Applying best practices from CAPs to a community-academic-corrections partnership: Academic partner perspectives

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ABSTRACT

Background: While correctional systems often function separately from academic and community-based organizations, there is opportunity for mutually beneficial collaborative partnerships to strengthen services and relationships. Community-academic partnerships (CAPs) are a well-established model in implementation science and in scientific literature. Applying best practices for CAPs to a partnership that includes community, academic, and correctional partners could contribute to a stronger partnership with more capacity to improve population health of people who experience incarceration.

Objectives: To describe our work to identify CAP best practices, and to discuss considerations and approaches for applying these best practices in an emerging community-academic-corrections partnership.

Methods: From the scientific literature, we identified best practices for CAPs across nine domains: bringing the community into the project; building new relationships while addressing the past; establishing mutually beneficial vision, goals, and purpose; roles and expectations of partners; communication; administration; leadership; project implementation and evaluation; and building community capacity and awareness. In this paper we describe considerations from the perspective of the academic partner regarding these nine best practice domains in the development of a community-academic-corrections partnership.

Conclusions: While established CAP best practices have relevance, there are specific considerations for partnerships with correctional authorities that require attention. Informed by best practices, planning and preparation for partnership can help mitigate challenges, support effectiveness, and strengthen relationships.

KEYWORDS: Community health partnerships, Community-Based Participatory Research, Power sharing, Process issues, Canada, Public Health, Prisoners, Data Collection

BACKGROUND

While correctional systems are typically administered by governmental authorities and separated from academic and community-based organizations through various physical, bureaucratic, and historical barriers, they may benefit substantially from partnerships to improve services and relationships. The scientific literature describes rare examples of partnerships between correctional systems and other organizations, such as an academic-corrections partnership between a university and a prison to support incarcerated women during pregnancy and in parenting,[1] and a community-academic-corrections partnership between a university, prison staff, people who were currently incarcerated, and community collaborators to understand incarcerated people's participation in prison activities.[2] These examples reveal specific considerations for partnerships involving correctional systems, as a governmental entity with unique characteristics, constraints, and obligations. Identifying best practices to support partnerships involving correctional systems could increase the interest in and feasibility of partnerships to advance correctional and societal interests, and inform the development, implementation, and evaluation of such partnerships.

Community-academic partnerships (CAPs) are a well established model for partnerships,[3-7] defined by Drahota et al. as "collaborations between community stakeholders and academic partners," with elements of equitable control, community-relevant goals, specific aims to achieve those goals, and involvement of both community members and academic researchers.[4] As a model, CAPs support project relevance, feasibility, acceptability, and sustainability for all partners.[7,8] They can be complex, often bringing together partners with different mandates, interests, and ways of working, and may therefore face substantial challenges.

Recognizing that a CAP represents a model with relevance for community-academic-corrections partnerships, and also that adding a correctional system as a partner may involve specific considerations, we identified best practices for CAPs and explicitly considered how to apply these best practices in an emerging community-academic-corrections partnership, as formative work for the partnership.

OBJECTIVES

In this paper, our objective is to describe our work to identify CAP best practices, and to discuss considerations and approaches for applying these best practices in an emerging community-academic-corrections partnership.

METHODS

Context

We received funding from the Public Health Agency of Canada (PHAC) for a project to develop a health surveillance system for a correctional authority. The funding period is 2020 to 2024, and our focus is at the national level (for Canada). PHAC did not have input regarding the design, implementation, or analysis of this project, and the views expressed herein do not necessarily represent those of PHAC.

