POSITION STATEMENT PS02/26

Menopause and mental health

Implications for clinical practice, services and policy

March 2026

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Acknowledgements

This position statement was developed by the Royal College of Psychiatrists' Menopause Expert Working Group together with College patient and carer representatives.

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Particular thanks go to:

- **All the Experts by Experience** who contributed their invaluable lived experience, which informed, shaped and strengthened this statement.
- **Dr Cath Durkin** and **Dr Philippa Greenfield**, Joint Presidential Leads for Women and Mental Health, RCPsych.
- **Dr Sophie Behrman**, RCPsych, for supporting and informing this statement, along-side ongoing commitments to women's health.
- **Dr Jo O'Reilly** and **Dr Rachel Gibbons**, Chair and Vice Chair of the Faculty of Medical Psychotherapy, RCPsych, for their valuable insight and expertise related to the psychological impact of menopause transition.

Additional thanks

- **Safiya Jones**, Policy and Influencing Manager, RCPsych, for her leadership in the development of this statement.
- **Dr Clare Doleman**, Bipolar UK, for advice and insight related to bipolar and menopause.
- **Dr Ed Beveridge**, Presidential Lead for Physical Health, RCPsych, for advice and insight from the perspective of physical health.
- **Dr Bernice Knight**, RCPsych, for developing initial concepts for graphics to be used in this position statement.
- **Dr Inder Sawhney**, Chair of the Faculty of Intellectual Disability, RCPsych, for advice and insight related to intellectual disability and menopause.
- **Dr Kate Womersley**, for contributing academic insight into the research ecosystem shaping women's mental health, including menopause.
- **Ruth Adams**, Head of EDI Strategy, RCPsych, for her oversight and coordination of cross-College input and expertise
- **Dr Lade Smith**, **Dr Amrit Sachar** and **Dr Raj Mohan**, RCPsych, for their ongoing support in ensuring College activity on women's mental health is routed in an intersectional approach that promotes fairness for all.

About this document

Terminology

This document refers to 'women' throughout. Aspects of this document will be relevant not only to women but also trans men, non-binary people registered female at birth and some intersex people'[1][a] with menopause-associated symptoms.

This document also refers to 'menopause' throughout. Unless otherwise stated, when we use the term menopause this refers to the wider biological, psychological and emotional stages of perimenopause, menopause and post menopause as well as the experience of early menopause and premature ovarian insufficiency and 'iatrogenic' menopause (i.e. caused by medical or surgical intervention).

Lived experience voices

To inform the development of this position statement, the College spoke to a range of Experts by Experience – patients and carers with lived experience of menopause and mental ill health. These experts were made up of College patient and carer representatives, as well as external patient and carer contacts with specialist expertise in the field.

Quotes from some of these experts have been threaded throughout this document, such as those immediately below.

> ***"It is everyone's business to understand the interplay between menopause and mental health."***
>
> — Anonymous, Expert by Experience

> ***"With help, support and guidance, there's no need to struggle in silence. [Menopause] can be a painful and lonely time; it can also be a time to shine!"***
>
> — Wendy, Expert by Experience

a Some people may prefer the term 'people with differences in sex development (DSD)'

1: Introduction

Setting the scene: menopause and mental health

Menopause is a normal stage in women's lives. Each woman's experience of it is unique and influenced by a range of biological, psychological and social factors. Menopause can be associated with both positive and negative experiences which can profoundly shape a woman's identity, her relationship with others and her position in society, including within the workplace.

Some groups experience greater barriers than others in accessing support for menopause and so are at higher risk of facing poorer outcomes. These groups include women who have severe mental illness (SMI),[b] are minoritised ethnic, neurodivergent, and belong to LGBTQ+ groups.[(2),(3),(4)]

As a result, significant health inequities exist as multiple and intersecting forms of marginalisation can compound disadvantage, leading to disproportionately poorer outcomes. We see these groups in mental health services.

> ***"Being treated by a professional who treats me as an individual, listens and looks beyond the labels of diagnosis has been of great significance… we have been able to build trust, explore various avenues together and collaborate in meaningful shared decision-making."***
>
> — Emily Grace, Expert by Experience

Menopause can have a significant yet often overlooked impact on women's mental health and wellbeing.

Psychiatrists are well placed to respond by offering a holistic, integrated approach to support women with the psychological, psychiatric and physical symptoms that can arise during menopause. To do so effectively, clinicians must be equipped to recognise and support women going through menopause, taking a personalised biopsychosocial approach that recognises menopause in the broader context of a woman's life course.

This is not optional – it's essential to providing women with the best possible healthcare. Delivering this relies not only on individual expertise, but on a wider system approach that supports clinicians to develop skills and implement good practice. Whilst menopause is defined as a particular biological event, it also represents a time of psychological and social transition which can affect women and their wider social networks over a

b SMIs are diagnosable mental, behavioural or emotional disorders that cause serious functional impairment that substantially interferes with, or limits, one or more major life activities.

sustained period of time. Women can enter menopause at different points in their life, depending on the influence of biological events including gynaecological surgery and primary ovarian insufficiency (POI) as well as a range of psycho-social vulnerabilities. Routine exploration of women's menstrual and reproductive health and intersecting needs as well as how these may change at different points across their life is essential for psychiatrists to offer robust support and treatment for our patients.

> ***"Then it was my turn to experience the change,***
> ***I wish I'd known more, so it wasn't so strange.***
> ***My mental health took a big decline,***
> ***I could no longer pretend to be fine.***
> ***Anxiety, low mood and depression,***
> ***Sleepless nights, rage and aggression.***
> ***Hot flushes and headaches were out of control;***
> ***I was falling down this menopause hole."***
>
> — Wendy, Expert by Experience

In addition to physical symptoms, for some women, the impact of hormonal shifts during menopause can be associated with the development of new psychological symptoms, such as low mood, anxiety and cognitive changes, and new onset mental disorders, as well as the exacerbation of pre-existing mental health conditions. Mental health symptoms and psychological distress can also arise from or be complicated by wider changes in a woman's life at this time.

Indeed, more women than men are prescribed antidepressants each year with the highest levels of prescribing being for women aged 50–59, meaning many of these women will be experiencing menopause alongside the condition for which they are being treated.(5)

If we are to improve the experiences of women going through menopause, it is important to understand and address these core areas:

- lived experience
- biopsychosocial factors
- empirical evidence, including women experiencing menopause who are marginalised based on multiple and intersecting personal characteristics.
- women's relationship with children and young people
- women in the workplace
- training for the psychiatric workforce.

To address these areas, this document sets out strategic aims, explains central evidence on these areas and gaps in knowledge, outlines the College position, and concludes by putting forward key recommendations for the College, the psychiatric workforce, medical school deans and teaching leads, policymakers, public bodies and employers.

If implemented, these recommendations will enhance awareness, inform best practice and improve healthcare responses for women experiencing menopause who use mental health services.

2: Key aims

This position statement has the following aims:

1. To promote training and education for the psychiatric workforce, enabling psychiatrists to better identify, understand and support the treatment of menopause-related health issues, while also adopting a person-centred, trauma-informed, biopsychosocial approach.
2. To promote wider understanding and awareness of the relationship between menopause and mental health in order to foster a holistic appreciation of how menopause can impact on women's mental health, wider physical health and psychological wellbeing.
3. To promote equity in identification of, and access to support and appropriate treatment for, women with menopausal symptoms and pre-existing mental health needs through recognising and addressing the barriers such women face in accessing care, including barriers faced by women who are marginalised due to having multiple intersecting characteristics.
4. To advocate for comprehensive, interdisciplinary approaches to menopause support and treatment across health systems.
5. To consider how a woman's experience of menopause and mental health can impact on their relationships with children and family, to help ensure the best possible chances for emotional wellbeing and mental health support for children and young people.
6. To make the case that employers in England, Northern Ireland, Scotland and Wales must promote and implement good quality workplace menopause policy which recognises the link between menopause and mental health.
7. To demonstrate the need for national-level decision makers, including policymakers, to sufficiently consider the relationship between menopause and mental health, including within their strategy development and implementation.
8. To set out key evidence to illuminate existing knowledge and treatment gaps about menopause regarding its interplay with mental health.

