NCIPC Board of Scientific Counselors
Open to the Public
September 24, 2024

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Atlanta, Georgia

Table of Content

Summary Proceedings 3
Call to Order, Roll Call & Meeting Process, Welcome & Introductions 3
Call to Order 3
Roll Call & Meeting Process 3
Welcome & Introductions 4
Approval of the June 6, 2024 NCIPC BSC Meeting Minutes 4
Director's Update 5
Updated Child Abuse and Neglect Research Priorities 6
Discussion Points 14
Updated Youth and Community Violence Research Priorities 19
Discussion Points 26
Public Comment Session 28
Overview 28
Public Comment 28
Announcements, Closing Remarks, & Adjournment 29
Certification 30
Attachment A: NCIPC BSC Member Attendees 31
Attachment B: Acronyms Used in This Document 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
BOARD OF SCIENTIFIC COUNSELORS (BSC)
Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)

Forty-Eighth Meeting
September 24, 2024

Virtual / Zoom Meeting
Open to the Public

Summary Proceedings

The Forty-Eighth meeting of the National Center for Injury Prevention and Control (NCIPC; Injury Center) Board of Scientific Counselors (BSC) was convened on Tuesday, September 24, 2024 via Hybrid / Zoom meeting. The BSC met in open session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). NCIPC BSC Co-Chair, Dr. Amy Bonomi, presided.

Call to Order, Roll Call & Meeting Process, Welcome & Introductions

Call to Order

Amy Bonomi, PhD, MPH
Dean and Professor of Pubic Health
College of Health and Human Services
San Diego State University

Dr. Bonomi officially called to order the Forty-Eighth meeting of the NCIPC BSC at 10:05 AM Eastern Time (ET) on Tuesday, September 24, 2024. She indicated that Dr. Harper would conduct the roll call and review the meeting process, given the Mrs. Tonia Lindley was addressing technical issues.

Roll Call & Meeting Process

Christopher Harper, PhD
NCIPC BSC DFO
Senior Epidemiologist, Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Harper conducted a roll call of NCIPC BSC members and *Ex Officio* members, confirming that a quorum was present. Quorum was maintained throughout the meeting. No conflicts of interest (COI) were declared. An official list of BSC member attendees is appended to the end of this document as Attachment A. Dr. Harper introduced Cambridge Communications and Training Institute (CCTI), who he explained would record the minutes of the meeting. To make it easier for them to capture the comments, Dr. Harper requested that everyone state their names prior to any comments for the record. He indicated that Mr. Victor Cabada would audio record the meeting for archival purposes to ensure accurate transcripts of the meeting notes. The meeting minutes will become part of the official record and will be posted on the CDC website at

the following URL: www.CDC.gov/injury/bsc/meetings.html. All NCIPC BSC and *Ex Officio* members were requested to send an email to Mrs. Tonia Lindley at ncipcbsc@cdc.gov at the conclusion of the meeting stating that they participated in this meeting. In addition, Dr. Harper explained the public comment process.

Welcome & Introductions

Amy Bonomi, PhD, MPH
Co-Chair, NCIPC BSC
Dean and Professor of Pubic Health
College of Health and Human Services
San Diego State University

Dr. Bonomi thanked everyone for their commitment to injury and violence prevention and expressed appreciation to them for taking time out of their busy schedules to participate in this important committee, which provides advice to the leadership of CDC and NCIPC on its injury and violence prevention research and activities. She welcomed new *Ex Officio* member, Diane Pilkey, RN, MPH, representing the Health Resources and Services Administration (HRSA).

She also thanked and welcomed members of the public for their interest and attendance. She indicated that there would be a Public Comment session from 12:10 PM to 12:25 PM and that at that time, Mr. Victor Cabada would be providing instructions for anyone wishing to make a public comment. Dr. Bonomi referred those joining by phone without access to the slides through Zoom to www.cdc.gov/injury/BSC where the slides could be downloaded in order to more easily follow the presentations.

Approval of the June 6, 2024 NCIPC BSC Meeting Minutes

Amy Bonomi, PhD, MPH
Co-Chair, NCIPC BSC
Dean and Professor of Public Health
College of Health and Human Services
San Diego State University

Dr. Bonomi referred BSC members to the copy of the minutes provided to them with their meeting materials from the June 6, 2024 NCIPC BSC meeting. With no questions or edits noted, Dr. Bonomi called for an official vote.

Motion / Vote

Dr. Johnston made a motion, which **Dr. Malik** seconded, to approve the June 6, 2024 NCIPC BSC meeting minutes. The motion carried unanimously with no abstentions.

Director's Update

Allison Arwady, MD, MPH
Director, National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Arwady began by expressing her gratitude for the presenters at the June BSC meeting, including Drs. Neetu Abad, Deborah Stone, Sarah DeGue, Ruth Leemis, and Lace DePadilla, and Ms. Laura Chang for their informative presentations, as well as the efforts of other NCIPC staff who made those projects and presentations successful. She reported on several important accomplishments across the Injury Center that have occurred since the June 2024 meeting.

The Division of Violence Prevention (DVP) released the *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*.[1] The resource covers programs, policies, and practices that can help communities and states focus on strategies with the best available evidence to prevent community violence. This latest release is a part of a suite of resources that guide how to prevent all forms of violence, including adverse childhood experiences (ACEs), child abuse and neglect (CAN), intimate partner violence (IPV), sexual violence (SV), and suicide.

With International Overdose Awareness Day in August, the Division of Overdose Prevention (DOP) released new data from CDC's State Unintentional Drug Overdose Reporting System (SUDORS)[2]. The report showed that 22% of people who died of drug overdose had a non-substance-use related mental disorder, such as depression or anxiety. Further findings suggested that approximately a quarter of these decedents had at least one potential opportunity for intervention a month before their deaths. For example, they were being treated for substance use disorder (SUD) or had a recent emergency department (ED) visit. These data suggest expanding efforts to identify co-occurring mental health and substance use disorders, integrating screening and treatment, and strengthening treatment retention and harm reduction services could save lives.

September is National Suicide Prevention Month. Suicide rates have increased during the last 20 years and remain high. On average, one person dies by suicide every 11 minutes. To help inform public health action to address this leading cause of death (COD), CDC released a *Vital*signs™ showing that in 2022, suicide rates were lowest in counties with the highest health insurance coverage, broadband internet access, and income[3]. These results suggest that implementing strategies that improve the conditions in which people are born, grow, live, work, and age may be an important component of suicide prevention efforts.

Dr. Arwady shared the Injury Center's nominees for the 2023 CDC Shepard Awards. These agency awards recognize excellence and innovation in science by CDC scientists. The Injury Center is honored to have three manuscripts being considered for these prestigious awards, which highlights the ground-breaking work that the Injury Center scientists lead.

[1] https://www.cdc.gov/violence-prevention/media/pdf/resources-for-action/CV-Prevention-Resource-for-Action_508.pdf
[2] SUDORS Dashboard: Fatal Drug Overdose Data | Overdose Prevention | CDC
[3] Vital Signs: Suicide Rates and Selected County-Level Factors — United States, 2022 | MMWR (cdc.gov)

- [4]Ms. Avital R. Wulz with colleagues from the Division of Injury Prevention (DIP) are nominated for their paper in the *Journal of Safety Research* linking the Social Vulnerability Index (SVI) with unintentional injury data.

- [5]Dr. Laruen Tanz with colleagues from DOP are nominated for their paper in *JAMA Network Open*, which analyzed trends and characteristics of buprenorphine-involved deaths before and after implementation of the prescribing flexibilities during the COVID-19 pandemic.

- [6]Dr. Elizabeth Swedo with colleagues from DVP and DIP are nominated for their paper in *JAMA Network Open* on a novel machine learning (ML) approach to estimating United States (US) firearm homicides in near real time.

Dr. Arwady noted that each of these manuscripts integrates and examines novel data that can help guide public health action to prevent injury and deaths, and congratulated all of the nominees. Selection of the winners will be made in October 2024.

She indicated that during this meeting, the BSC would hear about proposed updates to research priorities in two areas, for which a robust discussion was anticipated with the members. She indicated that Dr. Molly Merrill Francis with Dr. Andreés Villaveces would present updates to NCIPC's child abuse and neglect (CAN) research priorities, while Ms. Denise D'Angelo and Dr. Ashley D'Inverno would present on updates to youth and community violence research priorities. These forms of violence impact too many US youth. It is estimated that nearly 1 in 7 children experience CAN, with disparate impact on families living in poverty. Homicide is the third leading cause of death for young people ages 10–24 years of age, and the leading cause of death for non-Hispanic black or African American youth. Young people do not have to have these experiences. CAN and youth violence (YV) are both preventable. The research priorities to be presented during this meeting will help ensure that scientific efforts in the Injury Center focus on the science that is most likely to lead to impact and ultimately create a world that is free from violence.

