Maryland Violence Intervention and Prevention Program

Implementation and Impact Evaluation

Center for Justice Innovation

Maryland Violence Intervention and Prevention Program: Implementation and Impact Evaluation

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Executive Summary

Despite recent decreases in firearm-related homicides, Maryland has grappled with how to meaningfully decrease firearm fatalities and shootings. The Maryland Violence Intervention and Prevention Program Fund (VIPP) was established in 2018 under House Bill 432 to support localities in implementing and evaluating the efficacy of evidence-based and evidence-informed violence reduction strategies focused on gun violence. Administered by the Governor's Office of Crime Prevention and Policy (GOCPP), VIPP supports approaches that include:

- Nationally recognized models such as hospital-based violence intervention programs, street outreach (e.g., Cure Violence), cognitive behavioral therapy, group violence intervention, and crime prevention through environmental design;
- Adaptations of existing models; and
- Locally developed approaches informed by research, best practices, and/or community experience.

The purpose of this mixed-methods evaluation was to conduct 1) **implementation evaluations** of the programs included in the FY 2024 cohort, seeking to understand the programs' operations and document fidelity to intended plans, and 2) **impact evaluations** in select sites to look at changes in community indicators of firearm-related incidents.

We conducted implementation evaluations of eight of the ten programs and impact evaluations of three programs:

Site	Project Name	Model	Implementation Evaluation	Impact Evaluation
Anne Arundel County Department of Health	Gun Violence Intervention Team (GVIT)	Collaborative Building / Gun Lock Distribution	✓	✓
Kingdom Kare	Man Up Anne Arundel	Community Violence Intervention	✓	X
Lead4Life	A Better Way Gun Violence Prevention Program	Youth Violence Prevention and Intervention Programming	✓	X
Mayor's Office of Neighborhood Safety and Engagement (MONSE)	Supporting a Comprehensive CVI Ecosystem for Baltimore City	Collaborative Building	X	X
MedStar Washington Hospital Center	Community Violence Intervention Program (CVIP)	Hospital-based Violence Intervention Program	✓	X
St. Mary's County Health Department	Group Violence Intervention Program (GVI)	Collaborative Building / Group Violence Intervention	✓	X
The Tree House Child Advocacy Center	Problematic Sexual Behavior Program (PSB)	Youth Violence Prevention and Intervention Programming	✓	X
University of Maryland, Baltimore - EMBRACE Initiative	Collaborative Violence Intervention and Prevention Program (CVIPP)	Collaborative Building / Community Violence Intervention	✓	✓
University of Maryland Capital Region Medical Center (UMCAP)	Capital Region Violence Intervention Program (CAP-VIP)	Hospital-based Violence Intervention Program	✓	✓
Wicomico Partnership for Families and Children	Wicomico Violence Free Zones	Youth Violence Prevention and Intervention Programming	X	X

Methods

The **implementation evaluation** used four data collection strategies:

1. Site visits (in person and remote) that included interviews and focus groups with 52 staff across 42 interviews to understand program design, implementation fidelity, strengths, challenges, and populations served;
2. Quarterly programmatic data submitted via secure SharePoint portals, after establishing site specific data use agreements;
3. Participant satisfaction surveys (119 completed) administered in six programs, which assessed perceptions of safety, program engagement, staff relationships, and service value; and
4. Closeout interviews conducted with 12 staff from nine programs to document updates, adaptations, and impacts of funding disruptions.

The **impact evaluation** used two analytical strategies to assess program effects:

1. Difference-in-differences (DiD) with matching
2. Synthetic control methods (SCM)

These methods enabled comparisons of crime or firearm related outcomes in program ("treatment") areas relative to similar non-program ("comparison") areas over time. We also applied SCM to compare Maryland's statewide firearm mortality trends against groups of states with stronger or weaker gun laws to contextualize program-specific findings. Our primary data sources included:

- CDC mortality data (statewide analysis)
- Police incident data (open data portals)
- American Community Survey (ACS) census data
- Program participation and geographic service data

Findings

Across different program models, **implementation evaluation** findings were strong despite structural barriers. Programs demonstrated deep community embeddedness and commitment to trust building, use of credible messengers, trauma-informed approaches, holistic service delivery, and strong interagency collaboration. In terms of participant satisfaction, survey findings demonstrated strong satisfaction, high perceptions of safety, and positive views of staff cultural respect and responsiveness. Programs were able to sustain these positive

outcomes even when faced with major barriers such as short funding cycles and grant terminations, hiring challenges, staff turnover, and resource constraints. Our findings related to program reach are inconclusive given the diversity in programming as well as a lack of consistency in programmatic data collection and standardized definitions.

In contrast, **impact evaluation** findings were mixed:

- **Statewide trends** Our analysis demonstrated that Maryland's firearm death rate decreased more quickly than comparison states beginning in 2023, though statistical significance was limited. Nevertheless, our analyses suggest that Maryland is bucking national trends in firearm-related death rates, but it does not explain what is driving this effect. Nevertheless, this downward trend is important context for interpreting program-level impacts.

- **Program-level impact** Only the Anne Arundel County Gun Violence Intervention Team's gun lock distribution program demonstrated a statistically significant impact, specifically, a 35% reduction in attempted suicides in high-distribution ZIP codes. Other programs (Baltimore CVIPP's community violence intervention program and UMCAP CAP-VIP's hospital-based violence intervention program) showed no statistically significant reductions in firearm related incidents during the evaluation period. However, each of these analyses faces important limitations, and we caution against drawing strong conclusions in terms of whether a program "worked." In particular, both violence intervention programs experienced funding cuts during the study period that altered service delivery. For the HVIP program, key primary outcomes—such as client recovery trajectories and navigation of medical systems—were not available, and limited program volume further reduces the likelihood of detecting changes at broader geographic levels. Additionally, program data were captured at rough geographic scales, constraining our ability to classify and measure treatment areas with precision. These collective constraints, along with the complexities of community violence intervention work, likely contributed to the absence of detectable effects.

Recommendations

The sites in this evaluation are characterized by commitment and deeply relational practice but also constrained by structural instability and limited resources that impact the scalability of their activities. Sustained investment in people, partnerships, and infrastructure is essential

for these programs to realize their full potential and for the communities they serve to experience long-term safety and healing.

For funders:

- **Reconsider the one-year grant cycle** Multiyear grant cycles and support around sustainability planning could help programs retain staff and strengthen their community presence. At a larger scale, major investments to compensate for gaps in federal funding could support the coordination of programs and build regional ecosystems.

- **Reevaluate restrictions on budget amounts** The requirement that subsequent VIPP budget requests decrease by 10% limits sustainability planning and poses challenges for programs that do not have consistent annual resources to cover critical expenses, such as participants' relocation to safe housing.

- **Broaden spending categories** Restrictive spending categories require programs to draw from limited resources to cover resources essential for engagement activities.

- **Allocate resources for programmatic data collection** First, providing financial support to sites for the purposes of data tracking and reporting can reduce staff burden. Second, allocating funds for data-related training and technical assistance can improve the data capacity of programs to more precisely document the work being done and can be utilized for a more robust impact evaluation.

- **Allocate resources for qualitative data collection** Qualitative data can help to contextualize empirical findings, identify unexpected program outcomes, and capture insights from program participants and staff on what works. Conducting in-depth interviews with clients would require funding for travel, food, and incentives.

For programs:

- **Learn about your community and listen to its needs** Staff expressed that for a program to be viewed as legitimate, it must be informed by the people it is designed to serve.

- **Recognize the value of diverse expertise** Hiring staff from communities most impacted by gun violence is crucial.

- **Take a data-driven approach to implementation** Understanding the target population and its needs enables more precise program delivery. Programs with limited data capacity should consider partnering with public agencies or academic institutions.

- **Document events that affect service delivery** These details illuminate how programs can adapt to challenges and are essential for research partners interpreting empirical findings.

- **Provide context for safe storage efforts** Programs distributing gun locks considered how to tailor messaging to communities where firearm ownership is the norm.

- **Practice transparency in community engagement** For programs focused on building collaboratives, sharing information and decision-making authority, especially regarding funding, helps reinforce trust.

- **Develop a contingency funding plan** Programs that experienced funding losses relied on contingency planning.

- **Invest in start-up activities** Programs need time to build partnerships, establish referrals, train staff, and pilot interventions.

- **Engage in ongoing self-reflection** Staff emphasized the importance of monitoring personal biases and recognizing signs of burnout, which is vital for authentic engagement and maintaining service quality.

For researchers:

- **Identify, define, and measure program-specific goals and outcomes** Each VIPP program is unique in its programmatic approach and measurable goals and outcomes. Programs should work with technical assistance providers to define success at both program and individual levels.

- **Focus evaluation resources on programs prepared for rigorous study** Concentrated, high quality evaluations will better inform broader violence prevention and intervention strategies, while studies of programs that are not yet prepared for evaluation risk generating misleading or inconclusive results.

In conclusion, Maryland's VIPP investments have expanded the state's community violence prevention and intervention ecosystem, strengthened community capacity, and supported innovative, trauma-informed programming. While measurable reductions in outcomes were limited, and in some cases not evident, the evaluation shows progress in implementation quality, community trust-building, service delivery, and coordinated response. As VIPP continues to grow and evolve, the lessons learned from this evaluation highlight that working with sites to develop sustainable funding strategies, improved data systems, and continued partnership across agencies will be key to supporting the longer-term impacts of these programs on community safety and well-being.

Chapter 1

Introduction

Despite Maryland having some of the strictest gun laws in the United States,[1] the state has witnessed alarming increases in firearm mortality rates over the years. Between 2014 and 2021, firearm mortality rates increased by 68% and the rate increased each year from 2018 through 2021.[2] These increases were driven primarily by homicides, although firearm-related suicides also rose, aligning with the peak of the COVID-19 pandemic in 2021. Furthermore, while firearm mortality increased statewide, urban areas were disproportionately affected. Baltimore, for example, has been documented as a geographic hotspot, accounting for 67% of homicides in Maryland despite representing only 11% of the state population. The localized and anomalous nature of these trends, particularly when compared to national patterns, has signaled the need for further scientific investigation.[3]

As Maryland emerged from the COVID-19 pandemic, a renewed sense of hope followed as indicators suggested progress in reducing firearm-related fatalities. From 2021 to 2024, the state experienced a 22% decrease in firearm mortality rates.[4] This trend appears largely driven by reductions in homicides, which fell to their lowest levels in nearly a decade, while firearm-related suicides increased by 24% between 2022 and 2025.[5] Baltimore has continued to experience sustained declines in homicides and nonfatal shootings, with each decreasing by more than 50% between 2022 and 2025.[6] The factors driving these statewide and local changes remain unclear, but they may be linked to the ongoing efforts of local communities to implement programming focused on reducing gun violence and promoting the safe storage

[1] Giffords Law Center to Prevent Gun Violence. 2026. *Maryland Gun Laws*. Retrieved July 23, 2026 (https://giffords.org/lawcenter/gun-laws/states/maryland/)
[2] Centers for Disease Control and Prevention. 2026. "Firearm Deaths." Retrieved July 23, 2026 (https://www.cdc.gov/nchs/state-stats/deaths/firearms.html).
[3] Degli Esposti, M., J. Gravel, E. J. Kaufman, M. K. Delgado, T. S. Richmond, and D. J. Wiebe. 2022. "County-Level Variation in Changes in Firearm Mortality Rates Across the US, 1989 to 1993 vs 2015 to 2019." *JAMA Network Open* 5(6):e2215557.
[4] Centers for Disease Control *supra* note 2
[5] Maryland Department of Health. 2026. "Firearm Violence Dashboard." Retrieved July 23, 2026 (https://health.maryland.gov/dataoffice/mdh-dashboards/Pages/firearm-violence.aspx).
[6] Mayor's Office of Neighborhood Safety and Engagement. 2026. "Baltimore Public Safety Accountability Dashboard." Retrieved July 23, 2026 (https://www.baltimorecity.gov/monse/baltimore-public-safety-accountability-dashboard).

of firearms.

To support these local efforts, Governor Lawrence J. Hogan, Jr. approved House Bill 432 in 2018, establishing the Maryland Violence Intervention and Prevention Program (VIPP) Fund.[7] Administered by the Governor's Office of Crime Prevention and Policy (GOCPP), VIPP supports evidence-based and evidence-informed violence reduction strategies, particularly those focused on gun violence, through programs implemented across the state.[8] These approaches include:

- Nationally recognized models such as hospital-based violence intervention programs, street outreach (e.g., Cure Violence), cognitive behavioral therapy, group violence intervention, and crime prevention through environmental design;
- Adaptations of existing models; and
- Locally developed approaches informed by research, best practices, and/or community experience.[9]

In 2021, researchers from Johns Hopkins University conducted a mixed-methods evaluation of an early cohort of VIPP grantees and found that although programs made substantial efforts, their limited scale prevented them from achieving measurable reductions in gun violence.[10] Researchers emphasized that this did not indicate program failure; rather, the evaluation context, characterized by the pandemic and other external factors, warranted a broader definition of success beyond crime trends.

In 2023, GOCPP funded the Center for Justice Innovation (the Center) to conduct the second evaluation of a cohort of VIPP grantees. This mixed methods evaluation had two primary objectives:

- Conduct an **implementation evaluation** of the programs funded under VIPP, seeking to understand the programs' operations and document fidelity to intended plans,

[7] Maryland General Assembly. 2018. *House Bill 432*. Retrieved July 23, 2026 (https://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_148_hb0432E.pdf).
[8] Governor's Office of Crime Prevention and Policy. 2026. *Violence Intervention and Prevention Program (VIPP)*. Retrieved July 23, 2026 (https://gocpp.maryland.gov/grants/programs/vipp/).
[9] Governor's Office of Crime Prevention and Policy. 2026. *Violence Intervention and Prevention Program (VIPP): Explained*. Retrieved July 23, 2026 (https://gocpp.maryland.gov/wp-content/uploads/VIPP_-Explained.pdf).
[10] Reid, Alan, S. Ross, and J. Morrison. 2021. *A Third-Party Evaluation of the Maryland Violence Intervention and Prevention Program (VIPP) Implementation*. Retrieved July 23, 2026 (https://gocpp.maryland.gov/wp-content/uploads/MD-VIPP-Evaluation-Report.pdf).

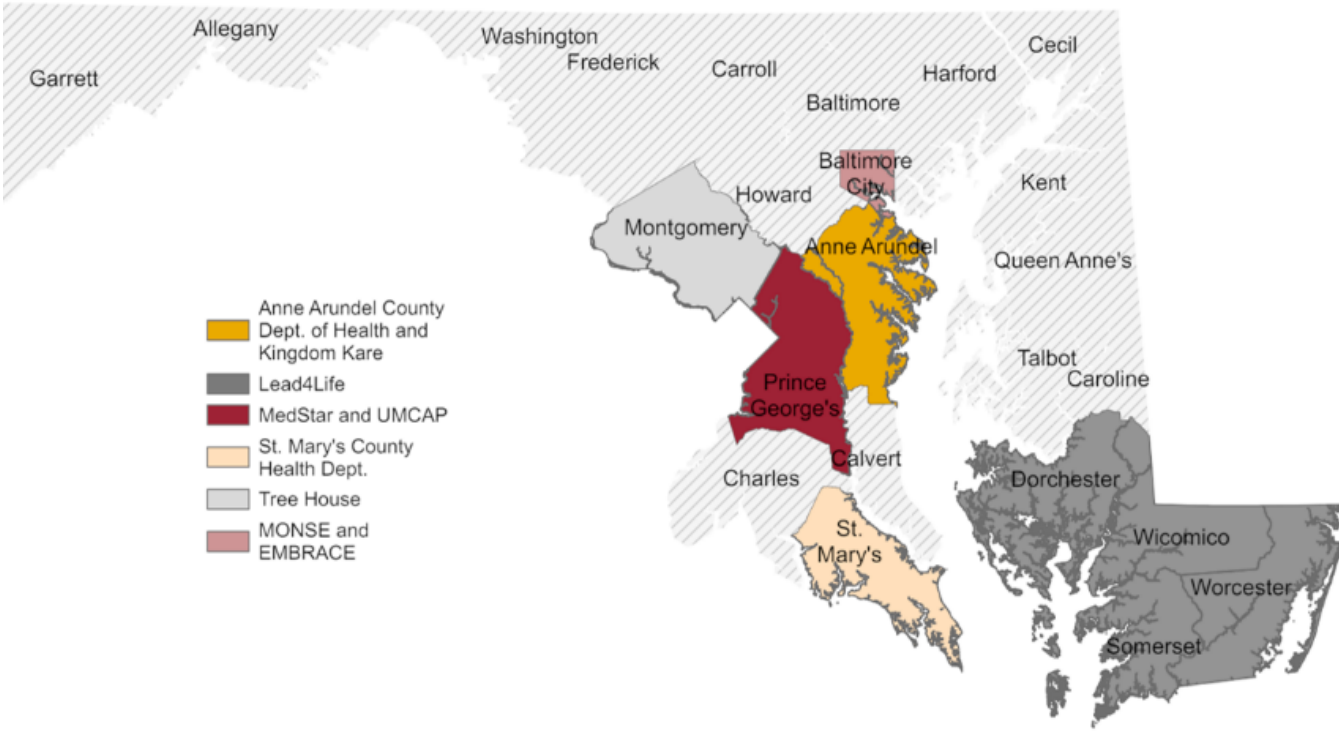
including a description of any adaptations to evidence-based models and reasons for changes.

- Conduct an **impact evaluation**, informed by implementation evaluation findings, to look at changes in community indicators of violence. The key research questions include: 1) How do Maryland's firearm-related death trends compare to those in other states following Maryland's investment in evidence-informed programming? and 2) For each program model with sufficient data, what has been the effect at the local level on violent crime or firearm-related incidents?

VIPP Grantees

The FY24 cohort initially consisted of ten programs; eight are included in this evaluation. The VIPP grantees included in the evaluation served Anne Arundel County (including Pioneer City), Baltimore City (specifically the Upton neighborhood of West Baltimore), the Lower Eastern Shore (Dorchester, Somerset, Worcester, and Wicomico counties), Montgomery County, Prince George's County, and St. Mary's County. This is displayed in *Figure 1.1.*

Figure 1.1. Map of FY24 VIPP Grantees' Service Areas



The two programs in the cohort that are not in the evaluation are the Wicomico Partnership for Families and Children and the Mayor's Office of Neighborhood Safety and Engagement (MONSE). Wicomico received funding to support youth mentoring and after-school programming but ceased operations during the first year of the project. MONSE experienced significant turnover and staff vacancies across the evaluation period, limiting engagement with the evaluators. While MONSE staffing stabilized in late 2025, staff turnover on the evaluation team in early 2026 further complicated engagement. MONSE staff participated in a closeout interview in May 2026, but no additional research activities.

As shown in *Table 1.1*, program approaches and funding amounts varied across sites. A total of $6,191,207 in VIPP funding was allocated to this cohort, with an average award of $619,121. Details about each program's model and activities are presented in Chapters 3 (youth violence prevention and intervention programs), 4 (community violence intervention programs), 6 (hospital-based violence intervention programs), and 8 (public-health led collaboratives).

Table 1.1. VIPP Grantees and Funding Received

Site	Project Name	Model	FY24 Award	FY25 Award	FY26 Award	Total
Anne Arundel County Department of Health	Gun Violence Intervention Team (GVIT)	Collaborative Building / Gun Lock Distribution	$143,720	$200,000	$135,000	$478,720
Kingdom Kare	Man Up Anne Arundel	Community Violence Intervention	$399,146	$175,000	$118,125	$692,271
Lead4Life	A Better Way Gun Violence Prevention Program	Youth Violence Prevention and Intervention Programming	$82,141	$175,000	$157,500	$414,641
Mayor's Office of Neighborhood Safety and Engagement (MONSE)	Supporting a Comprehensive CVI Ecosystem for Baltimore City	Collaborative Building	$339,950	$175,000	$118,125	$633,075
MedStar Washington Hospital Center	Community Violence Intervention Program (CVIP)	Hospital-based Violence Intervention Program	$267,593	$200,000	-	$467,593
St. Mary's County Health Department	Group Violence Intervention Program (GVI)	Collaborative Building / Group Violence Intervention	$318,901	$200,000	$134,483	$653,384
The Tree House Child Advocacy Center	Problematic Sexual Behavior Program (PSB)	Youth Violence Prevention and Intervention Programming	$254,872	$200,000	-	$454,872
University of Maryland, Baltimore - EMBRACE Initiative	Collaborative Violence Intervention and Prevention Program (CVIPP)	Collaborative Building / Community Violence Intervention	$399,740	$200,000	$179,956	$779,696
University of Maryland Capital Region Medical Center (UMCAP)	Capital Region Violence Intervention Program (CAP-VIP)	Hospital-based Violence Intervention Program	$244,900	$943,347	$299,671	$1,487,918
Wicomico Partnership for Families and Children	Wicomico Violence Free Zones	Youth Violence Prevention and Intervention Programming	$129,037	-	-	$129,037

Implementation Evaluation Methodology

The implementation evaluation included four primary data collection methods:

1. **Site visits** with key program staff, partners, and stakeholders;
2. **Quarterly programmatic data reports** documenting quantitative outputs;
3. **Participant satisfaction surveys** at select sites; and
4. **Closeout interviews** with key program staff.

A summary of the data collection schedule is provided in *Table 1.2*. Programs were invited to review and provide feedback on their site reports prior to finalization.

Table 1.2. Implementation Evaluation Data Sources

Site	Site Visit Date(s)	# of Interviews	# of Interviewees	Programmatic Data Reports	Participant Survey	Closeout Interview	# of Interviewees
Anne Arundel County Department of Health	Sept. 2024	4	4	✓	X	Mar. 2026	1
Kingdom Kare	Oct. 2024	6	8	✓	✓	Apr.2026	2
Lead4Life	Oct. and Nov. 2024*	4	4	✓	✓	Apr. 2026	1
Mayor's Office of Neighborhood Safety and Engagement (MONSE)	X	-	-	X	X	May 2026	1
MedStar Washington Hospital Center	Sept. 2024	8	8	✓	✓	Mar. 2026	1
St. Mary's County Health Department	Nov. and Dec. 2024*	3	3	✓	✓	Mar. 2026	2
The Tree House Child Advocacy Center	Oct. 2024*	4	7	✓	✓	Mar. 2026	2
University of Maryland, Baltimore - EMBRACE Initiative	Sept. 2024	4	9	✓	X	Mar. 2026	1
University of Maryland Capital Region Medical Center	Sept. 2024	9	9	✓	✓	Mar. 2026	1

Note: Sites with an asterisk participated in a remote site visit.

Site Visits

We conducted site visits with eight programs in 2024. Five visits occurred in person and three remotely, with follow-up interviews scheduled as needed. We interviewed program representatives in both administrative and direct service roles to understand program models, implementation strengths and challenges, and populations served. Interview topics covered seven substantive domains:[11]

1. **Program management and oversight** Including staffing structure; responsibilities of staff roles; hiring strengths and challenges; and training.
2. **Interagency collaboration** Including collaborations with other agencies; rationale behind collaboration; strengths and challenges associated with collaboration; and opportunities to engage with new partners.
3. **Program population** Including target populations; catchment areas; and participant recruitment, screening, and assessment.
4. **Program activities** Including primary program activities; description of program model; planning and implementation of program model; shared similarity with other gun violence programs; challenges to providing services; and fidelity to program model (including the rationale associated with any deviation).
5. **Perceived impact** Including interviewees' perceptions of the program's effect on individual clients and the community; program successes; and appropriateness of the model for the local community and target population.
6. **Barriers, facilitators, and sustainability** Including political, legislative, and community factors that potentially impacted the program (positively or negatively); plans for continued programming after the grant period ends; and other available resources identified to sustain programs.
7. **Recommendations and lessons learned** Including strengths, challenges, and lessons learned from implementation; broad feedback on VIPP; and recommendations that would enhance programming.

A total of 42 interviews and focus groups were conducted with 52 staff members. Interviews and focus groups lasted 30-90 minutes, were audio-recorded with permission, and were later transcribed. At several sites, evaluators also joined staff in the field.

[11] Study materials are available upon request. All protocols were approved by the Center's Institutional Review Board.

Quarterly Data Reports

We secured site-specific data use agreements (DUAs) at seven of the ten sites.[12] Although a single statewide DUA was initially planned, variation in program models and legal considerations led to a site-specific approach.[13] Members of the evaluation team engaged in conversations with key points of contact for data at each site to better understand 1) what data the sites are tracking and 2) how they are tracking it. After DUAs were executed, each site received a secure SharePoint link for quarterly data transfers.

Participant Satisfaction Surveys

To gauge participant satisfaction with those sites where appropriate, we created a web-based survey hosted on SurveyMonkey. Although the content was tailored to each site, the general domains included closed-ended questions about program involvement, satisfaction with program services, perceived impact of the program, and demographics. Participants could also answer open-ended questions where they could expand upon their responses. The survey consisted of 23 questions and was designed to take 10-15 minutes to complete.

We worked closely with staff at each program to field the survey, typically accessed through a link or QR code, with English and Spanish versions available.[14] Surveys were intended for participants aged 14 years or older, except in programs serving younger children (i.e., the Tree House), where legal guardians completed the survey. All programs used a site-specific secure spreadsheet to provide enrollment dates and unique IDs for participants, enabling us to calculate target survey dates and send weekly reminder emails to staff responsible for survey distribution. The breakdown of participants who accessed and completed the survey is presented in *Table 1.3*. In total, 211 individuals accessed the SurveyMonkey link across programs and 119 provided responses.[15]

We determined that participant satisfaction surveys were appropriate in six of the ten sites.

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[12] One site, EMBRACE, only transferred aggregate data rendering a DUA unnecessary. A DUA was never developed with MONSE. However, the evaluation team was able to extract data from MONSE's public dashboard to conduct the impact analysis of EMBRACE (see Chapter 5). Wicomico ceased operation during the first year of the project and never developed a DUA.

[13] Given the site-specific approach to the DUAs, the program outputs presented in this evaluation may not align with the outputs that programs submit to GOCPP for the purposes of grant reporting.

[14] Almost all respondents completed the survey in English; the Spanish survey was completed by 11 guardians of children enrolled in programming at The Tree House.

[15] In an effort to improve the response rate, we implemented a raffle near the end of 2025 where participants could enter to win one of 10 $25 prizes, to be delivered in the form of a gift card or cash app payment. Only two participants agreed to enter the raffle.

Two of the non-survey sites are coalitions and do not work directly with participants (Anne Arundel County Health Department and MONSE) and so were excluded from this research activity. The third non-survey site (EMBRACE) does work directly with participants, but in a high-risk setting where satisfaction surveys would not be appropriate.

Table 1.3. Participant Satisfaction Surveys by Site

Site	Who Completed the Survey	Survey Timing After Enrollment	# of Clients Who Accessed Survey	# of Clients Who Completed Survey
Kingdom Kare	Participants aged 14+	90 days	49	39
Lead4Life	Participants aged 14+	60 days	16	11
MedStar	Participants aged 14+	90 days	12	3
St. Mary's County Health Department	Participants aged 14+	60 days	N/A	N/A
The Tree House	Parents of participating children	60 days	39	28
University of Maryland Capital Region Medical Center	Participants aged 14+ and Men's Group participants	30 days and quarterly (Men's Group)	95	38
Total			**211**	**119**

Closeout Interviews

In Spring 2026, we conducted remote closeout interviews with key program staff to document program updates since the 2024 site visits. Although the evaluation team remained in contact with programs throughout the project, the closeout interviews provided an opportunity to formally re-administer the interview protocol and assess how federal-level changes (i.e., grant cancellations and budget cuts) affected local implementation. Nine interviews with 12 staff members were conducted between March and May 2026. All interviews were recorded with permission and transcribed.

Impact Evaluation Methodology

The impact evaluation had two major approaches:

1. An analysis of national firearm-related death trends relative to trends in Maryland to contextualize local findings (Chapter 2); and
2. Impact evaluations of three VIPP-funded programs, representing three program types: community violence intervention in Baltimore City (Chapter 5 – EMBRACE CVIPP), hospital-based violence intervention in Prince George's County (Chapter 7 – UMCAP CAP-VIP), and gun lock distribution in Anne Arundel County (Chapter 9 - GVIT).

Although a broader range of VIPP-funded programs merits evaluation, this report focuses on these three jurisdictions, representing three of the four program types, because they provided sufficient programmatic detail to identify treatment groups, and had accessible geocoded data on crime incidents and injuries spanning at least one year before and after the introduction of VIPP funding.[16]

As part of this funding cohort, these three programs received additional VIPP funding (all having previously received VIPP funding in the 2018 cycle) to launch or expand operations mid-2023. This timing overlapped with a period of substantial increases in gun assaults from 2020 to 2023, followed by declines through 2025 to levels lower than before the pandemic.[17] We used two research approaches—difference-in-differences with matching and synthetic control methods—that attempt to separate the effects of the intervention from broader trends affecting all areas. Rather than focusing on overall changes in crime, both approaches compare changes in treatment areas to those in similar comparison areas. This is important because crime declined in many places during the evaluation period for reasons unrelated to VIPP funding. For example, if crime falls by 10 percent in treatment areas but also falls by 5 percent elsewhere, the additional 5 percent decline could be attributable to the intervention, but not the full 10 percent. The national trends analysis uses only synthetic control methods, while the site-specific impact evaluations use both designs. *Table 1.4* summarizes data sources and analytic approaches for each site.

[16] The two sites categorized as delivering youth violence prevention and intervention programming, Lead4Life and The Tree House, lacked the data required to be included in the impact evaluation. We present findings from the implementation evaluation in Chapter 3.
[17] Lopez, Ernesto, and B. Boxerman. 2026. *Crime Trends in U.S. Cities: Year-End 2025 Updates*. Washington, DC: Council on Criminal Justice. Retrieved July 23, 2026 (https://councilonj.org/crime-trends-in-u-s-cities-year-end-2025-update/).

Table 1.4. Overview of National Trend Analysis and Impact Evaluation Designs

Analysis Focus	Data Sources	Study Design(s)	Study Period
National Firearm-Related Death Trends	Center for Disease Control: Firearm-related Deaths	Synthetic Control	2014-2024
Community Violence Intervention (Baltimore City)	Open Data Incidents, ACS	Difference-in-Differences, Synthetic Control	2022-2025
Hospital-based Violence Intervention (Prince George's County)	Open Data Incidents, Program Participation Data, ACS	Difference-in-Differences, Synthetic Control	2022-2025
Gun Lock Distribution (Anne Arundel County)	Open Data Incidents, Gun Lock Distribution Data, ACS	Difference-in-Differences, Synthetic Control	2021-2025

Difference-in-Differences with Matching Design (DiD)[18]

DiD compares the relative change in crime outcomes before and after the VIPP intervention begins for the treatment group (areas where the program is implemented/expanded) to a matched comparison group with similar incident trends before the VIPP intervention. Our models also included fixed-effects for the geographic unit and year/quarter; the former accounts for any time-invariant difference between geographic units, such as being patrolled by different police units, and the latter accounts for quarterly time effects that impact all units.[19] The main condition that needs to be met for causal inference is that the crime trends move in parallel leading up to intervention. Observing parallel trends allows us to infer that these two groups are both impacted by similar factors, and the only difference after a specific point in time (in this case, the start of VIPP funding) is the new intervention; thus, any differential change in crime can be attributed to the intervention. However, because the treatment areas generally exhibit higher crime rates and experience more socioeconomic challenges than surrounding areas, it may not be possible to find suitable comparison units

[18] For more detail see Cunningham, Scott. 2021. *Causal Inference: The Mixtape*. New Haven, CT: Yale University Press. Retrieved July 23, 2026 (https://mixtape.scunning.com/09-difference_in_differences).

[19] We use two-way fixed-effect Poisson difference-in-differences models. Estimates can be interpreted as a percent change in the expected number of crime incidents. Standard errors are clustered at the geographic level, such as census tract, to account for correlation of errors within a geographic unit and heteroskedasticity. When standard errors are not clustered, the standard errors are biased downward and increase the likelihood of overstating statistical significance. More specifically, the model is: $log\left(E\left[Y_{\{it\}}\right]\right) = \sum_{\{k \neq 0\}} \beta_k D^k_{\{it\}} + \alpha_i + \gamma_t$. $Y_{\{it\}}$ is the crime outcome in tract i and time t. $D^k_{\{it\}}$ if tract i is treated and at event time k, 0 otherwise. The post period will vary by intervention based on when the program was implemented. α_i is the tract fixed effects. γ_t is the year/quarter fixed effects.

that exhibit parallel trends to the treatment group.

Synthetic Control Methods (SCM)[20]

SCM can help to construct comparison groups in cases where there are no suitable matches with similar pre-intervention crime trends. This is accomplished by assigning weights to comparison units that indicate how closely their pre-intervention crime trends match those of the treatment areas.[21]

The synthetic control method assigns larger weights to comparison units with similar pre-trends to the treatment units.[22] If the pre-trends are tightly matched, this approach then estimates the difference in outcomes in the post-period. Some challenges of this approach are that the comparison group may only be composed of a handful of cases, or the approach overfits the comparison cases in a way that assigns minuscule weights to many comparison units which makes interpretability difficult. In other words, overfitting may create a synthetic group that is fit to noise in the data rather than substantive, structural trends.

While our preferred approach is the DiD and matching design due to its transparency and easier interpretability, SCM is an important alternative approach when we encounter conditions that violate the assumptions necessary for the DiD design. Further, consistent findings across both methods lend more confidence to any statistically significant findings.

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[20] Cunningham *supra* note 18

[21] For the assessments of national trends, we use the "Synth" package in R. For the impact evaluations, we use an extension of SCM through the "microsynth" package in R that can be utilized in scenarios with multiple treatment units and disaggregated, micro-level data and can be used in scenarios. This method can help improve the fit of synthetic control group, the precision of treatment effect estimates, and enable permutation inference. See Neil, Roland, Bonnie Ghosh-Dastidar, Beau Kilmer, Michael W. Robbins, and Kristin Warren. 2025. "The Impact of Drug Possession Decriminalization on Arrests: A Race-Specific Synthetic Control Analysis of Oregon's Measure 110." *Journal of Quantitative Criminology*. doi:10.1007/s10940-025-09632-8; Robbins, Michael W., and Steven Davenport. 2021. "microsynth: Synthetic Control Methods for Disaggregated and Micro-Level Data in R." *Journal of Statistical Software* 97(2):1–31. doi:10.18637/jss.v097.i02; and Robbins, Michael W., Jessica Saunders, and Beau Kilmer. 2017. "A Framework for Synthetic Control Methods With High-Dimensional, Micro-Level Data: Evaluating a Neighborhood-Specific Crime Intervention." *Journal of the American Statistical Association* 112(517):109–126. doi:10.1080/01621459.2016.1213634.

[22] As an example, consider that the treatment group has 6 units and the pool of potential comparison cases has 50 units. One comparison unit that is almost identical to the treatment group is a given weight of 2, three similar comparisons are assigned a weight of 1, four comparison units that are loosely similar are given weights of 0.25, and the remaining comparison units are assigned a weight of 0.

Both approaches are still dependent on what the data can capture: due to lack of access to more granular data, we were unable to study the efficacy of these interventions in other key domains like treatment linkages, recovery from injuries, medical legal need, or victim compensation, which is where a hospital-based program is likely to have a larger impact, rather than in crime reduction. In the chapters presenting impact evaluation findings (Chapters 2, 5, 7, and 9), we provide more details on the limitations and caveats related to each evaluation alongside the findings.

Chapter 2

National Trends

This chapter examines how firearm-related death rates in Maryland compare to national trends. This analysis is meant to provide an overview of general firearm-related death trends in the state, giving context for the three impact evaluations in this report. This analysis suggests that Maryland's firearm death rate has decreased relative to other states since 2023. However, as we discuss later in this chapter and in later chapters, we cannot confidently attribute changes in Maryland's outcomes directly to VIPP-funded interventions. This caution is due to both a lack of strong findings in the impact evaluations (Chapters 5, 7, and 9) and limitations outlined later in this chapter.

Data

This analysis uses mortality data for 2014-2024 from the Centers for Disease Control and Prevention, which reports annual firearm death rates per 100,000 people in each state. This dataset allows for consistent comparisons across states. The primary analysis compares Maryland to national trends, with a focus on 2023-2024. This treatment period aligns with the latest round of VIPP funding for violence prevention and intervention.

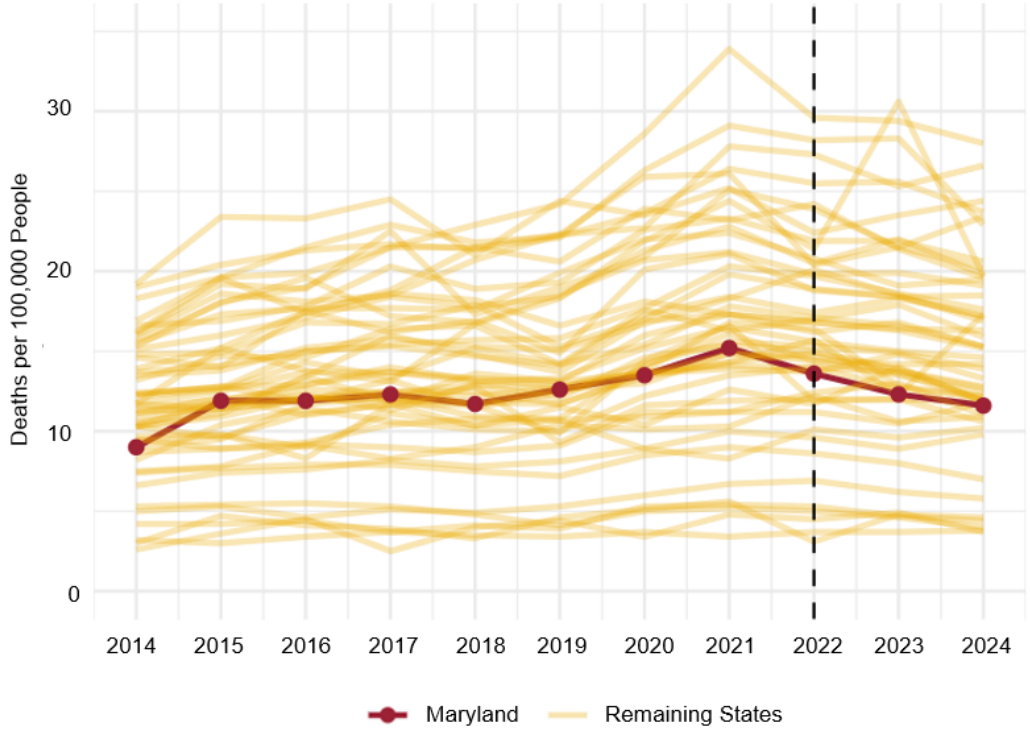
We also compare Maryland to two groups of states, comprised of nineteen states each, based on gun law strength, using ratings from Giffords Law Center to Prevent Gun Violence. One group contains states that have similar gun laws to Maryland; the states in the second group all have weaker gun laws. Maryland ranks eighth nationally in gun law strength, with policies such as universal background checks, permit requirements, restrictions on certain firearms, open carry regulations, and investments in community violence prevention. The states with the weakest gun laws generally lack a majority or the full range of these policies.

Firearm Death Trends

Maryland has historically had lower firearm death rates than many states. *Figure 2.1* displays the firearm death rate for Maryland versus the other 49 states and the District of Columbia. Between 2014 and 2022, Maryland had an average annual firearm death rate of 12.4 per 100,000 people, while the remaining states and DC combined had an average annual firearm death rate of 13.9 per 100,000 people. Maryland had the 19th lowest annual firearm death rate.

