

International Journal for School-Based Family Counseling

Special Topic Issue, 2017

Reducing inter-professional barriers affecting School-Based Family Counseling

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The purpose of this article is to highlight a serious problem obstructing the development of School-Based Family Counseling (SBFC). An important barrier for SBFC is competition and conflict with other mental health professions. The literature on this is sparse. This article adds to that literature by presenting three detailed case studies involving SBFC professional practice and university programs that were negatively impacted by conflict with other mental health professions. Reasons for the presence of these marginalizing and discriminatory inter-professional behaviors are discussed. The article concludes with some practical strategies for potentially dealing with these inter-professional barriers. Recommendations are made for future research.

Keywords: Barriers, inter-professional conflict, mental health guilds, School-Based Family Counseling.

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Introduction

School-based family counseling (SBFC) is an approach to helping children achieve school and personal success through mental health interventions that link two of the most important institutions affecting children: family and school (Gerrard, 2008; Carter & Evans, 1997; Soriano & Hong, 1997). Despite the fact that SBFC is a meta-model that can be used by any mental health approach (Gerrard & Soriano, 2013), mental health professionals who have developed SBFC programs have frequently encountered resistance from other mental health professionals (Gerrard, 2013; Laundy, Nelson, & Abucewicz, 2011; Luk-Fong, 2013). On occasion, this inter-professional barrier has resulted in the termination of the SBFC program, depriving children, families, and schools of services (Luk-Fong, 2013).

A barrier to entry for a SBFC program is anything that obstructs the ability of the program to exist. Barriers may be lack of funding, resistance from school district administrators, lack of

training of mental health professionals in SBFC, state licensing restrictions, or mental health inter-professional barriers. The type of inter-professional barrier this article will focus on is conflict which occurs when members of a different mental health approach attempt to block a SBFC professional from developing a SBFC program. The purpose of this article is to describe this problem, first as identified in the literature, and second through three detailed examples of SBFC barriers affecting professional practice and university programs. Next, a rationale is presented which the authors believe explains more succinctly the reason for this inter-professional barrier. The article concludes with some practical suggestions learned in the development of successful SBFC programs that had to deal with inter-professional barriers. Finally, suggestions are made on how to advance research in this topic despite it being potentially risky for the researcher.

Inter-professional barriers in the mental health professions

Conflict between the mental health professions: psychiatry, psychology, psychiatric nursing, social work, counseling, and marriage and family therapy, is commonplace. For example, it can range from disparaging remarks intended to convey that one's mental health profession is superior to another, to legal action intended to block a newer mental health profession from practicing. The literature documenting this inter-professional conflict extends over a 60 year period (Maddock, 2015; Thongpibul, 2012; Firmin, Johnson, & Wikler, 2009; Galassi & Akos, 2004; Schmitt, 2001; Herron & Mortimer, 1999; Bernhofen & Opie, 1997; Cott, 1997; Griffiths, 1997; Krass, 1997; Lister, 1982; Spitzer & Sobel, 1965; Zander, Cohen, & Stotland, 1957). Several authors have concluded that inter-professional conflict in mental health is the rule rather than the exception (Mason, Ilians, & Vivian-Byrne, 2002; Foster, 1998). Inter-professional conflict can have dire consequences for clients, including death (Kohn, Corrigan, & Donaldson, 2005; Romanow, 2002).

Firmin, Johnson and Wikler (2009) summarize this general failure of the mental health professions to collaborate with each other as follows:

The human service professions have a sordid history relative to collaboration...Inter-professional collaborative efforts have not generally been strong between the main human service professions...Randolph (1988) labelled the mental health community organizations as their own worst enemies in this regard. This is largely because of the inter-professional squabbles and sometimes outright hostility that exists between the groups – often expressed in the open media. (pp. 194-196)

According to Paul & Peterson (2001) the barriers to inter-professional collaboration described above are replicated in the post-secondary educational institutions where mental health professionals are trained. The consequences of this inter-professional conflict for clients is serious, and clients have been harmed or died because of a poor quality of care affected by inter-professional conflict (Grant, Barring, & Lake, 2011; Kohn, Corrigan, & Donaldson, 2000). In contrast, there is strong support in the literature for inter-professional collaboration benefiting clients (Charles et al., 2008; Salhani & Charles, 2007; Schmitt, 2001; Gilbert et al., 2000; Nottle & Thompson, 1999; Lary et al., 1997; Greene, Cavell, & Jackson, 1996; Poulton & West, 1993).

