CVI Research and Evaluation Road Map Scoping Review

Prepared for

The California Wellness Foundation
Charles and Lynn Schusterman Family Philanthropies
The Joyce Foundation

Prepared by

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THE CALIFORNIA Wellness FOUNDATION

CHARLES AND LYNN Schusterman FAMILY PHILANTHROPIES

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List of Acronyms

Acronym	Definition
CVI	community violence intervention
ECLIPSE	Expectation, Client group, Location, Impact, Professionals, Service
HVIP	hospital-based violence intervention program
LGBTQ+	lesbian, gay, bisexual, transgender, queer/questioning, plus (others)
PICO	Population, Intervention, Comparison, Outcome
SPICE	Setting, Perspective, Intervention, Comparison, Evaluation

1. Introduction

Community violence is defined by the U.S. Centers for Disease Control and Prevention as "violent events that occur outside of the home, often in public spaces, and between people who may or may not know each other."[1] In recent years, the rate of community violence has steadily increased and has had a disproportionate impact on racial and ethnic minoritized communities. Black males ages 15–34 make up 2% of the population in the United States but account for 37% of all gun homicide victims.[2] The impact of community violence extends beyond injury, as repeated exposure is associated with negative outcomes such as emotional and psychological stress, post-traumatic stress disorder,[3] and future violence victimization.[4] These pervasive effects of violence on community well-being make it critical to regard community violence as a public health issue and treat it as such with evidence-based strategies. Community violence intervention (CVI) is a public health approach to reducing near-term community violence, especially firearm violence, and is conducted in partnership with community organizations.

The public health approach recognizes social and structural determinants that contribute to the violence epidemic and provides multidisciplinary support systems to change them. The approach considers that racial and ethnic minoritized communities are most affected by these determinants and thus are most susceptible to community violence. Therefore, instead of using a single strategy, CVI focuses on the contributors to and predictors of gun violence with a combination of group and individual services. Some of these strategies include violence interruption, case management, trauma support, coaching and mentorship, and clinical therapeutic services. Intervention activities are conducted by community organizations and hospital-based violence intervention programs (HVIPs).[5]

Acknowledgment of CVI as an effective violence reduction strategy has increased in recent years, leading to greater investment in its implementation. Notably, the Biden administration increased funding and investment in CVI through the Bipartisan Safer Communities Act; American Rescue Plan; The White House Office of Gun Violence Prevention; and The Community Violence Intervention Collaborative, which convened CVI leaders and experts across the United States for joint learning in CVI. State, local, and philanthropic funders have also made similar investments by expanding and evaluating CVI programs nationwide. Nonetheless, CVI remains underfunded, and the research on evidence-based CVI programs is limited compared to research into other leading causes of mortality in the United States. As high rates of community violence remain a challenge nationwide, consistent and innovative evaluation is required to make the case for the effectiveness of more CVI programs and their core components.

The future of CVI requires first understanding the current CVI research and evaluation landscape through a scoping review. This scoping review seeks to take an initial step by mapping CVI-related research, evaluation, and other documentation. The goal is to identify topics that have been explored; common approaches to CVI evaluation to date; opportunities to develop a richer understanding of CVI; and implications for future research, practice, and policy.

The following research questions were investigated:

- What aspects of CVIs have been explored so far?
- What types of CVI models and strategies have been evaluated?
- What methodologies are commonly used to evaluate CVIs?
- What outcomes are commonly measured to evaluate CVIs?
- What is the evidence for CVI effectiveness?
- What research is still needed to understand the contribution of CVIs to reducing community violence?

2. Methods

Our scoping review of CVI literature, which was based on Arksey and O'Malley's[6] systematic process for synthesizing and mapping research evidence across diverse study designs, consisted of two components: (1) a peer-reviewed literature search and (2) a gray literature search. To ensure consistency and comprehensive coverage, we adapted the Population, Intervention, Comparison, Outcome (PICO) model to inform our search strategy, inclusion criteria, data extraction, and analysis. The modified PICO system incorporated elements from the Setting, Perspective, Intervention, Comparison, Evaluation (SPICE) framework and the Expectation, Client group, Location, Impact, Professionals, and Service (ECLIPSE) framework.[7] This combined approach allowed us to contextualize each study's setting, stakeholders, and practical impact, ensuring that we captured the breadth and complexity of CVI research while remaining grounded in established scoping review practices. This approach was further enriched by insights from the Community Violence Intervention (CVI) Action Plan,[5] which emphasizes the need for culturally responsive, grassroots-driven strategies to address community violence effectively. These combined frameworks provided a robust foundation, ensuring that we captured both academically rigorous studies and critical community-informed perspectives.

2.1 Working definition of CVI

A critical first step of this work was to define CVI for this scoping review, especially to understand which research and evaluation documents should be included and excluded. The field has yet to agree on one definition of CVI. Here, we use the definition developed by a group of over 300 leaders and practitioners in the CVI Action Plan.[5]

> Community violence intervention is an approach that uses evidence-informed strategies to reduce near-term violence through tailored community-centered initiatives. These multidisciplinary strategies engage very high-risk individuals and groups to disrupt cycles of violence and retaliation. CVI workers establish relationships between individuals and community assets to deliver services that save lives, address trauma, and provide opportunity (p. 48).

With this definition as a guide, we searched for publications about interventions that

prioritize individuals at highest risk of community violence perpetration or victimization,

are led by and take place in the community, and

include multiple strategies or components toward violence reduction and other goals.

As such, broader violence prevention initiatives such as positive youth development programs and firearm policies were excluded. School-based and law enforcement–led initiatives not driven by the community were also excluded. Programs involving law enforcement were included as long as law enforcement agencies were collaborators and not the primary drivers of the intervention. Interventions that consisted of only brief interactions, for example one-time discussions with victims at hospital intake with no follow-up, were not included. Full inclusion and exclusion criteria are described in the next section. We describe definitions of community violence and CVI used by the field in **Section 3.1.1**.

2.2 Organizing framework and search strategy

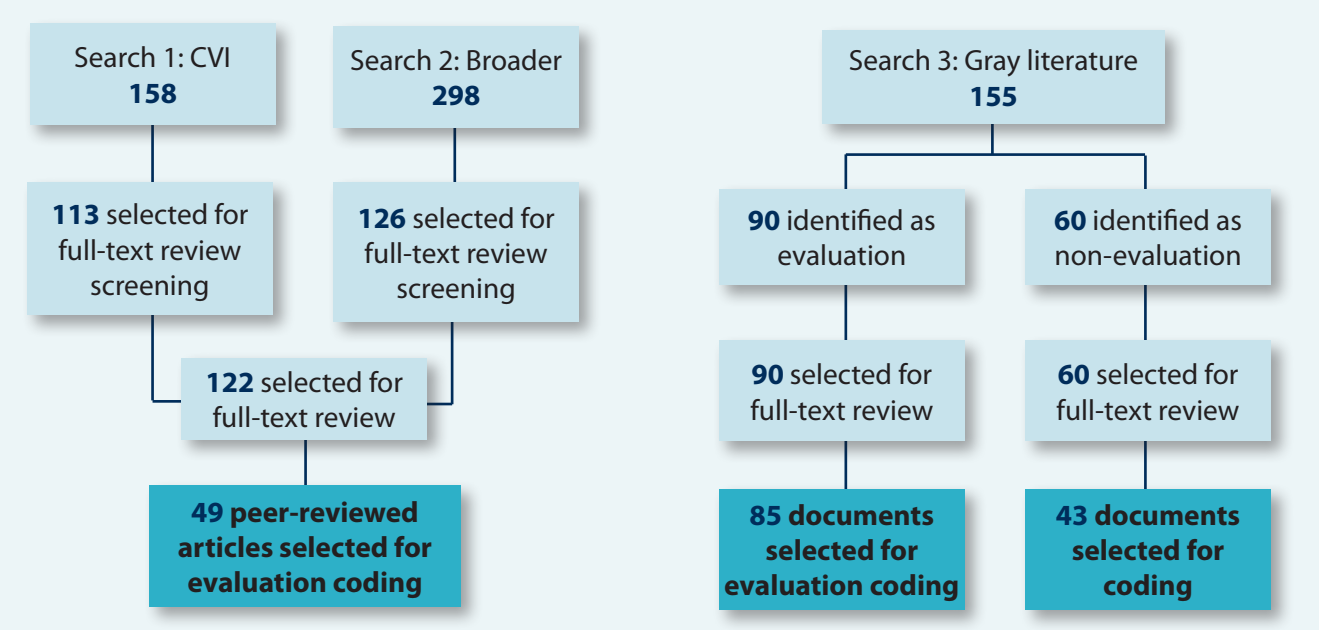
For the search strategy, we developed terms and categories that were informed by our understanding of the field and our community violence expertise, as well as PICO elements. The adapted framework for data extraction incorporated elements from PICO and complementary aspects from ECLIPSE and SPICE to ensure a comprehensive and nuanced approach.

