Master of Law: Advanced Studies in International Children's Rights

The Right to Mental Health of Unaccompanied Children: An Invisible Right?

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Executive Summary

As children outside their country of origin, deprived of their family environment and who went through a potentially fatal journey, unaccompanied Children ("UAC") are at an increased risk of developing mental health conditions, such as Post-Traumatic Stress Disorder ("PTSD") and depression. This thesis investigates the protection offered by the children's rights framework to UAC's mental health.

Chapter 2 explores the legal position of UAC before the United Nations Convention on the Rights of the Child ("CRC"). It highlights how UAC are not simply right-holders of the CRC but entitled to a right-plus framework, namely, to special protection and humanitarian assistance. Chapter 2 two also delve into the relevance and protection offered to UAC's mental health by Article 6, both with respect to the right to life and with respect to the right to development. It demonstrates how, already under Article 22 and Article 6, State Parties have an obligation to take measures that address UAC's mental health conditions.

Article 24 includes both an entitlement to health care and an entitlement to the underlying determinants of health (i.e., socio-economic and environmental conditions conducive of mental health). To that end, Chapter 3 and Chapter 4 respectively analyse their meaning applied to UAC's mental health. Chapter 3 briefly highlights how mental health falls within the meaning of health under Article 24. Next, after revising relevant General Comments ("GC"), it commends the CRC Committee for clearly recognizing that children in the humanitarian context have a right not only to physical care, but also to psychological and mental health services. However, an analysis of selected Concluding Observations ("CO") through the 3AQ model, reveals that the CRC Committee adopts a rather inconsistent approach in terms of recommending the provision of available, accessible, acceptable and quality mental health services to UAC.
Chapter 4 is devoted to children's entitlement to the underlying determinants of health. With reference to its jurisprudence, Chapter 4 notes that no guidance is offered by the CRC Committee on the meaning of the underlying determinants of mental health. As such, relying on findings in the field of psychology, Chapter 4 illustrates that access to basic needs and freedom from violence constitutes two important underlying determinants of UAC's mental health.

By relying on the jurisprudence of the Committee on Economic, Social and Cultural Rights ("CESCR") and CRC Committee, Chapter 5 investigates State Parties' obligations to respect, protect and fulfil UAC's right mental health. It also addresses the progressive and immediate nature of obligations incumbent on State Parties in an attempt to provide an answer to the main research question.
However, Chapter 5 ends with the open question of what it means that State Parties have a minimum core obligation to provide an adequate response to the underlying determinants of mental health, as established in its GC No.15.

Therefore, Chapter 6 delves into this question and identifies what international and European actors regard as the most essential elements of a mental health and psychosocial support (MHPSS) response in emergency setting. It argues that the identified essential elements should inform State Parties minimum core obligation to provide an adequate response to the underlying determinants of mental health.

In the Conclusion, the findings of Chapter 6, coupled with those in the previous Chapters, inform the suggested meaning of State Parties obligation to respect, protect and fulfil UAC's right to mental health. The suggested typification also considers the progressive or immediate nature of obligations.

Key Words

Unaccompanied Children - Right to Mental Health - Entitlement to Appropriate Mental Health Care - Entitlement to the Underlying Determinants of Mental Health - Obligations.

Overview of Main Findings

The main research question of this thesis was “what is the nature and extent of State Parties obligations with respect to UAC’s right to mental health?”.
In answering the abovementioned research question, I found that Article 6 is inextricably linked to mental health. Moreover, it offers specific protection to UAC’s mental health since Article 6§1 requires States to adopt positive measures that prevent both internal and external threats to their lives.
Arguably, these obligations are of an immediate nature.

I also found that the most relevant dimensions of Article 24 for discussing children’s right to mental health are the entitlements to appropriate mental health care and the entitlement to the underlying determinants of mental health (i.e., socio-economic and environmental conditions conducive of mental health). With respect to the former, a review of selected COs revealed a rather inconsistent approach from the part of the CRC Committee in demanding the provision of available, accessible, acceptable and quality mental health services to UAC. Regarding UAC' entitlement to the underlying determinants of mental health, it was found that no guidance is provided by the CRC Committee on how States should respond to them. However, by revising available literature in the field of psychology, I found that access to basic needs and freedom from violence are two important underlying determinants of UAC’s mental health.

By analysing relevant jurisprudence on the obligation to respect, protect and fulfil the right to health, I reflected on the meaning of the tripartite typology applied to the right to mental health of UAC. Moreover, by analysing the progressive and immediate nature of obligations arising from Article 24, I noted that an adequate response to the underlying determinants of health is included among the minimum core obligations by the CRC Committee. As such, I investigated what the immediate obligation to provide adequate response to UAC’s underlying determinants of mental health would, *in concreto*, demand from State Parties in emergencies.

I found that the very essential elements of a MHPSS response in emergency settings is represented by the provision of basic services, the adoption of sufficient security measures, and the provision of family/community support. As such, measures of implementation of these essential elements of a MHPSS should inform State Parties’ minimum core obligation to provide an adequate response to the underlying determinants of mental health.

By integrating all the findings and analysis conducted throught this thesis, in Chapter 7 I provided an overview of nature and extent of State Parties’ obligations with respect to UAC’s right to mental health. The findings concerning immediate obligations arising from UAC’s right to mental health are summarized below:
States have an immediate obligation to refrain from denying or limiting UAC’s access to mental health services based on discrimination. In addition, they also hold an immediate obligation to refrain from interfering directly or indirectly with their right to mental health, causing unnecessary harm to them by failing to provide access to basic needs (*obligation to respect*).
States also have an immediate obligation prevent violence in refugee settings by, *inter alia*, ensuring separation between UAC’s (*obligation to protect)*. This is established under Article 6§1, which requires State Parties to adopt protect UAC against external threats to their lives. Moreover, Article 6§1 also demands for immediate obligations to prevent suicides rates.
Finally, State has an immediate obligation to provide family/community support aimed at family tracing, reunification or (in)formal educational activities (*obligation to fulfil*).

List of Abbreviations

COs	United Nations Committee on the Rights of the Child Concluding Observations
CESCR	Committee on Economic, Social and Cultural Rights
CP	Civil and Political (Rights)
ESC	Economic, Social and Cultural (Rights)
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EU	European Union
GC	General Comment
IASC	Inter-Agency Standing Committee
MHPSS	Mental Health and Psychosocial Support
RCD	Reception Condition Directive
UAC	Unaccompanied Children
UN	United Nations
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

1. Introduction

The biennium 2020-2021 has been an unprecedented year in many regards. Measures to contain the spread of Covid-19 brought unique forms of loneliness that necessarily stems from social isolation and lockdowns. These circumstances, beyond normal experiences, have greatly impacted mental health, especially for children and adolescents, who, by definition, find themselves in an already vulnerable position in light of their developmental age, current educational status and need for protection.[1] However, as is often the case, emergency situations also represent a novel opportunity to challenge the *status quo*. To this end, Covid-19 has prepared the ground to discussing children's rights to mental health. For instance, if children have a right to mental health and what corresponding obligations do States have. This thesis is grounded in these questions. Yet, the recognition that vulnerable children face both an increased risk of developing mental health conditions and more barriers to access adequate psychological support mandated for a slightly different approach. As such, this work will explore the links between children's right to mental health and one of the most vulnerable group of children, namely, unaccompanied migrant children ("UAC").[2]

1.1. UAC. From bad to worse? The case of Moria.

There are many reasons why UAC flee their countries of origin. Some escape from wars, poverty or natural catastrophes. Others are pressured to leave their country by their parents in the hope of being reunited in a wealthier country with more opportunities.[3] Others do so to escape from discrimination or prosecution.

Despite the diverse reasons behind UAC's departure, one commonality is the experience of a traumatic life story in their home country, such as extreme poverty, being exposed to war, abuse or the brutal death of a loved one.[4] It is with this traumatic baggage that they embark on a potentially fatal journey, completely alone, in the hands of traffickers or smugglers.[5,6]

When the journey is not fatal, it is nevertheless characterized by pitfalls, traumas and human rights violations.[7] For instance, testimonies collected by Save the Children highlights that UAC who walked the Balkan route reported having been kidnapped by smugglers, having witnessed the injuries/deaths

[1] See, generally, S. Singh, D. Roy, S. Parveen et al, *Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations*, Psychiatry Res (2020).

[2] Unaccompanied migrant children are children, as defined in Article 1 of the Convention on the Rights of the Child, who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so. See: Office of the United Nations High Commissioner for Refugees (UNHCR), *Guidelines on Policies and Procedures in dealing with Unaccompanied Children Seeking Asylum* 1 (1997).

[3] D. Zak, *Fact Sheet: Unaccompanied Migrant Children (UAC),* November 2020, (https://immigrationforum.org/), last visited (21-06-2021).

[4] R. Hicks, R.N. Lalonde & D. Pepler, *Psychosocial considerations in the mental health of immigrant and refugee children*, *Canadian Journal of Community Mental Health*, vol. 12, 71-87 (1993).

[5] I. Derluyn & E. Broekaert, *On the way to a better future: Belgium as transit country for trafficking and smuggling of UAC*, International Migration, vol. 43, 31 (2005).

[6] The numbers of deaths of UAC in the Mediterranean Sea, 700 only in the past five years, represent a dramatic proof of the enormous risk they take during their journey to safety. See, M. Rullàn, *The Story of Europe's 210,000 UAC seeking asylum*, 24 September 2020, (www.euroactive.com), last visited (17-06-2021).

[7] Supra Note 5.

of migrants travelling with them or having survived in extreme harsh conditions.[8] At the EU level, when UAC finally cross EU borders, by air, land or sea, EU Law on asylum becomes applicable, meaning that they are entitled to apply for international protection and to remain in the country of first arrival until a final decision is taken on their status.[9] During this time, EU members states should provide for reception structures that are suited to children's age and maturity, whilst ensuring an adequate standard of living and providing the necessary health care.[10]
However, realities very much distant from compliance with obligations under international human rights law and the EU asylum acquis have emerged. The conditions for asylum seekers, including UAC, in the Eastern Aegean Greek Islands are testament this.

In its 2019 Report, the EU Agency for Fundamental Rights described the hygiene and sanitation conditions in Moria as absolutely unacceptable especially for UAC, in light of lack of support measures available to them.[11] The tragic death by dehydration of a nine-month baby in November 2019 illustrates the seriousness of the situation in Moria.[12] As such, UAC's prolonged permanence in Moria's refugee camp, in degrading living conditions and with a lack of security, worsens the pre-existing psychological distress arising from UAC past experiences, causing a further harm to their mental health.[13]

1.2. Problem Definition and Aim of the Research

The unacceptable conditions in which UAC can find themselves once in a receiving country, of which Moria is an extreme but certainly not isolated example,[14] undoubtedly constitute a violation of many human rights. From their right to access basic needs (Article 27), to their right to be protected against violence (Article 19) and not to be detained unless as a last resort measure and for the shortest time possible (Article 37). Although of fundamental importance, this thesis will not explore these human rights violations. Rather, it will focus on States' obligations with respect to their right to mental health. The reasons behind this choice are three-fold and can be linked both to the importance of addressing the issue of children's' mental health in general and to the intrinsic condition of UAC.

1.2.1 Why Mental Health?

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[8] Save the Children, *Struggling to Survive: Unaccompanied and Separated Children Travelling the Balkans Route* 33 and 10 (2019)

[9] Article 3, Regulation EU No 604/2013 of the European Parliament and of the Council of 26 June 2013.

[10] Article 24, Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013.

[11] EU Agency for Fundamental Rights (FRA), *Children in Migration in 2019: Annual Review* 14 (2020).

[12] Greece Euronews, *Baby dies in Moria migrant camp*, MSF reveals, 17 November 2019, (www.euronews.com), last visited (17-06-2021).

[13] See, generally: The Office of the United Nations High Commissioner for Refugees (UNHCR), *Refugee children: Guidelines on Protection and Care* (1994); T. Bean, I. Derulyn & E. Eurelings-Bontekoe, *Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents*, The Journal of Nervous and Mental Disease 288 (2007).

[14] On the degradable conditions amounting to de facto detention of UAC, see, e.g., Human Rights Watch, *Italy: Children Stuck in Unsafe Migrant Hotspot. Extended Stays, No Separation from Adults*, June 2016, (https://www.hrw.org/news), last visited (01-07-21); United Nations Human Rights Office of the High Commissioner (UNHCHR), Italy's Migrant Hotspots Centres Raise Legal Questions, (https://www.ohchr.org/), last visited (09-07-2021).

The first reason behind the choice of this topic is related to the crucial importance of mental health in children's lives. In fact, mental well-being constitutes an integral part of an individual capacity to conduct a fulfilling life. Activities such as studying, creating meaningful relationships, working as well as realizing day-to-day choices and decisions are all impacted by mental health.[15] More specifically, mental health conditions may cause impaired self-regulation or antisocial behaviour (externalizing consequences) but also depression, anxiety, hypersensitivity (internalizing consequences),[16] which adversely compromise children's capacities and functioning at the individual, welfare and societal level.[17] It is in light of the great impact that mental health has on children's life that this thesis will delve into it.
Second, mental illness and psychological suffering are still hugely perceived as something to be ashamed of and stigma is still frequently attached to seeking psychological help and mental health services.[18] Additionally, even if perceived stigma was not attached to mental health problems, the literature highlights how the majority of children experience lack of accessible psychosocial interventions.[19]

1.2.2 Why Mental Health of UAC?

Finally, exploring the link between the right to mental health and UAC has been chosen as the topic of this thesis since research shows that - as human beings in development, deprived of their family environment, who fled from their country of origin experiencing dramatic events - UAC are at particularly risk of developing maladaptive function and/or vulnerability to psychopathology, especially post-traumatic stress disorder, depression and anxiety disorders.[20]

1.2.3 Aim of the Research

The problem of UAC's increased level of psychological morbidity, due to traumatic events in their country of origin, during their journey to safety or during prolonged stays in refugee camps, would be without doubt eradicated by tackling its root cause, i.e., preventing and/or stopping conflicts, wars, extreme poverty, and disasters, in the first place. Arguably, to a certain extent, States have a duty to do so.[21] However, building on the sad recognition that conflicts, wars and extreme poverty will not end

[15] World Health Organization (WHO), *Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO secretariat for the development of a comprehensive mental health action plan 27 August 2012*, 2 (2012).

[16] See Generally: M. Weeks, G.B Ploubidis, J. Cairney et al., *Developmental pathways linking childhood and adolescent internalizing, externalizing, academic competence, and adolescent depression*, 30 (2016)

[17] Supra Note 15.

[18] Simmons found that 85% of children who need mental health treatment are not receiving any because of the perceived stigma associated with mental illness. J. Simmons, *Kid's mental health tackled,* Counseling Today, 1-26 (2000)

[19] The gap between the provision of treatment for mental disorders in children and the numbers of children in need of it is globally recognized as a treatment gap. See, generally, V. Patel, C. Kieling & P.K Maulik, *Improving access to care for children with mental disorders: a global perspective,* Arch Dis Child 98, at 323 (2013).

[20] I. Derluyn & E. Broekaert, *Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents*, Ethnicity and Health 142 (2007).

[21] In 2005, States affirmed their responsibility to protect their own populations from genocide, war crimes, ethnic cleansing and crimes against humanity while accepting a collective responsibility to support third countries to uphold this commitment. They also affirmed their will to take appropriate action, in accordance with the United

in the foreseeable future, this thesis aims to shed some light on what responses the children's rights framework provides with respect to UAC's right to mental health. In this sense, this work aims at filling the gap in the debate around children's rights with respect to UAC's right to mental health.
Highlighting the all-encompassing effect that mental health conditions have on children's lives and rights and emphasising that UAC are more exposed to psychological morbidity, this thesis also aims to stimulate further guidance from the part of the CRC Committee on the content and nature of States obligations with respect to children's right to mental health, more specifically, UAC.

1.3 Research Question

The primary research question of this thesis is "what is the nature and extent of State Parties' obligations with respect to UAC's right to mental health?". To answer this research question, a number of sub-research questions will be also addressed.
First, what protection, from a broad perspective, does the children's rights framework offer to UAC and which articles of the CRC become relevant, providing protection, in the discussion about their mental health?
Second, does the CRC Committee expressively recognize UAC's entitlement to appropriate mental health services arising from Article 24? If so, "to what extent does it demand State Parties to adopt measures of implementation of UAC's entitlement to appropriate mental health care?
Third, which are the underlying determinants of UAC's mental health? Does the CRC Committee provide guidance in this respect?
Responses to these research-sub questions are necessary to prepare the ground for answering the main research question of this thesis on the nature and extent of States' obligations with respect to UAC's right to mental health in Chapter 5 and Chapter 6.

