



Covid-19 Social Study

Results Release 27

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Executive summary

Background

This report provides data from the last 38 weeks of the UK COVID-19 Social Study run by University College London: a panel study of over 70,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this TWENTY-SEVENTH report, we focus on psychological responses to the first thirty-eight weeks since just before the UK lockdown was first announced (21/03 to 13/12). We present simple descriptive results on the experiences of adults in the UK. Measures include:

1. Reported compliance with government guidelines and confidence in the government
2. Mental health including depression, anxiety and stress
3. Harm including thoughts of death or self-harm, self-harm and both psychological & physical abuse
4. Psychological and social wellbeing including life satisfaction, loneliness and happiness
5. *****New in this report***** Knowledge of COVID-19, worried about family and friends, and social support

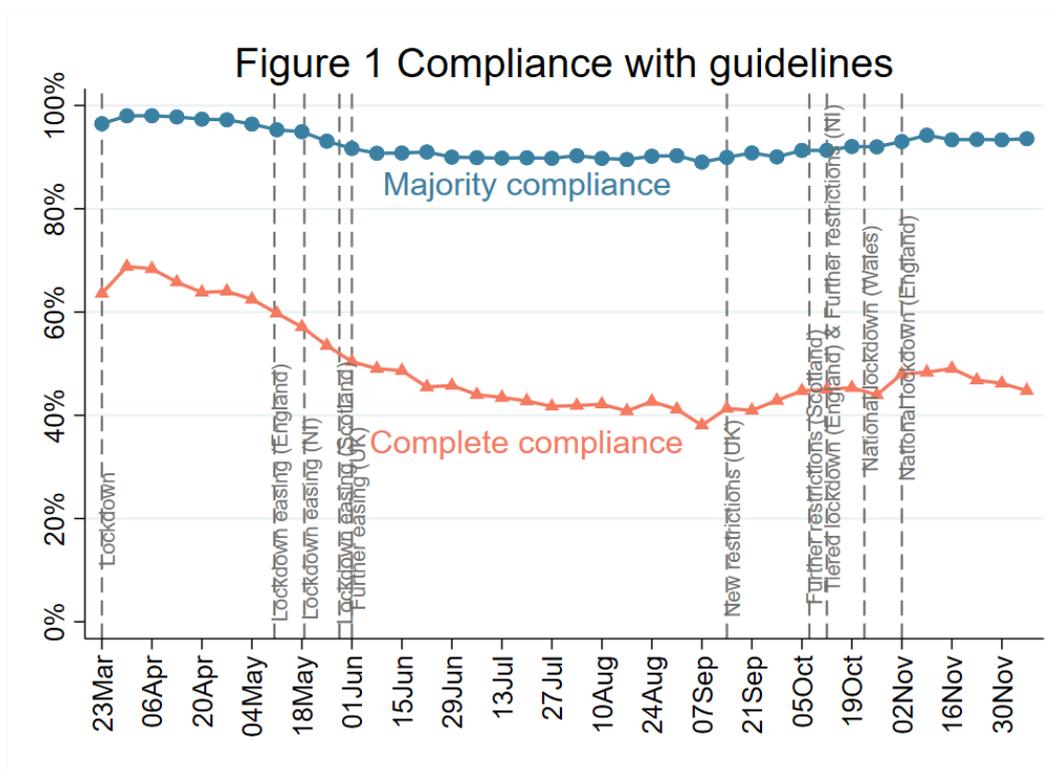
This study is not representative of the UK population but instead was designed to have good stratification across a wide range of socio-demographic factors enabling meaningful subgroup analyses to understand the experience of Covid-19 for different groups within society. Data are weighted using auxiliary weights to the national census and Office for National Statistics (ONS) data. Full methods and demographics for the sample included in this report are reported in the Appendix and at www.COVIDSocialStudy.org

Findings

- On average, self-rated knowledge about Covid-19 is relatively high and higher than it was in March when the first lockdown came in. Only 5% of people currently think they have very poor or poor knowledge (scores 1-3; down from 10% in March). The percentage who think they have good or very good knowledge (scores 5-7) has increased since March from 72% to 85%.
- Across the pandemic, self-rated knowledge has consistently been highest amongst adults over the age of 30 and slightly higher amongst people with physical health conditions, who may feel they are more at risk from the virus and therefore want to understand it more.
- At the start of lockdown, 67% of adults were worried about family or friends. Over the summer, these numbers decreased to around 43%. However, as virus cases have increased and new restrictions have been brought in, levels have risen again to 49%.
- Worries about family and friends have been higher amongst people with a diagnosed mental illness (61% currently worried vs 47% of people without a mental illness), women (59% currently worried vs 41% of men), younger adults, people with higher educational qualifications, people living with others, and people with a diagnosed physical health condition.
- Levels of social support have been relatively constant across the pandemic. There has been a slight increase since first lockdown, perhaps as people have been able to move around more and provide in-person support to others more easily. People living alone, with lower household income, and with a diagnosed mental or physical health condition have received consistently lower social support.
- Compliance with government rules to prevent the spread of Covid-19 increased across October and November as stricter measures were brought in across UK nations. However, as these have been eased in the past month, compliance has started to decrease again. Whilst people are broadly adhering to the rules, many appear to be making modifications.
- Patterns of compliance remain as they were for the last few months though, with compliance lower in higher income households, in England, in urban areas, amongst women, amongst people with a physical health condition, and amongst adults living with children compared to adults not living with children. However, younger adults have reduced the extent to which they were bending the rules over the past 3 months.
- Stress about catching Covid-19 or becoming seriously ill from it has decreased further in the past month. This might be assumed to be due to the national lockdown in England, but has also been seen in Scotland and Wales. This is despite the fact that cases are now increasing in many areas again.
- Measures of depression, anxiety, thoughts of death or self-harm, self-harming, abuse, life satisfaction, loneliness and happiness have remained stable in the past fortnight, although existing inequalities by gender, ethnicity, socio-economic position and diagnosed mental health conditions remain.

1. Compliance and confidence

1.1 Compliance with guidelines



FINDINGS

Respondents were asked to what extent they are following the recommendations from government such as social distancing and staying at home, ranging from 1 (not at all) to 7 (very much so). Of note, we ask participants to self-report their compliance, which relies on participants understanding the regulations. Figure 1 shows the percentage of people **across the whole of the UK** who followed the recommendations “completely” (with a score of 7) or to a large extent (with a score of 5-7; described below as “majority” compliance).

Compliance increased across October and November as stricter measures were brought in across UK nations. However, as these have been eased in the past month, compliance has started to decrease again.

Complete compliance has shown a small decrease over the past month across all demographic groups (Figures 2a-2l). However, majority compliance has stayed high and largely consistent across this period, indicating that people are broadly adhering to the rules, but with modifications (Figures 2m-2x). Notably, younger adults have increased their majority compliance over the past 3 months.

The patterns of compliance remain as they were for the last few months though, with compliance lower in higher income households, in England, in urban areas, amongst women, amongst people with a physical health condition, and amongst adults living with children compared to adults not living with children.

