Implications of State Policy Changes on Mental Health Service Models for Students with Disabilities

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For over 25 years, students with disabilities in California received educationally related mental health services through interagency collaboration between school districts and county mental health agencies. After a major change in state policy that eliminated state-mandated interagency collaboration, school districts in California are now solely responsible for providing all mental health services entitled to students with disabilities. This collective case study included three school districts, and examined mental health service provision immediately following the elimination of legally mandated coordination with county mental health professionals. Interviews were conducted with three district representatives from each of three school districts in California. Participant responses indicated confusion regarding the change in statutory regulations and disagreement surrounding assessment procedures and service providers. Implications for school districts as part of a system of care framework are discussed.

Keywords: systems of care, mental health services in schools, students with disabilities

Mental health care for students with disabilities (SWDs) is inextricably linked to the right to a free and appropriate public education. The Individuals with Disabilities Education Act (IDEA, 2004), mandates that students with emotional and behavioral disorders, along with students with other disabilities who have mental health needs, be provided with mental health services as required to benefit from their special education programs [20 U.S.C. §§ 1401 et seq.]. Research suggests that SWDs who

need mental health support are best served by a system of care (Stroul & Friedman, 1986), which is a single, bounded, well-defined set of expectations, policies, and service practices; a collaboration among partners and provider agencies at multiple levels of administration and service delivery; and sufficiently funded at the federal, state, and local levels (Hernandez & Hodges, 2003). Students with the most significant needs especially require and benefit from multiagency involvement and

collaborative partnerships (Bruns et al., 2010).

While a strong and cohesive system of care is ideal, SWDs often receive mental health services through fractured systems, with entities that are created in direct response to funding streams and specific reform initiatives. Schools serve as part of the system of care, but schools especially meet with increased strain as they are bound by federal law, but are forced to adjust when states take liberties in developing educational policy relative to their unique political and economic conditions (Marshall & Gerstl-Pepin, 2005). With the recent passage of the Every Student Succeeds Act (ESSA, 2015), states are granted increased flexibility to develop programs and measures that are best suited to local contexts, but when states make changes, there are direct effects on programs and potential effects on the services provided directly to students.

California's legislative history as it relates to mental health services for SWDs provides an important and unique perspective on the impact of state policy on schools' abilities to develop effective service delivery models and meet the mental health needs of their SWDs. Until October of 2010, California Assembly Bill (AB) 3632[1] defined the interagency responsibilities for providing mental health services to SWDs: school districts were responsible for identifying SWDs and ensuring the provision of school-based counseling; the Department of Mental Health (DMH) was responsible for recommending, providing, and funding

mental health services. State-mandated interagency collaboration had existed for over 25 years, and school districts depended on the model for developing collaborative partnerships and funding mental health services for students with mental health needs.

In response to a budget crisis, the State of California cut $133 million in funding for educationally related mental health services, rendering AB 3632 an unfunded mandate. On June 30, 2011, the California Legislature officially repealed AB 3632 with the passage of Assembly Bill (AB) 114[2], which transferred the responsibility of providing and funding related mental health services from county mental health and child welfare departments to school districts. The shift, while simple on paper, had significant implications for special education programs across school districts in California. School districts became solely responsible for service provision, and had to re-conceptualize and possibly restructure their mental health service models for SWDs.

Purpose of the Study

While school districts are mandated to provide educationally related mental health services to SWDs who require them, there are many barriers to establishing effective systems of care including, but not limited to, the following: schools lack adequate financial assistance, there may be obstacles to securing interagency commitment and assistance, and providers may not be adequately trained to deliver the services required (Dieterich, Snyder, & Villani, 2016). The purpose of the current study was to examine mental health service

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[1] Assembly Bill 3632. Chapter 26 (commencing with Sec. 75770), Div. 7, Title 1 of the Government Code, State of California, approved by Governor, September 30, 1984.

[2] Assembly Bill 114, Chapter 43 of the Government Code, State of California, approved by Governor, June 30, 2011.

models after a significant change in state policy, and explore the aforementioned barriers in the wake of potentially significant programmatic shifts.