1.4. Children's rights framework

This thesis will use a children's rights framework to analyse the issue of mental health of UAMs.
For the mere reason they are human beings, children are right holders of all international human rights instruments. However, CRC[22] will be used as the main point of reference for analysing UAC's right to mental health since, by focusing specifically on children, the CRC represents a milestone in securing their rights.[23]

Furthermore, although the "CRC applies to all children, at all times, wherever they may be"[24] it also specifically recognizes that "in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration".[25] Therefore, by recognizing the need to further protect vulnerable groups of children, the CRC reserves a special attention to UAC. Finally, the CRC is one of the few international human rights instruments which encompasses both CP rights and ESC rights. This allows us to address, in the same document, the implications that mental

Nations Charter and in cooperation with relevant regional organizations, if national authorities fail to protect their populations. See: UN General Assembly 2005 World Summit Outcome, October 2005, A/RES/60/1, paras 138 and 139.

[22] UN General Assembly, *Convention on the Rights of the Child, 20 November 1989, United Nations*, Treaty Series, vol. 1577, 3 (1989).

[23] When relevant issues are supported in other human rights documents or elaborated in the jurisprudence of other UN Treaty Bodies or Regional Court, these will be examined too.

[24] CRC Preamble.

[25] Id.

health of UAC has, not only on their right to health (ESC right), but also on their right to life (CP right). It is important to observe that the classic distinction between CP rights and ESC rights as two separated generations of rights is considered outdated by the academic literature.[26] In fact, obligations arising from CP rights are not only negative but also positive and therefore require allocation of resources and investment just as ESC rights do.[27] Nevertheless, it must also be noted that the CRC maintains the orthodox position of international human rights law and distinguishes between CP and ESC rights. Indeed, under Article 4, reference to available resources is confined to ESC, meaning that CP rights are of immediate obligations.[28] Therefore, sticking to the text of the CRC, this thesis will note a substantial distinction between immediate obligations arising from CP rights and obligations arising from ESC rights.

For these reasons, the CRC will be used as the hard law instrument of reference in addressing the question of State Parties obligations with respect to UASC's right to mental health.

1.5 Methodology and research techniques

Besides relying on the CRC as the hard law instrument, this thesis will also make use of soft instruments derived from the jurisprudence of the CRC Committee. Particular attention will be paid to GCs addressing children in migration contexts[29] and the GC on children's right to the highest attainable standard of health.[30] Furthermore, selected COs issued by the CRC Committee will be analysed in terms of reference to specific key words to assess whether and to what extent the CRC Committee recommends measures of implementation of UAC's entitlement to appropriate mental health care.

1.5.1 Selected Cos

The revised COs can be distinguished in two main categories: COs issued against receiving States at the EU level and COs issued against receiving States beyond EU borders. The rationale behind the selection of COs issued against EU countries was the following.

First, I selected the timeframe in which the highest number of unaccompanied asylum-seekers were registered in the EU. As shown in Annex 1, this period coincides with the record of migratory flows

[26] See e.g., S. Domaradzki, *Karel Vasak's Generations of Rights and the Contemporary Human Rights Discourse*, Human Rights Review volume 20, 423–443 (2019); See: United Nations Human Rights Office of the High Commissioner (UNHCHR), *Key concepts on ESCRs - Are economic, social and cultural rights fundamentally different from civil and political rights?,* (www.ohchr.com), last visited (17-06-2021).

[27] J. Tobin, "Article 4: A State's Obligation of Implementation", in J. Tobin, *The UN Convention on the Rights of the Child: A Commentary*, 129-131(2019).

[28] Article 4 CRC; UN Committee on the Rights of the Child (CRC), *General Comment No. 19 on public budgeting for the realization of children's rights*, July 2016, CRC/C/GC/19.

[29] UN Committee on the Rights of the Child, *General comment No. 6 on the Treatment of Unaccompanied and Separated Children Outside their Country of Origin*, 1 September 2005, CRC/C/GC/6.; UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW), *Joint general comment No. 4*, (2017) *of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families and No. 23 (2017) of the Committee on the Rights of the Child on State obligations regarding the human rights of children in the context of international migration in countries of origin, transit, destination and return,* 16 November 2017, CMW/C/GC/4-CRC/C/GC/23.

[30] UN Committee on the Rights of the Child (CRC), *General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, April 2013, CRC/C/GC/15.

ever registered in the EU, specifically, 2015-2016.[31] Moreover, I also included the year 2019 to verify whether there were changes in the approach adopted by the CRC Committee.
Second, I checked which were the first 5 countries for number of asylum-UAC applicants in the selected timeframe (2015-2016-2019) to verify if any of these countries were under review before the CRC Committee in these exact years. A match was found for the following 4 EU countries:
- Sweden: first country for number of applications lodged by UAC in 2015. In that exact year the CRC Committee issued a CO to Sweden.[32]
- UK and Bulgaria: 4th and 5th countries for number of applications lodged by UAC in 2016. In that year, the CRC Committee issued COs to both countries. [33]
- Belgium: 4th country for number of applications lodged by UAC in 2019. In that exact year, the CRC Committee issued COs to them. [34]

Since disaggregated data on UAC was not found for receiving countries outside EU borders, the COs for countries beyond the EU were selected based on different criteria.
- Turkey (CO of 2012), due to its geographical proximity to Syria, which entered a civil war in 2011 and the consequent drastic increase in the number of asylum-seeking coming from Syria in 2012;[35]
- Yemen (CO of 2014) due to the increase in asylum-seekers mainly coming from Somalia, Ethiopia and Eritrea in 2014.[36]
- Colombia (CO of 2015) due to its geographical proximity to Venezuela and the steady increase in the numbers of asylum seekers from Venezuela in the period 2015 – 2021.[37]

1.6 Outline of the Thesis

This thesis investigates the protection offered by the children's rights framework to UAC's mental health. In Chapter 2 I will highlight how UAC are not simply right-holders of the CRC but entitled to a right-plus framework. Moreover, I will also explore how Article 6 becomes relevant, providing protection, in the discussion about UAC's mental health.
Since Article 24 includes both an entitlement to health care and an entitlement to the underlying determinants of health, Chapter 3 and Chapter 4 will respectively analyse their meaning applied to UAC's mental health.
Chapter 5 will investigate State Parties' obligation to respect, protect and fulfil UAC's right mental health, while addressing the progressive nature of States obligations.
Chapter 6 will answer the question of what it means that States have a minimum core obligation to adequately respond to the underlying determinants of mental health.

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[31] Eurostat, *Asylum applicants considered to be UAC by citizenship, age and sex - annual data (rounded)*, (https://ec.europa.eu/), last visited (09-07-2021).

[32] Id.

[33] Id.

[34] Id.

[35] The Office of the United Nations High Commissioner for Refugees (UNHCR), Number of registered Syrian refugees triples to more than 300,000 in three months, (https://www.unhcr.org/), last visited (09-07-2021). t

[36] The Office of the United Nations High Commissioner for Refugees (UNHCR), *Yemen: Mixed Migration Update. January 2015*, (https://www.unhcr.org/), last visited (08-07-2015); The Office of the United Nations High Commissioner for Refugees (UNHCR), *2014 becomes the deadliest year at sea off Yemen*,(https://www.unhcr.org/), last visited (08-07-2021).

[37] ACAPS, Venezuelan Refugees, (https://www.acaps.org/country/colombia/crisis/venezuelan-refugees-), last visited (03-07-2021); C. Del Castillo, M. Díaz, P. López et. al, Análisis situacional de la primera infancia refugiada y migrante venezolana en Colombia. Bogotá, Colombia: Bases Sólidas (2020)

2. An Entitlement to a Right Plus Framework & the Relevance of Article 6

An answer to the main research question of this thesis – what is the nature and extent of States' Parties obligations with respect to UAC's right to mental health - cannot be separated from an analysis of Article 24 of the CRC, which provides them with the highest attainable standard of health.
However, prior to doing so, it is fundamental to understand, from a broader perspective, what kind of protection the children's rights framework offers to UAC and whether articles other than Article 24 become relevant when considering their mental health conditions. This Chapter will thus investigate the following sub-research questions: "What kind of protection does the children's rights framework offer to UAC?"; "What other provisions, other than Article 24, become relevant and provide protection to UAC's mental health?".
To answer the above research sub-questions, I will first tackle the issue of UAC as particular right holders under the CRC. Next, I will delve into both the relevance and protection offered by one of the jewels in the crown of the CRC, namely, Article 6 of the CRC.[38] I will argue that in light of their entitlement to a right plus framework and in light of the interconnectedness between mental health, the right to life and development, States hold a strong obligation to respond to their mental health conditions.

2.1 An Entitlement to a Right Plus Framework

For the mere reason they are children, UAC qualify as right-holders of all the rights set forth under the CRC.[39] Moreover, when they find themselves in the jurisdiction of a third country, irrespective of their *status* as not-citizens, State Parties to the CRC hold the obligation to respect and ensure their rights.[40]

However, importantly, UAC are not simply right holders of the CRC. They are also entitled to further protection. In fact, Article 22 establishes that, considering their multifaceted vulnerabilities and development needs, refugee or asylum-seeking children have a right to "[a]dditional protection and humanitarian assistance"[41]necessary for the actual enjoyment of the rights recognized under the CRC.[42] To put it in the words of Pobjoy, UAC enjoy a "rights-plus framework [that] gives expression to the long-lasting recognition that refugee children are entitled to special protection*".*[43]

What this special protection and humanitarian assistance entails in terms of State Parties' measures should change according to the circumstances of each specific case and depending on the child's age, maturity, needs as well as his/her past experiences.[44] However, as it will demonstrated below, in light of the interconnectedness between mental health and Article 6, the special protection they are entitled to under Article 22 should necessarily entail measures addressing their mental health needs.

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[38] Article 6 has been indeed defined by the CRC Committee as a guiding Principle. See: CRC Committee, *General Guidelines regarding the form and content of initial reports*, UN Doc. CRC/C/5, para. 13.

[39] Article 1 CRC.

[40] Article 2 CRC.

[41] Article 22 CRC.

[42] Article 22 CRC; J. M Pobjoy, "Article 22: Refugee Children*"*, in J. Tobin, *The UN Convention on the rights of the child: A Commentary*, 824 (2019).

[43] Id.

[44] G.S Goodwin-Gill, *Unaccompanied Refugee Minors: The Role and Place of International Law in the Pursuit of Durable Solutions*, 3 International Journal of Children's Rights 405, at 406 (1995).

2.2 Mental Health and Article 6: The Right to Life and Development.

Article 6 represents a precondition for the enjoyment of all the rights under the CRC. In fact, States' failures to meet their obligations under Article 6 renders the enjoyment of the CRC, if not impossible, meaningless.[45] Unsurprisingly so, the CRC Committee has identified Article 6 as a guiding principle of the Convention.[46]As it will be shown in the following paragraphs, both the civil and the ESC dimension of Article 6 become particularly relevant with respect to UAC's mental health.[47]

2.2.1 Mental Health and the Right to Life (Article 6§1)

The right to life, described as "supreme"[48] and "basic to all human rights",[49] is inherently and strictly interrelated to children's mental health. Indeed, threats to children's life can have negative, long-lasting repercussion on their mental health,[50] creating a breeding ground for the insurgence of critical psychological conditions which, in turn, may ultimately threaten their life, as the extreme act of suicide demonstrates.[51] In other words, if not taken sufficiently seriously and thus appropriately addressed, these mental health conditions could prove to be fatal and constitute an internal threat to their lives.

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[45] V. Vandenhole, "Article 6: The Right to Life, Survival and Development", in V. Vandenhole, E. Tűrkelli, S. Lembrechts, et.al, *Children's right: A Commentary on the convention on the rights of the child and its protocols* 88 (2019).

[46] CRC Committee, General comment (GC) No. 5 (2003): *General measures of implementation of the Convention on the Rights of the Child*, 27 November 2003, CRC/GC/2003/5 (Introduction on 'general principles').

[47] N. Peleg & J. Tobin, "Article 6: The Right to Life, Survival and Development", in J. Tobin, *The UN Convention on the rights of the child: A Commentary*, 188 (2019); Supra Note 45, at 88 and 98.

[48] United Nations Human Rights Committee, *General Comment No 14: Article 6 (Right to Life) Nuclear Weapons and the Right to Life*, 9 November 1984, HRI/GEN/1/Rev1, para 1.

[49] UN Human Rights Committee (HRC), *CCPR General Comment No. 6: Article 6* (Right to Life), 30 April 1982, para 1; UN Human Rights Committee (HRC), *General Comment No. 36: on article 6 of the International Covenant on Civil and Political Rights, on the right to life*, 30 October 2018, CCPR/C/GC/36, para 2.

[50] The World Health Organization (WHO) enlists exposure to war, disaster as well as exposure violence and neglect as adverse factors with respect to the development of mental health conditions. See: Supra note 16 at 3.

[51] C. Booysen, *Moving the Needle on Mental Health for Young People*, November 2019, (https://blogs.unicef.org/), last visited (21-06-2021).

Research shows that, as children deprived of their family environment who are exposed to multiple threats to their lives prior, during and after their arrival in a third country,[52] UAC face a particularly high risk of developing serious mental conditions (i.e., depression, self-harm, suicidal thoughts).[53]
In fact, actors such as Médecins Sans Frontières are reporting a worrying trend of increase in suicide, self-harm and suicidal thoughts among children living in the refugee camp of Lesbos.[54] Not dissimilar, the situation in the northwest Syria refugee camp, where - only from January 2021 to March 2021 - forty-two children aged fifteen years or younger attempted suicide.[55]

In sum, by leading to their pre-mature deaths, suicides among children in migration contexts are testament to the seriousness with whom their mental health conditions must be taken and of the interconnectedness between mental health and the right to life.

2.2.1.1 The Protection offered by Article 6§1

At its minimum, the right to life establishes that arbitrary[56] interference by the State resulting in the death of a child amounts to a violation of children's right to life (*obligation to respect*) [57]
However, the CRC Committee opts for a much broader interpretation of States obligations arising from Article 6§1, requiring that State Parties adopt positive, affirmative measures aimed at protecting children against both external and, more relevantly for the focus of this chapter, internal threats to their lives (*obligation to protect*).[58]

Since the right to life is a civil right, this entails that States have an immediate obligation to take measures aimed at preventing suicides and addressing children's suicides rates.[59] In fact, among the

[52] The particular exposure of UAC to threat to their lives was recognized by the CRC Committee itself in its Joint General Comment No. 4/23: "At any point during the migratory process, a child's right to life and survival may be at stake owing to, inter alia, violence as a result of organized crime, violence in camps, […] or extreme conditions of travel. Supra Note 29, at para 40.

[53] See Supra Note 13; Supra Note 20; F. Khan, N. Eskander, T. Limbana et.al, *Refugee and Migrant Children's Mental Healthcare: Serving the Voiceless, Invisible, and the Vulnerable Global Citizens*: *Serving the Voiceless, Invisible, and the Vulnerable Global Citizens*, Cureus vol. 12, (2020).

[54] Médecins Sans Frontières, *Self-harm and attempted suicides increasing for child refugees in Lesbos*, 17 September 2018, (https://www.msf.org/), last visited (17-06-2021).

[55] Save the Children, *North West Syria: Suicide Attempts and Deaths with Children accounting from 1 to five cases*, 29 April 2021, (https://www.savethechildren.net/), last visited (21-17-2021)

[56] According to the Human Rights Committee arbitrary must be interpreted as to include elements of "inappropriateness, injustice, lack of predictability, and due process of law [footnote omitted] as well as elements of reasonableness, necessity, and proportionality". See: UN Human Rights Committee (HRC), Supra Note 49, at para 12.

[57] For a discussion on the meaning of arbitrary deprivation with respect to children's right to life, see: Supra Note 47, at 200-202.

[58] See CRC Committee on the Rights of the Child, *General comment No. 21 (2011) on children in street situations, 21 June 2017,* 18 April 2011, CRC/C/GC/21, para 29; Supra Note 49, at para 26.