Literature on inter-professional barriers affecting School-Based Family Counseling (SBFC)

This section describes examples of inter-professional barriers affecting the development of SBFC university training as well as SBFC professional practice. The literature on inter-professional barriers to SBFC is sparse. Three examples of inter-professional conflict affecting mental health professionals developing SBFC programs were identified in the literature. The first, a barrier to SBFC professional practice, is described by Laundry, Nelson and Abucewicz (2011). It involved attempts by members of other mental health professions attempting to block school certification of MFT's in Connecticut:

Such a pattern certainly occurred in Connecticut, where there was at times contentious testimony against MFT school certification by allied mental health colleagues....Some were resistant to growing competition for their positions by MFTs in schools, despite the fact that the MFT field was itself started by psychiatrists, psychologists, and social workers seeking more short term and powerful ways to relieve constraints and improve mental health. (p. 385)

These attempts to block the certification of MFTs in schools were unsuccessful and school certification of MFTs was achieved in Connecticut in 2007.

The second example, involving a SBFC university training program, is a description by Luk-Fong (2013) of how she developed a specialization in SBFC within her department's M.Ed. program at the Hong Kong Institute of Education. The specialization involved courses in Parent Education and Family Support; Family Relationships; School-Family Collaboration; Parent Education; and Supporting Parents and Families with Diverse Needs. Luk-Fong retired shortly before the specialization was due to be launched, thus leaving no family systems or SBFC faculty in the department. Under pressure from the Graduate School to only allow each department to have one specialization, the department eliminated the specialization in favor of other emphases.

Gerrard (2013) has described how colleagues within a counseling psychology department presented barriers to the development of Mission Possible - a SBFC program that was providing services to 20 schools:

Because SBFC is a synthesis of family counseling and school counseling approaches, it is potentially threatening to traditional educators and mental health professionals who believe that there is only one correct way to approach schools or families. This opposition appeared in the early years of Mission Possible in several forms: as a motion at a department meeting to not support an early version of the SBFC program (the motion was not approved); as a program coordinator's decision to not send their students to Mission Possible for internships; and as demands that meetings of Mission Possible staff be reported in detail at department meetings. Although these challenges only came from a few colleagues, they opened the door to the possibility that a Mission Possible program that was departmentally based could quickly cease to exist. (p. 720)

Strategies described later in this article were used to overcome these barriers and currently, 35 years later, the Mission Possible program is still in existence. This example involved both

university training (as students in the university department provided most of the counseling) and professional practice (as Mission Possible was primarily a professional practice program delivering SBFC to schools).

The section that follows presents three new case studies illustrating barriers to SBFC professional practice and university training. Because the description of inter-professional conflict typically involves mental health professionals behaving in a marginalizing and discriminatory manner, open reporting of incidents can be dangerous for the reporter, resulting in further discrimination and harmful effects to programs. For this reason portions of the following case studies have been altered to maintain confidentiality.

Case study #1: The case of the “unqualified” therapist

This example of a professional practice barrier occurred at a western USA regional college. The dean wanted to help undergraduate students at risk of failure who required counseling because of stress that they were experiencing in making the transition from home. The dean had identified at least 30 students in this situation. Since the college’s on-campus counseling service was overwhelmed by referrals of students in acute crisis, the failing undergraduates received no counseling whatsoever. The dean, who had heard about SBFC, contacted the director of the off-campus SBFC community counseling center maintained for training purposes by another division of the college. A pilot project was drafted and implemented. The failing undergraduates were given appointments at the center. The dean took a personal interest in the first referrals and monitored their progress. The student clients reported great satisfaction with the counseling received. They began to feel better. So did the dean, as he now believed that the retention problem could be brought under control.

