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Understanding the Induction Experience of Licensed Mental Health Counselors Working in New York City School Based Mental Health Clinics

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Understanding the Induction Experience of Licensed Mental Health Counselors Working in New York City School Based Mental Health Clinics

A DISSERTATION

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DISSERTATION APPROVAL

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Abstract

The mental health symptoms and diagnosis rates of children and adolescents is rising in the United States (Oliver & Abel, 2018). To support the growing mental health rates and offset the work being provided by school counselors, school social workers, and school psychologists, schools are contracting with community mental health agencies to provide mental health counseling services in the school setting (Weist et al., 2017b). For some community mental health agencies, they are opening school based mental health clinics (SBMHCs) to provide more comprehensive mental health counseling services to reduce families having to seek services in their community (Weist et al., 2017b). The providers working in the school setting are licensed mental health professionals including professional counselors or mental health counselors and social workers (Mills & Cunningham, 2017). Prior research explored how school counselors acclimated to the school setting when new to the school community (Matthes, 1992; Curry & Bickmore, 2012;2013), however there is no prior research that explored the acclimation of licensed mental health counselors (LMHCs) within the school setting, including LMHCs working in SBMHCs.

This study sought to understand the induction experiences of LMHCs working in SBMHCs located in New York City schools. Drawing from the teacher preparation literature, induction is the process where novice teachers supported and mentored typically at the beginning of their career (Curry & Bickmore, 2012, 2013; DeAngelis Peace, 1995). Utilizing a phenomenological qualitative approach to understanding the LMHCs experiences, nine participants were recruited and shared their induction process across two semi-structured interviews. Data was analyzed using interpretative phenomenological analysis which allowed for both a descriptive and interpretative understanding of the findings. As a result, the findings yielded six themes and twelve subthemes which are presented from a descriptive and interpretive

lens. A discussion of the findings is presented alongside the relevant literature in addition to the strengths and limitations of the study. Recommendations for future research concludes the dissertation.

Keywords: school mental health, induction, licensed mental health counselors

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CHAPTER 1: INTRODUCTION

According to the Association for Children's Mental Health (n.d.), one in five children and adolescents have a diagnosable mental health disorder. Additionally, one in ten children and adolescents have a mental health diagnosis that can impair their functioning at home, school, and in the community (Association for Children's Mental Health, n.d.). Whitney and Peterson (2018) reported that 7.7 million of the 46.6 million children included in the 2016 National Survey of Children's Health were identified to have a treatable mental health disorder, yet did not receive treatment. Some mental health disorders, such as anxiety and depression, may stem from traumatic events (Oliver & Abel, 2017). Based on data collected from the 2011-2014 Behavioral Risk Factor Surveillance System (BRFSS), Merrick et al. (2018) examined the prevalence of adverse childhood experiences (ACEs) of noninstitutionalized adults aged 18 years and older. ACEs are defined as "potentially traumatic events that can have negative lasting effects on health and well-being" ranging from social, emotional, and cognitive development to disease, disability, and social problems (Boullier & Blair, 2018, p. 132). While only 23 states were included in the sample, approximately 62% of the participants reported having at least 1 ACE while nearly 25% of the participants reported having 3 or more ACES before the age of 18 years old (Oliver & Abel, 2018). Across levels of the United States (U.S.) government, lawmakers are working to support the growing mental health needs of children and adolescents based on data collected through surveys such as BRFSS.

At the federal level, the Affordable Care Act (ACA) increased mental health care access by ensuring that all insurance companies cover mental health services (Takkunen & Zlevor, 2018). Additionally, the ACA allocated 11 billion dollars to expand health centers, including school health centers and employment of mental health professionals to serve vulnerable populations (i.e., children and adolescents in underserved communities; Love et al., 2019). While

insurance companies have expanded mental health coverage, state and local funding now provides services for free or minimal cost for families without health insurance (Love et al., 2019). To further meet the needs of those limited in receiving needed services, Minnesota, Maryland, Florida (Cammack et al., 2017), and Montana (Butts et al., 2017) allocated special funding to increase school mental health programs within school districts (Dikel, 2020). New York City (NYC) has developed Thrive NYC, a program designed to increase access to mental health programs and services in various settings, including schools (Mayor's Office of Thrive NYC, 2018).

Schools have been identified as a primary location to support children's mental and general health needs (Cammack et al., 2017; Weist et al., 2017b). However, schools often lack enough trained staff and specialized services to help optimize all children's academic and social-emotional success (Weist et al., 2017a). To help fill this gap, school based mental health services (SBMHS) have been implemented across the US as a result of federal and state policies. SBMHS are defined as comprehensive mental health services provided in the schools by licensed mental health professionals from community-based organizations or school hired mental health professionals (Doll et al., 2017; Michael et al., 2017; Weist et al., 2002). Services are provided through two possible locations: school based health centers (Love et al., 2019) and school based mental health clinics (SBMHC; Weist et al., 2017b). The goal of these centers is to bring much needed services (i.e., medical, dental, mental health counseling) directly to the students who may not otherwise have access (Love et al., 2019).

Some schools use the public health model multi-tiered system of support (MTSS) focused on providing a range of academic and social-emotional services that aim to reach students at different levels using data to inform decision making: 1) as a school community (i.e., universal

or Tier 1); 2) to a specific group identified as at-risk of developing academic, behavioral, or mental health problems (i.e., selective or Tier 2); and 3) at the individual level (i.e., targeted, Tier 3) for students identified as displaying a behavioral or possible mental health problem (Cook et al., 2015; Weist et al., 2017b). Compared to other school wide interventions (i.e., Response to Intervention [RtI], Positive Behavioral Interventions and Supports [PBIS]), MTSS combines the two aforementioned interventions for its continuum of services beyond the academic needs of students (Weist et al., 2017b). RtI is described as a one-tiered model primarily focused on addressing academic needs of students (Weist et al., 2017b). Whereas, PBIS is most often used for the universal or school wide approaches to meet the school behavioral needs (Weist et al., 2017b). Despite the targeted population, all MTSS programs provide needed services to students, including mental health, in a collaborative manner across the school system (Weist et al., 2017a). These counseling and preventive mental health services also aim to reach students and their families who may have limited or no access to mental health services in their community (Weist et al., 2017b). SBMHCs play an integral role in the type of services delivered within schools across the three-tiered system.

Over the last 20 years, many scholars have described SBMHS from the perspectives of school counselors. Prior research provided insight into the implementation of SBMHS services (Natasi et al., 1998; Perfect & Morris, 2011; Weist et al., 2006); school counselor perceptions of mental health services in schools (Carlson & Kees, 2013; Repie, 2005); and meeting students' mental health needs (Brown et al., 2006; Collins, 2014; DeKruyf et al., 2013). One perspective absent from the literature is that of licensed mental health counselors (LMHCs), including how they are inducted within SBMHS and the larger school community.

Drawing from the teacher education literature, induction is defined as the process by which first year teachers are mentored and supported in a structured or unstructured manner as emerging professionals (Curry & Bickmore, 2012, 2013; DeAngelis Peace, 1995). The goal of induction is to help novice teachers acclimate into their respective school settings while learning and enhancing their teaching process through professional development and peer support (Wood & Stanlus, 2009). Induction programs have been found to help with school stability and retainment of teachers, increasing the knowledge and practice of teaching and pedagogy, and supporting teachers through first year stressors of working in a new school (Bressman et al., 2018; Hudson, 2012; Spooner-Lane, 2017).

Statement of the Problem

The US federal government has tracked the rates of child mental health issues over the last few decades through national, state, and local surveys including the Youth Risk Behavior Surveillance System and the National Survey of Children's Health (NSCH; Center for Disease Control and Prevention [CDC]; 2019). In examining the data set of the 2016 NSCH, Ghandour et al. (2019) identified the prevalence of anxiety, conduct/behavioral disorders, and depression among children aged 3-17. The CDC (2019) reported 9.4% of children aged 2-17 were diagnosed with attention deficit hyperactivity disorder. The rates of mental health diagnoses for youth is exacerbated with the reported rate of suicide among child and adolescents. According to the CDC (2015), suicide was the third leading cause of death for youth aged 10-14 years old. Furthermore, in 2013, 17% of youth considered suicide while approximately 14% of youth had made a suicide plan (CDC, 2015). Most recently, Curtin and Heron (2019) examined data from the National Vital Statistics System and identified that the suicide rate tripled for youth aged 10-14 from 2007 to 2017. Additionally, for age group 10-24, the suicide rate surpassed the homicide rate for the same time period (Curtin & Heron, 2019). Without access to appropriate mental

health services, students experiencing symptoms of mental health illnesses and/or having untreated diagnoses will have an impact on their personal functioning at home, in school, and in their community.

In a review of the literature regarding the correlations between student mental health and academic achievement, lack of early identification and intervention of problematic student behaviors (e.g., diminished social skills, disruptive externalizing behaviors) results in negative academic and behavioral consequences which continue into adulthood (Suldo et al., 2014). The deleterious consequences of children and adolescents with unmet health and mental health conditions include chronic absenteeism (Edwards, 2013; Love et al., 2019), lower graduation rates (Standard, 2003; Kerns et al., 2011), lower promotion rates to the next grade level (Strolin-Goltzman et al., 2014), and earned lower grades and less participation in schools (DeSocio & Hootman, 2004). Students with mental health challenges can also disrupt students' learning environment that may result in school suspensions (Bruns et al., 2005; Love et al., 2019). From an MTSS viewpoint, students identified with presenting mental health needs, coupled with the aforementioned academic challenges, would be prime candidates for Tier 3 level interventions (Weist et al., 2017b). Tier 3 services, viewed as the most intensive of the supports, would involve individual or family psychotherapy with a possible referral for a psychiatric evaluation.

Teachers often refer students for counseling services to address individual and classroom needs (Dikel, 2020; Reinke et al., 2011). Reinke et al. (2011) examined the perceptions of teachers regarding the needs, roles, and barriers to their students' mental health. While the 292 participants perceived themselves as having a responsibility to support students' behaviors and mental health, teachers identified school psychologists as having a significant role to address the

mental health needs of students (Reinke et al., 2011). However, school psychologists represent one of many health care providers in the school community (Kininger et al., 2018).

For students identified as more susceptible to develop mental health problems, schools have implemented a variety of Tier 1 (i.e., The Incredible Years: Parent, Teacher, Child Training Series) and Tier 2 (i.e., Social Skills Group Intervention) services that have been facilitated by teachers, school-hired mental health professionals, and school mental health counselors (Daly et al., 2017). In a longitudinal study of two universal, Tier 1, preventive programs (Family-School Partnership and the Good Behavior Game), Bradshaw et al.'s (2009) findings demonstrated successful outcomes of parental involvement, graduation rates, and a reduction in the use of special education services when programs are implemented early in a student's academic career. The Good Behavior Game is a classroom-centered approach, developed by Barrish et al. (1969), focused on students exhibiting early risk behaviors (e.g., poor achievement,being aggressive or shy; Bradshaw et al., 2009). The Family-School Partnership (Canter & Canter, 1991; Ialongo et al., 1999) was developed to improve collaboration between parents, school, and community staff (i.e., school mental health professionals) focusing on management skills to support healthy academic and social skills (Bradshaw et al., 2009).

In exploring the efficacy of the Confidence and Courage through Mentoring Program (CCMP) for middle school students, a Tier 2 intervention, Cook et al.'s (2015) findings indicated a reduction in internalizing problems (e.g., symptoms of anxiety and/or depression) of the students involved. Tier 2 interventions are less intensive than Tier 3 interventions (e.g., psychotherapy) but more supportive when Tier 1 interventions such as school wide screenings or monitoring is not sufficient (Cook et al., 2015). CCMP included activities aimed at managing emotions while promoting student self-efficacy within a mentorship setting (Cook et al., 2015).

Based on the findings of Bradshaw et al. (2009) and Cook et al. (2015), early intervention and key stakeholder involvement indicated positive results for students who participated in Tier 1 (i.e., school-wide) and Tier 2 (i.e., specific group of students) services. However, the availability of the services is dependent on the roles, duties, and accessibility of school professionals (i.e., teachers, school-hired mental health professionals).

School counselors, school psychologists, and social workers have similar yet specific roles in schools. School counselors use the American School Counselor Association (ASCA) National Model (2019) to guide their services and define their role with Kindergarten-12th grade students focusing on academic achievement, career development, and social-emotional support (Weist et al., 2017a). School psychologists conduct educational and mental health services by way of psychological assessments, program evaluation, and collaborating to enhance the student's learning environment (Weist et al., 2017a). Lastly, social workers establish connections for students and families with community support while providing a range of counseling services through individual and group counseling services (Weist et al., 2017a). Across the mental health professionals, they each focus on the needs of the students (i.e., vocationally, academically, social-emotionally). However, with the increasing mental health needs of children, the capacity for these mental health professionals are limited when attempting to reach all students. For example, research has been conducted on the rising caseloads of school counselors and their changing roles in the school community (Clark & Breman, 2009; Herr, 2002), the role of school social workers viewed as crisis support (Dikel, 2020; Kininger et al., 2017), and school psychologists as evaluators for students needing individualized education plans (Dikel, 2020; Kininger et al., 2017). The expanded roles can overextend the work for mental health professionals employed by the schools, which in turn can reduce the amount of Tier 3 direct

counseling services available to students. With the overextension of services demanded upon school providers, schools are collaborating with community-based organizations to provide mental health services in school for underserved students (Mills & Cunningham, 2017; Weist et al., 2017). Additional mental health professionals from SBMHC, including LMHCs, can provide additional mental health services.

With recent national and international crises such as the COVID-19 pandemic and the on-going lethal and abusive police violence against people of color that led to the Black Lives Matter Movement, supporting children's mental health is imperative. Whether individuals have had one or multiple adverse childhood experiences (Merrick et al., 2018), data indicate that exposure to traumatic events can have a negative developmental impact on several areas of peoples' lives, including school (Oliver & Abel, 2017). Thus, SBMHCs serve a critical role in providing comprehensive mental health services for all students, especially those exposed to trauma or without access to mental health treatment otherwise.

Scholars have examined the implementation of SBMHS and its associated challenges from a programmatic standpoint (i.e., adapting interventions to the schools' needs, development of program policies; Connors et al., 2019; Lyon & Bruns, 2019). However, no current research exists from the perspective of LMHCs who aim to reduce mental health challenges in schools. Furthermore, there is no existing research that reports on LMHCs' induction into the school community as new employees to the agency or field of school mental health.

Induction has been studied in K-12 education since the 1980s to better understand and respond to the challenges first year teachers experience as emerging professionals (Wood & Stanlus, 2009). The goal is to help novice teachers to join the school culture while developing their skills as teaching professionals (Smith, 2011; Wood & Stanlus, 2009). Throughout the last

three decades, the types of induction programs implemented have changed due to federal and state legislation (Wood & Stanlus, 2009). Research on induction range from types of support programs schools created for first year teachers (Bastian & Marks, 2017; Howe, 2006; Martin, Buelow, & Hoffman, 2016) to teacher retention rates based on implemented induction programs (Kang & Berliner, 2012; Ronfeldt & McQueen, 2017). Similarly, the induction experience has been explored with other school staff, including school counselors. Scant research has been conducted on how school counselors are inducted into their school system by way of mentorship or a structured year-long program (Curry & Bickmore, 2012; 2013). However, Curry and Bickmore (2012; 2013) reported how little has changed in the field of school counseling induction since Matthes's (1992) formative research on the induction process for novice school counselors and the challenges experienced.

In efforts to address the rising mental health needs of students and dire consequences if these needs are not met, schools continue to expand mental health services (e.g., MTSS; Weist et al., 2017b). Due to the overextension of school-hired MHPs, schools have turned to community organizations to provide additional services (Mills & Cunningham, 2017). Through these partnerships, schools have implemented SBMHCs so that all students may receive some type of mental health support. One group of professionals providing comprehensive mental health services in SBMHCs is LMHCs. While there is significant research describing the induction experiences of teachers acclimating to the school community (Wood & Stanlus, 2009), there is a dearth of research describing the induction experience of MHPs (Curry & Bickmore, 2012; 2013), especially LMHCs. Specifically, how LMHCs are acclimated to the school community to engage with stakeholders and families in addition to the types of services they provide is unknown. Induction, particularly for LMHCs, may aim to provide a structured program or series

of support to new staff as they learn about the school culture, policies and procedures of the school, and learning to provide comprehensive mental health services based on school and agency regulations. First year teachers have identified needing extra support in areas of pedagogical practices and behavior management when acclimating to a new school environment (Hudson, 2012). Thus, it appears that an induction process is important to provide this necessary support and feedback. As a result of the induction process, LMHCs may have a better understanding of the school community and the presenting mental health needs. As such, they will apply their clinical skills and knowledge to provide students needed mental health services. This proposed study aims to understand the induction experiences of LMHCs who are working in SBMHCs.

Research Question

My proposed research study intends to answer the following research question: *What are the induction experiences of licensed mental health counselors working in a New York City school based mental health clinic?*

Theoretical Framework

Neal and Neal (2013) identified Bronfenbrenner's Ecological Systems Theory (EST) as the most used theory when examining individuals or groups in efforts to understand interactions within and across systems. EST consists of people's environmental context based on four levels of ecological systems: microsystem, mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1979; Rosa & Tudge, 2013). These four systems nest within one another, creating concentric circles, and interact throughout the lifespan which results in unique influences on the individual's overall behavior (Bronfenbrenner, 1979; Rosa & Tudge, 2013).

The innermost circle to Bronfenbrenner's (1979) framework, the microsystem, is the individual or group of focus and their engagement within the immediate environment. Examples

of the microsystem include individuals interacting with family members, peers at school, or colleagues at work. While the microsystem focuses on the immediate environment, the second layer to the concentric circle, the mesosystem, focuses on interactions *between* individual's microsystems (e.g., a family collaborating with their child's school). The third layer of the concentric circle, the exosystem, refers to policies and procedures or changes in relationships that indirectly influence both the meso- and microsystem despite the individual's lack of an active role in this domain (Bronfenbrenner, 1979; Rosa & Tudge, 2013). The introduction of new school policies that determine the type of education programs students will receive and the respective service providers are examples of the exosystem. Lastly, the outermost circle, the macrosystem, focuses on the overall impact, beliefs, and influence of the larger community (Bronfenbrenner, 1979).

Bronfenbrenner's (1979) EST is a useful framework for this proposed study as I aim to study the induction experiences of LMHCs who work within school systems to provide comprehensive mental health counseling services. EST provides a framework to examine numerous interactions between different ecological systems (Bronfenbrenner, 1979) that include but are not limited to the classroom environment, the school based mental health clinic, and the entire school community, to name a few. There is an established school culture based on policies and procedures, in addition to the beliefs and values of the larger community (Dikel, 2020), that has an impact on the school community. For new staff, including LMHCs, the experience or process of induction influences their acclimation to the school community and within numerous interacting ecological systems (e.g., teachers, parents, school administration, agency and school policies).

Similarly, schools that use an MTSS to provide mental health services complements the EST systems-based perspective. Using an MTSS framework, the interactions of school stakeholders (i.e., school administration, teachers, staff) and mental health providers from SBMHCs have an influence on the overall school system and those served (Weist et al., 2006; Weist et al., 2017). LMHCs are introduced to the school system by way of community based organizations and school administrations to provide comprehensive mental health services as part of the school based mental health clinic. Hence, EST provides a comprehensive framework to study the numerous interactions across and within various ecological systems, from the microlevel to the macrolevel.

Significance of the Study

Additional mental health providers are now working in schools, a unique setting from community mental health clinics, as a result of more SBMHCs established over the last 15 years (Lever et al., 2017; Michael et al., 2017). For some LMHCs, it may be their first time working in schools. There are several ways this proposed study might contribute to the counseling profession. First, the proposed study is the first to specifically explore and understand how LMHCs are inducted into SBMHCs. Not only will this study further the counseling research knowledge base about SBMHCs and LMHCs but the results of this study could provide practicing counselors in school and agency settings insight into the unique role and counseling practices of LMHCs in school settings. Both LMHCs and clinical supervisors might gain new or additional knowledge on how to navigate school systems to provide more effective and efficient mental health services through their role in SBMHCs, including new and seasoned practitioners.

For clinical supervisors, the proposed study could provide insight into the successes and challenges of SBMHCs and ways to support LMHCs being introduced and working in this unique setting. Curry and Bickmore (2013) concluded that the novice school counselors

interviewed would have benefited from system support (i.e., district-based mentoring, consistent supervision, professional development for principals) to enhance their induction into their new roles. As a result of this study, the findings could provide a framework for future induction programs developed by clinical supervisors or in conjunction with their host school.

Similarly, continued professional development opportunities can increase the knowledge base of contributions from SBMH providers and school administrators in efforts to enhance provided services. Most importantly, the results of this study will expand the role and definition of clinical mental health counselors as it relates to their work in school settings. The proposed study could shift the identity of LMHCs who collaborate daily with the school community. Hence, the training needs and clinical roles of LMHCs might need to be expanded and redefined.

Given that the training of clinical mental health counselors (CMHC) does not include school mental health topics (Lever et al., 2017), the results of this study can also inform aspects of the counseling curricula by expanding the knowledge base of LMHCs working within SBMHCs. For example, a CMHC may opt to enroll in a school mental health special topics elective course that is rooted in both school mental health and child and adolescent literature. Additionally, aspects of the findings of this study and related literature can be included in courses such as Introduction to Professional and Ethical Issues in Counseling, Counseling Children and Adolescents, or Counseling in Schools. Furthermore, across these courses, students can explore the induction process and ethical considerations when providing mental health services, specific to SBMHCs, in school settings. Understanding the process of induction in schools may provide a sense of how to acclimate and collaborate across agency and school systems.

Definitions

Article 31 Clinics: Community outpatient settings located in New York that provide mental health counseling services as determined by the Article 31 Mental Hygiene Law (Office of Mental Health, n.d.).

Article 31 Mental Hygiene Law: A New York state law passed to regulate and oversee the quality of mental health services including compliance, prevention of abuse, and duties of service providers (New York Public Law, n.d.; New York State Senate, n.d.).

Community Based Organization: An agency that provides programs and services to a host (e.g., school) to support the needs of the community (Mayberry et al., 2008; Warren, 2005).

Induction: A term stemming from the field of education that describes the structured or unstructured process where novice teachers are supported and mentored typically at the beginning of their career (Curry & Bickmore, 2012, 2013; DeAngelis Peace, 1995).

Licensed Mental Health Counselor: An individual who has completed state requirements of supervised clinical experiences and successfully completed the comprehensive mental health exam. Some states identify such counselors as licensed professional counselors.

School Based Mental Health Clinic: A facility, co-located with the school, that provides comprehensive mental health services to students and families of the school community (Costello-Wells et al., 2003).

Multi-Tiered System of Support (MTSS) or Three-Tiered System: A public health model aimed to provide mental health services to the school community while prioritizing those students deemed in urgent need of mental health counseling services, from a school-wide approach to individualized services (Goodman-Scott et al., 2017; Weist et al., 2017b).

CHAPTER 2: LITERATURE REVIEW

The previous chapter provided an introduction and rationale to my proposed study of exploring the induction experiences of licensed mental health counselors working in New York City school based mental health clinics. In this chapter, I provide an in-depth review and critique of the literature as it relates to key topics for my proposed study. First, I will discuss current mental health issues and legislation passed to meet such needs for school aged children. A condensed history of school based mental health clinics and services these clinics provide will also be explored. Next, I will discuss the roles of school mental health providers and the concept of induction programs for educators, including how induction has been applied to school counselors. I will close with the theoretical framework of my study - Bronfenbrenner's (1979; 2005) Ecological Systems Theory (EST).

Mental Health Needs of Children and Adolescents

The prevalence rates of mental health disorders are an international public health issue for children and adolescents. According to the World Health Organization (WHO; 2020), 10-20% of children and adolescents were diagnosed with a mental health disorder. Alarmingly, compared to the WHO's reported percentage, the prevalence rate for the U.S. is slightly higher with an estimated 22% of individuals under the age of 18 reported to have or have had a mental health disorder (Child Mind Institute, 2015). The higher U.S. prevalence rate may be attributed to stigma towards mental health or lack of awareness where individuals may receive such services (Merikangas et al., 2011). Furthermore, the types of diagnoses seen in children and adolescents vary in the U.S. The 2018 National Survey of Children's Health (NSCH) indicated children 3-17 years old were diagnosed with several mental health disorders including Attention Deficit Hyperactivity Disorder (ADHD; 8.7%), anxiety (7.5%), Behavioral/Conduct Disorder (6.9%), depression (3.3%), and Autism Spectrum Disorder (ASD; 2.9%; CDC, 2019). These

aforementioned prevalence rates have increased amongst youth since the first comprehensive report on mental health surveillance in 2013 (Perou et al., 2013), indicating a rising trend in mental health symptoms and diagnoses.