[59] However, it must be also noted that no State holds an obligation to guarantee a child's life. The HR Committee stressed that States are under a due diligence obligation to undertake reasonable positive measures to protect the right to life but without an impossible or disproportionate burden to foresee threats to life originating from the conduct of private actors. As such, a State will be found in violation of Article 6 only if they knew or should have known that a particular child was at risk of killing him/herself (due diligence test). See Supra Note 49, at para 21; European Court of Human Rights Case (ECtHR), Osman v. UK, Application no. 23452/94, October 1998.

selected COs, the CRC Committee recommended Turkey and Sweden to ensure a more effective response to children suicides rate under the cluster "General Principles" in the section devoted to the right to life, survival and development.[60] Regrettably, however, neither of the two COs refer specifically to UAC.

It is interesting to note that the protection offered by Article 6§1 in terms of positive measures to prevent UAC's suicides rates, overlaps with the protection offered under Article 24§2(a) which requires State Parties to "[d]iminish infant and child mortality".[61] The overlap between the protection offered under Article 6§1 and 24§2(a) is demonstrated by the fact that, in other COs, for instance the ones issued against Belgium and Colombia, the CRC Committee recommended the State Parties to address the high prevalence of suicides rates under the cluster "Disability, basic health and welfare".[62] Regrettably, again, in none of the revised COs the CRC Committee made reference to UAC's particular psychological morbidity which renders them at an increased risk of committing suicides.

At its minimum, the approach of CRC Committee, tackling the issue of suicide sometimes under the cluster dedicated to the right to life and sometimes under the cluster dedicated to the right to health, confirms the inherent interconnectedness between mental health and the right to life highlighted in the previous paragraph. Additionally, even though neither under Article 6 nor under Article 24 2(a) States hold an obligation to ensure that no child, including UAC, commits suicides, the double protection offered by Article 6§1 and Article 242(a) is nevertheless remarkable in that it creates a strong duty of action to State Parties, especially considering that Article 6§1 is a civil right which triggers immediate and not progressive obligations.[63]

2.2.2 Mental Health and the Right to Development (Article 6§2)

Under Article 6§2 the CRC recognizes all children with a right to development. Differently from how development is commonly understood in International Law (i.e., from a collective perspective related to the enjoyment of economic, social, cultural and political development) the right to development under the CRC is characterised by a strong focus on the personal development of the child.[64] Indeed, in the CRC Preamble, the word "development" is utilized with the adjective harmonious, suggesting a strong link to concepts like wellbeing, happiness, understanding and balance,[65] whereas under Article 29 the concept of development is associated, *inter alia*, with the child's personality, talents and mental

[60] CO Turkey, CRC/C/TUR/CO/2-3, para 33 (a); CO Sweden, CRC/C/SWE/CO/5, para 21.

[61] Article 24(2)(a) CRC

[62] CO Colombia, CRC/C/COL/CO/4-5, para 42 (a); CO Belgium, CRC/C/BEL/CO/5-6, para 33 (a).

[63] As highlighted in the introduction, under Article 4 reference to available resources is only made with respect to ESC rights. Of course, compliance with positive obligations arising from Article 6§1 still require considerable resources and investment. Therefore, instead of maintaining those positive obligations arising from CP rights are always of an immediate nature, Scholar like Tobin proposes that the test to determine whether a State has failed to respect the positive obligations arising from the right to life will also, generally, require an assessment on the reasonableness of the measures taken in light of available resources. Moreover, the greater the consequences of the interference on the child, the greater the burden carried by the State should be. Finally, if a relatively low level of resources is required to protect the right to life against threats, States should be under a greater burden to allocate that resources. See, Supra Note 27.

[64] Supra Note 47, at 222; Hans-Otto Sano, *Development and Human Rights: The Necessary, but Partial Integration of Human Rights and Development*, 22 Human Rights Quarterly 734-52.

[65] Supra Note 45.

abilities.[66] Additionally, the CRC Committee points out that development must be understood as a holistic concept which includes children's mental, spiritual, moral, psychological and social development.[67]

When mental health conditions do not result in children's premature death, they could nevertheless impair their development. The strong link between development and mental health is, among the others, clearly recognised by the World Health Organization (WHO) which emphasizes how being mentally healthy is linked to different positive developmental outcomes, such as higher educational achievement and improved interpersonal relationships.[68] Moreover, scholars from the field of developmental psychology confirm that chronic stress alters children neurobiology to the detriment of their ability to succeed in school, in their future career and personal life.[69]
As such, being at an increased risk of suffering from mental health conditions, as is the case for UAC, automatically equates to a higher risk of encountering obstacles in the enjoyment of their right to development under Article 6§2.[70]

2.2.2.1 The Protection Offered under Article 6§2.

It is not easy to identify what kind of protection does Article 6§2 provide to UAC's mental health. Scholars like Peleg and Vandenhole highlight how the CRC Committee's interpretation of the right to development is vague in terms of concrete obligations.[71] However, the CRC Committee established that "the right to development can only be implemented in a holistic manner through the enforcement of all the other provisions of the Convention".[72]
It would seem, therefore, that the obligations arising from all the articles of the CRC inform the obligations arising from Article 6§2. As such, rather than providing with a specific and new kind of protection, Article 6§2 represent a crucial, additional provision that would be impacted by States' inaction with respect to UAC's mental health.

2.3 Concluding Remarks

An understanding of State Parties' obligations with respect to UAC's mental health cannot be separated from considering that they occupy a special position before the CRC. More than simply being right-holders, Article 22 recognizes them as entitled to extra protection and humanitarian assistance, which is necessary for their enjoyment of all the provisions of the CRC.

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[66] CRC Article 29§1; M. Nowak, *Article 6 the Right to Life, Survival, and Development* in Commentary on the United Nations Convention on the Rights of the Child, 7-8 (2005).

[67] Supra Note 46, at para 12.

[68] See, generally: WHO, *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (2010).

[69] Stressful experiences cause the activation of the hypothalamic-pituitary-adrenocortical axis (HPA)which has important psychological consequences such as increased focus on threat vigilance, motivation for self-defence and emotional arousal. R. A. Thompson, *The Future of Children*, Spring 2014, Vol. 24, No. 1, at 41 and 54 (2014)

[70] Supra Note 13.

[71] Supra Note 45, at 96; N. Peleg, "Time to Grow Up: The UN Committee on the Rights of the Child's Jurisprudence of the Right to Development" in *Law and Childhood Studies*, Law and Childhood Studies (2012).

[72] CRC GC 7 (n 64) para 10.

This enhanced protection must inevitably include measures aimed at addressing their mental health conditions in light of the inherent interrelation between mental health, the right to life and development. In fact, since Article 6 represents a precondition for the enjoyment of all the rights of the CRC, failure to address UAC's mental health conditions would jeopardise their enjoyment of the CRC *tout court*. States have thus a strong obligation to adopt positive measures aimed at protecting UAC against internal threats to their lives: Article 6§1 is a civil right, which arguably triggers immediate obligations not subject to progressive realization.

3. UAC's Right to Access Mental Health Care and the Jurisprudence of the CRC Committee

After having highlighted the special protection offered to UAC's mental health by the children's right framework with reference to Article 22 and Article 6, Chapter 3 will look into the core Article for addressing children's right to mental health, namely, Article 24.

As noted by Vandenhole, both the jurisprudence of the CESCR and that of the CRC Committee are clear in establishing that the right to health creates both freedoms and entitlements. With respect to the latter, Article 24 encompasses an entitlement to appropriate healthcare services and an entitlement to the underlying determinants of health.[73] Therefore, in this Chapter I will try to answer the following research sub-question: "Does the CRC Committee expressively recognize UAC's entitlement to appropriate mental health services?"; If so, "To what extent does it demand State Parties to adopt measures of implementation of UAC's entitlement to appropriate mental health care?"

To answer the above research sub-questions, I will first briefly highlight how mental health necessarily fall within the meaning of health under Article 24. Next, I will look at relevant GCs to see if the CRC Committee explicitly recognizes UAC's entitlement to receive mental health services. Finally, with reference to the 3AQ model, I will revise selected COs to address the CRC Committee approach in demanding measure of implementation of UAC's entitlement to mental health care.[74]

3.1 Mental Health under Article 24.

The meaning of health in international human rights law has been the object of debate. The World Health Organization (WHO) defines health as a "[s]tate of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[75] However, scholars have maintained that such a focus on well-being renders the right to health subjective and quantitatively unattainable, creating an unreasonable burden for duty bearers.[76]
In their jurisprudence, the treaty bodies of the CRC and CESCR have clarified that, although there is no right to be healthy under their respective instruments, the meaning of health is to be intended in a very broad and holistic sense.[77] More specifically, the CRC Committee clearly stated that the right to health is an:

> *[…] inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to grow and develop to their full potential and live in*

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[73] Supra Note 48, at para 8; Supra Note 30, at para. 24; V. Vandenhole, "Article 24: The Right Health", in V. Vandenhole, E. Türkelli, S. Lembrechts, et.al, *Children's right: A commentary on the convention on the rights of the child and its protocols* 256 (2019).

[74] For information and details regarding the rationale behind the selection of the countries and Cos, see: 1. Introduction, sub-paragraph 1.5.

[75] Constitution of the World Health Organization, (https://www.who.int/), last visited (07-07-2021)

[76] J. Ruger, *Toward a theory of the right to health: capability and incompletely theorised Agreements,* Yale J Int Law Hum Rights 18(2), 312 (2006); N. Daniels, *Meeting health needs fairly*, Cambridge University Press, 37 (2008). See also: J. Tobin, *Children's Right to Health*, in T. Liefaard & U. Kilkelly, International Human Rights of Children (2019).

[77] Supra Note 48, at paras 8-11; Supra Note 30, at para 2.

> *conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health.*[78]

As it can be observed, the CRC Committee defines the right to health in a very broad sense making specific reference to the "right to grow and develop". As such, the meaning of health under Article 24 necessarily includes mental health within its scope. After all, mental health represents an integral and essential component of health.[79]

3.2 UAC's Entitlement to Mental Health Services

Children's entitlement to appropriate health care arises from both Article 24§1 and from 24§2(b).
Indeed, under these provisions children enjoy:
- a right to facilities for health treatment and rehabilitation;[80]
- a right to be provided with necessary medical assistance and healthcare.[81]

Since mental health falls within the meaning of health under Article 24, all children are entitled to appropriate mental health care too. The CRC Committee seems to be aware of this logical inference. Indeed, it expressly recognized that "[s]tates have the obligation to provide adequate treatment and rehabilitation for children with mental health and psychosocial disorders".[82] Moreover, it also highlighted the numerous challenges faced by children in humanitarian emergencies, urging States to adopt all possible measure "to encourage […] psychosocial care to prevent or address fear and traumas".[83]Finally, with respect to UAC, it established that, in implementing their right to enjoy the highest attainable standard of health, in conjunction with Article 39, States must provide "culturally appropriate and gender-sensitive mental health care […] and qualified psychosocial counselling."[84]
In light of the above and of the numerous references made to the psychological conditions, traumas and fears faced by UAC in its GC No.6, it is clear that the CRC Committee recognizes that UAC's do have an entitlement to mental health services.
However, using the 3AQ model and revising selected COs, the following paragraph will assess to what extent the CRC Committee demands State Parties to take appropriate measures in this respect.

3.3 The 3AQ Model applied to Mental Health Care of UAC and the Jurisprudence of the Committee

Elaborated by the ESCR Committee and subsequently adopted by the CRC Committee,[85] the 3AQ model constitutes a useful tool for evaluating the appropriateness of States' measures with respect to

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[78] Id.

[79] World Health Organization (WHO), *Mental Health: strengthening our response*, 30 Mrch 2018, (https://www.who.int/news-room), last visited (1-07-2021).

[80] Article 24§1 CRC.

[81] Article 24§2 (b) CRC.

[82] Supra Note 30, at para. 39.

[83] Id.

[84] Supra Note 29, at paras 46-49.

[85] Supra Note 48, at para 12; Supra Note 46, at para 47 and Supra Note 30, at para 112.

children's right to health and their entitlement to mental health care.[86] As it will be highlighted below, the 3AQ framework is founded on the principles of availability, accessibility, acceptability and quality.[87]

3.3.1 Availability of mental health services

Availability refers to State Parties' obligation to ensure that there are sufficient mental health facilities, goods, services and personnel for children, including for children coming from "underserved and hard to reach" areas.[88] Although UAC are particularly prone to develop mental health conditions,[89] the availability of mental health services is problematic in humanitarian contexts[90] since priority is understandably given to food, water, shelter and education, the provision of which are already challenging, yet also fundamental for the actual enjoyment of the right to mental health (See Chapter 4).

A review of the selected COs[91] issued by the CRC Committee reveals that the problem of lack of available psychological services is recognized in general terms but that the CRC Committee rarely demands State Parties to scale up mental health services for UAC.[92] In fact, no recommendations were made in this respect neither to Sweden nor to the UK (Annexes 5 and 4). In its CO to Sweden, it recommended the State Party to ensure that victims of violence have sufficient access to psychological care, while no specific mention was made on the provision of these mental health services to children in migration contexts. Regarding asylum seeking children, a recommendation was instead issued with respect to the provision of basic needs, which questions whether absence to reference to the provision of psychological services was due to the fact that they were already available.[93] Conversely, we find reference to available mental health services for particular groups of children in migration contexts in the COs to Colombia, Bulgaria and Turkey.
With respect to Colombia, under the cluster "Special Protection Measures", it recommended the State Party to ensure access to basic needs, freedom from violence and integrated mental health and psychosocial support services to displaced children.[94] The recommendation to provide psychological services alongside the provision of basic needs is interesting since the same approach was not taken with respect to Sweden, only exhorted to provide access to necessities. Although the term displaced children do surely include UAC internally displaced, it also seems to exclude UAC who have crossed international borders, for instance, Venezuelan children[95] (Annex 6).

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[86] Supra Note 48, at para 12.

[87] Id.

[88] Supra Note 30, at 113.

[89] See, e.g., M. Fazel & A. Stein, *The mental health of refugee children*, Archives of Disease in Childhood 87, no. 5, 366 (2002).

[90] War Child, *Proactive Detection: Reaching Children and Families in Need of Mental Health Care*, 10 August 2020, (https://www.warchildholland.org/), last visited (21-06-2020)

[91] See, 1.5 Methodology of this thesis.

[92] COs scrutinized by words: "Psychological", "Mental", "Trauma", "Asylum-Seeking", "Unaccompanied".

[93] CO Sweden, 2015, CRC/C/SWE/CO/5, paras 28 (e) and 50 (e).

[94] CO Colombia, 2015, CRC/C/COL/CO/4-5, para 56 (a).

[95] Supra Note 37.

Similarly, another narrow recommendation to provide available mental health services to a specific group of UAC was issued against Bulgaria, which was exhorted to scale up services only to asylum-seeking children who participated in hostilities.[96]
Finally, a very strong recommendation with respect to child victims of violence in migration contexts was issued against Yemen, urged to *"ensure the provision of adequate medical treatment, mental health care and psychosocial support to refugee, asylum-seeking and internally displaced children who fall victim to sexual violence*".[97]

Notably, a very different language was used against Turkey, exhorted to simply identify asylum-seeking children in need of special support and to "consider" providing psychological assistance to them[98] (Annex 8).
More recently, in its CO to Belgium, the CRC Committee commendably noted that "there is lack of psychological support and mental health care for refugee and migrant children".[99] However, it then went on to recommend access rather than availability of mental health care for children in migration contexts. Belgium was indeed recommended to "ensure access to psychologists, psychiatrists and specialized therapists, as well as interpreters and intercultural mediators, for refugee and migrant children, including in shelter settings" (see Annex 2).[100]

In sum, we appreciate a lack of consistency in the CRC recommendations with respect to available mental health services for UAC in the past years. In some instances (Sweden and UK) reference to the provision of mental health care to children in migration contexts was not made at all. In others (Colombia, Bulgaria, Yemen), only with respect to specific sub-groups of UAC. Finally, the language adopted by the CRC Committee with respect to Turkey, exhorted to simply "consider" providing mental health services, wrongly suggests that UAC's entitlement to mental health care does not correspond to a real obligation from the part of receiving countries. However, more recently, the CRC Committee recommended Belgium to "ensure" access to psychological services to all asylum-seeking children.

It will be interesting to see if, in the future, the approach taken by the CRC Committee will be more consistent and systematic with respect to the availability of mental health and psychological support services to UAC. One would expect this since, by exacerbating their pre-existent mental health conditions, the Covid-19 pandemic have raised awareness around the fundamental importance of enhancing the availability of mental health support to refugee children.[101]

3.3.2 Accessibility of mental health services

The availability of mental health services is not sufficient for an actual enjoyment of the entitlement to mental health care. Indeed, Article 24 also recognizes that children have a right to *access* available services.

