Title

Scientific Advocacy to Eliminate Ageism: The Creation, Impact, and Global Expansion of the Canadian Coalition Against Ageism (CCAA)

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Abstract

Objectives:
Ageism is a pervasive yet underrecognized determinant of health and mental health in later life. Evidence shows that ageist attitudes and structures contribute to delayed recognition of treatable conditions, reduced access to evidence-based care, and heightened vulnerability to neglect and abuse. This article examines the creation, rationale, and early impact of the Canadian Coalition Against Ageism (CCAA) as a model of *scientific advocacy*—a novel, coalition-based approach that translates evidence and human-rights principles into system-level change.

Methods:
Drawing on peer-reviewed research, implementation science, and international human-rights frameworks, we situate the CCAA within national and global efforts to eliminate ageism. The coalition's governance, multisectoral design, and flagship interventions—particularly the Ageism Awareness Module and Toolkit and the Older Persons Advisory Group—are examined as translational mechanisms linking science, practice, and rights-based reform.

Results:
Global and national data confirm that ageism predicts poorer mental and physical health outcomes. The CCAA was established through co-design with older persons and cross-sector collaboration, producing freely accessible educational and policy tools now being adopted across clinical, educational, and organizational settings. Early implementation indicates shifts in awareness, reflective practice, and institutional norms across health, education, and community sectors.

Conclusions:
Eliminating ageism is a clinical, ethical, and systems-level imperative for all clinicians. The CCAA offers a reproducible model of rights-informed scientific advocacy that aligns public health, mental health, and human-rights mandates, and is timely considering the UN Human Rights Council's 2025 launch of a process toward a Convention on the Rights of Older Persons.

As international law evolves, geriatric psychiatry is positioned to lead a paradigm shift—from deficit-based models of ageing to rights-based, capability-enhancing mental health care across the life course. As a field grounded in dignity, complexity, and relational care, geriatric psychiatry is uniquely positioned to serve as a catalyst for a more deeply humanistic medicine across disciplines, settings, and stages of the life course.

Introduction

Ageism is among the most prevalent and least challenged forms of discrimination worldwide. The World Health Organization estimates that one in two people globally holds

ageist attitudes, with profound consequences for health, mental health, longevity, and social participation[1]. Far from being a benign cultural bias, ageism functions as a structural determinant of health[2]. It predicts delayed diagnosis, under-treatment, therapeutic nihilism, reduced help-seeking, and poorer outcomes across conditions including depression, anxiety disorders, cognitive impairment, and psychosis[3]. In later life, it also increases vulnerability to neglect, coercion and abuse, shaping not only how suffering is interpreted but whether it is recognized as legitimate at all [4,5].

In clinical practice, ageism manifests through diagnostic overshadowing, premature attribution of symptoms to "normal ageing," exclusion from psychotherapy and rehabilitation, and disproportionate reliance on containment-oriented or custodial models of care. These patterns erode autonomy and agency, reinforce social withdrawal, and normalize inequities in access to treatment. At a systems level, ageism shapes resource allocation, policy priorities, and institutional design, producing environments in which older persons are rendered peripheral to innovation and reform. The cumulative effect is a form of structural invisibility that undermines both mental health outcomes and human dignity [6,7].

Simultaneously, the scientific study of ageing is expanding rapidly, accompanied by renewed debate regarding whether ageing itself should be conceptualized as a disease[8]. While this discourse promises advances in prevention and treatment, it also risks re-entrenching narratives of inevitable decline and dependency. For psychiatry, the ethical stakes are immediate. How ageing is framed determines whose distress is taken seriously, whose recovery is imagined, and whose lives are considered worthy of sustained investment. Biomedical progress, absent a rights-based orientation, can inadvertently amplify stigma and therapeutic nihilism rather than dismantle them[9].