Looking again at *Figure 2.1*, while Maryland followed national increases in firearm deaths through 2020-2021, its trend began to decrease after 2022, diverging from the national pattern. The legislation creating VIPP was passed in 2018 with many grantees from the first wave of funding becoming fully operational during the 2020-2021 peak. Since 2022, Maryland's firearm death rate has consistently declined relative to the rest of the country. In 2023 and 2024, Maryland's annual death rate was 12.0 per 100,000 people, while the rest of the country had an average annual death rate of 15.1 per 100,000 people. These statistics suggest that with its decreasing death rates, Maryland is bucking national trends while the rest of country experiences an uptick or slower declines in firearm-related death rates. In the post period (after 2022), which includes the start of the 2023 round of VIPP funding, Maryland drops to the 14th lowest firearm death rate of all states.

Figure 2.1. Death by Firearm Rates by State



Note: This figure shows death by firearm per 100,000 people for Maryland versus the rest of the United States.

Analytic Approach

To assess whether Maryland's recent decline since the 2023 round of VIPP funding is statistically different from the trends in other states, we use synthetic control methods. This involves creating one or more counterfactual groups of states with similar firearm death rate trends leading up to the 2023 VIPP funding. Essentially, for each synthetic control group, all non-Maryland states in that category comprise the "donor pool", and each state is given a

different weight so that the synthetic control group has a pre-period trend matching that of Maryland.[23] We use three synthetic control groups: the first group's donor pool consists of all states and DC, the second group includes states with similar gun laws to Maryland, and the final group includes states with the weakest gun laws. Compared to the latter, Maryland should experience larger declines given its strong investments in firearm death prevention. This approach allows us to test whether Maryland's trends differ across relevant policy environments.

Findings

Analyses using each of the three synthetic control groups suggest that the death rate trends in Maryland are falling more quickly than in other states. *Table 2.1* shows that Maryland's death rate was 11 to 14 percent lower than the synthetic control group, and *Figure 2.2* shows a consistent decline for Maryland against each of the comparison groups. However, for the most part, these differences are not statistically significant; Maryland's trend exhibits marginal statistical significance when compared to the weak gun law states.[24]

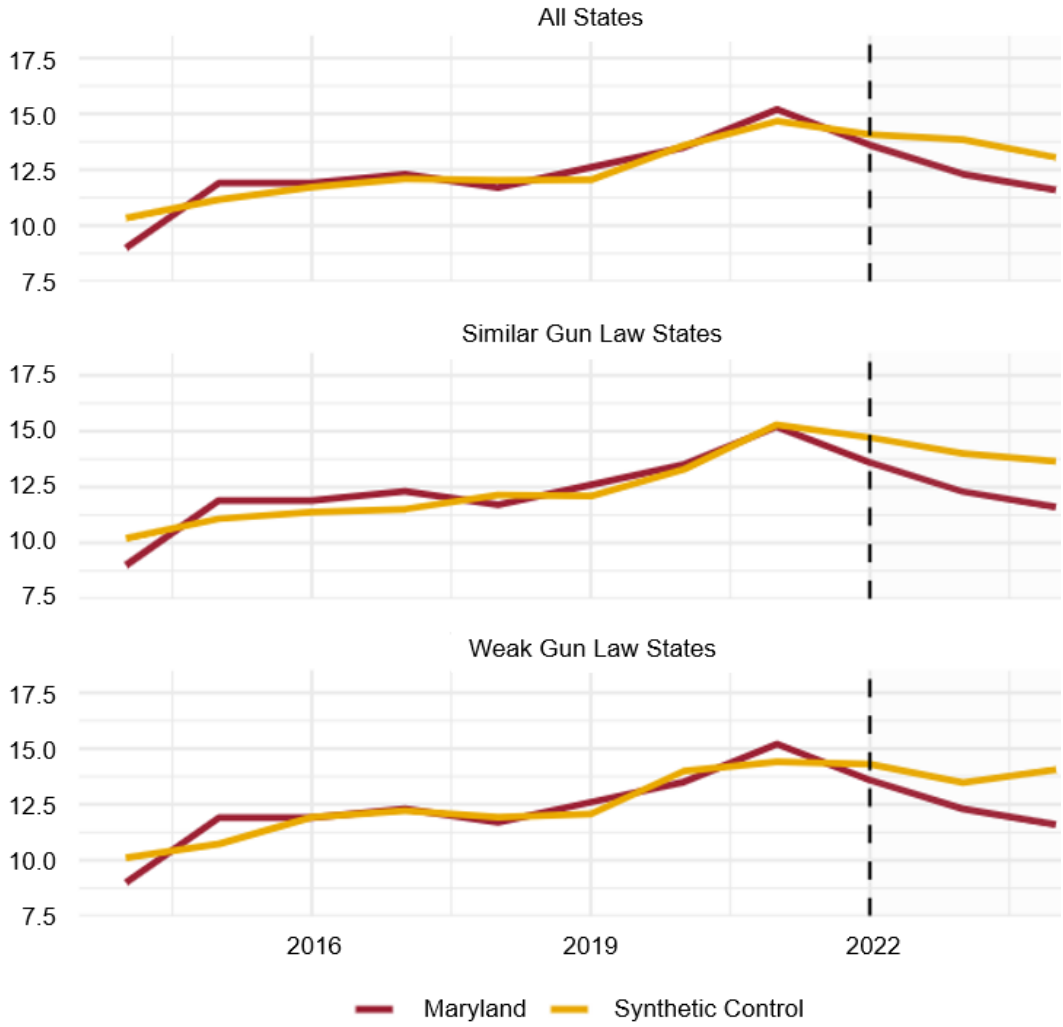
Table 2.1. Treatment Group versus Synthetic Control Results

Synthetic Control Group	Maryland Deaths per 100,000	Synthetic Control Deaths per 100,000	Percent Difference	Permutation P-Value	Maryland RMPSE
All States	11.95	13.45	-11%	0.14	2.46
Similar Gun Law States	11.95	13.83	-14%	0.20	2.60
Weaker Gun Law States	11.95	13.77	-13%	0.10	2.79

Note: This table displays the average death rate in the post period for Maryland versus the three synthetic control groups that pull from different subsets of states. The p-values are calculated by comparing Maryland's Root Mean Square Predicted Error (RMSPE) to the RMSPE from each of the permutations where the other state is categorized as the treatment group.

[23] We used the Synth package in R (see Abadie, Alberto, Alexis Diamond, and Jens Hainmueller. 2011. "Synth: An R Package for Synthetic Control Methods in Comparative Case Studies." *Journal of Statistical Software* 42(13):1–17. doi:10.18637/jss.v042.i13). This package uses the root mean squared predicted error (RMPSE) which is the difference between the predicted and observed outcomes for the post-period divided by the predicted and observed outcomes for the pre-period. Subsequently, the rankings of RMPSE from permutations are used to determine the p-value. A larger RMPSE indicates a large deviation in death trends. With the subgroup analyses, Maryland's RMPSE needs to be within the largest two to be statistically significant.
[24] *Figure A.1* and *Figure A.2* show the underlying permutations and test statistics used to determine statistical significance.

Figure 2.2. Firearm Death Rates for Maryland versus Synthetic Controls



Note: This figure shows death by firearm per 100,000 people for Maryland versus the synthetic controls that draw from different pools: all states, 19 states with similar gun laws to Maryland, and 19 states with weak gun laws. The dashed line indicates the period before VIPP-funding in 2023.

Summary and Limitations

Maryland's firearm death rate appears to be decreasing at a quicker rate than that in most states. As a robustness check, we ran two placebo tests using the same analyses but with the post period shifted to an earlier start date—one test using 2022 and one test using 2021. These placebo tests find null results, strengthening confidence in the main findings: Maryland's firearm death rate decreased more quickly relative to other states starting in 2023. However, there are substantial limitations in discerning whether the VIPP-funded programs drive the decrease. For instance, other factors or combinations of factors, such as changes in law enforcement priorities or the re-opening of public schools after the pandemic, could also affect firearm death rates.

Another limitation of this high-level analysis is that it lacks more granular data on what types of firearm deaths are falling; analyses of such data could provide more context on whether specific VIPP-funded interventions may be tied to the decrease. In addition, the data is organized at the annual level, which prevents us from mapping the analysis to the exact timing of this most recent round of VIPP funding. The data also ends in 2024, which prevents us from observing long term effects where VIPP-funded programs would have had more time for implementation. The subsequent impact evaluations in this report (Chapters 5, 7, and 9) take a deeper look at three programs' potential effects on these trends while implementation evaluation findings (Chapters 3, 4, 6, and 8) provide insight into individual program models, activities, and local context.

Chapter 3

Youth Violence Prevention and Intervention Programs

Youth violence prevention and intervention programs aim to reach young people before violent incidents occur or, when they do occur, before patterns of involvement become entrenched. The two programs examined in this chapter, Lead4Life's A Better Way Gun Violence Prevention Program and The Tree House Child Advocacy Center of Montgomery County's Problematic Sexual Behavior Program (PSB), represent distinct but complementary approaches to this goal. A Better Way provides wraparound violence prevention and intervention services to youth and young adults in Maryland's rural Lower Shore region, using a restorative, person-centered model to address violence and, for youth with offense histories, reduce reoffending. The Tree House's PSB program takes a clinical approach, delivering evidence-based group therapy to school-aged children exhibiting problematic sexual behaviors, with the understanding that early intervention addressing risk factors in childhood can reduce the likelihood of antisocial and violent behavior later in life. Though different in population and method, both programs share a commitment to trauma-informed practice, multidisciplinary collaboration, and meeting clients where they are. In this chapter, we describe each program's design, implementation, perceived impact, and the shared challenges that have shaped their operations during the evaluation period.

Lead4Life, Inc.’s A Better Way Gun Violence Prevention Program

Lead4Life (L4L) is a community-based youth development nonprofit founded in 2008 to serve youth, young adults, and families across Maryland. The organization’s goal is to reduce the number of youths entering the juvenile justice system, out-of-home placements, and youth recidivism rates. L4L delivers programming grounded in restorative practices and strengths-based, trauma-informed models. Specific to gun violence prevention, A Better Way is a peer-supported model that provides wraparound services to youth and young adults who have direct experience with gun violence or gun-related charges, or who are at high risk of such involvement, in Maryland's Eastern Shore region.

L4L first received VIPP funding in July 2023, which supported program personnel, services,

and training. As will be described below, the service delivery model shifted in September 2025 from one-on-one case management and mentoring to group programming facilitated in a drop-in center environment.

Program Description

Formerly known as the Gun Diversion Program, the initiative was rebranded as A Better Way to reduce stigma and broaden its appeal. In addition to the name change, the program was reframed to focus more broadly on violence prevention, with a specific emphasis on gun violence. The prior name, with its explicit reference to gun violence, often deterred participation, particularly among parents, and created hesitancy among referral partners such as probation officers, judges, and caseworkers. Since rebranding, staff have observed increased engagement and stronger support from system partners, including more frequent invitations to participate in court proceedings.

Eligibility Criteria A Better Way primarily serves individuals aged 16 to 24. However, participants as young as 13 may be accepted, particularly when referred by the Department of Juvenile Services. Eligibility also requires residency within Maryland's Lower Shore region, which consists of Dorchester, Somerset, Worcester, and Wicomico Counties. In practice, the program focuses on specific communities within these counties; however, staff agreed that the defined catchment area of the entire Lower Shore region is appropriate and does not require expansion or reduction.

Staff have developed working relationships across all four counties in the broad geographic region; however, the depth of these partnerships varies. Staff also highlighted significant differences in weapon use across counties. For example, some counties experience higher rates of knife-related violence, while others have seen increases in gun use, particularly among young women involved in gang activity. Poverty levels and the strength of the local service infrastructure also vary, shaping how programming is implemented across counties.

Recruitment and Screening Referrals originate from multiple sources, including the Department of Juvenile Services, the Department of Social Services, school resource officers, parole and probation officers, public defenders, courts, and the State's Attorney's Office. Parents may also reach out to request court advocacy for their child's participation. The program manager reviews each referral and contacts the youth or their parent or guardian to initiate intake. Intakes are typically conducted within 48 hours, though scheduling conflicts, particularly with parents, may extend this timeline.

As a Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited agency, L4L is contractually required to administer screening assessments during intake, touching on certain specified domains such as substance use and mental health.[25] L4L developed an in-house biopsychosocial assessment to measure these domains and help identify the youths' needs and goals. Staff strive to administer assessment questions in a conversational manner, avoiding the rigidity of overly structured tools, to build rapport while maintaining fidelity to required instruments.

Specific to gun violence, clients are screened using the Better Way Violence Prevention Questionnaire, which includes five targeted questions assessing participants' access to and involvement with firearms. Staff noted significant variation; some youths are actively engaged with firearms, while others report carrying primarily for protection. For example, staff described a successful student athlete who carried a firearm for personal safety despite not engaging in high-risk activities. Staff also reported an increase in youth use of Orbeez guns, which fire non-lethal water bead projectiles that can cause serious injury.

The program manager reviews the intake and assessment results to determine program fit. Youth assessed as being at higher risk and more deeply engaged with firearms are enrolled in A Better Way, while lower-risk youth may only be referred to L4L's mentorship or anger management services. If enrolled, L4L notifies the referring agency and schedules services, including group sessions and one-on-one mentorship.

Program Activities

A Better Way is a 12-week violence prevention and intervention program serving both system-involved youth and those who have not yet had contact with the legal system but are at high risk of future involvement. Participants may voluntarily continue services beyond 90 days, or legal mandates may require extended participation. The program conducts evaluations at 30, 60, and 90 days to assess compliance and progress. Upon successful completion, a letter of discharge is given.

The program employs a restorative, person-centered approach emphasizing accountability and individualized support. Staff consider this model a core strength, particularly when working with youth who carry weapons. For example, when a youth identifies protection as their reason for carrying a firearm, staff collaborate to establish goals and connect them to

[25] CARF is an independent nonprofit accreditor of health and human services. The international accreditation agency helps ensure the quality of services provided and that agencies are following established standards for quality, safety, and client-centered care.

appropriate services. These goals may include gun violence prevention education (e.g., firearm laws) as well as broader objectives such as securing employment or obtaining a learner's permit or driver's license.

Most participants attend weekly group sessions, and individual sessions are offered as appropriate – for example, for participants over age 18 or those not currently enrolled in school. Given that both victims and those who have perpetrated violence may be referred, staff take precautions to prevent them from being placed in the same group and may assign individual sessions when needed to ensure safety, particularly to keep victims separate from their perpetrators.

As of the 2024 site visit, key services provided by the program included:

- **Group Counseling Sessions** Delivered using a life coaching approach, groups were held on a weekly schedule across the Lower Shore counties: Dorchester (Monday), Wicomico (Tuesday and Thursday), Somerset (Wednesday), and Worcester (Friday). The program manager coordinated pick-up and drop-off transportation.
- **Individual Counseling Sessions** Conducted weekly, sessions were held both in person and virtually.
- **Anger Management** A six-week program with weekly meetings was led by a certified specialist. The program followed a curriculum developed by L4L, which is rooted in a restorative practice model. While not a core component of A Better Way, many court-mandated youth were required to attend, and others attended voluntarily. Participants received a certificate upon completion.
- **Crisis Intervention** Mentors responded to crises as needed. Participants 18 years of age and older were served through a case management model.
- **Mentorship** One-on-one mentorship provided general and targeted support (e.g., academic assistance).
- **Phone Contact** Weekly check-ins were conducted by the program manager via phone call, text, or email.
- **Group Outings** Enrichment activities included movies, sporting events, concerts, museum visits, and community engagement (e.g., volunteering at a food bank).

During the closeout interview in April 2026, staff described how in September 2025 they shifted the combination of one-on-one and group services described above to purely group service delivery in a drop-in center environment. The change was informed by 1) an observed lack of engagement from youth participating in one-on-one services, 2) the need for

more community centers providing youth programming in the rural region, and 3) turnover in qualified staff. Youth can request one-on-one services as needed.

A Better Way staff provide transportation to and from the center two to four days a week depending on the youth's programming. For example, partners from a psychiatric rehabilitation program come on Wednesdays to provide services to those with mental health needs, and youth go boxing on Fridays to promote positive outlets for aggression. Youth arrive and complete a distress check to identify how they are feeling. Next, youth discuss a question of the day tied to a learning activity (e.g., using internet resources for employment, creating a resume) and have free time (e.g., cooking a meal, playing games). In this group structure, three staff members are present to support youth, with some designated to attend to those with special needs. Youth complete the distress check at the end of the session with the goal of reducing any distress before staff transport youth home. Staff felt this shift had improved engagement and estimated that eight to ten youth were present on any given day, with 18-23 youth served weekly in total.

Program Outputs

A total of 122 youths were enrolled in programming with A Better Way between October 2023 and December 2025. The youths were predominantly both male (69.7%, n = 85), and Black or African American (79%, n = 96). The average age at enrollment was 15. The overall average number of days between referral and enrollment was 27 days. Broken out by referral year, this number decreased over time. For youth referred in 2023 (n = 13) this was 66 days; the average was 24 days for youth referred in 2024 (n = 55); and the average was 21 days for youth referred in 2025 (n = 54). Court referrals made up 84% (n = 103) of all referrals to A Better Way. Half of all individuals were enrolled in gun diversion programming only (n = 61), 44% were enrolled in anger management only (n = 54), and the remaining enrollments were for a combination of the two programs (6%, n = 6).

Staffing

Staffing Structure and Responsibilities A Better Way maintains seven staff positions. The engagement specialist and program manager provide direct services while the executive director and deputy director support program administration.

- **Engagement Specialist** The engagement specialist works with A Better Way participants, connecting youth to resources, providing education on firearm laws and consequences, and supporting positive decision-making. Originally implemented as one full-time staff position, L4L shifted to three part-time hires due to high turnover

in the full-time position. Staff described that the shift has thus far minimized turnover.

- **Program Manager** The program manager oversees partnerships, referral review, intake, and assessment. Specifically, they work to engage criminal legal system partners (e.g., attending juvenile court hearings, building inroads with adult probation) to increase program referrals. The program manager provides direct services including group facilitation, individual sessions, case management, check-ins, and crisis intervention. The role requires extensive travel throughout the Lower Shore, a valid driver's license, and successful completion of a background check.

- **Administrative Staff** L4L's administrative team includes an executive director and deputy director. The executive director, who founded the organization, oversees daily operations, manages grants, and leads fundraising. The deputy director oversees multiple programs, including A Better Way, and is responsible for program oversight, financial management, grant writing support, operations, and reporting.

Staff Training and Qualifications Staff have participated in extensive training, including restorative practices, conflict resolution, racial bias and LGBTQ+ awareness and competency, law enforcement-community relations, de-escalation, adverse childhood experiences (ACEs), change management, leadership, executive coaching, life skills development, motivational interviewing, and vicarious trauma and trauma-informed care. As a CARF-accredited organization, staff must complete 40 hours of annual training. However, training costs can be prohibitive; staff suggested that state-provided training opportunities could increase accessibility.

Lived experience was described as essential, particularly for the program manager role. Lived experience ensures that staff do not "speak from a demeaning place" and can "meet [clients] where they are." Staff identified this as especially critical given young people's skepticism of adult staff's ability to relate to their experiences. The former program manager was a returning citizen, which staff identified as especially beneficial.

Technological proficiency is also critical due to extensive documentation requirements. Staff noted efforts to expand training on documentation practices and HIPAA compliance to better understand client rights and documentation requirements. Additional key skills include youth engagement, facilitation, rapport-building, and professional communication with courts and government officials. Strong supervisory support and open team communication were also emphasized as essential for addressing programmatic challenges, maintaining data quality,

and aligning with performance measures. Staff expressed interest in learning from national violence prevention models to further strengthen the program's impact.

Collaboration

L4L collaborates with law enforcement, the Department of Juvenile Services, adult probation and parole, the Office of the Public Defender, and community-based providers offering GED preparation, energy assistance, and housing support. Collaboration is viewed as essential, as no single agency can meet all client needs independently. Staff emphasized that effective partnerships rely on clear communication, proactive outreach, and organizational credibility. It is important that case managers at partnering organizations view the program as valuable and believe that referring clients is worthwhile. For example, staff noted that due to L4L's credibility in the community, schools had begun reaching out to provide referrals. Ultimately, staff felt that such partnerships improve service coordination and broaden access to support.

Perceived Impact

Staff Perceptions Staff emphasized the program's positive impact on youth, parents, and the broader community. Many participants leave with renewed hope, particularly those who initially believe their future is "over." Some return for additional services, reflecting strong, sustained relationships with staff. Parents often report feeling supported and validated. Youth benefit from trusted mentorship and access to internships, which build confidence and future orientation. Success is often marked by participants resolving conflict nonviolently and choosing to "put the gun down."

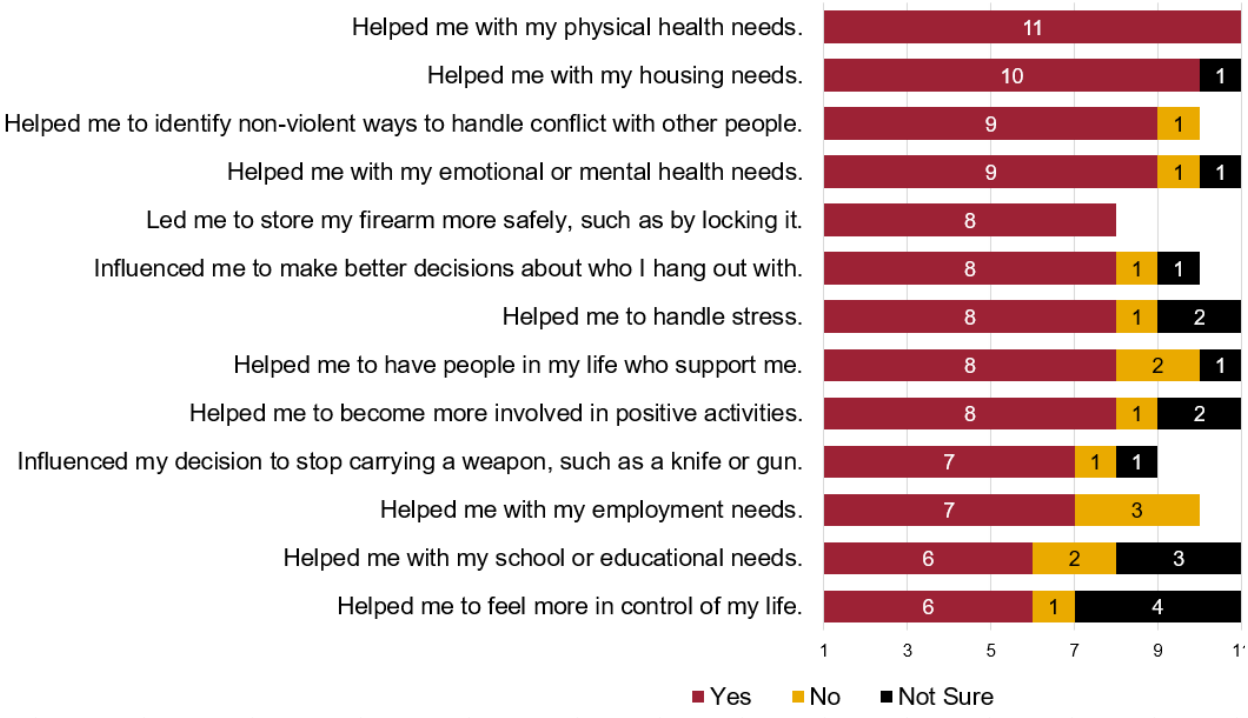
Client Perceptions Between May and December 2025, 11 L4L clients completed the participant satisfaction survey. Given the limited number of responses, we present counts instead of percentages. All responding clients identified as male; almost all identified as Black or African American (n = 9), with the remainder identifying as white or another race/ethnicity. The average age was 15 years old.

Responding clients had positive perceptions of L4L staff with all reporting that they felt safe in the program and staff respected their cultural background. Clients reported that staff responded quickly to questions or concerns (n = 10), and that they would recommend the program to others (n = 10). Most clients reported that staff treated them with respect (n = 8). L4L services were also viewed positively by respondents, who mostly endorsed that the services were available during times that worked with their schedule (n = 10). Somewhat fewer were satisfied with the service referrals (n = 9) or felt that the services made a difference in their lives (n = 8).

Clients were also asked to describe how L4L services addressed their underlying needs, but we must interpret responses with caution given the limited sample size. Clients most frequently reported that the services offered helped address their physical health (n = 11), housing (n = 10), conflict resolution skills (n = 9) and mental health needs (n = 9).

Although open-ended responses were very limited, some clients described how they were pleased with the program ("I like it here, I can't lie" and "it's fun and chill"). One felt it would be helpful to offer more off-site activities or education around finances. One client described that the program taught them to "look away from the negative things, thoughts, and people."

Figure 3.1. Lead4Life Perception Survey Responses



Note: Remaining responses were "not applicable." Counts are presented due to the limited sample size.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges Staff identified several barriers and challenges:

- **Limited Resources for System-Involved Individuals** Barriers include housing instability, limited employment opportunities, and high motor vehicle fees that impede access to identification and driver's licenses.

- **Service Delivery in Rural Areas** Delivering services in under-resourced rural

regions presents logistical and financial challenges. Long travel times—often 60 to 120 minutes—create logistical challenges in connecting youth with essential services such as mental health care or obtaining vital records. Staff noted that virtual services have proven largely ineffective for this population. Additionally, the federal funding cuts of 2025 have trickled down to the local level, resulting in reduced community-based programming for youth and diminished resources such as food pantries.

- **Program Enrollment** Staff noted that they needed to pivot in the middle of implementation after observing a lack of engagement in one-on-one programming that staff interpreted as an indicator that services were becoming "stale" with parents and youth. Although staff felt the pivot to group programming revitalized the program, it required patience from both staff and funders. Moreover, the program reach may feel limited, but as one staff member stated, "Serving 25 people multiple times a week and really investing in them is very different from just seeing 25 people for a quarter."

- **Staffing Shortages** As the program has expanded, so has the number and size of groups served. Program growth has outpaced staffing capacity, limiting the individualized support available to participants. Moreover, difficulty maintaining a full-time engagement specialist position prompted reconsidering the role as three part-time positions. Although staff felt this was a better fit for the position, the hiring process took time.

- **Rising Youth Gun Activity** Staff reported increases in youth firearm involvement, including among young women in gangs, and noted growing use of ghost guns (unserialized, untraceable firearms) assembled from components ordered by mail. Some firearms are later sold in urban areas such as Baltimore.

- **Funding Limitations** Food is essential for engagement but is not an allowable VIPP expense, creating budget strain. Staff suggested reconsidering this limitation.

- **Client Engagement Challenges** Staff noted voluntary participants are more likely to disengage than court-mandated youth. Staff recommended introducing clear consequences for non-participation, such as an unsuccessful discharge determination after 30 days without contact, to address this challenge. Limited awareness of the program also affects engagement, as some youths initially mistake staff for probation officers, which can create resistance. Communication challenges are also common

due to disconnected phones, parents taking away their children's devices, or inaccurate contact information from probation officers. Once initial contact is established, retention improves. Parental involvement varies, with some parents playing a key role in encouraging participation. Staff noted that the transportation services provided by the program ensure a consistent touch point with parents.

- **Hiring Challenges** Although some staff reported no difficulties, others identified obstacles to recruitment related to the relatively low pay and meeting standard degree requirements. Instead of a bachelor's degree, staff emphasized that lived experience remains a critical qualification for successfully engaging clients.

- **Bureaucratic Barriers** Staff noted that the referral process has become more complicated, and the multiple layers of approval delay the delivery of program services. The turnover in staff and leadership across partner agencies has disrupted continuity and the transfer of historic knowledge. For example, retirements and reorganization within key referral partners—including the Department of Juvenile Services, parole and probation officers, and local law enforcement in Salisbury—created situations in which new staff were unaware of the A Better Way program. Additionally, established school partners began requesting formal memoranda of understanding (MOUs).

- **Need for Earlier Referrals** Staff expressed that intake staff at the Department of Juvenile Services and local jails are not consistently engaged. Staff noted that sometimes new intake staff are not aware of available resources, including L4L, and will only refer clients to the resources they know. Thus, L4L aims to strengthen outreach and education efforts with local law enforcement and other agencies to increase awareness of its services. Earlier referrals are critical as they could prevent deeper legal system involvement. For example, a staff member described a case in which a youth was referred following an initial altercation with a parent, illustrating the value of early intervention focused on de-escalating conflict and creating alternatives to deeper legal system involvement.

Facilitators and Sustainability L4L staff noted that the biggest strength of the program was the engagement from the staff with youth. Specifically, they noted the diversity of the staff's backgrounds and how it enriched the programming. For example, one engagement specialist is a retired mason who is adept at showing youth how to work with their hands and demonstrates considerable patience while another is a schoolteacher skilled at de-escalating

situations without resorting to punitive responses. Staff were also proud of the opportunity to provide youth with a safe space in a region where there are few youth programs. Regarding programming, staff highlighted the opportunity to teach youth conflict resolution, positive communication, and coping skills.

In terms of sustainability, staff noted that L4L relies on a combination of grant funding and donations to run A Better Way. The program requires at least two staff members present at any given time for liability purposes. Shifting to part-time engagement specialists was identified as a strategy to ensure continued staffing coverage for that role. Staff felt that maintaining the program director would be key to sustaining the continuity of referrals with the courts.

The Tree House Child Advocacy Center of Montgomery County MD Inc.'s Problematic Sexual Behavior Program (PSB)

The Tree House was established in 2002 in response to Montgomery County's recognition that children who experience abuse require comprehensive, coordinated, and trauma-informed services. It was launched as a centralized, child-friendly setting designed to reduce trauma, improve investigative coordination, and strengthen outcomes for children and families.

With limited public funding available, the county pursued a public–private partnership model. The Tree House was jointly established by Montgomery County's Department of Health and Human Services and the Primary Care Coalition, a nonprofit organization that initially served as the administrative partner. In June 2016, the Tree House incorporated as an independent nonprofit, and in October 2017, it assumed full operational responsibility.

Today, the Tree House operates as a fully developed Child Advocacy Center (CAC), providing coordinated, trauma-informed services and serving as the hub for Montgomery County's multidisciplinary team (MDT) response to child abuse. The organization is accredited by the National Children's Alliance.

Tree House first received VIPP funding in July 2022 specifically to hire certified clinical staff and establish the Problematic Sexual Behavior program (PSB). VIPP funds were discontinued in June 2025. Staff described that VIPP was essential to the launch of the program, but a blend of additional funding sources has helped ensure program continuity.

Program Description

VIPP funding was used to establish the Tree House's PSB program, which is grounded in the Problematic Sexual Behavior–Cognitive Behavioral Therapy (PSB-CBT) model. This evidence-based model follows a six-module, group-therapy protocol for school-aged children and their caregivers.

Although neither the PSB program nor the Tree House directly focuses on gun violence intervention, staff emphasized that untreated PSB in childhood may contribute to later antisocial or violent behaviors. Clinical staff noted that several risk factors associated with gun violence overlap with those linked to PSB. By providing early intervention and treatment, the PSB program aims to equip children with the skills necessary to develop into healthy, nonviolent adults.

Eligibility Criteria More broadly, the Tree House serves victims and suspected victims of child physical abuse, sexual abuse, mental injury, and neglect in Montgomery County, along with their families (e.g., caregivers and siblings). Specific to the PSB program, children ages 7-12 who have a known incident of PSB are eligible for therapeutic services. As of March 2026, staff noted that eligibility had been expanded to include children up to 14 years of age. This age range reflects the specialized training of PSB staff, who are prepared to deliver developmentally appropriate interventions for this group. If a child or adolescent outside this age range is referred, they may be eligible for other clinical services offered by the Tree House. Although the Tree House primarily serves children residing in Montgomery County, staff have occasionally made exceptions, as the program was the only agency in Maryland offering this specialized resource at the time of the evaluation.

To participate in the PSB program, an eligible child must have a caregiver willing to participate who is not involved—or alleged to be involved—in sexual misconduct. Some children may be ineligible for group-based PSB treatment if they cannot meaningfully engage in a group setting. For example, certain children on the autism spectrum or those with developmental disabilities may face participation challenges. In such cases, they remain eligible but receive treatment through the family model (described below), which is not VIPP-funded.

Recruitment and Screening. Children are referred to the PSB program through the Tree House website. Primary referral sources include families, law enforcement, child welfare agencies, pediatricians, and public school system employees. Participation is voluntary. Staff noted that while court-mandated participation is possible, it has not yet occurred.

A licensed mental health provider conducts an initial phone screening for all referrals and consults with the clinical director, who makes the final eligibility determination. For eligible clients willing to participate, the family engages in a formal intake process on-site. During this process, the assigned clinician conducts interviews with the child and caregiver and administers assessments to establish a mental health baseline. These assessments are repeated midway through and at the conclusion of treatment to evaluate progress.

The intake process may span several hours across multiple sessions with the child, the caregiver, or both. It includes a comprehensive biopsychosocial assessment examining domains such as prenatal history, family history, mental health history, school experience, behavioral history, trauma exposure, media exposure, and weapon access. Safety planning was a critical component of intake and may include providing lockboxes for sharp objects and medications, as well as education on safe firearm storage. Staff noted that caregiver reports may sometimes be incomplete due to memory gaps or denial, necessitating collateral information from sources such as teachers or extended family members.

Program Activities

PSB-CBT Groups Weekly therapeutic groups are the primary modality of treatment. Groups are offered in English and Spanish based on need, with separate sessions for children and caregivers. Ideally, each group includes six to eight participants. The structured 19-week curriculum includes six modules:

1. Sexual behavioral rules
2. Feelings and relaxation
3. Self-control and behavior management
4. Social skills
5. Abuse prevention and sex education
6. Empathy and apology

To graduate, children and caregivers must complete all six modules, actively participate in sessions, and have no PSB incidents for three consecutive months prior to completion. Enrollment operates on a rolling basis. Families may miss up to three sessions before being discharged from the group and invited to restart.

PSB-CBT Family Model The family model adapts the group-based PSB-CBT approach for children for whom group therapy is not appropriate (e.g., some children with autism or developmental disabilities). It follows the same 19-week curriculum but is delivered

individually, with separate sessions for the child and caregiver.

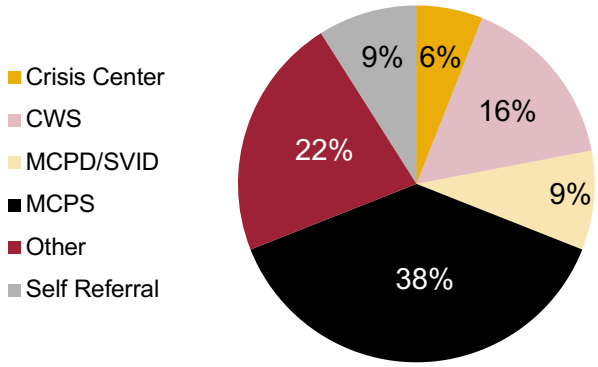
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with PSB-CBT This hybrid model is designed for children whose PSB is directly linked to traumatic experiences. Unlike the group and family models, this modality does not follow a fixed 19-week timeline and allows greater flexibility to tailor treatment. It is available to children ages 3-18, though only a subset of staff are trained to deliver this hybrid approach.

Additional Activities In addition to clinical services, the program coordinator and clinical director conduct community outreach and education. MDT members frequently request PSB-related training. For example, staff have partnered with the school system to launch school-based education efforts and train teachers on recognizing and addressing PSB. Staff have also increased engagement through the CAC's social media platforms to raise awareness about the program.

Program Outputs

There were a total of 32 referrals to the PSB program in 2024 and 2025, with 14 youths receiving services. The average number of days between referral and beginning services was 95 days. Eighty-four percent of referred youths were male, with an average age at referral of 9.5 years. Just under a third of referrals involved white youths (31.3%, n = 10), one quarter were Black or African American (25%, n = 8) and just over a third of referred youths were Hispanic or Latino (37.5%, n = 12). *Figure 3.2* shows the proportion of youths by referral source. Referral sources include the Montgomery County Public Schools (MCPS), Montgomery County Child Welfare Services (CWS), Montgomery County Police Department/Special Victims Investigation Division (MCPD/SVID), self-referrals, and other sources.

Figure 3.2. Proportion of Youths by Referral Source



Staffing

Staffing Structure, Responsibilities, and Qualifications At the time of the 2024 site visit, the PSB program included both administrative and clinical staff: an executive director, director of operations, clinical director, six full-time therapists, two part-time therapist contractors, one intern, two externs, and a psychologist contractor who supervises externs.

- **Clinical Staff** Clinical staff conduct intakes, assessments, and therapy. Essential qualifications include experience in trauma-informed care, PSB treatment, and evidence-based practice delivery. Bilingual capacity in English and Spanish is critical, as services are offered in both languages. Therapists must be licensed in Maryland.

- **Administrative Staff** Administrative leadership oversees operations, funding, and grant management. The executive director manages finances, board reporting, county relations, and fundraising. The director of operations manages data, reporting, and grant compliance. In addition to providing clinical services, the clinical director supervises staff, reviews referrals, assigns cases, conducts outreach and training, and supports grant development. The program coordinator divides time between clinical services—such as PSB treatment, client intakes, and community outreach—and administrative activities such as assigning clients to groups.

Staff Training To provide PSB-CBT independently, clinicians receive specialized training and certification from the National Center on the Sexual Behavior of Youth at the University of Oklahoma Health Sciences Center. During the first year of VIPP funding, all full-time therapists completed required PSB training, which included multi-day sessions and ongoing supervision. In 2025, the clinical director became certified to provide in-house PSB-CBT training. Staff noted this provided more stability for the program and reduced training costs.

Staff are also trained in Parent-Child Interaction Therapy. Additional training includes supervision, Tree House operational protocols, and child-centered language (e.g., referring to "a child with PSB" rather than labeling the child). Staff also attend professional conferences for continuing education. In addition to learning through training and conference attendance, program staff recently presented at a national symposium, on implementing a bilingual PSB program.

Collaboration

As noted in the introduction to this site report, the Tree House operates under a CAC model supported by an MDT. The MDT includes Child Welfare Services, the Special Victims

Investigation Division of the Montgomery County Department of Police, the Office of the County Attorney, and the State's Attorney's Office, and is formalized through a memorandum of understanding.

Through the MDT, staff identified both the prevalence of PSB among youth and the absence of appropriate services, which prompted development of the PSB program. For example, school and law enforcement-based MDT partners were eager to refer families to a therapeutic program rather than use law enforcement as the default response to PSB. MDT partners are now primary referral sources and collaborate closely on cases, creating a more coordinated pathway for connecting children and caregivers to services. Staff frequently provide training to school social workers, counselors, and parents on PSB-related topics.

One staff member noted during the 2024 site visit that the Department of Juvenile Services had not participated in the MDT despite repeated outreach efforts. Staff also reported working to strengthen relationships with pediatricians and family practitioners, who have become increasingly important referral sources.

Perceived Impact

Staff Perceptions Staff provided several examples of the program's impact. First, they reported that the program has steadily grown since its inception, with an increasing number of referrals and more families participating over time. They also noted that several families have successfully graduated from the program, meaning children have stopped exhibiting PSB, as confirmed by their families and schools.