Updated Child Abuse and Neglect Research Priorities

Andrés Villaveces, MD, MPH
Senior Scientist
Field Epidemiology and Prevention Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Molly Merrill-Francis, PhD, MPH
Health Scientist
Research and Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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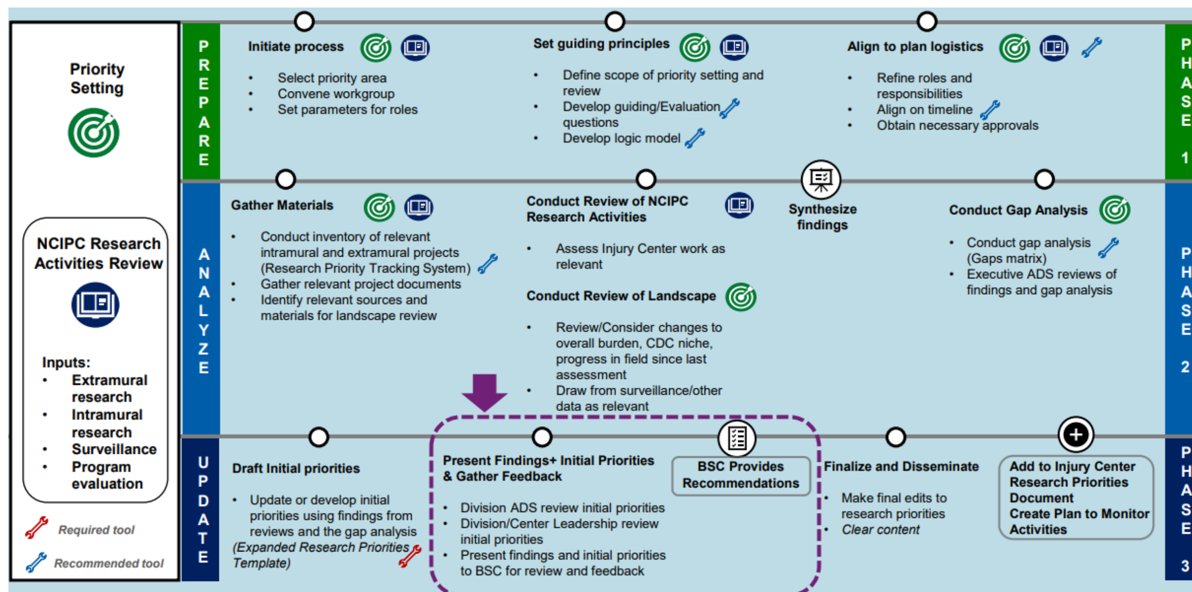
[4] Association between social vulnerability factors and unintentional fatal injury rates - United States, 2015-2019 - PubMed (nih.gov)
[5] Trends and Characteristics of Buprenorphine-Involved Overdose Deaths Prior to and During the COVID-19 Pandemic - PubMed (nih.gov)
[6] Development of a Machine Learning Model to Estimate US Firearm Homicides in Near Real Time | Public Health | JAMA Network Open | JAMA Network

Dr. Villaveces indicated that he and Dr. Merrill-Francis would summarize information from the internal and external landscape review of CAN prevention research,and present the proposed 2024 updates to NCIPC's CAN research priorities. As a reminder, the definition of CAN as used by the CDC[7] is that CAN includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (e.g., a religious leader, a coach, or a teacher) that results in harm, the potential for harm, or threat of harm to a child. There are 4 common types of abuse and neglect, including physical abuse, sexual abuse, emotional abuse, and neglect. This is the operational definition upon which much of the research is based.

To provide some context, the current CAN research priorities published in 2015[8] were to: 1) evaluate the effectiveness and economic efficiency of policies and practices that provide economic support to families to prevent CAN and promote safe, stable, nurturing relationships and environments; 2) identify the community conditions that increase or reduce risk for CAN or promote the development of safe, stable, nurturing relationships and environments; and 3) evaluate the effectiveness and economic efficiency of programs or strategies that can reduce multiple forms of CAN. The 2015 priorities are being utilized as a baseline from which to work on the new proposed priorities.

The reassessment process of the existing priorities includes 3 phases: the initiation process (completed), gathering materials (completed), and drafting the initial priorities (in progress) as depicted in the following graphic.



The guiding questions that drove this process included the following:

- ❑ What research has been carried out by the Injury Center to address CAN since 2015?
- ❑ How have external research and other federal agencies addressed gaps and priority areas that align with NCIPC's research priorities for CAN since 2015?
- ❑ How has the field or overall burden changed since priorities were last assessed in 2015?

[7] https://www.cdc.gov/child-abuse-neglect/about/index.html
[8] https://www.cdc.gov/injury/pdfs/researchpriorities/CDC-Injury-Research-Priorities.pdf#page=35

- ❑ What other issues or research questions have emerged from research and practice-based efforts since 2015?
- ❑ How has the field incorporated health equity into its work since 2015?

To explain the Phase 2 activities in more depth, the internal review evaluated progress on existing CAN research priorities and identified remaining gaps by scanning 3 main internal data sources, including the Research Priority Tracking System (RPTS), CDC website resources, and extramural research awards. A total of 144 outputs were identified in the RPTS, which included 31 evaluating the effectiveness and economic efficiency of policies and practices that provide economic support to families; 41 identifying the community conditions that increase or reduce risk for CAN or promote the development of safe, stable, nurturing relationships and environments; and 28 evaluating the effectiveness and economic efficiency of programs or strategies that can reduce multiple forms of CAN. Of the 144, over half addressed health equity issues in some way. A standard format was used to capture a series of questions pertaining to health equity, identification of the priorities, and links to other potential topics.

To identify funded research addressing the research priorities, Notices of Funding Opportunity (NOFOs) were assessed. Requests for Application (RFAs) were selected that specifically mentioned child sexual abuse (CSA), CAN, or ACEs. Within all of the projects that were funded, coders identified specific RFAs that were associated with each type of research priority. Most were linked to Research Priorities 1 and 2, and none were linked to Priority 3, as shown in this table:

NOFOs That Funded Projects that Addressed Current Research Priorities
RFA-CE-16-001: Research Grants for Preventing Violence and Violence Related Injury[1]
RFA-CE-18-002: Evaluation of Policies for the Primary Prevention of Multiple Forms of Violence[1]
RFA-CE-19-005: Research Grants for Preventing Violence and Violence Related Injury[1]
RFA-CE-20-002: Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth[2]
RFA-CE-20-003: Research Grants for Preventing Violence and Violence Related Injury (R01) [1,2]
RFA-CE-21-001: Rigorous Evaluation of Polices for their Impacts on the Primary Prevention of Multiple Forms of Violence[1]
RFA-21-004: Research Grants for Preventing Violence and Violence Related Injury (R01)[1]
RFA-CE-22-003: Rigorously Evaluating Programs and Policies to Prevent Child Sexual Abuse (CSA) [2]
RFA-CE-21-006: Rigorously Evaluating Programs and Policies to Prevent Child Sexual Abuse (CSA)[2]
RFA-21-004: Research Grants for Preventing Violence and Violence Related Injury (R01)[1]

[1]Research Priority 1: Evaluate the effectiveness and economic efficiency of policies and practices that provide economic support to families to prevent CAN and promote safe, stable, nurturing relationships and environments.

[2]Research Priority 2: Identify the community conditions that increase or reduce risk for CAN or promote the development of safe, stable, nurturing relationships and environments.

[3]Research Priority 3: Evaluate the effectiveness and economic efficiency of programs or strategies that can reduce multiple forms of CAN.

From the CDC website sources and products, 39 outputs were identified. Of these, a majority (n=31) addressed health equity in some capacity. Most addressed Research Priorities 1 and 2, and 11 addressed Priority 3.

For the external landscape review, the literature search was limited to reviews and meta-analyses published since 2015 and individual articles from 2022 onward in 4 areas:

- CAN prevalence/burden
- Risk and protective factors
- Research on efficacy/effectiveness of CAN prevention strategies
- Implementation science

This non-systematic review identified relevant publications, prioritizing literature reviews and meta-analyses (N=210) broken down as follows:

- Systematic reviews (N=49)
- Umbrella review (N=3)
- Scoping review (N=14)
- Meta-analyses (N=22)
- Narrative literature reviews (N=25)
- Original research article (N=86)
- Reports (N=5)
- Practice-focused article (N=6)

Health equity science was examined across all areas of the landscape review, and additional cross-cutting themes were considered (e.g., COVID-19, technology-facilitated violence).

Dr. Merrill-Francis summarized current progress on the CAN research priorities that was identified as a result of the landscape assessment. In terms of the research that has been carried out by the Injury Center to address CAN since 2015, CDC research has resulted in about 120 products that address CAN prevention and align with at least 1 of the current research priorities for CAN. These studies expanded the evidence about the association between economic support policies and CAN. Not as much research has examined non-economic community- and societal-level factors.

Regarding how external research has addressed gaps and priority areas for CAN, 46% of external research aligns with NCIPC's research priorities for CAN. Literature often highlighted that more research was needed on community- and societal-level factors, while more recent research delved into the association between economic support policies and CAN. The external literature noted some differences in risk and protective factors and prevention activities across types of CAN. In terms of how the field or overall burden have changed since priorities were last assessed, the National Child Abuse and Neglect Data System (NCANDS) estimated in FY2022 that 2,119,706 were screened in referrals for child protective services nationally, compared to 2,237,754 in FY2015. The evidence is unclear about whether there were changes in CAN burden associated with the COVID-19 pandemic.

