Hospital-based violence intervention: strategies for cultivating internal support, community partnerships, and strengthening practitioner engagement

Sheetal Ranjan, Aakash K. Shah, C. Clare Strange and Kate Stillman

Abstract

Purpose – *The purpose of this paper is to present strategies for cultivating internal support, community partnerships and practitioner engagement for Hospital-based Violence Intervention Programs (HVIPs). In response to growing concerns about community violence and calls to engage the community in its solutions, HVIPs have increased in popularity as innovative and transdisciplinary approaches to violence intervention. HVIPs are one strategy under the broad purview of public health approaches to crime and violence – focusing on reaching recent victims of violence in emergency departments and leveraging this "teachable moment" to offer wrap-around services geared toward preventing future violence or revictimization.*

Design/methodology/approach – *This paper uses an autoethnographic and case study approach of Project HEAL (Help, Empower and Lead), a newly established HVIP at Jersey Shore University Medical Center.*

Findings – *While there is no "standard" approach, the importance of strong community partnerships and practitioner engagement prior to and during the HVIP implementation process is second to none.*

Research limitations/implications – *This case study of Project HEAL's initial implementation will provide information that can assist other HVIPs in creating and sustaining necessary internal support, community partnerships and practitioner engagement, and potentially help navigate forthcoming statewide and federal efforts.*

Originality/value – *Development of meaningful community partnerships and achievement of a high level of engagement from practitioners are key to the successful implementation of HVIPs, the processes of which are not always documented in literature.*

Keywords *Transdisciplinary, Coordinated community response, Hospital-based violence intervention program (HVIP), Practitioner-engaged, Public health approach, Violence intervention*

Paper type *Case study*

Introduction

Hospital-based Violence Intervention Programs (HVIPs) are an innovative approach to assist victims of violence who seek medical services as a result of their injuries. HVIPs aim to provide wrap-around services that go beyond medical treatment to make the victim whole by connecting them to a range of community resources. The immediate goal of an HVIP is to break the cycle of violence with the long-term objective of decreasing rates of violent injury. HVIPs have primarily been established in urban areas, and while these programs share some common elements, the structure of each is tailored to reflect the communities they serve. Like many other direct interventions, community engagement and

Sheetal Ranjan, PhD, is based at the Department of Sociology & Criminal Justice, William Paterson University of New Jersey, Wayne, New Jersey, USA Aakash K. Shah, MD, MBA, MSc is based at the Department of Psychiatry and Behavioral Health, Jersey Shore University Medical Center, Neptune City, New Jersey, USA, the Department of Emergency Medicine, Hackensack University Medical Center, Hackensack, New Jersey, USA, and the Hackensack Meridian School of Medicine, Nutley, New Jersey, USA. C. Clare Strange, PhD, is based at the Criminal Justice Research Center at Pennsylvania State University, University Park, Pennsylvania, USA. Kate Stillman, JD, is based at the Department of Sociology & Criminal Justice, William Paterson University of New Jersey, Wayne, New Jersey, USA.

Received 18 March 2021
Revised 19 June 2021
Accepted 22 July 2021

practitioner involvement are key to HVIP success – and recent calls from the White House reinforce the importance of such community engagement in the fight against violence [1]. For this same reason, a recent funding opportunity for HVIPs by the New Jersey Office of Attorney General required a community partner to be identified in the funding application and involved in the program in a substantial way. Project HEAL (a new HVIP) was established at Jersey Shore University Medical Center using these funds. Strong advocacy efforts are leading to similar statewide initiatives to establish HVIPs across the USA. This case study of Project HEAL's initial implementation provides information that can assist other HVIPs in creating and sustaining necessary internal support, community partnerships and practitioner engagement and help navigate forthcoming statewide efforts.

Background/literature review

Transdisciplinary responses to violence

Transdisciplinary, or integrated approaches to violence are not new, and research highlights the benefits of such programming (Johnson *et al.*, 2019). Examples include Sexual Assault Response Teams (SARTs) and Domestic Violence Response Teams (DVRTs), which leverage the resources of, and access that hospitals, police and advocates have to victims of violence to improve victim safety immediately following the incident and intervention. HVIPs, a more recent transdisciplinary approach, follow these earlier models, capitalizing on their effective components and providing an innovative and community-coordinated approach to violence intervention. Importantly, HVIPs expand the narrower scope of SARTs and DVRTs to victims of all forms of violence.

