YS FairGaze MUN 3.0

WHO

STUDY GUIDE

—

Inclusive Mental Health Policies for Individuals with Physical Disabilities and Chronic Illnesses like COPD, Alzheimer's Disease, etc

Letter from the Executive Board

Dear Delegates

At the outset on behalf of the Executive Board, we warmly welcome all of you and congratulate you on being a part of the World Health Organization simulation at YS FairGaze MUN 3.0. We hope that as soon as you log into the committee session, you learn something new and that hopefully by the end of the conference you have grown in one way or another; whether it's your ability to overcome your fear of public speaking or your ability to lead a large group of people. If this is your first Model United Nations Conference, then don't worry too much and feel free to approach any of us at any point in the conference if you need any form of support.

MUN conferences do not end when the committee session is over, every conference broadens your mind and urges you to think differently and analytically. This document should not by any means bind your research to its limits. We encourage you to research as much as you want and try to understand the problem and relevant issues as best as you can. What we desire from the delegates is not how experienced or articulate they are. Rather, we want to see how they can respect disparities and differences of opinion, work around these, while extending their own foreign policy. Further, we seek an out-of-the-box solution from you, while knowing and understanding your impending practical and ideological limitations and thereby reaching an acceptable practical solution. We wish you all the best in your preparations and look forward to seeing you all.

BACKGROUND GUIDE

WORLD HEALTH ORGANISATION

Agenda: Inclusive Mental Health Policies for Individuals with Physical Disabilities and Chronic Illnesses like COPD, Alzheimer's Disease, etc

Some Tips on How to Research

The background guide merely serves as a starting point for a delegate's research. It introduces the topics of debate and highlights the issues residing within the status quo that should be addressed within the committee session. By first beginning with reading the background guide, delegates get a sense of what issues they should be looking to address collectively and conduct the appropriate research to understand these issues within the context of the countries they represent and how the precedent set by their countries can be applied to the global solution.

To prepare for this committee, begin by reading through resources that provide a clear understanding of your country's social, economic, and political stances, which serve as the foundation for its foreign policy. Understanding the foreign policy of your country will be useful in addressing the topics of debate in this committee and will act as the compass for determining your position in the committee.

After reading the background guide and conducting elementary research, you have hopefully gained a general sense of the global issue and your country's perspectives on it. The next step is determining how the issues translate to your country's national and local levels. Learn about what the issues pertaining to the debate at hand look like within your respective country, as a country's social, political, economic, and even religious positions can affect how the issues reveal themselves within the population. Then, assess the advantages and disadvantages of the current solutions derived by the state to address the issues. Thoroughly researching the current solutions to find out what works and what does not reveal the areas for potential improvement within the country's current policy infrastructure.

Finally, based on the current solutions, create some solutions of your own that could potentially address the gaps within your respective country's policies and be beneficial if applied on a greater scale in the committee through a working paper or resolution in the committee. These ideas do not need to be technically flawless or even close to perfect, but they should be realistic solutions that reflect a genuine understanding of your country's position on the topics in this committee. Understand that these are difficult issues to tackle, as there are many nuances to addressing such crucial issues requiring global cooperation as well as critical changes to the existing policies, infrastructure and systems, so bring forth any potential solutions you may have.

EVIDENCE IN THE COMMITTEE

While researching for the committee, keep in mind the credibility of the source you are using. You can use all the sources for gaining information and studying different angles/ viewpoints, but non-credible sources won't be accepted by the Executive Board as proof and supporting documents to your argument/ statement. Evidence/proof is acceptable from the following sources:

1. **NEWS SOURCES:**

- **Reuters**- Any Reuters article which makes mention of the fact or is in contradiction of the fact being stated by a delegate in the council. (http://www.reuters.com/)
- **State-Operated News Agencies-** These reports can be used in support of or against the state that owns that news agency. These reports, if credible or substantial enough, can be used in support of or against any country as such but in that situation, they can be denied by any other country in the council. Some examples are:

i. RIA Novosti (Russia) http://en.rian.ru/
ii. IRNA (Iran) http://www.irna.ir/ENIndex.htm
iii. Xinhua News Agency and CCTV (P.R. China) http://cctvnews.cntv