In terms of other issues or research questions that have emerged from research and practice-based efforts, research has called for understanding the differential impact of prevention strategies and risk and protective factors to address the unique needs of communities. The need also was recognized for identifying additional opportunities for intervention at the community and societal levels, understanding intergenerational transmission of CAN and other types of violence, and implementation science more generally.

With respect to progress on current CAN research priorities incorporating health equity, subjective nature, biases, and prejudices around reporting may limit the understanding of which groups experience the greatest burden of CAN. Outputs that were coded as addressing health equity most commonly addressed social determinants of health (SDOH). Economic determinants and inequities were discussed most frequently, with a few studies that assessed societal-level gender inequality. When findings were stratified by demographic characteristics (e.g., racial groups), there often were significant differences between associations. There was not a clear distinction between the effects of material hardship and actual neglect. Studies on CSA and technology-facilitated CAN may be less likely to involve health equity relative to other forms of CAN.

External subject matter experts (SMEs) were interviewed to gain additional perspectives on CDC's current CAN priorities, which included conversations with practitioners and partners (N=9) and academic researchers (N=5). Discussion topics with practitioners, partners, and academic researchers focused on the following areas, with a summary of the SME interviews after each topic:

- ❑ Advances in CAN research in the last decade
- ❑ Evidence of programmatic change (e.g., uptake) resulting from research advances
- ❑ Biggest gaps with potential to inform practice
- ❑ Emerging strategies, technologies, methods, practices, or needs that can enhance CAN research or should be the focus of research
- ❑ Highest priorities for CAN research in the next 3-5 years

Drs. Merrill-Francis and Villaveces independently rewatched these interviews and reflected on their notes to identify the most salient theme for each of the topics, which are summarized as follows:

- ❑ Greatest advances in CAN in the last decade:
  - Understanding individual-level response to CAN, such as home visitation, and a better understanding of family environments and the child welfare system

- ❑ Programmatic changes linked to research in CAN:
  - Increased need for more coordination and integration of current CAN prevention and protection services, as these oftentimes are divided across agencies and organizations

- ❑ Emerging strategies, technologies, methods, practices:
  - Use of technology for the delivery and role of other services beyond child protective services (CPS) to support families, such as thinking about links to economic supports

- ❑ Highest research priorities for the next 3 – 5 years:
  - Improvement of data comparability and linkages
  - Long-term follow-up to better understand effect of interventions (e.g., parenting programs) over time

- ❑ Information or data that are useful in reducing CAN:
  - Child mental and emotional wellbeing indicators, as well as linked contextual data to understand CAN

- ❑ Where research is sufficient to support practice efforts:
  - Understanding of the linkages between SDOH and CAN, as well as an understanding of some of the adverse outcomes

They next looked across the themes seen in the interviews and landscape assessment to pull out some of the biggest gaps in the CAN research, which included the following:

- Research on reducing inequitable burden:
  - More research is needed to identify which groups experience an inequitable burden of CAN and to understand the community- and societal-level factors and prevention activities to reduce the inequities.

- Holistic support of children and their families:
  - Critical research gaps include how to support families before their involvement with the welfare system or other systems like the justice system. This also includes the relationship between CAN and other injury and violence outcomes (e.g., IPV, opioid use).

- Implementation research:
  - Important questions remain about implementing and evaluating prevention efforts, with a focus on ways to coordinate and integrate across services and supports, as well as applying the appropriate intervention and intensity for the intended population. For some families, this might be a parenting program. For other families, this might be a link to community resources and economic supports.

- Data and data linkages:
  - More and better data quality (e.g., longitudinal data, consistent definitions, linked data) and improved access to data from a variety of sources are needed to evaluate prevention efforts and understand the burden of CAN.

Moving into the Phase 3 activities that are underway, revised research priorities were drafted based on the feedback from external SMEs and the gap analysis and were reviewed internally by Division and Center leadership. The draft priorities were then reviewed externally by both federal and non-federal partners. Based on this process, CDC's proposed priorities for CAN will focus on the following areas:

- Community- and societal-level risk and protective factors
- Community- and societal-level prevention and intervention strategies
- Implementation research

All research priorities will center health equity and prioritize gaps related to social and structural determinants of health. Based on the feedback received from the NCIPC BSC and the last feedback from external SMEs, the draft CAN research priorities will be revised and published when finalized. Dr. Merrill-Francis presented the 3 draft research priorities to the BSC. She emphasized that the 5 research questions under each priority were intended to be examples, were not exhaustive of research questions, and would highlight some key themes heard across the landscape assessments and in the interviews.

Research Priority 1: Identify the community conditions that impact families and their risk for CAN or support the development of safe, stable, nurturing relationships and environments (SSNREs).

Prior research has indicated that community conditions (e.g., decreased access to community resources, community conditions that result in increased incarceration levels, and gender inequalities) are associated with increases in CAN. Additionally, other co-existing injury and violence issues (e.g., community conditions that impact availability of opioids) may aggravate or otherwise be associated with CAN. While CAN is the result of a number of factors and interactions, less is known about the role of community- and societal-level factors and CAN victimization and perpetration.

Proposed Example Research Questions:
1. Which community- and societal-level conditions are linked with CAN or promote the development of safe, stable, nurturing relationships and environments?
2. What is the causal process or pathways by which linked community conditions (e.g., social and economic characteristics of neighborhoods, community access to quality education, jobs, safe neighborhoods) relate to CAN, and how can prevention strategies affect this relationship?
3. What are the social norms or narratives that impact the likelihood of CAN (e.g., communities' responsibility for supporting families), and what community conditions perpetuate these norms and narratives?
4. How can prevention policies or other community-level strategies for injury (e.g., opioid use), violence (e.g., intimate partner violence) or mental health outcomes support community-level environments that promote healthy families and prevent CAN?
5. What are the community- and societal-level risk and protective factors associated with preventing intergenerational transmission of CAN?

Research Priority 2: Evaluate the effectiveness and economic efficiency of policies and structures that support families to prevent CAN or support the development of SSNREs.

Research indicates that there are various community- and societal-level factors that are associated with CAN. However, research is needed about how policies and structures can be leveraged to impact these risk and protective factors. Many questions referring to social and structural conditions are directly intended to address health equity or the impact of inequalities in different populations.

Proposed Example Research Questions:
1. What is the impact of social and structural policy changes on intergenerational transmission of violence and family living conditions, such as food security, housing stability, income, and affordable and high-quality childcare, and how do these changes reduce the risk of one or multiple forms CAN?
2. How can social or economic policies that support or economically strengthen families with varying levels of resources and in different communities prevent CAN, and are there additive or synergistic effects of implementing multiple policies or structures in preventing CAN?
3. What is the impact or linkage of policies and structures that promote gender equality on rates of CAN, and do the policies reduce risk for one or multiple forms of CAN and promote safe, stable, nurturing relationships and environments?

4. What is the economic efficiency of social and structural policies that support and/or economically strengthen families?
5. What are the long-term impacts of social and structural policy changes on rates of CAN and other negative health outcomes?

Research Priority 3: Evaluate how the implementation of effective strategies influence efficiency and effectiveness in reducing CAN and promote SSNREs.

While there are many approaches identified to reduce forms of CAN, the best implementation is not yet understood. Understanding the core components of prevention approaches that make them effective in preventing CAN may advance the development and implementation of efficient and effective efforts with maximized impact. It is also critical to ensure that approaches are implemented in the appropriate setting and for the appropriate population. To evaluate questions related to implementation, innovative data approaches may be needed and are encouraged.

Proposed Example Research Questions:
1. What components (e.g., activities, resources) of evidence-based strategies and approaches (e.g., policies, programs) and which community engagement strategies increase their effectiveness in reducing CAN?
2. How does the effectiveness of virtually distributed approaches (e.g., parenting skills programs) compare to in-person efforts and how can implementation be maximized to increase efficiency and effectiveness in reducing CAN in different communities?
3. What and how can novel approaches to data collection and/or linkage be leveraged to evaluate strategy or approach implementation and which components reduce CAN?
4. To what extent are evidence-based prevention strategies or approaches to reduce CAN equally effective across populations?
5. To what extent do evidence-based prevention strategies or approaches widen, narrow, or maintain inequities in CAN and how can equity be improved?

The following discussion questions were presented to the BSC for feedback on the proposed research priorities:

1. To what extent do the proposed research priorities advance understanding of how to prevent CAN?
2. To what extent do the proposed research priorities address inequities?
3. To what extent do the proposed research priorities advance successful implementation of effective strategies?
4. Are there community- and societal-level factors that should be emphasized that are not included in the proposed research priorities?

Discussion Points

Dr. Ellis commended the group for zooming out and creating some priorities that help to understand the context that actually can breed cycles of CAN, as well as promote cycles that are much more virtuous and have positive impacts. When thinking about community- and societal-level factors, she asked whether any specific factors had been isolated in this framework or if they were thinking more broadly for the field around specific sectors (e.g., sectors of policies in particular) as opposed to just the factors.