Hospital-based violence intervention programs as innovative and transdisciplinary responses to violence

HVIPs are designed to use the knowledge and resources of different community partners to provide a coordinated, one-stop shop for victims of violence. This also shifts violence from a criminal justice to a health issue – helping build trust between programs and the diverse communities they serve (Garretson and Marks, 2020). The first point of contact is the hospital, to which most programs dispatch to the victim's bedside a peer intervention specialist with experience in community violence and training in violence intervention. They serve as a point of contact between the victim and case managers, clinicians and social workers as they develop an individualized service plan and link the victim to other community-based services. These established relationships continue even after the victim has been discharged to support and assist the victim throughout the stages of recovery (National Network of Hospital-Based Violence Intervention Program, 2019). Theoretical support for HVIPs comes from the Health Belief Model (HBM), which theorizes that people will alter a risky health behavior according to how they perceive their vulnerability to its effects, the severity of its consequences, the benefits of its prevention and their ability to follow prevention strategies (Rosenstock, 1974).

A key aspect of HVIPs is that they provide a coordinated community response in which the community collaborates to better the provision of services and dissemination of knowledge. A coordinated community response shifts the onus of victimization on the community (instead of the victim). Therefore, it requires that myriad community agencies and actors such as law enforcement, legal and healthcare systems, social service providers, educational and vocational programs and other stakeholders (e.g. religious, advocacy) cooperate and coordinate to provide services to the victim (Ranjan, 2020). The goal is to create relationships between the different groups to fill gaps in services and resources, providing a single, comprehensive response (Shorey *et al.*, 2014). Preliminary evidence shows that HVIPs can be effective in reducing repeat victimizations within communities (Chong *et al.*, 2015). There is also evidence to suggest that HVIPs help to improve the

mental and physical health of victims, increase their rates of employment and housing and improve relationships by increasing closeness to supportive friends, family and community members and decreasing involvement in gangs (Juillard *et al.*, 2016; Monopoli *et al.*, 2018). HVIPs may also decrease costs to the victims by way of lowering rates of incarceration and future hospitalizations (Evans and Vega, 2018). As such, HVIPs are promising interventions for myriad patient- and community-level outcomes, particularly for communities that suffer from high rates of violence.

Meaningful community partnerships and practitioner engagement as tools for HVIP implementation success

Recent calls from the Biden campaign (and echoed by the Urban Institute) suggest that community partnerships and practitioner engagement as essential to implementing necessary and sustainable programming to successfully combat violence (Farrell *et al.*, 2021). HVIPs are ideal environments for fostering these types of relationships because of their emphasis on the formation of networks, tailoring programs to the community they serve and their multidisciplinary approach to providing victims' services.

A "meaningful community partnership" is one in which all members of the community/group provide useful resources to advance a common goal and to provide a comprehensive set of services to the community as a whole and community members as individuals (Ranjan, 2020). Usually partners are groups, organizations or individuals who have an established interest in the issue of concern (victims of violence in the case of HVIPs) but unique specializations. These partners have built trust within the community, have knowledge about the specific needs of the community and have experience working within the community. Due to their specialized knowledge these partners bring different perspectives to HVIPs, enabling individualized plans for victims making it more likely for their needs to be addressed – which often include legal assistance, housing, workforce training and employment, alcohol and substance use treatments, mental health support and basic needs such as communication (e.g. phones), food and clothing (Boccellari *et al.*, 2007; Patton *et al.*, 2019).

