AGORA International Journal of Juridical Sciences, http://univagora.ro/jour/index.php/aijjs
ISSN 1843-570X, E-ISSN 2067-7677
No. 2 (2021), pp. 1-10

MENTAL ILLNESS TREATMENT IN LAW: ORIGIN AND EVOLUTION OF GLOBAL MENTAL HEALTH

A. AMIRANTE

Aldo Amirante
University of Campania "Luigi Vanvitelli", Department of Political Science "Jean Monnet", Viale Ellittico n. 31 - 81100 Caserta, Italy
aldo.amirante@unicampania.it
https://orcid.org/0000-0002-7816-3868

ABSTRACT

This analysis seeks to demonstrate the recognition of the right to mental health corresponding to an obligation on the part of the State to create the conditions for the pursuit of the right to protection of those who show conditions of "vulnerability".The study gives us the opportunity to highlight some interesting ideas. The work starts from the consideration of the role of the madman in legal and social history with an inevitable reference to some leading figures of nineteenth-century phrenology (Franz Joseph Gall, Ferraresi Miraglia, Dorothea Dix) who have also provided a substantial contribution to the legal treatment of the protection of mentally ill people. The birth of psychology and the affirmation of human rights in the twentieth century are other elements that lead to the United Nations Convention on the Rights of Persons with Disabilities of 2006 and subsequent acts, all reported by the WHO in the MiNDbank, including MI5 Principles and programs such as the 2013-2020 Mental Health Action Plan. Finally, the international process defining systems for the prevention, treatment and assistance of people with mental illnesses for the 21st century, called Global Mental Health (GMH) – promoted and supported by the World Health Organization (WHO) – ensures some internationally agreed minimum standards on health care worldwide, which was part of the Millennium Goals of the United Nations and the current Sustainable Development Goals.

KEYWORDS: mental, illlness, treatment, law.

HISTORICAL EVOLUTION OF MENTAL ILLNESS TREATMENT

From stigma to care

The consideration of madness and society's relations with madmen is represented by the isolation and social distancing of those whose behavior was considered to be out of "normality". One of the most accredited historical reconstructions of madness and its relationship with society can be found in the *History of madness in the classical age* by Michel Foucault, who, using the painting *The Ship of Fools* (a novel by Sebastian Brant, 1494) by Hyeronimus Bosch (1450 -1516) as an excuse, gives a description of madness and then goes on speculating that isolation turns into internment, hence imprisonment for the mentally ill. Once socially isolated, the madman's deprivation of liberty can also work as a way of protecting and preventing the society made up of "normal" people. Foucault also narrates the existence of internment places for the treatment of mentally ill people, mainly connected to the Middle Eastern world, prior to the Middle Ages, dedicated to treatment rather than isolation. At the same time, it shows how the establishment of internment places for the insane also becomes a tool for the internment of subjects who, despite not being insane, were unwelcome to society, or rather to political leaders.

The repressive use of internment, which today is defined as psychiatric, immediately leads to a distortion of law and intervention for health purposes from an instrument of regulation and preservation of society to an instrument of power and conservation of the established regime. Such a distortion has accompanied the treatment of mentally ill people as well as those assimilated to them up to the present day, with a view to subordinating the

individual to society and power, but above all in order to eliminate anything that in some way represented sin, guilt, even from a moral and religious point of view. According to Foucault, in the classical age all forms of extravagance, dissolute conduct, magic, alchemy, as well as all forms of sexuality deemed deviant, are neutralized through an identification with the incapacity to reason, according to the model of unreasonable madness theorized by Erasmus of Rotterdam (2016). The punishment also justifies the often inhumane conditions in which the insane were kept (or detained). The same conditions were also represented and denounced by Goya in his work of art *Casa de locos* (1819), when the Enlightenment attacked the existing mental institutions. In this context, the place of internment is also a place for the social isolation of troublesome subjects, so that the available legal frameworks (concerning weak people) were often used in the event of even small pathologies.