2. **GOVERNMENT REPORTS:**

These reports can be used in a similar way as the state-operated news agencies' reports can, in all circumstances, be denied by another country. However, a nuance is that a report that is being denied by a certain country can still be accepted by the Executive Board as credible information. Some examples are -

i. Government Websites like the State Department of the USA (http://www.state.gov/index.htm) or the Ministry of Defense of the Russian Federation (http://www.eng.mil.ru/en/index.htm)
ii. Ministry of Foreign Affairs of various nations like India (http://www.mea.gov.in/), PRC (http://fmprc.gov.cn/eng/), France (http://www.diplomatie.gouv.fr/en/), Russian Federation (http://www.mid.ru/brp_4.nsf/main_eng)
iii. Permanent Representative to the United Nations Reports (http://www.un.org/en/members/)
iv. Multilateral Organizations like NATO (http://www.nato.int/cps/en/natolive/index.htm), ASEAN (http://www.aseansec.org/), OPEC (http://www.opec.org/opec_web/en/), etc.

3. **UN REPORTS:**

All UN Reports are considered credible information or evidence.
i. **UN Bodies:** Like the SC (http://www.un.org/Docs/sc/), GA (http://www.un.org/en/ga/), HRC (http://www.ohchr.org/EN/HRBodies/HRC/Pages/HRCIndex.aspx), etc.
ii. **UN Affiliated Bodies** like the International Atomic Energy Agency (http://www.iaea.org/), World Bank (http://www.worldbank.org/), International Monetary Fund (http://www.imf.org/external/index.htm), International Committee of the Red Cross (http://www.icrc.org/eng.index.jsp), etc.
iii. **Treaty Based Bodies** like the Antarctic Treaty System (http://www.ats.aq/e/ats.htm), The International Criminal Court (http://www.icc-cpi.int/Menus/ICC)

Under no circumstances will sources like Wikipedia, Amnesty International, or Newspapers like The Guardian, Time of India etc. be accepted as PROOF but may be used for better understanding of any issue and even be brought up in debate if the information given in such sources is in line with the beliefs of a Government.

About the committee

Founded in 1948, the World Health Organization (WHO) is a United Nations agency that fosters international collaboration among nations, partners, and individuals to promote health, safeguard global well-being, and provide support to vulnerable populations. Its mission is to ensure that everyone, regardless of their location, has the opportunity to attain the highest level of health.
In the contemporary era, health has become a shared responsibility, encompassing equal access to essential services and collective defence against transnational threats.

WHO operates in an increasingly intricate and rapidly evolving environment. The boundaries of public health interventions are often ambiguous and extend to other sectors that influence health outcomes. To address these challenges, WHO has developed six agendas, each comprising six points that relate to two health objectives, two strategic priorities, and two operational approaches. The organization's overall performance is evaluated based on the impact of its initiatives on health outcomes.

1. **Promoting Development-**

This objective aims to address health disparities, particularly among disadvantaged and vulnerable populations. The World Health Organization (WHO) underscores the significance of health as a catalyst for economic and social development and endeavours to attain health-related objectives, including universal health coverage (UHC) and the Sustainable Development Goals (SDGs). These efforts encompass addressing neglected tropical diseases, enhancing maternal and child health, and mitigating poverty-related health disparities.

2. **Health Promotion-**

The World Health Organization (WHO) is responsible for safeguarding global populations from acute health risks, including pandemics, disease outbreaks, and other emergencies. This mandate encompasses the fortification of global defences against infectious diseases through initiatives such as the International Health Regulations (IHR). The IHR facilitates the detection, prevention, and response to public health threats by enabling countries to collaborate effectively. Additionally, WHO coordinates international responses to crises like COVID-19 and Ebola.
Since the implementation of the revised International Health Regulations in June 2007, the world's capacity for collective response to outbreaks has been significantly enhanced.

3. **Strengthen the health system-**

This section emphasizes the construction of vigorous national health systems that are accessible, equitable, and efficient. The World Health Organization (WHO) assists countries in enhancing their infrastructure, providing training to healthcare professionals, ensuring sustainable financing, and improving access to essential medications and services. A significant emphasis is placed on primary healthcare as the cornerstone of resilient health systems, as health services must be accessible to impoverished and underserved populations.

4. **Investigation, use of information and evidence-**

WHO promotes evidence-based decision-making by collecting and analyzing global health data. This includes setting standards for research, monitoring trends in public health, and guiding policies with scientific evidence. The organization also fosters innovation in medical technologies and public health interventions to address emerging challenges.