These clinical and ethical tensions unfold within a historic global moment. After more than a decade of advocacy and normative analysis, the United Nations Human Rights Council in April 2025 launched an intergovernmental process to draft a legally binding Convention on the Rights of Older Persons[10]. This decision, building on the work of the Independent Expert on the enjoyment of all human rights by older persons[11] and the Open-ended Working Group on Ageing, reflects international consensus that existing legal frameworks inadequately protect older people from discrimination, violence, exclusion, and denial of services, [12,13,14]. The emerging treaty process affirms that ageism is not merely a social ill but a human-rights violation requiring structural remedy[15,16].

The Canadian Coalition Against Ageism (CCAA)[17] was created within this converging scientific and moral landscape. Its premise is both simple and transformative: ageism is neither inevitable nor benign, and it can be dismantled through deliberate, evidence-informed, rights-based action. The CCAA was conceived not as a campaign but as an enduring social infrastructure—a multisectoral platform through which empirical evidence, lived experience, and ethical principles are mobilized into systems change.

This article traces the creation, architecture, and early impact of the CCAA and situates its evolution within the broader movement toward rights-based mental health in later life. We argue that the CCAA exemplifies *scientific advocacy*: the structured translation of research,

clinical insight, and human-rights norms into durable practices, policies, and institutions. In doing so, it offers geriatric psychiatry a reproducible model for advancing dignity, agency, and capability across the life course at a moment when global law itself is beginning to reflect these imperatives.

Scientific and Human-Rights Foundation for the CCAA

The creation of the CCAA was inspired and grounded in the World Health Organization's Global Report on Ageism, which brought into sharp relief a convergence of empirical evidence and normative urgency: ageism is pervasive, harmful, and modifiable, with direct consequences for health, mental health, and human rights[1]. Systematic reviews demonstrate that exposure to ageist beliefs is associated with higher rates of depression, anxiety, cognitive decline, cardiovascular disease, functional impairment, and premature mortality. These effects persist even after controlling for socioeconomic status and baseline health, indicating that ageism exerts a direct causal influence on outcomes across the life course[3]. Ageism carries massive economic costs, with a 2020 study finding it cost the U.S. healthcare system $63 billion annually for just eight common conditions, and estimates suggest potential annual losses to GDP of trillions by 2050 if older workers are excluded, impacting productivity, innovation, and overall economic growth by hindering experienced workers' participation and creating health disparities [18].

Ageism exerts direct and cumulative harm in clinical life: it delays diagnosis, narrows treatment horizons, and normalizes therapeutic nihilism by recasting suffering in later life as inevitable rather than remediable. These effects are not incidental. They are produced by systems in which age-based assumptions are embedded in thresholds, pathways, and expectations of care. Yet decades of rigorous evidence have failed to dislodge these patterns. Knowledge has accumulated without transformation. The problem is therefore not epistemic but structural: ageism is embedded across sectors—health, housing, labour, media, technology, and law—while evidence remains siloed within disciplines. Fragmented interventions cannot correct a phenomenon that is systemic by nature.

In parallel, international human-rights bodies have reached the same conclusion. After fourteen years of deliberation at the United Nations Open-ended Working Group on Ageing (OEWGA) and more than 900 submissions, the United Nations—guided by the Independent Expert on the rights of older persons—has formally acknowledged persistent gaps in the human rights of older persons under existing international law[10, 11, 12,19].

Unlike women, children, or persons with disabilities, older persons lack a dedicated, legally binding international instrument. In April 2025, the United Nations Human Rights Council therefore made a monumental decision: to initiate the drafting of a Convention on the Rights of Older Persons. This marks a historic shift. Ageism is no longer framed merely as a social bias, but as a human-rights violation—reorienting global ageing policy from charity and protection toward dignity, agency, participation, and accountability [20].

The CCAA emerged at the intersection of these scientific and normative trajectories. Its founders recognized that ageism could not be dismantled through isolated educational campaigns or professional exhortation. What was required was a durable, multisectoral

infrastructure capable of translating evidence and rights into practice. The coalition model was therefore not incidental but methodologically essential.

