# Submission of evidence to DHSC consultation on the Women's Health Strategy (June 2021)

**Introduction and Overview**

The Mental Health Foundation (MHF) vision is for a world with good mental health for all. Our mission is to help people understand, protect and sustain their mental health. Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place.

We welcome the government's call for evidence to inform the development of "a landmark government-led Women's Health Strategy, to improve the health and wellbeing of women across England and place women's voices at the centre of their care". In this submission we focus on women's mental health experiences and needs, which we consider should be central to any women's health strategy. The body and the mind are indivisible, and any strategy aiming to bring about genuine change in how women's health is regarded, supported and improved must be holistic, and take a 'whole person' approach to health.

It is also important that the women's health strategy should take a public health approach and encompass primary, secondary and tertiary prevention and maintaining recovery for women with mental health problems.

The evidence we are submitting in this response is survey evidence from MHF's Our Personal Experience Network (OPEN) members (see below), and evidence from our two longitudinal studies of the impact of Covid-19 on adolescents' and adults'/women's mental health.

**Note on OPEN and survey methodology**

Everybody has mental health, good or bad, and everyone has personal experiences we need to understand. The MHF Our Personal Experience Network (OPEN) is a diverse online community of people who want to contribute their views to help us in working towards our vision of good mental health for all. It comprises more than 3,000 adults around the UK who can easily be called upon to inform our work, through anything from quick feedback on a social media post, to fully participating in a research project.

At 6pm on 28th May 2021 we shared an adapted survey for OPEN members self-defined as women and living in England. This remained open until midday on 2nd June and received 174 responses. Our survey was shorter than the government's 'official' women's health survey, with more emphasis on mental health, rather than on health in general. This was to facilitate responses from people interested in this area and to draw out nuances and detail which might be lost in the more general consultation survey.

It was introduced as: *'A survey asking about your experiences as a woman which impact on your mental health (including life experiences and physical health), your views and experiences of mental health support/information, and some demographic information about yourself. Your response will inform our submission to the government's [Women's Health Strategy (England) Call for Evidence]. We are submitting evidence to help ensure that women's mental health, and the prevention of mental health problems, are seen as an essential part of this new strategy.'*

This survey was intended as a consultation exercise to supplement and enhance the call for evidence being run by the Government, and to inform the Foundation's response to the call for evidence. **It was intended to prioritise the voices of women who are interested in mental health and to give them an opportunity to have a say, rather than as a formal research** exercise, like the consultation survey used by the government.

In some areas, responses were specific to women's experiences; in others, they would be more broadly applicable, but have been highlighted by women as key to their mental health and therefore still important as part of a Women's Health Strategy. We have included some direct quotes from respondents throughout our submission.

***[Note on respondents:*** OPEN focuses on those who have lower support needs to participate, meaning it is likely to include fewer individuals at very high levels of risk. In some places we have therefore provided further evidence to contextualise the views and experiences they have shared with us.

The OPEN community comprises people who want to contribute their views to help us in our mission of supporting good mental health for all. **It is not intended as a statistically representative sample of the UK population or of women in England. It is however likely to include many people with a personal reason to become involved in promoting good mental health, which might include their own struggles or those of someone they know.** We are working towards building as much diversity within the community as possible, including socioeconomic diversity. The majority of respondents to this survey were aged between 30 and 59. Detailed information on the demographic characteristics of the respondents is provided in **Annex 1].**

## SECTION A. 'OPEN' SURVEY FINDINGS

### Topic 1: Factors affecting women's mental health

#### *Interactions between mental and physical health*

There is abundant evidence that mental health affects physical health, and that physical health affects mental health.[1] Consistent with this, we found this to be a clear and strong relationship for survey respondents'. The vast majority (90%) said that their physical health affects their mental health either a lot (43%) or somewhat (47%). Likewise, 90% of respondents said that their mental health affects their physical health either a lot (47%) or somewhat (44%).