5. **Expansion of Partnership-**

WHO collaborates with governments, other United Nations agencies, non-governmental organizations (NGOs), private sector entities, and civil society to align efforts towards shared health objectives. These partnerships facilitate resource mobilization, knowledge exchange, and coordinated action in addressing global health challenges.

6. **Improved Performance-**

WHO consistently strives to enhance its operational efficiency and effectiveness. This entails implementing internal process reforms, adopting results-based management practices, and fostering accountability at all organizational levels. By enhancing its performance, WHO ensures that it can effectively serve its member states and respond to global health challenges.

The World Health Organization's (WHO) Triple Billion targets are closely aligned with its strategic frameworks, particularly the Fourteenth General Programme of Work (GPW 14). These targets aim to achieve 1 billion more individuals benefiting from universal health coverage, 1 billion more individuals better protected from health emergencies, and 1 billion more individuals enjoying improved health and well-being. GPW 14, spanning the period 2025–2028, builds upon the progress and lessons learned from GPW 13 while addressing emerging global challenges such as climate change, demographic shifts, and geopolitical changes. It reinforces the Triple Billion targets by promoting transformative action in areas such as climate change and health, ensuring equity in essential health services, reversing catastrophic health spending trends, and enhancing preparedness for health risks. GPW 14 introduces a theory of change to align WHO's work with broader global health efforts, focusing on measurable impacts and strengthening regional and national capacities to drive progress toward achieving these ambitious goals

Historical context of mental health services for people with disabilities

For much of history, mental health care was provided mainly in psychiatric institutions. WHO notes that *"for centuries, psychiatric hospitals have been the primary model"* for mental health services. These institutions often housed people with mental illnesses or developmental disabilities together, and reports documented abuse and neglect. Beginning in the mid-20th century, countries began moving toward community-based care. The UN Convention on the Rights of Persons with Disabilities (2006) enshrined this change, affirming that people with psychosocial disabilities have the right to live in the community with dignity. This marked a major shift from "asylum" care to user-centered, rights-based support outside of institutions.

Current global status of mental health policies for individuals with physical disabilities

Globally, about 1.3 billion people (16% of the population) live with significant disabilities . WHO reports that persons with disabilities suffer stark health inequities: they often die roughly 20 years earlier than others and have about double the risk of conditions like depression, diabetes, asthma, stroke, etc. . The UN Convention on the Rights of Persons with Disabilities and WHO emphasize that disabled people must have "equitable access to effective health services" . In practice, however, implementation varies widely across countries. Some nations have passed comprehensive disability laws and inclusive health policies, while many poorer countries still lack basic rehabilitation services or face major barriers in delivering care.

- **Global facts (WHO):** An estimated 1.3 billion people have significant disabilities . These individuals on average die about 20 years earlier than non-disabled people , and they face roughly double the risk of major health conditions (depression, obesity, diabetes, etc.) . WHO also notes that disabled people find transportation and facilities much more inaccessible (e.g. 15× more limited by transport) .

- **Laws & policies**: Today most countries have some disability civil-rights law: indeed, 181 countries have enacted laws modeled on strong statutes like the US Americans with Disabilities Act . Nearly all UN member states have ratified the UN Disability Rights Convention, obliging accessible health care. WHO explicitly calls for persons with disabilities to have "equitable access to effective health services" , and disability inclusion is a stated goal of the Sustainable Development Agenda.

- **Healthcare barriers**: Despite laws, disabled people often face multiple obstacles in the health system. They are more likely to skip or delay care because of cost, inaccessible clinics or transport, and other hurdles . Studies document pervasive environmental and attitudinal barriers – for example, many clinics lack ramps or adjustable exam tables, and some providers lack training or hold discriminatory attitudes . In a UK survey, disabled adults reported worse access to care than others, citing transportation problems, costs, and long wait times as the main barriers . Similarly, US research finds that decades after the ADA, Americans with disabilities still experience significant healthcare disparities .

- **Rehabilitation gap**: Rehabilitation is an essential part of healthcare, but it is often lacking. WHO estimates ~2.4 billion people worldwide could benefit from rehabilitation services , yet in many low- and middle-income countries over 50% of those in need do not receive any rehab . In other words, basic rehabilitation programs and assistive services remain extremely scarce in many poorer health systems.