Figure 2a Complete compliance by age groups

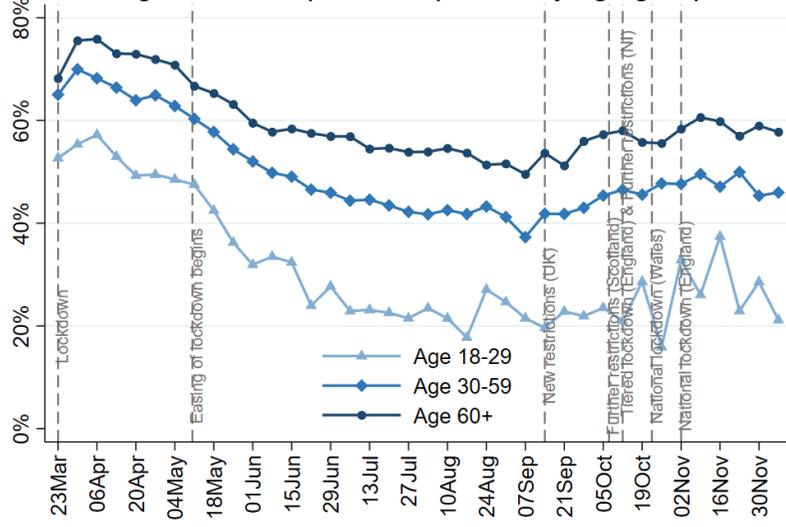


Figure 2b Complete compliance by living arrangement

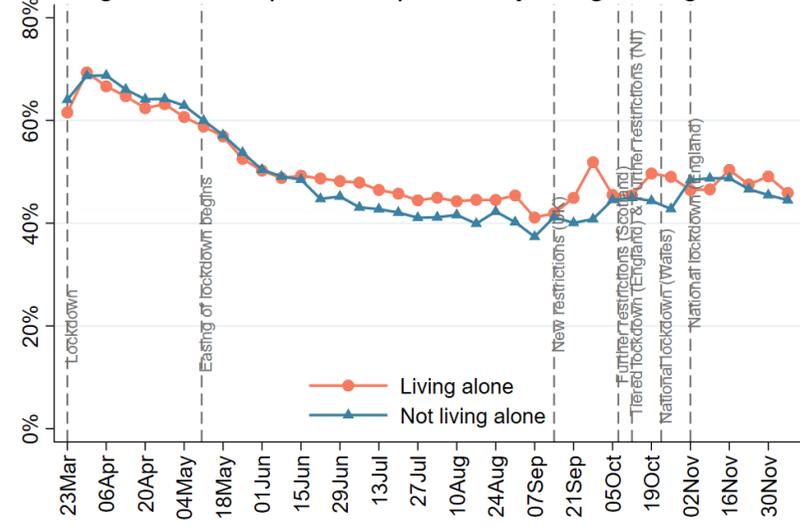


Figure 2c Complete compliance by household income

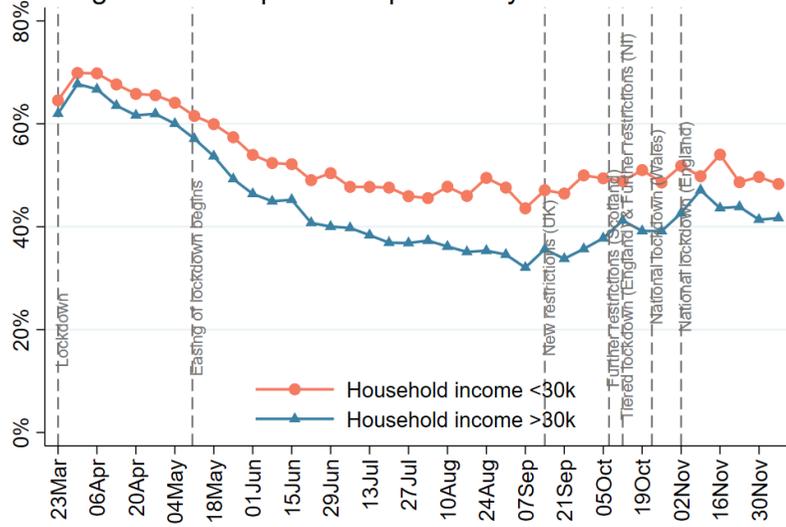


Figure 2d Complete compliance by mental health

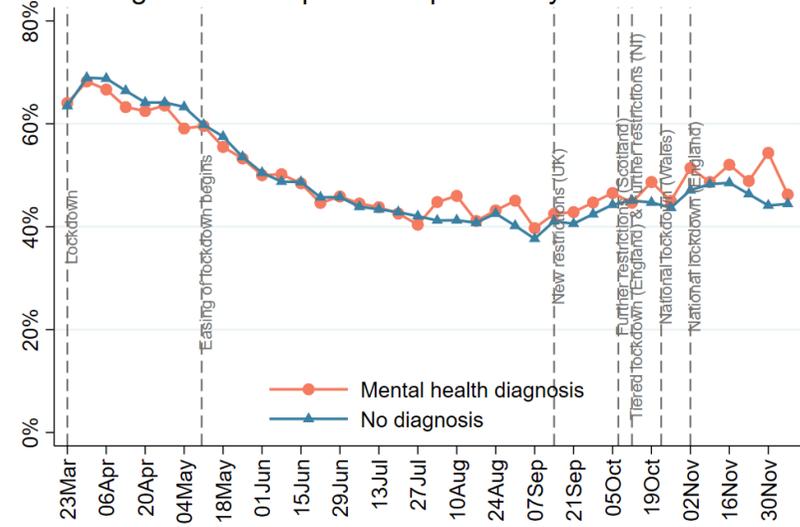


Figure 2e Complete compliance by nations

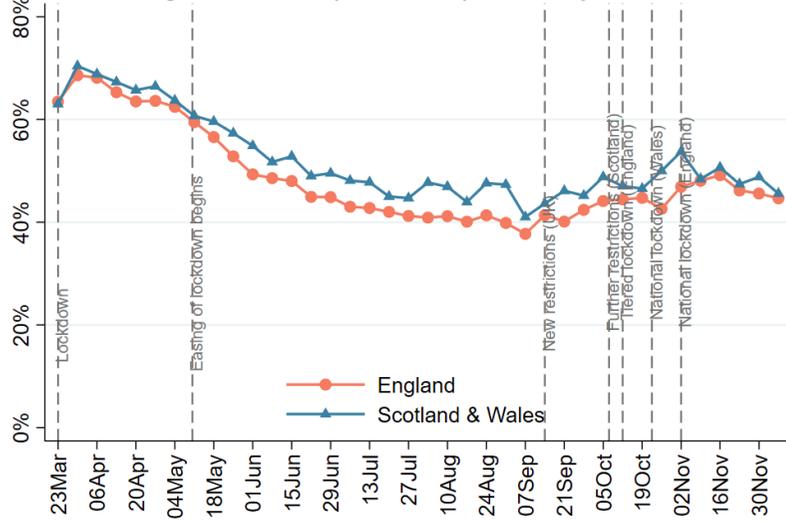


Figure 2f Complete compliance by keyworker status

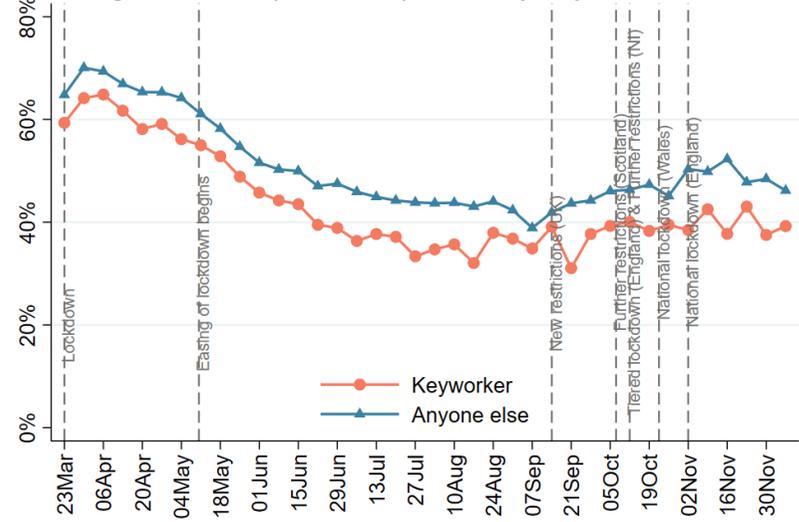


Figure 2g Complete compliance by living with children

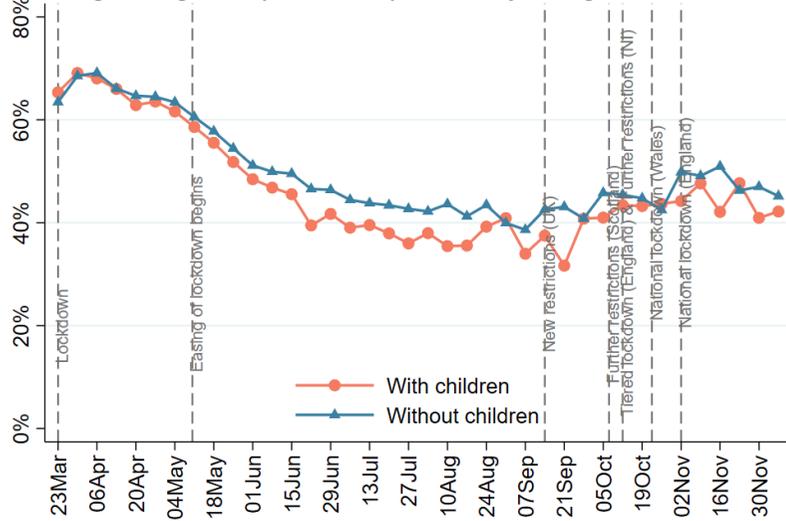


Figure 2h Complete compliance by living area

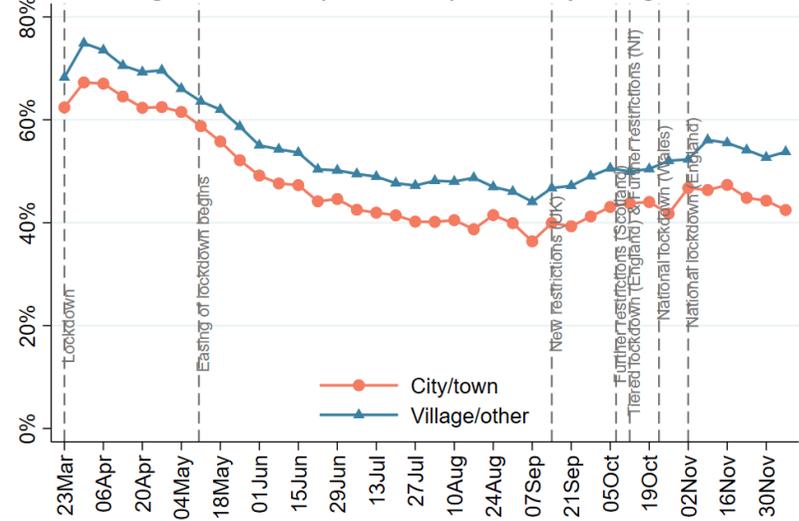


Figure 2i Complete compliance by gender