We listed a range of physical and sensory health experiences, conditions and disabilities, learning disabilities, and neurodiversity, and asked women whether any of them had ever made it harder for them to maintain good mental health, or had contributed to mental health problems. **Eight-five per cent** of women said that at least one of these experiences had impacted on their mental health. In order, these proportions of respondents cited each factor:

- Menstruation 41%
- Menopause 33%
- Other physical health problems or health conditions 29%
- Pregnancy or the first year after giving birth 25%
- A physical disability, or how society responds to it 19%
- Fertility pressures, infertility or perinatal loss 15%
- Contraception 12%
- Neurodiversity or autism, or how society responds to it 9%
- A sensory disability, or how society responds to it 5%
- A learning disability, or how society responds to it 3%

The most frequently mentioned (3+ mentions) 'other physical health problems or health conditions' listed included: pain (of feet, joints, neck), cancer, back problems, IBS (plus individual mentions of IBD and Crohn's Disease), weight, fibromyalgia, and skin conditions. When combined, there were also 5 mentions of other musculoskeletal issues (arthritis, bursitis, tendonitis and muscle stiffness). When combined, 4 people also mentioned reproductive health issues (Polycystic Ovary Syndrome [PCOS], endometriosis, hysterectomy).

**Key message: These findings indicate a strong need for a strategic approach to women's health that integrates mental and physical health, together with the need to pay greater attention to many 'women's' health issues.**

#### *Social, economic, cultural and personal factors affecting women's mental health*

[1] See for example: Naylor, C, Das, P, Ross, S *et al* (2016), *Bringing together physical and mental health: a new frontier for integrated care*, London: King's Fund.

We listed a range of potential life experiences, and asked women whether any of them had ever made it harder for them to maintain good mental health, or had contributed to mental health problems. **Ninety-eight per cent** of respondents said that at least one of the experiences had impacted on their mental health. In order, these proportions of respondents cited each factor:

*Relationship barriers, issues or breakdown* - 61%; *stress at work* - 61%; *pressure around looks and body image* - 60%; *social isolation or loneliness* - 58%; *my experiences in childhood* - 52%; *my lifestyle e.g. diet or exercise* - 50%; *financial pressures (e.g. having enough money for my basic needs, debt)* - 44%; *household pressures (e.g. balancing housework and my job)* - 38%; *violence or abuse* - 35%; *parenting and childcare pressures* - 28%; *fears about personal safety* - 26%; *academic pressures* - 26%; *other caring responsibilities (e.g. looking after an elderly or disabled person)* - 22%; *my housing situation - 18%; discrimination due to my gender* -14%; *discrimination due to another factor* - 14%; *the area(s) I have lived in* -13%; *Other* - 7%; *discrimination due to race/ethnicity* - 5%.

Nineteen per cent of women responding ticked 10 or more of these experiences as having an impact on their mental health; 71% ticked five or more.

The important 'other' difficulties mentioned were: bereavement (including by suicide), illness of a relative or loved one, neurodiversity of a relative or loved one, addiction, cultural loss/isolation and distance from loved ones, gender identity issues, workplace bullying, cultural norms/messaging about relationships, lack of progress at work, and medical negligence.

**Key message: While some of these issues *might* be over/underrepresented in our sample due to the nature of OPEN, these results demonstrate that women consider that a wide range of social factors have an impact on mental health. They also show the complexity of their lives, and that preventive action, support, advice and care is needed in a range of areas.**

**The need for trauma-informed care**

One of the areas we particularly wish to highlight is the impact of trauma on women's mental health, and the need for mental and physical health services to be trauma-informed. We support the excellent submission to this consultation from Agenda and Mind, which provides detailed insights and important recommendations in this area. Here, we wish to draw attention to the fact that 35% of respondents mentioned *violence or abuse* as a factor affecting their mental health, 26% mentioned *fears about personal safety* and 52% *my experiences in childhood*. These are all actual or potentially traumatising experiences. Discrimination related to gender (14%), race/ethnicity (5%) and unspecified other factors (14%) also feature in these results and for at least some respondents it is likely that these experiences will have been traumatic.