The director of the community counseling center was interested in this new client pool of undergraduates who had an average age of 20. Her center specialized in SBFC which had been developed around the goal of school success for school students. The college undergraduates were just a year or two out of school and into college. The center director stated that she hoped that the pilot project would demonstrate the applicability of the SBFC counseling model in which stances from the school counseling and family therapy models were combined. The pilot project produced exactly the results expected. The preliminary statistics showed a 90% correlation between the undergraduates’ academic underperformance and family issues. The family issues, such as divorce and the parents’ characterological complexities, combined with the undergraduates’ own developmental issues. This placed such weight on the undergraduates that they had no psychological space to meet the demands of the transition from school to college. The center director and her clinicians were excited at the prospect of expanding the center and tangibly demonstrating the good results of the pilot project. The director of the community counseling center was motivated to help the students and the dean. Her research indicated that lack of preparedness for the transition to college was becoming a pervasive problem for incoming college and university students. While she cared about the undergraduates and the outcomes of their counseling, the director also had a personal stake in the pilot program.

In her enthusiasm for the pilot project the director neglected to note that she was infringing upon the territorial interests of several powerful mental health professions. By instituting the school success model in her counseling center, which, as we have seen, combined stances from

each of the school counseling and family therapy models, the director was unwittingly infringing upon the interests of those two professions. When the director of the psychology doctorally-staffed on-campus student counseling service discovered the existence of the pilot project where failing students were referred to the off-campus counseling center staffed by SBFC Masters-level clinicians, he wrote to the college's top administrators with the following message: firstly, Masters-level clinicians are not competent to treat college undergraduates and, secondly, the SBFC pilot project creates a severe liability problem for the college. The letter was copied to the college's lawyer and provost. The pilot SBFC program which had operated successfully for four months was closed by the college administrators.

Case study #2: Befriending a resistant "guild" member

The following example of a barrier to SBFC university training is described in more detail as it contains useful examples of how strategies can be effectively employed to overcome barriers. About three years ago, several SBFC professors (Drs. A, B and C) were invited by the California State Department of Education's Student Mental Health Policy Workgroup (SMHPW) to help them proactively address mental health issues on public school campuses. The reason they were invited to join this workgroup was because the workgroup coordinator had recently attended a conference on SBFC and had also presented on SBFC in California schools. This multidisciplinary workgroup was charged with the goals of increasing mental health awareness for students, faculty, administration and staff, and increasing accessibility of mental health services for underrepresented groups on campus. They asked the SBFC professors to create a webinar in order to talk about SBFC as one of the possible interventions to address these needs.

At the first meeting that Dr. A attended in Sacramento, he was invited to sit in on one of the five working groups as an observer. He listened carefully to each of the multidisciplinary group members and they asked him specific questions related to their task. The group began to understand SBFC as a progressive model of intervention with students from multicultural backgrounds. Dr. A was soon appointed to the final review team of this workgroup. During the first year that he worked with this group, he served primarily in a facilitation role in the development of specific recommendations for increasing mental health awareness in teacher and administrative credentialing programs. One of the aspects of these recommendations was the inclusion of model programs or interventions and the group decided to include positive behavior intervention and support (PBIS), restorative justice, and SBFC.

The entire committee then discussed these recommendations at length before voting on them at the end of the day's meeting. Right before the vote was taken, the representative for the School Social Workers Association and the representative of the School Counselors Association both separately told the group that, while they supported the first two model programs, they did not want the inclusion of SBFC because they felt that it was not yet "evidence-based." Because Dr. A was facilitating the meeting, he really wasn't in a position to respond, but the group pushed back by saying that this type of intervention made sense and had an extensive history behind it. Despite this, these two group members said that they would not be willing to vote positively on the recommendation and in the end, the group omitted any model programs in the recommendation. Dr. A was reminded of the intense resistance to the use of family counseling in the schools, most of which he thought was related to fears of inadequacy for those who have not had experience in doing family counseling. This is also another example of how the

representatives of certain mental health “guilds” will work together to prevent changes in the status quo when they perceive that it will not benefit their members.