For families who have not yet graduated or have returned to the program, staff have observed significant progress, such as reduced PSB and other problematic behaviors, improved relationships between caregivers and children, and increased trust between therapists and children in the program. Families also benefit from healthier boundaries, protection from trauma, strengthened relationships, open communication about difficult topics and emotions, abuse prevention, and a clearer understanding of who safe adults are.

Staff also pointed to strong community and MDT partner support as indicators of the program's credibility and impact. For example, staff noted that the program receives a growing number of referrals, training requests, and consultations on PSB cases. Several staff members noted that this enthusiasm has allowed them to take a more proactive approach to addressing PSB rather than a reactive one. This proactive approach includes addressing PSB through community education and outreach, rather than responding solely to individual

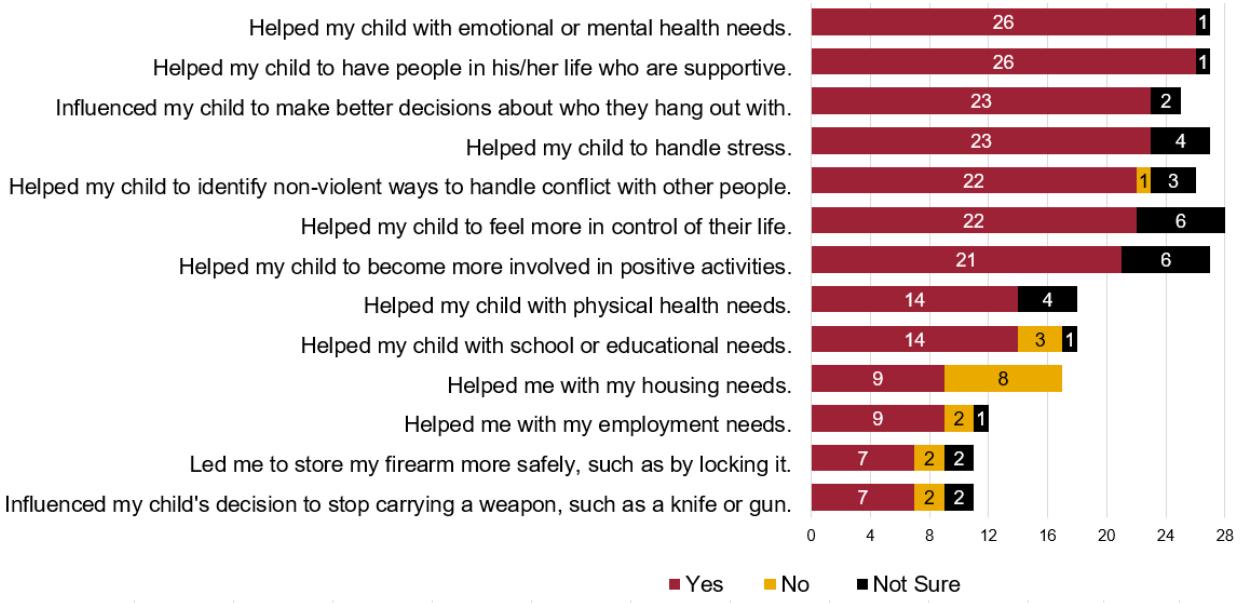
incidents referred to them.

Client Perceptions Between July 2024 and July 2025, 28 guardians of children enrolled in the PSB program completed the participant satisfaction survey. The sample was diverse with the majority of guardians reporting that their child identified as Hispanic or Latino (54%) followed by Black or African American (21%), white (14%), Asian or Asian American (7%) and other race (4%). All but one respondent reported being the guardian of a boy, and the average age of the children was 10 years. Over two-thirds reported they participated in the PSB group (64%), slightly more than a quarter were involved in the TF+PSB program (27%), and about one-tenth participated in the PSB family group (9%).

Guardians had extremely positive perceptions of Tree House staff with 100% of respondents reporting that they felt safe at the program, and that staff treated them with respect, including regarding their cultural background. Respondents reported that staff responded quickly to questions or concerns (96%) and that they would recommend the program to others (96%). Tree House services were also viewed positively by responding guardians who mostly endorsed that the services made a difference in their lives (96%), were available during times that worked with their schedule (96%), and that they were satisfied with the service referrals (89%).

Guardians were asked to describe how Tree House services addressed their children's underlying needs. Respondents most frequently reported that the services offered via the program helped their children’s emotional or mental health needs, support system, decisions related to peer networks, and how they handled stress. In contrast, fewer guardians endorsed that the program improved how they store firearms or provided support related to their housing or employment needs. Additionally, few reported that the program influenced their child’s decision to stop carrying a weapon (*Figure 3.3*).

Figure 3.3. The Tree House Perception Survey Responses



Note: Remaining responses were "not applicable". This ranged between 4% and 57% for all but one item (improved control).

The few open-ended responses we received were also positive. For example, one guardian noted how the "program is really helpful and informative" and how the staff members are "able to help me sort through questions or difficulties I may have." Two guardians noted that it would be helpful for the program to have more family advocates or services that were closer to their home. In terms of impact, several guardians noted improvements in their child's behavior and parent-child relationships while their parenting style has become less reactive and more consistent.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges Staff identified several barriers and challenges:

- **Funding** PSB program funding has ebbed and flowed. Additionally, staff noted that PSB training is costly, and that additional funding would be required to support expansion of services to other age groups. This barrier has been partially mitigated by certifying the clinical director to deliver training in-house.

- **Hiring** While one staff member noted a high turnover rate at the Tree House generally, turnover within the PSB program had been low. However, recruitment is challenging due to intensive specialized training offered only by a single out-of-state program. This barrier has been mitigated by certifying the clinical director to provide in-house training.

- **Caregiver Buy-In** Caregiver participation is essential, but may be hindered by denial, conservative beliefs about parenting and sex, behavioral justifications, or a desire to remove the child from the home. Staff noted that addressing these concerns during intake can improve engagement.

- **Obstacles to Participation** Transportation barriers, work schedules, lost wages, and childcare needs can limit participation. The program addresses these challenges through Uber rides, Zoom options, and childcare support.

- **Logistical Issues** The intake process is time-intensive and paperwork-heavy, contributing to staff's clinical workload. Evening sessions, offered to accommodate families' schedules, require staff to work late hours and may contribute to burnout. Finally, group-based treatment depends on the consistent attendance of participants; insufficient participation may result in session cancellation.

Facilitators and Sustainability Staff identified several key factors that have contributed to the success and sustainability of the PSB program. A primary factor is the strong relationships staff have developed, particularly through the MDT and with the Governor's Office. For instance, staff members highlighted how their collaboration with MDT partners, which involves referrals, case consultation, and training, was instrumental in creating the PSB program and ensuring its continued success. Furthermore, when grant funding or reporting issues arise, staff have been able to seek assistance from the Governor's Office, which has been a critical support system.

Funding, particularly through VIPP, was essential in the program's creation and remained a key facilitator of its early success. Staff described the VIPP funds as essential seed money that allowed them to build the necessary program infrastructure, supported early implementation, and ensured the program was implemented as intended. In addition to the loss of VIPP funds, staff noted the loss or reduction of several other state grants. However, no position was completely funded by a single funding source, ensuring staff continuity. As a result, the Tree House was able to reallocate its remaining resources to maintain the PSB program. Nevertheless, staff were largely working beyond standard working hours, given that program sessions are held outside of regular business hours.

Staff also noted that increased funding would allow the program to be more available and accessible to families as they could hire more staff to offer more group sessions, including via Zoom. Staff also expressed that sustained funding would help institutionalize the

program, embedding it as a core resource within the Tree House. Lastly, the staff acknowledged that research and evaluation are crucial to the program's long-term success as they can validate the PSB program's effectiveness.

Conclusions and Lessons Learned

Both Lead4Life's A Better Way and Tree House's PSB programs demonstrate strong foundations in trauma-informed, evidence-based practice. Each program takes a person-centered approach that prioritizes rapport-building and meeting clients where they are, qualities that staff across both organizations identified as central to engagement and impact. Staff quality and commitment stand out as a shared strength with both programs benefitting from teams with specialized training, diverse backgrounds, and deep dedication to their populations. Multidisciplinary collaboration is also a common asset, as both programs rely heavily on referral networks spanning law enforcement, child welfare, courts, and community partners; each has built sufficient credibility to drive ongoing referrals and requests for training.

Funding instability is the most prominent shared challenge. Both programs depend heavily on grant funding with no guaranteed continuity, and both experienced disruptions. A Better Way lost staff capacity and struggled with allowable expense restrictions, while Tree House lost VIPP funding entirely after June 2025. Staffing is a close second, as recruitment and retention proved difficult for both programs, driven by specialized training demands, relatively low compensation, and burnout risk. Engagement and participation barriers also appear in both programs, though they manifest differently. For example, L4L experienced voluntary disengagement and communication breakdowns, and there were caregiver buy-in challenges and transportation barriers at Tree House. Finally, both programs operate in contexts that require navigating bureaucratic complexity, including referral pipelines that depend on partner agency staff awareness and continuity, which is easily disrupted by turnover.

Several lessons stem from both programs. First, flexibility and willingness to pivot are essential and reflect a need for programs to know their target populations and their needs. L4L shifted from one-on-one to group programming when individual engagement stalled, while Tree House adapted its group model for children unable to participate in a group format. Neither program treated its original design as fixed. Second, early investment pays dividends as both programs required significant upfront resources (e.g., training, infrastructure, relationship-building) before reaching scale. Third, diversifying funding sources is necessary for long-term sustainability. Tree House's ability to continue after VIPP

funding ended came directly from its practice of not relying on a single funder for any one staff position. Finally, the experiences of both programs underscore that no single agency can meet all client needs. Sustained collaboration and clear communication with partners are essential foundations for program success.

Chapter 4

Community Violence Intervention (CVI) Programs

Community violence intervention (CVI) programs deploy credible messengers – individuals with lived experience in the communities they serve – to proactively build relationships, interrupt conflicts before they escalate, and connect residents to resources that address the underlying conditions that drive violence. The two programs examined in this chapter, Kingdom Kare's Man Up Anne Arundel program and the University of Maryland, Baltimore's EMBRACE Initiative Collaborative Violence Intervention and Prevention Program (CVIPP), each embody this approach while operating in distinct geographic and organizational contexts. CVIPP operates within high-violence areas of West Baltimore through a university-anchored collaborative model, and Man Up operates within the Pioneer City neighborhoods of Severn, Maryland, through a community-based nonprofit. Both programs rely on authenticity, sustained presence, and broad partnership networks as their core operating principles. In this chapter, we describe each program's design, implementation, impact as perceived by staff and clients, and the shared challenges that have shaped their operations during the evaluation period.

Kingdom Kare, Inc.’s Man Up Anne Arundel

Kingdom Kare is a nonprofit organization with more than 20 years of experience in early youth and community programming, childhood education, and preventive family services. Its mission is to empower children, youth, and families to thrive. As part of its community-based programming, Kingdom Kare created the Man Up program in 2022. Man Up began as an adaptation of the Cure Violence Global model, which applies a public health approach to firearm violence by deploying credible messengers to violence hot spots to conduct de-escalation, conflict mediation, and resource connection. In March 2026, the program officially implemented the Cure Violence Global model.

Kingdom Kare first received VIPP funding in July 2022; the funding supported the maintenance of the Man Up program. Separately, the Anne Arundel County Health Department allocated VIPP passthrough funding to Kingdom Kare to fund training and technical assistance from Cure Violence Global.

Program Description

Man Up's catchment area is the Pioneer City region of Severn, Maryland which serves four neighborhoods: Still Meadows, Spring Meadows, Meade Village, and Pioneer Village. These areas were selected based on violence data identifying them as crime hot spots. Canvassing is primarily focused in Still Meadows, which is considered "high risk" for gun violence, with the other neighborhoods considered "at risk." While there is no strict age requirement, the program primarily targets youth and young adults ages 14 to 27, who experience higher rates of firearm violence than people in other age groups. This criterion was informed by a local needs assessment conducted by Cure Violence Global as well as by the model's definition of what constitutes high-risk individuals (i.e., age, exposure to gun violence, being in the vicinity of someone who might own a weapon, being a part of any known groups or cliques).

Staff generally agreed that narrowing eligibility is unnecessary. Although expanding into other high-poverty communities (Seven Oaks and Maryland City) could be beneficial, staff noted that geographic expansion would require additional resources (e.g., staff and funding).

Recruitment and Screening Man Up identifies clients through neighborhood canvassing, community events, school partnerships, referrals, and a dedicated hotline. During canvassing, violence interrupters walk through target neighborhoods, initiate informal conversations, and build rapport. As trust develops, they identify residents' needs and provide referrals to community resources such as youth mentoring. Some violence interrupters have established such a strong community presence that residents seek them out directly for assistance.

Community events and workshops also serve as outreach opportunities. Violence interrupters distribute "connect cards," allowing residents to share contact information and request support. Staff follow up to assess needs, make referrals, or enroll individuals in Man Up services. The program also collaborates with local middle schools to engage youth early, recognizing that conflicts can escalate during high school years.

Once a client is identified, staff complete an intake and assessment form to document demographics and assess risk levels. This process distinguishes individuals who require intensive, long-term case management from those who need only brief engagement and service referrals.

Program Activities

Violence Interruption Man Up engages in direct violence interruption through conflict mediation and community-based intervention. Staff provide mediation services and operate a

confidential “Peace Hotline” where residents can report ongoing or potential conflicts. Violence interrupters estimate engaging approximately 40 residents per week. The program primarily serves youth involved in or at risk of criminal activity, focusing on trust-building and service connection. Additionally, Man Up leads a mentoring program in local middle schools (not funded by VIPP) that engages youth in out-of-school activities, including basketball and other youth-led initiatives. Staff noted that little had changed in terms of program activities with the official launch of the Cure Violence Global model in March 2026.

Case Management The Man Up outreach workers collaborate with the Anne Arundel County Department of Health’s Community Health Ambassador (CHA) program to provide weekly case management services, including needs assessments, goal setting, and direct support. Outreach workers assist with career development, violence prevention, and legal education. This includes helping clients obtain identification cards or job-related certifications. Staff address a wide range of needs, from securing basic household items to facilitating referrals for specialized services.

Originally, outreach workers used an assessment that was designed for the broader at-risk community (i.e., individuals who live outside the catchment area but have risk factors for involvement in community violence) and the case management plan would then be developed collaboratively with the client. Outreach workers now use a more “streamlined” assessment developed by Cure Violence Global that is designed specifically to measure the potential for high-risk activity, needs, and resilience. The assessment findings are translated into a case management plan for the individual. Staff noted that this approach creates a more structured framework for developing case plans, enabling staff to guide clients toward specific services during their conversations.

Community Education & Outreach The Man Up team conducts community education and outreach through events, communications campaigns, and workshops. Events such as job fairs, kickball games, cultural gatherings, jazz nights, and community bicycle rides foster relationships and increase awareness of available services. Broad communication campaigns use social media, flyers, yard signs, and canvassing to address topics such as access to care, gun violence, mental health, weather preparedness, and transportation. Violence interrupters also facilitate four monthly educational workshops on topics such as stress management and violence prevention.

Strengthening Families Program The team supports the Strengthening Families Program (SFP), held at the Severn Community Center, which focuses on strengthening

family bonds, improving communication, and enhancing parenting skills. The 14-week program includes a family dinner prior to each session and structured psychoeducational lessons. Man Up assists with family recruitment and engagement to promote sustained participation.

Gun Locks The Man Up team distributes gun locks in partnership with the local library, which operates an established gun lock distribution program through the Anne Arundel County Department of Health's VIPP-funded Gun Violence Intervention Team (GVIT; discussed in Chapter 8). Recognizing that some residents may be uncomfortable obtaining gun locks at the library, the team also distributes them at community events. Outreach messaging emphasizes child safety to encourage participation.

Program Outputs

During the project period of May 2024 through December 2025, there were 287 opportunities to provide communication and outreach for over 5,800 youths and young adults in the community. These opportunities included a variety of youth sports, mentoring sessions, work with students in schools, and other activities. Additionally, program staff held events including coat drives, behavioral health symposiums, and back to school events which were attended by over 3,000 community members.

Staffing

Staffing Structure, Responsibilities, and Qualifications Man Up maintains sixteen positions divided between direct service roles (violence interrupters and outreach workers) and administrative staff.

- **Violence Interrupters** The program includes four violence interrupters and two outreach workers. Violence interrupters canvass neighborhoods, build relationships, and identify individuals who may benefit from services. Staff emphasized the importance of hiring individuals with strong active listening skills and lived experience in the communities serve. Several violence interrupters were raised in—and continue to reside in—the community, which strengthens trust and rapport, in turn enabling them to connect residents to services effectively. The violence interrupters are supported by a site supervisor and program manager. Prior to formal implementation of the Cure Violence Global model, violence interrupters were referred to as "change agents," reflecting the multiple roles these staff members play and the collaborative nature of the work.

- **Outreach Workers** Two outreach workers work closely with the violence interrupters to connect clients to resources such as food assistance and mental health services. Although violence interrupters focus primarily on violence intervention, the outreach workers specialize in resource linkage, training, and education. Staff reported that roles often overlap in practice. The infrastructure for this outreach work is provided by the CHA program, which is funded through a separate initiative within the Anne Arundel County Department of Health that supports service linkages for the broader community. Prior to the launch of the Cure Violence Global model, this role was referred to as a CHA.

- **Administrative Staff** Man Up maintains four administrative positions. The executive director oversees grant management and board relations. The executive officer supervises programs, personnel, and grant compliance. The program director develops partnerships to secure funding and referral partners for clients. The program officer provides administrative support, including event coordination, partnership management, budget tracking, intake management, and liaison functions. Staff in these roles reported active community engagement, including participation in local events.

Staff Training At program launch, three professionals from Cure Violence Global conducted a week-long in-person training on violence interruption and community engagement, supplemented with bi-weekly remote coaching. Staff emphasized that at the time, Man Up adapted the Cure Violence model rather than adhering to strict replication. For example, staff noted that they tailored programming to community feedback and that staff "do what they need to do for their community." With the official launch of the Cure Violence Global model in March 2026, staff noted that little had changed in day-to-day canvassing aside from job titles and the adoption of metrics and databases used by Cure Violence Global (e.g., violence interrupters input a daily log to facilitate weekly canvassing reports).

Violence interrupters have completed additional training, including Mental Health First Aid, CPR, mediation tactics, interpersonal skills development, trauma-informed approaches, adverse childhood experiences (ACEs) education, and self-care strategies. Staff highlighted trauma-informed training as particularly valuable in helping them consider clients' potential triggers and empathic responses and expressed a hope to be able to translate such content to the larger community. Despite these opportunities, staff identified needs for further training in documentation practices, case note management, and activity tracking, such as maintaining event sign-in sheets. Ongoing "booster" training—especially related to

compassion fatigue—was also identified as important.

Collaboration

Kingdom Kare collaborates with approximately 50 partner agencies, primarily community-based organizations. Man Up and CHA staff connect clients to mental health services, housing, food assistance, childcare, and transportation. The team works with roughly 10 key organizations to address community violence; these include schools, libraries, and county agencies. For example, they partner with the Anne Arundel Workforce Development Corporation to secure paid youth summer employment. Staff emphasized that partnerships are effective due to shared goals and a mutual commitment to community well-being.

Perceived Impact

Staff Perceptions Staff reported that the program positively impacts clients and reduces violence in the broader community. By addressing basic needs (e.g., food, mental health services, and employment opportunities) the program reduces risk factors associated with violence. At the time of the 2024 site visit, staff highlighted a 100-day period without shootings in the catchment area, attributing this outcome to proactive engagement and mediation efforts. Although violent incidents occurred outside that period, staff noted that many involved individuals were from outside the immediate community. During the 2026 interview, staff were proud of the 63% decrease in crime over the previous three years.

Staff described their work as "helping one client at a time" break generational cycles of violence. For example, they shared the story of a client on parole for drug-related offenses who was struggling to support his family. By connecting him to stable employment, the program reduced his risk of reoffending and mitigated potential violence by improving family stability.

Client Perceptions Between July 2024 and February 2026, 39 Kingdom Kare clients completed the participant satisfaction survey. Somewhat more men (56%) completed the survey compared to women (44%) and respondents were 33 years old on average. Most clients described themselves as Black or African American (85%), with limited representation from white (10%) and Hispanic or Latino (5%) clients.

Clients were asked to report on all the programs they engaged and the reasons why. Most clients reported engagement with Man Up's violence interrupter programming (64%) with over a third reporting working with the CHA program (39%). When asked to report the reasons why they engaged Man Up's services, a plurality (41%) indicated that they required

access to resources. Nearly a third reported engaging with Man Up because they witnessed a violent incident (31%) with fewer respondents indicating they had been a perpetrator (18%) or survivor (18%) of violence.

Clients had extremely positive perceptions of Kingdom Kare staff with all survey respondents reporting that staff treated them with respect and that they felt safe in the program. Clients reported that staff responded quickly to questions or concerns and that staff respected their cultural background (97% for both). Man Up services were also viewed favorably by clients who frequently endorsed that the services made a difference in their lives (92%), were available during times that worked with their schedule (90%), and that they were satisfied with service referrals (89%). Over three-quarters of respondents reported that they would recommend the program to others (87%).

As displayed in *Figure 4.1,* clients most frequently reported that the services offered via the program helped address their emotional or mental health needs, provided social support, and improved their sense of control. Given the high proportion of "not applicable" responses, interpreting results for the remaining service areas is difficult; this pattern may reflect the program addressing client needs on a highly individualized basis. However, similar to the other client satisfaction survey findings in this report, safe firearm storage and carrying a weapon were cited as less common perceived impacts.

Figure 4.1. Kingdom Kare Clients Reported Improved Wellbeing and Social Support



Note: Remaining responses were "not applicable". This ranged between 15% and 77% for all questions.

In open-ended response, clients described how “everyone is helpful” and provided assistance such as navigating insurance, accessing medical supplies, supporting unhoused families, and raising awareness of available resources.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges Staff identified several barriers and challenges:

- **Shifting to a New Model** Although staff felt very little had changed since officially implementing the Cure Violence Global model, the transition still required effort to maintain established program activities while adapting to new data tracking and assessment requirements. Staff acknowledged a learning curve but noted they were able to navigate the transition with continued training and support from Cure Violence Global.

- **Consistent Engagement** Meeting client goals often requires sustained effort. For example, securing employment may take up to 90 days as clients must first complete steps such as obtaining identification or finishing required training. Some clients disengage once immediate needs are met, even when continued mentoring could further reduce long-term risk.

- **Limited Parental Involvement** Engaging parents, particularly for minors, is crucial. However, parental participation in events is low.

- **Funding Constraints** VIPP budget reductions have decreased staff hours and program activities. Sustaining full-time violence interrupter/change agent positions remains difficult, and expansion to activities within schools would require additional funding. For example, one outreach worker is part-time and must navigate how to support clients within limited hours.

- **Administrative Hurdles** Liability concerns and bureaucratic obstacles have hindered the program's efforts to secure a dedicated community space.

- **Community-Level Challenges** School policy changes have affected programming. For example, after school bus transportation was cut, staff escorted students to school due to safety concerns stemming from an increase in fights. Staff also noted ongoing community mistrust of service providers.

- **Emotional Impact of the Work** Because many staff members are from the

community, working with clients they know personally can be emotionally challenging. Some described the distress of having to report youth to law enforcement for engaging in violence, especially when they have personal connections to them. Despite these challenges, staff emphasized the importance of "practicing patience" with clients, particularly when guiding them through behavioral change to achieve long-term goals.

- **Data Management System** Staff identified the need for a centralized database to streamline data management and document fieldwork activities during the site visit. At the time, activities were tracked manually in Excel. Staff expressed that implementing a robust system would require additional funding but would strengthen the program's ability to demonstrate impact quantitatively. In spring 2026, the site launched a new system for tracking data with support from Cure Violence Global.

Facilitators and Sustainability Staff identified one of the program's greatest strengths as its consistent community presence—specifically, the commitment to meeting people where they are and showing up reliably. Staff recognize that they cannot be prescriptive about what the community needs; instead, they must listen to community members and work collaboratively with them to support change. Community events are key to helping seed engagement and secure buy-in for change. Staff also felt that the program's flexibility is an essential element that allows them to better serve the community rather than adhering to strict guidelines and rigid protocols.

Related to sustainability, staff noted they would continue to seek additional grant funding. Man Up also receives support from the Anne Arundel County Department of Health and can leverage services offered via the CHA program.

University of Maryland, Baltimore's EMBRACE Initiative Collaborative Violence Intervention and Prevention Program (CVIPP)

CVIPP seeks to address gun violence by establishing a coordinated network of wraparound services and prevention and intervention efforts in several West Baltimore neighborhoods with historically high rates of homicide. CVIPP is supported by two UMB entities: EMBRACE (which merged with another UMB structure, The Collaborative: A Healing Centered Community) and Rebuild, Overcome, and Rise (ROAR). CVIPP relies upon credible messengers from community-based grassroots organizations like the PEACE Team and We Our Us to provide outreach and peer-led case management tailored to communities

impacted by gun violence. More broadly, the vision is to use the infrastructure of UMB to establish a "pipeline" of resources that can be directed to those closest to the issues and equip them to respond to community needs.

CVIPP first received VIPP funding in July 2023. That funding supported the PEACE Team, We Our Us, and wraparound services offered via ROAR. In addition to VIPP, UMB was part of a large federal award from the Bureau of Justice Assistance (BJA) in 2023 to expand services through partnerships with the Black Mental Health Alliance and HeartSmiles. However, federal funding was abruptly terminated in June 2025, impacting the partnership so that service delivery did not happen. This forced CVIPP to choose between scaling back the model or narrowing its geographic focus; they chose the latter.

Program Description

Eligibility Criteria CVIPP's original catchment area was Pennsylvania Avenue in West Baltimore, particularly within the Upton and Druid Heights communities. The program focused on "hot spots" along the Pennsylvania Avenue corridor, including intersections at North Avenue, Laurens Street, and Dolphin Street. Services were available both to residents of that corridor and others who regularly spend time there but may live in a different neighborhood. Staff emphasized that this flexibility is essential, as violence frequently extends beyond neighborhood boundaries into surrounding areas. As a result, EMBRACE sought BJA funding to expand services to nearby Eutaw Avenue, running in parallel with VIPP-funded activities on Pennsylvania Avenue.

With the termination of the BJA award in June 2025, CVIPP was forced to reallocate VIPP funds from We Our Us toward the PEACE Team and pull out of Pennsylvania Avenue to support the programming on Eutaw Avenue, which had been entirely federally funded. This decision was made collectively by EMBRACE and its partners to more effectively respond to conflicts associated with drug trafficking in a nearby housing development. In contrast to the hot spots on Pennsylvania Avenue, which are surrounded by an established community that "felt more like a collective," the area around Eutaw Avenue is a "no man's land" of an open-air drug market with few permanent residents and numerous mobile service providers.

Program Activities

Since CVIPP is implemented as a collaborative of partnering organizations focused on addressing gun violence, programs facilitated by UMB (EMBRACE and ROAR) work directly with organizations like the PEACE Team and We Our Us while leveraging the broader violence prevention expertise within the network. Staff noted that organizations

including the Black Mental Health Alliance, HeartSmiles, Baltimore Brothers, the Maryland Department of Juvenile Services, the Maryland Department of Human Services, and Restoration Gardens 2 also contributed to CVIPP activities, although they may not be directly funded by VIPP. For example, Black Mental Health Alliance and HeartSmiles are community-based organizations that partnered with EMBRACE on the terminated BJA award to supplement CVIPP programming in the catchment area.

EMBRACE Initiative EMBRACE was originally known as The Collaborative: A Healing Centered Community. The Collaborative was a coalition of over 60 community-based and grassroots organizations, higher education institutions, and city agencies working together to provide services, education, and research focused on violence prevention in Baltimore City. Originally housed within UMB's School of Social Work, the Collaborative was subsequently merged with EMBRACE and relocated to UMB's Office of the Provost.

EMBRACE supports CVIPP by providing program coordination, data collection and dissemination, resource development, and training and technical assistance. Staff shared that EMBRACE assists partner organizations in articulating program models, conducting evaluations, and applying for grant funding. EMBRACE also facilitates training on topics such as relationship-building, trauma-informed services, violence prevention, program evaluation, mental health, and program implementation.

Rebuild, Overcome, and Rise (ROAR) Based within UMB’s School of Law, ROAR provides wraparound legal, social, medical, and mental health services to survivors of violence and their families using a “one-stop shop” model. For example, ROAR offers expungement services and facilitates peer healing circles for survivors of violence and their peers at their walk-in center in the Upton neighborhood. Although ROAR was included in the original VIPP proposal, budget reductions led to its removal from the project during the second funding year. As of March 2026, staff noted that ROAR would soon be absorbed by EMBRACE.

The PEACE Team Founded in 2002, the PEACE Team is a community-based organization and formal CVIPP partner that provides outreach, consultation, and program assistance across the city and in nearby counties. As part of CVIPP, credible messengers from the community canvass open air drug sites and hotspots along Pennsylvania and Eutaw Avenues to prevent and interrupt violence. Staff work in pairs along designated city blocks to mediate conflicts, gather information, assess neighborhood needs, negotiate and maintain peace agreements between rival groups, connect residents to services and resources, educate

community members about available support, and administer naloxone (NARCAN) when necessary.

The PEACE Team's approach centers on building relationships, establishing trust, and offering consistent support to residents. Staff described their work as deeply embedded in the community and inherently relational. On a typical day, staff begin making rounds along the Pennsylvania Avenue corridor at about 9:00 a.m., take a break around 12:00 p.m., and continue outreach until approximately 4:00 p.m. During these rounds, staff interact with a wide range of community members, including youth, older adults, individuals experiencing substance use challenges, and individuals involved in drug sales. These interactions provide critical insight into conditions in the neighborhood, including emerging needs or conflicts.

The relationships developed with residents are deeply individualized and personal. They are characterized by a range of behaviors, from small acts—such as checking in ("Are you good?"), asking whether someone needs anything, or offering a small amount of money when requested ("I'll give them a dollar if they ask for it")—to more collective efforts, such as pooling funds to help cover funeral expenses for a community member's loved one. These seemingly minor interactions were described as essential to building rapport and credibility, as well as demonstrating genuine care and intentionality. They were also viewed as critical to conflict prevention, as staff are often able to identify emerging tensions and intervene before situations escalate.

We Our Us Founded in 2015 following the death of Freddie Gray, We Our Us is a community-based, grassroots movement of Black men in Baltimore. Like the PEACE Team, the organization is a formal CVIPP partner. It provides consultation, outreach, and programmatic support through credible messengers from the community who engage individuals in open-air drug markets and hotspot areas along Pennsylvania Avenue to prevent and interrupt violence. Specifically, We Our Us conducts community outreach, conflict mediation, violence prevention messaging, street-based case management, youth entrepreneurship training, and referrals to mental health and other needed services.

Program Outputs

During the project period (January 2024-February 2025), CVIPP engaged 1,532 individuals for the first time, followed up with 7,292 cases, and closed 1,119 cases. Additionally, the PEACE team messaged around violence a total of 21,449 times and mediated 6,396 conflicts. CVIPP reported that 510 individuals received assistance including basic living supplies (59%, n = 302), job assistance (10%, n = 53), and transportation (7%, n = 35). The remaining

supports, all reported for less than 5% of individuals each, included help acquiring vital documents, accessing shelter or permanent housing, drug treatment, and legal services.

Staffing

Staffing Structure, Responsibilities, and Qualifications Different organizations within the collaborative focus on different roles. Administrative roles are housed at EMBRACE and ROAR. EMBRACE consists of a program director and program coordinator who serve as the administrative backbone of CVIPP. For example, EMBRACE provides operational support, leads fundraising efforts, offers data and evaluation assistance, and delivers training and technical assistance. In contrast, direct service staff affiliated with CVIPP engage directly with the community. For example, the PEACE Team employs 20 credible messengers who serve as violence interrupters, engage community members, mediate conflicts as they arise, and connect residents to resources (e.g., mental health services and peer support) provided at ROAR's walk-in resource center.

CVIPP relies heavily on cross-agency partnerships and direct engagement with individuals and communities affected by violence. As such, the ability to build trusting, collaborative relationships is a critical competency for all staff and reflects the core values of the EMBRACE Initiative. These values include shared leadership, civic responsibility, authenticity, and transparency.

Direct service staff highlighted several essential qualities for individuals working in these roles, including humility, approachability, punctuality, consistency, and emotional intelligence. They also emphasized the importance of having "strong morals and principles." One staff member emphasized the importance of recognizing and accepting when a situation cannot be controlled, such as when a conflict mediation attempt is unlikely to succeed.

Credibility and authenticity (i.e., "being real") were described as critical to effective violence prevention work. One staff member emphasized the importance of being "real and up front," noting that community members "see through the bullshit." Staff explained that appearing fake can quickly erode trust, particularly in a close-knit community such as the one surrounding Pennsylvania Avenue. Staff also discussed the nuances of credibility. For example, some noted that serving a lengthy prison sentence (e.g., 10 years) does not automatically confer credibility ("That don't mean nothing…") and that being "neighborhood respected" is not the same as being respected across West Baltimore or citywide.

Collaboration

Collaboration is central to the CVIPP model. Staff described a grassroots, community-based, and collaborative approach as essential when partnering with local individuals and organizations—qualities they felt were often missing from more "institutional" programs perceived as seeking "too much control."

EMBRACE staff noted that they regularly consult with the PEACE Team on funding allocation, program expansion, and coordinated responses to community violence. For example, they described sharing budgets and salary information transparently and striving to ensure that approximately 75% of funding is directed to community partners. EMBRACE staff also acknowledged that many partner organizations have a longstanding history of violence prevention work, and that their role is to build on this foundation by providing coordination, infrastructure, and support.

Some collaborations are governed by formal agreements, such as contracts or memoranda of understanding, while others are informal, relationship-based partnerships without written agreements. Staff viewed these informal collaborations as essential to community-based violence prevention efforts. For example, We Our Us is a volunteer-led group that conducts "Saturday walks" to distribute information about community resources. Despite its informal structure, the group plays an integral role by engaging credible messengers in outreach, resource fairs, and other violence prevention activities.

Similarly, CVIPP and EMBRACE staff have intentionally integrated community leaders whose lived experience and insight into "what is best for the community" are highly valued. These leaders often provide contextual guidance, endorse programming they believe will benefit the community, and support implementation efforts. Notably, EMBRACE secured endorsements from community leaders when applying for VIPP funding. CVIPP also leverages community leaders' influence in mediating conflicts, including negotiating peace agreements between rival groups.

Regardless of whether partnerships are formal or informal, CVIPP operates through shared decision-making and sustained community input. The intentional balance between structured agreements and relationship-based collaboration distinguishes CVIPP as a unique model.

Perceived Impact

Staff provided a range of examples illustrating EMBRACE's impact. During the 2024 site visit, staff reported observing fewer homicides and an overall reduction in violence since the

PEACE Team began its outreach work. For example, some staff noted that they had not recently witnessed gun violence along Pennsylvania Avenue. One staff member remarked that if the program were to "go away tomorrow," violence would likely increase. Staff also described strong community support for the PEACE Team's work; as one staff member stated, "Oh, they love it."

Although staff noted in March 2026 that shifting from Pennsylvania Avenue to Eutaw Avenue did not appear to have led to an increase in shootings in the original catchment area, they anecdotally observed that the loss of credible messengers potentially impacted overdose deaths. For example, staff noted that a bad batch of drugs led to increased overdoses in Baltimore in early 2026. As one staff member posited, "If the PEACE Team had been out there, if the news had gotten out early, could the response have been earlier?"

Across interviews, staff also identified systems-level outcomes. EMBRACE has leveraged university resources to hire direct service staff as university employees, enabling them to enroll in university courses at no cost. Administrative staff also negotiated reduced grant overhead rates so that a greater share of funding could be directed to frontline staff and services.

Cross-agency benefits were also highlighted, including collegiality and mutual support among team members. Staff described efforts to "strengthen one another," cover responsibilities when colleagues need time off, and provide emotional support during times of loss.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges Staff identified several barriers and challenges:

- **Insufficient Funding** Staff emphasized that current funding levels are inadequate to address the root causes of violence and have been exacerbated by the disinvestment of the federal government. One staff member described the current approach as "stopping the bleed," noting that CVIPP must go further by addressing underlying drivers of harm. Staff also stressed the need for adequate compensation for frontline workers who face personal risk in conducting outreach and violence interruption.

- **Funding Limitations** The one-year grant cycle presents significant challenges. Staff reported difficulty building long-term programming, hiring and retaining staff, and addressing the enduring consequences of systemic harms (e.g., redlining) within

short funding timelines. When coupled with the loss of federal funding, staff need to work quickly to shift resources to where they are most needed.

- **Hiring Challenges** Because EMBRACE operates within UMB, administrative staff initially faced barriers related to hiring individuals with criminal records due to university policies. Staff ultimately negotiated changes to remove this barrier. However, unstable and short-term funding continues to complicate recruitment and retention, as prospective staff may be hesitant to accept positions without long-term employment assurances.

- **Complex Needs** PEACE Team staff frequently encounter individuals facing intersecting challenges, including poverty, mental health needs, substance use, and limited parenting support—factors they identified as contributing to community violence. Staff emphasized that meaningful violence prevention must address these underlying, interconnected needs. These challenges are compounded by gaps in available services and resources. Substance use was described as the most common issue encountered in day-to-day outreach, with some team members reporting multiple NARCAN administrations within a two-week period in response to overdoses. While substance use was consistently identified as a key driver of violence, one staff member cautioned against conflating gun culture with drug culture, noting that many individuals engage in drug sales as a means of survival and that lasting change requires viable economic and social alternatives.

- **Community Engagement** Staff noted that complex service navigation processes and limited awareness of available resources often hinder community engagement. One staff member reported that individuals declined referrals after learning about the steps required to access services. As a result, much of the team's outreach involves educating community members about available local resources and helping them navigate access barriers. With the shift to Eutaw Avenue, staff noted these challenges were exacerbated, as both the individuals selling drugs and the service providers in the area are largely transient. Moreover, there is only one established community meeting in that area—the Business Leaders of Eutaw—and it does not represent the needs of the people in the open-air drug market. This stands in stark contrast to the established community leaders and providers on Pennsylvania Avenue.

Facilitators and Sustainability Staff highlighted several factors that facilitate and sustain their work. First, one staff member noted that centering the community as the experts in

violence interruption and prevention has been an important facilitator. They described that similar violence intervention programs have come into the community but failed, because they did not partner with community members who were already engaged in the work. One example of this approach was the difficult conversation EMBRACE staff had with community-based partners about the decision to shift programming away from Pennsylvania Avenue. Staff described that community leaders were aware programs could end and had experienced it with past partners. EMBRACE staff recognized they needed to initiate that conversation as soon as community leaders learned of the grant termination, in order to maintain transparency and collectively determine how to redirect remaining resources to continue serving the community.

In terms of sustainability, building the internal capacity of community-based organizations doing violence intervention and prevention work helps sustain this work long term. For example, EMBRACE staff help local organizations with their data and evaluation to guide programming, which also makes them more competitive to receive funding. Additionally, several staff members mentioned that having stable, sustained funding is critical to effective violence intervention efforts as it enables the hiring of more staff and expansion of community partners. However, staff cautioned that the federal disinvestment in community-based violence intervention programs has created a vacuum and pressing need to find other funding sources to sustain the work. One staff member noted that Baltimore's documented reduction in crime and homicide rates—achieved without widespread gentrification—represents an opportunity to engage non-traditional funders in conversations about the value of community investment over traditional criminal legal system responses. Staff expressed hope that engaging those funders and sharing Baltimore's story of progress could help the city move beyond the stigmas that have long defined its national reputation.

