Ageing and Society **20**, 2000, 699–723. Printed in the United Kingdom
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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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https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

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

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

prevalence rates amongst the over-65s of between 11 per cent (Copeland *et al.* 1987*a*) 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.

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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

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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 problem 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,

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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

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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

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

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

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as possible (*e.g.* Department of Health 1999*a*). 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

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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.* (1987*b*) 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

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

1996). 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 1999*a*). 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

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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 1999*b*). 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

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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

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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

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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 opportunities need to be taken and created to empower rather than contribute to the powerlessness of older women.

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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 context (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 1995). 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

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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

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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.

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

References

Acheson, D. 1998. *Independent Inquiry into Inequalities in Health Report*. The Stationary Office, London.

Aitken, L. and Griffen, G. 1996. Paid to care – gender issues in elder abuse in institutional settings. In Aitken, L. and Griffen, G. (eds), *Gender Issues in Elder Abuse*. Sage, London, 79–102.

Allen, H. and Burns, A. 1995. The non-cognitive features of dementia. *Reviews of Clinical Gerontology*, **5**, 57–78.

Arber, S. 1999. Gender. In Gordon, D., Shaw, M., Dorling, D. and Davey Smith, G. (eds), *Inequalities in Health*. Policy Press, Bristol, 197–206.

Arber, S. and Ginn, J. 1991. The invisibility of age: gender and class in later life. *Sociological Review*, **39**, 2, 260–91.

Arber, S. and Ginn, J. 1993. Gender and inequalities in health in later life. *Social Science and Medicine*, **36**, 1, 33–47.

Audit Commission. 2000. *Forget-me-not: Mental health services for older people*. Holbrooks, Portsmouth.

Balcazar, F. E., Keys, C. B., Kaplan, D. L. and Suarez Balcazar, Y. 1998. Participatory action research and people with disabilities: Principles and challenges. *Canadian Journal of Rehabilitation*, **12**, 2, 105–12.

Barnes, M., Cormie, J. and Crichton, M. 1994. *Seeking Representative Views from Frail Older People*. Age Concern Scotland, Edinburgh.

Barnes, M. and Walker, A. 1996. Consumerism versus empowerment: a principled approach to the involvement of older service users. *Policy and Politics*, **24**, 4, 375–393.

Barnes, M. and Bennett, G. 1998. Frail bodies, courageous voices: older people influencing community care. *Health and Social Care in the Community*, **6**, 2, 102–11.

Beck, C. M. and Pearson, B. P. 1989. The mental health of elderly women. *Journal of Women and Aging*, **1**, 3, 175–93.

Beekman, A. T. F., Copeland, J. R. M. and Prince, M. J. 1999. Review of community prevalence of depression in later life. *British Journal of Psychiatry*, **174**, 307–11.

Biggs, S. 1990. Consumers, care management and inspection: obscuring social deprivation and need. *Critical Social Policy*, **10**, 23–38.

Biggs, S. 1993. *Understanding Ageing: Images, Attitudes and Professional Practice*. Open University Press, Buckingham.

Blakemore, K. and Boneham, M. 1994. *Age, Race and Ethnicity: a Comparative Approach*. Open University Press, Buckingham.

Braye, S. and Preston-Shoot, M. 1995. *Empowering Practice in Social Care*. Open University Press, Buckingham.

Brodaty, H., Harris, L. and Peters, K., *et al.* 1993. Prognosis of depression in the elderly: a comparison with younger patients. *British Journal of Psychiatry*, **163**, 589–96.

Brown, G. W. 1987. Social factors and the development and course of depressive disorders in women: a review of a research programme. *British Journal of Social Work*, **17**, 615–34.

Brown, H., Kingston, P. and Wilson, B. 1999. Adult protection: an overview of research and policy. *The Journal of Adult Protection*, **1**, 1, 6–16.

Buck, M. 1997. The price of poverty: mental health and gender. *Critical Social Policy*, **17**, 1, 50, 79–97.

Carp, F. M. 1997. Living arrangements for midlife and older women. In Coyle, J. M. (ed), *Handbook on Women and Aging*. Greenwood Press, Westport, CT, USA, 253–70.

Carter, T. and Nash, C. 1992. *Pensioners Forum: an Active Voice*. Pre-Retirement Association, London.

