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PROPOSAL

For

The Behavioral Medicine Research Council

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Acronyms
BMRC = Behavioral Medicine Research Council
BMRN = Behavioral Medicine Research Network
SCRQ = Significant Clinical Research Question
SPRQ = Significant Preclinical Research Question

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Introduction

The Behavioral Medicine Research Council (BMRC) is the centerpiece of a novel and ambitious plan to advance the science and practice of evidence-based behavioral medicine. The BMRC is a new joint committee of some of the leading scientific organizations in behavioral medicine. Its mission is to identify and prioritize strategic research goals, and to catalyze concerted, multidisciplinary efforts to achieve them. This proposal, which has now been approved by four organizations, asked the leaders of these organizations to endorse the plan and enable their organizations to participate in its fulfillment. I submitted it to them in my capacity as the Editor-in-Chief of *Health Psychology* because the journal plays an integral role in the plan.

The premise of this plan is that well organized and persistent efforts to pursue strategic research goals are a powerful but underutilized way to make meaningful progress in behavioral medicine, the kind of progress that can change the lives of people who have or who are at risk for serious diseases and disabilities. By encouraging systematic efforts to achieve strategic research goals, the work of the BMRC will help to reinvigorate our field, renew our collective optimism that evidence-based behavioral medicine can have a significant impact on the health and quality of life of people who need our help, and create a sense of mission and excitement about behavioral medicine research that will attract new generations of trainees. It will also help to build stronger bridges between the science and practice of behavioral medicine.

Rationale

Behavioral, psychosocial, and psychiatric factors play very important roles in many different medical conditions, but despite several decades of behavioral medicine research, evidence-based behavioral interventions play commensurate roles in very few of them. Among the barriers that contribute to this discrepancy, one of the most important is that *stronger evidence is needed to convince guideline writers, policy makers, third party payers, and practicing physicians to embrace evidence-based behavioral interventions for medical problems.* As behavioral scientists, we may have little control over some of the other barriers, but strong evidence is ours to produce.

Nothing is as convincing for a medical audience as large, rigorous, multicenter trials that show clinically meaningful benefits, but there are few examples of such trials in behavioral medicine. The Diabetes Prevention Program (DPP) trial (Knowler et al., 2002) is one of the crowning achievements in our field, and it has had a significant impact on diabetes prevention efforts, but it is a rare exception. Evidence-based behavioral medicine will be much more likely to occupy its rightful niche in clinical practice guidelines and clinical care if we conduct more large, rigorous, multicenter trials of well-developed behavioral interventions with clinically meaningful outcomes and if effectiveness trials, dissemination and implementation studies, and other practice-based research efforts follow in the wake of impressive demonstrations of efficacy.

Despite the rapid pace of scientific and technological progress to which we have become accustomed, major achievements in behavioral medicine do not happen overnight. Large, multicenter trials such as the DPP build on years of preliminary research. After the empirical groundwork has finally been laid, it takes time and it may take multiple attempts to secure funding for a large multicenter trial, and it takes years to conduct the study once it is funded.

There is no guarantee that an intervention will prove to be efficacious in Phase III testing, but even if its outcomes are favorable, it takes time for clinical practice guidelines to incorporate it, for health care systems and third-party payers to support it, and for practitioners to be trained and to start providing it. *Thus, it will take well organized, sustained efforts, over many years, for evidence-based behavioral medicine to become mainstream medicine.*

"Well organized" and "sustained" are not the first words that come to mind when one surveys the field of behavioral medicine research. Most of us are like day traders in a field that needs more long-term investors. Our immediate goals are to beat the next guy to the latest hot topic, publish our next paper, and get our next grant. We are too busy trying to be nimble and innovative and to survive in academia to dream about behavioral Apollo projects, much less to make them happen. But by working together, we *can* make them happen.

Strengthening the Science of Behavioral Medicine

The crucial first step is to identify a series of strategic research goals, i.e., ambitious, long-term goals whose achievement depends on the concerted and persistent efforts of well-organized, multidisciplinary, multicenter research networks. The BMRC will be tasked with identifying and prioritizing two different kinds of strategic goals for behavioral medicine research: Significant Clinical Research Questions (SCRQs) and Significant Preclinical Research Questions (SPRQs).