The era of phrenology

It is only at the beginning of the nineteenth century that the madman begins to be separated from others for therapeutic purposes, and no longer for isolation and punishment, in a process stimulated by the evolution of the sciences, in particular the affirmation of Gall's phrenology and the phrenological schools emerging all over Europe which finally get to distinguish mental illness from all other forms of strangeness. Focusing only on the study of the mind, albeit according to principles that have proved not scientifically based, phrenology creates a watershed with respect to the previous model and the previous motivations for internment, gives authority and greater power to the medical science within the institutions and begins groping for therapeutic processes for mental illness. In this scenario, the misuse or even the abuse of internment becomes more complex since it requires the collaboration of like-minded doctors previously unnecessary, now jointly responsible.

In Italy one of the major phrenological schools is that of the Kingdom of Naples, whose epitomes were Luigi Ferrarese and Biagio Gioacchino Miraglia, which exerted a great influence throughout Europe, with its mental asylum approach (Baral, 2016). Ferrarese and Miraglia invented some innovative therapeutic processes, but they are also authors of some emblematic writings on the relationship between law and the treatment of madness, among which one must remember *Delle procedure a uso dei tribunali, Della frenologia e della applicazione all'educazione, alla morale e alla giurisprudenza criminale* (1855) and *La follia ragionante* (1873).

In the same years in the USA, Dorothea Dix, who was not a psychiatrist, but had the task of promoting the development of the status of mentally ill individuals in order to improve their care and living conditions, also became very influential both in her own country and abroad as an advocate of an innovative treatment for the care of mentally ill people. She suffered from a mental disorder and when she began to pay visit the centers for the housing and treatment of mentally ill people she was shocked by the conditions she saw. Her observations about these treatment centers led to changes in the custody, accommodation and treatment of mentally ill people. She visited England where she met many people interested in reforming treatment and improving the well-being of people with mental illness, and she conducted investigations into mental asylums in Scotland and other European countries (Okpaku et al.). Neither academic nor scientific, her essentially humanitarian contribution has been a break point between the activities of the two sides of the Atlantic.

The great contribution of 19th-century phrenology was to consider the subject separately from the disease, in order to identify the symptoms of psychic pathologies, to verify their subsistence patient by patient. It was a very important step towards the consideration of the individual as such and not in relation to the disease, and at the same time it brought to light the limits of the regulatory system which in fact deprived mentally ill people – as well as anyone who had the misfortune to enter, even erroneously, in a nursing home for the insane – of protection.

Towards the globalization of therapeutic models

Between the nineteenth and twentieth centuries, international collaborations and comparisons in health matters intensified, a series of international health conferences were convened in order to unify action against the growing spread of diseases related to international trade. The first meeting in Paris in 1851 is generally regarded as the opening of a new era of international action in public health. Following the 11th International Health Conference held in Paris in 1903, an international public health office was created in 1907, the *Bureau International d'Hygiène Publique*, whose functions were to disseminate general information on public health among its members, in particular with regard to the most common communicable diseases.

After the Great War, the of *Universal Declaration of Human Rights* has provided that everyone has the right to live under sufficient conditions to be guaranteed the health and well-being standard (with particular regard to food, clothing, housing and medical care). Furthermore, on the basis of Article 25, letter f of the League of Nations Covenant, the Health Organization was set up in 1920 (Burci, 2016). The second phase in the process of acquiring knowledge and awareness of the need for a global plan for mental illness has been dominated by leading scientists and social psychiatrists, and by the activities of three large organizations: *World Federation for Mental Health* (WFMH), *World Health Organization* (WHO), *World Psychiatric Association* (WPA).

