Meeting the mental health needs of older women: taking social inequality into account

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ABSTRACT

Whilst there is increasing acceptance that social inequalities have implications for mental health, there is minimal acknowledgement of their effects on the development and treatment of mental ill health in older people. This paper focuses on older women, as they are the majority sufferers of mental illness in later life, and are particularly vulnerable to the cumulative effects of lifelong and age-related inequalities. The authors, who draw upon literature from the fields of gerontology and mental health, argue that for effective care to be developed, older women’s mental ill health needs to be seen within the context of their past and present experience of social inequalities. Evidence particularly relates to socio-economic disadvantages as well as to the consequences of discrimination. It is argued that psychological vulnerability is further compounded by the gendered effects of social policy, and by a care system which constructs mental health needs as unrelated to oppression, and dislocated from their economic, social and historical roots. Finally, the authors outline the key components of a care and service system which takes account of social inequalities, and which accords centrality to the experiences, views and opinions of older women with mental health problems.

KEY WORDS – Social inequality, older women, gender, mental health.

Introduction

There is widespread acceptance that social inequalities have implications for health (e.g. Acheson 1998; Arber and Ginn 1993), and growing acceptance that they also have implications for mental health (Henderson et al. 1998). As yet, however, there is no coherent literature concerned with the effects of inequalities on the mental health of older people, nor on service responses to their care needs.

The collective political forces that gave rise to substantial literatures

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on gender, race and sexuality have not driven academic work concerned with the lives and health of older people. Only comparatively recently has there been any recognition that ‘age’ is a social construction (Walker 1982; Townsend 1993; Vincent 1999), one that has the capacity to generate disadvantage, both on its own (Minkler and Estes 1999; Walker 1981) and in conjunction with other dimensions of inequality. These dimensions include gender (Walker 1993; Ginn and Arber 1998), class (Norman 1985; Arber and Ginn 1991) and race (Dowd and Bengston 1978). This mainly sociological literature has yet significantly to shape provision and practice within the field of mental health.

Against this background, this paper directs attention to the mental health implications of social inequalities for older women; those aged 60 and above. It draws mainly, though not exclusively, upon studies carried out in the UK. In focusing on older women it is not being suggested that the mental health of older men is unaffected by social inequalities, simply that older women warrant separate and specific consideration. First, women predominate in old age with about three older women for every two older men; this pattern is expected to continue for at least the next 30 years (Hughes 1995), and also holds true for black and ethnic minority populations (Blakemore and Boneham 1994). Second, there is extensive evidence documenting the ways that social inequalities impact on the mental health of younger women (Levin et al. 1994; Williams 1999), and no logical reasons for expecting structural factors to be insignificant determinants of the mental health of older women. Third, although older women constitute the largest group of users of mental health services, they remain largely ignored by health policy makers, psychiatric professionals, mental health lobby groups and the academic community.

**Mental health of older women**

We start with a brief overview of some of the main findings about the mental health of older people, with particular reference to older women. Attention is given to depression and the dementias, the predominant mental illnesses of old age.

*Depression*

Depression is the most common mental health problem amongst elderly people. Community-based studies carried out in the UK reveal
prevalence rates amongst the over-65s of between 11 per cent (Copeland et al. 1987a) and 16 per cent (Livingston et al. 1990), compared to a prevalence rate of nine per cent in younger adults (Meltzer et al. 1995). A consistent finding in community studies of depression is that rates for women are approximately double those for males; this pattern persists in later life (Beekman et al. 1999; Copeland et al. 1999). There is also evidence that depression in old age tends to be more severe and more likely to result in hospitalisation than in younger adults (Livingston et al. 1990): this pattern of depression is particularly common amongst the oldest cohorts, the majority of whom are women. Depression often occurs alongside other mental health problems; evidence suggests that around 30 per cent of people with Alzheimer’s disease experience depressive symptoms (Warrington 1997; Allen and Burns, 1995).

The rate of depression in some black and ethnic minority elders may be higher than for white elders. Rates of depression, for example, amongst African elders in Liverpool and Somali and Bengali elders in London, appear to be higher than for their white counterparts (Copeland et al. 1992; McCracken et al. 1997). Reasons for this higher prevalence have yet to be studied but are likely to include socio-economic disadvantage and poverty (Qureshi 1998; Silveira and Ebrahim 1995). Work in this field does not permit separate consideration of depression amongst older women from black and ethnic minority communities.

