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Alyson E. King, Allyson Eamer, and Shanti Fernando

Abstract

In our research on supported education (SEd) programs in Canadian psychiatric hospitals, community-university partnerships have offered hopeful findings that demonstrate the potential for improved social and educational outcomes for patients in these programs. There were inherent challenges associated with conducting academic research on these programs alongside nonacademic partners. While some of our research collaborators, who were patient-educators with varying backgrounds, were fully engaged in the research process, others were only somewhat engaged, and some wanted minimal involvement. Because most psychiatric hospital–based research involves medical or pharmaceutical research, we did not locate established frameworks that could be used as models for our educational qualitative research. Although we encountered some obstacles to fully engaged partnerships, we still conducted productive collaborations that resulted in rich, broadly useful qualitative and quantitative data from interviews with students, teachers, and administrators. That being said, we found that in trying to respect the limited time availability of our partners, we ended up with less input from our partners than we had originally hoped for. The lessons we learned—such as the need for clearer role definitions and strategies to manage power imbalances, conflicting objectives, and time constraints faced by nonacademic collaborators—may be applied to other projects that engage community partners whose time and capacity constraints may inhibit their full engagement, such as municipalities supporting long-term care homes or emergency shelters.

The benefits of university-community and university-hospital partnerships have been well demonstrated. As a result, granting agencies strongly encourage such partnerships as a way of ensuring that communities, and society more generally, benefit from government-funded research (Buys & Bursnall, 2007; Jagosh et al., 2015; Social Sciences and Humanities Research Council [SSHRC], 2016). Hospitals and hospital-based programs are integral to the broader communities in which they are located, especially those mental health centers and psychiatric hospitals with nonmedical programs (e.g., supported education and supported employment) that help patients reintegrate into their communities. Our project was designed as a collaboration with instructors and administrators of hospital-based supported education (SEd) programs to assist with program assessment and to build professional development opportunities in adult education pedagogies through interprofessional networking. Both goals had the ultimate intent of improving program efficacy.

SEd programs aim to help people living with mental illness whose educational paths have been interrupted reconnect with their studies. Our research demonstrates that these programs give participants renewed hope for the future through increased literacy skills (Fernando & King, 2018). For us, the goal of helping to increase equity in our communities via our research was primary. For the SEd community workers, the goal of providing the best possible support for their students—while under the ever-present threat of cuts to program funding—was fundamental; therefore, they were interested in research that would attest to their programs' positive outcomes. Although a partnership may be rooted in common objectives, each partner may have a substantially different quality of experience, and initial enthusiasm can wane for a number of reasons. For example, academic researchers may become disillusioned if their contributions are not valued, and community workers may be disappointed if the academic partners do not provide the sort of feedback and input they had hoped for (Archer-Kuhn & Grant, 2014; Buys & Bursnall, 2007; Cobb & Rubin, 2006).

In this paper, we critically reflect on our experience as academic researchers working with community collaborators in four psychiatric hospitals in Canada. We developed these partnerships to analyze the social and educational impact of the hospitals' SEd programs, which

offer mental health support alongside educational programming and life skills training. For our pilot project, which emerged from an established relationship with a local literacy network, we received federal funding to collaborate with the manager of a SEd program in a provincial psychiatric hospital to help assess the program's effectiveness in supporting the educational goals of adults living with mental illness. We viewed this collaborative project as being in the spirit of Principle 13 of the United Nations Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care, which requires that those living in psychiatric hospitals have access to living conditions of the same standard as those in the community, including education facilities and vocational training (Funk et al., 2010). The manager at the first site provided guidance as to what the teaching staff and hospital administration hoped to learn from our research and facilitated the organization and recruitment of all the interviewees (staff, volunteers, and patient-participants).

Based on our findings, which pointed to the positive impacts of the SEd program on the lives of patient-participants (whom we will refer to as students), and in light of the dearth of research on these programs, the need for a larger project to further explore SEd programs in other Canadian psychiatric hospitals was clear. For this subsequent larger project, we sought new government funding and recruited SEd educators and program managers at other psychiatric hospitals to participate in the project. Some program staff contacted during the grant proposal stage were included as collaborators on the project, while others asked to be approached again after the project received funding. All those involved in the SEd programs were vital to the project because they provided the community perspective and insider point of view that we, as outside researchers, did not have.