Conclusions and Lessons Learned

Man Up and CVIPP center people with lived experience in the communities they serve as the backbone of their violence intervention work. This authenticity is viewed as non-negotiable and central to establishing credible messengers. Staff in both programs emphasized that community members quickly recognize inauthenticity, which erodes trust and undermines effectiveness. Related, both programs prioritize relationship-building as an ongoing practice rather than a one-time step and emphasize the need to operate through broad partnership networks rather than in isolation. For example, one staff member noted that food is an important relationship-building resource that is often not covered by grant funding: “Breaking bread with people is important.” Staff described the vital importance of meeting holistic client needs (e.g., connecting people to mental health services, employment, legal

assistance, and basic resources), rather than addressing violence narrowly. Finally, both programs are intentionally flexible and responsive to community needs. Rather than imposing rigid protocols, staff in both sites adapt to what communities actually need, and staff in both programs credited this responsiveness as a key driver of success.

In terms of common challenges, funding instability is the most significant shared challenge. Both programs operate on short grant cycles that complicate hiring, retention, and long-term planning. CVIPP experienced this most acutely when federal funding was abruptly terminated, necessitating a significant geographic contraction and resource reallocation. Man Up similarly faced staff hour reductions due to VIPP budget cuts. In both cases, the precariousness of funding undermines the sustained presence that credible messenger models require to be effective. Both programs also grapple with the complexity of client needs. Addressing these intersecting needs strains capacity, particularly when available services are fragmented or hard for clients to navigate. Moreover, both programs noted that some clients disengage once immediate needs are met, and that broader community members are sometimes wary of service providers due to mistrust, prior negative experiences, or the complexity of accessing services.

Several common lessons learned emerged for others engaging in CVI programming. First, community ownership matters enormously. Programs that parachute in without partnering with people already doing the work tend to fail. EMBRACE and Kingdom Kare emphasized that centering community members as experts, not just recipients, is essential to credibility and sustainability. Second, transparency with community partners during difficult moments, such as funding cuts or program changes, is critical to maintaining trust. CVIPP's experience navigating the BJA termination with its partners illustrates that honest, timely communication can preserve relationships even under adverse circumstances. Finally, capacity-building within community organizations (e.g., helping them with data, evaluation, and grant writing) creates a more durable infrastructure than simply funding direct services. This approach, practiced in particular by EMBRACE in CVIPP, makes partner organizations more competitive for future opportunities and less dependent on any single grant.

Collaborative Building Case Study: MONSE

MONSE's VIPP-funded activities are distinct from the other programs included in the evaluation. For example, the University of Maryland, Baltimore - EMBRACE Initiative is focused on collaborative building, but used VIPP funds to support CVI programs implemented by partners. In contrast, MONSE used VIPP funds to reinforce the ecosystem the office established under Mayor Brandon M. Scott in 2020, which is guided by a five-year Comprehensive Violence Prevention Plan. According to MONSE staff, VIPP funds were critical for facilitating peer-to-peer learning opportunities through conference attendance, an essential component of implementing the five-year plan. VIPP funding also supported the launch of the Peace Mobile in 2024. Staffed by a commercially licensed community member known as the peace liaison, the repurposed RV serves as a high-visibility outreach vehicle deployed reactively after qualifying violent incidents, such as mass shootings, and proactively upon formal request from community members. The peace liaison oversees scheduling, maintenance, and field coordination for the Peace Mobile, gaining on-the-job experience in community engagement across different neighborhoods and collaborating with representatives from CVI programs. The Peace Mobile was described as a critical hub for rapid engagement and neighborhood stabilization, combining recreational activities, such as video games and a recording studio, with access to resources and information. It has become an important asset for both immediate crisis intervention and ongoing community-building work.

Chapter 5

Impact Evaluation – EMBRACE CVIPP

In this chapter, we focus on EMBRACE's implementation of CVIPP in Baltimore City to estimate the effect of CVI (the intervention) on violent or gun-involved crime. Using difference-in-differences with matching, this analysis compares the relative change in crime incidents before and after the program implementation in the "treatment area" (where the program is active) with areas in the rest of the city that had comparable trends in crime incidents before the program started. We discuss data sources, how study groups were constructed, findings, and limitations.

Data

We utilized data from two sources: the NIBRS Group A Crime Data from the city's open data portal and the American Community Survey (ACS).

- The National-Incident Based Reporting System (NIBRS) is a standardized crime reporting system maintained by the FBI. Group A incidents focus on more serious crimes and exclude more common incidents like driving under the influence. The NIBRS crime data contains specific information about crime, such as location and the presence and use of guns. The data for these analyses include incidents between January 1, 2022, and December 31, 2025, in Baltimore City.[26] We specifically analyzed data on shootings, robberies, assaults, homicides, as well as any incidents involving guns, which include both violent and non-violent incidents.

- The ACS is an annual survey conducted by the U.S. Census Bureau that includes data on demographics and socioeconomic indicators among other domains, aggregated at various geographic levels. We utilized data from the 2021 ACS 5-year estimate, specifically regarding gender, age, household income, employment rate, public assistance rate, and health insurance rates at the census tract level.[27] We linked data

[26] Baltimore City Government. 2026. *NIBRS Group A Crime Data*. Open Baltimore. Retrieved July 23, 2026 (https://data.baltimorecity.gov/datasets/baltimore::nibrs-group-a-crime-data/explore).

[27] We chose census tracts as the level of geography for our primary analyses because they are both small enough to meaningfully reflect micro-location specific information, and large enough that the infrequency of certain crime incidents does not skew findings. Census tracts typically have populations between 1,200-8,000 people.

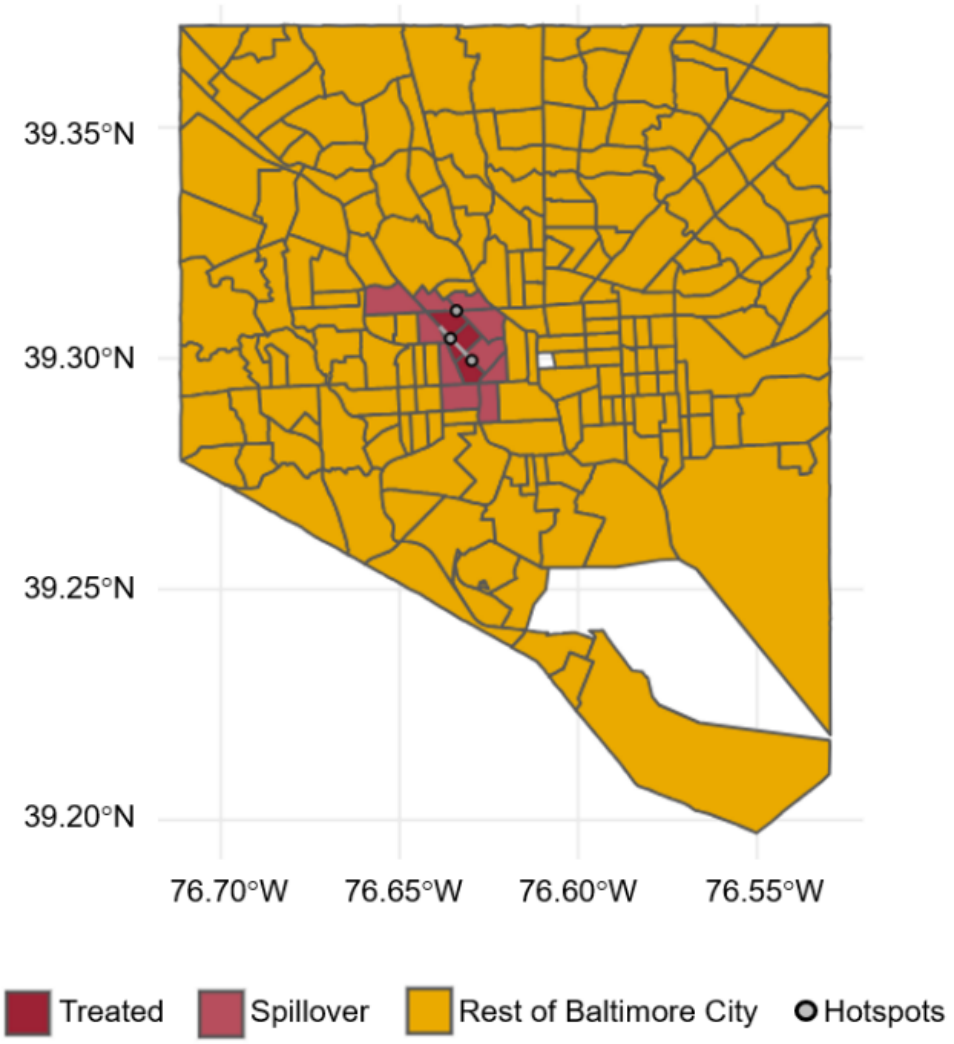
from these two sources to create panel-level datasets with counts of crime incidents in each census tract broken down by quarter; each tract has 16 observations over the 4-year study period in addition to the demographic and socioeconomic data.

EMBRACE received VIPP funding to expand CVIPP into the treatment area in July 2023. As such, the post-period where we are assessing changes in crime outcomes is set from July 1, 2023, to December 31, 2025. The pre-period is January 1, 2022, to June 30, 2023.

Treatment and Comparison Areas

To conduct the main analysis—difference-in-differences with matching—we first identified those census tracts in the treatment area. Based on program data and interviews with CVIPP staff, we identified the treatment area as those census tracts that include the Pennsylvania Ave. corridor between Bloom St. and W. Preston St. in the Upton neighborhood, and the three hotspots at the intersections of Eutaw Pl. and North Ave., Dolphin St. and Pennsylvania Ave., Laurens St. and Pennsylvania Ave. To account for spillover effects (social phenomena such as crime, opportunity, and social networks are not bounded by census tract lines) in our main analyses we also include all census tracts surrounding the three main treatment tracts in a larger treatment group. *Figure 5.1* displays a map of Baltimore City organized by census tract, showing the main treatment and spillover areas.

Figure 5.1. CVIPP Treatment Areas based on Baltimore City Hotspot Locations and the Pennsylvania Ave. Corridor



Notes: The map shows the treatment and comparison areas at census tract level. The off-white line represents Pennsylvania Avenue through the Upton neighborhood.

With a difference-in-differences approach, it is required that the comparison tracts have the same pre-period crime trends. Comparing treatment areas to the rest of the city, census tracts targeted by the intervention had higher violent crime rates during the pre-period.

Table 5.1 shows that in the period before the intervention, the main treated (not spillover) census tracts average 35.2 total violent incidents per quarter, including 5.6 robberies, 2.1 shootings, and 8 incidents where a gun was used. In contrast, tracts in the rest of the city average 24.8 total violent incidents per quarter, including 5.2 robberies, 0.7 shootings, as well as 5.7 incidents where a gun was used, indicating a lower level of violent crime and gun-related incidents. The treatment areas also present higher levels of socioeconomic

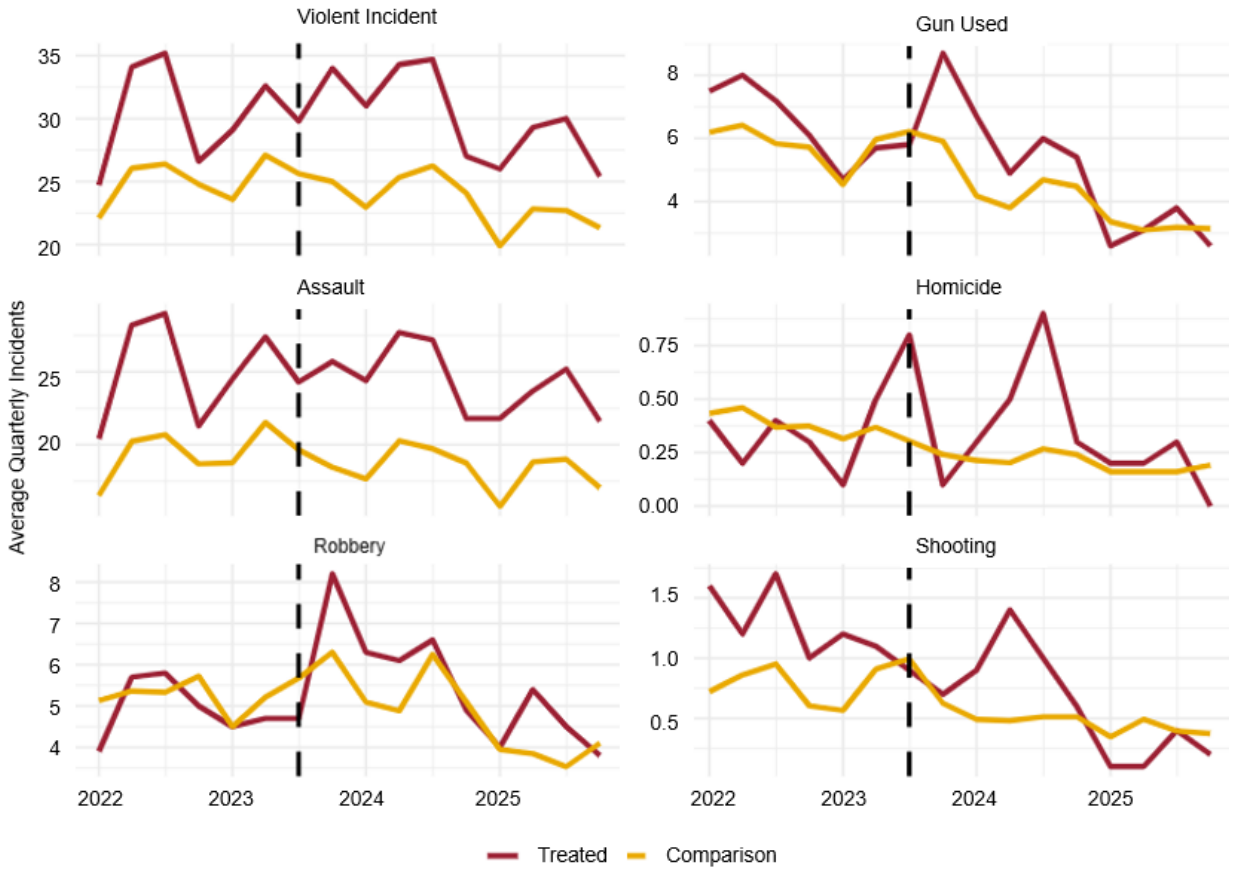
challenges where more households have incomes below $30,000, lower marriage rates, and lower employment rates. In addition, housing vacancies are higher, reflecting some level of neighborhood underinvestment.

Table 5.1. Crime Statistics and Demographics by Census Tract Category

Measure	Treated	Spillover	Comparison Pool
Number of Census Tracts	3	10	184
Mean Quarterly Incidents in the Pre-Period (Jan 2022 – Jun 2023)			
Overall Violent Incidents	35.2	30.4	24.8
Gun Used	8.0	6.5	5.7
Assaults	29.0	25.1	19.2
Homicides	0.6	0.3	0.4
Robberies	5.6	4.9	5.2
Shootings	2.1	1.3	0.7
Mean Quarterly Incidents in the Post-Period (July 2023 – Dec 2025)			
Overall Violent Incidents	31.6	30.2	23.5
Gun Used	6.8	5.0	4.2
Assaults	25.4	24.3	18.4
Homicides	0.5	0.4	0.2
Robberies	5.7	5.5	4.9
Shootings	1.4	0.6	0.5
Demographic and Socio-Economic Characteristics (%)			
Male	52%	47%	47%
Under age 24	16%	14%	14%
Hispanic/Latino	1%	1%	7%
Black or African American	89%	79%	60%
Moved in the past year	8%	15%	16%
Use car to travel to work	59%	52%	64%
Married households	10%	13%	22%
Annual household income below $30K	34%	41%	27%
Receive public assistance	33%	35%	27%
Employed	77%	91%	91%
Uninsured	8%	4%	7%
Housing vacancy	35%	23%	17%

For each crime category, *Figure 5.2* presents trends for the treatment group versus the rest of the census tracts in Baltimore City. The trends for overall violent incidents and assaults move in similar manners, while homicide, shooting, and robbery trends do not move together for the whole pre-period. For those latter four outcomes, this is called a violation of the parallel trends assumption.

Figure 5.2. Quarterly Time Trends of Crime Incidents at the Tract Level



Notes: The dashed line represents when VIPP funding was implemented on July 1st, 2023. The treated group contains both the main treatment and spillover census tracts.

Analytical Setup

To account for this violation, we use matching to create a distinct comparison group for each outcome, restricting the comparison groups to census tracts that exhibit more parallel crime trends to the treatment tracts for each respective crime outcomes and have similar demographic and socioeconomic profiles to the treatment area. For each treated census tract, we searched for two comparison tracts with similar pre-intervention crime trends and ACS

estimates for household income, employment rate, and share of population under age 24.[28] Units where there is no variation in crime outcomes, such as having no homicides throughout the study period, are excluded from the analysis. Treatment tracts are also excluded from the analysis where it is not possible to find similarly situated comparison tracts. Some census tracts in the treatment area had zero shootings and/or homicides; we excluded these as well as their corresponding comparison tracts from analysis of those respective outcomes. *Table 5.2* shows the post-matching treatment and comparison groups sizes.

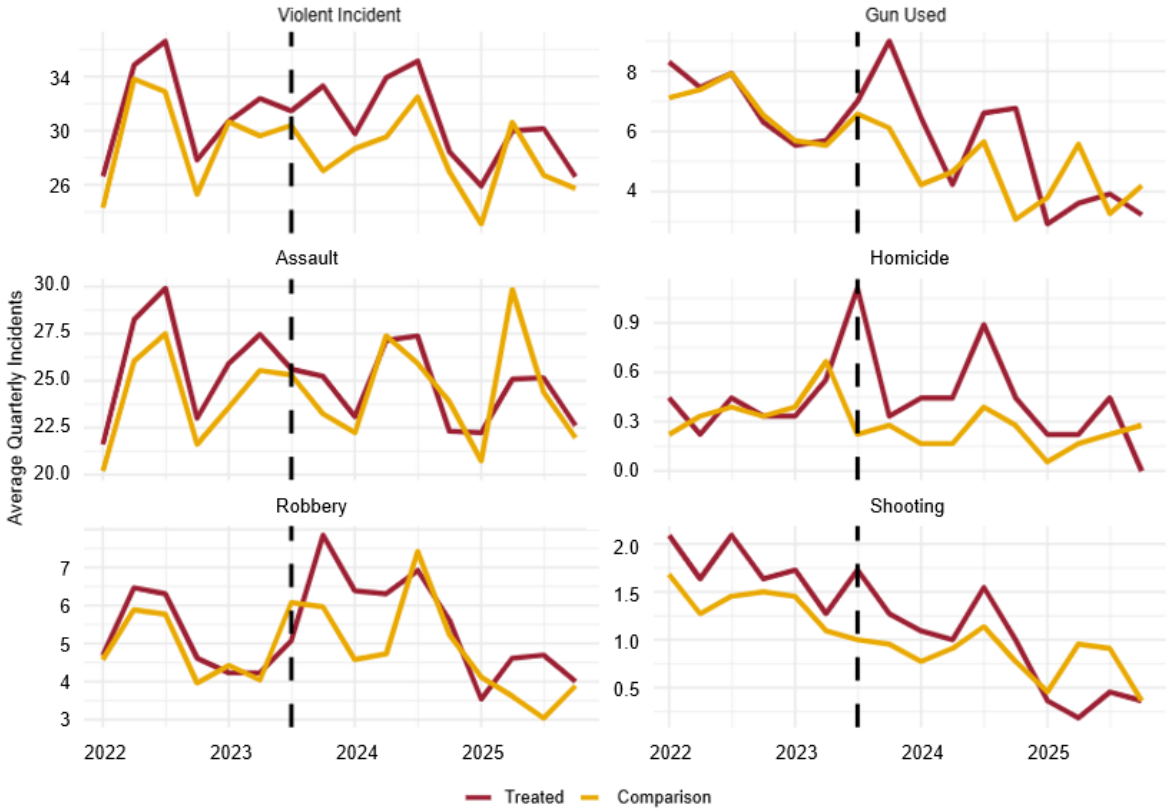
Table 5.2. Matched Sample Sizes

Outcome	Treated	Control
Total Violent	13	26
Gun Used	13	26
Assault	13	26
Homicide	9	18
Robbery	13	26
Shooting	11	22

Figure 5.3 displays the crime trends for each matched sample. In contrast to *Figure 5.2*, the crime trends in the pre-intervention period are now closely aligned. The exception here is homicides, where the treatment group experienced a spike during the summer of 2023. At a visual level, *Figure 5.3* suggests that there are parallel trends, satisfying the primary condition for causal inference in difference-in-differences designs. In addition to visual inspection, we also conducted statistical checks for parallel trends in the pre-period; from these checks we found no evidence of parallel trend violations (See Appendix *Figure A.3*).

[28] We do not use the full set of demographic and socio-economic indicators to match on because our primary focus is identifying cases with the same pre-period trends in crime outcome. When using the full set of census-level controls, the treatment group can drop by as much as half.

Figure 5.3. Crime Trends with Matched Samples

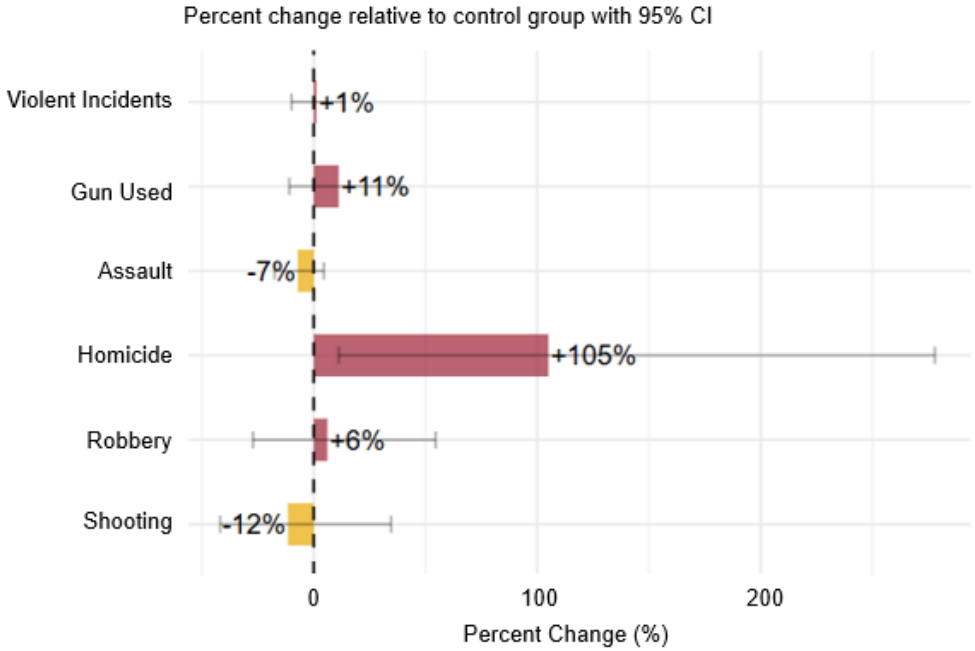


Note: This figure shows the crime trends for the treatment versus the comparison group after finding similarly situated census tracts with closely aligned pre-period crime trends.

What is the Effect of CVIPP on Crime?

Figure 5.4 displays the net change in crime incidents for the treatment group attributable to the intervention. In other words, the estimates show the change in the treatment area above and beyond what happened in the comparison areas. Changes in crime are considered statistically significant when the entire confidence interval (the horizontal line) does not overlap with the 0% mark. We observed a 12% decrease in shootings and a 7% decrease in assaults**;** however, these reductions are not statistically significant. The one statistically significant finding is that homicide rates are 105% higher in the treatment area. Based on prior descriptive trends, this indicates that homicide rates stayed flat in the treatment area while they fell in the comparison areas. This suggests that homicide rates are stubbornly stable in the treatment areas even as the rates decrease in the rest of the city. Overall, the majority of violent crime outcomes do not show differential reductions for the treatment area versus the comparison areas.

Figure 5.4. Difference-in-Differences Estimated Impact on Crime Rates



Notes: Figure shows the difference-in-differences estimates for the six crime outcomes. When the confidence intervals (CIs) do not overlap with 0, the results are statistically significant.

As a robustness check, we also use synthetic control methods and found similar null results (see Appendix for *Figure A.4* and *Table A.1*). An advantage of this approach is that it accounts for outcomes, like homicides, which do not show parallel pre-period trends and weighs the entire pool of comparison cases to create similar pre-period trends.

Summary and Limitations

We did not find evidence of the intervention reducing crime. Crime declined at similar rates in both treatment and comparison areas with the exception of homicides. Homicide rates continue to follow a cyclical pattern, with spikes during warmer months, although they appear to decline in 2025.

One key limitation is that the program lost federal funding for more robust service linkages, particularly mental health services provided through Black Mental Health Alliance and HeartSmiles. Based on program staff interviews, both organizations were close to beginning service delivery, but funding was abruptly cut in mid-2025. This also led to a shift of violence interruption from Pennsylvania Ave to Eutaw Street. As a result, our estimates reflect a more limited version of the program than originally intended.

Additionally, the analyses assume that comparison areas did not receive additional crime-reduction support relative to treatment areas. However, we do not know whether this is the

case. If this assumption does not hold and comparison areas did receive additional support, our estimates are likely to understate the true impact of the intervention. In addition, a recent study shows that a group violence reduction strategy that utilized focused deterrence was implemented in the Western District in 2022 and reduced crime. It could be the case that the focused deterrence program already reduced crime in the treatment area, and the violence intervention program yielded no additional benefit.

Another limitation is that our geographic units of analysis may not align with how the intervention is implemented. Violence interrupters operate flexibly across areas, responding to where conflicts arise rather than staying within fixed boundaries. However, we replicated the analyses using block groups and ZIP codes, as well as with only the primary treatment census tracts (excluding spillover areas), and continued to find no evidence of additional reductions in crime.

Critically, these analyses are restricted to crime outcomes due to data limitations and are unable to assess other outcomes targeted by the intervention, such as overdose prevention and treatment linkages. Consequently, this impact evaluation only provides a narrow assessment of the CVIPP program. Future assessments of CVIPP should seek to evaluate other outcomes beyond firearm-related crime.

Chapter 6

Hospital-Based Violence Intervention Programs (HVIP)

The hospital-based violence intervention program (HVIP) model is rooted in the premise that when individuals arrive at a hospital following a violent injury, they may be more open to considering change and accepting help, making timely, empathetic bedside engagement critical. The two programs examined in this chapter, the Community Violence Intervention Program (CVIP) at MedStar Washington Hospital Center and the Capital Region Violence Intervention Program (CAP-VIP) at the University of Maryland Capital Region Medical Center, are built on this premise. Both programs serve violently injured patients in the Washington, DC metropolitan region, deploying trained staff to conduct bedside outreach to potential clients, assess client needs, and provide case management and referrals to community resources following discharge. In this chapter, we describe each program's design, implementation, impact as perceived by staff and clients, and the shared challenges that have shaped their operations during the evaluation period.

MedStar Washington Hospital Center's Community Violence Intervention Program (CVIP)

CVIP is a hospital-based violence intervention program that engages violently injured patients treated at MedStar's Level I trauma center located in Washington, DC. CVIP uses a violence prevention model focused on addressing social determinants of health and risk factors for future violence. MedStar developed this model by consulting and reviewing hospital-based programs nationwide to determine the structure and design best suited to its site. The program provides trauma-informed case management, risk reduction services, counseling, advocacy, and connections to community and victim services for six months following hospital discharge. Serving a high volume of patients from Washington, DC, and neighboring Maryland, particularly Prince George's County, the program addresses rising gun violence and gaps in cross-jurisdictional service eligibility. CVIP seeks to reduce gun violence and promote individual goal attainment among participants.

MedStar was one of the original long-term VIPP grantees, first receiving funding in February 2019. However, VIPP funding was discontinued in June 2025. VIPP funds were used to support maintenance and expansion of CVIP, including the integration of a legal treatment

navigator to provide medical-legal assessments, rights education, and facilitated connections to civil legal services for Maryland residents.

Program Description

Eligibility Criteria Hospital patients are eligible for CVIP if they are ages 13-65, present with violent trauma (i.e., gunshot or stab wounds), and reside in Prince George's County or Washington, DC. After VIPP funds ended in June 2025, CVIP limited eligibility to DC residents using resources derived from the DC government.

As with CAP-VIP, individuals who present with self-inflicted injuries or who are currently under arrest or in police custody are ineligible. However, CVIP staff may provide ineligible individuals with program information and referrals. This approach allows staff to offer limited immediate assistance and raise awareness of CVIP services for individuals who may later be released from police custody. Individuals whose injuries result from intimate partner violence are referred to a separate hospital unit and are therefore ineligible for CVIP services.

Recruitment and Screening Staff determine eligibility by reviewing the hospital's patient intake log, which includes patients' names, residence, injury type, and current level of care. Once eligible patients are identified, treatment navigators conduct an initial bedside intake and assessment for those who express interest in CVIP.

The assessment examines several domains, including risk factors for future violence, medical and legal needs, self-sufficiency, and coping skills. The assessment is administered again after the client formally enrolls in the program. Assessment results inform the case management plan. For example, clients considered high-risk, such as those with prior injuries, prior incarceration, or housing instability, may require more frequent check-ins and may remain in the program beyond six months.

Program Activities

Staff described that CVIP activities include both standard and enhanced care. **Standard care** involves a treatment navigator conducting bedside outreach, typically within 24 hours of hospital admission, and providing information about the program. The **enhanced program** additionally consists of approximately six months of service provision following enrollment, which includes legal support and case management.

Legal Support This service focuses on helping clients obtain public benefits, such as insurance (e.g., Medicaid) and housing assistance (e.g., Section 8). Assistance is typically

provided in complex cases or when clients are appealing denials of services. Legal support may also assist clients facing eviction and promote awareness of crime victims' rights, including education about court processes, protection orders, and access to crime victims' compensation funds.[29]

Case Management and Client Referrals Treatment navigators provide individualized case management services informed by the intake assessment and client-generated goals. These goals remain in place for approximately six months. During the early stages of engagement, clients have four check-ins with navigators per month, shifting to two check-ins per month as engagement progresses. Throughout this period, navigators connect clients to public benefits and other needed services (e.g., housing, employment, educational resources). Recognizing that some clients present with urgent needs, the program also provides limited immediate support such as gift cards for food, toiletries, clothing, and school supplies.

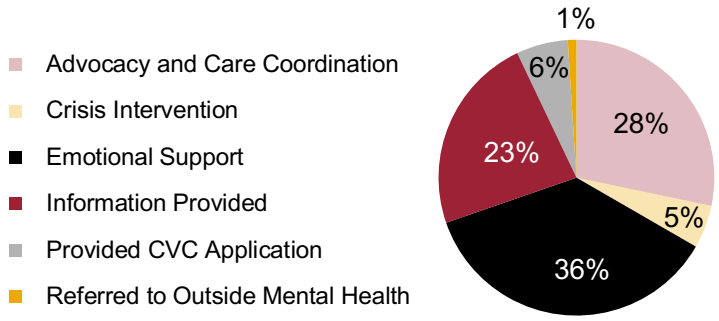
Program Outputs

Between the start of October 2023 and the end of June 2025, CVIP engaged 73 individuals through either standard care (n = 51) or enhanced care (n = 22). Out of these 73, MedStar successfully recruited 26 participants. At the time of reporting, 13 of these 26 participants were still active in programming, 12 had successfully completed enhanced care, and one's status was missing. Among program participants, 88% (n = 23) were male, 88% (n = 23) were Black or African American, and 77% (n = 20) were between the ages of 18 and 44. Most program participants had been hospitalized with a gunshot wound (87%, n = 18).

For the 26 active program participants, MedStar provided a total of 763 discrete interventions. *Figure 6.3* shows the types of interventions provided. Eighty-seven percent (n = 666) of these interventions involved emotional support, advocacy and care coordination, or information.

[29] A staff member noted that navigating external legal supports for Maryland and DC residents varied. For DC residents, additional legal services (e.g., accessing victims' compensation, protective orders) are provided by the Victim Legal Network of DC (VLDNC) overseen by the non-profit, Volare. The external supports available in Maryland have varied over time and are more limited relative to what is offered in DC.

Figure 6.3. MedStar Encounter Intervention Types



Staffing

Staffing Structure, Responsibilities, and Qualifications CVIP includes three client-facing roles, performed by six employees when the program is fully staffed: four treatment navigators, a legal navigator, and a licensed clinical social worker (LCSW) case manager. At the time of the site visit in 2024, the LCSW case manager and legal navigator positions were vacant. As of March 2026, the legal navigator position had been filled. The LCSW case manager position was filled in January 2026 but was soon vacated again.

- **Treatment Navigator** Treatment navigators establish initial bedside contact with prospective clients and conduct assessments. Following discharge, they provide individualized case management for up to six months, including biweekly check-ins. There are three levels of treatment navigators, ranging from entry level (level 1) to advanced (level 3), with the legal navigator role (below) sometimes classified at the higher level. Staff identified several critical relational skills for this role. Interpersonal skills, such as quickly establishing rapport with clients recovering from trauma and de-escalating conflict, were considered essential. Strong self-awareness, including recognizing early signs of stress or burnout and identifying personal trauma triggers, was also deemed critical. Staff emphasized the importance of not "taking things personally." Lived experience—personal exposure to gun violence or residence in the same neighborhoods as clients—was described as beneficial in building rapport and credibility. Staff also highlighted the importance of computer literacy and documentation skills, as navigators use multiple medical databases and maintain client records. However, staff noted that technical skills can be taught during onboarding, whereas lived experience and relational strengths are more difficult to cultivate.

- **Social Worker** The social worker conducts the assessment once again to help identify client needs and establish goals which will inform the case management plan.

- **Legal Navigator** The legal navigator provides case management for clients with complex public benefits and legal needs. This position requires specific certifications, however paraprofessionals with relevant lived experience may also be strong candidates. As with treatment navigators, relational skills, client-centered practice, self-awareness, and engagement in self-care were described as essential qualifications.

CVIP maintains four administrative roles. The program manager oversees fundraising, budget management, and day-to-day operations. The medical director is responsible for hiring CVIP staff. The program coordinator conducts community outreach, administers assessments, oversees grant reporting, maintains the Salesforce database, and supports performance monitoring.

Staff Training Treatment navigators receive a range of training and professional development opportunities including CPR, mental health first aid training, motivational interviewing, and trauma-informed training. Additional training includes University at Buffalo trauma-informed programming, University of the District of Columbia gun violence prevention training, and Peace Academy training focused on personal and vicarious trauma.

Collaboration

CVIP collaborates with community-based providers that offer housing and other essential supports. These partnerships help expedite clients' access to resources. For example, treatment navigators have developed relationships with staff at partner agencies, enabling them to work more efficiently and navigate bureaucratic barriers.

Some staff emphasized the importance of collaboration with other hospital departments. However, these internal collaborations are largely informal and depend on individual relationships developed by CVIP staff. These relationships can expedite clients' access to care, such as when staff contact departments directly to schedule appointments on behalf of clients. Staff cautioned against overusing the term "partnership," noting that some relationships with hospital staff reflect referral pathways rather than genuine cross-departmental collaboration. A more intentional effort may be needed to reduce siloed operations and develop formalized partnerships across departments.

Perceived Impact

Staff Perceptions Staff described multiple examples of the program's perceived impact. CVIP provides services to trauma patients that they might not otherwise receive, including emotional support and referrals for basic needs such as housing, insurance, and employment. Staff noted positive feedback from clients and observable shifts in clients' attitudes and outlook. Additionally, clients sometimes refer others to the program, which staff viewed as indicative of positive experiences. In March 2026, a staff member noted that the decrease in program contacts reflects both additional resources in the community, such as new trauma centers, and an overall decrease in violent injuries.

Client Perceptions Between July 2024 and June 2025, only three individuals provided responses to the participant satisfaction survey. The clients all identified as Black or African American men and were 26 years of age on average.

Given the limited reach of the survey, client perceptions of the program are largely unknown. All three clients had positive perceptions of CVIP staff and services. The three clients reported that CVIP helped them become more involved in prosocial activities and networks (e.g., positive activities, having supportive people in their lives, making better decisions about who they hang out with), improved their conflict resolution skills, and addressed their physical, emotional, and mental health needs. Two of these three respondents indicated that CVIP had influenced their decisions to stop carrying a weapon and to safely store their firearm.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges Staff identified several barriers and challenges:

- **Funding Uncertainty** The annual VIPP renewal cycle limits sustainability and complicates long-term planning. Staff noted that when funding ended in June 2025, the program had to reallocate remaining resources, which had a cascading effect on the services they could provide to clients.

- **Hiring Challenges** Hospital hiring standards, including restrictions related to criminal records, make it difficult to hire individuals with lived experience who may be well-suited for treatment navigator roles. Program administrators have sometimes advocated for specific candidates who were unable to clear background requirements. Program administrators also reported the need to advocate for competitive pay and stronger professional development opportunities to improve staff retention.

- **Lack of Trust** Some prospective clients decline participation due to distrust or concerns that CVIP staff collaborate with law enforcement. In these cases, staff still provide program information so individuals have it if they reconsider.

- **Language Barriers** Staff have access to a language line and interpreters and receive mandatory training about ways to access such resources. However, CVIP lacked Spanish-speaking staff throughout the evaluation, limiting engagement with monolingual Spanish-speaking clients.

- **Housing Challenges** Maryland's limited affordable housing poses significant challenges. Staff noted that housing resources are often more accessible for DC residents than for Maryland residents. Clients experiencing homelessness or housing instability present additional case management challenges, as maintaining consistent contact is often difficult.

- **Meeting People Where They Are** Individuals must make the choice to engage with services, and some may not feel comfortable talking to staff. They may want to move on, or they are unreachable due to inaccurate contact information or phones being shut off. This means that outreach efforts do not necessarily translate into meeting program objectives as far as participants enrolled.

Facilitators and Sustainability One of CVIP's key strengths is its staff's ability to build trust with survivors at their most vulnerable moments, particularly through bedside engagement in a trauma setting. This approach is reinforced by a team that combines formal training and certification with personal or adjacent experiences of community-based violence, creating authentic connections with clients. CVIP staff are also adept at identifying survivors' ongoing needs and navigating them toward resources, including public assistance. Beyond individual care, the program has developed meaningful institutional partnerships through Project Change, a collaborative that connects HVIP programs in metro Washington, DC.

CVIP's primary sustainability challenge is funding instability, which has directly curtailed key services such as rideshare support, a critical resource for survivors who cannot safely or physically use public transportation. The loss of VIPP funds has forced staff to be more strategic in how resources are distributed across participants, and the program is actively pursuing opportunities to reapply for funding. Looking ahead, the program has identified several priorities to strengthen its long-term viability: establishing clear and measurable

KPIs, building a flexible database infrastructure that can adapt as needs evolve, developing financial contingency plans so that funding disruptions do not compromise participant care, and continuing to invest in community outreach efforts such as Stop the Bleed sessions.