Population or Problem	This component focused on the primary populations on whom CVI efforts focused, such as adolescents, high-risk communities, and marginalized groups. Drawing from PICO and SPICE, this element captured demographic characteristics and the underlying community violence issues that each study tried to address.
Intervention or Exposure	Using elements from PICO and SPICE, this dimension detailed the specific CVI model (e.g., Cure Violence, HVIPs) and intervention strategies (e.g., conflict mediation, street outreach, case management) under investigation. We documented the approaches that were measured in each study.
Control	Drawing from SPICE, we documented whether studies used control or comparison groups. Although not all studies included control groups, we recorded any alternative interventions, comparison groups, or baseline measurements that offered points of contrast.
Outcome	Following both PICO and SPICE, we documented outcomes measured in each study, such as reductions in violence, improvements in mental health, or increased community cohesion, as well as process outcomes. This element highlighted the metrics of success for each CVI, including both quantitative outcomes (e.g., decreased crime rates) and qualitative impacts (e.g., enhanced sense of safety).
Context or Environment	Adapted from SPICE's Setting element and the Location element from ECLIPSE, this category captured the specific environments or contexts in which CVI programs operated. We documented the unit of analysis for each study, such as neighborhoods, police precincts, or cities. By documenting these settings, we were able to explore how CVI evaluations measured community changes.
Research Design	We documented the study designs and methodologies used to evaluate CVI programs, including quantitative, qualitative, and mixed-methods approaches. This element helped assess the methodological rigor of each study and the suitability of different methods for capturing complex social interventions.
Results	This dimension captured the findings of each study, focusing on the reported outcomes and impacts. This element allowed us to synthesize trends in CVI effectiveness across different study designs and populations.

We conducted searches across prominent academic databases, including PubMed, PsycINFO, Web of Science, and Google Scholar. The Population element of PICO, for example, covered groups who are often the subjects of CVI programs, such as "adolescents," "youth," "high-risk communities," "communities of color," "urban communities," and "LGBTQ+."[6] The Intervention component focused on terms reflective of different CVI models, including "community violence intervention," "violence interrupters," "trauma-informed programs," and "hospital-based violence intervention."[8] For studies that used control or comparison groups, Comparison terms such as "control group," "non-intervention comparison," and "alternative intervention" were included to capture studies with comparative designs, though these were not a requirement for inclusion. Finally, Outcome terms were selected to focus on measurable impacts of interventions, such as "violence reduction," "mental health," "community resilience," "social cohesion," and "trauma reduction."[9, 10]

We supplemented these database searches with requests to library services for literature on specific CVI models like Cure Violence, Advance Peace, and Ceasefire. The iterative nature of our search allowed us to refine search terms continuously on the basis of emerging patterns and insights from both academic and community-driven sources. **Figure 1** summarizes the search, screening, and sample selection process. If inclusion status was uncertain, the reviewers discussed the study's eligibility and reached consensus. The initial search resulted in a dataset of 158 peer-reviewed articles, of which 113 met the inclusion criteria on the basis of title and abstract alone. After a second search round, an additional 298 peer-reviewed articles were screened, with 126 selected for full-text review on the basis of title and abstract. After a full-text review, 49 peer-reviewed articles were selected for final inclusion in the evaluation coding.

Figure 1. Study Sample Selection Flow Chart



For the gray literature search, we used the CVI Action Plan,[5] created in partnership with active CVI organizations nationwide, to develop base terms for the search. Using Google, we individually and systematically searched each organization listed in the CVI Action Plan. Additionally, the terms "report," "evaluation," and "evaluation report" were searched in combination with the organizations' names to capture the evaluation-based reports they published online.

The search of the base terms yielded the main websites of each organization, which were examined for relevant documentation. Thereafter, the results of the search were reviewed until they yielded results that were not relevant to the base search term, CVI, or violence prevention broadly. The link path for each search was recorded to ensure that the search process was replicable and to avoid duplication of organizations that yielded similar results.

The gray literature search resulted in 155 documents identified for screening. The documents were then categorized into two groups for full analysis. Ninety of these documents were identified as evaluation literature, and 60 were identified as non-evaluation literature. Eighty-five evaluation documents and 43 non-evaluation documents were selected for inclusion.

Full lists of documents selected for inclusion are provided in the appendices.

2.3 Screening and eligibility assessment

Screening and eligibility assessment for research and evaluation were carefully structured. As shown in **Table 1**, inclusion and exclusion criteria were developed to ensure relevance to the U.S.-based CVI field, focusing on research and evaluations that addressed CVI efforts involving youth and adult populations and that reported on original research findings or comprehensive summaries, such as research briefs or policy reports.[6] Documents were excluded if they were very brief with limited description (e.g., conference abstracts), opinion based (e.g., commentaries), focused on interventions in non-U.S. settings, or not centered on community violence (e.g., domestic, sexual, or school-based violence).[11]

Table 1. CVI Research and Evaluation Inclusion and Exclusion Criteria

Concept	Inclusion Criteria	Exclusion Criteria
Populations	Adults, youth, adolescents, children; neighborhoods, communities, cities, counties	Organizations, government representatives
Comparisons	No comparison or control group required	N/A
Timing	Publications from 2010 through 2023	Before 2010*
Publication Type	Original research and evaluation	Evaluation protocols; implementation tools, toolkits, or handbooks; commentaries, editorials, or position statements; conference abstracts; presentations; dissertations/theses; program descriptions
Language	English	Non-English language
Location	United States	International studies
Program/Policy	Multilevel, disciplinary, and policy area strategies	Single-program strategies
Outcomes	▪ Community violence, gun or firearm violence, homicide, assault, aggression ▪ Perceptions, beliefs, or internalized norms pertaining to community violence ▪ Health and mental health ▪ Outcomes related to quality of life (including housing, employment, return to work, social support, healthy relationships, substance misuse, etc.) ▪ Reducing effects of CVI exposure (e.g., anxiety) for individuals exposed to or victims of community violence	▪ Domestic violence (including domestic violence, domestic abuse, spousal abuse, family violence, etc.) ▪ Child abuse, maltreatment, and neglect (including child abuse, child grooming, child sexual abuse, pedophilia, etc.) ▪ Gender-based violence ▪ Sexual/intimate partner violence (including sex trafficking, sexual assault, sexual harassment, rape, sexual violence, nonconsensual sex, sexual abuse, sexual coercion, revenge porn, teen dating violence, dating abuse, dating aggression, intimate partner violence, intimate partner abuse, etc.) ▪ School-based violence (e.g., school shooting, threat assessment) ▪ Risk and resilience factors of violence perpetration or victimization

* We included one highly cited paper published in 2009.

Documents from the gray literature search that were not evaluation focused were screened separately. Publication type was not a criterion for exclusion because of the variety of documentation in the category. Documents were excluded if they were not related to or did not address CVI. Documents were also excluded if they were not written in English, were internationally based, were about single-program strategies, or had some combination of these criteria.

2.4 Study coding

A structured and systematic approach[6, 12, 13] was employed for the scoping review extraction and coding, involving two independent reviewers. Full-text articles identified for inclusion were organized into a shared folder for review. Each reviewer independently assessed the articles and extracted relevant data into a standardized template. To further ensure consistency and accuracy, the primary reviewer examined a sample of the reviews completed by the secondary reviewers. Gray literature evaluation documents shared a format similar to that of peer-reviewed literature but were not published by peer-reviewed journals. Consequently, the same analytical approach was applied to these documents as to peer-reviewed literature. The extracted data included details on the population or problem being studied; the intervention or exposure; specific operational methods or activities of the intervention; the use of comparison groups; primary and secondary outcomes; context of the study (i.e., location); the professionals involved in executing the intervention; the study research methods (qualitative, quantitative, mixed methods, or systematic review); details regarding the study methodology and analyses; study results; stakeholder perspectives or potential users of the study findings; the time frame or duration of the study; the program name; assessment of outcomes; any additional notes, comments, or quotations; and determination of whether any specific validated instruments were used for data collection.

For studies incorporating process or implementation evaluations, detailed information was extracted on the specific program activities assessed within the study. These activities included strategies such as mediation, street outreach, mentorship, community mobilization, education, job training, case management, connection to resources, and public education campaigns. Extracted process evaluation findings summarized key implementation results, detailing how effectively the intervention activities were carried out. For studies that included an outcome evaluation, similar procedures were followed to extract details on the specific program activities assessed. Outcome measures were systematically recorded, specifying the particular outcomes evaluated—such as recidivism or employment—and the metrics used to assess them, including arrest and homicide rates. The extracted outcome findings included statistical results where available, summarizing key findings related to program impact and effectiveness.

This approach ensured that extracted information was comprehensive, methodologically rigorous, and structured in a way that facilitated comparisons across studies. The detailed extraction process supported the identification of common themes, strengths, and limitations in the peer-reviewed and gray literature, ultimately contributing to a more thorough understanding of CVIs and their evaluation outcomes.