Statistical overview: prevalence of mental health conditions among people with disabilities

Studies worldwide show people with disabilities report mental health problems much more often than others. For example, in the U.S., nearly one-third of adults with disabilities (32.9%) had frequent mental distress (14 or more mentally unhealthy days in a month), compared to only 7.1% of adults without disabilities. In other words, adults with disabilities reported poor mental health almost five times as often as those without. This pattern holds globally: having a disability (especially chronic or visible) greatly increases the risk of anxiety, depression and other disorders. Experts note that stigma, social isolation, and the stress of managing impairments all contribute to these higher rates.

The relationship between chronic illnesses and mental health disorders

Chronic physical illnesses and mental health disorders commonly occur together. People with long-term conditions like diabetes, heart disease or cancer are at higher risk of depression or anxiety. This is due to the stress of illness, medication effects, and biological factors. Conversely, depression itself raises the risk of chronic diseases: for instance, depressed individuals have higher rates of heart disease, diabetes, stroke and other conditions. In sum, physical and mental health affect each other. Someone with a chronic illness may develop depression because of ongoing pain or disability, while depression can worsen physical health by reducing self-care.

Challenges in accessing mental health services for people with disabilities

People with disabilities often face multiple barriers to care. A study found that although disabled people have more mental health needs, they report *"higher unmet mental health service needs"* than others. Barriers include lack of provider knowledge about disability, negative attitudes (ableism), and stereotyping. For example, therapists may assume a person's mood is "just because of" their disability and overlook treatable issues. Physical barriers (inaccessible buildings or transport) and communication barriers (lack of sign language interpreters) also block access. Those with intersecting identities – such as a disabled person who is also a racial or sexual minority – can face extra stigma and find it even harder to get respectful care.

WHO's 2022 World Mental Health Report ("Transforming mental health for all") assembled global evidence and found stark coverage gaps and inequities . Key findings include:

- Massive treatment gaps: Only a fraction of people in need access care. For example, ~71% of those with psychosis receive no services worldwide, and even in rich countries only ~30% of people with depression get minimally adequate care .

- Institutional funding bias: Around two-thirds of government mental health budgets often go to psychiatric hospitals instead of community-based care, despite evidence that integrated community services yield better outcomes .

- Widespread stigma and rights violations: Stigma, discrimination and even legal penalties (in some countries) against people with mental health conditions remain common, particularly affecting the poorest and most marginalized .

Recent WHO initiatives and guidance on mental health policy transformation

In recent years WHO has issued several major publications urging countries to overhaul their mental health systems. Its 2022 World Mental Health Report and a new 2025 policy guidance emphasize that mental health remains critically underfunded with vast gaps in access and quality of care. WHO stresses that old hospital-centric models must give way to community-based, rights-focused networks. These documents call for integrating mental and physical health, addressing social drivers (like housing and employment), and fully involving people with lived experience in policy design .

On 25 March 2025, WHO launched new guidance to help countries reform and strengthen mental health policies . This blueprint provides a clear framework with practical actions focused on:

- Protecting human rights: Ensure all mental health laws and services align with international human rights standards .

- Holistic, integrated care: Promote lifestyle, physical health, psychological, social and economic support together with mental health treatment .

- Addressing social determinants: Tackle factors like unemployment, poverty, housing and education that affect mental well-being .

- Prevention and promotion: Implement population-wide strategies to prevent disorders and promote psychosocial well-being .

- Lived experience participation: Empower people with mental health conditions to co-design policies and services, ensuring they meet real needs .

This guidance explicitly advocates community-based, person-centered care rather than old institutional models. It identifies five "policy areas requiring urgent reform" (leadership/governance,

service organization, workforce, person-centered interventions, and social/structural determinants) and provides a menu of strategies for each . For example, WHO calls for “comprehensive, community-based, rights-based, person-centered and recovery-oriented services” and “deinstitutionalization” of mental health care .

WHO also published detailed guidance modules (March 2025) on developing and evaluating policies. One module notes that “momentum is growing globally for rights-based, person-centered, and recovery-oriented mental health policies” . It outlines frameworks to integrate mental health into Universal Health Coverage and cross-sector programs (education, employment, housing) . It emphasizes the “crucial role of people with lived experience in shaping inclusive, responsive systems” and advocates cross-sector collaboration to deliver holistic interventions while promoting well-being and prevention .