In addition to the increase of reported mental health needs, the rates of suicide ideation and attempts are staggering for youth. According to Perou et al. (2013), "suicide was the second leading cause of death among children aged 12-17 years in 2010" (p. 1). Almost a decade later, suicide continues to be the second leading cause of death among those aged 10-24 (Curtin & Heron, 2019). What is striking is that children identified as having suicidal ideation were also found to have symptoms of a mental health disorder (Perou et al., 2013). Despite the rise in reported mental health symptoms and clinical diagnoses for youth, almost half of the children in the 2016 National Survey of Children's Health did not receive mental health treatment (Whitney & Peterson, 2018). Left untreated, mental health symptoms and undiagnosed disorders can have a deleterious effect on children's ability to live productive lives (Child Mind Institute, 2015; WHO, n.d.). For example, children diagnosed with ADHD and depression have been associated with educational difficulties and lower earned income as adults (Cuellar, 2015).

Mental health related issues have also been associated with an overrepresentation of children in the special education system, increased risk for substance use, and difficulty securing employment (Cuellar, 2015). Furthermore, untreated mental health symptoms result in less productivity (e.g., academic achievement, social development, job retainment) in addition to redundant services between special education, law enforcement, and health care systems (Cuellar, 2015; Ghandour et al., 2019; Glied & Cuellar, 2003). This redundancy costs $202-$247 billion dollars annually for health care and education systems (Child Mind Institute, 2015; Perou et al., 2013). In efforts to combat such economic losses, legislative policies have been enacted

across the U.S. federal, state, and local governments to better address the mental health needs of children in schools (Cuellar, 2015; Gould et al., 2009; Weist et al., 2017a).

Federal Government Response

For over 40 years, the U.S. government used surveys to track the health, and more recently, the rate of mental health issues of children and adolescents. Perou et al. (2013) released the first comprehensive report to better understand presenting needs (e.g., housing, community resources) including mental health diagnosis prevalence rates for children and adolescents (CDC, 2019; Glied & Cuellar, 2003). This report (Perout et al., 2013) included descriptions of the surveys used over the last 40 years with results of specific data collected between 2007-2011 on children and families. Each featured survey focused on one or more specific areas (e.g., mental health, housing, medical needs; CDC, 2019). According to Perou et al. (2013) the use of data collection to view trends and changes within society is critical to the development of policies and programming to meet identified needs for children and adolescents. Therefore, the U.S. government responded to these reported needs and prevalence rates by enacting legislation to increase access to and funding for youth mental health services and programs (Perou et al., 2013). The following sections will focus on legislation and program implementation from the last five decades that expanded children's mental health funding across all levels of government. These legislative acts resulted in the creation and expansion of school based mental health clinics and programs, including Thrive New York City, which will also be discussed.

Legislation from 1975 to Present

For almost five decades, the U.S. government enacted legislation to build upon existing school and community systems in efforts to address the mental health needs of children and adolescents. These legislative actions played a significant role in the development of school mental health services. One impetus was the Individuals with Disabilities Act of 1975 (IDEA)

which mandated educational services and support in schools to all students, including those identified with emotional disturbances (ED; Cuellar, 2015). Despite the enactment of IDEA, school systems with sparse monetary and staff resources limited the amount of support and access to special education services for students (Weist et al., 2017a). To respond to this challenge of limited resources, IDEA was updated in 1997 to develop partnerships with existing institutions in the community (e.g., schools, medical). According to Weist et al. (2017a), this change to IDEA laid the groundwork for expanded school-based mental health services by funding partnerships with community organizations aimed at prevention and intervention of mental health needs.

Another key event that contributed to the advancement of school mental health services was President Bush's enactment of the New Freedom Commission (NFC) on Mental Health in 2003. This commission was the result of the U.S. Surgeon General's 1999 seminal report which called for action in both policy and programming to support the mental health needs of all Americans, including children (Gould et al., 2009; Hegner, 2000). The NFC sought to expand mental health services in schools to meet the academic and behavioral needs of children (Atkins et al., 2010; Jacob & Coustasse, 2008). Specifically, the NFC established six goals to expand evidenced based child and adolescent mental health care practices that were consumer and family driven (Gould et al., 2009). One goal included the elimination of barriers and discrepancies in mental health services provided to children and families (Gould et al., 2009). This goal was addressed by expanding psychotherapy services through school based mental health clinics. With the expansion of school mental health services, uncoordinated systems (e.g., medical, school, mental health care systems) was a noted challenge to meeting the mental health needs of students (Cuellar, 2015; Gould et al., 2009). To remedy this challenge and build

connections between systems, federal legislation was passed from 1996 through 2010 aimed at increasing insurance coverage and access to mental health services (Takkunen & Zlevor, 2018).

Expansion of Insurance Coverage

Over the last three decades, several federal acts expanded insurance coverage for mental health needs with direct implications for mental health services within schools (Takkunen & Zlevor, 2018). These federal acts included the Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, and the Affordable Care Act of 2010 (Takkunen & Zlevor, 2018). In essence, the Mental Health Parity Act of 1996 resulted in annual or lifetime benefits for mental health coverage to that of coverage provided for physical illnesses. Hence, insurance companies could impose dollar limits comparable to those imposed on medical benefits (Congress.gov, n.d.; Takkunen & Zlevor, 2018). The second federal legislation, The Mental Health Parity and Addiction Equity Act of 2008, expanded the 1996 act to include addiction services covered by insurance companies (Centers for Medicare & Medicaid Services, n.d.). Prior to the enactment of these two laws, individuals might have been discouraged to seek mental health services due to high out of pocket costs, despite having insurance coverage (Stewart et al., 2018).

The last federal act that expanded insurance coverage of mental health benefits was the passing of the Affordable Care Act (ACA) of 2010. The ACA mandated insurance companies to cover mental health services (Health Care, n.d.). Through the ACA, licensed mental health counselors and social workers positioned at school based mental health clinics as in network providers were made eligible for insurance reimbursement (Cammack et al., 2017). Furthermore, the ACA expanded grant funding to increase access to screening and intervention for students (Cammack et al., 2017). As a result, the ACA provided sustainable programming for enhanced student access to mental health services (Cammack et al., 2017). The increase of insurance

coverage to include mental health services provided an incentive for individuals and families to enroll for insurance (Stewart et al., 2018). In efforts to maximize the benefits created through insurance coverage, the federal government coordinated efforts with other federal government agencies and individual states to implement a myriad of programs and services at the state and local levels (Cuellar, 2015; Gould et al., 2009).

State Government Response

The U.S. federal government provided special state funding for the implementation of comprehensive mental health plans, including community mental health block grants (CMHBG; Cooper et al., 2008; Gould et al., 2009). The CMHBGs provided special funding opportunities for grantees to implement mental health services for children and adolescents with emotional disturbances or a diagnosable mental illness (Substance Abuse and Mental Health Services Administration, 2020). While grantees adhere to federal guidance and reporting, funds are distributed across the 50 states to support state and local programmatic needs.

Gould et al. (2009) conducted the first analysis that examined components of state mental health plans, including where services are provided, types of services offered to youth across the U.S., and how the services related to goals set by the NFC. Results suggested state mental health plans were addressing the goals related to the NFC to varying degrees, with the majority of children's mental health services being provided in community mental health centers (96%), the juvenile justice system (94%), and school based services (90%; Gould et al., 2009). Within and across the aformentioned systems, service types included in-patient and outpatient treatment, crisis services, suicide and substance abuse prevention (Gould et al., 2009). In implementing federal government initiatives, the authors noted the important role of states and their influence on government initiatives such as the CMHBG (Gould et al., 2009). While it is difficult to

discern the specific needs of each state based on the data analyzed by Gould et al. (2009), two studies provided further insight into state needs and the implementation of services in school mental health settings (Butts et al., 2017; Cammack et al., 2017).

Cammack et al. (2017) summarized a variety of state-level implementations of mental health services in schools in relation to their respective funding sources (e.g., federal and state grants, medicaid, local budgets). For example, the state of Minnesota grant funded three-year projects to create a school mental health infrastructure across the state (Cammack et al., 2017). Funding covered counseling services provided by mental health professionals in addition to fiscal support for office space and materials (Cammack et al., 2017), thus increasing the development and access to SBMHC. In New Jersey and Kansas, school mental health programs received state funding to develop waiver programs to expand and provide services to students identified as emotionally disturbed (Cammack et al., 2017).

Butts et al. (2017) presented research to inform policies about effective school mental health practices in Montana's largely rural state. Their findings identified a "trilateral framework: partnership, research, and policy" (p. 75) to increase communication between state and local agencies aimed at providing school mental health services (e.g., therapy, training, community partnerships; Butts et al., 2017). In both studies (Butts et al., 2017; Cammack et al., 2017), state leaders recognized the importance of data to inform policies and to systematically determine program needs, funding sources, and overall structure. To further enhance federal and state response to mental health needs, partnerships with state and local level governments are necessary to further establish school mental health services across systems (e.g., schools, community partnerships) and secure funding sources.

Local Government Response

Researchers agreed schools are key locations for youth mental health services (Butts et al., 2017; Cuellar, 2015; Weist et al., 2017b). Federal legislation (e.g., ACA) and initiatives (e.g., the NFC) enabled school mental health services to receive a wide range of federal and state funding: the Children's Health Insurance Program (CHIP), medicaid or private insurance reimbursement, waivers, and inclusion of mental health services in school budgets (Butts et al., 2017; Cammack et al., 2017). As a result, additional mental health services became accessible to school aged youth and reimbursable through school-based mental health clinics (SBMHCs) at the local level (McCray, 2020; Takkunen & Zlevor, 2018).

Schools have partnered with local government agencies and community organizations to identify best approaches (i.e., SBMHCs, screening, educational programming; Bryan, 2005; Gross et al., 2015; Weist et al., 2017a) to meet student mental health needs. Fiscal sustainability is important to establishing long term programmatic support when federal and state funding is no longer available (Cammack et al., 2017; Giled & Cuellar, 2003). Carmmack et al. (2017) described three different school mental health programs (i.e., Washington D.C., Baltimore, Florida) and the variety of funding secured to remain sustainable (e.g., federal and state grants, medicaid reimbursement). Although the authors omitted the rationale for selecting these three specific programs, all programs demonstrated coordination across systems (e.g., school, community mental health, state or federal oversight) to provide services. Furthermore, Cammack et al. (2017) described the implementation of expanded school mental health services that included the use of mental health clinics within the school setting. In some instances, a sustainable mental health clinic program is of little to no cost to schools as a result of billing third party payers (Cammack et al., 2017; Costello-Wells et al., 2003). Therefore, expanding

services while identifying a variety of funding sources is essential to becoming and remaining sustainable on a local level.

One such sustainable program is Thrive New York City (NYC). In 2015, Thrive NYC was established to build mental health equity and reduce the stigma of accessing mental health services by increasing the number of available services, including school based mental health services (McCray, 2020; Plautz, 2020). Services are funded through private insurance and Medicaid, in addition to local and state funding (NYC DOE, 2020) which helps sustain programs. Thrive NYC is a municipal-level mental health program focused on consumer driven care (e.g., children, families) and rooted in evidence based practices (McCray, 2020). From a federal level perspective, Thrive NYC's mission supports the goals established in President Bush's NFC (2003) and further expanded on aspects of IDEA (1975, 1997) by way of increased community collaboration across NYC systems.

According to the New York City Department of Education (NYC DOE, 2020), school administrators identified an increase in poor academic achievement and behavioral challenges (e.g., increased mental health symptoms leading to emergency room visits). Hence, Thrive NYC's initiative to provide evidenced based care to individuals in need, including students, is key to addressing the aforementioned academic and behavioral challenges. Since Thrive NYC's inception, SBMH services expanded to include trauma-informed social and emotional learning, an increased number of school based mental health clinics (SBMHCs), and the new role of school response clinicians for schools without a SBMHC (Mayor's Office of Thrive NYC, n.d; McCray, 2020; NYC DOE, 2020). Due to the COVID-19 pandemic, telehealth services were expanded throughout established SBMHCs to support students' mental health needs (NYC DOE, 2020).

Mental health is an essential aspect of children's healthy development (Cooper, 2008; Gould et al., 2009; Stagman & Cooper, 2010). As a result of the striking data on children's mental health in the U.S., federal, state, and local governments have enacted legislation and policies aimed at meeting children and adolescents' mental health needs. With schools serving as key locations to provide behavioral health services (Cooper, 2008; Cuellar, 2015), school health and mental health services have expanded to include school based mental health clinics and collaborations with community mental health providers (DeSocio & Hootman, 2004; Jacob & Coustasse, 2008; Keeton et al., 2012). In this next section, a brief overview of the history of school based mental health services and key stakeholders who implement these services will be explored.

School Based Mental Health (SBMH) Services in School Based Health Centers (SBHC)

Although emotional health is considered a part of children's overall well being, addressing children's mental health was in its infancy during the mid-1900's (Weist et al., 2017a). Beginning in the 1960's and rooted in nursing and public health clinic traditions, School Based Health Centers (SBHC) were developed to provide expanded health services to students by school nurses and nurse practitioners (Weist et al., 2017a). In addition to providing health education, vaccinations, and detecting minor illnesses, the implementation of SBHCs broadened nursing services to include physical exams and treating accidents for students who otherwise would not have access to them (Flaherty et al., 1996; Weist et al., 2006; Weist et al., 2017a).

Researchers acknowledged numerous barriers to accessing health and mental health services for children and their families that included: limited community resources, parent's personal mental health needs and engagement in services, and stigma associated with such services (Flaherty et al., 1996; Costello-Wells, et al., 2003; Weist et al., 2017a). To reduce such barriers, school based mental health (SBMH) services (Jacob & Coustasse, 2008; Van Vulpen et

al., 2018) began in the early 1990s with mental health counseling provided within existing SBHCs (Flaherty et al., 1996; Keeton et al., 2012; Weist et al., 2017a). SBMH services include a variety of programming, assessment, and counseling provided in the school setting to better meet students' social and emotional needs (Flaherty et al., 1996; Hoover Stephan et al., 2015). Whereas SBHC nurses expanded their role to treat accidents and refer students for counseling services, SBMH were school employees hired to support student mental health needs. These practitioners represented the fields of school counseling, social work, and school psychology (Flaherty & Osher, 2003). At the same time, both SBHC and SBMH services resulted in improved student health and academic outcomes (e.g., grade point average, grade advancement) and a reduction in emergency medical services (Keeton et al., 2012; Knopf et al., 2016; Love et al., 2019).

SBMH services can be standalone programs or a component of the SBHC (Bains & Diallo, 2016; Hoover Stephan et al., 2015; Slade, 2003; Van Vulpen et al., 2018). The type of services provided to address the needs of individual schools may vary. For example, results from a longitudinal study examined the relationship between the availability of school based mental health services in SBHCs and school characteristics such as school size and location (Slade, 2003). Specifically, Slade (2003) reported mental health counseling services as a part of SBHCs were predominantly located and provided in urban (83.1%) and suburban (40.7%) schools, rather than rural areas (30.9%). Differences in the availability of services were attributed to variables such as geographic location, allocation of funding resources for rural compared to urban areas and types of mental health care or general health care services provided (Slade, 2003). Although Slade (2003) did not define rural and urban areas, factors such as population density and school size differentiated the two types of settings. Although the aforementioned data was collected

more than 20 years ago, currently, SBMH services are still predominantly located in urban locations (Bains & Diallo, 2016; Hoover Stephan et al., 2015).

Transition from SBMH Services to Expanded School Mental Health Programs (ESMH)

Whereas SBMH services are inclusive of overall programming and counseling related services, ESMH services brings contracted mental health providers directly into the school to address students and their family needs. Coined by Weist (Weist et al., 2002), ESMH programs provide an array of services including psychotherapy, psychiatric evaluations, preventive programming, and case management (Weist et al., 2017a; Weist et al., 2017b). ESMH services are composed of various community, medical, and mental health professionals and their respective organizations such as community mental health organizations, health departments, or university affiliated programs (Weist et al., 2002). These collaborative efforts augment what is already being provided by school hired mental health professionals (e.g., school counselors) with contracted community mental health providers (e.g., LMHC; Weist et al., 2003).

Five general formats and three dominant models have been developed to serve as guiding frameworks for organizing and providing ESMH services. According to Adelman and Taylor (2002a; 2002b), there are five general formats to describe the types of SBMH services: 1) school-financed student support services; 2) school-district mental health units; 3) formal connections with community mental health services; 4) classroom-based curriculum and special group intervention sessions; and 5) comprehensive, multifaceted and integrated approaches. In comparison, Jacob and Coustasse (2008) identified three dominant SBMH models according to Kutash et al. (2006): 1) the mental health spectrum; 2) interconnected systems which involves weaving academic and behavioral services to support varying student needs; and 3) positive behavior support (PBS). Positive behavior support aims to reduce disruptive behavior in the classroom in order to promote a positive learning environment. Commonalities across all of the

aforementioned formats and models include the identification and collaboration of mental health providers (e.g., school psychologists, school counselors, social workers); partnerships with community based organizations; weaving mental health supports into the school community; and opportunities for SBMHCs facilitated by third-party mental health providers (Adelman & Taylor, 2002a; 2002b; Jacob & Coustasse, 2008). However, the formats provide broad information about the delivery of ESMH and SBMH services while the three dominant models described by Jacob and Coustasse (2008) each have a different focus, if used with fidelity. For example, the mental health spectrum focuses on therapeutic approaches aimed at mental health diagnoses and not inclusive of academic need (Jacob & Coustasse, 2008).

While there have been proposed models and formats for SBMH services, there is no set framework or model. Schools often create separate mental health programs, such as social and emotional learning or clinical counseling (i.e., individual, group, family, etc.), rather than utilizing a cohesive strategy like the models actually propose (Jacob & Coustasse, 2008; Zins et al., 2004). Without a cohesive approach, the quality of mental health services in schools may suffer due to the lack of coordination, potential miscommunication, and redundancy of services from providers (Flaherty et al., 1996; Mellin et al., 2010; Weist et al., 2005). Coordination amongst providers seems imperative to the process of ESMH services, including school based mental health clinics.

School Based Mental Health Clinics (SBMHC): A Component of ESMH Programs

Being that the proposed study focuses on SBMHCs, it is important to report on the literature related to this component of ESMHs. SBMHCs are beneficial to schools as there is little to no cost to the school and third party providers (e.g., LMHCs) who work directly within the school community (Christian & Brown, 2018; Costello-Wells et al., 2003). The delivery of SBHMCs reduces barriers to accessing mental health treatment, including individual

psychotherapy. SBMHCs are described by authors using various terms: school based mental health services, school health services, and mental health programs (Adelman & Taylor, 2002; Armbruster et al., 1997; Flaherty et al., 1996; Jacob & Coustasse, 2008; Lean & Colucci, 2013; Weist et al., 2006). The following search engines were used to identify counseling and SMH related literature: Google Scholar, ProQuest Central, Science Direct, and EBSCO host utilizing key words and phrases such as: school based mental health clinics, co-located services in schools, school mental health, school based mental health services, community based organizations, and mental health in schools. Within the aforementioned terms, programs or services are commonly described as therapists or community based clinicians providing psychotherapy and supporting families with community referrals within a clinic setting. Such terms or descriptions can generate confusion among researchers in determining if the services involve a SBMHC or other SBMH service.

However, one conceptual article (Costello-Wells et al., 2003) was located which focused specifically on SBMHC's, including the actual term. The definition of SBHMC for this proposed study is adopted from Costello-Wells et al. 's (2003) explanation: SBMHCs are facilities co-located within a school which provide mental health services by a community based mental health organization. Although there is a dearth in the empirical literature utilizing the specific term SBMHCs, Costello-Wells et al. (2003) highlighted and presented one agency's implementation and interpretation of SBMHCs within the Indianapolis school district. Costello-Wells et al. (2003) identified several key components to developing and implementing SBMHC services that began in one school and expanded to 54 schools over the course of four years. A significant focus of their article is the description of licensed third party providers or therapists and their work in the SBMHC. The therapists were described as co-creators with the school

administration in developing referral processes, consulting with teachers, and providing referrals for families to community services, all integral aspects to the structure of SBMHC (Costello-Wells et al., 2003). Although the authors do not specify the license type of the therapists (Costello-Wells et al., 2003), they provided information about the role therapists can have in a SBMHC in supporting the mental health needs of their school community.

Multi Tiered System of Support (MTSS)

Researchers have suggested SBHC, ESMH, SBMHC programs should have defined roles in the school community along with clear policies and procedures when implementing SBMH services. Doing so would help minimize challenges associated with integrating SBMH services into the school community, such as streamlining screening procedures for mental health needs and maintaining confidentiality policies (Costello-Wells et al., 2003; Weist et al., 2003; Weist et al., 2005). For example, Weist et al. (2005) described protocol when referring students to SBMH services. To counteract challenges associated with infusing SBMH providers within the school system, it has been suggested that SBMH services within a multi-tiered system of support (MTSS) optimizes the integration of services within the school community (Hoover Stephan et al., 2015; Lean & Colucci, 2013; Shepard et al., 2013).

The MTSS is a structured model aimed to deliver academic and behavioral health services for the entire school community (Hoover Stephan et al., 2015; Lean & Colucci, 2013; Weist et al., 2017a). MTSS is the combination of two academic and behavioral service approaches: Response to Intervention (RtI) and Positive Behavior Intervention and Supports (PBIS; Hoover Stephan et al., 2015). The overarching goal of RtI is to identify students in possible need of special education services while PBIS's objective is to create a positive behavioral learning environment for all students (Shepard et al., 2013). Combined, PBIS and RtI

make MTSS a useful, comprehensive approach to serve schools on a community and individual level (McReal.Org, 2015).

The Three Tiers of MTSS

NYC Public Schools aim to meet students' social and emotional needs by using an MTSS approach, consisting of three tiers of interventions (NYC DOE, 2021). Specifically, MTSS uses tiers of activities and support for students at three levels: Tier 1/universal, Tier 2/selective, and Tier 3/targeted. Services are categorized within one of the three tiers based on individual or community need (Lean & Colucci, 2013; Shepard et al., 2013). Furthermore, data are collected to support student success across the three tiers (Lean & Colucci, 2013; Shepard et al., 2013). Tier 1/universal supports focus on the entire school community, such as a crisis response training for school staff (Hoover Stephan et al., 2015; Lean & Colucci, 2013). Tier 2/selective supports focus on students with behavioral challenges or the propensity to develop such challenges (Hoover Stephan et al., 2015; Lean & Colucci, 2013). Tier 2 interventions include a targeted classroom lesson to support group behavior or small group counseling. Lastly, Tier 3/targeted supports refer to an identified behavioral problem and case management services (e.g., individual and family psychotherapy; Hoover Stephan et al., 2015; Lean & Colucci, 2013). The tiered system is also used by school based mental health providers to describe provided ESMH or SBMH services (Lean & Colucci, 2013; McCray, 2020). For example, terms affiliated with MTSS, such as Tier 1, are incorporated into NYC Public School SBMH programs (NYC DOE, 2021). Consequently, this shared language used within an MTSS approach strengthens the collaboration between school and community agencies and their provision of services.

Services and supports are fluid within and between the three tiers of MTSS (Lean & Colucci, 2013). For example, students may participate in both school wide campaigns and receive individual services. ESMH or SBMHC services fall within the associated tiers of the

MTSS framework. For example, a SBMHC offering individual counseling would be a Tier 1 service. Schools may provide a range of Tier 1-3 services from a variety of providers, including school counselors and LMHCs (Lean & Colucci, 2013). Due to the unique needs within each school, the types of programs and funding available are not universal (Shepard et al., 2013). Thus, comprehensive counseling services or academic programs may not be available to all students in neighboring schools or school districts.