The CCAA integrates three epistemic traditions:

1. **Empirical science**, establishing ageism as harmful and modifiable.
2. **Implementation science**, demonstrating that sustainable change requires alignment across systems, incentives, and cultures; and
3. **Human-rights law**, articulating dignity, autonomy, participation, and non-discrimination as binding obligations rather than aspirational values.

From this synthesis arose a core premise: eliminating ageism is simultaneously a clinical responsibility, a public-health imperative, and a human-rights obligation. The CCAA operationalizes this premise by treating coalition-building itself as a scientific intervention—one designed to reshape norms, practices, and policies across the environments that determine mental health in later life.

From Evidence to Architecture: Why Coalition Is the Intervention

This section explains why coalition itself is the intervention. Decades of research have established ageism as harmful and modifiable, yet knowledge alone has not shifted practice or policy at scale. This gap reflects a structural problem: ageism is embedded across systems—health, education, housing, labour, media, and law—while evidence remains siloed within disciplines. Fragmented interventions cannot correct a phenomenon that is systemic by nature. What is required is not another campaign, but an enabling architecture through which evidence, lived experience, and human-rights norms can be mobilized into durable change. In this context, coalition is not merely a strategy for advocacy; it is itself the intervention. By aligning actors, norms, and incentives across sectors, a coalition creates the conditions under which scientific knowledge becomes operational, dignity becomes a standard of care, and rights become practices rather than aspirations.

Intersecting "Isms" and the Promise of a Virtuous Upward Spiral

Ageism rarely operates in isolation. In clinical and social contexts, it frequently converges with mentalism, ableism, racism, and other forms of structural exclusion, creating a compounded burden for persons who are older and simultaneously living with mental illness, cognitive impairment, disability, poverty, or minority status. These intersecting "isms" amplify invisibility, narrow clinical expectations, and normalize diminished horizons of care. What appears as benign pragmatism—lowered thresholds for intervention, curtailed rehabilitation, or risk-averse containment—often reflects this layered prejudice rather than clinical necessity. Recognizing ageism as intersectional is therefore essential to understanding its full impact on mental health and to designing remedies that do not merely shift harm from one axis of identity to another.

Yet the consequences of ageism are not only subtractive. By constraining expectations of contribution, ageism suppresses a vast reservoir of human capital. Older persons are systematically prevented from offering their experience, creativity, mentorship, and social

leadership to families, communities, and institutions. This exclusion weakens not only individuals but the social fabric itself. The World Health Organization's Healthy Ageing Framework [21] and the United Nations Decade of Healthy Ageing [22, 23, 24]articulate a fundamentally different logic: functional ability and well-being emerge from the dynamic interaction between intrinsic capacity and enabling environments. When environments affirm dignity, agency, and participation, older persons strengthen families, workplaces, and communities; in turn, these enriched environments reinforce individual resilience. A virtuous, upward spiral replaces the downward spiral of marginalization.

From this perspective, eliminating ageism is not merely protective—it is generative. It transforms later life from a phase of managed decline into a period of continued contribution and reciprocal growth. The CCAA is grounded in this positive systems logic. By dismantling ageist assumptions and redesigning environments to enable participation, it seeks not only to prevent harm but to unlock capability—at individual, institutional, and population levels. In doing so, the coalition operationalizes the central promise of the Decade of Healthy Ageing: that societies flourish when older persons are recognized not as burdens to be managed, but as agents of collective resilience and shared future.

Creation of the Canadian Coalition Against Ageism (CCAA)

The CCAA was launched through a national process that brought together clinicians, researchers, educators, older persons, civil society organizations, philanthropies, media partners, and policymakers. Its early development was catalyzed by a CIHR Institute of Aging–supported national Forum on Ageism[25].

Three design principles guided the coalition's formation.

First, **co-design with older persons** was embedded from inception. The CCAA established the Older Persons Advisory Group (OPAG) [26] as a standing governance body, not a consultative appendage. OPAG members are full partners in agenda-setting, tool development, and public representation. This structure operationalizes agency and counters the performative inclusion that often characterizes policy processes affecting older people.

