

COUNCIL OF REPRESENTATIVES

August 2 & 4, 2017

DRAFT MINUTES

I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its February 24 & 25, 2017, meeting.

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) Council voted to approve forwarding the following Bylaw amendment to the Membership for a vote (bracketed/strikethrough material to be deleted, underlined material to be added):

ARTICLE XIX

Dues and Subscriptions

1. The basic Association dues to be paid annually by Members and Associate members shall be determined by Council and shall include subscriptions to such publications as may be determined by Council. ~~[In addition to the basic dues, each Member shall pay a fixed amount, to be determined by Council, for each Division over and above one to which the Member belongs.]~~
2. The annual fees to be paid by International Affiliates, High School Teacher Affiliates, and Student Affiliates, and the publications of the Association to which they shall be entitled, shall be determined by Council.
3. Nonpayment of dues for one year shall be considered as equivalent to a request for resignation from the Association.
4. ~~[There shall be made available to each Division a fixed amount, to be determined by Council, from the dues paid by each member of the Association who is a member of that Division.]~~ A Division may require ~~[additional]~~ dues of its own members.

Council also voted to approve amending APA's Association Rules to become effective if and when the above Bylaws changes are approved by the Membership (bracketed/strikethrough materials to be deleted):

210-12. DIVISION DUES AND ASSESSMENT

210-12.1 ~~[For each APA member, \$2.00 of his or her regular dues shall be applied as dues of a division to which he or she belongs. If he or she is a member of more than one division, the dues shall be increased by \$2.00 for each additional division.]~~ Divisions may vote to make special assessments ~~[beyond this minimum amount,]~~ to be collected as part of the APA dues or collected separately by the divisions. All divisions must inform the Central Office in writing of the amount of their special assessments for the next calendar year within five days following the APA convention each year.

If a division fails to inform the Central Office within five days, the special assessment that applied the previous year will remain in force.

At the request of Council, the bylaw amendment ballot will be sent to the membership with only an explanatory statement.

B.(3) Council approves amending Article XIX of the Bylaws as follows: (bracketed/strikethrough material to be deleted, underlined material to be added):

APA BYLAWS

ARTICLE XIX: DUES AND SUBSCRIPTIONS

6. ~~[Any Fellow, Member, or Associate member who has reached the age of sixty-five and has been a member of the Association for at least twenty-five years shall become eligible for a dues exemption reduction process, culminating in dues exemption.]~~ There shall be a dues exempt category for those Fellows, Member and Associate members who reach eligibility requirements as set by Council. Such members shall retain all rights and privileges of membership in the Association except the privilege of receiving those publications of the Association ordinarily provided to its members as a membership benefit. In order to permit the receipt of such publications, however, an option to pay a reasonable subscription price/servicing fee for them shall be made available to dues-exempt members. (For purposes of this Subsection, membership in the American Association of Applied Psychology prior to its amalgamation with the American Psychological Association shall be counted.) Those dues exempt members opting not to pay the subscription price/servicing fee will be charged an administrative fee as set by Council.

At the request of Council, the bylaw amendment ballot will be sent to the membership with in favor of adopting and against adopting statements in addition to an explanatory statement.

C.(3a) Council voted to elect 70 members listed to initial Fellow status, on the nomination of the indicated divisions and on the recommendation of the Fellows Committee and the Board of Directors.

III. ETHICS

A.(4) Council voted to receive the *Report of the APA Commission on Ethics Processes*. Council also requested that the Board of Directors consider the Commission's recommendations and that implementing motions under Council's purview be brought back to Council for action. Melba J. T. Vazquez, PhD, and Paul Root Wolpe, PhD, Co-Chairs of the Commission, provided Council with a verbal report at the meeting.

IV. BOARD OF DIRECTORS

No items.

V. DIVISIONS AND STATE AND PROVINCIAL AND TERRITORIAL ASSOCIATIONS

A.(5) Council voted to refer the item, "Amendment to Association Rule 100-1.4: Division Position and Policy Statements" was referred to the Policy and Planning Board.

VI. ORGANIZATION OF THE APA

A.(6) Council voted to approve the following motion:

Council requests that 1) each APA board or committee Chair (or assigned designee) serve as the Civility Ambassador for the respective board or committee listserv, 2) the Council Leadership Team assigns a member of the CLT to serve as the Civility Ambassador for the Council listserv, and 3) the APA President assigns a member of the Board to serve as the Civility Ambassador for the Board listserv.

Civility Ambassadors are responsible for sending an annual statement to their assigned listserv regarding civility expectations and for providing corrective feedback to individual members when necessary.

B.(7) Council voted to approve extending the expiration dates of the *Guidelines for Preparing High School Psychology Teachers: Course-Based and Standards-Based Approaches* and *Record Keeping Guidelines* to December 31, 2022 and December 31, 2018, respectively.

C.(8) Council voted to receive the *Report of the Work Group to Review Organizational Policies and Procedures*.

D.(9) Council voted to postpone the item, "Transparency of Decisions (NBI #23C/Feb 2016)" to Council's March 2016 meeting.

E.(10) Council voted to approved the following motion:

Council requests that drafts of minutes and concise summaries of the Board of Directors and Council of Representatives meetings that have been approved by the Recording Secretary be posted on APA's website as soon as feasible following the meeting. Council also encouraged boards and committees to post drafts of minutes and concise summaries of meetings that have been approved by the chair of the respective board and committee on APA's website as soon as feasible following the meeting.

F.(11) Council received a verbal update from Jean Lau Chin, EdD on the Council Leadership Team's plans for diversity training in 2018.

G.(37) Council received as information the report of the Council Diversity Work Group. The co-facilitators of the Work Group, Melinda Garcia, PhD, Fred Millan, PhD and Karen Suyemoto, PhD, provided a verbal report at the meeting.

H.(38) Council received as information an update on the work of the Apology Letter Work Group.

I.(39) Council received as information an update on the Needs Assessment, Slating and Campaigns Committee.

VII. PUBLICATIONS AND COMMUNICATIONS

A.(12) Council voted to approve amending the Association Rules as follows (bracketed/strikethrough material to be deleted; underlined material to be added):

30-2. VOTES AND MINUTES

30-2.1 An affirmative vote of 25% of the members attending a Council meeting is required to order a roll call vote on any issue and to require the publication in ~~[the APA Monitor on Psychology]~~ a designated location on APA's website of the votes on any motion before Council.

100-2. PETITIONS FOR NEW DIVISIONS

100-2.1 ~~[Members interested in forming a new division shall be invited to attend the Division Leadership Conference (DLC) by means of an announcement published annually in the APA Monitor on Psychology. A steering committee of a proposed new division may send representatives to the DLC.]~~ The steering committee of a proposed new division shall ~~[also]~~ advise APA Central Office, by means of a letter of intent, of (1) its interest in forming a new division; (2) progress toward the formation of the division; (3) evidence of financial and organizational viability; and (4) evidence and materials supporting the need for a new division.

110-7. GUIDELINES FOR THE CONDUCT OF PRESIDENT-ELECT NOMINATIONS AND ELECTIONS

3. Call to membership of potential presidential nominees. An annual announcement ~~[in the December issue of the APA Monitor on Psychology will inform potential presidential nominees of the opportunity to speak at the February Council meeting and]~~ on APA's website will invite ~~[them]~~ presidential nominees to submit a brief statement (50 words or less) to accompany the President-Elect nomination ballot. The deadline for submission of such statements is close of business on January 15.

