I. MINUTES OF MEETING

A.(1) Council voted to approve the minutes of its February 15-17, 2019, meeting.

B.(1A) Council voted to reject suspending Association Rule 30-2.1 and agreed to not publish individual votes on open session agenda items.¹

II. ELECTIONS, AWARDS, MEMBERSHIP AND HUMAN RESOURCES

A.(2) Council voted to elect 95 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.

B.(3) Council voted to approve forwarding to the Membership for a vote the following amendments to the APA Bylaws (bracketed/strikethrough material to be deleted; underlined material to be added):

ARTICLE II

Membership

1. The Association shall consist of [three] four classes of members: Fellows, Members, and Associate members, and Graduate Student members.

4. Members of the Association shall be persons who are interested in the advancement of psychology as a science and as a profession and who have met the requirements described below. The designation Member as used in these Bylaws shall be deemed to include Fellows, except where there is an express provision to the contrary. The requirements for acceptance to Member, Associate member, or Graduate Student member status may be waived by the Membership Board, in special cases, for persons in fields other than psychology who have made continuing distinguished contributions to psychology.

5. The minimum requirement for acceptance to Member status shall be the receipt of the doctoral degree based in part upon a psychological dissertation or the doctoral degree based on other evidence of proficiency in psychological scholarship from a program primarily psychological in content. The doctoral degree must have been conferred by a graduate or professional school that

¹At its August 2018 meeting, Council voted that at the beginning of each Council meeting, after the meeting agenda has been determined, Council will vote on a motion to 1) suspend Association Rule 30-2.1 and 2) agree to require Council members votes on each open session agenda item, with the exception of procedural votes, (including votes in favor, against, abstaining, recusing or not voting) be published on the Association’s website with access for members only. (A 2/3 vote of all Council members present is needed to suspend the Association Rules. If the motion fails, Council members’ votes will not be published for that meeting).
is regionally accredited or that has achieved such accreditation within five years of the year the
doctoral degree was granted or that is one of equivalent standing outside the United States.

6. Associate members shall be persons who are interested in the advancement of psychology as
a science and as a profession and who have met the requirements described below. Associate
members may not vote or hold office in the Association but shall be entitled to all rights and
privileges of the Association not specifically denied them in these Bylaws. Associate members
shall achieve voting privileges after one [five consecutive] year[s] in the status of Associate
membership or Graduate Student membership.

7. The minimum requirement for acceptance to Associate member status shall be (a) completion
of at least two years of graduate work in psychology in a regionally accredited graduate or
professional school or (b) the master's degree in psychology from a regionally accredited graduate
or professional school.

8. Graduate Student members shall be persons who are pursuing graduate studies in the field of
psychology and who have met the requirements described below. Graduate Student members
may not vote or hold office in the Association, but shall be entitled to all rights and privileges of
the Association not specifically denied them in these Bylaws. Graduate Student members shall
achieve voting privileges after one year in the status of Graduate Student membership.

9. The minimum requirement for acceptance to Graduate Student member status shall be enrollment in good standing within the past twelve months in a regionally accredited graduate or
professional school for graduate work in the field of psychology.

10. Fellows shall be elected by the Council of Representatives (hereafter referred to as Council)
upon recommendation by the Board of Directors. Nomination of a Fellow shall be made by a
Division to which the member belongs.

11. Council shall have the power to designate additional requirements for acceptance to
Member, Associate member or Graduate Student member status.

12. The requirement of a doctoral degree, as defined in Section 5, or the requirement that
the five years of acceptable professional experience be subsequent to granting of the doctoral
degree, as appropriate, may be waived: (a) for Fellow status, by Council upon submission of
evidence satisfactory to Council of outstanding contribution or performance in the field of
psychology; (b) for Member status, by the Membership Board upon submission of evidence
satisfactory to the Board of significant contribution or performance in the field of psychology.

13. In addition to the regular membership classes, there shall be a class of International
Affiliates, who are not Members of the Association and who shall not represent themselves as
such. They shall have such rights and privileges as may be granted by Council, including special
rates for subscriptions and publications.
International Affiliates shall be psychologists who reside in countries other than the United States or Canada. An individual desiring affiliation with the Association must, at the time of application, be a member of the psychological association of the country in which the applicant resides or, if no such association exists, shall present evidence of appropriate qualifications. International psychologists who meet the requirements for membership may apply in the usual manner if they so desire.

There shall be a class of High School and Undergraduate Student Affiliates who are not Members of the Association and who shall not represent themselves as such. They shall have such privileges as may be granted by Council, including special rates for subscriptions and publications.

There shall be a class of High School Teacher Affiliates who are not Members of the Association and who shall not represent themselves as such. They shall have such privileges as may be granted by Council, including special rates for subscriptions and publications.

There shall be a class of 2-Year College Teacher Affiliates who are not Members of the Association and who shall not represent themselves as such. They shall have such privileges as may be granted by Council, including special rates for subscriptions and publications.

A Member (to include Fellows), Associate member, Graduate Student member or Affiliate may be dropped from membership or otherwise disciplined for conduct which violates the Ethical Principles of the Association, which tends to injure the Association or to affect adversely its reputation, or which is contrary to or destructive of its objects. Allegations of such conduct shall be submitted to the Ethics Committee.

The Ethics Committee shall formulate rules and procedures governing the conduct of the ethics and disciplinary process. However, such rules and procedures and any changes therein must be approved by the Board of Directors acting on behalf of Council. The Ethics Committee, acting at its own discretion or on direction of the Board of Directors, shall review such rules and procedures periodically and may amend them from time to time, subject to the approval of the Board of Directors, provided, however, that no such amendment shall adversely affect the substantive rights of a Member, Associate member, Graduate Student member or Affiliate whose conduct is being investigated or against whom formal charges have been filed at the time of amendment.

A person who has been dropped from membership pursuant to the rules and procedures of the Ethics Committee may reapply for membership after five years have elapsed from the date of termination of his/her membership. A person who has been permitted to resign under a stipulated agreement may reapply for membership only after the period of time stipulated in the agreement has elapsed, and all other conditions set forth in such agreement have been discharged. In all cases the Member, Associate member, Graduate Student member or Affiliate must show that he/she is ethically as well as technically qualified for membership. Such reapplications shall be considered first by the Ethics Committee, which shall make recommendation to the Membership Board.
ARTICLE III

Bill of Rights for Members

1. All Members and Fellows shall have the right to vote, to hold office, and to secure fair consideration for governance appointment in the Association. Voting in any Association election may be done by either mail or electronic means.

2. All Members, Fellows, Associate members, Graduate Student members, and Affiliates shall be treated with respect and without discrimination on the basis of race, national or ethnic origin, religion, gender, gender identity, or sexual orientation, age, mental or physical disability. This does not preclude the Association from fulfilling its obligation to carry out activities or programs that have as their goal the amelioration of conditions that may restrict Members from full participation in the Association or its activities and programs.

ARTICLE V

Composition of the Council of Representatives

5. Each APA Fellow, Member, [and] voting Associate member, and voting Graduate Student member shall choose the Division(s) or State/Provincial/Territorial Association(s) through which he/she elected to have his/her interest represented on Council by allocating, at the time of the annual dues statement, a total of ten (10) votes to the Division(s) and/or State/Provincial/Territorial Association(s) through which he/she wishes to be represented the following year. However, only Fellows, Members (or voting Associate or Graduate Student members) of the Divisions or State/Provincial/Territorial Associations so designated will be allowed to nominate and elect their Council Representatives.

ARTICLE VI

Divisions

2. Any Member of the Association may apply for membership in one or more Divisions under the rules of eligibility and election established by the Division. Associate members, Graduate Student members or Members may remain Associate members, Graduate Student members or Members without divisional affiliation. A Division may include in its membership those who do not qualify for or do not desire membership in the Association. It may determine its own qualifications for its
membership classes, provided that the designation Fellow shall be reserved for members of the Division who are Fellows of the Association.

ARTICLE XI

Boards and Committees

2. The Membership Board shall consist of no fewer than eight Members and one Affiliate of the Association. At least two of the members shall be Fellows of the Association. The remaining members shall be selected to represent the diverse membership of the Association. Members of the Board shall serve for staggered terms of three years each, except when filling a vacancy on the Board. The Board shall have responsibility for the oversight of membership recruitment and retention activities for the Association. The Board shall have the authority to elect qualified persons to initial Member, or Associate member or Graduate Student member status. The Membership Board is responsible for establishing and regulating the APA criteria that the Fellows Committee uses to review and to recommend member nominees for election to Fellow status. The Board shall receive nominations from the Fellows Committee and shall forward recommendations without alterations or comments to the Board of Directors.

5. The Ethics Committee shall consist of not fewer than eight persons, at least seven of whom shall be Members of the Association, elected from different geographical areas, for terms of not less than three years. Members of the Ethics Committee shall be selected to represent a range of interests characteristic of psychology. The Ethics Committee shall have the power to receive, initiate, and investigate complaints of unethical conduct of Members (to include Fellows), Associate members, Graduate Student members, and Affiliates; to report on types of cases investigated with specific description of difficult or recalcitrant cases; to dismiss or recommend action on ethical cases investigated; to resolve cases by agreement where appropriate; to formulate rules or principles of ethics for adoption by the Association; to formulate rules and procedures governing the conduct of the ethics or disciplinary process for approval by the Board of Directors acting on behalf of Council; and to interpret, apply, and otherwise administer those rules and procedures.

The work of the Ethics Committee, including information and recommendation on all cases before it, shall be kept confidential, except as provided by the Ethics Committee in rules and procedures approved by the Board of Directors, consistent with the objectives of the Committee and the interest of the Association.

