Health Promotion International, 2022, **37**, 1–11
https://doi.org/10.1093/heapro/daac062
Advance access publication 5 July 2022
Debate

Intersectoral violence prevention: the potential of public health–criminal justice partnerships

Erika Gebo*

Department of Sociology & Criminal Justice, Suffolk University, 8 Ashburton Place, Boston, MA 02108, USA
*Corresponding author. E-mail: egebo@suffolk.edu

Summary

Building successful intersectoral partnerships to address health is critical to reaching health promotion goals. With the confluence of the COVID-19 pandemic, the increase in violence during the pandemic and the heightened demand for racial justice resulting from police killings of people of color, particularly young, black males, intersectoral public health–criminal justice partnerships must be more thoroughly examined. Violence prevention is both a public health and criminal justice issue, with public health systems emphasizing primary prevention and criminal justice systems addressing violence prevention at secondary and tertiary levels. Public health–criminal justice collaborations can provide an opportunity to seize upon unrealized violence reduction goals across the spectrum of prevention. At the same time, issues remain that are at odds across field boundaries as exemplified through community violence prevention. While there have been successful examples of such collaborations, past public health–criminal justice partnerships also demonstrate the challenges of working together. These challenges have yet to be systematically described and rooted in the larger literature on partnerships. In this paper, collaborative challenges are enumerated and evidence-informed strategies to overcome those barriers to achieve violence reduction goals are identified as a way to ground further intersectoral partnership work between public health and criminal justice.

Keywords: violence prevention, intersectoral partnerships, collaboration

INTRODUCTION

Building successful intersectoral partnerships to address health is critical to reaching health promotion goals (WHO, 2014). The literature on partnership capacity building across diverse entities is also intersectoral, cutting across academic and practical fields of knowledge (Bryson *et al.*, 2014). To examine collaborative work toward health promotion, community violence prevention provides a timely context. The demand for changes to the status quo in community violence has been stimulated by confluence of the COVID-19 pandemic and racial justice movement, spurred by police killings of unarmed individuals. These events highlight growing disparities between white people and people of color with regard to the health effects of racial and economic inequality as well as discrimination. The events over the last 2 years also have drawn more attention to the negative impact of criminal justice practices on people of color, particularly black males. Data from the USA, for example, show that over the course of the pandemic, rates of fatal police shootings of people of color are three times that of whites (Lett *et al.*, 2021), and there have been stark increases in gun and group-related violence (Sutherland *et al.*, 2021). These events and statistics highlight the need to prioritize violence prevention.

Community violence prevention is both a public health and criminal justice issue. Public health systems emphasize primary prevention and criminal justice systems address violence at secondary and tertiary levels. Better partnering between public health and criminal justice may be one way to leverage benefits of both approaches to realize violence reduction gains. In the USA, emergency response recommendations from a national panel on criminal justice and COVID-19, recommended tighter links between public safety and public health integrating responses, data, communication and shared standards (Council on Criminal Justice, 2020). Yet there remain differences in how these disparate systems respond to emergencies and to chronic social problems. Violence is both an acute and

enduring problem in many areas of the globe. While there is recognition of the importance of these partnerships, there is a lack of information about how they best operate (Harris *et al.*, 2017). The limited literature on public health–criminal justice partnerships provide insights to the ways in which diverse entities can collaborate and the challenges with doing so. These challenges have yet to be systematically described and rooted in the larger literature on collaboration. In this paper, partnership challenges are enumerated and evidence-informed strategies to overcome those barriers are identified providing insight into how to reach shared violence prevention goals. Many of the examples in the scholarly literature and public domain come from the USA, but as Shute (Shute, 2013) warns, while ideas may be transferrable, programs and techniques need to be tested in other locations to fully understand effects.

Partnerships are also known as coalitions, networks and collaborations, with no clear distinctions among them (Kaiser, 2011). The term partnership primarily is used here to align with recent public health language (Nutbeam and Muscat, 2021). Partnering and related collaborative challenges are emerging as a distinct focus of scholarly research. Partnerships have been examined in diverse, multidisciplinary literature, and while discussions are rich, research is disjointed and disconnected across disciplines (Thompson *et al.*, 2009; Kaiser, 2011; Bryson *et al.*, 2015). Following the lead of seminal work by Bryson *et al.* [(Bryson *et al.*, 2006), p. 44], collaboration in partnerships is defined here as something that is accomplished jointly by two entities or more from different sectors that could not have been accomplished by one entity alone through the sharing of 'information, resources, activities, and capabilities'. The literature is far from clear on critical factors that lead to failure or success (Hunter and Perkins, 2012; McNamara *et al.*, 2020). Research on partnerships is further complicated by the fact that collaboration occurs across different types of partnerships—from intersectoral collaboration across private or government entities, to entirely community-based coalitions, to hybrid models that include government, and/or private, and/or community groups (Moore and Koontz, 2003). The determinants for partnership success may vary by partnership type and context (Daley, 2008; Bryson *et al.*, 2015) as have been identified in the health arena (Corbin *et al.*, 2018). With regard to violence prevention, intersectoral public health–criminal justice partnerships may very well include nongovernmental organizations and grassroots groups. Regardless of configuration, all partnerships face the need to work effectively together on issues of shared concern.

Scholarship published on the intersection of public health and criminal justice often provides examples of successful partnership projects, with little articulation of the challenges faced by partnerships or the factors that led to successful partnering (Morrissey *et al.*, 2009; Harris *et al.*, 2017). There is a need to understand more about how public health–criminal justice partnerships work best to achieve goals. The current examination centers on community violence as a specific health milieu, not on health care for individuals or treatment of health for criminal justice-involved individuals, though those contexts also are important. The global events of the last 2 years, and in the USA in particular, provide an opportunity to critically examine approaches to violence prevention. To that end, the approaches to violence prevention by public health and criminal justice entities are first described, followed by the potential benefits of collaboration. Grounded in the broader literature on partnerships and collaboration, challenges to public health–criminal justice partnerships and potential solutions are then discussed.

