ARCvi | Actionable Resources for Change in Violence Intervention

Temple University College of Liberal Arts | Public Policy Lab

Research Guide: What is the Current Evidence Supporting Hospital-based Violence Intervention Programs (HVIPs)?

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Key Takeaways

- A quick review of the literature indicates that there have been two systematic/narrative reviews examining HVIP effectiveness with violent reinjury as an outcome in the last five years (Lee et al., 2025; Webster et al., 2022), alongside three additional scoping reviews examining program reach, client needs, and evaluation readiness (Jang et al., 2023; Nofi et al., 2023; Piervil et al., 2025).
- The evidence base has shifted from "too limited to support firm conclusions" (Affinati et al., 2016) to "promising but still uneven" as of the most recent synthesis (Lee et al., 2025).
- Findings on violent reinjury remain mixed across studies, but criminal justice outcomes (e.g., arrest/re-arrest), mental health, employment, and goal attainment show more consistent improvement. This suggests that examining reinjury alone understates HVIP impact.
- The most rigorous recent evaluation (Jay et al., 2026, Boston) found regular program engagement was associated with roughly half the likelihood of reinjury or violence perpetration. This evaluation provides one of the strongest effectiveness signals to date.
- Persistent gaps remain in legal support, pediatric-specific programming, and rigorous outcome evaluation: most of the field's 383+ identified programs have not yet been formally evaluated (Piervil et al., 2025).

Hospital-based Violence Intervention Programs

According to the Health Alliance for Violence Intervention (HAVI's) "What is an HVIP?" resource, hospital-based violence intervention programs are multidisciplinary programs that identify patients at risk of repeat violent injury and connect them with hospital- and community-based resources to address the underlying drivers of violence. Trained violence prevention professionals, often credible messengers from the communities they serve, engage patients at the bedside or shortly after discharge to build trust and develop a discharge plan addressing immediate safety needs, service connections, and recovery goals. The HAVI traces the model's origin to the introduction of the first HVIP in the mid-1990s, noting that it has since proliferated into a nationwide movement across hospitals and trauma centers (The HAVI, n.d.).

While the first HVIP emerged in the mid-1990s, the *formalized* model (where shared standards have been developed collaboratively across a national network of programs, organizations, and the HAVI) dates to 2009. That codified model integrates social services and medical care and positions HVIPs as a mechanism for addressing both the acute and long-term impacts of violent trauma (Kaiser Permanente Center for Gun Violence Research and Education, n.d.).

About this Research Guide

This **ARCvi Research Guide** takes stock of that growing evidence base. It synthesizes systematic reviews, scoping reviews, and individual program evaluations published on HVIP effectiveness, with particular attention to studies published from 2022 through the present. Because HVIPs have historically been judged primarily on whether they reduce violent reinjury, this guide also looks beyond that single outcome to examine what the literature shows about criminal justice involvement, mental health, employment and education, service use, legal needs, and program costs — as well as who these programs currently reach and where evaluation gaps remain.

The most comprehensive research synthesis to date (July 2026)

The most recent comprehensive synthesis is Lee and colleagues' 2025 **systematic review of 25 HVIP studies**. Lee and colleagues' review followed a structured, PROSPERO-registered protocol that searched five databases through October 2024 and narratively synthesized findings across the 25 included studies rather than pooling them into a single effect size, distinguishing it methodologically from a meta-analysis. They examined variation in program design and summarized findings across several outcome domains, including violent reinjury, criminal justice involvement, mental health, education and employment, service use, legal needs, and costs. Overall, the review presents HVIPs as increasingly promising, particularly when they provide intensive and coordinated support, but it also shows that the strength of evidence differs considerably depending on the outcome studied (Lee et al., 2025).

Violent reinjury and criminal justice outcomes

Violent reinjury is the outcome most directly tied to the original purpose of HVIPs, but findings remain mixed. Lee and colleagues (2025) concluded that several programs reported reductions in violence-related reinjury, yet the studies varied substantially in design, sample size, follow-up period, and program intensity. Criminal justice outcomes (rearrest, conviction, incarceration, or other involvement in the legal system) are related but are not interchangeable with reinjury. Reinjury measures whether a participant is treated again for a violent injury, while rearrest measures subsequent contact with law enforcement and may reflect offending, enforcement practices, or supervision conditions rather than victimization alone. These distinctions matter because an HVIP may reduce one type of risk without producing a detectable change in the other.

