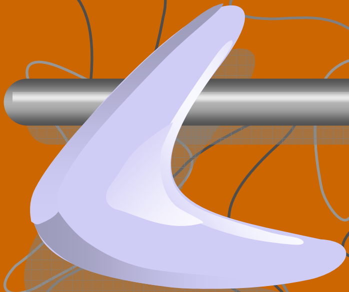
Trust between community based organisations



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- Why trust?
- First steps
- The Primary Care Partnership study
- Risk, trust and control
- Trust rules
- Implications for community-campus relationships
- Two examples of partnerships – CRCAH and MPHs

Why trust?

- From the mid 1980s the Victorian health system underwent continuous change
- In the late 1990s staff in community-based agencies frequently spoke of trust
- But, there was little clarity about it

- In 1999/2000 we undertook a measurement scale development process for the Trust Evaluation Scale
- The intention was to measure trust between individuals and trust between agencies

First steps 2

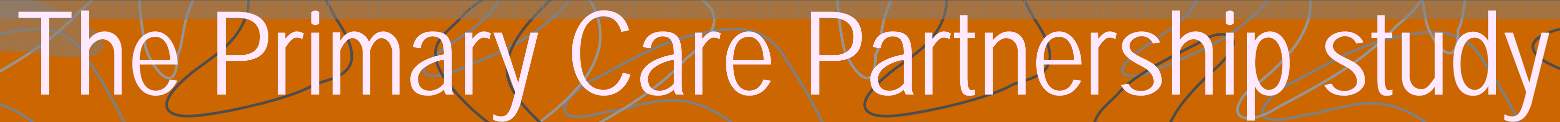
- Process:
  - Exploratory discussions
  - Focus on things that could be changed – qualities of trust-based relationships
  - Created a list of potential trust-relevant qualities of relationships
  - Discussion of list in focus groups
  - Draft scale
  - Survey to refine the scale and test reliability
  - Validation against an established instrument

Lessons learned 1

- What we learned
  - Trust in people and trust in organisations are based on different qualities - interpersonal Vs institutional
  - Interpersonal trust based on relationship qualities and perceived values and motivations
  - Trust in institutions based on perceived competence and then relationships/values and motivations
  - Interpersonal relationships are easy to change in comparison to institutional relationships

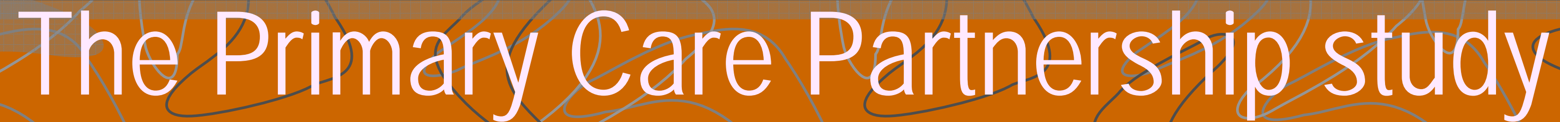
Lessons learned 2

- Benefits of trust include:
  - Sharing of information
  - Reduction in workload due to easier communication
  - Increased referral of clients
  - Improved client outcomes through better communication
  - Reduced need for self-protection



The Primary Care Partnership study 1

- A PCP is area based and links diverse primary care agencies
- It focuses on health promotion and service coordination
- We interviewed all committee members and had them complete the Trust Evaluation Scale
- Management committee – CEOs and senior managers
- Working parties – senior service providers
- Two rounds of data collection (89 interviews)
- Funded by NHMRC



The Primary Care Partnership study 2

- Began as a study of trust
- Became a study of the way trust is used to manage risk and facilitate action
- But, trust alone was insufficient because of the possibility of betrayal
- The exercise of power (control) was a companion to trust

Risk, trust and control 1

- Risk is: *'the probability of adversity related to our own actions, due to our own commitments'* (Sztompka, 1999:30).
- Risk perception is: *'a decisionmaker's estimation of the probablities of adverse outcomes occurring'* (Das & Teng, 2001:254).
- We used a social constructionist approach (Joffe 2003) – social, historical and group forces shape individuals' perceptions or risk

