Mental Health in Italy During the Pandemic: A Shift from Self-determination to Solidarity?

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Abstract The State of Exception caused by the pandemic constitutes an indispensable starting point of a redefinition of the relationship between public and private spheres in the perspective of protection of right to mental health. The authors trace the evolution of the right to health, in the international, European and domestic context and deepen the theme of the protection of the right to health of persons with mental illness. The Italian constitutional framework represents a peculiarity since it is characterised by a strong solidarity-based character and a specific attention on the right to health. Its constitutional formulation outlines a twofold role: fundamental right of the human person and interest of the community. The Italian legal system has given primary importance to mental illness, starting with the so-called Basaglia Law. The pandemic emergency has prompted the Italian government to adopt a series of welfare measures that do not always fully protect mental health. For this reason, the authors call for a reorganisation of the national health care system that can enhance the solidaristic principle.

Keywords Mental health · Right to health · Self-determination · COVID-19 · Solidarity

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1 Coronavirus and State of Necessity

The lockdown imposed by the pandemic emergency has had significant repercussions on mental health and on the legal relationships that concern them [1]. It therefore appears central to analyse the impact that the emergency legislation imposed by the spread of the COVID-19 syndrome has had on mental health.

It has been acutely observed that the coronavirus has led to a measurement of the quality of the possible or impossible relationship. If the physicality of the encounter contains within itself the ‘germ’ of a potential infection—if, therefore, the contact now holds in the form of a substantial contamination—, the reason for the detachment must prevail. Indeed, in this period, social and family relations also had to compare the reasons for social distancing, a new form of solidarity capable of stemming the spread of the pandemic and thus protecting individual and collective health [2]. Nevertheless, the social distancing itself has over time led to heavy repercussions in terms of mental health. Such mental health repercussions have ended up calling into question the public/private dichotomy, both with respect to the role of the State and the exercise of personal freedoms.

The theme of the relationship between pandemic, democracy and State of Emergency has been the subject of an animated Italian cultural debate. In particular, the discussion was opened by an article by the philosopher Giorgio Agamben, where he started from the observation that the institutional reaction to the pandemic shows itself—once again—the growing tendency to use the State of Exception (SoE) as a normal paradigm of government [3], p. 11. The effect of the decree-law immediately approved by the Italian government ‘for reasons of hygiene and public safety’ in fact was a real militarisation of the municipalities and areas in which at least one person is positive. In such cases, the source of transmission was unknown or the case was not attributable to a person coming from an area already affected by the virus infection.

Although Agamben has probably underestimated the risks and the real extent of the disease, he starts from a correct perspective of analysis: that which sees the need for security of the population as an instrument of government [4].

From a technical-legal point of view, the SoE constitutes a limit situation of suspension of the constitutional order in force, or of a segment of it [5]. In this circumstance, the figure of a supreme decision-maker emerges, whose role is to arbitrarily declare the SoE, defining its content and the methods of exercising power itself. The entire legal system therefore ends up falling back on the will of the decision-maker, who unlimitedly centralises every power and prerogative within himself. This definition, typical of Western legal thought, has its roots in the reflections of two thinkers, Carl Schmitt and Santi Romano.

In particular, Carl Schmitt defines the SoE as the dictatorship itself [6], associating this institution to the concept of sovereignty: the sovereign is the one who decides on the SoE [7]. In this way, sovereign power compensates for the absence of law. According to Schmitt, within the SoE, there would be an eclipse of the rule in favour of the decision alone, while maintaining a correlation with the law [6]

Santi Romano, on the other hand, makes an attempt to reconcile law and a SoE, through the paradigm of the State of Necessity. In fact, it would not be an eclipse of the legal system, but a constitutional condition of *ordinary* emergency, internal to the system itself and necessary to overcome a crisis situation [8].

On the contrary, this position is rejected by Giorgio Agamben, who affirms that necessity does not fall within the category of sources of law [3], p. 23. There would therefore be no relationship between the production of law and the State of Necessity. The latter remains relegated to the space of the non-juridical, which sees citizens at the mercy of the sovereign's will. In reiterating its incompatibility with the law, Agamben also observes how the paradigms of the SoE have become more and more normalised, turning into ordinary instruments of governance. This would also happen on the occasion of the recent pandemic. In fact, we would be faced with a substantial suspension of constitutional guarantees, in which the production of law is entrusted primarily (if not exclusively) to decrees of the President of the Council of Ministers (rules that formally are not law) [9]. From Agamben's point of view, the pandemic emergency situation could therefore be easily brought back within the framework of the SoE, having the executive power assumed the role of supreme decision-maker. In this space of non-juridicality, the individual would be perceived as a potential infected, allowing an arbitrary compression of his freedoms and rights [2, 3].

Moreover, the coronavirus pandemic has brought to light the importance of investigating the public/private dichotomy, analysing how the relationship between the two has changed and what role the public sphere tends to assume. The neoliberal myth that the best regulation would be that left to private self-regulation now emerges in all its fragile ideology. What happened seems to have brought out a generalised 'need for the State'. This perception has been exacerbated by a growing sense of insecurity, due to the severe economic crisis engendered by the lockdown and the prolonged paralysis of several productive sectors. This has led to a rethinking of the role of the State, calling for its more incisive intervention in income support and supplementation policies.

To better understand this scenario, however, it is necessary to analyse the particular evolution of the fundamental right to health.

2 The Right to Health as a Fundamental Human Right

The right to health is an essential part of internationally recognised fundamental human rights. The right of every person to enjoy the best conditions of physical and mental health that he or she is capable of attaining was first mentioned in 1946 in the Constitution of the World Health Organization (WHO), whose Preamble defines the concept of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The Preamble further states that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. The Preamble thus defines the right to health and explicitly connotes it as a fundamental right [10].

The right to health will find explicit recognition, 2 years later, in the Universal Declaration of Human Rights (UDHR). Everyone has the right to living standards that are appropriate for his or her own health and the welfare of his or her family, including nutrition, accommodation, and medical treatment, according to Article 25 of the Universal Declaration of Human Rights (UDHR), which was approved by the General Assembly of the United Nations (UN) on 10 December 1948.

In addition to these two documents, the provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR) must also be taken into account. This document was written according to the directions of the United Nations and was opened for signature by General Assembly resolution 2200 A (XXI) of 16 December 1966. It became effective only on 3 January 1976.