Partners

The project includes several partners and collaborators. We defined three formal partners from the academic, corrections, and community sectors, respectively: an academic family medicine department of a university, a Canadian correctional authority, and leadership of a national health surveillance network of primary care research networks. These partners all contributed to the development of the study proposal and committed to project engagement and partnership. In addition, collaborators include people with lived experiences of incarceration

(community partners), representatives from community-based non-profit organizations that support the health and wellbeing of people who are incarcerated (community partners), and academic researchers with relevant content expertise (academic partners). Recognizing that Indigenous peoples are over-represented in Canadian prisons, and that there are unique and pressing obligations and opportunities with respect to Indigenous health and data sovereignty, we specifically invited a National Indigenous Organization and researchers leading Indigenous scholarship to collaborate. Other areas of expertise for our academic partners include public health surveillance, primary care, prison law, and prison health. We consider both formal partners and collaborators as participants in the partnership.

Identifying best practices for CAPs

As the academic partner, we searched the literature for evidence regarding best practices for CAPs using keyword searches in PubMed and reference chaining. Two authors extracted data on best practices from relevant articles. We recognized that the best practices reflected key domains, i.e., substantive functions or characteristics of CAPs, and that identifying the domains in addition to the specific best practices would be valuable to highlight important areas for focus for effective partnerships and to support potential uptake of this knowledge. In an iterative process, two authors defined domains that each best practice illustrated, and categorized each best practice into a domain.

Considering the application of CAP best practices in an emerging community-academic-corrections partnership

As formative work in our development of a partnership, we considered the relevance and application of best practices for CAPs across each identified domain, including specific issues

related to having a correctional authority as a partner in a community-academic-corrections partnership.

RESULTS

Identifying best practices for CAPs

We identified a recent systematic review that summarized information on 12 facilitating factors and 11 hindering factors for CAPs,[4] and we used the findings of this review to develop an initial framework for key domains of best practices. We categorized these 23 factors into seven key domains; for example, we created a domain called *building new relationships while addressing the past*, which included multiple facilitating factors (good relationship between partners, trust between partners, and respect among partners) and hindering factors (bad relationship, mistrust among partners). We identified best practices in each of these domains from the review and other articles. [1-7, 9-26,] In addition, we identified best practices in other articles that fit into two additional domains: program implementation and evaluation,[5,9] and building community capacity and awareness.[2,6-7,10-17] The key domains and associated best practices are summarized in Table 1 and discussed in more detail in the subsequent text.

Table 1. Identified best practices for community-academic partnerships (CAPs)*

Domain	Best practices
Bringing the community into the project	• Involve the community and target population at all stages: planning, developing, and evaluating the project[2,3,7,9-11,18] • Include the right people: include the appropriate partners, with decision maker power and/or the respect of the community they represent,[1,4,19,20] e.g., through creation of a steering group or community advisory board[2,7,9] • Plan for meaningful, genuine, equitable collaboration of all partners[10,19,21,22] • Work to build community trust[4,6,7,12,13,15,22,23] • Bring the project to where the participants are – both physically, e.g., setting meetings in locations and at times that will work for partners, and contextually, e.g., based on the context of the project objectives[1,12]
Building new relationships	• Take the time needed for relationship formation, taking the time to build trust and confidence[3,13,24]

while addressing the past	• Build relationships with trust and respect[3-5,20,24] • Acknowledge and be aware of historical inequity; work to build cultural competency[13,15,16,24,25] • Be aware of power differentials as well as differences in research and community cultures[2,9,13,24,26]
Establishing mutually beneficial vision, goals, and purpose	• Plan for a positive, tailored community impact based on and responsive to community needs[6,7,9,12,13,17,20-22,24,26] • Aim for reciprocity, or mutual benefit for all[4,17,24] • Acknowledge, discuss, and honour different partners' divergent priorities; be open to compromise[5,14,19,24]
Defining roles and expectations of partners	• Clearly define expectations and roles of each partner[3,4,20]
Communication	• Communicate in ways that are open, effective, frequent, regular, ongoing, and transparent[3,4,6,10,15,16,19,20,22] • Establish a common language/terminology and use plain language when possible[2,4,14-16,20] • Create safe spaces to enable frank discussion about contentious but important issues[2] • Practice effective conflict resolution, understanding conflict is necessary to growth[4,15,16,20]
Administration	• Commit the appropriate resources, with consideration of project funding, evaluation, and sustainability[1,3,13,15,16,19,20] • Avoid excessive time commitment or a high burden of activities[4,13,20] • Have a program coordinator[10] • Hold well-structured meetings[4,20] • Set and meet deadlines[22]
Leadership	• Share leadership and control, including in decision-making and in co-creation of the project[6,10,14-16,21,24] • Provide good quality leadership[4,20] • Ensure leadership is culturally competent[25]
Project implementation and evaluation	• Identify the best processes/model to implement and evaluate the partnership's objectives using a systematic approach, paying conscious attention to assessment (including in assessing the partnership itself)[5,9] • Identify implementation barriers and facilitators[7] • Evaluate the program with strategies that evaluate impact, and are consistent with the literature making recommendations specific to community academic partnerships[5,16,24,26] • Manage concerns surrounding data governance, privacy, and confidentiality[12]
Building community	• Build community partners' skills and awareness in implementation, research, and knowledge translation through engagement in the process[2,6,10-16]

