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Research Guide: What Does the Research Say about "Best Practices" in Community Violence Intervention (CVI)?

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How evidence accumulates—and what recent studies suggest about effective community violence intervention

At a glance: Community violence intervention (CVI) refers to a set of non-punitive, community-led strategies, including street outreach, violence interruption, case management, hospital-based programs, and peace fellowships, that use trusted, credible messengers to engage the small number of people at highest risk of shooting or being shot, and connect them to the relationships and services that can interrupt that risk. The field uses the term "intervention" deliberately: unlike universal prevention efforts aimed at whole populations, CVI concentrates resources on individuals and networks already at the point of highest risk, often people with prior justice involvement, those who have previously been shot, or a close peer or family member who was shot, on the premise that violence clusters and spreads, and that credible, sustained relationships at that point of concentration can interrupt the cycle before it repeats.

What do we mean by a "best practice"?

A best practice is a program component, implementation strategy, or way of working that has repeatedly been associated with stronger delivery or better outcomes across more than one study or setting. The term should not be used simply because a practice is common, intuitively appealing, or promoted by a respected organization. In CVI, many practices are better described as "promising" or "research-informed" because the evidence is still developing.

Best practices are also different from branded program models. A model such as Cure Violence, READI Chicago, or a hospital-based violence intervention program contains multiple components. Research may find support for some components, such as high-risk targeting, credible messengers, cognitive behavioral-focused therapy, or intensive case management, even when findings about the overall model are mixed. Essentially, most evaluations have not been constructed to identify the components that were most associated with reductions in gun violence (Petrosino et al., 2015).

How does the literature build best practices over time?

The evidence base usually develops in stages. No single study establishes a best practice. Confidence grows when findings from different methods begin to point in the same direction and when results can be reproduced in different programs, populations, and cities.

1 **Program theory and community knowledge.** Practitioners, participants, and researchers identify a plausible mechanism—for example, that a trusted outreach worker can reduce conflict by gaining access, strengthening motivation, and connecting a participant to stabilizing resources.

2 **Implementation and process studies.** Researchers examine whether the component is actually delivered, to whom, with what quality, and under what organizational conditions. These studies reveal the staffing, training, supervision, trust, partnerships, and data systems required for the practice to operate.

3 **Outcome studies.** Programs track whether participants or communities improve over time. These studies are useful, but changes cannot automatically be attributed to the program because other factors may also be operating.

4 **Impact studies.** Rigorous evaluations use a control group or a carefully constructed comparison group and causal methods to estimate whether the program produced the observed change.

5 **Replication and synthesis.** Confidence becomes stronger when similar findings appear across sites and are synthesized through systematic reviews, meta-analyses, or well-designed evidence reviews.

Important distinction: Implementation and qualitative studies can identify mechanisms and help explain how a practice works. Rigorous impact studies are needed to establish that a program or component caused reductions in violence or other outcomes. Both kinds of evidence are necessary for developing useful best-practice guidance. See ARCvi.org's Key Research Terms for Understanding CVI Evidence for more information.

What recent research on CVI adds

1. Targeting should be precise—but risk is dynamic

One of the most consistent lessons across violence reduction research is that resources should be concentrated on the people, networks, conflicts, and places most closely connected to firearm violence. Broad eligibility rules can dilute services and make it difficult for programs to deliver the intensity needed by those at greatest risk.

Recent research also cautions against treating risk as a fixed label. In their study of Communities Partnering 4 Peace in Chicago, Ross, Burtner, and Papachristos (2025) analyzed more than 4,000 participants and nearly 200,000 contacts. Participants located in high-risk social networks received more contacts over longer periods, suggesting that frontline organizations were actively calibrating service intensity to changing risk and need rather than delivering an identical intervention to everyone.