3: Background

The College developed this document in response to several factors.

Policy context:

- A growing national awareness about the unmet physical and mental health needs of women going through menopause – something which has been highlighted in key policy such as the UK Government's Women's Health Strategy for England (2022),[6] commitments to develop an action plan and strategy for Women's Health in Northern Ireland as well as the Inquiry Report from The Northern Ireland Assembly All-Party Group on Mental Health: 'The Impact of Menopause on Mental Health',[7],[8],[9] the Welsh Government's Women's Health Plan for Wales (2024),[10] and the Scottish Government's Women's Health Plan (2021).[11]

Recognition of need:

- A recognition of the disparities in access to menopause care experienced by women with pre-existing mental health conditions, and that targeted interventions are required to address existing health inequalities and inequities more widely.
- A recognition within the College that more needs to be done to raise awareness of, and offer support for, the potential psychological, psychiatric and biological impacts of menopause on patients and clinical staff.

Guidance gaps:

- Limited inclusion of guidance related to the impact of menopause on mental health and the role of mental health services in national guidance.

Survey findings:

- Challenges highlighted by our members. In 2024, the College carried out a members survey focused on women and mental health. It found that 41% of psychiatrists who participated felt 'not confident at all' in responding to the 'hormonal health' (including menopause)' of women accessing their services. We expand on this finding later on, highlighting powerful quotes from survey respondents, in section 7.2: Psychiatric workforce training.

Health Services Safety Investigations Body recommendation:

- The recommendation from the Health Services Safety Investigations Body (HSSIB) for the Royal College of Psychiatrists 'to identify ways in which menopause can be considered during mental health assessments'.

The following sections of this position statement set out evidence and considerations relating to five core areas identified as important through our research on women affected by menopause and mental illness.

As discussed in the introduction, these cross-cutting areas relate to:

- lived experience
- biopsychosocial factors
- the empirical evidence-base including women experiencing menopause who are marginalised based on multiple and intersecting personal characteristics.
- women's relationships with children and young people
- women in the workplace
- training for the psychiatric workforce.

4: Lived experience

4.1 Insight from Lived Experience Experts

Experts by Experience highlighted that each woman's experience of menopause is unique. They detailed how some may find menopause empowering while others will not; and how some will have their experience affected by other personal characteristics such as their race, ethnicity, sexual orientation and disability.

The College heard multiple examples of women who were experiencing menopause alongside pre-existing mental health needs being dismissed by healthcare services, as well as examples of women experiencing new onset or significant relapse of a severe mental illness (SMI) during this time.

It was highlighted that women experiencing menopause must be empowered through straightforward access to good-quality and evidence-based information. This would support a positive experience with women feeling confident about the control and choice they can exercise over their care and treatment.

The experts were clear that psychiatrists should be supported to recognise and treat both mental health conditions and adverse side effects from menopause holistically. They emphasised that the potential mental health impact of menopause should be recognised among high-risk patient groups to ensure that all women are offered equitable access to support.

4.2 Experiences of menopause

Experts by Experience described a range of menopause-related experiences, which broadly fell into four themes:

Deterioration in mental health:

- Worsening anxiety and depression, which Expert by Experience Rachel Bannister described as "catastrophic thinking"
- Feeling trapped in what Expert by Experience Wendy described as a "menopause hole", characterised by a lack of knowledge and hope
- Stigma related to pre-existing mental health conditions
- Dealing with co-morbidities such as cancer alongside mental health decline and menopause
- Loneliness

Healthcare system:

- Knowledge gaps in the healthcare system
- Diagnostic overshadowing – i.e. the misattribution of symptoms of menopause to a comorbid mental health problem
- Delayed explanations for their symptoms
- The importance of appropriate use of medication
- The value of peer support/ networks

Work, finances and family life:

- Financial pressures
- Competing priorities of employment and family
- Taking demotions and leaving their job altogether
- Continuity of care and timely, easy access to support

Positive experiences:

- Redefining their identity
- As Expert by Experience, Wendy, highlighted, menopause can be a "time to shine".

4.3 Experiences of care

Experts by Experience also identified themes relating to good care, inadequate care and priorities for improvement as follows:

Good care:

- Effective multidisciplinary working.
- Meaningful shared decision-making.
- Timely access to specialist provision.

Inadequate care:

- Lack of public/patient awareness.
- Missed opportunities.
- Challenges accessing hormone replacement therapy (HRT).
- Health services lacking training and understanding of menopause and related mental health issues.
- Long waits.
- Lack of understanding, support and follow up for women who are further marginalised including women with severe mental illness (SMI) and with neurodivergence.
- Lack of contact with the same named healthcare professional.

Changes needed:

- Women being empowered to make informed choices.
- Improved understanding across the board that women experiencing menopause are often in a care-giving role and supporting others, for example having a young family and elderly relatives.
- Employer awareness of the impact of menopause.
- Learning from lived experience. Resident doctors should hear from women with lived experience of menopause and mental health conditions – for instance, via written testimonies, recordings or workshops. Facilitated dialogue and reflection between resident doctors and women with lived experience should be encouraged. Resident doctors should be taught the difference between a collaborative and a 'done to' approach.
- Improvements in prescribing guidance.
- Shared care and responsibility recognised as being important across the board.

4.4 Psychological factors

Written by Dr Jo O'Reilly and Dr Rachel Gibbons, Chair and Vice Chair of the Faculty of Medical Psychotherapy at The Royal College of Psychiatrists

The experience of menopause is profoundly shaped by psychological, cultural and societal factors. The ending of a woman's reproductive life and cessation of the menstrual cycle is a fundamental shift in her identity, bodily experiences and place in the world. Its meaning will differ for every woman, influenced by her personal history, feelings and thoughts about herself, her relationships and her life situation. Societal and cultural attitudes towards aging and post-menopausal women contribute to how this transition is navigated.

Emotional responses to menopause are often complex and ambivalent. Holistic, patient-centred care should involve an understanding of menopause as a psychological and social transition, not just a biological one. Psychiatrists and mental health professionals should be attuned to the importance of this fundamental change in a woman's life, and its meaning to her on an individual basis.

An understanding of the mourning process and defences that may arise against grief and loss allow for a comprehensive psychologically informed approach to case formulation and management planning. Deep sorrow, heightened anxiety, panic and social withdrawal may represent a normal grief response to a natural process and it is important that understandable psychological distress is not conflated with mental disorder. Supporting women in processing the psychological meaning of menopause involves engaging with issues of loss, identity and aging, in an individualised and culturally-sensitive way.

A well-supported menopause process allows for psychological growth and for different aspects of a woman's identity to emerge.

Cultural and societal expectations play a powerful role in shaping this. Many women may report feelings of invisibility and loss of confidence post-menopause whilst others find empowerment in this stage of life. In some cultures, menopause is stigmatised and shrouded in taboo; in others including many indigenous traditions, post-menopausal women are revered as sources of wisdom, power, and leadership.

For psychiatrists to be able to support patients' psychological and emotional responses to key life transitions and integrate this understanding into clinical care, psychological skill and an ability to factor in social and cultural contexts are required. Psychiatrists can combine this understanding with knowledge of psychiatric symptoms and hormonal changes, working collaboratively with the patient to support holistic understanding, formulation, diagnosis and management.

5: Epidemiological evidence and clinical considerations

To understand and improve women's experience of menopause alongside their mental health it is imperative to understand empirical evidence related to women's mental health and menopause.

5.1 At-risk groups

> *"I'm neurodivergent, which was new to me;*
> *During menopause, it was plain to see.*
> *I couldn't mask any longer;*
> *I couldn't be any stronger."*
>
> — Wendy, Expert by Experience

Some women are at increased risk of experiencing more severe and functionally impairing menopause-related symptoms and/or challenges accessing appropriate menopause care.

Factors include co-morbid mental illness,[12] race, ethnicity,[4] neurodivergence, disability including intellectual disability,[13] poverty, being working class,[14] having a history of trauma[15] and being from an LGBTQ+ group.[16] We must consider this intersection for women accessing mental health services.

