



## **Rethinking Collaboration: Winning Salience or Losing Favour**

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# Rethinking collaboration: winning salience or losing favour

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Bachelor of Aviation (with Distinction)  
Bachelor of Business and Commerce Honours (First Class)

A thesis presented for the degree of Doctor of Philosophy  
Department of International Business and Asian Studies  
Griffith Business School  
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## **Dedication**

I dedicate this thesis to my wonderful parents, Milton and Narelle Wearing. They have encouraged my continued learning and have given me the utmost support, love, assistance and enduring patience throughout. Their pride in my academic achievements has always fortified and spurred on my determination to succeed in academic endeavours.



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For all those mentioned above, I feel deep gratitude. With your help and encouragement I have been able to achieve a lifelong ambition to undertake postgraduate research and complete a PhD.

## **Statement of authentication**

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

(Signed) \_\_\_\_\_

Warwick Wearing



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## **Abstract**

This study examines collaboration when operationalised or enacted within the youth health sector. The youth health sector provides a unique opportunity to research collaboration as within this context government simultaneously promotes collaboration and the principles of New Public Management (NPM). As a result, collaboration is promoted in an environment where youth health service providers are involved in competitive tendering processes and each individual organisation is financially accountable for youth health services delivered. The youth health sector is a unique context to examine collaboration as government funding bodies sometimes enforce and coerce participation in collaboration as a condition of competitive tenders. Furthermore, within the youth health sector altruistic values associated with assisting youth in need are reasons to collaborate.

Collaboration is championed in NSW government policy aiming to improve youth health service delivery. It involves bringing together a broad range of expertise, knowledge and resources that enable comprehensive and innovative thinking about complex issues and the formulation and delivery of solutions. In the context of youth health service delivery, this means bringing together a range of organisations involved in youth health service provision in order to deliver youth health services more effectively and efficiently than could be achieved individually. However, the enactment of enforced or coerced collaboration in a context where competitive tendering processes *and* collaboration are both promoted by government is under-researched, particularly within the context of a government-coordinated youth health network.

This research gives some clarity around the rhetoric of collaboration. It shows the impact of existing management policies and practices on collaboration, particularly those that enforce and mandate collaboration between service providers. This research identifies, describes and examines the willingness of service providers, both government and non-government, to collaborate by understanding who is more or less important, eminent or salient when collaborating, and why this is the case. More specifically, this research provides a more contemporary and comprehensive theoretical understanding of collaboration by explaining how collaboration is operationalised or enacted within the youth health sector. Additionally, by relating the findings to the provision of youth health services, the research findings have practical or applied benefits for those involved in collaboration.

By using a qualitative multi-case study research design based in the realism paradigm, an inductively derived subjective reality of collaboration, as revealed by the research participants, is presented. A multi-case study research design allows for the investigation of collaboration, which is characterised by the interaction of a number of people occurring within a number of contexts, both within organisations and across organisational boundaries. It also allows the researcher to apply the theoretical principles of collaboration, social capital and stakeholder theories to better understand how collaboration is operationalised within the context of a youth health network.

A multi-case study research design allows the researcher to use purposive and snowball sampling methods to access a group of thirty-five research participants employed with a youth health network. This sample group includes administration staff, youth health practitioners and managers from both government and non-government organisations involved in collaborative activities. Data collection methods are semi-structured interviews, observation and document analysis.

The progressive comparative analysis method is employed and allows for deriving research conclusions and being theoretically sensitive to important themes emerging throughout the analysis process. This progressive and iterative analysis process involves coding the collected data from the descriptive to more analytical levels in order to advance collaboration theory and suggest implications for practice.

The research reveals that interviewees perceive collaboration as representing a myriad of cooperative working relationships which clearly involve competitive elements. Also shown is that youth health service providers are commonly competing for salience when collaborating. The research shows that high salience gives service providers increased opportunity to develop social capital and advantageous linkages with other salient stakeholders and thus perpetuate opportunities for future funding. The findings show that the risk of losing salience or favour has negative consequences for organisations, particularly less securely funded non-government organisations, as their opportunity to be involved in successful competitive tenders may be jeopardised and their sustainability compromised.

By mandating the involvement of particular stakeholders when collaborating, as a condition of competitive tendering, government acknowledges that some stakeholders have more salience than others. In addition, by mandating collaboration with particular stakeholders, government funding bodies offer service providers an opportunity to compete and develop

saliency for themselves when collaborating. Thus, collaboration occurring within the youth health sector in western Sydney is a forum where competition for saliency and developing beneficial social capital occurs.

The research concludes by presenting an addition to theory arguing that competition for saliency initially promotes collaboration, but ultimately limits collaboration if overt competitive behaviour threatens the saliency of other participants. A more comprehensive theory of collaboration is presented that includes saliency as a principle of collaboration and also incorporates the competitive element of collaboration that this research clearly reveals. Reflecting this development of collaboration theory, a more comprehensive definition of collaboration is presented. In addition to increased theoretical understanding, this research presents some implications for practice including a requirement for managers to consider the competitive motivations of stakeholders when involved in collaboration. In conclusion, this research shows that collaboration in the youth health sector is competitive, involving winning saliency or losing favour in the pursuit of funding.



## **Preamble**

In this preamble, I present my subjective views and my own experiences of collaboration. I acknowledge that collaboration is sometimes difficult and positive outcomes are not always assured. Understanding why this is the case motivated me to undertake this research so that I could provide a more comprehensive explanation of collaboration and to provide practical suggestions for those involved in collaboration.

Advocates of collaboration claim that by working together, joining forces and sharing values and goals, collaboration delivers win-win situations for those involved. Proponents of collaboration argue that collaboration is a process where participants are willing to make sacrifices for the betterment of others and achieve collective goals. They suggest a utopia of understanding where participants come together as one, leave jealousies and individual wants aside and embrace their commonness or togetherness. This may sound like a collaborative mantra, a manifesto of collaboration or even a collaborative scripture espoused by the prophets of participatory management strategies. Alternatively, I ask is collaboration just rhetoric and a process hijacked by self-interest under the auspice of collective goals and beliefs? Or are these driving participation in collaboration? Regardless of such cynicism, collaboration has proven successful in a variety of contexts! In addition, sometimes there is little choice for participants as circumstances force their involvement or participation.

For example, when the Berlin Wall came down, the German people embraced their togetherness, their ‘Germanic likeness’, and were excited at the prospect of a better future together. However, achieving collective goals has not been seamless or easy. Although German people from both former East and West Germany have a degree of sameness, they also have differences, and these differences can help and hinder the achievement of collaborative goals. Differences or inequalities between stakeholders result in some having more or less influence than others when collaborating and may influence their willingness to engage in collaboration. Yet circumstances require them to collaborate and their differences are somehow resolved, embraced or minimised.

I assert that the German example above can be considered a metaphor for the youth health sector. There is a degree of sameness or togetherness associated with delivering youth health services regardless of them being from government or non-government organisations. Circumstances have brought service providers together, both forcibly and voluntarily due to

factors such as competitive tendering processes and altruistic notions of assisting youth in need, irrespective of differences in ideology, ownership structures, funding and resources. However, what participants feel about these differences and, more specifically, how these differences make stakeholders more or less important when collaborating is to date undetermined. How they feel about enforced or coerced collaboration or where their priorities lie when collaborating are also unknown, particularly in a context where competitive tendering processes and individual organisational accountability are embedded principles promoted by government.

Reflections of my own experiences of collaboration have highlighted a sometimes difficult process where positive outcomes are not always assured. However, when successful, collaborative outcomes have exceeded my expectations. Consequently, understanding collaboration better has been a driving force in undertaking this research, particularly within the youth health context where increased understanding of collaboration may assist youth in need.

## **Chapter 1: Introduction**



## **1.1 Introduction**

This chapter begins by discussing the research background and showing that collaboration is being promoted in NSW government policy as a contemporary management strategy to assist in the delivery of youth health services. Support for collaboration within government circles to more efficiently and effectively deliver youth health services is buoyed by empirically based scholarly literature. Scholars argue that improving horizontal and vertical linkages between organisations results in synergistic benefits that allow for superior problem solving and delivery of better solutions (Head, 2008; Hill & Lynn, 2003; Huxham, 1993, 1996; Huxham & Vangen, 2005; McGuire, 2006).

This chapter then introduces the lack of clarity relating to collaboration when operationalised or enacted in a context where government also promotes the principles of New Public Management (NPM), including competitive tendering and individual organisational financial accountability. Also unclear is how the enforced, coerced and voluntary collaboration practices associated with competitive tendering impacts on collaboration, particularly when those involved also have altruistic motivations to assist youth in need.

After justifying this gap in understanding, this chapter introduces the application of the theoretical principles of collaboration, stakeholder and social capital theories to the research process. The theoretical contribution is made clear in terms of understanding how social capital and salience are characterised for participants collaborating within a youth health network and how they impact on collaborative engagement.

The research aims are then introduced. They involve understanding the impact of contextual factors when collaborating, including existing management strategies and enforced and coerced collaboration on the enactment of collaboration in a government-coordinated youth health network involving both government and non-government organisations (NGOs). Also introduced is the purpose of this research, which is to better understand collaboration, how youth health services and those working within the sector are impacted by collaboration and how the findings may relate to the provision of youth health services.

This chapter then justifies the research in terms of theoretical and practical or applied benefits. It makes explicit that without this research the ability of collaboration to deliver better youth health outcomes is compromised because the impact of existing management

strategies on collaboration is uncertain. In theoretical terms this research is justified, as it utilises broader theoretical principles to extend collaboration theory.

The research questions are presented and their relevance to achieving the aims and objectives of the research is clarified. This chapter then introduces the youth health sector as an ideal context to undertake this research. It is ideal as it has specific features, such as competitive tendering and enforced collaboration, which are critical to the aims of this research.

Following on, the use of a qualitative multi-case study research framework to collect and analyse the views and perceptions of research participants in relation to collaboration is introduced. Also introduced are the sampling methods used to collect data and the thematic and coding processes used to analyse the data. It is shown that the analysis process involves examination of data from the descriptive level to more abstract levels in order to develop theory. Lastly, the structure of the research report is outlined and the definitions of terms are presented and the delimitations of scope are summarised.

## **1.2 Background to the research**

Increasingly, governments are challenged to reduce the costs of health service delivery and maximise the effectiveness of limited resources including those in the government, non-government and private sectors (Duckett & Willcox, 2011; Hill & Lynn, 2003). Collaboration is increasingly being promoted as a contemporary and better strategy to mobilise both government and NGOs in order to more effectively and efficiently deliver health services, including youth health services (Brown & Keast, 2003; Hill & Lynn, 2003; Keast & Mandell, 2009b; McGuire, 2006; NSW Centre for the Advancement of Adolescent Health, 2011; NSW Department of Health, 2010a). This is because collaboration is said to result in a collaborative advantage (Huxham, 1993, 1996). *Collaborative advantage* is defined as ‘the synergistic and otherwise unreachable outcomes available through cooperation’ (Hibbert & Huxham, 2005, p. 59) that result from the creation of stronger vertical and horizontal linkages between participants. In the context of the youth health sector, collaborative advantage refers to the effectiveness and efficiency gains in youth health service delivery that result from individuals and organisations working together that would be unachievable if organisations worked individually. However, without this research which examines collaboration and what helps and hinders collaboration within the youth health context, the ability of collaborative advantage to achieve increased effectiveness and efficiency is unclear. Consequently, without

this research, collaboration within the youth health sector may not realise the benefits proposed within the literature.

Collaboration involves bringing together ‘a wide range of expertise, knowledge and resources that enable new thinking about complex issues, for both understanding problems and formulating solutions’ (Head, 2008, p. 734). Some espoused outcomes of collaboration include a higher level of innovativeness (Lasker, Weiss & Miller, 2001), increased access to resources (Huxham & Vangen, 2005), shared risk (Huxham & Vangen, 2005), reduced conflict (Gray, 1991), greater sustainability (Lasker et al., 2001), increased system-wide performance (Gajda, 2004), increased trust (Vangen & Huxham, 2003) and an ability to better address wicked or complex problems (Head, 2008). In the context of healthcare, the benefits of collaboration can include: continuity of health care, better case management and the ability to address the multifaceted needs of individuals, families and communities (Hill & Lynn, 2003). Within youth healthcare delivery, collaboration occurs when

service providers develop internal and external working relationships with other agencies that share similar service goals and target groups. Actions include communicating, networking and working together, both within and beyond the service’s immediate sector (e.g. health, education, welfare, drug and alcohol, recreation). Collaborative partnerships often involve cooperatively working together in service planning, implementation, review and evaluation (NSW Centre for the Advancement of Adolescent Health, 2005, p. 51).

However, whether these gains can be achieved and what helps or hinders collaboration within the context of a youth health network is uncertain. As such, there is a requirement for research on collaboration within this context.

Research examining collaboration within the youth health context is an opportunity to analyse unique contextual factors that are currently under-researched. These contextual factors relate to the impact of competitive principles and individual organisational accountability associated with NPM on collaboration.

The context of youth health also allows for examination of collaboration when engagement or participation is enforced, coerced or voluntary. Enforced or coerced collaboration refers to collaboration where government bodies controlling competitive tendering processes are coercing and mandating that service providers enter into collaborative arrangements in order for them to obtain funding or compete for funding. By examining collaboration, whether

enforced, coerced or voluntary within the youth health sector, this research better understands how these arrangements impact on stakeholder perceptions of other service providers in relation to collaboration. It also allows examination of whether government policy promoting and mandating collaboration helps or hinders the degree of stakeholder engagement in collaboration and why. This research asks whether government policy promoting voluntary collaboration whilst simultaneously decreeing or mandating collaboration through competitive funding policies is effective, or misguided, and why.

Furthermore, scholars are uncertain on whether the relationship between existing management strategies and collaboration differs for those at different hierarchical levels both in the government and non-government organisations which characterise the youth health sector. Nor is the literature clear on what characteristics may make stakeholders more or less salient or important to others when involved in collaboration, particularly in the youth health sector. Without research examining collaboration at different levels in government and non-government service providers, existing collaboration theory may be inadequate when applied in contexts where the principles of NPM and collaboration coexist, such as a government-coordinated network of youth health service providers.

The increased focus on collaboration by governments is reflected in the current NSW youth health policy for 2011–2016, *Healthy Bodies, Healthy Minds, Vibrant Futures* (NSW Department of Health, 2010a), which promotes collaboration and partnerships as a means of addressing the complex health needs of at-risk young people by bringing together a wide range of youth health service providers. However, the celebratory nature of literature relating to collaboration and the widespread and often generic use of the term has resulted in O’Flynn (2009) claiming that collaboration has become a *du jour* or a *fad* word in Australian policy circles. Consequently, O’Flynn (2009) believes the rhetoric has resulted in ‘a cult of collaboration where everyone believes but few practice’ (p. 112). However, how collaboration is perceived by those working within the youth health sector is unclear and thus examination of their perceptions and their understanding of collaboration is justified.

Scholars commonly agree that collaboration is a more contemporary, equitable and inclusive means of addressing wicked problems such as youth health service delivery (Hill & Lynn, 2003). As a result, collaboration is commonly promoted as a progression away from the use of government-driven competition to regulate and drive efficiency within service delivery (Entwistle & Martin, 2005). The scepticism voiced by O’Flynn (2009) and some other

scholars (Dowling, Powell & Glendinning, 2004; Hardy & Phillips, 1998) shows that there is discontent or disagreement amongst scholars and practitioners alike as to how collaboration best achieves its proposed benefits or how it is best applied within particular contexts. Consequently, research into collaboration within the youth health sector is required as it takes into account the impact of contextual complexities that may impact on collaboration and its ability to deliver on the benefits proposed within the literature.

This section has discussed the background of the research and showed that research examining collaboration within the context of youth health offers an opportunity to advance knowledge of collaboration and its ability to deliver the benefits proposed within the literature. It has shown that particular contextual factors such as existing management principles, competitive tendering practices and policies, individual organisational accountability and enforced, coerced and voluntary collaboration justify research in relation to collaboration. More specifically, research is required to understand the impact of contextual factors on helping or hindering collaboration to achieve the benefits it is proposed to offer.

The following section defines collaboration. It shows that much like the lack of clarity amongst scholars and practitioners concerning the application of collaboration to particular contexts, there are various definitions of collaboration presented within the literature.

### **1.3 Defining collaboration**

Within scholarly literature, there is a lack of clarity concerning the nature of collaboration. Although definitions commonly refer to collaboration as multifaceted relational process that allows for individual and collective benefits, definitions of collaboration have varying levels of description and areas of focus. For example, Huxham and Vangen (2005) refer to collaboration as ‘any situation in which people are working across organisational boundaries towards some positive end’ (p. 4). Other authors are more specific and refer to collaboration as an interactive process or a communicative activity or relationship between parties or stakeholders who use ‘shared rules, norms, and structures, to act or decide in issues related to that domain’ (Wood & Gray, 1991, p. 146). The definition used in this thesis claims that collaboration is a

process in which autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationship and ways to act or decide on issues

that brought them together; it is a process involving shared norms and mutually beneficial reactions (Thomson & Perry, 2006, p. 25).

This process definition of collaboration is used in this research due to it emphasising the interrelational nature of collaboration, the collective and individual outcomes sought by participants and its depth of description of the processes or elements inherent in collaboration. Thomson and Perry (2006) refer to the processes or elements inherent in collaboration as *principles* of collaboration which include: governance, administration, agency, mutuality and norms of trust and reciprocity. The principles of collaboration are described at length in Chapter 3.

This research also uses this definition because it allows collaboration to be distinguished from other cooperative working arrangements. For example, scholarly literature commonly presents collaboration as a more intensive relationship than other forms of cooperative arrangements such as cooperation and coordination (Gajda, 2004; Keast, Brown & Mandell, 2007). Thomson and Perry (2006) argue that these relationships can be classified and differentiated in terms of ‘depth of interaction, integration, commitment and complexity’ (p. 20). However, in the literature it is also acknowledged that the lines between these relationships are often blurred (Gajda, 2004; Keast & Mandell, 2009a). In addition, it is unclear whether competitive funding strategies and enforced or coerced collaboration between participants impact on the progression from cooperation to collaboration within the youth health sector.

#### **1.4 Theoretical foundations of the research**

There has been a strong focus on examining collaboration in recent times, particularly in relation to intra-organisational and inter-organisational networks (Berry, Krutz, Langner & Budetti, 2008). Much of the research is celebratory in nature, espousing the benefits of collaboration, and seldom cautious ‘with relatively little cross fertilisation across research traditions’ (Berry et al., 2004). For this reason, this research adopts a novel, interpretative approach as it allows for the multifaceted, relational and contextual nature of collaboration to be considered from multiple theoretical perspectives. By utilising the principles or doctrines of collaboration, social capital and stakeholder theories, this research broadens the theoretical perspectives by which collaboration is analysed and advances collaboration theory.

This section of the introduction chapter introduces collaboration, social capital and stakeholder theories and their application to this research. Each theory is introduced separately and their relevance to better understanding collaboration is discussed. It is shown that extant collaboration theory lacks the ability to explain the deeper dynamics of collaboration in the context of the youth sector when collaboration may be enforced, coerced or voluntary and where government promotes the principles of NPM and collaboration concurrently. The inadequacies of collaboration theory are then revealed as the theoretical gaps in knowledge that this research addresses.

Following on, the section on social capital shows that understanding the social linkages between those involved in collaboration is crucial to identifying emerging forms of influence that impact on the willingness of service providers to collaborate. Then it is clarified that stakeholder theory allows the researcher to identify who is more salient or important to others when collaborating (Mitchell, Agle & Wood, 1997). The sections on social capital and stakeholder theories will show how these theories can assist the researcher to address the theoretical gaps in collaboration theory, particularly when applied to the youth health context.

#### **1.4.1 Collaboration theory**

Collaboration theory identifies collaboration as a complex process requiring a number of factors, or antecedents, for it to occur and the desired outcomes to be achieved (Gray & Wood, 1991; Wood & Gray, 1991). Collaboration theory also argues that collaboration is an imperative in the current diversified working environment with high interdependence amongst participants (Gray, 1991). However, how government policy functions as an antecedent to effective collaboration is uncertain as the literature to date is unclear concerning enforced and coerced involvement in the context of not-for-profit youth health service provision.

Collaboration theory comprehensively describes the elements or principles required for successful collaboration. Thomson and Perry (2006) argue that the principles or elements of collaboration include governance, administration, agency and organisational autonomy, mutuality and norms of trust and reciprocity. In comparison, Ring & Van de Ven (1994) emphasise that collaboration involves the processes of negotiation, commitment, execution and assessment. Collaboration theory also states that collaboration can be managed in order to improve the performance of those involved and deliver better collaborative outcomes (Agranoff, 2004, 2006; Huxham & Vangen, 2005; Mandell & Keast, 2008; Wischnevsky &

Damanpour, 2006). Hence, collaboration theory allows for understanding of the factors that participants and managers consider and are involved in when collaborating.

Scholars acknowledge that the multidisciplinary, multidimensional and integrative nature of collaboration and the environment in which it occurs make managing collaboration difficult (Gazley, 2010; Hibbert, Huxham, Sydow & Lerch, 2010; White & Wehlage, 1995).

Consequently, collaboration theory tends to be descriptive and even prescriptive in terms of how successful collaboration should occur.

However, the descriptive and prescriptive nature of existing collaboration theory does not explain how the processes inherent in collaboration are operationalised or enacted, particularly within a government-coordinated network where collaboration is enforced and coerced by competitive government-funding processes. As such, it is not clear how government policy impacts on the willingness of participants to actively engage in collaboration or for what reasons. Nor does collaboration theory identify who are the key influencing participants, particularly when the collaborative network involves government and non-government youth health service providers.

Therefore, examination of collaboration theory allows the researcher to expose gaps requiring further knowledge, particularly in terms of explaining the deeper dynamics influencing the actions or behaviours of those involved in collaboration. The *theoretical gaps* in knowledge associated with collaboration theory and the areas requiring further research and understanding are:

1. the salience or importance of stakeholders or participants when collaborating, including those not directly involved in collaboration such as youth in need, government and funding organisations
2. the hierarchies of influence including normative pressure to collaborate for those within the youth health sector and how this impacts on the behaviour and collaborative engagement strategies of participants
3. the impact of enforced, coerced and voluntary involvement in collaboration on stakeholder engagement
4. the willingness of stakeholders to participate in collaboration in relation to policy, altruism, clinical factors and economic considerations
5. perceptions of responsibility to other stakeholders and the impact this has on collaboration engagement

6. the explicit and implicit goals when collaborating and how are they achieved
7. the specific actions service providers are willing to take to achieve individual and collective goals and why service providers develop particular collaborative engagement strategies.

#### **1.4.2 Social capital theory**

To understand collaboration more thoroughly, the researcher added and applied the theoretical principles of social capital theory to the research process. Social capital theory was applied because scholars commonly acknowledge that collaboration involves or includes social capital due to its inherently relational nature (Daley, 2009; Gaboury, Bujold, Boon & Moher, 2009; Levine & Moreland, 2004; Rocha & Miles, 2009; San Martin-Rodriguez, Beaulieu, D'Amour & Ferrada-Videla, 2005; Thomson & Perry, 2006; Thomson, Perry & Miller, 2009; Zhang & Huxham, 2009). Social capital theory was utilised as it is a socialised choice theory that can be used to explain the features of social linkages between members of a collaborative network (Portes, 1998; Putnam, 1995). Essentially, social capital theory focuses 'on the positive consequences of socialisability' (Portes, 1998, p. 2), placing those 'positive consequences in a framework of the broader discussion on capital' (Portes, 1998, p. 2). Social capital theory does this by focusing on the non-monetary benefits that can result in power and influence between members within the structure of a collaborative network (Lin, 1999, 2001). Consequently, social capital theory allows examination of the goodwill created within a structure of relationships when collaborating and allows the impact of a variety of factors such as the opportunity, motivation and ability of stakeholders to be considered (Tsai & Ghoshal, 1998).

By examining the structural, relational and cognitive dimensions of social capital (Nahapiet & Ghoshal, 1998), the researcher can understand the pressures on those working in the youth health sector to engage in collaboration. For example, those working within the youth health sector are driven by economic considerations and altruistic motivations associated with the needs of youth (McGorry, Purcell, Hickie & Jorm, 2007; NSW Department of Health, 2010a). Consequently, social capital theory also allows the researcher to examine the underlying and deeper willingness of stakeholders to collaborate. By doing so, the researcher can identify key players when collaborating, their willingness to collaborate and the impact their actions may have on other participants. Hence, conceptualisations of social capital allow for comparison of hierarchies based on traditional roles and structures within the youth health

sector by those emerging through the process of collaboration and the possession of social capital. In addition, social capital theory also allows social capital to be conceptualised as a resource giving benefit to those with higher levels of social capital.

In summary, the areas of investigation where social capital theory can advance understanding of collaboration are:

1. strategies for the investment, development, obtaining, maintenance, use and depletion of social capital when collaborating in a government-coordinated network with diverse stakeholder groups
2. use of social capital by stakeholders in collaboration to gain collaborative or competitive advantage
3. examination of stakeholders with more or less social capital and how this impacts on engagement in collaboration
4. how social capital helps or hinders collaboration in the context of youth health
5. the relationship of social capital on existing and emerging hierarchies when collaborating
6. the relationship between enforced, coerced and voluntary collaboration and social capital
7. the normative pressures to collaborate within a government-coordinated network
8. the relationship between altruism and social capital in relation to collaboration
9. the types of social capital in a collaborative network.

Now that it is clear to the reader how social capital can help increase understanding of collaboration, the following section discusses the benefits of applying the principles of stakeholder theory to the analysis of collaboration occurring within the youth health sector.

### **1.4.3 Stakeholder theory**

Stakeholder theory enables the researcher to address the question of stakeholder salience, that is, the degree to which key players or stakeholders give priority to stakeholder claims (Mitchell et al., 1997). Stakeholder theory allows the researcher to examine who are more or less salient when considering the elements or principles of collaboration including governance, administration, agency, mutuality and trust and reciprocity (Thomson & Perry, 2006; Thomson et al., 2009). It also allows the researcher to consider how the salience of participants impacts on the processes of negotiation, commitment, execution and assessment

involved in collaboration (Ring & Van de Ven, 1994). In other words, by applying stakeholder theory, the researcher identifies and classifies key players, or stakeholders, involved in collaboration in terms of their importance to others. In so doing, stakeholder theory allows identification and analysis of stakeholder willingness to be involved or not involved in collaboration and with particular stakeholders. As such, stakeholder theory allows directional congruence and strength of relationships between participants involved in collaboration to be analysed.

By applying the theoretical principles of stakeholder theory, the researcher could broaden the examination of stakeholders to include stakeholders not actively involved in the collaboration as well as those who are. This allows the researcher to examine the impact of government funding bodies and users of youth health services on collaboration. Furthermore, stakeholder theory allows the researcher to understand stakeholder multiplicity or the formation of alliances (Neville & Menguc, 2006) between participants when collaborating.

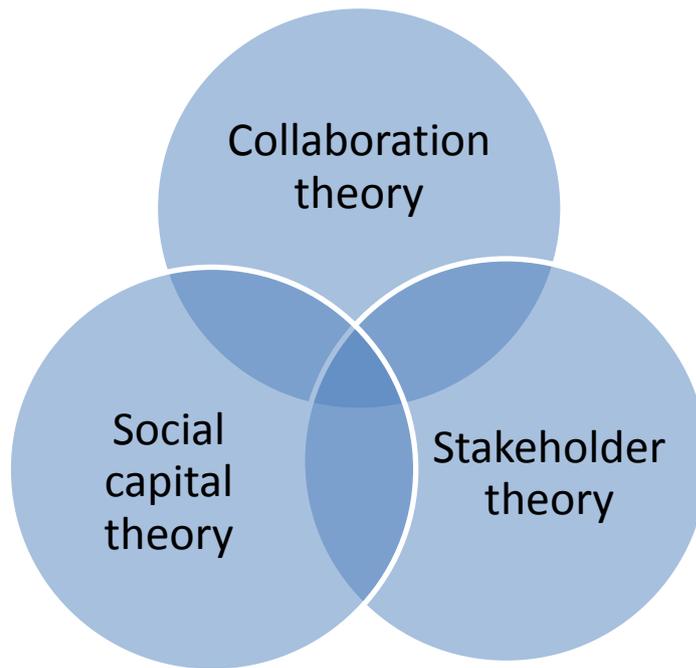
Stakeholder theory examines interactive relationships within a network in terms of directional congruence between stakeholders, the strength of influence between interacting stakeholders and the consideration of potential synergies arising from strategic collaboration between stakeholders (Mitchell et al., 1997). Essentially, this theory acknowledges that there is inequality within collaboration that is sometimes at odds with the ideals of equality, democracy and inclusiveness in decision making often associated with collaboration theory (Heath, 2007; Heath & Frey, 2004).

The above review of stakeholder theory showed how its principles can assist the researcher to understand collaboration from a unique perspective. By applying the principles of stakeholder theory this research advances knowledge of collaboration in the following areas:

1. identification of key stakeholders when collaborating in the not-for-profit sector including those not directly engaged in collaboration
2. identification of which stakeholders are more or less salient when collaborating in the youth health sector and why they are more or less salient or important than others when collaborating
3. application of stakeholder salience attributes (power, legitimacy and urgency) when collaborating within the youth health sector, including consideration of organisational type and employment group

4. relevance of stakeholder multiplicity and formation of alliances when collaborating in a network with government and non-government youth health service providers
5. advantages and disadvantages of being involved or not involved in alliances when collaborating
6. impacts of enforced or coerced participation in collaboration on stakeholder salience and stakeholder multiplicity
7. impacts of altruism and economic considerations on stakeholder salience in a collaborative environment.

In summary, this section has presented the theoretical foundations of the research. It has shown that by combining and using the theoretical principles of collaboration, social capital and stakeholder theories (see figure 1.1), this research can understand and explain how and why collaboration occurs, particularly in the context of youth health. Consequently, collaboration can be better understood by combining or overlapping the principles of these three theories. This overlap allows the researcher to examine collaboration in a unique and relevant way that is not evident in existing research on collaboration. The overlap between the theories involves understanding the relationship between how social capital is developed, obtained, maintained or depleted when collaborating and how stakeholders make decisions to maximise the benefits of social capital when collaborating and why, including the impact of social capital on stakeholder salience. In other words, the overlap allows the researcher to examine how and why youth health service providers engage in collaboration to create, maintain and use social capital to gain benefit and how and why youth health service providers make decisions when collaborating in order to maximise opportunities to gain salience.



**Figure 1.1: Theoretical foundations of the research**

The combined application of these theoretical perspectives to a collaborative network has not been attempted in a context of enforced, coerced and voluntary collaboration. Nor has the combined application of these theoretical principles been attempted in a context where government policy promoting collaboration coexists with policy promoting competition and individual organisational accountability, particularly within a not-for-profit youth health network. Additionally, the combined application of these theoretical principles has not been applied to research aimed at examining the impact of these contextual factors on the strategies of engagement in collaboration used by youth health service providers when collaborating.

Now that the relevance of combining principles of collaboration, social capital and stakeholder theories to advancing knowledge of collaboration when enacted in the youth health sector has been made clear, the following section makes explicit the theoretical contribution of this research.

## **1.5 Theoretical contribution**

This research project makes a theoretical contribution to the understanding of collaboration. It does this by examining collaboration occurring within a government-coordinated not-for-

profit network of organisations involved in the delivery of youth health services and where policies of financial accountability, competitive tendering processes and enforced and coerced collaboration coexist with government policy promoting collaboration. It also does this by examining collaboration using the combined theoretical principles of collaboration, social capital and stakeholder theories. Incorporating the unique contextual factors impacting on collaboration within the context of a youth health network and using a combination of principles associated with collaboration, social capital and stakeholder theories to examine collaboration, the theoretical contribution of this thesis is:

*Understanding how and why social capital is developed, maintained, used, depleted and competed for by stakeholders within a collaborative network in order for stakeholders to be more salient to network members and external stakeholders and the sources of salience when collaborating.*

By making this theoretical contribution, the research also contributes to collaboration theory by presenting a more contemporary and comprehensive theory of collaboration when operationalised within the youth health sector. In addition, the contribution to collaboration theory enables the researcher to present a more comprehensive definition of collaboration that better describes collaboration when enacted within the context of a youth health network.

## **1.6 Statement of purpose**

Collaboration is a principal strategy being championed as a means to improve the delivery of youth health services in New South Wales (Kang et al., 2005; NSW Centre for the Advancement of Adolescent Health, 2005, 2010; NSW Department of Health, 2010a). However, how collaboration is operationalised and why requires investigation, particularly in the context of a government-coordinated youth health network. Research is required to examine and understand collaborative effectiveness in achieving its promised benefits. Research is also required to ensure that the efforts of government are directed to areas where they have the greatest impact on improving the provision of youth health services for those in need. For these reasons the statement of purpose for this research is:

*to better understand the process of collaboration when enacted or operationalised in a network of organisations delivering youth health services from a combination of collaboration, stakeholder and social capital theoretical perspectives.*

However, there are also a number of more specific purposes of this research. These are:

- to obtain greater clarity around the rhetoric of collaboration, particularly when promoted in government policy, by examining what helps and hinders collaboration in the context of youth health
- to understand the impact of existing management policies and practices on collaboration, particularly those that enforce and mandate collaboration between service providers
- to identify, describe and examine the willingness of service providers to collaborate by understanding who is more or less salient or eminent when collaborating and why
- to advance collaboration theory by combining and utilising the principles of collaboration, social capital and stakeholder theories to make a unique contribution to knowledge
- to develop a more comprehensive definition of collaboration that incorporates the research findings and better reflects how collaboration is operationalised within the youth health sector.

In summary, the purpose of this research is to better understand collaboration, how youth health services are impacted by collaboration and how the findings may relate to the provision of youth health services. In doing so, the purpose of this research is to contribute to the body of research relating to collaboration and advance collaboration theory by combining and utilising the principles of collaboration, social capital and stakeholder theories to make a unique contribution to knowledge.

### **1.7 Aims of the research**

The aims of this research arise from a lack of knowledge relating to the impact of contextual factors such as existing management strategies on the enactment of collaboration in a government-coordinated network involving both government and non-government organisations engaged in the delivery of youth health services. The aims of this research also arise from a need to better understand enforced, coerced and voluntary collaboration according to policy and the willingness of stakeholders to be involved in collaboration from a combined collaboration theory, stakeholder theory and social capital theory perspective. This research aims to address the uncertainty associated with enforced and coerced collaboration

for government and non-government organisations and different employee groups involved in strategic and tactical collaboration in relation to youth health service delivery. Consequently, the hierarchy of aims for this research are:

1. to identify and examine the perceptions and views of those working within a network of organisations involved in the provision of youth health services in western Sydney in relation to enforced, coerced and voluntary collaboration by:
  - a. comparing and contrasting the perceptions and views of those from government and non-government organisations providing youth health services, including a coordinating organisation that was instrumental in creating government policy promoting collaboration, in relation to collaboration
  - b. comparing and contrasting the perceptions and views of those at both strategic and tactical levels
  - c. examining the impact of enforced or coerced collaboration by government on stakeholders
  - d. identifying what helps and hinders collaboration within a government-coordinated youth health network
  - e. examining the willingness of service providers to engage in collaboration with particular stakeholders.
2. to advance collaboration theory by applying the principles of collaboration, social capital and stakeholder theories to understand the willingness of those directly, indirectly or not involved in collaboration to engage in collaboration by:
  - a. understanding how social capital is developed, obtained, maintained or depleted in collaboration
  - b. understanding how stakeholders make decisions to maximise the benefits of social capital when collaborating and why, including the impact of social capital on stakeholder salience
  - c. identifying why stakeholders are more or less salient than other stakeholders when collaborating and how salience is developed, gained, maintained or lost.
3. to advance collaboration theory by examining the enactment or operationalisation of collaboration in a context where existing management strategies and collaboration coexist. For example, within the NSW youth health context, existing management

principles including individual organisational accountability and competitive tendering practices associated with NPM coexist with policy promoting collaboration.

## **1.8 Justification for the research**

This research is justified as it examines collaboration as a strategy used by government to address the intractable issue of how to better maximise the limited resources available to multiple youth health service providers in order to better deliver youth health services. The research is required because it examines the deeper dynamics of collaboration and presents a contemporary and comprehensive theoretical perspective of collaboration whilst also providing knowledge to assist those involved in youth health service delivery. Hence this research is justified as it has practical or applied and theoretical benefits. These justifications are consistent with scholarly endeavour and academic research. For example, Head (2010) states:

Both researchers and practitioners tend to share an ‘improvement’ perspective, or a ‘reformist impulse’, wherein knowledge is broadly seen as potentially useful *both* for greater understanding (cognitive benefits) *and* the improvement of processes structures, policies and programmes (impact benefits) (p. 576).

Consequently, this research benefits government, scholars, providers and users of youth health services and society in general.

### **1.8.1 Practical justification**

This research is justified as collaboration is currently being promoted in the recently released NSW youth health policy Healthy Bodies, Healthy Minds, Vibrant Futures, which was released on 17 December 2010. This is the first revision of the original 1998 NSW youth health policy and offers a timely opportunity to examine the impact of policy promoting collaboration for those involved in the provision of youth health services.

Management literature indicates a need to better understand the process of collaboration and whether collaboration achieves the benefits commonly proposed. For example, Dowling et al. (2004) claim that current thinking is ‘uncritically pro-collaboration’ (p. 2) whilst Hardy and Phillips (1998) have cautioned that when examining collaboration, ‘surface dynamics are not necessarily an accurate description of what is going on beneath’ (p. 217). Therefore, this research responds by casting a critical eye over the rhetoric of collaboration and the operationalisation of collaboration in order to better understand the dynamics of collaboration

when applied to a particular context. This research is warranted as it considers which aspects or characteristics of collaboration can be better managed in order to deliver superior collaborative outcomes.

Furthermore, without this research, the ability of collaboration to maximise limited funding and resources may be undermined and collaborative advantage may not be realised. The result of this is that resources could be potentially wasted or allocated elsewhere where government and funding bodies perceive they are better utilised.

Therefore, it is critical that collaboration be understood better when enacted within the youth health sector. It is essential so that key stakeholders, including funding organisations, government and youth health providers, perceive that promoting collaboration and its application as a management strategy in the youth health sector is money well spent.

This research is necessary as knowledge gained can assist in understanding how collaboration can contribute to change and innovation within the youth health sector and translate into better youth health outcomes. In addition, without this research the impact of collaboration on the sustainability of organisations involved in the delivering youth health services is unknown.

Despite the health benefits of being young, in Australia, youth account for nearly 10% of all hospital admissions, which equates to approximately half a million hospital admissions annually (Sturrock, Masterson & Steinbeck, 2007). Furthermore, around 22% of all young people experience some major health problem, including some which may be life threatening (NSW Department of Health, 2010a). For these reasons, young people account for a large proportion of health expenditure and focus from government through the provision and sponsorship of youth health services. Therefore, this research is justified as knowledge gained can assist government to maximise the ability of collaboration to more effectively and efficiently deliver youth health services.

In providing knowledge that can assist participants to collaborate more effectively, this research may also assist providers and recipients of youth health services. Therefore, this research is valuable as it may indirectly assist in the delivery of youth health services. As a result, youth at risk may have a better opportunity to grow and develop into positively contributing members of society in moral, social and economic terms.

A research participant who is a manager highlighted the repercussions of not addressing the health needs of at-risk youth when she questioned:

What will be the dollar cost if we don't support this young person now? If we don't support them what will be the dollar cost for each one of us and our different organisations? What will it be for government? What will it be for [the Department of] Justice, [the Department of] Housing or [the Department of] Health if we don't support them [youth]? ... Yes and what is the cost for society or the community if we don't work with this young person now? (BM3)

Furthermore, this research is necessitated by the lack of clarity in the literature regarding the impact of context on collaboration, particularly the impact of existing management strategies such as New Public Management (NPM), competitive tendering practices and enforced or coerced participation in collaboration. The lack of clarity can potentially result in misguided or poorly conceptualised and conceived strategies that don't consider the impact of combining different management principles. Thus, this research is essential as the literature is unclear concerning the impact of combining different management strategies that may or may not maximise the resources available to the sector, particularly the human resources which are integral to youth health service delivery.

Consequently, conducting the research in the context of the youth health sector is necessary as it provides an ideal context in which to incorporate these unique contextual and environmental factors. By incorporating contextual factors, this research is required to examine and explain whether collaboration is achieving the benefits policy proposes and why. In addition, knowledge gained may assist government to deliver future policy initiatives promoting collaboration and the effective and efficient allocation of resources.

### **1.8.2 Theoretical justification**

Due to the complex nature of human relations and influence of context on collaboration, some scholars argue for continuing research into 'dynamic, process oriented theory of inter-organisational relations and for research on the quality of collaborative relationships' (Prins, 2006, p. 336). Consequently, this research is intellectually justified as it is an opportunity to advance collaboration theory by better understanding its application and usefulness in the context of a government-coordinated youth health network. Without this research the relevance of existing collaboration theory to reflect the reality of how it occurs within particular contexts remains unclear. More specifically, its application and relevance in an environment of enforced and coerced collaboration and where the principles of NPM and

collaboration coexist in government policy is unknown. This research is justified as it addresses scholarly concerns relating to the reality of collaboration when applied to a particular context as compared to theoretical collaboration as proposed in the literature. For example, O'Flynn (2009) argues that 'what we are seeing is a phenomenon where everyone is talking about collaboration, but significant questions remain about whether they are actually doing collaboration' (p. 115). Therefore, this study is justified as it examines the relevance of existing collaboration theory to reflect the reality of how it is enacted within the context of a youth health network.

This research is warranted as it develops new knowledge relating to collaboration, particularly the revealed relationship between competition for social capital and salience and collaboration.

To the best of the researcher's knowledge, literature to date on collaboration has not employed a combination of collaboration, social capital and stakeholder theories to analyse collaboration, particularly in the context of an Australian youth health network. Due to this, there is uncertainty concerning the relationship between stakeholder willingness to engage in collaboration and levels of salience when collaborating, particularly in relation to existing organisational hierarchies or those emerging as a result of collaboration. The literature is also unclear concerning how and why social capital is developed, maintained, used, depleted and competed for by stakeholders within a collaborative network in order for stakeholders to be more salient to network members and external stakeholders. In addition, what forms the basis for salience when collaborating is also unclear. Furthermore, little is known concerning the willingness of stakeholders to engage in collaboration when collaboration within a youth health network includes enforced and coerced collaboration driven by policy dictates. Thus from a theoretical perspective this research is warranted as it examines collaboration from a broader scope of theoretical perspectives to extend knowledge of collaboration.

This study is justified as the literature lacks clarity in regards to mandating collaboration or forcibly creating collaborative working relationships which may impact on the synergistic benefits of collaboration and the goodwill between participants. In addition, the literature is unclear concerning the impact of altruistic motivations of participants on collaboration. Without this knowledge the potential for conflict, incongruence or misalignment between different management strategies and principles may not be revealed. Therefore, this research is critical to understand how government policy mandating collaboration impacts on the

engagement strategies of participants and whether it helps or hinders collaboration from delivering the benefits that government policy proposes. Without this knowledge government strategy may be ill-directed and may have negative impacts on the relationships between stakeholders with ongoing repercussions on youth health service delivery.

This research is required as it gives future researchers opportunities to verify, validate and build on the theoretical findings in similar and different contexts using various research methods and methodologies. Consequently, theoretical findings can be applied and tested in other contexts to examine whether developed theory has a degree of synergy in other contexts and at other times. As such, this research is justified as broadening collaboration theory and may lead to further research and knowledge generation.

In summary, this research is justified as it has theoretical and practical benefits. By using the principles of collaboration, social capital and stakeholder theories to better understand collaboration, knowledge gained may assist government and those working within the youth health sector to better deliver youth health services. In doing so, there are benefits for government, funding organisations, providers and users of youth health services and society in general. Researchers also benefit by advancing collaboration theory and giving opportunities for further research.

## **1.9 Research questions**

The following research questions have been developed in order to fulfil the research aims and address the identified gaps in the literature. By examining the perceptions and views of those working at different levels within government and non-government organisations, the research identifies what accelerates or obstructs collaboration within the youth health sector, including policy for coerced or forced collaborative relationships. Furthermore, analysis of these perceptions examines contextual implications on collaboration, the roles and salience of stakeholders involved and stakeholder willingness, particularly among service providers, to be involved in collaboration. The following research questions allow the application of collaboration theory, social capital theory and stakeholder theory in the analysis process. The research questions are:

1. Who collaborates in the youth health sector and why?
2. What are the impacts of collaboration within the youth health sector?
3. How is collaboration operationalised or enacted within the youth health sector?

These research questions are broad in nature as they encapsulate the research gaps identified and the purpose and the aims of the research discussed above. They allow issues and concerns considered important for research participants to be revealed and thus illustrate the inductive nature of this research.

### **1.10 Youth health context**

This section introduces the youth health context and makes it clear that it is an ideal context in which to undertake this research. It begins by defining youth and describing the multidisciplinary nature of youth health services. Following on, the fragmented nature of youth health services is discussed to illustrate why the NSW government is promoting collaboration as a management strategy to reform the delivery of youth health services.

Throughout this thesis the word *youth* is synonymous with adolescents and young people and refers to those from the ages of twelve to twenty-four years (NSW Department of Health, 2010a). In 2011, there were approximately four million youth (2 million males and 1.9 million females) in Australia (Australian Institute of Health and Welfare, 2011, p. 5).

Young people are mostly considered to be a healthy population as compared to other groups such as the elderly (Sturrock et al., 2007, p. 49). However, it is during this stage of life that individuals go through a 'period of rapid emotional, physical and intellectual change, where young people progress from being dependent children to independent adults' (Australian Institute of Health and Welfare, 2007, p. vii). As a result, young people may go through times of distress and insecurity that may result in mental illness, risky behaviours and other health-related problems. Governments are obligated morally, socially and economically to address the welfare of this group (Sturrock et al., 2007). The negative repercussions of not doing so can result in social distress for youth and their families, high costs for ongoing treatment (Burt, 2002) and unsuitability for employment (McGorry et al., 2007), to name just some. Therefore, research in the youth health sector is an opportunity to ensure that government resource expenditure is effective and offers a unique point of difference to much of the previous collaboration research.

Youth health services are defined as 'specialist health services providing multidisciplinary, primary healthcare to young people' (NSW Department of Health, 2010a, p. 27). They range from the provision of general medical services to specialist mental health services and from creative arts projects to education. Consequently, youth health service provision involves

bringing together a range of specialist services from government, non-government and private service providers. For this reason, the youth health sector is an ideal opportunity to examine perceptions and views, in relation to collaboration, of those from both government and NGOs involved in the provision of youth health services in relation to collaboration.

The multitude of service providers supplying a myriad of specialised services has resulted in Kang et al. (2003) claiming that ‘service provision for young people in NSW is fragmented’ (p. 951) and characterised by ‘poor linkages with other relevant services’ (Kang et al., 2003, p. 947). McGorry (2007) supports this view and also advocates that ‘it is generally agreed there are high levels of unmet need, poor access to and fragmentation of service, and a lack of quality care for adolescents and young adults’ (p. S53). Fragmentation of service provision in the youth health sector exemplifies that youth health service delivery is a meta-problem or wicked problem which has ‘no clear solutions, only temporary and imperfect resolutions’ (Harmon & Mayer, cited in McGuire, 2006, p. 34). Evidence suggests the youth health sector in NSW often functions as a disjointed system where cooperation and effective transfer of information and services is difficult due to the characteristics of existing structures and processes (NSW Centre for the Advancement of Adolescent Health, 2005). Hence, the youth health sector is a fruitful and important context where research may provide insight into what helps and hinders collaboration.

The New South Wales Government has acknowledged the need for reform within the youth health sector by creating the youth health coordinating, advocacy and policy-making body the NSW Centre for the Advancement of Adolescent Health (NSW CAAH). Government support for change within the youth health sector is also demonstrated by the release of the NSW Youth Health Policy 2011–2016: Healthy Bodies, Healthy Minds, Vibrant Futures in November 2010. The focus of this policy is to identify ‘the importance of understanding and responding in positive and innovative ways to the health needs of young people’ (NSW Department of Health, 2010a, p. 14). Included in this policy is the promotion of collaboration and partnerships as an innovative means to develop strong linkages between service providers to increase the effectiveness of service delivery. This policy also supports collaboration as a means to supply health services, both mainstream and specialist, to young people who may be outside the scope of government services, resourcing or political priorities. However, it is unclear whether the promotion of collaboration in policy is actually resulting in increased linkages between service providers or a willingness of service providers to collaborate. As

such, the youth health context enables this research to examine the intra- and inter-organisational linkages between stakeholders in order to understand stakeholder willingness to engage in collaborative arrangements. Furthermore, this context allows examination and comparison of those working at different levels within the youth health sector. Consequently, this context allows for improved understanding of what helps and hinders collaboration, and factors that impact on willingness to collaborate.

Furthermore, the broad aim of the NSW youth health policy is to ‘set new directions in young people’s health in NSW and align with the framework of NSW Government policy and plans’ (NSW Department of Health, 2010a, p. 2). This means that government policy makers see collaboration as integral to the current political climate of NPM. NPM involves using market-based approaches such as competitive tendering and contracts when allocating public resources (Head, 2010). Consequently, NPM has resulted in a climate where the sector is competing for funding. Not only is the sector competing with other health areas for government funding, but there is also competition from organisations *within* the sector for limited funding for a range of health initiatives. The result is an environment where there is ‘reactive counter advocacy’ (McGorry et al., 2007, p. S6) where organisations perceive there are winners and losers when competing for grants. Consequently, youth health offers an ideal context to examine how collaboration is characterised when enacted in a context where competitive processes and collaboration coexist.

NPM frequently supports a political environment where different stakeholders may have a range of power and influence that affect funding allocation (Braithwaite, 2004; Head, 2010). Such power factors may impact collaboration and offer an opportunity to apply the principles of collaboration, social capital and stakeholder theories in order to examine the willingness of stakeholders to collaborate with each other.

NPM acknowledges the importance of the non-government sector in the delivery of health services and the requirement for interdependence with public services and the broadening of networks that this brings (Head, 2010). This interdependence has resulted in new governance techniques that challenge the relevance of established hierarchical structures (Head, 2010; Pollitt & Bouckaert, 2011). This is because NPM requires managers to manage upwards, downwards and outwards (O’Toole Jr, Meier & Nicholson-Crotty, 2005) using negotiation, inter-organisational diplomacy, relationship development and collaborative skills (Head, 2010). However, assumptions that hierarchies based on existing structures and processes are

relevant to and supportive of collaboration are unclear. Therefore, research examining collaboration in the context of a government-coordinated youth health network is an opportunity to examine emergent roles and influence in collaboration and to make comparisons with existing hierarchies of power within the sector.

### **1.11 Methodology**

Qualitative research is considered appropriate for this research as it allows for the collection and analysis of the perceptions and views of research participants (Creswell, 1998).

Qualitative research is also considered appropriate for this research as it incorporates the researcher as the primary instrument in the research process and enables the researcher to maximise his knowledge, ability and intuition (Merriam, 1998). This allows the researcher to examine ‘relationships, patterns and configurations concerning the emotions, feelings and perceptions’ (Creswell, 1998, p. 11) of research participants in relation to collaboration. Qualitative research also allows the researcher to interpret and represent these views and perceptions by referring to the actual words of participants. Furthermore, qualitative research enables the researcher’s own descriptive language to be used in the interpretation and presentation of research findings and conclusions.

This research utilises a multi-case study research framework. This research design was chosen as it allows for the analysis of a central phenomenon (Yin, 2009), collaboration, which involves a number of participants or stakeholders employed in different youth health organisations.

Examination of a phenomenon within a context is fundamental for any qualitative multi-case study research project (Yin, 2009). Consequently, the researcher believes that collaboration cannot be separated from the context in which it occurs, which in this research is a network of youth health organisations in western Sydney. As confirmed by Graham (2000), when conducting qualitative multi-case study research the phenomenon under investigation is ‘a unit of human activity embedded in the real world ... which can only be studied or understood in context’ (p. 1). In other words, the separation of inter-organisational collaboration from the context in which it occurs is neither desirable nor practical in terms of answering the research questions. In fact, the researcher agrees with David (2006), who advocates that ‘it is from this contextual and embedded notion of the case that the case study research tradition tends to draw its legitimacy’ (p. xxvi).

Since this is so, the context gives the researcher the opportunity to gain insight into the historical, cultural and physical contexts that affect the views and perceptions of research participants in relation to collaboration. Essentially, the context of the youth health network is a manifestation of inter-organisational collaboration and provides an opportunity to study the phenomenon occurring in a number of sites and involving a number of people. Although briefly introduced here, the qualitative multi-case study research framework as applied to this research is explained in depth in chapters 4 and 5.

The multi-case study research framework also allows for the use of flexible data sampling techniques such as purposive sampling and snowball sampling techniques (Merriam, 1998; Yin, 2003). This allows the researcher to target and access a diverse sample group of research participants who could answer the research questions. In doing so, the researcher gained access to three non-government and four government (of which three were state-funded and one Commonwealth-funded) organisations involved in the provision of youth health services, including an organisation instrumental in promoting collaboration in the creation of youth health policy. In total, 35 interviews were conducted, with interviewees separated into three distinct employee groups:

- 5 managers (3 with hybrid management and youth health practitioner roles)
- 25 youth health practitioners (including youth workers, health promotional staff, psychologists and youth counsellors)
- 5 administration staff

The flexibility of the multi-case study research framework also allows for the use of multiple data collection techniques (Stake, 1995, 2006). Therefore, in addition to using semi-structured interviewees to collect data, the research also uses observation and document analysis. Interviews and semi-structured interviews were undertaken between January and September 2011 whilst document analysis was ongoing from 2010 to 2013. Using three data collection methods allows for the collection of a broad array of data that is progressively compared, contrasted and analysed throughout the research process. This allows the researcher to develop convergent and multiple lines of enquiry through the process of triangulation (Yin, 2009) in order to give credibility and rigour to research findings and conclusions.

The researcher utilises the progressive comparison analysis method to identify, confirm and develop codes, categories, concepts, themes and hypotheses within the collected data (Fitzgerald, 2002). This method allows the researcher to employ open, axial and selective coding processes to inductively derive research conclusions and develop theory (Boeije, 2009). This three-stage coding process allows the researcher to incorporate the principles of progressive comparison, analytical induction and theoretical sensitivity to analyse the data from descriptive to more abstract levels in order to develop theory (Boeije, 2009).

The use of a diverse sample group, establishing chains or lines of evidence by using quotes from participants to illustrate findings and having key academic staff confirm developed themes and constructs, also allows findings to have a credible degree of academic rigour (Yin, 2009).

When presented in this dissertation, each quote from an interviewee is accompanied by a 3 digit participant code (e.g. BM3). This de-identifies the interviewee to the reader (as per ethics requirements) but shows whether the interviewee is administration staff, a manager, or a youth health practitioner. The code also identifies whether the interviewee is employed in a government or non-government organisation. The following table illustrates the nature of the codes used.

**Table 1.1: Description of participant code**

<b>First digit: organisation</b>	<b>Second digit: employee group</b>	<b>Third digit: employee number</b>
A-C (Non-government organisation ) D-G (Government organisation)	A (Administration staff) M (Manager) Y (Youth practitioner staff)	1-8 (dependent upon number of staff from each organisation)

In addition to the coding processes, sampling techniques, peer confirmation and the use of quotes, the researcher is able to apply an analytical framework incorporating principles associated with collaboration, stakeholder and social capital theories. Consequently, the iterative process, although primarily inductive, had elements of deduction in that existing theory allowed the researcher to be sensitive to concepts discovered within the data.

In preparation for analysis, collected interview transcripts were uploaded into the computerised qualitative research management tool QSR NVIVO™. Using its data management capabilities the researcher was able to group and sub-group quotes under specific codes, categories, concepts and prominent themes that emerged from the data. These themes were then grouped together with reference to the research questions and emerging hypotheses.

Although briefly introduced here, the qualitative multi-case research framework is explained in depth in Chapter 4, as are the data sampling and collection methods. A comprehensive explanation of the progressive comparison analysis method including the coding processes used to develop research findings is found in Chapter 5.

## **1.12 Outline of this report**

This thesis is divided into a number of chapters. A brief description of these chapters is as follows:

- *Chapter 1* outlines the background, purpose and justification for the research and presents the research questions. It also introduces the research context, defines key terms and delineates the context of the research.
- *Chapter 2* shows that the youth health sector provides an ideal opportunity to examine collaboration enacted in a context where participation in collaboration may be voluntary, coerced and mandated or enforced and where governments concurrently promote the principles of collaboration and NPM.
- *Chapter 3* gives an in-depth insight into collaboration, stakeholder and social capital theory and the relationships between them. It also identifies the theoretical gaps leading to the research questions.
- *Chapter 4* outlines the method of knowledge creation (ontology and epistemology). The researcher's philosophical stance is justified, which for this research is realism. The researcher also discusses and justifies the use of the qualitative research paradigm and why multi-case study research framework is used. It is shown that qualitative multi-case study research allows for the identification and examination of the perceptions and views of those working within a network of organisations involved in providing youth health services in western Sydney in relation to collaboration. The research protocols are explained and justified. The methods of data gathering including purposive sampling are presented and the recruitment processes discussed.

Purposive sampling is shown to allow the researcher to access a group of participants who were willing to be involved and who could provide their perceptions and views of collaboration when operationalised within the youth health sector. Employee groups involved in the research are discussed and the data collection techniques explained and justified. The data collection methods used, including semi-structured interviews, observation and document analysis, are described and justified. Also discussed are the ethics processes undertaken by the researcher and the limitations of the methodology.

- In *Chapter 5* the method of analysis is presented, which in this research is the progressive comparison analysis method. The principles of progressive comparison, analytical induction and theoretical sensitivity, which are fundamental to the progressive comparison analysis method, are presented. The open, axial and selective coding processes used by the researcher to progress the collected data from the descriptive level to more abstract levels in order to answer the research questions and develop theory is explained. A framework used by the researcher to assist in the coding processes that conceptualises collaboration occurring at both vertical and horizontal levels is presented. This framework is shown to allow the researcher to incorporate issues such as hierarchy, structure, power and influence when collaborating and also allows the principles of collaboration, social capital and stakeholder theories to be incorporated when examining the data.
- *Chapter 6* introduces the voice of the participants by presenting their perceptions and views of collaboration, often in their own words. It identifies that for most interviewees collaboration represents almost all forms of cooperative relationships that aim to provide better youth health outcomes. However, in addition to altruistic motivations interviewees also revealed that for them collaboration is a particularly competitive and opportunistic process. They revealed that service providers often compete to develop salience so that they can better develop social capital and advantageous collaborative linkages with those stakeholders who provide opportunities for ongoing or future funding. Six characteristics that make stakeholders more salient than others in relation to collaboration are then presented, as is the identification of which characteristics service providers commonly attempt to influence.

- *Chapter 7* is the final discussion and conclusion chapter. The findings and analysis presented in Chapter 6 are synthesised in order to present the research conclusions and new theory relating to collaboration. Collaboration theory is presented, which shows that within the youth health context, competition initially drives collaboration but ultimately limits collaboration if overt competitive behaviour risks the salience or eminence of other youth health service providers involved in the collaboration. A new, more comprehensive theory of collaboration is presented that better explains the operationalisation of collaboration in the youth health sector by including the principle of salience and the competitive element or process of collaboration. Building on this knowledge a more contemporary definition of collaboration is presented. Also discussed are the implications for knowledge and practice and the limitations of the research. Last, future areas for research that can build on the research findings are identified.

### 1.13 Definitions of terms

Table 1.1 below explains some of the terms used in the text.

**Table 1.2: Definitions of terms**

Term	Definition and description
Collaboration	<p>‘The process in which autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationship and ways to act or decide on issues that brought them together; it is a process involving shared norms and mutually beneficial reactions’ (Thomson &amp; Perry, 2006, p. 25).</p> <p>In this thesis collaboration primarily relates to inter-organisational collaboration.</p>
Collaborations or Collaborative networks	<p>The structures or groups of stakeholders involved in collaboration or ‘multi-organisational arrangements for solving problems that cannot be achieved easily, by single organisations’ (Agranoff &amp; McGuire, 2001, p. 296).</p>

<b>Term</b>	<b>Definition and description</b>
Collaborative advantage	<p>‘the synergistic and otherwise unreachable outcomes available through cooperation’ (Hibbert &amp; Huxham, 2005, p. 59).</p> <p>‘Something that is achieved that could not be achieved without collaboration’ (Huxham &amp; Vangen, 2000, p. 1160).</p>
Collaborative effort	‘the primary method for achieving ideal short term and/or long-term goals that would not otherwise be attainable as entities working independently’ (Gajda, 2004, p. 65).
Competition	‘To be in competition, organisations are usually assumed to be similar in form and interdependent, competing for similar scarce resources to survive’ (Wolfram Cox, Mann & Samson, 1997, p. 286).
Competitive tendering	‘the process of selecting a preferred supplier from a range of potential contractors by seeking offers (tenders) and evaluating these on the basis of one or more selection criteria’ (Commonwealth Department of Health and Family Services, 1998, p. 7).
Stakeholders	Synonymous with key players and are ‘any group or individual who can effect or is effected by the achievement of the organisation’s objective’ (Freeman, 1984, p. 46).
Youth	Synonymous with adolescents and are ‘young people aged between 12 and 24’ (NSW Department of Health, 2010a, p. 3)

### **1.14 Delimitations of scope and key assumptions**

This research has a number of key assumptions. It assumes that those working within the youth health sector have an overarching or superordinate goal of assisting youth in need to the best of their ability.