University of Maryland Capital Region Medical Center's Capital Region Violence Intervention Program (CAP-VIP)

The University of Maryland Capital Region Medical Center (UMCAP; formerly known as the University of Maryland Prince George's Hospital Center) is a Level II trauma center and the second busiest trauma center in the state. Drawing on the model implemented by the University of Maryland Shock Trauma Center, CAP-VIP is a hospital-based violence intervention program that engages violently injured patients ages 15–35 upon arrival at the trauma center. Launched in 2017, the program applies principles of trauma-informed care to assess patients' medical and social needs at the time of injury and provide intensive case management after hospital discharge. CAP-VIP seeks to reduce future hospitalizations for violent injury while promoting conflict resolution skills and addressing clients' psychosocial needs.

CAP-VIP first received VIPP funding in October 2018. Under the current VIPP cohort, funds were used to support the program's maintenance and expansion, specifically increasing the program's capacity to serve 80% of eligible clients, up from 20%. In addition to VIPP and funding from the Washington, DC government, CAP-VIP received a large federal grant that aided in the expansion of services. However, those federal funds were abruptly terminated in spring 2025, coinciding with reductions in other state and local funding streams. The loss of resources has led to reduced staffing and modified program activities.

Program Description

Eligibility Criteria To be eligible for CAP-VIP, individuals must be victims of a gunshot wound or stabbing inflicted by another person and must reside in Prince George's County or Washington, DC.[30] The program typically serves clients between 14 and 35 years of age. For individuals older than 35, program staff will still conduct bedside outreach and offer assistance outside of the program, such as information on crime victim services, but interviewees noted that this happens infrequently.

[30] VIPP only funds clients who are Maryland residents, but the program serves clients in both Maryland and DC.

Individuals are ineligible if their injury is intentionally self-inflicted. Those under arrest are also ineligible, though those on probation may be eligible. If someone is arrested and the charges are later dropped, they may enroll at that time. As a result, contact information is collected even for individuals who do not initially meet eligibility criteria in case they later become eligible.

Individuals with domestic violence or sexual assault–related injuries are eligible; however, they are typically referred to the hospital's DV/SA department, which provides more specialized services. For those individuals who do not meet eligibility criteria, CAP-VIP staff provide limited assistance, such as informing them of available community resources (e.g., crime victims' services).

Recruitment and Screening Staff described how they conducted 24/7 recruitment and screening prior to the reduction in federal funding. They would review the list of patients admitted to identify individuals who may be eligible based on injury type, age, and place of residence. As of this report, the program operates from 7:00 AM – 11:00 PM Monday to Friday.

Once potential clients are identified, staff conduct bedside visits to introduce CAP-VIP and assess interest. Violence intervention specialists (VIS) conduct an initial intake and assessment for patients who express interest in participating. With the current reduced hours, and given that most violent incidents occur on weekends, this process now often looks different. For those who are admitted to the hospital over the weekend, staff try to engage hospitalized individuals on Monday. For those who have already been discharged, staff attempt to establish contact by phone—a process complicated by unreliable contact information and prospective clients' reluctance to answer calls from unknown phone numbers. Staff noted that the shift from bedside to remote recruitment has been challenging, as people are more receptive during in-person hospital interactions—where staff can take time to engage in thoughtful discussion and start building rapport—than when contacted by phone days after discharge.

Program Activities

Staff reported that CAP-VIP takes a holistic approach, helping clients achieve stability and access long-term resources. Many clients face systemic barriers prior to their injury (e.g., unemployment, housing instability), and these challenges are often exacerbated by the injury. For example, injuries may result in permanent disability, job loss, inability to drive, or legal complications. To address these varied needs, the program offers a broad menu of services:

- **Intake Assessment** After obtaining consent, staff conduct an intake assessment using an instrument developed by a former medical director. This assessment informs the client's individualized treatment plan and includes domains such as demographic information, mental health status, and criminal legal system history.

- **Case Management** Case managers generate referrals to community partners based on the intake assessment and treatment plan. Common referrals include job training, housing support (e.g., relocation, temporary housing, hotel stays, shelters), employment assistance, workers' compensation, mental health services, substance use treatment, crime victims' services, driving assistance (e.g., driving school or adaptive driving support), and assistance obtaining government identification. Case managers typically meet most frequently with clients immediately following discharge, when needs are most acute. Standard check-ins occur at 30, 60, and 90 days after enrollment. However, there is no fixed end date for case management; staff provide long-term support as needed.

- **Immediate Support** Staff often provide immediate assistance such as transportation stipends, food baskets, cell phones, and clothing.

- **Medical Care** Clients are offered up to five clinic appointments at the UMCAP medical clinic after discharge, including acute care surgery, orthopedic surgery, and internal medicine primary care. Neurosurgery is not included among the free clinic services; this is paid for out of pocket and/or by insurance. The program provides transportation support (e.g., Uber) to help clients attend appointments.

- **Pharmacy** Uninsured clients receive a $200 medication stipend at discharge. Clients with pending Medicaid enrollment are considered uninsured for this purpose and can receive this stipend.

- **Gun Locks** Gun locks are provided on an as-needed basis.

- **Wound Care Kits** Clients receive wound care kits along with instructions for proper wound care.

- **Men's Group** CAP-VIP offers a virtual Men's Group that meets weekly and is open to men ages 18-34 who meet the program's injury-related eligibility criteria. As a peer support group, discussion topics are typically generated by participants. Staff occasionally invite external organizations to present on topics such as mental health

or credit building. The program is exploring the addition of more sessions and the creation of a women's group.

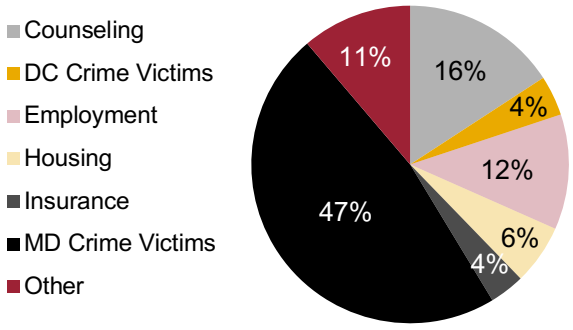
- **Additional Activities** CAP-VIP also offers weekly basketball games, retreats, camping trips, and an annual violence intervention community day, where clients and their families can connect with staff. The program aims to expand participation in these activities.

Program Outputs

Between October 2023 and September 2025, CAP-VIP made initial contact with 403 individuals, primarily male (86%) and Black or African American (84%). Seventy-two percent of those contacted were under the age of 30, with 11% younger than 18 years old. Regarding injury, close to two-thirds of those initially contacted were gunshot victims (65%). A total of 159 of these individuals had been previously injured in a violent incident, 39 of whom (26%) had gone to the hospital.

Among the 403 who were initially assessed, 49% (n = 196) received some type of case management service as displayed in *Figure 6.1*. Half of those who received some service (51%, n = 100) received crime victims services in either Maryland or Washington, DC.

Figure 6.1. Service Referrals from CAP-VIP



Staffing

Staffing Structure, Responsibilities, and Qualifications As of the 2024 site visit, CAP-VIP maintained ten staff positions divided between direct service and administrative positions. At the time of the site visit, direct service staff included four violence intervention specialists (VISs) and two case managers. CAP-VIP was also considering adding a social worker to provide counseling and mental health support. After the funding disruptions in spring 2025, CAP-VIP lost three of the four VISs

- **Violence Intervention Specialists (VISs)** VISs establish initial contact with patients in the trauma unit and introduce them to CAP-VIP. Staff emphasized the importance of strong relational skills, including the ability to build rapport, demonstrate empathy, remain nonjudgmental, and maintain composure in high-stress environments. Hiring individuals with lived experience (i.e., survivors of gun violence) was described as beneficial for building trust with clients, though staff noted that disclosure of lived experience should occur thoughtfully and only when contextually appropriate, such as during rapport-building.

- **Case Managers** Case managers connect clients to services and resources. Essential skills include communication, needs assessment, advocacy, and helping clients advocate for themselves. Staff also highlighted the importance of computer literacy and strong documentation skills, given the need to manage medical records, program databases, and referral documentation. Some staff noted role overlap and occasional ambiguity between VISs and case managers, given that VISs sometimes perform case management functions.

- **Administrative Staff** CAP-VIP maintains four administrative positions. The medical director, a trauma surgeon by training, oversees the program, supports research planning, and assists with grant proposals. A program manager oversees daily operations, supports grant management, and manages budgets and regulatory requirements. A grants administrator manages data systems, maintains the master client database, tracks receipts, records group attendance, and oversees time logs. Finally, the injury prevention coordinator provides training and injury prevention education required for reporting.

Staff Training VISs receive internal training on client engagement, outreach, and recruitment. Staff are also trained to collaborate effectively with referral partners (e.g., housing and mental health agencies). Some VISs noted receiving a detailed procedural guide outlining responsibilities from bedside engagement through discharge.

Additionally, the program manager provides training on operational processes, including data tracking and documentation systems. Staff expressed interest in additional documentation training to ensure essential client information is captured accurately without burdening clients.

Externally, staff participate in violence intervention and trauma-informed care training

offered by organizations such as the Health Alliance for Violence Intervention (HAVI), Project Change, ROCA, and Roper Academy. Staff also complete Stop the Bleed training and certification, which teaches techniques to control life-threatening bleeding.

Collaboration

CAP-VIP collaborates with various community-based organizations that provide housing, mental health support, and other services. For example, the program partners with Community Advocates for Family and Youth to provide housing assistance and cell phones. Additionally, memoranda of understanding with some agencies help expedite referrals. However, staff noted in March 2026 that reductions and disruptions to federal and local funding streams have also affected CAP-VIP's community partners. As a result, staff must now rely on a limited pool of no-cost resources offered through churches, food banks, and shelters.

Staff also work with crime victims services; however, this collaboration can be complicated by clients' mistrust of law enforcement, which may lead to some people declining services. Staff noted in March 2026 that they had recently begun informally engaging the Prince George's County Police Department in conversations about how CAP-VIP could improve tracking of legal system involvement. Conversely, staff emphasized that they do not share information with law enforcement without receiving the client's permission, as it could undermine trust in the program.

Within the hospital, some staff noted the importance of collaborating with the domestic violence/sexual assault and behavioral health departments. Some clients can be better served by specialized staff who can help them access community resources tailored to their needs. Externally, CAP-VIP participates in Project Change to collaborate with HVIP programs in metro Washington, DC.

Perceived Impact

Staff Perceptions Staff described several positive program impacts. CAP-VIP helps clients adapt to new physical limitations. For example, staff have assisted paraplegic clients in obtaining driver's licenses and providing wound care kits to support recovery. Staff also provide emotional support and facilitate connections to mental health services.

The program contributes to client stability by connecting individuals to critical resources such as safe housing. Staff highlighted the long-term relationships built with clients, noting that some clients advocated for staff during potential layoffs. The Men's Group and weekly

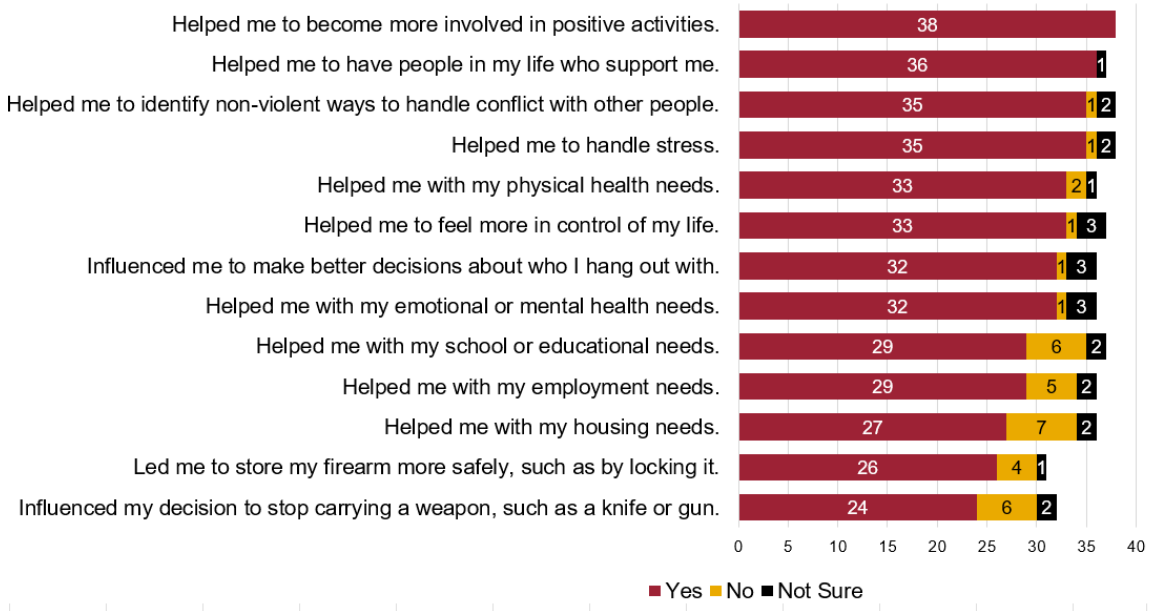
basketball activities further strengthen client engagement and relationships.

Client Perceptions Between August 2024 and January 2026, 38 individuals completed the participant satisfaction survey. Respondents primarily identified as Black or African American (90%) and men (95%) and were 29 years of age on average.

Clients had extremely positive perceptions of CAP-VIP staff with 100% reporting that staff treated them with respect and 97% reporting that staff responded quickly to questions or concerns. Almost all survey respondents reported feeling safe in the program (97%), that they would recommend CAP-VIP to others (95%), and that staff respected their cultural background (95%). CAP-VIP services were also viewed positively by clients; respondents frequently endorsed that the services made a difference in their lives (92%), that services were available during times that worked with their schedule (92%), and that they were satisfied with the service referrals (90%).

Clients were also asked to describe how CAP-VIP services addressed their underlying needs. As displayed in *Figure 6.2* clients most frequently reported that the services offered via the program helped them engage in more prosocial activities and networks, improved conflict resolution and stress management skills, and addressed physical health needs. In contrast, fewer clients endorsed that the program influenced their decision to stop carrying weapons, improved safe firearm storage, or addressed housing needs.

Figure 6.2. CAP-VIP Perception Survey Responses



Note: Remaining responses were “not applicable”. This commonly ranged between 3-5%, except for carrying a weapon (14%) and firearm storage (16%).

Several clients shared that staff helped them immediately following a violent incident; one described feeling "blessed" to have their support, while another noted they were "a major help toward their recovery and healing." Clients also noted how the program provided a sense of stability, community, and resources. A few clients expressed that they wish they had more time to speak with staff or that they could receive assistance with housing. Taken together, clients described program impacts related to improved outlook on life, health, well-being, and decision making.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges Staff identified several barriers and challenges:

- **Funding** The one-year VIPP grant renewal period creates uncertainty and limits long-term planning. This can create a lack of job security for staff who are fully grant funded. Funding constraints can also restrict the program's ability to meet urgent client needs, such as transportation. Shifts in the federal funding landscape directly affected CAP-VIP staffing as well as the resources available through community-based partners.

- **Hiring Challenges** Hospital background check policies limit the ability to hire staff with lived experience for the VIS position. The hospital's lengthy hiring process, combined with short grant cycles and delayed funding notifications, can prevent timely hiring and may result in unspent staffing funds being returned.

- **Lack of Trust** Mistrust can prevent clients from disclosing information such as accurate phone numbers or the reason for their injury. For instance, clients might believe the program collaborates or exchanges information with law enforcement. As noted above, collaboration with crime victims' services was cited as a specific example of how the mistrust of law enforcement may lead potential clients to decline CAP-VIP services. This mistrust may be exacerbated under the current shift to telephone outreach to compensate for the reduction in staffing.

- **Referral Processes** Staff described that even when clients are interested in services, the extensive paperwork can dissuade them from participating. Such procedural hurdles, as well as unresponsive external service providers, can delay service delivery and lead clients to become frustrated with CAP-VIP staff.

- **Housing Challenges** Limited affordable housing in Maryland significantly affects

clients. Many are unable to work for extended periods following injury, increasing housing instability. Due to limited alternatives, clients often return to the same neighborhoods where they experienced violence, increasing the risk of re-injury.

- **Emotional Impact of the Work** Staff experience emotional strain from working with trauma survivors, particularly those with lived experience. While staff attempt to maintain boundaries (e.g., turning off work phones on weekends and limiting hours) urgent client needs can make this challenging.

- **Support Structures** Some staff suggested designating structured time for the team to review and process cases together and to create space where staff feel heard in their experiences. Staff also noted high caseloads, which could be partly resolved by hiring additional staff or increasing work hours to allow them more time to complete their duties. Despite the high caseloads, staff mentioned they felt supported in requesting time off for mental health. However, some staff suggested that these days would ideally be built into the schedule to remove the onus on them to generate a request.

- **Technology** The current data system permits only one user at a time, slowing documentation. Leadership is working to transition to a more functional system. Staff also noted clients' difficulty accessing the hospital's virtual platform for activities such as the Men's Group.

Facilitators and Sustainability Staff identified two key components to the program's success. First, despite the daily challenges and funding uncertainty, staff remain incredibly committed to the program. Moreover, staff are skilled at building rapport with clients. For example, staff described how they do not pitch a program; instead, they focus on learning about the person and engaging any family members or visitors who are present to build trust before offering services during a critical window of engagement. Second, strong community partners are central to locating limited resources for clients. As one staff member described, "We [CAP-VIP] could have a full team, but if I have nothing to offer you then why do we even have a program?"

In terms of sustainability, the current unpredictability of the funding landscape has led CAP-VIP to focus on "just staying steady." As noted above, the program has been able to maintain core programmatic activities with modifications that account for limited staffing. The program has also tried to account for the funding disruptions experienced by their community-based partners by supplementing with no-cost resources offered through clothing

and food banks. Safe housing remains a challenge given the cost of living in Maryland. For example, staff noted that it can cost $5,000 to relocate one person and they have had to try and shift funding around to address this pressing need. Finally, the potential impact of H.R.1 on hospitals remains uncertain but could significantly affect medical costs for uninsured CAP-VIP clients as well as those receiving Medicaid or Medicare.[31]

Conclusions and Lessons Learned

Both CVIP and CAP-VIP are built on the premise that bedside engagement in a hospital setting while people are recovering from traumatic injury creates a critical window of heightened receptivity to intervention. Staff at both sites emphasized that this engagement must be conducted with empathy and without judgment in order to build the trust necessary for clients to accept an initial offer of care. Rather than pitching a program, staff at both sites described centering the person first before introducing program services. From that initial engagement to follow-up services, both programs take a holistic approach to client needs, recognizing that violence is rarely the only challenge a client faces. Housing instability, unemployment, legal complications, mental health needs, and lack of insurance are treated as interconnected issues requiring coordinated responses. Both programs connect clients to a broad network of community partners to address these needs, and both have developed informal relationships within their hospitals that help expedite care. Lived experience is valued at both programs as a hiring criterion for client-facing roles, with staff noting that shared backgrounds with clients meaningfully strengthen rapport and credibility.

The primary challenge facing both CVIP and CAP-VIP is funding instability. Both programs have experienced funding reductions or terminations forcing significant operational adjustments. For example, CAP-VIP lost three violence intervention specialists and had to shift from around-the-clock bedside intervention to a reduced weekday schedule and telephone outreach, while CVIP narrowed its eligibility criteria to serve DC residents exclusively after VIPP funding ended. This shift in the intake process can deepen clients' mistrust of law enforcement, particularly around engagement with crime victims' services. Both programs also face significant challenges in accessing safe housing resources for clients given the scarcity of affordable housing in the region; clients frequently return to the same environments where they were injured, and relocation can cost thousands of dollars per person. More broadly, staff noted that the funding instability affecting their programs has also affected community-based partners and available resources. Finally, both programs

[31] Also known as the "One Big Beautiful Bill Act," *H.R. 1* of 2025 introduced significant changes to healthcare including stricter eligibility criteria and work requirements for Medicaid.

shared hiring challenges associated with navigating strict hospital protocols and short-term VIPP grant cycles, making it difficult to hire qualified staff with lived experience.

When staff were asked to reflect on lessons learned from running HVIPs, several cross-cutting themes emerged. First, the timing and modality of engagement matter enormously. The hospital bedside is not just a convenient access point; it is a uniquely effective one, and any reduction in in-person capacity has outsized consequences for enrollment and trust-building. Second, community partnerships are not just supplementary, but the mechanism through which programs actually deliver on their promises. When partner organizations lose their own funding, the ripple effects compromise what HVIPs can deliver. Third, both programs point to the tension between hospital institutional standards and the lived experiences of staff best suited for violence intervention work. Securing organizational leadership buy-in is essential for negotiating with hospital administration to create hiring pathways for individuals with criminal records or non-traditional backgrounds, and for devising contingency plans to sustain staffing when the funding landscape shifts unexpectedly. Finally, the looming uncertainty around Medicaid, Medicare, and hospital financing under federal policy changes (specifically H.R.1) represents a systemic risk that neither program can address on its own, but that could significantly affect the uninsured and Medicaid-enrolled clients both programs predominantly serve. Staff advised that HVIPs should maintain a flexible database infrastructure and clear key performance indicators to enable rapid programmatic adjustments in response to shifts in the political or funding landscape.

Chapter 7

Impact Evaluation – UMCAP CAP-VIP

To estimate the effect of HVIP (the intervention) on violent or gun-involved crime, we focus on UMCAP's implementation of CAP-VIP in Prince George's County. We first discuss important local context from Chapter 6 that informed how we created treatment and comparison areas within the county. Then, we describe primary data sources, findings, and limitations.

Background

HVIPs assess the medical and social needs of violently injured patients and provide intensive case management after discharge. The HVIPs implemented by the two hospitals described in Chapter 6 (UMCAP and MedStar) used VIPP funding to primarily serve violently injured individuals in Prince George's County. In our interviews with program staff, they emphasized the importance of engagement during the first 24 hours of hospital admission—when that engagement is limited, it can reduce program participation rates given the voluntary nature of services and other barriers discussed in the earlier chapter. The programs intended to use VIPP funding to expand staff coverage in order to engage with more patients during those critical first 24 hours, so as to increase participation among eligible patients.

In 2021, UMCAP opened its own trauma center, which shifted most violently injured patients to their HVIP program, CAP-VIP. Program data confirm this shift, with the majority of cases in Prince George's County now served by CAP-VIP. Program staff described that reduced funding starting in July 2024 alongside the termination of a large federal award in spring 2025, led to reduced staff coverage. Accordingly, this analysis focuses on CAP-VIP, as the study period spans from 2022 to 2025.

In this evaluation, we use a difference-in-differences design, which focuses on finding comparison census tracts that have similar pre-intervention crime trends to the treatment areas and assesses the relative change in outcomes before and after the program's expansion. By doing so, we can find areas that are affected by similar factors over time, and the only difference is the program intervention after the additional VIPP funding. Since HVIPs do not have a catchment area in the same way that CVI programs do, we operationalize treatment areas as those areas where a larger number of potential cases for CAP-VIP reside. If the program is successful in reducing neighborhood violence, this should be felt most acutely in

neighborhoods where a greater number of residents have had the opportunity to receive CAP-VIP services.

Critically, these analyses are less precise in measuring both treatment exposure and program intensity than would be ideal. One major limitation in our test of the HVIP model is that we do not have access to data at the individual level. We are unable to evaluate the effect of CAP-VIP on primary outcomes such as injury recovery, re-injury, or navigating the medical and criminal legal systems.

In addition, the program data used to define treatment areas only reports the number of eligible cases by ZIP code, where only a subset of those individuals ultimately participate. The number of participants may therefore be too small to produce detectable changes in crime at broader geographic levels. Ideally, we would first compare recidivism rates of program participants to similar non-participants. If participants show lower rates of reinjury or rearrest, we could assess whether these individual level effects translate into neighborhood level crime reductions. Unfortunately, these data were not available for this analysis.

Data

We utilize three data sources. First, we use crime incident data from Prince George's County's open data portal, which contains incident descriptions and location for events occurring between January 1, 2022, and December 31, 2025.[32] Analysis specifically focuses on assaults, homicides, robberies, and shootings. Second, demographic information comes from the 2021 ACS 5-year estimate.[33] This source provides data at the census tract level on gender, age, household income, employment rates, public assistance rates, health insurance rates, and rates of car usage for commuting to work. Third, we use administrative program data (Chapter 6) that tabulates the total number of cases by ZIP code. We linked data from these three sources to create panel-level datasets with counts of crime incidents in each census tract broken down by quarters; each census tract has 16 observations over the 4-year study period.

Treatment and Comparison Areas

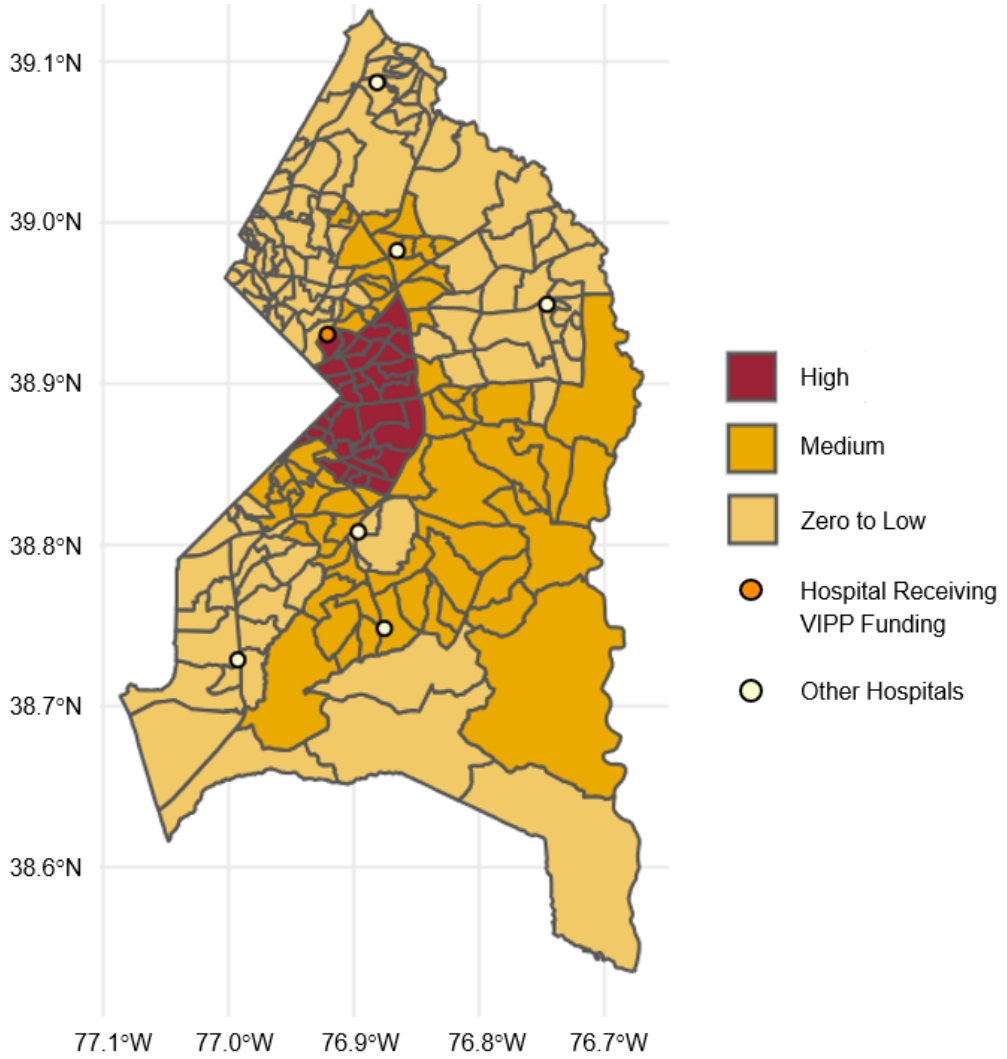
For our main analysis, we use a difference-in-differences design. Census tracts are assigned

[32] Prince George's County Government. 2023. *Crime Incidents July 2023 to Present*. Open PGC. Retrieved July 23, 2026 (https://data.princegeorgescountymd.gov/Public-Safety/Crime-Incidents-July-2023-to-Present/xjru-idbe).
[33] United States Census Bureau. 2026. *American Community Survey 5-Year Data 2021*. Retrieved July 23, 2026 (https://www.census.gov/data/developers/data-sets/acs-5year/2021.html).

to ZIP codes with the largest area overlap. Subsequently, we define the treatment group as census tracts falling within ZIP codes with high case volumes. We categorize ZIP codes with at least 40 cases as "high volume," 15-39 cases as "medium volume," and 0-14 cases as "zero to low volume." Only three ZIP codes meet the high volume threshold, displaying a distinct jump compared to medium volume areas, where the case count hovered around 20.

While our primary analysis compares these high-volume areas to all other areas, we also conduct a robustness check that omits the medium-volume areas from the comparison group entirely. *Figure 7.1* displays a map of Prince George's County organized by census tract and case volume based on the corresponding ZIP code, with treatment areas highlighted as dark red census tracts. The post-intervention period is set from October 1, 2023, to December 31, 2025, aligning with the timeframe when the CAP-VIP aimed to increase participation rates for eligible patients. For the analysis, we split the post-intervention period in order to separately test VIPP funding’s impact on trends in the expansion period (October 1, 2023, to June 30, 2024) and the post-expansion period (September 1, 2024, to December 31, 2025, when CAP-VIP’s funding was cut).

Figure 7.1. CAP-VIP Treatment Areas in Prince George's County Based on Case Volume



Notes: The map shows the treatment and comparison areas by census tract. The red census tracts are in ZIP codes where the case volume is at least 40 cases. The darker yellow census tracts are in ZIP codes with roughly 20 cases. The lighter yellow census tracts have 0-14 participants.

For difference-in-differences analyses to test the impact of the HVIP on crime, comparison tracts must have similar pre-period crime trends and they should have similar socioeconomic and demographic profiles. Therefore, if tracts in high-volume areas differ from other tracts on these indicators, we need to match treatment tracts to an appropriate sub-set of the other tracts prior to conducting the main analysis. Census tracts in the high volume areas exhibit higher crime rates and socioeconomic challenges than the pool of potential comparison tracts. *Table 7.1* shows that the high volume tracts average 1.44 assault incidents, 1.43 robberies, 0.45 shootings, and 0.13 homicides per quarter in the period before the intervention. In contrast, the low volume tracts average 0.92 assault incidents, 0.91 robberies, 0.11 shootings, and 0.03 homicides, indicating a lower level of violent crime. Beyond crime

rates, the treatment areas also have slightly lower income levels, a higher proportion of households receiving public assistance, and fewer married households. Demographic profiles differ as well with treatment tracts having a larger share of Black residents.

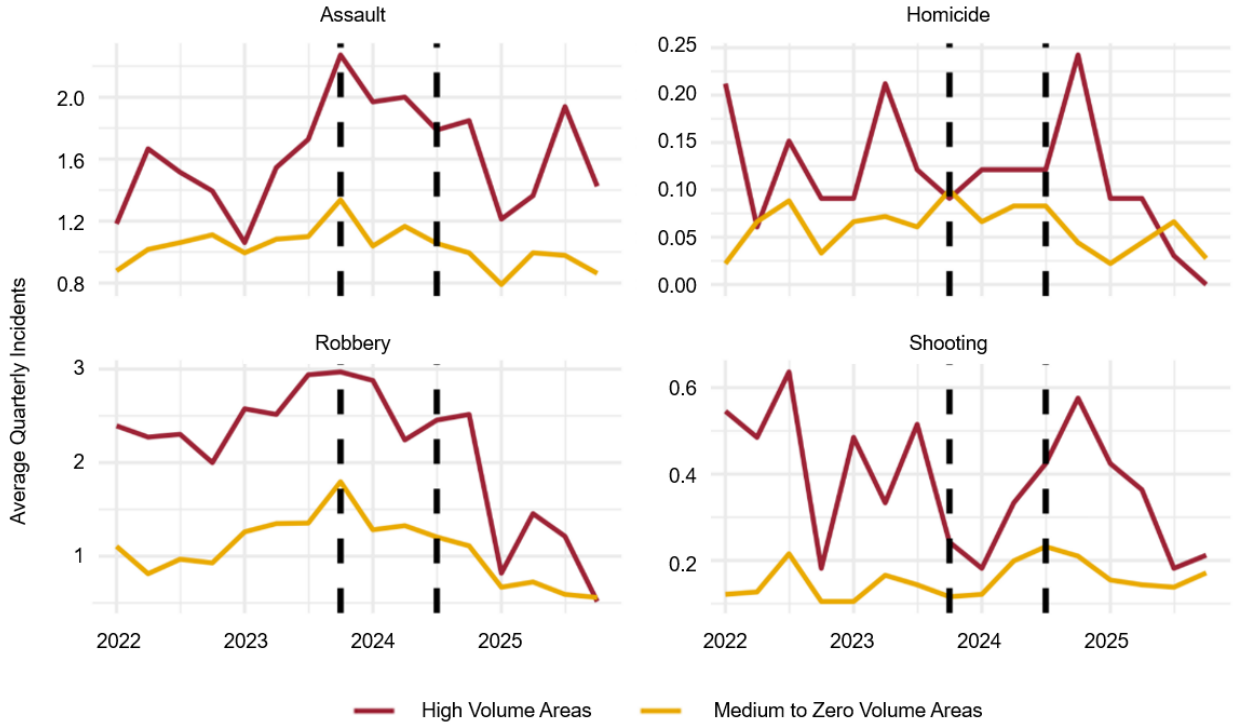
Table 7.1. Descriptive Statistics of Treatment to Comparison Areas

Measure	High Volume Area	Medium Volume Area	Low Volume or No Participants Area
Number of Census Tracts	33	68	113
Average Case Count Over Expansion Period at Corresponding ZIP Code Level	44.9	20.7	6.2
Mean Quarterly Incidents in the Pre-Period (Jan 2022 – September 2023)			
Assaults	1.44	1.22	0.92
Homicides	0.13	0.10	0.03
Robberies	2.43	1.44	0.91
Shootings	0.45	0.20	0.11
Mean Quarterly Incidents in the Post-Period (October 2023 – Dec 2025)			
Assaults	1.76	1.19	0.93
Homicides	0.10	0.07	0.06
Robberies	1.90	1.20	0.93
Shootings	0.33	0.22	0.13
Demographic and Socio-Economic Characteristics (%)			
Male	46%	47%	50%
Under age 24	15%	14%	17%
Hispanic/Latino	10%	13%	30%
Black or African American	84%	76%	49%
Moved in the past year	13%	13%	14%
Use car to travel to work	73%	74%	76%
Married households	28%	36%	41%
Annual household income below $30K	14%	10%	12%
Receive public assistance	17%	11%	11%
Employed	92%	92%	93%
Housing vacancy	7%	8%	15%
Uninsured	6%	5%	6%

Notes: This table compares the average quarterly crime incident counts and ACS survey estimates for the high-volume, medium volume, and low volume/no participant areas.

Figure 7.2 presents the crime trends for the treatment group versus the rest of the census tracts. While robbery trends exhibit different levels for the treatment group versus comparison pool, their trends move in the same direction in the pre-intervention period. For the remaining crime outcomes, both the trends and levels are different with the treatment group displaying higher crime rates as well as larger spikes or fluctuations. Consequently, we create a comparison group for each outcome, restricting the comparison groups to census tracts that exhibit more parallel crime trends to the treatment tracts for each respective crime outcome and share similar demographic and socioeconomic profiles.

Figure 7.2. Crime Trends for Treatment versus Comparison Pool Areas



Notes: This plot shows the average quarterly crime incidents by quarter for the high-volume areas versus the remaining areas for each crime type. The dashed line represents when increased participation rates should have occurred on October 1st, 2023. The second dashed line represents the post-expansion period when funding was cut.

Analytical Setup

For each outcome for each treated census tract, we search for two comparison tracts with similar pre-intervention crime trends and census estimates for household income, employment rate, and share of population under the age of 24.[34] Units where there is no variation in crime outcomes such as no homicides throughout the study period are excluded

[34] We do not use the full set of demographic and socio-economic indicators to match on because our primary focus is identifying cases with the same pre-period trends in crime outcome. When using the full set of census-level controls, the treatment group can drop by as much as half.

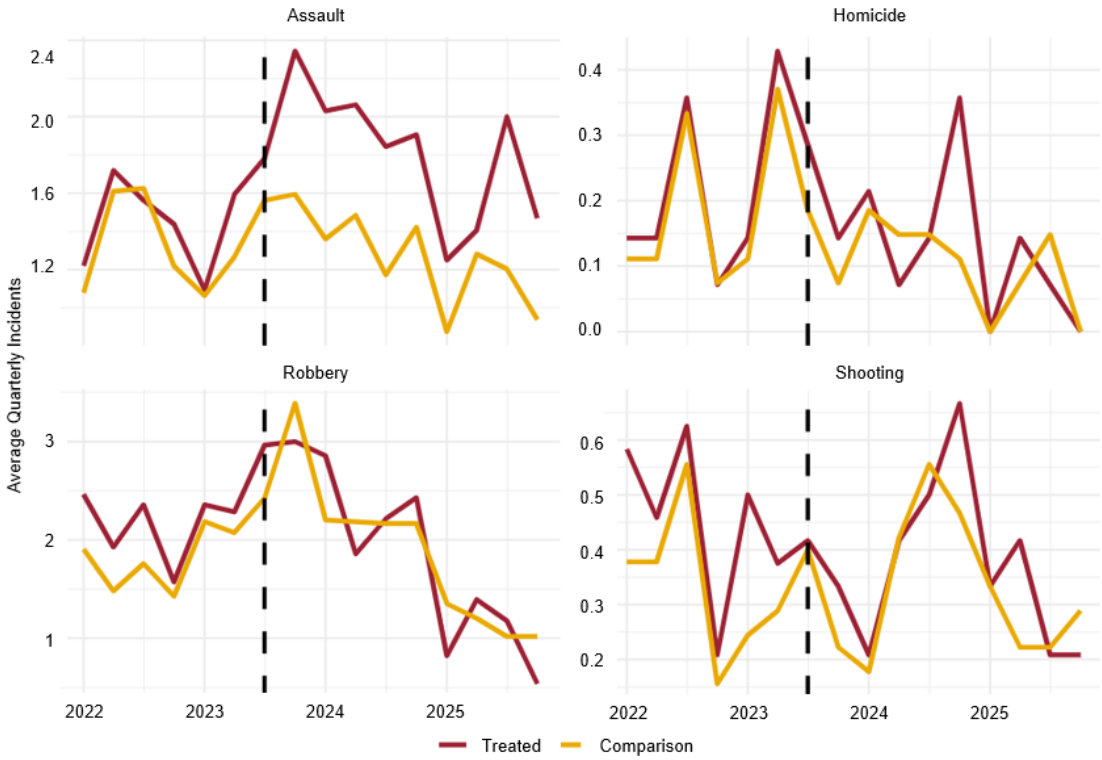
from the analysis. In addition, it may not be possible to find a similarly situated comparison tract for some treatment tracts; these tracts are also excluded from the analysis. *Table 7.2* shows the treatment and control groups sizes. For homicides, due to zero counts, a handful of treatment tracts and their corresponding comparison cases are excluded. In addition, some of the treatment tracts may only have one comparable census tract rather than two.