All of the participating SEd programs were housed in century-old psychiatric hospitals located in small (populations of 10,000 to 20,000) or medium-sized (population of 135,000) communities. The facilities and their programs are integrated into their communities, although only one has a dedicated community space for outpatient programming. All of the SEd programs had some relationship with local literacy and adult education programs or colleges, but some students faced challenges connecting with those programs because of the relatively rural locations of two of the sites. Nonetheless, the existing relationships permitted relatively seamless transitions for students from the hospital-based SEd programs to community-based programs.

Our intention was to develop partnerships to foster greater community engagement (e.g., we hoped to assist with training volunteers and arranging student practicum placements through local secondary and postsecondary institutions). However, the lack of similar research in the literature related to community engagement and partnerships with nonmedical hospital-based projects meant that we were not able to benefit from case studies or projects that mirrored our own. Some research has explored the use of civic engagement projects, service-learning, or other experiential learning programs that afford students the opportunity to learn while giving back to the community (Asghar & Rowe, 2018; Holbrook & Chen, 2017; Jacobs, 2020; Mitchell, 2008; Wollschleger et al., 2020); however, this literature tends to focus on student development rather than other research-oriented goals.

The purpose of this paper is twofold. First, we reflect on our attempts to create authentic and mutually beneficial relationships with our hospital-based collaborators. Second, we think through the inherent challenges (both those that were anticipated and those that were not) related to (a) power imbalances in those relationships, (b) the conflicting and aligned goals and objectives of university and hospital partners, and (c) the internal politics and tensions that reflect systemic challenges associated with partnerships with public sector institutions. Working with our partners in the psychiatric hospitals has been a positive and constructive experience overall. The lessons we learned may be applied to other community-university partnerships, especially those that engage with government-funded facilities or services (e.g., municipalities supporting homeless shelters, long-term care homes, or day cares) where there may be a mismatch of roles or staff who lack the time for fulsome engagement in lengthy research projects.

Literature Review

The existing research on partnerships between universities and hospitals focuses primarily on the implementation of new health-related programs or medical interventions (such as the creation of health data maps through a community-university partnership described by Buckeridge et al., 2002). Our project was not a health-related partnership but rather an adult education partnership. While

SEd programs have mental health benefits for patients, they also provide broader social and personal benefits, such as enhanced self-esteem, quality of life, and employment and educational opportunities (Eamer et al., 2017; Fernando et al., 2014, 2017). There is scant research specifically examining hospital-based SEd programs, and we have found none on partnerships between universities and hospitals with SEd programs. Without relevant community partnership literature, we relied on adult education and SEd literature to guide our project (Leonard & Bruer, 2007; Rogers et al., 2010; Unger et al., 2010).

In our planning, we aimed to create an engaged partnership that would benefit the SEd programs involved by identifying needed resources and providing interprofessional education (IPE) opportunities for program staff. As Burns and Squires (2011) noted, the idea of knowledge exchange recognizes that both community-based partners and university researchers have "valuable knowledge" and can be sources of "knowledge and wisdom" (p. 7). This perspective is embedded in the concept of IPE. As defined by Hammick et al. (2007), IPE occurs when members of at least two different professions "learn with, from and about one another to improve collaboration and the quality of care" (p. 736). The absence of an IPE framework risks the integrity of the collaboration by positioning one of the partners as being in possession of an esoteric body of knowledge or set of skills that is to be imparted to the other(s). While Hammick et al. (2007) indicated that an IPE approach can be driven by top-down or bottom-up initiators, inherent in the approach is a commitment to valuing and learning from each other's perspectives and expertise. Indeed, Suter et al. (2010) underscored that the two primary focuses of IPE projects ought to be the valuing of professional roles and effective communication between the professionals. Meister and Blitz (2016), referring to interprofessional learning as a "powerful source of practitioners' knowledge, skills, and dispositions" (p. 46), identified a number of different sorts of research-practice partnerships, including communities of practice, study councils, research alliances, design research projects, and networked improvement communities.

Research on authentic community-university partnerships often discusses power imbalances. Seifer (2007), for instance, noted the importance of the knowledge held within communities. Rather than talking about "empowering communities," one community leader cited by Seifer argued that "the people are already empowered; we are helping them to redirect some of their power or to discover their power" (Seifer, 2007, p. 2). This stance is reminiscent of Freire's critical consciousness-raising as part of the process of learning to self-advocate or resist hegemonic forces (Freire, 1970). Further, Barker (2004) reminded researchers that engaged scholarship is explicitly "reciprocal and collaborative" (p. 127) and works toward social transformation in some form.