This research also assumes that collaboration and collaborative activities are already being undertaken by those working in youth health, both in intra- and inter-organisational contexts. However, the research participants more commonly referred to inter-organisational collaboration rather than intra-organisational collaboration and thus, inter-organisational collaboration was the focus of this research.

As this research accepts that collaboration and collaborative activities are already being undertaken by those working in youth health, this research assumes that the examination of collaboration may lead to more effective collaboration and that research findings may potentially relate to better youth health outcomes. However, this research is not an examination of the effectiveness of youth health services but an in-depth analysis of collaboration as operationalised in a particular context in order to address the research aims.

In this research, all research participants were employed in the youth health sector in western Sydney. They were from both government and NGOs, including a peak coordinating organisation that was instrumental in promoting collaboration in the creation of youth health policy. This research accepts that the impact of the context and environment on collaboration makes the generalisation of findings to broader contexts problematic. However, the network of youth health service providers studied in this research shares similarities with other networks of youth health services providers, particularly those in metropolitan areas of Australian cities with lower socioeconomic characteristics. While recognising this limitation, this research assumes that findings are relevant to the organisations involved and may also have a degree of usefulness for other youth health networks and the development of wider collaboration theory.

### **1.15 Chapter summary**

This chapter began by introducing collaboration as a contemporary management strategy being advanced in government policy to better deliver youth health services by promoting stronger linkages and working relationships between youth health service providers.

However, this chapter identified that the impact of particular contextual factors when collaboration is operationalised or enacted in a government-coordinated network, particularly youth health networks, is unclear. These contextual factors included the impact of existing management strategies on collaboration, the impact of policy promoting collaboration and enforced or coerced collaboration. Consequently, it was shown that research into what helps and hinders collaboration within a network of organisations involved in the provision of

youth health services and what may impact on the willingness of stakeholders to engage in collaboration was justified.

This chapter presented the principles of collaboration, stakeholder and social capital theories and how they enable better understanding of collaboration and its effectiveness in achieving the benefits promised. The research questions were then presented as was the justification of the research, including theoretical and applied benefits. Theoretical benefits included advancing theory on collaboration and applied benefits included assisting government, those managing and involved in collaboration and ultimately assisting those who benefit from better youth health services: youth in need.

The context of the youth health sector was briefly described in order to show that the fragmented nature of youth health service delivery and the involvement of government and NGOs provided an ideal context in which to examine collaboration. This chapter then introduced qualitative multi-case study research as an appropriate research framework for understanding the perceptions and views of those working within the sector and involved in collaboration and collaborative activities. Finally, definitions of terms were presented and delimitations of scope and key assumptions were identified. As such, it was shown that the researcher assumes that better understanding of collaboration will assist those involved in collaboration to better deliver youth health services



## **Chapter 2: Context: youth health services**



## 2.1 Introduction

The previous chapter introduced the research and its aims and objectives. It presented the research questions and justified the theoretical value of research into collaboration and potential applied benefits. It highlighted that increased understanding of collaboration is required when enacted or operationalised in a context where competitive tendering processes and individual organisational accountability associated with the principles of New Public Management (NPM) coexist with government policy promoting collaboration. Also highlighted was a need to understand the impact of coerced or enforced collaboration on those working within the youth health sector and a requirement to understand who has more or less influence in the process of collaboration when taking contextual factors into account. In this chapter, the researcher shows that the youth health sector is an ideal context to undertake research into collaboration. More specifically, the youth health sector provides an opportunity to examine collaboration when it is enacted in forms that may be both enforced and voluntary. In addition, the youth health sector provides an opportunity to analyse collaboration when enacted in a context where governments concurrently promote the principles of collaboration and NPM aiming to more effectively and efficiently deliver youth health services.

The researcher acknowledges that any evaluation and examination of collaboration ‘must take cognisance of the context within which the policy or program is located’ (El Ansari, Phillips & Hammick, 2001, p. 218). This means the contextual factors associated with the youth health sector impact on how collaboration is enacted and hence, influence the research findings.

This chapter begins with evidence that providing youth health services has current and future social, moral and economic benefits for youth in need, government and society. Following on, it will be clear to the reader that youth health is but one government priority related to community health funding. The fragmented nature of youth health service delivery is also discussed to illustrate why government is making attempts to reform the sector through promoting collaboration, followed by discussion on how collaboration is being promoted as a response to criticisms of NPM. The result is that those working within the youth health sector are required to both collaborate and compete for funding, and individual organisations are financially accountable for their deliverables.

But first, the researcher will discuss why governments invest in youth health.

## **2.2 Reasons to invest in youth health**

Youth is a period where young people are forging a sense of identity, independence and autonomy (Burt, 2002; Kang et al., 2005). They are open to new ideas and experiences and are learning about the world. As a result, they are often engaging in what many consider risky activities (Burt, 2002; NSW Centre for the Advancement of Adolescent Health, 2005; NSW Department of Health, 2010a; Sturrock et al., 2007). Around one-fifth of all young people experience some major health problem including unintentional or self-inflicted accidents and injuries, mental health problems such as depression, anxiety and suicide, substance abuse and they may contract sexually transmitted diseases (NSW Department of Health, 2010a, p. 16). One-third of Australian youth are obese, 46% under-exercise, 95% do not eat the recommended amount of vegetables and 63% suffer from long-term medical conditions lasting six months or more (Australian Institute of Health and Welfare, 2007; NSW Department of Health, 2010a). Emerging additional health concerns for youth relate to the overuse and abuse of emerging technologies, resulting in problems such as cyber-bullying and high anxiety (Australian Institute of Health and Welfare, 2011).

Such disorders can result in social distress for youth and their families and result in high costs for treatment (Burt, 2002; McGorry et al., 2007). They can also lead to ‘enduring disability’ (McGorry et al., 2007, p. S5), which may include poor family and social functioning, failure in school and unsuitability for employment (McGorry et al., 2007). In addition, such disorders are difficult to reverse and may require ongoing treatment (Burt, 2002; McGorry et al., 2007). Similarly, the money invested by governments to get children to the youth or adolescent stage of life is considered wasted if high-risk health behaviours are developed (McGorry et al., 2007). Consequently, not only is the period of youth an opportunity to address negative health issues but evidence makes it clear that not addressing youth health concerns has ongoing negative repercussions for youth in need and broader society.

Healthy individuals are less likely to be a burden on the social welfare and healthcare systems and are more likely to contribute more in tax (Burt, 2002; Duckett & Willcox, 2011).

Research into the youth health sector is justified because healthy, productive and well-educated individuals are future social capital that will contribute to the social, moral and economic development of countries and populations (Burt, 2002; McGorry et al., 2007).

With potential benefits of investing in youth health evident, assisting the sector to achieve these benefits is critical. This research can contribute by understanding how collaboration as

a management strategy is enacted within the youth health sector. Without this research, the benefits of collaboration promoted by government and within the literature may not be maximised within the unique context of youth health.

### **2.3 Youth health services**

Youth health service provision is primarily undertaken by mainstream medical services. For example, youth are more likely to turn to general practitioners when dealing with a health issue (NSW Department of Health, 2010a). However, mainstream medical services are not usually youth specific, nor do they often tailor their services to the particular needs of at-risk youth (Bernard et al., 2004). For example, general practitioners frequently do not bulk-bill nor accept youth without a Medicare card. Mainstream medical services are also often perceived as unfriendly by many at-risk youth, as well as reluctant to provide treatment or unable to provide the treatment required (Bernard et al., 2004). In addition, general practitioners often don't have youth-specific training to put at-risk youth at ease (Bernard et al., 2004). For this reason, a number of specific youth health services catering to at-risk youth have been created. These youth health services can be defined as 'specialist health services providing multi-disciplinary, primary healthcare to young people' (NSW Department of Health, 2010a, p. 27). They range from general medical services to specialist mental health services. The diverse range of services provided include creative arts projects, education, hygiene services, drug and alcohol education, sexual education, legal services, housing and counselling. Specialist youth health services vary in focus but can generally be described as taking a more holistic view of youth health and focus on prevention as well as treatment (Burt, 2002). In addition, youth health services are often required to liaise with other non-youth-specific community services such as police, homelessness services, justice and welfare services. With such a broad agenda, the sector is characterised by a complex and diverse array of services, professionals and funding arrangements. The requirement to involve multiple services due to the health requirements of youth became evident whilst interviewing research participants when a youth health practitioner said:

I think when you are working with young people, especially the young people we work with that are so complex you often have numerous other services involved (GY7).

Youth health service provision involves bringing together a range of specialist services from government, non-government and private service providers. As such, the sector is characterised by high levels of interdependence. For this reason, the youth health sector

provides an excellent opportunity to examine perceptions and views of those from both government and non-government organisations involved in collaboration.

## **2.4 Funding for youth health**

Funding for youth health services comes primarily from governments (Commonwealth and state) but also from private organisations and philanthropic entities. Funding for youth health services is associated with a diverse array of programs and often does not have its own category or funding classification. As a result, delineating clear figures for youth health funding from other programs is problematic. Youth health funding is classified under the broad category *Community Health and Other* in the Australian Commonwealth Government financial statements (Australian Institute of Health and Welfare, 2012) to which the Commonwealth government contributed \$6.3 billion in 2010–2011 whilst state and territory governments contributed \$5.9 billion (Australian Institute of Health and Welfare, 2012).

Funding for non-government organisations (NGOs) providing youth health services comes from a variety of sources including religious organisations (i.e. Anglicare, Salvation Army and Wesley Mission), private donations and government grants and competitive tendering processes (Australian Institute of Health and Welfare, 2012). In addition, religious organisations involved in providing youth health services also receive government funding (Duckett & Willcox, 2011). Due to the diverse nature of NGO funding and the health services they provide, the exact figures for NGO funding for youth health is unclear.

Despite the vagueness of exactly how much youth health costs, the influence of government funding is significant, and governments have an obligation to the electorate to ensure money allocated to community health and youth health results in optimum social benefit (Duckett & Willcox, 2011). For this reason, governments focus on the effectiveness and efficiency of youth health service delivery by examining ways to increase system capacity, maximise the use of resources, improve the effectiveness and efficiency of service provision and demonstrate greater transparency and accountability (Duckett & Willcox, 2011).

Funding can also shift as political priorities change. To contend with shifting political priorities, the youth health sector has a number of advocacy organisations, both government appointed and membership based, lobbying for government funding and support.

Scholarly literature to date is not clear on whether collaboration increases the efficiency and effectiveness of youth health service delivery. However, as youth health services accounts for

a significant amount of government expenditure and as government is also promoting collaboration as a means to better deliver youth health services, analysis of collaboration in this context is required.

## **2.5 Fragmented provision of youth health services**

Rapid changes in physical, psychosocial and social behaviours of youth can cause ‘unique disease patterns, unusual symptom presentation’ (Sturrock et al., 2007, p. 50), creating a myriad of specialised services with claims that service provision within the sector is fragmented (Kang et al., 2003; Kang et al., 2005; McGorry, 2007). It is also claimed that fragmented service provision within the youth health sector has resulted in poor access to services and high levels of unmet demand (Kang et al., 2003; Kang et al., 2005; McGorry, 2007). It has also resulted in poor linkages between services and ‘increased the risk of services working in isolation, duplicating program efforts or recreating project resource materials’ (NSW Centre for the Advancement of Adolescent Health, 2005, p. 8).

Furthermore, fragmented service provision has resulted in inconsistent levels of communication and coordination, inefficiency and the prevention of innovation (Booth et al., 2002; Lowcay & Kalucy, 2003; NSW Centre for the Advancement of Adolescent Health, 2005) within the sector. This was observed when interviewing research participants, where one youth health practitioner stated:

It [the youth health sector] just feels really piecemeal at the moment. Everyone is doing good stuff, but we are duplicating a lot of services and are we wasting a lot of services, you know, I mean, even our service. I don’t think it [the youth health sector] works as efficiently as it should (CY2).

Hence, the sector is not operating at its optimum efficiency and effectiveness and thus provides ‘unique communication and healthcare management challenges’ (Sturrock et al., 2007, p. 50). For this reason, research by the NSW Centre for the Advancement of Adolescent Health (2005) into the deficiencies of the sector calls for reform and proposes ‘strategic approaches/protocols for working intra and inter-organisationally in order to capitalise on the benefits of collaboration and partnerships’ (p. 51). Therefore, this research, which examines what helps and hinders the development of collaborative linkages between service providers, is warranted. It is also necessary because the ability of collaboration to make the sector more effective and efficient remains unknown.

The call for increased collaboration is reflected in the NSW Youth Health Policy 2011–2016: Healthy Bodies, Healthy Minds, Vibrant Futures. This reform is an incentive to undertake this research and is discussed in greater depth in the following section.

## **2.6 Government reform**

The New South Wales Government has acknowledged the need for reform in the youth health sector and released the NSW Youth Health Policy 2011–2016: Healthy Bodies, Healthy Minds, Vibrant Futures in November 2010. This policy promotes collaboration as a management strategy aimed at achieving government and community youth health outcomes within New South Wales. This policy proposes working ‘collaboratively with private healthcare providers, other government agencies, non-government organisations and young people to focus its efforts on activities that support and encourage young people to develop and maintain healthy attitudes, lifestyles and behaviours in adolescence’ (NSW Department of Health, 2010a, p. 6). This implies that collaboration and the development of strong linkages between service providers is a means to supply health services, both mainstream and specialist, to young people who may be outside the scope of government services, resourcing or political priorities. As such, collaboration is perceived by government as a management strategy to more effectively and efficiently deliver youth health services by coordinating service delivery, utilising all the resources available within the community and streamlining program design and administration across different agencies. However, there is a lack of scholarly literature describing how it is operationalised within the youth health sector or whether those within the sector perceive it as achieving the goals proposed by government and for what reasons.

Government promotion of collaboration is particularly evident in government research reports (Booth et al., 2002; Kang et al., 2005; NSW Centre for the Advancement of Adolescent Health, 2005; NSW Department of Health, 2010b) fundamental to the development of the recently released NSW youth health policy. However the policy itself does not define collaboration, but rather calls for ‘collaborative action between services’ (NSW Department of Health, 2010a, p. 10). As such, the policy is vague in terms of defining collaboration but does bundle the term with other terms of a cooperative nature such as *partnering* and *networking* to explain the types of activities they prescribe. In addition, the policy does call for ‘new protocols for service delivery; strategies for sharing information and the provision of services’ (NSW Department of Health, 2010a, p. 10). Consequently,

collaboration is perceived as a change process to achieve policy outcomes. The use of prescriptive terminology is not really helpful in terms of how collaboration should take place or a reflection of how it is currently taking place. In fact, it seems that prescribed collaboration is merely rhetoric. Once again it confirms that the context of youth health, where collaboration is also decreed through competitive tendering, is an ideal context to study collaborative processes.

Although only recently promoted in government policy, cooperative or collaborative relationships between youth health service providers is not a new concept. Individuals and businesses have been involved in cooperative relationships in order to achieve objectives since trading began (McGuire, 2006). Even in the context of public administration the three tiers of Australian, state and local governments have often cooperated and still do (McGuire, 2006). In the area of primary and community healthcare, this also extends to government linking up with non-government and private organisations. Interestingly, research by Daley (2009) showed that collaborative rates *between* government health organisations were almost twice that of their non-government counterparts. However, the willingness of service providers to engage with either government or NGOs in a context where there is both decreed and voluntary collaboration is unclear. Therefore, the youth health sector provides a unique opportunity to research collaboration.

Although non-peer-reviewed, research sponsored by the government coordinating agency, the NSW Centre for the Advancement of Adolescent Health, which was instrumental in writing the youth health policy, defines and prescribes collaboration within the youth health sector as when:

[s]ervice providers (within a service, as well as different services within and across sectors) who share common service goals and target groups, network, communicate and/or work together to plan, deliver, review and evaluate their service provision to young people with a clear delineation of responsibilities (Kang et al., 2005, p. 20).

This definition describes collaboration as a process and emphasises the commonality of the goal, which is youth health service provision. But it also acknowledges that along with the relational and communicative nature of collaboration there are roles and responsibilities within the collaboration process, including reviewing and evaluating stakeholders and their contribution. As such, there is an emphasis on accountability and responsibility to other stakeholders involved. However, there is no mention of how agreement is reached, or who

has these roles and how these roles are appointed or agreed upon. Furthermore, this applied definition does not show how accountability is enforced and what penalties exist for non-delivery and noncompliance. It emphasises a governance process but lacks details on how this is operationalised or should be operationalised within the youth health sector. However, this definition of collaboration illustrates the complicated and multi-layered nature of collaboration and exemplifies the need for deeper understanding. Although this definition exists within government-sponsored research, is not evident within the youth health policy. This indicates an uncertainty by government to prescribe how collaboration should occur for service providers within the sector, yet acknowledges a desire for collaboration and the benefits it is proposed to offer.

The promotion of collaboration in the youth health sector exemplifies that government is adopting collaboration as a management strategy to more effectively and efficiently deliver youth health services. This is important for government as it is held accountable to the electorate for the effectiveness of its programs and spending, particularly as governments funded 69.1% of total health expenditure in 2010–2011 (Australian Institute of Health and Welfare, 2012). However, the literature is uncertain and questions remain concerning the nature of the collaboration itself as promoted in policy, and also its meaning when operationalised or enacted in a network of organisations involved in the delivery of youth health services. For these reasons, this research examines these issues from the point of view of those working in the youth health sector and involved in collaboration or collaborative-like activities.

## **2.7 Collaboration in the youth health sector: one contemporary management strategy**

The above section illustrated that collaboration is being conceptualised by government as a management strategy used to assist in youth health service delivery. However, collaboration is not the only management strategy used by government to deliver youth health services. This section examines the development of collaboration as a management strategy and its coexistence or relationship with existing management strategies used by government, specifically New Public Management (NPM). This review is required as the principles of NPM are fundamental to the context in which collaboration is being promoted and enacted within the youth health sector.

### 2.7.1 New public management

NPM is a neo-liberal concept and ideology that emerged in the 1980s and 1990s to address public management issues such as the efficient and effective delivery of healthcare services, including youth health services (Degeling, Maxwell, Kennedy & Coyle, 2003; Fitzgerald & Ferlie, 2000; Mo, 2008). NPM emphasises a managerial or business perspective to managing healthcare organisations that is often referred to as the *business of health* (Braithwaite, 2004; Kippist & Fitzgerald, 2012). NPM involves governments setting targets and using incentives that emphasise management accountability (Rhodes, 1996). A result of NPM is that healthcare organisations are driven by the need for cost reduction, performance measures and organisational efficiency (Braithwaite, 2004; Rhodes, 1996).

NPM also involves reducing the division between public and private organisations in the delivery of health services (Dunleavy & Hood, 1994). NPM involves governments shifting some of the responsibility and functions for service delivery away from government to the non-government and private sectors (Dunleavy & Hood, 1994). This is particularly evident in the context of youth health service delivery.

Central to NPM in the youth health sector is competition between service providers, particularly NGOs, for funding grants. The process of competing for funding grants is commonly referred to as competitive tendering, which can be defined as ‘the process of selecting a preferred supplier from a range of potential contractors by seeking offers (tenders) and evaluating these on the basis of one or more selection criteria’ (Commonwealth Department of Health and Family Services, 1998, p. 7).

For government funding organisations, competitive-tendering processes comprise the following elements:

1. specifying the outputs/products, activities, and/or outcomes to be achieved by the successful tenderer/s,
2. deciding the tender strategy,
3. establishing the criteria — or sets of criteria depending on the number of stages — for selecting successful tenderers, and
4. evaluating potential suppliers and their bids (Commonwealth Department of Health and Family Services, 1998, p. 7).

Mandated partnerships decreed by government funding organisations are sometimes central to tendering conditions. Collaborative arrangements for participants in competitive tendering processes are also often required to achieve performance targets set by funding organisations, often government. Consequently, the youth health sector offers a prime opportunity to examine the perceptions of those involved in collaboration to understand how mandatory and voluntary collaboration impact on how they collaborate.

The Commonwealth Department of Health and Family Services (1998) claims that the aim of competitive tendering is not competition per se, but rather ‘to facilitate effective competition to promote efficiency and economic growth while accommodating situations where competition does not achieve efficiency, or conflicts with other social objectives’ (p. 7). Hence, the government also uses conventional grant and funding processes within the youth health sector as evidenced by the existence of more securely funded government youth health service providers who are less reliant on funding related to competitive tenders. As such, the youth health sector allows for comparisons between those service providers who have more or less secure funding in terms of their willingness to collaborate. It also allows for examination of the impact of competitive tendering processes on collaboration within the youth health sector.

By the late 1990s criticisms had emerged of NPM, including whether competition, privatisation and specialisation of service delivery result in socially acceptable levels of health service provision (Duckett, 2007). For example, Ling (2002) argues that NPM results in a management focus towards organisational performance rather than system-wide health objectives. The literature also suggests that competition for funding in community services resulted in an emphasis on autonomy as organisations compete for funding to ensure their survival (Fine, 1995). A negative repercussion of this is that the horizontal linkages between organisations are restricted (Ling, 2002) and as a consequence ‘left government less, rather than more able to solve the important “wicked” problems’ (6, 1997, pp. 9–10) such as youth health delivery. By not developing horizontal linkages, Kettl (1996) argued that NPM was not effectively addressing the interdependence between agencies and not building critical synergistic linkages between them. Consequently, NPM was not maximising efficiencies and not creating an acceptable level of health service delivery or accessibility for those requiring health services (Hill & Lynn, 2003). The relationship between NPM and collaboration as perceived by those working within the youth health sector is unknown. Therefore, the youth

health sector offers an excellent opportunity to examine collaboration in a context where values of NPM are already entrenched.

### **2.7.2 Emergence of collaborative management strategy**

As a result of criticisms that NPM does not address interdependence between agencies nor build synergistic linkages, collaboration was promoted as a more contemporary, effective and efficient form of organisation to mobilise government, non-government and private organisations involved in delivering health services (Hill & Lynn, 2003; Kettl, 1996). This is because collaboration focuses more on developing and utilising horizontal linkages and on cooperative arrangements between health service providers rather than the traditional hierarchical relationships or economic- or market-based competitive processes (McGuire 2006).

By focusing on these horizontal linkages, collaboration is said to result in *collaborative advantage* (Huxham, 1993, 1996). In the youth health sector, collaborative advantage involves developing cooperative working relationships, both horizontal and vertical, amongst health service providers to provide a range of services to youth in need that individually would be otherwise impossible to provide. Consequently, collaboration is often perceived as contrasting to existing strategies.

The proliferation of literature espousing the benefits of horizontal linkages supports the notion that collaboration offers a new and more effective way of managing or organising resources leading to some scholars claiming ‘it is the age of network and collaboration’ (McGuire, 2006, p. 34). In fact, Gajda (2004) contends collaboration goes beyond a management strategy and can be referred to as an ideology, worldview or culture that is required to address complex public management issues. In the case of this research, the complex management issue is youth health service delivery. However, whether collaboration achieves the benefits espoused within the literature is not clear, particularly in a government-coordinated youth health network involving government and non-government youth health service providers. Therefore, the context of youth health offers an opportunity to examine the enactment of collaboration and to make comparisons with the rhetoric of collaboration within policy and within the literature.

The coexistence of collaboration and NPM in the context of the not-for-profit sector is considered within the literature. However, scholars specifically focus on the comparisons

between collaboration and competition. For example, Lamont (1991) concludes that collaboration and competition are polar opposites. Lamont (1991) states that ‘competition entails hiding, preserving and protecting something for yourself’ (p. 25), whilst in comparison to the individualist goals of competition, collaboration means ‘sharing for mutual gain or benefit’ (Lamont, 1991, p. 25). Therefore, the youth health sector is a prime context to examine collaboration as it offers a context where the competitive principles of NPM are intertwined with the promotion of collaboration when delivering youth health services.

Scholars have been critical of the impact of competition on collaboration within the health context. In the context of community services, Valente, Coronges, Stevens and Cousineau (2008) argue that competition between services negatively impacts on collaboration. This finding is supported by Gordon (2007) who argues that obstructions to collaboration are ‘exacerbated by the inherently competitive nature of economic development’ (p. 73). Gordon’s (2007) findings also show that a history of altruistic values will result in higher levels of collaboration whilst alternatively a competitive past hinders future collaborative activities. John, Ward and Dowding (2004) conclude that competitive tendering was open to political influence and did not improve the quality of bids for funding whilst Prins (2010) claims that competition negatively impacts on collaboration as competitive values make it difficult to establish direction and create collective goals. Prins (2010) also argues that competition between participants makes it difficult to keep the interdependent domain as the focus of change due to uncertainty of outcomes and working with others. Stevenson (2007) concludes that it is problematic for government to gain improvement through both collaboration and competition. These findings are interesting as in the context of youth health, collaboration is enforced in competitive tendering processes and, as such, reinforces that the youth health sector is an apt context to undertake this research. Consequently, this research addresses the lack of clarity in understanding concerning the effectiveness of combining the principles of competition and collaboration within the youth health sector.

What the above illustrates is that literature promoting collaboration rarely acknowledges competition, but when it does it is commonly presented as a contrasting management or organisational strategy. Because of this, the literature often polarises any relationship between collaboration and competition and downplays any internal competitive processes that may exist within collaboration. Nor does the literature examine mandated collaboration based on competitive tendering or whether NPM is helping or hindering collaboration within the youth health sector. As such, there is a gap in understanding that this research addresses.

This gap is addressed by acknowledging that the youth health sector provides an opportunity to examine collaboration where service providers are compelled to consider both collaboration and competition.

Therefore, by situating this research in the youth health sector this research critically examines whether collaboration delivers on the benefits it is proposed to offer when applied to the context of youth health, particularly from the point of view of those working in the youth health sector. In addition, research reported to date is inconclusive as to the relationship between competitive values, such as those associated with competitive tendering, and the impact these have on collaboration, particularly in the youth health sector. This research bridges this gap in understanding by examining collaboration as it is being enacted within a context where the management strategies of NPM and collaboration are occurring concurrently.

## **2.8 Chapter summary**

This chapter shows that the youth health sector is an ideal context to undertake research into collaboration for a multitude of reasons. First, research assisting the sector to operate more effectively and efficiently has moral, social and economic benefits. Second, the fragmented nature of service delivery and the interdependence of service providers show a need to develop more synergistic linkages between service providers. Third, in an effort to achieve better linkages between service providers and improve service delivery, the NSW government has recently introduced policy promoting collaboration. However, the rhetoric used by government to promote collaboration is unclear concerning how collaboration should take place or a reflection of how it is taking place. Fourth, this policy is being introduced in a context where the principles of New Public Management (NPM) are entrenched, including competitive tendering processes of which some scholars argue negatively impact on collaboration. Included in competitive tendering are mandated, coerced and voluntary collaboration. Hence, this context allows examination of how decreed, enforced, coerced and voluntary collaboration impacts on the willingness of participants to engage in collaboration and for what reasons. Last, there is no research to date examining how collaboration occurs within the youth health sector or whether those working in the sector feel collaboration is achieving espoused benefits and why. Hence, this section has shown that the youth health sector provides an excellent opportunity to conduct research into collaboration.



## **Chapter 3: Literature review**



### **3.1 Introduction**

The previous chapter acknowledged that the youth health sector provides an ideal context in which to conduct the research due to unique contextual factors including enforced collaboration and the coexistence of competitive tendering practices and policy promoting collaboration.

In order to advance theory and knowledge of collaboration, a more complete understanding of existing literature of collaboration is required to identify existing levels of knowledge and to identify where knowledge can be advanced. This chapter presents a critique of the literature on collaboration, social capital and stakeholder theory. This literature review also shows that each theory is insufficient in addressing the aims of the research but does have elements that can assist the researcher to advance collaboration theory. It then shows that by combining and applying their principles to the research process, collaboration theory can be expanded and extended.

More specifically, in addition to utilising collaboration theory to address the aims and objectives of this research, this research uses principles associated with stakeholder theory and social capital theory to better understand collaboration when enacted or operationalised within the youth health sector. The use of social capital and stakeholder theories allows the researcher to better scope collaboration research to identify how social capital relates to stakeholder salience when collaborating. In doing so, this literature review shows that research on the relationship between social capital and stakeholder salience for those involved in collaboration is unclear, particularly in a context where competitive principles associated with New Public Management (NPM) and enforced collaboration are the norm.

This literature review begins by restating the broad research problem and linking it to the research questions. In so doing, it is clear that there is a need to analyse collaboration in the unique context of a youth health network, where collaborative efforts are variously voluntary, coerced and strongly enforced through policy. In this context, collaboration takes place in an environment where participants have altruistic motivations and requirements to consider economic and performance implications. The research problem shows a need to compare the existing positions of influence within the sector to those factors or characteristics that influence the salience or importance of stakeholders emerging through the process of collaboration.

Following on, this literature review defines collaboration and shows that definitions emphasise goals, structure and interrelational processes. Collaboration is then differentiated from other cooperative arrangements. To understand the complicated nature of its definition, the dimensions and principles of collaboration theory are reviewed. This examination shows that extant collaboration theory is descriptive and even prescriptive. It is evident that collaboration theory lacks clarity and imposes unhelpful assumptions concerning some key issues relevant to organisations that are collaborating and involved in the provision of youth health services in a government-coordinated youth health network.

A review of this literature identifies that collaboration provides a number of advantages in terms of achieving individual organisational and collective goals. However, it also shows that collaboration involves potential cost and risk to participants. Hence, a review of collaboration when enacted in the youth health sector is required, particularly when accounting for contextual impacts on collaboration.

To better explain the dynamics at play when collaboration is enacted within the youth health sector and to explain the willingness of participants to be involved, this research utilises stakeholder theory and social capital theory. By reviewing these theories this literature review shows that due to the relational nature of collaboration, social capital theory gives deeper understanding of the contextual factors impacting on collaboration when enacted in a government-coordinated youth health network. It also shows that stakeholder theory allows for the identification of who the key players involved in collaboration are, who demands more or less action from other stakeholders and why they are more or less important or salient than other stakeholders (Mitchell et al., 1997).

Next, this literature review reiterates the purpose of this research and identifies how the intersection of collaboration theory, stakeholder theory and social capital theory can assist in addressing the research problem and the identified gaps in theoretical knowledge. The research questions are then presented with an explanation of how they can each address gaps in knowledge identified in the literature review.

This literature review concludes by making explicit the theoretical contribution that this research adds to understanding collaboration when enacted in a government-coordinated network of organisations involved in the provision of youth health services.

### 3.2 Research problem

Collaboration is a strategy being championed by the NSW Government in its youth health policy as a means to improve the delivery of youth health services in New South Wales. Collaboration is being promoted in the current environment of NPM, which involves governments setting targets and utilising competitive tendering processes that sometimes mandate collaboration between service providers (Head, 2010; Osborne, 2006). This is in addition to a willingness to be involved in collaboration due to altruistic motivations, employment requirements and funding or economic necessities. Key stakeholders influencing collaboration also include those not directly involved in collaboration such as users of services and funding organisations including government.

The youth health sector has unique contextual factors that impact on collaboration. These contextual factors require examination and understanding so that they can be better managed to help collaboration achieve the benefits that government and scholars promote. Therefore the problem statement for this research is:

There is a lack of understanding relating to how collaboration is operationalised in the youth health sector where involvement in collaboration is coerced and enforced by government and where governments concurrently promote collaboration and competitive principles and individual organisational accountability associated with the principles of New Public Management (NPM).

Implicit in this problem statement is a need to examine and understand whether collaboration achieves the benefits it is proposed to offer. Research is also required to ensure that the efforts of government are directed to areas with the most impact on improving the provision of youth health services for those in need. The research problem statement acknowledges contextual factors impacting on collaboration. To examine the impact of contextual factors on collaboration within the youth health context, the research examines who collaborates in the youth health sector and why, the impact of collaboration on the youth health sector and the operationalisation or enactment of collaboration in the youth health sector. Thus, the research questions are:

1. Who collaborates in the youth health sector and why?
2. What are the impacts of collaboration within the youth health sector?
3. How is collaboration operationalised or enacted within the youth health sector?

These research questions are broad and can encompass a variety of theoretical perspectives. To give these research questions focus and traction this research applies a combination of theoretical principles from collaboration, social capital and stakeholder theories. The application of principles from these theories allows the researcher to examine and understand the research problem in a unique fashion. As the following literature review reveals, combining the theoretical principles of these three theories allows the researcher to address the following theoretical research problem:

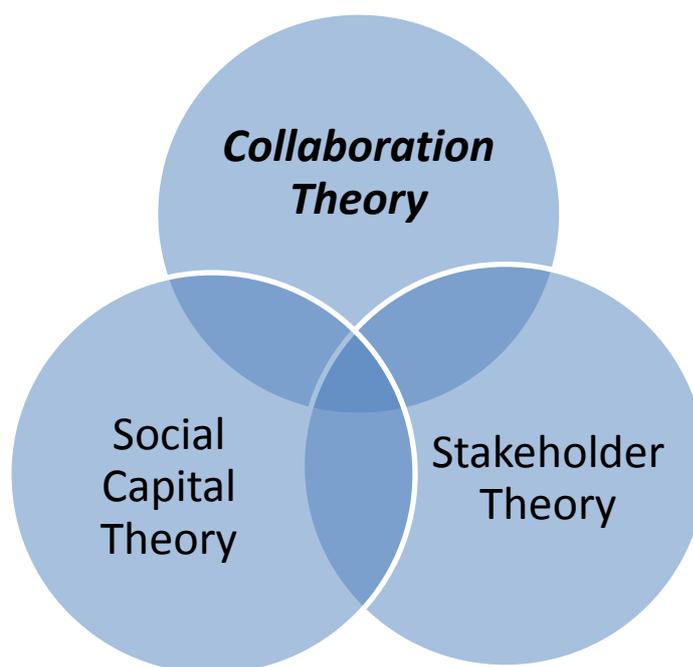
There is a lack of understanding about how and why social capital is developed, maintained, used, depleted and competed for by stakeholders within a collaborative network in order for stakeholders to be more salient to network members and external stakeholders and what salience is based upon when collaborating.

This section has made explicit the links between the research problem, the research theoretical problem and the research questions. It has shown that this research combines the principles of collaboration, social capital and stakeholder theories to understand how collaboration is enacted or operationalised in the context of a government-coordinated youth health network. This research is novel as it casts a critical eye over collaboration and delves deep into the operationalisation or enactment of collaboration to better understand the dynamics of collaboration when applied to a particular, previously unexplored context.

Now that the research problem, the research theoretical problem and the research questions have been linked, the literature review continues with a review of collaboration and collaboration theory to give the reader a better understanding of collaboration.

### **3.3 Collaboration theory**

Collaboration theory is the first theory of the theoretical framework used to better understand collaboration when operationalised in the youth health sector to be reviewed (see figure 3.1). Collaboration theory describes the elements or principles and processes required for successful collaboration. However, there is ambiguity to this theory when considering the impact of contextual factors particular to the youth health context such as enforced or mandated collaboration and collaboration promoted in policy. Following on from the discussion on collaboration theory, will be discussions on social capital theory and then stakeholder theory.



**Figure 3.1: Collaboration theory within the research theoretical framework**

### **3.3.1 Defining collaboration**

Within the NSW Youth Health Policy 2011–2016: Healthy Bodies, Healthy Minds, Vibrant Futures, collaboration is not defined. Rather, collaboration is variously described as an activity, process or normative goal in which participants within the youth health sector should engage to better deliver youth health services (NSW Department of Health, 2010a). Such prescriptive definitions or descriptions are common within management-directed literature, where the aim is to direct or manage the behaviour of participants (Keast et al., 2007). However, this research requires a deeper understanding of collaboration and what is actually enacted within the context of a government-coordinated youth health network.

Contrasting views or emphases by scholars in terms of defining collaboration have resulted in some scholars asserting that its meaning can be considered ‘elusive, inconsistent and theoretical’ (Gajda, 2004, p. 66). In terms of research, the ‘lack of consensus among scholars on the meaning of collaboration makes it difficult to compare findings across studies’ (Thomson et al., 2009, p. 24). However, this section shows that theorists mostly agree that collaboration is a communicative, relational, emergent and dynamic process (Gajda, 2004) that can occur between key players within a structure or network of participants in order to

gain both collective and individual outcomes. The following sections discuss goals, structures and interrelational processes that are commonly emphasised in definitions of collaboration and culminate in presenting the definition adopted for this research. However, they also make clear that generic definitions may not incorporate all the factors at play when collaboration is enacted within a particular context such as a youth health network. Consequently, they show that one difficulty in defining collaboration relates to the impact of contextual factors and thus definitions may need to be more context specific.

### *3.3.1.1 Collaboration as goal-oriented behaviour*

Commonly, definitions of collaboration emphasise working or coming together to take part in an activity or process to achieve an outcome (Huxham, 2003; McGuire, 2006; Thomson & Perry, 2006). However, the emphasis in the literature on who benefits from collaborative outcomes varies in terms of achieving individual or collective goals. Two schools of thought are evident within the collaboration literature, particularly public administration literature in regards to goal-focused definitions. Definitions of collaboration from the classic liberalism tradition emphasise collaboration to achieve individual goals (Thomson & Perry, 2006), whilst definitions of collaboration based in the tradition of civic republicanism focus on attaining collective goals larger than the goals of individual entities (Thomson & Perry, 2006). This section shows that both schools of thought focus on the goals of service providers rather than the recipients of services which in the youth health sector are at-risk youth. Nor do they address the salience or importance of stakeholders when collaborating to achieve particular goals.

In reference to public administration literature, definitions of collaboration based in classic liberalism emphasise collaboration as a means to achieve private interests and self-motivations by ‘aggregating private preferences into collective choices through self-interested bargaining’ (Thomson & Perry, 2006, p. 20). An example of a definition of collaboration based in classic liberalism is:

A mutually beneficial relationship between two or more individuals, groups or organisations, who jointly design ways to work together to meet their related interests and who learn with and from each other, sharing responsibility, authority, and accountability for achieving results (Schwarz, 2006, p. 282).

Classic liberalism with its focus on individual motivations is interesting in the context of youth health as stakeholders are brought together to collaborate with the common aim of

achieving better outcomes for youth health or the superordinate goal of youth health service delivery. In the context of youth health, service providers also collaborate to attain joint funding as part of competitive tendering processes. However, the relationship between altruistic values and individual organisational financial objectives is unclear, particularly in a climate of NPM where individual organisations are accountable in terms of their economic sustainability. In addition, each organisation's aims may vary considerably due to factors such as funding and ownership structures and varying obligations to policy.

Definitions based in classic liberalism imply that more powerful or salient organisations may benefit more from collaboration. However, power and salience of stakeholders is not explicitly addressed in classic liberalist definitions of collaboration. Also not explicit is who participants perceive as better or more legitimately able to deliver services when collaborating and why. Thus, this research is required as it examines the perceptions of those involved in collaboration to explain who participants feel are benefiting most from collaboration and why, and which stakeholders demand more attention than others when collaborating.

In contrast to definitions based in classic liberalism, definitions based in civic republicanism argue that collaboration allows for collective goals larger than the individual or entity involved (Thomson & Perry, 2006). These definitions assume that there is agreement between stakeholders and that the aims of the collaboration take precedence over individual stakeholder requirements. Such idealised assumptions may ignore the complexity of stakeholders' willingness to collaborate and their perceptions of the importance of collective objectives in comparison to individual organisational objectives, particularly in an environment of NPM that emphasises entrepreneurial management and individual organisational accountability (Osborne, 2006). An example of a definition based in civic republicanism that emphasises mutually beneficial collective goals is Gray's (1991) definition of collaboration that defines collaboration as 'a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible' (p. 5).

The contrasting views of both schools of thought are interesting in the context of youth health as both emphasise goals of the service providers and to a lesser extent the needs of the users of youth health services. The superordinate goal of service provision is less emphasised particularly in the classic liberalism definitions, where individual organisational goals could

possibly take precedent over collective goals. How participants perceive the legitimacy of their organisation to deliver collective goals as compared to others is unclear, particularly when altruistic motivations to help at-risk youth exist as an overarching or superordinate goal. Therefore, the researcher argues that definitions of collaboration based in the classic liberalism and civic republicanism traditions that emphasise an either/or of individual versus collective outcomes are somewhat simplistic. They are simplistic as they are unclear concerning the goals of other stakeholders such as users of youth health services and the outcomes or goals set by external parties such as government funding organisations. As such, it is unclear how individual or collective goals of participants in collaboration relate to stipulated overarching goals set by others.

In summary, definitions based in classic liberalism and civic republicanism do highlight the prioritisation of the individual or collective goals of service providers in a collaborative network. However, as this discussion has shown, the focus of these schools of thought on individual and collective benefits may not take into account the complexity of the youth health context. By examining the willingness or reasons why those in the youth health sector collaborate, this research examines which school of thought has more relevance to a context where collaboration is promoted by government to achieve collective youth health outcomes. Furthermore, it addresses the uncertainty of whether individual or collective goals are prioritised in a context where collaboration is coerced and enforced by government funding agencies, particularly when government sometimes sets the goals rather than the collaborative participants. By examining the perceptions of those involved in collaboration within the youth health sector and the outcomes they seek, this research will better understand the relevance of goal-focused theories of collaboration in relation to youth health.

Now that goal-focused definitions of collaboration have been discussed, the next section discusses definitions of collaboration that emphasise the structure of collaboration.

### *3.3.1.2 Collaboration as a structure*

In addition to emphasising collaboration as goal-oriented behaviour, collaboration can also be defined in concrete terms such as the tangible outcome of coming together. In other words, collaboration can mean a network or structure of organisations or people representing organisations coming together to achieve a desired outcome, such as committees, coordinating bodies, collaborative networks or even collaborations (Agranoff & McGuire, 2001).

Collaborative structures may involve participants beyond governmental, organisational and sectorial boundaries (McGuire, 2006). Participants may also be at different hierarchical and professional levels (McGuire, 2006). The settings and boundaries in which collaboration occurs can often be considered blurred or difficult to distinguish particularly as they may involve formal or informal linkages (Zhang & Huxham, 2009). However, examination of perspectives of collaboration from the point of view of managers, youth practitioners and administration staff working in government and non-government organisations (NGOs) in the not-for-profit sector is scarce. Also scarce is research examining the impact of government on collaborative structures when allocating resources through competitive tendering processes or how these may relate to emerging hierarchical structures when collaborating.

Scholars have attempted to distinguish between the different types of collaborative networks. Mandell and Steelman (2003) distinguish collaborative structures using the temporal dimensions: intermittent and temporary or permanent or regular. Mandell and Steelman (2003) also distinguish collaborative structures in terms membership, intensity of engagement and broadness of tasks. Agranoff (2003) goes further and distinguishes four different types of collaborative networks delineated by scope of activities. These networks are described as informational, developmental, outreach or action networks. However, whether such delineations are appropriate in the youth health context, where collaboration may involve multiple objectives and combinations of aspects of each different type of network and may also involve transient membership, is unclear. It is uncertain as there is a lack of empirical research on collaboration within the youth health context. As such, structural conceptualisations of collaboration in isolation may down play the organic and relational nature of collaboration.

Government policy promoting collaboration makes no delineation on the type of collaborative network that would maximise collaborative advantage within the youth health sector. Consequently, research on collaboration is required in the youth health sector. It is required as government influences the structures of collaborative networks through mandating participation and coercing involvement through rewarding particular outcomes. However, the influence of government mandates that enforce collaboration on the creation, sustainability and conclusion of collaborative structures is under-researched. This research addresses this vagueness and paucity by examining enforced collaboration from the point of view of those involved.

### *3.3.1.3 Collaboration as an interrelational process*

Thus far, this section has discussed the emphasis on goals and structure inherent in definitions of collaboration. Continuing on, this section shows that definitions of collaboration often conceptualise collaboration as a process involving humans and human relationships. This section also presents the process definition of collaboration used in this research and justifies why it is adopted.

Definitions of collaboration commonly include an emphasis on interpersonal relationships between two or more human elements within the process of collaboration (Alter & Hage, 1993; Levine & Moreland, 2004). Bailey and Koney (2000) agree that ‘although strategic alliance research focuses on organisations, the implementation of inter-organisational efforts has as much to do with individual relationships’ (p. 29). In fact, Gajda (2004) declares that when collaborating ‘the personal is as important as the procedural’ (p. 69). As such, the relational elements of trust and perceptions of others impact on the collaboration process (Levine & Moreland, 2004; Prins, 2006; Rocha & Miles, 2009; Thomson & Perry, 2006; Thomson et al., 2009; Vangen & Huxham, 2003). Therefore, this research focuses on analysing the perceptions of those involved in collaboration to explain how and why collaboration occurs within the youth health context.

An emphasis on relationships introduces the concepts of responsibility, authority and accountability and thus, power. Although definitions of collaboration often promote the sharing of responsibility, authority and accountability within collaboration, whether this occurs in reality within a youth health service network is unclear, particularly where stakeholders have varying obligations toward policy. Addressing the issues of responsibility, authority and accountability, Hanson (2006) calls for facilitating roles whilst Huxham and Vangen (2005) advocate for leadership to promote effective collaboration. How this power is enacted or leaders selected when collaboration is mandated or enforced by government, and how more or less influential positions are gained or accepted is unclear within the literature. More specifically, collaboration is under-researched in a network of youth health service providers, where government initiates collaborative action but has minimal influence in the operationalisation of the collaboration. In addition, why some stakeholders agree to less influential positions or roles when collaborating is also underexplored, as is what makes participants more or less influential or salient when collaborating. By examining the perceptions of those within the sector these issues are examined.

Definitions vary in the specifics of the relations underpinning the process of achieving outcomes. For example, Huxham and Vangen (2005) refer to collaboration as ‘any situation in which people are working across organisational boundaries towards some positive end’ (p. 4). Similarly, Wolfram Cox et al. (1997) contend that collaboration and cooperation are synonymous and involve different individuals, groups and organisations who engage in ‘non-competitive, mutually beneficial, win-win activities’ (Thomas, cited in Wolfram Cox et al., 1997, p. 290). Other scholars are more specific and refer to the process of collaboration involving ‘shared rules, norms, and structures, to act or decide on issues related to that domain’ (Wood & Gray, 1991, p. 146). As such, these more comprehensive, process-focused definitions of collaboration emphasise the collaborative goals, structures and interrelational aspects of collaboration. This research adopts Thomson and Perry’s (2006) more comprehensive process definition of collaboration which states that collaboration is a:

process in which autonomous actors interact through formal and informal negotiation, jointly creating rules and structures governing their relationship and ways to act or decide on issues that brought them together; it is a process involving shared norms and mutually beneficial reactions (p. 25).

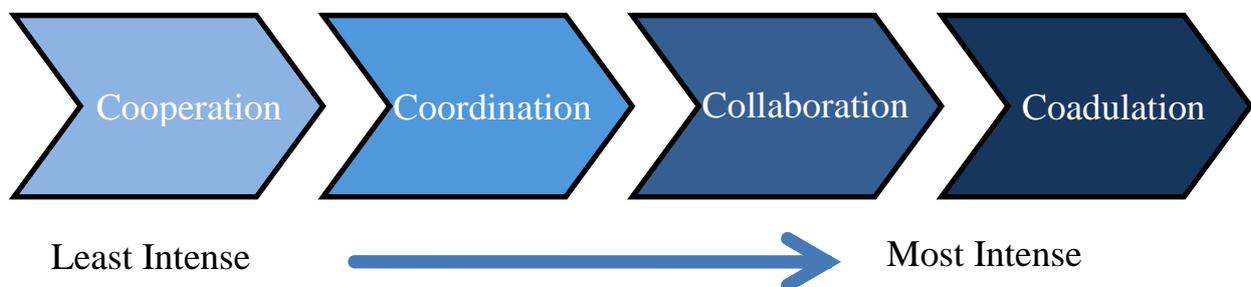
This contemporary process definition emphasises that collaboration involves the principles of governance, administration, mutuality, agency, or organisational autonomy and norms of trust and reciprocity (Thomson & Perry, 2006; Thomson et al., 2009). It emphasises the interrelational and structural nature of collaboration and the principles required to be addressed so that collaborative goals are achieved. Ring & Van de Ven (1994) contend that implicit in these principles of collaboration are negotiation, commitment, execution and assessment processes. These principles and process are discussed at length later in this chapter.

Although this research adopts this generic process definition of collaboration, there is no empirical evidence that it and the principles espoused within it reflect how collaboration is enacted within the context of a youth health network. Nor is there evidence that it reflects how collaboration occurs in a context where competitive tendering processes and enforced collaboration associated with NPM coexist with policy promoting collaboration. As such, questions remain as to whether all the contextual factors are taken into account when referring to collaboration within the youth health sector. Without this research, current process definitions of collaboration may not be specific enough to represent the reality of

collaboration for those involved within the context of youth health. If this is the case, emerging factors that are not included in definitions of collaboration may remain unrevealed and thus hinder knowledge creation and the ability of collaboration to achieve better youth health outcomes. If generic process definitions don't reflect the reality of collaboration their usefulness may be questioned and more context-specific theories of collaboration may need development.

### 3.3.2 Collaboration continuum

The definitional discussion above highlighted that there are varying definitions of collaboration. It also showed that definitions of collaboration commonly emphasise goals, structures and interrelational processes. These commonalities in definitions of collaboration are shared by a myriad of cooperative working relationships or management strategies including: cooperation, coordination, networking, joint ventures, networks, partnerships, consolidations, alliances and task forces to name just some (Gajda, 2004). To make distinctions between collaboration and other forms of cooperative arrangements, scholars often contend that collaborative efforts fall across a continuum of low to high integration with the level determined by the intensity of the alliance's processes, structure and purpose (Brown & Keast, 2003; Ciglar, 2001; Gajda, 2004; Keast et al., 2007). Consequently, Gajda (2004) argues that collaboration is an ideal to work towards whilst Brown and Keast (2003) suggest these distinctions are required, as understanding the characteristics of each form of joint relationship 'affords greater insights into their optimal application' (Brown & Keast, 2003, p. 6). This continuum typically presents these joint relationships in order from the least to the most intense. The continuum presented in Figure 3.2 is: cooperation, coordination, collaboration and coadulation. This continuum is as follows:



**Figure 3.2: Continuum of integrative work practices**

*(Adapted from Brown and Keast [2003] and Gajda [2004])*

By examining the description of each type of joint relationship it is evident that each differs in terms of ‘the intensity of the relationships, the communication flows and distribution of power between participants, length of relationship and the level of risks and reward’ (Keast & Mandell, 2009a, p. 1). This continuum assists understanding of the types of joint or collaborative actions being enacted within the youth health sector. Consequently, this allows the researcher to examine factors or issues that may impact on the willingness of participants to advance to more intense joint arrangements. It also allows the researcher to make comparisons between the understandings of collaboration by those involved and as described within the literature.

*Cooperation* is described as the most common and widespread form of joint relationship (Head, 2008). It entails the use of minimal resources, and mostly involves sharing information and providing mutual support, and so involves low levels of intensity and risk. Cooperation is also generally short term and task-focused with voluntary participation (Head, 2008). As such, Brown & Keast (2003) contend that cooperation is likely ‘to be undertaken by personnel at lower levels in the organisational structure’ (p. 7). When cooperating, participants’ independent goals and objectives are not merged and organisational identity is maintained (Gajda, 2004). Interestingly, in a context of NPM, individual organisational accountability is prioritised. This raises the question of whether government efforts may be more relevant to promoting cooperation rather than collaboration or whether government even makes such distinctions when using the term *collaboration* in policy.

*Coordination* involves common tasks and compatible goals (Gajda, 2004). This involves a degree of joint planning or joint programs, pooling and alignment of resources and thus increased risk due to greater interdependence (Keast & Mandell, 2009a). It may also involve a history of such activity between participants and a developed level of trust (Head, 2008). Gajda (2004) also suggests requirements for more formal membership and introduces a central coordinating role, often supplied by government. This illustrates that coordination is driven by more than goodwill but rather by the force of a mandate or objective. However, Brown and Keast (2003) are less clear on whether this force or mandate negatively or positively impacts on the goodwill of participants and inhibits progression towards collaboration and how.

Brown and Keast (2003) also suggests that due to the higher risk, coordination usually involves those at higher levels within the organisation. However, policy promoting

collaboration and partnership working within the youth health sector makes no such delineations.

According to Gajda (2004), *collaboration* involves the extensive integration of strategy and the concept of collective purpose. Head (2008) considers collaboration to have long-term goals and requires commitment from participants and consequently, collaboration is considered more stable and robust in nature (Head, 2008). However, the degree or nature of the robustness when collaboration is enforced by policy is under-researched.

Collaboration requires organisational participants to go beyond their organisational roles and objectives and develop new roles and functions that are specific or particular to the collaboration or the collaborative network (Head, 2008). As a result of this there is ‘genuine inter-dependence of risk sharing, and there is a genuine sharing of power, risk and reward’ (Head, 2008, p. 735). Head (2008) implies the existence or emergence of a new hierarchy but provides little detail about how it is formed or sustained, particularly when involvement or participation is mandated. Brown and Keast (2003) also argue that collaboration should be longer lasting and more enduring than cooperation due to higher levels of commitment and accountability. However, whether NGOs or government organisations are more or less willing to integrate and to what level and why is unclear. As such, contextual implications associated with the youth health sector on collaboration are uncertain.

Heath (2007) also asserts that unlike coordination and cooperation, which may have predetermined decisions, protocols, or solutions, collaboration aims to develop innovative solutions via indeterminacy and multiple options in decision making. What factors are influencing the decision-making processes within the youth health context is unclear. Consequently, research into the willingness of service providers to engage in collaboration is required.

Brown and Keast (2003) propose that collaboration involves participation by those in higher levels of an organisation and hence imply that collaboration has a level of exclusivity. However, policy promoting collaboration makes no assumption and promotes collaboration as an activity for all involved in the youth health sector. For example, the NSW Department of Health (2010a) in the NSW Youth Health Policy 2011–2016: Healthy Bodies, Healthy Minds, Vibrant Futures calls for ‘collaborative action between services ... [and] ... strengthening collaboration between services’ (p. 10). For this reason, examining the perceptions of different employee groups within the sector is required. It is required to

understand the perceived and enacted roles of participants, particularly in terms of who is more salient or eminent than others and why, when collaborating, and how they compare to existing hierarchical structures.

A more intensely integrated relationship than collaboration is *coadulation*. Gajda (2004) concludes that coadulation involves ‘unifying structures and combining cultures’ (p. 69). In other words, coadulation involves the merging of member organisations into one entity.

There is scholarly debate concerning the progression stages through this continuum and the meanings of terms (Thomson & Perry, 2006). For example, Ciglar (2001) and Leutz (1999) have set out four categories or levels of integration: informal, cooperative, collaborative and integrative. In comparison, Lawson (2002) identified five companion words relating to integration: collation, communication, coordination, collaboration and convergence.

The continuum implies that collaboration is an aspiration, ambition or desire rather than a starting point (Head, 2008). Brown and Keast (2003) created a matrix where cooperative relationships are compared with other variables such as structure, duration, goals/perspectives, structural linkages, formality and risks and rewards. Although these distinctions are made, ambiguity associated with addressing complex problems, the varying degrees of interventions, the commitment of participants and the services required to address the aims of coming together suggest that these elements are not static (Brown & Keast, 2003). In other words, relationships may move continuously and bi-directionally along the continuum, making planning more difficult for those involved (Brown & Keast, 2003). Consequently, compartmentalising a phenomenon that may be organic or fluid in nature is problematic. This research identifies whether research participants perceive collaboration as distinct from other cooperative working relationships. It also identifies what aids and obstructs those involved to move along the continuum and why. Research is required to determine whether movement and progression along the continuum is necessary to deliver the youth health objectives of government, particularly as the NSW Youth Health Policy is vague in terms of differentiating collaboration from other cooperative arrangements such as partnerships. It questions whether this vagueness is deliberate, as it hints of government being unsure of the level of willingness of participants to collaborate and whether collaboration is achievable or appropriate within the youth health sector.

By applying theoretical principles of stakeholder and social capital theories this research will investigate decision-making processes that may inhibit or accelerate progress towards

collaboration or even beyond to coadulation. For example, stakeholder theory allows the researcher to examine the concept of salience or what makes participants more or less important when collaborating (Mitchell et al., 1997) and why. Social capital theory enables the researcher to examine the features of social linkages created when collaborating (Putnam, 1995). These theories are discussed in greater depth as this chapter progresses.

Although the continuum of integration allows for better understanding of cooperative joint activities, by examining how research participants perceive collaboration this research examines the relevance of the term *collaboration* as a metaphor to understand a particular kind of interrelationship. For example, Wolfram Cox et al. (1997) postulate that metaphors ‘not only describe but also prescribe how reality ought to be viewed and evaluated’ (p. 308). Therefore, this research compares the relevance and comprehensiveness of collaboration as described within the literature to collaboration as described by research participants when enacted in a youth health context. Consequently, examining a contemporary metaphor such as collaboration challenges its relevance to reflect the reality of its use (Wolfram Cox et al., 1997). Therefore, this research analyses the relevance and usefulness of collaboration as a metaphor to describe the relationships participants feel they are involved in and the relevance of collaboration when promoted in policy.

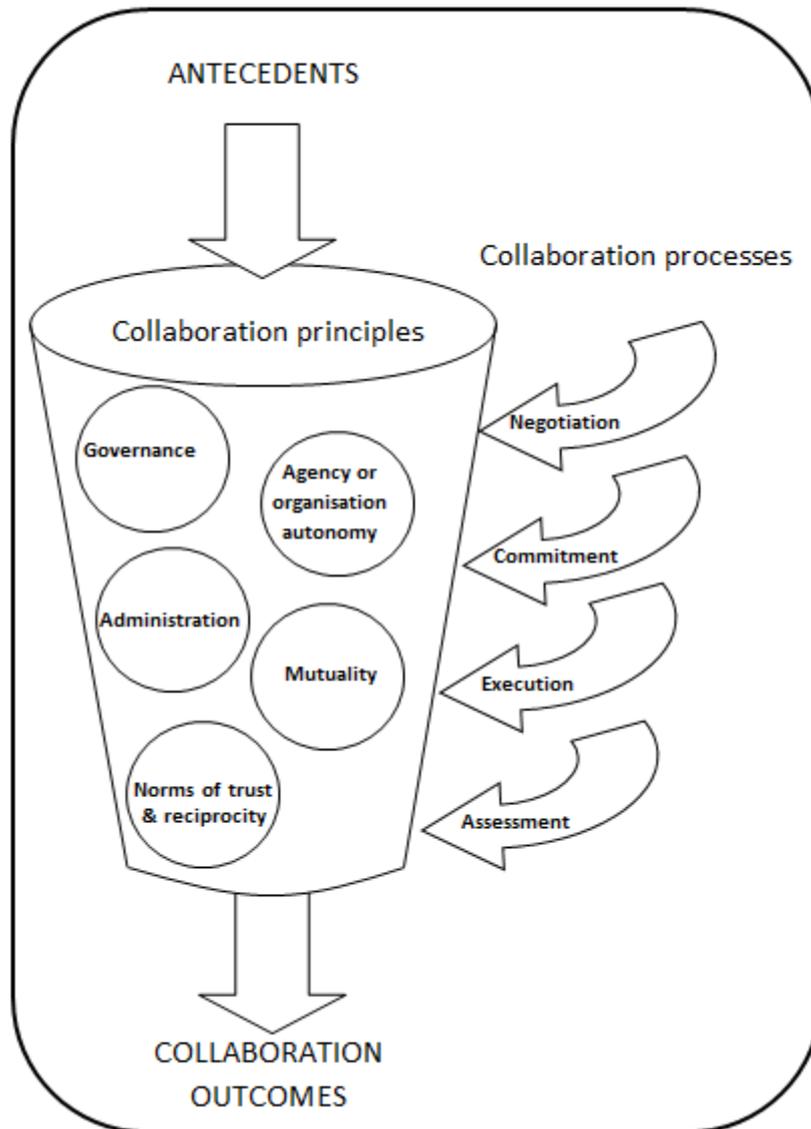
In summary, this section shows that scholars make attempts to delineate collaboration from other forms of cooperative arrangements. However this section shows that making these delineations in relation to a communicative, relational, emergent and dynamic process is problematic. For this reason, further research in different contexts is required to ascertain the level of understanding from those involved in collaboration or collaborative-like activities. Such research can identify emerging issues or characteristics not adequately addressed in understanding the delineation of collaboration from other cooperative activities. It also reveals what helps or hinders the movement of relationships along the continuum towards collaboration or whether this delineation is understood or relevant to participants involved.

### **3.3.3 Principles and processes of collaboration theory**

The above discussion highlighted that processes, structure and purpose differ between collaboration and other forms of cooperative arrangements. However, this research examines how collaboration is operationalised in an environment where collaboration is enforced and coerced on those working within the youth health sector. Consequently, a more in-depth review of the literature is required to explicate factors that characterise collaboration. A

review of extant collaboration theory shows that collaboration involves a number of required elements to occur successfully. Thomson and Perry (2006) describe these elements as the *principles* of collaboration. These principles are governance, administration, agency or organisational autonomy, mutuality and norms of trust and reciprocity (Thomson & Perry, 2006). Ring and Van de Ven (1994) provide guidance on how the principles of collaboration are enacted and assert that collaboration involves the *processes* of negotiation between participants, commitment to action, execution of collaboration and assessment of collaboration, its outcomes and the performance of other stakeholders. These additional processes are discussed as they are implicit in Thomson and Perry's (2006) principles of collaboration.

These principles and processes of collaboration are presented in Figure 3.3 depicting extant collaboration theory.



**Figure 3.3: Extant collaboration theory**

*(Adapted from Thomson and Perry [2006] and Ring and Van de Ven [1994])*

### 3.3.3.1 Governance

The principle of collaboration referred to as *governance* is defined by Scott, Ruef, Mendel and Caronna (2000) as ‘all those arrangements by which field-level power and authority are exercised involving, variously, formal and informal systems, public and private auspices, regulative and normative mechanisms’ (p. 173). McGuire (2002) calls this *framing*, which involves the determination of leadership and administration roles.