The Constitution of the WHO (1948), especially its Preamble, lists a set of groundbreaking principles that define health as both an international interest and a fundamental human right. The definition of health provided by the preamble – which states a "*complete physical, mental and social well-being and not simply the absence of disease or infirmity*" and that "*the enjoyment of the highest attainable level of health is one of the rights fundamental principles of every human being without distinction of race, religion, political creed, economic or social condition*" – have been incorporated in other subsequent international instruments.

The paradigm of health is now overturned compared to the past approach, moving from the treatment of the disease to the protection of health. In the same period the main international instruments for the protection of human rights are signed. These treaties had and continue to have a great influence on devising the concept of *Global Mental Health* as well as on its achievement.

The contemporary era, from the late seventies, saw the affirmation of the idea of mental health protection, up to the affirmation, in 2000, of the *Movement for Global Mental Health* and the *Grand Challenges in Global Mental Health*. This latter process arises from the confluence of three different phenomena. In the first place, the experience of the Second World War, which took barbarism to the extreme, and gave rise to the need to introduce international instruments to limit the powers of states; secondly, the "vision", the "imagination" and the search for a humanitarian response to the perversions inherent in the protection system for mentally ill people; finally, a rebirth of "humanitarianism", a sense of equity reinforced by the *Millennium Fund*.

HUMAN RIGHTS AND MENTAL HEALTH

The common framework of human rights

The relationship between mental health and human rights has been rarely highlighted (Roth et al., 2009:148-156). The right to mental health begins to take shape with the San Francisco Charter (Roth et al., 2009). The Charter of the United Nations affirms principles of dignity and the enjoyment of fundamental freedoms for all. The *Universal Declaration of Human Rights* and the subsequent *Covenants on Civil and Political Rights* (ICCPR) and on

Economic, Social and Cultural Rights (ICESCR), both of 1966, outline the general principles for the protection and promotion of those categories which the following *Barcelona Declaration* of 1998 will define as "vulnerable groups" (Rossi, 2015:12,18).

More specifically, the 1966 Pacts take two divergent paths. The ICCPR Pact protects the individual from government initiatives that violate the freedom, privacy and freedom of expression, even of people with mental disorders; while the ICESCR Pact outlines, through the rights, the duties of the State. In concrete terms, on the one hand, cruel, inhumane, degrading treatment of people in mental suffering is prohibited, and even any measure restricting personal freedom must follow procedures appropriate to the case; on the other hand, the Pact defines the structures and the economic and social services aimed at protecting the individual and the family, as well as "*the right of each individual to enjoy the best conditions of physical and mental health that he is able to achieve*" at the expense of the State (ex art.12), also allowing access to health services and education and training programs for people with mental illness (A.V.V., 2002:59-73).

The legal focus on people with mental suffering deepens with the signing of four other international conventions:

- the *United Nations Convention on the rights of women*, which provides the right to the protection of health and safety of working conditions, as well as the elimination of discrimination against women in the field of health care in order to ensure, on an equal footing with men, the means to access health services;

- the *Convention on the Rights of the Child*, which contributes to focusing on the rights of people with mental disabilities, when it is established, in art. 23, that "*a child with a mental or physical disability must lead a full and decent life in conditions that guarantee their dignity* [...]"(Rossi, 2015:63);

- the *International Convention for the Elimination of All Forms of Racial Discrimination* (Meron, 1985:283-318);

- the *Convention prohibiting torture and inhuman or degrading treatment*. The latter directly protects people with mental disorders who could often be subjected to cruel treatment in their family or in institutions.

Soft Law Acts

By the end of the seventies, the General Assembly of the United Nations, had acquired as pillars the principles of the Treaties, Pacts and Conventions. It had also adopted *the Principles for the protection of the rights of people with mental illness* (Rossi, 2015:14), first of all stating some freedoms and fundamental rights aimed to offer the best medical and psychiatric treatments available, the respect for dignity, the protection from abuse, and even the duty to treat patients in a less restrictive environment (Rosenthal et al., 1993:257-300). Precisely on this last aspect, the Principles define standards and procedures, including judicial procedures, for forced hospitalization, setting specific parameters (*The United Nations principles for the protection of people with mental illness: Applications and limitations*, in Psychiatry, Psycology and Law, 1996).