Mayfield and Lucas (2000) and Archer-Kuhn and Grant (2014) describe the challenges that can occur during interactions between the community and the university, noting the importance of having mutual awareness of and respect for each other's constraints, values, goals, and available resources. Tensions may arise regarding the different institutional contexts (Buys & Bursnall, 2007) and potential imbalances of power (Cobb & Rubin, 2006; Strier, 2011). Such tensions and power imbalances may preclude the cocreation of knowledge, which is a potential product of authentic partnerships and community-based participatory research (CBPR; Cook & Nation, 2016). Similarly, Price et al. (2013) emphasized the importance of clear communication among partners in their exploration of partnership process guidelines.

Cook and Nation (2016) have commented on the fact that universities often do not develop coherent frameworks for ensuring that there are both action and participation elements to their plans. As they note, the university-based teaching, research, and service functions and structures for rewards (e.g., promotion and tenure) tend to dominate when working with community participants, resulting in communities being viewed "as mere bit players" (Cook & Nation, 2016, p. 720). Yet, as Boyer (1990) noted, universities and society are necessarily interdependent. According to Boyer, to fulfill the promise of this interdependence, scholarship must shift away from traditional siloed approaches to allow for the integration and application of new knowledge in order for researchers to be "energetically engaged in the pressing issues of our time" (pp. 76–77). Such engaged research partnerships have the potential to span many years (Cook & Nation, 2016), a fact that most funding agencies, with their limitations on funding over extended periods, do not accommodate.

Methodology

In our research, we interviewed 97 Canadian students who were diagnosed as having a mental illness and were currently or previously

enrolled in a SEd program offered by one of four psychiatric hospitals. The interviews included both closed and open-ended questions about students' experiences with education before and during their SEd program, their participation's impact on their lives, and their expectations for future reintegration into their home communities. The learning spaces included general classrooms, secure forensic unit classrooms (for those designated as "not criminally responsible"), and a community-based classroom. In addition, we interviewed the patient-educators about their insights into the programs and their students.

Prior to starting the project, we sought out and received research ethics approval at our home university and at each of the hospital sites. While the hospital ethics boards were well established, their questions and processes were designed for medical studies rather than one focused on learning experiences and educational programs. Furthermore, our patient-educator collaborators had no experience engaging in the research ethics process. As a result, we led the writing of the ethics review applications in consultation with our collaborators. In addition, all of the ethics paperwork clearly indicated how the research data would be used in terms of reports, academic publications, and presentations.

In order to conduct the interviews, our collaborators first recruited participants and scheduled time for us to meet with them. Two academic researchers conducted the interviews to help ensure that students felt no pressure to participate and were not inhibited in their responses by the presence of their teacher. At the start of each interview, we carefully reviewed the consent form and participants' right to stop the interview at any time. Interviews were recorded and transcribed by an outside transcription service. Transcripts were de-identified to preserve privacy. Interviewees were given a small honorarium for their participation—a meaningful gesture for our participants, many of whom were living on small disability allowances. These transcripts were then reviewed for themes and analyzed using a collaborative process, primarily by the university-based collaborators (Butler-Kisber, 2018; Guest et al., 2012).

Results

In our research on SEd programs' impact on adults living with mental illness, we found that many adults in the participating psychiatric hospitals had experienced interruptions and discontinuities with their education; some dealt with educational challenges as early as elementary school, while others were in postsecondary education when their mental health disrupted their studies (Fernando & King, 2018). For the students enrolled in the SEd programs, their experiences tended to create a sense of motivation, a hopefulness for the future, and a feeling of belonging in the community while also improving their capacity for independence once released from the hospital (Fernando et al., 2021; King & Fernando, 2018). Our exploration of SEd programs also revealed that immigrants who had psychiatric disorders and were English language learners faced additional challenges to language acquisition (Eamer et al., 2017). Since these findings have been published elsewhere, we reflect here on the nature and engagement process of the partnerships.