PUBLIC HEALTH AND CRIMINAL JUSTICE STANDPOINTS ON VIOLENCE PREVENTION

Approaches to violence prevention are critical to understanding public health–criminal justice challenges to partnering. While violence has often been identified under the purview of criminal justice, the WHO has recognized violence prevention as a public health issue since 1996 with a resolution declaring violence as a worldwide health problem. Moore provided foundational work on the intersection of public health and criminal justice by outlining the key differences in approaches (Moore, 1995). Public health violence prevention focuses on primary prevention with policies and programs that universally address the social determinants of health, such as physical and psychological safety and economic and social well-being, promoting health for all persons, and recognizing that structural issues, such as racism and economic inequality, are barriers to full health. Violence is an outgrowth of ill health. Fundamentally, ecological context matters. This includes families, institutions such as schools and workplaces, as well as communities and societies. Public health approaches seek to remedy health disparities and recognize the importance of cross-sector and individual involvement in the process. Active community engagement is part of a public health approach to prevention.

In comparison, violence prevention traditionally has been addressed by criminal justice through arrest, prosecution, surveillance and incapacitation, with limited focus on rehabilitation or restoration. Criminal

justice systems include police, courts, corrections, community agencies and government agencies that detect and address behavior defined as illegal. Police may be the most visible sign of the criminal justice 'system' in the community. Addressing violence is often reactive, or at the tertiary prevention level, once individual(s) has been identified as perpetrating a crime. At that point, an investigation may lead to an arrest and a case may be turned over to the government for criminal prosecution. If found guilty, and the charges are serious enough, an individual can be incarcerated as a means of retribution for committing criminal activity and as a deterrent to further crime for that specific person as well as the general public. Criminal justice entities also are involved in secondary prevention through the detection of those most at risk for juvenile and criminal justice system involvement with diversion alternatives and resources aimed to stop future system involvement.

Differences in approach notwithstanding, these approaches can be complimentary (Moore, 1995; Welsh *et al.*, 2014; Gebo, 2016; Ceredá *et al.*, 2018). In the last 20 years, there has been slow movement toward more collaboration among public health and criminal justice entities (Lee, 2017). Public health–criminal justice partnerships provide an opportunity to seize upon unrealized violence reduction goals (Prothrow-Stith, 2004; WHO, 2014; Sanz-Barbero *et al.*, 2018). Working together at all levels of prevention, a combined approach can be more effective than siloed work; preventing violence from occurring at the outset with a focus on health promoting policies, within specific high risk for violence populations, and with perpetrators of violence. Despite these intersections, a US national survey of social and community service organizations found few connections between public health and criminal justice entities (Hamer and Mays, 2020). As individual countries and the world continue to grapple with the pandemic and violence in communities, public health–criminal justice partnerships must be more closely examined for their potential health promotion benefits.

COLLABORATIVE ADVANTAGES AND DISADVANTAGES

The largest potential benefits from public health–criminal justice partnerships are recognition, awareness and resources of the distal and proximal causes of violence. From this perspective, violence prevention through individual, group and community interventions are embedded within a larger promotion of health that recognizes the necessities of physical, psychological and economic safety. When different entities leverage their diverse strengths to address a problem collaboratively, the potential impact to reduce large-scale problems, like violence, is greater (Bryson *et al.*, 2014). There are many points of connection between public health and criminal justice including the health and well-being of individuals, families, institutions, communities and societies. Importantly, effects of the coronavirus pandemic and racial justice movement underscore that institutionalized racism plays a role in violence, something that traditionally receives little recognition in solely criminal justice-focused responses.

Much of the public health–criminal justice partnership literature often identifies a single successful initiative to tout the benefits of collaboration. Topical areas identified for collaborative work include penetrating wounds and firearm violence (Florence *et al.*, 2011; Butts *et al.*, 2015), youth violence (Welsh *et al.*, 2014) and gang violence (Gebo, 2016). Other illustrations of public health–criminal justice partnerships focus on the nexus of physical health, mental health and criminal justice from the social and human services arena. For example, a recent study of mental health and child protection services in one location showed that organizational factors that included cross-agency collaboration buffered against secondary trauma of mental health workers (Strolin-Goltzman *et al.*, 2020). Furthermore, funded by the federal government, the USA has created several Youth Violence Prevention Centers in high violence communities that combine public health and criminal justice entities informed by prevention science (Matjasko *et al.*, 2016). Specific issues also have been addressed through the colocation of services connecting public health and criminal justice. These have shown promise for individuals and families as well as for successful legal outcomes. Colocated services include family justice centers that house mental health services for victims of family violence and trafficking as well as justice advocacy services [e.g. (EMT Associates, 2013)], hospitals that have in-house violence intervention programs [e.g. (Bonne and Dicker, 2020)], child advocacy centers that house treatment and justice-serving entities under the same roof (Herbert and Bromfield, 2016), and police departments with embedded mental health professionals working alongside officers on specific incidents and cases (Shapiro *et al.*, 2015).

Community violence does not occur in a vacuum. One type of violence can co-occur with another, so a broad focus on health and well-being that extends from households to institutional criminal justice settings to the community also has been advocated (Decker *et al.*, 2018). For example, Woodall *et al.* (Woodall *et al.*, 2014) proposed an integrative health criminal justice framework in prison to support better outcomes for prisoners and returning citizens focusing on individual health and policy changes aligned with the Ottawa Charter for Health Promotion that recognizes the importance of individual agency, communities and

governments in creating positive change. By acknowledging the importance of proximal and distal causes of violence and health, the Scottish government has perhaps gone the farthest in supporting public health–criminal justice nexus. The government has formed a Health and Justice Collaboration Improvement Board to address violence and other social problems at the intersection of public health and criminal justice and has provided resources for joint initiatives (Murray *et al.*, 2021).

