

BOARD OF DIRECTORS

February 19 & 20, 2014

APPROVED MINUTES

Present: Nadine J. Kaslow, PhD; Barry S. Anton, PhD; Donald N. Bersoff, PhD, JD; Jennifer F. Kelly, PhD; Bonnie Markham, PhD, PsyD; Norman B. Anderson, PhD; Linda F. Campbell, PhD; Louise A. Douce, PhD; Jennifer Doran, MA; Josephine D. Johnson, PhD; Susan H. McDaniel, PhD; Diana L. Prescott, PhD; William J. Strickland, PhD

Absent: None.

I. MINUTES OF THE MEETING

A.(1) The Board voted to approve the minutes of its December 13-15, 2013, meeting.

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) The Board discussed the item on the petition for a new division and recommended a full discussion by Council on the motion requesting candidacy status for a period of two years for the Society for Technology and Psychology, Division 57 of the American Psychological Association.

B. In executive session, the Board voted to approve the appointment of Alan Groveman, PhD, to the Continuing Education Committee, for a three-year term beginning immediately and ending December 31, 2016.

III. ETHICS

A. In executive session, the Board took action on three Ethics cases.

B. In executive session, the immediate past Ethics Committee Chair, James N. Bow, PhD, ABPP, provided the Board with an overview of the ethics process in relation to the decision in the John Leso, PhD, matter. The Board released a statement on February 20 on the "No Cause for Action" decision regarding the ethics complaints against Dr. Leso (attached).

VI. ORGANIZATION OF THE APA

A. On its January 21 call, the Board voted to recommend that the Council of Representatives adopt the following Resolution Delegating Authority for Specific Duties to the Board on a Trial Basis:

WHEREAS the American Psychological Association has embarked on a project of good governance (the "Good Governance Project" or "GGP") in order to enhance and

improve the efficiency, nimbleness and effectiveness of APA's governance infrastructure;

WHEREAS the Good Governance Project Team brought forth to Council the Good Governance Project Report detailing ways that the governance infrastructure of APA can be more effective, more nimble and more efficient;

WHEREAS the GGP Report was received by Council at its July/August 2013 meeting;

WHEREAS the GGP Team brought forward for a vote to Council in July/August 2013 eight (8) motions relating to the implementation of the GGP Report including:

- Technology
- Leadership Development
- Triage
- Council Purpose
- Fiduciary Roles
- Board Composition
- Council Structure
- Implementation

WHEREAS among these motions, Council adopted Motion #5 at its July 31 & August 2, 2013 meeting which provides, as follows:

Motion #5 Fiduciary Roles (108/50/1)

Council supports delegating the authority for the following areas of fiduciary responsibility to the Board of Directors on a trial basis for a three-year period following implementation:

- *Financial/budget matters*
- *Hiring, evaluation and support for the Chief Executive Office*
- *Assuring alignment of the budget with the APA strategic plan*
- *Internally focused policy development*

In addition, Council will receive regular reports from the Board on the delegated areas during the trial period and retains its responsibility as set forth in the Bylaws. In the interest of transparency, such reports to Council will also be made available to the entire membership.

Council directs the President to instruct the IWG to develop an implementation plan that includes an evaluation process for the end of the three-year trial period and to present these to Council for approval beginning in February 2014.

WHEREAS Council has determined that it is in the best interests of the Association, and will facilitate APA fulfilling its mission, to allow Council to focus its work more fully on developing and adopting policy and ensuring APA policies are aligned with APA's plans;

WHEREAS Council has determined that it can best meet its fiduciary duty to the Association as a whole, and in particular in the areas of financial and budget matters, alignment of the budget with the strategic plan, management of the Chief Executive Officer, and internally focused policy development, by delegating evaluation, oversight, management and decision making authority for these areas to the Board of Directors;

WHEREAS pursuant to Motion #5, in order to allow Council to fulfill its fiduciary responsibility more fully so that it may focus its work on policy issues and alignment of policy with APA's mission and strategic plan, the Council of Representatives wishes to evaluate on a trial basis, without amending the Bylaws, the effectiveness of delegating authority for certain responsibilities involving financial and administrative tasks to the Board to discharge for a trial period of three years beginning on March 1, 2014;

WHEREAS Council will have the responsibility for approving the 2014 operating budget at the February 2014 Council meeting;

THEREFORE BE IT RESOLVED pursuant to its authority as set forth in Article IV, Sections 1 and 7 of the Bylaws, and pursuant to a suspension of Association Rules to the extent necessary to accomplish the purposes of this Resolution, the Council of Representatives hereby delegates to the Board of Directors, for a period of three years beginning March 1, 2014 and ending February 28, 2017, authority for the following areas:

- Financial and budget matters
- Hiring, evaluation and support of the CEO
- Assuring alignment of the budget with the APA Strategic Plan
- Internally focused policy development

The Board shall prepare and provide to Council semi-annual reports on these delegated areas during this period, which shall also be available to the membership.