ARTICLE XIX

Dues and Subscriptions

1. The basic Association dues to be paid annually by Members, Graduate Student members, and Associate members shall be determined by Council and shall include subscriptions to such publications as may be determined by Council.
7. Any Fellow, Member, [or] Associate member, or Graduate Student member who has been adjudged totally and permanently disabled shall be exempt from further payment of dues. Such members shall retain other rights and privileges of the Association.

ARTICLE XX

Amendments

1. The Association, by vote of the voting Members on the official rolls of the Association at the time of sending, may adopt such Bylaws or amendments to Bylaws as are consistent with the Association's Certificate of Incorporation and are deemed necessary for the management of the affairs of the Association.

2. Amendments may be proposed (a) by Council, (b) by the Policy and Planning Board, (c) by the Board of Directors when approved by Council by a majority vote, or (d) by petition signed by four percent or more of the Members of the Association. A copy of each amendment proposed, with space appropriate for voting and such explanations of the amendments as are deemed necessary, shall be sent to the last recorded address of each Fellow, Member, [and] voting Associate member, and voting Graduate Student member. Pro and con statements shall accompany amendments unless two-thirds of the representatives present and voting consider such statements to be unnecessary. Forty-five days after the date of sending, the poll shall be closed and the votes counted by the Election Committee, which shall certify the result to Council at its next meeting, at which time the amendment, if passed by two-thirds of all the Members voting, shall take effect.

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

10-1. MEMBERSHIP CLASSES

10-1.1 The APA Bylaws provide for [three] four classes of membership in the Association: Fellow, Member, [and] Associate member, and Graduate Student member. Requirements for each class of membership are given in the APA Bylaws.

10-4. APPLICATION PROCEDURES

10-4.1 Application or nomination forms for Member, Associate member, Graduate Student member or Fellow status shall be prescribed by the Membership Board, after consultation with other APA committees involved in their use. Such forms are used to collect information sufficient to establish the applicant's ethical and technical qualifications for membership and to create necessary membership records and APA Directory/Register records.

All applicants for Associate member, Graduate Student member or Member status shall indicate whether or not they have previously been rejected for membership in the Association or had
membership voided or have previously been convicted of a felony or sanctioned by any professional ethics body, licensing board, other regulatory body or any professional or scientific organization. All applications for Member, or Associate member, or Graduate Student member status shall carry the following statement, which the applicant shall sign:

"In making this application, I subscribe to and will support the objectives of the American Psychological Association as set forth in Article I of the bylaws, and the Ethical Principles of Psychologists and Code of Conduct, as adopted by the Association, and I affirm that the statements made in this application correctly represent my qualifications for membership, and understand that if they do not, my membership may be voided."

APA may seek evidence from schools and universities that the candidate has attended, state/provincial/territorial or local psychological associations, professional employers, and/or other appropriate sources of information, when the submitted documentation leaves doubt as to the applicant’s qualifications for membership in the Association.

Nominations for Fellow status shall be made by divisions to the Fellows Committee. The written nomination shall show that the candidate's doctoral dissertation was on a psychological subject and that the professional experience cited as qualifying an individual for Fellow status was work which the person was properly qualified to perform and that was appropriately supervised. The recommendation shall include the endorsement of at least three, but preferably more, Fellows of the Association. In instances when the nominee is working in a highly specialized area, one of the three endorsers may be a former APA Fellow who is no longer a Member of the Association. The recommendation shall make clear what evidence the division puts forward to support the "unusual and outstanding contribution" of the candidate. The division may assemble the information by whatever means it deems appropriate but shall make reasonable verification of it before submission to the Fellows Committee.

(a) With respect to the nomination of Fellows, each division shall, by such means as it shall determine, solicit nominations from its members of those who are deemed worthy of election to this honor. The division may require the nominator to indicate the evidence available in support of the nomination. It shall be the responsibility of the division to select from these nominees and to prepare the recommendations for submission as provided in the previous section.

(b) Divisions shall be informed that it is the assumption of Council that the final list of Members recommended for election to initial Fellow status contains only those Members officially nominated by the relevant divisions. Divisions are responsible for maintaining appropriate review schedules to meet this requirement. This rule does not deny the right of an individual Council member to challenge any nomination on the list.
10-5. INTERPRETATION OF EDUCATIONAL REQUIREMENTS

10-5.1 In acting upon an application for Graduate Student member, Associate member or Member status in the Association, the Membership Board and/or Membership Staff shall be guided by the following interpretation of the requirements stated in the APA Bylaws:

The applicant's graduate or professional school must have full regional accreditation at the time the applicant is elected to membership, although the applicant's training or degree may have been received during the five years prior to full accreditation. A regionally accredited institution is defined as an institution that is listed as fully accredited by the appropriate regional accrediting body in the Directory of Accredited Institutions of Postsecondary Education, published annually by the American Council on Education, or one of equivalent standing outside the United States.

10-14. STUDENT AFFILIATE

10-14.1 Applications from college and high school students desiring to become Student Affiliates may be accepted at any time by the chief staff officer, who shall have discretion in determining what form of evidence is sufficient to meet the requirements for this application.

A Student Affiliate who interrupts studies for a period not to exceed ten consecutive years shall be considered as a student throughout the break in studies for purposes of determining eligibility for Student Affiliate status.

Student Affiliates may subscribe to any of the journals published by APA or purchase other APA publications at the same reduced rates charged to members.

90-3. AMERICAN PSYCHOLOGICAL ASSOCIATION OF GRADUATE STUDENTS COMMITTEE

There shall be an American Psychological Association of Graduate Students (APAGS) Committee whose mission shall be to (a) promote the highest standards in the research, teaching, and practice of psychology in order to further the education and development of all students involved in the study of psychology; (b) represent all graduate study specialties of psychology, and facilitate exchange of information between these groups; (c) promote graduate student leadership development in order to communicate and advocate the concerns of graduate students; and (d) establish and maintain channels of communication between APAGS and schools, universities, training centers, institutions, and other members of the psychological community.

The APAGS Committee shall consist of nine members, three of whom serve three-year terms (the chair-elect, chair, and past chair), six of whom serve two-year terms. All shall be Graduate Student members of the Association. Each year, a call for nominations for the four open positions that will become vacant in the following year shall be broadly disseminated. Following the call, the committee shall prepare a slate of candidates for each position and hold an election in which all APAGS members are eligible to vote. Following the election, names of the winners of the election shall be forwarded to the Board of Directors as information.
The APAGS Committee shall report to Council through the APA Board of Directors.

100-2. PETITIONS FOR NEW DIVISIONS

100-2.3 In the event that the petitioners represent an established group of APA members, the additional material to be supplied shall include minutes of the meeting at which action was taken to seek affiliation, a full list of members, lists of officers for current and recent years, and bylaws of the group.

In the event that the group has been newly assembled, the petitioners shall supply (a) minutes of any organizational meeting of the group sponsoring the petitioners and a list of persons attending, (b) provisional bylaws of the proposed division that conform to requirements of the APA Bylaws, (c) a list of provisional members by class (e.g., Associate member, Graduate Student member, Member) if such is proposed, (d) a list of members who are not petitioners, and (e) a list of provisional officers.

If the petitioners feel it would be useful to Council, they may submit a statement amplifying the preface to the petition to make clear why they seek divisional status.

110-8. PRESIDENT-ELECT ELECTION

110-8.1 The election of APA President-elect is conducted by the Election Committee.

110-8.2 Candidates are nominated by Fellows, Members, [and] Associate members with voting privileges, and Graduate Student members with voting privileges. Nominations are made by preferential ballots, and up to five names may be listed in rank order. Nomination ballots are sent on or about February 1. The balloting period closes within 45 days. Only APA members are eligible for nomination.

110-8.3 The APA President-elect shall be elected by Fellows, Members, and those Associate members and Graduate Student members who have been granted voting privileges. The election ballot shall be preferential and shall list five candidates. Final election ballots shall be sent on or about September 15. The balloting period shall close within 45 days.

Each candidate is invited to submit a statement, to be sent with the election ballot, of no more than 1,000 words, stating his or her opinion of issues facing psychology and of the role APA should play regarding these issues.

110-8.4 Results are reported to the Board of Directors. Tallied results are reported to Council no more than 30 days after the ballot closes. Election results are published on APA’s website.

An explanatory statement and statements in favor of and against the amendment will accompany the Bylaws amendment ballot.
III. ETHICS

A.(28) Council received as information an update on the activities of the Ethics Code Task Force.

B.(29) Council was provided with information regarding the Ethics Committee’s pilot program of a limited change to its review of the felony convictions of APA applicants.

C.(29A) Council received as information an update concerning the Board of Directors’ consideration of recommendations stemming from the Report of the APA Commission on Ethics Processes (the Commission Report) which Council received in August 2017.

IV. BOARD OF DIRECTORS

No items.

V. DIVISIONS AND STATE AND PROVINCIAL AND TERRITORIAL ASSOCIATIONS

A.(4) Council voted to approve withdrawal of Council New Business Item #20B/Feb 2019 “Identify Language and Amend Association Rules 100-1.4 and 30-8 to Enhance APA and Division Position and Policy Statements.”

VI. ORGANIZATION OF THE APA

A.(5) Council voted to approve amending Association Rules 30-8.4 and 90-5 as follows (bracketed/strikethrough material to be deleted; underlined material to be added):

30-8. STANDARDS AND GUIDELINES

30-8.4 The Policy and Planning Board shall provide notice no less than two years before a standard/guidelines document will expire to the responsible reviewing body or entity. The reviewing body or entity responsible for review of the document shall recommend to Council that the document be extended, amended along with proposed revisions, nullified or placed in the APA archives. Placing documents in the archives indicates that they are no longer in effect as APA Policy. Should the responsible reviewing body or entity wish to extend or amend the document, the review process shall be done in accordance with Association Rule 30-8 as delineated for proposed new standards or guidelines, along with a new expiration date and the rationale for that date. If the responsible reviewing body or entity does not bring the standard/guidelines document to the Council of Representatives within this 2-year period, the standard/guidelines document will automatically sunset and the Policy and Planning Board shall notify the Council of such action.