Despite the potential advantages of partnership, the potential losses that come from partnering, or the collaborative disadvantage, is rarely, if at all, discussed in the public health–criminal justice literature. In a study of government–nonprofit collaboration, scholars identified financial costs, potential for mission drift, and more difficulty in evaluating results as partnering disadvantages (Gazely and Brundney, 2007). Further, if there are tight linkages to partnerships, loss of organizational autonomy through overreliance on interdependence may occur (Xu and Kim, 2021). In the current contentious landscape of blame, another potential pitfall of public health–criminal justice partnering is loss of legitimacy for public health organizations to partner with criminal justice organizations, especially police, and visa versa if members of the public feel that missions are being distorted. Public health entities may be subject to criticism for downplaying or ignoring social determinants of health, such as racism, by partnering with criminal justice entities. Criminal justice entities may be criticized for being 'soft on crime' by partnering with public health entities and taking a public health approach to violence or to offenders.

A public health–criminal justice partnership itself does not equate to measurable gains, but a recent innovative simulation experiment showed the benefits of a combined approach to reducing community violence using evidence-informed practices. In this scenario, after a violent incident, secondary and tertiary prevention is achieved by connecting perpetrators of violence with services. Meanwhile, police are strategically dispatched to the highest crime locations during the times at which violence is most likely to occur to deter and detect violence. Public health messaging to change community norms around use of violence also is employed. Cerdá *et al.* found this combined criminal justice–public health approach using focused deterrence and Cure Violence strategies reduced violence substantially more and in a substantially shorter period than a singular approach (Cerdá et al., 2018). Indeed, partnerships themselves do not ensure success, but careful articulation and attention to collaboration challenges may help entities meet collaborative goals (Gripp *et al.*, 2020).

The partnership itself must be examined to understand the collaborative advantage and disadvantage. Because partnerships may vary by context (Corbin *et al.*, 2018), only community violence prevention partnerships between public health and criminal justice are examined here.

Partnership aspects of community violence prevention are classified according to Turrini *et al.* (Turrini *et al.*, 2010) cross-disciplinary categorization of the determinants of successful collaboration. Determinants consist of a constellation of factors including external factors, or factors outside the collaboration that affect the collaboration itself, such as resources and politics; structural factors, or mechanics and organization of the partnership and functional factors, or process dimensions. Public health–criminal justice challenges and tools to overcome challenges are discussed and are grounded in the larger partnership literature.

PUBLIC HEALTH–CRIMINAL JUSTICE PARTNERSHIP CHALLENGES

Because public health and criminal justice collaborations have the potential to collectively achieve greater violence reduction goals, it is important to understand the challenges of collaboration among them. Researchers note that collaborating challenges may result in inability to reach shared goals as well as an inability to effectively evaluate those goals (Butts *et al.*, 2015). Unfortunately, much of the existent literature on public health–criminal justice partnerships recognizes that collaboration challenges exist, but little more (Jacoby *et al.*, 2018). Following Moore (Moore, 1995), Prothrow-Stith [(Prothrow-Stith, 2004), p. 84] recognized that there were fundamental differences in public health and criminal justice approaches to the problem as well as, 'the usual issues arising out of cross disciplinary collaboration such as different jargons, efforts to protect one's turf and competition for funding'. Other scholars examining a cross-section of public health systems and criminal justice systems point to additional challenges. In their scoping review of how law enforcement and public health address vulnerable populations, Enang *et al.* (Enang *et al.*, 2019) defined collaboration challenges as the need for a shared definition of the issue, shared understandings of each other's roles [also see (Potter and Rosky, 2013)], as well as shared protocols and processes. Other scholars note challenges related to trust (Worrall and Kjaerulf, 2018), information sharing (Gebo and Kirkpatrick, 2002; Shepherd and Sumner, 2017) and leadership (Butts *et al.*, 2015;

Strolin-Goltzman *et al.*, 2020). Many of these challenges also are subsumed under other names such as 'transparency' and 'communication' affecting collaborative commitment to the partnership [see e.g. (Morrel-Samuels *et al.*, 2016)]. Challenges to effectively working together are classified in Table 1 and are described in more detail.

Resources

External resource barriers arise with competition for limited funding and other types of support, such as technical assistance (Prothrow-Stith, 2004). Increasingly, however, governments and private funders are interested in intersectoral approaches to violence prevention and reduction, further promulgating intersectoral collaboration (Skogan, 2011; de Montigny *et al.*, 2017; Murray *et al.*, 2021). Funder preferences and mandates to collaborate across diverse entities may not overcome competition challenges, but they may compel entities to find better ways to work together to ensure resource stability. Other external factors influencing intersectoral collaboration cited outside public health–criminal justice partnership scholarship include such things as political support and organizational and community history of working together [e.g. (Turrini *et al.*, 2010; de Montigny *et al.*, 2017)].

Table 1: Public health–criminal justice partnering challenges

Collaboration dimension and barrier	Problem description	Reference
Resources	Competition for limited external resources	(Prothrow-Stith, 2004)
Cultural		
Knowledge	Separate knowledge bases leading to different orientations	(Moore, 1995; Enang *et al.*, 2019)
Language	Different language	(Moore, 1995; Prothrow-Stith, 2004; Shepherd and Sumner, 2017)
Structural		
Role	Roles not clearly defined/ understood	(Potter and Rosky, 2013; Enang *et al.*, 2019)
Information	Cross-system information sharing lacking	(Bolton *et al.*, 2017; Shepherd and Sumner, 2017; Murray *et al.*, 2021)
Accountability/ rewards	Absence or perverse systems of accountability and rewards	(Wolf, 2012)
Functional		
Leadership	Lack of leadership, buy-in and boundary spanners	(Butts *et al.*, 2015; Gripp *et al.*, 2020; Strolin-Goltzman *et al.*, 2020)
Trust	Lack of confidence in others and goodwill	(Worrall and Kjaerulf, 2018)

Cultural barriers

Cultural can be defined as shared ideas as well as learned and shared behavior within groups (Hofstede *et al.*, 2010). Individuals are inculcated into their professional cultures through trainings, interactions and processes in their respective fields. Layered onto professional socialization are individuals with their own cultural variants within those organizational cultures. Transmission of knowledge and norms, or ways of going about doing one's job, are necessary to develop competence and to complete tasks, but professional cultures also can be a barrier to successful intersectoral partnerships. In public health–criminal justice partnerships, cultural barriers include knowledge and language obstacles.