The Principles constitute one of the most direct expressions of the culture of human rights in relation to mental illness so far adopted by the United Nations. The drafting of the principles was then followed by the drafting of a series of manuals on the guidelines proposed by the WHO and the United Nations for the implementation of the principles on mental illness, manuals still being updated and written (UN General Assembly, Res. 46/119: *Guidelines for the application of the principles for the protection of persons with Mental Illness and for the Improvement of Mental Health Care*). Among these, the guidelines on the promotion of human rights for people with mental disorders deserve to be recalled and analyzed. In addition to the Principles, the United Nations has issued numerous other sources of *Soft Law* affecting the condition of mentally ill people, including:

- the *Declaration on the Rights of Mentally Retarded Persons*;
- the *Declaration on the Rights of Persons with Disabilities* (1975) which expressly refers also to persons with mental disabilities and provides for a broad catalog of civil, political, economic, social and cultural rights, also in order to endorse integration efforts in the community;
- *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* (1993).

Despite being all *Soft Law* acts, they indicated a collective will to recognize the rights of disabled people, and were the fertile ground that then generated the *Convention on the Rights of the Disabled of 2006* (A/RES/61/106 December 13th 2006).
In the UN Resolution of 29 June 2016, *Mental health and Human Rights*, concerns are expressed that people with mental health problems or psychosocial disabilities, in particular people who use mental health services, may be subject to "*discrimination, stigma, prejudice, violence, social exclusion and segregation, illegitimate and arbitrary institutionalization, hyper-medicalization and treatments that do not respect human dignity*".
Moreover, an interesting tool is the European *Barcelona Declaration on Policy Proposals to the European Commission on Basic Ethical Principles in Bioethics and Biolaw*, which, rather than being a legal instrument, provides for some guidelines compiled by the scientific community on the subject of mental disability, and which is of particular importance for the definition of four guiding principles: *autonomy, dignity, integrity and vulnerability*. Autonomy ought to be interpreted as the ability to give meaning and an end to one's life, to have "self-regulation" and one's own intimacy, to act and reflect without coercion, the capacity to have personal responsibility and to be politically involved, the ability to give informed consent; integrity as an untouchable nucleus, the basic condition for a life that is dignified, both physically and mentally, and that should not be subject to any external intervention; dignity, or the quality by virtue of which living beings possess an ethical status. Finally, vulnerability, which is a concept introduced by the Declaration, refers to a situation of particular weakness and fragility, that of individuals who, due to age, condition, etc., require a special protection. In a broad and general sense, the concept of vulnerability deals with the very precarious condition of all living beings, human and non-human, who are exposed, throughout their existence, to the risk of being injured, and are therefore eminently "vulnerable". Especially in this second meaning, with its strong ethical and anthropological value, vulnerability has some important implications in terms of care (*Final Report to the Commission on Project Basic Ethical Principles in Bioethics and Biolaw*, 1995-1998, part B).

2.3 *The Convention on the Rights of Persons with Disabilities*

The process towards the recognition of the rights of persons with mental disabilities finds in the *2006 Convention on the Rights of Persons with Disabilities* the most recent and most effective international instrument (Hoffman et al., 2016:28). People with mental illness are considered to be people with disabilities according to art. 1, co. 2 of the aforementioned Convention, underlining that disability, in whatever form, is due to a specific interaction between the impairment and the barriers to full social participation on an equal basis. However, it is controversial which mental pathologies can truly be considered disabling (Szmukler et al., 2014:245-252). The fundamental principles of equality, independence and non-discrimination define the legal framework one should refer to.
The Convention implements a Copernican revolution in the interpretation of disability: people with disabilities from objects to be treated, therefore protected, become persons, holders of rights like everyone else, including those to live in their own community and to have a public life, also by supporting their efforts to lead an independent life on an egalitarian and non-discriminatory basis (Kayess, 2008:29). As a consequence, states have in fact specific obligations, including not pursuing policies or actions that lead to a condition of

discrimination. As provided for by art. 4, par. 1, the Convention binds all States Parties to *"promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability*".

