Collaborative capability in the mental health and addiction sector:

A review of the literature

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Acknowledgements

This review has been written by Te Pou o te Whakaaro Nui.

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Executive summary

Introduction

Collaborative capability in the mental health and addiction sector is a workforce development project led by Te Pou o te Whakaaro Nui and Platform Trust to explore the meaning and application of collaborative capability in mental health and addiction (MH&A) services in New Zealand. This responds to broader policy requirements to more effectively integrate across service and organisation boundaries and to work in partnership with people accessing MH&A services.

This document reviews and synthesises the literature on collaborative capability so that the available evidence informs any subsequent workforce design. The review also clarifies the often-confusing terminology used across the collaboration and partnership literature.

The review is aspirational: it focuses on the future shape and nature of MH&A service delivery and the workforce planning needed to develop a “collaborative practice-ready workforce” (World Health Organization, 2010, p. 10). It is intended that the review be a resource to the MH&A sector to strengthen individual and organisational capacity for collaboration and to increase the focus on the rights of people accessing services. To achieve this, the outcome of this review is to identify the key components of:

- citizen engagement
- collaborative capability
- technical resources available to support collaborative capability.

Context

The vision for MH&A services in New Zealand centres around two key aspirations: first, a local system of support, based on purposeful and meaningful partnerships between people accessing MH&A services and the service network around them. Second, at a macro-level, a system oriented towards whole-population health and wellbeing, and engaged, healthy communities (Ministry of Health, 2012; Platform Trust & Te Pou o Te Whakaaro Nui, 2015).

The foundation of this vision is an evolved service environment based on new models of care primarily located in community settings; collaborative relationships between service providers and people accessing services and their family and whānau; increasingly integrated cross-sectoral service delivery; and co-design of services. Integration will be a process (not an outcome) to bring about a seamless experience for the person accessing support across a continuum of services and providers (Platform Charitable Trust, 2012; Platform Trust & Te Pou o Te Whakaaro Nui, 2015).

The aspirations of the MH&A sector are to work more effectively across the primary and secondary continuum, in a more integrated way, and to develop close working relationships with other services, agencies, organisations and sectors (Te Pou o Te Whakaaro Nui, 2015a). The broader strategic frameworks for health and social services in New Zealand support this direction of change, and are explicit about the need to develop collaborative skills across multiple sectors (Ministry of Health, 2012, 2016a).
For the MH&A sector specifically, the emphasis is on how to support the workforce to be adept at collaborating and working in partnership with a range of stakeholders and across professional, organisational and sector boundaries (Platform Trust & Te Pou o Te Whakaaro Nui, 2015).

Methodology
The primary purpose of this review is to distil out the key messages and resources from a crowded grey literature environment characterised by inconsistent and confusing use of terminology. The methodology focussed initially on review and synthesis of known literature with expansion of the subsequent literature reviewed based on identified gaps in information. It is important to note though, that this document is not based on a review of all the literature on collaboration and partnerships.

Much of the initial literature reviewed was provided through Te Pou o te Whakaaro Nui and Platform Trust’s existing knowledge of the grey literature and web-based resources. Subsequent literature and resources were identified through “snowballing”, that is, they emerged as the study unfolded (Greenhalgh & Peacock, 2005, p. 1064). Use of informal browsing approaches and serendipitous discovery widened the scope of the literature and resources accessed. The review includes a detailed discussion around the use and meanings of relevant terminology.

Approach
The purpose of this literature review is to provide clarity and direction for the MH&A sector around collaboration and partnerships. The emphasis throughout is on the development of breadth and depth of collaborative capability: across and within communities of people, culture, practice and place. The review considers collaboration through three lenses.

Citizen engagement focuses on expanding the scope and range of opportunities to work more closely with a broader range of stakeholders through:

- understanding rights conferred through citizenship
- more personalised approaches to support
- co-design of services
- community development and place-based health
- Whānau Ora.

The placement of citizen engagement at the forefront of the review is intentional. The most important collaborative relationship within the frame of MH&A supports is between the person accessing services (and their family and whānau) and MH&A practitioners providing that support. However, the literature on therapeutic relationships between practitioners and people accessing services was outside the scope of this review and so the workforce development or skill sets around this area are not addressed.
Collaborative capability describes:

- values, behaviours and approaches central to the development of a collaborative workforce
- Organisational culture and infrastructure that supports collaborative practice.

Technical approaches to partnerships focuses on the ideas, mechanisms and resources that support organisations to collaborate well, including:

- understanding and developing different types of partnerships
- risks and challenges in partnerships
- using agreements
- how to maintain partnerships over time.

Key messages

Widespread support

The push for collaborative capability is an international objective in the developed and developing world, across public and private interfaces, and straddling a range of traditional organisational and service delivery boundaries (Gray & Stites, 2013; OECD, 2015; World Health Organization, 2010). The literature on social sector collaboration borrows from business models and sustainability goals; blurs boundaries between philanthropic, private and state objectives; deinstitutionalises across organisational layers; and invites innovation in order to create the paradigm shifts required to adequately respond to social complexity. There is widespread support in the literature for collaborative practice to better respond to the failure of existing fragmented systems, and the increasing complexity of presenting need, as well as the changing expectations of citizens and communities (Ham & Alderwick, 2015; Institute of Policy Studies, 2008; Ministry of Health, 2016a; New Zealand Productivity Commission, 2015).

Long-term goals explored throughout this review, focus on capacity building in communities to better manage and respond to demand. In the context of health and social services, goals include:

- an emphasis on wellbeing coupled with a preventive approach
- development of opportunities for individual self-determination
- more adaptive and support options
- development and expansion of place-based integrated health and social services
- integrated support options evolving out of collaborative partnerships between non-traditional partners
- improved service effectiveness.

Direction of change

The literature indicates that the direction of change is away from traditional hierarchies, existing organisational structures, and transactional approaches (New Zealand Productivity Commission, 2015; Social Policy Evaluation and Research Unit, 2015; Taskforce for Whānau-Centred Initiatives, 2010). Instead there is an emphasis on the development of community-based resources and networks to support and empower citizens to
have greater influence over their own health and wellbeing. Services are partnering with citizens in much more equitable, innovative, and local ways. These include:

- personalised support approaches
- increased system flexibility to support individual choice and control over funding and services
- co-design of service delivery and systems
- investment in existing networks and communities, and increased fluidity of service delivery.

Place-based health is shifting emphasis into communities, in order to respond to the wider determinants of health and to utilise existing networks, resources and opportunities to determine and respond to demand in different ways. Whānau Ora employs all these strategies in ways that are specific, organic, purposeful and responsive.

**Macro and micro thinking and development**

The literature is clear that collaboration is much more likely to be successful when there is a focus on macro and micro components of the system at the same time (Hazel & Hawkeswood, 2016; Kippin & Fulford, 2016; Network 4, 2016). It can legitimately be very challenging for individuals to work more collaboratively, or for organisations to develop a collaborative culture, in the absence of collaborative leadership and higher-level infrastructural change.

Similarly, there needs to be investment in community, local services, people accessing services, family and whānau when collaboration is called for at a strategic level, in order that the reach of change is widespread. If the push for collaboration or integration takes place at a policy level, there has to be concurrent investment in local collaborative capability, development of leadership skills and understanding around the logistics of partnerships, and resourcing around time and space for innovation and collaboration.

**Purposeful collaboration**

Organisations need to be clear about the opportunities and costs of collaboration before they enter into a partnership (Department of Internal Affairs, 2007; Partnership Brokers Association, 2016). There are risks for organisations around collaborating with minimal preparation or capacity, or collaborating for the sake of it. Both scenarios are more likely to lead to failed partnerships.

The literature is clear that the shift towards collaboration and partnerships needs to be conscious, purposeful, goal-driven, and very cognisant of context (Gray & Stites, 2013; Mattessich & Rausch, 2013). Change, particularly transformative change, is difficult and requires comprehensive commitment from leaders, which is developed over time. Success is often dependent upon the presence of enablers, people with a highly developed collaborative skill set who generate and support collective will and action towards a particular end point.

Purposeful collaboration builds on good relationships, understands the problem/challenge well, is centred around a shared vision, is resourced well (time, funding, skills), is clear about ways of working and relationship processes, and uses binding mechanisms (such as agreements) and good quality evaluation to keep the partnership on track.
Collaborative capability

Collaborative capability is about values, behaviours, and approaches of individuals, as well as the organisational culture and infrastructure that support collaboration and partnerships. The capacity for people to network and collaborate within their own organisation or community (of people, practice, culture and place) is a critical antecedent for collaborating more broadly. Collaborative values include humility, honesty, kindness, and a commitment to equity, trust and diversity.

Collaborative behaviours include openness to ideas, commitment to a range of partners, opportunities, and ways of working, communal development of solutions, and an acceptance that solutions often lie outside traditional spheres of influence or organisational practice.

Collaborative approaches include the capacity to operate in a collective and multiplex environment, good human resource practice including having clear roles and responsibilities, skill set identification and support, opportunities for innovation and risk, and good conflict resolution practices. Collaborative leadership and the use of brokers, builds bridges between individual capability and collaborative organisational culture and system change. Collaborative leaders lead by example, at the same time as allowing space and opportunity for innovation and collective action.

The collaboration literature focuses most on the characteristics of collaboration at workforce and organisational levels. There is less information in the literature dealing directly with how to collaborate with people accessing services, outside of what is written about the process of engaging in a therapeutic relationship. This represents a significant gap in the literature and points to a need for future work around unpacking what collaboration with people accessing services looks like.

Where to start

There are two crucial starting points for any organisation that wants to collaborate more effectively. The first is to focus on internal organisational values, behaviours and culture, and to continuously reflect upon and develop the features that support collaboration. The second is to start with small networking or collaborative opportunities with other service providers or agencies, or through personalised approaches with people accessing services.

Human resource practice is critical to the development of collaborative capability through effective mentoring, shared learning opportunities, opportunities for role expansion, a focus on specific skills development (relationship building, communications, cross-sector capabilities, conflict resolution), leadership development, collaboration-focused performance management, and workforce planning and recruitment.

Technical support

The challenges around working more collaboratively are well documented in the literature. The biggest barriers to collaboration are inadequate resources (time, people and funding), poor leadership, an absence of vision or collective outcome, poor partnership processes (for example, around use of agreements, communications, conflict resolution, backbone support, evaluation), limited opportunity or mandate to innovate or explore divergent thinking, and poor or limited existing relationships and trust with prospective partners.
The technical resources available to support collaboration and the development of partnerships are expanding in scope as the mandate for collaboration evolves across sectors. There are a number of organisations that exist solely to support collaborative enterprise and expertise, and specific resources developed to assist with collaborative practice. These resources outline the continuum of partnership opportunities, and the life cycle of partnerships, and provide support around partnership processes and use of agreements.

**Te reo Māori terms**

The following terms are used throughout this review. These definitions are sourced from Te Aka Online Māori Dictionary (Moorfield, 2016).

**Iwi** – extended kinship group or tribe. Often refers to a large group of people descended from a common ancestor and associated with a distinct territory.

**Kōrero kanohi ki te kanohi** – conversing face-to-face or in person.

**Manaakitanga** – the process of showing respect, generosity and care for others. It also means hospitality, kindness and support.

**Mana whakahaere** – governance or authority, jurisdiction, management and mandate.

**Rangatiratanga** – refers to chieftainship or the right to exercise authority or ownership, leadership of a social group, or having the attributes of a chief. It can also mean sovereignty and has connotations arising from the Bible and Te Tiriti o Waitangi.

**Te Tiriti o Waitangi** – The Treaty of Waitangi was signed by representatives of the British Crown and Māori chiefs at Waitangi on 6 February 1840. As a founding document of New Zealand, it governs the partnership relationship between Māori and the Crown.

**Te ao Māori** – the Māori world.

**Whakapapa** – genealogy, lineage, or line of descent.

**Whānau** – extended family or family group. It may also be used as a familiar term to address a number of people, this may include people who do not have kinship ties.

**Whanaungatanga** – relationship, kinship, feeling of family connection that generates a sense of belonging. Develops as a result of kinship rights and obligations. Can extend to non-family reciprocal relationships.
Context

The vision

On Track: Knowing where we are going (Platform Trust & Te Pou o Te Whakaaro Nui, 2015) and Towards Integration (Platform Charitable Trust, 2012) describe an aspirational system of integrated MH&A services in New Zealand. On Track presents a system that, at a local level, is based around purposeful, organic partnerships between a wide range of services and the individuals who access those services and their whānau. At a macro-level, the system is focused on whole-population health and wellbeing, and engaged, healthy communities.

To achieve this, On Track outlines an evolved service environment based on new models of care primarily located in community settings, collaborative relationships between service providers and people accessing services, increasingly integrated cross-sectoral service delivery, and co-design of services. On Track requires that the MH&A workforce is adept at working in partnership with a range of stakeholders, and across professional and organisational boundaries.

Towards Integration focuses on different types of partnerships along a continuum of ways of working together. It emphasises that the most effective MH&A services are those that integrate across “educational, social, housing, employment and other sectors” (2012, p. 4). Integration is viewed, not as an outcome necessarily, but as a process to bring about a seamless experience for the person accessing support across a continuum of services and providers.

The following strategic frameworks underpin this vision:

- New Zealand Health Strategy: Future direction (Ministry of Health, 2016a)
- Blueprint II: How things need to be (Mental Health Commission, 2012)

The New Zealand Health Strategy (2016a, p. 14) emphasises a shift away from fragmented health care to “integrated social responses … thinking beyond narrow definitions of health, and collaborating with others to achieve wellbeing”. Blueprint II (2012, p. 11) describes a human rights and citizen-centred approach, where MH&A responses are designed around a person’s needs, where every contact supports a person’s “engagement and care for their own mental health and wellbeing”. Rising to the Challenge (2012, p. 7) emphasises the responsibility of health and social services to “value communities as essential resources to support family and whānau wellbeing … [and] form authentic partnerships” with people accessing MH&A services.

Complexity and fragmentation

Central government policy in New Zealand is increasingly focused on enhanced support for vulnerable individuals and families with multiple and complex needs (Social Policy Evaluation and Research Unit, 2015). The New Zealand Productivity Commission’s 2015 report More Effective Social Services clearly maps out the failure of fragmented health and social services to respond effectively to “disadvantaged individuals and families … [with] multiple and inter-dependent problems” (p. 5). The report states that services that are client-centred,
use resources more efficiently, span budgets across a range of services, and provide mechanisms to assist people to navigate the system, are much more likely to overcome the significant adverse effects from a fragmented system.

International research supports this shift in focus because of the universality of poor outcomes associated with fragmented service provision. The literature emphasises better linkages and integration within health and across health and social services, to better respond to the increasing complexity of presenting need (Bryson, Crosby, & Stone, 2006). The World Health Organization (2010, p. 10) supports the development of a “collaborative practice-ready workforce” in order to move “health systems from fragmentation to a position of strength”.

Integration

OECD research on effective support for vulnerable groups describes integrated services that address multiple underlying issues, reduce duplication and therefore cost, improve access to services, and facilitate sharing of information and knowledge. The research also states that increased cooperation and collaboration improves service quality and outcomes for people accessing services, and results in greater satisfaction with service delivery by those accessing services and providers (OECD, 2015).

Building on the work of the OECD and the NZ Productivity Commission, a 2015 policy paper by the Social Policy Evaluation and Research Unit (also known as Superu) on integrated social services for vulnerable people stated:

Integrated social services can potentially offer seamless and convenient access to services, increased uptake of services, better user experiences, holistic and individualised support, faster response times, and most importantly better outcomes for individuals, families and whānau (Social Policy Evaluation and Research Unit, 2015, p. 2).

The shifts required across the health and social system to achieve greater integration are multiple, complex and will take time (Social Policy Evaluation and Research Unit, 2015; World Health Organization, 2008). They also need to balance service specialisation and “linking and coordinating across administrative and professional boundaries” (New Zealand Productivity Commission, 2015, p. 16).

Mental health and addiction sector aspirations

The post-deinstitutionalisation growth of the non-governmental organisation (NGO) sector and the historical dominance of the secondary sector within M H & A services have resulted in uneven relationships between primary health, NGOs and other social services. Primary health care tends to coordinate and integrate poorly with the community-based health and disability NGO sector (Aldridge, 2012). Access to M H & A services is limited by restricted gateways, and M H & A support provided in a primary care setting tends to be narrow in scope and patchy in delivery (Platform Charitable Trust, 2012), with linkages more commonly happening at a referral level than at a shared service level (Aldridge, 2012, p. 19). There are pockets of service innovation and integration across the primary and secondary interface and with the community sector. However, again these developments are intermittent and not widespread.
The More Than Numbers (Te Pou o Te Whakaaro Nui, 2015a) stocktake highlighted the MH&A sector’s aspiration to work more effectively across the primary and secondary continuum, to work in a more integrated way, and to develop close working relationships with other services, agencies, organisations and sectors. In particular, the stocktake highlighted the MH&A sector’s aspiration to collaborate better with housing, justice, education and other social services. The stocktake also identified a need for improved integration within Vote Health, in particular between MH&A services and primary health, the disability sector, general hospital and emergency departments. The stocktake identified the sector’s aspirations to work better within MH&A, with services such as child and adolescent mental health services and mental health services for older people.

Why collaborate?

