service, 1999). Previous master’s-level suicide training has not yielded sustained suicide intervention skills (Raper, 2010) or self-confidence in one’s ability to recognize suicide risk (King, Price, Telljohann, & Wahl, 1999).

The need for change to master’s-level suicide training is also supported by assessments of master’s-level suicide training from employers, supervisors, and recent graduates and by the inconsistency of master’s-level suicide training that aligns with clinical, ethical/legal, and training guidelines. Research with employers and supervisors of counselors-in-training and recent graduates presents master’s-level suicide training as less than favorable (Hoffman et al., 2013; Shaw, 2014). Counseling center directors viewed entry-level counselors as less prepared in general compared to their colleagues from other mental health fields (Shaw, 2014). The directors rated recent counseling graduates 4 out of 6 in terms of preparedness to handle each of the following: suicidal ideation, self-injury behaviors, crisis intervention, and assessment. Hoffman et al. (2013) found that counseling supervisors view suicide as an important but inconsistently addressed element of counseling curriculum and evaluate some supervisees as prepared to work with suicidal clients and others as not prepared.

Counseling graduates have pointed to an overall lack of attention to suicide and/or crisis topics in counselor training (Freadling & Foss-Kelly, 2014; Wachter Morris &
Barrio Minton, 2012; Wozny & Zinck, 2007). Only 45% of recent graduates deemed the
counselor training they received on suicide assessment to be good or excellent (Wachter
Morris & Barrio Minton, 2012). Graduates reported the need for more in-depth master’s-
level training on suicide and/or crisis topics, particularly related to in-session
interventions and the hospitalization process (Freadling & Foss-Kelly, 2014; Wozny &
Zinck, 2007). Graduates have recommended that counselor educators and supervisors
utilize a variety of training methods such as activities and guest speakers (Wachter
Morris & Barrio Minton, 2012) and expose students to more complex cases in both
didactic courses and practical experiences such as supervised practica (Freadling & Foss-
Kelly, 2014).

Some programs appear to have made substantive advancements to master’s-level
suicide training (e.g., Barrio Minton & Gibson, 2012). Misalignment between counselor
training efforts (e.g., practicum manuals, textbooks, and course content) and the latest
clinical, ethical/legal, and accreditation guidelines related to suicide supports the need for
systematic change across counselor training. No-suicide contracts are recommended in
some practicum manuals and textbooks (Hodges, 2011; Scott, Boylan, & Jungers, 2013)
even though they are ineffectual, possibly harmful, and legally risky (Edwards &
Sachmann, 2010; Lee & Bartlett, 2005; Rudd, Mandrusiak, & Joiner, 2006). Counselor
training lacks certain suicide content altogether. Results of a national survey of 210
counselor educators revealed that counselors-in-training receive little to no training in
suicide-specific formal assessment instruments (Neukrug, Peterson, Bonner, & Lomas,
2013) even though it is believed that using a standardized instrument and clinical
interview in combination increases suicide assessment accuracy (Bryan & Rudd, 2006; USHHSOSG and NAASP, 2012).

Not all counselors-in-training receive practical training on suicide that allows them to enhance and demonstrate their skills. Raper (2010) found that completion of a crisis course was not correlated with increased suicide intervention skills in counselors-in-training. Some counselor training clinic directors believe that working with suicidal clients is a potentially frightening but essential way for counselors-in-training to develop competence (Hoffman et al., 2013). Other accredited training clinics list suicidal ideation as an inappropriate presenting-problem for clinic services (Lauka et al., 2014). Such extreme screening precludes counselors-in-training from developing and demonstrating suicide risk assessment and management procedures in practicum. It also leaves counseling programs unable to assess knowledge and skills of counselors-in-training within the practicum clinic environment.

Taken in combination, the published literature seems to suggest that the Counselor Education and Supervision field as a whole has struggled to provide master’s-level suicide training in a manner that comprehensively and consistently addresses accreditation and ethical standards and the needs and expectations of students and employers (Barrio Minton & Pease-Carter, 2011; Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Lauka et al., 2014; Neukrug et al., 2013; Raper, 2010; Shaw, 2014; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). There is a clear need for change to master’s-level suicide training. Guidelines within the counseling profession and related professions provide a foundation for change.
Foundation for Change

Developments have occurred within and beyond the Counselor Education and Supervision field that offer a foundation for change to master’s-level suicide training. The 2016 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2015) were released. The American Counseling Association updated its Code of Ethics (2014). Developments in the broader mental health community include: (a) revisions to diagnostic guidelines (American Psychiatric Association, 2013a, 2013b); (b) state laws about suicide training (The Jason Foundation, n.d.); (c) core competencies for working with individuals at risk for suicide (American Association of Suicidology, 2004); and (d) guidelines for training clinical students and professionals about suicide (Clinical Workforce Preparedness Taskforce, 2014). These developments provide an established base for changing master’s-level suicide training.

Accreditation and Ethical Standards

The 2016 Standards (CACREP, 2015) contain several changes in accreditation standards regarding suicide. The 2016 Standards standards expand core curriculum on suicide beyond suicide prevention models to include suicide risk assessment. The 2009 Standards (CACREP, 2009) standards regarding suicide risk assessment were present only for some specialty areas. Students in career counseling programs accredited under the 2009 Standards may not have learned suicide risk assessment skills.

The 2016 Standards (CACREP, 2015) include another relevant change: suicide appears to have been subsumed in this standards revision under the topic of crisis in specialty area standards. Specialty standards for Clinical Mental Health Counseling, Clinical Rehabilitation Counseling, and Marriage, Couples, and Family Counseling include “impact of crisis and trauma” on clients (p. 22; p. 25; p. 29). College Counseling and Student Affairs and School Counseling specialty standards address roles of those professionals related to emergency management, crises, disasters, and trauma (p. 27; p. 31). Standards for core curriculum pertain to “the foundational knowledge required of all entry level counselor education graduates” (p. 8). Specialty area standards pertain to the knowledge and skills students are expected to “demonstrate” (p. 20; p. 22; p. 24; p. 27; p. 31) or “possess” (p. 18; p. 29). Students in almost all specialty programs accredited under the 2009 Standards (CACREP, 2009) were expected to demonstrate suicide risk assessment and management skills. An implication of this change is that students in programs accredited under the 2016 standards will not necessarily learn or demonstrate skills for assessing and managing suicidal clients in their future work as counselors.

The American Counseling Association Code of Ethics (2014) specifies suicide as a client situation warranting cautious consideration regarding records that may be
requested by a court of law. The current code (2014) contains an added standard:

“Counselors who function as counselor educators and supervisors provide instruction
within their areas of knowledge and competence and provide instruction based on current
information and knowledge available in the profession” (p. 14). Developments within the
Counselor Education and Supervision field and counseling include these updates to
accreditation and ethical standards. An additional part of the foundation for change to
master’s-level suicide training comes from the broader community.

**Developments in the Broader Mental Health Community**

Developments beyond the Counselor Education and Supervision field and
counseling profession may inform the content and method of master’s-level suicide
training. Revisions in the Diagnostic and Statistical Manual of Mental Disorders, Fifth
Edition (American Psychiatric Association, 2013a) provided clarity on suicide ideation
and behavior in client presentations through cross-cutting measures that include suicide
risk assessment items and an expanded decision tree for suicidal ideation or behavior
(American Psychiatric Association, 2013b). Several states made suicide training
mandatory for school personnel (Jason Foundation, n.d.), a development impacting
counselor training. The American Association of Suicidology (2004) defined a set of core
competencies for working with individuals at risk for suicide. The National Action
Alliance for Suicide Prevention Clinical Workforce Preparedness Taskforce (2014)
developed training guidelines for educational institutions, continuing education, and
certification and licensure bodies.
Counselor training programs must ensure that they adequately provide master’s-level suicide training in order to align with accreditation standards and prepare ethical counselors. The aforementioned developments inform improving master’s-level suicide training through updated and effective content and preparation methods. Substantive changes, however, are unlikely to be successful without addressing how ready the Counselor Education and Supervision field is to change (Armenakis et al., 1993; Edwards et al., 2000; Holt et al., 2007). The readiness of the field to address these developments in master’s-level suicide training has not been fully investigated.

**Readiness for Change**

Readiness for change is a multifaceted construct typically considered a precursor to change (Armenakis et al., 1993; Chilenski, Greenberg, & Feinberg, 2007; Holt et al., 2007; Weiner, 2009). An organization is considered ready for change when members are committed to making change occur, when they believe change is possible, when they feel important and relevant to the change, and when the necessary resources are available for change (Weiner, 2009). The readiness for change paradigm has been used in multiple industries (Chilenski, Greenberg, & Feinberg, 2007), including behavioral health (Farro, Clark, & Hopkins Eyles, 2011) and substance abuse treatment (Lehman, Greener, & Simpson, 2002).

Readiness assessments can expose gaps between change expectations of individual members in a community (Holt et al., 2007). If there is “no action taken to close those gaps, resistance would be expected, and therefore, change implementation would be threatened” (p. 233). Evaluating readiness “can reveal the need to intensify efforts, use additional strategies to create readiness, and offer insights into how readiness
messages might be modified” (Armenakis, Harris, & Mossholder, 1993, p. 692). Some communities that have attempted change without first determining readiness have failed to achieve their intended goals, sometimes wasting much time and money in the process (Holt et al., 2007).

A readiness for change model that can transfer to the Counselor Education and Supervision context and the issue of suicide in master’s-level training seems essential. Programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) vary greatly regarding master’s-level suicide training (Barrio Minton & Pease-Carter, 2011; Lauka et al., 2014; Wachter Morris & Barrio Minton, 2012). “The CACREP Standards, despite the number and specificity of standards, yield many different program canvases” (Urofsky, 2013, p. 13). It is possible that some counselor training programs failed to improve master’s-level suicide training, while others may have experienced success. Programs may be at different phases of implementing master’s-level suicide training, and Counselor Education and Supervision community members may have different perspectives on how to incorporate recent ethical and other developments into counselor training. Therefore, it is important to identify a readiness for change model that is flexible in nature.

**Community Readiness Model**

The Community Readiness Model (http://triethniccenter.colostate.edu/communityReadiness_home.htm) serves as a theoretical framework in this study. The Community Readiness Model has been used to assess readiness of a variety of geographic, cultural, and organizational communities to address diverse issues such as suicide (Allen, Mohatt, Fok, Henry, & People Awakening Team, 2009), substance abuse
(Travis, Learman, Brooks, Merrill, & Spence, 2012), and trauma (Farro et al., 2011). The Community Readiness Model was developed in response to unsuccessful and/or inconsistent implementations of prevention efforts within and across communities (Oetting et al., 1995). The Community Readiness Model is versatile in that it can be used in communities with few current efforts and in those with ongoing efforts that may benefit from evaluation and redirection (Oetting et al., 1995). The result is a theoretically grounded model for proactively assessing readiness of a community to accept such efforts, based on community norms in several dimensions: knowledge of the issue, leadership, existing efforts and the community’s knowledge of efforts, community climate, and resources. The relevance of these dimensions to the Counselor Education and Supervision community and the issue of suicide are introduced below.

**Knowledge of issue dimension.** Knowledge of the issue relates to what information a community has about a specified issue – the type, comprehensiveness, correctness, and access to such information (Oetting et al., 1995; Tri-Ethnic Center for Prevention Research, 2014). Accreditation standards address knowledge of suicide, as do suicide training guidelines and, less explicitly, ethical guidelines for the counseling profession. The Council for Accreditation of Counseling and Related Educational Programs Standards (CACREP, 2009, 2015) outline foundational knowledge in eight common core curriculum areas. Both sets of standards include suicide knowledge in core curriculum. The 2009 Standards (CACREP, 2009) contained knowledge of suicide prevention models (II.G.5.g), and the 2016 Standards (CACREP, 2015) contain knowledge of suicide prevention models and strategies (2.F.5.l) and suicide risk assessment procedures (2.F.7.c). The National Action Alliance for Suicide Prevention’s
Clinical Workforce Preparedness Task Force (2014) shares a similar objective of ensuring that clinical training programs provide a “solid base foundation of knowledge necessary to serve individuals at suicide risk and their families” (p. 6).

Knowledge and related competence among educators and supervisors providing master’s-level suicide training is an ethical imperative (American Counseling Association, 2014). Instruction must be “based on current information and knowledge available in the profession” (p. 14). The guidelines from the Clinical Workforce Preparedness Task Force (2014) echo the need for individuals who provide suicide training to have demonstrated qualifications within the scope of practice: experience relevant to the subject and target audience.

Counseling professionals and counselors-in-training may have gaps in knowledge about suicide risk assessment and intervention (King & Smith, 2000; Wozny as cited in Wozny & Zinck, 2007). “It is likely that new and veteran counselor educators also lack preparation for crisis prevention, intervention, postvention, and education” (Wachter Morris & Barrio Minton, 2012, p. 265). No published research has investigated the knowledge that counselor educators and supervisors have of suicide. Assessment of the knowledge of suicide among Counselor Education and Supervision community members seems an important element to include in a study of the field’s readiness to provide master’s-level suicide training.

**Leadership dimension.** The Community Readiness Model defines leaders as “those who have influence in the community and/or who lead the community in helping it achieve its goals” (Tri-Ethnic Center for Prevention Research, 2014). The model conceptualizes the leadership dimension as leaders’ attitude and support toward the issue
and efforts to address it. Several types of formal leaders exist in Counselor Education and Supervision. Leaders in the field provide guidance on requirements for accredited programs (Council for Accreditation of Counseling and Related Educational Programs, 2009, 2015) and best practices in counselor preparation (Association for Counselor Education and Supervision, 2011). Leaders may offer organizational support for endeavors such as interest networks and taskforces (Association for Counselor Education and Supervision, n.d.-b). Journal editors influence what is published in the field on suicide and master’s-level suicide training.

Administrative and curricular leadership also exists at the level of each accredited program (Council for Accreditation of Counseling and Related Educational Programs, 2009, p. 7). Directors and other management may act as leadership at practicum/internship sites. The scant research in this area has focused on training clinic directors. Hoffman et al. (2013) found that clinic directors viewed suicide as a challenging but important topic to address in counselor training and master’s-level suicide training as a priority needing increased and systematic attention. Some counseling training clinic directors seem to disagree on the appropriateness of client suicide risk as part of the scope of clinic services (Hoffman et al., 2013; Lauka et al., 2014). Viewpoints from other local leadership, such as department chairs and program coordinators within counseling programs and managers at off-campus supervision sites, have not been studied.

In addition to formal or appointed leaders, the Community Readiness Model includes influential members of the community in the leadership dimension (Plested, Jumper-Thurman, Edwards, & Oetting, 1998). These “opinion leaders” (Rogers, 2010, p.
within the Counselor Education and Supervision field are important to consider regarding change initiatives (Ratts & Wood, 2011). For example, Counselor Education and Supervision opinion leaders on suicide and suicide training have outlined strategies for suicide intervention in counseling (Granello, 2010a; Juhnke, Juhnke, & Hsieh, 2012) and offered models for suicide supervision (Hoffman et al., 2013; McGlothlin, Rainey, & Kindsvatter, 2005). What is unknown is how counselor educators and supervisors perceive leadership’s attitude and support toward suicide and related efforts. The inclusion of the sociopolitical nature of communities in the Community Readiness Model’s focus and assessment (Oetting et al., 1995) make the model suitable for an investigation of Counselor Education and Supervision’s readiness to provide master’s-level suicide training.

**Efforts and knowledge of efforts dimensions.** The Community Readiness Model refers to programs, services, and other initiatives to address the issue as efforts (Plested et al., 1998). It seems important to understand what efforts are being implemented in Counselor Education and Supervision to provide master’s-level suicide training. Information relevant to this dimension includes existence of efforts and longevity and descriptions of their scope, goals, target audiences, and access in the community along with how community members learn about the efforts, perceive their strengths and weaknesses, and incorporate any evaluation results to adapt ongoing or new efforts (Oetting et al., 1995; Plested, Jumper-Thurman, & Edwards, 2006).

Examples of existing efforts described in the published literature include suicide-specific models of education (Miller, McGlothlin, & West, 2013) and supervision of counselors-in-training (Hoffman et al., 2013; McGlothlin et al., 2005), stand-alone
courses (Wozny, 2005) and workshops (Wozny & Zinck, 2007), and the use of an infusion approach that distributes crisis content throughout the curriculum (Wachter Morris & Barrio Minton, 2012). The descriptions of these efforts often lack detail. Published evaluations of these efforts has been limited to self-report data of students’ and graduates’ perceptions (Freadling & Foss-Kelly, 2014; Wozny & Zinck, 2007). Very little evaluation has included counselor educators’ and supervisors’ perspectives about specific efforts or on how evaluation results are used to inform new or continuing efforts. It is also unknown how much counselor educators and supervisors know about efforts by others in the field and how they access such information. Understanding what Counselor Education and Supervision members view as the strengths and weaknesses of master’s-level suicide training could inform a targeted action plan for changing master’s-level suicide training. Learning how much counselor educators and supervisors know and how they access information about master’s-level suicide training efforts could identify knowledge and communication gaps to address for improving the field’s readiness to change master’s-level suicide training.

Accredited counseling programs contain faculty and staff who may teach, supervise, research, administrate, and conduct service, including adjunct, affiliate, or clinical professionals (Council for Accreditation of Counseling and Related Educational Programs, 2009). Site supervisors in the field are also affiliated with accredited programs. Thus, Counselor Education and Supervision is a field that spans academia, practice, and research sectors. The Community Readiness Model is a pertinent framework in that it acknowledges the intertwined dimensions of efforts and the community’s knowledge of them. This seems particularly necessary since evaluation and related information about
master’s-level suicide training efforts may not be available in academic literature alone (Barrio Minton, Wachter Morris, & Yaites, 2014).

**Climate dimension.** The Community Readiness Model dimension of community climate relates to the community’s attitude toward the issue, support and perceived need for efforts, and obstacles for addressing the issue (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999). Current climate is a salient dimension to consider regarding the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training and is already a concern among some in the field. For instance, according to clinic directors in training, one reason suicide was not addressed in counselor curriculum was an attitude in the field that suicide is a “taboo” topic (Hoffman et al., 2013). Some authors have briefly mentioned the crowded counselor training curriculum (Wozny & Zinck, 2007) and a lack of crisis preparation among counselor educators and supervisors (Wachter Morris & Barrio Minton, 2012) as barriers to master’s-level suicide training.

No researchers have focused directly on the field’s attitude toward suicide and related master’s-level training, on obstacles Counselor Education and Supervision members face for providing master’s-level suicide training, nor on how members of the field have successfully overcome such obstacles or utilized available community support for master’s-level suicide training efforts. The climate in the field toward suicide and master’s-level suicide training efforts is generally unclear. The Community Readiness Model allows the conceptualization of barriers alongside that of support and perceived need as indicators of climate within a comprehensive assessment of readiness.
**Resources dimension.** The final Community Readiness Model dimension addresses resources available to the community to support efforts to address the issue (Edwards et al., 2000; Oetting et al., 1995). Examples of resources include funding and time, space, and expert and support staff (Plested et al., 1998; Tri-Ethnic Center for Prevention Research, 2014). This dimension also includes assessment of any proposals or action plans to find such resources (Plested, Jumper-Thurman, & Edwards, 2009). Some Counselor Education and Supervision literature about master’s-level suicide and crisis training efforts refers counselor educators and supervisors to information sources, such as frameworks for assessing and implementing counselor education efforts (Barrio Minton & Gibson, 2012; Wachter Morris & Barrio Minton, 2012) and suicide and crisis information and training for supervisor and faculty development (Wachter Morris & Barrio Minton, 2012).

It is important to identify the necessary logistical resources – time, money, and staffing – to apply such information to new and existing efforts. For instance, crisis and suicide research by counselor educators has been funded through grants from the Association for Counselor Education and Supervision and its regions (e.g., Wachter Morris & Barrio Minton, 2012; Wozny & Zinck, 2007). Release time and graduate assistance has been suggested for faculty managing evaluations of suicide/crisis and other student learning outcomes (Barrio Minton & Gibson, 2012). Funding available and used for master’s-level suicide training efforts that do not containing a research or program evaluation component is less clear. The Community Readiness Model provides a useful framework for examining financial and other resources the Counselor Education and
Supervision community can use to support implementation of master’s-level suicide training efforts.

The magnitude of the suicide issue, current accreditation requirements, and revised ethical, legal, and diagnostic obligations, along with demands and guidelines for improvements to mental health suicide training make a concerted focus on master’s-level suicide training important and timely. To adequately provide such training, it seems necessary to understand what support, resources, and knowledge the Counselor Education and Supervision field may have and not yet have available. A study of counselor educators and supervisors that employs the Community Readiness Model and Consensual Qualitative Research methodology is proposed to assess and explore readiness to provide master’s-level suicide training. It is anticipated the findings of the research will aid the Counselor Education and Supervision community in developing informed action plans for improving master’s-level suicide training.

Statement of the Problem

The content and method of adequate suicide training is well-established, including suicide risk assessment and management competencies (American Association of Suicidology, 2004) and Preparedness guidelines for training on suicide prevention, first aid and risk assessment, intervention, and continuity of care (Clinical Workforce Preparedness Task Force, 2014). The Counselor Education and Supervision field has struggled to consistently provide master’s-level suicide training that enhances suicide knowledge and skills and aligns with expectations from students, graduates, employers, and the broader community (Barrio Minton & Pease-Carter, 2011; Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Lauka et al., 2014; Neukrug et al., 2013; Raper, 2010;
Shaw, 2014; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). Counselor training programs must ensure that they adequately provide master’s-level suicide training in order to align with accreditation standards and to prepare ethical counselors. However, Counselor Education and Supervision’s readiness to provide master’s-level suicide training has never been assessed. Assessing and exploring the field’s readiness to provide master’s-level suicide training may provide insight into the discrepancy between established content and methods of suicide training and the current state of master’s-level suicide training.

Some in the Counselor Education and Supervision community may have successfully implemented changes to master’s-level suicide training that address the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009). For instance, one program reportedly infuses crisis content throughout several courses (Wachter Morris & Barrio Minton, 2012) and utilizes a rubric for students’ demonstration of suicide assessment skills (Barrio Minton & Gibson, 2012). It is unclear from this scant literature on crisis curriculum and student learning outcome evaluations what dimensions of readiness (e.g., leadership, climate, and resources) may have supported this program’s changes. The literature also does not provide many details about the efforts to provide master’s-level suicide and crisis training, such as instructional methods and evaluated strengths and weaknesses. Detailed findings can inform planning and implementation of improved master’s-level suicide training.

Counselor educators, supervisors, and program-level administrators are tasked with providing master’s-level suicide training and are positioned to influence its improvement. Some research has included their descriptive information of master’s-level
suicide and/or crisis training efforts (e.g., Barrio Minton & Pease-Carter, 2011) and/or revealed some of their perspectives on the status of suicide and/or crisis training (e.g., Hoffman et al., 2013). No studies have involved the perspectives of full-time and adjunct instructors, university and site supervisors, and program administrators on Counselor Education and Supervision’s readiness to provide master’s-level suicide training.

Counselor Education and Supervision must provide master’s-level suicide training in order to align with accreditation standards. Recent developments, such as a new code of ethics and state laws and the release of the latest diagnostic manual, suicide core competencies, and suicide training guidelines, necessitate further change to master’s-level suicide training. The stage and nature of the field’s readiness to provide such training remains unclear. Understanding the stage of the field’s readiness and themes related to the field’s efforts, knowledge, leadership, climate, and resources is important for improving master’s-level suicide training so that it addresses accreditation standards and recent ethical and legal, diagnostic, and training developments.

**Purpose of the Study and Research Questions**

There are two purposes for this study. The first is to assess the Counselor Education and Supervision field’s current stage of readiness to provide master’s-level suicide training. The second is to identify themes related to the field’s knowledge of suicide, leadership, training efforts, the field’s knowledge of those efforts, climate, and resources. The Community Readiness Model is the theoretical framework that guides this study. A Consensual Qualitative Research methodology, informed by a combination of constructionism and post-positivism, will be used to determine and describe the readiness of Counselor Education and Supervision to provide master’s-level suicide training in
accredited master’s in counseling programs. The following two research questions align with the purposes of the study:

Q1 What is the overall stage of Counselor Education and Supervision's readiness to provide master's-level suicide training and the readiness stages of the field's knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

Q2 What are the themes of the field’s readiness to provide master’s-level suicide training regarding the field’s knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

Research is needed that illuminates the readiness stage and nature of Counselor Education and Supervision to provide master’s-level suicide training. The Community Readiness Model provides guidance to determine readiness stage and explore readiness dimensions. Researchers have similarly applied change models to advance graduate health education, such as diffusion of innovation theory (Rogers, 1962, 2010) applied to the counseling research-practice gap (Murray, 2009) and the integration of social justice into counselor training (Ratts & Wood, 2011). Others have applied readiness for change frameworks to accreditation implementation, evaluation, and curriculum redesign in social work education (Nissen, 2014) and curriculum redesign in medical education (Jippes et al., 2013).

The population for this study is defined as counselor educators, supervisors, and administrators affiliated with accredited counseling programs, hereafter referred to as Counselor Education and Supervision members. This sub-set of the Counselor Education and Supervision community was identified because these members of the field are in a position to provide master’s-level suicide training and/or directly impact master’s-level
suicide training efforts, and yet their perspectives remain largely unrepresented in the empirical literature on this topic.

A random sample of members selected using explicit criteria will participate in phone interviews. The interviews will focus on their perspectives of the field’s readiness to provide master’s-level suicide training related to the Community Readiness Model readiness dimensions. A research team of four – one primary researcher, one external auditor, and two co-researchers – will follow Consensual Qualitative Research methodology (Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997) and the proposed methods to analyze the interview data. The analysis will result in an overall stage of readiness for the Counselor Education and Supervision field, stages of readiness for each dimension of readiness, and themes of readiness related to each dimension of community readiness.

Significance of the Study

This study is significant and timely because it serves to (a) fill gaps in the counselor preparation literature; (b) provide a proactive assessment of the Counselor Education and Supervision field’s readiness to implement recent accreditation and ethical standards; and (c) inform potential curriculum redesign and related program and field-wide changes to address expectations for master’s-level suicide training. Readiness assessment is considered an important preliminary step in the change process (Armenakis et al., 1993) and one that can inform successful implementation and mitigate resistance (Armenakis et al., 1993; Edwards et al., 2000; Holt et al., 2007). Counseling graduates and Counselor Education and Supervision members have called for improvement to master’s-level suicide training for over a decade (Allen et al., 2002; Dupre et al., 2014;
King, Price, Telljohann, & Wahl, 2000; Wachter 2006 in Wachter Morris & Barrio Minton, 2012; Wozny & Zinck, 2007; Wozny, 2005). These calls within the profession are echoed in the calls for change to pre-professional training across all mental health fields (Schmitz et al., 2012; U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012; U.S. Department of Health and Human Services, 2001). Developments in accreditation standards, the ethical code, diagnosis, federal and state policy, and suicide training guidelines have occurred over the last eight years, some as recently as this year. Thus, there is need for change and a foundation for change to occur.

An answer to research question 1 – What is the overall stage of the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training and the readiness stages of the field's knowledge of suicide, leadership, training efforts, knowledge of efforts, community climate, and resources? – should provide the field with a scaled gauge of its readiness to make changes to master’s-level suicide training. This information would contribute to filling gaps in the literature about competency-based suicide training aimed at skill development and the lack of published evaluation about the organizational contexts in which suicide training is situated (Osteen, Frey, & Ko, 2014). Authors and participants have named potential obstacles to improving pre-professional suicide training such as lack of knowledge about how to provide suicide training (Ruth, Gianino, Muroff, McLaughlin, & Feldman, 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); stigma regarding the issue of suicide (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). Members of the Counselor Education and Supervision community can use the study’s findings on the dimensional stages of the field’s readiness to prioritize efforts to improve readiness based on identified readiness gaps.

Research question 2 involves the themes of the field’s readiness to provide master’s-level suicide training regarding the Community Readiness Model dimensions of knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources. Answers to this question should fill several gaps in the literature. Research that demonstrates how master’s-level training on crisis (Wachter Morris & Barrio Minton, 2012), ethics, and assessment (Barrio Minton et al., 2014) align with accreditation standards is largely absent from the literature. This study elicits information about master’s-level suicide training efforts that may already be happening but are not yet shared through academic publications or in the public domain. Study participants may refer to completed program evaluations and thus contribute knowledge about suicide and master’s-level suicide training efforts that has remained unpublished, including that which identifies ways to successfully overcome obstacles. This information could be used by the members of the Counselor Education and Supervision field and programs to update content and methods of training and develop action plans for broader improvement to master’s-level suicide training.

**Definition of Key Terms**

*Community readiness* is defined as “the degree to which a community is willing and prepared to take action on an issue” (Tri-Ethnic Center for Prevention Research, 2014).
Counselor Education and Supervision field is defined as the profession focused on counselor training. For the purposes of this study, it is comprised of professionals affiliated with one or more counselor training program who provide education, supervision, and/or administration of counselors-in-training as well as those who research and/or guide the work of the profession (e.g., editorial boards and accreditation bodies).

Master’s-level suicide training is defined as the education and supervision provided to counseling students and interns to prepare them for post-graduate work in counseling. This study’s focus is limited to master’s-level training provided in programs accredited by the Council for Accreditation of Counseling and Related Educational Programs, as accredited programs share a minimum training standard set by the counseling profession.

Suicide is defined as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior” (Crosby, Ortega, & Melanson, 2011, p. 23). Phrases in this study like “the issue of suicide” or “master’s-level suicide training” are intended to broadly encompass training content related to suicide prevention, intervention, and postvention in counseling work.

Suicide intervention is defined as “a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition” related to suicide (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention [USHHSOSG and NAASP], 2012).

Suicide postvention is defined as “response to and care for individuals affected in the aftermath of a suicide attempt or suicide death” (USHHSOSG and NAASP, 2012, p. 141).
Suicide prevention is defined as “a strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors” related to suicide (USHHSOSG and NAASP, 2012, p. 141).

Delimitations

The purposes of this study are to assess and explore the readiness of Counselor Education and Supervision to provide master’s-level suicide training. Limitations on the population and constructs are necessary to define the scope of this study. The focus of the study is master’s-level training by accredited programs in the United States due to the role of accreditation standards and the potential impact of accreditation on master’s-level suicide training. The Council for Accreditation of Counseling and Educational Programs sets out minimal requirements for counselor training.

Suicide. The construct of suicide is limited to suicidal ideation, defined as “thinking about, considering, or planning for suicide” (Crosby et al., 2011, p. 11) and suicidal behavior included in suicidal self-directed violence (self-directed violence). Suicidal self-directed violence is “behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.” (Crosby et al., 2011, p. 21). Suicidal self-directed violence includes behavior that is fatal, as well as suicide attempts and other suicidal behavior such as preparatory acts (Crosby et al., 2011, p. 22). It is important to acknowledge the interconnectedness of non-suicidal self-injury and suicide (Crosby et al., 2011; Hjelmeland et al., 2002). However, it is not an explicit purpose of this study to determine
how the Counselor Education and Supervision field approaches or is prepared to approach master’s-level training on non-suicidal self-directed violence.

*Hastened death.* Another area of ethical counseling practice is end-of-life services for terminally ill clients considering hastened death (American Counseling Association, 2014). *Physician-assisted death, hastened death,* and other terms are considered more accurate and less biased than *physician-assisted suicide* (Death with Dignity National Center, n.d.; Kurt & Piazza, 2012). Master’s-level suicide training may briefly include clarification of the differences between suicide and hastened death as an end of life consideration for terminally ill individuals. However, it is not an explicit purpose of this study to determine how the Counselor Education and Supervision field approaches or is prepared to approach master’s-level training on end of life options such as physician-assisted death. Thus, the literature review and methodology will refer to suicidal behavior and ideation and related training.

*Master’s-level suicide training.* The implications of this study are intended to inform the training of master’s-level counselors-in-training to address client suicide risk in their future work as counselors. Two issues regarding suicide that impact Counselor Education and Supervision are outside of the scope of this study: (a) risk and management of suicide in counselors-in-training and counselor educators and supervisors, and (b) post-master’s education and supervision on suicide. These issues are beyond the focus of this study – master’s-level suicide training – and are not addressed within accreditation standards.
Summary

A comprehensive study on the readiness of the Counselor Education and Supervision field to provide master’s-level suicide training is needed to inform successful change in training that responds to newly released accreditation and ethical standards and the needs of students, employers, and the broader community. The Community Readiness Model (Oetting et al., 1995) is a thorough readiness-for-change framework for understanding the readiness of an identified community to address an identified issue (Oetting et al., 1995; Plested et al., 2006). Applying the Community Readiness Model to this study should extend the literature beyond a few discrete aspects of readiness and provide a full picture of Counselor Education and Supervision’s stage and nature of readiness to provide master’s-level suicide training. An understanding of the field’s stage and nature of readiness to provide master’s-level suicide training can inform the field about readiness gaps to prioritize when planning sustainable change and ways the field may successfully overcome obstacles to providing master’s-level suicide training aligned with accreditation and ethical standards.

The proposal contains three chapters. Chapter I served to introduce the Community Readiness Model as a theoretical framework for the study and explain the need for change, foundation for change, statement of the problem, purposes and research questions, and significance of the study. The chapter concluded with definitions of key terms and delimitations. Chapter II contains a comprehensive review of literature relevant to the Community Readiness Model dimensions applied to Counselor Education and Supervision and master’s-level suicide training. Chapter III serves to outline the methodology including the (a) philosophical paradigms, (b) application of Consensual
Qualitative Research, and the (c) methods pertaining to participants, data collection and analysis, and trustworthiness. Chapter IV serves to present the results of the study including the (a) participants; (b) domains, categories, and subcategories; and (c) Community Readiness Model scores. Chapter V contains a discussion of the findings, implications, limitations, and directions for future research.
CHAPTER II

LITERATURE REVIEW

The Counselor Education and Supervision field needs to change master’s-level suicide training for several reasons. New releases in accreditation and ethical standards require accredited programs update their delivery of counselor training. Ethical standards include alignment with “current information and knowledge available in the profession" (American Counseling Association, 2014, p. 14) such as recent developments in legal, diagnostic, and training guidelines. The broader mental health community and national organizations have called for Counselor Education and Supervision and other pre-professional training fields to improve pre-professional training on suicide.

Previous and current accreditation standards from the Council for Accreditation of Counseling and Related Educational Programs (CACREP) include requirements that master’s-level training address suicide. The 2001 Standards (CACREP, 2001) placed suicide content in gerontology and school counseling requirements. The 2009 Standards (CACREP, 2009) followed and include requirements that all students know suicide prevention models and students in almost all specializations demonstrate suicide risk assessment and management skills. The current 2016 Standards (CACREP, 2015) include
requirements that accredited programs cover suicide prevention models and strategies and suicide risk assessment procedures in core curriculum.

Updated counseling ethics and national diagnostic standards impact master’s-level suicide training. The revised American Counseling Association Code of Ethics (2014a) contains expanded guidelines regarding counselor educator and supervisor competence and use of updated information in instruction and a mention of suicide as an issue warranting additional consideration about client documentation storage. The latest Diagnostic and Statistical Manual of Mental Health Disorders (American Psychiatric Association, 2013) includes suicide risk assessment in its cross-cutting measures. It also includes an expanded decision tree for suicidal ideation and behavior (American Psychiatric Association, 2013b).

Recent developments in state law and sanctioned competencies and training guidelines also impact master’s-level suicide training. The Jason Flatt Act requires mandatory youth suicide awareness and prevention training for school personnel in 16 states (Jason Foundation, n.d.). This development particularly impacts school counselor educators and supervisors. Other recent developments impacting master’s-level suicide training include the release of suicide risk assessment, intervention, and management competencies (American Association of Suicidology, 2004) and related training guidelines for mental health graduate programs and continuing education providers (Clinical Workforce Preparedness Task Force, 2014).

Pre-professional suicide training is considered lacking across mental health fields (Schmitz et al., 2012), including counselor training (Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Shaw, 2014; Wachter Morris & Barrio Minton, 2012). Master’s-
level suicide training has not corresponded with sustained suicide knowledge (King et al., 2000), suicide intervention skills (Raper, 2010), or self-efficacy for crisis response (Wachtter Morris & Barrio Minton, 2012). Master’s-level suicide training may lack formal assessment content (Neukrug et al., 2013) and practical learning opportunities (Lauka et al., 2014) for counselors-in-training to develop competence to work with suicidal clients. Previous master’s-level suicide training did not fully address the expectations of students, graduates, employers, and counselor educators and supervisors themselves (Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Shaw, 2014; Wachtter Morris & Barrio Minton, 2012; Wozny & Zinck, 2007).

Accredited programs need to provide master’s-level suicide training to maintain accreditation and to prepare counselors-in-training for ethical practice. Counselor educators and supervisors have an ethical obligation to instruct counselors-in-training “within their areas of knowledge and competence and provide instruction based on current information and knowledge available in the field” (American Counseling Association Code of Ethics F.7.b., p. 14). The readiness of the Counselor Education and Supervision field to provide master’s-level suicide training is unknown. Without determining the field’s readiness to provide master’s-level suicide training, it is possible efforts will fail to accomplish desired outcomes (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). An assessment and exploration of the field’s readiness to provide master’s-level suicide training seems a crucial and timely endeavor in light of recent developments in accreditation, ethics, law, diagnosis, and training guidelines.

The purposes of this study are to assess the Counselor Education and Supervision field’s current stage of readiness to provide master’s-level suicide training and to identify
themes of readiness pertaining to the field’s knowledge of suicide, leadership, efforts, the field’s knowledge of those efforts, climate, and resources. Findings may guide the Counselor Education and Supervision field in action planning regarding master’s-level suicide training. Community readiness theory and research and the literature on suicide and master’s-level suicide training informed the design of this study. The Community Readiness Model is described in this chapter, along with a review of the literature on suicide and related pre-professional training in Counselor Education and Supervision and the broader community. This information serves to provide a rationale for a study of this significance.

**Readiness for Change**

Understanding the readiness of the Counselor Education and Supervision field to provide master’s-level suicide training seems an important step to improving counselor training. This section begins with an overview of the readiness for change paradigm and its varied application and an explanation of community readiness theory. Subsequent paragraphs identify the broader communities that surround the Counselor Education and Supervision community and describe the field as a community. This review serves to acknowledge the complex systems that impact master’s-level suicide training and to justify the application of a readiness for change paradigm and community readiness theory to a study on master’s-level suicide training.

Readiness for change is a multifaceted paradigm (Chilenski et al., 2007) that has been applied in a variety of communities and at various levels of an organization: individual, groups, and whole (Weiner, 2009). An organization ready for change has available resources, and members who are dedicated to change view change as possible
and themselves as significant in the change (Weiner, 2009). Indicators may include effective community leadership and the community’s history of involvement (Feinberg, Greenberg, Osgood, Anderson, & Babinski, 2002) as well as psychosocial characteristics such as ownership of the issue (Murphy-Berman, Schnoes, & Chambers, 2000).

The readiness for change paradigm has been applied to a variety of industries, including manufacturing (Cole, Harris, & Bernerth, 2006), information technology (Armenakis & Harris, 2002), behavioral health (Farro et al., 2011), and substance abuse treatment (Lehman et al., 2002). Recently, readiness for change has also been applied to education, including school-wide prevention programs (Oterkiil & Ertesvag, 2012), social work education (Nissen, 2014), and medical education (Jippes et al., 2013). Nissen (2014) posited a readiness for change framework may be beneficial for social work educators seeking to implement accreditation standards, especially for altering assessments of student practice behaviors, competency-based redevelopment of coursework, and deeper curriculum changes in the midst of lower budgets and higher demands for faculty.

One readiness for change theory is community readiness. The next section includes a description of community readiness theory and the broader community in which the Counselor Education and Supervision field resides. The broader context surrounding the field deserves acknowledgement in keeping with the systemic perspective of the theory.

**Community Readiness**

Community readiness theory highlights the context of a community system (Oetting et al., 1995). Backer (2000) contends that community readiness involves
acknowledging and responding to the community’s fears and “blind spots” as important steps in “addressing the complex human dynamics of change” (p. 367). Applied psychosocial concepts include shared experiences (Feinberg et al., 2002) and the placement of responsibility for addressing an issue (Murphy-Berman et al., 2000).

Being mindful of the community context within which the Counselor Education and Supervision field resides seems critical during a study on readiness to provide master’s-level suicide training. Counselor educators and supervisors and the accredited programs with which they are affiliated are responsible for addressing standards to maintain accreditation, and, in doing so, for aligning counselor training with ethical and legal standards as well as “current knowledge and projected needs concerning counseling practice in a multicultural and pluralistic society” (Council for Accreditation of Counseling and Related Educational Programs, 2009, p. 9). The broader social, educational, and political issues impact the Counselor Education and Supervision community through accreditation standards (Urofsky, 2013). For instance, social work faculty (Ruth et al., 2012) and counselor educators and supervisors (Hoffman et al., 2013) experience the social stigma around suicide as a barrier to pre-professional suicide training.

A study of the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training requires perspectives that acknowledge the sociopolitical and attitudinal factors that can impact a community. Positioning the CES field within its ecological system provides context for these factors and community’s need to be ready to provide master’s-level suicide training. The next section includes a description of the
systems within which the CES community resides. The history and current status of the CES field provides an understanding of CES as a community.

The broader community. It is important to situate the Counselor Education and Supervision community within a systemic framework to understand how master’s-level suicide training may be influenced by the broader community. Applying Bronfenbrenner’s (1977) social ecological model, one can acknowledge that a counseling program accredited by the Council for Accreditation of Counseling and Related Educational Programs serves as the microsystem with which an individual counselor educator or supervisor directly interacts. The Counselor Education and Supervision community is a mesosystem of programs and related leadership such as an accreditation body. The CES community is impacted by the broader exosystem of the mental health field, including the American Counseling Association (e.g., ethical guidance) and the American Psychiatric Association (e.g., diagnostic guidance). The surrounding macrosystem includes state and federal law and other national leadership (e.g., the U.S. Surgeon General National Strategy and resultant guidelines from the National Action Alliance on Suicide Prevention) and the cultural perspectives of the broader community on suicide and other issues.

The Counselor Education and Supervision community. Establishing and defining the Counselor Education and Supervision community provides a necessary background to understand the purpose and focus of Counselor Education and Supervision within the mental health field. A brief discussion of the field follows. Both the history and current state of Counselor Education and Supervision are described.
**History of Counselor Education and Supervision.** Considering the history of the Counselor Education and Supervision field is important because it provides a developmental background on the community of focus and its current readiness to provide master’s-level suicide training. An organization called the National Association of Guidance Supervisors began in 1940 (Sheeley, 1977) and accepted counselor trainers at its national meeting in 1944. Counselor trainers became equal members in 1952 when the association became National Association of Guidance Supervisors and Counselor Trainers as a division of the American Personnel and Guidance Association (Elmore, 1985; Sheeley, 1977). In 1961, counselor trainers began to refer to themselves as counselor educators, and local and state guidance supervisors joined with them in revising the National Association of Guidance Supervisors and Counselor Trainers into the organization still known as the Association for Counselor Education and Supervision (Sheeley, 1977). The Association for Counselor Education and Supervision established an academic journal that year: *Counselor Education and Supervision* (White, 1983). Professional members focused on “issues, problems, trends, practices, and research” and “shared a concern for the mutual interdependence of counselor education and supervision at all levels” (Miller, 1961 as cited in Elmore, 1985, p. 411).

**Current Counselor Education and Supervision community.** Since then, the Association for Counselor Education and Supervision diversified its scope due to the expansion of school counseling beyond guidance and the expansion of the counseling profession (Elmore, 1985). The Association for Counselor Education and Supervision (ACES) remains “dedicated to quality education and supervision of counselors in all work settings” (ACES, n.d.-b). Its journal, *Counselor Education and Supervision*, focuses
on “the preparation and supervision of counselors in agency or school settings, in colleges and universities, or at local, state, or federal levels” (ACES, n.d.-b). Other efforts that engage the Counselor Education and Supervision community include related journals (e.g., the Journal of Counselor Preparation), ACES regional organizations, ACES gatherings at the American Counseling Association conference, and an online listserv (CESNET). The field of Counselor Education and Supervision is a community of individuals engaged in supervision, teaching, and clinical training of counselors (Sexton, 1998).

A study of the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training requires a theoretical framework that addresses the complex systems and factors that impact the field. This is one reason the Community Readiness Model was selected as a theoretical framework for the study, along with a social constructionist and post-positivist qualitative paradigm. The qualitative paradigm will be described further in a subsequent section. The Community Readiness Model is detailed next to explicate its appropriate fit for this study.

**Community Readiness Model**

The Community Readiness Model (Oetting et al., 1995) served as the theoretical framework for a study of Counselor Education and Supervision’s readiness to provide master’s-level suicide training. The Community Readiness Model (CRM) originated as a framework to consider readiness for alcohol and drug abuse prevention (Edwards et al., 2000). Researchers have since applied CRM to a variety of issues, including substance abuse (Travis et al., 2012), trauma (Farro et al., 2011), and breast cancer (Lawsin, Borruyo, Edwards, & Bellosy, 2007). Studies have included CRM applied to the issue of
suicide, primarily with American Indian and Alaska Native communities, such as coordinated suicide prevention planning for 11 American Indian tribes in the Pacific Northwest (Portland Area Indian Health Service & Northwest Portland Area Indian Health Board, 2009) and to address suicide and co-occurring alcohol abuse among rural Alaskan native youth (Allen et al., 2009). The Suicide Prevention Resource Center (n.d.) presents CRM as a basic initial step for American Indian and Alaska Native efforts. The Substance Abuse and Mental Health Services Administration provides CRM guidance to such grantees and others for projects related to mental health such as substance use and suicide prevention (Plested et al., 2006; Substance Abuse and Mental Health Services Administration, 2014).

The next section includes a summary of CRM. This provides an introduction to this theoretical framework and demonstrates its fitting application to a study of the Counselor Education and Supervision community. The section includes the theoretical foundations of CRM, the development of the model, and its structure involving stages and dimensions of readiness. The section concludes with an application of CRM to the issue of suicide and the community of Counselor Education and Supervision.

**Theoretical Foundations of the Community Readiness Model**

The Community Readiness Model (CRM) is aimed at community change “while integrating the culture of a community, the existing resources, and the level of readiness” (Plested, Jumper-Thurman, & Edwards, 2009, p. 5). The purpose of applying CRM is to understand a community’s level of readiness so that targeted initiatives can be effective
and sustainable (Edwards et al., 2000). The theoretical foundations of CRM united the literature on psychological change and community development (Oetting et al., 1995).

The Transtheoretical Model or Stages of Change Model of psychological or therapeutic change (Prochaska & DiClemente, 1983; Prochaska & Diclemente, 1984) served as the personal change foundation of CRM (Oetting et al., 1995). The Transtheoretical Model is likely familiar to the counselor education and supervision community (Grencavage & Norcross, 1990; Savolaine & Granello, 2002; Vereen, Hill, Sosa, & Kress, 2014). The Community Readiness Model incorporated the Transtheoretical Model’s concept of staged change and its approach of identifying and applying stage-appropriate strategies to guide change. The characteristics of several of the Transtheoretical Model’s stages (pre-contemplation, contemplation, preparation, action, maintenance, and relapse) are present in CRM stages and described in the Structure section below.

The foundations of CRM (Oetting et al., 1995) also were derived from the community development literature, specifically the process concepts of diffusion of innovations (Rogers, 1962, 1983) and social and community action (Beal, 1964, and Warren, 1978, as cited in Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997). The characteristics of these processes (knowledge, persuasion, decision, implementation, and confirmation) and sub-processes (stimulation of interest, initiation, legitimization, decision to act, and action) are present in CRM stages and described in the Structure section below. It appears stage models for group action have been applied to community studies for a century or more (e.g., Lindeman, 1921).
Counselor educators and supervisors may be less familiar with these community development models than with the Transtheoretical Model and other psychological change processes. However, the combined intrapsychic and systems approach of CRM seems fitting for a study of the Counselor Education and Supervision community. Authors in counseling and counselor education and supervision have stressed the combination of these approaches for several decades (Bradley, 1978; Ponton & Duba, 2009). As Lindeman (1921) asserted, “A portion of these steps in community action are sociological, and some are psychological. There is no apparent means by which the sciences of sociology and of social psychology can be separated in this analysis” (p. 121).

The next section details the development of the Community Readiness Model to provide background for its resultant structure and application to various communities, including the Counselor Education and Supervision field.

**Development of the Community Readiness Model**

The Community Readiness Model outlines nine stages of readiness across five or six dimensions. A critical incident technique (Bitner, Booms, & Mohr, 1994; Flanagan, 1954) guided the development of the initial dimensions and stages (Kelly & Stanley, 2014). Developers of the model used this iterative process to discern dimensions and stages based on community change experts’ written descriptions of critical events involving community attitudes and behaviors they had encountered in their work (Edwards et al., 2000). The developers adopted from industrial psychology an assessment method of behaviorally anchored rating scales (Schwab, Heneman, & DeCotiis, 1975; Smith & Kendall, 1963). Behaviorally anchored rating scales have been applied to the
evaluation of psychotherapist traits (Michaels, 1983) and other employee performance measurements (Kingstrom & Bass, 1981). Expert raters developed dimensions, stages, and anchor statements on the rating scales using a process to ensure discriminant validation in which each rater placed shuffled anchor statements along a continuum and on any dimension (Edwards et al., 2000). Refinement continued via consensus discussion until reliable placement among raters was accomplished for each statement. Continued application with diverse communities allowed continued revision of the Community Readiness Model to include nine stages and five or six dimensions: Efforts and Knowledge of Efforts are sometimes combined into one dimension. Developers of the model reported 92% agreement between independent raters across 120 interviews and concluded the anchored rating scales were effective for scoring readiness (Plested et al., 2009).

**Structure of the Community Readiness Model**

The structure of the Community Readiness Model (CRM) involves stages and dimensions supported by anchored rating scales and scoring sheets. Developers of CRM and researchers have adapted the structures over time (Edwards et al., 2000; York & Hahn, 2007). This section includes a review of the stages and dimensions of CRM to explain how the CRM structure and evaluations of its application informed the design of this study.

**Stages of readiness.** The earliest conceptualization of a community readiness framework based solely on Prochaska and DiClemente's (1983) Transtheoretical Model of psychological change model quickly appeared to lack dimensional complexity and
broad scope of readiness stages needed for application to a community (Edwards et al., 2000). The model resulting from the critical incident and behaviorally ancored rating scales development with community experts includes stages that incorporate the Transtheoretical Model, diffusion of innovation concepts (Rogers, 1962, 1983) and social action processes (Beal, 1964; Warren, 1978 as cited in Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997). Developers of the Community Readiness Model incorporated community feedback and added the first stage: “before denial where the problem is so pervasive, it has become a way of life” (Edwards et al., 2000). The Community Readiness Model utilizes nine stages of awareness: no awareness, denial/resistance, vague awareness, preplanning, preparation, initiation, stabilization, confirmation/expansion, and high level of community ownership.

The assumptions of the Community Readiness Model include: 1) communities differ in their stages of readiness, 2) the readiness stage of a community can be assessed, 3) change in stages can occur, and 4) stage identification can inform stage-specific interventions and result in progressive movement to the next stage (Edwards et al., 2000). Some evidence supports these assertions. Rural minority communities have been assessed at lower stages of readiness for drug use prevention than their Anglo counterparts (Plested et al., 1999); African American and Anglo communities were found more ready than others for HIV prevention; and a Native American group landed at a higher stage than others related to intimate partner violence prevention (Oetting, Jumper-Thurman, Plested, & Edwards, 2001). Stage differences between communities beyond race/ethnicity have included readiness diversity between geographic areas (Engstrom,
Researchers have observed communities change to a different readiness stage, often following the use of stage-specific interventions. For example, a police department moved from denial to stabilization after employing initiatives informed by the Community Readiness Model (CRM) including an awareness campaign, funded compliance checks, and licensure enforcement (Engstrom et al., 2002). A randomized group trial revealed significant positive changes in three readiness dimensions following a CRM-informed community and in-school media intervention to prevent youth substance abuse (Slater et al., 2005).

The Community Readiness Model offers an assessment of a community’s stage of readiness involving several dimensions that can be used to inform the selection of stage-specific interventions. Assessment of Counselor Education and Supervision’s readiness to provide master’s-level suicide training should yield valuable guidance for identifying action the field can take to respond to newly released accreditation requirements and prepare ethical counselors. The Community Readiness Model dimensions provide a framework for informing future action by the Counselor Education and Supervision field to provide master’s-level suicide training. The next section describes the development of the readiness dimensions.

**Dimensions of readiness.** Community Readiness Model dimensions of readiness are considered “key factors which influence your community’s preparedness to take action” (Plested et al., 2009, p. 9). The original dimensions were: prevention programming, knowledge about prevention programs, leadership and community
involvement, knowledge about the problem, and funding for prevention (Oetting et al., 1995). Community climate became an additional dimension based on community feedback (Plested et al., 1999). Developers of the model adjusted the labels over time by expanding funding for prevention to Resources such as time, space, and people, and prevention programming to efforts that include activities and policies (Edwards et al., 2000; Plested et al., 1998). The efforts and knowledge of efforts dimensions were combined during interviewing but left intact in scoring (Plested et al., 2009). These two dimensions can be collapsed into one knowledge of efforts dimension, as in the most recent manual (Tri-Ethnic Center for Prevention Research, 2014). Additional dimensions may also be used. For instance, researchers on the Youth Tobacco Access Project included two climate dimensions when assessing eleven Illinois towns: one for town climate and another for police department climate (Engstrom et al., 2002).

It seems imperative to assess the readiness of the Counselor Education and Supervision field to initiate and sustain efforts to provide master’s-level suicide training. The application of the Community Readiness Model to this study should offer findings about the field’s readiness to provide master’s-level suicide training that could be used to inform the improvement of master’s-level suicide training. The next section begins with first steps for application of the model. These definitions of the issue and the community are foundational for progressing through a Community Readiness Model application.

Application of the Community Readiness Model

The application of the Community Readiness Model occurs in several steps and is guided by the fundamental belief that readiness is specific to the issue and to the
community (Oetting et al., 1995; Plested et al., 2006). The first step in the model is to identify and clearly define the issue, and the second step is to delineate the target community (Plested et al., 2006; Tri-Ethnic Center for Prevention Research, 2014). This section describes the application to the issue of suicide and the Counselor Education and Supervision community to justify the relevance of this particular model to a study of master’s-level suicide training.

The issue. Community Readiness Model studies have targeted the issue of suicide in several communities (J. Allen et al., 2009; Portland Area Indian Health Service & Northwest Portland Area Indian Health Board, 2009; Substance Abuse and Mental Health Services Administration, 2014; Suicide Prevention Resource Center, n.d.). A recent report from the Centers for Disease Control and Prevention (Crosby et al., 2011) provided uniform definitions related to self-directed violence, including suicidal self-directed violence. Suicidal self-directed violence and related ideation are the foci of this study and are defined next in the context of Counselor Education and Supervision and master’s-level suicide training.