During the three year period:

1) Council will rely on the Board of Directors to carry out its responsibilities in these four areas, subject to Council's overall power and authority as set forth in the Bylaws and;

2) Those portions of the Association Rules requiring a vote of approval by Council for action in these four areas shall be suspended until further action by Council, such as:

- Rule 110-11 (Chief Staff Officer evaluation)
- Rule 210-2.3/210-4 (approval by Council of long term goals for investing recommended by the APA Finance Committee)
- Rule 210-2.5 (approval by Council of Presidential Discretionary Fund);

- Rule 210-5 (approval of dues)
- Rule 10-12 (Life Membership Status dues exemption)
- Rule 50-3 (approve new ad hoc group if new funding is needed)
- Rule 210-2.2 (approval of budget by Council)

3) For the evaluation process

- The Chief Financial Officer, on behalf of the Board of Directors, Finance Committee and APA staff, will provide a bi-annual report to Council. This report will provide Council detail on how APA is meeting the organizational financial goals as set forth in the Association Rules.
- Two evaluations will be conducted under the direction of the Finance Committee which will solicit input from Council, Board of Directors, Finance Committee and appropriate APA staff.
- The first evaluation will be conducted in the spring of 2015. The Treasurer will report the findings of the evaluation to Council at its August 2015 meeting. Data collected will be used to modify the on-going trial.
- The second evaluation will be conducted in the spring of 2016. The Treasurer will report the findings of the evaluation to Council at its August 2016 meeting. Data provided will be used to improve the on-going trial period.

At the end of the trial period during the February 2016 meeting, Council will decide how to proceed.

B. On its February 4 conference call, the Board voted to recommend that Council approve the following motion:

That the Council of Representatives asks staff to bring to Council at its August 2014 meeting relevant Bylaws and Association Rules changes to reconfigure the Board of Directors so as to be consistent with Council's vote at its July 31 & August 2, 2013 meeting.

Council also approves that the public member is a voting member of the Board and that the Chair and Chair-elect of the Council Leadership Team (CLT) are the two members on the Board from the Council.

The Composition of the Board of Directors will be as follows:

- The President, President-elect and Past President, elected by and from the general membership
- The Recording Secretary and Treasurer, elected by the Council
- The Chair and Chair-elect from the Council Leadership Team, elected by the Council
- Six members-at-large elected by and from the general membership
- The APAGS Past Chair (elected directly by and from the APAGS membership)
- One public member appointed by the Board
- The Chief Executive Officer (ex officio; non-voting)

All members except for the Chief Executive Officer are voting members. All voting members serve three-year terms except as follows: The APAGS Past Chair serves a one-year term; the Presidential cycle is a three-year term in total; and the members from the CLT (Chair and Chair-elect) each serve a two-year term. A member cannot serve consecutive terms on the Board of Directors (including moving from one position to another) with the following exceptions: The Treasurer is eligible to serve two terms, but may not serve more than six consecutive years. A Board member is eligible to run for and serve as President. After at least one full year off the Board, members are eligible to run for election for a Board position.

The Needs Assessment, Slating, and Campaigns Committee (NASCC) will conduct an annual needs assessment and develop slates for the six seats on the Board elected by and from the general membership and shall ensure that at least one member of the Board is an Early Career Psychologist. NASCC will also develop the slate for the public member appointed by the Board.

C. On its February 4 conference call, the Board voted to recommend that Council approve the following motion:

That the Council of Representatives asks staff to prepare language for necessary Association Rule changes to create the new Needs Assessment, Slating and Campaigns Committee (NASCC). This committee is charged with conducting an annual needs assessment and developing slates for seats on the Board of Directors and Council that are elected from the general Association membership, soliciting and vetting candidates for the election slates, and helping support the dissemination of information about and conduct of elections to these seats. NASCC also develops the slate for the public member of the Board to be appointed by the Board.

The NASCC will consist of seven members, including one public member. Members will have three-year staggered terms and are eligible to serve two consecutive terms but cannot serve more than six consecutive years.

The members are appointed as follows:

- One member each (for a total of four members) appointed by the following boards: Board for the Advancement of Psychology in the Public Interest, Board of Educational Affairs, Board of Professional Affairs, and Board of Scientific Affairs.
- Three members, including the public member, appointed by individuals in the Presidential cycle (President, President-elect and Past President) after broad consultation.

Individuals who serve on the NASCC should be free of conflicts of interest or appearances of conflicts of interest with other roles they have held or seek within APA and also within Divisions and State, Provincial, and Territorial Psychological Associations (SPTAs). The following eligibility rules apply to all NASCC members:

- Individuals are not permitted to serve on the NASCC if they have served on the Board of Directors, Council of Representatives, or APA boards and committees in the past three years.

- Members of the NASCC are restricted from concurrent service on the Board of Directors, Council of Representatives, or APA boards and committees and for at least three years following their service on the NASCC.
- Members of the NASCC are not permitted to serve concurrently in elected officer positions in any Divisions or SPTAs.

The Draft Operations and Procedures for the NASCC as developed by the Good Governance Project Implementation Work Group (IWG) will form the basis of how NASCC will perform its duties. NASCC will be charged with developing an Operations and Procedures Manual which shall be consistent with the core criteria as recommended by the IWG.

D. On its February 4 conference call, the Board voted to recommend that Council approve the following motions:

- 1) That Council approves expanding its scope to focus on developing, directing and informing policy affecting the discipline and practice of psychology and ensuring APA policies are aligned with APA's mission and strategic plan.
- 2) That Council asks staff to develop the relevant Bylaw and Association Rule changes needed to establish the Council Leadership Team (CLT) as described below.

The CLT shall serve as the Executive Committee of Council and consist of a Chair, Chair-elect, Past Chair, the APA President, the APA President-elect (non-voting) the APA Treasurer, the APAGS Chair, an Early Career Psychologist Representative, three members-at-large and the Chief Executive Officer (without vote). The Chair of CLT presides over CLT. The President presides over the Council.

The CLT Chair, Chair-Elect, Past Chair, Members-at-large, and the ECP Representative shall serve one three-year term and shall be selected from the existing representatives on Council who have had at least one year of Council experience. The members-at-large shall serve for staggered terms of three-years.

