International Longevity Centre Canada

Human Rights do not have a best before date
Support a U.N. Convention on the Rights of Older Persons

TO WHOM IT MAY CONCERN:

This is to provide International Longevity Centre of Canada's (ILC Canada's) compliments and full support for the initiative by the International Psychogeriatric Association (IPA) and the World Psychiatric Association-Section of Old Age Psychiatry (WPA-SOAP) for their Joint Statement on the Rights of Older Persons with Mental Health Conditions and Psychosocial disabilities.

We commend the members and leadership of both organizations who join the United Nations (UN) and World Health Organization's (WHO) call to action to reduce ageism, change the status quo, and to fully embrace and support the human rights of older persons. The IPA and WPA-SOAP are also commended for their commitment to support and promote a UN convention on the rights of older persons to safeguard the human rights older persons with mental health conditions and psychosocial disabilities to ensure that they can live free from discrimination and are able to fully enjoy their rights.

Sincerely,

Margaret Gillis
President
ILC Canada

Kiran Rabheru
Chair of the Board
ILC-Canada

International Psychogeriatric Association
Better Mental Health for Older People

WORLD PSYCHIATRIC ASSOCIATION

RE: International Psychogeriatric Association (IPA) and the World Psychiatric Association-Section of Old Age Psychiatry (WPA-SOAP)
Joint Statement on the Rights of Older Persons with Mental Health Conditions and Psychosocial disabilities

Globally, mental health systems have been in crisis for decades, prompting calls for a "revolution" in mental health[i]. Today, there are 703 million people aged 65 or older, a number that is projected to reach 1.5 billion by 2050 [ii]. Of these, approximately 20% will have mental health conditions such as dementia, depression, anxiety and substance use, often complicated by physical and psychosocial comorbidities culminating in disability [iii].

The World Health Organization (WHO) global report on ageism published in March 2021 states that one in two people are ageist against older people[iv]. The most comprehensive global review of the health consequences of ageism is a meta-analysis published in 2020, with over 7 million participants[v] , demonstrating poor health outcomes in 95.5% of studies, with a strong association between mental health conditions and ageism. Individuals with internalized negative representations of old age had higher prevalence of psychiatric conditions of which depression was the most frequent in 6.33 million cases globally.

The first key study of the economic impact of ageism published in 2020 [vi] considered the impact of discrimination aimed at older persons, negative age stereotypes, and negative self-perceptions of aging on the health in persons aged 60 years or older as predictors of ageism in the United States. It estimated that over a 1 year, the financial impact of ageism on health care was $63 billion. Furthermore, it predicted that a reduction in ageism is likely to result in health benefits for older persons but also be cost-effective, especially for less-developed countries, where a large increase in the numbers of older persons is anticipated in the future.

The International Psychogeriatric Association (IPA) and the World Psychiatric Association-Section of Old Age Psychiatry (WPA-SOAP) join WHO call to action to reduce ageism, change the status quo, and to fully embrace and support the human rights of older persons in our professional roles. The IPA and WPA-SOAP has issued the attached Joint Statement on the Rights of Older Persons with Mental Health Conditions and Psychosocial disabilities. The IPA and WPA-SOAP are fully committed to support and promote a United Nations (UN) convention on the rights of older persons to safeguard that older persons with mental health conditions and psychosocial disabilities can live free from discrimination and are able to fully enjoy their rights.

William Reichman, President
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[i] World needs "revolution" in mental health care – UN rights expert https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689

[ii] United Nations Department of Economic and Social Affairs, Population Division (2020). World Population Ageing 2020 Highlights: Living arrangements of older persons (ST/ESA/SER.A/451). https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd-2020_world_population_ageing_highlights.pdf

[iii] WHO. Mental health of older adults https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

[iv] Global report on ageism. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.https://apps.who.int/iris/bitstream/handle/10665/340208/9789240016866-eng.pdf?sequence=1&isAllowed=y

[v] Chang E-S, Kannoth S, Levy S, Wang S-Y, Lee JE, Levy BR (2020) Global reach of ageism on older persons' health: A systematic review. PLoS ONE 15(1): e0220857. https://doi.org/10.1371/journal.pone.0220857

[vi] Becca R Levy, PhD, Martin D Slade, MPH, E-Shien Chang, MA, Sneha Kannoth, MPH, Shi-Yi Wang, MD, PhD, Ageism Amplifies Cost and Prevalence of Health Conditions, The Gerontologist, Volume 60, Issue 1, February 2020, Pages 174–181, https://doi.org/10.1093/geront/gny131

Title: IPA and WPA-SOAP Joint Statement on the Rights of Older Persons with Mental Health Conditions and Psychosocial disabilities

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IPA and WPA-SOAP Joint Statement on the Rights of Older Persons with Mental Health Conditions and Psychosocial disabilities[1]

Introduction

The United Nations (UN) has proclaimed that "Mental health is a human right" (Office of High Commissioner Human Rights, OHCHR 2018) a position supported by the World Health Organization (WHO) over 20 years ago (WHO, 1998). Globally, mental health systems have been in crisis, and in violation of basic human rights, segregated from the rest of health care, prompting calls by the UN Special Rapporteur on the Right to Health, for a sea change in mental health care systems to end decades of abuse, neglect and violence (OHCHR 2017).

