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Special Issue Article

Role of Dignity in Mental Healthcare: Impact on Ageism and Human Rights of Older Persons

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ARTICLE INFO

Article history:
Received May, 17 2021
Accepted May, 17 2021

Key Words:
Dignity
human rights
ageism
discrimination
older persons
geriatric
mental health

ABSTRACT

The global demographic shift toward an aging population is predicted to result in a significant burden of mental health conditions and psychosocial disability. There has been a greater awareness of ageism and its toxic effects creating a paradigm shift to include a human right, ethical, and social justice-based approach to augment the biomedical model of mental healthcare. The concept of dignity lies at the heart of human rights and must be a central concept integrated into public health and mental healthcare. Dignity denotes the self-respect and worthiness of an individual as well as social consideration of his/her identity. Dignity in older persons is multi-dimensional and includes several factors such as privacy, independence, inclusion, autonomy, etc. There are several determinants such as frailty, dependence, sensory, cognitive impairment and socioeconomic vulnerabilities, which tend to compromise dignity in the elderly and hence their fundamental rights. One such construct is that of ageism which comprises stereotypes, prejudice and discrimination based on age. Ageism and related forms of stigma impair dignified healthcare in older persons and deprive them of their rights. Mental health professionals are uniquely positioned to incorporate the strategies to promote dignity in their clinical care and research as well as advocate for related social/health policies based on a human rights approach. These intersections are discussed in this paper in light of the United Nations Convention on Rights of the Older Persons. (Am J Geriatr Psychiatry 2021; ■■:■■−■■)

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https://doi.org/10.1016/j.jagp.2021.05.011

Highlights

- Dignity in older persons is a multidimensional construct comprising of self-respect, social acknowledgment, independence, and privacy.
- Ageism adversely affects dignity and human rights of older persons.
- Rights-based approach in geriatric mental healthcare needs to be grounded in the voices and participation of older persons.
- The UN Convention on the rights of older persons provides an appropriate scaffolding for dignified mental healthcare and related policies in older persons.

INTRODUCTION: PROBLEM PREMISE

Population ageing is a global phenomenon. In 2019, there were 703 million individuals worldwide aged 65 years and above. This is estimated to double in 2050 to the extent that one in six people will be over 65 years of age.[1] While better survival rates, improvised general healthcare and enhanced control of infectious diseases have increased longevity, longer lifespans are affected with non-communicable disorders. Mental health burden forms a significant proportion of this. Based on the World Health Organization (WHO) data,[2] 6.6% of the total disability (measured in DALYs) is contributed by neuropsychiatric disorders. Roughly 15% of the global population of older adults (aged above 60 years) suffers from a mental disorder. There are several factors contributing to this psychosocial morbidity in older persons, which include frailty, cognitive and sensory deficits, medical illnesses, reduced mobility, chronic pain, dependence and socioeconomic vulnerabilities.[3,4] Social factors play an important role in the genesis of psychological problems in older persons, which involve their capacity, autonomy, dignity, social identity and health equity.[5,6] Though the understanding and medical management of late-life psychiatric disorders have improved significantly over the years; the need to preserve dignity in mental healthcare assumes overt importance to preserve the human rights of older persons, address age-based stigma and discrimination and foster social justice.