**Dementia**

UK surveys indicate that about six per cent of those aged 75–79, 13 per cent of those aged 80–84, and 25 per cent of those over 85 have ‘case level’ dementia (Ely et al. 1996). Dementia is a major cause of disability amongst elderly people, and those suffering from cognitive impairment make up a large proportion of those receiving long-term care (Melzer et al. 1999). Apart from longevity, the risk factors for developing dementia are largely unknown. The prevalence of dementia may be higher in some ethnic groups (Copeland et al. 1992). Although more women are diagnosed with dementia, evidence to date would suggest that this increased risk is mainly a function of longevity. However, there is no basis for concluding that the experience and management of this disease are unaffected by the existence of social inequalities in society. The existence of mental health problems with an organic aetiology does not over-write the past and present effects of social inequalities.
Other mental health difficulties

Research on anxiety in old age finds that, in common with younger age groups, the prevalence is higher amongst women compared with men (Victor 1991). There is considerable co-morbidity with the prevalence of depression (Livingston and Hinchcliffe 1993).

A small number of people grow old with severe and enduring mental health problems, including those diagnosed as schizophrenia. Some of these have spent many years in long-stay institutions and may have been resettled into alternative accommodation. Most are physically frail and need considerable support, and hence are likely to be living in specialist residential or nursing home care. Many are now very old and most are female (Audit Commission 2000).

Alcohol abuse amongst women is largely hidden (Szwabo 1993), and amongst older women is rarely identified as a social or personal problem. There is, however, some evidence that particular groups of older women are vulnerable to both alcohol and drug abuse. These are isolated and depressed women who live alone (Davison and Marshall 1996), women in institutional care, non-English-speaking elderly women who are culturally isolated (Russo 1990) and those who are homeless (Kutza and Keigher 1991). The extent to which older women rely upon non-prescribed drugs is unclear. However, as we note later, it is very evident that older women are the age-sex group that is prescribed the largest quantity of psychotropic medication.

It can be concluded from the available evidence that older women are particularly vulnerable to the development of mental health difficulties. There are indications that this pattern is common across different race and ethnic groups elsewhere in Europe and in the US (Copeland et al. 1999). It would be convenient, and consistent with the medical model, to explain this phenomenon as a manifestation of gender-linked physiological ageing. However, enough is known about the social causes of psychological distress in younger women to raise serious doubts about the validity of this explanation when applied to older women.

Inequality and mental health

We now summarise the literature that enables us to examine some of the ways in which lifelong and age-related social inequalities can create and perpetuate mental health difficulties in older women. Though the
available evidence is limited, it is sufficient to demonstrate the value and importance of this approach.

**Poverty**

That poverty is a risk factor for mental health problems is a well-established finding that has considerable face validity (Buck 1997). While we have not found any studies that have directly examined the mental health implications of poverty for older women, studies carried out within industrialised societies consistently find the highest level of poverty within this age-sex group (Walker 1992). Within the UK, 35 per cent of older women live in poverty compared with 23 per cent of older men, whilst approximately half of lone older women have incomes on or below the poverty line (Walker 1993; Milne et al. 1999). Living on a low income means that many older women are disadvantaged in a fundamental material sense, with a large percentage of personal expenditure being spent on basic necessities such as heating and food. Elderly women are both more likely to experience poverty and, because of enhanced longevity, be impoverished for a sustained period of time (Walker 1993). Many of the women who are poor in old age will also have experienced lifelong poverty. Explanations for this phenomenon are closely linked to the existence of sexual inequality in society, as well as to inequalities based on other dimensions such as class, race and sexuality. These include: reduced access to a work-based pension; dependence on an inadequate state pension; and a greater need for, but reduced access to, certain state benefits. The traditional pattern of women marrying older men also means that many older women live alone in later life and, in these circumstances, there is no one to share costs, and often no additional source of income (Davey Smith 1998).

**Housing and living situation**

Housing and living arrangements are well-documented determinants of health and psychological wellbeing in later life (Sixsmith 1990). Research consistently shows that enabling older people to remain in their own homes (Tinker 1994) is associated with a wide range of physical (Gurney and Means 1993) and psychological benefits (Clark et al. 1998).