An assessment of needs for the CLT will be provided to Council in advance of the nominations process. The 3 candidates for Chair, member-at-large, and ECP representative will be slated based on the highest number of nominations by Council. Election will be based on the highest number of votes by Council. The APAGS Representative shall be the APAGS chair. The terms of the APA President and APAGS Representative rotate annually.

The CLT will a) manage a procedure to select and oversee Council's mega issue discussions; b) prioritize and determine appropriate disposition of new items coming through the triage system; c) determine the priorities for Council and the order of business for meetings of Council; d) initiate and oversee the work of boards and committees reporting to Council; e) provide a recommendation to Council on all motions brought before Council for its consideration; f) regularly review the structure and

function of Council (including orientation of new members) and handle complaints about Council functions and operations; and g) lead Council in reviewing and revising the strategic plan and ensure that APA policies are aligned with APA's mission and strategic plan.

The CLT shall develop and adopt its own operating procedures and policies incorporating the use of technology.

X. PROFESSIONAL AFFAIRS

A. (3) The Board voted to recommend that the Council of Representatives approve in principle sun-setting the (C3) responsibilities of CAPP effective December 31, 2014, and request that the amendments to the APA Association Rules and APAPO Bylaws needed for implementing this change be brought to Council for action at its August 2014 meeting.

XI. SCIENTIFIC AFFAIRS

A.(4) The Board voted to recommend that Council reauthorize the continuation of support for the Archives of the History of American Psychology for 2014-2016 and approve the inclusion of \$60,000 in the 2014 Budget.

XII. PUBLIC INTEREST

A.(5) 1) The Board voted to recommend that Council archive the 1994 APA policy, *Firearm Safety and Youth*;

2) The Board voted to recommend that Council adopt as APA policy the following Resolution on Gun Violence Research and Prevention:

Resolution on Firearm Violence Research and Prevention

Research Summary

Firearms have been the subject of longstanding controversies in American society, culture and law. There are many firearms in the United States – more than 300 million (Hepburn, Miller, Azrael, & Hemenway, 2007) – about as many guns as people. The United States has the highest rate of civilian firearm ownership in the world (Small Arms Survey, 2007). Most firearm owners own multiple firearms, with perhaps as few as 4% of the population owning 65% of the guns (Hepburn et al., 2007). Thus, in one recent survey, a minority of households (37%) included gun owners, with 24% of respondents reporting that they owned a gun and 13% reporting that another member of their household owned a gun (DeSilver, 2013).

Firearm violence takes a number of different forms, including, but not limited to, suicide and suicide attempts, violent conflicts and disputes, intimate partner violence, unintentional deaths and injuries, violent criminal activity, and violent acts while intensely distressed, intoxicated, or acutely psychotic. Firearms contribute significantly to homicide and suicide as causes of death in the United States, causing 11,078 homicides and 19,392 suicides in 2010, 11,101 homicides

and 19,766 suicides in 2011 (Hoyert & Xu, 2012). Mass shootings receive intense media coverage, generate understandable public alarm, and appear to fuel the purchase of firearms.¹ However, the Congressional Research Service estimates that over the last 30 years (1983-2013) public mass shootings took 547 lives and left 476 victims injured, concluding that “while tragic and shocking, public mass shootings account for few of the murders or non-negligent homicides related to firearms that occur annually in the United States” (Bjelopera, Bagalman, Caldwell, Finklea, & McCallion, 2013, Summary section, para. 5). Thus, in order to be effective in reducing firearm violence, the national response must comprehensively address the phenomenon in its many forms.

The public health burden arising from firearms: Deaths, injuries, and other associated harms

Firearms are inherently dangerous and pose a substantial risk to the health of the public. Preliminary data for 2011, the most recent available, document that daily deaths from firearms averaged 54 suicides, 30 homicides, and more than 2 unintentional deaths, with totals of firearm-related deaths for the year equaling 19,766 of 38,285 suicides (52%), 11,101 of 15,953 homicides (70%), and 851 of 122,277 unintentional deaths (1%) (Hoyert & Xu, 2012). Additionally, for every firearm fatality, an estimated 2.25 persons suffer non-fatal injuries requiring emergency medical care or hospitalization (Gotsch, Annest, Mercy & Ryan, 2001). In 2012, there were 80,525 non-fatal firearm injuries: 4,068 self-inflicted injuries, 59,077 injuries from firearm assaults, and 17,362 unintentionally inflicted injuries (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014). The number of unintentional injuries and deaths may be underreported, especially among children (Luo & McIntire, 2013). One analysis estimated that gun violence imposed total costs of \$174 billion on the United States in 2010, an average of \$645 per gun in the United States, \$5.1 million for each fatality, \$433,000 for each gun injury requiring hospital admission, and \$116,372 for each firearm injury requiring emergency department admission only (Miller, 2012). These estimates do not include the impact on those who endure consequences from witnessing or fearing firearm violence in their homes or communities when firearms are used to intimidate and coerce (Sorenson & Wiebe, 2004; Truman, 2011).

