5

Mental Health, Irregular Migration and Human Rights

Synergising Vulnerability- and Disability-Sensitive Approaches

This book employs the wording 'right to health' to cover freedoms and entitlements in relation to both 'conditions and services that are conducive to a life of dignity and equality, and non-discrimination in relation to [physical and mental] health'.[1] While there is a general consensus among public health and human rights practitioners that there is 'no health without mental health', the latter remains largely underfunded in state health budgets and is undoubtedly a neglected element of what is included in the scope of the right to health.[2] Nonetheless, human rights scholarship and bodies have, over the last twenty years, increasingly helped to shape the normative content of the right to mental health, which has included harmonising it with newly established international disability law.[3] In reviewing the consistency of the human rights law approach to irregular migrant health – in which authoritative public health and disability standards are embedded – mental health, which exceeds 'the absence of mental disorders', and related disabilities must not be sidelined.

Migration, as mentioned in Chapter 4, is a determinant of health in itself, as it constitutes 'a process of social change where individuals face a degree of

[1] Dainius Pūras, 'Report of the Special Rapporteur on the Right to [...] Health (Focus: the Role of the Determinants of Health in Advancing the Right to Mental Health)' (12 April 2019 A/HRC/41/34, para 11.

[2] WHO, 'Mental Health: Strengthening our Response', factsheet (30 March 2018) <www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response> accessed 16 February 2021; a world average of 2 per cent of health expenditure is for mental health, with significant variations between regions of the world, see WHO, 'Mental Health Atlas 2017' (WHO Publishing 2018) 26.

[3] Paul Hunt, 'Report of the Special Rapporteur on the Right to [...] Health (Focus: Mental Disability and the Right to Health)' (11 February 2005) E/CN.4/2005/51, para 6; Dainius Pūras, 'Report of the Special Rapporteur on the Right to [...] Health (Focus: the Right to Mental Health' (28 March 2017) A/HRC/35/21, para 6.

change and [...] adjustment' to new conditions of living.[4] Changing language, leaving behind family and social networks and adjusting to a set of social norms in the new country setting and to a potentially lower socio-economic status, are among the several factors that can contribute to the stress of 'transculturation'.[5] While many persons in a situation of human mobility have resilience and adequate coping strategies against these challenges, others, who may be exposed to an interplay of particularly unfavourable social, economic and environmental factors, exacerbated by their migratory status (e.g. social exclusion, fear of deportation, poor living conditions, unsafe and informal working environments and restricted access to basic services), may not be able to navigate these challenges and may be at heightened risk of experiencing mild to severe psychological suffering and mental disorders as a result.[6]

Against this background, any regulatory framework, at different levels of governance, may either create oppressive power structures or 'function as [...] personal protector[s] and important vehicle[s] of social justice'.[7] For these reasons, examining the normative potential of human rights law, which is the only source of law that permits international scrutiny of domestic law, policy and practices that positively or negatively affect migrant mental health, is an exercise worth conducting.[8]

Therefore, to clarify what human rights law can offer, in terms of standard setting and avenues for international legal development and protection, to those irregular migrants who experience either mental health difficulties or have a psychosocial disability,[9] this chapter is structured as follows. Section 5.1 aims to clarify certain complex definitional and classification issues that are required when undertaking an analysis of the fields of mental health and disability law. It details how the conceptual framings and normative principles of all previous chapters (including non-discrimination, vulnerability, PHC and the determinants of health) are valid descriptive and prescriptive lenses

[4] Dinesh Bhugra and Susham Gupta (eds) *Migration and Mental Health* (CUP 2010) 337.

[5] Marco Mazzetti, *Strappare le radici: Psicologia e psicopatologia di donne e di uomini che migrano* (L'Harmattan Italia 1996); Marco Mazzetti, *Il dialogo transculturale: Manuale per operatori sanitari e altre professioni d'aiuto* (Carocci 2003).

[6] WHO and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health* (WHO Publishing 2014); WHO Regional Office for Europe, *Mental Health Promotion and Mental Health Care in Refugees and Migrants (Technical Guidance)* (WHO Publishing 2018).

[7] Gostin et al. (n 37, Introduction) Preface, v.

[8] Gable and Gostin (n 37, Introduction) 104.

[9] Following the guidance of the OHCHR and CRPD Committee, this chapter mainly employs the term 'psychosocial' disability instead of 'mental' disability. The reasons for this choice are explained in Section 5.1.1.

to apply a more holistic approach to the individual and collective right to the mental health of all migrants. The chapter then explores the human rights model of disability, as is enshrined in the UN CRPD, which represents an empowering and transformative approach to substantive equality and non-discrimination in relation to mental health and disabilities. To smoothly transition from introductory reflections to the core of the chapter, Section 5.2 details how pieces of human rights jurisprudence address the key relationships between mental health and human rights outside of the migrant-specific perspective. Sections 5.3 and 5.4 examine whether European and international human rights law and key human rights bodies consider the impact of human rights violations on migrant mental health and how they elaborate on the standards of mental health care and support for all, regardless of migratory status. Emergency-oriented decisions are examined alongside a human rights jurisprudence that supports preventive and promotional approaches to irregular migrants' mental health that are genuinely non-discriminatory, rights-based, community-oriented, disability-sensitive and equitable.

5.1 APPROACHING THE HUMAN RIGHT TO MENTAL HEALTH IN THEORY AND PRACTICE

5.1.1 *Definitional Challenges*

The WHO defines mental health as 'a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'.[10] The international right to mental health corresponds to the freedoms and entitlements necessary to achieve the 'highest attainable standard' of this condition, which is influenced by both biological, environmental, social and institutional factors.[11] Defining the scope of the analysis conducted in this chapter on mental health (issues) and psychosocial disabilities, with respect to irregular migration, is a challenge in itself, as different disciplines and schools within the fields of psychiatry, psychology, public health, law, human rights and disability studies do not share common ethical approaches, methodology and definitions.

[10] WHO, 'Strengthening our Response' (n 2). This definition has attracted criticism, see Silvana Galderisi et al., 'Toward a New Definition of Mental Health' (2015) *World Psychiatry* 14(2) 231.

[11] See *infra* at Sections 5.2.3 and 5.4.2.

Differences and nuances exist between terms such as mental health, mental disorder and mental disability[12] and although this thematic analysis cannot comprehensively capture these differences, the terminology employed in this chapter is worth explaining. International human rights law, reflecting disability and mental health users advocacy, has gradually shifted from employing words such as 'mental illness' or 'disorders' to describing the conditions of certain mental health service users,[13] which imply pathological processes that necessitate exclusively medical and at times institutionalised cures, to using a less stigmatising vocabulary such as persons with mental health issues and psychosocial disabilities.[14] Persons with mental health issues covers 'both persons having mental health difficulties and persons who are deemed or labelled with mental health difficulties'.[15] Furthermore, the Office of the United Nations High Commissioner for Human Rights (OHCHR) uses 'psychosocial' as an adjective to describe a disability with regard to persons who, 'regardless of self-identification or diagnosis of a mental health condition, face restrictions in the exercise of their rights and barriers to participation on the basis of an actual or perceived impairment'.[16] While this terminology is employed as a synonym of 'mental' disability in human rights law,[17] 'psychosocial' disability has the advantage of emphasising the societal barriers encountered by people with actual or perceived mental health conditions.[18] Furthermore, the term 'mental disability' may generate confusion; first, it is used to refer to 'both persons with intellectual disabilities and persons with mental health conditions', and second, 'in disability literature [of the recent

[12] Hunt (n 3) para 4.
[13] Ibid.
[14] Pūras (n 3).
[15] Bo Chen, *Rethinking China's Mental Health Law Reform: Treatment Decision-Making and the UN Convention on the Rights of Persons with Disabilities*, PhD thesis, NUI Galway, August 2019, 12.
[16] OHCHR, 'Report of the United Nations High Commissioner for Human Rights on Mental Health and Human Rights' (31 January 2017) A/HRC/34/32, para 5.
[17] Hunt (n 3); CRPD (n 36, Introduction) Article 1; CRPD Committee, COs on the Report of Denmark (30 October 2014) paras 5, 48–49. Since 2015, the CRPD Committee's COs stopped using 'mental disabilities' and instead started to employ 'psychosocial and intellectual disabilities'.
[18] There may be *overlaps* between categories of irregular migrants who are potential mental health service users, people with mental health conditions and persons with psychosocial disabilities, but *differences of meaning* exist as 'a user of mental health services may not have a mental health condition and some persons with mental health conditions may face no restrictions or barriers to their full participation in society', see OHCHR (n 16) para 5.

past], mental disability is more likely to be perceived as a transitional term after "mental retardation" but before "intellectual disability"".[19]

A further clarification is required on the use of 'psychosocial'. It is also employed to refer to any non-biomedical intervention, such as the provision of basic services, community support or psychological care in primary care settings, 'that aims to protect or promote psychosocial well-being' outside of psychiatric drugs and care.[20]

While introducing, albeit briefly, a number of concepts, conventional categories and constructs that public health and human rights studies employ, it is worth acknowledging that diversity in terminology may be welcomed to accord people the freedom to 'define their own experience of mental health'.[21] This also has the effect of extending the plethora of human rights standards and arguments to hold states to account for the realisation of the right to mental health of individuals and populations while avoiding discrimination and respecting people's equality, dignity and autonomy.

I will now summarise the diverse approaches that scholars and practitioners in the fields of health, disability and human rights employ when discussing mental health and disability. These include the (bio)medical approach, the social model, the biopsychosocial paradigm and the human rights approach to health, functioning and disabilities.

A purely (bio)medical model of mental health, which dominates mental health services worldwide, emphasises 'neurobiological aspects and processes as the explanation for mental conditions' and, in the case of 'mental disorders', the need to fix chemical imbalances via psychiatric treatment complemented with psychotherapy[22] for the health, security and well-being of the patient and society at large. Furthermore, this model inextricably links impairment and disability, which are considered biological and pathological states[23] to 'be treated, cured, fixed or at least rehabilitated'.[24] Medical paternalism and 'sanism' have dominated this orthodox approach to mental health care and

[19] Chen (n 15) 11. This chapter's personal scope, to avoid overgeneralisations, does not cover persons with intellectual disabilities. However, several considerations and arguments developed below may apply to the right to health of persons with both an irregular status and an intellectual disability.

[20] Inter-Agency Standing Committee, 'IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings' (IASC 2007) 15.

[21] Pūras (n 1) para 10.

[22] Pūras (n 3) para 18.

[23] Mike Bury, 'Defining and Researching Disability: Challenges and Responses' in Colin Barnes and Geof Mercer (eds) *Exploring the Divide: Illness and Disability* (The Disability Press 1996) 17–38.

[24] Theresia Degener, 'Disability in a Human Rights Context' (2016) *Laws* 2016 35(5) 2.

the law.[25] The operationalisation of this model has historically proven particularly problematic in relation to human rights law, as it is grounded on an accepted power imbalance between patient and carer and between disabled person and their substitute decision maker. This can lead to interventions such as involuntary admission to and detention in mental health institutions, involuntary treatment (including overmedicalisation) and deprivation of the legal capacity of people with psychosocial and intellectual disabilities. Therefore, it is incompatible with general human rights principles – such as autonomy and equal dignity, which have informed human rights adjudication – and is in contravention to the object and purpose of the widely ratified CRPD.[26]

The medical model has been harshly criticised by the proponents of the social model of disability, which frames disability as a social construct that facilitates domination and discrimination against persons with disabilities perpetuated by the society of the so-called able-bodied (and able-minded) at the expense of those who do not fit into a model of mainstream socially acceptable life experience.[27] This approach unveiled an oppressive social and institutional order 'which takes no or little account of people who have [physical or mental] impairments and thus excludes them from participation in the mainstream of social activities'.[28] The social model of disability has helped to 'debunk exclusion and denial of rights on the basis of impairment as ideological constructions of disability'[29] by focusing on the role of a prejudiced social environment rather than that of impairment[30] in disabling people from fitting in and contributing to society.

A third possible approach is the biopsychosocial model of mental health, which integrates elements of the above two paradigms and has been embraced by the WHO in the last two decades, in a move away from a purely medical

[25] Michael Perlin, *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (OUP 2012) 8. Perlin describes 'sanism' as 'an irrational prejudice against people with mental illness' that affects social perceptions of and legal responses to people who experience mental health conditions, see Michael Perlin, 'On "Sanism"' (1993) *SMU Law Review* 46 373.

[26] See Section 5.1.3, *infra*.

[27] See Michael Oliver, *Understanding Disability: From Theory to Practice* (St. Martin's Press 1996).

[28] Ibid, 32.

[29] Degener (n 24) 19.