Table 7.2. Matched Sample Sizes

Outcome	Treated	Control
Assault	32	64
Homicide	14	27
Robbery	28	54
Shooting	24	45

Figure 7.3 displays the crime trends for the matched sample. In contrast to *Figure 7.2*, the crime trends in the pre-intervention period are closely aligned for all four outcomes. Visually, *Figure 7.3* suggests that we have parallel trends and satisfy the primary condition for causal inference a difference-in-differences design. We also conduct statistical checks to see if the trends are significantly different in the pre-period and do not find evidence of parallel trend violations as shown in the Appendix (*Figure A.6*).

Figure 7.3. Crime Trends with Matched Sample



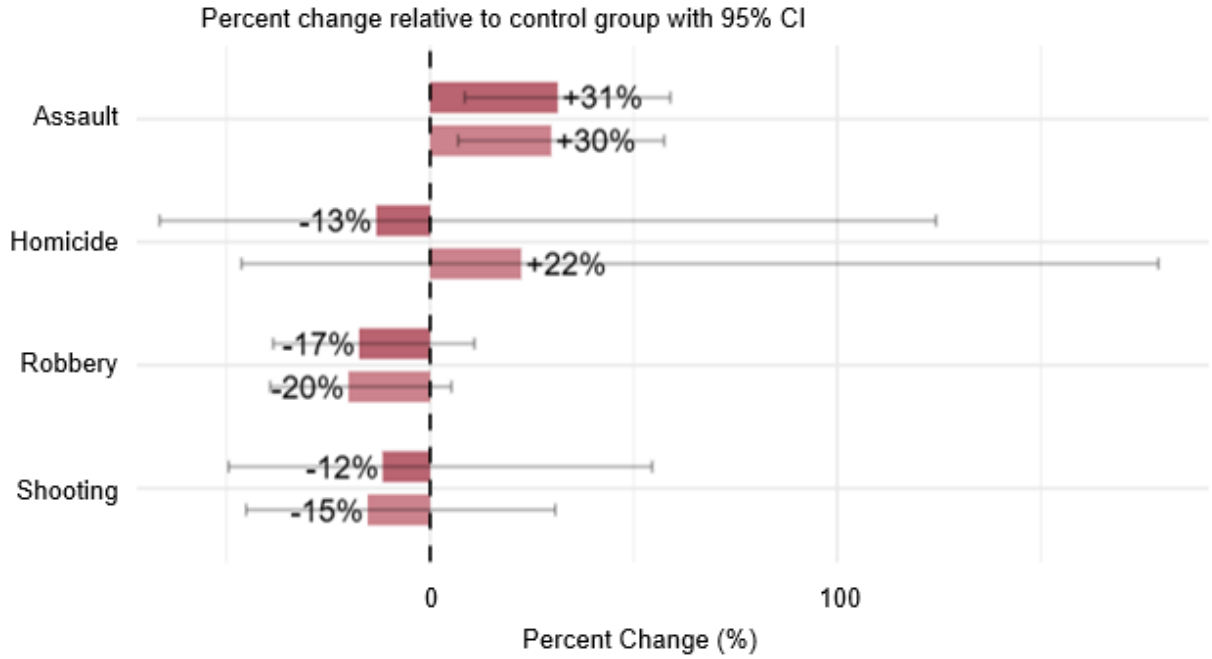
Notes: This plot shows the average quarterly crime trends by quarter for the treatment group versus the comparison group for each crime type. The dashed line represents when the HVIP program expanded. .

What is the effect of CAP-VIP on crime?

Figure 7.4 displays the net change in crime incidents for the treatment group attributable to the intervention. In other words, the estimates show the change in the treatment areas above and beyond what happened in the comparison areas. Changes in crime are considered statistically significant when the entire confidence interval (the horizontal line) does not overlap with the 0% mark. The estimates are split by the expansion period between October 1st, 2023, and June 30th, 2024, and post-expansion period between September 1st, 2024, and December 31st, 2025, when funding was cut. During the expansion period, the treatment areas experienced a non-significant reduction in shootings by 12%, robberies by 17%, and homicides by 13%. In the post-expansion period, we continue to see non-significant reductions except for homicides, which displays non-significant increases. In both periods, assaults increased by about 30% at a statistically significant level. The differences in assault trends are also clearly visible in the graph in *Figure 7.3*.

As a robustness check, we run the same analysis using synthetic control methods shown in the Appendix (*Table A.2*). We find similar results where assaults increased, and the remaining outcomes showed non-significant reductions. Altogether, we do not find evidence of differential reductions for the treatment area versus the comparison areas.

Figure 7.4. Difference-in-Differences Estimates on Crime Incidents



Notes: Figure shows the difference-in-differences estimates for the four crime outcomes. When the confidence intervals (CIs) do not overlap with 0, the results are statistically significant. The estimates are broken down for the expansion period, between October 1st, 2023, and June 30, 2024 (lighter red), and post-expansion period from September 1st, 2024, to December 31st, 2025 (darker red).

Summary and Limitations

We do not find evidence of differential reductions in crime incidents for the four violent crime types investigated. The changes in crime rates are similar before and after the funding cuts. Crime rates in the treatment and comparison groups followed similar trajectories, with the notable exception of assaults. Given CAP-VIP's theory of change, which focuses on individual intervention and conflict de-escalation, the observed increase in assaults is unlikely to be a causal effect of the HVIP program. This divergence may reflect the unique volatility of the treatment areas, which already experience disproportionately high rates of violent crime and may have been more acutely impacted by pandemic-era social shifts. Furthermore, our geographic units of analysis may be too broad to capture the highly localized effects of the HVIP model. It is also important to note that the model prioritizes holistic outcomes beyond traditional recidivism reduction, such as quality of care, recovery, and social reintegration, as well as reducing rates of re-injury rates among participants, none of which are captured by these analyses due to the lack of more granular data.

We run multiple robustness checks and find consistent results. First, we omit the medium volume census tracts to isolate the comparison group to tracts mostly or entirely untouched by the program. Second, we extend the pre-period through 2021 under the possibility that the matching or synthetic control approach is overfitting to noisy data rather than to substantive trends under the shorter pre-period. Third, we redefined treatment based on geographical proximity to the two trauma centers hosting HVIP programs, assuming participation is partially driven by hospital access. Again, we do not find evidence of additional crime reductions across these three specifications.

Chapter 8

Public Health-Led Programs

Public health departments are increasingly recognized as essential partners in addressing gun violence, bringing data-driven strategies, cross-sector coordination, and a prevention-oriented framework to efforts that have historically been led by law enforcement. The two programs examined in this chapter, St. Mary's County Health Department's Group Violence Intervention (GVI) program and Anne Arundel County Department of Health's Gun Violence Intervention Team (GVIT), represent distinct but complementary approaches to this goal. St. Mary's GVI program uses a focused deterrence model to engage individuals at highest risk of group-related gun violence, combining law enforcement partnerships with community outreach, case management, and safe storage promotion in a rural county with limited existing prevention resources. GVIT operates as a multi-agency coalition, implementing a broad portfolio of evidence-based strategies, including community violence intervention, gun lock distribution, and community education, across a large county that spans both urban and rural communities. In this chapter, we describe each program's design, implementation, perceived impact, and the shared challenges that have shaped their operations during the evaluation period.

St. Mary’s County Health Department’s Group Violence Intervention Program (GVI)

The St. Mary’s County Sheriff’s Office (SMCSO) implemented the Youth Gun Violence Task Force in the summer of 2020. For one year, the task force focused on enforcement, investigation, and intelligence-gathering activities in neighborhoods to identify individuals involved in gun crimes and disrupt access to illegally possessed firearms. This effort was supplemented by SMCSO's engagement with community members and organizations to gather additional information and build community support.

The task force served as the foundation for the sheriff’s office to initiate a partnership with the St. Mary’s County Health Department (SMCHD) to implement the GVI program in 2023. At the time, SMCHD was seeking to reestablish its Violence, Injury, and Trauma unit and believed that unit staff could complement SMCSO's work. GVI is an evidence-based model rooted in focused deterrence theory that brings together community members, local organizations, law enforcement, and social service providers to deliver a coordinated anti-

violence message aimed at reducing group-related homicides and gun violence.

SMCHD first received VIPP funding in July 2022 to support personnel, equipment, and training expenses associated with implementation of the GVI program. In parallel with this, SMCSO received a two-year training and technical assistance grant from the National Network for Safe Communities to train law enforcement personnel in implementation of the GVI model.

Program Description

Eligibility Criteria The GVI program's catchment area includes Lexington Park and Great Mills, specifically ZIP codes 20653 and 20634. SMCSO identified these areas as "hot spots" with high levels of firearm-related incidents and assaults involving individuals up to age 25, while SMCHD's analysis underscored significant health disparities within this area. The program has served individuals ages 15–22, though there is no age requirement for eligibility. Parental consent is required for minors.

Referrals The program receives both law enforcement and community-based referrals.

- **Law Enforcement Referrals** Within the catchment area, SMCSO uses intelligence and investigative activities as well as other legal system partners to identify individuals at high risk of involvement in group violence. Staff noted that although law enforcement drives the identification process, during the review of shooting incidents the team will consider outreach to other individuals. For example, rather than engaging the individual who was injured, the GVI program will engage a family member if there is a concern about retaliation.

- **Community-Based Referrals** As discussed below, GVI is one program within SMCHD's broader Violence, Injury, and Trauma unit, which also offers youth mentoring programming. Moreover, the lack of violence prevention or intervention programming in the rural county has positioned GVI as a resource for the broader community. The GVI program receives referrals from community partners such as faith leaders and schools for individuals who are seen as at risk but may not be directly involved in the legal system or community violence.

Program Activities

Shooter Reviews Shooter reviews are conducted monthly to discuss recent incidents in the catchment area and identify individuals who may be at risk of perpetrating or experiencing firearm violence. Staff noted that reviews may occur more frequently during periods of increased incidents. Due to the confidential nature of the information discussed, these reviews are limited to three core GVI staff members: the SMCSO sergeant serving as GVI lead, the GVI program manager, and the community health outreach worker (staff roles described below).

Custom Notifications Once individuals are identified, the SMCSO sergeant accompanies the GVI program manager and community health worker, sometimes in conjunction with other community leaders, to initiate contact through a custom notification. Custom notifications are flexible and involve direct engagement with individuals of interest, regardless of legal involvement, at a designated community location. During these meetings, law enforcement, the program director, and the community health outreach worker deliver a personal deterrence message coupled with an offer of assistance. Staff also noted that custom notifications have been conducted with individuals who are detained or incarcerated.

The messaging involved in custom notifications is similar to the messaging delivered via "call-in meeting" component of the broader GVI model but delivered in a face-to-face individualized meeting instead of a group setting. Staff noted that the relationship-based approach of custom notifications was more appropriate than the larger call-in meetings typically associated with the GVI model, given the program's rural setting.

Custom notifications emphasize four core components:

1. **Consequences,** including safety risks and potential legal consequences, communicated by SMCSO;
2. **Opportunities** to access available services such as housing, legal services, and financial support, presented by SMCHD staff;
3. **Responsibility,** meaning the individual's accountability for their decisions and those decisions' outcomes; and
4. **Empowerment,** providing encouragement and a supportive space, sometimes led by community leaders, including faith-based representatives.

The GVI team provides additional materials with information about available services and offers follow-up from the community health outreach worker to explore referrals.

Case Management Following the custom notification, the community health outreach worker conducts additional outreach to engage individuals in services and programming. Staff emphasized that the program does not aim to recruit participants; rather, its goal is to ensure individuals are aware of available services and to facilitate a warm handoff for referrals needed by the individuals. Participation is voluntary and not court mandated. Case management is tailored to each client's needs and may include referrals to employment opportunities, housing, mental health services, financial assistance, legal services, and mediation services through collaborating agencies. The community health outreach worker may also facilitate connections to faith-based leaders and other community partners as well as provide access to services such as gun lock distribution.

Mentorship As part of case management, clients may be referred to SMCHD's youth mentoring program where they can receive additional support and mentorship through faith-based partners. Staff noted that mentorship is offered to clients as young as 7-17 years of age, but support services can also be offered to adults by spiritual and faith-based leaders. This is another departure from what is typically seen in the GVI model, where adults tend to be the focus.

Safe Gun Storage Campaign A central and distinctive program element is a safe gun storage campaign, funded in part by the Maryland Department of Health. Given the rural cultural norms around legal gun ownership, staff recognized early on that messaging focused on discouraging firearm ownership was ineffective. Instead, the program partners with shooting ranges and community members to promote responsible handling and secure storage of legally owned firearms.

Program Outputs

During the activity period spanning July 2023 to December 2025, the program held a total of 313 community meetings, and 70 outreach and education events. The program reported that there were a total of 13,766 attendees at these outreach and education events. Custom notifications were given to a total of 80 participants, resulting in a total of 157 custom notification encounters. The majority of these individuals were younger than 22 years old (59%, n = 47), Black (93%, n = 74) and Male (99%, n = 79). Fifty-one percent of these individuals (n = 44) were in the community at the time of reporting, while the remaining 36 were incarcerated. The program provided services supporting navigating social services, including those offered through the Department of Social Services; employment, and education services; spiritual support services; and services for incarcerated individuals. Additionally, the program distributed a total of 292 gun locks through a direct mail

campaign.

Staffing

Staffing Structure, Responsibilities, and Qualifications As noted above, VIPP funds support SMCHD staff involved in the GVI program, while SMCSO uses separate resources to support the law enforcement components. The GVI program is housed within SMCHD's Violence, Injury, and Trauma unit, which also houses youth mentoring and family programming not supported by VIPP (specific programs mentioned below). Although multiple funding streams exist, staff described programming as integrated and largely supported by five core positions.

- **Director of Health Promotion and Community Services** This position designs and oversees implementation of health programs, including violence prevention initiatives, in collaboration with the Violence Injury, and Trauma unit director and community partners. Responsibilities include aligning programs with public health priorities, fundraising, grant reporting, and monitoring performance. A background in public health and strong communication, problem-solving, and technical skills are considered beneficial.

- **Director of Violent Injury and Trauma Unit** This position oversees three programs: GVI, Mentoring Connections, and Empowering Youth and Bridging Communities. Responsibilities include planning meetings, organizing outreach campaigns, partnering with SMCSO for town halls, and coordinating training on trauma-informed care and evidence-based violence prevention strategies.

- **Violence Prevention Coordinator** This position leads implementation of the GVI program in partnership with SMCSO. This role focuses on direct outreach and relationship-building with individuals at the highest risk of gun violence involvement. The role also involves direct engagement with schools, faith-based groups, service providers, and public safety agencies to address the root causes of violence through community outreach and education.

- **Youth Engagement Coordinator** This position facilitates the Mentoring Connections program and the Nurturing Parenting program, providing direct services to at-risk youth and their families. Through proactive outreach, program planning, and consistent follow-up, the coordinator engages youth, families, school, and local mentoring organizations for service delivery.

- **Community Health Outreach Worker** This position conducts outreach for both GVI and youth mentoring programs, explains services to prospective clients, and provides case management and care coordination. Staff noted that lived experience and community knowledge are essential qualifications for this role, which was developed in response to feedback from faith-based leaders.

Staff training SMCHD GVI staff received training and technical assistance from experts at the National Network for Safe Communities supporting SMCSO's implementation of the GVI model. Staff also receive training on working with victims of violence, preventing burnout, identifying trauma responses, and using verbal de-escalation techniques. Additional training topics include community violence intervention, adverse childhood experiences (ACEs), trauma-informed care, adolescent mental health, and first aid.

Collaboration

The relationship with the sheriff's office has been both a core strength and a significant challenge for the program. When a new sheriff was elected in 2023, near the start of VIPP funding, the program had to restart the process of building buy-in and educating new leadership on viewing violence through a public health and trauma-informed lens. SMCHD has since worked with three different SMCSO deputies due to transfers and promotions. To address this, SMCHD has worked on developing trainings for law enforcement to help shift their mindset toward working *with* individuals rather than against them. A train-the-trainer model is being developed to institutionalize this approach and reduce disruption from ongoing law enforcement staff turnover.

The GVI model requires collaboration with multiple stakeholders beyond law enforcement. While SMCSO spearheaded implementation in close partnership with SMCHD, other collaborating agencies include the Department of Juvenile Services, the Department of Social Services, the State's Attorney's Office, and community leaders, including local clergy. Many partners serve on the GVI Executive Board, which meets semi-annually.

The GVI program also leverages internal partnerships within SMCHD, including collaboration with the behavioral health division to provide crisis intervention and mental health services. The department also operates a health hub and a satellite office in another part of Maryland, where walk-in clients can access services such as resume building and job training.

Perceived Impact

Staff described several positive community impacts. For example, over 1,000 gun locks and more than 100 safety boxes have been distributed in recent years to promote safe firearm storage. Staff also reported increased community awareness that violence prevention requires a broader set of stakeholders beyond law enforcement. Additionally, staff noted that local data show a decrease in violence since the GVI program's implementation.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges. Staff identified several barriers and challenges:

- **Lack of Funding** Funding challenges particularly affect the youth programming that supplements GVI. For example, the program sought to reallocate unspent VIPP funds to support summer programming at the Boys and Girls Club, but procurement timelines prevented the reallocation before the end of the fiscal year.

- **Lack of Staff Capacity** With only one community health outreach worker providing case management, capacity for expanded outreach and awareness activities is limited.

- **Hiring Challenges** The rural location reduces the candidate pool. Additionally, criminal background restrictions may limit hiring individuals with lived experience for outreach roles.

- **Lack of Participant Buy-In** Some prospective participants are skeptical due to unmet promises made by other programs in the past. Others disengage once immediate needs (e.g., food or housing) are addressed. To combat the low program enrollment, the program is exploring incentives, such as offering engagement in mentoring or case management as a potential factor in probation reduction.

- **Barriers to Participant Engagement** Maintaining communication with detained or incarcerated individuals who have expressed interest in program services upon their release presents a significant challenge. Transportation barriers also exist due to state liability policies, particularly for clients in rural areas without reliable transportation.

- **Lack of Agency Buy-In** Partner agency turnover disrupts continuity. As a relatively new initiative, GVI lacks widespread recognition among service providers, which limits incoming referrals. Staff have prioritized relationship-building and have

allocated funds for marketing efforts. For example, a video was produced in 2024 to showcase the program and its impact.

- **Limited Violence Prevention Resources** Some agencies struggle to classify GVI as a violence prevention program because it does not operate a dedicated youth program, which is sometimes considered a requirement for violence prevention programs. Rather, SMCHD leverages connections to internal youth-based programming to supplement the GVI model. Staff noted that this lack of institutionalized preventive services inhibits cross-agency buy-in and collaboration. Limited community-based youth resources (e.g., local YMCA programs) also constrain prevention efforts.

Facilitators and Sustainability The program's greatest assets are its community embeddedness and personal relationships. Staff have deep familiarity with the community and have cultivated trust across law enforcement, faith-based organizations, and families. The collaborative, multi-sector approach bringing together public health, law enforcement, and community partners is seen as central to the program's credibility and reach. VIPP funding was credited as essential for making these partnerships possible and for putting evidence-based practices in place. The program also invested in a communications effort to document and share the collective impact of all partners, reinforcing a sense of shared ownership over violence prevention.

In terms of sustainability, funding remains a challenge. SMCHD started this work under their Violence, Injury, and Trauma unit with funding from the National Association of City and County Health Officials. This enabled SMCHD to launch its youth mentoring program alongside strategic planning to implement evidence-based violence programming such as GVI. After a year and a half, those funds ceased prompting SMCSO to apply for different funding streams through the Governor’s office, the Maryland Department of Health, and ultimately VIPP. Thus, staff are constantly monitoring the state grant funding landscape to figure out how to sustain resources for staff lines and programming.

Anne Arundel County Department of Health’s Gun Violence Intervention Team (GVIT)

On April 5, 2019, Anne Arundel County Executive Steuart Pittman issued an executive order declaring gun violence a public health crisis and establishing the Gun Violence Prevention Task Force to examine firearm violence in the county and develop recommendations for action. The task force consisted of 20 appointed members representing sectors including

public safety, behavioral health, public health, and community outreach. The task force released its final report on June 5, 2020, presenting 55 recommendations spanning state and county policy, data and information sharing, coordination and collaboration, programmatic strategies, and violence prevention education. The report also included targeted recommendations for specific sectors, including health and mental health, schools, and law enforcement.

GVIT was established on August 12, 2019, under the leadership of the Anne Arundel County Department of Health to implement the task force's recommendations.[35] GVIT operates as a multi-agency coalition composed of city and county agencies and works in partnership with stakeholders and community members. Through collaborative meetings and coordinated workgroup efforts, GVIT implements evidence-based, data-driven strategies to advance its mission. In September 2020, three workgroups were established to support and lead implementation efforts: Data, Education and Policy, and Community.[36] In 2022, a strategic plan was developed to guide implementation. The Anne Arundel County Department of Health first received VIPP funding in July 2022 to support GVIT personnel, training, consultation, and equipment.

Program Description

GVIT has six goal areas, as delineated in its strategic plan, which are implemented across the three workgroups.

- **Goal 1** Lead gun violence interventions in Anne Arundel County and the City of Annapolis.
- **Goal 2** Monitor and advance evidence-based gun laws.
- **Goal 3** Prevent gun violence through education and increased public awareness.
- **Goal 4** Collect and report data on gun-related incidents, injuries, and deaths.
- **Goal 5** Disrupt cycles of community violence through engagement with community members and partners.
- **Goal 6** Coordinate a response process to support victims of gun violence.

Catchment Area GVIT focuses its efforts, including initiatives and partnerships, on Anne Arundel County. For example, prevention initiatives such as the gun lock distribution program described below are available only to Anne Arundel County residents. However,

[35] Since the time the site visited was conducted, GVIT transitioned from the Health Department's Office of Assessment and Planning to Family Health Services.
[36] The Community Workgroup was formerly referred to as the Environmental Workgroup.

staff noted that this is not strictly enforced, as they do not require identification or turn individuals away who request gun locks.

Staff frequently use gun-related data curated by the Data Workgroup to identify specific populations or geographic areas within the county that may benefit from targeted interventions. For instance, GVIT recently implemented a suicide prevention educational campaign targeted toward older white men, who experience the highest rates of firearm-related suicide deaths, according to health department data.

Program Activities

Violence Intervention Programming GVIT oversees violence intervention programs across the county. GVIT used VIPP funds to support another VIPP grantee, Kingdom Kare, in implementing the model in the Eastport neighborhood of Annapolis (see Chapter 4 for a description of Kingdom Kare's VIPP-funded activities in Severn). Specifically, GVIT brought Cure Violence Global to provide training and technical assistance to Kingdom Kare. As described in Chapter 4, Kingdom Kare had already adapted elements of the model but officially launched as a Cure Violence Global program in March 2026. GVIT has also sought to expand the Cure Violence model to a second site in Severn, which GVIT manages directly, as well as to a third site in the northern part of the county.

Gun Lock Distribution GVIT has collaborated with the Anne Arundel County Public Library System since April 2023 to distribute gun safety locks at 16 library sites across 13 municipalities. A key early step was identifying a vendor capable of supplying gun locks, purchased with VIPP funds, within a reasonable timeframe to launch a pilot at three libraries. Additionally, GVIT staff prepared toolkits discussing safe storage and youth gun safety to accompany the gun locks and produced signage for libraries to amplify the resource (all paid for via county funds). After an overwhelmingly positive response, GVIT rapidly expanded the program to the remaining libraries and regularly amplified the message across multiple platforms: through joint press releases with GVIT partners, monthly social media posts from libraries and the Department of Health, and outreach events.

Anne Arundel County residents 18 years of age and older may pick up one to two locks during library hours. (Library hours generally range from 10:00 a.m. to 8:00 p.m., Monday through Thursday, and 10:00 a.m. to 5:00 p.m., Friday through Saturday. Seven libraries also offer Sunday hours from 1:00 p.m. to 5:00 p.m., September through May.) Interested individuals complete an eligibility form, and the program uses the information on this form to track distribution metrics, including date, branch location, race/ethnicity, preferred

language, number of locks requested and distributed, and referral source. The program operates on an honor system, meaning library clerks do not check identification to verify age, as GVIT wants people to feel comfortable retrieving the resource and to mitigate fears that guns will be confiscated.

Gun locks are also distributed by the Office of Emergency Management, and a Community Health Ambassador partner called Growth Matters. In total, there are 13 distributing partners, including internal Department of Health programs, other government Family Services agencies, and local community organizations such as Kingdom Kare.

Data Workgroup Led by an epidemiologist, this workgroup gathers and reviews local firearm violence-related data, including gun-related homicides, suicides, and hospital visits (i.e., emergency department and inpatient admissions). The workgroup also collaborates with police departments, hospitals, and state agencies to collect data on extreme risk protective orders (ERPOs).[37] The team analyzes these data to identify high-risk areas and populations that could benefit from targeted initiatives such as gun lock distribution, educational campaigns, and community-based violence intervention programs. To further support GVIT's goals, the workgroup frequently disaggregates data by gender, race/ethnicity, and age. The workgroup also maintains a public-facing gun violence data dashboard presenting gun-related homicides, suicides, hospital visits, and ERPOs in Anne Arundel County since 2016.[38]

Education and Policy Workgroup This workgroup focuses on policies and community education related to gun violence and safety across Anne Arundel County. On the policy side, the workgroup helps inform county-level legislation, develops policy briefs, and monitors key state-level legislation. It ensures GVIT's priorities are represented before the General Assembly and City and County Councils by drafting letters of support or opposition and providing testimony. On the education side, the workgroup conducts public education campaigns and develops informational toolkits available on GVIT's website. Toolkits address topics such as suicide prevention, youth gun safety, responsible gun ownership, and domestic violence. The workgroup also facilitates community meetings focused on gun violence, related topics such as suicide and gun safety, and the application of a public health approach

[37] An Extreme Risk Protective Order (ERPO) is a civil, court-issued order that temporarily prohibits a person from purchasing or possessing firearms and ammunition. Because ERPOs are civil orders, they do not involve criminal charges.
[38] Anne Arundel County Department of Health. 2026. "GVIT Data Dashboard." Retrieved July 23, 2026 (https://www.aahealth.org/gun-violence-intervention-team/gvit-data-dashboard).

to prevention.

Community Workgroup This workgroup implements "on-the-ground" public health and community engagement strategies. It facilitates community meetings, administers surveys, and supports shooting response and victim assistance efforts. Community meetings and surveys assess public awareness of issues such as youth suicide and gun safety. Meetings also provide a platform for sharing data with community leaders and distributing GVIT-developed educational toolkits.

A critical role of this workgroup is expanding shooting response and victim support efforts. For example, the group has partnered with the Massachusetts-based violence intervention program Roca, which operates a site in Baltimore.[39] The health department has leveraged this partnership to ensure credible messengers are present in affected communities to provide support following gun violence incidents. This collaboration has helped fill gaps resulting from limited staffing capacity and ensures that victim response and support services remain available

Although the workgroups have distinct roles, they frequently collaborate across activities. For example, the community workgroup recently distributed suicide prevention toolkits developed by the education and policy workgroup.

Program Outputs

We will expand upon the reach of gun lock distribution in Chapter 9 using data from the county's public dashboard. In examining other workgroup outputs, a total of 1,082 gun safety brochures were distributed at community events. The county Department of Health also tracked website views on gun-related issues including suicide prevention kits (391 views), ERPOs (243 views), and free gun locks (808 views).

Staffing

Staffing Structure, Responsibilities, and Qualifications VIPP funding supports a small team within the Anne Arundel County Department of Health to oversee GVIT's activities. At the time of the site visit, the team included the health officer, a special assistant to the health officer, the family health services director, an epidemiologist, a violence

[39] Hossain, Farhana, and Kyla Wasserman. n.d. *How ROCA Works for Young Men at Most Risk of Violence: Baltimore*. MDRC. Retrieved July 23, 2026 (https://www.mdrc.org/work/publications/how-roca-works-young-men-most-risk-violence-baltimore).

intervention program coordinator, and a program manager funded through VIPP.

Staff and leadership identified several critical skill sets. Personnel working in firearm violence prevention and intervention should have a working understanding of the full spectrum of gun violence, including interpersonal violence, unintentional firearm injury, and suicide. While new hires may initially have expertise in only one area, cross-training and on-the-job experience can build competency across the full range of issue areas. Knowledge of injury and suicide prevention is particularly important given the high incidence rates in the county. Other key qualifications include a public health perspective, project management experience, strong communication skills, the ability to work across agencies, and experience engaging residents, particularly those impacted by gun violence.

Staff Training There is no required gun violence–specific training during onboarding. To build expertise, staff attend local, regional, and national conferences focused on gun violence prevention research and best practices. These include the Safe States Alliance Annual Injury and Violence Prevention Conference; the National Association of County and City Health Officials (NACCHO360) Annual Conference; trainings offered by the Giffords Law Center to Prevent Gun Violence; and the National Research Conference for the Prevention of Firearm-Related Harms. Staff also emphasized the importance of standard operating procedures and experiential, on-the-job learning. New hires are required to complete local government and project management training, which can delay full integration into program activities.

Collaboration

GVIT is a coalition of 21 partner agencies. This includes representatives from higher education (Johns Hopkins University, University of Maryland, Anne Arundel Community College) and the City of Annapolis (housing authority, emergency management, police, and fire department), and county agencies (Department of Health; Partnership for Children, Youth, and Families; Department of Aging and Disabilities; Department of Social Services; county police and sheriff's departments; State's Attorney; emergency management; fire department; detention facilities; county board; public library; mental Health Agency; and public schools).

Each agency designates a representative to participate in monthly GVIT meetings to coordinate firearm violence prevention efforts, in addition to workgroup activities. Coalition members pool resources and expertise to support ongoing prevention efforts. Partners may provide "on the ground" community insight, letters of support for grant proposals, legislative

testimony, distribution channels for community surveys or gun locks, or other in-kind support.

In addition to government agencies, GVIT collaborates with community-based organizations that are not formal coalition members. For example, as noted, GVIT has supported Kingdom Kare's implementation of the Cure Violence Global model in Eastport and other violence intervention programming in the county. In addition to bringing in Cure Violence Global for training and technical assistance, GVIT has supported these efforts by helping secure office space within housing authority units, strengthening their community presence. GVIT also collaborates internally with other health department units, such as the Behavioral Health Bureau, to provide suicide prevention training and community events.

Staff also identified opportunities to expand collaboration, including engaging the Department of Parks and Recreation, emergency medical services, emergency preparedness, and hospitals; increasing school-based programming, bringing violence intervention to youth; and strengthening coordination with Baltimore-based organizations, given the cross-jurisdictional nature of gun violence and trauma care. For example, county residents are often transported to the nearest high-level trauma hospital located in Baltimore.

Perceived Impact

Staff described several areas of impact. First, GVIT has helped reframe gun violence as a public health issue and strengthened prevention efforts countywide. This broader framing has supported a comprehensive approach encompassing suicide, assault, and homicide prevention. Second, the countywide gun lock distribution program was cited as a major success, having distributed an estimated 10,000 gun locks while increasing awareness and normalizing conversations about responsible gun ownership. Third, staff also reported enhanced community engagement and expanded access to prevention resources. Finally, staff noted decreases in injuries and fatalities in Annapolis and Severn but acknowledged that multiple factors may have contributed. They emphasized the importance of continued data monitoring to assess long-term impact.

Program Barriers, Facilitators, and Sustainability

Barriers and Challenges. Staff identified several barriers and challenges:

- **Insufficient Resources** Several staff members noted resource constraints (e.g., funding, staffing, time) that limit capacity and possibilities for expansion. For example, one staff member stated that there are opportunities to increase the

engagement of GVIT members, but staff have limited bandwidth. Staff also discussed the need for more competitive salaries given that the county is a remote suburban location and faces recruitment challenges. Staff turnover has also required role adjustments to maintain continuity.

- **Short Funding Cycles and Restrictions** One-year grant cycles that require a 10% reduction in budget requests for renewals impede long-term planning and sustainability. Additionally, delays in award notifications create pressure to spend funds quickly, compressing implementation timelines and risking reductions in program quality. Finally, funding restrictions on food and giveaways, resources that are essential to community engagement, can limit GVIT's ability to foster meaningful participation.

- **Data Challenges** Staff reported that obtaining gun-related incident data from the state takes approximately two years, leaving GVIT members and the community reliant on outdated information. Additionally, staff described challenges in accessing firearm violence-related data from the Annapolis and Anne Arundel County Police Departments. These agencies were initially hesitant to share information due to open investigations. Although data use agreements have improved collaboration, they restrict geographic precision to the ZIP code level rather than specific addresses. This reduces precision in identifying hot spots and limits the ability to use data to inform geographic programming decisions. Finally, staff raised concerns about data accuracy as police department staff manually input the data shared with GVIT and staff have noted errors.

- **Shifting Priorities** County elections may affect continuity and funding, a concern that is heightened by two-year election cycles and term limits on the county executive. For example, a newly elected county executive could deprioritize gun violence prevention and intervention efforts, resulting in reductions to or elimination of vital funding streams.

- **Hiring Restrictions** Staff described that background check policies may prevent hiring credible messengers with the community social capital necessary to mediate gun disputes. Additionally, government agencies like the health department move slowly. Staff noted that this can frustrate community members who expect more rapid responses.

- **Geographic and Jurisdictional Challenges** Staff acknowledged that the county's mix of urban and rural areas complicates implementation. The limited physical presence of the health department in western areas impacted by gun violence (i.e., Odenton, Severn, Glen Burnie), necessitates reliance on local partners for violence interruption and support strategies. Additionally, gun violence frequently crosses county lines, particularly between Anne Arundel County and Baltimore City, creating coordination challenges that extend beyond GVIT's formal jurisdiction.

Facilitators and Sustainability Staff identified three core strengths of GVIT. First, staff described how holding open community meetings, gathering feedback, and being transparent with partners helped generate genuine support and inspire programming such as the gun lock pilot. For example, one staff member recounted that following a community meeting attended by 60 people to discuss safe gun storage, an initial skeptic said at the end of the meeting that they felt equipped to carry the safe storage message themselves. Staff emphasized that community members are far more receptive to ideas that originate from within their own community. Additionally, credible messengers from within the community were identified as essential to program effectiveness. Finally, staff noted the importance of looking at data to understand community needs and tailoring delivery accordingly, while being careful not to break trust by imposing a one-size-fits-all approach.

Staff highlighted several factors that could sustain their work. They emphasized the need for the state to provide more training to practitioners and community members on applying a public health approach to gun violence, a framework that remains relatively new in both Anne Arundel and Maryland. Second, strong connections with community-based gun violence prevention organizations were critical to the health department and GVIT in terms of staying informed about local conditions and securing community buy-in. In conjunction, staff noted the value of engaging with other recipients of VIPP funding, to network and share information with agencies engaged in gun violence prevention across the state. Third, staff felt that having access to more data (e.g., data on other crimes and data from other counties) could help sustain their work. Finally, several staff emphasized that longer funding cycles are essential to sustainable programming, with one staff member stating that addressing the root causes of gun violence requires "long-term plans" supported by "long-term funding."

Conclusions and Lessons Learned

Both GVI and GVIT demonstrate that community trust and deep local embeddedness are foundational to public health approaches to gun violence prevention and safe storage. St. Mary's GVI program relies on deep personal relationships with faith leaders, families, and

law enforcement, while GVIT built genuine community support through open meetings, transparent data-sharing, and listening before acting. In both cases, programming that originated from community input carried far more legitimacy than top-down approaches. Credible messengers emerged as a cornerstone of both programs, whether in the form of community health outreach workers with lived experience in St. Mary's County or violence interrupters in Anne Arundel County. Both programs also recognized that gun ownership is a cultural reality requiring pragmatic engagement rather than prohibition-focused messaging. Safe storage campaigns reflect a pragmatic, community-appropriate approach that avoids alienating residents who are legal gun owners. Finally, GVI and GVIT benefit from a multi-sector coalition model that brings public health, law enforcement, and community partners into coordinated roles, lending credibility and expanding reach beyond what any single agency could accomplish.

In terms of common challenges, GVI and GVIT have both experienced funding constraints. Both programs operate on short grant cycles that compress planning timelines, restrict spending flexibility (e.g., no food or giveaways for community engagement), and create uncertainty about long-term sustainability. Staff in both programs spend considerable energy monitoring the grant landscape rather than focusing solely on programming. Second, staff capacity and turnover limit both programs. This is compounded by health department hiring restrictions that screen out candidates with lived experience, who are often the most effective voices in credible outreach. Third, partner and leadership turnover repeatedly disrupts continuity. St. Mary's has navigated transitions involving three different law enforcement deputies and a newly elected sheriff, each requiring fresh relationship-building and education about the public health approach. Anne Arundel faces similar risks from two-year county election cycles and term limits that could shift political priorities. Finally, data access is a shared obstacle. St. Mary's relies on law enforcement intelligence that is not always shareable, while Anne Arundel faces lags in state-level data and limited precision from police department data use agreements.

Program staff shared several lessons learned to inform other public health departments engaging in work related to firearms. First, programs must invest time in learning about community needs and norms in order to calibrate programming and build trust. For example, St. Mary's GVI program expanded beyond traditional focused deterrence to serve the broader community in response to an observed lack of local resources. Second, public health departments need to invest in preparation before deployment. Anne Arundel's experience with the gun lock program illustrates the value of developing materials, securing supply chains, and understanding community needs *before* launch, leading to faster and credible

scaling. Third, institutionalizing partnerships to survive turnover is important for sustainability. The workgroups established in Anne Arundel illustrate how formal structures can support continuity, while the approach to law enforcement engagement in St. Mary's demonstrates how culture can be incrementally shifted over time. Fourth, the complex problems associated with gun violence require long-term funding. Staff at both sites emphasized that addressing the root causes of gun violence cannot be accomplished within one-year grant cycles. Sustainable impact requires multi-year commitments that allow for genuine community trust-building and program iteration. Finally, a public health approach to gun violence is still relatively new in these counties and requires active education. Both programs invest significant effort in providing ongoing education and framing for partners to reinforce that violence is a public health issue, not solely a criminal legal system concern.

Chapter 9

Impact Evaluation – GVIT Gun Lock Distribution

The Anne Arundel County Department of Health has focused on reducing firearm-related incidents through the distribution of over 10,000 gun locks since April 1st, 2023. As described in Chapter 8, gun locks are primarily distributed through public libraries with a smaller share distributed through community partners or other public events. The gun locks are accompanied by informational toolkits about safe storage and suicide prevention. Residents generally request and receive two gun locks per household. In this chapter, we estimate the effect of gun lock distribution (the intervention) on firearm-related incidents using difference-in-differences with matching. We describe the primary data sources and how we established treatment and comparison areas within the county before presenting findings and limitations.

Data

To estimate the effect of the intervention on violent crime incidents, this analysis utilizes three data sources. First, Anne Arundel County's Police Department and Annapolis's Police Department provided incident data, which contains descriptions and locations for incidents occurring between January 1, 2022, and December 31, 2025. During this time frame, Anne Arundel County's Police Department changed case management systems and their reporting criteria to align with the definitions used in the FBI's NIBRS system. As a result, the analysis is restricted to three measures that are tracked in a consistent manner for the entire period: shootings, reported shots, and attempted suicide. A key limitation is that the attempted suicide measure includes both non-firearm and firearm-related attempts. Second, demographic information is drawn from the Census Bureau's American Community Survey, specifically, 2021 ACS 5-year estimate.[40] This source provides census tract and ZIP code level data on gender, age, household income, employment rates, public assistance rates, health insurance rates, and rates of car usage for commuting to work. Third, the analysis uses program data on the number of requested and distributed gun locks by recipient home ZIP code.