Risk, trust and control 2

- Risks perceived by **managers** were at:
  - System level - risk to agency and clients eg changes to funding systems
  - Partnership level – eg PCP competes with members, relationship problems with partners
  - Agency level – eg waste of resources, threat to small agencies
- Risk perception based on recent policy history and current political currents – anchoring & objectification
- Risks perceived by **service providers** were minimal

Risk, trust and control 3

- Risk is a consequence of action.
- Trust occurs when a person acts despite the possibility of disappointment by others' actions (Luhmann 1988)
- Trust : 'the expectation that an actor:
  - can be relied on to fulfil obligations;
  - will behave in a predictable manner;
  - will act and negotiate fairly when the possibility for opportunism is present' (Zaheer, McEvily & Perrone, 1998:143).
- Trust is primarily in people, secondarily in institutions.

Risk, trust and control 4

- Control is the process of exercising power to regulate the partnership and make it more predictable (Das & Teng, 2001:256).
- In partnerships power can be used:
  - Actor's own benefit (power over)
  - Mutual benefit (power to)
  - Altruistic benefit (power for) (Huxham & Vangen, 2005:175)
- Mechanisms of control in partnerships:
  - Governance structures
  - Contractual specifications
  - Social control (Das & Teng, 2001)

Risk, trust and control 5

- The PCP **managers** exercised power overtly for *mutual benefit*. It's use for actors' *own benefit* was covert and considered 'naughty'. It was OK to be a 'little bit naughty'.
- The core value of the PCP was community (*altruistic*) benefit– a point of consensus when problems arose.
- The mechanisms were primarily social – exercised through the governance structures and in private relationships

- Accidental betrayal, or betrayal caused by funder pressure, could be ‘understood’ but required penance
- Repeated betrayal lead to marginalisation and probable exclusion from joint initiatives
- For PCP **service providers**, betrayal was not an issue – they were there for *altruistic and mutual benefit*

- **Commitment** is about '*being serious about what you are doing*'
- **Integrity** means an individual works *'in the interest of the people they are working with as well as themselves'*
- **Motivation** means that '*individuals are there for the right reasons*', they act with goodwill and '*try to do their best*'
- **Respect** means that individuals show attitudes of respect and are respectful in their actions towards others
- **Fairness** is a criterion used to judge the appropriateness of decisions

- **Confidentiality** is about individuals keeping other people's sensitive information private.
- **Reliability** means that if he or she has has committed to doing something they '*deliver the goods*'.
- **Open communication** means discussing issues even when there are disagreements and '*leaving organisational political agendas at the door*'.
- **Flexibility** accepts that '*all the agencies have their own [objectives] that they must meet*' so the partnership has to work within the context these objectives frame.
- **Acting for community benefit**

Lessons learned

- Trust is only an issue when people perceive risk. No risk – no trust required
- Risk perception is a consequence of history and current politics
- Perceived risks vary with a person's organisational level
- Trust creates efficiencies
- There are explicit rules for trust-based relationships
- Trust is contingent on **appropriate** controls being available to contain damage caused by people who betray trust

Implications for Community-Campus Partnerships 1

- Trust in people and trust in their organisations are very different things
  - Trust in people is based on relationships and perceive values and motivations. Competence is a relatively small issue
  - Trust in organisations is based on competence, then relationships and values/motivations
- People in community organisations primarily trust other people.

Implications for Community-Campus Partnerships 2

- To institutionalise CCP in universities we need to:
  - Establish internal processes that demonstrate competence to people in community based organisations
  - Select and support academics to work in trust-based relationships and to demonstrate appropriate values and motivations
  - Openly explore partners′ perceptions of risk
  - Select appropriate control mechanisms
  - As the primary control mechanism is likely to be social, partnership leadership is critical

- Cooperative Research Centre for Aboriginal Health (CRCAH) www.crcah.org.au
- Masters of Public Health
  - MPH (Consortium) http://www.latrobe.edu.au/publichealth/MPH/index.htm
  - Victorian Public Health Training Scheme (VPHTS) 5 subjects and 6x4 month placements

http://www.latrobe.edu.au/publichealth/VPHTS/index.htm

http://hnb.dhs.vic.gov.au/phb/vphtb/vphtb.nsf

Partners in the paddock:
Bushfire prevention . . .