In a survey conducted in February 2013, 48% of firearm owners reported that they own guns for protection. This reflects a substantial change since 1999, when only 26% of gun owners reported that they own guns for protection and 49% of gun owners identified hunting/sport shooting as the primary reason they have a gun (Pew Research Center, 2013). Paradoxically, firearms owners have increasingly identified protection as their reason for acquiring a firearm even as rates of violent crime have dropped substantially. Violent crime rates have dropped by half since 1993 (U.S. Department of Justice, Federal Bureau of Investigation, 2013) and the 2012

¹ On December 14, 2012, a gunman killed 20 first grade students and 6 school personnel at Sandy Hook Elementary School in Connecticut and wounded two others. In the next week, December 17-23, 2012, the most requests for background checks (a proxy for gun sales) in a week since 1998 were submitted to the National Instant Criminal Background Check System, 953,613 requests, nearly 50% larger than the next highest week (U.S. Department of Justice, Federal Bureau of Investigation, 2013).

murder rate of 4.7 per 100,000 persons compares to rates of 10.2 in 1980, 9.8 in 1991 and represents a decline of almost 17% since 2003 (U.S. Department of Justice, Federal Bureau of Investigation, 2013).

In addition, firearms are associated with increased risk. Purchase of a handgun is strongly associated with increased risk of suicide (Wintemute, Parham, Beaumont, Wright & Drake, 1999). Having a firearm in the home increases the likelihood of homicide or suicide of a family member (Dahlberg, Ikeda & Kreznow, 2004; Kellermann, et al. 1992; Kellermann, et al. 1998), including fatal shootings of women associated with intimate partner violence (Campbell, et al. 2003). Compared to other high-income countries, the United States by a substantial margin has the highest rates of firearm-related homicide, suicide and unintentional death and unintended injury among children and adolescents, leading the American Academy of Pediatrics to conclude that the “absence of guns from children’s homes and communities is the most reliable and effective measure to prevent firearm-related injuries in children and adolescents” (American Academy of Pediatrics, 2012, e14160).

A public health approach to preventing deaths and injuries from firearms

A public health approach to the prevention of public health problems is a scientific approach. Scientists define a problem, conduct research to identify risk and protective factors, and use the knowledge about risk and protective factors to develop preventive interventions. The interventions are implemented and evaluated for effectiveness. The evaluation results then guide efforts to ensure the widespread adoption of effective programs and policies to mitigate risks or support protective factors. Public health approaches commonly utilize multidisciplinary collaborations among a range of stakeholders to identify and achieve goals for community and individual health and safety. Sound science generally does not provide definitive answers in one study or at a single point in time. Instead, scientific knowledge develops over time as new research clarifies and expands upon past understandings. Accordingly, in applying a science-based approach, one begins with the best available evidence and subjects it to ongoing, systematic scientific scrutiny.

The American Psychological Association published a report by an expert panel in December 2013 (American Psychological Association, 2013) in an effort to inform the public regarding the current science on firearm violence and contribute to national efforts to prevent firearm-related death and injury. The report reviews research on development, gender, and culture as antecedents to gun violence and what works to prevent gun violence at the individual, family, community, and societal levels.

Because access to a firearm is the common denominator in firearm violence, reducing access to firearms has been an important focus in prevention. *Child access prevention laws*, which hold adults criminally liable for unsafe storage of firearms around children, have reduced adolescent suicides and unintentional shootings of children (Webster & Starnes, 2000; Webster, Vernick, Zeoli, & Manganello, 2004). Undercover operations and lawsuits against dealers have reduced the diversion of firearms to criminals (Webster, Bulzacchelli, Zeoli, & Vernick, 2006; Webster &

Vernick, 2013). Other prevention efforts focused on access to firearms include design and manufacture of firearms such as “smart guns” that can be fired only by an authorized user, limitations on access to certain firearms such as assault rifles or products such as high-capacity magazines, and systems of distribution and sales that help prevent illegal diversion of firearms and “straw purchases” of firearms (Sorenson & Webster, 2013).

Access strategies also include regulating access to firearms for particular classes of persons. For example, U. S. law prohibits firearm purchase and possession by, among others, felons and persons dishonorably discharged from the military, subject to a domestic violence restraining order, or “adjudicated as a mental defective” or “committed to a mental institution” (Firearms, 2014). These access restrictions are implemented by requiring federally licensed firearm dealers to request background checks on potential purchasers from the National Instant Criminal Background Check System (U.S. Department of Justice, Bureau of Alcohol, Tobacco, Firearms, and Explosives, 2005). One study has found that, if properly implemented, such prohibitions can significantly reduce violent offending among persons with histories of involuntary psychiatric commitment (Swanson, et al. 2013), but multiple impediments to their implementation have hampered their potential contribution to reducing firearm violence (Kinscherff, Evans, Randazzo, & Cornell, 2013)

Some, but not all, educational interventions to reduce firearm violence have shown promise. Promising interventions include counseling by health care providers (especially when combined with distribution of cable locks to secure firearms) (Barkin, et al. 2008), police training for de-escalation of persons in crisis in high-risk situations (Teller, Munetz, Gil, & Ritter, 2006), and community, family, and individual interventions to promote healthy social development and reduce aggressive behavior among children and adolescents (Cornell & Guerra, 2013). On the other hand, efforts to educate children about guns (largely to stay away from them), when tested with field experiments, indicate they are generally ineffective (e.g., Hardy, 2002). A “substantial body of scientific evidence [that] identifies important developmental, familial, and social risk factors for violence” (Cornell & Guerra, p. 5) can guide the development of additional interventions.

The research on firearm violence indicates that while empirically-derived structured clinical judgment and actuarial tools have been shown to distinguish relative violence risk among researched populations (e.g., male domestic violence offenders, offenders with violence histories and mental disorders), no methods currently exist for reliably predicting whether or not specific *individuals* will behave violently, nor the specific time, place or manner (including firearm use) in which they will behave violently (Lidz, Mulvey, & Gardner, 1993; Meehl & Rosen, 1955; Monahan, et al. 2005; Nielssen, et al. 2009). On the other hand, science-based risk assessment and management strategies using empirically-derived assessment tools for individuals with histories of violence have developed as the standard for preventing targeted violence in many settings (Kinscherff, Evans, Randazzo, & Cornell, 2013). In the *behavioral threat assessment model*, teams use highly individualized and situation-specific methods to

prevent violence by specific persons identified as making or posing a threat of violence, including risk of using a firearm.