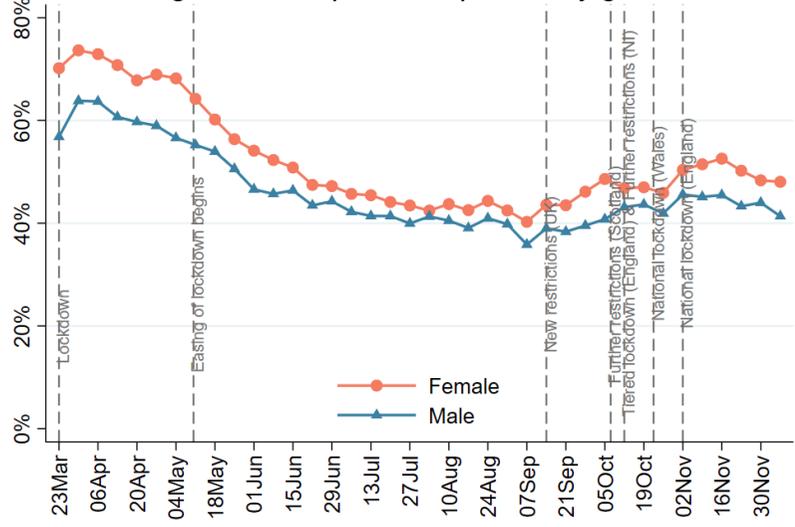


Figure 2j Complete compliance by ethnicity

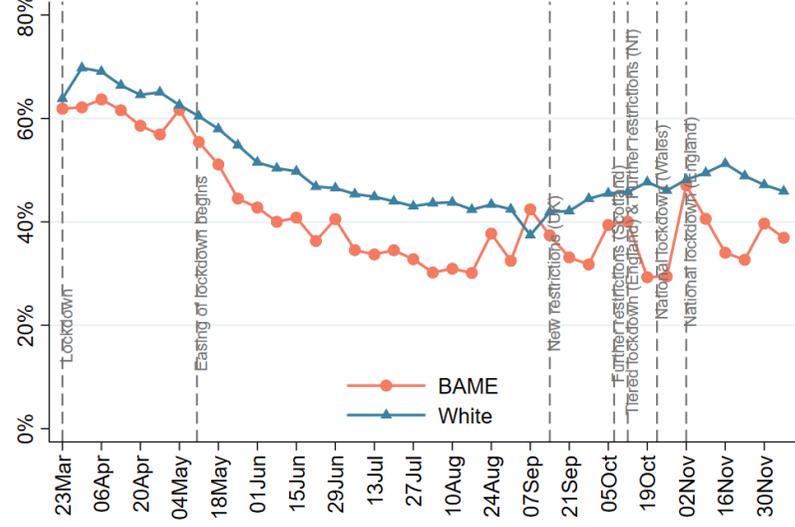


Figure 2k Complete compliance by educational levels

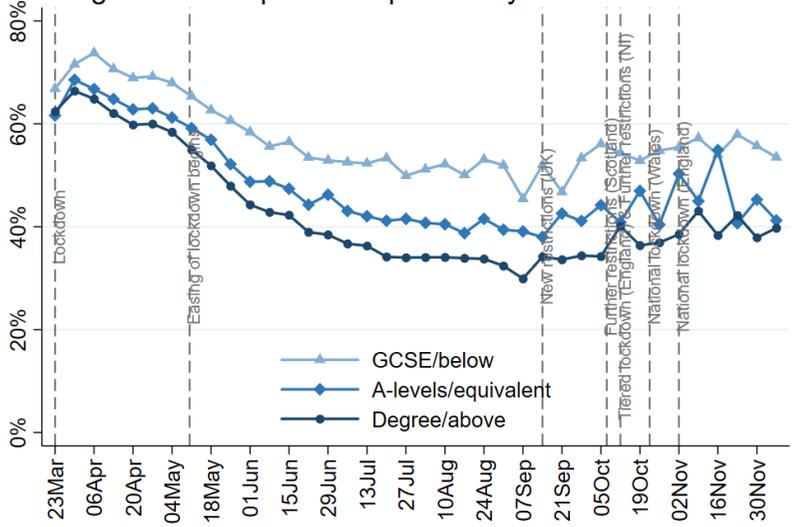
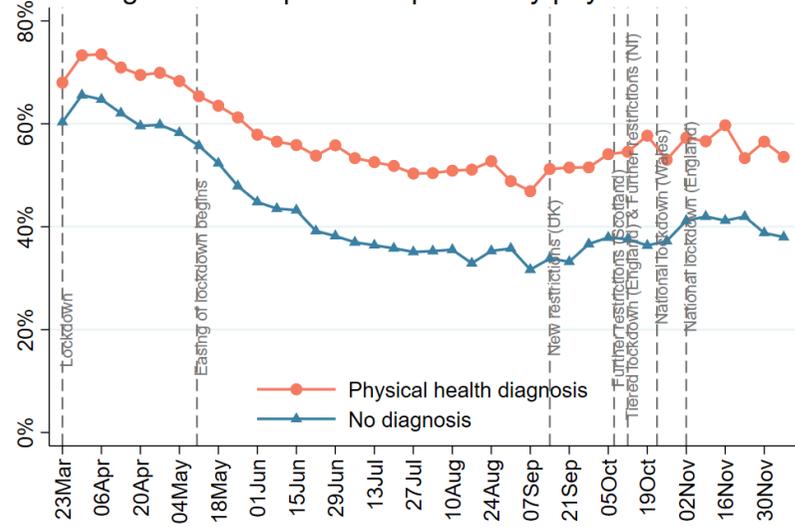
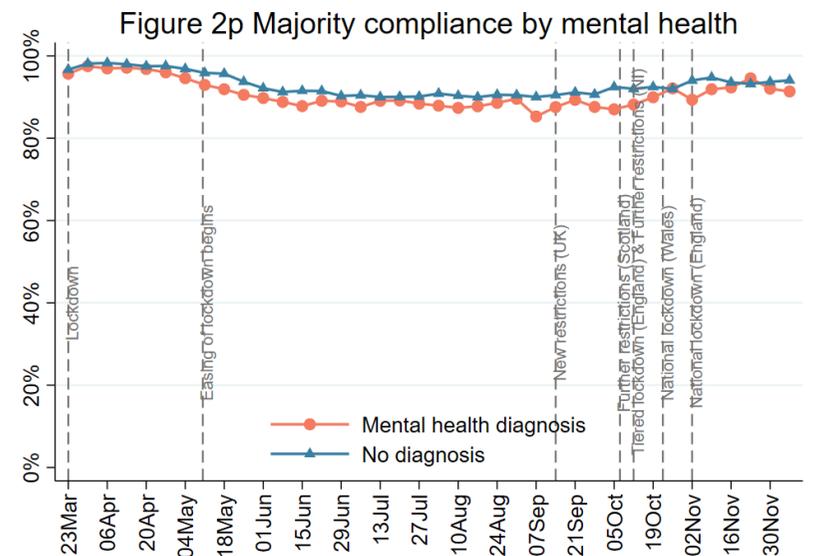
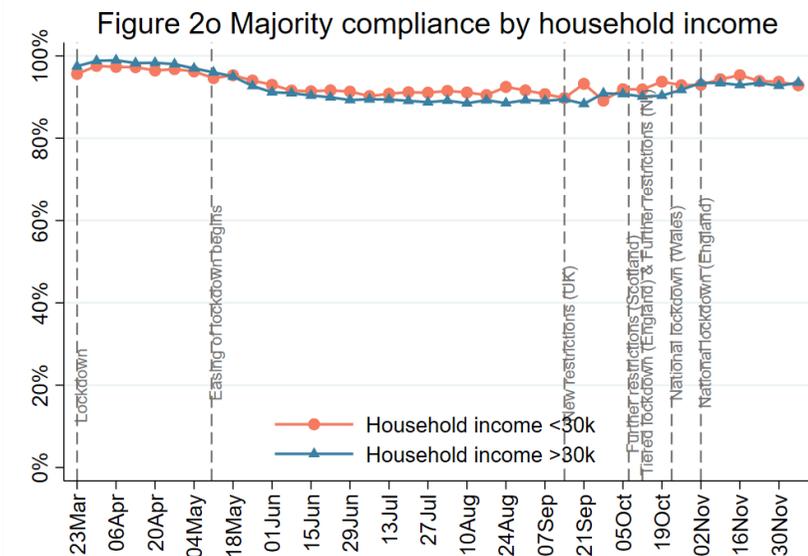
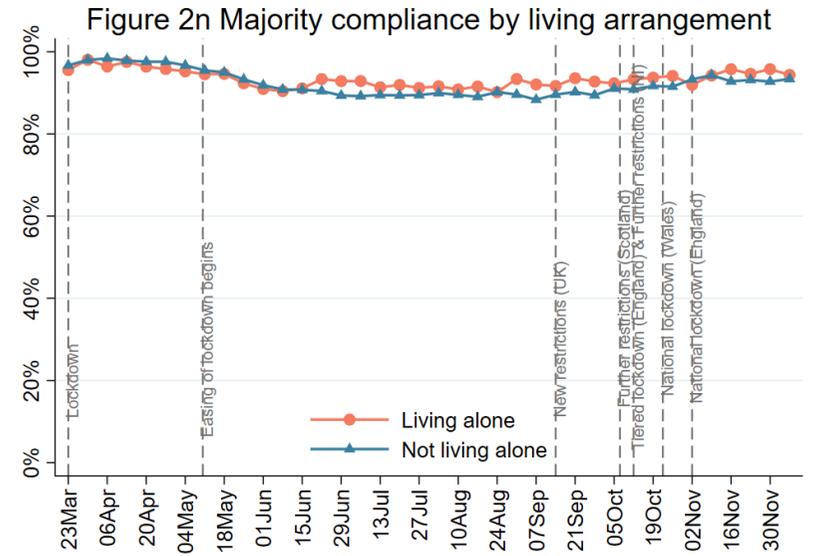
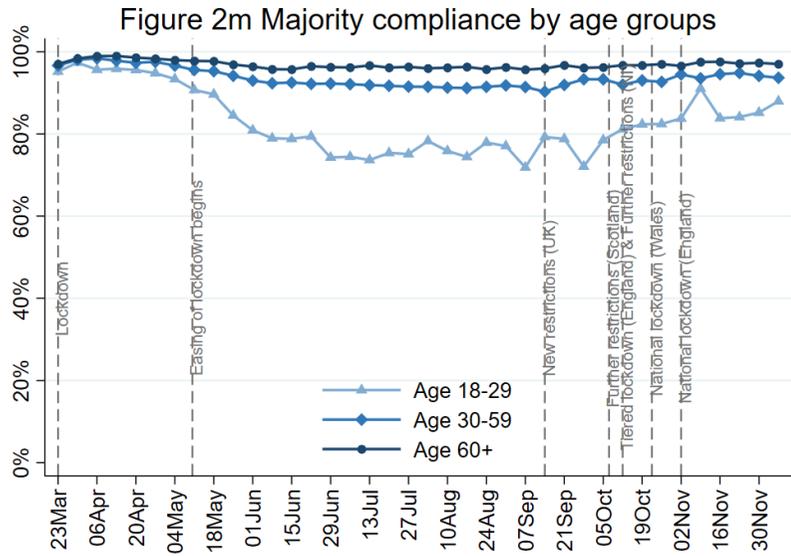
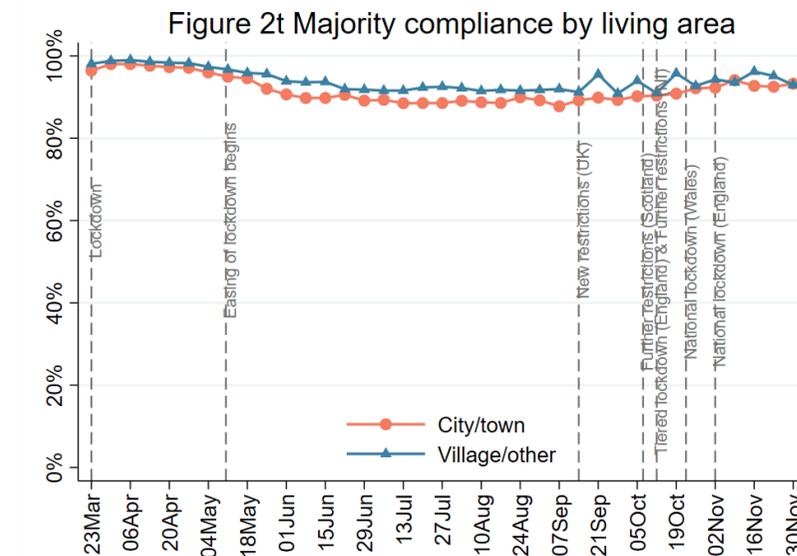
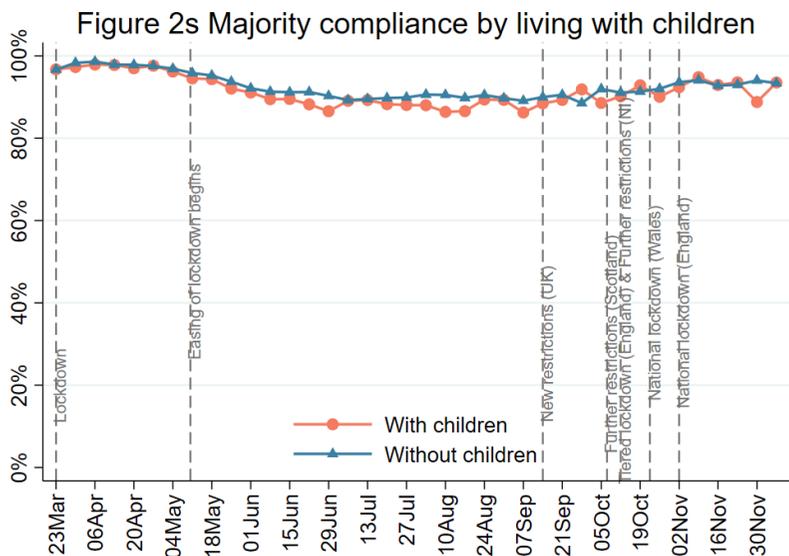
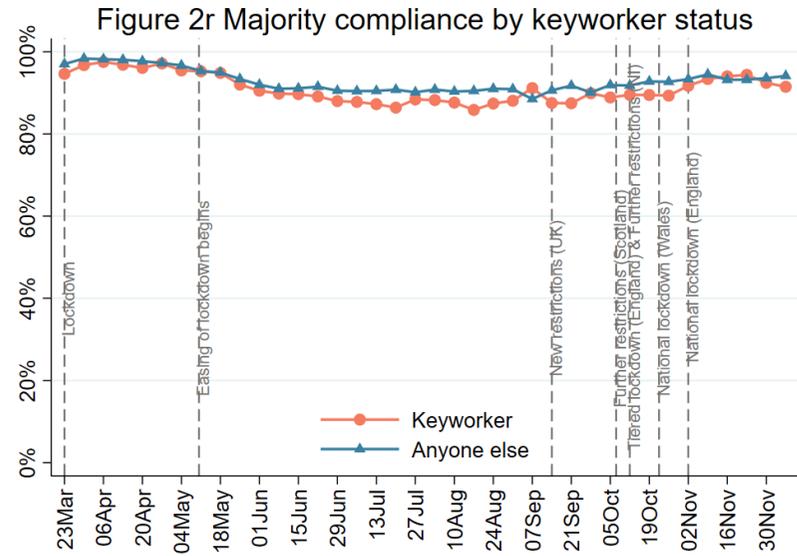
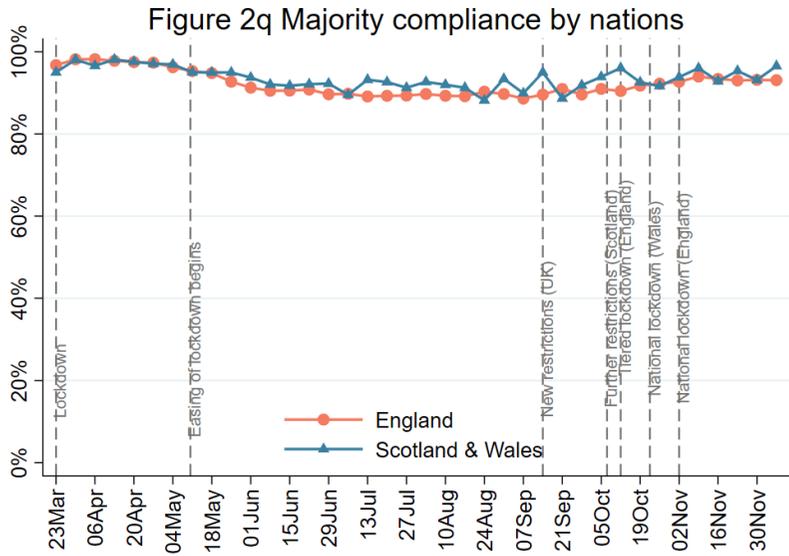
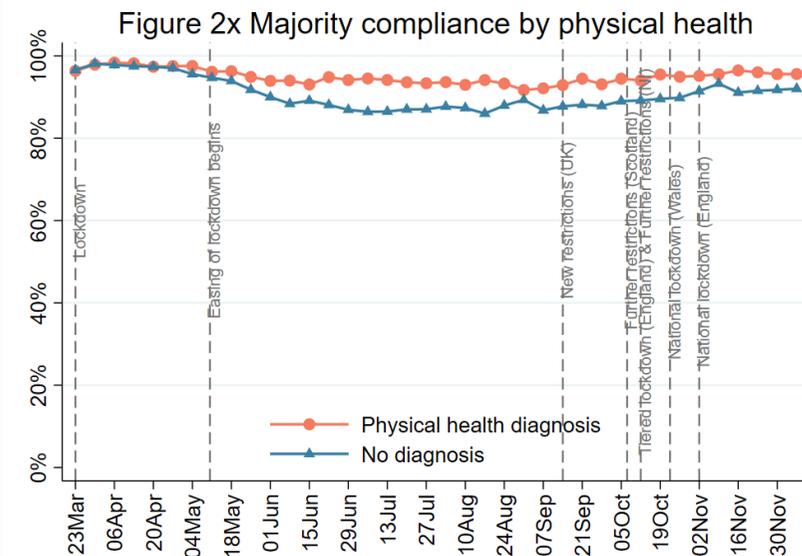
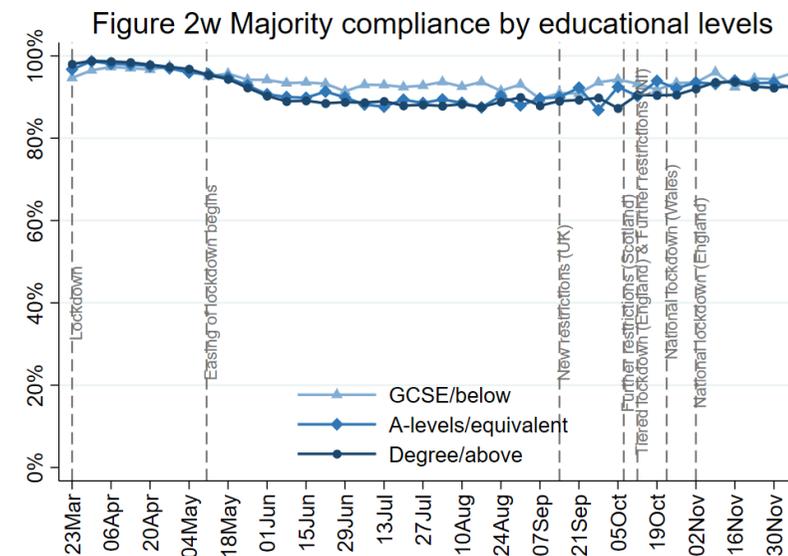
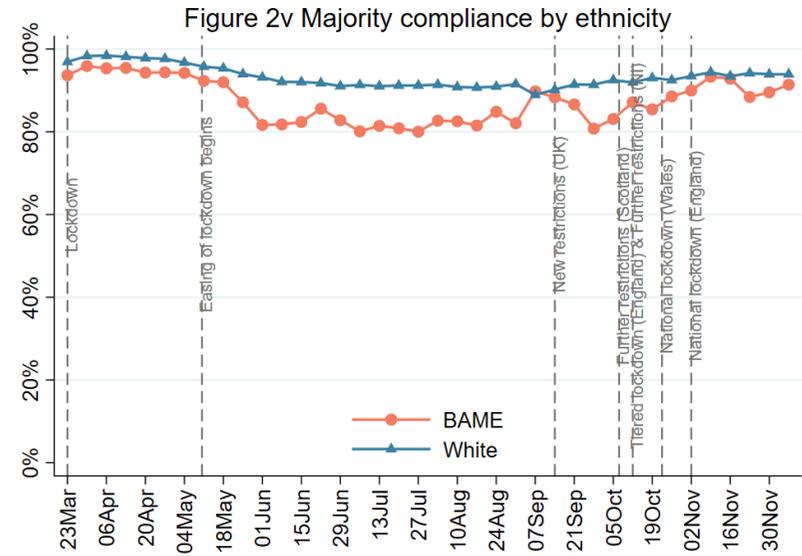
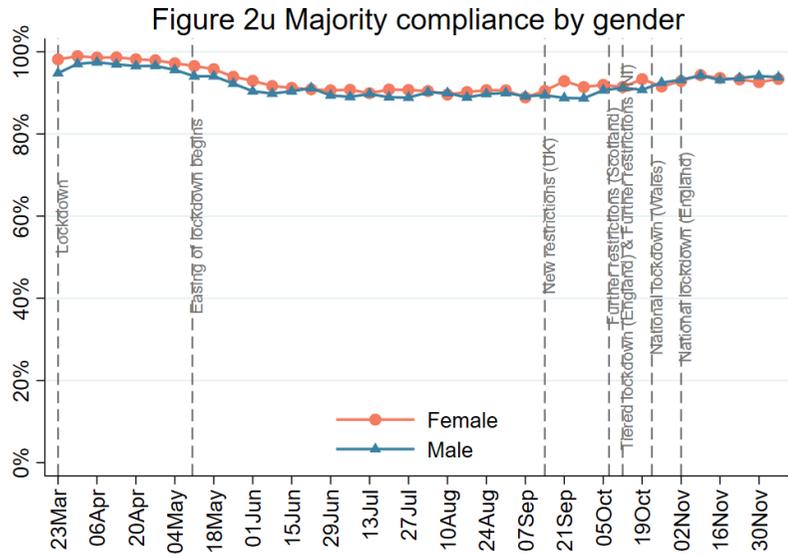


