NATIONAL BIODEFENSE SCIENCE BOARD

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PUBLIC MEETING

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WEDNESDAY,
SEPTEMBER 22, 2010

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The meeting convened at 9:00 a.m. at the Doubletree Bethesda Hotel, 8120 Wisconsin Avenue, Bethesda, Maryland, Dr. Patricia Quinlisk, Chair, and Dr. John Grabenstein, Acting Chair, presiding. Leigh Sawyer, DVM, MPH, CAPT USPHS, Designated Federal Official.

NBSB VOTING MEMBERS PRESENT:

JOHN D. GRABENSTEIN, Acting Chair, R.Ph., Ph.D
PATRICIA QUINLISK, Chair, MD, MPH
ROBERTA CARLIN, MS, JD
ALBERT J. DI RIENZO
KENNETH L. DRETCHEN, Ph.D
JAMES J. JAMES, MD, Dr.PH, MHA
JOHN S. PARKER, MD
ERIC A. ROSE, MD

NBSB EX OFFICIO MEMBERS PRESENT:

HUGH AUCHINCLOSS, MD, Principal Deputy Director, National Institute of Allergy and Infectious Diseases, Office of the Assistant Secretary for, Preparedness and Response (designated by Carol Linden)

DIANE BERRY, Ph.D, Chief Scientist Director, Threat Characterization and Countermeasures Office of Health Affairs, U.S. Department of Homeland Security

SHAWN L. FULTZ, MD, Senior Medical Advisor, U.S. Department of Veterans Affairs (designated by Victoria J. Davey)

BRUCE GELLIN*, MD, MPH, Director, National Vaccine Program Office, Office of Public Health and Science, U.S. Department of Health and Human Services

PETER JUTRO, Ph.D, Deputy Director, National Homeland Security Research Center, U.S. Environmental Protection Agency

REAR ADMIRAL ALI S. KHAN, MD, MPH, Director, Office of Public Health Preparedness and Response, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

ANNE KINSINGER*, Associate Director, Biology, U.S. Geological Survey, U.S. Department of the Interior, (designated by Deanna Archuleta)

GEORGE W. KORCH*, JR., Ph.D, Senior Science Advisor, Office of the Principal Deputy, U.S. Department of Health and Human Services

RANDALL L. LEVINGS, D.V.M., Scientific Advisor, National Center for Animal Health, U.S. Department of Agriculture

PATRICIA A. MILLIGAN, R.Ph, CHP, Senior Advisor for Emergency Preparedness, U.S. Nuclear Regulatory Commission

JOHN P. SKVORAK, DVM, Ph.D, Colonel, U.S. Army Commander of the U.S. Army Medical Research Institute of Infectious Diseases, U.S. Department of Defense

*Present via telephone

DISASTER MENTAL HEALTH SUBCOMMITTEE MEMBERS PRESENT:

BETTY PFEFFERBAUM, MD, JD, Chair
ELIZABETH BOYD, Ph.D
LISA M. BROWN, Ph.D
STEVAN E. HOBFOLL, MA, Ph.D
GERARD A. JACOBS, Ph.D
RUSSELL THOMAS JONES, Ph.D
DAVID SCHONFELD, MD, FAAP

DISASTER MENTAL HEALTH SUBCOMMITTEE EX OFFICIO MEMBERS PRESENT:

DANIEL DODGEN, Ph.D, Executive Director

INGRID HOPE, RN, MSN, Acting Chief, Occupational Health and Wellness Branch, Division of Workforce Health Protection and Operational Medicine, Office of Health Affairs (designated by Diane Berry)

RACHEL E. KAUL, LCSW, CTS, Senior Public Health Analyst, Office of the Assistant Secretary for Preparedness and Response (designated by Carol Linden, Ph.D.)

CAPT. DORI REISSMAN, MD, MPH, U.S. Public Health Service, Interim Clinical and Medical Science Director, World Trade Center Responder Health Program, Office of the Director, National Institute of Occupational Safety and Health, National Institutes of Health designated by Dr. Daniel Sosin)

MARC SHEPANEK, Ph.D, Lead, Aerospace Medicine
Deputy Chief, Medicine of Extreme Environments
Office of the Chief Health and Medical Officer

NBSB STAFF PRESENT:

LEIGH SAWYER, D.V.M., M.P.H., CAPT, U.S.P.H.S., Executive Director

LT. BROOK STONE, MFS, Executive Secretariat, DMH Subcommittee

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

(9:04 a.m.)

CAPT. SAWYER: Good morning. I would like to welcome the NBSB voting members, ex officios, and their designees, members of the Disaster Mental Health Subcommittee, and members of the public who are in attendance as well as those participating by phone.

This is the National Biodefense Science Board public meeting. I am Leigh Sawyer, the executive director of the National Biodefense Science Board. I also serve as the designated official for this federal advisory committee.

The purpose of the meeting today is to discuss and consider recommendations from the NBSB's Disaster Mental Health Subcommittee and from the NBSB's Future of the NBSB Working Group.

I'd like to make a couple of quick announcements before proceeding with the roll call. First, I would like to welcome two new members to the Board. Dr. Ali Khan, who is

present here in the room with us today, is the director of the Office of Public Health, Preparedness and Response, and he will represent CDC.

Dr. Dan Sosin who was previously in this position will remain as his alternate. and thank you for coming, Ali.

We also have joining us today by teleconference Anne Kinsinger who is the associate director for biology of the US Geological Survey at the Department of Interior, and she will serve as Deanna Archuleta's alternative. She is replacing Sue Haseltine who has retired.

Second, I want to inform the Board that Ruth Berkelman has requested a leave of absence from the Board for an indefinite period of time. It is expected that she will be not available to work on the Board from six months to about a year, so I'd like people to be aware of that.

Lastly, many of you have received a copy of the Disaster Mental Health report via

the NBSB email. Some of the language in the report is missing from that version, and there is a correct version that can be found on the NBSB website.

At this time, I would like to take roll of the NBSB. First, I call the names of the NBSB voting members, and when I call your name, please respond here.

Actually, I'm opening this meeting. The first person I'm going to call is Patty Quinlisk. She is on her way. She's been delayed by air traffic, and so we have today serving as the co-chair John Grabenstein.

So, Patty is not present at this time. Ruth Berkelman I mentioned is not in attendance. She's on leave of absence. Steve Cantrill, Roberta Carlin. Roberta may join us later.

Al Di Rienzo?

MR. DI RIENZO: Present.

CAPT. SAWYER: Ken Dretchen?

DR. DRETCHEN: Present.

CAPT. SAWYER: John Grabenstein?

DR. GRABENSTEIN: Present.

CAPT. SAWYER: Jim James?

DR. JAMES: Present.

CAPT. SAWYER: Tom MacVittie? John Parker?

DR. PARKER: Present.

CAPT. SAWYER: Andy Pavia? Eric Rose?

DR. ROSE: Present.

CAPT. SAWYER: Pat Scannon? I'd like to now call the names of ex officios. When I call your name, please respond, and if you are a designated alternate, please provide your name.

Peter Emanuel? Larry Kerr? Richard Williams? Frank Scioli? Randall Levings?

DR. LEVINGS: Here.

CAPT. SAWYER: Michael Amos? John Skvorak?

COL. SKVORAK: Here.

CAPT. SAWYER: Patricia Worthington? Ali Khan?

DR. KHAN: Present.

CAPT. SAWYER: Hugh Auchincloss?

DR. AUCHINCLOSS: Present.

CAPT. SAWYER: George Korch? Carol Linden? Boris Lushniak? Diane Berry? Deanna Archuleta? Anne, I know you're on the phone. Are -- Anne Kinsinger, are you on the phone?

(No response.)

She may -- is she on the speaker line? Okay. Anne, can you say you're present? She may not be available right now. Rosemary Hart? Kerri-Ann Jones? Vicki Davey?

DR. FULTZ: Shawn Fultz here for Vicki Davey.

CAPT. SAWYER: Oh, thank you, Shawn. Peter Jutro?

DR. JUTRO: Present.

CAPT. SAWYER: Patricia Milligan? Is there anyone's name I did not call? Okay.

DR. SHEPANEK: Marc Shepanek for Rich Williams.

CAPT. SAWYER: Oh, thank you, Marc.

Okay. The NBSB is an advisory board that is governed by the Federal Advisory Committee Act. The FACA is a statute that controls the circumstances by which the agencies or officers of the federal government can establish or control committees or groups to obtain advice or recommendations where one or more members of the group are not federal employees.

The majority of the work at the NBSB including information gathering, drafting of reports, and the development of recommendations is being performed not only by the full Board but -- are those on the phone able to hear us?

We'll wait just a minute.

DR. DODGEN: Leigh, might it be worth if -- this is Dan. Might it be worth if someone on your team maybe just sent a quick email to Bruce or to somebody that we know is monitoring saying we can hear you and we're working on it?

CAPT. SAWYER: MacKenzie's working

on that.

MR. CAVAROCCHI: Okay.

CAPT. SAWYER: Yes, we hope that they will have good manners. So, is this something that can be fixed or will they -- okay. Great. From what I understand, it's primarily the ex officios that are calling in, so I'm going to continue with what I need to say here.

So, let's go. The FACA is a statute that controls the circumstances by which agencies or officers of the federal government can establish or control committees or groups to obtain advice or recommendations where one or more members of the group are not federal employees.

The majority of the NBSB including information gathering, drafting of reports, and development of recommendations is being performed not only by the full Board, but by the working groups or the subcommittee who in turn report directly to the Board.

With regard to conflict of interest

rules, note the standards of ethical conduct for employees of the executive branch document has been reviewed by all Board members who as special government employees are subject to conflict of interest laws and regulations therein.

Board members provide information about their personal, professional, and financial interests. The information is used to assess real potential or apparent conflicts of interest that would compromise members' ability to be objective in giving advice during Board meetings.

Board members must be attentive during the meetings to the possibility that an issue may arise that could affect or appear to affect their interest in a specific way. Should this happen, it will be asked that the affected members recuse himself or herself from the discussion by refraining from making comments and leaving the meeting.

So, the next comment has to do with public comments, and so I may need to repeat

this when we have access to those people who are joining us by phone.

There will be two opportunities for the public to provide comments today. First, between 10:50 and 11:45. We ask that your comments be specific to the DMH report.

The second opportunity is between 2:30 and 2:50, and at this time, your comments should be specific to issues regarding the future of the NBSB. The second part of my comments have to do with those joining by phone.

Let's see how we're doing here. Are they on? Oh. I apologize for this, but it's actually good that we have people joining us by phone, so I'd like to wait just a minute.

Dan, in a few minutes we're going to ask you to introduce the DMH subcommittee members.

If it's all right with everyone here, I'm going to go ahead and proceed, and we hope that we will be joined by those on the

teleconference. First, I'd like to introduce John Grabenstein who --

All right, so we are going to proceed for all of those who made it to this building. Thank you for attending. Again, I'd like to introduce John Grabenstein, who was asked by Patty Quinlisk to chair the meeting today until her arrival.

Oh, okay. Let me start with Bruce Gellin. Are you on the line?

DR. GELLIN: Yes, ma'am.

CAPT. SAWYER: Great. I'm going to finish the roll call then. I'm going to name those that I heard talking on the phone. I believe I heard George Korch.

DR. KORCH: Right.

CAPT. SAWYER: Carol Linden? Bruce Gellin?

DR. LINDEN: Yes.

DR. GELLIN: Still here.

CAPT. SAWYER: Boris Lushniak? Okay. Did I miss anyone on the phone who is a member of the Board? Thank you for joining

us. Anne Kinsinger, you must be on as well?

MS. KINSINGER: I am on the line, correct.

CAPT. SAWYER: Great. Thank you for joining. I apologize for the problems this morning. I appreciate your holding on and working with us to get you on the phone.

What I've done is opened the meeting. I read through the FACA rules and the ethics concern. I want to then go back to our public comment period. There will be two opportunities for the public to provide comments today; first between 10:30 and 11:45 and then again between 2:30 and 2:50.

I'd like to remind you that everyone -- to everyone at this meeting that the meeting's being transcribed, so please when you speak, provide your name. Three mics can be on at one time. You have to use your mic for the public to hear us or the people on the phone.

The meeting transcript summary and any public comments will be made available on

our website. Now, I would like to turn it over to our acting chair, John Grabenstein, who is sitting in for Patty Quinlisk until she arrives today.

DR. GRABENSTEIN: Thanks very much. Good morning, everybody. Patty regrets being held up by the airlines, but she'll be here as soon as she can.

Today's session will be divided into two major parts. For the first half of the day, we're going to be discussing the Disaster Mental Health Subcommittee's report entitled Integrating Behavioral Health in Federal Disaster Preparedness, Response, and Recovery: Assessment and Recommendations.

We're delighted to have the members of that subcommittee with us today and ask Don to introduce them -- Dan to introduce them in a moment.

The second half of the day will be spent presenting the findings of the future of the NBSB working group. In other words, the working group on the future of the NBSB. Both

of those presentations will have portions for public comment so that we can incorporate the views of the people.

So, we have been very fortunate over the last few years to have the benefit of a really distinguished panel of people in our Disaster Mental Health Subcommittee.

Most recently, on September 22 last year, Dr. Lurie, the Assistant Secretary for Preparedness and Response asked the NBSB to convene the subcommittee to assess the department's progress in its efforts to better integrate behavioral health into emergency preparedness and response activities.

So, we're going to hear the results of that work effort today. Dr. Dodgen, would you please introduce to the room the members of the subcommittee?

DR. DODGEN: Thank you. This is Dan Dodgen, and I'm the executive director of the subcommittee. I'm going to just introduce all the folks here. I think many of you know everybody, but in case you don't, beginning to

my far right is Rachel Kaul who represents the Office of the Assistant Secretary for Preparedness and Response.

I believe that's Dr. Stevan Hobfoll, member of the subcommittee; Dr. Gerry Jacobs, member; Dr. Lisa Brown; Dr. Betty Pfefferbaum, who is also our chair and you'll be hearing a lot more from her in a minute; Brook Stone, who is known to all of you and who's our executive secretariat; Dr. David Schonfeld; Dr. Russell Jones; Captain Dori Reissman, who is the representative for Centers for Disease Control and Prevention; and who's hiding behind -- oh, Marc Shepanek, thank you, representing NASA; Dr. Beth Boyd; Ingrid Hope is our representative from the Department of Homeland Security; and I'll introduce Peter again, although he's already been introduced, who has represented his agency sort of on both groups.

So, we're very happy that everyone was able to be here. Am I turning it over to Betty now or back to you?

DR. GRABENSTEIN: Back to me to introduce Betty. So, on the fortunate scale, we were especially fortunate to have Dr. Pfefferbaum in the leadership role with this subcommittee.

She is a general and child psychiatrist, professor and chair of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center.

She's the director of the Terrorism and Disaster Center of the National Child Traumatic Stress Network. Dr. Pfefferbaum has been working in disaster and terrorism mental health since the 1995 bombing in Oklahoma City when she served on the board of the Oklahoma Department of Mental Health and Substance Abuse Services.

She has been them and continues assisting in planning and organizing disaster mental health services in communities. So, Dr. Pfefferbaum, if you'd like take the way and lead us through your report, we'd be very

grateful.

DR. PFEFFERBAUM: Thank you. Can you hear me? Good. I was going to begin today with a brief summary of the work of the Disaster Mental Health Subcommittee, which was appointed in June of 2008 to report on the mental health consequences of disasters and how to protect, preserve, and restore individual and community mental health in the wake of catastrophic events.

In November 2008, we submitted our first report, which included an extensive background review and recommendations in -- a set of eight recommendations.

In November of 2009, we submitted a report on actions to consider in preventing and mitigating adverse behavioral health outcomes during the H1N1 crisis.

Today, we're discussing our third report, which is on the integration of disaster, mental, and behavioral health into disaster preparedness response and recovery activities. Our report includes both a

description of our assessment and a set of recommendations.

I refer back to the initial report, which included eight recommendations. As I indicated, this report actually constitutes the critical background of the scientific literature that we refer to in this current integration report.

I've identified the eight recommendations on this slide very briefly, but you have the full text of the recommendations in the handouts that were distributed this morning.

As already mentioned, the ASPR asked us in September of 2009 to assess the Department's progress in its efforts to better integrate mental and behavioral health into disaster and emergency preparedness and response activities.

We conducted the assessment by holding teleconferences with representatives of the federal partners who were -- who participated on the subcommittee. Those

individuals or those offices included the office of the ASPR, the EPA, NASA, the CDC, the Department of Homeland Security, the VA, the Department of Defense, NIH, and SAMHSA.

Basically, we asked our federal partners to accumulate data using any methodology that they chose to address basically three questions. First, we wanted them to identify gaps within their agencies that should be addressed to achieve integration, to identify strategies to address those gaps, and to provide us with a time line for initiating and completing the process.

We also ask them to identify changes in interactions with other federal agencies that might improve their progress toward integration, and then we ask them to identify impediments for enhancing integration and potential strategies or suggestions for reducing those barriers.

We were not asked to address integration at the level of the states or local communities, but we thought that was

critical in understanding the situation at the federal level because, of course, much of the disaster preparedness responses and recovery activities occur at the state and local level.