30-9. COUNCIL POLICY MANUAL

30-9.1 All motions, resolutions, standards and guidelines approved by Council and designated as policy shall be recorded in the Council Policy Manual.
30-9.2 Policies that are standards and guidelines shall be reviewed pursuant to Association Rule 30-8.4. With regards to all other policies, every five years the Policy and Planning Board will notify the responsible reviewing body or entity of its obligation to review all of the policies recorded in its section of the Council Policy Manual. All such policies shall remain active unless the responsible reviewing body recommends to amend (with proposed revisions), rescind, or place the policy in the APA archives as no longer in effect as APA policy. Such recommendations must be approved by Council.

30-9.3 Rescinded policies shall be removed from the Council Policy Manual. Rescinded policies refer to those that have been previously passed and then rescinded by vote of Council.

30-9.4 All materials published in the active and archived sections of the Council Policy Manual shall be maintained on the website of the Association for historical purposes. Each archived policy shall indicate on each page of the document that it is no longer the date that it ceased to be an active policy of the Association.

B.(6) Council voted to approve amending APA’s Association Rules as follows (underlined material to be added):

90-5. AGENDA PLANNING GROUP

The Agenda Planning Group shall be composed of the APA President, who shall serve as chair; the chairs of the Policy and Planning Board, the Board of Professional Affairs, the Board of Scientific Affairs, the Board for the Advancement of Psychology in the Public Interest, the Board of Educational Affairs, the Committee on Division/APA Relations, the American Psychological Association of Graduate Students, the Committee on Early Career Psychologists, and the Committee on Legal Issues; a member of the Finance Committee as determined by the Finance Committee and a member of the Council Leadership Team (CLT) as determined by CLT.

The Agenda Planning Group shall have general oversight for the consolidated board and committee meetings and for the referral of agenda items.

Following the submission of a new item, the Agenda Planning Group shall consider if there is any overlap between the item and any on-going work within APA and the degree to which it aligns with the strategic plan before assigning a complete routing path for the item. This routing will include, minimally, a specification of all required consultations that must be obtained on the item as well as the final authority for action on the item. The APG may also specify any groups to be specifically informed about the item. The routing path may include the Board of Directors, Council of Representatives, APA boards or committees and staff.

APG recommendations are made to the Council of Representatives (through the Council Leadership Team), and to the Board of Directors (through the President.)

The Agenda Planning Group shall report to the Council of Representatives through the Board of Directors.

C.(7) Council voted to approve amending APA’s Association Rules as follows (bracketed/strikethrough material to be deleted; underlined material to be added):
60-1.2 CLT shall consist of twelve members, all of whom shall be current or former members of Council. CLT is comprised of a Chair; Chair-elect; Past Chair; the APA President; the APA President-elect; the APA Treasurer; the APAGS Chair, Chair-elect or other designee from the Executive Committee of APAGS; an Early Career Psychologist Representative; three members-at-large and the Chief Executive Officer (without vote).

Council members shall nominate current Council members who have served at least one year on Council or current CLT members whose terms are expiring for the position[s] of Chair-elect[s]. Council members shall nominate current Council members who have served at least one year on Council for the positions of Early Career Representative and member-at-large. CLT will conduct a needs assessment for upcoming CLT vacancies to be shared with Council prior to the nominations process. The Chair-elect, Early Career Representative and three members-at-large shall be elected by Council for three-year terms from slates of at least two candidates. Each year a Chair-elect and member-at-large are elected and every third year an Early Career Psychologist representative is elected. The candidate on each slate receiving the highest number of votes will be elected. The Chairs, members-at-large and the Early Career Psychologist representative cannot serve two consecutive terms in the same position and there is a lifetime limit of two elected terms on the Council Leadership Team (except when serving ex officio). The APA President, APA President-elect, APA Treasurer, APAGS Designee and Chief Executive Officer serve ex officio on CLT.


E.(8A) Council voted to approve the following 2019 Immigration and Refugee Policy Statement:

2019 APA Immigration and Refugee Policy Statement

Immigrants and refugees are at risk of psychological harm


In the Child and Adolescent Mental and Behavioral Health Resolution (APA, 2019), the American Psychological Association affirmed that toxic stress (prolonged exposure to trauma and the biological stress response) impacts early brain development (APA, 2018b; Center on the Developing Child, 2014; Shonkoff & Gardner, 2012) and that adverse childhood experiences (ACEs) have a profound impact on later adult health outcomes (Felitti et al., 1998). Subsequent research has clarified that this lifelong effect is due to significant changes in the nervous,
endocrine and immune systems from prolonged exposure to the stress response (Danese & McEwan, 2012). In short, health across the lifespan is impacted by early childhood experiences (Conti & Heckman, 2013; Halfon & Hochstein, 2002; Halfon, Wise, & Forrest, 2014). Research also shows that the impact of environmental risk factors can be lessened or even prevented (Masten, 2014), (Center on the Developing Child, 2015; Leslie et al., 2016). Moreover, reducing environmental risk factors has the potential to promote emotional health early in the life cycle (Center on the Developing Child, 2015).

The fear of deportation causes stress and can lead to serious health issues

Research has found that the fear of deportation and the perceived impact of the vulnerability on the family are associated with reports of poorer emotional well-being and academic performance for children (Brabeck & Xu, 2010). Another study found that the fear of deportation and harassment from law enforcement correlated with lack of access to health services (Martinez et al 2015). Raids and deportation are traumatic experiences resulting in fear, isolation and depression for children, who are mostly U.S. citizens (Brabeck & Xu, 2010; Lusk, McCallister, & Villalobos, 2013).

Family separation and child detention are especially harmful

Research has consistently demonstrated the negative impacts of family separation and child detention on immigrant and refugee mental health (Miller, Hess, Bybee, & Goodkind, 2018; Society for Community Research and Action, 2016). One study of children in schools found that those who had experienced longer separations from their parents also reported more signs of depression and anxiety than those who had not experienced long separations (Suárez-Orozco, Bang, & Kim, 2010). Other negative outcomes for children associated with separation from their parents include housing instability, food insecurity, interrupted schooling, poorer academic performance, and adverse behavioral/emotional responses (Chaudry et al 2010). Sustained parental separation also predicts the ongoing natural response of difficulty trusting adults and institutions, as well as reduced educational attainment (American Psychological Association, 2012).

Therefore, APA reaffirms its 1998 resolution on Immigrant Children, Youth, and Families (APA Multicultural Guidelines, 2017). Further, consistent with the ethical principle that psychologists respect the human rights, dignity and worth of all persons and peoples (American Psychological Association, 2017). APA supports practical and humane immigration policies that consider the well-being of immigrants and refugees, and particularly families, including the provision of appropriate medical, mental health and social services. APA also calls upon the federal and state governments to provide sufficient funding to ensure appropriate health and social services are provided.

References

American Psychological Association. (2010). Executive summary of the report of the APA Task Force on the psychosocial effects of war on children and families who are refugees from
armed conflict residing in the United States


Additionally, Council participated in small group discussion regarding how APA can better prepare psychologists to work with and/or advocate for the population of individuals included in the policy statement.

F.(24B/Aug 2019) A new business item, “Creation of Term Limits for Members of APA’s Council of Representatives to Increase Opportunities for New Voices in Council Decision-Making” was referred to the Policy and Planning Board, the American Psychological Association of Graduate Students, the Board for the Advancement of Psychology in the Public Interest, the Committee on Early Career Psychologists, the Committee on Ethnic Minority Affairs, the Committee on Aging and the Committee on Sexual Orientation and Gender Diversity.


H. (31) Council received as information an update on the work of the Advocacy Coordinating Committee.

VII. PUBLICATIONS AND COMMUNICATIONS

No items.

VIII. CONVENTION AFFAIRS

No items.

IX. EDUCATIONAL AFFAIRS

A.(9) Council voted to approve the recognition of Biofeedback and Applied Psychophysiology as a proficiency in professional psychology for a period of seven years, to expire in August 2026.

B.(10) Council voted to approve the recognition of Serious Mental Illness Psychology as a specialty in professional psychology for a period of seven years, to expire in August 2026.

C.(11) Council voted to approve the continued recognition of Behavioral and Cognitive Psychology as a specialty in professional psychology for a period of seven years, to expire in August 2026.

D.(12) Council voted to approve the continued recognition of Clinical Neuropsychology as a specialty in professional psychology for a period of seven years, to expire in August 2026.

E.(13) Council voted to approve the continued recognition of Industrial and Organizational Psychology as a specialty in professional psychology for a period of seven years, to expire in August 2026.

F.(14) Council voted to approve an extension of recognition of Clinical Child Psychology as a specialty in professional psychology for an additional period of one year, to expire in August 2020.
G.(32) Council received as information an update from the Board of Educational Affairs/Board of Professional Affairs Task Force to Delineate Competencies for Students Completing Master’s Level Programs in Health Service Psychology.

F.(37) Council received an update on the new business in progress item titled, “A Reiteration of APA’s Values on Discrimination in Light of Contemporary Resurgence in Discrimination and Hate Crimes (NBI #20A/February 2019).”