Suicidal self-directed violence involves fatal and non-fatal behavior directed at oneself with suicidal intent and potential or actual injury (Crosby et al., 2011). This violence includes suicidal behavior that does not result in death, such as suicide attempts and preparatory acts. Suicide ideation involves “thinking about, considering, or planning for suicide” (p. 11). Counselor training programs must cover suicide in order to maintain accreditation (Council for Accreditation of Counseling and Related Educational Programs, 2009, 2015) and prepare ethical counselors (American Counseling Association, 2014). Suicide prevention and risk assessment are crucial topics in pre-

Clinical training on suicide should cover a variety of topics, which are detailed later in this chapter. The topics include information on suicide prevention, suicide first aid and risk assessment, suicide intervention, and continuity of care (American Association of Suicidology, 2004; Clinical Workforce Preparedness Task Force, 2014). Other suicide topics that appear relevant for master’s-level suicide training are: postvention (i.e., care for clients and systems after a suicide attempt or suicide; Laux, 2002; Clinical Workforce Preparedness Task Force, 2014; Wachter Morris & Barrio Minton, 2012) and impact of suicide and related treatment on clinicians (Foster & McAdams, 1999; Hoffman et al., 2013). Non-suicidal self-directed violence involves no evidence of suicidal intent (Crosby et al., 2011) and falls outside of the issue of suicide for this study.

The community. Many Community Readiness Model assessments have targeted communities defined by geographical area such as a town/city, reservation, county (e.g., DeWalt, 2009) and entire countries (Johnson et al., 2005; Kennedy et al., 2004). Other applications of CRM have involved organized groups such as a college campus (Whipple, Caldwell, Simmons, & Dowd, 2008), a school district (Ehlers, Huberty, & Beseler, 2013), professional department (Kunz, Jason, Adams, & Pokorny, 2009), and combined groups of consumers and service providers such as in behavioral health (Farro et al., 2011). For the purpose of this study, the Counselor Education and Supervision
community is defined as the profession focused on counselor training. The Counselor Education and Supervision community includes those who provide education, supervision, and/or administration in counselor training programs and those who research and/or guide the efforts of the profession (e.g., editorial boards and accreditation bodies). The rationale for this definition is grounded in the fact these members of the field provide master’s-level suicide training and/or directly impact master’s-level suicide training efforts.

The next sections of this chapter review the literature relevant for this study along each of the Community Readiness Model dimensions: knowledge of the issue, leadership, efforts, knowledge of efforts, climate, and resources. These sections serve to establish what is already known about each community readiness dimension as it relates to master’s-level suicide training and to identify particular gaps that warrant further study. The researcher explicates how the Community Readiness Model framework informed the design of this proposed study.

Knowledge of the Issue

The Community Readiness Model dimension of knowledge of the issue relates to the community members’ knowledge and/or access to information on the issue being studied (Oetting et al., 1995; Tri-Ethnic Center for Prevention Research [TECPR], 2014). Knowledge of the issue may include the type of information available, how detailed and comprehensive the community’s knowledge is, and misconceptions or incorrect information. A community in which only a few or some members have basic knowledge of the issue, but information or access to it is lacking, is assessed at the vague awareness or preplanning stages of readiness (Plested et al., 2009; TECPR, 2014). Communities
with vague awareness may be best served by initiatives such as engaging, informational presentations or social marketing campaigns and identifying local data sources (Plested et al., 2009; TECPR, 2014).

This section begins with a brief review of the latest knowledge on suicide and how to address it in mental health practice. When applicable, the focus is narrowed to the mental health field of counseling (e.g., ethics). The literature review includes the Counselor Education and Supervision field’s knowledge and/or access to information on suicide. This serves to define the gap in the literature on the field’s knowledge of suicide, which this study may fill.

The Latest Knowledge on Suicide

The content from both taskforces serve as areas of suicide knowledge relevant for clinicians. The Clinical Workforce Preparedness Task Force (2014) identified ten areas of suicide content. This content appears to capture all elements of the Core Competencies for Assessing and Managing Suicide Risk (American Association of Suicidology, 2004) with the potential exception of understanding the phenomenology of suicide. Such an understanding involves the clinician’s use of a biopsychosocial theory or model of suicide to conceptualize cases, communicate to clients, and plan and facilitate treatment (Rudd, Cukrowicz, & Bryan, 2008). Additional areas of suicide knowledge relevant to the counseling field include postvention, e.g., counseling survivors of suicide loss (Laux, 2002; Wachter Morris & Barrio Minton, 2012) and the impact of client suicide and related risk on the clinician, e.g., vicarious trauma and suicide loss experienced by the counselor (Foster & McAdams, 1999; Hoffman et al., 2013). A comprehensive list of suicide content knowledge relevant for counselors-in-training includes:
• therapeutic relationship;
• suicide concepts and facts;
• legal and regulatory information;
• documentation requirements;
• follow-up/transition matters;
• cultural and local factors;
• specific setting issues;
• suicide first aid and risk assessment – exploration, screening, and development of short- and long-term plans;
• intervention – short- and long-term planning based on risk, imminent harm assessment, and safety planning;
• continuity of care;
• postvention; and
• impact on clinician.

The remainder of this section presents the most recent guidance on each suicide knowledge area. This review serves to identify the type of information counselor educators and supervisors might need to know about suicide in order to provide master’s-level suicide training. Based on this list of knowledge areas, the literature on the Counselor Education and Supervision field’s knowledge of suicide is then reviewed, along with a discussion of potential gaps in the literature.

**Therapeutic relationship.** The therapeutic alliance is considered paramount in counseling, and perhaps even more so with suicidal clients (Rudd, Joiner, & Rajab,
This relationship is characterized by empathy and respect and the recognition of the client’s “preferences, needs, and activities” (Clinical Workforce Preparedness Task Force, 2014, p. 18). The approach should be collaborative in that the client is acknowledged as the expert in his/her own story and an active participant in treatment regarding suicide (Michel & Jobes, 2011).

**Suicide concepts and facts.** Concepts and facts about suicide consist of (a) language and definitions, (b) facts and myths of suicide, (c) data such as demographics and characteristics, (d) attitudes and beliefs of clinicians, and (e) risk and protective factors (Clinical Workforce Preparedness Task Force, 2014). Theories of suicide also fit within this category of knowledge. Each element is briefly described here.

**Language and definitions.** Authors have debated and revised suicide nomenclature for many years (O’Carroll et al., 1996; Silverman, Berman, Sanddal, O’Carroll, & Joiner, 2007). This inconsistency has led to confusion from non-standardized data (Silverman et al., 2007; U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). The Centers for Disease Prevention and Control proposed a set of terms and standardized definitions to “improve communication among researchers, clinicians, and others” working with self-directed violence (Crosby, Ortega, & Melanson, 2011, p. 11). This guidance includes behaviors of self-directed violence – fatal and nonfatal acts of suicidal and non-suicidal intentional self-harm – as well as suicidal ideation. Among the eight terms and definitions are those for suicidal self-directed violence (suicide, suicide attempt, and other suicidal behavior). This proposal's first chapter contains an explanation of the term *suicidal self-directed violence.* The Centers
for Disease Prevention and Control panel also supplied a list of unacceptable terms, such as “completed suicide,” “failed attempt,” and “suicide threat” (Crosby et al., 2011, p. 23).

Concepts of suicidality. The concepts of suicidality are not explicitly defined in the suicide prevention training guidelines (Clinical Workforce Preparedness Task Force, 2014). The concepts described in this section are based on a review of the literature. The American Association of Suicidology (2004) Core Competencies for suicide risk assessment and management include describing the phenomenology of suicide (p. 2), which Rudd et al. (2008) explain as the “[a]bility to articulate a biopsychosocial model for understanding suicide” during supervised practice (p. 221). The authors suggest clinicians use the model toward suicide-specific case conceptualization and treatment planning and communicate the model to clients in ways they can easily understand. Several models exist, including sociological and psychological theories and suicide-specific models.

Sociological and psychological theories of suicide have been in place for many years. Sociological theories focus on factors within society that contribute to suicide risk (Granello & Granello, 2007). The most well-known is Durkheim’s theory that social integration and regulation yields four types of suicide: egoistic, altruistic, anomic, and fatalistic (Durkheim, 1897/1951). Psychological theories of suicide align with psychological theoretical orientation. These include explanations for suicide from psychodynamic, developmental, behavioral, cognitive, and humanistic-existential perspectives, as informed by the tenets of each theory (Granello & Granello, 2007).

Suicide-specific models abound. Westefeld et al. (2000) identified four predominant models of suicide: the Overlap Model (Blumenthal & Kupfer, 1986); the
Cubic Model (Shneidman, 1987); the Suicide Trajectory Model (Stillion, McDowell, & May, 1989); and the Three Element Model (Jacobs, Brewer, & Klein-Benham, 1999). Granello and Granello (2007) summarized nine more: the Integrative Social and Psychological Model (Giddens, 1971); Self-Discrepancy Model (Higgins, 1987); the Suicide Career Model (Maris, 1997), the Approval Model (Agnew, 1998); the Escape Model (Baumeitser, 1990; Dean & Range, 1999); the Multifactorial Model (Phillips, 1999); the Continuum Multifactor Model (Beautrais, 2000); the Hopelessness Model (Abramson et al., 2000); and the work of Leenaars (1996; 2004) in expanding Shneidman’s (1987) conceptualizations.

The Interpersonal Theory of Suicide (Van Orden et al., 2010) is a more recent suicide-specific model which offers a deconstruction of the hopelessness present in suicide. Two interpersonal states cause a person to consider suicide: thwarted belongingness and perceived burdensomeness. A person feels lonely and experiences no “reciprocally caring relationships” in the first state (p. 582). The second state involves the belief of oneself as a burden to others. Their combination creates hopelessness (i.e., the unchanging nature of both states) and passive suicidal ideation becomes more active (Ribeiro, Bodell, Hames, Hagan, & Joiner, 2013, p. 209). A person who has an acquired capability for suicide (i.e., fearlessness about pain and death and higher pain tolerance) progresses from suicidal ideation to suicidal behavior (Van Orden et al., 2010). Ribeiro et al. (2013) review the substantial empirical evidence for the theory and compare it to other suicide-specific models. Researchers developed and examined the Acquired Capability for Suicide Scale (Ribeiro et al., 2014; Van Orden, Witte, Gordon, Bender, & Joiner,
and the Interpersonal Needs Questionnaire (Van Orden, Cukrowicz, Witte, & Joiner, 2012) based on this theory.

**Facts and myths.** The second element of suicide concepts and facts is facts and myths (Clinical Workforce Preparedness Task Force, 2014). David Covington is a licensed professional counselor and member of the National Action Alliance Executive Committee who believes suicide mythology is a contributing factor to “a culture in behavioral healthcare nationwide that views crisis intervention and suicide intervention as a niche specialty – a secondary or tertiary focus – rather than a core element of the mission” (Grantham, 2011). Facts about suicide can replace popular myths. The American Foundation for Suicide Prevention (2013) has identified seven myths and their counterpoint facts. Examples include: the myth that suicide is not preventable versus the fact that suicide intervention can work, and the myth that lethal means restriction does not reduce suicide, whereas it has been shown to do so.

**Data.** Suicide data include characteristics and demographics (Clinical Workforce Preparedness Task Force, 2014). The National Strategy for Suicide Prevention (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012) provides a review of overall prevalence of suicide, suicide behavior, and suicidal ideation in the United States, including suicide rates and means by age, sex, race, and other demographics. Examples of data on suicide rates include higher prevalence in western states, in men in middle-age and older (Centers for Disease Control and Prevention, 2010), and in incarcerated populations (Mumola, 2005). Suicidal ideation and/or behavior is also elevated in people with mental and/or substance use disorders (Barak, Baruch, Achiron, & Aizenberg, 2008; Pompili et al.,
2010), youth who are sexual minorities (e.g., endorse same-sex attraction or behavior, or a gay/lesbian identity; Marshal et al., 2011), and those in the child welfare system (Pilowsky & Wu, 2006).

The prevalence of client suicide behavior during one’s mental health career and training represents other data relevant to the Counselor Education and Supervision community’s knowledge of suicide. Almost all social workers report having at least one suicidal client during their career (Feldman & Freedenthal, 2006). One out of nine psychology interns experience a client suicide, and one out of four experience a client suicide attempt (Kleespies, Penk, & Forsyth, 1993). A survey of American Mental Health Counselors Association members (Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001) revealed almost 30% has lost a client to suicide, and over 70% had a client who attempted suicide. McAdams and Foster (2000) found 18% of counselors lost a client to suicide while still in graduate training.

**Training participants’ attitudes and beliefs.** Maltsberger and Buie (1974) named *countertransference hatred* – feelings of malice and aversion in the therapist’s reaction to suicidal clients – as a factor that increases the risk of client suicide. Research has never fully substantiated this theory (Jobes, 2006). Studies on therapist attitudes toward suicide and suicidal clients have revealed strong feelings and beliefs of therapists. Feelings can include contempt, anxiety, and self-doubt (Richards, 2000). Therapists expressed beliefs that suicide is a sin and that it should be an option for a client (Knox, Burkard, Jackson, Schaack, & Hess, 2006). Negative attitudes from health professionals can exacerbate suicidal clients’ shame (Wiklander, Samuelsson, & Asberg, 2003) and preclude
Risk factors. Suicide risk factors are characteristics “that make it more likely that individuals will develop a disorder” (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention [USHHSOSG and NAASP], 2012, p. 142). Their presence increases the likelihood an individual will have suicidal ideation or behavior. A variety of frameworks have been used to understand and recall risk factors for suicide. Risk factors have been divided into chronic, predisposing and potentially modifiable, contributory, acute, and precipitating or triggering stimuli (American Association of Suicidology, 2013). Sareen et al. (2014) separated suicide risk factors in individual level, family level, and community level as a framework for reviewing the latest intervention research.

The National Strategy for Suicide Prevention included an expanded social ecological model (Dahlberg & Knug, 2002 as cited in USHHSOSG and NAASP, 2012). The major risk factors at each level are: (a) individual – mental illness, substance abuse, previous suicide attempt, and impulsivity/aggression; (b) relationship – high conflict or violent relationships, family history of suicide; (c) community – lack of supportive relationships, health care barriers; (d) societal – availability of lethal means and unsafe media portrayals of suicide. The guidelines from the Clinical Workforce Preparedness Task Force (2014) added to the National Strategy (2012) list: history of physical, sexual, and/or mental abuse; life loss or crisis; serious illness; and suicide cluster (p. 18).

Protective factors. Suicide protective factors are considered to “promote strength and resilience,” decreasing the likelihood of suicidal ideation and behavior when
heightened (USHHSOSG and NAASP, 2012, p. 13). The National Strategy’s (2012) model named the major protective factors at each level: (a) individual – coping and problem-solving skills, reasons for living, and moral objections to suicide; (b) relationship – connectedness to others along levels of the model and supportive relationships with healthcare providers; (c) community – safe and supportive schools and communities and post-psychiatric continuity of care; (d) societal – access to physical and mental health care and lethal means restriction. The Clinical Workforce Preparedness Task Force (2014) echoed these factors, referring to moral objections as “cultural and religious factors” (p. 9).

Legal and regulatory information. Another area of suicide knowledge is legal and regulatory information. This includes laws related to civil liability and privacy, as well as scope of practice and confidentiality requirements (Clinical Workforce Preparedness Task Force, 2014). This section outlines federal and state laws related to suicide in counseling and ethical codes from the American Counseling Association (2014) related to civil liability, privacy, scope of practice, and confidentiality.

Civil liability. “In the case of suicide…two factors determine a practitioner’s liability: foreseeability and reasonable care” (Corey, Corey, Corey, & Callanan, 2014, p. 197). Foreseeability refers to the counselor’s recognition and appropriate response to risk (Reid, 2003). Recognition involves comprehensive risk assessment. Reasonable care, otherwise referred to as standard of care, refers to the minimum accepted professional practice which many professionals, acting prudently, would have followed if posed with a similar situation (Granello & Witmer, 1998; Wheeler & Bertram, 2008). Legal
proceedings in many states have involved case law with suicide cases based on standard of care (Granello & Granello, 2007b).

No federal regulation exists regarding duty to warn or protect, and states differ widely in presence, detail, and approach to these duties (Johnson, Persad, & Sisti, 2014). Case law and/or statutes in some jurisdictions place a duty to warn on counselors and other professionals, which requires counselors to attempt to notify a client’s identified potential victim of harm. A duty to protect requires a counselor take action to protect an identified potential victim of harm (e.g., notifying authorities), but does not require counselors to disclose confidential information to the potential victim (Welfel, Werth, & Benjamin, 2009). Counselors can be held liable for not taking reasonable actions to protect clients at risk for suicide (e.g., involuntary mental health commitment).

Counselors should be aware of laws for states in which the counselor and the client reside (American Counseling Association, 2014). State statutes can include a variety of suicide-related items affecting counselors. Examples include state mandates regarding mental health treatment (Robinson, Connolly, Whitter, & Magana, 2007) and school suicide prevention (American Foundation for Suicide Prevention, 2015; Centers for Disease Control and Prevention Division of Adolescent and School Health, 2012).

Privacy. Two federal laws regarding privacy are the Family Education and Rights Privacy Act (1974, 1988) and the Health Insurance Portability and Accountability Act (1996, 2002). The Family Education and Rights Privacy Act provides parents and guardians the right to view and revise their children’s educational records until the student turns 18 years old or enters postsecondary education at any age. The Family Education and Rights Privacy Act regulations (1988) contain an exception in which
parents and others can be notified if a student’s safety is at risk (e.g., suicide risk). This does not apply to counselors whose files are considered medical records as opposed to educational records. For instance, a counselor at a college must follow state law and cannot utilize the act’s exception to disclose medical record information of a client at risk for suicide, whereas a nonmedical university staff member may notify parents if the information is not considered part of a medical file (Baker, 2009).

The Health Insurance Portability and Accountability Act (HIPAA, 1996) serves to protect an individual’s identifiable health information by controlling how it is used by health care providers and organizations. A counselor’s psychotherapy notes are considered protected health information, which may be shared after gaining authorization from the client. In the case of suicide risk, HIPAA allows counselors to disclose the minimum amount of health information necessary “to someone they believe can prevent or lessen the threat” (Office of Civil Rights Department of U.S. Department of Health and Human Services, 2003, p. 8). It is important counselors understand how these federal privacy laws interact with the laws in their state. The HIPAA Privacy Rule (2002) preempts state law unless the state law provides greater privacy.

**Scope of practice.** The American Counseling Association Code of Ethics (2014) states counseling professionals should not practice outside of their scope of competence, “based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.” (p. 8). Some authors have questioned how counselors and other mental health professionals without adequate suicide training can consider therapy with suicidal clients as work that fits within their scope of practice (Knesper, American Association of Suicidology, & Suicide Prevention
Clinicians have a responsibility “based upon the clinician’s presumed training and expertise in assessing the potential for suicide” to protect clients from harm (Feldman, Moritz, & Benjamin, 2004, p. 96). A combination of inadequate master’s-level suicide training and realities of suicide prevalence in counseling clients may create ethical dilemmas for counselors (Barrio Minton & Pease-Carter, 2011).

The American Counseling Association Code of Ethics (2014) also guides the practice of counselor education and supervision and implicitly addresses suicide in education and supervision in a number of areas. Counselor educators infuse ethics throughout the curriculum and provide policies and assistance regarding clinical experiences. Counselor educators and supervisors should have knowledge and competence in the areas they teach and supervise and “provide instruction based on current information and knowledge available in the profession” (p. 14). They inform supervisees of the ethical and legal responsibilities of the counseling field, responsibilities which educators and supervisors know and follow themselves as role models to students and supervisees. The first priority for supervisors is to monitor client welfare. Additional supervisor responsibilities directly related to suicide in counseling are: to inform supervisees about client rights such as privacy, confidentiality, and informed consent; and to inform supervisees of on-call supervisors to contact in crisis situations.

**Confidentiality.** Confidentiality is “the ethical duty of counselors to protect a client’s identity, identifying characteristics, and private communications” (American Counseling Association, 2014). Cases of suicide represent a possible exception to this
requirement “when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed” (p. 7). The latest Code of Ethics includes suicide among the client concerns that should prompt careful consideration by counselors regarding documentation retention due to the possibility of a court order to release documents (p. 8). Additional suicide knowledge regarding documentation is reviewed next.

**Documentation requirements.** Knowledge about documentation is especially important when working with clients at risk for suicide (Clinical Workforce Preparedness Task Force, 2014). Simpson and Stacy (2004) addressed liability concerns in cases of suicide and outline crucial documentation content:

- the use of a thorough suicide assessment involving all risk factors;
- answers to such assessment questions;
- pertinent client quotes;
- previous history of mental health concerns;
- positive and negative assessment findings (Joint Commission on the Accreditation of Healthcare Organizations as cited in Simpson & Stacy, 2004);
- results from consultation with others who know the client and with experts on suicide;
- the way in which potential hospitalization was discussed with the client; and
- attempts to manage risk and potential increase of risk.

Simpson and Stacy (2004) also recommended documenting the systematic approach the counselor uses and increasing the length and detail when a counselor’s
decision involves potential increased risk of suicide (e.g., not hospitalization).

Documentation of suicide risk assessment should also include a time-based summary of risk (i.e., acute or chronic) along a continuum from low to high (Pisani, Cross, Watts, & Conner, 2012). Granello and Granello (2007) recommended counselors who are documenting client suicide concerns: (a) write knowing administrative and legal personnel may read records; (b) document from first interaction forward and quickly after each interaction; and (c) keep all originals.

**Follow-up/transition matters.** Follow-up with a client post-intervention for suicide is an element of evidence-based clinical care practice (National Action Alliance: Clinical Care and Intervention Task Force, 2013). Follow-up communications, such as letters, phone calls, or appropriate online communication, are intended to reduce feelings of isolation and risk of future suicide behavior. Counselors and clients should decide follow-up procedure before release from a care setting.

Suicide risk is elevated during care transitions (Goldacre & Seagroatt, 1993; Ping & Nordentoft, 2005; Valenstein et al., 2009). One key measure to prevent suicide following an inpatient stay is the discharge intervention for transition. Discharge interventions can include (a) aftercare information, (b) outpatient therapy expectations, (c) methods to address barriers to aftercare access, (d) means restriction, and (e) family involvement (Knesper et al., 2010).

**Cultural and local factors.** The 2012 National Strategy (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012) highlights the importance of suicide-related endeavors that are culturally and geographically relevant. Examples of endeavors include: (a) clinical
training on ethnic/racial identity formation and lesbian, gay, bisexual, and transgender; (b) intervention and postvention that is culturally appropriate regarding family and community relationships, grief, and consideration of minority stress; and (c) preventive measures such as means restriction campaigns with gun enthusiasts and awareness education in the military that is sensitive to local culture. Cultural knowledge on suicide thus extends beyond naming cultural groups that experience high suicide rates to also involve cultural frameworks for addressing suicide in clients and communities of color (Chu et al., 2013; Rogers & Russell, 2014; Wong, Maffini, & Shin, 2014).

**Specific setting issues.** Suicide information can vary by setting in terms of rates, risk and protective factors, and best practices for addressing suicide. The National Strategy (2012) identifies groups with increased suicide risk that are specific to setting, including individuals in the justice system (e.g., prisons), child welfare system, and armed forces. The Strategy’s goals and objectives include targeting endeavors to clinical and nonclinical/community settings (e.g., schools and colleges, workplaces, and organizations serving older adults) and enhancing care coordination across diverse settings.

Suicide knowledge may be particular to specific settings aligned with the counseling specialties in the 2016 Standards (Council for Accreditation of Counseling and Related Programs, 2015): Addictions; Career; Clinical Mental Health; Clinical Rehabilitation; College Counseling and Student Affairs; Marriage, Couple, and Family; and School Counseling. Examples of suicide knowledge relevant to school counseling are: (a) prevalence of suicide behavior among youth (Centers for Disease Control and Prevention National Center for Injury Prevention and Control, 2010); (b) school suicide
Examples of suicide knowledge relevant to student affairs counseling are: (a) campus-wide prevention frameworks (Drum & Denmark, 2012), (b) impacts of gatekeeper training (Wallack, Servaty-Seib, & Taub, 2013), and (c) college postvention guidelines (Higher Education Mental Health Alliance, 2014).

**Suicide first aid and risk assessment.** Suicide first aid and risk assessment involves the exploration and screening of risk and protective factors toward the development of short- and long-term planning that addresses the client’s risk (Clinical Workforce Preparedness Task Force, 2014). Previous sections included a brief description of risk and protective factors. The exploration and screening process serves to identify potential risk that requires response and further assessment; and risk assessment specifies the severity of risk (Boudreaux & Horowitz, 2014). A screening procedure involving as few as three questions may be sufficient in some settings (National Action Alliance: Clinical Care and Intervention Task Force, 2013). “Any person who screens positive for suicide risk should be formally assessed for suicide ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk” (National Action Alliance: Clinical Care and Intervention Task Force, 2013).

Assessment of acute risk factors may be especially important. Acute risk factors are elsewhere referred to as precipitants (American Psychiatric Association, 2003; Boudreaux & Horowitz, 2014) and warning signs (Berman & Silverman, 2014; Rudd,
An American Association of Suicidology clinical taskforce developed the mnemonic IS PATH WARM (American Association of Suicidology, n.d.; Rudd, Berman, et al., 2006). IS PATH WARM represents the following warning signs: ideation, substance abuse, purposelessness, anxiety, trapped, hopelessness, withdrawal, anger, recklessness, and mood changes.

Formal suicide risk assessment instruments exist but require further validation. Examples of formal screening tools include the Patient Safety Screener (Boudreaux et al., 2013) and the 17 adolescent suicide screening instruments and programs reviewed by Peña and Caine (2006). Roos, Sareen, and Bolton (2013) examined the predictive validity of 10 formal suicide risk assessment tools and concluded that more research is needed to provide empirical validation for best practices in suicide risk assessment protocol. Other authors concluded the same (Boudreaux & Horowitz, 2014; Haney et al., 2012).

The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013a) provides some guidance for assessing suicide risk. The DSM-5 does not include the Global Assessment of Functioning as it did not provide enough clarity for concepts such as suicide risk. The crosscutting measures in DSM-5 include suicide risk assessment items. The DSM-5 contains an expanded decision tree for suicidal ideation or behavior (American Psychiatric Association, 2013b). New third and fourth branches of the decision tree cover DSM-5 conditions related to depressed mood and mixed states of depressive and manic symptoms.

Several authors have asserted that the combination of a standardized instrument and a clinical interview increases suicide assessment accuracy (Bryan & Rudd, 2006;
Silverman and Berman's review of empirical findings (2014) led the authors to suggest the use of multiple nonjudgmental probes inclusive but not limited to suicide ideation and self-administered, self-report, computerized screening and risk assessments. They believe these procedures illicit the most honest answers from clients.

Intervention. Intervention includes short- and long-term planning based on risk, imminent harm assessment, and safety planning (Clinical Workforce Preparedness Task Force, 2014). Risk-based planning involves (a) a clinical judgment about short- and long-term risk; (b) documentation including the rationale; (c) treatment planning for immediate and continuing ideation and behavior; and (d) referring for treatment if appropriate (p. 21). Assessment for imminent harm involves access to and/or use of lethal means or self-injurious behavior and intoxication. Results of risk-based planning and imminent harm assessment may call for the counselor and client to draft a safety plan.

A safety plan includes (a) an agreement; (b) means restriction; (c) contact plans between the client, counselor, and support systems; (d) information for emergency services; and (e) protective activities (Clinical Workforce Preparedness Task Force, 2014, p. 22). Suicide risk warning signs may also appear on a safety plan aligned with protective activities, i.e., individuals’ coping responses to suicide warning signs (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). Best practices in safety planning involve using a person-centered approach which highlights the client’s unique needs and values.
and completing safety plans collaboratively with the client (National Action Alliance: Clinical Care and Intervention Task Force, 2013).

**Continuity of care.** Clinicians individualize longer term care to the needs outlined in the safety plan and include continual risk assessment and relevant modifications (Clinical Workforce Preparedness Task Force, 2014). Continuity of care treatment planning outlines expectations for follow-through and communication among all parties involved, including the individual and his/her family and the counselor and other professionals. Counselors ensure continuity of care by communicating emergency contact information and involving community resources to address the needs of the family (e.g., support and education) and of any others who are affected (Knesper et al., 2010). In response to the National Strategy (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention [USHHSOSG and NAASP], 2012), the American Association of Suicidiology and the Suicide Prevention Resource Center commissioned a report on *Continuity of Care for Suicide Prevention and Research* (Knesper et al., 2010). The resulting ten Continuity-of-Care Principles are:

- Suicide is a public health problem for which continuity of care is one essential means for effective prevention.

- Epidemiologic studies need to focus on the associations between the severity and chronicity of mental illness and suicide ideation, attempts, and deaths.

- Anti-suicide therapeutics and interventions have been developed and/or may be developed grounded in existing research or the consensus of experts in suicidology.

- There is considerable urgency to identify anti-suicide therapeutics that are more rapidly effective than presently available cognitive-psychological and psychopharmacologic therapies.
• Providing patients with continuity of care is a potentially powerful suicide prevention strategy for individuals at acute, short-term, or long-term risk for suicide.

• The continuity-of-care goals of The National Strategy for Suicide Prevention require the adoption, at the national level, of expected best practices for discharge planning.

• Randomized controlled trials that use suicide attempts as outcome variables are practical and doable and much less expensive than trials involving the general public.

• Patients should be seen by certified professionals that have mastered suicide assessment and prevention skill sets.

• High priority needs to be given to building community capacity to accurately and capably track suicide deaths and attempts. Without such systems, community initiatives to prevent suicide behaviors cannot be evaluated.

• Designing, testing, and implementing integrated networks of care for community populations that ensure follow-up and evidence-based treatments for high suicide risk may prove to reduce suicide rates and, thereby, complement universal interventions aimed at the general public (pp. 112-117).

**Postvention.** Suicide postvention is “the response to and care for individuals affected in the aftermath of a suicide attempt or suicide death” (USHHSOSG and NAASP, 2012, p. 141). Individuals affected may include survivors of suicide loss bereaved by the suicide of a loved one (USHHSOSG and NAASP, 2012) and those exposed to suicide through more distant means, such as hearing about or witnessing the suicide of a stranger (Andriessen & Krysinska, 2012). Survivors may include partners and nuclear family members, other relatives, coworkers, classmates, and others with shared affiliations (Berman, 2011).

Survivors of suicide loss (SOSL) have elevated suicide risk (USHHSOSG and NAASP, 2012). Postvention endeavors for SOSL and others exposed to suicide should
focus on: (a) speed and flexibility of postvention efforts; (b) discouragement of contagion; (c) preplanning; (d) the needs of multiple targets; and (e) available resources (Westefeld et al., 2000). The American Association of Suicidology and the American Foundation for Suicide Prevention have dedicated sections of their websites for SOSL.

**Impact on clinician.** The final area of suicide knowledge relates to the impact of client suicide ideation and behavior on clinicians. Clinicians and those in training experience a range of responses to the possibility of client suicide risk, presentations of suicide ideation and intent, and client suicide attempt or suicide. This subsection includes the impact of client suicide ideation and behavior on clinicians and counselors-in-training, issues facing clinician SOSL, and available resources for clinician SOSL.

Clinicians have a variety of emotional, physiological, and behavioral responses to suicide issues in counseling. Beginning clinicians ranked client issues involving potential death (e.g., suicide or terminal illness) as more distressing to work with than other crises, including sexual abuse (Kirchberg & Neimeyer, 1991). Therapists reported feeling helpless, hopeless, and a sense of failure about their work with suicidal clients (Richards, 2000). More than 20% of counselors have experienced a client’s suicide, most while still in counselor training (McAdams & Foster, 2000). Their emotional responses included anger, guilt, lowered self-esteem, and intrusive thoughts and intense dreams. Emotional responses may be greater in younger clinicians or trainees than experienced ones (McAdams & Foster, 2000) and in those with insufficient support or a stronger sense of connection to the client (Castelli Dransart, Gutjahr, Gulfi, Kaufmann, & Séguin, 2013).

Glover (2014) collected and compared self-report and physiological data (e.g., blood pressure, galvanic skin response, and heart rate) while mental health students
watched videos of mock therapy sessions. No significant differences existed between responses to the suicidal client video and the non-suicidal client video. Seguin, Bordeleau, Drouin, Castelli-Dransart, and Giasson (2014) analyzed the literature on clinicians’ reactions following client suicide and concluded that affective responses and intensity of stress reactions vary widely. Stress symptomatology was present, but only a small proportion of most samples reached a clinical level of distress for Acute Stress or Post-Traumatic Stress Disorders.

Clinicians respond behaviorally to suicide issues in counseling. Counselors-in-training with sustained emotional impact from a client’s suicidal ideation had higher suicide intervention skills than their counterparts while counselors-in-training still impacted by the suicide of a client had lower suicide intervention skills compared to other counselors-in-training (Raper, 2010). Counselors and other clinicians have reported reacting to client suicide by being more focused on liability and conservative documentation (McAdams & Foster, 2000), more watchful for suicide risk among other clients (McAdams & Foster, 2000; Seguin et al., 2014), and more apt to use consultation (McAdams & Foster, 2000). Clinicians who have lost a client to suicide increasingly refer or find other ways of avoiding serving suicidal clients (McAdams & Foster, 2000; Seguin et al., 2014).

Clinicians face complex issues as survivors of suicide loss (SOSL). Family SOSL have reported believing the clinician withheld information, committed treatment errors, and fell short of doing all that was possible to protect their loved one from suicide (Peterson, Luoma, & Dunne, 2002). Clinicians may also become SOSL through the loss
of a friend or family member, colleague, or therapist (McIntosh & Clinician Survivor Task Force of the American Association of Suicidology, 2015).

Clinicians and trainees as SOSL can access resources of their own when faced with client suicide. Clinicians appear to use informal support following the loss, seek professional supervision, and have contact with the family of the deceased client (Seguin et al., 2014). Spiegelman and Werth (2004) offer training and response suggestions to trainees, supervisors, and training sites. The American Association of Suicidology has a Clinician Survivor Task Force and webpage dedicated to clinician SOSL:


This section includes a review of the latest knowledge on suicide aligning with guidelines on suicide training content (Clinical Workforce Preparedness Task Force, 2014). The next section includes a review of the literature on knowledge of suicide within the Counselor Education and Supervision community. This serves to identify gaps in the literature related to knowledge of suicide in the Counselor Education and Supervision field and to demonstrate the need for assessing issue-specific knowledge in a study on readiness.

**Knowledge of Suicide in Counselor Education and Supervision**

It seems important that counselor educators and supervisors who provide master’s-level suicide training have suicide knowledge in the identified areas. Counselor educators and supervisors have an ethical obligation to provide instruction based on their knowledge and informed by current knowledge in the profession (American Counseling Association, 2014). “To prepare competent practitioners, counselor educators must also
be competent in crisis-related topics so that they are able to critically examine and deliver curricula” (Wachter Morris & Barrio Minton, 2012, p. 266). Supervisors are responsible for both the supervisee and the client and face the risk of direct and vicarious liability (Bernard & Goodyear, 2009). Supervisors whose supervisees have a client with potential suicide risk have the dual task of monitoring client welfare and overseeing and evaluating the supervisee (Falvey & Cohen, 2003).

The Community Readiness Model’s knowledge of the issue dimension includes: (a) type of information available about the issue itself; (b) content and comprehensiveness of community’s knowledge about the issue; (c) access to the information; and (d) misconceptions about the information. This section includes a review of the Counselor Education and Supervision (CES) community’s knowledge of suicide and suicide in counseling related to these areas. This serves to identify the gaps this study may fill concerning the current suicide knowledge within the CES community. CES’ knowledge of master’s-level suicide training appears in subsequent sections, namely leadership and knowledge of efforts.

**Type of information.** The type of information available in the CES field on suicide comes in different forms. Suicide knowledge within the counseling field and CES community appears in publications by the American Counseling Association and the Association for Counselor Education and Supervision (e.g., books and journal articles) and continuing education opportunities (e.g., professional conferences and online webinars). The next paragraphs reveal the amount of items by each type. A review of their content and comprehensiveness appears in the following subsection.
A search of the American Counseling Association Bookstore (www.counseling.org/publications/bookstore) for the keyword suicide resulted in six books and one video. The six books are: *Assessment in Counseling* (Hays, 2013); *The Counselor and the Law* (Wheeler & Bertram, 2015); *Developing Clinical Skills in Suicide Assessment, Prevention, and Treatment* (McGlothlin, 2008); *Mastering the Art of Solution-focused Counseling* (Guterman, 2013); *Suicide Prevention in the Schools* (Capuzzi, 2009); and *Tough Kids, Cool Counseling* (Sommers-Flanagan & Sommers-Flanagan, 2007). The video is *Suicide Assessment and Prevention* (Westefeld, 2008).

Academic journals are another type of knowledge source in the Counselor Education and Supervision field. The American Counseling Association (ACA) and its member divisions publish 20 journals (ACA, n.d.-c). Journals such as *Counselor Education and Supervision*, *Journal of Counseling and Development*, and other ACA (e.g., *Journal of Humanistic Counseling*) and related journals (e.g., *Counseling Outcome Research and Evaluation*) contain articles disseminating suicide knowledge. A library database search of all 20 ACA counseling journals published from 2009 through 2015 yielded 16 articles containing *suicide* or *suicidal* in the title. The next subsection serves to review the content of these articles and of relevant books and continuing education about counseling and counselor education and supervision.

Continuing education offerings also contain the Counselor Education and Supervision field’s suicide knowledge. Presenters of continuing education for counselor educators and supervisors have provided conference sessions on suicide and master’s-level suicide training. A search of the Online Learning section of the ACA website (http://www.prolibraries.com/counseling/) for the keyword *suicide* yielded 26 results: 18
ACA Conference sessions and eight online courses. Additionally, a six-part ACA webinar series on suicide, *Confronting the Darkness*, is available to members and non-members through ACA Continuing Education (www.counseling.org/continuing-education/webinars).

**Content and comprehensiveness of the knowledge.** The searches of ACA and Association for Counselor Education and Supervision books, journals, and continuing education offerings revealed patterns in terms of the content and comprehensiveness of suicide knowledge provided in the Counselor Education and Supervision community. Most content focuses on suicide prevention (e.g., concepts and facts, risk and protective factors, legal and ethical concerns, issues specific to setting or specialization) and screening and risk assessment for suicide. Other recurring knowledge areas are suicide intervention, impact of suicide issues on the clinician, and continuity of care (mainly focused on protective activities). This subsection briefly includes a review of literature on counseling and counselor education and supervision regarding these knowledge areas.

The section on knowledge of efforts includes a review of content related to master’s-level suicide training.

**Suicide prevention.** The most prevalent suicide-related topic in literature on counseling and counselor education and supervision is suicide prevention. The knowledge areas in suicide prevention include: (a) therapeutic relationship; (b) suicide concepts and facts; (c) legal and regulatory information; (d) documentation; (e) follow-up/transition; (f) cultural and local factors; and (g) specific setting issues (Clinical Workforce Preparedness Task Force, 2014). Of these, the predominant content in counseling and counselor education and supervision publications and presentations
appears to be suicide concepts and facts (mainly risk factors), legal and ethical consideration, and specific setting issues (mainly schools). An earlier section contained a list of risk factors, which are subsumed in the next section on screening and risk assessment.

Scholars of counseling and counselor education and supervision often address legal and ethical information when focusing on suicide (Duba & Magenta, 2008; Fineran, 2012; Fulmer, 2014; McAdams & Keener, 2008; Neukrug & Milliken, 2011; Werth & Crow, 2009). Wheeler and Bertram's (2015) edition on legal and ethical counseling practice explicitly addresses suicide concerns. Issues of ethics, law, and risk management are among the knowledge areas addressed in the American Counseling Association’s six-part webinar on suicide. Tamara Suttle (2012) authored an American Counseling Association online course on ethics and legal issues related to counselor’s personal histories with suicide and other complexities.


**Screening and risk assessment.** Authors in the Counselor Education and Supervision field have provided articles covering suicide assessment in practice (e.g., Aizenman, 2009; Granello, 2010; Laux, 2002) and in master’s-level suicide training
Suicide risk assessment is addressed in several American Counseling Association (ACA) books (e.g., Capuzzi, 2009; McGlothlin, 2008). The ACA Traumatology Interest Network’s fact sheet on suicide assessment (ACA, 2011) appears on the ACA website. Suicide assessment, including how to distinguish suicide ideation from depression, is among the knowledge areas addressed in ACA’s six-part webinar on suicide. Assessment for suicide risk is a regular content focus in suicide-related presentations at conferences of ACA and the Association for Counselor Education and Supervision (Granello & Granello, 2013; Jencius & McGlothlin, 2010; Sommers-Flanagan & Sommers-Flanagan, 2013; Stapler, 2014).

Some content includes a combination of suicide risk assessment with intervention and/or other knowledge areas. Darcy Granello (2010a) offered a suicide crisis intervention model with 25 strategies for implementation. McGlothlin's (2008) SIMPLE STEPS suicide assessment model is an expanded method for counselors to address risk in continuing clients. The six-part ACA webinar series included knowledge on assessment and impact on clinician: Suicide Assessment and Counselor Self-Care After Client Suicide (ACA, n.d.-b).

Other resources in the Counselor Education and Supervision community are more comprehensive, covering several knowledge areas. Laux (2002) provided A Primer on Suicidology, which addressed theory, assessment, risk factors, intervention, prevention, postvention, and training. Juhnke et al. (2012) published a mnemonic – Stay, Consult, Apprise, Terminate, Truncate, and Transport to guide work with clients who require suicide intervention, such as hospitalization or monitoring. This memory aid contains
elements of suicide first aid, risk assessment, legal and regulatory, intervention, and some transition, and includes the importance of consultation and/or supervision.


It appears no resources on counselor education and supervision provide entire coverage of all areas of suicide knowledge. Taken together, however, the information available within the Counselor Education and Supervision community appears to be fairly comprehensive of this content. Knowledge areas that are not often addressed in publications and presentations are: prevention regarding follow-up and local factors, suicide-specific treatment planning, and continuity of care.

The latest knowledge on suicide is also available to members of the Counselor Education and Supervision field from resources outside the field (e.g., from the broader communities of mental health and national entities focused on suicide). Some examples include publications such as Michel and Jobes' (2011) book *Building a Therapeutic Alliance with the Suicidal Patient* and the U.S. Surgeon General’s National Strategy for Suicide Prevention (2012) and journals such as *Suicide and Life-Threatening Behavior, Crisis*, and *Archives of Suicide Research*. Professional organizations (e.g., American Association of Suicidology, American Foundation for Suicide Prevention, and the
Substance Abuse and Mental Health Services Administration) offer informational websites and conferences such as Healing after Suicide Loss and the World Congress of the International Association for Suicide Prevention. It is possible that Counselor Education and Supervision community members use these resources to fill gaps in the community information on suicide.

Counselor Education and Supervision (CES) community members may also draw from their personal and professional experience with suicide and suicide in counseling. They may gain knowledge of suicide through consultation, supervision, and collaboration with their CES and other colleagues, or from other resources. It is largely unknown how detailed and comprehensive the CES community’s knowledge is of suicide, nor if and how the community accesses it assesses suicide information from within or beyond the CES field.

**Access to information.** Access to information by community members about the issue of suicide is another important consideration of community readiness (Oetting et al., 1995). This review revealed that some CES members have knowledge of suicide, and that information about suicide is available to the CES community. Access to this information may depend on library access, professional membership, and choice to access.

Counselor Education and Supervision members with full rights to use university libraries likely have access to most of the literature in this review. Practitioners such as site supervisors who do not have library access through their affiliation with an academic institution are likely unable to retrieve most professional journals (Williams, Patterson, & Miller, 2006). One exception may be open access journals.
Some of the informational sources reviewed here are only available to American Counseling Association (ACA) members. These include podcasts and learning institutes offered through the ACA website. Therefore, counselor educators and supervisors who are not members of ACA do not have access to this knowledge.

It is unknown how Counselor Education and Supervision community members access information about suicide. Site supervisors and ACA non-members, in particular, may face barriers to accessing certain information. It is unknown if members of the Counselor Education and Supervision field who have library access and ACA membership use this access to build and update their knowledge of suicide.

**Potential misconceptions.** Some recommendations of authors on counselor education and supervision appear to match those of the federal government (Crosby et al., 2011; U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012), national suicide organizations (American Association of Suicidology, 2004, 2013), and empirical literature from other health fields (e.g., Brown & Jager-Hyman, 2014). In other cases, there is evidence that members of the Counselor Education and Supervision community may have misconceptions or outdated suicide knowledge in content areas outlined in this review. Authors in the Counselor Education and Supervision community have used terms in their recent publications (Ametrano, 2014; Douglas & Wachter Morris, 2015) deemed unacceptable by the federal government (Crosby et al., 2011) for suicide prevention and research (e.g., *failed attempt* and *suicide threat*). Some authors advised counselors-in-training to use no-suicide contracts (Hodges, 2011; Scott et al., 2013) after the use of no-suicide contracts was deemed ineffective and potentially detrimental (Center for
Substance Abuse Treatment, 2009; Edwards & Sachmann, 2010; Lee & Bartlett, 2005; Rudd, Mandrusiak, et al., 2006). It is unknown whether discrepancies between actions of counselor educators and supervisors and guidance from within and beyond the community reflect a lack of knowledge about the guidance, disagreement with this guidance, or another reason entirely.

Wachter Morris and Barrio Minton (2012) surmised that, like their survey sample of new counselors, “it is likely that new and veteran counselor educators also lack preparation for crisis prevention, intervention, postvention, and education” (p. 265). University and site supervisors should have knowledge of relevant ethics and laws (Bernard & Goodyear, 2009; Hipple & Beamish, 2007), suicide screening methods (Bongar, 1993; McGlothlin, 2008), and impact on the clinician (McAdams & Foster, 2000) when supervising counselors-in-training seeing suicidal clients. However, no published literature has assessed the Counselor Education and Supervision (CES) community’s knowledge of the issue of suicide. Understanding CES’ knowledge of suicide is an important element of conceptualizing the readiness of the CES field to provide master’s-level suicide training.

This review established a potential gap in understanding the detail, comprehensiveness, and correctness of CES’ current suicide knowledge. This study will be a first step toward filling this gap and uncovering what type of knowledge is available in CES outside of public forums and the ways in which CES members access the latest suicide knowledge. A study applying the Community Readiness Model should illuminate this dimension with information provided from a variety of community members. The use of Consensual Qualitative Research methodology will also provide the structure of
criterion-based sampling and random selection to reach a broad range of counselor educators and supervisors.

**Leadership**

The Community Readiness Model defines leaders as “those who have influence in the community and/or who lead the community in helping it achieve its goals” (Tri-Ethnic Center for Prevention Research, 2014, p. 44). This can include appointed or elected leaders and influential community members who are not elected or appointed (Plested et al., 2009). This dimension involves leadership’s general attitude toward the issue and efforts to address it, how much the issue is a concern or priority to leadership, and how leadership supports or opposes efforts. This section serves to establish what Counselor Education and Supervision (CES) leadership has publicly stated about its views on suicide and efforts to address it in counselor education and supervision. It begins with a brief explanation of leadership outside of the field that may impact or inform CES leadership. Also included in this section is a discussion of what is not clear about CES leadership’s attitude and support or opposition of efforts to address suicide in counselor education and supervision. This is meant to demonstrate a gap this study may fill regarding CES community leadership and the readiness of the CES field to provide master’s-level suicide training.

Several entities outside of CES have called for improvements in mental health education on suicide, namely the U.S. Surgeon General (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012), the American Association of Suicidology (Schmitz et al., 2012) and Suicide Prevention Resource Center (Knesper et al., 2010), and the Institute of Medicine
(Goldsmith, Pellmar, Kleinman, & Bunney, 2002). State policy leaders have imposed continuing education requirements to support suicide prevention (American Foundation for Suicide Prevention, 2015; Matt Adler Suicide Assessment, Treatment, and Management Act ESHB 2366, 2012; The Jason Foundation, n.d.). These members of broader communities appear to place suicide as a priority in pre-professional training. I describe the support further in the section on climate.

The Counselor Education and Supervision (CES) community’s formal leadership may include accreditation bodies, national and regional organizations, and program-level leadership such as department chairs and program coordinators. Informal and/or local leadership related to the issue of suicide and the CES community could also include the field’s noted authors on suicide and master’s-level suicide training. The next section includes a review of CES leadership’s stance and support/opposition of master’s-level suicide training efforts. This is meant to identify information about CES leadership and readiness for master’s-level suicide training that has yet to be explored and to explain the data-gathering methods proposed in this study.

**Accreditation Bodies**

The two bodies that provide field-specific accreditation to counseling programs are: the Council for Accreditation of Counseling and Related Educational Programs and the Council on Rehabilitation Education. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Council on Rehabilitation and Education were separate entities before 2013. The Council on Rehabilitation and Education (2013) became a corporate affiliate of CACREP, which allows rehabilitation counseling programs to become dually accredited provided they implement CACREP’s
new clinical rehabilitation counseling standards (CACREP, 2013a) and complete the required conversion process (CACREP, 2013b). The 2016 Standards (CACREP, 2015) include clinical rehabilitation among the Entry-Level Specialty Areas.

Both accreditation bodies act as leaders in counselor education and supervision, influencing how the field provides master’s-level suicide training. All sets of active standards these bodies delineate requirements for training counseling students on suicide and/or crisis. The specific standards are reviewed below, along with other suicide-related information from these bodies.

**Council for Accreditation and Related Educational Programs.** The 2009 Standards (CACREP, 2009) and the 2016 Standards (CACREP, 2015) are important to consider in the context of this study. Counseling programs accredited under the 2009 Standards and programs seeking new accreditation may have begun planning for implementation of 2016 Standards, as these standards go into effect on July 1, 2016 (CACREP, 2015). The 2009 Standards (CACREP, 2009) outlined expectations that accredited programs train counseling students in all counseling specialty areas on crisis intervention and suicide prevention. This was an evident change from earlier standards (CACREP, 2001), which named suicide in knowledge requirements for gerontological and school counselors among “conditions that affect older people” (p. 40) and “issues that may affect the development and functioning of students” (p. 50).

Five of the six specialty areas outlined in the 2009 Standards (CACREP, 2009) included the requirement that students demonstrate suicide risk assessment and management skills: Addictions Counseling; Clinical Mental Health Counseling; Marriage, Couple, and Family Counseling; School Counseling; and Student Affairs and
College Counseling. Two specialty areas included more specific requirements related to suicide. Addictions Counseling programs accredited under the 2009 Standards (CACREP, 2009) should include screening for self-harm or suicide potential, and accredited Marriage, Couple, and Family Counseling programs should cover family interventions to address suicide risk.

The 2016 Standards (CACREP, 2015) contain changes to content relevant to suicide and changes to placement within the standards. Content changes include standards that core curriculum include suicide prevention models and strategies and suicide risk assessment. This is an expansion from the 2009 Standards (CACREP, 2009), which focused on suicide prevention models.

Placement changes from the 2009 to the 2016 Standards are the inclusion of suicide risk assessment in core curriculum and the exclusion of suicide-specific content in specialty area standards. In the 2016 Standards (CACREP, 2015), core standards concern knowledge attainment, and specialty area standards concern demonstration or possession of both knowledge and skills. The placement of suicide within core curriculum standards serves to ensure students in all specialty areas receive master’s-level suicide training. Programs for all specialty areas accredited under the 2016 Standards (CACREP, 2015) should instruct students on suicide prevention models and strategies and suicide risk assessment. Explicit reference to suicide does not appear in specialty area standards in the 2016 Standards. Programs accredited under the 2016 Standards may include suicide knowledge and skills within those pertaining to crisis and trauma requirements for specialty areas. However, this training on skills to address suicide in counseling is not an
explicit requirement in the current 2016 Standards as it was in the previous 2009 standards.

**Council on Rehabilitation Education.** The standards for graduate rehabilitation counselor education programs (Council on Rehabilitation Education, 2014) required students demonstrate “a basic understanding of how to assess individuals, group, and families who exhibit suicide ideation” (p. 9). The Clinical Rehabilitation Counseling Standards (CACREP, 2013a) required for rehabilitation programs seeking dual accreditation did not mention suicide. Instead, students were to understand “the principles of crisis intervention for people with disabilities” (p. 3) and the “appropriate use of diagnosis during a crisis, disaster, or other trauma-causing event” (p. 5). Clinical rehabilitation counseling programs seeking accreditation from the Council for Accreditation of Counseling and Related Educational Programs (CACREP) after June 30, 2016, should implement 2016 Standards, including those concerning suicide outlined above.

It is unclear how accreditation standards influence the Counselor Education and Supervision community related to master’s-level suicide training and how accreditation status impacts student knowledge and behavioral outcomes on suicide issues. Even and Robinson (2013) studied a national sample of licensed counselors and found graduates from CACREP-accredited programs have incurred significantly fewer overall ethics violations than those from non-accredited programs. Ethics violations related to suicide, such as professional competency and breach of confidentiality represented 27.6% and 10%, respectively. However, Raper (2010) found suicide intervention skills were not significantly different between students in CACREP-accredited programs and those in
non-accredited programs. Students’ completion of a crisis counseling course also did not vary by accreditation status. This study may reveal how the Counselor Education and Supervision community views and responds to the influence that the Council for Accreditation of Counseling and Related Educational Programs has on master’s-level suicide training.

**National and Regional Organizations**

National and regional organizations comprise another group of recognized leadership in the Counselor Education and Supervision community, namely the Association for Counselor Education and Supervision and its regional affiliates. The Association for Counselor Education and Supervision and its regions have the opportunity to lead the community on counselor training via their publications (e.g., books and academic journals), professional conferences, communications (e.g., websites), and organizational structure (e.g., committees). An earlier section of this chapter addressed content of publications, conferences, and communications. Leadership’s influence on these endeavors seems particularly evident regarding publications. This section includes a review regarding the attitude, placement of priority, and/or support or opposition for master’s-level suicide training efforts from publication leadership and organizational structure.

**Publication leadership.** The Knowledge of the Issue section addressed knowledge on suicide in publications on counselor education and supervision. This subsequent Knowledge of Efforts section addresses the Counselor Education and Supervision field’s knowledge of master’s-level suicide training efforts. Influential
informal leaders include publication authors. In addition to the authors themselves, those who control publications are also leaders in the Counselor Education and Supervision and counseling communities. This subsection addresses this publication leadership.

Publication leadership with the American Counseling Association (ACA) and the Association of Counselor Education and Supervision (ACES) appear to support the publication of books and journals regarding suicide and related training as well as the provision of continuing education. The content of suicide knowledge made available through these publications is fairly comprehensive. This does not appear to be the case related to knowledge about master’s-level suicide training.

The latest book published by ACES – *Teaching in Counselor Education* – was intended to guide the field about student engagement in the teaching/learning process (West, Bubenzer, Cox, & McGlothlin, 2013). The only book chapter about counselor training content connected to previous accreditation standards focused on multicultural content (Day-Vines & Holcomb-McCoy, 2013). Barrio Minton (2010) provided specific suggestions to clinic directors in the ACES publication, *Developing and Maintaining Counselor Education Laboratories* (Mobley & Myers, 2010). Her recommendations covered clinic suicide-related training and support and suicide-related policies and procedures for treatment, supervision, and consultation. Few publications have attended to efforts to provide master’s-level suicide training and other crises (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012). “Uncertainty exists as to whether this silence reflects lack of activity or simply a lack of dialogue” (Barrio Minton & Pease-Carter, 2011, p. 7).
The *Journal of Counseling and Development* and *Counselor Education and Supervision* are particularly influential within the counseling profession by contributing to the flow of information in academic literature (Fernando & Barrio Minton, 2011). Pedagogy-specific content in American Counseling Association journals including *Counselor Education and Supervision* has lacked focus on three areas relevant to master’s-level suicide training: 1) ethics in master’s level training, 2) assessment in master’s level training, and 3) the preparation of doctoral students to instruct and supervise (Barrio Minton, Wachter Morris, & Yaites, 2014), begging the question, “Do those conducting instructional research or our editorial review boards place less importance on these areas of teaching?” (p. 172). An assessment of community readiness that includes targeted questions about Counselor Education and Supervision leadership’s attitude and support of master’s-level suicide training may partially answer this question.

