RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

# WOMEN'S *mental health matters*

## Strategy (2026-2031)

Foundations for Change

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# Foreword

Women's mental health is fundamental to the health of our society. Yet for too long, it has not been consistently considered, recognised, prioritised or addressed within health systems, policy or clinical practice. This strategy addresses what clinicians and women have been telling us for decades: the current approach is not working.

Women live longer than men but spend significantly more of their lives in poor health, a pattern seen globally and  in the UK(McKinsey Health Institute, 2024). This reflects a persistent and widening gender health gap, with direct consequences for both mental and physical wellbeing.

When we think about women's health, it is essential that mental health is considered alongside physical health across the different stages of their life-course. We know that women experience distinct patterns of mental illness, shaped by biological, social, environmental and structural factors. This evidence is well established, yet what has been missing is action.

Crucially, not all women are affected equally. Women facing the greatest burden of intersecting risk factors including poverty, gender-based violence (GBV) and severe mental illness (SMI) have the poorest outcomes and face the greatest barriers to care. Too often, these women's needs remain overlooked in both policy and practice.

At the same time, demand for mental health support is rising, and the complexity of need is increasing. For women, this challenge is particularly acute. Gendered experiences including discrimination, caring responsibilities, economic inequity and social pressures shape women's pathways to care, often making them longer, more complex and more difficult to navigate.

This must change. When health services are not designed around those with the greatest need, existing inequalities deepen. Placing those most at risk at the centre of care is essential to improving outcomes for all women.

Improving women's mental health requires a fundamental shift in how care is understood, designed and delivered. It demands coordinated action across government, the NHS and wider society, alongside meaningful partnership with women whose voices have too often gone unheard.

At its core, this strategy is about ensuring that women are listened to, believed, empowered and supported, with services that respond to the realities of their lives.

Improving women's mental health will benefit whole communities and the wider economy, and is central to patient safety, public health and long-term system sustainability.

This strategy sets out a clear path forward, grounded in clear action and collective responsibility at every level. What matters now is that we act with urgency, with ambition, and with sustained commitment.

Dr Lade Smith CBE, President, RCPsych

Dr Catherine Durkin, Presidential Lead for Women's Mental Health, RCPsych

Dr Philippa Greenfield, Presidential Lead for Women's Mental Health, RCPsych

*“Women’s mental health needs are misunderstood, misdiagnosed and underserved. This superb strategy provides a clear and comprehensive blueprint for change”*

— **Professor Linda Gask**

*“For far too long, mental health services have neglected the needs of women, across the life-course. It is vital that this important women’s mental health strategy is implemented as soon as possible by policy makers, commissioners and mental health practitioners. I believe it could deliver real improvements for service users, particularly when changes are measured and rigorously evaluated, using appropriate methodologies with disaggregated data”.*

— **Professor Louise Howard**

*“For the last couple of decades, women have been systematically disadvantaged by the way the health service is structured. It was designed by men for men and I think there have been so many problems with implementing and understanding how different women are.*

*I am delighted to have supported this work and am particularly keen to get men and boys involved as part of our allyship to implement the women’s mental health strategy.”*

— **Dame Lesley Regan**

## RCPsych approach

In line with the College’s approach to equity, it is considered good medical practice, across all areas of healthcare, to adopt a holistic, person-centred approach in order to fully understand each patient’s needs. Such care respects individual rights and preferences and is informed by the best available evidence. This document is based on this premise and encourages consideration of this approach throughout

As described in the CoSum report we acknowledge the high rates of co-occurrence of substance misuse disorders and mental health conditions and how this intersection further exacerbates poor health outcomes and barriers to accessing healthcare. Efforts to improve mental health outcomes must integrate access to, and support for, both mental health and substance misuse.

# Terminology

### A Trauma Informed Approach:

A programme, organisation, or system that understands the widespread impact of trauma and identifies pathways to recovery. It recognises the signs and effects of trauma in individuals, families, staff, and others involved with the system, and responds by embedding this understanding across policies, procedures, and everyday practice, while actively working to prevent re-traumatisation.

This approach includes trauma-specific interventions such as assessment, treatment and recovery support, alongside embedding core trauma-informed principles within organisation culture: safety, trustworthiness, peer support, collaboration, empowerment and choice, and awareness of cultural, historical and gender related factors (SAMHSA's Trauma and Justice Strategic Initiative, 2014).

### Domestic Abuse

The cross-government definition of domestic abuse used in England and Wales, as reflected in the Domestic Abuse Act (2021), defines domestic abuse as 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial or emotional'.

This definition includes so-called 'honour-based violence'(HBV), female genital mutilation (FGM) and forced marriage (FM).

Children who are related to the (adult) perpetrator or victim of domestic abuse, and who see, hear or otherwise experience the impact of domestic abuse, are also considered victims.

Definitions of domestic abuse across the UK nations are broadly aligned in recognising domestic abuse as encompassing physical, sexual, psychological, emotional and economic abuse, including coercive and controlling behaviour. However, legislative approaches differ. For example, in Scotland and Northern Ireland, domestic abuse is defined as a **course of abusive behaviour**, with a particular emphasis on the cumulative impact of coercive control within intimate or familial relationships. While the Northern Ireland definition includes both partners and family members, the Scottish legislation focuses specifically on partners and ex-partners.

### Gender-based violence

The European Commission defines gender-based violence (GBV) as violence directed at someone because of their sex or gender. It is forcing another person to do something against their will through violence, coercion, threats, deception, cultural expectations or economic means. Forms of GBV include sexual violence, domestic abuse, female genital mutilation (FGM), and so-called 'honour-based abuse' and forced marriage (FM).

GBV primarily impacts women and girls, and in this document the term will be used to refer specifically to them. For this reason, it is often interchangeably referred to as 'Violence Against Women and Girls (VAWG). It is understood as a violation of human rights and form of discrimination against women and girls, recognised to cause physical, sexual, psychological and economic harm.

## Intersectionality

The concept of intersectionality emerged from the Black Feminist movement in the United States during the 1980s. It highlights how overlapping aspects of identity such as race and gender can combine to create unique forms of discrimination, meaning the experiences of Black women cannot be fully understood by examining gender or race inequality in isolation (Crenshaw, 1989).

## Menopause

We use the term menopause to refer 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)

## Sexual, reproductive and hormone health

Sexual, reproductive and hormone health considers a person's complete physical, mental and social wellbeing in all matters relating to their reproductive system and its functions. In health, it covers a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections, protection from GBV and safe and healthy relationships (adapted from World Health Organisation)

## Sexual Violence

An umbrella term used to describe any kind of sexual act or activity (including online) that is unwanted and takes place without consent. It can take many forms including, but not limited to rape, sexual assault, sexual abuse and image-based abuse.

## Women

This document uses the terms "women" and "women's mental health" throughout. These terms refer to women across all stages of life, including childhood, adolescence, adulthood, and later years.

Some sections of this document may also be relevant to trans men, non-binary people who were registered female at birth, and some intersex people. We acknowledge that current research on transgender health is limited, and this document reflects that gap.

## What do we mean by empowerment?

United Nations (UN, 2018) defines women's empowerment as having five components:

- Women's sense of self-worth
- Women's right to have and to determine choices
- Women's right to have access to opportunities and resources
- Women's right to have the power to control their own lives, both within and outside the home
- Women's ability to influence the direction of social change to create a more just social and economic order, nationally and internationally.

## Methodology

This strategy is grounded in robust evidence as well as, crucially, in the lived experiences of women and girls. Over three years of consultation and engagement, it has been informed by the insights of clinicians, women with lived experience of using mental health services, third sector organisations, academic experts alongside professionals across broader health services, including the Royal College of Obstetricians and Gynaecologists (RCOG), Faculty of Sexual and Reproductive Health (FSRH) and the Royal College of General Practitioners (RCGP).

The intended audience includes Governments across the UK, NHS leaders, regulators, research funders, and partners across health, social care, the voluntary sector and the wider public.

## Executive Summary

Women's mental health is a fundamental component of overall health and wellbeing, yet it has not been consistently translated into practice across policy, service design and clinical practice. Despite clear evidence that women experience distinct patterns of mental illness, shaped by a combination of biological, social and structural factors, and evident in differences in prevalence, risk factors and disease burden (Morris, S. et al., 2025) - services are not yet consistently responding to these needs.

