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United Nations and World Health Organisation Engagement in Treating Global Mental Health, with a Special Focus on Dementia

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Abstract

A sharp attention is devoted to mental health and mental illness by International Law and many International Organizations (IO's) in XXI century. As a consequence of human rights huge extension, mental health is nowadays a target of international efforts striving to address both States national choices and international achievements. World Health Organization (WHO) is expressly engaged, but United Nations (UN) opened up the legal path in early nineties, by UN General Assembly (UNGA) 46/119 of 17 December 1991, The protection of persons with mental illness and the improvement of mental health care, where mental health care and facilities are pointed out; and if mental illness couldn't be defined, Principle 4 (Determination of mental illness) of this Resolution is crucial to direct next improvements layout. From there, UN and WHO have been carrying on a unique approach to mental health, as proved by binding and non-binding international acts, surveys, guidelines – as the 2010 WHO mhGAP Intervention Guide, now updated in its 2016 version – adopted as a result of States consultation. UNGA Resolution 70/1 of 21 October 2015, Transforming Our World: the 2030 Agenda for Sustainable Development, envisaging 17 Sustainable Development Goals (and replacing past 8 Millennium Development Goals to be gained in 2015 at last) is the last step on the road of a global approach to health, both physical and mental in an holistic view of human beings. As stated in Declaration's Introduction, "no one will be left behind". This article aims to investigate mental health as an international legal issue on a broad sense, not only compared to lack of mental illness, but in a comprehensive view dealing with it by implementing International Law on Human Rights. Dementia prevention and care above other mental diseases is perceived in a global framework of domestic economic and social balance (2012 WHO Dementia, a Public Health Priority), even though national health care systems still depend upon national policies in investments assets. But States' attitude to healthcare services in mental health should now be oriented by International Law current evolution.

Keywords: Health; Human rights; UN; WHO; Disabilities; Mental health; Dementia; SDG's

Introduction

It is not striking for International Law experts the attention paid nowadays to mental health: as "person" became an important reference unit in contemporary international legal order, any individual peculiarity is an addition to person intended as a whole. This proper legal approach aims to minimize single differences among human beings and to give emphasis on the idea of everyone's belonging to same humanity. But within it various and severe differences among individuals are manifest or can be envisaged; indeed, mental health is undoubtedly a personal condition implying so many aspects and uncertain medical treatments to induce International Law defining basic principles at least, in order to protect vulnerable people and to ban discrimination which could threaten their dignity. Therefore binding acts and non-binding rules have been adopted, mostly but non only by United Nations (UN) and World Health Organization (WHO), both trying to pave the right way either to take into account mental health affected people's special needs and to include them in the ordinary and manifold civil society. This paper aims to investigate main international acts, both binding and non-binding, to draw a unique approach with regard to mental health and notwithstanding its multipolarity.

Health and Human Rights

The right to health as the legal foundation of International Law approach to mental health: Is mental health a disability according to UN documents?

The right to health won't be investigated in this paper, but it has to be taken into account as a prerequisite of International Law attitude towards mental health legal framework, care and treatment. WHO Constitution doesn't provide a full definition of "health", stating in the Preamble that "(h)ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (italics added). It was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, and entered into force on 7 April 1948. Even though WHO Constitution doesn't provide a clear definition of its pivotal concept, health is conceived in all relevant elements composing human life, and it's consistent with international human rights law general approach. According to WHO Chapter I - Objective, Article I: "The objective of the World Health Organization... shall be the attainment by all peoples of the highest possible level of health." (italics added). Chapter II - Functions, Art. 2 states that "In order to achieve its objective, the functions of the Organization shall be: "(m) to foster activities in the field of mental health, especially those affecting the harmony of human relations." In 1946 the birth of an intergovernmental entity engaged in international cooperation on health topic was just meaningful itself and it brought forward 1948 UN Declaration on Human Rights and 1966 UN International Covenants, one on Economic, Social and Cultural Rights (CESCR) and the other

