AMERICAN PSYCHOLOGICAL ASSOCIATION

August 31, 2022

Michelle Bachelet
High Commissioner for Human Rights
Office of the United Nations High Commissioner for Human Rights
Palais des Nations
CH-1211 Geneva 10, Switzerland

Dear High Commissioner Bachelet,

I am writing on behalf of the American Psychological Association (APA) to respond to the recent "**Call for inputs: Draft guidance on Mental Health, Human Rights, and Legislation published jointly by WHO and OHCHR."** Our Association is committed to using psychology to promote and protect human rights, including population health approaches that seek to improve the mental health, equity, safety and wellbeing of populations. We commend the World Health Organization (WHO) and the UN Office of the High Commissioner for Human Rights (OHCHR) on their leadership in this important area of human rights work.

APA is a scientific and professional organization representing psychology, comprising a membership of more than 133,000 clinicians, researchers, educators, practitioners, consultants, and students across the United States (U.S.) and around the world. We work to advance the creation, communication, and application of psychological knowledge to benefit society and improve lives. Since 2000, APA has held the status of nongovernmental organization (NGO) at the UN. Based on its special consultative status with ECOSOC and affiliation with the Department of Global Communications, APA has an active team of volunteer psychologists advocating at the UN Headquarters in New York.

We welcome the opportunity to provide input on legislative considerations that contribute to mental health and human rights based on relevant science and Association policies. We have a long track record of providing psychological science to the U.S. government relating to legislative processes. Our organization also develops policies, resolutions, and statements to guide the future of the field. We will comment on specific sections of the guidance, identified by the relevant headings.

1.1 Context and challenges in mental health, pg. 16

Recommendation: Acknowledge the history and impact of White, Western hierarchy in mental health theory, practice, and service delivery. This section of the draft guidance addresses experiences of discrimination and challenges in accessing mental health care services. We believe it is important to acknowledge that the field of psychology and other disciplines, in the U.S. and elsewhere, often developed in environments that promote a White, Western hierarchy of mental health and wellbeing.

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Since its origins as a scientific discipline in the mid-19th century, psychology has, through acts of commission and omission, contributed to discrimination, dispossession, displacement, and exploitation of communities of color. This early history of psychology, rooted in oppressive psychological science to protect Whiteness, White people, and White epistemologies, reflected the social and political landscape of the U.S. and much of Western society at that time. Psychology, developed under these conditions, helped to create, express, and sustain them, continues to bear their indelible imprint, and often continues to publish research that conforms with White racial hierarchy (APA, 2021a). It is fundamentally necessary to implement broad steps related to addressing race/ethnicity and racism in all areas of mental health practice. For example, in order to advance health equity laws and policies can be designed to 1) advocate for increased funding for research in health equity (including scholars of color and scholars knowledgeable about health equity issues), 2) design health insurance reimbursement formulas and models that support culturally appropriate mental health services, and 3) develop and engage in partnerships and coalitions with other professional and policymaking organizations to address health equity issues in communities of color (APA, 2021b).

2.2.3 Respecting personhood and legal capacity in mental health services, pg. 47

Recommendation: Include positive assumptions of decision-making capacity as a key factor for supported decision making. The draft guidance notes that "supported decision-making should never be imposed on people." Positive assumptions about the capabilities of people with intellectual disabilities are important for supported decision-making to be successful. Stressing these assumptions will minimize assumptions often made that people with cognitive impairments or intellectual disabilities are incompetent to make their own treatment-related decisions (APA, 2022a). We recommend including information in this section that making positive assumptions of decision-making capacity is a key factor in supported decision-making (Shogren et al., 2006).

2.3 Informed consent and eliminating coercive practices in mental health care, pg. 52

Recommendation: Include information about certain adaptations needed to obtain informed consent. The draft guidance explains that legislation can ensure each person has access to the information and support required to make a truly informed decision. However, the consenting process for mental health services may require certain adaptations in order to obtain valid consent (APA, 2017a) for people with intellectual and other disabilities. Adaptations may include adjusting consent language, including both word type and level/complexity; modifying how the client accesses forms; and involving sign language interpreters (Fisher, 2003). We recommend including language in this section so that legislation can ensure these types of adaptations are made available as required.

2.3.2 Advance planning, pg. 57

Recommendation: Indicate that the capacity of an individual should be assessed based on clinical and legal professional standards guiding the jurisdiction and may need to be reassessed over time. In its section on advance planning, the draft guidance makes recommendations about when advance plans enter into force (usually when a person is found to lack decision-making capacity). The guidance is particularly relevant for older adults. For example, the civil capacity domains typically important to older adults include medical, sexual, financial, testamentary, driving, and independent living. Consideration of specific standards within the jurisdiction for each type of legal task under consideration should be used to guide assessment and recommendations of capacity. Medical and mental health professionals can make distinctions between decisional capacity, which refers to the capacity to make a particular decision

(e.g., refusing health care treatment) versus executional capacity, which relates to the capacity to implement a decision (e.g., managing a bank account and paying bills). Under some circumstances, it may be appropriate to monitor and reassess capacity over time. (ABA/APA, 2008; ABA, 2021).