[96] CO Bulgaria,2016, CRC/C/BGR/CO/3-5, 65 (c).

[97] CO Yemen, 2014, CRC/C/YEM/CO/4, para 76 (c).

[98] CO, Turkey, 2012, CRC/C/TUR/CO/2-3, para 61.

[99] CO Belgium, 2019, CRC/C/BEL/CO/5-6, para 32 (d).

[100] CO Belgium, 2019, CRC/C/BEL/CO/5-6, para 33 (d).

[101] See: UNHCR Regional Bureau for Middle East and North Africa, *Mental Health and Psychosocial Response during COVID-19 Outbreak*, June 2020.

Access to healthcare is understood as "the opportunity to reach and obtain appropriate healthcare services in situations of perceived need for care".[102] As such, it depends on the interaction between the demand side (i.e., awareness of availability, positive perception of mental health services) and the supply side of services (i.e., approachability, affordability etc.).[103] Moreover, the principle of accessibility is multidimensional and consists of non-discrimination, physical accessibility, economic accessibility and information accessibility.[104] The literature seems to agree that refugee children often do not access the mental health services they need.[105] Common barriers influencing under-utilization include language difficulties, lack of knowledge about services, frequent relocations, lack of mental health literacy and stigma.[106]

Regrettably, no recommendation was made in any of the revised COs to removing barriers that impede access to mental health care for UAC or children in general. The only exception is represented again by Belgium which, as already noticed, was exhorted to "ensure access to psychologists, psychiatrists and specialized therapists, as well as interpreters and intercultural mediators, for refugee and migrant children, including in shelter settings" (see Annex 2).[107]
Moreover, in its CO to Belgium it also recommended the State Party to "promote a positive image of mental health care"[108] encouraging children to seek psychological support when they need it (see Annex 2).[109]

In sum, while the literature reports that UAC face multiple barriers to access mental health care, only in one of the seven revised COs, did the Committee make recommendations in this respect.

3.3.3 Acceptability and Quality of mental health services

The last two general dimensions of the 3AQ model are acceptability and quality.

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[102] J. Levesque et. al, *Patient-centred access to health care: conceptualising access at the interface of health systems and populations*, International journal for Equity in Health 12, 4 (2013).

[103] See, for instance: L. Werlen, D. Gjukaj, M. Mohler-Kuo et.al, *Interventions to improve children's access to mental health care: a systematic review and meta-analysis*, Epidemiology and Psychiatric Sciences 29, e58 (2020)

[104] The non-discriminatory dimension of accessibility requires that health-related services, goods and facilities must be *de jure* and *de facto* accessible to all children without discrimination of any kind. The physical dimension of accessibility requires that children and their caregivers, including those coming from remote areas, can physically reach health facilities, services and goods within a reasonable distance. In the case of unaccompanied minors in refugee centres physical accessibility would entail mental health support on site or within a reachable distance through public transport. Economic accessibility demands that inability to pay health-related services does not result in denial of access. Finally, the information dimension of accessibility requires that children and their caregivers receive information "on health promotion, health status, and treatment options". CRC/C/GC/15 2013, para 114.

[105] See: V. Ardino & G. Di Benedetto, *Psychosocial care for UAC in Europe: is there an economic case? (Discussion Paper)*, 40-41 (2018); L. Werlen, D. Gjukaj, M. Mohler-Kuo et.al, *Interventions to improve children's access to mental health care: a systematic review and meta-analysis*, Epidemiology and Psychiatric Sciences 29, e58 (2020).

[106] Id.

[107] CO Belgium, 2019, CRC/C/BEL/CO/5-6, para 33 (d).

[108] CO Belgium, CRC/C/BEL/CO/5-6, para 33 c.

[109] CO Belgium, CRC/C/BEL/CO/5-6, para 50 (a) (c).

Acceptability refers to States' obligations to design and implement culturally appropriate health services which consider the needs, ethics, cultures and language of children.[110] The acceptability principle is inextricably linked to the barriers to access mental health services since culture and language differences may be determinant in avoiding seeking and/or refusing mental health support.[111] Interestingly, nether with respect to UAC nor with respect to asylum-seeking children more broadly, mention was made of appropriate and quality psychological services in the revised COs. However, the CRC Committee generally referred to quality and acceptability of mental health services in its COs to UK and Colombia.[112] With respect to the latter, it recommended to ensure the provision of quality mental health services taking into account indigenous culture.[113]

3.4 Concluding Remarks

UAC enjoy a right to be provided with available, accessible, acceptable and quality psychological services in that mental health fall within the meaning of health under Article 24 which provides an entitlement to appropriate health care.

The CRC Committee seems to be aware of this logical inference and, commendably, stresses States' obligations to provide adequate treatment and rehabilitation for UAC in its GCs. [114]However, when it comes to practically demand measures of implementation of UAC's entitlement to mental health care, the CRC Committee only specifically recommended Belgium to ensure accessible psychological services for UAC. In all other cases, it did not urge State Parties to scale up or ensure UAC's accessibility to mental health care. With respect to Turkey, the CRC Committee issued a very weak recommendation using the word "consider providing" which does not seem in line with the concept of obligations arising from Article 24 for all intents and purposes. More generally, a lack of consistency in its recommendations can be noted. Indeed, while sometimes it urged both the provision of basic needs and psychological care (Colombia – displaced children), in others it limited itself to recommend the provision of basic needs (Sweden – asylum-seeking children).

Moreover, since the revised COs concerned State Parties with relatively high numbers of UAC in the exact year of their review before the Committee, it is regrettable that so little attention was paid to their entitlement to appropriate mental health care. This seems to suggest that, albeit falling within the scope of Article 24§1 and Article 24§2(b), ensuring provision of mental health care to UAC is rarely demanded by the CRC Committee.

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[110] Supra Note 30, at 115; See e.g

[111] See, e.g., Supra Note 105, at 40-41 (2018); L. Werlen, D. Gjukaj, M. Mohler-Kuo et.al, *Interventions to improve children's access to mental health care: a systematic review and meta-analysis*, Epidemiology and Psychiatric Sciences 29, e58 (2020).

[112] CO UK, CRC/C/GBR/CO/5, para 61 (b).

[113] CO Colombia, CRC/C/COL/CO/4-5, paras 28 (g) and 42.

[114] Supra Note 30, at paras 46-49.

4. The Underlying Determinants of Mental Health under Article 24 and the Jurisprudence of the CRC Committee (GCs)

The right to health under Article 24 not only includes an entitlement to health care services, but also an entitlement to the underlying determinants of health, i.e., the socio-economic and environmental conditions that are conducive of health, such as access to potable water and adequate sanitation, nutritious food and a healthy environment.[115]

This Chapter will delve into the strong link established by the CRC Committee between the enjoyment of health and access to its underlying determinants. A review of the current literature, will provide an answer to the following research sub-question: "Which are the underlying determinants of UAC's mental health?"

Comparing the literature findings with the jurisprudence of the CRC Committee, I will argue that the CRC Committee adopted a quite narrow interpretation of the underlying determinants of health, making no explicit reference neither in its GC No.15 nor in its GCs devoted to children in the context of migration, to the importance or nature of the underlying determinants of mental health, preferring to exclusively focus on their importance for physical health.

This represents a missed opportunity to demand that, also under Article 24 and specifically with respect to UAC's mental health, State Parties must adopt appropriate measures to ensure access to basic needs and freedom from violence.

4.1 The Underlying Determinants of Health

Children's right to the enjoyment of the highest attainable standard of health under Article 24§1 is strictly linked to the concept of underlying determinants of health, namely, the socio-economic and environmental conditions conducive of health.[116] Indeed, the CRC Committee clearly stated that the entitlements arising from Article 24 "include access to a range of […] conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health"[117] and that Article 24§1 requires a "sustained attention to the underlying determinants of children's health.[118]
Explicit reference to the underlying determinants of health is also found under Article 24§2(c), which establishes that States shall pursue the full implementation of the right to health through, *inter alia*, the provision of food and water.

The strong link established by the CRC Committee between enjoyment of health and access to its underlying determinants,[119] coupled with the explicit reference in Article 24§2(c) to food and water, led authors like Smyth and Tobin to argue that there is a textual and principled basis for including, within

[115] Supra Note 48, at para 11; CRC Committee, General comment 15 on the right of the child to the enjoyment of the highest attainable standard of health, para. 24; Supra Note 73.

[116] Supra Note 30, para 23-24; Supra Note 48, at para 4.

[117] Supra Note 30, para 24

[118] Supra Note 30, para 28.

[119] Supra Note 30, para 2; See also, Supra Note 48, at para 11.

the scope of Article 24, also "the normative territory of other economic and social rights such as housing, education and the right to survival and development".[120]
In sum, the actual enjoyment of the right to health is not only informed by appropriate health care, but also by positive socio-economic and environmental conditions without which one cannot properly enjoy physical health.

4.2 Access to Basic Needs: Underlying Determinant of Mental Health.

The provision of food and safe-drinking water is essential for children's physical health in terms of morphological and functional development of the central nervous system, increased susceptibility to infections and even deaths.[121]

Importantly, however, research shows that access to basic needs is not only crucial for children's physical health but also for their mental health.[122] In fact, our capacity to remain mentally healthy is importantly determined not only by our individual and biologic characteristics but also by our socio-economic and environmental circumstances.[123] As such, poverty and poor access to basic services are considered by scholars adverse risk factors for developing mental health conditions since they significantly contribute to increasing level of chronic stress among children.[124] Importantly, research established that material deprivation can predict levels of PTSD more than exposure to life-threatening traumas connected to war and disaster.[125] Acknowledging the above research findings is particularly relevant in the discussion about UAC's mental health since, due to their inherent conditions, they are already exposed to incredibly high levels of mental distress (See Chapter 1 and Chapter 2).

If we look at GC No. 6, the Joint GC No. 4 and 23 and GC No.15, we find absolutely no reference to access to basic needs as an important underlying determinant of mental health for UAC's.
Furthermore, in its GC No.15, the Committee either generally recognises nutritious food and clean-drinking water as essential for combatting malnutrition[126] or – as reported below - dichotomously distinguishes between physical health and mental health:

> *All possible measures should be taken […] to protect them not only with physical support, such as food and clean water, but also to encourage special parental or other psychosocial care to prevent or address fear and traumas.*[127]

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[120] J. Tobin, *Children's Right to Health* in International Human Rights: International Human Rights of Children, 281 (2019); C.M. Smyths, *Towards a Complete Prohibition on the Immigration Detention of Children*, Human Rights Law Review, 28 (2019)

[121] See, generally, O.S. Ijarotimi, *Determinants of Childhood Malnutrition and Consequences in Developing Countries*, Curr Nutr Rep 2, 129–133 (2013).

[122] K.E Miller & M.G.D Jordans, *Determinants of Children's Mental Health in War-Torn Settings: Translating Research into Action*, Curr Psychiatry Rep 18, 58 (2016).

[123] World Health Organization (WHO), *Risk to Mental Health: An overview* 3 (2012).

[124] Supra Note 122.

[125] G.A Fernando, K.E Miller et.al, *The Impact of Disaster-Related and Daily Stressors on the Psychological and Psychosocial Functioning of Youth in Sri Lanka*, Child Dev. 1192–1210 (2010)

[126] Supra Note 30, at paras 43-47.

[127] Supra Note 48, at para 40.

In other words, the CRC Committee fails to highlight that access to basic needs is an underlying determinant not only of children's physical health but also, and more importantly for the relevance of this thesis, for their mental health.

In light of the cited research findings which demonstrate how UAC's access to basic needs represents an important underlying determinants mental health,[128] the CRC Committee should distance itself from a narrow interpretation of access to basic needs as conducive of physical health only and start stressing the importance of access to basic needs as an indispensable precondition of mental health too, especially with respect to UAC's.

4.3 Freedom from violence: Underlying Determinant of Mental Health.

As much as having access to food, water, sanitation and other basic needs represents a foundation for mental health, research shows that living in an environment free from violence is equally crucial for the enjoyment of children's right to mental health.[129]
In its GC No.15, the CRC Committee broadly refers to violence as a determinant of health in general:

> *[t]he Committee recognizes that a number of determinants need to be considered for the realization of children's right to health, […] including violence that threatens the life and survival of children as part of their immediate environment.*[130]

However, the point that freedom from violence represents a fundamental underlying determinant of mental health for UAC is not explicitly taken. Moreover, in its GC No. 6 and the Joint CMW/CRC No3 and 22, the Committee limits itself to highlight that UAC are at an increased risk of becoming victims of violence, *inter alia*, as a result of violence in camps, trafficking for sexual or labour exploitation and gender-based violence.[131] No further attention is paid to the fact that being free from violence is of critical importance for UAC's mental health. [132]

In light of the long-term psychological consequences of violence and of the already high psychological morbidity faced by UAC, it is recommendable that the CRC Committee stress the role played by freedom from (further) violence as a precondition of UAC's mental health. By doing so, the CRC Committee would include the obligations arising from the right to freedom from violence also under Article 24§1 since absence from violence constitute an important underlying determinant of their mental health.

4.4 Concluding Remarks.

If we want to understand State Parties obligations with respect to UAC's right to mental health, we cannot limit our attention to UAC's entitlement to appropriate mental health services. Indeed, Article 24§1 also include an entitlement to access preconditions that are conducive to mental health.

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[128] For access to underlying determinants of health as an entitlement see, CRC GC 15 para 24.

[129] S. Hillis, *Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates*, Paediatrics Volume 137, number 3 at 2 (2016).

[130] Supra Note 30, at para 17.

[131] Supra Note 29, para 40.

[132] Id. See, also, more generally: R.F Anda, A. Butchart, et.al, *Building a framework for global surveillance of the public health implications of adverse childhood experiences*, Am J Prev Med. 2010, 39 (1): 93–98.

Importantly, two underlying determinants of mental health, especially for UAC's, are represented by access to basic needs and freedom from violence.

It must be noted that the nature of State Parties obligations largely depends on the interpretation that the CRC Committee gives to the text of the CRC. Therefore, it is of crucial importance that the CRC Committee starts giving more weight to what the literature considers underlying determinants of mental health for UAC. In this way, it would render it more explicit what so far is a mere logical inference: States have an obligation to provide access to basic needs and to protect UAC from violence also under Article 24§1, in that the CRC Committee expressively recognizes children's entitlement to the underlying determinant of mental health and since mental health fall within the meaning of health under Article 24.

As such, permanence in unsecure reception facilities with no access to basic needs would be recognized as a violation of UAC's entitlement to the underlying determinants of mental health. Of course, this would also amount, *inter alia*, to violations of Article 27 and Article 19. However, it is of fundamental importance that the CRC Committee starts to conceptualise human rights violations and State Parties obligations also in terms of children's right to mental health. Otherwise, one might seriously wonder whether such right really exist under the CRC.

5. The Nature of State Parties Obligations: UAC's Right Mental Health.

As we have seen so far, even if not always explicitly endorsed by the CRC Committee, the right to mental health includes both an entitlement to mental health care (Article 24§1 and 24§2b) and an entitlement to the underlying determinants of mental health (Article 24§1), such as access to basic needs and freedom from violence.

But what does this implicate in terms of State Parties' obligation to respect, protect and fulfil UAC's right to mental health? Moreover, what is the nature of State Parties' obligations, considering that the right to mental health is an ESC right?

To answer this main research question, mainly relying on the jurisprudence of the CESCR and CRC Committee, I will try to clarify the meaning of State Parties' obligation to respect, protect and fulfil UAC's right mental health. I will also briefly discuss non-state actors' responsibilities to respect, protect and fulfil UAC's right to mental health. Next, I will delve into the progressive nature of States obligations and highlight which immediate obligations arise from Article 24, reflecting on their meaning with respect to mental health.

5.1 The Obligation to Respect, Protect and Fulfil

Both members of the academia and the CRC Committee accept that the general obligation outlined in Article 2 of the CRC - "to respect and ensure the rights set forth in the present Convention"[133] - encompasses an obligation to respect, protect and fulfil the rights recognized in the CRC.[134] The CRC Committee does not elaborate much on what this classic tripartition of States' obligations entail with respect to children's right to health. In fact, in its GC No. 15, it limited itself to say that State Parties have an obligation to respect freedoms and entitlements, to protect freedoms and entitlements from third parties and to fulfil the entitlements through direct provision.[135] As such, more guidance on what informs States' obligations to respect, protect and fulfil UAC's right to mental health, can be derived from the jurisprudence of CESCR, more specifically, from GC No.14.