This qualitative research study was designed to examine mental health service provision across three California school districts. In-depth qualitative research is necessary to document what takes place inside programs, and how practitioners change and adapt their programs in relation to their dynamic local contexts (Gutierrez & Penuel, 2014). Operating within a pragmatic paradigm, this study's emphasis was on obtaining detailed information from district staff members regarding their mental health program's process, development, and implementation (Mertens, 2010). The goal of the study was to explore how three school districts in California provided federally mandated educationally related mental health services to SWDs after the major change in state policy.

Method

A qualitative research design was used to obtain an in-depth account of mental health service provision in three school districts in California. This study employed a collective, multi-site case study approach (Creswell, 2007) by selecting three school districts to exemplify the development and implementation of mental health service models for SWDs following the repeal of AB 3632. The included cases were sampled based on a convenience sampling strategy, which involved locating sites from which the researcher could easily access and collect data (see Creswell, 2007, p. 126). Sampling was also purposeful (Creswell, 2007), in that cases were selected because they showed different perspectives on the issue and uniquely informed an understanding of mental health service in school districts. Cases were bound at the district level because service provision procedures vary by district, and special education policies and procedures are district-wide and not school specific. Although school districts must adhere to federal and state mandates, they operate as individual entities, developing their own cultures and systems based on the distinctive needs of their communities, staff, and students.

Participants

Three school districts, representing those in the process of redefining school-based mental health services for SWDs, were selected as cases. Demographic characteristics for each school district are included in Table 1.

As described in the following section, each district had a different set of circumstances that lent perspective to the challenges districts may face when confronted with policy changes, as well as the strategies employed to satisfy state mandates. From each school district, three individuals were selected to participate in in-depth interviews. The individuals included those involved in the development and implementation of their district's mental health service delivery models.

Table 1
School District Demographic Characteristics

	District A	District B	District C
Student Enrollment	14,500	10,500	14,500
Students by Race/Ethnicity			
Asian	7.7%	0.8%	56.6%
Hispanic or Latino	57.5%	91.2%	21.5%
Black or African American	7.6%	1.4%	3.0%
White	19.1%	4.2%	11.0%
Free/Reduced Price Meals (percent of enrollment)	61.8%	72.6%	13.3%
Special Education Enrollment (percent of total student enrollment)	8.8%	11.3%	7.8%
Students with Emotional Disturbance (percent of special education enrollment)	4%	3.4%	2%
2012 District Base Academic Performance Index (API)	832	739	909

Note: Total student enrollment is represented as an approximation. Race/ethnicity categories include the four largest represented groups within the districts.
Source: California Department of Education (2011-2012), Ed-Data (2010-2011)

District A. District A was selected as a case because its administrators opted to hire their own mental health professionals instead of contracting out to private agencies. District A speaks to the challenges districts may face when redefining roles of special education staff, especially when most of the mental health services are school-based or within-district. The interviewees from District A were three school psychologists, who were highly regarded by their peers and actively involved in the district's program changes. One of the school psychologists was formerly a special education program specialist for the same district, and became the lead psychologist for the district's largest comprehensive high school. The other two school psychologists were assigned to elementary and middle schools within the district, and both were involved in the district's transition from AB 3632 to AB 114.

District B. District B was selected due to its high percentage of students who are eligible to receive services through Medi-Cal, which is California's Medicaid welfare program serving low-income individuals. Additionally, District B speaks to the advantages and/or disadvantages of interagency collaboration as the district opted to continue contracting with outside agencies and providers for all of its mental health services. The interviewees from

District B were the Senior Director of Pupil Services, the Coordinator of Special Education, and a Special Education Local Plan Area (SELPA) representative. The Senior Director of Pupil Services and the Coordinator of Special Education both served in their positions for several years, were extremely knowledgeable about the district's mental health services, and represented two of the highest decision-making levels with regard to special education programs and services within the district. The SELPA representative was selected because the Coordinator of Special Education mentioned working regularly with this specific employee as a consequence of the district's new model of service delivery.