Dr. Villaveces indicated that in their discussions with some of the external SMEs, both sectors and issues were mentioned. Part of the integration of other sectors focused on CPS and what healthcare can do from the perspective of prevention and mental healthcare, which are areas where other and expanded levels of sectors could participate in preventing CAN. In addition to that, some specific areas mentioned with regard to themes were that food insecurity and jobs may be drivers of difficulties to accessing some services. Certainly, overdose is a major issue in some communities. Access by means of transportation or lack thereof are societal and contextual factors that are linked.

Dr. Merrill-Francis added that where they imagined some of that might be captured as well was in thinking about implementation and how to coordinate and integrate across agencies and in thinking about effective approaches. They could consider making this more explicit.

Dr. Ellis said the reason she brought this up was because one of the questions under Research Priority 1 mentioned identifying causal pathways. Oftentimes, these factors are actually outputs or outcomes from specific sectors that are a result of the policies or programs that may or may not be in place. She encouraged zooming out and not just identifying the factor, but also getting to the root of what is actual driving that factor or making that much more present in that particular environment.

Dr. Merrill-Francis said they definitely heard that understanding the causal pathway would be helpful to make sure that the right factors are being attributed to the end result.

Dr. Pollack Porter echoed the prior comments about applauding the work to think about more macro level factors. Regarding how intersectionality shows up in the priorities, it is important to look at certain marginalized groups. She did not see explicit mention of intersecting identities in the priorities. With Research Priority 2, there was a question pertaining to methods of engagement for facilitating community voices and some other sub-questions. She wondered under that question about the openness to look at things like power and how power shows up in community as part of engagement, and whether the question of engagement includes efforts to shift and build power amongst communities so that voices are part of the process. She made a plug in terms of finalizing these questions to connecting with the National Institutes of Health's (NIH's) PhenX Social Determinants of Health (SDOH) Assessments Collection Toolkit.[9] She was part of the working group in 2022 that identified some additional SDOH measures that are on the NIH website that suggests ways to measure some of the factors identified in the NCIPC priorities. She encouraged celebrating this toolkit to help to support the ability to compare across studies in term of standardized measures.

Dr. Villaveces expressed appreciation for the information about the NIH toolkit, which they will look at. In the priorities and by mentioning equity throughout, the team was very intentional in looking at the contextual driving factors that are affecting CAN. As Dr. Pollack Porter pointed out, the issue of intersecting identities is not specifically mentioned. Addressing equity or inequities that may exist and may affect populations differentially is tacitly incorporated. They are happy to consider suggestions about better ways to state this more explicitly. In terms of the methods of engagement to address power, all of the contextual issues are very important. In the spirit of summarizing, the language of equity was incorporated in a general umbrella type of approach. They hope to include issues of power and how populations are differentially affected not only by policies, but also by structures that affect CAN. Again, this is implicitly incorporated but suggestions for better language to incorporate this are welcomed.

[9] https://www.nimhd.nih.gov/resources/phenx/

Dr. Walley noted that CPS can function as a quasi- criminal or punitive institution. This is commonly the experience of his patients, most of whom have substance use issues in primary care. In terms of inequities and successful implementation of effective strategies, he did not hear enough about the harms that can occur from CPS. The evidence regarding when CPS works to prevent CAN or help families and when it does not is not well known, if it exists at all. Adding to Dr. Pollack Porter's comment on intersectionality, particularly around parents who use substances or are perceived to use substances, there are structural, regulatory and legal systematized processes that favor breaking up families specifically impacting people who use su. In his view, there is not adequate investment in trying to maintain family unification. A lot of that occurs under the rationale around safety or preventing CAN. His feeling is that oftentimes, the solution exacerbates the problem in the way things are structurally set up. He would like to see that more explicitly addressed in these research priorities in terms of taking a critical eye to the existing systems, looking for positive deviance and ways this does not work out. In terms of being more explicit, one of the starkest examples is the legacy of treatment of indigenous children throughout the country and all of the harms that have been done from what have been voiced as "good intentions." An explicitly acknowledgement is needed that good intent is not a sufficient goal to prevent CAN.
Dr. Merrill-Francis acknowledged that this was a recurring theme they heard in the conversations, particularly regarding some of the challenges of working with the CPS system and how to provide services outside the child welfare system and limit involvement with CPS system. One of the SMEs said that CPS is a lovely when the full weight of the government is needed, but there is evidence to indicate that it is perhaps not needed as often as it is being utilized. This came up particularly with regard to Research Priority 3 and some of the implementation pieces in terms of understanding the right intensity, programs, and components that are most effective.

Dr. Villaveces added that one of the reasons they mentioned linking other sectors is precisely to address some of the well-intentioned activities that may actually result in harm. The idea of incorporating other sectors is to incorporate more of the aspect of prevention and early identification so that a person or a family does not need to arrive at those stages. He expressed appreciation for the comments and suggestions about making this more explicit.

Dr. Ondersma said he resonated with Dr. Wally's comments and found them to be apt. He thought he recalled seeing a 46% match of externally funded research with the prior set of priorities, and wondered whether there are plans to ensure that externally funded research better matches the current priorities moving forward. He is interested in and endorses community- and societal-level focus 100%, but it is easy for researchers to frame much narrower or even individual interventions as perhaps being societal-level if they could be scaled up. That is partly because some of the true societal-level interventions do not fit a 4- or 5-year research project very well, the budget, or the powers of an individual research group—even with a lot of important collaborations. He wondered whether some examples or operational definitions might be useful in looking for funding that matches these particular priorities.

Dr. Villaveces agreed that operational definitions are very helpful. In terms of research priorities and insights, he and Dr. Merrill-Francis yielded to other colleagues within the DVP.

Dr. Tom Simon added that over the years, they have seen what Dr. Ondersma described in terms of calling for research at the outer levels of the social ecology and instead get more community-based research that is still targeting individual- or family-level factors. They have tried over the years to refine the language, emphasize the expectations in terms of training reviewers, and include specific examples of policies to make clear that there is interest in evaluating policy changes. He emphasized that they are very much aware of this issue, are working to address it, and welcome any suggestions.

Dr. Kathleen Basile added that they are limited by their budget, so they cannot always conduct the research the field calls for. Within these priorities, they try to fund as much external research as possible with the budgets available, make it reasonable, and try to link it to the outer-level community risk factors and so forth. Some of the NOFOs are focused on policies, which are somewhat easier than longer term studies on community factors.

Dr. Miller expressed gratitude for the outstanding and comprehensive presentation. She emphasized that the proposed research priorities are broad and expansive, and budgets are small. As everyone observed, more cross-sector collaborations and systems integration are needed. She wondered how they could lift up existing practice-based programmatic efforts through HRSA and the Substance Abuse and Mental Health Services Administration (SAMSHA) that look promising but need rigorous evaluation. CDC has evaluated promising strategies in the past as a way to promote cross-sector collaboration.

Dr. Villaveces indicated that they will follow-up on joint efforts with HRSA and SAMSHA on this important approach.

Dr. Johnston wondered about addressing some of the rural/urban disparities that have been noted, particularly in the *Children and Youth Services Review* from 2021[10] and how that might be included as a priority. From an evaluation research standpoint, there may not be methodologies to support integration across the ecologic model for many of the societal- and community-level factors. She asked to what extent NCIPC might support research that focuses on analytic models to improve assessment or evaluation of interventions.

Dr. Villaveces recognized that this is an important and challenging question. They certainly can make rural/urban differences more explicit. The inequities differential is mentioned, and some examples are provided. Many of the SMEs pointed out that some of the inequalities come from the rural/urban differences, especially in relation to access. This can certainly be made clearer. Methodologies represent an important challenge, and some of the priorities recommend addressing societal factors. It follows that developing methodologies to better study and measure this is very important and also can be made more explicit.

Dr. Merrill-Francis added that the proposed Research Priority 3 includes language to encourage innovative uses of data. For example, they heard from some external SMEs about novel ways they have been linking or collecting data or using qualitative data to answer the third implementation research priority in particular. She liked the idea of expanding on innovative data uses to include methodologies.

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[10] https://www.sciencedirect.com/journal/children-and-youth-services-review/vol/126

Dr. Shenoi observed that there does not seem to have been much movement in the statistics in terms of screened in referrals or deaths reported. There is known to be bias in identification and reporting of child maltreatment (CM) cases, especially among minority groups. He wondered how these factors could be minimized to more accurately monitor this burden and the effects of the interventions. For instance, perhaps there are other ways of measuring the outputs of the child welfare system (e.g., gainful employment, death reduction, home ownership) at the individual level. Interventions are being implemented in the same population groups that are at high risk for CM. Consideration must be given to how to minimize racial, ethnic, and economic bias and stigma.

Dr. Villaveces said that in terms of identification and reporting biases that may exist, one of the intensions with the proposed research priorities was to mention the need and relevance to improve data linkage and access to data was in part because of the need to access, incorporate, and connect data sources that provide more contextual information, identify cases in a better way (screened or substantiated) of CAN, and better describe the characteristics that surround those populations in particular situations they are experiencing and the contextual situations they encounter that might be affecting them. The point about racial and economic bias is well-taken and also was commented on by external reviewers. Sometimes people who may benefit from a particular intervention are over-burdened by a variety of requirements of those interventions. How to provide better resources represents a very important issue. Bringing up equity (e.g., racial, economic, rural/urban) is precisely because of those biases and is an incredibly important point. The methods and interventions that should be derived from the priorities should strive to address, minimize, or reduce those inequities.