So, we asked representatives from the multi-state disaster behavioral health consortium to meet with us, again through teleconference, to present their concerns and their report on the status of integration at the state level.

We asked them also a set of three questions, first to identify some best practice examples of successful integration and challenges and barriers that are encountered at their level.

We asked them to describe linkages between federal and state agencies and activities that support integration in challenges and barriers. Finally, we asked them to identify federal activities that could be initiated or adjusted to improve integration at the state and local level.

To place our work in context, I'd

like to link it to the National Health Security Strategy and FEMA's draft National Disaster Recovery framework, both of which have language related to community and individual resilience and both of which mention throughout mental and behavioral health.

Specifically, the National Health Security Strategy has identified two goals; the first to build community resilience and the second to strengthen and sustain health and emergency response systems.

We believe that accomplishing these goals will require systematic and sustained integration of mental and behavioral health issues throughout the disaster and emergency preparedness, response, and recovery process.

The overall results of our study indicated that while integration is occurring in the federal government, which has made some progress toward this goal, far more needs to be done.

We found that the most pressing and

significant problem that hinders integration is the lack of appropriate policy at the highest federal level and that compounding that problem is a lack of any clear statement as to where the authority to devise, formulate, and implement such a policy should reside.

We believe that attention to integration is necessary because mental health has not been addressed systematically or consistently. Integrated and sustained efforts have suffered when individuals and organizational structures have changed, and where it exists, integration has not been comprehensive or universally effective.

We note that without integration, efforts may be duplicated and they may even be contradictory. One concern is that lessons learned from one disaster may not be preserved for use in other disasters, and in the field without integration, responders have to search for and devise their own appropriate responses independently.

We think responders are not aware of the resources that are available or the resources that are effective and we think that training needs to occur to inform the responders in how to use the resources in their work.

The focus of our analysis was on two key issues; first, policy, and second, the organizational and structural elements needed to transform policy into effective action.

We recognize that success will require meaningful metrics and accountability so that the policy achieves its desired goal.

I'm going to now focus on our findings in several areas; first, communication because we believe that disseminating information, directives, and other messages is among the most important work in a disaster.

We're concerned that when mental and behavioral health response is fragmented, the messages to the public may be inconsistent and they may result in not only confusion, but

also non-compliance.

So, we recommend, emphasize that responders need to deliver consistent messages, and we recognize that this will require the integration of behavioral health issues in education and training for responders.

We had considerable concern in the area of research, particularly noting that preparedness, response, and recovery will require a much stronger evidence base than currently exist.

We are particularly concerned that program evaluation studies need to examine the effectiveness of existing crisis counseling programs.

We concluded that no single agency in the federal government can adequately address the research agenda in this area. We believe that one important place to begin might be to hold a forum to encourage the development, shared ownership, and coordination of the research agenda.

We were concerned that the federal role in disaster mental health has not been well clarified, which we think is essential. We point to one example, which is glaring, particularly for those of us who have worked at the level of the states and local communities, and that is that there is no stated policy on the federal government's role with respect to the most significant long-term mental health consequences, as well as the immediate consequences.

So, as an example, we're concerned that there has been no stated official role for the federal government in addressing things like diagnosable psychiatric disorders, PTSD, or clinical depression.

We believe that there should be a process to publicly debate the federal government's role to reach a consensus so that stakeholders both within and outside the government will not perceive the operational practices as arbitrary.

We were particularly interested and

impressed with the report of the status of integration at the level of the states and local communities. We learned that conditions for applying for federal money for disaster mental health efforts is now so complex and onerous that in some incidents, the states have decided not even to apply for funding. We think that is an unintended outcome.

We learned that from the state's perspective, federal departments and agencies are not well-coordinated or consistent and that there is no single point of contact within the federal government for the state agencies.

The perspective of the representatives of the states consortium was that the federal departments and agencies do not have a clear understanding of state and local capabilities in disaster mental health.

Now let me turn to that second set of findings that we assessed and that was the issue of organizational and structural integration. I'll preface that by indicating

what we think integration means and what it doesn't mean.

Integration in our mind does not equal consolidation, so it doesn't mean that disaster mental health activities should be consolidated into any single agency or department to the extent that attention to these issues is minimized in other departments or agencies or marginalized throughout the system.

It doesn't mean that existing effective programs specifically dedicated to disaster mental and behavioral health should be eliminated.

In contrast, we think it does mean that many different programs should contribute their valuable and sometimes unique expertise and services but that they should act as part of a coherent, organized structure with clear lines of responsibility, accountability, and communication.

One of the areas of concern that we focused on in our analysis was the issue of

resources. We believe that integration requires comprehensive and easily adaptable resources that are ready and waiting for use by both responders and the general public to be called on when needed.

We were particularly concerned about the issue of subject matter expertise and asked two questions; one, where in the federal structure does responsibility and authority rest to access specific subject matter expertise, and how is that expertise catalogued, maintained, and utilized?

We were able to identify through the assessment a number of examples of exemplary collaboration among federal agencies and departments. So, for example, we learned that the collaboration between ASPR and SAMHSA in response to the Haiti earthquake provided mental and behavioral health work force protection services to HHS responders.

They embedded mental health professionals in the NDMS teams and they included a mental health officer on the

Incident Response Coordination Team. We were concerned, however, that individual examples of exemplary collaboration would not result in a sustainable integration which we think requires a clear mandate and formal authority to undertake collaboration as well as funding for collaborative efforts.

We also report findings with respect to training. We were pleased that while there's a growing number of training activities related to disaster mental health, there is no locus of responsibility that identifies, for example, appropriate content, audiences, inventories of existing materials and resources, educational activities, or quality assurance.

We also believe that to improve response, research on the effectiveness of certain training models will be essential; for example, train the trainer models and just in time training.

Again, we were impressed with the response of our partners at the level of the

states. We learned that with respect to organization and structure that beginning in 2002, SAMHSA funded grants to 35 states to develop their own state level disaster mental health plans.

Unfortunately, funding to sustain those efforts has not been available. We learned that all states now have a state coordinator for disaster mental health, but again, in many instances, funding is lacking to create and sustain the staff and infrastructure necessary for activities at the level of the state.

Another interesting finding is that the federal government tends to treat mental health as part of public health while in many states the two are administrated separately.

From the perspective of the states, personnel in positions of authority at various levels from the state level, local level, and, for example, tribal entities, are not typically part of the larger comprehensive effort to integrate mental health, and they

have only limited power to initiate activities in their own particular sphere.

We concluded that the level of funding for preparedness, response, and recovery resources that flows to the states in the area of mental health is indefensibly small.

We are impressed that disaster, mental, and behavioral health elements are now being integrated into planning activities and documents in a number of areas, but we believe that putting these into action will require the development of a mental health concept of operations, a CONOPS, and we're pleased with the progress of Dan's office with respect to moving that recommendation forward.

We believe that creating, and I underscore implementing, a CONOPS would be an indication of successful integration.

The champions for disaster mental health at the federal level are relatively few but we're impressed with what we've seen. For example, in the recent Gulf oil spill

response, we watched on television ourselves the participation and the emphasis on mental health issues that was relayed by senior officials in the government.

We think, however, that implementing an integration policy will require more leadership at the top, and it will also require policy-based directions and expectations, clear lines of authority and accountability, and the personnel and resources established that currently do not exist.

I can stop if there are comments, or I can move to our recommendations and conclusions.

DR. GRABENSTEIN: Comments from anybody in the room? John? John Parker.

DR. PARKER: John Parker. Betty, that's pretty comprehensive. I just have a few questions that were running around in my head, and as you did the whole thing, as you looked at all three studies, and especially this last study, did you find that any

particular organization actually characterized mental health as an emergency?

DR. PFEFFERBAUM: As an emergency issue or as an emergency response?

DR. PARKER: As an emergency, like bleeding or trauma.

DR. PFEFFERBAUM: Oh. I think most of us in mental health would say that bleeding and trauma comes first, and we certainly recognize that. We recognize that the role of mental health in the immediate aftermath of a disaster is more supportive and should focus on implementing support services that facilitate the response for medical or safety and that our role might be in helping identify and triaging individuals whose emotional or behavioral response is severe or counter-productive.

DR. PARKER: Well, I didn't mean to characterize in a priority thing, but in a general way, my experience over a lot of years with different disasters. Mental health has not been on the minds of the providers at the

moment in time, and as you talk about your report, I consistently get a message that you want -- you say integration.

You're talking about integrating it into a disaster plan, but I would ask you a question and say do you think that the medical community at large, when the doctors and nurses and the teams hit the ground, have they integrated mental health into their concept and initiative as they go into a disaster?

DR. PFEFFERBAUM: Let me respond to that and then David Schonfeld wants to make a comment. One of our field's current emphasis is on training for first responders and medical personnel, as well as other support personnel in what we call psychological first aid, which allows those responders to conduct their services with sensitivity to emotional and behavioral health issues.

So, in that regard, if we can provide for and develop an infrastructure that supports that kind of training, we think that it will come naturally to those people who are

first responders. David?

DR. SCHONFELD: I just want to say that in my role, I was -- I joined the task force on terrorism for the American Academy of Pediatrics when it was formed after the events of September 11 and have noted -- and now I'm part of the Disaster Preparedness Advisory Council for the Academy, as well, and so I appreciate your question.

I have noted, at least within the pediatric field, marked movement towards appreciating the importance of including mental health considerations from very early on in the response.

It is part of the preparedness planning and the response efforts, I think, in our field to a growing degree. But, that is against the context and the backdrop and the history that it has not been included in that way and that many people are not yet trained and that often the mental health is considered during the recovery phase and it is not part of the preparedness and it is not part of the

response initially and that is one of the key reasons for integration.

So, even in the H1N1 response to the pandemic, the NBSB was -- I think showed a leadership role in requesting information about how to incorporate the mental health needs into the response, but that did occur many months after the pandemic had started and, I would comment, years after a lot of funding was already spent on planning efforts when I think that should have been part of the preparedness planning.

So, I think that's a very important point that you need to change the culture, and part of what we are suggesting is that that culture also needs to change within the federal government, as well.

So, there's a consistent message that behavioral and mental health is an integral part of preparedness and planning and response efforts, not solely in recovery.

DR. PFEFFERBAUM: I think Dori Reissman from the CDC, who's one of our ex

officio members, has a comment.

CAPT. REISSMAN: Yes, good morning. I just wanted to also take a chance to reframe a little bit of what you said because there's a bit of a divide when we say mental and behavioral health. Mental health tends to be thought of in terms of the diseases that people get diagnosed with rather than psychological perspectives and rather than behavioral actions.

Those of us -- some of us on this committee who think about all these things in terms of behavior and psychology more than disorder. So, when you think of it that way and you think about do people think about that as an emergency? Yes, because if people have a pill in hand for, let's say, anthrax response but they don't take it, their behavior prevents their safety.

So, we really think about things, about how people are taking the actions they need to take, whether they're adherent with the directives that we provide, whether they

evacuate when we say they should evacuate, and whether they can really follow the kinds of directives that we're expecting when we make our grand plans on a national scale.

DR. GRABENSTEIN: Dr. Hobfoll, did you want to add on something?

DR. HOBFOLL: Yes. I want to follow up with Dr. Reissman. She said -- I want to speak to the issue of what we mean or what I mean, I can't speak for the committee, by federal leadership on this and how it actually works in practice.

NIH and NIMH in particular a couple decades ago moved to a biological model which they press more and more of mental illness. That means biological and molecular.

That, in turn, means that the research dollars followed that line. That, in turn, has led to the almost disintegration of community psychiatry and community psychology, social psychology, social psychiatry, because there are no dollars there for research to develop these.

So, what happens is when a disaster strikes, you have no knowledge about how people react to trauma on a social level and how poverty, disability, resilience might act. All you have is how on the molecular and biological level experts might give pills to respond.

So, this is actually a problem in large part created by the federal government's policy within research that then has a 20-30 year history completely changing the fields involved.

Today, for example, even following September 11, not only are there no RFAs, there's nearly -- we have some of the only research on the immediate and then chronic, long-term effects of terrorism and war on people.

Not a priority. Not of interest. No dollars. So, the government shapes the field in these ways to create a situation in which you have good pills for improvement in the treatment of depression, schizophrenia,

etc., but a complete absence of kind of anything else.

DR. GRABENSTEIN: Thank you. Dr. Jacobs and we'll maybe come back to you then, Dr. Pfefferbaum.

DR. JACOBS: Two points that I would like to make. One is that the mental and behavioral health issues enable the providers of care for the bleeding and trauma to continue doing the work effectively.

The second is that it also assists the public response. I bring up the example of Japan where they began their national development of a disaster mental health and psychological first aid model following the Aum Shinrikyo sarin gas attacks in which they have found that the response of the public overwhelmed the local medical resources so that the people with genuine needs were unable to receive care.

That is when they understood that they needed to start addressing these issues in a central way and basically enhance the

ability of the medical responders to do their jobs.

DR. GRABENSTEIN: Thanks. John, any follow-up? John Parker?

DR. PARKER: I thank you all for your comments and it makes me feel like you've covered the subject fairly well, and you know where the gaps are for sure, and I'm sure your recommendations speak to that.

But, all of you and all of us who focus in any particular disaster, and especially the things that Dori was talking about, the behavioral compliance issues during a disaster to information -- I don't want to give a speech here, but we're up against a credibility wall in our country right now where the first thing people do is question everything.

I don't know where the American public is today about where they put their credible -- where do they put their credibility, who is their spokesman or where do they have to hear the message from to

anchor that credibility piece that's so important.

DR. GRABENSTEIN: Good. Thank you. Let me pause and do an administrative -- or take an administrative pause here. We're going to check to see -- make sure we've got good audio on the telephone and see what other ex officios or members may have joined us.

CAPT. SAWYER: I'd like to welcome Patricia Milligan. I see she's joined us today, and I understand that, Diane Berry, you are on the line from the Department of Homeland Security.

DR. BERRY: Yes, I am.

CAPT. SAWYER: Okay, and do we have a state department representative?

MS. HEINTZELMAN: Hi, yes. I'm from State, Leila Heintzelman.

CAPT. SAWYER: Thank you for joining us. Did anyone else join the line that I didn't mention that's a member of the Board? Okay.

DR. GRABENSTEIN: Great. Thanks

very much. Dr. Pfefferbaum, would you like to resume?

DR. PFEFFERBAUM: Yes. We have made a set of four recommendations and have some general conclusions that I'll present at this point.

The first recommendation is that the secretary develop a policy regarding disaster mental and behavioral health and a strategy to implement that policy. The policy should be developed in consultation with other federal departments, state, local, and tribal agencies, NGOs, civic and community groups, and subject matter experts.

The policy should clearly articulate the nature and scope of the federal government's roles and responsibilities with respect to disaster mental and behavioral health. It should identify and delegate responsibility and authority to designated federal agencies and other entities to prepare for a full range of psychosocial consequences and to provide for the assessment and

treatment of those consequences.

It should develop mechanisms to integrate disaster mental and behavioral health capability and responsibility across federal agencies and departments.

We deliberated some about specific strategies, and I'll offer just two that occurred to us. First, we recognize the limitations of the secretary with respect to other federal departments, but we believe that an approach that pursues integration within the HHS could be an example that might be followed by other federal departments and agencies.

We also recognize that gaps could be addressed in the pending PAHPA reauthorization and recommend that content that argues forcefully for mental and behavioral health and the integration of mental and behavioral health could be a strong -- could have strong effects.

I also re-emphasize the 2008 report that was submitted by our subcommittee and we

suggest that the eight recommendations that were provided in that report in 2008 be implemented or that part of the goal of HHS should be to implement those recommendations.

Our second recommendation was that the secretary should identify and empower an agency or office to serve as a leader for integrating disaster mental and behavioral health within HHS.

That office or agency should have authority to oversee efforts within HHS, define goals and measure progress toward those goals, coordinate activities among all sections of HHS to marshal existing expertise and to identify additional expertise as needed, to integrate the strategy, to share data as they emerge, and to generate a credible and unified response on the part of HHS, and that agency or office should develop a high-level CONOPS.

The third recommendation is to recommend that the secretary task senior HHS leaders with developing a set of coordinated

and prioritized research goals in the area of disaster and mental health and the necessary support to accomplish those goals.

One of our ex officio members, Farris Tuma from the NIMH, suggested after this report was prepared that some of the language in this recommendation should be modified.

He is suggesting that the language in the recommendation include examples of HHS leadership including directors of NIH, the ASPR, CDC, the Agency for Healthcare Research and Quality, and SAMHSA, and he also proposed that the research agenda should be developed in coordination with other federal departments and agencies including, for example, the Department of Defense, the VA, the Department of Homeland Security, and the Department of Education.

The fourth recommendation is that the secretary create and maintain a structure for subject matter experts to regularly assess and report to the secretary on progress on

integration and on other mental and behavioral health issues, as well.

We are suggesting that institutionalizing the Disaster Mental Health Subcommittee or some comparable body or some process would ensure an ongoing resource to provide the kind of expertise that's needed in the area of mental health.

With respect to our conclusions, we were pleased to find a number of examples that illustrate an awareness of the need for integration and that illustrates some progress toward integration.