Facilitating community-based living depends in good part on the quality of housing. However, the group least likely to own their homes is ‘the oldest old’, the majority of whom are widowed women. Single older women disproportionately occupy substandard older housing,
and the properties tend to be older and privately rented. The majority of those people living in houses without basic amenities (bath, inside toilet, etc.) are older women (Leather and Morrison 1997). Other living arrangements also have a negative impact on the mental health of older women (Carp 1997), including sharing the homes of relatives, institutional care and being homeless (Kutza and Keigher 1991).

Living alone, loneliness and social isolation are all causally related to the development of depression amongst elders (Livingston et al. 1990; Green et al. 1992). Older women are more likely to live alone and experience social isolation and loneliness; this leaves them more vulnerable to developing depression.

Marriage and home life

Many women in the current cohort of elders have worked exclusively within the home. Social and cultural norms about women’s reproductive and caring roles in the family, as well as institutionalised discrimination in the labour market, have limited their work opportunities and their access to the resources associated with paid work (Arber 1999). Women’s home roles are often characterised by considerable responsibility, a lack of power, and blame: there is now ample evidence that these exact a mental health cost (Brown 1987; Williams and Watson 1996; Williams 1999). In old age, women who have primarily worked within the home appear more likely to experience depressive illness than women who have also been employed, an outcome which, it is suggested, is mediated by low self-esteem, helplessness and poverty (Rodeheaver and Datan 1988).

Older women are also significantly more likely to be spousal carers: 35 per cent of all female caregivers are over 65 and most provide care for more than five years. Four in five of these caregivers provide care seven days per week without respite (Parker 1990; Office of National Statistics 1998). Depression is more prevalent amongst those who have caring responsibilities: around a third of those caring for a disabled spouse experience clinical level depression (Levin et al. 1994).

Trauma and abuse

In addition to the cumulative and contemporaneous effects of discrimination and oppression, some women may have to live with the consequences of trauma experienced as a child or younger adult. It is now widely accepted that structural inequalities, especially those based on gender, underpin imbalances of power that place girls and women at risk. The profound effects on mental health of power abuses in the
form of physical and sexual violence, are now very well documented (Goodman et al. 1997; Harris and Landis 1997). Accordingly, it is reasonable to expect substantial numbers of older women to have experienced physical or sexual abuse in their earlier lives. Certainly there is growing evidence from clinicians that changes in the wider culture are making it easier for some older women to talk about their histories of trauma (McCartney and Severson 1997; McInnis Dittrich 1996). There is also evidence confirming the high prevalence of childhood trauma in elderly women with a history of depression (Mullan and Orrell 1996). Experience of abuse has been shown to be associated with increased risk of re-victimisation in the context of family and other institutions, and current evidence allows for the possibility that this risk is carried into old age.

Research on the incidence and prevalence of elder abuse suggests that it is older women who are likely to be victims of abuse—particularly sexual abuse and domestic violence—and abusers more likely to be male (McCreadie 1996). Those elderly women who are particularly at risk appear to be women over the age of 75 years who have a mental or physical illness or disability and who are chronically dependent on a carer; many are also socially isolated (Coyne et al. 1993; Decalmer and Glendenning 1997). In the USA, older women account for 75 per cent of reported cases; the victim usually has a physical or mental illness and is often dependent on the person who abuses (Penhale and Kingston 1995; Manthorpe 1995). Comparable data have been reported in a UK study, where 80 per cent of those abused were found to be over 80 and, typically, also physically or mentally disabled (Social Services Inspectorate 1992). Their frailty and possible communication impairments, can make it very difficult for this group of elders to be heard in voicing their distress.

Health and disability

By the age of 85, 75 per cent of men and 85 per cent of women have some degree of physical disability (Victor 1997; OPCS 1998). As women dominate the fourth age, most will experience one or more physically disabling conditions. Additionally, there are considerably more women than men with physical disabilities at all levels of severity, except the least severe (OPCS 1998). Thus, while women tend to live longer than men, their health is often poorer. Given that physical wellbeing is a recognised contributor to mental health (Wenger et al. 1996), this contrast may partly explain the sex difference in depression.

The evidence reviewed here indicates that older women’s mental
health should be seen within the context of their past and present experience of social inequalities: this includes women whose difficulties have a clear organic component. The effects of social inequalities are mediated by poverty, housing, marriage and home life, trauma and abuse, and also physical health and wellbeing. Older women are typically the age-sex group that is most disadvantaged by these inequities in social life, and hence their psychological wellbeing is most at risk. Although gender is a key dimension of social inequality for women, it is not the sole dimension of inequality affecting their lives and experiences, and many women will also experience hardship and discrimination because of their ethnicity, sexuality and class. However, absence of relevant research makes it difficult to comment on the complexities of the interactions between these factors, other than to say that it seems reasonable to expect the effects to be cumulative.

