When mental health becomes disabling: supporting the human rights workforce

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Abstract: Amidst environments burning with hostility, violence, harassment, criminalisation, and political repression, the human rights workforce operates at front and rear under pressure. Coupled with experiences of injustice, urgency and institutional pressure, their psychological well-being is often threatened, at times to a disabling degree.
As July marks disability awareness month, it equally marks a juncture to reflect on the intersection between mental health and disability, and to advocate for better recognition, legal protections, and access to care for all, including human rights professionals. Beyond July, it behoves—more than ever—to assess the effectiveness of existing human rights frameworks in responding to these complexities, especially in the lives of those defending human rights themselves.

When does mental health become a disability?
Recognising mental conditions as disabilities hinges on the surrounding legal, medical and social context in which they are inscribed, echoing the continuing debates on terminology and conceptual frameworks. With discussions unfolding in time, the disability community, the WHO, and international human rights actors gradually adopted the social model; prioritising 'psychosocial disability' over 'mental disability'.

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Accordingly, international frameworks, such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD), recognise disabilities as the result of impairments interacting with societal barriers; conversely, national policies vary considerably in their recognition and protection of these conditions.
An inclusive and encompassing framework is fundamental in understanding the complexity of mental health issues; it acknowledges that individuals may experience disability due to discrimination, exclusion, or fluctuating symptoms, rather than solely as a consequence of a formal diagnosis. However, many affected by mental health disorders—such as severe depression, anxiety, PTSD, or even schizophrenia—face obstacles in accessing support, necessary accommodations, and protection from discrimination. Their symptoms, often not visible, hinder recognition, while adequate care largely depends on the availability of medical professionals to establish a long-term therapeutic relationship—an essential component in the treatment of chronic illnesses. As a result, these conditions are frequently excluded from legal protections afforded to individuals with disabilities. Their inherent invisibility also lead to doubt, disbelief, and prejudice, rendering legal assistance crucial for individuals seeking to uphold their rights and ensure fair treatment.
Amongst those most affected are human rights professionals, who may suffer long-term psychological stress, depression, burnout, or secondary trauma as a corollary of their employment, especially when working in repressive or high-risk environments. Yet, many remain excluded from disability protections or workplace accommodations due to the invisibility—sometimes intentional—or the episodic nature of their symptoms. Beyond, even those who have recovered from a mental disorder may continue to experience disability due to stigma, social exclusion, or the risk of relapse, while they may no longer qualify for support. Human rights workers often leave key positions in civil society organisations or legal institutions, not out of choice, but in spite of systems failing to provide the protections or care necessary for their well-being. Such departures affect individual lives but also jeopardise the continuity and resilience of the broader human rights movement itself.

Context matters: recognition across borders
These experiences, however, do not occur in a vacuum. Recognising and treating mental health conditions as disabilities varies according to the local context, between regions and cultures. In some countries, mental distress receives medical attention and is treated as a condition, while it may be regarded as temporary or non-disabling in others. Cultural beliefs condition health behaviours, service provision and the nature of legal protections. For instance, in some settings, stigma may prevent individuals from identifying as disabled and seeking support. In others, psychosocial disabilities may be legally recognised but not adequately supported in practice, or may be subject to policy changes depending on the shifting political climate. As such, even where legal

frameworks exist, their implementation may be inconsistent and contingent on the specific socio-political environment.

This fluctuating approach to disability policies was recently exemplified in the United Kingdom in March 2025, where a significant increase in mental illness was reported since the COVID-19 pandemic, yet was followed by a proposed bill to drastically reduce disability benefits. While emerging research highlighted the increase in disability benefit claims related to mental health conditions, sickness absence, and suicides; the UK government considered a multi-billion-pound reduction in financial support—disproportionately impacting people with psychosocial disabilities.

Changes in policy and public discourse not only affect people living with mental health conditions, but also the environments in which human rights professionals operate, undermining their ability to safeguard both the rights of others and their own psychological well-being. For instance, the term 'resilience', often praised as a strength, has increasingly been used by political and financial decision-makers to rationalise the reduction of support systems; thereby shifting the burden of endurance onto individuals rather than addressing harm-producing conditions. For human rights professionals, this narrative may intensify the pressure to endure trauma and burnout in silence, while structural protections and institutional accountability quietly recede.