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one on Civil and Political Rights (CCPR). These three legal acts taken together compose the International Bill of Human Rights. According to UN Declarations on Human Rights, Art.: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". Connecting to WHO Constitution Art. 1, General Comment N. 14 - adopted by the Committee on Economic, Social and Cultural Rights on 2000 – therefore enlightens "the right to the highest attainable standard of health" provided in Art. 12 of CESCR: health is considered a fundamental human right for the enjoyment and the exercise of all other human rights. Right to health can be pursued through several instruments, such as implementation of health programmes developed by WHO or the launch of national health policies. Departing from definition of health given by WHO Constitution, but relying on the whole concept of a right to health dependent upon the realization of many other human rights, CESCR Art. 12 gives emphasis to a right to health not confined to health care. In the 1960s it was still premature to rule this right to health differently than a medical perspective. Nonetheless, the International Bill of Human Rights allows a broader interpretation of it, ensuring conditions for next evolution.

According to CESCR Art. 12, the right to health is not to be meant as a right to be healthy. In order to make people reaching the highest attainable level of health, this right should be ruled around freedoms and entitlements: as far as concerns CESCR States parties' obligations, other General Comments prior to No. 14 specify different levels of obligations: to respect, to protect, to fulfil. Obligation to respect compels States to refrain from interfering with the enjoyment of the right to health. Obligation to protect requires States to act in order to prevent third parties from interfering with Article 12 provisions. Finally, according to obligation to fulfil States are expected to take any proper measure to guarantee the full implementation of the right to health. Moreover, obligation to fulfil contains obligations to facilitate, to provide and to promote. While General Comment No. 14 (2000) states an obligation to fulfil incorporating an obligation to promote, given the importance of health promotion in WHO policy and elsewhere.

States are required to actively guarantee the right to health, either by positive measures and refraining from raising discriminatory barriers to the exercise of it, as well as from failing to take any appropriate step towards the full realization of everyone's right to the enjoyment of the highest attainable level of physical and mental health. Violations can be envisaged according to CESCR Art. Since the latter compels States parties to take steps to the maximum of their available resources. It's noteworthy a distinction between State's inability and unwillingness to comply with obligations ruled by Art. 12. States' openness towards the right to health guarantees is crucial, because private parties' engagement is useful to reach the targets, but only States can implement the right to health by legislative measures and national acts.

Incidence of regional human rights instruments is important as well: the right to health is recognized by 1981 African Charter of Human and Peoples' Rights (Art. 16), 1961 European Social Charter as revised (Art. 11), 1988 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Art. 10), and some more international documents that will be mentioned further. International Organizations competent ratione materiae are called to cooperate with States to facilitate right to health implementation on a national level: thus International Labour Organization (ILO), UNICEF, United Nations Development Fund (UNDF), World Bank, International Monetary Fund (IMF), World Trade Organization (WTO) and any relevant body within UN system.

The International Bill of Rights doesn't focus on mental health, but strives to build a wide and coherent concept of health, still linked to medical health care but founded on many different and intertwined human rights. General Assembly (GA) Resolution 46/119 does not define mental health and is still focused on mental health care. The medical approach already stated by prior international acts is kept, but this resolution drives a change in attitude: recalling the Declaration on the Rights of Disabled Persons [1], it declares in that:" the term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessity of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capability." (italics added). Therefore a lack in full mental capabilities-a deficiency-is an impairment which leads to disability, so involving International Law basic principles on the matter. With regard not to disability or mental health itself, but ruling on mental health care, AG Resolution 46/119 goes further making reference to fundamental freedoms and basic rights-Principle 1-and to no discrimination on whichever ground - Principle 1, 4: "...Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory". As it will be better pointed further, "equality" among normal people and mental illness affected ones is an international target, but it doesn't mean same measures are taken: equality in gained results can be reached only by discriminatory actions, whenever starting points are not comparable because of a striking difference. According to Principle 1, (Fundamental freedoms and basic rights): "Discrimination does not include any distinction, exclusion or preference...necessary to protect the human rights of a person with a mental illness or of other individuals"; Principle 4 (Determination of mental illness), states that: "A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standard".