Some of the key characteristics of SCRQs were recently described in a landmark paper from the NIH Obesity-Related Intervention Trials (ORBIT) Consortium:

> For example, the clinical problem could be that there is no current treatment for a specific condition, a current treatment is not potent or durable enough to change an important clinical outcome, a current treatment is effective but adherence to it is poor, or a current treatment produces too many side effects for routine use in clinical practice.
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> The hypothesis that change in a behavioral risk factor could solve a clinical problem is one of the entry points for behavioral treatment development. The initial explicit identification of the clinical problem does several things. It encourages investigators to: (a) set sights on the Phase III efficacy trial which will test the benefit of the behavioral treatment on an outcome that is meaningful in clinical practice; (b) consider early on the primary behavioral, clinical, or biomedical endpoints in that efficacy trial; and (c) commit to achieving a sufficiently potent level of behavioral change to achieve meaningful change on the ultimate biomedical or clinical outcome (Czajkowski et al., 2015, pp. 4-5).

The types of clinical or biomedical endpoints to which the ORBIT framework refers include the onset of serious chronic illnesses such as asthma, diabetes, or COPD, as well as disease progression, death, or other adverse events in patients with established conditions such as AIDS, cancer, or heart disease. Thus, this framework for intervention research in behavioral medicine is applicable across the entire spectrum of primary, secondary, and tertiary prevention.

SCRQs pertain to behavioral, psychosocial, or psychiatric risk factors for medical outcomes. For example, the DASH (Appel et al., 1997) and PREMIER (Appel et al., 2003) trials showed that blood pressure and CVD risk can be reduced by modifying behavioral risk factors. Consequently, the JNC8 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (James et al., 2014) includes lifestyle factors. However, it does not identify a specific, evidence-based lifestyle intervention for hypertensive patients. Given such vague guidance, physicians usually gloss over their patients' prohypertensive lifestyle and focus on medications instead. However, if highly effective, rigorously proven, evidence-based behavioral services for the prevention or treatment of hypertension were readily available, physicians would probably be eager to refer their patients. Thus, the BMRC might decide that this is a high-priority SCRQ.

But if the highly visible DASH and PREMIER trials weren't sufficient to change the clinical practice of hypertension care, will further research make any difference? The answer is yes. Consider the fact that it took decades of research and numerous multicenter trials for statins to find their way into our lives (Endo, 2010). Fleeting attempts to develop and test behavioral interventions for medical outcomes have had modest effects on clinical care. More ambitious and persistent efforts can have a more significant impact. Although we face obstacles to conducting large trials, we can overcome them through larger, better organized, and more persistent efforts.

Whereas SCRQs focus on clinical outcomes, Significant Preclinical Research Questions (SPRQs) include targets of behavioral interventions corresponding to Stage 0-I research in the NIH Stage Model (Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014) and Phase I-II research in the NIH ORBIT Model (Czajkowski et al., 2015). SPRQs also include relationships between behavioral factors and medical illnesses and the biobehavioral mechanisms that underlie them. These sorts of questions rise to the level of an SPRQ if their complexity and implications call for large-scale, long-term efforts by multidisciplinary, multicenter research networks. They are the behavioral medicine equivalents of the Human Genome or Human Connectome projects – not because they will ever be as large or well-funded as those initiatives, but because they have the potential to resolve some of the most important and fundamental questions in our field.

Strong tests of SCRQ hypotheses depend on highly efficacious interventions for the behavioral factors in question. In many areas of behavioral medicine research, however, the best available interventions are moderately efficacious at best. SPRQ research can inform intervention development in ways that will make it possible to address SCRQs that are currently out of reach.

The answers to SCRQs depend not only clinical research, but on preclinical research as well. However, SCRQs call for different kinds of preclinical research than SPRQs. SCRQ research programs require preclinical studies that are specifically designed to meet the narrow objective of laying the groundwork for an anticipated Phase III trial. In contrast, SPRQ research programs have broader preclinical goals, such as addressing fundamental Stage 0-I translational questions about behavior change targets, mechanisms, or assays that could be relevant to many different health behaviors or behavioral risk factors for medical illnesses (Onken et al., 2014). The NIH Science of Behavior Change Program exemplifies this type of research. Similarly, preclinical research on biobehavioral mechanisms linking behavioral factors to medical outcomes can have broad implications for clinical research in behavioral medicine, as exemplified by the work of the NCI Network on Biobehavioral Pathways in Cancer (NBBPC).