UNDERSTANDING DIGNITY IN OLDER PERSONS

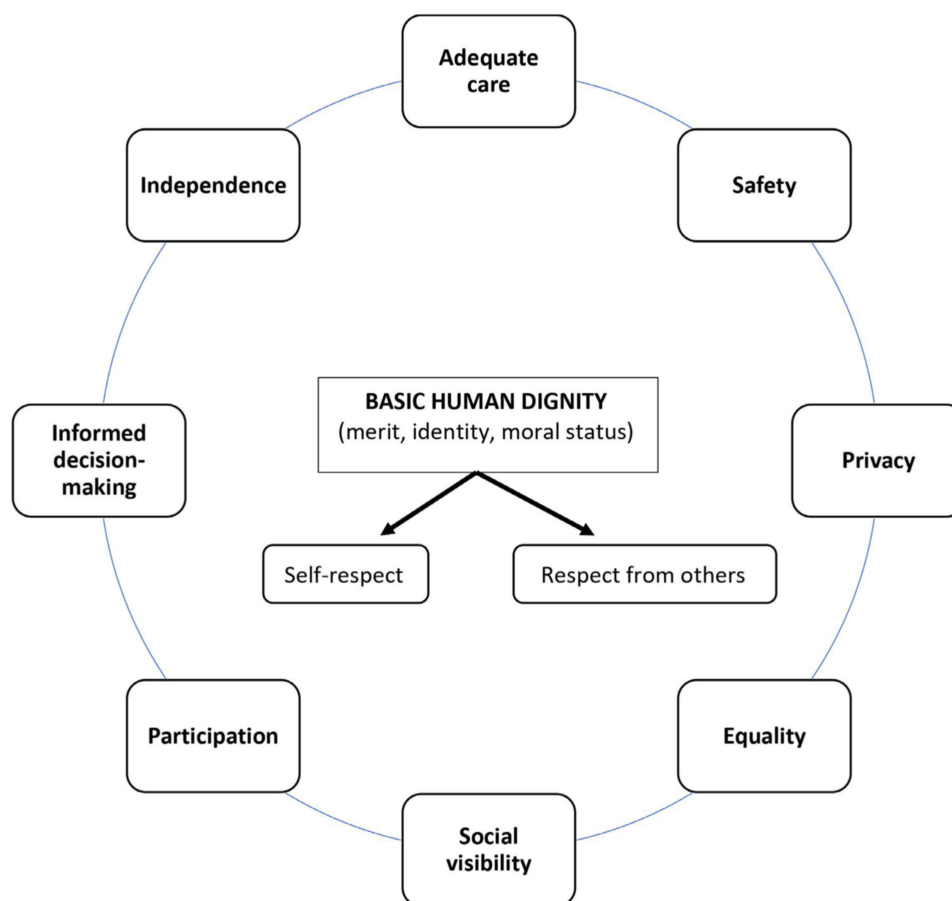
The English word "dignity" is derived from Latin *Dignitas* (worthiness). It has been used with varied connotations in social, political, ethical, moral and legal contexts. Dignity is the 'right' of a person to be respected and valued for their own sake and be treated ethically. The concept of equality also overlaps with dignity.[7] The WHO has highlighted values like participation, equality, justice, dependence and right to health in public health approaches. Dignity represents the 'status' and 'respect' associated with these constructs but is often subject to different interpretations in healthcare.[8] Though the concept is central to many worldwide policies aiming to support care delivery, but a single consensus definition is lacking. The various components and dimensions of dignity in older persons are depicted in Figure 1.

The Royal College of Nursing[9] defines dignity in healthcare delivery as

> *"Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals".*

In older persons, physical illness, dependence, social isolation and frailty can lead to decreased self-esteem and discriminative social perceptions towards them, ageism being one of the main offshoots. Based on Nordenfelt,[10] basic human dignity in the elderly consists of three components: the dignity of merit, dignity of

FIGURE 1. Multidimensional construct of dignity in older adults (components of 'self-respect' and 'respect from others', i.e., *"being acknowledged as an individual"*).



moral stature, and dignity of identity. Older persons consider privacy, respect, communication as important components of 'dignified healthcare' while emphasizing basic daily activities of living such as nutrition, eating, personal hygiene and toileting.[11,12] Integrity, respect, and perceived worthiness have also been considered as vital components of dignity.[13] Social determinants of health which include sociodemographics, environment, and ecology of an individual, play an important role in determining dignity and subjective state of well-being. A large study involved 85 focus groups consisting of 424 healthcare professionals from 6 European countries.[14] The themes consistent with dignified healthcare in older persons were person-centered holistic care, respect, independence, autonomy, maintenance of identity, involvement and effective communication. Being treated equally, not perceiving age-based discrimination and respecting individual rights were considered more important to maintain dignity rather than 'help with dressing or feeding.'[15] A recent meta-synthesis of "what constitutes dignity" based on the perceptions of older persons reported visibility and recognition as overarching themes.[16] Being acknowledged as "sufferers" rather than "patients," valuing their contribution to society and addressing their needs were essential components of dignified care as experienced by the older adults. In short, being respected as an individual, independence, safety, privacy, and participation are essential components of dignity in older persons. The need to maintain dignity becomes even important in vulnerable subgroups of older persons such as women, sexual and ethnic minorities, socio-economically backward groups, migrants and homeless individuals and those with

