Older women's human rights and mental health

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The ageing of the world's population is a feminised phenomenon. As the world's population ages and the proportion of people aged over 65 is increasing, women are comprising a higher proportion of this older population.[1] By 2060, women aged 85 and over will constitute the largest segment of the world's population. Though this phenomenon is shared globally, it affects the lower-and-middle-income countries (LMIC) disproportionately, with 64 per cent of older people currently living in LMIC.[2]

Although women tend to live longer[3] they also spend more years of their lives with functional limitations[4, 5] and fare poorly compared to men on most indicators of well-being and mental health.[4, 5] Moreover, the onset of ageing in women in many LMICs begins in the early forties.[6] Women also fare worse than men on a range of other indicators such as personal safety, labour market participation, financial security, secure housing, and stressors accompanying unpaid care responsibilities, all associated with poorer outcomes for mental health and wellbeing in later life.

Older women therefore face inequalities and disadvantages at the intersections of age, gender, and mental health and wellbeing that compromise their capacity to age well. In recognition of challenges faced by older women, a call was made for input into the Thematic Report on the Human Rights of Older Women to inform the Expert's forthcoming report to the 48th session of the Human Rights Council. The aim of this paper is to articulate the International Psychogeriatric Association (IPA) and the World Psychiatric Association Section of Old Age Psychiatry (WPA-SOAP) response to this call. The response aims to (i) elucidate the economic, social and cultural realities and discrimination faced by older women living with mental health conditions; and (ii) identify opportunities to protect their human rights.

Economic, social and cultural realities and inequalities lived by older women experiencing mental health conditions

To understand barriers to the realization of rights by older women, it is important to define the principle of gender equality. For the United Nations "inherent to the principle of equality between men and women, or gender equality, is the concept that all human beings, regardless of sex, are free to develop their personal abilities, pursue their professional careers and make choices without the limitations set by stereotypes, rigid gender roles and prejudices." The UN Convention on the Elimination of all Forms of Discrimination against Women explicitly notes that "extensive discrimination against women continues to exist", which "violates the principles of equality of rights and respect for human dignity"[7].

Age, gender and mental health merge in the crucible of inequality and disadvantage experienced by older women. According to WHO[8], over 20% of adults aged 60 and over experience a mental or neurological disorder; and specifically, among those over 50, women have higher levels of depression and lower levels of subjective wellbeing than men. Multiple studies suggest that women score higher than men on depression, anxiety and stress, and lower on psychological indicators of well-being and coping resources.[9] In a global study of gender differences across a range of health outcomes, "depression showed the clearest gender health gap across all countries and age groups".[10] Research also suggests that this gender gap in depression increases with age.[10] Even specifically among women and men with severe mental illness, women tend to do more poorly on health-related quality of life, with age particularly associated with worse outcomes on physical components of quality of life.[11] Women also constitute two-thirds of people with dementia and Alzheimer's Disease.[12] Mental health is therefore an important factor shaping gendered contours of inequality and disadvantage in later life.

Research reveals some social explanations for gender inequalities in mental health outcomes in later life, including socio-economic factors (such as financial resources) and psycho-social factors (such as critical life events and social support).[10] Women are disproportionately exposed to forms of social disadvantage and health risk that are associated not just with social and economic outcomes,[9-11] which are more widely discussed and theorized in the literature, but also with mental health outcomes. These gendered disadvantages accumulate over the lifecourse and are amplified in later life.[13] Some key areas of disadvantage are outlined below.

Physical and mental health:

Older people experience poorer physical health outcomes than the younger population. The role of gender in shaping these health and medical outcomes is limited by the lack of emphasis in medicine on gender disaggregated data in pre-clinical and clinical research[14]. Nonetheless, evidence suggests that physical and mental health come together to produce poorer outcomes for older women.