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

Chiva, T. 1995. The third age: a consideration of groups and their activities. In Jack, R. (ed), *Empowerment in Community Care*. Chapman Hall, London.
Clark, H., Dyer, S. and Horwood, J. 1998. *That Bit of Help: the High Value of Low Level Preventive Services for Older People*. The Policy Press, Bristol.
Copeland, J. R. M., Gurland, B. J. and Dewey, M. E., *et al.* 1987*a*. The range of mental illness among the elderly in the community: prevalence in Liverpool using the GMS-AGECAT Package. *British Journal of Psychiatry*, **150**, 815–23.
Copeland, J. R. M., Dewey, M. E. and Wood, N., *et al.* 1987*b*. Is there more to dementia, depression and neurosis in New York: a comparative study of the elderly in New York and London using the computer diagnosis: AGECAT. *British Journal of Psychiatry*, **151**, 466–73.
Copeland, J. R. M., Davidson, I. A. and Dewey, M. E., *et al.* 1992. Alzheimer's disease, other dementias, depression and pseudo-dementia: prevalence, incidence and three year outcome in Liverpool. *British Journal of Psychiatry*, **161**, 230–39.
Copeland, J. R. M., Beekman, M. E., Dewey, M. E. and Hooijer, A., *et al.* 1999. Depression in Europe, geographical distribution amongst elderly people. *British Journal of Psychiatry*, **174**, 312–21.
Coyne, A., Reichman, W. E. and Berbig, L. J. 1993. The relationship between dementia and elder abuse. *American Journal of Psychiatry*, **150**, 643–6.
Davison, S. and Marshall, J. 1996. Women with drug and alcohol problems. In Abel, K., Buszewicz, M., Davison, S., Johnson, S. and Staples, E. (eds), *Planning Community Mental Health Services for Women*. Routledge, London, 128–144.
Davey Smith, G. 1998. Poverty across the life-course and health. In Gordon, D., Shaw, M., Dorling, D. and Davey Smith, G. (eds), *Inequalities in Health*. Policy Press, Bristol.
Decalmer, P. and Glendenning, F. (eds). 1997. *The Mistreatment of Elderly People*. Sage, London.
Department of Health. 1991. *Care Management and Assessment: Managers (and Practitioners) Guide*. SSI/SWSG. HMSO, London.
Department of Health. 1998. *Modernising Health and Social Services*. Department of Health, London.
Department of Health. 1999*a*. *Personal Social Services Key Statistics 1997–1998*. Department of Health, London.
Department of Health. 1999*b*. Electro Convulsive therapy: survey covering the period from January 1999 to March 1999. Department of Health, London.
Dowd, J. J. and Bengston, V. L. 1978. Aging in minority populations: an examination of the double-jeopardy hypothesis. *Journal of Gerontology*, **33**, 427–36.
Dunning, A. 1998. Advocacy, empowerment and older people. In Bernard, M. and Phillips, J. (eds), *The Social Policy of Old Age*. Centre for Policy on Ageing, London, 200–21.
Ely, M., Melzer, D. and Opit, L., *et al.* 1996. Estimating the numbers and characteristics of elderly people with cognitive disability in local populations. *Research, Policy and Planning*, **14**, 13–18.
Fennell, P. 1996. *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*. Routledge, London.
Fernando, S. 1995. *Mental Health in a Multi-Ethnic Society: a Multi-disciplinary Handbook*. Routledge, London.
Frank, L. R. 1990. Electroshock: death, brain damage, memory loss, and brainwashing. *Journal of Mind and Behaviour*, **11**, 3/4, 489–512.
French, J. 1995. Charging elders: perverse incentives and poverty. *Critical Social Policy*, **44/45**, 96–106.
Ginn, J. 1993. Grey power: age-based organisations' response to structured inequalities. *Critical Social Policy*, 38, **13**, 2, 23–47.

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

Ginn, J and Arber, S. 1998. Gender and old age. In Bernard, M. and Phillips, J. (eds), *The Social Policy of Old Age*. Centre for Policy on Ageing, London, 142–162.

Goodman, L. A., Johnson, M., Dutton, M. A. and Harris, M. 1997. Prevalence and impact of sexual and physical abuse. In Harris, M. and Landis, C. L. (eds), *Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness*. Harwood Academic, London, 277–302.

Green, H. 1988. *General Household Survey 1985: Informal Carers*. HMSO, London.

Green, B. H., Copeland, J. R. and Dewey, M. E., *et al*. 1992. Risk factors for depression in elderly people: a prospective study. *Acta Psychiatrica Scandinavica*, **86**, 213–17.