District C. District C is located within a high socioeconomic status (SES) community and serves as a comparison to districts with lower SES. Analysis of District C's data enabled the research team to identify any differences in the challenges faced and/or strategies used when districts are comprised of students with more financial resources. District C's participants included the Administrative Director of Educational Services, the designated educationally related mental health services (ERMHS) school psychologist, and a school psychologist assigned to one of the district's comprehensive high schools. These three participants worked in the district for many years and represented three different levels of decision-making within the district's hierarchy. The Administrative Director of Educational Services worked for the district in several capacities, including as a school psychologist. This participant was the director for all special education programs and was highly regarded and well respected by his peers. The ERMHS school psychologist was recently appointed as the ERMHS school psychologist on special assignment. This participant worked just beneath the Administrative Director of Educational Services and oversaw the district's mental health service programs. The third participant represented the school psychologists who work under the leadership of the ERMHS school psychologist.

Procedure

A semi-structured interview protocol designed to explore mental health service programs for SWDs was developed and pilot-tested with a former district-level director of special education. Local professionals in the fields of special education, mental health, and educational advocacy reviewed the interview protocol and revisions were made according to their feedback. The final interview protocol consisted of open-ended questions pertaining to the district's mental health services for SWDs, such as "What has been the district's process in interpreting 'educationally related mental health services'?" and "What is the district's method of assessing and providing for mental health services when Designated Instructional Service (DIS) counseling is deemed inadequate to meet the student's mental health needs?" The protocol covered the following topics: (a) the district's immediate response to the AB 3632 repeal; (b) the process of policy development within district to address mental health services; (c) the funding structure for providing mental health services; (d) role descriptions and licensure requirements of direct service providers; (e) specific details regarding service delivery; and (f) opinions regarding strengths and weaknesses of the program, perceived efficacy, and methods taken to assess program fidelity and efficacy.

Following university Institutional Review Board approval, the first author

contacted representatives from the three school districts by phone or email to explain the purpose of the study and to request participation. A formal letter explaining the purpose of the study was provided to a designated contact person within each district. After district consent was obtained, key personnel from each site were invited to participate in an interview. Interviewees were selected based on their knowledge of their district's mental health services and their involvement in the decision-making process. After selected participants were identified, consent for participation was obtained following Institutional Review Board guidelines. Interviews were conducted during the Spring and Summer of 2013, lasted approximately one hour, were audio recorded, and were conducted in private, mutually agreed upon locations.

Data Analysis Procedure

The first author transcribed the audio recordings of the nine interviews, and both authors read each transcript line-by-line. Member checks were conducted by providing each interviewee with a draft of his or her transcript for review and comment, and by summarizing interview notes for each interviewee to ensure an accurate reflection of the interviewee's position (Mertens, 2010). Coding began once participants reviewed and approved the transcripts.

Code development and revision. Using the interview protocol as a framework, the authors developed a priori descriptive codes to summarize large segments of data (Miles & Huberman, 1994). The initial descriptive codes included the following five broad categories: program model, services, service providers, funding, and other. The authors reviewed each transcript and assigned descriptive codes to each segment of data. Using an inductive approach, the authors independently added notes and comments, which were discussed and used for refinement of existing codes and generation of new codes. The inductive analysis produced descriptive codes that parsed the broad categories into smaller units (e.g., descriptive codes for services were type, outside agencies, and assessment for services). A second review of the authors' notes and comments resulted in further refinement of each of the descriptive codes. The authors determined topics that would be included within each descriptive code and generated a final list of coding categories. The a priori codes, descriptive codes, and final coding categories can be seen in Table 2.

Check-coding. To facilitate consistency within and between researchers, the 11 coding categories were summarized in a table, which specified the codes, labels, operational definitions, and representative examples. The authors used the table to code the first transcript collaboratively, and any discrepancies in code assignment were discussed and resolved. A check-coding process was used to improve reliability and to clarify operational definitions of the codes (Miles & Huberman, 1994). The authors coded the second transcript independently, and subsequently met to review their analysis and discuss any disagreements. Discrepancies in coding were discussed and resolved through consensus, and operational definitions were revised as needed to improve clarity.