**Organizational communities.** Organizational structure is another way in which ACES and related leadership can support master’s-level suicide training. None of ACES’ committees, interest networks, special groups, or task forces are devoted to suicide, crisis, or trauma (Association for Counselor Education and Supervision, n.d.-a). This contrasts the ACA’s Traumatology Interest Network, which provides information on suicide and other issues to the counseling community (ACA, n.d.-a).

**Program-level Leadership**

Other leaders in the Counselor Education and Supervision community are those who guide counselor training at the program level. Administrative and curricular leadership within accredited counseling programs serve as program coordinators, practicum and internship coordinators, and other roles leading the academic unit (Council
for Accreditation of Counseling and Related Educational Programs, 2009, p. 7). Directors and other management may provide leadership to practicum/internship site supervisors affiliated with accredited programs. The academic literature on program-level leadership and master’s-level suicide training has focused primarily on on-campus training clinic directors.

Only one published research study has assessed the attitude of program-level leadership affiliated with accredited programs toward suicide and any support or opposition for master’s-level suicide training efforts. Hoffman et al. (2013) provided a grounded theory of counselor-in-training supervision for suicidal clients based on the perspectives of five on-campus training clinic directors. The resultant theory – *Supervision for Suicidal Clients as an Immediate, Versatile Collaboration between Counselor Trainees and Counselor Supervisors* – captures several attitudes relevant to this review. These clinic directors seemed to agree suicide and master’s-level suicide training should be priorities for the Counselor Education and Supervision field. They viewed opportunity for counselors-in-training to work with suicidal clients as “a formative learning experience” for both supervisor and supervisee, though one that comes with some challenges (p. 114). Challenges included the need to flexibly adjust supervision when a counselor-in-training has a suicidal client and the potential negative impact of client suicide behavior on the supervisory relationship. Potential positive impacts balance these challenges. Potential positive impacts include enhancement of the supervisory relationship and growth in a supervisee’s self-efficacy and skills resulting from having a suicidal client while still in counselor training. The clinic directors also
agreed that master’s-level suicide training in the counseling curriculum is lacking. The Knowledge of Efforts section includes more detail about their specific concerns.

Several authors commented on the importance of suicide training in the Association for Counselor Education and Supervision publication for training clinic directors, *Developing and Maintaining Counselor Education Laboratories* (Mobley & Myers, 2010). Barrio Minton highlighted master’s-level suicide training throughout her chapter on crisis. She asserted that clinic directors have the responsibility to ensure programs train counselors-in-training on crises before practicum and laboratory experiences include training, informational support, supervision, and consultation on suicide and other crises.

Some clinic directors disagree with Barrio Minton (2010) and other colleagues (Hoffman et al., 2013; Mobley & Myers, 2010) about counselors-in-training to serve clients at risk for suicide in training clinics. Some counselor training clinics maintain policies that suicidal ideation is an inappropriate presenting problem for their services (Lauka et al., 2014). Lauka and McCarthy (2013) include the development of detailed emergency policies in their proposed guidelines for counselor training clinics. The authors do not advise if and how clinics should train counselors-in-training about suicidal ideation and behavior in clients.

This limited information seems to demonstrate that counseling program leadership for clinical experiences is not in complete agreement on master’s-level suicide training. It is unclear from the scant literature how clinical leadership at the program-level prioritizes suicide and master’s-level suicide training in practice. The attitudes, concerns, and support or opposition of other program leaders (e.g., program coordinators
and department chairs) is also unknown. This study on the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training will include a variety of program-level leaders in order to fill this gap.

**Other Influential Leaders**

Other influential leaders in the Counselor Education and Supervision field regarding master’s-level suicide training include published authors and presenters on the topic and those who provide related professional service. Their active involvement has the potential to guide the field and affect master’s-level suicide training. This subsection includes a review regarding influential leaders and their suicide-related contributions in publications, presentations, and service. Information from their publications is present throughout this proposal.

**Published authors and presenters.** Counselor educators across faculty ranks are prolific contributors to the academic literature (Barrio Minton, Fernando, & Ray, 2008; Ramsey, Cavallaro, Kiselica, & Zila, 2002) and publish most often in journals affiliated with the American Counseling Association (Barrio Minton et al., 2008). These leaders have together provided the Counselor Education and Supervision community with fairly comprehensive knowledge on suicide. Very few published authors have detailed the implementation and outcomes of master’s-level suicide training and other crises (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012).

A number of published authors and presenters place suicide and/or master’s-level suicide training as a priority in their work. The endeavors of these leaders may support master’s-level suicide training by providing information to the field. Counselor Education and Supervision community members who have provided sizeable contributions to the
field’s knowledge on suicide and master’s-level suicide training include: (a) Gerald A. Juhnke; (b) McAdams and Foster; (c) Paul and Darcy Granello; (d) McGlothlin; and (e) John and Rita Sommers-Flanagan. This section describes a selection of their works.

Juhnke (1994) provided and researched perhaps the first published model for master’s level suicide training. The model used a training video covering the use of the SAD PERSONS acronym for suicide risk assessment (Patterson, Dohn, Bird, & Patterson, 1983). Juhnke and Hovestadt (1995) applied the acronym in supervision and reported research findings that both supervisees and supervisors benefited from using the acronym. The author collaborated with colleagues to create and evaluate a self-suicide assignment designed to enhance empathy, knowledge, and skills in doctoral students for working with suicidal clients (Cook et al., 2007). He served as the first author for the book, Suicide, Self-injury, and Violence in the Schools (Juhnke et al., 2011). Juhnke, along with his son Gerald B. Juhnke, and Pei-Hsuan Hsieh (2012) provided a mnemonic for more broadly addressing clients presenting suicide intent: Stay, Consult, Apprise, Terminate, Truncate, and Transport (SCATTT).

McAdams and Foster (2000) surveyed practicing counselors and revealed many had experienced client suicide as counselors-in-training and were emotionally impacted by the event. Foster and McAdams (1999) provided a conceptual article on implications for Counselor Education and Supervision based on the survey results. The authors then conducted and reported on a follow-up interview regarding coping and recovery among the counselor survivors of suicide loss (McAdams & Foster, 2002). McAdams and Keener (2008) offered a framework for responding to crises, including suicide, and for training counselors-in-training on crises: Preparation, Action, and Recovery.
Darcy Granello provided a suicide intervention model with 25 implementation strategies (2010a) and 12 principles for suicide risk assessment (2010b). She and her husband, Paul, authored a comprehensive text on suicide for helping professionals and educators (Granello & Granello, 2007). The Granellos served as co-authors for Juhnke’s book on suicide in schools (Juhnke et al., 2011). The Granellos offered numerous presentations to the counseling profession and the Counselor Education and Supervision community on suicide (e.g., Granello & Granello, 2013, 2014) and covered suicide assessment in one session of the six-part American Counseling Association (ACA) webinar series on suicide (Granello & Granello, n.d.).


John and Rita Sommers-Flanagan have provided books, articles, and presentations that address suicide (Sommers-Flanagan & Sommers-Flanagan, 1995, 2007, 2009, 2013), mainly in the context of clinical interviewing and the mental status exam and/or work with adolescents. John Sommers-Flanagan is the author of an ACA podcast entitled Tough Kids, Cool Counseling, which includes positive questions for youth suicide assessment interviewing (Sommers-Flanagan, n.d.). He presented a Wiley Faculty Network online lecture entitled Teaching Students the Art of Suicide Assessment.

This section provided acknowledgement of authors and presenters in the Counselor Education and Supervision who have made suicide a priority in their publications and presentations. They have served as informal leaders to the Counselor Education and Supervision community in support of the field’s efforts to provide master’s-level suicide training. Other authors’ published contributions on suicide in the context of crisis and/or school counseling are provided throughout the chapter, including those from Capuzzi, Barrio Minton, Wachter Morris, and Clemens.

Other influencers. It may be impossible to identify every counselor educator and supervisor who has engaged in service or consultation, or in other roles that influenced master’s-level suicide training. A few noted Counselor Education and Supervision community members have represented the Counselor Education and Supervision field in the broader context of suicide and related mental health training, e.g., Verl Pope and Brian Van Brunt both serve on the Clinical Workforce Preparedness Task Force (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

Very little information is available that details the attitude, concern, and support or opposition of Counselor Education and Supervision leadership on the issue of suicide and master’s-level suicide training efforts. It seems clear suicide and master’s-level suicide training is a concern for accreditation bodies, as communicated in previous and current standards (Council for Accreditation of Counseling and Related Educational
Programs, 2001, 2009, 2015; Council on Rehabilitation Education, 2014). It is impossible to conclude the priority that conference reviewers, editorial boards, and publishers place on suicide without knowing more about rate of submission and acceptance of suicide-related manuscripts and presentation proposals. However, it appears some Counselor Education and Supervision leaders, such as authors, presenters, editorial boards, and conference reviewers, have deemed suicide-related scholarly endeavors worthy of pursuit and support.

This study’s incorporation of leadership as a readiness dimension should reveal how the Counselor Education and Supervision community views leaders who influence master’s-level suicide training. Sampling and selection procedures include steps to target leaders of counselor training programs (e.g., chairs of departments, program coordinators, and clinic directors) and demonstrated experts in the field of suicide and master’s-level suicide training. The term leadership is defined broadly in data collection and analysis to include formal leadership such as accreditation and professional groups in Counselor Education and Supervision, individual leaders of organizations and programs, and thought leaders. The sample of program-level leaders and non-leader participants will share their perspectives about Counselor Education and Supervision leadership related to master’s-level suicide training.

**Master’s-level Suicide Training Efforts**

The Community Readiness Model's Efforts dimension includes programs, services, and other initiatives related to the issue being studied (Oetting et al., 1995; Plested et al., 1998). This dimension regards existence and longevity of a community’s efforts and descriptions of them (e.g., responsible party, scope, and schedule). This
section establishes a foundation about current efforts in the Counselor Education and Supervision (CES) field to provide master’s-level suicide training. It is important to understand what is known about efforts to provide master’s-level suicide training so that additional information gathered through this study can add to the literature. Understanding the latest guidelines from beyond and within the CES community may provide comparison for research and action planning by establishing a baseline of readiness related to efforts and identifying areas where an effort in the CES field may depart from recommendations about mental health suicide training. The Knowledge of Efforts section includes a more detailed review of perceived strengths and weaknesses and more formal evaluations of these efforts. This section, Master’s-Level Suicide Training Efforts, begins with a review of recommendations from national entities and CES community members on best practices for suicide training efforts. The remainder of the section includes a review of the literature about existing efforts in the CES field to provide master’s-level suicide training.

**Recommendations for Suicide Training Efforts**

Entities beyond the Counselor Education and Supervision community have offered recommendations for pre-professional suicide training efforts. The recommendations include: a national system that certifies health professionals’ mastery of suicide core competencies; uniform, standards-based curricula and competency-based education; and identification of the best means for teaching and disseminating suicide education (Knesper et al., 2010; Osteen et al., 2014; Rudd et al., 2008; Schmitz et al., 2012; U.S. Department of Health and Human Services Office of the Surgeon General and
National Action Alliance for Suicide Prevention [USHHSOSG and NAASP, 2012]. The Clinical Workforce Preparedness Task Force (2014) offered guidelines on both content and structure of suicide training. Authors from Counselor Education and Supervision and other mental health fields have also provided suggestions for pre-professional suicide training. What follows is a review of the recommendations, organized by structure and content fitting the informational areas of this Community Readiness Model dimension: existence of efforts and responsible parties, schedule, and scope. Another set of recommendations involves training methods.

**Existence and responsible parties.** Recommendations regarding existence of master’s-level suicide training include: suggested presence of suicide content in all counselor training and suggested increase in the amount. Those beyond the Counselor Education and Supervision community have urged mental health training programs increase and improve suicide training (Schmitz et al., 2012; USHHSOSG and NAASP, 2012). Authors in the Counselor Education and Supervision community have agreed (Barrio Minton & Pease-Carter, 2011; Dupre et al., 2014; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). Recent graduates also recommended counseling programs increase the amount and/or depth of attention on crisis preparation (Wachter Morris & Barrio Minton, 2012).

Several parties appear to be responsible for master’s-level suicide training. Those beyond the Counselor Education and Supervision community (Rudd et al., 2008; Ruth et al., 2012; Schmitz et al., 2012) as well as Counselor Education and Supervision authors and recent graduates (Dupre et al., 2014; Freadling & Foss-Kelly, 2014; McAdams & Keener, 2008; Wachter Morris & Barrio Minton, 2012) placed responsibility on
instructors and supervisors for training on suicide and other crises. An American Association of Suicidology task force on mental health training (Schmitz et al., 2012) also placed responsibility on accrediting bodies to “include suicide-specific education and skill acquisition as part of their requirements” (p. 298) and to ensure that training includes “detection, assessment, treatment, and management of suicidal patients” (p. 299) based on the established core competencies (American Association of Suicidology, 2004). The U.S. Surgeon General’s National Strategy for Suicide Prevention (2012) contains two objectives that highlight the responsibilities of accreditation organizations and training programs. Applying Objective 7.4 regarding accreditation bodies, the Council for Accreditation of Counseling and Related Educational Programs and the Council on Rehabilitation Education have the responsibility to “promote evidence-based and best practice suicide prevention training” in core education guidelines (p. 47). Applying Objective 7.4 regarding health professionals’ education, counselor training programs have the responsibility to adopt core education guidelines that address suicide.

**Schedule.** Another element of readiness in this dimension is the scheduling of efforts or a description of their availability and occurrence. Infusing suicide content throughout education and supervision is one recommendation for the schedule of master’s-level suicide training. Other recommendations include stand-alone courses, cocurricular workshops, and proactive coverage placed in anticipation of the next stage in a counselor-in-training’s developmental experience.

Infusion or repetitive coverage of suicide content in mental health training has overwhelming consensus from authors in the Counselor Education and Supervision field (Dupre et al., 2014; Hoffman et al., 2013; McAdams & Foster, 2000; Wachter Morris &
A counselor training program using an infusion approach might cover “setting-based, systems-level, and interdisciplinary crisis response procedures” in specialty courses, along with crisis-specific content in several core courses such as theories, ethics, and assessment (Wachtler Morris & Barrio Minton, 2012). Dupre et al. (2014) asserted this integration scheduling can help counselors-in-training understand how crisis is “intricately woven into the fabric of counseling practices. For students to develop competencies in crisis and emergency response, essential information must be integrated throughout the curriculum in a comprehensive way” (p. 92). This recommendation mirrors those for training mental health providers on suicide that is based on training research: pre-training preparation, training delivered in stages, and post-training support (Osteen et al., 2014). Ongoing or follow-up training appears necessary to sustain training outcomes (Beidas & Kendall, 2010).

Several authors in the Counselor Education and Supervision field recommend supervision on suicide should occur throughout a counselor-in-training’s supervision experience. Master’s-level suicide training in on-campus practica is an evolving supervision process (Hoffman et al., 2013). Hipple and Beamish (2007) suggested supervisors use conversations with supervisees to make a subjective judgment about developmental stages of supervisees relevant to crisis, which can inform what crisis topics need to be addressed as supervision progresses. McGlothlin et al. (2005) placed suicide supervision “(a) at the onset of supervision, (b) during suicidal situations, (c) after a session with a suicidal client, and (d) at the end of supervision to reflect on supervisees’ achieved progress” (p. 139). Other options for scheduling master’s-level suicide training are offering an entire course on suicide, crisis, or death issues in counseling (Barrio
Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012) and/or cocurricular or extracurricular workshops (Wachter Morris & Barrio Minton, 2012; Wozny & Zinck, 2007). Wozny (2005) argued for suicide and violence assessment/intervention to be placed within a separate course as well as infused throughout the curriculum, much like the placement of diversity issues in counseling evolved from integration to a combined infused and stand-alone course approach. Several recommendations from authors in the Counselor Education and Supervision field involve counselor-in-training development and the scheduling of suicide training before an anticipated event. Training clinic directors stated the topic of suicide should be introduced early in a counselor-in-training’s program as a proactive training measure (Hoffman et al., 2013). Recommendations for supervisors include proactively broaching conversations with supervisees (e.g., before practica and internship begin), and discussing: (1) the potential of having suicidal clients during this practical learning experience (Hoffman et al., 2013), (2) expectations for communications with supervisors and others during crisis situations (Osborn & Davis, 1996), including what specific client behaviors warrant immediate supervisory attention (Hipple & Beamish, 2007), and (3) supervisory and organizational policies on crisis (Falvey, 2002). Hipple and Beamish (2007) declared the supervisor should screen and assign clients to supervisees based on supervisee skill and training for intervening with crises.

Scope. Another element of the Efforts readiness dimension is scope of the efforts (i.e., content of master’s-level suicide training). The core competencies for the assessment and management of individuals at risk for suicide (American Association of Suicidology, 2004) were intended to serve as “a common framework for learning about
and gaining skills in working with clients at risk for suicide, comprehensive enough to provide the foundation for developing courses for graduate students and continuing education for mental health professionals” (American Association of Suicidology, 2006, p. 2). As a reminder, they dovetail nicely with more recent content recommendations from Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention (2014, p. 19-22).

Other suicide concerns relevant to master’s-level suicide training include postvention (Laux, 2002; Wachter Morris & Barrio Minton, 2012) and impact on clinician, i.e., counselors’ experiences of vicarious trauma and/or suicide loss (Foster & McAdams, 1999; Hoffman et al., 2013). A brief critique of the literature on master’s-level suicide training follows. This serves to connect the literature from the Counselor Education and Supervision field to the broader literature on suicide training content and identify areas of potential alignment and misalignment.

The literature on master’s-level suicide training content is largely aligned with the latest knowledge in the field of suicide education and supervision. All Clinical Workforce Preparedness content areas are addressed in the counseling and/or counselor education and supervision literature with some mention of the importance of covering them in master’s-level suicide training. There seems to be a heightened focus on the humanistic elements of counseling suicidal clients and master’s-level suicide training. The counselor education and supervision literature on suicide training content may be lacking or misaligned in areas such as evidence-based practice and formal assessment.

The counselor education and supervision literature appears to draw particular attention to affective/attitudinal and relational aspects of master’s-level suicide training,
namely counselor-in-training self-awareness (Gibbons, Spurgeon, & Studer, 2009; McGlothlin et al., 2005), the supervisory alliance (Hipple & Beamish, 2007; Hoffman et al., 2013), and the emotional impact of client suicide issues on the counselor-in-training (Foster & McAdams, 1999; Hoffman et al., 2013; McGlothlin, 2008). These authors urge counselor educators and supervisors to proactively and directly address these issues with counselors-in-training when teaching about suicide and/or supervising counselors-in-training seeing suicidal clients. They also position counselor educators and supervisors as emotional supports for counselors-in-training. Potential misalignment between literature from the Counselor Education and Supervision field and that from the greater community relates to suicide training content on empirically-informed practice. Guides for practicum and internship appear to advise counselors-in-training to use no-suicide contracts (Hodges, 2011; Scott et al., 2013) although there is evidence against this practice (Center for Substance Abuse Treatment, 2009; Edwards & Sachmann, 2010; Lee & Bartlett, 2005; Rudd, Mandrusiak, et al., 2006). Barrio Minton (2010) warned against the use of no-suicide contracts in her chapter of the Association of Counselor Education and Supervision guide on Developing and Maintaining Counselor Education Laboratories and recommends instead that counselor training clinics institute empirically-informed practices for crisis management, e.g., Collaborative Assessment and Management of Suicidality. The Collaborative Assessment and Management of Suicidality treatment model (Jobes & Drozd, 2004; Jobes, 2012), Joiner’s Interpersonal Theory of Suicide (Van Orden et al., 2010), and other evidence-based conceptualizations and psychotherapies for suicide prevention (Brown & Jager-Hyman, 2014; National Action
Alliance: Clinical Care and Intervention Task Force, 2013) achieve rare mention in the counselor education and supervision literature about master’s-level suicide training.

**Methods.** Training methods are not a standard element of the Efforts dimension of the Community Readiness Model, but authors from the Counselor Education and Supervision field and beyond have highlighted methods as an important aspect of master’s-level suicide training. The National Action Alliance's Workforce Preparedness Task Force (2014) provided guidance on structure of suicide training. The authors of the report acknowledge these recommendations may be more suitable for workplace training of postgraduate clinicians, e.g., having identified personnel to “advise the host organization…on any follow-up training needs/supports” (p. 15). However, authors in Counselor Education and Supervision and other fields have echoed several of the Clinical Workforce Preparedness methods recommendations in their suggestions for pre-professional suicide training, e.g., stated goals, qualified trainers, application of various teaching methodologies, and evaluation. A review follows of structure recommendations from beyond and within the counselor education and supervision literature.

Recommended methods for pre-professional suicide training generally fall into three categories: passive learning, active learning, and practical learning. Numerous authors (e.g., Miller, McGlothlin, & West, 2013; Clinical Workforce Preparedness Task Force, 2014; Rudd et al., 2008) recommend using a combination of these methods. I describe each method category and provide examples of specific recommendations related to pre-professional suicide training. The following section includes a review of the presence and nature of methods the Counselor Education and Supervision community may use for master’s-level suicide training.
**Passive learning.** “Passive learning takes place when students take on the role of ‘receptacles of knowledge’; that is, they do not directly participate in the learning process” (Ryan & Martens, 1992, p. 29). Perhaps the most well-known passive learning strategy is the lecture (Bonwell & Eison, 1991; Ryan & Martens, 1992). Lectures are recommended for disseminating suicide concepts and facts such as statistics and definitions of terminology (Rudd et al., 2008).

Other passive learning recommendations for master’s-level suicide training are expert guests, student observation of live simulations, readings, and watching videos. An educator or supervisor can invite guest lecturers and convene expert panels (Laux, 2002; Wachter Morris & Barrio Minton, 2012). Experts or the educator/supervisor can demonstrate suicide risk assessment and intervention (Cramer, Johnson, McLaughlin, Rausch, & Conroy, 2013; Rudd et al., 2008). An educator or supervisor may assign specific readings for students and/or provide a supplemental reading list such as the list Rudd et al. (2008) organized by suicide risk assessment and management competency (American Association of Suicidology, 2004). Videos may display suicide-related scenarios such as an enacted suicide assessment or intervention (Rudd et al., 2008). For example, Juhnke (1994, 1995) developed and utilized a videotape on suicide risk factors to teach counselors-in-training.

**Active learning.** The terms *active learning, experiential learning,* and *practical learning* are sometimes used interchangeably. In this proposal, active learning refers to “instructional activities involving students in doing things and thinking about what they are doing” (Bonwell & Eison, 1991, p. 19). Passive and active learning occurs along a continuum of student involvement: strategies become more active as they engage
Any addition of prompted reflection such as classroom discussion or a writing assignment enhances active learning.

Authors include recommendations for combining passive and active learning approaches among their suggestions for pre-professional suicide training (Juhnke, 1994; Rudd et al., 2008; Wozny & Zinck, 2007). For example, Wozny and Zinck (2007) described group discussions after showing videos to counselors-in-training about suicide stigma. Another example of an intermediate active learning strategy is case vignette followed by discussion or writing assignments (McNiel et al., 2008; Miller et al., 2013; Norrish, 2009; Rudd et al., 2008; Wozny & Zinck, 2007). Writing assignments may include clinical documentation such as case notes or assessment results and treatment plans (McNiel et al., 2008; Miller et al., 2013).

Other strategies for suicide training are more active. The active learning approach authors recommend most for suicide training is student role-play (Cramer et al., 2013; Hung et al., 2012; McNiel et al., 2008; Miller et al., 2013; Rudd et al., 2008; Walter & Thanasiu, 2011). Role-play variations abound in the training literature. For example, students can practice suicide risk assessment procedures or elicitation of the suicide wish (Rudd et al., 2008) or use contrast interviewing by enacting a purposefully bad role-play and a good role-play (Miller et al., 2013). The use of cutting-edge technology such as avatars and virtual reality is a creative suggestion for role-plays in pre-professional suicide training (Carpenter, Osterberg, & Sutcliffe, 2012; Miller et al., 2013).

Some authors recommend adding an evaluative component to role-plays such as peer or educator/supervisor feedback. Walter and Thanasiu (2011) described the use of pocket camcorder technology to record suicide risk assessment role plays for review and
discussion in class. Educators adopted the objective structured clinical examination method from medical training and applied it to psychiatry and psychology training on suicide (Cramer et al., 2013; Hung et al., 2012; McNiel et al., 2008). Trainees submitted videotaped role-plays in which they conducted a mock suicide assessment or intervention with a trained actor. The actor utilized a predetermined script and the evaluators rated the trainees’ skills using an established assessment form. Trainees received feedback sessions with faculty based on the assessment.

Experiential learning methods refers to teaching strategies that connect formal academic education with the field of work by directly exposing the learner to the focus of study (Kolb, 2015). Examples include field projects, cooperative education, work/study assignments, and internships. This proposal places experiential learning methods that do not involve counselors-in-training providing counseling services to clients with active learning. For example, Laux (2002) suggested faculty arrange class visits to crisis centers and emergency rooms. Further exposure might involve counselors-in-training shadowing a crisis worker or volunteering at a crisis hotline (Miller et al., 2013). This proposal delineates experiential learning in which counselors-in-training provide counseling as practical learning.

Practical learning. Practical learning is the method which counseling practica and internships employ. Practica and internship involve direct service and interaction with clients (Council for Accreditation of Counseling and Related Educational Programs, 2009). Counselors-in-training gain practical experience observing counseling live, acting as a co-counselor, and providing supervised counseling independently to clients (Laux, 2002). Textbooks written for counseling practicum and internship address suicide among
the situations counselors-in-training should prepare to encounter in practical learning (Hodges, 2011; Scott et al., 2013).

Master’s-level suicide training during internship and practicum may involve site supervisors and program supervisors (Council for Accreditation of Counseling and Related Educational Programs, 2009). These supervisors can utilize the passive and active learning strategies to review and solidify trainees’ knowledge and skills (Rudd et al., 2008). For instance, training clinic and site supervisors should orient supervisees to the clinic or organization’s crisis protocol (Barrio Minton, 2010; Ranahan, 2013). University supervisors overseeing off-site practical experiences can elicit real-life examples from counselors-in-training and facilitate sharing and discussion during group supervision (Ranahan, 2013).

Authors have recommended supervisors maximize practical learning opportunities at this stage in student’s program. Supervisors should work closely with supervisees when suicidal clients are encountered (Ranahan, 2013). Supervisory interventions during a crisis like suicide can take place outside the counseling room (e.g., live supervision without direct supervisor involvement), inside the counseling room (e.g., direct supervisor involvement in counseling session), and after hours in the case of non-live supervision (Hipple & Beamish, 2007). Master’s-level suicide training after a counselor-in-training sees a client in crisis can involve debriefing the situation with a supervisee (Hipple & Beamish, 2007) and addressing the potential of vicarious trauma (Hoffman et al., 2013). The literature includes numerous recommendations on pre-professional suicide training. Authors from beyond and within the Counselor Education and Supervision field appear to reach general consensus about the existence and
responsible parties, schedule, scope, and methods. Individual counselor educators, program and site supervisors, and program leaders (e.g., training clinic directors) are responsible for providing master’s-level suicide training. They should place master’s-level suicide training throughout the curriculum, at key points of transition (e.g., beginning and end of didactic portion and practical portion), and more intensely during practical experiences involving clients at risk for suicide. Counselor training programs and accreditation bodies should ensure counselors-in-training receive master’s-level suicide training by establishing core training guidelines pertaining to suicide that are based on core competencies and the latest knowledge.

Members of the Counselor Education and Supervision field have a broad range of content to include in training related to suicide prevention, assessment, intervention, continuity of care, postvention, and impact on clinician. The field appears to prioritize content involving risk assessment protocols and affective/attitudinal and relational aspects of master’s-level suicide training. The literature contains recommendations that educators and supervisors integrate passive, active, and practical learning methods. The next section includes a review of the literature on the efforts in the Counselor Education and Supervision field to provide master’s-level suicide training in comparison with these recommendations.

**Suicide Training Efforts in Counselor Education and Supervision**

This section includes a review of the scant literature about efforts in the Counselor Education and Supervision field to provide master’s-level suicide training. This is presented to demonstrate the need for a greater understanding of the field’s
existing efforts to provide master’s-level suicide training. The section includes (a) longevity, existence, and responsible parties and (b) schedule, scope, and methods of master’s-level suicide training.

**Longevity, existence, and responsibility.** There is little evidence within the counselor education and supervision literature of substantive efforts to provide master’s-level suicide training prior to the last decade. Juhnke (1994) may be the oldest publication describing an effort to provide master’s-level suicide training. He explains a suicide risk assessment video he created and showed to students. Crisis and suicide-specific counselor education and supervision models (e.g., Hoffman et al., 2013; McAdams & Keener, 2008; McGlothlin, Rainey, & Kindsvatter, 2005; Miller, McGlothlin, & West, 2013; Wozny & Zinck, 2007) were developed within the last 10 years. The actual prevalence of their use is unknown.

Prior to 2009, published research (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012; Wozny, 2005) demonstrated a lack of suicide and related training efforts in most counselor preparation programs. Most counseling programs, whether accredited by the Council for Accreditation of Counseling and Related Educational Programs or not, did not offer a crisis course (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012), and a mere 2% of accredited ones provided a course specific to suicide (Wozny, 2005). The majority of accredited programs estimated students received less than 10 hours of crisis training prior to graduation, with over 30% estimating less than five hours, and 7.7% estimating no crisis training (Barrio Minton & Pease-Carter, 2011). Recent graduates provided estimates closer to three hours or less (Wachter Morris & Barrio Minton, 2012). The amount of
crisis training that counseling students received did not differ based on the program’s accreditation status or professional setting of graduates (Wachter Morris & Barrio Minton, 2012). Counseling master’s and doctoral students estimated their programs devoted 5.6 hours of formal coursework specifically to suicide (Raper, 2010). Master’s students estimated spending 5.2 hours on suicide in practicum and internship.

Many counselors-in-training took advantage of required or optional workshops on crisis while in graduate training (Wachter Morris & Barrio Minton, 2012). Optional cocurricular workshops may be considered continuing education or professional development. Over 40% of recent counseling graduates said they completed crisis continuing education while graduate students (Wachter Morris & Barrio Minton, 2012). Master’s and doctoral students estimated completing seven hours of suicide-specific continuing education while in school (Raper, 2010).

Publications on efforts to provide master’s-level suicide training have named counseling faculty (Barrio Minton & Pease-Carter, 2011; Miller et al., 2013; Wozny & Zinck, 2007) and clinic directors and supervisors (Barrio Minton, 2010; Hipple & Beamish, 2007; Hoffman et al., 2013) as responsible for implementing the efforts. No descriptions have explicitly referred to adjunct or part-time instructors or supervisors. With the exception of clinic directors, other administrators such as department chairs and program coordinators have not been explicitly named as responsible for master’s-level suicide training. It may be assumed that any program-wide efforts regarding master’s-level suicide training involved administrators and/or adjuncts; however, these parties have not been clearly identified in the literature.
Schedule, scope, and methods. Master’s-level suicide training prior to 2009 appears to have fallen short of the recommendation for infusion throughout the curriculum. Nearly one-quarter of accredited programs did not cover crisis intervention practices until internship (Barrio Minton & Pease-Carter, 2011). Most programs that provided pre-internship crisis training did so in specialty courses such as school and college counseling courses (Barrio Minton & Pease-Carter, 2011). Some programs covered crisis in core courses such as helping relationships and group counseling. This information seems to communicate that the Counselor Education and Supervision field was inconsistent in its placement of crisis in counselor training.

Exceptions to these general descriptive statistics may have existed. Wachter Morris and Barrio Minton (2012) described one counseling program’s infusion approach to providing suicide and related crisis training in which crisis content appeared throughout core and specialty courses. Wozny (2005) described monthly suicide intervention workshops in a local training institute developed by a counselor educator. He recommended half-day length for these and similar workshops at professional conferences. It does not appear the Counselor Education and Supervision field as a whole strategically scheduled master’s-level suicide training at several points along a counseling student’s training experience.

The scope or content of pre-2009 master’s-level suicide training also appeared incomplete compared to the core competencies defined by the American Association of Suicidology (2004). A content analysis of crisis course syllabi (Barrio Minton & Pease-Carter, 2011) yielded no suicide-specific texts. Though 91% of the syllabi included suicide crises in the course objectives, many of the suicide content recommendations
were not present including specific crisis intervention skills. Wozny and Zinck's (2007) suicide workshop was delivered as an extracurricular, three-hour training for counselors-in-training and counselors. The workshop touched on content related to attitudes, myths, warning signs, risk factors, risk assessment, and “safety-based suicide interventions” (p. 5) but did not cover a number of other areas. McGlothlin, Rainey, and Kindsvatter's (2005) Cube Model of Supervision and Suicide addressed attitudes and beliefs among trainees, some elements of risk assessment and intervention, and the expectation for supervision during continuity of care. It also provided a structure for the supervisor to address potential traumatic stress in supervisees in balance with the supervisor’s and counselor’s responsibility for maintaining client welfare (McGlothlin et al., 2005). However, the prevalence of its actual use in supervision of counselors-in-training was not published.

The methods previously used in the Counselor Education and Supervision field to provide master’s-level suicide training may have aligned with the recommendation to combine passive, active, and practical learning approaches. More than half of crisis courses involved each of the following instructional methods: lectures, discussions, role plays, and demonstrations (Barrio Minton & Pease-Carter, 2011). Other educational methods included papers involving crisis literature (75%), journals or personal reflections (41.67%), case studies and presentations (33.33% each). Only three courses (25%) involved experiential learning such as service learning or an out-of-class visit to a crisis center. Supervisors in on-campus clinics described using a variety of methods during students’ practical learning experiences with suicide: identifying informational resources
for further reading, live observation, videotape review, and debriefing discussions (Hipple & Beamish, 2007; Hoffman et al., 2013).

Almost no information is available about current efforts in the Counselor Education and Supervision field to provide master’s-level suicide training. The only relevant study that uses data collected after the release of the 2009 Standards (Council for Accreditation of Counseling and Educational Programs [CACREP], 2009) involved a national survey of counselor educators about which assessment instruments they covered in counseling coursework (Neukrug et al., 2013). The educators ($n = 210$) ranked a suicide-specific assessment instrument a 2 ($M = 2.10$) on a scale of 1 to 5, indicating it is almost never taught in master’s coursework (Neukrug et al., 2013). No published literature is available to identify how the Counselor Education and Supervision field has addressed master’s-level suicide training since the 2009 Standards (CACREP, 2009) included an increased focus on suicide.

Recommendations for pre-professional suicide training have grown from beyond the Counselor Education and Supervision community (American Association of Suicidology, 2004; Clinical Workforce Preparedness Task Force, 2014) and from within the field (Barrio Minton, 2010; Foster & McAdams, 1999; Miller et al., 2013). Few comprehensive efforts to provide master’s-level suicide training seem to have been in place before the CACREP (2009) Standards (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). Master’s-level suicide training appears to have aligned somewhat with recommendations for learning methods, but less so with recommendations for scope and schedule.
Only one publication included post-2009 data involving master’s-level suicide training (Neukrug et al., 2013), and it focused exclusively on training about assessment instruments. It is impossible to conclude how the Counselor Education and Supervision field has provided master’s-level suicide training since suicide risk assessment and management training became a requirement for accreditation. This review provided a preliminary comparison of previous efforts in Counselor Education and Supervision against recommendations for master’s-level suicide training. The scant publications with evaluative information about implemented efforts in the field to address suicide are reviewed in the next section: Knowledge of Efforts.

**Knowledge of Efforts**

The Community Readiness Model dimension of knowledge of efforts relates to community members’ knowledge and/or access to knowledge about efforts to address the issue, including understanding the effectiveness of efforts (Oetting et al., 1995; Plested et al., 2006). Knowledge of efforts may include what goals and whom an effort targets, misconceptions, how community members learn of efforts, perceived strengths and weaknesses, and whether evaluation results are used to adapt ongoing or new efforts. This section of the review is intended to identify what knowledge is available in the literature about master’s-level suicide training, including evaluations of their effectiveness. This serves to pinpoint gaps in knowledge of master’s-level suicide training, which this study may fill.

Some research and evaluation has been published about pre-2009 master’s-level suicide training, mainly surveys and related studies on the perceptions of graduates, counselors-in-training, educators, and supervisors (Barrio Minton & Pease-Carter, 2011;
Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Wachter Morris & Barrio Minton, 2012; Wozny & Zinck, 2007). Other studies (Raper, 2010; Wozny & Zinck, 2007) allow examination of master’s-level suicide training efforts outcomes. Additional information on the strengths and weaknesses of efforts comes in the form of comments by authors in Counselor Education and Supervision (Dupre et al., 2014; Gibbons et al., 2009; Wachter Morris & Barrio Minton, 2012). Little is known about any misconceptions Counselor Education and Supervision members may have about the efforts, nor how they learn of them or apply results of evaluations to their own work.

The purposes of this section are to illuminate the overall lack of evaluative findings in the counselor education and supervision literature on master’s-level suicide training and to highlight the need for a study that elicits evaluative information about efforts to provide master’s-level suicide training. In particular, this information may be available in local contexts (e.g., individual counselor training programs or internship sites), but not yet within the published literature. This section of the review informed the design of the study, including sampling and selection and interview questions. The section addresses strengths and weaknesses of master’s-level suicide training, misconceptions among Counselor Education and Supervision members about master’s-level suicide training efforts, and field members’ access to and use of knowledge about such efforts.

**Strengths.** The primary strength of master’s-level suicide training efforts appears to be the use of active learning methods (Gibbons et al., 2009; Wozny & Zinck, 2007). Another strength is the inclusion of suicide content in practical learning. The close
attention live supervision during practicum offers counselors-in-training seems particularly valued (Dupre et al., 2014; Hoffman et al., 2013).

Counselors-in-training identified the use of active learning methods as a strength of master’s-level suicide training. Participants of Gibbons et al.’s (2009) workshop evaluated the role-play exercise as the most valuable part of the workshop. The role-play involved using a predetermined case vignette to act out one of the suicide risk assessment protocols covered in the workshop. Participants of Wozny and Zinck's (2007) three-hour suicide workshop for counselors-in-training and counselors assessed the training positively, especially related to the active learning method. Most exercises involved participants responding to videotaped or written vignettes by participating in group discussions and role-plays.

Counselors-in-training have requested even more active learning in suicide and crisis training. Wozny and Zinck's (2007) participants expressed appreciation about the inclusion of the activities and suggested that more be incorporated in future workshops. Recent graduates suggested counselor educators model crisis assessment and/or intervention practices, use role-play and small group activities to augment didactic training on crisis, and incorporate experiential activities including field experiences and volunteer experiences into the crisis curriculum (Wachter Morris & Barrio Minton, 2012).

The inclusion of suicide content in practical learning, especially live supervision, is another strength of master’s-level suicide training. Practicing counselors retrospectively described the supervision they had received as counselors-in-training as “consistently available, clinically focused, and well organized,” involving direct
observation of their work with clients via live supervision or video review (Dupre et al., 2014, p. 91). The counselors deemed this type of supervision far superior to the crisis supervision they were currently receiving as post-licensure counselors. Clinic directors agreed the potential immediacy of supervisory intervention and amount of supervision available to supervisees in on-campus training clinics makes supervision of counselors-in-training regarding a suicidal client a formative learning experience (Hoffman et al., 2013).

**Weaknesses.** Fewer than half of new counselors rated the graduate training they received on suicide assessment related to crisis as good or excellent (Wachter Morris & Barrio Minton, 2012). Though graduates assessed the quality of training on suicide assessment higher than other surveyed categories (e.g., sexual assault, community disaster, etc.), the authors commented: “Given the risk inherent in responding to crises, we consider even those to be unacceptably low” (p. 264). Additionally, the quality of suicide management/intervention training was assessed even lower by participants in this study (23% good, 15% excellent). Weaknesses of existing master’s-level suicide training seem to fall generally into these categories: lack of existence and infusion, lack of breadth and depth, and lack of sustained impact.

**Lack of existence and infusion.** Research on master’s-level suicide training pinpointed low presence and consistent attention throughout a counselor-in-training’s learning experience. Master’s-level suicide training prior to 2009 was reportedly absent or scarce in many counselor training programs (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). “Although many counselor education training programs incorporate a knowledge base of suicide theory and
assessments in their curriculum, training is often inconsistent and randomly addressed” (Gibbons, Spurgeon, & Studer, 2009, p. 9).

One study that highlighted strengths in supervision on suicide in the Counselor Education and Supervision field also highlighted weaknesses in the field’s education on suicide. Hoffman et al. (2013) interviewed training clinic directors who had supervised a counselor-in-training with a suicidal client in the previous two years. One participant stated counseling curriculum did not always include the topic of suicide and asserted, “It needs to be in the classroom as part of what we do as a profession” (p. 116). The other participants in the study agreed counselor education did not consistently cover suicide.

**Lack of breadth and depth.** Two published studies served to highlight lack of breadth and depth as a weakness of master’s-level suicide training. Recent graduates from an accredited clinical mental health counseling program currently working in community mental health centers said their counselor training program did not prepare them enough for crisis intervention and hospitalization process, case management, and documentation (Freadling & Foss-Kelly, 2014). They suggested that counselor training programs work to provide more training in didactic and practical courses on complex cases and to provide more crisis professionals as guest speakers.

Constructive criticism for Wozny and Zinck’s (2007) suicide workshop included the lack of content on how to provide advanced intervention and management for imminent risk and/or continuing clients. Elements of intervention training that seemed absent were “treatment level referral,” “family support and education,” and “longer term, ongoing clinical care management” (Clinical Workforce Preparedness Task Force, 2014). Though participants believed the workshop filled a gap in their counselor training related
to suicide knowledge and skills practice, the post-training focus groups indicated they wanted more breadth and depth. One participant commented: “If this person is going to harm themselves, now what do I do? Where do I go about getting them committed? Like...how does that process work? Who do I call?” (p. 7).

**Lack of consistent, sustained impact.** Researchers have investigated three outcomes of master’s-level training on suicide or crisis: self-efficacy, knowledge, and skills to address suicide in counseling. There is not conclusive evidence to suggest that the master’s-level suicide training that the Counselor Education and Supervision field provided before 2009 yielded moderate to high levels of any of these outcomes. No published literature contains research about outcomes of master’s-level suicide training since the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009) contained an elevated focus on suicide. This section includes a brief review of the research about master’s-level suicide training.

One objective of master’s-level suicide training may be that participants develop self-efficacy to address suicide and other crises in counseling. Allen et al. (2002) found more than half of school counselors felt not at all or only minimally prepared for crisis intervention. Though 87% of school counselors believed it was their responsibility to identify suicide risk in students, only 38% of school counselors believed they could do so (King et al., 1999). Survey participants who received crisis training as counselors-in-training rated their self-efficacy to address suicide in counseling as somewhat to moderately prepared ($M = 2.81$ of 5; Raper, 2010) and adequately to well prepared ($M = 3.86$ of 5; Wachter Morris & Barrio Minton, 2012). Satisfaction with crisis training correlated with crisis self-efficacy, and the amount of time counselors-in-training
completed in crisis training predicted crisis self-efficacy (Wachter Morris & Barrio Minton, 2012).

Another objective of master’s-level suicide training may include increasing knowledge counselors-in-training have about suicide. Over half of the school counselors surveyed by King et al. (2000) reported receiving suicide education in graduate training; however, they failed to answer correctly about appropriate suicide intervention in schools. As an example, 73% inaccurately believed school counselors should refrain from contacting police about a suicidal student. Wozny (as cited in Wozny & Zinck, 2007) found school counselors were able to distinguish real from fake suicide risk factors and to suggest appropriate interventions when provided in the form of a list. However, school counselors may not always encounter suicide in this form in their work with students and may lack the understanding needed to assess for suicide risk.

Skills related to suicide (e.g., clinical documentation and assessment techniques) are another outcome in suicide training research with pre-professionals and professionals (Osteen et al., 2014). Raper's (2010) dissertation appears to be the only available study of master’s-level suicide training and skills to address suicide in counseling. Raper (2010) found that counselors-in-training who had completed a basic counseling skills course had better suicide intervention skills than those who had not completed such a course. The same study revealed no correlation between the completion of a crisis counseling course and suicide intervention skills. It is unclear what may account for this surprising finding.

Outcomes research involving pre/post instruments would provide a clearer evaluation of master’s-level suicide training and intended objectives related to self-efficacy, knowledge, and skills. However, no such publications exist. No authors have
published studies that demonstrate how master’s-level suicide training aligned with accreditation standards (Council for Accreditation of Counseling and Related Educational Programs, 2009, 2015) may meet objectives to prepare counselors-in-training with knowledge and skills to assess and manage client suicide risk.

**Misconceptions.** Another element in the Knowledge of Efforts dimension involves misconceptions among the targeted community. Examples of possible misconceptions in this context are: believing all accredited programs offer a crisis course, assuming all site supervisors do provide master’s-level suicide training to supervisees, or thinking crisis instructors assign suicide-specific texts. No publications clearly identify misconceptions Counselor Education and Supervision members may hold about master’s-level suicide training. This study’s findings may illuminate this and other elements of knowledge in the field about master’s-level suicide training.

**Access to and use of knowledge.** The final element in the Knowledge of Efforts dimension involves access to and use of knowledge in the targeted community. Issues relating to access to and use of knowledge on master’s-level suicide training in Counselor Education and Supervision are: dissemination and availability of knowledge and application of knowledge to training efforts. How the field’s members find and use information about master’s-level suicide training is unclear; however, the academic literature, participation in internal evaluations of their own programs, and continuing education are likely sources. This subsection includes a brief review of information on access to and use of knowledge regarding master’s-level suicide training.

Members of the Counselor Education and Supervision field have disseminated knowledge about master’s-level suicide training through the academic literature
(Hoffman et al., 2013; Juhnke, 1994; Wozny & Zinck, 2007). Counselor educators’ and supervisors’ review of the academic literature may not provide them with much knowledge about the ins and outs of current master’s-level suicide training as publications that address this topic are so scarce. Published information may be available to Counselor Education and Supervision members with full library access, but not to others (e.g., site supervisors). It is important to note that information about current master’s-level suicide training may exist, but may not be disseminated through publications. Unpublished internal evaluations regarding a program’s success addressing the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009) on suicide are not available in the literature. Off-campus practicum and internship sites that may have evaluated the master’s-level suicide training they provide supervisees have also not published these findings.

Published and unpublished information may be disseminated to Counselor Education and Supervision members via continuing education. The Knowledge of Suicide section included reference to professional conferences in and beyond the Counselor Education and Supervision field and to online training opportunities. Another element of knowledge of efforts is how evaluation results are used to adapt ongoing or new efforts. The absence of published evaluations in the field’s literature may prompt the field’s authors to reference evaluations from psychology (e.g., Madson & Vas, 2003) and psychiatry (Fenwick, Vassilas, Carter, & Haque, 2004). However, the field’s authors have not explicitly described if and how they used these evaluations to adapt master’s-level suicide training. No publications in Counselor Education and Supervision to date
have addressed how the field’s members have used internal evaluations to adapt master’s-level suicide training.

Dupre et al. (2014) asserted: “The lack of attention in the literature to field-based crisis supervision exposes clients, counselors, and supervisors to a number of hazards…there is no assurance that counselors are adequately prepared to manage these complex clinical situations” (p. 83). Other authors made similar lamentations related to suicide/crisis education (Miller et al., 2013; Wachter Morris & Barrio Minton, 2012). A study that explores what the Counselor Education and Supervision community knows about published and unpublished efforts to provide master’s-level suicide training and how members access and apply the information would serve as a major contribution to the literature and the practice of counselor education and supervision.

**Climate**

The Community Readiness Model dimension of community climate relates to the community’s attitude toward the issue and efforts (Plested et al., 1999). Climate may include how much of a concern or priority the issue is among community members, community support for efforts and perceived need for additional ones, and obstacles to addressing the issue in their community. This section of the review covers literature on the climate in the Counselor Education and Supervision field toward suicide and master’s-level suicide training. It is intended to establish what is known about the attitudinal environment for master’s-level suicide training and to identify gaps in the literature about the field’s attitude toward suicide and master’s-level suicide training. The section begins with climate in the broader community to provide context to the discussion.
Broader Community Climate about Suicide and Suicide Training

Attitudes. Societal attitudes toward suicide have been part of an ongoing discussion for thousands of years. Perhaps the first written reference to suicide was in an Egyptian text from around 2000 B.C. (Colt, 1992 as cited in Granello & Granello, 2007). Multiple perspectives on suicide have existed throughout history, including suicide as (a) a basic human right; (b) an honorable and rational act; (c) an act of harm against one’s community; (d) a sin; (e) an illness; and (f) an escape from extreme emotional pain (Granello & Granello, 2007). Within mental health and related fields, therapist attitudes include suicide as immoral, a valid choice, a sign of weakness, and suffering (Knox et al., 2006). Negative attitudes can inhibit professionals from seeking additional training in suicide (Herron et al., 2001).

Little to no research has explored attitudes of mental health educators and supervisors toward the issue of suicide itself. Attitudes toward suicide training appear to be generally positive. Mental health educators and supervisors view suicide training as necessary and important, but appear to disagree about the current adequacy and need for improvement of pre-professional suicide training (Liebling-Boccio & Jennings, 2013; Ruth et al., 2012).

Priority. Suicide first became a priority for the federal government when the National Institute of Mental Health established the Center for the Study of Suicide Prevention in the 1960s (Resnik & Hathorne, 1973 as cited in Westefeld et al., 2000). Several decades later, the U.S. Surgeon General released the first National Strategy for Suicide Prevention (U.S. Department of Health and Human Services, 2001). A renewal of
this priority occurred with the release of the most recent National Strategy (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). The 2012 version highlighted mental health pre-professional training explicitly in two objectives — “Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education,” and “Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies” (p. 47).

National suicide organizations have elevated the priority of pre-professional training in recent years resulting in the:

- development of core competencies for addressing and managing client/patient suicide risk (American Association of Suicidology, 2004);
- guidelines for training on suicide prevention, first aid and risk assessment, intervention, and continuity of care (Clinical Workforce Preparedness Task Force, 2014); and
- recommendations for nationwide certification requirements (Knesper et al., 2010).

The priority for suicide training has emerged at the state level as continuing education requirements among licensed professionals (Matt Adler Suicide Assessment, Treatment, and Management Act ESHB 2366, 2012) and school personnel (American Foundation for Suicide Prevention, 2013a; The Jason Foundation, n.d.). In at least one state, suicide
prevention entities researched the need for pre-professional training requirements on suicide (Suicide Prevention Coalition of Colorado, 2013).

**Obstacles.** The broader community has also identified obstacles to pre-professional suicide training in its literature. Social work educators named the following obstacles to addressing suicide:

- stigma, anxiety, and lack of expertise among faculty;
- disagreement about placement in the curriculum;
- already “jammed” curriculum;
- competing research and teaching interests;
- “silos” separating departments as well as academia from practice; and
- lack of commitment to apply continuing education faculty members have received (Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012; p. 509).

Lack of consistent training, miscommunication, and assessment challenges also impede suicide preparation in field supervision, school psychology education, and mental health training program evaluation. Social work faculty mentioned the following obstacles in field placements: the existence of suicide training at placement depends on each site and each party; educators and on-site supervisors assume the other is doing the preparation (Ruth et al., 2012). Liebling-Boccio and Jennings (2013) surmised that lack of training in youth suicide may prevent school psychology professors from covering suicide in their courses. Systemic behavioral assessment of trainees’ learning can be time-intensive and expensive endeavors (Cramer et al., 2013; Hung et al., 2012).
Climate in Counselor Education and Supervision

It is possible the climate in the Counselor Education and Supervision community about suicide and master’s-level suicide training mirrors that of its broader context. This section includes a review of the literature on attitude, priority, support and perceived need, and obstacles. This serves to identify the gaps in the literature related to climate in the Counselor Education and Supervision field toward suicide and master’s-level suicide training.

Attitudes, priority, and perceived need. Very little published research exists concerning the attitudes, priority, and perceived need among counselor educators and supervisors for master’s-level suicide training. Only one published research study elicited this information. Hoffman et al. (2013) learned directors of counselor training clinics believed prepracticum master’s-level suicide training was lacking. One clinic director asserted: “I don’t think we’re nearly as systematic as we need to be about this issue as a profession” (p. 115). Another director indicated that the lack of suicide in the counseling curriculum may be due to the status of suicide as a “taboo” topic (p. 116).

Authors in the Counselor Education and Supervision field have called attention to the lack of priority and need for attention on master’s-level suicide training (Barrio Minton & Pease-Carter, 2011; Dupre et al., 2014; Wachter Morris & Barrio Minton, 2012). Half of accredited counseling programs marked “unable to respond” to survey questions about suicide risk factors and assessment in their curriculum (Barrio Minton & Pease-Carter, 2011). Researchers concluded that “response patterns likely indicated a lack of systematic attention to crisis preparation on the program level, relegating crisis
preparation priorities and curricula to the discretion of individual instructors” (Wachter Morris & Barrio Minton, 2012, p. 257). Wachter Morris and Barrio Minton (2012) also asserted that “Counselor educators should assess their programs to determine whether they are effectively preparing future counselors to be competent crisis interventionists” (p. 267) and recommended focus groups with recent graduates or program evaluations that elicit multiple perspectives. It is largely unknown if these needs are perceived by others in the Counselor Education and Supervision community.

**Community supports.** Some support for master’s-level suicide training appears available within the Counselor Education and Supervision community. Following the release of the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009) in which suicide was expanded, several authors provided some support for program implementation of suicide- and crisis-related standards (Barrio Minton & Gibson, 2012; Engels, Barrio Minton, Ray, & Associates, 2010; Graham, 2010; Wachter Morris & Barrio Minton, 2012). Graham (2010) suggested counselor educators collaborate with the university counseling center to incorporate students in a community counseling course into campus prevention screening days.

Engels, Barrio Minton, Ray and Associates (2010) provided crisis competencies aligned with the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009). Barrio Minton and Gibson (2012) used suicide risk assessment and management student learning outcomes within the Standards in a sample assessment rubric to demonstrate an evaluation measure linked to these standards. Wozny (2005) provided questions for counseling faculty seeking to evaluate their curricula on suicide and violence assessment/intervention. It is unknown if the Counselor Education
and Supervision community is aware of and/or utilizing these or other unpublished sources of support from within the community.

**Obstacles.** Some evidence exists that the Counselor Education and Supervision (CES) field faces obstacles similar to other pre-professional training fields. The obstacles named in the literature include a lack of published research and lack of room in the curriculum. Lack of knowledge and stigma about suicide may also serve as obstacles. This subsection includes a review of the scant literature on these potential obstacles in the CES field.

**Lack of published research.** Research on outcomes of suicide training in general is limited (Rudd et al., 2008). Research has shown clinical training on suicide can improve knowledge, attitudes, and skills, but rigorous research using standardized, objective measures to investigate any sustained improvement is still needed (Osteen et al., 2014). Very little research has served to evaluate clinical training related to suicide behavior among clients or communities (Osteen et al., 2014).