Women are disproportionately affected by common mental health conditions, exposure to trauma and gender-based violence, and the cumulative impacts of inequality across the life-course. (Oram et al., 2022; McKinsey Health Institute, 2024).

Not all women are affected equally. Women facing the greatest burden of intersecting risk factors including poverty, GBV, and SMI are more likely to experience poorer outcomes and greater barriers to accessing care. These women are often least well served by existing systems. Designing services around those with the highest levels of need is essential to improving outcomes for all women.

This strategy sets out a clear case for treating women's mental health as a core priority for the health system and wider society. It identifies three interlinked foundations that shape outcomes:

**1.** Women's sexual, reproductive and hormonal health

**2.** The impact of gender-based violence (GBV)

**3.** Structural inequity within the health and social care system.

These factors intersect and compound one another, contributing to delayed diagnosis, fragmented care and poorer outcomes, particularly for women experiencing multiple forms of disadvantage (Malina Bodea and Miranda Davies, 2025).

The consequences of inaction extend well beyond individual women. Poor mental health among women affects children, families and communities, places increasing strain on public services, and undermines workforce participation and economic resilience. While the overall cost of mental ill-health is substantial, a significant proportion is preventable through earlier intervention and more equitable, targeted care.

Despite increasing recognition of these challenges, progress has been limited. Previous strategies have been supported by a strong evidence base, but progress has been constrained by inconsistent implementation, insufficient accountability, and a lack of coordinated system-wide action.

This strategy sets out five national priorities for action:

**1.** National implementation of initiatives that lay the foundation for improvement in women's mental health.

**2.** Acknowledging and responding to gender-based violence as a major public health issue for women

**3.** Creating safe, trauma-informed and therapeutic mental health services for women

**4.** Improving physical health outcomes for women with severe mental illness (SMI) and/or trauma histories

**5.** Supporting a workforce equipped to deliver women-centred care.

These priorities are underpinned by three core principles: a trauma-informed approach, a life-course perspective, and an intersectional understanding of need. Each priority is accompanied by clear actions and identifies those responsible for delivery, supporting accountability and consistent implementation.

Improving women's mental health is both necessary and achievable. It requires coordinated action across government(s), health systems and wider society, alongside meaningful involvement of women with lived experience.

This strategy sets out a clear and practical path forward. The priority now is to move beyond recognition of the problem and deliver sustained implementation, accountability, and system-wide change.

# Introduction

Women's mental health has been overlooked for far too long. Despite significant evidence demonstrating the distinct ways women experience and access mental health care, (Department of Health and Social Care, 2022), this understanding has not been consistently translated into the design and delivery of health services.

This is not due to a lack of knowledge about what works. Models such as women's centres and Sure Start children's centres demonstrate the value of accessible, holistic services that are grounded in the realities of women's lives. Evaluations of Sure Start, for example, show that integrated, community-based support for families can improve outcomes when services are coordinated across health, social, and economic needs. (Sammons et al., 2015). Evidence from women's centres similarly highlights the effectiveness of gender-responsive, trauma-informed models that provide joined-up support and improve outcomes for women facing multiple disadvantage, including reoffending and improved wellbeing (Ministry of Justice, 2024) (Eva Neitzert, 2025). However, progress has been constrained by inconsistent investment and implementation.

As a result, women continue to face significant challenges in accessing timely, appropriate care, often reporting poor experiences within mental health services and poorer outcomes across the life-course. (Women's Mental Health Taskforce, 2018). These patterns reflect systems historically designed around male norms and fragmented service models that fail to account for the complexity of women's lives (McKinsey Health Institute, 2024).

Without gender-informed services, women's distress is more likely to be misunderstood, minimised, misdiagnosed, or inappropriately medicalised, without addressing underlying causes. This creates a cycle in which trauma, inequity and mental ill-health reinforce one another across the life- course.

The impact of this is increasingly visible. Women are significantly more likely than men to experience common mental health problems, with prevalence consistently higher across the population. In 2023/24, one in five (20.2%) adults in England were identified as having a common mental health condition, such as depression, generalised anxiety disorder (GAD), obsessive compulsive disorder (OCD) and panic disorder; however, rates among women were notably higher at 24.2% compared to 15.4% in men. This disparity is even more pronounced among younger age groups. Among 16 -24-year-olds, prevalence among young women has increased markedly, from 21.0% in 2000 to 36.1% in 2023/24 (Morris, S. et al., 2025).

In England, rates of mental disorder are significantly higher amongst young women than young men, particularly in late adolescence and early adulthood (aged 17-25) (Newlove-Delgado, T et al., 2023). Reflecting this, girls are increasingly represented in referrals to specialist mental health services, with recent evidence showing a rising proportion of Child and Adolescent Mental Health Services (CAHMS) referrals and accepted cases among adolescent girls (Ball et al., 2023). Young women are also overrepresented in some parts of the system, particularly eating disorder services (Newlove Delgado et al., 2023). Eating disorders, particularly anorexia, are associated with the highest mortality of any psychiatric condition. (Meczekalski et al., 2013).

For many women, their mental health problems are closely linked to GBV and structural inequity. GBV is strongly associated with both the onset and severity of mental illness, as well as increased risk of suicide (Lancet commission, IPV 2022).

A quarter of young women (25.7%) have self-harmed, and rates have tripled since 2000 (Morris, S. et al., 2025), and suicidal ideation is now one of the most common reasons girls seek help through Childline.

Suicide rates are highest for women between the ages of 45-54 (ONS), which coincides with the typical age of menopause. There is also increasing understanding of the association between suicide and suicidal ideation at times of hormone transition.

Evidence shows that between 2015 and 2021, 3,908 women in the UK died by suicide while in contact with mental health services; among those with available data, around one in four (26%) were known to have experienced domestic violence, alongside high rates of self-harm. (Turnbull et al., 2025). Failure to recognise and respond to these risk factors particularly within crisis care, represent missed opportunities for intervention. Presentations in crisis involving self-harm should therefore be recognised as key opportunities for a thorough biopsychosocial assessment and the delivery of timely, compassionate, and personalised suicide prevention support.

Women's mental health outcomes are shaped not only by gender, but by how it intersects with other forms of structural disadvantage. Women are more likely to experience economic disadvantage, reflecting lower life-course earnings, career disruption, and the unequal burden of unpaid care and domestic work (McKinsey Health Institute, 2024). For older women, these challenges are often compounded by chronic illness and disability, further widening inequalities in both mental health outcomes and access to care.

Women who face multiple forms of disadvantage are more likely to present later, sometimes through crisis or coercive routes, reflecting barriers to care that include stigma, structural inequality, and gender bias within healthcare. They may also be less likely to receive timely, preventative or culturally appropriate support. Without an intentional intersectional approach, service models risk reinforcing exclusion rather than reducing it.

Recent policy developments across the UK - including the Women's Mental Health Task Force 2018 (Department for Health and Social Care, 2018) followed by the first Women's Health Strategy for England (2022)(Department of Health and Social Care, 2022), the Welsh Government's Women's Health Plan for Wales (2024) (NHS Wales, 2024) and the Scottish Government's Women's Health Plan (2021) (Scottish Government, 2024), marked an important step in acknowledging these disparities at a national level and signalling a move away from a 'male as default' approach. The strategies highlighted women's experiences of being dismissed or having received inadequate support. They also recognised the consequences of long-term underinvestment in women's health and set out an initial pathway for reform. This direction has since been reinforced in the Renewed Women's Health Strategy for England (2026) (Department of Health and Social Care, 2026) and the Women's Health Plan: Phase Two for Scotland (2026) (Scottish Government, 2026). It should also be noted that Northern Ireland has yet to publish a dedicated Women's Health strategy, although we hope this will become a priority in due course.

There are significant structural barriers to developing integrated health strategies across the UK. Existing approaches remain fragmented, reflecting siloed policymaking and limited cross-government coordination. Without greater integration, efforts to improve women's mental health risk being partial, inconsistent, and unsustainable.

The Royal College of Psychiatrists (RCPsych) stands ready to support governments across the UK to embed mental health as a core component of women's health strategies, ensuring a coherent, life-course approach that reflects the realities of women's lives.