Table 2
Development of Codes

A Priori Codes	Generated Descriptive Codes	Final Coding Categories
Program Model	Past description	1. Relationship with DMH prior to the appeal.
	Current description	2. Model development, responsibility of leadership, transition since the repeal, program components.
	Future program	3. Discussion of an ideal model.
Services	Type	4. Description of services offered, including services that have ceased since the repeal
		5. ERMHS: specific information regarding services deemed as educationally related.
		6. Residential placement/services
	Outside agencies	7. Contracting with outside agencies to provide services.
	Assessment for services	8. Who is referred for assessment, who qualifies for assessment, types of assessment used, who performs the assessment.
Service Providers	Licensure	9. Opinions regarding who should be providing mental health services in both school- and clinic-based settings and the licensure required of those providers. Discussion of the use of interns to provide services.
Funding	Funding sources	10. Medi-Cal, private insurance, state/federal funding.
Other		11. Additional comments from participants that are unique to each case and may inform the overarching themes but have a distinct contribution.

Interrater agreement. The authors assigned one or more codes to each data segment. An agreement occurred when the authors assigned the same code to a segment of data. A disagreement occurred when one author assigned an additional code to a section of text that the other author did not, or when authors disagreed about a code assigned to a section of text.

Agreement among coders was 73% after the first independent coding, and agreement reached 86% for the subsequent coding. After discussing and resolving discrepancies, the authors coded the remaining transcripts independently. Interrater agreement met established criteria for qualitative research (Boyatzis, 1998); however, percent agreement may be

misleading in that two evaluators may assign the same code, but that code may not be the best reflection of an interviewee's intended meaning. Ultimately, an in-depth analysis of qualitative data involves a discussion of seemingly divergent interpretations, which may actually reflect concordance on some level within a wider framework (Armstrong, Gosling, Weinman, & Marteau, 1997).

Development of themes. During the coding process, illustrative quotes were extracted from the narratives to support the 11 coding categories. After completing coding of all transcripts, the authors discussed the illustrative quotes and other significant phrases and sentences, and then formulated meaning from those statements (Creswell, 2007). Once relationships between the formulated meanings were determined, those connections were clustered into themes, which allowed for the emergence of five overarching themes represented across the participants' transcripts.

Credibility and transferability. Data triangulation was accomplished through the use of one method (interviews) from multiple sources (different individuals and sites). The study's first author had pre-existing professional relationships with most participants, which resulted in an established trust and rapport. Accordingly, participants were comfortable with the interview process and willing to provide detailed and thoughtful responses to the interview questions. As described previously, member checking was used to further improve credibility. Transferability was addressed through provision of detailed descriptions of the context and sample to allow the reader to assess the applicability of the findings to other settings (Miles & Huberman, 1994). The use of multiple cases further strengthened this study's transferability (Yin, 2009).

Results

Data from the three school districts represented as cases in this study were systematically analyzed using a thematic approach. Five broad themes emerged, which are described in the following section.

Theme 1: *Service Models: Past, Present, and Future*

Past. Prior to the change in state policy, DMH assumed responsibility for service provision when students needed services more intensive than school-based counseling. Representatives from all three districts in this case study stated that DMH's involvement in the delivery of services under AB 3632 resulted in an inordinate number of recommendations for residential placement, which is the most restrictive educational setting. Participants felt that the districts lost a degree of control over the SWDs' cases, and were not able to provide the full continuum of services before DMH made the recommendation for placement in out-of-state residential facilities. The change in state policy allowed these districts to assert more control over their recommendations and placement decisions of SWDs requiring mental health care.

Present. Without state-mandated interagency collaboration, the three school districts were forced to take ownership of their service delivery models and create systems that reflected the unique needs of their schools, students, and communities. Although the school districts gained more control over their programs, the participants in this study shared in their frustration over rapid policy changes that affect a small, but vulnerable, population of students. SWDs who require mental health

services often need very intensive, consistent supports and disruption to services can seriously impede a student's ability to function in his or her academic environment. Participants reported that it was difficult to respond to the change in policy and restructure their mental health service models so that SWDs did not lose access to services they depended upon to be successful in school. Each district's model is discussed below.