Two remarks are required: 1) discriminatory measures are not forbidden, and on the contrary they are welcome, if adopted to increase protection of vulnerable subjects; 2) mental illness affection has to be determined not on the ground of national law, but relying on "internationally accepted standards". It is a meaningful remark, since national law application could hide discrimination on some grounds (cultural or political values, religious beliefs, ethnic origins): Principle 4, 2 of the Resolution is unequivocal.

Resolution 46/119 opens up a new perspective in mental illness legal framework, leaving from a strict medical approach, still prevailing by the mental health care and treatment keys, to give more emphasis on human rights implementation on people affected by mental illness.

Following the new attitude towards mental health and mental illness, 1993 Vienna Declaration and Programme of Action introduces the right to development as a fundamental human right that will next become a pillar in disability issue. Adopted by World Conference on Human Rights in Vienna on 25 June 1993, a short part of it is devoted to rights of the disabled person, and disability is not tackled as a discriminatory condition: Art. 64 are clear, as it declares the place of disabled persons is everywhere (Part II, B, 6. The rights of the disabled persons). It urges to draft standard rules on the equalization of opportunities for persons with disabilities, as guidelines in the matter: indeed, they were adopted by GA Resolution 48/96 of 20 December 1993. These Standard Rules on the Equalization of Opportunities for Persons with Disabilities rise from experience of United Nations Decade of Disabled Persons (1983-1992), and at 17 they qualify mental illness as a disability. The Standard Rules recall many previous international acts: the Declaration on the Rights of Disabled Persons (1975), the Declaration on the Rights of Mentally

Retarded Persons (1971), the Declaration on Social Progress and Development (1969), the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991).

The Standard Rules end the transition to a change in attitude towards a mental health general framework: in 1993 disabilities are not dealt with medical treatment as the prevailing therapy anymore; disabled people must be included in social environment taking into account diversity and promoting equal access: to enjoyment of rights, to any kind of services, to job opportunities, to political decision-making. It's noteworthy to remind also of 1993 WHO Mental Health Care Law: Ten Basic Principles, inspired by a comparative analysis of national mental health laws in a selection of 45 countries worldwide conducted by WHO in those last years and expressing principles drawn from 1991 Resolution 46/119. Principle 2, Access to Basic Mental Health Care, § 4, declares that: "Mental health care should be available on a voluntary basis, as health care in general." (bold in the text). On the topic, also relevant the Convention on the Rights of the Child (1989), the Convention on the Elimination of All Forms of Discrimination against Women (1979), the World Programme of Action concerning Disabled Persons (GA Resolution 37/52, 3 December 1982).

Persons affected by mental illness are concerned by rules on disability, meant as a general condition expressing diversity, but not as a status: the legal purpose is to bring equality where preconditions are not the same. In a rather short period of time, disabled and mental illness affected people stop to be seen as objects to be ruled, and become subjects in a leading role for everything concerning their life conditions [2]. A balance should therefore be searched between the active role of disabled persons and people affected by mental illness within the wide notion of disability, and protection deserved. In turn, protection does not only enhance legal guarantees for these vulnerable persons, but it also raises States' sensitivity towards proper national legislation. 1994 CESCR General Comment No. 5 expressly declares, at § 6: "The absence of an explicit, disability-related provision in the Covenant can be attributed to the lack of awareness of the importance of addressing this issue explicitly, rather than only by implication, at the time of the drafting of the Covenant over a quarter of a century ago.". Moreover, 1982 World Programme of Action concerning Disabled Persons, at § 3 states that: "the ultimate responsibility for remedying the conditions that lead to impairment and for dealing with the consequences of disability rests with Governments".