X. PROFESSIONAL AFFAIRS

A.(15) Council voted to approve amending the Association Rules as follows (bracketed/strikethrough material to be deleted; underlined material to be added):

110-15. SELECTION OF STANDING BOARD AND COMMITTEE MEMBERS

110-15.1 Elections of standing board and committee members are conducted by Central Office; nominating candidates for various offices to be filled by election of Council shall be the responsibility of the Board of Directors. The chief staff officer shall request suggestions of persons to serve on boards or committees from officers of divisions and state/provincial/territorial psychological associations, chairs of boards and committees, and the general membership. The list of persons shall be available to the various boards and committees when they are preparing nominations.

110-15.2 Candidates are nominated by the Board of Directors according to APA Bylaws, Article XI, Section 1. [Only APA members may be nominated, unless otherwise specified in the APA Bylaws.] In determining the slates of candidates, the Board shall receive recommendations from relevant boards and committees. If the Board is unable to fill the slate from the list of candidates and alternates provided by the board or committee, the Board shall consult with the chair of the board or committee to obtain additional nominees.

110-15.3 The Council elects members of standing boards and committees by a preferential election ballot; those voting assign a rank order to as many candidates as desired. Ballots are sent on the last working day in October. The balloting period closes within 30 days.

110-15.4 Results are reported to Council and the membership in a manner determined by the Board of Directors.

110-15.5 Standing boards or committees whose members are elected by the Council of Representatives may, for reasonable cause, petition the Board of Directors to remove a member from said body. With the exception of the individual in question, a two-thirds vote of all members must approve of the petition. For purposes of Bylaw Article XI-1, reasonable cause shall be defined as 1) absence from two consecutive meetings or 2) substantial absences from meetings, or 3) egregious misconduct so that continued service would not be in the best interest of the Association. The petition requesting removal shall inform the Board of Directors of the basis for and the evidence supporting said removal. No later than 30 days after receipt of said petition, the Board of Directors shall provide a copy of the petition to the member and the member shall have 30 days from receipt of the petition to provide to the Board of Directors a written response. Upon a two-thirds vote of all Board members, either by conference call or meeting, the Board of
Directors may remove said member if it determines that there is reasonable cause for removal and that removal is in the best interest of the Association. The Board of Directors will act upon this petition expeditiously but no later than the Board meeting following the receipt of the response from the individual. The Board of Directors shall promptly inform the member and the petitioning board or committee of its action. The action of the Board of Directors shall be final. The Board of Directors shall inform the Council of Representatives of its action at the next Council meeting.

110-15.6 Only APA members may be nominated or selected, unless otherwise specified in the APA Bylaws or Association Rules.

130-1. BOARD OF PROFESSIONAL AFFAIRS

130-1.1 The Board of Professional Affairs shall consist of thirteen members, including twelve APA members, three to be elected each year for staggered terms of three years, and one ex-officio member. The Council of Executives of State, Provincial and Territorial Psychological Associations (CESPPA) Representative to the Board of Professional Affairs shall serve as an ex-officio member. At least one member of the Board of Professional Affairs shall be an early career psychologist.

B.(24A/Aug 2019) A new business item, “A Call for a Psychologist General of the United States” was referred to the Board of Professional Affairs and the Board of Scientific Affairs.

C.(25) 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).”


E.(33) Council was provided with an update on the activities of the Working Group Developing Guidelines on Key Considerations in the Treatment of PTSD/Trauma.


XI. SCIENTIFIC AFFAIRS

A.(16) Council voted to approve amendments to Association Rule 140.6-1 as follows (bracketed/strikethrough material to be deleted; underlined material to be added):

140-6. COMMITTEE ON HUMAN RESEARCH

There shall be a Committee on Human Research whose responsibility it shall be to (a) facilitate the responsible conduct of research involving humans, and establish and maintain cooperative relations with organizations sharing common interests, (b) examine issues related to scientific integrity and regulatory requirements for research involving humans and disseminate accurate information about such research, and (c) develop and disseminate guidelines for protecting the rights and welfare of humans involved in research, and consult on the implementation of these guidelines.
The Committee shall consist of [seven] six members elected by the Board of Scientific Affairs. Each year, two members will be elected for a term of three years [; the seventh member will be elected from a slate developed jointly by the Board of Scientific Affairs and the Ethics Committee, and will also serve a term 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 Scientific Affairs.

XII. PUBLIC INTEREST

A.(17) Council voted to archive the following 2006 APA Resolution on Drug Abuse Treatment to Prevent HIV among Injecting Drug Users:

Resolution on Drug Abuse Treatment to Prevent HIV among Injecting Drug Users

Whereas the primary routes of HIV transmission among injection drug users (IDUs) is the sharing of contaminated injection equipment and unprotected sex; and

Whereas the HIV and hepatitis C epidemics and injection drug use are inextricably linked in American society; and

Whereas injection drug use is associated with one-half of hepatitis C cases and almost one-third of all AIDS cases both through direct transmission through shared needles and indirect transmission through sex with HIV-infected injecting drug users (CDC, 2002 and 2002a); and

Whereas one million active users of injection drugs live in the United States (CDC, 2002b); and

Whereas only a fraction of people who need substance abuse treatment are able to obtain it through public agencies (CDC, 2002b); and

Whereas infected injection drug users (IDUs) transmit HIV through the sharing of contaminated syringes and other drug injection equipment (CDC, 2002a); and

Whereas injection drug users inject approximately 1000 times per year (Lurie, Jones, and Foley, 1998); and

Whereas drug maintenance treatment including methadone maintenance therapy (MMT) and treatment with buprenorphine have been shown to reduce heroin use and drug-related HIV risk behaviors (Sees, Delucchi, Masson et al., 2000; Reynaud-Maurupt et al., 2000; Stock & Shum, 2004; Thiede, Hagan, and Murrill, 2000); and

Whereas participation in MMT is associated with a reduction in the number of sexual partners and a reduction in the number of high-risk partners (Sorensen and Copeland, 2000); and

Whereas participation in MMT is associated with an increase in the use of condoms (Lollis, Strothers, Chitwood et al., 2000), and

Whereas participation in MMT enhanced with harm reduction group therapy is associated with higher rates of abstinence from cocaine and fewer unsafe sexual practices (Avants et al., 2004), and
Whereas participation in MMT or buprenorphine treatment are both associated with reduced HIV risk behaviors (Mattick, Ali, White, O’Brien, Wolk, & Danz, 2003), and

Whereas participation in MMT (Hartel & Schoenbaum, 1998) or buprenorphine treatment is associated with lower rates of HIV infection (Reynaud-Maurupt et al., 2000; Sorensen and Copeland, 2000), and

Whereas participation in MMT provided in primary care settings results in similar HIV risk reduction outcomes as participation in traditional MMT settings (Keen et al., 2003), and

Whereas drug-free treatments including long-term residential, intensive outpatient, and short-term inpatient treatment for cocaine, alcohol, and polydrug use are associated with significant reductions in drug use and injection risks that lead to the transmission of HIV (Avins, 1997, Gottheil 1998; Hubbard, 1997; Longshore, 1998; McCusker, 1994; 1998; Sorensen and Copeland, 2000), and some of these drug-free treatments also reduce sexual risk behaviors; and

Whereas methadone treatment programs and providers are required to undergo an accreditation and review process that is costly in terms of compliance oversight and funds, and may discourage smaller treatment programs from applying to provide MMT (Department of Health and Human Services, 2001); and

Whereas the Drug Abuse Treatment Act of 2000 allows any physician choosing to take a short specialty training course and become certified to prescribe buprenorphine in an office setting, yet few have done so due to financing and services delivery barriers (West et al., 2004); and

Whereas access to drug treatment including opioid maintenance is particularly difficult in rural areas (Deck & Carlson, 2004) but in general, the availability of drug maintenance treatments for injection drug users is inadequate and discouraged by regulatory requirements;

Resolution

Therefore be it resolved that the American Psychological Association (APA) actively supports and promotes an increase in accessible, available drug treatment for IDUs in traditional substance abuse, mental health, correctional, educational, and medical care settings in both rural and urban areas to prevent the spread of HIV, hepatitis C, and other contagious diseases.

Moreover,
Given that psychologists have many areas of relevant practice competence, including assessment, intervention, and prevention skills, that could and should inform the discourse about HIV prevention and substance abuse treatment for IDUs and their significant others; and

Given that psychologists’ training in research makes them especially well-qualified to assist policy-makers in making informed judgments based on the best available science;

Let it be further resolved that the APA:
Encourages state governments, Congress, and the executive branch to promote public policies and revise regulations and provide increased training to potential providers to increase available drug treatment for HIV prevention in a variety of settings, and

Promotes increased funding for HIV prevention research that includes drug treatment provided in traditional substance abuse, mental health, correctional, educational, and medical care settings; and

Supports training in HIV prevention interventions, including addiction treatment for injection drug users, within psychology training programs at all levels; and

Promotes and facilitates psychologists’ acquisition of competencies in addiction treatment strategies that decrease transmission of HIV infection among injection drug users that are culturally responsive and gender appropriate, including mastery of the literature on treatment of injection drug users and familiarity with effective interventions that are employed to address this problem; and

Encourages psychologists to develop multi-cultural competencies that address the issues of subgroups of individuals, including various racial, ethnic, and gender groups who use and inject drugs; and

Advocates for reimbursement of psychologists for provision of drug treatment interventions that decrease drug-related HIV risk behavior among IDUs; and

Supports psychologists as they engage in interdisciplinary and international efforts involving other health, mental health, and substance abuse professionals who seek to enhance understanding and treatment of drug dependence and sexual risk behaviors.

References


Health Service Administration, 21 CFR Part 291, 42 CFR Part 8, [Docket No. 98N-0617], RIN 0910-AA52.