*Principles and approach of trauma-informed care*

Trauma-informed services put people before protocols and do not try to make women's needs fit into pre-specified boxes. Instead, they create a culture of thoughtfulness and communication, continuously doing their best to learn about, and adapt to, the different and changing needs of the individuals they work with. To do this, it is crucial that services are willing and able to engage with complexity. Trauma-informed care is most usefully defined in terms of ongoing processes, approaches and values, rather than fixed procedures. Four processes emerged from the research we did with Centre for Mental Health as being fundamental to trauma-informed care:

- **Listening:** Enabling women to tell their stories in their own words.
- **Understanding:** Receiving women and their stories with insight and empathy.
- **Responding:** Offering women support that is timely, holistic and tailored to their individual needs.
- **Checking:** Ensuring that services are listening, understanding and responding in a meaningful way.[2]

[2] Jo Wilton and Alec Williams (2019) *Engaging with Complexity: Providing effective trauma-informed care for women*. London: Centre for Mental Health and Mental Health Foundation for VCSE Health and Wellbeing Alliance.

These suggestions from our respondents illustrate well the need for such an approach:

*'A better awareness of CSA* [child sexual abuse] *in general, especially at the point of disclosure. Mental health professionals are quick to use the medical model and treat trauma with medication and labels. This delayed recovery for me. I needed specialist therapy, not medication.'*

*'More sensitive listening to women when they have gained the courage to speak to a professional and to give them the time to explore what could be going on for them.'*

***Factors contributing to mental health challenges for women***

Most respondents used this question to provide further insight into the (very often female-specific) factors and causes behind mental health struggles they had experienced.
There were 91 comprehensible comments in this area, some touching on more than one sub-theme. Many of the factors discussed were the same as those listed in our multiple-choice question (as above) – but there were some significant additions and nuances:

- Stress in many spheres of their lives at the same time (23)
- Discrimination and stereotypes (21)
- Violence, abuse, harassment and related fear (14)
- Workplace issues (12)
- Pressure around looks and body image (12)
- Menstrual and hormonal issues; contraception (11)
- Menopause (11)
- Pregnancy or the first year after giving birth (10)
- Confidence, assertiveness and self-esteem issues (8)
- Relationship issues (6)
- Fertility pressures or infertility (6)
- Parenting and childcare pressures (6)
- Physical health problems not being taken seriously (5)

Many commented on cultural norms and stereotypes and the impact these have on their mental health, and on how they are perceived:

*'As a woman I feel particularly insecure and anxious due to the societal double standard which causes women to be perceived as inferior, objectified and victimised by gendered violence and sexual crimes.'*

**Key message: The most notable theme to emerge here was the combination of different pressures: there was a strong sense that women are under stress in many spheres of their lives at the same time, as well as under pressure to perform well in each of them, or to live up to a certain 'image'.**

**Topic 2: Seeking support, accessing information, engaging with and listening to women about their mental health** ***(for listening, see also Topic 3 below & trauma section, above)***

***Sources of support:*** We asked people from which places in a list they would be most likely to seek support for their mental health, or issues impacting their mental health. Of those who had sought such support, the following proportions ranked each of the following in their top 3 support options:

Family/Friends/Partner - 68%; my GP - 55%; helplines/online support - 34%; other NHS services - 28%; private health services - 22%; charities - 22%; workplace support services - 14%; community support services (e.g. befriending, advice or drop-in centres) - 10%; religious groups or leaders - 5%; social care services - 3%; university or education provider - 2%.

***Access to information:*** 71% of people agreed that they had received or had access to enough information on mental health conditions; **22% disagreed** (6% did not know).

63% of people agreed that they had received or had access to enough information on how to prevent poor mental health or maintain their mental health; **28% disagreed** (9% did not know).
***Accessibility of support:*** We asked how accessible women think mental health support is in their area. 56% said it was either fully (5%) or somewhat (51%) accessible. 36% said it was either not very accessible (30%), or completely inaccessible (5%). Nine per cent did not know.