Women who experience the greatest severity of perimenopausal and menopausal symptoms are often those who are least likely to have their symptoms correctly identified and treated across healthcare settings, including mental healthcare services.

5.2 Mental illness

> *"On reflection, with the knowledge that I have now, this last episode of [depression, which lasted] approximately 15 months, could well have been triggered by hormonal changes in the perimenopause phase, but this was never discussed or, to my knowledge, considered as a factor in this episode."*
>
> — Anonymous, Expert by Experience

> *"I used the NHS mental health support line on a number of occasions when things became difficult as a result of my hormones fluctuating and/or becoming out of range resulting in a plethora of menopause symptoms."*
>
> — Emily Grace, Expert by Experience

The hormonal fluctuations and overall decline of oestrogen, progesterone and testosterone that occur in perimenopause are commonly associated with psychological symptoms in the general population[17] including low mood, anxiety, poor sleep and 'brain fog'. However, for some, psychological symptoms intensify to exacerbate underlying mental disorders[18] or may be linked to first episodes of new mental illness.

Compared with the period before menopause, a large UK study observed at perimenopause a 112% increase in incidence of bipolar disorder and 30% increase of major depressive disorder.[19] In addition, perimenopause may be a time of increased risk for women who experienced postpartum bipolar episodes.[20]

The large UK study[21] highlights that compared with the reference reproductive period, incidence rates of psychiatric disorders significantly increased during the perimenopause (incidence rate ratio (RR) of 1.52, 95% confidence interval (CI) 1.39–1.67) and decreased back down to that observed in the premenopausal period in the postmenopause (RR of 1.09 (95% CI 0.98–1.21)). The effect was primarily driven by increased incidence rates of major depressive disorder with an incidence RR of 1.30 (95% CI 1.16–1.45). However, the largest effect size at perimenopause was observed for mania (a key component of type one bipolar) (RR of 2.12 (95% CI 1.30–3.52)).

There is evidence of a reproductive pattern to mental ill health for many women, with menstrual and peripartum disorders being associated with subsequent perimenopausal relapse, but the association is poorly understood.[22],[23] Women with a history of trauma are at risk of menstrual disorders and a worsening of psychological symptoms in perimenopause, but the relationship is complex and also poorly understood.[24]

Menopausal depression is qualitatively different to depressive episodes in other demographics[25] and this needs to be taken into account when considering risk assessment and treatment plans. The relationship between mental health and menopause is complex. For example hormonal and physical changes associated with menopause may lead to relapse or new onset eating disorders.[26]

The neurosteroid effects of estrogens, progestogens and androgens are only just starting to be understood.[27] Thus, the interplay between psychotropic efficacy and the hormonal shifts of menopause is even less well-characterised, though it is possible that medication regimes that work for a woman pre-menopause may not be so effective peri- and post-menopausally.[28]

5.3 Treatment options

"HRT as an evidenced-based treatment was not drawn to my attention for discussion and a potential option for treatment of symptoms."

— Anonymous, Expert by Experience

For women with long-term mental illness who are entering menopause, hormone replacement therapy (HRT) can be a key treatment both in addressing their physical health risks and their mental health symptoms. However, barriers to accessing clear information on menopause and HRT further compound health inequalities faced by women.

NICE recommends the use of HRT as well as cognitive behavioural therapy (CBT) rather than antidepressants for perimenopause-associated low mood and anxiety symptoms,[29] but there are currently no specific guidelines for supporting the treatment of those with perimenopausal-associated mental disorders.

There is evidence that women with depressive episodes in perimenopause do not respond as well to selective serotonin reuptake inhibitors as other demographics,[30] with significant rates of discontinuation linked to adverse effects.[31] There is some evidence for the use of estradiol in combination with antidepressants or (to a lesser extent) as a standalone agent for managing perimenopausal depression.[32] Little is known regarding the complex interplay between endogenous hormones and psychotropics and more research in this area is needed.

Menopause is associated with an increased risk of cardiovascular disease and osteoporosis, both thought largely to be linked to the reduction in oestrogen. Women with severe mental illness (SMI) are already at increased risk of cardiovascular disease[33] and may also be chronically hypoestrogenic through potentially years of oligomenorrhoea associated with hyperprolactinemia from antipsychotics.[34]

Many perimenopausal women take HRT to alleviate their perimenopausal symptoms and/or to respond to osteoporotic risk; this is also thought to be linked to reduction in cardiovascular risk in most women if appropriate HRT is initiated before the age of 60 or within 10 years of menopause[35] but reducing cardiovascular risk in itself is not an indication to initiate HRT.

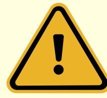
5.4 The need for accessible information

> ***"I delayed seeking the treatment I needed for several difficult months in this last episode [of depression] due to denial and being confused as there was 'no baby' connected to it, as had happened previously, and I was not aware of the potential impact of the menopause on mental health."***
>
> — Anonymous, Expert by Experience

There is a lack of awareness amongst women with a mental health condition about the potential impact of menopause. For example, in November 2022, Bipolar UK reported on their survey of women with bipolar.[36] The survey asked respondents about their experiences around menopause. Only 35% of respondents knew that this life stage could be a time of higher bipolar risk for them (and many of them said they only knew this through watching Bipolar UK's educational webinars).

Of those in the average menopausal age bracket:

- Over half – 55% – said perimenopausal or menopausal symptoms had impacted their bipolar.
- 28% of those said the impact was significant.
- A third (32%) said that, although they were experiencing symptoms linked to perimenopause, they had not been to their doctor about them.
- Only 31% of women had been offered HRT. Of those who were taking HRT, 64% said it had helped them, with 21% saying it was 'extremely effective'.



Content warning:
The following paragraph discusses themes of suicide. When life is difficult, Samaritans are here – day or night, 365 days a year. You can call them for free on 116 123, email them at jo@samaritans.org, or visit www.samaritans.org to find your nearest branch.

5.5 Suicide risk

> *"When I was 48, I developed symptoms of hypomania – significantly higher levels of energy, feeling 'wired', not needing sleep, and starting to take risks. My GP prescribed me a low dose of risperidone and by July of that year I was feeling a lot better.*
>
> *Only one month later, in August 2016, I experienced a very rapid and unexpected decline in my mental health and strong suicidal ideation."*
>
> — Jan, Expert by Experience

Studies identify an increased suicide risk for women in England and Wales between 45–54 years (peaking at 45–49 in 2021, and 50–54 in 2023). This maps on to the demographic most likely to be in perimenopause.[37],[38] This is an association with chronological age rather than correlated directly to reproductive stage.

There is also an increased prevalence in suicidal thoughts in women of this age demographic, even when adjusting for an increased rate of mental illness.[39] It is important to note that these epidemiological studies are age associations; one cannot infer any causal link with hormonal status and there are well evidenced multifactorial complexities of this group beyond the biological.[40] These include the challenges of mid-life including loss of a spouse, retirement or changing work patterns, physical ill-health, grown-up children leaving home, care responsibilities for grandchildren and changes to social and family networks. Factors associated with an increased risk of suicide in women in the typical perimenopausal age range include pre-existing mental health conditions, physical symptoms, hormonal changes and limited social support.[37]

Based on the higher risk of suicide in women of menopausal age, a thorough psychosocial assessment of self-harm and suicide, with elucidation of potential risk factors, must form an essential part of any psychiatric assessment. We must also see further research to better understand the relationship between suicidal ideation and reproductive stage. This is imperative and will support the saving of lives.

5.6 Inequities and intersectionality

"There are lots of things to keep in mind
To ensure no women is left behind.
Culture, background and life experience,
Family, home and workplace interference,
Racism, poverty & stigma too,
A holistic view is something you must do."

— Wendy, Expert by Experience

The College recognises the fundamental importance of addressing diverse experiences of menopause, including the experiences of those who face discrimination based on multiple and intersecting personal characteristics.