Different knowledge bases result in different approaches to the problem. Moore addresses these in detail, noting that '…the criminal justice approach sees violence primarily as a threat to community order; the public health approach sees it as a threat to community health' [(Moore, 1995), p. 243]. As a result of these different knowledge bases, orientations the problem with respect to causes and interventions are likely to vary, translating into collaborative quagmire when it comes to prioritization of issues and 'partnering' with the 'community' (Gebo and Kirkpatrick, 2002; Prothrow-Stith, 2004; Enang *et al.*, 2019). The very notion of what it means to partner and how to define community are rooted in experiences as well as knowledge of 'what works' to reduce violence.

The use of language that may be unfamiliar or mean something else to others is a common problem in public health–criminal justice partnerships (Prothrow-Stith, 2004; Shepherd and Sumner, 2017). Public health constructions of prevention include primary prevention of violence for everyone, regardless of circumstances or location, secondary prevention to those at high risk of violence and tertiary prevention to those who have committed violence. This language of prevention stands in contrast to criminal justice conceptions where prevention typically is construed as providing resources and services to those at high risk of violence and intervention

often is synonymous with tertiary prevention (Gebo, 2016). 'Community' also is likely to have different meanings across these fields. Public health practice is rooted in working with communities, grass-roots groups and individuals to address the social determinants of health, including systemic racism and unequal access to resources. Meanwhile, community partnering in the criminal justice arena is often construed as police, courts or corrections partnering with local human service agencies for the provision of individual-level services. Additionally, jargon abounds in both fields. Public health entities use terms that may not translate across fields such as adverse events, relative risk and intentional injuries. Similarly, criminal justice entities have their own lingo, such as focused deterrence, chronic offenders and hot spots. Effective partnerships require translational language that reaches across organizations and sectors.

Structural barriers

Alongside cultural barriers to public health–criminal justice partnerships, structural barriers may be present. Structural barriers are specific to the partnership itself. Two structural barriers found the public health–criminal justice partnership literature are role and information sharing. Confusion about each other's role and lack of understanding of what people do in their collaborative roles stand in the way of good partnering (Gebo and Kirkpatrick, 2002; Enang *et al.*, 2019). For example, the role of the health care provider in treating the patient confidentially as a primary goal may come in conflict with the law enforcement role of investigating and solving a crime. Role misunderstandings can lead to mistrust among entities and collaborative venture failures [e.g. (Collier, 2017)]. Role challenges also limit opportunities to leverage resources and joint-problem solving at every level of violence prevention (Potter and Rosky, 2013).

Information sharing between partners and across sectors is another structural challenge to collaboration (Murray *et al.*, 2021). For example, research has shown that police data are an incomplete data source in the case of penetrating wounds (Shepherd and Sumner, 2017). The Cardiff Model has demonstrated that police and hospital data combined provide a more accurate picture of shootings and stabbings from which to make data-driven decisions about allocation of resources and interventions. Before information sharing can be routine and institutionalized, however, legal and technological difficulties must first be addressed (Gebo and Kirkpatrick, 2002; Bolton et al., 2017). Laws are meant to balance private and public safety, and vary across jurisdictional boundaries. Harmful consequences to individuals and communities can potentially occur with greater access to information. Concomitantly, databases and technological tools, such as GIS mapping, are not typically created in ways that jointly serve both public health and criminal justice purposes, creating a barrier to the flow of information.

Accountability and reward systems are another potential structural barrier. Public health and law enforcement officials note that without accountability and reward systems that recognize value in partnering on shared social problems, collaboration is more difficult and *ad hoc* (Wolf, 2012). For example, if law enforcement is only held accountable and rewarded for reducing crime rates, then intersectoral partnerships are less likely. The broader literature on intersectoral collective action similarly notes that performance measurements toward shared goals are critical (de Montigny *et al.*, 2017), and partner systems of accountability and rewards help to build incentives for group achievements.

Functional barriers

Even if resources are plentiful, if culture cuts across boundary lines and intersectoral structures are set up for success, functional barriers can be roadblocks to achieving goals. Functional barriers are processes issues of collaboratives, or how the partnership works together to solve problems and resolve internal struggles (Turrini *et al.*, 2010). Notably, the public health–criminal justice literature does not mention a lack of shared goals as a barrier, though partnership scholarship in general identifies this as a common problem [see (de Montigny *et al.*, 2017)]. Functional barriers identified in the public health–criminal justice literature include lack of leadership and intersectoral trust issues.

A broad view of leadership is taken in the literature identifying intersectoral leadership in terms of boundary spanners, or those who bridge the relational gap between diverse entities and different levels of organizational structure, as well as traditional leaders in organizations, communities and government who can effectively champion causes and mobilize resources for initiatives. In the community violence context, public leader buy-in is a noted challenge for violence prevention approaches that emphasize public health over arrest and prosecution, such as the Cure Violence model where law enforcement is not at the forefront (Butts *et al.*, 2015). Simultaneously, community leaders are needed to spread nonviolence norms, but they can be reluctant to step into that role. A lack of leadership in intersectoral partnerships can lead to inefficiencies and negative effects on the well-being of workers in the partnership (Strolin-Goltzman *et al.*, 2020). Failure of leadership also may vary across different permutations of partnerships, whether that is among agencies, among community groups or among a mix of

agency and community groups and community leaders (McNamara *et al.*, 2020).

