Developing a scale to measure trust in health promotion partnerships

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SUMMARY

Developing and sustaining partnerships for promoting health has been identified as an important strategy for addressing the health challenges that face society. Trust is one of the most important factors that help partnerships function effectively. In health promotion partnerships, trust is an under-researched and poorly understood phenomenon. This study was designed to identify how trust is conceptualized in health promotion partnerships and to develop a trust measurement tool. Five focus groups were organized with 36 health promotion partners in order to explore how trust is conceptualized in their partnerships. Participants represented health, community, education, arts, sports and youth sectors. A content analysis was carried out on the transcripts and a 14-item, *five-point scale, was developed from the findings. This scale was incorporated into an overall questionnaire on partnership functioning which was posted to 469 partners in 40 health promotion partnerships. A response rate of 72% was achieved (n = 337) for the postal survey. The trust scale was subjected to reliability and validity tests. Principal Component Analysis yielded two components, named positive trust and mistrust, explaining 59% of the variance. Coefficients ranged from 0.845 to 0.511 with eigenvalues before rotation of 6.58 and 1.66. Cronbach's alpha was 0.91. Further research is required to establish whether the scale can be used with other types of partnerships.*

Key words: trust; scale development; health promotion partnerships

INTRODUCTION

Partnerships for promoting health are not a new idea. They go back to at least 1978 when the 'Health for All' movement was endorsed by the World Health Organization Alma Ata conference (World Health Organization, 1978). This was followed by *Targets for Health for All* [(World Health Organization, 1985), p. 5], which stated that 'multisectoral cooperation is the only way of effectively ensuring the prerequisites for health'. Various international conferences on health promotion followed, beginning with Ottawa in 1986 (World Health

Organization, 1986). The Ottawa Charter urged people in all walks of life to join forces so that *Health for All* becomes a reality. In 1997, the Fourth International Conference on Health Promotion was held in Jarkarta, Indonesia, on *Partnerships and Collaboration*. This put partnership once again at the forefront of health promotion action: 'Cooperation is essential; this requires the creation of new partnerships for health on an equal footing, between the different sectors, at all levels. Existing partnerships need to be strengthened and new partnerships must be explored' (World Health Organization, 1997). In 2005, the Bangkok Charter called for

worldwide health promotion partnerships (World Health Organization, 2005).

Many factors have been identified that help partnerships to work more effectively. Trust is one of the most important factors and according to Child and Faulkner [(Child and Faulkner, 1998), p. 6], 'no amount of energy from the partners will compensate for its absence'. In fact, Mill [(Mill, 1891), p. 85], more than a 100 years ago, noted that trust 'penetrates into every crevice and cranny of human life' and no cooperation between partners is possible without it. In spite of its importance to partnerships, trust is often taken for granted and people assume it is there (Williams, 2002). Thus, the building and maintenance of trust may be ignored and this can impact negatively on the effective functioning of the partnership. Trust is particularly important in health promotion partnerships as these can include partners from a number of different sectors and disciplines who might normally not choose to work together but who need to do so in order to solve community health problems (Williams, 2002). This is not like partnerships in the private sector where firms select 'partners for the dance but, when the music stops, they can change them' [(Child and Faulkner, 1998), p. 7].

Although there is no single definition of trust, it has been described from a number of different perspectives, including interpersonal, interorganizational and societal (Cummings and Bromiley, 1996). These are known as the psychological, organizational and sociological constructs of trust, each of which has two distinct dimensions: trusting and trustworthiness [(Johnson and Johnson, 2003), p. 128; Seppänen *et al.*, 2007]. The composite elements of trust—vulnerability and expectations—are found in most definitions (Benamati *et al.*, 2006). Cummings and Bromiley (Cummings and Bromiley, 1996) argue that trust is essentially about keeping commitments, negotiating honestly and avoiding taking excessive advantage.

There is disagreement in the literature as to whether trust and mistrust lie at opposite ends of a single continuous variable or whether they are distinct, but linked, dimensions. Currall and Inkpen [(Currall and Inkpen, 2006), p. 239] conceptualize them as a single continuous variable, whereas Benamati *et al.* (Benamati *et al.*, 2006) argue that they are distinct constructs and that low trust is not the same as mistrust. Whether distinct constructs or not, Boyle [(Boyle, 1999),

p. 56] notes that mistrust is a primary barrier to collaboration which can be due to a history of mistrust between the partners. Partner organizations involved in health promotion partnerships often have a history of mistrust, such as can exist between statutory and voluntary organizations, or the private and public sectors (Baron-Epel *et al.*, 2003).