Following what he perceived as a lack of progress, Dr. A asked that he be relieved from the role of facilitator in order to be able to sit and interact with the other group members during these discussions. Over the next 2 1/2 years, Dr. A spent time listening and getting to know the group members, especially Dr. D. Dr. A got to know him on a more personal level. He tried to learn more about what Dr. D’s resistance (and perhaps fear) of SBFC was all about. Dr. A learned that Dr. D actually understood a lot about family therapy although he had not had a lot experience doing it. As they talked more about how it worked, Dr. D began to understand it more and felt less threatened. An important thing was to focus on SBFC as a process rather than as a specific role for a school social worker, school counselor or MFT, which is a huge part of the truth about this approach.

Then, two things slowly appeared to happen. First, the entire workgroup began to really understand the importance of SBFC as a multicultural approach to helping students. They started to understand that any multicultural approach must include the involvement of immediate and extended family members and their community in order to be accepted by them and therefore, to be effective. Secondly, Dr. D, perhaps seeing what was happening politically in the group, but also reflecting upon his life’s work as he neared retirement, appears to have become more of a proponent of this type of intervention. This does not mean that he has not continued to actively advocate for the members of his " guild", but he appeared to have greatly reduced his resistance to the concept of SBFC.

Case study #3: The stillborn SBFC master’s degree program

This example of a barrier to SBFC occurred in the early 2000’s at a small south-western US college in a psychology department that had programs in school counseling and in family counseling. Because of student interest in becoming dual licensed as a school counselor (which permitted graduates to work in public schools) and as a family counselor (which permitted graduates to set up a private practice as a marital and family therapist), two faculty members experienced in SBFC approached their department about developing a SBFC master’s level degree program. These faculty members were familiar with the success of the California State University, Los Angeles, SBFC program described above and emphasized to their department the strong student interest in having such a program. The department and the dean initially supported moving forward with the proposed degree and over a 2 year period the SBFC curriculum was developed by integrating school counseling courses with family counseling courses. Then two significant events occurred: first, it became clear that in several of the family counseling courses (that would be taken by the SBFC students and also by the regular family counseling students) some school counseling content would be required. For example, in the family counseling course on history of family counseling coverage of the history of school counseling was necessary. The family counseling faculty viewed a school focus as irrelevant. Second, the senior SBFC faculty member left the department, leaving only one SBFC professional to advocate for the new degree.

Following the psychology department’s approval of the SBFC curriculum, the next step was to obtain the approval of the school-wide curriculum committee chaired by the dean. While the

SBFC professional was presenting the SBFC curriculum to this committee, the dean stated that she was no longer supportive of the new degree because it could interfere with the success of the two existing departmental programs: school counseling and family counseling. The proposed SBFC Masters degree program was abandoned with the result that many graduate students who were interested in taking the program had to go elsewhere for their training.

In the six SBFC programs described above, inter-professional conflict with mental health professions had a negative impact on slowing or eliminating the development of each program. Three of those programs were eliminated in a matter of weeks following more than a year of development by the SBFC professional in each case. Had these programs been developed, they could have brought SBFC to many underserved clients.

Reasons for inter-professional barriers affecting SBFC

How do we make sense of these marginalizing behaviors from mental health professionals towards SBFC? Inter-professional conflict affecting SBFC and other mental health professions has many causes according to the literature: lack of understanding of the content of the discipline of the other person's profession; lack of training in teamwork; lack of commitment to collaboration; communication problems; conflict over authoritative roles (Randolph & Swick, 2001; Randolph, 1988); fear of de-professionalization; need for clinical autonomy (Loxley, 1997); different philosophies and values in the professions (Drinka & Clark, 2000); closed role boundaries (Miller, Freeman, & Ross, 2001); protection of professional knowledge (Miller, Freeman, & Ross, 2001); power differences; territoriality and fear of domain infringement (Geva, Barsky & Westernoff, 2000); role insecurity (Hornby & Atkins, 2000); overlapping expert systems (Irvine et al., 2002); and loss of income to another mental health guild. What is missing is a conceptual model that can tie together these disparate elements. This is explored in the next section.