# Factors affecting Women's Mental Health Across the Life- Course

Women's mental health is shaped by three key interlinked factors across the life-course: the effects of sexual, reproductive and hormone health across the life-course; the impact of gender-based violence and the structural inequities that frame women's lives. Each of these factors is significant, but when they intersect, risks accumulate and vulnerability deepens for worse mortality and morbidity outcomes.

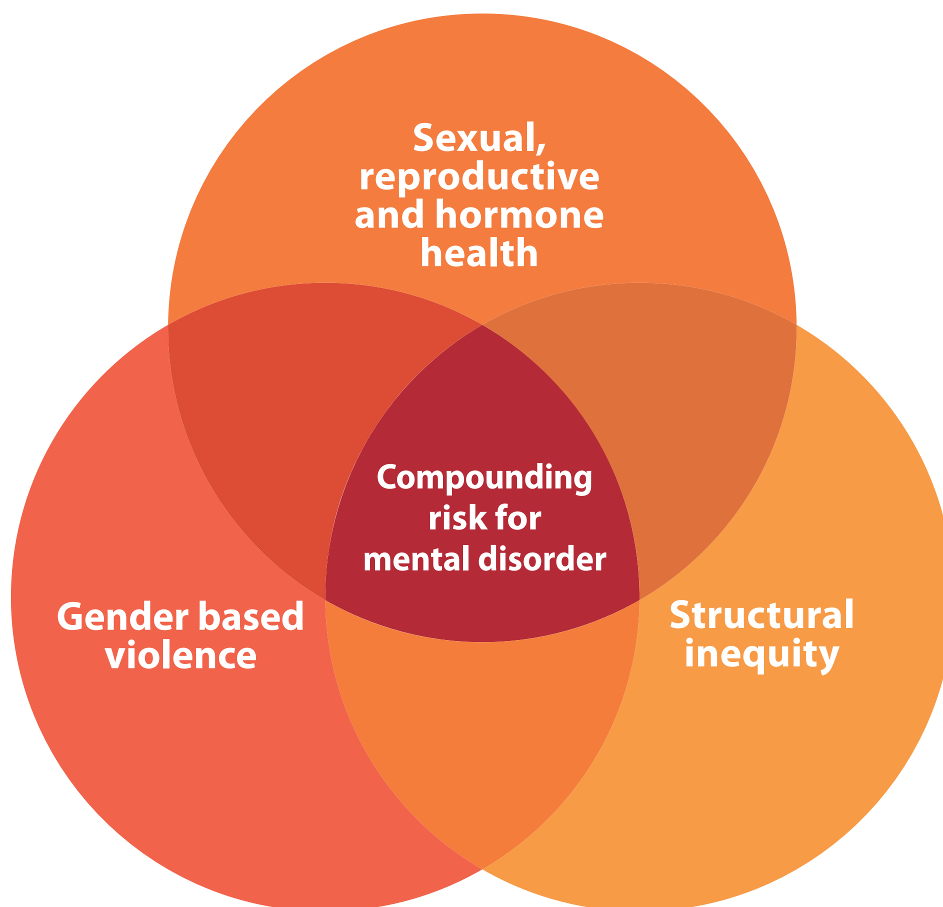


**Figure 1:** shows three key interlinked factors that impact women's mental health across the life-course.

## Women’s Sexual, Reproductive and Hormone Health across the life- course

*“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.”*

— **RCPsych member survey (2024)**

*“Mental illness must ‘not be seen as an isolated phenomenon but instead, a result of life experience (albeit with a potential genetic disposition to mental ill health).”*

— **Patient rep**

Women’s health needs vary across the life-course, with vulnerability to mental illness increasing during major biopsychosocial transitions. These include puberty, pregnancy, the postpartum period and menopause (Sommer et al., 2023). There is growing recognition that these periods can be associated with the onset, recurrence and destabilisation of a range of psychiatric disorders.

The extent to which services support women through these transitions, including pre-conception planning, pregnancy and postnatal care including when there is child loss, gender specific prescribing guidelines (Brand et al., 2026) and menopause support can directly influence both mental and physical health outcomes.

Women experience significantly higher rates of eating disorders, which most commonly emerge during adolescence and early adulthood (Solmi et al., 2022). While the exact causes of this condition are complex, both hormone changes associated with puberty and key psychosocial transitions during this life stage are implicated. (Klump, 2014).

Some women demonstrate heightened sensitivity to hormone changes that occur during the menstrual cycle (Marwick et al., 2025). There is increasing evidence of premenstrual exacerbation of psychiatric disorders, including worsening psychotic symptoms and increased rates of hospital admission in the last quarter of the menstrual cycle (Jang and Elfenbein, 2019) (Reilly et al., 2020).

Awareness of Pre-Menstrual Dysphoric Disorder (PMDD) has improved but remains insufficient. PMDD is a significant and often under-recognised mental health condition (Reilly et al., 2024) and delays in diagnosis and treatment continue to cause avoidable harm.

Up to one in four women experience mental health difficulties during or after pregnancy (Howard, Louise et al., 2018), and in the UK, suicide remains the leading cause of maternal death in the first year after birth (Knight et al., 2025). Women with pre-existing mental illness or a history of trauma are at an increased risk of poorer pregnancy and neonatal outcomes.

As highlighted in our **Menopause Position Statement**, emerging evidence also indicates heightened risks of mental illness during menopause. Research suggests that perimenopausal women may be at increased risk of developing mental health conditions, with some studies reporting more than a twofold increase in first episodes of mania (a key component of bipolar disorder) and a 30% higher risk of new onset major mood disorder . (Shitomi-Jones et al., 2024).

### Case Study: Clare's story – bipolar disorder, hormonal vulnerability and missed opportunities for care

Clare first began experiencing symptoms of bipolar disorder in her teens, but like many young women, her early warning signs were missed. From age 15, she experienced severe seasonal depressions coinciding with puberty, followed by increasingly intense summer highs marked by reduced sleep, irritability and impulsive, out of character behaviour. Despite this clear pattern, she remained undiagnosed for nearly a decade. She was finally admitted to hospital at 23 during a manic episode, at which point she received her diagnosis. Lithium brought stability, but she also faced distressing misinformation, including being told she might "never be able to have children," something she later learned was inaccurate and harmful.

As Clare built her career and later retrained as a psychologist, she became increasingly aware of how little guidance women receive about bipolar disorder, reproductive mental health and hormonal triggers. After experiencing postpartum psychosis herself, she dedicated her work to improving understanding of how hormonal transitions from menstruation to pregnancy to perimenopause can precipitate relapse.

Reflecting on her experience, Clare said:

*"Looking back… I don't think it was coincidental that that's when I started my periods… our cycles and hormones are a big trigger for our illness."*

*"I retrained in psychology… because of my concerns at the lack of preconception advice for women."*

*"So many people could live so much better lives if it just got a bit more attention."*

Women experiencing more severe perimenopausal and menopausal symptoms may be less likely to have these symptoms correctly identified and appropriately treated particularly where symptoms overlap with mental health conditions or are not recognised within routine clinical assessment (Royal College of Psychiatrists, 2026). This can lead to delays in diagnosis and fragmented care across both physical and mental health services.

In later life, women bear a disproportionate burden of Alzheimer's disease and dementia. Around two thirds of people living with dementia are women. Dementia has been the leading cause of death among women in the UK since 2011. (Alzheimer's Research UK, 2022).

Too often, women are left without appropriate care at the points when they are most vulnerable. These are not isolated challenges but a consistent pattern across the life-course – one that highlights systemic gaps in recognition, diagnosis and care, and underscores the need for urgent, coordinated action.

### Case Study: Toni's story – Caring across the life course

Toni is a parent carer to a daughter who accessed CAMHS. She highlights how women are over represented in caring roles, yet their needs and contributions are often overlooked. For her family, the life course lens is essential: her daughter was navigating adolescence, while Toni was managing menopausal symptoms both affecting their mental health and shaping how they engaged with services.

She describes the importance of carers being meaningfully involved in service planning, policy development and clinical decision making. Throughout her daughter's care, she encountered systems that often overlooked the perspectives of women carers, despite their central role in supporting recovery. Toni's positive involvement in co producing this strategy where she felt respected, listened to and treated as an equal demonstrated what trauma informed, inclusive practice can look like in reality.