More research is required to guide policy and practice since some promising measures have not yet been shown to be effective or may have unintended consequences (National Research Council, 2005; Institute of Medicine and National Research Council, 2013). Research can also help determine which initiatives are ineffective in reducing harm from firearm violence. For example, “buy-back” programs might raise public awareness of gun violence, but have been ineffective in reducing firearm deaths (Institute of Medicine and National Research Council, 2013; Makarios & Pratt, 2012). Additionally, controversies persist as to whether various legal requirements for mental health professionals to “warn or protect” when providing services to potentially violent persons are more likely to reduce violence or deter persons from seeking mental health care (Kinscherff et al, 2013).

Some research suggests that more rigorous reporting and background checks of persons whose mental health history disqualifies them from firearms ownership lowers risk of violent criminal offending (Swanson, et al. 2013). Yet, concerns persist about the risks of stigmatizing persons with mental illness while also potentially fostering public perceptions that firearm violence can be readily reduced to a “mental illness” problem (e.g., Appelbaum, 2013). Research could also help determine the effects of recent legislative efforts to bar medical care providers from asking patients about firearm possession and access (Medical privacy concerning firearms; prohibitions; penalties; exceptions, 2014; The Patient Protection and Affordable Care Act, 2010). Program developers and sponsors are encouraged to articulate clear rationales for policies, programs, and practices and to evaluate them.

There are some important barriers to the scientific research needed for a comprehensive public approach to the prevention of firearm violence. First, a universal system for collecting data on incidents of firearm violence does not exist. Several Institute of Medicine and National Research Council reports have identified the National Violent Death Reporting System as a promising approach for gathering essential data on firearm violence (National Research Council, 2002; National Research Council, 2005; Institute of Medicine and National Research Council, 2013), yet this system currently includes data from only 16 states (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013).

Second, state and federal restrictions, including restrictions on the Centers for Disease Control and Prevention (Omnibus Consolidated Appropriations Act, 1996) and the National Institutes of Health (Consolidated Appropriations Act, 2012), limit or discourage firearm violence research and preclude or discourage the collection and use of firearm violence information (Institute of Medicine and National Research Council, 2013; Kellermann & Rivara, 2013). These restrictions exist despite widely-accepted and widely-implemented research practices that safeguard the privacy of individuals (e.g., medical records research) in order to gather information on the occurrence of other public health problems (e.g., certain infectious diseases). If federal and state restrictions on such data are removed, research by psychologists and others can be used

to devise, implement, and evaluate research-based public health approaches to firearms-related death and injury.

Firearm violence and diversity

As noted above, access to a firearm is the common denominator in every firearm-related death or injury. Beyond this obvious fact, achieving a greater understanding of the different forms of firearm violence, the populations disproportionately harmed, and the factors relevant to preventive interventions will involve addressing considerable complexity. Firearm violence disproportionately affects specific groups within the United States. Patterns of injury and death from firearms (attempted and completed homicides and suicides, and unintentional injuries) differ according to factors including age, gender, gender identity and expression, sexual orientation, race and ethnicity, geographic region and locality, educational level, employment status, job and working conditions, income level, and social class (Hepburn & Hemenway, 2004; Institute of Medicine and National Research Council, 2013; Jenkins, 1996; Kegler & Mercy, 2013; Kennedy, Kawachi, Prothrow-Stith, Lochner, & Gupta, 1998; Loomis, Marshall & Ta, 2005; Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008; Peek-Asa, Erickson, & Kraus, 1999). These disparities reflect a complex interaction of multiple risk, protective, and contextual factors at individual, community, and societal levels, including differential access to resources that promote health and safety (Krug, Dahlberg, Mercy, Zwi, & Lozano-Ascencio, 2002).

For example, firearms are the most frequent means of suicide among older adult white men and contribute to them having a very high suicide rate (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013). White adolescent males also have elevated rates of suicide by firearms (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013). Young Black males living in impoverished urban communities bear the greatest risk of homicide by firearms (Hammond & Prothrow-Stith, 2001). Women are disproportionately more likely to be the victims of firearm violence by an intimate partner (Sorenson, 2006). In order to be developmentally and culturally appropriate and attentive to relevant aspects of diversity, public policy and prevention strategies must attend to the different relative risks, occurrence, and contexts across groups.

Firearm violence and mental illness

There is little research specifically on firearm violence among persons with severe² mental illness, but there is a relatively large literature on the relationship between severe mental illness and violence in general. As one commentator has put it, “[t]he vast majority of people with mental disorders do not engage in violence and the proportion of overall risk of violence attributable to mental disorders is small...The best U.S. data put the population attributable risk for violence due to mental disorder between 3% and 5%” (Appelbaum, 2013, p. 565, citing Swanson, 1994). Research has demonstrated a modest association of mental disorders with

² The terms “serious mental illness” and “severe mental illness” are both commonly found in research literature. The term “severe mental illness” is used here for the sake of consistency.