***Nature of response received:*** We asked how supportive people felt their employer/ university (if applicable) are in relation to their mental health. 56% said they were either very (28%) or somewhat (29%) supportive. 14% said they were either not very supportive (11%) or not supportive at all (3%). 18% did not know and 11% did not answer.

***Support: Listening to factors contributing to mental health concerns***
The Majority (88%) of our respondents had ever seen a health or care professional about their mental health – whether in relation to a specific problem or a more general concern e.g. stress.

Regarding their experiences with professionals, we asked these respondents how much they felt factors contributing to their problem or concern about mental health were listened to. The largest proportion, 39%, said that they had had mixed experiences depending on the person or the occasion; 39% said that they felt either very (24%) or fairly (16%) listened to about this; **22% said that they felt listened to about this either only a little bit (16%) or not at all (6%).**

***How do women think their experience of mental health is affected by their gender?***
We asked women 'How, if at all, do you think your experience of mental health or mental health problems is impacted by your gender/your identity as a woman? Please also consider whether your experience of mental health as a woman might be affected by other elements of your identity/experience (e.g. your ethnicity or sexuality).' There were 130 clear responses to this question. For those who felt their gender had had an impact on their experience of mental health comments fell broadly into two themes: *factors contributing to mental health challenges for women* **(91 comments)** and *attitudes to women's struggles, and experiences of seeking care* **(59 comments).**

Discussions about the intersections between female identity and other elements of identity and experience generally fell into two areas: different experiences of discrimination or stereotyping in the first area, and more general and nuanced experiences of attitudes to their mental health in the second:

*'As an Asian woman (from far east) living in a conservative area of England, it has been hard to keep my personal safety from unwanted attention from men and local people… e.g. verbal sexual harassment and hate crime, not showing understanding stance at all towards my ethnicity & cultural loss/isolation…'*

*'I'm transgender… living with self-rejection and for 20 years being in churches that made me believe my identity (which I was in total denial of) was evil. Believing you're a monster for existing doesn't aid mental health.'*

**Topic 3: Ensuring the health and care system understands and is responsive to primary and secondary prevention of women's mental health problems**

We asked what women thought could be done in this area **to help prevent mental health problems in women**. 113 people gave comprehensible suggestions (some more than one).
The most common themes mentioned (with number of mentions) were:

- Access/waiting times (34)
- Funding (23)
- Listening/attitudes (22)
- Better knowledge/training among staff or in research (21)
- More support/help/resources (6)
- Integrate physical and mental health (5)

Across the many different topics discussed, some cross-cutting topics were also evident: **psychotherapy** (11 references – often in relation to access and waiting times but also the types of therapy on offer) and **women's reproductive system/hormonal issues** (10).

**Key message: A life-course approach is clearly needed, to understand and respond to the risk factors for women's mental health at different times and stages of their lives:**

*'Perinatal mental health services in every part of the country and more Mother and Baby units.'*
*'More understanding that menopause affects mental health.'*

*'More understanding and empathy around woman's issues i.e. puberty, menopause, infertility.'*

However, some caution is also needed, as women's mental health is clearly affected by many other health issues not linked to their female biology. There should never be an automatic/immediate assumption that a woman's concern is linked to this; open-mindedness about its source is also vital:

*'As a woman I find it extremely offensive when asking for help my GP's first question basis was around menstrual cycles. It was very clear in my case that I had been through a huge trauma, and this was why I was suffering with my mental health. It had nothing to do with my being female.'*

**There were also references (24+) across many different themes** to a more nuanced approach to prevention of poor mental health, or paying attention to the causes of a problem **(including through better listening):**

*'There needs to be a greater focus on prevention and not just treatment once problems arise.'*

*'More diverse understanding of the contributing factors of mental health and a greater acknowledgement of individuals' experience.'*