5.1.1 Obligation to Respect

According to GC No.14, the obligation to respect requires states to refrain from denying or limiting equal access to health services to specific vulnerable groups "including asylum seekers and illegal immigrants".[136] Applying the above to UAC's right to mental health implicates that denying or limiting access to mental health services as a result of *de jure* or *de facto* discrimination, would amount to a violation of the obligation to respect their right to mental health.[137]

The obligation to respect also generally requires State Parties to refrain from interfering directly or indirectly by acts or omissions with the enjoyment of a right.[138] In its GC No.14 the CESCR stated that

[133] Article 2§1 CRC.

[134] M. Sepulveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights* 157-248 (2003);

[135] Supra Note 30, at para 71.

[136] Supra Note 48, at para 34.

[137] Supra Note 48, at para 50.

[138] Supra Note 48, at para 43

policies, laws or actions - either undertaken by the State or its representatives - that are "likely to result in bodily[139]harm unnecessary morbidity and preventable mortality", would amount to a violation of State Parties' obligation to respect children's right to heath".[140]

Applying the above to UAC's mental health implicates that States must refrain from exacerbating their already vulnerable mental health conditions. In this sense, depriving UAC from accessing to basic needs could constitute a violation of the obligation to respect their right to mental health, more specifically, to respect their entitlement to basic needs as an underlying determinant of mental health.[141] Indeed, as we have seen in Chapter 4, lack of access to basic needs expose UAC's to incredibly high levels of toxic stress, thus interfering – among the others - with their enjoyment of the right to mental health.

The hypothesis that failing to provide access to basic needs would constitute a violation of the obligation to *respect* UAC's right to mental health seems to find confirmation in a recent judgement of the ECtHR discussed below.

5.1.1.1 Parallels between the Obligation to Respect Article 3 of the ECHR and the Obligation to Respect Article 24 of the CRC (Mental Health).

Albeit the European Convention on Human Rights does not include a right to health *per se*, in its jurisprudence related to the conditions of UAC's detention, it found violations of Article 3 making specific reference to the repercussions that the conditions of detention had on UAC's mental health. In the case of *Sh.D. and Others v. Greece,* the ECtHR held that the administrative detention of three Afghani UAC in police stations amounted to degrading treatment.[142]

Applicants referred to as number 1 and 4 were all confined to their cells throughout the entire day. Applicant number 4 was malnourished, forced to sleep on a dirty mattress, without access to running water or a toilet.[143]

Interestingly, what informed the finding of a violation of the obligation to respect the prohibition of inhuman and degrading treatment, were, *inter alia*, the conditions of detention. In fact, lack of access to basic needs and psychological support, coupled with the applicants' vulnerabilities, were found to have caused severe negative mental health repercussions on the applicants.[144] Arguably, if this case had been considered under the CRC, among the others, a violation of Greece's obligation to respect UAC's right to mental health under Article 24 could have been found. In fact, Greece caused unnecessary mental harm and suffering to the applicants by allowing their detention in a police station under degradable conditions.

In other words, the way in which the ECHtR interpreted the obligation to respect the prohibition of degrading and inhuman treatment, might inform the obligation of State Parties to the CRC to respect

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[139] As it can be observed by the language adopted by the CESCR, the right to health is understood as mainly encompassing physical health.

[140] Supra Note 48, at para 50

[141] According to the CRC Committee State Parties have an obligation to respect freedoms and entitlements.

[142] ECHR, Sh.D. and Others v. Greece, Austria, Croatia, Hungary, North Macedonia, Serbia and Slovenia, application no. 14165/16, 2019.

[143] Id, at para 20 and 49.

[144] Supra Note 142, at paras 20-21.

children's entitlement to access to basic needs as an underlying determinant of mental and as an obligation to refrain from causing harm and unnecessary morbidity.[145]

5.1.2 Obligation to protect

In its GC No.14, the CESCR Committee specified that the obligation to protect the right to health requires State Parties to adopt necessary measures to regulate the behaviour of non-state actors.[146] Interestingly, a strong link has been established by the CESCR between States obligation to protect children's right to health and States' obligation to prevent violence.[147] Indeed, among the list of obligations falling within the scope of the obligation to protect the right to health, the CESCR Committee included the obligation to "take measures to protect all vulnerable or marginalized groups of society, in particular […] children [and] adolescents" against violence.[148] In that sense, the obligation to protect UAC's right to mental health is inextricably linked to UAC's entitlement to freedom from violence as an underlying determinant of mental health.
As such, failing to adopt necessary security measures to protect UAC against violence from third parties would amount to a violation of the obligation to respect UAC's right to mental health, more specifically, to respect their entitlement to freedom of violence as an underlying determinant of mental health.

The interpretation of the CESCR Committee is commendable and should be explicitly adopted by the CRC Committee, since, in this way, it would render more explicit that State Parties have an obligation to protect UAC against violence from third parties, not only under Article 19 but also under Article 24 of the CRC (See Chapter 4). After all, this "double protection" is particularly relevant for two main reasons: first, as recognized in the Global Survey on Violence Against Children, UAC are usually overlooked by public policies, ignored by the general population and invisible to most.[149] Second, the instability and uncertainty inherent in their conditions as UAC, put them at greater risk of becoming victims of violence and exploitation in and around refugee settings.[150]

5.1.3 Obligation to Fulfil

The obligation to fulfil children's right to health requires that states "give sufficient recognition"[151] to the right to health, "preferably by way of legislative implementation".[152] The concept of sufficient recognition is in line with what commentators such as Ruger have claimed to be crucial for the

[145] Supra Note 48, at para 50.

[146] Supra Note 48, at para 51; J. Tobin & C. Marshall, "Article 24: The Right to Health", in J. Tobin, *The UN Convention on the Rights of the Child: A Commentary,* 927 (2019).

[147] Supra Note 48, at para 51

[148] Id, at para 35.

[149] Office of the Special Representative of the Secretary General on Violence Against Children, *Toward a World free from Violence: Global survey on violence against children* 22-24 (2015).

[150] Supra Not 149.

[151] Supra Note 48, at para 36.

[152] Id.

operationalization of rights, namely, that the population of a State internalize a right as "worthy of social recognition, investment and regulation".[153]

The application of this concept to UAC's mental health implicates that receiving States are required to encourage political and social commitment for the recognition of their mental health as a right.[154] Their needs must be therefore "mainstreamed into the public health debates to ensure they remain visible and integrated rather than marginalized, isolated or ignored in the development of national health policies".[155] Moreover, the CESCR Committee has also clarified that under the obligation to fulfil the right to health, States must ensure appropriate training of doctors and medical personnel (quality), the provision of health-related facilities (availability) "with due regard to equitable distribution throughout the country" (accessibility).[156] As such, violations of the obligation to fulfil UAC's right to mental health may be represented by the misallocation of public resources or insufficient expenditure which results in the non-enjoyment of their entitlement to appropriate mental health care.[157]

In sum, the obligation to fulfil requires states to:
- recognize UAC right to mental health in their national legislation;
- integrate UAC right to mental health in the development of national health policies; and
- ensure available, accessible and quality mental health services.

5.2. Connecting the Dots: The Tripartite Typology Applied to UAC's Mental Health

The CRC Committee did not elaborate much on how to interpret the obligation to respect, protect and fulfil children's right to health, let alone UAC's right to mental health. It limited itself in establishing that State Parties have an obligation to respect freedoms and entitlements, to protect freedoms and entitlements from third parties and to fulfil the entitlements through direct provision.[158]

Conversely, in its GC No.14, the CESCR provided some guidance on the application of the tripartite typology of obligations to the right to health. By assembling available jurisprudence of the CRC and CESCR, that of the ECHtR as well as the literature available on the issue, we are able to conclude that:
- The obligation to respect UAC's right to mental health require State Parties to refrain from limiting or denying their equal access to mental health services. In this sense it is an obligation to respect their entitlement to appropriate mental health care (see Chapter 3). Moreover, it also requires that States refrain from interfering with their right to mental health by omitting to provide UAC with access to basic needs. In this sense it is an obligation to respect their entitlement to the underlying determinant of mental health (see Chapter 4).
-The obligation to protect UAC's right to mental health require that State Parties prevent and respond to violence against UAC undertaken by private actors. Therefore, it is an obligation to protect their entitlement to freedom from violence as an underlying determinant of health (See Chapter 4);

[153] J. Ruger, *Toward a theory of the right to health: capability and incompletely theorised Agreements*, Yale J Int Law Hum Rights 18(2), at 312 (2006)

[154] Supra Note 146.

[155] Supra Note 146; See, generally, Council of Europe Guidelines on Child Friendly Health Care adopted by the Committee of Ministers on 21 September 2011 at the 1121st meeting of the Ministers' Deputies.

[156] Supra Note 48, at para 37.

[157] Id., at para 52.

[158] Supra Note 30, at 71.

- The obligation to fulfil UAC's right to mental health require, *inter alia*, that State Parties provide available, accessible, acceptable and quality mental health care to UAC. Therefore, it is an obligation to fulfil their entitlement to appropriate mental health care (See Chapter 3).

5.3. The Role of Non-State Actors and State Parties obligations

The obligations to respect, protect and fulfil children's right to (mental) health is usually understood as an obligation incumbent on State Parties to the CRC.[159]
However, in its GC No. 16 on States' obligations regarding the impact of the business sector on children's rights, the CRC Committee clearly maintained that other actors, such as business enterprises and non-profit organizations play an important role in the provision of services, including health.[160] This was reasserted also in GC No. 5 on general measures of implementations, where the CRC Committee recognized that "all members of society […] have responsibilities regarding the realization of the right to health".[161] Therefore, while in emergency contexts is understandable that third actors give precedence to primary physical health, they also have a responsibility to implement children's right to mental health, by responding to UAC's entitlement to the underlying determinants of mental health and UAC's entitlement to appropriate mental health care.

However, it must be observed that State Parties always maintain responsibilities and obligations to implement UAC's right to mental health, even when it is third, non-state actors, who control the provision of its service. This principle is well exemplified by the ECtHR case of Sh.D v. Greece, in which the Strasbourg Court found Greece in violation of the positive obligations arising from Article 3 to protect and care for unaccompanied foreign minors[162] for not having done everything that could reasonably be expected of them.[163] The UAC in question lived in the makeshift Idomeni camp, set up by refugee themselves and beyond the control of the State authorities. The camp was run by non-governmental organisations, including Médecins Sans Frontières, ADM Dutch Collectivity and Praksis. The camp had no sanitary facilities and the surrounding fields and woodland were covered in excrement. The lack of sanitation facilities encouraged the outbreak of disease (cases of hepatitis A reported) and, together with the rains, led to the formation of a swamp that often flooded the tents and shelters in the camp.[164,165]

Even though the ECtHR recognised that Greece had no control over the camp, it nevertheless recognised that the expansion of the camp and the worsening living conditions within it were to some extent attributable to the slowness with which the State proceeded to dismantle the camp. Moreover, the ECtHR also noted Greece's failure to put in place the means to alleviate the humanitarian crisis, since the commitment of a few non-governmental organisations alone was not sufficient to deal with the scale of the problems in the Idomeni camp.[166]

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[159] Article 4 CRC; Article 24 CRC; Supra Note 46, at para 56.

[160] Committee on the Rights of the Child, General comment No. 16 (2013) on State obligations regarding the impact of the business sector on children's rights, CRC/C/GC/16, para 33.

[161] Supra Note 48, at para 42.

[162] ECtHR, Khan v. France, no. 12267/16, para 44, 2019; ECtHR, Rahimi v. Greece, No. 8687/08, para 74, 2011

[163] Supra Note 142, at para 61.

[164] Id, at para 54.

[165] Id, at para 10.

[166] Id.

As such, as illustrated by the ECtHR case, States are always the ultimate responsible for UAC's right to mental health.

5.4 The Progressive Nature of States Obligations regarding UAC's right to mental health.

The extent of State parties' obligations with respect to UAC's right to mental health appear vast and comprehensive, embracing not only UAC's entitlement to the underlying determinants of mental health but also UAC's entitlement to appropriate mental health services. In an ideal world, such obligations would be immediate. However, as the right to mental health is an ESC right, its implementation is not expected to be so. Rather, it is progressive and dependent on the maximum extent of resources[167] available to State Parties.[168] As maintained by CRC Committee in its GC No.5, the concept of progressive realization is a "realistic acceptance that lack of resources can hamper the full implementation of ESC rights in some States".[169]

While realization over time represents a flexible tool that reflects the sad reality of our world,[170] the obligation of progressive realization must not be interpreted as a leeway for States to indefinitely procrastinate the realization of children's right to mental health, ultimately depriving it of its raison d'être.[171] In fact, as will be highlighted in the next section, States are required to constantly progress in the realization of children's right to health. Additionally, there are minimum core immediate obligations that States must comply with under Article 24.

5.4.1 Immediate Obligations

The progressive nature of the obligation arising from Article 24 includes three immediate obligations.[172]
The first one, is an obligation to take some steps toward the realization of children's right to health.[173] In other words, "regardless of their level of development",[174] States are required to take immediate actions "as a matter of priority"[175] to comply with their obligations under Article 24.[176] Moreover, in the light of the immediate obligation to move forwards, retrogressive measures are generally not permitted, unless they constitute a measure of last resort adopted during a period of crisis and for the shortest possible period of time.[177] The prohibition to take retrogressive measures mandates that even in emergency circumstances States are required to demonstrate the necessity, reasonability,

[167] CRC Committee, Day of General Discussion on Resources for the Rights of the Child, para 65 (2007), (https://www.ohchr.org/), last visited (01-03-2021).

[168] Article 4 (2) CRC; Id.

[169] Supra Note 46, at para 7.

[170] CESCR, General Comment No. 3: The Nature of State Parties' Obligations (Art. 2, Para. 1, of the Covenant), E/1991/23 14 December 1990, para. 9.

[171] Id, at para. 9.; See also, generally, Supra Note 73.

[172] Supra Note 146.

[173] Id.

[174] Supra Note 30, at 72.

[175] Id.

[176] Id.

[177] Supra Note 28, at para. 31

proportionality, non-discriminatory and temporary nature of the retrogressive measure adopted, and to prove they have given special consideration to the impact of retrogressive measures on children living in vulnerable situations, as UAC.[178]

In line with Article 2 of the CRC, the second immediate obligation imposed on States under the right to health is to not discriminate in any manner when taking immediate actions to implement the right to health.[179]

Finally, State Parties have an immediate obligation to secure the minimum core of the right to health, namely, the minimum essential levels of obligations that derive from any ESC right.[180]

The CRC Committee has identified different minimum core obligations arising from children's right to health. These are:

> *(a) Reviewing the national and subnational legal and policy environment and, where necessary, amending laws and policies;*
> *(b) Ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs;*
> *(c) Providing an adequate response to the underlying determinants of children's health;*
> *(d) Developing, implementing, monitoring and evaluating policies and budgeted plans of actions that constitute a human rights-based approach to fulfilling children's right to health.*[181]

As we can see, except from "providing an adequate response to the underlying determinants of health" all the other minimum core obligations identified by the CRC Committee are somehow opaque regarding what they require from State Parties with respect to UAC's right to mental health. As such, the provision of an adequate response to the underlying determinants of mental health, will be further investigated in Chapter 6.

5.5 Concluding remarks

This Chapter outlined how UAC's right to mental health translates into the typical tripartite typology of States obligations. Relying on the jurisprudence of the CRC, CESCR and the case-law of the ECtHR, we provided examples of what might inform States' obligations to respect, protect and fulfil UAC's right to mental health.

Chapter 5 also observed that an answer to the question around the extent and nature of State Parties obligations cannot be separated from the recognition that the right to health triggers obligations of a progressive nature. At the same time, however, Article 24 also mandates that State Parties comply with immediate obligations. The first immediate obligation arising from Article 24 is to move as expeditious as possible toward the realization of UAC's right to mental health. The second immediate obligation is not to exclude UAC from the provision of mental health services based on their status. Finally, States have an immediate obligation to realize the minimum core obligations, namely, the minimum essential levels of obligations that derive from the right to mental health.[182]

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[178] Id.

[179] Supra Note 30, at para 72.

[180] Supra Note 28, at para 37.

[181] Supra Note 30, at para 73

[182] Id.

The language of the CRC Committee with respect to the minimum core obligations is not self-explanatory and give rise to doubts regarding what these minimum core obligations would entail with respect to UAC's right to mental health.

However, the Committee inserted "providing an adequate response to the underlying determinants of health" among the minimum core obligations.[183] Further reflection is therefore needed to understand what it means, *in concreto*, that receiving States have an immediate obligation to provide an adequate response to the underlying determinants of mental health. This question will be answered in the following, final Chapter.