Gurney, C. and Means, R. 1993. The meaning of home in later life. In Arber, S. and Evandrou, M. (eds), *Ageing, Independence and the Life Course*. Jessica Kingsley, London, 119–31.

Hallett, C. (ed), 1989. *Women and Social Services Departments*. Wheatsheaf, Hemel Hempstead.

Harding, T. 1997. *A Life Worth Living: the Independence and Inclusion of Older People*. Help the Aged, London.

Harris, M. 1998. Modifications in services delivery and clinical treatment for women diagnosed with severe mental illness who are also survivors of sexual abuse trauma. In Levin, B. L., Blanch, A. K. and Jennings, A. (eds), *Women's Mental Health Services: a Public Health Perspective*. Sage, London, 309–25.

Harris, M. and Landis, L. L. 1997. *Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness*. Harwood Academic, London.

Henderson, C., Thornicroft, G. and Glover, G. 1998. Inequalities in mental health: review article. *British Journal of Psychiatry*, **173**, 105–9.

Higgs, P. and Victor, C. 1993. Institutional care and the life course. In Arber, S. and Evandrou, M. (eds), *Ageing, Independence and the Life Course*. Jessica Kingsley, London, 186–200.

Howe, D. 1986. The segregation of women and their work in the personal social services. *Critical Social Policy*, **5**, 21–36.

Hoyes, L., Jeffers, S., Lart, R., Means, R. and Taylor, M. 1993. *User Empowerment and the Reform of Community Care: a Study of Early Implementation in Four Authorities*. SAUS Publications, Bristol.

Hudson, M. 1999. Psychiatric hospitals and patients' councils. In Newnes, C., Holmes, G. and Dunn, C. (eds), *Thinking about Psychiatry and the Future of the Mental Health System*. PCCS Books, Ross-on-Wye.

Hughes, B. 1995. *Older People and Community Care: Critical Theory and Practice*. Open University Press, Buckingham.

Hunter, S. (ed), 1997. *Dementia: Challenges and New Directions*. Jessica Kingsley Publishers, London.

Kitwood, T. 1997. The uniqueness of persons in dementia care. In Marshall, M. (ed), *State of the Art in Dementia Care*. Centre for Policy on Ageing, London, 36–39.

Knight, R. 1996. *Psychotherapy with Older Adults*. Sage Publications, London.

Kutza, E. A. and Keigher, S. M. 1991. The elderly 'new homeless': an emerging population at risk. *Social Work*, **36**, 4, 288–93.

Laing and Buisson 1996. *Care of Elderly People Market Survey 1996*. Laing and Buisson, London.

Leather, P. and Morrison, T. 1997. *The State of UK Housing*. Policy Press, Bristol.

Levin, E., Moriarty, J. and Gorbach, P. 1994. *Better for the Break*. HMSO, London.

Levenson, A. 1981. Ageism: a major deterrent to the introduction of curricula in ageing. *Gerontology and Geriatrics Education*, **1**, 161–2.

Lewis, H., Fletcher, P. and Hardy, B., *et al*. 1999. *Promoting Well-being: Developing a Preventive Approach with Older People*. Joseph Rowntree Foundation, York.

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

Lewis, J. and Glennerster, H. 1996. *Implementing the New Community Care*. Open University Press, Buckingham.

Linden, M., Lecrubier, Y., Bellantuono, C., Benkert, O., Kisely, S. and Simon, G. 1999. The prescribing of psychotropic drugs by primary care physicians: an international collaborative study. *Journal of Clinical Psychopharmacology*, **19**, 2, 132–40.

Livingston, G., Hawkins, A. and Graham, N., *et al*. 1990. The Gospel Oak Study: prevalence rates of dementia, depression and activity limitation among elderly residents in Inner London. *Psychological Medicine*, **20**, 137–46.

Livingston, G. and Hinchcliffe, J. 1993. The epidemiology of psychiatric disorders in the elderly. *International Review of Psychiatry*, **5**, 317–26.

Livingston, G. and Blanchard, M. 1996. Planning community mental health services for older women. In Abel, K., Buscewicz, M. and Davison, S., *et al* (eds), *Planning Community Mental Health Services for Women*. Routledge, London, 51–64.

Manthorpe, J. 1995. Elder abuse and dementia. *Journal of Dementia Care*, Nov/Dec, 27–29.