Gaps in access and quality of care

Large gaps remain in who receives care. Even where services exist, far fewer people get treatment than need it. For instance, less than 50% of people with major depression and only about 29% of those with psychosis worldwide receive any care. WHO points out that while treatments for mental illness are effective, *“most people living with mental health conditions do not have access to these”*. Quality also varies: some care is delivered by untrained workers or with outdated methods. In short, there are shortages of professionals, medicines and follow-up support, so many who do seek help get only partial or inconsistent care.

Many existing mental health systems rely on old-style institutions. WHO notes that even now a large share of mental health funds goes to psychiatric hospitals. In middle-income countries, over 70% of the mental health budget is spent on hospitals, compared to only about 35% in high-income countries. The new WHO guidance criticizes this pattern: *“many existing services rely on outdated institutional models that fail to meet international human rights standards.”*. Clinging to hospital-based care often means locking people away rather than helping them live in the community. Experts say a shift (deinstitutionalization) is needed so that funding and staff support people at home or in community clinics instead.

Human rights concerns in existing mental health systems

There are serious human rights issues in many mental health systems. Historically, and even today in some places, people with disabilities have been subject to unlawful confinement and forced treatments. A UN statement highlighted that individuals with psychosocial disabilities can face *“arbitrary or unlawful deprivation of liberty, disability-based institutionalization and other coercive and harmful practices”*. WHO similarly reports that such abuses in institutions have been “extensively documented”. International law (CRPD and UN resolutions) now rejects these practices. The focus is now on voluntary, person-centered care that respects autonomy and dignity. A human rights-based approach means ending abusive restraint and ensuring legal protections and consent in all mental health care.

Individuals with disabilities often experience social isolation and stigma that worsen mental health. WHO explains that health inequities for disabled people are driven by "stigma, discrimination, … and exclusion". Living with disability can involve facing pity, negative stereotypes, or barriers that keep people out of work and community life. This isolation can lead to loneliness, low self-esteem, and stress – all risk factors for depression and anxiety. Combating stigma (through public education and inclusive policies) is a key challenge in improving mental health for people with disabilities.

People with disabilities may face *multiple layers* of discrimination. For example, someone who is disabled and also a racial or LGBTQ+ minority can encounter bias on several fronts. Research shows that individuals with disabilities, plus other minority identities often struggle even more to get appropriate care. The Yale study found that people in this situation didn't know which part of their identity was affecting the provider's attitude. Such intersecting discrimination can intensify stress and lead to poorer outcomes. Addressing these issues means paying attention to how disability intersects with gender, race, ethnicity, and other factors in mental health policy and training.

WHO Comprehensive Mental Health Action Plan and Policies

In May 2013, WHO's member countries adopted a global Mental Health Action Plan, later extended to 2030. This plan sets clear objectives: to strengthen leadership and governance, provide integrated community-based care, promote and prevent mental disorders, and improve data and research. It also lays out milestones (the Mental Health Atlas) for countries to track progress. The goal is universal coverage: by 2030, everyone should have access to quality mental health and social support. Countries are encouraged to follow the plan's recommendations and report their advances (or gaps) to WHO regularly.

In December 2020 WHO launched a new Policy on Disability and an Action Plan for implementation. This policy commits WHO and its partners to make health systems inclusive of people with disabilities. It emphasizes removing barriers so that persons with disabilities receive the same quality of care as others. Key points include ensuring accessible facilities, training providers in disability issues, and promoting community-based rehabilitation. This policy aligns WHO's work with the UN Disability Strategy and calls on all countries to integrate disability inclusion into health planning.

The UN Disability Inclusion Strategy, adopted by the UN system in 2019, commits all UN agencies to *"leave no one behind"* regarding disability. Under UNDIS, every UN entity must ensure its programs and policies include persons with disabilities. This means that UN development, relief and advocacy work – including health and mental health projects – must involve disabled persons organizations and consider accessibility. The strategy is grounded in human rights (CRPD) and sustainable development. It has an accountability framework so agencies report on how they are including disability at headquarters, in the field, and in partnerships

Relevant UN resolutions on mental health and disability rights

Several UN resolutions have shaped this field. The Convention on the Rights of Persons with Disabilities (CRPD, 2006) explicitly recognizes the rights of people with psychosocial disabilities to live in the community and access health care. More recently, in 2023, the UN General Assembly

adopted its first resolution on mental health, stressing *"rights-based"* and community-focused approaches. A joint UN statement noted that the CRPD has "laid the foundation for a paradigm shift on mental health" away from coercive models. Other UN bodies (e.g. Human Rights Council) have passed resolutions endorsing human rights in psychiatry. Together, these resolutions push for abolishing involuntary institutionalization and ensuring mental health care respects autonomy and dignity.