increased violence, with greatest risk for those who have additional risk factors such as substance abuse, histories of being violently victimized, continued exposures to violence, antisocial personality traits, and histories of involuntary commitment (Appelbaum, 2013; Swanson, et al. 2002; Swanson, et al. 2013). Some recent research points to substance abuse as the primary factor in violence risk among persons with severe mental illnesses (Fazel, Gulati, Linsell, Geddes, & Grann, 2009; Fazel, Langstrom, Hjern, Grann, & Lichtenstein, 2009). One recent large longitudinal study found no significant independent association between severe mental illness and subsequent violent behavior, rather that people with severe mental illness had a greater likelihood of having other risk factors associated with violence, for example, a history of violent victimization and substance abuse (Elbogen & Johnson, 2009). Research has found that access to adequate mental health treatment in the community following psychiatric hospitalization reduced subsequent violent acts, most of which were minor assaults unlikely to significantly injure and were directed at known persons rather than strangers (Monahan, et al. 2001). In contrast to the small association between mental illness and violence directed at others, there is a significantly elevated risk of suicide among persons with mental disorders with some 90% of persons who commit suicide having some combination of symptoms of depression, other mental disorder, and substance abuse (Moscicki, 2001).

Aggressive acts often are distinguished by whether they are planned to achieve anticipated goals (variously termed *instrumental*, *targeted* or *predatory* aggression) or whether they are driven by intense emotions at a time of crisis (variously termed *affective*, *impulsive*, *reactive*, or *hostile* aggression). Persons engaging in impulsive violence are sometimes described as acting “in the heat of the moment” or “without considering the consequences.” Predatory and impulsive aggression implicate different neurological systems with impulsive aggression characterized by high levels of autonomic arousal and negative emotions such as fear or anger, usually in response to a perceived provocation or stressor (Siever, 2008).

Whether or not they suffer from a mental disorder, persons in intense emotional crisis are at higher risk of impulsive aggression and harming themselves (Wyder & De Leo, 2007; Zouk, Tousignant, Seguin, Lesage, & Turecki, 2006) or others (Meloy, 2006), including spouses (Edwards, Scott, Yarvis, Paizis, & Panizzon, 2003) and children (Fujiwara, Barber, Schaechter, & Hemenway, 2009; Rodriguez & Richardson, 2007). Persons in crisis include those experiencing desperation, despair, panic, rage or other intense emotions that may result in acts of impulsive violence involving a firearm, if one is accessible. Some participants in contemporary policy debates about firearm violence seem to assume that “bad guys” cause violence and the appropriate way to deal with violence is to arm “good guys” to deal with “bad guys.” Unfortunately, this approach will not be effective in preventing violence, because “an armed ‘good guy’ can become a ‘bad guy’ [who uses] a gun in a moment of temporary despondence or rage (Bandeira, 2013; Wintemute, 2013)” (Sorenson & Webster, 2013, p. 32).

One priority of the public sector mental health system is to meet the needs of people with severe mental illnesses. However, the public mental health system also has a second priority: to respond to serious emotional crises that can happen to anyone at any time, and especially to

respond at times when these crises produce elevated risks of harm to self or others. Yet, the steady loss of \$4 billion from state mental health budgets since 2008 (Appelbaum, 2013) has eroded the capacity to respond in a reliable, timely, and competent manner to those in intense emotional crisis. The broader system of mental health services beyond the public sector also has a crucial role to play in responding both to persons with severe mental illness and to persons in serious emotional crisis.

For the mental health system to play an optimal role in preventing firearm violence, policy makers will need to increase mental health care resources. However, in promoting such increases, policy-makers and advocates should take care to address both priorities of the mental health care system, to encourage help-seeking behavior by persons in crisis and by persons with mental illness, and to avoid reinforcing the stigma that both groups experience. Policymakers and advocates should go beyond the concern regarding mass shootings to focus upon the contribution of depression to the higher rates of suicide and the contribution of emotional crisis to incidents of gun violence.

The American Psychological Association Panel of Experts Report on Gun Violence (American Psychological Association, 2013) discusses various policies seeking to restrict access to firearms by persons with mental disorders. Many of these policies have been criticized for using broad criteria that bear little relationship to actual risk and for failing to identify persons who may pose significant or imminent threat of violence (Fisher & Lieberman, 2013). However, some research indicates such policies, if properly implemented, can significantly reduce violent offending among persons with histories of involuntary psychiatric commitment (Swanson, et al. 2013). Policy interventions such as these warrant ongoing evaluation given their potential for both reducing firearm violence and inadvertently deterring persons from seeking mental health care or being frank with their clinical care providers about risk factors for firearm violence.

Resolution

Consistent with the American Psychological Association's mission to advance the development, communication and application of psychological knowledge to benefit society and improve people's lives, this Resolution on Firearm Violence Research and Prevention has two primary goals: (1) to encourage the scientific study of firearm violence and its prevention, and (2) to encourage psychologists to respond to the problem of firearm violence as scientists, practitioners, and educators.

WHEREAS death and injury arising from firearms violence by suicide, homicide and unintentional shootings constitute a tragic and substantial burden upon public health in the United States;

WHEREAS mass shootings draw widespread attention to firearm violence from the media, the public, and policy-makers, but comprise a very small percentage of the U.S. firearm-related deaths and injuries that occur each year (Bjelopera, Bagalman, Caldwell, Finklea, & McCallion, 2013);

WHEREAS like motor vehicles, toxic household products, tobacco, and other products with inherent risks whose harms to the public health have been significantly reduced (Hemenway, 2007), firearms pose inherent risks that have been identified and can be addressed through a public health approach;

WHEREAS current federal and state policies that restrict or discourage firearms research, prevent access to routinely-collected firearms data, and create other impediments to science hinder the contribution of research, evaluation, and multidisciplinary practice to public policy and public health (Kellermann & Rivara, 2013; Institute of Medicine and National Research Council, 2013);