Guild-enhancing behavior: A rationale concerning inter-professional conflict

An additional explanation for inter-professional conflict that we believe worth considering is what we have labelled "guild-enhancing" behavior. This is basically a concept from economics. We realize that the application of economic theory and perspective to mental health is not commonplace and that mental health professionals are not accustomed to viewing their profession as engaging in economic competition that is at times aggressive and contradicts the profession's values. However, we regard this rationale as important for explaining the pervasiveness of inter-professional conflict in the mental health professions.

Some of the difficulties in growing the number and locations of SBFC and other mental health programs fit the classic "barriers to entry" situation in economics. Basic economic theory begins with the model of a free and open competitive economy with many sellers and buyers. Simple diagrams and formulae assume that such competitive freedom fosters innovation and tends to result in the most efficient allocation of available resources. At lower prices, more will be bought, as a rule, and more will be made for sale at higher prices. At some point these imaginary curves intersect. Markets functioning this way ideally lead to optimal efficiency for the economic society (see Figure 1).

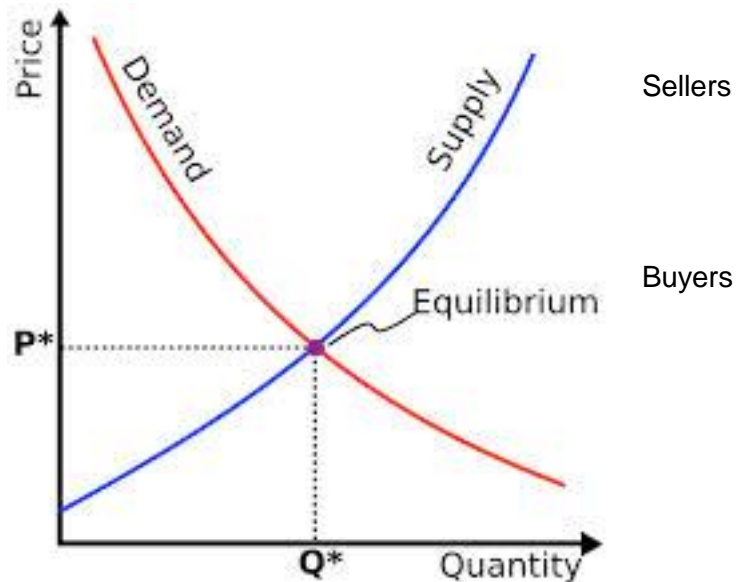


Figure 1 Curves showing the relationship between supply, demand, price, and quantity

To repeat, this assumes a free and open competitive economy, in which anyone with an innovative idea (for an improved product, or a cheaper way to make the same quality product) is able to enter the market and win customers. Anything that makes it more difficult to compete in the marketplace is called a “barrier to entry.” Such barriers can exist in the “marketplace of ideas,” as well as in the markets for goods and services. It is barriers in the marketplace of ideas, in universities and in the professions, especially the mental health professions, which interest us. But we begin with the economic free market and a fact contrary to the ideal model: individual competitors prefer monopoly to free and open markets, and will restrict competition when possible. Competitors don’t like it, and this includes mental health competitors.

Early examples of restrictive, anti-competitive behavior can be found in merchant and artisan guilds as northern European societies were beginning (in, say, the 15th century) to dress up in the trappings of capitalism, but before there was a theory of free markets. Guilds were not new then, and it was guilds of students and teachers that founded the early universities in Bologna (1088), Paris (1150), and Oxford (1167). In a recent essay Sheilagh Ogilvie (Ogilvie, 2014), professor of history at Cambridge (1209) defines a guild as “...an association formed by people who share certain characteristics and wish to pursue mutual purposes.” (p.169).