This precision-targeting principle is strongly reinforced by evidence from an adjacent field. Lipsey and colleagues' (2010) comprehensive meta-analysis of 548 evaluation studies of interventions for juvenile offenders found that risk level was the single most consistent predictor of intervention effect size: programs applied to high-risk youth

produced substantially larger reductions in reoffending than the same program types applied to low-risk youth, and this relationship held even among the highest-risk samples in the research. The practical implication for CVI mirrors what Ross and colleagues observed directly in Chicago: the highest-risk participants have the most room for improvement, and resources are used most efficiently when the most intensive services are reserved for them rather than spread evenly across a broader eligible population.

2. Relationship-building is a core mechanism—not an extra service

Recent mechanism-focused studies reinforce that the relationship between credible messengers and participants is central to CVI. Ross and colleagues (2025) found that mentoring was by far the most common service in the Chicago coalition, reaching more than 90 percent of participants. This suggests that sustained relational work is often the foundation through which employment, behavioral health, education, crisis response, and other supports become possible.

Simonsson and colleagues (2025) describe relational desistance mechanisms through which credible messengers may support change: creating trust, offering recognition, helping participants imagine a different identity, expanding pro-social ties, and remaining present through setbacks. Roman and colleagues (2026) similarly identify seven interpersonal skills and traits that support effective outreach and case management: adaptability, communication, credibility, empathy, openness/honesty, mentorship/leadership and patience. These studies do not by themselves suggest that these mechanisms or program characteristics lead directly to reductions in violence, but they begin to clarify the mechanisms and workforce capacities that impact evaluations should measure.

This non-punitive, relational orientation is not simply a value commitment; it is also what the broader intervention research shows to be more effective. Lipsey and colleagues' (2010) meta-analysis distinguished between two broad program philosophies: a therapeutic approach built around counseling, mentoring, skill-building, and coordinated case management, and a control approach built around discipline, deterrence, and surveillance. Across hundreds of studies, therapeutic programs consistently outperformed control-oriented ones, and programs built primarily around discipline or fear of consequences (such as prison-visitation or "scared straight" models) showed, on average, no benefit or even a negative effect on subsequent offending. While this research was conducted with juvenile offenders rather than CVI participants, it offers independent, rigorously synthesized support for the field's emphasis on trust and relationship over surveillance and control.

3. Conflict interruption/mediation is its own distinct practice

In addition to relationship building and case management (discussed above), a distinct set of activities is aimed directly at stopping violence before it happens: conflict interruption and mediation. Jannetta and colleagues' (2022) national practice guide for the Urban Institute identifies this as a core practice area, distinguishing two components: reactive response to active incidents, meant to prevent a shooting or stabbing from triggering retaliation, and proactive mediation of ongoing or emerging conflicts between individuals or groups before they escalate to violence.

Direct evidence on mediation itself, rather than the broader CVI service package, is more limited than evidence on case management or mentoring, but it is informative. Early studies related to evaluations of Baltimore's CeaseFire program offer descriptions of successful processes related to mediation: Whitehill, Webster, and Vernick (2013) analyzed 158 conflicts mediated by outreach workers in Baltimore's CeaseFire (a replication of Cure Violence) and found that outreach workers achieved immediate, nonviolent resolution in 65 percent of mediated conflicts, with another 23 percent resolved without violence at least temporarily; notably, the conflict's underlying risk factors (the risk level of those involved, whether it was retaliation-related, group size, and shooting likelihood) were not what determined whether a mediator succeeded, suggesting mediator skill and relationship, not just conflict type, drives outcomes. A companion qualitative study by the same team (Whitehill et al., 2014) found that successful mediation was built on trust and respect between violence interrupters and the community, especially the high-risk individuals

most likely to be involved in a shooting; interrupters relied on their own credibility and relationships, built over time on the street, to spot brewing conflicts and step in before they turned violent.