Regional initiatives and best practices

There are important regional initiatives and models of good practice. In Italy's Trieste region, authorities closed the psychiatric hospital in the 1970s and built a city-wide network of community mental health centers. This user-centered model focuses on social inclusion and rehabilitation, and it has inspired reforms worldwide. Similarly, some African and Asian programs have trained lay counselors to provide talk therapy in villages (e.g. Zimbabwe's Friendship Bench). In Europe, the EU has mental health action plans encouraging member states to share best practices. Such examples show that community-based, personalized care can work effectively and can be adapted to different setting.

Member states with progressive mental health policies

Some countries have taken leading roles. High-income countries often have strong laws and services: for example, much of Western Europe, North America and Australia have well-developed disability rights legislation and community mental health systems. Italy (Trieste model) and New Zealand are examples of rights-focused reform. In Asia, countries like Japan and South Korea have expanded community services. Even among low- and middle-income countries, a few (such as Costa Rica, Ghana, or Chile) have made notable strides in integrating disability into health policy. However, there are still large variations: WHO data show that high-income nations have **over 40 times** more mental health workers per capita than low-income countries. This gap underscores how resource availability varies between member states.

Member states with significant challenges

Many countries face major hurdles. In parts of Africa, South Asia, and other regions, mental health policies are underdeveloped or unenforced. Some of these countries have fewer than one psychiatrist per 100,000 people and virtually no community-based services. They may still rely on old asylums and have little disability infrastructure. Other challenges include political instability or competing health crises that push mental health down the priority list. These states often miss WHO targets (for example, few meet the goals for mental health policy implementation). Addressing these gaps requires international support, funding, and technical guidance.

Different countries show the range of efforts and gaps in disability-inclusive health:

- USA/UK: Both have strong civil-rights laws (the US ADA of 1990 and the UK Equality Act 2010) that require accessible healthcare. However, in practice gaps remain. Studies show Americans with disabilities continue to face major health disparities despite the ADA . In the UK, a cross-sectional study found disabled men and women report significantly worse

healthcare access than others, with transport issues, cost and long waits being main obstacles .

- Mozambique: Mozambique's constitution explicitly guarantees universal healthcare for persons with disabilities. It has a National Disability Action Plan and a Disability Rights Law, and WHO reviews praise its strong policy framework. A WHO/World Bank assessment noted Mozambique had a relatively high number of rehabilitation professionals and committed programs to serve people with disabilities .

- Malaysia: Since 1996 Malaysia has had successive disability-health action plans. The first national "Health Care of Persons with Disabilities" plan was published in 1996, and a second Plan of Action (2011–2020) further expanded services and rehabilitation programs . Malaysia continues to advance its efforts: it is now collaborating with WHO on a new 2024–2030 National Plan of Action for Inclusive Health Care, aiming to fully integrate disability inclusion into its health system .

- India: The Rights of Persons with Disabilities Act of 2016 is among the most progressive laws, requiring barrier-free access in all parts of every public and private hospital . It also mandates priority and free treatment (subject to income) for eligible disabled people . In principle this guarantees equal care, but many Indian health facilities (especially in rural areas) still lack ramps, accessible toilets, and other accommodations, so implementation is uneven.

- Other LMICs: In many low- and middle-income countries, inclusive healthcare is still at a very early stage. For example, Chile – despite recent disability laws – currently has no national policy specifically on inclusive health (it relies on a decree that gives disabled people priority scheduling in primary care) . WHO emphasizes that across poorer regions the majority of disabled persons are underserved by health systems: too few programs, lack of trained staff, and minimal rehab services mean basic health needs often go unmet .

Relevant UN agencies and programs and other advocacy groups

Multiple UN agencies work on disability and mental health. WHO (World Health Organization) is the lead UN agency for mental health and disability. It develops global strategies, standards, and technical support (like QualityRights and the Mental Health Atlas). Other UN programs address related issues: UNICEF works on child and adolescent mental health and disabilities; UN Women highlights the mental health of women and girls with disabilities; UNHCR focuses on refugees' mental well-being; the World Bank includes mental health in its health sector projects; ILO (International Labour Organization) covers disability and employment. WHO also co-chaired a UN COVID-19 disability working group involving OHCHR, ITU, UN Women, and disability NGOs to ensure an inclusive pandemic response. These partnerships show the broad UN commitment to rights-based, inclusive health (including mental health) for persons with disabilities.