Dr. Merrill-Francis added that this is what they were hoping to address with Research Priority 1, Question 3. They heard some of the challenges of the data, particularly CPS data, and the need to for innovation in data, linked resources, and different agencies' data to truly understand what is occurring in the context of known biases with reporting.

Dr. Malik emphasized the impact of systems that may break down and create barriers to care. He recalled Dr. Arwady mentioning in her update the impact of dual diagnoses on CAN. In terms of cross-sector collaboration, this is an amazing forum for the intersection of problems and solutions. The importance of addressing the barriers to mental health and addiction being integrated is finally being realized. These should be addressed together rather than in the ED. Data are needed to see the strategies pointing toward dual diagnoses on CAN in terms of whether mental health and/or addiction are being driven down and what social and economic determinants are impacting that realm as well. Barriers remain in terms of systems not facilitating solutions, which perpetuates patients staying away from providers. For instance, only a fraction of the addiction population is being treated because they are not presenting due to the dangers they feel are associated with treatment. This is analogous to everything good that systems are trying to do, but there is fear. Physicians have a responsibility to educate their peers, colleagues, and the population at large.

Dr. Villaveces emphasized the importance of intersectionality and the negative synergistic problems that may need to be addressed.

Updated Youth and Community Violence Research Priorities

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Dr. D'Inverno indicated that she and Ms. D'Angelo would summarize information identified from internal and external landscape reviews of community violence (CV) prevention, formerly YV prevention research, and present proposed updates to NCIPC's community violence research priorities. The same guiding principles were used for this review as those used by the CAN Research Priority Group. The research principles help the Injury Center set research goals, prioritize research that will have public health impact, encourage innovative research, and focus on CDC's public health expertise. The priorities are intended to cover the next 3 to 5 years. While some of these priorities might be difficult to accomplish in that time period, NCIPC would like to make progress in the proposed areas. The Research Priorities document is intended to be a living document that is updated on a regular basis.

While progress was assessed on the priorities related to YV, the new priorities expand to include a broader age range for CV, which now encompasses YV. This aligns with the recently released *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*[11] that also was an update to the *Youth Violence Prevention : Resource for Action: A Compilation of the Best Available Evidence*.[12] The current YV research priorities published in 2015[13] are to: 1) evaluate physical environment change strategies for their effectiveness in reducing youth violence behaviors, injuries, and fatalities and their economic efficiencies; 2) identify and evaluate strategies to decrease inappropriate access to and use of weapons by minors and to prevent lethal violence; and 3) evaluate the effectiveness and economic efficiency of prevention strategies that reduce the likelihood of different forms of youth violence.

The definition of "community violence" is "violence that happens in public places, such as streets or parks, between people who may or may not know each other. Examples include assaults, fights among groups, homicides, and fatal and nonfatal shootings."[14] It is known that youth and young adults 10–24 years of age, particularly those in communities of color, are disproportionately impacted.

The process for reassessing existing priorities that was used for the landscape review and proposed 2024 CV research priority updates was the same as used for the CAN research priority updates as depicted in the graphic shown on Page 7 of this document. Phase 1 of the CV research priority updates process has been completed, which included selecting priority

[11] https://www.cdc.gov/violence-prevention/media/pdf/resources-for-action/CV-Prevention-Resource-for-Action_508.pdf
[12] https://stacks.cdc.gov/view/cdc/158963
[13] https://www.cdc.gov/injury/pdfs/researchpriorities/CDC-Injury-Research-Priorities.pdf#page=38
[14] https://www.cdc.gov/violence-prevention/media/pdf/resources-for-action/CV-Prevention-Resource-for-Action_508.pdf

areas. Phase 2, or the analyze phase, is also complete in terms of gathering materials, conducting a review of research activities, conducting a landscape review, synthesizing the findings, and conducting a gap analysis. Phase 3 is underway, within which updated priorities were drafted and ready to be presented to the NCIPC BSC for feedback. The aim is to finalize and complete the process by the end of 2024.

The activities in Phase 2 included an NCIPC internal review, an external landscape review, and partner interviews to gather feedback about what is happening on the ground. The following guiding questions were used to help maintain focus on the goals of Phase 2, and also were used during the interviews with partners:

- What research has been carried out by the Injury Center to address YV and CV since 2015?
- How has external research and other federal agencies addressed gaps and priority areas that align with NCIPC's research priorities for YV since 2015?
- How has the field or overall burden changed since priorities were last assessed in 2015?
- What other issues or research questions have emerged from research and practice-based efforts since 2015?
- How has the field incorporated health equity into its work since 2015?

The approach and methodology for YV/CV internal and external reviews were similar to those for the CAN reviews. The goal for the NCIPC internal review was to evaluate progress on existing YV research priorities and identify CV research priorities, and identify remaining gaps by scanning internal data sources, including the RPTS; programmatic data from relevant DVP program funding announcements, such as "Preventing Teen Dating Violence and Youth Violence by Addressing Shared Risk and Protective Factors" and "Preventing Violence Affecting Young Lives (PREVAYL);" surveillance reports, including those from the National Violent Death Reporting System (NVDRS), Youth Risk Behavior Survey (YRBS), and School-Associated Violent Deaths (SAVD); and reports and supporting documents not in RPTS (e.g., success stories, impact statements, additional funding announcements, technical reviews/final reports, CDC products and webpages). The group reviewed about 180 products during this internal landscape review.

The approach and methodology for the external landscape review included reviewing studies and research gaps identified in the recently released *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*; conducting a non-systematic identification of relevant additional publications, prioritizing literature reviews and meta-analyses focused on YV/CV prevalence/trends, risk and protective factors, efficacy/effectiveness research, and implementation science; considering additional cross-cutting themes (e.g., COVID-19, technology-facilitated violence); and assessing health equity science across all areas of the landscape review (e.g., did studies measure disparities, assess impact by certain groups, focus on methods to improve health equity research and practice, assess the role of racism). The group reviewed 93 publications during the external landscape review process.

In addition to presenting the RTPS that captures outputs, the group wanted to showcase NOFOs that had YV- and CV-supported projects that align with the current priorities. They searched the DVP-funded research website for YV, CV, and firearm projects. Over $61 million in external funding for YV and CV research has been awarded from 2020–2024. Over $33 million in extramural funding has been awarded for firearm prevention research from 2020–2024, with all covering the topic of CV and fewer addressing the issue of youth specifically. The following tables list the outputs identified:

Youth Violence & Community Violence Prevention Extramural Funding

Year	RFA No.	Title	# of Awards
2020	CE20-003	Research Grants for Preventing Violence and Violence Related Injury (R01) – ACES focus	1 award
	CE20-002	Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth (K01)	2 awards
	CE15-002	The CDC National Centers of Excellence in Youth Violence Prevention: Building the Evidence for Community- and Policy-Level Prevention (U01)	2 awards
2021	CE21-003	Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth (K01)	1 award
	CE21-004	Research Grants for Preventing Violence and Violence Related Injury (R01) – ACES focus	2 awards
	CE21-001	Rigorous Evaluation of Policies for their Impacts on the Primary Prevention of Multiple Forms of Violence (U01)	2 awards
	CE21-005	The CDC National Centers of Excellence in Youth Violence Prevention (YVPCs): Rigorous Evaluation of Prevention Strategies to Prevent and Reduce Community Rates of Youth Violence (U01)	5 awards
2022	CE22-002	Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth (K01)	1 award
	CE22-005	Research Grants for Preventing Violence and Violence Related Injury (R01) – CV focus	3 awards
	CE22-013	Rigorous Evaluation of Community-Centered Approaches for the Prevention of Community Violence (U01)	2 awards
2023	CE23-003	Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth (K01)	1 award
	CE23-004	Research Grants for Preventing Violence and Violence Related Injury (R01) – CV focus	3 awards
2024	CE24-029	Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth (K01)	1 award
	CE24-030	Research Grants for Preventing Violence and Violence Related Injury (R01) – CV focus	3 awards
	CE24-034	Rigorous Evaluation of Policies for their Impacts on the Primary Prevention of Multiple Forms of Violence (U01)	2 awards
2025	CE25-021	Research Grants for Preventing Violence and Violence Related Injury (R01) – CV focus	Just announced
	CE25-029	Grants to Support New Investigators in Conducting Research Related to Preventing Interpersonal Violence Impacting Children and Youth (K01)	Just announced

Correction to slide: 2020 CE15-002 had 5 awards (not 2 as listed on the slide)

Firearm Injury Prevention Extramural Funding

Year	RFA No.	Title	# of Awards
2020	CE20-002	Grants to support new investigators in conducting research related to preventing interpersonal violence impacting children and youth (K01)	2 awards
	CE20-006	Research Grants to Prevent Firearm-Related Violence and Injuries (R01)	16 awards
2022	CE22-004	Research Grants to Prevent Firearm-Related Violence and Injuries (R01)	4 awards
2023	CE23-005	Research Grants to Inform Firearm-Related Violence and Injury Prevention Strategies (R01)	4 awards
	CE23-006	Research Grants to Rigorously Evaluate Innovative and Promising Strategies to Prevent Firearm-Related Violence and Injuries (R01)	8 awards
2025	CE25-030	Research Grants to Rigorously Evaluate Innovative and Promising Strategies to Prevent Firearm-Related Violence and Injuries (R01)	Just announced

To briefly summarize the responses to the guiding questions based on the internal and external landscape reviews, in terms of the research that has been carried out by the Injury Center to address YV/CV since 2015, the review of approximately 260 internal and external publications showed that the Injury Center has expanded knowledge related to physical environment change strategies, trends in homicides, and risk and protective factors for weapons carrying by minors. The economic impact of YV was calculated and the cost-effectiveness of physical environment approaches were examined.