neurocognitive disorders.[7,17] The latter group suffers from a gradual decline in judgement, social cognition and independent decision making, making it all the more important to uphold their dignity and social identity.

AGEISM AND HUMAN RIGHTS CRISIS: THE INTERSECTIONS

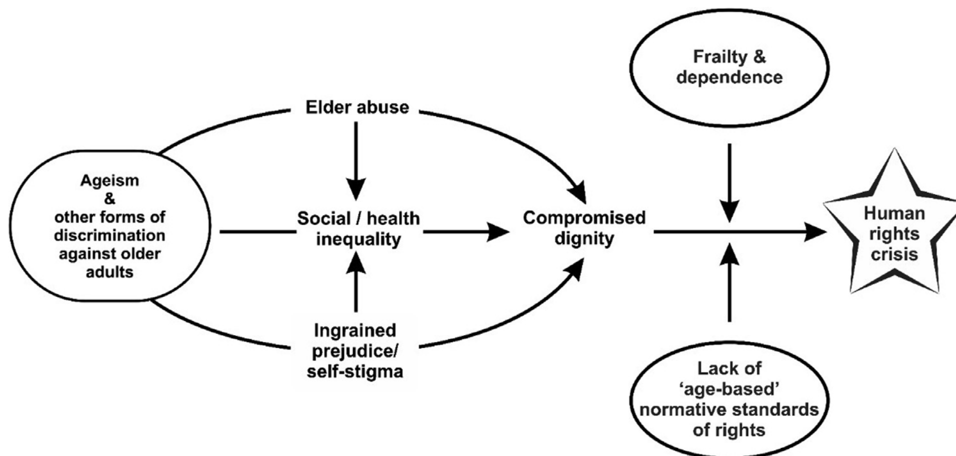
Ageism is one of the commonest ways in which the dignity of the elderly is compromised. Coined by Robert Neil Butler in 1969 to describe discrimination against older adults, it was initially based on sexism and racism as well. Later, the concept of ageism encompassed a wider angle of any form of discrimination and/or stereotyping and/or negative attitudes against individuals based on their age.[18] It is thought of as a social construct consisting of three interrelated processes: stereotyping, discriminatory practices and institutional/social policies, which perpetuate these practices.[18] It can be a potent driving force for elder abuse, age-related crimes, oppression, decreased self-esteem in the elderly and psychological frailty. Existing in both overt and covert forms, it serves as a major barrier for healthcare access in older persons.[19] Ageism is also perpetuated by "monolithic perceptions" of generalizability of all older persons, which is incorrect and promotes ageism, neglecting the heterogeneity and gerodiversity.[20]

Article 1 of the Universal Declaration on Human Rights states that *"all human beings are born free and equal in dignity and rights."* Understandably these rights are irrespective of age and gender.[21] Presently, the rights of older persons are non-specifically ingrained in international human rights conventions on economic, civil, social, political and cultural rights.[22] Due to socioeconomic factors such as retirement, pension benefits, institutionalization, social security and access to healthcare, the rights to financial security, the rights to equality and the rights to appropriate access to health/social care services assume more importance in the older persons. Age-based discrimination can be multidimensional and intersect with other factors of prejudice such as gender, ethnicity, race, sexuality, disability, income inequality and education levels.[23] In the absence of an age-specific international rights convention that is binding to all nations, various aspects of ageism can, in turn, impair basic dignity in older persons contributing more to discrimination, self-stigma, and psychological morbidities (**Fig. 2**).