Governance involves having the appropriate organisational and network structures and processes that allow participants to jointly make decisions and rules governing their behaviour, relationships, decision-making processes, what information needs to be provided and how costs and benefits are distributed (Huxham & Vangen, 2005; McGuire, 2002; Scott et al., 2000; Thomson & Perry, 2006; Thomson et al., 2009). Also central to governance is negotiation and commitment processes and the need for conflict resolution (Dietrich, Eskerod, Dalcher & Sandhawalia, 2010).

Governance is often described as either shared or participatory-based, or influenced by leadership or facilitating roles. For example, governance has been described as participative decision making (McCaffrey, Faerman & Hart, 1995), shared problem solving (Hellriegel, Slocum & Woodman, 1986), shared power arrangements (Crosby & Bryson, 2005) and shared responsibility (Himmelman, 1996). Implicit in these terms is a lack of hierarchical structures, division of labour and the idea of normative pressure to conform to decisions in which their input may be minimal. Radin et al. (1996) call this commitment to shared governance the 'ethic of collaboration' (p. 25). Also implicit is the acceptance that other stakeholders are legitimately or rightfully able to contribute to group consensus and action (McCaffrey et al., 1995) and that collaboration requires information sharing and respect for others when deciding on forms of action and governance (Thomson & Perry, 2006).

The vast amount of prescriptive literature on how to achieve effective governance when collaborating (Hardy & Phillips, 1998; Huxham & Vangen, 2005; Lasker et al., 2001; San Martin-Rodriguez et al., 2005) and research reporting the benefits and problems of participatory governance (Johnson & Osborne, 2003; White & Wehlage, 1995) indicates that governance is not without problems. Problems identified particularly relate to participants having varying priorities in terms of individual and collective objectives (Gazley, 2010). Problems identified also involve creating a climate or culture where shared and participatory governance is the norm (Schwarz, 2006) and creating structures that support emerging governance mechanisms (White & Wehlage, 1995). In terms of limited literature on mandated collaboration, Rodríguez, Langley, Béland and Denis (2007) argue that it is the inability to resolve issues of power that leads to underproductive participatory governance issues. Brummel, Nelson, Souter, Jakes and Williams (2010) claim that an inability to learn how to adapt to new governance structures makes governance in relation to collaboration problematic. Research on collaboration is limited in terms of resolving collective and individual goals, examining cultural considerations and analysing collaborative governance

structures within a government-coordinated youth health network. Also unclear is what makes participants more or less powerful when determining and resolving issues of governance when collaborating, particularly from a stakeholder and social capital perspective.

This research argues that new knowledge is required to understand power and influence in relation to governance and what makes stakeholders more or less salient or influential when collaborating, particularly in a context where there are government and NGOs involved. For example, Head (2008) suggests 'public agencies and large business players are often unwilling to deal with power imbalances among participants, for fear of losing their own authority and influence' (p. 734). As such, the literature implies collaboration involves the negotiation of power and that government organisations are possibly less well-off under a regime of increased collaboration. However, there is no empirical evidence of this within the context of youth health nor is the literature clear on what participants can win or lose when collaborating in terms of power or influence. Therefore, this research is required to understand engagement strategies of those involved in negotiating governance when collaborating.

In contrast to a lack of hierarchical structures relating to governance discussed above, other scholars call for leadership and centralisation of control (Bryson & Crosby, 2006; Schwarz, 2006; Steinacker, 2004) either from an individual or an organisation to influence governance processes when collaborating (McGuire, 2006). However, the literature does not call for authoritative control; rather it commonly promotes facilitative leadership to create a culture of collaboration where the values and assumptions, strategies and consequences are aligned and control is unilateral (Schwarz, 2006). However, literature examining the impact of existing entrepreneurial values and individual organisational accountability associated with a culture of NPM on collaboration governance is scarce. Research is required as the literature on leadership of collaboration implies NPM may negatively impact collaboration but it has not yet been empirically determined in the context of a government coordinated youth health network.

Although Bardach (1998) asserts there is no generic method of collaboration governance, scholars commonly argue governance can be achieved by recognising the need for collaboration, building common ground, structuring collaboration and delivering the action plan involving the processes of problem setting, direction setting and implementation (Gray,

1985; Wilson & Charlton, 1997). Such a process is said to require face-to-face communication and trust and reciprocity (Thomson & Perry, 2006; Zhang & Huxham, 2009) in order to come to a general consensus. The need for face-to-face communication suggests that strength of personality and better communication and negotiation skills can influence collaboration. It also implies a different hierarchy of influence from existing hierarchies which are often based on profession and position within an organisation within the youth health sector. The examination of existing versus emerging hierarchies as a result of collaboration is under-researched, particularly in the context of a government-coordinated collaborative network.

Other than explicit individual and collective goals, scholars are unclear in relation to implicit motivations that drive commitment to governance from participants and what level of commitment is required if agreement is reached or forced upon others. Also unclear is how governance in collaboration is enacted in the youth health sector when funding organisations allocate resources and control collaborative agendas. In addition, there is a lack of research examining governance from a stakeholder perspective and social capital perspective within the not-for-profit sector, particularly in the youth health sector, where policies promoting collaboration and competition coexist. This review of the literature shows that the lack of clarity associated with the governance of collaboration justifies this research.

### *3.3.3.2 Administration*

The administration principle of collaboration differs from governance in that it is concerned with implementation, execution and management of collaboration rather than planning (Thomson & Perry, 2006; Thomson et al., 2009). The administration dimension involves clarifying roles and responsibilities, developing communication channels that enhance coordination, and creating appropriate and agreed-upon monitoring mechanisms (Thomson & Perry, 2006; Thomson et al., 2009). Administration involves ‘finding the right combination of administrative capacity (through coordination and elements of hierarchy) and social capital to build relationships’ (Thomson et al., 2009, p. 25).

Prins (2006) acknowledges the difficulties of administering collaboration and contends that a collaboration ‘is an under organised open system with few controlling structures’ (p. 337) where ‘it is difficult to establish the primary task, procedures, roles and membership in advance’ (Prins, 2006, p. 337). Prins (2006) describes a fluid and emerging process of administration when participation in collaboration is voluntary and participants are

autonomous or semiautonomous and where ‘clarity of structures, lines of accountability and clear role boundaries are reduced or dismantled’ (Prins, 2006, p. 336). However, Thomson et al. (2009) argue that more structured processes, including a requirement for leaders or facilitators, are required as collaboration becomes larger or participation is less voluntary. Whether formal leadership is required and by whom in the youth health context where collaboration is sometimes mandated has not yet been empirically determined.

Much like governance, administration is problematic due to power structures and managing the inherent tension between collective and self-interests. The literature could be more explicit concerning how and why some take administrative roles when collaborating. By examining how collaboration is enacted within a youth health network, this research uncovers what motivates stakeholders to take on a leadership or more influential role and why when collaborating in the youth health sector. Furthermore, it identifies what gives participants more sway or influence when involved in administrating collaboration.

#### 3.3.3.3 *Agency and organisational autonomy*

Thomson et al. (2009) postulate that the agency or organisational autonomy principle of collaboration is a defining process of collaboration and is concerned with the reconciliation or resolution of individual and collective differences. Huxham (1996) calls this tension the *autonomy-accountability dilemma*. Put another way, agency or organisational autonomy involves understanding the management dilemma of achieving individual organisational goals compared to that of network or collective goals.

The literature commonly considers that a level of goal congruence between individual, organisational and collective goals is required for successful collaboration (Lasker et al., 2001). The literature prescribes a number of strategies to create goal congruence including managing resources, partner characteristics, relationships between partners and the external environment (Lasker et al., 2001). Such prescriptive generic and theoretical strategies commonly advocate for collaboration and imply inequalities in power and influence when collaborating can be managed, particularly if there are overarching common goals, such as altruistic goals (Dietrich et al., 2010; McGuire, 2006; Rosas & Camarinha-Matos, 2009). However, such assumptions may be problematic considering the literature highlights inequality (Imperial, 2005) and wider institutional settings (Dickinson & Glasby, 2010) contributing to unsuccessful collaboration. Therefore, further research is required in the youth health context as government power is integral to setting the collaborative agendas and

mandating participation. Furthermore, collaboration in the youth health sector involves government and non-government organisations that differ in terms of availability of funding and resources, ownership, operational structures and processes and ideology. The impact of these contextual factors on collaboration within a youth health network is under-researched, as is the impact of altruistic goals on agency.

The literature commonly assumes goal congruence is required for successful collaboration (Dietrich et al., 2010). However, the assumption of goal congruence downplays potential goal differences that may promote collaboration, particularly as a benefit of collaboration includes bringing together diverse stakeholders with varying perspectives (Huxham & Vangen, 2005). By examining the explicit and implicit objectives of stakeholders when collaborating, this research advances knowledge of collaboration relating to the degree of goal congruence required to successfully collaborate.

In summary, the agency or organisational autonomy principle means that participants have a distinct organisational identity separate to that of the collaborative network. However, the literature is less clear on how agency is impacted in situations of mandated collaboration or when collaboration is promoted in policy. The literature is vague in terms of what makes collaborative participants more or less salient or influential and why and how this salience may relate to achieving individual organisational and/or collective goals when involved in collaboration.

#### *3.3.3.4 Mutuality*

After discussing the governance, administration and agency principles of collaboration in the previous sections, this section explains the mutuality principle of collaboration. Mutuality in relation to collaboration involves the creation of mutually beneficial relationships between stakeholders (Thomson & Perry, 2006; Thomson et al., 2009). In other words, mutuality relates to forging mutual beneficial interdependencies based on differing interests or shared interests (Thomson & Perry, 2006; Thomson et al., 2009).

Creating win-win situations based on differing interests involves negotiating or accommodating the needs of other participants who may require resources (skills, expertise, money) from them or vice versa (Huxham & Vangen, 2005). In other words, mutuality involves the notion of gaining or sacrificing or even winning or losing as parties 'agree to forego the right to pursue their own interests at the expense of others' (Powell, 1990, p. 303).

However, the literature could be clearer when considering what stakeholders are sacrificing or gaining through collaboration in a government-coordinated not-for-profit network. Also uncertain is how much organisations are willing to sacrifice to achieve collective goals and what are the implicit organisational and collective goals that are in addition to goals made explicit by participants when collaborating. This begs the question: what are participants willing to do to achieve these goals? Therefore, further research is required to understand the deeper dynamics of collaboration to better understand the factors impacting on the collaborative engagement strategies of participants. It is required in the youth health context as individual organisations are accountable for their outcomes and financial sustainability.

In contrast to negotiating based on differing interests, mutuality can begin with identifying shared or common interests (Dietrich et al., 2010; Rosas & Camarinha-Matos, 2009). Predominantly noted within the literature as essential for successful collaboration is a requirement for commitment to a shared interest or common objective. For example, Thomson and Perry (2006) state that ‘commitment to similar target populations proved to be one of the most important factors holding collaboration together’ (p. 27). Whether commitment to youth and altruistic values within the youth health sector increases the likelihood of successful collaboration is unclear. Furthermore, the literature lacks clarity when considering how subgroups such as government or NGOs compare in respect to mutuality and achieving individual organisational versus collective goals.

#### *3.3.3.5 Norms of trust and reciprocity*

The final principle of collaboration highlighted by Thomson and Perry (2006) and Thomson et al. (2009) is norms of trust and reciprocity, which involves creating a climate in which participants are willing to fulfil reciprocal obligations to other participants (Bin, 2008; Thomson & Perry, 2006; Thomson et al., 2009; Vangen & Huxham, 2003; Zhang & Huxham, 2009). Ostrom (1998) claims that norms of reciprocity are related to trust or at least reputations of trustworthiness to fulfil or deliver on commitments between participants. The requirement for trust between actors is a common theme throughout the literature as a characteristic of successful collaboration (Ostrom, 1998; Thomson & Perry, 2006; Thomson et al., 2009; Vangen & Huxham, 2003; Zhang & Huxham, 2009). For example, Zhang and Huxham (2009) argue that trust is critical to collaboration as it reduces complexity and transactions costs. In comparison, Entwistle and Martin (2005) highlight that excessive trust can stymie productive debate concerning the best possible solutions to issues as participants

are reluctant to jeopardise friendships. However, the literature lacks clarity concerning levels of trust required for successful collaboration and what may impact on the development and loss of trust within a network of youth health service providers. More specifically, the relevance of trust when collaboration is mandated or decreed by government funding institutions is under-researched.

Huxham and Vangen (2000) contend that reciprocity does not need to be voluntary, and therefore implies successful involuntary or mandated collaboration. However, Rodríguez et al. (2007) argue that mandated collaboration is often unsuccessful if management practices don't account for power and political issues, particularly in public sector networks. Hence, there is a requirement to consider contextual issues relating to why some stakeholders may be more or less influential, salient or powerful than others when collaborating. By examining the perceptions of those involved in collaboration within the youth health network, this research identifies what impacts on the development and maintenance of trust and how this may impact on collaboration. In addition, this research shows what impacts on the willingness of those within the sector to be involved in reciprocal arrangements.

Thus far this section on the principles of collaboration has discussed governance, administration, agency and organisational autonomy, mutuality and norms of trust and reciprocity. However, an examination of the literature on collaboration shows that additional processes are required to address, resolve or enact the five principles of collaboration. These additional processes are negotiation, commitment, execution and assessment (Ring & Van de Ven, 1994).

The following sections discuss the processes of negotiation, commitment, execution and assessment in relation to collaboration and how they relate to this research project.

#### *3.3.3.6 Negotiation*

Negotiation between participants is a principle commonly expressed in theories of collaboration (McGuire, 2006; Ring & Van de Ven, 1994). As McGuire (2006) states: '[N]egotiation and mediation are in abundance in a collaborative network' (p. 3). Negotiation emphasises rules and roles in decision making and recognises the personal interrelationships between stakeholders as they interact and develop individual and aggregate goals. However, collaboration theory is not explicit concerning which stakeholders within the collaborative network are more or less important to negotiate with and why, either from the perspective of

individual participants or the aggregate. Addressing these questions appears important in understanding stakeholder actions as O'Toole Jr (1988) argues: negotiation in collaboration involves persuasion and conflict resolution. However, scholars are not clear on whether stakeholders compete amongst each other to have more salience or sway than other stakeholders when negotiating or how they may gain or lose influence when collaborating. In addition, collaboration theory is not clear on whether particular groups of participants form alliances within collaboration or why these groups or alliances may exist. The researcher is surprised by the scant use of stakeholder theory to analyse negotiation processes within collaboration.

The researcher is also surprised by the literature's use of the term 'negotiation' to describe a broad array of activities aimed at resolving issues of governance, administration, agency and mutuality. This surprise is based on the importance of the issues at stake in terms of organisational sustainability and the altruistic notions and the passions these issues may invoke. For example, Gazley and Brudney (2007) highlight the potential of collaboration to result in 'mission drift, loss of institutional autonomy or public accountability, co-optation of actors and greater financial instability' (p. 392), whilst Bardach (1998) asserts that collaboration reflects the values, ideologies, constituencies, turfs, powers and egos of participants. Consequently, the researcher argues that the intensity of negotiation needs further research along with whether negotiation is always an accurate description of the processes occurring. This research addresses this lack of knowledge and the lack of emotion within collaboration theory by examining negotiation strategies of those involved in collaboration within a youth health network where participants have economic and altruistic considerations.

#### *3.3.3.7 Commitment for future action*

Through negotiation, Ring and Van de Ven (1994) argue that participants in collaboration aim to build commitment for future action from participants. McGuire (2002) refers to inducing commitment and building support as mobilising processes. Commitment for future action can be through formal or legal contracts such as Memorandums of Understanding (MOUs) and psychological contracts neither formal nor legal, but normative. As such, scholars acknowledge normative pressure and formal authority to conform to joint agreements. By using the principles of social capital theory, these normative pressures can be

examined in depth to explain the willingness and actions of those involved in collaboration within the youth health sector.

In terms of commitment, Ring and Van de Ven (1994) emphasise accountability for action or inaction, with particular reference to preventing participants from free-riding or ‘gaining benefits from inaction or non-conformance’ (Ring & Van de Ven, 1994, p. 97). Although free-riding is mostly proposed to inhibit future collaboration with those engaging in it, the literature provides little detail of permissible or disallowed free-riding. Addressing the issue of free-riding is important for this research, as enforced collaboration may impact on the willingness of stakeholders to engage in collaboration with stakeholders who may be more or less committed to and motivated to achieve outcomes. In addition, the literature could be clearer concerning why stakeholders may be more committed to engaging with some particular stakeholders than others when collaborating or why this may be so.

#### *3.3.3.8 Execution of collaboration processes*

Execution of action is also commonly identified as a process involved in collaboration (McGuire, 2002; Ring & Van de Ven, 1994). Execution involves the implementation of commitments by participants. McGuire (2002) refers to execution as synthesising behaviour involving engendering productive and purposeful interaction from participants.

Although collaboration commonly involves joint agreement on collective initiatives and group strategies (Booher, 2004; Fung, 2006; Hajer & Wagenaar, 2003; Murray & Shaffer, 2004), collaboration is sometimes formed or driven by a central organisation or authority, such as government or in the case of youth health, government funding organisations. However, scholars have different views on who should influence others to execute or conform to committed actions. Different views often revolve around the role of leadership or facilitation of action within the collaboration. For example, Prins (2006) states that ‘the consensual nature of collaborative work inhibits the emergence of overt leadership’ (p. 336). Other writers advocate for greater power sharing and democratic values between network participants involved in collaboration (Booher, 2004; Fung, 2006; Hajer & Wagenaar, 2003; Murray & Shaffer, 2004). How leadership or influence for execution is enacted in government-coordinated collaborative networks with competitive funding practices and enforced collaboration remains undetermined. It remains uncertain as the literature is vague concerning the influence of government funding bodies external to the collaborative network as compared to accountabilities of stakeholders both vertically and horizontally within

collaborative structures. As Newman (1994) advocates, more research is required to explore the tensions and differences between ‘old and new patterns of authority and hierarchy for those collaborating’ (p. 63).

### *3.3.3.9 Assessment of other stakeholders and their deliverables*

Ring and Van de Ven (1994) claim that participants are making assessments and evaluations regarding activities including negotiation, commitment and implementation or execution of activity when collaborating. The evaluation by stakeholders is based on reciprocity, equity and efficiency of actions (Ring & Van de Ven, 1994). Based on individual and collective assessment, commitment to collaboration either increases or decreases as participants identify the benefits or problems of collaboration (Gordon, 2007). Thus, collaboration is a cyclical and ever expanding or reducing loop and as such demonstrates a potentially limited life cycle (Gordon, 2007; Ring & Van de Ven, 1994). However, collaboration is promoted in the NSW youth health policy as an ongoing, long-term strategy. Thus, by examining collaboration within the context of a youth health network, this research examines what limits and enhances the sustainability of collaborative arrangements. This is done by examining who within the network enables the longevity of collaboration and what stakeholder actions may diminish the capacity of collaboration to occur or continue over time. Furthermore, the research looks at processes and practices that are perceived by research participants to negatively and positively impact on collaboration.

Although some scholars (Koppenjan, 2008; Voets, Van Dooren & De Rynck, 2008) call for measurements of collaboration for management purposes, the relational and subjective nature of human relations makes this difficult (Mandell & Keast, 2008). Mandell and Keast (2008) call for evaluative frameworks that go beyond traditional frameworks that ‘incorporate multiple perspectives in effectiveness that is based on different types, level of analysis and stages of development of networks’ (p. 715). Checklists are a form of assessment promoted in youth health policy to prescriptively assist participants to evaluate the performance of themselves and others. Whether these checklists and systems of evaluation impact on the willingness of stakeholders to collaborate within the youth health sector has not been empirically determined. Therefore, although the literature acknowledges that stakeholders assess others when collaborating and presents different prescribed methods to evaluate the collaboration, the literature could be extended by determining how and why stakeholders evaluate each other and how this impacts on engagement in collaboration.

This section has discussed the deeper dynamics of collaboration by presenting and discussing the principles of collaboration, which are governance, administration, agency, mutuality and norms of trust and reciprocity. It has also discussed additional processes that are commonly presented within the literature as impacting on collaboration including negotiation, commitment, execution and assessment. In doing so, it is evident that further research aimed at advancing collaboration theory is required. It is required as the principles and processes discussed often prescribe what needs to be achieved to collaborate successfully. They don't necessarily explain how and why collaboration is operationalised within a particular context. Consequently, this research is an opportunity to explain how and why collaboration is enacted within the youth health context and in so doing, advance theoretical and practical understanding of collaboration. The areas identified as requiring further knowledge of collaboration are summarised in the section 'Summarising collaboration theory' and are inherent in the sections on social capital theory and stakeholder theory below.

#### **3.3.4 Reported benefits of collaboration**

Collaboration is commonly promoted due to the benefits it is proposed to offer (Agranoff, 2004; Gazley & Brudney, 2007; Huxham, 1996; McGuire, 2006). This section examines the benefits of collaboration as proposed within the literature.

Collaboration as a management strategy is promoted by scholars due to its perceived ability to tackle complex problems or issues (Gajda, 2004; Gray, 1985; Head, 2008; Huxham, 1993). It involves bringing 'together a wide range of expertise, knowledge and resources that enables new thinking about complex issues — for both understanding the problems and formulating solutions' (Head, 2008, p. 734). As Lasker, Weiss and Miller (2001) contend, 'By combining the individual perspectives, resources, and skills of the partners, the group creates something new and valuable together—a whole that is greater than the sum of its individual parts' (p. 184). The synergy created through collaboration is termed *collaborative advantage* (Huxham, 1993). In the context of youth health service delivery, this means bringing together a range of organisations involved in health service provision in order to more efficiently and effectively deliver youth health services than could be achieved individually.

Mandell and Steelman (2003) argue that increased innovation is a benefit of collaboration. Lasker, Weiss and Miller (2001) claim that collaboration results in more comprehensive problem solving due to examining a problem in a more holistic fashion. By linking a problem

to local resources, practical thinking concerning a problem is also a benefit of collaboration (Richardson & Allegrante, 2000). Transformation is another advantage of collaboration as stakeholders perceive and think about a problem in new or different ways (Mayo, 1997). Consequently, another benefit of collaboration is that it promotes change (Himmelman, 1998; Huxham & Vangen, 2005). In promoting change, Huxham and Vangen (2005) also assert that collaboration promotes learning for those involved. Collaboration also has benefits in terms of actions addressing complex problems. For example, critical mass results from bringing together stakeholders with similar views and goals, particularly in terms of advocacy of a certain issue (Wandersman, Goodman & Butterfoss, 1997). Furthermore, by pooling resources, there are advantages associated with reduced duplication, reduced conflict, increased efficiency and increased competitive advantage (Lasker et al., 2001). Another advantage of collaboration is that stakeholders gain access to the resources, expertise, knowledge and connections of others (Gray, 1991). By accessing the resources of others, collaboration also allows stakeholders to share risk (Huxham & Vangen, 2005). By harnessing the resources and knowledge of others, further benefits arise from collaboration including achieving economies of scale, greater sustainability and better system-wide performance (Lasker et al., 2001).

The development of trust between stakeholders involved in collaboration and the creation of more familiar, satisfying, mutually supportive and rewarding working relationships are also proposed benefits of collaboration (Campbell, 2006; NSW Centre for the Advancement of Adolescent Health, 2005; Sebuliba & Vostanis, 2001). Campbell (2006) asserts that high trust leads to better communication between participants, more confidence in the system and therefore better outcomes.

The ability to act comprehensively through multiple actions is another advantage of collaboration, particularly in addressing complex problems. For example, in the context of healthcare, benefits of collaboration include: continuity of healthcare, better case management and the ability to address the multifaceted needs of individuals, families and communities (Hill & Lynn, 2003). In other words, collaboration is said to promote seamless and coordinated service delivery (Hill & Lynn, 2003). According to the NSW Centre for the Advancement of Adolescent Health (2005) the benefits of collaboration in the context of health also include: addressing inequalities in health status, joint training, greater credibility and greater cost effectiveness and impact than with fragmented service delivery.

This section shows that the potential benefits of collaboration are profound. It shows that the benefits of collaboration can include new institutional structures, economic benefits, sociological gains, increased network performance, better resource allocation, achievement of political priorities and community transformation and empowerment (Gray & Wood, 1991). However, whether these benefits can be achieved in the context of a youth health network is unclear and has not been empirically determined. As such, there is a requirement for research on collaboration within this context.

### **3.3.5 Costs and risks of collaboration**

The literature, particularly that of an institutionalist and managerial nature, tends to focus on the benefits of collaboration and to downplay the rationale for avoiding collaborative arrangements and problems that can arise (Gazley, 2010; Kumar, Kant & Amburgey, 2007). In other words, the literature often tends to be celebratory of collaboration rather than critical in nature. However, there is some literature acknowledging the costs and risks of collaboration and the demands it places on those involved (Agranoff, 2006; Imperial, 2005; Kumar et al., 2007; White & Wehlage, 1995). For example, Huxham (2003) claims that ‘unless the potential for real collaborative advantage is clear, it is generally best, if there is a choice, to avoid collaboration’ (p. 421). However, as government promotes and mandates collaboration as a better means to deliver youth health services, research is required on how collaboration is operationalised within the youth health sector. It is required to understand whether collaboration can deliver the benefits proposed and to identify whether negative aspects of collaboration can be minimised and managed. A discussion on the costs and risks of collaboration presented within the literature follows.

Costs associated with collaboration include potentially high financial costs in terms of investing material, time, resources and political capital (Gazley, 2010; Head, 2008; Huxham, 1996). For example, costs involved in educating participants about processes and structural requirements of collaboration and also in building the trust, commitment and communicative channels between network participants may be excessive (Thomson & Perry, 2006). In addition, extra costs may be incurred due to overcoming negative experiences and perceptions of previous collaborations and high levels of distrust (Thomson & Perry, 2006). But what classifies as a negative experience is not always explicit within the literature. Acceptable or unacceptable levels of trust or even distrust within the youth health sector are

unclear as is the relationship between mandated engagement in collaboration and levels of trust or trustworthiness.

In addition to the costs of collaborating, there are also risks involved in collaboration. For example, collaboration may result in conflict between individual organisational goals and the collective goals of the collaborative network (Page, 2003; Thomson & Perry, 2006). There is risk associated with balancing what the parties feel they have to gain or benefit with the effort required to get there (Hoatson & Egan, 2001). Gazley and Brudney (2007) argue that other risks include:

mission drift, loss of institutional autonomy or public accountability, cooptation of actors, greater financial instability, greater difficulty of evaluating results, and the expenditure of considerable institutional time and resources in supporting collaborative activities (p. 392).

Huxham (1993) also introduces the possibility of diminished flexibility and control and the loss of recognition and potentially reduced power and status. For example, in the health sector Brinkerhoff (1999) suggests that threats to organisational autonomy and government bureaucracy inhibit non-government organisations partnering with public organisations. However, the literature does not detail who stands to gain from the reduced power of particular participants or why. Additionally, the literature is unclear about what makes stakeholders more or less powerful or influential when collaborating. Nor does the literature take into account factors such as mandated collaborative relationships between government and non-government organisations (NGOs) occurring within a government-coordinated not-for-profit youth health sector. This research redresses the lack of empirical investigation of collaboration within the youth health sector to determine what costs or risks exist for those collaborating and how they impact on engagement strategies.

Research in other industry sectors indicates that ‘it takes time (typically 4 to 6 years) to educate participants, overcome distrust, reach agreements, secure funding, and begin implementation’ (Leach, Pelkey & Sabatier, 2002, p. 666) of collaborative programs. This may be particularly problematic in the youth health sector as state and federal government electoral terms are typically three years and pressure for short-term promotable gains may impact on the effective creation of long-term sustainable collaborative networks. In addition, the immediacy associated with treatment of youth health further collapses collaboration timeframes. The literature is scant relating to collaborating on short-term projects in order to obtain resources to ensure organisational survival, particularly in regards to competitive

tendering. Consequently, this research shows a lack of empirical evidence concerning the impact of contextual implications on the risks of collaboration.

Thomson and Perry (2006) acknowledge the potential of participants to withdraw from the collaborative networks if short-term goals are not achieved. In other words, the literature shows that collaboration has a degree of fragility. However, research is unclear on the ability or strategies of participants to successfully collaborate if some participants engage in behaviours perceived by others as being negative. Consequently, this research is required as it provides empirical analysis of factors impacting on the robustness or sustainability of collaboration within the youth health network.

The costs and risks of collaboration have resulted in what Huxham (2003) has termed *collaborative inertia*. Collaborative inertia refers to the ‘resistance of participants to progress the collaborative process’ (Huxham, 2003, p. 421). Page (2003) argues that collaborative inertia is often the result of disagreement on common aims, inequality of power relations, distrust or difficulties in building trust and when communication linkages are less than effective. However, whether these costs and risks hold relevance to those collaborating in the youth health sector and what causes them has not been empirically analysed in the youth health sector. Therefore, this research is an opportunity to identify factors that participants believe are negatively impacting on collaboration or are impeding the ability of collaboration to achieve espoused benefits.

### **3.3.6 Summarising collaboration theory**

In summary, the above literature review of collaboration theory illustrates that although the benefits of collaboration are significant, collaborative arrangements are not without problems. McGuire (2006) agrees that ‘excitement over the possibilities of collaborative management should thus be tempered by the realisation that such management is difficult and not always beneficial’ (p. 40). When describing collaboration Ring and Van de Ven (1994) conclude that the ‘seeds for disintegration of relationships are contained within the very governance structures, safeguards, and processes that lead to their formation and growth’ (p. 108). However, the literature review showed that scholars have attempted to understand collaboration better in order to prescribe how collaboration should occur successfully. These efforts have included defining collaboration by emphasising its goals, structures and interrelational processes. They have also differentiated collaboration from other cooperative arrangements but acknowledge that such delineations can be problematic due to the

communicative, relational, emergent and dynamic nature of collaboration. To understand what collaboration involves, this literature review highlighted scholarly understanding of the principles and processes involved in collaboration. The principles of collaboration discussed in this literature review included governance, administration, agency, mutuality and trust and reciprocity. Also discussed were the additional processes of negotiation, commitment, execution and assessment implicit to achieving or enacting the principles of collaboration. The literature review revealed that the prescriptive nature of collaboration theory was inadequate in explaining how and why collaboration occurs within the context of a youth health network. The inadequacy or ambiguity was due to a lack of research on collaboration examining the contextual factors particular to the youth health sector. These contextual factors include mandated or enforced collaboration, competitive tendering practices, altruistic and economic considerations and inequality concerning collaborative partners such as government as compared to non-government service providers. If these contextual factors show incongruence or inconsistencies with existing collaboration theory, the researcher argues that the foundations of collaboration theory require investigation and revision. It requires investigation to empirically determine whether collaboration is actually occurring within the youth health sector or whether collaboration theory represents the activities being undertaken by participants involved in collaborative activities with the youth health sector. Consequently, this research is an opportunity to reveal factors that may extend collaboration theory.

The literature review showed that the benefits of collaboration can be profound but there is a lack of empirical evidence showing whether these benefits can be achieved in a government-coordinated youth health network. It also showed that the benefits of collaboration are not without cost and risk for those involved. Furthermore, the literature review revealed that costs and risks of collaboration within a youth health network are under-researched. Therefore, it is not determined whether collaboration can achieve the benefits proposed in government policy promoting collaboration within the youth health context. The literature review also revealed that the impact of contextual factors particular to the youth health sector on the nature of membership and the actions of participants involved in collaboration is also unclear. Furthermore, the literature review highlighted that the impact of altruistic motivations on collaboration is uncertain as is the impact of policy promoting collaboration. Consequently, this literature review revealed a need to compare and explain the relationship between existing hierarchies of influence and those emerging through collaboration.

After reviewing the literature on collaboration, the researcher identified the following points where further research on collaboration in the youth health sector is required:

1. the salience or importance of stakeholders or participants when collaborating, including those not directly involved in collaboration such as youth in need, government and funding organisations
2. the hierarchies of influence including normative pressure to collaborate for those within the youth health sector and how this impacts on the behaviour of participants
3. the impact of enforced, coerced and voluntary involvement in collaboration on stakeholder engagement and why
4. the willingness of stakeholders to participate in collaboration in relation to policy, altruism, clinical factors and economic considerations
5. perceptions of responsibility to other stakeholders and the impact these have on collaboration engagement
6. the explicit and implicit goals when collaborating and how are they achieved
7. the specific actions service providers are willing to take to achieve individual and collective goals.

The gaps above highlight a lack of understanding concerning the impact of particular contextual factors associated with the youth health context on the operationalisation of collaboration. The contextual factors highlighted are important as they indicate a lack of theoretical understanding relating to stakeholder influence or salience when collaborating and the willingness of service providers to collaborate. For example, the literature revealed there is a need to understand better the actions of stakeholders when collaborating particularly in relation to hierarchy, salience and influence. These specific theoretical gaps require analysis as they question the comprehensiveness of the principles and processes of collaboration theory discussed in section 3.3 of this literature review to describe collaboration when enacted within a government coordinated youth health network. To broaden the scope of the theoretical analysis of collaboration and address these theoretical gaps this research applies the principles of stakeholder and social capital theories.

The highlighted gaps in knowledge show that the prescriptive nature of collaboration theory does not adequately explain or accommodate the impact of contextual factors on collaboration. As the impact of context is wide ranging, broad research questions were required so that issues considered important by those working in the sector could emerge and

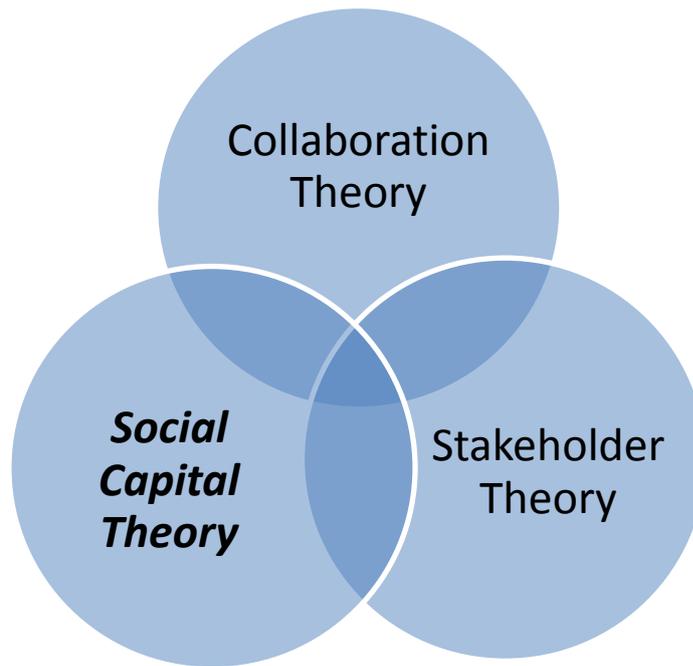
be related to the identified gaps in the literature. Therefore, the research questions involve identifying key stakeholders, why they collaborate and how collaboration impacts on the youth health sector. In addition, to incorporate contextual factors unique to the youth health sector, the research questions included examination of how collaboration was enacted or operationalised within that environment.

The above highlighted gaps in knowledge incorporate reference to the contextual factors impacting on collaboration within the youth health sector. They illustrate why qualitative multi-case study research processes were used in this research developing collaboration theory. As stipulated in section 4.4.2 of the methodology chapter, the author contends that theory development is dependent on context. Thus, it is through this contextual dependence that the researcher can make the theoretical contribution highlighted in section 1.5 and 3.8 of this research report.

To better explain how collaboration occurs for those working within the youth health sector, the research utilises theoretical principles associated with social capital and stakeholder theory. The following discussion will begin by reviewing literature associated with social capital theory.

### **3.4 Social capital theory**

Following on from the review of collaboration theory, social capital theory is discussed (see figure 3.4). After defining social capital and discussing the structural, relational and cognitive dimensions of social capital theory, the benefits and risks of social capital are identified. This section concludes in a summary of how social capital theory assists understanding of collaboration when operationalised within the youth health sector.



**Figure 3.4: Social capital theory within the research theoretical framework**

The above review of collaboration theory showed that it is prescriptive in terms of promoting the required activities that make collaboration successful. It was evident that collaboration theory lacks depth in explaining how collaboration occurs within a particular context such as a government-coordinated youth health network. For this reason, the researcher applies the principles of social capital theory to the research process as it helps explain the features of social linkages between members of a collaborative network who are involved in collaboration (Portes, 1998).

This section of the literature review critiques social capital theory as presented within scholarly literature and highlights how it can assist the researcher to address the shortcomings of collaboration theory and better address the research questions.

First, this section begins by defining social capital in order to show its relevance to understanding collaboration better. It shows that social capital can be conceptualised at an individual or a collective level, particularly in terms of who can access or accrue social capital and its benefits. It will be evident that for this research, social capital is considered a resource or asset that offers returns for those involved in collaboration.

Second, to understand the highly conceptualised nature of social capital a review of social capital theory will be presented including a critique on the structural, relational and cognitive

dimensions of social capital. It will be shown that the structural dimension of social capital emphasises hierarchy within a network of relationships that can assist the researcher to examine and compare social capital in terms of existing versus emerging structures of influence. The relational dimension of social capital will be reviewed with particular reference to bonding and bridging social capital in relation to the intensity and directions of relationships. The impact of shared values and beliefs associated with building trust and social capital when collaborating will be highlighted in a review of the cognitive dimension of social capital.

Third, the benefits of social capital will be outlined. Following on from that, it will be shown that social capital is not without risk. Last, how social capital can assist the researcher to understand collaboration better will be summarised.

### **3.4.1 Defining social capital**

Definitions of social capital vary in terms of being focused at the individual (Burt, 1997) or the collective level (Fukuyama, 1995; Nahapiet & Ghoshal, 1998; Putnam, 1993; Tsai & Ghoshal, 1998). Individually focused definitions of social capital conceptualise it as an asset accessible to those involved in social relations within a network (Burt, 1997). On the other hand, collectively focused definitions of social capital propose that social capital is inherent within a network structure (Fukuyama, 1995; Nahapiet & Ghoshal, 1998; Putnam, 1993; Tsai & Ghoshal, 1998) and available to all regardless of levels of involvement in social relations (Fukuyama, 1995). This section will define social capital from an individual *and* collective focus. It will show that both individually and collectively focused definitions of social capital have relevance to understanding the interrelational nature of collaboration. This section will illustrate how social capital is relevant to understanding the enactment of collaboration within the youth health sector.

Individually focused definitions commonly describe social capital as resources available to those involved in relationships within a network structure of participants (Zheng, 2010). For example, Portes (1998) defines social capital as ‘the ability of actors to secure benefits by the virtue of membership in networks and other structures’ (p. 8), whilst Adler and Kwon (2002) argue that social capital is the ‘goodwill that is engendered by the fabric of social relations that can be mobilised to facilitate action’ (p. 17). As evidenced in these definitions of social capital, scholars commonly refer to social capital as the accrued benefits of positive social relations. As such, social capital can be referred to as a resource. For example, Lin (2001)

defines social capital as the ‘resources embedded in one’s social network, resources that can be accessed through ties in networks’ (p. 73). As a resource, Bourdieu (1985) believes social capital can be converted to other forms of capital such as human and cultural capital and can be used to substitute or complement other resources. Consequently, there is sometimes vagueness from scholars in relation to whether social capital is conceptualised as separate from the benefits it can accrue. Regardless of this ambiguity, there is agreement amongst scholars that social capital is embedded in the relationships between two or more participants that can result in achieving individual ‘ends, returns or benefits that in its absence would not be possible’ (Rostila, 2011, p. 310). This researcher adopts the conceptualisation that social capital is a resource consisting of various benefits that can be utilised or leveraged through collaborative relations. It is adopted because the resources or benefits accrued through social capital have congruence with collaboration theory (Huxham & Vangen, 2005; Thomson & Perry, 2006; Thomson et al., 2009), particularly when conceptualised as goodwill, trust and norms of reciprocity. For example, Rostila (2011) classifies the benefits or resources accessible through accruing social capital into three groups. First, obligations, expectations and trustworthiness; second, potential for information; and third, norms of behaviour that facilitate and constrain behaviour. Furthermore, Woolcock (1998) defines social capital as the ‘information, trust and norms of reciprocity inhering in one’s social networks’ (p. 153). Consequently, there is an overlap between collaboration theory and social capital theory as scholars commonly argue that trust and reciprocity are essential to successful collaboration (Huxham & Vangen, 2005; Thomson & Perry, 2006; Thomson et al., 2009). Therefore, the overlap between the theories shows the relevance and usefulness of social capital theory to examine collaboration, particularly the interrelational processes between those collaborating.

Individually focused definitions of social capital are relevant to this research as they imply that the benefits accrued from social capital are between those more actively engaging in relationships with others rather than those who don’t. Consequently, they allow the researcher to examine whether participants involved in collaboration are achieving more or less benefits through social capital than others and why this may be the case.

In contrast to individually focused definitions that emphasise that benefits are available only to those involved in social relationships, collectively focused definitions of social capital stress that social capital is non-exclusive and available to all those within a network. For example, Woolcock (2001) claims that social capital is merely:

the structure of networks and social relations that lead the way to mutual benefit through cooperation, but not the adjoining behavioural dispositions that often accompany these, such as trust, reciprocity, honesty and institutional quality measures (p. 12).

Exemplifying the broadening scope of social capital, Fukuyama (2001) argues that ‘social capital can range from a norm of reciprocity between two friends, all the way up to complex and elaborately articulated doctrines like Christianity or Confucianism’ (p. 1). Consequently, collective definitions of collaboration are also relevant to understanding the enactment of collaboration within the youth health sector as they acknowledge that those involved in collaboration belong to wider groups such as occupations or employee groups delivering youth health services. However, by assuming that social capital is mutually available to those within the network, they downplay potential inequality between those within a collaborative network, particularly in terms of who benefits less or more from social capital when collaborating due to intensity of relationships. However, collectively focused definitions of social capital do allow the researcher to conceptualise the benefits available to those within a group. This is important in this research on collaboration because those involved in collaboration in the youth health sector have particular altruistic values and the benefits of social capital within this group is largely unexplored.

Regardless of whether social capital is conceptualised at an individual or collective level, this research considers social capital as an asset with expected returns (Lin, 1999). Coleman (1988) argues that as an asset, social capital can be developed, appropriated and depleted within a process of collective action such as collaboration. Coleman (1988) also argues that social capital cannot be owned by the individual. However, this research takes Watson and Papamarcos’s (2002) view that ‘social capital accrues to the individual as his or her stock accumulates in the form of other people’s obligation to reciprocate previous favours’ (p. 540) and thus having more is beneficial. Therefore, although social capital may not be owned by an individual, it can be accumulated by an individual or an individual organisation and utilised within collaborative arrangements for individual and collective benefits.

Coleman (1988) considers the qualities and capabilities of those who make up the relational network and therefore introduce inequality within the network. However, the social capital literature is unclear as to which stakeholders within a collaborative network offer more opportunity to accrue social capital and for the benefit of whom, particularly in the context of a youth health network. Nor is it clear what quality social capital involves or which

stakeholders can offer better social capital than others. The literature is also uncertain in relation to how investment in social capital is characterised in a network of organisations involved in collaboration in the youth health delivery.

Therefore, using the concept of social capital allows the researcher to conceptualise the non-monetary benefits that can result in information transfer, influence and solidarity between members within the structure of a collaborative network (Cots, 2011). In addition, social capital theory allows the researcher to consider the social, relational and communicative nature of people involved in collaboration and the impact of a variety of factors such as the opportunity, motivation and ability of stakeholders (Adler & Kwon, 2002). This is important in the context of this study because examining social capital also allows inequalities of influence to be examined within a collaborative network in terms of who has more or less social capital when collaborating and why this may be the case.

Therefore, the concept of social capital allows the researcher to examine the process of social connectedness and cohesiveness between a community of participants to attain action, or more effective action. It also allows the researcher to conceptualise social capital as a human relational resource or asset (Watson & Papamarcos, 2002) that can be leveraged when collaborating. Social capital theory also allows the researcher to understand how collaboration may be influenced by those who have more or less access to social capital when collaborating. Hence, social capital allows identification of those perceived as more or less important when collaborating and allows examination of the willingness of participants to collaborate.

This section has defined social capital at both individual and collective levels and shown how social capital can assist in understanding the interrelational aspects of collaboration, particularly issues surrounding norms of trust and reciprocity. However, to understand how social capital influences collective action, a deeper understanding of social capital is required. The following section discusses the dimensions of social capital in order to understand better the highly abstract nature of social capital and the influence it has on those involved in collaboration.

### **3.4.2 Social capital theory**

The multifaceted nature of social capital is made clear within the literature by social capital theory, which commonly divides social capital into three interrelated dimensions. These

dimensions are the structural, relational and cognitive dimension of social capital (Nahapiet & Ghoshal, 1998). By reviewing the literature relating to these dimensions of social capital, the following sections will show how conceptualising social capital along these lines allows the researcher to better understand social capital and its impact on collaboration within the youth health sector. It will be clear that the structural dimension allows the impact of hierarchy and competition to be considered when developing social capital. The impact of trust will be emphasised as fundamental to developing both bonding and bridging social capital when considering the relational dimension of social capital. Last, a review of the literature relating to the cognitive dimension of social capital will discuss the impact of shared values and beliefs in relation to effectively building trust and social capital when collaborating. Although the three dimensions are reviewed separately, it will be evident that they are interrelated and assist the researcher to examine how social capital is characterised within collaborative arrangements.

#### *3.4.2.1 The structural dimension*

The structural dimension of social capital refers to the ‘overall pattern of connections between actors ... who you reach and how you reach them’ (Nahapiet & Ghoshal, 1998, p. 244). In other words, the structural dimension refers to the organisation of the network or group members in terms of ‘roles, rules, precedents and procedures as well as a variety of networks that contribute to cooperation’ (Uphoff, 2000, p. 218). Coleman (1990) proposes that structure allows ‘obligations and expectations, responsibility and authority, and norms (or roles) and sanctions’ (p. 313) to be clear for participants. Structure impacts on the nature of relationships and the subsequent development of social capital. Adler and Kwon (2002) conclude that the structures of relations involve hierarchical relations and market relations. The following paragraphs will review both in regards to this research. They are reviewed as collaboration has varying structures that may be fluid or more rigid depending upon arrangements agreed upon by participants and in the case of youth health services, structure is sometimes imposed by government funding bodies.

Hierarchical relations within organisations and networks influence opportunity to develop social capital by specifying roles and influencing decision making and workflow. Hierarchy also influences the provision of wages and incentives and thus the motivation of those involved. Hierarchy also has an impact on ability through skills training, authority, resource allocation and the development of culture (Adler & Kwon, 2002). In other words,

relationships and the social capital accrued between participants are influenced by structured hierarchical relations. This contrasts somewhat with the ideals of inclusion, shared decision making and a lack of hierarchy sometimes promoted in literature concerning collaboration (Booher, 2004; Fung, 2006; Hajer & Wagenaar, 2003; Murray & Shaffer, 2004). However, it aligns with other scholars who promote hierarchy and leadership as necessary for effective collaboration (Bryson & Crosby, 2006; Schwarz, 2006; Steinacker, 2004).

In this research, collaboration in policy and enforced collaboration by government funding organisations shows a perceived legitimacy by government to control or influence collaboration by mandating and structuring relationships. This view conforms to those of institutional theorists and political scientists who believe that formal government authority advances the development of social capital (Adler & Kwon, 2002). Alternatively, liberal-individualist and anti-authoritarian ideologies perceive such bureaucracy as ‘stifling informal organisation and government as constricting civil society’ (Adler & Kwon, 2002, p. 29). Consequently, there is tension within the literature concerning the ability of formal and informal hierarchies or structures to foster relationships and the development of social capital. However, it is clear that both impact on the development of social capital within a network and allow the researcher to conceptualise the development of social capital at vertical and horizontal levels in relation to collaborative relationships.

Research by Evans (1996) concludes that government is able to build social capital if it displays integrity in internal structures and processes and there is synergy with relations with stakeholders. However, Evans’ (1996) research does not include a situation of enforced collaboration by government funding bodies. Evans’ (1996) dated research also does not address current government practice of structuring collaborative relations within the youth health sector but leaving governance and administration of the collaboration to those involved. This approach appears to utilise aspects of both formal authority and informal individualist approaches where participants create their own structures after participation is mandated by government funding bodies. However, the literature is ambivalent in terms of the development of social capital using this approach and thus research situated within the youth health sector is required. It is also required to determine whether those within the youth health sector perceive government as acting with integrity and why when enforcing collaboration and how this impacts on the development of social capital.

Therefore, conceptualising the impact of hierarchy allows the researcher to identify how social capital is developed, maintained or lost when collaborating by analysing vertically and horizontally structured relationships. As a consequence, the structural dimension of social capital also allows the researcher to analyse and compare existing hierarchies, whether formal or informal within the sector, to those emerging roles of influence due to collaboration, and how this relates to the development of social capital.

In addition to the influence of hierarchical structures on the development of social capital, scholars also state that social capital can be accrued due to relationships resulting from competitive market relationships (Adler & Kwon, 2002). Cots (2011) agrees and states 'that social capital is the type of network relationship in cases of cooperation and collective action' (p. 330), implying both cooperative or competitive collective relationships. Although this research is situated in the not-for-profit sector, competitive tendering exists in the youth health sector where service providers collaborate to compete against other similar consortia for funding. The literature addresses competitive tendering and its impact on social capital with O'Shea (2007) concluding that competitive tendering processes cause the:

destruction of social capital, as the cooperative relationships between organisations could be destroyed; blocking shared knowledge and resources which could also affect an organisation's capacity to bond with the community (p. 66).

Therefore, O'Shea (2007) contradicts conclusions drawn by Adler & Kwon (2002) and Cots (2011) and argues that social capital created through cooperative relationships is destroyed as a result of competition. O'Shea (2007) also concludes that social capital developed between stakeholders as a result of networking practices can overcome the destruction of social capital due to competitive tendering. However, O'Shea's (2007) conclusions are not taken from a context where collaboration and networking is forced upon participants through a competitive tendering process. Furthermore, O'Shea's (2007) research includes the views of the community whereas this research examines collaboration between service providers. Consequently, it is unknown whether O'Shea's (2007) conclusion that competition negatively impacts on social capital is true in the youth health context where competition drives collaboration through competitive tendering and thus potentially builds social capital by promoting collective but selective relationships. Therefore, this research is required to advance knowledge relating to relationships created through competitive structures promoting social capital when collaborating.

Although some scholars argue that inter-organisational collaborative networks are different from hierarchical or market systems (Powell, 1990), others suggest that due to there often being a lead organisation, a 'clear distinction between hierarchies and collaborative management is not always accurate' (McGuire, 2006, p. 36). This has resulted in some scholars arguing that inter-organisational networks are 'very much like an organisation in its own right' (Bardach, 1998, p. 21) in terms of being driven by roles and hierarchy (Herranz Jr, 2005). If this is the case, research is needed to examine the differences that may exist between emerging hierarchies through collaboration and existing hierarchies within the youth health sector in order to understand how social capital development can lead to better collaborative outcomes.

This review of the structural dimension of social capital has made it clear that relationships are impacted by network structures and thus the development of social capital. It has acknowledged that accruing social capital is impacted by formal and informal hierarchical structures. This section showed that research examining social capital is vague or lacking depth in relation to government-mandated collaborative structures where participants govern and administer the collaborative network via various means. This section also identified that further research is required to understand better the impact of competition on the development of social capital within a youth health collaborative network. The following section reviews the relational dimension of social capital.

#### *3.4.2.2 The relational dimension*

The relational dimension of social capital is rooted in the idea that social capital is produced through interaction and interrelationships between participants (Lin, 1999). Adler and Kwon (2002) agree that social capital 'in all its forms is a relation, not a thing' (p. 27). Therefore, understanding how these relationships are characterised within a collaborative network is fundamental to understanding the development of social capital and the benefits it brings for those involved in collaboration.

The relational dimension of social capital reflects 'how relationships are understood as a history of interactions characterised by trust, reciprocity and emotional intensity' (Cots, 2011, p. 332). By highlighting a history of relationships, Cots (2011) implies an ongoing need for developing trust and reciprocity, which is also a common theme in collaboration literature (Onyx & Bullen, 2000; Zhang & Huxham, 2009). In other words, social capital requires trusting and reciprocal relationships that are built and become more concrete over time

through continuing social interactions (Gulati, 1995). As Putnam (1993) argues, ‘[T]he greater the level of trust within a community, the greater the likelihood of cooperation. And cooperation itself builds trust’ (p. 170). It is through these continuing relationships that participants are more likely to be considered trustworthy (Gabarro, 1978), resulting in others making efforts to build relationships with them. Consequently, the literature suggests that stakeholders considered more trustworthy have more influence or salience than others and this reinforces the conceptualisation that social capital is an asset with potential or expected returns. However, the literature is vague in terms of how trust is developed in the youth health sector or what trust is based on, particularly when considering the diversity of the government and non-government service providers involved. Furthermore, the literature is unclear whether trust is required or to what level in situations of mandated collaboration, particularly considering collaboration may be short lived rather than ongoing.

Scholars commonly refer to the intensity or direction of these relationships when analysing social capital by conceptualising it as *bonding* or *bridging* social capital (Daubon & Saunders, 2002). Daubon and Saunders (2002) describe bonding or community social capital as cohesion ‘applicable to acquainted individuals within circles of reciprocal trust’ (p. 178). In other words, community or bonding social capital refers to the strength or usefulness of existing ties between actors to attain certain outcomes or interests. Some scholars argue that bonding social capital is useful for preserving or maintaining resources (Lin, 1999). Other scholars such as Hansen (1999) propose that the strength or intensity of ties influence the type of information shared and that weak ties result in more innovative solutions to complex problems whilst stronger ties facilitate the transfer of more complex and tacit information. However, Hansen’s (1999) research is not situated in the not-for-profit sector or more specifically, the youth health sector. Therefore, the strength of ties required when delivering youth health services is unclear as is why stakeholders choose to build stronger ties with some stakeholders rather than others. As such, the characteristics of bonding social capital within a collaborative network of youth health providers are unknown.

Others scholars argue that excessive trust in regards to bonding social capital can lead to negative outcomes such as an inward-looking focus and isolation (Li, Savage & Pickles, 2003; Paxton, 2002), particularly as participants conform to expected norms within those relationships. Consequently, social capital theory assists the researcher to examine the normative pressures of participants to comply with social norms associated with trust and reciprocity when collaborating. Examination also includes the repercussions of

noncompliance. This research is required as literature examining the impact of bonding social capital or the strength and intensity of relationships between those collaborating in the youth health sector is unclear. It is also undetermined whether closer ties developed through collaboration impact future collaborative arrangements, particularly in terms of who may have more or less influence or involvement based on their access to, or levels of, social capital.

Bonding social capital is in contrast to public or bridging social capital. Bridging social capital is 'applicable to unacquainted strangers in a broader group ... across such circles of trust' (Daubon & Saunders, 2002, p. 178). This means social capital is created by producing new linkages between actors or reaching out to those who may not have developed levels of trust or trustworthiness. Interestingly, NSW youth health policy emphasises building broader linkages more so than stronger linkages across services (NSW Department of Health, 2010a), implying that trust varies within the youth health sector and collaboration is a means to develop social capital and trust within the sector. The plausibility of this assertion is assisted by research findings proposing that building bridging social capital more readily occurs when there is a shared covenant between those involved (Daubon & Saunders, 2002). In the context of a youth health network, a shared covenant may refer to a common goal of assisting at-risk youth or attaining funding. However, whether altruistic values or funding goals associated with youth health delivery act as a means or covenant to promote trust and allow the development of bridging and bonding social capital within the youth health sector is uncertain.

This section has shown that the relational dimension of social capital is influenced by trust built through ongoing relationships and the trustworthiness of potential participants. It was also shown that researchers analyse relational influences on social capital based on an inward-bonding focus or and outward-bridging focus. In doing so, it was evident that bonding social capital can be linked not only to positive outcomes through strengthening relational linkages but also negative outcomes such as an inward focus. The inward focus of bonding social capital contrasts with literature on collaboration which often calls for the inclusion of diverse opinions or views rather than conformist perceptions, in order to discover new and better outcomes. However, collaboration literature appears to focus on the positive effects of trust on the collaboration process, often downplaying the negative. This section showed that the impact of bonding and bridging social capital in the youth health sector is vague but some scholars assume that relationship building can be facilitated due to common altruistic values.

However, whether this occurs within the youth health sector has not been empirically determined.

Now that the structural and relational dimensions of social capital have been critiqued, the next section reviews the cognitive dimension of social capital.

#### *3.4.2.3 The cognitive dimension*

The cognitive dimension of stakeholder social capital ‘refers to the extent to which stakeholders share a common perspective or common understanding’ (Cots, 2011, p. 332). The cognitive dimension ‘is embodied in attributes like a shared code or a shared paradigm that facilitates a common understanding of collective goals and proper ways of acting in a social system’ (Tsai & Ghoshal, 1998, p. 465). Although each stakeholder group may have different interests, they may concurrently share common interests (Rowley & Moldoveanu, 2003). Cognitively based, mutually held belief systems are fundamental to social capital and collective action as they impact on the flow of information and knowledge (Lesser, 2000).

As introduced in the section above concerning the relational dimension of social capital, shared or mutually held belief systems can help facilitate relationship building through assisting the development of trust. However, the literature is unclear when considering the impact of altruistic values on social capital between participants collaborating in the youth health sector. Also vague is how the competitive tendering and individual organisational accountability principles associated with an entrenched culture of New Public Management (NPM) impact on the shared cognition and the development of social capital when collaborating.

Tsai and Ghoshal (1998) argue that the cognitive dimension relates to those assets created and leveraged through relationships including trust and trustworthiness, based on ‘shared representation, interpretation and systems of meaning among parties’ (Tsai & Ghoshal, 1998, p. 244). These belief systems manifest themselves as social norms or ‘properties of a social system’ (Coleman, 1990, p. 241) where certain actions are considered appropriate or not appropriate. Consequently, norms are communicated and internalised governance systems where people feel normative pressure to conform to the behaviours or expectations of others. How these belief systems differ between participants in youth health sector collaborations is unclear, particularly as the sector is characterised by government and non-government organisations.

To assist in understanding internalised belief systems of those involved in collaboration, the literature distinguishes between rules and norms. For example, taking a more instrumental perspective, Ostram (2005) compares norms to rules by arguing that although ‘both permit, prescribe, or proscribe action’ (p. 140), nonconformance to rules result in sanctions whereas norms do not (Ostram, 2005). This research explores whether nonconformance to norms when collaborating results in specific types of sanctions or sanctions at all, particularly as participation in collaboration in the youth health sector is sometimes mandated by government funding bodies.

The above review of the literature on the structural, relational and cognitive dimensions of social capital showed how social capital is manifested in the relationships, beliefs and attitudes of those within a structured network, whether formal or informal. It also showed that the structural, relational and cognitive dimensions of social capital are interrelated. First, the structural dimension showed that accruing social capital is impacted by formal and informal hierarchical power. It highlighted that little or no research examines social capital in government-mandated collaborative structures where participants govern and administer the collaborative network via various agreed-upon means. It was also made clear that competitive relationships can also result in the development of social capital, which is pertinent to this research due to competitive tendering processes.

Second, a review of the relational dimension of social capital illustrated the importance of trust or trustworthiness built through ongoing relationships. It was shown that relationships are often conceptualised as based on intensity and direction resulting in bonding or bridging social capital. It was made clear that excessive levels of trust can create a closed mind-set that may minimise learning and innovation, particularly in relation to bonding social capital, that could potentially hinder productive collaboration. It was also shown that bridging social capital sometimes requires assumptions of trust or trustworthiness, which can be facilitated by a shared covenant. For example, the shared covenant could involve shared altruistic values associated with youth health service delivery. However, this has not been empirically determined in the context of youth health prior to this research.

Third, this section reviewed the cognitive dimension of social capital. It reinforced that mutually held belief systems such as altruistic motivations and determinants of trust impact on the development of social capital. Also discussed was the development of norms of behaviour resulting from shared belief systems. However, how these belief systems are

manifested and enforced within the youth health context is unknown and thus indicates why research into collaboration within the youth health sector is required.

### **3.4.3 Benefits of social capital**

The literature outlines a number of benefits associated with social capital. More efficient information transfer and less need for bureaucratic processes are considered a benefit of increased social capital as there is less need to formalise reciprocal arrangements due to increased levels of trust and solidarity between participants (Burt, 1997; Putnam, 1993; Watson & Papamarcos, 2002). However, whether a common altruistic goal creates enough trust, solidarity and social capital to facilitate efficient information transfer within the youth health sector is unclear, particularly as individual organisations are financially accountable due to the entrenched principles of NPM.

Adler and Kwon (2002) state that increased social capital ‘facilitates access to broader sources of information and improves information’s quality, relevance and timeliness’ (p. 28). However, the literature is not clear as to why information is transferred by collaborative participants and what influences its transfer within the context of youth health, including social capital between service providers.

Influence, control and power are benefits derived as a result of social capital (Lin, 1999, 2001). For example, Lin (1999) claims that having social relationships with others may be perceived by organisations and their agents as ‘certifications of the individual’s social credentials and therefore, illustrates power or influence by association’ (p. 30). If this is the case, it raises the question, who benefits more from higher levels of social capital when collaborating within the context of a government-coordinated youth health network? It also raises the questions, how do these stakeholders maintain their levels of social capital and is this to the detriment or benefit of others? By examining how collaboration is enacted within the youth health sector, this research explores how the benefits accrued through having more social capital than others is enacted within a youth health network. In addition, it examines how social capital is used to achieve individual and collective objectives.

Lin (1999) also claims that reinforcement of identity and recognition are benefits of social capital:

[O]ne's worthiness as an individual and a member of a social group sharing similar interests and resources not only provides emotional support but also public acknowledgement of one's claim to certain resources (Lin, 1999, p. 31).