With regard to how external research addressed gaps and priority areas that align with NCIPC's research priorities for YV since 2015, research from inside and outside of CDC relatd to Injury Center priorities has improved the understanding of effective interventions for physical environment change strategies and their costs; examined effective interventions to reduce unauthorized firearm access by minors; identified effective interventions for bullying, though limited to cyberbullying/online violence; and increased knowledge about the role of some economic supports.

Regarding how the field or overall burden changed since priorities were last assessed in 2015, the internal and external landscape reviews revealed increases in homicide rates and ED assault visits between 2019 – 2021. Homicide rates have been declining since 2021, but remain above 2019 rates. There are substantial, ongoing disparities in CV by race/ethnicity, with Black males at highest risk. There are multiple risk factors that persist for elevated CV related to COVID-19. New research is emerging on the role of technology-facilitated violence in CV, but there is still limited research on effective interventions to address violence that emerges online.

Pertaining to other issues or research questions that have emerged from research and practice-based efforts since 2015, there is a need for evaluation of approaches that address underlying structural and social factors that drive CV and risk for CV. The field needs standardized measures so that different approaches can be evaluated similarly. Better dissemination and translation are needed so that communities know what interventions are effective. There is a need for research to understand effective strategies to improve school climate and equitable educational attainment. Understanding is needed about what implementation practices facilitate success and can be replicated in other settings.

As mentioned earlier, health equity science was examined in the review in terms of how the field has incorporated health equity into this work since 2015. Less than half (42% to 44%) of the research examined assessed health equity. Health equity science in YV/CV has primarily focused on measuring disparities and SDOH and addressing racism. Research has measured disparities and documented that some groups, such as Black adolescents and young adults are at higher risk of YV/CV compared to their White counterparts. For SDOH, there has been a paradigm shift toward implementing community-level strategies that address the social and structural root causes of violence. There is a need to identify and examine community, social, and structural risk and protective factors that contribute to inequitable risk of violence, including structural and systemic racism. Relevant to addressing racism, there is an emerging and renewed focus on anti-racism work within the field of violence prevention. However, there is limited research examining the impact of racism on YV/CV. Some specific research questions focus on the topics of how stress resulting from racism contributes to violence perpetration; and how the approach to study design, community recruitment and engagement, and other factors related to the research process change when the research community is diversified.

Ms. D'Angelo reported that during the partner reviews, the group sought to hear the perspectives of experts on YV and CV from outside of CDC about research progress relative to the agency's existing priorities, current needs, and direction of the field. Contact was initially made with 3 partner organizations, of which 2 were available to participate. In addition, there were conversations with 4 academic researchers and 3 people from the Department of Justice (DOJ). The discussions with the partner organizations focused on innovations, programmatic work, and emerging needs from practice. Conversations with the academic research and staff at DOJ focused on research progress, gaps, and highest priorities for research in the next 3 to 5 years. The topic of health equity was covered by all groups.

At a high level, a number of common themes were heard during the partner interviews. First, there is a disconnect between research and communities. Research may not be filtering down to communities, and communities may not be selecting prevention approaches that are the most effective. Second, there is a need for a comprehensive approach to bring partners together and create standardized measures so that different approaches can be evaluated similarly. Third, there is a need to increase the diversity of researchers to better represent affected communities. Fourth, there are emerging issues that may require adjustments to research and practice. Fifth, there is a need for research on system-level approaches and upstream factors.

To highlight some of the specific issues heard about during the interviews, people talked about shifting demographics that they noticed in their work. Examples include perceptions of an increase in younger offenders 10–12 years of age, more girls and women involved in perpetration, and individuals incarcerated in the 1990s re-entering communities in their 40s and 50s. New challenges from the overdose epidemic and the COVID-19 pandemic impacted youth were noted, such as loss of caregivers and orphanhood; family stress, hardship, and trauma; and high exposure to ACEs. On the positive side, more collaboration and community engagement among researchers, practitioners, and community organizations were noted. More engagement of communities directly in the design and implementation of prevention strategies was observed.

Suggestions were also heard to explore innovative ideas, such as looking to key institutions in communities with existing infrastructure, such as healthcare institutions and higher education, to more proactively invest in and support prevention activities in their communities; and to utilize Mayors' offices and Offices of Violence Prevention to increase reach and sustainability of programs and facilitate access to services for CV prevention program participants. Other specific comments were related to the need for implementation science to better understand what policies and practices facilitate success and can be replicated, and what training competencies and skills are needed for effective program outcomes. There was a recognition of the continually evolving role that technology and social media can play in escalating violence and how they might be used for prevention. The need was identified for research on promising programs and a focus on upstream factors due to research highlighting the impact of addressing root causes. It was noted that there is a need for better dissemination and translation of findings.

With the partner interviews completed, the review group compiled and synthesized all of the information from the internal and external landscape reviews, including the "Future Directions" section of the recently released *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*, and the partner interviews to perform a gap analysis to inform the development of the new CV research priorities. In terms of key gaps identified, evaluation research is needed on innovative strategies that communities are using but that have not yet been rigorously evaluated. Implementation

research is needed to understand what elements facilitate success, scalability, and adaptations for specific groups and for how to maximize reach, effectiveness, and sustainability. Pertaining to underlying factors that influence CV and inequities in risk for CV, research is needed on approaches that address underlying factors and SDOH (e.g., educational attainment, housing stability, and economic security). For technology-facilitated and online CV, research is needed to better understand how technology and social media influence violence dynamics and to explore the impact of specific apps or online communities on violent behavior. With respect to engaging communities and people with lived experience (PWLE), research is needed on ways to promote community leadership and meaningfully engage PWLE in all parts of the research process.

Phase 3 of the research priority development process is now underway. The new CV research priorities have been drafted, which were presented to the NCIPC BSC for consideration. As mentioned earlier, the findings were synthesized from the entire process to draft the updated research priorities. These priorities have already received preliminary internal review by DVP and Injury Center leadership. Input received from the NCIPC BSC will be taken into consideration and draft priorities will be reviewed externally by federal and non-federal partners before finalizing them. All research priorities will center health equity and prioritize gaps related to social and structural conditions.

Research Priority 1: Evaluate the effectiveness of prevention approaches with potential to reduce CV and inequities in the risk of CV.

Proposed Example Research Questions:

1. To what extent are practice-based approaches (i.e., those implemented in communities, but not yet evaluated) and promising approaches (i.e., those requiring more rigorous evaluation) effective at preventing CV or inequities in risk for CV?
2. To what extent are innovative technology-based approaches effective at preventing CV or inequities in risk for CV both in-person and online?
3. To what extent are policies and other approaches (e.g., paid family leave, subsidized childcare) that address underlying structural and social drivers to improve the physical, social, and economic conditions of neighborhoods effective at preventing CV or inequities in risk for CV?
4. To what extent are approaches that create positive and equitable school climate and school connectedness effective at protecting against CV?
5. To what extent are environmental design and anti-displacement strategies effective for preventing inequities in risk for CV?

Research Priority 2: Identify factors that influence implementation and reach of effective CV prevention programs, policies, and practices.

Proposed Example Research Questions:

1. What are the drivers of effectiveness when implementing policies, programs, and practices focused on preventing CV? How do differences in implementation affect CV and inequities in risk for CV? Potential areas to examine include the type and nature of partnerships, organizational characteristics, staffing, and resources.
2. What methods of engagement are most effective for facilitating community and youth leadership; developing authentic partnerships; and incorporating understanding of lived experiences in communities most impacted by CV? How can community strengths and assets be elevated and leveraged through community engagement to improve effectiveness of approaches that prevent CV and inequities in the risk of CV?

3. What are the best methods to recruit, select, and support program staff (including outreach workers) to promote health, safety, retention, and program effectiveness? What training competencies and skills are needed to effectively implement, monitor and improve or sustain an effective program, policy, or practice? How can training and technical assistance (TTA) best support community leaders and CV prevention practitioners?
4. How can effective approaches be adapted for use in different settings, scaled up, monitored and sustained to achieve community or population-level impact in communities most affected by CV? To what extent are effective approaches cost-effective and economically feasible for communities to implement?

Research Priority 3: Increase the understanding of how structural and social determinants of health and other underlying factors influence CV and inequities in risk for CV.