Webster and colleagues' (2022) structured narrative review provides a clearer study-by-study comparison of these outcomes. The authors reviewed randomized and observational studies that measured subsequent violence involvement through reinjury, violent behavior, arrest, incarceration, or other criminal justice outcomes. Most programs included credible messengers, intensive case management, service referrals, or brief behavioral interventions. The review found encouraging findings in some studies but emphasized that many trials were too small to reliably detect changes in relatively uncommon outcomes such as repeat violent injury.

One of the strongest positive findings came from a highly intensive Baltimore program studied a decade ago by Cooper, Eslinger, and Stolley (2006). Participants in the Violence Intervention Program (VIP) at the R. Adams Cowley Shock Trauma Center at the University of Maryland Medical Center were adults already on probation or parole and received individualized case planning, regular contact with social workers and supervision officers, home visits, and hospital-based support groups. Participants were randomized into intervention and control groups; the intervention group received intensive psychosocial follow-up services, family/group therapy, and substance abuse treatment support. Compared with controls, participants had lower violent rearrest and conviction rates, and violent reinjury was 5 percent among participants compared with 36 percent among controls. However, the study was small, served a highly specific justice-involved population, and tested a more intensive model than many HVIPs, limiting how broadly the results can be generalized.

Other studies found benefits for criminal justice outcomes without significant reductions in reinjury. Becker and colleagues (2004) found no significant differences in reinjury or death, but the HVIP group was less likely to experience any negative criminal justice outcome than controls (33 percent compared with 49 percent). Cheng and colleagues (2008) found that participating youth were less likely to engage in misdemeanor activity and showed reductions in aggression and increases in self-efficacy, although the intervention did not consistently reduce fighting, injury, or weapon-carrying outcomes.

Several studies reported no statistically significant effects on their primary reinjury or justice outcomes. Snider and colleagues (2020), who evaluated the Community Emergency Department Violence Intervention Program in Winnipeg, Canada, found no significant difference in repeat violent injury or related hospital use. Zun, Downey, and Rosen, evaluating a Chicago Emergency Department program for youth and young adults ages 10–24, found no significant effects on rehospitalization, arrest, or incarceration (Zun et al., 2006). These null findings do not necessarily establish that HVIPs are ineffective. Many studies had small samples, short follow-up periods, substantial attrition, or incomplete information about whether participants received the intended level of services (Webster et al., 2022).

Earlier evidence reviews

Affinati and colleagues' 2016 evidence-based review captured the earlier state of the field. It included ten adult HVIP studies conducted in six U.S. cities—four randomized trials and six observational studies—and concluded that the available evidence was insufficient to make a firm recommendation about effectiveness. No study in that review demonstrated a statistically significant reduction in violent reinjury, and most focused narrowly on reinjury, death, arrest, or incarceration. Employment, education, substance use, mental health, attitudes toward violence, and other recovery outcomes were examined far less often.

The main limitation was not simply that results were mixed. The studies were generally too small, inconsistent, and methodologically limited to estimate the true effects of HVIPs with confidence (Affinati et al., 2016). Webster and colleagues (2022) reached a similar but somewhat more optimistic conclusion several years later: some better-resourced and more intensive programs produced encouraging reductions in reinjury or criminal justice involvement, but the field still lacked enough large, rigorous studies to determine which program components were most effective.

Scoping and systematic reviews on program reach, gaps, and evaluation readiness

A related line of scoping and systematic reviews assess HVIPs in a different way, asking not whether HVIPs reduce reinjury or other health and criminal justice outcomes, but who they reach, what needs they actually meet, and how ready the field is for rigorous evaluation. Jang and colleagues (2023) conducted a systematic review of how well HVIP services matched clients' self-reported needs, screening more than 3,300 records to develop a final set of U.S.-based studies. They found that programs consistently offered long-term case management, follow-up linkage to community services, mentoring, and home visits through violence intervention specialists, but that data on quantitative needs assessments and needs-based outcomes remained limited. Their conclusion echoes the legal needs gap identified by Lee and colleagues above: community partnerships are essential to addressing survivors' social determinants of health, but few studies have measured whether HVIPs are actually closing the gap between what survivors need and what they receive (Jang et al., 2023).

Nofi and colleagues (2023) narrowed the lens to HVIPs serving children under 18, conducting a scoping review of the literature on violence intervention programs for pediatric and youth populations. They found a small but growing literature describing program structures for pediatric populations and concluded that while early evidence is

promising, most programs and evaluations remain adult-oriented, leaving open questions about how HVIP models should be adapted for younger children and their families.