Figure 2l Complete compliance by physical health

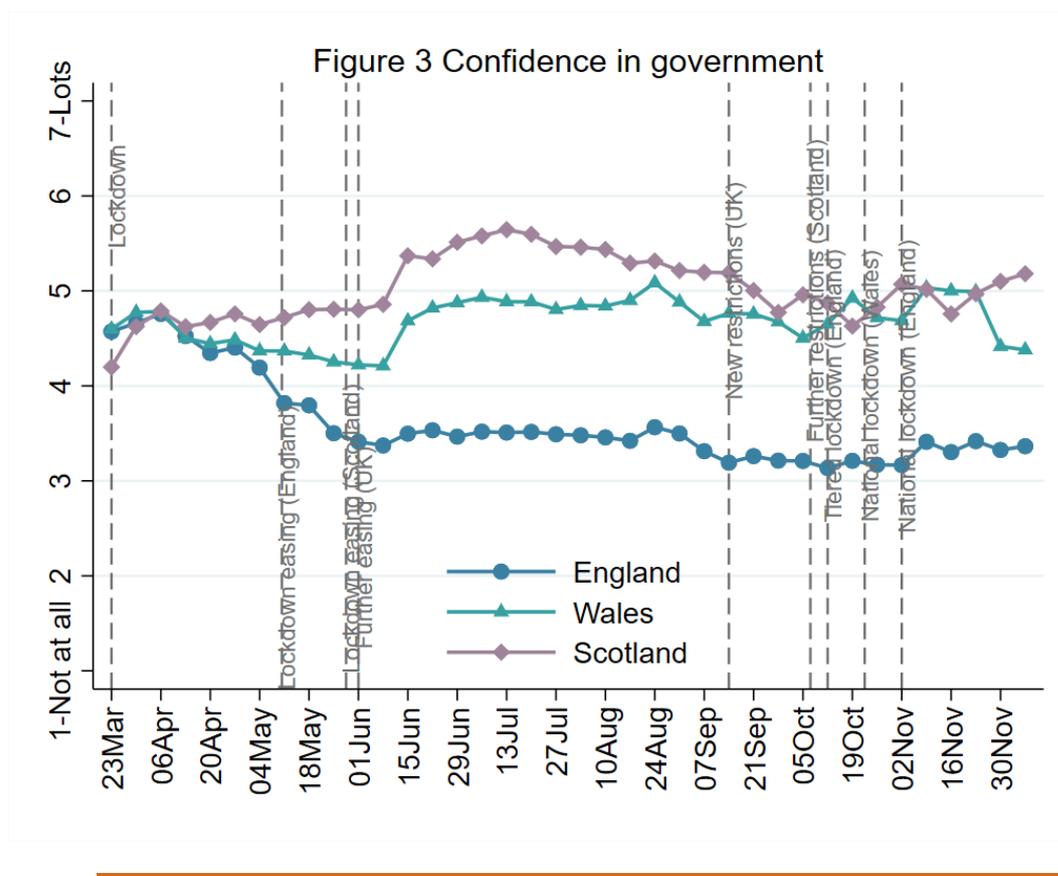








1.2 Confidence in Government



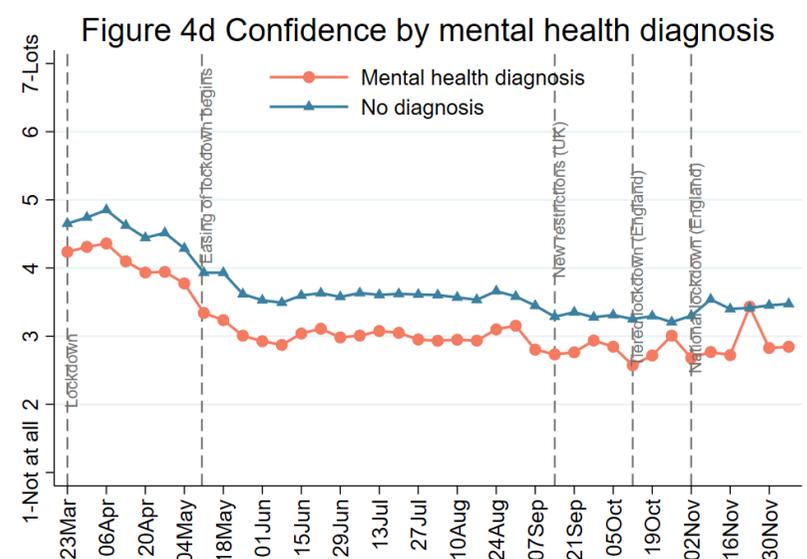
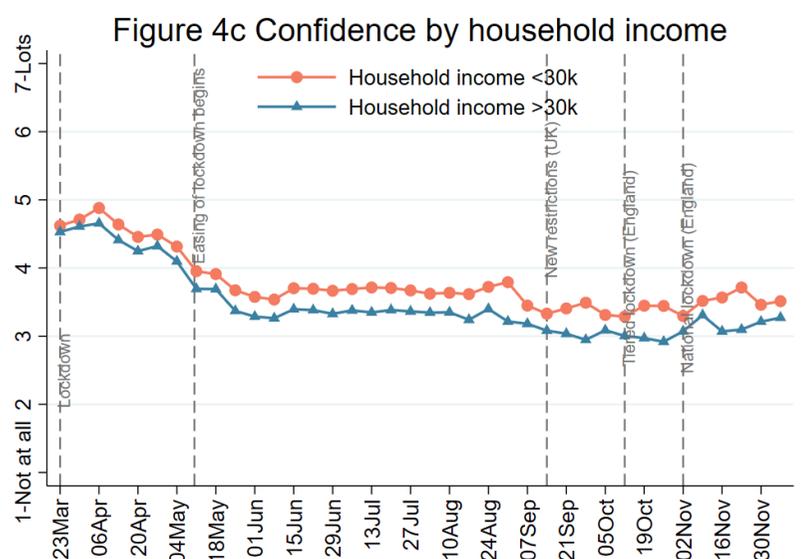
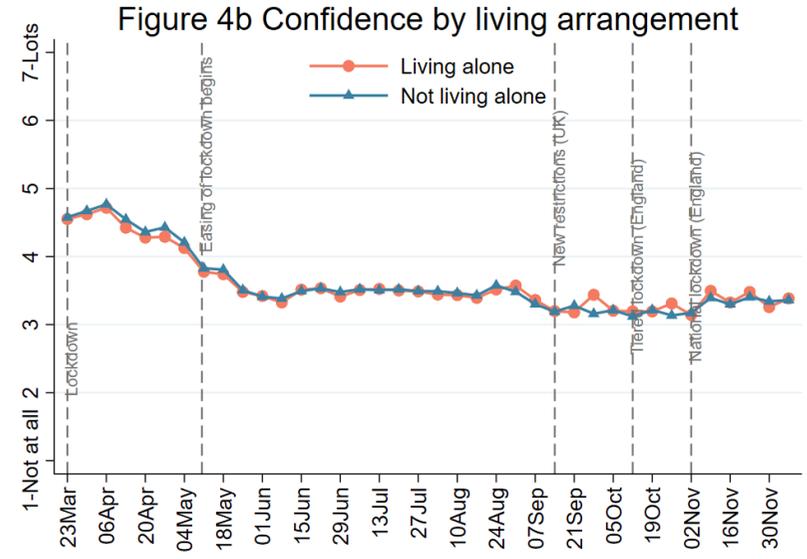
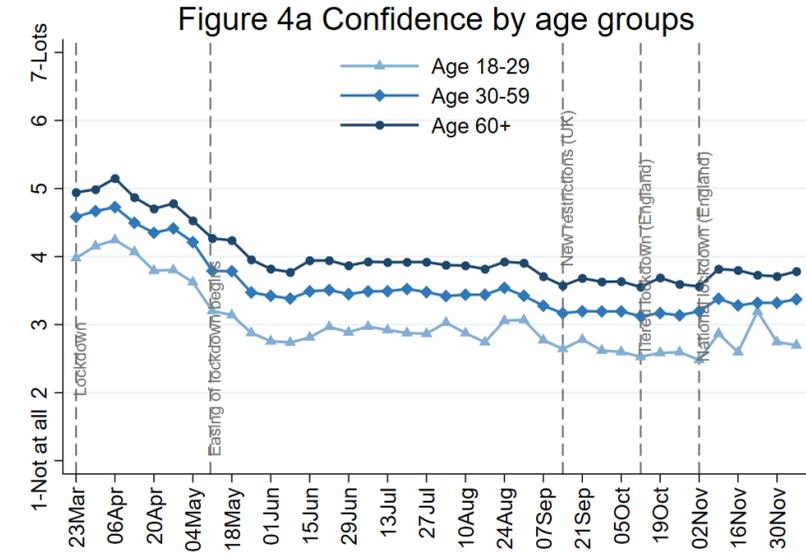
FINDINGS

Respondents were asked how much confidence they had in the government to handle the Covid-19 epidemic from 1 (not at all) to 7 (lots). People living in devolved nations were asked to report their confidence in their own devolved governments.

Levels of confidence in central government to handle the Covid-19 epidemic have not changed over the past fortnight, remaining substantially lower than for devolved nations¹. Levels in Scotland have shown a slight increase since announcements in early November that tougher restrictions have been having effects. However, levels in Wales have decreased in the past fortnight. It remains to be seen whether these are an indication of a new pattern within Wales, and this will be explored in future reports.