The CES literature lacks published research on master’s-level suicide training. Published outcomes research on CES’ educational efforts is deficient (Barrio Minton et al., 2014), including efforts to provide master’s-level suicide training. Master’s-level suicide supervision research also appears slim. Lauka et al. (2014) found that, in 65% of counselor training clinics, no research was being conducted, even though these locations may be conducive to research (Mobley & Myers, 2010).

Instrumentation is an important consideration for evaluating the effectiveness of master’s-level suicide training. Two self-efficacy instruments for counselors and counselors-in-training measure perceived knowledge of suicide intervention and efficacy:
an untitled instrument from King and Smith (2000) and the Counselor Suicide Assessment Efficacy Survey (Douglas & Wachter Morris, 2015). However, researchers have not applied these instruments to a variety of diverse samples. The instruments do not comprehensively measure core competencies for suicide assessment and management (American Association of Suicidology, 2004); and they rely on self-report data only. An alternative method of researching training derives from medical education: the Objective Structured Clinical Evaluation or Examination uses standardized actors or real clients and supervision with structured observation reports for evaluating the performance of clinical trainees, and thus also suicide training effectiveness (Cramer et al., 2013; Hung et al., 2012). No published studies from Counselor Education and Supervision have used the Objective Structured Clinical Evaluation to evaluate master’s-level suicide training.

Educational research on core areas of the counseling accreditation standards such as ethical practice, assessment, and others are underrepresented in the counseling and counselor education and supervision literature (Barrio Minton et al., 2014). The authors question if such deficiencies are due to a perceived lack of importance by editorial board members in the field. Regardless of the reason, the lack of published research evaluating master’s-level suicide training impacts the Counselor Education and Supervision community. “Without a clear sense of the status of crisis preparation in our profession, counselor educators may struggle to develop evidence-based crisis pedagogy responsive to the CACREP (2009) accreditation standards and the realities of practice across settings” (Wachter Morris & Barrio Minton, 2012, p. 257). The deficiency may also act as an obstacle for Counselor Education and Supervision members seeking to provide master’s-level suicide training that addresses recent developments, namely the 2016
Standards (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015) and the ethical requirement for educators and supervisors to instruct based on the latest knowledge in the field (American Counseling Association, 2014).

Lack of room in curriculum. The already full curriculum has been acknowledged as a potential barrier for suicide training in counselor education (Wozny, 2005). Some counseling programs offered suicide and related crisis courses as electives prior to 2009 (Barrio Minton & Pease-Carter, 2011). “However, the inherent problem with having suicide and violence assessment/intervention as an elective course is the choice element” (Wozny, 2005, p. 273). It is unknown how the Counselor Education and Supervision field and accredited counseling programs have overcome the lack of room in the curriculum when addressing the 2009 Standards (CACREP, 2009), nor how programs intend to overcome this obstacle when implementing the 2016 Standards (CACREP, 2015).

Wozny and Zinck (2007) acknowledged that a problem in that their workshop is not required training. The authors describe a counselor educator’s effort to offer a local training institute of low-cost half-day workshops to counselors and students. Barriers for potential participants to attend training workshops are “location, cost, and time” (p. 8). Other educators provide extra credit to those students who attend. However, no information is available about the obstacles posed to the counselor educator, nor the resources for overcoming them.

Resources

The final Community Readiness Model dimension relates to resources available to the community to support efforts to address the issue (Oetting et al., 1995; Plested et al., 1999). Examples are time, money, people, and space (Plested et al., 1998). This
dimension includes the availability and support to use current and future funding opportunities, staffing and expertise, proposals or action plans to find resources. This section of the review includes information on monetary and other resources available to and within the Counselor Education and Supervision field to support master’s-level suicide training. Curriculum design and changes in higher education can occur at the course, program, and university level supported by resources such as staff, faculty funding, and release time from teaching (Lattuca & Stark, 2009). Staff may be faculty peers who collaborate on individual course planning and leaders who guide a larger project. Faculty members apply content expertise, and leaders provide administrative structure. Universities’ teaching and learning centers may provide instructional expertise (Farrell, 2003; Lattuca & Stark, 2009; Lechuga, 2006). Other staff resources for curriculum design and change projects are those with expertise in technology and evaluation, particularly at for-profit, online institutions (Gappa, Austin, & Trice, 2007).

Faculty funding is another resource for curriculum change projects (Lattuca & Stark, 2009). Funding often comes in the form of salary supplements or incentive funds. Another resource is release time. Release time occurs when a faculty’s course load is reduced (Stanley, 2004). Release time for instructional purposes allows faculty more time to focus on curriculum redesign and/or faculty development related to teaching (Lattuca & Stark, 2009; Stanley, 2004) and can be as extensive as a sabbatical (Wolverton, 1998).

**Resources in Counselor Education and Supervision**

Counselor Education and Supervision members have utilized similar resources during curriculum change projects. For instance, the National Transforming School
Counseling Initiative funded a school counselor education curriculum change project involving faculty work groups, liaisons, and project directors (Saije, Seppanen, & Romano, 2002). Barrio Minton and Gibson (2012) describe one counseling program’s use of the following resources for a student learning outcomes evaluation project which resulted in curriculum change: (a) assessment personnel; (b) staff members or graduate assistants focused on data collection; (c) project leaders; (d) commercial data collection systems; and (e) release time. No published research describes what resources counselor educators and supervisors need or use to provide master’s-level suicide training. The findings of this study should reveal what resources are needed and which ones are already available and in use for master’s-level suicide training efforts.

Summary

“Unless counselor educators can find a workable method of training counseling students and practicing counselors in suicide assessment/intervention, counselors will continue to have a competency gap in a commonly encountered issue in counseling” (Wozny & Zinck, 2007, p. 9). Past master’s-level suicide training was inadequate (Barrio Minton & Pease-Carter, 2011; Dupre et al., 2014; Freadling & Foss-Kelly, 2014; Hoffman et al., 2013; Neukrug et al., 2013; Raper, 2010; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). The 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009) outlined suicide knowledge and skills requirements in accredited programs. It is unknown if and how counseling programs have successfully responded to these accreditation requirements in providing master’s-level suicide training. Developments since 2009 that impact master’s-level suicide training include:
• the release of the 2016 Standards (CACREP, 2015),
• a revised ethical code (American Counseling Association, 2014),
• a new version of the Diagnostic and Statistical Manual of Mental Disorders
  (American Psychiatric Association, 2013a), and
• guidelines on suicide training for the clinical workforce and pre-professionals
  (Clinical Workforce Preparedness Task Force, 2014).

The Counselor Education and Supervision field must provide master’s-level
suicide training that aligns with accreditation and ethical standards. Ethical obligations
for counselor educators and supervisors include providing instruction within their areas
of competence that is based on current available knowledge. A step toward ensuring that
counselors-in-training are fully trained to handle suicide issues in counseling is an
understanding of the current readiness of the field to provide master’s-level suicide
training.

The Community Readiness Model includes nine stages of readiness along six
dimensions (Plested et al., 1998). An application of this framework would provide an
assessment of the Counselor Education and Supervision field’s readiness to provide
master’s-level suicide training. Community Readiness Model dimensions of readiness as
applied to master’s-level suicide training are: the field’s knowledge about suicide; the
field’s leadership who influence the field’s efforts to provide such training; training
efforts; the community’s knowledge of the efforts; and the climate and resources in the
field for master’s-level suicide training.

This literature review served to demonstrate that efforts in the Counselor
Education and Supervision field to provide master’s-level suicide training were
inadequate prior to the 2009 Standards (CACREP, 2009). There is some evidence that the field is not consistently providing master’s-level suicide training that integrates the latest knowledge on the issue of suicide, aligns with recommendations and requirements from the field’s leadership, is comprehensive in scope, and is being improved based on outcomes evaluations. A review of literature suggests the climate in the Counselor Education and Supervision field regarding master’s-level suicide training includes attitudes and information among some members that can support efforts and obstacles such as suicide stigma and lack of curricular space that may hinder efforts. The literature contains almost no mention of the resources that members of the field use for master’s-level suicide training.

Very little literature is available that illuminates these dimensions of the Counselor Education and Supervision (CES) field’s readiness to provide master’s-level suicide training following the release of the 2009 Standards (CACREP, 2009). It is not at all clear what CES is currently doing to provide master’s-level suicide training, nor how well it is working. It is also unclear if and how CES uses updated information on suicide, CES leadership, community climate, and resources to support master’s-level suicide training. It is uncertain how ready CES is to implement the 2016 Standards (CACREP, 2015) related to master’s-level suicide training. A Community Readiness Model study can assess CES’ stage of readiness along each of these dimensions toward a greater understanding of the field’s readiness to provide master’s-level suicide training to address developments in accreditation, ethical and legal, diagnostic, and pre-professional training expectations.
An early phase in the research process is establishing the paradigms that inform the research (Denzin & Lincoln, 2011). Chapter III pertains to the methodological process of this study project and includes a more detailed explanation of the theoretical framework and philosophical paradigm. A philosophical paradigm combining social constructionism and post-positivism serves as a guide for this study. The use of social constructionism allows the researcher to honor multiple perspectives from a variety of members in the Counselor Education and Supervision field and to consider how the community’s readiness is collectively constructed through members’ interaction with others in and beyond the community. Social constructionism also allows researchers to collaborate with each other and the participants to construct collective meaning around the field’s readiness to provide master’s-level suicide training. The addition of post-positivism primarily supports the use of structured methodology, which seems practical for studying a complex topic (readiness to provide master’s-level suicide training) about a diverse community (Counselor Education and Supervision) situated in a changing environment (recent accreditation, ethical, legal, diagnostic, and training developments).

This combined philosophical paradigm of social constructionism and post-positivism aligns with the selection of a theoretical framework about community-constructed readiness using structured dimensions and stages: the Community Readiness Model (Oetting et al., 1995). The philosophical paradigm also aligns with a methodology that derived from constructionism and post-positivism: Consensual Qualitative Research (Stahl, Taylor, & Hill, 2012). The proposed methodology and methods for this study of Counselor Education and Supervision’s readiness to provide master’s-level suicide training comprise the next chapter of this proposal.
CHAPTER III

METHODOLOGY

The literature review in Chapter II included recent accreditation, ethical, legal, diagnostic, and training developments impacting the counseling profession and master’s-level suicide training. Counselor Education and Supervision’s readiness to provide master’s-level suicide training is unclear from the existing literature. Research is needed that illuminates what members of the Counselor Education and Supervision field know about suicide and related training efforts and the perceived leadership, climate, and resources for such efforts. This study served to begin filling this gap through the application of the Community Readiness Model to assess the field’s stage of readiness and explore the field’s readiness to provide master’s-level suicide training. The research questions are:

Q1 What is the overall stage of Counselor Education and Supervision's readiness to provide master's-level suicide training and the readiness stages of the field's knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

Q2 What are the themes of the field’s readiness to provide master’s-level suicide training regarding the field’s knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?
This chapter begins with my researcher stance. Next, I explain my constructivist philosophical paradigm and related assumptions. The theoretical framework of the Community Readiness Model is then followed by the Consensual Qualitative Research methodology and methods of this study. Based on figures from Crotty (1998, p. 4) and Merriam (2009, p. 68), Figure 1 serves to communicate the relationship between the philosophical paradigm, theoretical framework, methodology, and methods. It is important to note that the relationships are not separate, but rather each phase and frame informs the next and beyond. The chapter concludes with my plans to maximize rigor in the study. Denzin and Lincoln's (2011) five phases of the research process informed the organization of this chapter.

![Figure 1. The qualitative design of the study.](image)

**Researcher Stance**

The researcher’s reflection is the first phase of a research process on her or his individual history, worldview, and ethical and political issues related to the research (Denzin & Lincoln, 2011). Considering and communicating a “critical self-reflection by the researcher regarding assumptions, worldview, biases, theoretical orientation, and
relationship to the study that may affect the investigation” serves to inform the researcher and readers on these viewpoints (Merriam, 2009, p. 229). The purpose of a researcher stance is to provide context for design decisions and maximizes credibility through reflexivity (Merriam, 2009). Sim, Huang, and Hill (2012) recommended that researchers applying Consensual Qualitative Research provide a stance in order to address biases and expectations. My stance as a researcher for this study is a result of my professional, academic, and personal experiences with suicide and master’s-level suicide training. I share next those experiences, my assumptions and biases, and my current role in the field that may influence how I view the data.

My professional experience with master’s-level suicide training includes training and presenting to graduate mental health students on suicide awareness, assessment, intervention, and management and supervising counselors-in-training related to client suicide risk. I reviewed the academic and nonacademic literature on suicide and master’s-level suicide training to prepare for such a role. I also attended continuing education on both subjects. I acknowledge I have a bias related to this. I believe a person who anticipates serving in a role of educating or supervising others should endeavor to learn about both the topic s/he will be guiding and the suggestions for guiding others on that topic. I believe that the endeavor to learn should involve reading at least some academic literature.

I received little education – a two-hour lecture – on suicide during my master’s program in counseling. The program was accredited by the Council for Accreditation of Counseling and Related Educational Programs prior to the 2009 Standards which included suicide content in core coursework. I do not recall receiving any master’s-level
suicide training prior to graduation. I deeply value the education I received from my program. I also view master’s-level suicide training as a concerning gap in my graduate education. I completed my license in professional counseling at a college/university where a therapist in another department, who was very passionate about suicide prevention, was trained as a trainer for an internationally-recognized suicide gatekeeper program. She offered the training to employees for free. I attended the training and became aware of how little I knew about suicide rates and risk assessment. I was struck by the similarities between the underlying philosophy of the training and values of the counseling profession and the basic communication approaches practiced in counseling. I was surprised how my new awareness and skills yielded conversations with clients whom I could now conceptualize as suicidal. I discussed this gap in my knowledge with my supervisor and professional colleagues, who acknowledged sharing that lack. I hold several beliefs based on this experience: (a) a one- or two-day training, or the equivalent in course time, can cover a great deal of material, if done well; (b) a training “done well” includes philosophical elements about the nature of suicide, the importance of nonjudgmental caring, and the practice of concrete skills; and (c) gatekeeper training may be a helpful precursor to more intensive suicide training for current or future mental health practitioners. I believe counselors are not gatekeepers: we are the ones whom gatekeepers refer clients to for more advanced care.

My first personal experience with suicide was in middle school when my grandfather shot himself and died. I had never heard of suicide before then. It was a shock to our family of six members across two generations. The following circumstances made this event especially hard to navigate: (a) the beliefs about suicide in my
grandparents’ small Southern town and Southern Baptist community and the differences between those beliefs and those of my immediate family (my parents’ and my beliefs); (b) the temptation I and others felt to find one simple explanation for his suicide; and (c) not knowing how to accept everyone’s diverse reactions to suicide, nor how to be accepted myself. I developed the following assumptions based on that experience: (a) Anyone can attempt (and complete) suicide; (b) People around them can be unaware it is a risk; (c) Sometimes morality can get in the way of inviting and authentically hearing another person; (d) People often look for one simple way to explain death, perhaps especially suicide; and (e) Rarely is suicide that easily explained.

The precipitating event that led me to actively pursue suicide work in counseling practice and later in education and research involved another personal experience: one which happened almost 20 years after my grandfather completed suicide. My best friend lost a dear friend of hers to suicide in 2008. The deceased had also served as the childcare provider for my best friend’s three children. I did what I could to support my best friend and her family about the tragic loss. Several people made comments to me and to her about me during that time that alluded to their belief that I must know a lot about suicide since I was a counselor. For instance, they asked me what causes a person to attempt suicide, what they should have done to prevent her from attempting, and the right things to explain about suicide to the children impacted. I answered their questions from my perspective as best I could, but also felt very ignorant. While I believed suicide was not exactly simple, I thought I should know so much more about it. I spoke with other mental health practitioners for guidance, some of who responded with concrete information (e.g., a title of a children’s book about suicide). Other practitioners acknowledged they felt
I began to reflect on the moments when suicide had touched my life. My takeaways from this experience were: (a) Sometimes things have to be repeated before they really “stick;” (b) The core conditions of counseling and foundational skills like active listening may be enough to comfort someone and help them trust you, but critical topics like suicide require coverage of more concrete information; (c) There can be warning signs, though most people are unaware of how to recognize and respond to them; and (d) People assume counselors know more about suicide than most of us actually do.

It is also important that I consider the ethics and politics of this study (Denzin & Lincoln, 2011). I currently perceive myself as both inside of and outside of the Counselor Education and Supervision field since my experiences providing counselor education and supervision consist of adjunct teaching and co-teaching and co-supervision as a doctoral student. I considered how I fit into the puzzle of this study and realized I may know much more about the issue than my participants because suicide and related training for counselors-in-training, professionals, and laypeople has been my research focus over the last several years. I also realized there is likely much about suicide and master’s-level suicide training that I cannot possibly know. Not much research has been completed on the topic. I also have no lived experiences of being a full-time educator, supervisor, researcher, or administrator, nor a full-time counselor affiliated with an accredited counseling program as an adjunct or site supervisor. I desired to know more about the issue from this perspective, and realized there was little available to me and others in the form of research. I chose the qualitative tradition to explore the subject because it is a fairly new research content area.
Sharing my researcher stance is an attempt to make clear my experiences and potential biases about the issue of master’s-level suicide training. It also serves as context for the remaining phases of the research process: philosophical and theoretical paradigms and frameworks, methodology, and methods. I explain additional methods I will use for reflexivity later in the chapter.

**Philosophical Paradigms and Perspectives**

The next phase in the research process is identifying and applying paradigms and perspectives (Denzin & Lincoln, 2011). A paradigm imposes “particular demands on the researcher, including the questions he or she asks and the interpretations the researcher brings to them” (Denzin & Lincoln, 2011, p. 19). In the qualitative paradigm, “researchers are interested in understanding the meaning people have constructed, i.e., how people make sense of their world and the experiences they have in the world” (Merriam, 2009, p. 13). Merriam (2009) described the purpose of qualitative research as one of exploring complex or previously unexplored phenomenon that is sensitive to its context. Suicide and related training may be considered well-researched topics. However, the readiness of the Counselor Education and Supervision field to provide master’s-level suicide training has never been examined.

Huff (2009) explained that philosophy in research offers an overall guide to conceptualizing the problem, the research questions, and the approach to answering the questions. Philosophy includes assumptions related to ontology (the nature of reality), epistemology (the nature of knowledge), axiology (the role of values), and methodology (the research process itself). I describe in the next section my combined constructivist and post-positivist paradigm and its influence on my selection and application of a
Community Readiness Model theoretical framework, Consensual Qualitative Research methodology, and methods. Figure 1 served to communicate the embedded layers of the design, moving from the broad philosophical paradigm to the theoretical framework, and then zooming closer via the methodology and method. I review the paradigm next and describe its application to this study.

**Constructionism and Post-positivism**

Creswell (2013) commented: The application of multiple assumptions “may be related to research experiences of the investigator, her or his openness to exploring different assumptions, and the acceptability of ideas taken in the larger scientific community of which he or she is a part” (p. 19). The paradigm of constructionism is the primary guiding philosophical paradigm for this study. I also apply some elements of post-positivism.

Post-positivism is an additional paradigm that influences, to a much lesser degree, my approach to this study. I include some post-positivist elements, mostly methodological, based on three reasons: a) I believe some considerations about suicide and master’s-level suicide training can be viewed objectively; b) I recognize my strongly-held beliefs about the topic, and want to apply a systemic approach to manage them; and c) I believe the combination of social constructionism with some post-positivism matches my current role as an insider-outsider to the field. I briefly describe post-positivism in this section and explain further its place in my proposed study. The next section includes a description of how I apply constructionism (specifically, social constructionism) and
post-positivism to this study. This serves to justify and explain the ontological, epistemological, and axiological foundations of my researcher lens on this work.

**Ontology and Epistemology**

Ontology is the nature of reality, while epistemology represents one’s beliefs about how that reality is known (Creswell, 2013). Constructionism is “the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998, p. 42). A constructionist view is based on the assumptions that (a) no singular truth exists, but rather a variety of perspectives; and (b) meaning is constructed as humans interact with their world. I discuss these assumptions next, in connection with the purposes of this study. I then explain the specific selection of social constructionism and post-positivism for this study. The purposes of the study were: (a) to assess the Counselor Education and Supervision field’s current stage of readiness to provide master’s-level suicide training, and (b) to identify themes related to the field’s knowledge of suicide, leadership, master’s-level suicide training efforts, the field’s knowledge of those efforts, climate, and resources.

“Intentionality is a radical interdependence of subject and world” (Crotty, 1998, p. 45). Constructionism’s intentionality, or relatedness, applies to this study as it serves to honor the subject-and-world relationships of: (a) the researched and researcher, (b) the researched and the immediate educational environment of a counseling program, and (c) the researched and the societal world connected to suicide and master’s-level suicide training. A final such relationship is that of the researcher and her societal world related
to suicide and master’s-level suicide training (a societal world which may, at parts, overlap that of her participants). Crotty (1998) described two types of constructionism: constructivism and social constructionism. This study is, in part, guided by social constructionism. I define social constructionism next and describe its relevance and application to this study.

**Social constructionism.** Whereas constructivism focuses on the development of meaning undertaken by an individual, social constructionism focuses on collective meaning-making shaped by social interactions (Schwandt, 1994). Berger and Luckmann (1967) described social constructionism as the view of individuals and world intertwined in a dialectic process of meaning-making and change. Individuals and society engage in an ever-changing interaction in which humans create and externalize phenomena in the world, and then internalize the objective reality that becomes of the phenomena.

I did not seek to understand via this study the meaning individual educators or supervisors have developed outside of the context of their personal and professional experiences or outside of the environments in which they educate and supervise counselors-in-training. The research questions focus on the Counselor Education and Supervision (CES) field as a whole and in context. I applied social constructionist epistemology to help me learn how members of the CES community “come to share an intersubjective understanding of specific life circumstances” (Schwandt, 2001, p. 31-32), namely the field’s readiness to provide master’s-level suicide training.

The readiness of the CES field to provide master’s-level suicide training is a complex issue to research. The field is comprised of counselor educators, supervisors, administrators, and researchers who work in a variety of roles and settings related to
students enrolled in accredited counseling programs. Each individual operates within systemic contexts that may influence the meaning they have made about master’s-level suicide training, including academic settings, states and regions, and counseling specialties (e.g., school, college, behavioral health). The social constructionism paradigm allowed me as a researcher to consider the “multiple realities constructed through our lived experiences and interactions with others” (Creswell, 2013, p. 36).

**Post-positivism.** Post-positivism developed as a reaction against positivism, a viewpoint that fully embraces a single external reality that researchers can accurately discover, views knowledge as verifiable only through use of the scientific method, and upholds values-neutral objectivism (Crotty, 1998). Post-positivists believe reality does exist outside of human experience, but may not be so absolute (Creswell, 2013; Lincoln, Lynham, & Guba, 2011). I weighed this ontology with social constructionism and acknowledged that I believe Counselor Education and Supervision’s readiness to provide master’s-level suicide training may eventually be measurable as a reality and that existing theories of readiness can be applied to the phenomenon as a lens through which reality is understood. “In practice, postpositivist researchers view inquiry as a series of logically related steps, believe in multiple perspectives from participants rather than a single reality, and espouse rigorous methods of qualitative data collection and analysis” (Creswell, 2013, p. 24). The consideration of multiple perspectives dovetails with that of my social constructionist lens. I applied this combination throughout my methodology.

Epistemologically, postpositivism espouses the idea that statistics approximate reality through the researcher’s removed role (Creswell, 2013; Lincoln et al., 2011). “Validity comes from peers, not participants” (Creswell, 2013, p. 36). I believe mainly in
the social constructionist perspective that reality is co-developed in society through social
interactions. However, I was concerned that my passionate views about master’s-level
suicide training could create undue interpersonal influence and potentially bias
participants and/or my interpretation of participant data. I wanted to be challenged and
shaped by co-constructing reality with my participants and research peers and by validity
checks from research peers and an external reviewer. This epistemological view informed
my design and methodology. I used both inductive (constructionist) and deductive
(postpositivist) methods: applying a theoretical framework as a directional lens
(postpositivist) to semi-structured interview data (constructionist) in order to reach
consensus on emergent ideas (constructionist).

**Axiology**

Axiological beliefs in qualitative research refer to the role of values among the
individuals involved in a study (Creswell, 2013). I explain next the axiology of
constructionism and post-positivism and the ways in which the application of these
paradigms impacted the design of the study. “Objectivity and subjectivity need to be
brought together and held together indissolubly. Constructionism does precisely that”
(Crotty, 1998, p. 44). Much about master’s-level suicide training may be considered
objective. Suicide statistics may give the impression that this phenomenon and related
training are well-researched subjects. Substantial quantitative findings provide some
suicide knowledge, which may be used in counseling and master’s-level suicide training
as objective knowledge about the phenomenon. Suicide is a life/death situation, a serious
legal and ethical consideration in counseling, and required content in accredited
programs.
However, to assume that the study of members of the Counselor Education and Supervision field and their experience related to master’s-level suicide training should be or is purely objective would have neglected the subjective nature of the phenomenon and its context. My researcher stance served to explain my role as a part of and apart from the Counselor Education and Supervision field I am researching. My application of social constructionism allowed me to negotiate the complexities of meaning with others (Creswell, 2013). I do not believe as strongly as other post-positivists do that all researcher biases can and “need to be controlled and not expressed in a study” (Creswell, 2013, p. 36). However, I think some management of my biases and very explicit expression of my biases to my peers, auditors, and readers is important. I considered my role in the field and the research and I wanted to respect the views of educators and supervisors that may be divergent from my own, while applying obvious rigor to maximize trustworthiness of the results. I believe this combined approach also served to uphold social constructionist axiology by valuing individual and shared values via negotiation (Creswell, 2013; Lincoln et al., 2011).

Little is known about the complex subject of the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training. The use of social constructionism allowed the researcher to study this subject and account for the layered contexts related to suicide, master’s-level suicide training, the field, and the interrelationships of the participants and their worlds, while maintaining consistency and addressing bias through the combination of some post-positivistic elements. Guided by this philosophical perspective, the theoretical framework for the study was the Community Readiness Model.
Theoretical Framework:  
Community Readiness Model

Merriam (2009) advocated for a theoretical framework in qualitative research and attention to philosophical paradigm and methodology. She explained, “All aspects of the study are affected by its theoretical framework” (p. 67) which “is derived from the orientation or stance you bring to your study” (p. 66). I describe the ways in which the Community Readiness Model (Oetting et al., 1995; Plested et al., 1998) theoretical framework impacted this study. This section begins with a review of the model.

The Community Readiness Model is aimed at community change “while integrating the culture of a community, the existing resources, and the level of readiness” (Plested, Jumper-Thurman, & Edwards, 2009, p. 5). The model utilizes six dimensions of readiness considered “key factors that influence your community’s preparedness to take action” (Plested et al., 2009, p. 9). The dimensions include:

- community knowledge about the issue,
- leadership,
- community efforts,
- community knowledge of the efforts,
- community climate, and
- resources to address the issue.

The model utilizes nine stages of awareness:

1. no awareness,
2. denial/resistance,
3. vague awareness,
4. preplanning,
5. preparation,
6. initiation,
7. stabilization,
8. confirmation/expansion, and
9. high level of community ownership.

**Community Readiness framework.** A theoretical framework informs the problem and purpose statements and decisions about what to attend to in design, data collection, and analysis (Merriam, 2009). The Community Readiness Model provided a contextual lens for understanding the literature on master’s-level suicide training and the study’s findings. This study focused on community perception and the complexities of community change, as does the Community Readiness Model. A theoretical framework also guides the phrasing of the research question and its placement in a problem statement (Merriam, 2009). The study’s research questions are:

**Q1** What is the overall stage of Counselor Education and Supervision's readiness to provide master's-level suicide training and the readiness stages of the field's knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

**Q2** What are the themes of the field’s readiness to provide master’s-level suicide training regarding the field’s knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

By applying the Community Readiness Model, I hoped to learn what Counselor Education and Supervision professionals say about the field’s efforts and climate for master’s-level suicide training, including the leadership and resources for such training.
A theoretical framework informs data collection and analysis techniques and the interpretation of findings (Merriam, 2009). The application of the Community Readiness Model (CRM) as a theoretical framework had implications for the proposed methodology. It informed data collection in that sampling targeted different sectors of the identified community. Interviews served to elicit perspectives from and about the entire community and included questions about each CRM dimension. CRM also informed analysis in two ways. Coding the interview data involved applying the dimensions. The CRM scoring procedure served to determine the community’s stage of readiness. I describe the scoring and other procedures in the next section.

Methodology

According to Denzin and Lincoln (2000), the next phase in the qualitative research process is to determine a research strategy or methodology that fits the researcher and philosophical perspectives. I applied Consensual Qualitative Research (CQR) as the methodology. A description follows of CQR and its justified use in this study. I then detail the proposed method.

Introduction to Consensual Qualitative Research

Hill et al. (1997) originally designed CQR to provide a rigorous method of qualitative research that included the best elements of phenomenology, grounded theory, and comprehensive process analysis (Hill et al., 2005). Qualitative research can serve to give voice to the unique human experience, yielding a rich and intimate understanding (Merriam, 2009). Consensual Qualitative Research is appropriate for research questions focused on participants’ inner experience as well as on larger processes and constructs.
This study utilized a qualitative research approach and CQR methodology to explore and describe, from the perspective of those in Counselor Education and Supervision, the readiness of the field to provide master’s-level suicide training.

Consensual Qualitative Research methodology shares several things in common with the combined philosophical paradigm and the theoretical framework of this study. Hill et al. (2005) called CQR “predominantly constructivist, with some post-positivist elements” (p. 197). Constructionism and post-positivism (Creswell, 2013; Crotty, 1998), the Community Readiness Model (Oetting et al., 1995; Plested et al., 1998) and CQR (Stahl et al., 2012) aligned well in terms of ontology, epistemology, axiology, and methodology. Applying them together supported: (a) the construction of multiple realities through social interaction, (b) the negotiation of values and viewpoints toward consensus with peers, and (c) flexible systematization of emergent data through a defined lens.

Consensual Qualitative Research provides a structured method for researching a previously unexplored phenomenon based on experiences of participants (Clemens, Welfare, & Williams, 2010; Hill et al., 1997). This research was the first study with purposes of assessing and exploring community readiness in Counselor Education and Supervision. Consensual Qualitative Research served the goal of this study to better understand the field’s readiness by allowing the researcher to represent experiences of a varied group of individuals who instruct, supervise, and oversee graduate counseling training. “CQR is 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 selection of CQR also connected to my researcher stance. The design
of the study served to explore the how’s and why’s about Counselor Education and Supervision’s readiness to provide master’s-level suicide training. I used a systematic way of doing so in order to challenge and balance my many viewpoints on suicide and master’s-level suicide training.

Key elements of CQR include: (a) open-ended questions and semi-structured data collection, (b) multiple researchers analyzing the data and arriving at consensus, (c) one or more auditors, and (d) the use of domains, core ideas, and cross-analyses (Hill et al., 2005). Wang (2008) identified other elements including criterion-based sampling of as few as eight cases and a verbal description of the phenomenon. CQR methodologists (Hill et al., 2005, 1997) also recommended some use of randomization. The next section includes each of these elements regarding participants, data collection, and data analysis. The subsequent section on trustworthiness also includes these elements.

**Method**

The next phase in a qualitative research process is identifying methods of collection and analysis, as informed by previous phases (Denzin & Lincoln, 2000). This section addresses the proposed procedures regarding participant selection, data collection, and data analysis, as informed by recommendations for Consensual Qualitative Research and by findings from a pilot study. I received approval from the University of Northern Colorado Institutional Review Board before contacting potential participants. I describe the pilot study in full in Appendix A.

**Participants**

The population of interest was educators, supervisors, and administrators affiliated with accredited master’s programs in counseling. Educators included instructors
of counseling courses. Supervisors included university and site supervisors. Administrators included those who provide oversight of emphasis areas, practical/clinical experiences, programs, or departments such as coordinators, clinic directors, and chairs. I selected this subset of the Counselor Education and Supervision community because these members of the field can provide and/or impact master’s-level suicide training. A research study using this sample served to fill a gap in the literature. Few publications have included perspectives of counselor educators, supervisors, and administrators regarding master’s-level suicide training. Consensual Qualitative Research methodologists (Hill et al., 2005, 1997) recommended that the sample be randomly selected, homogeneous, and knowledgeable about the phenomenon. The next section describes the application of these standards to this study, including (a) sample outcome, (b) sample size, (c) selection criteria, (d) sampling procedures, and (e) recruitment and selection procedures.

**Sample outcome.** Round 1 yielded eight participants and Round 2 yielded seven. Random sampling resulted in four administrator participants, five educator participants, and three supervisor participants. Snowball sampling resulted in one administrator participant and two supervisor participants. Of the 46 individuals who received recruitment emails in Round 1, 19.56% \((n = 9)\) completed the online informed consent and demographic questionnaire. Of those, eight completed a research interview. One individual who completed the consent and questionnaire dropped out due to medical leave. Of the 44 individuals who received recruitment emails in Round 2, 9.09% \((n = 4)\) completed the online informed consent and demographic questionnaire and completed a research interview.
The sample included five educators, five administrators, and five supervisors. All participants met the criterion to participate: currently teaching, supervising, and/or serving as an administrator in affiliation with an accredited master’s in counseling program. Table 1 displays the participant demographics and Table 2 displays the program information. Separate reporting of participant and program information and aggregation of program information serve to protect participants’ identities.

The 15 participants consisted of 13 women and two men, 13 of whom identified their race/ethnicity as Caucasian/White. One participant did not answer the question on race/ethnicity and another answered it with the name of her city/town. Two participants identified as topic experts (i.e., having specialization or expertise in suicide and/or related education in counselor training). All participants had provided master’s-level suicide training within the last year.

Four participants endorsed singular responsibilities of the options provided: three as supervisors and one as an administrator. The remaining 11 participants endorsed two or all three of the responsibilities: five endorsed both teaching and supervision, one endorsed supervision and administration, and the remaining five endorsed all three responsibilities. Administrator participants included university participants who endorsed an administration responsibility on the demographic questionnaire. The only exception was case 10 who explained in the interview that she had not yet entered the administrator role as the position would begin the following semester. I assigned her as an educator participant. Administrators’ roles ranged from program coordination or oversight of practical training (e.g., internships and/or on-campus clinic) to chairing the department.
Table 1

**Participant Demographics by Type (N = 15)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Case</th>
<th>Race/Ethnicity</th>
<th>Gender</th>
<th>Setting</th>
<th>Respons.</th>
<th>Primary Role</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ed</td>
<td>1</td>
<td>Caucasian</td>
<td>M</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Ed</td>
<td>4</td>
<td>N/A</td>
<td>F</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Ed</td>
<td>6</td>
<td>Caucasian</td>
<td>F</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Ed</td>
<td>9</td>
<td>Caucasian</td>
<td>F</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Ed</td>
<td>10</td>
<td>Caucasian</td>
<td>F</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Admin</td>
<td>2</td>
<td>White</td>
<td>F</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Admin</td>
<td>3</td>
<td>White</td>
<td>M</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Admin</td>
<td>5</td>
<td>Caucasian</td>
<td>F</td>
<td>University</td>
<td>T, S, A</td>
<td>Administrator</td>
<td>Yes</td>
</tr>
<tr>
<td>Admin</td>
<td>7</td>
<td>N/A</td>
<td>F</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Admin</td>
<td>8</td>
<td>Caucasian</td>
<td>F</td>
<td>University</td>
<td>A</td>
<td>Administrator</td>
<td>Yes</td>
</tr>
<tr>
<td>Sup</td>
<td>11</td>
<td>Caucasian</td>
<td>F</td>
<td>Nonprofit</td>
<td>S, A</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Sup</td>
<td>12</td>
<td>White</td>
<td>F</td>
<td>School</td>
<td>S</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Sup</td>
<td>13</td>
<td>Caucasian</td>
<td>F</td>
<td>Nonprofit</td>
<td>S</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Sup</td>
<td>14</td>
<td>Caucasian</td>
<td>F</td>
<td>Nonprofit</td>
<td>S</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Sup</td>
<td>15</td>
<td>White</td>
<td>F</td>
<td>Private</td>
<td>T, S</td>
<td>Adjunct and site supervisor</td>
<td>No</td>
</tr>
</tbody>
</table>

*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

Educator participants endorsed a primary role of full-time faculty and responsibilities that included teaching and excluded administration with the exception of case 10 explained above. Site supervisors indicated on the demographic questionnaire a primary role of site supervisor and responsibilities including supervision. The only
exception is case 15 who sent information via email indicating she worked as an adjunct supervisor for Practica and/or Internship and also served as a site supervisor at her private practice. I subsequently assigned her as a supervisor participant.

Table 2

<table>
<thead>
<tr>
<th>ACES Region</th>
<th>SACES</th>
<th>NCACES</th>
<th>NARACES</th>
<th>RMACES</th>
<th>WACES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Public</th>
<th>Private</th>
<th>Multiple locations</th>
<th>Online</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note.* ACES = Association of Counselor Education and Supervision; SACES = Southern ACES; NCACES = North Central ACES; NARACES = North Atlantic ACES; RMACES = Rocky Mountain ACES; WACES = Western ACES.

The sample spanned various locations, types of universities, and specialty areas. Participants hailed from all five regions of the Association for Counselor Education and Supervision and both public and private universities. Three programs contained multiple locations and one program was online. The demographic questionnaire did not address participants’ practice or research specialties. Participants identified during the interviews with their following counseling and related specialties: clinical mental health counseling; school counseling; marriage, couples, and family counseling; addictions counseling; offenders and criminal justice; lesbian, gay, bisexual, and transgender clients; adolescents; psychology; marriage and family therapy; and social work. Participants mentioned research specialties including: bullying; spirituality; grief/loss; addictions; and ethics.

**Sample size.** The target number of participants for this study was 15 to 19. Hill et al. (1997) identified the ideal sample size for Consensual Qualitative Research studies as 8 to 15 participants. Hill and Williams (2012) stated 15 to 19 participants may be better if
subgroups emerge during analysis. The researchers argued that differences and similarities across cases can be examined, and cases beyond this number rarely offer additional insight about the phenomenon. The perspectives of site supervisors, instructors, university supervisors, and program leaders about Counselor Education and Supervision’s readiness to provide master’s-level suicide training may vary. These groups hold overlapping but distinct ethical responsibilities (American Counseling Association, 2014) and can differ in terms of education and perspective on ethical concerns (Lee & Cashwell, 2001). The emergence of subgroups was possible in this study based upon these or other distinctions. I describe the few discernible differences in the Results section.

The community representing the Counselor Education and Supervision field was defined in this study as individuals whose roles may include providing master’s-level suicide training in affiliation with a program accredited by the Council for Accreditation of Counseling and Related Educational Programs. This included full-time and part-time faculty and adjunct instructors, university and site supervisors, and administrators. Hereafter, I refer to this community group as Counselor Education and Supervision (CES) members.

**Selection criterion.** The focus of this study was master’s-level suicide training. All accredited programs should address the topic of suicide at some point in the curriculum (Council for Accreditation of Counseling and Related Educational Programs, 2009, 2015). Following Consensual Qualitative Research principles (Hill et al., 2005, 1997), the target sample was homogeneous in nature in that all participants were Counselor Education and Supervision members affiliated with accredited programs. The
use of target sample criteria that introduce some variation served to enhance
transferability of the study. “Maximum variation in the sample, whether it be the sites
selected for a study or the participants interviewed, allows for the possibility of a greater
range of application by readers or consumers of the research” (Merriam, 2009, p. 227).
The selection criteria were:

- A participant must teach, supervise, and/or serve as an administrator in a master’s
  in counseling program accredited by the Council for Accreditation of Counseling
  and Related Educational Programs.
- The target sample will include individuals who represent different segments of the
  Counselor Education and Supervision community (e.g., full-time faculty and
  adjunct instructors, university and site supervisors, and administrators).
- The target sample will include programs from diverse geographical areas (i.e.,
  multiple regions of the Association for Counselor Education and Supervision
  representing areas with varying suicide rates).
- The target sample will include programs that use diverse educational delivery
  methods and that exist within various types of universities (e.g., live and online
  courses, private and public institutions representing varying pedagogy, funding
  sources, and values environments).

**Sampling procedures.** Following the recommendations of Hill et al. (Hill et al.,
1997; Hill & Williams, 2012), I used a combination of sampling and selection strategies,
namely random sampling applying a study criterion. Researchers applying Consensual
Qualitative Research (CQR) typically utilize a criterion-based approach in which
researchers explicitly define participant requirements to guarantee the participants’
experience represents the phenomenon of focus (Hill et al., 1997). Researchers (Thompson, Frick, & Trice-Black, 2011) have applied CQR and criterion sampling using participants in master’s-level counseling by hand-selecting programs. Flynn, Chasek, Harper, Murphy, and Jorgensen (2012) used a combination of criterion-based and snowball sampling in a CQR study involving accredited counseling programs by recruiting participants via regional listservs, solicitation emails, in-person verbal invitations, and in-person and telephone contacts based on recommendations from professionals. However, CQR methodologists warned these types of sampling and recruitment approaches may introduce participant bias, which can be better controlled through random sampling (Hill et al., 2005, 1997). I used a recruitment strategy that relies primarily on random and criterion sampling and minimal use of snowball sampling.

The entire procedure consisted of two sampling rounds and yielded a sample of 15 participants representing: (a) all five regions of the Association for Counselor Education and Supervision or ACES, (b) all four program characteristics, and (c) all three types of participants. Table 3 outlines the step-by-step procedure for sampling and recruitment. The programs directory on the website of the Council for the Accreditation of Counseling and Related Educational Programs allows filtering by program type: master’s, doctoral, and all. The master’s programs in the online directory totaled 621 at the time of sampling. There are five regions: North Atlantic (NARACES), North Central (NCACES), Southern (SACES), Rocky Mountain (RMACES), and Western (WACES). There are four program characteristics: multiple sites, online, private, and public.
### Table 3

**Sampling and Recruitment Procedure**

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Randomly selected 40 master’s programs from the directory on the CACREP website</td>
</tr>
<tr>
<td>2</td>
<td>Ensured the programs list included at least one program from each ACES region. (When it did not, I randomly selected one program from each missing region.)</td>
</tr>
<tr>
<td>3</td>
<td>Ensured the programs list included at least one program with each CACREP program characteristic: private, public, multiple sites, and online. (When it did not, I randomly selected one program from each missing characteristic.)</td>
</tr>
<tr>
<td>4</td>
<td>Randomly selected one individual from each program’s list (or two if site/adjunct supervisor list is also available for that program).</td>
</tr>
<tr>
<td>5</td>
<td>Contacted each individual by phone and email to request participation including informed consent and demographic questionnaire.</td>
</tr>
<tr>
<td></td>
<td>Interested.</td>
</tr>
<tr>
<td></td>
<td>Not interested.</td>
</tr>
<tr>
<td>6</td>
<td>Requested referrals to site supervisors and/or adjuncts. If provided, contacted referrals following step 5.</td>
</tr>
<tr>
<td>7</td>
<td>Tentatively scheduled interview. Reviewed demographic questionnaire to ensure qualification:</td>
</tr>
<tr>
<td></td>
<td>• currently teaches, supervises, and/or serves as an administrator in affiliation with a CACREP-accredited master’s program</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Confirmed and conducted interview.</td>
</tr>
<tr>
<td>9</td>
<td>Requested referrals to site supervisors and/or adjuncts. If provided, contacted referrals following step 5.</td>
</tr>
<tr>
<td>10</td>
<td>Once I collected data from five individuals in one participant type (educator, administrator, or supervisor), I stopped recruitment and data collection of that participant type.</td>
</tr>
<tr>
<td>11</td>
<td>When steps 1-10 did not yield a total of 15+ individuals with at least one in each region, program characteristic, and participant type, I identified which criteria were missing and repeated all steps relevant to the criteria.</td>
</tr>
</tbody>
</table>

*Note.* CACREP = Council for Accreditation of Counseling and Related Educational Programs; ACES = Association of Counselor Education and Supervision.

I used random sampling for listed participants, then snowball sampling to reach unlisted participants (e.g., adjunct instructors and site supervisors) who were affiliated.
with the randomly sampled or other accredited counseling programs. A random number generator produced numbers for each random sampling step. Snowball sampling occurred when a randomly sampled individual shared the recruitment information (a) with another individual in the organization due to their role or expertise or (b) by posting a recruitment notice to a program listserv.

Recruitment and selection. I contacted each randomly selected individual from the faculty and supervisor lists then contacted them by phone and email about the purpose and process of the study. Appendix A includes the recruitment email transcript. The email contained a link to the online informed consent (Appendix B) and demographic questionnaire (Appendix C). The brief questionnaire served to collect demographic information. I tentatively scheduled research interviews when possible.

The subsequent Data Collection subsection contains a detailed description of the demographic questionnaire in Appendix C. I contacted potential participants again by phone and/or email after one week as a final request for completion of the questionnaire. The qualifying criterion for individual participants was that they currently teach, supervise, and/or serve as an administrator in affiliation with an accredited master’s in counseling program. I reviewed each demographic questionnaire for final qualification and sent an email to confirm the scheduled interview with each individual who qualified. I replied to anyone who declined or indicated they did not qualify to participate by requesting referrals to site supervisors. I requested referrals to site supervisors or adjuncts at the end of each interview and contacted any referrals. I limited the sample to only two individuals per program. Data collection proceeded as described in the next section for
each participant that fit the relevant criteria and agreed to participate via the online informed consent. Next I describe the sample.

Data Collection

In-depth interviews are the primary source of data in Consensual Qualitative studies (Hill et al., 2005, 1997). A purpose of in-depth interviews is to allow the researcher to “grasp and articulate the multiple views of, perspectives on, and meanings of some activity, event, place, or cultural object” (Johnson & Rowlands, 2012, p. 102). This section addresses the demographic questionnaire, interview protocol, and follow-up communications.

Demographic questionnaire. The University of Northern Colorado Institutional Review Board approved the online questionnaire containing an informed consent document and a demographic questionnaire. The informed consent is Appendix B of this proposal, and the demographic questionnaire is Appendix C. The demographic questionnaire included questions about basic personal and professional demographics (e.g., age, race/ethnicity, gender identity, title, name of university, years employed in the Counselor Education and Supervision field, preferred contact information). It also included verification that each participant meets the study criterion: currently teaching, supervising, and/or serving as an administrator in affiliation with an accredited master’s in counseling program.

Interviews. I used semi-structured interviews in which I asked 10 to 15 interview questions. This structure resulted from the evaluative case study, the literature review, researcher self-examination, the constructionist-postpositivist perspective, and the Community Readiness Model framework. Appendix D displays the introduction and
potential questions. The interviews began with a review of the introduction and terminology, then a broad question intended to “get the participants talking and to establish rapport” (Burkard, Knox, & Hill, 2012, p. 86). Two questions per dimension and any clarification and spontaneous probing questions (Hill et al., 2005) addressed all dimensions of the Community Readiness Model. This interview protocol aligned with the recommendations for Consensual Qualitative Research methods (Burkard et al., 2012). This subsection covers the development of the interview protocol and the interviewing and transcription process.

**Interviewing and transcription.** I conducted interviews via telephone. Interviews ranged from 45 minutes to 1.5 hours long. Interviews with 15 participants occurred over a period of 9.5 weeks. I completed all the interviews using the proposed semi-structured interview protocol which included the flexibility to ask spontaneous questions. It became obvious in Phase 1 after scoring the first interview that I needed to include the question, “How long have these efforts been in place?” because longevity is a determining factor for a Community Readiness Model efforts score of 7 instead of 6.

Burkard et al. (2012) acknowledged in-person and face-to-face interviews as alternatives to phone interviews in Consensual Qualitative Research, but noted phone interviews provide a physical and psychological space apart from the interviewer (Sturges & Hanrahan, 2004) and less temptation for response bias (Musselwhite, Cuff, McGregor, & King, 2007). Burkard et al. (2012) stated that, in their research experience with Consensual Qualitative Research, phone interviews did not appear to deter participants from sharing.
I transcribed seven of the 15 interviews. The other two primary team members each transcribed one interview. A graduate assistant transcribed four interviews. Transcriptions were verbatim following recommendations from Burkard et al. (2012), including: (a) confidential references, (b) utterances, (c) nonverbal data, and (d) line numbers. I edited all transcriptions by listening to the recording and correcting any incomplete information.

**Follow-up communication.** I conducted interviews of up to 1.5 hours as described above followed by a member check and solicitation of post-interview reflections through a follow-up email communication with participants. An example of the follow-up email is shown in Appendix E. The email included a maximum of three questions intended to clarify any interview data deemed confusing during analysis. The email also contained a list of preliminary domains and a request for feedback along with an invitation for any additional reflections. I asked the participants to respond to the follow-up communication within one week.

Burkard et al. (2012) recommended the use of two interviews with each participant in Consensual Qualitative Research studies. However, Hill et al. (2005) stated: “Our experiences indicate that second interviews were often not as productive as hoped” (p. 199). Burkard et al. (2012) also recommended the use of member checks, a technique described by Lincoln and Guba (1985) to verify accuracy of researchers’ understanding and conclusions in qualitative research. However, Hill et al. (2005) questioned the use of member checks after finding Consensual Qualitative Research studies may have suffered from methodological challenges during member checking due to rare responses from participants and the difficulty for researchers to interpret responses upon sending final
results to participants for their review. The evaluation of the pilot revealed that some
follow-up communication helped to clarify the researcher’s potential misconceptions and
fill gaps in the data. The Analysis section contains a detailed description of the domains
development process.

**Data Analysis**

The Consensual Qualitative Research (CQR) analysis process involves a research
team’s construction of domains and core ideas followed by cross-analysis (Hill et al.,
1997). This study’s data analysis included these three elements and the Community
Readiness Model scoring procedure to determine the stage of readiness. This section
contains descriptions of the research team followed by the step-by-step analysis process
of domains, core ideas, cross-analysis, and scoring.

**Research team.** A primary research team of three researchers and one external
auditor followed recommendations for CQR methodology (Vivino, Thompson, & Hill,
2012), including team membership, development, and responsibilities. Team members
immerse themselves in the research data and rotate responsibilities. This and the
following subsections address the application of these recommendations for CQR teams.

**Team membership and development.** Hill et al. (2005) deemed it appropriate for
a thesis/dissertation advisor to serve as external auditor as the team resubmits revisions
based on his/her feedback. My dissertation chair, Dr. Elysia Clemens, meets the
suggested requirements for an external auditor (Hill et al., 2005) in that she has expertise
in CQR methodology and auditing and strong knowledge of master’s-level suicide
training in the Counselor Education and Supervision context. She also has lived
experience as a full-time counselor educator, university supervisor, and administrator
within an accredited counseling program. Vivino et al. (2012) recommended the consideration of team member hierarchy when determining team membership and the inclusion of “members at the same level of power if differences seem likely to be an obstacle to group functioning” (p. 51). To address power and hierarchy, I developed a primary research team of me and two other individuals with similar or complementary experience in counseling, education, supervision, and/or research.

Dr. Janessa Parra is a graduate from the University of Northern Colorado Counselor Education and Supervision (UNC CES) program where she received training and experience in research. She is a full-time faculty member at Adams State University in Alamosa. She also became Clinical Mental Health Counseling Program Coordinator during the course of the study. She has conducted qualitative and quantitative research studies and contributed to research and evaluation teams including participation on a CQR team related to homeless youth. She has participated in suicide gatekeeper training – Question Persuade Refer – and has some experience addressing client suicide issues in her work as a counselor. Her area of expertise is crisis education with a particular focus on training counselors-in-training regarding child maltreatment. Her dissertation resulted in a set of competencies for counselors to assess and manage the impact of child maltreatment in their clients. Janessa and I are friends and colleagues who have used our shared interests to collaborate on research projects and state, regional, and national presentations on crisis education. She offered to serve on the research team upon hearing my ideas and plans for my dissertation project.

I targeted a UNC CES doctoral research course to recruit another primary team member following the recommendation of Dr. Clemens. I developed a recruitment flyer
that highlighted responsibilities, potential benefits, and qualifications. My short
presentation to the class included greater details about the project, answers to students’
questions, and a call for curriculum vitae or emails about potential team members’
backgrounds relative to the qualifications. I received an email from one interested student
before the deadline and another the day after; I selected the former.

Connie Couch is a UNC CES doctoral student. She is a licensed professional
counselor in Alabama and is awaiting her endorsement in Colorado. She received her
master’s in Counseling from the University of Montevallo in Alabama in 2006 and spent
the nine years between her master’s and her doctoral program working in intensive
outpatient and related programs, in-home intervention, and Employee Assistance
Program services. Her clinical experience has included assessing, intervening, and
managing numerous clients at risk for suicide. Connie also has two years of experience as
a site supervisor at a substance abuse treatment center. She worked with two supervisees
from beginning Practicum through completion of Internship. Her research training and
experience includes master’s research courses and two doctoral courses which she
completed while serving as a team member on the current study: Doctoral Research
Seminar for Counselor Education and Supervision and Qualitative Research. She had
prior experience coding qualitative interview transcripts as a doctoral graduate assistant.

Training of the research team is a hallmark of Consensual Qualitative Research
(Hill et al., 2005). The research team followed team training recommendations for this
methodology (Hill et al., 2005; Vivino et al., 2012), including: (a) literature review, (b)
responsibilities, (c) team discussion, and (d) dissemination. Training began when I
emailed the primary team with instructions for preparation and a scheduling request for
our first meeting. I asked the team members to review the foundational literature on the
method (Hill et al., 2005, 1997), at least one of the exemplar studies identified by Hill et
al. (2005) and Vivino et al. (2012), and Chapter III of my dissertation proposal. I also
recommended they review the latest Community Readiness Model manual (Tri-Ethnic
Center for Prevention Research, 2014), scoring video (https://www.youtube.com/watch?
v=h0C6Sf3B6CM&feature=youtu.be) and read the Consensual Qualitative Research
book (Hill, 2012) if they desired.

Our first team meeting occurred via Google Hangouts which allowed for video
images and screen sharing. It lasted three hours in which we discussed team members’
responsibilities and expectations, our biases about the research topics, and an overview of
the analysis and consensus process. We discussed group dynamics in this initial meeting
including our commitment to valuing each individual’s input and agreed to discuss these
dynamics throughout the project. I invited primary team members to provide any
anonymous input to the external auditor who could provide suggestions for addressing
concerns. Subsequent meetings included a reflective conversation about team members’
experiences of the previous phase and a detailed discussion of procedural steps and team
member responsibilities for the upcoming phase. I describe team responsibilities and
interpersonal processes next.

**Team consensus process.** Team meetings occurred via videoconference and in
person and lasted between two and five hours. The team used a combination of NVIVO
and Microsoft Word for coding, communications, consensus, and audit. The team used
several methods to support teamwork and reach consensus. Speaker rotation, process
conversations, reflection breaks, and reflexive discussions occurred in team meetings. An
example of a process conversation comment that occurred is: “It seems like we are
getting bogged down in the details of what the resources would be used for. Could we
simply agree money resources are available and sort out the details in cross-analysis?”
The team held entire process conversations anytime a change of procedure occurred (i.e.,
progression from one phase to the next). Reflexive discussions occurred when team
members mentioned areas in which they struggled to understand the data and/or biases
they have that may affect their coding and analysis. The team also used coding
comparison queries following the external auditor’s recommendation.