The 1966 Covenant, instead adopting the WHO definition of right to health, provided its own definition mentioning that everyone has the right to the enjoyment of the highest attainable 'standard' of physical and mental health (Article 12(1)). Further, it specifies how this right must be guaranteed including reducing stillbirth rates and infant mortality for child health development; better environmental and industrial hygiene; epidemics, endemics, occupational diseases and other problems should be prevented, treated and controlled; and make sure you get all the medical care that individuals need (Article 12(2)).

Although the three mentioned documents identify health as a fundamental human right, they do not provide the jurist with precise parameters to connote the right in question. It is unclear what is concretely meant by 'standard' of health, and as a result, the specific content of international obligations still remains a debated issue. Albeit having to respect, protect and realise the right to health are the basis for understanding the obligations of State parties, the actions to be taken in practice are less clear. This gives rise to a second issue: the lack of clarity on obligations risks leaving State Parties with a dangerous margin of discretion. If there is no obligation to allocate a specific number of resources in the health system, the State, especially if it is a developing country, can claim an absence of resources and thus justify not allocating money in the health sphere. This problem is often highlighted, but still unsolved: people in poor countries tend to have less access to health services than those in better-off countries [11]. However, investing in health for a developing country represents a great opportunity for economic growth and State health budgets should be as sizable as possible, as that makes investing in wealth returns. It has also been shown that in reality, measures to improve the health *status* of individuals are not a costly operation for States, quite the opposite. In 1993, the World Bank stated that 'spending on health can also be justified on purely economic grounds. Improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness' [12].

Despite the difficulties highlighted above in identifying an objective standard in health, it is remarkable to note that the Court of Justice of the European Union (CJEU) explicitly resorted to the above-mentioned WHO's definition issuing the judgement in the case *United Kingdom of Great Britain and Northern Ireland v Council of the European Union* (Case C-84/94, judgement of 12 November 1996), which concerned occupational health and safety matters [13].

While it is unquestionably assumed that the right to health is a fundamental right, it should nevertheless be kept in mind that the concrete needs for health protection, although they may be *latu* sensu common, are profoundly different depending on the geographical areas taken that, despite being broadly ubiquitous, the actual demands for health protection vary greatly depending on the regions that are being considered.

On the other hand, however, the right to health, like the majority of human rights commitments, everyone is entitled to the right to health, regardless of their *status* as a person in the eyes of the law. Stateless people, detainees, and unauthorised migrants are all covered. The realisation of the right to health shall be gradual and progressive, similar to other social and economic rights. Under Article 2(1) of the ICESCR Covenant, states that ratify the covenant must take all necessary steps to gradually realise every facet of this right, including enacting legislative measures.

The provision of a gradual realisation of this right (*verbatim* 'progressively') implicitly entails that the implementation of any cultural, social or economic right must be fully realised through time; it is not achievable in the short term. Each State Party is only required to realise the right to health in as gradual a manner as possible rather than instantly implementing it in its entirety. This right indeed cannot be realised at once, unlike other rights such as the right to life. In other words, the complete realisation of a right that falls under the area of economic, social and cultural rights, like the right to health, requires a longer term strategy across time.

This does not mean, however, that State Parties do not have obligations to individuals. States, in ratifying any human rights convention, must meet three requirements: respect, protect and realise the fundamental rights and freedoms enshrined in the agreement. The right to health is no exception, as specified by General Comment No. 14 of the Committee on Economic Social and Cultural Rights. Indeed, it makes it clear that: 'health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity'. Recognising health human rights implies that the State Party must not interfere, directly or indirectly, with the enjoyment of the right. For example, the State may not discriminate (implicitly or explicitly) against individuals or grant access to the right to health only to certain categories, as it would constitute interference with the right. Protecting health as a human right also requires affirmative action by the State: it must take steps to prevent third parties from undermining the exercise of this right. Operating on the human rights level requires a more dynamic approach, demanding the State Parties to take concrete action through the adoption of legislative, administrative and financial measures to realise progressively the right to health to the fullest. This means that the State must commit to allocating a certain number of resources for health and must create laws that lead to the highest enjoyment of the right to health.

More broadly, the right to health also presupposes an additional obligation: cooperation. States must cooperate as much with international organisations, such as WHO or the UN, as with non-governmental organisations and other States. As a progressive right, the right to health needs joint actions, for without them there could be no question of success in respecting, protecting and realising rights. If a State has the means to influence other countries about the enjoyment of the right to health, it should attempt to cooperate as much as possible.

2.1 Implementation of the Right to Health at International Level

It was outlined above how health should be regarded as a human right. As a result, it stands as an underpinning for all other fundamental rights. Due to the pivotality of the right to health, States and their bodies are held responsible for far more than just managing health systems. They ought to take it upon themselves to detect and identify the elements that have a detrimental effect on everyone's well-being through proper cooperation. Nevertheless, they should implement those that have a favourable effect. The fulfilment of ad hoc initiatives by the WHO is crucial for the progressive implementation of the right to health. Two approaches, in particular, have been adopted since the 1980s.

They are, respectively, known under the name of 'Health for All' strategy and 'Health Promotion', or Ottawa Charter. These measures are intended to achieve two strategic goals: illness prevention and health promotion.

In 1981, the WHO Assembly unanimously adopted the 'Global Strategy for Health for All by the Year 2000'. This document states that: 'as a minimum *all* people in *all* countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live'. To achieve these goals, it is stated that: 'every individual should have access to primary health care and through it to all levels of a comprehensive health system' [14].

A few years later, in 1986, the First International Conference on Health Promotion conference was held in Ottawa. The Conference outlined strategies for a global, coordinated effort focused on the person's physical and psychological welfare. As a prominent outcome of this Conference, the Ottawa Charter was subsequently signed by the WHO Member States. The human being is at the centre of the Ottawa Charter. The Charter is based on a comprehensive understanding of the human being as a whole, rather than as a combination of its own parts. In line with this, social organisation is seen as a cohesive totality.

In this light, in order for everyone to reach their full health potential, they must be placed in the most favourable situation. Any stakeholder (governments, private and public health organisations, as well as whatever non-governmental organisations) can actively participate in the implementation of this new approach to the right to health, ordered to equity. According to the Ottawa Charter, health promotion is the process of empowering people to exert more control over and enhance their well-being. As a result, health develops into an essential asset for daily living and an outcome that improves the world itself. Everyone needs to develop his or her capacity to take care of both himself or herself and the others. In this manner, the Ottawa Charter supports a social health accomplishment aimed at establishing the optimal conditions for a healthy human development at all stages of life and under all circumstances.