How identification and recognition as a worker in youth health impacts on social capital in the youth health sector is unclear. Identity and recognition is pertinent in this research as youth health has a unique identity as do government and NGOs within the youth health sector. How these identities are impacted by collaboration and vice versa is also unclear.

High levels of social capital also assist in addressing wicked problems more successfully due to collective use of resources (Productivity Commission, 2003). The Productivity Commission (2003) also argue that participants able to access social capital are more 'hired, housed, healthy and happy' (p. x) than those without and that government is more economically efficient through the maximisation of limited resources and the broadening of policy options. However, the Productivity Commission did not undertake primary research and based their views on secondary literature, which often focuses only on the positive advantages of social capital. For example, Cots (2011) argues that the very nature of social capital relates to the positive 'advantages created by actual and potential resources embedded in social relationships among actors' (p. 330) and placing those 'positive consequences in a framework of the broader discussion on capital' (Portes, 1998, p. 2). Like much of the literature on social capital, the Productivity Commission advocate developing social capital and display a lack of critical analysis of its potential pitfalls or risks. The pitfalls or risks of social capital are discussed in the following section.

This section has highlighted some of the proposed benefits of social capital. It has shown that although these benefits have been empirically verified in a number of contexts, they have not been examined within a government-coordinated youth health network; nor have they been applied specifically to an environment of enforced collaboration involving government and non-government youth health service providers. This research addresses this lack of knowledge.

#### **3.4.4 Risks of social capital**

Although the bulk of the scholarly literature focuses on the positive benefits of social capital, such as increased levels of trust and solidarity between participants (Burt, 1997; Putnam, 1993; Watson & Papamarcos, 2002), some scholars refer to negative outcomes of social

capital (Adler & Kwon, 2002; Fine, 1999; Portes, 1998). This section highlights the risk of social capital.

The risks of social capital can sometimes outweigh the benefits (Adler & Kwon, 2002; Fine, 1999). First, investment in time and resources to develop social capital may not be cost efficient and may be costly to maintain (Portes, 1998). Furthermore, results of investment are 'characterised by less transparency and more uncertainty' (Portes, 1998, p. 4), particularly in terms of time and reciprocity. Second, power gained through the acquisition of knowledge may make information sharing and the development of linkages with others less of a priority (Adler & Kwon, 2002). As such, this implies an emphasis on individual rather than collective gain.

Third, over-embeddedness associated with solidarity may inhibit innovativeness and create inertia (Powell & Smith-Doerr, 1994). Over-embeddedness associated with solidarity may also result in free-riding as actors in the network take advantage of the benefits being accrued by the aggregate (Adler & Kwon, 2002; Portes, 1998). Whether high levels of social capital inhibit collaboration or result in free-riding in the context of youth health is uncertain.

Fourth, control over the aggregate may be compromised as solidarity of minor groupings may compromise the broader aggregate and also cause fragmentation of the broader whole (Brass, Butterfield & Skaggs, 1998). In other words, as with stakeholder theory, there is an acknowledgment of potential sub-alliances. However, whether social capital between particular stakeholders results in sub-alliances with a collaborative network of youth health service providers is unclear. Potential sub-alliances and their basis are explored in this research.

Fifth, Putnam (2001) recognises the dark side of social capital and argues that like other forms of capital, social capital 'can be used to ends that are in some instances destructive' (Putnam, 2001, p. 3). Consequently, scholarly literature suggests that in addition to being used for positive ends, social capital can be used for destructive purposes (Levi, 1996; Schulman & Anderson, 1999; Van Deth & Zmerli, 2010).

The above risks highlight the need for caution when promoting the development of social capital. As Adler and Kwon (2002) claim, critics of the concept of social capital 'are on strong ground in highlighting the risks of policies designed simply (and, therefore, simply-mindedly) to strengthen social capital' (p. 31)

Whether these risks are evident in the context of a network of youth health providers where collaboration is promoted in government policy and enforced through competitive tendering processes is a focus of this research thesis.

Thus far this section on social capital theory has defined social capital and reviewed the structural, relational and cognitive dimensions of social capital. Following that, it outlined the benefits and risks relating to social capital. The next section clarifies how social capital theory enables new understanding of collaboration.

### **3.4.5 Strengthening collaboration theory with social capital theory**

This review of the literature illustrated that the theoretical principles of social capital theory can assist the researcher to advance understanding of collaboration and answer the research questions. The areas where social capital theory can advance understanding of collaboration follow.

Social capital can assist a better understanding of collaboration theory by:

1. explaining strategies used by participants for the investment, development, obtaining, maintenance, use and depletion of social capital when collaborating in a government-coordinated network with diverse stakeholder groups
2. explaining the use of social capital by stakeholders in collaboration to gain collaborative or competitive advantage
3. revealing how having more or less social capital impacts on engagement in collaboration
4. identifying how social capital helps or hinders collaboration in the context of youth health
5. making known the relationship between existing and emerging hierarchies of influence and social capital when involved in collaboration
6. identifying the relationship between enforced, coerced and voluntary collaboration and social capital
7. explaining the normative pressures to collaborate within a government-coordinated network
8. understanding the relationship between altruism and social capital in relation to collaboration

9. understanding the relationship between economic considerations and social capital in relation to collaboration
10. identifying the types of social capital in a collaborative network.

The gaps highlighted above show that there is a need to understand whether stakeholders with more or less social capital are key players in relation to collaboration. If so, it raises the question whether gaining or maintaining social capital impacts on the willingness of stakeholders to collaborate and what levels of social capital are required and why these levels are required. Consequently, there is a need to understand how social capital impacts on those collaborating, i.e. in addition to the synergistic benefits of social capital explicit in both collaboration theory and social capital theory. In other words, there is a need to know how social capital is related to the individual and collective goals of those involved in collaboration, both implicit and explicit. Furthermore, research is required to explore contextual factors such as altruistic motivations, competitive tendering processes and mandated collaboration and the impact these have on the development of social capital in a collaborative context. This also means understanding the impact of existing or emerging hierarchies of influence when collaborating either through structural, relational or cognitive processes. To address these gaps in knowledge, the research includes a broad research question aimed at understanding the operationalisation of collaboration when enacted within the youth health sector.

The gaps listed above also show that better understanding of collaboration can be gained by utilising the principles of social capital theory when researching collaboration within the youth health context. Examining the literature on social capital theory is important as it identifies a variety of contextual factors impacting on the development of social capital when collaborating that are not explicitly addressed in collaboration theory. This indicates that the theoretical principles and processes of collaboration discussed in section 3.3.3 of this literature review lack comprehensiveness in explaining social capital between stakeholders when collaborating and thus require review. Therefore, the author argues that the application of social capital theory to gain a more comprehensive theoretical understanding of collaboration and to develop collaboration theory further is justified.

The gaps presented above showing where the application of social capital theory can assist in better understanding collaboration incorporate reference to the contextual factors impacting on collaboration within the youth health sector. They illustrate why qualitative multi-case

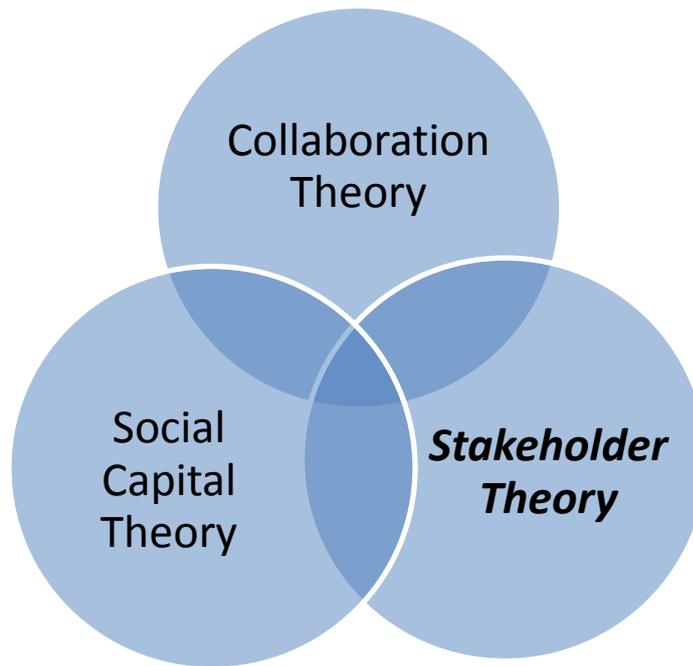
study research processes were used in this research developing collaboration theory. As stipulated in section 4.4.2 of the methodology chapter the author contends that theory development is dependent on context. Thus, it is through this contextual dependence that the researcher can make the theoretical contribution highlighted in section 1.5 and 3.8 of this research report.

In summary, social capital theory enables analysis of the social and communicative processes and benefits these processes bring for participants when collaborating. Social capital theory also allows for understanding of complementary capabilities and contingencies when examining the benefits and risks of social capital. Furthermore, social capital theory allows analysis of the roles of those collaborating by comparing hierarchies based on traditional roles and structures within the youth health sector to those emerging through the process of collaboration and the possession of social capital. Social capital theory is also relevant to the aims of this research as the network of youth health service providers is only partly driven by economic considerations. In other words, those within the youth health sector are also driven by altruistic motivations associated with the health needs of at-risk youth. Therefore, social capital theory provides a useful framework to examine the underlying willingness from stakeholders to collaborate by examining the impact of views and perceptions of service providers concerning non-altruistic motivations, such as personal power and influence by other stakeholders in relation to collaboration.

Now that social capital theory has been reviewed and shown to have relevance to understanding collaboration better, the following section on stakeholder theory does likewise.

### **3.5 Stakeholder theory**

To this point, the literature review has shown that social capital theory has a degree of overlap with collaboration theory, particularly in terms of building trust and reciprocity. However, an objective of this research is to explain the willingness and actions of stakeholders to engage with others when collaborating. For this reason, this research adds some principles of stakeholder theory (see figure 3.5) to explain how collaboration is operationalised within the youth health sector.



**Figure 3.5: Stakeholder theory within the research theoretical framework**

A review of the relevant literature on stakeholder theory and how stakeholder theory, particularly stakeholder salience, can address the research questions follows.

Stakeholder theory, based on rational, resource-dependent social capital and instrumental theories (Mitchell et al., 1997), is premised by the argument that ‘organisations should be managed in the interests of all their constituents, not only the interests of shareholders’ (Laplume, Sonpar & Litz, 2008, p. 1153). Consequently, Phillips, Freeman and Wicks (2003) argue that stakeholder theory differs from other management theories because it ‘explicitly addresses morals and values as a key feature of managing organisations’ (p. 481). For this research, managing organisations based on the principles of stakeholder theory allows the economic and business characteristics of organisations involved in the delivery of youth health services to be considered as well as the social and moral implications of their actions on stakeholders in collaboration and vice versa (Freeman, 1994). These considerations have relevance within the youth health context where the economic and business ideals of NPM and the social and moral obligations of youth health service delivery are both at play. Consequently, stakeholder theory, in particular stakeholder salience, allows the researcher to take into account how altruistic, economic and other stakeholder motivations impact upon collaboration in the context of youth health service delivery.

### 3.5.1 Stakeholder classification and salience

Addressing the questions of ‘who (or what) are the stakeholders of the firm and to whom (or what do managers pay attention’ (Mitchell et al., 1997, p. 853) is fundamental to stakeholder theory. In terms of identifying stakeholders, Freeman (1984) takes a broad view of stakeholders as ‘any group or individual who can affect or is affected by the achievement of an organisation’s objective’ (p. 46). Brugha and Varvasovszky (2000) argue that stakeholders can be individuals, groups and organisations. This research proposes that a stakeholder also includes any individual, group or organisation that can affect or is affected by the achievement of both an individual organisation’s objectives and the actions of a collaborative network. Hence, stakeholders include youth who are end-users of youth health services and funding sources such as governments: local, state and federal. As this research focuses on understanding how collaboration is enacted within a collaborative network of youth health service providers, it primarily focuses on stakeholders involved in collaboration, which in this research are the youth health service providers and their employees. However, it acknowledges that the willingness of service providers to be involved in collaboration and their collaborative engagement strategies will be impacted by stakeholders not directly involved in the collaboration process, including clients and funding providers.

Stakeholder theory asks why managers pay attention to particular stakeholders more so than others. Mitchell et al. (1997) refer to this as *stakeholder salience*, which is the ‘degree to which managers give priority to competing stakeholder claims’ (Mitchell et al., 1997, p. 854). Mitchell et al. (1997) argue that managers prioritise action towards other stakeholders based on their possession or attributed possession of one, two or three of the attributes; power, legitimacy and urgency. Essentially, the more attributes stakeholders have, the more management will be required to respond to that stakeholder (Mitchell et al., 1997). In comparison to Mitchell et al.’s (1997) theory, Blair and Fottler (1990) claim that stakeholders can be classified as: supportive, mixed blessing, non-supportive and marginal. Regardless of the merits of the classification system used, Mitchell et al.’s (1997) theory provides a way to analyse the salience, influence or eminence of different stakeholders and indicate which stakeholders are perceived as key players in collaboration and why. By analysing the perceptions and views of those involved in collaboration, Mitchell et al.’s (1997) theory of stakeholder salience allows the researcher to identify and explain what stakeholder attitudes, intentions and actions impact on the willingness of youth health service providers to engage with others and collaborate.

Consequently, this research confirms the descriptive, normative or instrumental nature of stakeholder theory. It is descriptive in terms of understanding how organisations behave when collaborating, normative in terms of how firms should behave and instrumental in terms of how behaviour affects collaborative performance and outcomes (Laplume et al., 2008). As such, stakeholder theory overlaps collaboration theory as it has the ability to help explain the willingness and actions of youth health service providers when making choices to engage more or less with other stakeholders when involved in voluntary, coerced and enforced collaborations. In addition, Mitchell et al.'s (1997) theory of stakeholder salience allows for explanation of stakeholder actions when negotiating, making commitments to action, executing activities and assessing the performance of themselves and others involved in collaborative processes. In doing so, stakeholder theory also overlaps with social capital theory because perceptions of other stakeholders and their legitimacy, power and the urgency of their claims for the attention of others is impacted by individual and collective views of trust, trustworthiness and shared norms associated with relational, cognitive and structural dimensions of social capital.

### **3.5.2 Stakeholder multiplicity**

A criticism of Mitchell et al.'s (1997) theory of stakeholder salience is that it 'implies that stakeholder groups independently contend for managerial attention and resources' (Neville & Menguc, 2006, p. 377). In comparison, Neville and Menguc (2006) declare 'that organisations do not respond to each and every stakeholder individually, but to the interaction of multiple influences from the entire network' (p. 380). As such, Neville and Menguc (2006) argue that Mitchell et al. (1997) ignore the interaction, competition, cooperation and formation of alliances with other stakeholders within a complex stakeholder network. This criticism is relevant to this research as it examines collaboration, which by its very nature is a collective process. However, this research aims to explain the views and perceptions of individuals concerning their relationships with others, both at an individual and collective level. Due to this aim, the researcher believes that Mitchell et al.'s (1997) theory of stakeholder salience is particularly relevant to understanding the willingness of stakeholders to engage more or less with others when collaborating. Furthermore, the researcher argues that by examining the perceptions of individuals in relation to collaboration any alliances or collective groupings within collaboration will be revealed. However, because the researcher acknowledges that within collaboration there may be influences due to multiple relationships and stakeholder alliances, stakeholder multiplicity is considered and reviewed below.

Dynamic network relationships are referred to as *stakeholder multiplicity* (Neville & Menguc, 2006), or ‘the degree of multiple, conflicting, complementary, or cooperative stakeholder claims made to an organisation [or network]’ (Oliver, cited in Neville & Menguc, 2006, p. 380). Neville and Menguc (2006) examine interactive relationships within a network in terms of directional congruence between stakeholders, the strength of influence of interacting stakeholders and the consideration of potential synergies arising from strategic cooperation (or competition) between stakeholders. Neville and Menguc (2006) propose that to understand the degree of congruence between two or more parties requires three forms of fit: fit as matching, fit as moderation and fit as gestalts. These forms of fit are based on examining the direction, strength and synergy of the interacting claims of stakeholders, which in this research are youth health service providers and their employees. Stakeholder multiplicity is relevant to this research by assisting the researcher to understand how and why service providers may form alliances when collaborating. It also assists the researcher to understand how these alliances impact on the development of social capital and collaborative advantage or synergistic benefits within a collaborative network. Additionally, stakeholder multiplicity acknowledges that inequality exists within a network and that this inequality can be an object of study, which align with the aims of this research. Furthermore, as there are distinct groups such as government and non-government service providers involved in collaboration within the youth health sector, conceptualising stakeholder multiplicity allows the researcher to compare potential alliances based on ideology and ownership to other reasons revealed by research participants.

Neville and Menguc (2006) incorporate environmental factors impacting on stakeholder relationships and propose the use of an actor’s attributes, types of relationships and types of issues or events, to determine stakeholder multiplicity in terms of complementary or conflicting relationship congruence. However, Neville and Menguc’s (2006) theory and research reflect a focus on private enterprise firms. Applying stakeholder multiplicity to the previously unexplored context of a youth health network provides a means to examine if, how, when and why alliances are formed within a network of organisations involved in collaboration.

Rowley and Moldoveanu (2003) and Wolfe and Putler (2002) also add identity and a need to protect interests whilst Rowley and Berman (2000) take a more broad view and contend stakeholders form alliances when they are aware, willing and capable. In terms of collaboration, Butterfield, Reed and Lemak (2004) believe that stakeholder groups come

together due to feelings of duty, perceptions of value, past history, high network density, shared economic interests, shared vision and commonality of cause and to meet the prerequisites of collaboration. Although these reasons to come together are highlighted within the literature, they have not been empirically analysed or verified within a network of organisations collaborating in the youth health sector. In addition, what feelings of duty are based upon and what is perceived as valuable for a diverse stakeholder group including government and NGOs is unclear. Also vague is how economic interests and altruistic goals impact on engagement strategies when involved in collaboration within the youth health sector. Hence, the lengths service providers will go when collaborating to achieve individual and collective goals are vague. This lack of clarity may be due to a lack of opportunity to access a youth health network by previous scholars.

Although Butterfield et al. (2004) consider mandates or legal reasons to come together, they do not compare organisations with varying levels of obligations to mandates or government policy as reasons to collaborate and how and why others respond to alliances when collaborating. In addition, scholars to date have paid scant attention to emotions, responses or resonance associated with forming alliances particularly when collaborating (Laplume et al., 2008). By revealing the thoughts, emotional responses and perceptions of those involved in collaboration within the youth health sector and applying the principles of stakeholder salience, this research addresses this lack of knowledge. In addition, by examining and comparing the thoughts of managers, youth health practitioners and administration staff, this research on collaboration utilising stakeholder theory examines areas previously not considered within the literature.

Analysis of potential alliances is particularly relevant in this research as there are two distinct groups of organisations involved in collaboration in delivering youth health services: non-government and public organisations. This research also examines the varying perceptions and actions of different employee groups within these organisations. Examination of a diverse sample group involved in collaboration within the youth health sector is important as both Mitchell et al.'s (1997) and Neville and Menguc's (2006) theories primarily assume it is managers who are involved in decision making and inter-organisational relationships as representatives of employees and organisations. Whether stakeholder salience and stakeholder multiplicity hold relevance to managers, youth health practitioners and administration staff involved in collaboration is unclear.

One aim of this research is to examine the impact of collaboration in the youth health sector on those involved in collaborative work. Consequently, this research looks to analyse the impact or repercussions of management decisions on individual organisations (both themselves and other organisations), groups of organisations, employee groups and collective outcomes. As such, this research expands on Barnett's (2007) concept of *stakeholder influence capacity* by exploring reasons why stakeholders or groups of stakeholders may hold varying levels of salience or influence when involved in collaboration in a government-coordinated, collaborative youth health network.

The above analysis shows how stakeholder theory assists the researcher to examine the relationships within a collaborative network. As Brugha and Varvasovszky (2000) declare, stakeholder theory can be used to:

generate knowledge about the relevant actors so as to understand their behaviour, intentions, interrelations, agendas, interests and the influence or resources they have brought – or could bring – to bear on decision-making processes (p. 239).

Consequently, the researcher examines inequality between participants involved in collaboration within the youth health sector, which is sometimes at odds with the ideals of equality, democracy and inclusiveness in decision making often espoused within collaboration theory.

### **3.5.3 Strengthening collaboration theory with stakeholder theory**

The above review of stakeholder theory has shown how its principles can assist the researcher to understand collaboration better. However, this review also shows areas where further knowledge is required. Areas where this research can advance knowledge relating to collaboration theory through applying some of the theoretical principles of stakeholder theory follow.

Stakeholder theory may assist a better understanding of collaboration theory by:

1. identifying key stakeholders when collaborating in the not-for-profit sector including those not directly engaged in collaboration
2. identifying which service providers have more salience when collaborating in the youth health sector and why this is the case
3. understanding the strengths and importance of stakeholder salience attributes (power, legitimacy and urgency) when collaborating within the youth health sector

4. exploring the relevance of stakeholder multiplicity and formation of alliances when collaborating in a network with government and non-government youth health service providers
5. identifying the advantages and disadvantages of being involved or not involved in alliances when collaborating
6. identifying the impacts of mandated or decreed participation in collaboration on stakeholder salience and stakeholder multiplicity
7. examining impacts of altruism on stakeholder salience in a collaborative environment
8. exploring the relevance of principles of stakeholder salience to different stakeholder groups when collaborating (i.e. organisational type and employment group).

The gaps identified above show how stakeholder theory can assist in better understanding collaboration. They show a requirement to understand the salience or importance and thus the influence of particular stakeholders on collaboration within the youth health sector. In addition, they allow the researcher to identify stakeholders not directly involved in collaboration but who still impact upon collaboration. The gaps identified show that the principles of stakeholder salience assist the researcher to understand why stakeholders decide to collaborate with some stakeholders more than others. More specifically, they allow the researcher to do this in an environment characterised by coerced and enforced collaboration by government funding bodies and where service providers have altruistic and economic motivations. Stakeholder theory also offers a means to advance understanding of collaboration by examining the formation of alliances and the impact this may have on collaboration within the youth health sector. Consequently, stakeholder theory assists the researcher to explain the operationalisation or enactment of collaboration within the youth health sector. As such, stakeholder theory allows the researcher to examine collaboration by not only describing collaboration as enacted within the youth health sector but also to give explanations of the actions of those involved.

The gaps listed above highlight the areas where the application of stakeholder theory can assist understanding of collaboration occurring within a network of youth health service providers. The application of stakeholder theory to examine collaboration is important as it shows a lack of comprehensiveness of the theoretical principles and processes of collaboration theory discussed in section 3.3.3 of this literature review to describe the operationalisation of collaboration within a particular context. More specifically, the gaps above illustrate the lack of comprehensiveness of existing collaboration theory to address

contextual factors such as the salience of particular stakeholders when collaborating and what factors may create influence when collaborating. Therefore, the application of stakeholder theory to better describe and understand collaboration occurring within the youth health context in order to advance theoretical understanding of collaboration is warranted.

The gaps identified above where the application of stakeholder theory can assist in better understanding collaboration incorporate reference to the contextual factors impacting on collaboration within the youth health sector. They illustrate why qualitative multi-case study research processes were used in this research developing collaboration theory. As stipulated in section 4.4.2 of the methodology chapter the author contends that theory development is dependent on context. Thus, it is through this contextual dependence that the researcher can make the theoretical contribution highlighted in section 1.5 and 3.8 of this research report.

In summary, by using stakeholder salience, stakeholder multiplicity and stakeholder attributes such as power, urgency and legitimacy to understand the enactment of collaboration within a particular context, this research gives an indication of how stakeholders are managing and should manage other stakeholders in order achieve better collaborative outcomes.

Consequently, this research has normative and instrumental implications for stakeholder theory.

### **3.6 Advancing theory**

After reviewing the literature on collaboration theory it was evident that it was prescriptive and lacked depth in explaining how collaboration is enacted within a particular context. To explain the operationalisation of collaboration in a different and unique fashion, social capital and stakeholder theories were reviewed. In doing so, areas requiring further knowledge were highlighted and how all three theories can assist to better understand collaboration within a particular context was made known. This section looks to synthesise the identified gaps and the following section will relate them to the research questions posed in this research.

However, before doing this, the following discussion examines the overlap between the three theories to highlight the theoretical gap identified.

This literature review involved an in-depth examination of literature relating to collaboration theory, social capital theory and stakeholder theory. In doing so it showed that due to the complicated nature of collaboration, one theory alone was inadequate in describing and explaining collaboration when it occurs within the context of youth health services.

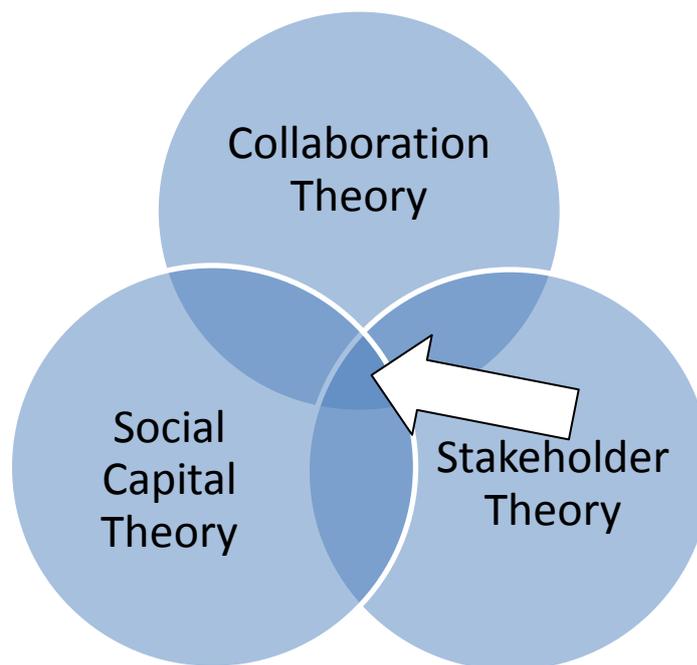
Collaboration theory comprehensively describes the principles of collaboration including processes required for successful collaboration such as governance, administration, agency and organisational autonomy, mutuality and norms of trust and reciprocity. The review also highlighted that these principles involved the processes of negotiation, commitment, execution and assessment. However, the *prescriptive* nature of collaboration theory does not explain how these processes are operationalised or enacted, particularly within a government-coordinated network where collaboration is enforced and coerced by competitive government funding processes. Nor does collaboration theory identify who the key participants are in this context, how collaboration impacts those involved in collaboration or the willingness of participants to actively engage in collaboration and for what reasons. Due to its prescriptive nature, the theoretical principles associated with social capital and stakeholder theories were used by the researcher to better explain collaboration.

A review of social capital theory showed that it assists the researcher to examine the impact of positive communication and relations, including goodwill, for those involved in collaboration. A review of social capital theory also showed that social capital can be conceptualised as a resource or asset giving benefit to those with higher levels of social capital. It also showed that social capital can be developed, maintained or depleted either through collaboration or competition. And by examining the structural, relational and cognitive dimensions of social capital, the researcher may understand the pressures on those working in the youth health sector to engage in collaboration. Hence, social capital theory allows for analysis of influence, including altruism and hierarchy, of those involved in collaboration. However, social capital theory is less clear on why stakeholders may decide to engage in collaboration with some stakeholders more so than others or who the key players are when collaborating.

By applying the theoretical principles of stakeholder theory, the researcher can broaden the examination of stakeholders to include those not actively involved in the collaboration as well as those who are. This allows the researcher to examine the impact of government funding bodies and users of youth health services on collaboration. Stakeholder theory also allows the researcher to understand why stakeholders decide to engage more or less with some stakeholders than others when collaborating. Or, in other words, why some stakeholders were considered more salient than others. As such, stakeholder theory allows directional congruence and strength of relationships between participants involved in collaboration to be analysed. Furthermore, it allows the researcher to understand the

formation of alliances between participants when collaborating. However, stakeholder theory was unclear on the relationship between social capital and stakeholder salience for those involved in collaboration.

In summary, by using the theoretical principles of collaboration, social capital and stakeholder theories to answer the research questions, the researcher identifies an overlap or shared gap between the three theories (see figure 3.6).



**Figure 3.6: Theoretical overlap within the research theoretical framework**

This overlap or shared gap allows the researcher to examine collaboration in a unique way that is not evident in existing research on collaboration. The overlap between the theories involves understanding the relationship between how social capital is developed, obtained, maintained or depleted in collaboration and how stakeholders make decisions to maximise the benefits of social capital when collaborating and why, including the impact of social capital on stakeholder salience. In other words, the overlap is that stakeholders engage in collaboration to create, maintain and use social capital to gain benefit and that stakeholders make decisions when collaborating in order to maximise opportunities to obtain social capital and gain salience. Also, what is not clear is the relevance or application of collaboration theory in a context of enforced, coerced and voluntary collaboration where government

policy promoting collaboration coexists with government policy promoting competition and individual organisational accountability. Furthermore, there is a lack of clarity concerning the impact of these contextual factors on the strategies of engagement in collaboration used by stakeholders, and why, when collaborating. Thus, the main gap in understanding that this research addresses is

*a need to explain the salience or eminence of stakeholders when collaborating within the youth health context and the sources of salience. The gap in knowledge also relates to a lack of understanding of how and why social capital is developed, maintained, used, depleted and competed for by stakeholders within a collaborative network, particularly in terms of its relationship with stakeholder salience.*

The areas requiring further knowledge or understanding that were highlighted in the literature review are presented in Table 3.1, which follows.

**Table 3.1: Gaps identified in the literature**

<b>Collaboration theory</b>	<b>Social capital theory</b>	<b>Stakeholder theory</b>
<p>A need to explain the deeper dynamics of the actions or behaviours of those involved in collaboration.</p> <p>The salience or importance of stakeholders or participants when collaborating, including those not directly involved in collaboration such as youth in need, government and funding organisations.</p> <p>The hierarchies of influence including normative pressure to collaborate for those within the youth health sector.</p> <p>The impact of mandated, coerced and voluntary involvement in collaboration on stakeholder engagement, particularly within the youth health sector.</p> <p>The willingness of stakeholders to participate in collaboration in relation to policy, altruism, clinical factors and economic considerations.</p> <p>Differences in how the principles and dimensions of collaboration relate to subgroups within collaboration processes such as government and non-government youth health providers and managers, youth health practitioners and administration staff.</p> <p>Perceptions of responsibility to other stakeholders and the impact this has on collaboration engagement.</p> <p>The explicit and implicit goals when collaborating and how they are achieved.</p> <p>The specific actions service providers are willing to take to achieve individual and collective goals.</p>	<p>Strategies for the investment, development, obtaining, maintenance, use and depletion of social capital when collaborating in a government-coordinated network with diverse stakeholder groups.</p> <p>The use of social capital by stakeholders in collaboration to gain collaborative or competitive advantage.</p> <p>Understanding of stakeholders with more or less social capital and how this impacts on engagement in collaboration.</p> <p>How social capital helps or hinders collaboration in the context of youth health.</p> <p>The relationship between existing and emerging hierarchies and social capital.</p> <p>The relationship between enforced, coerced and voluntary collaboration and social capital.</p> <p>The normative pressures to collaborate within a government-coordinated collaborative network.</p> <p>The relationship between altruism and social capital in relation to collaboration.</p> <p>The types of social capital in a collaborative network.</p>	<p>Identification of key stakeholders when collaborating in the not-for-profit sector, including those not directly engaged in collaboration.</p> <p>Which stakeholders are more or less salient when collaborating in the youth health sector and why?</p> <p>The strengths and importance of stakeholder salience attributes (power, legitimacy and urgency) when collaborating within the youth health sector.</p> <p>Relevance of stakeholder multiplicity and formation of alliances when collaborating in a network with government and non-government youth health service providers.</p> <p>The advantages and disadvantages of being involved or not involved in alliances when collaborating.</p> <p>The impacts of mandated or decreed participation in collaboration on stakeholder salience and stakeholder multiplicity.</p> <p>The impacts of altruism on stakeholder salience in a collaborative environment.</p> <p>The relevance of principles of stakeholder salience to different stakeholder groups when collaborating (i.e. organisational type and employment group).</p>

This section discussed the benefits of using collaboration, social capital and stakeholder theories to develop theory and new knowledge of collaboration. It presented the gaps in knowledge that this research aims to address. These gaps were then presented in Table 3.1. The next section explains how the research questions address the gaps identified within the literature review. Following on from that, the theoretical contribution that this research makes is presented.

### **3.7 Development of research questions**

This section explicates the research questions addressed in this research project. It also highlights how each question can strengthen and add to understanding of collaboration by addressing the identified gaps in knowledge associated with collaboration theory, social capital theory and stakeholder theory outlined in the table above (Table 3.1). Due to the complicated nature of collaboration and the embeddedness of collaboration in context, strict delineations between the questions are problematic and, as such, there is a degree of overlap.

*Research question 1: Who collaborates in the youth health sector and why?*

This question allows for identification of stakeholders involved in and excluded from active collaboration within the youth health sector. It also allows the researcher to make comparisons between different employee groups to explain their level of involvement in collaboration and identify what factors influence their willingness and decisions to engage in collaboration. Insight is desired into how stakeholders perceive collaboration and why they are motivated to be involved. Factors identified as reasons to collaborate can be related to enforced and voluntary collaboration. This question also allows identification of explicit and implicit pressures on stakeholders to collaborate, including normative, altruistic, clinical, economic and institutional pressures.

*Research question 2: What are the impacts of collaboration within the youth health sector?*

Question 2 allows the researcher to identify positive and negative impacts of collaboration within the youth health sector. It also allows the researcher to identify, compare and contrast the impact of collaboration on different stakeholder groups, such as government and non-government youth health service providers and different employee groups. This question also assists the researcher to identify the impact of collaboration on the development of social capital and vice versa and whether social capital is helping or hindering the ability of collaboration to deliver its stated aims. Also highlighted is the degree of willingness and

motivation for stakeholders to engage in collaboration to obtain social capital. Consequently, strategies used by stakeholders that maximise the positive impacts of collaboration and minimise the negative impacts are explored, for example, gaining or developing salience and the formation of alliances. This question also allows for emerging themes that may be perceived as both positive and negative for service providers, either collectively or for individual organisations.

By identifying the impact of collaboration within the youth health sector, the researcher gains insight into how collaboration differs from existing or other alternative methods of organisation as experienced by interviewees. Consequently, emergent hierarchies of influence resulting from collaboration can be compared to those already existing within the youth health sector and how these impact on the willingness of stakeholders to engage in collaboration.

*Research question 3: How is collaboration operationalised or enacted within the youth health sector?*

By answering how collaboration is operationalised or enacted in the youth health sector, the researcher can explore how collaboration occurs within a government-coordinated youth health network where competitive tendering practices coexist with enforced, coerced and voluntary collaboration. By examining how collaboration actually occurs within the youth health sector, the researcher can identify and analyse what interviewees perceive as enabling or hindering collaboration when pursuing individual and collective objectives. The researcher can explore how hierarchies of influence are developed and maintained when collaborating, with particular emphasis on the development, maintenance and depletion of social capital when collaborating and the impact this has on stakeholder salience. As such, this question assists the researcher to explore winners and losers when collaborating and how and why these inequalities are accepted or resisted by different stakeholders. It also allows for identification of which stakeholders are perceived as more salient or important when collaborating in the context of the western Sydney youth health sector, including government and NGOs and how this impacts stakeholder decisions to actively engage in collaboration. Hence, the researcher can identify who stakeholders believe have more or less influential roles when collaborating, including government. Additionally, this question allows political processes at play within collaboration to be examined, including the formation of alliances within collaborative networks. Examining how collaboration is enacted also allows formal

and informal communication processes to be examined. Also examined is how shared norms and formal structured processes impact on collaboration. Further, the researcher can compare and contrast how different organisational types or employee groups engage in collaboration and their differences and similarities examined. Furthermore, this research question allows for examination of how issues are negotiated, agreed upon, accepted, delivered and enforced, and by who, within a government-coordinated youth health network in the not-for-profit sector.

### **3.8 Theoretical contribution**

Now that the theoretical gaps in understanding have been identified and discussed, this section presents the theoretical contribution to the understanding of collaboration that this research makes. It does this by examining collaboration occurring within a government-coordinated not-for-profit network of organisations involved in the delivery of youth health services and where policies of financial accountability, competitive tendering processes and enforced collaboration coexist. It also does this by examining collaboration using the combined theoretical principles of collaboration, social capital and stakeholder theories. By combining both the unique contextual factors impacting on collaboration and using three theories to understand collaboration better, the theoretical contribution of this thesis is:

*Understanding how and why social capital is developed, maintained, used, depleted and competed for by stakeholders within a collaborative network in order for stakeholders to be more salient to network members and external stakeholders and sources of salience when collaborating.*

### **3.9 Chapter summary**

In reading this literature review, the reader was presented with the background to this research in the form of a critical review of collaboration theory, stakeholder theory and social capital theory and how these theories assist the researcher to fulfil the research aims.

The literature review began by presenting the research problem and the need to analyse collaboration in a unique context of enforced collaboration by government, where participants in collaboration also have altruistic motivations and organisational requirements to consider economic and performance implications. It was shown that due to the descriptive and prescriptive nature of collaboration theory, there is a lack of clarity in explaining how key principles and processes of collaboration occur in the youth health context. This lack of

clarity was evident when considering a government-coordinated youth health network where collaboration is being used by government as a contemporary management strategy to improve the delivery of youth health services and provide benefits for participants.

To better explain the deeper dynamics of collaboration and to understand the willingness of participants to be involved, this literature review highlighted that the application of the theoretical principles of social capital theory and stakeholder theory is required to strengthen knowledge of collaboration. It was made clear that social capital theory allows the synergistic benefits of social relations to be considered an asset that is related to the structure of relations, the relationships between participants and cognitive interpretations of those involved. It was also clear that stakeholder theory allows for the identification of who are the key players involved in collaboration and who demands more or less action from other stakeholders.

By reviewing collaboration, social capital and stakeholder theories, gaps in understanding were identified which were summarised and related to the research questions. The overlap or merging of the three theories was also shown. This illustrated how combining these theories enabled better understanding of collaboration by allowing the researcher to analyse collaboration in a unique and original way. This literature review culminated by presenting the theoretical benefits of this research in terms understanding how stakeholders involved in collaboration make decisions in order to obtain social capital to improve their salience within a collaborative network.

Now that the relevant literature for achieving the aims and objectives of this research and for answering the research questions has been reviewed, the next chapter explains the methodology used to collate findings that address the gaps in knowledge identified in this chapter.



## **Chapter 4: Methodology**



## 4.1 Introduction

The previous chapter reviewed the literature on collaboration and contained a discussion on how the theoretical principles of collaboration, social capital and stakeholder theories can assist in answering the research questions and addressing the aims of the research. It also concluded with a presentation of the theoretical contribution of this research. The theoretical contribution involved understanding stakeholder collaborative engagement strategies aimed at increasing social capital in order to improve their salience when collaborating.

In this chapter, the researcher justifies and explains the methodology used to develop research findings and conclusions. More specifically, this chapter outlines:

1. method of knowledge creation (ontology and epistemology). The researcher's philosophical stance is justified, which for this research is realism. The researcher also discusses and justifies the use of the qualitative research paradigm and why a multi-case study research framework is used in this research.
2. method of data gathering. The researcher describes research protocol, including ethics, and discusses the limitations of the methodology.

The method of analysis used in this research is not discussed here. Rather, it is discussed in the next chapter, which is solely dedicated to the method of analysis used in this dissertation. This chapter is presented as a foundation to the method of analysis chapter by describing how and why the researcher used a multi-case study research framework based in the qualitative paradigm. In this chapter, the researcher presents the tools and methods used to collect the required research data. The next chapter builds on these conclusions to show how they were applied to the analysis process.

This chapter begins with a reiteration of the research questions and a brief discussion on the 'how' and 'why' nature of the questions posed. The researcher discusses, describes and justifies the application of a multi-case study research framework to this research, which is based in the qualitative paradigm. It is shown that qualitative multi-case study research allows for the identification and examination of the perceptions and views of those working within a network of organisations involved in providing youth health services in western Sydney. In so doing, the researcher can examine the impact of particular contextual factors such as enforced, coerced and voluntary collaboration within a context where government promotes collaboration and the principles of New Public Management (NPM) concurrently.

In this chapter, the researcher also presents the data collection methods used. Purposive sampling is shown to allow the researcher to access a group of participants who were willing to be involved and who could provide their perceptions and views of collaboration when operationalised within the youth health sector. Employee groups involved in the research are discussed and the data collection techniques explained and justified. Data collection methods are semi-structured interviews, observation and document analysis.

Following on, the limitations of the research are then described. Lastly, the ethics processes required for this research are explained.

## **4.2 Qualitative research**

The researcher used qualitative research because:

The purpose of qualitative research is to describe and understand social phenomena in terms of the meaning people bring to them. The research questions are studied through flexible methods enabling contact with the people involved to an extent that is necessary to grasp what is going on in the field. The methods produce rich descriptive data that need to be interpreted through identification and coding of themes and categories leading to findings that can contribute to knowledge and practical use (Boeije, 2009, p. 11).

In terms of this research project, qualitative research allows the researcher to better understand the process of collaboration when enacted or operationalised in a network of organisations delivering youth health services. It allows the researcher to examine collaboration from a combination of collaboration, stakeholder and social capital theoretical perspectives. Qualitative research enables the researcher to obtain greater clarity around the rhetoric of collaboration, particularly when promoted in government policy, by examining what helps and hinders collaboration in the context of youth health. Qualitative research also allows for examination of the impact of existing management policies and practices on collaboration. It assists the researcher to identify, describe and examine the willingness of service providers to collaborate by understanding who is more or less salient or eminent when collaborating and why. Qualitative research methodology allows the researcher to search for meaning within the collected data by using the descriptions, views and perceptions of the research participants. It also permits the researcher to present word-rich qualitative findings in order to understand collaboration better, particularly within the western Sydney youth health sector.

Importantly, qualitative research allowed me (the researcher) to enter into the research equation. In other words, as a human being involved in the research process and interacting with research participants, I became part of the research process. Being part of the research process involves me providing an interpretation of collaboration according to the research participants. Thus, in this chapter I will commonly refer to myself in the first person to signify the inherently personal and relational processes involved in qualitative research within the social sciences.

Flexibility of research methods means that qualitative research allowed me to utilise a variety of data collection methods such as purposive sampling and semi-structured interviews. By using purposive sampling, I was able to access a group of people working within a network of youth health service providers who are commonly involved in collaboration. Furthermore, through open-ended questioning and semi-structured interviews I was able to collect rich, thick data containing reflections of the views and perceptions of collaboration according to research participants. Furthermore, I could use the words of the research participants in the presentation of findings. These research methods are discussed in depth later in this chapter.

By gaining access to staff working within organisations providing youth health services and who are also involved in collaboration and collaborative activities, I was able to examine what collaboration means to them. I was also able to understand what they bring or contribute to the collaboration process and why. This allowed for examination of how research participants feel collaboration impacts on themselves and others, their organisations and the youth health sector in general. In doing so, I present an interpretation of the world of research participants in relation to collaboration. This concurs with Creswell (1998), who argues that qualitative research allows for examination of research participants' perceptions and experiences, and 'the way they make sense of their lives' (Creswell, 1998, p. 162).

Through the extensive use of quotes or words used by research participants in the presentation of findings, I was able to justify and reinforce my own interpretation of the views of research participants in relation to collaboration within the western Sydney youth health sector. In other words, I was able to justify my research findings, which concluded that collaboration when enacted within the youth health sector is sometimes characterised by competition and why that is so. As Boeije (2009) claims, the qualitative research process allows the researcher to 'reinterpret the information while preserving the participant's meaning' (p. 14).

Qualitative research also incorporates the researcher as the primary instrument in data collection and the analysis process (Creswell, 1998; Denzin & Lincoln, 2005). As such, I was able to maximise my knowledge, ability and intuition during the research process. This meant I was able to use my knowledge of scholarly literature on collaboration and my knowledge of the research process when developing research conclusions. I was also able to utilise my ability to apply the multi-case study research framework and the research methods to the research process. In addition, throughout the research process I was able to use my intuition to follow certain lines of enquiry that I perceived as important for research participants.

In summary, qualitative research allowed me to develop research findings that have theoretical and practical implications. Although qualitative research is discussed in this section, its application to this research is expanded upon and justified further in the following sections. In doing, so the following sections begin with a review of the research questions addressed.

### **4.3 Research questions**

Although the research questions were outlined in Section 1.6 of the introductory chapter, this section emphasises the nature of the questions posed. The research questions are essentially how and why questions. They ask why are those working within the youth health sector collaborating and how is collaboration occurring and impacting on those involved in the provision of youth health services and the sector in general. As such, the research questions are developed to examine and understand the perceptions and thoughts of those employed within a youth health network in relation to inter-organisational collaboration, including the impact of policy.

The research questions are aimed at identifying, describing, explaining and understanding abstract concepts relating to collaboration such as stakeholder salience, social capital and the influence of contextual factors.

The research questions are also aimed at identifying, describing and explaining what influences those within the sector to be more or less willing to be involved in collaboration. Consequently, the research questions allowed me to consider contextual factors such as the implication of the coexistence of policy promoting collaboration and competitive tendering practices. In addition, the research questions allowed me to consider the salience of stakeholders and the impact of social capital in relation to collaboration.

The research questions are not aimed at proving or disproving a hypothesis or measuring abstract concepts. Rather, they are aimed at developing or facilitating the emergence of understanding in relation to collaboration whilst also building on existing knowledge relating to collaboration, stakeholder and social capital theories. The researcher argues that theory development is primarily inductive but also involves deductive reasoning.

Reiterating, the research questions are:

1. Who collaborates in the youth health sector and why?
2. What are the impacts of collaboration within the youth health sector?
3. How is collaboration operationalised or enacted within the youth health sector?

#### **4.4 Method of theory development**

A broad aim of this research is to advance knowledge and theory relating to inter-organisational collaboration. The function of theory is exemplified by Kerlinger (1979), who states that a theory:

is a set of interrelated constructs (variables), definitions and propositions that presents a systematic view of phenomenon by specifying relationships among variables with the purpose of explaining natural phenomena (p. 64).

Thus, in this research, I aim to build theory by better and more comprehensively providing knowledge of the constructs, definitions, variables and propositions relating to collaboration. In addition, I aim to build theory by explaining and examining the relationships between the identified constructs, definitions, variables and propositions relating to collaboration which leads me to ultimately argue for the inclusion of competition and salience in collaboration theory. I aim to build on existing collaboration theory by describing, explaining and understanding the operationalisation of enforced and coerced collaboration in relation to competitive tendering processes and New Public Management (NPM) when collaboration is concurrently being promoted in youth health policy.

To do this, existing collaboration theory and related literature was examined to understand the level of existing scholarly and industry knowledge. It was also examined to identify where further knowledge is required; in other words, identify a gap in existing academic and scholarly literature. As such, this research aims to build on existing collaboration theory by identifying and developing themes within collected research data. Consequently, this research

is a mix of both induction and deduction. This means that although the research is primarily inductive, it has elements of deduction in that existing theory allowed the author to be sensitive to concepts discovered or to be discovered within the collected data (Boeije, 2009). For example, an examination of stakeholder theory introduced the researcher to the concept of salience, which helped explain the dynamics at play when collaborating. Another example relates to social capital being utilised as a means to comprehend relational obligations leveraged by youth health service providers to gain continued funding. Using prior academic knowledge in the research process is supported by Emory and Cooper (1991) who advocate that ‘fact and theory (induction and deduction) are each necessary for the other to be of value’ (p. 62). The role of prior theory within the research process is expanded upon in Chapter 5.

Now that the aims and objectives of the research are discussed, particularly theory development, the following section shows that the research is situated in the realism paradigm. In doing so, I acknowledge my position in the research process when developing new knowledge or theory.

#### **4.4.1 Research paradigm: realism**

As the research aims to reveal how collaboration is viewed, perceived and enacted by those working within the youth health sector, this research is an interpretation of collaboration according to the perceptions of the research participants and me. This means I present a subjective and interpretive account of the reality of collaboration according to the research participants. For this reason, I have adopted a realist view for this research.

By taking a realist view, I acknowledge that my interaction with people in the world influences the world as well as influences me. However, I also believe that the world ‘can be made an object of human perception’ (Hugli & Lubcke, 1997, p. 185). In other words, realism contends that the world ‘is largely autonomous, though created by us’ (Healy & Perry, 2000, p. 120). For this research, realism does not mean that reality exists independently of one’s consciousness; rather, I am taking the position that things in the world, such as the phenomenon of inter-organisational collaboration, can exist independently or with a degree of separation of consciousness in order to be a focus of investigation. However, realism also acknowledges that meanings and perceptions of inter-organisational collaboration do not. Consequently, this means acknowledging how my values impact on the research process.

By positioning the research in the realism paradigm, I argue that my position as a researcher is ‘neither value-laden nor value-free’ (Healy & Perry, 2000, p. 123), but rather, ‘value-aware’ (Healy & Perry, 2000, p. 1). This means accepting that there is a reality of inter-organisational collaboration and collaboration in general but this reality is based on the multiple perceptions of the research participants, the researcher and the reader.

As a result of this, I do not claim to present the absolute truth but claim that research findings are usable and credible for understanding and advancing knowledge relating to inter-organisational collaboration. In other words, I claim that the research makes credible and usable inferences about inter-organisational collaboration taking into account that knowledge created will be an interpretation of both me and the research participants. Further still, the results will also be interpreted by readers and subsequent researchers.

The above sections have discussed the paradigmatic or theoretical issues of reality, subjectivity and realism when applied to this research thesis. The following section will justify the use of qualitative research in relation to this research dissertation.

#### **4.4.2 Justification of qualitative research**

In this section, I justify using qualitative research methodology. In doing so, I show that qualitative research is justified because it allows me examine the reality of collaboration according to the research participants and to consider the impact of the context of youth health service delivery on their perceptions. Qualitative research is also justified as it involves the collection of soft data, permits the use of flexible sampling methods and allows me to use both inductive and deductive reasoning when building knowledge and advancing collaboration theory.

First, qualitative research allowed me to get ‘close to the reality’ (Sarantakos, 2005, p. 44) of the research participants in order to develop understanding of collaboration as revealed by them. Qualitative research allows the voice of the research participants or those involved in collaboration within the youth health sector to be central to the development of research findings. Stake (2006) claims that ‘the more the study is qualitative, the more emphasis will be placed on the experience of the people in the program or with the phenomenon’ (p. 27). In order to collect data, qualitative research allows for and often promotes researchers to interact with research participants and become immersed within their world (Bryman, 1988; Neuman, 2006). As a result, qualitative research enabled me to present a version or

interpretation of their reality of collaboration, particularly inter-organisational collaboration. As a consequence, qualitative research is justified as it enabled me to draw conclusions and present an interpretation of findings for the reader. As argued by Bryman (1988), qualitative research has the ability ‘to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied’ (p. 46), which in this case are those working in the youth health sector. Sarantakos (2005) argues that qualitative research offers a means to examine the ‘world in action’ (p. 46) according to the research participants and the researcher. As a result of being able to analyse the reality of collaboration for research participants, qualitative research was considered the best means to answer the research questions.

Second, qualitative research is justified as it allows for examination of the impact of contextual and unique environmental factors on how collaboration is operationalised or enacted within the youth health sector. I argue that collaboration cannot be separated from the environment or context in which it occurs and by attempting to do so will diminish the ability of this research project to answer the research questions and add to theory. In this sense, I concur with Flyvbjerg (2006) who argues for the necessity of ‘context-dependent knowledge’ (p. 221).

Third, qualitative research is justified for this research as it involves the collection of soft data, which Neuman (2006) refers to as perceptions, impressions, words, sentences and illustrations to name just some. Consequently, soft data allowed me to take a holistic and inclusive view of a complex phenomenon (Creswell, 1998) such as collaboration. This is because qualitative research encourages the research participants to describe collaboration and its impact and operationalisation within the youth health sector using their own terms of reference (Creswell, 1998). As such, soft data gives me the ability to examine ‘relationships, patterns and configurations concerning the emotions, feelings and perceptions’ (Creswell, 1998, p. 11) of research participants in relation to inter-organisational collaboration. It also allows me to interpret and represent these views and perceptions by referring to the actual words of participants. Furthermore, qualitative research allows my own descriptive language to be used in the presentation of research findings and conclusions.

Fourth, qualitative research allows for the collection of rich data from a smaller number of research participants (Creswell, 1998), where interviewees were able to discuss at length issues relating to collaboration. Consequently, qualitative research allowed me to target those

who were involved in collaboration at different levels within the sector through the use of flexible sampling techniques such as purposive and snowball sampling. By using these sampling methods I was able to recruit research participants who were able to comprehensively explain their thoughts and views on collaboration. In other words, research participants were considered to be data rich.

Fifth, qualitative research allows for both inductive and deductive research processes to be used by the researcher when developing theory. Consequently in this research, qualitative research does not reduce complex relational principles and processes associated with collaboration into predetermined variables for numerical testing or verification. The reasoning is that the research aims to derive issues or characteristics that research participants felt was impacting on collaboration for them. Consequently, the emergence of issues not explicit in collaboration theory, such as competition when collaborating, may have remained undiscovered if quantitative data was collected.

In summary, qualitative research is justified as it:

- allows me to get close to the reality of research participants
- enables the impact of context to be considered in the research process
- involves the collection of soft data
- allows for the use of flexible sampling methods, and
- allows for both inductive and deductive research techniques to be used in theory development.

Qualitative research was considered by me to be the only appropriate and sensible way to advance theory in this research due to the richness of information collected, the sample size used, its applicability to the aims and objectives of the research and its ability to assist in answering the research questions.

#### **4.4.3 Multi-case study research framework**

The above sections include discussions and justifications of qualitative research when applied to this research project. However, there is a multitude of qualitative research techniques. In this section, I will justify and describe the multi-case research design framework used in this research.

Multi-case research strategy is defined by Stake (2006) as ‘a special effort to examine something having lots of cases, parts or members’ (p. vi). In terms of this research, multi-case research strategy allows for investigation of collaboration occurring in a number of sites, or contexts, involving a number of people. In other words, the ‘primary focus within the case studies that make up a multi-case study will be the characterisation of the program or phenomenon’ (Stake, 2006, p. 26). Consequently, this research utilises a multi-case study framework where the cases were used to understand a central phenomenon (Healy & Perry, 2000): collaboration and more specifically inter-organisational collaboration.

Using a multi-case study research framework involves developing and applying a research protocol. The research protocol used in this research allows me to gain access to research participants working in a variety of youth health service providers, or organisations involved in coordinating youth health services, who are involved in collaboration or collaborative activities. To do so, I adopted a research protocol that includes the use of research sampling methods such as purposive and snowball sampling processes. These sampling methods were used to access and recruit three distinct worker classifications including managers, youth health practitioners and administration staff from both government and non-government youth health service providers. By utilising semi-structured interviews, observation and document analysis, I collected data containing and reflecting the perceptions, thoughts and views of research participants in relation to collaboration. The multi-case study research framework also allows for the application of the progressive comparison analysis method, which is discussed in detail in Chapter 5.

As identified in the paragraph above, the cases used to understand collaboration were the organisations, both government and non-government, involved in the provision of youth health services in western Sydney. These cases included examination of the three distinct employee groups in order to compare and understand their views and perceptions of inter-organisational collaboration. As such, investigation of these cases involved examination of situational issues, the interpretation of patterns within each case and analysis of cross-case findings (Stake, 2006). In using the multi-case study research framework, I was able to make claims and assertions about inter-organisational collaboration in the context of a youth health network in western Sydney.

## **4.5 Method of data gathering**

Thus far in this chapter, I have discussed and justified the use of qualitative research methodology and showed how qualitative research enables the development of collaboration theory. The how and why nature of the research questions was discussed and the application of the multi-case research framework described. In this section, I build on these foundations and explain the research protocol used, particularly the methods of data gathering used for this research. Discussed in this section are purposive and snowball sampling techniques. Following is a discussion on recruitment processes used for this research. After that there is an explanation on the data collection methods used in this research which are semi-structured interviews, observation and document analysis. But first, this section begins with a discussion on purposive sampling.

### **4.5.1 Purposive sampling method**

Purposive sampling is the primary sampling selection method used in this research. Purposive sampling is defined by Patton (1990) as a method that ‘selects information-rich cases for in-depth study’ (p. 181). In other words, purposive sampling allowed for flexibility to target a sample group of people able to provide information to address the research questions and contribute to the evolving theories (Creswell, 1998). This means cases and research participants were selected as they provided an ‘opportunity to learn’ (Stake, 2006, p. 26) about a given phenomenon, which in this case is inter-organisational collaboration. For this research, this meant targeting and selecting a network of organisations involved in the provision of youth health services in western Sydney. These organisations and their employee groups (managers, youth practitioners and administration staff) were selected and invited to participate because they represent cases where inter-organisational collaboration is manifested in work practices and policy directives.

In addition to purposive sampling, the snowball sampling method was also used. This method utilises recommendations and referrals from research participants of other people who meet the criteria of the research, who may be able to supply data appropriate to the aims of this research and who might also be willing to participate (Sarantakos, 1998). These referrals allowed me to access information-rich research participants from a number of organisations providing youth health services in western Sydney. This sampling method allowed access to a smaller youth health centre operating on a part-time basis that was in addition to the larger, more-established centres which were more easily discovered. If this centre was not referred

by a larger, more-established centre, the researcher may have missed an opportunity to include them in the research. Therefore, after initial investigation of prominent youth health service providers in western Sydney and applying a purposive sampling technique, snowball sampling enabled me to gain access to a broader or more complete range of youth service providers within a particular geographical area.

The sampling techniques used in this research allowed me to recruit a diverse sample group. Stake (2006) contends that diversity in sample selection adds variety and richness to the data collected. Stake (2006) also argues that if the characteristics of the organisations or cases included in the study were the same, research findings may not be as useful or reflective of the context in which collaboration is being investigated. For this reason, the sampling techniques used allowed me to access potential participants who came from both government and NGOs and included three different employee groups.

The justification or rationale of selecting this diverse sample group, each with particular characteristics, to participate in this research project is discussed below.

Seven organisations were selected to take part in this research and these included government and NGOs involved in the provision of youth health services in western Sydney. These organisations were invited to participate as they commonly engage in enforced, coerced and voluntary collaborative activities with the aim of delivering youth health services. They were also selected as their funding arrangements, management priorities, structural composition and obligation to adhere to the aims, goals and objectives of NSW youth health policy differ. This group of organisations included:

1. one state government organisation that led the development of and wrote the 2010 NSW Youth Health Policy in conjunction with the NSW Department of Health
2. two state government-funded organisations providing youth health services
3. one Commonwealth government-funded youth health organisation providing youth health services
4. three non-government organisations providing youth health services. (Refer to Appendix A for a brief summary of participant organisations involved in the research.)

The diverse group of organisations offered an opportunity to examine and contrast how and why these groups or organisations collaborate. This diversity also allowed analysis of how

collaboration, particularly inter-organisational, impacts upon them when collaborating to provide youth health services. In addition, these distinct differences allowed me to contrast the varying perceptions and views of those within these organisations to examine how enforced, coerced and voluntary collaboration and government policy promoting collaboration is enacted within the youth health sector.

#### **4.5.2 Employee groups**

To add further richness to the data, employees within the organisations listed above were divided into three groups. These three groups represent the main employee groups within youth health service providers and included 8 managers (5 with hybrid management and clinician roles), 22 youth health practitioners (counselling and medical staff) and 5 administration staff.

##### *Group one: managers*

The 8 managers included youth health centre managers, area managers and policy writers, with 5 managers having a hybrid management and clinician role.

In terms of the literature, managers were selected as some scholars (Brown & Keast, 2003) consider collaboration as a function for those at higher levels within organisations. However this remains undetermined in the context of collaboration within the youth health sector.

Managers were invited to participate due to knowledge of individual organisation and sector-based strategic objectives, including financial objectives. Managers also have knowledge of management requirements and responsibilities that relate to current collaborative activities. In addition, managers are able to identify key stakeholders in collaborative networks and also have vital perceptions of stakeholder salience or importance when collaborating. They also revealed a capacity to understand how and why policy promoting collaboration and mandated or enforced collaboration impacts on the ability of their organisations to deliver strategic and operational objectives and collaborative or collective goals. Managers are also able to give opinions of why their organisations get involved in collaborative networks and the impact this has on their own organisations and personnel. Furthermore, some managers were already involved in formal collaborative bodies such as the NSW Youth Health Council and others were involved in the development of policy concerning collaboration. Further still, managers are able to champion knowledge gained through this research. This means that managers may be able to apply and disseminate to others within and beyond their organisations the research

findings, particularly the practical implications of this research which are highlighted in the discussion and conclusion chapter.

For the above reasons, managers were essential to answering the research questions and achieving the research objectives.

*Group two: administration staff*

Administration staff were invited to participate in this research due to their understanding of administrative processes and procedures required to support inter-organisational collaboration and those collaborating with youth health practitioner and management roles. Their administrative skills and their understanding of communication processes, practices, protocols and procedures proved relevant to this research and as such, administration staff were able to provide information about the impact of these factors on collaboration and why. They also had knowledge of formal and informal communication channels between organisations involved in collaboration, particularly as some had a gatekeeper role in terms of inter- and intra-organisational communication. Administration staff also had unique perspectives of involvement within collaborative processes.

Brown & Keast (2003) consider those with lower positions within organisations, such as administration staff, to be more suited to cooperative arrangements rather than more intensive collaborative arrangements. However, Thomson and Perry (2006) argue that shared values and assumptions are necessary when developing social capital, which is considered essential for collaboration, and do not differentiate values based on hierarchy. In addition, collaboration promoted in policy also doesn't differentiate collaboration according to organisational levels. Consequently, including administration staff in the research provided a point of comparison that to the best of my knowledge is not evident in previous collaboration research.