District A. This district's Director of Special Education made the unilateral decision to hire additional Local Education Agency (LEA) personnel and cease contracting with any outside service providers. One participant remarked that there was no transition from the model under AB 3632 to the district's present form of service delivery—all mental health services were taken back practically overnight. A licensed clinical social worker and Marriage and Family Therapist (MFT) were hired to oversee the district's mental health service program, and several interns were also hired to provide individual and group therapy to referred students. Although a model was in place, the participants expressed frustration that it was not clearly defined and that there was no clear system for separating mental health services designated for SWDs from those available to all students.

District B. Participants in District B noted that developing a model immediately after the repeal of AB 3632 proved to be quite difficult. One participant remarked on the district's immediate response once funding for services was eliminated:

It was very stressful…we were sent a little bit scrambling just to figure out…no one knew what to do. In other words, we had a lack of understanding of, ok, so funding is cut off for AB 3632, are we going to get funding, or is it just gone? We don't even know what resources we're going to have to deal with this issue to start with.

Unlike District A, District B chose to continue contracting out for mental health services for SWDs. The district's school psychologists provided DIS counseling, and if more intensive services were deemed necessary by an IEP team, a clinician would be contacted to conduct an educationally related mental health services (ERMHS) assessment. The assessment was intended to reflect the type of assessment that DMH would perform when considering additional services through county mental health agencies. If any mental health related services were deemed necessary, District B provided those services through contracts with outside providers. At the time of the interview, District B only provided an assessment and additional mental health services to students identified as emotionally disturbed (ED), as stated by a district administrator.

District C. Like Districts A and B, participants in District C remarked on confusion following the AB 3632 repeal. The district's Administrative Director of Educational Services stated the following:

The problem is that when it came out it was done in a way that was really not only rushed but very unclear—what were the ramifications, what were the consequences of it—to the point that really there was not a single voice…explaining this is what it's all about, this is what's going to happen, and this is what we expect you to do.

As noted by another participant in District C, school districts in California were left with the mandate to provide mental health services, but did not have the internal capacity to do so:

> We had to really re-conceptualize what services could be provided by counselors and psychologists and what was outside of our scope of practice that really needed to be referred out. And then how we would refer that out and to whom we would refer that out. A lot of the difficulty was around the fact that a lot of our highest needs students did not have insurance and did not have any ways of obtaining outside services. So there was this big gap in terms of what had been provided and what we're mandated to provide and what we then had in terms of resources to provide.

District C's Administrative Director of Educational Services immediately began working on a plan to provide mandated services under the new regulations. District C opted to develop a program that was a hybrid of school-based and clinic-based services. The Administrative Director of Educational Services assigned one of the district's school psychologists to supervise the ERMHS program and oversee the team of school psychologists. The program was designed such that the district's school psychologists provided DIS counseling and also conducted ERMHS assessments when additional mental health services were necessary. The designated ERMHS school psychologist would be called upon to assist with assessments, IEPs, and recommendations. If additional services were deemed necessary, District C provided those services through contracts with outside service providers.

Future. Although the three school districts developed different models of service delivery, when asked what the ideal model would be going forward, the participants in each of the three districts gave remarkably similar responses. Ideally, the participants would like to have a licensed therapist available at the district office to consult with and see students individually. The participants remarked that when districts create models in which services are purely contracted out, transportation issues often exist, and there may be a lack of generalizability from the therapeutic setting to the school environment; however, purely school-based services have the potential to threaten confidentiality and limit the ability to work more intensively with families. The participants in this study felt that there would be great advantage in coordinating efforts with private mental health agencies, university programs, and community organizations, but hiring at least one licensed clinician as a district employee would assist in bridging the gap between school-based and clinic-based services.

Theme 2: *Scope of Services*

Although participants expressed serious concerns over DMH's involvement in recent years, they felt that working with DMH was advantageous because students had access to the full scope of services. When the collaboration with DMH ceased, districts found themselves without the resources to provide the same services. One participant stated the following:

> What about medication management? What's going on there? We can't offer that. We don't have people who are equipped to prescribe or monitor any student.