Aside from developing partnerships within the community a key aspect of HVIPs is getting engagement from a variety of practitioners. This is part and parcel of the work related to community engagement, as those most immediately impacted by policy or program changes often hold expertise in these areas and should be the main knowledge contributors (Farrell *et al.*, 2021). In the case of HVIPs, practitioners may include doctors and nurses who treat physical injuries as well as mental health professionals and social workers who can address victims' mental health and other concerns such as housing, education and employment. Notably, healthcare providers, like any other stakeholders, are not monolithic and so the appeal varies depending on the individual. The emergency medicine providers may be interested in being able to shift the cognitive load of tackling difficult social issues (e.g. transportation, food security assistance, job training and placement) onto HVIP staff, trauma surgeons may be interested in being able to discharge patients more efficiently and safely (e.g. arrange for emergency housing) with the support of HVIP staff and others may simply be drawn to the work on an ideological level.

Relationships with practitioners need to be carefully developed such that they are able to provide input into the project and feel a sense of ownership over its mission. Preexisting hospital systems that provide healthcare to victims of violence should be leveraged in this way because they likely have roots in the community to address different healthcare needs. These networks can be expanded through connections with other community partners who can address the social needs of the victim to provide comprehensive care. Practitioner engagement is built into the HVIP model, whereby an intervention specialist meets with the victim at the bedside to initiate the community response and begin developing a plan to

address the victim's medical and social needs (NNHVIP, 2019). This component makes fostering practitioner engagement all the more essential to HVIPs.

Current study – methods

Ours is a mixed methods study; we use elements of autoethnographies and pre-implementation case studies, including observational data from Project HEAL as well as ten short surveys with members of its program and evaluation teams. Ethnographic and case study methodologies are useful for examining program and individual practices in the natural place and time that they occur (LeCompte and Schensul, 1999), which is particularly useful for exploring pre- and early-implementation characteristics of a nascent HVIP in a new setting/implementation environment. From the responses we highlighted themes (Figure 1) and drew illustrative quotes, also using preliminary program and community data to characterize the findings.

Results

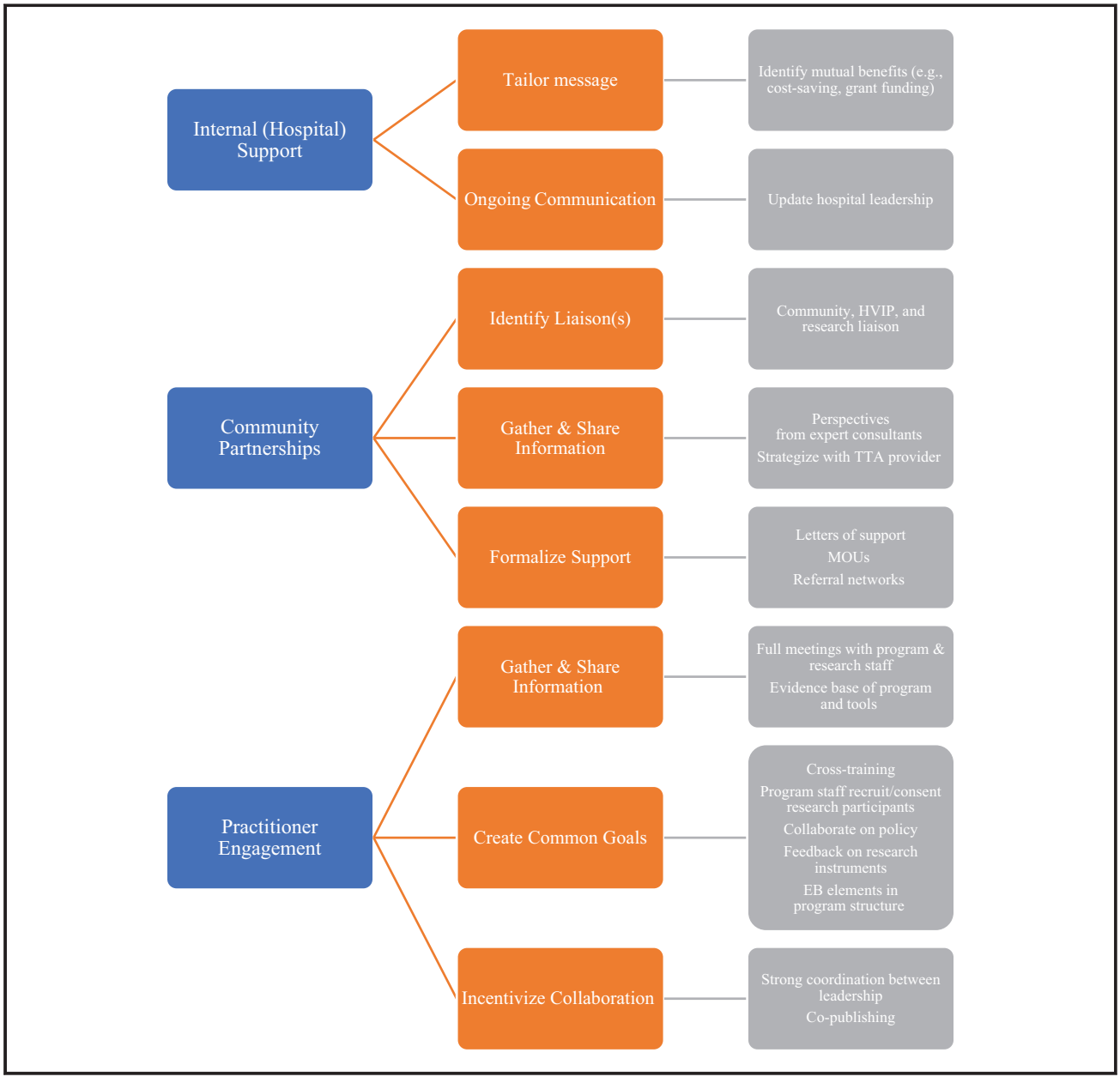
Cultivating support, partnerships and strengthening practitioner engagement during the pre-implementation phase of Project HEAL