Physical and mental health are closely interconnected in later life. Illness and disability can increase chances of mental health conditions or exacerbate existing mental health conditions[15]. At the same time, mental health conditions in later life can contribute to poorer outcomes for physical health. In general, persons with mental health conditions have a much-reduced life expectancy compared with the general population, with an estimated drop in life expectancy of 20 years for men and 15 years for women[16]. According to WHO[9], 6.6% of all disability (disability adjusted life years-DALYs) among people over 60 years is attributed to mental and neurological disorders. The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively. Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1% and around a quarter of deaths from self-harm are among people aged 60 or above. Substance abuse problems among older people are often overlooked or misdiagnosed. Mental health problems are under-identified by health-care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help. Those with dementia are frequently denied the basic rights and freedoms available to others[17]. In many countries, physical and chemical restraints are used extensively in care homes for older people and in acute-care settings, even when regulations are in place to uphold the rights of people to freedom and choice. In some countries, the absence of community-based mental health care means the only care available is in psychiatric institutions, which are associated with gross human rights violations, including inhuman and degrading treatment and

living conditions[18]. An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure access to the highest quality of care for people with dementia and their carers.

As *women* are more likely than men to be living with mental health conditions in later life, and more likely to be living with dementia (see figures earlier in the submission), they are also more likely to experience the impacts this has on physical health and wellbeing. Older women also have different experiences of health service use. Stigma and discrimination are together significant limitations to accessing good quality health care and access to the full range of health services required by older women with mental health conditions[19]. The absence of appropriate geriatric medicine and health care are grounds of discrimination that prohibit older women from enjoying their human rights[20]. Women are also over-represented in long term care institutions.[21]

Poverty and socio-economic disadvantage:

Older people are disproportionately affected by poverty, predominantly because they do not have access to adequate retirement incomes, nor do they have a regular income from employment. The lack of a secure minimum income causes many older persons and their families to fall into poverty. Older women are much more likely than older men to live in poverty in later life. This is because women on average have more interrupted workforce participation over the life course (mostly due to unpaid care responsibilities) and lower wages, so they have fewer opportunities to accumulate adequate pensions or savings.[22] Women are also much more likely to experience financial hardship associated with separation and divorce.[23] Women are more likely than men to be partially or fully reliant on mean-tested social assistance style payments for their incomes in later life, which are often set at a low rate and can be heavily stigmatized.[22] Older people, and particularly older women, are also more likely to be victims of financial abuse.

For older women with *mental health conditions*, the challenges in achieving financial security in later life are deeper still. People living with mental health conditions are likely to experience career interruptions throughout the life course associated with their mental health condition,[24] experience discrimination in employment associated with their mental health condition[25] and have lower lifetime earnings than those without mental health conditions.[26] Mental health conditions are also associated with increased likelihood of receipt of means-tested income support payments.[27] It is therefore not surprising that financial disadvantage influences health-related quality of life for older women with severe mental illness.[11]

Older women are also less likely to have access to secure housing in later life. This is a consequence of a range of factors. Women's lower lifetime earnings provide fewer opportunities to purchase their own homes.[23] Their ownership of, or access to, land may be restricted due to discriminatory inheritance laws and practices. For example, in some countries, inheritance laws deny women the right to own or inherit property when their husband dies.[28] Consequently, older women are more likely to be homeless or experiencing housing precarity in later life. In Australia, for example, older women are the fastest growing group in the homeless population.[29]

Older women living with a *mental health condition* are even more likely to be living in insecure housing in later life. There is a strong relationship between homelessness and mental health conditions.[30] The nature of that relationship is complex. Precarious housing is a contributor to poor mental health and wellbeing. At the same time, mental health conditions combined with other factors such as socio-economic disadvantage can precipitate housing insecurity or

homelessness.[31] According to the most recent General Social Survey in Australia, for example, "people who reported having a mental health condition were more than twice as likely to have experienced homelessness in their lifetime, compared with people who did not (25% compared with 10%)".[32]

Care of children, people with a disability or chronic illness or frail older relatives

Women undertake a much greater proportion of unpaid care of family members and other reproductive labour than men. Globally, women undertake approximately three-quarters of the total amount of unpaid care of work, with men undertaking a quarter.[33] Despite widespread recognition of the gender gap in the provision of care, progress in reducing the gap has been slow. Between 1998-2012, "across 25 countries with comparable data, women's unpaid care work decreased by only 10 minutes, whereas men's unpaid care work increased by only 13 minutes, with women continuing to spend disproportionately more time on unpaid care work than men". [33] In many countries, the care provided by women and its contribution to social and economic prosperity is 'invisible' in public policy, rarely publicly acknowledged of valued (outside of families).[34]