The wide sweep of that definition makes it still quite useful today, even though the term guild itself is now somewhat quaint. A very important element of merchant and artisan guilds is that they controlled the apprenticeship training that was required for entry into the craft. The artisan guilds, in particular, guarded trade secrets about processes and techniques. In other words, the guilds were anti-competition and anti-innovation by creating barriers to entry.

Ogilvie concludes:

My own reading of the evidence is that a common theme underlies guilds' activities: guilds tended to do what was best for guild members. In some cases, what guilds did brought certain benefits for the broader public. But overall, the actions guilds took mainly had the effect of protecting and enriching their members at the expense of consumers and nonmembers; reducing threats from innovation, competition, and audacious upstarts; and generating sufficient rents to pay off the political elites that enforced guild arrangements and might otherwise have interfered with them. (p. 174)

Ogilvie's words are notably direct for academic writing. She is saying that the social benefit of guild behavior is outweighed by its basically self-serving, turf-guarding results, maintained by laws, licensing, and regulations enacted by legislatures. The role of guilds as lineal precursors to modern labor unions, industrial organizations, and professional associations is not entirely agreed on by historians, but thematic comparisons can be made with some assurance. In the case of professional associations in the mental health fields, much guild-like behavior is found, including the exclusive territory guarding, anti-innovation, anti-competitive, and self-promoting activity condemned by Adam Smith in 1776 and revealed again by Ogilvie in 2014.

The mental health professions are not simply guild-like. They are in fact guilds and they exhibit both the positive and the negative characteristics of the 15th century guilds. Positive characteristics of mental health guilds (MHGs) include: establishing standards of practice (although often State agencies become involved in regulating this if the guild fails to do so adequately); maintaining educational pathways for becoming a MHG member through university/college training, as well as post-degree training under supervision (which is similar to 15th century apprenticeship); forming MHG associations which engage in public education about the MHG and lobby on behalf of members; and engaging in "guild-enhancing" behaviors that promote the reputation of the MHG and the fiscal strength of the MHG members. It should be noted that to be "guild-enhancing" is not a bad thing in itself. It is very human to want to promote oneself or one's organization or profession.

The negative characteristic is the one Adam Smith railed against: monopolizing behaviors. Every MHG has at one point engaged in attempts to restrict the practice of another, newer MHG. This is typically done through the pernicious technique described by Ogilvie (above) as "generating sufficient rents to pay off the political elites that enforced guild arrangements and might otherwise have interfered with them." Guild rents are income derived from the practice of one's profession: income from client fees for private practice counseling/therapy, income from MHG guild salaries in public or private agencies and universities/colleges, and income from workshops, speaking engagements, and publications. The implication of Ogilvie's point is that MHGs use their income (rent) to influence politicians and political bodies such as state regulatory agencies to take action to block newer MHGs from becoming licensed to practice. This is monopolizing behavior and in most instances is a corrupting behavior on the part of the MHG disguised as "protecting the public" from the newer MHG.

Other examples of this are include the political lobbying by the psychology MGH in California to block the attempt by the psychiatric nursing MHG to establish a Doctor of Mental

Health degree (Combs et al., 2014); the political lobbying by the psychiatric, psychology, and social work MHGs in Connecticut to block the MFT MHG from becoming licensed to work in public schools (Laundy, Nelson, & Abucewicz, 2011); and the political lobbying by the MFT MHG in California to defeat Senate Bill 1101 in 2016, which was an attempt by the Alcohol Counselor MGH to become licensed (Nielsen, 2016, 2016a). These political blocking attempts by MHGs are designed to monopolize a particular MHG's ability to practice by setting up a legal barrier that excludes competition.

We believe that this is a useful model for explaining the inter-professional conflict that is described in the SBFC case examples above, and that it links together many of the different causes of inter-professional conflict described in the literature. But what can be done about it? This brings us to a consideration of strategies SBFC professionals can employ to mitigate these barriers.