Therefore, including administration staff in the research allowed me to obtain a more comprehensive view of collaboration across organisations and enabled me to determine who is more or less salient or important in relation to collaboration when enacted within the youth health sector.

In addition to managers and administration staff, youth health practitioners were also considered essential to this research due to altruistic motivations to collaborate to assist youth

in need and as such provide a point of comparison to much of the literature relating to collaborating for efficiency and effectiveness gains.

#### *Group three: youth health practitioners*

In this research, youth health practitioners include a broad range of staff involved in the actual delivery of clinical and non-clinical youth health services to those youth in need. Youth health practitioners include doctors, psychologists, psychiatrists, counsellors, caseworkers and health promotional staff.

Youth health practitioners were invited to participate as they had in-depth knowledge of youth health services provided and the impact of collaborative activities in the delivery of youth health services. As such, they gave perspectives as to the impact of collaboration on service delivery. Furthermore, their focus on the actual delivery of youth health services may contrast with the broader areas of consideration by managers, such as resource allocation and financial objectives. They also had unique perspectives of stakeholder roles in collaboration and how and why these impact on the delivery of youth health services. Furthermore, their views on enforced collaboration and collaboration in policy and how and why this impacts on youth health service delivery were essential to achieve the aims of this research.

#### **4.5.3 Sample size**

The sample size used in this research was determined by the:

- geographical area of western Sydney
- number of organisations involved in providing youth health services within the region
- number of willing participants
- time and resources available to the researcher.

The sample size was determined by the geographic area of western Sydney and the number of organisations within that area involved specifically in the delivery of youth health services. This sample size was determined by searching health service directories, particularly on the internet, for youth health service providers in western Sydney (Parramatta, Penrith and Mt Druitt) that were youth specific, rather than those providing a broader range of health service provision. This activity exemplified the use of the purposive sampling technique. These services were then approached to participate both in writing and or by personal phone calls to their managers where the research was broadly outlined. This communication resulted in me

forwarding research advertisements (refer to Appendix B) and information sheets and consent forms (refer to Appendix C) that outlined the aims and objectives of the research and what participation in the research would involve. This technique resulted in identifying all but one organisation providing youth health services which became involved in this research. Calls to these organisations also resulted in references to other services that were appropriate for the aims of this study, as per the snowball sampling technique. This resulted in identifying two more potential organisations of which one was reluctant to be involved due to time and resource restraints. The sample size was then determined by the number of organisations willing to be involved and also the time and resources available to the researcher.

Although the recruitment process was briefly introduced here in order to explain the determination of the sample size, a more detailed explanation of the recruitment process follows.

#### **4.6 Recruitment**

With the sample group selected, I progressed to the recruitment phase of the research. In order to recruit participants to be involved in the research, I first made a list of youth health service providers in western Sydney. After identifying youth health service providers I made contact with the most senior manager from these organisations by email and telephone to discuss the research and its aims and objectives and whether I could forward research advertisements and information sheets and consent forms regarding the research. In addition, I also attended a NSW Youth Health Council meeting in western Sydney where there was opportunity to meet with a number of managers from local youth health centres and discuss the research to garner support and access.

With agreement from managers to participate, I progressed through an ethical process (discussed in Section 4.9 of this chapter) and gained the required ethical approvals (refer to Appendix D). Ethical approvals allowed for a recruitment process which involved the distribution of research advertisements and information sheets and consent forms on noticeboards within the organisations willing to be involved. Also included on the noticeboards was a list where potential participants could leave their name and contact details. This allowed me to follow up on any interested people. This process resulted in agreement for times and locations so that data collection could take place.

## **4.7 Data collection**

For this research I utilised three data collection techniques. These included semi-structured interviews, observation and document analysis. Interviews and semi-structured interviews were undertaken between January and September 2011 whilst document analysis was ongoing from 2010 to 2013.

### **4.7.1 Semi-structured interviews**

Individual semi-structured interviews were the primary means of data collection used in this research. They were used due to ‘the depth of information and detail that can be secured’ (Cooper & Schindler, 2003, p. 325) both verbal and non-verbal (Cooper & Schindler, 2003).

Semi-structured interviews enabled me to access each interviewee’s opinions, attitudes, views and perceptions of collaboration within the youth health sector (Yin, 2009). As Kuhn (2009) agrees, semi-structured interviews ‘reveal what people think, as much as what they say’ (p. 86).

The interviews were conducted in a relatively informal manner for interviewees to be relaxed, open and communicative and to encourage stories, anecdotes and jokes to be shared. Interviews were also formal enough to ensure interviewees respected the interview process. The aim was to build rapport and a level of trust with participants for them to open up and communicate issues that were important to them in relation to collaboration and collaborative practices.

Semi-structured interviews allowed me to approach each interview with a set of open-ended questions (refer to Appendix E). Open-ended questions encouraged the participants to define the focus of the response rather than me (Denzin & Lincoln, 1994; Goodrick, 2010). For example, by asking the research participants how they perceive collaboration impacts the youth health sector, they were able to formulate the focus of their response as either positive or negative, or as impacting on youth, themselves, their organisation or the sector in general.

Open-ended questions also allowed me the flexibility to follow particular lines of enquiry relating to collaboration in a conversational manner (Yin, 2003). As such, semi-structured interviews encouraged elaboration from interviewees on particular points. In doing so, semi-structured interviews with open-ended questioning allowed topics and themes of relevance for the interviewees to emerge from dialogue which were then explored in subsequent

interviews. In other words, open-ended research questions had enough structure to provide consistency throughout the interview process but also allowed for additional information to be collected (Punch, 2005). This permissive technique allowed peoples' priorities, thoughts and own agendas to emerge (Yin, 2003) from the interview dialogue. For example, when asking research participants why they collaborate, two different lines of enquiry emerged including collaboration for altruistic reasons and collaboration as a means to gain funding.

In addition, semi-structured interviews also gave me the flexibility and scope (Goulding, 2002) to bring up stories or themes that stimulated discussion concerning inter-organisational collaboration. For example, to stimulate conversation I would bring up examples of collaboration from other work environments to open up discussion on how this compares to their own experiences of collaboration within the youth health sector. By using examples from other contexts rather than the youth health context, I did not influence interviewees' responses by allowing them to feel I had an opinion on collaboration within their work context.

Although I used a common interview schedule, I understood that the roles and functions of the three employee groups differ. As such, I endeavoured to keep the discussion relevant to their experiences by discussing collaboration as relevant to them and their job role. For example, interviews with managers often revolved around issues pertaining to strategic management, such as funding objectives when collaborating; for administration staff, discussion related more to processes and practices relating to and supporting collaboration or those within their workplace involved in collaboration. In other words, I made efforts to keep the discussion relevant to them. This displayed my sensitivity to promote conversation with interviewees regarding how collaboration impacts them whilst undertaking their employment.

Interviews were conducted individually in order for the interviewee to feel comfortable expressing opinions without others within their workplace being present. They were also conducted at times convenient to research participants at places they felt comfortable and less pressured. This resulted in interviews being conducted in the interviewees' offices, patient or client consulting rooms and unattended lunch rooms.

All interviews were audio-recorded and transcribed. The transcriptions were then stored in the computerised QSR NVIVO™ qualitative data management program to assist me in conducting thematic analysis, which is described in depth in Chapter 5 of this dissertation. All files were de-identified and securely stored as per ethical requirements. This computer

program allowed me to store my interview memos, transcripts and collected documents in a central digital repository. In addition, the program's features allowed me to more efficiently conduct analysis in terms of coding when compared to manual techniques. Furthermore, the features of the program allowed me to conduct audit trails when illustrating research findings. As a result, I agree with Marshall and Rossman's (2006) statement that computer-assisted qualitative data analysis systems 'enhance rigour, while maximising imaginative engagement with data' (p. 61).

Interviewees were also given the opportunity to verify the accuracy of interview transcripts once transcribed.

#### **4.7.2 Observation**

Although interviews were the primary method of collecting data, I also employed observation as a data collection method. Observation by me was used within interviews to observe the reactions and non-verbal actions of interviewees in response to particular questions and points of discussion (Neuman, 2006). For example, it allowed me to identify the passion and excitement that some interviewees showed when discussing youth health. Another example related to some interviewees being concerned of being heard by others and speaking out against current practices and the norm and even voicing their negative views on collaboration. Observation also allowed me to acknowledge the context and physical surroundings and the impact they may have on the responses of interviewees. For example, some interviews were conducted in youth counselling and clinical consulting rooms that sometimes emphasised to the participants that space was at a premium and resources limited. As argued by Neuman (2006), 'listening to both what is said and how it is said or what was implied' (p. 382) can reveal something of significance.

These observations were recorded in the memos or reflective journal written by me associated with each interview (refer to Appendix F for an example of an interview memo). These memos were comprehensive and detailed and included paraphrasing and the recording of particular quotes of the interviewees. Consequently, they allowed me to record the emotions and behaviour of the interviewees in addition to the researcher's own thoughts and perceptions. These memos were primarily written shortly after each interview whilst listening to the transcriptions with the interview fresh in my mind. Writing memos after each interview was due to initial interviews showing me that note taking during interviews distracted the interviewee and often had a negative impact on the flow of conversation.

Memos written after each interview relating to my observations, descriptions and insights of each interview also allowed me to look at the interviews as a whole rather than focus only on segmented pieces of text or interview data inherent in the coding process. As such, I was able to take a more macro view of the data collected in addition to a more micro view. Memos also allowed me to track my analytical insights as the interviews progressed. Consequently, written memos also acted as a reflexive journal where my thoughts and interpretations could be tracked throughout the interview process (Goodrick, 2010).

In summary, observation proved insightful and essential to my interpretation of the discussions with interviewees. Consequently, observation assisted me to identify important and relevant categories and themes within interviews that may have appeared less significant if I had relied only on written or audio transcripts.

#### **4.7.3 Documents for analysis**

Documents were also collected for analysis. The benefit of document collection is to corroborate and augment evidence collected during interviews and observation (Yin, 2009).

Documentation collected included the 2010 NSW Youth Health Policy (NSW Department of Health, 2010a) and publically circulated drafts (NSW Department of Health, 2010b).

Documentation also collected included the Access studies (Kang et al., 2005; NSW Centre for the Advancement of Adolescent Health, 2005, 2010) that contributed to the development of the youth health policy, and as such, provided an opportunity for analysis.

Documents can also illustrate the objectives of the writers (Yin, 2009). This means that they illustrate the writer's bias, influence, effects and imposition on collaboration within the youth health sector. As such, document analysis allowed me to identify these objectives and interpret the contents of these documents and their effects on collaboration (Yin, 2009). For example, although collaboration was heavily promoted in drafts of the policy, reference to collaboration as distinctly different to other forms of cooperative working relationships was less evident in the final policy.

The above sections have discussed the use of semi-structured interviews, observation and document analysis as data collection techniques. This section showed that three data collection methods allowed the researcher to collect a diverse array of data in order to add richness to the analysis process. These methods of data collection allowed for triangulation of findings and various lines of questioning for the researcher. Consequently, the data collected

allowed me to develop more credible, useful and trustworthy research findings and conclusions and thus gave the research process rigour.

Now that the method of theory development and the research protocol has been explained, the following section acknowledges that there are limitations to this research.

## **4.8 Limitations of methodology**

The researcher acknowledges that there are limitations with the research protocols. This section will begin by showing that although the research has limitations in terms of generalising to other contexts it does have an ability to generalise to theoretical propositions. Also discussed is that although the research may not be generalisable to other contexts it has high levels of (face) validity. In this section, I also discuss potential bias from me and the research participants that can negatively impact on research findings. However, I will explain that subjectivity is in the nature of qualitative research. In this section, I also present research protocols associated with reflexivity that were used to limit bias and ensure credible and trustworthy findings. It will be shown that although the research is context- and time-bound, this is considered a methodological limitation rather than a limitation in terms of theoretical findings. But first, the discussion on limitations begins with generalisability.

### **4.8.1 Generalisability**

Although an aim of this thesis is the development of theory, this section acknowledges that developed theory is an analytical generalisation only. In analytical generalisation, Yin (2003) claims that findings from case studies are ‘generalisable to theoretical propositions but not to populations’ (p. 10) as in statistical generalisation. This means that this research project aims to build on existing collaboration theory within the context of a youth health network. Therefore, there are limitations on the ability to generalise findings based in a specific context to broader populations due to the peculiarities of the context under investigation. However, I concur with Kennedy (1979), who argues that the focus should be on the strength of generalisability rather than a binary focus on being generalisable or not. As such, I argue that although the developed theory will be context specific, the research findings have relevance to other youth health networks and broader collaboration theory.

Although the research is limited in terms of generalisability to other contexts or populations, the research findings have high face validity. Validity asks ‘does the measurement technique look like it measures the variable that it claims to measure’ (Gravetter & Forzano, 2005, p.

78) or in the case of this research, does emerging theory accurately represent collaboration when operationalised in the youth health sector. Some scholars argue that face validity is an inferior form of validity as ‘face validity measures are measures which have not yet achieved as great a degree of certitude of validation as measures validated empirically’ (Turner, 1979, p. 85). Others argue that validity and reliability measures are based in the quantitative paradigm and have little significance when applied to qualitative research (Wolcott, 1994), preferring to use terms such as *trustworthiness*, *usefulness* or *credible* when evaluating research findings. I claim that the research findings from this research are a trustworthy, useful and credible interpretation of collaboration when enacted in the youth health sector and have validity due to the rigour associated with the research protocols employed.

The research protocols used include the methods of data gathering and sampling procedures that allowed the collection of rich, thick data relating to collaboration. These research protocols have been discussed in depth in the sections above. In addition, analysis protocols which are discussed in detail in Chapter 5 also increase (face) validity and the trustworthiness of findings. These research protocols include constant and progressive comparison of emerging findings including saturation, confirmation of findings with an academic panel and utilising existing theory to understand emerging versus existing knowledge.

Now that the limitations of generalisability have been discussed and face validity in this research explained, I argue that this research offers opportunities for future research to confirm or discount this research project’s theoretical contribution, particularly within other contexts. In so doing, future researchers can validate further the research findings both within the same context and others and can apply quantitative research methodology, which focuses on reliability, repeatability and validity measures. Researchers can determine the generalisability of research findings within other contexts. Opportunities for future research are discussed further in the discussion and conclusion chapter of this thesis.

In summary, evidence of generalisability is a ‘matter of judgement’ (Kennedy, 1979, p. 664) for those wishing to use the findings of the research. This means that the rigour in which the research was conducted should give the reader the confidence to either test or duplicate the research findings in other contexts or apply the research findings to their own environment and context for their own ends.

#### 4.8.2 Bias

As an aim of this thesis is to identify, interpret and examine the emotions, feelings and perceptions of research participants, findings will be subjective and therefore can potentially contain bias. This is because subjectivity is the nature of interpretive qualitative research in which the aim is to understand human behaviour from the participant's own perspective or frame of reference (Hussey & Hussey, 1997). This section discusses the protocols used to limit or minimise bias including reflexivity, confirmation of findings with academic peers and accepting the perceptions of interviewees as authentic representations of their reality of collaboration.

Qualitative research assumes that the researcher's and research participants' values and bias will enter the research process (Girod-Séville & Perret, 2001). Salmon and Faris (2006) are more specific and argue that the researcher's values and biases 'enter into the research at every point, from the words selected to frame the problem to the description of the subject's actions' (p. 277). For this reason, bias of the researcher and the research participants can potentially limit credibility of findings. However, I claim that my version of collaboration based on the findings of this research can transcend opinion and personal bias by employing a number of protocols. These protocols ensure the credibility, usefulness and trustworthiness of findings by minimising any negative impacts researcher values or bias may have.

Throughout the research I underwent a continuing process of *reflexivity* (Willis, 2006). This process ensured that I reflected on the impacts that cultural, political, social, linguistic and ideological origins had on my perspectives and on those interviewed (Willis, 2006). This meant that I acknowledged my background as a white, Christian, middle class, educated male from a western culture with moderate and contemporary views on society and with limited knowledge of youth health service provision. My views or bias associated with this research are evident within the preamble of this dissertation. In the preamble, I acknowledged the increased popularity of promoting collaboration as a mantra to solve wicked social problems such as youth health service delivery. In addition, I made clear that although having potential benefits, collaboration requires research due to inequalities between participants particularly when situation and circumstance forces them to engage in collaboration. In the case of this research, it is government policy and competitive tendering processes that enforce or coerce engagement in collaboration. I argue that rather than this research being a biased view of

collaboration, the issues outlined are worthy of research and fundamental to the aims and objectives of this dissertation.

Reflexivity also meant that I acknowledged my initial distrust of the sector. This distrust was based on past negative experiences with youth counsellors during my adolescent years. This also involved acknowledging my growing respect for those interviewed as I gained insight into their passion to improve the lot of at-risk youth in need of health services.

To minimise bias I discussed, evaluated and confirmed any conclusions with my university supervisory panel and academic peers when identifying codes, categories, concepts and themes throughout the data analysis process. This was done through a process of independent data coding. Independent data coding meant coding processes and conclusions developed were confirmed by academic supervisors and peers on three distinct occasions:

1. Data transcripts including field notes, memos and coding lists were checked and brushed coded by both the researcher and his academic supervisors independently prior to interview 19. In addition, the researcher discussed and confirmed early codes as they emerged from the data with fellow PhD candidates.
2. At interview 19 the researcher confirmed with his academic supervisors that competition was emerging as a prominent theme during analysis and would be the focus of further examination.
3. After interview 19 when competition when collaborating was a focus of analysis, independent confirmation of coding lists and research conclusions were completed by his supervisory panel and debated by fellow PhD candidates.

Furthermore, the analysis process of progressive comparison, saturation, and core relevance helped reduce and forestall any bias by constantly returning to the data sample (Glaser, 1992).

Finally, the believability of accounts of participants has also been accepted as authentic throughout the research process in an effort to reduce researcher bias (Burr, 2003). This meant that although I interpreted the recollections of participants, these recollections were accepted as authentic perceptions and views of the research participants.

By reflecting on these factors, I confronted and minimised bias that I may have had that could have impacted on research findings. As such, I assert that the research has credible, useful and trustworthy findings.

I was aware that research participants may have biased views concerning collaboration, their fellow network members and their working environment. Identifying these views and perceptions, why they exist and how they impact on collaboration within their working context is a focus of this study. To identify the perceptions and views of research participants I maintained a neutral stance in order not to influence these perceptions. I did this by linking my general curiosity to research questions rather than disclosing a view (Marshall & Rossman, 2006). In other words, I attempted to not influence the responses of the interviewees with leading questions. Rather, the flexibility associated with semi-structured interviews allowed the interviews to revolve around the perceptions of the interviewees rather than only the questions of the researcher. As a result of using this technique I was able to discover, describe and analyse interviewees' biases and perceptions that were fundamental to achieving the aims of this research. Consequently, I concur with Neuman's (2006) statement that 'a field researcher does not eliminate subjective views to get quality data but rather, quality data include his or her subjective responses and experiences' (p. 388) and that of interviewees.

#### **4.8.3 Context- and time-bound**

The above limitations are a result of the research being viewed as a co-production between the researcher and the researched (Burr, 2003). However, the research also has limitations in that it is context- and time-bound. This means that the research is a conceptualisation of inter-organisational collaboration situated in a particular context and moment in time.

Consequently, applying the methodology again or in a different location, such as a different youth health network, may generate alternative findings. For example, workers come and go and change positions within the workplace and new workers may have different views and perceptions in relation to collaboration to those interviewed. In addition, different youth health networks may have different contextual factors to those in western Sydney. As such, perceptions concerning collaboration may vary. Furthermore, youth health providers also come and go, particularly with changing government funding priorities. Consequently, the relevance of research findings begins to diminish immediately upon the completion of the research as society and people's values progress and the youth health sector changes.

Although I acknowledge that the research is context- and time-specific, the revision of youth health policy being the first in over ten years is an indication that progress or advancements within the sector may be slow. This indicates that this research may have some relevance for

some time. I argue that the context- and time-specific nature of collaboration is an accepted characteristic of interpretive qualitative research that does not necessarily diminish the credibility and usefulness of research findings.

In summary, in this section I discussed the limitations of the research methodology relating to generalisability, potential bias and the contextual and time-bound nature of interpretive qualitative research. These limitations do not prevent the research creating credible and trustworthy findings, particularly considering the use of research protocols. In addition, by considering the interpretive nature of qualitative research and the how and why nature of the research questions posed, these potential limitations reflect the subjective nature of qualitative research and as such they are acknowledged and, in fact, help drive the research. Further, this research aimed to uncover the biases of the research participants in relation to collaboration. By using the protocols discussed and being clear concerning aims and objectives of the research, the limitations discussed are minimised and thus allow the research findings to be credible, useful, dependable and trustworthy.

#### **4.9 Ethics**

This research involved the study of humans regarding their perceptions and involvement in relation to collaboration. As stated in the NSW Government research ethics and governance webpage:

All research involving humans conducted within the NSW public health system must be ethically and scientifically reviewed and approved by a Human Research Ethics Committee (HREC) in accordance with the National Health and Medical Research Council (NHMRC) National Statement of Ethical Conduct in Human Research (NSW Government, 2013, p. 1).

The purpose of the *National Statement of Ethical Conduct in Human Research* is to promote human research that is conducted in an ethically good manner (National Health and Medical Research Council, Australian Research Council & Australian Vice-Chancellors' Committee, 2007, p. 7). It fulfils this purpose by requiring that participants are respected and protected during the conduct of research (National Health and Medical Research Council et al., 2007). This protection is assured by clarifying the responsibilities of 'institutions and researchers for the ethical design, conduct and dissemination of results of human research; and review bodies in the ethical review of research' (National Health and Medical Research Council et al., 2007, p. 7).

As the research involved eight different organisations I was required to obtain ethics approval from multiple human research ethics committees (HRECs), including my university. The ethics process undertaken is outlined below.

In order to commence data collection in public organisations, I completed the National Ethics Application Form (NEAF). This standardised ethics form was then submitted to the Sydney West Area Health Service (SWAHS) HREC (Code EC00152) for consideration and was subsequently approved (see Appendix D1 for approval document). However, in order to gain access to each public health organisation involved in the research, I also completed a Site Specific Application (SSA) for each. The aim of the SSA process was to ensure ethical conduct within each site visited and involved enlisting managers from each public organisation to oversee the conduct of the research on each site. In doing so, it considered such matters as staff, resources, insurance and indemnity requirements. Three SSA forms were submitted and subsequently approved (see Appendix D3 for approval documents).

I was also required to gain ethics approval from my university's HREC, the University of Western Sydney (UWS) HREC (Code EC00314). This process was expedited as the Sydney West Area Health Service HREC is considered a lead ethics committee. This means that it was:

accredited by the NSW Department of Health to conduct the single ethical and scientific review of multi-centre research projects on behalf of all sites within the NSW public health system (NSW Government, 2013, p. 1).

Upon receiving the above ethics approvals, I forwarded these documents, along with the original completed NEAF, to the managers of all the NGOs invited to participate in the research. These approvals were then forwarded to their own organisation's ethics committees and boards. Upon review, managers then emailed the researcher informing the researcher of their organisation's approval to participate. Ethics approval was gained from all NGOs invited to participate.

#### **4.10 Chapter summary**

In this chapter, I justified the use of a qualitative multi-case study research framework for answering the research questions and developing theory relating to collaboration. I began by discussing and justifying the use of qualitative research methodology in addressing the 'how' and 'why' nature of the research questions.

Following on, I discussed the method of theory development. I showed that qualitative research methodology enabled me to get close to the reality of research participants by identifying and examining the perceptions and views of research participants in relation to collaboration. However, by taking a realist perspective, I acknowledged my account of collaboration is a subjective interpretation of collaboration according to interviewees.

The qualitative multi-case study research framework was justified as it enabled me to investigate collaboration, which is characterised by the interaction of a number of people occurring within a number of contexts both within organisations and across organisational boundaries.

The methods of data gathering were then discussed. The application of purposive sampling was justified as it assisted the researcher to target a diverse selection of data-rich participants who could provide perceptions and views of collaboration when operationalised within the youth health sector. Recruitment processes were then discussed. The application of data collection methods including semi-structured interviews, observation and document analysis were also justified as appropriate to this research. I also showed that the flexibility associated with open-ended questioning within semi-structured interviews allowed for relevant and interesting themes such as competition for salience when collaborating to emerge and be explored.

Following on, the limitations associated with the research methodology were highlighted including reference to research protocols applied to minimise the impact of these limitations. Finally, I explained the ethics process required to carry out the research.

The next chapter builds on the research protocols discussed in this chapter to give an in-depth explanation of the method of analysis used in this research. The progressive comparison analysis method is discussed and justified as is its principles of progressive comparison, analytical induction and theoretical sensitivity. Also explained are the coding processes used to develop themes, constructs and categories that were pivotal to developing and collating research findings.

## **Chapter 5: Method of analysis**



## 5.1 Introduction

In the previous chapter, the researcher discussed the research protocols. In doing so, the method of theory development, the methods of data gathering, the recruitment process, the ethics process and the limitations of the research methodology were outlined. This chapter builds on the previous one by focusing on the method of analysis, how the research conclusions were collated and how collaboration theory was advanced.

In this chapter, the researcher demonstrates how he developed his research conclusions by analysing the collected data using the progressive comparison analysis method. The progressive comparison analysis method is explained and its application in this research project described. It is shown how this analysis method allows for the development of a more comprehensive theory of collaboration explaining how collaboration is enacted within the youth health sector. The actual research findings are detailed in the following two chapters: the research findings chapter and the conclusion and discussion chapter.

This chapter begins with an explanation of the progressive comparison analysis method. The principles of progressive comparison, analytical induction and theoretical sensitivity, which are fundamental to the progressive comparison analysis method, are presented. Following on, the open, axial and selective coding processes used by the researcher to progress the data from the descriptive level to more abstract levels in order to answer the research questions and to develop theory are explained.

## 5.2 Progressive comparison data analysis

The overall analytical framework used in this research thesis is termed *progressive comparison analysis* (Fitzgerald, 2002). This analysis process involves the gradual and progressive ‘abstraction of data from the descriptive level to higher order theoretical categories’ (Goulding, 2002, p. 46) in order to answer the research questions, build theory and add insight into collaboration occurring within a network of youth health service providers in western Sydney. This iterative and reflective analytical method means that the researcher segmented and reassembled the collected research data in light of the research questions and emerging findings. More specifically, the progressive comparison analysis process involved coding or naming the segments of transcribed interview data into categories, interpreting the data and distinguishing themes or analytical concepts of interest and developing theory relating to collaboration.

To clarify, a *code* is ‘a word or string of words used as a name for a category generated during analysis’ (Boeije, 2009, p. 95) and a *category* is ‘a group or cluster used to sort parts of the data during analysis and designated with a code’ (Boeije, 2009, p. 95). A *concept* is term that refers ‘to a category and is used as a building block in a theory’ (Boeije, 2009, p. 95) whilst a *theme* relates to ‘the matter with which the data are mainly concerned’ (Boeije, 2009, p. 95).

Progressive comparative analysis is based on three fundamental principles which are progressive comparison, analytical induction and theoretical sensitivity (Boeije, 2009). These principles are inherent, intertwined and operationalised in the coding processes used to collate findings and develop theory. Hence, although the principles of progressive comparison analysis are presented separately they are indeed connected. The principles of progressive comparison, analytical induction and theoretical sensitivity are discussed below and include coding examples from this dissertation used to illustrate their application.

### **5.2.1 Progressive comparison**

The purpose of progressive comparison is to describe the variation in relation to collaboration from the point of view of interviewees but then make sense of these descriptions by theorising about their meaning and progressively comparing, inductively deriving and verifying these conclusions at more abstract levels. As Boeije (2009) advocates, ‘[T]he circumstances of a specific manifestation [in this case: inter-organisational collaboration] can be found by systematically comparing the research material’ (p. 83). Fitzgerald (2002) argues that this process is progressive rather than constant as each phase of comparison builds upon previous comparisons of the research data. More specifically, the process of systematically comparing the data is progressive as the researcher progresses the data from the descriptive to more abstract levels when collating research findings and developing theory. When applied to undertaking the research, progression involves the researcher moving from open to axial to selective coding. Although the coding processes are discussed at length later in this chapter, the following paragraphs briefly summarise the progressive comparison principle of the progressive comparison analysis method.

- First, progressive comparison involves exploring and discovering concepts within the data through *open coding*. This activity is where I coded collected data that described the comments from participants or their perceptions and views of collaboration. For

example, I coded the impacts of collaboration according to participants as either positive (34 codes) or negative (28 codes).

- Second, the progressive comparison involved me progressively and systematically developing or specifying categories, concepts and themes that were developed from the codes identified through open coding. This process is called *axial coding* and also involves reviewing the uncovered concepts and determining which concepts require further analysis. For example, I reviewed the positive and negative impacts of collaboration and grouped the codes into four positive and negative categories which were confirmed as interviews progressed. Additionally, whilst exploring these codes and categories I identified that interviewees believed some participants were benefiting more or less than others when collaborating and why. In doing so, I identified that analysis was required into who was more or less important or salient when collaborating, particularly in terms of facilitating or enabling the flow of benefits to those within the collaborative network and why.
- Third, *selective coding* is the reduction phase of progressive comparison. This phase involved me examining and describing the relationships between categories and concepts in order to determine the core or higher level concepts. In other words, ‘concepts are developed that account for perceived patterns in sets of data observations [with] each concept indicated by a set of empirical observations’ (Locke, 2001, p. 45). Whilst undertaking selective coding, I tested and verified the concepts before developing the final theory. This was done by looking at the interview transcripts as a whole to verify and corroborate findings and also triangulate findings with those discovered through observation and document analysis. For example, when examining who are more or less important when collaborating, I developed six characteristics of stakeholder salience. These characteristics were referred back to the interview transcripts as a whole to ensure that they commonly reflected the views of participants as well as being reflected and traceable within my interview memos.

Findings developed through progressive comparison were achieved whilst concurrently considering and undertaking the processes of analytical induction and theoretical sensitivity outlined below. Only through considering all three principles can the research findings be generated.

In summary, progressive comparison involves the researcher progressively moving through an iterative and reflective but systematic coding process to produce research findings and develop theory.

### 5.2.2 Analytical induction

This section discusses the analytical inductive nature of progressive comparison analysis as applied in this research. Although the research is primarily inductive, there are also deductive elements, particularly in terms of using existing theory to distinguish between inductively derived categories and concepts and those confirmed by existing theory.

This research is aimed at not only describing inter-organisational collaboration according to research participants but also to provide insight into why they may have these perceptions. As such, the aims of the research include developing theory in order to explain how and why these perceptions relating to collaboration existed. The four stages of analytical induction that the researcher progressed through are discussed below and examples of their application to this research are given.

- First, the analytical induction principle of progressive comparative analysis involved *utilising the theoretical principles* of collaboration, stakeholder and social capital theory to make some initial sense of the data. For example, I utilised collaboration theory when coding the concerns of interviewees in relation to issues associated with resolving organisational and collective goals under the *agency* category which is identified in existing collaboration theory (Thomson & Perry, 2006). Maso and Smaling (1998) refer to this activity as the first stage of analytical induction or the *incubation stage*.
- Second, is the *confrontation stage* of analytical induction (Maso & Smaling, 1998). Here I compared codes, categories, concepts and themes within the data to existing literature and in doing so I noted points of difference and similarity. This means I used elements of induction and deduction when making sense of collected data. The use of deduction allowed for confirmation of developed categories, concepts and themes and allowed findings to have the correct descriptions for the concepts being studied (Yin, 2009). For example, prior theory on collaboration recognised the constructs of governance, administration, agency, mutuality and trust as principles of collaboration (Thomson & Perry, 2006). This assisted the research findings to have face validity and even construct validity (Yin, 2009) and consequently assisted in

giving the research academic rigour. In going through the process of modifying, rejecting and elaborating on the comparisons, I inductively derived, identified and examined themes and constructs that were not comprehensively addressed within existing theory. For example, competition when collaborating was commonly evident within interview transcripts but not referred to in collaboration theory and scarcely referred to within the literature promoting collaboration.

- The third or *generation stage* (Maso & Smaling, 1998) allowed me to make or inductively develop new propositions relating to theory which were then discounted, clarified, rejected or confirmed as the data collection and progressive comparative process continued. For example, after identifying that collaboration when enacted in the youth health sector has competitive characteristics, I then identified what interviewees were competing for and why. In doing so, I made use of the theoretical principles of stakeholder and social capital theory to make propositions involving competing for salience and social capital.
- In the fourth and final *closure stage* of analytical induction (Maso & Smaling, 1998), these propositions were confirmed in subsequent interviews and examined in light of the memos written by the researcher. The closure stage was fundamental to answering the research questions and the development of collaboration theory.

The incubation, confrontation, generation and closure stages of analytical induction are operationalised in this research project through the processes of open, axial and selective coding, which are discussed in depth later in this chapter.

Thus far, this section has explained the analytical induction principle of the progressive comparative analysis method when applied to this research. It showed that when analytical induction is operationalised in this research it includes a level of deductive reasoning by the researcher as comparisons are made with existing literature. Thus, prior theory was used to assist in the triangulation of findings. This means that it was used as a confirmatory tool when categories, concepts and themes were identified when analysing the data. For example, as discussed above, the issues of governance, administration, agency, mutuality and trust were evident within the collected data. These themes were examined and compared to the collected data and the context of a youth health network in order to identify and determine new knowledge. The research expanded theory relating to collaboration by showing that collaboration was characterised by competition when enacted in the youth health sector.

Therefore, although the research was primarily inductive, in terms of inductively deriving new theory, deductive reasoning was required (Eisenhardt, 1989). Thus far, principles of progressive comparison and analytical induction have been described. The next section discusses the third principle inherent in progressive comparison analysis, which is theoretical sensitivity.

### **5.2.3 Theoretical sensitivity**

The third principle of progressive comparison analysis is theoretical sensitivity. Theoretical sensitivity is described by Boeije (2009) as ‘the researcher’s ability to develop creative ideas from research data by viewing the data through a certain theoretical lens’ (p. 88). In this research, this meant using collaboration theory, stakeholder theory and social capital theory to identify categories, concepts and themes within the interview transcripts. For example, by examining findings utilising principles associated with stakeholder theory (Mitchell et al., 1997) and social capital theory (Adler & Kwon, 2002; Coleman, 1994; Cots, 2011; Nahapiet & Ghoshal, 1998; Portes, 1998; Putnam, 1995; Tsai & Ghoshal, 1998), I was able to identify and understand that service providers are competing for social capital and salience when collaborating in order to promote funding opportunities. As such, I was able to identify points of similarity and difference between existing theory and the context of analysis, which is the youth health sector, and thus illuminate areas of new knowledge.

As theoretical considerations associated with competition when collaborating are also highlighted in the previous section relating to analytical induction, it is evident that the principles of progressive comparison, analytical induction and theoretical sensitivity are not separate but impact and relate to each other during the analysis process.

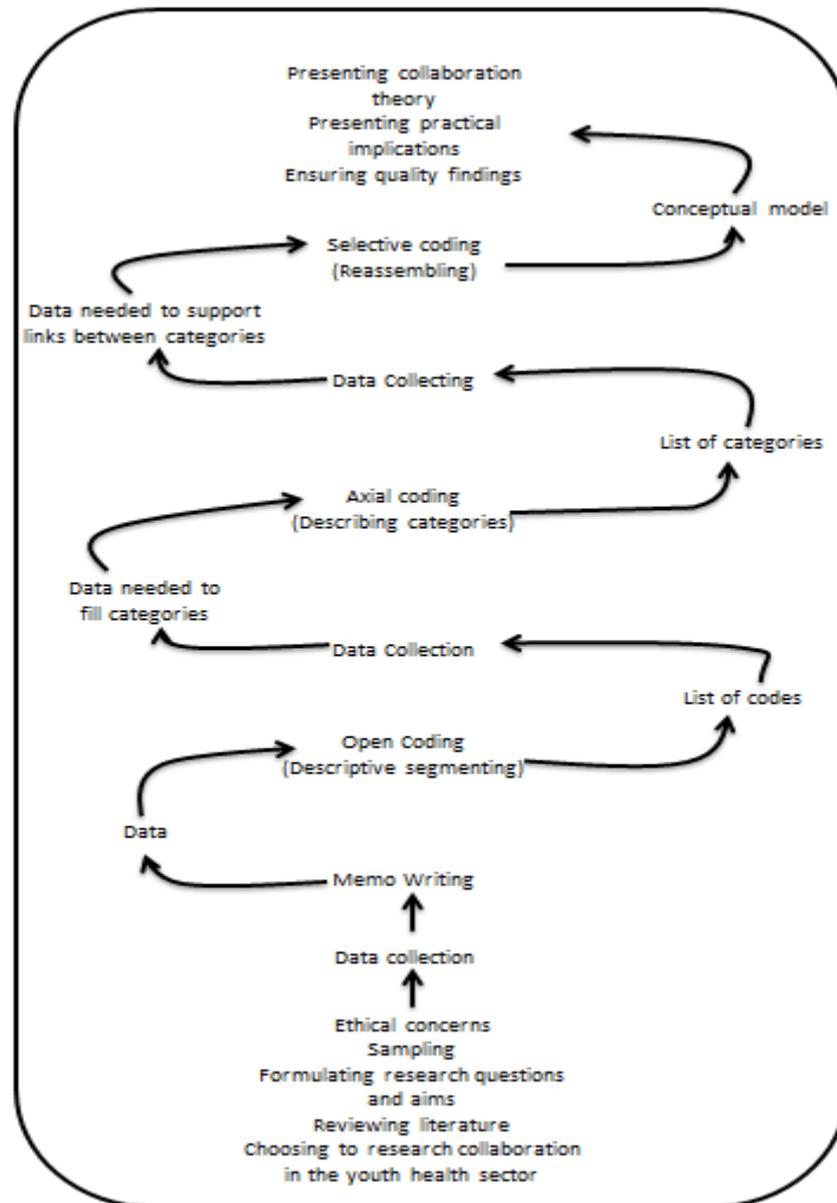
Thus far in this chapter the discussion on the progressive comparative analysis method has delineated the principles of progressive comparison, analytical induction and theoretical sensitivity. It was shown that the systematic but highly abstract analysis approach allowed the researcher to answer the research questions and develop theory. Although examples of the coding process were used to illustrate these principles, it was not shown in depth how the coding processes are applied in this research. The following section examines the coding processes used in this research.

### 5.3 Coding processes

Now that the principles behind the progressive comparison analysis have been outlined, in this section I discuss the open, axial and selective coding processes that I undertook to analyse the collected data. Coding of collected data was essential to this research to make sense of it at a variety of analytical levels in order to develop a more comprehensive theory of collaboration.

Lewins and Silver (2007) claim that a code may ‘represent a deeply theoretical or analytical concept; it could be completely practical or descriptive; or it could represent “interesting stuff” or “data I need to think about more”’ (p. 83). As such, codes used were both descriptive and interpretive and allowed me to identify and describe what was happening or what the meaning of a certain event or experience was for an interviewee by assigning a word or terms to the fragment of data. Strauss and Corbin (2007) describe the coding process as ‘breaking down, examining, comparing, conceptualising and categorising data’ (p. 61) so that the data could be compared, filed and assigned to groups that address similar or the same themes or concepts (Strauss & Corbin, 2007).

As described previously in this chapter, the progressive comparison analysis method is referred to as *progressive* because it involves a progression of comparative or coding techniques as the collected data goes through the different phases of analysis from the descriptive to the more abstract (Fitzgerald, 2002). These phases are illustrated in the following data analysis diagram (Figure 5.1), which shows the progression of analysis from open coding to axial coding to selective coding. The diagram illustrates the cyclical nature of the research process, which progressively spirals upwards towards the development of theory.



**Figure 5.1: Coding processes**

*(Adapted from Boeije [2009])*

Although the process appears linear, it is in fact a circular, iterative and reflective process (Boeije, 2009). Theoretical (coding and analysis) and empirical (data gathering) activities are not strictly separated but rather are tightly interwoven in order to benefit from each other, thus allowing me to advance the growth of insight (Glaser & Strauss, 1967) and develop research findings. Essentially, the coding process involved me ‘taking comparisons from the data and reaching up to construct abstractions and simultaneously reaching down to tie these

abstractions to data' (Charmaz, 2006, p. 181). Consequently, the coding processes allowed me to use quotes or the words of interviewees to illustrate my findings.

The flexibility associated with the coding process allowed me to be open, creative and able to manage and improvise in the identification and development of themes and categories within the collected data (Goulding, 2002). Hence, these themes and categories, particularly those associated with competition for stakeholder salience and social capital whilst collaborating, were explored as the research progressed in order to build theory relating to collaboration.

Prior to any coding I listened and re-listened to interview recordings and read and reread interview transcripts. This was done in order to immerse myself in the data and gain a strong familiarity with each interviewee's thoughts and perceptions in relation to inter-organisational collaboration. Furthermore, coding for each interview did not start until I had completed the memo relating to that interview transcript. This allowed me to approach each transcription with a clear idea of each interview. It also allowed me to consider what other factors such as particular interview observations or implicit considerations that I identified that were not expressed in words during the interview. Only after immersing myself in memo writing and listening and re-listening to the interview did I begin the coding processes for each interview.

Now that the coding process has been introduced and the memo writing and listening of interview transcriptions discussed, the following sections discuss in more detail the analytical coding processes of open coding, axial coding and selective coding as used in this research.

### **5.3.1 Open coding**

The aim of open coding was to begin the exploration of inter-organisational collaboration according to interviewees. Open coding involved the collection of descriptive answers from participants, including managers, youth practitioners and administration staff, particularly in regard to the first two research questions, which are: 'Who collaborates in the youth health sector and why?' and 'What are the impacts of collaboration within the youth health sector?'

Open coding involved dividing and summarising the interview transcripts into named fragments called codes (refer to Appendix G for an example of the coding process progressing from open to axial to selective coding). In some cases, the codes reflected elements of existing literature or theories whilst others were my unique interpretations or constructions of:

What is going on here? What is this about? What is the problem? What is observed here?  
What is the person trying to tell? What else does this mean? Which experience is represented here? (Boeije, 2010, p. 99)

Examples of some of the initial codes that I used include: *definitions of collaboration*, *positive impacts of collaboration*, *negative impacts of collaboration*, *helps collaboration*, *hinders collaboration*, *youth health context*, and *leadership*.

Codes were often fluid in nature as sometimes they were developed into higher level categories, concepts or themes when more specific coding showed that they were too broad or incorporated interesting and relevant information pertinent to the development of research findings. For example, analysis showed that although *competition* was initially grouped under the codes *helps collaboration* and *hinders collaboration*, it was determined that it warranted its own code, which ultimately developed into concepts and themes incorporating a variety of codes and concepts such as *competition for social capital* and *competition for salience*. The development of codes from descriptive to more analytical or higher levels was often the result of axial and selective coding processes which are discussed in the following sections. Open coding also allowed me to group or assign fragments of texts to multiple codes; and consequently, codes developed during open coding were fundamental in the foundation and formation of coding table trees or hierarchies within the QVR NVIVO™ program, which were incorporated into coding tables to assist me in the analysis process (refer to Appendix G for an example of a coding table evidencing the progression of the code *competition* to higher order categories and themes).

The process of open coding continued as interviews progressed and continued until no new codes were found in subsequent interviews. In other words, open coding had reached the point of saturation which is described by Strauss and Corbin (1998) as the point ‘at which no new properties, dimensions, or relationships emerge during analysis’ (p. 490). The saturation point for many codes, such as *lack of funding and resources* that was a branch of the code *hinders collaboration*, was evident early in the interview process whilst other emerging codes such as *competition* required more analysis and developed into higher order categories, concepts and themes as interviews progressed.

To ensure the credibility of the findings, the researcher discussed and confirmed the relevance and adequacy of codes and the grouping of codes into particular categories or concepts with his academic supervisory panel and made comparisons to existing literature.

This was done in order to gain *inter-rater reliability* (Strauss & Corbin, 1998). The point of saturation for codes was also confirmed by the researcher's supervisory panel.

In summary, by undertaking open coding, the researcher was able to make initial judgments and decisions on whether the fragments were relevant to addressing the research or just confirming existing knowledge. The second phase of data analysis, or axial coding, is discussed in the following section.

### **5.3.2 Axial coding**

Axial coding is the second more focused and more abstract round of coding that I used during the analysis process. It refers to 'a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories' (Strauss & Corbin, 2007, p. 96). In other words, axial coding involved taking the codes and categories uncovered during open coding to a more abstract or conceptual level. I did this by relating categories to subcategories, identifying and specifying the dimensions and properties of a category and reassembling the data fractured during initial coding to give cohesion and traction to the emerging analysis (Charmaz, 2006).

To make sense of the properties and dimensions of the codes identified during open coding, for the axial coding processes I applied a framework to the analysis that looked at how collaboration is enacted or occurring within the youth health sector at vertical and horizontal levels. As elaborated on below, this framework was chosen based on its relevance to the structural dimension of social capital and it allows consideration for power structures and hierarchy within the youth health sector and what they are based upon. By doing so, I could better address the third research question, 'How is collaboration operationalised or enacted within the youth health sector?' Essentially, this framework allowed me to conceptualise the inherently complex relational nature of collaboration when operationalised within a particular context. It did this by assisting me to conceptualise and to understand the nature of influence when participants are collaborating and how this may compare to an existing hierarchy within the sector. It also allowed me to utilise and consider existing theory. The vertical and horizontal conceptual framework has a number of distinctive characteristics.

- First, the conceptual framework allows analysis of the interview transcripts whilst considering or being sensitive to the theoretical principles of collaboration, stakeholder and social capital theories. This means identifying and explaining what

makes stakeholders more salient than others when collaborating by utilising Mitchell et al.'s (1997) theory of stakeholder salience and its principles of legitimacy, power and urgency. It also means applying the principles of social capital theory to understand the relational and structural linkages between those involved in collaboration (Adler & Kwon, 2002; Cots, 2011; Portes, 1998). The principles of collaboration theory were also considered when examining the relationships between salience, social capital and the processes and principles of collaboration, which are negotiation, commitment, execution, assessment, governance, administration, mutuality, agency and trust and reciprocity (Ring & Van de Ven, 1994; Thomson & Perry, 2006; Thomson et al., 2009). Consequently, the framework allowed me to utilise the principles of analytical induction and theoretical sensitivity when progressively comparing the data through the coding processes.

- Second, the conceptual framework enabled me to examine collaboration through two lenses, vertical and horizontal. The vertical lens involves examining collaboration as enacted within the youth health sector from the bottom up and the top down. The vertical lens means examining collaboration by acknowledging power and hierarchy within the sector. Complementing the vertical lens, the horizontal lens involves examining collaborative relationships that are more equal or at least without overt management, professional or government hierarchy. By examining collaboration on horizontal and vertical levels, I was able to examine influence when collaborating and make comparisons with existing hierarchy within the sector.

Unlike open coding which was focused on coding the raw data, the primary purpose of axial coding is the determination of which categories, subcategories or codes uncovered during open coding are more or less important in addressing the research questions (Boeije, 2009). In doing so, I examined and compared the nature, dimensions and factors relating to the codes and categories emerging from the coding processes such as context, conditions, interactions and consequences as evidenced in the collected data. Axial coding also allowed me to incorporate the theoretical principles associated with collaboration, stakeholder and social capital theories in terms of analytical induction and theoretical sensitivity.

Consequently, the aim of axial coding was not just to identify the most common factors but also identify categories that required further confirmation or exploration in subsequent interviews. In doing so, axial coding allowed me to reduce the data set and give the research focus. For example, after the eighteenth interview I decided, in conjunction with my

supervisory panel, to further investigate the competitive characteristics of collaboration that were commonly being referred to by interviewees. It was duly noted by the eighteenth interview that competition was clearly an issue or concern for interviewees when collaborating and that scholarly literature was scant on the competitive elements of collaboration.

The following examples of the research processes illustrate the axial coding process:

- By undertaking axial coding I discovered that many of the *negative impacts of collaboration* and some of the *positive impacts of collaboration* relate to competition. As a consequence, the code *competition* became elevated to a higher order category, particularly due to the lack of clarity in collaboration theory concerning collaboration being a competitive process. The axial coding process allowed me to ask the data how and why are interviewees competing when collaborating and who stands to gain or lose when doing so.
- Axial coding allowed me to consider *who are more important or salient* when collaborating and why, particularly as interviewees made comments on deciding who they choose or compete to collaborate with.
- Axial coding allowed me to make connections between the different reasons to collaborate. In doing so, I uncovered that a focus on *attaining funding and resources* clearly underlined the other reasons given by interviewees to collaborate.

Like in open coding, axial coding continued until a point of saturation. Saturation in relation to axial coding is described by Boeije (2009) as ‘meaning that the definition and properties of each category (axis) are clear and that no further adjustment is needed’ (p. 114). The development of codes and categories was tracked through written memos giving coherence to the coding process.

With the competitive characteristics of collaboration confirmed and agreement from my supervisory panel to pursue a strategy to understand collaboration and its competitive elements better, the researcher adopted a more focused research approach. This more focused and attentive research approach involved identifying and discussing the competitive elements of collaboration within subsequent interviews. However, the researcher remained ever mindful of not influencing the thoughts of interviewees with leading questions. Rather, the researcher allowed competitive elements of collaboration to emerge naturally from the

discussions with interviewees. For example, when interviewees disclosed that some service providers were competing for funding, the researcher would prompt interviewees to disclose what strategies organisations may use to attain funding or what gives organisations better opportunities to get funding. In doing so, the researcher uncovered that interviewees perceived that collaborating with particular stakeholders would increase their opportunity to gain funding, to increase their standing within the sector and improve their ability to deliver youth health services.

Although axial coding allowed me to focus on emerging codes and categories, I remained mindful of not forcing results from the data. This was done by acknowledging quickly that if evidence was not found immediately in subsequent interviews it was not present.

The finding that collaboration is characterised by competition also prompted the researcher to return to the literature to understand how other scholars perceived the relationship between collaboration and competition. This research identified that scholars often perceive competition as diametrically opposed to collaboration (Browning, Beyer & Shetler, 1995; Lamont, 1991; Prins, 2006) and often inhibiting the effectiveness of collaboration (Gordon, 2007; Hoatson & Egan, 2001; Lee, Feiock & Lee, 2012; Milbourne, Macrae & Maguire, 2003). It also reaffirmed that collaboration is a management strategy born out of the perceived failings of competition (Hill & Lynn, 2003; Kettl, 1996; McGuire, 2002, 2006). This review also showed that some other scholars believed that collaboration and competition have a degree of synthesis, with terms being coined such as ‘coopertition’ (LeTourneau, 2004a; Lombard & Morris, 2010; D.J. Watson & Morris, 2008) or even ‘communitition’ (Hutter, Hautz, Füller, Mueller & Matzler, 2011) that reflect characteristics of both collaboration and competition.

In summary, axial coding allowed me to compare the fragments of data assigned to codes, define the categories and determine the relationships between the main categories to the codes and subcategories (Boeije, 2009). It allowed me to reveal the competitive nature of collaboration when operationalised in the youth health sector, particularly in terms of gaining salience or eminence within the sector through collaboration. Axial coding also allowed me to identify that collaboration is perceived by interviewees as a means to gain funding in order to better deliver youth health services. However, axial coding is only the second phase of coding and is not sufficient to develop theory. To develop theory explaining collaboration

when operationalised in the youth health sector, I undertook a third phase of coding called selective coding.

### **5.3.3 Selective coding**

The selective coding phase is the final coding phase of the research process. It is sometimes referred to as theoretical coding (Charmaz, 2006) and is fundamental to the development of the final theory explaining collaboration when enacted within the youth health context. More specifically, selective coding culminates a coding process that allowed me to develop theory that identifies who is more or less salient or important when collaborating in the youth health context and why and how salience impacts on the relationship between collaboration and competition. In fact, this coding process allowed me to develop a more comprehensive theory of collaboration that builds on existing collaboration theory and better explains how collaboration occurs when enacted within the youth health sector.

As the final coding process, selective coding allowed me to describe the most important concepts developed through the open and axial coding processes whilst again incorporating the principles of progressive comparison, analytical induction and theoretical sensitivity.

Selective coding involved a number of activities. These activities included the determination and verification of core concepts and the relationships between them. For example, to explore the findings I utilised principles of stakeholder theory, such as power, urgency and legitimacy (Mitchell et al., 1997) to understand core concepts discovered during axial coding in relation to what makes stakeholders more or less salient when collaborating. In other words, I verified six characteristics that make stakeholders salient when collaborating within the youth health context in western Sydney and called them the *six characteristics of salience*.

The six salience characteristics when collaborating are:

1. links to government
2. access to funding
3. authority to delegate funding
4. networking skills
5. credibility within the sector
6. delivery of services.

The characteristics of salience will be discussed in depth in the following research findings, discussion and conclusion chapters.

Axial and selective coding assisted me to determine that links to government, access to funding and authority to delegate funding are distinctively more mechanistic, in that they are not easily influenced and changed by the actions of individual organisations. Axial and selective coding also assisted me to determine that the characteristics of networking skills, credibility within the sector and delivery of services are much more organic and are more readily influenced by individual organisations.

What the findings show is that competition for salience is more commonly associated with the organic characteristics of stakeholder salience rather than the mechanistic characteristics. This is because findings indicate that there are two ways for creating saliency in order to better obtain funding. First, is to have the authority, legitimacy, or power to obtain funds directly from the government and other funding agencies, for example, more securely funded government youth health service providers. Second, is to develop social capital and advantageous collaborative linkages with those organisations that have the authority and control of resource allocation or the relationships with those that do. For example, individuals identified by interviewees as *champions* within the youth health sector have high levels of social capital which enables them to have high respect and credibility and thus demand the attention of others including funding organisations or agencies. These findings are discussed in detail in the following research findings chapter.

By answering question 3, the analysis also confirmed that collaboration in the youth health sector is not primarily about delivering services, but about obtaining funding to ensure organisational sustainability. This contrasts with the passionate comments found in question 1 which would indicate altruistic motivations are primary.

The selective or theoretical coding phase of the analysis process enabled the researcher to build on the six characteristics of salience and develop theory that explains competing for salience when collaborating in order to attain funding. In doing so, the researcher made new propositions relating to theory which were then discounted, clarified, rejected or confirmed as the progressive comparative process continued. This process involves the researcher examining new theoretical propositions by clarifying them with the thoughts, views and words of interviewees and the initial findings regarding competing for salience in order to attain funding. It also involved continued reference to the literature to acknowledge unique

points of difference and thus involved progressive comparison, analytical induction and theoretical sensitivity and illustrated the iterative and reflective nature of progressive comparison analysis.

Lastly, this process resulted in the researcher presenting a theory that argues that competition for salience is born out of a concern for organisational sustainability and is reflective of an environment of New Public Management (NPM) where government promotes competitive principles and individual organisational financial accountability. The theory also argues that as collaboration increases, competitive pressures to remain salient also increase and that this competition ultimately limits the level of collaboration. In other words, increased collaboration creates increased competition and, whilst initially promoting collaboration, increased competition also results in a level of angst, tension or conflict between participants as they compete to maintain their standing within the sector and within the collaboration process.

I also used social capital theory to assist in developing propositions of what stakeholders are competing for when collaborating. In other words, selective coding involved interpreting, positioning and writing the findings in relation to existing literature in order to draw conclusions and answer the research questions.

Consequently, selective coding involved me reassembling the data by identifying the core concepts that addressed the research questions. As in axial coding, I also identified and explored points of difference between the core concepts discovered in the collected data and existing literature relating to collaboration, stakeholder and social capital theories. This reflection of the literature was fundamental to discovering theoretical gaps in existing literature. It was also fundamental to determining where emerging knowledge can add to collaboration theory in order to more comprehensively explain collaboration when operationalised in the youth health sector. Concepts discovered through selective coding were explored as interviews continued, particularly from interview nineteen onwards as this was the point at which competition when collaborating had been identified as a concept requiring further investigation.

As in the previous open and axial coding processes, selective coding proceeded until a point of saturation. Saturation in this phase of the coding process is described by Boeije (2009, p. 118) as ‘meaning that new data collection provides data which are consistent with descriptions thus far and fit the theoretical model’. Strauss and Corbin (1998) refer to the

saturation point as ‘the point in thematic development at which no new properties, dimensions, or relationships emerge during analysis’ (p. 490). Exemplifying the selective coding process, after verifying the characteristics that make stakeholders salient when collaborating and how competition relates primarily to attaining organic characteristics of salience, I began to look broadly at how competition limits or enhances collaboration. I was able to conclude that competition between service providers to develop salience, build social capital and develop the most advantageous collaborative working relationships in order to perpetuate funding, as well as deliver youth health services, promotes collaboration within the youth health sector. However, I was also able to verify that ultimately competition between service providers limits collaboration. It limits collaboration as services perceive that blatant, unfair competitive behaviour of others negatively impacts on their own salience and therefore, collaborative relationships within the collaboration are negatively impacted and social capital is potentially lost.

Summarising, the thematic development process described above consisted of coding the data, developing categories, ‘comparing incidents applicable to each category [including naming or coding, comparing and memo writing], integrating categories and their properties, delimiting theory, and writing the theory’ (Locke, 2001, p. 45). Furthermore, this fluid, three-stage coding process allowed me to incorporate the principles of progressive comparison, analytical induction and theoretical sensitivity. Although abstract and often iterative, this inductive, progressive, systematic and analytical process allowed me to develop, collate and write up research findings using the words of participants. It also allowed me to incorporate my own analytical thoughts and analysis skills. By going through various levels of descriptive to abstract analysis, I was able to answer the research questions, address gaps in the literature and build theory relating to collaboration.

#### **5.4 Chapter summary**

In this chapter, the method of analysis used in this research was presented. It was shown how the researcher collated research findings and developed or extended current collaboration theory. More specifically, it was shown how this researcher came to better understand the competitive elements inherent in collaboration, particularly when enacted or operationalised within the context of a western Sydney youth health network.

The chapter began by introducing the progressive comparison analysis method used in this research to analyse collaboration. The principles of the progressive comparison analysis

method which are progressive comparison, analytical induction and theoretical sensitivity were discussed and examples were used to illustrate their application. It was shown that by using these three principles, in conjunction with a coding system, the researcher was able to provide a thesis explaining how collaboration occurs within a particular context.

To show how the progressive comparison analysis method was applied or operationalised for in this research, an in-depth examination of the analytical coding processes used were presented. It was shown how the coding processes allowed the researcher to develop convergent and multiple lines of enquiry in order to give credibility and rigour to research findings and conclusions.

Each coding process was explained in turn, from the most descriptive to the more abstract level. This began with a discussion on the open coding process where collected data was initially described and analysed. The second coding process, called axial coding, was then explained. Axial coding involved taking the codes and categories uncovered during open coding to a more abstract or conceptual level. To assist in axial coding, the researcher applied a framework that conceptualised collaboration occurring at both vertical and horizontal levels. In this chapter, I showed how this framework allowed me to incorporate issues such as hierarchy, structure, power and influence when collaborating. The framework also allowed me to incorporate the principles of collaboration, social capital and stakeholder theories when examining the data.

The third and final coding process, the selective coding process, was then discussed. It was shown that selective coding enabled me to identify and describe the most important concepts, such as competition, that were revealed and analysed through the coding processes. Selective coding allowed me to conceptualise, describe and explain the relationships between concepts to answer the research questions and develop theory.

In conclusion, in this chapter I presented and explained the progressive comparison analysis method used in this research to collate research findings and develop theory, particularly that associated with the relationship between collaboration and competition. I showed that the progressive comparison analysis method allowed me to use multiple data sources, link the words of the research participants to illustrate findings and have key academic staff confirm developed codes, categories, concepts and themes revealed within the data.

Now that the method of analysis has been explained, the following chapter presents the research findings.

## **Chapter 6: Research findings**



## 6.1 Introduction

This chapter reports analysis of the data, which reveals that collaboration within the youth health sector is characterised by competition. This finding is important considering that collaboration is often considered by scholars as having opposing principles (Browning et al., 1995; Lamont, 1991; Prins, 2010) and that competition hinders collaboration, indicating that the two organisational strategies are incongruent (Gordon, 2007; Hoatson & Egan, 2001; Lee et al., 2012; Milbourne, 2009; Milbourne et al., 2003). However, the findings indicate that collaboration within the youth health sector is competitive as it involves service providers competing to be perceived as more salient or influential. This chapter highlights that salience is considered worth competing for as it perpetuates opportunities to attain funding and ensure organisational sustainability. As shown in the previous chapter, the analysis of the data revealed at least six characteristics that make stakeholders more salient when collaborating with the sector. These characteristics are referred to as characteristics of salience and reiterated include:

1. links to government
2. access to funding
3. authority to delegate funding
4. networking skills
5. credibility within the sector
6. delivery of services.

These findings are expanded upon in this and the final discussion and conclusion chapter which develops and presents a theory explaining the relationship between increasing collaboration and increasing salience, being first promoted and then second limited by increasing competition.

This chapter is divided into three sections that correspond to the research questions which reiterated are:

1. Who collaborates in the youth health sector and why?
2. What are the impacts of collaboration within the youth health sector?
3. How is collaboration operationalised or enacted within the youth health sector?

Section one describes who collaborates when and why. By answering question 1, 'Who collaborates in the youth health sector and why?' it will be revealed that interviewees

perceive collaboration as normative behaviour for all those working in the youth health sector. It will also be shown that interviewees perceive collaboration as representing a myriad of cooperative working relationships. It will be clear that interviewees collaborate for altruistic reasons, such as delivering health services to youth in need. However, it will also be evident that due to resource limitations there is a clear willingness from many interviewees to collaborate to gain funding and address contextual complexities such as resource limitations. Furthermore, by answering question 1 it will also be clear that interviewees collaborate to develop social capital that allows them to achieve individual organisational objectives and collective objectives, particularly those objectives associated with gaining funding and the delivery of youth health services.