Monmouth County, NJ, though suburban (population ~620,000), is an ideal location for an HVIP. According to the Uniform Crime Reports (UCR), there are multiple violent crime "hot spots" near Jersey Shore University Medical Center (JSUMC) in Monmouth County, the location of Project HEAL (Help, Empower and Lead) – including Asbury Park, Neptune Township and Long Branch City. These cities reported (on average) 85 cases of aggravated assault and 359 cases of domestic violence in 2016. This, along with JSUMC's high capacity to serve victims of violence through its trauma-I center and established SART and DVRT programs makes it an appropriate, albeit unique location for an HVIP.

With 71 referrals and 50 active clients since its "launch" on March 1, 2021, Project HEAL is one of several recent programs to receive Victims of Crime Act (VOCA) funding through the New Jersey Attorney General's initiative to establish HVIPs across the state. According to the Bureau of Justice Statistics (2018), millions of dollars are allocated to Victim Service Providers (VSPs) annually through both federal (e.g. VOCA, Office for Victims of Crime) and nonfederal (e.g. state, local, tribal government) sources. HVIPs represent a small portion (roughly 3.2%) of VSPs that that use mainly federal (but also nonfederal) funds to maximize the opportunity to intervene immediately post-injury to break the cycle of violence. While there are over 40 established HVIPs across the U.S. (see www.thehavi.org/ for details), each program may receive its funding through unique sources. In 2019, the New Jersey Office of the Attorney General (NJOAG) announced $20m in VOCA grants to fund nine HVIP sites for a period of 21 months (Johnson, 2019). The awarding of VOCA funds by the NJOAG's Office represented the first time that New Jersey funded HVIPs. This funding dovetailed with a new package of laws designed to combat gun violence by expanding violence intervention programs at hospitals across the state. These laws launch an initiative to get more hospitals to create violence intervention programs (NJ Senate Bill No. 3301),[2] require certain hospitals to provide such programs to be designated as Level One or Level Two trauma centers (NJ Senate Bill No. 3312),[3] and mandate that the state Victim of Crime Compensation Office partner with trauma centers to refer victims to those programs (NJ Senate Bill No. 3323) [4].