Creating Authentic University-Community Research Partnerships

University-community research partnerships can span a continuum of engagement from the inauthentic (primarily for the optics of engagement) to the robust (authentic, full partnerships). In our project, we aimed to have robust engagement with our partners, but we fell short due to unanticipated logistical challenges (see Table 1). Apart from the pilot project, we initiated and undertook our research by actively seeking out psychiatric hospitals with SEd programs and willing SEd staff. For the pilot project, the manager of the supported education program served as a collaborator, while we collaborated with a patient education coordinator and a rehabilitation services supervisor from two other hospital sites on the larger project. In both cases, the community partners understood the broad parameters of the proposal but did not directly shape it. Rather, they helped to shape the subsequent interview questions and evaluation process at their site.

Our funder, Canada's SSHRC, defines a collaborator as "an individual . . . who may make a significant contribution to the intellectual direction of the research or research-related activity, and who may play a significant role in the conduct of the research or research-related activity" (SSHRC, 2021). Researchers can strengthen their grant applications by involving members of the community or other professions as collaborators. While well-meaning on its face, this requirement at the grant stage may encourage inauthentic partnerships, since some university researchers may be motivated solely by the optics of involving outside collaborators rather than

the benefits of interprofessional and community engagement. Alternately, a genuine openness to collaboration can lapse into a more hierarchical arrangement due to misunderstood roles, conflicting schedules, or workplace changes. For example, while our SEd community collaborators were involved primarily through facilitating the recruitment of participants and providing space for interviews, they reviewed, provided input on, and suggested changes to the final assessment reports, and they were interviewed for the project. Their input was highly valued and always incorporated, but they did not always have time for in-depth engagement in the process. While our project was genuinely open to collaboration and input, there was a premium on the collaborators' time that we recognized and respected.

CBPR is a model that offers useful approaches to working in a "good way" (Ball & Janyst, 2008) with community collaborators. Ball and Janyst (2008) described their collaborative research with Indigenous communities as involving the building of trust, familiarity, and mutual respect, which can be particularly challenging when project sites are located in distant communities and travel times constrain the possibilities of getting to know collaborators in ways that build trusting relationships. This premise of building trust, familiarity, and mutual respect is important for any community-based collaborative research. Time and resource commitments are also significant challenges for robust CBPR projects (Buys & Bursnall, 2007; Sahs et al., 2017). Minkler (2005) described the benefits of a CBPR orientation for projects related to complex urban health problems and settings as well as some of the tensions that may arise in such projects, many of which mirrored our own experience. For instance, the initial idea for our original study came from one of the hospital-based patient-educators. Yet, tensions arose when some of our findings were critical of the SEd program design and implementation.

An authentic partnership with strong community engagement may depend on whether the university and hospital partners approach the collaboration as an IPE opportunity. While such an approach may not be articulated explicitly, an IPE framework shapes collaboration in ways that promote an authentic partnership. Our own study fits most closely with Meister and Blitz's (2016) conceptualization of a community of practice. Specifically, our partnership aligned with the following elements of their definition: a loosely connected group of self-selected cross-field practitioners and experts seeking to "generate new knowledge, build new capabilities and bridge the knowing-doing gap" (Meister & Blitz, 2016, p. 47).

Table 1. Challenges to Ideal Partnerships

Ideal partnership	Challenges	Resulting partnership
• Fulsome engagement by all partners in all aspects of the research • Interprofessional learning among all partners • Insider views and information brought by each partner to the project Benefits: • Stronger research findings • Potential for long-term relationships • Data that benefit all partners • Findings that result in program/policy changes	• Motivations: continuum from inauthentic (optics-only engagement) to robust (fulsome engagement with all partners at all stages to create robust research findings) • Time: inadequate time available for engagement in all parts of the project; competing demands for time • Commitment: potential lack of commitment from all partners to critical analysis of findings, especially if program is found to have flaws • Data collection: potential impact on working relationships if data point to program/service quality concerns	• Lapse into hierarchical relationships • Limited engagement in all aspects of the project • Limited integration of findings into a reimagined program/service • Tensions if critical analysis identified need for program improvement

Challenges Related to Partnership Power Imbalances

Creating an authentic partnership in our context of psychiatric hospitals was particularly challenging. Because our research was being conducted in a hospital setting, the role of the students was limited to agreeing to be interviewed or not. Although we sought the feedback of the students participating in the SEd programs, as well as that of the instructors and administrators, our partnership was essentially with the program managers as approved by senior administrators. There was little input from the students at any stage of the project. Logistically, including students more fully would have been challenging because (a) not all patients take part in the SEd programs; (b) participation is often transitory, with patients coming and going from the program and from the hospital; and (c) some patients, while well enough to participate in an hour-long interview, were not well enough to be involved in the project on a long-term basis.