Women provide a much larger proportion of care of dependent children than men. The figures on parental care suggest that mothers on average provide more than double the hours of care per day compared with fathers.[35] As a consequence, mothers experience much greater interruptions to their employment over the life course than fathers, resulting in fewer opportunities for career progression, lower lifetime earnings, and lower retirement incomes.[22] Mothers are more likely than fathers to experience mental health conditions during the early years of a child's life.[36]

Older people are also heavily involved in the care of children. Globally, grandparents are a common source of childcare, supporting parents to participate in paid work.[37] Research on contemporary grandparenting suggests that the extent of involvement by grandparents in the care of grandchildren varies between countries, and is linked to familial and cultural norms, rates of maternal labour market participation, and the availability of affordable formal childcare options.[38] In some countries where formal childcare systems are weak, such as the Southern European countries, where both parents participate in work, the involvement of grandparents in childcare is much more intensive.[38] Research suggests that grandparents reduce their labour market participation to be able to provide care for their grandchildren, reducing their financial security in later life.[37] While research suggests that providing regular care for grandchildren can have strong benefits for grandparents' mental health and cognitive functioning[39], it also finds that when that care becomes too intensive, it can begin to have detrimental effects on mental health.[40] While the gender gap in the provision of childcare is slightly narrower among grandparents than among parents, grandmothers provide the overwhelming majority of regular care for grandchildren, and where grandfathers are involved, it is more often in play-based tasks rather than routine tasks such as bathing and feeding which are more onerous.[41] Grandmothers, therefore, are more likely to experience the benefits, and challenges, for mental health associated with grandparent childcare.

Women also provide a much greater proportion of care for family members with disabilities, chronic illnesses and ageing relatives. Research suggests that the likelihood of providing unpaid care for a relative with a disability, chronic illness, or an older relative, increases with age until the age of 74, at which time it begins to go down again.[22] This increase is also gendered, with women in every age group providing the majority of unpaid care.[22] 'Mental

health carers', a phrase sometimes used to describe unpaid carers of a family member with a mental health condition, are also much more likely to be women.

Unpaid carers of a family member with a disability, chronic illness or an older relative have much lower levels of labour market participation than non-carers, and much lower lifetime incomes and retirement incomes.[22] Providing unpaid care also has considerable impacts on the physical and mental health of carers. In national surveys, carers regularly report among the lowest levels of wellbeing of any group.[42] There is now a considerable body of work revealing considerable challenges to mental health experienced by carers.[42] According to some outcomes, mental health carers have the worst outcomes from among all groups of carers.[42-43]

Consequently, the provision of unpaid care is not only a gendered determinant of socio-economic disadvantage, but it also closely intertwined with mental health outcomes throughout the life course. These factors interact to produce much worse outcomes for women who provide unpaid care. However, in most countries, current policy settings are grossly inadequate in mitigating or ameliorating the impacts of care on women's outcomes, and in promoting a more gender-equal sharing of unpaid care.

Gender-based violence**:**

The Human Rights Special Rapporteur on violence against women, its causes and consequences, and the Independent Expert of the Human Rights Council on the enjoyment of all human rights by older persons have called for full recognition and respect of older women's rights, including specifically the prevention of all forms of violence as well as the abolition of widowhood rites and other harmful traditional practices. Global estimates published by WHO indicate that about 1 in 3 women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime[44]. However, most surveys to-date have focused only on women between 15 and 49 years of age, called reproductive age. There is an assumption that domestic violence is mainly experienced by younger women and State responses to domestic violence have conventionally focused solely on spousal violence or violence towards younger women.[45] Therefore, there is no accurate data about the numerous manifestations and also the extent of domestic violence against older women perpetrated by a wider range of family members and caregivers. Yet gender *and* age are both important axes of inequality when it comes to the prevalence of violence.