Council also voted to adopt following 2019 Resolution on Drug Abuse Treatment to Prevent HIV Among People Who Inject Drugs as APA policy:

Resolution on Drug Abuse Treatment to Prevent HIV Among People Who Inject Drugs

WHEREAS the primary routes of HIV transmission among people who inject drugs (PWID) is the sharing of contaminated injection equipment and condomless vaginal or anal intercourse;

WHEREAS injection drug use is inextricably linked to the HIV epidemic in the United States and in many other countries;

WHEREAS in 2016 in the United States and 6 U.S. dependent areas (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the U.S. Virgin Islands), an estimated 3,425 diagnoses of HIV infections among adults and adolescents were attributed to injection drug use, of which, 43% were among Whites, 31% among Blacks/African Americans, and 21% among Hispanics/Latinos (CDC, 2017);

WHEREAS vulnerable populations, including people who live in disadvantaged neighborhoods, sexual and gender minorities, individuals with mental illnesses, and individuals with a history of sexual, physical, and emotional abuse, are more likely to abuse illicit drugs (Centers for Disease Control and Prevention, 2013);

WHEREAS close to half a million persons in the United States, aged 12 or older, report using a needle to inject heroin, cocaine, methamphetamine, or other stimulants in the past year (Substance Abuse and Mental Health Services Administration, 2009);

WHEREAS 50% of injection drug users reported reusing a needle at their last injection, 13% reported using a needle that had been used by others, and 29% reported cleaning the needle with bleach prior to their last injection (Substance Abuse and Mental Health Services Administration, 2009);

WHEREAS only a fraction of people who need substance abuse treatment are able to obtain it through public agencies (Substance Abuse and Mental Health Services Administration, 2013);
WHEREAS effective drug abuse treatment includes HIV prevention because it reduces activities that can spread disease such as sharing injection equipment and engaging in unprotected sexual activity (NIDA, 2018);

WHEREAS people who inject drugs and do not enter drug abuse treatment are up to six times more likely to become infected with HIV than those who enter and remain in drug abuse treatment (NIDA, 2018);

WHEREAS participation in drug abuse treatment also facilitates HIV screening and referral to early HIV treatment (Gardner et al., 2016; NIDA, 2018);

WHEREAS participation in medications for opioid use disorder (MOUD), including methadone maintenance and buprenorphine treatment, is associated with decreased illicit drug use, drug use HIV risk behaviors, and criminal activity (Avants, Margolin, Usobiaga, & Doebrick, 2004; Beg, Strathdee, & Kazatchkine, 2015; Keen, Oliver, Rowse, & Mathers, 2003; Krupitsky et al., 2006; Reynaud-Maurupt et al., 2000; Schottenfeld, Chawarski, & Mazlan, 2008; Sees et al., 2000; Stock & Shum, 2004; Sullivan et al., 2008; Teesson et al., 2008; Thiede, Hagan, & Murrill, 2000);

WHEREAS participation in MOUD has been shown to be associated with reduced sexual activity, number of sex partners, and risky sex partners in some studies (Avants et al., 2004; Lollis, Strothers, Chitwood, & McGhee, 2000; Meade et al., 2010; Sorensen & Copeland, 2000);

WHEREAS participation in MOUD and needle exchange programs is associated with reduced risk of HIV seroconversion (Beg, Strathdee, & Kazatchkine, 2015; Hartel & Schoenbaum, 1998; MacArthur et al., 2012; Van Den Berg, Smit, Van Brussel, Coutinho, & Prins, 2007);

WHEREAS participation in MOUD is associated with increased likelihood of reaching virological suppression among participants living with HIV (Reynaud-Maurupt et al., 2000; Roux et al., 2009; Sorensen & Copeland, 2000);

WHEREAS substance use treatment levels of care, including long-term residential, intensive outpatient, and short-term inpatient treatment for cocaine, alcohol, and poly-drug use, are associated with significant reductions in drug use and injection risks that lead to HIV transmission (Altice, Kamarulzaman, Soriano, Schechter, & Friedland, 2010; Avins et al., 1997; Durvasula & Miller, 2014; Farrell, Gowing, Marsden, Ling, & Ali, 2005; Gottheil, Lundy, Weinstein, & Sterling, 1998; Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997; Longshore & Hsieh, 1998; McCusker, Bigelow, Stoddard, & Zorn, 1994; McCusker, Willis, Vickers-Lahti, & Lewis, 1998; Sorensen & Copeland, 2000);

WHEREAS methadone treatment programs and providers are required to undergo an accreditation and review process that is costly in terms of compliance oversight and funds, and may discourage smaller treatment programs from applying to provide methadone maintenance therapy (MMT) (Department of Health and Human Services, 2001; Substance Abuse and Mental Health Services Administration, 2006);

WHEREAS the Drug Abuse Treatment Act of 2000 allows physicians to take a short specialty training course to become certified to prescribe buprenorphine in an office setting, yet few have done so due to financing and services delivery barriers, including a cap on the number of
patients who can be treated and the frequency of office visits required to achieve stabilization (Pating, Miller, Goplerud, Martin, & Ziedonis, 2012; West et al., 2004);

WHEREAS access to drug treatment, including MOUDs, for people who inject drugs is inadequate, particularly in rural areas (Compton, Thomas, Stinson, & Grant, 2007; Deck & Carlson, 2004; Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013; Stein et al., 2015; Zaller, Bazazi, Velazquez, & Rich, 2009);

WHEREAS psychologists have many areas of relevant practice competence, including assessment, intervention, and prevention skills, that could and should inform the discourse about HIV prevention and substance abuse treatment for people who inject drugs and their significant others;

WHEREAS psychologists’ training in research makes them especially well-qualified to assist policy-makers in making informed judgments based on the best available science;

WHEREAS syringe service programs (SSPs) have been recognized by The Centers for Disease Control and Prevention (2018) and the U.S. Department of Health and Human Services (2016) as an effective component of comprehensive, integrated approach to HIV prevention among people who inject drugs; and

WHEREAS the Consolidated Appropriations Act of 2016 Division H, Sec. 520, provides states and local communities, under limited circumstances, with the opportunity to use federal funds to support certain components of SSPs;

WHEREAS psychologists should be included in those healthcare professionals who are able to provide drug abuse treatment in order to prevent HIV among people who inject drugs.

THEREFORE BE IT RESOLVED that the American Psychological Association (APA) actively supports and promotes an increase in accessible, available drug treatment for people who inject drugs in traditional substance abuse, mental health, correctional, educational, and medical care settings in both rural and urban areas to prevent the spread of HIV and other infectious diseases.

BE FURTHER RESOLVED that the APA:

Encourages state governments, Congress, and the executive branch to promote public policies and revise regulations and provide increased training to potential providers to increase available drug treatment for HIV prevention in a variety of settings.

Encourages the support for syringe service programs (SSPs), which have also been referred to as syringe exchange programs (SEPs), needle exchange programs (NEPs) and needle-syringe programs (NSPs), that are community-based programs that provide access to sterile syringes and injection equipment, free of cost, and facilitate the safe disposal of used syringes and injection equipment.

Promotes increased funding for HIV prevention research that includes drug treatment provided in traditional substance abuse, mental health, correctional, educational, and medical care settings.
Supports training in HIV prevention interventions, including addiction treatment for people who inject drugs, within psychology training programs at all levels.

Promotes and facilitates psychologists’ acquisition of competencies in addiction treatment strategies that decrease transmission of the HIV virus among people who inject drugs that are culturally responsive and gender appropriate.

Encourages psychologists to develop multi-cultural competencies that address the issues specific to sub-groups, including individuals from diverse racial, ethnic, gender, sexual orientation, and socioeconomic groups, who use and inject drugs.

Advocates for reimbursement of psychologists for provision of drug treatment interventions that decrease drug-related HIV risk behavior among people who inject drugs.

Supports psychologists as they engage in interdisciplinary and international efforts involving other health, mental health, and substance abuse professionals who seek to enhance understanding and treatment of drug dependence and sexual risk behaviors.

References


Centers for Disease Control and Prevention. (2013). Fact Sheet: HIV and Substance Use in the United States. Atlanta, GA.


B.(18) Council voted to archive the following the following 1991 APA Resolution on Neuropsychological Assessment and HIV Infection:

**Neuropsychological Assessment and HIV Infection**

Whereas concern has been raised that some persons who are infected with HIV or diagnosed with AIDS experience intellectual, cognitive or neuropsychological difficulties;

Whereas many persons with HIV disease and AIDS do not have clinically significant intellectual, cognitive, or neuropsychological deficits;

Whereas establishing the existence of intellectual, cognitive, or neuropsychological impairment requires the use of reliable, valid and appropriate assessments;

Whereas HIV antibody and antigen testing determine only the presence of viral infection;

Whereas HIV serological screening is not a sensitive, specific, or appropriate indicator of intellectual, cognitive, or neuropsychological status;

Whereas determination of functional, intellectual, or cognitive impairment requires a direct psychological assessment of intellectual, cognitive, or neuropsychological status;

Resolution

Therefore, be it resolved that serological screening for HIV infection cannot be used to assess functional, intellectual, or cognitive impairment.