The same article goes on listing a series of detailed obligations that States assume through the ratification of the Convention, ranging from the abrogation of all discriminatory norms, to the development and use of technologies that help people with disabilities, and even the guarantee of access to information. Furthermore, these goals must be achieved through reasonable means. Hence the need for a law that does not establish immutable rules, since it must arrange a process of continuous adaptation which includes various issues so as to allow the weak and disadvantaged to develop their own identity and point of view. *The Convention on the Rights of Persons with Disabilities* marks a certain change in the concept of dignity. In fact, it does not repeat the usual sentence whereby human rights are "derived" from an inherent dignity of the human person but it constantly refers to the respect for the "rights and dignity" of people with disabilities, implicitly suggesting that these are separate issues and human dignity, in particular, is a prerequisite for guaranteeing any human right (Carozza, 2013:1-16).

Another fundamental point of the Convention, particularly relevant for mental disability and compulsory treatment, is Article 12, concerning the legal capacity of people with disability interpreted as a "capacity to act", with its central role for the recognition of other fundamental rights, such as the right to personal freedom, the right not to be subjected to any coercive treatment contrary to human dignity, as well as the right to family and social life. In fact, the Convention implements "the revolution" requiring that people with disabilities must be recognized everywhere as persons before the law. Consequently, all States Parties must act to give any support that people with disabilities might need in the exercise of their capacity, as well as to ensure that all measures provide for appropriate and effective safeguards to prevent abuses.

3. Global Mental Health

3.1 *Definitions and contents*

An area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; it involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and it is a synthesis of population-based prevention with individual-level clinical care (Koplan et al., 2009:1993-1995).

Global Mental Health, according to a widespread academic interpretation, is an extension of the above-mentioned definition to the field of mental health (Patel et al., 2010:1976-1977). It is an international movement that takes as its guiding principle an improvement in the conditions to achieve a good mental health. Other authors (such as O. Okpaku and S. Biswas in *History of Global Mental Health*) provide another definition of Global Mental Health, explaining that 5 criteria are required to detect the phenomenon:

1) a universal or transnational approach; they give some examples concerning the role of poverty in mental illness and its stigmatization around the world;

2) the problem should have a common basis within the population, for example, violence;

3) an international arrangement between the interested parties should be put in place, through bilateral or multilateral agreements; it might also involve educational or scientific institutions, government bodies, NGOs or individuals;

4) the problem should fall within the competence of the recipient organization, institution or country in question;

5) the groups committed to the project should have a multidisciplinary nature as well as different origins.

The concerns of the scientific community are largely focused on the issue of health within the most-needy groups of communities in low and middle-income countries; although they are aware that poverty does not affect only the developing countries. In fact, homeless people are also present within the richest communities and the protection of the human rights of individuals suffering from mental illness is a universal issue. While no utopian answer can be sought, the United Nations and the World Health Organization, the World Bank and the IMF are reported to play a significant role in contributing to the success of the commitments enshrined in the Millennium Development Treaties and Rio de Janeiro. The treaties impose a commitment by UN member states to eradicate health inequalities and provide decent living conditions for all individuals regardless of race, gender, age or socioeconomic class.