The Composition, Purpose, and Functions of the BMRC

The constituent organizations will ask some their best and brightest senior scientists to serve on the Council. Individuals who are seasoned enough to see the big picture of behavioral medicine beyond their own research interests, and optimistic enough to imagine a future in which evidence-based behavioral medicine services are *de rigueur*, will be especially welcome. Most of them will have served on major committees or in leadership positions within their organization, and many will also be members or fellows of one or more of the other participating organizations. Consequently, the BMRC will comprise some of the most distinguished scientists in our field, representing some of our most respected scientific organizations.

The Council's identification and prioritization process for SCRQs will entail preliminary reviews of behavioral, psychosocial, and psychiatric risk factors for significant clinical outcomes and considering whether more effective interventions are needed for these targets. It will also take into account: 1) input from the constituent organizations; 2) current and anticipated research funding initiatives and priorities, including those of NIH, the VA, and large foundations; 3) trends in health care financing and potential opportunities for coverage of behavioral medicine services; 4) pleas from researchers who are eager to pursue particular SCRQs; 5) the agendas of major goal-setting entities such as the DHHS's *Healthy People 2020*; and 6) needs identified by health care service organizations, health care professionals, and patients through practice-based research. They will also aim for diversity in 1) behavioral, psychosocial, and psychiatric risk factors; 2) medical conditions; and 3) primary, secondary, and tertiary prevention strategies.

The Council's method for identifying SPRQs will differ from the SCRQ process because some of the considerations listed above will be irrelevant, and because emerging opportunities and trends in key areas of research may be more salient. The highest-priority SPRQs will be ones with the translational potential to facilitate research on multiple SCRQs

For each goal that it identifies as a high priority, the Council will commission a writing group composed of leading area experts to produce a scientific statement. Each writing group will be chaired by a member of BMRC, preferably one who is *not* an area expert, in order to keep the writing group on track and as objective as possible, and to give BMRC members some publication credit for their involvement on the Council. Each statement will conclude with the judgment of its authors as to whether or not the SCRQ or SPRQ in question warrants the long-term investment in scientific talent and funding that will be required to pursue it as a strategic research goal. The writers will be free to reach positive or negative conclusions, as they see fit.

Negative statements are unlikely to dispute the significance of the SCRQ or SPRQ, but they will cast doubt on the prospects for progress and ultimate success, thereby redirecting our collective attention to more promising strategic goals. Affirmative statements will end with clarion calls for the formation of research networks to embark on the long process of addressing the question. Each scientific statement will be will be authored by the members of its writing group "for the Behavioral Medicine Research Council." The statements will be vetted by the Council and then submitted for independent peer review and co-publication in leading behavioral medicine journals including *Health Psychology*, *Annals of Behavioral Medicine*, and *Psychosomatic Medicine*. Publication in high-impact medical journals may also be pursued in some cases.

Because of their distinguished provenance and the care with which they will be developed, these scientific statements will have gravitas. Affirmative statements will send a clear signal to researchers who have an interest in the strategic goal in question that the time has come to pursue it in an organized fashion. They will be cited in grant applications when research networks seek funding to pursue SCRQs or SPRQs. They will be cited by the authors of preliminary studies as evidence of the significance of their work, and they will carry weight with reviewers and editors.

Strategic Research Networks

Affirmative statements will be for naught unless well-organized, multicenter, multidisciplinary research networks that are committed to the long-term pursuit of specific SPRQs or SCRQs form in response to them. The Council will not depend on these networks to form spontaneously. Instead, they will employ several strategies to encourage their formation.[1]

First, the writing groups will comprise some of the leading experts in their own areas of research. Some of them are likely to want to form or join a research network to pursue the SPRQ or SCRQ that they've identified as deserving just such an effort, and they would be well positioned to assume leadership positions in these networks. Consequently, each writing group that produces an affirmative statement will be expected to hold a meeting or conference call as soon as its statement has been accepted for publication, to discuss the formation of a research network. Second, the statements themselves will urge other interested researchers to form or get involved in a network to pursue the SPRQ or SCRQ. Third, the constituent organizations will be asked to inform their members about opportunities to get involved in research networks, through their newsletters, SIGs, or other channels.