Perhaps the single most significant barrier to achieving shared outcomes is trust (Zanini and Migueles, 2013). Trust cuts across functional and structural dimensions of partnerships, and trust is affected by cultural dimensions. Examples from public health–criminal justice partnerships show that when those working on the ground distrust each other, they are not effective in reaching shared goals (Prothrow-Stith, 2004; Enang *et al.*, 2019). Partnership trust has multiple layers, including at the organizational, unit and personal levels. The ways in which trust operates at each of these levels is nuanced (Zhong *et al.*, 2017) and can change over time. The wider collaborative literature shows that leadership capabilities affect trust, and that may be particularly important at critical stages of the partnership, such as at inception (Schilke and Cook, 2013).

OVERCOMING PARTNERING CHALLENGES

Comprehensive partnerships that involve diverse government and community entities may be needed to fully address violence prevention. While smaller scale public health–criminal justice partnerships are informative, research examining US federal government interagency collaborations identified solutions that include cultural, structural and functional dimensions. They were: (i) bridging organizational cultures, (ii) defining outcomes and accountability mechanisms, (iii) defining leadership, (iv) clarifying roles and responsibilities, (v) including all relevant partners, (vi) identifying resources and (vii) writing guidance/agreements for collaboration (Mihm, 2012). Most of these solutions have been identified in the current public health–criminal justice literature, but research does not sufficiently address how to overcome collaborative challenges.

Potential solutions often cut across cultural, structural and functional dimensions of the partnerships. Importantly, addressing one barrier, such as accountability and reward systems, is likely to affect other areas, such as information sharing. Rooting collaborative enterprises in research that provides promising practices and guidance on how best to collaborate toward shared goal is critical. Meanwhile, tools aimed at measuring the strength of the collaboration itself have been developed and refined [e.g. (Retrum *et al.*, 2013; Brewster *et al.*, 2019)], with specific research devoted to the health context as well [e.g. (Corbin *et al.*, 2018; Calancie *et al.*, 2021)]. Tools that have demonstrated potential to address public health–criminal justice collaborative barriers are identified in Table 2, while the broader literature on potential collaborative elements of success are incorporated into the discussion that follows, providing a more robust consideration of potential solutions.

Table 2: Public health–criminal justice collaboration tools

Collaboration tool	Collaborative dimension addressed	Reference
Formalization	*Cultural*—trust *Structural*—roles, accountability and rewards	(Shepherd and Sumner, 2017; Enang *et al.*, 2019)
Cross-agency training	*Cultural*—knowledge, trust *Structural*—information	(Bolton *et al.*, 2017; Murray *et al.*, 2021)
Leadership development	*Functional*—leadership, trust	(Worrall and Kjaerulf, 2018; Gripp *et al.*, 2020)

Public health–criminal justice partnerships research shows that formal shared protocols, processes and role descriptions can help overcome cultural and structural barriers and build trust (Shepherd and Sumner, 2017; Enang *et al.*, 2019). When diverse entities know what is expected of them and have guidance on how to address the interdependent nature of their work, shared goals can be met (Gebo and Bond, 2020). Formalization is method to establish accountability and reward structures for partnering entities and provide mechanisms for continued focus on work toward collaborative goals, even if key personnel turnover occurs (Ziviani *et al.*, 2013). The larger literature on collaboration indicates that formalization can help with sense making, addressing cultural and structural barriers (Vlaar *et al.*, 2006), but formalization must be balanced. Overly structured formalization can suppress nimbleness, innovation, creativity and individual commitment to the partnership (de Montigny *et al.*, 2017).

In the violence prevention context, and perhaps in most intersectoral partnerships, cross-agency training may help break down cultural barriers between partners. Scotland is a leader in the development of these intersectoral partnerships with government support. At the community level, Scotland has included police, and social and mental health service providers in trainings and education to increase knowledge, understanding and collaboration among diverse entities (Murray *et al.*, 2021). Ensuring opportunities for learning and leading by utilizing the different skills of collaborative partners as a way to bridge cultural gulfs and build buy-in and respect for collaborative projects has been asserted (Bolton et al., 2017). Cross-agency trainings also force trainers and trainees to be deliberate in their consideration of language and translation across siloed divides. On a broader scale, continual trainings

and collaborative learning can help ensure that partnerships are innovative to the changing landscape of social problems including violence (Kania and Kramer, 2013).

Information sharing is an area of health promotion work that needs that specific guidance relative to public health–criminal justice partnerships. Much of the current best practices in criminal justice target those at highest risk for committing violence, putting them on notice that they are closely being watched and will be prosecuted to the greatest extent of the law if violations occur (Braga *et al.*, 2018). These individuals also are given the option to obtain help through social, employment and educational services. What information should be shared, with whom, and how, are critical questions that could compromise health and well-being of individuals, groups and communities if not done correctly. The racial justice movement brings this point in focus with the systemic targeting of young males and community distrust in government institutions. Information-sharing guidance will vary depending on specific context and laws. The MacArthur Foundation (nd), for example, identifies three distinct levels of information sharing (individual-specific, law, policy, and program-specific and evaluation-specific) and provides a tool kit for jurisdictions to share information under their Models for Change initiative. Legal barriers across sectors and jurisdictional boundaries must be carefully negotiated with attention to potential unintended consequences of information sharing.

Relational aspects of partnerships—trust, respect and good will—are critical to meet shared goals (Hunter and Perkins, 2012; Gittell, 2016). Good leadership can increase the positive relational dimensions of partnerships (Hunter and Perkins, 2012). In the broader public health partnering arena, Jones and Barry (Jones and Barry, 2011) have developed and piloted a trust measurement tool for health promotion partnerships that shows promise in monitoring partnership functioning. While still in exploratory phases, this could be applied to public health–criminal justice partnerships. With regard to public health–criminal justice partnerships specifically, Worrall and Kjaerulf (Worrall and Kjaerulf, 2018) have used a leadership development tool in Kenya to help law enforcement and government leaders increase respect and trust as initial steps toward better collaboration. Meanwhile, a community violence intervention project showed that leaders who to move across organizational boundaries and are effective at conflict resolution were a key ingredient to violence reduction (Gripp *et al.*, 2020). The importance of leaders who can buffer and nurture relationships across sectors has been shown to facilitate collaborative success more generally as well (McNamara *et al.*, 2020). Leadership may be particularly important in the current crisis where communities are not part of the solution, have high levels of distrust, and publicly call for defunding and dismantling the police (van Dijk and Crofts, 2017).