Robust evidence of the effectiveness of violence interruption comes from Los Angeles, where the city operates the Gang Reduction and Youth Development (GRYD) program through the Mayor's Office. GRYD is a comprehensive violence reduction strategy that combines prevention services, family-based case management, mentoring, and violence interruption. Within designated GRYD Zones, the Incident Response Program deploys intervention workers following shootings and other violent incidents to reduce the likelihood of retaliation and further escalation. Brantingham and colleagues (2020) applied statistical models designed to estimate how violence propagates across space and time—methods adapted from models used to study phenomena such as earthquake aftershocks and infectious disease transmission—to assess the effects of GRYD's incident-response activities. They found that incident response was associated with an approximately 41 percent reduction in gang-related retaliatory violence. A subsequent study (Park et al., 2021) employing a refined version of this modeling approach similarly found evidence of reductions in retaliatory violence, with estimated declines of approximately 18 percent in areas somewhat farther from the initiating incident and 14 percent in the area immediately surrounding it. It should be noted that GRYD's Incident Response Program is a partnership across three groups, known as the GRYD Triangle Partnership: Community Intervention Workers (community members, including some with former gang involvement, trained to engage directly with those at risk), GRYD Regional Program Coordinators (who lead the crisis-response and community-engagement side of the effort), and the Los Angeles Police Department. Rather than operating as independent "free agents," these three parties share information and coordinate their response to each incident under a formal protocol. The reduction in retaliations documented above reflects the effect of this coordinated, police-inclusive model, not a community-based, police-free approach evaluated on its own.

4. CVI is usually a package of individualized and coordinated supports

Street outreach is often described narrowly as violence interruption, but recent evidence shows that the work is much broader. In the Ross and colleagues' Chicago study (2025), programs delivered mentoring, employment assistance, case management, education, behavioral and physical health support, legal services, material assistance, family support, and conflict resolution. Four service profiles emerged—low dosage, medium dosage, behavioral services, and high dosage—showing that participants receive different combinations of support. Petrosino and colleagues (2015) also stress that to combat a problem as broad as youth violence requires a multiagency effort. No single service, delivered alone, or within one sector, is likely to match the complexity of what puts a young person at risk in the first place.

This strengthens the case for multi-component CVI programming, while also warning against assuming that every participant needs every service. A more useful best practice principle is to maintain a strong network of supports and tailor the combination, sequence, and intensity to participants' risks, goals, readiness, and circumstances. Much more research should be done to examine what this "tailoring" should look like and which particular service or combination of services should be an integral component of service provision within CVI.

5. Duration and dosage matter, but there is no single magic number

Programs need enough time and contact to build trust and support meaningful change. Ross and colleagues (2025) found wide variation in tenure and service intensity, with the highest-dosage group receiving a median of 551 contacts over more than two and a half years. Participants in higher-risk networks also received substantially more contact than other participants.

These findings should not be interpreted as proof that more contact always produces better outcomes. The study was descriptive and could not determine whether the observed dosage was optimal or causal. Instead, it shows why evaluations should measure frequency, duration, service type, gaps in engagement, and baseline risk rather than classifying all enrolled participants as having received the same treatment.

Lipsey and colleagues (2010) reached a similar conclusion in their meta-analysis of juvenile justice interventions, describing the amount of service much like the dose of a medicine: each type of service (family counseling, cognitive behavioral therapy, mentoring, and so on) has its own target duration and contact hours, set at the median found in the supporting research for that service type, and programs needed to reach at least that target to achieve the average effect for the type. For example, Aggression Replacement Training, a cognitive behavioral intervention, is specified at 10 weeks and roughly 30 hours of direct contact; other service types carry their own, different targets. Effects did not continue to improve indefinitely beyond the target, however, so more contact was not simply "better" past a certain point. This offers a useful complementary frame for CVI practitioners and evaluators: dosage thresholds may exist below which meaningful change is unlikely, even though there is no single ideal number of contacts that applies to every participant or program model, and any target would need to be specific to each type of service CVI programs deliver.

