

# WORKING WITH OTHER PROVIDERS

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Every program has strengths and challenges impacting our ability to provide services. Unfortunately many victim's advocacy programs are under-equipped to address co-occurring issues impacting safety and health such as substance use disorders, mental health concerns or disability issues. Similarly, service providers who address other issues often struggle when addressing domestic violence, sexual assault and other trauma-related issues.

One of the challenges presented by multi-abuse trauma – for providers from all disciplines – is its complexity. Multi-abuse trauma defies simple, quick-fix, one-size-fits-all solutions. Cooperation between providers is crucial in order to address the multiple issues involved. All providers need to expand current practices and explore new strategies for working together to address safety, sobriety, wellness and justice.

## Advantages of working with other providers

Addressing multiple co-occurring issues requires the inclusion of providers from diverse backgrounds and disciplines. Working in partnerships, collaborations and coalitions with other community providers offers several advantages for everyone involved:

- Working in partnership with others, while challenging, can be a powerful tool for mobilizing individuals and groups to action, bringing community issues to prominence and developing policies (Cohen, Baer and Satterwhite, 2002).
- Community coalitions and collaborations can help everyone remain up to date on what other providers are doing regarding a particular issue, as well as what resources are available in the community to address the issue (Cohen and Gould, 2003).
- Rather than creating new projects or programs, such associations can help everyone avoid duplication of services, and thereby avoid wasting scarce resources (Cohen, Baer and Satterwhite, 2002).
- Effective coalitions can accomplish a broad range of goals that reach beyond the scope and capacity of any one single institution or organization (Cohen & Gould, 2003).
- More and more, funders are requiring that provider groups work together to solve a problem (Cohen & Gould, 2003).
- Perhaps most importantly, establishing relationships with a variety of other providers can help all of us provide more and better services. A survivor shares the impact on her

when a domestic violence agency developed an ongoing relationship with a dentist in the community:

“There’s a program called Give A Smile Back, and it’s pro bono. You had to have damage done to your teeth by domestic violence. They are putting several thousand dollars worth of work in my mouth, and they are giving me my smile back.”

Partnerships and collaborations also can help us improve our outreach efforts. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at Standing Together Against Rape (S.T.A.R.) in Anchorage, AK, says:

“We go into the psychiatric institute and the correctional facilities, and work closely with our forensic nurses. We have great connections with our military branches. We have a strong partnership with our school district. Those have all been helpful tools in not only spreading our preventive education, but also connecting with survivors.”

## **Barriers to cooperation among providers**

Unfortunately, human services have never been organized into coherent systems; rather, domestic violence, mental health, substance abuse, child welfare, and other providers are each organized as systems unto themselves with different funding and accountability structures. Developing linkages or collaborating across these sectors is fraught with difficult problems, and many barriers to cooperation exist:

- **Fragmentation of services.** Because social service systems in many communities are fragmented, providers themselves may have trouble keeping up with what’s available. Providers may experience problems when trying to access other services on behalf of people they serve. As one example: In some states, social service providers who work with incarcerated people inside a prison are forbidden from serving the same individuals after they’ve been released. This can make follow-up services difficult or impossible.
- **Lack of trust.** Providers from different disciplines such as victim’s advocates, substance abuse counselors, mental health providers and criminal justice personnel often have differing philosophies and theoretical orientations and may not trust each other because of this (Warshaw et. al., 2003). For example, drug and alcohol treatment providers may be focused on accountability, while the criminal justice system is often focused on punishment and victim’s advocates are focused on healing and empowerment.
- **Cultural differences.** Additional trust issues may develop stemming from cultural differences between providers – for example, “wounded healers” vs. “professionalized” staff, “expert” role vs. “peer” role, and services within indigenous communities vs. those provided by the dominant culture (Duran, 2006). For example, many “mainstream” philosophies tend to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007).

- Lack of standardized ways to measure outcomes. Both specialized programs and collaborative efforts are often difficult to measure. Providers are often required to compile data on program outcomes specified by funders or agency mandates. Recommendations for best practice are limited by the lack of standardized evaluation data across programs, on outcomes of importance to service recipients as well as to providers and funders (Nicholson et. al., 2001).