Non-governmental organizations and advocacy groups are key voices. International NGOs like Humanity & Inclusion (formerly Handicap International) and development consortia like the International Disability and Development Consortium (IDDC) promote disability-inclusive practices. Mental health advocacy groups – such as Mental Health Europe, the World Federation for Mental Health, or national groups like NAMI (USA) work on stigma reduction and patient support. These civil society groups often work with governments or UN agencies to develop guidelines, run awareness campaigns, and hold authorities accountable. For example, WHO's collaborations list shows broad participation of such groups in advising on policies.

Disabled Persons' Organizations (DPOs) as Key Disability Rights Advocates

Over one billion people worldwide live with disabilities (≈15% of the global population) . These communities often organize themselves into Disabled Persons' Organizations (DPOs) – advocacy groups and service networks led by persons with lived disability experience. Internationally, DPOs unite under bodies like the International Disability Alliance (IDA) and its regional members (e.g. the European Disability Forum, African Disability Forum). IDA's mission is to advance full implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD) "through the active and coordinated involvement of representative organizations of persons with disabilities at the national, regional, and international levels." . Notably, the CRPD negotiation itself was unprecedented in including persons with disabilities as core participants – "the first human rights treaty negotiation to benefit from the participation of … persons with disabilities" . DPO leaders thus helped shape the Convention, and today these networks (IDA, EDF, ADF, etc.) continue to press governments and UN bodies to respect CRPD standards. IDA actively supports national and regional DPOs by providing training, resources, and strategic guidance so they can engage UN human rights processes (treaty bodies, UPR, Human Rights Council) and hold governments accountable .

National and Local DPO Engagement

At the country level, national or local DPOs (for example, councils of disabled people, autism or mental health consumer associations, independent living centers, etc.) serve as intermediary bodies between policymakers and people with disabilities. They advise on laws and policies, run awareness campaigns, monitor service delivery, and sometimes even provide community-based services. Strengthening these "representative organisations" is seen as key to realizing disability rights: by channeling lived experience to decision-makers, DPOs help ensure that persons with disabilities enjoy their human rights "on an equal basis with others" . Under Article 4(3) of the CRPD, States are obliged to consult DPOs in policy-making. In practice, many countries include DPO representatives in disability councils, task forces or independent monitoring bodies. UN reviewers regularly recommend that governments guarantee the "full participation of persons with disabilities through their representative organizations" in monitoring and implementation of the Convention . In sum, DPOs at all levels advise legislators and administrators on accessible education, employment, social protection and other policies, ensuring disabled people's perspectives drive change .

- Global networks: IDA (with 14 global/regional members) and allied bodies (e.g. EDF, ADF) coordinate international advocacy, represent over a billion people with disabilities, and

engage at UN forums .

- CRPD monitoring: These networks helped negotiate the CRPD and now work through the annual Conference of States Parties (COSP) and CRPD Committee to review national implementation. The CRPD's monitoring provisions (Art. 33) explicitly call for DPO involvement; UN experts repeatedly urge states to empower DPOs in these bodies .

- Local councils and OPDs: At national levels, umbrella DPOs (e.g. national disability councils, autism societies, organizations of persons with psychosocial disabilities) routinely consult on legislation. They may serve on advisory boards or run grass-roots monitoring of rights (e.g. CRPD shadow reports). CBM Global notes that OPDs "play an important role as intermediary bodies between policymakers and persons with disabilities," helping translate rights into practice .

- Advocacy and education: DPOs educate lawmakers and public servants about disability issues. They lobby for reforms (e.g. updating mental health laws to respect consent and legal capacity), often forming coalitions with human rights NGOs. These groups also raise awareness to combat stigma and discrimination.

Focus on Inclusive Services and Rights

A core DPO priority is ensuring accessible, inclusive services and communities. For example, CRPD Article 25 recognizes the right of persons with disabilities to the "highest attainable standard of health," and Article 19 affirms the right to live independently and be included in the community. DPOs have pushed for these rights to be realized. They campaign for accessible healthcare facilities and equipment, inclusive medical and rehabilitative services, and disability-sensitive community support. As CBM Global explains, "access to health and community-based services is critical for people with disabilities and is required by the Convention on the Rights of Persons with Disabilities" . In practice, disability advocates work with health ministries to remove barriers (e.g. sign language interpreters, wheelchair ramps, antistigma training for providers) and to integrate disability into public health planning.