4. Statement on the issues facing psychology. After the slate of candidates is announced, each one will be invited to provide a statement regarding their candidacy. The candidates' statement accompanying the election ballot should be confined to discussion of issues facing psychology and the APA and should not exceed 1,000 words. ~~[The APA Monitor on Psychology will provide]~~ Coverage of the candidates in a question and answer format will be highlighted in issues of the APA Monitor on Psychology published between their nomination and the election, with a link to the full text on APA's website. Each board and committee reporting to Council or the Board of Directors will be invited to develop questions, which will be reviewed by the Election Committee. Taking into consideration input from the various constituencies, six (6) final questions reflecting important issues to APA's overall mission and strategic plan will be selected by the Election Committee and presented to each candidate. Their written responses will be edited for APA style by APA Monitor on Psychology editors and returned to the candidates for approval before appearing ~~[in tabular format, over three subsequent issues of the APA Monitor on Psychology]~~ on APA's website. The answers to each question will be limited to 100 words. Each candidate will also be given the opportunity to write a short statement, not to exceed 300 words, as a lead into their questions and answers. The Past President, as chair of the Election Committee, is responsible for enforcing these limitations.

C. Promulgation of These Guidelines

The guidelines in their entirety shall appear ~~[in the December or January and the May issues of the *APA Monitor on Psychology*]~~ on APA's website. ~~[Each January the Election Committee will send the guidelines to divisions, state/provincial/territorial psychological associations, coalitions, and newsletter editors.]~~

110-8. PRESIDENT-ELECT ELECTION

110-8.4 Results are reported to the Board of Directors. Talled results are reported to Council no more than 30 days after the ballot closes. Election results are published ~~[in the *APA Monitor on Psychology* in the earliest issue possible]~~ on APA's website.

170-6. EDITOR ~~[AND CONTENT]~~ OF THE AMERICAN PSYCHOLOGIST

170-6.1 The *American Psychologist* shall be the official organ of the APA. The Board of Directors shall designate the editor and determine his or her term of office. ~~[Minutes of the annual business meeting; reports of the APA Treasurer, chief staff officer, and Policy and Planning Board; lists of officers, boards, committees, and representatives of the APA; lists of new members and associates; and such other reports as the Council may direct shall have preferential treatment in the *American Psychologist*. In selecting other material for publication from such sources as the addresses of officers of the APA and its parts, reports of boards and committees, and original contributions, the editor shall strive best to represent the APA as a whole].~~

220. AMENDING APA BYLAWS

220-1.1. In the event that any change in the APA Bylaws is proposed, ~~[the text]~~ notice of such change shall be published in the *APA Monitor on Psychology*, with a link to the full text of such change on the APA website, at least one month before the ballot is sent and preferably long enough in advance to permit comment.

B.(13) Council voted to approve the Division 17 request for authorization to publish a divisional journal, to be titled, *Journal of Prevention and Health Promotion (JPHP)*.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(14) Council voted to approve amending Association Rule 120-4.1 as follows (bracketed/strikethrough material to be deleted; underlined material to be added):

120-4. CONTINUING EDUCATION COMMITTEE

120-4.1 There shall be a Continuing Education Committee consisting of ~~[no more than fourteen]~~ not fewer than sixteen members appointed by the Board of Educational Affairs for staggered terms of three years. At least one member of the Committee shall be an early career psychologist. The Committee shall report to Council through the Board of Educational Affairs.

B.(15) Council voted to approve changing the wording in Criterion 2 of the 2016 ROPCSPPP criteria from “professional psychology” to “health service psychology” as follows (bracketed/strikethrough materials to be deleted; underlined material to be added):

In accordance with APA Policy, after 1/1/2018, certifying bodies seeking recognition will have policies that permit certification only of candidates who have completed, after 1/1/2018, APA/CPA accredited doctoral degrees in [~~professional~~] health service psychology; and after 1/1/2020, certifying bodies will have policies that permit certification only of candidates who have completed, after 1/1/2020, APA/CPA accredited internships in [~~professional~~] health service psychology. The same timelines apply for doctoral programs and internships accredited by an accrediting body other than APA, only if that accrediting body is recognized by the U.S. Secretary of Education for the accreditation of [~~professional~~] health service psychology education and training in preparation for entry to practice.

C.(16) The item, “Guidelines on Core Learning Goals for Master’s Degree Graduates in Psychology” was postponed to Council’s March 2018 meeting.

D.(17) Council voted to adopt as APA policy the *Guidelines for Education and Training in Consulting Psychology/Organizational Consulting Psychology* and approved August 2027 as the expiration date for the Guidelines.

E.(18) Council voted to adopt as APA policy the *Guidelines for Education and Training in Industrial Organizational Psychology* and approved August 2027 as the expiration date for the Guidelines.

F.(19) Council voted to approve an extension of recognition of Clinical Neuropsychology as a specialty in professional psychology for an additional period of one-year to expire in August 2018.

G.(20) Council voted to approve an extension of recognition of Behavioral and Cognitive Psychology as a specialty in professional psychology for an additional period of one year to expire in August 2018.

H.(21) Council voted to approve an extension of recognition of Personality Assessment as a proficiency in professional psychology for an additional period of one-year to expire in August 2018.

I.(22) Council voted to approve an extension of recognition of Family Psychology as a specialty in professional psychology for an additional period of one-year to expire in August 2018.

J.(23) Council voted to approve a one-year extension of the recognition of Psychopharmacology as a proficiency in professional psychology to August 2018.

K.(24) Council voted to approve a one-year extension of the recognition of Assessment and Treatment of Serious Mental Illness as a proficiency in professional psychology to August 2018.

L.(25) Council voted to approve the renewal of recognition of Addiction Psychology as a proficiency in professional psychology for a period of seven years.

M.(26) Council voted to approve the renewal of recognition of Professional Geropsychology as a specialty in professional psychology for a period of seven years.

X. PROFESSIONAL AFFAIRS

A.(36) Council received as information an update on the business pending item, "Guidelines for Psychologists Regarding the Assessment of Trauma for Adults (NBI #25A/Aug 2013)."

B.(40) Council received as information an update on the work of the Advisory Steering Committee for Development of Clinical Practice Guidelines and APA Guideline Development Panels and plans for 2017

XI. SCIENTIFIC AFFAIRS

A.(27) Council voted to adopt as APA policy the following *Resolution Reaffirming Support for Teaching and Research with Nonhuman Animals*:

Resolution Reaffirming Support for Research and Teaching with Nonhuman Animals

Research with nonhuman animals has contributed significantly to advances in the field of psychology (Carroll & Overmier, 2001; Laborda, Miguez, Polack, & Miller, 2012; Maestriepieri & Roney, 2006; Mehta & Gosling, 2008). It has laid the foundation for understanding diverse behavioral and biological processes underlying phenomena such as attention, perception, learning, memory, social behaviors, emotion, and decision making, accounting for diverse behavioral, cultural, and social contexts. Research with nonhuman animals has also furthered our understanding of similarities and differences across species, which has both intellectual and practical significance. Knowledge about other species has been crucial in guiding conservation efforts in various habitats across the world (Higham, 2016; O'Brien & Robeck, 2010; Swaisgood, Zhou, Zhang, Lindburg, & Zhang 2003; Zimbler-DeLorenzo & Stone, 2011). Nonhuman animal research has proven invaluable for exploring the complexity of diverse behaviors across genetic, molecular, cellular/neuronal, circuit, network, cognitive, and behavioral levels. The assembly and application of findings from nonhuman animal research has contributed to numerous clinical applications that have significantly improved the health and well-being of both human and nonhuman animals (Carroll & Overmier, 2001; Raffel, Hoverman, Halstead, Michel, & Rohr, 2010; Raffel et al., 2013; Tizzi, Accorsi, & Azzali, 2010). Importantly, maintaining high standards of research animal wellbeing is not only of ethical importance to scientists, but is also critical to collecting data that allow for robust conclusions upon which scientific breakthroughs are grounded.