[183] Supra Note 30, at para 73

6. An Adequate Response to the Underlying Determinants of Mental Health in Emergency Settings

The right to mental health of UAC in emergency setting is as important as it is difficult to grasp. Can it be really enforced or is it utopia? After all, the first image that comes to our mind when we think about provision of mental health services is, with all likelihood, that of psychologists delivering expensive therapy sessions from the comfort of their studios to patients who can afford it.[184]

This image could not be further from the ones that come to our mind when we think of refugee camps and the conditions of despair and degradation in which child applicants for international protection find themselves, including UAC (See Figure 2).

Figure 1 Moria Refugee Camp, [Kevin McElvaney/Al Jazeera]

Importantly, the CRC Committee include an adequate response to the underlying determinants of health among the minimum core obligations arising from Article 24. Hence, this Chapter will try to answer the following research sub-question "What does an adequate response to UAC's underlying determinants of mental health mean in emergency settings?".

To answer this research question, Chapter 6 will look at operational reports from the humanitarian field. Reference will be mainly made to the operational Guidelines on MHPSS in Emergencies Settings elaborated by the Inter Agency Standing Committee (IASC)[185] and to the Reception Condition Directive[186] with its Practical European Asylum Support Office's (EASO) Guidance on Reception

[184] Access to mental health services is problematic also for the general population due to, among the other things, economic barriers.

[185] The Inter-Agency Standing Committee (IASC) is composed by the heads of a broad range of UN and non-UN humanitarian organisations. It was established in 1992 in response to General Assembly Resolution 46/182, which established the IASC as the primary mechanism for facilitating inter-agency decision-making in response to emergencies.

[186] The Reception Condition Directive, aimed at ensuring common standards of reception conditions throughout the EU, is an act addressed to EU countries and must be transposed by them into their national laws. See: Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013.

Conditions for UAC.[187] By identifying operational standards and concrete indicators, EASO Guidance offers concrete insights on how to practically implement an adequate response to UAC's entitlement to the underlying determinants of mental health.[188] The review of the above-mentioned reports will be necessary to understand what it is considered an adequate Mental Health and Psychosocial Support (MHPSS) response in emergency settings. It will be argued that the most essential elements of an adequate MHPSS response should inform the meaning of providing an adequate response to the underlying determinants of UAC's mental health as a minimum core obligation arising from Article 24.

6.1. The Foundations of the IASC Pyramid

At the UN level, the IASC developed a set of Guidelines on how to operationalize MHPSS in emergency situations.[189] As can be seen in Figure 3, operationalizing MHPSS in emergency settings requires the provision of services at several levels. While ideally, all services should be implemented simultaneously, access to basic needs, security and community/family supports are collocated at the very foundations of the MHPSS pyramid.[190]

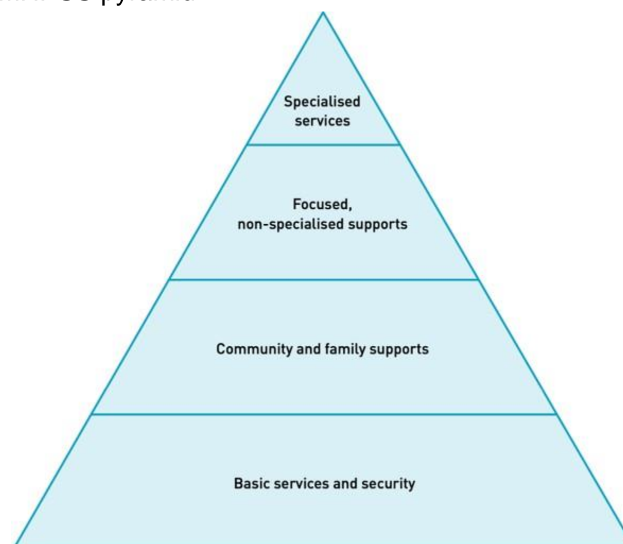

Figure 2 MHPPS in emergencies, IASC Guidelines

The very first two layers constitute the most essential elements of any MHPSS response in emergency settings. Arguably, measures of implementation of these first two layers should inform what an adequate response to the underlying determinants of UAC's mental health entails.

6.2. First Layer: Access to Basic Needs and Security

laying down standards for the reception of applicants for international protection (recast)

[187] The EASO operational Guidance support EU+ States in the implementation of the RCD. European Asylum Support Office (EASO), *Guidance on reception conditions for UAC: operational standards and indicators*, EASO Practical Guides Series (2018).

[188] Id., at 6

[189] Inter-Agency Standing Committee (IASC), IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC, 11 (2007).

[190] Id.

6.2.1 Access to Basic Needs

In line with the literature findings discussed in Chapter 4 – the IASC Guidelines establishes that "the well-being of all people should be first protected through the (re)establishment of services such food, shelter, water."[191] Providing an adequate standard of living to children applying to international protection is also reflected, at the EU level, in the Reception Condition Directive (RCD) which lay down minimum standards to whom EU Member States have agreed to be bound.[192]

EASO Guidance shed some light on the practical measures States are called to implement in order to provide basic services in accordance with regional and international standards.[193] Some of the operational standards with respective indicators, are reported in Table 1 below.

Table 1. Operational Standards – Access to Basic Services

STANDARD	EXAMPLES OF INDICATORS	
Food: Ensure that UAC have access to sufficient and adequate food. [194]	The meals ensure a balanced and varied diet. [195]	A minimum of five meals are served per day of which at least one is cooked and served warm. [196]
Water: Ensure that UAC have access to potable water 24/7.	Each child is provided with a minimum of 2,5 litres of water per day while personal physiology and climate are taken into account.	
Clothing and other non-food items: Ensure that UAC possess sufficient clothing.	UAC possess sufficient underwear for a week without having to do laundry.	UAC have at least two different pairs of shoes.

6.2.2. Security

Another essential element of any MHPSS response in emergency settings is represented by ensuring sufficient security. The fact that security is collocated at the very first layer of the IASC pyramid is in line with literature findings discussed in Chapter 4 which identified freedom from violence as an underlying determinant of mental health.

What constitutes an adequate response to freedom from violence as an underlying determinant of mental health can be derived, once again, by EASO Guidance. Under the RCD Directive, States have agreed that UAC shall be accommodated in institutions and facilities suitable for taking care of their needs and age.[197] When this is not possible, in order to protect them against violence, they should be

[191] Supra Note 189.

[192] Article 17 (1)(2) and Article 23, RCD.

[193] See: Article 2g of the RCD and access to basic needs as an underlying determinant of mental health under Article 24

[194] Supra Note 187, at 47.

[195] Id.

[196] Id.

[197] Article 24§2 (b), (c) RCD.

accommodated in sufficiently secure accommodations.[198] Practical indicators of implementation of this standard are found in Table 2.

Table 2. Operational Standards – Security

STANDARD	EXAMPLES OF INDICATORS
"Ensure sufficient security measures." [199]	- Access to the premises is monitored; - The need for UAC to walk alone through or to isolated areas is restricted; - Access to adults not members of the staff Is restricted; - Appropriate lighting of areas is guaranteed .[200]

6.3 Second Layer: Access to Community and Family supports

The second layer of the pyramid realized at the UN level to operationalize MHPSS in emergency setting is represented by community and family supports which include measures, such as:[201]
- receiving assistance and support to family tracing and reunification;[202]
- receiving formal and non-formal educational activities;[203] and

Without entering in the discussion of the importance attributed by the CRC to family as the most important group of society,[204] it suffices here to note that parents are the most important psychological support for children[205] and that "threat to psychosocial well-being is inevitably increased when lengthy or permanent disruptions occur between child and primary care-giver, or child and family".[206] For these reasons, UNHCR establishes that restoring normalcy for UAC by tracing parents must begin immediately. [207]

Integrating what the above with what has been found in Chapter 4, it can be observed how having the support of their family constitutes another important underlying determinant of mental health for UAC. Additionally, also educational activities of a formal or informal nature are also widely recognized as essential in supporting the emotional development and coping techniques of children in migration contexts.[208]

[198] Id.

[199] Supra Note 187, at 57

[200] Id.

[201] Supra Note 189, at 9.

[202] IASC, 13 (2007). According to UNHCR, for children who cannot be reunited with their families, community-based care must be built on local culture and provides continuity in learning, socialization and development.

[203] Supra Note 189, at 13.

[204] See: CRC Preamble, Articles 8, 20, 21 CRC.

[205] World Health Organization (WHO), *Health of refugee and migrant children: Technical guidance*, 11 (2018).

[206] See e.g., Office of the United Nations High Commissioner for Refugees (UNHCR), *Refugee Children: Guidelines on Protection and Care* (1994).

[207] Supra Note 206.

[208] Supra Note 89.

6.3.1 Good Practice Example: Informal educational activities - UNHCR-South Sudan[209]

UNHCR's created child friendly spaces (CFS) to offer refugee children in South Sudan psychosocial services through the provision of informal education with trained facilitators. Through educational play, children enjoy the opportunities to express themselves and to interact with their peers, while staff members can identify at risk behaviours and, if necessary, refer the children concerned for more specialised care.[210]

6.3.2 Good Practice Example: Formal Educational Activities – Nepal

With respect to educational activities, recent studies highlight how school psychosocial intervention, based on Classroom-Based Interventions (CBI)[211] produce moderate reductions on general psychological difficulties, aggression and increased sense of hope for children in conflict affected countries.[212] In particular, a study, conducted to 325 school-going children affected by conflict in southwestern Nepal confirmed that the use of CBI prevent risk for developing psychopathology but more specialized services are required to address psychiatric symptoms, psychopathology and resilience promotion for the community at large.[213]

In sum, access to basic needs, sufficient security and family/community supports represent the very essential elements of MHPSS responses in emergency settings in that they are collocated at the very foundation of the IASC pyramid and regarded as fundamental also at the EU level. As such, measures of implementation of these layers should inform the meaning of States minimum core obligation to provide an adequate response to UAC's underlying determinants of mental health.

6.4 Third Layer: Focused, non-specialised supports

The third layer of the IASC pyramid is represented by support services necessary for a smaller number of UAC who, besides receiving family and community support, require more focused individual or group interventions by trained and supervised workers.[214] This layer includes the provision of psychological first aid (PFA), namely, a set of techniques and rules that offers first-line emotional support to children experiencing acute distress and are at risk of hurting themselves or others.[215] PFA is not a service that only professional can provide but health staff, teachers or trained volunteers

[209] South Sudan hosts a total of 298,069 refugees from Sudan, 61 percent of whom are under the age of 18.

[210] Office of the United Nations High Commissioner for Refugees (UNHCR), *UNCHR's Approach to Mental Health and Psychosocial Support in Displacement*, 11 (2019).

[211] "The Classroom-Based Intervention (CBI) is a 5-week, 15-session (approximately 60-minute sessions) protocolized group intervention. CBI is an eclectic intervention based on concepts from creative-expresssive and experiential therapy, cooperative play and cognitive behavioural therapy." M. Jordans, I. Kamproe, W.A Tol, et. al, *Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial*, Journal of Child Psychology and Psychiatry, 824 (2010).

[212] M. Jordans, I. Kamproe, W.A Tol, et. al, *Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial*, Journal of Child Psychology and Psychiatry, 824 (2010).

[213] Id.

[214] Supra Note 189, at 11.

[215] WHO, Psychological Firs Aid: Guide for Field Workers (2011).

too.[216] The importance to access psychological health services is stressed not only at the UN operational level under the IASC, but also at the EU level under the RCD[217] and the EASO practical Guidance, where specific reference is made to health care and access to first aid in reception facilities.

Table 3. Operational Standards – Focused, Non-specialized support

Standard	Indicators
"Ensure access to necessary healthcare, equal to that of nationals including preventive, mental, physical and psychosocial care".[218]	- Arrangements are made to ensure access to first aid in emergencies - Healthcare is available within reception facilities or within a reasonable distance on foot or via public transport [219]

6.5 Fourth Layer: Specialised services

The last layer, the tip of the IASC pyramid, is represented by the additional support required for those UAC whose psychological suffering, despite the access to the services already mentioned, is still intolerable and interferes with their basic daily functioning.[220] Although specialised services are required only for a small percentage of UAC, in large emergencies the group of children in need of it amounts to thousands of them.[221]This layer calls for specialised psychological and psychiatric support for children with serious mental health conditions, such as depression, PTSD, anxiety etc.[222]
These serious psychological conditions experienced by UAC "*require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers*".[223] Together with IASC, the EASO practical guidance for reception conditions of UAC also establishes standard and indicators with respect to the provision of ad-hoc, specialized mental health services.[224]

Table 4. Operational Standard - Specialized Service

Standard	Indicator
"Ensure access to mental healthcare, rehabilitation services and qualified counselling for UAC who suffer from psychological difficulties […] by developing and implementing	"UAC in need of mental healthcare, […] are provided with such services by the presence of a clinical psychologist in the reception facility or the access to one outside the centre." [226]

[216] World Health Organization (WHO), *Mental Health in Emergencies*, June 2019, (https://www.who.int/news-room/), last visited (01-07-2021).

[217] RCD, Article 23 § 4: "Member States shall ensure access to rehabilitation services for minors who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts, and ensure that appropriate mental health care is developed and qualified counselling is provided when needed."

[218] Supra Note 187, at 40.

[219] Id.

[220] Supra Note 189, at 13.

[221] Id.

[222] Supra Note 189, at 13.

[223] Id.

[224] Supra Note 187, at 41.

[226] Id.

SOPs on Mental Health and Psychosocial Support (MHPSS)".[225]	

In sum, the last two layers of the IASC pyramid, focused non-specialised support and specialized support fall outside the meaning of underlying determinants of UAC's mental health since they require provision of (more or less) specialized mental health services. Therefore, State Parties have an obligation to move as expeditiously as possible toward their implementation according to available resources but seem not immediately required to implement them.

6.6 Concluding Remarks

This Chapter has shown that there is international consensus on considering the first 2 layers of the IASC pyramid - access to basic needs, security and family/community support - as the most essential elements of any MHPPS response in emergency setting.
Therefore, an adequate response to UAC's underlying determinants of mental health should be informed by measures of implementation of the first two layers of the IASC pyramid. Conversely, falling within the meaning of UAC's entitlement to appropriate mental health care, the last 2 layers trigger progressively realizable obligations that must, however, be implemented as expeditiously as possible (See Figure 4).

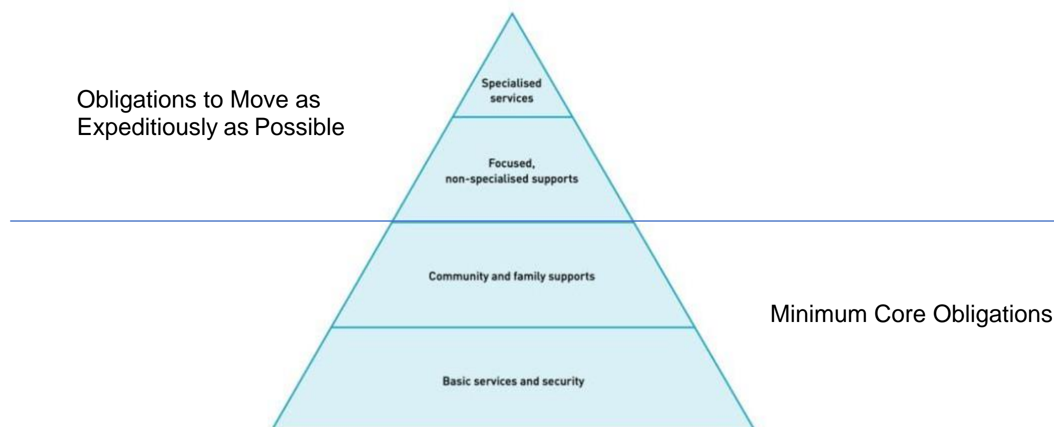

Figure 3 IASC Pyramid and Progressive Nature

The implications that derive from this finding are considerable given that an adequate response to the underlying determinants of health is described by the CRC Committee as a minimum core obligation (See Chapter 5). Therefore, access to basic needs, at least under Article 24, arguably fall out the territory of rights progressively realizable, even though it is traditionally framed as an ESC right.[227] With respect to freedom from violence, measures of immediate implementation are represented by, *inter alia*, separation between UAC and unrelated adults and monitoring access to UAC's premises. While such measures would also fall within the scope of other articles of the CRC, it is remarkable that they also fall within the meaning of Article 24 not as measures subject to available resources, but as measures that must be immediately implemented.