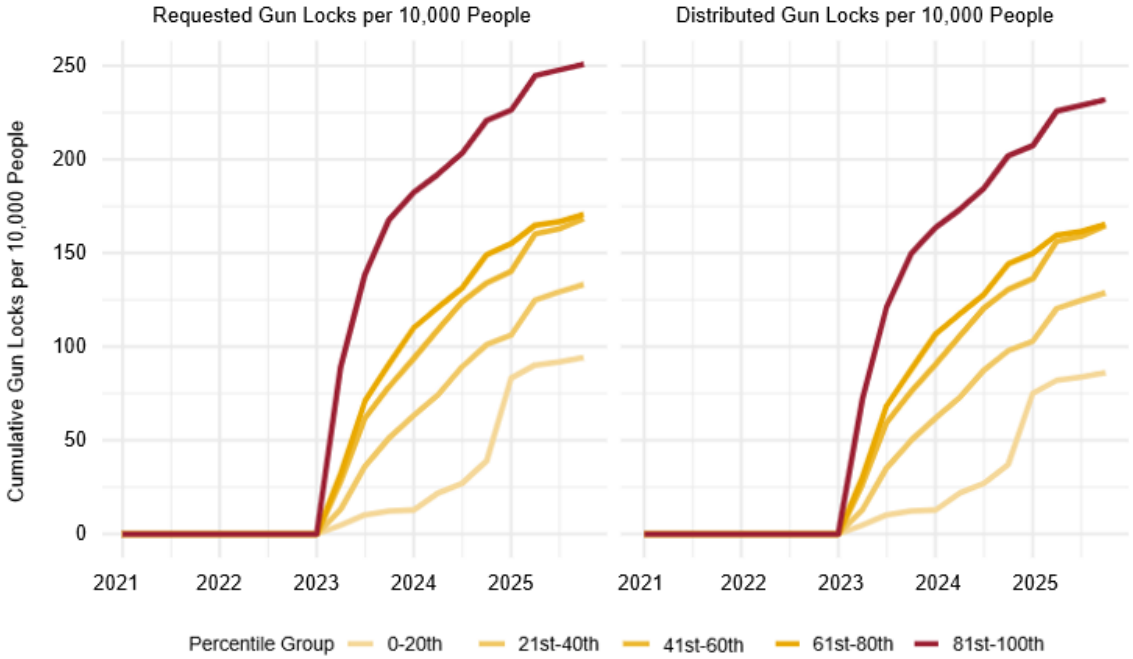
[40] United States Census Bureau *supra* note 33.

Treatment and Comparison Areas

We define the treatment group as census tracts falling within ZIP codes in the top 20th percentile of requested gun locks per 10,000 people from April 1, 2023 to March 31, 2024. Census tracts are assigned to ZIP codes with largest area overlap. We use a one-year period because gun lock distribution was slowly rolled out, and the early adopters thus receive a larger treatment effect in both volume and duration. *Figure 9.1* displays the average cumulative requested and distributed gun locks per 10,000 people by the five percentile groups. From the very start of distribution, the top percentile group substantially deviates from the others, suggesting that these ZIP codes and the census tracts in them benefitted from the intervention through greater interest and quicker uptake. By the end of 2025, enough gun locks were distributed to cover at least 2-3% of the population in the main treatment tracts.

A challenge with measuring the effectiveness of the gun lock distribution is that gun locks were widely distributed across the county, preventing the analysis from using a comparison group that had no gun locks distributed. This limitation can potentially lead to underestimates of the efficacy of gun lock distribution, as we are comparing high volume areas to low volume areas which would partially benefit from the intervention, rather than comparing to areas with no distribution.

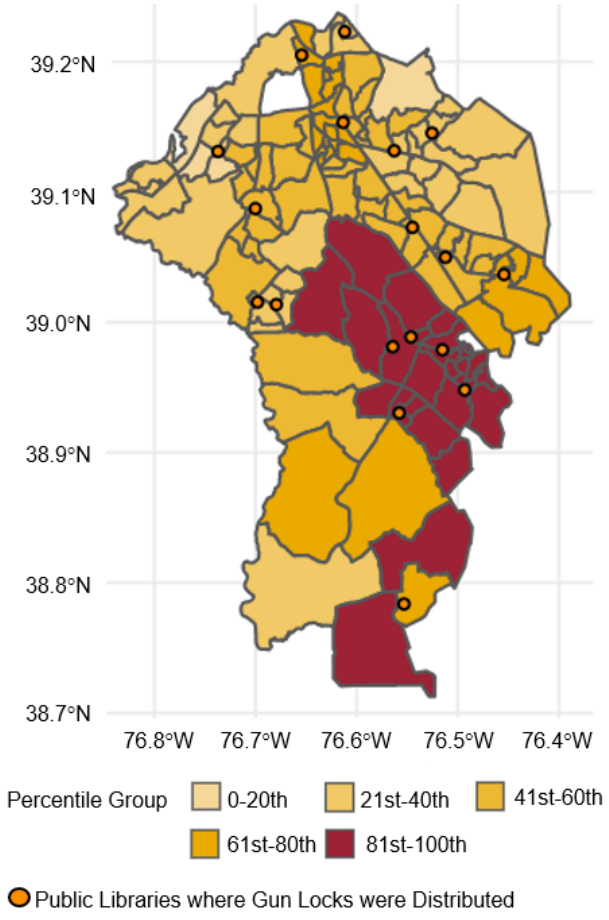
Figure 9.1. Cumulative Requested and Distributed Gun Locks per 10,000 People



Notes: The figure shows the cumulative requested and distributed gun locks per 10,000 people by ZIP codes broken into five percentile groups. The main treatment areas in red are in the top percentile group.

We conduct two robustness checks to address this limitation. First, we run the same analyses but drop the 60-80th percentile group from the pool of potential comparison tracts. Second, we repeat the analyses but change the threshold for main treatment areas from the top 20th percentile to the top 25th percentile. The results are consistent, and the remainder of this section presents the top 20th percentile group as the treatment group. *Figure 9.2* displays a map of Anne Arundel County organized by census tract and gun lock distribution percentile with treatment areas in red.

Figure 9.2. GVIT Treatment Areas in Anne Arundel County based on Requested Gun Locks per 10,000 People



Notes: The map shows the treatment and comparison areas at census tract level. The main treatment areas in red correspond with the ZIP codes in the top 20th percentile of gun locks requests per 10,000 people.

The pre-intervention period is from January 1st, 2021, to March 31st, 2023. The post-intervention period is set from April 1, 2023, to December 31, 2025, aligning with the timeframe when the program widely distributed gun locks.

For difference-in-differences analyses to test the impact of gun locks on firearm-related

incidents, comparison tracts must have similar pre-period incident trends. Therefore, if tracts in high-volume areas differ from other tracts on these indicators, we need to match treatment tracts to an appropriate set of comparison tracts. *Table 9.1* shows that in the period before the intervention treatment areas, equivalently tracts in the top 20th percentile, averaged 0.21 attempted suicides, 1.17 reported shots, and 0.18 shootings per quarter. These areas averaged 139.5 requests for gun locks per 10,000 people. In the remaining groups, during the pre-period, the mean quarterly attempted suicides ranged from 0.20 to 0.36, shots ranged from 1.11 to 2.03, and shootings ranged from .06 to 1.11. Gun lock requests per 10,000 people ranged from 20.0-101.5. The demographic and socioeconomic characteristics vary between percentile groups, highlighting that there are no discernible trends in the way that gun locks were distributed across different communities.

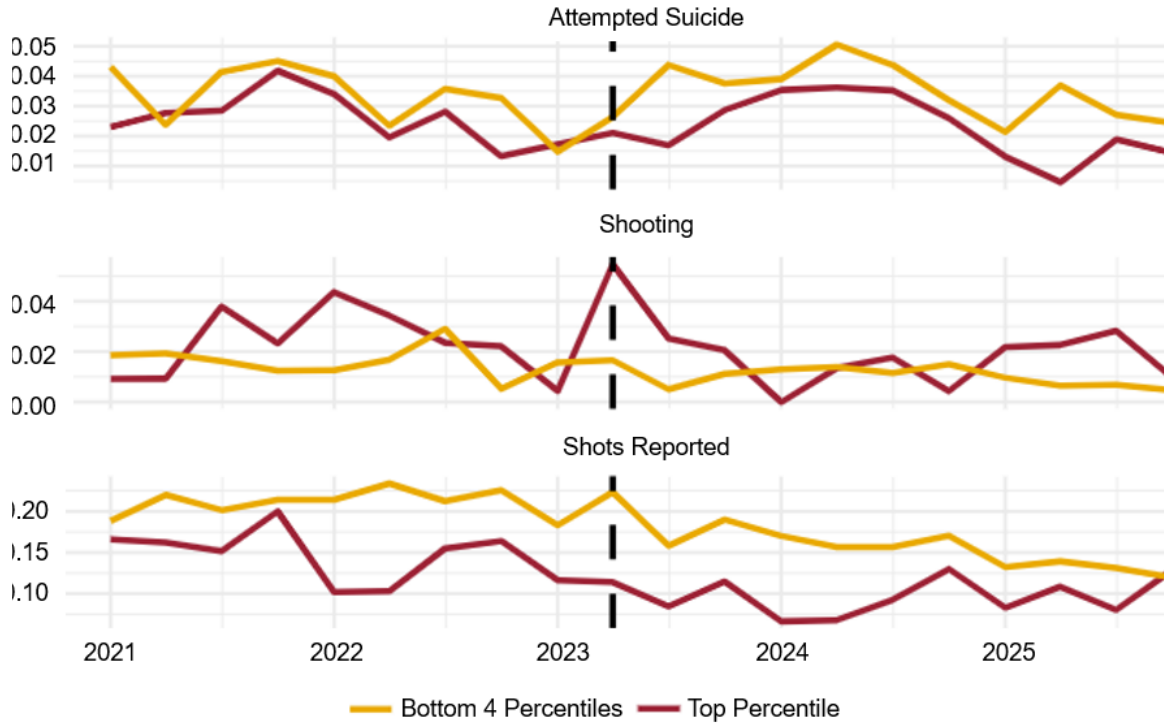
Table 9.1. Descriptive Statistics of Areas by Percentile Group

Measure	0-20th	21-40th	41-60th	61-80th	81-100th
Locks Requested	19.8	252.4	285.0	388.9	370.6
Locks Requested per 10k	20.8	64.0	93.2	101.5	139.5
Tract Count	6	32	39	24	27
ZIP Code Count	4	7	7	5	6
Mean Quarterly Incidents in the Pre-Period (Jan 2021 – September 2023)					
Attempted Suicides	0.20	0.36	0.28	0.25	0.21
Shots	1.11	1.76	2.03	1.98	1.17
Shootings	0.06	0.14	0.11	0.22	0.18
Mean Quarterly Incidents in the Post-Period (April 2023 – Dec 2025)					
Attempted Suicides	0.15	0.34	0.35	0.33	0.19
Shots	0.82	1.54	1.59	1.55	0.82
Shootings	0.05	0.10	0.10	0.10	0.17
ACS Tract Rates (%)					
Male	46%	49%	49%	48%	50%
Under age 24	16%	16%	16%	15%	14%
Hispanic/Latino	11%	10%	7%	7%	8%
Black or African American	26%	16%	19%	20%	12%
Moved in the past year	21%	12%	14%	12%	14%
Use car to travel to work	87%	85%	83%	86%	78%
Married households	58%	54%	57%	48%	52%
Annual household income below $30K	6%	7%	8%	11%	8%
Receive public assistance	4%	7%	8%	9%	5%
Employed	82%	93%	93%	93%	94%
Housing vacancy	3%	5%	4%	4%	5%
Uninsured	4%	5%	5%	5%	8%

Notes: This table compares the average quarterly crime incident counts and ACS survey estimates for the different percentile groups based on the requested gun locks per 10,000 people. Because census tracts may be larger than ZIP codes and census tracts are assigned to ZIP codes with the largest geographic overlap, the number of unique ZIP codes per percentile group will not be equal. This factor also affects the average requested gun locks statistics because the ZIP codes with more underlying census tracts are given additional weight. If the gun lock data had coordinates or was organized as the census tract level, it would allow for more precise calculations.

Figure 9.3 presents the incident trends for the treatment group versus the rest of the census tracts. Attempted suicides trends move in a similar manner, but the level of attempted suicides is slightly lower in the post-period. Shootings, which are rarer, move up and down with a spike in second quarter of 2023 for the treatment group. Given the difference in incident levels and trends, we create a comparison group for each outcome measure, restricting the comparison groups to census tracts that exhibit more parallel incident trends to the treatment tracts for each respective outcome and share similar demographic and socioeconomic profiles.

Figure 9.3. Incident Trends for Treatment versus Comparison Areas



Notes: This plot shows the average quarterly incident trends by quarter for the high-volume area (red) versus the remaining areas (yellow). The dashed line represents when the department of health started distributing gun locks on April 1st, 2023.

Analytical Setup

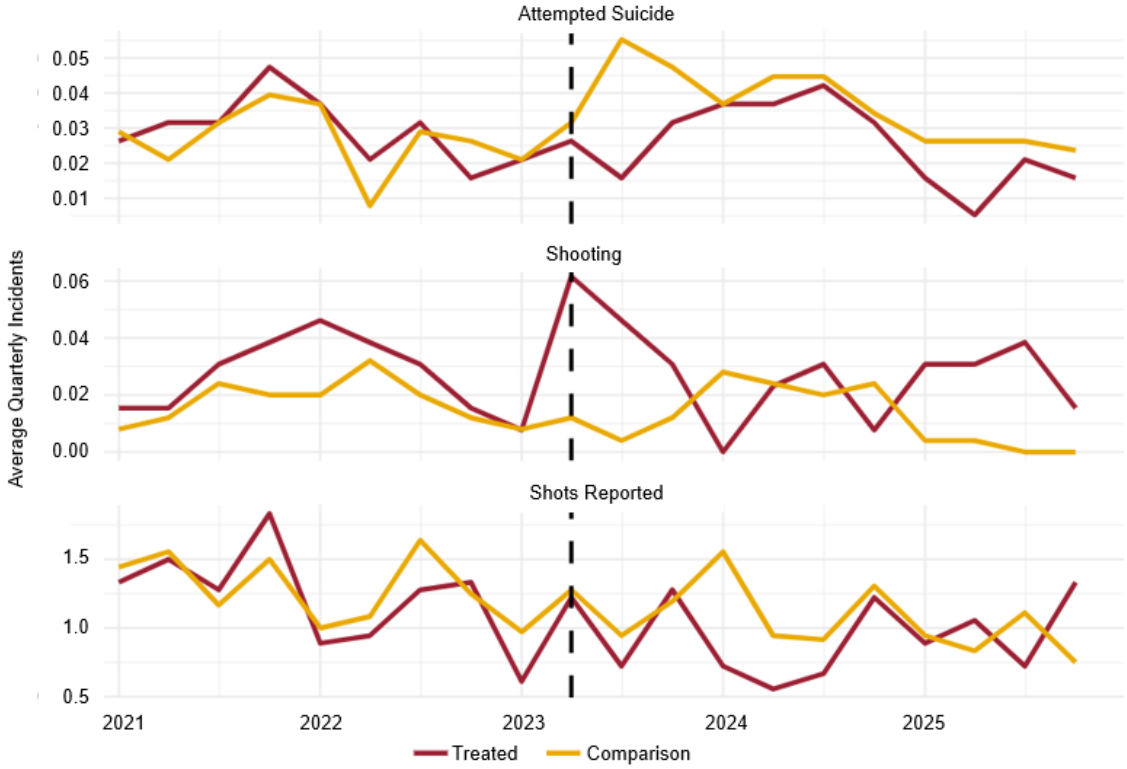
Table 9.2 shows the treatment and comparison groups sizes. For shootings, due to zero counts, a handful of treatment tracts and their corresponding comparison cases are dropped. In addition, some of the treatment tracts may only have one comparable census tract rather than two.

Table 9.2. Matched Sample Sizes

Outcome	Treated	Control
Shooting	13	25
Suicide Attempted	19	38
Shots Reported	18	36

For each treated census tract, we search for two comparison tracts with similar pre-intervention incident trends and census estimates for household income, employment rate, and share of population under the age of 24.[41] *Figure 9.4* displays the incident trends for the matched sample. Compared to *Figure 9.3*, the incident trends in the pre-intervention period are closely aligned. Visually, *Figure 9.4* suggests that we have parallel trends, satisfying the primary condition for causal inference in a difference-in-differences design. We also conduct statistical checks to see if the trends are significantly different in the pre-period and do not find evidence of parallel trend violations as shown in the Appendix (*Figure A.9*).

Figure 9.4. Incident Trends with Matched Samples



Note: This figure shows the incident trends for the treatment versus the comparison group after finding similarly situated census tracts with closely aligned pre-period incident trends.

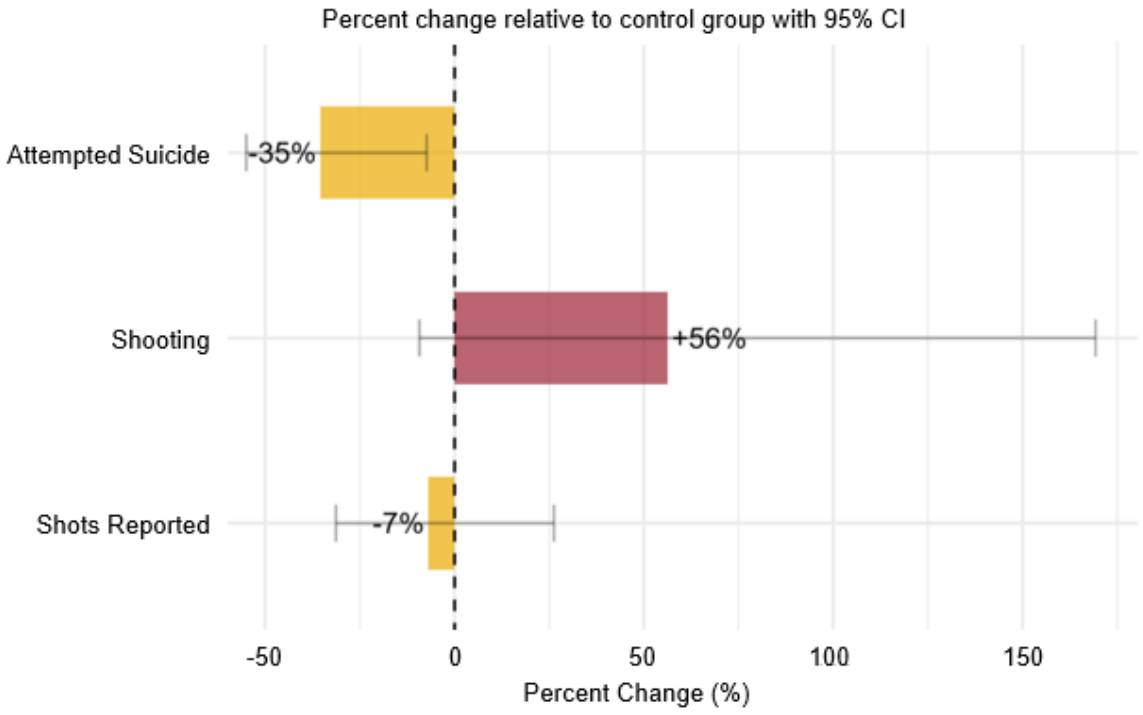
[41] We do not use the full set of demographic and socio-economic indicators to match on because our primary focus is identifying cases with the same pre-period trends in firearm incidents. When using the full set of census-level controls, the treatment group can drop by as much as half.

What is the effect of gun lock requests on firearm incidents?

Figure 9.5 displays the net change in firearm incidents for the treatment group attributable to the intervention. Changes in incidents are considered statistically significant when the entire confidence interval (the horizontal line) does not overlap with the 0% mark. Attempted suicide incidents, the primary outcome where we would hypothesize change, decreased in the treatment areas by 35% at statistically significant levels and are. Regarding the other outcomes, the treatment areas experienced a non-significant 7% reduction in reported shots and a non-significant 56% increase in shootings.

We also conduct a similar analysis using synthetic control methods where the comparison group is composed of a weighted set of tracts from the comparison pool to more closely mirror incident trends prior to the intervention. The Appendix (*Table A*.3) shows similar reductions in attempted suicides as well as a marginally significant 22% reduction in shots reported.

Figure 9.5. Difference-in-Differences Estimated Impact on Firearm Incident Rates



Notes: Figure shows the difference-in-differences estimates for the three incident types. When the confidence intervals (CI) do not overlap with 0, the results are statistically significant.

Summary and Limitations

The Department of Health distributed a high volume of gun locks over the past few years, totaling more than 10,000 by the end of 2025. In areas that received a high volume of gun

locks in the distribution program's first year, the number of attempted suicides and shots reported decreased more quickly than in comparison areas that had fewer gun locks distributed or received gun locks at a later date.

While these results are encouraging, this analysis faces some limitations that prevent strong conclusions. Foremost, the county police department, which provides the majority of the incident data, changed case management systems and reporting criteria during the study period which restricted our analysis to three incident types that appear to be tracked in a similar manner for the whole study period. Additionally, for attempted suicides, we cannot distinguish between firearm and non-firearm involved incidents; we would expect gun locks to primarily reduce firearm-related suicides.

In addition, this analysis uses comparison groups that also received gun locks which likely underestimate the distribution program's effect since the comparison groups also partially benefitted from the gun lock distributions. Under an ideal research scenario, we would restrict the comparison tracts to those that did not receive an gun locks, but they do not exist in this context. At the same time, the threshold for the treatment group categorization is based off inspections of a visual divergence in trends rather than a more concrete, pre-defined criterion. While we use robustness checks that use different thresholds and find similar results, the categorization is still partially arbitrary.

Chapter 10

Conclusions

We conclude our evaluation with a discussion of key findings and lessons learned. First, we present common strengths and challenges observed across the four program categories (youth violence prevention and intervention, CVI, HVIP, and public health-led programming). Next, we discuss impact evaluation findings. Finally, we present recommendations for funders (including both the Maryland General Assembly and GOCPP), VIPP grantees, and researchers to consider in future funding cycles.

Implementation Evaluation Findings

Despite differences in local context, target populations, and activities, the programs funded under the FY24 cohort share several common themes that highlight the strengths and challenges associated with program implementation. These themes illustrate what is required for sites to implement sustainable programming that addresses the multifaceted drivers of gun violence.

Common Strengths

One of the central cross-cutting themes was the importance of *authentic, trust-based engagement* when implementing program activities. Whether occurring at a hospital bedside, through credible messengers canvassing neighborhoods, during workgroup meetings, or in therapeutic settings with children and families, meaningful engagement is grounded in empathy, respect, and consistency. Staff repeatedly emphasized that credibility cannot be manufactured. Lived experience and deep community embeddedness are essential to establishing trust and are often the most powerful tools available to frontline workers and program leadership.

Programs also demonstrated that *community-centered approaches are critical to legitimacy and effectiveness*. Initiatives rooted in local voices, rather than in externally imposed models with no community input, may yield stronger community buy-in and smoother partnership development. Close coordination with community stakeholders helped tailor interventions to local needs. Many of the programs worked alongside long-standing community leaders, faith-based groups, neighborhood organizations, and residents who understood local dynamics and could help shape strategies. Community ownership extends beyond

engagement; it also functions as a protective factor that supports program sustainability and resilience during challenges such as funding disruption.

Programming across all sites embraced a *holistic approach to service delivery,* recognizing that clients require multiple needs to be addressed simultaneously for meaningful change to occur. These needs are shaped by the deep connection between violence and trauma and exacerbated by broader social and economic conditions. The programming offered across each site was illustrative of the need for strong multisector partnerships and broad referral networks spanning healthcare, behavioral health, social services, law enforcement, courts, schools, and grassroots organizations. These formal and informal relationships widen program reach and help clients navigate complex service systems.

Finally, sites consistently demonstrated that *adaptability is key to sustainability*. Several programs had to pivot during the evaluation period by shifting engagement strategies, adjusting eligibility criteria, modifying service models, or revising recruitment protocols. In some cases, these changes were proactive responses to the emerging community needs observed by staff. For other programs, they were reactions to external pressures, such as funding termination. Whether proactive or reactive, the decision to adapt illustrates that programming requires continual iteration, learning, and recalibration guided by data, available resources, and community feedback.

Common Challenges

Funding instability was the most pervasive and destabilizing challenge, affecting all programs to varying degrees. For VIPP specifically, staff described how short grant cycles and reductions in subsequent budget requests hindered sustainability planning and, in some cases, staffing continuity. Restrictions on spending categories, such as food or publication materials, forced program staff to find other funding sources for community engagement. Some programs experienced additional disruptions due to federal funding losses, which led to significant programming changes and reduced staffing. Although many programs relied on blended funding, the loss or reduction of a single source required rapid adjustments to maintain operations—diverting staff time away from program delivery and risking community trust.

These funding challenges, combined with the emotional intensity of the work, contributed directly to *staffing instability*. Recruiting and retaining qualified staff, particularly those with the lived experience essential for authentic engagement, was experienced across most programs. Staff cited low compensation, burnout, rigid hiring requirements, and the

unpredictability of grant-funded positions as key barriers. Compounding this, some programs experienced turnover in staff at key partner agencies which necessitated rebuilding relationships and reestablishing a shared understanding of the program.

Programs also faced significant barriers related to *data access, quality, and infrastructure*. Timely data was critical for defining eligibility criteria, scaling activities, and setting priorities. Some programs benefited from partnerships with local researchers or internal analysts but still faced delays in interagency or state-level data sharing. Other programs relied on needs assessments conducted by training and technical assistance providers but still required guidance on tracking key metrics with fidelity. Indeed, the variability in the programmatic data presented in this evaluation and the lack of consistent key performance indicators across VIPP-funded programs underscores the different ways sites are tracking program activities. Developing clearly defined performance indicators and adaptable data can benefit both GOCPP and grantees.

Finally, programs emphasized that *sustainable, long-term funding is required to achieve lasting change*. Short-term grant cycles are mismatched to the long-term effort required for gun violence reduction, trauma recovery, and community trust-building. Staff repeatedly emphasized that meaningful progress depends on stable multi-year funding that protects staffing continuity, builds institutional capacity and expertise, enables programs to deepen their partnerships, and strengthens community trust. In essence, culture change requires time and effort. The sites in this evaluation are working to educate local partners and communities that gun violence is a public health issue. In some localities, communities have been sharing that message for years and have built the foundation to discuss what comes next. In other places, this represents a new way of thinking that requires consistent education and reinforcement that is delivered in a manner that can bring different parties together to find a solution.

Impact Evaluation Findings

Complementing the implementation evaluation findings, in-depth quantitative analyses and robust empirical evidence can help guide future development and investments in programming. While these analyses require more granular data and programs with sufficient reach, they are crucial to informing program efficacy and understanding how programs can evolve to better serve the community and public safety.

Maryland is bucking national trends in firearm-related death rates. Since the 2021 peak, the state's rate has consistently declined and at a faster pace than in other states. Our impact

evaluation takes a deeper look at three programs to examine whether the most recent rounds of VIPP-funded interventions contributed to this comparatively steeper decline: 1) violence interrupters in Baltimore City, 2) hospital-based violence intervention in Prince George's County, and 3) gun lock distribution in Anne Arundel County. We use difference-in-differences with matching and synthetic control methods to assess differential changes in firearm-related incidents between treatment and comparison areas. We drew on the implementation evaluation to set-up the impact analyses, identifying treatment areas through program data and stakeholder interviews. The advantage of these approaches is that they aim to disentangle the effects of the interventions from broader time-related trends driven by external factors such as the pandemic and seasonality.

For both violence interruption programs, we find no empirical evidence of additional reductions in incidents attributable to the interventions. In the gun lock distribution analysis, we find a statistically significant 35% decrease in attempted suicide incidents by, attributable to the more than 10,000 gun locks distributed by the public health department in conjunction with community partners.

However, each of these analyses faces important limitations, and we caution against drawing strong conclusions. In particular, both violence interruption programs experienced funding cuts during the study period that altered service delivery. For the HVIP program, we do not have data on primary outcomes such as client recovery or navigation of the medical system. In addition, the program volume is low making it difficult to expect a change at larger geographic levels. The program data were also captured at a broad geographic scale, limiting our ability to classify treatment areas with greater precision.

As Maryland continues its effort to impact firearm related incidents, specifically gun violence, these evaluation findings can help the further development and design of VIPP-funded interventions. Impact evaluations for programs with more robust data can be used to inform interventions across the state where sufficient data is not available. In parallel, implementation evaluations for programs who are testing a new theory of change but lack sufficient case volume can still provide a blueprint for other jurisdictions contemplating a new pilot program. A cycle of mixed-methods research will foster healthy innovation in programming that can adapt to changing times. In particular, multi-disciplinary partnerships, such as the collaboration between public health departments, community-based organizations, and the legal system, are ripe grounds for new policy ideas that can provide helpful information to both Maryland and the broader field.

Recommendations

The sites in this evaluation are characterized by commitment and deeply relational practice but also constrained by structural instability and limited resources that impact the scalability of their activities. Sustained investment in people, partnerships, and infrastructure is essential for these programs to realize their full potential and for the communities they serve to experience long-term safety and healing. Several recommendations emerged for GOCPP, VIPP grantees, and researchers.

Recommendations for Future VIPP Funding Cycles

Program staff were thankful for the support of GOCPP in navigating questions and challenges as they came up. As noted above, several areas for how the Maryland General Assembly allocates funding to VIPP and how GOCPP operates funding streams could potentially enhance existing work:

- **Reconsider the one-year grant cycle** A consistent theme throughout our interviews was the uncertainty about funding and how it hinders sustainability planning. Moreover, the federal funding landscape has created a vacuum. At a minimum, multi-year grant cycles coupled with direct support from GOCPP to address sustainability planning (i.e., how to build diversified funding streams) could help programs retain staff and strengthen their community presence. At a larger scale, major investments from the Maryland General Assembly to compensate for gaps in federal funding could support the coordination of programs and build regional ecosystems.

- **Reevaluate restrictions on budget amounts** The requirement that subsequent VIPP budget requests decrease by 10% limits sustainability planning and poses challenges for programs that do not have consistent annual resources to cover critical expenses, such as participants' relocation to safe housing.

- **Broaden spending categories** Staff noted the importance of providing food for community gatherings and snacks for youth programming. Restrictive spending categories require programs to draw from limited resources to cover resources essential for engagement activities.

- **Allocate resources for programmatic data collection** First, providing financial support to sites for the purposes of data tracking and reporting can reduce staff burden. Second, allocating funds for data-related training and technical

assistance can improve the data capacity of programs to more precisely document the work being done and can be utilized for a more robust impact evaluation. Collectively, these investments can help programs collect information in a more efficient manner, design systems that make information linkable, and utilize existing data sources to manage workloads.

- **Allocate resources for qualitative data collection** Qualitative data can help to contextualize empirical findings, identify unexpected program outcomes, and capture insights from program participants and staff on what works. We utilized participant satisfaction surveys to measure feedback from clients as surveys were viewed as the most cost-efficient way to collect data from 10 sites across the state, but they lacked the nuance that is only possible with in-depth interviews. Conducting in-depth interviews with clients would require funding for travel, food, and incentives.

Recommendations for VIPP Grantees

Staff identified several lessons for future grantees:

- **Learn about your community and listen to its needs** Staff expressed that for a program to be viewed as legitimate, it must be informed by the people it is designed to serve. This requires authentic community engagement and collaborative problem solving.

- **Recognize the value of diverse expertise** Hiring staff from communities most impacted by gun violence is crucial. Collaboratives also require that those with professional expertise recognize the equally important expertise held by grassroots organizers, community advocates, and faith-based leaders.

- **Take a data-driven approach to implementation** Understanding the target population and its needs enables more precise program delivery. Programs with limited data capacity should consider partnering with public agencies or academic institutions. For example, Anne Arundel County's public health department collaborated with local police to access incident data to inform where to focus programming.

- **Document events that affect service delivery** These details illuminate how programs can adapt to challenges and are essential for research partners interpreting empirical findings.

- **Provide context for safe storage efforts** Programs distributing gun locks considered how to tailor messaging to communities where firearm ownership is the norm. Messaging emphasized responsible ownership rather than prohibition.

- **Practice transparency in community engagement** For programs focused on building collaboratives, sharing information and decision-making authority, especially regarding funding, helps reinforce trust. For example, EMBRACE informed partners quickly about federal funding cuts and collaborated on program adjustments.

- **Develop a contingency funding plan** Programs that experienced funding losses relied on contingency planning. HVIPs required hospital leadership support to redesign funding. CVIs collaborated with community stakeholders to refocus efforts geographically. A youth therapeutic program invested early in staff training to facilitate bringing costly external trainings in-house.

- **Invest in start-up activities** Programs need time to build partnerships, establish referrals, train staff, and pilot interventions. Early planning resources strengthen the likelihood of successful scaling.

- **Engage in ongoing self-reflection** Staff emphasized the importance of monitoring personal biases and recognizing signs of burnout, which is vital for authentic engagement and maintaining service quality.

Recommendations for Future Research

Although the current evaluation found limited empirical evidence of programming impact on firearm-related incidents, the limitations point to ways that GOCPP can strengthen future evaluation efforts:

- **Identify, define, and measure program-specific goals and outcomes** Each VIPP program is unique in programmatic approach and measurable goals and outcomes. Programs should work with technical assistance providers to define success at both program and individual levels. For example, a program focusing on providing treatment and case management services to youths with problem sexual behaviors should measure fidelity to the model (program level success) and changes in behavior (individual level success).

- **Focus evaluation resources on programs prepared for rigorous study** Rather than evaluating every program in a cohort, it may be more effective to look

across all funding cycles to identify programs ripe for research. Resources could then be concentrated in studying established programs that are already collecting the appropriate data, have high case volume, and can clearly establish treatment and comparison groups. Concentrated, high-quality evaluations will better inform broader violence prevention strategies, while studies of programs that are not yet prepared for evaluation risk generating misleading or inconclusive results.

Conclusion

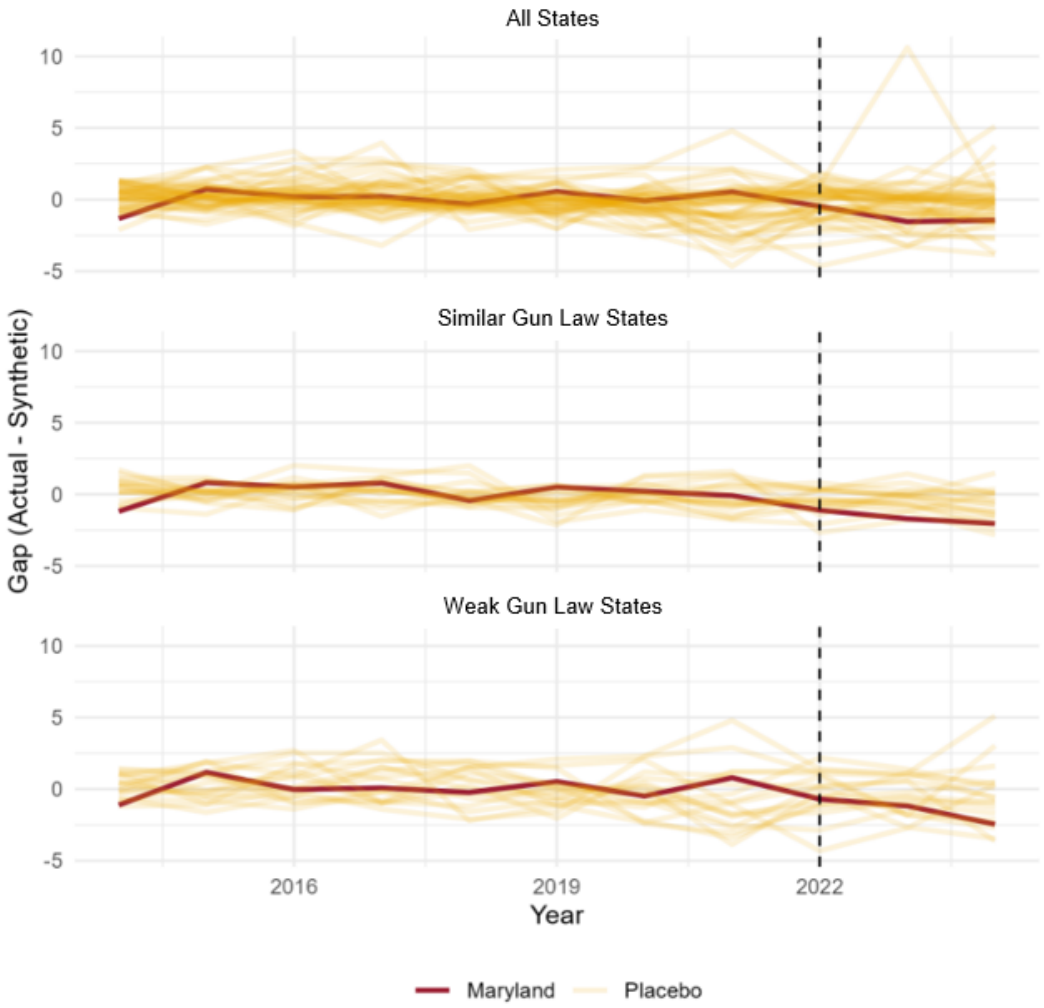
Taken together, our findings illustrate that Maryland's VIPP investments are unfolding within a shifting landscape of firearm-related harm, marked by both historic increases and more recent declines in violence. While the programs in this cohort demonstrated strong community engagement, adaptability, and commitment, they also faced persistent structural challenges that shaped their implementation and potential impact. Although our impact analyses found limited evidence of program-specific effects on firearm-related incidents, these findings reflect the complexity we observed in statewide trends and the early stage of many interventions rather than a lack of promise. Continued investment in long-term, community-rooted strategies, strengthened data capacity, and thoughtful scaling of programs prepared for rigorous evaluation will be essential to sustaining Maryland's progress and deepening understanding of which approaches most effectively reduce gun violence.

Appendix

This appendix contains more detailed technical information on some aspects of the analyses in Chapters 2, 5, 7, and 9. This supplemental information includes statistical checks for post-matching parallel trends for difference-in-differences analyses, robustness checks, and findings from the synthetic control methods analyses.