The literature is consistent around the reasons for working collaboratively and forming partnerships. Collaboration is more likely to occur in turbulent environments, either due to crisis or increasing complexity, or a failure of existing approaches to address issues (Bryson et al., 2006; Institute of Policy Studies, 2008; Partnership Brokers Association, 2016; Roche & Skinner, 2005; Timmins & Ham, 2013). Partnerships are commonly formed when there are external factors such as changes to funding environments, including an emphasis on greater efficiency, policy imperatives, and what Roche and Skinner (2005) call “major paradigm shifts” (such as provision of MH&A services in primary health settings) (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010; Roche & Skinner, 2005, p. 4; Social Policy Evaluation and Research Unit, 2015; Timmins & Ham, 2013). The third theme coming through the literature is simply around the power of working collectively, to solve problems that are difficult to solve in isolation, and often this can evolve out of established relationships, collective sharing of problems, or just chance conversations with like-minded people (Hazel & Hawkeswood, 2016; Waitakere City Council, 2009a).

The World Health Organization (2010) explains there is clear evidence that collaborative practice in community mental health settings results in:

- increased patient and carer satisfaction
- greater acceptance of treatment
- reduced duration of treatment
- reduced cost of care
- reduced incidence of suicide
- increased treatment for psychiatric disorders
- reduced number of outpatient visits.

Collaborative capability

Central to the collaborative direction in New Zealand government policy is the evolution of Whānau Ora frameworks and practice across health and social services. Whānau Ora services are based around a whānau-centred framework that leads to:

“strengthened whānau capabilities, an integrated approach to whānau wellbeing, [and] collaborative relationships between state agencies in relation to whānau services” (Taskforce for Whānau-Centred Initiatives, 2010, p. 6).
Whānau Ora has the potential to significantly change health and social service delivery in New Zealand because it “transcends sectors” by integrating “socio-economic wellbeing, as well as cultural and environmental Integrity” (Taskforce for Whānau-Centred Initiatives, 2010, p. 30). Whānau Ora focuses on the needs of the individual and the collective, based on service delivery by teams, networks of providers, or broker/navigators. Whānau Ora also shifts outcome measures away from a deficit approach to a positive emphasis on wellbeing, and collective responsibility for developing an outcome pathway and defining success. The More effective social services (New Zealand Productivity Commission, 2015) report states a Whānau Ora approach has many essential characteristics of an integrated services framework for families with multiple and complex needs, including: navigator services, decision-making close to whānau, consideration of wider context, devolution of control, opportunities for innovation, and flexible population-based budgets.

Te Pou’s Scope it right (Te Pou o Te Whakaaro Nui, 2015b) research on working to top of scope includes a discussion on enhanced capability. The emphasis is on “how” people work: values, attitudes and ethics, and ‘soft’ skills such as communication, creativity and adaptability. It also includes the ability to collaborate and work in partnership with a range of stakeholders. Network 4’s Closing the Loop (Network 4, 2016) reviews the capacity of New Zealand primary health to create “alliances, partnerships and collaborations that are capable and responsible for the achievement of local population outcomes in mental health and addictions”.

**Sector response**

The political push for improved collaboration puts the onus on health and social sectors to develop strategies on how to collaborate better through improved understanding and development of workforce and organisational collaborative capability. However, there are concerns raised in the literature about central government support for collaborative practice. The Incubate report (Hazel & Hawkeswood, 2016) on barriers to collaboration in the New Zealand non-profit sector highlights concern around the collaborative mandate as a veiled attempt to save money in the health and social sectors. The report also notes a lack of government clarity around definitions of collaboration and ways of collaborating effectively. The Auditor General’s report Whānau Ora: The first four years (Office of the Auditor General, 2015, p. 5) describes systems that are “a burden for service users”, strategies by key government agencies that undermine Whānau Ora’s approach, despite evidence of success, and mixed messages and lack of understanding from government around cross-agency aims and accountability.

The reasons for collaboration are central to its success. As such, the purpose of this review is to respond to these broader policy objectives and contextual constraints by exploring the key issues and clarifying the fundamental skills to support collaborative capability in the MH&A sector.
Methodology

This literature review was commissioned by Te Pou o te Whakaaro Nui and Platform Trust and was developed from an initial literature scan to:

- assess the usefulness of the existing collaboration and partnership literature for the MH&A sector
- provide clarity and direction for the MH&A sector within a crowded grey literature environment around collaboration and partnerships, and confusion and inconsistency around terminology.

The literature reviewed was predominantly known grey literature, with a smaller number of peer-reviewed articles and web-based resources. The search methodology was based on a number of approaches. Much of the initial literature reviewed was provided through Te Pou o Te Whakaaro Nui and Platform Trust’s existing knowledge of the literature and web-based resources. Subsequent literature and resources were identified through “snowballing”, that is, they emerged as the study unfolded (Greenhalgh & Peacock, 2005, p. 1064). Use of informal browsing approaches and serendipitous discovery widened the scope of the literature and resources accessed. The DeepDyve literature search tool was used for subsequent searches.

Much of the literature accessed is UK-based, because of the volume of work on collaboration and place-based health being developed in the UK. The 2016 OECD review of health care quality in the UK identifies the UK as an international pioneer of “tools and policies to assure and improve the quality of care” (OECD, 2016, p. 3).

This review considers a number of case studies or examples of innovative collaborative practice. Many of the case studies are examples of emerging practice or represent service paradigms where evidence of efficacy is limited or non-existent. Where the case studies reviewed include information on efficacy, these results have been included in this review.

Exclusions

The review focuses on collaborative relationships between practitioners and people accessing services, but this does not include workforce development or skill sets around therapeutic relationships. This document also excludes literature on inter-professional education.
Overview

If one of the long-term goals for the M H&A sector in New Zealand is a seamless experience for people accessing support across a continuum of integrated services and providers, there are short- and medium-term goals that support sector-wide movement towards that point. A key approach is to develop the knowledge and skills required for collaborative and collective work across the M H&A sector. The emphasis on developing a collaborative skill set is not necessarily on developing fully integrated services right now, although in many cases it may be, but also to support a sector-wide shift in how to think about relationships with other stakeholders, and how to get more out of those relationships in ways that improve the experience of people accessing services.

The link between collaboration and an evolved integrated service framework is clear: integrated service delivery cannot happen without good relationship skills and effective networking, collaboration and partnerships in communities, and with stakeholders and people accessing services.

The intent of this document is to provide guidance, based on the available evidence, to the M H&A sector on how to collaborate well, both at an individual practitioner level (workforce capability), and in terms of organisational behaviour (culture and practice). The document has three main parts.

**Citizen engagement** – expanding the scope and range of opportunities to work more closely with a broader range of stakeholders through:
- understanding the rights conferred through citizenship
- personalised approaches to support
- co-design of support
- community development and place-based health
- Whānau Ora.

**Collaborative capability** – values, behaviours and approaches in communities of practice, people, culture and place that enable and develop:
- individual collaborative capability
- organisational collaborative capability.

**Technical approaches to partnerships** – a toolbox of key ideas and resources that focus on:
- networking
- understanding and developing different types of partnerships
- addressing risks and challenges
- using agreements
- maintaining partnerships over time.

The collaboration literature focuses most on the characteristics of collaboration at workforce and organisational levels. There is less information in the literature dealing directly with how to collaborate with people accessing services, outside of what is written about the process of engaging in a therapeutic relationship. This represents a significant gap in the literature and points to a need for future work around unpacking what collaboration with
people accessing services looks like. Practitioners in the MH&S sector are encouraged to include this important level of collaboration in future evaluations, to increase the evidence base in this regard.
Terminology and definitions

The purpose of this review includes clarifying the inconsistent and confusing use of terminology in the collaboration literature. This confusion arises, in part, because the genesis of thinking around collaboration and partnerships comes from a broad array of fields of practice, as well as grassroots community and sustainable development goals and objectives. Collaboration can be a messy process: the terminology reflects this.

The purpose of this section is to clarify some of the more confusing terminology used in the collaboration literature. As such, this section is more than a glossary; it includes definitions from the literature and some of the background around the evolution of terms. Some of the definitions are developed further throughout the literature review.

**Capability** is the ‘how’ of practice, it is having the capacity to continually improve, reflect and generate new understanding, to be both reactive and proactive (Edmonstone, 2011; Vincent, 2008). Capability moves beyond competency (the ‘what’ of practice) into “excellence, creativity, or wisdom” (Lester & Chapman, 2000). Capability is “a collaborative process that can be deployed and through which individual competencies can be applied and exploited” (Vincent, 2008). Capable people are both adaptive to the environment in which they operate, and are able to adapt the environment in order to be more effective (Lester & Chapman, 2000). The Sainsbury capability framework lists five dimensions of capability within MH&A services:

- performance – skills and achievements in the workplace
- ethics – integrated knowledge of culture, values and social awareness
- reflection – reflective practice in action
- effectiveness – implementation of evidence-based interventions
- learning – ongoing implementation of new knowledge and practice (The Sainsbury Centre for Mental Health, 2001, p. 2).

**Citizenship** is defined as the state of having legal status as a citizen, based on being competent to undertake citizen responsibilities, including having a “set of virtues [and] following the rules and norms of one’s society” (Isin, 2002, 2008b; cited in Hamer, Finlayson, & Warren, 2014, p. 204). In turn, citizens expect to receive certain entitlements around liberty, freedom, equality, and opportunities to exercise civil, political and social rights.

**Co-design** is a process of engaging “consumers and carers in all aspects of the design and development of health services, practices and systems. It involves partnering between all of the people who are most affected by decisions and services at every stage in decision making from problem identification to design, development, delivery and evaluation” (Co-design Initiative, 2016, p. 9).

It is important to note there is overlapping use of terminology in the literature between the terms ‘co-design’, ‘co-production’ and ‘co-creation’ (Metz, 2015). McDougall (2012, p. n.p.) acknowledges that there is overlap, but differentiates between the three as follows: “Co-design is an attempt to define a problem and then define a solution; co-production is the attempt to implement the proposed solution; co-creation is the process by which people do both”. Metz (2015 n.p.) explains that ‘co-design’ is more commonly used in health, ‘co-production’ in socio-environmental science, and ‘co-creation’ in business, with ‘co-construction’ sometimes used in social services to describe collaboration and partnership”. 
Collaboration, as a term, has become “hopelessly ambiguous” and is commonly confused with the term partnership (Donahue, 2010; cited in Gray & Stites, 2013). Some authors also use the term ‘collective impact’ (defined below). Collaboration can be a collective way of behaving, from the verb to ‘collaborate’, which means to work with someone else to create something jointly.

Or collaboration can be an outcome as a result of working together, so it is a type of partnership with specific features. The former meaning is the preferred definition used throughout the document to describe a way of relating to others and working together.

Collaboration as a specific type of partnership (an outcome) is defined as a “mutually beneficial relationship between two or more parties to achieve common goals by sharing responsibility, authority and accountability for achieving results” (Chrislip, 2002, p. 1). Collaboration is based around creating “a shared vision and joint strategies” to create a result that is greater than what could be achieved individually (Chrislip 2002, p. 1).

Collective impact is a form of collaboration and is defined (and differentiated from other forms of collaboration) by the presence of five conditions: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support (Hanleybrown, Kania, & Kramer, 2012, p. 1). Collective impact takes a framework approach to tackle complex social problems across a range of sectors, organisations and communities to achieve social change (Centre for Social Impact & Social Leadership Australia, 2016). There is considerable academic debate about the features of collective impact that distinguish it from community development and collaboration (Kania & Kramer, 2016; Wolff, 2015).

Community development is when a “community leads in identifying the issue or issues they want to address, the outcomes they want to achieve, and the process for getting there”, although projects can be initiated by government or by the community and can have varied sources of funding (Thornley & Ball, 2015, p. 10). Community development aims to empower communities and build capacity.

Community-led development is “place-based, cross-sectoral, and outcome-driven, and emphasises grassroots engagement and authentic community leadership” (Loomis, 2012 cited in Thornley & Ball, 2015, p. 10). Inspiring Communities (2013b, p. 8) defines community-led development as “working together in place to create and achieve locally owned visions and goals: ‘learning by doing’”.

Competency is defined as “the quality or state of being functionally adequate or having sufficient knowledge, strength and skill” (Vincent, 2008).

Integrated health services are defined by the World Health Organization as:

The organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money (Waddington & Egger, 2008, p. 5).

The World Health Organization's emphasis is on integration as a process, not an end point, with the features of integration changing depending upon the perspective. For example, it describes:

- integration for the person accessing services as healthcare that is “seamless, smooth and easy to navigate”

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1 New Oxford American online dictionary.
• integration for professional groups as “joined up services” based on health professions and specialities working together
• integration for providers as coordinated or combined technical and management support systems
• integration for health managers and policy-makers as connected and networked decision-making and regulation
• integration for organisations as “mergers, contracts or strategic alliances” (Waddington & Egger, 2008, pp. 5-6).

The New Zealand Health Strategy breaks integration down into:

• integration based on a pathway of care for a particular population group or disease condition
• integration of services, for example co-location of different services in one place
• integration across sector boundaries, for example between health and housing
• integration across geographical areas, for example shared services or access for remote communities (Ministry of Health, 2016a, p. 31).

Superu’s review of Integrated Social Services for Vulnerable People uses the OECD definition of integrated services: “joined up social services, for the benefit of service users and to improve the efficiency in delivery by providers” (OECD, 2015, p. 6; Social Policy Evaluation and Research Unit, 2015).

**Inter-professional education** occurs when “two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (World Health Organization, 2010, p. 13).

**Networking** is based on developing and maintaining informal relationships through discussions, information sharing and cooperation. It is about developing awareness of other key stakeholders who are operating in similar spheres of influence. It does not include shared decision-making (Department of Internal Affairs, 2007).

**Organisational culture** is defined as “implicit norms, values, shared behavioural expectations, and assumptions of a work unit that guide behaviours” – the ‘way things are done here’ (Davies et al., 2000; cited in Palinkas et al., 2014, p. 83).

**Partnership** can be used to describe a process or an outcome but the approach in this document is to consider partnership as an outcome, that is, a working relationship between two or more parties with degrees of formality in the relationship. Not all partnerships are collaborations. Instead partnerships are:

Dynamic, multifaceted and can be expressed as a continuum of working together arrangements which span from coexistence to formal partnership (Waitakere City Council, 2009a, p. 13).

More recent definitions of collaboration and partnership extend the continuum to include organisational mergers (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010; Ellison & Flint, 2010; New Zealand Productivity Commission, 2015; Waddington & Egger, 2008) and generative services that are based on “co-development of services between communities and providers” (Network 4, 2016; Oftelie & Leadership for a Networked World, 2014; Social Policy Evaluation and Research Unit, 2015, p. 4).

**Place-based health** is defined as a blurring of “organisational boundaries across a location to provide integrated care for individuals, families and communities” (Selbie & Kippin, 2016 n.p.). Place-based health has developed out of broader place-based approaches that involve stakeholders collaborating to address issues “experienced
within a geographic space, be it a neighbourhood, a region, or an ecosystem” (Bellefontaine & Wisener, 2011 n.p.). Typically place-based approaches are utilised to respond to ‘wicked’ complex problems with multiple interacting causes, such as climate change, poverty, obesity, and crime (Bellefontaine & Wisener, 2011).
Key messages

Increased complexity of need, increasing demand, and an emphasis on citizenship and citizens’ rights is shifting the focus of health and social services to the broader determinants of health and wellbeing. The result at a practical level is collaboration with a broader range of partners based on:

- enhanced opportunities for individual agency (both for people accessing services and those providing support)
- an emphasis on place-based health and collective responsibility for health and wellbeing
- a network of supports that are embedded in and build on existing community networks
- expanded scope and increased fluidity of service delivery
- more adaptive and personalised practice
- altered demand for services through improved community capacity to respond to M H & A need.

The direction of collaborative change is away from traditional hierarchies, organisational solutions, and transactional and regulative approaches, towards equity of expertise, community solutions, and co-creation of support opportunities.

Effective support is in situ. It responds and adapts to the person as much as is possible, and it builds on existing social capital: family, peers, whānau, institutions, knowledge, and community.

Introduction

Collaboration in a M H & A context and the future of M H & A services is centred on purposeful, organic and collaborative partnerships between citizens and their support networks. On Track (Platform Trust & Te Pou o Te Whakaaro Nui, 2015) and Towards Integration (Platform Charitable Trust, 2012) describe an evolved service environment determined by support needs, context, and the intentions and aspirations of people accessing services. In this evolved environment, service delivery is embedded in communities, interconnected with whānau, fluid and adaptable, equitable, and most of all, effective.

This model for the future represents a “paradigm shift” (Roche & Skinner, 2005, p. 4) in the intent and delivery of M H & A services in New Zealand. This section explores this paradigm shift, looking at ways that partnerships and collaborative capability might manifest in a service context. What does an expanded range of partnership opportunities look like for people accessing services? These opportunities are reviewed in terms of citizen engagement, co-design of services, Whānau Ora, and place-based health and community development. This is followed by a series of examples to provide context for the theory.
Citizenship

An exploration of citizen engagement in the context of MH&A services needs to be grounded in a clear understanding of what citizenship means for people accessing health and social services. The United Nations Convention on the Rights of Persons with Disabilities emphasises “full and equal enjoyment of all human rights” for people with physical, mental, intellectual or sensory impairments, because of the disabling effects of “society’s barriers and prejudices”.