The same is true for family reunification, family tracing and formal and non-formal educational activities. States have an immediate obligation to put them in place also under Article 24 since they

[225] Id.

[227] Article 27 CRC.

constitute other underlying determinants of mental health to which they must provide an adequate response.

Conversely, as we move toward the third and fourth layers of the pyramid - focused non-specialized and specialised mental health services - we enter the territory of provision of mental health services, which is not an immediate obligation but subject to available resources. Remarkably, as we have seen in Chapter 2, even the provision of non-specialized or specialised mental health services can carry a component of immediate obligation when such mental health services are needed to address and respond to suicides rate. Moreover, States also have an immediate obligation to refrain from prohibiting or limiting UAC's access to mental health services based on discrimination (See Chapter 3).

In the following general conclusions, the classic tripartition of States' obligations will be integrated into the above-mentioned analysis, so as to have a clearer picture of the nature and extent of State Parties obligations with respect to UAC's right to mental health.

7. Conclusion

UAC report increased levels of psychological morbidity, especially post-traumatic stress disorder, depression and anxiety disorders. The reasons behind this unfortunate trend can be found in a multitude of factors, such as the traumatic experiences they faced during their journey to safety and/or in their country of origin and the vulnerabilities inherent in their status as children deprived of their family environment and outside their country of origin. [228]

Throughout this work, we outlined which responses the children's rights framework could offer to the above-mentioned problem, attempting to answer the research question of "what's the extent and the nature of State Parties obligations with respect to UAC's right to mental health?"

To this end, we investigated the legal position of UAC before the CRC, finding that they are not mere rights-holders of the CRC. Rather, they occupy a quite unique position, since Article 22 explicitly recognises them as entitled to special protection and humanitarian assistance necessary for an effective enjoyment of their rights under the CRC. Arguably, already in light of their entitlement to a right-plus framework, States have an obligation to provide services that respond to UAC's psychological distress. In fact, mental health conditions can impair the very enjoyments of all the provision of the CRC via impairing their enjoyment of the right to life and development.
The extreme act of suicide, on the one hand, and developmental disorders arising from their untreated mental health conditions, on the other, were taken as examples of the inherent interrelation between mental health, the right to life and the right to development.
We were therefore able to conclude that receiving States have a strong obligation to respond to UAC's mental health conditions. This is so not only in light of Article 22, but also in light of Article 6§1 and 6§2. More specifically with respect to Article 6§1, we found that the interpretation given by the Committee to the right to life encompasses not only an obligation to refrain from interfering with their right to life but also to prevent and address suicides rates. This was *inter alia* demonstrated by reference to such measures under the cluster devoted to the right to life in the revised COs.
However, the answer that States have an obligation to provide a response to UAC's mental conditions under Article 22 and 6, was only part of the answer to our research question. Indeed, the investigation of what protection Article 24 provided to the problem of UAC's high psychological morbidity, was still missing. After briefly illustrating how the meaning of health necessarily include mental health, we proceeded in discussing two of the entitlements encompassed under Article 24, namely, the entitlement to appropriate mental health care services and the entitlement to the underlying determinants of mental health (i.e., the socio-economic and environmental conditions that are conducive to mental health).

In order to understand State Parties' obligations regarding UAC's entitlement to mental health care services, we turned to a thorough analysis of selected COs, to assess to what extent the CRC Committee demanded measures of implementation in this respect. Albeit the CRC Committee explicitly recognizes UAC's entitlement to receive psychological support in its GCs, it hardly ever recommended State Parties to provide available, accessible, acceptable and quality mental health services to UAC in the COs. In fact, it explicitly referred to availability and accessibility of mental health services only in the most recent CO, the one issued against Belgium. Conversely, with respect to Turkey, it adopted a radically different approach by exhorting it to "consider" providing psychological support to UACs. More generally, we noted a lack of consistency in its recommendations which is

[228] Supra Note 20.

exemplified by the fact that, while sometimes it urged States to ensure both access to basic needs and psychological care (Colombia – displaced children), in others it limited itself to recommend the provision of basic needs (Sweden – asylum-seeking children). As such, although UAC do have an entitlement to mental health care services, the jurisprudence of the CRC Committee in its COs did not offer a clear picture or guidance on the extent of State Parties obligations in this respect.

In Chapter 4 we turned into UAC's entitlement to the underlying determinants of mental health, noting that CRC Committee does not explicitly refer to them neither in its GC on children's right to health, nor in its GCs related to children in migration contexts. The absence of guidance from the CRC Committee on the meaning of the underlying determinants of mental health called for an analysis of the current literature in the field of psychology. What we found is that access to basic needs and freedom from violence are two fundamental underlying determinants of mental health, especially for UAC.

In Chapter 5, we analysed UAC's entitlements in light of the classic tripartite typology of states obligations', trying to give sense to the obligation to respect, protect and fulfil UAC's right to mental health. We concluded that the obligation to respect embraces an obligation to provide access to mental health services without discrimination and to refrain from causing harm through actions or omissions that are likely to aggravate UAC's mental health. The ECHtR case of S.H.D v. Greece guided the finding that, *inter alia*, lack of access to basic needs may amount to a violation of States' obligations to respect UAC's right to mental health under Article 24 of the CRC (obligation to respect UAC's entitlement to mental health care and to access basic needs as an underlying determinant of mental health).

Regarding States' obligations to protect UAC, relying on the jurisprudence of the CESCR Committee, we established that State parties must adopt necessary measures to regulate the conduct of others to protect UAC against violence, in light of the great impact that becoming further victims of violence have on their mental health (obligation to protect UAC's entitlement to freedom from violence as an underlying determinant of mental health).

With respect to the obligation to fulfil, we found that State Parties are called to, *inter alia*, provide available, accessible and quality mental health services (obligation to fulfil UAC's entitlement to mental health care).

We then turned into a discussion of the progressive nature of UAC's right to mental health. We concluded that - as much as lack of resources can hamper the provision of mental health care in humanitarian contexts - States are nevertheless called to undertake immediate actions toward its implementation. Moreover, we also highlighted how States have an immediate obligation to implement minimum core obligations arising from Article 24. Finally, we found that "adequate response to the underlying determinants of health" was mentioned among the minimum core obligations of the right to health.

As such, in Chapter 6, we looked at what an "adequate response to the underlying determinants of mental health" in emergency contexts would require, *in concreto*, from State Parties. What we found is that access to basic needs, freedom from violence and family/community support, are considered the very essential elements of an adequate MHPSS response in emergency settings. Therefore, we argued that measures necessary to implement the first 2 layers of the IASC pyramid should inform the measures that States must immediately adopt in order to provide an adequate response to the underlying determinants of mental health.

However, we also noted that the full realization of UAC's mental health requires the provision of (non-) specialized mental health services, which is subject to available resources in that it is not included among minimum core obligations. At the same time, in light of what we found in Chapter 2 and 5, we also noted how the provision of mental health services is not in absolute terms an obligation of a progressive nature but can carry a dimension of immediacy as well: State Parties must not exclude

UAC from accessing mental health services based on their status (See Chapter 5) and must adopt positive measures that address suicide rates (See Chapter 2).

By assembling all the findings and conclusions we have reached throughout this thesis, we are able to summarise the nature and extent of State Parties obligations as follow:

Table 5.

<table>
<tr><th colspan="3">IMMEDIATE OBLIGATIONS</th></tr>
<tr><th></th><th>Article 24§1</th><th>Article 6§1</th></tr>
<tr><td rowspan="2">Respect</td><td>Entitlement to the Underlying Determinants of Mental Health
• Obligation to provide access to basic needs (i.e., at least 5 meals a day; 2,5 litres of safe drinking water)
See Chapter 4, 5 and 6</td><td rowspan="2">• Obligation not to arbitrary interfere with UAC's right to life
See Chapter 2</td></tr>
<tr><td>Entitlement to Appropriate Mental Health Care
• Obligation to provide access to mental health services without discrimination (i.e., not de jure or de facto exclusion of UMAs based on their status)
See Chapter 3,5</td></tr>
<tr><td rowspan="2">Protect</td><td rowspan="2">Entitlement to the Underlying Determinants of Mental Health
• Obligation to provide a reception environment free from violence (i.e. separation between adults and UMAs, control of premises)
See Chapter 2</td><td>Positive obligations against external threats to UAC's lives
• Obligation to provide a reception environment free from violence (i.e., separation between adults and UMAs, control of premises)
See Chapter 2 and Chapter 6</td></tr>
<tr><td>Positive obligations against external threats to their lives
• Obligation to prevent suicides and address suicides rates
See Chapter 2</td></tr>
<tr><td>Fulfil</td><td>Entitlement to the Underlying Determinants of Mental Health
• Social Support
(i.e., family tracing and reunification, to formal and non-formal educational activities)
→ Underlying Determinants of Health
See Chapter 6</td><td></td></tr>
</table>

As we can see, under Article 24§1 State Parties have an obligation to *respect* UAC's right to mental health by refraining from directly or indirectly interfering with UAC's entitlement to access to basic needs as an underlying determinant of mental health. As such, this obligation is of an immediate nature. The obligation to respect also requires that State Parties refrain from denying or limiting UAC's equal access to mental health services. Even though the provision of mental health care is not enlisted in the minimum core obligations, States nevertheless have an immediate obligation not to discriminate.

In sum, the obligation to *respect* responds to UAC's entitlement to access to basic needs as un underlying determinant of health and UAC's entitlement to appropriate mental health care on a non-discriminatory basis.

State Parties also have an immediate obligation to protect UAC's right to mental health against third parties by, *inter alia,* preventing violence in refugee settings. The obligation to *protect* by preventing violence is immediate in that it responds to UAC's entitlement to freedom from violence as an underlying determinant of mental health. Importantly, this obligation also falls within the scope of Article 6§1, according to which State Parties have an obligation to protect UAC against external threats to their lives. Additionally, always under Article 6§1, States have an immediate obligation to protect their right to life by preventing suicides and addressing suicides rates (internal threats to UAC's life).

Finally, State Parties have an immediate obligation to *fulfil* UAC's right to mental health by providing family/community support aimed, among the others, at family tracing, reunification or (in)formal educational activities. In fact, in Chapter 6 we found that education and restoration of their family environment constitute other two essential preconditions of UAC's mental health. Therefore, the obligation to fulfil respond to UAC's entitlement to education and restoration of their family environment as other important underlying determinants of mental health.

Table 6.

PROGRESSIVE OBLIGATIONs		
	Article 24§1	**Article 6§2**
Fulfil	*Entitlement to Appropriate Mental Health Care* • Focused non-specialized support (i.e, psychological first aid) See Chapter 5 and Chapter 6	• Focused non-specialized support (i.e, psychological first aid) See Chapter 2 and Chapter 6
	Entitlement to Appropriate Mental Health Care • Specialised Mental Services (i.e counselling, therapy etc) See Chapter 5 and Chapter 6	• Specialised Mental Services (i.e counselling, therapy etc) See Chapter 5 and Chapter 6

Finally, as we can see in Table 6, States also hold obligations of a progressive nature under Article 24 and under Article 6§2 to fulfil UAC's right to health by providing (non)specialized mental health services for UAC in distress or who experience mental health conditions for which their lives are not at risk. Their implementation must move as expeditiously as possible and, alongside the implementation of the immediate obligations, would lead to the full realization of UAC's right to mental health.

7.1 Recommendations

7.1.1. To Receiving States:

- Receiving States are recommended to comply with their international obligations arising from UAC's right to mental health. As such, they must immediately provide an adequate response to the underlying determinants of mental health, following the guidance provided by operational reports of what an the most essential level of a MHPSS response entail. Additionally, they must also immediately

comply with their obligation to refrain from limiting or denying access to mental health care services based on UAC's status and provide mental health services for UAC at serious risk of harming themselves. Furthermore, they shall move as expeditiously as possible toward the full realization of UAC's right to mental health by providing available, accessible, acceptable and quality mental health care, seeking international cooperation, where needed;

- Receiving States at the EU level are recommended to fully transpose into domestic legislation the minimum standards they have decided to be bound to in the Reception Condition Directive and the Family Reunification Directive, especially with respect to those standards most relevant in the discussion about UAC's mental health, namely, the provision of mental health services, access to basic needs, freedom from violence and community/family support;
- Receiving States are recommended to comply with the Responsibility to Protect principle, which include a responsibility to assist other States in protecting their population from genocide, war crimes, ethnic cleansing and crimes against humanity as agreed in the 2005 World Summit. Indeed, the best solution to tackle the problem of UAC's mental health morbidity (at least for those UAC who escape from conflicts in their country of origin) would eradicate its root cause and prevent that UAC will have to escape from their country of origin in the first place.

7.1.2. To the CRC Committee

- The CRC Committee is recommended to organize a Day of General Discussion and to draft a General Comment on children's right to mental health in order elaborate concrete responses to urging and open issues, such as:
What are States' obligations to respect, protect and fulfil children's right to mental health?
Which are the minimum core obligations with respect to children's right to mental health?
What are to be considered underlying determinants of mental health?
What does it mean that States have an immediate obligation to provide "an adequate response" to the underlying determinants of mental health?
In part, this worked proposed possible starting points of discussion or answers to the above-mentioned questions. However, further elaboration is needed from the part of the Committee.

- Throught this thesis, it appeared evident how language contributes to shaping reality. The inconsistent approach adopted by the CRC Committee in the revised COs created opacity regarding the extent and nature of State Parties obligations.
Therefore, the CRC Committee is recommended to consistently investigate the measures taken by receiving States under review in terms of adequate response to the underlying determinants of mental health and the provision of available, accessible, acceptable and quality mental health services for UAC. With respect to the provision of mental health care, although it is an obligation of progressive realization, the Committee should distance itself from the language used in its COs to Turkey, exhorted to "consider" providing psychological support to asylum seeking children.
It should instead adopt a language that is appropriate to UAC's entitlement to appropriate mental health care. In this respect, it could find inspiration and remain consistent to the approach adopted in the recent COs issued against Belgium or the CO issued against Colombia (albeit reference was made to displaced children).

- Always with respect to language choices and future advisable approaches, it is interesting to note that in the list of issues for the coming periodic reports of Greece, the CRC Committee asked the State to "[c]larify the efforts being taken to […] prevent and effectively address psychological distress and

cases of violence and self-harm" of migrant children.[229] However, in the previous paragraphs, not dedicated to children in migration context, the formula "please provide information on: measures taken to prevent and address suicide among children" was preferred. This difference risks conveying the message that State Parties' obligations with respect the right to mental health of children in migration contexts are always of progressive nature. Conversely, throughout this work we highlighted that this is not always the case. Therefore, the CRC Committee is recommended to pay particular attention in adopting a language not conducive of misunderstandings.

7.1.3. To Civil Society Organisations:

Civil Society Organization are recommended to influence governments to put children's mental health, especially that of UAC, high in their agendas. The contemporary historic and political context is particularly favourable to achieve this goal. Indeed, Covid-19 has highlighted the fundamental role played by mental health in children's lives and the greater vulnerability to psychological conditions experienced by children coming from disadvantaged positions. Moreover, investing in mental health of children in migration contexts can be presented as an opportunity to reduce the high social and economic cost of mental health, enhancing productivity and decreasing the risk of antisocial behaviour which is one of the externalising symptoms of mental health problems.

[229] List of issues in relation to the combined fourth to sixth periodic reports of Greece, para 10, CRC/C/GRC/Q/4-6.