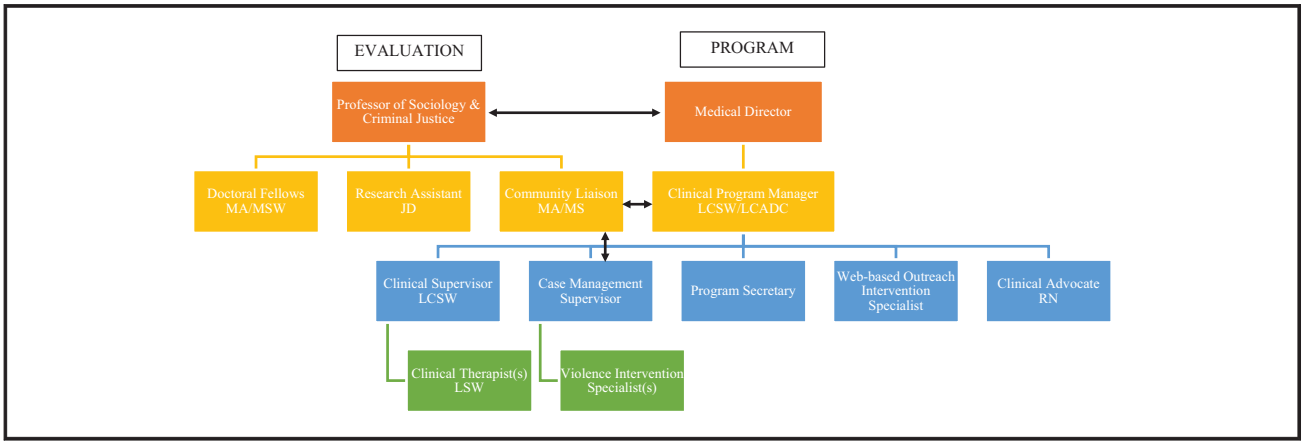
Typically, HVIPs address only community violence and operate in more metropolitan areas. However, Project HEAL is unique among HVIPs in that it serves victims (and their families) of community and intimate partner violence (IPV) in the economically distressed, suburban areas of Monmouth County. One other aspect of Project HEAL that distinguishes it from other HVIPs across the country is its partnership with an academic evaluation and data team (from a Criminology/Criminal Justice Program) through the funding application,

Figure 1 Cultivating community partnerships and practitioner engagement during the pre-implementation phase – action steps from Project HEAL



program planning and implementation stages. This partnership ensures that the program benefits from the newest evidence-based strategies, as well as develops policies, protocols and data collection instruments that will allow for high quality evaluation efforts over time (Dicker *et al.* (2017). This transdisciplinary partnership across medical and criminological fields of knowledge transcends traditional boundaries and integrates the natural, social and health sciences. The partial embeddedness of the evaluation and program teams (Figure 2) is essential due to the applied nature of the research. In particular, regular communication and collaboration between the Project HEAL Medical Director, Clinical Program Manager and Case Management Supervisor with the evaluation team's principal investigator (PI) and the Community Liaison assures that the evaluation team has a clear understanding of the

Figure 2 Project HEAL organizational chart



program, and how best to evaluate it. Tasked with serving victims of violence and their families in an economically distressed, suburban area, those involved in Project HEAL have taken steps to cultivate internal support, develop community partnerships and engage practitioners during early implementation and initial rollout. These strategies are listed in Figure 1, and the sections that follow describe them in more detail.

Cultivating internal support for Project HEAL in the hospital network

The first step in establishing this HVIP was cultivating support internally at JSUMC to get approvals to apply for the grant funding. To do this, it was helpful to tailor the message to the audience. The JSUMC network leadership has a general interest in advancing their medical school which is focused on the social determinants of health. Also, the network leadership, as is common everywhere, is interested in managing its budget. Therefore, the Medical Director (co-author), spoke to the leadership about how the HVIP could be the quintessential opportunity to address the focus on social determinants. The HVIP program would make JSUMC's medical school attractive to medical students for their rotations. Further cost reductions would be achieved by breaking cycles of violence that would help reduce readmissions. Once the network leadership was convinced, buy-in from departmental leadership was sought by addressing their interest in trauma-informed care and explaining to them how an HVIP could help advance such care throughout the department and hospital, and this would reverberate with community partners, practitioners and the like. These efforts led to support for the funding application. Now that the program is funded and newly established, the network and departmental leadership has been updated about progress on a weekly basis. This constant interaction not only allows the opportunity to leverage their knowledge and heft to navigate hospital systems and departments such as legal, human resources, technology services, etc., but also creates a sense of ownership and sustained buy-in for the program.