WHEREAS The American Psychological Association has long acknowledged the importance and contributions of nonhuman animal research to advancing scientific knowledge and promoting the wellbeing of human and nonhuman animals (APA, 1990; Dewsbury, 1992); and
WHEREAS Nonhuman animal research is comprehensively regulated through an integrated oversight system comprising federal, state, and local regulations (U. S. Department of Agriculture, 2013), as well as institutional peer review (National Institutes of Health, Office of Laboratory Animal Welfare, 2015) and peer review by funding agencies, both of which attest to the necessity of the research, its scientific validity, and the humane and ethical treatment of the animals involved; and

WHEREAS Scientists bear several responsibilities for the conduct of research with nonhuman animals, which include ensuring humane care and treatment that is sensitive to species-specific needs; being informed about and adhering to relevant laws and regulations pertaining to such research; and communicating respect for these research subjects to employees, students, and

colleagues (APA, 2012, 2013, 2016; National Research Council, 2011; Public Health Services, 2015); and

WHEREAS The majority of scientists support and encourage the use of nonhuman animals in scientific research (Pew Research Center, 2015); and

WHEREAS Observational learning through classroom demonstrations and hands-on learning through the conduct of experiments with nonhuman animals are integral to science education (Akins, Panicker, & Cunningham, 2005, National Research Council, 1989, National Science Teachers Association, 2008); and the early exposure of students to such experiences engenders creativity, original thought, critical thinking, and problem-solving skills (APA, 2003; Madrazo, 2002); and

WHEREAS Students exposed to nonhuman animal research are more likely to develop and retain a better appreciation for such research (Akins, Panicker, & Cunningham, 2005; Edwards, Jones, Bird, & Parry, 2014; Offner, 1993); and

WHEREAS The APA recognizes the general public may not fully appreciate the nature of nonhuman animal research and its benefits to society, due to overabundance of misinformation and simultaneous dearth of accurate information available in the public domain (Speaking of Research, n.d.); and

WHEREAS The APA recognizes the concerted efforts of entities opposed to research with nonhuman animals and dedicated to the abolition of such research (Speaking of Research, 2013); and

WHEREAS The American Psychological Association deplores harassment of scientists, students, and technical personnel engaged in nonhuman animal research, as well as destruction of nonhuman animal research facilities (APA, 2004; 2014);

THEREFORE BE IT RESOLVED that the American Psychological Association reaffirms its earlier resolution (APA, 1990) and joins with other scholarly organizations (Alzheimer's Association, 2015; American Association for the Advancement of Science, 1990; American Heart Association, 2010; Federation of American Societies for Experimental Biology, 1994; Society of Toxicology, 1999) in continuing to support ethically sound and scientifically valid research with nonhuman animals.

BE IT FURTHER RESOLVED that scientists support the efforts to improve research animal wellbeing through the implementation of evidence-based policies and regulations that do not compromise the scientific integrity of the research (Thulin et al, 2014).

BE IT FURTHER RESOLVED that the American Psychological Association supports the integration of student research projects with nonhuman animals in institutions capable of providing proper oversight and supervised by teachers who are trained in the care and treatment of nonhuman animals in laboratory and/or field settings (Akins, Panicker, & Cunningham, 2005).

BE IT FURTHER RESOLVED that scientists support initiatives that further the education of students, colleagues, and the general public on the merits of nonhuman animal research and its benefits to public health, the environment, and society at large.

BE IT FURTHER RESOLVED that the APA and affiliated societies and research institutions publically defend research with nonhuman animals and the scientists who conduct such research from the sustained, multi-pronged attacks by entities opposed to such research.

BE IT FURTHER RESOLVED that the American Psychological Association encourages affiliated societies and research institutions to endorse this resolution.

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XII. PUBLIC INTEREST

A.(28) Council voted to approve withdrawal of Council New Business Item #23D/Aug 2010: Resolution on Aid in Dying.

B.(29) Council voted to archive the following *Resolution on End-of-life Issues and Care* which was adopted by Council in 2001:

Resolution on End-of-life Issues and Care

Whereas the nature of dying and death has changed across the twentieth century, occurring primarily in an institutional setting rather than at home (Benoliel & Degner, 1995); and

Whereas death has become more frequently the result of chronic illness (Battin, 1996); and

Whereas medicine and technology have evolved to the point where the terminal period can be significantly prolonged (Field & Cassel, 1997); and

Whereas there are many more people living longer with terminal diagnoses and thus having more time to make end of life decisions; and

Whereas end of life decision making is complex, involving areas of ethics, religion, medicine, psychology, sociology, economics, the law, public policy, and other fields; and

Whereas the population of the United States is aging, resulting in larger numbers of people who may request psychological support in making end of life decisions; and

Whereas in the United States there is significant social stratification related to cultural, ethnic, economic, gender, and religious differences; and

Whereas this diversity in our society leads to an equally diverse range of views regarding end of life care and decisions; and

Whereas reasonable, well informed people starting from different values and priorities concerning what is valuable at the end of life can and do hold different positions regarding end of life care and decisions; and

Whereas autonomy is an important guiding principle in the law and in medical, ethical, and psychological aspects of decision making, but in and of itself is insufficient to capture the full range of complex medical, familial, social, financial, psychological, cultural, spiritual, and legal issues involved in end of life decision making; and

Whereas there is increasing public support for control over end of life decisions but this support is weakest among groups who express concerns about being pressured to die (i.e., older adults, people with less education, women, and ethnic minorities) (Blendon, Szalay, & Knox, 1992); and

Whereas in the United States medical end of life decisions are made in a context of serious social inequities in access to resources such as basic medical care; and

Whereas some evidence suggests that there are fluctuations in the will to live (Chochinov, Tataryn, Clinch, & Dudgeon, 1999) and in wishes regarding life sustaining treatments (Weisman, Haas, & Fowler, 1999); and

Whereas pain and clinical depression are frequently under-treated, which can lead to suffering that may result in requests for, or assent to, medical interventions that affect the timing of death (Foley, 1995); and

Whereas more people are aware of the possible benefits to be gained by using psychological services to help them make end-of-life decisions; and

Whereas psychology has been largely invisible in the end of life arena; and

Whereas psychologists have many areas of competence, including assessment, counseling, teaching, consultation, research, and advocacy skills that could potentially contribute to the science of end-of-life care and to the treatment and support of dying persons and their significant others; and

Whereas psychological research on end of life issues is limited in comparison with the magnitude of the issue; and

Whereas there have been no systematic efforts to educate psychologists about end of life issues; and