3.2 *The contribution of the World Health Organization: results*

The disparity between rich and poor countries concerning both the respect of human rights and the treatment of people with mental disorders is one of the most evident inequalities. Low and middle-income countries are home to over 80% of the world's population, but they control less than 20% of the share of mental health resources. The resulting "therapeutic gap" is itself a violation of basic human rights. For example, over 75% of those identified with severe mental disorders (related to anxiety, mood, impulse control, or the use of psychotropic substance) in surveys carried out in low and middle-income countries received no treatment, despite showing substantial disability. The report *Global Burden of Disease* surprised the global health community with its discovery that five of the top ten elements leading to a life with disabilities, globally are mental disorders (Murray et al., 1996).

In 2020 and 2021 Mental health is one of the most neglected areas of health globally. This was true before COVID-19 (coronavirus), but the pandemic has further worsened the status of mental health (https:// unitedgmh.org/sites/default/files/2020-09/The%2BImpact%2BOf%2BCovid19%2BOn%2BGlobal%2BMental%2BHealth%2BReport.pdf). There are several reasons why mental health has been ignored. The first one is an associated stigma. The second is a perception of mental health disorders as a "luxury good", as opposed to actual illnesses. The additional top reasons include a fragmented and outdated service model. Some of these include the provision of mental health services mainly in psychiatric hospitals, severe lack of preventative mental health service; lagging policy changes and also a shortage of human resources. The social and economic impact of mental disability is varied and far-reaching. People with mental health problems often see their human rights violated and are rarely aware of it. In addition to restrictions on the right to work and education, they can also be subject to unsanitary and inhumane living conditions, physical and sexual abuse, neglect and harmful and degrading treatment practices in health facilities.

Failure to provide basic necessities, such as adequate nourishment, clothing, shelter, comfort and privacy, as well as unauthorized and uncontrolled detention, or chaining and immobilization are all well-documented abuses which are still to be dealt with since they are considered as 21st-century health challenges. Today, nearly 1 billion people live with a mental disorder and in low-income countries, more than 75% of people with the disorder do not receive treatment. Every 40 seconds, a person dies by suicide (https://www.who.int/en/news-room/fact-sheets/ detail/suicide).

According to the World Health Organization (WHO), the COVID-19 pandemic has disrupted or, in some cases, halted critical mental health services in 93% of countries worldwide, while the demand for mental health is increasing. Given the chronic nature of the disease, this translates into a significant economic impact worldwide. Countries spend less than 2% of their health budgets on mental health. It is expected that in the next ten years,

depression will put more burden on nations than any other disease (https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey). Data highlight that effective pharmacological and psychological treatments exist for a range of mental disorders and that unskilled health care professionals can offer psychological treatments or care interventions at increasing levels for mental disorders, with large treatment effects that are sustained over a long period of time.

During the World Health Assembly in May 2021, governments from around the world recognized the need to scale up quality mental health services at all levels and endorsed WHO's Comprehensive Mental Health Action Plan 2013-2030, including the Plan's updated implementation options and indicators for measuring progress.

In 2007-2008, the WHO launched the *Mental Health Action Plan*, and two specific programs for mental health: the *WHO MiND (Mental Improvement for Nations Development*) (https://www.who.int/ mental_health/policy/country/en/) and the *MhGAP* (*Global Action Program for Mental Health*); in addition to a series of proposals. The *WHO MiND* is a database of all documentary tools useful to deal with *Global Mental Health*; and the MhGAP program provides tools for adapting therapeutic processes and protocols around the world.

The WHO has also aimed at promoting certain aspects considered essential in order to pursue the objectives of the *Mental Health Plan*. For example, the integration of mental health care into programs already in place for other health conditions, which represents a pragmatic and efficient approach that may only marginally require additional resources. The most vulnerable people with mental disorders are those living in severe, long-lasting and disabling conditions: intellectual disabilities, schizophrenia and dementia are distinctive examples of these conditions.

For these people, there is an urgent need for de-institutionalization and the provision of acute and continuing care services closer to the communities where those affected live. For the WHO, respect for human rights is not just a package of rules to be recognized for the individual, even if suffering from mental illnesses, but it represents an ethical guide for both health and legal professionals involved and it is a tool for strengthening the so-called *Recovery* whose goal is to grant any individual the best possible health and integration, without being discriminated.