WHEREAS steps can be taken to safeguard the confidentiality of information and the privacy interests of individuals in research about firearms, just as these safeguards are widely used in other areas of public health (Institute of Medicine and National Research Council, 2013);

WHEREAS many policies, programs, and practices intended to reduce harms associated with firearms currently lack evidence of efficacy and may contribute to unintended consequences (National Research Council, 2005; Institute of Medicine and National Research Council, 2013)

WHEREAS a variety of useful and rigorous methods have been developed to assess the efficacy of policies, programs, and practices (Shadish, Cook, & Campbell, 2002), but are not consistently utilized;

WHEREAS more psychologists are needed with training to conduct basic and applied research and evaluate programs and practices for prevention and intervention in firearm violence (Aiken, West, & Millsap, 2008);

WHEREAS there are multiple, complex conditions and circumstances that give rise to firearm-related death and injury and the forms, risks, and consequences of firearm violence are not spread uniformly throughout the United States (Institute of Medicine and National Research Council, 2013);

WHEREAS there are currently no reliable methods to accurately predict which individuals will or will not engage in firearms violence at a particular time or under specific circumstances, although there are methods for behavioral threat assessment and person-specific violence risk management planning once an individual has been identified as making or posing a threat of violence, including firearm violence;

WHEREAS mass shooting incidents have contributed to public apprehension that persons with-- as compared to persons without--severe mental illness are at substantially greater risk of committing firearm violence;

WHEREAS policy makers have responded to public apprehension about the role of severe mental illness in mass violence towards others in ways that result in policies and practices that

further stigmatize persons with serious mental illness and may deter them from engaging in needed psychological or other services (Appelbaum, 2013);

BE IT RESOLVED that the following principles will guide APA in public education and policy advocacy regarding firearms violence research and prevention:

Principle 1: Comprehensive science-based public health approaches that reflect psychological knowledge and involve psychologists should guide policy and practice regarding firearms violence research and prevention.

BE IT RESOLVED that the American Psychological Association advocates a scientific public health approach to firearm violence research, prevention, risk identification and management, treatment, and evaluation at the individual, family, community, and societal levels in order to guide the achievement of intended goals while avoiding unintended consequences.

BE IT RESOLVED that the American Psychological Association promotes the application of psychological knowledge and the involvement of psychologists in firearms violence research, prevention, risk identification and management, treatment, and evaluation in collaboration with multiple stakeholders and disciplines.

BE IT RESOLVED that the American Psychological Association calls for the expansion of the U.S. National Violent Death Reporting System to all states and for the repeal of legislative and administrative barriers to public health research on firearm violence, provided the research methods safeguard the privacy interests of individuals.

BE IT RESOLVED that the American Psychological Association promotes firearm violence policies, programs, and practices that are evidence-based, reflect sound models of best practices, or have been rigorously evaluated for effectiveness and opposes broad implementation or institutionalization of novel policies and practices until shown to be efficacious in pilot studies or trial implementation.

BE IT RESOLVED that the American Psychological Association encourages graduate psychology programs to rigorously train students in evidence-based program development, implementation, and evaluation methods so as to support the ability of psychologists to help reduce firearms violence across multiple levels (e.g., individual, family, community, and societal) and populations and to enhance their ability to effectively interpret and communicate the results of such efforts to the public and to policy makers.

Principle 2: Increasing and applying knowledge about the disparate occurrence and types of firearm violence across different populations and at different levels (e.g., individual, family, community, societal) is fundamental to firearms violence research, prevention, risk identification and management, treatment, and evaluation.

BE IT RESOLVED that the American Psychological Association encourages research, public health programs, and public policy to address the full breadth of firearm fatalities and injuries.

BE IT RESOLVED that the American Psychological Association promotes greater awareness that harms arising from firearms vary across diverse groups, situations, settings, and communities and encourages research that identifies firearm violence risk and protective factors reflecting the full range of this diversity, in order to inform the development and implementation of empirically-based prevention strategies, threat assessment and risk management practices, treatments and other interventions, and outcome evaluations that effectively address the disproportionate effects of gun violence on different groups and communities in developmentally and culturally appropriate ways.

BE IT RESOLVED that the American Psychological Association opposes the stigmatization of persons with mental illness and others who are the target of prejudice and discrimination and supports further evaluation of public policies and practices addressing firearms violence to assess their effectiveness and potential for unintended consequences, including deterring them from seeking appropriate mental health care or being candid with clinical care providers.

BE IT RESOLVED that the American Psychological Association encourages psychologists to join with multiple stakeholders and disciplines to identify, evaluate, and implement effective primary prevention: (a) *universal* preventive interventions for entire populations (e.g., school-based programs facilitating healthy social development and reducing aggressive behavior among children and adolescents); (b) *selective* preventive interventions for specific higher risk groups (e.g., suicide prevention interventions for older males); and (c) *indicated* preventive interventions for specific individuals showing signs of risk of firearm violence (e.g., conflict resolution interventions for young men who are involved in gangs).

BE IT RESOLVED that the American Psychological Association endorses the implementation of rigorously tested psychological and educational interventions that facilitate healthy family and social development and reduce aggressive behavior generally and gun violence specifically across the lifespan and multiple domains.

BE IT RESOLVED that the American Psychological Association encourages further development of approaches and interventions that specifically address the contribution of gender, gender roles, and gender norms to disproportionate risks of perpetrating and being victims of violence—including firearm violence and interpersonal violence.