Partnering challenges and methods to overcome them in health promotion arenas is in its infancy compared with other fields, but lessons can be learned from fields where organizational change and collaborative enterprises are more developed (Batras *et al.*, 2014). Guidance on how to implement solutions can be found in organizational science literature across academic domains. For example, resource competition may be partially addressed through identifying resources, but could be baked into funding mandates and policy directives that may lead to success (McNamara, 2016). Leadership is critical to accountability and rewards structures as ways to help build capacity and incentivize collaborative work toward shared goals (de Montigny *et al.*, 2017). It is clear that communication and coordination are essential to address all of these challenges (Brewster *et al.*, 2019). The broader partnership literature shows that deliberate attention to the partnership can enhance and strengthen the cultural, structural and functional dimensions of collaborative work to meet shared goals (Bolton et al., 2021).

CONCLUSION

The COVID pandemic and racial justice movements have served to increase calls for partnerships across public health and criminal justice landscapes (Council on Criminal Justice, 2020). Current examples of public health–criminal justice partnerships exist in piecemeal fashion, but taken together provide insight into common challenges. These challenges align with broader research on collaboration that can be aggregated into resources, cultural, structural and function domains. This work has contributed to understanding the collaborative dimensions of public health–criminal justice partnerships by grounding those examples in a research-based collaboration framework. While the current literature identifies some avenues to overcome those challenges, large gaps in our knowledge of what works remain. The partnership literature from diverse academic and organizational sectors can help to fill in those gaps.

Future research should identify how successful public health–criminal justice partnerships have achieved that success and examine collaborative failures to inform the current state of knowledge (McNamara *et al.*, 2020). Another fruitful avenue of exploration for future research is to take an action research approach to implementing promising collaborative improvements and monitor outcomes to understand what works best in the public health–criminal justice context.

Large-scale government partnering as seen in Scotland is rare; the reality is that most public health–criminal justice collaborations take place on a local scale. As a result, the focus on specific aspects of violence prevention could mean solutions address small-scale intermediary health benefits, rather than large-scale policy changes that create universal change (Holt *et al.*, 2017). While small changes may improve health, it is also important to support changes that result in broad health promotion strategies that address structural inequalities.

Creating genuine partnerships between public health and criminal justice systems can result in mobilizing more resources for the problem (Moore, 1995; Enang *et al.*, 2019), cost savings (Florence *et al.*, 2014), and lead to addressing root cause policy issues essential to reducing violence and increasing health and well-being (Woodall *et al.*, 2014). It may be that not all problems that have public health and criminal justice overlaps can be addressed through such partnering [see (Collier, 2017)] but we need to know more about their collective effectiveness on outcomes for individuals, groups and communities (Morrissey *et al.*, 2009; Harris *et al.*, 2017). Understanding how these partnerships can operate more effectively can lead to collective improvements (Daley, 2008). The pandemic and the racial justice movement have called into question longtime preventive and responses to violence and provided a window of opportunity to address these problems collectively, critically and holistically.

REFERENCES

Batras, D., Duff, C. and Smith, B. J. (2014) Organizational change theory: implications for health promotion practice. *Health Promotion International*, **31**, 231–240.

Bolton, R., Logan, C. and Gittell, J. (2021) Revisiting relational coordination: a systematic review. *The Journal of Applied Behavioral Science*, **57**, 290–322. doi:10.1177/0021886321991597

Bolton, K. W., Maume, M. O., Halls, J. J. and Smith, S. D. (2017) Multisectoral approaches to addressing youth violence. *Journal of Human Behavior in the Social Environment*, **27**, 760–767.

Bonne, S. and Dicker, R. (2020) Hospital-based violence intervention programs to address social determinants of health and violence. *Current Trauma Reports*, **6**, 23–28.

Braga, A. A., Weisburd, D. and Turchan, B. (2018) Focused deterrence strategies and crime control: an updated systematic review and meta-analysis of the empirical evidence. *Criminology and Public Policy*, **17**, 205–250.

Brewster, A. L., Tan A. X. and Yuan, C. T. (2019) Development and application of a survey instrument to measure collaboration among health care and social services organizations. *Health Services Research*, **54**, 1246–1254.

Bryson, J. M., Crosby, B. C. and Stone, M. M. (2006) The design and implementation of cross-sector collaborations: propositions from the literature. *Public Administration Review*, **66**(Suppl 1), 44–55.

Bryson, J. M., Crosby, B. C. and Stone, M. M. (2014) The design and implementation of cross-sector collaborations: moving beyond traditional public administration and the new public management. *Public Administration Review*, **74**, 445–456.

Bryson, J. M., Crosby, B. C. and Stone, M. M. (2015) Designing and implementing cross-sector collaborations: needed and challenging. *Public Administration Review*, **75**, 647–663.

Butts, J. A., Roman, C. G., Botswick, L. and Porter, J. R. (2015) Cure Violence: a public health model to reduce gun violence. *Annual Review of Public Health*, **36**, 39–53.

Calancie, L., Frerichs, L., Davis, M. M., Sullivan, E., White, A. Cilenti, D. *et al.* (2021) Consolidated framework for collaboration research derived from a systematic review of theories, models, frameworks and principles for cross-sector collaboration. *PLoS One*, **16**, e0244501.

Ceredá, M., Tracy, M. and Keyes, K. M. (2018) Reducing urban violence: a contrast of public health and criminal justice approaches. *Epidemiology*, **29**, 142–150.

Collier, R. (2017) Is police-public health collaboration an oxymoron? *CMAJ*, **189**, E760–E761.

Corbin, J. H., Jones, J. and Barry, M. M. (2018) What makes intersectoral partnerships for health promotion work? A review of the international literature. *Health Promotion International*, **33**, 4–26.