After answering question 1, question 2, ‘What are the impacts of collaboration within the youth health sector?’ will be answered. By answering question 2 the positive and negative impacts of collaboration within the youth health sector will be apparent. However, by answering question 2, the findings also show that interviewees perceive that collaboration results in increased competition. It will be shown that increased competition is related to individual organisational funding objectives related to organisational sustainability.

The third section addresses research question 3, ‘How is collaboration operationalised or enacted within the youth health sector?’ This section discusses the six organisational characteristics of salience to show how collaboration is enacted in the youth health sector. Section three also shows how collaboration can assist in breaking down walls between organisations and how collaboration introduces forms of competitive behaviour for creating salience. However, section three also shows there is a level of tension between service providers that develops as collaboration with competitive characteristics increases and that a high level of salience and a high level of collaboration is not sustainable in the long term, which could indicate uncertain futures for individual youth health services.

This chapter concludes by discussing the six salience characteristics, whilst the final theory relating to increasing competition and increasing collaborating is not presented until the conclusion chapter, where its implications for theory and practice are also highlighted and discussed.

## **6.2 Question 1: Who collaborates in the youth health sector and why?**

By using the words of interviewees, the following section addresses the first part of question 1, which identifies those working within the sector who are involved in collaboration. Reasons why they are involved in collaboration follow in the section after that.

### **6.2.1 Collaboration is normative behaviour**

Collectively, participants responded that everyone involved in youth health services collaborates in one way or another; youth practitioners, administration staff and managers alike. Thus, collaboration is normative behaviour within the youth health sector. For example, an interviewee who is a youth health worker stated:

I think working in the youth sector, there is generally a lot of collaboration. It is unusual not to have collaboration (GY2).

Consequently, findings show that collaboration is normal working practice and that there is normative pressure to conform to collaborative working practices. Normative pressure, which is grounded in the values and beliefs that matter to organisations and their employees (Mintzberg, 1996; Perry & Wise, 1990), exerts control over participants to conform to these values. Therefore, the research findings concur with research by Tschirhart, Christensen and Perry (2005) involving the impact of normative pressure on public sector employees involved in collaboration. Hardy, Phillips and Lawrence (2003) and Lawrence, Phillips and Hardy (1999) refer to normative pressure enacted on members of collaborations as governance by group- or clan-like mechanisms. Hence there is pressure to develop social capital and be successful at collaboration within the sector and conform to the expectations of those involved in collaboration. However, as will be demonstrated later in this section, competitive values are also institutionalised within the sector as a result of competitive tendering practices associated with NPM and these values also impact on how collaboration is characterised within the sector.

Interviewees commonly believed that collaboration is integral and necessary to their job role. For example, a youth health practitioner said:

You have to have contact with other organisations in your job role anyway ... you have to do it, it is part of your job to go to meetings, interagency meetings, meet people (GY2).

The above quote shows that at the clinical service delivery level, interviewees perceived they

are collaborating. In addition to youth health practitioners, administration staff also believed they were commonly involved in collaboration. For example, when discussing participation in collaboration with an interviewee who works in an administration role, she responded with the comment:

Most of the ones I collaborate with are medical practices and getting information about the clients, a lot of the work is following up on their mental health plans (EA5).

Interviewees who are managers also commonly reported they were collaborating at both clinical and strategic levels. For example, a manager described his role in promoting linkages between health service providers in his statement:

I see my role as to not only get the youth health services working together, but to have Youth Health working with other parts of the [health] sector (GM1).

Giving an example, the same manager said:

So, we work with those two services to coordinate our services with theirs, and to actually collaborate and work together and there is actually some really good collaboration going on (GM1).

The finding that interviewees who are administration staff, youth practitioners and managers regularly perceive they collaborate contrasts with research by Brown and Keast (2003), who argue that collaboration is for those working at higher levels within organisations. However, despite interviewees believing they commonly collaborated, they did not distinguish or make comparisons of collaboration with other forms of cooperative processes they may be involved in.

Collaboration is often presented within the literature as a point on a continuum of interrelational or cooperative processes. For example, Gajda (2004) presents cooperation, coordination, collaboration and coadulation as interrelational cooperative processes from the least intense to the most intense ‘in terms of their depth of interaction, integration, commitment, and complexity’ (Thomson & Perry, 2006, p. 20). Consequently, collaborating for interviewees implies organisational actors have a *great deal of involvement in a myriad of cooperative activities and the quotes presented here confirm a loose definition of collaboration*. Thus, interviewees from across the sample group indicated all those working

within the youth health sector were involved in collaboration as a result of the nature of their role and employment.

*Why* they are involved in collaboration is discussed in the following sections. The reasons why participants collaborate within the youth health sector are revealed by themes commonly identified within interviewee transcripts. Identified reasons to collaborate include: *to assist youth in need, to access and share resources, to build personal working relationships and to gain funding*. The following sections also show that government policy promoting collaboration had little impact on giving interviewees reason to collaborate. However, government policy relating to competitive tendering processes that sometimes involved enforced collaboration did.

### **6.2.2 Assist youth in need**

Collectively, interviewees revealed they collaborate to *achieve a shared or common aim or purpose*. For example, in answering the question why people are collaborating, a manager mentioned ‘individuals, organisations and services working toward a shared vision’. Some participants were general in their reference to what the shared vision entailed whilst other interviewees were ardent and particular in emphasising that the common or collective goal for them was the delivery of youth health services to those in need. For example, an interviewee who is a youth health practitioner advocated that:

It [collaboration] is more than just working together, especially in this type of industry it’s [collaboration] working together with other local services in the area to help out a young person to get the appropriate help (EY2).

Collectively, interviewees were *explicit and passionate in referring to the needs of youth as being the primary reason for why they collaborate*. This was demonstrated by the large amount of comments referring to collaborating for the benefit of clients. For instance, when asked why she collaborates, a youth health practitioner declared: ‘Yes, the needs of the client definitively’ (GY3) whilst another youth health practitioner proclaimed: ‘It [collaboration] is not about us but the clients’ (EY3).

The common altruistic aim of delivering youth health services appeared to *bond the sample group together* and principally drive the need to collaborate. In other words, the common aim of delivering youth health services resulted in goal congruence, a degree of alignment of incentives and high levels of commitment which are considered by Dietrich et al. (2010) to be

essential elements for effective collaboration. This also exemplified Thomson and Perry's (2006) mutuality dimension, relating to forging mutually beneficial interdependencies based on shared interests.

A sense of commonality is indicated within interview transcripts by the collective references to *common goals, outcomes, and aims and objectives* when collaborating. For example, a youth worker said:

Collaboration is working together for a common goal or to achieve a common outcome (GY3).

Consequently, findings suggest a sense of shared purpose associated with having common goals and objectives and a willingness to collaborate to achieve these goals. In other words, a sense of collegiality or, as an interviewee who is a manager declared, a 'like-mindedness' (DM2) in the common cause of advocating for the health needs of youth. The sense of commonality is referred to in the literature. Westley and Vredenburg (1991) acknowledge common interest as a precondition to effective collaboration. In addition, Leach et al. (2002) and Lubell (2005) claim that stakeholders need to collectively be passionate in addressing or improving an issue they consider salient. Furthermore, a common mind-set or cognitive-based, mutually held belief system are considered by Coleman (1990) fundamental to building or sustaining social capital and enabling collective action. Lesser (2000) argues that a common mind-set is required for building social capital through collective action as it impacts on the flow of information and knowledge.

### **6.2.3 Access and share resources**

Interviewees collectively agreed that they collaborate to *access the resources of other youth health service providers*. For example, an interviewee who is a youth health practitioner said:

I think it [collaboration] widens and opens a lot of doors and a lot of different possibilities where more people are involved, more agencies are involved with different resources, different skills and different focuses. It helps. It diversifies the services we provide (GY3).

Furthermore, interviewees also collaborated to *share resources* between youth health service providers. For example, an interviewee who is a youth health worker identified 'pooling resources' (FY1) as a reason to collaborate. The following quote shows that managers seek out collaborative opportunities to access the resources of others and to share their own resources in order to better deliver youth health services:

I think people actually seek out collaboration because it is a way of making a project better and yet overcoming the barriers. Yeah the low money and perhaps low resources that you might have; so sharing resources, sharing ideas and sharing manpower kind of stuff (CM1).

As the above quotes exemplify, interviewees collaborate to gain *access to the resources of other service providers* because they believe it is difficult for one service alone to provide the range of health services required to address complex youth health needs. For example, an interviewee in a practitioner role acknowledged that collaboration is required in the youth health sector ‘because working with young people in isolation can be very difficult’ (GY4).

Consequently, interviewees commonly perceived *collaboration as a means or opportunity to gain resources beyond those available within their own organisation*. In other words, interviewees collaborate to gain more than they have or can give on behalf of the client. This aim coheres with the literature on collaboration which contends that collaboration can unlock distinct competencies of other stakeholders (Entwistle & Martin, 2005) and in doing so, expands the resources available to participants. The scarcity of resources and high levels of interdependency are also highlighted as reasons to collaborate. This finding reflects the commonly held view within the literature that interdependency resulting from a lack of available resources is an antecedent of collaboration (Gray & Wood, 1991).

#### **6.2.4 To build personal working relationships**

In accessing the resources of others, findings show that interviewees also *collaborate to build and develop working relationships* both within and beyond organisational boundaries. For example, an interviewee who is a youth practitioner stated:

I like building relationships so for me that is a really big motivator to collaborate with others (EY1).

In doing so, interviewees commonly referred to *raising awareness* and learning about the services provided by other stakeholders. For example, an interviewee who is also a youth health practitioner stated:

I guess the interest in collaboration is finding out how we can link together so we are not stepping on each others toes as well as how we can provide our services to the client and I guess it is both vice versa (EY3).

As the above quotes exemplify, a reason to collaborate was to *build synergistic positive working relationships whilst sharing knowledge of their services*. This finding confirms collaboration literature, which emphasises the interrelational aspect of collaboration, particularly the requirement for trust (Gajda, 2004; Thomson & Perry, 2006; Thomson et al., 2009; Vangen & Huxham, 2003). However, the literature relating to collaboration is less conclusive concerning which stakeholders are more important in personal relationships and how altruistic and economic considerations compare and contribute to collaboration. The finding that research participants collaborate to build positive working relationships also exemplifies the relational dimension of social capital, where it is produced through the interaction and interrelationships between participants (Lin, 1999). In addition, the findings confirm research that positive relationships between participants create social capital and increased learning (Falk & Harrison, 1998).

This research shows that for those with both altruistic and economic considerations within the youth health sector, building personal working relationships is a common reason why interviewees collaborate. In addition, building relationships between those working within the sector through collaboration was consistently mentioned by both research participants from government and non-government service providers. This finding shows that interviewees were willing to collaborate with both government and non-government youth health service providers in order to deliver youth health services. Evidently, the differences between government and non-government organisations (NGOs) involved in the delivery of youth health services did not prevent them from collaborating with each other to build personal working relationships with the common aim of health service delivery. However, as will be discussed below in sections examining the negative impacts of collaboration, collaboration sometimes exacerbates the differences between government and NGOs, which can be perceived as a negative impact of collaboration.

### **6.2.5 Collaborating for funding**

Interviewees commonly collaborated in order to *overcome perceived underfunding and resource constraints*. Resource limitations within the sector are evident as shown by the following comment by a youth health practitioner from a non-government service provider:

We shouldn't have to be scrounging for funding every year and I don't know about all the other organisations and whether they have to scrounge for funding every year too (CY2).

Resource and funding limitations have resulted in interviewees collaborating to advocate for funding for the health needs of youth and to advocate for funding for organisations involved in the provision of youth health services. For example, a manager from an NGO concerned with the availability of future funding for her organisation pondered:

I mean collaboration is very important in this prospect of looking for funding. If we don't collaborate with other services; perhaps that is the way to continue this service is to collaborate with other services and pool resources and continue this service with other services utilizing this space (CM1).

The following comment by an interviewee who is a youth health practitioner from a government service provider confirms that those within the sector collaborate to attain funding:

It's [collaboration] very important because we are very isolated services, we don't have a very strong funding behind the adolescent or youth health services. Without collaboration or a common voice you can't ... It's very hard for you to achieve something without the backup (DY5).

The quotes above show that those working in both government and NGOs share concerns relating to funding and that collaboration offers opportunities to gain funding.

The above comments also show that interviewees *collaborate to develop social capital and salience* so that they can individually and collectively be legitimately able to lobby for and attain funding. As such, this finding shows that collaboration provides a forum where individual stakeholders can lobby to attain salience within the collaborative network and within the youth health sector.

Collaboration is often portrayed in the literature as a means to overcome funding limitations by increasing efficiency, maximising the use of resources and reducing duplication (Gazley, 2010; Xyrichis & Lowton, 2008). However, the literature relating to collaboration is less clear in reference to collaborating to achieve salience or to influence the actions of others who are not part of the collaborative network but have power over those within the network, such as funding bodies. This research addresses this gap by more deeply examining the strategies used by research participants when involved in collaboration to attain salience and funding from external stakeholders whilst simultaneously collaborating with other youth health service providers to achieve altruistic and individual organisational funding objectives.

Consequently, this research adds to collaboration theory by expanding the current scope of the reconciliation of not only individual and collective goals but also considering the impact of overarching altruistic goals and the influence of stakeholders who have power over the collaborative network.

The strategies used by research participants to attain funding and salience when collaborating are discussed in depth in this chapter when addressing question 3, ‘How is collaboration operationalised or enacted within the youth health sector?’

### **6.2.6 Government policy promoting collaboration**

This section discusses the impact of the NSW Youth Health Policy 2011–2016: Healthy Bodies, Healthy Minds, Vibrant Futures and broader competitive funding policies, and whether they impact on why interviewees engage in collaboration. This section is relevant to the research because mandated or enforced collaboration associated with *competitive funding policies was identified as a reason why interviewees collaborate*, particularly those in management roles.

However, the findings show that *the promotion of collaboration in the NSW youth health policy did not directly impact on interviewees’ decisions to participate in collaboration*. Rather, interviewees commonly argued that NSW youth health policy does not assist them to deliver youth health services and is often removed from the realities of their work. For example, a youth worker declared:

I never read it [NSW youth health policy]. It is a hassle. When I actually do read it, I think yeah really, most of this is bleeding obvious, is self-evident in a way (GY2).

Furthermore, a manager scoffed at the current youth health policy, arguing that as a policy statement it is a guide to action only:

The issue with the youth health policy is that I think, in terms of collaboration, it’s a policy about collaboration with no deliverables (GM1).

Although the NSW youth health policy was rarely read by any of the interviewees, other interviewees believed that collaboration in government policy was positive as it acknowledged and promoted the activities that they believed they were already involved in. For example, when discussing government policy promoting collaboration, an interviewee in a youth practitioner role said:

In some aspect it [NSW youth health policy] obviously drives your profession and how you are expected to network or behave or connect with other services ... so really it [NSW youth health policy] kind of just promotes what we are already doing (EY3).

A supportive view of collaboration in policy was presented by an interviewee in a management role within the organisation instrumental in developing policy, as evident in her comment, 'Well that [NSW youth health policy] does set a bedrock' (DM1).

The findings imply that although many interviewees had negative thoughts concerning the relevance of the NSW youth health policy to overall health outcomes, the policy at least recognised the collaborative element of their job role and therefore did not give them reason not to collaborate. Rather, the findings showed that some interviewees believe that collaboration as a policy lays a foundation concerning appropriate or normative ways to act or behave within the youth health sector. As such, policy is prescriptive, particularly as it contains a checklist to assist those involved in collaboration. However, the NSW youth health policy is an advisory directive only and not a legally binding or enforceable policy and as the findings suggest, it does not give most interviewees reason to collaborate.

In comparison to the prescriptive and advisory nature of the NSW youth health policy are the competitive tendering policies and practices associated with New Public Management (NPM). Competitive tendering practices often mandate or enforce collaboration with particular service providers as a condition of tendering. Alternatively service providers are coerced into collaboration with other stakeholders in order to supply the deliverables stipulated within the tender. These tenders are commonly produced by government funding bodies. Research findings show that this form of policy *does* give reasons for interviewees to collaborate. For example, a manager from a government youth health service provider said:

This grant we are just about to submit around binge drinking, it is a national grant, and there is, you know, funding of up to \$500 000 for partnership organisations. Obviously, government organisations cannot access that funding but in partnership they can (FM4).

The finding that *competitive tendering processes give stakeholders reasons to collaborate* shows that government is controlling participation in the collaboration process by stipulating which organisations must be included in collaboration in order to gain funding. For example, when discussing an example of mandated collaboration an interviewee in a management role said that the funding organisation stipulated, 'Look, we'll give you the money but you must work with XXXX [a particular health service provider]' (DM4). Hence, findings show that

salience or importance in relation to collaboration relates to having government support within the sector as it is through government support that other organisations can be forced to collaborate with them.

Competitive tendering processes also impact on participation in collaboration by influencing the development and sustainability of collaboration by financially rewarding those collaborative tenders that funding organisations, often government, perceive as better able to deliver youth health services according to government health priorities. A result of this is that governments are promoting collaborative linkages amongst organisations involved in successful tendering bids and thus are assisting those organisations to build capacity, skill and social capital. For example, the following interviewee comment shows how awarded funding fosters collaboration:

We have got a national gathering happening in December so we are all going to Melbourne for two days to sort of meet everyone. So I guess logistically that all then becomes tricky but they have got a lot of money and are actually paying for us all to go. So part of that collaboration is supported through the grant (DM4).

Therefore, findings imply that salience or importance within the sector and the sustainability of health providers is based on the ability to deliver government policy objectives. This finding implies that the NSW and Commonwealth governments are using collaboration as a means to enforce their influence or will on the sector and to favour organisations which they may feel are better aligned to their priorities and able to achieve their political goals. This finding is important as it shows that governments are influencing the collaboration process by controlling and developing social capital among participants of successful tendering bids through the provision of funding. This finding is also important as it shows that collaboration in the context of youth health is not without political influence. This finding is aligned with Mintzberg's (1996) views that the separation of politics and administration in government is a myth and as these research findings show, this includes collaboration. The findings show that competitive grant applications are reasons why participants collaborate and for participants the rewards or failures of successful involvement may be ongoing in terms of their salience and sustainability within the sector.

The finding that the NSW youth health policy is an advisory directive only but competitive funding policies can mandate collaboration appears paradoxical to the researcher. It appears paradoxical as it demonstrates an incongruent approach from government and a questionable

level of commitment from government to collaboration as currently described within the literature. The lack of clarity by government concerning its commitment to a coordinated approach to collaboration is also evident within the NSW youth health policy as there is little distinction of collaboration from other forms of cooperative arrangements, such as partnerships. This contrasts with earlier government-sponsored research documents (Booth et al., 2002; Kang et al., 2005; NSW Centre for the Advancement of Adolescent Health, 2005) that were fundamental to the development of the NSW youth health policy and that are more clear concerning the principles and characteristics of collaboration as a means to change and improve service delivery within the sector. However, the findings show that there is a link within government policy between collaboration, competition and funding. Recognising the link between government policies promoting collaboration, competition and the allocation of government funding, an interviewee who is a manager said:

I guess policy kind of filters down to you know, decisions, or translates into even where the funding is going (EM6).

Consequently, the findings show *collaboration, competition and funding allocation have a degree of connectedness for government and this connectedness impacts on the perceptions and values of those working within the sector*. In other words, the findings suggest that it is government funding policies that concurrently promote collaboration and competition rather than NSW youth health policy that promotes collaboration, that have a greater impact on why interviewees engage in collaboration. This finding is important and shows that collaboration and competition have a degree of connectedness for interviewees that appears supported and driven by governments' competitive funding policies. This degree of connectedness or synthesis of collaboration and competition is confirmed later in Section 6.3.3 of this chapter, when findings reveal that collaboration results in increased competition.

In summary, answering the question 'Who collaborates in the youth health sector and why?' showed interviewees from across the sample group commonly believe they are involved in collaboration or collaborative activities. However, the findings also showed that for many interviewees collaboration represented a multitude of cooperative arrangements, indicating a broad understanding of collaboration and a focus on attaining the benefits of coming together rather than the specific processes involved.

This section also showed that for interviewees, collaboration is normative behaviour and for those working within the sector, there is a shared and accepted need to come together and

collaborate to assist in delivering youth health services. Consequently, not only is collaboration supported by existing top-down structures through policy, the health needs of clients or youth is also driving collaboration from the bottom up. In addition to these vertical drivers, normative pressure from service providers is also driving collaboration at a horizontal level. Structural and directional drivers of collaboration are described in depth in Section 6.4 of this chapter, pertaining to stakeholder salience within the sector.

This section showed that interviewees presented a number of reasons why they collaborate, with the overarching explicit reason being to better assist youth in need. Interviewees acknowledged that they needed to access the resources of others on behalf of youth and in doing so, acknowledged their own resource limitations. Resource limitations also related to funding and were another reason why interviewees collaborate. In other words, in addition to altruistic motivations, research participants collaborated with economic considerations. Economic considerations were related to attaining funding for their organisations and the sector in general. To achieve altruistic and economic goals, this section showed that interviewees engage in collaboration to develop advantageous personal working relationships. This section also made it clear that interviewees collaborate due to government policy involving competitive tendering practices rather than NSW youth health policy promoting collaboration. As a result, the findings show that for those working within the sector there is a perception that collaboration, competition and funding allocation have a degree of connectedness and that this perception is supported from the top down by government funding policies. The perception of interviewees that collaboration and competition have a degree of connectedness is a reflection that interviewees perceive that collaboration reflects a myriad of cooperative working relationships that is aimed at delivering youth health services.

The following section answers question 2 which asks, ‘What are the impacts of collaboration within the youth health sector?’ It examines the positive and negative impacts of collaboration and confirms the connectedness or synthesis of collaboration and competition by revealing that collaboration policy somewhat perversely results in increased competition within the youth health sector.

### **6.3 Question 2: What are the impacts of collaboration?**

The preceding section has shown that collaboration is a normative activity that allows participants to overcome resource constraints within the youth health sector to better assist

youth in need. The preceding section also showed that interviewees' willingness to collaborate relates to gaining individual and collective benefits and salience within the sector by better delivering health services, having more resources at their disposal and developing advantageous personal working relationships. The previous section also introduced the notion that collaboration and competition have a degree of connectedness and this connectedness also relates to the allocation of funding. This section shows that collaboration profoundly impacts on the youth health sector, as proclaimed by an interviewee who is a manager: 'Collaboration is definitely ... I reckon it is huge in our sector' (BM3). However, this section goes further to explain that the motivations and actions of participants involved in collaboration leads to both positive and negative impacts of collaboration on the youth health sector. Positive impacts of collaboration according to research participants include *raising awareness, developing personal working relationships, developing a sense of inclusion and achieving common goals*.

Negative impacts of collaboration according to interviewees include *exacerbating the divisions within the sector, imposing extra time and duties and the prioritising of individual organisational agendas over collective goals*. Interviewees also displayed a *level of cynicism* towards collaboration due to perceptions of collaboration being similar to cooperative activities already undertaken and concerns about underlying opportunistic motivations of other stakeholders within the collaborative process. This section also shows, develops and confirms findings that there is a degree of connectedness between collaboration and competition by showing that collaboration both promotes competition between services providers and has competitive characteristics.

### **6.3.1 Positive impacts of collaboration**

Interviewees commonly perceive that collaboration has positive impacts for the youth health sector. Optimism about collaboration is evident in the comment by a youth health practitioner who exclaimed, 'I think it [collaboration] is a positive! It has a really positive impact!' (AY1). Quotes by interviewees showed that the opportunity to come together when collaborating resulted in numerous advantages for delivering youth health services and therefore has some overlap with question 1 above (Section 6.2), which examines the reasons why those in the youth health sector collaborate. This section highlights the positive impacts of collaboration on the youth health sector.

### 6.3.1.1 Raising awareness

Interviewees commonly highlighted that collaboration resulted in *increased awareness*, particularly of the services provided by others within the sector. For example, when discussing the benefits of collaboration a youth health practitioner said:

I think it [collaboration] is richer for the audience because whatever project we are doing we talk about our services and then they are becoming more aware of different services and the different skills that other organisations can bring (AY1).

The above quote exemplifies that collaboration and the ability to come together have a number of positive impacts including *sharing information*. Interviewees also agreed that by sharing information, collaboration raised *awareness of other service providers and their youth health services offered*. For example, when considering the impact of collaboration, an interviewee who is a health practitioner exclaimed: 'It [collaboration] opens up my mind to many things I don't normally consider' (FY2). In other words, collaboration allowed participants to become knowledgeable and learn about the capabilities of others. This concurs with much of the literature that contends that collaboration leads to higher levels of innovativeness and increased learning (Head, 2008; Huxham, 1993; Huxham & Vangen, 2005; Mandell & Steelman, 2003; Mayo, 1997). Alternatively, collaboration also allowed service providers *to promote their own youth health service capabilities* to other youth service providers so that other youth health service providers could utilise their capabilities and share resources. For example, an interviewee who is a youth health practitioner said:

In fact, it was only a few months ago, there was a big meeting at XXXX [name] Council. They had invited all the services around here and we all got together to have this day of everyone promoting their service. That went quite well (CY2).

By becoming more aware of other youth health service providers, interviewees could identify and make decisions or judgments concerning *who they should collaborate more closely with in the future*. For example, an interviewee said that collaboration allows her to find 'who to contact, who specifically to contact' (GY8). This exemplified the ability of collaboration to build bridging social capital by allowing participants to make decisions to reach out and develop new ties or linkages (Adler & Kwon, 2002) with other youth health service providers. Alternatively, *evaluation of others* when collaborating also allowed research participants to identify those who they would rather not collaborate with in the future. In other words, collaboration allowed research participants *to consider which stakeholders were*

*more salient* within the network of youth health service providers in terms of who would better help them deliver youth health services and alternatively, who they could better assist in delivering youth health services. For example, an interviewee who is a youth health worker said:

I guess working collaboratively will determine, okay, what other services have similar goals to what I want to achieve and so okay, we can work with this and let's create that partnership, but I have been to meetings where it wasn't really relevant to what I was doing (BY1).

The evaluative or assessment component or principle of collaboration is discussed by Ring and Van de Ven (1994) within the literature. However, Ring and Van de Ven (1994) are not explicit concerning strategies of how and why stakeholders develop closer ties with some stakeholders than others, particularly in terms of assessing and obtaining salience. In addition, there is little reference to assessment of salience in a situation of enforced collaboration. Regardless, findings of this research show that collaboration impacts on the youth health sector by offering a forum where participants are able to evaluate the salience of others and how and why they make decisions in relation to collaboration based on this assessment. How this actually occurs or is enacted or operationalised in the youth health sector is addressed in Section 6.4 later in this chapter.

#### 6.3.1.2 *Development of personal working relationships*

Another positive impact of collaboration is the ability to *meet face to face* with others and create more personable and closer working relationships and thus develop social capital (Lin, 1999). As the following quote exemplifies, interviewees sometimes believed that face-to-face contact allows them the opportunity to evaluate the commitment of other stakeholders to the collaboration process and youth health outcomes. For example, when describing positive collaboration, a youth worker said:

You are putting a face to that information, a contact. It is really about that. When I phone somebody, firstly I know who they are and I have met them and I know they are on board in terms of wanting to facilitate change for young people (GY2).

Collectively for research participants, personal contact and the *development of closer and more familiar relationships* through collaboration also allow for more effective youth health service delivery. This means that collaboration allows research participants to build bonding social capital by strengthening existing linkages between network stakeholders (Adler &

Kwon, 2002) as well as developing new relationships and thus also build bridging capital (Adler & Kwon, 2002). The positive impact of closer relationships resulting from collaboration on the delivery of youth health services is evident in the following comment by a youth health practitioner:

I have been to, like a young person's interagency group, which has been quite helpful because you actually get to meet some of the service providers, some of the people from different organisations and ... you have met them before, you know them by name, you are not just ringing up a service cold ... and sometimes we have quite strong relationships that just our organisations have with another organisations, like with XXXX [name] Youth Care for example. When we refer young people there for accommodation and stuff like that, it is often taken up pretty quickly because of the nature of our relationship (GY4).

As the above quote exemplifies, for some interviewees closer working relationships allowed them to *expedite working processes* and more quickly achieve youth health service delivery objectives. This finding aligns with the literature: the social relationships built through collaboration allow for effective information transfer (Gray, 1991; Head, 2008; Lasker et al., 2001). However, the finding that personal relationships expedite working processes contrasts with other literature suggesting that collaboration can increase decision-making processes and slow down work processes (Dickinson & Glasby, 2010; Hoatson & Egan, 2001). This finding is important as it shows that informal social collaborative relationships can advance or further working relationships. In addition, this finding is important as it shows that attempts to formalise and prescribe instructions on how to collaborate, such as the checklist in NSW youth health policy, may not be the optimum means to promote collaboration. For example, interviewees' resistance to formal instruction within policy on how to collaborate is evident in the following comment:

I would hope that it [checklists] doesn't restrict people's, you know, critical thinking and approaches to collaboration because I think everyone has a different way of working, like individually, and have a different skill set and background and knowledge. So everyone is such a valuable resource and someone might come up with different ways of doing things. I would hate for policy to stifle that (FM4).

In addition, some interviewees involved in established collaborative networks felt that checklists serve to formalise established trusting relationships that can add to bureaucratic

process and thus hinder effective delivery of youth health services. For example, when discussing checklists an experienced and established youth health worker said:

I guess the idea of it [checklists] is to provide structures and important procedures which make things happen quicker but personally, I just pick up the phone and talk to somebody and it happens a lot quicker (GY2).

Therefore, findings show that flexibility and structure are both considerations for those collaborating within the youth health sector. This means that some interviewees are concerned that policy may stifle their flexibility in choosing who to collaborate with and how and may indicate that prescriptive checklists in policy may be met with some resistance.

By collaborating with others, interviewees were able to *build long-term, satisfying and successful working relationships* with others. For example, when describing successful long-term collaborative arrangements an interviewee who is a manager said:

Okay I can give an example, one which is working really well ... say with XXXX [name] Centre. It is just a very longstanding relationship and in fact, I have even heard them say you are like our brother or our sister (DM4).

The finding that collaboration can allow stakeholders to *create a positive history* between participants that can be utilised in future collaborative efforts concurs with the literature on collaboration (Campbell, 2006; Sebuliba & Vostanis, 2001). However, unlike much of the collaboration literature which emphasises the requirement for trust (Thomson & Perry, 2006; Thomson et al., 2009; Vangen & Huxham, 2003), there was minimal reference by interviewees to trust per se. This finding suggests that research participants may not perceive that trust and collaboration are connected or alternatively they may perceive that trust is inherent in long-term positive collaborative relationships where participants can be trusted to deliver on promises and engage in reciprocal relationships.

Another positive impact of collaboration involved the *creation of mutually supportive relationships*. For example, an interviewee who is an administrative worker said:

You are supporting one another ... because you know, I think there is a reasonable perception that the health industry isn't really necessarily supported, but from the workers in different organisations I think they are very good at supporting one another in that respect. So the collaboration starts those conversations and builds those relationships (AA3).

The finding that collaboration results in the development of mutually supportive relationships and bonding capital is consistent with the literature promoting benefits of collaboration in terms of building supportive relationships (Kang et al., 2005; Sebuliba & Vostanis, 2001).

#### 6.3.1.3 *Sense of inclusion*

For some interviewees, another positive impact of collaboration was that it allowed them to have *input or say* whilst collaborating. In other words, collaboration allowed them *opportunity to communicate or have voice* in relation to collective actions and outcomes. For example, when discussing positive impacts and examples of collaboration an interviewee who is a youth health practitioner said:

I guess in terms of the program itself when we come together, I do feel like my voice is respected and heard and my opinion as a professional is heard (GY8).

This comment shows that a positive impact of collaboration is the *feeling of involvement* resulting from participation. In other words, interviewees feel respected and valued by others involved in the collaboration process. This means that interviewees feel that being involved in collaboration can allow them a level of salience or importance. Comments relating to feelings of involvement related to administration staff, youth practitioners and managers alike, indicating that all three employee groups wish to be valued and respected when collaborating regardless of their professional status. Feelings of involvement exemplify positive relations between participants and result in the development of social capital between participants (Bolino, Turnley & Bloodgood, 2002; Moran, 2005).

#### 6.3.1.4 *Common goal*

Another positive impact of collaboration for interviewees is that collaboration *reinforces to them that the common goal* of their collaborative efforts is to improve the wellbeing of youth. In other words, collaboration creates a degree of collegiality, solidarity, commonness and shared like-mindedness for those collaborating in their quest and struggle to overcome resource limitations and deliver youth health services and to advocate for the health needs of youth. For example, an interviewee who is a manager said:

I think you know in this area [youth health sector] you have got lots of opportunity to have collegial kind of relationships ... because a lot of people work in this industry because they love it, not for the money or anything and um a lot of the times you receive very minimal funding. I think people actually seek out collaboration because it is a way of making a project

better and yet overcoming the barriers like the low money and perhaps low resources that you might have. So sharing resources, sharing ideas and sharing manpower kind of stuff (AY1).

Furthermore, when discussing her experiences collaborating, an interviewee who is a youth health practitioner said the collaboration process would result in her asking:

What are we doing here? Who are we helping? It is not about us but the clients (EY3).

Therefore, it appears that collaboration is positively impacting on interviewees by reinforcing or re-emphasising to them that they collectively work in youth health to deliver the overarching goal of youth health service delivery. This finding confirms research by Dietrich et al. (2010) who argue that recognition of why an issue is important is necessary for successful collaboration.

This section has recognised that research participants identified a number of positive impacts of collaboration. The following section will show that interviewees also identified a number of negative impacts of collaboration.

### **6.3.2 Negative impacts of collaboration**

Although the above section showed that interviewees highlighted a number of positive impacts of collaboration, examination of interviewee transcripts also showed that collaboration has a number of negative impacts for them.

#### *6.3.2.1 Exacerbate divisions within the sector*

A negative impact of collaboration is that it *highlights and exacerbates divisions between government and non-government organisations (NGOs)* within the youth health sector and these differences can sometimes inhibit collaboration. For example, a youth worker from an NGO when discussing her experiences whilst collaborating said:

Every organisation whether it be NGO or public has their own policy and procedures which they need to abide by and we have certain processes which we have to abide by... but sometimes I think public people seem to think that, how can I put it? Government may be a little bit better than an NGO. You know I am better than you because I am in the public sector sort of thing. They do have I guess, have a lot more [funding and resources] because it is government (BY2).

Another interviewee who is a manager from a government organisation argued that:

Oh, there is definitely a different kind of ethos or, you know, ways of going about things with NGOs and government [service providers] that I think sometimes make it harder for them to work together (DM4).

Therefore, interviewee comments show that the sense of common cause or shared concern for the health needs of youth is somewhat undermined by tensions between NGOs and government service providers and that this tension can potentially inhibit collaboration. This finding contrasts with views by Lee et al. (2012), who contend that collaboration results in differences between participants in collaboration being lessened due to increased mutual understanding. However, the findings concur with other scholars who claim that ‘personal perceptions of institutional differences often made collaborative working difficult’ (Stevenson, 2007, p. 32). Although the findings indicate that interviewees sometimes consider the differences between government and non-government services negatively, they often still successfully collaborate. Therefore, the findings add to knowledge by indicating that although personal perceptions of institutional differences are sometimes considered negatively they do not overcome the reasons why interviewees collaborate, such as altruistic motivations and collaborating to gain funding and resources. Reasons why interviewees collaborate were reviewed in Section 6.2 of this chapter.

Collaboration also highlights and *exacerbates the division between management and clinical staff*. This division is evident when interviewees distinguish between collaboration for clinical purposes versus strategic purposes and that collaboration for strategic purposes was mostly exclusive to those working at a management level. For example, when discussing her involvement in collaboration an interviewee with a hybrid manager and clinician role said:

There is that second part of the collaborative approach, you know the client stuff, which is I guess is a step down, because it is not project stuff, it is not the big stuff (GM5).

The finding that interviewees sometimes perceive strategic collaboration as more significant than clinical collaboration is important. Although interviewees argue that service delivery is the primary reason they collaborate, the findings suggest that some interviewees perceive that collaborating for funding and resources, which is often inherent in strategic collaboration, is more significant. As such, this finding gives strength to the argument that organisational funding priorities and sustainability are significant drivers of collaboration within the sector as they allow organisations to deliver youth health services. The researcher observed that although altruistic motivations were always explicit and upfront, as the interviews would

progress interviewees, particularly managers, would express that funding requirements drive collaboration for them. Therefore, findings imply that not only is collaboration exacerbating the differences between government services and NGOs it is also *emphasising the differences between altruistic and economic motivations to collaborate*. As such, this research adds to knowledge by making explicit that collaboration can be driven by altruistic and economic considerations simultaneously even if the values associated with both are significantly different.

By exclusively including only managers in strategic collaboration, *collaboration also maintains existing hierarchies within the sector*. Although this may be perceived as a positive by those in management as it allows them to strengthen bonding capital between management participants, it somewhat contrasts with concepts of inclusiveness evident within the literature on collaboration (Gajda, 2004). This means that existing hierarchies of influence are maintained or even strengthened through using collaboration, which contrasts with the development of horizontal linkages promoted as a benefit of collaboration (Hill & Lynn, 2003; McGuire, 2006). In other words, although collaboration is being promoted as a more contemporary or different strategy to assist in the delivery of youth health services, by including only particular existing decision makers, collaborating for change within the sector may be hindered. As a consequence of maintaining existing power structures, collaboration may be no different to existing hierarchical interrelational processes currently in use.

Additionally, by making strategic collaboration exclusive to managers, those unable to attend particular collaborative meetings or forums may not have the opportunity to contribute ideas that may positively impact on them and the youth health sector. Making strategic collaboration exclusive contrasts with positive impacts of collaboration highlighted by interviewees such as perceptions of involvement and the development of solidarity associated with sharing a common cause, which were highlighted as positive impacts of collaboration in the section above. Thus the findings show that by excluding some participants from collaboration, the development of social capital and goodwill built through developing horizontal linkages is potentially thwarted.

#### 6.3.2.2 *Imposes extra time and duties*

Interviewees, particularly within NGOs, commonly expressed concerns that *collaboration imposes extra time and duties* in addition to work activities already being undertaken. For

example, when discussing collaboration an interviewee expressed her frustration with the comments:

Time is a huge thing especially where you have service specifications of your funding program. There are certain things you need to cover. There are meetings to attend to, client numbers you need to see, seeing the clients one on one, doing group work programs, having other meetings, whether it be here or outside that you have got to go, I mean you only get like 7.6 hours in a day (BY2).

Furthermore, interviewees were also concerned about *time and resources invested in collaboration not resulting in positive outcomes*. In other words, there were concerns from interviewees, particularly those in management roles, that resources invested in collaboration may not result in better youth outcomes. For example, the following quote by a manager shows concern when staff is involved in collaborative-like activities that may not result in better youth health outcomes:

I think you have to be really clear that networking and collaboration are not the same. I had this conversation with staff and they said we are collaborating with these people and I said no you are not, you are meeting, talking and going away and doing your separate stuff. Collaboration is about joint delivery (GM1).

Another manager was frustrated and lamented time wasted when collaborating as evident in her reference to collaboration as a ‘talkfest’ (CM1). Therefore, the research findings show that some managers are concerned that the time required building social capital through collaborative and networking events increases pressure on their organisations to achieve reportable outcomes. Hence, findings show that the risks associated with non-achievement of outcomes is a concern for managers in an environment where organisations are held accountable for deliverables and youth health outcomes. The literature relating both collaboration and social capital often acknowledges the time, commitment and resources required to build productive relationships (Adler & Kwon, 2002; Gray & Wood, 1991; Hoatson & Egan, 2001)

Furthermore, interviewees contend that they often just *don't have the resources to be involved in some collaborations*. For example, an interviewee in a management role said:

Due to having a higher workload I no longer go to a lot of the inter-agency meetings due to time restrictions. I have a very multifaceted role, so it is very different to get out all the time to collaborate and network with people (CM1).

Consequently, interviewees often have to *choose which collaborative event to be involved in* to better achieve performance requirements, which in an environment of NPM are individually and organisationally based (Simonet, 2008). Hence, for those working within the youth health sector, there is a need to consider competing priorities associated with different collaborations and they often balance their level of involvement based on achieving individual goals. This finding confirms that the principles of NPM impact on the values and priorities of those within the sector. As such, findings show that collaboration impacts on the sector by adding further complexity to time pressures to achieve performance targets.

Findings also show that some interviewees believe there is *too much collaboration* and that it is hindering their ability to focus on their core function of youth health service delivery. For example, an interviewee who is a manager showed concern regarding the current environment where collaboration is actively promoted by government when she said:

It is partnerships gone crazy. There are so many people involved that it is almost unwieldy (DM4).

Consequently, the findings show that *there is a level of collaboration that is synergistic but if this level is surpassed collaboration becomes less effective*. This research adds to knowledge by showing that collaboration is mediated by individual organisational objectives as these are considered before engagement in collaboration occurs. Additionally, findings show that collaborations are competing to be relevant to individual organisational aims in order to ensure participation. This section has shown that stakeholders consider who best assists them to achieve organisational objectives in relation to collaboration. Thus this section highlights that service providers consider which stakeholders and which collaborative networks are more influential or salient before engaging in collaboration. Stakeholder salience is discussed further in Section 6.4 of this chapter.

### 6.3.2.3 *Prioritising individual agendas*

Although the characteristics of the sector require individual organisations to consider their own performance requirements, interviewees commonly perceived that some service providers *push their own agenda when collaborating* to the detriment of collective goals and

youth health outcomes in general. For example, frustration and resentment was evident when an interviewee who is a manager, when referring to an example of collaboration, angrily exclaimed: ‘They have completely one focus, theirs!’ (AM5). Another manager reflected on her negative impressions of stakeholders pushing their own agenda in her comment:

... this particular working party may not actually achieve or try to achieve the goal that everyone else is trying to achieve and they sort of go off on their own agenda and that seems to happen. People are bringing an [individual] agenda to the table rather than working on the [collaborative or collective] agenda (CM1).

This finding is interesting as interviewees were often explicit in declaring that collaboration is an opportunity to achieve individual organisational aims. For example, the same manager also declared she considers how collaborative meetings can benefit her organisation as well as her organisation’s clients before making decisions to attend, when she said:

So I think what is the purpose of the meeting? Am I going to gain anything from being at that meeting or what is in it for me, for the organisation or for the client I am dealing with? (CM1)

Another manager acknowledged the prospect of achieving individual goals through collaboration when she declared:

So I think that [collaboration] is a huge benefit and opportunity for me. I think it [collaboration] is extremely opportunistic (AM5).

Therefore, findings indicate that there is an acceptable and even normative level of opportunistic behaviour when collaborating. However, findings also indicate that when this level is surpassed, distrust or frustration from other participants towards stakeholders acting in an overly opportunistic manner results. This finding is significant for two reasons. First it shows that there is normative pressure to conform to collective goals when collaborating even when collaboration is also considered an opportunity to achieve individual organisational agendas. Hence the findings indicate that shared understanding and values associated with achieving individual and collective goals are sometimes in conflict and that the point of conflict is subjective. Second, there is sometimes complexity for stakeholders within the sector when coming to agreement concerning the reconciliation of individual organisational and collective goals when collaborating. For example, an interviewee who is a manager lamented the difficulty of sometimes getting agreement between collaborating stakeholders when she said:

Even if they have a sense, they have a common goal they feel there is too much compromise (DM4).

Consequently, some interviewees were concerned with the level of sacrifice required to achieve collective goals. However, interviewees often perceived that they are involved in successful collaboration and therefore, findings show that collaboration is entered into with a level of goal congruence associated with altruistic and economic collaborative goals but with services maintaining their individual organisational identity and objectives. Hence, the findings indicate that some interviewees consider how the collaboration can benefit their organisation and its goals rather than how their organisation can benefit the collaboration or achieving its collective goals. As such, the researcher was often left thinking that the common altruistic goal is sometimes lost or at least blurred as organisations consider individual organisational objectives, particularly funding priorities. Furthermore, the researcher was left with an impression that altruism and economic considerations are sometimes in conflict even though both are successfully driving collaboration within the sector.

#### 6.3.2.4 *Cynicism*

Another negative impact of collaboration for interviewees is that there is a level of cynicism from interviewees regarding its place within the youth health sector. Cynicism appears due to interviewees perceiving that collaboration is already integral to their job role. For example, a manager states that collaboration is the current ‘buzz word’ (GM5) for existing aspects of their job. In addition, when asked to define collaboration a youth health worker scoffed and said:

I think collaboration is a vague term. So when you talk about collaboration, you are basically talking about the work you are doing anyway (BY1).

Examination of transcripts shows that for interviewees, managers, youth practitioners and administration staff alike, collaboration represents almost any form of coordinated partnership as evidenced by interviewees commonly referring to collaboration as ‘working together’ (EY4), ‘consulting’ (FY3), ‘partnership’ (DM4) and ‘networking’(BY1). This shows that collaboration is commonly perceived by interviewees as little different to the many interrelational or cooperative activities they are already undertaking and as such, the characteristics of other interrelational activities also characterise collaboration. For example, when describing collaboration an interviewee who is a manager said:

So it [collaboration] is about being able to work together to deliver the best outcomes for the patients (GM1).

Whilst another stated collaboration is:

Different organisations of people working together to reach a similar goal; a particular goal (AM5).

Therefore, findings show that interviewees perceive collaboration as a broad interrelational activity that is outcome driven. As a result, some interviewees were sceptical or cynical towards the current emphasis on the term 'collaboration' in policy as they feel they are already involved in these activities, albeit by another name. For example, an interviewee with a youth practitioner role declared, 'I just think that it [collaboration] is common sense' (GY7). Cynicism towards collaboration is reflected in current commentary on collaboration with O'Flynn (2009, p. 112) suggesting that the broad use of the term has created a new 'fad word in government circles' (O'Flynn 2009, p. 112). This contrasts somewhat with the bulk of the literature relating to collaboration, which promotes it as a contemporary and different form of organising human resources in order to address wicked or complex problems.

Regardless of interviewees displaying a level of cynicism directed at the term *collaboration* and its use or meaning, they are more concerned how it achieves outcomes of delivering youth health services. In other words, findings indicate that interviewees are content to use broad terms such as *working together* or *coming together* that may imply varying types of activities with a tendency to focus on the positive outcomes of collaboration rather than the specific processes on how they are achieved.

This section has illustrated that in addition to positive impacts of collaboration on the youth health sector there are sometimes negative impacts. This section has also shown that collaboration is often not differentiated from other forms of working relationships aimed at delivering youth health services. Therefore, it implies that other forms of organisation impact or characterise collaboration. The following section shows that the large amount of quotes from interviewees referring to competition mean that interviewees believe that collaboration impacts on the youth health sector by promoting an environment of increased competition. Although this may not be considered a negative impact by some, particularly those who support competitive practices, collaboration scholars rarely examine this impact. More commonly scholars perceive collaboration and competition as different and opposing

concepts (Browning et al., 1995; Lamont, 1991; Prins, 2010). Therefore, the following section refers to competition as neither positive nor negative but considers it an impact worthy of further examination, particularly as an aim of this research was to better understand collaboration when occurring in an environment where both collaboration and competitive funding practices are promoted concurrently in government policies and practices.

### **6.3.3 Increased competition**

A surprising or unexpected impact of collaboration was that collaboration is often associated with competition, a concept distinctly different from collaboration. This association was evident with a large proportion of interviewees, both at a clinical and strategic level, referring to competitiveness when collaborating. For example, an interviewee who is a manager said that whilst collaborating, ‘I think sometimes there is competitiveness amongst groups’ (DM2). The same manager also argued that other managers share his concerns that collaboration and competition are associated as evident in his comment:

XXXX [Manager’s name], for example, speaks very openly about her concern that there is competitiveness and she sees organisations like the XXXX [name] youth coalition richly funded from the federal government, and other NGOs struggling (DM2).

As the above quotes exemplify, comments from interviewees often highlighted competition between stakeholders when collaborating. Examination of the quotes revealed that competition was frequently associated with competitive tendering processes which often involve collaboration. For example, an interviewee who is a manager when discussing competitive tendering said, ‘People are putting their hat in the same ring’ (FM4). In addition, an interviewee identified that competition for funding can cause divisions within the sector as different collaborative tenders compete for funding.

But luckily for us, the bid that got the money actually was the one we chose. So this huge \$27 million grant. We are part of that group that got that money. It was literally dividing the sector in a very big way because it is a huge pot of money (DM4).

The finding that competition for funding can cause divisions within the sector and can potentially inhibit collaboration by negatively impacting on trust supports research by Milbourne (2009), who concludes that ‘the continuing emphasis on competitive contracts and centrally driven frameworks undermines collaborative work and community trust’ (p. 277) by serving short-term state interests and devaluing the very community level work aimed at

addressing complex social problems (Milbourne, 2009). This research adds to knowledge by showing that competitive tendering both promotes collaboration and can potentially limit collaboration yet service providers continue to engage in collaboration to achieve both altruistic and economic goals within the context of youth health as a matter of necessity.

Interviewee quotes also showed that stakeholders were competing to be recognised or perceived as being more reputable than other providers of youth health services due to the benefits this provided, such as increased salience. For example, an interviewee in a youth health practitioner role referred to the importance of reputation when making decisions on who to collaborate with when she declared:

[I]f there is a fantastic reputation and say they helped me, they helped a young person, they are fantastic, this is the service that they will provide, then yes that will get me to link up with them, but if someone has negative opinions about a certain organisation I will not base my choice on those as it might be just their personal experience with one organisation. I would rather build my own perspective around it before jumping the gun and not allowing the young person to connect with that organisation (EY3).

The above quote also shows that interviewees perceive that having more salience results in other stakeholders making attempts to collaborate with them. Hence, being perceived as a reputable service provider allows for future collaborative opportunities and thus further opportunities to deliver youth health services, develop a credible reputation and potentially gain future funding to ensure organisational sustainability. As such, the findings are in agreement with Hamel, Doz and Prahalad (1989), who acknowledge that collaboration and alliances which may have competitive aspects should be viewed as opportunities. However, rather than competition being perceived as opportunities to learn as proposed by Hamel et al. (1989), this research shows that competition is associated with opportunities to develop advantageous social capital with salient and important stakeholders within the sector. As such, winners are those who develop social capital and salience and losers are those who don't. How this competition is characterised and what makes stakeholders more salient is discussed in Section 6.4 of this chapter relating to how collaboration is operationalised within the youth health sector. The findings of this research add to knowledge by showing that collaboration is a means or an activity that does not necessarily oppose or supplant competition for interviewees, as is often proposed in the literature (Prins, 2010; Wolfram Cox et al., 1997). Rather, collaboration in the context of youth health is a process that involves competitive practices.

In summary, by answering the question, ‘What are the impacts of collaboration within the youth health sector?’ interviewees contend that collaboration positively impacts on the youth sector because it brings together like-minded people who share a common goal to deliver youth health services. This concurs with much of the literature which promotes the benefits or outcomes of collaboration as *collaborative advantage* (Huxham, 1996). Interviewee responses also agree with Gajda’s (2004) claims that collaboration is an imperative in the delivery of government services in the current climate. The findings showed that by bringing youth health service providers together, participants share information and learn about other service providers. The findings also made clear that collaboration enables interviewees to build deeper, familiar and meaningful working relationships. Furthermore, it was shown that by participating in collaboration interviewees are able to identify and evaluate other youth health service providers in terms of salience in order to potentially develop future or closer collaborative ties.

However, the findings showed that collaboration also results in negative impacts for interviewees and the youth health sector. For instance, collaboration highlights and exacerbates differences between stakeholders in a negative manner. In the case of the youth health sector, the difference lies primarily in the distinction between government and NGOs involved in the delivery of youth health services. Collaboration also enables the maintenance of existing hierarchies that may hinder collaboration and change within the sector. Other negative impacts of collaboration include pressures on time and resources and potential wasted time when positive outcomes are not achieved. Further negative impacts of collaboration included negative emotions such as frustration and distrust, particularly in regards to collaborating to attain individual rather than collective goals. Furthermore, a level of cynicism towards collaboration was identified as some participants perceived collaboration as either problematic or little different to existing ways of working. All the negative impacts of collaboration and the factors that contribute to them result in what Huxham and Vangen (2005) term *collaborative inertia*, which is ‘when collaborations make slow progress and others die without achieving anything’ (Huxham & Vangen, 2005, p. 3).

An unexpected finding was the repeated and commonly unsolicited comments from interviewees associating collaboration with competition. This finding was pronounced for the researcher as the amount of comments and strength of awareness or consideration by interviewees regarding the competitive motivations of other youth health service providers when collaborating was unexpected. It was particularly unexpected when considering that

interviewees shared a passion for delivering health services to those in need. Consequently, findings show that research participants perceived that an impact of collaboration is competition, and that collaboration included competitive elements or characteristics. This contrasts somewhat with many scholars who portray collaboration and competition as opposites or at least having contrasting values (Catalano, Hawkins, Berglund, Pollard & Arthur, 2002; Hoatson & Egan, 2001; Stevenson, 2007). Even for scholars who acknowledge a more symbiotic relationship between collaboration and competition (Lee et al., 2012; Mascia, Di Vincenzo & Cicchetti, 2012; Tong & Reuer, 2010) there is a lack of clarity on how and why they are related and what participants are competing for and why. This research adds to knowledge by showing that services are competing for salience within the sector as having salience gives more opportunity to develop social capital and advantageous collaborative linkages in order to perpetuate opportunities for continued funding. This lack of clarity concerning the relationship between competition and collaboration is explored in depth in the following research question, ‘How is collaboration operationalised or enacted within the youth health sector?’

#### **6.4 Question 3: How is collaboration operationalised or enacted within the youth health sector?**

This section addresses the third research question, ‘How is collaboration operationalised or enacted within the youth health sector?’

Thus far this chapter has answered the first two research questions, ‘Who collaborates in the youth health sector and why?’ and ‘What are the impacts of collaboration within the youth health sector?’ By answering the second research question, this chapter also introduced the notion that *collaboration involves competition*. This section goes further to examine *how* collaboration is operationalised or enacted in a government-coordinated network, and more specifically, in the youth health sector.

This section identifies and discusses the six characteristics of salience that were highlighted using the framework of analysis which included examining how collaboration is enacted at vertical and horizontal levels within youth health. Vertical level refers to top-down and bottom-up collaboration. Top-down collaboration is collaboration driven by government and management hierarchies whilst bottom-up relates to collaboration being driven by the users of health services. On the other hand, horizontal collaboration refers to collaboration between organisations that are relatively equal in terms of hierarchical structures. As the following

analysis will show, having the characteristics of salience gives organisations more influence and power than others in relation to collaboration and also the ability to gain funding. Examining vertically and horizontally driven collaboration was essential to identify who was more or less important in determining how service providers engage in collaboration and why. It also allowed the researcher to identify what qualities or characteristics make stakeholders more salient or able to drive the engagement of others to collaborate by utilising the principles of collaboration, stakeholder and social capital theories.

Investigating how collaboration is enacted, the findings indicated six organisational characteristics make stakeholders more eminent or salient when collaborating. These are referred to in this thesis as characteristics of salience or stakeholder salience characteristics and are: links to government, access to funding, authority to delegate funding, networking skills, credibility within the sector and delivery of services. Although the analysis will show that the characteristics of stakeholder salience are interrelated and impact on each other, their identification adds to knowledge by understanding how stakeholders are more salient when involved in collaboration that has competitive characteristics. Briefly, the six characteristics of salience are described thus:

1. *Links to government* refer to organisations or individuals who have either formal or informal links to government. Links to government more commonly refers to government service providers but also those who have developed strong social capital between themselves and government.
2. *Access to funding* means organisations that already have access to funding and resources. This access may be based on formal or informal linkages with funding organisations.
3. *Authority to delegate funding* refers to those with the authority to decide which organisations and collaborative networks receive funding. This funding can be through direct grants or through competitive tendering.
4. *Networking skills* refer to those who have the collaboration, communication and political skills to effectively develop and sustain collaborative relationships.
5. *Credibility within the sector* means those individuals and organisations that have a reputation for effectively delivering youth health services and collaborating. They are also those who have positive reputations of trust and reciprocity.
6. *Delivery of services* refers to those organisations that have the capability to effectively deliver youth health services or fulfil their role in delivering youth health services.

The six characteristics of salience are important to consider as having these characteristics gives stakeholders more salience or sway when engaging in collaboration. Findings point to a clear motivation for collaboration within the youth health sector to maximise the limited resources on offer and to obtain funding. For example, it may be more beneficial for some youth health organisations to collaborate with government organisations rather than non-government organisations in an effort to attract more funding. This section will reveal that having the characteristics of salience gives stakeholders a competitive advantage when collaborating, particularly in terms of gaining funding and resources to ensure the sustainability of their organisations. Furthermore, this section will show that service providers will engage in competitive behaviour in order to gain these attributes or create advantageous collaborative relationships with those stakeholders that have salience and funding.

After discussing the six characteristics that make stakeholders salient when collaborating, this investigation then groups the six characteristics into two distinct groups: organic and mechanistic. Organic characteristics are those characteristics of salience that service providers are more able to change, which are networking skills, credibility within the sector and delivery of services. In comparison to organic characteristics, mechanistic characteristics are those characteristics which service providers are less likely to influence, which are links to government, access to funding and the authority to delegate funding. By making the distinction between the two types of characteristics of salience, the researcher can show that the competitive strategies that service providers use to gain or develop their salience are more commonly related to the organic characteristics, i.e. networking skills, credibility within the sector and service delivery. Following on from that, in the next chapter, the theory will be developed to show the relationship between increasing collaboration with competitive characteristics and levels of salience. Also shown will be the implications for theory and the implications for practice. But first, the following section outlines each individual characteristic of salience and shows how they were discovered by examining collaboration driven at vertical and horizontal levels and by using the words and comments of interviewees when discussing collaboration during interviews. The characteristics of salience are not distinctly separate but are intertwined and impact on each other. However, for clarity they are separated in order to give meaning to the analysis and coherence to the findings.

#### 6.4.1 Links to government

The findings show that having links to government increases the salience of youth health service providers. This finding was apparent when examining what drives collaboration at a horizontal level and discovering that service providers, particularly NGOs, would make efforts to collaborate with government organisations. As the following comment by a government service manager reveals, collaborating or partnering with a government organisation rather than an NGO could potentially result in more funding and thus financially sustain organisations, particularly NGOs:

Yes they [governments] promote it [collaboration] in theory, but when you put it into practical terms, a small NGO depends on a certain grant to survive. So at the end of the day you can't blame them for being competitive and for not wanting to collaborate with other NGOs in the area. You know, for being competitive to want to partner up with us or another government department or whatever, because that is their survival (GM5).

The above comment also shows that some service providers, particularly NGOs, compete to collaborate with securely funded government service providers. Due to this, findings show that collaboration when enacted within the sector reinforces the salience and embeddedness of government organisations more so than NGOs as government organisations often have the opportunity to choose which NGOs they would prefer to collaborate with. As Provan, Huang and Milward (2009) suggest, there is greater legitimacy for more embedded stakeholders within a collaborative network. This apparent disproportionate salience that government providers have over NGOs exemplifies the *Matthew Effect* (Merton, 1968) as participants reinforce the salience and recognition of government providers by competing to collaborate with them. Consequently, government organisations may have more power when involved in collaborative negotiation processes and even have influence over the financial sustainability of NGOs through their decisions on which NGO to collaborate with. As a result of embedding and increasing the salience of government organisations, findings suggest that collaboration increases rather than decreases the divide between government and NGOs. Exacerbating divisions within the sector was also highlighted as a negative impact of collaboration when answering the second research question, 'What are the impacts of collaboration within the youth health sector?'

Therefore, this research shows that collaboration as enacted within the youth health sector does not promote equality but rather reinforces government structures. This finding shows

that collaboration can be used as an instrument to maintain the salience of government and hence does not conform with ideals of shared decision making within the collaboration process.

Findings that collaboration reinforces the eminence of government structures concur with research by O'Brien (2006), Milbourne (2009) and Taylor (2003), with Milbourne (2009) arguing that the rhetoric of collaboration and valuing different approaches ensures that 'community organisations remain "junior partners" while powerful agencies determine the rules' (Milbourne, 2009, p. 280). Therefore, evidence suggests that collaboration as enacted within the youth health sector is promoting inequality, which contrasts with the ideals of democracy and equality often promoted by some scholars as an outcome of collaboration (Sebuliba & Vostanis, 2001).

The finding that collaboration promotes inequality within the sector may also explain why some interviewees in Section 6.3.2.4 of this chapter expressed a level of cynicism towards collaboration and that collaboration highlighted or exacerbated inequalities between government and NGOs. Consequently, the findings suggest that government policy may not be the most effective means of promoting collaboration if collaboration rhetoric is perceived as a tool of the state to strengthen the influence of government organisations over NGOs.

In summary, having links to government makes service providers more salient than those that don't. This finding is important as it shows that collaboration when enacted within the sector is a process that maintains the role of government even when its authority is less direct by promoting the salience of government organisations within the sector.

#### **6.4.2 Access to funding**

Interviewees commonly state that they choose to engage in collaboration with other service providers who they perceive will assist them to gain access to funds and resources. As the following quote by a manager from an NGO reveals, collaboration for individual financial gain is sometimes prioritised over collaborating to assist youth in need:

The motivation for you to collaborate with them is often a result of their access to funding or other issues rather than the common good of youth (BM3).

Collaborating to maximise the use of limited resources in order to deliver services is well documented within public management literature (Hill & Lynn, 2003; McGuire, 2002).