Policy developments in the UK

Mental health services have been transformed by the policy reforms that have taken place over the last 10 years (Audit Commission 2000). Here we note how the failure of these reforms to take account of social inequalities, has had an impact on the quality of mental health provision for older women.

One of the most significant changes in service provision has been the shift towards community-based care, a change which has particular implications for those who are most vulnerable, including elderly women with mental health problems (Parker 1993; Lewis and Glennerster 1996). Widespread substitution of long-stay hospital care (free at the point of delivery) with residential/nursing care (for which there is a charge) has particular implications for people with dementia for whom the health service has traditionally provided long-stay care. At least 34 per cent of people with dementia in the UK are in residential/nursing care homes or in hospital care, and older women predominate in this group (Audit Commission 2000). Similarly, the contemporary thrust of local authorities to deploy charges for community-based care has a particularly acute impact on elderly women with chronic health problems. As they are both the majority recipients of care and are often living on low incomes, charging disadvantages them disproportionately and carries the risk of their exclusion from services (French 1995).

There has been a growing interest in the development of services which help older people to maintain or regain as much independence
as possible (e.g. Department of Health 1999a). There has been recognition that, even when they are increasingly frail, older people want to have more control over their lives, and that they continue to hold aspirations about a wide range of features of wellbeing. These features include adequate income, suitable housing, good advice and home care, not just those relating to health and social care services. Accordingly, those providing primary care for older people are being encouraged to identify physical health problems and dementia and depression in their early stages, so that they are best placed to engage the person as an active partner in their treatment and care (Audit Commission 2000). Also, initiatives by local authorities are being funded that improve the ways in which older people are able to influence local decision-making and services (Harding 1997).

This broad class of interventions can be expected to have mental health value in that ageism is challenged, isolation reduced, the contribution of older people to the community is enhanced, and their role in shaping policy and service provision is strengthened (Lewis et al. 1999). However, while the direction of these developments is promising, in themselves, they are rarely sensitive to any dimension of inequality other than age. To be effective, these efforts at empowerment need to be grounded in the best possible knowledge of the ways in which individuals and groups have been disempowered.

Service provision

The particular difficulties that women encounter in obtaining help with their mental health problems in old age, is partly a function of the model of ageing that underpins service provision. This model fails to accord importance to the effects of social inequalities on the past and present lives of older people. Instead, ageing is equated with a process of deterioration, dependency, passivity and an ‘inevitable’ decline in functioning (Wilson 1991). The assumed natural decline associated with later life imposes myopia on practitioners and limitations on services, which both perpetuate disadvantage and fail to meet the needs of elderly women. Some of the particular ways in which social inequalities shape mental health provision for older women will now be considered.

Community care

Whilst eligibility criteria for community care services recognise the emotional and social needs of younger users, this is rarely the case in
service provision for older people. In social services, the needs of elderly people are commonly pre-determined by a set of working practices which emphasise practicality and the allocation of standardised packages: this practice is then perpetuated by the habitual allocation of elderly cases to unqualified or assistant staff (Hallett 1989). Implicit ageism is thus evident in the content and practice of service provision for older people and their carers (Howe 1986). As the majority consumers of care, and the most disadvantaged, older women with chronic physical and/or mental health problems experience these discriminatory processes most acutely.

Care management was intended to be a key organisational mechanism for delivering the aims of community care policy (Department of Health 1991). This system for allocating and distributing welfare resources, however, was not intended to address issues of structural inequality (Biggs 1990). In dislocating the elderly person from their social and historical ‘world’, it fails to define, and therefore to meet, those needs with social, economic or historical causes. The status and value accorded to older women also makes it difficult for them to voice their needs or to feel entitled to participate in decision-making about their care. Additionally, many lack the income and social resources to deploy creative choice.