*'… Mental health affects us all and everything, look after a woman's mental health and you'll find that less kids will need help because mum is able to cope and dads.'*

*'Not only offering CBT and listening to woman* [sic] *about how much of a struggle it can be juggling motherhood and work.'*

**Within the topic of access and waiting times** – which was very often connected to 'funding' - **psychotherapy was a notable theme** (8). Equity around the country was also mentioned:

*'Greatly reduce the waiting times and the number of sessions available. Six weeks-plus when your mind is in pain is not acceptable and there's no point having a fixed number of sessions as it might take several weeks for someone to feel comfortable enough to get to the heart of the problem or find themselves in the middle of dealing with an issue when everything shuts off.'*

*'I think more funding is needed to reduce waiting times to enable quicker access to primary services - delays can often cause difficulties to escalate into crisis.'*

**Within the theme of 'listening and attitudes'** were mentions of empathy, supportiveness, seeing people as individuals, and taking people/women seriously:

*'To have more empathy and not be condescending towards women (I have experienced this).'*

*'Staff to take women seriously. Listen to a woman the same as they would listen to a man.'*

**Within the theme of knowledge/training among staff or in research** were mentions of mental health generally, women's issues such as puberty, hormones, infertility, menopause, the menstrual cycle and

contraceptive options, and specific topics such as equality, the impact of abuse, and the microbiome. Other areas mentioned by smaller numbers included better publicising the support available, allowing more time for discussions, and general equality:

*'By listening to the sufferer and having enough time to.'*

*'Specific healthcare services for women. Regular compulsory training on equality and diversity with a robust follow up disciplinary approach. Create safer spaces for women. Whilst the therapist in hospital helped me with many emotions, there are many female specific areas they could open up and offer validating activities and talking groups that need to be planned and delivered.'*

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***Attitudes to women's struggles, and experiences of seeking care***

As well as discussing factors behind their struggles, many women also used this question to reflect on the way society as a whole, or in some case health services, had responded to their struggles or mental health challenges. There were 59 comprehensible comments in this area, some touching on more than one sub-theme. The themes in this area were very clear and striking. They often related to reasons for which women's mental health concerns might not be taken seriously. Some were closely connected, with slight nuances; others felt slightly contradictory (potentially reflecting double standards and/or the different experiences of the individual respondents):

- Women are expected to 'just get on' and to be able to cope with many stressors (18)
- Women are not taken seriously as they are deemed weak, oversensitive or overemotional (14)
- Lack of attention to female-specific causes of mental health problems (10)
- Some struggles are 'expected' or seen as normal for women (6)

The idea of **'just getting on with it' or being expected to cope** was often paired with the above-mentioned combined pressures facing women from many areas of their lives. It also often went hand in hand with an expectation that women put the needs of others above their own:

*'It feels like there is an expectation that I just have to cope with life's stressors, as there are many people depending on you.'*

The idea of **women being considered overemotional, weak or oversensitive** was in contrast to this but also powerful:

*'I finally got a diagnosis of Bi-polar at 56 years of age. I have often felt that my depression and anxiety was marginalised due to being a woman I was seen as being weird and overly excitable…'*

*'Seen as neurotic by GP and Practice Manager, feel ignored because I'm a woman.'*

**Topic 4: Workplaces and employers – maximising women's health in the workplace**

We asked what women thought workplaces and employers could do to help prevent mental health problems in women. 108 people gave comprehensible suggestions (some more than one). The most common themes mentioned (with the number of mentions in brackets) were:

Improve awareness and understanding by the organisation/managers (25); awareness, education or training – either for employees, or it was unclear for whom (21); attitudes generally or around MH (20); support systems (17); organisational systems and issues (13); flexibility, including working from home (11); equality and female representation (8); sick leave for mental health or menstrual/menopausal issues (6).