[30] For a critical analysis of the unsettled impairment/disability divide, see Mike Oliver 'Defining Impairment and Disability: Issues at Stake' in Colin Barnes and Geof Mercer (eds) *Exploring the Divide* (Disability Press 1996) 39–54; Michael Rembis, 'Challenging the Impairment/Disability Divide: Disability History and the Social Model of Disability' in Nick Watson and Simo Vehmas (eds) *Routledge Handbook on Disability Studies* (Routledge 2020).

model approach that has historically been in place. Without neglecting the relevance of an impairment in the experience of disability, which may necessitate appropriate health care, this model also emphasises the relationship between the psychological aspects of life experience and the importance of supportive relationships and healthy contexts in the community.[31] The 2001 WHO International Classification of Functioning, Disability and Health generally endorses this model by 'recognising the [dynamic] role of environmental factors in the creation of disability, as well as the role of health conditions'.[32] Like all aspects of health, the determinants of mental health are constituted by a range of biological, psychological, social and environmental factors.[33]

The most recent model is the human rights model of disability, which was built largely on the social model of disability championed by the 2006 CRPD. The stated purpose of the CRPD is 'to promote, protect and ensure the "full" and "equal" enjoyment of all human rights [. . .] by all persons with disabilities, and to promote respect for their inherent dignity'. People with disabilities, including people with mental disabilities, are now explicitly recognised in the groundbreaking CRPD treaty text as individuals endowed with dignity and full legal capacity and not as passive recipients of care and cures. This treaty is a contemporary ode to equality and non-discrimination on the grounds of disability in the full enjoyment of human rights – although it does not neglect other personal statuses and circumstances which exacerbate stigma and discrimination – that entails the adoption of positive measures to guarantee substantive equality, structural change and contextual adjustments at the group and individual levels.[34] Impairments are not dismissed in this model; in fact, like disability, they should in principle trigger a number of positive state duties in the social sphere without undermining individual

[31] International Federation of Red Cross and Red Crescent Societies, 'Strengthening Resilience: A Global Selection of Psychosocial Interventions' (Centre for Psychosocial Support – IRCRC 2014) <https://pscentre.org/wp-content/uploads/2018/02/Strengthening-Resilience.pdf>; International Network for Education in Emergencies, 'Psychosocial Support and Social and Emotional Learning for Children and Youth in Emergency Settings', Background Paper (2016) <https://reliefweb.int/sites/reliefweb.int/files/resources/INEE.pdf> accessed 1 March 2021.

[32] T. B. Üstün et al., 'The International Classification of Functioning, Disability and Health: A New Tool for Understanding Disability and Health' (2003) *Disability and Rehabilitation* 25 (11–12) 565.

[33] WHO, 'Mental Health Action Plan 2013–2020' (6 January 2013) 7 <www.who.int/publications/i/item/9789241506021> accessed 1 March 2021.

[34] CRPD (n 36, Introduction) Preamble, Articles 1–5.

autonomy. Unlike the social model, this model frames social rights as potentially empowering tools and not merely charity provisions.[35]

Demonstrating its grounding in the social model, the CRPD's Preamble describes disability as an 'evolving concept' that 'results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on equal basis with others'. The 'definition' is further qualified in Article 1 CRPD, which adds that disabled people '*include* those who have *long-term* physical, mental intellectual or sensory impairments'.[36]

While mental disabilities are explicitly listed and the word 'include' suggests that other types of impairment are covered by the scope of the Convention, mention of the long-lasting duration of the 'impairment' leaves room for discretionary state interpretation in cases of transitory mental conditions.[37] This has caused the UN special rapporteur on the right to health to distinguish between 'users of [mental health] services' and people who have 'psychosocial disabilities'. For him, the former category includes those who 'experience occasional and short-lived psychosocial difficulties or distress that require additional support' and, at minimum, triggers the protection of general human rights law, including reasonable social rights without discrimination. The latter, 'based on the barriers they face' because of their disability, are more likely to be covered by the transformative equality standards of the CRPD.[38] However, such a distinction is more nuanced in practice, and the CRPD, with the purpose of extending its protective material and personal scope as much as possible, does not attempt to provide an exhaustive definition of disability. Indeed, 'including long-term [...] impairments' does not fully exclude short-term impairments and also means that impairment does not have to be permanent to be covered by the CPRD: 'an injury or a psychiatric episode that requires an extended period of rehabilitation but leaves no ongoing impairment would count'.[39]

Health, impairment and disability are dynamic concepts that vary across time, cultures and societies,[40] as well as across individual human experiences and regulatory frameworks.

[35] Degener (n 24) 5–7.

[36] CRPD (n 36, Introduction) Preamble, recital (e) and Article 1, emphasis added. The CRPD intentionally does not technically 'define' disability but instead provides a non-exhaustive wide list of those who may be considered disabled.

[37] Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) *Modern Law Review* 75(5) 752, 758.

[38] Pūras (n 3) para 4.

[39] Kris Gledhill, 'Disability Law and Mental Health' in Gostin et al. (n 37, Introduction) 923.

[40] Benedicte Ingstad and Susan R. Whyte (eds) *Disability and Culture* (University of California Press 1995).

5.1.2 *Theoretical Grounding: The Concepts of Vulnerability and Disability as Tools of Substantive Equality*

This chapter extends the theoretical and legal scope of this book to cover the rights of persons with disabilities. Indeed, international disability law can offer especially protective legal standards while giving explicit weight to different layers of personal and group identities.[41] The purpose of this section is to attempt to harmonise the conceptual filters that this monograph has thus far employed, to support consistent human rights–based positive obligations with regard to the protection and promotion of the highest attainable standard of health of irregular migrants (non-discrimination, substantive equality and vulnerability), with the human rights model of disability, which derived from the social model.

The reason for this exercise is that disability scholars tend to be critical of the concept of vulnerability, as it evokes a spectrum of 'victimhood, deprivation, [social control,] dependency or pathology', which perpetuates the oppressive manufactured image of disabled persons as inherently in need of cures, charity-like attention and substitute decision-makers.[42] Furthermore, the label special vulnerability can have the stigmatising effect of emphasising the otherness of persons with disabilities or framing disability as a deviation from normality.[43]

Although it lacks agreement between and within different disciplines on what vulnerability means and, thus, on who is vulnerable,[44] it is worth noting that the operationalisation of this concept in human rights law – as a heightened risk of a multidimensional harm because of either inherent personal features or the socio-political contexts within which people live – has nonetheless led to an overall tightening of the scrutiny of monitoring bodies in relation to certain people or groups that are depicted as (especially) disadvantaged or marginalised.[45] This practice, in certain legal frameworks, has explicitly included irregular migrants and subgroups of the same,[46]

[41] Degener (n 24) 9–12.

[42] Beverly Clough, 'Disability and Vulnerability: Challenging the Capacity/Incapacity Binary' (2017) *Social Policy and Society* 16(3) 469, 475; Kate Brown, 'Questioning the Vulnerability Zeitgeist: Care and Control Practices with "Vulnerable" Young People' (2014) *Social Policy and Society* 13(3) 371, 383.

[43] Jackie Leach Scully, 'Disability and Vulnerability: On Bodies, Dependence and Power' in Mackenzie et al. (n 331, Ch 2) 219.

[44] Jonathon Herring, *Vulnerable Adults and the Law* (OUP 2016) 5. See further details at Section 2.7.

[45] See Section 2.7.

[46] In particular, see Sections 2.7, 3.1.1 and 4.1.2.

facilitating the conceptualisation of irregular migrants as real human rights holder, particularly vis-à-vis the neglect of their basic capabilities and socio-economic rights by state authorities. The special vulnerability of irregular migrants, which human rights law aims to mitigate – although without comprehensively grappling with its underlying causes – is, first and foremost, determined by structural and institutional conditions that deprive undocumented individuals and communities of legal status, thus exposing them to social exclusions and precarious living conditions that are detrimental to their health and well-being. As such, vulnerability, as a descriptive and normative concept, constitutes a 'useful set of tools to interrogate the structures, concepts and institutions that further inclusion or exclusion'.[47]

Irregular migrant vulnerability or precariousness is the result of political choices and can be described as a socially or legally constructed form of majoritarian community oppression over outsiders, whose mere existence or permanence in a state territory is deemed illegal. Thus, irregular migrants with psychosocial disabilities have at least a double layer of socially constructed vulnerability vis-à-vis human rights enjoyment, originating in their legal status and the ways in which migrant and non-migrant communities in society respond to their impairment. Without contradicting the social model of disability, this take on vulnerability emphasises situational risks of harm and social and legal environments as a panacea for discrimination and disempowerment.[48] In human rights practice, vulnerability and disability are transformed from constructs of oppression into powerful considerations and potential weapons of either substantive[49] or transformative equality.[50] They, in principle, require states to adopt a set of affirmative measures to rebalance the opportunities or capabilities of people who are likely to be marginalised, excluded and impoverished, including on the grounds of migratory status, actual or perceived disability or impairment. Furthermore, the state duties required under an international human rights approach to disability, as developed in the CRPD, are designed to lead to structural changes in power relationships between rights holders with disabilities and institutional duty bearers.[51] For irregular migrants with disabilities, including those with psychosocial disabilities, this very detailed and widely ratified Convention adds a

[47] Siobhán Mullally, 'Gender Equality, Citizenship Status and the Politics of Belonging' in Martha A. Fineman (ed) *Transcending Boundaries of Law: Generations of Feminism and Legal Theory* (Routledge 2011) 192.
[48] Mackenzie et al. (n 331, Ch 2) 7.
[49] Chapman and Carbonetti (n 320, Ch 2); Peroni and Timmer (n 337, Ch 2).
[50] Degener (n 24) 17 referring to Fredman (n 312, Ch 2).
[51] Ibid.

significant layer of protection because, for instance, the denial of disability-related health care and social support on the grounds of irregular migratory status can constitute a discrimination on the ground of disability.[52] In concrete circumstances, the above context-related vulnerabilities of irregular migrants are compounded by the inherent vulnerability of migrant children and the structural vulnerability of migrant women, inter alia.[53]

According to both the human rights model of disability and vulnerability-based human rights law, which are compatible with a reinterpretation of well-being in terms of the development of human needs and capabilities,[54] state authorities must play a supportive and positive role in rebalancing the actual opportunities available for people to enjoy human rights while also respecting diversity and agency.[55]

5.2 MENTAL HEALTH AND HUMAN RIGHTS LAW

To comprehensively understand whether human rights law has reached a satisfactory stage of standard setting regarding the rights of irregular migrants with mental health conditions, it is worth summarising briefly how this branch of international and European law has developed freedoms and entitlements by elaborating on the relationships between human rights and mental health in general (i.e. from a non-group–specific perspective). Borrowing from authoritative scholarship on health and human rights, three important relationships between mental health and human rights can be identified: (1) mental health laws and policies can affect human rights; (2) human rights violations can affect people's mental health; and (3) human rights law and mental health policies can be shaped as reinforcing promotional strategies for

[52] See Section 5.4, *infra*.

[53] See Sections 3.4.3 and 4.3.2, *supra* and 5.4.2.2, *infra*.

[54] See Section 2.3.

[55] Nussbaum (n 68, Ch 2) 70 (on capabilities, human rights and institutional support); Caroline Harnacke, 'Disability and Capability: Exploring the Usefulness of Martha Nussbaum's Capabilities Approach for the UN Disability Rights Convention' (2013) *Journal of Law, Medicine and Ethics* 41(4) 768 (on the synergies between capability and disability approaches); Degener (n 24) 5–6 (on the role of socio-economic rights in the human rights model of disability); Fineman (n 195, Ch 4) 269 (on the active role of social institutions in building resilience and target human vulnerability); Mikaela Heikkilä, Hisayo Katsui and Maija Mustaniemi-Laakso. 'Disability and Vulnerability: A Human Rights Reading of the Responsive State' (2020) *International Journal of Human Rights* 24(8) 1180 (on the obligations of responsive states to 'materialising substantive equality for persons with disabilities as vulnerable legal subjects').

enhancing individual and collective (mental and physical) health and well-being.[56]

5.2.1 *Mental Health Regulation on Human Rights*

The first relationship can be captured, for example, by human rights standards associated with involuntary admissions to and living conditions in mental health institutions. Since the 1970s, states and international human rights bodies have established hard and soft law,[57] as well as judicial or quasi-judicial precedents, on the human rights of people with mental disabilities who are deprived of their liberty. For instance, the ECHR has been employed to establish safeguards to prevent arbitrary forced confinement within an institution, requiring that the law must 'clearly define' the conditions under which confinement is permitted and that the constrained environment must be therapeutical.[58] Three conditions are required to lawfully 'detain' a person with mental health issues under Article 5 ECHR, outside of 'emergency' cases.[59] The first is that a 'true mental disorder' must be established by a competent authority on the basis of 'objective medical evidence'. Second, the mental health condition must be of 'a kind or degree that warrants compulsory confinement', and third, the severe disorder must persist to justify the detention.[60] Furthermore, the conditions of residents in mental health institutions or inmates in psychiatric wards of prisons may violate the right to freedom from inhuman and degrading treatment (Article 3 ECHR). However, the European Court considers a treatment to be inhuman only if it reaches a level of gravity 'involving considerable mental or physical suffering' and degrading if the person has undergone 'humiliation or debasement involving a minimum level of severity'.[61] The case law of the ECtHR has traditionally

[56] Lance Gable and Lawrence Gostin (n 37, Introduction) 105, referring to Mann et al. (n 33, Introduction).

[57] UNGA, 'Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care' Res 46/119 (17 December 1991); UNGA 'The Standard Rules on the Equalization of Opportunities for Persons with Disabilities', Res No 48/96, annex (20 December 1993); CRPD (n 17, Introduction).