Non-evaluation gray literature was categorized into five document types: (1) organizational and progress reports; (2) research and analyses; (3) evaluations and impact assessments; (4) policies and strategies; and (5) frameworks, guidelines, and toolkits. These documents were not coded systematically because of the wide variation in content. Instead, they were briefly summarized and then synthesized by category to identify common themes.

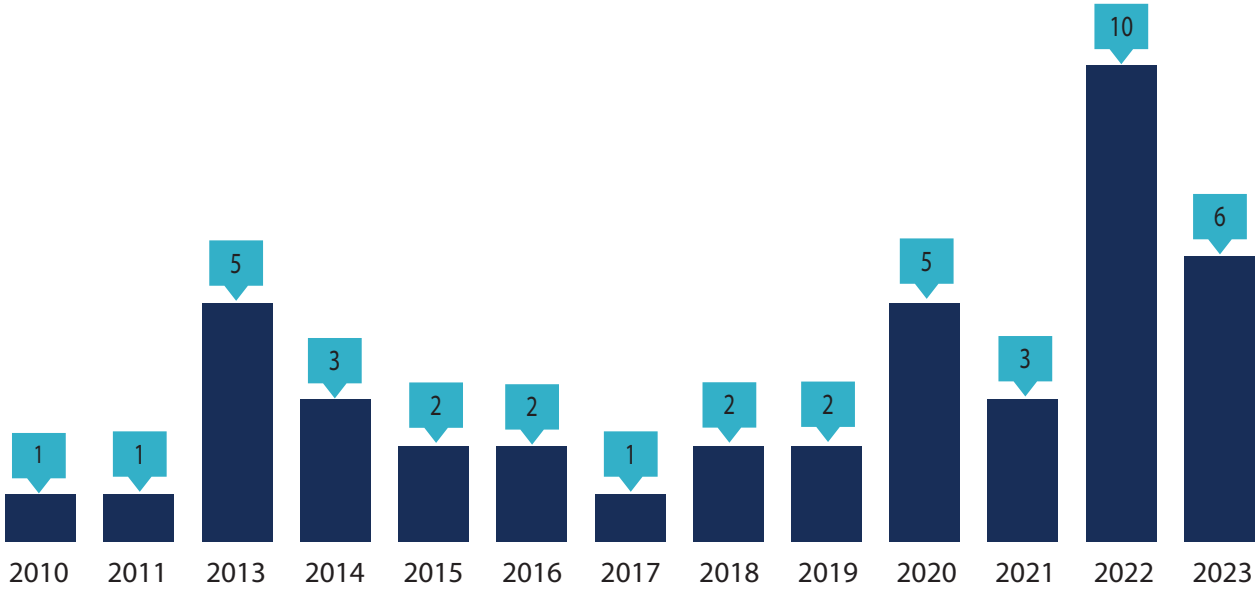
2.5 Analysis and study quality assessment

Two staff members coded articles in each of the PICO categories. They developed inductive codes as themes and details emerged from the data that were not captured by adapted PICO categories. A random sample of articles was coded by both staff members and aligned for consistency. Codes were synthesized across all articles and used as the basis for the report.

3. Results

A total of 49 peer-reviewed and 85 gray literature research and evaluation articles were coded following an adapted PICO framework (see **Appendices A and B**). The number of peer-reviewed CVI research articles has generally increased since 2009 (**Figure 2**). Counts rose from 2010 to 2013, then gradually declined through 2017. After a few stable years, counts again rose, reaching a peak in 2022.[a] The following section reports findings for each research question.

Figure 2. Count of Peer-Reviewed Articles by Year



Note: As described in text, a few studies published online in 2023 but in print in 2024 are included in the review but are not counted here.

3.1 What aspects of CVI have been explored so far?

We first explored how peer-reviewed literature defined community violence and CVI to get a sense of the existing consensus (or lack thereof) on the problem being addressed and which solutions are considered "CVI" among investigators. We then categorized the topics explored in the literature.

3.1.1 Defining community violence and CVI

A few articles defined community violence as interpersonal violence between individuals or small groups that may or may not know each other, similar to the definition provided by the U.S. Centers for Disease Control and Prevention.[14] However, most articles did not define community violence specifically but instead referred broadly to high rates of firearm violence and homicides geographically concentrated in low-income and minoritized communities. Others referred to urban or youth violence. Regardless of the definition, many articles noted that violence disproportionately affects people of color, men and boys in disadvantaged areas, or both.

Few articles defined CVI. Those that did offered a variety of descriptions, including interventions that address firearm and interpersonal violence, those that occur at both individual and the community level, and those that focus on individuals most at risk for involvement in gun violence. None included all those aspects in one definition. Other studies described specific intervention components such as interventions that use street outreach workers, mediate conflicts, or provide mentorship or case management services. Most studies described the specific intervention being evaluated rather than defining CVI more broadly.

[a] Note: A few studies published online in 2023 but in print in 2024 are included in the review but not shown here because an updated full search was not conducted at the end of 2024.

3.1.2 Topics covered

Research and evaluation covered a variety of topics, including intervention effectiveness, program implementation, workforce experiences, and others, such as CVI frameworks and program prevalence. Gray literature evaluations were more likely to cover more than one topic area.

Effectiveness. More than half of peer-reviewed research (n = 29; 59%) and almost all evaluation gray literature (n = 81; 94%) evaluated intervention effectiveness. Most studies were concerned with intervention impact on violence reduction. Five peer-reviewed studies (10%) focused on the change in perspectives about violence and conflict resolution, relationships, and program effectiveness, whereas 26 gray literature evaluations (30%) measured changes in similar topics as well as change in perceptions of community safety and trust in law enforcement. More details about effectiveness studies are included in **Section 3.5**.

Implementation. Six peer-reviewed studies (12%) investigated program implementation. All but one focused on barriers to and facilitators of implementation. Framing gun violence as a public health issue, establishing community–hospital–university networks, clearly communicating effectiveness and community benefits, and establishing a patient recruitment and enrollment pathway were found to facilitate CVI implementation.[15] Staffing shortages and lack of funding were cited as barriers to implementation.[16] Being located in rural areas exacerbated barriers,[17] as did implementation during the height of the COVID-19 pandemic,[18] when the inability to interact face-to-face and the changes in hospital processes reduced ability to deliver services.[19] Despite challenges, outreach workers reported resolving conflicts in which they intervened most of the time.[20]

Almost all gray literature evaluations (98%) evaluated implementation and process outcomes. Most documents reported counts and described program activities in detail, and some assessed sustained participant engagement. However, they were less likely to investigate specific barriers and facilitators.

Workforce experiences. Five peer-reviewed studies focused on workforce experiences. CVI staff often use personal experiences and knowledge to support their clients.[21] Staff who have experienced similar circumstances and violence conceptualize their work to help others as a "mission." When clients see how staff have changed their own lives, they see the possibility of doing the same.[21] However, these deep staff–client relationships are not without challenges. CVI staff are reminded of, or even confronted with, their own past; they lose clients or close relationships to violence despite their best efforts, which takes a toll on their mental health. One study showed that the outreach workers displayed 9 out of 17 symptoms of secondary traumatic stress.[22] No gray literature evaluations included workforce experiences.