This pragmatic approach is connected to the fundamental principles of the WHO itself, affirmed and shared, at least theoretically, by all the states adhering to the Organization, and in particular to the principle that the best possible state of health constitutes a fundamental right of every being human. It should be noted that it was a precise choice to go beyond a simple cooperation scheme on health matters to conceive a wider and more comprehensive system of interventions. Consequently, the goal of the organization becomes the best possible level of health for all peoples. Furthermore, WHO can, in collaboration with UNESCO, undertake the activities it deems advisable in the field of mental health, and presumably invoke the encouragement of psychiatric methods worldwide. Among the fundamental principles on which an effective international health program should be based, the healthy development of the child, so that they can live harmoniously in changing the total environment, plays an important role according to the WHO charter. The introduction of psychiatric techniques in public education systems is clearly a consequence of this statement. The preamble of the WHO Constitution also recognizes that the achievement of high levels of health throughout the world can play a vital role in the pursuit of peace and security and, to this end, the extension to all peoples of medical, psychological benefits and their related knowledge will be sought in every possible way.

CONCLUSIONS

The evolutionary process of the treatment of mental illness has meant that the normal treatments are now considered, in most cases, real abuses, through various stages of transformation. Having identified mental illness as an affliction to be isolated and combated, even when not curable, the need arises to adapt the places of internment, transforming them into places of care, and therefore improve the conditions themselves, typically horrible and monstrous, in acceptable conditions of care. The transition towards a system of recognition of some fundamental individual rights for the sick subject, and even of social rights, still in progress, was not faster, having to bring together a plurality of interests to get to create structures that would allow their recognition; the process also involved an important change in the social perception of the mentally ill. While in the past any change in the consideration of madness inevitably led to the removal of the subject from the society of "normal", the recognition of new rights, and in particular the human rights applied to a mentally ill individual, require the inclusion of the subjects in their social and family context, and, as far as possible, their right to self-determination. Considering some examples, in particular, from countries such as the United States, where homeless people are a scourge, or the United Kingdom, where the health service is in great difficulty, the next challenge will be the elaboration of strategies compatible with local development conditions.

The future of *Global Health* and *Mental Health* is likely to be influenced by a variety of key factors. One of these is activism. This implies a greater role for civil society, acting as advocates for patients and health service users, their families and the whole community. Various WHO agreements, national and international mental health policies as well as many health agencies support this position. A related driving force is the reduction of stigma and the inclusion of the most vulnerable individuals. The study of mental illnesses together with the rehabilitation and job placement of users represent a good practice. Another great driving force is the changing perception of the definitions of *health* and *mental health*, which requires that a greater importance should be given to the social determinants of health, especially mental health, such as poverty, immigration, human trafficking and modern slavery. Other well-known factors include mass crimes, national and international conflicts and wars, which have highlighted the role of violence as a risk factor for mental illness. Climate change, lack of water resources and poverty are all factors related to mental distress which significant consequences on health. With regard to all these aspects the implementation of national or regional programs is still completely inadequate, that is why a global approach and international cooperation efforts are necessary.

BIBLIOGRAPHY

1. WHO, *MiND Policy and Services*: https://www.who.int/ mental_health/policy/country/en/
2. WHO, https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey.
3. WHO, https://www.who.int/news/item/27-08-2020-world-mental-health-day-an-opportunity-to-kick-start-a-massive-scale-up-in-investment-in-mental-health#textMental%20health%20is%20one%20of,every%2040%20seconds%20by%20 suicide
4. WHO, https://www.who.int/en/news-room/fact-sheets/ detail/suicide.
5. Erasmo da Rotterdam, *Elogio della follia*, Italian version, *Suisse Book Edizioni*, Milano 2016.
6. S. Baral, *Il frenologo in tribunale. Nota per una ricerca sul caso italiano*, Criminocorpus, Folie et justice de l'Antiquité à l'époque contemporaine, June 2016, http://journals.opene dition.org/criminocorpus/3283.
7. O. Okpaku - S. Biswas, History of Global Mental Health.