Seifer (2007) noted the importance of having agreements or understandings at the institutional level since institutional and staff priorities may change during the research. Before agreeing to participate in the research project, the educators consulted with the hospital administrators responsible for the SEd programs. The administrators all expressed their consent and desire for the research to take place, and the project proceeded. At the start of the project, the educators and/or administrators of the SEd programs provided preliminary information about their program, told us what they hoped to learn from the research, facilitated the recruitment and availability of participants, and made arrangements for our space requirements in the hospital. Everything else—interviews, data analysis, and research dissemination—was done by the academic researchers.

Although this model may not appear to be an authentic partnership, it was a necessarily pragmatic approach given the reality that the SEd program staffers were taking part in the project while still having to meet all the other requirements of their respective jobs. Their institutions did not see research as essential to their jobs, whereas engaging in research is a substantial component of the academic partners' job descriptions. We observed that, for the collaborators, deep engagement in the nuances of data analysis was not seen as essential, although we offered many opportunities for them to participate in the analysis process. In other words, enthusiasm was high when the project was proposed, but it declined as the amount and complexity of work involved became clear. Sahs et al. (2017) similarly noted this challenge as being connected to limited resources and declining "buy-in" (p. 654) among collaborators as the project progressed and time commitments increased. One recommendation made by Sahs et al. (2017) stands out here: Incentives for collaborators need to be "tangible, desired, and consistent such as protected time for research" (p. 657). In our case, such incentives were not easily available due to the small and specialized nature of the collaborating programs.

Power imbalances may exist when academic researchers enter a community space to make recommendations to those involved in the day-to-day running of programs. In our research, for example, the small staff sizes in individual programs may have inhibited the interview responses of educators and administrators concerned about maintaining the confidentiality of their comments. Indeed, in the case of one staff interviewee, body language, hesitant responses, and a request to speak "off the record" indicated that there was a level of frustration with program management.

At the same time, hospital staff collaborators were in the unique position of selecting patients to be interviewed by the university researchers. An awareness that the researchers would be, at least indirectly, evaluating their effectiveness as professionals could have resulted in a biased presentation of patients available for interviewing. As researchers external to the hospital, we relied entirely on the judgment of program staff with respect to which patients were well enough, or sufficiently interested in our goals, to participate. Indeed, in some cases, staff advised us that a particular patient might find the interview too stressful to continue through to its completion (which, in fact, turned out to be the case) or that a patient's medication may affect their ability to answer coherently. It is entirely possible that specific patients were excluded from the opportunity to participate in interviews for reasons that the hospital staff were not obligated to share with us. That said, consciously or unconsciously, hospital staff could have steered only those patients who had satisfactory experiences in the SEd program toward participating in interviews with the researchers, potentially resulting in skewed findings. These sorts of concerns are well documented in the literature. Alcantara et al. (2015), for example, compellingly described the inherent tensions in navigating the various community partner

roles (e.g., "keyholder") and researcher roles (e.g., "broker"), while Mayan and Daum (2016) discussed the "muddled relationships" that can arise within CBPR.

Systemic Challenges and Internal Tensions

Universities, psychiatric hospitals, and funding agencies are all bound by significant rules and regulations about the ethics of research. In our case, the academic partners secured ethics approvals from both the university's and the hospitals' research ethics boards and completed any required on-site security training. Because our project was focused on education rather than on a pharmaceutical or other medical intervention, not all of the ethics boards at the participating hospitals understood the low risk of our research. Most had ethics forms that included questions unrelated to the type of qualitative research we were conducting. Our collaborators had limited or no experience dealing with such issues. While some projects have been derailed by problems like these, having the academic researchers deal with these logistical details ensured that the project moved forward smoothly.