Institutional care

We have noted elsewhere (Williams 1999) that social status can determine access to valued services; and there is evidence both that the quality of service provision for older people is affected by their social position in the wider society, and that older women are especially vulnerable in this respect. Frail older women, for example, are most likely to be admitted to a care home, the care option that is regarded as least desirable by most elderly people (Tinker 1994). It is not surprising, therefore, to learn that nearly 50 per cent of elders in institutional settings are depressed, a finding which Copeland et al. (1987b) suggest is as likely to be a consequence of admission as it is a cause.

Although nursing homes are the dominant ‘treatment’ paradigm in the UK for elders with chronic mental health problems, these facilities have not been developed to meet mental health need, merely contain it. In 1998, 79 per cent of registered beds in nursing homes specifically for people with mental health problems, were filled by women (Melzer et al. 1999). This group tends to be aged 85 or over and to lack family support, and nearly all lived alone before admission (Laing and Buisson
Additionally, research suggests that lower socio-economic status and poverty, in conjunction with other factors, prompt admission (Peace et al. 1997; Higgs and Victor 1993). It is clear that social inequalities have had an impact upon the past and present lives of such women, on their physical and mental health, and on their service options.

Finally, older people, and particularly older women, are significant users of psychiatric hospitals; people over 65 account for nearly 40 per cent of all admissions. For first admissions, the rates for women are approximately one-third higher than for men (Department of Health 1999a). There has been grave concern for many years about the quality of care that can be provided within these contexts.

**Safety**

The abuse of older women in family settings has already been considered above. Older people in care are also at risk of abuse, especially in institutional care (Aitken and Griffen 1996; Brown et al. 1999). Whilst research about prevalence is relatively weak at present, a number of scandals and official enquiries imply that widespread abuse exists (Social Services Inspectorate 1992). Evidence suggests that those most at risk are elders with chronic mental health problems; it is this group who are also the least likely to be able to challenge neglect or abuse (Coyne et al. 1993). Many older women who experience abuse will not feel entitled to complain, and they are very unlikely to have access to an advocate to act on their behalf. Although there is some awareness of the need to prevent abuse in services, there is a reluctance to identify elder abuse as an issue which requires a significant shift in the nature of care to older people, as well as in the training and management of staff (Decalmer and Glendenning 1997).

**Clinical interventions**

Whilst there is growing acknowledgement that elderly people require individualised care, little attention has been paid to the existence and meaning of social inequalities in later life. Mental health professionals and practitioners often relate to older people as if their gender, class and race no longer had any real significance. They fail to analyse the experiences of older women and men separately, assuming homogeneity amongst elders, which presents as neutral the gendered process of growing older (Biggs 1993).

Despite the long-established assumption that ‘elderly people’ cannot benefit from therapy, studies of the efficacy of treatment for depression
suggest that older people may be as responsive as younger people to a variety of interventions, including therapy (Beck and Pearson 1989). Whilst some attention has been given to developing appropriate models of psychotherapy with older adults (e.g. Knight 1996; Orbach 1996), little work has been done either to develop gender appropriate models of clinical work, or to evaluate the effectiveness of current therapy models for older women.

Medication remains the intervention of choice. Prescription rates for psychotropic drugs are consistently found to vary according to age, gender and class (Linden et al. 1999). Many of these drugs are unnecessary and reflect the somatising of older women’s health problems by doctors. They are commonly taken in dangerous doses and combinations. The fact that 80 per cent of all acute drug reactions among elderly individuals arise from misuse of tranquillisers and sedatives suggests that older women are particularly at risk (Green 1988). The side-effects of combining drugs inappropriately – confusion, errors in judgement, apathy, diminished co-ordination – mimic the symptoms of Alzheimer’s disease and can lead to misdiagnosis and mistreatment (Victor 1991).

Women are two to three times more likely than men to receive electroconvulsive therapy (ECT) treatment (Frank 1990), with older women being particularly at risk (Fennell 1996). In hospital care, women over 65 years receive ECT out of proportion to their numbers (Thompson et al. 1994). Government statistics on the use of ECT show that four in ten treatments are given to patients over the age of 65; the majority of the older patients were not detained under the Mental Health Act 1993 (Department of Health 1999b). This suggests that older women continue to receive ECT extensively and in contexts where their rights may be compromised.

In short, the likelihood of women being offered ‘physical treatments’ rather than ‘talking treatments’ for mental health difficulties, increases with age. There are very real indications that this changing pattern is not determined by need, but by the declining status and power of this user group. Older women are especially likely to be offered poorly formulated interventions and to suffer the damaging side-effects of overuse, and long-term use, of psychotropic drugs (Yonkers et al. 1992).

