The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Senate Standing Committees on Community Affairs

Issues related to menopause and perimenopause

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Advocacy and collaboration to improve access and equity

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Royal Australian and New Zealand College of Psychiatrists' submission

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The RANZCP has over 8400 members, including more than 5900 qualified psychiatrists (consisting of both Fellows and Affiliates of the College) and over 2400 members who are training to qualify as psychiatrists (referred to as Associate members or trainees).

Introduction

The RANZCP welcomes the opportunity to contribute to the Senate Community Affairs References Committee's (the Committee's) Inquiry into issues related to menopause and perimenopause (the Inquiry). This submission has been developed in consultation with RANZCP Committees, including the Section of Perinatal and Infant Psychiatry, and expert members, including Professor Jayashri Kulkarni AM.

The RANZCP has detailed its commitment to gender equity in its Gender Equity Action Plan.

Menopause will have an increasing impact on Australians as life expectancy at birth continues to grow. Along with other Western countries, Australia has seen slowing population growth and a long-term increase in the average age at which mothers first give birth,[1, 2] leading to an ageing population in which menopause will increasingly affect productivity and healthcare demand.

Menopause is a gender equity issue because women's health is under-researched, research inappropriately excludes female participants, and women are chronically underserved and underdiagnosed by medicine.[3] Troublesome symptoms of menopause, particularly mental health symptoms such as depression, anxiety and 'brain fog', are undertreated unnecessarily, and this together with the experience of menopause-related stigma and discrimination may cause suffering, relationship disruption, lost quality of life and productivity. Adverse experiences in menopause compound the economic and mental health disadvantage experienced by midlife women, who make up the majority of carers in the 'sandwich generation', who forgo earning potential to care for both children and ageing parents.[2, 4-6]

Some transgender and gender-diverse people also experience menopause. This group has inequitable access to healthcare and poorer health outcomes than average.[7] They need care that respects their identities, and more research is needed into how healthcare systems can serve them over their lifespans.

Noting the Terms of Reference for the Inquiry and the expertise of RANZCP members, this submission will primarily comment on:

> c. the mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support;

Where this relates to mental health, however, it may also touch on:

> e. the cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause, including specifically considering culturally and linguistically diverse communities and women's business in First Nations communities;
>
> f. the level of awareness amongst medical professionals and patients of the symptoms of menopause and perimenopause and the treatments, including the affordability and availability of treatments;

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Physiological and direct factors affecting mental health during menopause

Evidence increasingly shows the heightened prevalence of **depression, anxiety and suicidality** in perimenopause and menopause is caused not only by psychosocial factors, but by menopausal fluctuation of the major brain steroids oestrogen, progesterone and testosterone.[8-11] People with previous mental illness history, especially hormonal mental illness such as Pre-Menstrual Dysphoric Disorder (PMDD) or Post-Natal Depression (PND), are at higher risk.[11-13] Antidepressant treatment for menopausal depression has shown a low rate of improvement, but recent studies suggest hormone treatment may be much more effective, though further replication is required.[14]

Perimenopause also commonly involves **cognitive complaints** of deterioration in attention, processing speed and memory.[15] This may cause distress, disruption to relationships and productivity,[6] and loss of quality of life. Some research associates cognitive function loss in premature menopause with increased risk of dementia in later life.[16, 17]

The **physical symptoms** of menopause generally pass in time, but they will have adverse mental health effects if they sufficiently disrupt life function. In some cases there are severe long-term health implications where premature hormone loss goes unmanaged.[18] The subjective experience of suffering will be mediated by experience of shame or stigma around menopause, and by positive or negative or attitudes to ageing.[19-21]

Patients who experience **menopausal psychosis** are of special concern to psychiatrists – whether as a first episode of psychosis occurring in menopause, or those with pre-existing psychotic illness who experience reduced effectiveness of antipsychotic medications in menopause.[22-24] More research is needed on these effects and their management. Meanwhile, safe and effective care for people with psychotic illness continues to be compromised by severe workforce shortages in psychiatry and across the mental health sector, described in the RANZCP Australian pre-budget submission 2024-25.

Psychosocial and indirect factors affecting mental health during menopause

Menopause is a feature of ageing for all people with a uterus and ovaries, and research has shown that the experience of menopause is correlated with **positive or negative attitudes to ageing**.[20, 25, 26] Possible positive attitudes to ageing have been identified as generativity, gratitude, the presence of meaning and search for meaning.

Negative attitudes to ageing, by contrast, have been shown to be correlated with accumulated life adversity [25, 27] – which for women can often include acquiring elder-care responsibilities in midlife.[3, 25] Logically it can be expected that people who experience the **negative social determinants of health** will be more vulnerable to negative experiences of menopause.