Whereas psychologists in clinical practice have not typically been involved in end of life decisions to the degree that they could be; and

Whereas psychologists could assume a significant role in helping health care providers to understand and cope with the concerns and needs of dying individuals and their families; and

Whereas psychologists could be instrumental in supporting public education efforts to raise awareness of issues related to dying, death, grief, mourning, and loss;

Therefore, be it resolved that the American Psychological Association, an organization committed to promoting the psychological well being of individuals across the life span, should redress psychology's historical under commitment to end of life care by actively promoting and

supporting psychology's involvement in end of life care. In order to advance this involvement, be it further resolved that the American Psychological Association:

Promote and encourage research and training in the area of end-of-life issues within psychology programs at all levels; and

Encourage and promote the development of a research agenda on end of life issues; and

Support efforts to increase funding for research associated with end-of-life issues; and

Encourage psychologists to obtain training in the area of ethics as it applies to end-of-life decisions and care; and

Promote and facilitate psychologists' acquisition of competencies with respect to end of life issues, including mastery of the literature on dying and death and sensitivity to diversity dimensions that affect end of life experiences; and

Encourage practicing psychologists to be aware of their own views about the end of life, including recognizing possible biases about entitlement to resources based on disability status, age, sex, sexual orientation, or ethnicity of the client making end of life decisions; and

Encourage psychologists to be especially sensitive to the social and cultural biases which may result in some groups and individuals being perceived by others, and/or being encouraged to perceive themselves, as more expendable and less deserving of continued life (e.g., people with disabilities, women, older adults, people of color, gay men, lesbians, bisexual people, transgendered individuals, and persons who are poor); and

Support interdisciplinary efforts to increase the competency of psychologists and other health care professionals in end of life issues; and

Promote quality end of life care including palliative care, access to hospice services, support for terminally ill people and family members, accurate assessment of depression and cognitive capabilities of dying persons, and assistance with end of life decision making; and

Advocate for access to, and reimbursement for, professional mental health services for seriously ill individuals and their families; and

Promote and support public policies that provide for the psychosocial services for dying individuals and their families; and

Support psychologists who wish to participate in ethics committees dealing with end of life issues; and

Support psychologists as they work cooperatively with caregivers, medical providers, and multidisciplinary teams to enhance understanding of the psychological aspects of dying and death and to improve quality of care for the dying; and

Endorse the following principles on end of life care as articulated in the Institute of Medicine Report entitled *Approaching Death: Improving Care at the End of Life* (Field & Cassel, 1997):

- Care for those approaching death is an integral and important part of health care;
- Care for those approaching death should involve and respect both patients and those close to them;
- Good care at the end of life depends on clinicians with strong interpersonal skills, clinical knowledge, technical proficiency, and respect for individuals, and it should be informed by scientific evidence, values, and personal and professional experience;
- The health community has a special responsibility for educating itself and others about the identification, management, and discussion of the last phase of fatal medical problems;
- More and better research [in the areas of biomedical, clinical, psychosocial, and health services] is needed to increase our understanding of clinical, cultural, organizational, and other practices or perspectives that can improve care for those approaching death;
- Changing individual behavior is difficult, but changing a culture or an organization is potentially a greater challenge -- and often is a precondition for individual change.

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Council also voted to adopt as APA policy the following *Resolution on Palliative Care and End-of-Life Issues*:

Resolution on Palliative Care and End-of-life Issues

WHEREAS the issues and terminology of end-of-life have evolved since the American Psychological Association (APA)'s 2001 Resolution on End-of-life Issues and Care; and

WHEREAS palliative care is a team-based approach to care focused on: improving the quality of life for individuals facing serious or life-limiting illness and their care partners (e.g., families of origin or families of choice); preventing and relieving suffering by means of early identification;

thorough, culturally-sensitive assessment and treatment of pain and physical, psychosocial, and spiritual problems; and by providing bereavement care (Kelley & Morrison, 2015; National Consensus Project for Quality Palliative Care, 2013); and

WHEREAS palliative care is appropriate at any age and at any stage of a serious illness, can be provided at the same time as disease-directed or curative treatment, and is not dependent on prognosis (World Health Organization [WHO], 2016); and

WHEREAS end-of-life or hospice care, which is often tied in the United States to the Hospice Medicare Benefit, focuses on palliative care for terminally ill individuals who may have only limited time to live and have elected no longer to pursue curative treatment for their underlying disease (Kelley & Morrison, 2015); and

WHEREAS most hospice programs are limited in their present structure and reimbursement mechanisms to meet the needs of children with serious and life-limiting illness and their families (National Hospice and Palliative Care Organization, 2001); and

WHEREAS many more individuals with terminal diagnoses across the lifespan are living longer than before and thus have more opportunity to make end-of-life decisions (Morrisey, Herr, & Levine, 2015; Murtagh et al., 2014); and

WHEREAS death has become more frequently the result of advanced serious illness that must be managed for weeks and often years, with multiple health, functional, and emotional changes occurring throughout the disease process (Institute of Medicine [IOM], 2014); and

WHEREAS individuals with advanced serious illness will grapple with multiple conditions that may interact in complex ways and will face a system of care that is often fragmented, uncoordinated and confusing (Byock, 2012; Coalition to Transform Advanced Care [C-TAC], 2015; IOM, 2014); and

WHEREAS the nature of death and dying has changed across the twentieth century, occurring primarily in an institutional setting rather than at home (Centers for Disease Control and Prevention [CDC], 2005); and

WHEREAS systemic barriers continue to exist to integrating evidence-based treatment programs and practices into standards of care system-wide (Allison & Sudore, 2013; Lynch, 2013; Weaver et al., 2015); and

WHEREAS medical technology has advanced to the point where patients in hospitals infrequently die without a decision to withhold or withdraw life-supporting therapy (Gedge, Giacomini, & Cook, 2007; Lantos, 2011) with those decisions being psychologically complex for all parties involved, especially in the absence of advance directives; and

WHEREAS end-of-life decision making is complex, involving areas of ethics, religion, medicine, psychology, sociology, economics, the law, public policy, and other fields (Baergen, 2001; National Consensus Project for Quality Palliative Care, 2013; Wells-DiGregorio, 2008); and

WHEREAS some evidence suggests that there are fluctuations in the will to live (Chochinov, Tataryn, Clinch, & Dudgeon, 1999) and in wishes regarding life-sustaining treatments (Fried et al., 2006); and

WHEREAS autonomy is an important principle in the law and in medical and ethical aspects of decision making, but in and of itself is insufficient to capture the full range of complex psychosocial, medical, familial, financial, cultural, spiritual, and legal issues involved in palliative care and end-of-life decision making (Byock, 2009; Winzelberg, Hanson, & Tulskey, 2005); and

WHEREAS in the United States, end-of-life decisions are made in the context of significant social stratification related, but not limited to, age, culture, disability status, ethnicity, gender identity, geographic location, health status, immigration status, marital status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status, leading to inequalities in access to resources such as basic health care and resources for in-home supported living (Canetto, 2011; Payne, 2016; Lee et al., 2017; Robinson, et al., 2009; Sue, 2001); and