Second, the coalition adopted a **multisectoral architecture**. Ageism does not originate in health care alone; it is produced through labor markets, housing policy, media representation, digital design, and legal frameworks. The CCAA therefore recruited partners across sectors, enabling cross-pollination of evidence and norms. Health professionals learned from housing advocates; educators engaged with business leaders; older persons informed media campaigns.

Third, the CCAA committed to **evidence as infrastructure[27]**. Rather than relying on slogans or episodic awareness campaigns, the coalition positioned empirical research as the backbone of its work. Global and national data on the prevalence and impact of ageism, the effectiveness of educational and intergenerational interventions [28], and the mental-health consequences of discrimination were synthesized into shared narratives and tools. Evidence became not merely persuasive but operational - translated into checklists, training modules, policy briefs, and clinical prompts.

From the outset, the CCAA moved from diagnosis to construction. Its working groups—spanning public awareness, health-sector education, intergenerational engagement, and research—were charged not with messaging alone, but with building tools and pathways that could live inside real institutions. Rather than standing outside systems as a critic, the coalition embedded itself within them as a partner in redesign. Hospitals, universities, professional associations, community organizations, and government bodies were invited not to endorse a message, but to re-engineer practice. In this way, the CCAA became a platform for scientific advocacy: a living mechanism through which evidence, lived experience, and ethical commitments are translated into durable systems change. Together, these initiatives recognize the contributions of older persons, advance their rights, and counter ageism through education, storytelling, and community participation—aligning local action with global frameworks, including the United Nations Sustainable Development Goals [29].

The Ageism Awareness Module and Toolkit

A central early achievement of the CCAA is the development of the *Ageism Awareness Module* [30]and *Ageism Toolkit* [31]. They are freely accessible, bilingual (English/French) educational resources co-designed with older persons and stewarded by International Longevity Centre Canada. These tools translate abstract evidence into everyday practice, providing a foundational introduction to what ageism is, why it matters, how it shapes health and mental health, and how it can be challenged across sectors. The accompanying national webinar [32] exemplifies "process as outcome": older persons, clinicians, educators, and policymakers engaged in real time, modelling bottom-up power and collective agency. The Module cultivates reflective public awareness of implicit bias. A central pedagogical principle is the distinction between intention and impact: well-meaning actions may still erode dignity, autonomy, and agency.

The accompanying Toolkit operationalizes these insights through clinical prompts, organizational checklists, and policy lenses that render ageism visible as a modifiable feature of systems rather than an immutable cultural norm.

For geriatric psychiatry, the implications are immediate. The Module and Toolkit counter therapeutic nihilism by reframing later life as a period of ongoing capability rather than inevitable decline. They normalize complexity without pathologizing age. They restore agency to persons whose narratives are often overwritten by diagnosis. Most importantly, they translate ethical commitments into everyday practice. Dignity becomes a clinical competency; agency becomes an outcome; rights become operational[33].

Early uptake of these tools across health, education, and community sectors demonstrates their catalytic role. Users report heightened awareness of implicit bias, changes in language and documentation, reconsideration of treatment thresholds, and redesign of routines in long-term care and community services. These shifts, though incremental, are precisely the mechanisms through which structural change emerges.

The Module and Toolkit thus exemplify the CCAA's core thesis: evidence achieves impact only when it is embedded in tools that reshape behavior and systems. They convert the abstract harms of ageism into actionable domains for clinical, organizational, and policy reform.

PRISM and the Paradigm Shift Toward Rights-Based Mental Health

PRISM [7] provides the ethical and operational grammar of the CCAA. The conceptual backbone of the CCAA's work is articulated through the PRISM framework—**Protection against intersecting forms of discrimination**. PRISM reflects a core empirical and ethical insight: ageism rarely operates in isolation. Its effects are amplified through interaction with mentalism, ableism, racism, sexism, and socioeconomic exclusion. These intersecting "isms" shape whose distress is recognized, whose autonomy is respected, and whose lives are considered worthy of sustained investment [6].