3 The Right to Health in the European Context

In the European context, it should be borne in mind that in 1998 the WHO Regional Office for Europe (WHO/Europe) adopted the 'Health for All in the 21st Century'. The document is also known as 'Health 21' not only because it deals with health in the twenty-first century, but also because it lays out 21 'targets' for improving the health of Europeans. Keeping the findings of the 'Health for All' strategy of two decades earlier, this document aims to achieve a successful translation of policy to action, taking the European framework as a reference. With the awareness that the range of strategies available to improve health is wide and the availability of resources is constrained, the WTO/Europe requires States to carry out a priority-setting [15].

In addition to WHO/Europe, reference must be made to the Council of Europe and the European Union (EU) when it comes to health in Europe. With respect to the former, as noted by Harris et al. [16], the right to health, similar to the other 'social rights', is not explicitly stated in the 'European Convention on Human Rights' (the ECHR), in force since 3 September 1953. This is precisely why it was necessary for the European Court of Human Rights (the ECtHR) to intervene.

By way of an evolving and thorough interpretation of other sections of the Convention, especially Article 3 (the prohibition of torture) and Article 8 (respect for private and family life), the ECtHR has gradually increased the protection of the right to health.

The limits of this indirect means of defence are, however, evident. Purely on its own, the right to health is not safeguarded. It is only when its violation takes the form of the infringement of another right expressly recognised by the Convention that a broad protection can include the right to health. The ECtHR jurisprudence clearly shows this pattern. See the following cases in particular: ECtHR, *Kudla v Poland*, application no. 30210/96, Judgement of 26 October 2000; ECtHR, *Poltoratskiy v Ukraine*, application number 38812/97, Judgement of 29 April 2003; ECtHR, *Bensaid v UK*, application no. 44599/98, Judgement of 6 February 2001; ECtHR, *Vo v France*, application no. 53924/00, Judgement of 8 July 2004; ECtHR, *Pretty v UK*, application no. 2346/02, Judgement of 29 April 2002; ECtHR, *Tysiac v Poland*, application no. 5410/03, Judgement of 20 March 2007; ECtHR, *Ashot*

Harutyunyan v Armenia, application number 34334/04, Judgement of 15 June 2010; ECtHR, *K. H. v Slovakia*, application no. 32881/04, Judgement of 28 April 2009; ECtHR, *Evans v UK*, application no. 6339/05, Judgement of 7 March 2006; ECtHR, *Dybeku v Albania*, application no. 41153/06, Judgement of 18 December 2007.

Instead, the 'European Social Charter' (ESCr), a Council of Europe instrument that was adopted in 1961 and later amended by additional protocols, establishes everyone's entitlement to the right to health [17]. The text of the treaty was also completely revised in 1996. The ESCr, Part I (11), provides that: 'everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable'. Additionally, the ESCr has a clause in Article 11 that specifically mentions the 'right to protection of health'. The 'appropriate measures' of the States Parties, who vowed to uphold the right to health, are outlined in the wording of the conclusive part of Article 11, that (without any claim to completeness) enumerates the following:

- To eliminate the root causes of ill-health as much as feasible
- To offer resources for guidance and education aimed at promoting health
- To encourage personal responsibility for the individual's health
- To eradicate endemic, epidemic, and other diseases as much as possible

In particular, the States Parties undertake the above-mentioned measures either directly or in conjunction with public or private organisations.

It should be borne in mind that this treaty is characterised by a so-called *a la carte* system, whereby single States can decide which specific articles to bind themselves to. This obviously diminishes its impact. With reference to Article 11, only one of the 43 States Parties decided not to bind. Namely, Armenia [17].

By adopting 'appropriate measures', the States Parties are obligated to guarantee 'the effective exercise' of the right to health under Article 11 of the ESCr. The 'Statement of Interpretation of Article 11 - Conclusions 2005' (Council of Europe, 2018) by the European Committee of Social Rights made it clear that in order to fulfil the duty to ensure the right to health protection, positive measures (i.e. legislative, administrative, technical measures) must be taken that are appropriate for achieving the goals specified by the provision.

Along these lines, the Social Rights Committee stated that States Parties ought to consider taking measures to eliminate the causes of poor health as a positive obligation. Therefore, they must ensure that everyone who needs healthcare can get it and afford it. Such access cannot be limited by a lack of financial means. As a result, States Parties that have ratified the ESCr are required to ensure that all people with no income have free access to healthcare.

Concerning the actual implementation of the right to health by the Council of Europe, one more significant document must also be mentioned: the 'Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine', opened for signature on 4 April 1997 in Oviedo (the Oviedo Convention).

Ratification of the Convention is not limited to States Parties to the Council of Europe, but is extended to all States that participated in the preparatory work. The provisions of the Oviedo Convention effectively respond to the challenges of a constantly changing medical field and the risk of indiscriminate use of bio-medical technologies. The Oviedo Convention reaffirms the centrality of the right to health: at Article 2 it states that '[t]he interests and welfare of the human being shall prevail over the sole interest of society or science'.

At the European level, the protection of the right to health guaranteed by EU regulations must also be kept in mind. The highest level of protection is provided by the Treaty on the Functioning of the European Union (the TFEU), which implements cross-cutting actions. Also worthy of particular attention regarding the right to health in the EU context is the 'Charter of Fundamental Rights of the European Union' (CFR), ratified 7 December 2000 and entered into force on 1 December 2009. Moreover, more recently, precisely in 2017, the EU Commission adopted the 'European Pillar of Social Rights' (EPSR).

In the TFEU, Article 6 assigns to the EU competence to carry out actions aimed at supporting, coordinating or supplementing the Member States' measures. The preservation and enhancement of human health is one of the areas covered by such initiatives. Article 9 states that the EU is required to define and implement its policies and activities, taking its actions and protocols, taking into consideration standards related to the development of a high level of human health protection.