- Significant health disparities persist among people in contact with mental health services, with women experiencing particular disadvantage. Structural disadvantage and diagnostic overshadowing[41],[42] are recognised as contributing factors, whilst misinformation and cultural stigma surrounding women's health conditions remain deeply embedded, limiting the impact of awareness campaigns.[43]

- Research has shown that disparities are faced in access to HRT for women with severe mental illness (SMI)[44] and that minoritised ethnic groups are over-represented amongst women accessing secondary mental health services,[45] but beyond this there has been limited research into menopause symptoms and experiences of care for women with pre-existing mental health conditions.

- Being from a minoritised ethnic group, having a co-morbid mental health condition, having a disability, experiencing trauma and/or poverty and being working class are all associated with more severe symptoms of menopause.

- Minoritised ethnic women can face additional challenges with menopause when racial discrimination or bias are also present. Clinical lack of awareness of the differences in the type, severity and time of onset of menopausal symptoms across ethnic groups can contribute to symptoms being overlooked or misattributed. These factors could make it difficult for women to access appropriate support or have their symptoms taken seriously.

- Fear of intersectional discrimination has prevented some Black women from talking about menopause, while in some South Asian communities, there are cultural conventions that may contribute to secrecy and shame, inhibiting help-seeking and open conversations.[4]

- LGBTQ+ groups, young women and minoritised ethnic women face specific challenges related to stigma, prejudice and exclusion. Stigma, prejudice and exclusion specifically related to menopause further compound these difficulties. For example, evidence states that: "Trans men and non-binary people are left out of menopause conversation due to both a pervasive unwillingness to:

    a. see beyond the experiences of cisgender women,
    b. to adapt social systems to trans and non-binary peoples' needs." This causes harm and exclusion.[4,46]

- The lack of research about the link between menopause and mental health includes a lack of research on LGBTQ+ groups' experiences of menopause including "trans men [and] non-binary people's experiences"[(4),(14),(47)] as well as a lack of research on young women, and the stigma faced by them due to poor understanding about premature menopause, and its impact on fertility.[(4)]

- It is imperative to understand that there is an overlap between these different areas, with there being women who face challenges due to holding multiple, intersecting characteristics and life experiences.

Figure 1: Intersectional Factors Influencing Menopause and Mental Health

5.7 Children and young people

Women's experience of menopause and mental health is affected by, and impacts on, their familial relationships, including with children and young people.

Children and young people's emotional wellbeing is directly impacted by those caring for them.

Many adults seen in adult mental health services have children or caring responsibilities for children and young people. As highlighted throughout this document, menopause can have a significant impact on women's mental health and emotional wellbeing including the development of new onset psychological and/or psychiatric systems or escalation of underlying mental health difficulties.

This can impact on women's ability to support their children's needs, particularly for women who have children in Child and Adolescent Mental Health Services (CAMHS) as these children are likely to have heightened needs.

As we highlight in the 'Psychiatric workforce training' section, training for CAMHS psychiatrists is particularly important to identify mothers in need of support during menopause.

6: Critical research gaps

> *"Clinicians would also benefit from further research into how surgical menopause differs from a natural menopause especially with regards to the notion that often higher levels of estradiol are required for symptom alleviation in younger patients."*
>
> — Emily Grace, Expert by Experience

With ongoing research, we are beginning to understand possible connections between mental illness trajectories and menopause. However, there remains a need for more research and data, particularly related to the experiences of women who experience 'early', surgical and iatrogenic menopause as well as who are from marginalised groups.

Building on previous sections, the following areas provide a starting point for further research and data analysis:

- For women with severe mental illness (SMI), the hormonal fluctuations associated with perimenopause and menopause can impact on the effectiveness of psychotropic medication prescribed for women with mental illness, with these patients having reduced response rates[30] and needing higher doses.[28]

- Menopause confers higher risk rates of developing osteoporosis[48] and cardiovascular disease.[49] Women with SMI already face worse health outcomes in these and other areas secondary to a variety of common risk factors including side effects of medication, poverty and diagnostic overshadowing.[50] Eating disorders may amplify physical health risks of menopause due to the compounding risks of poor bone health and early menopause. The combined risk of menopause on women with SMI exacerbates health inequality. As indicated above, women with SMI are less likely to be prescribed HRT than the general population.[44]

- LGBTQ+ groups experience challenges accessing appropriate menopause care yet there remains a dearth of research on LGBTQ+ experiences of menopause, with these groups excluded from conversation about menopause. This is within the wider context of systemic LGBTQ+ health and healthcare inequalities, with LGBTQ+ groups experiencing poorer health, and poorer health outcomes, than non-LGBTQ+ groups. Similarly, good practice guidance tends to exclude LGBTQ+ issues.[4],[16],[47]

- Minoritised ethnic women appear more likely to experience delays in diagnosis of menopause.[14] However, more research into these experiences is required including on how menopause impacts women from different ethnic minority groups and how cultural differences might influence the extent to which women report their symptoms.[14]

- The experiences of neurodivergent women and those with an intellectual disability going through perimenopause are poorly understood, but there is some evidence that the onset of menopause can present new difficulties, and access to appropriate

healthcare is challenging.[13] Women with intellectual disabilities, particularly those with limited communication abilities, can face additional barriers to identification of menopause. For example, physical discomfort may be expressed through changes in behaviour, such as withdrawal, restlessness, aggression, or disrupted routines. These changes can easily be misinterpreted as behavioural problems or mental health deterioration rather than indicators of underlying physical causes.

- Women with intellectual disability may reach menopause earlier than others. This is more pronounced in women with intellectual disability associated with Down syndrome who will often experience menopause in their mid-40's.[51] Equally, wrongly attributing menopause symptoms to mental illness in women with intellectual disability can result in inappropriate use of psychotropic medicines. Indeed, there is evidence of overprescribing of psychotropic medicines in people with learning disabilities.[52]

- There are also women who will experience menopause alongside experiencing a substance use disorder. These women will have complex social and medical needs, often complicated by psychological distress or mental illness. RCPsych has recently published College Report CR243 on the importance of supporting patients experiencing co-occurring substance misuse and mental illness: Co-occurring Substance Use and Mental Health Disorders (CoSUM).

- Women's hormones have largely been neglected as a focus of psychiatric interest, which is evident in the paucity of research. Given the complexity of intersecting biological, psychological and social factors, the topic calls for a proactive, nuanced and creative approach, both clinically and academically.

7: Workplace and workforce implications

7.1 Workplace impact and employer responsibility

> *"I had to return to work well before I was ready because I would have been in financial dire straits if I had not done so."*
>
> — Jan, Expert by Experience

It is key that employers understand the link between menopause and the development of mental, psychological and physical health symptoms which can impact on women's abilities to function well in the workplace. This must include a recognition of the link between rates of mental illness and menopause which remains frequently overlooked and misunderstood in guidance and policy.

During discussions with women with lived experience of menopause and mental health conditions it became apparent that addressing menopause in the workplace is fundamental to improving women's experience of menopause, allowing women to thrive in their careers and wider life.

Additional research, much of which is reported on by the House of Commons Women's and Equalities Committee, demonstrates the economic benefit in addressing the barriers associated with menopause that women face and can impact their ability to work:

- The number of women who will experience menopause whilst in employment is increasing.

- Pre-pandemic research showed that women over the age of 50 were the fastest growing group in the workforce. There are currently around 4.5 million women aged 50–64 in employment in the UK.[53] Women are also staying in work for longer. In 1986, the average age of labour market exit for women across the UK was 60.3 years; it increased to 64.5 years in 2024, the highest level on record.[53]

- Women also make up a substantial proportion of the psychiatric workforce[54] and the majority of the wider NHS workforce.[55]

- Evidence to the committee inquiry pointed out that women in this age group are highly skilled and experienced, typically at the peak of their careers, and are role models for younger workers. The committee reported how many of these women feel forced to leave work because of menopausal symptoms.