We found, however, that much of the work is proceeding in an ad hoc way largely the result of commitment and effort on the part of experts and motivated individuals rather than as a consequence of a formal policy.

We found, as I mentioned earlier, that the most pressing and significant problem that hinders the integration of disaster mental and behavioral health is the lack of

appropriate policy at the federal level and that compounding that problem is the lack of any clear statement about where the authority to devise, formulate, and implement such a policy should reside.

And as I mentioned earlier, we recognize that the secretary can foster an integration policy and strategy only within HHS, but we believe that the ability of HHS to act as a guide and role model for other federal departments should not be underestimated.

Just a brief thank you to a couple of individuals and entities that have been instrumental in helping us develop this report and in conducting the assessment and analysis. First, Robert Taylor and David Lindley who served as consultants in the development of the report; Dan Dodgen and his able staff, including Rachel Kaul who serves as the ASPR ex officio member; and Darren Donato who has contributed greatly at every step in our process.

I've mentioned how impressed we have been with the state's disaster behavioral health consortium, so a special thank you to representatives of that group, and of course, our own subcommittee and the NBSB, which contributed a couple of members who helped greatly in our understanding of disaster mental health issues. Thank you.

DR. GRABENSTEIN: Thank you very much. So, let's open the paper and the recommendations to discussion by the voting members first, then the ex officios, and John Parker is up. John?

DR. PARKER: I like your recommendations and your conclusions very much. I just want to make a comment to the subcommittee that I'd like to recommend a comment somewhere in the recommendations or the conclusions that sometimes we don't recognize disasters that actually have the huge mental health behavioral component in them.

Very specifically, the newspapers

would say that we're coming out of the recession and it's over, but we just went through a pretty good disaster, I would say, on the recession and the recovery, and we have a lot of ailing people out there.

We see a lot of coaching and cheerleading, but we don't really see really good mental health behavioral messages for people who are really caught up in the depths of this recession. So, I would like to have somewhere in there saying we just don't recognize some disasters because they just are almost all mental health behavioral component.

DR. PFEFFERBAUM: Thank you.

DR. GRABENSTEIN: Eric?

DR. ROSE: I echo --

DR. GRABENSTEIN: Eric Rose. My job is to remind people to say your name.

DR. ROSE: Sure. I echo John's comments with regard to the recommendations, but one of things that I'm a bit surprised by is you identified communication as a -- or its lack thereof or the quality thereof as a key

impacter, and did you consider any recommendations with regard to communication strategy or policy as part of your recommendations?

DR. PFEFFERBAUM: I'm going to turn this to other members of the subcommittee, but our report does address the findings with respect to communication, and I think you're right.

I don't think we specifically addressed that in the recommendations, so the recommendations were more global than finding the really specific content areas. But, does anybody else have a comment? Steven?

DR. GRABENSTEIN: Any other communication channel?

DR. PFEFFERBAUM: David?

DR. SCHONFELD: If I can just add, I think that part of what we struggled with as a subcommittee was that our charge had to do with the discussion of integration of disaster and behavioral mental health within HHS and not about specific strategies or approaches

through which disaster and behavioral mental health might be improved in preparedness response and recovery.

So, we did make several recommendations that related specifically to communication in our last report and instead of reiterating them, we had suggested that -- we have a recommendation that there needs to be action on those items.

So, there were specific recommendations related to communication strategies and approaches that we felt the development of a toolkit and other -- and the development of additional resources and approaches and strategies, so we might want to reference back to that.

Maybe if you would desire, we could put those into this report instead of referencing back to that report.

DR. PFEFFERBAUM: Actually, two of our eight recommendations in the 2008 report focused on communication.

DR. GRABENSTEIN: I'm going to ask

HHS colleagues in the room then I'll come to Kim, on Page 20 of the written document, it says -- the chief recommendation, recommendation one, is that the secretary shall develop -- or should develop a policy, et cetera, et cetera.

Coming out of the Department of Defense, I know how DoD generates policy in a way that it's remembered. Usually, often times these things are numbered documents or they have titles in uppercase. How does HHS issue a policy? How does the secretary issue a policy? Is it -- are there policy letters? Are there instructions to the agencies? What's the structural means by which a secretary issues a policy?

CAPT. SAWYER: Bruce Gellin or George Korch, are you available to answer that?

DR. GELLIN: I'm listening. I'm trying to think of --

CAPT. SAWYER: This is George Korch?

DR. GELLIN: No, this is Bruce.

CAPT. SAWYER: Bruce.

DR. GELLIN: I guess in a variety of ways. Sometimes depending on where the decision is made, it may be a decision memo, but that's not generally -- that's not as generally publicly available.

I'm thinking of the H1N1 experience where these things turned into sort of guidance documents that CDC would put out and post, but I'm not sure, John, if that's exactly the same kind of format you're asking about.

DR. GRABENSTEIN: You're on -- I think you're getting my point, Bruce. So, I'll leave it as an open question unless somebody wants to jump in with another example.

My worry is that -- or my concern is that the product of the subcommittee is good and solid stuff that talks about lessons learned and itself deserves to be remembered and perpetuated, and I want to make sure we're

recommending to the secretary that she do it in a way that is, indeed, remembered.

Anybody else want to pitch in on that? All right, then we'll come back over to Ken. Ken Dretchen.

DR. GELLIN: So, in your transmittals --

DR. GRABENSTEIN: Go ahead, Bruce.

DR. GELLIN: I guess in your -- I'll get off the speaker phone. It may be easier. In your transmittals from the Board to the secretary, you have recommendations. So, with that, is this -- this is based on what you want to articulate as a piece of that recommendation.

DR. GRABENSTEIN: Thank you. Ken Dretchen.

DR. DRETCHEN: So, again, I agree with everybody else. This report was really spot on, just a terrific report. I have a question regarding the second recommendation where you say "identify and empower an office or an agency to serve as the leader."

So, I guess I would want to know if you want to take that down another level and basically identify, if you will, a particular officer. I don't mean by name, but I mean is it the ASPR, is it the head of CDC, only because the fact is I know that through a university if you say, well, this office is in charge, it -- the buck always gets passed around.

On the other hand, if we name a particular individual to a task, obviously, there's somebody who is on point and is responsible. So, have you thought about taking that down to the next level?

DR. DODGEN: I guess I've been nominated to respond to that, and I think, speaking for what I understand the subcommittee's deliberation to be, but I think the issue that is that under current statute as well as under current practice, there are significant responsibilities in the area of disaster behavioral health that are housed in different places.

SAMHSA has certain responsibilities, particularly through their memorandum of understanding with FEMA for the crisis counseling program, but other responsibilities, as well.

ASPR has certain responsibilities. CDC has certain responsibilities, and so I think the -- what the subcommittee is really pointing out is that there's a lot of good people doing good work in various places who have unique responsibilities, but there isn't any single place where the authority is clear that it is their responsibility to ensure that all of those various entities are collaborating and coordinated.

It tends to happen ad hoc, but there is no official policy or authority that ensures that it will continue to happen.

DR. PFEFFERBAUM: So he's asking, Dan, if we want to identify the agency or office that would take the leadership in this regard.

DR. DODGEN: Or offer an example or

two.

DR. PFEFFERBAUM: Or an example. Dan doesn't want to answer that.

DR. DODGEN: Yes, I perfectly understand the question, and I am explaining what the issue is, but I certainly don't think it's for me since I represent an agency that does have many coordinating functions, but I think that that's something that, perhaps, the Board could deliberate, but I think that's also something that the secretary needs to say, "Here's how we're going to do this in the future," in a way that ensures the full collaboration of the entire department.

DR. GRABENSTEIN: Al Di Rienzo?

MR. DI RIENZO: First of all, I'd like to thank the subcommittee for your excellent work and for your commitment. Just a lot of time and effort went into this.

I'm curious to what level, though I understand structurally and from a population perspective they may be different, that you've looked at the international community,

certainly places like Israel, the UK, and so forth, how focus and behavioral and mental health. Certainly, the Scandinavian countries do.

Again, I know they have a more homogeneous population, certainly a very different environment than the U.S., but have you looked at models or what's going on in the international community?

I do know there was mention of what's going on in Japan, but if you could elaborate on that.

DR. PFEFFERBAUM: Just briefly to note that the international literature was part of the literature review that we conducted for the first report. It's not specifically integrated into this one.

DR. GRABENSTEIN: One of the -- Dr. Hobfoll, did you want to make a comment?

DR. HOBFOLL: Actually, I have a more general comment that I want to make, but I'll hold off on that. But, in a specific response, this last question raises a very

interesting point.

In the area of AIDS, for example, we know that by doing research in Africa and places like -- immigrants from Tajikistan to Moscow, we learn a lot before it comes to the United States, and we get to that point.

There's a recognition in the area of AIDS and we need to do that international research, but this is another example where there is not only not lack of recognition, there's resistance to doing this work because, for example, Israel doesn't have the scientific resources to actually study and innovate on a way that can bring evidence.

It's more let's do what we think works, and that would be a great example of making a priority of looking at those models, researching them, helping refine them, and then helping -- and then translating them to U.S. context.

It does not exist right now. In fact, there are road blocks to doing it.

DR. GRABENSTEIN: Thank you. One

of the things that I was doing was cross-comparing the beginning part of your report with the conclusion and recommendations section.

So, as an individual, I certainly applaud all your comment about integration, but I don't see it spelled out in the recommendations part. So, I'm wondering if it would be -- what the Board and the secretary think about the worthiness of calling out as a specific recommendation something about recommending that every response plan and any of the HHS agencies include a disaster mental and behavioral health section annex, appendix component to make sure that all of those plans have taken into account all the good things that you cited.

For example -- well, along these same lines, I don't see in the conclusions and recommendations section a call to go implement the '08 recommendations. I mean, I think you mentioned it in the presentation, but it doesn't -- if somebody were to open up the

recommendations and say, "Let me go implement the recommendations," it's not there.

So, and there may be other things that others have noticed, as well, but I would offer that as a recommendation to you, and I don't know if anybody else wants to -- would agree with me or not, but an observation of mine.

CAPT. REISSMAN: Thanks. It's hard to see in here. I'm having trouble seeing names that far away.

I just wanted to raise a couples issue just in having heard this process over the past couple of years. In 2008 when this committee -- the subcommittee put forth the recommendations, they were approved by the NBSB and they went forward to a secretary who was then leaving and a new secretary then came in and then we had a change in the ASPR.

As a result of that, I think that the first set of recommendations sort of got stuck between administrations and we're stuck here trying to answer a question of the new

administration without being able to fully integrate all the work that was done previously, even though it's in the envelope here.

I'm wondering if one way to do that would be to append the full report, the prior report, into this one, and secondarily, to get a better sense, at least for my edification, from the Board in that I think it comes down to a four-part recommendation that this committee has suggested.

There's a lack of policy structure, accountability, and funding to enable real action in the federal government for integration.

So, at risk of the fact that I am an ex officio and that my boss is sitting at the table, I think that it would be important for us to be able to say yes, that's true, but it's not this particular subcommittee's job to say how you should do the policy, how you should do the structure, how it should be accountable, and where the funding should come

from because that's not the knowledge of this body.

That becomes the knowledge of the executive individuals who would then be appointed and tasked by a higher authority. It's just my thinking, unless my thinking is off.

DR. GRABENSTEIN: So, are you suggesting the need for a change from what we've got in front of us or something other?

CAPT. REISSMAN: No. I'm suggesting that -- I'm hearing a number of comments that are asking us to go into more detail about exactly what should happen in communication, exactly what should happen in structure, and I'm not sure that this body -- this subcommittee would be the right level of comment on that.

They're not government process experts, and that's really something that requires a special task force within government to do.

DR. GRABENSTEIN: Are you on the

communication -- is this arising from the communication conversation earlier primarily or something different?

CAPT. REISSMAN: It's connected to communication and it was connected to the question about exactly what structure and whose authority and who's responsible. That kind of --

DR. GRABENSTEIN: Dr. James?

DR. JAMES: My comments go a little bit along the lines of what Dori was saying, but go beyond that. I have always been perplexed by the absolute -- not maybe absolute, but the lack of integration not just of mental health but the lack of integration of preparedness and response functions within the federal government, also with the state and local level.

I don't know how we proceed with this, but rather than looking at it simply within the context of needing to better integrate mental health, we need to better integrate pediatrics. We need to better

integrate geriatrics. We need to -- I mean, you can go down a whole laundry list, and when we talk about identifying an office to do a specific function for one specific condition, if you will, or set of conditions, I think we need to go a step further.

I really think we need some type of integrative office or function for preparedness and response, I think the countermeasures. This is almost like listening to a lot of the countermeasures debate.

It's frustrating because I think we all know what we want to do but we don't know how to do it.

DR. DODGEN: This is Dan. If I could just make an additional comment. Dr. Pfefferbaum talked about the development of a concept of operations for disaster behavioral health, and I did want to let people know as she was updating you that we are actually moving forward with the development of such a concept of operations

and ASPR is taking the lead in convening everybody, pulling the right people to the table, ensuring that we have the right folks on an HHS working group to make sure that that happens, and then outlining through our plans office to make sure that it's consistent with other departmental plans.

I think part of the work of that group will be to begin to make some of the decisions and take into account all of the kinds of issues that you're raising and to develop. Although a concept of operations is not a policy statement, I think doing it will force us to look at some of the policies and some of the issues.

So, I do think that some of the steps that are currently underway may make it easier to answer some of the questions that you're asking now, so I think we are taking the steps that will help us to answer some of those questions, but I don't think we're there yet.

DR. GRABENSTEIN: Dan, the concepts

of the operations that I'm familiar with start with a scenario and then add detail. So, an anthrax CONOPS would start with an anthrax release and a smallpox CONOPS would start with a smallpox release and go from there.

What would the disaster mental health CONOPS start with? Something nasty has happened and people are upset and now let's add detail?

DR. DODGEN: Yes.

DR. GRABENSTEIN: I don't mean to -- I'm not trying to --

DR. DODGEN: No, I hear you. We're not -- because what you're describing, I think, is more towards being more like a play book and we're not thinking about doing a play book at this stage, so I think it will be a little bit higher level than what you're describing, although I agree with you and we've got lots of those, as well, which we constantly try.

Many thanks to folks like Rachel and Darren and Dori and others at the table

for ensuring that we do integrate behavioral health into those kinds of scenario-based documents.

But what we're thinking about is not so high level as to be just a statement, but not as detailed as what you're talking about. So it really will be when a disaster and event happens, here are the roles that each agency or entity has, here are the kinds of capabilities that can be utilized, here are the ways that these folks interact, here's how command and control occurs.

Those, I think, are the kinds of issues but not at the level of specific scenarios, although, again, we do have play books that do that and we do try to integrate behavioral health into those play books, but it won't be quite at that level, I don't think.

DR. GRABENSTEIN: Is it the starting point or a points to consider for the earthquake planners and the red nuke planners and the cyanide planners and --

DR. DODGEN: More of a base document in that sense.

DR. GRABENSTEIN: Dr. Jones, we haven't heard from you yet.

DR. JONES: Yes. There's always a question -- we've got a number of, I think, very good recommendations. One of the questions always is who's going to do what? I mean, we're all very, very busy people.

One of the recommendations that we had was to -- the continuance of the subcommittee. A number of questions were raised before in terms of the level at which certain initiatives have been spoken to, communication for example.

We've taken a number of those things into account over the past two years and really nuanced a number of the very important issues. For example, in the area of research, one of the recommendations was to bring together the various agencies to talk about different research agendas as it relates to disaster preparedness behavioral and mental

health to find out what folks are doing and what types of things that need to be done.

I'm reminded of earlier experiences with Katrina, and I remember my second deployment into Jackson, Mississippi, and one of my recommendations was the need for continued assessment of how individuals were doing as it relates to PTSD and depression and a number of the other correlates of depression.

We were fortunate to get funding for that, that was through the Harvard -- Katrina Community Harvard Group, and we produced a number of publications that were supported by NIMH.

However, the lack of funding has not enabled us to look at other disasters at the same level to see the extent to which one disaster is nested in another disaster.

So, again, the need for this committee is willing to continue to look at a number of those very important points to follow through and also move forward on a

number of these very important issues.

DR. GRABENSTEIN: I'd like to acknowledge Dr. Carlin and welcome her to the meeting. Dr. Parker, do you have your placard up?

DR. PARKER: I don't want to miss -- have the group miss one of Dori's comments. The three studies that you've done do articulate with each other and because the three studies did cross a transition point, I'd recommend that the subcommittee draft a cover letter pointing out that this report is a third piece of a three-part series and that you are including the first and second report for convenience to the readers so that they see a picture of a continuity of study by the subcommittee.

DR. GRABENSTEIN: Thanks. A comment that came up at dinner last night, and I was leafing through the report to see if it was in writing or not, so I'll ask it as a question, and I don't see it in the conclusions and recommendations sections.

Should something go forward as a conclusion or a recommendation about attending to the mental health needs of healthcare workers and volunteers?

I'm sure you would all say yes. I think that's come through from previous communications, but that's also not in the recommendations. It is?