Proposed Example Research Questions:

1. What social and structural determinants are contributing to inequitable risk for CV? How do factors related to the diversity of researchers, the way communities are engaged, and the promotion of positive narratives about youth contribute to CV prevention?
2. How can social and structural conditions such as historical, collective community, or intergenerational forms of trauma (e.g., adverse childhood experiences, structural racism, patriarchal social structures, toxic stress) be addressed to prevent CV and inequities in risk for CV?
3. How can data sources be linked and analyzed to provide more thorough and accurate understanding and monitoring of social and structural determinants of health to understand underlying drivers of CV and inequities in risk for CV? How can data integration be more timely?

Research Priority 4: Identify and evaluate strategies and approaches to prevent homicides and potentially lethal violence, including shootings.

Proposed Example Research Questions:

1. To what extent are novel approaches for preventing potentially lethal CV, or reducing key risk factors like unauthorized access to, or carrying of firearms or other weapons effective at preventing shootings, injuries and deaths?
2. What adaptations to programs, policies, or practices enhance effectiveness for different populations in a culturally appropriate manner to prevent homicides and potentially lethal CV among youth and young adults?
3. To what extent do strategies that raise awareness, promote adoption, ensure equitable implementation, and minimize potential harms of existing policies and practices help reduce potentially lethal CV youth and young adults?

The following discussion questions were posed to the BSC for feedback on the proposed research priorities:

1. What suggestions do you have to ensure the research priorities advance the understanding of how to prevent CV?
2. What suggestions do you have to ensure the research priorities address inequities?
3. What suggestions do you have to ensure the research priorities advance implementation of effective strategies?

Discussion Points

Dr. Shenoi emphasized the importance of learning more about social and health equity in terms of their individual and collective contributions to reducing CV, given that planning required for these interventions with respect to investment, level of community engagement for policy changes, and duration of involvement. He also commended the group on highlighting the issue of misinformation and rumor mongering in recent times. There already is a level of mistrust between those who have power and those who do not, which is one of the most challenging aspects of trying to address community violence at the community-level.

Dr. Nation expressed gratitude for the excellent review, noting that it is always nice to see how the field has evolved over the course of time. It is nice to see the greater recognition of the social and structural factors affecting CV reflected in what has happened and what is planned. While he understood some of the reasons for the clear shift in the language from YV to CV, it also raised some concerns for him because the CV world is a lot bigger than YV, has some different emphases, tends to be much later in the process of intervention, and is more tertiary prevention versus early intervention or primary prevention with YV. He asked whether there will be some specific efforts to preserve the youth elements of violence prevention work as a part of this next stage, because he fears that just by the sheer number of proposals submitted, YV could easily fade out of the emphasis of CDC's work. He would hate to see that happen. In terms of gaps, there seems to be a disconnect between the decisions some communities are making about violence interventions and the current evidence. He wondered whether any of the potential NOFOs will address examination of how communities are making decisions. There seems to be an implicit assumption, with which he agrees, about bringing people together to have a community process and buy-in to what is proposed for CV prevention. However, his experience has been that this is not always the way in which decisions are being made, and he fears that many resources will be allocated to this process while decisions are still being made in a different space that will not reflect any of this work. He wondered whether there are ways to bridge that and the priorities moving forward.

Ms. D'Angelo indicated that when they conducted the external interviews, an issue the partners talked about the most related to implementation. The partners pointed out that due to the limited range of the funding, many communities are not even hearing about the research at all. There is a small universe that is connected with CDC and more aware of the research, as well as another universe of people doing the best they can. The priority that addresses the need to better disseminate and translate information more broadly could be further expanded, even beyond what CDC is able to fund. Examination of the process for how decisions are made is a fantastic idea that could fall within the implementation piece.

Dr. D'Inverno added that there is a need to perform rigorous evaluation of practice-based efforts. There are communities that are implementing interventions that they feel work, but for which there has not yet been documentation of the results. DVP certainly does not want to diminish the work of YV and all of the historical research, knowledge, and dedication that have been devoted to that for decades. There were many reasons for expanding the age range. They heard from a lot of communities that for them, the problem is somewhat more with young adults than with youth. However, primary prevention certainly can continue in the YV space as well. As mentioned, this aligns with the shift in the *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults* to think about violence more broadly in communities, but with a focus on the age range for which there is known to be a disproportionate burden of violence.

Dr. Nation agreed that the data are clear that the burden is heavier in the later ages, such as young adulthood. The issue is that this is also the age group for which it takes the most resources to make change. That has been a traditional reason for more emphasis on earlier intervention and earlier engagement, which he hopes is not lost in the process of appropriately trying to address what communities are saying with respect to the demand at later ages.

Dr. Simon offered reassurance that even within the recently released *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*, there is specific discussion about addressing youth and young adult violence. The goal is to be clear about expanding the age range, but it is not at the expense of early prevention, which will continue to be emphasized. NCIPC still has appropriations from Congress for the Youth Violence Prevention Centers (YVPCs). The Injury Center also would not like a scenario in which everyone shifts to the older age range and the younger age range and opportunities for early prevention are neglected. There are some strategies that can be put in place to avoid that, such as specifying in the secondary review that there needs to be balance across age range, address upstream factors and early prevention, and include interventions targeted toward young adults who are most at risk for homicide. Research Priority 4 includes a focus on preventing shootings, homicides, and lethal violence. This will provide not only an opportunity to focus on the select group of highest risk individuals within communities who are often young adults, but also will still allow for opportunities to address YV.

Dr. Caine emphasized that the CAN and YV/CV presentations offered thorough and thoughtful reviews in defining new directions and priorities, while recognizing the benefits of the 2015 priorities. There is a core for CAN and YV/CV in terms of communities and structural policy. He asked how much geospatial overlap there is between communities that are experiencing the burdens of CAN and violence, and whether there are common areas with these separate initiatives that are not so separate in the lives of the people who live there.

Ms. D'Angelo responded that this came through very clearly. The CAN team focused considerably on economic security strategies, which are also some of the key strategies in the updated *Community Violence Prevention Resource for Action: A Compilation of the Best Available Evidence for Youth and Young Adults*. The CV team included a sub-question related to social and structural drivers in terms of proposed research, which is an important area that could be expanded.

Dr. Caine asked whether it would be possible to publish integrated NOFOs focused on families and communities in a way that recognizes that there is no bright line between them. While communities already often integrate these, whether researchers think in this way is another issue.

Dr. D'Inverno concurred that more work is needed on addressing cross-cutting forms of violence. It is known that there are many shared risk and protective factors, and it is efficient to think in that way. The Injury Center has done this through research cooperative agreements in the policy space, such as funding evaluations on policies and laws that may impact multiple forms of violence. She agrees that this is a space in which the Injury Center should continue to work.

Dr. Basile added that the 2015 iteration of the research priorities included a set of cross-cutting priorities. It is a good idea to look across the proposed priorities to determine what is similar across the topical research priorities. The policy NOFO that Dr. D'Inverno mentioned cuts

across violence topics, which could be done again in terms of cross cutting approaches to prevention.

Dr. Caine emphasized that this was an issue of concern for him. Thinking about opioid deaths, violence, CAN, suicide, and other issues, the Injury Center has DOP, DVP, and DIP but common communities suffer many of these burdens. He worries sometimes that the divisions separate what ought to be integrated.

Public Comment Session

Amy Bonomi, PhD, MPH
Co-Chair, NCIPC BSC
Dean and Professor of Pubic Health
College of Health and Human Services
San Diego State University

Victor Cabada, MPH
Office of Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Overview

Dr. Bonomi and Mr. Cabada thanked everyone for their participation in the BSC meeting and indicated that all public comments would be included in the official record and would be posted on the CDC website with the official meeting minutes at CDC.gov/injury/bsc/meetings.html. They provided instructions and pointed out that while questions would not be addressed during this public comment period, all questions posed by members of the public would be considered by the BSC and CDC in the same manner as all other comments. Those who did not have an opportunity to speak in person were invited to submit their comments in writing to the BSC website at ncipcbsc@cdc.gov.

Public Comment

Qing Li, MD, DrPH
OB/GYN-Trained Perinatal Injury Epidemiologist
Affiliated with University Colorado
Representing Herself

Hello. Good afternoon. This is Qing Li, affiliated with University of Colorado, and an OB/GYN-trained perinatal and injury epidemiologist. I represent myself. Before I make public comment, I want to say that in the minutes for the June session, there is a public comment I made at that time. I appreciate the committee contacting me for revision of my public comments draft. I provided that on July 29th and September 8th. The current version includes the updated revision for the public comments in July. I appreciate the consideration and for the action. Thank you for allowing me to make public comments. I really appreciate this opportunity to listen to 2 presentations today. I want to piggy-back on Dr. Caine's comments to emphasize the need for interagency collaboration and looking at the level in the ecological framework to design and nurture effective preventive interventions at multiple levels. Specifically, I want to encourage the members to consider the role of relational health in preventing child neglect and abuse and community violence. I want to call your attention to 2 publications this year. The first one is by

leading author Stirling and the title is “The Pediatrician’s Role in Preventing Child Maltreatment: Clinic Report” published in *Pediatrics* this year.[15] Another commentary by myself, Palusci, and Krugman is “Forgotten Interventions to Promote Relational Health to Prevent Child Maltreatment” published in the *Children and Youth Services Review*.[16] I provided the 2 citations to the committee. I hope you can check that and see there is a comment to look at relational health in preventing child maltreatment and community violence in the broader scope. Thank you.