Negative experiences of menopause also arise from the internalisation of **stigma and discrimination** – such as social beliefs that devalue older women or restrict women's role to child-bearing.[19, 26, 28, 29] Efforts to improve attitudes to menopause in the community should take care to note the great variety of cultural specificities in Culturally and Linguistically Diverse (CALD) [30-33] and Aboriginal and Torres Strait Islander communities.[34]

People with more severe mental illness will be at higher risk for medical failure to diagnose menopausal depression, menopausal psychosis or other adverse effects of menopause, due to diagnostic overshadow, as well as the same social determinants that cause poorer physical health in this group than the general population.[35] Improving diagnosis of perimenopause and menopause in this group would assist in meeting the aims of the Australian National Mental Health Commission's Equally Well Consensus Statement.

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Availability and understanding of therapies

Menopausal Hormone Treatment (MHT) received significant negative publicity in Australia in 2002 due to a now largely discredited American study that claimed hormone therapy increased risk for breast cancer and cardiovascular disease.[36] However, clear criteria for risk screening are now available when prescribing MHT. For patients who have no identified risk factors at screening, failure to prescribe MHT for significant mental or physical ill health at menopause is now considered higher risk than prescribing it.[36] Many doctors and many patients continue to hesitate over MHT.[11, 37-39] Both public and medical education are needed.

Accessibility of MHT is significantly hampered by cost of medication, with many medications and delivery methods not subsidised by the Pharmaceutical Benefits Scheme (PBS).[40] This prevents access by low-income women and gender-diverse people, who are on average already more medically and psychologically vulnerable, and creates an unjust economic burden for those who can and do pay. Australian supply of transdermal MHT medicines has also been compromised by recent shortages and discontinuations,[41] leaving consumers without access to the form of MHT that is medically most safe and suitable for them.

Non-hormonal medications and treatments for menopause are also underprescribed and underutilised, perhaps due to spillover from MHT's poor reputation, but perhaps also as part of menopausal women's feelings of self-stigma.[39] In an environment of hesitance towards medically proven therapies, unproven claims are made for so-called natural substances (for instance, compounded bioidentical hormones[42]) and complementary medicine practices. Increasing the volume of valid scientific research in this area would help protect patients from unproven and unregulated treatments, while potentially also uncovering evidence for new treatments.

Severe workforce shortages in psychiatry and across the mental health sector, as well as shortages in the general health and primary care workforce, will continue to make it difficult for Australians to access diagnosis and treatment. The RANZCP's recommendations for growing the psychiatric and wider mental-health workforce are available in the RANZCP Australian pre-budget submission 2024-25.

A special population: transgender and gender-diverse people and menopause

People who have a uterus and ovaries will experience menopause, with the effect modified by any gender-affirming hormone treatment being used. People using female hormone treatment who withdraw from this treatment will experience menopause-like symptoms.[43]

It is important that messaging around menopause respects the gender identities of this group, as described by RANZCP Position Statement 103: The role of psychiatrists in working with Trans and Gender Diverse people. Framing of menopause as only a women's health issue risks causing dysphoria and a reluctance to engage with needed treatment.[44]

The long-term health effects of gender-affirming hormone treatment need more research, so that health systems can better support transgender and gender-diverse people over their life spans.[43]

The RANZCP's recommendations

- All relevant medical specialties should screen for perimenopause or menopause when people with a uterus and ovaries, who are within the predicted age range for menopause, present with mental health difficulties. Equally, they should screen for mental health difficulties when diagnosing perimenopause or menopause. A possible tool is the Meno-D.

- All medical specialities likely to encounter perimenopause or menopause should receive education regarding latest evidence on mental ill-health and suicide risk in menopause, and the suitability and safety of MHT as a treatment option upon risk screening.
- The Australian Government should consider fast-tracking the approval of more MHT medicines for PBS subsidy, and take steps to improve security of the supply of this key class of medicines for Australians' mental and physical health.
- The general public should receive education against menopause stigma. This education should consider encouraging positive attitudes to ageing and midlife, consider gender inclusiveness for trans and gender-diverse people, and promulgate up-to-date information on menopause medication safety and encourage accessing medication when needed.
- The Australian Government should make menopause a medical research funding priority.
- The Australian Government should continue to act urgently to grow and retain the mental health workforce.

Further information

The RANZCP thanks the Senate Standing Committees on Community Affairs for the opportunity to provide this submission on issues related to menopause and perimenopause. If you have any questions or wish to discuss any details in this submission further, please contact Nicola Wright, Executive Manager, Policy, Practice, and Research via or on .

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