Council also voted to adopt the following 2019 Resolution on Neuropsychological Assessment of Persons Living with HIV Infection as APA policy:
Resolution on Neuropsychological Assessment of Persons Living with HIV Infection

WHEREAS in the era of combined antiretroviral therapy (cART), persons living with HIV/AIDS (PLWHA) are living longer and rates of neurocognitive impairment and HIV-associated neurocognitive disorder (HAND) remain high (up to 52%; Heaton et al., 2010; Heaton et al., 2011);

WHEREAS rates of HIV-Associated Dementia (HAD) have decreased yet more individuals in the post-cART era exhibit milder forms of neurocognitive impairments, suggesting that neurocognitive outcomes remain a pertinent issue as people live longer with HIV/AIDS (Foley et al., 2008; Heaton et al., 2010);

WHEREAS asymptomatic neurocognitive impairment has demonstrated increased progression to symptomatic HAND (Sacktor & Roberston, 2014), suggesting that early identification in patients without subjective cognitive complaints is important for early intervention;

WHEREAS nearly half of PLWHA are aged 50 years or older, and older PLWHA may also be at greater risk for neurocognitive impairment (CDC, 2016; Cherner et al., 2004; Effros et al., 2008; Foley et al., 2010; Hardy et al., 2009);

WHEREAS HIV/AIDS disproportionately affects racial/ethnic minority populations who are also at greater risk for neurocognitive impairment related to other comorbid disorders (e.g., cerebrovascular disease, Hepatitis C; Cargil & Stone, 2005; CDC, 2013; Marquine, et al., 2016; Rivera Mindt et al., 2008);

WHEREAS HIV-related neurocognitive impairment is associated with increased risk for significant functional impairments among non-Hispanic white, racial/ethnic, and linguistic minority populations (e.g., deficits in activities of daily living, medication adherence, vocational functioning; Gorman et al., 2009; Heaton et al., 2004; Hinkin et al., 2004; Marquine, et al., 2018; Rivera Mindt et al., 2003; Thames et al., 2013);

WHEREAS HIV antibody and antigen testing determine only the presence of viral infection;

WHEREAS HIV serological screening is not a sensitive, specific, or appropriate indicator of neurocognitive status;

WHEREAS determination of functional or neurocognitive impairment requires a direct psychological assessment of neuropsychological status;

WHEREAS brief screening measures of cognitive status are often insensitive to milder forms of HAND and are not intended to be diagnostic tools (de Almeida, 2017; Sakamoto, 2013);

WHEREAS evaluating neurocognitive impairment requires the use of reliable, valid and culturally and linguistically appropriate assessments in order to accurately assess and diagnose HAND (Antinori et al., 2007; Rivera Mindt et al., 2008; Woods et al., 2004).

THEREFORE BE IT RESOLVED that baseline and regular follow-up (e.g., annual) assessment of HAND is needed to inform treatment and improve neurocognitive and health outcomes among
PLWHA; and

THEREFORE BE IT FURTHER RESOLVED that direct neuropsychological assessment of functional or neurocognitive impairment, utilizing reliable, valid and culturally and linguistically appropriate assessments is the preferred method to evaluate and diagnose HAND (Antinori et al., 2007; Arentoft et al., 2012; Rivera Mindt et al., 2008); and

Therefore, initial and routine assessment of HAND should be implemented as part of the standard of care for PLWHA in order to inform treatment and improve neurocognitive and health outcomes among PLWHA; and

Therefore, funding should be increased to support research and training to better understand and optimize neurocognitive outcomes of PLWHA, particularly for those who may be at greater risk for HAND (e.g., racial/ethnic minority adults, older adults; Cherner et al., 2004; Rivera Mindt et al., in press); and

Therefore, neuropsychologists and trainees in neuropsychology should be specifically trained in the issues related to evaluating HAND; and

Therefore, Congress, the executive branch, state and local governments, and non-governmental organizations should promote public policies that increase multidisciplinary, interdisciplin ary and transdisciplinary awareness of proper neuropsychological evaluation and HIV infection.

References

Cherner, M., Ellis, R. J., Lazzaretto, D., Young, C., Rivera Mindt, M., Atkinson, J. H., ... the HNRC Group. (2004). Effects of HIV-1 infection and aging on neurobehavioral functioning: Preliminary findings. AIDS, 18, S27-34.
and future research directions. *Clinical Infectious Diseases, 47,* 542-553.


C.(19) Council voted to archive the following 1991 APA Resolution on Legal Liability Related to Confidentiality and the Prevention of HIV Transmission:

**Legal Liability Related to Confidentiality and the Prevention of HIV Transmission**

*Whereas* the status of privileged communication between psychologists and client is legally protected;

*Whereas* information regarding an individual's HIV status may be particularly sensitive given the personal nature of such information and the potential for discrimination involved;

*Whereas* providers of psychological services are also concerned about the prevention of HIV transmission and promotion of the public health;

*Whereas* respect for personal dignity, protection of clients/patients from harm, and promotion of access to mental health services demand protection of confidentiality in all but the most extraordinary circumstances;

*Whereas* psychological services to HIV-infected individuals make an important contribution to the reduction of risk behaviors that spread such infection;

*Whereas* legislatures considering exceptions to privileged communications in cases involving HIV infection may benefit from the APA position on this issue;

Therefore be it resolved that APA's position on legislation regarding confidentiality and the prevention of HIV transmission is as follows:

1. A legal duty to protect third parties from HIV infection should not be imposed.
2. If, however, specific legislation is considered, then it should permit disclosure only when (a) the provider knows of an identifiable third party who the provider has compelling reason to believe is at significant risk for infection; (b) the provider has a reasonable belief that the third party has no reason to suspect that he or she is at risk; and (c) the client/patient has been urged to inform the third party and has either refused or is considered unreliable in his/her willingness to notify the third party.
3. If such legislation is adopted, it should include immunity from civil and criminal liability for providers who, in good faith, make decisions to disclose or not to disclose information about HIV infection to third parties.

Council also voted to adopt the following 2019 *U.S.-Based Legal Liability Related to Confidentiality and the Prevention of HIV Transmission Resolution* as APA policy:

**U.S.-Based Legal Liability Related to Confidentiality and the Prevention of HIV Transmission Resolution**

WHEREAS the status of privileged communication between psychologists and client is legally protected;

WHEREAS information regarding an individual's HIV status may be particularly sensitive given the personal nature of such information and the potential for discrimination involved (Association of Nurses in AIDS Care, 2014);

WHEREAS criminalization of potential HIV exposure and high risk behavior among people living with HIV has public health implications for HIV prevention and care (Lehman, 2014);

WHEREAS providers of psychological services are also concerned about the prevention of HIV transmission and the promotion of public health (Conserve et al., 2015);

WHEREAS respect for personal dignity, protection of clients/patients from harm, and promotion of access to mental health services demand protection of confidentiality in all but the most extraordinary circumstances;

WHEREAS psychological services to individuals living with HIV make an important contribution to the reduction of high risk behaviors that spread HIV infection;

WHEREAS legislatures considering exceptions to privileged communications in cases involving HIV infection may benefit from the APA position on this issue;

THEREFORE BE IT RESOLVED that APA's position regarding confidentiality and the prevention of HIV transmission is as follows:

1. Legislation should not impose a legal duty to protect third parties from HIV infection.

2. If, however, specific state legislation is proposed, then it should permit disclosure only when (a) the provider knows of an identifiable third party who the provider has compelling reason to believe is at significant risk for infection; (b) the provider has a reasonable belief that the third party is unaware the client/patient is living with HIV; and (c) the client/patient has been urged to inform the third party and has either refused or is considered unreliable in the individual's willingness to notify the third party.
3. If such legislation is adopted, it should include immunity from civil and criminal liability for providers who, in good faith, make decisions to disclose or not to disclose information about HIV infection to third parties.

If such legislation allows, disclosure to a public health official (e.g., local health department) responsible for partner notification is preferable.

4. In the case of disclosure to a third party by a psychologist, the psychologist should notify the patient and take steps to repair any harm to the psychologist-client relationship.

5. All psychologists should be familiar with the applicable HIV laws in their jurisdiction as they relate to HIV status disclosure.

References


D.(20) Council voted to archive the following 2012 APA Resolution on Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention:

Resolution on Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention

Background
Thirty years after the initial discovery of the virus that causes AIDS, the epidemic continues to spread, both nationally and globally, and it continues to affect millions of individuals across the developmental spectrum (UNAIDS, 2010). Although daunting challenges remain, there have been major advancements in biomedical approaches to reduce HIV transmission during the past 10 years as a result of the increased tolerability and decreased cost of anti-retroviral treatment (ART) and vaccines (e.g., Hepatitis B, HPV vaccine), the expanding range of medical options (e.g., male circumcision, microbicides), and improvement in technological approaches (e.g., female condom). The interest in biomedical approaches has dramatically increased in recent months with the release of findings from the CAPRISA 004 (Karim et al. 2010), the iPrEx (Grant et al. 2010), and HTPN052 [National Institute of Allergy and Infectious Diseases (NIAID), 2011] trials.

South African scientists associated with Caprisa, a Durban-based research center, announced in July 2010 that women who used tenofovir, a vaginal microbicidal gel containing an antiretroviral medication widely used to treat AIDS, were 39 percent less likely over all to contract HIV than those who used a placebo (Weiss et al. 2008). Even more impressive, those women who used the gel most regularly reduced their chances of infection by 54 percent (Karim et al. 2010). In November 2010, scientists associated with the iPrEx (Pre-exposure Prophylaxis Initiative) trial reported that the HIV infection rate in HIV-negative gay men who were given a daily dose of
truvada (a pill containing two HIV drugs [tenofovir plus FTC] was reduced by 44 percent, compared with men given a placebo (Grant et al. 2010). In May of 2011, results were released from the HIV Prevention Trials Network (HPTN) 052 study (NIAID, 2011) indicated that initiation of antiretroviral therapy (ART) reduced transmission from HIV+ men and women to their seronegative sexual partners by 96 percent.

For many, the results from these three recent studies constitute “game-changing events” suggesting the need to prioritize biomedical over behavioral approaches to HIV prevention. However, close inspection of the results demonstrates that biomedical approaches to HIV prevention are optimized when they are combined with behavioral approaches. Although biomedical approaches to HIV prevention such as “test-link-and-treat strategies” and pre- and post-exposure prophylaxis are important tools for HIV prevention, in order to optimize prevention outcomes, they must be combined with evidence-based behavioral strategies including structural interventions that increase access to services, decrease costs, and reduce stigma and discrimination to ensure broad-scale implementation (Morin et al., 2011). The debate over the value of biomedical versus behavioral approaches to HIV prevention can affect funding decisions associated with the implementation of the National HIV/AIDS Strategy (NHAS) released by President Barack Obama in July. The NHAS is intended to guide our national efforts to reduce HIV/AIDS incidence, increase access to care, and reduce HIV-related health disparities.