Cultivating community partnerships with Project HEAL

Strong community partnerships have been essential to Project HEAL. These partners include myriad community organizations and stakeholders such as IPV intervention agencies and other direct service providers, community colleges, law enforcement, religious leaders, legislators and other local officials. Importantly, community partners need not be directly involved in the HVIP to aid (or hinder) its implementation. The first step is to

gain the trust of these partners, and second, to define and solidify a robust and ongoing working relationship.

An essential component to cultivating community partnerships with Project HEAL was identifying a community liaison. While nascent HVIPs may have limited financial resources, the importance of this position cannot be overstated. The Project HEAL community liaison was identified through word-of-mouth from local leaders known to the evaluation team's PI. The liaison was selected for their extensive experience working in Monmouth County, as well as their personal connections among local agencies and stakeholders. These connections increased the liaison's comfortability with presenting the program to community partners and forging collaborations. Importantly, the community liaison was included in meetings among the Project HEAL evaluation team members, which provided them a sense of how community partners may be impacted by (and potentially recruited for) research endeavors. Because the liaison did not have any prior research experience, training in this area (including human subjects training and reviewing the Institutional Review Board [IRB] protocols) was prioritized. These trainings were essential for increasing the liaison's confidence in explaining the research components to community partners as needed. The community liaison's most essential contributions centered on identifying:

- direct service agencies that might serve Project HEAL participants through referral networks;
- stakeholders from whom buy-in was essential; and
- potential research participants for community focus groups.

The participation of the PI in program development using a hands-on approach and including the liaison on both the program and evaluation teams for Project HEAL increased the synergy between these teams and maximized the involvement of the community in each.

The next component to cultivating community partnerships with Project HEAL was gathering information from and sharing information with, community partners. Where there was a need, Project HEAL called on the community to meet that need. For example, a local college program provided training to Project HEAL's frontline staff and information technology experts assisted with the project website and largescale data cleaning and management. While not local, Project HEAL also leaned heavily on the expertise of its training and technical assistance (TTA) provider, the Health Alliance for Violence Intervention (HAVI) and the NJOAG. Under their guidance, and the leadership of the Medical Director and the PI, meetings were set with community providers and stakeholders to share the purpose and goals of Project HEAL, as well as the ways in which they may be involved in, or impacted by, the program. This helped garner buy-in, including from those who may not be directly involved in the program but have local influence.

Another component to cultivating community partnerships with Project HEAL was formalizing its support network. This process helped to solidify what community partners could expect from the program and vice versa. One strategy for doing so included gathering letters of support for IRB and grant applications from agencies willing to serve Project HEAL participants. While not formal agreements, securing these letters fostered conversations between the Project HEAL program, the evaluation team and community service providers about how a partnership might be mutually beneficial. A more formal strategy is to draft memoranda of understanding (MOUs) that outline the mutually agreed-upon expectations between the HVIP and the community partner. Additionally, HVIPs may seek to establish referral networks, that is, the general path that HVIP participants will take when their service needs warrant interventions not directly provided by the HVIP (e.g. substance use, housing, education). In establishing their referral network, the Project HEAL staff and community liaison first vetted agencies for the types and quality of services they

provide. This step was important to ensure the breadth and value of services availed to participants but also addressed an issue that plagues HVIPs – treatment heterogeneity (i.e. a vast array of treatment interventions, dosages and qualities). While this may require a longer-term vision than perhaps emerging HVIPs have the bandwidth for, addressing treatment heterogeneity early has positive implications for a high-quality outcome evaluation. From this standpoint, formalizing support for Project HEAL addressed both programmatic and evaluation needs, which is an essential consideration at every step.