McCartney, J. R. and Severson, K. 1997. Sexual violence, post-traumatic stress disorder, and dementia. *Journal of the American Geriatrics Society*, **45**, 1, 76–8.

McCracken, M., Boneham, M. A. and Copeland, J. R. M., *et al*. 1997. Prevalence of dementia and depression among elderly people in black and ethnic minorities. *British Journal of Psychiatry*, **171**, 269–73.

McCreadie, C. 1996. *Elder Abuse: Update on Research*. Age Concern Institute of Gerontology, London.

McInnis Dittrich, K. 1996. Adapting life-review therapy for elderly female survivors of childhood sexual abuse. *Families in Society*, **77**, 3, 166–73.

Meltzer, H., Gill, B. and Pettigrew, M., *et al*. 1995. *The Prevalence of Psychiatric Morbidity among Adults Living in Private Households*. HMSO, London.

Melzer, D., McWilliams, B., Brayne, C., Johnson, T. and Bond, J. 1999. Profile of disability in elderly people: estimates from a longtitudinal population study. *British Medical Journal*, **318**, 1108–11.

Milne, A., Hatzidimitradou, E. and Harding, T. 1999. *Later Lifestyles: a Survey by Help the Aged and Yours Magazine*. Help the Aged, London.

Minkler, M. and Estes, C. L. 1999. *Critical Gerontology: Perspectives from Political and Moral Economy*. Baywood Publishing Company, New York.

Morris, J. 1997. *Community Care Partnership with Service Users*. Ventura Press, Birmingham.

Mullan, E. and Orrell, M. 1996. Early life experience in elderly women with a history of depression: a pilot study using the Brief Parenting Interview. *Irish Journal of Psychological Medicine*, **13**, 1, 18–20.

Norman, A. 1985. *Triple Jeopardy: Growing Old in a Second Homeland*. Centre for Policy on Ageing, London.

Office of National Statistics. 1998. *Informal Carers: an Independent Study Carried out by the ONS on behalf of the Department of Health as a Part of the 1995 General Household Survey*. The Stationary Office, London.

Office of Population Censuses and Surveys. 1998. *General Household Survey 1995*. HMSO, London.

Orbach, A. 1996. *Not Too Late: Psychotherapy and Ageing*. Jessica Kingsley, London.

Padgett, D. K., Burns, B. J. and Grau, L. A. 1998. Risk factors and resilience: mental health needs and service use of older women. In Lubotsky Levin, B., Blanch, A. K. and Jennings, A. (eds), *Women's Mental Health Services: Public Health Perspective*. Sage, London.

Parker, G. 1990. *With Due Care and Attention: a Review of the Research on Informal Care*. 2nd Edition. Family Policy Studies Centre, London.