DR. PFEFFERBAUM: It's in the first --

DR. GRABENSTEIN: It is in the first recommendation. I missed it. All right.

DR. PFEFFERBAUM: It's in the first report.

DR. GRABENSTEIN: So much for my vision. Okay. Thanks. All right. Dr. Schonfeld?

DR. SCHONFELD: In the comments that I've heard raised, I think one of the issues that I think we probably should address directly is that although we were asked to talk about integration, and it's very

important to think about how all of the parts of the response are coordinated with each other to optimize their effect, a pre-condition of integration is actually inclusion.

So, part of the issues that we didn't directly state in our report but maybe we should have is that you can't integrate something until you actually do it at all.

So, part of what I am hearing are questions about the components of the recommendations that we made two years ago that have not been acted upon. So, we did not restate them, but that is not because we reaffirmed them.

We think they are still important, but we were asked to talk about how those responses were integrated with other responses but the reality is those recommendations weren't acted on, so they can't possibly be integrated.

So, I think -- I don't know how to finesse a response to that, but I think that

that's what I'm hearing here is why didn't you talk about all those other parts but that wasn't what we were asked to do but it's a very important point.

So maybe we can think about whether the report needs to be revised or maybe it's more a strategy of trying to act on the recommendations that the NBSB already recommended several years ago be acted on.

DR. GRABENSTEIN: My own -- as an observer of institutions, I think we're going to be sending something new up to new people or people who haven't seen the previous transmissions. We should at least refer by attachment, and maybe convert the list of recommendations from '08 into a table, and we can talk about those.

We have between now and through the lunch break to figure out the format that we would be voting on today so we can be curious to hear your own recommendations on how we might structure that.

Dr. Hobfoll, your placard's up.

DR. HOBFOLL: Thank you. I want to follow up to what Dr. Schonfeld said and maybe state it more starkly, and there are examples across the board, but what -- speaking as an individual, not speaking for the Board, I would say that NIH and NIMH's policy moves against not only the integration but the inclusion of optimal behavioral response to disaster in terrorism, and interferes with, creates an obstacle, and it even directly squashes efforts.

So, integration is so far to the other side of a policy that in part by intent is meant to undermine the kinds of recommendations that we're making.

DR. GRABENSTEIN: Can I ask you a question on that as someone not knowledgeable? I assume that NIMH does a research funding role similar to the other institutes. What's the intersection between research and integration for activity?

DR. HOBFOLL: Well, what I mean by research would be the science base that gives

you credibility to know what you might do, and as in most science, following probably a lot of dead ends to produce a few kernels of truth that then become gems as they move along in the scientific process.

I want to speak more generally, though, about this, and it's a matter of scope. Often, when we talk about -- if we talk about mental health problems, and actually, we really mean mental illness because mental health is a euphemism for mental illness, and that puts us way off on the issue of scope.

To take a step back into -- on the defense side, I was asked to be part of a committee before the invasion of Iraq about the mental health impact of the war after the war was over in about three months.

This was going to be an unfunded committee at the Pentagon, and I wrote back saying what you're calling the mental health response is called an uprising and that is the war. What you're calling the war is not a

war. It'll only take two weeks.

So, that's what's being off by scope, missing -- we were talking about being off by, what, 97-98 percent of your inclusion of resources, your intent, your battle plan, et cetera, is off because of ignoring what is the behavioral response.

Just a few statistics that make this maybe more understandable. In a severe disaster, nearly 100 percent of those on the ground, including the decision makers who touch the ground and the first responders, et cetera, have acute stress reaction, which is really PTSD, but you don't have time to call it PTSD yet because you need a month.

Even if they're responding well at that point, they're internally undergoing severe reactions that greatly impact their decision-making.

At one month, about 30 percent of those involved, again, including the decision makers, first responders, et cetera, who are on the ground, have PTSD.

Turned another way, at one year if you have a chronic disaster or chronic terrorism, our studies have showed that 70 percent of Israelis have clinical sleep disorder, which means that they're going to have long-term impact on heart disease, hypertension, diabetes, et cetera, et cetera, but my point of all these things is you're talking about all of us, not them, not someone you point the finger at.

So, for example, what that means is that the president and his advisors make wrongful decisions at the time because they get caught up in this same litany.

Police abandoned their posts in Katrina, so you have no -- you don't have police policing the streets. Even the doctors, the few doctors that independently did well are doing well while they're experiencing these acute stress reactions.

So, what that would mean for integration is that at senior levels, you need people with expertise on this at the table to

begin with. Or in Pentagon terms two-star generals, not colonels and now that you make one-star generals who are, and I appreciate the rank of a one-star general, but the ones that are one-star generals are then, again, mental illness experts within, for example, the Pentagon, not behavioral experts.

Those are back to lieutenant colonel, so it's moving these people up in the hierarchy so that you have knowledge at the table that it's turned to and not in a mere advisory, secondary, or tertiary manner.

DR. GRABENSTEIN: Good. Thank you for those comments. Let me check the telephone lines and see if the ex -- any members or ex officio members on the line have any comments or questions.

Hearing none -- okay, so we're going -- we're about, not quite but almost, ready to progress to a break and come back. What I would like -- we will have our comment -- public comments segment when we come back and then continue discussion.

I want to focus on -- are any changes needed in the document? Here are the -- I've been writing out a list of things that we've talked about so far that we might want to huddle on over the break or over lunch or -- but then in the discussion period please tell me if you think any of this is wrong and should be struck and therefore not changed or if there's anything missing.

So, we talked about communication. We talked about the -- how best to get the '08 recommendations -- had to remind the leadership of the '08 recommendations, or inform them, I guess, in some cases, what kind of policy or do we need to clarify what kind of policy the secretary would issue such that it would be remembered?

Do we or don't we want to name a specific office or agency as the leader for the integration efforts? Do we explicitly recommend that all response plans include a disaster mental and behavioral health component or appendix?

Is there a need to call up the needs of healthcare workers and volunteers? So, maybe your list is longer than that, but why don't we take the break and come back with -- for the public comment period and the discussion about what to do with the written document.

Come back please at -- shall we make it 10:55? Let's do that; 10:55 please.

DR. KORCH: John Grabenstein?

DR. GRABENSTEIN: Yes?

DR. KORCH: Hi. This is George Korch. Can I just ask you quickly whether you're envisioning as a function of having the annexes something similar to how we develop or had developed in the Army medical annexes to a FDAAA plan?

DR. GRABENSTEIN: That's the analogy I was using, George, was -- and I'm sure it would be called -- have different names other than annex in some document series, but that's all I mean, an annex or an appendix or -- but a chunk of the document

that would be devoted to mental health and -- mental and behavioral health.

DR. KORCH: Okay. Thank you, John.

DR. GRABENSTEIN: Thank you; 10:55.

(Whereupon, the foregoing matter went off the record at 10:41 a.m. and went back on the record at 11:03 a.m.)

DR. GRABENSTEIN: So, I'd like to welcome everyone back to the current session of the National Biodefense Science Board public meeting. Do we have phone connections?

Dr. Gellin or Dr. Korch, you are the designated confirmees of sound check.

DR. GELLIN: Yes, we are getting a sound check.

DR. GRABENSTEIN: Excellent. Thank you. So, I'm pleased to recognize the arrival of Dr. Quinlisk. The weather gods have smiled, and she's with us. She's asked me to continue as chair pro tem, I'll say that, just for the sake of knowing who's said what and the like and I will probably pass the baton back to you at lunch time or something. I

don't know. We'll figure this out.

So, shall we proceed with the public comment period? That would probably be the wisest thing to do. We're a little bit behind, so we apologize to those of you who have been patiently waiting.

Dr. Sawyer, would you lead the instructions to the operator?

CAPT. SAWYER: Yes. First, we'll go to the operator to ask if anyone is on the line who wants to make a public comment and have them queued up please. Operator, are you there? Operator?

OPERATOR: Yes, ma'am.

CAPT. SAWYER: Do we have anyone on the line who would like to make a public comment?

OPERATOR: At this time, no, ma'am.

CAPT. SAWYER: Thank you. Is there anyone in the audience that would like to make a public comment? Okay. Could you please introduce yourself.

DR. RODRIGUEZ: Yes. Okay. My

name is Bill Rodriguez. I'm with the Food and Drug Administration and the Office of the Commissioner, Office of Pediatric Therapeutics.

These are my commentaries. I don't represent the Agency, but as a biased pediatrician, I'm realizing after looking at the report that the word pediatrics or children came up in very nice things due the report as we move into the recommendations.

I mean, when you talk about people that are affected by "separation anxiety governance," for example, children have a double dose in there and also, very importantly, they are also at the developing stage so whatever they get is going to get even worse there, so I just wonder whether we always have to play catch-up with children and whether in this situation we can go ahead of the game.

We've been playing catch-up with BBCA, with FDAAA, for example, trying to include the labeling for drugs for children,

and I think that children in disaster are -- I consider them to be doubly, doubly vulnerable.

Number one, mentally; number two, because they depend on other people more than any other people or maybe vulnerable people who are -- have other problems.

So, I just wanted to make a point that this is my bias. Thank you.

CAPT. SAWYER: Thank you for your comment. Is there anyone else with a public comment?

OPERATOR: At this time, if you would like to ask a question, please press star then the number one on your telephone keypad.

(No response.)

CAPT. SAWYER: Operator, do you have anyone that wants to make a public comment?

OPERATOR: At this time, there are no audio questions.

CAPT. SAWYER: Thank you.

DR. GRABENSTEIN: Great. Thank you

very much. So, I sort of rhetorically challenged the subcommittee before the break to ponder whether there are needs for any changes in the document as presented to us this morning.

Let me ask the voting members if they have any comments along those lines or the ex officios and then come to the subcommittee members as the third part. Any comments from the voting members about need for changes in the document?

(No response.)

DR. GRABENSTEIN: Okay. Ex officio members?

(No response.)

DR. GRABENSTEIN: All right. Subcommittee members, what do you advise?

DR. PFEFFERBAUM: I think the consensus of the group that's here today would like to add one recommendation that references the first report in 2008 and that first set of recommendations.

So, if there's no additional

business at this time, we would use the time to prepare that recommendation for your consideration before your vote.

DR. GRABENSTEIN: Okay, so we would be moving -- so I'm going to take this in big buckets and then come down into the finer detail. So, that would be a path forward. We -- is there any other sense of need for other recommendations?

I'm wondering if -- how you feel about calling out explicitly that -- recommending to HHS that every response plan or every -- that may be too narrow a term for the moment -- that every response plan should include an annex, an appendix as a component that calls out behavioral and mental health issues, because I'm not sure that that's covered otherwise. Dr. Schonfeld?

DR. SCHONFELD: Yes. I'm wondering if that may be already recommended in our Recommendation 1B, which talks about at the national -- it says include language in mental health substance abuse and behavioral health

and all appropriate legislation regulations and grants integrated into exercising and performance benchmarks.

So, a lot of -- I'm sorry. In the report from 2008, again, I think that recommendation is excellent and was actually the first recommendation of the 2008 report, so I think if we can -- when we pull out the recommendations and embed it as Dr. Pfefferbaum has suggested, we might also want to maybe call out some of that portion of Recommendation 1, but I think it would be embedded in what we already have planned.

DR. GRABENSTEIN: Thank you for reminding us of things we've handled as old business.

DR. SCHONFELD: Thank you.

DR. GRABENSTEIN: All right. So, how about other -- so, during the break, I heard mention of the literature review performed was -- ended up being a 60-page document, if I heard that right, so I would like to do credit to the person or persons who

did all that work and named that thing and put it in a footnote and so that it wouldn't have to be repeated so it might be findable in the future.

DR. PFEFFERBAUM: It is referenced in the footnotes as part of that report. So, the report included the background, as well as the eight recommendations.

DR. GRABENSTEIN: I keep recommending things that you've already done, so that's a good sign, I think. All right. So, are there other -- is there other discussion? John Parker?

DR. PARKER: Betty, as you formulate that so-called hanging recommendation, before the break we talked about the integration and then I heard the committee talking about it, that the third report makes no sense unless we have something to integrate.

So, your -- if the recommendation that you're making, and you might have to go back -- you could do it as a free-floating

recommendation and just say -- just start the recommendation by saying you can't integrate what you don't have and then go on -- and the rest of the recommendation paragraph says that to do anything that we talk about in the first -- in this report, you must completely understand our first two reports and execute them.

Without that kind of a statement, I think people will miss the importance of the first two reports. Then as I say this, I look at Dan and Dori and those people who are physically in the department, and I guess I will reflect and ask Dan what are the obstacles that you run up against of getting some of these policies into play or is that -- I don't know if it's out of your purview, but what can we do to help what you do get out?

DR. DODGEN: Well, I'll answer as best as I can. I think the challenge for integration, I think, occurs on many levels. One of the most basic, of course, is that the department, because of the way that it's set

up, as you know, it's very different than some of our other departments in that each piece of the department typically has its own funding streams, authorities, statutory and regulatory requirements, so that the department is often challenged by silos that are created by the statutes and the regulations that govern the pieces of the department.

I think that's particularly true in disaster mental health because one of the largest activities that the department undertakes is related to the crisis counseling program which is, in fact, not even an HHS activity.

HHS is involved in it through a memorandum of understanding between SAMHSA and FEMA, so I think we sort of start at a disadvantage in that the various functions of the department are siloed in the way that they've been created.

So, we have to work against those silos. It doesn't mean that we can't do it and it doesn't mean that it isn't important

that we do do it, it just means that that's an obstacle and they're asking what the potential challenges and obstacles are.

I think there's a larger one, and I think it's what Dr. Hobfoll and Dr. Pfefferbaum and Dr. Schonfeld, particularly, have been referring to throughout our discussion, and that is that at the end of the day, mental health -- I mean, if you all remember the new Freedom Initiative report that was published a couple of years ago in the previous administration, the quote I believe, and Roberta, you may remember exactly, but I believe the quote was that the mental health system in the United States is a shambles.

This was a report that was approved by the previous administration, so when the administration admits that a whole system is in shambles, you get a sense.

Mental health in this country is -- if health is a stepchild and public health is a step-stepchild, mental health is the bastard

stepchild, if you'll pardon my French. It's just -- it's such an underfunded, under-resourced part of the fabric of our health system that I think we struggle every day to get mental health to the attention of anything that we do as a nation.

It gets headlines, but it doesn't get the funding and resources commensurate with those headlines, so I think the other challenge is that the mental health system and substance abuse systems in this country are so underfunded and poorly connected that we're trying to take those resources combined with underfunded public health -- we've got all these systems, all these silos, and we're just really starting at significant disadvantages.

I apologize for my long response, but I think there's a lot of pieces to this puzzle.

DR. PARKER: Well, Dan, I appreciate what you said. Maybe it's too late to wrestle with it, but during a disaster, we're dealing with a different kind of mental

health and behavioral issue than what I would call -- that's called out in the DSM.

There's disease and then there's reaction to a disaster. The reaction to the disaster has significant mental and behavioral component, but it's not a disease. It's a -- it's something that happens and then if it's not taken care of, it may linger -- it may migrate into a disease pattern if you don't attack it, but having not gone through the report word-for-word, do you talk about that a little bit in some of the -- in one of the three parts of your work?

DR. DODGEN: I'll defer to the members to the members of the subcommittee, but it certainly is in the 2008 report and someone else may want to elaborate.

DR. JONES: I'll be happy to respond to that. Yes, we do, and we talk about it in a number of different areas, but one I think is very important is the area of research and assessment.

We talk about the need for acute

assessment shortly thereafter and if that doesn't take place, the negative consequences that occur. So, for example, getting into Katrina, for example, talking with the individuals immediately thereafter. We know that those that develop acute stress disorder, if not treated and helped, many times it would then lead on to post-traumatic stress disorder.

Three months later, you have chronic PTSD, which has a number of very neurological and biological consequences, so we do address that. But, again, there are just so many roadblocks along the way.

Talking with a colleague not long ago in New Orleans. One of the real problems has been the Stafford Act and the need to make significant changes with that. There's been a number of recommendations. I have a report here in front of me that talks about the need for adjustments with the Stafford Act.

Just for example, the need for cultural competence and linguistics in that

act and nothing has been done. So, again, just a number of roadblocks, and I guess one of the things that this committee has tried to do is who is the go-to person? How do we get the attention of that person or body of persons that can lead to the enactment of some of these recommendations?

We've worked very hard for two years to bring forth what we think is a very impressive document, very substantive, very research-based and everything else. But, again, the question is where does it go from here? How do we couch it? How do we present it in a way that it gets the kind of traction that's needed so the needs of the people are met?

DR. GRABENSTEIN: That was Dr. Jones. Thank you very much. Dr. Quinlisk?

DR. QUINLISK: Hi. First of all, I just want to, since this is the first time I'm saying something, is to apologize for being late this morning, but, unfortunately, I have no control over thunderstorms in Chicago, but

I am glad to finally be here.

I would like to just commend you on one thing in the report. Working at a state level, one of the things that I think we've seen from the federal government is the interest in doing things within this area but sort of not translating into, as you say so concisely, into the policy and the trickle down.

One of the things that you talk about, and I think is very important and perhaps at some future time even make clearer, is one other thing that's happened within public health is after 9/11 that there were dedicated people now within state health departments for emergency response period, which we did not have before.