Indeed, inequalities rise from a non-disabled conceived society. International Law places mental health in the disability context, so increasing standard levels of protection, at the same time opening the way to devote specific principles and rules for mental illness. This is the purpose of the Convention on the Rights of Persons with Disabilities and Optional Protocol, the first international act crucially focused on disability. Adopted by UNGA on 13 December 2006, it came to force on 3 May 2008. Widely participated, it counts 165 parties, 164 State and European Union, which ratified the Convention on 23 December 2010, to the extent of its competences. The Convention summaries and gives large emphasis to relationship between full enjoyment of human rights and disability and it is rooted on some main principles: non-discrimination, respect for individual autonomy and freedom to make one's own choices, equality of opportunity, respect for diversity and acceptance of persons with disabilities as part of human diversity (Art. 3). The change of attitude towards disabilities is sketched by 'reasonable accommodation' as "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms" (Art. 2). Definitively leaving the medical approach to disability, the Convention adopts the human rights approach by considering disabled people as persons first and then as different because of disability, but part of a unique humanity. Consistently, Art. 5 play an important role even in theoretical terms: it envisages 'equality' and 'non-discrimination' as the proper balance to guarantee a 'reasonable accommodation' innovating approach to disability. The Convention sounds like a human rights code ruling on disability and on mental illness affected people too, included in disability issue. Equal recognition before the law is the starting point for a new strategy to disability and mental illness, fulfilled by protecting the integrity of the person, both physically and mentally on an equal basis with everybody else.

The Convention is worth in shifting the disability approach, no more linked to 'special care for special needs', and past perspective is overruled: all people enjoy the same rights notwithstanding diversity, and States should act in order to guarantee the enjoyment of same rights for all people: States' actions are efficient and sufficient if a 'reasonable accommodation' is gained. The principle of 'reasonable accommodation' is notably relevant to mental health approach according to International Law - and national laws implementing it. All international instruments on the issue are consistent even when lexicon changes: in Europe, Council of Europe mirrors evolution recorded at UN level. European Convention on Human Rights, adopted in 1950, doesn't mention persons with disabilities and only refer to persons with mental health problems in Art. 5 on the right to liberty and security, declaring the "lawful detention of persons...of unsound mind..." European Social Charter as revised in 1996 marks a patent change of attitude towards social integration of people affected by disabilities, and the Council of Europe Action Plan confirms a "paradigm shift from patient to citizen". To be mentioned also Council of Europe Recommendation Rec (2006)5 of the Committee of Ministers to member states on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015, adopted on 5 April 2006; and Recommendation Rec (2004)10 concerning the protection of the human rights and dignity of persons with mental disorder, adopted on 22 September 2004.

It has been already remarked that UN Standard Rules give birth to a social model of disability and that a definition of disability is not given by the Convention, as it is "an evolving concept" (Preamble, lett. e)), but all UN rules, both binding and non-binding ones, follow the same direction by softening the medical approach to get a more comprehensive view of disability. If Council of Europe documents use the term 'reasonable adjustment' instead of reasonable accommodation, the meaning is unambiguous and reiterated by European Court of Human Rights case law. European Union (EU) law follows itself the same logic than other legal acts already dealing with it. In mid-1980s EU launched its first initiative concerning participation of persons with disabilities, and skipping the medical approach it got a 'rehabilitation' model, mainly implemented in the field of employment. By the 1990s European Commission's Communication on Equality of Opportunity for People with Disabilities: A New European Community Disability Strategy [3]. EU enlightens barriers hindering people with disabilities, refraining them from the enjoyment of rights and opportunities. A non-discriminatory approach was thus adopted by Council Directive 2000/78 of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, the so called Employment Equality Directive, and transition from a rehabilitation

approach to a rights-based approach has been accomplished by entry into force of the Charter of Fundamental Rights of the European Union, as incorporated in Lisbon Treaty, Artt. 21 and 26.

To sum up, the Convention on the Rights of Persons with Disabilities founded an open-ended concept of disability ensuring people with mental health problems inclusion into this concept either at UN and EU levels, being EU a party to the Convention. It can only drive to an increasing number of legal guarantees for these vulnerable people: an excellent collection of any relevant international instruments on mental health as a European topic is provided by European Union Agency for Fundamental Rights (FRA) [4].