[58] *Kawka v Poland* App no 25874/94 (ECHR 2001) para 49, See also *Aerts v Belgium* App no 25357/94 (ECHR 1998); *L.B. v Belgium* (n 274, Ch 2).

[59] *Hertz v Germany* App no 44672/98 (ECHR 2003) describes as emergencies those circumstances where public safety or patients' best interest are deemed at risk. However, the Court held that appropriate medical examination must occur immediately after emergency admission.

[60] *Winterwerp v the Netherlands* App no 6301/73 (ECHR 1979) para 39; *Stanev v Bulgaria* App no 36760/06 (ECHR 2012) para 145.

[61] Council of Europe, 'ECHR Toolkit', <www.coe.int/en/web/echr-toolkit/definitions> accessed 1 March 2021.

proved to be 'highly deferential to mental health authorities';[62] however, highly abusive circumstances (e.g. severe overcrowding, considerable length of detention, handcuffing in solitary confinement, extremely poor living conditions in institutions) in a number of cases in recent years have caused the Court to increasingly decide in favour of applicants.[63] Among other sensitive areas, Article 8 ECHR (respect for private life) has grounded a number of judgments that have restating the right to freedom of correspondence and the right to be ensured appropriate procedural safeguards against forced medication in mental health institutions.[64] Despite the trend towards more protective human rights standards, the case law of the ECtHR rests on the idea that certain interferences with the rights to liberty and physical and mental integrity, deriving from the implementation of mental health policy and legislation, may be permissible, subject to a test of legality, legitimacy and proportionality, if they are in the interest of the human rights holder with a mental health condition or of the safety of society at large. The 2006 CRPD 'radically departs from this approach' in considering as discriminatory and prohibiting any deprivation of liberty based on physical or mental disability, such as forced institutionalisation, without free and informed consent.[65] Moving away from the practice of institutionalisation entails the adoption of special measures to protect the life in dignity of people with psychosocial disabilities, including making available adequate community-based or alternative social care services as a less intrusive alternative to confinement.[66]

5.2.2 *Human Rights Violations on Mental Health*

The second relationship concerns the effects on mental health that human rights violations may cause. Human rights bodies have highlighted this relationship in an extremely wide-ranging body of jurisprudence, of which only

[62] Gable and Gostin (n 37, Introduction) 143.

[63] For example, *Romanov v Russia* App no 63993/00 (ECHR 2005); *Kucheruk v Ukraine* App no 2570/04 (ECHR 2007); *Stanev* (n 60).

[64] *Herczegfalvy v Austria* App. No. 10533/83 (ECHR 1992); X *v Finland* App no 34806/04 (ECHR 2012) para 220.

[65] CRPD (n 36, Introduction) Article 14; OHCHR, 'Annual Report of the UN High Commissioner for Human Rights [...] Thematic Study [...] on Enhancing Awareness and Understanding of the CRPD' (26 January 2009) A/HRC/10/48 para 48; CRPD Committee, 'General Comment No. 1: Equal Recognition before the Law' (19 May 2014) para 14; CRPD Committee, 'General Comment No. 6: Equality and Non-discrimination' (26 April 2018) para 30.

[66] HRCtee, GC36 (n 193, Ch 1) para 24; HRCtee, 'General Comment no. 35 – Liberty and Security of Person' (16 December 2014) para 11.

four examples are provided here. Gender-based violence is a form of discrimination that inflicts emotional and mental suffering[67] and that requires state agencies to activate targeted psychological support.[68] The denial of appropriate sexual and reproductive health care services, such as therapeutic abortion, may affect psychological integrity by creating mental anguish and constituting gender-based violence and ill treatment.[69] Furthermore, the psychosocial risks factors of work have been attentively considered by human rights bodies to interpret and monitor the right to fair and decent working conditions and occupational safety.[70] Finally, it is worth mentioning the case of children living in homelessness who are exposed to particularly poor and unhealthy living conditions. This situation raises human rights concerns regarding the responsiveness of housing and other targeted social services in protecting children from potentially severe consequences of homelessness on their 'physical, mental, spiritual, moral and social development' and mental health.[71]

5.2.3 *Synergies between Public Health and Human Rights in Right to Mental Health*

The third relationship is that public mental health and human rights can be mutually reinforcing in terms of the protection and promotion of mental health 'to the betterment of [all] human beings'.[72] This inextricable link is exemplified by the international conceptualisation of the right to 'the highest attainable standard' of health, the implementation of which means adopting intersectoral measures regarding, *inter alia*, the prevention of suffering, the promotion of mental health and access to health services while also respecting everyone's freedom and legal capacity to control one's life, health and body.[73] For instance, Article 12 ICESCR, Article 24 CRC and Article 11 ESC, as interpreted by the monitoring bodies of these treaties, require states to enhance the standards of health protection for individuals and communities.

[67] CEDAW Committee, GR35 (n 162, Ch 4) para 29.
[68] *R.P.B. v The Philippines* Com no 34/2011 (CEDAW Committee 2014).
[69] *L.C. v Peru* (n 243, Ch 2) para 7.2; *Siobhán Whelan v Ireland* App no 2425/2014 (HRCtee 2017).
[70] ECSR, Conclusions 2013 – Statement of interpretation of Article 3; ECSR, 'Conclusions 2017' (January 2018) <https://rm.coe.int/compilation-of-conclusions-2017-by-country/16807860 61> accessed 25 February 2021; Grover (n 182, Ch 4) para 44.
[71] CRC (n 42, Introduction) Article 27; CRC Committee, 'General Comment No. 21 – Children in Street Situations (21 June 2017) para 53; ECSR, *DCI v Belgium* (n 216, Ch 1) paras 81, 97, 121, 128–129.
[72] Gable and Gostin (n 37, Introduction) 107.
[73] See Section 2.4, based on CESCR, GC14 (n 27, Introduction).

As public health aims to create 'conditions for populations to be healthy',[74] mental health policies should, for example, catalyse public and private actors' efforts to realise positive social and underlying determinants of mental health, by focusing on creating healthy and supportive contexts and non-violent relationships.[75] The discourses of human rights and the social determinants of health should therefore converge to advance mental health standards that target enabling environments and structural causes, as well as essential care and support, rather than engaging exclusively with a biological approach to mental health and disability, which overemphasises treatment of mental illness.[76] The realisation of obligations to secure social determinants to promote mental health requires both 'cross-sectoral action'[77] and the enjoyment by all members of society of a broad array of interconnected human rights, including those that directly target material needs (socioeconomic rights), and the eradication of structural violence towards certain groups (people with disabilities and victims of gender-based violence). Indeed, failure to target the above structural determinants of health may bring about situations of multidimensional poverty and discrimination that are disproportionately associated with mental health conditions, and that prevent people with psychosocial disabilities from accessing equal care and support services.[78]

As far as mental health care and treatment within the scope of the right to health are concerned, it is worth recalling that for health policies and service provision to be human rights compliant, they must conform to the AAAQ framework,[79] and, in particular, they should be equity-oriented, non-discriminatory and affordable. State obligations stemming from the right to health care, which also include the progressive development of a comprehensive health care system that covers preventive, curative, rehabilitative and palliative services, overlap with those related to the implementation of the right to life and freedom from ill treatment which require states to provide urgent and emergency health care.[80]

[74] Institute of Medicine, *The Future of Public Health* (National Academies Press 1988) 19.

[75] Pūras (n 1) paras 3, 4, 47.

[76] Audrey Chapman et al., 'Editorial: Reimagining the Mental Health Paradigm for Our Collective Well-Being' (2020) *Health and Human Rights Journal* 22(1) 1, 3. See also, Gable and Gostin (n 37, Introduction) 160–162. The realisation of supportive social determinants of mental health is one of five key objectives of the WHO Mental Health Action Plan (n 33).

[77] Pūras (n 3) para 71.

[78] Pūras (n 1) paras H, 36, 84; Jonathan Kenneth Burns, 'Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination and Mental Disability' (2009) *Health and Human Rights Journal* 11(2) 19, 22.

[79] See Section 2.4.2.3.

[80] See Sections 3.3.1 and 3.3.2.

As noted previously, the classification of health-related obligations in General Comment No. 14 has been strongly influenced by a public health–based PHC paradigm, which strongly emphasises primary care as an essential level of care, as well as measures regarding health promotion.[81] As mental health is one widely accepted dimension of health,[82] the PHC approach, which includes primary care, cannot disregard people's mental health needs. Indeed, integrating mental health services into PHC is one of the WHO's most fundamental health care recommendations,[83] and primary and community care occupy a foundational position among the formal services in the (mental) health care pyramid of the WHO.[84] Primary care, together with other levels of care, can significantly contribute to human rights protection by helping to reduce stigma and discrimination towards people with mental health conditions, improve access to and continuity of care, enhance their social integration and 'prevent people from being admitted into psychiatric institutions [which are] often associated with human rights violations'.[85]

Finally, to ensure a beneficial relationship between mental health policies and human rights, it must be considered that the right to health is also conceptualised within the framework of the CRPD. Article 25 CRPD establishes that people with disabilities, including those with psychosocial disabilities, must have non-discriminatory access to general health care and to specialised services required by their impairment, both of which should be located 'as close as possible to people's own community'.[86] Furthermore, the text of the CRPD explicitly expands the 'broader social matrix'[87] of the right to health by adding a right to 'habilitation and rehabilitation' (Article 26), which is interlinked with other key provisions such as the right to independent living (Article 19). Indeed, 'poor physical and social environments can aggravate primary conditions and exacerbate secondary [co-morbid] consequences of primary conditions'.[88] These obligations, which together are a genuine

[81] See Section 2.4.2.
[82] WHO Constitution (n 22, Introduction) Preamble; ICESCR (n 23, Introdution) Article 12.
[83] WHO, *The World Health Report 2001: Mental Health: New Understanding, New Hope* (WHO 2001).
[84] WHO and WONCA, *Integrating Mental Health into Primary Care: A Global Perspective* (WHO 2008) 16.
[85] Ibid, 3.
[86] CRPD (n 36, Introduction) Article 25(a)(b)(c).
[87] Sylvia Bell, 'What Does the Right to Health Have to Offer Mental Health Patients?' (2005) *International Journal of Law and Psychiatry* 28 141, 142.
[88] Catalina Devandas Aguilar, 'Report of the Special Rapporteur on the Rights of Persons with Disabilities (Focus: Right to Health of Persons with Disabilities)' (16 July 2018) A/73/161, paras 4–5.

expression of the interdependence of human rights, entail the implementation of support services and programmes in the community, including 'peer-support' and 'particularly in the areas of health, employment, education and social services'.[89] This moves beyond the practice of institutionalisation and also addresses the 'revolving door phenomenon', whereby mental health service users who are left without adequate community care are more likely to require repeat specialised mental health care.[90] Finally, to create synergies between mental health regulations and international human rights law for people with disabilities, and build healthy and non-discriminatory communities of people, 'immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement'[91] by funding 'community-based and non-coercive psychosocial services'.[92] Building on this prioritisation of community-based primary care and supportive environments for mental health, the following sections analyse whether these paradigms are actually endorsed in international law and jurisprudence concerning service users or right holders who are irregular migrants and who, by virtue of their immigration status, are often the target of exclusionary policies and immigration law enforcement.

5.3 EUROPEAN HUMAN RIGHTS: QUALIFIED RISKS FOR MENTAL HEALTH AND EMERGENCY APPROACHES

Previous sections of this book have generally depicted the European human rights approach to the health needs of irregular migrants as guided by principles of emergency care and exceptional interventions.[93] Overall, the sophisticated case law of the ECtHR is severely constrained in the field of social entitlements, which are beyond the material scope of the text of the ECHR. Furthermore, the fact that irregular migrants are not labelled by the ECtHR an 'especially vulnerable group' per se has prevented the liberal use of positive obligations to concretely realise their human rights in this legal frame. By contrast, the ECSR has combined several principles of interpretation of international human rights law to successfully adjudicate on the social rights of irregular migrants, thereby overcoming the textual limitations of the ESC, which exclude this group from the treaty's scope of application.

[89] CRPD (n 36, Introduction) Article 26.
[90] Antoinette Daly, Donna Tedstone Doherty and Dermot Walsh, 'Reducing the Revolving Door Phenomenon' (2010) *Irish Journal of Psychological Medicine* 27(1) 27.
[91] Pūras (n 3) 65. See also, CRPD Committee, GC6 (n 65) para 30.
[92] Aguilar (n 90) para 29.
[93] See Sections 3.2 and 4.2.

While this section's findings do not significantly depart from these paradigms, European judgments and decisions that were specifically focused on the mental health of irregular migrants add interesting nuances. These are mainly examples of the second of the aforementioned relationships between mental health and human rights (human rights violations affect mental health) and are instructive in demonstrating how the deportation and detention of irregular migrants and their access to social and medical assistance can be minimally regulated to avoid levels of mental health distress that could constitute human rights violations.