I think one of the things that we need to do is have a policy and then, of course, the funding to have dedicated people within the mental health area because one of the things that I've seen -- often we have an emergency come up. We call our mental health

people who often are project managers for very siloed, money coming down for very specific response things, usually day-to-day things not emergency, and also then ask them to stop all of that and switch over to an emergency response is very, very difficult for them and often times just not real feasible because they still have their day-to-day responsibilities.

So, maybe one of the things at some point is to have personnel somewhat dedicated to just dealing with emergency response mental health issues at a state or local level working then, of course, with the feds who are designated also.

So, but I thought that you did get at some of those issues within your report, and I did think it was very good because it doesn't really matter what policy you have at the federal level. If it doesn't trickle down to the community, it doesn't mean a whole lot. Thank you.

DR. GRABENSTEIN: Great. Thank

you. Captain Reissman?

CAPT. REISSMAN: One of the things I wanted to answer -- I can't quite see your last name, but Mr. John -- Dr. John, the psychological and social determinants of behavior is, I think, what you were getting at when we're thinking about disasters and recovery and the trajectory that somebody goes on, which may lead to a chronic mental illness.

It may lead to chronic role dysfunction without a mental illness diagnosis and that role dysfunction might throw somebody out of their ability to work and produce adequate income for their household and change the whole trajectory of the people who live in that family.

So, I like the way that you were putting that forth, and I personally want to see a real separation between how we focus on the psychological and social determinants of behavior in disasters, in response, in leadership, and how we set the tone for the

recovery trajectory as opposed to moving down the line and then reconnecting back up with the public mental health system which is really in a state of crisis, as is public health but more so.

If we can keep our focus there, I think that's the purpose of this group dealing with more of the acuity when the disaster strikes, how we prepare for how people will respond, how do we set expectations or set certain skills in play so that maybe we can change the trajectory of how individuals, families, and communities might be ready to deal and how they cope over time.

DR. GRABENSTEIN: Thank you. Dr. Jacobs?

DR. JACOBS: Oh, thank you. Responding to Dr. Parker's question in terms of whether we've addressed that issue of basically having the difference between disaster mental health and clinical fields, I think in the first report, the 2008 report, we addressed at some length the importance of

training people to be not necessarily clinicians but rather understanding the difference between clinical whatever field and between disaster mental health or disaster psychology in those fields.

So, that was a real emphasis in the 2008 report. Now, I think joining into what Dr. Jones was referring to with the research agenda, I remember talking with one of the federal officials about doing preventative research and understanding how preparing the public could build the resilience and prevent the onset of clinical disorder, and the response was we're not interested in preventing mental illness. We're interested in curing mental illness.

So, until we have those priorities set, until we understand the relevance of those things and the economy of preventing instead of curing, those challenges remain.

DR. GRABENSTEIN: Okay. So, let's focus on what to do with the report and so procedurally, this is what I think is going to

happen, and Robert's Rules of Order allow you to tell me when I'm wrong and correct me.

So, and it builds on what we've talking about this morning. So, I think what we are envisioning or -- so this will be a proposal anyway, is that there'd be a relatively succinct transmittal level presuming that the Board endorses the report, which I'm sensing that they do, but we'll see that in a vote.

But, what we would have would be a relatively succinct transmittal letter from the Board to the secretary endorsing or -- I think the word is endorse -- the report of the subcommittee.

So, many people have called for a reminder or a reiteration of the previous works of the subcommittee, so perhaps the report would be based on the document provided to us this morning -- or previously -- and with the previous two reports as attachments to that report, but probably calling out the recommendations of the '08 report in a special

way.

We talked, I think, about having that as a table in this present 2010 report citing the source as the '08 report and a new and additional recommendation calling for implementation or fuller implementation or whatever the right word would be of the '08 recommendations.

Dr. Pfefferbaum, is that the way you would recommend we do it or would you recommend a different process or a different document?

DR. PFEFFERBAUM: I think that's consistent with what our group would like to do pointing out, though, that we would like to include a new recommendation that calls for the implementation of the '08 recommendation, so that might be in your letter, but we'd also like to add it to our document.

We'd like to add a table with the full text of the recommendations from 2008. I think we would delete the action steps because those were very specific and not -- more

detail than is needed.

DR. GRABENSTEIN: I'm sorry. I'm not sure what you mean by the action steps.

DR. PFEFFERBAUM: Pardon me? The '08?

DR. GRABENSTEIN: The action steps in the '08 document.

DR. PFEFFERBAUM: Right.

DR. GRABENSTEIN: Okay.

PARTICIPANT: David, go ahead.

DR. GRABENSTEIN: Dr. Schonfeld?

DR. SCHONFELD: Just to point one thing out because this may not be as complicated as it seems, if you turn to the report under conclusions and recommendations, the second paragraph begins with in its earlier reports of the NBSB, this Disaster Mental Health Subcommittee made eight broad recommendations for mitigating the mental and behavioral health consequences of disasters and emergencies.

The second sentence talks about the importance of implementing, but does not

phrase it as a recommendation. We could easily change that language and say I'm not asking you to vote on this, but something to the effect of a necessary precondition for integration would involve taking the actions outlined within these recommendations as summarized below that remain largely unfulfilled.

These action steps stand to serve as an important foundation for the successful establishment of policy and structures through which successful integration can occur.

Then we can just put the table in there. I just thought maybe a concrete example of how we could do that, so it doesn't actually require changing the recommendation, but just drawing it out and emphasizing it in the second paragraph.

If we want, we could bold it, we could put a bullet in front of it, but I think it is there. It just did not read as strongly as it should have.

DR. GRABENSTEIN: I think that's a

very prudent approach. Any disagreement or anybody want to add to that?

DR. PFEFFERBAUM: Well, my question would be, and you'll know much better than me so I ask you, is it likely to be lost even if it's bolded if it's not listed as a fifth specific recommendation?

DR. GRABENSTEIN: What we have done with our previous reports is to number the recommendations and I would put it in the list, so if somebody's going through checking boxes, it's a box to be checked.

I also pulled out your '08 report, and I would -- and I'm now remembering the action steps that you talked about, and I -- because of the work that you expended in specifying them, I would send forward this report or attach this report in its entirety because that -- the detail of those action steps is very instructive, I think.

DR. PFEFFERBAUM: Yes. I think we would agree. There was some discussion among our group about the appropriateness of

including the H1N1 2009 report. It wasn't at the same level of intensity. It isn't -- it wasn't the same kind of document.

It does, however, I think, provide an excellent example of successful integration. So, I think to include it as an appendix is -- I'm not sure the whole group's going to agree with me, but I favor doing that personally, and I guess we'll take a vote.

DR. DODGEN: I would just say I think it's appropriate just -- we need to be clear that it doesn't have sort of the same status as the original set of recommendations, and I mean, as long as we provide summary language for that, I think it's okay.

DR. GRABENSTEIN: I think you can do that when you figure out the point where you're going to say and add Attachment 2, you'll find this, and oh, by the way, it had those caveats that you just mentioned.

Board, voting members comfortable with where we're going? Ex officios, subcommittee members? John?

DR. PARKER: That's a very interesting point you just made, that the H1 -- your second report codifies the fact that integration can work. Is that pointed out in this report as an example of taking a policy and having it integrated?

DR. PFEFFERBAUM: I think it is. It's on Page 7, and the report -- and that H1N1 report is referenced on Page 7. It's in the first full paragraph. I'm just trying to see if we actually said this was an example of success.

DR. PARKER: You said it underscores the importance of integration.

DR. PFEFFERBAUM: I don't -- I think we want to change the -- yes, we can change the footnote to see attachment, but I think we may want to highlight it as an example of a successful effort.

DR. PARKER: That would be great from my --

DR. DODGEN: So, this is Dan. I'm going to be super concrete here. So what

we're now looking at is adding in on Page 7 a small section that says an example of successful integration is -- in the same sentence it's currently footnoted, we'll say see attachment instead, but basically just like a sentence.

It sort of says why we're considering this to be an example of success.

DR. PFEFFERBAUM: I would add the website, as well, Dan. So I think that --

DR. DODGEN: Yes. No, I think both is fine.

DR. PFEFFERBAUM: Okay.

DR. DODGEN: Okay, and then in the recommendations section, we're going to add in as Dr. Schonfeld described the -- under Paragraph 2 in the -- which is I think a bit more lengthy description and then in the bulleted list of actual recommendations, we're going to reiterate the point that the subcommittee reaffirms those original recommendations and also believes that they have not been fully implemented but need to be

and then we're going to number those instead of bulleting them.

I'm sorry to be so super concrete, but just want to make sure that we're -- that we know what our task is over the next hour.

DR. GRABENSTEIN: Add a bullet that is the recommendation to implement the '08 recommendations.

DR. DODGEN: Right.

DR. GRABENSTEIN: While we're doing the laundry list, somebody said that the 60-page letter to review was here as a footnote, but I don't see it.

DR. PFEFFERBAUM: I thought it was -- well, no, wait. Aren't we talking about the 2008 report? Isn't that what we're referencing is the literature review?

DR. DODGEN: Well, I'm not clear. Or are we talking about the 2009 HHS response to --

DR. PFEFFERBAUM: Oh. Oh, it's Darren's --

DR. DODGEN: That, I think, is a

somewhat different document.

DR. GRABENSTEIN: Dan, turn on your microphone.

DR. DODGEN: Oh, I'm sorry. There was another report, which was prepared primarily by my team, Rachel Kaul and Darren Donato, but through working with the entire department that was a response to the 2008 recommendations.

It was sort of the official HHS response to the recommendations of the NBSB for disaster mental health.

DR. GRABENSTEIN: Ponder it over lunch and just decide whether it's worthy of inclusion or not. Dr. Schonfeld?

DR. SCHONFELD: I was just going to ask the group when they're suggesting adding the recommendation would it be sufficient to just say something to the effect of the secretary should test senior HHS leaders with implementing the eight recommendations outlined in the 2008 report of the Disaster Mental Health Subcommittee that was approved

by the NBSB?

Are people looking for more than that if we have outlined them above a couple paragraphs?

DR. GRABENSTEIN: Dr. Quinlisk?

DR. QUINLISK: Yes, I just -- I think that sounds good, but I think you might want to make some kind of reference this is the base on which needs to be built the recommendations that you have here so that it makes logical sense that sort of this is the next step, but cannot do this fully unless those are done, too.

DR. SCHONFELD: I was suggesting that this would be the bullet that would come under the recommendations that would be numbered. The paragraph I'd suggested before, which explained why this was a necessary precondition, would follow that two paragraphs prior.

So, I'm just responding to the fact that people wanted it reiterated in a bulleted, numbered list.

DR. QUINLISK: Right.

DR. SCHONFELD: Or do we want to move that paragraph into the numbered list is what I'm asking.

DR. QUINLISK: Well, I guess I was thinking if you just have a list of recommendations that somebody might just look at the recommendations if they look at that being the first one with no reference back to why you're reiterating it, it might not make as much sense as if you were to add something right then and there saying we are reiterating this recommendation because of this issue so that those recommendations can sort of stand alone and one would not have to go back to the narrative of the document itself.

DR. PFEFFERBAUM: David, I think on Page 7 in that paragraph we should reference a table that will actually list the eight recommendations.

DR. SCHONFELD: I think we should put that in, actually in the recommendation section.

DR. PFEFFERBAUM: Oh, okay. We'll discuss it. We will come to some consensus.

DR. GRABENSTEIN: Okay. Great. Any other -- I have one more, but does anybody else have any other changes needed? I'm sorry. Roberta?

DR. CARLIN: Yes. Now that we've talked about adding these other documents and for the importance of integration and showing the history, can you review what is going to be on the succinct, one-page letter describing what it is the document is --

DR. GRABENSTEIN: I'm sorry. We were going to sidebar --

DR. CARLIN: Oh, okay. No, I'm saying that we've had additional conversations talking about the other documents and referencing them and integrating them and making reference to them, I'm a bit confused now what would be in the one-page, succinct letter that would be going forward?

DR. GRABENSTEIN: Well, that remains to be drafted.

DR. CARLIN: Yes.

DR. GRABENSTEIN: So, what would you recommend?

DR. CARLIN: Well, I just think we should think about it because we're adding a lot more and we're trying to make the argument basing this report based on the history of the prior reports. Just concerned that we just don't get too much and then that's all diluted and we're missing our message.

DR. GRABENSTEIN: Okay. So, let's hold that for a moment because I want to deal with one more thing that I think has to be grappled with in the subcommittee report, and it's the red text stuff that was on the slide for recommendation 3 dealing with the research agenda and -- so maybe -- how about over lunch, why don't you guys settle on whether or not you want to make any modifications at that point and make that recommendation to us after lunch. Would that be okay?

DR. CARLIN: Yes, that's fine.

DR. GRABENSTEIN: Do you have any

other comments on the base report -- on the subcommittee report? Okay.

Now, let's come to Roberta's point about what are we, the Board, going to do in our one-page -- what I proposed as a one-page transmittal where the Board might be endorsed or might not be if you would prefer a different verb. What do you all want to say? Jim?

DR. JAMES: Wouldn't it be good for somebody to put a draft together that we can look at and then take it from there?

DR. GRABENSTEIN: You're turning tables on me. Yes, I guess it would be better. Leigh reminds that in the past we have used the verb adopt as opposed to endorse, so I guess the alternative here would be to adopt as our own the recommendations to be found in attachment whatever.

DR. QUINLISK: I think that's great. I think, though, given how great the work has been of this subcommittee, I think it would be nice if we could add some kind of

statement about not only do we endorse this but that we fully recognize the challenges and the richness of the review and the recommendations as being very important to the whole process of disaster response so that it's not just a yes, we endorse this but that we put sort of our opinion of the weight and the importance of this behind the word endorse also.

DR. GRABENSTEIN: So, of course, your penalty for making a recommendation is you're going to have to scratch out the few words to put that into -- I'm doing the same thing myself at this very moment -- put that into the report, so anybody with -- if you have a preference for how the words go, please scratch them out and give them to me. Roberta?

DR. CARLIN: No, I was going to echo comments about maybe a draft first and then we'd review, but I guess the piece was how much are in the cover letter will we reference the prior reports and --

DR. GRABENSTEIN: What do you recommend?

DR. CARLIN: Well, I think they should be definitely referenced, and I thought that you had said that, too --

DR. GRABENSTEIN: Yes, so --

DR. CARLIN: -- it's just that we continued on with further discussion.

DR. GRABENSTEIN: Yes, I mean, so we can dispassionately say there are recommendations from 2008 that still haven't been implemented or we can add emotion or we can stay dispassionate. Does anybody have a preference?

DR. JAMES: I think we should put a draft together so we can address those things. I think this letter has to carry a strong, but simple message that's going to the secretary, and the more we put in there, the less likely it's going to be looked at closely.

DR. CARLIN: I would agree. That's my point. The thicker the report is the less

attention it may get so that the letter is really critical.

DR. GRABENSTEIN: Dr. Sawyer?

CAPT. SAWYER: So, I just wanted to clarify that was Jim James and then Roberta Carlin for those on the phone. What I wanted to be sure is that people are clear about are we talking about the 2008 just recommendations which is a kind of short summary versus the report because we've used both terms. Just to be sure everyone knows whether or not we're going to actually be attaching the report or attaching the recommendations.

DR. GRABENSTEIN: Which might be the choice between a 7-document and a 20-something page document.

DR. PFEFFERBAUM: I think our preference would be to lift the specific -- eight specific recommendations into a table in the report and to append the full document. I see lots of yeses.

PARTICIPANT: All right. Fine.

DR. GRABENSTEIN: More comments?

Roberta? Any ex officios, subcommittee members? Anybody on the phone?

Okay. So, then why don't we -- if it's agreeable, why don't we adjourn for the lunch break because there's a bunch of work that has to get done over the lunch break.

Dr. James will be stopping by my computer to assist me with wording, and we shall reconvene at 1:00 sharp. Any objections?

Thank you very much. Thank you for a great morning and we shall pick this back up at the top of 1:00. Thank you.

(Whereupon, the foregoing matter went off the record at 11:42 a.m. and went back on the record at 1:12 p.m.)

DR. GRABENSTEIN: Welcome back to the second half of the public meeting of the National Biodefense Science Board. The purpose of the next session is to reach agreement on the final form for the Disaster Mental Health report that, if adopted, the Board would send up to the secretary and then

we'll proceed on to discussion of the future of the NBSB.

So, let at this point ask Dr. Pfefferbaum if she would like to describe the intended changes to the report based on all the conversation this morning and the subsequent discussions of the subcommittee members during the break. Dr. Pfefferbaum?

DR. PFEFFERBAUM: Yes. Thank you. On Page 7 of the report, we reviewed the language that already existed regarding our H1N1 report in 2009 serving as an example of successful integration.

We think that the text as written was adequate to convey that, so we made no changes there.

On Page 19, the second paragraph under conclusions and recommendations has been revised and let me -- may I just read briefly what we've agreed upon?

In its earlier to the NBSB and footnote 5, which is on that page, the DMH subcommittee made eight broad recommendations

accompanied by supporting specific action -- you hold it here for me, Brook. Sorry.