Resolution on Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention

Whereas recent findings from the CAPRISA 004 trials (Karim et al. 2010) (women receiving Tenofovir gel were 39 percent less likely to contract HIV than those receiving placebo), the Pre-exposure Prophylaxis Initiative (iPrEx) trials (Grant et al. 2010) (HIV-negative gay men given Truvada had 44 percent lower infection rates than men given placebo), and the HPTN 052 trials (NIAID, 2011) (HIV+ individuals initiating ART decreased transmission rates to sexual partners by 96 percent) clearly establish the importance of biomedical approaches to HIV prevention, they do not justify decreased focus or funding for behavioral prevention strategies; and, 

Whereas these recent biomedical studies represent significant breakthroughs, combination approaches to prevention of HIV and other sexually transmitted infections (STIs) that comprise both biomedical and psychosocial components work best for optimizing health outcomes (Coates et al. 2008; Piot et al. 2008); and, 

Whereas the success of biomedical interventions is dependent on behavioral factors affecting medication adherence and treatment uptake (i.e., treatment acceptability and use) (Weiss et al. 2008); and, 

Whereas the efficacy of the CAPRISA, iPrEX, and HTPN 052 studies were optimized by behavioral approaches (Karim et al. 2010; Grant et al. 2010; NIAID, 2011); and, 

Whereas women in the CAPRISA study who accessed the adherence counseling program and used the gel most regularly had an HIV infection rate that was 54 percent lower than controls, while those with low adherence had an HIV infection rate that was only 28 percent lower than controls (Karim et al. 2010); and,
Whereas treatment adherence played a central role in the iPrEX study as evidenced by the fact that 91 percent of the men assigned to the treatment group who later tested positive for HIV had no detectable levels of Truvada in their bloodstream (Grant et al. 2010); and,

Whereas behavioral approaches played a central role in the HTPN 052 study (NIAID, 2011) in which all participants were given HIV care that included safe sex counseling; and,

Whereas biomedical interventions for HIV and other STIs without combined behavioral approaches have shown suboptimal medication adherence and treatment uptake [e.g., 80 percent of women do not receive medication to prevent HIV Parent to Child transmission (Temmerman et al. 2003); 80 percent of uncircumcised Zambian males have expressed no interest in considering circumcision as an HIV risk reduction option (Weiss, 2011); only 27 percent of drug users in need of the Hepatitis B vaccine completed the required three dose regimen (McGregor et al. 2003); and only 28.2 percent of young women at a clinic who were offered the human papillomavirus vaccine accepted and of those who accepted only 55.7 percent completed all three required doses (Moor, et al. 2010); and,

Whereas medication adherence and treatment uptake of biomedical interventions can be addressed by behavioral interventions that enhance knowledge and build skills while incorporating attention to factors such as age, socioeconomic status, literacy, religious beliefs, chronic or acute health conditions and disability, developmental understanding, cognitive impairment, race immigration history and status, language, gender, gender identity, sexual orientation, family context, culture, stigma, mental health, substance abuse, attitudes, prior knowledge, etc. (Liebowitz et al., 2011; Underhill et al., 2011); and,

Whereas policy and recommendations have yet to be established as to whether biomedical interventions for HIV prevention will be viewed as life-long or as short-term solutions for high-risk individuals (Paltiel et al., 2009); and,

Whereas successful behavioral engagement in biomedical prevention models may be out of reach for certain populations (e.g., human trafficking victims, sex workers, people living in poverty, children, etc.) necessitating the development of concurrent models that can be accessed by multiple at-risk populations (Bowleg, Neilands & Choi, 2008); and,

Whereas there is insufficient behavioral research to assess the potential for unintended consequences and unanticipated ethical issues in everyday clinical use of HIV biomedical interventions (e.g., individuals might engage in more risky behavior; individuals may not use biomedical agents as prescribed; there may be health disparities in access to biomedical interventions; there may be as yet undefined, long-term, negative health implications and side effects from an exclusive reliance on biomedical interventions; etc.);

Resolution
Therefore behavioral research is needed to optimize medication adherence and treatment uptake, to document real-world decision making processes associated with biomedical interventions, and to better understand the possible unintended and/or undesired consequences of biomedical interventions; and,

Therefore HIV/STI prevention research teams of the future must bridge biomedical and behavioral approaches and develop new combination approaches that consider biological,
cognitive, attitudinal, affective, behavioral, gender, familial, developmental, cultural, educational, social, racial, linguistic, socioeconomic, religious, and environmental factors (Fisher et al., 2010; National Institutes of Health Research Teams of the Future, 2011); and,

Therefore funding should be increased for HIV prevention research that incorporates mental health, substance abuse, behavior change, and adherence strategies to optimize the health outcomes of biomedical strategies with special attention paid to the development of combination prevention interventions that can be accessed by multiple at-risk populations; and, Therefore Congress, the executive branch, state and local governments, and non-governmental organizations should promote public policies that increase support for multidisciplinary, interdisciplinary and transdisciplinary training, practice, and research; and, Therefore psychology should continue to be mobilized to conduct research on strategies for improving health outcomes based on behavioral optimization of biomedical approaches to HIV/STI prevention and to continue basic and applied research to identify and disseminate effective universal and selective prevention strategies.

References


Council also voted to adopt the following 2019 *Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention Resolution* as APA policy:

**Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention Resolution**

**Background**

Thirty years after the initial discovery of the virus that causes AIDS, the epidemic continues to spread, both nationally and globally, and it continues to affect millions of individuals across the developmental spectrum (UNAIDS, 2017). Although daunting challenges remain, there have been major advancements in biomedical approaches to reduce HIV transmission during the past 10 years as a result of the increased tolerability and decreased cost of antiretroviral treatment (ART) and vaccines (e.g., Hepatitis B, human papillomavirus (HPV) vaccine), the expanding range
of medical options (e.g., male circumcision, microbicides), and improvement in technological approaches (e.g., female condom, computerized counseling, and mobile phone messaging services to promote treatment adherence). The interest in biomedical approaches dramatically increased with the release of findings from the Centre for the AIDS Programme of Research in South Africa (CAPRISA) 004 trial (Karim et al., 2010), the Pre-exposure Prophylaxis Initiative (iPrEx) (Grant et al., 2010), and HIV Prevention Trials Network (HPTN) HTPN 052 trials.

South African scientists associated with CAPRISA, a Durban-based research center, announced in July 2010 that women who used tenofovir, a vaginal microbicidal gel containing an antiretroviral medication widely used to treat HIV/AIDS, were 39 percent less likely overall to contract HIV than those who used a placebo (Karim et al., 2010). Even more impressive, those women who used the gel most regularly reduced their chances of infection by 54 percent (Karim et al., 2010). In November 2010, scientists associated with the iPrEx trial reported that the HIV infection rate in HIV-negative gay men who were given a daily dose of Truvada (a pill containing two HIV drugs) was reduced by 44 percent, compared with men given a placebo (Grant et al., 2010). Among subjects with a detectable tenofovir-FTC level, the odds of HIV infection corresponded to a relative reduction in HIV risk of 92% (Grant et al., 2010). During this trial, men using tenofovir did not increase sexual risk behaviors (Liu et al., 2013). In May 2011, results released from the HPTN 052 study (NIAID, 2011) indicated that initiation of ART reduced transmission from HIV-positive men and women to their seronegative sexual partners by 96 percent, and a subsequent follow-up study showed that early ART provided a 93 percent lower risk of linked partner infection than delayed ART (Cohen et al., 2016).

Epidemiological U.S. data point to the rise of incident HIV infections among individuals who engage in injection drug use (IDU), particularly with increased national prevalence of opiate and other substance use (CDC, 2012). The seminal randomized controlled trial of pre-exposure prophylaxis (PrEP) use of tenofovir among individuals who engage in IDU conducted in Thailand found reduced risk of HIV infection among those receiving tenofovir relative to placebo (Choopanya et al., 2013). Further, this study highlighted that greater adherence to tenofovir (as measured by tenofovir drug concentration levels) were associated with decreased HIV incidence (Choopanya et al., 2013), highlighting the important role of behavioral interventions to increase adherence to PrEP as a biomedical prevention strategy.

For many, the results from these recent studies constitute “game-changing events” suggesting the need to prioritize biomedical over behavioral approaches to HIV prevention. However, close inspection of the results demonstrates that biomedical approaches to HIV prevention are optimized when they are combined with behavioral approaches. For instance, women in the CAPRISA study who accessed the adherence counseling program and used the gel most regularly had an HIV infection rate that was 54 percent lower than controls, while those with low adherence had an HIV infection rate that was only 28 percent lower than controls (Karim et al., 2010). Similarly, behavioral approaches played a central role in the HPTN 052 study (NIAID, 2011) in which all participants were given HIV care that included safe sex counseling. In order for biomedical HIV prevention products to work as intended, people must uptake the product and adhere to the treatment. Adherence and uptake of biomedical interventions can be addressed by behavioral interventions that enhance knowledge of the products and build skills for their effective use while incorporating attention to factors such as age, socioeconomic status, literacy, religious beliefs, chronic or acute health conditions and disability, developmental understanding, cognitive impairment, race immigration history and status, language, gender, gender identity, sexual orientation, family context, culture, stigma, mental
health, substance use, attitudes, prior knowledge, among other factors (Liebowitz et al., 2011; Underhill et al., 2011). Thus, although biomedical approaches to HIV prevention such as “test-link-and-treat strategies” and pre- and post-exposure prophylaxis are important tools for HIV prevention, in order to optimize prevention outcomes, they must be combined with evidence-based behavioral strategies including structural interventions that increase access to services, decrease costs, and reduce stigma and discrimination to ensure broad-scale implementation (Bekker, Beyrer, and Quinn, 2012). The debate over the value of biomedical versus behavioral approaches to HIV prevention can affect funding decisions associated with the implementation of the National HIV/AIDS Strategy (NHAS) released by former President Barack Obama in 2010. The NHAS is intended to guide our national efforts to reduce HIV/AIDS incidence, increase access to care, and reduce HIV-related health disparities.

Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention Resolution

WHEREAS recent findings from the CAPRISA 004 trials (Karim et al., 2010) (women receiving Tenofovir gel were 39 percent less likely to contract HIV than those receiving placebo), the iPrEx trials (Grant et al., 2010) (HIV-negative gay men given Truvada had 44 percent lower infection rates than men given placebo), and the HPTN 052 trials (NIAID, 2011) (HIV-positive individuals initiating ART decreased transmission rates to sexual partners by 96 percent), and the Dapivirine Ring studies, MTN-ASPIRE (Baeten et al., 2016) and IPM-The Ring Study (Nel et al., 2016) (incidence of HIV infection was 27 percent and 31 percent lower, respectively, in the intervention arms compared to the control arms) clearly establish the importance of biomedical approaches to HIV prevention;

WHEREAS the success of biomedical interventions is dependent on behavioral factors, such as those affecting medication adherence and treatment uptake (i.e., treatment acceptability and use) (Weiss et al., 2008), and thus behavioral and social science research can also help to understand vulnerable populations and risk settings, improve behavioral and social factors risk reduction, prevention, and care, strengthen design and outcomes of biomedically focused research in HIV treatment and prevention, and contribute to integrated HIV/AIDS prevention and treatment approaches (Gaist & Stirratt, 2017);

WHEREAS the efficacy of the CAPRISA 004, iPrEx, and HTPN 052 studies were optimized by behavioral approaches (Karim et al., 2010; Grant et al., 2010; NIAID, 2011);

WHEREAS women in the CAPRISA study, all of whom had access to the adherence counseling program, that used the gel most regularly had an HIV infection rate that was 54 percent lower than controls, while those with low adherence had an HIV infection rate that was only 28 percent lower than controls (Karim et al., 2010);

WHEREAS treatment adherence played a central role in the iPrEx study as evidenced by the fact that 91 percent of the men assigned to the treatment group who later tested positive for HIV had no detectable levels of Truvada in their bloodstream, indicating they were non-adherent to the medication regimen thus the reason for treatment failure and their acquisition of HIV (Grant et al., 2010);

WHEREAS behavioral approaches played a central role in the HTPN 052 study (NIAID, 2011) in which all participants were given HIV care that included safe sex counseling in order to achieve the high levels of ART adherence required to achieve viral suppression and thereby reduce HIV
transmission risk to partners;

WHEREAS biomedical interventions for HIV and other sexually transmitted infections (STIs) without combined behavioral approaches have shown suboptimal medication adherence and treatment uptake e.g., 80 percent of women do not receive medication to prevent HIV Parent to Child transmission (Temmerman et al., 2003); 80 percent of uncircumcised Zambian males have expressed no interest in considering circumcision as an HIV risk reduction option (Weiss, 2011); only 27 percent of drug users in need of the Hepatitis B vaccine completed the required three dose regimen (McGregor et al., 2003); and only 28.2 percent of young women at a clinic who were offered the HPV vaccine accepted and of those who accepted only 55.7 percent completed all three required doses (Moore et al., 2010);

WHEREAS medication adherence and treatment uptake of biomedical interventions can be addressed by behavioral interventions that enhance knowledge and build skills while incorporating attention to factors such as age, socioeconomic status, literacy, religious beliefs, chronic or acute health conditions and disability, developmental understanding, cognitive impairment, race, ethnicity, immigration history and status, language, gender, gender identity, sexual orientation, family context, culture, stigma, mental health, substance abuse, attitudes, prior knowledge, etc. (Liebowitz et al., 2011; Underhill et al., 2011);

WHEREAS cost-effectiveness analysis suggests that PrEP could significantly reduce the lifetime risk of HIV infection in persons at high risk in the United States (Paltiel et al., 2009);

WHEREAS successful behavioral engagement in biomedical prevention models may be out of reach for certain populations (e.g., human trafficking victims, sex workers, people living in poverty and/or homeless, children, transgender individuals, those with an undocumented immigration status, etc.) necessitating the development of concurrent models that can be accessed by multiple at-risk populations (Bowleg, Neilands & Choi, 2008);

WHEREAS there is insufficient behavioral research to assess the potential for unintended consequences and unanticipated ethical issues in everyday clinical use of HIV biomedical interventions (e.g., individuals might engage in more risky behavior (Liu et al., 2013; Marcus et al., 2013); individuals may not use biomedical agents as prescribed; there may be health disparities in access to biomedical interventions; there may be as yet undefined, long-term, negative health implications and side effects from an exclusive reliance on biomedical interventions; etc.);

WHEREAS the federal government’s goal of ending HIV in the United States by 2030 will require the integration of behavioral science/behavioral health with biomedical HIV prevention;

WHEREAS the opioid epidemic in the U.S. is a public health crisis with increased risk for acquisition and transmission of both HIV and Hepatitis C Virus (HCV), comprehensive biomedical and behavioral intervention strategies to target the full HIV and HCV continuums of care for individuals with opioid use disorder (OUD) are necessary and novel public health approaches that address the intersection of opioid use, injection drug use, HIV and HCV are urgently needed to proactively address disparities experienced by individuals with OUD accessing and receiving HIV and HCV prevention and treatment services (Brown, 2019);

WHEREAS these recent biomedical studies represent significant breakthroughs, combination
approaches to prevent HIV and other STIs that comprise both biomedical and psychosocial components work best for optimizing health outcomes (Coates et al., 2008; Piot et al. 2008; Rausch, Grossman, & Erbelding, 2013);

THEREFORE BE IT RESOLVED behavioral research is needed to optimize medication adherence and treatment uptake, to document real-world decision making processes associated with biomedical interventions, and to better understand the possible unintended and/or undesired consequences of biomedical interventions.

BE IT FURTHER RESOLVED HIV/STI prevention teams should continue to bridge biomedical and behavioral approaches (Farber, Ali, Van Sickle & Kaslow, 2017) and develop new combination approaches that consider the intersection of biological, cognitive, attitudinal, affective, behavioral, gender, familial, developmental, cultural, educational, social, racial, linguistic, socioeconomic, religious, and environmental factors (Fisher et al., 2010; National Institutes of Health Research Teams of the Future, 2011).

BE IT FURTHER RESOLVED funding should be increased for HIV prevention research that incorporates mental health, substance abuse, behavior change, and adherence strategies to optimize the health outcomes of biomedical strategies with special attention paid to the development of combination prevention interventions that can be accessed by multiple at-risk populations.

BE IT FURTHER RESOLVED Congress, the executive branch, state and local governments, and non-governmental organizations should promote public policies that increase support for multidisciplinary, interdisciplinary and transdisciplinary training, practice, and research.

BE IT FURTHER RESOLVED psychology should continue to conduct research on strategies for improving health outcomes based on behavioral optimization of biomedical approaches to HIV/STI prevention and to continue basic and applied research to identify and disseminate effective universal and selective prevention strategies.

References


controlled phase 3 trial. Lancet, 381(9883), 2083-2090.


E.(21) Council voted to adopt as APA policy the Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization and approved August 2029 as the expiration date for the Guidelines.

F.(22) Council voted to adopt as APA policy the Race and Ethnicity Psychology Guidelines in Psychology: Promoting Responsiveness and Equity and approved August 2029 as the expiration date for the Guidelines.

G.(27) Council received as information an update on the business pending item, “Police/Citizen Contact New Business Item from Peace Psychology Division Violence Summit (NBI#21A/Feb 2017).”

H.(35) Council was provided with an update on the work of the Task Force on Human Rights. The Task Force was established in 2016, charged with providing strategic advice to the Association in its engagement in the promotion and protection of human rights.

I.(35A) Council voted to approve the following motion:

That Council requests that APA forms an 8-12 person taskforce/work group that will be in effect for the duration one year with the charge of performing an environmental scan of available resources (within and outside of our organization) and identifying potential strategic partners with the purpose of making recommendations that will directly lead to the development of a Public Education Campaign and supporting infrastructure designed to address racism, discrimination and hate.

XIII. ETHNIC MINORITY AFFAIRS

No items.

XIV. INTERNATIONAL AFFAIRS


XVI. FINANCIAL AFFAIRS

A.(36) Council received as information the 2018 Audited Financial Statements.
On Wednesday morning, Jean Carter, PhD provided Council with the financial report.

On Wednesday afternoon, recently deceased members were honored. Dr. Diana Prescott recognized Dr. Rich Tirman and Dr. Frank Farley recognized Dr. Wilbert (Bill) McKeachie.

Additionally, on Wednesday afternoon, the Committee on Early Career Psychologists presented Division 42 with a recognition for promoting the expertise of early career psychologists and encouraging early career involvement in leadership.

On Friday morning, Dr. Ronald Rozensky was presented with the Raymond D. Fowler Award for Outstanding Member Contributions. Additionally, Dr. Alberto Figueroa-Garcia was presented with a posthumous presidential citation.

On Friday morning, Drs. Jean Carter and Beth Rom-Rymer provided Council with an update on the trial delegation of authority.