Furthermore, Title XIV of the TFEU in its heading explicitly refers to public health and, in its provisions, assures that all EU actions and protocols will provide a high level of health protection for people. According to Article 168(1), EU action must complement national protocols and be focused on enhancing public health, mitigating both mental and physical diseases, and eliminating sources of risk to one's physical and mental well-being. It follows from this provision that, instead of establishing health policies, the EU operates as a coordination body.

Furthermore, according to Article 168(2), the EU will foster collaboration among Member States in the area of health protection and, when deemed necessary, shall lend support to their action. The CFR, at Article 35, establishes within the EU the right of everyone to have 'access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices', and provides that a 'high level of human health protection' will be ensured through implementation of health policies and activities.

The EPSR, dating back to 2017, upholds the right to health in relation to the workplace. The EPSR outlines 20 principles on the related factors affecting health, such as social protection and equitable workplace conditions. With this regard, Chap. 2 (10) states that workers have the right to a high level of protection of their health.

4 Protection of the Right to Health of Persons with Mental Illness in the International Law

Within the general context of the right to health, special attention should be paid to mental health. The debate leading to a pronouncement on the international level has been extensive and time-consuming [18]. In 1991, the UN General Assembly adopted the ‘Principles for the protection of persons with mental illness’ (MI principles) [19]. This is a detailed international statement that provides agreed (but non-legally-binding) basic standards of care for mental illness. The MI principles ensure the best medical and psychiatric care available, including respect for people’s dignity, non-discrimination, protection from exploitation, abuse, and any other kind of degrading treatment are fundamental freedoms and rights [20].

The MI principles recognise the difficulties associated with protecting human rights in mental health facilities and emphasise that assistance should, whenever possible, be carried out within the community. This bias is motivated by the duty to treat patients in the least restrictive environment possible. The aim is to allow the patients’ personal autonomy to be preserved as much as possible. The MI principles define a set of legal standards and procedural safeguards for involuntary patients. In this way, the MI principles clearly establish under what circumstances a person may be subjected to involuntary admission [21]. To ensure that involuntary admission or retention meet the requirements set out in the MI principles, a patient must be put in a position to conduct a procedure as provided by domestic law before an impartial and independent court or review body. This corresponds to a fundamental option: the MI principles offer strong protection in the case of involuntary admission or retention, as they are aimed at achieving a balance between autonomy and coercion [22].

In any case, the MI principles guarantee persons with a mental illness a range of civil and political rights, including rights of confidentiality, full respect, privacy, information access of individual health, freedom of communication and of religion or belief. Besides, these principles ensure specific social, economic and cultural rights like the right to social services appropriate to health needs, an individualised treatment plan, recreational and educational services. In this respect, it can be easily inferred that psychiatric facilities must be allocated resources comparable to those provided for other health facilities [23]. As pointed out by some scholars [24], civil and political rights are provided for the benefit of all persons with mental illness. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights.

In addition to the MI principles, the United Nations has promulgated numerous other sources of soft law whose application is intended to improve the condition of the mentally ill. Among these sources, it is worth mentioning declaration on the rights of mental retarded, and the standard rules on the rights and equal opportunities for disabled persons [25–27]. The ‘Declaration on the Rights of Disabled Persons’, in particular, broadly defines a person with a disability as ‘any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities'. It contains, as well, an extensive list of civil, political, economic, social and cultural rights, including 'the right to medical, psychological and functional treatment' and 'the right to economic and social security and to a decent level of living'.

Lastly, the World Conference on Human Rights, which was held in Vienna in 1993, adopted the 'Declaration and Program of Action' [28]. This Declaration recognised that disabled persons are entitled, 'without distinction of any kind', to all human rights and fundamental freedoms, in line with the UDHR 'common standard' for everyone [29]. Furthermore, this Declaration provides an action program aimed at raising awareness of human rights in the context of disability.

5 The Right to Health in the Italian Constitution

The right to health is established in the Italian Constitution at Article 32(1) mentioning that the State safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. Article 32(2) states that nobody can be forced to receive medical care unless it is mandated by law and that, in any event, the law cannot go beyond the bounds set by the dignity of the human person.

Article 32 intends to configure a balance between the individual and the collectively; the former's rights correspond to the latter's interest. Precisely, it emphasised the centrality of the individual's right to health, while putting it in necessary relation to the interest of the collectivity. From this it follows that within the Italian legal system, there cannot be a right to health that concerns only the individual by his or her own. This right on the contrary requires establishing a relationship between the individual and the collectivity.

Whilst the Italian Constitution directly regulates health at the constitutional level in Article 32, the text's underlying concept of health appears to imply that it ought to be regarded as an integral part of the human person. We are therefore faced, in the words of Pietro Perlingieri [30], with a unitarian value. The Italian Constitution's Articles 2 and 3 must be considered in combination with Article 32. Therefore, in the framework of the principle of solidarity, it is necessary to recognise the right to health as a fundamental human right for everyone, and any discrimination will not be admitted [30]. Four subjective legal dispositions are thus established in such a brief text: an individual right to freedom, a communal interest, and two distinct social rights, as correctly noted by Papa [31]. The right to obtain essential treatments is included in the first type of provisions referred to as the individual right to freedom, as does the right not to necessarily receive treatments if one chooses not to be treated.

In correspondence with this right, can be inferred the requirement to refrain from any positive conduct, which burdens, as pointed out by D'Aloia [32], everybody so as to permit the self-determination of the individual. The second type of regulations relating to the collective interest guarantees that the right to make personal health decisions independently will not compromise the common interest in health.

As remarked by Papa [31] in order to care for the human person, the State must consequently develop a reasonable balance of interests when deciding whether or not require compulsory medical treatments [31]. When prescribed to avert the transmission of an infectious disease, such as when it is in the prodromal phase of wide diffusion, the requirement to undergo this kind of mandatory treatments must be regarded as legal. Instead, the argument over preventative therapies, including vaccinations, is still controversial, despite their function is not limited to preventing citizens from getting sick while simultaneously avoiding them from harming the entire community [33]. The issue arises with particular complexity with regard to mental illness, since in this case the patient may express consent or dissent with respect to the vaccine that may be compromised by his or her contingent mental health condition. Not only does this affect the patient's future prospects for good health, but in general terms it has a reverberation on the community's interest in health.