capacity and awareness	• Disseminate the results of the activities the partnership undertook (i.e., research, implementation) to all collaborators, including those outside the group, guided by community input[2,7,12,16,17] • Create awareness of political implications of work[13]

*The domains are ordered based on the general life cycle of a project that includes varied partners.

The application of CAP best practices in an emerging community-academic-corrections partnership

Bringing the community into the project: This domain is fundamentally about bringing together the right partners, conducting meaningful and effective engagement at all stages of the project, and building trust. The three formal partners began engagement during the initial conceptualization of the project and grant writing, which was led by us as the formal academic partner. And as the academic partner, we are the grant recipient and we are accountable to the funder for project, and we have assumed functions of a coordinator and facilitator of project activities. Once we received funding for the project, we began engagement with collaborators in addition to the formal partners, and we identified specific collaborators based on existing relationships and suggestions from those engaged for others to involve.

Ongoing work with partners and collaborators occurs through two main structures, which meet regularly. The Project Implementation Team includes team members from the university (i.e. the formal academic partner), the national primary care network, and the correctional authority, and focuses on implementation of the surveillance system. The Project Advisory Committee includes team members from the university (i.e. the formal academic partner), people with lived experiences of incarceration, and representatives from community-based non-profit organizations that deliver services to and conduct advocacy regarding people who are incarcerated (including a National Indigenous Organization), and focuses on strategic and

practical issues related to the acceptability and relevance of project activities and health surveillance overall.

We have also engaged directly with senior decision makers in the correctional authority who are not on the Project Implementation Team, which we have done through emails, written project updates, and meetings. We have engaged with academic researchers with relevant content expertise (in addition to those involved as the formal academic partner) through occasional meetings as well as emails, as well as more intensive collaboration with specific researchers on particular initiatives.

As the academic partner, we facilitate the key project structures (i.e., the Project Implementation Team and Project Advisory Committee) and use various strategies to communicate regarding ongoing project activities, which provides continuity and ensures sharing of key information across all partners and collaborators. We engage with all partners and collaborators frequently and with transparency regarding activities and any challenges we encounter, to support trust and ongoing progress. While all partners and collaborators are committed to and contribute to the partnership and bring unique perspectives and contributions, we have set up partnership structures and engagement so that not all partners and collaborators engage at the same time. While perhaps unusual for a partnership, this separate engagement was developed deliberately in the context of varying (and at times conflicting) interests and challenging relationships between the various parties involved in the project based on historical and current factors. This set up supports the comfort and safety of people with lived experience of incarceration, by not having to engage directly with staff working in a correctional system that previously incarcerated them, and circumvents potential challenges related to direct engagement for organizations with current legal actions in process against the correctional authority.