8. L. Burci - A. Cassels, *Part IV Activities of Organizations*, Ch.21 Health, in *The Oxford Handbook of International Organizations*, Oxford University Press, Oxford 2016. https://doi.org/10.1093/law/9780199672202.003.0021.
9. L. O. Gostin, *Human Right in Mentan Health*, in M. Roth - R. Bluglass, *Psychiatry, Human Rights and the Law*, Cambridge University Press, Cambridge 2009.
10. S. Rossi, *La salute mentale attraverso lo spettro dei diritti umani*, in «Forum di Quaderni Costituzionali/Rassegna», 2015, 3.
11. T. Meron, *The Meaning and Reach of the International Convention on the Elimination of All Forms of Racial Discrimination*, in *The American Journal of International Law*, 1985, 79, 2.
12. *Principles for the Protection of Person with Mental Illness* Res. 46/119 of December 17th 1991. S. Rossi, *La salute mentale attraverso lo spettro dei diritti umani*.
13. E. Rosenthal - L. S. Rubenstein, *International human rights advocacy under the "principles for the protection of persons with mental illness"*, in *International Journal of Law and Psychiatry*, 1993, 16, 3-4, pp. 257- 300; S. Rossi, *La salute mentale attraverso lo spettro dei diritti umani*, cit.
14. *The United Nations principles for the protection of people with mental illness: Applications and limitations*, in Psychiatry, Psycology and Law, 1996, 1, 3.
15. UN General Assembly, Res. 46/119: *Guidelines for the application of the principles for the protection of persons with Mental Illness and for the Improvement of Mental Health Care.*
16. *Final Report to the Commission on the Project Basic Ethical Principles in Bioethics and Biolaw, 1995-1998, part B, Peter Kemp, Center for Etik og Ret i Natur og Samfund.*
17. *S. Hoffman - L. Sritharan - A. Teipar, Is the UN Convention on the Rights of Person with Disabilities Impacting Mental Health Laws and Policies in High-Income Countries? in Canada BCM International Health and Human Rights, 2016, 16, p. 28.*
18. *G. Szmukler - R. Daw - F. Callard, Mental health law and the UN Convention on the rights of persons with disabilities, in International Journal of Law and Psychiatry, vol. 37, issue 3, May-June 2014, pp. 245-252, https://www.sciencedirect. com/science/article/pii/S0160252 71300126X#.*
19. *R. Kayess - P. French, Out of darkness into light? Introducing the Convention on the rights of persons with disabilities, in Human Rights Law Review, 2008, pp. 29 ss.*
20. P. G. Carozza, *Part III Structural Principles, Ch.14 Human Dignity*, in D. Shelton, *The Oxford Handbook of International Human Rights Law*, Oxford 2013.
21. P. Koplan - T. C. Bond - M. H. Merson MH et al., *Towards a common definition of global health*, in *Lancet*, 373, 2009.
22. V. Patel - M. Prince M, *Global mental health: a new global health field comes of age*, in J*ama*, 303, 2010, pp. 1976-1977. doi:10.1001/jama. 2010.616.
23. C. Murray - A. Lopez, *The Global Burden of Disease, Harvard School of Public Health*, WHO and World Bank, Boston 1996.
24. THE IMPACT OF COVID-19 ON GLOBAL MENTAL HEALTH A BRIEF 2020, *UN Policy Brief: COVID-19 and the Need for Action on Mental Health*, May 2020 https:// unitedgmh.org/sites/default/files/2020-09/The%2BImpact%2 BOf%2BCovid19%2BOn%2BGlobal%2BMental%2BHealth%2BReport.pdf