2.4.1 Parity between physical and mental health, pg. 68

Recommendation: Suggest strengthening the scope and enforcement of mental health parity laws in countries where they may already exist. This section of the draft guidance makes note that equitable access to mental health care is essential to physical health. It also mentions several federal laws passed in the U.S. that attempt to address parity between physical and mental health. However, in the U.S. patients and psychologists continue to experience a number of barriers unique to mental health treatment, including coverage and reimbursement disparities, exceedingly narrow networks of mental health providers, and inadequate enforcement among state and federal authorities. Some plans in the U.S., such as state employee insurance plans, are not covered by federal parity law at all. We recommend including language that explains, despite some progress towards achieving equal coverage of mental health treatment through federal parity laws, it is important for parity legislation to be written very specifically in order for parity laws to reach their full potential.

We believe that the real measure of access is whether a consumer needing mental health care can get an appointment within a reasonable time, at a reasonable distance, with a mental health professional suited to the patient's particular needs. We believe the draft guidance can recommend laws to reduce reimbursement disparity and network adequacy through 1) assessing the impacts of reimbursement disparity on patient access to care through network adequacy measures recently revised by the National Association of Insurance Commissioners and being developed in certain states, 2) promoting more timely resolution of parity complaints on these issues, as aided by the next two recommendations, and 3) devoting greater funding and resources to parity enforcement activities (APA, 2016).

2.4.2 Financing of mental health, pg. 70

Recommendation: Include public financing to support access to affordable health insurance and preventative services. The draft guidance makes several important recommendations about financing of mental health care, including earmarked funds for mental health services. Importantly, laws can also support access to affordable health insurance that includes preventive services and substance use coverage. Laws can also support public policies that ensure parity with medical coverage for mental health and substance use treatment services, regardless of ability to pay, and can encourage access to high-quality health care for all individuals, regardless of their types and levels of disabilities (APA, 2022b).

2.4.3 Affordable and equitable access to mental health care, pg. 71

Recommendation: Further elaborate on improving data collection on social determinants of health (SDOH). In its discussion of reduction of disparities in access to mental health care, the draft guidance could better address the collection of SDOH data. As SDOH have a significant impact on health outcomes, addressing the impacts of SDOH is essential to the achievement of greater health equity (APA, 2021c; WHO, 2008). We propose that the draft guidance include a recommendation for the collection of SDOH data to be consistent across systems (e.g., providers, payers, and other stakeholders) and the establishment of diagnostic codes to facilitate the routine screening and intervening for SDOH.

The establishment of diagnostic codes provides a mechanism and incentive for providers to deliver SDOH screening and intervention for patients.

Recommendation: Propose the development of or expanded access to mental health care services via telehealth, where technological advances allow. Access to mental health care via telehealth is an important avenue and should be included in the draft guidance. The evidence is clear that psychotherapy delivered by telehealth is at least as effective as in-person care. There is also clear evidence that the provision of mental health services over the telephone is equally as effective as face-to-face visits for patients with depression and anxiety. A review of 13 studies found reduced symptoms of anxiety and depression when therapy was conducted via telephone (APA, 2021d). In addition, telehealth provides an opportunity for discreet and convenient access to mental health services for those who would not seek services due to the stigma associated with mental illness, live in rural or underserved communities, or lack transportation to face-to-face appointments.

Moreover, the COVID-19 public health emergency forced mental and behavioral health providers to find new ways to meet the needs of their patients, as leaving home put patients and those with co-morbid conditions at risk of exposure to the virus. In September 2020, about 96% of psychologists in the United States provided some or all services via telehealth and 33% worked with patients who lived in a different state than where they were licensed (APA, 2021e). Without the pandemic-era expansion of telehealth coverage across multiple health insurance programs, beneficiaries would have lost access to mental and behavioral health services at a time when their health, both physical and mental, was extremely vulnerable. These expansions include, but are not limited to, allowing patients to receive services via telehealth from their own homes, ensuring equal reimbursement for telehealth services, allowing more services to be furnished via telehealth and allowing patients to use audio-only devices. Because the mental health impact of the pandemic will long outlast the pandemic itself, APA believes these expansions should be made permanent for mental and behavioral health services.

2.4.4 Gender-responsive mental health care, pg. 71

Recommendation: Include language that promotes an intersectional lens when providing gender-responsive mental health care. The draft guidance aptly explains discrimination based on gender within the context of mental health treatment, diagnosis and services. We recommend including language in this section that identifies the unique intersections of gender-based discrimination with other forms of discrimination. For instance, the APA Guidelines for Psychological Practice with Women with Serious Mental Illness note that the intersectionality of identities among women with serious mental illness plays a part in how these identities uniquely impact experiences with serious mental illness. (APA, 2022c). Women and girls experiencing multiple marginalizations (e.g., girls who are also racial and ethnic minorities, women with disabilities) may be impacted differently based on the multiplicity of their social contexts and intersections (APA, 2017b).