MTSS and SBMH Services

An MTSS approach to service provision and the expansion of SBMH services seemed to arise parallel to each other, but not as a result of one another. Weist et al. (2017a) suggested that integrating SBMH services within a MTSS framework was beneficial and important for three reasons. First, schools are children's primary learning environment; students function best in a place that is positive and stable (Weist et al., 2017a). Second, an MTSS approach provides structure for programming and identifying children needing SBMH services (Weist et al., 2017a). Third, an MTSS approach allows all children to learn skills that would be beneficial to them as they get older (Weist et al., 2017a). Other authors concurred with Weist et al. (2017a) as they (Lane et al., 2014; Lean & Colucci, 2013) also described the MTSS approach as one that can be integrative of community based mental health services within schools. They also believed that integrating SBMH services could be done by developing a strong, collaborative relationship between the behavioral and academic supports and their respective school and community based mental health providers (Lane et al., 2014; Lean & Colucci, 2013). An example of partnership includes NYC Public Schools partnering with community based organizations to provide an array of services including psychotherapy in SBMHCs and other related SBMH services within an MTSS approach (NYC DOE, 2021).

The Role of Mental Health Professionals in Schools

Kininger et al. (2017) described a *school mental health professional (SMHP)*, as an individual who provides or plays a role in the mental health services provided within schools. This role can include school hired employees, such as school counselors or contracted employees such as LMHCs. Marsh and Mathur (2020) noted that approximately 77% of schools employ a part time SBMHP to implement needed services. Researchers acknowledged that collaboration between SBMHP and other school hired mental health professionals addresses the aforementioned challenge of the amount of services provided by a part time employee (Lane et al., 2014; Mills & Cunningham, 2017; Weist et al., 2003; Weist et al., 2006).

While school counselors, school social workers, and school psychologists all share a mental health background and receive training to support the mental health needs of students, their roles in schools differ (Dikel, 2020; Flaherty et al.,1998; Kininger et al., 2017). Across the three school mental health professions, each follow competencies set by their respective national associations: American School Counselor Association (ASCA), National Association of School Psychologists (NASP), and National Association of Social Workers (NASW; Kininger et al., 2017). One goal across the three competencies is to provide a framework for providing quality school mental health services (ASCA, 2019; NASP, 2020; NASW, 2012).

School psychologists have a foundation in education and psychology where the majority of their work revolves around the educational and mental health needs of students in the form of psychological assessments, program evaluation, and service implementation (Flaherty et al., 1998; Kininger et al., 2017). While school psychologists may be trained to provide mental health interventions, they often find themselves doing special education determination assessments (Kininger et al., 2017). However, school social workers and school counselors can provide more targeted, individual mental health services.

The role of school social workers are comparable to that of a licensed mental health counselor (LMHC) in two ways: 1) providing mental health counseling services; and 2) establishing connections between individuals and community services based on individual needs (Flaherty et al., 1998; Kininger et al., 2017). One difference between school social workers and LMHCs are their respective employers. Whereas a school social worker is employed directly by the school (Flaherty et al., 1998; Kininger et al., 2017), a LMHC often works for a community mental health clinic (Christian & Brown, 2018). When considering the services provided by school social workers, NASW (2012) provides a framework for service provision that is based on the MTSS framework to meet the needs of all students in the school setting. In a national survey which explored types of services provided by school social workers, Kelly et al. (2015) reported an overextension of their work duties due to multiple clinical and administrative services.

Lastly, school counselors are tasked with supporting the academic, vocational, and behavioral needs of students through a comprehensive school counseling program (Flaherty et al., 1998; Goodman-Scott, et al., 2017; Kearn et al., 2017; Kininger et al., 2017). ASCA competencies state school counselors should understand and support the mental health needs of students and make community connections for long term therapy when necessary (ASCA, 2019). Lean and Colucci (2013) described school counselors as instrumental when integrating services within the school community due to their knowledge of child behavior and supporting students' overall function.

Researchers have argued that it is essential that SBMHP, including school counselors, collaborate in the school setting (Bemak, 2000; Bryan & Holcomb-McCoy, 2007; Gibbons et al., 2010). However, SBMHPs contracted roles and duties can impede the implementation of

programs or overlook students in need of school mental health services (Blake, 2020; Collins, 2014; Flaherty et al., 1998). To expand quality services, schools collaborate with community mental health clinics and other programs to support the mental health needs of students (Christian & Brown, 2018; Mellin et al., 2010; Mellin & Weist, 2011; Weist et al., 2001; Weist et al., 2010). It is not understood what the experience is like for external providers (i.e., LMHCs) coming into the school setting to provide the necessary services. However, Christian and Brown (2018) examined the SBMH literature comparing the training, role, and experience of both school counselors and clinical mental health counselors. As a result of this comparison, the authors defined the role and training of a SBMH counselor as a licensed clinical mental health counselor who completed courses related to the provision of mental health services to school-aged children, credentialed by their state, and employed by a school or community agency (Christian & Brown, 2018). Their roles include collaborating with school counselors who provide clinical services informed by school based data (Christian & Brown, 2018). Although Christian and Brown (2018) do not specify LMHCs working in a school based mental health clinics, they describe SBMH counselors as providers of individual and group counseling sessions, which are aspects of school based mental health clinic services (Costello-Wells et al., 2003). Christian and Brown (2018) were the first and only to define the role of SBMH counselors that highlights the credential of the LMHCs.

Representation of LMHCs in SBMH Research

While there is research focused on school based mental health providers (SBMHP), it is often presented in general or broad terms. For example, researchers utilized terms such as therapist or clinician, which does not specify their licensure affiliation or specific mental health profession (e.g., clinical mental health counselor, psychologist, social worker) (Christian & Brown, 2018; Doll et al., 2017; Hoover Stephan et al., 2015). There are only two studies to date

(Carlson & Kees, 2013; Larson et al., 2017) that mention LMHCs working in SBMH services. Larson et al. (2017) examined the characteristic differences of school based health centers (SBHCs) with and without mental health services and found that 85% (978 of 1381 clinics) of the SBHCs had licensed social workers or therapists on staff. School based health centers with mental health providers (MHPs) on staff were able to provide more crisis intervention, mental health education, and referrals when compared to SBHCs without MHPs.

Carlson and Kees (2013) studied school counselor perceptions of mental health services in schools provided by SBMHPs. All 120 participants self-identified as school counselors, in addition to their professional counselor licensure and/or certification. Hence, of the 120 participants, 112 self-identified solely as school counselors, 11 self-identified solely as licensed professional counselors, and 9 self-identified as both a school counselor and a Licensed Professional Counselor (Carlson & Kees, 2013). Participants responded to survey questions aimed to understand school counselor's mental health training, comfortability with diagnoses and counseling skills, and attitude towards working with school based therapists (Carlson & Kees, 2013). Results indicated that SBMHPs were comfortable with anxiety and disorders primarily diagnosed in childhood (e.g., ADHD) as compared to other mental health diagnoses (Carlson & Kees, 2013). Additionally, SBMHPs completed a range of counseling and child and adolescent coursework and strongly endorsed the need for SBMHPs in the school to offset the workload of school counselors (Carlson & Kees, 2013). The authors of the study identified 91% of participants responded positively to having school based therapists in the school setting who have knowledge of the role of school counselors and mental health services in schools. However, only 34% of participants identified working alongside a school based therapist (Carlson & Kees, 2013). The authors suggested school based therapists should know how to navigate the school

community and understand the role of school counselors in coordinating mental health services (Carlson & Kees, 2013). Larson et al. (2017) suggested that future research should qualitatively study how licensed SBHCs integrate with school hired mental health professionals, including school counselors. Furthermore, using qualitative research designs or methodologies to understand how LMHCs learn information about their school community and the roles they have would provide a depth to the perceptions and provisions of school mental health services.

Crespi et al. (2000) acknowledged that contracting with school based mental health counselors (SBMHCs) is increasing, whether that is in school based health centers or contracted to work in schools from a community agency (Carlson & Kees, 2013; Christian & Brown, 2018; Larson et al., 2017). It is difficult to determine if the services are provided in a school based mental health clinic as there is no mention of such a setting in the aforementioned research (Carlson & Kees, 2013; Larson et al., 2017). Despite the increase of SBMHCs being hired to work in schools, Lean and Colucci (2013) described the issue of schools creating services without understanding how these mental health professionals can function optimally in the school community. Therefore, the placement of newly hired clinicians in school based settings without knowledge of the complexities of their roles places a challenge to integrate them into the provision of existing school services (Christian & Brown, 2018; Lean & Colucci, 2013; Stephan et al., 2015). It is imperative for researchers, educators, and supervisors to understand the training needs and role of LMHCs in schools to help LMHCs acclimate to their position.

One approach to acclimate SBMHCs to the school mental health system is through induction. Rooted in the field of teacher preparation, *induction* is a process in which new staff are trained, supported, and/or mentored through a variety of activities (e.g., supervision) typically during their first two to five years of employment (Ingersoll & Strong, 2011; Strong,

2005; Hoover, 2010; Wong et al., 2005). It is important to consider how school mental health professionals are introduced or inducted into their role within the larger school system due to the numerous individuals and systems involved (Curry & Bickmore, 2012; 2013a). However, limited induction research has been conducted with school counselors (Curry & Bickmore, 2012, 2013a; Matthes, 1992) and none-to-date for LMHCs who are employed in the schools. Therefore, drawing from the teacher preparation literature provides an understanding of induction, its application to teachers and school counselors alike, and how it could benefit SBMHCs.

Teacher Induction Programs

Tate introduced the term *induction* in 1943, which focused on high school teachers' adjustment during their first year on the job (Kearney, 2014). Tate (1943) noted the problematic turnover rate for high school teachers because individual teachers were charged to develop instructional standards rather than utilize a cohesive school-wide approach. To address the high turnover rate, Tate (1943) described several induction activities to support teachers' acclimation to their role and to support a more cohesive approach: (a) meeting with the superintendent for feedback and support; (b) understanding school policies and teacher expectations; (c) scheduling consistent meetings with peers for instructional support and development; and (d) utilizing teaching manuals to support student learning.

During the 1950s a shift in teacher training occurred for certified teachers and new graduates to participate in a one-year internship that was funded through private grants (Serpell, 2000). By the 1970s, internship years were established as part of bachelor's and master's programs with the support of federal grants through colleges and universities (Serpell, 2000). However, internships did not reduce challenges experienced by novice teachers, nor did it constitute an induction program (Serpell, 2000). It was not until the 1980s when induction became a research focus in the teacher preparation due to increased attention on teacher retention

and challenges experienced in the first three years of their job (Hoover, 2010). The goal of teacher induction programs aims to support the adjustment of new teachers in hopes to increase teacher retention and to better manage workplace stressors that typically occur within the first three years of their new job (Hoover, 2010; Kearney, 2014; Mitchell et al., 2017). Ingersoll and Strong (2011) described induction as a continuation of support and growth in teachers' professional identity that will also improve the growth and learning of students. Ingersoll (2012) identified schools as a place of additional learning where novice teachers can explore how to become independent and successful functioning teachers.

Challenges in the Teaching Profession

The longevity of teachers remaining in the profession has changed significantly due to an influx of new teachers entering the profession (Ingersoll, 2012; Strong, 2005). Despite an increase in hiring novice teachers, teachers are less likely to stay in the field beyond their first few years (Ingersoll, 2012). Teachers are leaving the profession prematurely as a result of challenges experienced in the workplace (Fantilli & McDougall, 2009; Hoover, 2010; Ingersoll, 2012; Strong, 2005). These challenges for novice teachers include teaching more classes, obtaining more duties as compared to returning staff, feelings of isolation, inadequate feedback and supervision, lack of emotional or instructional support, and few opportunities for professional development (Hoover, 2010; Kearney, 2014; Nolan & Hoover, 2008).

In an U.S. urban school context, researchers reported novice teachers are more likely to leave the profession as a result of difficulties with classroom discipline, child behavior, large workload, and challenges with the school environment (e.g., cultural differences, language barriers; Ingersoll, 2003; Gaikhorst et al., 2014; Gaikhorst et al., 2017). Teachers in the U.S. felt unprepared to work with the challenges presented to them with little support from school administration or other resources (Gaikhorst et al., 2014; Gaikhorst et al., 2017). The

aforementioned stressors indicate a variety of support is needed for teachers to acclimate to the school community that can only be learned on the job in their respective schools. Fantilli and McDougall (2009) argued that schools must identify challenges their teachers are experiencing and support them in their acclimation to the school community. Induction programs are designed to support teachers as a way to counteract such challenges.

An Overview of Induction Programs

While induction and mentoring may be used interchangeably in the literature (Strong, 2005), Wong et al. (2005) argued that induction is the primary program which comprises opportunities for staff development *with* mentorship as "a component of the induction process" (p. 379). Wong et al. (2005) compared and contrasted five countries' (i.e., France, Japan, New Zealand, China [Shanghai], and Switzerland) induction programs to that of the U.S. as a source to enhance induction programs in the U.S. Across the five countries, the induction approaches were structured, monitored for effectiveness, and comprehensive. While in the U.S., there is inconsistency in the provision of induction programs (i.e., only mentoring or lack of monitoring; Wong et al., 2005).

With no formal guidelines regarding the development of induction programs in the U.S., Wang et al. (2002) created a framework to evaluate induction programs and state policies that provided oversight and structure. Rooted in previous research on induction policies and programs, Wang et al.'s framework to evaluate induction programs consisted of three parts: (a) legislation and funding, (b) state district and union roles, and (c) program components (Wang et al., 2002). The authors further categorized program components into design features, beginning teacher support and resources, and roles for teachers and other supporters (Wang et al., 2002). Wang et al. argued the three main parts informed each other to structure a school's induction process. For example, funding from the state legislature would provide the necessary resources

for a local school district to develop and implement an induction program that meets state guidelines and local teacher needs. Furthermore, state education and local school district policy makers would have a set of guidelines that inform induction program components such as the length of time and eligibility for both mentor and mentee.

More recently, the New Teacher Center (2018) developed three core standards for a comprehensive school induction program for principals and teachers: foundational, structural, and instructional. The foundational standard focuses on program development and implementation of induction activities for new teachers (New Teacher Center, 2018). Specifically, this standard involves principals and lead teachers developing induction programs that engage novice teachers' individual goals and commitment to the school community (New Teacher Center, 2018). The structural standard consists of the following activities: 1) school administrators developing the training and role responsibilities for mentors, 2) mentors developing skills to assess mentee's teaching practices, and 3) onboarding with professional learning opportunities for novice teachers (New Teacher Center, 2018). Onboarding involves novice teachers understanding school expectations, the district's mission, and student goals in order to create a positive learning environment (New Teacher Center, 2018). For example, after learning school policies, mission, and goals, novice teachers participate in mentorship or differentiated learning workshops with identified mentors or lead teachers (New Teacher Center, 2018). Lastly, the instructional standard focuses on assessment of teaching practice and overall classroom learning environment. For example, mentors provide resources and feedback to novice teachers to support the diverse needs of their students' learning. These standards support novice teachers to be independently practicing teachers and create an optimal learning environment for all students.

Although the New Teacher Center (2018) suggested standards for induction programs, there is literature describing components used to develop induction programs within schools (Fantilli & McDougall, 2009; Hoover, 2010; Ingersoll, 2012; Ingersoll & Strong, 2011; Kearney, 2014; Mitchell et al., 2017; Wong et al., 2005). Components of a school's induction program can also include group activities, orientation to the school community, reduced workloads, meetings with school administration, teaching strategies, opportunities for professional development, and the most commonly used method--mentoring (Fantilli & McDougall, 2009; Hoover, 2010; Ingersoll, 2012; Ingersoll & Smith, 2004; Kearney, 2014; Smith & Ingersoll, 2004; Spooner-Lane, 2017). Spooner-Lane (2017) conducted an integrative literature review on mentorship for new Kindergarten - sixth grade teachers. The author identified a variety of mentorship and induction programs which included school based induction, university sponsored interventions, district based induction, and beginning teacher support and assessment (Spooner-Lane, 2017). Participation typically lasted one to three years depending on the school district or program availability (Hoover, 2010; Ingersoll, 2012; Spooner-Lane, 2017). In addition to components of induction, there is new research exploring the impact of teachers participating in such programs.

Ingersoll and colleagues focused their research on the impact of induction programs for teachers (Ingersoll, 2003, 2012; Ingersoll & Smith, 2004; Ingersoll & Strong, 2011; Smith & Ingersoll, 2004). Ingersoll and Strong's (2011) most recent study included a critical examination of 15 quantitative studies that focused on the effect of induction programs since the mid-1980s. The 15 studies included evaluations of induction programs and outcomes of induction programs focused on variables including teacher retention, teaching approach, classroom management, and student success (Ingersoll & Strong, 2011).

A significant finding of this literature examination was a positive impact for teachers participation in induction programs across the aforementioned outcomes (Ingersoll & Strong, 2011). Ingersoll and Strong's (2011) findings supported results from other studies which identified positive effects of induction programs (Hudson, 2012; Ingersoll & Smith, 2004; Smith & Ingersoll, 2004). For example, Ingersoll and Smith (2004) qualitatively examined components of teacher induction on teacher retention. Results indicated teachers who engaged in induction activities, such as common planning time, were less likely to transfer to another school or leave their current position after the first year (Ingersoll & Smith, 2004). Similarly, utilizing a nationally representative sample of novice teachers in the U.S., Smith and Ingersoll (2004) identified an increase of teacher participation in induction activities, such as teacher collaboration, which decreased the likelihood of them leaving their position after the first year of service.

Therefore, it is possible that teachers who participate in induction activities are more likely to remain in their position. A limitation to Ingersoll and Strong's (2011) study was the exclusion of qualitative studies, limiting rich data about the teacher's inductive experience. Similarly, Smith and Ingersoll (2004) and Ingersoll and Smith (2004) utilized national surveys that were not inclusive of qualitative questions which limits the teacher's description of their experience in induction activities. The aforementioned literature examines the application, practice, and participation of induction with teachers. Given the proposed study aims to understand the induction process of Licensed Mental Health Counselors (LMHCs) in school based mental health clinics (SBMHCs), several researchers have extended the application of induction to school counselors (Curry & Bickmore, 2012; 2013; Loveless, 2010; Matthes, 1992; DeAngelis Peace, 1995).

Induction Programs for School Counselors

Researching the topic of induction programs for school counselors yielded seven studies. This intentional search process included selected search engines to identify empirical and conceptual articles related to this topical area: Google Scholar, ProQuest Central, Science Direct, and JSTOR. Key terms used included school counselors, induction programs, induction, mental health induction, and school counselor induction. Given the few articles yielded by the aforementioned terms and search engines, only articles describing school counselor induction were included in this literature review and publication dates ranged from 1992 to 2013. Specifically, two of the seven articles consisted of principals and counselor educators as study participants and hence were omitted as school counselors were not included (Bickmore & Curry, 2013; Neuer Colburn & Bowman, 2021). Therefore, the final review of the literature related to induction programs for school counselors yielded five articles (Curry & Bickmore, 2012; 2013; Loveless, 2010; Matthes, 1992; DeAngelis Peace, 1995).

In their transition from graduate student to practitioner, Jackson et al. (2002) applied the concept of induction to school counselors. The authors explained the role of school counselors as "internalized" or learned on the job as a result of their navigation through processes such as induction (Jackson et al., 2002, p. 177). Although a specific time frame was not defined, DeAngelis Peace (1995) described how induction programs can range from a short term onboarding process of introducing policies and procedures to a series of workshops with little supervision provided by the school. Novice school counselors may be assigned to more than one school based on geographical setting (e.g., urban, rural) with varying student to school counselor ratios (Matthes, 1992). Having multiple school assignments or varying student ratios may lead to feelings of isolation and little peer support (Matthes, 1992). Thus, it is important that school

counselors feel supported and adjusted to the school setting while being oriented to policies and procedures.

Matthes's (1992) qualitative study was the first of its kind to apply the concept of induction to school counselors. This seminal study provided information into the reported processes and problems of forty novice school counselors in their adjustment to their new schools (Matthes, 1992). To understand the induction experience of school counselors, Matthes (1992) used the *Conditions for Professional Practice: Counselor's Perceptions* questionnaire. This questionnaire consisted of three parts: demographic information, information about the school characteristics, and six vignettes that novice counselors may encounter in their role (Matthes, 1992). The topics of the six vignettes included: student-counselor relationship, public presentation, psychological education, testing, parent-counselor relationship, and teacher-counselor relationship, respectively (Matthes, 1992). Participants indicated the primary person(s) who resolved the situation that was similar to the vignettes or supported the participant in the resolution process. Participants mainly consisted of school counselors working in urban school settings with previous teaching experience in the same Iowa teaching district in which they were currently employed (Matthes, 1992). The top three vignettes most encountered were the student, parent, and teacher-counselor scenarios with the principal often being the source of support to resolve the situation (Matthes, 1992). Challenges in interpersonal dynamics within the school community may reduce school counselors' feeling of contribution to the school community (Matthes, 1992). Matthes (1992) acknowledged that novice school counselors were in a "sink or swim" type of environment and were provided minimal support by their school principals who were identified as the primary supervisor by 87% of participants in the study (p. 245). Furthermore, 39 of the 40 participants indicated they had the same workload expectations as

experienced school counselors (Matthes, 1992). Results of the completed vignettes by participants indicated high expectations in workload and limited opportunities for mentorship. Furthermore, novice school counselors reported feelings of isolation and uncertainty when managing problems that arose in the school setting (Matthes, 1992).

In efforts to reduce adjustment issues and increase skill development as novice school counselors, DeAngelis Peace (1995) developed a model for school counselor induction programs. DeAngelis Peaces' (1995) proposed model served two purposes: 1) to coach mentors to supervise school counselors, and 2) to support novice school counselors. Supervisors engaged in a class-like setting to develop their supervision skills (e.g., guided reflection, feedback). In turn, supervisors engaged novice counselors in clinical skill development and school counseling program implementation. Although the article was conceptual in nature with minimal demographic data collected from supervisor and novice school counselor participants, DeAngelis Peace piloted their model in a North Carolina school district and provided quotes from participants in the program. Responses from participants indicated a positive learning experience for both the supervisor and novice counselor (DeAngelis Peace, 1995). For example, supervisors who participated in the program described the supervisor training as helpful in becoming attuned to novice counselors' concerns and how to respond to their needs (DeAngelis Peace, 1995). Novice school counselor participants reported the feedback from examining tapes with their supervisor aided in their individual and group counseling skill development (DeAngelis Peace, 1995). Similar to Matthes's (1992) sink or swim description, DeAngelis Peace (1995) stated, "the leap from their [novice school counselors] preservice program to assuming full responsibility for a school counseling program can be a precarious trial by fire experience" (p. 177). Matthes (1992) and DeAngelis Peace (1995), alluded to school counselors having little

direction when acclimating to their role and feeling unsure about their school counseling development.

A decade later, three studies were conducted which added to the school counselor induction literature (Curry & Bickmore, 2012, 2013; Loveless, 2010). Research on the aforementioned three studies about school counselor induction used qualitative methodologies to gather the essence and perspectives of participants' experiences (Curry & Bickmore, 2012, 2013; Loveless, 2010). Curry and Bickmore (2012, 2013) studied the induction of novice school counselors through the interactions and relationships built within the school setting and perception of the induction programs provided. In their first study, Curry and Bickmore (2012) reported on the professional needs of novice school counselors and the construct of mattering. Mattering focused on the school counselors' connection and feeling of importance to their school community (Curry & Bickmore, 2012). Using a qualitative design, seven novice school counselors participated and identified primarily as first year school counselors who were White, female, and in their 20s. In their following study, Curry and Bickmore (2013) examined school counselors and their principals' understanding of induction in their school community and how it met the personal and professional needs of novice school counselors. Participants in the study included seven- first and second year school counselors and 5 principals who worked in Kindergarten-12th grade settings. Participants also noted their prior work experience ranging from teaching, accounting, or no prior work experience. Across both studies, identified themes regarding the induction process included collaborating with school administration and staff, receiving informal mentorship, orienting themselves with the school community, engaging in professional development opportunities, and acclimating to their caseload (Curry & Bickmore,

2012; 2013). Yet, at times, participants reported how these services were not provided in a planned or programmatic manner (Curry & Bickmore, 2012, 2013).

As a result of the varying induction experiences, school counselors reported several associated challenges (Curry & Bickmore, 2013). First, school counselors reported differing expectations based on what they learned in graduate school versus their daily job duties. For example, school counselors reported administering benchmark exams and test monitoring (Curry & Bickmore, 2013). Additionally, school counselors reported feelings of workplace stress due to general orientation to the school community, which included training that was more teacher focused rather than school counselor focused (Curry & Bickmore, 2013). Lastly, school counselors reported challenges communicating with principals and few mentorship opportunities during their acclimation to the school community. Responses from the principals indicated awareness of the aforementioned stressors and principals' expectations of novice school counselors should be at the level of experienced counselors (Curry & Bickmore, 2013). These findings demonstrated a range of support and processes for school counselors as they adjust in their roles, connect to their school community, and develop their counselor identity (Curry & Bickmore, 2012, 2013). For example, Curry and Bickmore (2012, 2013) described school counselors reporting their professional needs not being met. Curry and Bickmore (2012, 2013) stated that such needs may be addressed through various induction processes such as relationships with school stakeholders, parent and teacher interactions, and feedback through mentoring. However, these induction processes are often done in an informal and unstructured way (Curry & Bickmore, 2012, 2013).