The most frequent victims of elder abuse are women, particularly those with cognitive impairment.[46] As many women age and their independence declines, they become more vulnerable to abuse, exploitation and violence. Older women in prison, older sex workers and older women with disability face especially severe neglect and abuse as they age; they also face insecurity in respect of their financial, medical and other basic needs[20]. Violence against older women requires special attention whether it is perpetrated by an intimate partner, a family member, the community or the State[7]. Some forms of violence against older women, such as sexual violence, are largely invisible in public policy and advocacy, yet clearly documented in research.[47] A range of violent practices against women are masqueraded as traditional practice. For example, witchcraft accusations are commonly used to deprive women of their land, property and/or their inheritance.[48] Factors at the community level, which allow for impunity for perpetrators, include the unwillingness to intervene prior to, or during, such attacks, and the fear of reporting and/or providing information to the police[45]. In addition to causing physical harm, violence increases women's long-term risk of other health problems such as drug and alcohol abuse and depression.[49] Furthermore, the costs of caring for women in low-and-middle-

income countries may be dealt with by abandoning them, this action constituting a type of abuse or violence by abandonment and neglect.[50]

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Discrimination

Older women are routinely treated differently and unfairly because of their age and gender. They are the subjects of intersectional discrimination, facing discrimination (or different or less favourable treatment) for being "both old and female simultaneously".[54] Discrimination against older women is often based on deep-rooted cultural and social bias. Ageism, defined as prejudice, stereotyping and discrimination towards people based on age, can be both interpersonal and a result of institutional practice. Where countries have prohibited age discrimination by law, this usually only relates to employment and not to other areas such as social care, healthcare or other services[55].

Gender discrimination is largely underpinned by gendered inequalities in the distribution of power and decision-making, stereotyping of older women, a lack of recognition of the value of paid and unpaid work carried out by women, as well as a general lack of respect for older women's human rights[55].

Gender inequality has deep and established roots that strongly influence the disproportionate negative impact on women as they age starting at a very critical formative stage in their lives. In many settings, especially in low-and-middle-income countries, paternalistic values, attitudes and preference for male offspring still prevails; women are often left behind with higher mortality rates in female offspring, condoned customs of child marriage, intimate partner violence, poor sexual and reproductive health, deprivation of early education, and attainment of social power within family and society.[56-58]

Currently in most OECD countries, older men have higher levels of formal education than older women.[59] Beyond this, women are more likely than men to experience workplace discrimination on the basis of both gender and age.[54] The impact of gender inequalities throughout a woman's life span is reflected in old age, and it often results in unfair resource allocation, maltreatment, abuse, gender-based violence and prevention of access to basic services. In many cases older women are marginalized and deprived of participation equal terms in the social, economic, cultural and political activities of their society.[20]

Older women living with mental health conditions experience additional forms of stigma and discrimination across multiple domains, including employment.[60] At the same time, experience of discrimination is itself a stressor associated with the development or exacerbation of mental health conditions such as depression,[61] especially among people experiencing intersectional forms of discrimination[59].

Recommendations

In sum, although the Universal Declaration of Human Rights guarantees rights and freedoms to women and reaffirms that men and women are equal, gender relations structure the entire life cycle, from birth to old age, influencing access to resources and opportunities and shaping life choices at every stage. Good health, economic security and adequate housing are essential requirements of ageing with dignity, but older women in both developed and developing countries face difficulties in accessing these on a basis of equality with men[20]. The impact of gender inequalities in respect of education and employment opportunities and access to health services is present at every stage of individual life. As a result, older women experience a 'double jeopardy': they are more likely than older men to experience poverty and deprivation of basic needs[20].

Deepening the disadvantage at the intersections of age and gender, people with mental health conditions face greater barriers to social and economic participation than people without mental health conditions. Moreover, older women with mental health conditions experience vulnerability and discrimination at the intersections of these socio-demographic factors – a 'triple jeopardy' – which makes the need to address them particularly important. The lifelong impact of circumstances and experience on older women's mental health means that social structures that support and enhance the lives of girls and women at all ages will benefit older women and increase the potential for their continuing contribution to society. Equality needs to start from birth - equal access to education, health and other goods and services for women. Acknowledgment of the contribution of women throughout the life course, including their reproductive and caregiving contributions can be a means to empowerment. Specific strategies for addressing these inequities important to older women include:

- giving voice to older women in policy that affect their lives;
- ensuring greater access to affordable health care. This includes providing health information and support and promoting health and service literacy to improve access to and navigation of health, aged care and other services;
- ensuring greater respect from healthcare providers. Each older person should be treated as an individual with a history. Rather than focusing on symptoms, providers could attend to enhancing whatever means there are of ensuring that older women experience social interdependence, appropriate physical activity and good nutrition, and that their lives include purpose and meaning;
- health and social programmes targeted at vulnerable or "invisible" groups such as those who live alone and rural, indigenous, LGTBQI[62] and culturally linguistically diverse populations;
- poverty-alleviation measures for older women including redressing the gendered distribution of retirement income with proactive financial acknowledgment of unpaid caregiving during women's working lives;
- access to appropriate and affordable housing options, including aged care options, for older women;
- community development programmes;
- much stronger measures are required to mitigate the impacts of unpaid care on labour market participation and economic security, such as subsidized formal care services, opportunities for flexible work, access to workplace leave, access to appropriate income support, and measures in the retirement incomes system that mitigate the impact of time spent in unpaid care;

- stronger measures encouraging the more equal sharing of unpaid care between women and men, such as public education campaigns and parental leaves with father quotas.
- better support for people with unpaid care responsibilities, including respite services, support groups and mental health support;
- better measures that protect the personal safety and freedom of movement of older women;
- adult safeguarding programmes to prevent and deal with elder abuse that are mindful of the aforementioned inequities and are focused on empowerment of women, rather than perpetuating the victimhood of women;
- Public education to counter ageist and gender stereotypes;
- Adequate recognition of the valuable social and economic contributions for older women;
- stronger legislative measures to protect older women from discrimination across multiple domains, and opportunities for redress for older women who have experienced discrimination;
- greater involvement of older women in policy making processes, so that they can influence the policies designed for or affecting them.

The contours of disadvantage and discrimination experienced by older women are also heavily shaped by mental health. Special measures are therefore also necessary to ensure the guarantee the rights of older women living with mental health conditions. WHO[8] has identified the main guidelines to respond to the mental health needs of the older population, including:

  - training for health professionals in providing care for older people.
  - preventing and managing age-associated chronic diseases including mental, neurological and substance use disorders.
  - designing sustainable policies on long-term and palliative care.
  - developing age-friendly services and settings.

The prompt recognition and treatment of mental health disorders and neurological and substance use disorders in older adults are essential. This relies on both psychosocial and pharmacological interventions (when required). Training all health providers in working with issues and disorders related to ageing is therefore important. Effective, community-level primary mental health care for older people is crucial. It is equally important to focus on the long-term care of older adults living with mental health conditions, as well as to provide caregivers with education, training and support. An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure the highest quality of services to people with mental health conditions and their caregivers.

More broadly, the mental health of older women can be improved through promoting active and healthy ageing. Mental health-specific health promotion for older adults involves creating living conditions and environments that support wellbeing and allow people to lead a healthy life. Promoting mental health depends largely on strategies to ensure that older people have the necessary resources to meet their needs, such as safe communities, economic security and adequate services:

- providing security and freedom.
- adequate housing through supportive housing policy.
- social support for older people and their caregivers.

- health and social programmes targeted at vulnerable groups such as those who live alone and rural populations or who experience a chronic or relapsing mental or physical illness.
- programmes to prevent and deal with elder abuse.
- community development programmes.

When older women experience a state of wellbeing in which they are able to use their skills and capacities, feel valued, enjoy gratifying relationships, and are enabled to continue contributing to communities and society, this not only improves their quality of life but benefits their communities. More positive action would be to introduce policies that reflect the contributions of older women to society and encourage even greater participation, as a means to promoting good mental health. To the same end, service delivery should be based on consultation with those who use and are likely to use the service to ensure that it is non-discriminatory and conducive to good mental health.

It is a win-win situation both for the empowerment of women and the betterment of society if we render the invisible more visible, acknowledging the accumulated lifetime contributions of older women to economic, social and cultural life, and most importantly - in the face of a pandemic of ageism - inter-generational solidarity and support.

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