Recommendation: Reconsider use of the term "conversion therapy" and clarify why such practices should be banned. The term "conversion therapy" does not constitute a legitimate, accepted form of therapy. Alternatively, APA has adopted and recommends use of the terms, "sexual orientation change efforts" and "gender identity change efforts" which, while less familiar, are descriptive and more accurate. We also suggest an addition to the sentence: "Conversion therapy to change a person's sexual orientation, gender identity, or gender expression should be also banned." The sentence should become, "Efforts to change a person's sexual orientation, gender identity, or gender expression should be also banned because being lesbian, gay, bisexual, transgender or gender nonbinary is not a mental

illness and because these practices are ineffective and can cause serious harm. (APA, 2021f; APA, 2021g).

2.5.1 Integration of mental health in general health care settings, pg. 75

Recommendation: Specify the need for integrated care models, such as the Primary Care Behavioral Health Model (PCBH) in general health care settings. The draft guidance states that legislation can "promote the creation of mental health services in general hospitals." In these settings and others, integrated care models provide a useful approach for service delivery to people with disabilities. Some people with disabilities receive mental health treatment in a setting that utilizes some form of integrated care model. Psychologists have long been at the forefront of developing evidence-based integrated primary care and behavioral health services. One of the leading models of integrated care is the Primary Care Behavioral Health Model (PCBH), in which primary care providers, behavioral health consultants (BHCs), and care managers work as a team, sharing the same health record systems, administrative support staff, and waiting areas, and collaborate in monitoring and managing patient progress in order to improve the management of behavioral health problems and conditions.

Initiatives and incentives to promote integrated care should support implementation of not just PCBH programs, but all evidence-based models of integrated care. Because of differences in providers' patient populations and access to behavioral health providers, there is no "one size-fits-all" approach to effective integrated primary care. More than a decade of research has shown that programs implementing the PCBH model, the collaborative care model, and blended models of integrated care can increase access to care and achieve the health care triple aim of improving patient outcomes, increasing satisfaction with care, and reducing overall treatment costs. A concerted effort to promote evidence-based integrated primary and behavioral health is needed because unfortunately, implementation of integrated care remains limited. (APA, 2022d).

2.8.2 Access to justice, pg. 97 (Police involvement)

Recommendation: Propose research and program development for police functions that may be more effectively carried out by community policing practices or collaborative problem-solving with community members. In the absence of accessible and appropriate mental health services, treatment programs, and community-based supports, police are too often called upon to intervene in behavioral health and nonviolent interpersonal crises (Steadman & Morrissette, 2016), and where such encounters may escalate to a point where police believe that use of force is warranted (APA, 2022e). We recommend including language in the draft guidelines to support research and program development for police functions that may be more effectively carried out by others, as well as community policing practices such as community engagement or collaborative problem-solving that involves community members (APA, 2022e). Ensuring accountability of the police through legislation is warranted. The use of community-led and trauma-informed initiatives can inform the revision of policing practices, help eradicate violent deaths, and attain justice.

2.8.2 Access to justice, pg. 101 (Training for the administration of justice)

Recommendation: Include police de-escalation training and strategies in the suggested practices. The draft guidelines suggest that justice officials, including police, participate in human rights-based training. Specifically, we also recommend including a recommendation to support trauma-informed training that engages de-escalation strategies when interacting with individuals with intellectual and developmental

disabilities, mental health disorders, substance use disorders, and in communities that have been historically traumatized by interaction with law enforcement. APA also generally supports research and subsequent program development in collaboration with police and communities to promote equity in the administration of justice (APA, 2022e).

3.1 Actively involving persons with mental health conditions and psychosocial disabilities, pg. 103

Recommendation: Specify the need for supportive and accessible spaces to ensure full participation of people with disabilities in the development of legislative policies. The draft guidance provides recommendations for the active involvement of individuals with mental health conditions in the legislative process. One approach to dismantling the hierarchies and systems that have historically been oppressive for people with mental health conditions and psychosocial disabilities is to authentically engage those same people in the development of legislation that will impact their human rights. Centering the voices of those who are most impacted by systems of oppression can help legislators gain a more critical perspective and lead to development of more effective legislation (Eaton et al., 2021; Neville et al., 2021). Through inclusive and affirming practices and legislation, the narratives of oppressive groups revise disjointed histories that reinforce power and privilege.

In the legislative process, a safe and supportive space is fully accessible for all persons with mental health conditions and psychosocial disabilities. The use of services, supports, and environments that are least restrictive, most integrating, and most effective will allow people with mental and physical disabilities to fully participate in the legislative process (APA, 2008). Additionally, assuring appropriate communication reduces the risk of discrimination resulting from inadequate opportunities for people with disabilities to be involved in their care (APA, 2022a). Appropriate communication refers to the preferred mode of communication, including the use of assistive technology, by the individual with a disability.

Thank you for the opportunity to express support and offer suggestions for these important guidelines. If APA can provide any further assistance, please feel welcome to contact Kelley Haynes-Mendez at khaynes-mendez@apa.org or Gabriel Twose at gtwose@apa.org.

Sincerely,

Maysa Akbar, PhD
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Chief of Psychology in the Public Interest (Interim)
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