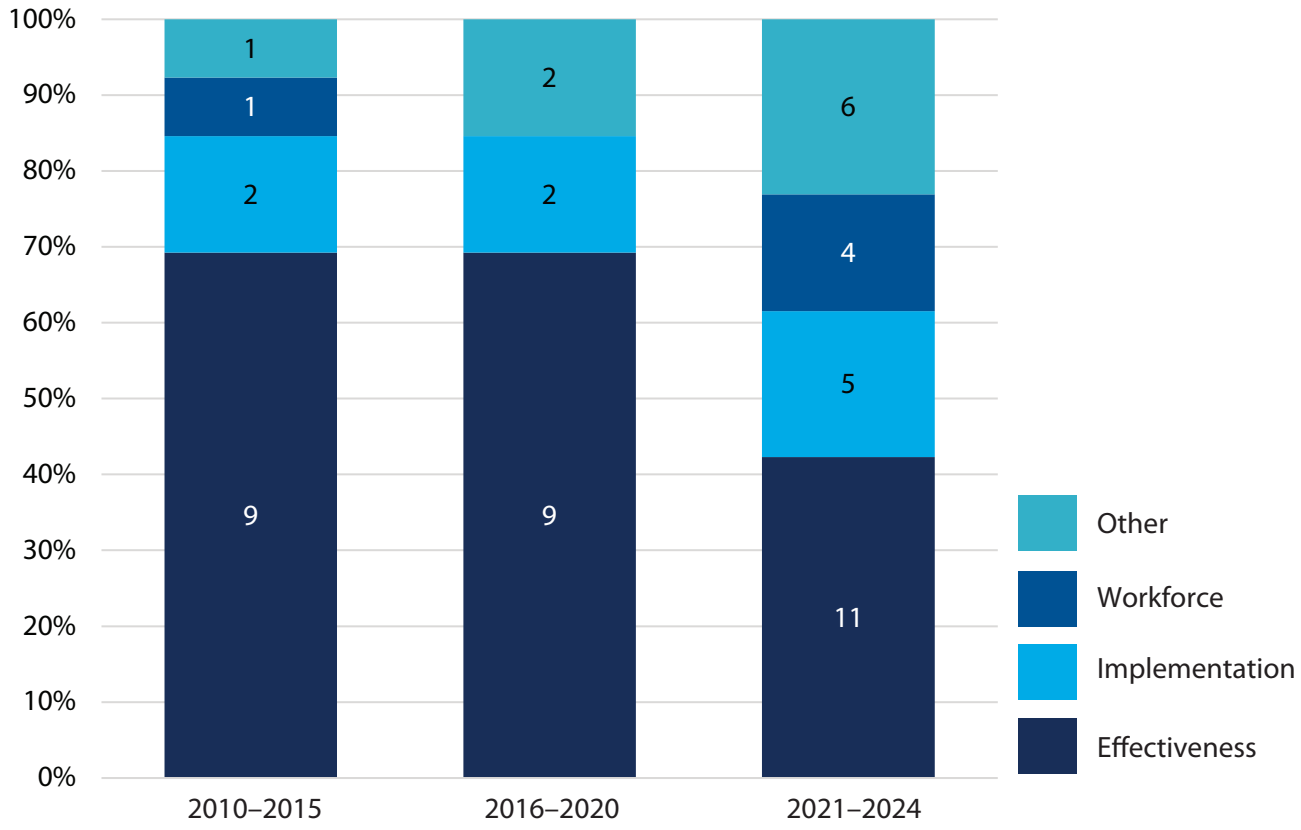
Other topics. Two studies described CVI programs detailing multiple components and strategies[23, 24] but provided no implementation analysis. One study explored the effect of CVI on relationships, finding that participants reported feeling more integrated into their communities and less isolated.[25] Another study found that participants who gained immediate access to psychological services improved trauma outcomes but found inconsistent long-term healing outcomes.[24] Two studies investigated frameworks for CVI to identify different approaches to community violence prevention[26] and the conditions necessary to achieve fidelity to a specific CVI model.[27] One study conducted a budget analysis of city spending on CVI using coronavirus-related state and local fiscal recovery funds.[28] One study identified the underlying assumptions that influence the CVI narrative. One study tested the psychometric properties of an assessment to measure provider activation to prevent violence.[29]

3.1.3 Topics over time

The focus of peer-reviewed CVI research has shifted and become more varied over time. **Figure 3** shows the count and percentage of articles in each category over time. Research focused on CVI effectiveness has dominated the field through all time periods; however, most recently, CVI research has covered a wider variety of topics. Research focused on the CVI workforce has increased. The number of articles nearly doubled in the last period.[b]

[b] Total adds to more than 49 because 3 peer-reviewed articles covered both effectiveness and implementation topics.

Figure 3. Peer-Reviewed Topics Over Time



3.2 What types of CVI models and strategies have been evaluated?

Most peer-reviewed articles focused on a specific CVI model. The most common model was Cure Violence or Ceasefire[c] (n = 23; 47%), followed by the HVIP model (n = 8; 16%). Two studies focused on the Advance Peace model. Almost one-quarter focused on other interventions (n = 18). Two investigated environmental interventions such as greening lots. Five publications (10%) referred to CVI in general. Six articles (14%) evaluated other locally developed models.

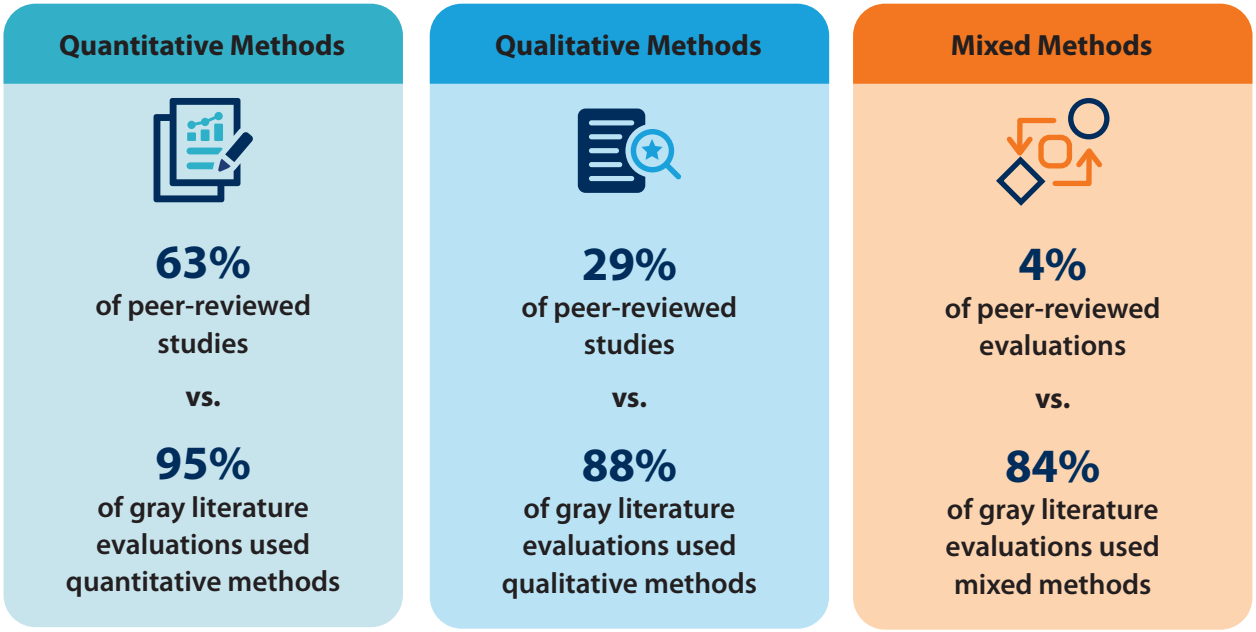
The most common model was Cure Violence or Ceasefire (n = 23; 47%), followed by the HVIP model (n = 8; 16%). Two studies focused on the Advance Peace model.

Most studies described multiple intervention components or strategies toward reducing gun violence in the introduction and background sections. However, less than one-quarter of articles measured any activities (n = 10). The most commonly referenced CVI component was the use of street outreach workers, violence interrupters, conflict mediators, or a combination of these (n = 7), followed by community mobilization, efficacy, workshops, and events (n = 4). Three articles measured connecting with services via case management, social work, or referrals (n = 3). Two measured mentorship; one measured education, life skills, or job training. Even when activities were measured, they were not incorporated into effectiveness analyses as mediators or moderators but instead were reported on descriptively before the outcome analyses were reported.

[c] See **Section 6.2** for a discussion of challenges in identifying Cure Violence and Ceasefire programs.

3.3 What methodologies are commonly used to evaluate CVI ?

Most peer-reviewed studies used quantitative research methods (n = 31; 63%), including 13 quasi-experimental studies and one study that used random assignment. Of these, 20 used comparison groups to estimate intervention effects by comparing participants receiving services with a similar group that did not. The most common comparison groups were matched controls (n = 6), followed by within-group comparisons using pre- and post-implementation analyses (n = 3). Two quantitative studies used synthetic controls, which use administrative data to create a comparison group that mimics a matched control. Both studies are relatively recent, from 2021 and 2022, reflecting advances in methodology. Studies used a variety of analytic approaches, including interrupted time series, difference in differences, growth curve modeling, regression point displacement, and multilevel regressions. Twenty studies ran descriptive or exploratory analysis reporting frequencies, percentages, and sometimes t-test and chi-square test results. One study used geospatial descriptive analysis to describe intervention reach.



Of the 85 gray literature evaluations, the majority included quantitative data (n = 81; 95%), and 43 (51%) used a quasi-experimental design. Among studies with a quantitative component, matched controls or comparison groups were used in 13 evaluations. Within-subject pre- and post-implementation comparisons appeared in 8 evaluations, measuring changes in key indicators—such as attitudes toward violence, employment stability, or recidivism rates—before and after program participation. Only one employed a randomized controlled trial. Interrupted time-series analyses, used in 3 evaluations, assessed the impact of interventions on long-term trends, such as changes in violent crime rates before and after program implementation.

A little more than one-quarter of the peer-reviewed studies used qualitative methods (n = 14; 29%). Of those, almost all conducted interviews or focus groups (n = 11). Six used observations or reviewed program and implementation documentation. Many studies stressed the importance of including the community in intervention and study design as well as in data collection. Four articles were case studies.

Of the 85 gray literature evaluations, 76 (88%) used qualitative data. Surveys were collected in 75 (87%) studies, and 67 (78%) used interviews or focus groups. Case studies were used in 18 studies (20%). Community-based participatory research was used in studies using mixed-methods designs (n = 16) and qualitative-only designs (n = 3).