Finally, the Council will establish an online database, the Behavioral Medicine Research Network (BMRN) Registry. The registry will include both formative and functioning networks. The former will facilitate the development of new networks by giving interested researchers a point of contact, and the latter will help researchers find existing networks that they might want to join. The registry will also be an important resource for *Health Psychology* and other journals that will be eager to receive submissions from the research networks.

Senior and mid-career investigators will have to take the lead in organizing strategic research networks, but they won't necessarily be the ones to see the work all the way through Phase III and beyond. Early-career investigators and trainees will also have to be included in the networks, so that they can eventually pick up the baton from the senior investigators. The BMRN registry will enable research networks to document their efforts to engage new investigators and trainees.

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[1] There may be room in some cases for more than one network to form around a particular SPRQ or SCRQ. For example, there might be several different ways to intervene in the behavioral risk factor, or diverse populations or health care delivery settings may need different interventions. In some cases, existing research networks (e.g., ones that have been created by NIH, VA, foundation, or other funding mechanisms) might be well positioned to conduct SPRQ- or SCRQ-focused research. However, this would not necessarily preclude the formation of additional, field-initiated networks to address the same SPRQs or SCRQs.

For its part, *Health Psychology* will encourage trainees and early-career faculty to devote some of their time and talent to participation in strategic research networks. It can be difficult for early-career investigators to participate in team science projects that will be great for their careers in the long run but for which they may receive little credit in the short run. It can also be difficult for investigators who are not well connected or who work at academic outposts far from the leading centers of behavioral medicine research to gain entry into multicenter collaborations. *Health Psychology* will address these challenges as part of its educational mission.

The Need for a Behavioral Medicine Research Council

Most of us have spent our careers identifying and pursuing significant research questions of our own, without the help of a Behavioral Medicine Research Council. Why, then, do we need to form the BMRC? We need it to identify strategic research goals that are far too ambitious for any individual investigator, and even for any research group, lab, or center to tackle.

The organizations that will participate in the Council have devised their own ways to identify important research issues, so why do they need the BMRC? The Council offers these organizations several advantages. First, as a trusted and autonomous joint committee, the BMRC will make it possible to achieve an unprecedented degree of inter-organizational cooperation on the identification of strategic research goals. Second, the BMRC's goals, priorities, and statements will carry more weight than could those of any single organization, because they will have the implicit backing of *several* of the leading organizations in the field. Finally, the BMRC will have some unique ways to mobilize organized networks to achieve strategic research goals.

The Council will have complete autonomy to identify and prioritize strategic research goals without having to seek the approval of the constituent organizations. However, the organizations will have several ways to influence the Council and the research that it will inspire, including: 1) choosing members of their organization to serve on the Council, 2) advising the Council about strategic research goals and priorities, 3) nominating area experts to serve on writing groups, 4) encouraging members to form or join strategic research networks, and 5) helping to create environments for the networks that are conducive to productivity. The participating organizations will be free to establish their own internal processes for all of these activities.

Health Psychology and other behavioral medicine journals have gotten along just fine without a BMRC, so why do they need one? Claims of translational relevance and calls for further research are so common in our journals that they are almost a cliché. Valid though they may be, very few of them ever serve as launch pads for major, long-term, multicenter, multidisciplinary research initiatives. But that is exactly what the BMRC's scientific statements will be designed to do. They will also enable our journals to recognize the significance of the studies that will emerge from these initiatives, even the small, preliminary ones that are far upstream and many years in advance of anything resembling a Phase III multicenter trial.