## Impact of gender-based violence

GBV is widespread across women's lives, from childhood through to older age. Its psychological, physical, emotional and economic impacts are cumulative, significantly increasing the likelihood of developing both common and severe mental illness, while also heightening vulnerability to further victimisation. Women with severe mental illness experience domestic and sexual violence at substantially higher rates than the general population and are more likely to experience poorer mental health outcomes if they have a history of GBV (Oram et al., 2022).

GBV is a serious form of trauma and a major contributor to women's mental ill-health. Women in contact with mental health services are disproportionately affected by domestic and sexual violence (Oram et al., 2022). A 2024 RCPsych survey found that 59% of psychiatrists identified violence and abuse as a primary driver of poor mental health among women (Royal College of Psychiatrists, n.d.).

Domestic abuse affects nearly 1 in 4 women in England and Wales in their lifetime (Office for National Statistics, 2025), while 15% of girls experience child sexual abuse before the age of 16 (Kairika Karsna and Liz Kelly, 2021). It is a leading contributor to premature mortality, and to both physical and mental health morbidity across the life-course.

Early-life experiences are critical. Exposure to parental domestic abuse is associated with childhood anxiety and depression, increased risk of adult mental ill-health, and a higher likelihood of experiencing domestic abuse in later life. It is also, though less commonly, associated with perpetration of domestic abuse (Oram et al., 2022).

In adulthood, domestic abuse is strongly associated with developing common and severe mental illness, including depression, anxiety, PTSD, bipolar and schizophrenia. It is also a major but often overlooked risk factor for suicide among women. Improved data collection has strengthened understanding of this risk factor, contributing to its inclusion in the national suicide prevention strategy, which identifies support for survivors and victims as a core component of reducing suicide risk among women.

Despite its high prevalence, particularly among women with mental health problems, mental health services are still not consistently designed or commissioned to support identification and response to GBV. This limits opportunities to ensure safety and mitigate long-term harm.

An example of this is the CQC report 'Safety in Mental health settings' (Care Quality Commission, 2018), which identified significant and systemic concerns about safety within inpatient mental health and learning disabilities services. The report highlighted that incidents of sexual harassment, assault and rape, alongside failures in risk assessment, observation practices and reporting mechanisms. It found that many services were not taking sufficient action to prevent harm, and that "sexual safety" was not consistently prioritised as a core component of patient care and safeguarding.

In response to these findings, NHSE commissioned the National Sexual Safety Collaborative, led by the RCPsych National Collaborating Centre for Mental Health, to develop national standards and guidance to improve safety across inpatient pathways (National Collaborating Centre for Mental Health, 2020). While this represents an important step forward in recognising sexual harm as a system-wide issue, evidence and service experience suggest that implementation has been variable. Persistent gaps in governance, accountability and inconsistent adoption of best practice continue to limit progress, leaving many women at ongoing risk of harm within services intended to support their recovery.

Similarly, the Department of Health and Social Care's mandate that all "NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice," has not been effectively translated into practice.

*"Despite the fact that we know the majority of women using our services have experienced sexual or domestic abuse, we do not ask the questions, and current diagnostic frameworks and pathways of care fail to understand or respond to this need. The message becomes that there is something wrong with you, rather than recognising that you have experienced trauma and how this has profoundly impacted your whole person. In doing so, our systems at best minimise women's difficulties, but at worst actively cause harm."*

— **Dr Philippa Greenfield**

The physical health consequences of GBV are equally significant. Domestic abuse is associated with increased lifetime risk of chronic illnesses including cardiac disease and Type 2 Diabetes, cancer, and adverse pregnancy outcomes (Oram et al., 2022).Growing awareness and improved data have highlighted previously overlooked harms. Traumatic brain injury is increasingly identified as a consequence of domestic abuse (Brainkind, n.d.), while non fatal strangulation (NFS) is now a standalone criminal offence in England and Wales, (Institute for Addressing Strangulation, 2025) reflecting its serious impacts . Evidence shows that NFS is associated with an increased risk of future domestic homicide, elevated suicide risk, and significant physical health consequences, including cardiovascular injury and stroke, (Bichard et al., 2022b). NFS is also increasingly recognised as a common cause of stroke in young women (Bichard et al., 2022a).

Risk is heightened at life stages. Pregnancy can trigger or escalate abuse, while physical or cognitive frailty can increase vulnerability for older women. Women's overrepresentation as caregivers can also increase domestic abuse exposure.

Despite its scale and impact, domestic abuse is still often framed as a "social issue" rather than a major public health priority. Routine, compassionate enquiry recommended by NICE since 2018 remains inconsistently embedded across mental health services (Neill and Read, 2022). While national policies increasingly reference trauma-informed approaches, meaningful system level implementation, supported by clear governance and accountability remains limited.

### Case Study: Sara's story – When trauma goes unrecognised

After the birth of her son, Sara, a survivor of domestic abuse, developed severe PTSD. She had previously received effective trauma specialist care abroad and knew what support she needed, but after moving to the UK this care was no longer available. As she explains: *"I knew what care I needed after the birth of my son because I'd received it before and it worked. Unfortunately, it had to reach crisis point before that trauma was taken seriously."*

Without trauma informed support, her symptoms escalated rapidly. Later, when she and her son became homeless, services again overlooked the psychological impact, leaving her feeling unsafe, dismissed and unsupported. Sara's experience illustrates how unrecognised trauma and fragmented pathways can lead to avoidable crisis and long term harm.

## Structural barriers to care

*"I have firsthand experience being close with peers who have had inadequate physical healthcare because of their mental health. This has ranged from a friend with PCOS being labelled as 'attention-seeking' by requesting check-ups and treatment, to friends avoiding seeking medical care (e.g. GP) at all due to unclear information about their rights, and how GPs can (and often will) provide trauma-informed care."*

— **Patient rep**

Addressing inequity in women's mental health care requires recognising how the structural inequities faced by women across the life-course are both risk factors for developing mental illness and barriers to accessing timely and high-quality care which impacts health outcomes.

### Intersectionality

Women with SMI have some of the poorest physical health outcomes across the life-course. Services must be designed with this in mind, so that the women most affected by mental ill health are not those least able to access support.

Gender also intersects with multiple compounding forms of structural disadvantage including poverty, social class, race, sexual orientation, gender identity, disability (including physical and intellectual) and neurodevelopmental conditions. Many of these factors are not yet consistently addressed in service design.

Additional barriers arise from migration, particularly insecure immigration status, being a victim of human trafficking, and limited language accessibility. Recognising these intersecting factors is essential to delivering equitable and responsive healthcare (Anderson et al., 2019) (Robertson et al., 2021) (Department of Health and Social Care, 2018).

Evidence and lived experience suggest that women experiencing trauma, poverty or marginalisation may be more likely to encounter stigmatising or dismissive response within healthcare, rather than trauma-informed, needs based care. This is particularly evident for women in contact with the criminal justice system, where cumulative trauma is widespread and care pathways do not always reflect the complexity of women's needs (NHS England, 2023).

As one clinician working in prisons described:

*"In my experience of working in a prison in the last six years, I can't think of one patient who hasn't had a cumulative experience of trauma, we have dismissed these women and denied them access to appropriate services."*

Women in prison have significantly higher physical and mental health needs compared to both men in custody and women in the general population and experience high rates of domestic abuse (NHS England, 2023a). Similar patterns are seen among women experiencing homelessness: they experience high rates and complex interactions between homelessness, domestic abuse and poor mental health (Joanne Bretherton and Nicholas Pleace, 2021), and life expectancy has been estimated at as low as 43 years in earlier analyses (Thomas, Bethan, 2012).

Inequities are also evident across ethnicity and physical health. For example, Cardiovascular risk tends to rise during the menopause transition, and growing evidence suggests that women from ethnic minority backgrounds may experience greater cardiometabolic risk in midlife.(Vallée et al., 2025) (Cortés & Marginean, 2022) while women with SMI experience poorer access to screening, higher cancer mortality, and inequitable menopause care. These patterns demonstrate how disadvantage accumulates across both the life-course and intersecting identities.

## Research and data

A fundamental structural barrier has been a historical lack of research and investment in women's health needs. Mental health datasets have not always been routinely disaggregated by sex, meaning that analysis may rely on gender-neutral averages that do not fully reflect women's experiences, potentially limiting the effectiveness and appropriateness of interventions (Howard et al., 2017).