For subgroup analyses in Figures 4a-d and 4f-h, we restrict our results to respondents living in England in order to have sufficient sample sizes for meaningful subgroup analyses (further separate analyses are focusing on subgroups in devolved nations). In England, confidence in government is still lowest in those under the age of 30. Confidence is also lower in urban areas, amongst people from BAME backgrounds, amongst people with higher educational qualifications, and in people with a mental health diagnosis. Confidence is also slightly lower in people of higher household income.

¹ Figures for Northern Ireland have now been removed from our daily tracker graphs due to a small sample size that makes extrapolation even with statistical weighting unreliable. These data are being analysed in other papers and reports.



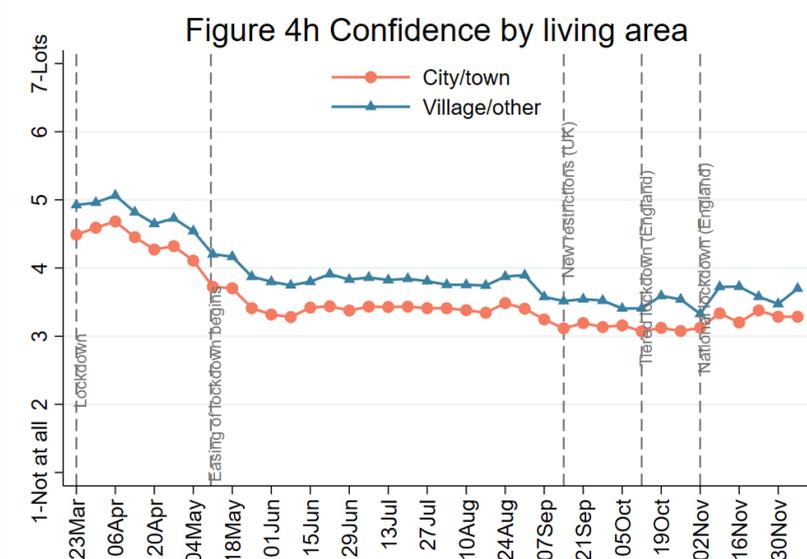
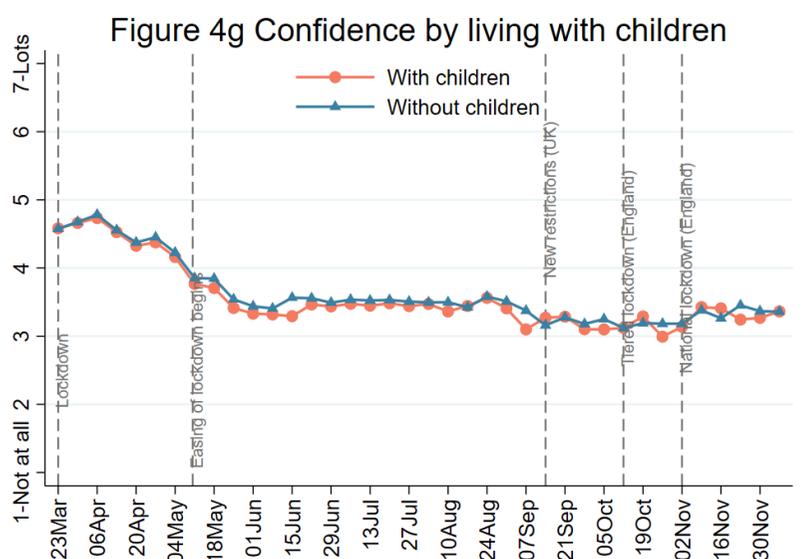
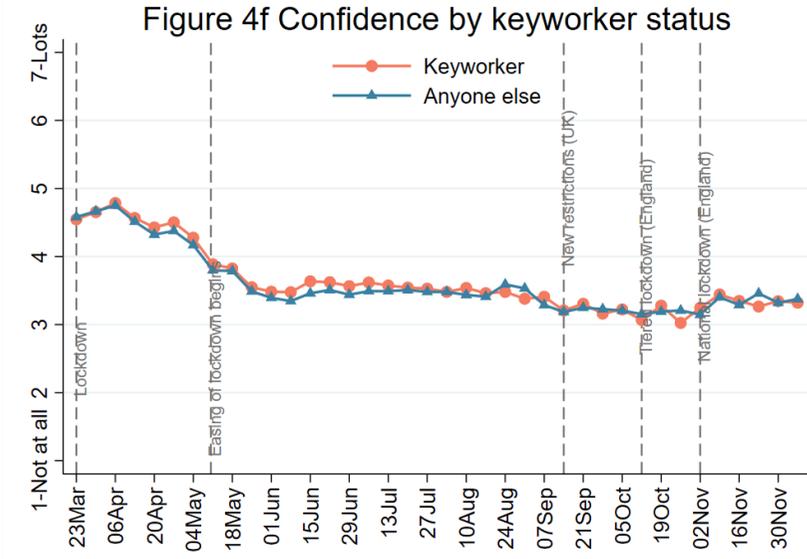
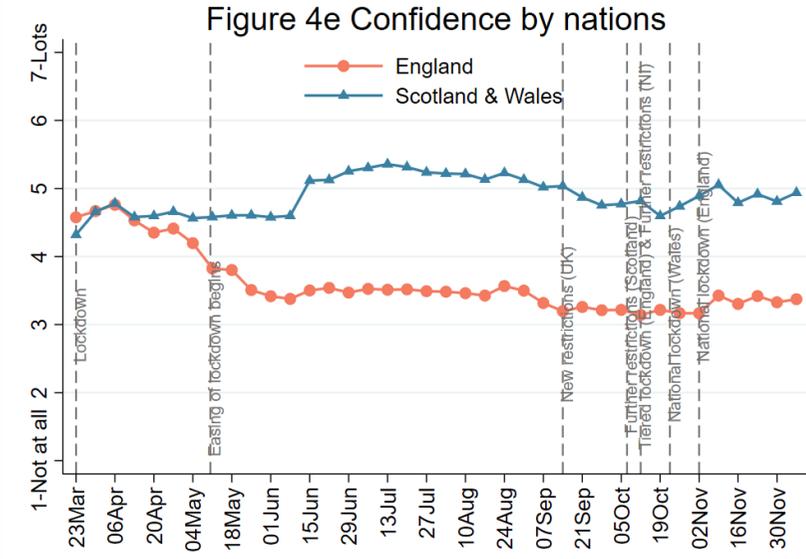


Figure 4i Confidence in government by gender

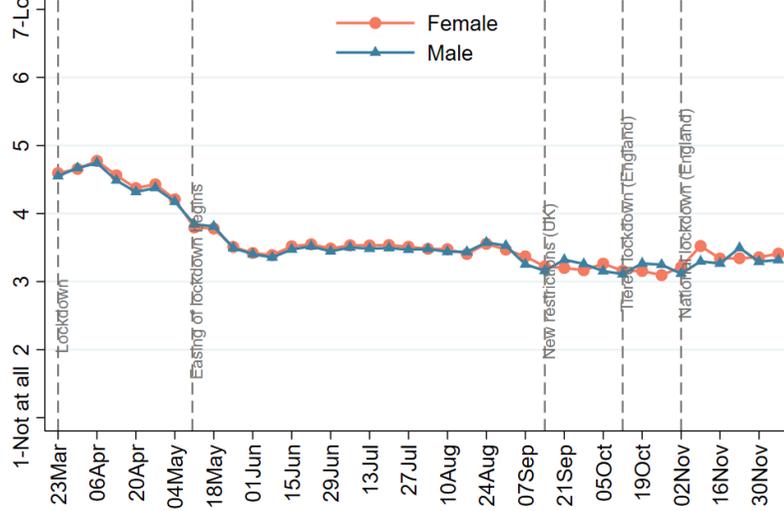


Figure 4j Confidence in government by ethnicity

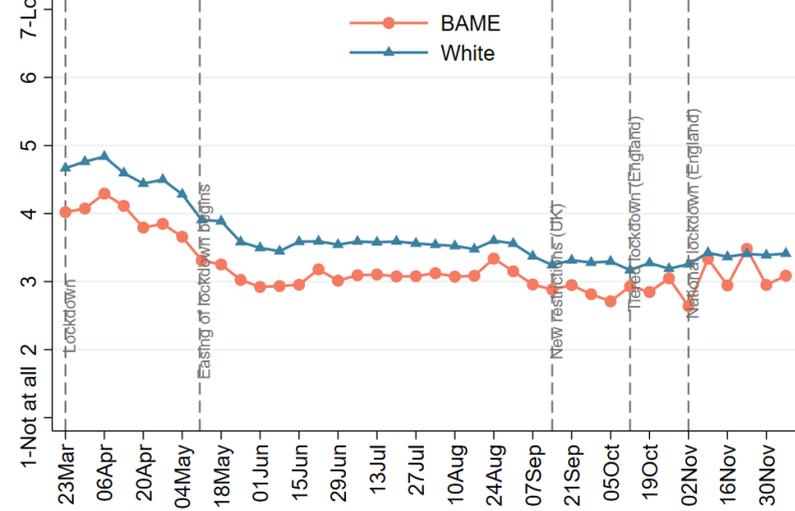


Figure 4k Confidence in government by educational levels

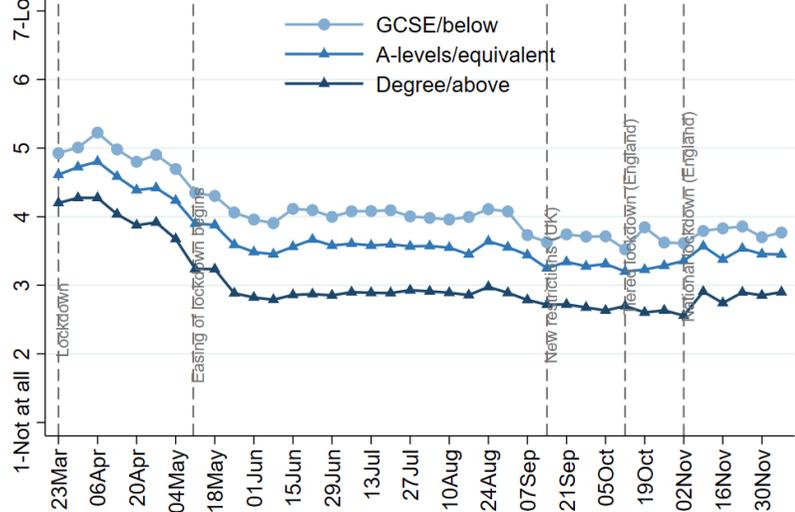
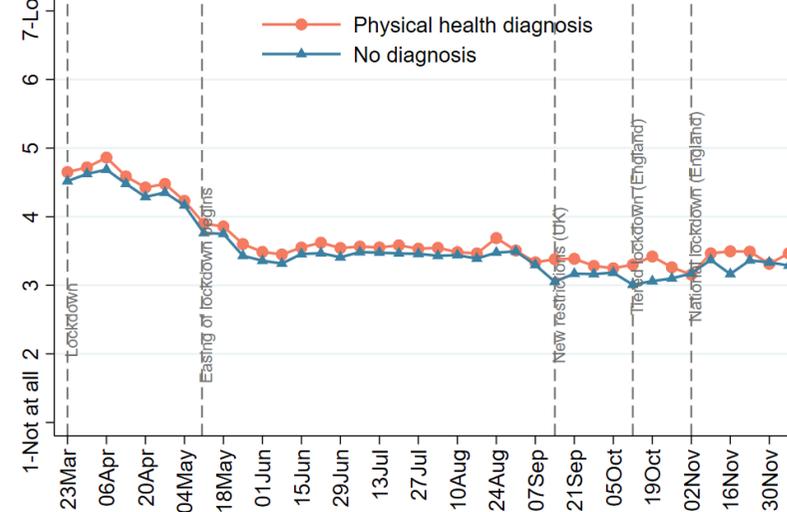
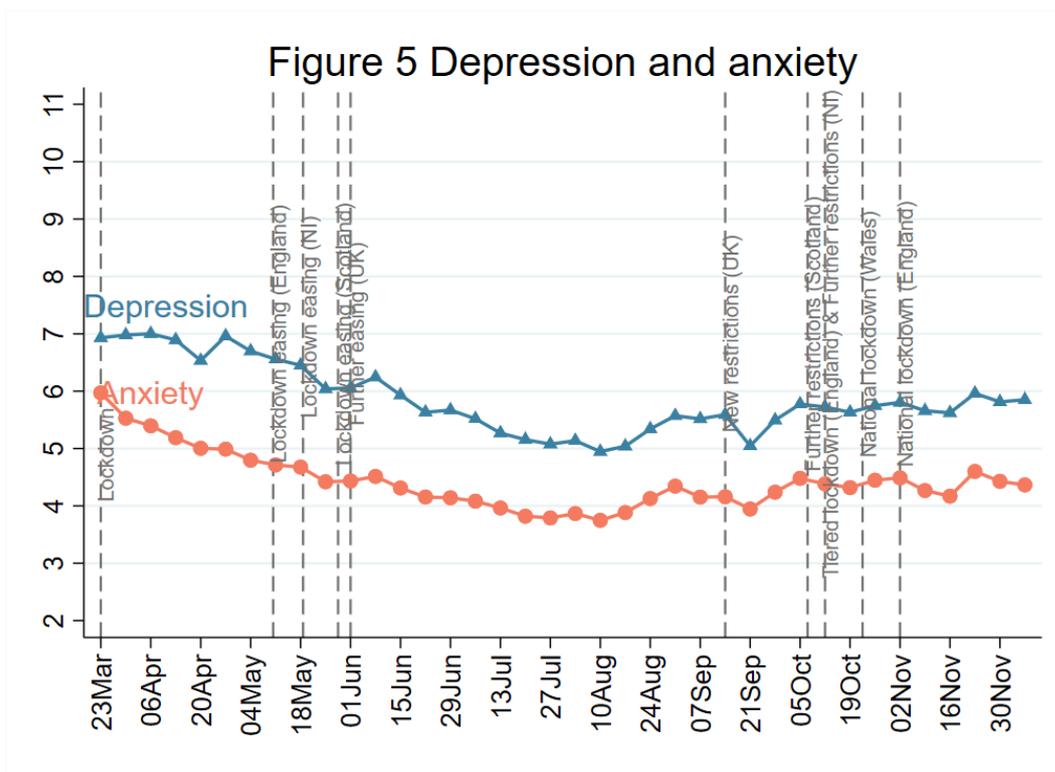


Figure 4l Confidence in government by physical health



2. Mental Health

2.1 Depression and anxiety



FINDINGS

Respondents were asked about depression levels during the past week using the Patient Health Questionnaire (PHQ-9) and anxiety using the Generalised Anxiety Disorder assessment (GAD-7); standard instruments for diagnosing depression and anxiety in primary care. These are 9 and 7 items respectively with 4-point responses ranging from “not at all” to “nearly every day”, with higher overall scores indicating more symptoms. Scores of higher than 10 can indicate major depression or moderate anxiety.

Depression and anxiety levels have stayed relatively constant in the past two weeks. Although this study focuses on trajectories rather than prevalence, the levels overall are higher than usual reported averages using the same scales (2.7-3.2 for anxiety and 2.7-3.7 for depression²).

Depression and anxiety are still highest in young adults, women, people living alone, people with lower household income, people with a long-term physical health condition, people with lower educational qualifications, people from BAME backgrounds, people living with children, and people living in urban areas. People with a diagnosed mental illness have still been reporting higher levels of symptoms (as might be expected) (see Figures 6).

² Löwe B, Decker O, Müller S, Brähler E, Schellberg D, Herzog W, et al. Validation and Standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the General Population. *Medical Care*. 2008;46(3):266–74. | Tomitaka S, Kawasaki Y, Ide K, Akutagawa M, Ono Y, Furukawa TA. Stability of the Distribution of Patient Health Questionnaire-9 Scores Against Age in the General Population: Data From the National Health and Nutrition Examination Survey. *Front Psychiatry*. NB in the absence of identified directly comparable prevalence estimates in the UK, these studies look at prevalence in the US in the general population.