Measuring trust in partnerships is challenging for a number of reasons. The first of these is the level of analysis, as trust operates in partnerships at an individual level, at a group level where there are subcommittees, at overall partnership level and at intra- and interorganizational level [(McEvily and Zaheer, 2006), p. 294]. Currall and Inkpen [(Currall and Inkpen, 2006), p. 235] argue that is possible to measure trust at one level by examining trust at another level. In terms of health promotion partnerships, at least two different levels of trust are operating, interpersonal (between the partners) and interorganizational (between the organizations on the partnership). Partners need to trust each other and also believe that the organizations or groups represented by the partners can be trusted.

The second challenge is clarity about the concept being measured. Seppänen *et al.* (Seppänen *et al.*, 2007) in a review of research into the measurement of interorganizational trust, found major inconsistencies in its conceptualization, operationalization and measurement. They also note that trust is often measured from the perspective of its components, such as credibility or benevolence, and not as a single global measure. Cook and Wall (Cook and Wall, 1980) have suggested three different ways of measuring trust which are relevant to the present study: infer trust from observable behaviours, use level of performance as a proxy or measure how people experience trust.

Although many trust scales have been developed (Seppänen *et al.*, 2007), we chose not to use any of the existing scales in our study, as a majority of these are designed to measure interpersonal trust between individuals, components of trust such as benevolence or credibility not trust as a holistic construct, or inter-firm trust within the private sector. Health promotion partnerships are different to private sector partnerships in that there may be many partners, from many sectors or disciplines, working together to achieve a population health

outcome, whereas private sector partnerships usually consist of two or a few partners.

There have been some studies that measured trust in health partnerships, although not in health promotion partnerships. Costa *et al.* (Costa *et al.*, 2001), in a study of 112 teams of social care professionals, found that trust was positively related to team performance. Snavely and Tracy (Snavely and Tracy, 2002) showed that trust in partnerships was influenced by leadership, and Armistead *et al.* (Armistead *et al.*, 2007) found that trust was a key factor in terms of partnership effectiveness but was an 'intangible, ephemeral phenomenon' more easily lost than created, and experienced more in its absence than its presence. Tesoriero (Tesoriero, 2001) studied trust in one health promotion partnership and found that the partnership was characterized by mistrust and unequal power.

Although the health promotion literature is cluttered with anecdotal accounts of the importance of trust, there have been very few studies carried out on its measurement in health promotion partnerships. Having a reliable way of assessing the perceived level of trust is helpful for monitoring the functioning of a partnership at different stages of development. This study was designed to (i) identify how trust is conceptualized in health promotion partnerships, (ii) develop a new trust measurement scale and (iii) test the scale in health promotion partnerships in the Republic of Ireland.

METHODS

The development of a new scale to measure partnership trust presupposes that all items in the scale share a common cause, that is the latent variable trust, and that item-total scores relate to this variable [(DeVellis, 2003), p. 11]. In addition a scale has a pattern of responses and an intensity structure [(McDowell, 2006), p. 10], both of which are needed to measure levels of trust in a partnership. Likert scales were chosen as appropriate measures for this study as they have a set of responses on which respondents can indicate opinions with a choice of intensities. Scale construction involved collecting a set of items that reflect the underlying trust construct, and writing the item pool to make a meaningful whole.

As this was a national study, focus groups were held in four different cities to facilitate as many people as possible in terms of travel and convenience. Because of the challenges in recruiting people for focus groups and the importance of getting a representative sample of people with partnership experience, two different invitation strategies were used [(Morgan, 1998), p. 67; (Wilkinson, 2004), p. 195]. Health promotion managers, of which there are 10 in the Republic of Ireland, were asked to nominate one or two people from their teams who had partnership experience, and partnership chairs/leads interviewed for a previous study (Jones, 2008, Unpublished PhD thesis) were asked to nominate a partner from their partnership. A total of 36 people agreed to attend the focus groups. Participants included partners from the following sectors: hospitals, community health services, health service managers, education, youth sector, sports, arts and voluntary groups. The literature recommends focus group numbers of 2–14 people [(Bloor *et al.*, 2001), p. 26; (Wilkinson, 2004), p. 178] and as numbers in the focus groups varied from 5 to 10, each group had enough participants.