In summary, older women with mental health problems are additionally disadvantaged by the ‘care and service system’ itself. This limits treatment options, reinforces the ‘inevitable decline’ model of ageing, and constructs need as dislocated from the elder women’s social and historical context. Services deploy a range of mechanisms which fail to take account of the role of social inequalities in the creation and
perpetuation of mental ill health amongst older women: social inequalities as cause and/or effect of mental ill health are not part of the explanatory paradigm, nor is addressing them typically part of the ‘treatment programme’.

Implications for action

Knowledge base

While there is sufficient evidence to substantiate the claim that social inequalities significantly affect the mental health of older women, and the services they receive, the evidence base is limited and lacks specificity. The research challenge is substantial; to clarify the role of past and present oppression on the mental health of older women, and to learn from them how they avert and survive mental health crises. In developing appropriate concepts and methods to explore this agenda, gerontology can draw upon tools that have already been developed in work with other disadvantaged social groups (Thompson 1998; Williams 1996). A key principle in taking forward this type of research should be the central involvement of older women and their carers. Again there are precedents for maximising ‘user group’ involvement in research, and reflexive use of existing processes and procedures (e.g. Balcazar et al. 1998) should help to identify achievable ways of increasing the impact of ‘older women’s voices’ (Tozer and Thornton 1995; Peace 1999). Funding bodies can help to facilitate this change by making ‘user participation’ a criterion for awarding funding. This principal is being adopted by some funding agencies in relationship to research around older people’s issues although this has yet to be adopted for work in the field of elder mental ill health.

Members of the academic community who have already established interests in the mental health of oppressed social groups, should also be encouraged to include older people within the domain of inquiry. There are signs that this is beginning to happen. For example, it has become more common in recent years for chapters on older women to be included in edited texts on women’s mental health (Livingston and Blanchard 1996; Padgett et al. 1998).

Training

Older people, and older women in particular, have not achieved sufficient collective strength to challenge the replication of ageism and associated age-related oppressions in the training of professionals. It is
important therefore, that training bodies and organisations actively assume responsibility for addressing these issues. The models and assumptions that underpin work with older people need to receive similar critical attention to that directed to service provision for other disadvantaged social groups (Razack 1999; Weber 1998). The quantity and quality of teaching about older people is an equality issue, and this needs to be evident in the policies and practices of training providers and professional bodies (Levenson 1981). Training improvements accompanying the Modernising of Health and Social Services (Department of Health 1998) presents an opportunity for addressing some of these deficits, although there is no explicit expectation that older people will contribute to training.

Challenging social inequalities

If social inequalities are a significant determinant of the mental health of older women, it follows that addressing these inequalities is one of the keys to prevention. Available evidence enables a number of issues to be identified as important, though older women themselves are best placed to establish priorities for action. The feminisation of poverty in old age clearly needs to be tackled. A poverty strategy needs to address inequalities in women’s access to pensions and benefits, and the provision of better support (including financial support) to older women who are caring for dependants (Milne et al. 1999; Harding 1997).

Policy can help challenge disadvantage and provide impetus for change; it has a crucial role to play in addressing the failure of mental health services to respond effectively to the needs of older women. A coherent policy that takes in elders with mental health problems including dementia as its focus, would be a good starting point. Recent policy directives (e.g. Audit Commission 2000) may be helpful in this respect. However, it is vital that such policy developments heed the type of evidence presented here, and do not contribute to minimising, trivialising and ignoring the effects of inequalities.

Better services

There is growing expertise within primary care settings about ways of helping women whose psychological distress is rooted in trauma and oppression linked to their social position (Harris and Landis 1997; Williams 1999). It is important that primary care workers, including GPs, now reflect upon the relevance of these interventions for older
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women, and on ways of increasing their access to these and other forms of relevant help (Brodaty et al. 1993).

Secondary mental health provision for older people in the UK is discrete; there are specialist community mental health teams, specialist social work staff, and day and residential services. Within the boundaries of these services, counselling and therapy are scarce commodities. Yet, many older women could benefit from talking treatments that are sensitive both to their lifelong experiences and to the psychological implications of oppression, discrimination and disadvantage. One way forward is to challenge the explicit and implicit ageism inherent in the referral criteria for counselling and therapy services. There is no convincing rationale for such services to exclude users on the basis of age, and the evidence that does exist suggests that therapy can be highly successful with older people (Knight 1996). The problem, however, is not simply that of improving accessibility; ‘talking treatments’ for older people also need to be relevant. Most therapeutic support offered to older women will need to extend and develop competence if it is to serve this group in a way which is accessible and effective. The existing clinical literature, which has developed within the social inequalities paradigm, is an obvious resource (Fernando 1995; Williams and Watson 1996; Harris and Landis 1997).

