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). 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 can be 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. (Standing Together Against Rape) 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 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).

References