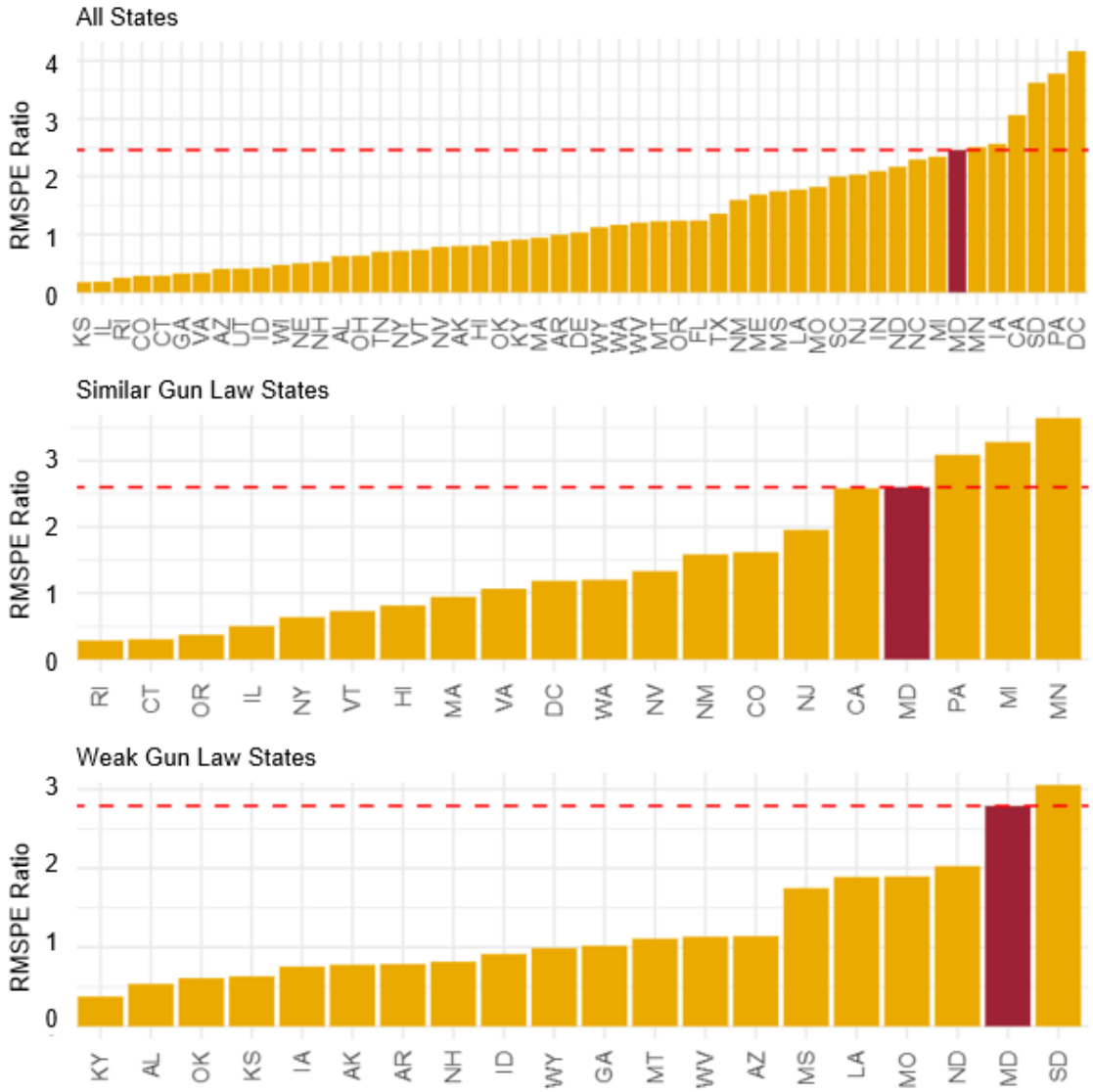
Chapter 2: National Trends

Figure A.1. Gap Plots Showing the Difference in Annual Firearm Death Rates For Each Permutation



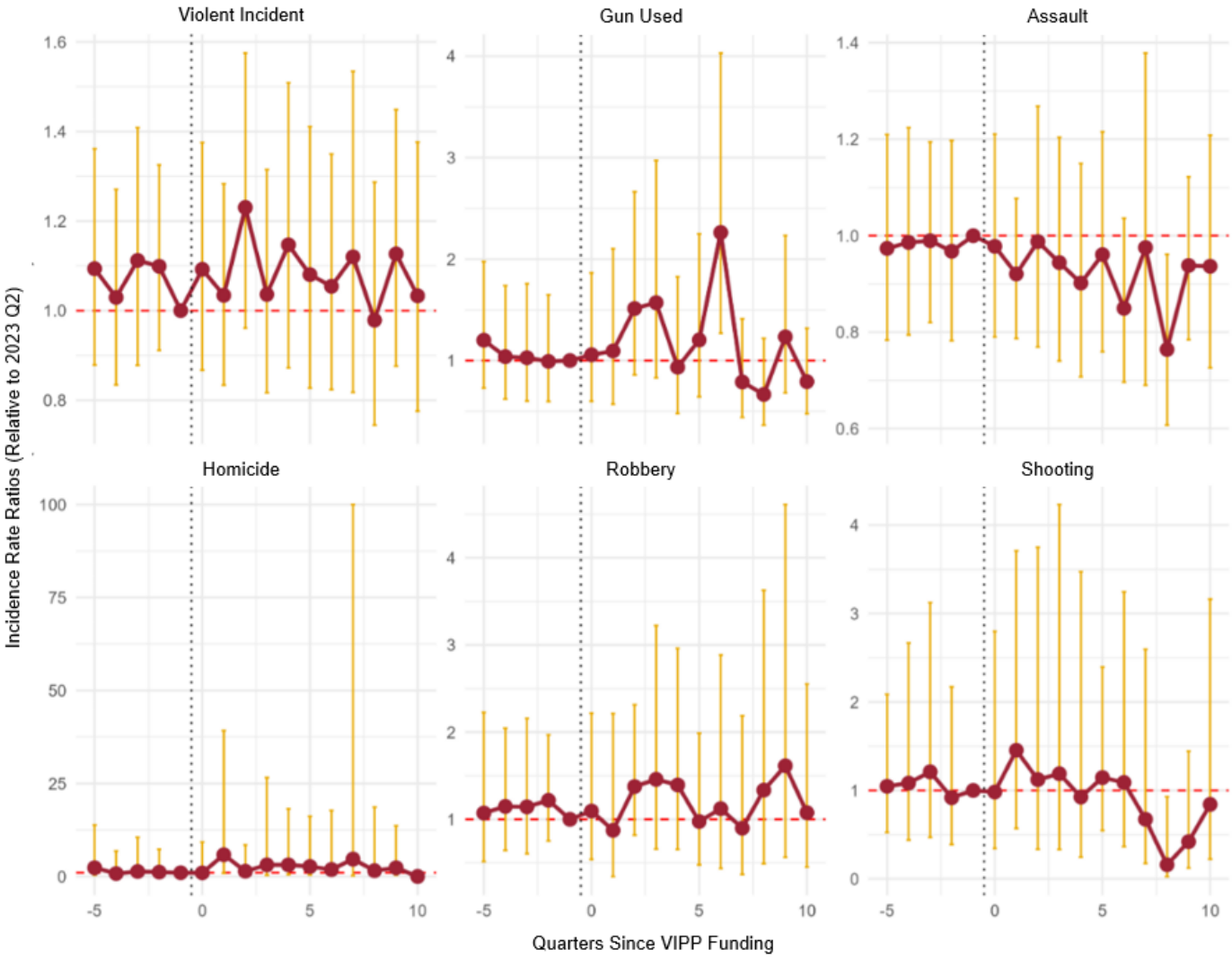
Notes: This figure shows the difference in firearm death rates for each year between the treatment group and synthetic control group for the three comparison groups and each permutation. The yellow lines represent the permutations while the red line represents when Maryland is the treated state.

Figure A.2. RMPSE by State



Note: This figure shows the RMPSE ratio for each permutation where Maryland's RMPSE in red is ranked against the RMPSEs of the other states to determine the p-value.

Figure A.3. Event Study Assessing Parallel Trends



Notes: In addition to the visual inspection presented in Chapter 5, we also conduct an event study to check for parallel trends between the treatment and matched comparison group. This event study compares crime rates by quarter while accounting for geographic unit and year/quarter fixed effects. We use the quarter prior to the intervention as a reference period, from April 1, 2023, to June 30h, 2023(2023 Q2). We expect the difference between the treatment and comparison group in each preceding quarter to be similar to the difference in the reference period. In *Figure A.3*, for each quarter, the gap between its difference and that for the reference period is indicated by the incidence rate ratio. When the gap between the two groups is statistically different for any given quarter, the point and confidence intervals will be far enough from the incident rate ratio of 1 that it no longer overlaps with the dashed red line.

Synthetic Control Methods

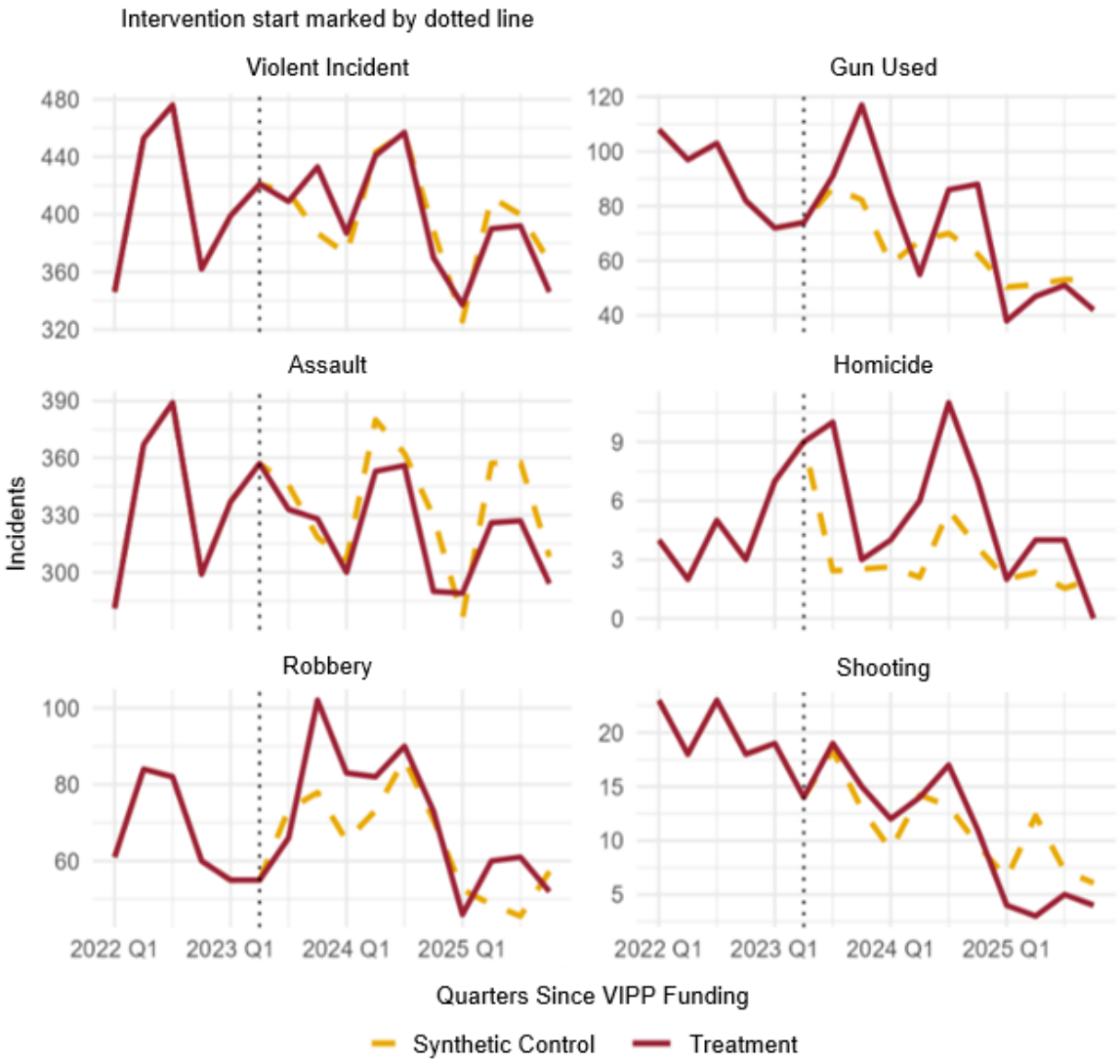
We utilized synthetic control methods (SCM) as a secondary check on the main difference-in-differences with matching analysis (in addition to repeating that analysis block group and ZIP code level). For each outcome of interest, SCM creates a comparison group built by weighting similar census tracts to closely match the treatment area's pre-intervention trends. When findings from the synthetic control analysis approach or are consistent with the difference-in-differences estimates, it strengthens confidence that observed changes are driven by the intervention.

Figure *A.4* shows the crime trends for the treatment group versus each synthetic control group. The groups' pre-intervention trends are identical across the six crime outcomes, indicating that the synthetic control groups are appropriate. In the post-period, the trends oscillate up and down in a similar manner, although there are some differences in overall levels. Table *A.1* summarizes the differences in post-period crime incidents and their statistical significance.[42] *Figure A.5* is a gap plot that demonstrates how statistical significance is calculated using permutation tests. These permutation tests involve randomly shuffling treatment assignment across the pool of census tracts, creating a synthetic control group, then recording the difference in the post-period 250 times, Statistical significance is based on the observed difference with the actual treatment areas versus the differences found in the permutations.

Shootings and assaults show non-significant reductions. Robberies and incidents where guns were involved show non-significant increases. Homicides show a statistically significant 90% increase which appears to be driven by the spikes during the summers of 2023 and 2024 followed by declines in 2025. Consistent with the difference-in-differences results, homicide rates appear higher in treatment areas primarily because they declined more slowly than in the comparison areas, even though overall levels decreased over time.

[42] This table also displays two assessments of whether any synthetic control group is driven by a handful of comparison units or if the synthetic control groups are composed of many units with small weights, which would indicate overfitting. The top 3 comparison units with the largest weights account for 7-13% of weights indicating the comparison groups are not driven by a handful of units. In addition, 17-30% of comparison units constitute 75% of weights which suggest overfitting is not occurring. When overfitting occurs, the synthetic control group is matched to the noise of the data rather than the structural trend which subsequently leads to inaccurate inference.

Figure A.4. Outcome Trends for Treatment Group versus Synthetic Control Group



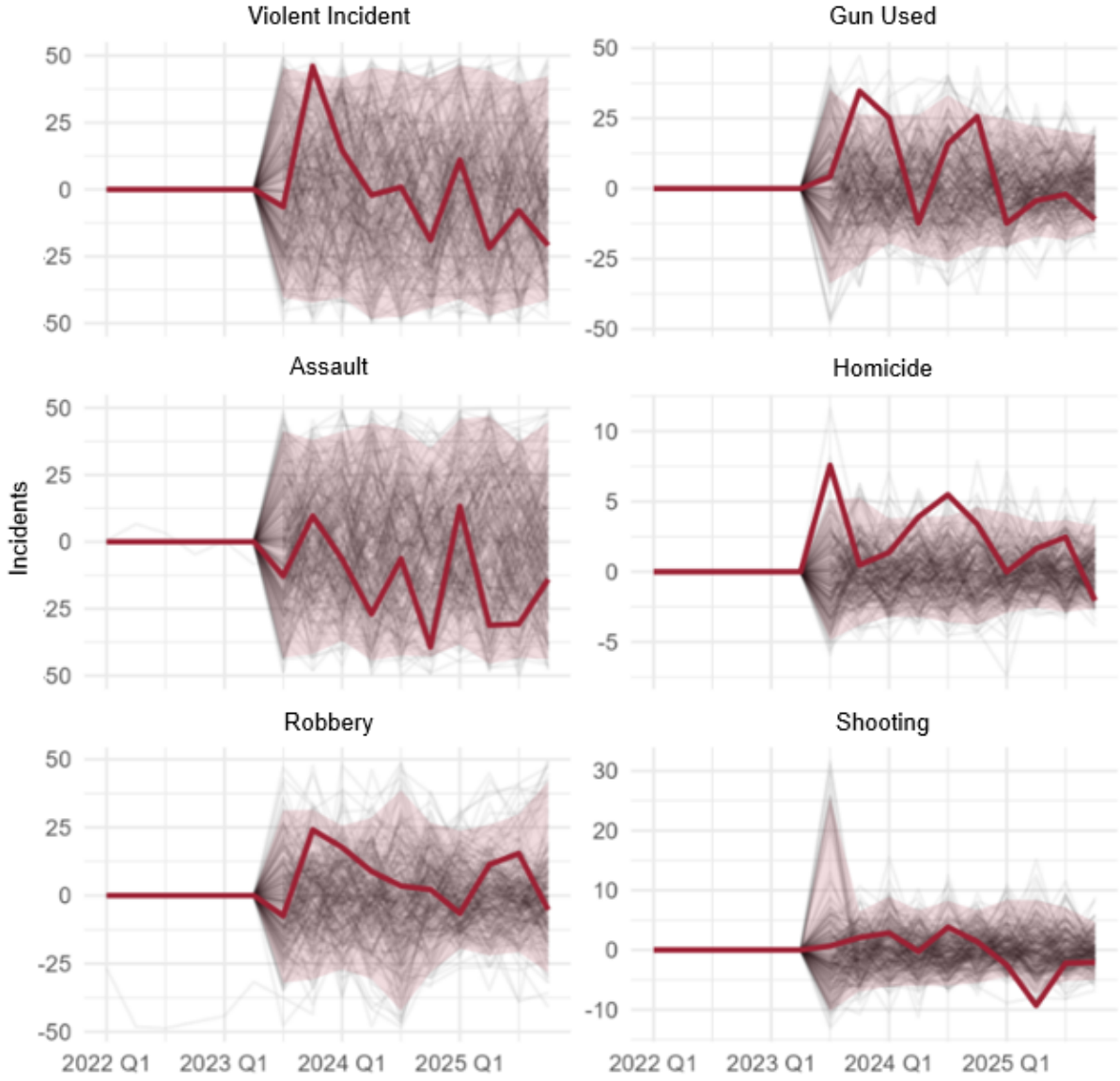
Note: This figure shows the count of incidents for the treatment group and each synthetic control group.

Table A.1. Treatment Group versus Synthetic Control Group Results

Measure	Treatment Count	Synthetic Control Count	Percent Difference	Lower Bound (95% CI)	Upper Bound (95% CI)	P-Value	Weight of Top 3 Comparison Units	n of Comparison Units for Top 75% of Weights
Violent Incidents	3962	3968	-0.1%	-7.5%	9.5%	0.96	11%	45
Incidents Where Gun Was Present	699	635	10%	-5.8%	23.8%	0.264	7%	55
Assaults	3196	3341	-4.3%	-14%	6%	0.584	8%	55
Homicides	51	27	90.6%	17.6%	99.4%	0.016	13%	32
Robberies	715	651	9.8%	-4.8%	25.2%	0.264	9%	48
Shootings	104	110	-5.1%	-32.8%	24%	0.856	13%	41

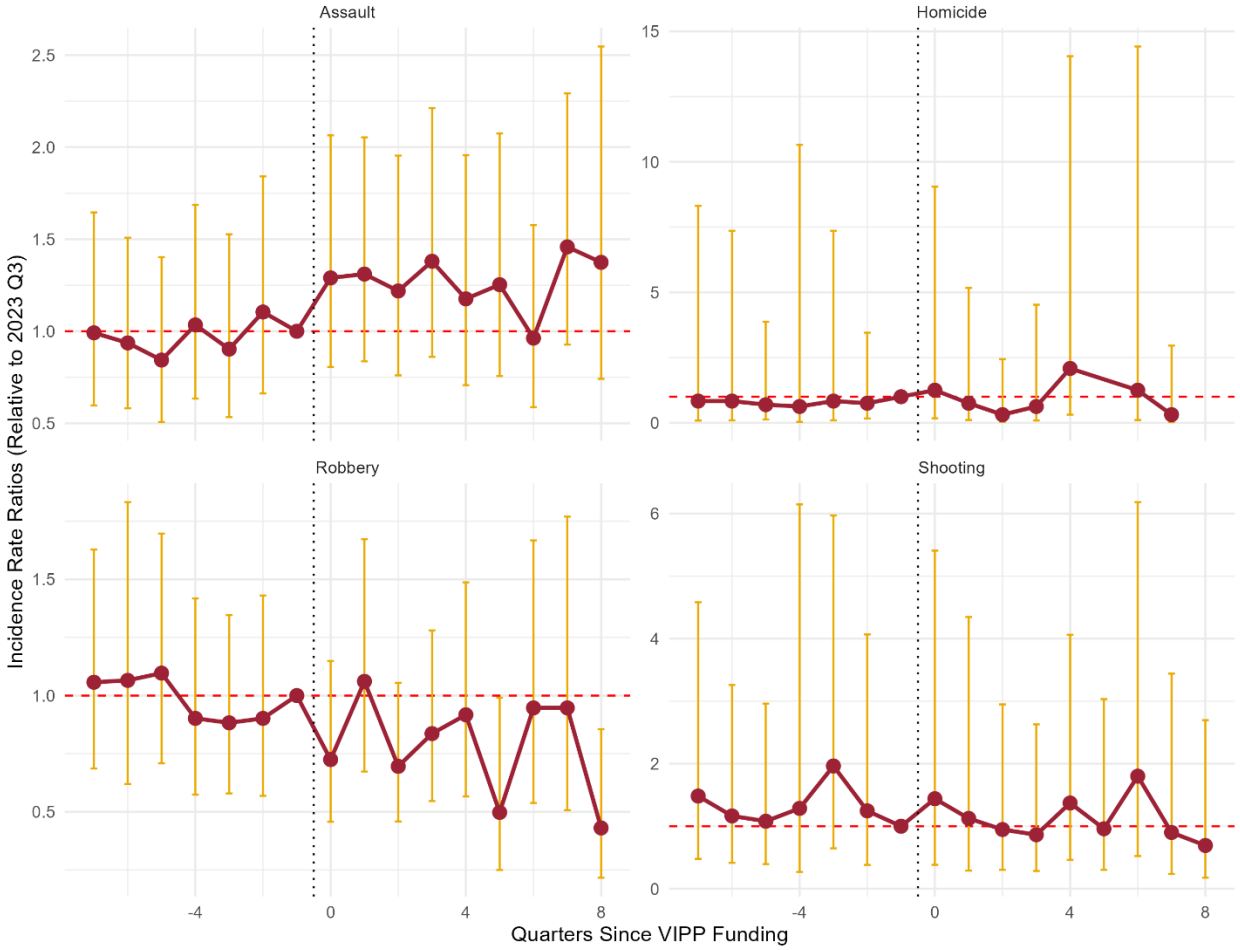
Notes: This table shows the count of incidents in the post-period for the treatment group versus the synthetic control group. The 95% CI lower bound, 95% CI upper bound, and p-values are based on 250 permutation tests where the treatment and comparison assignments are randomly shuffled and the actual difference between the treatment and synthetic control group is compared to the distribution derived from the permutations. The cumulative weight of the top 3 comparison units is calculated to check if the synthetic group is comprised of just a handful of units. To check against overfitting, the number of units, ranked by weights, accounting for 75% of the weights is calculated; a high number indicates that the synthetic control is being overfitted.

Figure A.5. Gap Plot Showing the Difference in Crime Incidents Using 250 Permutations



Notes: This figure shows the difference between the treatment group and synthetic control group for each of the six crime types. The dark red line represents the actual difference. The light grey lines in the background represent the 250 permutations in which treatment assignment is randomly shuffled and the difference is estimated to create the distribution needed to infer statistical significance. The shaded areas represent the 95% confidence intervals.

Figure A.6. Event Study Assessing Parallel Trends



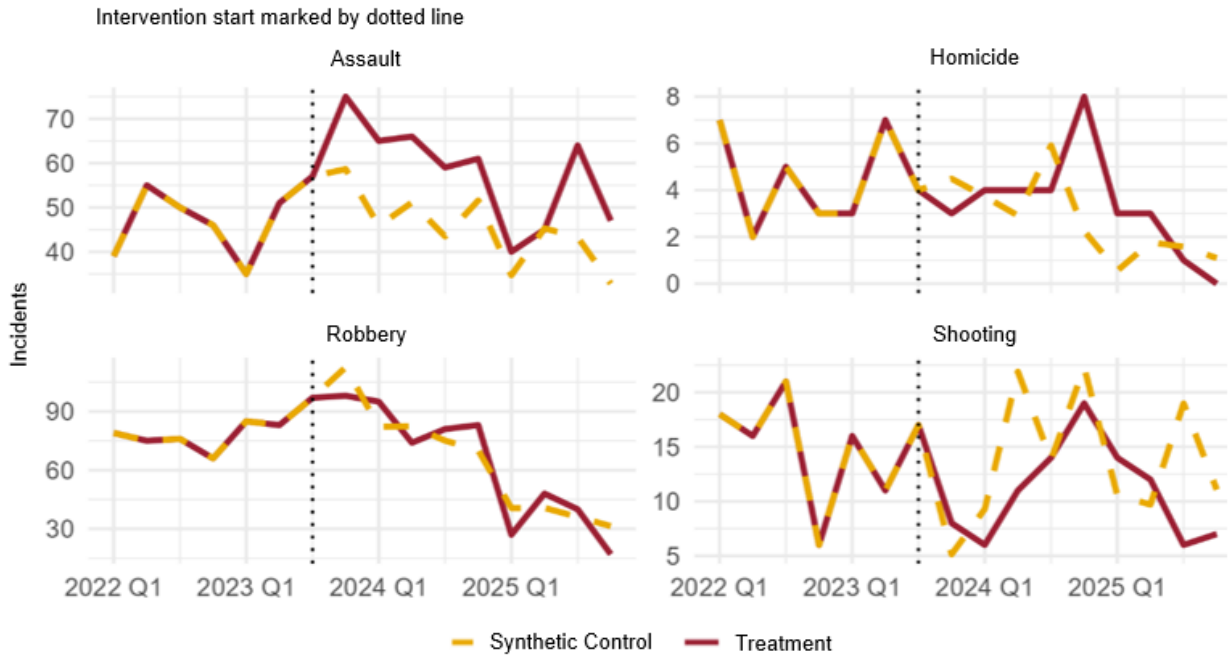
Notes: To check for parallel trends, we conduct an event study which compares crime rates by quarter while accounting for geographic unit and year/quarter fixed-effects. We use the quarter prior to the intervention as a reference period, from July 1, 2023, to September 30, 2023, in which we expect the difference between the treatment and comparison group to be similar in preceding quarters as in the reference period. When the gap between the two groups is statistically different for any given quarter, the point and confidence intervals will be far enough from the incident rate ratio of 1 that it no longer overlaps with the dashed line.

Synthetic Control Methods

Findings from the synthetic control approach are consistent with the difference-in-differences estimates. *Figure A.7* shows the crime trends for the treatment group versus each synthetic control group. The groups' pre-intervention trends are identical across the four crime outcomes. In the post-period, the trends diverge for assault and are similar for robberies. For shootings and homicides, the trends are noisier and do not appear to move in parallel. *Table A.2* summarizes the differences in crime incidents and their statistical significance.[43] *Figure A.8* is a gap plot that demonstrates how statistical significance is calculated using permutation tests. Shootings and robberies show non-significant reductions. Homicides exhibit a non-significant increase. Assaults are 28% higher for the treatment group, a statistically significant difference. These results roughly match those from the difference-in-differences estimates.

[43] This table also displays two assessments on whether any synthetic control group is driven by a handful of comparison or the synthetic control groups are composed of many units with small weights indicating overfitting. The top 3 comparison units with the largest weight account for 8-19% of weights indicating the comparison groups are not driven by a handful of units. In addition, 16-34% of comparison units constitute 75% of weights which suggest overfitting is not occurring. When overfitting occurs, the synthetic control group is matched to the noise of the data rather than the structural trend which subsequently leads to inaccurate inference.

Figure A.7. Outcome Trends for Treatment Group versus Synthetic Control Group



Note: This figure shows the count of incidents for the treatment group and each synthetic control group.

Table A.2. Treatment Group versus Synthetic Control Group Results

Measure	Treatment Count	Synthetic Control Count	Percent Difference	Lower Bound (95% CI)	Upper Bound (95% CI)	P-Value	Weight of top 3 Comparison Units	n of Comparison Units for Top 75% of Weights
Assaults	522	407	28.3%	10.3%	38.1%	0.00	8%	62
Homicides	30	24	23.5%	-28.1%	62.6%	0.42	19%	40
Robberies	563	571	-1.4%	-19.9%	17.7%	0.94	10%	41
Shootings	97	123	-21%	-56.6%	3.2%	0.18	17%	29

Notes: This table shows the count of incidents in the post-period for the treatment group versus the synthetic control group. The lower bound, upper bound, and p-values are based on 250 permutation tests where the treatment and comparison assignment are randomly shuffled and the actual difference between the treatment and synthetic control group is compared to the distribution derived from the permutations. The cumulative weight of the top 3 comparison units is calculated to check if synthetic group is comprised of just a handful of units. To check against overfitting, the number of units, ranked by weights, needed to account for 75% of the weights is calculated; a high number indicates that the synthetic control is being overfitted.

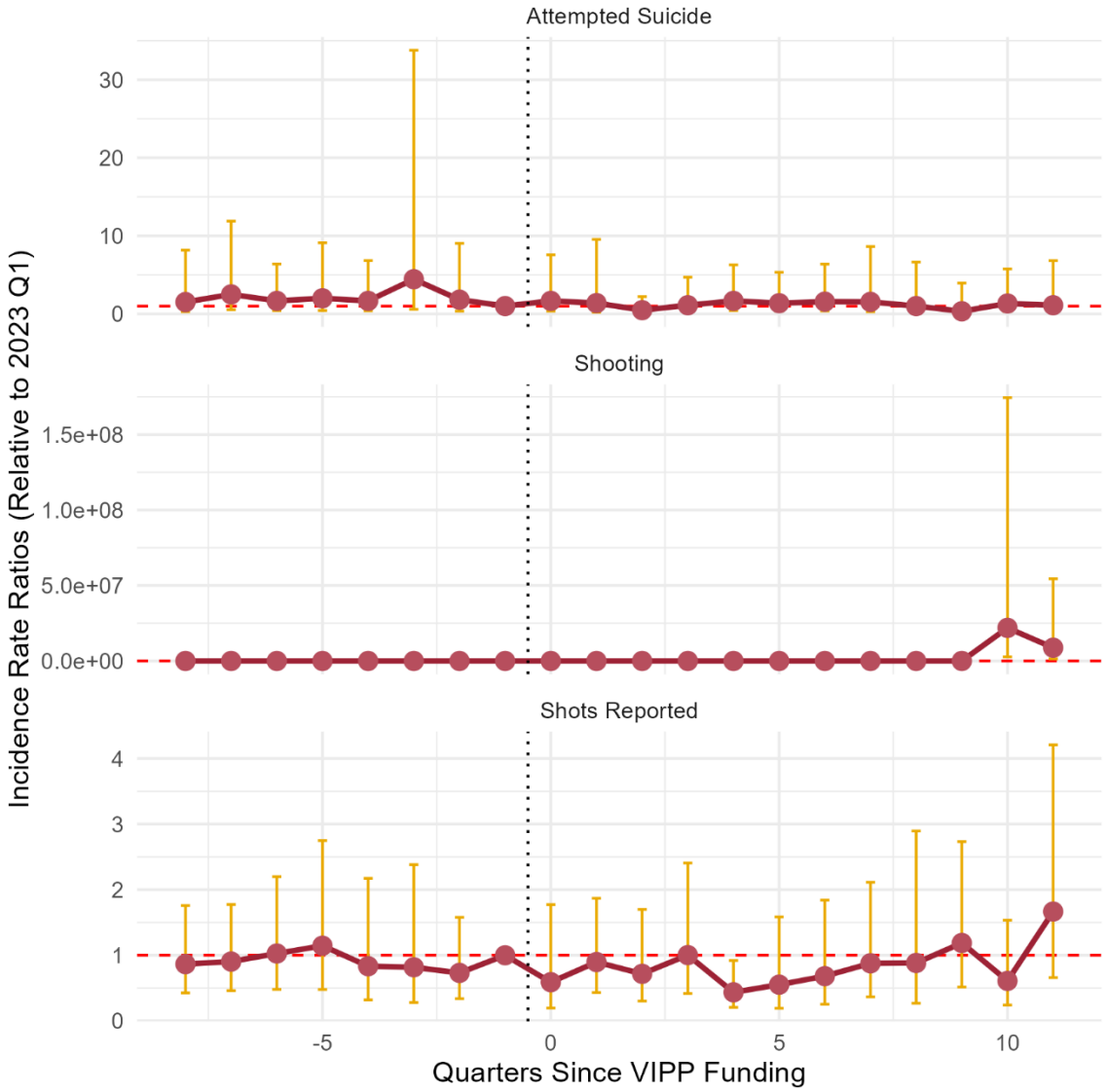
Figure A.8. Gap Plot Showing the Difference in Crime Incidents Using 250 Permutations



Notes: This figure shows the difference between the treatment group and synthetic control group for each of the four crime types. The dark red line represents the actual difference. The light grey lines in the background represent the 250 permutations in which treatment assignment is randomly shuffled and the difference is estimated to create the distribution needed to infer statistical significance. The shaded areas represent the 95% confidence intervals.

Chapter 9: Impact Evaluation – Gun Lock Distribution

Figure A.9. Event Study Assessing Parallel Trends



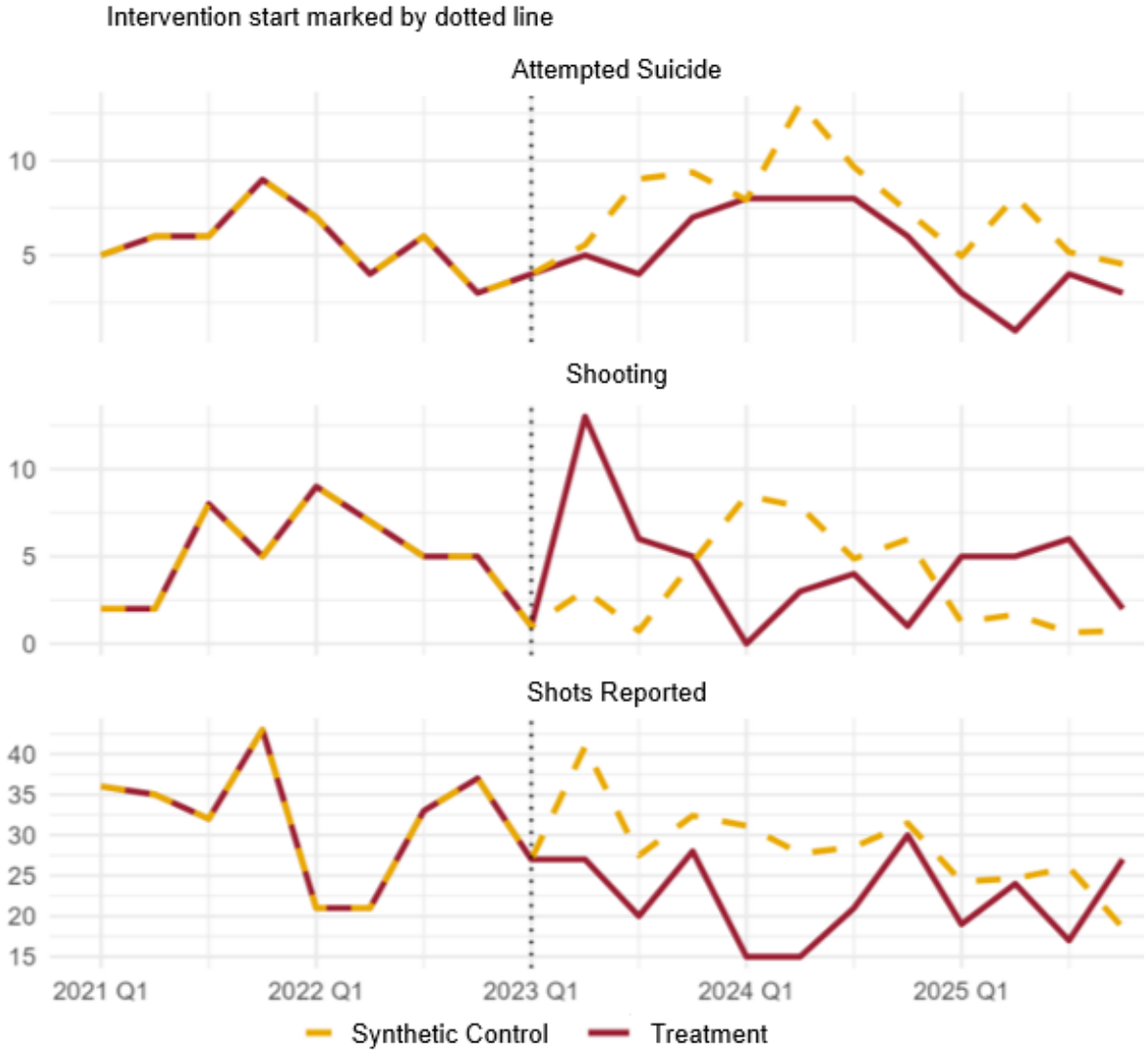
Notes: To check for parallel trends, we conduct an event study which compares incident rates by quarter while accounting for geographic unit and year/quarter fixed-effects. We use the quarter prior to the intervention as a reference period, from January 1, 2023, to March 31, 2023, in which we expect the difference between the treatment and comparison group to be similar in preceding quarters as in the reference period. When the gap between the two groups is statistically different for any given quarter, the point and confidence intervals will be far enough from the incident rate ratio of 1 that it no longer overlaps with the dashed line.

Synthetic Control Methods

Findings from the synthetic control approach are consistent with the difference-in-differences estimates. *Figure A.10* shows the incident trends for the treatment group versus each synthetic control group. The groups' pre-intervention trends are identical across the three incident types. In the post-period, the number of attempted suicides and reported shots in the treatment area are consistently below those in the synthetic control groups. For shootings, the treatment tracts have increased shootings during summer. *Table A.3* summarizes the differences in incidents and statistical significance.[44] *Figure A.11* is a gap plot that demonstrates how statistical significance is calculated using permutation tests. Attempted suicides are significantly lower by 32.6%, shootings are 25% higher at a non-significant level, and shots reported are 22.4% lower at a marginal level of statistical significance. These results suggest larger reductions in incidents compared to the difference-in-differences estimates.

[44] This table also displays two assessments of whether any synthetic control group is driven by a handful of comparison or the synthetic control groups are composed of many units with small weights indicating overfitting. The top 3 comparison units with the largest weight account for 6-20% of weights indicating the comparison groups are not driven by a handful of units. 40-49% of comparison units constitute 75% of weights which suggest some moderate overfitting could be occurring. When overfitting occurs, the synthetic control group is matched to the noise of the data rather than the structural trend which subsequently leads to inaccurate inference.

Figure A.10. Outcome Trends for Treatment Group versus Synthetic Control Group



Note: This figure shows the count of incidents for the treatment group and each synthetic control group.

Table A.3. Treatment Group versus Synthetic Control Group Results

Measure	Treatment Count	Synthetic Control Count	Percent Difference	Lower Bound (95% CI)	Upper Bound (95% CI)	P-Value	Weight of Top 3 Comparison Units	n of Comparison Units for Top 75% of Weights
Attempted Suicides	57	85	-32.6%	-69.8%	-9.1%	0.024	6%	49
Shootings	50	40	25.2%	-19.7%	71.9%	0.448	20%	40
Shots Reported	243	313	-22.4%	-47.1%	-0.8%	0.08	8%	40

Notes: This table shows the count of incidents in the post-period for treatment group versus the synthetic control group. The lower bound, upper bound, and p-values are based on 250 permutation tests where the treatment and comparison assignment are randomly shuffled and the actual difference between the treatment and synthetic control group is compared to the distribution derived from the permutations. The cumulative weight of the top 3 comparison units is calculated to check if synthetic group is comprised of just a handful of units. To check against overfitting, the number of units, ranked by weights, needed to account for 75% of the weights is calculated; a high number indicates that the synthetic control is being overfitted.

Figure A.11. Gap Plot Showing the Difference in Firearm Incidents Using 250 Permutations



Notes: This figure shows the difference between the treatment group and the synthetic control group for each of the three incident types. The dark red line represents the actual difference. The light grey lines in the background represent the 250 permutations in which treatment assignment is randomly shuffled and the difference is estimated to create the distribution needed to infer statistical significance. The shaded areas represent the 95% confidence intervals.