This imperative is driven by global population ageing, with progressive rises in the proportion of the population aged over 65, from 6% in 1990 to 9% in 2019, projected to rise to 16% in 2050, by which time 1.5 billion people will be over 65 (UN Department of Economic and Social Affairs, Population Division, 2020). Of these, approximately 20% will have mental health conditions such as dementia, depression, anxiety and substance use, often complicated by physical and psychosocial comorbidities culminating in disability.

As such, older people may experience multiple jeopardies of discrimination and stigma conferred by age itself (ageism) and having a mental disorder ("mentalism") (WHO-WPA, 2002; Chang et al, 2020; Peisah et al, 2019), with marginalized groups such as Lesbian, Gay, Transexual, Bisexual, Intersex (Peisah et al, 2018) and indigenous elders (Viscogliosi, etal, 2020) faring worst. "Segregation" in residential care, whereby people living with dementia or other mental health conditions or psychosocial disabilities are congregated together, confined within the care home and segregated from other residents and the community at large, can exacerbate this discrimination and societal abandonment (Steele et al, 2019). Older persons facing this level of stigma are often "invisible", have no voice, nor support for autonomy, nor advocacy. Older people facing ageism and mentalism are often left behind and disproportionately excluded from social protection and survival support, profoundly evident during the COVID-19 pandemic (Ayalon et al., 2020; Carrieri et al., 2020; Fraser et al., 2020). On a backdrop of a perfect storm brewing globally for older persons pre-COVID-19, the human calamity of the pandemic has been disproportionately felt by older persons (World Economic Forum, 2020), particularly those with mental health disorders (Lee et al, 2020).

This "grossly unmet need" for rights-based mental health and psychosocial care is the result of a combination of several factors. Among these are the failure to incorporate the voices of those most affected in health and government policy and inadequate environmental, social, home and family

[1]This title was purposefully chosen to recognize the rights of the spectrum of older people at risk of, or living with, mild to severe mental health conditions and psychosocial disabilities.

supports. Such lack of supports often leads to overreliance on the biomedical model, psychotropic drug use, and physical restraints, especially in institutional care, despite evidence– based, best practices recommendations to the contrary (OHCHR, 2017). Much of this is attributable to "structural ageism" - ageist discrimination in institutional policies, practices, behaviours and procedures – rife in health across clinical and research settings, and increasing (Chang et al, 2020).

The International Psychogeriatric Association (IPA) and the World Psychiatric Association Section of Old Age Psychiatry (WPA-SOAP) join the call to change the status quo. We seek to ensure that older persons with mental health conditions and psychosocial disabilities are not discriminated against based on their age, or their mental health or psychosocial disability status, and are treated as full citizens enjoying all rights on an equal basis with other citizens. This Joint Statement aims to (i) lend IPA and WPA-SOAP support to the call for a rights-based approach to mental health; (ii) raise awareness amongst mental health professionals regarding the human rights of older persons; and (iii) provide practical guidelines on "how to" recognize, support, manage, mitigate and advocate, to ensure that human rights are front and centre on the radar of health professionals in everyday clinical, research and medicolegal practice.

Human rights challenges for all older people

The human rights of older people with mental health conditions and psychosocial disabilities are the same as those of all older people. Since the 1948 Universal Declaration of Human Rights, a raft of human rights treaties have addressed various civil, economic, social, cultural and political rights, but older person's human rights were not specifically addressed until the UN Principles for Older Persons (1991) (OHCHR, 1991) and the Madrid International Plan of Action on Ageing (2002). The rights of persons with disabilities were given treatment under the United Nations Convention on the Rights of Persons with Disabilities (CRPD). However, the rights of older people under these treaties have not been actualized due to ageism, systemic inertia and failure to recognize their specific needs (Byrnes, 2020; Doron and Apter, 2020). This has led to a debate regarding the need for a UN convention on the rights of older persons (Byrnes, 2020; Doron and Apter, 2020; Doron, 2015; Herro and Byrnes, 2020), proponents for which include several governments, UN institutions and leaders (including the UN Secretary-General and the High Commissioner for Human Rights), civil society organizations, older people's organizations and human rights institutions.

IPA and WPA-SOAP support the efforts of the international community in this pursuit and reiterate that older persons with/or without mental health conditions and psychosocial disabilities hold and should exercise their rights to be treated without discrimination on an equal basis with other citizens. Key themes that underpin human rights peculiar to all older people include autonomy, dignity, care and treatment, safety and privacy. Specifically, human rights most relevant to older people's mental health include, but are not limited to, the rights to (not in any hierarchical order):

1. enjoyment of the highest attainable standards of affordable mental and physical health, including at the end of life, and respecting specific needs that arise on account of disability;

2. autonomy with equal recognition before the law, including the right to equal legal capacity, expression of will and preferences, with support for decision making when required;

3. dignity and quality of life;

4. an ageism-free world;

5. safeguarding against undue influence and abuse, freedom from cruel, inhumane, degrading treatment and punishment;

6. living independently and being included in the community, participating in the cultural and social life of the community;

7. making contributions to the community through work or other activities, and to be protected during these activities as any other citizens;

8. provision of adequate income to meet basic needs for food, housing, clothing and other necessities;

9. accessible, integrated, affordable housing, the right to which is protected even when legal capacity is compromised;

10. accessible leisure and education as available to other citizens;

11. respect for family, relationships, sexual health and the right to intimacy;

12. confidentiality and privacy; and

13. to practice a spiritual life of one's choosing.