Figure 6a Depression by age groups

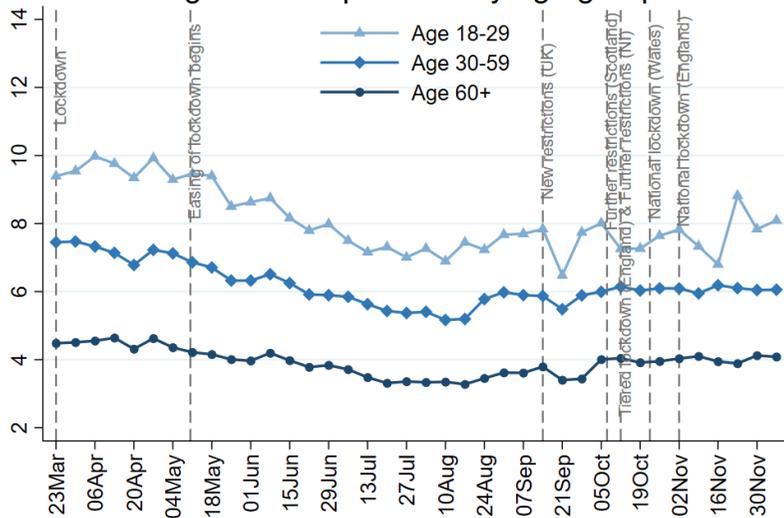


Figure 6b Depression by living arrangement

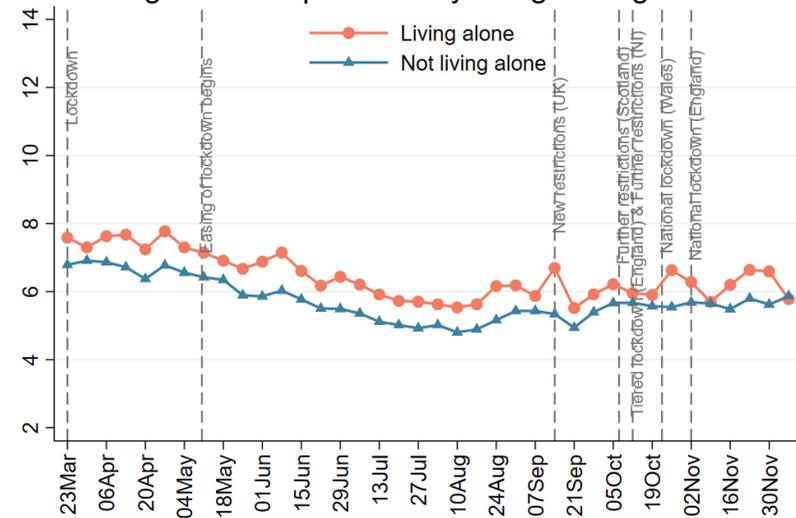


Figure 6c Depression by household income

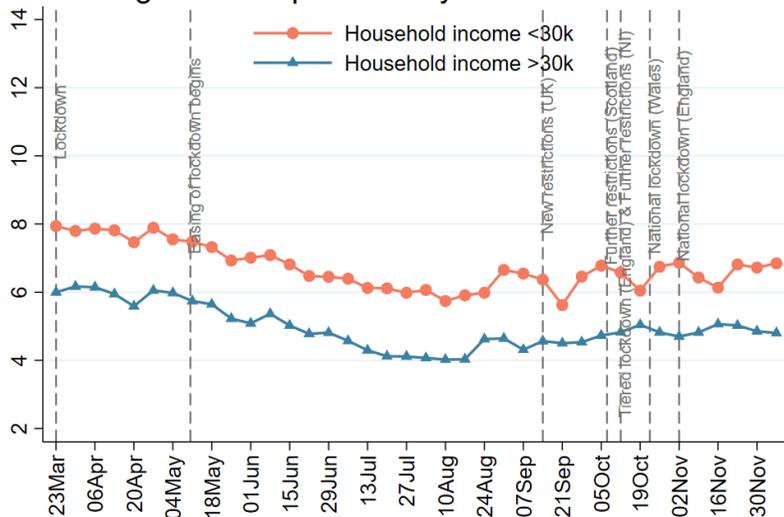


Figure 6d Depression by mental health diagnosis

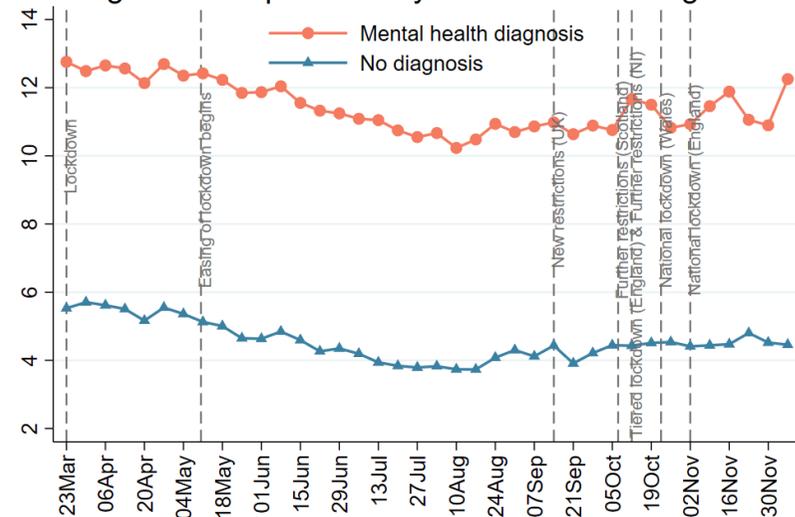


Figure 6e Depression by nations

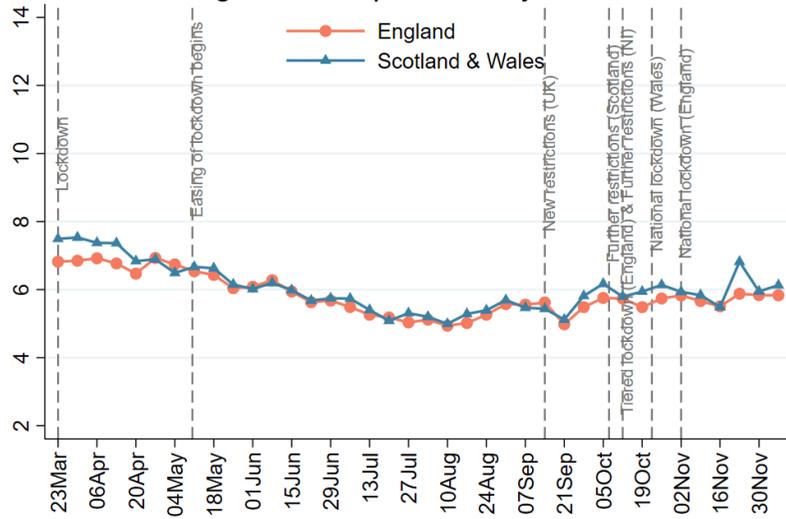


Figure 6f Depression by keyworker status

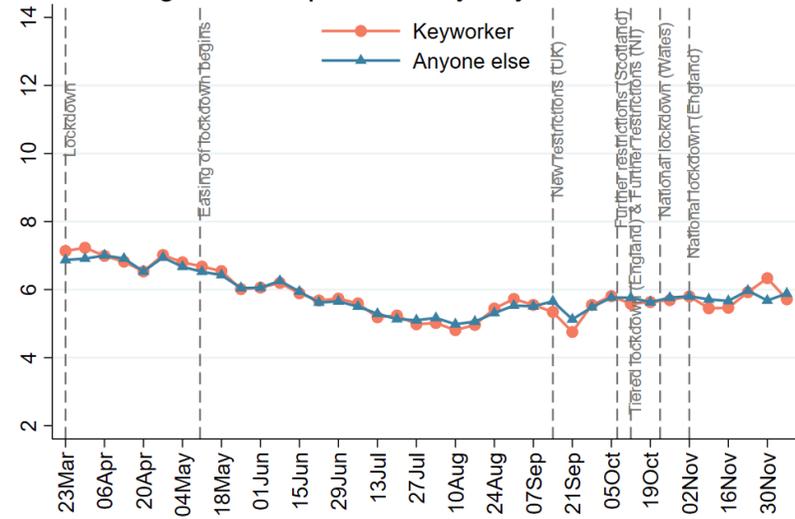


Figure 6g Depression by living with children

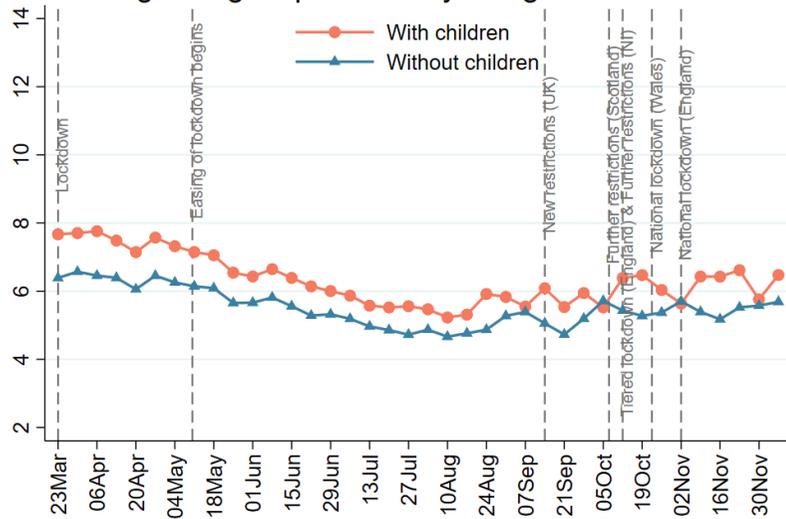


Figure 6h Depression by living area

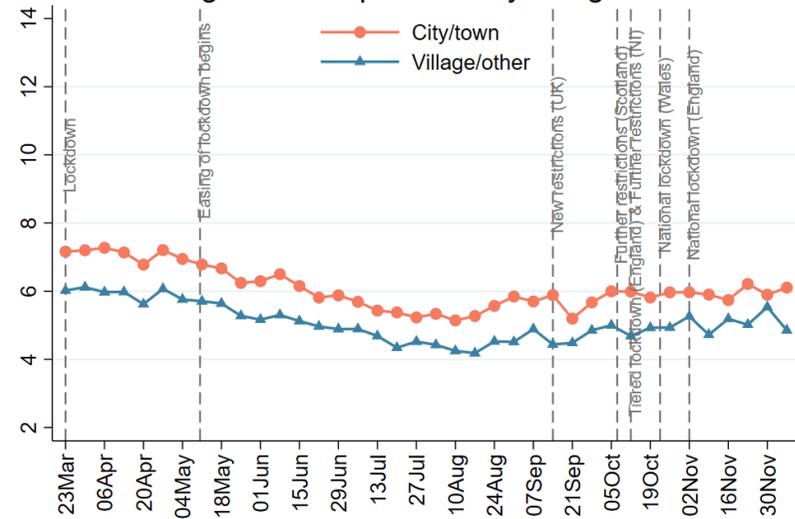


Figure 6i Depression by gender

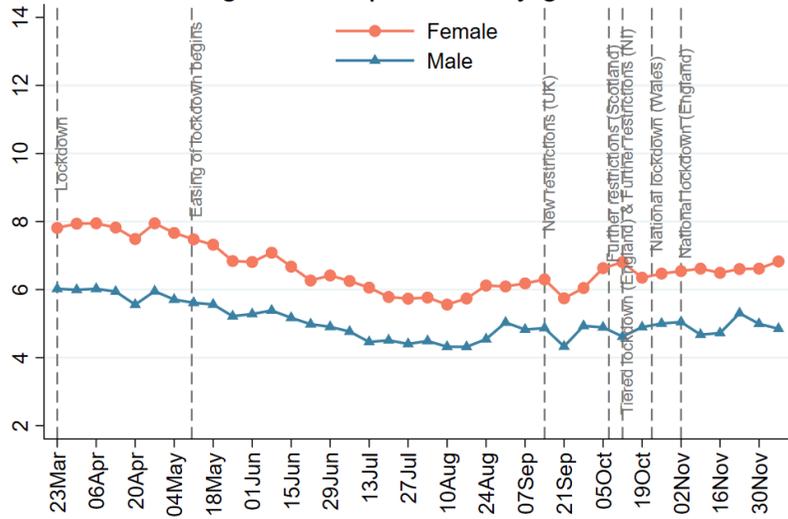


Figure 6j Depression by ethnicity

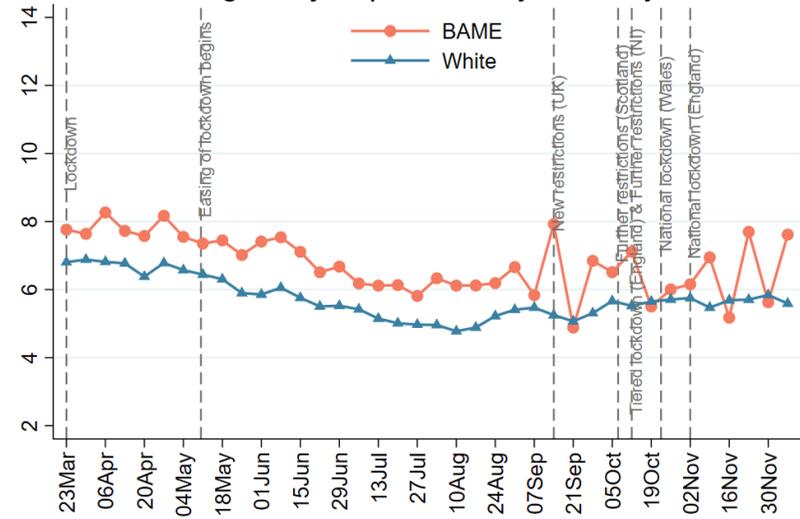


Figure 6k Depression by educational levels

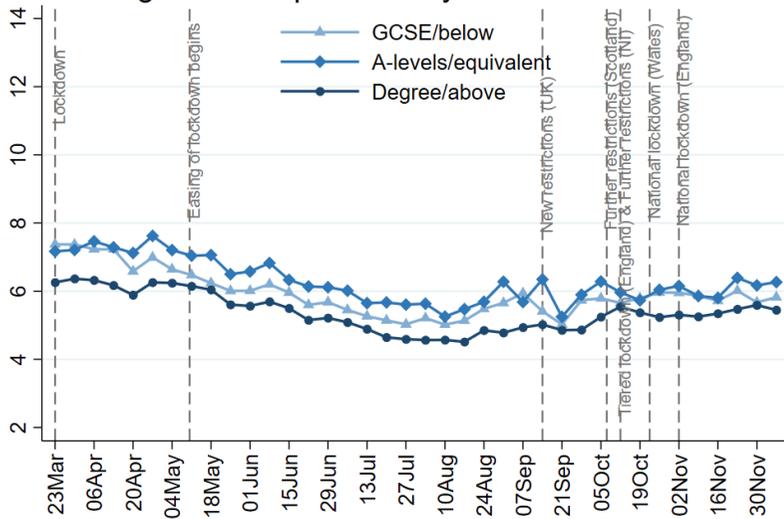


Figure 6l Depression by physical health diagnosis

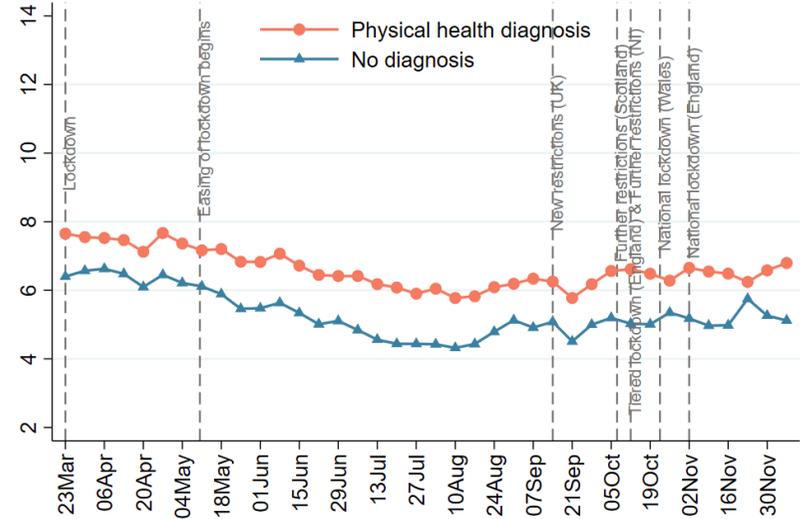


Figure 7a Anxiety by age groups