Traditional biomedical models, while indispensable, can inadvertently obscure these dynamics. In later life, clinical focus on pathology may eclipse context, reducing persons to diagnoses and normalizing exclusion from decision-making. Vulnerability becomes understood as intrinsic to age rather than as a product of environments that fail to adapt. PRISM reframes this logic. It situates impairment within social and institutional contexts and shifts responsibility from the individual to the systems that structure opportunity and participation.

PRISM is anchored in five interdependent pillars:

1. **Dignity** – the inherent worth of every person, irrespective of age, diagnosis, or dependency.
2. **Agency** – the right and capacity to participate in decisions affecting one's life.
3. **Capability** – the opportunity to develop and exercise functional, social, and psychological capacities.
4. **Equity** – the obligation to address structural disadvantage and cumulative marginalization; and
5. **Accountability** – the requirement that systems be answerable for harms and exclusion.

This aligns with the World Health Organization's Healthy Ageing framework [21], which defines functional ability as the outcome of interaction between intrinsic capacity and enabling environments. It also resonates with contemporary human-rights jurisprudence, which emphasizes participation, autonomy, and non-discrimination as enforceable obligations rather than aspirational values.

Within mental health care, PRISM offers a corrective to entrenched patterns of therapeutic nihilism. It reframes later-life care from maintenance to flourishing, from risk avoidance to capability enhancement. Under PRISM, the ethical question is not whether decline is inevitable, but whether systems have created conditions in which persons can exercise agency despite change. A person living with dementia is not reduced to cognitive loss but recognized as a rights-bearing subject whose preferences, relationships, and aspirations remain central.

Operationally, PRISM provides a lens through which clinicians, educators, and leaders can interrogate routine practice[34]:

- Does this assessment process preserve dignity or default to paternalism?
- Does this care plan enable agency or merely ensure compliance?
- Do institutional routines expand or constrict capability?
- Whose needs are systematically deprioritized?
- Who is accountable when exclusion becomes normalized?

By embedding these questions within the Module and Toolkit, PRISM becomes more than a theoretical construct. It is enacted in charting language, consent processes, environmental design, and policy evaluation. It transforms ethical commitments into measurable dimensions of quality.

Crucially, PRISM bridges clinical practice and human-rights law. The same principles that guide bedside care—dignity, agency, capability—now anchor international efforts to articulate binding protections for older persons. As the United Nations moves toward a Convention on the Rights of Older Persons, PRISM provides a translational framework through which legal norms can be enacted within health systems.

In this way, the CCAA advances a paradigm shift. Ageing is no longer framed primarily as decline to be managed, but as a phase of life requiring environments that enable continued participation and meaning. Mental health care becomes not only treatment of illness but stewardship of rights across the life course.

Coalition as Method: Scientific Advocacy at Scale

The CCAA reconceptualizes advocacy as social infrastructure rather than episodic persuasion. Despite robust evidence that ageism harms health and is modifiable, it persists across institutions. The barrier is not knowledge but the absence of mechanisms through which evidence reshapes environments. Traditional knowledge translation assumes linear uptake—evidence is published, guidelines follow, behavior changes. Ageism defies this model because it is culturally embedded and structurally reinforced.

Coalition therefore becomes the intervention. The CCAA treats coalition-building as a scientific method through which evidence, lived experience, and implementation are braided into systems change. Older persons articulate harms and priorities; researchers operationalize these into measurable constructs; clinicians test interventions; organizations modify routines; outcomes inform further refinement.

The Older Persons Advisory Group (OPAG) exemplifies this architecture. OPAG is not consultative but governing—co-designing tools, shaping narrative, and directing strategy. This structure operationalizes agency and ensures that dignity is enacted institutionally rather than invoked rhetorically.