Our ability to leverage online platforms such as Zoom and Microsoft Teams for ongoing meetings has made it easier to support engagement of people across geographies (e.g., partners and collaborators live and work in four different time zones) and settings, to bring the project to where the partners and collaborators are. Recognizing the valuable contributions of people who are currently incarcerated to this work as key stakeholders, we have overcome barriers to participation in the Project Advisory Committee for one person who is currently incarcerated, for example obtaining institutional permission to support his participation and arranging for him to call another team member by phone and be placed on speaker to participate in videocalls, in the absence of internet access to be able to join the videocall directly.

Building new relationships while addressing the past: In this partnership, we have been able to leverage existing relationships, e.g., between the academic partner and collaborators, as well as establishing new relationships, e.g., between the academic partner and the national health surveillance network. We continue to develop relationships with and between all partners and collaborators over the course of the three and a half year-long project, based on roles, expertise, capacity, and interests. Developing strong and trusting relationships takes time, especially in the context, as noted, of potential mistrust and particular barriers to relationships with the correctional authority for certain collaborators. We hope that one of the lasting impacts of the project, beyond the funded project period, will be strengthened relationships including greater trust, and that collaborative work will continue in areas of mutual interest, including but not limited to health surveillance. We are also explicitly considering historical inequities, cultural safety, and power differentials, which are important factors to address in any partnership, but particularly one focused on the health of people who are incarcerated.[27-29] As noted, within our partnership, we have developed separate streams of engagement through the Project Advisory

Committee and the Project Implementation Team, which we hope will make spaces safer to speak and share perspectives and information, e.g., for people with lived experiences of incarceration, while minimizing the risk of potential harms from engagement, e.g., re-traumatization in the context of a real or perceived lack of interest or influence.

In addition, recognizing the disproportionately high incarceration rates for Indigenous people in Canadian correctional facilities and the relevance of several Truth and Reconciliation Commission Calls to Action[30] (in particular 18, 19, and 30 involving health care, health outcomes, and the overincarceration of Indigenous peoples), we are taking steps to build the capacity of project team members regarding Indigenous data and Indigenous data governance. For example, we supported ten people from the Project Advisory Committee and academic partner staff in completing a training course on the First Nations Principles of OCAP, i.e., ownership, control, access, and possession of data,[31] and we invited those who participated in that course to participate in a group discussion about the course and its relevance for the project. This work to recognize the historical and current context of Indigenous peoples and the effects of colonialism informed ongoing conversations about Indigenous data needs and data sovereignty. We are assessing the partnership through an external evaluator, which was a requirement of the grant. The evaluator conducted a survey of partners and collaborators at the project baseline, and will conduct a second survey as well as interviews in the final year of the project. This assessment will focus on team members' perspectives regarding relationships within and between project structures, collaboration, influence on and input into the project, meeting facilitation, and potential project impacts. The assessment will support ongoing and future partnership and relationship development.

Establishing mutually beneficial vision, goals, and purpose: As articulated in our original funding proposal and related project documents (including the terms of reference for the Project Implementation Team and Project Advisory Committee), our project's explicit goal is to develop a health surveillance system for people incarcerated in Canadian prisons. This project goal has potential value for the correctional authority and for broader society, including project partners and collaborators, and advances work toward our shared vision of population health for people who experience incarceration.

We recognize that partners and collaborators have different mandates, interests, and concerns, which may contribute to divergent perspectives regarding the project and its context. As the partner responsible to the funder, the academic partner works to foster discussion of these issues and also to keep all partners and collaborators focused on project aims and objectives through managing the workplan, facilitating meeting discussions, and through written periodic project updates. Throughout the course of the project there are also opportunities to define and advance new goals, consistent with the overall objective of prison health surveillance, and collaborators can and have suggested new avenues of work.

As a specific initiative to elucidate how best to focus and prioritize work toward our vision, we are conducting an embedded mixed methods research project to understand stakeholders' needs and priorities for health surveillance. We recognize that various factors influence health surveillance, and that this research will represent one input of many into decision-making; for example, there may be feasibility issues regarding data collection or reporting, and priorities identified may not be consistent with current policy or political priorities. We also appreciate that if the findings of this research do not influence health surveillance, this may challenge partners' confidence in the partnership and relationships.