*Coding comparison.* The coding comparison query (CCQ) function in NVIVO
provides a report of the agreement and disagreement between the coding of two
members. Table 4 contains the CCQ summary for all cases except case 2. I calculated the
CCQ agreement and disagreement averages by averaging the percentages of each across
the three pairs per domain per case, then averaging the case averages to arrive at a
domain average across cases.

| Table 4 |

<table>
<thead>
<tr>
<th>Coding Comparison Query Summary</th>
<th>Agreement %</th>
<th>Disagreement %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Range</td>
</tr>
<tr>
<td>Efforts</td>
<td>91.81</td>
<td>[87.48, 95.12]</td>
</tr>
<tr>
<td>Knowledge of Efforts</td>
<td>91.15</td>
<td>[85.24, 95.2]</td>
</tr>
<tr>
<td>Leadership</td>
<td>97.59</td>
<td>[96.65, 99.14]</td>
</tr>
<tr>
<td>Climate</td>
<td>92.71</td>
<td>[88.7, 96.57]</td>
</tr>
<tr>
<td>Knowledge of Suicide</td>
<td>94.67</td>
<td>[91.61, 97.04]</td>
</tr>
<tr>
<td>Resources</td>
<td>96.83</td>
<td>[95.19, 98.46]</td>
</tr>
</tbody>
</table>

*Note.* The table represents case 1 and cases 3 through 15.
Coding differences contributed to challenges during consensus conversations. It was sometimes hard to agree on what the participant intended to mean. We drafted clarification questions in team meetings which I included in my follow-up emails to participants. Team members described their differing perspectives during consensus conversations. These conversations were particularly important regarding efforts, knowledge of efforts, and climate as the team experienced greater than 10% disagreement for some cases. First I address efforts and knowledge of efforts.

Consensus conversations regarding efforts and knowledge of efforts often focused on distinguishing the coding between these two domains. Team consensus often involved discussions about (a) what constitutes a master’s-level suicide training effort; (b) whether an effort one participant described as existing in another program should be coded as efforts or knowledge of efforts; (c) what constitutes evaluation of master’s-level suicide training; and (d) whether double coding or partial coding was appropriate. Multiple coding (e.g., double or triple coding) involves coding the same portion of data to more than one dimension. Partial coding involves coding one portion of a sentence or phrase to one dimension and another portion to one or more other dimensions. As an example, some data portions included a participant naming an effort (efforts), explaining its intended result (efforts0 as connected to a belief they have toward master’s-level suicide training (climate), and describing the success of the effort (knowledge of efforts). Sometimes this combination occurred all in one sentence.

We eventually agreed (a) to code anything a participant considers master’s-level suicide training as an effort; (b) to code efforts participants identify in other programs as efforts; (c) to consider anything a participant considers master’s-level suicide training
evaluation as knowledge of efforts – evaluation; and (d) to use double and partial coding very intentionally - only when needed to capture distinct data content. These decisions allowed us to stay true to the participants’ perspectives. I address the nuances of the data in Chapters IV and V.

Another issue of coding efforts and knowledge of efforts related to the placement of a participant’s answer relative to the interview question. The interview protocol proceeded from questions about efforts to questions about knowledge of efforts. Some participants indicated they did not know the answer to an efforts interview question and/or identified an effort for the first time within the interview portion targeting knowledge of efforts. Team members did not always independently code the former in knowledge of efforts and the latter in both efforts and knowledge of efforts.

Consensus conversations involving knowledge of efforts also focused on the distinction between this domain and knowledge of suicide. Some participants described ways they developed knowledge about suicide within the interview portion of the interview targeting knowledge of efforts. This participant’s answer to the question “How would you say that those in Counselor Education and Supervision learn about efforts in our field to provide master’s-level suicide training?” is an example:

Yeah, that’s a good question. I know there are specific areas of textbooks for people. I use the Danica Hays text for my Assessment class and there’s a chapter on suicide assessment in there. So I think that finding a good resource for your class is very important as well as supplementing some of these professional practices and training. You get an outside perspective from just the teacher, or the instructor that is providing your education, but you get more of the applied piece with that. I think it is well-rounded. But as far as they become known, I think it’s just… ahh … it's just based on your experiences, how you are trained, what that looks like and really looking for that- those opportunities in your area. You know, I can't remember in my master’s program if I had explicit suicide training, and I think that’s a big problem. But I don't know how the faculty really get on board
with finding out that it's not being done. I am getting a little rambly here, but for example our faculty work really really closely with one another. And we are saying ‘Who is covering these standards and in what class?’

Consensus conversations about climate often focused on (a) the distinction between climate in and around the Counselor Education and Supervision field; (b) the distinction between attitudes toward master’s-level suicide training (climate) and appraisal of master’s-level suicide training efforts (knowledge of efforts); and (c) the overlap of lack of resources as an obstacle (climate) and the exact resources (resources) that are unavailable for master’s-level suicide training. The team initially discussed about the first focus the possibility that all data related to a community beyond the CES field could be considered an environment surrounding the community (climate). We noted as interviews progressed that the “broader community” data seemed connected to specific topics (i.e., readiness domains) and decided to code it as such. A distinguishing factor the team found between attitudes toward master’s-level suicide training (climate) and appraisal of efforts (knowledge of efforts) was that the former relates to beliefs about how master’s-level suicide training should occur and/or feelings that Counselor Education and Supervision members have about providing master’s-level suicide training (climate). The latter instead relates to members’ critiques (knowledge of efforts) of existing efforts. We, with guidance from our external auditor, decided to double code and analyze (i.e., develop core ideas) the data in which the participant identifies a lack of resources (resources) as an obstacle (climate). This helped us ensure we stayed true to participants’ messages and captured the data in a way that would support clearer communication of the findings and implications. The next subsection addresses the analysis procedures.
**Analysis process.** The team preparation and analysis process lasted 17 weeks. The analysis process involved three phases: (a) Phase 1 for cases 1 through 3, (b) Phase 2 for cases 4 through 15, and (c) Cross-analysis. We analyzed the initial and remaining cases using steps that followed Consensual Qualitative Research methodology and incorporated the Community Readiness Model scoring of readiness stage. The cross-analysis phase contained two steps: categorization into themes and representation. The next subsections contain detailed descriptions of the three phases and their repeated steps. See also Appendix F.

**Phase One: Initial cases.** The first phase involved analysis and Community Readiness Model scoring of the first three interviews, resulting in domains, core ideas, and stage of readiness scores. Consensual Qualitative methodology (Hill et al., 2005) provides researchers the option of using a *start list* (Miles & Huberman, 1994 as cited in Hill et al., 2005) of domains to apply and modify throughout analysis. The start list consisted of the readiness dimensions from the theoretical framework of the study: knowledge of suicide, leadership, master’s-level suicide training efforts, knowledge of efforts, climate, and resources. Appendix G provides a brief description of each dimension. We used consensus to clarify the domains as analysis progressed. We did not add new domains beyond the existing Community Readiness Model dimensions although we were prepared to do so if needed.

The use of the Community Readiness Model (CRM) scoring procedure to assess readiness of the community related to the issue is an addition to traditional Consensual Qualitative Research methodology. Per instructions in CRM manuals, I adapted the anchored rating scales and scoring sheets from CRM for our use (Plested et al., 2009).
Determination of readiness level is a step-by-step process involving: (a) independent scoring by two or more scorers using a 1 through 9 scale for each of the six dimensions of readiness, (b) scorers’ discussion to consensus, (c) averaging across interviews for each dimension, and (d) averaging across dimensions. The final score indicates the community’s stage of readiness about the issue of focus. Appendix H provides a brief description of the overall readiness stages. Phase 1 contained eight steps which I describe next.

**Step 1: Independent coding of case 1.** Analysis in Phase 1 began with each team member independently coding the case one transcription by highlighting portions of the data that align with one or more readiness dimensions.

**Step 2: Consensus on case 1 coding and preparation for analysis and scoring.** The first team analysis meeting focused on (a) clarifying the CRM dimensions and reaching consensus on coding and (b) introductory practice with core ideas. We accomplished the former by proceeding case-by-case, reading each highlighted thought unit aloud, considering the context of the case, and exchanging viewpoints toward consensus (Hill et al., 2005). “The next step in the data analysis is constructing core ideas or summaries of the data that capture the essence of the participant’s statement in fewer words” (Thompson, Vivino, & Hill, 2012, p. 111). Core ideas allow researchers to compare across cases and use consistent language. We reviewed the concept and process of core ideas and practiced creating some together.

**Step 3: Independent analysis of case 1.** Team members then returned to independent work on case 1 before the next meeting by analyzing (i.e., developing core ideas) for case 1.
Step 4: Secondary consensus and scoring of case 1. This team meeting focused on reaching consensus on case 1 coding and analysis (i.e., domains and core ideas). The team consulted the data and reached preliminary consensus. This step also included Community Readiness Model (CRM) scoring. The CRM manual (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014) contains anchored rating scales for adaptation to each CRM study. We scored the first case together by proceeding dimension-by-dimension, reading the anchored rating scale from bottom to top, and highlighting or underlining data portions that refer to anchored rating statements. If the interpreted transcript as a whole appeared to exceed the first rating statement, the scorer considered the next rating statement in this same manner. Scorers used a scoring sheet to assign participant scores for each of the dimensions of readiness. The discussion resulted in a preliminary consensus score for the case.

Step 5: Auditor review of domains, core ideas, and scoring. I used NVIVO to develop a report approximating a “consensus version” (Thompson et al., 2012, p. 109) that includes the following information: (a) case number, (b) reference number, (c) portion of raw data, (d) domain, and (e) core ideas. I forwarded this report, the primary researcher’s CRM scores, and the preliminary consensus scores to Dr. Clemens for her review and recommendations. The external auditor’s case one feedback prompted me to develop and use (a) file sharing procedures and NVIVO queries to produce coding comparisons and (b) NVIVO queries for identifying and addressing un-coded data prior to the audit. Audit feedback for the team concerned our success in combining the participant’s wording and language of the CRM dimension in our core ideas and the team’s need to further differentiate our coding between efforts and knowledge of efforts.
and between climate and resources. The team discussed recommended changes from the
auditor regarding our case 1 analysis to reach final consensus on domains, core ideas, and
readiness score.

**Step 6: Independent coding, analysis, and scoring of cases 2 and 3.** All steps of
Phase 1 repeated following data collection of the second and third case with independent
work collapsed to include coding, analysis, and scoring. The team members
independently coded and analyzed cases 2 and 3 to prepare for the consensus meeting.
We also each scored cases 2 and 3 independently.

**Step 7: Consensus on cases 2 and 3.** This meeting focused on reaching
preliminary consensus on domains, core ideas, and scores for cases 2 and 3. We coded
and completed core ideas for some of case 2 together as we continued to familiarize
ourselves with the Community Readiness Model framework, NVIVO, the Consensual
Qualitative Research process, and our teamwork. This served to “further coalesce the
team and to ensure that everyone is ‘on the same page’” (Thompson, Vivino, & Hill,
2012, p. 112). We reached consensus on cases 2 and 3 – the last cases of Phase 1.

**Step 7: Auditor review of domains, core ideas, and scoring.** I sent Dr. Clemens
the preliminary consensus version and scoring for cases 2 and 3 at the same time. Audit
feedback included: (a) a recommendation to code all relevant data including those which
are redundant and to revisit case 3 in particular to code such data; (b) a recommendation
to consider how we might consistently include data regarding students into our coding
and analysis; and (c) a request to include reports of independent Community Readiness
Model scores and consensus explanations for auditing.
Step 8: Follow-up consensus on cases 2 and 3 and preparation for Phase 2. The team met to discuss the result of the audit, discuss our reflections about the process, and make necessary adjustments.

Phase 1 lasted two and a half weeks though I had anticipated it would take six weeks. Hill et al. (2005) recommended a simplified approach to analysis after the initial cases. I describe Phase Two next.

Phase 2: Remaining cases. Phase 2 comprised cases 4 through 15. We followed the proposed procedures which differed from Phase 1 in that (a) I developed the core ideas myself; (b) two members scored each case; and (c) meetings typically spanned three cases at a time. The team members continued to independently code the data in Phase 2. All researchers 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). Only two members independently completed Community Readiness Model scoring for readiness for each case. I scored all cases and developed a schedule that alternated the other two team members. We completed consensus and auditing in sets of three or four cases at a time. This served to alleviate undue responsibilities for the non-primary team members while still honoring the shared, structured process of Consensual Qualitative Research methodology.

We utilized a pre-consensus process prior to each Phase 2 consensus meeting in which team members independently reviewed others’ coding compared to our own and commented on disagreements in a pre-consensus document. We provided in the document the line numbers, our initials and independent coding, and a rationale and alternative ideas. This allowed us to review each others’ rationale and ideas prior to the
consensus meeting and guided our conversations as did the coding comparison queries.

Table 5 displays two examples from pre-consensus documents.

Table 5

<table>
<thead>
<tr>
<th>Case and Lines</th>
<th>Coding</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 15 Lines 29-45</td>
<td>M1: Efforts</td>
<td>M1: She is describing the local organizations’ information she provides students as an MLST.</td>
</tr>
<tr>
<td></td>
<td>M2: KoS</td>
<td>M2: I re-read it and don’t see where she says she provides them as MLST.</td>
</tr>
<tr>
<td></td>
<td>M3: Efforts (or KoS?)</td>
<td>M3: Is handing out pamphlets MLST? Even though I’m not sure of the soundness of the MLST she’s talking about, I think it is an effort. Could be Knowledge of Suicide though.</td>
</tr>
<tr>
<td>Case 10 Lines 191-197</td>
<td>M1: Resources</td>
<td>M1: I included her reasoning/intention behind the idea of putting failing in the syllabus. Curious to hear your rationales.</td>
</tr>
<tr>
<td></td>
<td>M2: Effort</td>
<td>M2: I had a hard time with this one. She seemed to be talking about the existence of her effort; but maybe it is Resources actually because she is talking about a plan that hasn’t begun.</td>
</tr>
<tr>
<td></td>
<td>M3: KoE</td>
<td>M3: It sounded like she was again evaluating the effort. It is a plan, so she is not doing that yet.</td>
</tr>
</tbody>
</table>

Note. M1 = Team member one initials; MLST = master’s-level suicide training. M2 = Member 2 initials; M3 = Member three initials.

The case 15 example illustrates reflexivity as the team member acknowledged a bias regarding quality of master’s-level suicide training methods. This occurred several times throughout analysis as members recognized and shared relevant biases with each other. It became apparent while coding and analyzing the Efforts domain that we needed to remember that our role in this study was not to evaluate the legitimacy or quality of the effort. This issue arose during similar instances such as coding data on suicide awareness events and training on no-suicide contracts. The team reviewed and reached consensus on
the case 15 example by reviewing together a larger portion of the data that appeared before and after the coded data portion. We concluded the participant was describing an effort which involved providing local and national suicide prevention organization brochures as handouts to supervisees.

The case 10 example shows the beginning of a team member decision process regarding where to code ideas or intentions for future efforts. The team discussed during several consensus meetings whether or not these belong in the resources domain since an interview question targets action plans and initiatives for resources. We eventually decided after coding a few cases this way that intended future efforts belonged in efforts while plans for securing resources belonged in resources. We resolved to consider potential categorization for intended efforts when we reached cross-analysis. The next subsections contain descriptions of five repeated steps in Phase 2. See also Appendix F.

**Step 1: Independent coding and analysis.** We followed the same procedure as in Phase 1 to code the transcripts for domains after each transcription. I developed core ideas and sent a follow-up email to each participant. I completed my independent analysis of each case in NVIVO and shared the file with the other two primary team members for review.

**Step 2: Pre-consensus and independent scoring.** We reviewed each other’s coding prior to the initial consensus meeting and commented in a pre-consensus document in preparation for the consensus meeting. I and another team member independently scored the transcript for readiness as described in Phase 1. We held a consensus meeting for each set of three cases.
Step 3: Initial consensus. The three primary team members held an initial consensus meeting to progress case-by-case, reviewing data portions and core ideas for each domain and any responses I received from my follow-up emails to participants. We discussed any potential additional domains as well as core ideas for each data portion. The two Community Readiness Model scorers determined a preliminary consensus score for readiness for each of the three cases. Consensus discussions continued in secondary meetings when necessary.

Step 4: Auditor review of domains, core ideas, and scoring. All Phase 2 audit requests contained a “consensus version” (Thompson et al., 2012, p. 109) regarding domains and core ideas and Community Readiness Model score information. Community Readiness Model score information included each team member’s independent score, the preliminary consensus score, and a brief explanation of case-specific information that supported the consensus decision. An example of an explanation is:

Team member X assigned a climate score of 6 while team member Y assigned a score of 4. The team members re-reviewed the original data and agreed on 5 because the participant expressed that community has a concern about suicide and a positive attitude toward master’s-level suicide training and improving it, however she focused on several obstacles and did not mention any other community members working on new or improved master’s-level suicide training.

The audit feedback on cases in Phase 2 was for the team to continue differentiating between efforts and knowledge of efforts coding. The external auditor recommended we review all cases for distinctions between domains before moving to cross-analysis.

Step 5: Follow-up consensus. The team discussed recommended changes from the auditor regarding our analysis of each set of three cases, then reached final consensus on domains, core ideas, and readiness score.
All five steps of Phase 2 repeated following data collection of all remaining sets of three cases each. Phase 2 lasted five and a half weeks which approximated the original estimation. After consensus was completed for all cases, I used Word and NVIVO to develop cross-analysis documents containing all the core ideas for each domain. Each core idea referenced the case number, pseudonym, and line number to use in referring back to the raw data. This served as the “mega-document” of all consensus results sorted by domain (Ladany, Thompson, & Hill, 2012, p. 117).

Phase 3: Cross-analysis. The cross-analysis phase of Consensual Qualitative Research entails analyzing the data at a “higher level of abstraction” (Hill et al., 2005, p. 200). The two elements of cross-analysis are categorization into themes and frequency. Consensus and auditing occur throughout. We followed the suggestion of Ladany, Thompson, and Hill (2012) to begin the cross-analysis phase with independent development of potential categories for “a relatively small and easy domain so that the team can gain competence with the task of conducting a cross-analysis” (p. 118). We chose Leadership based on the Coding Comparison Query results. Cross-analysis consensus meetings focused on (a) consensus on category and subcategory structure for one or two connected domains (i.e., Climate and Resources) and (b) consensus on the placement of core ideas into categories and subcategories. We utilized similar strategies to reach consensus as those in Phases 1 and 2: review of original data; explanations of our rationale; process conversations; reflexive discussions; and breaks.

An example of a process conversation occurred when a team member pointed out her goal during cross-analysis was to support parsimony of the category structure. The other two team members acknowledged they focused more on coverage: ensuring that the
category structures captured all core ideas. These differing goals guided the complementary roles team members played during this phase.

Another example of a process conversation occurred when I developed a subcategory structure under Content in Efforts that perfectly aligned with the list of suicide content knowledge I presented in Chapter II. As a reminder, I compiled the list based on the suicide training guidelines (Clinical Workforce Preparedness Task Force, 2014), Core Competencies (American Association of Suicidology, 2004) and Counselor Education and Supervision literature (Foster & McAdams, 1999; Hoffman et al., 2013; Laux, 2002; Wachter Morris & Barrio Minton, 2012). We first attempted to categorize the data using this structure and even discussed re-categorizing related subcategories in Leadership and Knowledge of Suicide. One team member requested a pause in our consensus discussion to hold a process conversation. She shared that she felt we were beginning to force the data to fit a category structure that was not organic to the data nor specifically guided by the Community Readiness Model framework. She wondered if I was feeling excited to return to writing my dissertation and was already conceptualizing my discussion of findings. This conversation brought awareness to my inner process and the need to stay mindfully present in the present phase. It also encouraged re-reflection on the research team’s role and the dynamics between team members. I asked the team members to pay close attention to category terminology and placement that I suggest to ensure categorization was not driven by my existing knowledge of the literature. The next subsections contain detailed descriptions of the five steps in this phase. See also Appendix F.
Step 1: Categorization within all domains. The primary team began cross-analysis by progressing domain-by-domain, placing core ideas into categories and subcategories based on common themes. Categorization discussions took place in group team meetings toward consensus.

Step 2: Audit of categorization. I sent Dr. Clemens the list of categories and subcategories for all domains once categorization consensus was complete.

Step 3: Frequencies. Step 3 of 4 in the Cross-analysis phase involves frequencies or counts of representation for categories across cases. I independently analyzed the frequency of the categories following the guidance of Ladany et al. (2012) and my proposed methods. Consensual Qualitative Research methodologists (Hill et al., 2005; Ladany et al., 2012) defined these frequency labels for samples of 15 or fewer participants:

- General: all or all but one case
- Typical: more than half of the cases
- Variant: from two to half of the cases

I followed the recommendation to calculate overall frequencies and to contrast potential subsamples related to frequency. Frequency differences seemed possible since the Community Readiness Model scores for site supervisors ranged from 21 to 30 whereas those for university participants ranged from 26 to 35. Knowledge of efforts scores for site supervisor participants contained 1 through 3 whereas those for university participants ranged from 4 to 7. Table 6 shows the frequency labels appropriate for this sample and potential subsamples. Findings must differ by at least two frequency levels to qualify as potential subsamples (Ladany et al., 2012).
The initial frequency calculation revealed that frequency labels varied by two levels for two categories: I.G. Efforts - target audience and III.G. Leadership - broader community’s impact on master’s-level suicide training. I checked my intended plan with the external auditor and reconvened the team to explore these differences. Each of us independently reviewed the original data and core ideas for these subcategories. We considered: (a) any errors or discrepancies during coding, analysis, and/or cross-analysis that may have contributed to the frequency differences, (b) options for addressing these errors, and (c) ways to present the data as subsamples if applicable.

Table 6

<table>
<thead>
<tr>
<th>Frequency Labels for the Current Study</th>
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<tbody>
<tr>
<td>Site supervisors ($n = 5$)</td>
</tr>
<tr>
<td>General 5</td>
</tr>
<tr>
<td>Typical 3 – 4</td>
</tr>
<tr>
<td>Variant 1 – 2</td>
</tr>
</tbody>
</table>

Our further exploration of I.G. Efforts - target audience revealed we neglected to create core ideas in Phase 1 relevant to interns and practica students as target audiences. Re-analysis involved categorizing relevant core ideas as supervisees. This resulted in full representation from all participants in the Efforts – target audience category.

Our further exploration of III.G. Leadership - broader community’s impact on master’s-level suicide training and subsequently III.E. Leadership - awareness about leadership and V.A. Knowledge of suicide - Sources of knowledge about suicide revealed several trends in the data. The majority of core ideas in Leadership – broader community (seven of nine) related to broader community leadership (e.g., professional organizations) providing active support for learning among counseling professionals and/or Counselor
Education and Supervision community members. These leaders and their contributions also appeared in V.A. Knowledge of suicide - Sources of knowledge about suicide. This finding led us to explore any trends in this category. No frequency label differences exist for Sources of knowledge about suicide; however fewer core ideas from site supervisors existed in Sources of knowledge about suicide subcategories of professional development and organizations than from university participants. Of those, only two site supervisors explicitly named broader community training providers.

We wondered if a contributing factor to the lack of core ideas from site supervisors in the Leadership – broader community category was a lack of awareness among site supervisors about leadership. No frequency label differences exist for III.E. Leadership - awareness about leadership; however this Leadership awareness subcategory of lacking awareness about leadership represents four site supervisor participants and four university participants. Of those, we could not find any qualitative differences between site supervisors and university participants related to leaders in the broader community.

Another area of Leadership we further explored was III.D. Leadership - lacking support. We specifically discussed the subcategory entitled Calls to leaders for needed support. A theme of needed support involved a request for leaders within and beyond the Counselor Education and Supervision field to require suicide training of site supervisors and university instructors. We determined this finding emerged across site supervisors and university participants.

Our final area of further exploration was climate. Related ideas emerged in site supervisor interviews which we coded in IV.B. Climate - political climate as politics and
the broader community. Core ideas from site supervisor interviews did not explicitly name leaders; however, they identify the impact of state policies that impact master’s-level suicide training. Two site supervisors mention the political climate related to suicide training for Counselor Education and Supervision members: a low priority on suicide training in the local community and the lack of university support to host a particular workshop.

We concluded from our further exploration that university participants more than site supervisor participants identified organizations in counseling and other broader communities as leaders that impact master’s-level suicide training by supporting learning. We therefore moved core ideas from L-BC to III.A. Leadership - active support under the subcategory supporting learning, necessarily removing the original Leadership – broader community category. We also concluded site supervisors’ perspectives about the broader community’s impact on master’s-level suicide training centers on the climate in which the participants supervise and practice. It appears site supervisor participants’ primary message about broader community leadership and their own professional development is a call for state policies requiring site supervisors complete suicide training. This theme emerged in III.D. Leadership - lacking support; therefore we did not make further changes to categorization. Chapter IV contains further details about results in the leadership domain. I also report the final frequencies calculations in Chapter IV and in the domains, categories, and subcategories table in Appendix J.

*Step 4: Community readiness score.* The Community Readiness Model (Plested et al., 2009) defines the following scores for the nine stages of readiness:
• No Awareness: 1
• Denial/Resistance: 2
• Vague Awareness: 3
• Preplanning: 4
• Preparation: 5
• Initiation: 6
• Stabilization: 7
• Confirmation/Expansion: 8
• High Level of Community Ownership: 9.

Appendix H displays the descriptions of each readiness stage. I followed Community Readiness Model guidelines (Plested et al., 2009) to calculate aggregate scores for community readiness. I totaled independent dimensional scores for each dimension and divided by the total number of interview participants. I determined the overall stage of readiness by totaling this calculated score and dividing by six dimensions, then rounding down to represent the overall stage of Counselor Education and Supervision’s readiness to provide master’s-level suicide training. I report the Community Readiness Model score results in Chapter IV and Appendix I: calculated scores for each dimension, the overall readiness score, and the stages these scores represent.

Step 5: Final meeting. A final team meeting involved review and discussion of all findings. Phase 3 lasted two and half weeks instead of the six weeks estimated.
Trustworthiness

Researchers have shared a multitude of perspectives and opinions about validity, reliability, and evaluation of qualitative research, creating a sizable terminology (Creswell, 2013; Merriam, 2009). Lincoln and Guba (1985) developed the concept of trustworthiness in qualitative research to denote the quality of a study and its findings, including a set of terms for trustworthiness criteria: (a) dependability, (b) credibility, (c) confirmability, and (d) transferability. I describe in this section strategies to support trustworthiness and explain their application in the context of this study.

Sim et al. (2012) provided recommendations to address biases and expectations for five portions of Consensual Qualitative Research (CQR) studies: (a) team selection, (b) recording biases and expectations, (c) data collection, (d) analysis, and (e) post-analysis and write-up. The use of a research team in CQR serves to enhance trustworthiness, particularly related to reflexivity, bracketing, and management of bias (Williams & Hill, 2012). Research peers provide prompts to other team members to distinguish perceptions and interpretations, and auditors review the team’s work from a potentially different perspective. These actions support the team toward the goal of accurately representing the study participants’ experiences of Counselor Education and Supervision’s readiness to provide master’s-level suicide training. This section addresses evaluative criteria from CQR methodologists (Hill et al., 2005, 1997; Sim et al., 2012) in terms of dependability, credibility, confirmability, and transferability.

Dependability

Dependability is the consistency of the results with the data collected in a study (Lincoln & Guba, 1985; Merriam, 2009). Merriam (2009) identified four strategies to
maximize dependability: triangulation, use of an audit trail, reflexivity, and peer examination. Creswell (2013) added another strategy for strengthening dependability – intercoder agreement. This study entailed all five of these strategies as I describe next.

**Triangulation.** Triangulation involves the examination of a statement from multiple viewpoints, such as data sources, researchers, theoretical perspectives, and/or methods. Consensual Qualitative Research studies do not typically involve the use of multiple data points such as varying types of data collection or number of interviews, and it would not be feasible for this project. However, the study entailed data triangulation through the inclusion of participants who serve in various roles related to master’s-level suicide training. This served to invite potentially differing viewpoints. I also used investigator triangulation (Merriam, 2009) or triangulating analysts (Patton, 2002) in that a team of researchers discussed their many viewpoints and work toward consensus. Additionally, an external auditor weighed in from her standpoint.

**Audit trail.** Audit trails are detailed logs of the process of the research study (Merriam, 2009). Such trails serve to report the research process including the role of the various data sources, researcher decisions and related rationales (Halpern, 1983 as cited in Lincoln & Guba, 1985). The researcher can use audit trails for help with tracking and reflexivity, and an external auditor can also review them (Schwandt, 2007). The audit trail I used for this study focused on the process of analysis as conducted by the research team and me, and included some of the content and appendices from this chapter, my researcher journal, and conversations with my external auditor.

**Reflexivity.** Reflexivity encompasses both the self-reflection process and its communication to others, namely readers (Merriam, 2009). The beginning of this chapter
served to communicate my worldview, which is an important consideration to begin the qualitative research process (Denzin & Lincoln, 2000). Sharing my researcher stance can boost credibility by explaining my location within the study (Janesick, 2000). Williams and Hill (2012) highlighted the importance of maintaining awareness of one’s biases and differentiating them from Consensual Qualitative Research (CQR) participants’ understanding. This is similar to the process I have used as a counselor when clarifying my values and viewpoints as separate from concerns of a client.

An earlier section of this chapter served to describe the team for this proposed study. I selected team members based on diversity of biases and expectations and capacity for teamwork. I explained during team training why reflexivity is important and requested a stance from each team member. We discuss our biases and expectations as a team during periods of strong agreement and invite disagreements. We established an agreement on related practices to apply throughout the study based on CQR recommendations. For instance, we sometimes rotated the order of speakers and often took reflection breaks during team meetings, especially after intense discussions.

Other ways to maintain reflexivity throughout the research process include researcher journals, intentional consideration of the literature, and focus on participants. “Moving from the field to the text to the reader is a complex, reflexive process” (Denzin, 1994). I maintained a researcher’s journal and suggested my other team members also do so to sustain self-awareness throughout the study. I used the suggestion by Burkard et al. (2012) to take notes during and after CQR interviews on my experience of the interview and used the notes to reflect on my reactions and potential biases. Crook-Lyon, Goates-Jones, and Hill (2012) suggested the literature review serve to form research questions
and design of a CQR study and that researchers revisit the review when interpreting results but bracket the literature during other steps. For instance, I focused on the experiences of the individual participants during data collection and the team focused on the exact words of the participants during data analysis (Crook-Lyon et al., 2012). We accessed the interview transcripts in a further attempt to consider the content closely.

**Peer examination.** Merriam (2009) stated that “a thorough peer examination would involve asking a colleague to scan some of the raw data and assess whether the findings are plausible based on the data” (p. 220). The research team process described in this dissertation seems to exceed this suggestion. Hill et al. (1997) urged researchers to be critical in scrutinizing the consensual process in CQR. The research team followed their specific suggestions as described earlier to compare results against the transcript data often and to monitor any changes to domains, core ideas, and categories.

**Intercoder agreement.** Intercoder agreement is “the use of multiple coders to analyze transcript data” (Creswell, 2013, p. 253). I used intercoder agreement in three elements of the analysis: initial analysis, Community Readiness Model scoring, and cross-analysis. In analysis, all members of the primary research team independently analyzed the first transcripts by highlighting data and generating additional domains and core ideas. All three team members also scored readiness for the first three cases by following Community Readiness Model protocol. We continued to use intercoder agreement for independent readiness scoring and for the community’s final score. Cross-analysis involved consensus on categorization of themes. Team members worked separately by independently designing tentative categorization schemes, and then worked together to reach consensus on a final scheme.
Credibility

Credibility speaks to the believability of the findings based on how the data were presented (Lincoln & Guba, 1985). The researcher can achieve credibility by assuring he or she is providing an accurate representation of the participants’ views (Schwandt, 2001). Merriam (2009) identified six strategies to maximize credibility in a qualitative study: (a) triangulation, (b) reflexivity, (c) peer examination, (d) member checking, (e) adequate engagement, and (f) negative or discrepant case analysis. I have already described triangulation, reflexivity, and peer examination. I employed the other three strategies – member checking, submersion or adequate engagement in the field and discrepant case analysis – to one degree or another.

**Member checking.** Several qualitative research experts have placed importance on member checking, or soliciting feedback from participants on researchers’ emergent conclusions (Creswell, 2013; Lincoln & Guba, 1985; Merriam, 2009). Member checks are not always considered necessary for trustworthiness in effective Consensual Qualitative Research studies (Hill et al., 2005, 1997). Hill et al. (2005) “questioned the utility of including this step” (p. 202), while Williams and Hill (2012) emphasized the benefit of member checks for verification, clarification, and a chance for participants to “reflect on the interview content” (p. 196). I outlined an abbreviated member check process for this study in this chapter’s Data Collection section. Each participant received an email with the most updated list of domains, clarification questions, and an invitation to share post-interview reflections.

**Exposure.** Exposure, or adequate engagement in the field, is another validation strategy in qualitative research (Lincoln & Guba, 1985). This immersion serves to inform
the researcher about the participants and their culture. Researchers applying ethnography and other qualitative methodologies use prolonged immersion via observation (Creswell, 2013). Researchers applying Consensual Qualitative Research (CQR) may instead use data immersion. “All team members must become deeply immersed in all of the data” (Hill et al., 2005, p. 203). Team members accomplished data immersion by reading and rereading interview transcripts and creating and editing domains, core ideas, and categories.

**Discrepant case analysis.** Discrepant, or negative, case analysis is the practice of identifying an instance that differs from an emerging conclusion (Schwandt, 2001). Researchers use such analysis to clarify their explanations toward a more credible set of findings. Intentionally seeking such variation may not be an explicit step in CQR; however, CQR methodologists recommended the inclusion and examination of variant cases, viewpoints, and frequencies (Hill et al., 2005, 1997). I utilized variation through sampling and recruitment, in the viewpoints through team discussion, and in cross-analysis. Hill et al. (2005) added a new frequency level for samples of 15 or more participants. Researchers assign the frequency level of *rare* when only two or three cases contain a category. Researchers employing CQR do not report findings emerging from single cases in the data analysis (Hill et al., 2005, 1997). I instead considered single case findings as potential areas for future research and included them in this study’s Chapter V discussion.

**Confirmability**

Confirmability concerns the ability to corroborate the findings as those which emerged from the data (Lincoln & Guba, 1985), “not merely figments of the inquirer’s
imagination” (Schwandt, 2001). Merriam (2009) identified four strategies to maximize confirmability: (a) triangulation, (b) reflexivity, (c) peer examination, and (d) use of an audit trail. Lincoln and Guba (1985) also identified external audits. I describe my use of external audits below.

**External audits.** Consensual Qualitative Research (CQR) methodology requires one or more external auditors (Hill et al., 2005, 1997). I employed both internal and external auditing in this study. Internal auditing, described in the previous sections about the research term and analysis process, involved team member review of Community Readiness Model scores, domains, and core ideas. The developers of CQR (Hill et al., 2005, 1997) provided substantial guidance about auditing which we will follow in this study. Hill et al. (1997) stated that external auditors review and provide feedback to the research team throughout all phases of the process to ensure the steps of domain, core ideas, and cross-analysis serve to represent the raw data. Hill et al. (2005) strongly recommended the person serving in this role should have experience with auditing, an understanding of CQR, and potentially expertise with the phenomenon as well. Hill et al. (2005) also suggested: (a) the external auditor become involved as early as interview design; (b) the external auditor critically question the research protocols (e.g., about conceptual organization of the categories to best explain the data); and (c) the research team continually revise and resubmit to the external auditor based on his/her feedback. This chapter’s sections on data collection and data analysis served to outline my application of these recommendations.
Transferability

Transferability concerns the applicability of the findings beyond the present study, which may researchers achieved by providing enough information for a reader to consider the appropriateness of transferring such information to a specific context (Lincoln & Guba, 1985). Merriam (2009) identified three strategies to maximize transferability: (a) maximum variation in the sample, (b) modal comparison, and (c) a rich, thick description of the context and findings. I used two of these strategies: maximum variation and rich, thick description.

**Maximum variation.** A researcher’s use and description of a varied sample provides more readers the opportunity to transfer and apply a study’s findings to a variety of contexts (Merriam, 2009). Researchers achieved maximum variation by attending during sampling and selection to diversity in participants and participants’ contexts. The sampling, recruitment, and selection strategies for this study were an attempt to balance maximum variation with the recommendations of random selection and a sample homogeneous in its experience of the phenomenon when employing Consensual Qualitative Research (Hill et al., 2005, 1997). The qualifying criteria defined a Counselor Education and Supervision population who has experience providing master’s-level suicide training within varying roles, locations, and programmatic contexts.

**Rich, thick descriptions.** Rich, thick descriptions allow readers the information they need to consider applicability of findings beyond the present study (Merriam, 2009). Descriptions are considered rich when they detail the interconnections between ideas. Descriptions are considered thick when they provide a substantial amount of details about a case or theme (Stake, 2010). I followed the explicit recommendations of Hill et al.
(1997) to detail the research process, the research team members, and the context of the research study in this chapter and I provided rich, thick descriptions of the participants and concepts in Chapters IV and V. Hill et al. (2005) noted the richness of reporting findings using a visual representation. This study includes a relational model and logic models in Chapter V.

**Summary**

The purposes of this study were to assess and explore the readiness of Counselor Education and Supervision to provide master’s-level suicide training. This chapter included information about the philosophies and assumptions underlying the study and the study’s methodology and methods. The philosophical foundations were a combined social constructionist and post-positivist paradigm and the Community Readiness Model framework. The methodology was Consensual Qualitative Research. The philosophical paradigm, theoretical framework, and methodology guided the development of a method for this first-time exploration of the field’s readiness from the perspective of counselor educators, supervisors, and administrators affiliated with accredited master’s in counseling programs. Results of an evaluative case study on the piloted project informed the design. A substantial list of strategies served to enhance trustworthiness of the study’s findings.
CHAPTER IV

RESULTS

The purposes of this study were to assess and explore the readiness of Counselor Education and Supervision to provide master’s-level suicide training. This chapter contains the results of the study. The study included interviews with 15 members of the Counselor Education and Supervision field. A three-person team analyzed the data and scored for readiness using a Community Readiness Model framework and Consensual Qualitative Research methodology. An external auditor reviewed the team’s analysis. This chapter contains the results including Community Readiness Model scores and domains, categories, and subcategories.

Community Readiness Model Scores

Community readiness scores provide a measure of “the degree to which a community is willing and prepared to take action on an issue” (Tri-Ethnic Center for Prevention Research, 2014). These scores are the result of consensus between two scorers using anchored rating scales for each readiness dimension. The process yields overall and domain specific readiness scores which correspond with readiness stages. The use of this approach in the current study was intended to answer the first research question:
Q1 What is the overall stage of Counselor Education and Supervision's readiness to provide master's-level suicide training and the readiness stages of the field's knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

The Community Readiness Model contains nine stages of readiness ranging from a score of 1 for no awareness to a score of 9 for high level of community ownership (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). The results of the overall score for Counselor Education and Supervision’s readiness to provide master’s-level suicide training is 4.9 which aligns with a readiness score of 4 out of 9 and a readiness stage of preplanning. Brief descriptions of each Community Readiness Model readiness stage appear in Appendix H.

Three of the dimensions also received scores that aligned with the preplanning stage (4 out of 9): knowledge of efforts, leadership, and climate. Two dimensions received scores aligned with higher stages of readiness. The score for knowledge of suicide – 5 out of 9 – aligns with the preparation stage, one stage above preplanning. The score for efforts – 6 out of 9 – aligns with the initiation stage, two stages above Counselor Education and Supervision’s overall readiness stage of preplanning. The score for the resources dimension – 3 out of 9 – aligns with vague awareness which is one stage lower than preplanning.

The scoring process involves scores for each dimension, a calculated score, stage scores, and an overall score. The dimension score is the total of consensus scores for all cases for each dimension. Appendix I displays the consensus scores for all cases. A stage score is the dimension score divided by number of cases: 15. The total calculated score is the sum of stage scores. The overall score is the calculated score divided by the number
The overall score aligns with the stage of readiness by rounding down. Table 7 displays the final scores and stages for each dimension and the overall score and stage for the community.

Table 7

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Dimension scores</th>
<th>Scores and stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Efforts</td>
<td>99</td>
<td>6.6 Initiation</td>
</tr>
<tr>
<td>B: KOE</td>
<td>72</td>
<td>4.8 Preplanning</td>
</tr>
<tr>
<td>C: Leadership</td>
<td>67</td>
<td>4.5 Preplanning</td>
</tr>
<tr>
<td>D: Climate</td>
<td>67</td>
<td>4.5 Preplanning</td>
</tr>
<tr>
<td>E: KOS</td>
<td>83</td>
<td>5.5 Preparation</td>
</tr>
<tr>
<td>F: Resources</td>
<td>54</td>
<td>3.6 Vague Awareness</td>
</tr>
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</table>

Calculated score: 29.5

<table>
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<tr>
<th>Overall score and stage</th>
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<tbody>
<tr>
<td>4.9 Preplanning</td>
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Note. KOE = knowledge of efforts. KOS = knowledge of suicide.

The overall score of 4.9 and preplanning stage indicates the Counselor Education and Supervision field clearly recognizes suicide and master’s-level suicide training as concerns, however existing efforts may be largely unknown in the community and resources are limited. This contrasts with a score of 3 which represents a lack of concern about suicide for some in the field; little motivation to take action on master’s-level suicide training; a lack of and/or vague knowledge about suicide; and limited and unused resources. An overall score of 5 would have instead represented a concern about suicide and intention to act on master’s-level suicide training; a basic knowledge of suicide and existing efforts among a majority of the field; active leadership support for continuing and/or improving efforts; and secured resources.
The Counselor Education and Supervision field appears most ready to provide master’s-level suicide training related to the current efforts and least ready related to resources to support those efforts. The field’s readiness in the other four dimensions shows a basic level of readiness among some in the community with considerable room for enhancing readiness to provide and improve master’s-level suicide training. I describe the score and stage results for each dimension next.

**Dimension results.** Counselor Education and Supervision’s master’s-level suicide training efforts received the highest readiness score of all dimensions. The calculated score for efforts is 6.6, which aligns with the readiness stage of initiation (Plested et al., 2009; Tri-Ethnic Center for Prevention Research [TECPR], 2014). A 6 on the anchored rating scale for Efforts indicates the field has implemented master’s-level suicide training efforts, whereas a 5 represents efforts in planning. A 7 represents efforts existing for four years or longer. A majority of the participants \( n = 9 \) indicated efforts with at least four years of longevity; however the remainder were unable to confirm this length of time.

Half of the dimensions received scores approximating the overall community score. The calculated score for knowledge of efforts is 4.8, which aligns with the readiness stage of preplanning (Plested et al., 2009; TECPR, 2014). The result of 4 indicates that some Counselor Education and Supervision members know about master’s-level suicide training efforts. A 3 represents a few community members have heard about efforts but have only limited knowledge of them. A 5 represents a majority of members with awareness of existing efforts. Participants were able to provide information about some master’s-level suicide training efforts, particularly their own.
The calculated score for Leadership is 4.5, which also aligns with the readiness stage of preplanning (Plested et al., 2009; TECPR, 2014). A result of 4 indicates that field leaders acknowledge a need for master’s-level suicide training and provide general support, but do not attempt to improve or evaluate the efforts. A 3 represents leadership having a concern about the issue, but not prioritizing or acting to support efforts. A five represents basic active support among leadership without direct guidance on efforts. Participants indicated a priority for master’s-level suicide training among leaders; however support may be attitudinal rather than active and ongoing.

The calculated score and stage for climate is also 4.5 and preplanning. A score of four indicates a concern about suicide and a desire to provide master’s-level suicide training among community members; however the prevailing attitude may be expressed as “We have do something, but we don’t know what to do” (Plested et al., 2009, p. 23) or a belief that “current efforts are sufficient to address the issue” (TECPR, 2014, p. 50). A three represents a concern, but low priority for the issue and no motivation to act via efforts. A 5 represents a desire to act on the field’s concerns about the issue through more or improved efforts. Participants described a complex climate in and surrounding the Counselor Education and Supervision field that includes attitudes, policies, and logistics that act as obstacles to action through master’s-level suicide training efforts.

Two dimensions received scores higher than the overall score for the community: efforts and knowledge of suicide. The calculated score for knowledge of suicide is 5.5, which aligns with the readiness stage of preparation (Plested et al., 2009; TECPR, 2014). A result of 5 indicates basic knowledge about suicide and related counseling (e.g., risk factors and assessment) among some Counselor Education and Supervision members. A
4 represents limited knowledge among some members. A 6 represents a majority of members have basic knowledge about the issue. Participants described inconsistent knowledge of suicide among members of the field.

The dimension with the lowest score is resources. The calculated score for the final domain – Resources – is 3.6, which aligns with the readiness stage of vague awareness (Plested et al., 2009; TECPR, 2014). A result of 3 indicates resources are limited or unstable and there is little motivation within the Counselor Education and Supervision field to allocate resources to master’s-level suicide training. A 2 represents leaders and/or members not encouraging use of available resources for efforts. A 4 represents leaders and/or members seeking additional resources to support efforts. Participants reported they were unaware of any resources for master’s-level suicide training and resources that do exist are only conditionally available.

The dimension scores indicate the Counselor Education and Supervision field’s readiness to provide master’s-level suicide training ranges from 3.6 to 6.6 out of 9. It seems clear that the field is much more ready than the lowest Community Readiness Model stage of readiness: no awareness; however the community’s overall stage of preparation is four stages below the Community Readiness Model’s highest score and stage of readiness – 9 for high level of community ownership. A score of 9 would have instead indicated that members in the field have detailed knowledge about suicide and master’s-level suicide training and leaders continually evaluate efforts and support diversified resources. The results regarding the second research question provide supporting information about how the field is and is not ready to provide master’s-level suicide training. Those results comprise the remainder of this chapter.
Domains, Categories, and Subcategories

The Community Readiness Model dimensions served as a start list of domains (Miles & Huberman, 1994 as cited in Hill et al. 2005) for this Consensual Qualitative Research study. No additional domains or dimensions of readiness emerged in this study. The domains, categories, and subcategories address the second research question:

Q2 What are the themes of the field’s readiness to provide master’s-level suicide training regarding the field’s knowledge of suicide, leadership, efforts, knowledge of efforts, community climate, and resources?

The team’s coding, analysis, and cross-analysis procedures described in Chapter III resulted in six domains with three to seven categories within each domain. Table 8 displays the frequencies per category for site supervisors, university members, and the total sample. Consensual Qualitative Research methodologists intended frequency labels to “reflect the commonality of a theme” which (a) contributes to thorough procedures, (b) aids researchers and readers in communicating and understanding results, and (c) supports comparison between studies (Ladany et al., 2012, p. 124). I present category frequencies and summarize each domain then detail qualitative findings by domain.

Five of the seven categories in the efforts domain represented all participants in the sample ($N = 15$). The other two represented 12. Categories in the efforts domain describe what, how, when, who, for how long, and why of master’s-level suicide training efforts in the Counselor Education and Supervision field. We placed participants’ evaluative comments about efforts into the knowledge of efforts domain along with how members learn about efforts and how much they know about them. Four of the five categories in knowledge of efforts represented the entire sample. The fifth represents 12.
Table 8  

*Frequency Calculations*

<table>
<thead>
<tr>
<th>I. Efforts</th>
<th>Label (Frequency)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Content</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>B. Methods</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>C. Format and Schedule</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>D. Target audience</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>E. Responsible parties</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>F. Longevity and Existence</td>
<td>Typical (3)</td>
<td>Typical (12)</td>
</tr>
<tr>
<td>G. Intentions</td>
<td>Typical (4)</td>
<td>Typical (12)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>II. Knowledge of Efforts</th>
<th>Label (Frequency)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Sources of information on efforts</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>B. Knowledge of efforts varies</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>C. Evaluation of MLST</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>D. Positive appraisal</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>E. Negative appraisal</td>
<td>Typical (3)</td>
<td>Typical (12)</td>
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</table>

<table>
<thead>
<tr>
<th>III. Leadership</th>
<th>Label (Frequency)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Active support</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>B. Types of leaders</td>
<td>Typical (3)</td>
<td>Typical (13)</td>
</tr>
<tr>
<td>C. Concern or Priority</td>
<td>Typical (4)</td>
<td>Typical (12)</td>
</tr>
<tr>
<td>D. Lacking support</td>
<td>Typical (3)</td>
<td>Typical (9)</td>
</tr>
<tr>
<td>E. Awareness about leadership</td>
<td>Typical (4)</td>
<td>Typical (9)</td>
</tr>
<tr>
<td>F. Attitudinal support</td>
<td>Variant (2)</td>
<td>Variant (7)</td>
</tr>
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<table>
<thead>
<tr>
<th>IV. Climate</th>
<th>Label (Frequency)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Attitudinal climate</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>B. Political climate</td>
<td>General (5)</td>
<td>General (14)</td>
</tr>
<tr>
<td>C. Logistical climate</td>
<td>Typical (4)</td>
<td>Typical (12)</td>
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<table>
<thead>
<tr>
<th>V. Knowledge of Suicide</th>
<th>Label (Frequency)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Sources of knowledge on suicide</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>B. Comprehensiveness and Content</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>C. Lack of Awareness about Knowledge of Suicide</td>
<td>Variant (2)</td>
<td>Variant (3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VI. Resources</th>
<th>Label (Frequency)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Unaware or unavailable resources</td>
<td>General (5)</td>
<td>General (15)</td>
</tr>
<tr>
<td>B. Available resources</td>
<td>Typical (4)</td>
<td>Typical (13)</td>
</tr>
<tr>
<td>C. Conditional resources</td>
<td>Typical (3)</td>
<td>Typical (11)</td>
</tr>
</tbody>
</table>

MLST = master’s-level suicide training.
Category representation in the leadership domain was less equal. One category represented the entire sample. Three of the six categories represented 12 or more participants and the other three represented nine or fewer. Categories in the leadership domain describe who leaders are and how and how much they support master’s-level suicide training efforts. *Awareness about leadership* emerged as an additional category. Three types of climate emerged as categories within this fourth readiness domain: two with general frequency \((n = 14 \text{ or } 15)\) and one with typical \((n = 12)\).

Categories in the knowledge of suicide domain were similar to those in knowledge of efforts in that they included how Counselor Education and Supervision members learn about suicide and how much they know about the topic. We also placed the content of their knowledge within this domain. These categories represented the entire sample. *Lack of awareness about knowledge of suicide* emerged as an additional but variant category which only represented three participants. Category results in the final domain included unavailable and available resources and a category about the conditionality of resource availability. The former resources category was general while the latter two have frequencies of typical.

Analysis resulted in two to three subcategories per category. Appendix J displays a full list of domains, categories, and subcategories. The remainder of the chapter is a rich description of the qualitative findings. Table 9 displays pseudonyms and basic demographics for reference regarding participant quotes. Data from some domains appeared more verbally illustrative of the findings than those from other domains. I present quotes from the former in an attempt to honor participants’ language and deepen the readers’ understanding. I summarize the latter without using quotes.
Efforts

Seven categories emerged in the efforts domain. The entire sample ($N = 15$) commented on master’s-level suicide training efforts in terms of the content, methods, and format and/or schedule. Subcategories on target audience and responsible parties also represent all 15 participants. Twelve participants spoke to the existence and/or longevity of the efforts and the intentions.

Table 9

**Pseudonyms and Basic Demographics**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Type</th>
<th>Setting</th>
<th>Respons.</th>
<th>Primary Role</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dillon</td>
<td>Ed</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Samantha</td>
<td>Ed</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Carolyn</td>
<td>Ed</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Sarah</td>
<td>Ed</td>
<td>University</td>
<td>T, S</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Christine</td>
<td>Ed</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
</tr>
<tr>
<td>Susan</td>
<td>Admin</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
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<tr>
<td>Henry</td>
<td>Admin</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
<td>No</td>
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<tr>
<td>Irving</td>
<td>Admin</td>
<td>University</td>
<td>T, S, A</td>
<td>Administrator</td>
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<tr>
<td>Elizabeth</td>
<td>Admin</td>
<td>University</td>
<td>T, S, A</td>
<td>Full-time faculty</td>
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</tr>
<tr>
<td>Shawna</td>
<td>Admin</td>
<td>University</td>
<td>A</td>
<td>Administrator</td>
<td>Yes</td>
</tr>
<tr>
<td>Lynn</td>
<td>Sup</td>
<td>Nonprofit</td>
<td>S, A</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Bonnie</td>
<td>Sup</td>
<td>School</td>
<td>S</td>
<td>Site supervisor</td>
<td>No</td>
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<tr>
<td>Priscilla</td>
<td>Sup</td>
<td>Nonprofit</td>
<td>S</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Dr. Smith</td>
<td>Sup</td>
<td>Nonprofit</td>
<td>S</td>
<td>Site supervisor</td>
<td>No</td>
</tr>
<tr>
<td>Mary</td>
<td>Sup</td>
<td>Private</td>
<td>T, S</td>
<td>Adjunct and site supervisor</td>
<td>No</td>
</tr>
</tbody>
</table>

*Note.* Respons. = Responsibilities; Admin = Administrator; Ed = Educator; Sup = Supervisor; T = Teach; S = Supervise; A = Administrate; Private = Private Practice

**Content.** Participants provided a lengthy list of suicide content areas in current master’s-level suicide training efforts. The most cited content was risk assessment ($n = 14$). The research team included in risk assessment all comments from participants related to: (a) informal and formal assessment and clinical interviewing, (b) risk factors
and “triggers or motivations to attempt suicide,” and (c) means assessment. Ten participants each mentioned (a) intervention, (b) suicide awareness and response, and (c) beliefs and emotional reaction. Intervention included (a) comments regarding safety planning and/or no-suicide contracts; (b) coping strategies and reasons for living; (c) means restriction and harm reduction; and (d) diagnosis, treatment, and treatment planning. Suicide awareness and response encompassed (a) overviews and introductions on suicide, (b) “noticing suicide” and “invitations” to talk about suicide, (c) suicide prevention efforts, and (d) suicide first aid or gatekeeping (i.e., Question, Persuade, Refer and Applied Suicide Intervention Skills Training). Beliefs and emotional reactions included (a) attitudes toward death and suicide, (b) myths about suicide, (c) suicide stigma, and (d) countertransference and related responses to suicide issues in counseling.

A majority of participants mentioned master’s-level suicide training content involving legal and ethical issues and/or policies and protocols (nine participants each). These areas encompassed (a) mandated reporting requirements, (b) duty to warn laws, (c) processes to engage hospitalization and law enforcement, and (d) dilemmas related to suicide. Also included were clinic and site protocols regarding (a) intakes, (b) initial sessions, (c) assessment, and (d) emergency calls. Six university participants mentioned homework assignments for supervisees to obtain crisis protocols for their off-campus Practica and/or Internship sites.

Other master’s-level suicide training content included (a) general crisis response, (b) prevalence, (c) the client-counselor relationship, (d) and conceptualization (i.e., the nature of suicide and case conceptualization including suicide risk). Master’s-level suicide training content on referrals covered local and other resources to provide to
clients. Professional behavior and development addressed the importance of seeking supervision and consultation and the distinction between counselors’ and other helping professionals’ responsibilities with suicidal clients. Content on culture included suicide in different populations including (a) age, (b) developmental levels, and (c) other cultural demographics.

Methods. CES members described a variety of methods used in master’s-level suicide training efforts. Almost all participants (n = 13) mentioned master’s-level suicide training via practical learning with clients in Practicum and/or Internship. Active learning in the form of role-plays also appears in these practical learning experiences and in skills-based courses like Prepracticum, Applied Methods, and Counseling Skills. Variations of role-plays included graduated scenarios that increase in challenge and recorded demonstrations as assignments. Didactic delivery of suicide information (e.g., lectures) arose in 12 of the interviews. The research team also included in this category CES members telling stories from their own experience.