The WHO Mental Health Action Plan 2013-2020: An Improvement of the Human Rights-Based Approach

If WHO is the primary intergovernmental organization by expertise and authority in health, human rights legal acts seen above opened the way to a contemporary perspective on disabilities and mental health. International and regional human rights instruments move away from an illness paradigm towards a disability paradigm "aiming at understanding the social consequences of mental illnesses…If the right to health is to become tangible, rather than aspirational, international institutions, governments and civil society must articulate achievable methods of implementing and enforcing it." [5]. As health is not only absence of disease and recognizing that disabled persons – and mental health affected ones included among them – should play an active role in society, according to their specificity, in May 2012 WHO adopted WHA65.4 Resolution on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. Next, in 2013 a comprehensive Mental Health Action Plan 2013-2020 was launched from States consultation, in order to draw a global strategy on the issue. In the Action Plan, the term 'mental disorders' denotes a range of mental and behavioural disorders falling within the International Statistical Classification of Diseases and Related Health Problems. In the Plan, mental health is defined as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, able to give a contribution to the community he or she belongs. According to WHO Constitution, mental health is an integral part of health and well-being therefore deserving a global approach including any mental disorders, taking into account relevance of other diseases often connected to them, and compelling to cooperation of States at global and regional level, in order to extend services on mental health and free financial resources. The Action Plan depicts a framework of mental health and disorders according to different criteria and parameters, then developing four objectives: 1) to strengthen effective leadership and governance for mental health; 2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; 3) to implement strategies for promotion and prevention in mental health; 4) to strengthen information systems, evidence and research for mental health. From these four targets, the Action Plan draws six principles and approaches:

- Universal health coverage
- Human rights
- Evidence-based practice
- Life course approach
- Multi-sectoral approach
- Empowerment of persons with mental disorders and psychosocial disabilities.

The Action Plan sounds rational and ambitious at the same time. It takes a snap of services and States involvement in mental health issues, pointing out different starting conditions and stressing the importance of regional peculiarities. It introduces the notion of 'recovery', consistent with a community-based care and support. It also outlines an action taking place within countries, especially in the low-income and middle-income groups, where needs are high and resources are few [6].

Mental health problems are dramatically high in number and variety, and a single approach would be inefficient. Mental health affections should be taken into account at a global stage, their spreading on a regional scale and financial availability in promoting a productive approach either for society as a whole and for people affected by mental health problems, in order to enhance their empowerment. Whenever a global perspective has to be adopted, 'strategy' is the only proper tool to be used. 2012 World Health Assembly 65.4 Resolution urges States to act in a positive manner for a comprehensive plan developing a social awareness and involvement. Mental disorders determine impairments possibly leading to disabilities, but a radical change in attitude has to be promoted, according to 2011 World Report on Disability. The Action Plan aims to translate in operative terms any key principles underlined by international acts analysed before, and it's successful in its efforts. Moreover, the Action Plan rely on pivotal contribution of 2010 WHO Mental Health Gap Intervention Guide for mental neurological and substance use disorders in non-specialized health settings, providing a full guide of mental health problems, like psychosis, bipolar disorders, behavioural and developmental disorders, self-harm and suicide and dementia included. Mapping all fundamental international legal instruments relevant on mental health, and given general principles of care, the Guide summarizes shared patterns to recognize first and treat then any single pathology among those listed, firstly identifying symptoms and then resorting to both a medical and psychological support. Dementia is defined as "a syndrome due to illness of the brain, which is usually chronic and progressive in nature. The conditions that cause dementia produce changes in a person's mental ability, personality and behaviour. People with dementia commonly experience problems with memory and the skills needed to carry out everyday activities..." In October 2015, a Mental Health Gap Forum on "Mental health innovations and their uptake into policy and practice" was held in Geneva, therefore confirming the high level of attention paid to the issue [7]. Mental health is also tackled by OECD, rather unexpectedly.

WHO recently updated 2010 MhGAP Intervention Guide, relying on new evidence as well as extensive feedback and recommendations from experts in all WHO regions using the first version of this Guide [8].