Approximately 84% (n = 72) of gray literature evaluations used a mixed-methods design, whereas only two peer-reviewed studies did so.

Two peer-reviewed studies were systematic reviews. These studies concluded that CVIs were generally effective in reducing violence; however, they found that some strategies—for example, public health and community mobilization approaches[30]—were more effective than others or that programs had positive effects on some violent outcomes and not others.[8, 31]

3.4 What outcomes are commonly measured to evaluate CVI?

Table 2 summarizes evaluation designs and outcome measures used to describe findings. Most peer-reviewed research assessed violent outcomes such as homicide rates, reinjury, and shootings (n = 27). Gray literature evaluations measured similar violent outcomes. However, they also commonly examined other outcomes, such as community engagement improvements, behavioral changes in high-risk youth, employment and education attainment, mental health, and well-being.

Table 2. Evaluation Designs and Outcome Measures

Quantitative Methods

Outcome Categories	Outcomes
Violence reduction	▪ Community violence rates (e.g., Safe Streets intervention) ▪ Gang-related violence, assaults, robberies (e.g., Operation PeaceWorks)
Reinjury/recidivism	▪ Rates of repeat violent injury and arrests for violent crimes (e.g., HVIPs) ▪ Time to rearrest for various crimes (e.g., Ceasefire evaluations)
Behavioral and mental health	▪ Coping skills, aggression, and delinquency (e.g., youth coping interventions) ▪ Anxiety symptomatology and trauma recovery
Community and social indicators	▪ Social cohesion, community engagement, informal social control ▪ Academic outcomes like GPA and truancy (e.g., SAFER Latinos project)

Qualitative Methods

Outcome Categories	Outcomes
Community perceptions	▪ Trust in police, collective efficacy, and safety perceptions ▪ Engagement with violence prevention programs (e.g., Safe Streets)
Workforce experiences	▪ Emotional, behavioral, and social impacts of job-related trauma on outreach workers ▪ Factors of resilience and coping among intervention staff
Implementation barriers	▪ Funding shortages, institutional support, and challenges with service delivery during the COVID-19 pandemic ▪ Barriers to data sharing and program scalability
Youth and participant narratives	▪ Experiences with mentoring relationships and program activities ▪ Changes in attitudes toward conflict resolution and violence

Mixed Methods

Outcome Categories	Outcomes
Program effectiveness	▪ Violence reduction and youth engagement in community change (e.g., Youth Empowerment Solutions) ▪ Improved leadership and conflict management skills
Community-level impacts	▪ Cleaner streets, improved neighborhood relationships, and increased parental involvement
Implementation processes	▪ Facilitators and barriers to program delivery and adoption ▪ Success metrics defined through community-based participatory methods
Social and behavioral outcomes	▪ Changes in attitudes toward guns and violence ▪ Mental health improvements, including reduced anxiety and PTSD

Systematic Reviews

Outcome Categories	Outcomes
Intervention effectiveness	▪ Comparisons of public health and community mobilization strategies ▪ Reductions in gun violence, youth violence, and violent injuries
Mental health outcomes	▪ Reductions in PTSD, depression, and anxiety for youth exposed to violence
Implementation fidelity and models	▪ Evaluation of frameworks like Cure Violence and HVIPs ▪ Conditions necessary for achieving program fidelity
Outcome measure gaps	▪ Identification of inconsistent reporting and lack of standardized metrics

Note. GPA = grade point average; HVIPs = hospital-based violence intervention programs; PTSD = post-traumatic stress disorder; SAFER = Seguridad, Apoyo, Familia, Educacion, y Recursos.

Nine peer-reviewed studies focused on implementation outcomes, such as identifying barriers to and facilitators of program implementation. Facilitators of implementation included establishing multidisciplinary networks and building relationships between outreach workers and participants. Demonstrating program effectiveness was critical in engaging communities.[15] However, data sharing necessary for understanding program effectiveness required coordination across researchers, intervention programs, and other organizations (e.g., hospitals). Meeting important but labor-intensive data security standards required time and effort from multiple staff across organizations and was difficult for smaller or resource-constrained organizations.

Other implementation studies examined the extent to which the program was able to deliver services. For example, five studies reported on changes in perceptions of violence and safety and social cohesion. Studies found that CVIs improved neighborhood relationships, decreased positive attitudes toward violent retaliatory actions, and increased positive attitudes toward intervening before a situation becomes dangerous.[32, 33] One study showed that CVI reduced feelings of isolation and increased positive attitudes toward intervening in conflicts.[34]

Although many peer-reviewed articles described general intervention activities in the study narrative, only six (12%) measured program activities. In contrast, almost all gray literature evaluations (99%) tracked program activities, services, and policies through measures such as the number of high-risk individuals engaged, referrals made, attendance at community events, mentorship or case management sessions provided, and conflict mediation efforts conducted.

Two peer-reviewed implementation studies described the processes used to engage multilevel organizational collaborations. One study assessed the implementation of a citywide surveillance system including academic, municipal, and grassroots community organizations, finding that improved data infrastructure for violence prevention planning increased adoption of evidence-based practices. Another study described how one suburb used a community participatory model to select specific CVI strategies tailored to the large immigrant population in the area. Researchers found that even carefully community-selected CVI strategies faced challenges in building relationships between partner organizations, addressing multiple root causes of violence, and engaging enough participants to generate community-level effects.

The unit of analysis for outcome measures varied widely across both peer-reviewed articles and gray literature, with many studies using more than one unit across different analyses (**Table 3**). In both types of evaluations, most outcomes were analyzed at an aggregate level. However, specific geographical boundaries of analyses varied. Gray literature evaluations reported outcomes at the neighborhood level in 30 documents (35%), in contrast to three peer-reviewed articles (10%). Five peer-reviewed articles used the police precinct level as the unit of measure, and two studies used citywide outcomes. Most studies occurred in single cities. Chicago was the most frequently studied city, followed by Baltimore, Philadelphia, and Boston.

Populations of interest also varied. Most studies assessed outcomes among people at high risk of experiencing community violence. Three studies focused on individuals who were exposed to or were victims of community violence, and five studies focused on perpetrators of community violence. Eleven studies focused on CVI staff. Five studies evaluated outcomes for program participants only.

Table 3. Units of Analysis for Outcome Measures

Unit of Analysis	Peer-Reviewed Count	Gray Literature Count
Aggregate	**20**	**67**
Program activity	1	0
Gangs	1	0
Other (e.g., street segment, housing cluster, ward)	3	6
Neighborhood	3	30
Law enforcement area (e.g., police precinct, crime analysis unit)	5	12
Implementation zone	1	1
Census block group	2	1
Census tract	0	3
City	2	10
Zip code	1	4
County	1	0
Individual	**17**	**49**

Gray literature evaluations were more likely than peer-reviewed articles to measure outcomes at the neighborhood level.

Many studies discussed the fact that gun violence disproportionately affects communities of color, and many interventions were described as prioritizing either Black or Latine individuals or young men of color for program engagement. However, only two peer-reviewed studies formally investigated program effects on a specific population by restricting their research participation requirements on the basis of race, and three on the basis of age (e.g., 10–25). Both studies that restricted participation on the basis of race included only individuals who self-identified as Black.[18, 35] No studies in this sample focused on any specific gender or other demographic characteristics (e.g., LGBTQ+, immigration status).

3.5 What is the evidence for CVI effectiveness?

Peer-reviewed studies revealed significant reductions in violence and related outcomes. For example, Phalen et al. demonstrated a statistically significant reduction in gun violence during Baltimore Ceasefire intervention weekends,[36] and Corburn et al. reported an 18% citywide decline in gun violence after the implementation of the Advance Peace program.[37] Similarly, Braga et al. found that Boston's Operation Ceasefire reduced gang-related shootings by 25% in treated areas ($p < 0.05$).[38] Studies focused on reinjury and recidivism showed notable successes; Aboutanos et al. observed no reinjury or mortality in patients receiving brief violence intervention combined with case management,[39] and Thomas et al. reported that treatment participants were 1.94 times less likely than members of the control group to return to trauma centers with violent injuries.[35] Bridgewater et al. observed a 30% reduction in youth gun violence and a 15% decrease in trauma exposure 6 years post-intervention ($p < 0.05$).[40] Studies of Chicago CRED found a 73% reduction in participants' likelihood of being arrested for a violent crime relative to comparisons but no statistically significant change in likelihood of gunshot victimization.[41, 42]

Gray literature evaluations also show positive effects. Studies on HVIPs highlight significant reductions in recidivism and improvements in patient outcomes. The Capital Region Violence Intervention Program at the University of Maryland Prince George's Hospital Center reported notable reductions in trauma recidivism, with very few participants returning for repeat violent injuries after their initial enrollment.[43] In the University of California, Davis Medical Center's Wraparound HVIP,[44] no program completers were readmitted for violent injuries within 1 year of their initial hospitalization. Interviews underscored how clients valued the program for fostering personal growth, emotional healing, and stronger family relationships. Some clients highlighted the program's broader impact on their ability to navigate health care and social services, with one participant describing Wraparound as a "lifeline" that helped him access critical resources. These results suggest that HVIPs can disrupt cycles of violence and reduce the likelihood of future violent incidents.