5.3.1 *Deportation Measures and Mental Health*

During the last twenty years, the ECtHR has had several opportunities to clarify the circumstances in which the removal of illegally staying individuals with severe health conditions to their country of origin or provenance would constitute refoulement, which constitutes a breach of Article 3 ECHR. The rationale is that 'the suffering which flows from naturally occurring illness may be covered by Article 3 where it is, or risks being, exacerbated by ill treatment [...] flowing from [...] expulsion or other measure, for which the authorities can be held responsible'.[94]

Early judgments established that the prospect of ill treatment should prevent deportations on health grounds if there are 'substantive grounds to believe' that, if deported, a 'critically ill' person would be at 'imminent risk of dying'.[95] Affected by this restrictive approach, the ECtHR set a seminal precedent with *Bensaid* v. *United Kingdom* regarding the relevance of a mental health condition (in the words of the Court, a 'schizophrenic [person] suffering from a psychotic illness') as a human rights issue in deportation procedures. The applicant in this case was an Algerian national who had lived for ten years in the UK and who suffered from schizophrenia and was in receipt of mental health care that kept his condition under control. Mr Bensaid held that his deportation to Algeria, in consideration of his diagnosis of mental illness and the limited access in the receiving country to the drugs that helped him to avoid psychotic episodes and enhance his social functioning, would expose him to a risk of inhuman and degrading treatment and jeopardise his physical and moral integrity, which can be considered elements of the right to private life. This claim was based on the fact that

[94] *Savran* (n 44, Ch 3) para 44.
[95] *D. v UK* (n 122, Ch 1) paras 43, 52–53; *N. v UK* (n 122, Ch 1) paras 42–51.

his hometown in Algeria was 70 km away from the closest hospital in which the necessary treatment was only available on an inpatient basis.

Deportation-related stress and environmental conditions in Algeria, including the practical difficulties in accessing the treatment Mr Bensaid required because of his condition, would have exacerbated – according to his psychiatrist – the risk of recurring psychotic episodes, and would have led to a significant deterioration of the applicant's mental health to the extent that he 'would be at risk of acting in obedience to the hallucinations telling himself to harm himself or others'.[96]

On the merits of the case, the Court started its assessment by highlighting the sovereign state power to control immigration. It then held that, although the severity and the long-term nature of the applicant's mental illness was beyond discussion in that it had been under observation and treatment for years in the UK, the claims of the applicant (e.g. the adverse consequences of the deportation on his mental health, the reduced access to treatment in Algeria and the unsafe nature of the trips to and from the hospital) were largely 'speculative'.[97] In other words, the applicant failed to discharge his burden and standard of proof: the ill treatment of a particular severity resulting from all the circumstances of the case was not proved beyond any reasonable doubts. At that time, the threshold of severity of human suffering necessary to trigger the applicability of Article 3 ECHR in exceptional health-related return cases was extremely high; the criteria employed in *D. v. UK* coincided with 'subjecting [the applicant] to acute mental and physical suffering' to an extent that constituted a risk of death.[98]

Even though the Court left a door open to severe mental health conditions as circumstances that may prevent the removal of a migrant, the 'terminal illness' or 'risk of death' criterion, together with a high standard of proof, seemed ill-fitted to the specific characteristics of mental health conditions, which, while they may greatly impair the overall health and standard of living of people with mental disabilities, are not 'lethal' per se.

Furthermore, although the 'preservation of mental stability is [considered] an indispensable precondition to effective enjoyment of the right to respect for private life' (Article 8), the scope of which extends to the development of 'relationships with other human beings and the outside world', the Court found no violation of this right. Once again, evidentiary problems played a central role, as well as a state-biased approach according to which the

[96] *Bensaid v UK* (n 271, Ch 2) paras 21 and 16.
[97] Ibid, para 39.
[98] Ibid, para 40.

'protection of the economic well-being of the country' – an argument raised by the government to deny the applicant leave to remain because of the cost of his mental health care and the cost of generalising such a human rights standard – was hurriedly indicated by the Court as a legitimate interference with the right to private life of a returnee.[99]

While uncertainty regarding the existence of sufficiently severe risks regarding his mental health played against Mr Bensaid in the above case, in the *Aswat* case, uncertainty regarding the type of detention conditions and mental health care that the applicant would encounter in a detention facility in the USA contributed to a finding that the extradition of the applicant – a person with schizophrenia – to the USA would constitute a violation of Article 3 ECHR.[100] Although this case did not technically entail the deportation of an irregular migrant, as it concerned the extradition of a person whose 'nationality [was] not known', it is worth considering as an example of a series of circumstances that can cumulatively play a role in successfully triggering the applicability of Article 3 ECHR. A person with a 'severe' mental disorder (schizophrenia, the same condition that Mr Bensaid suffered from) was to be extradited to a 'country where he had no [family] ties and where he [. . .] face [d] an uncertain future in an as yet undetermined [detention] institution'.[101] The latter two circumstances were not present in the case of *Bensaid*, and, in light of these and medical evidence, the Court found 'that there was a real risk that the applicant's extradition to a different country and to a potentially very hostile prison environment would result in a significant deterioration in his mental and physical health, and that such a deterioration would be capable of reaching the Article 3 threshold'.[102]

The threshold of severity to trigger Article 3 ECHR was, in consideration of all the circumstances of the case, lowered from the 'risk of dying in distress' to a 'significant deterioration of physical and mental health'. This approach was crystallised, for health-related deportation cases, in the 2016 *Paposhvili* case, where the Court stated that a removal would constitute a violation of Article 3 ECHR whereas it brings about a '[r]eal risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a *serious, rapid and irreversible* decline in [. . .] health [status] resulting in intense suffering *or* to a significant reduction in life

[99] Ibid, paras 44–49.
[100] *Aswat v UK* (n 271, Ch 2) para 52.
[101] Ibid, para 56.
[102] Ibid, para 57.

expectancy'.[103] The latest additions to this saga are the ECtHR's Chamber and Grand Chamber judgments in *Savran* v. *Denmark*, which adjudicated on the application of the principle of non-refoulement under Articles 3 and 8 to a proposed deportation of a person with paranoid schizophrenia.[104] On the merits of this case, the seven-judge Chamber of the ECtHR, while acknowledging the high threshold of Article 3 ECHR and the state power to regulate border and immigration control, applied some elements of the *Paposhvili* test. This test was used to ascertain whether the removal of a person suffering from mental health conditions constituted prohibited ill treatment and required the state to perform a case-by-case assessment on the availability of treatment and the actual accessibility of care in the country of deportation. For the Court, the accessibility test entails examining the cost of medicines – which must be affordable – the existence of social and family networks of the applicant, and the distance between the applicant's domicile and the place where care, cure and rehabilitation services are provided.[105] If doubts remain on whether the applicant would have a real possibility of accessing necessary care and support services, individual and sufficient assurances must be sought by the deporting state and must be received from the receiving state.[106]

From a human rights and disability perspective, this case is significant because both the application and the judgment include supportive environmental factors (e.g. 'regular contact person supervision, [...] follow up scheme [...] assistance from social worker [...] occupation' and 'family network'), not just medication and psychiatric intensive care, as part of the care necessary to prevent disabling mental suffering, the lack of which would heighten the risk of relapse and suffering.[107] The lack of such care would, therefore, likely to be in breach of Article 3 ECHR.

The Chamber judgment is accompanied by two dissenting opinions from three of the seven judges who sat on the panel. These contain interesting as well as concerning remarks on their views on mental health, which they regarded as inherently different from physical health. They believed that the difference should not warrant any special assessment of the threshold criteria of Article 3 ECHR and cast doubt on the qualification of mental health conditions as serious illnesses able to meet the *Paposhvili* test.[108] The three dissenting judges criticised the Chamber's findings, which mainly relied on

[103] *Paposhvili* (n 122, Ch 1) para 183, emphasis added.
[104] *Savran* (2019) (n 45, Ch 3) and *Savran* (2021) (n 44, Ch 3).
[105] *Savran* (n 44, Ch 3) paras 43–47.
[106] Ibid, referring to *Tarakhel* (n 134, Ch 1) para 120.
[107] Ibid, paras 37, 58–63.
[108] Ibid, dissenting opinion of Judges Kjolbro, Motoc and Mourou-Vikstrom, paras 11, 13 and 21.

the appropriateness of available care options and assurance tests, rather than scrutinising attentively whether deportation would expose the applicant to 'a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy'.[109] One of the judges went even further in stating the following: 'Mental illness is more "volatile" and open to question. It cannot therefore constitute an obstacle to removal in the light of the criteria established in *Paposhvili* and requires [. . .] a higher threshold for finding a violation of Article 3.'[110]

The recent Grand Chamber judgment in this case reversed the Chamber findings on both Articles 3 and 8 ECHR. Emphasising the state sovereign powers in the field of immigration,[111] the Court found that the Court Chamber had departed from applying the full *Paposhvili* 'threshold test' to engage Article 3 ECHR which requires the seriously ill applicant to demonstrate that his expulsion to Turkey would determine exposure to a 'serious, rapid and irreversible decline in his state of health resulting in intense suffering'.[112] Only after preliminary evidence of this qualified risk is adduced by the applicant does the returning state have a duty to verify that specialised and targeted care is available and accessible in the state of deportation, including by obtaining assurances by the the latter state authorities.[113] The Court found that while Article 3 and the *Paposhvili* test in principle apply to mental health cases,[114] the applicant failed to provide sufficient evidence that his individual situation in the country of deportation was suitable to meet all the 'qualifications' of the risk of his prospective decline in health and suffering, required by the high threshold of this provision as interpreted by the Court.[115]

While accepting that a 'physical medical condition relies more on objective elements than mental illness, which can sometimes be assessed subjectively',[116] it can be argued that it is precisely the knowledge and funding divide between physical and mental health care vis-à-vis real experiences of intense suffering that would constitute a good reason to depart from overly strict rights interpretation or at least require a certain argument adjustment to make freedom from ill treatment effective,[117] even within the already strict criteria

[109] Ibid.
[110] Ibid, dissent of Judge Mourou-Vikstrom, para 29.
[111] *Savran* (n 44, Ch 3) paras 124, 133 and 181.
[112] Ibid, para 134.
[113] Ibid, para 135.
[114] Ibid, paras 137 and 14.
[115] Ibid, para 143.
[116] Dissent of J. Kjolbro, Motoc and Mourou-Vikstrom (n 107) para 21.
[117] Ibid, Partly Concurring and Partly Dissenting Opinion of Judge Serghides, paras 13–41.

for the application of Article 3, to avoid neglecting mental health as an undisputed component of human health. Indeed, as Judge Serghides holds in his dissenting opinion, 'a rapid and irreversible' health decline threshold is hardly compatible with the nature of certain mental illnesses such as schizophrenia which is characterised by 'fluctuations and by the fact that any attempt to stabilise it depends on regular supervision of the patient'.[118] Furthermore, the Grand Chamber judgment, unlike that of the Chamber, failed to consider the combined nature of the treatment for the mental health condition of a person with a mild intellectual disability,[119] which according to medical evidence should include a follow-up scheme, outpatient treatment and supervision. This could have required a different argument modulation and evidence assessment to ascertain the risk of ill treatment outlawed by Article 3 ECHR in cases of deportation of people severe mental health issues.

As previously observed,[120] considering that the application of the principle of non-refoulement may directly restrict the sovereign state power to control immigration, the ECtHR has developed very strict criteria for successfully claiming a human rights violation under Article 3 in removal cases linked to the quality of health care provided in a third country. In the cases recalled here, mental impairments and a lack of appropriate health care are key factors that may exceptionally prevent deportation, while disabling environments appear to play a more marginal role.

This Grand Chamber judgment also offers interesting clarifications regarding the factors that must be considered in a proportionality test for permissible and necessary rights limitations under Article 8 ECHR (the right to protection of private life) and that should be balanced against those favouring a decision not to lift expulsion orders with regard to people with mental health issues. The Court, citing *Bensaid*, recalled that 'mental health is a crucial part of private life' and that 'preservation of mental stability' is necessary to realise a right to 'personal development, and the right to establish and develop relationships with other human beings'.[121] While Article 8 is a provision that had not been successfully adjudicated in cases of deportation of unhealthy people, in this judgment the Court observed that, 'on account of his mental condition, the applicant was more vulnerable than an average "settled migrant" facing expulsion' and, as such, medical factors should be thoroughly assessed by domestic jurisdictions in interests balancing

[118] Ibid, dissenting opinion, para 21.
[119] Ibid, dissenting opinion, para 13.
[120] See Section 3.2.1.
[121] *Savran* (n 44, Ch 3) para 172, citing *Bensaid*).

exercises.[122] While these medical factors were found to be adequately assessed in this case, the Court concluded that other extra-medical factors were not sufficiently taken into consideration in determining whether expulsion and re-entry bans were proportionate interferences with the applicant's private life. These included: (1) that the commission of the criminal offence while the applicant had most likely been suffering from a mental disorder should have limited the extent to which the respondent state could legitimately rely on the serious nature of the criminal offence to justify his expulsion; (2) a reduced risk of reoffending, given the applicant's overall good conduct for years, before the final decision in the revocation of the expulsion order was held; (3) the different intensity of social, cultural and family ties with the host country vis-à-vis those existing in the country of destination.[123]

Family ties were particularly emphasised by Judge Jelic to criticise the fact that the rest of the Court decided to assess compliance with Article 8 ECHR by conducting an analysis of any interference with 'private life' instead of 'family life'. Indeed, 'the applicant's vulnerability caused by his serious mental illness may result in even stronger emotional bonds with the parents than in regular circumstances not characterised by vulnerability'. On that account, 'his emotional and social dependence on those whom he understood as his family' should have led the court to an extended notion and broad interpretation of the concept of family and family life.[124]

Overall, it is worth highlighting that the quality of environments, support services and relationships are gradually gaining weight in Court and concurring and dissenting opinion findings. This initial line of argument, if supported in the future, may contribute to developing a social determinants of health-sensitive jurisprudential trend that would helps discrediting a purely biological approach to severe mental health impairments.