Only one study was located that examined structured induction programs for acclimating and supporting novice school counselors. Loveless (2010) defined a structured induction

program as the organized approach of mentors bringing activities and topics to the mentee regarding their school counselor role and professional counselor identity. This one-year structured induction program included monthly meetings on topics such as small group lessons, classroom guidance, technology in the school, and maintenance of the counseling records (Loveless, 2010). Additionally, mentors met with their mentees for consultations, accountability studies, and individual support on a weekly or as needed basis.

A unique aspect to this structured induction program was the development and oversight of the induction program by experienced school counselors who are familiar with the standards set forth by the American School Counselor Association (ASCA), as well as the local school district policies and procedures. Additionally, supervision of the novice school counselors within the structured induction program was provided by experienced school counselors. This supervision differs from previous studies that described supervision and oversight of novice school counselors provided by school principals (Curry & Bickmore, 2012, 2013; Matthes, 1992). For example, Curry and Bickmore (2012, 2013) described school counselor professional needs as not being met through their respective induction programming due to school administrators not fully understanding the role and training of school counselors. Therefore, training and supervision by experienced school counselors may better support acclimation to the school setting and further develop professional identity for novice school counselors.

Loveless's (2010) structured induction program consisted of 11 participants representing 10 different elementary schools within the same school district. Although Loveless (2010) did not collect demographic data, all participants were newly hired elementary school counselors: seven novice and four veteran. Loveless (2010) described novice school counselors as new to the school district and counseling field, whereas veteran school counselors were new to the school

district but have previous counseling experience. Utilizing a case study, Loveless (2010) collected data from multiple sources to examine mentees' perceptions of the structured induction program: semi-structured individual interviews, observations of the new counselors, and program documents related to school counseling resources and school policies. Field notes were collected based on four observations that were conducted on classroom guidance lessons and program planning consultations. Additionally, examined documents included school program calendars and a counselor handbook provided to participants. A noteworthy limitation of Loveless's (2010) study was the absence of data collected from mentors who participated in the induction program.

Participants reported a relatively positive perception of their school induction experience. For example, of the 34 times program structure was mentioned in the interviews by participants , 25 were identified as positive (Loveless, 2010). Participants identified orientation to policies and school resources, sharing of resources, mentor support, and consultation on cases as helpful to their acclimation as school counselors (Loveless, 2010). However, six participants provided suggestions for improvement to the program: increase the length of the program from one to two years, additional one-on-one time with mentors, and more mentors to increase the time spent with their assigned mentees. Overall, significant contributions from the school counseling induction literature based on the aforementioned programs includes the identified need of support, professional development, and relationship building within the school community to build on their counselor identities and acclimation to their professional role (Curry & Bickmore, 2012, 2013; Loveless, 2010; DeAngelis Peace, 1995).

The aforementioned research (Curry & Bickmore, 2012, 2013; Loveless, 2010; Matthes, 1992; DeAngelis Peace, 1995) demonstrates the application of induction for school counselors. Within the school mental health literature, schools are expanding their mental health services and

collaborating with community mental health programs and personnel, including LMHCs. As external mental health providers coming into the school setting, LMHCs must acclimate to their setting much like they would any new role. Therefore, the concept of induction can be applicable to LMHCs who are new to working in SBMHCs. An area of research not seen in the school mental health literature is the representation of LMHCs working in SBMHCs. Also, there is no representation of LMHCs and the process of induction into their school community. The proposed study aims to understand how LMHCs experience induction within the SBMHC and their respective school communities. Being that schools are a complex system with numerous individuals working within the larger system (Dikel, 2020; Germain & Bloom, 1999; Hooper & Brandt Britnell, 2012; Rudasill et al., 2018), a framework to understand the induction experience is Urie Bronfenbrenner's (1979) Ecological Systems Theory (EST).

Theoretical Framework

Bronfenbrenner's (1979, 2005) Ecological Systems Theory (EST) rests on the assumption that individuals interact with environmental systems that influence their overall development and the relationships within their local and global communities (Rosa & Tudge, 2013; Shelton, 2019). Within the school setting, there are numerous systems (e.g., community based organizations, school administrations, teachers, parents, supervisors) working across and with each other to support students' academic, career, as well as social and emotional needs. The EST serves as a useful framework for the proposed study to understand the induction experience of LMHCs who work in SBMHCs across the many interactions and systems present in schools.

Bronfenbrenner's (1979, 2005) original work presented four concentric circles or systems nested within one another: microsystem, mesosystem, exosystem, and macrosystem (Rosa & Tudge, 2013). Later, in 1986, he added a fifth system called the chronosystem (Bronfenbrenner, 2005; Eriksson et al., 2018; Rosa & Tudge, 2013). Rosa and Tudge (2013)

identified the first four circles as the focus of Bronfenbrenner's original writings, introducing EST as a way to understand the ecological systems between the individual and their interactions within and across the systems. Additionally, Rosa and Tudge (2013) suggested that researchers who use EST as their framework should identify the specific version being used. The proposed study will focus on the first four concentric circles to understand the interactions that LMHCs have within the school setting through their process of induction. Hence, Bronfenbrenner's original version of EST is most appropriate for this study and will be summarized below.

EST originally focused on the child at the center of the system and explored the interactions and relationships within and across the four systems (Bronfenbrenner, 1979, 2005; Rosa & Tudge, 2013). However, scholars have expanded the center of the system to include any individual or group of people (Bronfenbrenner, 1979, 2005; Rosa & Tudge, 2013). Therefore, LMHCs will serve as the center of the system for this proposed study. The first level of EST, the microsystem, refers to the immediate environment (i.e., home, school, neighborhood) in which LMHCs interact with and form relationships within the school and agency of employment (Bronfenbrenner, 1979, 2005; Rosa & Tudge, 2013). The mesosystem refers to the relationships and interactions among various microsystems (Bronfenbrenner, 1979, 2005; Rosa & Tudge, 2013). For example, relationships between LMHCs and teachers or parents may impact the microsystems of the students' homes or classrooms using skills taught by the LMHC. Furthermore, school wide mental health programming provided by the LMHC may lead to additional students and families interested in mental health services.

Next, the exosystem refers to events that occur within a setting that does not directly involve the group of people but indirectly affects them as a result of events or policies (Bronfenbrenner, 1979, 2005; Rosa & Tudge, 2013). For example, policies enacted by the

agency operating the SBMHC directly affects LMHCs; however, these policies also may affect the parents or teachers as a result of participating in services offered (e.g., consultations). Lastly, the macrosystem refers to the larger cultural context in which this group of people live, work, or participate and is influenced by cultural norms, beliefs, and laws (Bronfenbrenner, 1979, 2005; Rosa & Tudge, 2013). For example, the school and agency culture in which LMHCs work would be considered part of the macrosystem. Researchers have suggested and demonstrated that the use of EST (Bronfenbrenner, 1979, 2005) provides a framework to understanding the contexts in which a phenomena occurs and the interactions within and among the various systems, including schools (Germain & Bloom, 1999; Hooper & Brandt Britnell, 2012; Rudasill et al., 2018).

EST Applied in Schools

Germain and Bloom (1999) conceptually applied EST to a variety of settings, including schools. School settings have evolved over time to focus on the students' academic and social-emotional needs through mental health services, afterschool programs, or social support services, to name a few (Germain & Bloom, 1999). This evolution is a result of the changing influences that occur not only within the school setting but outside school walls. The relationships between students and various components of the school, such as mental health services, can be viewed at the micro and meso level of EST (Bronfenbrenner, 1979, 2005; Germain & Bloom, 1999). On a macro level, laws have changed to benefit student learning and help them gain access to a variety of supports and services (e.g., SBMH) in lieu of barriers to quality education (Bronfenbrenner, 1979, 2005; Germain & Bloom, 1999).

From a systems perspective, Hooper and Brandt Britnell (2012) described the utility of EST as a framework for mental health counselors and researchers alike. These authors stated EST can be used to identify context and individuals to be studied and the phenomena to be viewed within and across levels that may not be taken into consideration (Hooper & Brandt

Britnell, 2012). For example, EST is useful when looking at partnerships between schools and mental health professionals due to the emphasis placed on interactions between and among systems (Hooper & Brandt Britnell, 2012). Burns et al. (2015) suggested that research using EST can assist practitioners in the student advocacy such as the role of school-based mental health professionals in supporting children's needs and the systems in which children are involved (i.e., school administration, school district).

While there are conceptual articles applying EST to school settings (Hooper & Brandt Britnell, 2012; Neal & Neal, 2013; Rudasill et al., 2018), research using EST as its theoretical framework in school settings varies based on the individuals or environments of focus. Burns et al.'s (2015) literature review identified studies using an EST framework within the field of school psychology between 2006 and 2015. Of the 349 articles published in *School Psychology Review*, 46.1% examined students interacting with their specific environment such as the classroom, 37.4% focused on the environmental context of the intervention being studied, and 33.2% considered multiple environments within their study (Burns et al., 2015). Environmental context referred to situations presented in the study that reflected a typical day in the selected setting while multiple environments referred to more than one environment examined in the study. Burns et al. (2015) noted that these aforementioned studies more often looked at student-level variables (e.g., testing needs), which aligns with Bronfenbrenner's initial four concentric circles with the student at the center. A limitation to Burns et al.'s (2015) findings was the minimal description of the studies analyzed. To date, Burns et al.'s (2015) article is the most extensive review of the literature solely focusing on the use of EST in the field of school psychology.

Researchers have used EST in a range of conceptual and empirical articles to understand or examine the school setting from several disciplines including higher education, child psychology, and school psychology (Herselman et al., 2018; Hong & Eamon, 2012; Lee, 2011; Leonard, 2011; Trach et al., 2018). Some examples include (a) a case study to understand community partnerships in an urban school (Leonard, 2011); (b) a quantitative study regarding students' perceptions of unsafe schools (Hong & Eamon, 2012); (c) a conceptual literature review that focused on group processes to address behavioral problems in schools (Trach et al., 2018); (d) a quantitative study understanding contributing factors to bullying behaviors in middle school students (Lee, 2011); and (e) a case study on the use of technology in South African rural schools (Herselman et al., 2018). Across the aforementioned studies, the researchers focused on a group of individuals within a specific context (Herselman et al., 2018; Hong & Eamon, 2012; Lee, 2011; Leonard, 2011) or applied EST to a topic of interest based on previous research conducted (Trach et al., 2018). The application of EST to school settings are also showcased in these studies. What is missing from the literature is the use of EST with an application to counseling or school mental health settings.

Application for the Proposed Research

As previously mentioned, schools are large and complex environments that have many individuals and relationships interacting within and across them. Included in that system are mental health professionals who support students' mental health needs. As a result, utilizing EST as the framework will be useful for interpreting and understanding relationships between and across systems, specifically for LMHCs working in SBMHCs. Therefore, the induction experiences described by LMHCs will be viewed through and applied within the four concentric layers of EST. Due to a lack of literature surrounding the experiences of LMHCs, this proposed

study will be the first of its kind to use EST as the theoretical framework to better understand the induction experiences of LMHCs working in SBMHCs.

Summary

The field of school mental health has been growing and evolving for over 50 years. As a result of this evolution, SBMH services have branched into many programs and approaches, including the option for schools to open SBMH clinics. It was imperative to examine and understand the literature related to such services and the providers of SBMHC services. What has been demonstrated in the literature review is the minimal representation of licensed mental health counselors who work in SBMH and SBMHC settings. Scholars have acknowledged therapists working in these settings (Carlson & Kees, 2013; Christian & Brown, 2018; Larson et al., 2017) or conceptualized the role of a school based mental health counselor (Christian & Brown, 2018), yet it is unknown how LMHCs are introduced and interact with their school community. To better understand how LMHCs acclimate to their role within the SBMHC and overall school setting, the concept of induction will be utilized and explored for this study. Furthermore, this chapter included the utility of Bronfenbrenner's (1979, 2005) EST to conceptualize LMHCs role and interactions across systems within the school setting. The results of this study will be useful for practicing counselors, counselor educators, and counselors-in-training to better understand the induction process for LMHCs in SBMHCs. Furthermore, results of the proposed study may aid in the development of appropriate SBMHC training materials. The next chapter will discuss methodology for the proposed study.

CHAPTER 3: METHODOLOGY

As a clinical mental health master's level student, I did not receive formal training in school mental health services. Yet, my counseling experience includes working in a school based mental health clinic (SBMHC) as a licensed mental health counselor (LMHC) for six years. Although I did not participate in a formalized induction program, I learned how to navigate and understand the school culture through clinical supervision, professional development, and informal feedback from colleagues.

My insider experience as a LMHC working in a SBMHC serves as the foundation for this proposed study. Despite my lack of an induction experience, I was able to successfully navigate a unique setting where LMHCs are working more and more frequently. Using creative ways to gain trust from school stakeholders, including teachers and school administration, I established myself as a credible member of the school community to provide mental health services. My curiosity to propose the current study is based in part on a desire to study the essence of induction experiences for other LMHCs working in SBMHCs, as a result of my experience of being the first LMHC to work in my respective SBMHC. While studies have been conducted about the induction experience of teachers (Hoover, 2010; Joiner & Edwards, 2008; Kearney, 2014) and few studies with school counselors (Bickmore & Curry, 2013; Curry & Bickmore, 2012; 2013; Jackson et al., 2002; Loveless, 2010; Matthes, 1987; 1992; Peace, 1995), there is no empirical research that focuses specifically on the induction experiences of LMHCs in SBMHCs. One consequence of this study is the development of an evidence base for understanding LMHCs' professional needs and growth areas when working in SBMHCs. It also helps inform how SBMHC specific induction programs can be constructed. Researchers who use a social constructivism paradigm "seek to understand the world in which they live and work" (Creswell & Poth, 2018, p. 24). To better understand the induction experience, I used a qualitative

approach to answer the overarching research question: *What are the induction experiences of licensed mental health counselors working in a New York City school based mental health clinic?* Due to my insider perspective as an LMHC in a SBMHC, the social constructivism paradigm aligned well with my proposed research study. The goal of using a social constructivist paradigm was to understand multiple perspectives and realities of the participants of interest (Bloomberg & Volpe, 2019).

In this chapter, I share how I used a phenomenological research design with a focus on interpretative phenomenology. I describe how I used my chosen design including participant selection, recruitment, data collection, and data analysis using interpretative phenomenological analysis. I conclude with how I established trustworthiness and presented my researcher stance.

Philosophical Roots of Social Constructivism

According to Creswell et al. (2007), it is important to make explicit the researcher's paradigm stance from designing the study to presenting the interpretation of the findings. Five philosophical assumptions serve to assist researchers in their choice of a specific qualitative research paradigm: ontology, epistemology, axiology, rhetoric, methodology (Creswell et al., 2007). For the purpose of my study, I used a social constructivism paradigm to establish ontology, epistemology, and axiology. Social constructivism is defined as the collective subjective experience and interactions of individuals in a specific context (Creswell & Poth, 2018). Ontology is defined as the nature of reality and what can be known about the phenomena of interest (Creswell, 2007; Ponterotto, 2005). Epistemology is defined as what is known by the researcher and the relationship between the researcher and participants (Creswell, 2007; Ponterotto, 2005). Lastly, axiology is defined as the researchers' values in the research process (Creswell, 2007; Ponterotto, 2005). Creswell and Poth (2018) stated that social constructivism

and constructivism are used interchangeably, therefore, I will use constructivism throughout this chapter.

There are three central assumptions of constructivism: reality, knowledge, and learning (Kim, 2001). Epistemologically, constructivists believe that reality is constructed from social interactions and meaning is created based on the interactions with other individuals in the environment in which it occurs (Bloomberg & Volpe, 2019; Kim, 2001, Ponterotto, 2005). Ontologically, constructivists believe multiple meanings stem from the numerous interactions of those who engage in the same phenomena, in lieu of a single reality (Bloomberg & Volpe, 2019; Kim, 2001; Ponterotto, 2005). Creswell and Poth (2018) noted this interaction is what forms the meaning of experiences, hence the term social constructionism. Axiologically, researchers who use a constructivist approach view the nature of inquiry as value bound or influenced by the researcher and the context being studied (Bloomberg & Volple, 2019; Lincoln & Guba, 1985; Ponterotto, 2005).

With limited empirical research about the induction process for LMHCs working in SBMHCs, a social constructivist paradigm allowed for the exploration of induction and the meaning participants attributed to their experience in SBMHCs (Creswell & Poth, 2018; Kim, 2001). A qualitative research approach associated with a constructivist paradigm includes phenomenology (Creswell & Poth, 2018). In the following section I describe my selection of a specific phenomenological approach, interpretative phenomenology.

Phenomenological Research Design

Edmund Husserl, German philosopher and mathematician, is a significant contributor to the development of phenomenology as both a philosophy and method of inquiry (van Manen, 2014; Wojnar & Swanson, 2007). Husserl believed that objects exist as a result of how they appear to individuals and become part of their consciousness (Groenewald, 2004).

Consciousness becomes an individual's reality which Husserl described as the "pure phenomena" and where data are obtained from (Groenewald, 2004, p. 43). At the core of phenomenology, researchers aim to understand the *lived experience* or core essence of participants' points of view and how they make sense of their experience (Bloomberg & Volpe, 2019; van Manen, 2014; Wojnar & Swanson, 2007). The concept of *lived experience* is translated from the German word, *erlebnis*, meaning the "active and passive living through experience" (van Manen, 2014, p. 39) occurring throughout life (Sommer, et al., 2019).

There are two main approaches to phenomenology often used in qualitative research to create meaning of an experience: descriptive and interpretive (Wojnar & Swanson, 2007). Descriptive phenomenology is defined as the description of daily conscious experiences while bracketing the reseacher's opinions (Reiners, 2012). A researcher using interpretative phenomenology goes beyond describing the everyday conscious experiences by seeking the meaning given to the experiences described (Reiners, 2012). Using an interpretative phenomenological approach granted me the ability to describe and interpret the induction experiences shared amongst participants of the study.

Interpretative Phenomenology

Wojnar and Swanson (2007) summarized interpretative phenomenology as describing the human experience in relation to their historical, social, and political context that gives meaning to the phenomena of interest. The social and cultural makeup of schools has an impact on decisions made for the welfare of students, including the provision of mental health services and those who provide such services (e.g., SBMHC; Viner et al., 2012). Heidegger (1962), a key figure in interpretative phenomenology, introduced the term *dasein* to situate an individual in various contexts (i.e., social, political, historical) that influence the choices made which give meaning to the specific experience being studied (Wojnar & Swanson, 2007). According to

Groenewald (2004), *dasein* is described as the dialogue an individual has between self and the world they live in. Within my study, the *dasein* reflected my intent to explore the rich experiences and meaning attributed to participant's induction through interviews.

There is merit to the use of interpretative phenomenology in qualitative research as the results yield a unique understanding of the meaning of an experience so that others may be able to obtain knowledge needed to address client needs (Matua & van Der Wal, 2015). Similarly, phenomenologist van Manen (2014), coined the phrase *phenomenology of practice* to describe phenomenology as a way to "address and serve the practices of professional practitioners" (p.15). This phrase is important to my study as I interpreted the meaning or essence participants have given to their induction experience to help current and future LMHCs working in SBMHCs.

Participant Recruitment Process

Purposeful sampling is used in qualitative research to understand a specific group of people who experienced the same phenomena (Creswell & Poth, 2018; Merriam & Tisdell, 2016). Three types of purposeful sampling was used for this study: criterion, convenience, and snowball. Criterion-based sampling is defined as the process of identifying specific characteristics that participants must possess in order to determine eligibility for the proposed study (Merriam & Tisdell, 2016). For this study, all participants self-identified as LMHCs who have been working or previously worked in an Article 31 SBMHC for at least one academic K-12 school year. Article 31 clinics specialize in comprehensive mental health services (Children's Defense Fund, 2016) guided by Article 31 regulations, which provide the oversight and protocol of services for mental health providers in New York State (Office of Mental Health, n.d.), including SBMHCs. Sample sizes in phenomenological studies can range from 2 to 25 participants (Alase, 2017; Padilla & Diaz, 2015). Thus, a sample size goal of 6-12 participants

was set for the proposed study to capture the essence of induction for LMHCs working in SBMHCs. Upon completion of the study, a total of nine participants completed both interviews. There were no participants who completed only one interview.

One full year experience working in a SBMHC focused on participants who were more acclimated to the school setting as compared to their counterparts who are new to the agency. Also, at least one full year was essential so that the participants can speak to their acclimation of school and agency culture using an operational definition of induction that was shared in the first interview. Induction was operationalized as the structured or unstructured process where novice professionals are supported and mentored typically at the beginning of their career (Curry & Bickmore, 2012, 2013a; DeAngelis Peace, 1995). Previous counseling research on counselor self-efficacy posited licensed counselors having a mastery of skills that helps them make clinical decisions without significant supervisor oversight as compared to pre-licensed counselors (Barnes, 2004; Cashwell & Dooley, 2001; Gray & Erikson, 2013; Kozina et al., 2010). Therefore, only fully licensed counselors were included as part of the criteria due to their experience, training, and completed supervisory hours as licensed clinicians.

Prior research on school counselor induction experiences have set participant criteria ranging from one to two years since beginning in the field (Bickmore & Curry, 2013a; 2013b; Curry & Bickmore, 2012; Loveless, 2010). Loveless (2010) described having more experienced school counselors, in addition to novice school counselors (i.e., two years or less in the field), in their sample. It is noteworthy to mention that Loveless omitted a definition of veteran school counselors for the participant criteria. To ensure that participants from a diverse range of clinical experiences in the schools can speak to their own induction experience, the maximum number of years since they began their respective positions in a SBMHC was capped at five years.

In addition to criterion-based sampling, convenience sampling was used as a result of my insider-position in the proposed research and network of colleagues. Convenience sampling is defined as selecting participants based on location, time, access to participants who meet the established criteria (Merriam & Tisdell, 2016). Information about the proposed study was shared with colleagues within the NYC school mental health network. Furthermore, snowball sampling was used to allow participants to refer additional LMHCs who may meet the established criteria (Merriam & Tisdell, 2016) for the study during the recruitment phase. All interested participants completed a screening questionnaire to confirm eligibility (see Appendix B for screening questionnaire). Additionally, the screening questionnaire encouraged prospective participants to share the questionnaire to other professionals who might qualify for the study. Qualifying participants received a confirmation email detailing the receipt of their screening questionnaire and details for the scheduled interview process.

I submitted my study to Montclair State University (MSU) Institutional Review Board (IRB) that included a site agreement from one agency, Astor Services, with an established school based mental health program and network. Furthermore, my study was also reviewed by Astor Services IRB to recruit from their network of providers and clinics. There are several steps I used to recruit participants. First, the recruitment process began with emailed letters of interest to community-based organizations (CBOs) that had an onsite SBMHC. CBOs are defined as agencies that provide programs and services to a host (e.g., school) to support community needs (Mayberry et al., 2008; Warren, 2005). Outreach was also conducted with school mental health managers by email who work with LMHCs in NYC schools. A general email was sent to the school mental health network on two occasions and mentioned at one of the quarterly meetings with NYC providers. The purpose was to cast a wide net to identify and connect with individuals

associated with their respective CBOs. Additionally, participants were recruited from colleagues and one agency that I have current professional experiences at Astor Services. All email communication encouraged the directors, supervisors, and colleagues to share with LMHCs. Lastly, participants were recruited via social media groups on Facebook, including the American Counselor Association of New York and New York City School Mental Health. Flyers were distributed to the aforementioned point of contacts (see Appendix A).