Interventions using the Cure Violence model also showed positive results. The Cure Violence initiative in the South Bronx and East New York reported a 37%–50% decrease in gun injuries and up to a 63% reduction in shooting victimizations.[45] Another evaluation of a New York–based Cure Violence intervention found that the program reduced shootings by 28% and decreased homicide rates by engaging high-risk individuals through street outreach and mediation efforts. The evaluation of Safe Streets Baltimore employed a synthetic control methodology, revealing a statistically significant decline in gun violence in treatment areas compared to control regions. Similarly, the Save Our Streets initiative in Brooklyn's Crown Heights,[45, 46] which combined outreach and public education, resulted in gun violence being 20% lower than expected when compared with trends in similar neighborhoods.

Other CVI models retrieved from the gray literature review also report reduction in violence outcomes. For example, the READI Chicago program,[47] which combined cognitive behavioral therapy with employment support, found that participants experienced 50% fewer shooting victimizations, with a benefit–cost ratio from 4:1 to 18:1, indicating substantial social savings. Similar programs showed significant success in reducing arrests and victimizations, suggesting that economic stability for individuals plays a crucial role in violence prevention. The Aim4Peace program,[48] which combines mentorship, community outreach, and violence mediation, showed reductions in hospital visits for violence-related injuries and community-level declines in violent crime in Kansas City.

Peer-reviewed studies showed positive impacts on mental health outcomes. Community and social indicators improved as well, with Ohmer finding a 25% increase in community members' likelihood to intervene in conflicts ($p < 0.01$) and Edberg et al. reporting a 20% increase in family cohesion scores post-intervention.[32, 49] Twelve gray literature evaluations also showed that participants improved their mental health outcomes, although sometimes improvements were similar to those in comparison groups.

Qualitative studies provided additional context for these results, focusing on program implementation and community perceptions. Hardiman[50] noted that 85% of residents reported feeling safer because of the intervention. Wical[16] documented a 50% decline in outreach activities during the COVID-19 pandemic, highlighting service delivery challenges. Workforce-focused studies, such as Free and MacDonald's, reported that 70% of outreach workers identified job-related trauma as a significant challenge to program effectiveness.[51] These results emphasize the lived experiences of community members and outreach workers, shedding light on how CVIs build trust, strengthen community cohesion, and address structural barriers to violence prevention.

These results emphasize the lived experiences of community members and outreach workers, shedding light on how CVIs build trust, strengthen community cohesion, and address structural barriers to violence prevention.

On the other hand, several peer-reviewed studies reported null or negative outcomes, reflecting the challenges inherent in implementing and evaluating CVIs across diverse contexts. For example, Buggs et al. used synthetic control methodology to evaluate Cure Violence in Baltimore and found no significant effects on homicides or nonfatal shootings compared to placebo tests.[52] McVey et al. reported mixed results from Ceasefire in New Orleans, where the target zone experienced a 20.7% increase in penetrating trauma (i.e., when an object breaks the skin and enters the body) after program implementation, while neighboring zip codes showed inconsistent results, with some zones experiencing increases and others decreases in violent incidents.[53]

In a broader review, Riemann highlighted the mixed effectiveness of Cure Violence interventions, with some sites showing significant reductions in violence and others demonstrating null effects or even increases in violence.[54] Circo[55] evaluated Detroit's Ceasefire program and found that shooting victimizations in treated precincts decreased at rates similar to or slightly slower than those in the rest of the city, suggesting limited program-specific effects.[55]

3.6 What research is still needed to understand CVI's contribution to reducing community violence?

Most CVI research is focused on the efficacy of reducing gun violence as measured by aggregate-level rates of homicide and fatal or nonfatal shootings. Many studies also assess individual-level effects on reinjury or rearrest. However, gray literature suggests availability of a wider array of outcome measures that are meaningful to communities, such as changes in community norms, relationships between community members and institutions (e.g., law enforcement), and improvement in community and individual-level well-being. The field is wide open for innovative research that can provide evidence for richer understanding of CVI impact.

Researchers face several challenges with CVI evaluations. Many authors of peer-reviewed publications cited the lack of a robust comparison group, which would allow for analysis of changes that are above and beyond broader trends in the area. Even for studies that had access to comparison communities, another concern was intervention spillover, wherein the indirect transmission of knowledge or consequences causes some change in the control group. This can happen, for example, when a CVI program works closely with a gang in one "treated" community and the rival gang resides in a "non-treated" community, but violence in both communities decreases because one side has received the intervention. Another common limitation was the lack of longitudinal data about participant outcomes. Cross-sectional data do not allow for the evaluation of changes over time and inhibit the use of some causal inference methods. Studies also cited the lack of data at the smaller neighborhood level as diluting results that were measured at larger geospatial levels (e.g., zip code), which are not true representations of the community or the focus area of the intervention. This is an especially difficult challenge given the tailored nature of CVIs. When interventions cannot be

assessed at the level of program implementation, it is difficult to interpret results, leaving CVI research open to harsh critique and casting doubt on valuable evidence. Innovative research approaches are desperately needed to address these challenges and allow for more rigorous and robust evidence about which CVIs are most effective in which areas.

Many studies were constrained to small sample sizes, which limits generalizability of findings. Additionally, there is little to no research on some populations that are heavily affected by gun violence, such as school-aged youth, women and girls, and Indigenous communities. More research is needed to understand which CVIs are effective for whom and how CVIs can develop tailored and culturally responsive activities for subpopulations in need of support.

Although frequency is increasing over time, there are few studies investigating CVI implementation. Most peer-reviewed effectiveness studies do not measure implementation activities. As a result, evaluations that find mixed and negative effects tend to cite "implementation challenges" generally but have no way to link specific barriers with poor outcomes. Likewise, there is no way to link positive outcomes with specific facilitators of success. Although most gray literature reviewed here included measures of CVI activities, the measures were not directly connected to reported outcomes. The field lacks effectiveness research that intentionally incorporates implementation to explain outcome findings—such as hybrid designs or statistical modeling using program activities as mediators or moderators—that would explain which CVI activities are most effective.

More implementation research is also needed to help understand *how* activities are conducted such that positive outcomes result. This work would yield a richer understanding of how CVI staff approach difficult and dangerous job responsibilities and how the work affects them as individuals and community members. Research analyzed here shows that outreach workers use a variety of approaches, some that are deeply personal and all of which are mentally, physically, and emotionally taxing. However, more evidence is needed to develop resources to train and support staff in order to continue this important work.

4. Non-evaluation Gray Literature

The gray literature search resulted in 43 documents that were not focused on evaluation but that we felt were important to summarize here. The categories were (1) organizational and progress reports; (2) research and analyses; (3) evaluations and impact assessments; (4) policies and approaches to public safety; and (5) frameworks, guidelines, and toolkits. **Figure 4** summarizes document types. Specific documents are listed in **Appendix C**.

Figure 4. Non-evaluation Gray Literature Document Categories

4.1 Organizational and progress reports

This category includes organizational overviews, annual reports, and progress reports. These 11 documents provide descriptive information about programmatic structure and general updates on an individual CVI's accomplishments. Written for a variety of audiences, including community members, stakeholders, and funders, they describe the goals, strategies, activities, progress, and finances of individual CVI organizations, usually over a 1-year period. For example, in its 2021 annual report, Chicago CRED detailed the structure of its offerings, including Flip 4.0 (direct engagement of high-risk individuals), 2020 Vision 2.0 (public safety messaging), On-Call Peacekeepers, and outreach coordination.[56] These documents are asset based through the description of strengths and resources to achieve successes and overall positive impact on reducing gun violence or reducing overall negative outcomes of their target population.

Additionally, these documents outline upcoming goals for implementation and progress at the programmatic level, based on the previous year's achievements. Goals include expanding networks, expanding and diversifying funding sources, building organizational capacity, and expanding programmatic opportunities for participants.

4.2 Research and evaluations

This category includes 17 documents categorized as research briefs, research summaries, evaluations, impact reports, and case studies. These documents differ from those in the evaluation gray literature category because they do not include detailed elements of a research design, such as methods and outcomes, and instead describe the research for a broad audience. They could not be coded using the PICO schema. They differ from the non-evaluation organizational and progress report category because they do not provide organizational overviews and focus on conveying findings from research. For example, a research brief published by John Jay College of Criminal Justice in 2017 presented survey data testing the association between three Cure Violence programs in New York City and the social norms present in individuals, finding that participants reported they were less likely to act violently, that they were better role models and parents to their children, and that they saw CVI staff as leaders of change in the community.[57] The brief is short (14 pages) and includes colorful graphics and easy-to-read tables. Presenting the data in this way allows for a more concise and accessible description of research findings than in peer-reviewed literature, along with more detail regarding implementation than would be found in an organizational or progress report.