WHEREAS severe health disparities in timely and adequate access to care profoundly influence the nature and availability of end-of-life care for underserved individuals and communities and, consequently, affect the concerns of individuals and their care partners making end-of-life care decisions (Johnson, 2013; Koffman et al., 2007; Lynch, 2013; Robinson et al., 2009; Williams et al., 2012); and

WHEREAS the 20 percent of the U.S. population living long-term with disability or chronic illness (e.g., HIV/AIDS) (Shorthill & Demarco, 2017) commonly experiences social stigma that can be further compounded by the stigma of approaching death, and end-of-life care offered to individuals with disabilities (e.g., often involving nursing home placement) may inadvertently compound their vulnerability by disrupting their carefully cultivated self-management and support systems (Stienstra, D'Aubin, & Derksen, 2012, thereby increasing social disconnection, lack of agency, and risk of abuse and coercion by caregivers (who may also have decisional authority); and

WHEREAS 42 percent of people with disabilities experience sexual abuse and 87 percent experience verbal abuse and inhumane practices in caregiving situations (Baladerian, Coleman, & Stream, 2013); and

WHEREAS over the next two decades, the number of individuals age 65 and older (the age group that encompasses the majority of people with advanced illness) will nearly double to more than 72 million, with racial and ethnic minority older adult populations projected to increase to 21.1 million in 2030 (Administration on Aging [AOA], 2015), thus significantly increasing the need for culturally competent palliative and hospice care; and

WHEREAS vulnerable populations of adults with diminished capacity for autonomous decision making and living with advanced serious illness may lack the ability to communicate medical decisions and may experience daily fluctuations in awareness or lucidity (American Bar Association [ABA] & APA, 2008; Stormoen, Almkvist, Eriksson, Sundstrom, & Tallberg, 2014; Trachsel, Hermann, & Biller-Adorno, 2015); and

WHEREAS there are 400,000 children in the United States with life limiting illness, with cancer as the leading cause of disease-related death for adolescents and young adults (Friebert, 2009; State Initiatives in End-of-life Care, 2002); and

WHEREAS survival with these illnesses has improved far less for 15 to 24-year-olds than it has for older individuals (Bleyer, O'Leary, Barr, & Ries, 2006; Institute of Medicine [IOM], 2013; Robison, 2011), and about one fourth of children with cancer will die prematurely (Murphy, Xu, & Kochanek, 2013; Vinchon, Baroncini, Leblond, & Delestret, 2011); and

WHEREAS individuals with serious or life-limiting illness often rely on family members (of origin or of choice) for care, and this care can be rewarding and also challenging and result in significant psychological and physical morbidity and strain, including economic strain, to the care partner (Morgan, Williams, Trussardi, & Gott, 2016; Roth et al., 2013; Rumpold et al., 2016; Vanderwerker, Laff, Kadan-Lottick, McColl, & Prigerson, 2005; Wadhwa et al., 2013); and

WHEREAS care partners of individuals with serious or life-limiting illness often are at risk for complications associated with anticipatory grief and bereavement and many risk factors for grief and bereavement can be addressed through quality palliative and end-of-life care (Garrido & Prigerson, 2014; Hudson et al., 2014); and

WHEREAS for immigrant and first generation U.S. families, caregiving and end-of-life decisions may cross borders due to transnational circles of care, and health providers should be mindful of the implications of U.S. policies on caregivers and family decision makers who are either abroad or who hold different cultural views on palliative care and end-of-life decisions (Baldassar, 2011; Baldassar, 2017; Baldassar & Merla, 2013; Kilkey & Merla, 2014); and

WHEREAS diversity in human values, status, power, and resources leads to an equally diverse range of views and needs and power regarding palliative care and end-of-life care and decisions (Boucher, 2016); and

WHEREAS reasonable, well-informed people start from different values and priorities concerning what is valuable at the end-of-life, and can and do hold different positions regarding end-of-life care and goals of care (Crawley, 2005); and

WHEREAS there is significant public support for individual control over end-of-life decisions but support for hastening death is weakest among groups who express concerns about being pressured to die (e.g., older adults, people with disabilities, people with less education, people with fewer financial resources, women, racial and ethnic minorities) (Crawley, Marshall, Lo, & Koenig, 2002; Krakauer, Crenner, & Fox, 2002; Lyon et al., 2008; Phillips et al., 2000); and

WHEREAS the absence or avoidance of advance care planning results in substituted decisions for or against aggressive care near death that may be incongruent with individual values, and associated with greater symptom and financial burdens, reduced quality of life, and greater risk of psychiatric complications for care partners (Alexi et al., 2008; Detering, Reade, & Silvester, 2010; Sucore & Fried, 2010; Temel, Greer, Muzikansky, Gallagher, & Admane, 2010); and

WHEREAS individuals living with advanced serious illness and nearing death experience a range of symptoms that often are unrecognized and/or undertreated, including but not limited to pain, depression, anxiety, worry, existential distress, dyspnea/shortness of breath, fatigue, and

anorexia (Azuerro, Allen, Kvale, Azuerro, & Parmelee, 2014; Fisher et al., 2002; Hughes et al., 2016; Kamal, Nipp, Bull, Stinson, & Abernethy, 2015; Kissane, 2012; Moens, Higginson, & Harding, 2014; Yennurajalingam et al., 2013); and

WHEREAS these symptoms can lead to suffering that may result in requests for, or assent to, medical interventions that affect the timing of death (Ruijs, Kerkhof, van der Wal, & Onwuteaka-Philipsen, 2013); and

WHEREAS psychologists have begun the important work of developing, evaluating, and disseminating evidence-based psychological interventions for people with advanced serious illness and their care partners, yet to date these interventions are limited in scope and underutilized (Allen et al., 2014; Hudson et al., 2012; Kasl-Godley, King, & Quill, 2014; Kuhne et al., 2012; Northhouse, Katapodi, Song, Zhang, & Mood, 2010; Wallio & Twillman, 2010); and

WHEREAS behavioral and psychological issues intersect and interact with the biological, social, and spiritual issues faced by people with serious illness, and psychologists' skills can enhance and optimize communication and interventions delivered by professionals from other disciplines (Feldman, Sorocco, & Bratkovich, 2014; Sullivan, Mongoue-Tchokote, Mori, Goy, & Ganzini, 2016); and

WHEREAS there is increasing consumer demand for psychological services (Bureau of Labor Statistics, 2016-17) and need for addressing end-of-life stressors and decision making with psychologists' support (Murtagh et al, 2014; Nydegger, 2008); and

WHEREAS psychologists have many areas of competence including, but not limited to, assessment, intervention, teaching, consultation, research, and advocacy skills that could contribute to the science of palliative care and end-of-life issues and to the treatment and support of people with advanced serious or life-limiting illness, their significant others, and other health care providers (Carpenter, 2015; Connor, Lycan, & Schumacher, 2006; Gamino & Ritter, 2012; Golijani-Moghaddam, 2014; Johnson, Cramer, Conroy, & Gardner, 2014); and

WHEREAS psychologists possess these intervention, research, and teaching competencies and yet are underutilized due to reasons including, but not limited to, formal or informal exclusion from care systems and programs, lack of opportunities for reimbursement, perceptions that psychological services are not warranted, and lack of understanding by other providers regarding the specific skillset and competencies that psychologists provide near the end-of-life (Azuerro et al., 2014; Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003; Patterson, Croom, Teverovsky, & Arnold, 2014); and