- Indeed, a 2023 survey conducted by the Chartered Institute for Personnel and Development (CIPD) found that two-thirds (67%) of women (aged 40–60 in employment) with experience of menopausal symptoms reported they had a mostly negative effect on them at work. In the same survey, people with menopausal symptoms reported experiencing a wide range of physical and psychological symptoms. The most common symptoms are psychological, such as mood disturbances, anxiety, depression, memory loss, panic attacks, loss of confidence and reduced concentration. These are reported by two-thirds of respondents (67%).[56]

- As reported by BUPA to the House of Commons Women's and Equalities Committee, almost 900,000 women in the UK had left their jobs because of menopausal symptoms.[4]

- As well as the costs to women themselves (related to symptoms, a lack of workplace support, reduced hours/loss of income and lack of career progression) there are many other costs of failing to support menopausal employees. These include the loss of talent, financial costs to the individual employer, and costs to the wider economy. Oxford Economics suggested that if a woman earning £25,000 a year leaves her job due to problematic menopause symptoms, it will cost her employer over £30,500 to replace her. A survey of 1,000 women by Health and Her estimated that menopause costs the UK economy 14 million working days per year, in terms of time spent alleviating menopause symptoms. Over half the women surveyed worked extra to 'compensate' for the time lost.[4]

- One reason the UK economy is underperforming is a lack of attention to the impact of women's and reproductive health on participation in the workforce. Absenteeism, decreased productivity or dropping out of work altogether are commonplace for women facing health or reproductive challenges.[57]

- In contrast, there are significant benefits to employers becoming more inclusive, supportive and menopause friendly. These relate to reputational benefit, improved recruitment and retention, and potentially saving organisations money. Of fundamental importance is that improvements in the workplace would improve the experience of talented women who want to work, allowing them to thrive.[4]

- It should be noted that most of the research that focuses on the workplace is about professional or managerial white, middle-class, able-bodied women.[4]

7.2 Psychiatric workforce training

Despite the significant clinical impact of menopause on mental health, gaps remain in services, education and professional confidence.

> *"Shockingly, a lack of training and consequently understanding of menopause and related mental health issues appears to be extremely limited within health services"*
>
> — Rachel Bannister, Expert by Experience

> *"Access to post surgical menopause care needs to be timely and more education and training is required to help clinicians understand the impact on an individual's physical and mental health as a result of the drastic drop in hormones following surgical removal of the ovaries."*
>
> — Anonymous, Expert by Experience

> *"I have never received any training on the impact of menopause/ perimenopause on mental health"*
>
> — Psychiatrist

> *"This [presenting to primary care with menopausal symptoms] should have been a trigger and opportunity for the GP to ask about my mental health (having known my previous history) and to inform me about how the hormonal changes in my body and brain could affect my mental health during the years of menopausal transition."*
>
> — Anonymous, Expert by Experience

> *"We need training to change culture so hormonal health is understood and considered in, for example, first episode psychosis in perimenopausal women."*
>
> — Psychiatrist

> *"Perimenopause/menopause are by far the biggest need here from what I see in the population I deal with. I am amazed at the number of women around menopause presenting with first episode of mental health difficulties and often they only come to mental health services after years of failed treatment in primary care... and nobody has thought about their hormonal state.'*
>
> — Psychiatrist

This position statement has set out how psychiatrists have an important role in understanding and responding to the interface of physical and mental health needs; menopause is a central area where responses to physical and mental health require careful co-ordination and specialist psychiatric knowledge.

Psychiatrists, therefore, require an understanding of hormonal changes and the wider impact of menopause, so that they are able to provide holistic care and support for women. This could include support through offering a choice of treatment options and lifestyle changes that can alleviate both psychological and physical symptoms.

Gaps in knowledge about menopause among healthcare professionals contribute to delays in recognition and timely access to appropriate care for menopause related symptom.[58] In fact, 41% of the UK's medical schools that responded to a 2021 survey did not include mandatory menopause education as part of their curriculum. Instead, many expected that healthcare professionals would receive this education during their early years of medical practice. However, this may not always be the case.

This means that accessing appropriate treatment and care for menopause is often not straightforward.

These findings were mirrored in our own College survey of women's mental health, conducted among psychiatrists. It found that over a third of respondents (41%) did not feel at all confident in helping women and girls with hormonal health (including menopause) and that many psychiatrists wanted more training on the effects of major life transitions and hormonal health on mental health, including effects related to menopause.

Stigma continues to prevent clinicians and patients from having open conversations about their experience of menopause. Many women report feeling misunderstood or dismissed by healthcare professionals when discussing menopausal symptoms with them.

Improved knowledge of this area, therefore, will allow psychiatrists to build better therapeutic relationships and offer more comprehensive support, improving patient outcomes. This therapeutic alliance forms the foundation of how we as psychiatrists should be working with all of our patients.

Embedding trauma-informed principles of care across the wider health landscape will support addressing poorer menstrual and reproductive health outcomes for currently underserved groups such as those with SMI, a history of substance misuse and homelessness, all of whom are more likely to have had traumatic experiences.[59] Application of the College Report CR204 Core values for psychiatrists will support this practice.

Given the frequent co-morbidity of broader health and social care needs amongst those accessing mental health services it is also essential that there is joint working between psychiatrists and other parts of the system including primary care. Similarly, whilst this position statement focuses primarily on psychiatrists, we emphasise that the wider health and care workforce also have a responsibility to support the diagnosis, treatment and signposting of their patients who present to them with menopause and mental health related symptoms. This is particularly relevant to general practitioners given many women's first point of contact will be with their GP.

Child and adolescent psychiatrists, in particular, should be aware that identifying and supporting a mother going through menopause to receive good care may be an effective part of a treatment plan for a young person.

Some key clinical actions to support women experiencing menopause are outlined below.

Key clinical actions

Include **routine enquiry** about menstrual and reproductive history in all mental health assessments.

In women aged 35–55, consider **perimenopause or menopause** in all new presentations of psychiatric disorder, cognitive change or behavioural concern.

Adopt a trauma-informed and holistic approach, recognising the interaction between physical health, mental health and social context.

Empower and support women to **discuss menopause with their GP**, including keeping a record of symptoms where appropriate.

Advocate for **equitable access to the full range of menopause treatments**, including HRT, for women with mental illness.

Work collaboratively with primary care and other services to ensure coordinated assessment and treatment.

Where appropriate, consider the wider family context, recognising that supporting a mother experiencing menopause may form part of a young person's treatment plan

Advise women and carers to **seek further medical review**, from their GP or other healthcare professional, if symptoms are not adequately assessed or addressed.

8: The College position

Menopause can have a significant, and too often, ignored impact on mental health. In addition, diagnostic overshadowing and other barriers exist for women with pre-existing mental health conditions accessing appropriate advice and support. Menopause can be a liberating and positive experience, yet this is not the case for enough women.

Whilst policy and practice does address menopause, much more is required in terms of development and implementation to ensure consistency across the UK; to address the interplay between menopause and mental health; to ensure more women have consistently good experiences of menopause; to ensure psychiatrists feel equipped to provide good care and to ensure targeted action for at-risk and marginalised groups, including those who are marginalised based on multiple, intersecting grounds.

Delivering meaningful and sustainable change in relation to menopause and mental health requires:

- **Cultural and societal recognition**
  There needs to be widespread recognition that menopause is a significant transition in a woman's life course that can impact on a woman's mental health.

- **A responsive and equitable healthcare system**
  The healthcare system needs to be able to meet the mental, psychological and physical health needs of women experiencing menopause and mental illness, including those with severe mental illness (SMI) and other groups who are marginalised on multiple, intersecting grounds.

- **Person-centred, integrated healthcare responses**
  Responses cannot be 'one-size-fits-all'. They must be person-centred, grounded in an understanding of the individual and their wider networks, and delivered in an integrated and holistic way through interdisciplinary collaboration.

- **Co-produced policy development**
  Menopause and mental health policy needs to be developed and implemented in collaboration with people who have lived experience.

- **Normalisation of menstrual and reproductive health conversations**
  Discussions about health and wellbeing should routinely consider menstrual health, addressing both positive and negative impacts of menstrual health on women across their life.

- **Trauma-informed principles**
  All initiatives need to embed these principles throughout.

9: Recommendations

9.1 For the College

Overarching recommendation:

The College should ensure there is improved awareness of the associations between mental health and menopause in women's lives.