Erin Patterson-Sexson at S.T.A.R. in Anchorage says insisting that our way of doing things is “better” than what others are doing, or that our priorities are more important, can create barriers to cooperation:

“It is helpful to understand that each of us is coming to the table with different agendas, and none of those agendas is designed to hurt the victim. When we come to the table with the attitude that we are the only ones who have the best interest of the victim at heart, then we get ourselves into trouble. It’s easy for us advocates to do that because that’s our job title. But if you look at the forensic nurses, that’s their job title too. They are here to help sexual assault victims. They do have to stay objective, they do have to ask the tough questions. So if we are on a crusade to be the only people in the game to protect victims, then we are going to be in a constant war with all the other disciplines that are trying to do the same thing, only in a different way” (Patterson-Sexson, 2010).

## **Creating alliances**

When working with people impacted by multiple issues, cooperation with other community providers and systems is essential. Cultivating relationships with other providers is well worth the time and effort, according to providers who have been successful in this regard. Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK, says:

“We’re really connected with all of the services here in Homer. I’ll call Mental Health, and usually they have a waiting list, but if the person is someone we’re serving here, they’ll put them on a hot potato list for cancellations. We have an independent living center here and if survivors have a disability or are elders, they’re put on a fast track. We also have the homeless prevention project, and if we’re really packed and can’t take a homeless person in, they’ll put them up in a hotel” (Lee, 2010).

Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, describes the partnerships her agency has created:

“We partner with whatever agency or village wants us to go in. I’m also part of the Women’s Community Coalition staff, and we have typically had some money to go and do domestic violence and sexual assault prevention, training and response. Our

## WHAT DO WE NEED TO KNOW?

Advocates and other service providers cannot be expected to know everything, and we don't need to be an expert on everything. But here's what we do need to know:

- How to recognize signs that a person we are serving may have a problem other than the one we're trained to deal with.
- How to recognize when a person has problems other than the problem they are seeking services or treatment for.
- What resources are available in the community so we can make appropriate referrals.
- How to get word out about our own services so that others in the community know we exist and know what we have to offer.
- How to establish working relationships with other providers to ensure a continuum of care.

villages and regional hubs or statewide agencies, Native and non-native, ask us to do trainings. We go in with a lot of prior planning. They self-identify what they want. If they want to focus on domestic violence, we go in and we might have planning meetings with whoever the village identifies as their contact person, talking about what domestic violence issues they have, and then we coordinate with them and set up a talking group. They identify people they would like to have attend our training, usually three to four days in a location that is agreed upon by everyone that is going to attend. We have gone to small villages. We partner with our public health nurses, our mental health providers. A lot of our villages have mental health advocates. We work with them and their supervisors and their clinicians, the troopers, whoever the village or region or hub identifies as people who can address domestic violence issues. We do the DV 101, usually, and historical trauma, and the effects of domestic violence on children. Then we do brainstorming, break into small groups, and they are the ones who identify strengths, needs, and barriers. And then they try to come up with solutions or ways that they can develop safe homes, what kind of safety net would work in their region or village. They are really creative" (Moses, 2010).

When working with other providers:

- Conduct "trauma-informed" education for both advocates and other providers to increase everyone's knowledge and understanding of the prevalence of trauma, re-traumatization, and coping adaptations (and their negative consequences) by individuals

who have experienced trauma. Establish a universal presumption of trauma, recognizing that it could be part of the life experience of anyone with whom we interact (National GAINS Center, 2006).

- All providers need training to recognize co-occurring issues and make appropriate referrals. Agencies can provide education and cross-training in partnership with each other. Develop community partnerships or work groups to address these issues together. Brown bag lunches and Peer Review while maintaining confidentiality can be helpful.
- Acknowledge controversies rather than pretending they don't exist – “wounded healers” vs. “professionals”, “peers” vs. “experts”, theoretical differences, etc. Training should address dealing with conflict stemming from philosophical differences among multiple helping systems and emphasize the importance of working together for the benefit of individuals who receive our services.
- When encountering providers with different priorities and philosophies, it may help to find areas of agreement first, then work on addressing philosophical differences. Cindy Obtinario, a chemical dependency/domestic violence specialist at New Beginnings in Seattle, WA, finds that it helps to explore the “why” behind the other provider’s philosophy by first asking questions. “I give them the opportunity to explain their philosophy, and then ask them, ‘Could you consider this?’ And after they’ve had their opportunity to share, then I’ll present mine” (Obtinario, 2010).
- When seeking to resolve differences, choose your battles. Is the “difference” truly harming someone we serve? Can the providers “agree to disagree” on some issues such as language or terminology? Cindy Obtinario at New Beginnings in Seattle says:

“I explain that the domestic violence movement is based on empowerment, and we believe that each woman solves her own problems in her own way and time, and each woman is responsible for her own conduct. If you need to monitor progress and conduct in your program, I understand, but that’s not what we do here” (Obtinario, 2010).
- Do not imply that other social service providers are bad people, or negligent in some way. They may be unable to provide certain services for very valid reasons, such as ethical concerns about providing services beyond their level of expertise.
- Focus on what we can learn from each other. Assume that we can benefit from the other provider’s knowledge as much as they can from ours. As human beings, we tend to be resistant to learning things from people who don’t want to learn from us. That’s just human nature.
- Respect the professional expertise that each party brings to the table. This means sharing what we know and, just as importantly, asking for help and information in areas where our own knowledge base is lacking. For example, most victim’s advocates are not experts on mental health care and, conversely, most mental health care providers are not

experts on domestic violence. We do not have to be “experts” in each other’s fields, but we do need to recognize and capitalize on each other’s expertise (Nudelman & Rodriguez Trias, 1999).

- Recognize the limits of each philosophy or theoretical orientation. Karen Foley is a behavioral health specialist and founder of Triple Play Connections, a Seattle-based non-profit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers working together to cross-train and network in local neighborhoods throughout Washington State. She says:

“I think it’s extremely important to look at different approaches for the different issues. For example, I believe that if you try to treat domestic violence through the lens of addiction, using a medical model, you will do a disservice. For example, trying to get someone to accept responsibility for things that are not theirs to own is a form of victim blaming. And the same is true if you try to solely use an empowerment model when somebody is dealing with addiction. Then the provider can miss the boat in being able to help” (Foley, 2010).

- Hold abusers accountable for their behavior and encourage other providers to do so as well. Don’t blame victims of domestic violence, sexual assault, stalking or other forms of abuse for the harm that has been done to them or the tools they have used to cope. Remember, in many cases abusers have fostered substance use and created stress and trauma for the people they have hurt and abused.

## **Types of providers, their philosophies and priorities**

Even when priorities and philosophies are different, this doesn’t mean we must compromise our own standards to work effectively with others. Nor is it necessary for other providers to compromise their standards or priorities to work effectively with us. When working with other providers, keep in mind:

- Different issues may require different priorities and different approaches. For example, it’s perfectly appropriate that a victim’s advocate would be focused on safety for victims of violence while a substance abuse counselor focuses on sobriety for people with substance use disorders, a child welfare caseworker focuses on the best interest of children and a criminal justice professional focuses on community safety. Karen Foley of Triple Play Connections says:

“It’s really important to learn more about the other issues, and even if you don’t agree, to understand why different philosophies and different models are practiced. I’ve found that the most beneficial thing that I can do is listen rather than talk. I’ve come a long way in understanding that it’s really important to look at each issue separately, and to understand and learn the value of each approach. So when do you use the medical model versus the empowerment model? And when are you looking at a mental health issue versus a chemical dependency issue versus an oppression

issue? I think it's very important not to only look through one lens, but to understand the philosophical differences and when you apply them to what issues" (Foley, 2010).

- A key to reconciling differing priorities is to take a *both/and* approach rather than an *either/or* approach, so that priorities and philosophies are not necessarily seen as being in conflict with each other. For example, an advocate's priority of helping a parent get safe from violence is certainly compatible with a child welfare caseworker's priority of protecting the best interest of the children. Karen Foley offers another example:

"The medical model is really, really important when dealing with addictions, because we know that it's a body change, that the body is different in somebody who's addicted or alcoholic versus someone whose body does not respond to alcohol or other drugs in the same way. So there are chemical changes that have happened. It's not about being a bad person. It's about having a bad disease. On the opposite end, when you try to solely use an empowerment-based model on someone who is dealing with the disease of addiction, they don't get help for their addiction, and often end up back in an abusive situation" (Foley, 2010).

- Individual counselors or other professionals within the same discipline may also have differing approaches and philosophies, so it may be possible to find professionals in each discipline whose philosophies are compatible with your own and cultivate relationships with these individuals for the purpose of making referrals.

Here are some examples of types of providers, along with ways to reconcile their philosophies and priorities with your own for the benefit of the people you both serve:

- ***Substance abuse counselors.*** In recent years, a number of substance abuse counselors have begun moving away from the heavily confrontational approaches that were once popular in treatment centers (Obtinario, 2010). Some counselors employ *motivational interviewing*, an approach which helps people change harmful behavior such as alcohol or drug abuse by exploring and resolving the ambivalence most people feel when they seek to make major changes in their lives (Rollnick & Miller, 1995). Emphasis is on respecting individuals' right to make their own decisions as they are ready to do so, which makes the approach compatible with the empowerment approach favored by victims' advocates. Many treatment programs also offer gender-specific programs, which may be more appropriate for women with interpersonal violence issues (IDHS, 2000).