The university and community partners' goals aligned in many ways: All believed in the value of SEd programs and wanted to know whether they were effective, what their impacts were, and what might be improved. However, there were some conflicting goals. There is considerable pressure on academic partners to take a critical and analytical approach to reviewing the efficacy and impact of programs. Meanwhile, the hospital-based partners face internal pressure to keep costs low and to administer programs with minimal staffing, which often leads to a concentration on efficiency rather than effectiveness. While these goals are not necessarily in conflict, they are still different goals. In one case, we believe that the program administrators were looking primarily for affirmation that their program was running well and needed minimal improvement. The others were looking for assessments, but they also needed to show program efficacy given the precarious nature of SEd funding. Since our funding was based on our declared objective of providing policy and curricular recommendations and compiling a set of best practices, we were compelled to collect and analyze data accordingly. It follows, then, that some of our observations reflected shortcomings in the programs we visited.

Regardless of how carefully we described those shortcomings in our articles and reports, we recognized that the hospital staff might understandably feel defensive for two reasons: (a) Staff might have been concerned about their programs, patients, or individual staff members being identifiable, and (b) they undoubtedly worried that their program shortcomings would be detailed in a formal academic publication with a wide readership. While we provided reports to the specific institutions outlining successes and areas for improvement for internal consideration, any academic publications could reach a larger audience. This approach almost certainly would give pause to staff members who were hosting us in their classrooms and providing their reflections. We shared our academic publications with the staff, but we did so anticipating that a level of awkwardness would follow if they felt that their program was being unfairly critiqued. Castleden et al. (2010) took up the challenges of knowledge dissemination in CBPR, particularly in cases where the community partner comprises a vulnerable population.

From the perspective of the university researchers, the hierarchy of hospital roles was not intuitive. For instance, we did not expect that a certified teacher would have less decision-making power within the SEd program than an occupational therapist due to the higher value placed on the medical model (causation and remediation) versus a holistic educational philosophy. In one hospital, for instance, we observed that the teacher was excluded from team meetings with the other staff even though her programming might have benefited from understanding the intervention strategies and medications being used with her students. Internal hierarchies and politics within the hospital can reflect interprofessional tensions or lack of regard—especially for education programs, which are often marginalized within the hospital structure. Such tensions may worsen when introducing yet another professional role: that of the university researcher. Some staff indicated frustration that their teaching qualifications were not valued as highly within the hospital system as those associated with regulated healthcare professions. Indeed, at least one manager suggested that workshops in teaching strategies for their staff were unnecessary because the staff had already "read about it," revealing a lack of institutional regard for the complexities of curriculum design and educational philosophy. At the same time, those staff members who were certified teachers or who had training as adult

educators enjoyed the opportunity to demonstrate their knowledge to the researchers and to confide their frustrations.

Tensions and imbalances of power (Buys & Bursnall, 2007; Cobb & Rubin, 2006) can lead to a lack of trust between partners, as we discovered when some of the hospital-based partners appeared to be threatened by our offers to provide professional development opportunities. According to Hossain and Scott-Villiers (2019), researchers and their community partners may have different understandings of what constitutes the partnership's "usefulness," with conceptions of "success" involving the achievement of practical, emancipatory, and/or critical goals. One member of our team was highly experienced in adult education teaching methods and was available to provide lunch hour or after-school workshops on topics suggested by staff members. At one site in particular, where the program was running without a single certified teacher, we had substantial concerns about program quality. While we applaud the commitment of volunteers and the expertise of nurses and occupational therapists, we were concerned about an apparent lack of awareness of the skill set that a certified teacher would bring to the program. Hoping to fill this gap, we offered, at one meeting, to provide professional development for the staff. The offer was politely acknowledged by management, but later, after repeated reminders and requests to set dates, we determined that there was no genuine interest in taking us up on our offer. During that same meeting, staff expressed a need for support in teaching specific subjects outside their comfort zone, including computer literacy, clearly demonstrating a disconnect between the perceptions and priorities of management and frontline staff. By contrast, the three other sites were open to collaboration and welcomed the opportunity to develop their SEd programs. These programs had only certified teachers as SEd instructors and had much greater license to seek out professional development for improving their programs.