Disaggregated data is also essential for identifying broader intersectional differences including sexual orientation, gender identity, race, disability and socioeconomic status, which further shape mental health outcomes. Without this, evidence generation remains inequitable, limiting scientific rigour and preventing the development of precise, safe and effective interventions that genuinely address women's needs. In addition, clinical trials have historically excluded women of childbearing age, meaning findings are not always readily generalisable to women.

## Diagnosis and treatment

Historically, women have been underrepresented in diagnostic frameworks and research. An example of this is the often missed or delayed diagnoses of neurodevelopmental disorders, including autism and ADHD amongst women and girls (Gellert et al., 2025; Martin et al., 2026). This can result in inappropriate care pathways, delayed access to treatment, and missed opportunities for early intervention. In conditions such as ADHD, treatment can significantly reduce risks of suicide, and substance use (Zhang et al., 2025).

Similarly, psychopharmacology has not always adequately accounted for women's physical states. Despite well-established sex differences in body composition and hormone transitions that influence drug efficacy and tolerability, prescribing guidance has historically been incomplete in addressing these differences across the life-course. This may affect clinical response and side effect profiles, with important implications for both mental and physical health outcomes.

## Leadership and coproduction

The absence of women's meaningful participation in leadership and coproduction has contributed to longstanding structural weaknesses in service design. As a result, services do not always reflect the realities of women's lives, which can leave some women feeling dismissed, or unsafe within the systems intended to support them. The continued lack of inclusive coproduction may undermine trust and reinforce structural barriers that limit the ability of services to meet women's needs effectively.

A lack of leadership that recognises and actively addresses these structural barriers can contribute to the persistence of systems that do not fully address the needs of women.

Lived experience can help highlight gaps and barriers to better care and how to address them. For example, a survivor led study of menstrual health in psychiatric inpatient settings in England found that basic needs were often not adequately met, including limited access to appropriate menstrual products, restrictions on their use, and a lack of privacy, contributing to distress and loss of dignity (Porter, 2025).

## Service design

Despite clear evidence of gendered differences in how women access care and the barriers they face, systemic gaps are further illustrated by the way services have historically been designed.

Early Intervention in Psychosis (EIP) services, for example, had initially been designed around age ranges that reflect earlier onset patterns more typical in men, potentially limiting access for some women whose onset occurs later in life (Brand et al., 2026).

Inpatient services including forensic settings and Psychiatric Intensive Care Units (PICUs) have not always been designed with women's specific needs in mind. Evidence highlights gaps in the provision of gender responsive care, including limited consideration of reproductive health needs such as menstruation and menopause, and the importance of privacy and dignity (Porter, 2025; Archer et al., 2016). Provision of specialist services tailored to women also remains variable across the system (Archer et al., 2016).

Despite women in inpatient psychiatric care being more likely to present with histories of trauma, and often having complex social, reproductive and safety needs, these are not consistently integrated into service design. While outcomes for women with SMI are recognised to be comparable to those for men over the long term, current service models do not always reflect these needs.

Differences in help-seeking and service design mean that women may not always access care at the point of greatest need. This is notable given that women with conditions such as schizophrenia experience long-term outcomes and readmission rates broadly comparable to those of men.

At the same time, reduced inpatient capacity has resulted in limited specialist provision for women, with expansion of trauma informed and community based alternatives not always keeping pace with demand. The absence of services that are consistently trauma informed, neurodivergent aware and gender responsive has important consequences for safety and quality of care.

*"I have worked on inpatient units with no supply of sanitary products and have had to go to the shops myself to buy pads for patients with psychosis on their period."*

**— RCPsych member survey (2024)**

## Safety in inpatient settings

Sexual violence is not confined to the community; without sufficient attention to safety, it can occur within mental health and learning disability inpatient services. The Care Quality Commission has identified sexual safety as a significant concern in these settings, highlighting the need for urgent system-level action to better protect patients (Care Quality Commission, 2018).

Women accessing mental health services are disproportionately likely to have experienced domestic and sexual abuse. Inpatient services must therefore prioritise privacy, dignity and proactive measures to ensure safety and prevent further harm. Implementing best practice in sexual safety is essential, including initiatives such as the RCPsych National Collaborating Centre for Mental Health's National Sexual Safety Collaborative (NCCMH, 2020).

Sexual safety is also a critical issue for the workforce. Healthcare staff, including doctors, report experiencing sexual violence both within and outside of work settings, alongside barriers to reporting and disclosure. National initiatives, such as the NHS England Sexual Safety in Healthcare Organisational Charter have been developed to address these risks and support a safer working environment (NHS England, 2023b).

*"Women using our services have so often had repeated trauma experiences that have resulted in the very need for them to seek help.  When we don't prioritise women's safety it is not just an omission of care, but we replicate and further harm."*

— **Dr Philippa Greenfield**

## Case Study: Sexual safety in inpatient settings – insights from RCPsych's Culture and Care programme

*"What made the experience especially damaging was that it happened within a psychiatric ward. I had been detained there for my own safety, yet I felt trapped and terrified, with no way to escape. When I tried to report what had happened, the staff did not believe me, and I felt too ashamed to tell my family. The memory of that night remains deeply ingrained in my mind and continues to affect me. For a long time, I believed I was alone in this experience, but through peer support spaces I discovered that others had gone through similar harm. I hope stronger measures are put in place so that incidents like this never occur."*

## Case Study:  Privacy and dignity for women in inpatient services

Anita was 25 when she was admitted to a mixed-sex acute ward while experiencing psychosis. During this time, she believed that God was punishing her because she felt ashamed for not sharing the gospel. She interpreted this as a command to remove her clothes, so that she would feel as ashamed of herself as she believed God felt about her. As a result, she undressed and walked into the mixed-sex lounge.

Staff did not attempt to cover her. Instead, both male and female staff restrained her and returned her to her room. A female staff member asked, "Why are you doing this, Anita?", but Anita did not respond. She returned to the lounge without clothes on two more occasions, and each time staff restrained her and took her back to her room. Eventually, a staff member was stationed outside her room to prevent her from leaving.

Reflecting on the experience later, Anita said: *"When I recovered, I felt deeply ashamed about what had happened. No one ever asked me about it at the time, and it has never been addressed in my care since. I believed I was the only person who had ever behaved this way."* She has since learned that this kind of disinhibition can occur when people are unwell, as she was. *"We need to talk more openly about this to reduce the shame. I am also still surprised that simple measures such as single-sex wards are not consistently in place in mental health services, as they could greatly improve safety, privacy, and dignity for women."*

The inpatient environments designed to support women are frequently not trauma-informed and too often lack the safeguards required to provide safe and appropriate care. Supporting privacy, dignity and safety must be core principles of service design and individual care planning.

## Education and Training

*"I have never received any training re impact of perimenopause/menopause on mental health; this would be helpful. I work in an over 65 service, but when I worked in a community team, I would sometimes receive referrals for women in their early 50s with concerns about cognition. In retrospect, I have wondered if a proportion of these referrals related to perimenopause symptoms, but I did not recognise this at the time."*

— **RCPsych member survey (2024)**

Professional training does not always fully account for differences in how health conditions, including mental health conditions, present in women and men. Evidence from a Royal College of Psychiatrists member survey suggests that almost half (45%) of psychiatrists feel their clinical training has not adequately prepared them to deliver high-quality care for women and girls. (Royal College of Psychiatrists, n.d.) These gaps may contribute to differences in diagnostic assessments and care. (McKinsey Health Institute, 2024).

Women may also experience delays in diagnosis in some conditions, and there is growing recognition that medical education and clinical frameworks can unintentionally reinforce gendered and intersectional biases that shape how symptoms are interpreted.

# The Cost of Inaction

## The economic cost of inaction

Mental ill-health carries substantial economic cost. In 2022, the Centre for Mental Health estimated that the overall cost of mental ill-health in England was approximately £300 billion, reflecting a combined burden of healthcare need, reduced economic participation and reduced quality of life among people living with mental health difficulties (Frederico Cardoso and Zoë McHayle, 2024).