The quality of ‘day-to-day’ care practice offered by home carers, residential care workers, day care and other support staff, requires particular attention because it represents the majority of care contact older women have with the community and residential services. Recent practice initiatives suggest a gradual shift in perspective towards user empowerment, the promotion of choice and partnership (Barnes and Bennett 1998) and the introduction of anti-ageist practice (Hughes 1995; Braye and Preston-Shoot 1995). These positive changes have yet to emerge widely within older people’s services and imported into practice in the field of elder mental ill health, and, we would argue, need to be informed by a social inequalities perspective.

Developments in the field of dementia care, in particular work which underlines the concept of ‘personhood’, have significantly influenced academic and professional understanding of dementia care (Hunter 1997). Kitwood (1997) argues that if the ‘uniqueness of persons’ is to be fully appreciated, two things are necessary: detailed personal knowledge about the individual dementia sufferer’s past life, lifelong experiences and lifestyle, and empathy, having an understanding of what another is experiencing. Insofar that lifelong and age-related inequalities impact upon the experience of ‘being old’, and contribute
to the experience of being mentally ill, the concept of understanding
the ‘uniqueness’ of the individual with dementia offers a useful
template upon which to build a social inequalities approach.

Providers and purchasers of mental health services for older people
need to take account of research which indicates that discrimination
against women, and other disadvantaged groups, is common within
services. Discussion with service users will help to identify ways in
which discrimination may be significantly affecting service provision
for this group. This will help to define monitoring tasks for services, and
to inform strategic attempts to address problems of inequality
(Thompson 1998). Improvement in the quality of mental health
services to older women needs to be coupled with an improvement in
safety. Many women with mental health problems, including women
with organic diagnoses (McCartney and Severson 1997), will have
developed difficulties in response to the experience of trauma: it is
axiomatic that they should not be re-victimised within services.
Training mental health workers to understand and work with the
effects of social inequalities on mental health will alert them to the
significance of preventing or replicating abuse within services (Williams
and Keating 1999). There is also a developing literature in this field
that can be used to inform the development of safe practices and
services (Brown et al. 1999; Harris 1998).

We have argued that the over-medication of older women with
mental health problems is largely due to the low value accorded them
as a result of their age, gender, and psychiatric status. The identification
of more effective ways of responding to the mental health needs of older
women may help to reduce the current reliance on physical treatments
(McInnis Dittrich 1996). Mental health providers could also be
required to ensure that older people meaningfully consent to physical
treatment; if they are unable to consent they should not only be
afforded the protection of the Mental Health Act but that of an
independent advocate. The extension of funding and provision of
independent advocacy to older people with mental health problems is,
therefore, a matter of priority (Teasdale 1998). Knowledge is power,
and campaign groups such as MIND, Help the Aged and Age
Concern, could play a role in enabling older people to be informed
consumers about treatment options and potential abuses. All opportun-
ities need to be taken and created to empower rather than contribute
to the powerlessness of older women.
Consultation, collaboration and participation

To date, the voices of older women are rarely heard in debates about mental health service provision, nor do they influence decision-making. They need better opportunities to participate, and to be listened to. Without clear direction from those who have first-hand experience of mental distress, mental health services will continue to achieve little and replicate the poor practice that permeates many community and residential services.

Service provision for older people has not benefited from the same kind of collective action that has contributed to the development of better services to younger women, to people from the black community, and to lesbians and gay men. This suggests that effort should be directed to supporting greater political action amongst older people and women in particular (Ginn 1993). Such efforts could be small scale and local and aimed, for example, at identifying ‘action points’ in a local Community Care Plan or influencing the development of an advocacy service. Currently, there is little evidence to suggest that women users and carers are being consulted in the community care planning process in most local authorities (Hoyes et al. 1993). Though older user forums have been established in some parts of the country with the stated aim of collaborating with agencies around ‘Community Care Planning’ and service development (Carter and Nash 1992), they tend to represent the views of younger, fitter users. There is considerable scope, and there are some precedents (Barnes and Bennett 1998; Barnes et al. 1994; Barnes and Walker 1996), for action to strengthen the participation of more frail elders, amongst whom women predominate.