This tangled issue imposes the implementation of the principle of precaution. Article 191 TFEU states this principle. It directs the selection of the proper safety measures to provide security in the healthcare sector. However, it is not enough to respond to a potential health danger. It is instead recommended to act in advance to prevent future risks [30], p.101. The application of the precautionary principle raises complex hermeneutical issues, as one cannot disregard a balancing of principles of constitutional significance. Furthermore, this balancing operation among constitutional principles needs to be accomplished with consideration of the principle of proportionality, that is crucial in an uncertain situation like the health one. It is important to consider the above-mentioned issues in regard to the CoVID-19 epidemic, which the WHO classified to be a pandemic on 11 March 2020 [34]. The pandemic had a peerless impact on collective health, as it has not happened. It had an adverse global impact on individuals' psychological health [35] and also involved working environments [36].

Beginning in 2021, the vaccine campaign received widespread and unexpected backing from citizens. However, it simultaneously led to broad responses from many individuals who refused to receive the vaccine. Such unfavourable responses call for a compromise between two constitutional principles in the framework of the Italian Constitution: individual freedom and self-determination and a common interest in health [33]. Anyways, this requires special attention when persons with mental distress are involved [1], p.16.

To conclude the analysis of Article 32 of the Italian Constitution, it should be noted that two social rights are established such as the right to receive health care treatments, and medical care with no costs. This is deemed applicable to both Italian and foreign citizens [37]. Finally, it should be kept in mind that the notion of the right to health that can be deduced from Article 32 of the Italian Constitution cannot be limited to the physical aspect and medical implications. In other words, this notion must not be restricted to treating illnesses, but it comes to involve the well-being of the human person in a broad perspective, as a single, indissoluble psycho-physical entity [30], p.131.

6 From Medical Paternalism to *Homo Dignus*: The Central Role of the Basaglia Law in the Italian Legal System

Together with personal freedom, and self-determination, the right to health will play a pivotal role. While recognising health as a fundamental right of the individual and as an interest of the community provides that no one can be obliged to a specific health treatment except by law. Furthermore, neither can the law violate the limits imposed from respect for the human person. This way the primacy of the individual over his own body is restored, avoiding functionalization of health, which risks appearing paternalistic. The right to health, on the other hand, shows its subversive potential from the outset, entailing on the one hand the guarantee of the habeas corpus by the State and local authorities, as clearly emerges from the Law No. 833/1978 establishing the National Health Services (NHS) [38]. This clarifies not only that the Republic protects health as a fundamental right of the individual and collective interest through the NHS, but also the protection of physical and mental health according to dignity and freedom. Accordingly, the Basaglia law imposed the closure of all mental hospitals in Italy and regulated compulsory health treatment, establishing public mental health services [39], p.26.

Provisions on voluntary and compulsory medical examinations and treatments have not only determined a new consideration of the mentally ill, but also affirmed the cardinal rule regarding compulsory health treatments. This is based on to which they must be disposed of in compliance with the dignity of the person and the civil and political rights guaranteed by the constitution, including as far as possible the right to free choice of doctor and place of treatment. The Italian NHS is implemented and broadened in scope in the sense that even compulsory health treatment must always be accompanied by initiatives aimed at ensuring consent and participation. Persons who are obliged to do so and in the course of compulsory medical treatment, the patient has the right to communicate with anyone he deems appropriate. These norms have forced us to reconsider the relationship between the mentally ill and society, since it has introduced the mentally ill person into civil society as had never happened for centuries, forcing the person to social relations with all other subjects of the community [38, 40].

The attention that developed in Italy in the 1970s for mental illness and the protection of the dignity of persons who are unable to understand and express their will will lead to a reconfiguration of the same relationship between physician and patient. Shifting the gaze of the law on mental illness has allowed Italy to personalise the dialogue between the physician and the patient with mental illness (and not only), calibrating it according to the level of understanding of the person and above all adapting the semantics of communication to the patient's level of understanding [41]. This however explains because also law scholars were the first to tackle the relevance of the right to health above all from an individualistic point of view, focusing on the specialty of the relationship of care between physician and patient, to guarantee health self-determination of the latter. Lastly, freeing it from traditional medical paternalism. In this sense, the bio-juridical debate has moved, from issues concerning procreative self-determination (medically assisted procreation and gestation for others) to the end of life (advance directives for treatment and assistance in suicide).

It follows that the debate in recent years has mostly marginalised the aspect of health protection as an interest of the community, improving instead the role of the patient in the therapeutic relationship [42]. Starting from the nineteenth-century codifications, which subjected patients to the physician's authority, until the emergence of the personalist principle and the resulting revolution of 'informed consent', which shifted the focus on patients and was finally recognised [43]. Indeed, in the eighteenth century, people's lives became an object of study and government for medical science, which ended up 'medicalizing' life itself, that is to say, translating into medical terms those issues that could have been dealt with by social measures [44]. That means exploiting dependence on the doctor's help for domain purposes, and ultimately, using knowledge in terms of power over the patient [45]. In fact, the therapeutic relationship entails functional subjection to treatment, which has historically implied the non-recognition of patients' authority over their bodies; indeed, the etymology of the term 'patient' refers to those who passively accept other people's actions [42]. Throughout almost the whole twentieth century, the healthcare professional was considered to have technical and scientific knowledge, which placed him or her in a dominant position, compared to the patient, who needs care and assistance. Thus, the physician–patient relationship is seen by the jurist as very similar to a family law relationship, characterised by the physician's authority as opposed to the patient's subjection [45].

The growing attention to people's bodies and human life, in the modern State, also led to the progressive widening, beyond the State of Exception, of the decision on 'bare life', to the point of reaching an area of indistinction between fact and law, where sovereignty enters in a more intimate symbiosis not only with the jurist but also with the physician, the scientist, the expert, the priest [5, pg. 135]. Therefore, who rules the ill citizen's body? [46] Following the atrocities that emerged during the Nuremberg Trial [47], as well as the principles outlined in post-conflict Constitutions, it can be argued that, in the Italian legal system, each citizen rules his own body [48]. Apparently, sovereignty over the citizen's body passes from the State, and thus from a public law discipline to the citizen, hence to a private law discipline. However, this is the legacy of what Michel Foucault called the 'microphysics of power', referring to the power that branches into all social relationships, becoming widespread [49]. And not without reason, concerning the different power devices, which tend to curb and define human subjectivity, the philosopher stressed that the 'right' to life, to the body, to health, to happiness, to satisfy basic needs, the 'right' to regain, beyond all the oppressions or 'alienation', what we are and what we might be, this 'right' that is so incomprehensible to the traditional legal system, is the political reply to all these new political procedures [50]. Although in a changing rules and principles scenario, the patient's self-determination in his relationship with the physician, will be a further hypothesis of 'juridification' of the human person [46, 51].