WHEREAS psychology has been integrated into interdisciplinary, palliative care teams in the Veterans Health Administration (VHA, 2016), but psychologists in clinical practice outside of the VHA have not typically been involved in palliative care and end-of-life decisions to the degree that they could be (Garrido, Penrod, & Prigerson 2014; Haley et al., 2003); and

WHEREAS current Medicare policy authorizes reimbursement for advance care planning conversations only for physicians, nurse practitioners, or their supervisees (Jones, Acevedo, Bull, & Kamal, 2016), yet psychologists trained in palliative and end-of-life care possess knowledge and skills to help people obtain the health information they need, effectively communicate questions to their providers, weigh the risks and benefits of different choices, reflect on their

preferences and values, and communicate their wishes when contemplating end-of-life situations; and

WHEREAS there have been few systematic efforts to educate psychologists about end-of-life issues in comparison with the magnitude of the issue and opportunity (APA, 2000; Kasl-Godley, King, & Quill, 2014); and

WHEREAS core competencies in palliative and end-of-life care are now widely articulated and psychological issues are a core practice domain, yet psychologists remain largely absent from professional work groups involved in developing these competencies (Ryan et al., 2014); and

WHEREAS psychological research on palliative care and end-of-life issues is expanding but remains limited in comparison with the magnitude of the issue (Keall, Clayton, & Burtow, 2015; Naik, Martin, Moye, & Karel, 2016; Singer et al., 2016; Xiao, Kwong, Pang, & Mok, 2012); and

WHEREAS The National Institute of Nursing Research (NINR, 2013), the Coalition to Transform Advanced Care (C-TAC, 2015), and the Institute of Medicine (IOM, 2014) have identified gaps in compassionate science, including: (a) integrating behavioral and psychosocial sciences into palliative care; (b) developing a scientific basis for clinical practice for people with advanced serious illness of all ages, that is person- and family-centered; (c) relieving symptoms and suffering; (d) enhancing communication among persons with advanced serious illness, their care partners and clinicians; and (e) understanding decision making about care among persons with advanced serious illness; and

WHEREAS psychologists could assume a significant role in helping other health care providers understand and cope with the concerns and needs of individuals with serious or life-limiting illness and their care partners (Allen, Haley, Roff, Schmid, & Bergman, 2006; Gustin, Way, Wells-Di Gregorio, & McCallister, 2016); and

WHEREAS psychologists could be instrumental in supporting interprofessional public education efforts to increase health literacy and raise awareness of issues related to palliative and end-of-life care including advance care planning, symptom management, dying, death, grief, mourning, and loss (Higginson et al., 2014; Long, 2011); and

WHEREAS psychologists could assume a significant role in the development and implementation of standardized tools for measuring outcomes of palliative and end-of-life care (Kearns, Cornally, & Molloy, 2017); and

WHEREAS the practice of palliative and end-of-life care is, at its best, interprofessional to address the complex care needs of individuals and their care partners, and that collaborative practice operates from a biopsychosocial perspective to provide more patient-centered, comprehensive, ongoing assessment, treatment planning, and interventions in the most efficient and effective manner (APA, 2008; Kelly & Morrison, 2015; National Consensus Project for Quality Palliative Care, 2013); and

WHEREAS team-based health care results in higher quality care and interprofessional practice competencies are recognized as integral to palliative and end-of-life care, yet few professions, including psychology, have opportunities across all levels of professional education and development to train together, leaving them unprepared for the practice environments in which

they will work (Interprofessional Education Collaborative Expert Panel, 2011; Ryan et al., 2014); and

WHEREAS a number of national and international organizations have issued their own policy statements and documents and have collaborated on developing guidance documents regarding end-of-life issues, often without the involvement of APA representatives or other psychologists, including *The Clinical Practice Guidelines for Quality Palliative Care* (The National Consensus Project for Quality Palliative Care, 2013), *Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of-life* (IOM, 2014), and the *White Paper on Standards and Norms for Hospice and Palliative Care in Europe* (European Association for Palliative Care, 2009).

THEREFORE, BE IT RESOLVED that the American Psychological Association, an organization committed to promoting the psychological well-being of individuals across the life span, actively promote and support psychology's involvement in palliative care and end-of-life issues in the United States of America and as invited on international platforms.

In order to advance this involvement, be it further resolved that the American Psychological Association:

Promote and encourage research and education in the areas of palliative care and end-of-life issues within psychology training at all levels.

Encourage psychological research and the use of clinical skills to assess and address the psychological factors that have an impact on end-of-life decision making and will to live, including, but not limited to, untreated or undertreated distressing physical symptoms, depression, anxiety, loss of perceived dignity, existential distress, cognitive capacity, and increased social marginalization experienced by individuals already living with marginalized health conditions (including HIV/AIDS, substance abuse, mental health disorders) or disabilities.

Promote psychologists' collaboration with other disciplines and organizations in the formulation and implementation of a behavioral and psychological research agenda on palliative care and end-of-life issues.

Advocate for funding for behavioral and psychological research on palliative care and end-of-life issues, collaborating when possible with other palliative and hospice-focused professional organizations.

Encourage psychology to bring its perspective in organizational systems to close research gaps and to implement best practices system-wide for persons across the lifespan with serious or life-limiting illness.

Promote psychologists' acquisition of knowledge and skill competencies with respect to palliative care and end-of-life issues, including, but not limited to, developmentally-sensitive assessment and treatment of bio-psycho-social-spiritual aspects of advanced illness; dying, death, and bereavement care; communication and advance care planning; interprofessional practice; legal and ethical issues; and, sensitivity to all diversity and developmental dimensions that affect end-of-life experiences.

Promote psychologists' acquisition of competence in interprofessional collaboration that is the foundation of palliative and end-of-life care.

Encourage psychologists working with minors living with advanced serious or life-limiting illness to obtain training at all levels in the area of ethics as applied to decision making by and care of minors who may have no legal rights, but are supported by public policy to be involved in decision making about their health care, consistent with the principles of justice and respect for peoples' rights and dignity.

Encourage psychologists working with vulnerable populations of adults with diminished capacity for autonomous decision making and living with advanced serious illness to obtain training at all levels in the area of ethics as applied to decision making by individuals with diminished capacity, consistent with the principles of justice and respect for peoples' rights and dignity.

Encourage all psychologists to obtain training at all levels in the area of ethics (including APA ethical standards), social justice, and legal issues as they apply to palliative care and end-of-life issues. In addition, psychologists working with vulnerable persons living with serious or life-limiting illness are encouraged to obtain training in ethics as they apply to their research and practice when working with individuals of all developmental stages and cultures with serious or life-limiting illness.

Encourage psychologists to be aware of their own attitudes about palliative care and end-of-life issues that may influence their clinical practice, research, education/training, and advocacy, and to recognize possible biases about quality of life or entitlement to resources based on group identities and their related social statuses, including, but not limited to, age, culture, criminal justice involvement, disability status, gender identity, geographic location, health status (including stigmatized conditions such as HIV, substance use, mental health disorders), immigration status, marital status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status.