A Focus Group Guide [A copy of the Focus Group Guide is available from the corresponding author.] was developed as recommended by Kreuger [(Kreuger, 1998), p. 21]. Questions asked about trust and mistrust included: What is the role of trust in partnership working? What is the role of mistrust in partnerships? Can you give me examples of trusting behaviours in your partnerships? Can you give me examples of how your partners show they are trustworthy? Can you give me examples of untrusting behaviours of your partners? Can you give me examples of ways your partners show their untrustworthiness? A Sanyo cassette recorder TRC 8800 was used to record the focus groups and to transcribe the focus group tapes. Participants gave their consent to be recorded and all five tapes were transcribed verbatim in the manner described by Bloor *et al.* [(Bloor *et al.*, 2001), p. 58].

A line-by-line content analysis was carried out on the focus group transcriptions using simple counting [(Silverman, 1993), p. 163] and data reduction techniques [(Miles and Huberman, 1994), p. 253]. The analysis included counting how often a trust or mistrust behaviour in partnerships was identified, by how many people, and in how many focus groups, as recommended by Miles and Huberman [(Miles and Huberman, 1994), p. 90]. An independent

coder also coded the transcripts to obtain frequency counts of how often, and in what way, each participant described trust and mistrust behaviours. Intercoder reliability varied between 85 and 100% depending on the item.

Writing an item pool is an art in itself because items need to be meaningful, fresh and interesting to respondents, strongly worded but not extremely so [(DeVellis, 2003), p. 80], not too mild, and written in a way that avoids floor and ceiling effects [(Bradley, 1994), p. 7]. In addition, wording should be clear and unambiguous and easy for the respondents to understand [(Moser and Kalton, 1971), p. 359]. All of this advice on scale construction was followed. Five-point Likert scales were used, where 5 is 'always' and 1 is 'never', with a 'don't know' option. This was to allow for sufficient response choice without increasing respondent burden [(Moser and Kalton, 1971), p. 36]. In addition, the odd number of response choices allowed for equivocation [(DeVellis, 2003), p. 77]. Data from individual items of a Likert scale were regarded as ordinal level data [(Nunnally and Bernstein, 1994), p. 16] and the total score was treated as interval data [(McDowell, 2006), p. 19].

Analysis of focus group transcripts and scale development

The vast majority (78%) of focus group participants report trust as being the foundation of partnerships and as contributing the most to partnership productivity. Almost half (47%) of focus group participants think trust is assumed or presumed to be there in the partnership and that it is not actually discussed by the partners. The content analysis yielded key themes describing trust and mistrust behaviours that occur in partnerships. Only those behaviours named in all five focus groups were selected. Table 1 displays trust and mistrust behaviours which occur most frequently in health promotion partnerships.

The overall themes shown in Table 1 were rewritten as positive and negative scale items in the manner recommended by DeVellis [(DeVellis, 2003), p. 66]. All items were worded from the perspective of the partnership and not the individual. One item—Dedicated time is spent building trust among the partners—was removed from the scale following reliability checks as it had a corrected item-total

correlation of 0.18. The item—Power is shared by all the partners—was also removed as it correlated much more strongly with the power scale used in the questionnaire. The final five-point 14-item trust scale is shown in Table 2.

The 14-item trust scale was incorporated into an overall questionnaire on partnership functioning which was sent to 469 partners in 40 health promotion partnerships in the Republic of Ireland during October 2006 (Jones, 2008, Unpublished PhD thesis) [A copy of the full questionnaire is available from the corresponding author.]. All regions of the country were represented and partnership duration ranged from 1 to more than 5 years. The questionnaire included nine other partnership functioning factors, including community and expert assets, skills, organization culture, power, leadership, synergy, administration and efficiency (Jones, 2008, Unpublished PhD thesis). A response rate of 72% was achieved ($n = 337$). According to DeVellis [(DeVellis, 2003), p. 88] this sample size is large enough for new scale development. SPSS Version 15.0 was used to carry out all statistical analyses.

General performance, reliability and validity of the trust scale

The 14-item trust scale yielded 80% ($n = 270$) completed responses from which overall scale scores could be computed. Mean scores ranged from 4.3 to 3.5 with standard deviations ranging from 0.98 to 0.72. Total scores for the trust scale ranged from 24 to 78 out of a possible range of 16–80. The mean total score was 62 with a standard deviation of 8.8. Cronbach's alpha for the trust scale was 0.91. Corrected item-total correlations ranged from 0.79 to 0.52 which are very good, as the general recommendation [(Moser and Kalton, 1971), p. 364] is that corrected item-total correlations should be >0.3.