The program evaluation component of our research made it quite distinct from other university-hospital partnerships that are motivated by shared objectives, such as the collaborative development of a specific tool or an acknowledged imbalance in skill sets that the partnership is intended to address. Wharff et al. (2014), for example, described an in-service suicide risk assessment training program developed by an American university at the request of a hospital social work department. After identifying staff knowledge gaps using a needs assessment, hospital administrators invited a university team to develop and offer a two-session training program. Staff, in turn, provided evaluations of the training program that enabled the university team to make improvements in program content and delivery. Thus, both parties in this university-hospital partnership benefited from their relationship to each other—despite the nature of the partnership reflecting one party's need for the knowledge possessed by the other party. In our case, however, the very nature of the project implied a hierarchical relationship: We were in the role of using our expertise to identify strengths and areas for improvement within the hospitals' SEd programs. It is admirable indeed that, in the case of our pilot project, it was the hospital's SEd program administrator who invited our evaluative approach. Remarkably, that same hospital proved to be the least open to our suggestions for strengthening the program.

Another challenge is that psychiatric hospitals have different security and confidentiality requirements than academic partners do. The necessary training and security measures at the psychiatric hospitals can understandably slow down data collection, which can be frustrating for academic researchers. On the other hand, the lengthy academic process of analysis, writing, and publishing is hard for the hospital-based partners to understand. One related conflict centered on confidentiality. Protecting participants' privacy is a value shared by both researchers and practitioners; at the same time, many academic journals specializing in qualitative research typically require a robust description of participants in order to buttress the arguments put forward by the authors. In our case, the limited number of Canadian psychiatric facilities offering SEd programs increased the possibility that participants could be identified if described using any two or three typical identity markers, such as age, race, gender, first language, or country of birth. Therefore, we were required to negotiate with journal editors in at least one case in order to arrive at a solution that both protected anonymity and provided enough demographic descriptors to allow for meaningful qualitative interpretation of the data. In one article, in addition to using pseudonyms for both the participants and the hospitals, we provided general age ranges and geographic regions in support of our theorizing about the acculturation and language

learning experiences of new Canadians in the SEd programs. This negotiation process served to delay publishing even further.

Improving Collaborations and Partnerships: Authenticity Through Mutualism

In planning authentic collaborations and partnerships, a helpful conceptual framework might be the symbiotic relationships that can occur in nature between two species in a given ecosystem: mutualism, commensalism, and parasitism. In mutualism, both species benefit from the arrangement. The often-cited partnership between sea anemones (who protect) and clownfish (who do cleanup duty) is an example of mutualism. In an authentic university-hospital partnership, both parties should benefit in tangible ways, such as in a collaboration to digitize hospital records to create archival collections (Macdonald et al., 2016).

In commensalism, one species tolerates the presence of another species while the other benefits from the relationship. While one member is unharmed by the arrangement (whales), the other profits significantly (barnacles that are chauffeured by the whales between plankton feeding sites). This sort of partnership is no doubt a common one between university researchers and hospitals: Researchers are able to meet their research and publication requirements, while hospital staff may experience no real improvement in their job satisfaction or work environments. This is especially true for projects in which the researchers make recommendations without having a full and rich experience of the hospital context or without understanding the budget and policy constraints at the senior administration level. Unfortunately, our pilot project had some hallmarks of commensalism, as staff were unable to improve the program because of institutional constraints.

In parasitism, the well-being of one organism is compromised by another organism, which benefits from the relationship (fleas on a dog). Academia has a regrettable history of these sorts of unethical relationships, particularly those involving researchers and Indigenous peoples. Bull (2010), for example, in her review of research among Indigenous peoples in Canada, recounted myriad examples of insufficient consultation, misappropriation of traditional knowledge, and use of methodologies that did not reflect the values of Indigenous participants. Others, such as Blanchard et al. (2017) and Smylie (2005), described how important findings related to genetic and epidemiological testing have not benefited—or, in some cases, not even been shared with—the Indigenous communities within which the research was conducted, in spite of the fact that the findings had the potential to shape policies that would significantly impact their communities. The World Health Organization's (n.d.) directive regarding all public health research contains four principles that encapsulate the need for authentic mutualist partnerships: respect for persons, beneficence, nonmaleficence, and justice. In short, authentic research partnerships must include at least the potential for both parties to benefit, must ensure that no harm results from the objectives of the partnership, and must address quality of care, life, or work experience for at least most of the stakeholders.

Conclusion

Our project was intended to be an authentic partnership between university and community collaborators. However, the space for robust engagement was limited by the nature of the project and by the institutional constraints faced by the hospital-based SEd participants. Our intent was to provide space for student voices to be heard while allowing teachers and administrators an opportunity to reflect on the history, current operation of, and possibilities for the strengthening of the SEd programs. Our published findings have helped shine light on the value of SEd programs, and the programs received help with resource identification and adult education pedagogy. We also realize that we learned several lessons that could make future research more effective.