Defining roles and expectations of partners: We defined roles and expectations for partners *a priori* in the project proposal, agreements, and terms of reference for committees, and continue to adjust them iteratively over the course of the project. The initial project proposal included high level descriptions of roles for each formal project partner. We developed collaborative membership agreements between signatory partners, which explicitly detail roles and obligations. We developed terms of reference for the Project Implementation Team and for the Project Advisory Committee. We discuss roles and expectations between and among partners and collaborators during meetings, by email, and in project updates, both proactively and in response to any issues arising. In addition, meeting minutes with action items are circulated following each meeting, and reminders sent by email by the academic partner to the person responsible for each action item, in order to track and facilitate the day-to-day project work.

Similar to the CAP model, each of the partners and collaborators plays a unique role in the partnership, and these contributions can help achieve more relevant, feasible, and useful outcomes than would a community-academic or an academic-corrections partnership alone. The community-based collaborators help us focus the work on what matters through setting goals, ensuring the relevance of the work, and providing feedback on how to communicate findings. The academic partner contributes substantive expertise, project management, and knowledge translation. The community-based research network provides specific expertise on health surveillance and focus on technical issues. The correctional partner provides the overall mandate and supports implementation in the correctional authority.

Communication: As the recipient of the project grant and the facilitator between all groups, the academic partner manages most communications. Some of the methods for improving communication include forwarding high-level meeting summaries and action items to

everyone in the group (including those unable to attend the meeting), creating bi-annual project updates and sending them to the full list of partners and collaborators, promptly responding to emails, ensuring a common language and understanding at meetings (e.g., explaining acronyms and process steps), cultivating a safe and honest meeting environment for team members to allow for challenging topics, and engaging one-on-one or in small groups outside the formal meetings with varied partners to facilitate engagement (e.g., for those unable to attend meetings) or to discuss topics better addressed in smaller groups.

Administration: To support this project, we obtained dedicated funding through a grant, which pays for the salary of a dedicated and skilled Project Coordinator, contributions of the community-based research network, and honoraria for Project Advisory Committee members who are not participating in this work as part of a paid position, as well as other costs. The correctional authority and other project collaborators provide in-kind contributions. Beyond the funded grant period, future partnership and project work would need to address how to support the partnership and related work without the dedicated resources of the grant to be sustained; potential strategies may include making the partnership less structured, applying for funding, or having the correctional authority take over leadership of the partnership as part of their routine operations. In terms of project work, we conduct meetings with an agenda and hold time within each meeting to discuss important topics that are not on the agenda. As the academic partner, we aim to avoid too much burden on partners and collaborators. Our baseline partnership assessment survey has offered guidance about the timing of meetings, with most partners saying the timing that we initially set was sufficient and not too much, and at least one person saying the Project Advisory Committee could meet even more often. We maintain a detailed workplan that we

revise iteratively as needed, which includes detailed timelines for all project activities as well as budget tracking and projections.

Leadership: While we endeavour to support meaningful engagement and contributions to decision-making by all partners and collaborators, we recognize that there are specific constraints that limit power sharing. As the academic partner and grant recipient, we lead project activities, consistent with our contractual obligations to the funder. The correctional authority has ultimate decision-making regarding health surveillance activities in the correctional authority, including participation in the national primary care surveillance network. We have signed agreements between the academic partner and other formal partners, i.e., the national primary care network and the correctional authority, which clearly articulate the rights and obligations of these partners. The contractual obligations to the funder and having only the three formal partners as signatories may limit power sharing and project "ownership" by other partners and collaborators.

These constraints notwithstanding, as the academic partner, we aim to create opportunities to hear and elevating collaborators' voices and perspectives to address structural power imbalances. We are constantly striving to ensure that project activities respond to and address community needs, for example through our mixed methods research project to define stakeholders' needs and priorities for health surveillance, through the partnership evaluation, and through work to improve cultural competency through the OCAP training course. Using transparent strategies such as internal project communications and publication, we aim to influence ongoing partnership work and health surveillance by providing relevant inputs (including evidence), advice, and supports.

