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 priority 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 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. 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).

- 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?
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 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.

• 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 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.

References

Foley, K., Triple Play Connections, Seattle, WA. Personal interview with Debi Edmund, July 2010.