Piervil and colleagues (2025) took a still broader approach in their study, describing a systematic screening and assessment methodology used to identify hospital-based youth violence prevention programs nationally that are ready for rigorous evaluation. Drawing on the 2017 American Hospital Association Annual Survey of Hospitals, an environmental scan, and key informant interviews, they identified 383 hospital-based violence prevention programs across the country, then convened two expert review panels to assess which programs had the infrastructure and characteristics needed to support a future evaluability assessment. This work is a useful reminder that the evidence summarized elsewhere in this guide reflects only the subset of HVIPs that have been formally evaluated; a much larger number of programs exist but have not yet been assessed with rigorous methods.

McCarthy and colleagues (2025) took a distinctive research approach to a regional HVIP in Colorado, using a research team made up mostly of Violence Prevention Professionals (VPPs) rather than academic researchers. Key informant interviews with clients (n = 7), VPPs (n = 9), and healthcare collaborators (n = 8) produced a conceptual framework and logic model (which has three process-based themes, three outcome-based themes, and four foundational programmatic goals) intended to guide future evaluation of HVIP fidelity and effectiveness.

Mental health, employment, education, and participant goals

A major contribution of the more recent literature is its broader view of what HVIPs are intended to accomplish. Lee and colleagues (2025) identified three studies examining mental health outcomes, including post-traumatic stress and psychological distress, and all three reported improvements. The evidence base remains small, but these findings suggest that HVIPs may support recovery even when reductions in reinjury or rearrest are not statistically detectable.

Studies of education and employment also suggest that intensive case management and peer support can help participants obtain work, continue their education, and access stabilizing services (Lee et al., 2025). These outcomes matter because employment, education, housing stability, and behavioral health support may represent intermediate pathways through which programs reduce longer-term violence risk.

Webb and colleagues' 2024 review focused specifically on HVIPs using peer support specialists. Across the included studies, peer specialists appeared valuable because they could relate to participants' social and cultural circumstances, build trust, demonstrate care and compassion, provide mentorship, and connect survivors with opportunities and services (Webb et al., 2024). These findings reinforce the importance of the peer support relationship as a mechanism through which HVIPs engage participants and support recovery.

Studies of whether HVIPs help participants meet self-identified goals also show why reinjury should not be the only outcome. Reported goals have included follow-up medical and mental health care, treatment for pre-existing conditions, victim compensation, housing and other basic needs, employment, education, and legal assistance. Across three studies reviewed by Webb and colleagues (2024), goal attainment varied considerably: in one program, participants met nearly 90 percent of their top three goals within one year; in another, about half met their goals within six months; and in a third, 19 percent met their goals within one year. These differences reflect variation in participant needs, program intensity, follow-up periods, and how goals were defined.

Costs, legal needs, and program infrastructure

Lee and colleagues (2025) also reviewed four studies suggesting that HVIPs may be cost-effective or cost-saving when they prevent repeat hospitalizations, emergency treatment, or other downstream costs. This is an important part of

the evidence because even modest reductions in reinjury or service use may produce meaningful savings for hospitals and public systems.

At the same time, the review identified a persistent gap in legal support. Survivors may face housing instability, employment problems, victim-compensation barriers, protective-order needs, or other civil legal issues after injury, yet relatively few HVIPs have formal medical-legal partnerships (Lee et al., 2025). This suggests that HVIPs should be understood not only as reinjury-prevention programs, but also as broader recovery and stabilization interventions that may improve health, psychosocial, legal, and financial outcomes.

What the rest of the recent effectiveness literature shows

Beyond the systematic and scoping reviews above, a number of individual program evaluations published since 2022 add further texture to the evidence base. Because most are single-site studies, understanding where each was conducted, who was eligible to participate, and which outcomes were measured is important context for interpreting the findings.

Mueller and colleagues (2025) evaluated Life Outside of Violence (LOV), the first multisystem, region-wide HVIP in the United States, spanning two adult and two pediatric Level I trauma hospitals across the St. Louis, Missouri area. Eligible participants were violently injured patients ages 8 to 30 treated at a LOV-partner hospital between August 2018 and December 2022 who enrolled in the program; enrolled participants were matched to eligible but non-enrolled patients using propensity score matching. The study assessed violent reinjury one year after the index injury. The pilot-phase findings did not show a statistically meaningful difference in reinjury between LOV participants and matched controls, which the authors attribute in part to the small sample size available during the program's early pilot phase.