Strategies for overcoming barriers to entry for SBFC

Based on the authors' extensive experience in dealing with inter-professional guild barriers to SBFC programs, two of which have successfully lasted over 25 years and are currently ongoing (the Mission Possible SBFC program at the Center for Child and Family Development, University of San Francisco, and the SBFC M.Sc. program in the Division of Special Education and Counseling at California State University, Los Angeles), we have identified ten strategies that have proved helpful to us in overcoming these barriers.

Strategy #1: Do not attack other disciplines.

While it may be true that SBFC is a superior approach in many respects, describing other mental health disciplines as "narrow" or "deficient" will make enemies who may make it their life's goal to block a SBFC program.

Strategy #2: Use discipline-inclusive language.

Emphasize that SBFC is a meta-model that is used by all the mental health approaches. Use inclusive language such as "SBFC professional" rather than "SBFC counselor."

Strategy #3: Be familiar with the SBFC literature within other disciplines.

You can do this by reading SBFC literature reviews (such as Gerrard, 2011). Building bridges with members of other mental health guilds is extremely important. Point out that SBFC is a meta-model already being used within their profession. Emphasize that a SBFC program is not intended as a replacement for what they do, but is an approach that can make their mental health guild more effective.

Strategy #4: Make friends with the opposition.

This is the Nelson Mandela strategy of "If you want to make peace with your enemy, you have to work with your enemy. Then he becomes your partner." This strategy may take time, and involves looking for opportunities to build a friendship. It may also involve sitting down with a professional colleague who disagrees with you and/or feels threatened by a SBFC program. Showing empathy for this colleague may plant the seeds of collaboration.

Strategy #5: Develop political support.

Implementing this strategy is difficult for most mental health professionals because our professions emphasize being facilitative, caring, and empathic. However, failure to develop political support as, for example, obtaining the support of a dean, chairperson, or principal, may be fatal for a SBFC program if the “opposition” develops that support and uses it against you. Basically, this is the time-honored strategy once used by Leonardo da Vinci who “attached” himself to Prince Machiavelli, and obtained both fiscal and political support. Failure to use this strategy affected the outcome in case study #3 (above). Presence of this strategy was instrumental in the success of the SBFC program in case study #2, despite repeated mental health guild opposition.

Strategy #6: Don't go it alone.

Develop a team or network of SBFC colleagues so that one is not working in isolation and in situations where one can be ganged up on in departmental or committee meetings. An inability to use this strategy was critical in case study #3 (above).

Strategy #7: Ensure leadership succession for a SBFC program.

When a leader has to leave a SBFC program that they developed, it is critical to find a strong, effective leader who can continue the program. Failure to do this can mean the rapid collapse of the program.

Strategy #8: Gather evidence-based support for the program.

This is important in getting funding for the SBFC program, and will also provide ammunition for fending off critics of the program.

Strategy #9: Identify underlying causes of resistance and develop a plan to address them.

If someone opposes an SBFC program, it may be for a reason other than the one they advance. For example, a colleague may oppose a program on the grounds that it “isn't a widely accepted approach” or is “theoretically inconsistent” with their mental health guild. The real reason, however, may be because they are afraid the SBFC program will be more successful than their program. Finding a way to deal with their insecurity (e.g. by emphasizing inter-program collaboration) is essential. Failure to implement this strategy was a factor in case study #1 (above).

Strategy #10: Expect resistance and be prepared for it.

Don't be naïve. Understand that inter-professional conflict and barriers are the norm in many institutions.