Strengthening practitioner engagement with project HEAL

Practitioner engagement in the Project HEAL initial rollout and early implementation phases has been essential. In the current context, the term "practitioner" refers to the members of the Project HEAL program team (i.e. those who have direct involvement in serving program participants). An essential component to strengthening practitioner engagement with Project HEAL was gathering and sharing information across the evaluation (research) and program (i.e. practitioner) teams. Gathering and sharing information across teams has been the most impactful for building a high-quality program design and fostering synergy. For example, prior to initial rollout Project HEAL hosted a full meeting where each member of the team (e.g. researchers, social workers, medical professionals, administrative staff) was allotted time to present their educational background and work experience, current role in the HVIP, and their hopes for the program. Team members were then able to ask questions of one another, which helped to satisfy concerns or misperceptions between the evaluation and program teams, as well as set expectations. A noteworthy exchange occurred when members of the evaluation team explained and took questions regarding the research base for HVIPs and the specific program tools to be used therein (e.g. screeners, assessments). This helped the practitioners to understand why these tools were important and how they could be optimally incorporated into the program, ultimately increasing buy-in. Meetings of this sort should be regular occurrences for the sake of strong, ongoing collaborations among the different teams involved in the HVIP.

Another component to strengthening practitioner engagement with Project HEAL was to create common goals between the evaluation and program teams. Cross-training was one critical step to achieving this. Evaluation staff were trained in crisis intervention, for example, which was online (and free), and thus a feasible way for them to gain a better understanding for the practitioner experience. To a similar end, certain program staff were trained in research methods and human subjects research. Cross-training breeds empathy between teams with different roles and objectives and fosters a common language.

In service of another common goal, Project HEAL practitioners, in recognition of their rapport-building and clinical skills, were incorporated into the recruitment and consent processes for research and evaluation-related goals. Increasing research enrollment or locating participants who have been lost to follow-up capitalizes on the access and expertise of the program team while helping the evaluation team reach their enrollment goals necessary for a high-quality evaluation (an issue that plagues many past HVIP evaluations). Further, this familiarized the Project HEAL practitioners with the evaluation agenda and related goals.

Other common goals among Project HEAL researchers and practitioners included the mutual drafting and approval of the Project HEAL policy documents and evaluation instruments (e.g. focus group/interview questions, fields in the electronic medical record form). These mutual efforts ensured that research and program concerns could be addressed prior to initial rollout. An additional example includes the research team's efforts to identify a violence risk assessment to be used with Project HEAL participants that was empirically validated (i.e. evidence-based) but also helpful to the practitioners planning the types, intensity and duration of intervention.

The last component to strengthening practitioner engagement with Project HEAL was to incentivize collaboration, which starts at the "top." The leaders of their respective teams (i.e. program and evaluation, respectively), the Project HEAL Medical Director and Principal Investigator have been close collaborators since before the program's inception. Regular meetings and long-term, "big-picture" planning ensure the program's longevity and place within the larger "public health solutions to violence intervention" landscape. A second method to incentivizing collaboration included the prioritization of co-publishing between the program and evaluation staff. While program staff may not be well-versed in research methods or the academic literature on violence intervention, their perspectives are invaluable for asking the "right" research questions and characterizing the results in such a way that is translational to practitioners from myriad fields. Several Project HEAL-related publications are planned that will require and benefit from practitioner input, and they will be offered authorship for their contributions.

Benefits of a multidisciplinary team

Through all the strategies described above Project HEAL has benefited from having a highly multidisciplinary team. From program leadership to frontline workers, Project HEAL members have experience in the fields of medicine, law, education, criminology, psychology, sociology and social work. Figure 2 outlines the organizational chart for the Project HEAL program and evaluation teams.

These members have reflected on how their diverse training and experiences have contributed to Project HEAL's successful implementation:

> "Having clinical training and many years of work in the field has helped me better understand the presenting problems and needs of the clients we will serve in the HVIP-especially the need for our staff/program to view everything within a trauma informed lens." – Clinical Program Manager, on the usefulness of frontline experience in managing an HVIP team.