While these costs affect society as a whole, women bear a distinct and often underestimated share of the burden. The economic consequences of women's mental ill-health extend well beyond individual health outcomes. Care costs are frequently absorbed across families, particularly where women carry primary responsibility for caring for children, older relatives or disabled family members (McKinsey Health Institute, 2024). When women's mental health needs are unmet, the resulting impacts ripple across households, services and the wider economy.

Data suggests that for every £1 invested in obstetrics and gynaecology services, up to £11 could be returned per woman in England through reduced health costs, improved productivity and wider social benefits (Bridget Gorham and Olivia Langham, 2025). Closing the gender health gap could generate almost £39 billion in annual GDP in the UK by 2040 (Sarah Graham, 2024).

Despite this, underinvestment remains a persistent barrier. In 2024, an RCPsych survey on women's mental health found that inadequate funding was identified as the most significant factor preventing services from delivering good quality care for women and girls, with one in four psychiatrists naming it as the single greatest challenge (Royal College of Psychiatrists, n.d.).

There are wider labour market impacts of poor women's health. Women are significantly over-represented among those who are economically inactive due to long term sickness. Data shows that women spend 25% more time in ill-health (McKinsey Health Institute, 2024).

Failure to address the drivers of women's mental ill-health also carries substantial avoidable costs as a result of domestic abuse . Its impact extends far beyond individual suffering: the Home Office estimates that domestic abuse costs society £66 billion in a single year in England and Wales (equating to around £85 billion in 2024 prices. Domestic Abuse Commissioner, 2024), with £47 billion attributed to the physical and emotional harms on victims particularly the emotional harms (the fear, anxiety and depression experienced by victims as a result of domestic abuse), which account for the overwhelming majority of the overall costs (Domestic Abuse Commissioner, 2024; Oliver, Rhys et al., 2019).

## What Good Looks Like

A system that works for women recognises the realities of their lives, and must integrate physical and mental health care, alongside access to services, information and support that takes account of the wider determinants of health as part of a preventative, and for some, lifesaving approach. This must include specialist support for GBV, social care and welfare rights, as well as specialist community and peer support that reflect the local population served.

These services must be co-designed and developed with women with lived experience to ensure they are equipped to meet the needs that women present with. In practice, this means a system that is integrated, trauma informed, life course oriented and structurally equitable.

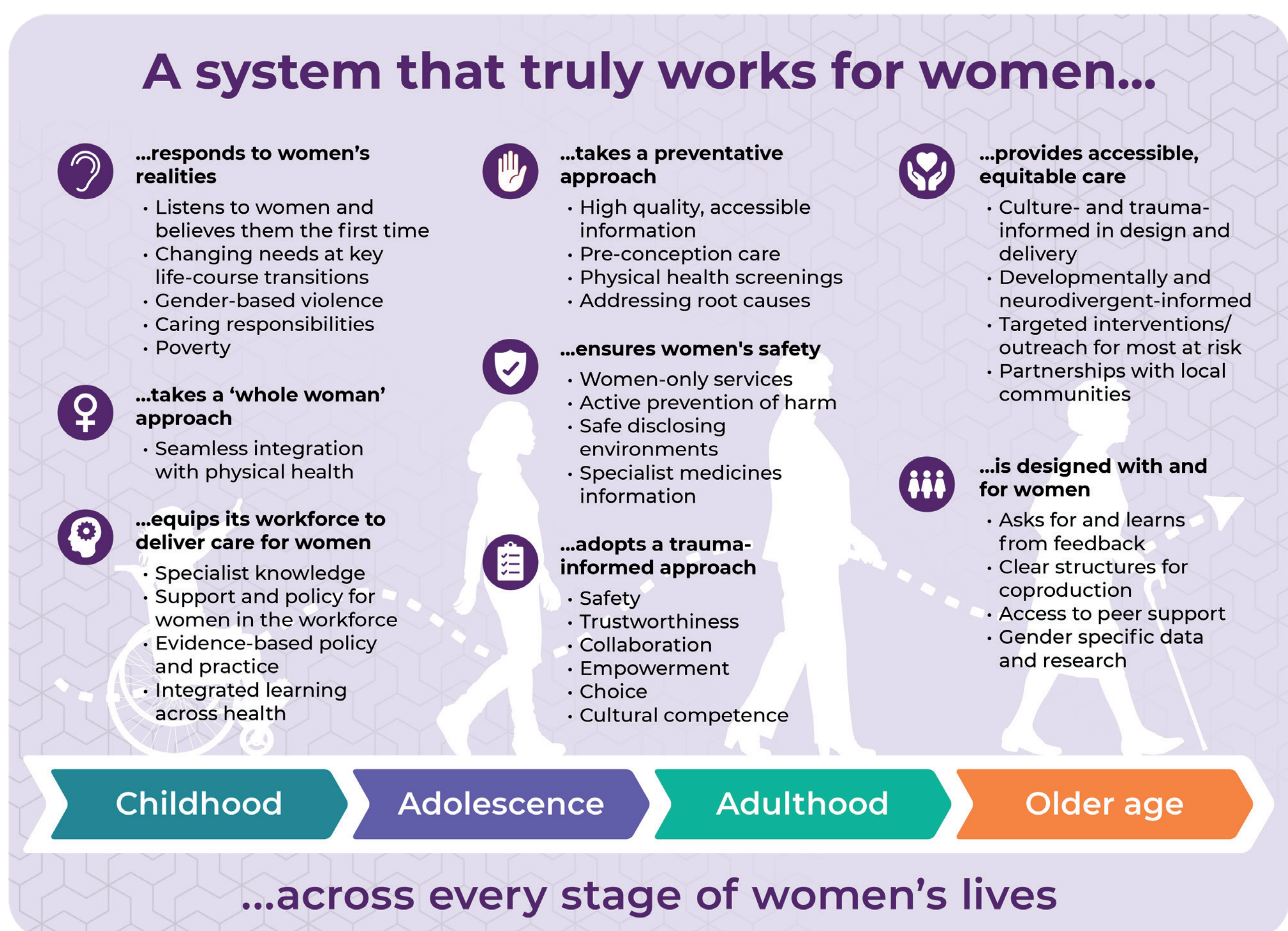


**Figure 2:** illustrates what an integrated, trauma-informed, life-course oriented and structurally equitable system looks like in practice.

In a system that gets this right, women are taken seriously when they first seek help. Their symptoms are not dismissed or minimised but understood in a non-judgmental way within the context of gendered experiences, including trauma, sexual, reproductive and hormone health, caring responsibilities, neurodivergence and socioeconomic inequality. Services should also create the psychological and physical conditions women need to disclose what is happening in their lives, enabling earlier support, better outcomes and greater trust in care.

## Life-course approach

Women accessing mental health and related health and social care services should receive a comprehensive, biopsychosocial assessment that routinely explores the key factors shaping their mental and physical health. This includes menstrual and hormonal health, pre-conception needs, physical health screening history, and experiences of gender-based violence.

**Figure 3:** outlines a recommended approach for assessing women's mental health needs.

Routine enquiry about domestic abuse should be embedded across care pathways and revisited over time, rather than treated as a one-off intervention, recognising that women with trauma histories, abuse, or longstanding mental ill-health often face significant barriers to accessing physical and mental healthcare. These factors should be explicitly integrated into formulation and treatment planning, and reflected in the design of accessible, joined-up pathways of care.

Women with mental health needs, particularly those with SMI or identified risk factors, should be proactively offered preconception care. This includes targeted interventions to reduce modifiable risks for poor health outcomes, including identification and response to domestic and sexual violence, support for substance misuse, contraception advice and pre-conception planning, and medication advice for pregnancy and breastfeeding, alongside wider modifiable risk factors such as smoking and diet.

This targeted approach should be embedded within community-based provision, including primary care services, emergency departments, sexual and reproductive health services, gynaecology clinics, maternity services, prison healthcare and homelessness services. It should also be included as part of a holistic psychiatric assessment in secondary care and inpatient mental health services, including as part of routine SMI health checks. This must be more than a paper- based pathway into mental health services. A more effective model should include embedding mental health care within Women's health hubs, enabling the delivery of integrated, person-centred care for women most at risk of both physical and mental ill-health.

Clinicians should adopt a developmentally and culturally informed, needs-adapted approach, with explicit consideration of the mental health effects of GBV, reproductive and hormone transitions, and the role of pre-conception care in improving long-term outcomes for women and their children.