Council on Criminal Justice, National Commission on COVID-19 and Criminal Justice. (2020) Experience to action: reshaping criminal justice after COVID-19. https://counciloncj.foleon.com/covid19/experience-to-action/welcome/ (last accessed 1 January 2022).

Daley, D. M. (2008) Interdisciplinary problems and agency boundaries: exploring effective cross-agency collaboration. *Journal of Public Administration Research and Theory*, **19**, 477–493.

de Montigny, J. G., Desjardins, S. and Bouchard, L. (2017) The fundamentals of cross-sector collaboration for social change to promote population health. *Global Health Promotion*, **26**, 41–50.

Decker, M. R., Wilcox, H. C., Holliday, C. N. and Webster, D. W. (2018) An integrated public health approach to interpersonal violence and suicide prevention and response. *Public Health Reports*, **133**, 65S–79S.

EMT Associates Inc. (2013) Final evaluation results: phase II California family justice initiative statewide evaluation. http://issuu.com/familyjusticecenteralliance/docs/evaluation___outcomes_-_cfji_final_ (last accessed 12 January 2022).

Enang, I., Murray, J., Dougall, N., Wooff, A., Heyman, I. and Anston, E. (2019) Defining and assessing 'vulnerability' within law enforcement and public health organisations: a scoping review. *Health & Justice*, **7**, 1–13.

Florence, C., Shepherd, J., Brennan, I. and Simon, T. (2011) Effectiveness of anonymized information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis. *British Medical Journal*, **342**. doi: 10.1136/bmj.d3313

Florence, C., Shepherd, J., Brennan, I. and Simon, T. (2014) An economic evaluation of anonymized information sharing in a partnership between health service, police and local government for preventing violence-related injury. *Injury Prevention*, **20**, 108–114.

Gazely, B. and Brundney, J. L. (2007) The purpose (and perils) of government-nonprofit partnership. *Nonprofit and Voluntary Sector Quarterly*, **36**, 389–415.

Gebo, E. (2016) An integrated public health and criminal justice approach to gangs: what can research tell us? *Preventive Medicine Reports*, **4**, 376–380.

Gebo, E. and Bond, B. J. (2020) Improving interorganizational collaborations: an application in a violence reduction context. *The Social Science Journal*. doi:10.1016/j.soscij.2019.09.008

Gebo, E. and Kirkpatrick, J. T. (2002) The challenge of collaboration between law enforcement and medical communities. *Criminal Justice Studies [formerly known as The Justice Professional]*, **15**, 19–28.

Gittell, J. H. (2016) *Transforming Relationships for High Performance: The Power of Relational Coordination*. Stanford University Press, Stanford, CA.

Gripp, C., Jha, C. and Vaughn, P. E. (2020) Enhancing community safety through interagency collaboration: lessons from Connecticut's Project Longevity. *The Journal of Law, Medicine, & Ethics*, **48**, S47–S54.

Hamer, M. K. and Mays, G. P. (2020) Public health systems and social services: breadth and depth of cross-sector collaboration. *American Journal of Public Health*, **110**, S232–S234.

Harris, J. K., Jonson-Reid, M., Carothers, B. J. and Fowler, P. (2017) The structure of policy networks for injury and violence prevention in 15 US cities. *Public Health Reports*, **132**, 381–388.

Herbert, J. L. and Bromfield, L. (2016) Evidence for the efficacy of the child advocacy center model: a systematic review. *Trauma, Violence, & Abuse*, **17**, 341–357.

Hofstede, G., Hofstede, G. J. and Minkov, M. (2010) *Cultures and Organizations: Software of the Mind*, 3rd edn. McGraw Hill, New York, NY.

Holt, D. H., Frohlich, K. L., Tjørnhøj-Thomsen, T. and Clavier, C. (2017) Intersectoriality in Danish municipalities: corrupting the social determinants of health? *Health Promotion International*, **32**, 881–890.

Hunter, D. and Perkins, N. (2012) Partnership working public health: the implications for governance of a systems approach. *Journal of Health Services Research & Policy*, **17**, 45–52.

Jacoby, S. F., Kollar, L. M. M., Ridgeway, G. and Sumner, S. A. (2018) Health system and law enforcement synergies for injury surveillance, control and prevention: a scoping review. *Injury Prevention*, **24**, 305–311.

Jones, J. and Barry, M. M. (2011) Developing a scare to measure trust in health promotion partnerships. *Health Promotion International*, **26**, 484–491.

Kaiser, F. M. (2011) *Interagency Partnership Arrangements and Activities: Types, Rationales, Considerations*. Congressional Research Services, Washington, DC.

Kania, J. and Kramer, M. (2013) How collective impact addresses complexity. *Stanford Social Innovation Review*. https://ssir.org/pdf/Embracing_Emergence_PDF.pdf (last accessed 12 January 2022).

Lee, B. X. (2017) Causes and cures XV: synthesis and integration. *Aggression and Violent Behavior*, **35**, 91–96.

Lett, E., Asabor, E. N., Corbin, T. and Boatright, D. (2021) Racial inequality in fatal US police shootings, 2015–2020. *Journal of Epidemiology and Community Health*, **75**, 394–397.

MacArthur Foundation. (nd). Models for change information sharing tool kit, 2nd edn. http://www.infosharetoolkit.org/ (last accessed 12 January 2022).

Matjasko, J. L., Masetti, G. M. and Bacon, S. (2016) Implementing and evaluating comprehensive evidence-based approaches to youth violence: partnering to crate communities where youth are safe from violence. *Journal of Primary Prevention*, **37**, 109–119.

McNamara, M. W. (2016) Unraveling the characteristics of mandated collaboration. In Morris, J. C. and Miller-Stevens, K. (eds), *Advancing Collaboration Theory: Models, Typologies and Evidence*, Chapter 4. Routledge, New York, NY, pp. 65–86.