5.3.2 *Immigration Detention and Psychological Suffering*

Immigration detention is the practice of depriving migrants of their personal liberty when these people are, for example, suspected of irregular entry into a state or held while arrangements are (or 'should' be) being made for their deportation. Health scholars have reached a certain consensus on the fact that 'loss of liberty, [. . .] the threat of forced return to the country of origin' and the length of stay and exposure to poor material conditions in detention centres

[122] Ibid, paras 191, 192.
[123] Ibid, paras 195–199.
[124] Ibid, Concurring Opinion of Judge Jelić, paras 4–5.

constitute significant stressors that can cause the onset or worsening of personal mental health difficulties.[125] The case law of the ECtHR has considered psychological health problems of applicants as factors to take into consideration when determining whether immigration detention constitutes a human rights violation. However, their legal appreciation, as indicated later in this section, varies from case to case, and generally only contributes to a finding of violation in cases of dire deprivation.

It must be restated that immigration control is one of the justifications for the deprivation of adults' liberty in Article 5(1)(f) ECHR, and states are not required to justify the necessity of the measure in this legal framework,[126] unlike, for example, in the context of the ICCPR.[127] Nonetheless, immigration detention must not be arbitrary, and the assessment to determine this must take into account, *inter alia*, the appropriateness of detention conditions in relation to the health status of the applicant.[128] Unlike cases of people suffering from degenerative physical diseases,[129] the situation of a migrant who has a diagnosis of mental illness and who is placed in a detention centre with medical attention and psychological support is considered prima facie non-arbitrary under Article 5(1) ECHR.[130]

The poor material conditions in detention centres and their effects on mental health have also been assessed for their compliance with freedom from inhuman and degrading treatment. Indeed, the Court has consistently held that detention conditions must be compatible with 'human dignity', which necessitates that 'the manner and method of the execution of the measure do not subject [the detained person] to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that [...] health and well-being are adequately secured by, among other things, providing [...] medical assistance'.[131] For example, in the case of a victim of torture who had irregularly crossed the Turkish/Greek border and was detained in a facility next to a border guard station, pre-existing psychological trauma, compounded by severe limitations of personal liberty and unhealthy living conditions, contributed to the ECtHR ruled that the

[125] Martha Von Werthern et al., 'The Impact of Immigration Detention on Mental Health: A Systematic Review (2018) *BMC Psychiatry* 18, 382.
[126] See *Saadi* (n 117, Ch 1) and Section 1.3.1.2.
[127] See Section 1.3.1.2.
[128] *Saadi* (n 117, Ch 1) para 74.
[129] *Yoh–Ekale Mwanje* (n 42, Ch 3) para 124.
[130] *Thimothawes v Belgium* App no 39061/11 (ECHR 2017) para 79; *K.G. v Belgium* App no 52548/15 (ECHR 2018) para 88.
[131] *Kudła* (n 37, Ch 3) para 94.

applicant's detention conditions had attained a sufficient level of severity to qualify as ill treatment and fell within the scope of Article 3 ECHR.[132] The appreciation of this minimum level of severity, as frequently stated throughout this book, is relative and depends on, *inter alia*, 'the nature and context of the treatment, as well as its methods of execution, its duration, its physical or mental effects, as well as, sometimes, the sex, the age and state of health of the victim'.[133] For irregular migrant adults, the case law suggests that a violation of Article 3 is likely to be found only where evidence indicates exceptionally abusive detention conditions, entailing dire physical and mental suffering.[134] Although they are not recognised as a particular vulnerable group per se by the Court, the provision of health care and psychological support in detention constitute the content of a positive obligation,[135] which however does not apply outside cases of deprivation of personal liberty.[136]

As far as children are concerned, the ECtHR has developed a consistent body of jurisprudence according to which their immigration detention is deemed a traumatising experience, which prima facie raises several human rights issues in terms of lawfulness and necessity of the measures (Article 5.1), ill treatment (Article 3) and physical and mental integrity (Article 8), as interpreted in relation to the key principles of the CRC (e.g. the best interests of the child and children's development).[137]

The starting point of the ECtHR's reasoning in such cases is that the 'extreme vulnerability of children' should take 'precedence over other considerations relating to [...] the status as illegal immigrants'.[138] From this stems positive obligations of care and protection on the part of states to prevent children from experiencing unbearable living conditions and being deprived of their personal liberty, which cause them considerable distress.[139] During analysis of their age-related and immigrant contextual vulnerability, the Court has repeatedly described the placement of accompanied and unaccompanied migrant children in transit or detention centres as an experience of 'stress and anxiety, with particularly traumatic repercussions for their mental state',

[132] *S.D.* (n 150, Ch 1) para 52.
[133] *Moustahi v France* App no 9347/14 (ECHR 2020) para 53.
[134] *J.R. and others v Greece* App no 22696/16 (ECHR 2018); *Kaak and others v Greece* App no 34215/16 (ECHR 2019); *Aden Ahmed* (n 273, Ch 2).
[135] Ibid.
[136] There is no fully-fledged right to health in the ECHR. See Section 2.6.1.
[137] *Mayeka and Mitunga* (n 154, Ch 1); *Muskhadzhiyeva and others v Belgium* App no 41442/07 (ECHR 2010); *Moustahi* (n 121); *Kanagaratnam v Belgium* App no 15297/09 (ECHR 2011); *Popov* (n 153, Ch 1); *Rahimi* (n 148, Ch 1).
[138] Mayeka and Mitunga (ibid) para 55.
[139] Ibid 58.

demonstrating 'a lack of humanity to such a degree that it amounted to inhuman treatment'.[140] The ECtHR recognises that the detention of young children in conditions ill-suited to their special needs is likely to have serious psychological effects on their mental and emotional development, and this has significantly contributed to the Court tightening its scrutiny by lowering the high threshold of Article 3[141] and reducing the state margin of discretion in adopting measures affecting their personal liberty or private and family life.[142]

5.3.3 *Social Entitlements and Mental Health*

The jurisprudence of the ECSR has interpretatively extended the personal scope of application of the ESC, which is set out in the Appendix, to cover 'emergency' social and medical assistance for irregular migrant adults.[143] These types of assistance that states are required to provide under Article 13 ESC include the necessary 'accommodation, food, emergency care and clothing' to address an 'urgent' and 'serious' state of need. The ESC also indicates that these criteria of urgency and seriousness should not be interpreted 'too narrowly'.[144] In the absence of applicable jurisprudence, as far as mental health services are concerned, the subsidised provision of counselling and psychological care at the primary or community level seems to exceed the 'emergency' requirement set by the ECSR for irregular migrant adults. While the extent to which social contexts and living conditions affect mental health has already been clarified,[145] it must be noted that the provision of 'emergency social assistance' – the standard required by the ECSR to target the special needs of irregular migrants – at least contributes to creating a minimal social baseline that targets the most basic material needs, the lack of which may seriously endanger people's mental health.

More generous standards emerge from the jurisprudence on the social entitlements of migrant children, including those with an irregular migratory status. The decision of *DCI* v. *Belgium* operationalised the concept of the interdependence of human rights to hold that the failure to provide accommodation, care and assistance to (irregular) migrant children violated the ESC, as it exposed them to the risk of being victim to violence or exploitation in the street environment, 'thereby posing a serious threat to the enjoyment of

[140] Ibid, para 58; *Moustahi* (n 121) para 66.
[141] *Kanagaratnam* (n 125) paras 67–69.
[142] Ibid 89–95; *Muskhadzhiyeva* (n 125) paras 69–75; *Mayeka* (n 154, Ch1) para 75–87.
[143] See Sections 1.4.2, 3.2.2 and 4.2.2.
[144] *FEANTSA* (n 221, Ch 1) and *CEC* (n 218, Ch 1).
[145] Pūras (n 1); See Section 5.2.3, *supra*.

their most basic rights, such as the rights to life, to psychological and physical integrity [...] and health'.[146] Furthermore, the ECSR affirmed 'the right of migrant minors unlawfully in a country to receive health care extending beyond urgent medical assistance and including primary and secondary care, as well as *psychological assistance*'.[147] In the European human rights system, the inherent vulnerability of all migrant children enhances the right standards for this group, including social rights standards, while the normative role of disability linked to a mental impairment has not yet been explicitly employed in relation to irregular migrants in these legal frameworks.

5.4 INTERNATIONAL HUMAN RIGHTS BODIES: EMPHASISING MENTAL HEALTH IN PRIMARY CARE AND SUPPORT SERVICES

Unlike the constrained interpretation of European human rights law, international human rights bodies have not only considered 'impact on mental health' as an element or consequence of human rights violations but also created a number of powerful normative and argumentative tools to establish a non-discriminatory right to health care beyond situations of clinical emergency and extending to the determinants of health, which can be applied to protect the mental health of irregular migrants. First, this section explores how a number of treaty provisions, as interpreted by several UN treaty bodies, can positively address the mental health of people who are about to be expelled and are being held in immigration detention centres. Second, based on a triangulation of arguments, consisting of those of the UN human rights bodies on non-discrimination and vulnerability, the contribution of the WHO's recommendations and studies commissioned by this organisation and the human rights treaty-based approach to disability, I present a number of human rights–based reasons to expansively define the scope of the right of irregular migrants to access mental health care and support.

5.4.1 *Mental Health Considerations in Human Rights Violations*

Like in the case of the ECtHR, most of the jurisprudence of UN treaty bodies directly concerning the protection of the mental health of undocumented people to avoid human rights violations is related to the contexts of deportation and detention as irregular migration containment measures.

Article 7 of the ICCPR (freedom from cruel, inhuman or degrading treatment or punishment) is arguably one of the most invoked human rights

[146] *DCI v Belgium* (n 218, Ch 1) 82.
[147] Ibid, para 128, emphasis added.

provisions in cases of deportations that may constitute refoulement, where the mental health consequences for the returnee are deemed ill treatment. In such cases, the HRCtee assesses whether the removal of a migrant from a state territory would expose them to a personal risk of an irreparable harm.[148] In the case of *C. v. Australia*, the Committee considered that the removal of the complainant to Iran, where the necessary 'medication and back up treatment' for his mental health condition were likely to be unavailable, constituted a violation of Article 7 ICCPR.[149] In *A.H.G. v. Canada*, the Committee considered the author of the communication, a person diagnosed with a severe mental illness and with a criminal record who had lived for several years in Canada and was deported to Jamaica, as a particularly vulnerable person because of his mental impairment. In the circumstances of the case, the expulsion constituted an 'abrupt withdrawal of the medical and family support on which a person in his vulnerable position is necessarily dependent' and was deemed a form of ill treatment and refoulement.[150] The case *Monge Contreras v. Canada*, concerning the removal of a failed asylum seeker, shed light on the steps that states are required to take to avoid breaching Article 7 ICCPR. The Committee ruled that adequate weight be given to the fact that the complainant had a 'medical certificate, according to which the [complainant] suffered from chronic post-traumatic stress disorder and that he would be highly vulnerable to psychological collapse in case of return' to his origin country where he would face other threats to his psychical and mental integrity.[151]

Other problematic circumstances have arisen in cases where migrants who had been witnesses in criminal proceedings were (about to be) deported to countries where they would be exposed to a highly probable risk of irreparable harm to their human rights to life and physical and mental integrity at the hands of non-state actors.[152] In one such case, *A.H. v. Denmark*, the author of the communication, in support of his claims, provided evidence of his 'unstable state of [...] mental health', which the Committee considered a determining factor that made him 'particularly vulnerable [and] disclose[d] a real risk [...] of treatment contrary to the requirements of Article 7 of the Covenant as a consequence of his removal' from the respondent state territory to the origin country.[153]

[148] For further details see Section 2.3.3.
[149] *C. v Australia* Com no 900/1999 (HRCtee 2002) para 8.5.
[150] *A.H.G. v Canada* Com no 2091/2011 (HRCtee 2015) para 10.4.
[151] *Jose Henry Monge Contreras v Canada* Com no 2613/2015 (HRCtee 2017) para 8.9.
[152] *Osayi Omo-Amenaghawon v Denmark* Com no 2288/2013 (HRCtee 2015); *A.H. v Denmark* Com no 2370/2014 (HRCtee 2015).
[153] Ibid (*A.H.*), para 8.8, emphasis added.