In addition, the establishment of the Council will remove what might otherwise be a formidable barrier to the publication of joint scientific statements. Most of the journals in our field are owned by organizations that have pride in their own identities. Consequently, publication of joint scientific statements that are explicitly cosponsored or coauthored by other organizations could pose some difficulties for all concerned. Authorship of the scientific statements "…for the Behavioral Medicine Research Council" will eliminate this problem. The constituent organizations will receive due credit for their role in the Council, but it will be provided on the Council's website and in an acknowledgement in each scientific statement, rather than in the form of authorship or headline sponsorship of the statements.

Finally, there is a growing recognition, both nationally and internationally, of the tremendous potential of strategic preclinical and clinical research networks in many different areas of health care (e.g., Blum et al., 2013; Clancy, Margolis, & Miller, 2013). There is also a growing awareness that such networks should embark on their research only after a systematic review of the evidence regarding what is already known about the problem, and only if the review supports the network's strategic research goal (Chalmers & Nylenna, 2014). The establishment of the BMRC and the BMRN Registry, the publication of carefully crafted and vetted scientific statements, and the formation of strategically-focused research networks, will ensure that we are keeping pace with these important trends. More importantly, these developments will, in the long run, maximize the real-world impact of behavioral medicine research.

Approval and Start-up

Organizations: As of January 2017, the BMRC proposal has been enthusiastically and unanimously approved by the Academy of Behavioral Medicine Research (ABMR), the Society for Health Psychology (SfHP [Division 38 of the American Psychological Association]), the American Psychosomatic Society (APS), and the Society of Behavioral Medicine (SBM). It has also been endorsed by the NIH Science of Behavior Change Steering Committee. Once the Council has been established, other organizations might also be invited to participate.

Strategic research goals and priorities in behavioral medicine may differ across countries, because of differences in research funding mechanisms and opportunities, as well as differences in health care systems and health care financing. Thus, the involvement of international organizations such as the International Society of Behavioral Medicine (ISBM) might complicate the Council's decision-making process. On the other hand, international engagement would enrich the Council and expand its horizons. For this reason, the founders of the BMRC should consider inviting ISBM to participate in the Council.

The BMRC and the BMRN Registry will operate, at least initially, under the aegis of the Publications & Communications Council of the Society for Health Psychology, and will start on a shoestring budget. The Council will conduct most of its work via no-cost methods such as email, conference calls, or Skype, and in order to minimize travel expenses, it may hold meetings in conjunction with major conferences. When it is ready to estimate its budgetary requirements, the Council will request whatever support it needs from the constituent organizations.

If permission is received from NIH, an R13 grant application will be submitted to convene the founding members of the BMRC, leaders of the participating organizations, the editors of journals that will co-publish the Council's scientific statements, NIH program officers and other funding agency representatives, and key consultants (e.g., a representative from the U.S. Preventive Services Task Force). The primary aim will be to clarify the Council's mission, ground rules, procedures, and funding. Additional aims will include optimization of the Registry, formulation of strategies for organizing and funding behavioral medicine research networks, and development of plans for the long-term sustainability of the BMRC.

Projections and Implications

There are dozens of strategic research goals that the BMRC might consider, but each one that it decides to investigate will require time and effort. The size of the Council will depend on the number of constituent organizations and the number of representatives per organization; regardless, it will be a fairly small committee with limited resources. Thus, in any given year, the Council may only be able to identify and prioritize a handful of new strategic research goals; about three per year is probably reasonable expectation. At that rate, if the Council includes 8 members, and each member serves a 3-year term, each member would only have to take the lead on 1 or 2 SPRQs or SCRQs during his or her tenure.

When the Council announces new goal, it may take a few months to form the writing group. The writing group will have a completion deadline (e.g., nine months) for its statement. Assume that the BMRC announces its first set of three top-priority goals in January 2018, that all three writing groups are up and running by March 2018, and that all three scientific statements are ready for publication by March 2019. Also assume that everything goes just as well for the next four years, and that at least one responsive, viable, multidisciplinary, multicenter research network is in its infancy within 3 months of each statement's publication.

Given these assumptions, the first three research networks would be up and running by July 2019, although it may take them another year or longer to obtain their first dollar of funding to do any of the preliminary research that they deem necessary. By July 2023, at least 15 different research networks would be in pursuit of 15 different strategic research goals. Some of the oldest networks might be ready to propose or even to conduct a Phase III multicenter trial or some other major multicenter research project, but the newest ones would just be getting started.