Summary of Participant Demographics

As a result of the aforementioned recruitment efforts, nine licensed mental health counselors were eligible and participated within the study (see Table 1). All participants selected their own pseudonym during the first interview to ensure anonymity. The participants identified having worked in SBMHCs ranging from two to five years with the average time being 3.3 years. The ages of participants ranged from 26 to 35 years old. Majority of the participants were female identifying (n=8) and one male identifying participant. The race/ethnicity of the participants were as follows: 33% Caucascian, 33% Latino/a/x, 11% Black/African American, 11% Multiracial, and 11% Other. Although space was provided for participants to elaborate upon their identities, participants identifying as “multiracial and other” opted out of expanding upon their race/ethnicity. However, one participant self-identified as a gay, cisgender male and another participant self-identified as bilingual-Spanish speaking. Participants worked in a range of schools: elementary, middle, and high school, as well as co-located K-8 and 6-12 schools. Additionally, all five boroughs of New York City were represented with the Bronx serving as the highest representation of participants. Five participants reported having worked or working in multiple boroughs. Lastly, the reported caseload numbers of the participants ranged from 15 to 40.

Table. 1

Participant Demographic Information

Participant	*Age*	*Gender Identity*	*Race/Ethnicity*	*Years Licensed*	*School Setting*	*Boroughs Worked in*	*Average Caseload Number*
Kate	28	Female	Caucasian	2	Co-located 6-12, Elementary, Middle, and High	Bronx, Queens	30-35
Madame	35	Female	Black/African American	6	Co-located K-8	Bronx	40
Greg	31	Male	Caucasian	6	High	Brooklyn, Staten Island	25
Lynn	30	Female	Latino/a/x	1	Middle, High	Bronx, Queens	20-25
Ruth	31	Female	Latino/a/x	6	Elementary, Middle, High	Manhattan	15
Sarah	26	Female	Caucasian	9 months	Co-located K-8	Bronx	35
Canopy	28	Female	Latino/a/x	2	High	Bronx, Brooklyn	28
Samantha	35	Female	Multiracial	6	Middle, High, Co-located 6-12	Bronx, Manhattan, Staten Island	35-40
Marie	27	Female	Other	6 months	Co-located 6-12	Bronx	15-25

Data Collection

Methodologically, phenomenology from a constructivist framework approaches the phenomena through an inductive method. This method typically involves the use of interviews or observations pertaining to the specific experience (Creswell & Poth, 2018; Merriam & Tisdell, 2016; Seale, 2018; van Manen, 2014). Interviews rest on the assumption that there is a structured

shared essence to an experience that can be narrated by the researcher (Creswell & Poth, 2018). From the interviews, the researcher reduces the textual (i.e., what) and structural (i.e., how) meanings of the identified phenomena (Bloomberg & Volpe, 2019; Creswell & Poth, 2018).

Seidman (2019) described phenomenological interviews, or in-depth interviews, as a way of being interested in other's stories while learning about a common experience through a meaning-making process. Similar to the tenets of interpretative phenomenology, Bloomberg and Volpe (2019) described the use of interviews as descriptive and interpretive wherein the researcher interprets the phenomena being studied to give meaning to the experience. For this proposed study, the common experience was the induction process of LMHCs working in SBMHCs.

Seidman (2019) described interviewing as a three-part series: 1) to establish the participants' experience; 2) to reconstruct the details of their experience within the context in which they shared it; and 3) to reflect on the meaning of the experience. Each of the interviews draw from the phenomenology framework, starting broadly at the phenomena of interest and ending at the meaning-making experience (Seidman, 2019). Seidman (2019) noted three separate interviews might not yield full engagement of the participants in the study due to potential costs, time needed for the interviews, and schedules of each participant. In order to account for such potential challenges, I used two rounds of interviews instead of Seidman's (2019) three-part interview series in a semi-structured approach to allow for clarification questions throughout the interviews.

Prior to the first interview, participants completed a demographic survey using Google Form. This form collected information related to age, race and ethnicity, gender, number of years licensed, number of years working in a SBMHC, and size of caseload (See Appendix C for the

demographic form). Each participant also signed and received a copy of their consent form, including a handout with the operational definition of induction.

In adaptation to Seidman's (2019) three-part interview series, the first interview broadly explored the individual experiences of induction within the school system (see Appendix D). The second and final interview combined Seidman's (2019) interviews two and three for the "details of the lived experience" and "reflection on the meaning" (pp. 22-23). Using an adapted version of Seidman's (2019) structure allowed for follow up regarding the first interview while providing space to reflect on the meaning making experience. Participants were provided a copy of their first interview transcribed verbatim prior to the second interview (See Appendix E). Providing a space to reflect on the first interview for additional information and reviewing their first transcribed interview served as a form of member checking (Merriam & Tisdell, 2016). Furthermore, participants reflected on their induction experience as an LMHC in a SBMHC and the meaning associated. Again, participants were provided a copy of their second interview transcribed verbatim to ensure accuracy of their interviews.

Both interviews lasted no more than 45-50 minutes each and were transcribed verbatim using Rev.com services. Rev.com transcription services are stored in a secured database and note a 99% accuracy in their transcription of the interviews (Rev, n.d.). All interviews were conducted and recorded via a secure web-based platform (i.e., Zoom) to ensure confidentiality. The interviews are stored on a locked computer in a password protected file in accordance with Montclair State University Institutional Review Board guidelines.

Data Analysis

Interpretative Phenomenological Analysis (IPA) was used as my method to analyze the interviews. Grounded in critical theory (Guba, 1990) and the interpretative paradigm (Burrell & Morgan, 1979), IPA allows the researcher the ability to interpret the impact of the lived

experiences (Alase, 2017). IPA involved a double hermeneutic process wherein the researcher interprets the phenomena experienced by the participants and integrates how the researcher attempted to understand the meaning participants gave to their experience (Creswell & Poth, 2018). Using IPA for data analysis granted the ability to describe the phenomena of participants working in school settings and interpret what that experience meant to participants in their roles as LMHCs. IPA provided a framework to identify emerging categories and themes about the phenomena which is presented in a narrative form, ultimately describing their induction experiences in SBMHCs.

Smith and Osborn (2008) identified four steps of IPA: 1) reading each transcription closely to immerse in the data; 2) describing the initial data based on keywords or phrases used by the participant; 3) interpreting keywords into categories; and 4) interpreting the categories into emerging themes or clusters. Smith and Osborn (2008) also described the researcher as immersing themselves in the reading and listening of the transcripts several times to become as familiar as possible with the data. Therefore, in accordance with the four steps, I read and listened to each interview to immerse myself in the data. To summarize this process, for each interview, I thoroughly read and coded the data that was then grouped into categories and later into themes across all interviews (Griffin & May, 2018; Smith & Osborn, 2008).

Smith and Osborn (2008) described data analysis using a three part table with the transcript in the middle column. On the left side margin, I identified key or repeated phrases which according to Smith and Osborn (2008) brings the researcher as close to a textual analysis or a gaining of new insights from the information shared. On the right side margin, emerging categories and themes were identified (Smith & Osborn, 2008). Throughout the analysis, the researcher and participants intersubjectively construct shared meaning through dialogue as a

third-person account (Griffin & May, 2018). Using the categories and themes identified across both interviews, a table of superordinate themes was developed, meaning the data will be prioritized and reduced to themes most salient to the study (Smith & Osborn, 2008).

Upon data completion, Smith and Osborn (2008) described the write up as a narrative account using verbatim quotes. The use of verbatim quotations is a central component of IPA to illustrate the participants' voices (Alase, 2017; Griffin & May, 2018). In order to present the data, a thick description of participants narrating the induction experiences working in SBMHCs was created. Knowing it is important to protect identifying information of the participants, pseudonyms of their choice are used. Other identifying information (i.e., names of school/agency) was de-identified (Alase, 2017).

Establishing Trustworthiness

Trustworthiness refers to the credibility of the findings as a result of the methodology, data collection and analysis methods used and conducted in an ethical manner (Connelly, 2016; Merriam & Tisdell, 2015). Lincoln and Guba (1985) developed four common procedures to help establish trustworthiness: 1) credibility (i.e., confidence in the procedures used); 2) dependability (i.e., conditions of the study); 3) transferability (i.e., generalizability of the findings to other settings); and 4) confirmability (i.e., the degree to which the findings can be repeated and are consistent; Connelly, 2016). To ensure credibility of the findings, I established trustworthiness in four ways: 1) member checks; 2) journaling; 3) a critical friends' group; and 4) the use of a thick description.

Member Checking

According to Birt et al. (2016) member checking involves presenting the transcribed interview or initial data findings to the participants to provide feedback on its representation of what they shared. Lincoln and Guba (1985) described how member checking serves to enhance

the rigor or credibility of a qualitative study as a result of the interpretation of the phenomena of interest. Member checking was done at various points of data collection. During interviews, participants were asked to clarify or elaborate on responses, providing opportunities to confirm accuracy of understanding. After interviews, participants were provided a copy of their individual transcripts after each interview to review for accuracy, clarity, and detail. This form of member checking, called member checking using data (Birt et al., 2016), gave participants the chance to review the transcribed interviews to provide feedback wherein the participants can recognize their experiences within the transcript (Birt et al., 2016; Merriam & Tisdell, 2015). Finally, at the conclusion of data analysis, all participants were provided an executive summary of findings to further confirm the accuracy of interpretations (Hannon et al., 2019).

Journaling

Generally, qualitative researchers must explore their own experience with the identified phenomena known as the *epoche* (Creswell et al., 2007; Merriam & Tisdell, 2016). *Epoche* is where the researcher's prejudices and assumptions are bracketed or set aside to then study the consciousness of the phenomena (Creswell et al., 2007; Merriam & Tisdell, 2016). However, from an interpretative phenomenological framework, preconceived notions become part of the knowledge learned about the phenomena (Matua & Van Der Wal, 2015; Reiners, 2012). According to Matua and Van Der Wal (2015), Heidegger believed that interpretation inevitably occurs due to the preconceived notions on the topic. However, the pre-understanding of the topic may help the researcher, and ultimately the reader, to have a deeper understanding of the phenomena (Matua & Van Der Wal, 2015). Therefore, I journaled about my experience and interpretations throughout the research process, in addition to presenting my biases and preconceived notions in the form of a researcher stance.

Vicary et al. (2016) examined the relationship between journaling as a learning process in qualitative research while establishing validity when using IPA, particularly as doctoral student researchers. Juxtaposed with the stages of IPA (Smith & Osborn, 2008), the use of journaling, alongside the data, strengthened the quality and validity of the study by serving as an audit trail (Vicary et al., 2016). Similar to Vicary et al.'s approach (2016), my use of journaling provided an audit trail and a form of transparency regarding how I analyzed and identified themes throughout my research process using IPA. I journaled about my experiences in several ways including interrogating my biases, reflecting on my progress within the study, and my process of identifying themes within the interviews.

Positionality. Suzuki et al. (2007) described data collection in qualitative research as reflective process and is often completed through a researcher stance. Using this reflective process, it is imperative within qualitative research that I acknowledge my own biases and assumptions (Creswell et al., 2007; Wang, 2016). Therefore, I present my own background knowledge and experience on LMHCs in SBMHCs which includes my assumptions as I complete this study.

I am a LMHC with 5 years experience working in a SBMHC in NYC. In 2015, when I began working in the school mental health setting, I did not have a formal induction process. I recall being introduced to school administrators and other key stakeholders (i.e., dean, school counselor) but often had a feeling of learning as I go. My memories of being inducted to the school where I worked include navigating the school policies (e.g., crisis support, understanding 504 plans) as a result of my assigned clients' needs while establishing relationships across the school community through staff training and school events. As the first SBMHC for my supervisors, we attended monthly SBMHC provider meetings during my first year. While it was

helpful, running a SBMHC was new for the agency. The primary focus for the monthly meetings was to ensure clinical mental health services were being provided. As a result, the supervision and administrative support I received was often clinically focused. Additionally, I collaborated with my supervisor to learn more about the needs of the school and services being requested (e.g., clinical meetings) to develop ideas. Overtime, I became adjusted to this new setting by creating plans that fit the mental health needs in an ever-changing setting.

Challenges that I encountered as a newly employed LMHC working in a SBMHC included differing expectations between the school and the agency. While my primary role was to provide counseling services, there were additional needs within the school community (e.g., teacher training, classroom intervention) that my supervisors wanted me to address. It took significant coordination and collaboration during school-led meetings (i.e., attending staff and school administration meetings to establish rapport) and participating in school events to engage the school community. At times, the confidentiality and boundaries were unclear due to agency and school policies that I was unfamiliar with. For example, teachers or school administration requested information during a student crisis that was protected by Health Insurance Portability and Accountability Act (HIPAA) laws.

I also experienced successes, particularly in the first two years of employment. As a LMHC, I provided targeted interventions in the form of individual and family therapy services based on referrals from the school community (i.e., teachers, parents). Additionally, I collaborated with and supported the school community on school wide initiatives including de-stigmatizing mental health services, co-facilitating school administration meetings, and training staff on a variety of mental health topics (e.g., de-escalation in the classroom). Lastly, I provided modeling and small group support for at-risk students identified as needed counseling services.

While my experiences were my own, I acknowledge how my own assumptions and beliefs might or might not reflect other LMHC's induction experiences.

I assume participants in the study will not have experienced some type of formal induction experience. With that said, I assume LMHCs will describe having guidance from their clinical supervisors or agency directors regarding clinical services. However, I think LMHCs will have less guidance when it comes to their direct supervisors' understanding of school mental health settings. Also, in my experience, LMHCs may describe having more support from school administrators because the services provided by a SBMHC are those that are requested by the school.

In my experience, I assume LMHCs will share specific aspects related to the induction process including outreach to families, being supported by the school community, and the overall stigma of mental health expressed by school administrators, teachers, and parents. I am assuming the aforementioned challenges may be relevant to the induction process and influence how LMHCs are accepted into the school culture. Schools are composed of many policies and procedures that describe how schools and classrooms function, in addition to the role families play in their child's academic careers. Additionally, I believe that there may be influences from the outside community (e.g., policies set by the agency or funding source) that have an impact on how services, including mental health, are viewed and accepted across stakeholders. Within these influences and policies, I assume the LMHC experiences induction by self-navigating and establishing themselves to meet the needs of the school community in the context of their school. My experiences provide previous knowledge into the phenomena itself, however, I anticipate other reflections from participants working in a SBMHC that might be different from my own.

As a researcher, my experiences serve to help understand and interpret their own induction experience.

Critical Friends' Group

Throughout the dissertation process, I participated in and received feedback from my critical friends' group that will help filter my own assumptions of the research from the interpretation of the participants' experience in SBMHCs. Critical friends' group is defined as trusted individuals who ask questions, clarify what is being explained, and offer a critique of the work being presented (Appleton, 2011). The criteria for my critical friends' group was 2-3 doctoral candidates who are outside of the school mental health discipline, in addition to a program director of a local school based mental health program. One of the doctoral candidates used a similar methodology, thus they can discuss with me my approach to using phenomenology and fidelity to the process. Also, I preferred individuals outside of my discipline to provide a different perspective to my own in order to consider all aspects of the data collected. The program director ensured that I am using the language of the participants while providing feedback and support throughout the process. Between the doctoral candidates and program director, I encouraged them to challenge me and provide feedback that has me consider my blindspots when reading and interpreting the data.

Thick Description

By definition, thick description means a detailed presentation and description of the findings (Merriam & Tisdell, 2016). The use of a thick description helps enhance the transferability or probability that the results can be applied to another setting (Merriam & Tisdell, 2016; Shenton, 2004). Thick description is often provided in the form of quotes from participants, field notes, and documents (Merriam & Tisdell, 2016) obtained within the study and has been used in many research methods, including phenomenology (Ponterotto, 2006). As

previously mentioned in my data analysis section, I present the findings of my study using direct quotes from my participants to demonstrate their experience related to the particular category or theme being discussed.

Summary

In chapter three, I described my use of an interpretative phenomenological research design for my research question. After providing a detailed examination of my research design approach, I described the criteria set for my participants, recruitment process, and ultimately the demographics of my nine participants who participated in the study. Next, I described my data collection methods used during the semi-structured interviews and the use of IPA as my data analysis method. Lastly, I closed with how I established trustworthiness in my study which included my researcher stance.

CHAPTER 4: RESULTS

The previous chapter focused on the qualitative methodology used to answer the primary research question: *What is the induction experience of licensed mental health counselors working in New York City school based mental health clinics?* The findings presented in this chapter precipitated from an Interpretative Phenomenological Analysis (IPA). Utilizing Smith and Osborn's (2008) four step approach to IPA provided an immersive collection and analysis process with data collected from the nine participants. Through this iterative and interpretative process, six themes and twelve sub themes were present in the dataset. The themes presented capture the essence and meaning of the LMHCs induction experiences in this study: 1) *Navigating the Agency*, 2) *Navigating the Schools*, 3) *Relationship Building*, 4) *Counselor Identity*, 5) *Clinical Growth*, and 6) *Operationalizing and Enhancing Induction*. Additionally, all but one theme has a range of one to four subthemes. The identified sub themes were evident from at least six or more participants who experienced or described the phenomena. This threshold used represented more than half of the participants in the study. Quotes from participants are presented to demonstrate their experiences for each theme and sub theme identified. In effort to align with the aims of an IPA research design, interpretations of the results are provided within the text in *italics* and as an interpretive summary (Harman, 2022; Molnar, 2022), based on the researcher's professional and lived experiences as a school based mental health counselor and supervisor, as well as some of the suggestive experiences of the participants. Furthermore, the following themes and subthemes are categorized based on Smith's (2011) three gems (shining, suggestive, and secretive), which is a key component in IPA research. Smith defined a shining gem as a phenomenon or meaning that is obvious and explained clearly by the participants' experiences. Suggestive gems refers to a phenomenon that is partially present in the participants' experiences and awareness that the researcher draws out

(Smith, 2011). Lastly, Smith described a secretive gem occuring when the researcher pays close attention to the participants' experiences and finds the hidden meaning that participants are not fully aware of .

Theme 1: Navigating the Agency

The first theme of the induction experience centers on participants navigating the agency since they were hired by the agencies directly to work in the school based mental health clinics (SBMHCs). All nine participants described having this shared experience of navigating the agency as they were onboarded and learned about the policies and procedures of their position. During this time, participants described agency engagement in a variety of ways such as being supportive as they established their role. Agencies also worked closely with schools on developing procedures that align with their own policies and that of the school policies. The first theme consists of two sub themes: *Agency Onboarding* and *Supportive Clinical Supervision Experience*s with both playing a distinctive role in participants' acclimation while navigating their respective agencies and SBMHCs. This theme and subsequent subthemes were shining gems of the participant experiences given the explicit examples and discussion around agency onboarding and supervision.

Agency Onboarding

Following the start of their position, all nine participants experienced an agency onboarding process. During this process, participants reported establishing their role that included learning agency standards such as using the electronic health record, understanding the documentation process, and knowing the lines of communication between agency and school. Through this experience, participants began to understand their role expectations in what was often described occurring within a supportive environment. Sarah described her onboarding experience as helpful, "...because it taught me like our system that we use and kind of like the

basics around paperwork.” Through the participants' onboarding experiences, knowing the electronic health record and documentation process appeared important to documenting their work with the participants' clients per agency regulations.

Participants also learned how the agency’s engagement in the school will support their daily documentation and approach to services. When reflecting on the communication experienced during the onboarding process Samantha illustrated this experience in a positive manner:

> From the very beginning the lines of communication [between agency and school], like who does what, um, I, I'm very grateful that my supervisor is organized and was able to put these things in place before I came into the picture so that it was more of a streamlined process onboarding, that really helped having the relationship there. And then in terms of policies, like kind of outlining a little bit more of like, who is doing what and when, was important to onboarding.

In Samantha’s experience, the communication set at the beginning allowed for an understanding of who to contact at both the school and agency level. For example, contacting the school administration and supervisor during a crisis. In the aforementioned experiences, a majority of participants expressed that the support and training received at onboarding was beneficial to their acclimation of the daily work. On the other hand, one participant reported her onboarding did not have a significant impact on her day to day work experience. Madame stated:

> None of the trainings, I believe that I received directly from the agency had a significant impact on my day to day work in the school. Cause it was just, um, it wasn't as specific for what that would look like.

Madame appeared to implicitly express a feeling that there was missing information that would be helpful as a representative of the agency and their policies, although she did not specifically identify what information was needed. Madame described her navigation of the agency as on the ground work in the school that better taught her the policies and procedures. *The ground work appeared to fill gaps of information that was not explicitly shared during initial training and onboarding. Generally all participants had an agency onboarding experience that was viewed as positive because it helped them in three areas: understand the agency as a whole, processes for documentation, and communication approaches. It seems predictable that many of the aforementioned experiences with the agency would occur for any LMHC who is onboarding to work within a SBMHC.*

Supportive Clinical Supervision Experiences

The next sub theme of navigating the agency focused on the role of the supervisor and the participants engagement in supervision which were identified as integral parts in the acclimation into the SBMHCs. Supervisors were described as exhibiting supportive and engaging roles with both the participants and school personnel as a whole to ensure services were being provided. This rapport and experience left participants feeling supported by their supervisors to establish their role while making connections within the school. Additionally, participants offered suggestions to their supervisor to enhance their role or overall program in the school. Madame described her interactions with her supervisor as granting creativity to expand her role… “It was very rare that I think of an initiative and like, Hey, what if it is possible to try this? It was very rare that I'd, um, get shot down from her.”. In a similar supportive manner, Canopy also described a supportive relationship with her supervisor:

> So there were a lot of opportunities to ask questions and to feel supported by supervisors within the agency. I think that was integral to my feeling more comfortable in the role as I progressed further into it.

Generally, participants perceived experiences with their supervisors as necessary to the induction experience because the supervisors' supportive approach provided a space to talk about needs and new ideas. Participants communicated the importance of supervision not only for their work with clients but themselves as LMHCs in schools. Based on the researcher's lived experience and an implicit suggestion within the participants' experiences, supervisors with a more supportive approach could play a significant role in how participants acclimate to their role and the length of time they remain at their respective SBMHC. Participants alluded to the idea that the support from their supervisor was one of the reasons why they continued in their roles or grew within the SBMHC.

One significant way participants' supervisors supported them was through clinical supervision. Participants reported supervision consisted of individual supervision or a combination of individual and group supervision. In these experiences, supervisors again provided feedback on their progress in acclimating to the school, as well as provided suggestions to enhance their role. Participation in positive and engaging supervision was helpful for participants' acclimation to the agency and school. Madame illustrated her supervision experience as:

> …very hands on with the ins and outs of the agency, school and she [the supervisor], she would make it, her business say, hey, I think this is a meeting you should be in on. I think that this is, um, something we could try.

Additionally, supervision was a space for participants to reflect on their presenting challenges and learn from colleagues while acclimating to their role. Greg positively expressed his experience as, " a space for us to provide feedback on just what we were feeling was, um, some of the ongoing challenges." From a group supervision perspective, Kate stated it, "was helpful in being able to hear other people's experiences with their acclimation to their schools, especially people who had been in their roles prior to me." The individual and group supervision experiences provided a meaningful space for collaboration with other mental health providers at their agencies who also worked in SBMHCs in becoming more comfortable in their role and sharing of ideas to support their students.

As part of the group supervision experience, four participants described their unique participation in a group called *new clinicians group (NCG)* as key in their acclimation into the schools. Sarah reported her NCG experience as: "… paramount for me to just have a space, to be like, oh my gosh, you know, to be allowed to be overwhelmed and to ask questions."
NCG was a space where participants were able to vent their needs and challenges as a new clinician to the agency while learning approaches and clinical skills to enhance their daily work with students in the schools. Lynn illustrated a sense of connectedness amongst NCG and her overall agency as she participated in the group, "I think that having that space [NCG] as a group that definitely helped me feel more connected, not only to my agency, but to my job". Overall, participation in supervision played a key role for all participants, no matter the combination of supervision their respective agencies offered. It was a positive space to express their challenges and growth within their role and connect with other clinicians in their agency. *Generally, the aforementioned types of supervision experience appears to be an integral way in which participants and LMHCs would learn and better acclimate to their role within the SBMHC.*

Uniquely, participation in the NCGs appears to be an approach that other agencies with SBMHCs could implement within their own onboarding process. Participants appeared to indicate a positive response to NCGs which provided an opportunity to collaborate and have a sense that they are not alone in the learning and onboarding process. The specific space that NCG offered seemed to establish positive rapport with supervisors and other new clinician's alike.

Outside of supervision, supervisors were reported to play a key role in establishing connections and having meetings with key stakeholders in the school, such as the community based organization (CBO), to ensure that services were being offered in accordance with goals set by the school and agency. Lynn described her experience with her supervisor as, "she would have meetings, she would try to have meetings with the school and like really make sure that like all the things that we were trying to implement were being implemented". Similarly, Sarah identified a positive connection between the supervisor and key stakeholder stating, "I would say my supervisor and my director were, um, really helpful in connecting me with CBO.". In a contrasting experience, Ruth reported a lack of effective support from her supervisor:

> It was just like a really hard year to have been my first year to not really have like, like she wasn't here… So like when, I mean like when she was here, it didn't feel effective really.