Furthermore, a comparison of the findings in A.N. and *J.B.*, two recent 'Dublin' cases against Switzerland before the CAT Committee, demonstrates that the combination of evidence of being a victim of torture and experiencing serious mental health problems is critical in preventing the removal of a migrant to a country where the necessary specialised care is not easily accessible to migrants. In A.N., the Committee found that the ill treatment to which the non-European complainant would be exposed upon return to Italy (his first country of asylum), where shelter, food and basic needs are not always guaranteed, would entail the risk of his depression worsening 'to the extent that he would be likely to commit suicide and that, in the circumstances of this case, this ill treatment could reach a level comparable to torture'.[154] Such 'a precarious situation endangering the life of the complainant would leave him no reasonable choice but to seek protection elsewhere, exposing him to a risk of chain refoulement to his home country'.[155] By contrast, in *J.B.*, the lack of sufficient medical proof of a situation of particular vulnerability, considered in the context of a return to Bulgaria, led the Committee to hold that there were not substantial grounds to believe that the complainant would be at risk of torture if returned.[156]

The CAT Committee's most recent general comment specifically concerned migrant victims of torture in deportation procedures. According to this authoritative document, all people who claim to be victims of torture should be able to access medical and psychological examinations before the deportation is enforced,[157] and migrants who are confirmed as victims of torture should not be expelled to countries where these services are non-existent.[158] Furthermore, in their credibility assessment regarding factual circumstances to validate the refoulement claim, state parties should 'appreciate that complete accuracy can seldom be expected from [those] victims of torture' who experience post-traumatic stress disorder.[159]

In relation to immigration detention, unlike the ECtHR, the HRCtee considers that whereas 'detention of unauthorised arrivals is not arbitrary per se, [. . .] remand in custody could be considered arbitrary if it is *not necessary* given all the circumstances of the case: the element of proportionality

[154] A.N. *v Switzerland* (n 181, Ch 1) para 8.10.
[155] Ibid, para 8.5.
[156] *J.B. v Switzerland* (n 181, Ch 1).
[157] CAT Committee, GC4 (n 178, Ch 1) para 41.
[158] Ibid, para 22.
[159] Ibid, para 42.

becomes relevant'.[160] Detention is not an automatic corollary of the state power to enforce immigration law; it must be justified,[161] and the mental health status of irregular migrants upon arrival at a detention centre is key in determining the proportionality and necessity of the restriction of their personal liberty according to Article 9 ICCPR (the right to liberty and security).[162] Prolonged detention can give rise to a finding of violation of Article 10 ICCPR (the right to be treated with humanity in detention) if the conditions are not dignified or the type of detention is not based on 'a proper assessment of the circumstances of the case' but is, as such, 'disproportionate'. This was found to be so in the case of *Madafferi* v. *Australia*, the complainant of which was a person with irregular migration status who was placed and kept in a detention centre against the advice of various doctors and psychiatrists and who, as a consequence, experienced a deterioration of his mental health situation.[163] These maxims are generalised and restated in General Comment No. 35, in which the HRCtee clarified that immigration detention 'must be justified as reasonable, necessary and proportionate in the light of the circumstances and [periodically] reassessed'. The decision must but be 'necessary' and 'proportionate' in that it must consider, *inter alia*, 'less invasive means of achieving the same ends' and 'the effect of the detention on the [. . .] physical or mental health' of migrants.[164]

Health deprivation in detention may also trigger the applicability of Article 7 ICCPR (the prohibition of torture and ill treatment). In C. v. *Australia*, where the state party's courts and tribunals had accepted that the worsening of the complainant's mental health was a consequence of the protracted immigration detention, the HRCtee found a violation of this provision on the basis that the state party 'was aware of the author's mental condition and failed to take the steps necessary to ameliorate the author's mental deterioration'.[165] Furthermore, in two other cases against Australia, the HRCtee considered that the prolonged and indefinite detention of migrants and asylum seekers in Australian off-shore migrant camps inflicted 'serious psychological harm upon them [to such an extent to] constitute treatment contrary to Article 7 of the Covenant'.[166] Although medical treatment was available during detention, the Committee, in its decisions, confirmed that respect for human rights should

[160] *Madafferi* (n 189, Ch 1) para 9, emphasis added.
[161] C. (n 137) paras 8.2 and 8.3.
[162] *F.K.A.G.* (n 239, Ch 2) para 9.3; *Madafferi* (n 189, Ch 1) para 9.
[163] Ibid (*Madafferi*) para 9.3.
[164] HRCtee, GC35 (n 67) para 18; See also C. (n 137) paras 8.2. and 8.3.
[165] Ibid (C.) para 8.4.
[166] *F.K.A.G.* (n 239, Ch 2) para 9.8; *M.M.M.* (n 239, Ch 2) para 10.7.

take precedence over the enforcement of immigration measures such as detention in cases where medical treatment and psychological support are insufficient to mitigate the inhuman psychological consequences of indefinite detention.

5.4.2 *Irregular Migrants' Right to Mental Health: Non-discrimination, Vulnerability and Disability Arguments*

To appreciate the extent to which international human rights law, drawing on interdisciplinary sources, has contributed to delineating the scope of the right to mental health of irregular migrants, which may resonate and be implemented in other normative frameworks, this section presents a staged analysis. First, it examines significant examples of the jurisprudence of the UN human rights bodies on mental health care and the determinants of mental health of migrants in precarious situations and with irregular migratory status, in light of the findings of Chapters 3 and 4 regarding a vulnerability- and PHC-based approach to the right to health. Second, adding to these general remarks, it elaborates on a number of layers of identity or factors of inherent and social vulnerability that have contributed to the development of a differentiated human rights approach. Finally, it examines the consequences of using the new CRPD model of equality, which has the potential to cement international law's normative favour for establishing a supportive environment for mental health and for reducing discrimination, social exclusion and disablement for all, including for irregular migrants.

5.4.2.1 Mental Health in the PHC Model for Irregular Migrants

Chapter 2 stressed the validity of the PHC approach, which includes consideration of the social determinants of health, as an influential model for the normative development of an equity-oriented right to physical and mental health in international human rights law. Indeed, this paradigm targets social and health vulnerabilities while granting states a certain margin of appreciation regarding the programmatic realisation, organisation and actual provision of health and social services.[167] Authoritative international public health declarations, backed by the WHO, have defined PHC as a 'strategy' for eliminating health inequity and realising the right to health by prioritising the 'levels' of primary and preventive health care and adopting intersectoral

[167] See Sections 2.4.2.4 and 2.4.2.5.

measures that target the social determinants of health.[168] Thus, for instance, the CESCR established a number of PHC-inspired core obligations relating to the right to health with immediate operational force. These included the duty to secure equitable access to 'health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalised groups' and the provision of essential drugs and food, basic housing and adequate water supply for all.[169]

The normative priority accorded to PHC in the conceptualisation and operationalisation of the right to health, including via vulnerability-oriented core obligations in the context of the ICESCR, were explained in Chapters 2 and 3 to ground a human rights–based theory that limited the margin of discretion afforded to states for interpreting and implementing health rights for irregular migrants. In particular, the rules of interpretation of international law, the qualification of irregular migrants as vulnerable people, the applicability of the non-discrimination principle on the grounds of migratory status in relation to the core elements of this right and the substantive notion of equality that qualifies state obligations have all contributed to establishing that the international right to health of irregular migrants cannot be restricted to a right to emergency medical treatment only.[170]

As Article 12 ICESCR explicitly applies to both physical and mental health, mental health services and psychosocial interventions should be offered in a consistent way with the PHC approach and the core obligations in General Comment No. 14. Accordingly, following their non-discriminatory and equity-oriented guidance, these services should be at least partially integrated into primary or community care, complemented with other levels of services and made accessible for irregular migrants as persons who experience contextual vulnerability and who should not be discriminated against.[171] This is generally synchronised with the recommendatory approach of the WHO on this subject. Indeed, if mental health care were to be provided only in specialised care settings, the migratory and socioeconomic status of some prospective service users may prevent them from being able to have equal and affordable access this care.[172] Additionally, primary care, as formerly indicated, might reduce the stigma and discrimination associated with the use of psychiatric care – which, for irregular migrants, is often compounded by the discriminatory

[168] Declaration of Alma-Ata (n 28, Introduction); Declaration of Astana (n 174, Ch 2); WHO/UNICEF (n 1, Ch 3).
[169] CESCR, GC14 (n 27, Introduction) para 43.
[170] See, in particular, Section 3.3.
[171] CESCR, GC14 (n 27, Introduction) paras 17, 36 and 43. Bell (n 89) 141–153.
[172] WHO Europe (n 6) 14.

labelling they experience as non-nationals with no legal status – and minimise the potential for violations of human rights to occur behind the closed doors of institutions.[173]

In contrast, urgent care, such as that required in cases of relapse of certain psychotic episodes, should be accessible for irregular migrants as an ICCPR-related obligation concerning the right to life in dignity, which entails the right 'to receive any [mental health] care that is "urgently" required for the preservation of their life or the avoidance of irreparable harm to their health'.[174] Essential psychotropic drugs, as periodically listed by the WHO, should be available on a universal basis as a right-to-health core obligation,[175] although their inclusion should be periodically reviewed in accordance with a risk–benefit analysis.[176] For any 'mental health system to be compliant with the right to health', the biomedical or pharmacological approach to mental health must be appropriately balanced with psychosocial interventions, 'the arbitrary assumption' that biomedical interventions are the most effective strategy for addressing mental health conditions should be avoided[177] and 'diversity of care' should be pursued.[178]

At several points in this book, it is specified that the scope of the right to the highest attainable standard of physical and mental health not only entails ensuring access to appropriate health care services but also embraces underlying or social determinants of health. The SDH model, as incorporated in human rights law, applies to both physical and mental health and explains inequalities in health outcomes at population and individual levels.[179] Public health and social medicine studies have often associated inadequate income, substandard housing and status inequality with the prevalence of mental disorders.[180] In addition, the onset of mental health conditions have been associated with, among other factors, low levels of social trust and cohesion,[181]

[173] WHO and WONCA (n 84).
[174] HRCtee, GC36 (n 193, Ch 1); *Toussaint* (n 190, Ch 1) para 11. Similarly, ICMW (n 42, Introduction) Article 28.
[175] CESCR, GC14 (n 27, Introduction).
[176] Dainius Pūras, 'Report of the Special Rapporteur on the Right to [...] Health (Focus: Mental Health and Human Rights: Setting a Rights-based Global Agenda' (15 April 2020) A/HRC/44/48, paras 40 and 43.
[177] Pūras (n 3) para 20.
[178] Pūras (n 164) paras 61–66.
[179] See Section 4.1.
[180] Kate Pickett, Oliver James and Richard Wilkinson, 'Income Inequality and the Prevalence of Mental Illness: A Preliminary International Analysis' (2006) *Journal of Epidemiology and Community Health* 60 646–647.
[181] Richard Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier* (New Press 2005).

negative views of self-status and self-worth,[182] and a perceived lack of control over one's work and life.[183] All of these are stressful circumstances that unprivileged migrant populations are likely to experience in the xenophobic climates of modern Western societies.[184] Irregular or undocumented migrants, as a direct or indirect consequence of their precarious migratory status in receiving countries, 'are vulnerable to exploitation, long working hours, unfair wages and dangerous and unhealthy working environments' that affect their material living conditions and health status.[185] These circumstances, together with social isolation, fear of being returned to their origin country and difficulties obtaining entitlements,[186] are considered by the WHO to be stressors or risk factors for mental health problems.[187] Against this background, the current COVID-19 pandemic and widespread public health responses are reported to have 'worsened pre-existing mental health conditions and [...] created new vulnerabilities' for migrant populations with a precarious migratory and socio-economic status.[188]

The UN special rapporteur on the right to health has been particularly vocal regarding the need to support the social determinants of mental health of people in situations of human mobility, including irregular migrants, via collective and individualised measures at both the preventive and assistance levels. At the macro level, the special rapporteur has recommended decriminalising irregular migration and taking steps to prevent the fuelling of intolerance and xenophobia towards people on the move, which are manifestations of structural violence and discrimination that directly impact the context in which people live and affect their mental health.[189] While the UN rapporteur has emphasised the importance of supportive environments and relationships for preventing critical mental distress and meeting the right to public mental health of migrant populations, this goal can only be facilitated by regulating

[182] Simon Charlesworth, Paul Gilfillan and Richard Wilkinson, 'Living Inferiority' (2004) *British Medical Bulletin* 60(1) 49.
[183] Michael Marmot, *Status Syndrome: How Your Social Standing Directly Affects Your Health and Life Expectancy* (Bloomsbury 2004).
[184] Achiume E. Tendayi, 'Report of the Special Rapporteur on Contemporary Forms of Racism (Focus: Xenophobia)' (13 May 2016) A/HRC/32/50; Tendayi (2018) (n 26, Ch 3).
[185] CESCR, GC23 (n 143, Ch 4) para 47. For further details, see Section 4.3.
[186] Christa Straßmayr et al., 'Mental Health Care for Irregular Migrants in Europe: Barriers and How They Are Overcome' (2012) *BMC Public Health* 367; Lena Andersson, Anders Hjern and Henry Ascher, 'Undocumented Adult Migrants in Sweden: Mental Health and Associated Factors' (2018) *BMC Public Health* 18.
[187] WHO Europe (n 6) 4.
[188] Justo Pinzón-Espinosa, 'The COVID-19 Pandemic and Mental Health of Refugees, Asylum Seekers, and Migrants' (2021) *Journal of Affective Disorders* 280 407.
[189] Pūras (n 253, Ch 2) paras 30–32, 78, 79, 83.

socioeconomic rights for all migrants and, in particular, by providing psychosocial services for migrants with mental health issues without discrimination.[190]

This would require national, regional and local government departments to pay greater attention to irregular migration and adopt intersectoral measures and services targeted at achieving at least a minimum level of social integration and meeting the basic needs of all migrants,[191] in accordance with the principles of indivisibility and interdependence of all human rights. Although this would represent the optimum from both a human rights and a health promotion perspective, Chapter 4 explained how difficult it may be to fully implement these general standards in the context of irregular migration. Indeed, the exercise of sovereign governmental powers in the fields of immigration policy and social welfare, and the still uneven playing field where civil and political rights tend to obscure socioeconomic rights in human rights, in practice create regulatory barriers to holistic and inclusionary care as a human rights issue.[192]

However, I would argue that if the services included in psychosocial support were qualified as a valid and necessary alternative or as essential supplementary 'care' to psychiatric treatment,[193] in particular for anxiety and depression, this would place them in the realm of 'essential health care' and they should, therefore, be covered by the combined scope of the aforementioned right to primary and community health care, as well as by the scope of the right to a life in dignity with no discrimination. Finally, it must once again be reiterated that to make these entitlements real in practice, 'firewalls' must be established in relation to all public services to ensure that irregular migrants enjoy mental health care and support services for mental health without factual barriers based on immigration status.[194]

To conclude this human rights analysis, which applies the arguments developed throughout the book to the neglected area of mental health, it can be asserted that general international human rights law offers compelling normative and argumentative reasons to include non-discriminatory preventive and primary health care, as well as urgent health and social care, within the levels of health care and material conditions that meet the 'right to mental health' obligations of irregular migrant adults. In relation to certain

[190] Ibid, paras 2, 30, 36, 39, 53, 57, 63, 72, emphasis added.
[191] Social integration is one of the four critical areas of intervention to promote mental health of all migrants according to WHO Europe (n 6).
[192] See Section 4.1.4.
[193] Pūras (n 1) paras 36, 50–52.
[194] Ibid, para 56.

subcategories of irregular migrants, age-, gender- and disability-related considerations in human rights law support the equalisation of standards in relation to the care provided to citizens and regular migrants.