Walking the talk: strategies supporting human rights in our professional roles working in mental health

IPA and WPA-SOAP are committed to bridging the implementation gap between the articulation and actualization of older person's human rights, by embracing human rights frameworks as standards of accountability and advocacy in our everyday work (Peisah et al, 2020). Practical behaviours and measures undertaken by mental health professionals to support the human rights of older people with mental health conditions and psychosocial disabilities include:

1. Be vigilant and speak out against ageism in health care as manifested by lack of diagnostic and treatment zeal, and therapeutic nihilism (Peake et al, 2003), to which older people with chronic or severe mental health conditions are most vulnerable, despite having greater physical health burden, comorbidities and premature mortality (Houben et al, 2019). In a practical sense, this often means

advocating for our patients' equal right to medical treatments in acute care environments and ensuring triage decisions for life-saving treatment are based on individualized assessment, not diagnosis nor place of residence such as a care home (Peisah et al, 2020). We need to accept the responsibility that as mental health professionals we are often the conduits to equitable access to health care;

2. Recognise that equitable access to high quality end of life and palliative care, including pain relief is a human right owed to all, regardless of diagnosis or place of residence (Lapid et al, 2020). This right is often not enjoyed by those with mental health conditions, particularly those living in care homes, necessitating proactive attention from clinicians to ensure that appropriate care and attention is available and provided at the end of life (Froggatt et al, 2020);

3. Ensure that paternalistic and excessively medicalized approaches towards support for those with mental health conditions give way to participatory, psychosocial care and support in the community to promote autonomy and resilience. This means supporting the social and care environment regardless of the physical setting, whether it be residential or home care, supporting the family (who may themselves be ageing), professional caregivers and the wider community;

4. Understand the human rights violations that drive changed behaviors in dementia with regard to unmet need, will, and preferences, such as those arising from miscommunication, social isolation and unmet intimacy. Respecting specific needs that arise on account of disability will often (not always) negate the need for psychotropic medication;

5. Understand and utilise the construct of relational autonomy (i.e. autonomy and identity of individuals founded upon their social connections and context) (Ells et al, 2011) to support the human rights of older people with mental health conditions and psychosocial disability. Older people with mental health conditions and psychosocial disability do not exist in isolation, but rather function within various interacting social and family systems, often in dependent relationships with family members and carers (Peisah, 2006). This can confer both disadvantage – by way of undue influence (Wand et al, 2018) and advantage, whereby interconnectedness, communication, and collaboration with their social network can empower, promote relationships and community involvement. Specificallly, in care facilities, staff must maintain vigilance and a commitment to respecting residents' will, preferences and autonomy by supporting exercise of decision-making skills wherever possible, regardless of the severity of the mental condition (Sherwin et al, 2010; Peisah et al, 2013).

6. Prioritize autonomy and respect for will and preferences in clinical settings when delivering treatment by rigorously pursuing free and informed consent and supported decision-making when required. Presume capacity unless there is evidence to rebut that presumption, understand that capacity is not diagnosis –bound (i.e. linked to a diagnosis of mental disorder) and revert to substitute decision making only as a last resort (O'Neill and Peisah, 2019; Peisah, 2017);

7. Reference human rights when undertaking medicolegal work and adopt an eyes-wide open approach with regards to elder abuse in both clinical and medicolegal roles;

8. When government action is taken to protect persons with impaired capacity, support the provision of stringent substantive and procedural protections of the sort found in modern mental health statutes. These include narrow criteria to determine incapacity and the need for hospitalization and the rights to (i) hearing before appointment of a substitute decision maker, (ii) representation by legal counsel; (iii) advance notice of hearings; (iv) testify on one's own behalf, (v) call witnesses, (v) appeal adverse findings to a higher court, (vi) periodic review and (vii) abolishment of plenary orders.

9. To support access to the highest standard of health, address the lack of representation of older people in research, trial participation and guideline development, from which older people are often excluded due to arbitrary upper age limits and a range of other exclusion criteria, even in diseases that predominantly affect older people (Ilgili et al, 2014; Gottlieb et al, 2011).

Conclusion

This Joint Statement builds on previous WPA Position Statements and Bills of Rights for people with mental conditions and disabilities (WHO-WPA, 2002; WPA, 2017a; WPA, 2017b; Katona et al, 2009). As the adage goes: "What you permit, you promote". Neither civil societies nor health systems can be permitted to be complicit in promoting the devastating violation of human rights of older persons.

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