Sub-recommendations:

9.1.1 The College should develop its understanding of diverse experiences of menopause and mental health and will take action to learn from and address these experiences. A particular focus will be on reaching women who are marginalised based on multiple, intersecting characteristics. This will include the College setting up a working group to focus on intersectional experiences.

9.1.2 The College should use various platforms and channels to raise awareness of the links between menopause and mental health, including its internal staff menopause policy, events such as webinars, external policy and communications (for example, press activity), and education and training outputs, e.g. Professional Standards.

9.1.3 The College should publicise training on menopause and mental health to all psychiatrists from all sub-specialties. This will include regularly updating and publicising College 'Continuing Professional Development' (CPD) modules. Training will aim to increase awareness of and enhance competency in identifying menopausal symptoms, discussing menopause with patients and providing timely holistic care for menopause. The College will ensure those with lived experience of mental health needs during menopause will be involved in developing and delivering training and assessment.

9.1.4 The College should continue to support a multidisciplinary approach to menopause and mental health across the healthcare system. This includes the College commitment to develop a joint course with the Royal College of Obstetrics and Gynaecologists (RCOG) focusing on a life-course approach to women's sexual and reproductive health.

9.1.5 The College should encourage the promotion and further development of internal support for staff and members whose mental health may have been adversely affected whilst experiencing menopause.

9.2 For the psychiatric workforce

The College recommends the following actions for the psychiatric workforce. As indicated by the other recommendations in this section, the psychiatric workforce requires adequate policy and resources to be able to take forward these actions.

Overarching-recommendation:

Women accessing mental health services should receive a comprehensive biopsychosocial assessment that investigates their mental, menstrual and reproductive health history across the life course – from menarche to menopause and beyond. Psychiatrists should take a needs-adapted approach that is developmentally appropriate and includes an awareness of the impact of early or surgical/iatrogenic menopause and the needs of women who experience this.

Sub-recommendations:

9.2.1 Psychiatrists should understand the core features of menopause, including early menopause, perimenopause, surgical/iatrogenic menopause and post menopause in mental health patients and their carers.

9.2.2 Psychiatrists working in children and young people's mental health services should have an understanding of how menopause may impact parenting and caring.

9.2.3 Psychiatrists should respond to their patients experiencing menopause holistically and, as well as addressing mental health needs, should at a minimum be able to have an understanding of treatment options for menopause and be able to provide relevant general health information about menopause, for example from the British Menopause Society.

9.2.4 Psychiatrists should recognise that menopause can be associated with the development of new onset psychiatric symptoms (including suicidality) and/or exacerbation of pre-existing mental health symptoms or conditions, including in women with experience of severe mental illness (SMI). They should be alert to how these symptoms may present differently for different women including women with intellectual disability.

9.2.5 Psychiatrists should be aware that marginalised patient groups are less likely than other groups to be engaged in other parts of the health system and have their menstrual and reproductive health needs appropriately met. Such groups include, but are not limited to, women who are living with severe mental illness (SMI); women who are minoritised ethnic; women who are homeless, seeking asylum and/or refugees; neurodivergent women; women living with an intellectual disability and LGBTQ+ groups. To support addressing these inequities, psychiatrists should recognise and act on their important role as patient advocates.

9.2.6 Psychiatrists should be confident to explore the holistic impact of menopause on a patient's mental health and wider life (including identity, relationships, work, caring responsibilities) and how this can impact on a patient's health and wellbeing.

9.2.7 Psychiatrists should recognise their important role as part of a coordinated multidisciplinary response to patients experiencing menopause and mental ill health. This includes formulating appropriate care and safety planning that considers the complex interplay between biological, psychological, social and physical factors affecting the patient.

This response should be based on:

- an understanding of how menopause and mental ill health can impact on the patient and their wider network, including their children and others they may care for.
- an understanding of the importance of regular continuity of care and communicating clearly to patients and other services, including primary care services.
- an understanding of the psychological needs of patients including support to access psychological therapies.
- knowledge of the physical risks associated with menopause, including those related to bone and heart health.
- knowledge of the physical effects of menopause, including bone, cardiovascular and brain health, to be incorporated within wider holistic physical health assessment.
- knowledge of the higher risk of suicide for women at menopausal age, and acknowledgement that contributing factors are often multifactorial. A comprehensive biopsychosocial risk assessment should be an essential part of any psychiatric assessment.

9.2.8 Psychiatrists working in both community and inpatient settings should follow best practice guidance to support women at risk of suicide. They should adopt a holistic, person-centred approach based on understanding each person's situation and managing their safety. Best practice guidance includes NHSE's guidance, 'Staying safe from suicide: Best practice guidance for safety assessment, formulation and management' that the College is proud to have been involved in developing with NHS England.

Key principles of this guidance include the following:

- Risk prediction is ineffective: Mental health practitioners, including psychiatrists, should move away from risk rating scales and risk stratification.
- Biopsychosocial safety assessment, formulation and management: Mental health practitioners, including psychiatrists, should follow the '5Ps' set out in the guidance.
- Safety assessment and formulation: Mental health practitioners, including psychiatrists, should reach a shared understanding with the patient about safety and the changeable factors that may affect this.

- Dynamic understanding: Mental health practitioners, including psychiatrists, should regularly assess and adapt formulations and safety plans based on the individual's changing needs and circumstances.
- Trusted others: Mental health practitioners, including psychiatrists, should encourage the involvement of 'trusted others', e.g. family, friends and carers, whom the patient identifies as sources of additional support.
- Relational Safety: Mental health practitioners, including psychiatrists, should build and maintain trusting, collaborative therapeutic relationships – these are the strongest predictors of good clinical outcomes.

9.3 For medical school deans and teaching leads

Overarching-recommendation:

Medical school deans and psychiatry undergraduate teaching leads should ensure all medical students gain a full understanding of menopause including the impact it can have on a woman's life, risk factors for mental health decline, treatment options and associated health inequities.

Sub-recommendations:

9.3.1 Medical school deans and teaching leads should ensure the relationship between mental health and menopause is included in medical school training.

9.3.2 Medical school deans and teaching leads should ensure medical schools consider how the subject areas of menopause and mental health relate to other subject areas of the curricula and within the Medical Licensing Agreement (MLA).[c]

9.3.3 Medical schools deans and teaching leads should ensure medical students hear from women with lived experience of menopause and mental health conditions – for instance via written testimonies, recordings and workshops.

We encourage postgraduate deans and medical directorates to report on progress in these areas.

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c The Medical Licensing Agreement (MLA) is the standard exam all medical students have to sit: Medical Licensing Assessment - GMC

9.4 For policymakers in England, Northern Ireland, Scotland and Wales

Overarching-recommendation:

To enable effective change and the implementation of recommendations throughout this position statement, policymakers in England, Northern Ireland, Scotland and Wales should recognise and fulfil their role in securing progress for women experiencing menopause and mental ill health. This will require implementation and further development of national strategy on women's health.

Sub-recommendations:

9.4.1 Policymakers in England, Northern Ireland, Scotland and Wales should invest in initiatives, including effective menopause policy and action plans, to retain and grow the psychiatric and wider health and care workforce so that staff have capacity to provide care to the best of their ability.

9.4.2 Policymakers in England, Northern Ireland, Scotland and Wales should require all employers, including the NHS and HSC to implement menopause policies and action plans that comprehensively address the relationship between menopause and mental health in line with recommendation 9.6. This is core for retaining staff who are likely to have accumulated years of knowledge and skill. Governments should work with experts, including RCPsych, to define what good policy in this area should include. Within this context, we welcome the Government's Employment Rights Act (2025) requiring large UK employers to create and publish Equality Action Plans which include detail on steps for supporting employees through menopause. We are ready to work with Government and other stakeholders on further development of this policy.

9.4.3 Policymakers in England, Northern Ireland, Scotland and Wales should ensure women's health strategies in each nation are published, funded and implemented with specific reference to improving the experience of women experiencing menopause and mental health related conditions.