Some of the challenges we encountered were due to the nature of the project rather than specific mistakes on our part. Nonetheless, in hindsight, there are things we could have done differently to strengthen the university-community partnership. For instance, we did not anticipate that institutional constraints (including internal politics related to security, confidentiality, and time management) would add unanticipated hurdles to the successful implementation of the project. As Buys and Bursnall (2007) have suggested, the tensions resulting from different institutional contexts may be reduced by including more institutional voices at the inception of the project. Because of security and confidentiality, a program administrator or lead staff member mediated access to students, volunteers, and staff. This mediation is a necessary part of conducting research in a mental health center, but as the project progressed, we realized that this would be a limitation in our analysis.

Similarly, the limited ability of nonacademic collaborators to commit to the very time-consuming process of designing the questions, conducting the research, analyzing the data, and writing about the research meant that their contributions to the project as a whole tended to be constrained and focused on facilitating the project. A gap in our research, therefore, is that we did not collect data on the collaborators' reflections about the project. Additionally, we did not invite program staff to participate in the data analysis and dissemination process because we had not originally asked this of them. In retrospect, and especially in light of research such as Armer et al. (2020), we will plan for collaborative data analysis and "cocreated scholarship" in future collaborations.

While our intent was to respect the time constraints and anonymity of community collaborators, we could have used more creative methods of gathering feedback. This shortcoming on our part led to a lack of community voices in our project results. We did not fully develop a coherent framework designed to ensure strong community collaboration, something that Cook and Nation (2016) have pointed to as essential, and, therefore, we did not fully engage our community collaborators to the extent that we might have been able to with better planning. In future projects, we must have more frank discussions about the academic and community partner roles in the project, and we must look for ways to include community partners more fully in data analysis, dissemination, and feedback despite time and privacy/anonymity constraints. More fulsome meetings with administrators and managers to discuss time commitments, privacy concerns, and plans for exit interviews may increase staff members' confidence in their ability to fully engage in the research.

In spite of these challenges, the positive responses from many of the participants and staff involved in our larger project indicate that such projects are worthwhile. Our involvement and assessments have given program staff resources, practical suggestions, and reports that they can use as they advocate for continued support for their SEd programs. These types of programs are still gaining traction as a best practice, and they may benefit from research that demonstrates their value. Drawing on the experiences of other researchers working in the field and the feedback from our community partners can help us plan future projects in ways that mitigate the inevitable difficulties that arise in interprofessional partnerships.

While the nature of our current project meant that there was not always adequate space for extensive collaboration, in all sites, the voices of staff, managers, and patients were heard; in three of the four sites, staff contributed to the evaluation report in terms of direction. Future projects could aim to engage partners in ways that support their ability to contribute without taking time away from their regular duties, perhaps by budgeting for temporary staff while nonacademic collaborators are engaged in research activities. Additionally, future projects could include value-added IPE, such as the creation of a networked community of practice around hospital- and community-based SEd programs wherein best practices in adult education and mental health could be shared between staff at different SEd programs.

By implementing more of the tenets of authentic community-university-hospital partnerships, all stakeholders could have equal power and input in the project design. Each partner would bring to the table their particular area of expertise, resulting in outcomes that last beyond the end of the project, such as programming that more consistently helps students transition from hospital-based to community-based education programs. Such larger partnerships will require a more intentional and systematic approach to the collaborative process than we were able to accomplish. Ybarra and Postma (2007) provided an interesting overview of how a 4-year academic-community partnership was managed using consensus decision-making and a community advisory board in addition to the core partners. In that project, work was shared between the two groups: The advisory board made recommendations regarding priorities and the appropriateness of data collection instruments, and the core groups took care of most administrative duties (p. 37). It is these types of clear role definitions that create fulsome partnerships from project inception and allow for a mechanism that ensures collaboration throughout. A variety of strategies must be explored and implemented to mitigate the challenges of power imbalances and to facilitate an understanding of the sometimes-conflicting objectives held by the different partners. This increase in partnership authenticity and engagement would be welcomed by both university and community researchers and could lead to longer-term sustained community development outcomes.

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