Many documents in this category provide landscape analyses and outline challenges for CVIs. They show that practitioners are residents of the communities they serve and are significantly under-resourced. The documents call for investment in data and organizational infrastructure[58]; more funding, especially for upfront costs; cooperation between city, county, state, and federal partners; and alignment in statutory rules (e.g., hiring) to reduce tension between organizations.[59]

Some documents include first-person testimonials and interviews from recipients of CVI programs, providing anecdotal evidence of success. These firsthand accounts serve as evidence of the programs' impact, complementing quantitative metrics and highlighting the personal experiences of individuals supported by CVI interventions.

4.3 Policies and approaches to public safety

These seven documents highlight policy failures and describe approaches to public safety in the context of violence reduction, suggesting improvements to better align with CVI strategies that are community centered. Rather than merely describing CVI strategies, these documents prioritize justifying and explaining their use and efficacy, advocating for their broader implementation beyond individual programs to a larger scale.

These documents identify historical and structural barriers as the root cause of violence. Examples include the history of white supremacy in America, poverty and income inequality, inequitable education and health care systems, and persistent exposure to violence.[60] They also suggest structural solutions, often describing an ecosystem of violence prevention where organizations in multiple policy areas (e.g., legal, health, economic) and at multiple levels (e.g., neighborhood, city) work together toward common goals of reducing community violence and increasing safety and

well-being. This approach emphasizes (1) establishing formal rules and policies to institutionalize and systematize cooperation for long-term sustainability and lasting improvements and (2) doing so in ways that involve communities as coproducers of public safety.[61]

To support the design of a public health approach to violence intervention, some documents establish foundational principles for designing community violence intervention and prevention policies and practices. These include, for example, a public health approach to violence, community engagement and interagency collaboration, and establishment of evaluation and accountability practices.[62]

Other documents describe specific policies for "reimagining" public safety. For example, a policy agenda for Los Angeles proposes policy changes in three areas: incarceration, youth justice, and violence intervention.[63] Alternatives to incarceration seek to expand non–law enforcement response to crisis, as well as follow-up services. Often, interactions with law enforcement occur early in life; thus, the authors also propose transitioning youth out of adult law enforcement processes and into a new Department of Youth Development. Finally, the agenda describes the efforts of the Los Angeles Office of Violence Prevention and the successes of its Cure Violence program. The document also describes key accomplishments toward moving closer to proposed policies.

Overall, these policy-oriented documents are crucial for advocating for CVI strategies, providing easily digestible evidence of their effectiveness, and pushing for necessary institutional changes to support and expand these initiatives.

4.4 Frameworks, guidelines, and toolkits

The eight documents in this category provide concrete resources and actionable steps for CVI organizations. This includes instructions for conducting CVI programs with specific strategies, such as culturally informed teachings, and guidance on improving existing frameworks through outlining key aspects that are essential to CVI implementation, such as the public health approach.

These documents go beyond explanation by offering practical instructions for conducting CVI work. For example, the Health Alliance for Violence Intervention has published multiple articles that describe considerations for implementing HVIPs and the characteristics that qualify a program for this designation.[64, 65] Similarly, Everytown Research published *Hospital-Based Violence Intervention Programs: A Guide to Implementation and Costing*,[66] which provides costing considerations that include staff, transportation, crisis support services, and operations. The guide also includes a customizable costing workbook to assist organizations in planning and budgeting.

Other resources provided in these documents include assessment tools and templates for implementing various programmatic aspects of CVI. By offering practical tools and detailed guidance, they support the effective implementation and scaling of CVI strategies, ensuring that organizations have the necessary resources to succeed. Overall, these resource-oriented documents are crucial for empowering CVI organizations with the tools and knowledge needed to implement and enhance their programs, driving meaningful change in the CVI landscape.

5. Discussion

The findings from this scoping review underscore the essential role of CVI programs in addressing community violence and supporting public health outcomes across urban centers in the United States. Through systematic analysis, several core themes emerged, illuminating the current landscape of CVI research, CVI effectiveness, and the limitations of available data and methodologies. This discussion synthesizes these findings to highlight the strengths, challenges, and policy implications of CVI as an intervention strategy.

The review revealed consistent evidence supporting the effectiveness of violence interruption programs. The Cure Violence model demonstrated reductions in gun violence by up to 29% in neighborhoods where it was implemented,[67] and HVIPs showed a significant decrease in violent reinjury and recidivism, especially when paired with long-term case management and community support.[35]

Despite these positive findings, success varied by location, underscoring the critical role of contextual factors. For instance, implementation fidelity, community engagement, and the severity of violence in the area influenced outcomes, suggesting that site-specific adaptations may be required for optimal effectiveness. This underscores the need for continued diversification of research and evaluation to improve our understanding of how program development, implementation, and staff experience influence program effectiveness.

Our review identified a growing body of evidence advocating for comprehensive, multisectoral CVI strategies that incorporate both public health and criminal justice frameworks. Studies combining law enforcement strategies (such as hotspot policing) with violence interruption demonstrated more significant violence reductions than stand-alone interventions. For example, one study showed through simulations based on real community data that, by increasing the police force by 100% (i.e., doubling it) and using hotspot policing, annual victimization would be reduced by 11%. However, if the community instead increased the police force by only 40% and also added violence interrupters, gun violence would decrease by 19%.[68] This evidence supports the value of coordinated approaches that include community organizations, law enforcement, health care providers, and social services, which can amplify the impact of CVI programs and enhance community cohesion.

A prominent theme across the literature was the central role of outreach workers and violence interrupters, who leverage their local knowledge and community connections to mediate conflicts effectively. Programs using street outreach workers, such as Cure Violence and Advance Peace, demonstrated the importance of trust-building and lived experience in violence prevention. However, the challenging nature of outreach work, compounded by high levels of stress and risk, points to the need for workforce support structures to prevent burnout and to ensure retention of skilled staff. Future CVI initiatives should consider providing mental health resources, professional development, and community support for these workers to sustain program quality and effectiveness.

Because CVI employs a multipronged approach, various measures can demonstrate its effectiveness. A critical aspect of this scoping review is to aid in the development of a standard set of those measures. A notable finding was the diversity of outcome measures used across different evaluators to assess CVI program success, including violence rates, mental health indicators, and community cohesion metrics. For example, gray literature evaluations were more likely to measure and report changes in community perceptions of safety and violence than was the peer-reviewed literature. Gray literature was also more likely to assess nonviolent outcomes such as employment, educational persistence or attainment, and mental health. They often reported on more than one of these outcomes. These data were collected by local organizations via surveys, which are often time-consuming and thus costly, reflecting the organizations' commitment to understanding and delivering services that community members view as effective and valuable, as well as to changing community norms. Community members, in turn, may be more willing to interact with and complete data collection activities by familiar staff of local CVIs than by staff of large institutions such as universities. However, when each CVI uses a locally developed survey, it is difficult to understand CVI contributions to violence reduction more broadly.

The complex and multifaceted nature of CVIs and their role in the community highlights the need for collaboration between local organizations and larger institutions to conduct research and evaluation that allows for cross-program comparisons and meta-analyses. To strengthen the evidence base, developing an agreed-upon definition of CVI and a standardized framework of key performance indicators for CVI programs is critical. Such standardization would enable more rigorous evaluations, facilitate comparative analyses, and enhance the field's ability to advocate for sustained funding and support. However, standardization must be balanced with an understanding of local context, needs, and goals. It is imperative to include local organizations and community members in the development of standardized practices as well as in research and evaluation implementation.

The review found considerable variation in the conceptualization and unit of analysis for "community" in CVI studies, ranging from individual-level data to broader citywide metrics. This lack of consistency reflects the challenges inherent in defining and measuring community outcomes, particularly when data infrastructure is limited. Gray literature evaluations were more likely than peer-reviewed articles to measure outcomes at the neighborhood level. This is

perhaps because of the difficulty in empirically drawing consistent boundaries around neighborhoods for quantitative data analysis. Even for community members it is sometimes difficult to name, and reach consensus on, which street separates one neighborhood from another. Peer-reviewed studies that used neighborhood-level metrics relied on city partners to provide geospatial data, sometimes requiring specialized software (e.g., ArcGIS). To improve future research, CVI studies should (1) adopt more explicit theoretical frameworks that clearly define "community" on the basis of intervention goals and contextual constraints and (2) partner with local government agencies or communities that can provide specific neighborhood boundaries. This approach will ensure that data collection and analysis are aligned with program objectives and more accurately reflect the intervention's community-level impact.