By linking health, education, housing, labor, philanthropy, business, media, and government, the CCAA aligns incentives across environments. This approach is consonant with emerging equity-focused implementation science, which argues that evidence-based values—such as dignity and inclusion—must be embedded in multisectoral structures,

metrics, and partnerships if they are to achieve real-world impact, particularly in populations facing structural disadvantage[35], [36]. Implementation science predicts that such coherence is essential for durability. The coalition thus becomes an enabling environment for evidence—one in which dignity, agency, and capability shift from aspirational ideals to default expectations[37], [38].

For geriatric psychiatry, this model fundamentally reframes professional responsibility. Advocacy is not ancillary to care; it is integral to clinical effectiveness. When systems normalize exclusion, clinicians inherit constraints that shape diagnosis, treatment, and prognosis. Scientific advocacy therefore becomes a form of clinical stewardship: each clinician is positioned not only as a provider of care, but as a change agent within the systems that govern care. This extends the therapeutic mandate beyond the consulting room into the structures that determine whose suffering is recognized, whose agency is respected, and whose recovery is imagined. In this model, combating ageism is not an optional moral stance—it is a core clinical competency.

The ethos of geriatric psychiatry—its attention to complexity, its resistance to reductionism, and its commitment to dignity, relationship, wisdom, and meaning—infuses the CCAA's architecture. These are not parochial values of a subspecialty; they are broadly generalizable principles for humane care across medicine. In this sense, the CCAA does more than address ageism: it positions geriatric psychiatry as a catalyst for cultural change in clinical practice, training, and policy. The coalition's multisectoral design allows this ethos to travel—into hospitals, universities, housing systems, professional bodies, and government—where it reframes what "good care" means far beyond later life.

From National Innovation to Global Architecture

The logic of coalition has not remained bounded within Canada. Through the International Longevity Centre Global Alliance—now spanning sixteen countries—the CCAA framework is informing the early development of the Global Alliance for Rights-Based Care and Support for Older Persons (GARBCS-OP) [7], conceived as a translational bridge between emerging international law and everyday practice.

This global expansion coincides with a historic inflection point. In April 2025, the United Nations Human Rights Council launched an intergovernmental process to draft a legally binding Convention on the Rights of Older Persons, affirming that existing legal frameworks inadequately protect older people from discrimination, violence, and exclusion. Where treaties establish rights in principle, coalitions operationalize them in lived reality.

GARBCS-OP builds directly on the CCAA's architecture: co-governance with older persons, multisectoral alignment, and evidence-based tools grounded in PRISM. It enables countries to adapt shared human-rights principles within diverse cultural and institutional contexts while maintaining conceptual coherence. In this way, abstract norms become clinical competencies, organizational standards, and measurable practice.

For geriatric psychiatry, this moment is unprecedented. The field now operates within an emerging international legal architecture that recognizes ageism as a rights violation.

Clinical environments become sites where international law is either realized or denied. The CCAA's evolution from national coalition to global prototype demonstrates that rights-based mental health is not aspirational rhetoric, but an achievable systems transformation enacted through scientific advocacy.

Implications for Geriatric Psychiatry

Ageism is not peripheral to psychiatric practice; it is a determinant of diagnosis, treatment, prognosis, and access. It shapes whose symptoms are taken seriously, which interventions are offered, and which futures are imagined. Diagnostic overshadowing and therapeutic nihilism remain pervasive, producing delayed care, preventable suffering, and avoidable loss of function.

The CCAA reframes these patterns as quality-of-care failures rather than cultural residue. By rendering ageism visible as a modifiable feature of systems, it equips clinicians to interrogate everyday practice:
Why is this patient not being offered psychotherapy?
Why is risk framed as restriction rather than enablement?
Why are goals narrowed to maintenance rather than recovery or growth?

Through the Ageism Awareness Module, Toolkit, and PRISM framework, dignity and agency become clinical competencies. Language, thresholds, consent processes, and care pathways are repositioned as sites of ethical and therapeutic action. Advocacy ceases to be extracurricular and becomes integral to excellence in care.