A principal component analysis (PCA) was carried out on the items in the trust scale. An inspection of the correlation matrix showed all values were >0.4 which supported the factorability of the correlation matrix. Two components were extracted explaining 59% of the variance. These were named positive trust and mistrust. The scree plot and parallel analysis confirmed this result. A Promax rotation was performed which showed each item loading

Table 1: Key themes describing trust and mistrust behaviours in partnerships, the number of times they were identified and the number of participants who identified the behaviours

Trust and mistrust behaviours in partnerships	No. of times behaviour identified	No. of participants who identified the behaviour
Openness	61	26
Productivity/motivated	54	26
Hidden agendas	39	20
Reliability/dependability/keep promises	39	21
Power bases/cliques	34	16
Time and energy wasted due to mistrust	32	13
No support from partner organizations	31	16
Time spent building trust	30	17
Partners are supportive	29	17
Information withheld/guardedness	28	16
Goal of partnership clear and understood	27	18
Roles of partners clear	26	14
Flexibility	24	12
Partners equal	23	14
Power shared/not shared	19	11
Work not done if there is mistrust	16	13

Table 2: The 14-item trust scale

Trust and mistrust items	Likert scale
Partners have hidden agendas and bring these into the partnership	1–5 and do not know
The contributions of all partners are valued equally, irrespective of whether a majority agree or disagree with their point of view	1–5 and do not know
Partners can be relied on to do what they say they will do for the partnership	1–5 and do not know
Partners meet in unofficial groups to progress their own agenda with a view to undermining the main partnership agenda	1–5 and do not know
The partnership is highly productive in relation to the work of the partnership	1–5 and do not know
Partners withhold information of relevance to the partnership	1–5 and do not know
Partners eagerly volunteer to take on tasks associated with the partnership	1–5 and do not know
Partners' time and energy are wasted due to mistrust	1–5 and do not know
Partner organizations behave in ways that benefit the partnership as a whole	1–5 and do not know
The purpose of the partnership is clearly understood by all the partners	1–5 and do not know
Partners are guarded about putting their ideas forward for discussion	1–5 and do not know
Partners' roles are clearly understood and they fulfil these roles	1–5 and do not know
Partners are supportive of each other	1–5 and do not know
Partners keep the promises they make to the partnership	1–5 and do not know

substantially on only one component as shown in Table 3.

Although determining validity is 'exceedingly hard' [(Moser and Kalton, 1971), p. 355], face, content and two measures of construct validity—convergent and discriminant—were established for the subscales. Face validity may have little or no relationship to true validity but it is not trivial. Respondents may refuse to complete questions that 'look stupid' and face validity is therefore very important [(Moser and Kalton, 1971), p. 353]. The fact that 80% of respondents were able to complete the question on trust is an indication of face validity. Content validity is usually decided and tested by a team of experts in the field numbering between 3 and 20 [(DeVellis, 2003), p. 49; (McDowell, 2006), p. 31]. The 36 people who attended the focus groups were all experienced partners involved in health promotion partnerships and the positive trust and mistrust items identified from the focus group transcripts were sent to participants to ensure they were an accurate reflection of the views expressed in the focus groups.

Convergent validity means that measures correlate positively with others that are designed to measure the same constructs. Discriminant validity means that measures do not correlate with others that are designed to measure different

Table 3: Pattern matrix for PCA with Promax rotation of the two factor solution for positive trust and mistrust items

Trust and mistrust items	Positive trust	Mistrust
Partner organizations behave in ways that benefit the partnership as a whole	.845	−.085
Partners' roles are clearly understood and they fulfil these roles	.829	.028
Partners eagerly volunteer to take on tasks associated with the partnership	.813	−.116
The partnership is highly productive in relation to the work of the partnership	.803	−.034
The purpose of the partnership is clearly understood by all the partners	.782	−.009
Partners are supportive of each other	.759	.055
Partners can be relied on to do what they say they will do for the partnership	.744	.049
Partners keep the promises they make to the partnership	.719	−.001
Contributions of all partners are valued equally, irrespective of whether a majority agree or disagree with their point on view	.511	.283
Partners meet in unofficial groups to progress their own agenda with a view to undermining the main partnership agenda	−.233	.819
Partners withhold information of relevance to the partnership	.072	.811
Partners' time and energy is wasted due to mistrust	.149	.728
Partners have hidden agendas and bring these into the partnership	.007	.704
Partners are guarded about putting their ideas forward for discussion	.028	.649

All communalities were >0.3 and <0.1 as recommended. In addition, structure coefficients showed that all items were more correlated to their own component than the other component. No item loaded >0.3 on another component [(Nunnally and Bernstein, 1994), p. 502].

constructs. The positive trust and mistrust sub-scales were subjected to item-convergent and item-discriminant tests and all items correlated more strongly with their own subscale than with all other scales used in the questionnaire and ranged from 0.51 to 0.79 ($p < 0.01$).