However, when collaboration occurs within the youth health context a shift sometimes appears in the focus of service providers towards resource acquisition rather than service delivery. As a result, there appears to be a clear emphasis on individual organisational funding objectives rather than collective goals. This finding is aligned with the principles of NPM which emphasise individual organisational financial accountabilities and performance targets, particularly in a context where there is only limited funding on offer. As such, rather than collaborating to maximise the resources on offer the researcher was often left with the impression that interviewees were collaborating to maximise their share of the resources on offer. This impression is significant as findings suggest that collaboration is perceived as an opportunity to achieve organisational funding objectives where service providers compete with each other for funding rather than pooling resources to maximise opportunities for service delivery. This finding is important as it shows that the agency and mutuality dimensions of collaboration are particularly complicated to resolve in the context of youth health. Collaboration is complicated because although altruistic notions to deliver youth health services can create a common cause that bonds service providers together, within this context the common need to attain funding also bonds service providers together. However, the findings suggest that the common need to attain funding is characterised by competition that pits organisations against each other to access limited funding and that this competition erodes opportunities for building social capital between service providers. For example, the following comment by a youth health service worker exemplifies how individual organisational financial considerations are sometimes prioritised over altruistic values and how this leads to levels of resentment for some interviewees:

There was one particular client that was quite well off and not mentioning names obviously, there was a service who said oh we will take him [a client] on, and I was ‘Why, because the client has money?’ How stupid is that! Maybe because they thought they’d get more donations. I don’t know, but I know there was a hidden agenda behind it and that made me think that is wrong (BY4).

Regardless of how service providers gain the characteristic of salience *access to funding*, the findings suggest an emphasis on funding priorities. The findings also suggest that success within the sector is sometimes based on accessing resources as much as delivering youth health services.

### 6.4.3 Authority to delegate funding and resources

The authority to delegate funding principally relates to collaboration driven from the top down and relates to power based on controlling scarce and critical resources, which concurs with the views of Hardy and Phillips (1998). The authority to delegate funding impacts on how collaboration is enacted within the youth health sector in a number of ways.

First, at an inter-organisational level, some stakeholders (principally government funding bodies and some non-government funding organisations) have the authority to delegate funding in order to drive collaboration by mandating collaboration as a condition of competitive tendering processes or grants. Government authority to mandate collaboration is exemplified by the following comment by an interviewee who is a manager:

It is interesting because this list [enforced list of collaborative partners] was literally dictated by the [government] funding people. They are saying well these are the people we want you to partner with to do this project (DM4).

Mandated or enforced collaboration appears a means to promote the sustainability of smaller, less influential or less salient service providers by ensuring that they are included in collaboration, have access to funding and have the opportunity to develop characteristics of salience for themselves. Thus those with the authority to delegate funding acknowledge inequality within the sector and that some service providers are less salient than others and as such, require assistance.

Although, findings suggest that enforced or mandated collaboration promotes collaboration and can reduce inequality within the sector, for some interviewees, mandated collaboration results in a level of apprehension and frustration. This appears to be based on service providers gaining undeserved benefit, taking advantage of other stakeholders when collaborating and concerns of whether service providers have the ability to adequately contribute to the aims and objectives of the collaborative network. For example, the following comment by a manager shows that stakeholders are sometimes pushed to collaborate with services that they perceive incapable of contributing to the objectives of the collaboration:

I guess funders don't always look into whether the people can pull off the deal. But the funders did say, 'We'll give you the money but you must work with XXXX [a particular

youth health service provider]’. But they never actually asked us do we want to work with them or is it okay with you and we were already chock-a-block full with projects (DM4).

The finding that mandated collaboration results in a level of apprehension and frustration suggests interviewees are concerned when collaborating with services that are perceived as having less salience or importance within the sector. It also suggests a reluctance to collaborate with less influential service providers rather than more salient service providers who can offer better opportunities to gain funding. Findings also suggest a reluctance to collaborate with service providers who may engage in unfair, opportunistic and blatantly competitive behaviour. Competitive behaviour is discussed later in this section.

Second, stakeholders with the authority to delegate funding also drive collaboration by setting performance targets relating to grants that would be unattainable if service providers did not work together and collaborate. By using their authority to delegate funding, funding organisations are promoting the development of collaboration without directly imposing their authority by mandating collaboration with particular stakeholders. In other words, by operationalising or enacting collaboration in this manner, service providers retain a sense of autonomy in deciding who to collaborate with. This sense of autonomy appears important as it allows services to choose or make efforts to engage in collaboration with salient services that are perceived as able to contribute to service delivery and funding goals. For example, the following comment by a manager shows that a balance between authority and autonomy is required to ensure successful collaboration.

I think you kind of need to have both approaches [bottom up and top down]. If it is all bottom up, people think it is not supported by the top, but if it is all top down everyone will protest and won't do it because it is seen as all top down (DM4).

So far this section has discussed government or funding agencies using their authority to impose development of working relationships and potential social capital between service providers. Enforced involvement in collaboration contrasts with some scholars who contend that participation in collaboration must be voluntary (Keast et al., 2007). Enforced involvement in collaboration is examined by Benson (1975), who argues that mandated collaboration requires some degree of bureaucratic or authoritative strategies. Rodríguez et al. (2007) agree but also add the influence of market and clan-based mechanisms of control to bureaucratic or hierarchical governance mechanisms when referring to mandated collaboration. As such, Rodríguez et al. (2007) refer to the influence of social capital and also

power and legitimacy on collaboration. Regardless of differing views within the literature, participants indicated they commonly feel they are involved in effective and successful collaboration that is sometimes enforced by government funding agencies.

Third, although governments sometimes mandate collaboration as a condition of competitive tendering processes, often involvement is also voluntary. However, sometimes involvement in voluntary competitive tendering bids is not voluntary at all but a financial necessity, particularly for resource limited NGOs. For example, when discussing the dire financial predicament of her organisation, a manager of an NGO said:

I am in the process of finding money to continue this service otherwise this service after thirteen years will die ... I mean collaboration is very important in this prospect of looking for funding (CM1).

Therefore, the findings show that collaboration is sometimes entered into as a perceived opportunity to achieve competitive funding objectives, particularly for those organisations that rely heavily on funding grants to survive. However, although competitive tendering promotes involvement in collaboration, there appears to be some drawbacks. As one manager from a government service provider indicated:

We were told, point blank by another organisation, that they were [collaborating] purely to stay afloat. To stay afloat and it shouldn't be like that. I understand where they are coming from, like as in you know we have staff, but we need money and that is the way it is for non profits. But it is an inappropriate usage of what the funds are there for and the end result is that young people miss out (FM4).

Consequently, competitive tendering processes can result in financial considerations being prioritised over the clinical requirements of youth in need and for some interviewees, this circumstance is perceived as a misallocation of funding. The above comment also suggests that competitive tendering creates a context where opportunistic behaviour occurs, born out of financial necessity. Although interviewees regret this behaviour, the above quote also suggests that such behaviour is considered normal and accepted by those within the sector. For the researcher, continued references by interviewees to the dire financial predicaments of some service providers indicate a sense of sympathy and empathy from interviewees for these organisations. For example, as evidenced in the following quote, a manager of a government service provider lamented the financial struggle of a particular NGO and noted that collaboration could be a means to ensure the financial sustainability of that organisation.

The very real examples that are bothering me, at the moment, are small NGOs that are struggling and failing. I am seeing this in an organisation called XXXX [name] which has run out of money because it is supported just by fundraising in the public sector and does not have government support. It doesn't have an organisation to merge with or collaborate with really but might have to think along those lines (DM2)

The finding that collaboration is sometimes characterised by opportunistic behaviour indicates that for some interviewees the stakes are high when involved in collaboration, particularly if their organisation relies on grants for survival and sustainability.

Consequently, the authority to delegate funding, set the collaborative agenda and mandate participation in collaboration is principally based on existing management and hierarchical structures within the sector. As such, the importance of these structures is maintained and reinforced through collaboration and competitive tendering processes.

In addition to maintaining existing hierarchies within the sector, the findings also show that collaboration perpetuates the competitive principles associated with NPM, which are maintained and institutionalised further as these principles are impacting on how collaboration is enacted within the sector. As such, this research adds to knowledge that collaboration and competition can have a degree of synthesis and that this degree of synthesis allows funding organisations, principally governmental, to achieve their objectives and maintain their position of influence within the sector.

The finding that collaboration can have competitive characteristics is interesting because scholars often consider the concepts of collaboration and competition as diametrically opposed (Browning et al., 1995; Lamont, 1991; Prins, 2010). Furthermore, prominent scholars of collaboration such as Huxham and Vangen (2005) present themes relating to collaboration practice which don't include competition. Other authors use terms such as *negotiation* to describe the processes involved in collaboration surrounding issues of mutuality, agency, administration and governance. However, terms such as negotiation do not adequately reflect the opportunistic and competitive characteristics of collaboration that appear evident within the youth health sector where service providers are competing for funding. Other authors more openly acknowledge that collaboration and competition have a degree of synthesis and some have coined concepts such as *coopertition* (Leroux & Carr, 2007; LeTourneau, 2004a; Lombard & Morris, 2010) that more reflect how collaboration is being enacted within the youth health sector. Regardless of whether collaboration as

operationalised within the sector is perceived as true collaboration by scholars, those within the sector perceive that they are successfully involved in collaboration that has competitive characteristics.

Fourth, the findings show that collaboration was influenced by those with authority at higher levels within individual organisations and as such, collaboration reinforces existing hierarchy and the prioritising of individual organisational objectives over collective goals. For example, a manager revealed his role is to delegate and control the involvement of his workers in relation to collaboration in this comment:

From my view it's about making sure that the appropriate people are doing the appropriate work and that is probably the one place where I put my management hat on rather than the clinical hat (GM1).

The top-down influence of management also relates to control and allocation of resources. For example, a youth health practitioner whilst discussing a successful example of clinical collaboration stated:

We are constantly feeding up what we need to our managers at every level. The workers who are leading the case or working directly with the young people all have one representative from their agency who attends these specific executive meetings [strategic collaborative meetings]. So, we request what we need to the top. Decisions are made and reallocated back down. It [collaboration] is more top down. So, we get listened to, and we also get the resources discussed and they are delegated (FY2).

The above quotes exemplify that existing organisational hierarchical structures are often operating independently even up to the executive level for those involved in inter-organisational collaboration. As a result managers sometimes consider individual organisational priorities before making decisions associated with inter-organisational collaborative goals. This finding is important as it shows that collaboration adds complexity for managers as they may have conflicting concerns between individual organisational priorities and those of the collaborative network. Conversely, by not making decisions regarding engagement of subordinates in collaboration, employees could be torn between allegiances to their own organisation or the collaborative network.

Therefore, the impacts of individual management decisions go beyond individual organisations to have an effect on other service providers within the collaborative network.

As such, managers are managing in an environment of blurred organisational boundaries. This finding is important as the focus of NPM is on individual organisational accountability to financial and evidence-based performance targets (Aucoin, 1990) whilst collaboration promotes both individual and collective gain and the notion of potential sacrifice for collective gain (Gazley, 2008; McGuire, 2006). Consequently, it appears paradoxical to the researcher that managers are required to be involved in collaboration and share resources and decision making whilst managing in an environment of NPM.

It also seems paradoxical that funding agencies acknowledge inequality within the sector and that mandated collaboration is an attempt to *level the playing field* between service providers. However, at the same time government is also promoting competition between service providers when competing for funds, which can potentially limit collaboration by reducing the likelihood of trust and the development of social capital.

#### **6.4.4 Networking skills**

The above sections have made it clear that collaboration is perceived by interviewees as an opportunity to make productive collaborative linkages with stakeholders considered more eminent due to their links to government, access to funding and authority to delegate funding. Therefore, the findings suggest that collaboration is a political and opportunistic process as stakeholders consider the implications of choosing collaborative partners.

As a result of a perceived need to make the best social connections or linkages, the findings also show that collaboration involves a degree of politics where drive, networking and communication skills can assist those involved in collaboration to develop salience. For example, when describing examples of individuals who are good at collaborating, a manager revealed:

Some people are just really good at getting what they want and that sort of thing; they have got those networking skills, connections and credibility (FM4).

The benefits of having good networking skills were indicated by interviewee references to *champions* or those individuals who inspire and drive participation in collaboration:

I think that for Youth Services in particular, it [collaboration] works best when there is a champion, where there is someone who is willing to get in there and advocate, and advocacy is a big part we have to play in terms of collaboration for services because [a champion] needs to inspire, needs to lead, needs to manipulate, needs to suck up (GM1).

Another interviewee comment shows that champions effectively develop social capital by creating horizontal and vertical social linkages across government, NGOs and private organisations to inspire participation and commitment for collaboration:

I think being a good communicator, being passionate about whatever the cause is that they believe in, for instance: [a persons name] for example. She has been the champion for youth health for many years. She is an excellent communicator. She can speak at any level. So I think that is very important as well. She is not just speaking to parliament or whatever, she can speak to the young people, to the marginalised at-risk young people, so she has that wide span of communication skills and I believe that is very important (CM1).

The references by interviewees to champions suggest that excellent networking skills can offer an alternate path to salience or influence when collaborating rather than through management and government hierarchy. Confirming research by other scholars (Benson, 1975; Milbourne, 2009), findings from this research show that having excellent networking skills result in an ability to develop social capital within the sector. Developing these social linkages gives power and legitimacy to demand the urgent attention of others, including those with authority and control of resources, namely government.

In an effort to be more salient than other services, some managers look for personal characteristics and networking skills when looking to hire employees. For example, when discussing selecting new staff a manager stressed the importance of personal skills that she believed made her staff more effective at networking and collaborating when involved in collaboration:

Personal characteristics, I look for them in anyone I employ from admin staff to seniors. I look for those skills because if people have those qualities, those characteristics, then they are more likely to take initiative you know, more likely to be innovative, and more likely to be open and flexible and open to new ideas (AM5).

Consequently, another strategy used by some managers to improve the salience of their organisation is to consider networking skills in addition to clinical skills when hiring new employees. This competitive strategy aimed at gaining salience appears significant due to the numbers of comments by interviewees showing concern over the transient nature of the workforce in the youth health sector and the time taken to establish collaborative relationships.

#### 6.4.5 Credibility within the sector

Interviewees commonly reveal they choose partners to collaborate with based on them having a credible reputation. For example, an interviewee reflects on why others would choose to engage in collaboration with her organisation and likens a credible reputation with trust:

I think you need to be credible. Your organisation has to be perceived as credible to them. They trust you, then they will collaborate with you (DA5).

Interviewees commonly associated a credible reputation with the ability to deliver youth health outcomes. For example, a manager believed that other stakeholders collaborate with his organisation based on its reputation for successfully delivering youth health outcomes:

For the most part we have been around over twenty years as a service, almost thirty years, and there is a reputation there and there is an acknowledgment that we can achieve those outcomes (FM4).

In situations of enforced collaboration, interviewees commonly made assessments of other services based on their reputations, and these reputations impact on engagement strategies when collaborating. For example, a manager when discussing enforced collaboration said:

They [the funding organisations] are saying well these are the people we want you to partner with to do this project. So that is a little bit tricky but, you know, I looked down the list [of enforced collaborative partners] and I sort of think to myself, yes they would be good, they'd be good, they'd be dodgy, they'd be you know left field (DM4).

Consequently, findings show that being recognised as a reputable and credible youth health service provider that has legitimately achieved success in delivering youth health services results in more salience or sway in relation to collaboration. This means that when collaboration is enacted within the youth health sector, gaining a credible reputation is desirable and advantageous due to willingness of other service providers to engage in collaboration with credible service providers and potentially develop social capital. Having credibility results in what Hardy and Phillips (1998) refer to as 'discursive legitimacy' (p. 228), which ensures recognition and ability to speak legitimately on certain issues and thus influence meaning for participants when collaborating.

Although scholars commonly consider that trust or reputations of trust enable collaboration (Ostram, 2005), this research offers new knowledge and explores the lengths stakeholders

will go to gain a credible reputation or disseminate their reputation to others. This research adds to knowledge by showing that stakeholders will compete with others to gain credibility in order to become more salient or influential when collaborating.

Interviewees commonly competed with each other to collaborate with recognised credible government service providers to gain credibility through association. For example, an interviewee from a government service provider stated that other service providers wanted to collaborate with her organisation because:

We can get the NSW Health logo on the [promotional] document [about a particular collaborative project]. None of those other agencies would be able to do that (DM4).

Gaining salience through association was also identified as a competitive strategy to impress funding agencies or those with the authority to delegate funding with their eminence within the sector. For example, an interviewee revealed:

The whole flyer is information and all this bottom bit is all logos and it is all about, we needed it for our funding body (FY1).

Therefore, the research findings show that service providers compete to engage in collaboration with credible service providers to develop a credible reputation by association, make linkages with more eminent government service providers and to impress upon funding organisations that they are successful at collaborating to deliver youth health services. In other words, service providers are collaborating to improve their organic attributes to make better linkages with those stakeholders with mechanistic attributes. The use of branding to gain credibility as perceived by funding organisations concurs with research by Tschirhart et al. (2005), who argue that ‘branding serves as an instrumental tool for competitively attracting resources for both collaborations and the collaboration partners’ (p. 74). In addition, Merton (1968) argues such associations can retroactively affect work appraisals and heighten recognition for later accomplishments. As such, benefits of association for service providers are high and suggest that collaboration involves a degree of reputation management where service providers compete to maximise the impact of their brand and reputation. As such, collaboration may reduce resources allocated to clinical needs as individual organisational financial objectives are considered and resources are allocated to developing and maintaining a credible reputation. Concerns by interviewees in regard to individual

organisations' logos on collaborative promotional material also emphasise a focus on individual organisational objectives rather than commitment to a collective brand.

#### **6.4.6 Delivery of services**

Interviewees reveal that the health needs of young people drive collaboration within the youth health sector from the bottom up. For example, when discussing the choice of who to collaborate with, an interviewee who is a youth health practitioner disclosed:

It [who to collaborate with] really depends on what the client needs. That is what I base it [who to collaborate with] on (EY2).

Hence, linking the health requirements of youth to the services offered by youth health service providers and considerations of best practice are also reasons why interviewees engage in collaboration with other health service providers. Therefore, potential partner organisations are considered important if they can deliver health services required by youth in need. However, this finding implies that larger organisations providing a broad array of services have a reduced need to collaborate if services can be supplied in-house. It also shows that those with less funding or more specialised services are under more pressure to collaborate successfully to be considered as future collaborative partners.

Reputation for service delivery was often associated with differences between NGOs and government organisations with the general consensus of views from interviewees agreeing with the following interviewee comment:

[T]he NGOs tend to be able to do things faster but the staff are generally not as trained because they don't pay as well, so they are less skilled ... Whereas government departments tend to do things of higher quality but are bogged down in bureaucracy and take a long time to do things, but generally things are of higher quality (DM4).

Therefore, the findings show that delivering services relates the other characteristics of salience such as links to government, access to funding and credibility within the sector; hence the characteristics of salience are interdependent. However, underlying the ability to deliver youth services is access to funding. Without funding, service providers are unable to continue service delivery. Thus the more securely government-funded organisations are better positioned financially to deliver youth health services whilst for NGOs the need to collaborate to access funding is more critical.

#### **6.4.7 Competitive implications: organic and mechanistic characteristics of salience**

Thus far this section answering question 3, ‘How is collaboration operationalised or enacted within the youth health sector’, has discussed the six characteristics that make stakeholders salient when collaborating within the youth health sector. This section now discusses some of the strategies used by service providers to gain salience when collaborating. It will be clear that strategies used often revolve around competing to develop social capital with organisations who offer opportunities to gain funding and resources.

Examining salience to understand how collaboration is enacted within the youth health sector shows that divisions within the sector are maintained through collaboration, even mandated or enforced collaboration, and that the ideals of inclusion and democracy that are proposed benefits of collaboration are somewhat challenged or diluted. They are challenged as the ability of youth services to deliver the health services required by youth in need is dependent on existing structures within the sector and whilst these structures remain, change through collaboration remains hindered.

Competition to be perceived as a credible provider of youth health services, particularly to their funding bodies, resulted in some service providers acting in an underhanded manner. Interviewees were commonly concerned about other youth health service providers getting undeserved recognition and were forthright in stating that this was not uncommon within the sector. For example, a manager referred to network members reporting collective outcomes as their own in his comment:

They use us or use our outcomes, or the common goal we are working towards, for their own benefit that it is actually open for everyone who sits on that collaboration to get recognition for (BM3).

As the following quote by an interviewee reveals, some service providers go as far as exaggerating client numbers or results when collaborating to get funding and resources:

I have worked in that service and I know that they bump the stats and that is not a true figure. It is all about retaining funding, where really it is about the quality of the service (FY1).

Some interviewees rationalise this competitive behaviour because of the dire financial predicament of some organisations. For example, a manager from a government organisation stated:

I guess wanting to, you know, secure their own turf and maybe just to achieve recognition for their individual achievements rather than sharing the space, you know, with a view for a better outcome in general. We see this a lot in the youth health field. I think there are small organisations who are struggling (DM2).

Therefore, this research shows that competitive behaviour is sometimes rationalised and considered normal when involved in collaboration, particularly for smaller financially constrained NGOs. In fact, a shared understanding about a lack of resources appears to galvanise participants as evidenced in the amount of references concerning funding limitations. However, as the following discussion reveals, competitive behaviour in terms of unfairly gaining recognition was mitigated to an extent by formalised agreements and exclusion from future collaborative opportunities by offenders.

To ensure deliverables and accountability when collaborating, some interviewees identified the requirement for memorandums of understanding (MOUs) or service-level agreements to formalise reciprocal arrangements and deliverables. For example a manager said:

I think it is important to formalise it ... but it is really about, you know, our responsibility, your responsibility; this is what we are trying to achieve and this is how we are going to measure it and all that kind of stuff (GM5),

Therefore, some participants perceived that MOUs or service-level agreements formalised collaborative endeavours and outlined associated rules of engagement in a logical, sensible way to ensure the reciprocal nature of collaboration. As such, they indicate a level of seriousness and commitment from both sides and provide a tangible way of demonstrating you are collaborating and looking outside your own organisation to deliver better services. The need for formal structures indicates that there could be less than ideal or desirable levels of trust between some participants when collaborating within the youth health sector. As the above interviewee comments indicate, less than ideal levels of trust are sometimes the result of negative competitive behaviour occurring between participants when collaborating. This finding contrasts with collaboration literature, which often promotes collaboration as encouraging trust and reducing conflict (Entwistle & Martin, 2005). It also contrasts with earlier findings showing that interviewees prefer informal collaboration as it expedites working processes.

In comparison to formal rules of engagement, findings show that unfair competitive behaviour results in repercussions for offenders. Interviewees claim that they are less likely to

collaborate with stakeholders in the future who fraudulently gain undeserved recognition. For example, when discussing a stakeholder who took underserved recognition a manager said:

[W]e would not enter into any collaboration with them in the future ... they took all our outcomes, not just us, a whole group of us and they reported it in the papers, in the reports and they forget that we will eventually find out and then we sidelined talk. And from then on I think they have struggled to get other projects off the ground and that particular concept they took just disintegrated. Once one talks, we all get together, and other things, you get phone calls and that is how close we are. We all work in the same area, so when word of mouth gets out ... (BM3).

Consequently, there are informal and normative sanctions in collaboration that regulate destructive or negative competitive behaviour. Therefore, competitive behaviour is regulated by participants themselves with minimal influence from authority, such as government. As such, competition within collaboration has some congruence with existing informal collaborative governance mechanisms, which often rely on trust and reciprocity. It has congruence as both collaborative and competitive motivations govern the competitive behaviour of services when collaborating. These findings contrast with Milbourne (2009), who argues that competition undermines collaborative work and community trust. Therefore, this research adds to knowledge of collaboration theory by showing that competitive characteristics of collaboration have a degree of congruence with collaboration. This research shows that competition promotes engagement in collaboration and is also related to formal and informal governance processes to ensure that competition remains healthy and fair rather than negatively impacting on the salience of other participants.

This section has discussed the six characteristics of salience identified through the analysis process and discussed the competitive implications these characteristics have on collaboration within the youth health sector particularly in terms of strategies used by service providers to gain salience or eminence within the sector. The findings showed that having these characteristics make stakeholders more salient or important when collaborating as they drive others to engage in collaboration with them, particularly if they give service providers the opportunity to gain funding.

The findings also showed that service providers make opportunistic and competitive efforts to achieve these characteristics in order to gain funding. The findings also showed that these competitive efforts were more associated with the organic attributes of stakeholder salience,

which are networking skills, credibility within the sector and the delivery of services. This finding is not surprising as the organic characteristics of salience are more easily influenced by service providers as compared to links to government, access to funding and the authority to delegate funding, which are considered in this research as mechanistic characteristics of salience. They are considered mechanistic attributes as service providers are less able to influence these characteristics as they are controlled or set by government and management hierarchical structures.

Although competition was clearly evident when associated with stakeholder salience, collaboration for competitive funding has not been previously discussed in relation to collaboration theory, particularly in reference to salience and attempts to develop social capital to attain salience. However, according to the interviewees, competition when collaborating is the norm in youth health services. Therefore, organisations that are successful in acquiring funding are salient and matter most to those who need to collaborate with them to also gain some funding. However, it is not a given that salience is fixed or sustainable. Hence the scramble for repeated competitive funding, which may give the impression to those working within the sector and the researcher that funding acquisition is more important than the actual delivery of youth health services. If the success passes, service providers might matter less to other stakeholders and might lose collaborative support. This cycle of demand and supply of funds could create a new level of collaboration or fluctuating collaboration that does not surpass a level where competitive actions limit collaboration. The promoting and limiting effect of competition on collaboration and the level of salience of participants are explained further in Section 7.2.5 of the following conclusion and discussion chapter.

This chapter has identified six characteristics of salience for those collaborating in the youth health sector. It also showed that service providers sometimes engage in competitive behaviour to attain characteristics of salience, particularly through manipulating the organic characteristics of salience. The following section summarises the analysis chapter.

## **6.5 Chapter summary**

By analysing the data this chapter revealed that collaboration within the youth health sector has competitive characteristics. This chapter also revealed that competitive characteristics are based on gaining salience within the sector. Having salience is considered desirable by interviewees and worth competing for as it allows services to develop social capital and make

the most advantageous collaborative linkages with stakeholders who may have the ability to access resources, such as those with linkages to government or those with the authority to delegate funding. This chapter concluded by presenting the six characteristics of salience in detail and showing the competitive implications these characteristics have when collaboration is enacted within the youth health sector.

This chapter began by answering the first research question which asks, ‘Who collaborates in the youth health sector and why?’ Analysis showed that collaboration is driven by both economic motivations to attain funding and altruistic motivations to assist youth in need. It also showed that interviewees collaborate to develop social capital and advantageous personal working relationships. By answering question 1, this chapter also showed that interviewees associate collaboration with competitive tendering policies and funding allocation, rather than NSW government youth health policy promoting collaboration. This finding introduced a level of connectedness between collaboration, competition and funding allocation that was confirmed by answering question 2, ‘What are the impacts of collaboration within the youth health sector?’

By answering question 2 this chapter identified that positive impacts of collaboration within the youth health sector, which include raising awareness, developing personal working relationships, creating a sense of inclusion and emphasising common altruistic goals. However, this chapter showed that negative impacts of collaboration include some service providers prioritising individual agendas over collective goals. This chapter showed that to a point, opportunistic behaviour when collaborating is considered normative and accepted by those within the sector but punished by exclusion from future collaborations if normative boundaries are violated, particularly if they negatively impact on the salience of other participants. Consequently, the findings led the researcher to conclude that although competition promotes collaboration through increased engagement, competition ultimately limits the level of collaboration. Therefore, there is congruence and incongruence between current competitive government funding practices associated with NPM and collaboration, depending on the level of competition and the salience of individual participants. The incongruence is due to NPM emphasising individual organisational goals and collaboration emphasising collective goals. However, by answering question 2 this chapter made clear that collaboration has competitive characteristics as stakeholders compete to be more salient within the sector in order to perpetuate opportunity for funding which drives collaboration and illustrates a level of congruence.

By answering question 3 which asks, ‘How is collaboration operationalised or enacted within the youth health sector?’ the researcher was able to build on the findings of question 2 and identify six characteristics that make stakeholders salient when collaborating. These characteristics of salience were grouped as either mechanistic or organic. Mechanistic characteristics of salience were those less able to be influenced or changed by service providers and include: links to government, access to funding and authority to delegate funding. The second group of characteristics of salience were referred to as organic as they were more readily able to be influenced by service providers and include: networking skills, credibility within the sector and delivery of services. This chapter showed that competition amongst service providers is mostly related to organic attributes in order to develop social capital and advantageous linkages with those who have mechanistic characteristics of salience and who can potentially assist in gaining funding.

This chapter has given a unique insight into the willingness of service providers to engage in collaboration that clearly has competitive characteristics aimed at gaining salience and perpetuating funding opportunities. This chapter showed that by using the principles of stakeholder, social capital and collaboration theories this research has identified that service providers base collaborative engagement strategies on perceptions of stakeholder salience. This chapter also showed that stakeholders compete to develop salience so that they can better develop social capital and advantageous collaborative linkages with those stakeholders who can perpetuate opportunities for funding in order to ensure organisational sustainability.

The following chapter builds on the findings revealed here to present theory relating to the relationship between increasing collaboration and increasing salience. It will be shown how competition, although initially promoting collaboration through mandated and voluntary involvement relating to competitive tendering policy, ultimately limits the level of collaboration because the development of social capital between participants is compromised



## **Chapter 7: Discussion and conclusion chapter**



## 7.1 Introduction

The explicit theme of this chapter is the contribution to knowledge made by this research. This chapter builds on the findings discussed in the previous chapter to demonstrate a contribution to knowledge related to identifying and explaining competitive elements of collaboration occurring within the youth health sector and extending collaboration theory. It is shown that competition primarily revolves around service providers competing to increase their salience or importance within the sector and when collaborating. In doing so, it is shown that service providers also compete to build the most advantageous linkages and social capital with who they perceive matters most in terms of offering them opportunities to gain funding and develop their own levels of salience. To present the contributions to knowledge that this research makes, this chapter is divided into a number of sections.

First, the research conclusions are presented. These research conclusions are built on the findings revealed by answering the research questions in the previous analysis chapter.

Briefly these research conclusions are:

- collaboration emphasises inequality between service providers
- inequality between service providers can be expressed in terms of salience
- New Public Management promotes collaboration as an opportunity to achieve individual organisational goals
- collaboration is a competitive process
- competition both promotes and limits collaboration.

Second, the theoretical implications of findings are presented. It is shown that current collaboration theory does not reflect all the factors at play for youth health service providers collaborating within the youth health sector, particularly the competition between service providers to be more salient than others when collaborating. A more comprehensive theory of collaboration is presented that includes salience as a principle of collaboration and competition as a process within collaboration theory. Also presented is a more contemporary definition of collaboration.

Third, the implications for practice are outlined. The researcher suggests a classification system for service providers based on their levels of salience in order to assess their propensity to engage in competitive behaviour when collaborating. Strategies for engagement are then suggested.

Fourth, the implications of this research for government policy are discussed. It is proposed that although policy promoting competition and collaboration concurrently initially drives collaboration, it is not without risk.

Fifth, the limitations of the research are acknowledged, particularly the limitations associated with the complexity of human behaviour.

Last, opportunities for future research that can expand on the research findings revealed by undertaking this research are presented.

But first, the following section discusses the research conclusions.

## **7.2 Research conclusions**

### **7.2.1 Collaboration emphasises stakeholder inequality**

Collaboration emphasises the inequality of service providers, particularly in terms of funding and resources. As revealed in the analysis chapter, collaboration exacerbates division within the sector, particularly between government and non-government service providers.

Collaboration is proposed by scholars as an activity to bring together a diverse array of stakeholders in order to address a complex or wicked problem (Head, 2008; Huxham, 1996; Keast & Mandell, 2009b; Wood & Gray, 1991) such as youth health service delivery. Scholars promoting collaboration argue that collaboration allows for the differences between stakeholders to be embraced so that better, more innovative solutions to wicked problems can be discovered and implemented (Head, 2010; Huxham, 1993; McGuire, 2002). Consequently, differences between stakeholders are embraced and perceived as a positive attribute of collaboration, which relates directly to the mutuality principle of collaboration (Thomson & Perry, 2006; Thomson et al., 2009). For example, in the previous chapter it was shown that within the youth health sector, collaboration between different service providers is driven by common altruistic goals of assisting youth in need.

However, collaborating to provide youth health services also highlighted to research participants the limited funding available to the sector and their organisations. For example, an interviewee in a management role stated that the youth health sector is

concerned about the disaffiliated youth, under-resourced, and altruistically driven, but anxious of our resources (DM2).

Although scholars call for differences between stakeholders to be positively embraced in order to achieve common service goals, in the context of the youth health sector, inequality in terms of funding and resources, particularly between government and NGOs, was given as a reason to collaborate. For example, an interviewee in a youth health practitioner role declared:

That is what gets people involved [in collaboration]. It is usually about resources (GY2), indicating that for some in the youth health sector collaboration is about efficiency and accessing resources rather than synergy. Furthermore, when discussing reasons to collaborate, interviewees' comments commonly referred to funding and resource inequalities as evident in the following comments from managers:

We are not eligible for a lot of the funding that the NGOs are and they don't get the funding that we do (GM1).

and

I acknowledge that we have resources that others don't and not just the resources around the service, but we have got consistent funding (FM4).

In addition, as revealed in the previous chapter, having more funding and resources, or at least the ability to access funding and resources, made service providers more influential or salient within the sector as other service providers collaborated with them to access their resources. Thus interviewees commonly acknowledge their own funding and resource limitations and that some service providers needed to collaborate due to their inability to provide the range of health services required by their clients. Therefore, although existing literature acknowledges that interdependency between stakeholders is a key driver of collaboration (Gray, 1985), this research shows that inequality in terms of funding and resources, in addition to common altruistic goals, drives service providers to collaborate.

### **7.2.2 Inequality between service providers can be expressed in terms of salience**

This section shows that inequality within the youth health sector can be expressed in terms of salience and more specifically it can be expressed in terms of possessing some or all of the *six characteristics of salience* that make service providers more important or eminent than others when collaborating. It can be expressed in terms of salience as the six characteristics of salience revealed in the previous chapter are integral to obtaining funding for service

providers and enabling them to better deliver youth health services when collaborating. After reiterating the six characteristics of salience, inequality conceptualised as salience and the impact this has on collaboration is discussed in this section.

The *six characteristics of salience* are: links to government, access to funding, authority to delegate funding, networking skills, credibility within the sector and delivery of services. The meaning of each is briefly summarised below.

1. *Links to government* refer to organisations or individuals that have either formal or informal links to government. Links to government more commonly refer to government service providers but also those who have developed strong social capital between themselves and government.
2. *Access to funding* means organisations that already have access to funding and resources. This access may be based on formal or informal linkages with funding organisations.
3. *Authority to delegate funding* refers to those with the authority to decide which organisations and collaborative networks receive funding. Funding can be from direct grants or through competitive tendering. It can also be related to those service providers who control the distribution of funds and resources when collaborating.
4. *Networking skills* refer to those who have the collaboration, communication and political skills to effectively develop and sustain collaborative relationships.
5. *Credibility within the sector* means those individuals and organisations that have a reputation for effectively delivering youth health services and collaborating. They are also those who have positive reputations of trust and reciprocity.
6. *Delivery of services* refers to those that have the capability to effectively deliver youth health services or fulfil their role in delivering youth health services.

The researcher concludes that funding and resources impact on the characteristics of salience and vice versa. For example, findings show that having *links to government* were perceived by research participants to result in more secure funding whilst *access to funding* and the *authority to delegate funding* refer directly to funding and resource requirements. *Credibility within the sector* is often based on *delivering youth health services* which is dependent on funding.

The research also determined that social capital impacts on a number of the characteristics of salience. For example, *networking skills* are impacted by the ability of service providers to

build positive working relationships with others when collaborating. The findings also show that *credibility within the sector* is based on the ability to engage in positive relationship building and develop social capital with other salient service providers when collaborating in order to perpetuate funding opportunities and develop their own levels of salience. Therefore, salience when collaborating is impacted by building or attaining social capital in addition to funding and resources.

Having high levels of the characteristics of salience makes service providers more influential in relation to collaboration. First, possessing the characteristics of salience increases their attractiveness and appeal to other service providers who make efforts to collaborate with them in order to gain funding and develop social capital. For example, an interviewee described the benefits of developing social capital with influential service providers in her comment:

I also found that if you are stuck and you have built a good rapport with one organisation they can help you (EY3).

In addition, a manager from a more financially secure government service provider referred to sharing resources with other service providers with whom they have a close relationship, in his comment:

We are happy to support services to work from here ... So what we have done is set up an in-service for them (FM4).

Second, as a result of other less salient service providers making efforts to collaborate with them, salient service providers have choice concerning with whom to collaborate. When discussing the choice of collaborators, a youth health practitioner from a securely funded government service provider said:

I guess sometimes that organisation's reputation may have something to do with it. In this area you get to know who does what, and I guess how well they do it (GY7).

Consequently, this comment exemplifies service providers assessing the salience of others in terms of credibility within the sector and their ability to deliver the required youth health services. Using this assessment, service providers make decisions on who to collaborative with. In terms of competitive tendering bids, service providers assess the salience of service providers involved in each bid and can make decisions concerning which tender would more

likely be successful in attaining funding. Service providers can consider which tender would more likely result in their organisation gaining funding. The assessment of others when collaborating is addressed by Ring and Van de Ven (1994) but assessing stakeholders in terms of salience is not. This research addresses this lack of knowledge of the impact of stakeholder salience when choosing collaborative partners within the youth health sector.

Gaining salience is important as it has immediate and ongoing consequences for service providers. In terms of an immediate focus, being salient when collaborating gives service providers say or input when collaborating, for example, when determining governance of the collaboration. In addition, gaining salience by proving to others their ability to deliver services and contribute to collaborative outcomes allows service providers to increase their credibility within the sector and creates opportunities to build social capital with salient service providers and perpetuate opportunities for funding. For example, a manager from an NGO shared her thoughts regarding the need for NGOs to develop salience when she said:

Their funding is less secure, so they really need to prove themselves (AM4).

In terms of ongoing positive consequences of being salient, service providers with high salience are more likely to be involved in successful competitive tendering bids as compared to tenders involving less salient service providers. Therefore, collaboration offers service providers a *forum* to improve their reputation, credibility and salience within the sector.

In summary, the research conclusion that inequality can be expressed in terms of salience allows the researcher to highlight what makes service providers more or less influential and important when collaborating in the youth health sector. It also allows the impacts of funding and social capital on the characteristics of salience and vice versa to be considered.

### **7.2.3 New public management promotes collaboration as an opportunity to achieve individual organisational goals**

The entrenched values and principles associated with New Public Management (NPM), influence service providers to often prioritise individual organisational objectives over collective objectives when collaborating.

NPM emphasises a managerial or business perspective to managing healthcare organisations with a focus on cost reduction, performance measures and organisational efficiency, which are driven by competitive principles (Braithwaite, 2004; Commonwealth Department of Health and Family Services, 1998; Rhodes, 1996). This macro environment results in

managers in particular, who are responsible for the ongoing financial viability of their organisations, to commonly consider and prioritise individual organisational objectives when collaborating over collective goals. For example, expanding on the prioritisation of individual agendas discussed in the previous chapter, a manager of an NGO when giving her reasons to collaborate said it depends on ‘what’s in it for me’ (AM5). Her comment shows a focus on individual organisation priorities rather than collective goals.

There is a concern expressed by research participants, managers, youth practitioners and administration staff alike, relating to a lack of funding for the sector and the ongoing financial sustainability of their own organisations. This concern is principally related to the ability of their organisation to obtain ongoing funding. Ongoing funding is often dependent on evidence-based results set by funding organisations and securing or winning competitive tendering grants. Evidence that individual financial considerations and competitive principles often drove engagement in collaboration was apparent when research participants declared that competitive tendering policies and procedures, rather than policy promoting collaboration for altruistic reasons, drove them to collaborate.

Furthermore, NPM creates an environment where individual service providers are focused on winning competitive tendering bids to ensure the ongoing financial sustainability of their organisation, particularly in an environment where funding is limited and government priorities change. Thus collaboration provides an *opportunity* for service providers to compete to gain salience or influence within the sector. For example, an interviewee declared that when collaborating

[i]t’s almost like they [service providers] come together to promote what they are doing, as opposed to what we can do together (FY1).

As a forum or opportunity to gain salience, the researcher argues that whilst collaborating, service providers make efforts to develop advantageous linkages and social capital with other salient service providers in order to extend opportunities for funding and to ensure the financial sustainability of their organisation.

The focus of managers on the financial sustainability of their organisation was reflected by youth health practitioners who were ever mindful of the resource limitations of their organisations and the sector in general. In addition, the findings showed that managers

oversee the allocation of individual organisational resources to collaborative projects and therefore the influence of NPM occurs also at the clinical level.

The conclusion that collaboration when enacted in the youth health sector is impacted by existing values associated with NPM confirms findings by Hibbert and Huxham (2010), who argue that manifested attitudes and traditions impact on collaboration. This research extends Hibbert and Huxham's (2010) conclusions and claims that institutional influences such as those associated with NPM manifest in the values and behaviour of service providers within the youth health sector in relation to collaboration.

In summary, NPM creates an environment where individual service providers are focused on winning competitive tendering bids to ensure the ongoing financial sustainability of their organisation. In addition, this environment commonly leads to a prioritisation of individual organisational goals over collective goals.

#### **7.2.4 Collaboration is a competitive process**

The above conclusions highlighted that collaboration emphasises the inequality of participants and that inequality can be expressed in terms of having some or all of the characteristics of salience. It was also shown that collaboration is perceived as an opportunity or forum to achieve individual organisational aims and that this perception is influenced by the entrenched principles of New Public Management (NPM).

This section builds on the findings of the previous chapter that revealed that collaboration results in increased competition and has competitive implications for those service providers involved. It concluded that service providers *compete* to be more salient or influential than other service providers when collaborating and thus collaboration is characterised by competition when enacted or operationalised within the youth health sector. For example, an interviewee who is a youth practitioner reflected on her experiences collaborating and proclaimed, 'There IS competition!' (FY1). This conclusion builds on the previous research conclusion that inequality is related to possessing the characteristics of salience and that the competitive nature of collaboration in the youth health sector revolves around service providers developing, maintaining and defending their characteristics of salience.

The competition is necessitated due to funding limitations within the sector and the uncertainty of the organisational sustainability of many service providers, particularly NGOs

within the sector that often operate on very limited budgets. Exemplifying limited funding available to service providers is the following comment by an interviewee:

We don't have the manpower or the hours or the staff, nor do we have the dollars (BM3).

As highlighted in the sections above, winning the competition to be more salient than others rewards service providers. Reiterating, winning salience assists service providers to develop advantageous linkages with other highly salient stakeholders, assists in the development of social capital through these linkages, helps in the delivery of health services and perpetuates opportunities for future funding.

The research concludes that competition to develop salience when collaborating revolves around service providers developing some characteristics of salience more than others. In the findings chapter, the researcher showed that the characteristics of salience *links to government, access to funding and authority to delegate funding* are not easily influenced but are set by government bureaucratic systems and changing government agendas. As these characteristics of salience are less likely to be influenced by the actions of individual stakeholders when collaborating, the researcher refers to these as the *mechanistic characteristics of salience*. In comparison to the mechanistic characteristics of salience, the *organic characteristics of salience* have potential to be influenced by service providers. The organic characteristics of salience are *networking skills, credibility within the sector and delivery of services*. (See Table 7.1 below.)

**Table 7.1: Mechanistic and organic characteristics of salience**

<b>Mechanistic characteristics of salience</b>	<b>Organic characteristics of salience</b>
Links to government	Networking skills
Access to funding	Credibility within the sector
Authority to delegate funding	Delivery of services

Competition for salience or influence when collaborating commonly involves service providers competing to develop their *organic characteristics of salience*. By developing their

organic characteristics of salience, service providers can better compete to create collaborative linkages and develop social capital with service providers who already possess the *mechanistic characteristics of salience* and thus perpetuate future funding opportunities and promote their own salience further.

In terms of maintaining or defending their salience, more salient service providers make choices on who to collaborate with. Choice enables them to achieve their organisational goals and thus maintain and protect their salience within the sector. Consequently, competition involves developing, maintaining and defending their social capital and collaborative linkages in order to promote their salience within the sector.

It is argued that salience or influence within the sector is not a given. However, it is more likely available to government service providers that already have the *mechanistic characteristics of salience*. In comparison, non-government service providers are, due to the nature of the structure of the youth health sector, less salient than government organisations because they don't possess, or at least possess to a high degree, the *mechanistic characteristics of salience*. Government and non-government service providers alike can lift their influence or salience within the sector by developing working relationships and social capital with more salient or important service providers, particularly those with the mechanistic characteristics of salience.

The result of service providers competing to be more salient than others when collaborating is that service providers are trying to build linkages with some service providers to the exclusion of others. The result is that service providers often attempt to build potential alliances within the collaborative network based on who is perceived as more salient or influential than others in terms of how they can help achieve individual organisational funding objectives and assist in developing levels of salience.

Competition for salience by jockeying to develop social capital with salient or eminent service providers maintains the influence of existing salient organisations. In the case of the youth health sector this means government service providers or NGOs with high levels of salience. Therefore, findings imply that collaborating for change within the sector may not be a priority for government. This conclusion is based on government entrenching the principles of NPM in the sector and creating a climate where the sway or salience of government service providers is maintained or ensured.

Scholars have been critical concerning the impact of competition on collaboration within the health context. For example, Gordon (2007) argues that obstructions to collaboration are ‘exacerbated by the inherently competitive nature of economic development’ (p. 73). Gordon’s (2007) findings also show that a history of altruistic values will result in higher levels of collaboration whilst alternatively a competitive past hinders future collaborative activities. This thesis argues that collaboration and competition are not necessarily distinctly different concepts but rather, collaboration is characterised by competition. More specifically, it is claimed that collaborating service providers are competing to be more salient than other service providers.

### **7.2.5 Competition both promotes and limits collaboration**

This section shows that the competition inherent in collaboration promotes and limits collaboration within a western Sydney youth health network.

First, the research participants acknowledged that competition to be more salient than other service providers drives them to engage in collaboration. For example, whilst discussing what drives him to engage in collaboration, an interviewee who is a youth health practitioner said, ‘[I]t is all about retaining funding’ (FY1) so as to better deliver youth health services. Another interviewee acknowledged the need to compete for limited funding within the youth health sector when she declared that funding organisations ‘can’t give funding to both [organisations]’ (BY4).

Competition also drives collaboration in the youth health sector as service providers compete to be more salient than others. For example, a manager claimed that some service providers engage in competitive behaviour when collaborating due to a ‘need to claim status’ (DM1), whilst a youth health practitioner declared that other service providers enter into collaborative agreements ‘to help their service get recognition’ (FY1). In doing so, youth health service providers compete to build their credibility, salience or sway within the sector. Therefore, within the context of a youth health network, competition drives and promotes engagement in collaboration.

As a consequence of an acceptance of competitive behaviour when collaborating, it is suggested that lower levels of trust can result in successful collaboration. This finding contrasts with some scholars who emphasise the need for high levels of trust or trustworthiness (Gajda, 2004; Hibbert & Huxham, 2010) when collaborating. This finding is

significant as it shows that mandated collaboration with service providers can be successful as can collaboration characterised by competition when enacted within the youth health sector.

Second, the research concludes that although competition initially promotes collaboration, it ultimately limits the level of collaboration. Competition ultimately limits collaboration as service providers become aware and concerned that overt competitive behaviour from other service providers may negatively impact on their own levels of credibility and salience. For example, the previous chapter showed that interviewees were concerned that the competitive behaviour of other service providers, such as *free-riding* or unfairly reporting collaborative outcomes as their own, diminished their deserved benefits associated with the achievement of collaborative outcomes. As the previous analysis chapter also made clear, such behaviours may result in *distrust* towards offending service providers, *increased cynicism* towards the collaboration process and perceptions that other service providers were *pushing their own individual agendas* to the detriment of other participants. It also showed that distrust in other service providers resulted in reluctance to collaborate with the offending service providers in the future. Therefore, competitive behaviour when collaborating can negatively impact on collaboration as it can increase levels of distrust, diminish goodwill and social capital between participants and reduce participation in collaboration.

The point where competitive behaviour begins to limit collaboration occurs when participants perceive that their own salience is threatened by the competitive actions of others. The researcher refers to the point or level where the competitive behaviour of service providers begins to negatively impact on collaboration as the *competitive threshold*. The competitive threshold is subjective and determined by the participants involved. It is subjective as participants have varying views concerning *when or at what point* does competition negatively impact on the salience of others and *what* competitive behaviours are perceived as acceptable or unacceptable.

Empathy shown by interviewees regarding the financial position of some offending service providers increased the competitive threshold. For example, an interviewee in a management role empathised about the financial position of some service providers and declared service providers compete when collaborating:

[t]o stay afloat and it shouldn't be like that. I understand where they are coming from (FM4).

Furthermore, findings indicate a degree of blame for competitive behaviour towards government and their funding processes rather than the service providers pushing the competitive threshold. For example, when discussing the financial predicament of some service providers an interviewee who works as a manager frustratingly exclaimed:

I often wonder how they [government] allocate their funds! Really!! (AM5)

Another manager expressed dissatisfaction and blame towards government and the negative impact of competitive tendering processes when he said:

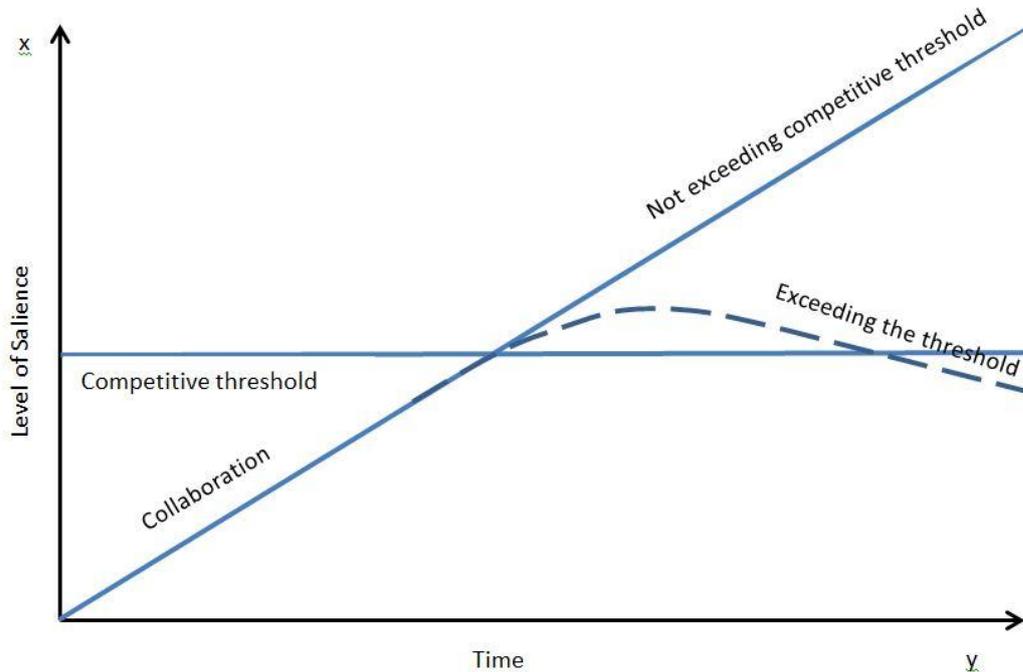
Competitive tendering is something that is actually detrimental to service delivery (GM1).

This research concludes that the point where the competitive threshold, or competitive behaviour to be more salient than other service providers, negatively impacts on collaboration occurs when other service providers perceive that their own salience is at risk due to this competitive behaviour.

Exceeding the competitive threshold has consequences or repercussions for those who risk the salience of others. For example, as identified in the previous chapter, interviewees illustrated a reluctance to be involved in future collaboration with offending service providers. As a result the organisational financial sustainability of offending service providers may become precarious, particularly situations where collaboration is not mandated. Thus, although competitive behaviour initially promotes collaboration, the long-term effects of this behaviour may decrease future opportunities to collaborate. Therefore, this research concludes that competition both promotes and limits collaboration within the youth health sector.

Thus far, it has been shown that competition to be more salient than other service providers initially drives engagement in collaboration but limits collaboration when it risks the salience of others or, in other words, exceeds the competitive threshold. The following diagram (Figure 7.1) depicts the relationship between competing to be more salient than others and collaboration. The X axis depicts the level of salience whilst the Y axis time. Also on the X axis is the competitive threshold that can move up and down depending on the perceptions of service providers. The solid line in the diagram depicts collaboration increasing over time and the positive impact this has on the level of salience of the service providers involved. However, the dotted line in the diagram also depicts the negative impact of exceeding the

competitive threshold for both collaboration and the level of salience for the offending participants.



**Figure 7.1: Competitive threshold**

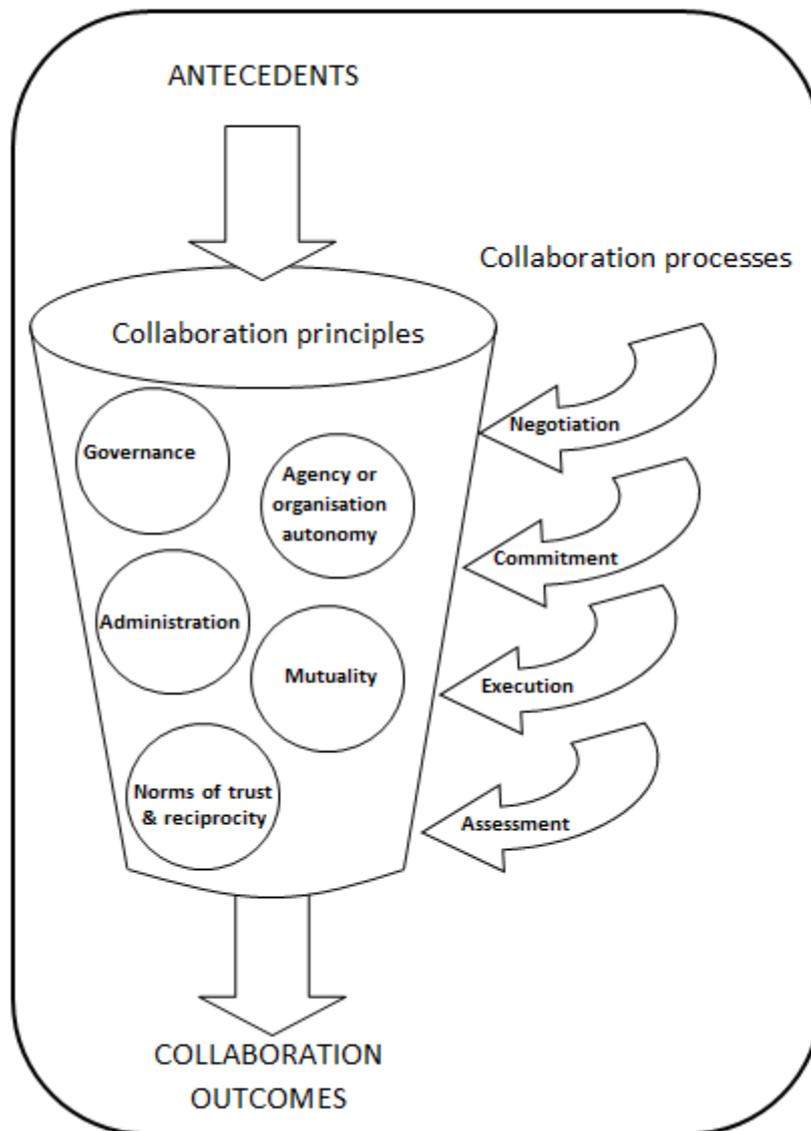
In summary, the research conclusions show that collaboration emphasises inequality between the service providers involved and that inequality can be conceptualised in terms of who is more important or salient when collaborating. It was concluded that when collaboration is enacted within the youth health context where the principles of NPM are entrenched, participants commonly prioritise individual organisational financial objectives when collaborating. Thus collaboration is perceived by service providers to be an opportunity or forum to achieve individual organisational financial goals in addition to collaborative goals. To perpetuate ongoing funding, the research concluded that service providers compete to be more salient or important than other service providers when collaborating. More specifically, service providers compete to develop, maintain or defend some or all of the six characteristics of salience. To do so, it was shown that service providers compete to develop social capital and advantageous collaborative linkages with more eminent or salient stakeholders. Last, it was concluded that competitive behaviour both drives and limits

collaboration and the point where competition begins to limit collaboration can be referred to as the competitive threshold. Now that the research conclusions have been presented the following section outlines the theoretical implications of the findings.

### **7.3 Theoretical implications of the findings**

In this section, the incompleteness of extant collaboration theory to represent and explain how collaboration is enacted within a government-coordinated youth health network is addressed. The analysis process revealed that current collaboration theory does not include all the elements at play for those involved. The lack of reference within collaboration theory to salience and particularly, the competition to be more salient than others when collaborating is dealt with. A new, more complete theory of collaboration that more accurately reflects collaboration when it is enacted or operationalised within a youth health network in western Sydney is presented. The following discussion begins by reiterating extant collaboration theory that was discussed in depth in section 3.3 of the literature review. It then shows that the analysis process revealed that salience is an additional principle of collaboration theory. Last, the final theory of collaboration that was developed as a result of the analysis process is presented. In this more comprehensive theory of collaboration the principle of salience and the process of competition is included to more accurately represent how collaboration occurs within the context of a youth health network where collaboration and the principles of New Public Management (NPM) are concurrently promoted in government policy.

An examination of existing collaboration theory showed that collaboration involves the principles of governance, administration, mutuality, agency or organisational autonomy and norms of trust and reciprocity (Thomson & Perry, 2006; Thomson et al., 2009). It also involves the processes of negotiation, commitment, execution and assessment (Ring & Van de Ven, 1994). The principles and processes of collaboration are presented in Figure 7.2.



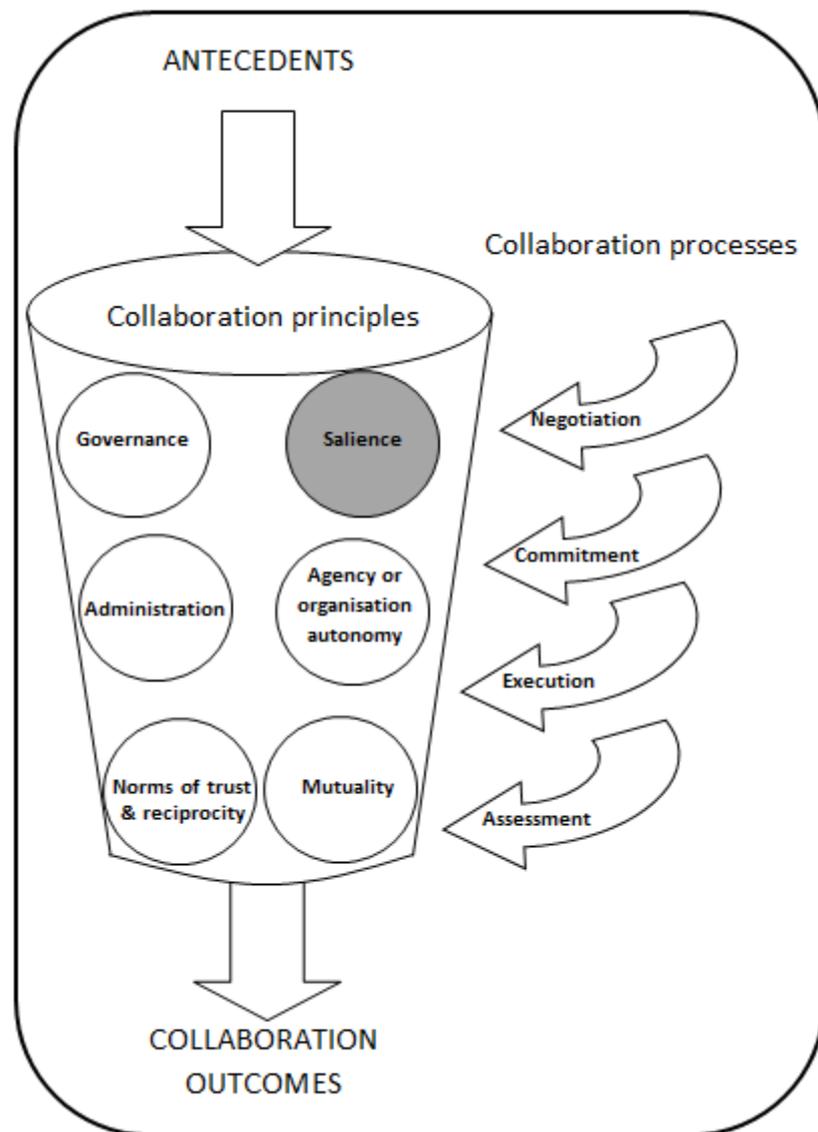
**Figure 7.2: Extant collaboration theory**

*(Adapted from Thomson and Perry [2006] and Ring and Van de Ven [1994])*

A review of the literature relating to collaboration theory showed that collaboration theory is more prescriptive and descriptive rather than explanatory. It lacks depth in explaining how collaboration actually occurs when it is enacted within the youth health sector. Consequently, collaboration theory is inadequate in explaining collaboration when enacted within a context where the principles of NPM, including individual organisational accountability and competitive tendering, are entrenched. To go beyond the prescriptive limitations of

collaboration theory and explain how collaboration is enacted within the youth health sector in a unique and previously unexplored manner, the principles of collaboration, social capital and stakeholder theories were applied in analysis. The application of these principles enabled the researcher to develop the research findings and conclusions presented in this and the previous chapter.