The growing importance of the personalistic principle, following the 1947 Constitution's enactment, led to a noteworthy modification of the physician–patient relationship [52]. This change will then strengthen what we may call the 'bioethical' paradigm [53], which tends to distance medical knowledge from exclusive science and insiders' competence, to recognise a specific competence of the patient [54]. The peculiarity of this new paradigm is that morality is intended as a social, not a natural institution, consisting of a set of rules and shared values in a given society, aimed at promoting coexistence, as well as a dignified level of well-being and self-fulfilment; namely 'quality of life' [55, 56].

This moral approach involves not only the decay of the sanctity of life and the irrelevance of finalism but also the distinction between biological and biographical life, as well as the loss of the almost sacredness of medical acts. Nevertheless, the most interesting scenarios of the change in the power relation between physician and patient seem related to the recent developments of informed consent. The Italian Constitutional Court gave it a prominent role, being the synthesis of two fundamental rights of the patient: the right to health and to personal self-determination [57].

As Stefano Rodotà has masterfully pointed out, we may believe that self-determination is the foundation of free governance of the self, and sovereignty over our bodies [55, pg. 267]. Naturally, self-determination has its limits since it can restrict the freedom of others and can be contradictory. The subject of imposing limitations is a particularly delicate point because it immediately produces hostility towards 'paternalistic' Legislators, who have no right to invade the sphere of personal freedom [56], p. 250. Furthermore, only since the 1990s, the privileged system of medical malpractice has been facing a deep crisis, caused by both criminal [58] and civil case-law, after the affirmation of the patient's right to individual self-determination, within the therapeutic relationship [59]. Thus, in the context of the 'constitutionalization' of the person [51, 56], informed consent ends up entailing a substantial legal paradigm shift, by reshaping the private law relationship between the healthcare professional and the person assisted, restoring the patient's control power over himself/herself and his/her health. In this way, the physician–patient relationship switches from a paternalistic perspective [60] to a potentially equal approach, based on cooperation. While the first one sees the physician as the only one competent to determine whether the damage exists and how much it amounts to, the second view is summarised by the expression 'therapeutic alliance' between patients and physicians.

Furthermore, the developments in case-law regarding informed consent are deeply affected by the ambiguous nature of such consent, which assumes different functions, of using different narrative stratifications, depending on the case. It may be considered as a condition and foundation of the legitimacy of the medical act, and thus an essential requirement of the relationship concerned; it can be taken as a criterion for transferring the risk of treatment from physician to patient, through consent [61]; finally, it may be seen as the expression and exercise of people's fundamental rights, such as health and self-determination [62–64]. Therefore, in recent studies, the information obligation represents an integral part of the therapeutic performance, as well as a sort of independent (and not accessory) healthcare, just like the diagnostic intervention [65]. The emergence of the patient's self-determination in the care relationship has increased the number of subjective legal situations that physicians can harm in their work. The right to self-determination represents a form of respect for the freedom of the individual and, at the same time, a means to pursue his or her best interests. It consists not only of the right to choose between different possibilities of medical treatment but also to possibly refuse therapy and to consciously decide to interrupt it, considering the personalistic principle, which animates the Italian Constitution. This sees a human being as an ethical value in itself, which must be respected at any time of his life and in his entirety, in the light of the set of ethical, religious, cultural and philosophical convictions that guide his volitional determinations [46, 66]. Furthermore, the violation of the right to self-determination has become fully independent from the infringement of the right to health. This means that the lack of informed consent to medical treatment can take on significance for compensation purposes, although there is no damage to health, or if such damage is not causally connected to the violation of that right, in all cases involving negative consequences (which must be quite serious, in case of non-material damage) resulting from the violation of the fundamental right to self-determination, considered by itself [67]. Thus, in this perspective, the right to informed consent represents one aspect of the inviolable right to personal freedom, since the *homo juridicus* has acquired the *homo dignus* legal identity, according to an axiological interpretation not only of constitutional rights but also of those mentioned in European sources.

By accepting the authoritative doctrine, the judges of the Italian Court of Cassation recalled the legislative sources underlying the right to informed consent, a genuine right of the person. Thereby, following Stefano Rodotà's reconstructive proposal, the Court of Cassation identified human dignity as an inevitable common denominator, a legacy of the constitutionalism of the second post-war period, drafting both a new *status* of the person and a new framework of constitutional duties [56, pg. 179]. First of all, *homo dignus* is a self-determined man, who is enabled to define his life project. Hence, in a legal system based on the anthropological model of *homo dignus*, no external will can replace that of the person concerned, especially in the physician–patient relationship. Then, under living law as laid down by the constitutional statements and by the Italian Court of Cassation, as well as by the osmosis between interpretation, on the one hand, and internal and international rules, on the other, concerning healthcare interventions on patients, the State and its institutions, including the judge, have a duty to ensure a *focus* on the dimension of the human person in its concrete existentiality, due to its dignity, that governs fundamental rights, and without which these rights may be subject to limits capable of downgrading their impact. It also represents an axiological value, which underpins the legal system as a whole and thus, *a fortiori*, each ordinary rule. Therefore, if *homo juridicus* is now *homo dignus*, as held by Italian Court of Cassation in judgement No. 7237/2011, by accepting the authoritative doctrine and by starting from various provisions on human rights, case-law is further improved in these hypotheses. In any case, the jurisprudence crystallised the principle according to which the omitted or insufficient information with a healthy intervention represents a violation of the right to personal self-determination which, however, becomes compensable only if the patient attaches that, due to this, he or she has suffered a truly harmful consequence in terms of subjective suffering and contraction of the freedom to self-determination.