DISCUSSION

This study set out to identify how trust is conceptualized in health promotion partnerships and to develop a trust measurement scale. A 14-item trust scale was developed from focus group findings and two components were extracted named positive trust and mistrust. The reliability and validity test scores found in this study were more than adequate. Overall, the findings of the study confirm that trust in health promotion partnerships is conceptualized and operates in a very similar fashion to the way that trust is conceptualized in the literature. What is different about this study is that trust in health promotion partnerships has been empirically measured with a valid instrument.

Participants in the focus groups reported that trust is often taken for granted, not talked about, or partners assume it's there in the partnerships. This is consistent with the literature (Williams, 2002). The dynamic and flexible nature of trust is evident from the focus group findings, which was also noted by Solomon and Flores [(Solomon and Flores, 2001), p. 89]. In other words, time is spent building trust, trust then exists in the partnerships, and if this trust is not maintained time is wasted.

The factor analysis findings support the argument that trust and mistrust are distinct components and functional equivalents. This means that although they are interlinked (Benamati et al., 2006), they each have their own distinct effects on health promotion partnership functioning. For example, the mistrust behaviour 'partners meeting in unofficial groups' has no opposite among the positive trust behaviours in the scale. However, the findings are also consistent with the theory that trust and mistrust are at opposite ends of a continuum. For example, focus group participants think trust is about openness and transparency whereas mistrust is about withholding information and watching your back. Trust contributes to productivity and mistrust stops progress. These are opposite, not different, effects. Further research is needed into whether they are actually distinct constructs.

The time-wasting and energy-draining effects of mistrust reported by participants is consistent with similar effects noted by Challis et al. [(Challis et al., 1988), p. 273] and has important opportunity-cost consequences for health promotion partnerships. The findings also show that trust and mistrust affect partnerships in ways that are paradoxical and this is consistent

with Nooteboom's [(Nooteboom's, 2006), p. 247] argument that 'trust is full of paradox'. Trust solidifies and frees up the workings of the partnership whereas mistrust seizes up and at the same time cracks open the partnership.

Building trust is an important part of partnership functioning and Challis *et al*. [(Challis *et al*., 1988), p. 273] recommend uninterrupted and prolonged opportunities for partners to get to know each other in order to build this trust. It is curious therefore, that in this study, the item 'dedicated time is spent building trust among the partners' was removed from the original scale as it did not meet the reliability criteria. It can be inferred from this that, while spending time together is a determinant of trust, time itself is not a component of the construct of trust. The Weiss *et al*. (Weiss *et al*., 2002) study identifies the building of trust as a component of leadership which is supported by the findings of this study.

The focus group findings confirm the way trusting and trustworthiness are conceptualized in the literature as two distinct concepts. Trusting (openness and sharing) and trustworthiness (support and acceptance) are both identified by participants [(Johnson and Johnson, 2003), p. 128]. The vulnerability and expectations inherent in trust (Benamati *et al*., 2006) are also evident from the focus group findings with participants feeling able to take risks and make themselves vulnerable where there is trust, and expecting partners to keep their promises.

The study had a few limitations that should be noted in interpreting the data. The sample of partnerships that participated in the postal survey was a convenience and not a random sample. In addition, these partnerships were deemed to be performing 'adequately to very well' with fewer performing 'not so well', which introduced sampling bias. This is a frequent problem when sampling partnerships as opposed to individuals, and is virtually unavoidable. Weiss *et al*. (Weiss *et al*., 2002) encountered the same problem.

The largely anecdotal rhetoric in the health promotion literature on the importance of trust to health promotion partnerships is confirmed by this study which provides the empirical evidence as to its importance and its measurement. Far from being an 'intangible ephemeral phenomenon' as posited by Armistead *et al*. (Armistead *et al*., 2007), trust and mistrust are strongly conceptualized in health promotion partnerships. This study shows that trust and mistrust behaviours can be measured empirically in health promotion partnerships.

CONCLUSION

Although trust is an important factor in health promotion partnerships, its measurement has been largely anecdotal or the survey measures used have not been validated. The trust scale used in this study has been shown to be a valid and reliable instrument for measuring trust in health promotion partnerships. Measuring perceived levels of trust will be helpful in monitoring the functioning of partnerships at different stages of their development. Further research is required to establish whether the scale can be used with similar or other types of partnerships.

FUNDING

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