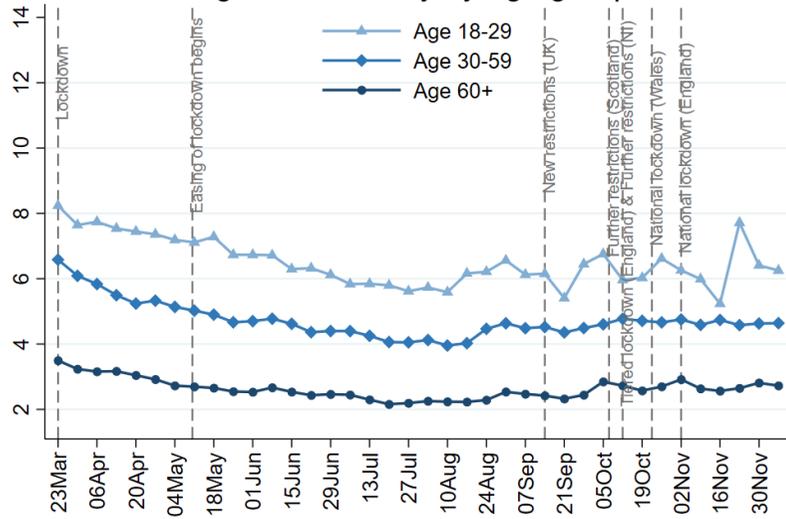


Figure 7b Anxiety by living arrangement

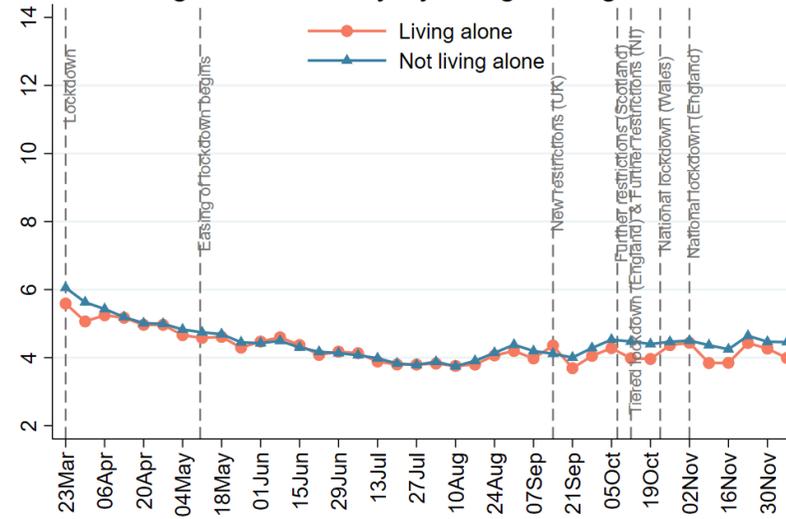


Figure 7c Anxiety by household income

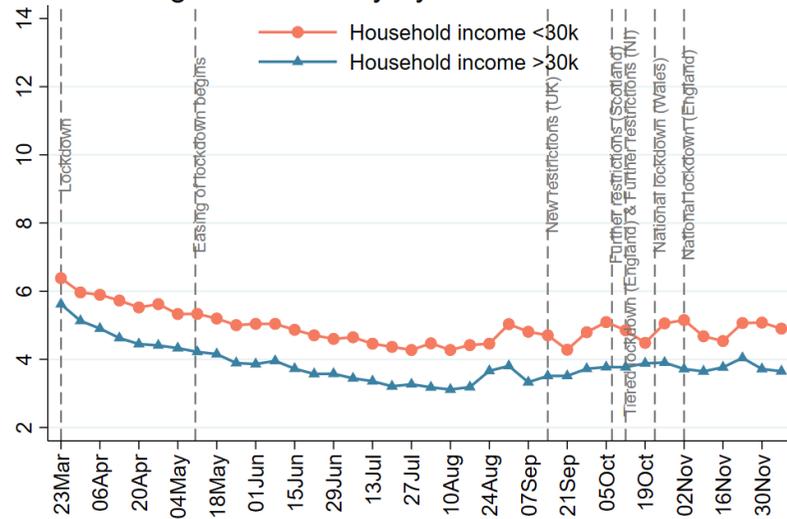
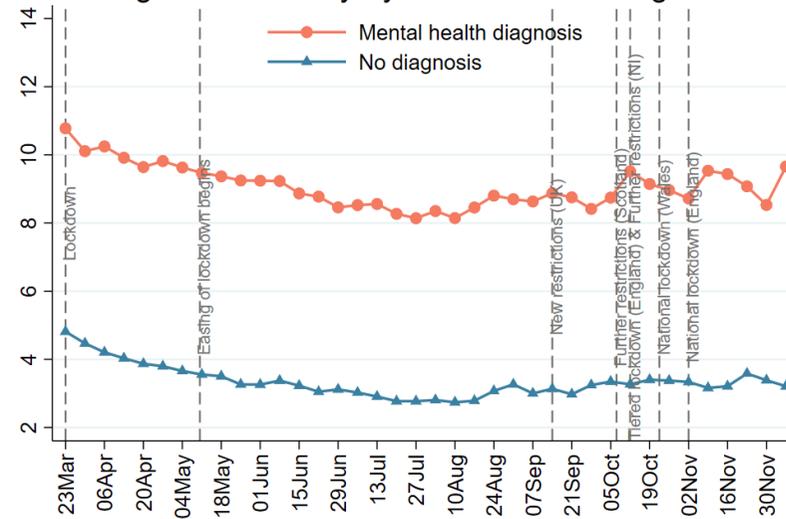


Figure 7d Anxiety by mental health diagnosis



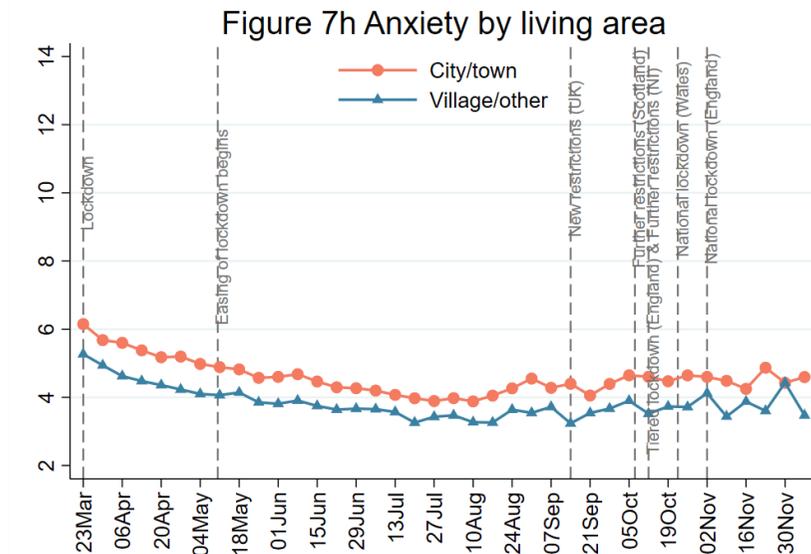
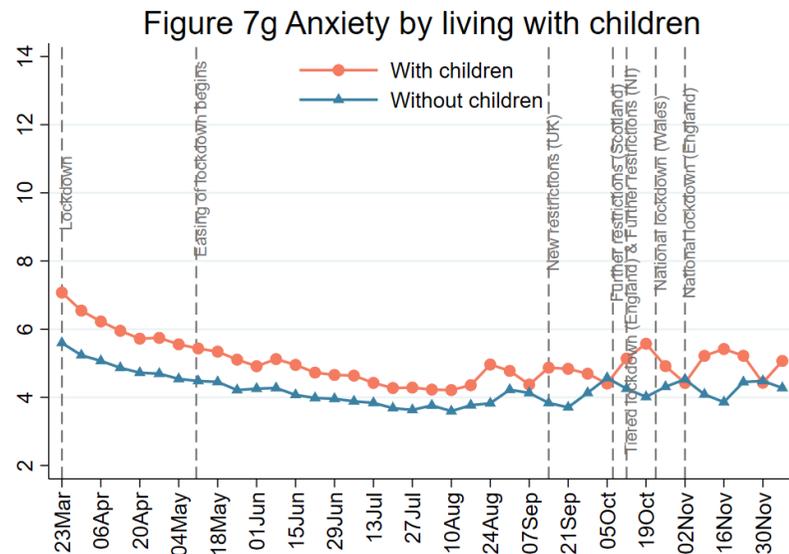
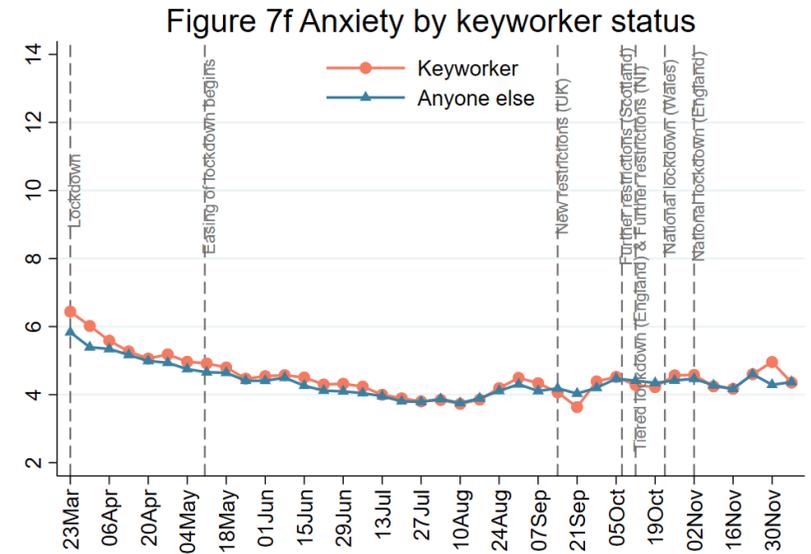
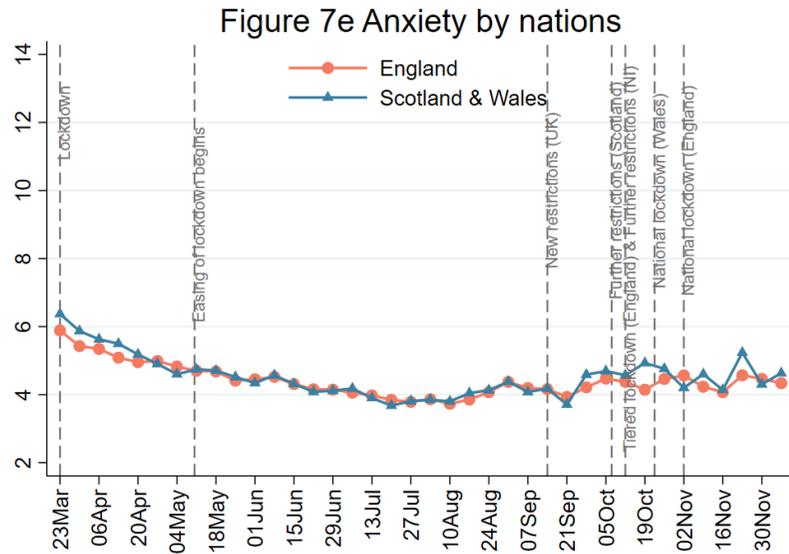


Figure 7i Anxiety by gender

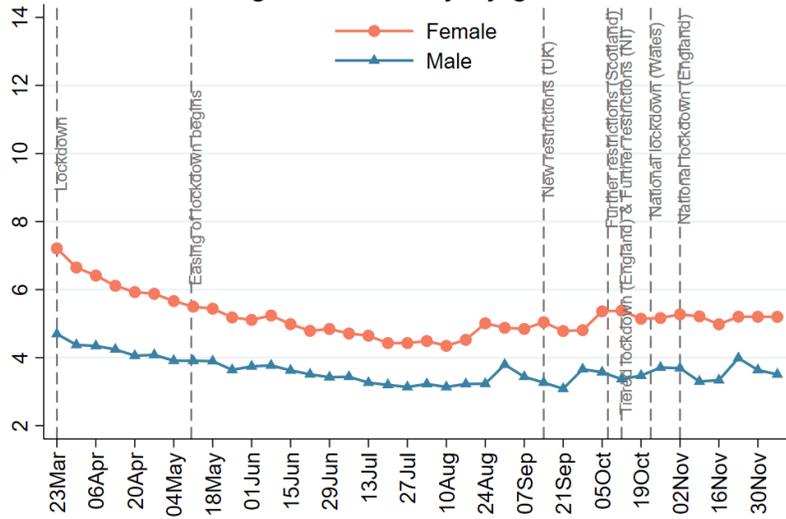


Figure 7j Anxiety by ethnicity

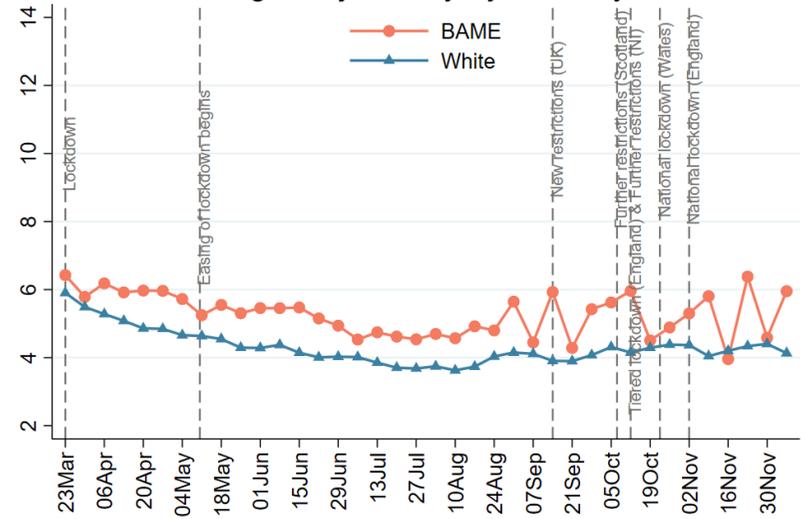


Figure 7k Anxiety by educational levels

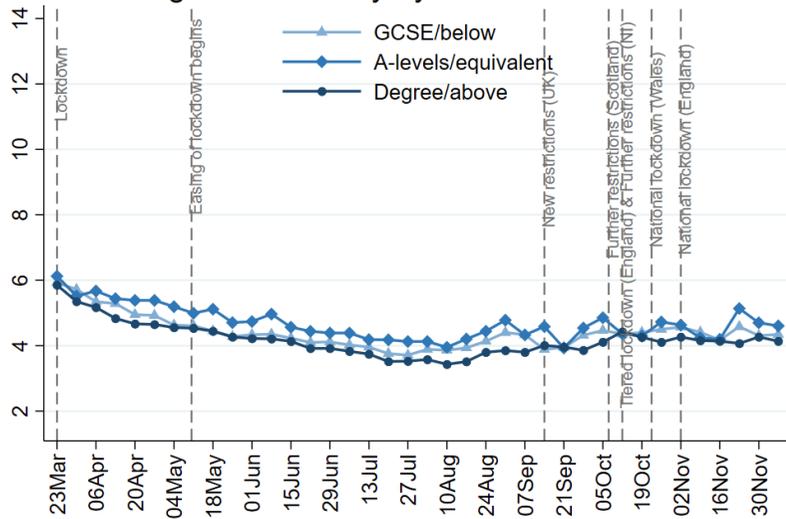
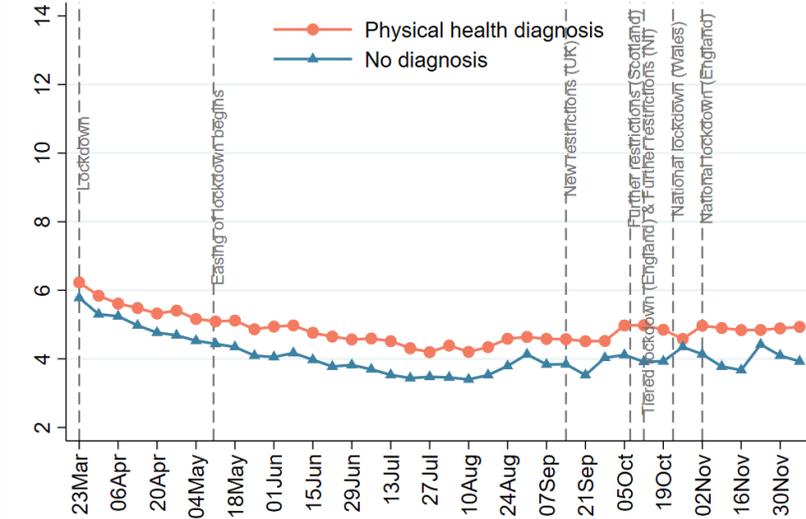
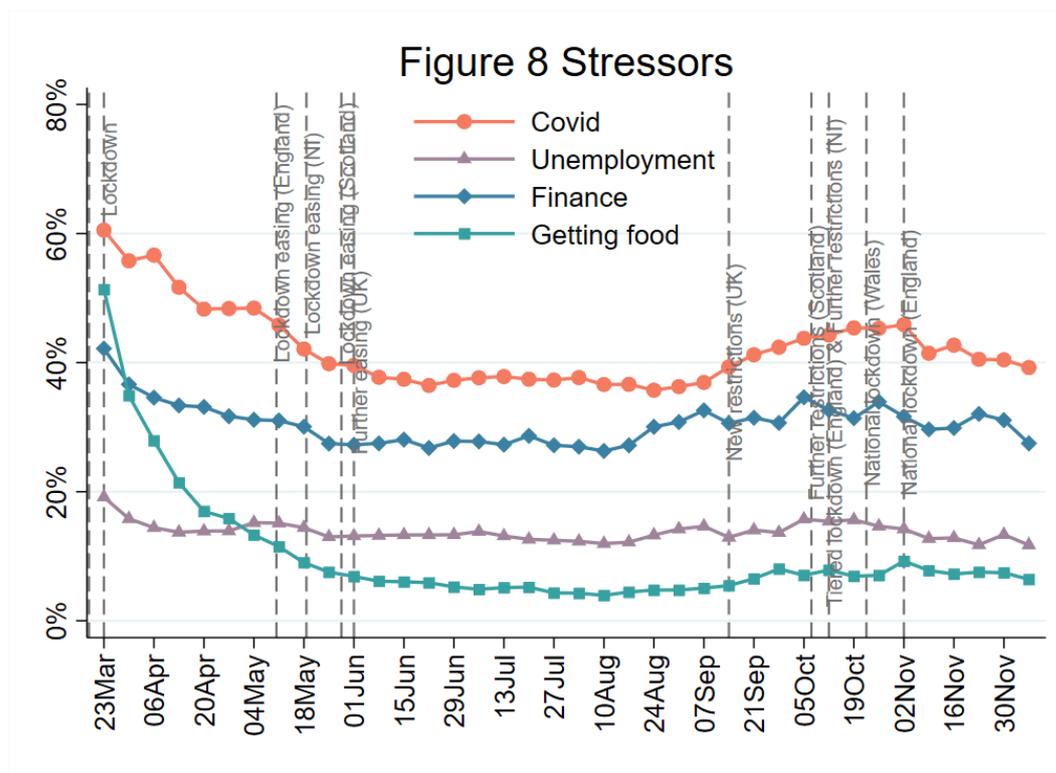


Figure 7l Anxiety by physical health diagnosis



2.2 Stress



FINDINGS

We asked participants to report which factors were causing them stress in the last week, either minor stress or major stress (which was defined as stress that was constantly on their mind or kept them awake at night).