Dementia and International Law: A Public Health Priority

The WHO nine global targets to reduce non-communicable diseases

At present, a big part of humanity enjoying a longer life than in the past, mental health problems unveil a worrying side of social system sustainability. As it's now technically feasible to get an early diagnosis of mental health diseases, individuals concerned can successfully be helped other than in the past, but States have to bear heavy economic burden. Similarly, social awareness of mental health problems has to be promoted, in order to set a more comfortable environment for those concerned and realize the empowerment urged by any recent international legal acts. Dementia is not a normal part of ageing, but it interests a growing number of old people, therefore countries

should include dementia on their public health agenda. Dementia is a syndrome due to brain diseases, it has a chronic or progressive nature and it is evident by several disturbances of multiple higher cortical functions, including memory, comprehension, calculation, language, learning capacity. Impairment of cognitive functions is often sided by decline in social behaviour and emotional control. Consciousness is not undermined. The most common form of dementia is Alzheimer disease. Dementia is not a specific disease, and it is a group of symptoms affecting mental tasks; caused by several factors, Alzheimer is one of the commonest. Alzheimer is a progressive brain disease slowly impairing cognitive functions. WHO is firmly engaged in all mental health problems and cognitive impairments, widely helped by Alzheimer Disease International (ADI), an international federation of Alzheimer associations around the world, officially linked to WHO. ADI Alzheimer Reports are a main source for WHO activities on the topic: 2016 is the latest available, centred on healthcare for people living with dementia [9].

In 2012 WHO released a Report focused on Dementia, understood as a public health priority [10] underlying all main key items of dementia care. The four commonest subtypes in order of frequency are Alzheimer's disease, vascular dementia (VaD), dementia with Lewy bodies (DLB) and frontotemporal dementia (FTD). Indeed, among other mental health diseases affected people, dementia patients are less able to be empowered in society where they live, and require care treatment often long lasting and uneasy for families. Since care services are expensive, family members are the main caregivers of dementia patients, therefore recording severe consequences in their own lives. The new dementia paradigm rely on a strong cooperation among different categories of health care providers, patients and their families: people with dementia should be the heart of a complex network, composed by primary family caregivers, family members, relatives and friends, neighbours and community, local and national governments, NGO's, international organizations. So far, family caregivers are still the main regular help in dementia people care and that means that informal caregiving prevail. It is nonetheless foreseeable a change in population demographics conducive to a decrease in availability of informal caregivers. According to First WHO Ministerial Conference on Global Action against Dementia, held in Geneva, 16-17 March 2015, States have the main responsibility in setting a national health plan properly conceived to face with dementia and non-communicable diseases. If people living with dementia are increasing, and mostly in low and middle income countries, social costs are growing even faster. Proportion estimated in older people increasing worldwide is, by 2050, around 2 billion people over the age of sixty and 145 million case of dementia are expected as well. A comprehensive plan is needed in order to slow this progression, and perspective should rely on a human rights-based approach. Despite WHO reports and statements, often dementia is not a priority in national health agenda; social awareness is lacking and fear and stigma still rest on dementia issue. Intended as a global challenge, huge costs in research can be balanced by wise planned investments – also bearing in mind that pharmaceutical companies do not find profitable any aspects of them with reference to neurodegenerative diseases.

Social awareness of dementia people needs urges to be increased, and States are committed to act in order to promote a campaign in favour of such an aware feeling and behaviour and to organise services really helping informal caregivers. Leaving to families the most of dementia daily care does not envisage a developed health system for people affected by dementia. The Report underlines that it is time to act by:

- promoting a dementia friendly society globally;
- making dementia a national public health and social care priority worldwide;
- improving public and professional attitudes to dementia;
- investing in health and social system to improve care and services for people with dementia and their caregivers;
- Increasing the priority given to dementia in the public health research agenda.

A fully awareness of the need for a comprehensive approach to mental disorders, including Alzheimer's disease, is already quoted by WHA65.4 Resolution of May 2012 on Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level, stressing that "...mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global non-communicable disease burden, necessitating provision of equitable access to effective programmes and health-care interventions;" (IV considerandum) [11] and that "treatment gap for mental disorders is high all over the world" (IX considerandum). The Resolution recalls some prior GA resolutions on the matter and, among them, crucially important is A/RES/66/2, Political Declaration of the High Level Meeting on the Prevention and Control of Non-Communicable Diseases (NCDs), adopted on 19 September 2011 and published on 24 January 2012.