Although the evidence indicates that CVI programs can effectively reduce violence, gaps remain in understanding the mechanisms through which they operate and the programs' long-term effects. Many studies faced limitations in funding, sample size, and data availability, which restricted their ability to conduct longitudinal analyses and evaluate broader impacts. Community engagement and collaboration between local agencies and organizations showed the potential for developing CVI ecosystems to support sustained violence reduction. However, more research is needed to understand how successful coalitions driven by community members are built and sustained. Additionally, challenges in maintaining program fidelity across diverse contexts suggest that policies should support adaptable, community-driven approaches rather than rigid models. More research is needed to understand the core components and supporting strategies of effective CVI.

Implementation evaluations highlight challenges that must be addressed in order for programs to conduct future research. Ensuring the sustainability and scalability of CVI programs is essential for understanding how interventions can contribute to sustaining safer communities. Many programs struggle with tracking long-term participant outcomes because of high rates of disengagement, making it difficult to measure sustained reductions in violent behavior. Funding instability and inconsistent municipal support hinder long-term impact, with some programs struggling to maintain operations, let alone secure funding for research and evaluation. Although many interventions track short-term participation, long-term outcome assessments on behavioral change remain limited. Training and workforce development also pose challenges, as programs like Los Angeles's Violence Intervention Training Academy (LAVITA) have limited capacity to certify intervention workers. Approaches such as street outreach, hospital-based violence prevention, mentorship, and community engagement have proven effective, but they require consistent investment, improved data tracking, and strengthened community-led efforts. Moving forward, expanding these strategies with sustained funding, integrated evaluation mechanisms, and strengthened partnerships will be crucial to maximizing the effectiveness of CVI programs in reducing violence and promoting public safety.

To address these limitations, policymakers should consider increasing investment in CVI research and supporting data infrastructure at the local level. Investments in longitudinal studies, diverse outcome measures, and workforce support systems will enhance the scalability and sustainability of CVI programs. Given the significant social and economic costs of community violence, continued policy support for CVI programs is crucial to creating safer, more resilient communities.

6. Conclusion

The insights from this scoping review confirm the potential of CVI programs as a vital component of public health and safety strategies in violence-affected communities. By leveraging community trust, incorporating multilevel approaches, and addressing the social determinants of violence, CVI programs offer a holistic approach to violence prevention. However, realizing their full potential requires standardized evaluation metrics, workforce support, and sustained policy investment. Future research should focus on refining intervention frameworks and developing robust evaluation strategies to optimize CVI program effectiveness across diverse contexts.

6.1 Implications for practice, policy, and research

The findings from this scoping review also provide several key implications for CVI practice, policy, and research. As the field advances, integrating evidence-based strategies with flexible, community-driven approaches will be essential to sustaining and expanding the impact of CVI programs. We outline the primary implications of this review as follows.

1. Strengthening Standardization for Evaluation and Cross-Comparison.

The diversity of outcomes and methods currently used in CVI research underscores the need for standardized metrics to allow for more meaningful comparisons across studies. Developing a common framework of core standardized outcomes would help facilitate evidence synthesis and improve clarity on the effectiveness of CVIs. Additionally, a set of guidelines for data collection and analysis would enable practitioners and policymakers to better understand what is working, where, and why. This standardization could be pursued through partnerships among CVI funders, policymakers, and researchers to ensure alignment on prioritized metrics. It must include local communities to ensure flexibility for local context and need.

2. Increasing Investment in Workforce Support and Capacity Building.

The demanding nature of outreach work in CVI programs highlights the need for investment in workforce support structures. Outreach workers and violence interrupters, who often operate in high-risk environments, require mental health support, professional development, and adequate compensation to maintain their engagement and effectiveness. Policymakers and funders should prioritize resources for workforce training, resilience-building programs, and retention initiatives to support these critical frontline workers. Creating a national or regional body for CVI workforce development could also provide standardized training, promote best practices, and facilitate knowledge sharing across programs.

3. Enhancing Long-Term Sustainability Through Multisectoral Collaboration.

The review shows that comprehensive, multisectoral CVI programs—those that integrate public health, law enforcement, social services, and community organizations—achieve better outcomes than single-sector approaches. Policymakers should promote multisector partnerships and create funding streams that encourage collaboration among agencies and organizations involved in community-level violence prevention. Additionally, public health and criminal justice systems could work together to align data infrastructure and resource allocation, optimizing support for at-risk communities. Ensuring that funding structures incentivize collaborative work can help build sustainable systems for long-term violence reduction.

The review shows that comprehensive, multisectoral CVI programs—those that integrate public health, law enforcement, social services, and community organizations—achieve better outcomes than single-sector approaches.

4. Broadening the Scope of CVI Outcomes to Address Social Determinants of Health.

The success of CVI programs often depends on addressing underlying social determinants, such as economic instability, housing insecurity, and lack of educational and employment opportunities. Policymakers should consider funding CVI programs that incorporate holistic, wraparound services addressing these social determinants or include CVI as part of larger citywide strategy to address violence that includes efforts to address social determinants of health. Including measures of community well-being and quality of life in CVI evaluations gives stakeholders a better understanding of how interventions affect not only violence rates but also broader indicators of community health and resilience. Expanding the scope of CVI outcomes to include these factors would enable a more comprehensive view of program impact and would strengthen the case for CVI as a public health intervention.

5. Promoting Research and Data Infrastructure to Support CVI Innovation.

Investing in data infrastructure at the local and national levels is crucial for the continued development of the CVI field. Current limitations in data availability, particularly at the community level, hinder efforts to conduct

rigorous evaluations and assess long-term outcomes. Policymakers and funders should prioritize initiatives to improve local data collection, provide technical support to CVI programs, and enhance data-sharing practices across sectors. Additionally, funding for longitudinal research and innovative methodologies—such as community-based participatory research—would help capture the nuanced, contextual factors influencing CVI effectiveness. Establishing a data infrastructure that supports robust research will be critical to advancing the science of CVI and guiding evidence-based policy decisions.

By addressing these areas, practitioners, policymakers, and funders can enhance the scalability, sustainability, and overall impact of CVI programs in violence-affected communities. Continued investment in these priorities will be essential to reducing community violence and fostering safer, more resilient neighborhoods.

6.2 Limitations of the scoping review

We report only on information about CVIs that was discussed in publications. We did not investigate every CVI model independently; therefore, our results do not reflect the full scope of CVI activity. Absence of a particular CVI strategy or outcome from this report does not imply that it is not important to the staff of any given CVI. For example, if a research publication focused only on conflict mediation, we coded the intervention as "conflict mediation" even if that CVI engaged in other activities. We recognize that there are CVI strategies and outcomes of interest that have not yet been published on and thus are not reflected here.

The scoping review faced several limitations that warrant consideration when interpreting its findings. One significant challenge was the lack of a universally accepted definition of CVI. This absence made it difficult to establish consistent inclusion criteria, potentially resulting in the exclusion of relevant studies or the inclusion of those not directly aligned with the review's objectives. Additionally, although the review aimed to be comprehensive, its focus on U.S.-based interventions limited the ability to draw insights from international contexts, and the exclusion of purely descriptive documents or non–peer-reviewed literature may have overlooked valuable contributions from community-driven initiatives or emerging practices.

The adaptation of multiple frameworks, such as PICO and SPICE, allowed for a broad and nuanced approach to capturing CVI-related data. However, the integration of these frameworks introduced complexities in standardizing data extraction and synthesis, which may have affected the clarity and consistency of categorizations. Despite iterative refinement of search terms and inclusion criteria, the reliance on database-driven searches may have missed studies published in less prominent journals or relevant gray literature, particularly from smaller or less-resourced organizations.

The review faced challenges in contextualizing findings across diverse operational settings, such as urban neighborhoods, hospitals, and other community environments. This variability in context made it difficult to identify overarching factors that influence CVI effectiveness and limited the generalizability of conclusions. It was also difficult at times to determine the specific model under evaluation. The distinction between Cure Violence and Ceasefire was especially muddy. Cure Violence evolved from the Ceasefire model; however, the models have become quite different, particularly in their relationships with law enforcement. Ideally we would have analyzed these models separately (e.g., **Section 3.2**). However, many articles were unclear whether the model being evaluated was closer to Cure Violence or Ceasefire at the time of the study. For example, many articles referred to the program as a "Cure Violence (formerly Ceasefire)" model. In addition, the lack of details provided about intervention activities made it impossible for us to make the distinction on our own. Future research should acknowledge the similarities and differences between CVI models, clearly identify which model is in use (if any), and describe and measure intervention activities.

This limitation highlights the inherent complexities of conducting a scoping review on a multifaceted topic like CVI. Future reviews would benefit from clearer frameworks, more inclusive search strategies, and increased resources to ensure a robust and comprehensive synthesis of evidence. Despite these challenges, the review provides critical insights into the CVI landscape and offers a foundation for advancing research and practice in this field.

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Appendix A. Peer-Reviewed Literature

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Appendix B. Gray Literature Documents Selected for Evaluation (85)

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Appendix C. Gray Literature Documents Not Selected for Evaluation (43)

Organizational and Progress Reports (11)

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