Assessments must be accessible, trauma-informed and embedded within integrated local pathways. They should recognise the dynamic interplay of hormonal, social and structural factors shaping women's mental health, and ensure that enquiry about relevant experiences is routinely included and revisited across the care journey.

## Trauma-informed approach

A trauma-informed approach is grounded in an understanding of the role trauma exposure and adversity can have on mental and physical health, shaping neurological, psychological and social functioning across the life- course. For many women accessing mental health services, experiences of trauma are not isolated events but cumulative, intersecting with inequity, marginalisation and barriers to care.

While there has been progress in introducing trauma-informed initiatives within parts of the system, this approach has yet to be embedded consistently across the NHS and other parts of the health system. Too often, trauma-informed practice is treated as a frontline clinical intervention rather than a system-wide responsibility. Meaningful change requires leadership from the top, with trauma-informed principles across policy, commissioning, workforce development, clinical care and service design.

Without this system-wide approach, services risk unintentionally compounding harm. When the impact of trauma is not recognised or responded to appropriately, women may experience dismissal, exclusion or re-traumatisation within the very services intended to support them. These risks are more likely to affect women, those with pre-existing mental health needs and other marginalised groups, who are more likely to have experienced adversity and to face poorer mental and physical health outcomes.

Embedding trauma-informed approaches across the system not only supports the delivery of trauma-informed care but is also important to the wellbeing and retention of the workforce, recognising the prevalence of lived and vicarious trauma and helping to reduce burnout. Over time, a consistent, trauma-informed approach aligns with wider NHS priorities on prevention, patient safety, suicide reduction and addressing health inequalities. By enabling earlier, more appropriate support and reducing the risk of escalation to crisis, it also offers the potential to contribute to long-term cost savings and more sustainable recovery.

## Intersectional and integrated approach to data, research and evidence

A core priority is strengthening the data, research and evidence base. Routine sex-disaggregated data collection, inclusive research, and evidence-based interventions are essential to understanding women's needs and driving service and workforce development.

Urgent action is also required where harms are already well documented. This includes implementing national standards and governance frameworks to address sexual violence in mental health and learning disability inpatient settings, and acting on key findings from inquiries such as MBRRACE-UK, which highlight maternal suicide and deaths related to substance abuse, often in the context of complex social stressors including child custody loss. (Knight et al., 2025). Clear, actionable implementation guidance, alongside robust accountability and transparent reporting, is essential to preventing further avoidable harm.

Greater representation of women in leadership, alongside meaningful involvement of those with lived experience of mental health services is important in informing and shaping change. However, representation alone is not sufficient. Progress depends on clear recognition of the issues, robust use of data, and a willingness to act on evidence. As illustrated by gender pay gap initiatives, change does not occur by chance; it requires deliberate action, strong governance, and transparent metrics. Policies addressing the barriers women face in the workforce, including flexible training and caring responsibilities, must be implemented without delay.

Meaningful coproduction must be embedded across organisations, supported by clear structures that ensure women's voices shape policy, service design and evaluation.

Accessible, high-quality information on women's mental health is essential to enable informed decision-making and equitable access to care.

Services delivering mental health care to women should also demonstrate how they recognise and respond to women's needs in practice. Benchmarking, quality assurance and regulatory bodies should ensure accountability against key quality and safety indicators including accessibility, safety, dignity, access to appropriate health information, provision of menstrual products, consideration of caring roles, and zero-tolerance approaches to sexual violence.

# Conclusion

The evidence is clear. Women's mental health has too often been shaped by systems that were not designed for women or with women in mind. The result has been fragmented care, missed opportunities for prevention, and avoidable harm particularly for those facing multiple forms of disadvantage.

The finding that a substantial proportion of women with mental health problems have experienced or are experiencing GBV highlights a critical area for urgent and focused improvement.

This strategy does not call for marginal adjustment, but for a fundamental shift in how women's mental health is understood, prioritised and delivered. It sets out the key drivers of inequity, and the actions required to address them across policy, prevention, service design, the workforce and regulation. These actions are practical and achievable and must be taken forward as a coordinated whole.

Progress will depend on sustained leadership, shared responsibility, and clear accountability. National policy, local systems, regulators, funders and professional bodies all have a role to play. So too does the meaningful involvement of women whose experiences have too often been overlooked, but whose insight is essential to improving care.

Improving women's mental health is a shared responsibility. It is central to patient safety, public health, workforce sustainability and economic participation. The question is no longer whether change is needed, but whether it will be delivered with the urgency and consistency required. What matters now is action.

# Recommendations

Women's mental health must be treated as a core, system-wide priority, otherwise inequities in access, experience and outcomes will persist.

RCPsych is committed to bringing about improvement and taking action to address issues identified within this strategy – see separate RCPsych Women's Mental Health Matters Action Plan available on the RCPsych website.

The following recommendations set out five national strategic priorities calling on collective action to improve women's mental health across the UK. Each priority is supported by clear actions and identifies the range of stakeholders responsible for delivery, ensuring progress is intentional, consistent and accountable.

**1. National implementation of initiatives that lay the foundation for improvement in women's mental health.**

**2. Acknowledge and respond to gender-based violence as a major public health issue for women**

**3 Create safe, trauma-informed and therapeutic mental health services for women**

**4. Improve physical health outcomes for women with severe mental illness (SMI) and/or trauma histories**

**5. Support a workforce equipped to deliver women-centred care.**

# Priority 1:
## National implementation of initiatives that lay the foundation for improvement in women's mental health.

**AIM: To embed women's mental health into all policy, strategy and service planning at national level.**

## WHAT:

### 1.1 Embed mental health in women's health policy

- a) Integrate mental health, trauma awareness and intersectional considerations into the development and implementation of all UK national women's health strategies, including the forthcoming Women's Health Action Plan in Northern Ireland and existing strategies in England, Scotland and Wales.
- b) Ensure commissioning streams provide sufficient funding to enable the effective implementation of national women's health strategies across the UK.
- c) Ensure policies and their implementation reflect the needs of women with SMI, neurodivergence, and multiple intersecting disadvantages, including poverty, race/ethnicity and LGBTQ+ identities.
- d) Introduce Women's Mental Health Impact Assessments for all new national policies.
- e) Ensure appropriate psychiatric expertise informs national clinical guidance, particularly in relation to sexual, reproductive and hormone health and GBV.

### 1.2 Involve women with lived experience

- a) Involve women with mental illness and/or trauma histories in the design, implementation and evaluation of national policies and local services.
- b) Use trauma-informed frameworks to support collaboration and decision-making.

### 1.3 Deliver integrated, accessible health services for all women

- a) Expand the existing Women's Health Hub models in England, Wales and Northern Ireland (including within 'neighbourhood health' in England) through trauma-informed services that truly integrate physical and mental health care to ensure accessibility for women with SMI and/or trauma histories.
- b) Local systems, in particular Integrated Care Boards (ICBs) in England and NHS Trust/NHS Boards, should routinely collect and report on demographic data, and compare this against local population data to identify and address inequity in access and outcome.
- c) Maintain dedicated funding for specialist women's mental health services (e.g. perinatal mental health services) to protect against budget cuts.
- d) Expand maternal mental health services to ensure they support women who have experienced child loss, including perinatal loss and child removal.
- e) SMI health care checks should be expanded to address the inequity for women:
    - i) Checks should be routinely offered to women with SMI and/ or contact with mental health services and a trauma history.
    - ii) Checks should include key risk factors for poor health outcomes in women, alongside modifiable risk factors eg. Routine enquiry into domestic abuse, pregnancy planning and contraception.

### 1.4 Strengthen prevention and public health approaches

- a) Embed a public health approach to GBV within the implementation of all national health strategies.
- b) Include mental and physical health checks at key life-course transitions, including puberty, pregnancy, post-partum and menopause.