PRESERVING DIGNITY IN MENTAL HEALTHCARE OF OLDER PERSONS

Dignity has been a central concept in bioethics and public healthcare. Article 11 of the Declaration of Helsinki states that the duty of physicians involved in research and treatment is to safeguard the life, health,

FIGURE 2. Intersections between ageism, dignity and human rights in the older adults.



integrity, privacy, dignity, self-determination, and confidentiality of their subjects.[24] Mental health professionals are uniquely positioned to address older persons with psychiatric disorders in a humane and holistic way, dealing through the 'biopsychosocial lens.' It is well known that psychological morbidity, resultant disability and stigma lead to further worsening of self-respect and dignity through social drift and inequality.[25] This is a 'double-hit' for the older persons when the aspect of ageism comes in. The ongoing Coronavirus disease 2019 (COVID-19) has also unmasked several of such ageist challenges and marginalization for the older people besides the critical public health burden.[26] Although older adults face a range of challenges they should not be defined by these challenges.[27] It is essential that support to meet the challengers faced is provided in a way that preserves feeling respected and personal identity as much as possible.

In a study by Lyons et al.,[28] experiences of ageism in older individuals were associated with increased depression, anxiety, stress and poorer well-being. Ageism in mental healthcare has multiple dimensions: physician-patient interaction, use of screening procedures, involvement in treatment decisions, informed choice-making, autonomy, and perceived coercion.[19] Especially severe mental disorders and dementias, where the autonomous decision-making, capacity to consent and judgement are compromised: antiageist attitudes in mental healthcare are of renewed importance to uphold their dignity and rights. Sense of personal dignity stems from internal (how I perceive myself) and external attributes (how others perceive me), both of which need consideration for age-specific health needs.[16]

"We've been listening, have you been learning?" the Patients Association[29] annual report comprised of accounts mainly from older persons. Lack of an audience and empathy as well as poor communication and impeded independence were common. The accounts from their relatives and even healthcare professionals are disturbing and depict how dignity can be compromised in healthcare systems. A multidisciplinary approach to care was lacking.

> *"Relatives explained how disturbed they were to see patients ill-kempt, with dirty fingernails and soiled clothes. Hospital wards were often described as dirty and unhygienic.... In some cases, nobody seemed to be in charge, and absence of continuity led to inadequate care."*[30]

Similar accounts of "what should not be done" were reported in the British Geriatrics Society led campaign 'Do not Forget the Person', the Care Quality Commission and the Equality and Human Rights Commission. They focused on person-centered dignified care for older persons with appropriate training and recruitment of staff.[30,31]

From the mentally ill older persons' vantage point, loss of control, loss of self-identity, existential suffering, loss of meaning and perceiving themselves as a burden to their caregivers are factors that affect dignity.[32] Jacobson, in her grounded theory analysis,[33] highlighted the processes of "rudeness, condescension, dismissal, indifference, disregard, objectification, dependence, intrusion, restriction, labelling, discrimination, contempt, deprivation, abjection, revulsion and assault", which violates dignity in healthcare. In another study that explored life-situation experiences of mentally ill older persons, loss of dignity and yearning for respect emerged as components of the main theme "struggling for existence."[34] The role of caregivers and MHPs were highlighted in acknowledging the "lifeworld" of older persons to rebuild their dignity as they constantly strived to master their existence. Hence, working with the families is essential to maintain dignity in healthcare.

Dignified Healthcare and Human Rights

The International Plan of Action on Ageing (UN General Assembly, 1982), The UN Principles for Older Persons (1991), The Madrid International Plan of Action on Ageing (MIPAA 2002, 2007) and finally the "Open-Ended Working Group of Ageing" (2016) have all attempted international human rights protection for the elderly, to prevent ageism and foster dignity in healthcare.[35] The UN Convention on Rights of People with Disabilities (UNCRPD) intends to protect the rights and dignity of persons with disabilities, considering them as full and equal members of the society.[36] Mental and sensory impairments are included in this treaty which is based on "reasonable accommodation", civil, political, legal, cultural and socioeconomic rights.