Announcements, Closing Remarks, & Adjournment

Amy Bonomi, PhD, MPH
Co-Chair, NCIPC BSC
Dean and Professor of Pubic Health
College of Health and Human Services
San Diego State University

Dr. Bonomi expressed gratitude to the presenters, members of the public who listened in throughout the day, the CDC audio technician, Cambridge Communications staff, and CDC staff who made the meeting possible. She reminded all BSC members and *Ex Officios* to send an email to Mrs. Tonia Lindley at ncipcbsc@cdc.gov stating that they participated in this meeting.

With no announcements made, further business raised, or questions/comments posed, **Dr. Bonomi** officially adjourned the Forty-Eighth meeting of the NCIPC BSC at 12:19 PM ET.

[15] Stirling, J., Gavril, A., Brennan, B., Sege, R.D., et al. 2024. The Pediatrician's Role in Preventing Child Maltreatment: Clinical Report. *Pediatrics*, 154(2). https://doi.org/10.1542/peds.2024-067608
[16] Li, Q., Palusci, V.J., & Krugman, R.D. 2024. Forgotten interventions to promote relational health to prevent child maltreatment. *Children and Youth Services Review*, 163, 107783. https://doi.org/10.1016/j.childyouth.2024.107783

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the September 24, 2024 NCIPC BSC meeting are accurate and complete:

______________________	______________________
Date	**Amy Bonomi, PhD, MPH** **Co-Chair, NCIPC BSC**
______________________	______________________
Date	**Elizabeth Miller, MD, PhD** **Co-Chair, NCIPC BSC**

Attachment A: NCIPC BSC Member Attendees

NCIPC BSC Chairs
Amy Bonomi, PhD, MPH
NCIPC BSC Co-Chair
Dean and Professor of Public Health
College of Health and Human Services
San Diego State University

Elizabeth Miller, MD, PhD
NCIPC BSC Co-Chair
Professor and Chief
Children's Hospital of Pittsburgh
University of Pittsburgh Medical Center

NCIPC BSC Members
Eric Caine, MD
Professor of Psychiatry, Emeritus
Department of Psychiatry
University of Rochester Medical Center

Wendy Ellis, DrPH, MPH
Associate Professor, Global Health
Director, Center for Community Resilience
Sumner Redstone Global Center for Prevention & Wellness
School of Public Health
George Washington University

Mohammad Jalali (MJ), PhD, MSc
Assistant Professor
Harvard Medical School
Harvard University

Yvonne Johnston, DrPH, MPH, MS, RN, FNP
Associate Professor & Founding Director
Master of Public Health Programs
Division Of Public Health
Decker College of Nursing and Health Sciences
Binghamton University

Hillary V. Kunins, MD, MPH
Director of Behavioral Health
San Francisco Department of Public Health and Mental Health San Francisco

Angela Lumba-Brown, MD
Associate Professor
Emergency Medicine, Pediatrics and Neurosurgery
Co-Director, Stanford Brain Performance Center
Stanford University School of Medicine

Designated Federal Officer (DFO)
Christoper Harper, PhD
Senior Epidemiologist
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Kaleem Malik MD, MS, FAAEM
Dean of Global Health
The Chicago Medical School
President & Chief Executive Officer
Meridian Emergency Consultants

Ramiro Martinez, Jr., PhD
Professor, School of Criminology and Criminal Justice
Northeastern University

Maury Nation, PhD
Professor of Human and Organizational Development
Peabody College
Vanderbilt University

Steven J. Ondersma, PhD
Professor, Division of Public Health
CS Mott Endowed Professor of Public Health
Charles Stewart Mott Department of Public Health
Department of Obstetrics, Gynecology, Reproductive Biology
College of Human Medicine
Michigan State University

Keshia Pollack Porter, PhD, MPH
Bloomberg Centennial Professor
Bloomberg Centennial Chair
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health
Johns Hopkins University

John Rich, MD, MPH
Director, RUSH BMO Institute for Health Equity
RUSH University System for Health

Rohit P. Shenoi, MD
Professor of Pediatrics
Department of Pediatrics
Section of Emergency Medicine
Baylor College of Medicine

Alexander Walley, MD, MSc
Professor of Medicine
Clinical Addiction Research and Education Unit
Boston Medical Center

NCIPC BSC *Ex Officio* Members
Dawn Castillo, MPH
Director, Office of Extramural Coordination and Special Projects
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

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Science Policy and Evaluation Branch
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National Institutes of Health
National Institute of Mental Health

Carmen Clelland, PharmaD, MPA, MPH, MS
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National Institutes of Health

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National Institute of Child Health and Human Development
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Injury Epidemiologist / Health Statistician
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Senior Medical Epidemiologist, Regulatory Science and Applied Research (RSAR) Program
Regulatory Science Staff (RSS), Office of Surveillance and Epidemiology (OSE)
Center for Drug Evaluation and Research (CDER)
United States Food and Drug Administration

Constantinos Miskis, JD
Bi-Regional Administrator
Administration on Community Living, Administration on Aging

Diane Pilkey RN, MPH
Emergency Medical Services for Children Program
Health Resources & Services Administration

CDC NCIPC Attendees
Sandra Alexander, MPH
Allison Arwady, MD, MPH
Grant Baldwin, PhD
Mick Ballesteros, PhD
Kathleen Basile, PhD

Victor Cabada, MPH
Denise V. D'Angelo, MPH
Lara DePadilla, PhD
Ashley D'Inverno, PhD
Joyce Dieterly, MPH
Denise V. D'Angelo
Leslie Dorigo, MPH
Lianne Estefan, PhD, MPH
Marissa Goodson, RN, MPH
Melissa Mercado, PhD
Molly Merrill Francis , PhD
Corinne Ferdon, PhD
Derrick Gervin, PhD
Marissa Goodson, RN, MPH
Christopher Harper, PhD
Jeffrey Herbst, PhD
Kristin Holland, PhD
LaTonya Jackson
Alana Vivolo-Kantor, PhD. MPH
Laura Kollar, MPH
Juliet Haarbauer-Krupa, PhD
Ruth Leemis, PhD
Tonia Lindley
Reshma Mahendra, MPH
Karin Mack, PhD
Greta Massetti, PhD, MA
Molly Merrill-Francis, PhD, MPH
Marilyn Metzler, RN MPH
Rozeah Owens, MPH
Donna Polite
Judy Qualters, PhD
Katie Sakai, MPH
Thomas Simon, PhD
Sally Thigpen, MPA
Fred Thomas III, MPA
Andrés Villaveces, PhD, MPH
Mikel Walters, PhD
Aisha Wilkes, MPH
Allison Yatco, MPH

Other Attendees
Qing Li, MD, DrPH
Stephanie Wallace, PhD, MS

Attachment B: Acronyms Used in This Document

Acronym	Expansion
ACEs	Adverse Childhood Experiences
ACL	Administration on Community Living
AoA	Administration on Aging
BSC	Board of Scientific Counselors
CAN	Child Abuse and Neglect
CCTI	Cambridge Communications and Training Institute
CDC	Centers for Disease Control and Prevention
CDER	Center for Drug Evaluation and Research
CIOs	Centers, Institutes, and Offices
CM	Child Maltreatment
COD	Cause of Death
COI	Conflict of Interest
CSA	Childhood Sexual Abuse
CPS	Child Protective Services
CV	Community Violence
DFO	Designated Federal Official
DIP	Division of Injury Prevention
DOJ	Department of Justice
DOP	Division of Overdose Prevention
DVP	Division of Violence Prevention
ED	Emergency Department
ET	Eastern Time
FACA	Federal Advisory Committee Act
FY	Fiscal Year
HHS	(Department of) Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IPV	Intimate Partner Violence
NCANDS	National Child Abuse and Neglect Data System
NCHS	National Center for Health Statistics
NCIPC / Injury Center	National Center for Injury Prevention and Control
NICHD	Eunice Kennedy Shriver National Institute of Child Health and Human Development
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NOFO	Notice of Funding Opportunity
NVDRS	National Violent Death Reporting System
OSE	Office of Surveillance and Epidemiology
PREVAYL	Preventing Violence Affecting Young Lives
PWLE	People With Lived Experience
RPTS	Research Priority Tracking System
RSAR Program	Regulatory Science and Applied Research Program
RSS	Regulatory Science Staff

Acronym	Expansion
SAMSHA	Substance Abuse and Mental Health Services Administration
SAVD	School-Associated Violent Deaths
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SSNREs	Safe, Stable, Nurturing Relationships and Environments
SUD	Substance Use Disorder
SUDORS	State Unintentional Drug Overdose Reporting System
SV	Sexual Violence
SVI	Social Vulnerability Index
TA	Technical Assistance
TTA	Training and Technical Assistance
US	United States
YRBS	Youth Risk Behavior Survey
YV	Youth Violence
YVPC	Youth Violence Prevention Center