6. Implementation infrastructure is part of the intervention

A recent scoping review of Cure Violence implementation by Solomon and colleagues (2025) identified 42 implementation strategies across hiring and retention, training, violence detection and interruption, identifying and supporting high-risk participants, community norm change, and broader sustainability. The review highlighted stable funding, community trust, and staff characteristics as important contextual conditions.

This literature supports a broader understanding of fidelity. Fidelity does not mean mechanically copying every activity from another city. It means protecting the program's core functions while building the staffing, supervision, partnerships, data systems, and local adaptations required to carry them out well. Underfunding, high turnover, weak supervision, or fragmented referral systems can prevent a strong model from operating as intended.

Lipsey and colleagues (2010) identified a closely related factor in their meta-analysis: quality of implementation, meaning the extent to which a program was delivered as intended for every participant, was itself associated with the size of a program's effects. Indications of high dropout, staff turnover, incomplete service delivery, and poorly trained personnel were linked to smaller effects, while programs with a written protocol, staff training, active monitoring, and a mechanism for corrective action performed better. Lipsey's team translated these meta-analytic findings into a practical tool, the Standardized Program Evaluation Protocol (SPEP), which scores a local program against the profile of characteristics research has shown to matter most, offering a possible model for how the CVI field might someday translate its own accumulating evidence into a similar diagnostic and improvement tool.

7. Data systems and their performance measures must reflect how CVI actually works

Recent reviews of CVI evaluation methods find substantial variation in how programs define participants, services, exposure, and outcomes (Girma et al., 2025). A best practice is therefore not simply to collect more data. Programs and evaluators should co-design measures that capture meaningful work without undermining safety or credibility. Useful systems should distinguish outreach contacts from formal enrollment, record service type and intensity, track pauses and re-engagement, document referral follow-through, and protect sensitive information.

8. Community credibility and community engagement shape quality

Community credibility affects whether programs can reach people who are disconnected from conventional systems and whether participants remain engaged (Roman et al., 2026). Community-engaged research is equally important to the quality of the evidence (Fontaine et al., 2026). Staff and people with lived experience can help define what services mean, identify important outcomes, interpret unexpected patterns, and prevent researchers from imposing measures that do not fit the work.

The Chicago study (Ross et al., 2025) used an ongoing community-engaged partnership to harmonize data while allowing organizations to retain control over their own information. This is a practical lesson for the field: stronger evidence is more likely when evaluators invest in trust, shared decision-making, technical assistance, and data governance rather than treating programs only as sites of data collection.

9. Workforce wellness is tethered to program quality, not separate from it

CVI work asks credible messengers to build sustained, personal relationships with people who are at the highest risk of violence, often in the same communities and social networks where the messenger's own past trauma originated. Bocanegra and Aguilar (2024) conducted in-depth interviews with 35 street outreach workers and supervisors in Chicago and found that the same relational closeness that makes outreach workers effective also carries real risk for the workers themselves. Participants described a mutually reinforcing dynamic they called "tethered healing," in which supporting a participant's transformation is also personally healing for the worker, alongside a darker counterpart, "tethered harm," in which a participant's setback, injury, or death is experienced by the worker as a personal failure. Some workers also described "falling back," a temptation to revert to risk behaviors when their outreach work repeatedly places them back in contact with the same people, places, and stressors tied to their own histories.

These findings reframe workforce wellness as a program quality issue rather than a separate human resources concern. The authors conclude that because these occupational hazards are predictable byproducts of the work itself, employers should address them proactively, through how staff are supervised, how team meetings are structured, and how the organization responds to crises, rather than treating burnout or secondary trauma as an individual worker's problem to manage alone. This adds a workforce-facing complement to the implementation-infrastructure findings above (see #6): a program cannot sustain fidelity, retention, or community trust without also sustaining the people delivering the intervention.