- Health care: DPOs lobby for non-discriminatory health policies, equal insurance coverage, and disability accommodations in clinics and hospitals. Many also campaign for universal design in public health campaigns (e.g. Braille or audio for medical information).

- Community inclusion: DPO networks promote inclusive education, employment programs, and transportation access so persons with disabilities can fully participate. They may run or advise on community living programs and personal assistance services, reducing reliance on institutional care.

- Human rights monitoring: By linking legal expertise and lived experience, DPOs help document abuses (e.g. involuntary psychiatric detention, denial of assistive devices) and bring cases to human rights bodies. They advocate for laws to prohibit forced institutionalization and ensure legal capacity (in line with CRPD Art. 12).

Shaping Mental Health Services and Laws

Disability rights activists have increasingly emphasized mental health and psychosocial disabilities. Organizations led by users/survivors of psychiatric services (often framed as OPDs) insist that mental health systems respect human rights and personal autonomy. In CBM's mental health plan, for instance, "Priority 1" is a strong voice of people with psychosocial disabilities; other priorities include community inclusion and equitable access to care . In practical terms, DPO advocates support community-based psychosocial support (instead of institutionalization), peer support networks, and anti-stigma campaigns. They also push for revision of mental health laws to eliminate coercive treatments and recognize legal capacity (echoing CRPD standards). By organizing conferences, submitting policy briefs, and engaging media, DPO-led mental health groups are ensuring that the voices of people with lived mental health experience shape services and legislation .

In summary, Disabled Persons' Organizations – from international alliances to local grassroots groups – are essential stakeholders in disability and mental health policy. Through advocacy, consultation, monitoring and direct action, they promote accessible healthcare, community inclusion, and the full human rights of persons with disabilities. Their participation is enshrined in the CRPD and continues to influence laws and services worldwide. Each DPO in effect ensures that people with disabilities ("nothing about us without us") have the opportunity to shape the systems that affect their health and well-being .

Case Study: India Is Us & Viklang Sahara Samiti – A Grassroots Model for Inclusive Mental Health Support for Persons with Disabilities and Chronic Illnesses

Overview:

This case highlights the impactful work in disability rights, community development, training, and social inclusion. Through the collaborative efforts of India Is Us and Viklang Sahara Samiti, significant strides have been made in transforming grassroots challenges into structured support systems for individuals with physical disabilities—particularly children with special needs and locomotor impairments.

Organizational Snapshot:

Organizations: India Is Us, Viklang Sahara Samiti

Mission: To empower and rehabilitate individuals with multiple disabilities through inclusive development initiatives, community engagement, and access to essential services.

Alignment with WHO Agenda:

Focus Area: Inclusive Mental Health Policies for Individuals with Physical Disabilities and Chronic Illnesses such as COPD, Alzheimer's Disease, etc.

Key Contributions in Line with WHO's Framework:

1. Mental Health & Social Inclusion

The organizations address emotional distress, isolation, and stigma by fostering peer support groups, encouraging community participation, and promoting inclusion at all levels.

2. Support for Chronic Illnesses

While primarily focused on physical and developmental disabilities, the model is adaptable for chronic conditions such as COPD and Alzheimer's, thus aligning with WHO's vision for integrated, inclusive care.

3. Bridging Policy and Practice

By working closely with NGOs, government agencies, and development consultants, the initiatives translate policy into real-world outcomes, ensuring accessibility, equity, and sustainability.

4. Capacity Building & Training
Regular training of caregivers, community volunteers, and stakeholders builds a network of informed supporters, ensuring consistent mental and emotional care delivery at the grassroots level.

5. Focus on Vulnerable Populations
A major focus is placed on underprivileged children with special needs—an often overlooked demographic—highlighting the organizations' commitment to equity and inclusive development.

Conclusion:
India Is Us and Viklang Sahara Samiti represent a compelling model of how grassroots leadership, when combined with community-based programming, can drive inclusive mental health reforms. Their work not only supports individuals with physical disabilities but also provides a scalable and replicable framework for addressing chronic illnesses within marginalized populations—reinforcing WHO's global agenda for inclusive mental health policies.