Encourage psychologists to obtain an understanding of how power, social status, and facets of identity, including, but not limited to, age, culture, criminal justice involvement, disability status, gender identity, geographic location, health status, immigration status, marital status, mental health status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status contribute to disparities in palliative and end-of-life care. Specifically, psychologists are encouraged to apply this understanding to: (a) promote the elimination of inequities related to access to care, retention, and outcomes; (b) increase awareness of provider and patient biases; (c) improve communication about goals of care and related decisions; (d) expand recognition that social disenfranchisement of marginalized individuals may intensify at end-of-life in ways that influence decision making; and (e) understand the treatment preferences and values of individuals to assist with advance care planning and decision making.

Encourage psychologists to familiarize themselves with the roles and competencies of, and clinical care provided by, medical, social work, nursing, and chaplaincy and other professional colleagues related to end-of-life issues, decision making, and care.

Encourage psychologists' efforts to increase the understanding of other health care professionals with regard to behavioral, psychological, and diversity aspects of palliative care and end-of-life issues.

Promote high-quality and effective palliative and end-of-life care that includes support for individuals across the lifespan with advanced serious illness and their care partners all along the illness trajectory; culturally sensitive assessment and treatment; thorough symptom management; promotion of mental health and psychological wellbeing; optimal expression of cognitive capabilities; facilitation of effective communication and assistance with advance care conversations and decision making that is shared and informed by individual/family needs, values, and preferences; bereavement care; and promotion of quality of life in all these activities.

Advocate for access to, and insurance coverage for, mental health services for seriously ill individuals and their care partners, across all settings of care and geographic locations, and for family members during bereavement.

Promote and endorse public policies that provide for behavioral and psychosocial services for seriously ill individuals across the lifespan, and their care partners.

Advocate for expansion of Medicare coverage to include psychologists among those providers who may conduct advance care planning conversations and provide hospice consultations.

Advocate and endorse legislation to make public and private health, and mental health systems more flexible for meeting the health and mental health needs of children and adolescents with serious and life-limiting illness.

Advocate for public and private financial support of psychology and interprofessional training in palliative care and end-of-life issues at the pre-doctoral, internship, postdoctoral, and post-licensure level.

Advocate for psychologists' participation in national, state, and local interdisciplinary efforts to inform the development of policy and standards for palliative care and end-of-life issues including, but not limited to, involvement in research funding advisory groups, practice and treatment guideline and quality assurance outcomes development efforts, ethics committees, clinical care committees, and administrative work groups.

Support interprofessional efforts to increase the competency of psychologists and other health care professionals in identifying and addressing the behavioral, psychological, and social aspects of serious or life-limiting illness.

Endorse the following principles on care for individuals with advanced serious illness as articulated in the Institute of Medicine Report entitled *Dying in America: Improving Quality and Honoring Individual Preferences Near the End-of-life* (IOM, 2014):

- Care for individuals with advanced serious illness should be comprehensive, of high quality, accessible, and available through governmental and private health insurers and care delivery programs. Comprehensive care is integrated, interdisciplinary, patient-centered and family oriented, coordinated across all providers and settings;
- Individuals should have the opportunity to engage in conversations about their health care, the results of which should be incorporated into ongoing care plans. Clinician-patient communication and advance care planning should be guided by quality standards that reflect evolving population and health system needs, are measurable, actionable and evidence-based, are adopted by both payer and health care delivery

- organizations, and linked to reimbursement. Professional societies should adopt policies that facilitate tying standards to reimbursement, licensing and credentialing;
- Educational institutions, credentialing bodies, accrediting boards, state regulatory agencies and health care delivery organizations should establish appropriate training, certification, and/or licensure requirements to strengthen basic palliative care knowledge and skills of all clinicians caring for individuals with advanced serious illness. This knowledge and these skills should include communication skills, interprofessional collaboration and symptom management;
 - Federal, state, and private insurance and health care delivery programs should integrate and finance coordinated medical and social services necessary to support the provision of quality care consistent with the values and goals of individuals with advanced illness. Payment and health care delivery systems should collect and report quality measures, outcomes and costs regarding care for individuals with advanced illness and near the end-of-life;
 - Public outreach, engagement, and education about care of individuals with advanced serious illness is needed to dispel myths and facilitate advance care planning and informed health care decision making.

Renew its strong commitment and become a transformative force in the field of mental health and palliative care and end-of-life issues.

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C.(30) Council voted to approve amending the *Resolution on Assisted Dying* as follows (bracketed/strikethrough material to be deleted, underlined material to be added):

Resolution on ~~[Assisted Suicide]~~ Assisted Dying

WHEREAS the issue of assisted ~~[suicide]~~ dying is complex, involving areas of ethics, religion, medicine, psychology, sociology, economics, the law, public policy, and other fields; and

WHEREAS in the United States there is significant social stratification related to ~~[cultural, ethnic, economic, gender, and religious differences]~~ diversity, i.e. age, culture, disability status, ethnicity, gender identity, geographic location, health status, immigration status, marital status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status (Canetto, 2011; Payne, 2016; Sue, 2001); and

WHEREAS these differences in our society are associated with an equally diverse range of views regarding assisted ~~[suicide]~~ dying (Crawley, 2006; Gallup, 2016; Pew Research Center, 2013); and

WHEREAS in the United States decisions about assisted ~~[suicide]~~ dying are made in the context of social devaluation of marginalized groups (e.g., Lund, Nadorff, Winer, & Seader, 2016) and serious social inequities in access to resources such as basic medical care; and

WHEREAS autonomy is an important guiding principle in the law and in psychological and medical aspects of decision-making, but in and of itself is insufficient to capture the full range of complex medical, familial, social, financial, psychological, cultural, spiritual (Chochinov, 2002; Steck, Egger, Maessen, Reisch, & Zwahlen, 2013), and legal issues (Washington et al. v. Glucksberg et al., 1997) involved in the practice of assisted ~~[suicide]~~ dying; and
 WHEREAS ~~[there is increasing]~~ public support for assisted ~~[suicide,]~~ dying ranges from 47-69%, but this support is weakest among groups who express concerns about being pressured to die

(i.e., older adults, people with disabilities, people with less education, women, and racial and ethnic minorities) (Blenden, Szalay, & Knox, 1992; Gallup, 2016; National Council on Disability, 1997; Pew Research Center, 2016); and

WHEREAS reasonable, well-informed people starting from different positions about costs and gains associated with assisted [suicide] dying disagree about the potential effects of legalizing the practice; and

WHEREAS people with different values and priorities can reach different conclusions about the advisability of assisted [suicide] dying; and

WHEREAS some evidence suggests that there are fluctuations in the will to live (Chochinov, Tataryn, Clinch, & Dudgeon, 1999; Fried et al., 2006; Kissane, 2004) and in wishes regarding life-sustaining treatments ([Weisman, Haas, & Fowler, 1999]; Emanuel, Fairclough, & Emanuel, 2000); and

WHEREAS pain, demoralization, and clinical depression are frequently unrecognized and under-treated, which can lead to suffering that may result in requests for assisted [suicide] dying (Foley, 1995; Berghmans & Lossignol, 2012; Ganzini, Goy, & Dobscha, 2008; Kissane, 2004; Kissane, 2012; Quill & Cassel, 2003); and

WHEREAS evidence suggests that some people rescind their requests for assisted [suicide] dying when they receive [more aggressive] palliative and comprehensive care (Chochinov, 2002; De Lima et al., 2017; Ganzini et al., 2000); and

WHEREAS psychological, familial, social, and financial factors seem to be more important than physical factors in requests for assisted [suicide] (Breitbart, Rosenfeld, & Passik, 1996; Emanuel, Fairclough, Slutsman, & Emanuel, 2000; Sullivan, Hedberg, & Fleming, 2000) dying (Emanuel, Onwuteaka-Philpsen, Urwin, & Cohen, 2016; Oldham, Dobscha, Goy, & Ganzini, 2011; Ohnsorge, Gudat, & Rehmann-Sutter, 2014; Smith, Harvath, Goy, & Ganzini, 2015); and

WHEREAS [little] limited empirical data exist to determine the effects of assisted [suicide] dying on survivors and on society (Cooke et al., 1998; Emanuel, Fairclough, & Emanuel, 2000; Ganzini, Goy, Dobsch, & Prigerson, 2009; Swarte, et al., 2003); and

WHEREAS the empirical database, legal developments, and policy discourse related to assisted [suicide] dying are evolving rapidly;

THEREFORE, BE IT RESOLVED that the American Psychological Association take a position that neither endorses nor opposes assisted [suicide] dying at this time.