The research networks will vary widely in size and composition, and whereas network-related research may dominate some individuals' careers, others of us may spend comparatively little of our time and effort on network-related activities. Because of these variables, it is hard to guess how much of our collective time, energy, and funding will be devoted to network-related research by 2022. For the sake of argument, let's say that it's somewhere in the vicinity of 25%. It could be higher, or it could be lower, but it will not be inconsequential. And it won't necessarily end with 15 strategic goals and 15 strategic networks; there could be more to come.

There is no guarantee that any of these events will come to pass. However, the organizational leaders who voted to approve this plan did so assuming that they *will* come to pass. They also considered whether such a remarkable upgrade of our collective ambitions and such a major transformation of our communal *modus operandi* are in our best interest as scientists and in the general public's interest as the ultimate beneficiaries of our research. They opted to try something bold, new, and ambitious instead of sticking with the familiar status quo.

Risk Assessment

What do we have to lose if this plan is implemented? Even if none of the large, multicenter trials or other blockbuster projects ever get funded, the networks will produce numerous studies and manuscripts in areas of research that have been identified by leading experts as high priorities. Thus, the risk is fairly low from that perspective, but some researchers may be concerned that NIH funding is a zero-sum game in which support for strategic research networks would make it harder for us to obtain grant support for our other research projects. However, several NIH program officers who have reviewed this proposal insist that NIH funding does not work like that. They believe that funding for productive behavioral medicine research networks will help rather than hurt our chances of securing funding for non-network behavioral medicine research.

Some organizational leaders initially expressed concerns that the BMRC might encroach on their organization's mission or plans. I've been involved in all of these organizations for many years, and I value their distinctive roles and their important contributions to behavioral medicine. To the best of my knowledge, however, none of them has ever occupied or even tried to occupy the BMRC's unique niche. Each organization that endorsed this proposal determined that its participation in the BMRC will bolster rather than detract from its own mission and vitality, and recognized that there will be a variety of ways for it to do so.

Some leaders also worried at first that involvement in the BMRC might somehow place their organization at a disadvantage relative to one or more of the other participating organizations. However, the BMRC's structure is explicitly designed to ensure that the participants are equal partners and that no single organization can dominate the council or control its priorities.

Organizational behavior specialists have found that *mutual trust* is what enables organizations and corporations to work together, and that when they do, they can achieve results that far exceed the sum of their parts (Lewis, 1999). There may not be a long history of effusive trust among behavioral medicine research organizations, but we do have an extensive history of interwoven memberships. Many of us have loyalties to several of these organizations and have no interest in seeing any of them diminished by any of the others. Besides, the participating organizations will not have to engage in extensive trust-building efforts with one another in order to participate in the BMRC because the essential arena for mutual trust will be within the BMRC itself. The Council's mandate will be for its members to work together to identify strategic research goals and priorities. If organizational loyalties play any role at all in their deliberations, they will be far outweighed by much more important considerations.

Productivity and Evaluation

We won't know for at least 5 or 10 years whether this plan will have the transformative impact it aims to achieve. In the interim, it should be evaluated in terms of how much progress is being made toward the achievement of strategic research goals. This might include such metrics as the number of scientific statements and network-based empirical reports that have been published, the number of grants that have been awarded for network-related studies, and the number of early career investigators and trainees who are actively participating in networks. Some of these indicators could be obtained from queries of the BMRN Registry, if it is designed to serve this purpose. In addition, the networks might be asked to produce periodic reports on their progress and estimates of how much closer they are to achieving their strategic goals.

Moving Forward

Thank you very much for reading about this strategic initiative to strengthen the future of behavioral medicine research. I would be happy to discuss it with you if you have any questions or concerns about the Behavioral Medicine Research Council, or any suggestions that might improve it. The motion that was approved by ABMR, SfHP, APS, and SBM is attached.

MOTION
To Endorse the Proposed Strategic Research Plan
And to
Participate in and Support the Behavioral Medicine Research Council

(Organization) hereby endorses this plan for strategic behavioral medicine research and agrees to participate in and to support the Behavioral Medicine Research Council.