Hamer, Finlayson and Warren’s (2014) review of attitudes towards citizenship discusses how the biomedical context of MH&A services restricts opportunities for full citizenship for people accessing services. The authors argue that mental health practitioners often lack understanding of the “oppressive social structures that impact on service user’s status” and limit personal realisation of citizenship rights (p. 209). Assumptions by professionals around people’s competence or insight also restrict choices and place conditions on citizenship. Citizenship is predicated on opportunities for “personal agency”, including the right to take risks and the possibility of failure (Hamer et al., 2014, p. 703). A recovery focus uses a strengths-based approach that supports people as citizens and allows for personal agency. Hamer and Finlayson (2015, p. 703) state:

Partnerships that support mutual understanding, responsibility and collaboration for treatment planning are one way of reducing the conditions on their citizenship status.

Ideas of citizenship also apply to individuals as members of society (Durie, 2002). Sir Mason Durie’s (2002, pp. 597-598) analysis of the components of citizenship for Māori include:

- rights of an individual to participate in general society
- partnership rights conferred through Te Tiriti o Waitangi, and
- indigenous rights that support Māori rights to “participate in Māori society”.

The implication of these three components is that the state has an obligation to support citizenship based on concurrent realities: individual “equality and democratic rights, participation in society, including te ao Māori”, and the Treaty relationship between Māori and the Crown (Durie, 2002, p. 600). The effect of these approaches across government policy is a strategic emphasis on Māori succeeding as Māori (Comer, 2008). He Korowai Oranga: Māori health strategy (Ministry of Health, 2014) guides the direction of the health and disability sector to achieve the best health outcomes for Māori and weaves these three notions of citizenship throughout. The key elements of He Korowai Oranga are wai ora (healthy environments), whānau ora (healthy families), and mauri ora (healthy individuals). The strategy has a number of guiding features, including Māori control over their own health and wellbeing, equity, community development, Māori participation, and cross-sectoral effectiveness.

Citizenship confers rights around individual, social and cultural agency. In a MH&A context, these rights necessitate a partnership approach and the creation of opportunities for individuals and communities to determine the shape, nature and context for support frameworks. This review emphasises citizenship rights as the foundation for developing the individual practitioner collaborative capability and shifts in organisational culture and behaviour required to realise the MH&A sector’s broader aspirations around developing collaborative capability and integration across traditional boundaries.
Personalised approaches

The UK place-based health manifesto Get Well Soon describes an “arc of citizen engagement”: a continuum of ways that organisations and services can engage with the public (New Local Government Network & Collaborate, 2016, p. 37; citing Involve (2005) as a source). This arc is shown in Figure 1.

![Five steps on an arc of citizen engagement](image)

**Figure 1: Five steps on an arc of citizen engagement**


The Get Well Soon authors state that organisations commonly engage with the public at the “inform” and “consult” end of the spectrum. They argue that instead “the core of every clinical and professional interaction with individuals” should be based on personalised approaches to health and social service delivery (p. 37). The authors argue that a personalised approach centres on “individual agency, community capacity and social capital” to build a more health-empowered population (p. 35). The benefits include shifting health focus away from reactive, acute, hospital-based services to proactive, less institutional, community-based health and wellbeing services.

The New Zealand Productivity Commission (2005) report More Effective Social Services states that empowering clients to make “core choices” improves client wellbeing, but that the system needs to change to allow this to happen. System changes include a shift in the balance of power away from funders and services, the development of mechanisms such as improved funding flexibility, provision of information to support client empowerment, and a shift in attitudes of many providers and government officials. The reforms proposed by the productivity commission are intended to develop client pathways focussed on employment, physical and mental health, and social connections, access to services better matched to need and context, and empowerment through improved information and choice around services (p. 24).
Co-design

Co-design of services is a key feature of the collaboration literature. Co-design utilises the person accessing a service as a design specialist based on their personal expertise (Sanders & Stappers, 2008 n.p.). Co-design allows people to participate in the design of public services in order to better respond to increasing complexity, build trust in government, develop greater responsiveness, relevance and effectiveness of services, and develop social capital (Bradwell & Marr, 2008). Co-design is a way of working together that emphasises:

- equal partnership
- shared decision-making
- innovation
- integration (Co-design Initiative, 2016, p. 9)

Co-design blends community engagement and participatory design and places people accessing services at the centre of design and delivery of services, minimising the power imbalance between different stakeholders. Co-design is best used in “complex services where expertise and information is widely dispersed, and where it is crucial to build wider support for, and ownership in, the service design” (New Zealand Productivity Commission, 2015, p. 134).

In the context of integrated services for vulnerable people, Superu has used the Human Services Value Curve (Oftelie & Leadership for a Networked World, 2014) to describe “generative” processes and outcomes that are based on multi-stakeholder co-creation of resources, services and partnerships to “address the underlying determinants of community health and wellbeing” (Social Policy Evaluation and Research Unit, 2015, p. 3). Generative responses develop “healthy communities by co-creating solutions for multi-dimensional family and socioeconomic challenges and opportunities” (Oftelie & Leadership for a Networked World, 2014, p. 5).

A major challenge for the co-design movement in the context of health services provision is recognising:

- The profound cultural, identity and practice challenges posed by co-production at every level and in every area of health system functioning and health professional practice (Dunston, Lee, Boud, Brodie, & Chiarella, 2009, p. 49).
- The co-design process requires what Dunstan et al. (p. 49) call “a co-productive health professional” who has a mixture of technical skills and soft skills, including being good at listening, trusting the capacity of people accessing services to contribute to their own care, and a commitment to equity of relationship between health professionals and citizens.

Bradwell and Marr’s (2008) international survey of co-design of public services showed co-design has moved from a theoretical perspective to a practical approach across a wide range of international public services. However, their review of co-design in Australia and New Zealand found evidence of a narrower, “customer-service” type of collaboration.

Looking at co-design in a more concrete context, the New Zealand Productivity Commission (2015) argues the current system of access to social services fails to respond to variation in the capacity of individuals to coordinate their own services. The authors represent this variation using the diagram in Figure 2.
Figure 2: Characteristics of clients of the social services system

The group in Quadrant C are described as people with often “complex and inter-dependent needs [who have] the capacity to coordinate the services they require” (p. 53). The term ‘co-production’ is used at a more micro level by the commission to describe the process of clients “tailoring services to meet their own needs” (p. 134). The commission states there is considerable scope in New Zealand for developing “client-directed service models” that offer people scope to budget hold, and select how, and when and from whom they receive services. The commission outlines a number of international examples of client-directed service models (pp. 279-280).

Place-based health

The place-based health agenda in the UK is driven by a shift towards “systems of care” to respond to increasing demand, financial constraint and pressure on services, as well as risks around increasingly siloed behaviour by health agencies and organisations (Ham & Alderwick, 2015, p. 5). The argument is that providers need to collaborate and work together in communities of place to respond to the wider determinants of health: social, economic and environmental. The emphasis on place assumes that most health care provision is local and that integration works best at clinical and service levels (and not so well at an organisational level). Place-based health forces consideration at a local system level rather than “trying to address system problems with organisational solutions” (Kippin & Fulford, 2016, p. 5).
Get Well Soon (New Local Government Network & Collaborate, 2016, p. 40) describes place-based health as a process of understanding local health challenges and opportunities. They describe better use of “social and neighbourhood networks” involving local authorities, schools, businesses, housing providers, community organisations and local people, to improve health and wellbeing. The authors reflect on two different questions to demonstrate the reasoning behind place-based health. The first is “What health services do you want?” versus “What would help you enjoy life more?” (p. 10). The former is likely to elicit a clinical response; the latter a response around home, family, community, work, or aspirations. Place-based health is underpinned by a system that allows the second question to be achieved, based on the integration of health, local government, housing and other services, and a preventative approach, within a geographic area. Place-based health is also based on an assumption that broad groups of people will be able to collaborate, in community contexts, to develop more local support around health and wellbeing.

Adebowale, Kippin and Billiald (2015 n.p.) describe a paradigm shift, based around place-based “new models of care that transcend existing institutions”. They argue for three shifts in focus to bring about this change:

- responding to demand through a much more profound understanding of community resources
- framing productivity and outcomes away from organisations to collaboration in communities
- a redefinition of patients as “collaborators” and development of collective social responsibility for outcomes.

Community and community-led development

Place-based health, as a sphere of changing practice, overlaps with substantial research and resources around community development initiatives to improve health outcomes. Community development is an enormous area of research and thinking, but is only touched on lightly here. There are many resources available around community development as it links to health outcomes.

Inspiring Communities Learning by Doing (2013b, p. 7) emphasises the importance of “community resilience and neighbourhood strengthening” as critical contributors to mental wellbeing and “feeling safe, supported and connected to the people and environment around us”. Learning by Doing also explains that community-led development is enhanced through the presence of more active citizens and purposeful support for enhanced collaborative practice.

Matthesich and Rausch’s (2013) research in the US on collaboration success factors highlighted that community development agencies found they could only improve health outcomes when they worked across sectors and engaged with communities, including having leaders deeply rooted in their communities and community ownership of approaches and outcomes. Participants noted the importance of mechanisms for “active listening” and long-term strategies for engagement outside of traditional ways of engaging with communities (p. 8).

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2 Note the definitions of these terms in the terminology section – with the key difference being community-led development’s focus on “place, cross-sector collaboration and inclusion of system change” ( Inspiring Communities, 2013b, p. 15: footnote 11).

3 For example, Volume 30 of the Health Affairs Journal (2011) devotes the entire edition to research on links between community development and health.
Whānau Ora

The New Zealand Productivity Commission (2015, p. 335) explains that the responsibility of government under Te Tiriti o Waitangi is to “create opportunities for Māori groups to exercise mana whakahaere (authority) in delivering social services”, including devolving commissioning decisions to Māori. Whānau Ora represents a comprehensive opportunity to provide integrated services and respond more effectively to whānau aspirations.

Whānau Ora combines all four features discussed so far: citizen engagement, co-design of services, place-based health and community development. It also has a cultural dimension of Māori succeeding as Māori, and of relationships between whānau and providers based on whakapapa (genealogy) or whanaungatanga (kinship relationships) (Taskforce for Whānau-Centred Initiatives, 2010). Feedback to the productivity commission during the development of More Effective Social Services identified additional “collective duties of care” arising from manaakitanga (hospitality) and rangatiratanga (the right to exercise authority) (New Zealand Productivity Commission, 2015, pp. 329-330).

The productivity commission emphasises that the New Zealand system of social services needs to be flexible around responding to Māori aspirations and service preferences, and much more nuanced in its understanding of Māori social organisation. The Taskforce for Whānau-Centred Initiatives outlined a series of principles underpinning the development and delivery of whānau-centred services and empowered whānau. These principles include:

- relationships between all stakeholders based on equity, trust, respect, a strengths-based approach, and belief in the worth of each other
- whānau wellbeing, based on the needs, support, aspirations of, and solutions identified by whānau
- adequate time to develop and strengthen relationships, engagement and knowledge
- whānau-centred services based on “integrated multi-service delivery”, early intervention and prevention, collaboration, and flexibility and innovation of delivery
- success measured on the basis of whānau experience and knowledge
- strategic leadership responsibilities of iwi within tribal territories, and on behalf of providers, to identify priorities, hold government accountable, support cultural development and work collaboratively to “benefit whānau wellbeing” (Taskforce for Whānau-Centred Initiatives, 2010, pp. 39-41).

How do theories of citizen engagement work in practice?

The examples provided below give context to citizen engagement, co-design, place-based health, community development, and Whānau Ora, in the design and delivery of services. The examples demonstrate a range of macro and micro ways of thinking about collaboration, integration and collective responsibility for health and wellbeing outcomes. They also demonstrate citizenship in action: opportunities for individuals to have much more control over and involvement in decision-making, through personalised approaches, services delivered and embedded in communities, and utilisation of neighbourhood resources and networks. The examples range from citywide, broad-based objectives, to small-scale local opportunities to work with individuals and their communities.
Personalised approaches

The 3-conversation model

A personalised approach should start with a conversation with a person about their personal goals and outcomes. A good example of this type of conversation comes from the work of UK-based OLM Systems (Newman, n.d. n.d.), which has collaborated with the West Berkshire Council to implement a 3-conversation model to replace the existing triage-assessment-referral approach to accessing care services. The 3-conversation model is mapped out as follows.

**Conversation 1:** How can I connect you to things that will help you to get on with your life – based on your assets, strengths and that of your family and neighbourhood? What do you want to do? What can I connect you to?

**Conversation 2:** When people are at risk, what needs to change to make you safe and regain control? How do I help to make that happen? What offers do I have at my disposal, including small amounts of money and using my knowledge of the community to support you? How can I pull them together in an ‘emergency plan’ and stick with you (like glue) to make sure it works?

**Conversation 3:** What is a fair personal budget and where do the sources of funding come from? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning? (Newman, n.d. n.d.)

Newman states there are rules associated with the 3-conversation model.

- All options in conversations 1 and 2 must be explored before progressing to conversation 3.
- Certain terminology and ways of working are banned for example, “triage”, “assessment”, “referrals”, and “waiting lists”.
- Staff must co-produce a ground-up way of working within this model.
- Data must be collected daily about what employees are doing and there must be opportunities to reflect on practice with peers.
- Staff must get to know the neighbourhoods and communities within which people accessing services live and work.

The result of implementing this model for the West Berkshire Council has been a significant reduction in the number of long-term care packages required, compared to other teams operating using existing methods. OLM Systems report that council employees prefer the 3-conversation approach, even though interactions tend to take longer and staff initially felt “de-skilled” and more vulnerable through being more personally involved in people’s lives. Employees say they have a much better understanding of people, their families and their community context. They feel more pro-active and are able to see things through to a more satisfying conclusion. People accessing services report much greater satisfaction with the process, they no longer have to repeat their story multiple times, they have more autonomy throughout the process, and are more quickly able to access support.
Family Mosaic - personalised support

Family Mosaic is a social housing provider in London, UK. In 2016, they published results from a three-year study comparing health and wellbeing outcomes for 433 tenants aged over 50 who received different health and wellbeing interventions in a randomised control trial. The three different interventions were as follows.

- **Group 1** – Tenants received no additional support (the control group).
- **Group 2** – Tenants were directed to health and wellbeing services by their local housing manager.
- **Group 3** – Tenants “received intensive personalised support from a dedicated health and wellbeing support worker, including being accompanied to relevant local services” (Family Mosaic, 2016, p. 4)

The findings show that Group 3 interventions resulted in a significant drop in planned hospital usage and emergency GP visits. The results were more prominent in participants identified as very vulnerable. The interventions had no significant impact on acute hospital usage. Many people in the study whose health and wellbeing improved were not previously involved with any local or community health services. The authors argue that the capacity for their staff (who already knew the tenants) to have a positive impact was a result of pre-existing relationships based on trust, a conscious and purposeful decision to connect with tenants, a commitment to supporting tenants in their own home, and a commitment to networking and linking tenants with the services they needed.

- Tenants overwhelmingly responded to having someone to talk to and take an interest in them. The authors discussed challenges around encouraging independence, rather than developing dependency and noted the importance of the specialist skill set in the person providing support. Family Mosaic is exploring opportunities to provide physical space for health hubs to provide health and recreational services for their housing tenants.

The navigator role in New Zealand

There is considerable support in the literature for the development of more personalised and facilitated access to services. This is particularly apparent in New Zealand through the work of the Productivity Commission, Superu, Network 4, and the Taskforce for Whānau-Centred Initiatives.

The productivity commission advocates strongly for the development of “navigator” roles in New Zealand health and social services to better support the most vulnerable people. In the commission’s model, the navigator facilitates access to services via a budget-holding mechanism and works with individuals or with whānau to determine what services are best going to meet people’s needs. The success of the navigator role is dependent on their having cultural and geographic ties, and building a relationship of trust, with the person (or their family or whānau or community). Navigators collaborate with the person needing support and their family and whānau, and allocation of services is based on outcomes agreed by the person accessing services, the navigator and the funder.

Navigators are already being used in Whānau Ora or whānau-based initiatives. Superu describe the features of whānau navigators as being “well-versed in and respected for their knowledge of tikanga and te reo Māori and with extensive community knowledge” (Social Policy Evaluation and Research Unit, 2015, p. 12). An example is the Kaitoko Whānau initiative that implemented whānau navigator roles in 2009. The whānau navigators are hosted by existing Māori providers, and work with vulnerable whānau to assess their needs and aspirations and develop a plan to achieve a range of goals and aspirations (Kennedy, Paipa, & Cram, 2011, p. v).
Co-design

Large-scale co-design examples

Co-design at a system and place-based level (a generative approach) was developed in San Diego County in the US through the development of an integrated child welfare, behavioural and public health agency. The county used a generative approach to develop a 10-year plan to “repurpose” existing budgets to provide wrap-around health and social services, incorporating education, literacy, housing and other socio-economic spheres of influence (Ofteltie & Leadership for a Networked World, 2014, p. 18).