Half of the participants mentioned discussions in (a) individual and/or group supervision, (b) whole-class or subgroup conversations, or (c) breakout conversations in workshops or orientation meetings. These discussions often following a suicide event or in response to a role-play, lecture, reading or written assignment. One course instructor utilizes advanced students to facilitate process groups and act as process observers. Observation of instructor modeling, licensed therapists response, and video demonstrations also occur. One educator described the positive educational impact for other students when she performed an impromptu suicide risk assessment on a counselor-in-training in class. Master’s-level suicide training reading assignments derive from
textbooks, case examples, and suicide prevention organization communications. Only two participants detailed master’s-level suicide training writing assignments. These included a case paper outlining an assessment and intervention plan and a question on a quiz and on a final exam. The remaining writing assignments were reflective in nature: journal entries, video reaction paper, and a self-efficacy self-reflection paper.

**Format and schedule.** This category within the efforts domain contains the format of master’s-level suicide training efforts (e.g., types of courses or other offerings) and placement of the effort within a learning experience. Participants also commented on whether programs infused these efforts throughout counselor training or segmented it. We also included the modest amount of data about the length of such efforts.

All participants mentioned master’s-level suicide training in Practica and/or Internship. Three participants indicated the training occurs in the program’s core course addressing professional, legal, and/or ethical issues. Other courses with master’s-level suicide training that are likely core courses for many counseling programs are

- Orientation;
- Human Growth and Development;
- Appraisal, Assessment, and/or Diagnosis;
- Trauma and/or Crisis; and
- Basic Skills and/or Pre-practicum/Applied Methods.

Additional courses containing master’s-level suicide training that may be open to all students in some programs are (a) Grief and Loss, (b) Spirituality, and (c) one-credit courses on suicide. One participant identified a suicide prevention walk effort by the program’s Chi Sigma Iota chapter as an effort. Four participants specified Clinical
Mental Health courses containing master’s-level suicide training: (a) a foundational Clinical Mental Health course, (b) Trauma and Crisis Intervention, and (c) a Case Studies course. Only one participant identified a School Counseling course containing master’s-level suicide training: School Assessment.

Nine participants described master’s-level suicide training in workshops or online offerings for counselors-in-training. Three participants described suicide trainings required by supervision sites or the counseling program, namely in-service and on-site trainings for site supervisees and a commercial suicide first-aid training workshop which is offered by a faculty member from another department and serves as a required assignment for a core course. Other suicide trainings were optional for counselors-in-training to complete and included offerings sponsored by the program or site (e.g., a Chi Sigma Iota event) and local trainings and conference sessions Counselor Education and Supervision members may or may not have helped publicize.

Other elements of category I.C. Format and schedule are Placement within a learning experience, Infusion or segmentation, and Length. The most cited placement was what might be termed “reactive supervision.” Twelve participants described master’s-level suicide training occurring in reaction to a supervisee’s experience with suicide issues in a client session (e.g., case review and assistance with protocol). All but one participant \( (n = 11) \) explained this response necessarily occurs after a supervisee brings it to the attention of the supervisor. Four participants described the intentional placement of master’s-level suicide training early in a learning experience such as a group discussion in the first course or site meeting or in an orientation. Four participants described master’s-level suicide training as “segmented,” “a one-time effort,” “one and done,” and
“stand-alone.” Three participants stated the suicide training occurs via infusion, or integration throughout master’s training. Three participants said such efforts last one class session or one course lesson, though they did not provide an exact length of time. The Practicum Orientation that one participant described was three hours long and suicide was among the topics in the meeting. The in-service suicide training one participant described was 1.5 hours long.

**Target audience and responsible parties.** The most cited Target audience was supervisees with all 15 participants mentioning supervisory master’s-level suicide training efforts. Six participants described efforts intended for all counselors-in-training in a program (i.e., in a core course). One exception was a participant’s description of an effort that entailed counselors-in-training receiving informational emails during Suicide Prevention Month and participating in class discussions (e.g., question and answer or reflective conversations) in all courses.

Five participants named one or more master’s-level suicide training efforts that target Clinical Mental Health students only. All of these courses appeared to be Clinical Mental Health versions of a course for which one might assume a School or other version(s) exist. One exception was Trauma and Crisis Intervention which was mandatory for Clinical Mental Health students. Elizabeth indicated, “The School people do not get the Crisis Intervention course although a lot of them want to take it as an elective. But they don’t get any electives usually.” Other target audiences for master’s-level suicide training efforts included (a) one School Counseling course; (b) an interdisciplinary course combined with health sciences; and (c) trainings for graduate assistants and interns working in the clinic or on grant projects.
Several parties emerged in the data as responsible for master’s-level suicide training efforts. The most cited Responsible Parties were supervisors and educators. Supervisors included (a) site supervisors, (b) university supervisors of Practica and Internship, and (c) local professionals who provide additional supervision. Educators included (a) full-time faculty, (b) adjunct instructors, and (c) visiting professors.

Counselors-in-training emerged as a responsible party when 10 participants described their role in prompting master’s-level suicide training to occur. This refers primarily to reactive supervision that relies on the counselor-in-training to alert the supervisor or another party about a case of potential suicide risk. Other counselors-in-training with responsibilities in suicide training include Chi Sigma Iota leaders and graduate assistants whose roles involve delivering and/or coordinating suicide trainings. Six participants attributed responsibility to members of the broader community when they identified local suicide trainings, on-site trainings, and conference sessions as efforts. Other responsible parties included clinic directors or clinical training directors and licensed professionals on sites that require supervisees to seek a co-therapist when suicide risk emerges in a client session.

Longevity and existence. Eight participants reported the Longevity of the master’s-level suicide training efforts they described. Responses from six of them ranged from three to five years. Two commented that some efforts have existed for 10 years or longer, though others are newer. Two participants tied the longevity to the program’s accreditation or reaccreditation under the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009) Standards. Four participants remarked that master’s-level suicide training efforts were rare or nonexistent when they
completed their graduate training. Mary declared, “It was mostly limited to a chapter in the book.” One participant explained that master’s-level suicide training existed at all Practicum II sites and all Internship sites, but may not exist in all sections of Practicum I. Others confirmed that existence varied by type of setting, instructor, and/or client caseload that semester.

**Intentions.** Intentions include the goals of existing master’s-level suicide training efforts which nine participants addressed. The other element in this subcategory is intended future master’s-level suicide training efforts which seven participants described. Four participants indicated their idea for a future effort arose through participation in the current study.

Two primary themes regarded goals to (a) ensure counselors-in-training could smoothly and calmly recall information when they are present with clients and (b) address legal and ethical concerns. Some of the Counselor Education and Supervision members described master’s-level suicide training efforts such as role-plays are meant to support recall and lessen anxiety over time. Christine presents 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.”

Some master’s-level suicide training efforts aimed at legal and ethical concerns focus on safety plans and no-suicide contracts, site policies, and protocols related to suicide. One site supervisor explained the ethical and legal rationale for safety plans and against no-
suicide contracts to help supervisees understand the underlying reasoning and avoid malpractice in future work. She also reviews weekly logs from supervisees that identify clients with previous or current crisis concerns to prioritize cases for discussion and to ensure she is addressing her own liability. 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.

Two participants indicated master’s-level suicide training placement was intended to prepare counselors-in-training before they started seeing clients. 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 goals for existing efforts included: (a) a certificate of completed suicide training for students to add on their résumé; (b) a rubric to allow counselors-in-training to understand the instructor’s expectations for a recorded demonstration assignment; (c) a review of recorded sessions with suicidal clients to uphold gatekeeping and aid in remediation; and (d) articles postings on the online course management tool to address lack of in-class time.

Several intended efforts or ideas for future efforts aligned with goals for current efforts. An educator participant anticipating her upcoming administrator role said she intends to ensure Internship instructors know to address suicide early in the semester. The school site supervisor said she plans to introduce the school’s crisis plan earlier with her next intern and shared her idea to provide co-counseling during suicide assessments and potential reports of child neglect. One educator hoped that she will be approved to add a
policy to her Internship syllabus stating that students will face course failure if they neglect to address a client’s suicide risk. She imagined that reading the course policy will send a clear message to students that avoiding a client’s suicide issues is a serious ethical violation.

Other goals of intended future efforts were consistent dissemination of master’s-level suicide training and more breadth and depth. A site supervisor was considering a mandatory, formal training seminar on suicide to ensure consistency across supervisees. She also intends to develop a checklist of suicide topics to cover in group supervision to ensure her master’s-level suicide training is thorough. An educator described two ideas regarding site protocols: assignments for Internship students to (a) collect and compare suicide protocols from different sites and (b) share master’s-level suicide training information with site supervisors. Her objectives for these new efforts were to deepen critical thinking among counselors-in-training, improve university-site collaboration, and support new counselors’ advocacy for clients. One site supervisor generated an idea for students to organize a formal suicide training that site supervisors could require supervisees to attend. She believed student organizers would benefit from the added responsibility and learn more deeply about suicide and local resources.

**Knowledge of Efforts**

Four categories emerged in the knowledge of efforts domain. The entire sample $(N = 15)$ named one or more Sources of information about efforts for the Counselor Education and Supervision community. The category II.B. Knowledge of efforts varies also represents all 15 members as does II.C. Evaluation of master’s-level suicide training.
All or most of the sample provided positive appraisal \((n = 15)\) and negative appraisal \((n = 12)\).

**Sources of information about efforts.** All 15 participants identified one or more sources for information about efforts. The most cited source \((n = 13)\) was professional development and networking. Professional development included conference sessions at national, state, and regional professional organizations and at training workshops. Dillon explained, “It is very easy to get stuck in your own little slice of life,” so Counselor Education and Supervision members use professional conferences to overcome this. Networking at such professional development events or via “word of mouth” conversations with program/site or outside colleagues received mention from nine participants. Two participants mentioned learning about master’s-level suicide training efforts through a colleague who attended a training or conference session that she did not attend. One administrator noted that these informal conversations occur more during program re-accreditation because faculty talk with each other about where suicide appears in the curriculum.

Two other common sources for knowledge of efforts were literature and organizational communications \((n = 8)\) and counselors-in-training \((n = 6)\). Communications included professional literature such as journals and textbooks and national and regional organizational websites and listservs. Counselors-in-training included supervisees and students in class. The three site supervisors who mentioned counselors-in-training said they learned about university master’s-level suicide training through conversations with and appraising their supervisees. The three educators said they learned about university master’s-level suicide training from comments students
made about other courses. Carolyn specified, “I too frequently hear graduate students say, ‘Gee that was never addressed until you talked to us about it.’”

Other sources for knowledge of efforts included (a) master’s-level suicide training received in their own graduate training, (b) formal communications, and (c) experience counseling. Formal communications include scheduled meetings with other CES members and consultation. Two educators described learning about master’s-level suicide training during visits to practica/internship sites. Two administrators explained they know about efforts in their program because the faculty met to decide on its placement in the curriculum. Three participants identified professional practice as a source for knowledge of efforts. Another source was participation in the current research study: two participants indicated they learned about master’s-level suicide training when prompted to reflect on it and informally evaluate it and receiving the thumbdrive incentive.

**Knowledge of efforts varies.** All 15 participants commented on varying knowledge within the Counselor Education and Supervision community: Knowledge of efforts varies. The most-cited reason was that members lack knowledge of efforts beyond their individual roles: lack of knowledge beyond responsibility or niche. About half of the sample supported a second reason: members’ Lack of preparation on providing master’s-level suicide training.

Almost all participants (*n* = 14) commented on CES members’ lack of knowledge about master’s-level suicide training efforts beyond their individual work. Eight CES members disclosed a lack of knowledge about master’s-level suicide training efforts in their own departments or sites. Susan expressed:
I think one of the shortfalls, particularly with the School Counseling program, is that once I leave them, I don’t know where else they are going to get it. They could be getting it from their field professors. I will have to ask them.

Priscilla, a site supervisor, responded, “I guess that would require in my case some proactive seeking of that information.” Five members stated they were unaware about master’s-level suicide training efforts in other training sites and programs.

Four site supervisors stated they did not know about university master’s-level suicide training. Priscilla said “In all the conversations about suicide, no one has ever said, ‘Oh they’ve taught me about this already.’ Or ‘I took training on it.’” Mary said, “You’re being asked to ‘Here is your evaluation. Sign these papers.’ And the students bring you the papers. Yeah, you are kind of doing your own thing.” Three educators stated they did not know about site master’s-level suicide training. Dr. Smith expressed:

They [university CES members] have no idea. They never inquire specifically, and I never reported at any of the schools. They’ve 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 illustrated:

It’s like all of us [w]e 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?

Three participants also explained that CES members’ focus on individual niches contributes to variation in knowledge about master’s-level suicide training efforts. Elizabeth said, “I think if somebody is not into that area or really has not had a lot of
training, it depends.” Susan stated she attends suicide-related conference sessions as a source of knowledge about master’s-level suicide training and suicide and explained:

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.

Several participants (n = 7) commented on a lack of preparation on how to provide master’s-level suicide training. Such preparation appears lacking in doctoral training, site supervision preparation or requirements, and adjunct training. Some participants identified this under-preparation among Counselor Education and Supervision members as a weakness of the master’s-level suicide training they provide.

**Evaluation of efforts.** Almost all participants (n = 13) stated they were not aware of any evaluations of master’s-level suicide training efforts in the Counselor Education and Supervision field. Dillon explained how clinical sites operate:

a crisis management model of “Let’s get through this” and “What do we have to do?” But I don’t see as much reflection on “What happened?” and “Did that happen well?” so much as an “Okay, time to move to handling the next crisis.”

Some participants identified this lack of master’s-level suicide training evaluation as a weakness in the CES field.

Existing evaluations connected to master’s-level suicide training efforts include (a) a workshop satisfaction survey, (b) students’ self-efficacy reflection discussions or assignments, and (c) positive feedback from site supervisors about supervisees’ preparedness to address suicide. Three participants described assessments of student learning including “a quiz question here and there,” observations of graded and ungraded
role-plays, and the potential use of assessments associated with an online training. Three participants answered the interview question about evaluations of master’s-level suicide training by describing faculty conversations or use of rubrics from the Council for Accreditation of Counseling and Related Educational Programs during reaccreditation or curriculum redesign projects. Five participants commented their participation in the current research study prompted them to reflect on and informally evaluate their master’s-level suicide training efforts. These and other appraisals appear next.

**Positive appraisal.** All 15 participants provided one or more positive comments about master’s-level suicide training efforts. Six participants offered general positive comments about master’s-level suicide training as “adequate,” “good,” and “thorough.” Five participants affirmed master’s-level suicide training increases suicide awareness among counselors-in-training. One administrator described receiving positive feedback from site supervisors that interns arrive with an understanding of suicide. Two site supervisors said universities “cover suicide reasonably well” and provide master’s-level suicide training that “adequately covers the fundamentals” to prepare counselors-in-training before Internship. Two site supervisors and one administrator could identify only strengths in the master’s-level suicide training efforts in their site/program.

Other positive appraisal for master’s-level suicide training in general emerged when participants (n = 7) identified the implications of the training’s strengths. The most cited positive implication addresses the developmental nature of master’s-level suicide training in counselor preparation, namely that such efforts help counselors-in-training experience discomfort that decreases over time and learn basic skills that become more complex and individualized with continued practice in counselor training and beyond.
Some participants pinpointed results of master’s-level suicide training including the following increases among counselors-in-training: suicide knowledge, self-reflection about skills, and acceptance of people struggling with suicide concerns. Three participants commented on professional benefits: (a) counselors-in-training (CITs) confront the reality that client suicide issues are prevalent in counseling practice; (b) certificates of completed training enhance credibility in internship and job searches; and (c) the mention of suicide in coursework inspires some CITs to seek and complete external suicide training.

Most of the specific positive appraisal related to content and comprehensiveness. Eight participants spoke to beliefs and emotions regarding suicide. Master’s-level suicide training that addresses CITs' reactions to the topic of suicide serves to combat societal myths, build CITs’ comfort in talking openly about suicide and “saying the word,” to help CITs overcome anxiety and stay calm with clients, and to normalize suicide intent. Seven participants focused praise toward risk assessment content: concrete, step-by-step assessment protocols provide CITs a clear plan and covering several protocols offers CITs a variety of options. Four participants named conceptualization content as a strength of master’s-level suicide training, including (a) hopelessness and suicide; (b) “the fears, worries, and other feelings behind the verbalized intent or the actions;” and (c) how to integrate a client’s suicide warning signs into case conceptualization. Other content areas appeared in positive appraisal of master’s-level suicide training including intervention, legal and ethical, cultural factors, and therapeutic relationship.

Other targets of positive appraisal regarded method, schedule, or format of master’s-level suicide training. Nine participants spoke affirmatively about active and
practical learning methods in master’s-level suicide training. The main theme of comments was the slow, thorough, and supportive nature of supervision. Three members attributed the same qualities to their role-plays and demonstrations, particularly when the Counselor Education and Supervision member uses recording and/or pausing for reflective discussion. Carolyn said, “We do a recording so we can really see where they were weak and strong. I can address right there in the moment, ‘Okay, think about how you worded that. Is there another way you could do that?’” Sarah described:

They don’t know what is coming or what I’m going to say. I play the client and I have them be the counselor. I will stop I the middle of it or wherever and say, “Would anyone have handled this in a different way? And what would you have done?” So it is kind of a collegial consultation thing rather than a “You’re right. You’re wrong. You are a bad student or a good student.” Really walking them through it and having them stretch their brains and think about why they are doing what they’re doing and what they were getting ready to do with a client rather than just reacting.

Other methods that received positive appraisal from Counselor Education and Supervision members were lectures, handouts, and discussions. Four participants identified lectures and handouts as strengths of the master’s-level suicide training efforts. Three participants highlighted the vicarious learning and increased awareness that occur during class discussions.

Three participants discussed positive attributes related to schedule or format. One identified infusion as a strength of her program’s master’s-level suicide training. Another pointed to the fact she addresses the most urgent topics first in supervision, namely suicide, child abuse, and duty to warn. Another described the intensity of the suicide workshop format as its primary strength.
Negative appraisal. Twelve participants offered negative appraisal of master’s-level suicide training. General negative appraisal concerned the historical and increasing inadequacy master’s-level counseling training and the lack of deliberate planning for master’s-level suicide training. Two site supervisors described contextual problems with master’s-level suicide training in the Counselor Education and Supervision field. Dr. Smith believes that master’s-level mental health training is generally inadequate and that, in combination with a lack of supervisor requirements creates a revolving pattern of subpar master’s-level suicide training. 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. I don’t mean to say that in a snotty way. 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?

Another site supervisor observed the quality of master’s training appeared to have decreased as the program focused on increasing enrollment. One administrator attributed the fact that the optimal content, methods, and schedule of master’s-level suicide training is not in place to a lack of intentionality from Counselor Education and Supervision members.

The four most cited specific weaknesses of master’s-level suicide training were (a) inconsistency, (b) poor timing and placement, (c) inapplicability, and (d) lack of breadth and depth. Six participants noted inconsistencies in master’s-level suicide training between and within programs, instructors, sites, supervisors, and textbooks. Poor timing and placement related to (a) too little time spent covering suicide in coursework, (b) not addressing the topic of suicide early in Internship, and (c) a lack of infusion throughout the counseling curriculum. Participants believed these weaknesses may allow
students to maintain an avoidant attitude toward suicide and prohibit any sustained learning results from master’s-level suicide training.

One critique related to inapplicability was lack of active and/or practical learning opportunities and related feedback. Two educators called for more active learning with clinical interviews and specific suicide risk assessments. Lynn critiqued the master’s-level suicide training supervision she provides:

    Actually my challenge as a supervisor is because I tend to come from a relatively supportive place. I am probably not as critical. It’s like I am emphasizing being supportive to the point where sometimes that judgment does not happen as much as it may need to.

Dr. Smith named the lack of on-campus clinics in some counseling programs and administrative-only site supervision as weaknesses related to master’s-level suicide training.

The person at this site prior to me did case report: “I saw this person. This is what they talked about. This is what I said. Blah, blah, blah.” There was no analysis of any kind of theory. There was no discussion of dynamics. I’m sure if somebody was suicidal they would deal with that. But to me, that was just oversight versus any kind of real training like what we get as a doctoral student – that awesome clinical training.

The other critique related to inapplicability was outdated or impractical content. Four CES members attributed outdated or impractical to instructors without recent counseling experience to share with counselors-in-training. Two members pointed to outdated information in textbooks and handouts.

The fourth specific weakness that emerged was lack of breadth and depth. Eleven participants criticized the lack of comprehensiveness in master’s-level suicide training. An example indictment from Dr. Smith was: “From what I have been told by the students as well as what I have observed, none of my students had more than a cursory overview
of suicide training.” Participants identified specific content that is missing or inadequate. Interventions and populations received mention from three participants. Two site supervisors indicated supervisees seem prepared to assess for suicide but do not know how to intervene with safety plans or provide ongoing counseling. Two participants complained that master’s-level suicide training focuses on adult suicide and lacks information about suicide presentation in children. Two participants each mentioned (a) risk assessment (namely, risk factors and standardized risk assessment instruments), (b) beliefs and attitudes, (c) conceptualization, and (d) broader community referral sources. One educator commented that more instructors need to emphasize the prevalence of suicide concerns in counseling, especially for naïve students from sheltered upbringing.

**Leadership**

Several elements regarding leadership emerged in this study. The Counselor Education and Supervision (CES) members in the study referred to types of leaders, types of existing support, and the level of concern or priority CES leaders give suicide and master’s-level suicide training. They also identified support that was lacking and/or needed. Another category that surfaced in this domain was awareness among CES members about leadership.

*Types of leaders.* Several participants – 10 of the 15 – cited program leaders (e.g., counselor training program administrators) as CES leaders who impact master’s-level suicide training. The second most cited type of leader was those from the broader community, primarily counseling and related national organizations such as the American Counseling Association Ethics Board and suicide organizations and their regional or state affiliates. University participants also identified the Council for Accreditation of
Counseling and Related Educational Programs, published authors and presenters, and leaders in charge of publications and conferences (i.e., journal editors and proposal reviewers). Two site supervisors pointed to management at their sites. Participants often described the types of support these leaders did or should provide to master’s-level suicide training efforts.

**Active support.** Participants cited three types of active support from leadership: support of learning, policies and decisions, and curricular support. Support of learning and policies and decisions each garnered mention from 10 of the 15 participants. Several leaders appear to support learning among CES members. Authors and presenters along with publication and conference leaders who approve their contributions actively sustain continuing education on suicide for the CES community. University participants pointed to leaders in the broader community who support learning by offering and/or requiring suicide training for professionals. Two site supervisors highlighted program leaders’ support as forwarding information on suicide training and showing their presence at them. Christine described intentionality of regional conference leaders:

> I helped coordinate the [regional organization] conference and there was a conversation among the conference coordinators and the organization’s board that programs or 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.

The CES members in the study identified policies and decisions as leadership’s active support. University members named the Council for Accreditation of Counseling and Related Educational Programs (CACREP) as the primary leader regarding impactful policies. Participants stated that accreditation standards related to suicide or crisis ensure that master’s-level suicide training exists in counseling curriculum. Dillon stated that
these and policies from the American Counseling Association 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.”
Site supervisor participants instead cited site management’s policies regarding screening
and assignment of supervisees to supervisors and of clients to supervisees.

Leadership’s support impacts master’s-level suicide training curriculum directly.
Four participants named published experts whose works appear or inform efforts.
Program leadership also supports master’s-level suicide training by guiding the focus of
efforts and counselor training in general. Lynn, a site supervisor, explained:

In my state, they [training programs] are teaching to the exam to a substantial
extent, say to theoretical orientation. And I would say that is a problem. I
definitely have that complaint when it comes to teaching domestic violence. I feel
like I’m having to play catch-up all the time. But I haven’t seen it be as much of a
problem with the suicide training part. Suicide is one problem that they will teach
to the problem.

**Attitudinal support.** Another type of support leadership offered by master’s-level
suicide training was attitudinal. Several of the comments from participants in this
category were general statements such as, “They seem supportive” and “I feel
supported.” Susan asserted, “In my program it is absolutely supported. Almost everything
I say I am going to do, my chair is like, ‘Absolutely, it’s good for the field. It’s good for
the students, go for it!’” Specific attitudes and beliefs among leadership about master’s-
level suicide training also emerged here. Program leaders appear to be view these efforts
as an essential part of counselor training following the shift from viewing crisis as a niche
focus to a core counseling competency. Susan described her department chair’s reaction
to master’s-level suicide training she provided:
I feel like his mind is a constant spinning CACREP manual. ‘Where are we’re 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.

**Concern or priority.** Participants’ responses on how much concern or priority Counselor Education and Supervision leaders place on suicide and master’s-level suicide training were mixed. Some (7 of the 12 participants represented in this subcategory) made general statements judging leadership’s concern or priority as greater than average or very high. The remaining participants considered it to be moderate or lower. 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 radar.” A few participants (c) explained program and national leaders are not more focused on master’s-level suicide training because they juggle competing priorities: other topics (i.e., trauma) and responsibilities (i.e., finding adjuncts).

**Lacking support.** Nine participants in the sample took the opportunity to name leadership support for master’s-level suicide training that is needed or lacking. Five participants pointed out a discrepancy in leadership support that differs between “what we say and what we do.” Sarah answered: “Well, I think if you sat them down [leaders in the field] and asked them, they would say they support it [master’s-level suicide training]. But you don’t see the action. What are they doing to make sure that enough emphasis is put on it with the students?” Henry admitted:

> 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 would give us a five [out of 10].
All nine participants represented in this subcategory specified support they view as needed or lacking and appealed to particular leaders for such support, primarily program leaders. Requests for program leaders’ support included: sharing more information about external suicide trainings, hosting on-campus suicide trainings, and designating placement of suicide content in the counseling curriculum since an accreditation body cannot do so. The most cited support requested was requirements of suicide training for Counselor Education and Supervision members. Site supervisors and university participants alike called on program leaders, state policymakers, and accreditation bodies to mandate suicide training for site supervisors and/or instructors.

Dr. Smith asserted,

I don’t think it is the resources that are the problem. It is that 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. Shouldn’t their program require something of their supervisors to try to ensure the quality of their training? I think sometimes they are just so desperate to get supervisors, but I don’t know if that is a good long-term strategy for the field.

Awareness of leadership. A theme emerged from data on leadership related to a lack of or distanced awareness among participants about Counselor Education and Supervision leadership. Carolyn said, “Nobody at the moment is coming to mind. I just don’t have the impression there has been a particularly well-organized effort at that level.” Three other participants made similarly overt statements that they could not name any Counselor Education and Supervision leaders on suicide and/or had “no idea” about leadership’s stance on master’s-level suicide training. Participants couched their answers to leadership interview questions with comments like, “Well this is just a speculation.” Answers to follow-up question about what contributes to the need to speculate included:
• “I don’t think CES leadership is supporting it [master’s-level suicide training] really…unless I am missing some of the discussion online, which, honest truth, I don’t have a lot of time to look at.” (Carolyn)

• “I’m not a huge consumer of the current research right now. I have a lot going on with the new chair job and transition into full-time faculty work. I’m not paging through JCD [the Journal of Counseling and Development] and CES [Counselor Education and Supervision journal] or watching CESNET as much as I used to, so I don’t know enough.” (Irving)

• “I don’t know who the writers are – the current researchers, the leading people.” (Dr. Smith)

Other barriers participants said hindered awareness of leadership were: attendance at conferences and sessions only within their specialization and distance from program leadership (i.e., disconnection and lack of communication between program leaders and site supervisors, faculty turnover, and the amount of time that had passed since completing graduate training). A few \( n = 4 \) participants credited their source of information about leadership to: experiences with supervisees, memories of master’s-level suicide training received, and surmising from attendance at conferences or overhearing faculty returning from conferences that conference leadership supported suicide-related sessions.

**Climate**

Three types of climate fit participants’ interview responses in this domain: attitudinal, political, and logistical. The attitudinal climate encompasses attitudes toward master’s-level suicide training and toward suicide and suicide issues in counseling. I also
described participants’ lack of awareness about attitudinal climate. The political climate encompasses priority and perceived need assigned to master’s-level suicide training, disagreement within the Counselor Education and Supervision field, and the impact of broader community policies on the field and master’s-level suicide training. The logistical climate relates to a lack of resources for master’s-level suicide training and other practical obstacles for the field to provide such training.

**Attitudinal climate.** This section provides details on the IV.A. Attitudinal climate subcategory. Participants described two elements of attitudinal climate: attitudes toward master’s-level suicide training and attitudes toward suicide and suicide issues in counseling. Two site supervisors also expressed a lack of awareness about attitudinal climate in the Counselor Education and Supervision community.

**Attitudes toward master’s-level suicide training.** Attitudes toward master’s-level suicide training emerged regarding roles and responsibilities and best practices. Counselor Education and Supervision members shared positive and negative views in the field about providing master’s-level suicide training. The participants also discussed the attitudinal climate related to counselors-in-training.

The central theme about roles and responsibilities was that one’s responsibility for providing master’s-level suicide training depends on one’s role. Six participants (four site supervisors and two educators) described the attitude that Counselor Education and Supervision members with supervision roles (i.e., site supervisors and university supervisors in applied courses) are mainly responsible for providing these efforts. One site supervisor attributed to counselor educators a hope that site supervisors will provide more in-depth master’s-level suicide training than the university did. Three other site
supervisors appeared to agree, emphasizing the “super vital” role site supervisors in particular play in providing the efforts because “that is where they get most of their training.” 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, so to speak, the cost of doing business. That’s just part of my job.

Other participants seemed unsatisfied with a stark differentiation between roles. Sarah stated some counselor educators and administrators believe students “will ‘figure it out when they get there.’ But what they don’t realize is you’re just as responsible for what these people do when they graduate as anybody else.” Two others expressed a desire to collaborate with site supervisors about master’s-level suicide training without imposing the “ivory tower” power differential of academia versus field professionals.

Three attitudes emerged regarding best practices for master’s-level suicide training. About half \((n = 7)\) of the participants articulated or attributed to other CES members an attitude that providing master’s-level suicide training requires practical experience with suicide issues in counseling and/or other suicide expertise. A site supervisor with high school counseling experience prior to spending the last 13 years in elementary explained that she no longer feels equipped to provide suicide training at her school because of her lack of recent experience with suicidal students. Sarah, who has over 10 years of counseling experience, expressed this attitude:

Somebody who is just an instructor who went straight out of school into teaching and never went into the field as a counselor, then they really are at a disadvantage, I think, in the classroom. They can talk about it [suicide] and say, ‘Well this is how it’s handled.’ But they really don’t get it and they don’t have the personal
experience to incorporate and share with the students. So it is another “Blah blah blah, here’s another thing you got to think about” – putting them to sleep in class.

Five participants similarly named a lack of confidence about one’s experience with suicide as a potential obstacle. The two male participants described the vulnerability required for a counselor educator to ask questions of colleagues about master’s-level suicide training and/or model a suicide assessment to counselors-in-training because “it right away highlights my skill and competency level.” Two administrator participants imagined that educators without suicide expertise or recent practical experience avoid providing master’s-level suicide training:

- “A lot of us in the field are in different areas, so they may feel they had a little bit on it when they were in school and they had one hour of training on it somewhere, but they may not feel expert. So that could hold people back.” (Elizabeth)
- “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.’” (Irving)

Both administrators mentioned that some faculty members view suicide as solely connected to crisis or trauma curriculum, which serves to remove the responsibility from instructors to provide master’s-level suicide training in other courses. Both were also quick to add that suicide is not their area of practice or research expertise, but that they can still provide master’s-level suicide training.

The other two attitudes regarding best practices in master’s-level suicide training were that students learn best via practical experience that includes supervision and that master’s-level suicide training should differ depending on a student’s concentration. Two
site supervisors shared the former attitude. One added that some site supervisors feel reactive supervision (master’s-level suicide training provided on an as-needed basis following suicide risk in a supervisee’s client) was sufficient, making formal and proactive master’s-level suicide training unnecessary at sites. Two administrators identified the latter attitude and pointed specifically to the belief among Counselor Education and Supervision members that master’s-level suicide training need not be provided in as much depth to school counselors-in-training. Henry disagreed with this belief in his community, saying:

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.”

Positive and negative views toward master’s-level suicide training were quite divergent. Ten of the CES members identified positive and supportive views toward master’s-level suicide training, providing favorable comments on how valuable it is to prepare counselors-in-training for addressing suicide in their future work. Three participants also commented that their individual experiences with suicide issues in personal and/or professional relationships have increased their support of master’s-level suicide training. Negative comments stood in stark contrast: participants labeled master’s-level suicide training as “a necessary evil,” “emotionally draining,” and something that “takes up a lot of time and energy.” Three participants described the relief they and/or other Counselor Education and Supervision members feel when they do not have to provide master’s-level suicide training because they believe someone else is.
Eleven members in the sample attributed attitudes about suicide and master’s-level suicide training to counselors-in-training. The central theme is that fear about the topic of suicide among counselors-in-training and resultant avoidant behavior or emotional overreaction impacts master’s-level suicide training. Some participants believed that certain counselor-in-training factors may compound these feelings and behaviors: ignorance and misinformation about suicide and suicide issues in counseling, previous experience counselors-in-training may have with suicide, and their religious views on suicide. An educator from a counseling program at a faith-based institution explained students who are more zealous in their faith prefer to pray the client through the suicidal ideation instead of engaging crisis response protocols.

Participants spelled out some implications of these opinions about counselors-in-training. Two university participants explained that instructors who believe students would rather avoid the topic of suicide topics can be tempted to sidestep it in class to keep students comfortable. This may be particularly true for pre-tenured faculty concerned about student evaluations and at private institutions with higher tuition costs. One educator described a preference among some Counselor Education and Supervision members to protect students from too much or too advanced information which leaves students ignorant about suicide but also prevents them from developing an over-inflated sense of competence. Priscilla supervises at a site with a policy of screening clients who have previous suicide ideation or greater risk out of supervisees’ caseloads. She “would have a little more trust that they would not totally freak out in session if that came up or totally miss it” if she knew supervisees were receiving really good university master’s-level suicide training.
Attitudes toward suicide and suicide issues in counseling. Another element emerged in attitudinal climate related to attitudes toward suicide and suicide issues in counseling. Participants portrayed suicide as a serious, heavy topic and described the broader community context regarding the issue of suicide. They offered several views on suicide and perspectives on counseling best practices to address suicide.

Four participants described suicide as something extremely complex that lacks clarity and certainty. These attributes make suicide hard to assess for and deal with in counseling and challenging to explain in master’s-level suicide training. Several members depicted suicide as “very serious,” “emotional,” “really heavy,” and “traumatizing.” Dillon connected these attitudes toward suicide to master’s-level suicide training: “I think some of our own feelings about death and suicide, if we haven’t fully dealt with those issues then that can compromise our ability to provide master’s-level suicide training – either make it less effective or lead us to not dealing with the suicide topic at all.” Susan described suicide as a “secret, taboo, shameful topic” for some beginning counselors-in-training and for society.

Five participants mentioned the broader community in relation to attitudes toward suicide. Three including the administrator above described what one site supervisor termed “suicide stigma” in the local community or society in general. A participant who serves as a clinic director described broader community attitudes toward suicide as “selfish” and “never serious” and in line with the “pull yourself up by your boot heels” mentality. Mary described her local community as “backwards” for ensuring suicide is always well-hidden in obituaries and community conversations. She relayed a story of group counseling clients reacting to a member who broached suicide: “Nobody else could
say the word and actually everybody was trying to change the subject. That’s the norm around here.”

Three participants highlighted differences in suicide response practices between school counseling and other specialties between specific school settings. School counseling professionals may quickly refer students with suicide issues to other internal school professionals and/or to external services. This may be complicated in rural settings wherein few external mental health services exist. Prevalence of suicide issues in schools may increase with the educational level. It seems notable that only one participant enumerated best practices for addressing suicide in counseling. This site supervisor offered five assertions about suicide risk assessment, intervention, emergency response, and continuity of care.

**Political climate.** The most cited issue in IV.B. Political climate was prioritization of master’s-level suicide training and its perceived need. The Counselor Education and Supervision members described the political climate in the broader community toward suicide and master’s-level suicide training. Also present in this category are disagreements within the field about master’s-level suicide training.

**Priorities and perceived need.** The prevailing attitude among participants regarding priorities was that competing priorities for Counselor Education and Supervision members, counselors-in-training, and the broader community create an obstacle for master’s-level suicide training. Nine of the 15 participants in the sample addressed competition among the large amount of curricular and supervision topics Counselor Education and Supervision members feel required to cover. An example of a general comment about this conundrum comes from Carolyn: “There is just so much that
needs to be incorporated in the program. We are currently at 60 hours in the curriculum. And that does not leave enough room to focus on certain specific issues.” Items that educators and administrators may prioritize over suicide and master’s-level suicide training are

- theoretical orientation
- licensure requirements
- distance technology
- comprehensive exam topics
- basic skills practice
- health insurance
- in-class research recruitment and participation
- program stabilization
- accreditation and reaccreditation

Another site supervisor stated her local practice community prioritizes trauma and teen topics over suicide. Two participants argued that supervisors must consciously make master’s-level suicide training a priority. Incoming clinic director, Christine, said suicide “could get lost if it is not on the front of the agenda, like intentionally put on the front of the agenda.”

The main factor that creates a perceived need for master’s-level suicide training is prevalence of suicide and other crises. Four participants mentioned an increase in suicide and crisis within their on-campus clinic, local community, and in counseling in general as precipitating or supporting an increase and/or improvement of master’s-level suicide
training. Two of those specifically highlighted increased prevalence of suicide issues in schools and younger school populations than before.

*Politics and the broader community.* This subsection of political climate relates primarily to policies beyond accredited counseling programs and how they impact master’s-level suicide training. Four participants highlighted state policies and/or foci that impact master’s-level suicide training, including:

- Requirements to assess for homicide when assessing for suicide
- Licensing exam content
- Demand for social workers and addiction providers and related training and employment incentives
- Medicaid-driven community health system
- Requirements regarding school counseling internships

Three participants highlighted the political climate around counselor liability regarding suicide. 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.” Irving offered an almost identical statement referring to site master’s-level suicide training: “I think the agencies do it more from the liability perspective and the emergency perspective rather than the educational perspective if that makes sense.” Participants also mentioned issues setting-specific issues such as differing and inconsistently-applied protocols regarding suicide, historically unstable mental health service organizations, and suicide response protocols in schools. University or site-level policies included goals to increase counseling program enrollment and decrease selectivity, site protocols that must
align with accreditation standards for health and human services organizations, and protocols to screen clients with previous and/or current suicide risk out of supervisees’ caseloads.

**Disagreement.** One administrator declared the faculty in her program have consensus regarding master’s-level suicide training. One administrator and three educators do not experience their programs that way. One educator described two different philosophies about counselor preparation that impact master’s-level suicide training: some educators see it as preparation toward independent practice and therefore want to expose counselors-in-training to as much information as is reasonably possible while others prefer to “shelter” students from challenging topics the educators believe counselors-in-training cannot handle. Three educators pointed out the lack of control a faculty member has over what others do. Carolyn exclaimed, “As far as I am concerned, those issues [suicide and other crises] get covered every time I teach a Practicum. I don’t know what our other Practicum instructors do…even though I keep standing on a soapbox and screaming about it.”

**Logistical climate.** The findings located in IV.C. Logistical climate concern the obstacle of lacking resources and logistics related to clients, counselors-in-training, and the broader community that impact master’s-level suicide training. Eight participants highlighted that a lack of time and money resources serves as an obstacle for master’s-level suicide training. The subsequent Resources section contains details about the availability and unavailability of such resources. It also includes conditions on resources. This lack of readily available resources across the Counselor Education and Supervision
community appears to contribute to the logistical climate for master’s-level suicide training.

Five participants identified obstacles to master’s-level suicide training related to clients and/or counselors-in-training. The overwhelming theme among these core ideas was access and scheduling. Site supervisors and university participants acknowledged students’ lack of time to attend extracurricular master’s-level suicide training due to life as working adults and/or long commutes which results in low workshop attendance. Mary commented that “students today have so much going on the brain is just not as effective” to focus on master’s-level suicide training before a suicide situation emerges. Another supervisor mentioned the hassle of client schedule workaround for supervisees to attend suicide training workshop. Other logistical obstacles for master’s-level suicide training include (a) the lack of supervision for school counselors-in-training, (b) limited local suicide prevention resources, and (c) a lack of suicide issues among clients at some practice sites.

**Knowledge of Suicide**

Three categories emerged in the knowledge of suicide domain. The entire sample named one or more sources of suicide knowledge for the CES community. The category V.B. Comprehensiveness and content also represents all 15 participants. The “Other” category encompasses the three participants who indicated a lack of awareness about the Counselor Education and Supervision field’s suicide knowledge and singular comments that did not fit the larger themes.

**Sources of knowledge.** The source of knowledge about suicide cited by most participants (12) was professional development. Professional development included
conference sessions at national, state, and regional professional organizations and local and online training workshops. Some participants mentioned completing such professional development to receiving continuing education units for maintaining licensure and credentialing. Four educators said site supervisors have access to commercial trainings provided on-site and community workshops counselor training programs offer. Only one of the five supervisors who contributed to this subcategory mentioned onsite suicide training for staff and none mentioned attending program-sponsored workshops. The majority of participants who named specific workshop providers identified Question, Persuade, Refer and Applied Skills and Intervention Suicide Training.

Other commonly cited sources of knowledge about suicide were master’s-level suicide training that Counselor Education and Supervision members received (n = 9), professional experience (7 participants), and professional literature (6 participants). Master’s-level suicide training included suicide-related education and supervision provided at the university and practical training sites. Participants mainly associated learning from professional experience with interacting with suicidal people in professional settings beyond their master’s-level suicide training experiences (e.g., at a suicide hotline or in post-graduate work). An administrator said he had heard of supervisors asking their interns to teach them content from university master’s-level suicide training. No site supervisor endorsed that source.

Professional literature included textbooks and journal articles. One educator contended counselor educators are more likely to educate themselves on suicide via peer-reviewed articles whereas site supervisors are more likely to read books; however the
trend was not well-supported by the data from this sample. One administrator identified books as the only literature source. Another administrator listed books and research literature, but said she is not currently reading much research literature. An educator believed educators and supervisors who are active practitioners use research as a source of knowledge about suicide. The one site supervisor represented in this subcategory identified both books and research articles.

Less commonly cited sources (3 participants each) included personal experience, informal conversations with other professionals, and local and national suicide or mental health organizations. Personal experience included attempts and suicides in one’s family and friends relationships and experiencing one’s own suicide risk. One participant identified as transgender (“trans”) and highlighted her personal experience as a trans person and in the trans community impacting her knowledge of suicide in this and other specific populations (i.e., adolescents).

Informal conversations occur between colleagues in the same program, in networking events, and with other health professionals. Dillon explained this is “because counseling is such a relational field.” Participants also mentioned increasing their suicide knowledge by reading communications from several organizations. Appendix K contains a list of organizations from this and other areas of the study’s results. One participant stated she increased her knowledge about suicide through participation in the current study’s research interview.

**Comprehensiveness and content.** Five participants estimated that most members in the Counselor Education and Supervision community have a moderate amount of suicide knowledge. One educator assigned a lot of knowledge to the faculty in her
program, but doubted that is true for other counseling programs. She was among 12 participants who asserted that comprehensiveness varies. The most cited contributor to varied knowledge of suicide was a member’s academic or professional experience. Most participants attributed more suicide knowledge to members with more practical experience. Henry said, “We know the statistics. We can read the research. We can go to the trainings. However there is a difference between ‘here is what we need to do’ and now doing it.”

Other participants noted the potential for more updated knowledge among more recent graduates. Dillon attributed more knowledge of suicide to recent graduates from programs accredited by the Council for Accreditation of Counseling and Related Educational Programs because they likely completed one specific Crisis course. He also distinguished newer supervisors who are “not as “entrenched in their own ways” as those with greater suicide knowledge than:

some people in the clinical community whose perspective is “I don’t need to collaborate. I know what I’m doing. And you as my intern are going to handle it this way.” Because it is sort of this feeling of “I’ve been doing this so long, I don’t have to keep up with anything. I don’t have to continue to educate myself. I know what’s right.”

Three administrators noted that the nature of a member’s professional experience can impact knowledge of suicide. School counselor educators may have limited experience addressing suicide issues because state and/or school protocols require they quickly refer such students to other professionals. 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.”
Misperceptions, existing content, and missing content. Participants answered an interview question about any misconceptions about suicide in the Counselor Education and Supervision community. Six responded that they were not aware of any. Three described misperceptions around no-suicide contracts. One educator who believes no-suicide contracts are part of effective counseling with suicidal clients said some members of the field hold a misconception that a client will not attempt suicide after the end date of the no-suicide contracts. Christine said a textbook she uses:

has a recommendation to do a no-suicide contract. And I just personally think it is ludicrous. Because a client tells you that they’re thinking about committing suicide, 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.

Elizabeth explained:

Most of us who were trained in the 70’s and 80’s even I guess into the 90’s - I forget when this changed – pretty much all of us were trained to do contracts. So I had to kind of undo that. [laugh]. And that is true of psychiatrists too because I just read an article about that. In the literature even psychiatrists are saying, “The contracts mean nothing.”

Several participants identified content they perceive is missing from Counselor Education and Supervision members’ suicide knowledge. Others identified that which they perceive is present. Table 10 displays perspectives on missing and existing content and misperceptions. Other specific issues that appeared in existing as well as in missing or misconceptions are: suicide behavior among children (i.e., prevalence), cutting as an indicator of suicide risk (i.e., risk assessment), and the concept of suicide ambivalence (i.e., conceptualization). Two areas of misconceptions represent participant reports about a misconception among members of the field and researcher observations of a misconception. The use of no-suicide contracts is both a reported and observed
misconception about interventions. One participant reported that some members lack knowledge about “suicidal ambivalence;” however the description she provided of suicidal ambivalence does not match the definition used in the literature.

Table 10

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<th>Knowledge of Suicide in Counselor Education and Supervision</th>
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<td><strong>Existing</strong></td>
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<td>Interventions</td>
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<td>Prevalence</td>
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<td>Legal issues</td>
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Suicide prevention

*Note: *Includes reported and observed misconceptions.

An observed misconception related to language and definitions (conceptualization of suicide). A publication from the Centers for Disease Control (Crosby et al., 2011) provided uniform definitions and data elements for self-directed violence including suicide including unacceptable terms. Seven participants in the sample \( N = 15 \) used one or more of these terms: *successful*, *completed*, *threat*, and *suicidality*. The explanation regarding the first two terms is an implication of a desired outcome for something that is undesirable related to goals of reducing health concerns. Threat and related terms (e.g., *gesture*) imply a negative value judgment. The term suicidality erroneously combines suicidal thoughts and suicidal behavior which “should be addressed separately” (p. 23).

*Lack of awareness about knowledge and other.* Three participants said they had little awareness about knowledge of suicide in the Counselor Education and Supervision field. One site supervisor said this was because she has worked at the same site for a long
time. She also explained she focuses on her job responsibilities and does not attend community meetings.

**Resources**

The Counselor Education and Supervision members responded to questions about resources for master’s-level suicide training. Most indicated they were not aware of such resources or believed them to be generally unavailable. Several identified one or more available resource currently used for master’s-level suicide training. Participants identified resources that may be available upon certain conditions.

**Unaware of and unavailable resources.** Almost all participants indicated they were not aware of available logistical resources for master’s-level suicide training \((n = 14)\) or believed one of more logistical resources was unavailable to Counselor Education and Supervision members \((n = 12)\). Three participants acknowledged their lack of awareness may be that they had not searched for such resources. Two participants, a site supervisor and an administrator made blanket statements that logistical resources for such training are altogether absent. All but one participant in the sample named money as a resource that is lacking. They listed needs for money: to secure external training offerings for counselors-in-training; to pay speakers (i.e., community members, experts in Counselor Education and Supervision, and internal faculty) to provide master’s-level suicide training; and to support members’ professional development. Six participants identified time as a lacking resource including (a) time for members to receive and provide or coordinate suicide training and (b) time in courses or across the curriculum to devote the efforts. One participant stated she did not know of any external training providers.
Available resources. Participants also named money and time as available resources. Approximately half of the total sample \((n = 7)\) identified money available for master’s-level suicide training: salary and internal budgets (i.e., funding from within the program or site); external budgets (i.e., district-level or university-level funding); and grants. Grant funders included the Substance Abuse and Mental Health Services Administration and Chi Sigma Iota. These resources currently cover small and sizable printed materials for training recipients and giveaways. Three site supervisors and one educator believed they could receive time off to attend suicide training. One of those supervisors and another educator affirmed time off and flexible scheduling is available for Counselor Education and Supervision members to provide master’s-level suicide training.

People and space were other resources participants deemed available for master’s-level suicide training. Approximately half of the total sample \((n = 7)\) named types of available people resources including: external suicide experts and/or training offerings, internal experts (i.e., professionals within the department or site), and support staff including graduate assistants. Several participants pointed out that some of these identified people currently do or would likely be willing to volunteer their time. An educator and a supervisor indicated the university or nonprofit site provides space for training at no cost. One administrator mentioned that faculty had offered their homes as lodging for several speakers the program secured to deliver community education workshops.
Conditional resources. Twelve participants related that resources are often conditional and all twelve named conditions on financial support. Conditions on financial support for suicide training include:

- for conference attendance only if one is presenting at the conference;
- for a project only if it includes a research component;
- for an expert trainer only if the training content is applicable across all programs in a department; and
- for efforts that already exist and perfectly match earmarked budget items.

Other ways participants described conditional resources were by stating the availability of resources simply depends on the setting. Some programs or sites lack funding whereas others do not. Three participants indicated money is tight because they work in a nonprofit, a private college, or a university in a state that is financially struggling. Some sites provide on-site training, whereas other sites and most universities do not.

Several participants discussed resources master’s-level suicide training as somehow ineligible for resources. Six participants identified available money resources not currently allocated for master’s-level suicide training. State funding and regional monies are available for other topics deemed higher priorities such as trauma, Native Americans, gays and lesbians, and substance abuse. One site pays for staff members to attend an onsite commercial suicide training, but supervisees cannot attend. Two programs provide community education workshops for local professionals, not counselors-in-training and on topics other than suicide. One participant said she felt confident state and university officials would make money available for master’s-level
suicide training if a local crisis incident occurred. Two educators indicated that financial support at their university is reserved for efforts deemed critical to maintain accreditation or to address an imminent need. Neither participant was confident master’s-level suicide training qualifies. Christine was notable for contending that Counselor Education and Supervision members do not need any additional resources for master’s-level suicide training:

Time? I feel like if you are a faculty member and you are conducting suicide training throughout your courses, that is just built into your courses. So you have the time. If you are wanting to do a specialized training outside, I feel like that would be a volunteer of your efforts time. So I think that would be a personal decision that is intrinsically supported. If you do it in your courses and your internship and supervision, it is just part of your conversation with your students and supervisees. So that is supported by your salary.

This subsection included a presentation of the domains, categories, and subcategories. The next section offers the results of the Community Readiness Model scores. A summary concludes the chapter.

**Summary**

A Consensual Qualitative Research study involving interviews with 15 members of the Counselor Education and Supervision field yielded domains of the field’s readiness to provide master’s-level suicide training. Analysis by a three-person primary research team with guidance from an external auditor and the Community Readiness Model framework produced six domains: (a) efforts, (b) knowledge of efforts, (c) leadership, (d) climate, (e) knowledge of suicide, and (f) resources. Three to seven categories and two to thirteen subcategories emerged within these domains. Findings indicate the field is in the preplanning stage of readiness to provide master’s-level suicide. Efforts have been in place and many members have basic knowledge about suicide. However, many master’s-
level suicide training efforts remain unknown and unevaluated. The leadership and climate in and around the Counselor Education and Supervision field were not fully conducive to master’s-level suicide training and resources were found lacking. The next chapter includes a discussion of the domains, categories, and subcategories; implications of the findings; limitations of the study; and directions for future research.
CHAPTER V

DISCUSSION

The purposes of this study were to assess and explore the readiness of Counselor Education and Supervision to provide master’s-level suicide training. The previous chapter covered the results of the study. The current chapter serves to situate the results within the literature and establish the significance of the findings for the field. The chapter begins with an overview of the findings and a relational model to conceptualize the relationships between the domains. I then present implications for leaders in the field and beyond and for counselor educators and supervisors. Directions for future research and limitations conclude the chapter.

**Readiness to Provide Suicide Training**

Counselor Education and Supervision’s stages for the six dimensions reveal readiness ranging from vague awareness (3 out of 9) regarding resources to initiation (6 or more out of 9) regarding efforts. The overall score for the field’s readiness to provide master’s-level suicide training was 4 out of 9. This aligned with the readiness stage of preplanning. This score indicates the field clearly recognizes suicide and master’s-level suicide training as concerns, however existing efforts are largely unknown in the community and resources are limited (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014).
The preplanning stage of Counselor Education and Supervision’s readiness positions the field between vague awareness and preparation. The field is ready to provide master’s-level suicide training based on the existence of efforts, concerns about suicide and master’s-level suicide training, and a basic knowledge of suicide among many members. However, much of the Counselor Education and Supervision community may be unaware of master’s-level suicide training efforts beyond their own roles and programs and may lack evaluative knowledge of master’s-level suicide training. Resources to support master’s-level suicide training seem particularly scarce.

The stage above preplanning in the Community Readiness Model is the preparation stage. Enhancing readiness to the preparation stage would entail secured resources and increased knowledge of suicide and of others’ efforts for a majority of the field. The role for effective leadership to provide more active support for continuing and/or improving efforts and members has the potential to provide master’s-level suicide training that is more consistent and comprehensive.

Findings indicated the domains of Counselor Education and Supervision’s readiness to provide master’s-level suicide training exist in relation to each other. I introduce a relational model of these findings next. The discussion includes an integration of score results and qualitative findings and the study’s position relative to the existing literature. The implications section of this chapter contains logic models which members of the Counselor Education and Supervision field can use to increase readiness from the preplanning stage to preparation and to ultimately improve master’s-level suicide training.
Domains and Relational Model

The six Community Readiness Model readiness dimensions (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000) served as a start list of domains (Miles & Huberman, 1994 as cited in Hill et al. (2005) for the study. The team identified no additional domains. The domains of Counselor Education and Supervision’s readiness to provide master’s-level suicide training are: master’s-level suicide training efforts, knowledge of efforts, leadership, climate, knowledge of suicide, and resources.

A relational model in Figure 2 provides a framework for understanding the interconnectedness of the Counselor Education and Supervision’s readiness domains to provide master’s-level suicide training. The model is an illustration of the findings’ interrelated domains and the implications of the study. The study’s findings suggest (a) climate frames the field’s readiness to provide master’s-level suicide training; (b) knowledge of suicide and efforts have reciprocal relationships with efforts; and (c) leadership and resources can serve to support and impact the domains and relationships. The climate within the Counselor Education and Supervision field and in the broader community acts as a contextual factor for master’s-level suicide training efforts. Participants identified factors such as professional and personal experience and the master’s-level suicide training and professional development members had received as precursors to knowledge of suicide. Knowledge of suicide and efforts contribute to each other as do knowledge of efforts and efforts. Leadership and resources serve as foundations and/or facilitate relationships within the domains.
Figure 2. Relational model of readiness. KOS = knowledge of suicide. KOE = knowledge of efforts.