Family therapy…who is offering family therapy? Parent training was supposed to be another component of this program. We were supposed to provide parent training after hours. That hasn't happened yet. And I know it's a work in progress, but these are things that kids need now. Right now we took it all on and we're not providing the full scope of services.

The three districts mentioned medication management, family therapy, and day treatment as services that DMH provided, but were burdensome for districts given that the districts did not yet have an infrastructure to support the full scope of services. Participants also felt that medication management was not within a school district's purview.

Interpretation of educationally related mental health services. Many school districts in California have adopted the term "educationally related mental health services," or ERMHS, to refer to the services previously provided by county mental health agencies. This term has resulted in some confusion, especially when professionals believe that these services are somehow separate from the related services outlined in IDEA. When asked to define ERMHS, all participants from the three cases in this study provided a definition similar to that of related services, which are any services a special education student requires to benefit from his or her special education program. When asked specifically which services would be considered as ERMHS, participant responses varied. Responses across all three districts revealed that participants were uncertain about which services (e.g., individual therapy, family therapy, medication management) they were

mandated to provide under the related services provision of IDEA.

Theme 3: *Assessing for Mental Health Services*

For SWDs who require DIS counseling, participants from all three school districts reported that school psychologists provided the school-based counseling services. If a student was not making adequate progress through DIS counseling, the next step would be to conduct a mental health evaluation /assessment to determine the most appropriate type and intensity of service. The three school districts, however, were not in agreement as to when to assess, who assesses, and what the assessment means. In District A, school psychologists were asked to conduct an ERMHS assessment, although the school psychologists did not feel comfortable with that directive:

We're not equipped to provide diagnoses no matter what. For us to be completing a mental health evaluation doesn't make any sense. That's how we all feel…all of the psychologists feel that we are not equipped to complete a mental health diagnosis.

The participants in District B vehemently stated that school psychologists do not have the qualifications to perform mental health evaluations. If an ERMHS assessment is required, District B contracts with a licensed clinician to conduct the assessment; under no circumstances are the district's school psychologists asked to complete a mental health evaluation. District C did ask its school psychologists to conduct an ERMHS assessment, but the assessment is essentially an update to the ED evaluation for eligibility purposes. Unlike District A, the school psychologists

interviewed in District C did not have complaints about being asked to complete an ERMHS assessment, and the assessment itself appeared to be far less cumbersome than the mental health evaluation protocol used by school psychologists in District A.

Theme 4: *Service Providers*

Once past the assessment process, all three districts were in agreement that licensed clinicians should provide mental health services that are therapeutic in nature. For Districts B and C, licensure requirements had not been an issue since both districts contracted out to mental health agencies for therapeutic services. District A, however, opted to hire MFT, social work, and school psychology interns to provide the mental health services at the district office under the supervision of a licensed MFT and clinical social worker. All three participants from District A expressed concern that the interns lacked experience, only provided services during the academic year, and often completed their required hours in one year; consequently, students did not have access to services during summer months and there was turnover among providers. One participant aptly described the concern:

> My biggest complaint about interns of any sort is that they're only there for a year or two, and then they move on. So the consistency of treatment…you know you get a kid that has trouble connecting, has trouble trusting, and you get them in with an intern and they trust and they like and they develop that rapport and that relationship, and then after nine months the intern is gone.

A major factor in deciding whom to hire within a district is cost. Some interns will work for free as they are completing hours required for licensure; others work for a minimal hourly wage. Interns are far less expensive than hiring several clinicians, but interns have less experience and training than licensed clinicians. In District A, school psychologists were asked to refer a special education student to the district's mental health program if DIS counseling had been insufficient to meet the student's needs. The more intensive level of therapy offered through the district program was provided by interns. Thus, the participants expressed their reluctance to refer students to the district's program because they felt the DIS counseling that the school psychologists provided was equal to—if not better than—the individual therapy provided by the interns.