In Australia, the Brisbane Primary Health Network used co-design to develop a mental health intervention through the Partners in Recovery programme (Cheverton & Janamian, 2016). Stakeholders in the co-design process included specialist MH&A services, primary health providers, emergency services, social services, people accessing services, and their families and carers. More than 100 organisations were involved in the development phase, and workshops with stakeholder groups identified key outcomes of the model. Twenty-two organisations formed a working collaborative and from this a management committee was formed. Consumer and carer representatives met regularly with CEOs and senior managers of agencies to share experiences and map out service initiatives. Feedback was provided to all stakeholders through social media, newsletters, website and annual forums. The primary health network provided backbone support, but otherwise power was shared equally and the process operated as a high-trust model.

The co-design model expanded to consider practical approaches to improving an individual’s journey across the primary and secondary interface. A wider advisory group, including disability services, police, emergency services, housing and homelessness agencies, has been established to develop better integration responses. Further collaborative work has occurred with community pharmacies, employer groups, and the development of stepped-care housing and support models. Consumer evaluators are currently reviewing the project. Early reports show a significant reduction in unmet need and improvements in connecting to services. The major challenges reported are around the time commitment in co-design processes, and the difficulty for agencies in giving up “long-held models of care that may work for individual agencies but are not effective from a systems perspective” (Cheverton & Janamian, 2016, p. S40).

Some smaller-scale co-design examples

Research in the UK (Freire & Sangiorgi, 2010) compared four completed co-design health projects, and evaluated the extent to which the projects transformed healthcare systems and processes. The projects were for:

1) self-managing diabetes (Agenda Cards).
2) motivating people to conduct healthier lives (Activmobs).
3) engaging people not connected with primary care services (Open Door).
4) improving care for people with multiple sclerosis (Enable).

The authors considered drivers and barriers for healthcare innovation and identified success factors for co-design processes. Their results indicated that successful co-design should be more than a person-centred approach. Instead it must be “centred on the community of co-creation” in order to unravel the “professional-patient relationship”, which (echoing the findings of Dunstan et al. (2009)) they argue is one of the main barriers to the transformation of healthcare services (p. 9).
The most successful projects reviewed were Activmobs and Open Door. Activmobs created opportunities for people to participate in the design of services, then used their ideas to implement and develop a service platform solution to support lifestyle change. Open Door engaged the whole co-design community to completely rethink the core “assumptions of what a normal healthcare centre should be” (p. 9).

Co-design is already used in the disability sector in New Zealand, with individualised funding packages available for a range of services in certain geographic areas. The Enabling Good Lives individualised funding model was rolled out in Christchurch in 2013, using a deliberate co-design approach to develop the demonstration model. The model is centred on individuals and families having one plan, developed around their strengths, preferences and aspirations, and control over pooled funding that enables them to access supports of their choice (Enabling Good Lives, 2016).

A review of the Christchurch Enabling Good Lives demonstration identified that the co-design process needed to be much more clearly understood by all parties, in particular that the principles and practice of shared decision-making needed to be very explicit in order to be implemented effectively. The other key lesson from the demonstration was that the implementation workload was much higher than expected, particularly around setting up funding and administrative systems, developing key roles, and understanding the model in the context of community development processes (New Zealand Productivity Commission, 2015).

The Australian National Eating Disorders Collaboration (Dunston et al., 2009) is a partnership between researchers, clinicians, people accessing services and their carers to develop resources for people recovering from eating disorders. The process of developing the resource involved an iterative series of conversations reference group, and a staff team. The end result is a module-based resource that is still evolving. See www.nedc.com.au

Co-design resources
Waitemata District Health Board (2010) has a Health Service Co-Design web resource to support health services undertake co-design processes to develop a new service, improve an existing service, or solve a specific issue. See http://www.healthcodesign.org.nz/index.html

The Co-design Initiative (2016) resource contains a number of practical examples of co-design in the Australian MH&A sector and links to other international co-design resources. See https://auspwn.files.wordpress.com/2016/05/codesign-shared-perspectives-report-vf1-5-040616.pdf

Place-based examples
The place-based examples below illustrate ways of reframing communities of place as catchments for planning responses to health and wellbeing challenges. The scale of the response can be large (for example, citywide planning to develop healthy communities), small (for example, localised integration supporting healthy communities), or adaptive (for example, de-centralised support across multiple sites). The central frame in all cases is thinking about health and wellbeing in the context of communities of place, regardless of whether that place is a city, a neighbourhood, a school, a marae, or a person’s home.
The implication, in terms of collaborative capability, is that relationships and partnerships are with a much wider set of stakeholders and the notion of expertise is dispersed across more diverse environments.

**On a large scale**

The development of large-scale place-based initiatives revolves around frameworks that support individual agency and active citizenship. The King County\(^4\) Board of Health in the US developed Guidelines: Planning for Healthy Communities (2016b) to influence local land use and transportation planning and development that supported healthy choices for all people and communities. The guidelines outline community-planning elements that influence physical activity, nutrition, harmful environmental agents, active transport, injury and violence prevention, tobacco and alcohol use, mental health and wellbeing, and access to health care (Fleming, Karasz, & Wysen, 2010, p. 13).

King County has also recently published its Draft King County Equity and Social Justice Strategic Plan 2016-2022 (2016a) developed in collaboration with county employees and community partners. The plan aims to shift county practices from reactive to proactive investment in equity (digital, economic, education, environment, health and human services, housing, justice and transportation) through coordinated cross-sector solutions. All government departments are legally obliged to consider equity and social justice objectives in their planning and decision-making processes (King County, 2016a).

The Association of Greater Manchester Authorities in the UK has developed a memorandum of understanding to guide health and social care integration, and implement health and wellbeing priorities. These priorities include:

- giving children and young people the best start in life
- supporting the community to improve their own health and wellbeing
- shifting health provision into community settings
- providing support based on right place/right time principles
- “turning around the lives of troubled families”
- improving mental health and wellbeing
- increasing employment and productive opportunities
- supporting independence for older people in their community (Manchester City Council Health and Wellbeing Board, 2015, pp. 1-2).

Manchester City Council’s overarching objective is to shift health outcomes from some of the worst in the UK to some of the best, through “a focus on prevention of ill health and the promotion of wellbeing” (p. 1).

The state of Virginia in the US has developed a plan for wellbeing for Virginia. One of the plan’s goals focuses on the system of health care: “with a strong primary care system linked to behavioural health care, oral health care, and community support systems” (Virginia Department of Health, 2016, p. 34).

The strategies identified to achieve this goal include the development of accountable communities of care, access to primary care via “patient-centred medical homes”, integration of primary care with behavioural health care,

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\(^{4}\) King County is in the US state of Washington and includes the city of Seattle, population 1.9 million as at the 2010 census. Source United States Census Bureau www.census.gov.
addiction and oral health care services, and reorganisation of health care payment systems around prevention and support for health and wellness (p. 34).

At a similar level in New Zealand, the Canterbury Clinical Network aims to transform the Canterbury health system through integrating health and social services, keeping people, families and communities at the centre of the system, and using devolved resources to improve health outcomes. The network supports people to take greater responsibility for their own health and wellbeing and enhances local services to provide continuity of care and maintain people’s independence at home and in their community (Canterbury Clinical Network, 2016).

At a more local scale

Closing the Loop (2016) vision for MH&A services amalgamates place-based health and co-design of service pathways. Closing the Loop advocates for development of fourth-wave health and social systems focussed on citizen wellbeing, integrated support, and effective outcomes. The authors argue that meaningful outcomes need to be based around services that are located close to home, easy to access and use, culturally appropriate, and available in a variety of settings. They advocate for “Healthcare Homes” that connect individuals with a wider health and social system, facilitating access and coordinating care.

An international example of a ‘healthcare home’ is the Brandywine Centre in Coatesville, Pennsylvania in the U.S. The Brandywine Centre is a collaborative organisation providing health and housing services for low-income residents. Services provided on-site include housing for low-income seniors, critical health care, dental care, paediatric behavioural health services, prenatal care, support for chronic disease management, mental health services, social services and interpreter services. The centre has a pharmacy, a children’s library and a community meeting space. The foundation that governs the centre provides nursing scholarships, college scholarships, youth mental health first aid courses, a youth intern programme, equity programmes, and health enrolment programmes for uninsured and unregistered residents (Brandywine Health Foundation, 2016a)

The guiding principles for the Brandywine Health Foundation are stewardship, equity, wellness, collaboration and leadership. The foundation’s strategic principles on collaboration and leadership state:

The health and well-being of our entire community requires meaningful collaboration between civic, government, education, business, healthcare, community-based organizations and the public in order to address a broad range of personal, social, economic and environmental factors that influence health status and health inequalities … By strengthening and broadening community leadership and participation, we will engage stakeholders to find solutions for promoting improved healthcare and health outcomes for all. (Brandywine Health Foundation, 2016b)

The Loft service at Eastgate Shopping Centre in Linwood, Christchurch combines place-based health and co-location of services. Co-location is defined as agencies housed in one building but not necessarily providing coordinated services (Social Policy Evaluation and Research Unit, 2015, p. 5). The Loft development houses a range of social and health services to create a one-stop-shop family and community wellbeing centre. The intent is to develop collective capacity through shared location, better service accessibility and reduced complexity for people accessing services. The choice of location is important because of the existing high-volume public use of the site as a shopping mall and public library. The intent is also to provide hot-desk space for other agency staff
Collaborative capability in the mental health and addiction sector: A review of the literature

(Police, Inland Revenue, and Ministry for Social Development) to maximise the provision of services locally (Aviva Family Violence Services, Barnardos, & Family Help Trust, n.d.).

The Kohitanga collective in South Auckland providing Whānau Ora services has implemented a number of service co-location and place-based changes to improve accessibility and to better support whānau needs. These changes included hosting external services on site (psychologist, drug and alcohol services, pharmacy services), developing relationships with additional services (credit union and budgeting services), expanding the scope of services (parenting programme), and expanding the range of services (educational support) (Te Puni Kōkiri, 2015, p. 81). The collective provides services across a range of sites including marae and local medical centres and is developing its capacity to provide alcohol and other drug, and mental health secondary services from community sites.

Kapiti Youth Support is a one-stop-shop provider of health and social services for youth aged 11 to 25 years. Like MH&A services provided in schools, youth services such as Kapiti Youth Support improve uptake of services by building relationships, establishing trust and providing a more seamless experience for young people accessing the service. Specialist services (e.g. child and adolescent mental health services offer services from the Kapiti Youth Support site, and the provider has working relationships with a range of community, health and social service providers (Aldridge, 2012, p. 74).

Horizontal integration

The discussion around citizen engagement and place-based health, focuses thinking around the location and manner of service delivery. It emphasises the capacity for services to be more responsive to, and adaptive around, meeting people’s needs, as well as providing opportunities for people to more actively engage in and determine their own health and social outcomes.

The implications in terms of collaborative capability are around reframing who partnerships are with and in what context. The examples below act as prompts around expanded networking in communities of place. Other features for consideration include nimbleness and fluidity around the shape and nature of how services are delivered, the benefits of freeing up existing hierarchies or professional boundaries, and the necessity of embedding services in community contexts.

Co-location and place-based health can occur through the location of services in existing institutions. In Denmark, GP practice is more fluid, less anchored in traditional practice settings and uses co-location to enhance collaboration across the primary/secondary interface. In Danish hospitals, GPs are employed part-time to support the coordinated management of people with multiple health needs and to facilitate transition of patients generally along their care pathway. In some instances, GPs are also attached to local social services in order to achieve greater integration between health and social care. GPs are expected to provide individual care, as well as develop system improvements to improve organisational integration. In Norway, GPs are also required to work in activities in school health and nursing homes (OECD reports on health care in Denmark and Norway; cited in OECD, 2016, p. 96).

Another example is the embedding of MH&A services in schools. There is considerable support for, and evidence in the literature of the success of provision of MH&A services in school settings (Ballard, Sander, & Klimes-Dougan, 2014; Grossman & Vang, 2009; National Association of School Psychologists, 2015; Powers,
Swick, Wegmann, & Watkins, 2016; Taras, 2004). For example, Grossman and Vang (2009) cite multiple studies showing that youth accessed physical and mental health services much more frequently and proactively when services were co-located on school sites. Closing The Loop (Network 4, 2016, p. 24) includes an Auckland case study of nurses, GPs and psychologists housed in schools, with referrals made by teachers and school counsellors. The result has been increased uptake of services by students and improved ease of referrals into secondary M H&A services.

Odyssey House in Auckland provides an alcohol and drug treatment programme and delivers services across a variety of settings: in individuals’ homes, as part of residential services, in institutional settings such as schools and prisons, as well as in workplaces (Aldridge, 2012, p. 78). Odyssey House has extended the reach of addiction interventions through the upskilling of primary care providers at an Auckland medical centre. Odyssey House specialists worked alongside primary care professionals to integrate addiction interventions into regular primary care practice (Network 4, 2016, p. 23).

The provision of Mental Health First Aid programmes by Ko Awatea in South Auckland is another example of fluid service delivery and the embedding of services in local community contexts. Counties Manukau District Health Board provides mental health first aid programmes to any adult living within its geographical area. The programme teaches lay adults in the community how to assist people who are developing a mental illness or are in a mental health crisis (Ko Awatea, 2015).

The Prime Minister’s Youth Mental Health Project takes a population focus at a policy level but applies it across spheres of influence that are local and community-oriented. The project is currently implementing 26 initiatives across health, education, social development, Whānau Ora and place-based locations. The initiatives range from online tools, new school-based behaviour and wellbeing programmes, development of existing school-based health, social and Whānau Ora services, youth-specific workforce training, development of youth-specific services, and improved access to existing M H&A services (Ministry of Health, 2016b)

Superu’s 2016 review Going Digital to Deliver Wellbeing Services to Young People considers opportunities for different ways of delivering services that are “devolved, user-centred and co-created” (Social Policy Evaluation and Research Unit, 2016, p. 2). The report notes the capacity of technology to overcome barriers to accessing traditional services, offer more democratic support options that are available closer-to-home, and provide enhanced opportunities for self-management.

Conclusion

Citizen engagement frames the idea of collaboration in two ways. First it looks at the responsibility of the M H&A sector to respond to individual citizens. What does a partnership based on equity and trust look like with individual citizens? The literature describes this in terms of partnerships with citizens based around personalised approaches to developing support options, individualised funding packages, or the use of navigators to personalise and guide access to services. The emphasis is on the rights of people accessing services to work in partnership when determining the shape and nature of support options.

The second way of looking at collaboration is around social citizenship. Citizens are situated in communities, and the context of those communities should determine the nature of the health and social sector response.
whether it is planning for health and wellbeing at a city-scale, or local community-based responses, or adaptable services that reach and impact on citizens in more effective ways. Whānau Ora inherently does both things; it sets up a system of support that responds to individual need, and at the same time establishes a support response around the individual in the context of their whānau and community.

The implications for the MH&A sector are a workforce development approach that supports the development of a much wider set of collaborative skills, in particular:

- the capacity to work in partnership with individuals in a way that is meaningful and effective
- the capacity to collaborate in varied community contexts.

The section that follows explores the collaborative capability required to work in partnership with individuals and to collaborate across a range of community settings.
Collaborative capability

Key messages
Expanding the scope and nature of service delivery into community settings, and personalising support around the health and wellbeing of individuals, requires a workforce that is adept in collaboration.

Collaborative capability applies to individuals as well as to organisational culture and practice. The development of collaborative skills has to occur at both a micro and macro scale in order to be effective. The breadth and depth of collaborative capability across communities of practice, people, culture and place requires a focus on:

- values, behaviours and approaches
- new roles for brokers and specific skills around collaborative leadership
- the specific skills required to collaborate with people accessing services
- development of comprehensive and embedded networking practice
- increasing utilisation of resources to support collaborative capability
- commitment to skills support and training, professional opportunities, good human resource practice, and purposeful education to develop collaborative skill sets.

Introduction
The international and New Zealand literature on collaboration and integrated services emphasises that the MH&A sector needs support and access to better resources in order to develop collaborative capability (Hazel & Hawkeswood, 2016; Network 4, 2016; Platform Charitable Trust, 2012; Platform Trust & Te Pou o Te Wahaaro Nui, 2015; Roche & Skinner, 2005; World Health Organization, 2010).

Collaborative capability is essential for the MH&A sector to be able to:

- form mutual partnerships with individual people accessing services
- integrate across existing boundaries
- collaborate within communities.

There are pockets of innovative integrated service delivery across New Zealand with evidence of the MH&A workforce and services collaborating well with and within their communities. Many other MH&A practitioners and services aspire to work more collaboratively, but are not sure how to start or what to put their time and energy into.

Many health workers believe themselves to be practicing collaboratively, simply because they work together with other health workers (World Health Organization, 2010, p. 36).

5 See On Track (Platform Trust & Te Pou o Te Wahaaro Nui, 2015, p. 50) for emerging models of health and social service delivery in New Zealand. See also More Effective Social Services (New Zealand Productivity Commission, 2015) for a range of examples.
This section describes collaborative capability at an individual and organisational level. The focus on individual capability describes personal values, behaviours and approaches, including essential networking skills. It also describes the features of collaborative leadership and specialised broker roles that sustain connections between partnerships.

Organisational collaborative capability considers the culture and practice required to develop and sustain collaborative practice. Again the emphasis is on values, behaviours and structural approaches to collaboration. There are links to resources for readers to explore further. The section concludes with a description of ways to develop a collaborative skill set.