Within this context:

- We welcome commitments to develop an action plan and strategy for women's health in Northern Ireland. This commitment must be implemented urgently and address the relationship between menopause and mental health.
- We are pleased that national strategies for women's health now exist in Wales and Scotland. These strategies must be implemented in full, with implementation addressing the relationship between menopause and mental health.
- Whilst the 2022 Women's Health Strategy in England represents some progress, we welcome commitments from the Department of Health and

Social Care (DHSC) to refresh this strategy and to ensure NHS health checks in England include questions that will help improve menopause care. It is imperative that bodies representing mental health, including the College, are involved early in the development of this work. Both pieces will need to address:

a. the impact that menopause can have on mental health, and

b. the diagnostic overshadowing and other barriers that exist for women with pre-existing mental health conditions accessing appropriate advice and support for symptoms of menopause.

9.5 For public bodies

Research funding bodies

Overarching-recommendation:

The research funding ecosystem, including UK Research and Innovation, Health and Care Research Wales, the National Institute for Healthcare and Research (NIHR), the Wellcome Trust and charitable funders, should invest in research into menopause and its effects on mental health. This is imperative and will support the saving of lives.

Sub-recommendations:

9.5.1 Funding should be invested in research that aims to address existing research gaps that prevent us from understanding the access and care needs for groups who are marginalised based on multiple, intersecting grounds, including people who:

- have severe mental illness (SMI)
- are from a minoritised ethnic group
- are neurodivergent
- have an intellectual disability
- have a history of trauma
- belong to LGBTQ + groups, including those who identify as transgender or non-binary.

Research should adopt an intersectional approach that acknowledges how some women's experience of menopause and mental health will be shaped by the multiple and intersecting disparities they are faced with.

9.5.2 Funding should also be invested in research that addresses existing gaps in understanding:

- new onset mental disorder (including those associated with suicidal ideation) in women who experience menopause and have pre-existing mental disorders.
- the experience of menopause for patients with complex emotional needs and/or a history of trauma.

- the complex interplay between endogenous hormones and psychotropics. This would improve understanding of treatment options.
- the specific benefits of hormone replacement therapy (HRT) for women with severe mental illness (SMI).
- epidemiological, physiological and pharmacological factors that relate to the relationship between menopause and mental health.

National guidance

Overarching-recommendation:

Developers of national-level clinical guidance (i.e. In England, the National Institute of Care and Excellence (NICE)) should ensure psychiatric involvement in the development of guidance relevant to menopause and further guidance should be developed to fill gaps.

Sub-recommendation:

9.5.3 NICE and equivalent bodies in Northern Ireland, Wales and Scotland should develop guidelines for supporting the treatment of perimenopausal symptoms and associated mental disorders.

National Health Services and Health and Social Care (HSC)

Overarching-recommendation:

National Health Services in England Scotland and Wales as well as Health and Social Care (HSC) in Northern Ireland should ensure all healthcare professionals understand the links between mental health and menopause and can appropriately address and/or signpost patients to support and treatment through effective multi-disciplinary working.

Sub-recommendations:

9.5.4 National Health Services in England, Scotland and Wales as well as HSC in Northern Ireland should promote a shared learning approach to address health inequities that exist across specialties – such as the planned diploma between RCOG and RCPsych.

9.5.5 National Health Services in England, Scotland and Wales as well as HSC in Northern Ireland should ensure greater multidisciplinary working and interoperability between relevant services and healthcare professionals to address menopause and mental health. This should include integrated treatment pathways between primary care, gynaecology and mental health services. Any ongoing planning

or service design related to women's health hubs should consider improving access for women with pre-existing mental health conditions.

9.5.6 National Health Services in England, Scotland and Wales as well as HSC in Northern Ireland should prioritise continuity of care including the allocation and prioritisation of consistent staff for patients.[60] There should be an understanding amongst services that continuity of care strengthens the therapeutic relationship between staff and their patients.[61]

9.5.7 National Health Services in England, Scotland and Wales as well as HSC in Northern Ireland should ensure all health professionals understand that asking individuals about menstrual and reproductive health (including menopause) should form part of a holistic, psychosocial response to suicide.

9.5.8 National Health Services in England, Scotland and Wales as well as HSC in Northern Ireland should integrate consideration of menopausal symptoms into routine health monitoring and behavioural assessments to help avoid mis-diagnosis, delayed diagnosis or inappropriate treatment. They should ensure healthcare professionals:

- routinely ask women about menstrual and reproductive health including menopause
- explore the impact this may be having on the woman's mental health
- ensure this is recorded
- ensure appropriate evidence-based interventions are offered with appropriate accommodations considered. This practice should be based on shared decision-making with the patient. It should be reflected in mental health service standards and incorporated into existing standards associated with women's physical health.[62] Within this context we welcome recent commitments from the Department of Health and Social Care in England, see recommendation 9.4.3.

9.6 For employers

Overarching-recommendation:

All employers should ensure an effective workplace menopause policy is in place and mental health employer organisations should ensure the provision of adequate occupational health support for all staff.

Sub-recommendations:

9.6.1 As part of a workplace menopause policy, employers should ensure the following:

- Mandatory training for employees in line management roles is implemented to ensure an understanding of:
  - The impact of the interplay between menopause and mental health.
  - How, without employer intervention, these conditions can adversely impact an employee's experience in the workplace and their career progression.
  - At-risk groups and how some women experiencing menopause will face discrimination based on multiple and intersecting personal characteristics.
  - The positive impact women likely to be experiencing menopause can have on organisational retention, performance and productivity.
  - How some employees affected by menopause may have additional pressures caused by caring responsibilities e.g. children and/or elderly relatives.
- Clear options for phased returns to work, flexible working and special leave are available for all employees who are experiencing symptoms relating to menopause which are impacting on their mental health. This policy should reflect the differing needs of women as well as the fluctuating nature of symptoms.

9.6.2 Mental Health employer organisations should ensure adequate occupational health provision for all staff, including those experiencing menopause. Provision should include expertise in physical disability, mental illness related disability and neurodivergence in the workplace.

Appendix

Engagement with Experts by Experience – unabridged summary

Broad themes

Menopause-related difficulties reported by Experts by Experience:

- Having to return to work before they are ready for financial reasons.
- Co-existing mental health conditions including anxiety and depression worsening to what one expert, Rachel Bannister described as “catastrophic thinking” as they become post-menopausal, with women reporting “mental health decline”.
- Competing priorities of employment and family (including co-occurring responsibilities of children and elderly parents), adding to the pressure they have from menopause and mental health conditions. Women report making changes and compromises to their working lives to try and lessen this pressure. This includes women taking demotions and leaving their job altogether, with this likely to be mirrored in the healthcare workforce.
- Wishing they had known more about menopause before entering it, accompanied by a sense of what one expert, Wendy, referred to as falling down a “menopause hole” with a lack of knowledge and hope.
- Eventual explanations for their symptoms alongside a continued lack of information.
- ‘Physical and emotional symptoms’, including hot flushes, headaches, sleepless nights, rage and aggression.
- Mental ill-health symptoms, including anxiety, low mood, depression and even suicidal ideation.
- Loneliness and the importance of peer support/networks.
- Co-morbidities, e.g. cancer diagnosis alongside experiences of menopause.
- Experience of menopause is interdependent with social factors including racism, poverty and stigma.
- Menopause can be a transitional period that women can find challenging for several reasons including having to redefine their identify and take demotions at work.
- There are women who are discovering they are neurodivergent (autistic and ADHD) due to no-longer being able to mask symptoms during menopause.
- Menopause can also be associated with some positive experiences, being a new phase of life to embrace. For example, according to one expert, Wendy, “it can also be a time to shine”.
- The importance of being able to access suitable HRT without delay to reduce the impact of menopause on their mental health.

- The importance of easy access to treatment and timely treatment reviews with a known clinician.
- The importance of reducing incorrect use or overuse of medication that does not meet their needs. For instance, psychiatric medications being prescribed when the cause of symptoms may be hormonal.
- Conversely, not being offered timely psychotropic medication when this was needed.
- The importance of individualised, holistic and appropriate provision of care for women who are experiencing menopause, including those who have specific needs/conditions e.g., related to neurodivergence and intellectuality disability.