Application of strategies to the case studies

In case study #1 the SBFC community center director failed to implement Strategy #4: Make friends with the opposition, and Strategy # 5: Develop political support. In retrospect, the SBFC community center director should have met with the student counseling center director, who had a very different guild philosophy about helping university students. Making friends with the student counseling center director, and allaying his concerns about the SBFC counseling project, could have prevented the opposition that resulted. In addition, the SBFC community center director could have developed political support from higher level administrators, rather than

relying just on the support of the dean. If higher level university administrators supported the SBFC program, this might have lessened the student counseling director's ability to block the new program. In case study #2 the key missing strategy was Strategy #6: Don't go it alone. The departmental support that was present during the development of the SBFC program evaporated after the death of an influential SBFC colleague. In case study #3 the SBFC professional met with strong guild-based opposition to his introducing SBFC ideas to the Task Force. He overcame this opposition by using the following strategies. First, he avoided confronting the opposition (Strategy #1). Second, he resigned his position as group facilitator in order to strategically place himself in a position where he could make a case for a SBFC point of view (Strategy #9). Third, he advanced the SBFC point of view as being a multi-culturally sensitive approach relevant to all the mental health guilds (Strategy # 2). Fourth, he made friends over a 2 ½ year period with one of the original guild opponents (Strategy # 4). In doing this he overcame the guild-based resistance to SBFC and was able to insert SBFC recommendations into the task force's report.

Recommendations for further investigation and research

The literature on inter-professional conflict between the mental health professions is not easily accessible. It is widely scattered across the mental health professional journals and is infrequent. A possible reason for this is that it can be professionally dangerous to criticize colleagues in another profession, since criticism invites rebuttal and counter-criticism. As noted above, sometimes the conflict is intra-professional - between colleagues within the same department (e.g. counseling psychologists and counselor educators). In this instance criticism of colleagues can lead to retribution that affects promotion and allocation of departmental resources. Likewise, conducting research on inter-professional barriers to SBFC can be dangerous. This is a central problem in investigating inter-professional conflict.

The use of case studies, suitably disguised where necessary, is an approach we recommend. As SBFC programs continue to expand in the future, it may be possible to develop a larger number of cases, thus helping to more clearly reveal which strategies are most beneficial in dealing with inter-professional barriers. We recommend further research addressing these questions: What is the extent to which SBFC professionals have experienced inter-professional barriers to entry? Which mental health guilds (professions) are most involved in posing barriers to entry for SBFC? What strategies are most effective in reducing these barriers? The use of survey designs that protect confidentiality may also be useful for investigating this. We recommend further investigation into the utility of our guild-enhancing explanation of the causes of inter-professional barriers.

Conclusion

Although there is a literature on inter-professional conflict, it is relatively sparse and scattered across the numerous journals of the seven mental health professions. There were only three examples in the literature of inter-professional conflict affecting SBFC, and all three were in one recent source (Gerrard & Soriano, 2013). In the six SBFC examples described in this article, inter-professional conflict terminated the development of two programs. In one case the result was a lack of university training opportunities for students interested in SBFC; in the other case the result was prevention of SBFC services being made available to clients. In all four of the SBFC programs that survived inter-professional conflict, those programs were delayed in their

implementation. This seems to us to be a very serious matter requiring investigation, research, and constructive action. It is perhaps reassuring to know that inter-professional conflict is not a barrier unique to SBFC, but is shared by all the mental health professions. It is important that SBFC professionals, whether developing training programs at universities, or implementing SBFC in professional practice, understand that these barriers are real, but that there are ways to deal with them.

The concept of guild-enhancing behavior that we have presented to explain mental health inter-professional conflict is something that we hope will stimulate further investigation. Mental health professionals tend to think of their professions in noble terms. But the behavior of mental health guilds in trying to block the acceptance of other mental health guilds does not seem noble. By pointing to the way mental health guilds behave as guilds generally, in attempting to establish an economic monopoly through collaboration with political elites, we hope to have opened up a direction of research that will help explain these self-serving and often aggressive behaviors.

The strategies we outlined for overcoming barriers to SBFC came from two successful SBFC programs – one a university training program, the other a primarily community service program administered from a university. Both programs have existed for over 30 years due, we believe, to the successful application of the strategies discussed. Whether these strategies are useful for other SBFC professionals remains to be seen. The fact that they worked for us in two large impact SBFC programs gives us cause for hope.

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