Although some user and carer organisations are being involved in national level consultations, the groups least likely to contribute are frail elders, elders with mental health problems, and those living in institutional care. Again the majority are older women. To be fair and effective, these consultations need to be inclusive. One resource is the substantial literature describing and theorising the development of viable user groups in comparable service contexts (Morris 1997; Sassoon and Lindow 1995; Williams and Lindley 1996).

In addition to initiatives involving service users, the UK older citizens self-help movement has developed a number of models of collaboration (Chiva 1993). The majority have a social or educational focus such as the University of the Third Age. Others aim to support elders with particular health difficulties, or to involve them in achieving a socio-political change such as improving standards of living and
income maximisation. The majority of organisations run by older citizens tend to be run by fit, active older people who are not users of welfare services.

Whilst the majority focus of the older people’s movement is the welfare of the ‘older citizen’, there are examples of initiatives run by older people offering support to both older citizens and service users (Wertheimer 1993). In particular, it is useful to note the growing significance of citizen advocacy. Evidence suggests that citizen advocacy schemes offer older people advice about poverty, housing and age discrimination, and that they offer service users advice in relation to disability, protection from abuse and admission to residential care. Specific groups of particularly vulnerable older people such as those with a mental health problem, benefit from advocacy around compulsory admission to psychiatric hospital, psychiatric treatment and admission to a care home (Thornton and Tozer 1994; Dunning 1998). Patients’ Councils are a further mechanism that could lead to improvements in the quality of mental health services (Hudson 1999). They offer a way of creating and strengthening links between day and residential services and the wider community, and of breaking down some of the barriers created by age, physical and social location, and psychiatric labels. Though they are known to improve the quality of care given to younger people, we are unaware of any attempts to explore the potential of Patients Councils within mental health services for older people.

Here we have identified some of the positive developments in policy and practice, which can usefully begin to acknowledge and address the effects of social inequalities. We have also emphasised that service providers and users, struggling to achieve these changes, may find it useful to consider developments that are occurring elsewhere within health and social care. We are not suggesting that interventions should be uncritically replicated, but that they could be used as a resource and as a reminder of the value of taking action.

**Conclusion**

This paper has outlined the relationship between social inequalities and older women with mental health problems. We have argued that both lifelong and age-related inequalities create and perpetuate mental ill health in older women, and that until the ‘care system’ acknowledges and addresses this dimension of ‘need’, it will continue to fail older women and may further disadvantage and mistreat them. There are a
number of key steps towards building a care and service system for older women with mental health problems which is receptive to taking account of social inequalities.

First, there remains a lack of coherent theory, which links psychological and intra-psychic phenomena to structural inequality, both with regard to old age in general, and gender in particular. The development of a theoretical framework which adopts a social inequalities perspective could offer a foundation upon which to build services and develop practice with older women with mental health problems.

Secondly, the role of research in building a solid evidence base, linking social inequalities to mental ill health amongst older women, is essential. As discussed, what evidence there is tends to be insufficiently focused, and research has singularly failed to take account of the perspectives of older women themselves.

Thirdly, services need to be developed in a climate where older women are accorded the same rights and opportunities as younger adults, and where investment in creative and therapeutic service options, driven by older women themselves, takes precedence over medicalised and institutionalised treatments.

Fourthly, clinical practice renders invisible the social origins of mental ill health; it constructs ‘need’ as dislocated from the older woman’s economic, social and historical context and as unrelated to oppression or discrimination. Adopting a social inequalities perspective shifts the professional understanding of ‘need’ towards acknowledging the ‘whole’ experience of the older woman, and incorporates resolutions which require change in the external environment as well as within the individual.

Finally, there is much to be learned from older women about their cumulative experience of surviving and coping with the social consequences of being female, elderly and suffering from mental ill health. Until we can accord the perspectives of older women a central role in changing responses to mental illness, the care system will continue to fail to relieve mental distress and will perpetuate a ‘lack of fit’ between the welfare system and the welfare of the individual. Taking social inequalities into account offers a new approach to a growing area of health care concern; it creates new options, choices and possibilities that offer the potential to address effectively the mental health needs of older women, both now and in the future.
References


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