McNamara, M. W., Miller-Stevens, K. and Morris, J. C. (2020) Exploring the determinants of collaboration failure. *International Journal of Public Administration*, **43**, 49–59.

Mihm, J. C. (2012) *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*. Government Accountability Office, Washington, DC.

Moore, M. H. (1995) Public health and criminal justice approaches to prevention. *Crime and Justice*, **19**, 237–262.

Moore, E. and Koontz, T. (2003) A typology of collaborative watershed groups: citizen-based, agency-based, and mixed partnerships. *Society and Natural Resources*, **16**, 451–460.

Morrel-Samuels, S., Bacallao, M., Brown, S., Bower, M. and Zimmerman, M. (2016) Community engagement in youth violence prevention: crafting methods to context. *Journal of Primary Prevention*, **37**, 189–207.

Morrissey, J., Fagan, J. A. and Cocozza, J. J. (2009) New models of collaboration between criminal justice and mental health systems. *The American Journal of Psychiatry*, **166**, 1211–1214.

Murray, J., Heyman, I., Dougall, N., Wooff, A., Aston, E. and Enang, I. (2021) Co-creation of five key research priorities across law enforcement and public health: a methodological example and outcomes. *Journal of Psychiatric and Mental Health Nursing*, **28**, 3–15.

Nutbeam, D. and Muscat, D. M. (2021) Health promotion glossary 2021. *Health Promotion International* **36**, 1578–1598. doi:10.1093/heapro/daaa157

Potter, R. H. and Rosky, J. W. (2013) The iron fist in the latex glove: the intersection of public health and criminal justice. *American Journal of Criminal Justice*, **38**, 276–288.

Prothrow-Stith, J. (2004) Strengthening the collaboration between public health and criminal justice to prevent violence. *Journal of Law, Medicine and Ethics*, **32**, 82–88.

Retrum, J. H., Chapman, C. L. and Varda, D. M. (2013) Implications of network structure on public health collaboratives. *Health Education & Behavior*, **40**, 13S–23S.

Sanz-Barbero, B., Corradi, C., Otero-García, L., Ayala, A. and Vives-Cases, C. (2018) The effect of macrosocial policies on violence against women: a multilevel study in 28 European countries. *International Journal of Public Health*, **63**, 901–911.

Schilke, O. and Cook, K. S. (2013) A cross-level process theory of trust development in interorganizational relationships. *Strategic Organization*, **11**, 281–303.

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A. and Stergiopoulos, V. (2015) Co-responding police-mental health programs: a review. *Administration and Policy in Mental Health*, **42**, 606–620.

Shepherd, S. A. and Sumner, J. P. (2017) Policing and public health strategies—strategies for collaboration. *JAMA*, **317**, 1525–1526.

Shute, J. (2013) Family support as a gang reduction measure. *Children & Society*, **27**, 48–59.

Skogan, W. G. (2011) Community-based partnerships and crime prevention. *Criminology and Public Policy*, **10**, 987–990.

Strolin-Goltzman, J., Breslend, N., Deaver, A. H., Wood, V., Woodside-Jiron, H. and Krompf, A. (2020) Moving beyond self-care: exploring protective influence of interprofessional collaboration, leadership and competency on secondary traumatic stress. *Traumatology*. doi:10.1037/trm0000244

Sutherland, M., Kenny, M. and Elkbuli, A. (2021) Gun violence during COVID-19 pandemic: paradoxical trends in New York City, Chicago, Los Angeles, and Baltimore. *American Journal of Emergency Medicine*, **39**, 225–226.

Thompson, A. M., Perry, J. L. and Miller, T. K. (2009) Conceptualizing and measuring collaboration. *Journal of Public Administration Research and Theory*, **19**, 23–56.

Turrini, A., Cristofoli, D., Frosini, F. and Nasi, G. (2010) Networking literature about determinants of network effectiveness. *Public Administration*, **88**, 528–550.

van Dijk, A. and Crofts, N. (2017) Law enforcement and public health as an emerging field. *Policing and Society*, **27**, 261–275.

Vlaar, P. W. L., Van den Bosch, F. A. J. and Volberda, H. W. (2006) Coping with problems of understanding interorganizational relationships: using formalization as a means to make sense. *Organizational Studies*, **27**, 1617–1638.

Welsh, B.C., Braga, A. A. and Sullivan, C. J. (2014) Serious youth violence and innovative prevention: on the emerging link between public health and criminology. *Justice Quarterly*, **31**, 500–523.

Wolf, R. V. (2012) The overlap between public health and law enforcement: sharing tools and data to foster healthier communities. *International Review of Law, Computers & Technology*, **26**, 97–107.

Woodall, J., de Viggiani, N., Dixey, R. and South, J. (2014) Moving prison health promotion along: towards and integrative framework for action to develop health promotion and tackle the social determinants of health. *Criminal Justice Studies*, **27**, 114–132.

World Health Organization. (2014) Health in all policies. https://www.who.int/cardiovascular_diseases/140120H-PRHiAPFramework.pdf (last accessed 12 January 2022).

Worrall, R. and Kjaerulf, F. (2018) Building collaborative capability between law enforcement and civil society leaders to prevent urban violence. *International Journal of Public Health*, **63**, 969–976.

Xu, C. and Kim, M. (2021) Loss or gain? Unpacking nonprofit autonomy-interdependence paradox in collaborations. *American Review of Public Administration*, **51**, 308–324.

Zanini, M. T. F. and Migueles, C. P. (2013) Trust as an element of informal coordination and its relationship with organizational performance. *Economica*, **14**, 77–87.

Zhong, Q., Su, C., Peng, J. and Yang, Z. (2017) Trust in interorganizational relationships: a meta-analytic integration. *Journal of Management*, **43**, 1050–1075.

Ziviani, J., Darlington, Y., Feeney, R., Meredith, P. and Head, B. (2013) Children with disabilities in out-of-home care: perspectives on organizational collaborations. *Children & Youth Services Review*, **35**, 797–805.