Mission: The Behavioral Medicine Research Council (BMRC) will be a joint committee of some of the leading scientific organizations in behavioral medicine. Its mission will be to identify and prioritize strategic research goals in behavioral medicine and to foster the development of organized, multidisciplinary, multicenter research networks to pursue these goals.

Membership: The voting members of the BMRC will be eminent senior scientists who are members, fellows, or leaders of the constituent organizations, who are chosen by the executive leadership or council of their organization, and who agree to serve. There will be two positions on the Council for each participating organization. The Council will elect a Chair once a year from among its current membership

Advisors: The Council may seek advice as it sees fit from experts on subjects that are germane to its mission. To avoid any appearance of conflicts of interest, the Editors of the journals that publish the BMRC's scientific statements will not serve as voting members of the Council. They will serve instead on an ancillary, non-voting, editorial advisory board. Key personnel from NIH and other research funding sources will also be asked to serve in an advisory capacity.

Duration of Service: Ordinarily, each member will serve a three-year term on the Council. However, in order to establish staggered terms, one of the initial appointees from each organization will only serve for two years. Members may serve a second term if reappointed.

Strategic Research Goals: For the purposes of the BMRC, a *strategic research goal* is defined as an important scientific question that will require an organized, long-term, multidisciplinary, multicenter effort to address. The Council will identify both preclinical and clinical research priorities. Preclinical goals will be referred to as Significant Preclinical Research Questions (SPRQs), and clinical goals will be called Significant Clinical Research Questions (SCRQs). SPRQs will focus on phenomena with major NIH Stage 0-I translational implications for behavioral medicine research. Some SCRQs will pertain to the prevention of chronic medical conditions in at-risk populations, and others will concern the improvement of medical outcomes in patients with pre-existing conditions. All SCRQs will focus on potentially modifiable behavioral, psychosocial, or psychiatric risk or protective factors for these medical outcomes.

The Council's Tasks:

1. The Council will announce at least three new strategic research goals per year.
2. The Council will commission a multidisciplinary writing group for each new strategic research goal. They will invite leading experts on the topic of interest to participate. Each writing group will include approximately 5 to 7 authors and will be chaired by a member of the BMRC, preferably one who is not actively or prominently involved in research on the topic of interest, in order to keep the writing group on schedule and to promote greater objectivity. Each writing group will produce a single SPRQ or SCRQ statement, with a nine-month completion deadline and a one-year publication goal.
3. If a writing group produces an affirmative statement, it will be expected to hold a meeting or conference call as soon as the statement is accepted for publication, to discuss the formation of a research network to address the strategic goal. It will also use other methods to encourage networks to form.
4. The Council will vet the writing groups' scientific statements. The authors will submit approved statements to participating behavioral medicine journals for peer review. In addition, the editorial advisory board will explore potential opportunities for statements or executive summaries to be published in high-impact general medical journals, leading medical specialty journals, or other appropriate outlets.
5. The Council will maintain an online Behavioral Medicine Research Network (BMRN) Registry to identify the networks that are working toward strategic research goals and to collect essential data on their composition, structure, and activities.
6. The Council will operate in a transparent manner and communicate on a regular basis with the participating organizations about its activities, seek their input on research goals, and ask them to nominate area experts to serve on writing groups.

Founding Conference: If a conference grant can be obtained, a founding conference will be held to convene the initial members of the BMRC, leaders of the constituent organizations, NIH program officers, and consultants with relevant expertise. The primary aim will be to clarify the Council's mission, ground rules, procedures, governance, and means of support. Secondary aims will include optimization of the BMRN Registry, formulation of strategies for organizing and funding strategically-focused behavioral medicine research networks, and development of a long-term sustainability plan for the BMRC. The Council may submit conference grant applications in future years to support subsequent meetings.

Funding: The Council will do whatever it can to minimize its expenses. However, it will probably need some funding to develop and maintain its website and the BMRN Registry, and possibly for other functions as well. The Council will submit an initial joint budget request to the constituent organizations as soon it is able to estimate its expenses, and annual budgets thereafter. Each organization will be expected to cover its share of the budget.

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