However, the age-specific connotation is often missing, and there exists a marked "implementation gap". Also, most of these treaties are considered to be 'soft' laws that are more morally than legally binding on the states. This lack of provision for human rights provision in older persons is termed as a 'normative

gap' where their basic dignity and rights are not addressed adequately by existing human rights laws.[37] The Royal College of Psychiatrists' position statement[38] called for age-inclusive dignified and comprehensive mental healthcare, which facilitated participation and communication from the consumers. On similar lines, the WHO has recently mentioned the incorporation of anti-ageism strategies in psychosocial services provided during the COVID-19 pandemic.[26] The role of MHPs is also paramount in dignity research, advocating for human rights and involvement in tailored policies. The mentally ill older adult needs to be perceived as an "individual with rights" and approached with empathy, care and a nonjudgmental way.[39] Equitable access to mental health resources, social networks and human rights-based approach have been shown to build "a sense of purpose" and resilience in depressed older persons, which leads to lesser discrimination, better coping, and optimal stress management.[40] Day-to-day clinical care for older persons can be expanded to ensure food and housing security, safety and sense of belonging to the community. Any decision about meeting an individual older person needs should be taken in collaboration with that individual. Continuity of care is especially important to ensure that understanding of the older persons perspective and needs is kept in mind by somebody who the older adults knows and trusts. The older person must feel that they matter in all their encounters and is entitled to a full explanation of all decisions that are taken about their situation and care in jargon free language.[41]

Considering the various areas in practice where dignity can be affected and ageist attitudes can creep in, **Table 1** summarizes some of the possible approaches by mental health professionals to dignified mental healthcare.

THE WAY FORWARD: DIGNITY IN CARE AND THE UN CONVENTION ON THE RIGHTS OF OLDER PERSONS

The UN Decade of Healthy Ageing (2021−2030) is a global collaboration aligned with the Sustainable Developmental Goals (SDG) of the last decade.[42] Healthy ageing includes abilities to meet basic needs, make decisions, be mobile, build relationships and participate in social activities. The UNCRPD further extends these rights to people with disabilities. The dignity of older persons can be addressed through neighborhood and community, strengthening social relations, prioritizing socioeconomic resources, civic participation and culturally sensitive ways of mental healthcare. In the light of the "normative gap" of human rights laws mentioned above, the proposed UN Convention on the Rights of Older Persons (UNCROP) holds immense promise in addressing demographic issues arising due to population ageing.[43] Though not yet formalized, it is being strongly advocated by human rights groups such as the HelpAge International, Committee on Economic, Social and Cultural Rights (CESCR), the International Labour Organisation (ILO) and the Committee on the Elimination of Discrimination against Women (CEDW). Aimed as an anti-discrimination convention, the UNCROP attempts to safeguard the rights against ageist discrimination, rights to autonomy and participation, along with their implementation and incorporation into policies. Besides setting the normative standards of human rights for older individuals, a unique aspect of this convention is to address the social evil of elder abuse, which is usually considered to be an "individual concern" and falls out of other human rights laws. The popular argument which has still halted its formalization is that the rights of older persons are already subsumed in the existing legal frameworks, and as such, the UNCROP has nothing much to add on its own. This is essentially not true and has been extensively critiqued.[37,44,45]

To create an evidence-based framework of dignified mental healthcare in older persons to combat ageism and preserve their rights, a convention like the UNCROP is warranted to:

- Fight age-based discrimination
- Modify lived experiences, knowledge, attitudes, self-esteem and power among the elderly
- Clarify legal-binding of responsibilities
- Improve accountability of the member states and set consequences for violation of the norms
- Guide age-inclusive policies

With a paradigm shift of psychosocial care towards a human rights-based approach, adequate sensitivity, knowledge and training of the MHPs in this regard will set the future pathway for dignified mental health interventions in older persons that are devoid