BE IT RESOLVED that the American Psychological Association encourages community-based problem-solving approaches seeking to prevent firearms violence or to address the consequences of firearm violence when it has occurred in a community.

BE IT RESOLVED that the American Psychological Association encourages the further development and evaluation of policy interventions for firearms violence across the full lifespan of firearms from design and manufacture to use.

Principle 3: A continuum of mental health services to meet the needs both of persons with severe mental illness and of persons in emotional crisis is essential to firearm violence prevention.

BE IT RESOLVED that the American Psychological Association promotes greater awareness among the public and policy-makers that most persons who display risk factors for violence will not actually act violently or use firearms if they do and no methods currently exist for reliably predicting whether or not specific *individuals* will behave violently, nor the specific time, place or manner of a violent act.

BE IT RESOLVED that the American Psychological Association encourages use of evidence-based structured clinical judgment and actuarial tools in risk assessment and management with appropriate populations, and further evaluation and subsequent dissemination of behavioral threat assessment models for use when a specific individual has been identified as making or posing a threat of violence.

BE IT RESOLVED that the American Psychological Association encourages further evaluation of the effectiveness and consequences of restrictions on access to firearms by some individuals who are identified as at elevated risk of violence, including firearm violence.

BE IT RESOLVED that the American Psychological Association promotes a continuum of mental health services sufficient to reliably meet both the chronic needs of persons with serious mental illness and the immediate needs of persons in emotional crisis as one element of comprehensive and integrated violence prevention, behavioral health, and public health systems at the local, state, and federal levels.

BE IT RESOLVED that the American Psychological Association encourages psychologists to seek post-doctoral and continuing professional education in order to increase the contribution of the profession of psychology to firearm violence prevention.

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*Several references were updated following the Board meeting at the Board's request. The above Resolution includes the updated references.

B.(6) The Board received information on efforts for improving disability related access at the APA Convention.

C. In executive session, the Board voted to approve reauthorizing the Ad Hoc Committee on Psychology and AIDS for an additional five years from February 2014 through February 2019.

XIV. FINANCIAL AFFAIRS

A. The Board voted to recommend that Council approve the following revisions to the Asset Allocation Guidelines section of the Long-Term Investment Policy statement (bracketed material to be deleted; underlined material to be added):

Asset Allocation Philosophy and Guidelines

Philosophy

APA's current policy to not draw from the long-term portfolio to support operations allows the APA long-term portfolio to withstand normal market volatility. Further, APA recognizes that tactical asset allocation* adjustments involve an element of market timing that can be difficult to judge and can cause meaningful deviation from targeted returns. As a result, APA has adopted a strategic asset allocation** philosophy.

* Tactical asset allocation is defined as establishing long-term asset allocation guidelines and then using frequent allocation adjustments to take advantage of expected short-term or intermediate-term moves in the market or changes in economic conditions.

** Strategic asset allocation is defined as the establishment of long-term asset allocation guidelines with allocation adjustments being made only periodically to bring the investment portfolio back to the target asset allocation percentages.

Given the strategic asset allocation philosophy, the APA considers asset allocation/portfolio change recommendations based on the following categories/frequency:

- emergent actions – require immediate attention by the IC/FC; and,
- strategic decisions – require consideration by the IC/FC annually.

Guidelines

Investment management of the assets of the Long Term Portfolio shall be in accordance with the following asset allocation guidelines:

1. Aggregate Long Term Portfolio Allocation Guidelines (at market).

Asset Class	Minimum	Maximum
Equity Securities/Mutual Funds	50%	[85%]<u>100</u>
<i>US Large Cap Equities</i>	<i>10%</i>	<i>50%</i>
<i>US Small/Mid Cap Equities</i>	<i>5%</i>	<i>25%</i>
<i>Developed International Equities³</i>	<i>0%</i>	<i>25%</i>
<i>Emerging Markets Equities¹</i>	<i>0%</i>	<i>20%</i>
Fixed Income Securities	[10] <u>0</u>%	50%
<i>Core Fixed Income</i>	<i>[5] <u>0</u>%</i>	<i>35%</i>
<i>Non-Core Fixed Income</i>	<i>0%</i>	<i>20%</i>
Commodities	0%	15%

³ APA's target allocation for international equities need not be achieved through the use of international equity specialists, but may instead be achieved by allowing the purchase of international equity holdings by APA's domestic equity managers at their discretion (not to exceed the maximum allocation of 45%).

Under the current asset allocation model, and the current investment policy, APA places mid cap stocks under the large cap asset category since mid-cap stocks are considered part of the large cap stock universe.

2. The Association's real estate holding (namely the 10 G Street LLC) can be viewed as the equivalent of a fixed income investment. When viewed as such, the 10 G Street LLC property represents a diversifying asset when evaluating the relative amounts of equity and fixed income holdings within the Long Term Portfolio.

[2] 3. The Finance Committee may employ investment managers whose investment disciplines require investment outside the specific asset allocation for which they were initially retained. However, taken as a component of the aggregate Long Term Portfolio, such disciplines must fit within the overall asset allocation guidelines established in this statement. Such investment managers in addition to receiving these policies will receive written direction from the Finance Committee through the Investment Consultant regarding specific objectives and guidelines.

[3] 4. The Finance Committee will periodically review these guidelines to determine if the Long Term Portfolio is in compliance. When guidelines are exceeded for an extended period of time, the Finance Committee will work with the Investment Consultant to rebalance the portfolio in accordance with the Long Term Portfolio's investment policy.

B. By unanimous vote on email in January, the Board voted to appoint Greg Mitchell to the audit subcommittee for a 3-year term beginning immediately and ending December 31, 2016.