After many years of bioethical, deontological and bio-juridical reflection, on 14 December 2017, the Senate of the Italian Republic finally approved the legal text 'Rules on informed consent and advance treatment provisions', carefully legislating on ethically sensitive issues, such as the care relationship and the end of life [68]. Although medically assisted death and assisted suicide are still not recognised, the law approved by the Senate appears to be consistent with regulations aimed at protecting *homo dingus*. Indeed, it is keen to ensure the patient's self-determination and dignity, which have primacy over 'other' choices of the healthcare professional or the interested party's family, under Articles 2, 13 and 32 of the Italian Constitution, and Articles 1 ('Human dignity'), 2 ('Right to life') and 3 ('Right to the integrity of the person') of the CFR of the EU. Overall, by incorporating the main supranational directions and the best national court decisions, the law introduces significant innovations in the Italian legal system.

7 Solidarity as a Principle for Reinterpreting Health and Other Fundamental Rights

Regarding the theory of the State of Exception, essentially centred on the restriction of individual freedom, there is a need for a more aware reconstruction of the concreteness of the pandemic situation [69]. In particular, these measures, by the very nature of the epidemic phenomenon, must operate a prudent balance, which takes into account the protection of individual freedoms and ensures the effectiveness of the rights of the community within which these freedoms are exercised [70]. A reasonable and proportional compression of some individual rights could therefore be justified, in the specific case, by the solidarity need for the protection of public health. This is true, in particular, for the subjects most vulnerable to the risk of possible contagion. Beyond any theoretical reconstruction, there is a need for a concrete solidarity perspective, [71] which adequately considers the general constellation of interests that gravitate around the pandemic.

Health, in a collective sense, has instead been brought to the centre of attention with respect to the case of compulsory vaccinations. A question regarding the issues of constitutional legitimacy raised by the Veneto Region, ten compulsory vaccinations were provided for minors up to 16 years of age, including unaccompanied foreign minors, with simultaneous provision, for cases of non-compliance, administrative pecuniary sanctions, and the prohibition of access to services educational for children. In this regard, the Italian Constitutional Court found the question unfounded, since the laws that provide for vaccination obligations if they coordinate the protection of collective health with the individual right to health, as well as, in the specific case of compulsory vaccinations, with the interest of the child, which also requires protection against parents who do not fulfil their care duties. The coordination of these multiple fundamental rights and principles, therefore, leaves room for the discretion of the Legislator in choosing how effective prevention of infectious diseases is ensured.

The issue of vaccines has also been questioned by Italian scholars with special reference to persons with mental frailty and the mentally ill. Here too, therefore, the criterion to be affirmed is that the person concerned, even when mentally different from others, will need only himself or herself, even in the case of coronavirus, to express valid consent to vaccination [1, 33]. It is clear, on the other hand, that the pandemic has put on the balancing plate not only the right to health, in its individual and collective dimension but a whole series of constitutional freedoms, whose compression seems to be justified in conformity with the principle of social solidarity under Article 2 of the Italian Constitution.

Among the ‘new generation’ fundamental rights that risk being compressed due to the lockdown, for example, there is the protection of personal data. In this regard, it is interesting to underline the issue of the processing of personal data: in the case of data tracing, a treatment that seems necessary to monitor and contain the spread of the pandemic can be highly problematic, due to the need for a balance with the rights and freedoms of all and of each. On the other hand, health data, unlike other sensitive data, see the fundamental right of the person concerned not to disclose his medical and health situation to be more clearly contrasted with the interest of the community or of third information parties [1, 70].

The need to balance these opposing legal situations at stake, however, confirms that no information is valid for itself, but for the context in which it is inserted, for the purposes for which it is used, and for the other information to which it is connected [70]. Even the coronavirus, then, places us in front of the need to balance interests that lean in favour of collective health already by the provision of Article 9 of the General Data Protection Regulation (i.e. EU Regulation No. 2016/979), which allows the use of personal data even without the consent of the interested party just when the processing is necessary for reasons of public interest in the public health sector [1], p.101.

That no fundamental right is incompressible, on the other hand, is confirmed by Article 52 of the CFR of the European Union, where it is envisaged that, in compliance with proportionality, fundamental rights and freedoms may be limited where necessary and for purposes of general interest. ‘General interest’, ‘public interest’ and ‘community interest’ are all notions that, in an emergency and uncertain situation such as that caused by COVID-19, require broadening the scope of the duty of solidarity [71, 72].

8 The National Health System to the Test of the Pandemic

The health emergency due to the pandemic has left its mark on the emotional and psychological spheres of many persons. A considerable number of persons found themselves dealing with disorders such as anxiety, depression, stress and psychological fragility, more or less directly related to the situation and a suddenly uncertain and changing context. Although in all countries, the knowledge on the impact of the pandemic on mental health is still limited and mostly derived from experiences only partially comparable to the current epidemic, the demand for psychosocial interventions will likely increase significantly in the coming months and years. Investing in nationwide mental health services and programs, which have suffered from limited funding for years, is therefore now more important than ever. The past few months have brought many challenges, particularly for healthcare professionals, students, family members of COVID-19 patients, people with mental disorders, and more generally people in disadvantaged socioeconomic conditions, and workers whose livelihoods have been threatened.

At the EU level is of interest the report 'The impact of the CoVID-19 pandemic on the mental health of young people', published by the EU Commission on the occasion of the European Year of Young People (2022) [73]. This research analyses how European countries have addressed the challenges posed by the pandemic to the mental and emotional well-being of young people.

According to the report, member States took a proactive approach to address the mental health of young people during the pandemic emergency. One of the most common measures taken was to strengthen psychological support in schools, both by increasing the number of psychologists and counsellors available to students and by training school staff to recognise and address signs of mental distress. Six sectors were mainly involved: mental health protection, education, information on the impact of the pandemic on psychological well-being, youth work, leisure, and sports. To concretely help citizens in combating these issues, the Italian Legislature, by decree-law of 30 December 2021, converted by Law No. 15/2022, introduced as an additional form of economic support the 'psychologist *bonus*'. The measure is designed to provide help in supporting expenses related to psychological and psychotherapeutic care pathways. It should be noted that there is no age distinction for obtaining the psychologist *bonus*, and this is a particularly important aspect of the facility, given that it is precisely minors and children who have often suffered from psychological distress due to the major changes that the pandemic has brought to their daily lives. One need only think of distance education, which while it has allowed school teaching programs to continue, it has also taken young and very young people away from direct contact with their peers [74]. The psychological *bonus* measure appears important, but it is an intervention with an occasional and temporary character. The advantage of the *bonus* is that it opens up the possibility of those who have no resources to meet with a professional figure. But the sessions allowed by the *bonus* sums allow 4 to 12 sessions, realistically few for those facing a serious psychic problem.