**Within the theme of 'awareness and understanding by the organisation/managers',** some suggestions (6) were around mental health and mental health problems; others (5) were around 'issues affecting women', including: caring, menstruation and menopause:

*'More training for managers to understand impact of MH on work life and output.'*

**Within the theme of 'attitudes',** some suggestions were around a generally empathetic and supportive approach (5), and others around positive attitudes to mental health (14), such as challenging stigma or promoting parity for mental and physical health:

*'Show that you care. Have empathy. Be open and share personal mental health struggles. Do not stigmatise people when they come forward.'*

*'Lifting of taboos, so that employees don't have to suffer in silence or lie about why they need a 'sick' day.'*

**Within the theme of 'support systems',** specific suggestions included MHFA (Mental Health First Aid) (9), and EAPs (Employee Assistance Programmes) (3):

*'Mental health First Aiders on site who check in with official bodies/wider services to ensure they have up to date information on signposting and good understanding of supporting those with MH issues.'*

**Within the theme of 'organisational systems and issues'** were actions such as reducing workplace challenges, such as stress (6), and dealing with managerial problems, abuse and whistleblowing (3):

*'Do not ignore your employees when they raise issues. Actively change things instead of paying lip service.'*

**Suggestions around 'equality and female representation'** were varied and included simply reducing discrimination and promoting equality, and more specific suggestions:

*'Actively work towards promoting a more inclusive workplace - stop the 'male banter' which makes some women afraid to speak up.'*

**Other areas** mentioned by smaller numbers included regular check-ins with staff, childcare, pay/internships, and good policies/strategies (e.g. on mental health, wellbeing, parental leave, menopause issues):

*'Regular supervision where mental health is explored. Recognising work pressures and the effect on MH and then putting support in place.'*

## SECTION B: MHF RESEARCH ON THE IMPACT OF COVID-19 ON MENTAL HEALTH

The MHF's ***Covid-19 Adolescent Study***[3] is conducted jointly by MHF and Swansea University with funding from MQ. We have collected three waves of data between August 2020 and March 2021. When adolescents were asked to rate their overall mental health, 80% of respondents said their mental health was excellent; very good; good or fair, and **18% said their mental health was poor**. Those who rated their mental health as poor **were more likely to be female** (22% v 14% for male); more likely to be an older teenager, especially aged 18 or 19, and more likely to have at least one parent who is unemployed. Questions about **suicide and self-harm** have only been asked of 16-19-year-olds, and this began in the third wave (February-March 2021). Eleven per cent of teenagers (4% of those aged 16-17, and 7% of those aged 18-19) said they deliberately hurt themselves once a day or more, nearly every day or a few times a week. Ten per cent of young people aged 16-17 had passing thoughts of suicide, which increased to 15% for 18-19-year-olds.

While these figures are for both young men and young women, not everyone in the population is at the same risk of self-harm. According to Agenda, self-harm is more common among people who face poverty and disadvantage, and this appears to be particularly the case for women, with young women living in the

[3] The survey is conducted by YouGov and reaches a representative sample of approximately 2,200 people aged 13-19 across England, Wales and Scotland

lowest-income households being five times more likely to self-harm than those in the highest-income homes.[4] A proportionately universal preventive approach would allow the most resources to be put into communities most at risk, including those from low incomes.[5]

We are also leading and sponsoring the ***Coronavirus: Mental health in the pandemic study****,* a four-nation longitudinal study using repeated cross-sectional surveys of a representative sample of more than 4,000 UK adults, via YouGov.[6] It covers approximately 20 topics, including the pandemic's impact on mental health and the key drivers of risk.[7] For women, we have found that:

- *Worry about the pandemic has negatively affected* 1 in 5 *women's sleep*
- *Half of women are anxious and worried* compared to 32% of men
- Women *(35%) are more likely* than men (24%) *to use alcohol as a coping mechanism*
- Women (66%) *are coping with stress of the pandemic slightly better than men* (62%)
- Women (50%) are *less able to cope with uncertainty* than men (34%)
- Women (30%) *appear to be more lonely than men* (22%)

For both men and women, we have found that our most vulnerable groups have struggled more over the past year, namely: **single parents, people with pre-exiting mental health conditions** and **people with long-term health conditions**. Their levels of anxiety and worry are higher than those of the general population (46%, 58% and 45%, respectively, compared to 42%) and they are also drinking and eating more to cope with the stress of the pandemic. However, it should be noted that 42% of the general UK adult population have felt more anxious and worried, while 19% of them have drunk more as a coping mechanism, and 36% have eaten more as a coping mechanism. These findings clearly have implications for a very significant number of women in the general population.