> "My experience as a nurse helps me to think critically when assessing a patient's overall needs." – Clinical Advocate, on the usefulness of clinical experience during needs assessment with victims of violence.

> "I have been able to use majority of my prior training and education during the HVIP implementation process, specifically my experience in working with those who have experience complex trauma throughout their lifetime. This has enabled me to train and prepare direct care staff to support individuals with varying layers of trauma to ensure they are receiving the quality of care they deserve and need through the HVIP model.'' – Clinical Supervisor, on the importance of clinical training to meet the needs of program participants.

> "I use my experience in nearly everything that I do regarding evaluation. When considering program and research design elements, I am constantly considering how those will impact the people on the front lines carrying out this work, as well as their clients." – Doctoral Fellow, on the usefulness of having frontline experience as a program evaluator.

> "The trainings provided me with a conceptual understanding of the HVIPs, practical considerations that arise in their implementation and resources in the community to engage." –Medical Director, on the importance of interdisciplinary training prior to initial rollout.

Impacts of COVID-19 on project HEAL program development and implementation

As with many direct service programs, the COVID-19 pandemic presented challenges for the implementation of Project HEAL. Hospital resources (both financial and personnel) were

diverted, blanket hiring freezes and personnel reassignments occurred, and the recruitment of community partnerships had to occur virtually. Additional protocols were added to IRB proposals that required the use of temperature checks, masking and social distancing, and even virtual focus groups and interviews. Through these barriers, however, leveraging the strong relationships forged between Project HEAL, hospital leadership and community partners meant that the program could be implemented as intended even under these circumstances.

Discussion and conclusion

The study of HVIPs and other victim support programs is essential for understanding the elements of a successful implementation. The use of case study, ethnographic, observational and other qualitative approaches permit the in-depth exploration of staff, participant and stakeholder experiences (from their perspectives), which can be used to inform implementation at every stage. Further, these methods can highlight the ways in which programs can improve how they coordinate services within the community and engage practitioners – both essential elements of HVIPs.

Through interviews and observations we were able to highlight the importance of transdisciplinary and practitioner engaged approaches to assisting victims of violence specific to Project HEAL and its immediate community context. This is important because communities differ in terms of their needs and resources to address violence and case study and similar approaches permit the identification and characterization of those differences (and their implications) in a way that quantitative approaches cannot. A potential limitation of this approach, however, is that our results may not generalize to all HVIPs or victim support programs. We believe, however, that with increased HVIP funding, as well as the growing number of programs being implemented in suburban areas does suggest that our results will be more and more generalizable.

We highlighted how much of the machinations that can bring such a program to fruition are often lost in the initial chaos of getting a grant project off the ground when there is minimal staff support. This paper could not have been written if the collaboration between the medical director (leading the entire program as well as the program team) and the academic partner (leading the evaluation team) did not pre-date the funding application stage. Further, the early collaboration between the two teams in every aspect of program planning and development allows for an integrated approach in the formation of the HVIP. This allows for the program to be grounded in current best practices and maintain high integrity.

Moving forward, the Project HEAL program and evaluation teams will continue to collaborate to enhance the program's effectiveness and embeddedness within the community. This partnership has positioned Project HEAL for successful process and outcome evaluations, as the evaluators have an intimate understanding of the program and its implementation history, and the program team has a clear understanding of and desire to cooperate with evaluation efforts. This collaboration serves as a useful example to other programs and interventions, supported by calls from VOCA (and echoed by the Biden administration) for programs to establish community partners. In short, the stronger these partnerships, the better their evaluations (and therefore, evidence). Having high-quality evidence of effectiveness has major implications for ongoing funding and the additional allocation of resources.

Notes

1 www.whitehouse.gov/briefing-room/statements-releases/2021/02/17/readout-of-the-white-houses-meeting-with-community-violence-prevention-experts/

2 www.njleg.state.nj.us/2018/Bills/S3500/3301_R1.HTM

3 www.njleg.state.nj.us/2018/Bills/S3500/3312_R1.HTM

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Corresponding author

Sheetal Ranjan can be contacted at: ranjans@wpunj.edu