### Features of individual collaborative capability

The features of a workforce adept in collaboration apply across a wide range of types of partnerships and ways of relating. The World Health Organization describes a “collaborative practice-ready health workforce” that is ready and capable of working collectively in order to respond to complexity and emerging problems (World Health Organization, 2010, p. 20).

Collaborative capability described in the literature is a mix of values, behaviours and approaches that range from individual practice through to organisational culture and practice. This section starts with a review of attributes of individual practitioners and enablers of individual collaborative capability. It also looks at skill sets of brokers and the nature of collaborative leadership.

### Values, behaviours and approaches

Values are a person’s principles or standards of behaviour: what is important to that person. Behaviours are the ways that a person conducts him or herself, or individual ways of working. There is some overlap between behaviours and approaches but in this context approaches are external mechanisms that enable an individual to practice collaboratively. Approaches are enabled through good human resource practice and a commitment by an organisation or by leadership to developing individual collaborative capability.

Table 1 outlines these individual features.

<table>
<thead>
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<th>Table 1: Features of collaborative capability</th>
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<tbody>
<tr>
<td>Individual practitioner attributes</td>
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<tr>
<td>Attribute</td>
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<tr>
<td>Values: Humility about what can be achieved alone and commitment to the benefits of mutual gain.</td>
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<tr>
<td>Commitment to equity, openness and trust, respect and diversity.</td>
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The key to collaboration is – in our humble view – humility. It is about exploring, unpacking and improving by working with others – inevitably an uncertain and somewhat messy process (Kippin & Fulford, 2016, p. 4).
<table>
<thead>
<tr>
<th>Behaviours</th>
<th>Source</th>
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<tbody>
<tr>
<td>Honesty and kindness.</td>
<td>Kippin &amp; Fulford, 2016</td>
</tr>
<tr>
<td>Open to risk and innovation.</td>
<td>The Partnering Initiative, 2016b</td>
</tr>
<tr>
<td>Flexibility and adaptability, particularly around decision-making.</td>
<td>Department of Internal Affairs, 2007; State Services Commission, 2008</td>
</tr>
<tr>
<td>Respect for potential partners and motivation to connect with others.</td>
<td>Gray &amp; Stites, 2013; Hanleybrown et al., 2012; The Partnering Initiative, 2016b; Whitehead, 2015</td>
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<tr>
<td>Open to and can accommodate different points of view and alternative working styles.</td>
<td>State Services Commission, 2008</td>
</tr>
<tr>
<td>Able to actively seek out people of a similar mind and motivation.</td>
<td>Department of Internal Affairs, 2007</td>
</tr>
<tr>
<td>Capacity to relinquish autonomy/equalise power and work for a greater good/social outcomes.</td>
<td>Bryson et al., 2006; Kippin &amp; Fulford, 2016; The Partnering Initiative, 2016c</td>
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<tr>
<td>Good relationship and communications skills, including open and frequent information sharing.</td>
<td>Allen and Clarke Policy and Regulatory Specialist Ltd, 2010; State Services Commission, 2008</td>
</tr>
<tr>
<td>Capacity to work in inter-professional teams and with individuals, family, whānau, carers and communities.</td>
<td>World Health Organization, 2010</td>
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### External enablers of individual collaborative capability

<table>
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<tr>
<th>Enabler</th>
<th>Source</th>
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<tbody>
<tr>
<td>Collective identity, purpose and vision.</td>
<td>Allen and Clarke Policy and Regulatory Specialist Ltd, 2010</td>
</tr>
<tr>
<td>Clear roles and responsibilities to reduce tension and conflict and to enable cooperation.</td>
<td>Whitehead, 2015</td>
</tr>
<tr>
<td>Space (commitment and resourcing) for negotiation and collaboration.</td>
<td>(Kippin &amp; Fulford, 2016)</td>
</tr>
<tr>
<td>Identification and development of “passionate and visionary staff” and strategic leaders.</td>
<td>(Allen and Clarke Policy and Regulatory Specialist Ltd, 2010; Department of Internal Affairs, 2007, p. 21; Hanleybrown et al., 2012, p. 8; Whitehead, 2015, p. 7)</td>
</tr>
<tr>
<td>Access to good advice to support decision-making.</td>
<td>(State Services Commission, 2008)</td>
</tr>
<tr>
<td>Development of a culture of learning.</td>
<td>(Hanleybrown et al., 2012)</td>
</tr>
<tr>
<td>Opportunities to share what works.</td>
<td>(Prescott &amp; Stibbe, 2016)</td>
</tr>
<tr>
<td>Reduced internal compliance/removal of bureaucratic barriers to allow for creativity and risk taking.</td>
<td>(Thornley &amp; Ball, 2015; Whitehead, 2015)</td>
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</table>
Brokers

There is varied terminology in the literature about the people who are best at making and sustaining connections between partners. The literature most commonly describes this role as a “broker” (Bryson et al., 2006; Courtney, 2007; Palinkas et al., 2014; Partnership Brokers Association, 2012) but variants of this role are also described as: “public entrepreneurs” (Institute of Policy Studies, 2008; Kippin & Fulford, 2016), “bridge builders” (Waitakere City Council, 2009b), “system translators” (New Local Government Network & Collaborate, 2016), “partnership facilitators” (Prescott & Stibbe, 2016), “influential champion” (Hanleybrown et al., 2012) and “facilitative leadership” (Partnership Brokers Association, 2016).

There is considerable support in the literature for a broker-type role to contribute to the success of partnerships (Bryson et al., 2006; Courtney, 2007; Palinkas et al., 2014). The Partnering Toolbook describes a broker or intermediary as an individual (either internal or external) whose role is to “build and strengthen the partnership – especially in its early stages” (Tennyson, 2011, p. 19). The Partnership Brokers Association (2016, p. 22) survey of international partnerships highlighted that brokers are:

Critical to the successful navigation of contextual issues – in other words, to the way the partners and the partnership learn how to steer through contextual challenges and, sometimes, even how they can actively challenge and change the ‘rules of the game’.

Get Well Soon (New Local Government Network & Collaborate, 2016) describes a variant of the broker role as a “system translator” with an essential skill set to support a shift from service silos to systems outcomes. The report discusses the critical features needed to enable outcome-focussed collaboration at a local level.

System translators have an important, but often poorly appreciated skill set. They are found across professions, services and organisations and typically have career experience across sectors. They are comfortable working in the ambiguous spaces between silos or professional groups, or between public and private service provision. System translators are the glue in organisational relationships, or in the development of integrated services; they bring people together and hold them in place over time. They network instinctively, they build and maintain relationships, inspire trust and confidence, overcome inter-professional tension, and help others feel supported and able to commit to shared outcomes. They tend to be creative problem-solvers and are not constrained by existing boundaries or prior ways of doing things (New Local Government Network & Collaborate, 2016).

Research by the Partnership Brokers Association (2012, p. 36) assessed 250 logbooks maintained by brokers working in collaborative partnerships across a range of international multi-stakeholder contexts. They found that brokers had the most impact on:

- relationship-building and management
- modelling partnership skills and approaches
- supporting partnerships and partners through conflict and to expand the scope of collaborative work
- supporting and encouraging reflective practice.

They identified that the people in these roles are not necessarily leaders of a project, but noted the importance of knowing who they are in order to utilise their skills purposefully from an early stage. The Partnership Brokers Association has developed a broker role description adapted to different stages of the partnering cycle (outlined...

Collaborative leadership

The UK-based collaborative think-tank (called Collaborate) has developed what it calls an Anatomy of Collaboration (Kippin & Fulford, 2016) specifically aimed at leaders in health and social services. Collaborate argue that the most significant shift in public service practice needs to be in modes of leadership. In particular, they argue that successful contemporary leadership must embrace complexity, non-linearity, devolved power, be systems-based, and committed to co-production of services with the people accessing them. The onus is on leaders taking more risks, being open to and supportive of new approaches, modelling collaborative behaviour, and building opportunities for collaboration into everyday practice. Collaborative leadership accepts not knowing all the answers, and promotes and models asking questions instead. Collaborative leadership incorporates both leading from the front and leading from within.

Leading from the front

Leaders set the culture for the whole organisation. If an organisation aspires to be more collaborative, then its leaders need to model collaborative and community-building behaviour to support the development of these practices across the wider organisation (Alton, 2015; State Services Commission, 2008). Collaborative leaders provide legitimacy and mandate for change (Department of Internal Affairs, 2007; State Services Commission, 2008). Collaborative leaders are adaptive (Collaboration for Impact, 2016), “they foster environments that are flexible, open, with a strong sense of purpose” (Whitehead, 2015, p. 7) and take “responsibility for convening stakeholders and facilitating agreements for collective action” (Fitchett, 2016, p. 68). Collaborative leadership is non-hierarchical and inter-organisational (Collaboration for Impact, 2016; Fitchett, 2016, p. 68). Collaborative leaders help maintain momentum, they must be able to push the thinking of other strategic partners, particularly when there is conflict or differences in organisational values and culture that threaten to derail projects or partnerships (Collaboration for Impact, 2016; State Services Commission, 2008, p. 17).

A social neuroscience approach to collaboration reinforces these ideas and clarifies that different styles of leadership promote or prevent positive engagement (including collaboration) in a workplace. Employees with a more positive mind state have improved problem solving skills, are able to collaborate better and generally perform better in the workplace (Frederickson, 2001, and Jung-Beeman, 2007; cited in Rock, 2008, p. 3). The SCARF model explains how perceived neurological threats or rewards play out across five social domains: status, certainty, autonomy, relatedness and fairness. The model highlights the features of leadership that are likely to promote or prevent collaborative behaviour.

Leaders who make an employee feel good about themselves, have clear expectations, allow autonomous decision-making, trust their staff and are fair, are much more likely to foster an environment of commitment, creativity and innovative problem-solving. Conversely, a leader who provides a lot of direction, but little positive feedback, reduces certainty through lack of clarity, undermines autonomy through micro-management, is aloof
and lacks transparency in decision-making, will be much less likely to generate a productive, creative and innovative working environment (Rock, 2008).

**Leading from within**

The collaboration literature emphasises that a collaborative workplace has multiple types of leadership spread across an organisation, rather than just at the front (Hanleybrown et al., 2012; Inspiring Communities, 2013a; Kippin & Fulford, 2016; Tennyson, 2011). Inspiring Communities describe this as being “leaderful”, where “power is distributed, shared and where leadership comes from many corners of the community” (2013a, p. 7).

Tennyson (2011) acknowledges the challenge of being a “leader”, in a context that is based on collaboration, equity, and shared responsibility. The challenge is resolved through a broader understanding of leadership roles that may include:

- being guardian of the partnership’s mission
- coaching partnership behaviour
- challenging established ways of thinking or doing things
- empowering others to act, innovate, make mistakes
- fostering optimism when facing challenges (p. 20).

This leadership narrative shares obvious links with the broker skill set, and a number of authors see the development of the broker skill set as a critical way of developing collaborative leadership skills within and across an organisation (Adebowale et al., 2015; Hanleybrown et al., 2012). Hanleybrown et al (2012) describe an “influential champion” (or group of champions) who have the leadership skills to bridge gaps between services, organisations, or sectors, to coalesce and maintain critical relationships over time, and to remain focussed on outcomes, but allow individual stakeholders the opportunity to innovate and create solutions to the problem or complexity at hand. Kippin and Fulford (2016) describe a “public entrepreneurship skill set”, which they argue needs to be developed to better leverage resources, improve decisiveness of decision-making, and create a more nimble and innovative workforce. The authors state that the development of this workforce skill set is important for spreading the “narrative about leadership beyond a cadre of existing heads-of-organisations” (p. 10).

Chapter 4 of Inspiring Communities’ Learning by Doing (2013a) focuses exclusively on the more nuanced ways that leadership plays out in community contexts. The chapter contains many links to other resources and can be accessed on: [http://inspiringcommunities.org.nz/wp-content/uploads/2015/10/Learning-By-Doing-chapter-4-leadership1.pdf](http://inspiringcommunities.org.nz/wp-content/uploads/2015/10/Learning-By-Doing-chapter-4-leadership1.pdf).

**Networking matters**

All collaborative partnerships or innovative service developments start with people making connections, valuing what others have to offer, and sharing ideas. The very point of working together is that you can achieve more when you are working collectively than you can on your own. A collaboration-ready workforce is able to network intuitively and organically, and prior networks are a crucial antecedent for the development of collaborative partnerships (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010; Bryson et al., 2006, p. 46; Department of Internal Affairs, 2007, p. 21; Hazel & Hawkeswood, 2016).
The New Zealand Government push for health and social services to collaborate more is geared towards an end goal of more integrated services (New Zealand Productivity Commission, 2015; Platform Trust & Te Pou o Te Whakaaro Nui, 2015). However, not all organisations are ready to collaborate, or their environment is not conducive to collaboration. In fact, the literature universally cautions against collaborating for the sake of it, largely because of the time and energy costs, which may outweigh the benefits (Hazel & Hawkeswood, 2016; State Services Commission, 2004, 2008). Instead collaboration should be purposeful and oriented towards particular and explicit outcomes (Hazel & Hawkeswood, 2016; State Services Commission, 2004; Waitakere City Council, 2009a).

Networking, on the other hand, should be a fundamental part of everyday practice. Networking is typically informal, it is based around sharing information and building relationships, it is about knowing who is in your community and what they are doing (Waitakere City Council, 2009b). Networking also builds trust, it provides opportunities to share expertise, learn what others are doing, and learn from others, without necessarily altering what you are doing locally (Hazel & Hawkeswood, 2016). Networking lays the groundwork for more complex and involved partnerships further along the collaborative continuum (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010).

There are some disadvantages to networking, particularly when more formal partnership approaches are called for or when specific outcomes are sought. Research on networking within the UK National Health Service highlighted disadvantages with the clinical networks studied including:

- too many meetings and not enough output
- weak focus (in the absence of clear targets and milestones)
- limited momentum (particularly in the absence of resources to support relationships, including broker skills)
- domination by particular professional groups (Ferlie et al., 2010; cited in Ham & Alderwick, 2015, p. 27).

From an everyday perspective, good networking doesn’t have to be complex or difficult, but it should be about investing in relationships as the basis of everything you do. The following are some basic networking skills to consider as a starting point.

- Start small – relationship building takes time and energy and practice.
- Improve relationships and networking within your own organisation.
- Communicate well – internally and externally.
- Be culturally responsive – prioritise your personal and organisational cultural responsibilities towards other stakeholders.
- Have soft doors – as an organisation be open, permeable, transparent and welcoming; make it easy for others to approach you.
- Practise and understand kōrero kanohi ki te kanohi as a preferred way of communicating (O’Carroll, 2014).
- Have obvious and easily navigated points of contact for yourself or your organisation – across a range of platforms.
- Always respond to communication coming in, and expect the same of other organisations – don’t be a black hole that information disappears into.
- Make the most of opportunities to network with others – give and get invitations.
• Get out of your office or usual workspace and into your community.
• Know your networks – of people accessing services, providers, agencies and support networks.
• Identify who you want to get close to and purposefully make connections with them.
• Know your organisation’s reputation – find out what people, community stakeholders and other providers think about how they are treated by your organisation and their service experience, and what they think you could do to improve things.
• Seek feedback and treat complaints as a positive opportunity to improve.

The Community Tool Box (Work Group for Community Health and Development, 2016) resource established by the University of Kansas has good advice on basic networking and relationship building. See Chapter 24 on http://ctb.ku.edu/en/table-of-contents

The Department of Internal Affairs Good Practice Participate resource (2014) has guidance for organisations on how to work with specific population groups and where to go for advice and support. See http://www.communitymatters.govt.nz/vwluResources/Good_Practice_Participate_Working_with_Specific_Groups/$file/GPP_working_with_specific_groups.pdf

Collaborating with people accessing services

The Australian Co-design Initiative (2016) has developed a resource to support co-design processes in the MH&A sector. The principles and practice described in the resource outline fundamental skills required to collaborate with people accessing MH&A services. The skills listed are mirrored in the broader collaboration literature. However the difference is that the Co-design Initiative resource is specifically tailored around working with citizens, whereas the broader literature tends to focus on collaboration between workforce groups, services, organisations and sectors.

Some of the key co-design skills described by the Co-design Initiative (2016) include:
• having honest conversations between all the people involved
• sharing, listening to and valuing stories of personal experience
• meeting face to face
• allowing time to build relationships and trust
• understanding that solutions come from an inclusive process and mindset
• allowing for very open dialogue
• involving lots of people and using peer networks extensively
• providing flexibility around ways for people to be involved
• developing common ground and learning together.

All of these features are central to the collaborative capability required for partnerships with people accessing services.
Features of organisational collaborative capability

Values and behaviours

Collaborative organisations must focus on developing and strengthening relationships inside their own organisation, as well as with external stakeholders. This necessarily means focusing on internal values, being explicit about what those values are, and what they should be (Kippin & Fulford, 2016, p. 8). These findings are echoed in the State Services Commission (2008) report on collaboration: organisations that can collaborate internally will be much more successful in partnerships with external agencies. This internal emphasis applies to organisational culture and work practice, as well as individual capability. Organisations must be able to continually assess the “degree to which they are organisationally ‘fit for partnering’ and take steps to adjust and continually improve” (Prescott & Stibbe, 2016, p. 9).