As regards services, an intervention program to manage the impact of the epidemic was promoted as part of the Working Group 'Mental health and CoVID-19 emergency', established by decree of the President of the 'Istituto Superiore della Sanità' in April 2020 of COVID-19 on mental health and an Intervention Program for the management of anxiety and perinatal depression in emergency and post-emergency COVID-19. Both programs were aimed at ensuring the care of persons with psychiatric disorders or at high risk of anxiety disorders and depression. In particular, as regards the perinatal mental health program (which includes screening and early intervention of proven efficacy), it was proposed to adapt it to facilitate its integration—in the current emergency—within the different program's interventions at the regional level. The Working Group also provided indications for the management of the needs of family members of patients admitted to COVID-19 hospital wards [74].

About taking charge of citizenship in general and the management of anxiety and stress deriving from isolation and the fear of the consequences of the pandemic, the Working Group assessed the state of first- and second-level telephone services, drawing up two reports that collect recommendations and critical issues on the matter that are important for the management of subsequent pandemic waves or other emergencies. The Working Group is currently engaged with the Ministry of Health and the main scientific societies in the field of psychiatry in a fact-finding investigation on the functioning of mental health services since the beginning of the epidemic, to verify whether patients have been offered continuity of care and in what way. The survey, which will be addressed to all Mental Health Departments throughout the country, will be important to reorganise care and assistance in light of the persistence of emergency conditions.

Also, to facilitate access to mental health services, the Working Group has also started collaboration with the Ministry of Health for the preparation of the Italian Health Equity Status Report with the coordination of the WHO/Europe. Factors such as lower education, low-quality employment, poverty and the resulting income inequalities can have an impact on mental health because they affect access to services both for prevention and treatment of acute episodes [75]. However, putting the principle of solidarity at the centre of the problems caused by the pandemic implies reconsidering the relationship between the NHS and the right to health, a fundamental right which—as already noted—in the Italian Constitution is protected in the dual capacity of individual law and collective interest. This double dimension, which therefore also implies the social dimension, is also found in the law establishing the NHS, a law reformed starting in the 1990s and which, also due to the allocative choices imposed—more or less directly—from the EU, it requires a reflection on the effectiveness of the right to health [39, 69].

The allocative choices of the NHS, as highlighted by the pandemic, are shown in all their tragedy. The problem is that of now structural tension between supply and demand concerning treatment since the demand has made the need for treatments increasingly complex, and more and more expensive, either due to the ageing of the population or because the treatments are technologically more sophisticated. Given the relevance of the human person and his fundamental rights, among which health is the main one, it is necessary to ask oneself if financially there are the resources to make the right to health emotional. The Italian Constitutional Court also intervened, recognising the legitimacy of the balance between available resources and the protection of the right to health [76].

From a constitutional point of view, however, there is a problem of balancing. Here the crucial problem arises, which we will discuss in the coming years: the renewed role of the State. If before the pandemic, the hegemonic role of the market seemed prominent in the dichotomy State/market, today it is questioned. Furthermore, the market tends to be considered as responsible for the deterioration of the NHS. In this sense, some scholars invite us to reconsider the origins of the NHS and the idea of participation that characterised its conception [77]. In this regard, the idea of the NHS as a 'commons' (i.e. the idea according to which a different articulation of the territorial fabric that involves the enhancement of participation can and should also work on the level of the NHS and the protection of collective health) is of renewed interest [78].

The problem is that we have faced emergency management of the pandemic, which pushes us to make tragic choices, due to a lack of planning accompanied by effective action in the definition of the health service. Today we are facing the need to rethink a health service in which health is rewarded and where therefore produces healthy effects in all social policies. The debate appears polarised: on the one hand, there are power groups who are asking to resume production in all ways, on the other hand, those who ask for more caution and mapping of the circulation of the virus. Added to this is the clash between those who would like to continue privatising health care and the forces that oppose it, who are aware that health is the product of social struggles—as Chiara Giorgi well underlines [79].

If the NHS was born from social and political struggles, today it is necessary to implement the model, to guarantee primary prevention activities through a defence of the environmental matrices in which we live, and to rethink, through advanced common management, a health system that promotes the health and not the disease. The idea of participation and social control of the population was present in the NHS at its origins. Moreover, the implementation law found a problem in its implementation precisely about political participation in health management, a principle affirmed by Giulio Maccacaro (one of the greatest interpreters of the 'Medicina Democratica' movement) [80]. This participation was immediately declassified as a representative of political parties, hence all the criticisms made since the 1980s on the 'patronage' management of local health companies (so-called USL). This was one of the causes that later led to the progressive corporatization of the USL, to their transformation into companies with the 1992 counter-reform of the NHS [39], p.86.

Today, in the pandemic and post-pandemic phase, we should then rediscover the importance of collective participation to find the authentic roots of the NHS. This is the only way to give effect to the principle of solidarity [69, 72]. Hospital-centricity, whose criticism is now 20 years old, has more marked its presence in some Italian Regions, while in other contexts, it has been slowed down [81]. The capillary network model of services and institutions, built in the 1980s, has undergone continuous variations and repercussions since the 1990s, as in the rest of the Italian territory where the neoliberal model of ethics of individual responsibility, but has fortunately withstood the challenge imposed by the COVID-19 disease [82].

9 Conclusions

In conclusion, we can note that psychological well-being and mental health are deeply sensitive issues. During the pandemic, psychiatric well-being became and still is of particular importance with strong repercussions, not only in the short term. In Europe and in Italy, the issue of prevention and treatment of these disorders seems to be pivotal in achieving an inclusive and sensitive citizenship. It was precisely the spread of the CoVID-19 that demonstrated how a public health service is the only organisation that can effectively deal with an exceptional event [81]. Effective mental health protection would require structural measures, specific mental health services on the territories and opportunities for constant psychological visits.

Furthermore, it has been observed that public responsibility in health protection cannot be separated from a related responsibility in guaranteeing the other human rights [83]. This evidently should place a number of obligations on the health care organisation that go beyond the mere arrangement and provision of services and benefits instrumental to the treatment of illness. Therefore, it is desirable that in investing in an Italian health system that takes care of the persons in a proactive manner and is capable of contemplating the socioeconomic determinants of mental health, we will move rapidly towards participative and solidaristic goals.

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