- ***Mental health providers:*** Advocates who work with domestic violence and sexual assault survivors often come from a social justice perspective and employ the *advocacy model*, which emphasizes safety and empowerment, support and access to resources, accountability for abusers and perpetrators, and social change (Warshaw, 2010). Mental health providers, on the other hand, often employ a *clinical model*, which focuses on identifying and relieving symptoms that interfere with an individual's quality of life or ability to function. But Warshaw (2010) points out that common goals of advocates and mental health providers include health, safety, freedom and connection. Also, an

## A WORD ABOUT LANGUAGE

While it's important not to dilute our own message, there are steps we can take to improve communication with other providers across disciplines:

- Avoid jargon. Each discipline has a tendency to create its own brand of alphabet soup. Terms like DART, TRO, OP, MISA, IEP or WRAP may not make sense to people outside your own discipline. If someone else uses acronyms or jargon, don't be afraid to ask what they mean.
- Try to get past "language" differences and listen for the content of what the other person is saying. If you have a preferred term ("program participant" vs. "client," for example), use your own language when talking with other providers, but do not insist that others use it.
- Learning some of the common terms used by other providers – and incorporating some of their language where possible – can aid in building bridges rather than fences. In the Appendix: Definitions, we have included a glossary of terms commonly used by service providers in the various disciplines: victim's advocates, substance abuse counselors, mental health professionals, social workers, and other providers.

increasing number of mental health professionals have recognized the need for *trauma-informed care*, which is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (Huckshorn, 2004). Develop relationships with mental health providers whose approach emphasizes trauma-informed care, particularly those familiar with and experienced with complex trauma.

- ***Disabilities advocates:*** Many providers are concerned about the expense that might be involved in making facilities and services accessible to people with disabilities. However, increasing accessibility need not always be an expensive proposition, says Christine King at the University of Alaska Center for Human Development, who has worked in the field of disabilities for more than 18 years. Sometimes improving accessibility may be as simple as relaxing a policy or rule, or giving someone more time to complete a task or goal. King adds that disabilities advocates are eager to offer their assistance to providers with questions about how to make their services more accessible (King, 2009).

- ***Child welfare workers:*** The number one priority for child welfare workers is to protect the best interests of children who are at risk of harm. Domestic violence increases the risk



of child abuse and neglect, especially when substance abuse is involved (IDHS, 2000). Even if they are not intentionally targeted for abuse, children in a home where a parent is being battered are often injured while trying to intervene in a violent incident. And even when children are not physically abused themselves, they still often suffer the traumatic effects stemming from exposure to batterers. Advocates and other providers are mandated to report child abuse and/or neglect to their state's child welfare agency. When child abuse or neglect is suspected, a thorough physical and psychological assessment may also be necessary, as well as other services. Advocates, substance abuse counselors, mental health professionals and child welfare caseworkers should also collaborate to ensure that children exposed to batterers (and their non-offending parents or caregivers) receive resource information and a safety plan.

• ***Criminal justice personnel:*** When working with a survivor of multi-abuse trauma who is, or has been, incarcerated, keep in mind that preventing recidivism is a priority for most criminal justice professionals. Studies repeatedly show that safe housing, employment and appropriate social services are critical to reducing recidivism for these individuals (Covington, 2002). Many survivors suffered traumatic experiences in their lives long before they developed the coping mechanisms that may have led to their incarceration or other involvement with the criminal justice system. Emphasize that helping survivors get the help they need to heal from past abuse or trauma can go a long way toward reducing recidivism.

• ***Indigenous providers:*** Differing patterns of caregiving across racial and ethnic groups strongly underscore the need for culturally relevant services (Nicholson et. al., 2001). The dominant culture's social services system tends to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007). Some advocates and other professionals are uncomfortable with issues of religion and spirituality, while many persons from marginalized groups view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 2007). Advocates should collaborate with indigenous providers, when available. Recognize and enlist the assistance of recognized helpers such as indigenous healers and elders. Also provide cross-training for all providers on diversity issues. Get to know the cultures in your area and invite people from these cultures to provide training for staff.