There are consistent features identified in the literature about what makes a partnership or collaboration process successful, and what can cause a partnership to fail. Alignment around a common vision and shared goals is often a time-intensive process but is critical to the success of collaborative projects (Hanleybrown et al., 2012; Huang & Seldon, 2014; Palinkas et al., 2014). The beginning processes in a collaborative project are arguably the most important, but also the most time consuming (Department of Internal Affairs, 2007). Establishing solid relationships between collaborative partners is a crucial part of the partnering process, which is why prior networks are so important, but the groundwork laid at the start of a process is often the key to long-term success (Department of Internal Affairs, 2007; Hazel & Hawkeswood, 2016).

Mattesich and Rausch (2013) surveyed professionals working in health, education, social services, housing, transportation and community development finance, to identify the factors that underpin successful cross-sector community health initiatives, and the obstacles that prevent collaboration between the health and community sectors. All interviewees were employed by organisations with a focus on improving community health outcomes. The researchers followed the survey with in-depth interviews across 27 organisations.

The respondents identified three factors that they believed most strongly influenced collaborative success:

- skilled grassroots and organisational leadership
- mutual respect and understanding among partner organisations
- a shared vision and common goals.

Respondents also identified that community engagement and relationships were critical to project success. Inadequate funding and resources were identified as the most significant barriers to the success of collaborative projects.

The Partnership Brokers Association (2016) surveyed international partnerships to assess the critical features of working collaboratively. Its research focussed on ways that partnerships brought about transformational change through a controlled process of “creative dissent”. Its tips for helping create more transformational partnerships are as follows:
• develop a culture of reflection (and efficiency through reflection)
• communicate continuously and imaginatively
• use real examples – to develop confidence and risk taking
• ask lots of good questions (instead of having answers)
• make everything outcome-based
• build collaborative capability
• encourage openness and bravery
• explore divergent views as opportunities for innovation
• allow space and time for ideas and solutions to emerge
• be aware that partnership is not the only mechanism to bring about change (p. 27).

Structural approaches
More formal features of collaborative organisations include clear communication strategies; conflict resolution policies (including a problem-solving orientation); effective use of agreements; shared decision-making processes, including forums to identify, discuss and resolve differences – all identified and implemented early in the process and maintained throughout the stages of partnerships (Hurlburt et al., 2014, p. 167; Palinkas et al., 2014, p. 20; Victorian Health Promotion Foundation, 2001; World Health Organization, 2010). Clarity around what each party brings to the table is also important, particularly around capacity (time, financial and human resources, backroom and technical support) (Braunstein & Lavizzo-Mourey, 2011).

Other structural approaches include, effective governance and other accountability mechanisms (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010), clarity of process through the use of policies, procedures and agreements (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010), clarity around ways of working (Hanleybrown et al., 2012), and ongoing review of the partnership’s success (Bryson et al., 2006; Tennyson, 2011).

The Stanford Social Innovation Review of collective impact projects identified two key structural elements that hold collaborative partnerships together: “backbone organization” and “cascading levels of linked collaboration” (Hanleybrown et al., 2012, p. 6). A “backbone organization” provides strategic leadership and infrastructure, including relationship support, communication, funding, and information management functions. The leadership function provided by the backbone organisation has to manage the tension between spearheading an initiative, and behind the scenes coordination that opens out opportunities for other partners to drive innovation and change. Fitchett (2016) describes this as leadership having a stake in agreeing outcomes and encouraging divergent ways to reach those outcomes.

“Cascading levels of linked collaboration” describes use of an oversight group or steering committee to oversee the development of a common agenda and strategic framework, with separate working groups developed to work separately on specific goals, but coordinating with other working groups and the oversight group (Hanleybrown et al., 2012, p. 12).

Success and longevity in partnerships is about ongoing evaluation of the success of a partnership and whether outcomes have been met (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010; Bryson et al., 2006). Bryson et al.’s (2006) review of successful cross-sector collaborations identified partnership resilience through
consistent review of what is working. The authors showed collaboration is more likely to be successful where there are accountability systems that track inputs, processes and outcomes, using a variety of data methods, and built on strong relationships with constituencies. The authors recommend always celebrating successes, big and small, and the importance of publicising those successes to keep internal and external stakeholders engaged.

Allen and Clarke (2010) recommend use of agreements to guide conflict resolution, accountability, success criteria, outcome measurement and stakeholder turnover.

The Partnering Initiative state that a successful partnership should be able to demonstrate either that it has achieved what it set out to do; that it is “having impact beyond its immediate stakeholder group”; that it is sustainable, either through ongoing commitment by stakeholder organisations or evolution into another mechanism or form; and finally, that it has added value to partners through learning or improvements to systems, or through transformational change (Tennyson, 2011).

Palinkas et al (2014) reviewed inter-organisational collaboration between Californian agencies. The authors identified internal and external features that most influenced the successful provision of wrap-around services for at-risk youth. The review was based on interviews with providers of probation, mental health and child welfare services in a randomised control trial to scale up the use of evidence-based multidimensional treatment. The researchers identified key success characteristics of participating organisations and individuals. They described an organisational culture of collaboration (the “inner context”) as containing the following characteristics:

- a common language
- shared recognition of the problem
- shared goals and values
- commitment to innovation and change
- accountability – through a range of mechanisms
- interpersonal relations and social ties
- willingness to serve as a broker or advocate
- supportive leadership
- a reputation for honesty, trust and respect.

The research showed that organisations need a commitment to innovation and change, and a policy framework that supports transparency and accountability.

Ways of developing a collaborative skill set

The literature is less resolved around how to develop collaborative capability. Part of the complexity around developing collaborative skills is that it’s best to learn by doing, and if sectors generally are not behaving in particularly collaborative ways, then it is more difficult for practitioners to develop collaborative capability.

The literature describing ways to develop a collaborative skill set focuses primarily on workforce development opportunities. There is some emphasis in the literature on ways of developing a partnership culture in an organisation, with very little literature on how to develop capability around partnerships with people accessing
The five key collaborative workforce development areas identified in the literature are:

- inter-professional education
- skills support and training
- shared learning opportunities
- good human resource practice
- formal education opportunities

**Inter-professional education**

The World Health Organization has written extensively on the role of inter-professional education in developing a collaborative practice-ready workforce. The World Health Organization argues that inter-professional education is essential to the development of the collaborative capability needed to respond to increasingly fragmented service delivery and complexity of need. Inter-professional education aims to “shift the way health workers think about and interact with one another”, this in turn changes workforce attitudes and organisational culture in a way that impacts positively on the end user of health services (World Health Organization, 2010, p. 22). A substantial body of evidence exists to show that inter-professional education contributes significantly to improved teamwork, clearer understanding of roles and responsibilities, improved communication, better learning and critical reflection skills, enhanced capability around building relationships with and recognising the needs of the person accessing services, and more ethically-based practice (p. 26).

Part of the World Health Organization’s focus in the development of collaborative capability includes identifying the necessary practice-level mechanisms to support this capability. The remainder of this section highlights what services or organisations can do locally to improve workforce and organisational collaborative capability.

**Skills support and training**

Skills support and training in collaborative leadership, communication and relationships are crucial components of the development of collaborative capability (Matessich & Rausch, 2013). Essential collaborative skills training includes improving team performance through development of skills such as appreciating others, being able to engage in purposeful conversations, and how to productively and creatively resolve conflicts (Gratton & Erickson, 2007).

Opportunities to develop partnership skills are increasing with the growth, particularly in the context of sustainable development goals, of organisations focussed on building collaborative capacity and providing training for partnership brokers. Prescott and Stibbe (2016) describe these as “capacity building organisations” that provide partnership effectiveness training for individuals and partnership development for organisations (p. 13).

For example, the Partnership Brokers Association specialises in partnership skills development and support for “partnering process management” across a range of sectors (Partnership Brokers Association, 2016). It provides training opportunities in New Zealand, see: [http://partnershipbrokers.org/w/training/](http://partnershipbrokers.org/w/training/).
Provision of brokering services at an organisation or sector level is growing internationally. OLM Systems in the UK is an example of a specialist organisation working specifically in the care industry to develop integrated systems, to support change in organisation culture and behaviour, and provide support around working in partnerships (OLM Systems, 2016).

Shared learning opportunities

A n additional mechanism for developing a collaborative skill set is through shared learning opportunities, and this can take a number of forms. Coaching and mentoring is critical to developing collaborative behaviour (State Services Commission, 2008), and the more coaching and mentoring is embedded in everyday activities and across an organisation, the more likely it is to increase collaborative behaviour (Gratton & Erickson, 2007).

Shared learning can also occur through more formal networks for disseminating successful collaborative practice. This can be face-to-face through local groups, or at a distance through an online repository of good practice (Braunstein & Lavizzo-Mourey, 2011). Oxfam’s approach to shared learning is to bring in outside people with wider experience to share new ideas and bring fresh perspectives (Whithead, 2015, p. 8). The effects of sharing good practice and new ideas are twofold. They provide an opportunity for reflection for practitioners, to think about ways to enhance an existing collaboration, based on input from others. They also provide motivation to others to build their own collaborative opportunities (Mattessich & Rausch, 2013).

Shared learning can also include support around the technicalities of funding opportunities and programmes and other operational issues, as well as opportunities to learn and train in a cross-sectoral way (Mattessich & Rausch, 2013).

Good human resource practice

Good human resource practice is also central to developing a collaborative skill set. The Anatomy of Collaboration describes how human resource systems can help align organisational culture with everyday collaborative good practice. The authors describe a very real tension for workers when they are faced with “acts of betrayal” against their organisation “in order to do what is needed and support citizens properly” (Kippin & Fulford, 2016, p. 8). The authors argue for a shift in emphasis away from the “organisational logic” that drives unethical decisions, to a system that rewards values- and outcomes-based career choices.

Two things are needed: first career arcs and workforce strategies that more explicitly value cross-sector experience and social innovation ... second, a more nuanced form of performance management that can create incentives for individuals to adapt and collaborate (Kippin & Fulford, 2016, p. 8).

The Get Well Soon (New Local Government Network & Collaborate, 2016) authors argue that there is insufficient development of the broker or system translator skill set across the public sector; and that brokers tend to fall into collaborative processes by accident, rather than being purposefully identified, developed or
recruited for particular projects. Get Well Soon outlines a number of ways to establish and grow this capability through good human resource practice.

- Identify the skill set and develop through:
  - performance management competencies and capabilities
  - education and training
  - workforce planning and recruitment strategies.
- Create opportunities for role expansion through:
  - job-swapping between partner organisations
  - job role flexibility beyond core tasks and service or organisational scope to focus on wider outcomes
  - networking between wider workforce teams to allow expanded engagement, issues resolution, and development of integration practice (New Local Government Network & Collaborate, 2016, p. 59).

**Formal education opportunities**

The role of formal education in developing collaborative capability largely gets picked up in the inter-professional education literature. The Anatomy of Collaboration (Kippin & Fulford, 2016) describes universities and other sector bodies as critical partners in efforts to support the shift to collaborative practice and to get public sector organisations thinking outside of their usual “service lens”.

Deakin University in South Australia has developed a graduate profile that applies to every graduate, regardless of his or her course or professional affiliation. The profile describes learning outcomes based on sets of knowledge and capabilities that build on graduates’ discipline-specific expertise. The intention is to prepare and support graduates for employment and life-long learning in complex, changing, inter-disciplinary and globalised work environments. Table 2 shows a summarised version of Deakin’s graduate learning outcomes.
Table 2: Deakin University graduate learning outcomes

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discipline-specific knowledge and capabilities</td>
<td>At an appropriate level related to a specific discipline or profession</td>
</tr>
<tr>
<td>Communication</td>
<td>Oral, written, interpersonal communication to inform, motivate, and effect change</td>
</tr>
<tr>
<td>Digital literacy</td>
<td>Use of technology to find, use and disseminate information</td>
</tr>
<tr>
<td>Critical thinking</td>
<td>Evaluation of information using analysis and judgement</td>
</tr>
<tr>
<td>Problem solving</td>
<td>Creating solutions to real world and complex problems</td>
</tr>
<tr>
<td>Self-management</td>
<td>Independent working and learning and self-responsibility</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Working and learning with others from different disciplines and backgrounds</td>
</tr>
<tr>
<td>Global citizenship</td>
<td>Ethical and productive professional engagement with diverse communities and cultures</td>
</tr>
</tbody>
</table>

Source: Deakin University (2016).

Deakin’s graduate profile presents a useful way of thinking about what capabilities services might expect of their workforce, outside of traditional professional competencies. A local example of this in action is the work of Ko Awatea at Counties Manukau District Health Board. Ko Awatea’s mandate is to explore and create opportunities for proactive health promotion through development of leadership and innovative thinking, change programmes and continual improvement of existing systems. Ko Awatea hosts an education centre and provides workforce development opportunities (Ko Awatea, 2015).

Some key resources to support the development of collaborative capability

The Partnering Initiative has developed a range of tools to support organisations to develop their collaborative skills and to ensure the success of partnerships. Of particular note is their Fit for Partnering Framework (The Partnering Initiative, 2016b) that gives an overview of the key components of an organisation’s ability to partner. The framework can be accessed at: http://thepartneringinitiative.org/tpi-tools/the-fit-for-partnering-framework/.

The Partnering Initiative (2016a) has also developed a summary tool of twelve steps of successful partnerships, which can be found on http://thepartneringinitiative.org/tpi-tools/12-steps-towards-successful-cross-sector-partnerships/. Table 3 shows the 12 steps.
Table 3: 12 steps towards successful cross-sector partnerships

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>1.</td>
<td>Understand the issue</td>
</tr>
<tr>
<td>2.</td>
<td>Know and respect your partners</td>
</tr>
<tr>
<td>3.</td>
<td>Knowledge and skills</td>
</tr>
<tr>
<td>4.</td>
<td>Clear partnership objectives</td>
</tr>
<tr>
<td>5.</td>
<td>Start small and scale up</td>
</tr>
<tr>
<td>6.</td>
<td>Partnering agreements</td>
</tr>
<tr>
<td>7.</td>
<td>Organisational commitment</td>
</tr>
<tr>
<td>8.</td>
<td>Project management</td>
</tr>
<tr>
<td>9.</td>
<td>Relationship management</td>
</tr>
<tr>
<td>10.</td>
<td>Strong communication</td>
</tr>
<tr>
<td>11.</td>
<td>Ongoing review</td>
</tr>
<tr>
<td>12.</td>
<td>Planning for the longer term</td>
</tr>
</tbody>
</table>


The Australian Government is focusing on innovation in the Australian public service. The emphasis is on supporting organisations to identify good ideas and to implement frameworks that allow those ideas to progress into new ways of thinking, changes in practice and improved systems. The rationales for encouraging innovation includes citizen and stakeholder expectations about how publically funded services behave and act. The assumption is that innovation “flourishes in an environment of openness and collaboration” and that improved engagement with people accessing services, communities of practice, and other stakeholders enables better problem identification, access to a broader range of insights, and more innovative solutions (Department of Industry, 2011 n.p.). The Public Sector Innovation website has tools for assessing organisational innovative capacity (Department of Industry, 2011). See http://innovation.govspace.gov.au/tools/.

The NZ Navigator (2016) is an online tool that allows community organisations to self-assess their organisational infrastructure and guides decision-making to improve organisational effectiveness and efficiency. It includes review domains around communication (connecting with others) and relationships (collaboration, partnerships and working effectively with others). The tool can be accessed on https://www.nznavigator.org.nz/.

The Community Toolbox (Work Group for Community Health and Development, 2016) is an online tool developed by the University of Kansas to support community health and development. The toolbox includes toolkits around supporting partnerships, development of leadership, management and facilitation, and resources for community development. The toolbox can be accessed on http://ctb.ku.edu/en

Collaboration for Impact (Collaboration for Impact, 2016) is an Australian community of practice and online collaboration toolkit. The resource builds on Kania and Kramer’s (2011) work on collective impact. The resource includes comprehensive support around developing organisational collaborative capability. The resource can be accessed on www.collaborationforimpact.com.
Conclusion

The development of collaborative capability across the MH&A sector requires a concurrent macro and micro focus in order to be effective. Collaborative capability applies to individual practitioners, at the level of workforce development, and at an organisational system level. An emphasis on all three approaches is required in order to develop partnerships with citizens, across traditional boundaries and multiple contexts.

There are key broker and leadership roles that are central to any collaborative endeavour. But all organisations that want to be better at collaborating should start by looking at their own internal organisational values and their capacity to network well with others. Good human resource practice is essential to good collaboration. An understanding, and valuing of the skills required to collaborate well, and an expansion of ideas about collaborative leadership should form the basis of organisational practice.

There is an expanding range of resources available to support individuals and organisations to collaborate well and the opportunities for collaborative workforce development are expanding as many sectors and interests embrace collaboration as a mechanism to respond to the complexities of need and increased demand for services. The next section explores in more detail the technical resources available to support the development of collaborative capability.
Key messages
The technical resources available to support collaboration and the development of partnerships are expanding in scope as the mandate for collaboration evolves across sectors. The literature describes a range of partnerships along a continuum of collaboration and the stages or life cycles of partnerships.

Barriers to collaboration include inadequate resources (time, people and funding), poor leadership, an absence of vision or collective outcome, poor partnership processes (for example, around use of agreements, communications, conflict resolution, backbone support, evaluation), limited opportunity or mandate to innovate or explore divergent thinking, and poor or limited existing relationships and trust with prospective partners.