Based on the majority of the participants' experiences, supervisors play an important role in the induction process. Not only at the initial onboarding of the participant but throughout their day to day experiences to allow them to ask questions, provide feedback, and engage schools to ensure that services were being provided.

Theme 2: Navigating the Schools

The ways participants navigated the schools in their daily role emerged as an overarching theme for all participants. Navigating the schools occurred simultaneously with navigating the agency because this period marked when participants were learning about the roles and procedures from both viewpoints while establishing themselves within their role. The participants described navigating their schools as a positive experience that also presented challenges. Participants described how they worked to increase their caseloads and supported the school in understanding services the participants provided. Navigating the schools consisted of four sub themes that described the ways they acclimated to their school: 1) *Role Creativity in the School,* 2) *Integrating into School Culture, 3*) *Managing Crises, and* 4) *Impact of COVID-19*. Each sub theme impacted how participants learned about the school environment and ways in which they could be a part of the school community to support students' mental health needs.

Role Creativity in the School

When reflecting on their induction experience, all participants reflected their role within the school and types of services they provided to students. According to all participants, their role in schools focused primarily on providing individual, group, and family therapy. Marie illustrated her primary role involved , "picking up my kids, for sessions, you know, either on the different floors, um, spending most of my day in my office with kids." Participants communicated that students received their services primarily in two ways: 1) referrals made directly by school administration, school mental health staff (i.e., school counselors, school social workers), or parents; and, 2) self-referrals. These two approaches appeared helpful in establishing caseloads ranging on average from 25-40 students. When students were absent, participants became creative in their scheduling approaches in order to maintain agency standards, including minimum billable services. Kate explained, "Like, you know, if a kid is

absent, then you have to go pick another kid or, you know, you have numbers and standards to meet." This creativity allowed participants to meet several students a day to achieve billable services.

It is noteworthy that when describing the services offered to the school, six participants identified and expressed their work using the three tiered system of the multi-tiered systems of support (MTSS). A MTSS approach allowed participants to determine the type of support needed such as a tier three individual counseling intervention or a tier one school wide campaign. They expressed that using the MTSS approach allowed schools to identify and refer students to the SBMHC or other supportive service personnel, such as the school counselor. Other services participants provided included marketing their services to key stakeholders to build their caseloads, facilitating social skills groups, providing mental health training to parents and staff, observing classrooms, executing school wide mental health campaigns, and participating in after school activities that participants often invited themselves to. The participants' description of their school's use of the MTSS approach suggested ways schools integrated participants into the larger school system and how their services were incorporated across the three tiers. *Based on an interpretation of the participants' experiences, using an MTSS approach seemed to be a way of understanding the range of services provided across the school setting and where the participants in the study could have the most impact based on the services provided. Participants suggested the MTSS framework helped them navigate the school by providing a common language to communicate with many key stakeholders.*

However, at times, participants perceived that schools did not understand the entirety of their role. Participants perceived these experiences as an obstacle because they felt as if they had more to offer the school. When school staff were uncertain of the school needs and how

participants can support these needs, participants reported the use of marketing or advocating for their role as part of the acclimation process to the school. The participants' use of self-advocacy and marketing allowed for conversations about the participants' observations of school and the services that could offset the needs identified. Greg shared, “I've learned a lot about how, what kind of approaches to marketing therapy can look like so that the key players saw the need in the school.” In his experience, as well as with other participants, they were sharing ideas of what they can contribute in areas that included classroom management, observations, and individual student needs. Participants also expressed seeking new clients to build their caseloads. In most cases, schools were open to the information offered and expanded the services being provided. *Based on the data and my own experience, self-advocacy seemed to be a significant influence in the acclimation within the SBMHC because of the skills that LMHCs can bring alongside their understanding of the school's needs. LMHCs in this study shared with the school the impact their role can have and how programs or ideas can be achieved which would further establish rapport with the school community. It seems participants experienced self-advocacy more often than what was described within the interviews. Role creativity was a shining gem throughout the participant experiences because they explicitly shared ways of approaching their work to meet the needs of their students and for themselves to provide necessary services.*

Integrating within School Culture

Integrating within the school culture emerged as an important sub theme of the induction process when navigating the school setting across all nine participants. Participants used words like *profound* and *important* to describe ways they engaged and learned about their school’s culture to understand the students and their needs. These words suggested a significant meaning to them regarding the integrating experience of their overall induction. Sarah stated:

> That's probably the biggest lesson that I learned is being open to it [school culture]. Just showing that you're open to learning about the culture and community that you're coming into, no matter where it is that you're working, there is a community established.

It was important to the participants that they were mindful of their approach to becoming a part of the school community, as well as techniques used within counseling sessions to ensure they were culturally responsive to the languages spoken by students and families, larger community, and overall views of mental health. According to Madame, "So you have to have a grasp of the culture of the school and the place you're gonna be working or else the trust won't be there and you won't even understand what your role could be". Similarly, Ruth shared, "knowing that [school culture] helps to really understand, you know, the kids when they're coming into session, because there are subcultures that are happening that we don't think are happening, but they [the students] feel it". Based on participants' responses, there was a perceived need to learn as much as possible about the school culture. Participants learned this information not only from students directly but within school conducted meetings and events. When knowing the school culture, participants perceived being able to support students better and understand how the school and outside community influenced students' day to day school experiences. *Generally, integrating within the school culture was an explicit experience or shining gem that yielded positive results within the school setting. It is noteworthy how one participant mentioned that learning the school culture was not in their induction experience and that it did not have meaning in their induction experience as a whole. However, given the experiences of the majority of participants, the one participant more than likely experienced aspects of integrating within the school culture. Integrating within the school culture is perceived as important to the induction process as one*

begins to learn the school, the values and beliefs of key stakeholders regarding mental health, and overall student mental health needs.

In addition to learning about the school culture, one form of integration within the school setting that more than half of the participants experienced was increasing their visibility within the school. According to participants, visibility directly impacted their induction process as this approach was how students and staff came to know them and the services being offered. Participants communicated that sitting in their offices was not an option because being in the hallways, classrooms, meetings, or events supported their acclimation within the school. Samantha expressed several ways she was visible in her school:

> I was a part of staff welcoming on Monday mornings, and I would be invited to certain meetings, of course, student support team. And that would be, give me the opportunity to introduce myself and remind them every month and [they] became used to [it] over time.

Going into the classrooms and providing information sessions or lessons was another way participants would increase visibility in the school which yielded positive feedback and engagement from students and staff. Canopy illustrated her own classroom engagement and school visibility:

> I would pop in at the beginning of every semester or even a couple times during the semester, I would pop into the health class. So I had a good relationship with the health teacher and during her mental health part of her curriculum, she would have me come into the classroom and talk to the kids and just like first off, just let them know that there was a resource there in the school for them for that.

As a result of heightened and intentional visibility, participants established relationships with the school community that yielded referrals for counseling services offered and reduced the stigma

of providing mental health services in the school. *Participants' intentional visibility in the schools suggested a positive way of establishing rapport with the school and integrating oneself within the school community.*

One participant, Lynn, worked in three SBMHC sites with similar roles and offered several perspectives to the induction experience. Lynn offered a contrasting experience regarding visibility and how the schools made efforts to ensure she knew the students and the school community. Lynn stated:

> I think that was like really the first time where, um, the, like the school really put a lot of effort into making sure that the students knew who I was. Um, whereas before, like maybe not so much. The students who were on my caseload would know who I was, but like nobody else.

Lynn's prior experiences suggested that one of her schools did not introduce her to school staff and were not responsive to her visibility approaches as she perceived staff disinterest in mental health services. For a majority of the participants, their experiences with visibility and integrating within the school setting was positive that yielded more awareness of the services within the school and how they can support the larger school community. However, for Lynn, her range of experiences indicated both successes and challenges as a result of different school's mental health awareness or lack thereof .

Managing Crises

When navigating the schools during their induction experience, all participants reported managing crises as a weekly, if not daily, occurrence. Participants expressed managing crises consisted of understanding both agency and school regulations while collaborating with school staff to ensure students understood available resources in times of need. Samantha expressed how, "Crises happen all the time and it sure did in the beginning, because I was, you know, I

think when students were learning that there was a therapist on board and they were realizing that they needed a lot of support". In these experiences, it helped participants acclimate to their role within the school and support the school community while simultaneously enhancing their learning of crisis response. Canopy reflected on her working knowledge and growth when going into crises :

> When it comes to the social, emotional support that you need to provide in those moments, that is yes, you can have some understanding of what that will look like, but you don't really know exactly what will be as effective until you practice right until the moment has come. Um, so I think that was very valuable in terms of my induction process, because [navigating crises] helped truly acclimate me to some of the chaos.

During crises, all participants perceived challenges associated with ways to approach the crises from the agency standpoint while following school and school district regulations. Greg expressed this experience as, "It was very much by the book kind of chancellor regs [regulations]. This is a thing we have to report, even though it did not make any sense to, to escalate it, the way that I needed to be done". The experiences of managing crises left participants feeling as if their agency regulations were not a part of the discussions with the school. Schools were perceived as largely following their district regulations with little regard to the regulations of the clinic which participants perceived as both equally important to the SBMHC process. For example, when participants hospitalized a student for suicidal ideation, participants experienced challenges by school administration regarding their approaches to ensure student safety. While participants expressed differing approaches alongside the school during crises, participants believed it was because they were new to the school and still learning their role within these particular situations. *Experiencing and managing crises seemed to be a*

significant part of the LMHC role working in a SBMHC, therefore being a shining gem in the participants' experiences. Furthermore, it appears to be advantageous for LMHCs to be aware of crisis management policies and procedures alongside key stakeholders from both the school and agency. Based on the participants' experiences, having awareness of school crisis management plans aided LMHCs in navigating the policies and procedures quicker within the school building and reducing stressors when acclimating to their role.

Impact of Covid-19

Given that participants in this study worked in a SBMHC within the last five years or less, all but one participant described and reflected on their experience with navigating the schools during the COVID-19 pandemic. One participant left her role right before the pandemic and indicated that COVID-19 did not have an impact in her role. The remaining participants expressed challenges of engaging clients in their therapeutic work using telehealth. Participants communicated feelings of stress related to barriers when conducting telehealth sessions including student access to proper electronics and students locating private space for sessions at their respective homes. To illustrate the impact of COVID-19, Kate shared, "I think that it really changed the work that we were, that I was doing with the kids. It was harder to get them on. It was harder to engage them." *A suggestive finding or gem in their experience signaled a parallel adjustment: participants working virtually and students attending school from home. Participants explicitly found the transition difficult as well due to agencies ensuring continuity of care for all students by providing services remotely using new platforms. Participants also implied the hard work they did to learn their role virtually to meet the needs of their schools. Based on the participants' experiences, there seemed to be a comparison between participants who were inducted prior to and during COVID-19.*

For example, participants inducted prior to COVID 19, shared experiences of establishing rapport with key stakeholders (i.e., teachers, students) in person and online and challenges associated with approaching both spaces. Some participants started during the pandemic and expressed the challenges of establishing relationships remotely while navigating school protocols and closures that occurred due to positive cases. Sarah stated, “I started in August, 2020, but I think I was back in the building for like a minute and then we closed again… the lack of consistency played a part too [for student engagement]”. As a result of the changing regulations and school closures, consistency was a challenge for participants and their students in establishing a routine for mental health services. Additionally, participants reflected on the changes to their own approaches to supporting students and themselves when navigating the COVID-19 pandemic. For example, participants expressed feelings of uncertainty when preparing for telemental health sessions while navigating their own emotions associated with the COVID-19 pandemic. Greg expressed his thoughts associated with working during COVID-19 as , “what exactly do I need to do right now to prepare myself for like my clients? Because clients aren't sure of how to navigate this.” *Generally, all but one participant indicated challenges acclimating to their role and when providing services using telemental health. Furthermore, participants' experiences suggested it was challenging when ensuring students had the mental health services they needed because participants were learning how to provide services in newer environments of the students’ homes alongside learning to provide telemental health services. As a suggestive gem, the aforementioned experiences appeared to have caused stress on the participants while acclimating to their role both as a new clinician and as a result of the pandemic.*

Theme 3: Relationship Building

The third theme to emerge within the participants' induction process was the importance and experience of relationship building, including how they collaborated or navigated their setting with the many stakeholders involved. They also reflected on the importance of maintaining trust with staff and students after establishing rapport. Two sub themes emerged with relationship building: *Establishing Rapport with Key Stakeholders* and *Collaboration with Key Stakeholders*. Relationship building was a shining gem for the participants as they illustrated the importance of relationships within the school and how it helped them navigate and acclimate to their school settings.

Establishing Rapport with Key Stakeholders

According to all of the participants, rapport building laid the foundation for students and staff alike to know about the mental health services available to the school community. For example, although participants received referrals from teachers and school administration, strong relationships with students had a positive effect on increasing their caseload for the SBMHCs. Participants reflected on experiences in which students knew that they were there to support them and teach them skills based on specific needs. As a result, students engaged in self-referrals because of the positive rapport participants established with students. Sarah positively reflected on her rapport with the school community and the change overtime in her school stating, “It has, um, it has really reduced the stigma around therapy in my school building. Um, the kids see me coming and they're like, Hey, like, can you pick me up? Like I need therapy”. Sarah’s experience strongly demonstrates positive rapport with students within her school community and their understanding of her role. Students are one of the many key stakeholders and primary recipients of the mental health services within the school. *Based on the participants' experiences, it can be inferred that the stronger the rapport participants had with students, the more likely students*

were to use the SBMHC services. Although it was not explicitly shared by the participants, unique in their induction approach was the way they engaged the students such as asking them about their favorite music or discussions about hair. Using these engaging approaches seemed to have a positive effect that established strong rapport through their induction experiences.

Additionally, participants discussed their developing sense of trust with staff due to the staff assistance aided in their induction process. Canopy illustrated forming relationships with staff as it, "...really helped me not only acclimate to the culture, but also gain credibility with the students and the staff and, you know, all of these different players that I had to interact with". In Canopy's experience, in addition to other participants, school counselors and teachers who demonstrated an interest in the mental health services asked participants to present workshops to their students or walked them to classrooms as part of introduction to the services. These activities established further credibility for participants with other staff because of the positive engagement with initial school staff. *It appears that establishing rapport with key stakeholders came from more influential staff within the school community who understood the role and services that the participants could provide. Although it was not directly expressed by participants, the influential staff seemed to positively impact more reluctant staff and increase knowledge about the participant's role and services. The influential staff's unspoken, yet recognized power seemed to change the reluctant staff's engagement with participants to a more positive one. As a result, participants seemed to utilize their initial support or influential staff to further the rapport development and sense of trust amongst the school community and more reluctant staff members.*

In contrast, participants also reported challenges when establishing rapport with staff and feeling like an outsider to the school community. All participants perceived that the outsider

experience played a role in the initial school staff engagement such as initial meetings or introductions. For example, Lynn identified feeling different as a third party agency working in the school stating, “Like we're not gonna really gonna let you in. And I felt like that was like their [school staff] mo[tive] with like everyone that wasn't like a hundred percent DOE [Department of Education] staff”. Similar to Lynn’s experiences, challenges with rapport building hindered ways in which the majority of participants approached meetings and classroom activities because they were viewed as an outsider coming into the school community. When participants were not invited to staff meetings or school wide events, such as back to school and parent teacher conferences, they felt as if their voice was absent from the school community. In these instances, staff were unfamiliar with who they were or their role within the school. As a result, participants shared spending more time in their office and less time engaging with the school community and rapport building. *It can be inferred that the more supportive the school staff are regarding the mental health services, the more successful the relationships between the participants and school community as a whole can be. However, participants implied in their outsider experiences the belief that the more consistent they are with staff, the more likely school staff are to respond to the services provided. For example, the more physical visibility the participants displayed, the more likely that staff may gain interest in the mental health services provided. Consistency and physical visibility could be portrayed by more classroom involvement, teacher workshops, and engagement during school meetings which may show staff the participants dedication to support and be a part of the school community.*

Collaboration with Key Stakeholders

Once rapport was established, collaboration with key stakeholders was an integral experience for the nine participant’s induction process. Participants often described meeting with school administrators and working with key stakeholders on a student’s case, including

caseworkers and other agencies. Collaboration helped them learn about the school and the overall process when helping students while providing the best care. Collaboration was also integral to meeting the needs of the school regarding additional activities outside of therapy sessions. For example, Sarah described her reflective collaboration with key stakeholders that occurred on a regular basis: “So we [supervisor and I] had a meeting with our principal, we have like a monthly meeting”. Reflective collaboration meetings involved strengthening the relationship between the school and agency through critical discussions on services being offered and how such services could be enhanced to meet evolving needs. However, collaboration was not always a smooth process. Lynn provided a contrasting experience between two schools she worked in:

> So this school is very much like let's collaborate, let's figure it out together. Let's do it together and we trust you. The other school was like, nope, too bad. Like if they were in a crisis, it already happened and we don't really want your opinion.

When school administration and staff did not include participants in mental health related meetings or situations, the experiences left seven participants feeling uncertain of how to collaborate, which led to feelings of isolation. Participants communicated seeking out support from their supervisor or school staff they had a strong relationship with in order to gain insight into working with various stakeholders or situations. They shared this form of reflective collaboration with their supervisor or school staff provided them feedback on ways to further strengthen collaboration with key stakeholders. For example, participants identified learning the best time to meet with teachers or sharing a formal plan with key stakeholders. *It appears that collaborating is a key skill and approach to take when learning the school community and establishing formative relationships with key stakeholders. As with establishing rapport,*

consistency and working with at least one formed relationship with a school staff member appears to be supportive within the induction process. Based on the participants and my own experience, consistent physical visibility within the school and communication amongst key stakeholders are two key approaches to establishing and collaborating with formed school relationships. In doing so, it helps participants and future LMHCs navigate how to approach mental health services within the school.

Theme 4: Role Clarification as an LMHC

As all nine participants established themselves over time within their schools, *Role Clarification as an LMHC* was an important component of the induction process. Participants reflected on their experiences being mislabeled as a social worker or school counselor. Mislabeling of their work title led participants to self-advocate within their schools and agencies as a LMHC as compared to other school and agency mental health professionals by sharing handouts about the role of LMHCs, including a comparison chart of LMHCs, school counselors, and social workers. Participants perceived that stakeholders were receptive to this information by way of clarification questions from school stakeholders even though it had to be repeated several times. Additionally, participants demonstrated creativity in creating their own handout of services they provided for key stakeholders.

However, participants described emotions of confusion, empathy, and frustration when school personnel would request participants to perform lunch duties or watch classrooms. These duties were outside of their role per agency guidelines and clinical training. Lynn expressed balancing between asks of the school and her agency duties:

> Like we're there to provide this service, this one on one service, working with the kids directly, working with the families, helping with escalations and things like that. And making sure that the school isn't pulling us for things that we wouldn't necessarily do.

In these experiences, participants found themselves unsure of how to approach the requests by school administrators and community school directors, even if it was outside of their scope. Particularly when it came to client confidentiality, schools often compared the role of participants to that of the school social worker or school counselor and expected to know information even when it was protected by privacy laws. The participants had to explain the limits of protected information with the school and what it meant for them in their counselor identity and overall role.

Participants expressed the impact that time had in solidifying their actual role rather than the expectations of others at the respective schools. For example, Madame positively expressed how time supported changes in her role:

> It took, I would say even more time, to kind of figuring out, oh hey, what's my role here. I think that, um, getting inducted by people figuring out that there were places where I could assist and once I was in those positions, then it opened up avenues for other things.

When schools had a strong understanding of what the participant could provide in the parameters of their role, it allowed for the school and participants to place them in positions that made sense for their role. For example, actively participating in counseling team meetings. Additionally, participants identified that the support from the community based organization was also integral to role clarification as they would enforce agency guidelines based on an ask of the school.

The theme of role clarification appeared to be significant across all participants as they explicitly and implicitly shared a variety of experiences pertaining to their counselor identity within schools. It appears to be a suggested gem that clarifying their role and counselor identity is an experience that is consistent and occurs throughout their induction process. It is possible

that clarifying the LMHCs role continues beyond their induction time frame due to future new staff members. Based on participants' experiences and the researcher's lived experience, having a strong identity and knowledge of their counseling role seemed important to self advocacy and setting boundaries (i.e., confidentiality) when needed.

Theme 5: Clinical Growth

All nine participants in the study described and reflected on their clinical growth throughout the induction process that aided in their skill development and navigating spaces such as group counseling or workshops with parents. Participants expressed strategies to overcome their fears of public speaking included offering groups and workshops to the school community. These forms of public speaking aided in their clinical growth to publicly engage and share their knowledge with the school community in large and small settings. At times, participants felt there was little guidance when situations arose leading them to feel like they were on their own. In these situations, it seemed as though participants learned by "diving in the waters" when tasked with or experiencing a new situation. For example, this feeling of being on their own was noted when their role was unclear and unknown for a school lock down or a meeting to review an individualized education plan. These experiences provided opportunities for participants to learn how to support student academic needs and emotional stress in real time. As a result, participants described the aforementioned experiences as confidence building or learning something that they could not get out of a textbook because of the on the job learning. Participants demonstrated an openness to learning and identifying how the aforementioned experiences, such as public speaking, incorporates within their own clinical practice. They utilized their graduate school education with on the job learning that led to new knowledge and practice. Within their clinical growth induction experience, two sub themes emerged: *Learn as I Go* and *Clinical Skills Development*.

Learn as I Go

All nine participants described experiences as related to *learning as I go*. These experiences were specific to the organizational policies and procedures of their school setting. Participants identified feeling uncertain when navigating classroom spaces or learning procedures in moments of crises or school situations (i.e., fire drills). Although training was provided at the initial onboarding by the agency and school, participants described the information as overwhelming, which occurred more often within the first year of their role. Lynn expressed her acclimation at one of her schools as if she was "thrown into the fire, like this is your site, this is where you're gonna be. These are the expectations". Similarly, Ruth described feeling as if she had to grow up by herself stating, "I feel like she [supervisor] started me off in the beginning and then like, it was like, okay, you kind of know the basics". Participants perceived the initial training did not fully incorporate all that they needed to know when approaching their work within the school. *As a result of their on-the-go training experiences, participants took initiative to engage the school by learning the policies and procedures to incorporate into their practice. This initiative seemed to serve the participants positively in their experiences when learning on the go.*

Participants also reflected on the nuances and the interaction of many systems within the schools. It was not clear to the participants when they began how many systems (i.e., school administration, community based organizations) are involved within the school setting. Learning on the go helped participants understand the NYC Department of Education System. Knowing the system appeared to have supported participants in understanding important policies such as fire drills or how the individualized education plan played a role for students. Samantha reflected on feelings of being overwhelmed when learning about the systems involved with school safety: "you know, you might be in a meeting or having a session and then there's a fire drill. So you

like what to do when those fire drills are happening, um, or a lockdown drill, for example." Participants communicated they would bring the aforementioned experiences into supervision to seek the guidance of their supervisor to ensure that they were providing services within their role.

Generally, the knowledge learned on the job appeared to aid participants' clinical growth in an organizational way. For example, participants reported an increased understanding of how the school and agency systems interact with each other in addition to gaps in their training germane to the school setting. For example, participants reported the need to understand an individualized education plan. Additionally, this subtheme is a shining gem that was explicitly presented within their experiences. Given the novelty of these experiences for the participants, supervision appeared supportive to validate their new learning experiences and growth as a LMHC in the school. Yet the participants identified gaps in their onboarding training which demonstrates a need for additional information beyond the initial onboarding provided by the supervisors. Implicitly shared in the participants' experiences were suggestive ideas or gems to inquire about topics such as the fire drill protocol. Also, based on the data and my lived experiences, it seems recommended to ask both the supervisor and the school administration about the school and agency systems that key stakeholders interact with. These systems include the school district, school programs, and agency funding programs. By understanding these systems, LMHCs gained an understanding about the funding and school resources available to the school community.

Clinical Skills Development

In addition to learning in the moment, all participants reflected on their clinical skill development as school-based mental health counselors. Participants described having developed skills aimed at engaging with students and families creatively across the school and within

counseling sessions and learning therapeutic interventions. To demonstrate the essence of clinical skill development, Canopy expressed her experience in rich detail:

> So there were, when I even think about the different diagnoses, right, that I got to interact with right out of grad school, um, it was just such a great opportunity to learn, right. There was everything from high functioning anxiety and depression to severe trauma and things that were actually higher on the spectrum of, you know, impacting functioning. So it really taught me how to just gain skills that otherwise I probably would've taken years to learn. Um, and there was just regular exposure to a lot of different kinds of situations. Um, so it helped me build my confidence level up as a mental health worker.