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

Parker, R. 1993. Ideology and the private sector of welfare. In Johnson, J. and Slater, R. (eds), *Ageing and Later Life*. Sage Publications, London, 239–45.
Peace, S. (ed), 1999. *Involving Older People in Research*. Centre for Policy on Ageing, London.
Peace, S., Kellaher, L. and Willcocks, D. 1997. *Re-evaluating Residential Care*. Open University Press, Buckingham.
Penhale, B. and Kingston, P. 1995. Elder abuse: an overview of recent and current developments. *Health and Social Care in the Community*, **3**, 5, 311–20.
Qureshi, T. 1998. *Living in Britain – Growing Old in Britain: a Study of Bangladeshi Elders in London*. Centre for Policy on Ageing, London.
Razack, N. 1999. Anti-discriminatory practice: pedagogical struggles and challenges. *British Journal of Social Work*, **29**, 2, 231–50.
Rodeheaver, D. and Datan, N. 1988. The challenge of double jeopardy. *American Psychologist*, **43**, 648–54.
Russo, N. F. 1990. Overview: forging research priorities for women's mental health. *American Psychologist*, **45**, 3, 368–73.
Sassoon, M. and Lindow, M. 1995. Consulting and empowering black mental health system users. In Fernando, S. (ed), *Mental Health in a Multi-Ethnic Society: a Multi-disciplinary Handbook*. Routledge, London.
Silveira, E. and Ebrahim, S. 1995. Mental health and health status of elderly Bengalis and Somalis in London. *Age and Ageing*, **24**, 474–80.
Sixsmith, A. 1990. The meaning and experience of 'home' in later life. In Bytheway, W. R. and Johnson, J. (eds), *Welfare and the Ageing Experience*. Avebury, Aldershot, 172–92.
Social Services Inspectorate. 1992. *Confronting Elder Abuse*. HMSO, London.
Szwabo, P. A. 1993. Substance abuse in older women. *Clinics in Geriatric Medicine*, **9**, 197–208.
Teasdale, K. 1998. *Advocacy in Health Care*. Blackwells, Oxford.
Thompson, J. W., Weiner, R. D., Richard, D. and Myers, C. P. 1994. Use of ECT in the United States in 1975, 1980 and 1986. *American Journal of Psychiatry*, **151**, 11, 1657–61.
Thompson, N. 1998. *Promoting Equality: Challenging Discrimination and Oppression in the Human Services*. Macmillan, Basingstoke.
Thornton, P. and Tozer, A. 1994. *Involving Older People in Planning and Evaluating Community Care: a Review of Initiatives*. Social Policy Research Unit, University of York.
Tinker, A. 1994. The role of housing policies in care of elderly people. *Caring for Frail Elderly People*. OECD, Paris, 57–82.
Townsend, P. 1993. The structured dependency of the elderly: a creation of social policy in the twentieth century. In Bornat, J., Pereira, C., Pilgrim, D. and Williams, F. (eds), *Community Care: a Reader*. Open University Press, Buckingham, 178–183.
Tozer, R. and Thornton, P. 1995. *A Meeting of Minds – Older People as Research Advisers*. Social Policy Research Unit, University of York.
Victor, C. 1991. *Health and Health Care in Later Life*. Open University Press, Buckingham.
Victor, C. 1997. *Community Care and Older People*. Stanley Thornes, Cheltenham.
Vincent, J. 1999. *Politics, Power and Old Age*. Open University Press, Buckingham.
Walker, A. 1981. Towards a political economy of old age. *Ageing and Society*, **1**, 1, 73–94.
Walker, A. 1982. Dependency and old age. *Social Policy and Administration*, **16**, 2, 115–35.
Walker, A. 1992. The poor relation: poverty among older women. In Glendinning, C. and Millar, J. (eds), *Women and Poverty in Britain: the 1990's*. Wheatsheaf, London, 178–98.
Walker, A. 1993. Poverty and inequality in old age. In Bond, J., Coleman, P. and

https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press

Peace, S. (eds), *Ageing in Society: an Introduction to Social Gerontology*. Sage, London, 280–303.
Warrington, J. 1997. Depression and dementia. In Hunter, S. (ed), *Dementia: Challenges and New Directions*. Jessica Kingsley, London, 79–90.
Weber, L. 1998. A conceptual framework for understanding race, class, gender, and sexuality. *Psychology of Women Quarterly*, **22**, 1, 13–32.
Wenger, G. C., Davies, R. and Shahtahmasebi, S., *et al*. 1996. Social isolation and loneliness in old age, review and model refinement. *Ageing and Society*, **16**, 3, 333–55.
Wertheimer, A. 1993. *Speaking Out: Citizen Advocacy and Older People*. Centre for Policy on Ageing, London.
Williams, J. 1996. Social inequalities and mental health: implications for service provision. *Journal of Community and Applied Social Psychology*, **6**, 5, Special Issue.
Williams, J. 1999. Social inequalities, mental health and mental health services. In Newnes, C., Holmes, G. and Dunn, C. (eds), *Thinking about Psychiatry and the Future of the Mental Health System*. PCCS Books, Ross-on-Wye.
Williams, J. and Lindley, P. 1996. Working with mental health service users to change mental health services. *Journal of Community and Applied Social Psychology*, **6**, 1, 1–14.
Williams, J. and Watson, G. 1996. Mental health services that empower women: the challenge to clinical psychology. *Clinical Psychology Forum*, **100**.
Williams, J. and Keating, F. 1999. The abuse of adults in psychiatric settings. In Stanley, N., Manthorpe, J. and Penhale, B. (eds), *Institutional Abuse: Perspectives across the Life Course*. Routledge, London, 130–51.
Wilson, G. 1991. Models of ageing and their relation to policy formation and service provision. *Policy and Politics*, **19**, 1, 37–47.
Yonkers, K. A., Kando, J. C., Cole, J. O. and Blumenthal, S. 1992. Gender differences in pharmacokinetics and pharmacodynamics of psychotropic medication. *American Journal of Psychiatry*, **149**, 5, 587–95.

Accepted 16 March 2000

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https://doi.org/10.1017/S0144686X01007942 Published online by Cambridge University Press