There are a number of resources available to support organisations to form more formal partnerships. The resources emphasise a focus on:

- understanding the partnership context through scoping out the problem, building relationships and knowledge, and the use of feasibility assessments to assess collaboration opportunities and whether a more formal partnership is warranted
- using agreements to bind a collaborative relationship
- managing partnerships through identifying the resources needed, developing a shared vision and collective outcomes, developing ways of working, and understanding the phases of partnership processes
- using evaluative techniques to review progress and ensure the health of the partnership.

Introduction
The technical side of collaborative capability, particularly for organisations, is based around more formal partnership processes and mechanisms that provide structure and security around new organisational relationships. Get Well Soon (New Local Government Network & Collaborate, 2016) describes these mechanisms as “commitment devices”, which, broadly speaking, are structural arrangements that bind the relationship and guide collaboration process and organisational activity.

The literature is dense with analysis of the technical components of partnerships, but there is some evidence that the more technical resources are not being utilised by the health and social services sector in New Zealand. Hazel and Hawkeswood’s (2016) review of collaboration in the New Zealand community services sector found that few of the collaborative case studies they reviewed focussed on the technical aspects, with evidence of considerable variability around process, and little utilisation of available resources. This is not necessarily a bad thing. The organisations interviewed in Hazel and Hawkeswood’s (2016) review emphasised relationship building as central to their collaborative approaches and this is entirely validated in the literature, with a checklist approach to collaboration generally unsupported, especially at the start of a collaborative process (Hazel & Hawkeswood,
However, it is important for organisations to be aware of when to engage with more structured approaches. Ham and Alderwick’s (2015) research highlights the risk of getting stuck at the networking phase when more formal support would allow a partnership to progress. Get Well Soon (New Local Government Network & Collaborate, 2016, p. 60) states that if:

*Commitment devices … are deployed at the right time by partners based on good relationships and along a trajectory towards integration, they can serve to deepen and embed integration.*

There is clearly a balance within organisational collaborative capability between a focus on relationships and outcomes, and the technical side of partnerships. The emphasis here is to support services and organisations to be purposeful and considered as they enter more formal partnerships. There are many resources available, so this section highlights the main points arising out of the literature and links to key resources that cover off types of partnerships, stages of partnerships, features and pitfalls, and use of agreements.

### Collaboration partnership continuum

There are many visual descriptions of the collaboration or partnership continuum in the literature. The continuum below is an amalgamation of two sources. It identifies commonly described collaborative relationships along a continuum and lists the characteristics of each type of relationship. These relationships range in formality and degree of relational integration from co-existence, to networking, to cooperation and coordinated activities, to formal collaboration and partnerships, and finally full mergers. The continuum below describes structural approaches, so it does not represent the citizen engagement processes outlined in the Citizen Engagement section of this review, but focuses instead on the ways that services or organisations typically work together across the continuum.

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6 The continuum above combines the *Better Connected Services for Kiwis* (Institute of Policy Studies, 2008) continuum of inter-governmental integration and the *Putting Pen to Paper* partnership continuum (Department of Internal Affairs, 2007).
Collaborative capability in the mental health and addiction sector: A review of the literature

Table 4: Relationships and structural characteristics along the collaboration continuum

<table>
<thead>
<tr>
<th>Types of collaboration</th>
<th>Nature of relationship</th>
<th>Relationship features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coexistence</td>
<td>Self-reliance</td>
<td>Autonomous</td>
</tr>
<tr>
<td>Networking &amp; communication</td>
<td>Shared information</td>
<td>No formal communication</td>
</tr>
<tr>
<td>Cooperation &amp; coordination</td>
<td>Shared projects</td>
<td>May have common concerns</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Shared goals</td>
<td>Separate systems</td>
</tr>
<tr>
<td>Partnership</td>
<td>Shared accountabilities</td>
<td></td>
</tr>
<tr>
<td>Merger</td>
<td>Amalgamation</td>
<td></td>
</tr>
</tbody>
</table>

- Developing relationships
- Get together on common interests
- Share information as needed
- Maintain autonomy
- Alignment of interests
- Regular working together on shared projects
- May share resources
- No ongoing/ formal commitment
- Formal commitment to working together
- Negotiated and agreed actions
- Shared policies and/or practices
- Trade-offs around loss of autonomy
- Mutual obligations
- Shared values, vision, resources, accountability, power, and decision-making
- Integrated programmes
- May involve more integrated planning or funding
- New organisational form
- Single system

Increasing formality, complexity and risk, commitment and interaction, and integration of services and relationships. More likely to govern relationship through the use of agreements.

Adapted from Institute of Policy Studies (2008) and Department of Internal Affairs (2007).

The key message about the collaboration continuum is that it works best as a guide for ways of working together, but should not be used as a definitive description of how partnerships will proceed. The nature of a partnership and where it sits on the continuum will depend on existing relationships and the outcomes sought, as well as capacity, willingness and mandate to collaborate. In fact, many collaborative endeavours can exist at different points along the continuum at one time (Courtney, 2007; Waitakere City Council, 2009a).

Different stages of partnerships

There are a number of different frameworks in the literature describing the stages that partnerships typically go through. One of the most comprehensive models is that developed by the Partnering Initiative (2016c), which provides a systematic framework based around four stages.
1. Scoping and building.
2. Managing and maintaining.
3. Reviewing and revising.
4. Sustaining outcomes.

Figure 3 shows the partnering cycle broken down into the four stages of partnerships.

**Figure 3: The partnering cycle**


These stages are analysed further below, with supporting evidence from the wider literature.

**Scoping and building**

The scoping phase should include an assessment of whether more formal collaboration is going to improve a situation. Barriers to collaboration may be difficult to overcome, so it is important to understand barriers before you start. The Partnering Practice Guide for Waitakere (Waitakere City Council, 2009b) outlines five reasons why collaboration may be very difficult to undertake.

1. Historical conflict – based on prior experiences or interpersonal disputes, trust issues, or conflicting values – personal and organisational.

2. Competition and contracting arrangements – particularly in a constrained funding environment.

3. Ignorance – based around “the way we’ve always done things” or lack of insight into the benefits of working with others.
4. Resource constraints – most commonly time, but also lack of skill set and minimal financial resources to support collaboration.

5. Barriers – physical, cultural, ideological, or bureaucratic that make an organisation difficult to approach.

These context-related issues and challenges also include cultural differences and variance in leadership expectations (Partnership Brokers Association, 2016, p. 22). However, it can be the complexity of the context that often creates the most interesting opportunities for innovation and transformational change. Context should strongly influence the shaping up of vision and goals, identifying the type of partnership that will work best, personnel involved, other resourcing needed, and the process for developing a partnership.

Whatever the reasons for collaborating, a key message from the literature is to be very clear how much time and energy collaboration can take, especially at the start of the process when partners are getting to know each other (Department of Internal Affairs, 2007). The Auditor General’s review of Whānau Ora noted the “extra work involved in delivering services in a whānau-centred way”, with mixed messages from government funders about recompensing providers for the extra workload arising out of more collaborative behaviour and the provision of a more integrated model (Office of the Auditor General, 2015, p. 53).

Even when an organisation is well resourced, collaboration may not be the best approach. A number of authors emphasise the importance of undertaking a feasibility assessment before collaborating. Such an assessment might ask questions such as:

- What is our goal and do we need to collaborate to succeed?
- Is there capacity within the organisation to collaborate?
- Does the problem need to be resolved quickly (collaboration takes time)?
- Is there a willingness to share power and decision-making and are there any differentials in power that will need to be managed?
- Do we have enough information about the context and potential partners?
- Is there capacity for flexibility, innovation and risk?
- And overall, do the benefits outweigh the risks?


Reasons for not collaborating include the need to act quickly, target groups that are too diverse, “significant differentials in power”, and either a top-down push for collaboration that lacks grassroots support, or the converse, grassroots support with little leadership commitment (Allen and Clarke Policy and Regulatory Specialist Ltd, 2010, p. 22). Organisational risks around the decision to partner include damage to “reputation, loss of autonomy, conflicts of interest, drain on resources, implementation challenges” and difficulty managing the partnership (Waitakere City Council, 2009b, p. 9).
Tools to help with the feasibility process

The Victorian Health Promotion Foundation website includes a Partnerships Analysis Tool (VicHealth, 2011) to assist organisations entering into or working in a partnerships and to assess, monitor and maximise partnership effectiveness. The tool has particular relevance for cross-sector partnerships. See https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool

The Working Together More fund (The Working Together More Fund) has New Zealand-specific checklists “How Well Prepared Are We To Collaborate” and “Tips When Collaborating”. The fund also has a funding stream to support collaborative projects get up and running. See http://www.workingtogether.org.nz/new-checklists-learn-from-others-about-preparing-and-implementing-strong-collaborations/

The U.S.-based Fund for Our Economic Future (Thompson, 2016) has developed a collaboration handbook to support civic partnerships between philanthropic organisations. The handbook includes a series of evaluative tools that include partnership feasibility and evaluation of the outcomes of collaboration. See http://www.thefundneo.org/sites/default/files/CollaborationHandbook_FINAL.pdf

When to use agreements

Many partnership relationships work well without an agreement in place. But entering into a formal agreement demonstrates a concrete commitment to a partnership and a collaborative way of relating, so to a greater or lesser extent, it formalises accountability. Even if that accountability is just a commitment to keep each other informed or meet regularly.

The Partnering Toolbook makes a distinction between agreements and contracts. Agreements are generally not legally binding, they are voluntary, easily re-negotiable, often open-ended, and are mutually developed between parties. The complexity of the partnership may necessitate more formal contractual agreements (Tennyson, 2011).

A joint initiative between The Partnering Initiative and The Partnerships Resource Centre has developed the Partnering Agreement Scorecard, a resource to help create new partnership agreements or review existing ones (Pfisterer, Payandeh, & Reid, 2014). The resource is based around the presumption that an agreement should “reflect and enable the objectives of the partnership” and supports both transactional exchanges and the transformational aspects of collaborative partnerships (Reid & Pfisterer, 2014, p. 65). The scorecard states that a good agreement will:

The point at which commitment devices are deployed across the healthcare system is critical. Use them too soon and you create friction if solid relationships are not yet in place and partners do not yet trust each other’s motives ... Yet without any commitment devices at all, partnerships tend to get beached at the bottom end of the scale, having meetings that lead nowhere and maintaining separate ways of working despite the appearance of good relationships (New Local Government Network & Collaborate, 2016, p. 61).
• define the problem
• specify roles and responsibilities
• articulate commitments
• formalise relationships
• support the partnering process and guide decision-making
• reduce misunderstanding and conflict
• maintain focus
• support review and evaluation (Pfisterer et al., 2014, p. 8).


The best New Zealand resource around agreements to support partnerships is the Department of Internal Affairs (2007) Putting Pen to Paper. The guideline advises that there is no one size fits all agreement, instead the agreement should be specific to the partnership, the history between partners, the type of collaborative relationship sought and any accountability mechanisms included. Putting Pen to Paper includes a good description of agreement types, the likely trigger for considering that agreement and some general requirements around the use of each type of agreement. The guideline can be found on the Inspiring Communities website [http://inspiringcommunities.org.nz/working-together-2/](http://inspiringcommunities.org.nz/working-together-2/).

**Managing and maintaining**

At the start of a partnership, the emphasis should be on identifying leaders and initiators, making sense of the problem, learning to share information between partnership members, and being clear around the resources required if a partnership proceeds (Hazel & Hawkeswood, 2016; Institute of Policy Studies, 2008).

Identification of the right people in the right roles is also critical. Hazel and Hawkeswood (2016) split personnel into:

• decision-makers and managers
• service delivery personnel
• facilitators
• external stakeholders, including people accessing services and community.

In terms of team composition, people work together better if they see themselves as alike, and if there are some (but not too many) prior relationships between group members. The more experts there are in a group, the more likely it is that conflict will occur (Gratton & Erickson, 2007).

Decisions need to be made about the skill set required, representation of stakeholders, and clarity around roles and responsibilities (Institute of Policy Studies, 2008). Collaboration improves when roles are clearly defined and well understood (Gratton & Erickson, 2007). In the absence of role clarity, team members are more likely to focus on negotiating roles or patch protection than getting on with tasks. Gratton and Erickson note that the balance between role clarity and task ambiguity is critical to developing a creative approach. Role clarity supports people to work independently and with autonomy. Task ambiguity encourages innovation, because individuals have to develop their own solutions to achieve the collective goal.
The early stages of a partnership should also include the development of a governance structure with “strong and credible champions” (Hanleybrown et al., 2012, p. 3). Governance can be based around self-governing structures, a lead organisation, or a network administrative organisation (Bryson et al., 2006, p. 49).

In terms of making sense of the problem or challenge, it is important to collaborate around a clear vision or set of goals and shared measures of success. Gray and Stites (2013) emphasise that having a shared vision is not the same as having the same goals. In fact, often organisations can have different goals that coalesce under a shared vision. The process of developing a vision should be built on an open-minded exploration of similarities and differences, and the capacity to hold your own organisation’s goals, alongside the goals of other stakeholders, which might be quite different, in the context of broader objectives.

Identification of need and challenges should include a rich understanding of the contextual factors: the more complex the context, the clearer the vision needs to be (Partnership Brokers Association, 2016). Fundamental to this is a commitment to working with and on behalf of citizens and the affected community and shaping the problem or need based on an individual and community perspective (Waitakere City Council, 2009b). This part of the partnership process can be very time consuming but it is important not to rush or force an outcome. Often most learning and development happens through the process of understanding the issues, relationship building, and exploration of the challenge (Institute of Policy Studies, 2008).

Ways of working is about practical process and should be based on shared values and expectations around engagement and participation. All parties need to have a voice and feel safe to speak, there need to be ground rules for interactions and how to manage conflict (Gray & Stites, 2013; Hanleybrown et al., 2012). The Partnering Toolbook outlines good partnering practice based around partnership language, working from an evidence base, good partnership conversations, management of meetings, keeping records, creating a learning culture, and setting ground rules (Tennyson, 2011, pp. 23-26).

Trust is central to productive ways of working. It is a key component of good interpersonal relationships and organisational competence, it is a bond between partners, and it generates good will towards the process. Trust is developed through sharing of information and knowledge, commitment to the process and outcome, and honesty and good will between stakeholders (Bryson et al., 2006). The development of trust and ensuring participation should also be based on a commitment to cultural capability and making sure that whānau-centred approaches are an integral part of identifying need, establishing commonality and developing solutions (Te Puni Kōkiri, 2015).

Managing conflict is central to successful partnerships. Bryson et al’s (2006) review of cross-sector collaboration identified that conflict is common (and should be expected) and most often emerges from differing aims and expectations of partners or power differential between partners. Partnerships are most likely to succeed when “partners use resources and tactics to equalize power and manage conflict effectively” (p. 48). Conflict resolution demands “people be willing to open themselves, recognize their blind spots and rigid preconceptions … to challenge respective biases and assumptions” (Gray & Stites, 2013, pp. 44; quoting Senge et al., 2006: p. 2429).

7 See Te Puni Kōkiri’s Understanding Whānau-Centred Approaches for a detailed description of whānau-centred approaches and cultural capability, both for individual workforces and organisations (Te Puni Kōkiri, 2015).
Development of a collective outcome will arise out of the process of identifying need and establishing ways of working. The outcome will depend on many factors and may be a more superficial change such as improvement in reputation, or a deep transformational change such as a complete system redesign. Outcomes can be process-focused, such as integration of function or increased participation, or technical, like defining models of governance. Outcomes can be broad and difficult to measure, for example, improvements to quality of life, or implementation of culturally responsive practices, or very specific, such as the implementation of training opportunities (Gray & Stites, 2013).

The Partnering Toolbook (Tennyson, 2011) is a comprehensive resource that provides guidance around building partnerships, use of agreements, management of the partnership process, and partnership longevity and sustainability. It contains a number of templates, checklists and questionnaires and can be accessed at http://thepartneringinitiative.org/wp-content/uploads/2014/08/Partnering-Toolbook-en-20113.pdf

Reviewing and revising

Evaluation of the success of a partnership should be built into the process from the beginning. The Partnering Toolbook outlines the following areas of review:

- monitor progress
- audit results or impacts
- review the partnership (including the partnership agreement)
- clarify revision procedures
- develop moving on and exit strategies (Tennyson, 2011, p. 26).

Evaluation is dependent on the development of useful and measurable outcomes that can be process or ends-based. Measuring progress early on in the partnership demonstrates achievements during more challenging stages of the partnership and allows opportunities to celebrate success to help maintain motivation (Bryson et al., 2006; State Services Commission, 2008, pp. 15-16). Evaluation also contributes to a culture of accountability within the partnership (Hanleybrown et al., 2012). The development of a strong evidence base, based on outcomes is critical for the scaling up of projects, replication at other sites, and influencing outside decision-making and policy (Whitehead, 2015).