However,

Given that psychologists have many areas of competence, including assessment, [counseling] intervention, teaching, consultation, research, and advocacy skills that could potentially enlighten the discourse about assisted [suicide] dying, palliative and end-of-life treatment, and support for [dying persons] people with serious advanced illness and their [significant others] care partners; and

Given that psychologists could be instrumental in helping health care providers to understand and cope with the concerns and needs of ~~[dying individuals]~~ people with serious advanced illness and their ~~[families]~~ care partners; and

Given that ~~[practicing]~~ psychologists may receive requests to be involved in the education of various groups regarding assisted ~~[suicide]~~ dying; and

Given that ~~[there is one state in which assisted suicide]~~ assisted dying is legal in multiple states and the District of Columbia, and psychological or psychiatric assessment and consultation is required under certain circumstances; and

Given that practicing psychologists may be part of ~~multidisciplinary~~ interprofessional [end-of-life] palliative care and hospice teams including ones exploring requests for assisted ~~[suicide]~~ dying;

Let it be further resolved that the American Psychological Association will assist in preparing the profession to address the issue of assisted ~~[suicide]~~ dying by taking the following actions:
Advocate for quality palliative and end-of-life care for all individuals; and

Encourage and promote the development of research on assisted ~~[suicide]~~ dying; and

Monitor legal, policy, and research developments that may require or encourage psychologists to involve themselves in assisted ~~[suicide]~~ dying cases; and

Promote policies that reduce suffering that could lead to requests for assisted ~~[suicide]~~ dying; and

Promote psychologists' involvement in research on ethical dilemmas faced by clinicians and researchers dealing with issues related to assisted ~~[suicide]~~ dying; and

Promote psychologists' participation in ~~[multidisciplinary]~~ interprofessional teams and ethics committees involved with reviewing end-of-life requests; and

Encourage psychologists to obtain training in ~~[the area of]~~ ethics (e.g., medical ethics, professional codes of conduct) in the context of diversity, as ~~[it applies]~~ applied to palliative and end-of-life decisions and care; and

Encourage ~~[practicing]~~ psychologists to inform themselves about criminal and civil laws that have bearing on assisted ~~[suicide]~~ dying in the states in which they practice; and

Encourage ~~[practicing]~~ psychologists to recognize the powerful influence they may have with ~~[clients]~~ individuals who are considering assisted ~~[suicide]~~ dying; and

Encourage psychologists to identify factors leading to assisted ~~[suicide]~~ dying requests (including clinical depression, demoralization, levels of pain and suffering, adequacy of comfort care, and other internal and external variables) and to fully explore alternative ~~[interventions]~~ approaches (including hospice/palliative care, refusal or discontinuation of life-sustaining measures, and other end-of-life options such as voluntarily stopping eating and drinking) for clients considering assisted ~~[suicide]~~ dying; and

Encourage ~~[practicing]~~ psychologists to be aware of their own views about assisted ~~[suicide]~~ dying, including recognizing possible biases about quality of life and entitlement to resources based on ~~[disability status, age, sex, sexual orientation, or ethnicity]~~ age, culture, disability status, ethnicity, gender identity, geographic location, health status, immigration status, marital status, race/ethnicity, religion, sex, sexual orientation, socioeconomic status, and veteran status of the ~~[client]~~ individual requesting assisted ~~[suicide]~~ dying; and

Encourage psychologists to be especially sensitive to the social and cultural biases which may result in some groups and individuals being perceived by others, and/or being encouraged to perceive themselves, as more expendable and less deserving of continued life (e.g., ~~[people with disabilities, women, older adults, people of color, gay men, lesbians, bisexual people, transgendered individuals, and persons who are poor]~~ as above).

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D.(31) The item, "Resolution on Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders" was postponed to Council's March 2018 meeting.

E.(32) The item, "Report of the Working Group on Health Disparities in Boys and Men" was postponed to Council's March 2018 meeting.

F.(33) Council voted to receive the report, *Stress and Health Disparities: Contexts, Mechanisms and Interventions Among Racial/Ethnic Minority and Low Socioeconomic Status Populations*.

G.(34) Council voted to adopt as APA policy the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality, 2017*, and approved 2027 as the expiration date for the Guidelines. Council also voted to archive the *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists, 2002*.

H.(42) Council received as information an update on the new business in progress item, "Police/Citizen Contact New Business Item from Peace Psychology Division Violence Summit (NBI#21A/Feb 2017)."

XIII. ETHNIC MINORITY AFFAIRS

No items.

XIV. INTERNATIONAL AFFAIRS

No items.

XVI. FINANCIAL AFFAIRS

A.(41) Council received as information the 2016 Audited Financial Statements.

On Wednesday morning, Jean Carter, PhD provided Council with the financial report. Following this report, Council met in executive session to receive an update from APA's General Counsel, Deanne Ottaviano, JD, on pending litigation.

On Wednesday afternoon, Council participated in small and large group discussions related to master's level training and practice in psychology. At the conclusion of the discussion, there was agreement among Council members that current issues and developments have risen to the level that APA should take a position on master's level training and/or practice and that staff and governance should identify and explore options for APA to pursue.

Additionally, the Committee on Early Career Psychologists presented Division 17 (Society of Counseling Psychology) with a recognition for promoting the expertise of early career psychologists and encouraging early career involvement in leadership.

On Friday morning, Armand R. Cerbone, PhD was presented with the Raymond D. Fowler Award for Outstanding Member Contributions.

On Friday, Frank Worrell, PhD and Deanne Ottaviano, JD, engaged Council in a discussion on a proposed APA Bylaws amendment to provide Council greater authority to amend the APA Bylaws.

The following new business items were submitted at the August 2017 meeting (referral groups will be provided when available: NBI #35A/Aug 2017, Sunsetting APA Policy/Task Force Statements on Media/Video Game Violence Due to Inconsistent Evidence Base on Effects and NBI #35B/Aug 2017, Resolution to Amend the 2015 Resolution to Amend the 2006 and 2013 Council Resolutions to Clarify the Roles of Psychologists Related to Interrogation and Detainee Welfare in National Security Settings, to Further Implement the 2008 Petition Resolution, and to Safeguard Against Acts of Torture and Cruel, Inhuman, or Degrading Treatment or Punishment in All Settings (heretofore referred to as the August 2015 Resolution).

DRAFT