## WHO:

**Governments across the UK (health departments, HM Treasury, Home Office), Local Systems, National Health Services in England, Wales, Scotland and Health and Social Care (HSC) in Northern Ireland, Public bodies with responsibility for developing and publishing guidance i.e. The National Institute of Care and Excellence (NICE) and The Scottish Intercollegiate Guidelines Network (SIGN).**

## Priority 2:
**Acknowledge and respond to GBV as a major public health issue for women.**

**AIM: Ensure that health systems actively prevent and respond to GBV, reducing its long-term impact on women's mental health.**

## WHAT:

### 2.1 Improve 'sexual safety' for women in inpatient mental health services

- a) Record, report and review all incidents of sexual harm within services. In England, serious incidents should be classified as Never Events. Reporting processes should not require categorisation of harm as 'low, medium or high', as this risks minimising both the physical and psychological impact.
- b) Ensure all incidents of sexual violence (including harassment) in inpatient mental health services are reported as preventable patient safety incidents to the NHSE Learn from Patient Safety Events service (LFPSE), and equivalent systems in Northern Ireland, Scotland and Wales.
- c) Ensure robust scrutiny of this data, alongside clear action by organisations to respond to incidents and embed best practice.
- d) Ensure the prevention and response to sexual violence is a key quality indicator for healthcare regulators (e.g. In England, the Care Quality Commission (CQC) as part of Fundamentals of Care), and is reflected within standards for safety and safeguarding.
- e) Phase out mixed-sex Psychiatric Intensive Care Units (PICUs) in the UK, in line with the joint RCPsych-NAPICU statement (link to this), supported by capital investment and demand management guidance. This should act as a foundation for moving towards single-sex accommodation across all inpatient mental health and learning disability settings.

### 2.2 Embed specialist support in health services

- a) Commission the co-location of Independent Domestic Violence Advisors (IDVAs) in all secondary mental health settings to support safety and recovery. This should be supported by ring-fenced funding, and strong integration with third sector services and "by and for" specialist support organisations.
- b) Integrate fully funded, sustainable, trauma-informed GBV interventions within primary care, building on evidence-based programmes such as IRIS.

### 2.3 Address suicide and violence links

- a) Ensure a national focus on the interconnections between domestic abuse, trauma, suicide risk, and domestic homicide. This should include mandating local systems to develop a strong cross-sector response in relation to all domestic abuse related deaths.
- b) Improve data collection, ensuring domestic abuse data is collected as part of the mandatory mental health dataset and training on compassionate routine enquiry is consistently embedded within all holistic psychiatric assessments.
- c) Commit to a national suicide prevention strategy that truly reflects the risk factors for suicide in women.

## WHO:

**Governments across the UK (health departments, HM Treasury, Home Office), National Health Services in England, Wales, Scotland and Health and Social Care (HSC) in Northern Ireland, Local Systems, Psychiatric workforce, Health regulators (i.e. the CQC in England, HIW in Wales, HIS in Scotland and RQIA in Northern Ireland).**

## Priority 3:
**Create safe and therapeutic mental health services for women.**

**AIM: Ensure mental health services are trauma-informed, women-centred and responsive to life-course needs.**

## WHAT:

### 3.1 Deliver trauma-informed care

- a) Ensure all mental health services adopt trauma-informed principles, including safety, choice, collaboration and empowerment. Effective delivery will require clear system-level implementation, guidance and accountability frameworks, and prioritised by leaders at both national and local levels.

### 3.2 Provide specialist trauma pathways

- a) Establish trauma-specific services for women who have experienced GBV. Access to these services must be monitored and those experiencing intersectional, and therefore additional disadvantage, should be prioritised.

### 3.3 Targeted physical health pathways for women in inpatient and learning disability settings

- a) Develop clear local pathways that provide timely intervention to meet the physical health needs of women whilst in these settings. These pathways should integrate specifically sexual and reproductive health, obstetrics and (uro)gynaecology services.

### 3.4 Embed clinical safety guidance

- a) Implement Non-Fatal Strangulation and Suffocation (NFSS) guidance across all mental health services, with appropriate training to support effective implementation. Services should also ensure accessibility for all women, including consideration of caring responsibilities, menstrual health and experiences of domestic and sexual abuse.

### 3.5 Regulatory oversight and quality assurance

- a) Ensure regulators assess the adoption of trauma-informed approaches as a core element of service quality.

### 3.6 Research and evidence generation

- a) Prioritise data collection on issues that affect women's mental health eg. Mandatory collection of domestic abuse as part of the mandatory health dataset
- b) Routine disaggregation of health data and research to ensure safe and effective care for women and inform national policy and strategy in women's mental health
- c) Invest in key gaps in women's mental health in research which is representative of women's real lives.

## WHO:

**National Health Services in England, Wales, Scotland and HSC in Northern Ireland, ICBs, Health regulators (i.e. the CQC in England, HIW in Wales, HIS in Scotland and RQIA in Northern Ireland), Research funding bodies (including UK Research and Innovation, Health and Care Research Wales, the National Institute for Healthcare and Research, the Wellcome Trust and charitable funders), Psychiatric workforce.**

# Priority 4:
**Improve physical health outcomes for women with SMI and/or trauma histories.**

## AIM: Ensure women with SMI and/or trauma histories receive equitable, integrated physical and mental healthcare.

## WHAT:

### 4.1 Embed trauma-informed approaches across systems

• a) Ensure trauma-informed frameworks are implemented across health and related public services to support integrated care for women with co-occurring mental and physical health conditions.

### 4.2 Life-course health checks

• a) Ensure routine NHS health checks are delivered at key hormone and life-course transitions, including reproductive milestones and menopause, and include specific assessment of mental health.

### 4.3 Equitable access to screening

• a) Establish national targets and trauma-informed pathways to improve uptake of breast and cervical cancer screening among women with SMI and/or trauma histories.

## WHO:

**Governments across the UK (health departments), National Health Services in England, Wales, Scotland and HSC in Northern Ireland, UK National Screening Committee (UK NSC), Local systems, Psychiatric workforce.**

# Priority 5:
**Support a workforce able to deliver women-centred care.**

**AIM: Build a sustainable, competent health workforce equipped to deliver trauma-informed, integrated care.**

## WHAT:

### 5.1 Grow and retain the psychiatric workforce

- a) Expand psychiatry and mental health training capacity, and address bottlenecks across medical education and training pathways.
- b) Implement flexible working arrangements and career pathways to improve recruitment, retention and progression of women within the workforce.

### 5.2 Education and training across the healthcare workforce

- a) Ensure workforce training includes trauma-informed approaches, compassionate routine enquiry, and integrated mental–physical healthcare.
- b) Ensure training is developmentally and culturally informed and addresses intersectional disadvantage.

### 5.3 Safe and inclusive workplaces

- a) Implement clear, system-wide action to address key workforce issues affecting women, including sexual harassment and sexual violence, domestic abuse (including support for those staff impacted by GBV), pregnancy, menopause, child loss, infertility, staff as carers. This should be supported by accountable leadership and the sharing of best practice.
- b) Adopt and Implement College standards on sexual safety, disability, retention and tackling racism.

### 5.4 Support women carers

- a) Identify and support women carers through policy and service frameworks, recognising the mental health impact of caregiving responsibilities.

## WHO:

**Governments across the UK (health and social care departments), Medical School Deans and teaching leads, Employers including NHS provider organisations.**

# Acknowledgments

This work has only been possible because of the College's strong leadership and its sustained commitment to tackling inequity, set within the wider landscape of the ongoing focus on women's health via national strategies and leadership.

We are grateful to:

- **Dr Lade Smith CBE**
- **Dr Philippa Greenfield**
- **Dr Catherine Durkin**
- **Dr Amrit Sachar**
- **Dr Raj Mohan**
- **Sonia Walter**
- **Corinne Bishop**
- **Ruth Adams**
- **Salimah Lalji**
- **Safiya Jones**
- **Koyin Fuwa**
- **Melanie Hargreaves**
- **Professor Louise Howard**
- **Professor Linda Gask**
- **Dr Sophie Behrman**
- **Dr Kate Womersley**
- **Sara Metz**
- **Toni Wakefield**
- **Emma Wakefield**
- **Emily Elson**
- **Verity Westgate**
- **Emilola Johnson**
- **Elisha McQueen**
- **Fiona Watson**

We would like to acknowledge and thank all who joined focus groups, stakeholder panels and shared their personal lived experiences. We also thank our growing network of equity champions, whose dedication to embedding an equity lens across all College activity has been invaluable.

We are grateful to Dame Lesley Regan, and Sue Mann for their support and collaborative input throughout the development of this document.

Our ambition is that this strategy provides solid foundations and supports lasting, systemic change in women's mental health.

# Appendix


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