Impact of care experiences

Good care:

Experts by Experience reported having positive care experiences in various situations, including:

- **Access to psychological therapy:**
  Being able to see a clinical psychologist (albeit after a long wait) and having 12 sessions with them.

- **Co-ordinated, multidisciplinary care:**
  Receiving care from a GP, an occupational health physician (OHP), an outpatient consultant and an outpatient clinical psychologist who worked in partnership with the patient to support her recovery. Regular face-to-face appointments allowed time to talk freely and with honesty.

- **Person-centred specialist care:**
  Being supported by a GP menopause specialist who listened carefully and looked beyond preconceptions and diagnostic labels, upon which there can be an overreliance. The patient reported that this approach allowed for a relationship to be built based on trust, meaningful shared decision-making and exploring different options together. This allowed the patient to feel in control, which they had not felt in the past.

- **Continuity of care:**
  Receiving regular remote GP appointments during the Covid-19 pandemic. This allowed for continuity of care and an opportunity for the patient and GP to develop a therapeutic relationship.

- **Individualised nursing support:**
  Feeling better supported by a woman's mental health nurse than by other professionals who had previously provided care. The nurse provided individualised advice and a different form of HRT that better suited the patient.

- **Timely support and guidance:**
  Where help, support and guidance were provided, women reported feeling that they had avoided "suffering in silence".

Inadequate care

Experts by Experience reported receiving inadequate care in a range of situations, including:

- **Gaps in professional knowledge:**
  Health services lacking training on, and understanding of, menopause and related mental health issues. This includes:
  - Failure to consider the impact of perimenopause:
    A lack of investigation into hormonal changes caused by perimenopause being a potential cause of the patient's mental health episode. (A lack of public and patient awareness also contributed to this, with the patient delaying seeking treatment due to not being aware of the potential impact of menopause on mental health.)
- **Missed opportunities in primary care:**
  GPs missing opportunities to ask patients reporting intermittent menses about their mental health and to inform them of the impact of hormonal changes on mental health during menopause transition. This is particularly important for patients who have a known history of mental health conditions.
- **Issues accessing HRT:**
  - GPs not raising or discussing HRT with patients as a potential option to treat symptoms.
  - Negative experiences with quick remote GP appointments and immediate HRT prescriptions without adequate conversation.
  - Lack of availability of suitable HRT which no clinician nor organisation seemed to have responsibility for.
- **Access difficulties and delays in specialist care:**
  Difficulty securing follow-up appointments with menopause specialists or clinics, with reported 6-month waits to be reviewed by a service.

  Inadequate support for people with severe mental illness (SMI):
  Discharge planning and follow-up care that did not meet the needs of individuals with severe mental illness (SMI). One patient with premenstrual dysphoric disorder (PMDD) described being discharged from their long-term community psychiatric nurse (CPN) less than a week after having a hysterectomy. The patient was signposted to a mental health support line.

  While the support line provided some benefit (distraction, skills coaching) it was not able to provide the immediate relief the patient required, which they later found related to their hormones and adjustments to HRT prescription. The same patient highlighted how when they reported feeling suicidal to a service, they were not offered adequate support and were instead told to attend a menopause support group three weeks later.

What needs to change?

Experts by Experience reported that the following needs to change to improve how mental health and menopause is addressed:

- Improved knowledge and awareness of menopause and mental health
- Improving awareness of the potential impact of perimenopause, menopause and post menopause on mental health – especially for women who are at higher risk of mental health decline due to having experienced previous mental ill health episodes.
- Clinicians should understand the impact of menopause on a person's physical and mental health. A specific understanding of the impact of surgical menopause is required including the impact of sudden hormonal changes following removal of the ovaries. There needs to be:
  - Promotion of ways to empower women to make informed choices.
  - Peer support/group support and psycho-eduction, with targeted interventions specific for people with SMI.

- **Work and employment**
  - Employer awareness of the impact of perimenopause, menopause and post menopause on mental health.
  - Employer awareness of the impact menopause can have on women's careers.
  - Workplace adjustments/flexible working for women experiencing menopausal symptoms and mental ill health.
  - Longer time periods for phased returns to work following leave for menopause and mental health related leave. Expert by Experience, Jan, highlighted: "My employer agreed to a phased return over 6 weeks which was helpful but nowhere near long enough."
  - Open, supportive cultures and an inclusive working environment in which everyone is treated fairly.
  - Workplace policies should include menopause guidance, support and adjustments.
  - Employers should address barriers that could hinder women from performing and developing to their full potential as they go through menopause transition.

- **Healthcare workforce**
  - ***Medical education and training***
    - Mental health and menopause should be a significant part of medical school training.
    - All medical students should gain a full understanding of menopause and its impact on a woman's life. This should include an understanding of the role menopause can have on mental health decline and an awareness of risk factors and treatment options.
    - Resident doctors should hear from people with lived experience of menopause and mental health conditions – for instance via written testimonies/recordings.
    - GP training should ensure an awareness and detailed knowledge of menopause, its impact and available evidence-based treatments to address adverse symptoms.

- *Staff*
  - Clinicians should develop a holistic person-centred approach in their clinical practice.
  - Clinicians should be confident and comfortable with asking their patients about their menstrual cycle, contraception and HRT. Such conversations may unlock information that improves treatment.
  - Clinicians should understand the interactions between medications, illnesses (physical and psychological), temperature and other variables which may affect the metabolism and effectiveness of an individual's HRT.
  - Trained peer workers with lived experience of menopause and mental health should form part of health services.
  - Primary care should be able to provide or refer to specialists in mental health conditions and menopause.
  - Medical training and education should ensure clinicians fully understand the impact of hormones on mental health. This should include understanding the treatment options to address the causal link between oestrogen levels (both low and high) and menopausal mental ill health.
  - Clinicians should be able to identify and support the treatment of vasomotor symptoms.
  - Clinicians should be able to recognise and avoid diagnostic overshadowing in menopausal patients.

- **Research**
  - There should be further research into how surgical menopause differs from what one Expert by Experience, Emily Grace, described as a "natural" menopause, including how treatments/treatment regimens for the two may differ.

- **Healthcare system**
  - Continuity of care is essential. Patients should be able to access regular contact with the same specialist healthcare professional (e.g., psychiatrist, community psychiatric nurse, GP).
  - Patients should have any risk factors related to their mental health and experience of menopause identified within primary care.
  - A system should be developed in primary care that flags if a patient who has experienced a mental illness is pre-menopausal.
  - Patients should have equal and equitable access to healthcare services.
  - Training and awareness for 24-hour mental health crisis support services so that they are equipped to meet the needs of people experiencing menopause and mental health symptoms.
  - A system for patients to access 24-hour support for their mental health and menopause.
  - Establishing safe, compassionate wards and preventing suicide should be a priority. To support this, wards should have access to correct HRT and staff should understand the importance of this being given as prescribed e.g., no delays, changes in brand etc.
  - There should be greater multi professional working between relevant services and healthcare professionals. This should include integrated treatment

pathways between primary care, gynaecology and mental health services. Teams should be able to speak to each other and take joint responsibility for patients experiencing mental ill health and menopausal symptoms.

  - Across the care pathway as well as in prisons, staff should record if a patient/prisoner is experiencing perimenopause, menopause or is post menopause. Staff should consider the needs of these cohorts and respond with appropriate care.
  - Women who have experienced surgical menopause should be offered targeted support which includes addressing the grief and sense of loss that some women will experience as a result of entering menopause earlier than average.
  - Clinicians and pharmacists should be supported with prescribing guidance.
  - Relevant social prescribing can provide support and aid sustained recovery.

- **Families, friends and wider networks**
  - If a person presents with mental illness and menopausal symptoms, the impact of their symptoms on their family unit should be routinely explored. Where appropriate, carer's assessments and support should be offered to the family, with particular attention given to the needs of children and young people. Women experiencing menopause and mental illness should be signposted to easily accessible peer support, with this being particularly important following discharge.

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