The analysis process showed that for collaboration theory to more accurately depict how participants compete to be more salient or important than others when collaborating, it needed extending and modifying. The following diagram shows how, in addition to the existing principles of collaboration, the researcher adds the principle of *saliency*. Saliency is added because research participants identified, considered and acted upon the inequality in terms of saliency between service providers involved in collaboration. The findings also revealed that when collaborating, participants engage in collaboration to position themselves as more salient or eminent than others and compete to do so. (See Figure 7.3 below.)



**Figure 7.3: Building collaboration theory with salience**

*(Adapted from Thomson and Perry [2006] and Ring and Van de Ven [1994])*

Although salience is considered distinct from the other principles of collaboration there is some overlap. It has some overlap with the agency principle, which involves understanding the management dilemma of achieving individual organisational goals compared to that of network or collective goals (Thomson & Perry, 2006; Thomson et al., 2009). This is because salience primarily relates to the eminence or sway of individual service providers when collaborating to achieve collective objectives. However, the agency principle does not specify

that service providers are considering their salience, sway, or eminence within the collaborative network or the wider youth health sector when formulating collaborative objectives and engagement strategies for collaboration. Nor does the agency principle acknowledge that participants are jockeying or competing to be more salient than others and that in doing so, the polarisation of individual versus collective benefits is insufficient or blurred. Consequently, a whole dynamic at play when collaborating is not considered in collaboration theory.

Although considered distinct from the mutuality principle, which involves the creation of mutually beneficial relationships between stakeholders (Thomson & Perry, 2006; Thomson et al., 2009), salience and mutuality are related. They are related as salience is a feature considered by service providers when developing mutually beneficial relationships. However, the mutuality dimension is unclear in reference to alliances built within a collaborative network as participants compete to make collaborative linkages and develop social capital with salient service providers to the exclusion of others.

Salience is also distinct from the collaborative principles of governance and administration. However, findings showed that having more salience than others gives service providers more influence or sway in terms of decisions associated with governance and administration. For example, a manager from a securely funded salient service provider considered her organisation's ability to influence the collaborative process in her comment as:

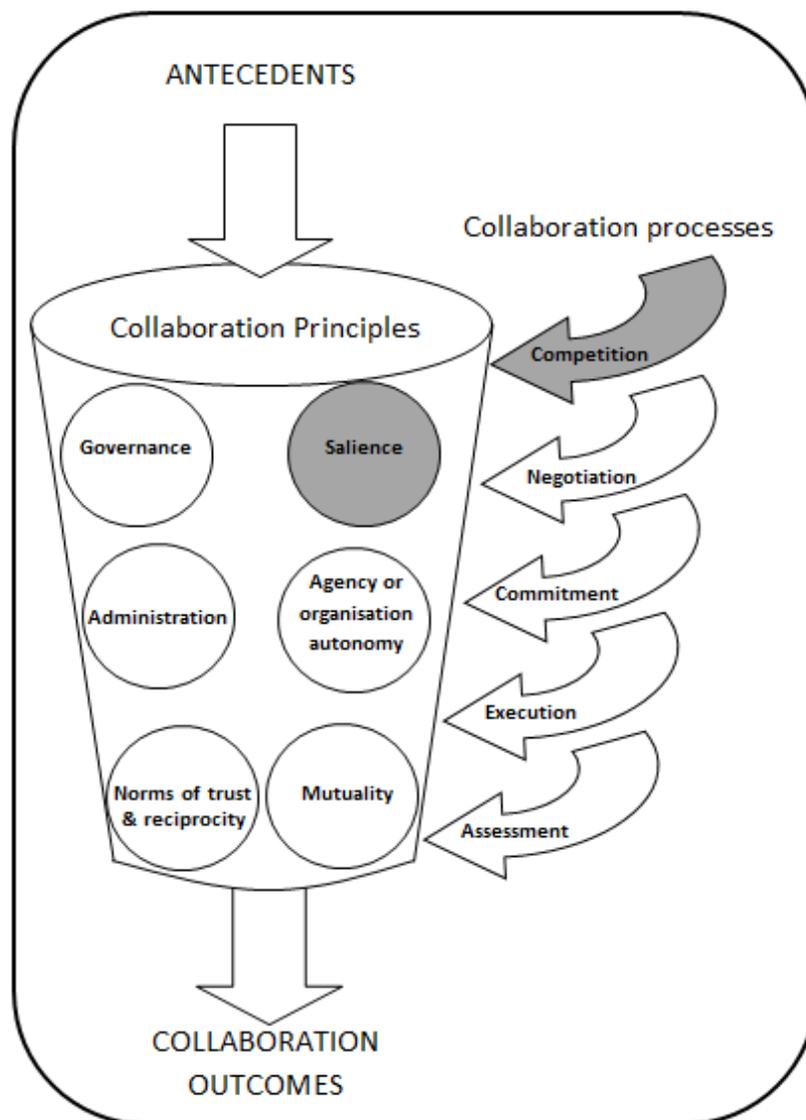
[h]aving the ability or the power to put our own agenda on the table, because we have an agenda (GM5).

Salience also has a degree of overlap with trust and reciprocity (Thomson & Perry, 2006; Thomson et al., 2009) because salience is impacted by trust. For example, one of the characteristics of salience identified in this research, *credibility within the sector*, is impacted by the trust or distrust between participants. However, salience needs to be considered distinct from trust and reciprocity as other characteristics of salience identified, including *links to government*, *access to funding* and the *authority to delegate funding*, do not imply a requirement for trust. For this reason, although salience is impacted by trust it is considered a separate principle of collaboration.

The above discussion related to the inclusion of salience as a principle of collaboration theory. It was shown that although there is a degree of overlap with some of the other

principles of collaboration, salience is distinct and therefore, a principle of collaboration in its own right. The discussion now continues with an explanation of the inclusion of *competition* as a process in collaboration that is separate or distinct from the existing processes of collaboration which are negotiation, commitment, execution and assessment (Ring & Van de Ven, 1994).

Extant collaboration theory is also incomplete as there is no reference that collaboration is a forum and process where participants *compete* to be more salient than other participants. There is also no reference to competition between participants to build advantageous collaborative linkages and social capital between themselves and other salient service providers. For this reason, competition is added to the new theory of collaboration presented in Figure 7.4 below.



**Figure 7.4: Building collaboration with competition and salience**

*(Adapted from Thomson and Perry [2006] and Ring and Van de Ven [1994])*

Although competition is presented separately from negotiation, commitment, execution and assessment, there is a degree of overlap. For example, it could be argued that negotiation is a competitive process where service providers can employ a strategy where competitive motivations can be implemented or employed. However, negotiation does not make a distinction between individual and collective goals nor does it credibly represent or reflect the depth of competition for salience and social capital as revealed by research participants. The

researcher argues that service providers are not negotiating levels of salience when collaborating but are actively involved in competition to be more salient than others. Consequently, the researcher argues for the inclusion of competition in the more comprehensive theory of collaboration that is presented above.

As with negotiation, the processes of commitment, execution and assessment are used to implement competitive strategies used by research participants. For this reason, each is distinctly different from competition and therefore presented separately within the new, more comprehensive theory of collaboration shown above.

The conclusion that collaboration is characterised by competition appears paradoxical, particularly as scholars have traditionally considered collaboration and competition as opposing concepts (Catalano et al., 2002; Entwistle & Martin, 2005; Gordon, 2007; Hoatson & Egan, 2001; Prins, 2010; Stevenson, 2007; Wolfram Cox et al., 1997). However, some scholars have acknowledged a symbiotic relationship between collaboration and competition coining terms such as *coopertition* (Lee et al., 2012; Mascia et al., 2012; Tong & Reuer, 2010; D.J. Watson & Morris, 2008) to better describe competition occurring within a cooperative or collaborative context. Hutter et al. (2011) refer to coopertition as ‘a situation where competitors simultaneously co-operate and compete with each other’ (p. 5), whilst LeTourneau (2004a) provides more contextual detail and defines coopertition as the ‘idea of competitors working together to open markets, develop new products, or improve the market position of all parties involved’ (p. 82). In other words, coopertition refers to building competitive advantage through collaboration (Lombard & Morris, 2010). LeTourneau (2004b) even prescribes strategies for fostering relationships based on coopertition that are similar to those proposed by scholars promoting collaboration, which vary between different authors. Although coopertition has relevance to collaboration as enacted within the youth health sector, it does not reflect all the dynamics at play observed in this research. This is because the external focus of coopertition, particularly in terms of gaining a competitive advantage for the collaborative network through collaboration (Lombard & Morris, 2010), does not adequately explain how or why competition occurs between service providers involved in the collaboration within the context of a youth health network. More specifically, it doesn’t explain how the participants are competing to be more salient than others and to build social capital with salient stakeholders within the collaborative network in order to perpetuate funding opportunities. As such, coopertition lacks depth in terms of describing internal competitive processes at play for those collaborating. However, it does explain the

competitive aspirations of participants at a more macro level. Consequently, this research confirms knowledge of coopertition and collaboration by showing that boundaries between the terms are blurred (Lee et al., 2012).

Other terms such as *communitition* have also been presented by scholars to refer to the symbiotic relationships between competition and collaboration. Hutter et al. (2011) refer to communitition as involving ‘the elements of competitive participation without disabling the climate of co-operation’ (p. 3). Although the scholarly attempts to develop new terminology to better explain the relationship between competition and collaboration have merit, much like definitions of collaboration there is conjecture and disagreement of the exact meaning of each term. There is also conjecture and a lack of clarity regarding their application in different contexts, particularly a government-coordinated youth health network.

Research addressing coopertition or communitition has not been undertaken in the youth health sector nor has it been undertaken in a context where government promotes collaboration in an environment where the competitive principles of NPM are entrenched. Furthermore, collaboration is promoted in youth health policy and within the sector rather than the terms coopertition and communitition.

Although the development of new terms such as coopertition and communitition is of scholarly value, particularly as Wolfram Cox et al. (1997) claims there is a ‘metaphorical drifting’ (p. 286) resulting from the ‘current practice of talking collaboration and walking competition’ (Wolfram Cox et al., 1997, p. 286), the researcher argues that definitions of collaboration should represent this changing focus. The researcher also argues that definitions of collaboration should reflect its current use and how it is perceived by those using it. For example, the term *collaboration* has evolved from when it was negatively associated with the term *collaborators* or the popularised phrase *collaborating with the enemy*, to the more positive connotations as used today. The researcher also argues that the terms coopertition and communitition were not known or considered by research participants indicating their lack of use in contemporary discourse. In addition, as revealed during the research process, research participants believed they were involved in collaboration that for them involved elements of competition. Thus, the researcher claims that scholars should acknowledge and accept the competitive nature of collaboration rather than focus on developing newer and more imaginative terms to describe an activity that those involved in perceive as

collaboration. By presenting a more contemporary collaboration theory that acknowledges the competitive nature of collaboration, this research takes this theoretical objective forward.

In conclusion, the theoretical implications of this research revolve around the discovery that stakeholders compete for salience when collaborating. As a result of revealing the competitive nature of collaboration, the researcher has extended extant collaboration theory. This was done by adding *salience* as a principle of collaboration and *competition* as a process of collaboration to present a more comprehensive theory of collaboration that better reflects how it occurs within the youth health context.

#### **7.4 Definitional implications of findings**

In this section, an extended and more comprehensive definition of collaboration is presented that draws on the theoretical implications for collaboration theory presented in the section above. The researcher argues that definitions of collaboration ought to reflect how collaboration is enacted, which in the case of this research is within the context of a youth health network. As claimed by Wood and Gray (1991), ‘a general theory of collaboration must begin with a definition of the phenomena that encompasses all observable forms and excludes irrelevant issues’ (p. 143). The definition of collaboration presented in this section builds on Thomson and Perry’s (2006) definition of collaboration used in this thesis. It does this by incorporating the revealed findings that participants compete to be more salient or eminent than other participants when collaborating.

For this reason, the researcher presents the following definition of collaboration as a:

process in which autonomous actors and organisations interact through formal and informal negotiation *and competition*, jointly creating rules and structures governing their relationship and ways to act or decide on issues that brought them together; it is a process involving shared norms and mutually beneficial reactions. (*Definition of collaboration developed from Thomson and Perry, 2006 p. 23.*)

This definition of collaboration acknowledges that autonomous actors (which in the context of this research are youth health service providers) formally and informally, and individually and collectively, compete for salience and to develop social capital with other important or salient service providers when collaborating. As the analysis process revealed, competition is considered an aspect of collaboration and is a normative process or behaviour for those involved in collaboration.

Even though the research revealed that participants in collaboration compete to develop social capital with other salient stakeholders, social capital is also implicit in the reference to relationships within this definition of collaboration. Thus, including social capital within the definition would be superfluous.

Although competition is added to the definition of collaboration, the term *saliency* is not. Saliency is not added because it is implicit in determining ‘the rules and structures governing the relationships between participants’ (Thomson & Perry, 2006, p. 23) and impacts on the ‘ways to act or decide on issues that brought them together to collaborate’ (Thomson & Perry, 2006, p. 23). Furthermore, saliency is implicit in shared values and norms that impact on achieving individual and collective goals. Therefore, like the collaborative principles of administration, mutuality, agency and trust (Thomson & Perry, 2006), saliency is not explicit within the definition of collaboration.

In summary, this section presented a more contemporary definition of collaboration that includes the term *competition* to better reflect the phenomenon of collaboration as operationalised with the youth health sector. Therefore, not only has the research allowed the researcher to extend collaboration theory, it also permitted the researcher to present a more complete definition of collaboration that incorporates competition for saliency when collaborating.

## **7.5 Implications for practice**

This research has practical implications for those involved in collaboration as well as governments promoting collaboration in policy.

### **7.5.1 Implications for participants involved in collaboration**

The practical implications for service providers participating in collaboration with competitive characteristics relate to developing *competitive collaboration strategies*. These strategies can allow service providers to develop their saliency and enable them to build social capital with eminent and salient service providers. They can also inform service providers when to expend resources in competing, for example to protect their reputation, and when to save the effort and to achieve shared goals. The following points give direction to youth health service providers involved in collaboration or who are considering engaging in collaborative arrangements within the youth health sector.

### 7.5.2 Assume that some service providers have competitive motivations when collaborating

As collaboration is perceived by service providers as a competitive opportunity to improve their salience and address inequality within the sector, service providers involved in collaboration need to acknowledge that some service providers enter into collaborative arrangements often with a degree of self-interest, particularly in terms of competing to be more salient or influential than other service providers. Service providers should recognise that other service providers are competing to build social capital and relational linkages with stakeholders who they perceive will benefit them in terms of giving them more eminence or sway when collaborating.

### 7.5.3 Assess and classify service providers according to their salience

Service providers can envisage or conceptualise the competitive behaviour of other service providers by assessing or classifying their levels of salience. Service providers can also assess and classify their own levels of salience in order to develop their own competitive collaboration strategy.

Table 7.2 assists service providers to assess and classify service providers based on who matters more or who is more salient when collaborating.

**Table 7.2: Stakeholder classification**

	<b>More salient stakeholders</b>	<b>Less salient stakeholders</b>
<b>Mechanistic characteristics of salience</b>	Definitive stakeholders	n/a
<b>Organic characteristics of salience</b>	Definitive stakeholders Aspirational stakeholders	Distressed stakeholders

This table classifies service providers into three groups depending on their possession of mechanistic and/or organic characteristics of salience and the degree to which they are more or less salient in relation to collaboration:

1. First are *definitive stakeholders*. Definitive stakeholders are the most salient service providers when collaborating as they possess the mechanistic characteristics of

salience and hence are likely to be government service providers. They are also likely to possess at least some of the organic characteristics of salience due to increased access to funding which allows them to better deliver youth health services and gain a credible reputation for delivering youth health services. Definitive service providers matter the most when collaborating as aspirational and distressed service providers are motivated to collaborate with them in order to perpetuate future funding opportunities and build their own salience or sway within the sector. Definitive stakeholders are concerned with protecting their influence within the sector and have the ability to choose which stakeholders to collaborate with to maintain their position.

2. Second are *aspirational service providers*. Aspirational service providers possess developed organic characteristics of salience and are more likely to be non-government service providers. By having the organic characteristics of salience, their future financial sustainability is more assured than the distressed service providers, but not as assured as definitive stakeholders. Due to possessing the organic characteristics of salience, aspirational service providers commonly compete with other aspirational and distressed service providers to build collaborative linkages and social capital with definitive stakeholders in order to increase their own salience and gain better access to government funding. Definitive service providers may also make efforts to build social capital with aspirational service providers as aspirational service providers have the ability and credibility to assist in delivering collaborative youth service goals. Consequently, aspirational service providers have a competitive advantage over distressed service providers when collaborating due to having high levels of organic characteristics of salience. Aspirational stakeholders have the ability to use their competitive advantage to maintain and develop their sway or influence within the sector possibly to the detriment of others, particularly other aspirational service providers and distressed service providers.
3. The third group are *distressed service providers*. Distressed service providers have low salience or underdeveloped organic characteristics of salience. They are distressed because definitive or aspirational service providers do not compete with each other to build social capital and develop collaborative linkages with them. The lack of interest from definitive and aspirational service providers relates to distressed service providers being less likely to perpetuate funding opportunities or assist in the promotion of salience. Distressed service providers are potentially in a financially precarious position as they are less likely to be invited to join collaborative networks

or be involved in successful competitive tendering bids and thus they are more likely to push the competitive threshold. Distressed service providers benefit most from mandated or enforced collaboration associated with some competitive tendering processes as it offers them an opportunity to compete for salience and social capital and to gain funding.

In this section service providers were classified into three groups depending on the level of salience or sway within the sector and their possession of mechanistic and/or organic attributes of salience.

#### **7.5.4 Propensity to engage in competitive behaviour when collaborating**

Now that service providers are classified based on their salience within the sector, in this section the researcher discusses the propensity of each group to exceed the competitive threshold when collaborating.

Possessing both mechanistic and organic characteristics of salience, *definitive service providers* are less likely to exceed the competitive threshold. They are less likely to be concerned about losing salience particularly due to possessing the mechanistic characteristics of salience, which are determined more by bureaucratic systems and structures rather than individual organisational influences. In addition other less salient service providers are competing to develop working relationships with them and therefore helping to maintain their salience or sway when collaborating. However, with changing government priorities, salience is not assured in the long term even for definitive stakeholders and thus definitive stakeholders may make efforts to protect their influence or salience within the sector. This is done by assessing the ability of other service providers to achieve collective outcomes and engaging in closer relationships with those who they perceive can.

By possessing the developed organic characteristics of salience, *aspirational service providers* are likely to compete with other aspirational and distressed service providers to build linkages and social capital with definitive service providers or other highly salient aspirational service providers. Aspirational service providers are likely to have some level of competitive focus when collaborating as they are concerned about ongoing financial sustainability. Aspiring to develop their influence within the sector, aspirational service providers are likely to compete with other organisations to develop further their organic characteristics of salience and possibly develop mechanistic characteristics of salience so that

they are considered important or influential by definitive stakeholders and funding bodies. However, due to already possessing developed organic characteristics of salience, aspirational service providers may also be less likely to exceed the competitive threshold as they potentially may risk their standing or credibility within the sector.

Due to their dire financial predicament and their lack of salience, *distressed service providers* are more likely to prioritise individual organisational financial priorities before that of collective goals and engage in competitive behaviour to help address the inequality between themselves and other service providers. This was evidenced by financially challenged service providers that pushed the competitive threshold by reporting undeserved collaborative outcomes as their own. Distressed service providers have less salience to risk and much to gain from competitive behaviour when collaborating and are more likely to exceed the competitive threshold in a desperate bid to improve their salience and ability to access funding.

This section relating to the propensity of definitive, aspirational and distressed service providers to engage in competitive behaviour to be more salient than others indicates an inverse relationship between levels of salience and the propensity to engage in competitive behaviour. This relationship is illustrated in Table 7.3.

**Table 7.3: Stakeholders’ propensity to engage in competitive behaviour**

<b>Service provider classification</b>	<b>Stakeholder propensity to engage in competitive behaviour</b>
Definitive service provider (high salience)	Low (protecting rather than building salience, less likely to exceed the competitive threshold)
Aspirational service provider (moderate-to-high salience)	Moderate (protecting and building salience, likely to be competitive or use their salience for competitive advantage but less likely to exceed the competitive threshold)
Distressed service provider (low salience)	High (highly competitive due to concerns relating to financial sustainability and more likely to exceed the competitive threshold)

In summary, definitive service providers are less likely to exceed the competitive threshold, aspirational service providers are likely to engage in moderate levels of competitive behaviour and distressed service providers are more likely to exceed the competitive threshold.

#### **7.5.5 Develop strategies of engagement to build or maintain salience within the sector**

In this section, potential competitive collaboration strategies for definitive, aspirational and distressed service providers are suggested.

*Definitive service providers* can use their influence to assist aspirational and distressed service providers who they feel can better contribute to achieving youth health service delivery goals and maintain their influence and position when collaborating. Alternatively, definitive service providers can also use their influence or sway to make it difficult for those who are not contributing adequately to the collaboration or are a destructive influence when collaborating. However, as definitive stakeholders are commonly government service providers, their position of influence should not be abused as potential distrust from non-government organisations may ultimately hinder collaborative engagement, positive youth health outcomes and in the long term, their own level of salience.

Although *aspirational service providers* have developed levels of salience and thus have some competitive advantage as compared to distressed stakeholders, their salience requires maintenance and protection from other service providers, particularly as there is only limited funding for the sector. The researcher recommends that relationships and social capital with definitive service providers need to be fostered and developed. In other words aspirational service providers need to strengthen bonding social capital in existing relationships with definitive service providers and build bridging social capital with other definitive or highly salient aspirational service providers. Aspirational service providers also must consider that although other aspirational service providers may assist them to gain salience, they may also be competing with them to gain favour with definitive stakeholders and funding organisations.

Aspirational service providers can also utilise the resources of distressed service providers who may make efforts to collaborate with them. However, due to being less salient or influential within the sector, there is some risk when collaborating with distressed service providers.

For *distressed service providers*, collaboration must be considered an opportunity to improve their low levels of salience. Distressed stakeholders need to consider which service providers to collaborate with that offer them the maximum benefits in terms of gaining salience and funding. They can compete to develop social capital with other eminent or salient service providers, in particular definitive service providers, so that this can be leveraged for future financial gain. However, distressed stakeholders need to consider that exceeding the competitive threshold may negatively impact on their financial sustainability, particularly as they have low salience to begin with. Distressed service providers should also focus on networking with definitive stakeholders and funding organisations to increase opportunities to be included in competitive tendering bids that mandate or enforce other definitive and aspirational service providers to collaborate with them.

In this section relating to the implications for practice, it was suggested that service providers classify other service providers in order to identify their propensity to engage in competitive behaviour when collaborating. Strategies for engaging in competitive collaboration were also suggested for service providers within the youth health sector.

## 7.6 Implications for government policy

This research showed that collaboration can successfully occur when government promotes collaboration and competition simultaneously in policy. It also showed that collaboration can successfully occur in a context where the principles of NPM are entrenched. This research showed that youth health policy promoting collaboration gave little reason for research participants to engage in collaboration yet the altruistic values it promoted did. Due to considerations of financial sustainability, policy promoting competitive tendering did give research participants a reason to collaborate, as did mandated collaboration as a condition of competitive tendering processes. Therefore, this research provides empirical evidence that competitive tendering policies and practices, offering financial incentives and mandating or enforcing collaboration as a condition of tendering processes, successfully promote collaboration. It also shows that government *can* promote collaboration and competition in policy simultaneously and that competition does drive engagement in collaboration, albeit only to a level accepted by participants. This finding contrasts with the view of some scholars who claim that competition exacerbates antagonisms amongst those collaborating and only negatively impacts on collaboration (Stevenson, 2007). However, this research shows that competition to be salient or eminent within the sector can drive collaboration as long as the competitive threshold is not exceeded resulting in distrust and diminished social capital between participants. Therefore, there is a degree of risk when promoting both collaboration and competition because competition can ultimately limit collaboration.

The strategy of the NSW Government to promote both collaboration and competition within government policy also maintains the salience or importance of government youth health service providers as they can be classified as definitive stakeholders. Therefore, not only is government influencing the behaviour and sustainability of service providers through funding allocation but it also indirectly influences the sustainability of non-government service providers by enabling definitive government service providers to assess the ability of NGOs to achieve government youth health priorities by making choices on whether to build collaborative linkages with them. In other words, in the context of youth health, the ongoing organisational survival of NGOs is impacted by their ability to continue collaborating with government service providers in order to perpetuate funding opportunities. Therefore, by promoting collaboration in a competitive context where service providers use collaboration as an opportunity to compete for salience in order to gain funding, the influence of government is maintained or even expanded.

In summary, the simultaneous promotion of collaboration and competition in policy successfully promotes collaboration within the youth health sector and promotes the importance of government service providers.

### **7.7 Limitations of the research**

Although this research comprehensively explores collaboration when operationalised within in a western Sydney youth health network and identifies and examines the competitive character of collaboration, there are some limitations to the research. First is the complexity of understanding human behaviour. Second is the complicated relational nature of collaboration and third is conjecture concerning what collaboration constitutes. For these reasons, the focus of the research was clear in scope. For example, the research does *not* explore the impact of collaboration on users of youth health services or evaluate the effectiveness of youth health services for those in need. Rather, it explains how collaboration occurs for, and is perceived by, those delivering youth health services and involved in collaboration. As such, the views of clients and their families who are sometimes involved in collaborative decision making regarding their clinical treatment are not included. In addition, it was surmised that users of youth health services are unlikely to be privy to the underlying willingness or reasons why service providers engage in collaboration or how they develop collaborative engagement strategies.

Those working in government funding organisations were also not included in this research and they also are not part of the network of organisations delivering youth health services within western Sydney.

In summary, the researcher argues that the complexity of human behaviour does not limit this research but presents exciting future research opportunities. For example, to address the complexity of human behaviour when examining inter-firm cooperation, Parkhe (1993) suggests a messy research approach that converges ‘hard’ methodological approaches with ‘soft’ behavioural variables. Although such methodology has merit, by having a clear research focus and scope and using a multi-case study research framework involving progressive comparison analysis, this research has realised an opportunity to better understand collaboration occurring within the context of youth health. Future research opportunities arising from this research are discussed in the following section.

## 7.8 Opportunities for future research

The research conclusions collated in this thesis provide future research opportunities. Future research opportunities include:

1. The competitive nature of collaboration requires further understanding, particularly in different contexts with different influencing factors and contextual peculiarities. Research is required to understand the characteristics of salience better, including whether they are relevant to other contexts and situations. This will identify other classifications or subclassifications that may be useful when examining collaboration occurring in different contexts. Determining and validating the importance of identified characteristics of salience will also increase understanding relating to who matters most when collaborating.
2. This research has highlighted the influence of reputation in collaboration. Reputational collaboration requires further research, particularly in terms of one organisation with a highly positive reputation managing other less well-considered 'subcontractors'. Furthermore, the impact of outsourcing based on reputation could be explored further in terms of quality of services delivered and how reputational influences are impacted in an environment of NPM.
3. Viewpoints from government policy makers concerning competitive collaboration could be collated and compared to the reality of those involved in collaboration within the youth health sector. Doing so will identify and understand further congruence or incongruence between government policy makers or funding organisations and those involved in collaboration and the impact this has on collaborating to deliver youth health services.
4. The research showed that the competitive threshold is subjective depending on the perceptions of those involved. The researcher argues that future research should examine whether the competitive threshold varies in different contexts and why. Further research is required to understand how the threshold can be managed so as to achieve better collaborative outcomes.
5. This research showed the benefits of examining collaboration using different theoretical principles associated with collaboration, stakeholder and social capital theories. The researcher calls for future researchers to apply different theories or theoretical principles when analysing collaboration, particularly the competitive characteristics of collaboration. For example, complexity theory could be used to

examine the competitive characteristics of collaboration in a chaotic relational context.

6. The very conceptualisation of collaboration needs further investigation. This research has showed that collaboration is impacted by the perceptions and competitive actions of those involved, which appear fluid. This implies that rather than being separate from the emotions and views that impact on its enactment, future research could focus on whether collaboration is, in fact, an emotion itself. Such research could be extended beyond management research to areas of organisational behaviour and psychology.

The complicated nature of human working relationships when collaborating and the ever-changing nature of people's values and contexts in which collaboration occurs present ongoing opportunities for research into collaboration. This research has shown that contemporary environments impact on collaboration and the context of the youth health sector provided an opportunity to advance collaboration theory, particularly as within this context competitive principles and collaboration are concurrently promoted in policy. By utilising the principles of collaboration, social capital and stakeholder theories, this research was able to reveal that service providers compete to matter more or be more salient than others when collaborating.

In conclusion, it is argued that research should continue into collaboration to present explanations of how and why collaboration occurs and how collaboration can better deliver positive solutions to complex problems. It needs to utilise the new theory and definition of collaboration presented in this research and to advance the practical collaborative strategies suggested. Future researchers need to capitalise on and progress the knowledge of collaboration developed through this research which involved the researcher reconceptualising or rethinking collaboration to reveal that that service providers compete to win salience when collaborating or conversely lose favour when they fail to collaborate effectively.



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## **Appendices**



## **Appendix A: Summary of participant organisations**

### **Government organisation 1**

This government organisation is involved in protecting and promoting the health and wellbeing of young people in NSW by partnering with healthcare, non-government, education, academic, and community and advocacy bodies to ensure better adolescent health outcomes. Its mission includes:

- developing information and resources to increase knowledge and understanding of youth health issues
- capacity building to increase organisational skills and confidence in addressing young people's health needs
- supporting applied research and promoting better practice in youth healthcare
- supporting advocacy and policy development to increase leadership and action for adolescent health.

This organisation provides a number of services including:

- developing resources
- professional development
- applied research
- advocacy and policy development.

This organisation has a small core team consisting of only six personal but also includes a number of specialist consultants. All but one staff member in an administration role are very experienced in youth health service provision with the management team very accomplished and known throughout the youth health sector. Most staff members including management and health promotional staff have had previous management and clinical positions prior to their current roles and have extensive knowledge of the youth health sector. Their coordination function within the sector and their influence in developing policy help make this organisation key to achieving the successful outcomes of this research.

This securely funded, government-appointed coordinating organisation considers itself a peak youth health coordinating agency in NSW. However, it is not membership based as compared

to some other coordinating bodies. Its premises, although reasonably small, are well appointed.

## **Government organisation 2**

This government-funded organisation is primarily involved in youth health service provision, both clinical and administrative, within western Sydney under the catchment area of the Sydney West Area Health Service (SWAHS). It works with young people aged 12–24 years (and their significant others) and prioritises the needs of marginalised, homeless and at-risk young people. This organisation provides a range of specialised services to effectively meet the health needs of young people and works to build the organisational capacity of SWAHS to respond appropriately to the range of health needs required by young people. Services provided include:

- health workers on duty
- health education and information services
- health promotion
- referral services
- advocacy and support for young people and their needs
- medical and clinical services
- nursing
- counselling
- coordinating and group work
- community training.

This organisation has a diverse work force, including youth workers and youth counsellors, nurses, administration staff and managers who also have a clinical background. Staff is predominantly female but there is some experienced male staff on their roster. This service has approximately ten full-time staff with additional medical staff such as general practitioners and nurses working on a part-time basis. Its work force ranges in ages and demographics with most being highly experienced within the sector.

This organisation is well established and has been in operation for approximately twenty years with a history of delivering health services effectively. The organisation's building is a demountable structure and in reasonably poor condition but well used. It is situated in a highly busy and visible area of a socially disadvantaged suburb with high social problems.

### **Government organisation 3**

This organisation is a publicly owned healthcare clinic funded by the NSW Department of Health under supervision of Sydney West Area Health Service (SWAHS). It is part of the Primary Care and Community Health Network and commonly works with the organisation above to focus on the health needs of all young people aged 12–24 years (and their significant others) connected to the SWAHS catchment area. This organisation prioritises the needs of marginalised, homeless and at-risk young people.

This organisation provides a range of specialised services to effectively meet the health needs of young people and works to build the organisational capacity of SWAHS to respond appropriately to young people. Services provided include:

- worker on duty
- basic needs services (food, showers, laundry, short-term lockers)
- internet access
- health education and information
- health promotion
- referral, advocacy and support
- medical (GP) clinic
- dental clinic
- nursing
- counselling (generalist, art therapy and AOD)
- key work (including quit smoking support)
- group work
- community training.

This organisation has a range of staff including administration staff, youth health workers, counsellors, psychologists and managers who also have a clinical background. Other medical staff, including general practitioners and nurses, work at this organisation on a temporary basis. The organisation has a core full-time staff of six people ranging in ages but most are under the age of 40 and predominantly female. However, they are all experienced workers with experience ranging from five to twenty years working within the sector.

The building is located on a quiet street in a low socioeconomic area but appears well funded, equipped and clean.

## **Government organisation 4**

Part of the Youth Mental Health Initiative (YMHI), this Commonwealth-funded organisation focuses on the mental health and wellbeing of all Australians with a particular emphasis on addressing youth mental health. This organisation is part of a network of centres that provide services to young people across Australia that are located in every state and territory and cover metropolitan, regional and rural locations. Each centre provides support, information and services to assist young people and their families. Services are provided at a community level by a consortium of service providers addressing specific needs of young people, including allied health, drug and alcohol workers and mental health practitioners.

This organisation offers young people access to information, support and a broad range of health services. It supplies services relating to:

- general health
- mental health and counselling
- education, employment, housing and other services
- alcohol and other drug services
- sexual health services

This organisation has a core staff of six that include administration staff, mental health workers, caseworkers and a manager with clinical experience. The team appeared young with on average five to ten years experience each, not including the manager, who had over ten years working within the sector. The centre appeared well equipped and resourced and was co-inhabited by another health service provider. The centre was located in a busy thoroughfare in a socially disadvantaged area.

## **Non-government organisation 1**

This non-government organisation is funded by Family Planning NSW. Funding comes from the Commonwealth Department of Health and Aging through the Public Health Outcome Funding Agreement and the NSW Department of Health through the non-government organisation program. Funding is also generated through the sale of goods and services associated with reproductive and sexual health. This independent not-for-profit organisation is responsible to a voluntary board of directors.

This service provides reproductive and sexual health services to men and women of all ages in the western area of Sydney but due to the nature of services provided and the demographics of the area in which it is situated, there is often an increased focus on youth.

Services provided include:

- information and provision of contraception (including IUD and contraceptive implant insertion [Implanon NXT<sup>®</sup>] and diaphragm fitting)
- emergency contraception
- sexual health and safer sex information
- assessment, testing and treatment of Sexually Transmissible Infections (STIs)
- fertility assessment and referral
- pregnancy tests, information and counselling regarding pregnancy options and pre and postnatal checks
- pap tests (cervical cancer screening) and breast awareness information
- assessment and management of menstruation and bleeding problems
- menopause information and management
- referrals for vasectomy and tubal ligation
- meeting room and emergency accommodation facilities
- health promotion programs and education sessions can be delivered to schools and other community groups in Penrith and surrounding areas
- young parents network
- accredited training and education courses.

This organisation is situated in a standalone building and has large, well-equipped facilities including temporary accommodation. It has a core staff of seven workers including administration staff, youth caseworkers, health promotion officers and managers. General practitioners and other specialist medical staff also attend the centre on a part-time basis. The work force is female who range in experience within the sector and age.

## **Non-government organisation 2**

This organisation is a non-government organisation that receives the bulk of its funding from a faith-based organisation. This organisation focuses on addressing youth health issues, particularly youth homelessness. This organisation takes a holistic approach to youth health service provision and includes services relating to:

- domestic violence
- sexual assault
- alcohol and other drug abuse
- education
- gang violence and crime
- early intervention case management
- therapeutic counselling
- referral services
- practical assistance
- art therapy program.

This organisation is based in a retail area of western Sydney and although the offices are relatively small, they are well appointed and equipped. It has a core staff of five including management, youth caseworkers and counselling staff and a part-time administration officer. The staff is experienced, having a minimum of five years and a maximum of twenty years experience within the sector. The staff is predominantly female.

### **Non-government organisation 3**

This non-government organisation attains its funding from a number of sources including the Nepean Division of General Practice. This small organisation consists of only three staff who operate on a part-time basis. This includes a manager with a clinician role, a doctor and an administrative person. This organisation primarily provides clinical and medical services to youth in need. They also provide referral services for those youth identified with particular health requirements.

This small organisation has limited and unsecure funding and the offices used are small and resources limited. However, the clinical staff is very experienced, with each having over twenty years working within the sector. All staff are female.

## Appendix B: Research advertisement

  
University of  
Western Sydney

### Collaboration and the Youth Health Sector

**Study Title: Network Collaborations in Health Policy: Is it Window Dressing?**

**Who am I?**  
Warwick Wearing, doctoral candidate at the University of Western Sydney.

**What is the research is about?**  
Collaboration within the NSW youth health sector

**Why is this important?**  
This is important for **youth health services** because the project can...  

- Identify effective collaboration in the sector
- Understand what helps and hinders these collaborations
- Help services strengthen existing collaborations
- Raise the profile of youth health services

  
This is important for **youth health policy** because the project can...  

- Inform the development of the policy, with particular reference to collaboration within and beyond the youth health sector
- Identify the government support required to bolster collaboration

  
This is important for **young people** because the project can...  

- Increase access to youth health services

**Who can be involved?**  
Managers, youth service providers and administrative staff from organisations involved in youth health services in western Sydney

**What does participation involve?**  
Allowing me to:  

- Visit the service to understand how it operates and how it works with other services
- Consult with team members to learn how they collaborate with others

**How can I get involved or learn more?**  
Contact:  
Mr Warwick Wearing, Doctoral Candidate  
Centre for Industry and Innovation Studies (CIIS) Research Group  
University of Western Sydney  
✉ [W.Wearing@uws.edu.au](mailto:W.Wearing@uws.edu.au)  
☎ 0404 887 504  
or  
Dr Ann Dadich (Supervisor and Research Lecturer) on: Telephone or email  
✉ [a.dadich@uws.edu.au](mailto:a.dadich@uws.edu.au)  
☎ (02) 9685 9473

This Research project has been approved by the Western Sydney Local Network Human research Ethics Committee  
Version: 2  
Date: 21<sup>st</sup> April 2011

SWAHS (Westmead Campus) Human  
Research Ethics Committee

APPROVED

can... 13.5.11

## Appendix C: Information sheet and consent form

### PARTICIPANT INFORMATION SHEET AND CONSENT FORM

**Study Title:** Network Collaborations in Health Policy: Is it Window Dressing

UNSW Western Sydney Human  
Research Ethics Committee

APPROVED

Date: 13.5.11

#### Chief Investigator

#### Invitation

You are invited to participate in a research study into inter-organisational or network collaboration.

The study is being conducted by: Warwick Wearing (PhD student, School of Management, College of Business, University of Western Sydney).

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

#### What is the purpose of the study?

The purpose of this study is twofold. Firstly, to understand the process of collaboration within an inter-organisational network where there is collaboration promoted in policy and secondly, to provide mechanisms that will assist in facilitating collaboration.

#### Who will be invited to enter the study?

You are invited to participate in this study because you are employed in an organisation involved in the delivery of youth health services within the western Sydney youth health network.

#### Do you have a choice?

I acknowledge that refusal to take part in this study will not affect my employment

#### What will happen on the study?

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. This study will be conducted over the next two years. Participation involves taking part in a semi-structured interview of approximately 45 minutes. This interview includes questions relating to collaboration and collaborative practices. It also involves being observed whilst involved in collaboration and collaborative practices within the work environment over a one month period

#### Are there any risks?

There are minimal, if any foreseeable risks to the individuals who participate in this research project. This is because participants are only required to give their perceptions of collaboration and collaborative work practices. As such, they are not required to disclose any personal information or discuss any potentially traumatic issues.

#### Are there any benefits?

Research participants/practitioners may better understand:

1. How to translate policy about collaboration into practice
2. The factors that help and hinder collaboration
3. Ways to optimise the effective and efficient management of their respective services through collaboration

## PARTICIPANT INFORMATION SHEET AND CONSENT FORM

**Study Title:** Network Collaborations in Health Policy: Is it Window Dressing

### **Confidentiality / Privacy**

All research participants will be de-identified throughout the research process by the use of codes or fictitious names. All aspects of this study, including results, will be confidential and only the researchers listed above will have access to information on participants. A report of the study will be submitted for publication, but individual participants will not be identifiable in such a report. All collected data will be held securely at the University of Western Sydney.

### **Will taking part in this study cost me anything, and will I be paid?**

Participation in this study will not cost you anything.

### **What happens with the results?**

If you give us your permission by signing the consent document, we plan to discuss/publish the results as a thesis. In addition, results will be disseminated in appropriate peer reviewed academic and industry journals and at appropriate academic and industry forums and conferences. In any publication, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

### **Complaints**

This study has been approved by Western Sydney Local Health Network Human Research Ethics Committee. If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact:

### **Contact details**

When you have read this information, the researcher Warwick Wearing will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact Warwick Wearing on phone 0404887504. If you have any problems while on the study, please contact Warwick Wearing. Working Hours phone number 0404887504. After Hours phone number 0404887504 (NS 2.2).

**Thank you for taking the time to consider this study.**

**If you wish to take part in it, please sign the attached consent form.  
This information sheet is for you to keep.**

## PARTICIPANT INFORMATION SHEET AND CONSENT FORM

**Study Title:** Network Collaborations in Health Policy: Is it Window Dressing

### CONSENT TO PARTICIPATE IN RESEARCH

#### Chief Investigator:

1. I understand that the researcher will conduct this study in a manner conforming to ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.
2. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Warwick Wearing and I, being over the age of 16 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.
3. I acknowledge that I have been given time to consider the information and to seek other advice.
4. I acknowledge that refusal to take part in this study will not affect the usual treatment of my condition.
5. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.
6. I acknowledge that this research has been approved by the Western Sydney Local Health Network Human Research Ethics Committee.
7. I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

*Before signing, please read 'IMPORTANT NOTE' following.*

#### IMPORTANT NOTE:

*This consent should only be signed as follows:*

1. *Where a participant is over the age of 16 years, then by the participant personally.*

Name of participant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of participant \_\_\_\_\_

Signature of participant \_\_\_\_\_ Date: \_\_\_\_\_

Signature of researcher \_\_\_\_\_ Date: \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date: \_\_\_\_\_

# Appendix D: Ethics approval documents

## Western Sydney local health network ethics approval document



**HREC Committee Secretariat**  
Professor Stephen Leader AO  
Chair  
Professor of Public Health &  
Community Medicine

Dr Jani Hoad  
Secretary  
Medical Director  
Epidemiologist

**HREC Committee Members**

Dr Patricia Bellamy PhD  
General Practitioner

Ms Theresa Burke  
General Practitioner

Ms Patricia Fry  
General Practitioner

Mr John Fisher  
Lawyer

Dr Doug Godfrey  
University Science Graduate

Ms Alan Guyone Lewis  
Public Health Officer

Dr Anthony Hayes  
Medical Director - Psychiatry

Ms Sheila Henderson  
CEO - GP Network

Ms Ann Kemp  
Clinical Health Institute

Assistant Manager  
Healthcare and Biomedical

Ms Sarah Chesser  
Member of Parliament

Mr John Stone  
Lawyer

Dr Geoff Emsel  
Medical Director - Surgery

Dr Howard Smith  
Medical Director - Endocrinology

Prof Stephen Wang  
Medical Director - Paediatrics

Ms Shane Watson  
Lawyer

Ms Christine Howard  
Clinical Psychologist

Our Ref: **HREC2011/3/4.10(3279) AU RED HREC/11/AVMEAD/35**

13 May 2011

Mr Warwick Wearing  
58 Raymond Avenue  
Campbelltown NSW 2560

Dear Mr Wearing

**Project Title: Network collaborations in health policy: is it window dressing?**

Thank you for your letter dated 21 April 2011 addressing the matters raised in the Western Sydney Local Health Network HREC's letter dated 6 April 2011 following single ethical review of the above project at its meeting held on 29 March 2011.

This HREC has been accredited by the NSW Department of Health as a lead HREC to provide the single ethical and scientific review of proposals to conduct research within the NSW public health system. This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ACH Note for Guidance on Good Clinical Practice*.

I am pleased to advise that the HREC has now granted ethical approval of this multicentre research project to be conducted by you / A/Prof Annika Fitzgerald at:

• [Redacted]  
• [Redacted]  
• [Redacted]

The following documentation has been reviewed and approved by the HREC:

- NEAF submission code AU/1/EE46018
- Protocol / Confirmation of Candidature
- Revised Master Participant Information and Consent Form Version 2 dated 21 April 2011
- Recruitment Poster Version 2 dated 21 April 2011

Please note the following conditions of approval:

- The Coordinating Chief Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- The Coordinating Chief Investigator will immediately report any protocol deviation / violation, together with details of the procedure put in place to ensure the deviation / violation does not recur

**HUMAN RESEARCH ETHICS COMMITTEE**  
Research Office, Room 1012, Level 1, Education Block,  
Westmead Hospital, Hawkesbury Road, Westmead NSW 2145

Telephone: 02 9545 8133  
Facsimile: 02 9545 8552  
Email: ResearchOffice@westmead.health.nsw.gov.au

Western Sydney Local Health Network  
ABN: 41 702 291 764

Level 2, Dental School, Westmead Hospital  
Darcy Street, Westmead NSW 2145  
PO Box 61, Parramatta NSW 2151  
Tel: (02) 643 7026 Fax: (02) 6469 2581

Providing health services to the communities of Auburn • Baulkham Hills • Blacktown • Hornsby • Parramatta

- Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, must be provided to the HREC to review in the specific format. Copies of all proposed changes must also be provided to the relevant Research Governance Officer.
- The HREC must be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
- The Coordinating Chief Investigator must provide an annual report to the HREC and a final report at completion of the study, in the specified format. HREC approval is valid for 12 months from the date of final approval and continuation of the HREC approval beyond the initial 12 month approval period is contingent upon submission of an annual report each year. A copy of the Annual / Final Research Report Form can be obtained electronically from the Research Office on request.
- It should be noted that compliance with the ethical guidelines is entirely the responsibility of the Coordinating Chief Investigator.

You are reminded that this letter constitutes *ethical approval only*. This research project must not be commenced at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained. Copies of this letter, together with any approved documents as enumerated above, must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any queries about the HREC's Terms of Reference, Standard Operating Procedures or membership, please contact the HREC Executive Officer through the Research Office on 9845 8183 or emailing [researchoffice@swahs.health.nsw.gov.au](mailto:researchoffice@swahs.health.nsw.gov.au).

In all future correspondence concerning this study, please quote approval number **HREC2011/3/4.10(3279) AU RED HREC/11/WMEAD/36**.

The HREC wishes you every success in your research.

Yours sincerely



Ms Tina Goddough  
HREC Executive Officer  
WSLHN Human Research Ethics Committee

## University of Western Sydney ethics approval document

### UWS HUMAN RESEARCH ETHICS COMMITTEE

31 May 2011

Associate Professor Anneke Fitzgerald,  
School of Management

Dear Anneke and Warwick,

I wish to formally advise you that the Human Research Ethics Committee has ratified your research proposal H9147 *Network collaborations in health policy: Is it window dressing?*, until 1 February 2015 with the provision of a progress report annually and a final report on completion.

Please quote the project number and title as indicated above on all correspondence related to this project.

This protocol covers the following researchers:  
Anneke Fitzgerald, Ann Dadich, Louise Kippist, Warwick Wearing.

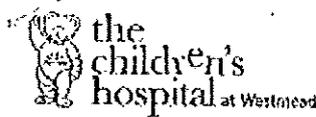
Yours sincerely



Dr Anne Abraham  
Chair, UWS Human Research Ethics Committee

*[Faint signature]*

Western Sydney local health network ethics site-specific approval documents



The Sydney Children's  
Hospitals Network  
*(Research and Development)*

**Research and Development  
Contact for this correspondence:**  
Name: Liza Nadolska  
Email: [Liza@chw.edu.au](mailto:Liza@chw.edu.au)  
Phone: (02) 9845 1272  
Facsimile: (02) 9845 1317

Cover Hawkesbury Road  
Frd Harroworth Street  
Locked Bag 1001  
Westmead 2145 NSW 2145  
Sydney Australia  
DX 8213 Parramatta  
Tel 181 2 9845 0000  
Fax 181 2 9845 3489  
[www.chw.edu.au](http://www.chw.edu.au)  
ABN 53 126 171 101

0:ROATA\Research\GOVERNANCE\SSA\Application\Approval Letters & Memo\11.SCHN.148  
Liza Lina Roberto.docx

19 August 2011

[Redacted]  
The University of Sydney

Dear [Redacted]

**HREC reference number:** 11/SCHN/148  
**Project title:** Network collaborations in health policy: Is it window  
dressing?

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place here at Sydney Children's Hospital.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;
2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the research governance officer.

Yours sincerely,

[Redacted]  
Ms Liza Nadolska  
Research Governance Manager

CC: Mr Warwick Milton Wearing



Research Governance Officer  
Nepean Blue Mountains Local Health District and  
Western Sydney Local Health District  
Room 1072, Level 1, Education Block, Westmead Hospital  
Hawkesbury Road Westmead NSW 2145

Telephone: (02) 9549 9634  
Facsimile: (02) 9549 8636  
Email: [marjorie.toussaint@westernsydneyhealth.nsw.gov.au](mailto:marjorie.toussaint@westernsydneyhealth.nsw.gov.au)

30 August 2011

[Redacted]

Dear [Redacted]

**HREC reference number:** HREC/11/WMEAD/35  
**SSA reference number:** SSA/11/WMEAD/178  
**Project title:** Network collaborations in health policy: Is it window dressing?  
**Protocol number:** Confirmation of Candidature

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site:

- [Redacted]

The approved information and consent documents for use at this site are:

- Participant Information Sheet and Consent [Redacted] Youth Health Service version 1 dated 22 August 2011 based on master version 2 dated 21 April 2011
- Recruitment Poster version 2 dated 21 April 2011

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Non WSLHD research team members who will be conducting study visits with the [Redacted] Youth Health Service are to organise a time with the Research Governance Officer to sign a confidentiality agreement and obtain ID badge prior to conducting study visits with High Street Youth Health Service
2. Insurance certificate must be current for governance clearance to remain valid. The insurance certificate submitted expires 31 October 2011. Please submit updated certificate when issued.

Western Sydney Local Health District  
Attn: 48741 591784  
Level 3, Donor School, Westmead Hospital  
Holly Road, Westmead NSW 2145  
PO Box 914, Westmead NSW 2145  
Tel: (02) 9549 2202 Fax: (02) 9549 2001



3. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;
4. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Yours faithfully

Maggie Piper  
NBMLHD and WSLHD  
Research Governance Officer

c.c Warwick Wearing, 56 Raymond Ave, Campbelltown NSW 2560

Western Sydney Local Health District  
604 48 767 794 754

Level 3, Dental School, Westmead Hospital  
Darcy Road, Westmead NSW 2145  
PO Box 974, Westmead NSW 2145  
Fax 604 994 7025 Tlx 02 5529 4941



Health  
Western Sydney  
Local Health District

Research Governance Officer  
Nepean Blue Mountains Local Health District and  
Western Sydney Local Health District  
Room 1072, Level 1, Education Block, Westmead Hospital  
Hawkesbury Road Westmead NSW 2145

Telephone: (02) 9845 9834  
Facsimile: (02) 9845 9836  
Email: [marjaret.prior@health.nsw.gov.au](mailto:marjaret.prior@health.nsw.gov.au)

30 August 2011

Dear [REDACTED]

HREC reference number: HREC/11/WMEAD/35  
SSA reference number: SSA/11/WMEAD/179  
Project title: Network collaborations in health policy: Is it window dressing?  
Protocol number: Confirmation of Candidature

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site:

- [REDACTED]

The approved information and consent documents for use at this site are:

- Participant Information Sheet and Consent [REDACTED] version 1 dated 22 August 2011 master version 2 dated 21 April 2011
- Recruitment Poster version 2 dated 21 April 2011

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Non WSLHD research team members who will be conducting study visits with the [REDACTED] are to organise a time with the Research Governance Officer to sign a confidentiality agreement and obtain ID badge prior to conducting study visits with WAAT;
2. Insurance certificate must be current for governance clearance to remain valid. The insurance certificate submitted expires 31 October 2011. Please submit updated certificate when issued.

Western Sydney Local Health District  
ABN 42 722 596 764

Level 11, Dental School, Westmead Hospital  
Hawkesbury Road, Westmead NSW 2145  
Tel: (02) 9845 9834 Fax: (02) 9845 9836



Health  
Western Sydney  
Local Health District

3. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;
4. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Yours faithfully



Maggie Piper  
NBMLHD and WSLHD  
Research Governance Officer

c.c Warwick Wearing, 56 Raymond Ave, Campbelltown NSW 2580

Western Sydney Local Health District  
GPO Box 971, Sydney NSW 1585

Level 3, Central School, Westmead Hospital  
Banyhill Rd, Westmead NSW 2145  
PO Box 533, Westmead NSW 2145  
Tel: (02) 9615 7500 Fax: (02) 9615 7511

## **Appendix E: Semi-structured interview questions and prompts**

### **General interview questions (Interviews 1–18)**

1. What do you perceive as collaboration within the youth health sector? Give an e.g.
2. Why do you collaborate within the youth health sector?
3. What is the impact of collaboration within the youth health sector? Give an e.g.
4. What helps collaboration within the youth health sector?
5. What hinders collaboration within the youth health sector?
6. Do you want to be more or less involved in collaboration and why?
7. What are your thoughts of youth health policy promoting collaboration?
8. Are you pressured to collaborate?

### **General interview questions (Interviews 19–35)**

1. What do you perceive as collaboration within the youth health sector? Give an e.g.
2. Why do you collaborate within the youth health sector?
3. Why do you think other service providers collaborate?
4. What is the impact of collaboration within the youth health sector? Give an e.g.
5. What helps collaboration within the youth health sector?
6. What hinders collaboration within the youth health sector?
7. Do you want to be more or less involved in collaboration and why?
8. What are your thoughts of youth health policy promoting collaboration?
9. Are you pressured to collaborate?
10. How do you feel about your role in collaboration within the youth health sector?
11. How do you feel about the role of others in collaboration within the youth health sector?

### **Interview prompts**

These are examples of interview prompts that were used in various interviews to stimulate further discussion:

- How does collaboration help you do your job? Give an e.g.
- Could you be more involved in collaboration and why?
- What roles are there when you are collaborating in the youth health sector?
- How do you perceive others when collaborating and why?
- Do you have input when collaborating and why? Give an e.g.
- Are you supported when you collaborate? Give an e.g.
- Could be better supported when collaborating and how? Give an e.g.
- Is there a leader when collaborating and who?
- Who should lead or facilitate the collaboration?
- What makes someone good and bad at collaborating?
- Do others hijack the collaboration process? Give an e.g.
- Is there pressure to collaborate and why? Give an e.g.

- Do you feel everyone has an equal voice in collaboration? Give an e.g.

## Appendix F: Example of an interview memo

### Interview No. 16

**Interviewee: X**

**Organisation: X**

### Observations

- The interview is taking place in a medical consultant room. *Space limited*
- Walls in organisation have pictures and artwork created by youth. *Vibrant environment/positive*
- The interviewee is female with a project management role and has extensive clinical and management experience within the sector.
- The interviewee is very confident in herself and her responses.

### Interview notes

- Definition of collaboration: mind-set, willing, wanting, essential
- Collaboration dependent on organisational culture. Need, transparency, communication to match plans and policy
- Requirement for leader and facilitator
- Identifies informal influences
- Leadership dependent on who has knowledge or who has the funding and resources
- Concerns about obstructive members
- She makes distinctions between a leader and a project officer. Implies distributed leadership. Although she has a leadership role in collaboration due to her employment position, she declares herself not a typical leader in terms of actions. Begs the question: What is typical?
- Leadership based on strength to offer ideas
- Innovation results from collaboration
- Flexibility required for collaboration but adds risk to quality!
- Larger collaborations require more rules due to more participants. Formal processes can control those involved, i.e. MOU
- Sees her organisation as legitimately able to lead collaboration within the sector. Why? *Money and resources, legitimacy of government*

- Why organisations choose not to be involved: CAN make people do things, attending occasionally is fine, people dip in when they have something to offer. *What is it they have to offer? Fluid membership in collaboration.*
- Following up is an issue associated with collaboration (*governance/administration*). Says follow-ups should be one on one. *This contrast with issues of transparency mentioned earlier. Potential hierarchy within collaboration. What is this based on?*
- Limitations of collaboration: ‘clunky old process’
- Collaboration is normative behaviour
- ‘demand from the area drives collaboration’ (15:25) . *Collaboration driven from the bottom up.*
- Limited influence of policy
- Different levels of collaboration (management versus clinical collaboration). Divisions between management and clinical staff
- Outcomes need to be relevant to clinicians to get buy-in. *Inclusion of services in decision making*
- Long-term collaboration requires networking and relationship building
- Clinical collaboration is short-term or tactical and based on client needs
- Questions the relevance of face-to-face meetings (20:40) *Email/Skype! contrasts to some existing literature*
- Hinders collaboration: Organisational priorities, culture, availability of resources, cultural issues
- Public versus NGO. NGOs more responsive, more driven by funding. Collaboration more critical to NGOs
- Rhetoric about collaboration. Hinders collaboration: Organisations with different angles, unique tensions in the workplace, need to claim status in leadership and priority. Jockeying to jump on board. Who has invested more? *Further evidence of COMPETITION for salience. Competition within collaboration. Competing for recognition, money, power and legitimacy*
- ‘those with money have power’ (25:40). More quotes about power legitimacy and money (26:20)
- Policy gives collaboration legitimacy. Quotes (27:35). More evidence for engaging in collaboration to gain recognition.

- She questions very nature of collaboration ‘means to an end or end in itself’ (28:35)
- Discusses: tensions (*agency*), measurement of collaboration, free-riding, complexity of process

### **Concluding notes**

- Confirmed further the *competitive* nature of collaboration, particularly collaboration to get recognition (ON-GOING THEME)
- The later part of the interview allowed the interviewee to unload about the problems of collaboration. Initially she appeared to have a more positive outlook on collaboration before she let her perceptions free and emphasised the competitive aspirations of service providers when collaborating.
- Highlighted the informal nature of collaborating
- Hierarchy to explore further
- Issues of agency and mutuality highlighted
- Salience when collaborating is based on money and resources and knowledge to assist in delivering youth health services. (Explore further)

## Appendix G: Example of the coding process

Below is an example of the coding processes undertaken in this research dissertation. This particular example shows the progression of competition from being a code to becoming a category, concept and theoretical theme of collaboration theory. It shows that competition not only is initially a code (open coding) itself but is also exemplified in numerous codes and as such becomes a category (axial coding) containing the more prominent codes identified when examining interview transcripts. Also shown is how the theoretical principles of collaboration, social capital and stakeholder theories were applied when examining competition as a concept, including the emerging characteristics of salience (axial coding/selective coding). The final column illustrates competition and salience as theoretical themes (selective coding). This example illustrates the coding process simplistically. Multiple tables like this were used by the researcher when coding and these codes and categories also influenced the emergence of competition for salience when collaborating and assisted in developing the other characteristics that make service providers more salient than others when collaborating.

<u>OPEN CODING (codes)</u>	<u>AXIAL CODING (categories)</u>	<u>AXIAL CODING/SELECTIVE CODING (concepts)</u>	<u>SELECTIVE CODING (themes)</u>
	<i>Incorporating collaboration, social capital and stakeholder theory AND analysis framework (vertical and horizontal collaboration)</i>	<i>Incorporating collaboration, social capital and stakeholder theory AND analysis framework (vertical and horizontal collaboration)</i>	
Competition (160 codes referring to competition)	Competition (160, including all associated codes referring to competition)		<b><i>Competition to be more salient than other service providers AND Competing to build social capital with salient service providers AND Competing to build collaborative linkages with salient service providers</i></b>
Competition between NGO & government service providers (2)			

Competing collaborations (1)			
Competition for approval to sign off (1)			
Competition for credibility (24)	LINK: Competition for credibility (24); competition for recognition (35); and competition for promotion (16); competition for reputation (4); competition for status (1);	Salience based on reputation/credibility  Salience based on service delivery (see other tables)	
Competition for information (4)			
Competition for recognition (35)	LINK: Competition for credibility (24); competition for recognition (35); and competition for promotion (16); competition for reputation (4); competition for status (1);	Competing for salience	
Competition on different levels (1)			
Competition as positive (2)			
Competition between collaborations for stakeholder involvement (1)			
Competition for access (1)			
Competition for clients (8)	For clients	Salience based on evidence of service delivery (see other tables: positive and negative impacts of collaboration)	
Competition for easy clients (1)			

Competition for funding (27)	LINK: Competition for funding (27); competition for resources (2). (Also link to other tables relating to reasons to collaborate)	Organisational sustainability (see other tables concerning funding and helps and hinders collaboration)	
Competition for knowledge (2)			
Competition for legitimacy (2)			
Competition for profits (2)			
Competition for promotion (16)	LINK: Competition for credibility (24); competition for recognition (35); and competition for promotion (16); competition for reputation (4); competition for status (1);	Saliency based on promoting reputation/saliency based on disseminating reputation (building social capital) (see other tables)	
Competition for reputation (4)			
Competition for resources (2)	LINK: Competition for funding (27); competition for resources (2). (Also link to other tables relating to reasons to collaborate)		
Competition for status (1)			
Competition internally within an organisation (1)			
Competition not to be a leader (1)			
Competition to be heard (1)			
Competition to be on funding applications (1)			
Competition to be on funding applications (4)			
To be popular (1)			

Competition versus complementary services (3)			
Competition for leadership (1)			
Competition and game playing (1)			
Competition to secure turf (1)			