WHO's commitments in the issue, and the comprehensive approach adopted, are both confirmed by the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020, which again recalls 2011 GA Political Declaration on the item and define a global monitoring framework on NCDs to report on the attainment of nine global targets for NCDs by States in 2025. These global targets are: 1) a 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases; 2) at least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context; 3) a 10% relative reduction in prevalence of insufficient physical activity; 4) a 30% relative reduction in mean population intake of salt/sodium; 5) a 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years; 6) a 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blue pressure, according to national circumstances; 7) halt the rise in diabetes and obesity; 8) at least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes; 9) an 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major non communicable diseases in both public and private facilities.

These nine global targets aim to reach six objectives: 1) to raise the priority accorded to the prevention and control of non-communicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy; 2) to strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of non-communicable diseases; 3) to reduce modifiable risk factors for non-communicable diseases and underlying social determinants through creation of health promoting environments; 4) to strengthen and orient health systems to address the prevention and control of non-communicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage; 5) to promote and support national

capacity for high-quality research and development for the prevention and control of non-communicable diseases; 6) to monitor the trends and determinants of non-communicable diseases and evaluate progress in their prevention and control.

WHO 2012 Report portrays the state of art of dementia care system in XXI century and it emerges a detachment from the human rights-based approach built for disability: person is still the core unit in mental health global system, but it is not so easy to make people with dementia more involved in decisions concerning themselves. Dementia is exceptional in terms of size, costs and impact and the social value of intervention is crucial. Dementia is highly present in all countries, but because of high costs to deal with it, intervention gap among low-income and high-income countries is increasing. Stigma of dementia should therefore be struggled and reduced, but in order to reach this goal all society is called to intervene. Awareness is much but it is not enough and a transition to acceptance would be preferred. Notwithstanding great achievements in mental health global attitude, centred on human rights and empowerment of people with disabilities, those suffering of dementia still have to be protected and managed by effective cooperation from subjects involved. It cannot be ignored that an overloaded health system risks to collapse. Nonetheless, it is important to keeping high the level of international attention to the issue, to foster research, to spotlight any relevant factor of dementia as a social phenomenon. Finally, to draw a conclusion it has to be remarked that international approach to mental health moved away from the medical pattern to social awareness and even acceptance, but with regard to dementia treatment States support is necessary and decisive to the attainment of goals.

Health and Development

International legal frame on mental health is rather clear, on the ground of basic prior assessment. In order to fully understand how current perspective envisages a global health plan, UN engagement has to be called once again: GA Resolution 70/1 of 21 October 2015, Transforming our world: the 2030 Agenda for Sustainable Development, replaces eight Millennium Development Goals (MDG's) - launched in 2000 and to be reached within 2015 - by seventeen Sustainable Development Goals (SDG's). The new agenda is rather ambitious, since some of MDG's had be only partially achieved in 2015 and moreover the 17 SDG's are sided by 169 targets. The Declaration states that "no one will be left behind" and conceives a comprehensive approach rooted on three dimensions: economic, social and environmental. It aims to "a world of equitable and universal access ... to health care and social protection, where physical, mental and social well-being is assured" and to reach this goal "we must achieve universal health coverage and access to quality health care". Goal 3 is devoted to health, "Ensure healthy lives and promote well-being for all at all ages" and 3.4 declares that"By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (italics added). Declaration doesn't need to be more detailed on mental health, as implicitly recalling relevant WHO documents on it. Non-binding legal acts, conveying soft law, contribute to international customary rules creation, binding for all States; therefore, UN Resolutions provide a global frame on sensitive topics for international community and linked to it thorough and more specific provisions are given by International Organizations competent on the matter [12]. A joint effort in this sense is found in 2010 UN (DESA)-WHO Policy Analysis, Mental Health and Development: Integrating Mental Health into All Development Efforts Including MDG's, where mental health is declared as an emerging development issue and that "Including mental health as an integral part of development is relatively new to the United Nations and its development partners. There is growing recognition within the international community that mental health is one of the most neglected yet essential development issues in achieving the Millennium Development Goals (MDGs)" and that "Mental health represents a critical indicator of human development, serves as a key determinant of well-being, quality of life and hope, has an impact on a range of development outcomes and is a basis for social stability". It is then noteworthy 2010 WHO document on Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group, relevant for stressing development primary role in strengthening people affected by mental health problems, vulnerable and subjected to social exclusion. GA Resolution 65/95 of 10 February 2011, Global health and foreign policy, underlines "the central role of the global partnership for development and the importance of Goal 8 in achieving the Millennium Development Goals". Finally, a most interesting framework on relationship between disabilities and development, mental health included, is given by 2015 UN Global Status Report on Disabilities and Development, which investigates on accessibility requirements to development for any kind of disabled person [13].