The Amherst H. Wilder Foundation has developed a tool to assess how collaboration is progressing relative to 20 success factors and based on a five-point scale for each factor (Mattessich, Murray-Close, & Monsey). See http://www.wilder.org/Wilder-Research/Research-Services/Pages/Wilder-Collaboration-Factors-Inventory.aspx

Sustaining outcomes

Partnerships may end because they lose resources; they achieve certain goals; because new partnering opportunities are available; priorities or context changes; or because the need or challenge no longer exists. A number of authors recommend building in exit planning or a moving on strategy so that partners can leave with minimal friction (Halper, 2009; Huang & Seldon, 2014; Tennyson, 2011). Partnerships may disband through handover of responsibility from one partner to another, or based on a decision that the work or programme is better managed independently. Or a third independent organisation may take over the partnership (Tennyson, 2011, p. 29).
The greatest risk to partnering is staff turn-over resulting in loss of organisational knowledge and damage to key relationships, particularly if the person leaving has been a broker or key facilitator (Waitakere City Council, 2009b, p. 21). The Waitakere partnering practice guide (Waitakere City Council, 2009b) includes a ‘Relationship Hand-over Template’ to support succession planning. See http://www.waitakere.govt.nz/abtcnl/pp/pdf/Partnering-Practice-Guide.pdf

Some of the literature also describes the end of partnerships as part of a cyclical nature of relationships. Inspiring Communities compares partnership evolution to an ecological cycle, noting that the failure or completion of a partnership is an opportunity for learning, new thinking, and developing of new opportunities (Inspiring Communities, 2016).

The Moving On handbook (Halper, 2009) is a specific resource that supports partnerships through exits, transitions, and the end of partnerships. It includes advice around hand-overs, communication guidelines, and links to further resources. See http://thepartneringinitiative.org/publications/toolbook-series/moving-on/

The life cycle of partnerships

The Better-Connected Services for Kiwis (Institute of Policy Studies, 2008) report describes the life cycle of partnerships, including typical characteristics of each stage and opportunities or strategies that can be used to compensate or advance the partnership. The tool assumes there will be high points and low points throughout the life of a partnership. The authors note that some partnerships will never get past stage 2, as illustrated in Figure 4, which is why conflict resolution strategies are so important.

![Figure 4: The partnership life cycle](image)

Table 5 below outlines the characteristics of each stage of the partnership process and approaches to move partnerships forward. The emphasis is on explicitly describing the behaviours of partnership stakeholders and how those behaviours can support or hinder the success of partnerships.

Table 5: Characteristics of the partnership life cycle

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Focus should be</th>
</tr>
</thead>
</table>
| Stage 1 Forming | • Enthusiasm for common cause  
• Exploration of challenges and relationships  
• Unclear commitments | • Opportunities to build relationships  
• Focus on common vision  
• Define tasks and outcomes  
• Use evidence |
| Stage 2 Frustration | • Disputes and questions about partnership priorities and methods  
• Doubts and suspicion about hidden agenda and partner contributions  
• Competition for control | • Revisit common ground  
• Celebrate little wins  
• Facilitate opportunities for constructive disagreement |
| Stage 3 Functioning | • Renewed vision and focus  
• Progress through joint project teams  
• Clarity around roles and responsibilities  
• Development of mutual accountabilities | • Agree objectives, responsibilities, success measures, and principles for collaboration  
• Encourage shared leadership and accountability  
• Develop common methods and quality standards  
• Develop learning opportunities through cross-partner project teams, joint training and review |
| Stage 4 Flying | • Achievement of partnership goals  
• Shared leadership  
• Transformational change in behaviour or service provision  
• Trust and respect | • Anticipate future challenges and develop capacity to respond  
• Develop a succession plan  
• Review group performance  
• Enhance communications  
• Review partnership effectiveness  
• Continue to celebrate success |
| Stage 5 Failing | • Disengagement  
• Tension  
• Lack of commitment  
• Relationship breakdown | • Review stage 2 actions  
• Wind up the partnership |


Conclusion

The technical resources to support partnerships are expanding in scope, although the emphasis in the literature is still predominantly on collaboration between organisations rather than partnerships with citizens. This is a gap in the literature around more specific support for collaboration with service users, and this presents a sizeable challenge for the MH&A sector as it moves to develop partnerships with a broad range of stakeholders.
The literature signals the need for clarity around when to shift into a more technical and structured approach to collaboration. The timing around this shift is important because of the risks of partnership failure due to poorly organised and unsupported collaborative processes. There is a balance also between maintaining opportunities for organic, fluid relationship building and more structured and time-consuming partnerships. It is important for the M H A sector to be cognisant of the types of partnerships, stages of partnerships, features and pitfalls of collaborative processes, and when and how to use agreements and other commitment devices.
Summary

There are key messages in the collaboration literature that are relevant for M H & A services in New Zealand.

1. There is widespread, international, cross-sector support for collaboration and partnerships to better respond to fragmented service delivery, complexity of need and community expectations.

2. The direction of collaborative change is towards community and place-based systems of support, detached from traditional settings. The direction of change is underpinned by equity and partnerships with citizens, and a dismantling of traditional hierarchies and professional boundaries.

3. An integrated system of support is more likely to develop when there are concurrent macro and micro approaches to collaboration and partnerships.

4. Collaborative approaches should be conscious, purposeful, goal-driven and highly contextual.

5. The proposed system change is challenging, and requires support and appropriate resourcing.

6. There are numerous opportunities and resources to support the development of collaborative capability.

Widespread support for collaborative capability

The literature on collaboration and partnerships is extensive and encompasses a broad range of settings and agenda. In general, the collaboration literature reflects a shift away from traditional transactional interactions based on state-mandated “doing to”, towards disseminated collaborative and integrated approaches based around “working with”, underpinned by the rights of citizens to determine the shape and outcomes of support and development.

Primary reasons given for the shift to more collaborative approaches are:

- the failure of fragmented systems to meet need
- the complexity of need and situation
- changing community and citizen expectations.

Increasing demand for services, the complexity of problems and individual or community need, community expectations, and an emphasis on rights-based citizenship, are all influencing the shape, nature and purpose of health and social services.

Long-term goals expressed in the literature focus on responding to demand through combined collective responsibility and capacity building in communities. In the context of health and social services, an emphasis on wellbeing is coupled with a more preventive approach, the development of opportunities for individual self-determination, and the development and expansion of place-based integrated health and social services.
The direction of collaborative change

The direction of collaborative change is away from traditional hierarchies, existing organisational structures and transactional approaches. Instead there is an emphasis on altering demand through the development of community-based resources and networks to support and empower citizens to have greater influence over their own health and wellbeing.

Citizen engagement is enhanced through:

- personalised support approaches
- increased system flexibility to support individual choice and control over funding and services
- co-design of service delivery and systems
- investment in existing networks and communities and increased fluidity of service delivery.

Place-based health shifts emphasis into communities in order to respond to the wider determinants of health and to utilise existing networks, resources and opportunities to determine and respond to demand in different ways. Whānau Ora employs all these strategies in ways that are specific, organic, purposeful and responsive. In general, there are gaps in the literature around how to build better relationships with people accessing services and there is significant opportunity to improve capability in this regard.

Macro and micro thinking

Collaboration is much more likely to be successful when there is a focus on macro and micro components of the system at the same time. It can legitimately be very challenging for individuals to work more collaboratively or for organisations to develop a collaborative culture, particularly where there is an absence of collaborative leadership and higher-level infrastructural change.

Similarly, there needs to be investment in community, local services, people accessing services, family and whānau when collaboration is called for at a strategic level, in order that the reach of change is widespread. This is particularly important for MH&A services. If the push for collaboration or integration takes place at a policy level, there has to be concurrent investment in local collaborative capability, development of leadership skills and understanding around the logistics of partnerships, and resourcing around time and space for innovation and collaboration.

Purposeful collaboration

There is often a tipping point that propels organisations (or services, teams and individuals) towards more collaborative behaviour. The tipping point can be around frustration with the current way of doing things, overwhelming demand or complexity, changes in policy direction or funding environments, or just a collective will to solve problems in partnership. However, organisations need to be clear about the opportunities and costs of collaboration before they enter into a partnership. There are risks for organisations around collaborating with minimal preparation or capacity, or collaborating for the sake of it. Both scenarios are more likely to lead to failed partnerships.
The literature is very clear that the shift towards collaboration and partnerships needs to be conscious, purposeful, goal-driven and very cognisant of context. Change, particularly transformative change, is difficult and requires comprehensive commitment from leaders that is developed over time. Success is often dependent upon the presence of enablers or brokers, people with a highly developed collaborative skill set who generate and support collective will and action towards a particular end point.

Purposeful collaboration builds on good relationships, understands the problem/challenge well, is centred around a shared vision, is resourced well (time, funding, skills), is clear about ways of working and relationship processes, uses binding mechanisms (such as agreements) and good quality evaluation to keep the partnership on track.

Collaborative capability

Collaborative capability is about values, behaviours and approaches of individuals as well as ways that people think and behave within an organisation. The literature emphasises the features of collaborative leadership, the critical skill sets of system translators or brokers, and organisational culture and infrastructure that supports collaboration and partnerships.

The capacity for people to network and collaborate within their own organisation or community (of people, practice, culture and place) is a crucial antecedent for collaborating more broadly. Collaborative values include humility, honesty and kindness, and a commitment to equity, trust and diversity.

Behaviours include openness to ideas, commitment to a range of partners, opportunities and ways of working, communal development of solutions, and an acceptance that solutions often lie outside traditional spheres of influence or organisational practice.

Approaches include the capacity to operate in a collective and multiplex environment, good human resource practice including clear roles and responsibilities, skill set identification and support, opportunities for innovation and risk, and good conflict resolution practices. Collaborative leadership and the use of brokers builds bridges between individual capability and collaborative organisational culture and system change. Collaborative leaders lead by example at the same time as allowing space and opportunity for innovation and collective action.

Where to start

The literature highlights two key interlinked starting points for any organisation that wants to collaborate more effectively. The first is to focus on internal organisational values, behaviours and culture, and to continuously reflect upon and develop the features that support collaboration. The second is to start with small networking or collaborative opportunities with other service providers or agencies, or through personalised approaches with people accessing services.

Beyond this it is crucial for organisations to develop collaborative skills, with small but developing opportunities to seek professional support for this in New Zealand. Human resource practice is critical to the development of collaborative capability through effective mentoring, shared learning opportunities, opportunities for role expansion, a focus on specific skills development (relationship building, communications, cross-sector
capabilities, conflict resolution), leadership development, collaboration-focused performance management, and workforce planning and recruitment. Workforce development in the MH&A sector needs to implement strategies that foster a collaborative skill set.

Technical support for collaboration

The challenges around working more collaboratively are well documented in the literature. The biggest barriers to collaboration are inadequate resources (time, people and funding), poor leadership, an absence of vision or collective outcome, poor partnership processes (for example, around use of agreements, communications, conflict resolution, backbone support and evaluation), limited opportunity or mandate to innovate or explore divergent thinking, and poor or limited existing relationships and trust with prospective partners.

The technical resources available to support collaboration, new partnerships and reconfiguration of the existing system are expanding in scope as the mandate for collaboration evolves across sectors. There are a number of organisations that exist solely to support collaborative enterprise and expertise, and specific resources that assist with collaborative practice. Table 6 below outlines the main technical components of collaboration. All the resources used throughout this review are listed in a Resource Appendix at the end of this document.

Table 6: The technical components of collaboration

<table>
<thead>
<tr>
<th>Technical resource</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>The partnership continuum</td>
<td>Describes the characteristics of different collaborative</td>
</tr>
<tr>
<td></td>
<td>relationships</td>
</tr>
<tr>
<td>The partnership cycle</td>
<td>Describes the typical life-cycle stages of partnerships</td>
</tr>
<tr>
<td>Feasibility tools</td>
<td>Determine readiness for collaboration</td>
</tr>
<tr>
<td>Agreement resources</td>
<td>Provide examples and agreement evaluation tools</td>
</tr>
<tr>
<td>Partnership processes</td>
<td>Describe partnership success features</td>
</tr>
<tr>
<td>Evaluation tools</td>
<td>Assess internal and external partnership effectiveness</td>
</tr>
<tr>
<td>Moving on strategies</td>
<td>Supports staff turnover and the winding up and transition of</td>
</tr>
<tr>
<td></td>
<td>partnerships</td>
</tr>
</tbody>
</table>
Conclusion

The push for collaborative capability is an international objective in the developed and developing world, across public/private interfaces, and across a range of traditional organisational and service delivery boundaries. The literature on social sector collaboration borrows from business models, interfaces with sustainability goals, blurs boundaries between philanthropic, private and state objectives, deinstitutionalises across organisational layers, and invites innovation in order to create paradigm shifts and respond to complexity of need.

There are strong signals across the health and social services sector in New Zealand that collaborative capability is central to the development of fourth-wave integrated, community-based, and citizen-focused MH&A support options. There are many resources available to support the MH&A sector to develop collaborative capability: both individual workforce values, behaviours and approaches to collaboration, as well as structural and attitudinal changes at an organisational and system level.
Resource appendix

Co-design
Waitemata District Health Board health service online co-design resource

Co-design Initiative report on co-design in MH&A services in Australia
https://auspwn.files.wordpress.com/2016/05/codesign-shared-perspectives-report-vf1-5-040616.pdf

Community development and collective impact
University of Kansas Community Toolbox online toolkits on community development, supporting partnerships, and leadership
http://ctb.ku.edu/en
Australisn Collaboration for Impact online resource supporting collective impact and collaboration. The link below provides access to a range of online resources

Brokers
Partnership Brokers report on good practice for brokers

Leadership
Inspiring Communities Learning by Doing report – Chapter 4 on leadership in communities

Networking and relationship building
University of Kansas Community Tool Box online resource Chapter 24 Section 3, which is focused on networking, but the entire resource covers all aspects of collaboration
http://ctb.ku.edu/en/table-of-contents
New Zealand Department of Internal Affairs online tips for working with specific population groups

Training
Partnership Brokers training opportunities in New Zealand http://partnershipbrokers.org/w/training/

Partnership feasibility
The Victorian Health Promotion Foundation online Partnerships Analysis Tool
The New Zealand Working Together More Fund online partnership checklists:

- ‘How Well Prepared Are We To Collaborate’
- ‘Tips When Collaborating’


**Partnership skills and processes and evaluation**


The Amherst H. Wilder Foundation online collaboration evaluation tool [http://www.wilder.org/Wilder-Research/Research-Services/Pages/Wilder-Collaboration-Factors-Inventory.aspx](http://www.wilder.org/Wilder-Research/Research-Services/Pages/Wilder-Collaboration-Factors-Inventory.aspx)


**Using agreements**

Department of Internal Affairs Putting Pen to Paper resource on partnership agreements can be found on the Inspiring Communities website [http://inspiringcommunities.org.nz/working-together-2/](http://inspiringcommunities.org.nz/working-together-2/)

**Ending partnerships**

The Waitakere City Council Partnering Practice Guide for Waitakere includes a ‘Relationship Hand-over Template’ to support succession planning


**Innovation and organisational effectiveness**


The NZ Navigator online community organisation infrastructure and decision-making self-assessment tool [https://www.nznavigator.org.nz/](https://www.nznavigator.org.nz/)
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Providing</th>
<th>Web address</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Partnering Initiative</td>
<td>UK not-for-profit developing partnership capability to meet United Nations sustainable development goals</td>
<td><a href="http://thepartneringinitiative.org/">http://thepartneringinitiative.org/</a></td>
</tr>
<tr>
<td>Collaborate</td>
<td>UK collaboration think tank developing cutting-edge approaches</td>
<td><a href="http://collaboratei.com/">http://collaboratei.com/</a></td>
</tr>
<tr>
<td>The Partnership Brokers Association</td>
<td>International professional body providing training and capability development for people managing and developing collaboration processes</td>
<td><a href="http://wwwpartnershipbrokers.org/">http://wwwpartnershipbrokers.org/</a></td>
</tr>
<tr>
<td>The Amherst H Wilder Foundation</td>
<td>US non-profit social services organisation providing community research and partnership tools</td>
<td><a href="https://www.wilder.org">https://www.wilder.org</a></td>
</tr>
<tr>
<td>Kansas University</td>
<td>Community development expertise and Community Toolbox resource</td>
<td><a href="http://ctb.ku.edu/en">http://ctb.ku.edu/en</a></td>
</tr>
<tr>
<td>Vic Health</td>
<td>Australian health promotion arm of Victorian government developed the Partnerships Analysis Tool</td>
<td><a href="https://www.vichealth.vic.gov.au">https://www.vichealth.vic.gov.au</a></td>
</tr>
<tr>
<td>Collaboration for Impact</td>
<td>Australian community of practice and online collaboration toolkit</td>
<td><a href="http://www.collaborationforimpact.com">www.collaborationforimpact.com</a></td>
</tr>
<tr>
<td>Superu</td>
<td>New Zealand Government social policy evaluation and research</td>
<td><a href="http://www.superu.govt.nz/">http://www.superu.govt.nz/</a></td>
</tr>
<tr>
<td>The Working Together More Fund</td>
<td>New Zealand collaboration support for community groups including partnership evaluation tools</td>
<td><a href="http://wwwworkingtogether.org.nz/">http://wwwworkingtogether.org.nz/</a></td>
</tr>
<tr>
<td>Inspiring Communities</td>
<td>New Zealand community-led development support, networking and best practice</td>
<td><a href="http://inspiringcommunities.org.nz/">http://inspiringcommunities.org.nz/</a></td>
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