Next I offer a discussion of the domains in the relational model. This initial discussion serves to connect Community Readiness Model score results to domain and category results and to the existing literature. I highlight findings that may extend beyond the Community Readiness Model framework and/or filled gaps in the literature.

**Climate.** The climate in and beyond the Counselor Education and Supervision (CES) field frames the field’s readiness to provide master’s-level suicide training. Its readiness to provide master’s-level suicide training is in the preplanning stage for climate (4 out of 9). This may indicate an uncertainty in the CES community about how to proceed and/or a belief that the status quo is sufficient (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). Much like psychology (Liebling-Boccio & Jennings, 2013) and social work educators (Ruth et al., 2012), CES members seem to agree that master’s-level suicide training is crucial, but disagree about the need to improve master’s-level suicide training. A number of obstacles for master’s-level suicide
training face the CES field which emerged within categories of attitudinal, political, and logistical climate.

The study’s findings appear to align with the existing literature on climate in pre-professional training on suicide and expand the understanding of the impact of climate in readiness to provide master’s-level suicide training. Only one previous publication contained findings on the attitudes of Counselor Education and Supervision members toward suicide and master’s-level suicide training, and the sample was limited to on-campus clinic directors (Hoffman et al., 2013). Findings from the current study were consistent with Hoffman et al. (2013) regarding (a) the view of suicide as a complex topic that is scary and potentially traumatizing, (b) supervisors’ sometimes weighty responsibility for master’s-level suicide training, and (c) the value of practical experience with suicidal clients for learning skills and increasing self-efficacy. Social work educators identified similar obstacles to master’s-level suicide training: stigma and anxiety among faculty and competition within educators’ areas of interest and within curriculum content (Ruth et al., 2012).

The current study’s findings expand the literature in the application of these attitudes and obstacles to Counselor Education and Supervision’s readiness to provide master’s-level suicide training. Participants extended the issues of suicide stigma, responsibility, and competing priorities, counselors-in-training, and the broader community. The findings also expand from attitudinal climate into political and logistical climate. These three issues frame the field’s readiness in that they serve as a context for the other domains: knowledge of suicide, efforts, knowledge of efforts, leadership, and resources.
The findings indicate climate is present throughout the Counselor Education and Supervision field and outside communities and may have direct and indirect impact on all other readiness domains. Climate frames readiness in terms of (a) suicide stigma; (b) responsibility and role, and (c) competing priorities because they act as contextual factors that influence the internal domains. I explain each of the three elements of the climate framework and situate the findings on climate within the existing literature.

**Suicide stigma.** Negative and fearful attitudes toward the topic of suicide emerged as participants attributed suicide stigma to the broader community, counselors-in-training, and Counselor Education and Supervision members. The current study’s findings are consistent with the literature on attitudes of suicide as shameful and pathological among society (Granello & Granello, 2007) and therapists (Knox et al., 2006) and as a “taboo topic” among counseling clinic directors (Hoffman et al., 2013, p. 116) and social work educators (Ruth et al., 2012). The study’s findings extend the literature by describing an emotional-behavioral response shared by broader community members, counselors-in-training, and Counselor Education and Supervision members.

The members in the current study believed all three groups experience fear about suicide and react with avoidant or over-reactive behavior. Community members who are afraid of suicide may neglect to get help for their suicidal child and omit the word *suicide* in obituaries. Counselors-in-training are “terrified” of suicide and may shun suicide-related class discussions and role-plays, evade suicide assessment with suicidal clients in supervision, or “totally freak out in session” if suicide issues materialize. Participants described the topic of suicide as “emotional” and “traumatizing” and depicted master’s-level suicide training as “a necessary evil” that some members of the field avoid.
Counselor Education and Supervision members practice in a context that includes policies they may consider over-reactive.

The view of suicide as a complex topic that is scary and potentially traumatizing appears connected to policies and to master’s-level suicide training efforts. Participants related stories of policies from litigious-focused university administrators and over-reactive police departments. They described some master’s-level suicide training efforts as focused on liability instead of education and serving goals of addressing their liability as a supervisor and ensuring counselors-in-training understand counselor liability related to suicide.

Suicide stigma also affects master’s-level suicide training efforts: the study’s findings indicate educators who attribute suicide stigma to counselors-in-training may be hesitant to address suicide. Those who teach in private institutions and religious-affiliated institutions or contexts may have heightened concerns that students will believe master’s-level suicide training is not worth the high tuition or that it conflicts with their moral values. University educators who are pre-tenure may particularly fear that students’ perceptions of master’s-level suicide training will lead to negative faculty evaluations.

Participants described an emotional-behavior response shared among members of the broader community, counselors-in-training, and members of Counselor Education and Supervision. When stigma surrounds a topic such as mental illness or suicide, this can lead to avoidant and/or over-reactive behavior (Corrigan et al., 2002; Frey, 2015). The current findings demonstrated a climate including suicide stigma that encompasses the field and impacts its readiness to provide master’s-level suicide training. Another element
of climate is responsibility and role to address suicide and provide master’s-level suicide training.

**Role and responsibility.** The study’s findings included beliefs about who holds responsibility to address suicide in counseling and to provide master’s-level suicide training and the qualities Counselor Education and Supervision members must possess to provide master’s-level suicide training responsibly. Climatic concerns include (a) greater responsibility among those in the role of supervisor or applied course instructor and for members in rural communities and (b) the prerequisite of practical experience or expertise with suicide issues in counseling to responsibly provide such training. These findings aligned with some of the literature and contradict others.

Participants in the current study identified an attitude in the Counselor Education and Supervision field that supervisors and applied course instructors and members in rural communities are roles with greater responsibility to provide master’s-level suicide training and that school members have less responsibility. Participants described a prevailing attitude in the field that general responsibility of master’s-level suicide training falls mostly on the shoulders of supervisors and of educators who teach applied coursework. Members in rural settings may feel more responsible to provide master’s-level suicide training since counselors-in-training and graduates may become some of the few counseling resources in the area. The role of school counselor educator or supervisor has less responsibility to provide master’s-level suicide training than members in other specialties (i.e., clinical mental health) because the school counselor role does not involve fully assessing and treating suicidal students.
The findings of Hoffman et al. (2013) highlight the supervisors’ challenging role in master’s-level suicide training and identified a sentiment among training clinic directors that instructors need to take more responsibility for providing master’s-level suicide training than they have in the past. Ruth et al. (2012) discovered an attitude among social work faculty that master’s-level suicide training is “a shared responsibility between field educators and class-room based instructors” (p. 506). Leadership in the Council for Accreditation of Counseling and Related Programs (CACREP) placed suicide content in school and gerontology counseling requirements in the 2001 Standards (CACREP, 2001) before placing it in among core standards (CACREP, 2009) and school suicide prevention has held ongoing focus in the counselor education and supervision and other literature (American Foundation for Suicide Prevention & Suicide Prevention Resource Center, 2011; Capuzzi, 1994, 2009; King & Smith, 2000). The current study also contained findings that instructors of foundations, ethics, and crisis courses currently provide master’s-level suicide training efforts. It is possible this disjointed set of findings is further evidence that the field’s master’s-level suicide training efforts preceded full readiness: attitudinal climate has not yet aligned with the reality of current efforts. If members who provide master’s-level suicide training outside of supervisory and applied instructional roles still believe it should not be their responsibility, this may contribute to the negative attitude toward master’s-level suicide training.

Findings on attitudes emerged about the qualities Counselor Education and Supervision members must possess to responsibly provide master’s-level suicide training and the impact this climate has on efforts. Participants described a belief that providing master’s-level suicide training requires expertise with the topic of suicide and/or “enough
experience” counseling suicidal clients (i.e., high knowledge of suicide). Lack of suicide knowledge or experience and/or low self-efficacy to provide master’s-level suicide training among members of the field precludes some from doing so. This appears to align with research that indicates social work educators’ lack of suicide expertise is an obstacle for providing master’s-level suicide training and with other authors’ musings that this lack among professors of school psychology (Liebling-Boccio & Jennings, 2013) and counseling (Wachter Morris & Barrio Minton, 2012) deters them from providing such efforts. Training clinic directors in the Hoffman et al. (2013) study emphasized the impact of practical experience with suicidal clients on skill development and self-efficacy improvement in counselors-in-training. This study serves to extend the Hoffman et al. (2013) findings to include the importance of Counselor Education and Supervision members’ practical experience and expertise in suicide on skills and self-efficacy to provide master’s-level suicide training.

Findings from the current study unveiled attitudes in the Counselor Education and Supervision field about role and responsibility to provide master’s-level suicide training. This attitudinal climate may contribute to lower self-efficacy to provide master’s-level suicide training and reluctance to provide it. The element of climate frames readiness in that the attitudes, policies, and logistics regarding role and responsibility set the tone for the remaining domains. They appear to inform members’ appraisals of knowledge of suicide, knowledge of efforts, and efforts in that each of the three is viewed in comparison to role and expertise expectations. The Counselor Education and Supervision members also perceive a need for more leadership and resources support to increase
knowledge of suicide and knowledge of efforts and to improve efforts. Participants described competing priorities as an obstacle for members and leaders.

**Competing priorities.** Another area of the climate framework for Counselor Education and Supervision’s readiness to provide master’s-level suicide training is competing priorities. Findings indicated members of the field have concern for the training but contend with numerous tasks and training content that rival training efforts and suicide. This was consistent with the literature that, despite a strong conviction that suicide is an important topic, master’s-level suicide training does not necessarily receive high priority when social work educators (Ruth et al., 2012) and counseling clinic directors (Hoffman et al., 2013) juggle competing professional interests and curriculum. The current study’s findings extended this obstacle to counselors-in-training and to other leaders in Counselor Education and Supervision and the broader community. Findings also served to illustrate how this climatic element surrounds other dimensions of the field’s readiness to provide master’s-level suicide training.

The issue of competing priorities impacting Counselor Education and Supervision’s (CES) readiness to provide master’s-level suicide training occurs within the CES context. Participants echoed existing literature (Ruth et al., 2012; Wozny, 2005) when they explained there is “so much to cover” and “not enough room” in the counseling curriculum and supervision agenda “to fit it all in.” Supervisors may focus on their other work responsibilities including crisis response above providing thorough master’s-level suicide training and developing their own knowledge of suicide and knowledge of efforts. Some participants sympathized with program and national leaders who have to attend to trauma as a trending topic and more urgent work responsibilities
such as ensuring teaching coverage. Participants mentioned how counselors-in-training who juggle other work/life responsibilities as adult learners cannot always attend extracurricular and external suicide training or be mentally present during master’s-level suicide training efforts. Some participants stated that Counselor Education and Supervision members and counselors-in-training must make a conscious effort to prioritize master’s-level suicide training lest it “get lost” among its competitors.

The issue of competing priorities also exists in the broader community and impacts Counselor Education and Supervision’s readiness to provide master’s-level suicide training. Participants stated local and other training providers dedicate professional development efforts to topics other than suicide which limits professional development resources for building knowledge of suicide and knowledge of efforts. State leaders focus licensing exams on other content and prevention efforts on other issues. Funding sources prioritize other issues above suicide and research projects above master’s training efforts.

Climate appeared to frame Counselor Education and Supervision’s readiness to provide master’s-level suicide training in its presence within and beyond the field and influence on all readiness domains. The study served to expand three climatic concerns from existing literature to members of the field, counselors-in-training, and the broader community: suicide stigma, responsibility, and competing priorities. Next I explain the placement of knowledge domains and efforts in the relational model.

**Knowledge and Efforts.** Knowledge of suicide and efforts appeared to have a reciprocal relationship as do knowledge of efforts and efforts. Similarities that unite two or more of these domains are suicide content, master’s-level suicide training received,
and lack of evidence-based practice. I discuss the Community Readiness Model scores for these three domains then describe these relationships and similarities and situate the information in the literature and the current findings. The overall readiness of Counselor Education and Supervision to provide master’s-level suicide training was in the preplanning stage; variance in readiness was evidenced among domains. Specifically, knowledge of suicide was in preparation, the efforts dimension was in initiation, and knowledge of efforts was in preplanning.

Counselor Education and Supervision’s readiness to provide master’s-level suicide training was at the preparation stage (5 out of 9) regarding knowledge of suicide. This indicated basic knowledge about suicide and related counseling (e.g., prevalence and risk factors) among some members of the field (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). It seems important to note that a Community Readiness Model score of 6 means a majority of members have basic knowledge about suicide and related counseling. It was likely, based on this study’s data, that some members of Counselor Education and Supervision are seen as lacking this basic knowledge.

The field was found to be in a stage of preplanning regarding knowledge of master’s-level suicide training efforts (4 out of 9), indicating some members have specific knowledge about efforts while others do not. Members in this sample described efforts they individually provided in some detail. A few were able to offer information about efforts by others: specifically, a handful of university participants could name their immediate colleagues’ efforts without providing much detail. Several could not name or detail others’ efforts.
The Counselor Education and Supervision field was found to be in a stage of initiation for master’s-level suicide training efforts (6 out of 9) which indicates the field has implemented such efforts. Programs accredited by the Council for Accreditation of Counseling and Related Educational Programs have one or several master’s-level suicide training efforts during the course of a counseling student’s training; however not all programs contain master’s-level suicide training efforts that existed before four years ago. Most members in the sample stated efforts had been existence for four to five years. Others were not sure of the longevity or indicated efforts had been in place for three years or less. The Community Readiness Model anchored rating scale for efforts displays a score of 6 for “Efforts (programs/activities) have been implemented.” and a score of 7 for “Efforts (programs/activities) have been running for at least four years” (Plested et al., 2009, p. 20). Had one more participant been able to confidently state the latter, the score for this dimension would have been a 7.

All three domains – knowledge of suicide, efforts, and knowledge of efforts – have similarities regarding suicide content, depth, and applicability. Risk assessment and legal and ethical issues emerged in the findings as areas of high knowledge of suicide among Counselor Education and Supervision members, recurring foci of master’s-level suicide training efforts, and strengths of such efforts. Risk assessment also emerged in the findings as an area of misconceptions in knowledge of suicide among members of the field (i.e., risk among youth and self-injurious behavior) and a topic that was lacking in master’s-level suicide training efforts in terms of practical learning and standardized instruments. The centrality of risk assessment and legal and ethical issues in knowledge of suicide, efforts, and knowledge of efforts is fitting as those topics remain among the
most commonly addressed in publications on counseling and master’s-level training related to suicide (American Counseling Association, 2011; Berg, Hendricks, & Bradley, 2009; Granello, 2010b; Juhnke, 1994).

Lack of depth in knowledge of suicide, current master’s-level suicide training efforts, and knowledge of efforts was among the participants’ criticisms. Individuals in the current sample described common knowledge of suicide among Counselor Education and Supervision members as “basic” and master’s-level suicide training efforts as “cursory” in that they focus primarily on warning signs, essential clinical interview questions, and the fact that counselors are mandated reporters. Participants’ knowledge of efforts included describing their own efforts sans evaluations, sometimes naming efforts within their program, and rarely identifying efforts in other programs. This finding is consistent with the literature containing criticisms from graduates and counselors-in-training (Freadling & Foss-Kelly, 2014; Wozny & Zinck, 2007) and comments from authors about Counselor Education and Supervision members lacking knowledge of crisis and related education (Dupre et al., 2014; Wachter Morris & Barrio Minton, 2012).

The issue of applicability also echoed themes from the literature on needed improvements. Findings indicated some members of the field have outdated knowledge of suicide which they “pass on to students” in master’s-level suicide training efforts. Counselors-in-training and graduates praised the Counselor Education and Supervision field for master’s-level suicide training efforts that include active and practical learning while requesting more of these methods for applying knowledge (Freadling & Foss-Kelly, 2014; Wozny & Zinck, 2007) just as the current study’s participants identified active and practical learning as strengths and weaknesses of master’s-level suicide
training like Elizabeth’s assertion that “they [counselors-in-training] feel comfortable enough, which is the key point. But I do think we need more practice.”

**Master’s-level suicide training received.** The primary way in which efforts contribute to knowledge of suicide was via master’s-level suicide training received. Master’s-level suicide training received represents efforts in the field for counselor educators and supervisors who completed master’s programs in counseling. Study participants attributed more knowledge of suicide to Counselor Education and Supervision members who completed master’s training more recently than others due to likely increased and updated master’s-level suicide training efforts. One example regards no-suicide contracts as members who completed master’s training before no-suicide contracts were deemed inappropriate (Edwards & Sachmann, 2010; Lee & Bartlett, 2005) may not be aware of this change. Participants also named master’s-level suicide training received as a source of knowledge of efforts.

**Review of literature and evaluation.** The findings suggested Counselor Education and Supervision members may not consistently use master’s-level suicide training literature, suicide literature beyond the field, or evaluation of master’s-level suicide training efforts to inform their knowledge of suicide, efforts, and knowledge of efforts. Participants named professional literature as the fourth source for knowledge of suicide behind professional experience and master’s-level suicide training received. Literature was the second source of knowledge of efforts with counselors-in-training and master’s-level suicide training received as third and fourth. Participants identified several authors and presenters on suicide topics in the Counselor Education and Supervision field, but
master’s-level suicide training literature and authors and literature beyond the field achieved only rare mention.

The fact that participants identified counselors-in-training and master’s-level suicide training received as sources of knowledge of efforts could be concerning. Asking counselors-in-training what master’s-level suicide training efforts they received and/or using observation and informal appraisal of counselors-in-training may yield misconceptions about such efforts. The Counselor Education and Supervision members’ conclusions may be confounded by variables such as the developmental stage of a counselor-in-training, inaccurate memory about an effort, and emotional state when performing. Members who base their knowledge of efforts on the master’s-level suicide training they received may develop misconceptions about the status or best practice of master’s-level suicide training when the training received was inadequate then or is outdated now. The same may be true if a member relies on counseling experience as a lone source of knowledge of efforts on master’s-level suicide training.

Increased reliance on master’s-level suicide training literature, suicide literature beyond the Counselor Education and Supervision field, and evaluation of efforts seems crucial. Relevant literature contains information on master’s-level suicide training models (McGlothlin et al., 2005; Miller et al., 2013), training clinic policies (Barrio Minton, 2010), and learning evaluations (Barrio Minton & Gibson, 2012). Sources beyond the field have provided updated information on suicide-related practice such as Core Competencies (American Association of Suicidology, 2004) and evidence-based suicide intervention (Jobes, 2012; National Action Alliance: Clinical Care and Intervention Task Force, 2013; Ribeiro et al., 2013) and information such as suicide training guidelines
(Clinical Workforce Preparedness Task Force, 2014) and evaluation practices (Cramer et al., 2013; Osteen et al., 2014). Evidence-based practices for crisis education may be lacking or inconsistent in literature on counseling and counselor education and supervision (Barrio Minton, Fernando, & Ray, 2008; Barrio Minton, Wachter Morris, & Yaites, 2014). The study’s finding that few unpublished internal evaluations may exist despite their benefit for informing efforts should prompt the Counselor Education and Supervision field to engage in future evaluation.

The findings outline reciprocal relationships between knowledge of suicide efforts, and knowledge of efforts. This study highlights the importance of consistent, comprehensive, and updated knowledge of suicide among Counselor Education and Supervision members; the infusion of such content along with active and practical learning throughout master’s-level suicide training efforts; and the need for review of research and evaluation to improve knowledge of suicide and knowledge of efforts and to inform such efforts. An integral component of the field’s readiness to provide master’s-level suicide training is the combination of leadership and resources as potentially supportive and facilitative of and between knowledge of suicide, knowledge of efforts, and master’s-level suicide training.

**Leadership and Resources.** Leadership and Resources was placed below and between the domains of in the relational model. These placements reflected the support and impact of leadership and resources on the domains directly and on the relationships between the domains (e.g., members’ application of knowledge of suicide to inform efforts). The readiness of the Counselor Education and Supervision (CES) field to provide master’s-level suicide training is in the preplanning stage for the leadership
domain (4 out of 9), which indicates that CES leaders have concern for master’s-level suicide training and may offer some support, but do not support specific improvement or evaluation initiatives (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). The Community Readiness Model score and the qualitative data reveal the need for more active involvement and direct guidance from CES leadership on master’s-level suicide training efforts. Leaders in CES may believe they are prioritizing master’s-level suicide training in word and/or in deed; however CES members want more engagement from leadership that clarifies what is expected of them in terms of master’s-level suicide training and helps them feel and be prepared to provide it.

Counselor Education and Supervision’s readiness to provide master’s-level suicide training was in the vague awareness stage (3 out of 9) regarding resources. Resources appeared to be insecure or otherwise inadequate. The field’s members, its leaders, and those in the broader community do not seem concerned to designate existing resources or seek out new ones. Members may experience several barriers to securing existing resources for master’s-level suicide training. My impression was that most participants had never considered the possibility of needing or receiving resources for such training, nor how training efforts can be made eligible to receive existing resources.

Findings indicated that Counselor Education and Supervision members experience and wanted leadership and resource support to directly bolster knowledge of suicide, efforts, and knowledge of efforts. They also appeared to experience and want some leadership and resource support to influence the relationships between the domains: to help them apply knowledge of suicide and knowledge of efforts to master’s-level suicide training efforts and to address climate. Participants listed several leadership and
resource types. Attitudinal leadership support seemed generally present though active leadership support and resources seemed conditional. I discuss active leadership and resource support for each domain and for the relationships between domains and distinguish leader and resource types and resources and conditions.

**Support for efforts.** Participants assigned direct influence on master’s-level suicide training efforts to the Council for Accreditation of Counseling and Related Educational Programs, providers of such training content, program leaders, and management at supervision sites. Participants attributed active support to the accreditation body for providing standards to guide previous and current master’s-level suicide training efforts. One participant pointed out that inclusion of crisis in the 2009 Standards ensured future counselor educators receive such training. No participants mentioned the 2016 Standards. Findings did not indicate accreditation leadership is ensuring master’s-level suicide training includes “detection, assessment, treatment, and management of suicidal patients” (Schmitz et al., 2012, p. 298) based on the (American Association of Suicidology, 2004) Core Competencies.

Participants acknowledged textbook authors and training facilitators for providing master’s-level suicide training content. These leaders appear to deserve credit for the variety of risk assessment models Counselor Education and Supervision members incorporate into master’s-level suicide training efforts (e.g., Juhnke, 1994; McGlothlin, 2008) and for the gatekeeper training offerings programs endorse for extracurricular and/or incorporated master’s-level suicide training efforts (e.g., certified instructors of Question Persuade Refer and Applied Suicide Intervention Skills Training).
Some program leaders provided active support for efforts though others do not and members of the field may desire more support from them. Two site supervisors acknowledged site leaders for their support of site supervision related to client suicide issues via client and supervisee screening policies. Program leaders were the primary target for participants’ comments about leadership’s support that was “saying but not doing.”

Some program leaders also provided active support by guiding the placement of master’s-level suicide training within the curriculum but members requested further guidance. The findings suggested some programs apply the infusion approach for master’s-level suicide training that enjoys consensus among authors in the field (Dupre et al., 2014; Hoffman et al., 2013; McAdams & Foster, 2000; Wachter Morris & Barrio Minton, 2012). However, most participants indicated a lack of coordinated initiatives to ensure consistency between course sections and practice site and comprehensiveness across training.

All participants commented on a lack of resources available for master’s-level suicide training, particularly money and time. This finding was consistent with previous literature (Cramer et al., 2013; Hung et al., 2012; Ruth et al., 2012; Wozny & Zinck, 2007; Wozny, 2005). The study’s results suggest that Counselor Education and Supervision members desire resources for master’s-level suicide training and for development of their knowledge of suicide and efforts.

**Support for knowledge.** The most cited type of active support was supporting learning (i.e., knowledge of suicide and knowledge of efforts). This was also the primary request for increased leadership and resource support. Participants acknowledged
“opinion leaders” (Rogers, 2010, p. 27) and organizational leaders for providing and facilitating professional development such as literature and conference sessions. However they pointed out that not all Counselor Education and Supervision members have adequate access to money and time resources to complete professional development and those who do often spend their professional development resources with little direction from others. Counselor educators and supervisors who completed master’s in counseling degrees from programs accredited before 2009 may not have received master’s-level suicide training and those who did may not have found it to be adequate (Barrio Minton & Pease-Carter, 2011; Hoffman et al., 2013; Raper, 2010; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). These conditions may contribute to inconsistencies in knowledge of suicide and knowledge of efforts.

The Counselor Education and Supervision members in this study believed that program leaders, state policy leaders, and accreditation leaders should help them bridge gaps in their knowledge of suicide and knowledge of efforts. Requests for program leaders included hosting on-campus suicide trainings, disseminating information about local trainings, and requiring suicide training for site supervisors. Two members each called on accreditation bodies to require suicide professional development among counselor educators and on state officials to require it for supervisors or licensed counselors. This request aligns with an American Association of Suicidology taskforce recommendation (Schmitz et al., 2012) that state licensing board leaders enact suicide professional development requirements for mental health professionals renewing their licenses. State policies requiring suicide training exist for licensed professionals in Washington state (Matt Adler Suicide Assessment, Treatment, and Management Act
and for school personnel in 16 states (American Foundation for Suicide Prevention, 2013a; The Jason Foundation, n.d.); however, no additional requirements exist for supervisors or educators. There is a precedent for state policies on suicide training requirements, but not for those who provide pre-professional education or supervision.

Participants did not address resources available for curriculum design and change initiatives although some named similar resources earmarked for professional development or other expenses. Resources that appear in the literature include funding (Lattuca & Stark, 2009), time (Barrio Minton & Gibson, 2012; Lattuca & Stark, 2009; Stanley, 2004; Wolverton, 1998), and people (Barrio Minton & Gibson, 2012; Farrell, 2003; Lattuca & Stark, 2009; Lechuga, 2006). Some study participants indicated they had access to funding and time off to attend professional development they could use to develop KOS and KOE while others stated they were not provided those resources.

**Overall leadership and resource support.** Leadership and resource support appeared to be a promising and vital element of readiness to address issues with consistency and quality throughout the other readiness domains. More than half the sample \((n = 9)\) described a lack of or only indirect awareness of leadership and several attributed it to leadership’s lack of organized initiative for master’s-level suicide training and lack of communication with Counselor Education and Supervision members. Program leaders in particular may be central in decision-making and communication for master’s-level suicide training change.

Not only did leadership and resources serve as foundation for the individual domains of knowledge of suicide, knowledge of efforts, and efforts, they appeared to be
facilitative of relationships within these domains and influential on climate. More active support from program leaders can facilitate the application of knowledge of suicide and knowledge of efforts to master’s-level suicide training efforts and the application of resources throughout the domains on the relational model. I include examples from the findings below and then address climate.

Program leaders received requests to facilitate more communication between members of the Counselor Education and Supervision field. Most university members who mentioned a desire for collaboration between universities and sites described it as meetings for interpersonal knowledge exchange. Site supervisors, however, described the meeting goals as increased understanding of program requirements for supervisors and opportunity to explain their site supervision and how they meet those requirements. Both goals focus on improving consistency of knowledge of efforts among program members. This seems a particularly important endeavor since the study’s findings identified assumptions and misconceptions in members’ knowledge of efforts which is consistent with the literature (Ruth et al., 2012).

An example of a potential inconsistency and misconception regards master’s-level suicide training via practical experience counseling clients with suicide risk. Findings from the study mirrored the disagreement I observed in Chapter II about these clinic policies (Barrio Minton, 2010; Hoffman et al., 2013; Lauka, McCarthy, & Carter, 2014; Mobley & Myers, 2010). A program clinic director and an educator who will soon become a clinic director expressed opinions consistent with other clinic directors (Hoffman et al., 2013) and authors in Counselor Education and Supervision (Barrio Minton, 2010; Mobley & Myers, 2010) that all counselors-in-training should receive
master’s-level suicide training in their practical training experiences which can include counseling clients with suicide risk. However, a site supervisor in the sample expressed agreement with her site’s policy to screen clients with previous or current suicidal ideation or greater risk out of supervisees’ caseloads: a policy that exists among some counselor training clinics (Lauka et al., 2014). Another site supervisor indicated that her supervisees have never received practical master’s-level suicide training because suicide has “never come up” for their elementary school students. Most participants mentioned an master’s-level suicide training effort of reviewing crisis protocols (Falvey & Cohen, 2003); however program and field leadership does not appear to be fully addressing the practice policy climate for master’s-level suicide training.

Active leadership support regarding climate for master’s-level suicide training was less obvious in the findings. One participant each credited: the American Counseling Association for supporting a climate in which suicide and master’s-level suicide training are priority topics, regional Association for Counselor Education and Supervision leadership for prioritizing suicide as a conference topic, and a program leader for securing a national suicide grant. A request for leadership and resources support regarding climate seemed implied and reasonable.

Member and leader participants disagreed about master’s-level suicide training. Two program leaders in the study discussed their disagreement with the attitude that only Counselor Education and Supervision members with a practice or research niche in crisis or trauma can provide quality master’s-level suicide training. Other disagreements or inconsistencies regard core suicide content and differences between master’s-level suicide training efforts for counselors-in-training in certain counseling specialties (e.g.,
school versus clinical). The study’s findings included leadership decisions that may address disagreements though additional conversations may be needed to establish consensus.

Leaders are positioned to prioritize master’s-level suicide training in the Counselor Education and Supervision (CES) field, facilitate information sharing within CES and between the field and other entities, and guide coordinated master’s-level suicide training initiatives. Leadership from the Council for Accreditation of Counseling and Related Educational Programs served to improve master’s-level suicide training since 2009 in that efforts likely exist in all accredited programs and greater infusion is present than before (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012; Wozny, 2005). Authors and presenters in CES have continued to support knowledge of suicide and knowledge of efforts; however CES members may lack awareness of master’s-level suicide training literature from within and beyond the field and need more facilitated communication and resources from leaders to develop knowledge of efforts via collaborations and evaluations.

Leadership support is still needed to ensure consistency and comprehensiveness within counselor training programs (Freadling & Foss-Kelly, 2014; Gibbons et al., 2009; Hoffman et al., 2013; Wozny & Zinck, 2007). Wachter Morris and Barrio Minton’s (2012) observed from their researching findings “a lack of systematic attention to crisis preparation on the program level, relegating crisis preparation priorities and curricula to the discretion of individual instructors” (p. 257). This problem remains for master’s-level suicide training, appeared connected to inadequate knowledge of suicide and knowledge of efforts, and may be best solved by a comprehensive readiness assessment and
improvement initiative led by program leaders in Counselor Education and Supervision. I explored the implications for program and other leaders and members of the field next.

**Implications**

Logic models serve to describe how an initiative can function to address an issue given certain conditions (Bickman, 1987). Logic models include inputs, activities, outputs, impacts/outcomes (Julian, 1997; Strosberg & Wholey, 1983) and often antecedent variables and mediating factors (Harrell et al., 1996). I define these components then apply them to the current findings and previous literature on readiness and master’s-level suicide training. The purpose of providing these logic models is to provide Counselor Education and Supervision members with tools to increase readiness and to ultimately improve master’s-level suicide training.

Antecedent variables and mediating factors are contextual elements “external to the program and not under its control [that] could influence its success” (McLaughlin & Jordan, 2004, p. 9). Antecedent variables exist prior to an initiative whereas mediating factors represent potential changes during an initiative. These elements are similar across Counselor Education and Supervision’s readiness domains to provide master’s-level suicide training and appear in all logic models in this section. Antecedent variables for a counselor training program’s master’s-level suicide training readiness initiative include policies regarding suicide at the state level and at practice sites, geographic and economic factors affecting the university and mental healthcare in the region, and societal attitudes toward suicide and master’s-level suicide training. Mediating factors for such a readiness initiative include reaccreditation timelines, changes in staff, and unanticipated events such as local or widely televised relevant crises.
Inputs include resources and other information necessary to support an initiative (McLaughlin & Jordan, 2004). Inputs for a program’s readiness initiative are also similar across domains. I include logistical resources and information resources in all logic models with some small distinctions. Relevant logistical resources could include time, money, and/or people. Information resources could include sources the participants identified for knowledge of suicide or knowledge of efforts, guidelines in the 2016 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2015), core competencies (American Association of Suicidology, 2004) and suicide training guidelines (Clinical Workforce Preparedness Task Force, 2014), or other information inputs relevant to the domain.

Activities constitute “all of the action steps necessary to produce program outputs” (McLaughlin & Jordan, 2004, p. 9). Baseline activities for a master’s-level suicide training readiness initiative include readiness assessments, team planning, and engagement of responsible parties. I highlight activities beyond those foundational processes in the logic models.

Activities yield outputs and impacts or outcomes (Julian, 1997; McLaughlin & Jordan, 2004; Strosberg & Wholey, 1983). Outputs represent the deliverables to participants. Short-term outcomes encompass near immediate results of the outputs which in turn yield intermediate and long-term outcomes. The results are primarily unique to each logic model.

I provide four examples of logic models for Counselor Education and Supervision’s readiness to provide master’s-level suicide training relevant to: (a) leadership and resources, (b) climate, (c) knowledge of suicide, and (d) efforts and
knowledge of efforts. An assumption underlying these models derives from the Community Readiness Model: that assessing and enhancing readiness dimensions will improve a community’s readiness to address an issue. Each component contains findings from the current study and/or previous literature.

The first model – resources and leadership – focuses on activities for program leaders relative to resources and advocacy to leaders beyond the program and on activities for outside leaders that should enhance Counselor Education and Supervision’s readiness to provide master’s-level suicide training. The next three models target individual counselor training programs with the intention that a program’s leaders and members can use these models to inform program evaluation on readiness for master’s-level suicide training. These models address activities by program leaders and members of the field for (a) climate, (b) knowledge of suicide, and (c) efforts and knowledge of efforts. Together the four models represent guides for readiness improvement initiatives at the individual, program, or broader levels.

Logic Model 1: Resources and Leadership

The study’s findings have many implications for leadership including program and site leaders, the Council for Accreditation of Counseling and Related Educational Programs and other leaders in the Counselor Education and Supervision field, and leaders who impact state policy. This study’s results suggested leadership initiatives should target aims of greater consistency and communication. I combine resources and leadership in the discussion of implications because (a) the leadership domain shows greater readiness than resources, (b) leaders are positioned to identify and secure resources, and (c)
leadership and resources appear to operate in tandem in their relationships to the other readiness dimensions. The dimension with the lowest score was resources at the vague awareness stage (3 out of 9). The leadership stage was higher than resources: preplanning (4 out of 9). Participants identified leaders as responsible for determining priorities in the field and allocating resources. Findings indicated initiatives to increase knowledge of suicide and knowledge of efforts (i.e., professional development) and improve efforts (i.e., intentional planning) require both leadership and resources support. This logic model outlines how the field can undertake initiatives to increase overall readiness to provide master’s-level suicide training by targeting specific areas of leadership and resources. Antecedent variables for resources and leadership include geographic and economic factors and societal and local attitudes. Participants mentioned tight budgets in private and nonprofit organizations and those in states that are “really hurting for education funding.” Rural communities also arose as lacking information resources and services. Rural and religious communities may have climates that are not conducive to suicide prevention and training resources and initiatives.

Inputs for resources and leadership include time and money resources and information on funding protocols, advocacy models, and policies. The study’s findings indicate leaders also struggle with competing priorities to devote to master’s-level suicide training readiness initiatives and leaders in the study demonstrated a need for more information. I begin this subsection on leadership and resources by encouraging the use of program-level readiness assessment then I use the logic model to briefly describe the study’s implications regarding resources and for other types of leaders.
Antecedent variables
geographic and economic factors affecting the region, field, and nation
societal and local attitudes toward suicide and MLST

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
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<tbody>
<tr>
<td>- Logistical resources: time and money for leadership activities</td>
<td>- Program leaders allocate time and people resources for PD, evaluation, and MLST efforts.</td>
<td>- Identified time and people resources</td>
</tr>
<tr>
<td>- Information resources: funding protocols and existing policies</td>
<td>- Program leaders identify funding sources and oversee their use.</td>
<td>- Identified funding and oversight</td>
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<td></td>
<td>- Field leaders provide guidance on standards and practice related to suicide and MLST.</td>
<td>- Clarification on standards</td>
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<td></td>
<td>- State policy leaders devise PD requirements.</td>
<td>- PD policies</td>
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<td></td>
<td>- Funding leaders increase resources for MLST.</td>
<td>- Identified funding</td>
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<tr>
<th>Short-term Outcome</th>
<th>Intermediate Outcome</th>
<th>Long-term Outcome</th>
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<tbody>
<tr>
<td>- More resources for MLST efforts and related activities (i.e., PD, evaluation)</td>
<td>- Awareness and use of resources for MLST efforts and related activities</td>
<td>MLST efforts that are supported by existing resources</td>
</tr>
<tr>
<td>- Increased communication about expectations for MLST and related activities</td>
<td>- Increased and corrected knowledge of suicide and efforts</td>
<td>- Provided by knowledgeable CES members</td>
</tr>
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<td></td>
<td>- Greater consistency of knowledge across CES members</td>
<td>- More accurate and consistent</td>
</tr>
<tr>
<td></td>
<td>- CES members who are more supported and better prepared to provide MLST</td>
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Mediating factors
reaccreditation timelines
changes in staff
unanticipated suicide or related events

Figure 3. Resources and leadership logic model. MLST = master’s-level suicide training; PD = professional development; CES = Counselor Education and Supervision.

Some mediating factors could impact leadership initiatives for master’s-level suicide training. Participants indicated increased prioritization of master’s-level suicide
training during accreditation projects. Staff turnover is a common mediating factor (McLaughlin & Jordan, 2004). Such changes in programs and universities, professional organizations for counseling and counselor education and supervision, and state and national institutions responsible for policy and funding can affect master’s-level suicide training readiness initiatives. Findings also indicated that news of a suicide by a local community member or celebrity and related concerns (i.e., increase of bullying incidents) can result in increased resources for suicide prevention.

**Program leaders.** Even a brief preliminary assessment of program readiness can help guide leadership initiatives and prepare members for change (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). Other ways to gather more readiness information are focus groups and online surveys (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). Plested et al. (2009) pointed out that readiness assessments not only guide the development of “infrastructure and support that will make it possible to implement projects successfully” (p. 57) but are often used to show funding sources how ready the community is. Program leaders may benefit from the use of readiness assessments to pursue financial resources such as university funding, seed grants, and support from local, state, and/or national sources.

Activities for program leaders include allocating and identifying resources to increase readiness on knowledge of suicide, knowledge of efforts, and master’s-level suicide training efforts. The study’s findings revealed resources for such training were conditional at best. Some participants identified resources in their organizations that are not applied to master’s-level suicide training efforts or professional development such as community workshops, suicide experts, and training space. Program leaders can actively
support master’s-level suicide training readiness by identifying and overseeing grants, volunteer speakers, and nominal entrance fees for professional development offerings.

**Field leaders.** Field leaders include opinion leaders and leaders of organizations such as the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the American Counseling Association, and the Association for Counselor Education and Supervision. Their activities involve supporting and providing professional development and ongoing communication about suicide and master’s-level suicide training standards and practice. I outline activities for organizational leaders then leaders of opinion, conferences, and publications.

It is apparent from the data that the accreditation standards have a direct impact on master’s-level suicide training. None of the participants mentioned they had considered the 2016 Standards (CACREP, 2015) regarding master’s-level suicide training or other content. The 2016 Standards provide greater specification of suicide content in core training, but crisis and trauma training in specialty areas do not explicitly include suicide content. It may be helpful for accreditation leadership to provide or otherwise support understanding among Counselor Education and Supervision members and others regarding specific changes from the 2009 Standards (CACREP, 2009) to the 2016 Standards (CACREP, 2015). For example, a clarification of what constitutes crisis and trauma should benefit program leaders and individual educators and supervisors.

The American Counseling Association Code of Ethics (2014) contains a change pertinent to members of the field and accreditation leadership: “Counselors who function as counselor educators or supervisors provide instruction within their areas of knowledge and competence and provide instruction based on current information and knowledge
available in the profession” (p. 14). A proactive support initiative includes communication from relevant leadership about the meaning of this ethical standard and its implications on changes from the 2009 Standards (CACREP, 2009) to the 2016 Standards (CACREP, 2015). These communications could guide opinion and organization leaders in their work providing publications and professional development.

Participants in the current study praised authors and presenters and editorial boards and conference committees for providing ongoing information in support of knowledge of suicide and knowledge of efforts. Readiness should increase if those leaders focus on providing the most updated and comprehensive professional development on suicide and master’s-level suicide training. Leaders should provide suggestions on master’s-level suicide training that aligns guidance such as the 2016 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2015) and the ACA Code of Ethics (2014) and with Core Competencies (2004), Clinical Workforce Preparedness Guidelines (2014), and evidence-based practice.

**State policy leaders.** Another target of study participants’ appeals for suicide training requirements was state policy leaders. Suicide training requirements exist in some states for school professionals (The Jason Foundation, n.d.) and licensed counselors (Matt Adler Suicide Assessment, Treatment, and Management Act ESHB 2366, 2012). A workgroup comprised of policymakers, leaders in Counselor Education and Supervision and related fields, and suicide prevention specialists could support master’s-level suicide training by establishing professional development requirements for these professionals.

Funding leaders, those who oversee the development and allocation of funding, who are at the university, state, and national level should increase resources for master’s-
level suicide training. Several participants in the current study asserted that no resources were available to support master’s-level suicide training. Examples included funding conditions that preclude training expenditures for efforts, professional development received, and projects that contain no research component. Leaders who control funding can better support master’s-level suicide training by identifying financial resources for efforts, professional development, and evaluation or research.

These resources and leadership activities should result in outputs and outcomes. Outputs include identified resources, guidance on master’s-level suicide training, and professional development requirements. Short-term outcomes meet the requests of the study’s participants for more available resources and increased communication from leaders about master’s-level suicide training. The Counselor Education and Supervision members in the current study believed leaders were not actively supporting master’s-level suicide training via resources and policies as much as they should. More active involvement and coordinated initiatives by leaders within and beyond the Counselor Education and Supervision field should produce intermediate outcomes of improved support and preparation of members in the field to provide master’s-level suicide training which enhances master’s-level suicide training long-term.

The study’s findings indicated a need for more resources, more active leadership support, and greater consistency and comprehensiveness within program’s efforts. The Counselor Education and Supervision members positioned leaders as influential guides of intentional decision-making about master’s-level suicide training efforts and requested they actively support master’s-level suicide training with resources and initiatives for increased knowledge of suicide and knowledge of efforts. Logic Model 1 addressed
resources and program-level and broader leadership for master’s-level suicide training readiness in Counselor Education and Supervision. The next three models focus on programs only including members of the field and program leaders.

**Logic Model 2: Climate**

It is important to remember that changes implemented without first considering readiness often fail to sustain intended outcomes (Holt et al., 2007). Understanding local overall and dimension-specific readiness can ensure leaders do not initiate before their local community is ready. For example, a preemptive master’s-level suicide training initiative in a program with a climate involving a negative attitude toward suicide and related training could instead create greater resistance among Counselor Education and Supervision members. An initial assessment of program climate toward suicide and master’s-level suicide training would allow the community can enact strategies to improve the attitude before endeavoring to change master’s-level suicide training.

The study’s findings indicated the Counselor Education and Supervision field could improve readiness to provide master’s-level suicide training by focusing on three climatic concerns: suicide stigma, responsibility and role, and competing priorities. Antecedent variables for climate initiatives are similar to those for resources and leadership. Geographic and economic factors and societal and local attitudes emerged in the study as logistical and attitudinal climate. Findings indicated ethical and accreditation standards precede attitudes about responsibility and priorities. Study participants described suicide-related protocols in the broader community such as police response and hospitalization processes mainly in juxtaposition to a more ideal climate for clients.
Antecedent variables
geographic and economic factors affecting the region, field, and nation
societal and local attitudes toward suicide and MLST
suicide-related protocols in the broader community
accreditation and ethical standards

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Logistical resources: time and money for communication and advocacy</td>
<td>- Leaders model positive attitudes about suicide and MLST.</td>
<td>- Increased attitudinal support from leaders</td>
</tr>
<tr>
<td>- Information resources: phenomenology of suicide, advocacy models, standards</td>
<td>- Leaders support advocacy projects to combat stigma.</td>
<td>- Support for advocacy</td>
</tr>
<tr>
<td></td>
<td>- Leaders clarify expectations for MLST efforts regarding responsible parties and competence.</td>
<td>- Outlined expectations</td>
</tr>
<tr>
<td></td>
<td>- Leaders prioritize MLST.</td>
<td>- Proactive discussions and planning</td>
</tr>
<tr>
<td></td>
<td>- CES members develop positive attitudes about suicide and MLST.</td>
<td>- Supportive attitudes</td>
</tr>
<tr>
<td></td>
<td>- CES members participate in advocacy projects.</td>
<td>- Involvement in advocacy</td>
</tr>
<tr>
<td></td>
<td>- CES members consider their competence and fulfill their responsibilities.</td>
<td>- Plans for efforts</td>
</tr>
<tr>
<td></td>
<td>- CES members prioritize MLST.</td>
<td>- MLST conversations and objectives</td>
</tr>
</tbody>
</table>

- Increased attitudinal support from leaders
- Support for advocacy
- Outlined expectations
- Proactive discussions and planning
- Supportive attitudes
- Involvement in advocacy
- Plans for efforts
- MLST conversations and objectives

Short-term Outcome | Intermediate Outcome | Long-term Outcome

- Reduction of attitudinal obstacles in CES and broader community
- More understanding of expectations for MLST
- Prioritization of MLST
- Greater ease for CES members to provide MLST efforts
- Increased consensus and collaboration among CES members and leaders
- A conducive climate for MLST that
- Addresses positive attitudes toward suicide for CITs
- Aligns with broader community climate
- Derives from program consensus

Mediating factors
reaccreditation timelines
changes in staff
unanticipated suicide or related events
changes to suicide-related policies/protocols in broader community

Figure 4. Climate logic model. MLST = master’s-level suicide training; CES = Counselor Education and Supervision; CITs = counselors-in-training.
Similar mediating factors and inputs exist for climatic initiatives with some alterations. Changes to these protocols during the course of the initiatives could act as mediating factors. Inputs to support such initiatives include time and money for departmental communications and advocacy projects and information such as phenomenology of suicide, advocacy models, and accreditation and ethical standards. I discuss the implications for program leaders and Counselor Education and Supervision members based on a logic model example for a program initiative to enhance master’s-level suicide training readiness regarding climate.

**Stigma and responsibility.** The findings indicated climatic issues for members include views of suicide as an important but serious and heavy topic and master’s-level suicide training as “a necessary evil.” A preliminary approach is the use of program-level climate assessments and self-assessment. Self-assessment can reveal one’s attitudes and the way in which they support or hinder master’s-level suicide training efforts.

Strategies for self-assessment include formal instruments and self-reflection. Relevant formal instruments include measures such as the Attitudes to Suicide Prevention scale (Herron et al., 2001) and scales on reluctance and behaviors in situations involving suicide issues (Wyman et al., 2008). Introspective reflection about countertransference reactions to client suicidal behavior may also be helpful (Cureton & Clemens, 2015). Counselor Education and Supervision leaders and members may improve their attitudes toward suicide and master’s-level suicide training by reading relevant literature on hope in counseling with suicidal clients (Quinnett, 2009) and master’s-level suicide training practices for addressing fears of counselors-in-training about suicide issues in counseling (Miller et al., 2013). Leaders can set an attitudinal tone for a climate that is conducive to
master’s-level suicide training. Leaders can use information about the phenomenology of suicide to develop and model positive attitudes toward suicide and master’s-level suicide training.

**Broader advocacy.** Only a couple of participants in this study mentioned suicide prevention and advocacy projects in the Counselor Education and Supervision field which seem a fitting activity for climate initiatives to combat suicide stigma among members of the field, counselors-in-training, and broader community members. Program leaders such as department chairs and Chi Sigma Iota advisors may be positioned to guide faculty and students in local advocacy projects. The Community Readiness Model offers some suggestions for communication and social marketing initiatives (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014). Applied to suicide stigma among counselors-in-training and Counselor Education and Supervision members, they include:

- Events should be engaging and beneficial to counselors-in-training and members of Counselor Education and Supervision beyond only building knowledge about suicide and master’s-level suicide training.
- Speakers should connect the topics of suicide and master’s-level suicide training to other topics the community may be more ready to address (e.g., trauma, addictions, and bullying).
- Speakers should relate the information to the local situation (e.g., program and study priorities, a recent event, etc.).

Leaders and members of the Counselor Education and Supervision field can address suicide stigma in the broader community to enhance the climate for master’s-
level suicide training. Potential strategies include using local media and suicide prevention events to connect the field and the broader community. Two programs represented in the study employ similar projects through coordination of a suicide prevention walk and inclusion of relevant information in communications with students during Suicide Prevention Month. These initiatives can focus on reducing stigma and raising general awareness among the local community, the student population, and Counselor Education and Supervision professionals. This seems especially needed in communities where the attitudinal climate is unsupportive and/or knowledge about suicide and master’s-level suicide training is low.

**Clarifying and taking responsibility.** The study’s findings revealed beliefs about specific roles and competence required to provide master’s-level suicide training. Two of the program leader participants described their disagreement with these beliefs. Program leaders should clarify expectations about responsibility and competence for master’s-level suicide training. They may decide to address these attitudinal obstacles by reframing master’s-level suicide training as a shared and accessible responsibility for educators and supervisors in their program. Leaders could also support master’s-level suicide training by providing ways for Counselor Education and Supervision members with low self-efficacy to consider and achieve their responsibilities. Team teaching and use of online training or other sources may help supplement curriculum. I suggest ways for the field’s leaders to support its members for increasing their knowledge of suicide and knowledge of efforts using the next two logic models.

The study served to reveal obstacles for master’s-level suicide training throughout the Counselor Education and Supervision field and broader communities. Obstacles
concerned suicide stigma, role and responsibility, and competing priorities. Findings indicated a need for leadership and membership to improve attitudes, clarify definitions of responsibility and competence, and prioritize master’s-level suicide training.

These climatic activities should result in outputs and outcomes. Outputs may include increased leadership support and improved attitudes toward suicide and master’s-level suicide training, support and involvement in advocacy for the broader community, clearer expectations and planning conversations for addressing master’s-level suicide training responsibilities. Short-term outcomes meet the apparent needs for reduced obstacles, increased clarity, and greater prioritization. The Counselor Education and Supervision members in the current study described several elements of the climate within the field and the broader community which were not conducive to master’s-level suicide training. Initiatives that directly address climate issues should produce intermediate outcomes of greater ease, consensus, and collaboration among members and leaders of Counselor Education and Supervision regarding master’s-level suicide training which and leads to improved master’s-level suicide training. The next two models addresses knowledge in the field and master’s-level suicide training efforts.

**Logic Model 3: Knowledge of Suicide**

The study served to identify themes regarding knowledge of suicide in the Counselor Education and Supervision field. Findings indicate knowledge of suicide varies greatly between members due to differences in experience and training. The context of suicide knowledge is basic for most members and contains some misconceptions. Current sources of suicide knowledge may also be lacking. Inconsistent
knowledge of suicide overall appears to contribute to inconsistent master’s-level suicide training in the Counselor Education and Supervision field.

The study’s findings indicated the Counselor Education and Supervision field could improve readiness to provide master’s-level suicide training by addressing comprehensive and accuracy in suicide knowledge content and sources of content. Antecedent variables for knowledge of suicide initiatives are similar to other logic models. Geographic and economic factors and societal and local attitudes emerged in the study as impactful on the availability of suicide knowledge sources and the nature of their content. Suicide-related policies such as state requirements for suicide training among certain professionals may impact members’ knowledge of suicide. Ethical standards address the need for knowledge of suicide to ethically provide master’s-level suicide training and accreditation standards serve to name target areas of suicide knowledge for inclusion in master’s-level suicide training. Findings indicated member factors such as prior experience and training determine a member’s knowledge of suicide.

Similar mediating factors and inputs exist for knowledge of suicide and climate initiatives. A program’s involvement in reaccreditation, changes in staff and policies or protocols, and unanticipated suicides could act as mediating factors during knowledge of suicide initiatives. Inputs to support such initiatives include time and money for knowledge-sharing and information such as the American Association of Suicidology Core Competencies (2004) and evidence-based practice for counseling suicidal clients (National Action Alliance: Clinical Care and Intervention Task Force, 2013). I discuss the implications for program leaders and members of the field based on a logic model regarding knowledge of suicide, beginning with assessment of program members.
Antecedent variables
geographic and economic factors affecting the region, field, and nation
societal and local attitudes toward suicide and MLST
suicide-related protocols and policies in the broader community
accreditation and ethical standards
member factors (professional and personal experience, MLST and PD received)

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Logistical resources: time and money</td>
<td>- Leaders establish professional development requirements on suicide.</td>
<td>- Set(s) of PD requirements</td>
</tr>
<tr>
<td>- Information resources: access to latest information</td>
<td>- Leaders share information about KOS sources.</td>
<td>- Communications about KOS sources</td>
</tr>
<tr>
<td></td>
<td>- Leaders correct CES members’ misconceptions.</td>
<td>- Conversations about updated knowledge</td>
</tr>
<tr>
<td></td>
<td>- Leaders model and encourage use of literature and KOS discussions.</td>
<td>- Conversations about seeking KOS via professional literature and connections</td>
</tr>
<tr>
<td></td>
<td>- CES members complete professional development on suicide.</td>
<td>- Evidence of PD completion</td>
</tr>
<tr>
<td></td>
<td>- CES members use literature and discuss KOS.</td>
<td>- Citations of literature and KOS conversations</td>
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</tbody>
</table>

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<tr>
<th>Short-term Outcome</th>
<th>Intermediate Outcome</th>
<th>Long-term outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Clarity about PD requirements</td>
<td>- Increased and corrected knowledge of suicide</td>
<td>- MLST efforts that are provided by knowledgeable CES members</td>
</tr>
<tr>
<td>- Increased awareness of KOS sources</td>
<td>- CES members who are better prepared for and comfortable providing MLST</td>
<td>- Informed by the latest knowledge in the field</td>
</tr>
<tr>
<td>- Higher completion of PD related to suicide</td>
<td>- More willing to review literature and discuss KOS</td>
<td>- More accurate and consistent</td>
</tr>
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</table>

Mediating factors
reaccreditation timelines
changes in staff
unanticipated suicide or related events
changes to suicide-related policies/protocols in broader community

Figure 5. Knowledge of suicide logic model. MLST = master’s-level suicide training. PD = professional development; KOS = knowledge of suicide; CES = Counselor Education and Supervision.
A first step to enhance Counselor Education and Supervision’s readiness to provide master’s-level suicide training via knowledge of suicide is to assess members’ knowledge about suicide. It may be informative for members to complete formalized instruments despite the lack of standardization (Osteen et al., 2014). Potential instruments include: (a) the Suicide Intervention Response Inventory-2 (Neimeyer & Bonnelle, 1997); (b) any of the short scales developed by (Wyman et al., 2008) on knowledge, preparedness, and efficacy; and (c) the Counselor Suicide Assessment Efficacy Survey (Douglas & Wachter Morris, 2015). It is important to note that the latter two concern self-efficacy and that none of these measures are based on the American Association of Suicidology (2004) Core Competencies. A member of the Counselor Education and Supervision field may also benefit from self-reflection on one’s knowledge and efficacy by reviewing the core competencies (American Association of Suicidology, 2004) and the items on the Competency Assessment Instrument for Suicide Risk (Hung et al., 2012). Next I address knowledge of suicide implications for program leaders and other members of the field.