Conclusion

Does international law development in mental health issues play a role in mental health care?

This research aims to depict the international legal framework on mental health, since paying attention to this most relevant issue a relevant support is given to States in order to address national policies, either to healthcare systems or to domestic legal rules. Both UN and WHO are working hard to keep high the global attention on health, in order to promote proper rules to manage mental health and dementia above all brain diseases. Considering mental health, and mostly dementia, as a disability and, before that, a human rights concern, is an outstanding step ahead in International Law. A subtle distinction between International Law and national rules on mental health problems affected patients have to be made: indeed, the first cannot compel States to adopt specific national acts in order to provide a proper health care for patients. It means that International Law cannot affect States' tendency to make dementia patients' families responsible for their care; and that international rules are not relevant to address national healthcare policies, depending on each single State's decisions on investments. Nonetheless, it should be emphasized International Law recent attitude to mental health issues, celebrating them within the wide range of human rights, therefore binding States in implementing human rights law standards on mental health care national policies; and promoting social awareness, to keep the new approach and remove some stigmas: among them, attitude to dementia as a social disease [14-16]. Services are necessary to face multiple needs required by the high number of people affected by mental health, but cultural tissue is the inherent requisite to reach any other goal.

References

1. (1975) GA Resolution 3447 of 9 December.
2. Smebye KL, Kirkevold M, Engedal K (2012) How do persons with dementia participate in decision making related to health and daily care? A multi-case study. BMC Health Serv Res 12: 241.
3. Daly R, Bunn F, Goodman C (2016) Shared decision-making for people living with dementia in extended care settings: Protocol for a systematic review. BMJ Open 6: 1-7.
4. COM (1996) 406 fin of 30 July .

5. FRA (2011) The legal protection of persons with mental health problems under non-discrimination law. Publications Office of the European Union, Luxembourg.
6. Arena Ventura CA (2014) International law, mental health and human rights. The centre for civil and human rights, University of Notre Dame, p: 9.
7. Saxena S, Funk M, Chisholm D (2013) world health assembly adopts comprehensive mental health action plan 2013-2020. Lancet 381: 1970-1971.
8. Mackenzie J (2014) Global mental health from a policy perspective: A context analysis – Characterizing mental health and recommending engagement strategies for the Mental Health Innovation Network. Report.
9. (2016) MhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. World Health Organization Library, Geneva, Switzerland.
10. (2016) ADI World Alzheimer Report. Improving healthcare for people living with dementia-coverage, quality and costs now and in the future.
11. WHO (2012) Dementia: A public health priority.
12. Patel V, Chisholm D, Parikh R, Charlson FJ, Degenhardt L, et al. (2015) Addressing the burden of mental, neurological and substance use disorders: Key messages from Disease Control Priorities, 3rd edition. Lancet 387: 1672-1685.
13. Patel V, Chisholm D, Dua T, Laxminarayan R, Medina-Mora ME (2015) Mental, Neurological and Substance Use Disorders. Disease Control Priorities, 3rd edition. World Bank, Washington, DC, USA.
14. Wildeman SM (2013) Protecting rights and building capacities: Challenges to global mental health policy in light of the convention on the rights of persons with disabilities. J Law Med Ethics 41: 48-74.
15. UN Department of Economic and Social Affairs (2015) Global status report on disabilities and development, prototype. Unedited version.
16. Mental Health Foundation (2015) Dementia, rights and the social model of disability-A new direction for policy and practise? Policy Discussion Paper.