There are around 1.8 million single parents in the UK, making up nearly a quarter of families with dependent children; 90 per cent of single parents are women, and their average age is 39.[8] Their levels of anxiety and worry, and their coping mechanisms, are of concern not only for their own mental health and wellbeing, but for that of their children.

**Key message: The women's health strategy must take specific account of the impact of the pandemic on single mothers, women with pre-existing mental health conditions, and women with long-term health conditions.**

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***For further information about this OPEN survey, and/or MHF's two studies of the impact of the Covid-19 pandemic on mental health, please contact Lucy Thorpe, Head of Policy (LThorpe@mentalhealth.org.uk), or Policy@mentalhealth.org.uk.***

[4] Agenda & Natcen. (2020). Often Overlooked: young women, poverty and self-harm

[5] UCL's Covid Social Study has found that people from the lowest incomes have higher rates of thoughts about death and self-harm during the pandemic. Fancourt et al (2021) Covid-19 Social Study Results Release 30.

[6] More information on the study, copies of our briefings and highlights from each wave of data are available at: https://www.mentalhealth.org.uk/our-work/research/coronavirus-mental-health-pandemic

[7] Our lead academic partner is the University of Cambridge; others are Swansea University, Strathclyde University, Queen's University Belfast and De Montfort University Leicester. We have gathered 10 waves of quantitative data since March 2020, most recently in February/March 2021, supplemented by qualitative research to add insight and depth to our findings.

[8] Gingerbread briefing (Sept 2019): Single parents today in the UK; https://www.gingerbread.org.uk/what-we-do/media-centre/single-parents-facts-figures/

**ANNEX 1 - Demographic characteristics of our respondents**
All 174 respondents were living in England and identified as female/women. We know that OPEN members have a range of economic/financial situations, but not yet how this compares to the UK population. We also do not yet know whether education level or employment situation is representative. Certain particularly vulnerable or disadvantaged groups (e.g. very disabled people or those who do not speak English) are likely to be missing. People in OPEN are likely to have more of an interest and awareness around mental health than the overall population; they may also be more likely to have experienced mental health problems.

**Age:**

| | |
|---|---|
| 18-19 | 1% |
| 20-24 | 4% |
| 25-29 | 6% |
| 30-39 | 20% |
| 40-49 | 28% |
| 50-59 | 31% |
| 60-69 | 8% |
| 70-79 | 1% |
| 80+ | 0% |
| Prefer not to say | 1% |

**Sexuality:**

| | |
|---|---|
| Heterosexual/straight | 86% |
| Bisexual or pansexual | 8% |
| Homosexual/gay/lesbian | 3% |
| Queer | 1% |
| Prefer not to say, don't know, uncertain, questioning | 2% |

**Ethnicity:**

| | |
|---|---|
| White | 88% |
| Mixed/Multiple ethnic groups | 5% |
| Black/African/Caribbean/Black British | 3% |
| Asian/British Asian | 2% |
| Gypsy, Roma or Traveller | 1% |
| Other ethnic group | 1% |
| Prefer not to say | 0% |

**Region in England:**

| | |
|---|---|
| London | 21% |
| South East | 18% |
| South West | 14% |
| North West | 11% |
| West Midlands | 9% |
| East of England | 7% |
| Yorkshire & Humber | 7% |
| East Midlands | 7% |
| North East | 5% |

**Gender assignment:** only 1 person said that their identity as a woman was not the same as the sex assigned to them at birth; 1 person preferred not to say.