5.4.2.2 Age- and Gender-Related Considerations

The multidimensional development needs of children – which are proxies for inherent vulnerability to physical and psychological harms, with potentially long-lasting consequences on health and well-being in adult life – have played a key role in enhancing the protective scope of international law regarding the quality of state obligations vis-à-vis children rights.

Accordingly, the most prominent of the applicable human rights treaties in this area, the CRC, contains much more detailed textual treaty obligations than general human rights law, which reduce the state margin of discretion in discharging human rights treaty obligations regarding, for example, the provision of 'necessary medical assistance' and the development of social determinants–sensitive PHC policies.[195] For instance, the CRC Committee has acknowledged that 'mental health and psychosocial problems [...] are primary causes of ill health, morbidity and mortality among adolescents, particularly among those in vulnerable groups' and has urged states to adopt, within the context of a comprehensive multisectoral response, 'an approach based on public health and psychosocial support rather than overmedicalization and institutionalization'.[196] The international jurisprudence recognises that human rights–compliant state actions should dedicate 'increased attention for behavioural and social issues that undermine children's mental health, psychosocial well-being and emotional development'.[197] Child-focused human rights law is premised on the fact that the 'best interests of the child' are a primary consideration in all decisions that concern children and may displace other state interests,[198] such as immigration control or the related state interest of reducing access to services by irregular migrants for the protection of the economic well-being of a country.

In the same spirit, the CRC and CMW Committees have stated outright that reduced access to social and health services, which is normally associated with irregular migration status, 'can negatively affect the physical, spiritual,

[195] CRC (n 42, Introduction) Article 24. See also Articles 25–29.
[196] CRC Committee, 'General Comment No. 20 on the Implementation of the Rights of the Child During Adolescence' (6 December 2016) para 58; See also CRC, Committee, GC15 (n 173, Ch 2) para 38.
[197] Ibid.
[198] CRC (n 42, Introduction), Article 3; CRC Committee, GC14 (n 204, Ch 3).

mental and social development of migrant children'.[199] In the light of this, the Committees held that:

> Every migrant child should have access to health care 'equal' to that of nationals, regardless of their migration status. This includes all health services, whether preventive or curative, and mental, physical or psychosocial care, provided in the community or in health-care institutions.[200]

These human rights treaty bodies embrace a strict approach to the principle of non-discrimination on the grounds of nationality and legal status to the extent that no degree of differentiated treatment is acceptable, as 'states have an obligation to ensure that children's health is not undermined as a result of discrimination, which is a significant factor contributing to vulnerability'.[201]

The right to health of migrant children, like that of adults, goes beyond access to mental health care, psychological support and rehabilitation services but also extends to the adoption of coherent intersectoral measures that address 'a variety of factors, including structural determinants such as poverty, unemployment, [...] violence, discrimination and marginalization'.[202] Furthermore, given that the maintenance of stable support networks and family relationships are especially critical determinants of children's mental health, regulations and decisions concerning deportations and family reunification should adequately consider the effects on the mental health and development of every child.[203]

In addition to age, gender is a social determinant of physical and mental health[204] and a prominent ground of non-discrimination.[205] A gender-sensitive approach to the human right to health must consider and address those biological, socially constructed and environmental factors that disproportionally affect the achievement of the highest attainable physical and mental health standards by women, as interrelated with other human rights.[206] For instance, the right to sexual and reproductive health has a broad scope that applies to all, but some of its dimensions are especially critical for or exclusively relate to the health and well-being of women because of their

[199] CMW and CRC Committees, JGC 3/22 (n 175, Ch 1) para 40.
[200] CMW and CRC Committees, JGC 4/23 (n 175, Ch 1) para 55, emphasis added.
[201] Ibid.
[202] Ibid, para 54.
[203] Pūras (n 253, Ch 2) paras 69–70.
[204] CSDH Report (n 109, Ch 2) 145–155.
[205] For example, ICCPR and ICESCR (n 42, Introduction) Articles 2(2) and 3; CEDAW (n 42, Introduction).
[206] CEDAW Committee, GR24 (n 240, Ch 2) paras 6 and 12.

reproductive capacity.[207] Therefore, included in the right to health are state obligations to provide access to antenatal, perinatal and postnatal care, 'safe abortion services and quality post-abortion care [...] and to respect the right of women to make autonomous decisions about their sexual and reproductive health'.[208]

To avoid gender-based discrimination, all women, particularly women belonging to lower social classes and vulnerable groups such as irregular migrants, should have access to comprehensive sexual and reproductive care.[209] A WHO review of relevant literature on this topic demonstrates a strong causal relationship 'between psychological distress, depression and anxiety disorders, and aspects of reproductive health', such as childbirth, sexual violence and adverse maternal outcome.[210]

A growing body of international jurisprudence has found that the denial of access or limitations to appropriate sexual and reproductive health services that specifically address women's health, such as therapeutic abortion or post-abortion counselling and mental health services, can affect psychological integrity by creating mental anguish and can constitute forms of gender-based violence, ill treatment and violation of the right to health.[211] In the light of the reinforced protection of the principle of gender equality in human rights law – to be achieved via formal and substantive anti-discriminatory measures – and considering the entrenched relationships between reproductive health and mental health, all women, regardless of their migration status, should have comprehensive access to mental health and support services, at least in relation to their sexual and reproductive health.

Limiting irregular migrant women's access to sexual and reproductive health care and related psychological care constitutes discrimination on multiple grounds. It directly differentiates their enjoyment of the right to health and interrelated rights on the grounds of legal status vis-à-vis citizens and regular migrants, which should remain proportionate to its aim and, by disproportionately affecting women, it constitutes indirect gender-based discrimination between irregular migrant women and migrant and non-migrant men. The seriousness of the bundle of rights at stake, the enjoyment of which affects women and men differently, and the variable breath of socially

[207] CESCR, GC22 (n 209, Ch 2) para 25.
[208] Ibid, para 28.
[209] See Sections 3.4.3.2 and 4.3.2.
[210] WHO and UNFPA, *Mental Health Aspects of Women's Reproductive Health: A Global Review of the Literature* (WHO 2009) 159.
[211] *R.P.B.* (n 68); *L.C.* (n 243, Ch 2) para 7.2; *Siobhán Whelan v Ireland* (n 69); CESCR, GC22 (n 209, Ch 2).

constructed 'disadvantages, discrimination and subordination suffered by women' in all societies, especially in the context of migration, requires strict human rights scrutiny.[212]

Furthermore, as poor mental health suffered by women in the context of sexual and reproductive health is often associated with disadvantaged socio-economic conditions[213] and aggravated by structural inequalities in the work environment and in relation to household responsibilities,[214] pursuing gender equality – which is a key human rights principle – would require making psychosocial services that target the underlying structural determinants of health accessible to all women, including irregular migrants.

5.4.2.3 The CRPD: A Transformative Tool for Combating Multiple Sources of Discrimination and Health-Related Rights Violations

The CRPD – which builds on the social model of disability, according to which disability is an oppressive social construct – is a young human rights treaty system that aims to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities'.[215] It establishes a number of detailed positive obligations regarding civil, political, economic, social and cultural rights. By ratifying the CRPD, states commit to reverse discriminatory attitudes and enable people with disabilities to live as equal rights bearers and achieve their full potential in society on an equal basis with others.[216]

Article 5(2) of this treaty stipulates that 'state parties shall prohibit all discrimination on the basis of disability, and guarantee to persons with disabilities equal and effective legal protection against discriminations *on all grounds*',[217] which includes the provision of reasonable accommodation in particular cases.[218] This provision establishes far-reaching positive duties and stipulates that 'discriminations on all grounds' should be interpreted as

[212] Bantekas (n 32, Ch 1) 508.
[213] WHO and UNFPA (n 199) 25.
[214] CSDH Report (n 111, Ch 2) 145.
[215] CRPD (n 18, Introduction) Article 1.
[216] Ibid, Article 3.
[217] Ibid, Article 5(2).
[218] According to Article 2 CRPD, 'reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed *in a particular case*' to allow the enjoyment of human rights by people with disabilities, emphasis added.

including 'migrant [...] status', as well as multiple and intersectional discriminations.[219]

In the CRPD, equality and non-discrimination 'are principles and rights' and constitute 'an interpretative tool for all the other principles and rights enshrined in the Convention', which demand the adoption of transformative 'cross-cutting obligations of immediate realisation'.[220]

Therefore, Article 25 CRPD on the right to health of people with disabilities is equally applicable to all migrants with mental or psychosocial disabilities. Denying or restricting access to the 'specific health services needed' because of a mental impairment to an irregular migrant can constitute a multiple discrimination on the grounds of disability, health and migration status. Indeed, it is worth noting that 'discrimination on any ground [...] is both a cause and a consequence of poor mental health'.[221] In contrast to the aims and principles of the Convention and to the specific purpose of this article – which includes 'minimis[ing] and prevent[ing] further disabilities' – reduced access to care, combined with the suffering associated with mental impairment and the social response to the same, is likely to result in disabling and discriminatory outcomes. In this course of action, the specific needs, in terms of psychosocial care and support, of irregular migrants with mental health issues, would be treated like those of other people on the move, or citizens who do not have any psychosocial impairment or disability.[222] Further textual qualifiers of this right include that health services should be located as close as possible to people's own communities, which reinforces the CRPD's duty to deinstitutionalise care.[223]

As far as access to 'general' health care that does not precisely target the impairment of the disabled person, irregular migrants with psychosocial

[219] CRPD Committee, GC6 (n 65) paras 19 and 21: 'Protection against "discrimination on all grounds" means that all possible grounds of discrimination and their intersections must be taken into account. Possible grounds include but are not limited to: disability; health status; genetic or other predisposition towards illness; race; colour; descent; sex; pregnancy and maternity/paternity; civil; family or career status; gender expression; sex; language; religion; political or other opinion; national, ethnic, indigenous or social origin; migrant, refugee or asylum status; belonging to a national minority; economic or property status; birth; and age, or a combination of any of those grounds or characteristics associated with any of those grounds.' On the need to address multiple or intersectional discrimination, including on the ground of migratory status, see CRPD Committee, COs on the Report of Norway (7 May 2019) CRPD/C/NOR/CO/1, para 8; Slovenia (16 April 2018) CRPD/C/SLV/CO/1, para 7, Morocco (25 September 2017) CRPD/C/MOR/CO/1, para 13.

[220] Ibid, para 12.

[221] Pūras (n 1) para 36.

[222] CRPD (n 36, Introduction) Article 25(b).

[223] Ibid, Article 25(c).

disabilities should have access to the 'same range, quality and standards of free and affordable health care and programmes as provided to other persons'.[224] This provision may require further interpretative clarifications, as the meaning of the comparator 'other persons' is fundamental for understanding the scope of the applicable principle of non-discrimination. If we qualify the position of irregular migrants with disabilities according to their migratory legal status, the latter may justify differentiated or restricted access to non-disability–specific care under the several legal frameworks discussed in Chapters 3 and 4. Accordingly, the non-disability–specific health care that they should be able to access would be the same as that provided to all irregular migrants in that particular country, and in any case, as formerly argued, should include access to affordable primary services and preventive care and essential drugs, as well as urgent and emergency care.[225] On the other hand, if 'other persons' is interpreted as 'other persons without disability regardless of their migration status', irregular migrants with psychosocial disabilities should be offered comprehensive and affordable health care on an equal basis with an abstract non-disabled person in the country. While the latter may appear more in line with the inclusionary and precautionary object, purpose and text of the treaty, particularly considering that mental disabilities contribute to significant physical morbidity,[226] only the development of international practice will indicate whether this is the case. Indeed, this exposes the unresolved tension in international law between the exclusionary state powers regarding immigration and the prima facie inclusive scope of human rights law, frequently mentioned throughout this book.