Jay and colleagues (2026) studied the Violence Intervention Advocacy Program (VIAP) at Boston Medical Center in Boston, Massachusetts, using a target trial emulation design. (Target trial emulation is a method for analyzing non-randomized data as if it had come from a hypothetical randomized controlled trial.) Eligible participants were patients treated at Boston Medical Center for a violent injury; the study compared violent reinjury and violence perpetration at one, two, and three years after the index injury for patients who engaged with VIAP against those who did not. Regular engagement with the program was associated with roughly half the likelihood of being reinjured or committing violence compared with patients who did not engage, making it one of the more rigorous and encouraging findings in the recent literature, though the authors note the effect was concentrated among more engaged participants rather than uniform across all enrollees.

Schenk and colleagues (2023) conducted a multimethod evaluation, using the RE-AIM framework, of an emerging HVIP at Yale New Haven Hospital in New Haven, Connecticut. Eligible participants were individuals who presented with non-fatal assaultive firearm injury between 2020 and 2022. The study assessed reach and recruitment, violent reinjury outcomes, and service provision, and supplemented these quantitative measures with qualitative interviews of HVIP participants and administrators as well as clinician surveys on referral awareness. Of 319 HVIP-eligible individuals, only 39 (12 percent) were enrolled; limited clinician awareness of HVIP services and participant concerns about police involvement were identified as key barriers to reach and engagement.

Voith and colleagues (2022) used interviews with HVIP staff to better understand what helps or gets in the way of engaging Black and Latinx youth in services. The researchers interviewed 12 staff members from five HVIPs in cities across the Midwest and Northeast. Importantly, this was not an impact study: the researchers did not compare outcomes for youth who did and did not participate in an HVIP or test whether HVIPs reduced reinjury or other adverse outcomes. Instead, they asked experienced HVIP staff what they had learned about recruiting and keeping

young people engaged. Staff emphasized the importance of relationship-building, trust, rapport, and meaningful connections with youth, while also identifying barriers such as distrust of institutions and competing immediate needs in young people's lives. The study therefore provides insight into how HVIPs may strengthen recruitment and engagement, rather than evidence about whether HVIPs improve participant outcomes.

Khan and colleagues (2025) conducted a quality improvement study at a pediatric tertiary care hospital in Milwaukee, Wisconsin. They wanted to assess whether children and families who were eligible for an HVIP were actually referred to the program. Eligible participants were patients ages 0 to 18 who presented to the emergency department for assault-related concerns between December 2021 and June 2024. The study's primary outcome was the percentage of HVIP-eligible patients who received a referral to the program, with a goal of increasing referrals by 20 percent over 12 months. They interviewed hospital staff, examined where eligible patients were being missed, and introduced electronic medical record tools designed to prompt or automatically trigger HVIP referrals.

The changes substantially improved the hospital's ability to connect eligible patients to the HVIP: the referral rate increased from 53.6% before the interventions to 93.5% afterward. Importantly, however, the authors found that this increase in referrals did not lead to increased program enrollment.

The Bottom line

The HVIP evidence base has moved from too limited to support firm conclusions toward genuinely promising, if still uneven. Across the last two decades, there is evidence that intensive (i.e., high-touch) programs can reduced violent reinjury, rearrest, or broader criminal justice involvement, and even studies that found no significant effect on those outcomes have shown real gains in mental health, self-efficacy, employment, education, service access, or progress toward participant goals (Affinati et al., 2016; Webster et al., 2022; Lee et al., 2025; Webb et al., 2024). Notably, the most rigorous recent evaluation to date, Jay and colleagues' (2026) target trial emulation of Boston's VIAP program, found that engaged participants were roughly half as likely to be reinjured or commit violence. This is one of the strongest effectiveness signals the field has produced.

The strongest conclusion is not that all HVIPs work equally well, but that benefits appear most likely when programs combine credible peer engagement, intensive case management, sustained follow-up, strong community partnerships, and access to behavioral health, employment, legal, and other stabilizing supports. What the field most needs now is more randomized and other rigorous designs to confirm and extend these findings. True randomization is difficult in this setting because few programs can ethically or practically withhold services from eligible patients, but promising models like target trial emulation, and randomized control trials (RCTs) built around limited program capacity (where demand for services already exceeds available slots), offer realistic paths forward. Given how far the evidence has come already, that next generation of rigorous studies is well within reach.

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