Annex 1: Asylum Applicants Considered to be UAC in Europe

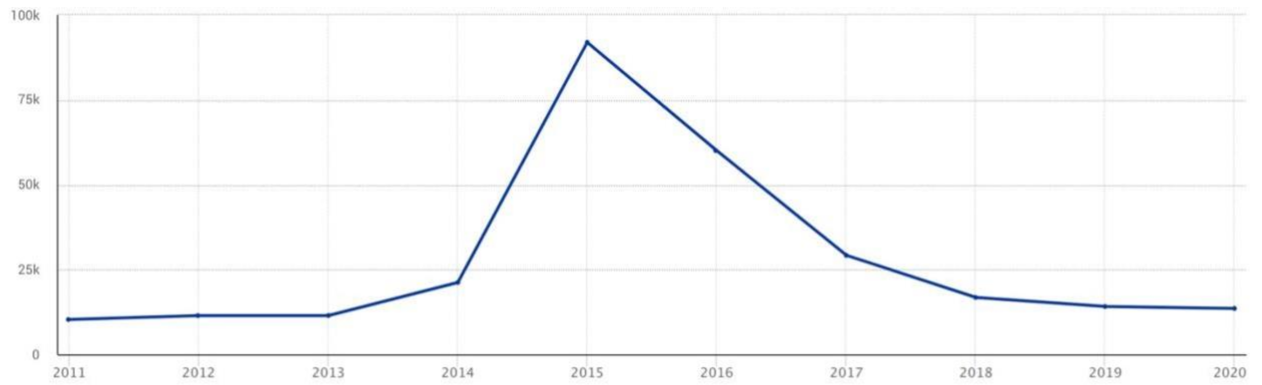

Figure 4, Source Eurostat

Annex 2: COs to BELGIUM, CRC/C/BEL/CO/5-6, 2019

Found by words "Psycho" AND "Mental"

CLUSTER: G. Disability, basic health and welfare (arts. 6, 18 (3), 23, 24, 26, 27 (1)–(3) and 33)
Para 32 "The Committee is also concerned that: […]
(a) There is insufficient timely and accessible primary psychological assistance, while medication and placement in psychiatric care are commonly used to treat psychological problems;
(c) Seeking mental health care is negatively perceived;
(d) There is a lack of *psychological* support and *mental health* care for *refugee* and migrant children".

Found by words "Psycho" AND "Mental" AND "Refugee"

Para 33. "Taking note of target 3.4 of the Sustainable Development Goals, the Committee recommends that the State party:
(a) Undertake studies on the causes and prevalence of stress, suicide and attention deficit hyperactivity disorder among children and, on the basis of the results of those studies, take comprehensive measures to effectively address these phenomena, including by means of psychological, educational and social measures and therapies.
(c) Conduct awareness-raising programmes, including campaigns to promote a positive image of mental health care, and encourage children to seek psychological support whenever needed;
(d) Ensure access to psychologists, psychiatrists and specialized therapists, as well as interpreters and intercultural mediators, for refugee and migrant children, including in shelter settings."

Cluster: I. Special measures of protection (arts. 22, 30, 32–33, 35–36, 37 (b)–(d) and 38–40)
<u>Follow-up to previous concluding observations and recommendations on the Optional Protocol on children in armed conflict</u>
*Para 50*The Committee […] recommends that the State party:
(a) Develop and implement identification mechanisms for children who have been involved in or affected by armed conflict, including asylum-seeking and migrant children;
(c) Ensure that the children concerned are treated as victims of trafficking in the context of armed conflict exploitation for criminal purposes, in accordance with Security Council resolution 2331 (2016), and are protected from retaliation and new recruitment and **provided with the necessary assistance,** rehabilitation and reintegration, including psychosocial support and legal aid;

Found by words "Unaccompanied"

Cluster: I. Special measures of protection (arts. 22, 30, 32–33, 35–36, 37 (b)–(d) and 38–40)
<u>UAC</u>
Para 42. With reference to the Committee's general comment No. 6 (2005) on the treatment of unaccompanied and separated children outside their country of origin, the Committee recommends that the State party:
(b) Effectively investigate cases of abuse with regard to UAC;
(c) Strengthen immediate protection measures for all UAC, and ensure systematic and timely referral to the guardianship service;
(d) Improve the provision of shelter to UAC, including by ensuring the availability of the youth welfare system and foster care for all UAC, regardless of their age.

44. With reference to joint general comments No. 3 and No. 4 (2017) of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families/No. 22 and No. 23

(2017) of the Committee on the Rights of the Child on the human rights of children in the context of international migration, the Committee reiterates its previous recommendation (CRC/C/BEL/CO/3-4, para. 77) and urges the State party:

(c) Take effective measures to safeguard children's rights in its territory, in particular those of UAC, to ensure that children do not fall prey to traffickers, and expedite status determination procedures for children who may be victims of trafficking for the purposes of exploitation;

Annex 3: COs to BULGARIA, CRC/C/BGR/CO/3-5, 2016.

Found by words “Psycho“ AND “Mental”

Cluster: F. Disability, basic health and welfare (arts. 6, 18 (3), 23, 24, 26, 27 (1)-(3) and 33)
Mental health
Children with disabilities
Para 38. […] it is concerned that:
(e) Inclusion of children with intellectual and psychosocial disabilities remains unsatisfactory due to a lack of trained specialists, including speech therapists, mental health professionals and psychologists.

Cluster: F. Disability, basic health and welfare (arts. 6, 18 (3), 23, 24, 26, 27 (1)-(3) and 33)
Mental health
Para 42. The Committee notes certain measures taken by the State party to address mental health issues and particularly welcomes the combined educational and social measures adopted for treating children with behavioural problems. The Committee is, however, concerned about the shortage of qualified child psychiatrists and community-based mental health services.

Para 43. The Committee recommends that community-based mental health services be made readily **available** and preventive work in schools, the home and care centres be strengthened. It also recommends that the **number of child psychiatrists and psychologists be increased.**

Found by words “Psycho” AND “Refugee” AND “Unaccompanied”

Cluster: H. Special protection measures (arts. 22, 30, 32, 33, 35, 36, 37 (b)-(d), 38-40)
Follow-up to the Committee’s concluding observations on the Optional Protocol to the Convention on children in armed conflict (CRC/C/OPAC/BGR/CO/1)
65. The Committee welcomes the State party’s decision to abolish obligatory military conscription, in 2008, and the fact that children under the age of 18 years are not permitted to serve in the Bulgarian armed forces. However, the Committee regrets the lack of information provided on measures taken to:

(c) Ensure that psychological assistance, rehabilitation and reintegration into society is provided for asylum-seeking, refugee and migrant children, including UAC, who may have been involved in armed conflicts or recruited for hostilities abroad.

Found by words “*Unaccompanied” AND “Psycho”*
Cluster: H. Special protection measures (arts. 22, 30, 32, 33, 35, 36, 37 (b)-(d), 38-40)

Asylum-seeking and refugee children
50. While welcoming the State party’s continued cooperation with the Office of the United Nations High Commissioner for Refugees and the efforts made to improve reception facilities and the registration process for asylum seekers and refugees, the Committee is concerned that:
(b) Owing to lack of space in reception centres, in some cases, unaccompanied asylum-seeking children are placed in rooms with adults; in addition, reports suggest that overcrowding and poor hygiene place children at risk;

51. In the light of general comment No. 6 (2005) on treatment of unaccompanied and separated children outside their country of origin, the Committee recommends that the State party:
(a) Ensure that sufficient provisions are made to prevent unaccompanied asylum-seeking children from being placed in rooms with unrelated adults;

Follow-up to the Committee's concluding observations on the Optional Protocol to the Convention on children in armed conflict (CRC/C/OPAC/BGR/CO/1)

65. The Committee welcomes the State party's decision to abolish obligatory military conscription, in 2008, and the fact that children under the age of 18 years are not permitted to serve in the Bulgarian armed forces. However, the Committee regrets the lack of information provided on measures taken to:
(c) Ensure that psychological assistance, rehabilitation and reintegration into society is provided for asylum-seeking, refugee and migrant children, including UAC, who may have been involved in armed conflicts or recruited for hostilities abroad.

Annex 4: COs to UK, CRC/C/GBR/CO/5, 2016.

Found by words - "Psycho" AND "Refugee" AND "Unaccompanied"

CLUSTER: I. Special protection measures (arts. 22, 30, 32, 33, 35, 36, 37 (b)-(d) and 38-40)
Asylum-seeking, refugee and migrant children
Para 77. With reference to its general comment No. 6 (2005) on treatment of unaccompanied and separated children outside their country of origin, the Committee recommends that the State party:
(c) Conduct age assessments only in cases of serious doubt through multidisciplinary and transparent procedures, taking into account all aspects, including the psychological and environmental aspects of the person under assessment;

Found by word "Mental"

Cluster: G. Disability, basic health and welfare (arts. 6, 18 (3), 23, 24, 26, 27 (1)-(3) and 33)
Mental health
61. The Committee recommends that the State party:
(a) Regularly collect comprehensive data on child mental health, disaggregated across the life course of the child, with due attention to children in vulnerable situations and covering key underlying determinants;
(b) Rigorously invest in child and adolescent mental health services and develop strategies at the national and devolved levels, with clear time frames, targets, measurable indicators, effective monitoring mechanisms and sufficient human, technical and financial resources. Such strategy should include measures to ensure availability, accessibility, acceptability, quality and stability of such services, with particular attention to children at greater risk, including children living in poverty, children in care and children in contact with the criminal justice system;
(c) Expedite the prohibition of placing children with mental health needs in adult psychiatric wards or police stations, while ensuring the provision of age- appropriate mental health services and facilities;
(d) Support and develop therapeutic community-based services for children with mental health conditions;
(e) Review current legislation on mental health to ensure that the best interests and the views of the child are taken duly into account in cases of mental health treatment of children below the age of 16 years, in particular with regard to hospitalization and treatment without consent.

Found by word "Unaccompanied"
Cluster: I. Special protection measures (arts. 22, 30, 32, 33, 35, 36, 37 (b)-(d) and 38-40)
Asylum-seeking, refugee and migrant children
77. With reference to its general comment No. 6 (2005) on treatment of unaccompanied and separated children outside their country of origin, the Committee recommends that the State party:
(e) Review its asylum policy in order to facilitate family reunion for
unaccompanied and separated refugee children within and outside of the State party, including through implementation of the European Union Dublin III Regulation.

Annex 5: COs to SWEDEN 2015 CRC/C/SWE/CO/5

Found by words "Psycho" AND "Mental"

Cluster: D. Violence against children (arts. 19, 24, para. 3, 28, para. 2, 34, 37 (a) and 39)
Abuse and neglect
Para 28. The Committee recommends that the State party take all the necessary measures to […]
(e) To ensure that children who have suffered violence and abuse have sufficient access to adequate physical and psychological care.

44. The Committee urges the State party to establish a system of independent expert monitoring of the diagnosis of ADHD and other behavioural specificities, and of the use of drug treatments for the children diagnosed; and to:
(b) Ensure that appropriate and scientifically based psychological counselling and specialist support for children, their parents and teachers is given priority over the prescription of drugs in addressing ADHD and other behavioural specificities.

46. The Committee recommends that the State party increase the resources available for school health services, to ensure that children have access to, and receive appropriate, psychosocial and mental health support and psychiatric health care in a timely manner, as previously recommended by the Committee on the Rights of Persons with Disabilities (see CRPD/C/SWE/CO/1, para. 18).

Found by words "Asylum" *AND "Mental"*

Cluster: **F. Disability, basic health and welfare (arts. 6, 18 (para. 3), 23, 24, 26, 27 (paras. 1-3) and 33)**
Health and health services
41. While welcoming the provision of equitable health care for asylum-seeking children, the Committee is concerned that there continue to be considerable disparities in the physical and mental health of children from different economic backgrounds.

Mental health
44. The Committee urges the State party to establish a system of independent expert monitoring of the diagnosis of ADHD and other behavioural specificities, and of the use of drug treatments for the children diagnosed; and to:

Cluster: G. Special protection measures (arts. 22, 30, 32-33, 35-36, 37 (b)–(d), 38– 39 and 40)
Asylum-seeking and refugee children
50. The Committee urges the State party to take prompt measures to ensure that if children are to be returned to their country of origin, the principle of non-refoulement is always respected. Furthermore, the Committee recommends that the State party:
(e) Expedite the processing of asylum applications and ensure that all asylum-seeking children are fully provided with basic necessities, in particular adequate clothing and personal hygiene articles, as well as all the necessary school materials.

Annex 6: COs to Colombia, CRC/C/COL/CO/4-5, 2015

Found by word “Refugee”

III. Main areas of concern and recommendations
G. Special protection measures (arts. 22, 30, 32, 33, 35, 36, 37 (b)–(d) 38, 39 and 40)
Displaced children
56. The Committee recommends that the State party:
(d)Further strengthen its cooperation with the Office of the United Nations High Commissioner for Refugees and fully adhere to the Guiding Principles on Internal Displacement (E/CN.4/1998/53/Add.2).

Found by words “Psychological”

C. Violence against children (arts. 19, 24, para. 3, 28, para. 2, 34, 37 (a) and 39)
Freedom of the child from all forms of violence
28. the Committee urges the State party to prioritize the elimination of all forms of violence against children, and in particular to:
(g) Ensure the availability and quality of prevention, protection, rehabilitation and reintegration programmes, including health services and psychosocial support, free helplines and appropriate shelters for all victims;

E. Disability, basic health and welfare (arts. 6, 18, para. 3, 23, 24, 26, 27, paras. 1–3, and 33)
Mental health
41. While noting the measures taken by the State party to address mental-health problems among children, the Committee is concerned that many children suffer from mental-health problems. It is also concerned about the increasing prevalence of suicide among children, in particular adolescents and indigenous children.

G. Special protection measures (arts. 22, 30, 32, 33, 35, 36, 37 (b)–(d) 38, 39 and 40)
56. The Committee recommends that the State party:
(a) Evaluate the “mobile units” strategy and similar initiatives and, based on lessons learned and in line with the Constitutional Court decisions, strengthen measures to protect displaced children and their families from violence, and ensure their access to food, adequate housing, education, recreation, health, civil registration, justice and integrated mental health and psychosocial rehabilitation services. Resources should be increased and monitoring mechanisms and coordination among relevant bodies strengthened;
Follow-up to the Committee’s previous concluding observations and recommendations on the Optional Protocol on children in armed conflict

Found by word “*Mental”*

E. Disability, basic health and welfare (arts. 6, 18, para. 3, 23, 24, 26, 27, paras. 1–3, and 33)
Mental health
41. While noting the measures taken by the State party to address mental-health problems among children, the Committee is concerned that many children suffer from mental-health problems. It is also concerned about the increasing prevalence of suicide among children, in particular adolescents and indigenous children.

42. The Committee recommends that the State party strengthen the mental-health programmes for children and provide quality services, taking into consideration the culture of indigenous children, and:

(a) Urgently conduct an in-depth study to analyse the root causes of suicide and other mental-health problems among children, with special focus on adolescents, as a basis for the adoption of a comprehensive strategy of prevention and early intervention. The Committee also recommends that counselling services be provided in schools and communities and that awareness-raising activities be carried out to prevent mental-health problems and suicide;

(b) Take measures to increase the number of multidisciplinary teams and specialists in children's mental health, including for eating disorders, and to provide proper facilities, and outpatient services, for psychosocial rehabilitation;

(c) Ensure that all professionals working with children are trained to identify and address mental-health problems, including suicidal tendencies, in particular in schools, alternative-care settings, displaced communities, indigenous communities and juvenile detention centres.

Annex 7: COs to Yemen, CRC/C/YEM/CO/4, 2014

Found by word "Psychological".

IV. Main areas of concern and recommendations

Cluster: F. Disability, basic health and welfare (arts. 6, 18 (3), 23, 24, 26, 27 (1–3) and 33 of the Convention)
Mental health
62. The Committee urges the State party to adopt effective measures to address the mental-health condition of children suffering trauma and other psychological disorders in conflict-affected areas. This should include community-based efforts to identify affected children and provide accessible services at local level.

Found by words "Refugee" AND "*Unaccompanied"* AND "*Mental*"

Cluster: H. Special protection measures (arts. 22, 30, 32–33, 35–36, 37 (b)–(d), 38, 39 and 40 of the Convention)
Asylum-seeking and refugee children
75. It is further concerned at:
(c) Cases of sexual violence against refugee, asylum-seeking and internally displaced children;
76. The Committee recommends that the State party adopt a comprehensive legal framework in line with international standards for refugees and asylum seekers, and develop an efficient and well-founded cooperation mechanism with the Office of the United Nations High Commissioner for Refugees to identify and provide assistance to children in need of protection, especially unaccompanied refugee and asylum-seeking children. The Committee also urges the State party to:
(c) Ensure the provision of adequate medical treatment, mental health care and psychosocial support to refugee, asylum-seeking and internally displaced children who fall victim to sexual violence;

Annex 8: COs to Turkey, CRC/C/TUR/CO/2-3, 2012

Found by words "Refugee" AND "Psychological"

III. Main areas of concern and recommendations
Cluster: H. Special protection measures (arts. 22, 30, 38, 39, 40, 37 (b)-(d), 32-36 of the Convention)

Asylum-seeking and refugee children

61. In accordance with the Guidelines on protection and care of refugee children, issued by the Office of the United Nations High Commissioner for Refugees (UNHCR), the Committee
recommends that the State party ensure that every effort is made to identify children who require special support on their arrival in the State party, and consider providing adequate psychological assistance to them. The Committee encourages the State party to seek technical assistance from UNHCR.

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