This reframing aligns with the evolving international legal landscape. As the United Nations moves toward a Convention on the Rights of Older Persons, informed consent, participation in care, access to mental health services, and freedom from degrading treatment become not only ethical imperatives but emerging legal obligations. Geriatric psychiatry thus stands at the nexus of medicine and law.

In this model, the psychiatrist is not only a diagnostician or prescriber but a steward of dignity within systems. Clinical expertise extends beyond symptom management to shaping the environments that determine whose lives are valued. Advocacy becomes a form of care.

Conclusion

Ageism is not an abstract bias; it is a modifiable injustice with direct consequences for mental health, safety, and participation in later life. The Canadian Coalition Against Ageism demonstrates that dismantling it requires more than awareness—it requires infrastructure. Through scientific advocacy, the CCAA transforms evidence into environments that sustain dignity, agency, and capability.

Its architecture—co-governance with older persons, multisectoral alignment, the Ageism Awareness Module and Toolkit, and the PRISM framework—offers a reproducible model of systems change. As this work scales through the International Longevity Centre Global Alliance and the emerging Global Alliance for Rights-Based Care and Support for Older Persons, it aligns with a historic global shift: for the first time, international law is moving

toward recognizing ageism as a human-rights violation through a dedicated United Nations Convention on the Rights of Older Persons.

This convergence of science and law marks a paradigm shift. Ageing is no longer framed solely as decline to be managed, but as a phase of life requiring environments that enable participation, meaning, and growth. Mental health care becomes not only treatment of illness, but stewardship of rights across the life course.

Geriatric psychiatry is uniquely positioned to lead this transformation. Clinical expertise, ethical tradition, and proximity to lived experience confer both authority and responsibility. The CCAA shows how leadership can be enacted—through coalition, through tools, and through the deliberate translation of evidence into systems.

The implication is inescapable. Every clinician, educator, leader, and policymaker shapes the conditions in which older persons live, suffer, and flourish. Scientific advocacy ensures that dignity is not rhetorical, agency not symbolic, and rights not abstract. It redefines what it means to care in later life—and what it means to practice psychiatry in an ageing world.

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As Founding Chair of the CCAA, I am profoundly grateful to the older persons who have envisioned and shaped this work from its inception. The Older Persons Advisory Group (OPAG)—led with wisdom, courage, and clarity—has ensured that dignity, agency, and lived experience remain at the centre of every decision. Their guidance has transformed advocacy into partnership and principle into practice. They remind us, continually, that this work is not *for* older persons, but *with and led by* them.

Sincere thanks are extended to the Founding Members of the CCAA, the Steering Council, Executive Team, Committee members, Working Group leads, Secretariat, and Communications team. Their vision, dedication, and labour have built a truly multisectoral coalition spanning health, education, civil society, philanthropy, research, media, and policy. Their commitment has enabled the translation of evidence into tools, relationships, and systems change—and has shown what becomes possible when sectors align around shared values.

I acknowledge with deep appreciation the foundational role of International Longevity Centre Canada (ILC Canada) [39] and its Board in incubating and sustaining this work, and the leadership of colleagues across the International Longevity Centre Global Alliance (ILC GA)[40] who are now helping to scale these ideas internationally. The early development of the Global Alliance for Rights-Based Care and Support for Older Persons (GARBCS-OP) reflects a

shared conviction that dignity and human rights must be embedded in care systems worldwide.

This work has been enriched and strengthened by colleagues and partners across the global ecosystem of ageing and mental health, including collaborators within the World Health Organization, the Office of the High Commissioner for Human Rights, the Independent Expert on the enjoyment of all human rights by older persons, the United Nations system, the International Psychogeriatric Association (IPA) [41], the World Psychiatric Association, the American Association of Geriatric Psychiatry (AAGP), the International Federation on Ageing (IFA) [42], and the Global Alliance for the Rights of Older People (GAROP)[43] . Their leadership, scholarship, and persistence have shaped both the evidence base and the moral framework that make this moment possible.

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