Reinforcing the considerations above, in its 2016's COs on Italy, regarding Article 11 CRPD on 'situations of risks and humanitarian emergencies', the CRPD Committee recommended that states 'ensure that *all persons* with disabilities arriving in the State party are able to access facilities on an *equal basis* with others and that those with psychosocial disabilities are given appropriate [mental health] support and rehabilitation through strengthened systems'.[227] Furthermore, 'psychosocial and legal counselling, support and rehabilitation' to be provided for all migrants with psychosocial

[224] Ibid, Article 25(a).

[225] See Sections 3.3.1 and 3.3.2.

[226] Samantha Battams and Julie Henderson, 'The Physical Health of People with Mental Illness and "The Right to Health"' (2010) *Advances in Mental Health* 9(2) 117; Javed Latoo, Minal Mistry and Francis J. Dunne, 'Physical Morbidity and Mortality in People with Mental Illness' (2013) *British Journal of Medical Practitioners* 6 3.

[227] CRPD Committee, COs on the Report of Italy (6 October 2016) CRPD/C/ITA/CO/1, para 25, emphasis added.

disabilities should be 'disability-, age- and gender-sensitive and culturally appropriate'.[228]

The indivisibility and interdependence of all human rights are intentional structural features of the provisions of the CRPD. For example, the right to independent living in Article 19 CRPD is an autonomy-based civil right with a strong social matrix because of the public support and funding that are needed to materialise it as an alternative to institutionalisation.[229] It is crucial for this analysis that the CRPD provisions target the underlying structural and intermediate determinants of disability and health in a holistic way. Enabling relationships and social contexts, which are impairment-cognisant but non-discriminatory, play a key role in enhancing people's dignity and health in the human rights–based approach to disability and health.[230]

Article 26 CRPD (habilitation and rehabilitation) is an integral element of this strategy for minimising the impact of disability, including intellectual and psychosocial disabilities. It requires states to offer, *inter alia*, 'comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education, [and] social services', including via peer support, 'to enable people with disability to attain and maintain [. . .] full physical, mental, social and vocational ability'.

The precise scope of this article, read in the context of the treaty, clearly militates against episodic health interventions and emergency social assistance and is premised on the fact that all persons with disabilities, which 'include those who have long term impairment', may require continuity of care and support. The special rapporteur on the rights of persons with disabilities considered the provision of these services to be core obligations, thus highlighting their primary importance and the immediate nature of the measures that states should take to implement them.[231] Given the transversal applicability of Article 5 on equality and non-discrimination on 'all grounds', the absence of limitation clauses within the treaty, and the transformative and inclusive purpose of the CRPD in general and of Article 26 in particular, there is no reason why this provision should not apply to irregular migrants with disabilities, including those of a psychosocial nature. This is also endorsed by actors outside the CRPD treaty monitoring system: for instance, the special rapporteur on the right to health also recognised that 'mental health care and

[228] CRPD Committee, GC6 (n 65) para 73(p).
[229] Degener (n 24); CRPD (n 36, Introduction) Article 19.
[230] Pūras (n 1) para 4.
[231] Aguilar (n 90) para 18.

support services should be accessible to people on the move with disabilities on an *equal* basis with others'.[232]

The fact that the CRPD aims to achieve structural changes vis-à-vis mainstream perceptions of disability, thereby unveiling disabling social constructs to be addressed, constitutes a paradigmatic change in grappling with the human rights of traditionally marginalised groups in society. Irregular migrants with psychosocial disabilities have been subject to a number of disabling and disempowering labels: they are institutionally or socially considered immigration law breakers or even criminals, as well as 'sick or mad people'. While the latter may even go unnoticed or be absorbed within the narrative of the 'illegal migrant', the combination of these labels, compounded by other critical factors such as gender, race and poverty, is a perfect recipe for exclusionary and discriminatory patterns that, in practice, can prevent the enjoyment of human rights on an equal basis with others.[233] The CRPD's approach to equality, which also targets intersectional discrimination, seeks to 'address the socially constructed barriers, stereotypes, negative customs and practices which hinder the full enjoyment of rights by marginalized groups'.[234]

In the spirit of the CRPD and according to its text, all migrants with disabilities should be the target of truly inclusionary and intersectoral measures. Indeed, the general principles or goals of this treaty include a fully rounded approach to non-discrimination and participation in society on an equal basis with others. As such, the CRPD's transformative approach, which entails the adoption of a broad array of 'positive measures that change structures and systems',[235] if fully embraced, may have the ability to shake the foundations of social policies that are exclusionary towards irregular migrants.

Although the 'unreserved' letter[236] of this treaty and the early jurisprudence of the CRPD Committee, respectively, urge and recommend the need to implement non-episodic health care and support services for *all* non-nationals with disabilities, regardless of their 'migrant status', it is worth making a few remarks on the inclusiveness and operationalisation of this legal instrument and its key principles, while bearing mind that the concerns raised later in this

[232] Pūras (n 253, Ch 2) para 57, emphasis added.
[233] Pūras (n 1) para 27.
[234] Andrea Broderick, 'The Long and Winding Road to Equality and Inclusion for Persons with Disabilities', PhD thesis, Maastricht University, the Netherlands, 20 November 2015, 36.
[235] Degener (n 24) 17.
[236] No state added any reservations to the treaty articles that are of relevance here (Articles 5, 25, 26 CRPD) to limit the scope of the rights of the Convention to certain migrants only.

section may dissipate vis-à-vis the development of new jurisprudence on the interpretation and implementation of the CRPD.

First, while the jurisprudence of the CRPD Committee has been generally inclusive (referring to 'all migrants' or 'non-discrimination on the ground migrant status'), it has thus far failed to recommend a certain course of action with specific regard to *irregular* migrants with disabilities. The impression that the CRPD Committee avoids the politically sensitive wording of 'irregularity' is supported by the fact that asylum seekers' and refugees' situations, unlike those of irregular migrants, are explicitly mentioned in the monitoring of the CRPD's rights.[237] Second, it would be useful for the CRPD to clarify in its jurisprudence what the general principle of 'participation' might mean with regard to the rights of irregular migrants with disabilities. Considering that it is antithetical to the widely recognised 'sovereign immigration policy' principle, its operationalisation may either require true structural changes to the way states approach irregular migration in the field of disability or remain an empty promise. Finally, the concrete and non-illusory realisation of the ambitious human rights programme to disability in the context of human mobility must include the recommendation and adoption of intersectoral and reinforced firewall mechanisms (which prevent information sharing between service provision departments and immigration authorities) to allow safe and unreported access to mental health care and support services by irregular migrants with disabilities.[238]

5.5 CONCLUSIONS

Feeding into the overall objective of this monograph, this chapter offers an analysis of the legal and interpretative trends that specifically concern the international and European right to care and support of people with mental health issues and psychosocial disabilities, in the context of irregular migration, and the different levels of protection they offer. Indeed, the responsiveness of human rights law in this area constitutes a critical inclusiveness and consistency test for a truly universal and holistic rights-based theory and practice.

To adequately approach this topic, Section 5.1 summarises the contentious definitional and conceptual challenges that discussing mental health and

[237] CRPD Committee, COs on the Report of Slovenia (n 206) para 30; Montenegro (22 September 2017) CRPD/C/MNE/CO/1, para 10; and Cyprus (8 May 2017) CRPD/C/CYP/CO/1, para 15.

[238] See Section 3.4.2.

disability entails. In particular, it clarifies that contemporary human rights and public health tend to agree that mental ill health or disability is the result of a combination of biological and environmental factors. The 'social environment, and in particular social affiliations and social status, may be important risk factors [or vulnerability factors] in relation to psychosocial health' or disability.[239] This consideration has indeed affected the scope of the right to health care and to the social determinants of mental health in terms of prevention, promotion and care and shaped the duties that states should adopt to avoid discrimination on the grounds of disability and to minimise further disability. Furthermore, vulnerability and disability are presented as potentially synergetic protective arguments, born from constructs of oppression, that ground positive human rights duties in relation to mental health care and promotion for irregular migrants.

While Section 5.2 clarifies the conceptual and normative boundaries, which includes unpacking the different relations between mental health and human rights, Section 5.3 examines the applicable jurisprudence of the ECtHR and the ECSR. While both monitoring bodies consider the impact of human rights violations on the mental health of people as a relevant factor in their human rights examination, they are constrained by the material and personal scope of the ECHR and ESC, respectively, and have developed an 'urgent health-related' human rights jurisprudence regarding irregular migrant adults. Thus, violations of rights are likely to be found only where particularly qualified rights deprivation exposes people to a real risk of severe consequences on their mental health in the context of detention or deportation. Nonetheless, the jurisprudence of these bodies has gradually attributed greater weight to the quality of environments, support services and relationships as factors that contribute to human rights verdicts in cases concerning migrants with mental health problems, rather than exclusively focusing on the provision of medical care. Furthermore, arguments related to vulnerability and psychological development have generated an especially protective European body of jurisprudence on the rights of migrant children to mental health and well-being, which should be prioritised over the enforcement of migration policies.

Finally, Section 5.4 offers four main lines of argument, grounded in the vulnerability- and disability-sensitive international human rights law. First, key cases and general comments of the HRCtee and the CAT Committee demonstrate the extent to which the deportations and immigration detention of

[239] Richard G. Wilkinson, 'Ourselves and Others – For Better or Worse: Social Vulnerability and Inequality' in Marmot and Wilkinson (n 101, Ch 2) 341, 344.

people with mental health difficulties can negatively affect mental health and are, therefore, not considered necessary and proportionate (which is a test that the ECtHR does not fully perform in the case of immigration detention). Second, a general right to mental health care for irregular migrants can be derived from the approach developed in Chapters 3 and 4. This is based on the combination of the recommended standards of global public health (including PHC and SDH) with the preceptive human rights principle of non-discrimination read in conjunction with the scope of human rights as developed by the treaty bodies. These standards are influenced by the application of the conceptual and normative lens of contextual vulnerability: limitations of preventive, promotional and curative measures vis-à-vis those offered to other community members should not be excessive in consideration that undocumented immigrants because, given the constraining effect of their legal status, they are exposed to unhealthy socioeconomic conditions that constitute particularly unfavourable determinants of physical and mental health. Therefore, the obligations under the ICESCR and ICCPR require states to make the right to life in dignity, and the right to health care effective and accessible by at least providing, without differentiation on the grounds of legal status, essential drugs, community mental health care and basic support, as well as urgent and emergency care.

Several human rights bodies have also employed age- and gender-related factors to extend health rights standards. Mental health care and measures to ensure healthy environments for regular migrant and national children should be comprehensive and should 'equally' extend to irregular migrant children as a result of the operationalisation of the principles of non-discrimination, the 'best interest of the child' and 'children's development needs'. Mental health care and support, which are a necessary component of women's reproductive care, should also be equalised between migrants and all non-migrant populations to avoid discrimination of people on the grounds of gender. Preventing or restricting access to such care would treat men and women the same despite different objective needs and would not address substantive and structural discrimination on the grounds of gender.

Finally, the CRPD is arguably a true game changer with regard to the human rights of traditionally marginalised groups, as it requires states to make structural changes in the form of collective and individualised positive duties targeting discrimination on the grounds of disability, as compounded, by other grounds of discrimination and marginalisation. The scope of application of the CRPD and its definition of persons with disabilities are intended to be sufficiently broad to include those who experience disability as a result of the interaction between impairments and social barriers. As far as irregular

migrants with psychosocial disabilities are concerned, their disabling experience is, at the bare minimum, the result of unaddressed social or institutional discriminatory practices on the grounds of disability and migratory status. Article 5 CRPD outlaws any law, policy or practice which contribute to this 'status quo' specifying that all persons with disabilities must have 'equal and effective legal protection against discrimination on all grounds'. With respect to health care and support services, disability-specific services should be enjoyed by all persons with disability, as any status-based restrictive practice would indirectly result in discrimination on the grounds of disability between those who experience impairment and disability and those who do not.

The CRPD is also a treaty that 'textually' realises the principle of indivisibility and interdependence of human rights. The right to community-based health care, the right to 'habilitation and rehabilitation' and the right to independent living are strongly related and mutually reinforcing, including in relation to disease prevention and health promotion targets. As related state duties must target all people with disabilities, this approach offers truly holistic, comprehensive and textual human rights protection for all migrants with psychosocial disabilities, which is not as fully fledged in other legal frameworks. The CRPD is conceived as a truly transformative convention insofar as its scope of application exceeds disability policies and requires the adoption of intersectoral measures and reforms that embrace, *inter alia*, health, social and immigration law and policies. However, its potential is yet to be operationalised, via the jurisprudence of the CRPD Committee, with respect to the rights and needs of irregular migrants. These normative developments and state responses to detailed obligations will be a critical test of the real transformative and inclusive nature of the ambitious human rights approach to (psychosocial) disabilities.