Program implementation and evaluation: This paper describes considerations regarding implementation based on CAP best practices, signalling our focus on evidence-informed implementation. We are also using structured project management tools and evaluation strategies, including the external partnership assessment as described as well as tools such as Gantt charts to plan and communicate about concurrent streams of work. In addition to structural and contractual implementation challenges, we have identified specific logistical challenges to project implementation and partner and collaborator engagement. A national project in the Canadian context may mean navigating across multiple time zones, which requires planning to avoid inconveniencing some partners and collaborators with meeting times that are too early or too late and clearly communicating about timing. We have also developed creative strategies to include people who are currently incarcerated as active team members, for example facilitating phone vs. videocall participation, as noted. Managing data governance, privacy, and confidentiality of personal health information is both required and complex in this context. There are specific legal obligations that are relevant for health surveillance, for example the correctional authority is the custodian for health data, and specific legal authorities constrain data collection, use, and disclosure. As a concrete example, we have identified concerns regarding re-identification risk with reporting data at the level of institutions and regions, and we recognize that having data available at a higher, more aggregate level may limit their usefulness for health care and program development. There are also specific (and different) data governance considerations for Indigenous data, including OCAP for First Nations, which may not be able to be realized given the current context of correctional authority data governance, which is one of the reasons we engaged in the OCAP training course. Finally, there are substantial sensitivities regarding data access and transparency given historical and current considerations regarding

incarcerated populations and concerns regarding inequities, including stigmatization of health conditions and care for people who are incarcerated. Attending to these issues is important for demonstrating trustworthiness and building trust.

Building community capacity and awareness: Through project structures and specific project initiatives, we are building our collective understanding of health surveillance in the correctional authority and opportunities to advance health surveillance, as well as regarding research to define stakeholders' needs and priorities. As described, we are using transparent strategies to share information about project processes and outputs, such as internal updates, academic postings and departmental updates, publications, and reports to the project funder. As relevant, we will address policy and political implications for enhanced health surveillance in more detailed project outputs, i.e., publications.

CONCLUSIONS

The CAP model has relevance for community-academic-corrections partnerships, and building the knowledge base regarding strategies to support successful partnerships as well as lessons learned could help advance effective partnerships and important work to advance population health.

There are several limitations of this paper. We did not conduct a systematic search of articles to define best practices for Community-Academic Partnerships. However, given that we drew on a recent systematic review and involved two co-authors in searching for, reviewing, extracting, and categorizing best practices, we are confident that our processes are appropriately rigorous for the purposes of this formative work, and that we have identified valid domains and best practices. In addition, we discuss the application of these best practices across key domains at a time when the partnership is still developing, and our partnership structures and practices

may change during ongoing implementation. We recognize that there may be specific considerations in partnership with Indigenous organizations and populations, and additional, focused work is required to explore preferred structures and processes and to define best practices for these partnerships. Finally, we fundamentally assume that best practices for CAPs are relevant to community-academic-corrections partnerships, and assessment of factors associated with successful community-academic-corrections partnerships is needed to understand how best practices for CAPs and community-academic-corrections partnerships may be similar or different.

We hope that this formative work on a partnership to improve health surveillance in a correctional authority will support greater partnership work by and with correctional authorities, recognizing both the value and challenges of such partnerships and also the lack of scholarly work regarding academic and community partnerships involving correctional authorities. To advance work that is effective and acceptable, we recommend building on evidence for best practices for CAPs. In parallel, we need to build an evidence base regarding partnerships with correctional authorities, including community-academic-corrections partnerships, by sharing lessons learned and best practices as we develop collaborative models to enhance correctional health surveillance, correctional health care, and ultimately, the population health of people who experience incarceration.

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