Accompanied by supporting specific action steps for mitigating the mental and behavioral health consequences of disasters and emergencies.

A necessary precondition for integration would involve taking the actions outlined within these recommendations as summarized below, which remain largely unfulfilled.

These action steps stand to serve as an important foundation for the establishment of policy, structure, accountability, and funding through which successful integration can occur.

Then we would insert the table or a box that was that slide I presented this morning that briefly stated the eight recommendations in the 2008 report.

Then we will number the recommendations and start with the first one being -- let me just scroll down here. Sorry.

The secretary should task senior HHS leaders with implementing the eight recommendations outlined in the 2008 report of the DMH subcommittee, again footnoted, that was approved by the NBSB on November 18, 2008, which are summarized in, and then the box, again, and enumerated in the appendix.

The action steps can serve as an important foundation for the establishment of policy structures, accountability, and funding and are a critical pre-condition for successful integration efforts.

So, that basically restates, in large part, the paragraph that we changed. Then the final change would be to accept the language in red that referred to -- that, in essence, added specific HHS leadership and specific federal departments to the recommendation regarding research.

DR. GRABENSTEIN: So, there would be five recommendations rather than the current -- or the original four. Is that right?

DR. PFEFFERBAUM: That's correct.

DR. GRABENSTEIN: Okay. Great. Are there any comments about this proposal?

DR. QUINLISK: Yes, this is Patty Quinlisk. You're going to put the box with the eight recommendations in twice or --

DR. PFEFFERBAUM: I think we're -- I thought we were going to put it at the end.

PARTICIPANT: We're going to put it in once, but she just --

DR. PFEFFERBAUM: And then refer back to it.

DR. QUINLISK: Yes, but I think that would make more sense because they are only going to be a few sentences apart.

DR. PFEFFERBAUM: Right.

DR. QUINLISK: Yes. Okay. Thank you.

DR. GRABENSTEIN: Any other comments? That was Dr. Quinlisk. Okay.

DR. KHAN: Khan from CDC.

DR. GRABENSTEIN: Oh, I'm sorry. Ali -- Dr. Khan -- or General Khan -- or

Admiral Khan.

DR. KHAN: Many of these recommendations actually are duplicative of the eight if you look at them. So, it sort of -- the first one, the third one, the fourth one, I can't see the fifth one, are in those original eight that we need a federal policy, we need a research agenda.

I clearly remember the research agenda, etc., so how are you differentiating the eight from the additional four? So it's sort of like these -- first amounts equals for those first four as opposed to the other four. It just should be clear because in the table, they're just going to show up again.

DR. GRABENSTEIN: Dr. Pfefferbaum, I think you all perceive them as a different set or in a different plane. Am I right?

DR. PFEFFERBAUM: Well, I'd have to go back and look at them a little more closely. Certainly, the research -- they're stated differently. The research agenda, I believe, is a duplication. I need to look at

our first recommendation.

I think while the statement of the eight recommendations, the summary statement is very similar. The content under is not, but we might want to insert language that indicates that we recognize there's some duplication. Would that be acceptable?

DR. GRABENSTEIN: Let's -- maybe we should go through them one by one. So, contemporary recommendation one of five would be go implement the '08 recommendations.

Two would be develop a policy, and I don't see a policy in the '08 recommendations at all.

DR. PFEFFERBAUM: Well, no, it's not stated that way. You're correct.

DR. GRABENSTEIN: Then empower a specific office or agency to coordinate things --

DR. PFEFFERBAUM: That's not in.

DR. GRABENSTEIN: That's not in --

DR. PFEFFERBAUM: No.

DR. GRABENSTEIN: -- '08. Then

task the leaders with developing a set of coordinated research goals is the second one of the '08 --

DR. PFEFFERBAUM: That's recommendation two of the '08 recommendations, but the '08 recommendations, I think, were much more specific. Comparable, but stated differently.

DR. GRABENSTEIN: Then the fifth of five of the contemporary recommendations is create and maintain a structure by which disaster mental health experts regularly assess.

DR. PFEFFERBAUM: That's not included --

DR. GRABENSTEIN: That's not in '08.

DR. PFEFFERBAUM: -- in the eight.

DR. GRABENSTEIN: So, there's one --

DR. PFEFFERBAUM: There's one --

DR. GRABENSTEIN: -- that may or may or may not be a duplication, and how

different or similar is it that you think it --

DR. PFEFFERBAUM: Well, I personally prefer the new statement. Let me just find that -- was recommendation two of the '08, and I think it stated differently. I think the emphasis in the recommendation in 2008 was to increase research in the area.

I think the current recommendation reflects more our concern that the federal agencies and departments develop a research agenda and that that coordination among the agencies is vitally important.

So, I think it's stated differently, and I think that the current statement probably reflects better what our current thinking is, and we did a lot of work on this to make sure we handled it in a way that would be sensitive for the various federal agencies involved.

DR. GRABENSTEIN: Dr. Khan, how's that sound to you?

DR. KHAN: That sounds fair. It

just depends on how you read the 2008 recommendations and what you implement.

DR. GRABENSTEIN: Dr. Quinlisk?

DR. QUINLISK: I think since we're already implying that the recommendations today are building on the recommendations in '08, I don't -- I think it's okay if they address similar issues because I do agree with you, Betty.

It sounds like that the -- what we're seeing now is sort of, in a way, building on the enhancing the research agenda now to saying basically having people get together and coordinate and to prioritize the research agenda.

To me, that is building, so as long as I think the paragraph where we're introducing the eight from '08 has something about it needs to be built on or enhancing or whatever.

I think that should take care of the fact that they're addressing some similar issues.

DR. GRABENSTEIN: Dr. Jones? Wait, wait. I don't think you got power on your mic.

DR. JONES: Pat, I think you're absolutely right. That first one that was done, we were just talking about the need for more research and that kind of thing.

Subsequent to that, we actually contacted the NIMHs and found out what their agendas were, and so that second set of recommendations or that second recommendation built on that in a much broader sense. So, I think that captures it.

DR. GRABENSTEIN: Thank you.

DR. PFEFFERBAUM: In addition, I think in the new recommendation one we indicate that the previous recommendations serve as an important foundation, so I think we covered that adequately.

DR. GRABENSTEIN: All right. So, are there other questions or comments about what we intend the subcommittee report to look like, the document from this morning with

revisions that'll be made based on what Dr. Pfefferbaum has just described.

Questions? Comments? Well, yes. So, what's on the screen is irrelevant at this point because we haven't gotten to that point, but that's on my mind.

All right. So, if there's no questions or comments, I will entertain a motion to adopt the modified report of the subcommittee.

DR. ROSE: So moved.

DR. GRABENSTEIN: Eric Rose moves. Second?

DR. QUINLISK: Second.

DR. GRABENSTEIN: Betty Quinlisk second. Discussion on the motion? Anybody on the telephone? Hearing none, we'll proceed to the vote on the motion, which is to adopt the modified report. All those in favor say aye.

MEMBERS: Aye.

DR. GRABENSTEIN: All those opposed say nay. We don't need to call role, do we? Or do we? They're okay? It's a majority.

The Chair recognizes a unanimous vote in favor of adopting the modified report.

So, I'll pause as chair to thank the subcommittee for lots and lots of hours of hard work and deliberation and discussion and I think we're all very pleased to be able to send this forward.

Now, how do we send it forward? At the lunch break with a few people looking over my shoulder, I drafted what's being projected, which is in really fine print, especially if you have eyes like mine.

I don't intend in this session to get the absolute wording in place, but I want to describe in general what would be the core elements of this transmittal letter, and I think the real chair is going to get us all together at the end of the meeting to talk about a few things and what we'll settle on on final wordings.

But, at the moment, it would be -- the style would be from NBSB to the secretary, hello, how are you? Then the core of the

message would be at our meeting today we adopt -- the Board adopted five recommendations on and then names the title of the report, integrating behavioral health in federal disaster preparedness response and recovery.

Oh, by the way, mental is not -- mental and is not in that title, so let's just make sure we're comfortable with that. These recommendations arise from a detailed September 2010 report of the Board's disaster mental health subcommittee, which is attached.

We'll have some sort of paragraph about why this is important, and we got hungrier -- we got hungry before we finished the final wording of what that paragraph is, so it's in italics so we're not -- we haven't settled on that, but we will.

Then the letter would go on to say in brief we recommend that the secretary, and then there would be a succinct version of the five recommendations and Eric's right; we would re-sequence them so it matches the --

DR. ROSE: Start with the verdict.

DR. GRABENSTEIN: Whatever. Fine, we will settle this later. That's a fine idea. I don't like the formatting of the paragraphs. We'll fix that, too.

But it would be a succinct clause or phrase that describes each of the five recommendations and then close with something like the Board endorses the findings of the subcommittee and acknowledges the importance and the challenges our nation faces in adequately addressing mental health and behavioral needs in disaster settings, including the unique needs of children, people with disabilities, and others with special needs. Sincerely, however we usually sign it.

So, two questions. Do we -- should the full report have mental and in its title? Should it be mental and behavioral?

DR. PFEFFERBAUM: I think it should be both, yes.

DR. GRABENSTEIN: So we would want to fix the report also?

DR. PFEFFERBAUM: Yes. We'll fix

the report.

DR. QUINLISK: So -- this is Patty. So, it's going to be integrating mental and behavioral health in federal disaster preparedness response and recovery. Is that what we're --

DR. PFEFFERBAUM: Yes.

DR. GRABENSTEIN: Okay. Then somebody, after we went off to get lunch, put some words in in red. I don't know who it was, and I don't -- we didn't do fingerprint checks. I don't care who it was, but it talks -- inserted were the words funding and lines of accountability.

That actually doesn't -- I don't see that that matches what's in the report, so I'm not sure about it and we can -- I'm not -- if anybody wants to make a comment about it or stand up for it and defend it or leave it to us to settle on later.

DR. PFEFFERBAUM: It's in that second paragraph on Page -- under conclusions and recommendations. It's in the new

languages, which says these action steps stand to serve as an important foundation for the establishment of policy structure, accountability, and funding through which successful integration can occur. That's our new language.

DR. QUINLISK: I'm sorry. That's -- I didn't -- that's going to be in recommendation number one?

DR. PFEFFERBAUM: No. That's in --

DR. QUINLISK: In the language --

DR. PFEFFERBAUM: Oh, I think -- yes, it's also captured in recommendation one.

DR. QUINLISK: Okay.

PARTICIPANT: One page previously.

DR. QUINLISK: So, that's going to be in the new number one that you read off earlier?

DR. PFEFFERBAUM: That's correct.

DR. QUINLISK: Okay. Got you. Thank you.

DR. GRABENSTEIN: So, again, structurally, I'm harking back to my

Department of Defense policy days when policy would set policy and it would not necessarily talk about budget because it would be presumably spanning multiple fiscal years, so I'm not sure how we're going to handle that, so -- Dr. James?

DR. JAMES: I also think at the secretarial level you don't want to give the impression that you're advising them how to distribute their resources and spend their money.

I think it's more important to use words that imply such things such as establish, create, etc.

DR. PFEFFERBAUM: We can live with that then. You can delete it. I point out it's in two places, though. It should be deleted in both places.

DR. GRABENSTEIN: So, I think we'll reconcile all this --

DR. PFEFFERBAUM: Yes.

DR. GRABENSTEIN: -- when we get your document up here and put the whole word

processor thing together and --

DR. PFEFFERBAUM: Great.

DR. GRABENSTEIN: -- settle on the final version if that's all right. Okay. Any other comments or -- so how was -- did we get a C or higher on the transmittal letter? B minus?

Any changes or something you saw that you didn't like or anything along those lines?

All right. So, we won't vote on the -- will we vote on the -- we won't vote on the transmittal letter. We're going to settle on that later. So, are there any other comments on the topic of the --

PARTICIPANT: I think you need to vote that you're going to --

DR. GRABENSTEIN: Oh, yes. Well, so we adopted the report, so let's vote to -- shall we --

PARTICIPANT: The report and recommendations?

DR. GRABENSTEIN: I will entertain

a motion to empower the chair -- the real chair and the executive secretary --

PARTICIPANT: With your help.

DR. GRABENSTEIN: -- to finalize the wording of the transmittal letter and, indeed, transmit it to the secretary. Would anybody like to make that motion?

DR. JAMES: I would like to make that motion as stated.

DR. GRABENSTEIN: Dr. James, thank you very much. Second?

DR. PARKER: Second.

DR. GRABENSTEIN: Dr. Parker, second. All those -- discussion? All those in favor of transmitting the recommendations to the secretary empowering the two people and transmitting it to the secretary say aye.

MEMBERS: Aye.

DR. GRABENSTEIN: Opposed nay. Unanimous. Now, any --

PARTICIPANT: No, not unanimous. Majority.

DR. GRABENSTEIN: No, it was

unanimous. There were no nays even though I didn't vote.

DR. PARKER: Well, the full board was not here.

DR. GRABENSTEIN: Of those attending, it was unanimous.

DR. JAMES: Unanimous of those attending.

DR. QUINLISK: Right.

DR. GRABENSTEIN: Yes. All right. So, before I relinquish the distinguished chair to the real chair to move on to the next item of business on the agenda, are there any other comments about disaster mental health or behavioral health?

Seeing none, thank you sincerely to the subcommittee for all of its hard work and we want to have the ceremonial changing of chairs.

DR. QUINLISK: I'd like to just thank you for -- you get to stay here. John, thank you very much. You did a great job, and I appreciate you ushering that on through and

thank you for helping this morning and doing that.

Okay. So, I think we are now through that agenda item with a great shepherding. Again, I'd like to just add my thanks to the subcommittee for all of their wonderful work and for a great report and we will, indeed, as we voted on, get a letter and send it on up to the secretary in a prompt fashion.

So, thank you, again for all of your hard work. We really appreciate it.

Okay, the next item on our agenda -- and I have now put my agenda away, sorry. The next item on our agenda is to look at the future of the NBSB Working Group Presentation.

I believe that most of the members present have been involved with this at some point and certainly have seen the letter that was put together and drafted. I think you should all have had it in your package, too, right? The draft letter.

So, the draft letter should be in

front of you. I guess I'd ask everybody to go ahead and pull that back out. As you know, we did receive a letter asking us specific questions, and we did have a charge from Dr. Lurie.

This letter was in response to those specific items, as well as some additional input from the Board. I think most people have seen this letter, probably multiple times at this point, so what I'd like to do right now is go ahead and open up the Board to discussion of this letter and how we now are going to proceed with this letter.

So, I would like to go ahead and open it up for any discussion. Go ahead, Ken.

DR. DRETCHEN: I guess I would just say, I mean, many member -- all the members present as well as the members who are not able to be here today have gone through and massaged this letter on numerous occasions.

This will probably be the fifth or the sixth time that we've looked at the same letter, and it still reads the same. So, I

would -- I'm sure that everybody will urge adoption.

DR. QUINLISK: Okay. Yes, we -- I will just say for those people on the phone, et cetera, who may not have seen the draft that was sent out as prior to this meeting, it has not changed, I don't think at all. It certainly has not changed substantially since the original letter was sent out. So, I think you're right, Ken.

Any other comments, suggestions, discussion? Go ahead, John Parker.

DR. PARKER: For those that weren't intimately involved in not just the construction of the letter but the construction of the content, I just want to say to the people that are in the room and those that are listening on the telephone that the debate and prioritization of a lot of issues and then the condensation of those issues is represented in the letter.

Although a lot of things went up on yellow stickies, a lot of things were taken

off the wall and thrown on the floor or consolidated into bigger areas that are in the suggested short-term priority areas or the long-term priority areas.

This letter -- the work group and the letter was constructed predominantly from looking at source documents in the HHS about their strategic plan and also some comments that were made by ex officios and people actually in headquarters HHS.

So, the letter that's drafted and in front of you today is not an out-of-the-blue letter. There's significant work behind that letter with significant discussion and significant shuffling of ideas about what the work ahead should be for the board just to give people a snapshot that this wasn't just a letter that someone sat down and wrote. It has a lot of history behind it.

DR. QUINLISK: Thank you, John. It certainly doesn't appreciate all the work that went into it because there was -- as people probably know, there was a meeting as well as

lots of discussion prior to the formation of this letter and the recommendations.

Seeing nobody else in the room, let me ask the operator if there is anybody on the phone that has any comments or discussion.

OPERATOR: At this time, if you would like to ask a question, please press star then the number one on your telephone keypad.

At this time, there are no audio questions.

DR. QUINLISK: Okay. So, I'll ask for a final time, are there any other comments, suggestions, discussions, on this letter? Because what we are going to go to then is a vote on whether or not to approve this letter and send it on forward to the secretary.

So, final call? Go ahead, John.

DR. PARKER: John Parker. I hate to be kind of a rapporteur, but for the folks who had never seen that letter before, in the last two paragraphs we do talk about the

nomination and the process for revitalizing -- that's a bad term -- well, revitalizing the Board or having Board turnover, and when the original charter for the NBSB was written, I don't think it was envisioned that it would come so quickly on the new Board with so many people being -- meeting their what I would call their obligation and years on the Board.