Challenges in accessing mental health care and disability rights protections

Beyond the medical and legal recognition of psychosocial disabilities—whether in international or national frameworks—there remain barriers in receiving the appropriate care when seeking support. As reminded by the former Special Rapporteur on the right to health, the implementation of mental health services must consider systemic obstacles impeding their accessibility; covering availability, ease of access, acceptability and quality. For human rights defenders and professionals, these barriers are compounded by precarious working conditions, institutional silence around mental health, and fear of professional stigma.

Availability of services is too often compromised by a general lack of specialised care and community support—yet central in enabling care and supporting social inclusion. **In the human rights sector, this gap is particularly acute** as many organisations lack the funding or policies to offer support structures tailored to trauma-exposed environments. Horizontal—as opposed to vertical—integration is needed in mainstreaming services across health and social care systems for a rights-based and early support.

Ease of access to services, for its part, implies financial and geographical reach, particularly through primary care and community service delivery models to reach underserved populations. For human rights professionals, **access is often obstructed by geography—**especially in conflict-affected or remote settings**—but also by job precarity, lack of insurance, and** limited-service availability **within overstretched organisations**.

Acceptability requires tackling persistent misconceptions surrounding mental health care. For human rights professionals, self-stigma and the culture of sacrifice often hinder help-seeking—where admitting vulnerability is equated with weakness, and self-care is seen as selfish or unprofessional. Many professionals internalise the belief they must 'push through' trauma. Accordingly, mental health care must be context and culturally appropriate, gender-sensitive, non-coercive, and grounded in dignity, autonomy, and informed consent. These services must also acknowledge and challenge harmful internal narratives within the human rights community itself, while attending to the needs of other marginalised groups for whom traditional models often reproduce prejudice or exclusion.

Lastly, *qualitative care* ought to be evidence-based and person-centred. It requires training stakeholders—including peers, teachers, social workers and community actors—in human rights principles, while also eliminating coercive or over-medicalised practices. In the case of human rights workers, **building internal capacity and creating peer-informed, trauma-sensitive support systems** can enhance both individual well-being and organisational sustainability. Service users—professionals and communities alike—are to be recognised as active rights holders, whose lived experience and agency inform the design and delivery of support.

Overall, these systemic failures feed a cycle of marginalisation, furthering isolation from social and political participation, education, and the labour market. For those defending human rights, this often leads to burnout, attrition, and emotional exhaustion; thereby **weakening the very movements that rely on their resilience and engagement**.

Moving towards a rights-based approach

Promoting mental health cannot be reduced to preventing harm; they must empower individuals with psychosocial disabilities, including the human rights workforce, to access quality care, regain agency, and integrate positively. A rights-based mental health approach requires tackling the social and structural determinants of well-being through social investment and community-based services. In 2017, the former UN Special Rapporteur on the right to health, Dainius Pūras, had already called for pressing reform to promote an approach based on human rights, autonomy and social inclusion, whereby mental health is no longer considered as a clinical issue but is intrinsically linked to freedom, dignity, and full participation in society.

This reframing calls for coordinated efforts across sectors of education, employment, housing and justice, to deconstruct systemic barriers to participation. For example, workplaces—not least within civil society, advocacy organisations, and legal institutions—must become emotionally safe, non-discriminatory spaces that value psychosocial well-being. This means moving beyond cultures of self-sacrifice and 'resilience', creating space for open dialogue, and embedding self- and collective care

as core elements of organisational culture. As such, promoting psychosocial well-being means not only providing support services, but also implementing protections against discrimination, flexible arrangements, and cultures of openness where disclosure does not lead to exclusion nor compromises career and credibility.

Altogether, legal frameworks, health systems and social protection policies must reflect the lived experiences of people concerned and enable their realities to shape the design and delivery of support, recognising both the structural roots of distress and the resilience of those affected. Integrating mental health into a rights-based approach and the broader psychosocial disability rights movement stands central both in guaranteeing accessible care, but also in upholding the equal and effective enjoyment of all other human rights, as well as its very own workforce in doing so.