**Program leaders and knowledge of suicide.** Participants in the current study described obstacles to comprehensive and accurate knowledge of suicide among all members of Counselor Education and Supervision including deficiencies related to preparation to provide master’s-level suicide training, awareness of professional development, and suicide knowledge sources. One solution they identified was program requirements for suicide training. Some participants specifically called on program
leaders to establish suicide training requirements for site supervisors. This recommendation seems fitting for both supervisors and educators.

Participants in the current study described members’ misconceptions about suicide such as the distinctions and connections between non-suicidal self-injury and suicide and the use of no-suicide contracts. Leaders may be positioned to help members identify and correct their misconceptions. Participants also requested more communications from program leaders and included alerts about suicide knowledge sources such as upcoming professional development opportunities which members could use to update their knowledge of suicide.

The study’s findings included suicide knowledge sources other than professional development which may problematic. Master’s-level suicide training received, professional and personal experience, and informal conversations may not provide comprehensive, accurate, and updated knowledge of suicide. A few members in the sample mentioned professional exchanges in departmental meetings and site visits and collegial conversations about master’s-level suicide training. Leaders can model and encourage members to consult professional literature and online sources and to hold more professional conversations about suicide knowledge. Examples of literature and online sources appear in Table 11. Professional conversations could include consultations with suicide experts, departmental meetings on special topics, and collaborations between university members and site supervisors.
Table 11

*A Short List of Suicide Information Resources*

<table>
<thead>
<tr>
<th>Books</th>
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<tbody>
<tr>
<td>1. Suicide prevention in the schools: Guidelines for middle and high</td>
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<tr>
<td>school settings (Capuzzi, 2009)</td>
</tr>
<tr>
<td>2. Suicide: An essential guide for helping professionals and educators</td>
</tr>
<tr>
<td>(Granello &amp; Granello, 2007)</td>
</tr>
<tr>
<td>3. Building a therapeutic alliance with the suicidal patient (Michel</td>
</tr>
<tr>
<td>&amp; Jobes, 2011)</td>
</tr>
<tr>
<td>4. Counseling suicidal people: A therapy of hope (Quinnett, 2009)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A primer on suicidology: Implications for counselors (Laux, 2002)</td>
</tr>
<tr>
<td>2. Suicidal clients and supervisees: A model for considering supervisor</td>
</tr>
<tr>
<td>roles (McGlothlin et al., 2005)</td>
</tr>
<tr>
<td>3. Taking the fear out of suicide assessment and intervention: A pedag</td>
</tr>
<tr>
<td>ogical and humanistic practice (Miller et al., 2013)</td>
</tr>
<tr>
<td>4. Core competencies in suicide risk assessment and management: Implica</td>
</tr>
<tr>
<td>tions for supervision (Rudd et al., 2008)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. American Association of Suicidology (<a href="http://www.suicidology.org">www.suicidology.org</a>)</td>
</tr>
<tr>
<td>2. The Jason Foundation (<a href="http://www.jasonfoundation.com">www.jasonfoundation.com</a>)</td>
</tr>
<tr>
<td>4. Suicide Prevention Resource Center (<a href="http://www.sprc.org">www.sprc.org</a>)</td>
</tr>
</tbody>
</table>

These knowledge of suicide activities have intended outputs and outcomes.

Outputs include identified requirements for and completion of suicide-related professional development and communications about suicide knowledge and professional sources. Short-term outcomes meet the requests of the study’s participants for greater clarity about training, sources, and suicide knowledge content. Members of the Counselor
Education and Supervision field should also experience more willingness to consult professional sources for suicide knowledge. More guidance from program leaders and intentional action by members to seek suicide knowledge should produce intermediate outcomes of increased and corrected knowledge of suicide and the preparation and self-efficacy to provide master’s-level suicide training. As a result, master’s-level suicide training efforts should become more accurate and comprehensive since they are informed by the latest knowledge in the field and more consistent since they are provided by Counselor Education and Supervision members with more consistent suicide knowledge.

The Counselor Education and Supervision members in the sample conveyed a high value and need for preparation to provide master’s-level suicide training including enhanced knowledge of suicide. The knowledge of suicide domain received one of the higher readiness scores in the study; however findings clearly indicated that the nature and source of suicide knowledge content needs to improve. Initiatives regarding professional development and professional exchanges should enhance knowledge of suicide. Similar activities apply to knowledge of efforts and efforts which I discuss next.

**Logic Model 4: Efforts and Knowledge of Efforts**

The readiness stage for efforts is initiation (6 out of 9) and the stage for knowledge of efforts is preplanning (4 out of 9). The goal for increasing readiness in communities at the initiation stage is to “provide community-specific information” such as increasing evaluations and using in-services and outside meetings “to provide updates on progress of your efforts” (Plested et al., 2009, p. 28). The goal for increasing readiness at the preplanning stage is to “raise awareness with concrete ideas” and one strategy is a
review of existing efforts and consideration of their success (p. 28). I combine efforts with knowledge of efforts in the logic model below because these stage goals are complementary and efforts and knowledge of efforts have a reciprocal relationship.

The study’s findings indicated that master’s-level suicide training efforts do not comprehensively address suicide content for pre-professional counselor training, can contain inaccurate or outdated information, and vary by instructor and location. Participants attributed these issues of quality to insufficient planning and evaluation of master’s-level suicide training. Results also pointed to a lack of knowledge among Counselor Education and Supervision members about master’s-level suicide training beyond their own efforts.

Logic model 4 outlines a coordinated effort to improve efforts and knowledge of efforts in the Counselor Education and Supervision field. Antecedent variables for these initiatives are similar to other logic models. Geographic and economic factors and societal and local attitudes emerged in the study as impactful on efforts and knowledge of efforts. Suicide-related policies such as emergency response may impact master’s-level suicide training efforts. American Counseling Association ethical standards address the need for efforts that address ethics. Accreditation standards (Council for Accreditation of Counseling and Related Educational Programs, 2009, 2015) serve to guide the provision of master’s-level suicide training efforts and knowledge of efforts related to evaluations of student learning outcomes. Several participants in the current study described existing program structure that impacts master’s-level suicide training such as the division of program tracks by specialty area and the use of an on-campus training clinic versus off-campus practica.
Antecedent variables
geographic and economic factors affecting the region, field, and nation
societal and local attitudes toward suicide and MLST
suicide-related protocols and policies in the broader community
accreditation and ethical standards
program structure

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Logistical resources (time, money, space, and people)</td>
<td>- Leaders initiate and facilitate consensus meetings regarding program expectations informed by CACREP Standards and updated knowledge.</td>
<td>- Consensus conversations</td>
</tr>
<tr>
<td>- Information resources (guidelines for counseling practice and counselor training)</td>
<td>- Leaders plan and guide MLST evaluations.</td>
<td>- Evaluations of MLST efforts</td>
</tr>
<tr>
<td></td>
<td>- Leaders encourage members’ to maintain KOE.</td>
<td>- Meeting notes of leadership encouragement</td>
</tr>
<tr>
<td></td>
<td>- CES members participate in consensus meetings regarding program expectations for MLST placement, content, and methods.</td>
<td>- Consensus conversations</td>
</tr>
<tr>
<td></td>
<td>- CES members contribute to MLST evaluations.</td>
<td>- Evaluations of MLST efforts</td>
</tr>
<tr>
<td></td>
<td>- CES members maintain KOE via communication with other professionals and professional development.</td>
<td>- Completed conversations, reading, and training</td>
</tr>
</tbody>
</table>

Short-term Outcome
- Consensus about placement, content, method, and responsible parties for MLST
- Increased understanding of CACREP Standards and latest knowledge
- Greater clarity about program requirements

Intermediate Outcome
- Increased knowledge of efforts
- CES members who are better prepared to provide ideal MLST efforts
- Improved quality and consistency of MLST

Long-term Outcome
- MLST efforts that are Derived from program consensus and aligned with program requirements
- Informed by evaluations
- Based on CACREP Standards and latest knowledge

Mediating factors
reaccreditation timelines
changes in staff
unanticipated suicide or related events
changes to suicide-related policies/protocols in broader community

Figure 6. Efforts and knowledge of efforts logic model. MLST = master’s-level suicide training; CACREP = Council for Accreditation of Counseling and Related Educational Programs; KOE = knowledge of efforts; CES = Counselor Education and Supervision.
The model also includes mediating factors and inputs. Similar mediating factors exist for efforts and knowledge of efforts initiatives. Inputs to support such initiatives include logistical resources such as time, money, space, and people for delivering, evaluating, and redesigning master’s-level suicide training efforts. Information resources include guidelines for counseling practice regarding suicide and for counselor training and specifically master’s-level suicide training. Evaluation models can also inform knowledge of efforts initiatives.

Program leaders can establish expectations for master’s-level suicide training efforts that target goals of comprehensiveness, accuracy, and consistency between efforts. Findings indicated disagreement among Counselor Education and Supervision members regarding master’s-level suicide training. Administrators, educators, and supervisors can work together to reach agreement on ideal placement, content, and methods as some participants described during program reaccreditation projects.

The study’s findings indicated members of the Counselor Education and Supervision field utilize professional development, literature, and formal communications to develop knowledge of efforts; however no participants depicted program-level evaluations of master’s-level suicide training. Program leaders can facilitate conversations among members affiliated with the program about current and potential master’s-level suicide training efforts. Members of the field can continue to seek knowledge of efforts from such sources. Leaders can guide evaluative initiatives and the use of results to inform future efforts. These logic models and literature on program assessments and planning in the Counselor Education and Supervision field (Barrio
Minton & Gibson, 2012; Engels, Barrio Minton, Ray, & Associates, 2010) offer structure for these initiatives.

The activities for efforts and knowledge and efforts have associated outputs and outcomes. Outputs include deliberate conversations and evaluations of master’s-level suicide training. Short-term outcomes meet the apparent need for greater consensus and clarity about current and target efforts and the standards, knowledge, and program goals that guide them. Added intentionality and strategy should yield greater knowledge of efforts and preparation to provide master’s-level suicide training that is consistent within a counselor training program. Resultant master’s-level suicide training efforts should be aligned with standards, objectives, and updated knowledge and informed by evaluation.

Findings from the current study indicate similar deficiencies between knowledge of suicide, efforts, and knowledge of efforts. Efforts and knowledge of efforts in Counselor Education and Supervision lack comprehensiveness, accuracy, and consistency. The study’s findings indicate the field could improve readiness to provide master’s-level suicide training with more intentional planning and communication.

This section included logic models for resources and leadership, climate, knowledge of suicide, and efforts and knowledge of efforts. A coordinated project could feasibly involve all models. Such a project may be more justifiable to university leaders and other support sources and more impactful for Counselor Education and Supervision members and the community. More research is needed to understand the issues of readiness and master’s-level suicide training in counselor education and supervision. I identify directions of future research in the next section.
Directions for Future Research

The study’s findings prompt future research projects related to master’s-level suicide training and other pre-professional preparation topics. A number of gaps remain in the areas of training efforts and knowledge of such efforts, leadership, climate, and resources. I briefly enumerate them here.

Efforts and Knowledge of Efforts

No members in the current study stated that their programs utilized the education and supervision models in the master’s-level suicide training literature (Hoffman et al., 2013; McAdams & Keener, 2008; McGlothlin, Rainey, & Kindsvatter, 2005; Miller, McGlothlin, & West, 2013; Wozny & Zinck, 2007). It may benefit the Counselor Education and Supervision field to know if any counselor or other training programs incorporate these models and if so, how and to what effect. Given the amount of conceptual literature in the field on master’s-level suicide training, results from such a study could guide application of these models in other programs, inform the models, and indicate the level of need for any continued conceptual contributions.

An example arose in the study of a member using an online course management system for delivering master’s-level suicide training content in an attempt to overcome the obstacle of lack of time. Counselor Education and Supervision members may use nontraditional or innovative teaching methods to overcome obstacles to master’s-level suicide training and other training. A number of publications include ideas and descriptions of such methods in counselor education (e.g., Young & Hundley, 2013) including suicide training (Cook et al., 2007; Miller et al., 2013). It is unknown how
many members of the field use such approaches for suicide and related training efforts, nor how they serve to overcome obstacles and how well they work.

A key finding in this study was the lack of master’s-level suicide training evaluation efforts. There is a dearth of research literature on counselor training on ethics and assessment (Barrio Minton et al., 2014) and suicide training outcomes across mental health and other fields (Osteen et al., 2014). More publications are needed that contain outcomes research including program evaluations on master’s-level suicide training. Members of the Counselor Education and Supervision field could greatly benefit from reviewing the findings as well as the methods to consider adopting evaluation procedures into their work.

Elements to support training and training research are defined competencies and standardized measures. The American Association of Suicidology (2004) Core Competencies provide competency domains for those who work with individuals at risk for suicide. The U.S. Surgeon General asserted through the National Strategy for Suicide Prevention (2012) that: graduate programs should “ensure that graduates achieve the relevant core competencies in suicide prevention appropriate for their respective discipline” (p. 47). No published research identifies the core competencies for counselors or counseling specialties regarding suicide prevention. A continuing need exists for standardized measures of competency-based knowledge, skills, attitudes, and self-efficacy to address suicide issues in counseling (Osteen et al., 2014).

This study’s findings supported the need for future research that addresses the literature gap on doctoral preparation to instruct and supervise (Barrio Minton et al., 2014). Studies that seem particularly relevant regard doctoral preparation that (a)
addresses attitudes toward counselor training content, (b) covers the American Counseling Association Code of Ethics (2014) standards for counselor educators and supervisors, and/or (c) targets specific counselor training content (e.g., suicide, crisis, or trauma).

Climate and Leadership

Several directions emerged for future research related to climate and leadership. The study’s findings revealed a sharp distinction between positive and negative attitudes toward master’s-level suicide training. A study of attitudes and belief toward suicide and other counselor training topics could serve to reveal areas of the attitudinal climate that most support and hinder counselor educators and supervisors from addressing these topics in their efforts. This information could be used to guide campaigns within the profession to improve negative attitudes. The issue of priorities also arose in the study and within more than domain. No published literature has served to explore how Counselor Education and Supervision members and leaders prioritize counselor training topics and what impact their prioritization has on efforts. Such a study could reveal what factors influence members’ priorities most and could also be used to compare against counselor training content priorities among counselors-in-training, recent graduates, and employers. This line of research could inform understanding of program’s gaps in efforts and curricular decision-making approaches, comparable and distinct desires among stakeholders, and potential needs for enhancing curriculum or accreditation standards.

Program leaders were the target of praise, criticism, and requests in this study. A few areas of future research may benefit program leaders regarding master’s-level suicide training and related training administration. Comments from this study’s participants
pertained to communication and leadership approaches among program leaders. A study on leadership and/or communication styles among program leaders and the perceived impact on accreditation implementation and other markers of program success could highlight beneficial leadership practices for program administrators. A few participants mentioned their programs hold community development trainings and/or site supervisor trainings and meetings. A relevant idea for future research is a study about the engagement of site supervisors by counselor training program leaders and representatives. Understanding the impetus, process, and resources for such an initiative could inform the creation of similar initiatives across the Counselor Education and Supervision field. Knowing the challenges and results of these initiatives could also benefit program leaders and others.

Other areas of future research include accreditation standards and policies. The study’s findings seem to indicate that the Counselor Education and Supervision members have not yet considered the 2016 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2015) and their implications for master’s-level suicide training and other efforts. A study could serve to explore how members of the field interpret the relevant 2016 Standards and what ideas or plans they have to implement them. This seems important considering the possibility that the removal of suicide-specific language in the 2016 specialty standards could result in a regression away from infusion throughout the curriculum. Accreditation and thought leaders in the field of Counselor Education and Supervision may use this information to create targeted messages of alternative implementation options for master’s-level suicide training and other crisis topics.
The study’s findings may indicate either a lack of awareness among members of Counselor Education and Supervision about existing state policies related to suicide training or a desire to mimic them in their settings. The impact of these policies remains largely unknown. A study about changes attributed to the implementation of the Matt Adler Act and the Jason Flatt Act could inform policymakers as well as counselors, members of the field, and field leaders who wish to pursue related policies in their states.

**Knowledge of Suicide and Resources**

The study’s findings revealed a lack and inconsistency of suicide knowledge among counselor educators and supervisors. Future research on the missing content and primary contributions to inconsistency would inform program and thought leaders on needed professional development. Journal and conference leaders might use this information to create special issues and/or sessions on missing content.

Only one program represented in the study appeared to have significant financial resources to support master’s-level suicide training. Future research on counselor training programs with large and steady funding and other resources could inform program leaders and administration above them on potential methods for securing support for master’s-level suicide training and other initiatives.

A final direction of future research is readiness assessment and change implementation. In addition to the Community Readiness Model, a number of change models exist (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Fullan & Scott, 2009; Rogers, 1962, 2010) that could guide future assessment and implementation research on Counselor Education and Supervision and master’s-level suicide training. Future studies could serve to explore the readiness of a specific program to provide master’s-level
suicide training or the readiness of another mental health field to provide master’s-level suicide training. Future readiness studies could include other members of the counseling or Counselor Education and Supervision communities and/or a sample containing equal representation of members by settings. I explain this further in the next section which addresses limitations of the current study.

**Limitations**

There are numerous implications and directions for future research identified as a result of this study. Some limitations also exist. Limitations primarily regard the design. Two limitations relate to the sample. The community defined in this study was the Counselor Education and Supervision field including educational, supervisory, and administration professionals affiliated with master’s programs and professionals who research and/or guide the work of the profession such as the Association for Counselor Education and Supervision and the Council for Accreditation of Counseling and Related Educational Programs. Counselors-in-training were necessarily excluded from the sample based on the definition of the community. Users of the Community Readiness Model often include community members who may be directly served by the prevention effort (Plested et al., 2009). I wanted to focus solely on community members who provide and/or impact master’s-level suicide training. The findings, particularly those that emerged in climate about members’ attitudes toward master’s-level suicide training and counselors-in-training, appear to demonstrate that counselors-in-training can and do impact master’s-level suicide training if indirectly. Future application of the Community Readiness Model to Counselor Education and Supervision’s readiness to provide
master’s-level suicide training may be improved with the inclusion of counselors-in-training and even recent graduates.

Another limitation related to the sample was the use of snowball sampling. This method of sampling is more appropriate and acceptable in the qualitative research paradigm than in quantitative studies. Its use in this study resulted in two programs being represented by two participants each: a university member and a site supervisor member. It is difficult to say what positive or negative impact this may have had on the findings, especially since the two representatives provided fairly different data in both program cases. Future research of the Counselor Education and Supervision’s readiness to provide master’s-level suicide training in which university and site members comprise the sample may be improved with equal representation from both parties throughout the sample.

A limitation related to analysis was the reduced responsibilities for the other two team members in Phase 2. All members coded the data; however only two members scored for the Community Readiness Model and I developed the core ideas for the team to review and edit. Consensual Qualitative Research methodologists offer this option of “shortcutting the process,” and we followed their direction to ensure “all members of the team remain close to the data and reach consensus on the content of each core idea” (Thompson, Vivino, & Hill, 2012, p. 115-6). This seemed a reasonable option especially as a dissertation study. Nonetheless this restricted the amount of independent analysis by two of the team members.

The study appears to have fulfilled its purpose of assessing and exploring Counselor Education and Supervision’s readiness to provide master’s-level suicide training. The intention of this endeavor was to provide the field with updated information
that members and leaders can use to understand and enhance readiness in preparation for improving master’s-level suicide training efforts. The results addressed this need and also include information about potential relationships between readiness domains for master’s-level suicide training and calls for support from leaders beyond the Counselor Education and Supervision field.

**Conclusion**

Recent developments in accreditation, ethical, practice, and training standards provide a foundation for the Counselor Education and Supervision field to change master’s-level suicide training. It was unclear, however, if and how the field is ready to change master’s-level suicide training as no published research comprehensively addressed diverse perspectives from Counselor Education and Supervision community members on the field’s readiness to provide master’s-level suicide training. No publications contained updates on the status of master’s-level suicide training efforts since the implementation of the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009) and very little was known about the field’s leadership, climate and resources for master’s-level suicide training nor the knowledge about suicide and master’s-level suicide training among members.

The Tri-ethnic Center faculty initially created the Community Readiness Model to stop the trend of unsuccessfully or inconsistently implemented prevention efforts (Edwards et al., 2000). This readiness model was applied to a study of the Counselor Education and Supervision field and master’s-level suicide training in an effort to lay the groundwork for change in the field. Counselor Education and Supervision is in a preplanning stage (4 out of 9) to provide master’s-level suicide training with readiness
ranging from initiation (6 out of 9) for efforts to vague awareness (3 out of 9) for resources. The stage results alone indicate the field may have implemented master’s-level suicide training efforts before the community was fully ready to sustain successful change.

The inclusion of master’s-level suicide training content in core standards in the 2009 Standards (Council for Accreditation of Counseling and Related Educational Programs, 2009) has resulted in improved knowledge of suicide for some Counselor Education and Supervision members and in changed perspective of master’s-level suicide training as a central counselor training topic. The study’s findings indicate community-wide issues remain with consistency, communication, prioritization, and preparation. Obstacles regarding climate and resources include lingering negative perspectives, differences in power and policies, and economic realities which impact the field and master’s-level suicide training. Leaders and members can collaborate to self-evaluate and address these obstacles and to improve the climate toward suicide and master’s-level suicide training in the field and beyond. Readiness initiatives may benefit from the existing concern in the broader and Counselor Education and Supervision communities about suicide as a public health issue, the belief that master’s-level suicide training is an important component of counselor training, and its presence in the 2009 Standards and the 2016 Standards. Readiness initiatives may serve to harness these attributes to translate them into greater priority for consistent and quality master’s-level suicide training efforts.

Several foundations support the Counselor Education and Supervision field to provide master’s-level suicide training. Counselor educators and supervisors who aim to address their ethical obligation to use the latest knowledge in the field to provide
master’s-level suicide training that meets accreditation standards can access guidance from the field’s thought leaders and information from national organizations such as the American Association of Suicidology (2004) Core Competencies and the Clinical Workforce Preparedness Guidelines (2014). Leadership’s policies and support have increased the focus on suicide and mental health issues and funding and resulted in suicide training offerings and suicide prevention organizations that members of Counselor Education and Supervision can use to improve knowledge of suicide, master’s-level suicide training efforts, knowledge of efforts, and climate.

This study includes logic models for these dimensions that leaders within and beyond Counselor Education and Supervision (CES) and members of the CES field can use to appraise and guide readiness enhancement and master’s-level suicide training improvement initiatives. Increased existence of master’s-level suicide training efforts in counselor training programs and continuous support of knowledge of suicide from some CES leaders provides the field an opportunity to further assess readiness and evaluate master’s-level suicide training. This study and its implications included practical tools that community members can use to ensure readiness-based intentional change initiatives in the CES field become an enduring trend.
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APPENDIX A

PILOT STUDY
PILOT STUDY

An evaluative case study served as a pilot for a Consensual Qualitative Research project using the Community Readiness Model to explore Counselor Education and Supervision’s readiness to provide master’s-level suicide training. The purpose of the case study was to use explicit criteria to evaluate the application of: (a) the Community Readiness Model framework and (b) the Consensual Qualitative Research methods of data collection, analysis, and researcher collaboration. The evaluative study involved case study methodology specific to evaluation, including cross-case analysis and other means to maximize rigor.

Three case study participants included two members of the Counselor Education and Supervision field which I refer to as CES participants and one co-researcher participant. The CES participants consisted of one program administrator and one full-time instructor and the co-researcher participant was a doctoral student in Counselor Education and Supervision. The participants had varying levels of education and experience including academic and professional engagement in multiple counselor training programs across three regions of the Association for Counselor Education and Supervision.

Each CES participant completed a one-hour, 18 to 20-question interview conducted by one co-researcher while the other observed. I developed a list of 26 interview questions in preparation for a pilot study by customizing interview questions from Community Readiness Model manuals (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014) to fit the issue of suicide and the community called the Counselor Education and Supervision community. I referred to efforts as suicide
preparation efforts. In addition to two broad questions, two to four questions targeted each dimension of readiness. The first interview contained 22 questions and lasted just over an hour.

I transcribed the first CES participant interview. Then the co-researchers completed independent coding and analysis followed by a consensus meeting to develop a follow-up email for the CES participant. The follow-up email included requests for clarification and expansion about some of the interviewee’s responses.

The interview with the second CES participant differed slightly from the first based on emergent findings using data from the first interview observation, researcher journals and discussions, and feedback from the first interview participant. The second interview: (a) contained fewer questions per dimension and a total of 17 questions; (b) was preceded by an email to the participant containing the interview questions, which included an introduction to the scope of the research and terminology used in the interview; (c) began with a spoken review of the introduction; (d) was less structured in that it included more verbal attending such as minimal encouragers, more clarification questions and example prompts, and more open-ended questions.

Recommendations for the full study were the result of these data and case study interviews with each of the three participants about their perspectives on the evaluative elements. The evaluative case study of the pilot revealed that modifications between the interview with the first CES participant and the second CES participant were beneficial. I determined that fewer questions and a longer interview could potentially yield even richer data. Participants and researchers concluded that using the following terminology would be clearer: Counselor Education and Supervision field instead of Counselor Education
and Supervision community and counselor preparation on suicide or something similar instead of suicide preparation. Interviewers and researchers confused the term suicide preparation with suicide prevention. I incorporated feedback from my dissertation committee during my proposal and changed the term to master’s-level suicide training.

The evaluation of the pilot revealed that some follow-up communication helped to clarify the researcher’s potential misconceptions and fill gaps in the data. This follow-up communication was reportedly convenient and effective. The full study included an abbreviated member check based on results of the pilot study. The member check involved a follow-up communication email that includes the emerging domains, up to three clarification questions, and a request for any further reflections.

Community Readiness Model Framework

The Community Readiness Model (CRM) framework appeared fitting and sufficient for the constructs and population. Participants spoke about the Counselor Education and Supervision community related to suicide, defined efforts, and provided data that aligned with CRM dimensions. Some content of the interview participants’ answers and of the co-researchers’ discussions were outside of the study’s intended scope (e.g., pertaining to supervision toward licensure post-graduation). Researchers needed more time in team meetings to address and reach consensus on CRM scoring. The resultant design of the proposed full study includes: (a) a refined purpose and scope, (b) more clearly defined constructs (e.g., readiness of Counselor Education and Supervision to provide master’s-level suicide training) and (c) greater attention to CRM scoring time in the proposed analysis process.
Consensual Qualitative Research Methodology

The case study served to evaluate three methodological sub-elements: (a) data collection, (b) analysis, and (c) researcher collaboration. Data collection included a demographic questionnaire and an interview. The findings included an evaluation of the demographic questionnaire as convenient, comprehensive, and mostly clear. A recommendation to boost clarity in the full study involved changing the matrix about previous roles into separate questions.

Data collection seemed inhibited when the research interviewer precisely applied the Community Readiness Model manual interview protocol (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014) in a highly structured fashion. Participants found some language confusing, especially when the following were absent: (a) an introduction including terminology and definitions, (b) consistent repetition of phrases, and (c) use of clearer terms targeting the scope of the research. The interview with the second participant involved: these three elements as well as a less structured protocol and fewer questions. These changes aligned more closely with Consensual Qualitative Research guidance (Hill et al., 2005). The second interviewee participant and researchers reported more clarity in the second interview than in the first. The proposed full study incorporates these elements in its data collection design including

- an hour and a half timeframe for each interview;
- a typed and spoken introduction to the interview which includes the scope of the research as the focus of the interview and a list of terminology and definitions; and
• a semi-structured interview format containing, clarification and example
  prompts, minimal verbal and nonverbal encouragers, and fewer questions.

Data analysis evaluation focused on the coding and analysis process and the
member check process and product. Researchers concluded independent coding and
analysis was fairly convenient and somewhat clear. The use of Community Readiness
Model dimensions as domains aided in segmenting and coding the data. This streamlined
the analysis process for interpretation of meaning within each dimension and potential
follow-up questions.

Interview participants reported appreciating but fully agreeing with the content of
the member check. This finding supports the assertion of Hill et al. (2005) that traditional
member checking may not always be effective or necessary in Consensual Qualitative
Research. The full study included an abbreviated member check based on pilot study
results. This involved a follow-up communication email that includes the emerging
domains, up to three clarification questions, and a request for further reflections.

The researcher collaboration process was another methodological sub-element
evaluated in the case study. The use of two researchers was an easy enough process,
though researchers anticipated the addition of the recommended third team member and
external auditor (Hill et al., 1997) could add further complications to information
management, discussion time, and team member responsibilities. For these reasons, the
study instituted (a) tracking and version control procedures (e.g., line and file
numbering), (b) a team schedule, (c) longer team meetings, and (d) procedural
simplifications, such as team rotation and a second phase (Hill et al., 2005; Thompson et
al., 2012).
APPENDIX B

RECRUITMENT EMAIL
Dear Dr. _____,

My name is Jenny Cureton, and I am a doctoral candidate at the University of Northern Colorado (UNC). Your name was randomly selected as a potential participant for my dissertation study on the readiness of Counselor Education and Supervision to provide master's-level suicide training. This study has received approval from the UNC Institutional Review Board.

You do NOT have to have expertise in suicide-related topics or experience providing master's-level suicide training to participate.

Anticipated total participation time of two hours includes:
1. brief (less than 10-minute) online questionnaire linked below
2. 1-1.5 hour phone interview scheduled at your convenience, and
3. your optional response to follow-up email containing less than five questions.

Click here to complete an online informed consent and brief demographic questionnaire. You are welcome to forward this link to other instructors, supervisors, and administrators in your or other programs accredited by the Council for Accreditation of Counseling and Related Educational Programs. Thank you for considering participating in this study of our field.

Sincerely,

Jenny Cureton, LPC

P.S. Participants who complete the study will be provided with: a compact disc of suicide resources, an executive summary of the research including a reference list, and a $20 gift card.
APPENDIX C
ONLINE CONSENT
ONLINE CONSENT
UNIVERSITY OF
NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH

Project Title: Readiness of Counselor Education and Supervision to provide master’s-level suicide training
Primary Researcher: Jenny Cureton, Counselor Education and Supervision, 817-988-2164 jennycuretonLPC@gmail.com
Faculty Advisor: Dr. Elysia Clemens, Counselor Education and Supervision, 970-351-3044 elysia.clemens@unco.edu

Thank you for your potential interest in participating in my dissertation study on the readiness of the Counselor Education and Supervision field to provide master’s-level suicide training. My name is Jenny Cureton, and I am a Ph.D. Student in Counselor Education and Supervision at the University of Northern Colorado. Whether you learned about the study because you were randomly selected as a potential participant or you heard about it from a colleague, I am glad you arrived to this page, which will provide more information about study for your consideration. If you provide consent to participate below, you will then be guided to a brief, 11-item questionnaire on demographics and study criteria.

The criterion for participating in the study is to teach, supervise and/or serve as an administrator (e.g., program coordinator, department chair, training clinic director) in affiliation with a counseling program accredited by the Council for Accreditation of Counseling and Related Educational Programs. Both full-time and part-time instructors and supervisors (e.g., adjuncts, site supervisors, as well as full-time faculty) qualify to participate. You are welcome to forward this link to other instructors, supervisors, and administrators in your or other accredited programs.

Participation of two hours or less:
1. One questionnaire: less than 10 minutes, online, 11 questions
2. One phone interview: 1-1.5 hour at your convenience, audio-recorded
3. One email response (if desired): review a list of domains, answer up to three clarification questions, share any additional reflections

Beyond potential inconvenience of your time contributing to this research, two common risks are known: the unintended release of confidential information to unidentified third parties and discomfort in discussing the topic. These risks are considered no greater than those experienced during a normal work day. To protect your confidentiality, you will provide an alias. Only I, the primary researcher, will know your real name. A research
A team consisting of me and two other members will complete an initial analysis of the interview transcript. Data will be stored in a password-protected computer file. Software applications used in this study utilize data security measures, including password protection and/or data encryption: Qualtrics - Transport Layer Security encryption; NVivo - No encryption available (However, NVivo software is required to open any file. File-level passwords will be used to restrict access.); and Dropbox - 256-bit Advanced Encryption Standard and Secure Sockets Layer/Transport Layer Security. Only de-identified data will be shared with the research team (i.e., your name, your university name, and location redacted), and research team access to these data will end upon completion of data analysis. Consent forms will be deleted three years after final submission of my dissertation. The names of participants will not appear in any professional report of this research, and demographic and other information that may be particularly identifying will be masked. Also, though the focus of the study is master’s-level suicide training, discussing such a topic may result in some discomfort. Some participants (e.g., those who have experienced the loss of a client by suicide) may be vulnerable to traumatic stress or grief symptoms when discussing this topic. Participants are encouraged to self-monitor for such responses and to seek therapeutic assistance if needed or desired.

You may stand to benefit from participating in this study by learning more about suicide, suicide in counseling, and suicide training. You may also learn more about the readiness framework applied in this study and/or the Consensual Qualitative Research (CQR) method. Participants who complete the study will be provided with: a compact disc of suicide resources, an executive summary of the research including a reference list, and a $20 gift card. Finally, your participation may benefit the field of Counselor Education and Supervision and the study of suicide training.

Participation is voluntary. You may decide not to participate in this study. If you begin participation, you may decide to withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. You may print this screen for future reference. Please let me know what questions you may have about the study. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, 25 Kepner Hall, University of Northern Colorado, Greeley, CO 80639; 970-351-1910.

After reading this and getting your questions answered, simply click here if you are interested in participating. By clicking here, you are giving permission to participate. The link will first take you to a page that will prompt you to print out the Consent Form for your records. You can then proceed to a brief demographic questionnaire, which should take less than 10 minutes to complete.

Thank you for considering participating in this study of our field.
Sincerely,
Jenny Cureton, LPC
APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE
DEMOGRAPHIC QUESTIONNAIRE

Thank you for your agreeing to participate in my study on the readiness of the Counselor Education and Supervision (CES) field to provide master's-level suicide training. Basic information about study participation is repeated here, followed by a brief questionnaire.

Sincerely,
Jenny Cureton, LPC

*Indicates a required field.

*Name:

Preferred prefix (Dr., Ms., etc.):

*Preferred email address:

Preferred phone number:

*Do you currently do the following in a CACREP-accredited master’s in counseling program(s)? Check all that apply.
  Teach (full-time or otherwise)
  Supervise (as either a university or a site supervisor)
  Serve as an administrator (e.g., department chair)
  None of the above

What is your primary current role in that program?
  Full-time faculty
  Adjunct instructor
  University supervisor
  Site supervisor
  Program administrator

How recently have you provided master’s-level suicide training (education and/or supervision of counseling students and/or interns about addressing suicide in counseling)? NOTE: This is not a required criterion to participate in this study.
  Within the last year
  Within the last two years
  Within the last five years
  Within the last eleven years
  More than eleven years ago
Do you have specialization or expertise in suicide and/or related education in counselor training? Such expertise may include publications or presentations on counselor preparation related to suicide or crisis, or having received training as a trainer for suicide education of counseling/clinical professionals). NOTE: This is not a required criterion to participate in this study.

Yes
No

Gender:

Ethnicity:

Name of university NOTE: This information will not be shared in any public forum. It is simply for the researcher to use in gathering program-specific data toward the goal of program diversity in the study sample.

Thank you for completing the demographic questionnaire. I will be in touch via email shortly to schedule and/or confirm the phone interview.
APPENDIX E

INTERVIEW INTRODUCTION AND QUESTIONS
INTERVIEW INTRODUCTION AND QUESTIONS

Thank you for your willingness to participate in this interview! Below is an explanation of the focus and terms used in the study. Also included is a list of potential interview questions, in case you would like to follow along during our discussion.

Terms

This study’s focus is the readiness of the Counselor Education and Supervision (CES) field to provide master’s-level suicide training. Readiness may involve efforts to provide master’s-level suicide training and the field’s knowledge of these efforts, the climate in CES related master’s-level suicide training, CES leadership’s approach regarding such training, the field’s knowledge about suicide, and resources available to those in the CES field for master’s-level suicide training.

The Counselor Education and Supervision field (CES) refers to:
- counselor educators (full-time, adjunct, and others),
- counseling supervisors (university, site, and others), and program administrators,
- as well as researchers, organizational leaders, etc.

Master’s-level suicide training refers to:
- education and/or supervision provided to master’s in counseling students
- in any/all counseling specialty areas related to the topic of suicide.

I invite you to use your previous experiences and different roles in the field to inform your answers. However, please focus your perspectives on current readiness.

Interview Questions

*Asterisks indicate potential prompts that can be used, as needed, to elicit more information from interview participants.

1. In general, what has been your experience with master’s-level suicide training?

I would like to ask you about efforts in CES to provide master’s-level suicide training. By efforts, I mean education and supervision provided to master’s in counseling students about suicide.

2. Can you briefly describe the efforts CES takes to provide master’s-level suicide training? (*When do they happen? Where? What is the approach/method of training? What is the content?)

3. How much do members of the CES field learn about these current efforts to provide master’s-level suicide training?

4. Do you know if there are any evaluations of master’s-level suicide training efforts that let CES know what works and does not work when it comes to providing master’s-level suicide training? Please explain.

5. What you believe are the strengths of the efforts?

6. What about the weaknesses?
I would like to ask you about leadership in CES. Leadership includes anyone in CES who serves as a guide for the field or otherwise has influence.

7. Do leaders in CES support or oppose current efforts to provide master’s-level suicide training? (*Who? How?)

8. On a scale from 1 to 10, how much of a concern or priority is master’s-level suicide training to the leadership of CES, with 1 being “not at all” and 10 being “of great concern”? Please explain.

What about other members of the CES field including faculty, adjuncts, university and site supervisors, researchers, etc.

9. What is the CES field’s attitude about providing master’s-level suicide training?

10. What are the primary obstacles for CES to provide master’s-level suicide training?

Now I would like to ask more specifically about suicide.

11. How much would you say members of the CES field know about suicide? Nothing, a little, some, a lot? Please explain.

12. Are there misconceptions about suicide in the CES field? If yes, what are they?

13. How do CES field know or learn about suicide? (*How do they access and use information on suicide?)

When it comes to support for master’s-level suicide training efforts…

14. Are there resources to support master’s-level suicide training? (*Money, time, staff, training, etc.) Please explain.

15. Are you aware of any proposals or action plans in CES to improve master’s-level suicide training?
APPENDIX F

FOLLOW-UP EMAIL EXAMPLE
FOLLOW-UP EMAIL EXAMPLE

Dear Dr./Ms./Mr. _____,

Thank you again for your participation in my dissertation study on the readiness of Counselor Education and Supervision (CES) to provide master's-level suicide training. Below are current research domains. We welcome your clarification and answers to the follow-up questions. To ensure your response is included in continued analysis, I kindly ask that you reply by next Wednesday.

Sincerely,
Jenny Cureton, LPC

Dimensions
Community Efforts
Community Knowledge of the Efforts
Leadership
Community Climate
Community Knowledge about the Issue
Resources related to the Issue
Another dimension, if determined by research team

Examples of Potential Follow-up Questions
1. You mentioned in your interview that CES leadership seems very supportive of master's-level suicide training efforts, and you specifically mentioned ways you and others have received such support. Could you speak to how long that has been the case, and anything you believe was a catalyst or is a prerequisite for this type of support?

2. During your interview you contrasted the efforts, knowledge, and support for master's-level suicide training to your area of expertise (child abuse and neglect). Do you believe there is an explanation of how or why CES seems more ready to address one than the other? Please explain.

Opportunity to Share Additional Reflections
If you would like to share additional reflections on the topics we discussed in the interview, please do so here.
APPENDIX G

ANALYSIS PROCESS OVERVIEW
ANALYSIS PROCESS OVERVIEW

| Phase 1: Initial cases | 1. Independent coding – case 1 |
|                        | 2. Initial consensus – case 1 |
|                        | 3. Independent analysis – case 1 |
|                        | 4. Secondary consensus and scoring – case 1 |
|                        | 5. Audit – case 1 |
|                        | 6. Independent coding, analysis, and scoring – cases 2 and 3 |
|                        | 7. Consensus – cases 2 and 3 |
|                        | 8. Audit – cases 2 and 3 |
|                        | 9. Follow-up consensus and preparation for Phase 2 |

| Phase 2: Remaining cases | 1. Independent coding and analysis – each set of three cases |
|                         | 2. Pre-consensus and independent scoring |
|                         | 3. Initial consensus |
|                         | 4. Audit |
|                         | 5. Follow-up consensus and repeat for next set of three cases |

| Phase 3: Cross-analysis | 1. Categorization |
|                         | 2. Audit |
|                         | 3. Frequencies |
|                         | 4. Final scores |
|                         | 5. Final meeting |

*Figure 7.* The analysis process overview displays the three phases of analysis and their corresponding steps.
APPENDIX H

DIMENSIONS OF READINESS
**DIMENSIONS OF READINESS**

The wording describing the six dimensions below has been adapted from the Community Readiness Model (Plested et al., 2009; Tri-Ethnic Center for Prevention Research, 2014) to fit the identified issue, focus on efforts, and community of this study.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of Suicide</td>
<td>The nature and extent of knowledge in the Counselor Education and Supervision field about suicide</td>
</tr>
<tr>
<td>Leadership</td>
<td>The attitude and support of leaders in the Counselor Education and Supervision field related to master’s-level suicide training</td>
</tr>
<tr>
<td>Efforts</td>
<td>The existence and nature of efforts in Counselor Education and Supervision to provide master’s-level suicide training (e.g., instruction, supervision, policies, etc.)</td>
</tr>
<tr>
<td>Knowledge of Efforts</td>
<td>What and how much members of the Counselor Education and Supervision field know about master’s-level suicide training efforts and their effectiveness</td>
</tr>
<tr>
<td>Climate</td>
<td>The attitude in Counselor Education and Supervision toward suicide and master’s-level suicide training</td>
</tr>
<tr>
<td>Resources</td>
<td>The nature and availability of resources (e.g., people, time, money, space, etc.) present and needed to support efforts in Counselor Education and Supervision to provide master’s-level suicide training</td>
</tr>
</tbody>
</table>
APPENDIX I

STAGES OF READINESS
STAGES OF READINESS

The wording of the nine readiness stages was adapted from the Community Readiness Model (Plested et al., 2009; TECPR, 2014) to fit the identified issue, focus on efforts, and community for this study.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: No Awareness</td>
<td>The Counselor Education and Supervision field (CES), including its leaders, are not generally aware or concerned about master’s-level suicide training. There is no knowledge about the issue, efforts, or resources.</td>
</tr>
<tr>
<td>2: Denial/Resistance</td>
<td>Members of CES believe suicide and related master’s-level training is not a concern in the field or believe it cannot or should not be addressed. No support for resources exists. Only a few have knowledge about suicide and related master’s-level training, but many misconceptions exist.</td>
</tr>
<tr>
<td>3: Vague Awareness</td>
<td>A few members feel suicide and related master’s-level training is a concern in CES, but knowledge is lacking and vague and resources are limited and not yet in use. There is no immediate motivation to act.</td>
</tr>
<tr>
<td>4: Preplanning</td>
<td>There is clear recognition suicide and related master’s-level training is a concern that should be addressed in CES. Efforts that exist remain largely unknown, and resources are limited.</td>
</tr>
<tr>
<td>5: Preparation</td>
<td>The field is concerned and intends to act on suicide and related master’s-level training. Most of the field has basic knowledge of suicide and related master’s-level training efforts. Leaders actively support continuing and/or improving efforts, including resources.</td>
</tr>
<tr>
<td>6: Initiation</td>
<td>CES members see master’s-level suicide training as their responsibility, and have basic knowledge of suicide and related master’s-level training efforts. Leaders play a key role in supporting existing and new efforts, including allocating resources.</td>
</tr>
<tr>
<td>7: Stabilization</td>
<td>CES members have more than basic knowledge about suicide and related master’s-level training. They take responsibility and are involved in efforts. Continuous support in resources and leadership exists, including leadership commitment to ensure long-term viability of efforts.</td>
</tr>
<tr>
<td>8: Confirmation/Expansion</td>
<td>CES members have solid knowledge about suicide and related master’s-level training, including effectiveness of efforts. Efforts and resources are strong, participation is high, and future improvement is being considered.</td>
</tr>
<tr>
<td>9: High Level of Community Ownership</td>
<td>Members of CES have detailed knowledge about suicide and related master’s-level training. Leaders continually evaluate efforts and support diversified resources.</td>
</tr>
</tbody>
</table>
APPENDIX J

COMMUNITY READINESS SCORE RESULTS
COMMUNITY READINESS SCORE RESULTS

Table 11

*Consensus Scores*

<table>
<thead>
<tr>
<th>Cases</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>Dim Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Efforts</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>7</td>
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<td>7</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>B: KoE</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>6</td>
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<td>3</td>
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<td>2</td>
<td>3</td>
<td>72</td>
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<td>C: Leadership</td>
<td>6</td>
<td>5</td>
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<td>8</td>
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<td>6</td>
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<td>3</td>
<td>3</td>
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<td>3</td>
<td>67</td>
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<tr>
<td>D: Climate</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
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<td>3</td>
<td>4</td>
<td>3</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>E: KoS</td>
<td>6</td>
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<td>F: Resources</td>
<td>4</td>
<td>3</td>
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<td>7</td>
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<td>3</td>
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<td>3</td>
<td>2</td>
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</tbody>
</table>

Case Totals 35 31 28 40 26 30 33 34 27 32 30 26 24 24 22

*Note.* KoE = Knowledge of Efforts; KoS = Knowledge of Suicide. Case totals are not a standard procedure in the Community Readiness Model.
APPENDIX K

DOMAINS, CATEGORIES, AND SUBCATEGORIES
### Table 13

#### Final Domains, Categories, Frequencies, and Subcategories

<table>
<thead>
<tr>
<th>Categories (Frequencies)</th>
<th>Subcategories</th>
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</thead>
<tbody>
<tr>
<td>I. Efforts</td>
<td></td>
</tr>
<tr>
<td>A. Content (15)</td>
<td></td>
</tr>
<tr>
<td>1. Risk assessment</td>
<td></td>
</tr>
<tr>
<td>2. Intervention</td>
<td></td>
</tr>
<tr>
<td>3. Suicide awareness and response</td>
<td></td>
</tr>
<tr>
<td>4. Beliefs and emotional reaction</td>
<td></td>
</tr>
<tr>
<td>5. Legal and ethical</td>
<td></td>
</tr>
<tr>
<td>6. Protocols and policies</td>
<td></td>
</tr>
<tr>
<td>7. Referrals</td>
<td></td>
</tr>
<tr>
<td>8. Conceptualization</td>
<td></td>
</tr>
<tr>
<td>9. Client-counselor relationship</td>
<td></td>
</tr>
<tr>
<td>10. Professional behavior and development</td>
<td></td>
</tr>
<tr>
<td>11. Crisis</td>
<td></td>
</tr>
<tr>
<td>12. Culture</td>
<td></td>
</tr>
<tr>
<td>13. Prevalence</td>
<td></td>
</tr>
<tr>
<td>B. Methods (15)</td>
<td></td>
</tr>
<tr>
<td>1. Practical learning and supervision</td>
<td></td>
</tr>
<tr>
<td>2. Active learning</td>
<td></td>
</tr>
<tr>
<td>3. Lecture</td>
<td></td>
</tr>
<tr>
<td>4. Discussion and presentations</td>
<td></td>
</tr>
<tr>
<td>5. Observing others</td>
<td></td>
</tr>
<tr>
<td>6. Readings</td>
<td></td>
</tr>
<tr>
<td>7. Written assignments and tests</td>
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</tr>
<tr>
<td>C. Format and Schedule (15)</td>
<td></td>
</tr>
<tr>
<td>1. Format</td>
<td></td>
</tr>
<tr>
<td>2. Placement within a learning experience</td>
<td></td>
</tr>
<tr>
<td>3. Infused or segmented</td>
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</tr>
<tr>
<td>4. Length</td>
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</tr>
<tr>
<td>D. Target Audience (15)</td>
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</tr>
<tr>
<td>1. Supervisees</td>
<td></td>
</tr>
<tr>
<td>2. All CITs</td>
<td></td>
</tr>
<tr>
<td>3. Clinical Mental Health CITs only</td>
<td></td>
</tr>
<tr>
<td>4. Other students</td>
<td></td>
</tr>
<tr>
<td>E. Responsible Parties (15)</td>
<td></td>
</tr>
<tr>
<td>1. Supervisors</td>
<td></td>
</tr>
<tr>
<td>2. Educators</td>
<td></td>
</tr>
<tr>
<td>3. Students</td>
<td></td>
</tr>
<tr>
<td>4. Broader community</td>
<td></td>
</tr>
<tr>
<td>5. Directors of practical training</td>
<td></td>
</tr>
<tr>
<td>6. Licensed professionals</td>
<td></td>
</tr>
<tr>
<td>F. Longevity and Existence (12)</td>
<td></td>
</tr>
<tr>
<td>1. Longevity</td>
<td></td>
</tr>
<tr>
<td>2. Existence</td>
<td></td>
</tr>
<tr>
<td>G. Intentions (12)</td>
<td></td>
</tr>
<tr>
<td>1. Goals of existing efforts</td>
<td></td>
</tr>
<tr>
<td>2. Intended future efforts</td>
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</table>
Table 13 (continued) *Final Domains, Categories, Frequencies, and Subcategories*

<table>
<thead>
<tr>
<th>Categories (Frequencies)</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>II. Knowledge of Efforts</td>
<td></td>
</tr>
</tbody>
</table>
| A. Sources of information about efforts (15) | 1. Professional development and networking  
2. Literature and organization communication  
3. CITs  
4. MLST received  
5. Formal communications  
6. Experience counseling  
7. Other sources |
| B. Knowledge of efforts varies (15) | 1. Lack of knowledge beyond responsibility or niche  
2. Lack of preparation on providing MLST |
| C. Evaluation of MLST (15) | 1. Lack of evaluation  
2. Existing evaluation |
| D. Positive appraisal (15) | 1. General positive and implications  
2. Content and comprehensiveness  
3. Method, format, and schedule |
| E. Negative appraisal (12) | 1. General and other negative appraisal  
2. Inconsistency  
3. Poor timing and placement  
4. Inapplicable  
5. Lack of breadth and depth |
| III. Leadership |               |
| A. Active support (15) | 1. Supporting learning  
2. Policies and decisions  
3. Curricular support |
| B. Types of leaders (13) | 1. Program leaders  
2. Leaders in the broader community  
3. CACREP  
4. Published authors and presenters  
5. Publication and conference leadership  
6. Management at supervision sites |
| C. Concern or priority (12) | 7. Concern or priority  
8. Competing priorities |
| D. Lacking support (9) | 1. Discrepancy between attitudinal and active support  
2. Calls to specific leaders for needed support |
| E. Awareness about leadership (9) | 1. Lacking awareness about leadership  
2. Sources of awareness |
| F. Attitudinal support (7) | 1. Attitudinal support  
2. Attitudes and beliefs of leaders |
<table>
<thead>
<tr>
<th>Categories (Frequencies)</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. Climate</td>
<td></td>
</tr>
<tr>
<td>A. Attitudinal climate</td>
<td></td>
</tr>
<tr>
<td>(15)</td>
<td>1. Attitudes toward MLST</td>
</tr>
<tr>
<td></td>
<td>2. Attitudes toward suicide and suicide issues in counseling</td>
</tr>
<tr>
<td></td>
<td>3. Lack of awareness about attitudinal climate</td>
</tr>
<tr>
<td>B. Political climate</td>
<td></td>
</tr>
<tr>
<td>(14)</td>
<td>1. Priorities and perceived need</td>
</tr>
<tr>
<td></td>
<td>2. Politics and the broader community</td>
</tr>
<tr>
<td></td>
<td>3. Disagreement</td>
</tr>
<tr>
<td>C. Logistical climate</td>
<td></td>
</tr>
<tr>
<td>(12)</td>
<td>1. Lack of resources</td>
</tr>
<tr>
<td></td>
<td>2. Logistics regarding clients, CITs, and the BC</td>
</tr>
<tr>
<td>V. Knowledge of Suicide</td>
<td></td>
</tr>
<tr>
<td>A. Sources of knowledge about suicide (15)</td>
<td>1. Professional development</td>
</tr>
<tr>
<td></td>
<td>2. MLST received</td>
</tr>
<tr>
<td></td>
<td>3. Professional experience</td>
</tr>
<tr>
<td></td>
<td>4. Professional literature</td>
</tr>
<tr>
<td></td>
<td>5. Personal experience</td>
</tr>
<tr>
<td></td>
<td>6. Informal conversations</td>
</tr>
<tr>
<td></td>
<td>7. Organizations</td>
</tr>
<tr>
<td>B. Comprehensiveness and Content (15)</td>
<td>1. Amount of comprehensiveness</td>
</tr>
<tr>
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<td>2. Knowledge of suicide varies</td>
</tr>
<tr>
<td></td>
<td>3. Misconceptions</td>
</tr>
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<td>4. Missing content</td>
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<tr>
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<td>5. Existing content</td>
</tr>
<tr>
<td>C. Knowledge of Suicide - Other</td>
<td>1. Lack of awareness about suicide knowledge</td>
</tr>
<tr>
<td></td>
<td>2. Other knowledge of suicide</td>
</tr>
<tr>
<td>VI. Resources</td>
<td></td>
</tr>
<tr>
<td>A. Unaware of or Unavailable Resources (15)</td>
<td>1. Does not know of any</td>
</tr>
<tr>
<td></td>
<td>2. Had not considered or sought resources for MLST</td>
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<tr>
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<td>3. Lacking resources</td>
</tr>
<tr>
<td>B. Available resources (13)</td>
<td>1. Money</td>
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<tr>
<td></td>
<td>2. People</td>
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<tr>
<td></td>
<td>3. Time</td>
</tr>
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<td>4. Space</td>
</tr>
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<td></td>
<td>5. Other available resources</td>
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<td>C. Conditional resources (11)</td>
<td>1. Conditions on money</td>
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<td></td>
<td>2. Depend on setting</td>
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<tr>
<td></td>
<td>3. Ineligibility</td>
</tr>
</tbody>
</table>

Note. Categories and subcategories appear in order of frequency. CITs = counselors-in-training; MLST = master’s-level suicide training; CACREP = Council for Accreditation of Counseling and Related Educational Programs; BC = Broader community.
APPENDIX L

KNOWLEDGE SOURCES
## KNOWLEDGE SOURCES

Table 14

**Organizations, authors, and training providers**

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Authors</th>
<th>Trainings (Providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association of Suicidology</td>
<td>Darcy Granello</td>
<td>AMSR (SPRC)</td>
</tr>
<tr>
<td>American Counseling Association*</td>
<td>Paul Granello</td>
<td>ASIST</td>
</tr>
<tr>
<td>American Psychological Association</td>
<td>Danica Hays</td>
<td>(LivingWorks)</td>
</tr>
<tr>
<td>American Mental Health Counselors Association</td>
<td>Gerald Juhnke</td>
<td>QPR (QPR Institute)</td>
</tr>
<tr>
<td>American School Counselor Association*</td>
<td>Marsha Linehan</td>
<td>Star Behavioral Health Providers</td>
</tr>
<tr>
<td>Association for Counselor Education and Supervision*</td>
<td>Jason McGlothlin</td>
<td></td>
</tr>
<tr>
<td>National Alliance on Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Public Radio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Prevention Resource Center (SPRC)*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.*-Includes regional and/or state branches. AMSR = Assessing and Managing Suicide Risk. ASIST = Applied Suicide Intervention and Skills Training. QPR = Question Persuade Refer.