What that whole paragraph kind of says is that we don't want to have so many people leave the Board that it becomes dysfunctional and there's other ways to do it so that the Board maintains a continuity and has function. That's why we talked about that nomination process and set that into the letter for people to be thinking about.

DR. QUINLISK: Final call for comments, suggestions, discussion?

CAPT. SAWYER: No, but we had the agenda posted, so what we're discussing here is that we did have it posted that there would be a public comment period between 2:30 and 2:50 this afternoon, so whether we need to

wait for that time, it's -- so, I don't know. Do we have many people on the line?

MS. VRANNA: There are four public and then one speaker.

CAPT. SAWYER: So, unless there -- we can ask one more time whether there are any people on the line that would like to make a comment on this working group report letter to the secretary and we'll wait to see if there are any comments and then we'll proceed.

OPERATOR: At this time, if you would like to make a comment or ask a question, please press star then the number one on your telephone keypad.

DR. QUINLISK: Okay, well, hearing no other comments and seeing no comments needed in this room, what I'd like to do is see if we are ready to go ahead with a vote and the vote will be on whether or not to approve the letter as it is written for sending -- formally sending it up to the secretary as our response to the questions and some of our recommendations for both the

subcommittee and the Board process.

So, do I hear any -- what's the word? Motions? Thank you. Do I hear a motion to send the letter on to the secretary?

DR. ROSE: So moved.

DR. QUINLISK: Eric Rose -- I'm sorry. Moved. Thank you. My mind -- motion -- sorry. Okay, do I hear a second? I got that part right.

DR. CARLIN: Second.

DR. QUINLISK: Okay. We have two seconds, John and Roberta, so what I'd like to do is go ahead and just take a voice vote. All those in favor say aye.

(Chorus of ayes.)

DR. QUINLISK: All those opposed? It passes unanimously for those who are present. Thank you very much. We will get that finalized, signed, and sent on up.

Okay. Well, we are going through our agenda a little bit faster than expected, but I think that's just fine. One of the things that we wanted to go ahead and go to at

this point is to talk about our next steps, both for the Board -- I'd also like to open it up for issues or topics that we would like to have updates or briefings on, etc.

So, I think what I'd like to do is just open up this next section sort of very broadly and solicit people's thoughts, advice, and issues that they would like to see for our next steps. So, I'd like to just open it up now and I think -- see if anybody's got thoughts.

We actually had a few thoughts over lunch as we were eating our sushi, so we do have a few things that we can add, but I'd like to see what other people have first just in case there's other ideas out there.

Jim, you look like you're -- you got something to say.

DR. JAMES: No.

DR. QUINLISK: Nothing?

Okay. The two Johns have thing -- John Grabenstein.

DR. GRABENSTEIN: Grabenstein

first. Well, the logical thing to do with the future of the NBSB stuff is start working on the things we think are appropriate for the future of the NBSB, so --

DR. QUINLISK: Right. As we --

DR. GRABENSTEIN: You know, at-risk populations, community resilience, e-health technologies, FDA engagements, health security workforce, Biennial Implementation Plan of the National Health Security Strategy. NDMS is one that makes sense to me in terms of recapping past recent disasters, emerging infectious diseases, medical counter pressures, strategic planning, distribution of dispensing plans, so those would be my ideas.

DR. QUINLISK: Okay. Okay. I hear you, and then I think I'll let John Parker give his comments.

DR. PARKER: Well, John sort of went over the whole thing.

Over the last few weeks, HHS and the ASPR have been working very, very hard with the recent Gulf oil spill. There's a lot

of things that could come out of that about what they learned about where was there good community resilience and where it was bad, what made the differences, and so my feeling would be to kind of focus in on community resilience and look at a recent kind of broad-spread disaster and maybe at our next meeting we could get folks from ASPR to tell us what they saw and what they learned and then move from there as to some way about what are the grip holds on the moving car about community resilience.

DR. QUINLISK: Okay.

DR. JAMES: Now I'm ready.

DR. QUINLISK: You're ready? Jim --

DR. JAMES: I am ready.

DR. QUINLISK: Take it away, Jim.

DR. JAMES: Take it away. Anyway, I don't like to a hundred percent agree with John, but I hundred percent agree with John. I think resilience is going to be one of the absolute major struts going forward, and it's

really going to come out of the work in the Gulf.

The only thing I would recommend as we look at the other what I see as emerging major strut and that's e-health technologies and their applications and also in the Gulf itself. It was just absolutely fascinating. The role of things like Facebook in bringing data, which was more timely and just as accurate as official data.

When you go into the experience in Haiti without the application of e-technologies, a disaster would have been a mega -- it was a mega disaster, but it would've been even worse.

I really think that is going to just by necessity be one of our major focuses, and I think in combination with resilience -- and they really do go together. E-technology is possibly the best way to generate resilience, and so that's where I think if you had to pick a one and two, they would be mine.

DR. QUINLISK: You may go ahead,

John.

DR. PARKER: Goody. The other things that came out of the Gulf was that we learned that we wanted some information that wasn't available. In other words, there were gaps in science, and so as we look at that whole thing, I think we want to look at -- we're looking back at this disaster already and we see gaps.

How can we focus our research in the future so that we reduce the amount of gaps when we talk about human health when it's interacting with our environment?

DR. QUINLISK: Jim, I'm going to go back to you and ask you do you have specific topics, people that you're thinking of on the e-health technology that you think would be useful for this Board to hear from?

DR. JAMES: Yes. I'm sorry. Absolutely. I mean, I'm not ready to go identify right here and now, but I've been at a number of meetings and presentations where these things have been put out in a very data-

driven -- not bench-top research level, but certainly in an epidemiological and behavioral science research level and we could -- yes. The short answer is yes.

DR. QUINLISK: Okay. I'm going to -- I see you, Eric, but one of things that we discussed over lunch was, and I think it sort of gets to what you're talking about, Jim, too, was the whole issue of how to communicate risk, how to do that effectively, quickly, etc., and I think that that, though it's not exactly what you're talking about, obviously those two topics very much meld together and so I'm wondering if maybe we could find somebody who could not only address or a group of people address sort of the use of e-tech and things like that for communications, but also to get people to talk to us just about this new age of communication, how to best use it, etc.

One of the things that we sort of discussed was with the H1N1 vaccine, there was so much misinformation out so quickly that one

of the things that I would be very interested in is how do you address risk communication from the standpoint of getting your word out faster.

If you're behind the ball, how do you correct misinformation, etc., which isn't, again, exactly what you're talking about, Jim, but I think the two items would very easily mesh and we might have people who could have thoughts on both sides of that.

DR. JAMES: I absolutely agree, and again, so much of that came out not just in H1N1 but strikingly in Haiti.

One resource I would identify that we can go to is National Library of Medicine, and they've been involved in two broad initiatives. One is what I will call the gray literature.

So much of what we talk about as research observational studies, etc., in the areas of preparedness and response do not appear in peer reviewed journals. They're in a body of work out there termed the gray

literature.

It's like Wikipedia almost, and it is very effective and very good. The other thing they have is from -- sponsored by the National Library of Medicine is the area of e-health technologies and their application to preparedness and disaster.

Some of the presentations that I was able to be at were by individuals who actually responded to Haiti under the umbrella of that National Library of Medicine.

So I think -- and last thing I want to say, I think you're absolutely on target. I believe personally we need to stop separating communication from e-health technologies because they all wrap up the same way.

It's really important that the communication doesn't always get looked at in a unidirectional way. It has to be bidirectional, and that can be a whole new world of surveillance and assessment for us.

DR. QUINLISK: Eric?

DR. ROSE: Just to amplify the communication theme, though. I think -- e-health, I think, addresses more of the issue of the channels of communication. I think the content and validity of the communication and effectiveness of it, I think, is also something that belongs in our purview.

The other thing I wanted to add, we spent a lot of time last year on the MCM review and when we had our meeting to -- over the summer to plan this, we really didn't have the report.

I think it's worth spending some time to digest the final report and to have our own, I think, final discussion on that because we spent so much time on it to begin with. To leave that loose, I think, makes no sense.

DR. QUINLISK: I think you're right. I'm wondering is there anybody that you would recommend that we would ask to come for sort of a -- more of a formal response and what's going on now that we approve that and

send it out.

DR. ROSE: I think George Korch.

DR. QUINLISK: Okay. Okay. So, I think it would be nice -- so often I think we send these things out into Never-Never Land and don't know what happens with them and it'd be nice -- yes.

Tell us what happened. Okay. Thank you.

DR. JAMES: One last comment because I think it's partly an answer to your question. Within the IOM forum, we're very much looking at the possibility of having an e-health workshop which would include the kinds of applications that Eric is speaking to, as well.

So, that would be another potential bridge for the NBSB to focus on these particular areas.

DR. QUINLISK: Thank you, Jim. Ken?

DR. DRETCHEN: Yes, Eric -- one of the two topics I want to talk about Eric had

already mentioned, which is we spent so much time on the contra medical report -- I mean, a lot of people spent a lot of time on that report and the fact is in a sense we got an answer based upon the document that we received, and I think it definitely is worth some time for us to think about what the report says and how it jives and was in discordance with what we had proposed.

The second area was one of what I consider is unfinished business, which is where are we now with the med kits? That is -- I guess there has been more field trial out there with it.

I don't know about the issues about Cipro and doxycycline in adult versus pediatric dose formulations, etc., like that, and I think Boris might be a good individual to kind of bring us up-to-date in terms of that as a quick report.

DR. QUINLISK: I agree and might get something from Ali over there, too, on where we stand with the application of med

kits and if there has been some new research and things like that, too, so I think that would be a nice one.

We've heard so much about it for a while and then it seemed to sort of -- with H1N1 sort of go to the background and it probably needs to be brought back out to the light again, too. So I think, Al, you were next.

MR. DI RIENZO: Al Di Rienzo. So, first of all, to all my colleagues on their e-health comments, I'd just like to say thank you.

But, what Dr. James was saying on preparedness and response for e-health, so e-health, I think, absolutely can address those things that Eric was talking about, but it's sort of holistic in the sense that it gets into content transport mechanisms, data integrity, so it can be tracking patients from first contact through the system.

So, it just depends on how big you want to make it or do you want to get some

focus. Maybe it's community resilience component first, but anyhow, I think that it can address a lot of the things both on a medical countermeasure side, on things with community resilience, and I think it is important for us to take on.

DR. QUINLISK: Well, certainly, in the report that we just approved from the mental and behavioral health issue, they did talk a lot about the need for communications and how important that is for having resilience and just for information and knowing what's going on in your community, which sort of brings up another issue that we talked about with Ali and that is if you will remember, we had -- at the time that we set up this Board, there was also a biosurveillance issue that was brought up, which sort of gets back to a little bit of what you were talking about, Al, too.

There was a committee set up, and I can't remember exactly how, but it was under CDC to specifically look at biosurveillance

and those issues and we did have a couple updates on that, but I think we would like to, if the Board approves, maybe ask for another update to find out where it's going.

I think, too, it'd be interesting to know where biosurveillance stood, too, in doing surveillance for some of the mental health issues in communities either before, during, or after a disaster.

So, I'm not sure if that's something that they're looking at in that committee or not. So, I think that'd be -- that would mesh quite well with some of these other issues, and I think we -- I don't know which one of you were first. John Parker?

DR. PARKER: I agree about the biosurveillance, but I think we're going to be disappointed in what we hear. But, the -- hopefully not. I just wanted to add on into the comments of Jim and Al and Eric that we look at a disaster and we look at the risk communication and nine times out of ten the groups that look at that look to how do you

eliminate the noise?

How do you allow the good stuff to come through? Well, if you flip that hourglass over, we probably should look at it how does an individual survive in a multimedia environment when they're hearing so many things? What mechanisms can they learn to sort that out as an individual?

DR. QUINLISK: Thank you. I think that's an interesting concept, but I think a very important one. Roberta?

DR. CARLIN: Well, thank you for what you said because it was -- I was sitting here thinking the same thing, but I just -- I wasn't on this working group, and I just want to applaud the working group for identifying as number one under the structure and priority areas the at-risk populations and how these characteristics impact preparedness in emergency response, and as I thought about it -- and I, of course, have seen this prior to today -- I really see how the whole community resilience and even the individual resilience

piece kind of fits together and that also fits together quite well with the whole area of e-health and technology.

So, though the priority areas are enumerated, there is a tremendous overlap and then been thinking about the report that was issued today and thinking about the individual resilience and how that plays into preparedness, particularly for at-risk populations, I think there's -- I think we're on the right track.

DR. QUINLISK: I'll just interject. Yesterday, there was a -- or the day before that, there was a whole report that came out about the use of texting by the deaf community changing the way in which they do their communications.

I think that sort of gets to both issues, of communication and the use of technology for that communication. So, I think there's some very interesting things we can learn along those lines. Al?

MR. DI RIENZO: Yes, just two quick

comments. One is, yes, even if you look at things, which have been out there for a while now, things like Second Life and other sites where people who are dealing with disabilities, it's sort of the way they communicate and how they socialize.

It's how they get information out even on different disease states and how were they treated and what sort of success there is with those types of things, and I do believe -- and John made me think of this and actually Roberta, John and Ken and I were having some discussion of this at lunch -- I think we need to consider when we're talking about communications and when we talk about presentation of information, how do you make sure you're getting alarms and responding to those alarms or taking the correct course of action as we need to bring a human factors component into the things that we do, especially when you start talking about e-health.

You've got to bring in that

computer human interface, the whole ergonomics, and how data's presented and so forth.

DR. QUINLISK: I'm going to just inject a personal note here. A couple years ago in Iowa we had a bear that we thought was rabid at a petting zoo, and we went back to find out how people found out that they had been exposed to a rabid bear.

Even though it was on the TV, the radio, the newspaper, etc., somewhere around 85 percent of people found out from another person. It was not our use of the usual ways of communicating, and I would guess that today with things like texting and all of that, and Twitter, that today it would be even a fewer percent would find out about it through the typical routes of communication.

I think that gets to your point. How do we use that to the best advantage to getting information out especially, I would think, in disaster settings where some of the typical ways of communications are not working

as well as they would normally.

So, I think that's very good. Did you have another comment, Roberta?

Okay. Well, I'll just say it sounds like there's a lot of issues around communications, use of technology, and all of that, so I think that will be something on our agenda for our next meeting, hopefully, and we'll see about trying to get appropriate people to talk about that, so I would just like to request that the Board, if you have specific people in mind or specific topics, that there might a person or a group of people who would be appropriate to ask to talk on that comment, if you could let the staff know because I think that we might be able to put together a really nice session talking about all these issues.

The thing we have to keep in mind, of course, how do we then integrate that into us coming up with identifying needs, actions need to be taken, recommendations that we would need to send on to the secretary, so we

need to keep sort of that balance in mind.

Leigh, did you have something?

CAPT. SAWYER: There may have been some ex officios that wanted to comment. I guess -- was your card up, Ali?

DR. QUINLISK: Yes, I didn't mean to exclude you, Ali. Please.

DR. KHAN: This was to pick up on your comment about the med kits. There's a number of activities currently in the interagency arena looking at medical countermeasures and alternate methods of deployments and also around bio security and bio safety, so I'm not sure about the full remit of this Board, but there's a significant expertise on this Board that you may want to look at how the federal government is going to address some of these, many within your communities, and provide advice back to us on the best way to do so.

DR. QUINLISK: Let's open it up for -- let's see if there's comments from any of our ex officio members. Any topics

specifically on communication or on some of these other issues that we've talked about?

Let me -- I think we have some people on the phone who are members, right?

CAPT. SAWYER: Is there anyone on the line that would like to make comments? The Board members in particular?

OPERATOR: At this time, if you would like to make a comment or ask a question, please press star one on your telephone keypad.

At this time, there are no comments or questions.

DR. QUINLISK: Okay. I think what I'd like to do now, though, is bring, as John Grabenstein suggested, back to us looking at the areas that we have identified as priorities and see if there are some drill-down issues within these things.

Let's look at the first -- the short-term priority areas and see if there's issues or people we would like to have to give updates, etc., on some of these things. We

talked a bit about the at-risk populations, community resilience, especially with communications, e-health.

Really have not talked much about the FDA engagement and being from the great state of Iowa where we've recalled a gazillion amounts of eggs. This has been an issue, obviously, that I've been dealing with, just the whole issue of food safety.

So, is there things here that we would like to ask for updates on or topics to be brought to the attention of the Board? Go ahead, Leigh.

CAPT. SAWYER: I was just going to make a comment that currently our next scheduled meeting is for April 2011. We do expect that there will be a meeting in December, and the dates for those of you who do not have those it's April 28 and 29, 2011 and then September 22 through 23, 2011.

DR. QUINLISK: Could you say those again slower?

CAPT. SAWYER: Oh, so that -- yes,

they're far advance.

DR. QUINLISK: Okay. So, repeat those.

CAPT. SAWYER: Okay, April 28-29, 2011, September 22-23, 2011.

DR. QUINLISK: Okay, but you say there's also probably a meeting in December?

CAPT. SAWYER: Because the rotation in the Board, the terms of appointment for those Board members that are rotating off, is 12/31/2010, there may be a meeting called in December, but that has not been set yet.