10. Coordination across the CVI ecosystem may be important for large-scale program/individual model success

The case for tailoring individual services within a CVI program or model rests on an even more fundamental point: no single program, however well-designed, operates in isolation from the broader system around it. Crandall, Gonzalez, and Cunningham (2024) set out to explain a puzzle in the field: many cities have funded and adopted evidence-informed CVI program models, yet relatively few have achieved sustained, city-level reductions in violence. Rather than asking whether any single program model works, the authors asked what city-level conditions allow effective programs to translate into citywide impact. To answer this, they identified six hypothesized "key capacities" through a literature review spanning criminology, public health, and public administration, then tested those capacities against the actual violence reduction histories of seven major U.S. cities (Baltimore, Boston, Cincinnati, Los Angeles, New Orleans, Oakland, and Philadelphia) over a 15-year period, drawing on more than 30 impact evaluations, public records review, violence trend data, and dozens of interviews with local stakeholders and national subject matter experts in each city.

Cities that sustained meaningful reductions in violence consistently had one thing in common: cross-sector collaboration on a shared strategy, meaning government agencies, law enforcement, and community-based CVI organizations were not just co-located but coordinated around a common theory of change, with a convening body responsible for aligning their efforts. Cities lacking this coordination, even those funding effective individual programs, struggled to translate program-level success into citywide reductions in violence. Although this study was focused on cities and not individual programs, there are implications for programs: the study strengthens the case for connecting to whatever ecosystem infrastructure exists, or advocating to build it: shared referral pathways, participation in city-level violence reduction councils and collaboratives, data-sharing agreements, alignment with a citywide theory of change, rather than operating as an island.

What is well supported—and what remains uncertain?

The literature increasingly supports

- Focusing resources on people, networks, conflicts, and places at highest risk
- Using credible, trusted staff to build sustained relationships
- Combining immediate violence response with individualized longer-term supports
- Investing in training, supervision, staff wellness, retention, and organizational capacity
- Adapting service intensity and type to participant risk and need
- Using community-engaged and context-sensitive implementation and evaluation

The field still needs stronger evidence about

- Which specific components cause reductions in shootings
- The optimal duration, frequency, and combination of services for different participants
- How outcomes vary by baseline risk, readiness, age, gender, and local context
- How informal mentoring and conflict mediation should be measured
- Which adaptations preserve core functions and which weaken the model
- How CVI ecosystems and multiple programs interact at the neighborhood level

Implications for CVI programs and funders

- Use local data and frontline knowledge together to identify the people, networks, conflicts, and places at highest risk of gun violence perpetration and victimization.
- Treat relationship-building, mentoring and case management as measurable core work, not as an unrecorded activity that happens around conflict mediation or other components (such as cognitive behavior interventions or subsidized jobs).
- Build access to a broad set of supports, but individualize the service package rather than requiring every participant to follow the same path.
- Track dosage in more than one way: frequency of contact, duration, service mix, gaps in engagement, and the intensity of crisis periods.
- Invest in the conditions that make implementation possible, including stable funding, manageable caseloads, training, supervision, staff safety, wellness, and retention.
- Develop data systems with frontline staff and community partners so documentation supports learning without creating unnecessary privacy or legal risks.
- Evaluate both implementation and impact. A null impact finding is difficult to interpret when the study cannot show who was reached, what services were delivered, or whether the program operated as intended.
- Use the phrase “best practice” carefully. Be transparent about whether a recommendation is supported by causal evidence, repeated implementation findings, practitioner consensus, or emerging qualitative research.

Bottom line

The strongest reading of the CVI literature is not that the field has found one universally superior program. Rather, evidence is converging around a set of linked practices: precise targeting, conflict mediation, trusted relationships (many of which are anchored via credible messengers), individualized and sustained support, strong implementation infrastructure, community legitimacy, and evaluation methods that capture how services vary across people and over time. These principles are increasingly well supported, but many questions about causal mechanisms, dosage, and local adaptation still require rigorous evaluation.

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