Theme 5: *Funding*

Participants from all three districts remarked on the expense of providing mental health services to SWDs, although some of the expense was alleviated by Medi-Cal and private insurance companies. Districts A and B are considered lower SES (based on the percentage of students receiving free and reduced price meals) and have a higher number of SWDs who are eligible for Medi-Cal. In those cases, the districts have more liberty to refer students to outside mental health agencies who will provide services and bill Medi-Cal. Students who are covered by private insurance also have the option of seeking services through outside providers and are not dependent on what the school is able to provide. District C, which is a high-SES LEA, has relatively less pressure to provide mental health services since families have access to other resources, as stated by one participant:

> If you notice the area that we service is high and middle class to people that are really high income.

And these people have means. There are a lot of kids that I'm sure with needs that the parents themselves take care of.

From the participants' responses, it appears that students from low and high SES communities have the advantage of insurance coverage. SWDs are offered and can utilize the school district's mental health program, but they can also access other programs and providers. The concern is for SWDs who do not have or do not qualify for insurance that covers mental health services. For these students, who may access mental health services only through school systems, funding for appropriate care is largely dependent on state and federal funds earmarked for mental health services in schools.

Discussion

The three school districts in this collective case study illustrate two interrelated issues in the area of mental health service provision for SWDs. The first is the school districts' conceptual understanding of how to effectively provide mental health services. For school districts in California, DMH previously provided the gamut of mental health services, and were bound by law to do so. Once school districts became responsible for service provision, they had to consider a systems-level approach, and meet student needs within the confines of funding allocations. As evident in the participants' responses, the school districts had to make decisions regarding assessment procedures, licensure of service providers, and the extent to which the district would continue developing collaborative partnerships with outside agencies. These decisions had to be made quickly due to the policy change, and the districts appeared to have difficulty

conceptualizing their mental health models at the systems level that would enable continuity in service provision.

The second issue evident in this collective case study is how school districts adapt their systems to respond to changes in educational policy. The repeal of AB 3632 and subsequent passage of AB 114 may be unique to California, but it represents a larger problem within the field of special education, which is that programs often suffer under hasty and massive legislative, regulatory, and funding changes. In difficult financial times, states make large cuts to educational programs, which puts enormous pressure on districts to adjust (Marshall & Gerstl-Pepin, 2005). School districts in this study were not provided with the time or resources to properly re-conceptualize their service models and create appropriate systems of care. As mentioned by the participants in this study, their systems of care had to shift quickly, and there may have been gaps in care as a result of limited resources.

Results from this collective case study should be interpreted with caution given the limited number of included cases. Although each case provides a unique perspective on the issue under study, school districts across California vary widely and are affected by their local conditions. Sampling of additional participants from various school districts is necessary to determine if the common themes in this study generalize to other school districts in California. Additionally, interviews for this study were conducted immediately following the repeal, and the districts' programs and participants' perspectives have likely changed; future research would be helpful in tracking the continuous progress of districts as they adjust to policy changes over time.

This study's findings, while restricted to three cases, are consistent with research indicating that no two systems or program models develop in exactly the same way (Vinson, Brannan, Baughman, Wilce, & Gawron, 2001). Systems of mental health service delivery should be sensitive and adaptive to the local context, and districts must create models that are responsive to local need (Hernandez & Hodges, 2003). Variability across districts is not a problem per se, as long as the mental health needs of SWDs are adequately met within each unique model. Future research is needed to explore the relationship between organizational change and service efficacy with consideration of practice variables such as student populations, models of service delivery, provider organizations, and financing of programs (Schoenwald & Hoagwood, 2001).

Although it is very difficult to assess the efficacy of complex organizational structures such as those that comprise a system of care (Hernandez & Hodges, 2003), an ideal evaluation of mental health service programs within school districts would focus on "changes associated with accomplishing organizational change that reflects systems-of-care values and principles" (Hernandez & Hodges, 2003, p. 23). Ultimately, school districts should build models of mental health service delivery for SWDs that include a well-defined set of regulations; clear definitions of roles, responsibilities, and expectations of practitioners; specific requirements of collaborating partners and provider agencies; and a very clear protocol that is outlined and communicated to all personnel involved in the system. Going forward, school districts in California, as well as other states, would benefit from continued research on specific strategies and program components that lead to the most efficacious models of mental health service delivery.

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