Participants further reflected on the training they completed in their master's programs which they stated was often focused on treating adults. Participants shared seeking out training aimed at treating children and adolescents to better treat the symptoms and needs of their clients. Participants indicated seeking out webinars on school mental health topics and attending local workshops provided by the Office of School Health. These resources were deemed as important to their growth because they focused on specific aspects of the school mental health realm, such as the role of classroom observations. It appears that the combination of on the job learning and training sought out furthered their confidence working in SBMHCs, thus aiding in their clinical growth as LMHCs within the schools. *Furthermore, based on an interpretation of the participants' induction experiences, it is suggested that clinical skills continue to develop by participating in continued continuing education on school mental health topics specifically. Participants inferred that their graduate level training did not include information related to school mental health approaches, therefore taking the initiative to seek out their own additional training which represents a suggestive gem within their experiences. This subtheme is more*

developmental in nature, which is different from the organizational emphasis in the previous subtheme.

Theme 6: Operationalizing and Enhancing Induction

The final theme focused on the meaning and definition of induction and ways the process can be enhanced. Given that all participants experienced induction to various degrees, they provided their own definition of induction which was operationalized and interpreted by the researcher to create a collective definition. Additionally, participants reflected on their experiences and provided insight on how the induction process could be enhanced by way of a framework. Two sub themes emerged in this final theme: *LMHCs Collectively Defined Induction* and *A Framework to Navigate Schools Would Be Useful.*

LMHCs Collectively Defined Induction

Following their meaning-making reflections on their induction experience, all participants shared an individual definition of induction. Participants defined induction as the process of knowing how to provide services to the school based on their current need and functioning. For example, Madame shared her induction definition as, “meeting the agency, meeting the school, meeting the needs of the community, where they are, because it's going to vary differently based on the community that you're in, based on the age range of the school”. In addition to meeting the various systems in a developmental manner, it was evident that time influenced the induction process as a way for key school stakeholders to acclimate and understand who the participants were in the school setting and their role within the school culture. Canopy illustrated the impact of time in her induction experience:

> You have to kind of understand that, that [rapport building] takes time and understand that people have every right to be wary of strangers and people in your role. Um, so just, just being super, super mindful of the culture that you're walking into and like not

> rushing it, not pushing your agenda too soon, just under like, trusting that that will happen when, and if it should happen.

Sarah further defined the induction experience as unstructured while, "...becoming accustomed to the school culture really. Um, and like integrating yourself into this working system.".

Collectively, participants in this study defined induction as creating a working partnership between the school and agency where professional counselors understand the resources available to the school community along with the school culture and individuals within the school. Additionally, induction furthers skill development that is tailored to working in the school as professional counselors to better meet the needs of children and adolescents in their own setting. *It appears that this subtheme is a suggestive gem for the participants as the collective definition summarizes the range of induction experiences described and perceived by the participants of the study as well as interpreted by the researcher across all participants. During the interviews, participants were observed often agreeing with the definition provided to them at the beginning of the interviews while adding their own meaning and definition of their induction experience. Participants appeared to have an overall positive induction experience with challenges along the way. They often shared their school mental health role as their passion. Thus inferring that there are strengths and a personal drive to their work but not many challenges associated with their induction process.*

A Framework to Navigate Schools Would Be Useful

When reflecting on the significance of their induction experience, all nine participants provided feedback or recommendations. In essence, participants described having a framework would better support their induction within the school due to the complex system and processes participants learned on the job. One part of the framework would include relationship building. Samantha expressed the importance of relationship building as part of navigating their

acclimation to the school setting and overall SBMHC, “There was a lot of learning to do in the school based program where at least in a school you’re not just meeting with the client themselves, there’s a whole community behind them that is important to have meetings with”. Similarly, Ruth simply stated, “Um, you know, so kind of like just teaching them how to navigate those relationships [teachers, parents, school administration]. Um, and then obviously it's the orienting to specifically what we have to do.” In their experiences, participants reflected on the need to know who are the key stakeholders in the school and the key stakeholders’ role in the overall school system. Greg elaborated on the need for a framework that acknowledged the complexities of the systems within the school system:

> What is the things relevant for us as mental professionals to know, let’s say about the Department of Education, what is the culture or climate of the Department of Education? How does that impact perhaps a mental health professional in this particular setting? In what ways does it collaborate? Um, certain basics, like education around IEPs [individualized education plans], or education around the Chancellor’s regulation does, I think, need to be fostered. And there needs to be much more of a clear understanding of what are the systems that schools have to work within.

Greg’s inquiries, and echoed by majority of participants, provided insight into areas of the school mental health system that are deemed key to knowing when working within SBMHCs, including the participants’ roles within the school. *A structured induction experience is perceived as something missing from the induction process that participants shared would be most helpful to acclimate within the overall school mental health setting. Without a framework, it appeared that experiences of stress, confusion, and navigating the school on their own was common across all*

participants in the study. This experience was expressed throughout the participant's interviews in an explicit way leading this subtheme to be a shining gem.

Interpretative Summary

The findings of this study are presented in both a descriptive and interpretive format detailing the rich experiences of the participants. For each theme, interpretations were made based on a variety of experiences participants identified as part of their induction process. Broadly presented here are some general interpretations to the overall experience. First, based on the data analysis, participants shared and implied significant meaning associated with their induction experiences. Interestingly, participants perceived a largely positive induction experience to their schools and SBMHCs. Despite having some challenges such as learning school policies, participants appeared to have an inherent motivation to learn about their school environments and collaborate with those stakeholders that supported them to result in a positive induction experience. In their interviews, participants explicitly shared phrases such as "my experience was profund to my growth" and "as I reflect, it [induction process] meant a lot to me because I learned about myself as a LMHC". These phrases and inherent motivation suggests drive within their work that supported their acclimation process and as a result had a meaningful impact on them on a personal and professional level. While participants did experience challenges associated with their work and role, their data and reflection indicates a positive and unique experience.

Next, presented in their experiences is a wealth of information that participants had to learn throughout their role as a LMHC working in a SBMHC. It can be deduced from their experiences that these are approaches and areas to explore when a new LMHC begins working in a SBMHC. For example, asking about school policies and procedures and engaging in weekly supervision served to enhance their acclimation to the school setting. These experiences seemed

to be integral to their acclimation and continued success in their role. The findings also present thoughtful questions or ideas that participants deemed necessary in their role that new LMHCs could consider when beginning within their role. Using participants' strategies and recommendations to enhance their induction experiences seem to indicate the possibility of a more structured induction process for both the supervisor and LMHC.

Lastly, the daily activities shared by participants indicates a range of clinical mental health services that were and can be provided within the school setting. Participants shared creative approaches they took working with students in classroom, group, and individual sessions. For example, Canopy excitingly reflected on a social skills group she provided based on a board game students enjoyed. The use of a well known board game seemed to facilitate a strong group amongst the students. Participants also appeared to be strong advocates across school meetings to benefit children and their role as providers in the school. The aforementioned experiences demonstrate participants having a strong interest in working with children and families or in schools in general. Additionally, suggested and implied in their expressions were the passion they held for working with the students in their own environment and the opportunity that existed for mental health providers to create meaningful change.

Summary

The current chapter presented a rich narrative of nine participants who worked in NYC SBMHCs and experienced the phenomena of induction. As a result of using IPA, six themes and twelve sub themes emerged. Participants shared their daily experiences while reflecting on what it meant to them as they navigated the environments and who they interacted with. All participants expressed experiences with agency and school navigation while also enhancing their clinical skills and establishing rapport with key stakeholders across the systems. Participants also

defined induction and expressed how the process can be improved. The next chapter presents a discussion of the analysis and findings, as it relates to school mental health research.

Chapter 5: DISCUSSION

In the previous chapter I presented the results of my study. In this chapter, I present key findings pertinent to existing literature and to Ecological Systems Theory (EST), the theoretical framework of the study (Bronfenbrenner, 1979; 2005). Additionally, I highlight the strengths, limitations, and implications of the study. To conclude this chapter, I present recommendations for future research.

Discussion of Findings

There are two overarching themes from my findings that help to understand the essence of participants' rich induction experiences: 1) *The Initial Induction Experience,* and 2) *Navigating a Unique Landscape as a LMHC in Schools*. The *Initial Induction Experience* describes the interactions that participants had with their supervisors and key school stakeholders as they initially began in their roles. *Navigating the Unique Landscape as a LMHC in Schools* focuses on the daily job duties and collaborative interactions participants had, in addition to COVID-19 experiences. Throughout the discussion of findings, connections to the EST framework are made. As indicated in chapter two, the EST consists of five concentric circles that focus on an individual or group of interest: Microsystem, Mesosystem, Exosystem, Macrosystem, and Chronosystem (Bronfenbrenner, 1979; 2005). For the purposes of this study, the center of these concentric circles are the participants who identified as licensed mental health counselors (LMHCs) working in NYC SBMHCs.

The Initial Induction Experience

It was evident from the findings that all participants experienced some form of an induction experience, despite the word induction was not used specifically by their supervisors or school administrators. Within this section, there are two subcategories that highlight the

participants initial induction experience: *The Role of the Clinical Supervisor and Supervision* and the *School Induction Experience*.

The Role of the Clinical Supervisor and Supervision

Clinical supervisors were the first point of contact for the participants when beginning at their respective agency. During this time, supervisors were tasked with onboarding participants to their agency policies and to the assigned school. Participants experienced various forms of agency orientation which included learning agency policies and procedures, as well as clinical documentation requirements. Drawing from current literature on induction, these examples can be considered components of induction because they help new hires acclimate to the expectations of their roles (Ingersoll, 2012; Ingersoll & Strong, 2011; Kearney, 2014; Mitchell et al., 2017; Wong et al., 2005). From an exosystem lens of EST, these policies and procedures developed by leaders of the respective agencies impact how LMHCs provide services to the school community.

During the induction process, the majority of the participants described their supervisors as supportive, allowing room for creativity and growth within their role. Participants perceived their supervisors as leaders in helping them establish relationships with key stakeholders (e.g., principal) in the school community. Furthermore, participants found it helpful to their acclimation when supervisors were knowledgeable of the school community and SBMHCs' contributions to the larger school system. This finding aligns with previous research that recommended supervisors having a working knowledge of the school community (e.g., policies, climate, key stakeholders) when supporting supervisees' learning of the school landscape (Stephan et al., 2006). By knowing these aspects about the schools, supervisors can help solve challenges with their supervisees and promote supervisees' further growth within the school mental health setting (Stephan et al., 2006).

A unique finding in the study pertained to clinical supervisors providing clinical supervision, which differed from previous school induction literature. Although participants did not explicitly state their supervisors' specific licensure, Article 31 clinics are supervised by mental health providers such as Licensed Clinical Social Workers, Licensed Mental Health Counselors, and Licensed Psychologists (Office of Mental Health, n.d.). Therefore, the participants' supervisors were licensed clinical mental health professionals who have education and experience to provide feedback on their clinical approaches in counseling. The findings of this study are the first to include clinical supervision insight within the induction process from clinical supervisors rather than school administrators. This supervision differs from the school counseling induction literature which indicated supervision was largely provided by the school principal in lieu of school counselors (Curry & Bickmore, 2012, 2013; Matthes, 1992).

Additionally, these findings reveal a distinction between the supervision of LMHCs in SBMHCs and previous induction literature that described a lack of supervision or feedback for school counselors (DeAngelis Peace, 1995; Jackson et al., 2003). As a result, this study is the first to provide insight into supervision for LMHCS in SBMHCs. For participants in this study, clinical supervisors played a significant role in the provision of clinical supervision throughout their time at their respective agencies. There was a focus on clinical and administrative supervision to enhance their growth and development as professional counselors. Participants experienced and reflected on participation in weekly individual, group, or combination of both types of supervision. These findings are consistent with research describing the importance of frequent, weekly supervision for mental health providers (Borders et al., 2014; Herbert, 2016), especially for providers working in school mental health settings (Stephan et al., 2006). The one

on one support, supervision, and onboarding experiences between the clinical supervisor and the participants represents a microsystem level of interactions within an EST framework.

Unique to the findings of this study was an additional level of supervision that participants described as a "new clinician's group" (NCG). This group provided opportunities for the newest clinicians to have a specialized space to ask questions in a group setting that focused on acclimating them to the school alongside supervisors of their agency. Relationships established within this group allowed for the newest clinicians to share ideas with one another and obtain feedback from peers and supervisors. The experiences and engagement within the NCG between the participants, peers, and supervisors represents a mesosystem level of interaction because of the individual microsystems interacting with one another. Although there is no prior literature that highlighted a similar group, based on teacher induction literature, mentorship can be a useful method to learn from peers or other school staff in their own induction process through individual or group settings (Loveless, 2010; Ingersoll & Smith, 2004). It appears that the NCG and mentorship can offer similar support and growth during the induction process. Furthermore, these findings also indicate peer-to-peer support that aids in their acclimation within the school setting.

The School Induction Experience

The induction experience within the SBMHC and larger school community presented many new experiences for participants. Previous school counselor induction literature (Curry & Bickmore, 2012; 2013; Matthes, 1992) did not provide as much depth and detail about the induction experiences compared to the interpretive and descriptive findings of this study. Rather, previous studies were more descriptive of school counselor experiences (Curry & Bickmore, 2012; 2013) and utilized case studies to understand the approach and experience in their induction process (Matthes, 1992). Below are several highlights from this study's findings.

First, participants were accompanied by their supervisors on their first day for a brief introduction with school administration. Participants seemed to indicate introductions were often positive. However, at times in these experiences, participants indicated feelings of uncertainty as they described the initial introduction or situations as "being thrown into the fire" or "sink or swim to learn the school". While participants acknowledged the support of their clinical supervisor during their acclimation, the experience of being "thrown into the fire" is a familiar occurrence based on prior research regarding introductions and beginning to work with the school community (Curry & Bickmore, 2012; 2013; Matthes, 1992).

Secondly, as participants acclimated to their role, they began to insert themselves within school meetings (e.g., grade team meetings, attendance meetings) to learn more about the school needs and strengths of the school and broader community. Participants then became more of a participant rather than observer in the school system. In these meetings, microsystem and mesosystem interactions occurred as exemplified by participants sharing the importance of physical visibility in order for teachers and students to get to know them and their role in the school. This process supports previously reported research in which school counselors sought visibility in their schools which indicated a positive impact on their induction to the school community (Curry & Bickmore, 2012; 2013).

From an EST macrosystem level of interaction, participants indicated the importance of learning and understanding school culture related to their work in the SBMHC. Participants seemed to be mindful of their counseling approaches and language used to describe mental health services to children and families. Participants used words such as "profound" to emphasize the impact knowing the school culture had on their induction experience based on interactions with teachers and students across the school community. This finding was the first of

its kind in the literature to describe ways LMHCs learned about the school culture explicitly. With the current study situated in New York City schools, the use of EST served as an appropriate lens to demonstrate cultural responsiveness of the participants within the five systems of the theory. Specifically, participants demonstrated culturally responsive approaches to their work such as understanding subcultures within the school and the languages used within the school community. Viewing the interactions of the participants within and across the systems of EST allows for an understanding of the languages, values, and traditions of individuals within the school system and ways to provide culturally responsive mental health services. Previous studies about induction experiences described interactions between members of the school community; however, learning the school culture was not explicitly a part of the findings (Curry & Bickmore, 2012; 2013; Ingersoll & Smith, 2004; Ingersoll & Strong, 2011; Matthes, 1992). Aligned with previous scholars, understanding the school culture for LMHCS helped them to better understand the beliefs and challenges of the school community, current resources for mental health services, and structure of the school system (Peterson & Deuschle, 2006).

Throughout the school induction experience, participants indicated having an unstructured induction process and suggested a more structured approach or model would better support their acclimation within a SBMHC. This former type of induction is characterized by informal introductions with the school community or lack of a consistent school point person. This unstructured experience format is similar to what has been reported in previous studies on school counselors' induction experiences within the school setting (Curry & Bickmore, 2012; 2013). Participants indicated a need for more training as a part of the induction process within the following areas: 1) providing mental health services in school based settings; 2) engaging with teachers and students in social and emotional development lessons; and 3) counseling

approaches associated with children and adolescents. The participants' suggestions align well with Loveless' (2010) formal induction structure for school counselors. Within Loveless's structure, mentors and leadership provided trainings that helped understand the duties of school counselors. Furthermore, prior induction research indicated that a more structured induction process can have positive effects on the adjustment for a novice professional to the school setting (Loveless, 2010; Ingersoll & Smith, 2004; Ingersoll & Strong, 2011). Although the participants of the study indicated a need for a more structured induction process, participants seemed to have a positive induction experience in its unstructured form.

Navigating a Unique Landscape as a LMHC in Schools

In addition to the initial induction experience provided by the participants' clinical supervisor and key school stakeholders, there were also experiences specific to participants' focus on navigating the landscape as a LMHC in schools. These experiences are categorized in three areas: 1) *LMHCs Day-to-Day Experiences*; 2) *Collaboration and Rapport Building*; and 3) *Induction During COVID-19*.

LMHCs' Day-to-Day Experiences

Participants in the study shared in rich detail their day to day experience in their school settings. There were numerous daily tasks associated with their role: scheduling and outreach of new students referred to the SBMHC; providing a range of individual, family, and group counseling services; and engaging the school through parent workshops, teacher professional development on mental health topics, and classroom consultations. These activities exemplify EST's micro and mesosystem level as indicated by interactions between and across systems that LMHCs provided to their school community. In addition, these daily activities align with tasks that licensed mental health counselors can provide in schools (Christian & Brown, 2018).

Participants also communicated directly and indirectly a range of emotions associated with their daily work including confusion, frustration, and excitement. However, participants suggested that these interactions with individuals across the school community helped them grow clinically and professionally as they had to go out of their comfort zone to advocate and engage in different school spaces. Participants' emotions support Curry and Bickmore's (2013) findings in which school counselors experienced a range of emotions such as confusion and frustration through an unstructured induction process. It appears evident that LMHCs may experience both feelings associated with stress and success within their role as school based mental health counselors.

Across these daily experiences, participants had to clarify their role and counselor identity as a LMHC working in the school due to school staff confusing them for a school counselor or school social worker. Role confusion seemed to occur at the agency and school level as agency titles were listed as social worker and school administration did not have an understanding of the mental health counseling license. The experience of role clarification for LMHCs in schools is consistent with previous research wherein school counselors sought to understand the role of school based mental health counselors or LMHCs working in schools (Carlson & Kees, 2013; Larson et al., 2017; Molnar, 2022). Furthermore, role clarification has been documented in the counseling literature as part of professional identity and establishing oneself within their role (Chandler et al., 2018; Paolini & Topdemir, 2013). Authors of school counseling role clarification studies framed this term from the perspective of demonstrating accountability and effectiveness of their services (Paolini & Topdemir, 2013) and the duties of school counselors (Chandler et al., 2018). Whereas in this study, role clarification was focused

on engaging stakeholders to understand their training and skills that could be provided, as well as their professional identity as LMHCs.

Lastly, participants' daily tasks coincide with the role of a school counselor such as supporting students in crisis, engaging with school leadership, and scheduling and meeting with students (ASCA, 2019; Christian & Brown, 2018; Molnar, 2022). However, what differentiates the participants' experiences from the role of a school counselor is the long term mental health services they provide to a specific set of students, in comparison to the school counselor who typically has the school community as a caseload (Molnar, 2022; Mullen et al., 2021). Participants indicated diagnosing students based on student's experiences and presenting symptoms in accordance with their New York licensure and providing evidence based practices in their therapy sessions. These experiences such as diagnosis and long term counseling are consistent with Christian and Brown's (2018) recommendations about the duties and function of school based mental health counselors.

Collaboration and Rapport Building

Within their daily roles and duties, collaboration and rapport building seemed to positively impact the induction experience of participants working in SBMHCs. Collaborating and rapport building aligns with the mesosystem of EST as participants worked within and across systems to establish relationships to promote their roles. At times, participants were seen as outsiders to the school staff which presented challenges when collaborating with school stakeholders. For example, participants perceived school staff as not willing to engage or be open to the services being offered to the students, as well as not being invited to counseling team meetings. To overcome such barriers, participants explained the services provided to the school community to educate stakeholders on what services the LMHCs provided and the value of clinical services. Participants also joined school-based meetings, such as counseling or grade

team meetings, as ways to encourage collaboration and understanding of their role and duties. Prior researchers not only affirmed similar experiences for therapists coming into school settings but also stated it is important that therapists have collaborative support with key stakeholders to develop trust with school staff (Mellin & Weist, 2011; Weist, 1997; Weist et al., 2012).

On the other hand, previous scholars reported on the positive impact therapists have when collaborating with schools on certain processes, such as the referral process and program development (Costello-Wells et al., 2003). It is noteworthy that Costello-Wells et al. (2003) did not specify the licensure of the therapists identified in their study. Yet Costello-Wells et al.'s findings indicate a collaborative role that therapists can have when establishing SBMHC services. The findings of this study highlight the collaborative approach that LMHCs took when working within their schools.

For example, participants indicated collaboration with school administration and teachers as necessary because it helped them feel a part of the school community and feel validated for their clinical opinions. This finding is consistent with a similar study describing the phenomena and importance of *mattering* for school counselors being inducted into their new school setting (Curry & Bickmore, 2012). Curry and Bickmore identified aspects of *mattering* to include relationships that school counselors establish and school counselors feeling a connection to the school community. To achieve this experience of mattering, Curry and Bickmore noted that informal and formal elements (e.g., meetings with the principal, positive parent interactions, feedback from supervisors) can help facilitate relationship building and a sense of belonging. Participants in the current study seemed to experience similar collaborative moments across the school and agency interactions which helped them feel connected in their role within the school.

Participants collaborated on a weekly to monthly basis depending on the established goals between the school and SBMHC.

This study's findings on collaboration and rapport building with school stakeholders and agency staff are consistent with previous studies highlighting the importance of collaboration in school mental health (Mellin et al., 2010; Stephan et al., 2011; Molnar, 2022). For example, participants shared instances where they collaborated on school mental health policies which aided in their engagement and support of the school community. Additionally, previous research on the induction experiences of school counselors also described collaboration with school stakeholders as being important to their induction process (Bickmore & Curry, 2013; Curry & Bickmore, 2012; 2013; Loveless, 2010). Thus, the findings of this study support the importance of collaboration and rapport building when acclimating to a new role. Furthermore, from a EST chronosystem level lens, the longer the participants worked and collaborated within their role, the more the school community began to understand the role and services of the participants.

Induction During COVID-19

Given one of the criteria to participate in this study was of LMHCs who have worked in a SBMHC within the last five years, at least three of those years occurred during the COVID-19 pandemic. Within the findings, it was evident how COVID-19 played a role in the induction experience. Participants of the study shared challenges with establishing and continuing rapport with the school staff and students virtually during COVID-19 lockdown and when schools began to resume in person learning. Furthermore, eight participants expressed providing mental counseling via telehealth for the first time. Establishing rapport with students and learning how to provide virtual mental health services had a challenging effect on how they provided services to students on their caseload.

Participants in the study experienced work from home as isolating at times during lockdown because they did not have a connection to the school environment. However, once in-person learning resumed, they began to establish in-person relationships with the school community while navigating challenges associated with schools opening and closing due to COVID-19 positive cases in school. Participants shared having to switch from in person services to virtual services which reduced the students' ability to receive mental health treatment. For example, students were able to change their in person learning status at various points in the school year or were out for periods of time due to COVID-19 exposure. As a result, participants would have to change their schedules or how they interacted with students to ensure continuity of services. These findings are unique because they provide first hand accounts of LMHCs providing services within SBMHCs during the COVID-19 pandemic, while understanding their experiences from an induction viewpoint. However, there have been several studies conducted that corroborate the experiences of the participants relating to barriers to providing services to students during the pandemic (Alexander et al., 2022; Kruczek et al., 2022) and adapting the delivery of mental health services to students (Limberg et al., 2022; Villares et al., 2022) from the perspective of school counselors. It is noteworthy that participants also described an increase in mental health service participation as a result of teachers and parents recognizing their students' mental health needs as a result of stressors experienced during COVID-19 and having a SBMHC available. This finding supports Hertz and Barrios' (2021) study which indicated there is value to agency-school partnerships during COVID-19 to support student mental health needs.