So, at this time, at least it has been our precedent that we've awaited a letter from the ASPR or the secretary asking the Board to take on a particular topic. So, I just wanted to bring to your attention that the next public meeting is not for sometime in advance of this date.

DR. QUINLISK: Let me ask you, Leigh, given my discussions with Lisa and others and particular interest in community resilience, which, obviously, sort of overlaps

with the discussions we've had here on communications and e-tech, do you think there would be a possibility for having a meeting, say, in December on these issues?

CAPT. SAWYER: Yes, I think there could be, and I think it just awaits the acknowledgment of the ASPR as to what really she wants this Board to take on, and we could also have working group meetings.

We could have a public teleconference. We can use some of the venues that we've used before to have meetings before our scheduled meetings.

DR. QUINLISK: Well, let me ask you this. It sounds like everybody is very interested in the very broad issues of communications and use of e-technology and all of that.

Let me open this up to the Board and ex officio members. Do you think this would be something that would be most appropriate to first put together a working group on, have the working group identify

issues, talk to people, whatever, and then bring to the Board other issues?

CAPT. SAWYER: As you remember, the disaster medicine working group did put together a task force, a telecommunications task force, telehelp task force, and, of course, Al could speak to that and John Parker, and Ken, I think you were involved, but one of the risks is that if the Board goes on to do things that they want to do but is not necessarily what the ASPR or the secretary is particularly hoping this Board will address, since we do have an ONC, the Office of the National Coordinator for telehealth or IT, I'm not sure where we want to share the path with that particular office.

DR. QUINLISK: Okay. Do Al and then Jim?

DR. JAMES: I just -- I mean, this is me talking, but what we're talking about here in e-health goes way beyond what we started under telehealth. If you remember why we got so bogged down in telehealth, it was

for lots of good and some not so good reasons.

I really think we need to take a -- not being able to get the information and a few other snags. I really believe e-health is much more comprehensive, will not have the same kinds of security constraints and governmental constraints that we ran into under the more constricted telehealth.

So, I would recommend a fresh start.

DR. QUINLISK: Let me -- so, Jim, what you're suggesting is sort of revamping it and putting together a slightly different working group with a slightly different focus? Okay.

DR. JAMES: Yes.

DR. QUINLISK: Al?

MR. DI RIENZO: Just a comment related to the item four under the short-term concerning FDA. I believe if we do take on e-health in whatever manner, whether it's the broadest sense or very focused, that we're going to need to get folks from the FDA

involved because I will tell you science and technology is not going to be the challenge.

It's going to be regulation. It's going to be law. It's going to be those things that -- how can you truly leverage the power of what e-health can bring? So, there's plenty of demonstration projects out there that show that these things work.

They've been out there for 10 or 15 years; John can attest to that and Jim can attest to that, but so I would think we would want to engage the regulatory folks in that type of discussion and how can they help make those tools quickly utilized and available.

DR. PARKER: It may sound a tiny bit bizarre, but we're not teenagers on the Board. I think it would be really good to have some teenagers come in and tell us how they communicate and what do they do to bring attention to certain messages versus other messages, and I think it would be valuable to me because --

DR. QUINLISK: That was John

Parker. Go ahead.

DR. JUTRO: Peter Jutro. Hi. Your question was kind of what -- how should we move forward on communications and 90 percent of the answers so far is how we should move forward on telecommunications or e-health.

So, I was wondering if you could clarify your intention, if you, in fact, have one yet, on what the relationship is between communication content and communication modality.

DR. QUINLISK: I think that's a very good point, and I think Jim sort of said that earlier. Communications can include a lot of different things. Electronic and technology is just one mode of communication, and I think that's something that we need to think about.

I think -- I'll just personally -- my thought here is if we're talking about community resilience and use of communication to enhance community resilience, we're not going to be just talking about one mode of

communication.

We're going to be talking about every single possible mode of communication that's necessary to get to whoever we need to get to. Jim?

DR. JAMES: Just to underscore that and sort of address that and talk about some of the regulators and all of that, communication today -- and like John asked the question before about credibility of the spokesperson, and the fact of the matter is the information that's on Facebook and those kinds of places, that's where people are going.

That's what they consider credible information. The amazing thing is when you really look at it in any kind of a study evaluation kind of mechanism, when you look at the large numbers, there are over 500 million people on Facebook alone. The truth wins out.

DR. QUINLISK: Well, I think it'd be interesting just along those lines to have somebody who is in the communications field

who uses it whether it be at HHS or CDC or whatever and ask them do you use Facebook? If you do, how do you use it? What is the method? What kind of impact has this had?

I do know that during H1N1, there were a lot of people using Twitter, but I have no idea how good it was and what the response was. Go ahead.

DR. JUTRO: I was going to say that we've had a fair amount of experience with academics in departments and universities that have done a lot of work on electronics and crisis communication and other faculty members in these -- I don't want to say which ones I'm thinking of right now -- have had experience in this area.

So, this might be a wonderful opportunity if you do end up creating a subcommittee to bring in a speaker or two to inform us if precisely -- rather than us trying to identify teenagers to bring in, there are people who've actually made their living and got their tenure studying this kind

of stuff.

Some of it's absolutely fascinating. I've had my eyes opened a couple of times by what I've learned, and I'd be happy to share some ideas of who might be good people to talk about who to talk to.

DR. QUINLISK: That would be great because I think there seems to be a lot of interest in the subject, so I think we would like to solicit from everybody possible speakers and topics. Roberta, did you --

DR. CARLIN: Well, I kind of had a thought, but yesterday there was -- here in Washington, there was a planning meeting for the CDC for the National Center on Birth Defects and Developmental Disabilities. Their ten-year anniversary's next year, so some of the CDC people, leaders actually, came down and some of us in the disability community met with them.

We basically discussed communication and trying to develop a series of events and whatnot for 2011, but the whole

idea of the use of social media, and they have a name for it, trans-media, incorporating all the different types of communication methods.

It was really quite interesting how many of the organizations and the federal government is using Facebook and Twitter and YouTube and -- now whether or not -- I have not seen these methods and the quality of information and if this has all really been under any scientific review and looked to see in terms if any of it's really been evaluated and measuring of the outcomes, but it is here to stay, and so -- and there are people down at CDC and I'm sure in other agencies in the federal government that are utilizing these methods.

So, I think it's certainly worth exploring.

DR. GRABENSTEIN: I was just going to endorse Peter's comment and maybe would do HHS a service if we organized a workshop or a public session, whatever, to hear from the academics who study it, but also maybe the

hearing impaired community as one example and if there's specific cases where the disability community has taken advantage and hear their stories and hear the analytics and bring it all together into a common session.

DR. QUINLISK: I'm still going to look at Leigh here. I think probably these are -- the things that we're discussing right now are sort of overlapping the three of our short-term priority areas that we have identified.

So, maybe the thing to do at this point is to go back to Dr. Lurie and say we have had a pretty robust discussion. There's a lot of interest around the areas of communications, community resilience, use of communications, types and modes of communication, and we're thinking of how to address this and then solicit some feedback and then maybe bring that feedback back to this group on what would be the her or their response to that.

I've heard a couple things; a

working group we could put together, a workshop could be put together. There's a lot things here, I think, that we could possibly do, but I think you're right. The bottom line is we need to get this letter sent on up the chain and then say here's some of our right now, concerns and interests.

What would be the best way of integrating their needs with our interest. Does that sound --

CAPT. SAWYER: That sounds good. I would expect that we will get a response to this letter, and I think this dialogue helps to start to think about how we might respond if we are asked to address any one of these and perhaps there'll be more opportunity for us to suggest other areas.

I do know that the information that Ali Khan shared -- there is a lot going on with the personal preparedness, the federal -- it's actually the federal response to the directive that was -- which was, I guess, assigned to HHS for the response.

The federal -- what was the -- the department is responding to a directive about how to engage and how to get prepared antibiotic packages, med kits out through the postal service. This is something that Ali was referring to, as well as other ways that we can help prepare the population for a response.

So, we have not been involved as a Board in those activities.

DR. KHAN: It's an executive order.

CAPT. SAWYER: Executive order.

DR. QUINLISK: Well, and I think we would need to say we're interested in this and what are the areas in which you need our feedback and our guidance on and our advice, so I guess what I would -- oh, Roberta? Go ahead.

DR. CARLIN: I just had one thought, just following the flow of the conversation, when we list here as enhancing community resilience, is there any reason that individual resilience was not part of that

phrase or as the working group put this priority list together, is individual part of the community? Is that what you were all thinking?

DR. QUINLISK: Yes. I think we all agreed that with individual resilience, you have community resilience, and therefore, the two are very much linked. Because there was discussion about particularly the at-risk groups and things like that that obviously all of that would need to be addressed to truly have community resilience.

DR. CARLIN: Okay.

DR. QUINLISK: Let me just say I'm looking at my list of all the things we talked about here, and I really -- so many of them overlap with the community resilience communications, etc., that I think, if it's all right with the Board, what I will do is work with Leigh, get the letter sent up to the secretary, talk to Dr. Lurie and Lisa, and come back to the Board with sort of their thoughts on what would be most useful to them

given our discussion here today and see about what would be the best way of putting together our response.

I think this is an area that we might be able to have some really good input to us from and yet then turn around and get some good advice back out. So, does that sound like a plan?

I think at this point we really can't make decisions until we get some feedback. Does that sound all right?

Okay. So, I will do that on sort of the communications/community resilience areas, but let's go back and talk a little bit more. There were some areas here that weren't sort of in that area, some issues, and I just want to make sure we're not going to have other issues that are out there that we feel that we should address that we have not yet discussed, so I'd like to open it back up for discussion again for other topics or issues that the Board might take on. Jim?

DR. JAMES: Just -- I worry when we

get too much of a shotgun out there for two reasons. Number one, it dilutes the efforts from the primary focal points, but number two, you've got have a -- in this arena, you've got to have a reserve, a flexibility.

We don't know what's going to be on the screen tomorrow or what's going to be most important, and I'd hate to be so bogged down with things that we really lose our flexibility.

DR. QUINLISK: I would agree, Jim. Thank you. John?

DR. GRABENSTEIN: I'd like to pull the last -- or point out the last one on the list, which is the adequacy and integration of the distribution and dispensing plans, and that's -- when we did the mega MCM review document, I mean, that was the point where we had to declare too much -- enough -- we've run out of time.

It's an elephant that needs its own review and maybe it's -- maybe HHS, CDC, ASPR is not yet ready for us to do this because I

know there's a variety of - Monique Mansoura is doing some stakeholder input sessions and the like so they may not be ready for us to tackle that one, but I'd like maybe for the dialogue to include whenever you're ready, let us know, but it's something I think is a huge thing to be worked into the workflow at the appropriate time.

DR. QUINLISK: Yes, Al?

MR. DI RIENZO: John, just a quick question on that one. Do you see as part of that there being an educational and compliance component, as well? Sort of so you get the dispensing and then sort of the follow-on to that?

DR. GRABENSTEIN: Yes. Distribution and dispensing is actually the shorthand for -- there's a concluding step, which is the adherence piece and it gets to some of the behavioral health stuff we talked about today. It's not just getting the tablets in the little bottle in the person's pocket.

They've got to consume then so it's got to go all the way to the end, the end consumer.

DR. QUINLISK: Let me ask you, John, are there things that you think we could learn out of the H1N1 distribution of the vaccine that would address some of these things or has that sort of been done and over?

DR. GRABENSTEIN: I'm sure we could learn from it, but there is not -- there was not the time acuity, in my opinion, in fall '09 that you would have if you had to get an antibiotic in the hands of everybody in Des Moines tonight.

So, I think that it'll teach us some things, no doubt, but it's -- there's more to it.

DR. QUINLISK: Oh, yes. I guess I'll ask the members of the Board again to look since were just talking about the long-term priority areas, maybe just take another look at those long-term priority areas and see if there is anything that you would want us to

address in the near future.

I'll just -- while you're looking at that, we've talked about the med kits, and I think that goes hand-in-hand sort of what you were talking about, John, with the distribution and dispensing plans.

We also talked about the biosurveillance system, so those were pieces -- oh and then the MCM update and response. All the rest of them were sort of around these things with communications. So, Randall, did you have something you'd like to --

DR. LEVINGS: Yes, just a question on the long-term. It includes commenting the Biennial Implementation Plan for the National Health Security Strategy. My understanding is the comments are -- I mean, they're closed to the public for the first draft. There's going to be another draft.

Then it's probably going to final. So, was -- I don't recall; I was part of the discussion, but I don't recall, did this group want to comment the draft before it goes final

or did you want to comment the final as far as okay, that's pretty broad. I think you ought to do this, this, and this to make that happen?

CAPT. SAWYER: That actually is a good point. The comment period for the Biennial Implementation Plan is closed, so I think we probably have had that in there earlier.

We may want to amend the letter to remove that or at any point we could comment on the National Health Security Strategy parts of it. I don't know if Ali wants to talk about the distribution and dispensing portion of that implementation plan.

I know that there is some discussion. I don't -- I know you're new to your position, so I don't know how much you've been involved, but there is some aspect of the BIP which involves this part which they haven't completely written yet for how they will do the implementation of the dispensing -- distribution dispensing portion of that

plan.

DR. KHAN: In what form and what context? Do you mean at the next Board meeting?

CAPT. SAWYER: No. It has to do with what the department's doing with that BIP and how they want to still respond to different chapters, whichever chapter is going to involve the distribution dispensing portion of it.

DR. KHAN: Which is currently in process and review and clearance.

CAPT. SAWYER: Okay. So, maybe they've added -- this has been going through quite a few reiterations, and I think there are portions of it that had not been complete, and I think that was one they wanted to spend more time on.

But -- so that was just to get back to John's point about are we going to have input on that? There might be some time later where we'll have more opportunity to discuss and be part of those discussions.

DR. KHAN: I would queue this up for your conservation with the assistant secretary. Again taking -- I heard a couple of comments about what is within your remit and what you would like to focus on, so I would just bring that up with her and say this is important to us or what priority it is and have her schedule the appropriate brief for you by the appropriate people.

DR. QUINLISK: I think -- take a second and get back to the comment about do we need to modify the letter. I would just suggest since we use the Biennial Implementation Plan just as an example and we've already approved the letter that we just let it stand, if that's all right.

We're just using it as an example. That's all right. Okay. Okay, other topics or issues that people would like to see us maybe focus on a little bit for possible action?

Why don't we go ahead to the telephone then and make sure that they have an

opportunity to talk and add their comments. Operator?

OPERATOR: At this time, if you have a comment or would like to ask a question, please press star one on your telephone keypad. Again, that is star one.

DR. QUINLISK: I'm sorry, operator. I don't understand? Were there any comments, operator?

OPERATOR: Yes. Your first question comes from the line of Nick Cavarocchi.

DR. QUINLISK: Okay. Go ahead.

MR. CAVAROCCHI: Hello?

DR. QUINLISK: Yes, please. Go ahead.

MR. CAVAROCCHI: Oh, no. I don't have a question --

DR. QUINLISK: I'm sorry, you're breaking up so much we're not being able to understand what you're saying.

OPERATOR: He has withdrawn his question.

DR. QUINLISK: Oh. Okay. Thank you. Okay. I guess we're sort of getting to an end here. Let me one last call for any comments, suggestions, ideas?

I think then, Leigh, you had something you wanted to -- go ahead.

CAPT. SAWYER: Yes. I wanted to be sure to give special recognition to the NBSB staff and two of them walked out the door before -- I hope that they'll come in, but in particular, Brook Stone has served as executive secretary for the Disaster Mental Health Subcommittee and spend an extraordinary amount of time and effort to pull together the subcommittee's activities and reports and scheduled all of their calls.

She also served as the executive secretary for the Future of the NBSB Working Group. I certainly want to be sure that she's recognized for that.

In addition, we have outstanding staff in MacKenzie Robertson who has provided all the logistics for all the meetings and

this, again, is a very successful meeting. I appreciate that very much.

Don Malinowski has provided his golden contributions, both with the phone and others, in trying to organize these meetings.

Then Jomana Musmar, I wanted to thank her, as well. She's one of the contract staff that we're hoping to bring on, but she's providing quite a lot of behind the scenes work, that will come forward I know in the next couple of meetings. So, thank you all, and that's all.

DR. QUINLISK: I would like to ask the members of the Board if you would stay for a little while afterwards. I want to just do a little bit more wordsmithing on that letter that we are going to be sending up with the report from the mental health subcommittee.

Let me just ask, do we need to say anything about tomorrow?

CAPT. SAWYER: Oh, no. There is an administrative meeting tomorrow. It's the review on the ethics and also on the security

clearance. Eight o'clock.

DR. QUINLISK: It's in the Wisdom Room.

CAPT. SAWYER: You've got to get your clock right.

DR. QUINLISK: One final call for any comments or suggestions from anyone. Brook, you're just coming right back in the room after Leigh said so many very nice things about you, but thank you very much for all your work, particularly on the mental health subcommittee. We do appreciate it.

Okay. Well, then if there's no further comments, I will declare this meeting to be adjourned. Thank you very much, everyone.

(Whereupon, the above-entitled matter was concluded at 2:32 p.m.)