TABLE 1. Possible Strategies to Ensure Dignity in Mental Healthcare for Older Persons

Areas of Dignified Mental Healthcare	Strategies
General principles	• Care and empathy • Respect for individual identity • Nonjudgmental • Safety • Direct and open communication • Social justice
Autonomy	• Participation in treatment • Privacy and confidentiality • Informed decision making • Foster independence • Awareness about rights and legal provisions for protection
Prevention of stigma against mental illness	• Prioritize antidiscrimination strategies • Raise awareness and KAP • Collective responsibility (government, NGO, service provisions, patient organizations, human right bodies, families and general public) • Mental health education • Social care programs and policies
Fight ageism	• Challenge myths and social stereotypes about old age/older persons • Prevent isolation and alienation in older adults • Retirement and social welfare benefits • Economic/pension/legal protections at the workplace • Legislations to prevent age-related crimes and oppression of older persons • Fight associated discriminations: sexism, racism, etc.
Preventing elder abuse	• Awareness among the older persons • Foster early detection (recognition of signs) and hassle-free reporting • Active collaboration of healthcare professionals, law enforcement agencies and senior citizen forums • Prevent financial abuse at home/workplace • Prevent violence, neglect and abandonment • Address ageism and marginalization
Address social determinants of mental health	• Literacy • Safe physical environment • Social security • Address income inequality • Food and housing security • Physically and emotionally safe working conditions • Spiritual development
Institutionalized care	• Participation in decision making • Positive staff attitudes and well-trained staff • Dignified palliative care • Supported accommodation • Balance independence, privacy and autonomy with safety precautions • Cohesion among the older residents and staff • Good communication skills
Management of psychiatric disorders	• Avoid polypharmacy • Eliminate unnecessary medicines • Involvement of older persons in treatment choice • Restrict physical and chemical restraints
Neurocognitive disorders	• The target of management: improve quality of life, dignity and comfort (at all stages of dementia) • Engagement in decision-making (as long as possible) • Activities of daily living • Discussion about the choice of treatments • Caregiver education • Preserve the "individual identity" throughout the trajectory of cognitive decline
End-of-life care	• Principles of respect, privacy and dignity • Honor advance directives • Consider the medical, ethical, legal connotations • Adequate control of pain and daily activities • Assisted feeding • Physician-assisted death (needs multi-disciplinary approach and continued discussion with caregivers) • Women

(*continued*)

TABLE 1. (*continued*)

Areas of Dignified Mental Healthcare	Strategies
Special populations among the older persons (facing minority stress and marginalization)	• Sexual and ethnic minorities • Those living in sheltered houses • Severe mental disorders • Homeless individuals and migrants • Specialized care and health/social policies to improve their dignity and quality of life • Social inclusion
Research and training	• Dignity and rights-based special mental healthcare training at all levels • Lived experiences of older patients and MHPs in what constitutes 'dignity' in service delivery • Ethics (autonomy, beneficence, justice, veracity) • Sensitize the primary care physicians and social professionals • Knowledge-based curriculum and mental health promotion in undergraduate medical and postgraduate psychiatric training
Miscellaneous	• Respect human rights of older individuals • Special medical and psychosocial support for frailty • Digital literacy among older persons • Recreational and spiritual issues • Capacity building in telepsychiatry for mental healthcare • Advocate for dignified mental healthcare and influence related policies • Multi-disciplinary community-oriented dignified mental healthcare • COVID-19: Health awareness, health risk communication and prevent stigma, abuse, isolation

Notes: KAP: Knowledge Attitude Practice; NGO: Nongovernmental Organization; MHP: Mental Health Professional.

of age-based discrimination and prejudice. Such strategies may qualify for an age-friendly comprehensive geriatric healthcare as we initiate the UN Decade of Healthy Ageing.

AUTHORS' CONTRIBUTION

All the authors conceptualized and designed the manuscript. DB drafted the manuscript with inputs from KR, CAML and GIMBE. The final version of the paper was read and agreed upon by all the authors.

DISCLOSURE

None declared.

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