Strengths of the Study

There are several strengths to the current study. This study is the first known study to report on the experience of LMHCs who worked in SBMHCs within New York City schools. Previous literature that focused on school based health centers or school based mental health

services implied professional counselors were included in their samples (Carlson & Kees, 2013; Larson et al., 2017) but utilized the term therapist rather than specifying the license participants held. Additionally this study is the first to apply the concept of induction to LMHCs. Previous researchers used the concept of induction to focus on the experiences of teachers and school counselors when acclimating to the schools (Curry & Bickmore, 2012; 2013; Matthes, 1992).

Another strength of the study was the range of mental health experiences represented in the sample. First, all five New York City Boroughs were represented in the sample, in addition to kindergarten through 12th grade school settings. This representation indicates there is a wide range of school mental health services being used across the NYC school system. Also, seven of the nine participants identified as having worked in more than one SBMHC setting which adds to the range of participant perspectives and experiences. There are also findings that are unique to this study. Article 31 clinics have been in NYC schools for over 10 years (McCray, 2020), however no studies to date have provided insight to how schools are using them or the staff who provide the services. There is an increase in counseling related literature detailing the experiences of school mental health during COVID-19 (Folk et al., 2021; Limberg et al., 2022; Villares et al., 2022), with this study contributing to these findings.

Lastly, based on the findings of this study, it appears that the definition of induction can be expanded that is more tailored to working in a school based mental health setting. Within the interviews, participants explicitly shared aspects of their induction experience including being oriented to the school, meeting with staff and students, and navigating their role within the school community. These experiences are consistent with previous studies that described and defined school counseling induction experiences (Curry & Bickmore, 2012; 2013; Matthes, 1992). The findings suggest there are more specific approaches to the induction experience for

school mental health professionals that can further our understanding of induction and how to better support new LMHCs to SBMHCs by school administration and clinical supervisors.

Limitations

While there are strengths to this study, there are also several limitations. First, participants all identified having worked in New York City SBMHCs which were located within the NYC school system. Therefore, the study was limited to a specific geographic area of the U.S. and not reflective of all SBMHCs. Also, the sample was limited in terms of gender and racial diversity. For example, eight of the nine participants were female identifying and six of nine identified as caucasian or Latino/a/x. While a female identifying demographic majority is consistent with demographics within the mental health field (U.S. Bureau of Labor, 2023), it limits the diversity of perspectives obtained within the sample of the study.

Next, it is important to acknowledge the methods used within the study and limitations that are present. Interviews were conducted via Zoom in two parts to better meet the time needed for participant engagement in the study. However, Hays and Singh (2012) described rapport with participants as important to the IPA process to enhance their comfort level in order to share rich details of their experiences. It is possible that the online interviews were a barrier in the rapport established between myself and participants which could have impacted the amount of information shared. I noticed that the length of interviews lasted no more than 30 minutes and some responses were brief in nature. It is possible that participants had more to share about their induction experience but the online interview did not feel as natural of a conversation had it been conducted in person. Furthermore, I observed several participants doing their interviews within their school offices. It is possible they might not have felt comfortable sharing openly in their spaces based on the make up of their office location.

Regarding the use of IPA, it is important to acknowledge the limitations of analyzing the data across the interviews and the amount of time to complete the analysis. Smith et al. (2012) recommended that data analysis begins when all of the data has been completed. However, data analysis took place over multiple sessions across both interviews due to the immense amount of data collected from the participants (n=18 transcribed interviews). While I was able to immerse myself within the transcripts through recordings and verbatim transcripts, the length of time could have contributed to inconsistencies within the analysis process (Smith et al., 2012). To ensure validity of the findings, I met with a critical friends group to verify the results of the data. Additionally, feedback was elicited from participants through the verbatim transcripts and summary of findings to confirm the presentation of the findings.

Implications

The findings from this study offer several implications for counseling professionals, including licensed mental health counselors, counselor educators, clinical supervisors, as well as school administration. Presented in the following sections are recommendations for improved induction experiences from the participants of the study, as well as drawing from relevant literature.

Licensed Mental Health Counselors (LMHCs)

There are several areas of the induction process that LMHCs can focus on when beginning their work in SBMHCs to set them up for success. The first is understanding their own interest and inherent personality characteristics for wanting to work in SBMHCs. Participants in the study expressed the idea that working in a SBMHC and school setting in general is not for everyone. Participants shared they had this motivation and interest to work in schools which required them to be more outgoing and willing to place themselves into school activities to establish rapport with the school community. Drawing from the participants' experiences,

LMHCs interested in school mental health and SBMHCs could explore their comfortability with going into settings unknown and being proactive to share about their services offered to the school community.

Molnar (2022) recommended school based mental health counselors to take clear steps to establish oneself through strong relationships within the school community, such as teachers and school administration, to help make their SBMHC more successful. Understanding the importance of collaboration is key to practicing within a school mental health setting (Adelman & Taylor, 2000). Participants shared numerous examples of collaborating with their schools (e.g., supporting student social and emotional needs, observing classrooms and providing feedback to teachers) when referring students to counseling services. Furthermore, LMHCs can collaborate with school counselors as part of their induction process to learn best approaches to school mental health services alongside their counseling colleagues.

LMHCs could identify the key stakeholders in their respective schools and establish rapport with them in three distinct ways. First, LMHCs can begin with the school principal and ask for a roster of the school administration and faculty to acquaint themselves with the school community. Using this roster would help the LMHC familiarize themselves with the range of staff in the school, as well as scheduling information. Next, LMHCs could establish consistent meetings with school administration and their counseling staff. The LMHC can share important data such as caseload, classroom observations, and information about the school community to better explore with school administration how their services can be best implemented based on the school needs. Once rapport and collaboration are established, it would be advantageous that LMHCs engage in reflective meetings with the school administration and their supervisor regularly to ensure that the services are being delivered in accordance with their agreement.

Successful school mental health services and programs are indicative of strong support from school administration and continuous reflection of the services being provided (Christian & Brown, 2018; Langley et al., 2010; Molnar, 2022). Also, LMHC should join grade team meetings and other school events to become more visible to the school community to learn about students and their needs. Strong rapport with consistent communication would allow LMHCs and key stakeholders to discuss their role within the school and how they would best collaborate together.

Lastly, given this study's focus on induction, LMHCs can explore how current or prospective employers orient and acclimate their supervisees to the SBMHC and larger school community. Therefore, LMHCs could ask about policies and procedures, clinical supervision schedule, mentorship and training opportunities, ways of engaging with the school community, and key strategies when navigating the school setting.

Clinical Supervisors

It is also well documented in the counseling literature about the importance of supervision for professional counselors when providing mental health services (Borders et al., 2014; Crespi & Dube, 2005; Goodyear & Bernard, 2011; Stephan et al., 2006). Furthermore, both the American Counseling Association (ACA) and National Board for Certified Counselors (NBCC) Code of Ethics stresses the need for supervision to ensure that supervisees are providing competent mental health counseling services to the clients they serve (ACA, 2014; NBCC, 2023). Therefore, supervisors having a working knowledge of the school mental health landscape and providing weekly supervision is important to a LMHC's induction to SBMHCs. Seeking out additional clinical training and supervision guidelines from resources such as the *National Center for School Mental Health Webinars*

(https://www.schoolmentalhealth.org/Webinars/) would serve supervisors well in their own knowledge and skill development to support their LMHCs.

Supervisors could offer consistent individual, group, or a combination of both supervision types pending upon agency availability and the number of LMHCs in schools. Also, supervisors need to consider a new clinicians group supervision model which would be advantageous for supervisors to connect with other new LMHCs to support their acclimation and connectedness to the agency. Furthermore, a new clinicians group (NCG) could provide a space for reflection on the school mental health landscape. Based on participant interviews, NCG is a short-term group focused on establishing a community for new clinicians as they acclimate to their role. Therefore, it is suggested that NCG run for 8 to 12 sessions to support and mentor new clinicians within their first two to three months. This can be provided on a weekly basis or biweekly for one hour to lengthen the amount of time of support and collaboration amongst new clinicians. Within this group, supervisors can introduce topics to the new LMHCs such as engaging the school community and strengthening clinical skills through diagnosis and assessment in schools. Additionally, new clinicians may present cases or situations they are encountering within their schools to receive feedback from their peers and supervisor facilitating the group.

Drawing from De Angelis Peace (1995) and Loveless (2010), supervisors could also become knowledgeable of induction frameworks and perhaps customize their own induction process for the first year of employment for LMHCs. Components could include weekly supervision, monthly school meetings, in addition to mentorship opportunities. Further, school mental health training and reinforcement of clinical skills needed for their job can also be components of an induction framework.

School Administration

When collaborating with SBMHCs and their respective counseling agencies, it would serve the school administration to have a comprehensive understanding of their student's current mental health needs by way of a school wide survey or consultation with a counseling agency to determine the best course of action. Furthermore, it would benefit the school administration to understand the role and services of the LMHC because they can serve as strong advocates to encourage the prioritization of student mental health. School administrators could have a list of services that the LMHC provides from the agency to help implement within their school for their students. Additionally, school administrators can collaborate with the agency to develop a document about the mental health process in schools to aid in the understanding about the limits of confidentiality and to help create crisis protocol. School administrators who serve as leaders and advocates of mental health services may lead to positive results including an increase in students accessing mental health services (Molnar, 2022).

Lastly, when acclimating third party providers into the school, school administrators can play a key role in the creation and implementation of the induction process (Curry & Bickmore, 2012; 2013). School administrators would benefit from having a coordinated induction plan with the agency featuring a handbook introducing the LMHC to school policies, schedules, recommended meetings to attend, mentorship opportunities with school staff, and a plan to introduce to the school community. This induction approach can be a part of a collaborative plan facilitated by the school administration with the new staff (i.e., school hired and community mental health) while building connections between programs and services within the school (Office of School Linked Services, 2023). Additionally, identifying a school point person for the LMHC would be beneficial when crises or a need arises during the acclimation process. This

person would help the LMHC understand policies or assist them in navigating the school landscape.

Counselor Educators

Counselor educators have an important role in introducing graduate students to an array of counseling theories, techniques, and settings in which professional counselors practice (CACREP, 2016; Lever et al., 2017). Specifically, clinical mental health tracks tend to focus on working in hospital or community mental health based settings (CACREP, 2016; Lever et al., 2017). Participants in this study expressed the need for additional counseling training when working in a school mental health setting. Counselor educators may consider several ideas when developing course materials and options for school mental health internships.

First, counselor educators may consider including school mental health articles across the counseling curriculum in courses such as introduction to professional and ethical issues in counseling and counseling children and adolescents. This introduction would expose graduate students to the possibilities of working in schools which align with CACREP standards when learning about various settings that professional counselors can work (CACREP, 2016). Next, counselor educators may consider offering an elective course on school mental health counseling. Such a course would provide depth and exploration of the school mental health field and introduce counseling graduate students to aspects of school counseling that stem beyond course topics outlined by CACREP Standards . One textbook to possibly use is *Counseling Children and Adolescents: Working in School and Clinical Mental Health Settings* (Ziomek-Daigle, 2017). This textbook bridges important topics from school and clinical mental health fields such as counseling theories and approaches specific to children and adolescents, understanding the MTSS framework, and working in a school and clinical mental health environment. These topics would provide an enriching overview that would be a good fit for a

school mental health course. Additionally, the topics would align with CACREP Standards such as learning about the history of school (Section 5-G.1.a), clinical mental health counseling (Section 5-C.1.a), the role of school (Section 5-G.2.a-e), and clinical mental health counseling professionals (Section 5-C.2.a; CACREP, 2016).

If a special topics course is not viable, counseling programs might consider allowing clinical mental health graduate students the option to take introductory school counseling courses as an elective to provide knowledge about the school landscape when considering a career in school mental health. Lastly, counselor educators serve as supervisors, liaisons, and gatekeepers when students are taking clinical courses (Cicco, 2014). Therefore, counselor educators would benefit from establishing relationships with schools who have SBMHCs to provide an opportunity for clinical mental health graduate students to complete their practicum or internships in a school mental health setting. The aforementioned options would provide a range of experiences for graduate counseling students who may consider entering the growing field of SBMHCs.

Recommendations for Future Research

The findings of this study serve as a foundation for further exploration and understanding of LMHCs experiences with induction in SBMHCs. Here are several recommendations for future research. Scholars have acknowledged that SBMHCs are a growing service across the United States (Christian & Brown, 2018; Costello-Wells et al., 2003). Therefore, it would be beneficial to study SBMHCs from both a qualitative and quantitative perspective regarding the role school mental health providers play within their respective school settings across the U. S. given the diversity of mental health needs and experiences. Also, it would be beneficial to compare the experiences across urban, rural, and suburban areas to provide more depth to the induction experience. Using a qualitative perspective would deepen understanding of SBMHCs and

perhaps expand the current knowledge on the range of services and approaches within the school setting. If a researcher is using interviews as part of data collection, encouraging a more private space such as home in the consent form might provide more comfortability and sharing of information between the participant and researcher. Furthermore, use of a quantitative or mixed-methods approach can help uncover the number and types of services provided in SBMHCS to the school community. Using this methodology could potentially further knowledge about a school's use and needs of mental health services in hopes to identify services most used or most helpful to the school community.

Prior research has applied the concept of induction largely to school settings for teachers (Hoover, 2010; Ingersoll, 2012; Ingersoll & Strong, 2011; Kearney, 2014; Mitchell et al., 2017; Wong et al., 2005) and several for school counselors (Curry & Bickmore, 2012; 2013; Loveless, 2010; Matthes, 1992; DeAngelis Peace, 1995). Future research may consider additional applications of induction in the mental health field such as community mental health clinics or hospital based settings to provide deeper insight into the experiences of practicing counselors. Examining these settings may help to improve clinical training during graduate school or at the agency level. To further understanding and use of induction, future research could consider developing an induction framework aimed at school based mental health settings that is inclusive of school counselors and professional counselors. Being inclusive of both providers in school settings may validate previous research on school counselor induction experiences, including the experiences of the participants in this study.

When considering the number and types of services provided, it would be beneficial to examine the *impact* of the services on student variables such as student retention rates, students' GPA and participation rates in counseling services. Also, it would be worthy to explore the

impact of a LMHC's induction process on variables such as staff retention rates and satisfaction, students' use of mental health services, school climate and engagement, and mental health awareness across students and faculty within the school. The findings of this study and future studies on the impact of services and induction can further the counseling profession's understanding of induction through more intervention research.

Christian and Brown (2018) conceptualized and coined the term school based mental health counselor and the role they can have in schools, the findings of this study provide some level of insight into the day to day role of LMHCs working in SBMHCs. Future research should focus specifically on the role of school based mental health counselors to provide in depth knowledge to inform both clinical training and program development. Additionally, understanding the supervision experiences and role of the supervisor within a SBMHC context would further expand our understanding of the clinical supervision needs of professional counselors and supervisors. Lastly, several participants reflected on the experiences of isolation and being labeled as a social worker in their role within the SBMHC. There have been documented experiences of school counselors experiencing similar feelings of isolation and identity confusion (Curry & Bickmore, 2012; 2013; Matthes, 1992). Future studies focused on LMHCs experiences of isolation and role clarification would further add to the growing school mental health literature.

Summary

In this chapter, I presented the rich findings of the study in relation to existing literature. This study adds to the induction literature and furthers our understanding of LMHCs experiencing induction within SBMHCS. Additionally, the findings of the study were also discussed and applied to the EST framework which presented an understanding of the numerous interactions between the participants and systems (Bronfenbrenner, 1979; 2005). Strengths and

limitations highlighted both areas that add to the school mental health and induction literature, as well as areas for future research. There are many implications identified within this chapter that would support an array of professional counselors, counselor educators, and school administrators alike to support LMHCs induction process. Lastly, this chapter closed with recommendations for future research to further our knowledge on this minimally studied topic in counseling yet largely important to consider when supporting future counselors coming into the field of school mental health.

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Appendix A

Recruitment Flyer

Appendix B

Screening Questionnaire Part 1 of 2

Thank you for your interest in this research study. As a result of this study, I intend to learn more about the induction experience that licensed mental health counselors (LMHCs) have when working in a school based mental health clinic (SBMHC) located within the New York City public school system. Within the two interviews, I will explore your experiences when being introduced to the school community as a licensed mental health professional.

If you are interested in being a participant in the study, please note the following:

- You must identify as a LMHC who currently works or has worked in a SBMHC in a New York City public school for at least one year. Unfortunately, limited permit holders are not eligible to participate in this study.
- You must be able to participate in two interviews, approximately 90 mins each, to be completed within the next 3-6 months.

Due to the COVID-19 restrictions and for the health and safety of interested participants, interviews will be conducted via web-based platforms (Zoom, Google Hangouts). If you meet the requirements listed and are interested in participating in this study, please complete the brief survey provided in Part 2.

Screening Questionnaire Part 2 of 2

When complete, please email back to Raymond Blanchard, Doctoral Candidate at Blanchardr3@montclair.edu.

1. What is your name?
2. What is your preferred email address?
3. What is your preferred telephone number?
4. Do you currently identify as a Licensed Mental Health Counselor in New York State?
5. Are you currently working in a school based mental health clinic (SBMHC) in a New York City public school?
6. Is or was your SBMHC an Article 31 clinic? An Article 31 clinic is defined as operating under the New York State Office of Mental Health Article 31 Regulations.
7. Do you have at least one year of experience working in your SBMHC?
8. How long have you worked in a SBMHC? To be eligible, the maximum number of years is 5.
9. Are you willing and able to participate in two interviews as needed for the purpose of this study?

Thank you for your responses, I will contact you upon receipt of your screening questionnaire. Also, if you know an LMHC who may be interested in participating in this study. Please share my email indicated above.

Appendix C

Demographic Questionnaire

Please answer the following questions to the best of your ability. If you have any questions, please contact Raymond Blanchard, Doctoral Candidate, at Blanchardr3@montclair.edu. Thank you.

1. What is your name?
2. How old are you?
3. What is your gender identity?
    a. What are your pronouns?
4. How do you identify your race/ethnicity?
    a. Asian/Pacific Islander
    b. Black/African American
    c. Caucasian
    d. Latino/a/x or Hispanic
    e. Multiracial or Biracial
    f. Other
5. How many years have you been a Licensed Mental Health Counselor in New York State? (in years).
6. What type of school setting have you worked in? (Mark all that apply)
    a. Elementary
    b. Middle school
    c. High school
    d. Co-located K-8 Setting
    e. Co-located 6-12 Setting

7. What boroughs have you or do you currently work in? (Mark all that apply)
    a. Bronx
    b. Brooklyn
    c. Manhattan
    d. Queens
    e. Staten Island
8. What is your average caseload number?
9. Please use the space below to indicate any other identities you hold that you believe are important to your experience including additional licensure and/or certifications, academic degrees, religion, and disability status.

Appendix D

Interview Protocol Part 1 of 2

Thank you for taking the time to meet with me and share your experiences about being a licensed mental health counselor (LMHC) working in a school based mental health clinic (SBMHC). As part of our interview, I want to encourage you to answer each question to the best of your ability and share only information you are comfortable with. At the end of the interview, I will provide an opportunity to share any additional information that you believe is important to your interview and the topics being discussed. Do you have any questions before we begin?

First, I would like to provide you with the operational definition of induction as it pertains to my study. Induction is defined as the structured or unstructured process where novice professionals are supported and mentored typically at the beginning of their career (Curry & Bickmore, 2012, 2013; DeAngelis Peace, 1995). At any point during the interview, please feel free to refer to this definition.

Beginnings as an LMHC and SBMHC

1. Tell me about what led you to working in a SBMHC?
    a. Describe the school setting (elementary, middle, high school) that your former/current SBMHC was/is situated in?
        i. Have you worked in more than one SBMHC? If so, please describe your additional school setting(s).
2. Describe your everyday experience working in your SBMHC.

Introduction to the SBMHC

3. Describe your induction experience into your school community and SBMHC.
    a. Tell me how your agency inducted you to the school community.
    b. Tell me how your school inducted you to the school community.

Defining Induction

4. In your own words, how do you define induction as a LMHC working in a school meeting?
5. How can the induction process be improved to support LMHCs and their transition working in the school community?

Closing

6. Do you have anything else you would like to share as it pertains to your experience of induction?
7. Lastly, what pseudonym would you like me to use to protect your identity within this study?

Thank you for taking the time to participate in my study today. You will receive a verbatim transcription of your interview to review to ensure that I have captured your interview in its entirety. I will provide more information and direction when that is sent to you. Lastly, if you know of any other LMHCs who fit or may fit the criteria of the study, please feel free to share my contact information if they are interested in participating.

Appendix E

Interview Protocol Part 2 of 2

Thank you for taking the time to meet with me for a second interview. Your participation in this study is much appreciated. Today's interview will consist of follow up questions based on your first interview. It will provide an opportunity to reflect on what your experience means to you while giving an opportunity to update any information based on your transcript and initial themes from the first round of interviews. Do you have any questions before we begin?

1. Prior to our meeting today, I provided you with a copy of our first interview transcript word for word. Have you had an opportunity to review the transcript? If so, do you believe the information you provided in the interview was accurately recorded in the transcript?
    a. Are there any corrections?
2. Our first interview consisted of your experience as an LMHC working in a SBMHC and how you were inducted or introduced into the school community, the types of services you provided and who you collaborated with. Tell me what does this experience mean to you as a LMHC?
    a. Can you share a story about your induction experience that was really meaningful to you, no matter if it was positive or negative?
    b. Can you share what you learned as a result of your induction experience?
    c. Is there additional personal meaning that you would like to share that is relevant to this study?

    Thank you for your participation in today's interview. This concludes your participation in the study. You will be provided a copy of your transcript from this interview to review

for clarity and accuracy. Should you have any questions or would like to see the final findings of the study, please contact me using my email address provided to you.

APPENDIX F

IRB Approval Letter

MONTCLAIR STATE UNIVERSITY

Raymond Blanchard <blanchardr3@montclair.edu>

IRB-FY20-21-2066 - Initial: Expedited Review
1 message

cayuseIRB@cayuse.com <cayuseIRB@cayuse.com> Wed, Apr 6, 2022 at 9:20.
To: blanchardr3@mail.montclair.edu, sheelya@mail.montclair.edu
Cc: reviewboard@montclair.edu, ferrantec@montclair.edu

MONTCLAIR STATE UNIVERSITY

Institutional Review Board
School of Nursing & Graduate School Building
Room 333
Office: 973-655-7583
Fax: 973-655-3022

Apr 6, 2022 9:20:30 AM EDT

Mr. Raymond Blanchard
Dr. Angela Sheely Moore
Montclair State University
Department of Counseling, Grad Asstship Stipend
1 Normal Ave.
Montclair, NJ 07043

Re: IRB Number: IRB-FY20-21-2066
Project Title: SS Understanding the Induction Experience of Licensed Mental Health Counselors Working in New York City School Based Mental Health Clinics

Dear Mr. Blanchard,

After a review to federal regulations, 45CFR46, category:

- 6. Collection of data from voice, video, digital, or image recordings made for research purposes.
  7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Montclair State University's Institutional Review Board (IRB) approved this protocol on April 6, 2022. Your study will require an Administrative Check In (ACD), every two years, updating our office with the status of your research project. Your check in date is April 6, 2024. We will send you a reminder prior to that date. Please note if your study has gone 90 days past the ACD, with no response from the research team it will be administratively closed.

This study has been approved under the conditions set forth by current state regulations due to COVID-19 and Montclair State University guidance. You are required to follow the approved plan for face-to-face research interactions. If you have any questions about the impact of COVID-19 with regards to the methods proposed in your study, please do not hesitate to contact us.

All active study documents, such as consent forms, surveys, case histories, etc. , should be generated from the approved Cayuse IRB submission.

When making changes to your research team, you will no longer be required to submit a Modification, unless you are changing the PI. As Principal Investigator, you are required to make sure all of your Research Team members have appropriate Human Subjects Protections training, prior to working on the study. For more clarification on appropriate training contact the IRB office.

If you are changing your study protocol, study sites or data collection instruments, you will need to submit a Modification.

When you complete your research project you must submit a Project Closure through the Cayuse IRB electronic system.

If you have any questions regarding the IRB requirements, please contact me at 973-655-2097, cayuseIRB@montclair.edu, or the Institutional Review Board.

Sincerely yours,

Dana Levitt
IRB Chair

cc: Ms. Caren Ferrante, Graduate Student Assistance Coordinator, Graduate School