Stress about catching Covid-19 or becoming seriously ill from it has decreased further in the past month. This might be assumed to be due to the national lockdown in England, but has also been seen in Scotland and Wales. This is despite the fact that cases are now increasing in many areas again.

Worries about finance have also shown a slight decrease in the past two weeks, now affecting around 1 in 4 people (down from 1 in 3 at the start of October).

Other worries, though, remain relatively constant: around 1 in 8 are worried about unemployment; and around 1 in 12 people are worried about access to food.

People with diagnosed mental illness have been more worried about all factors. But other predictors of stressors have varied. People with lower household income are becoming more worried about Covid-19 than people with higher household income, and they are more worried about finances, but less worried about unemployment. Older adults have worried less about unemployment and food. Unemployment has worried people in England and in urban areas more. Women are more worried about catching the virus or becoming seriously ill from it, as are people with long-term physical health conditions. But there is little difference by ethnicity or education. However, people from BAME backgrounds are more concerned about losing their jobs and financial issues, as are people with higher educational qualifications. There is no difference in worries about food security by gender, education or ethnicity, but people with physical health conditions are slightly more concerned about this.

Figure 9a Covid-19 stress by age groups

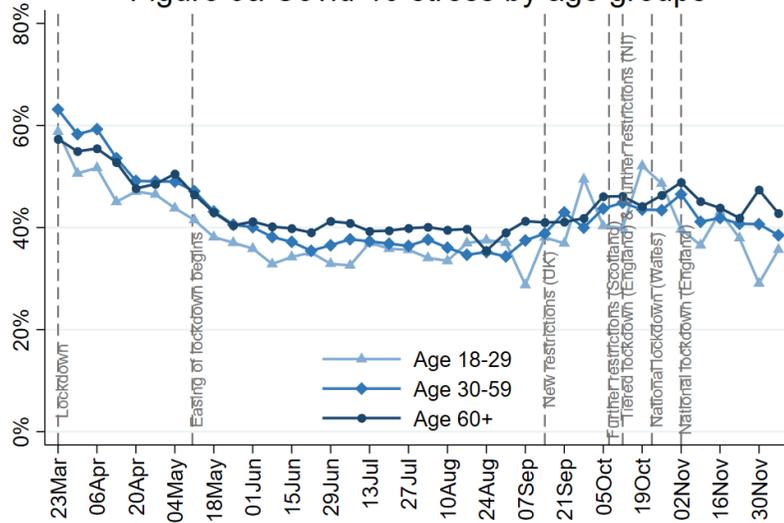


Figure 9b Covid-19 stress by living arrangement

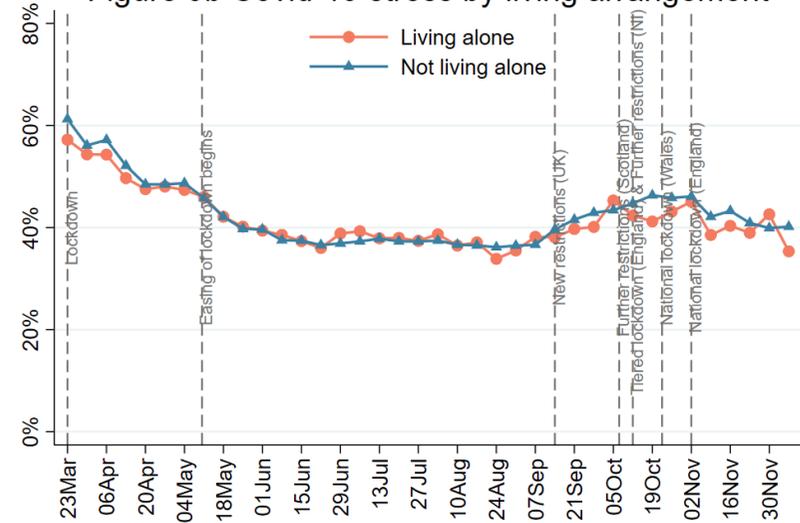


Figure 9c Covid-19 stress by household income

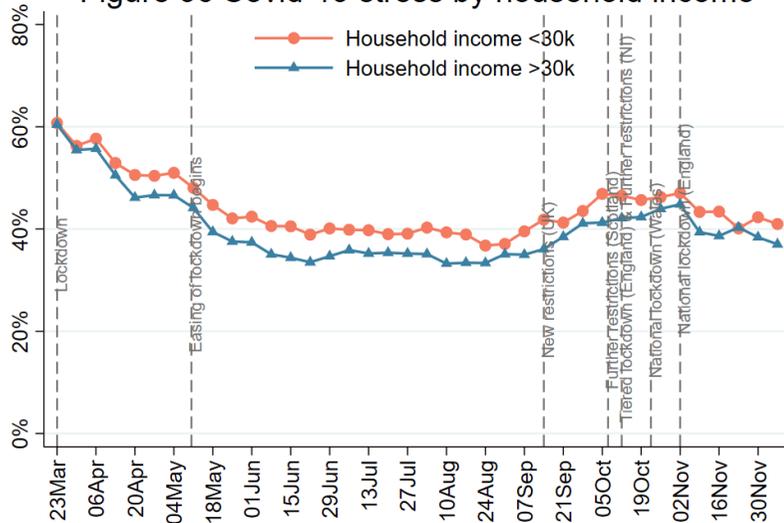


Figure 9d Covid-19 stress by mental health diagnosis

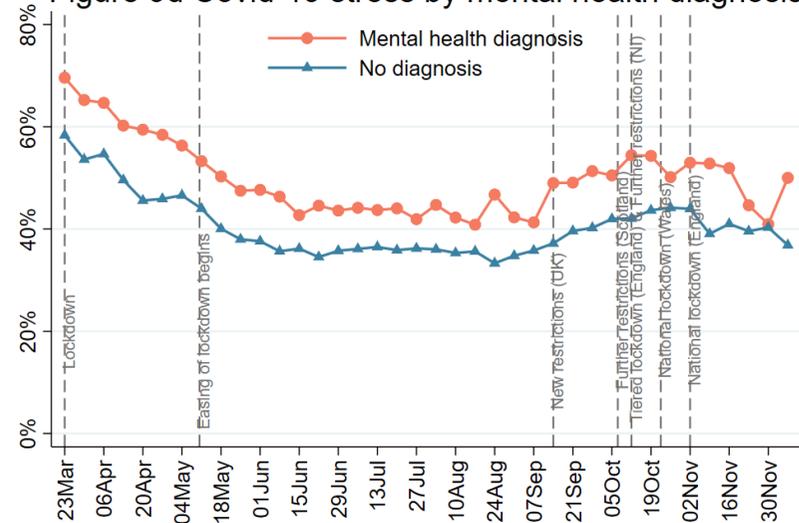


Figure 9e Covid-19 stress by nations

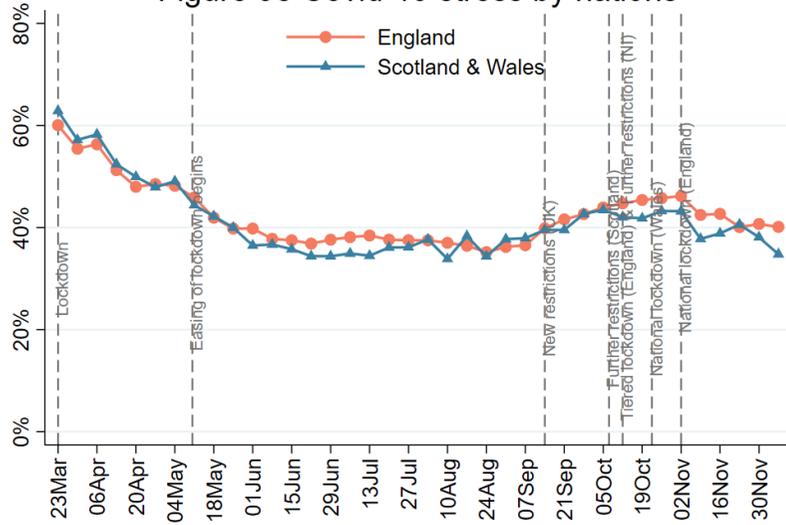


Figure 9f Covid-19 stress by keyworker status

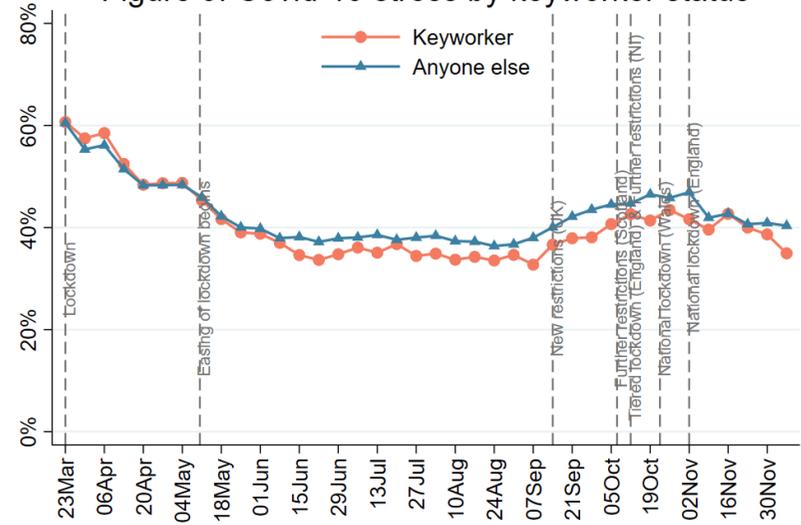


Figure 9g Covid-19 stress by living with children

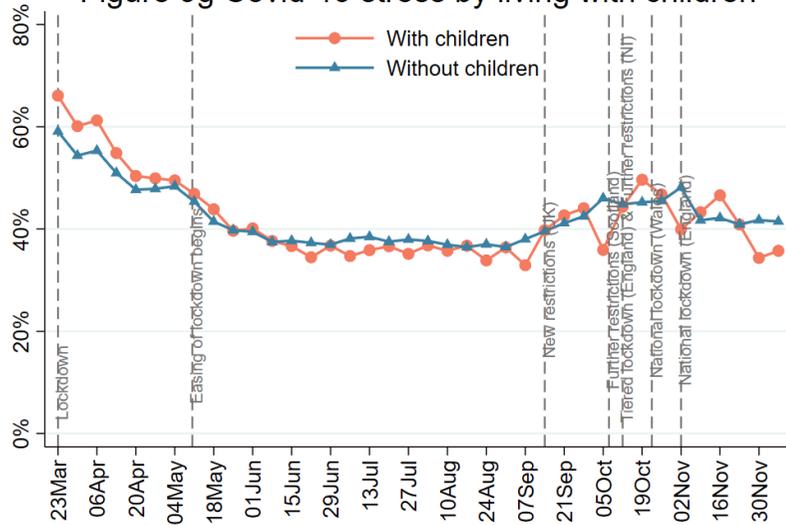


Figure 9h Covid-19 stress by living area

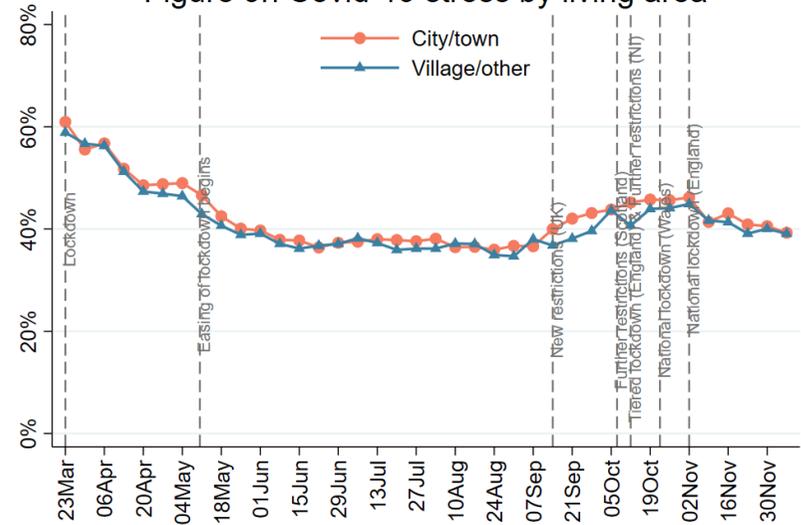


Figure 9i Covid-19 stress by gender

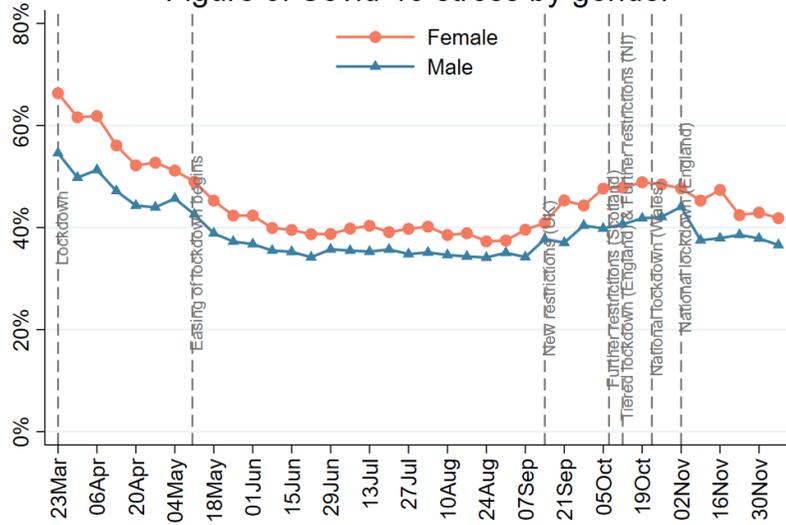


Figure 9j Covid-19 stress by ethnicity

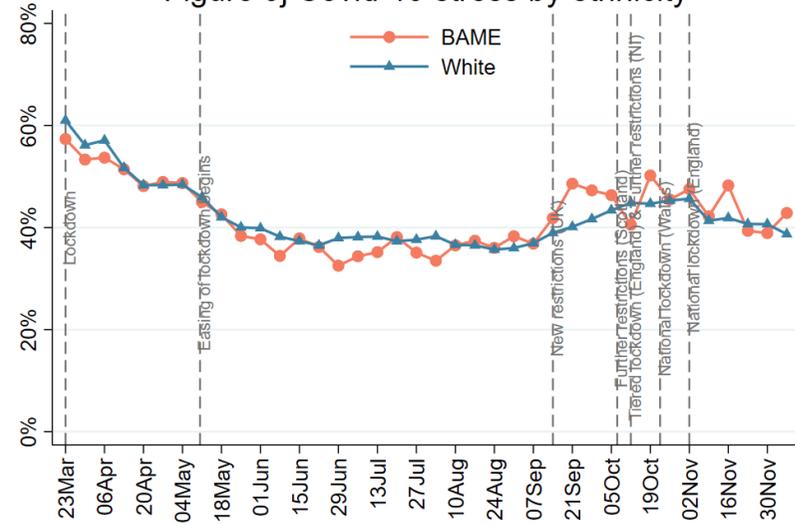


Figure 9k Covid-19 stress by educational levels

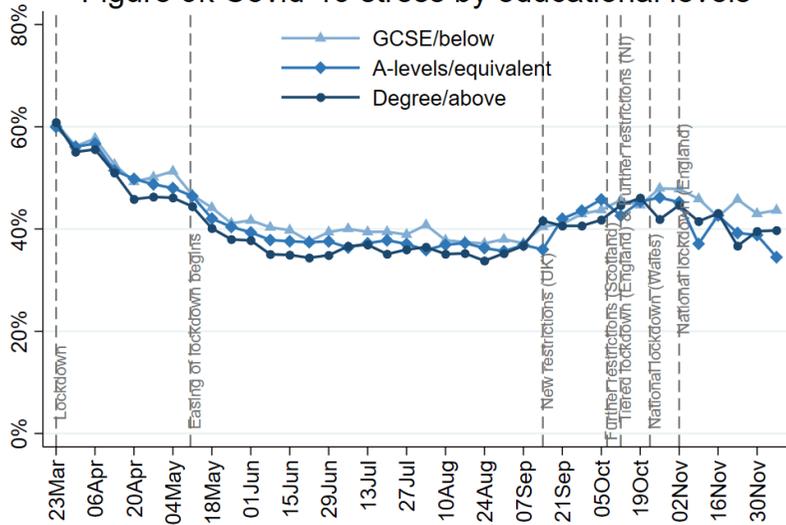


Figure 9l Covid-19 stress by physical health diagnosis

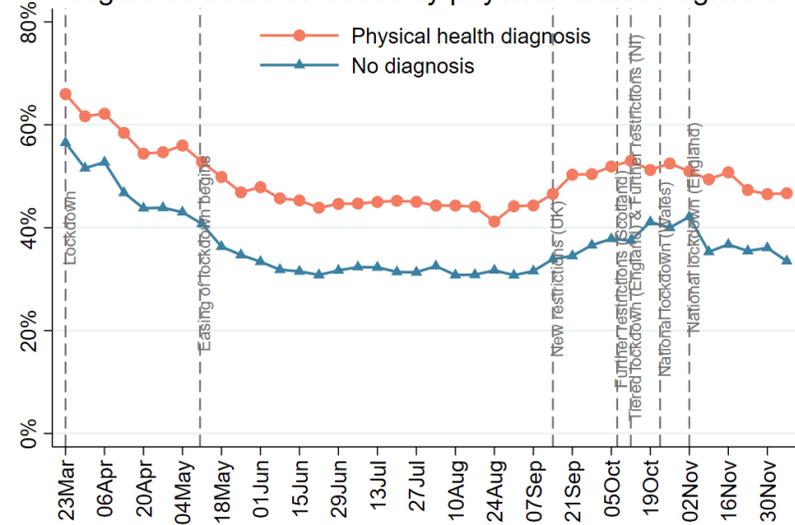


Figure 10a Unemployment stress by age groups

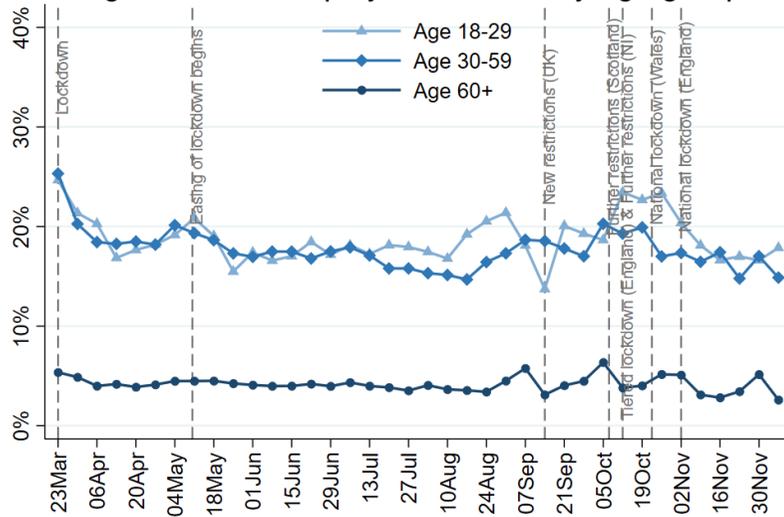


Figure 10b Unemployment stress by living arrangement

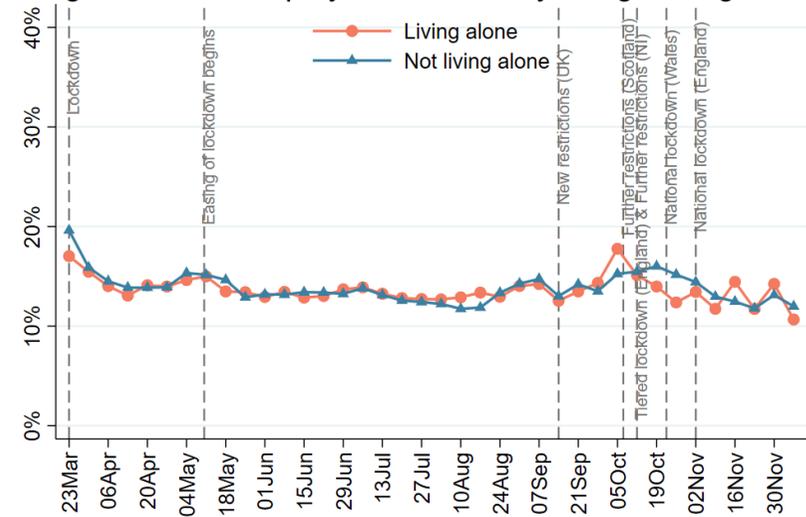


Figure 10c Unemployment stress by household income

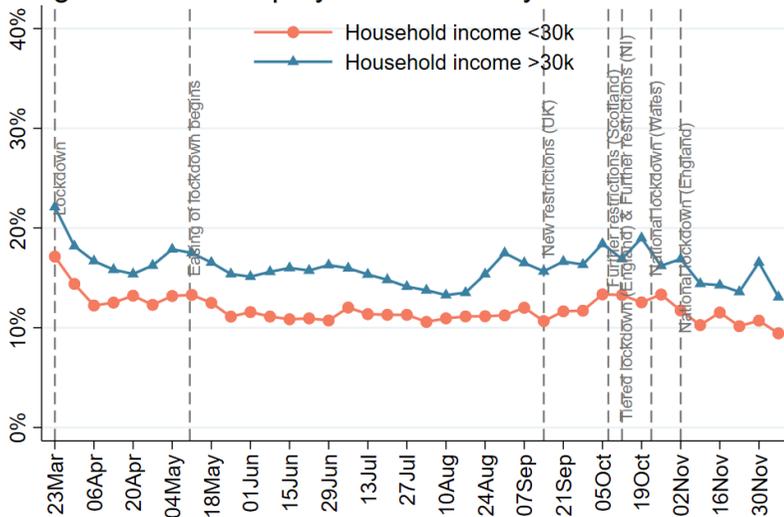


Figure 10d Unemployment stress by mental health

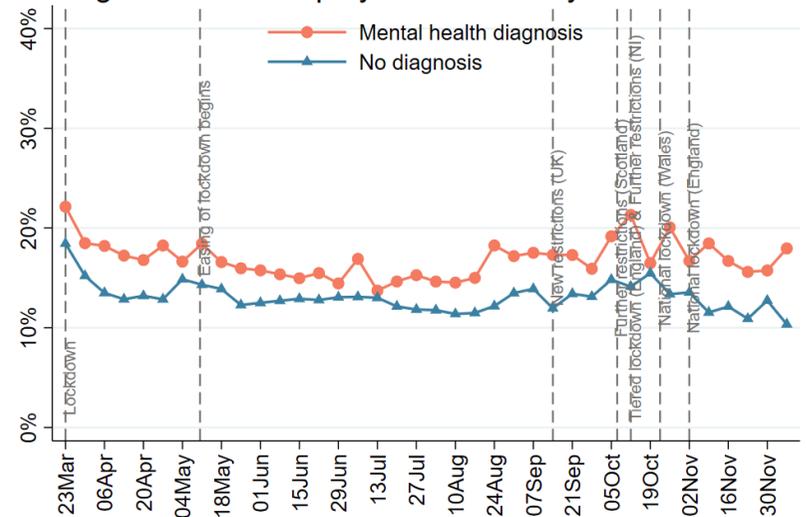


Figure 10e Unemployment stress by nations

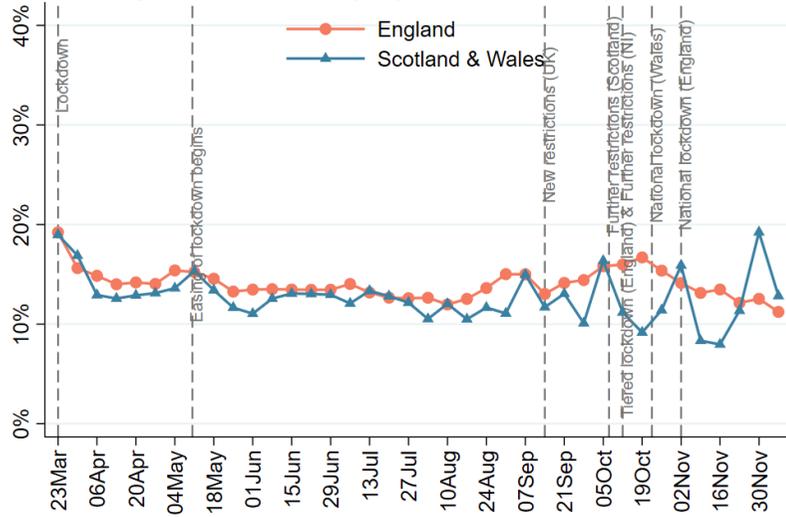


Figure 10f Unemployment stress by keyworker status

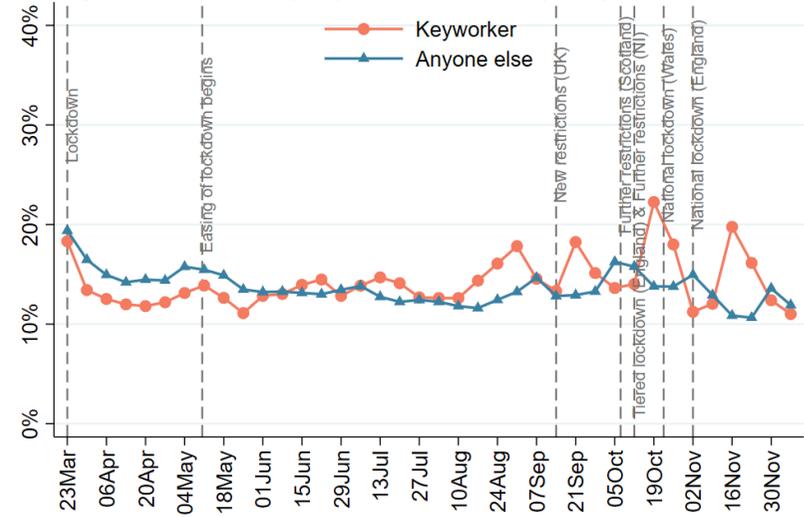


Figure 10g Unemployment stress by living with children

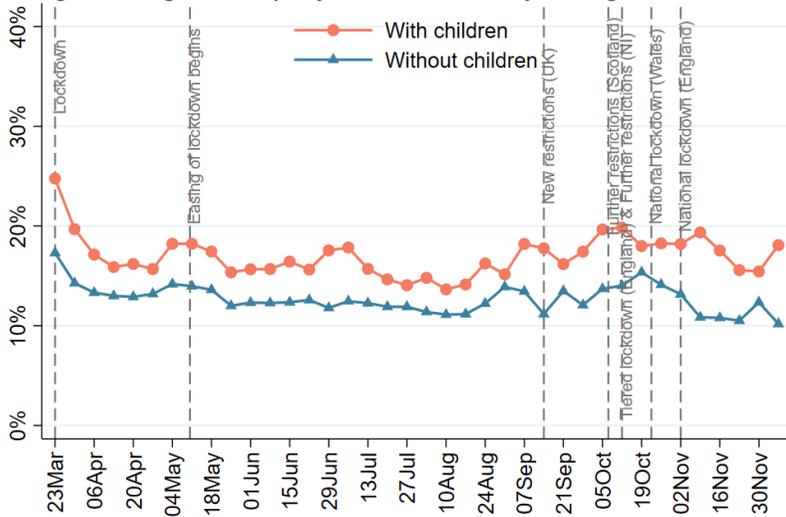


Figure 10h Unemployment stress by living area

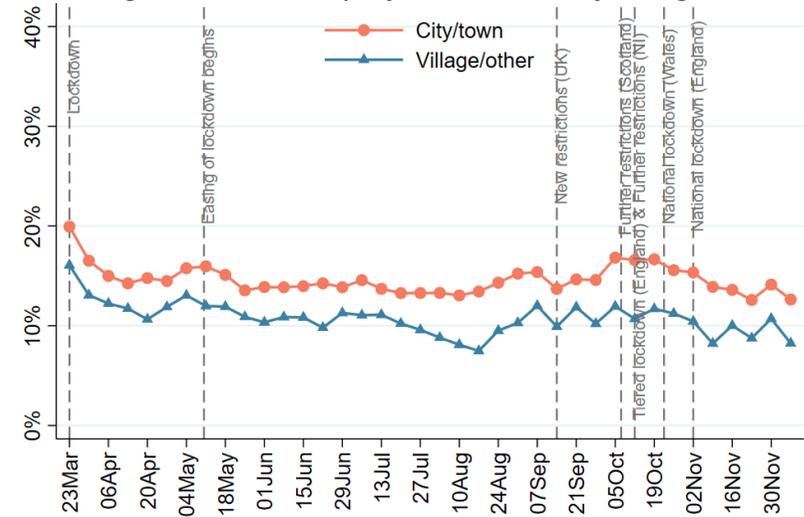


Figure 10i Unemployment stress by gender

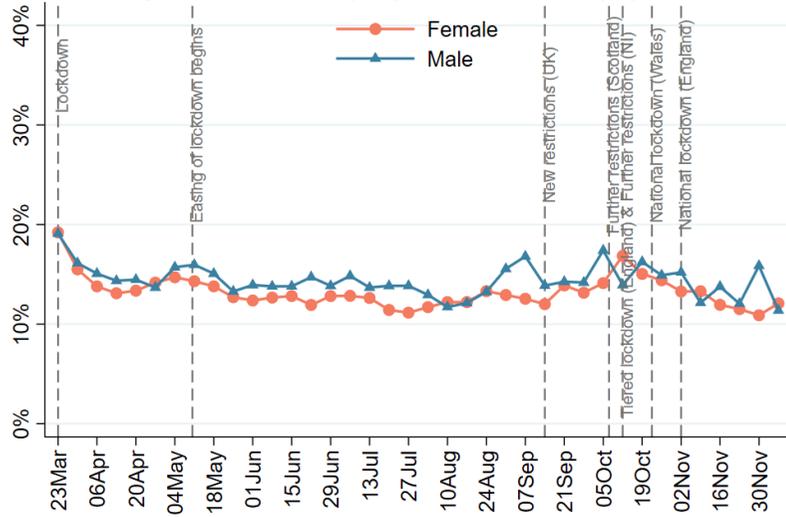


Figure 10j Unemployment stress by ethnicity

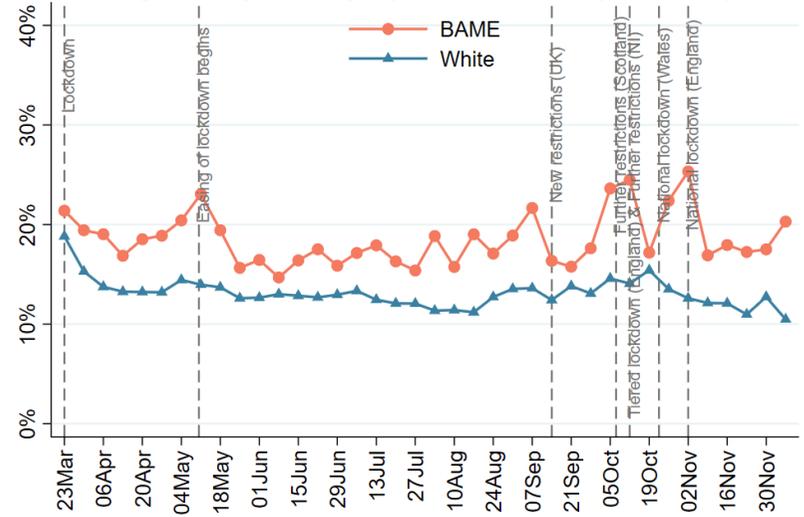


Figure 10k Unemployment stress by educational levels

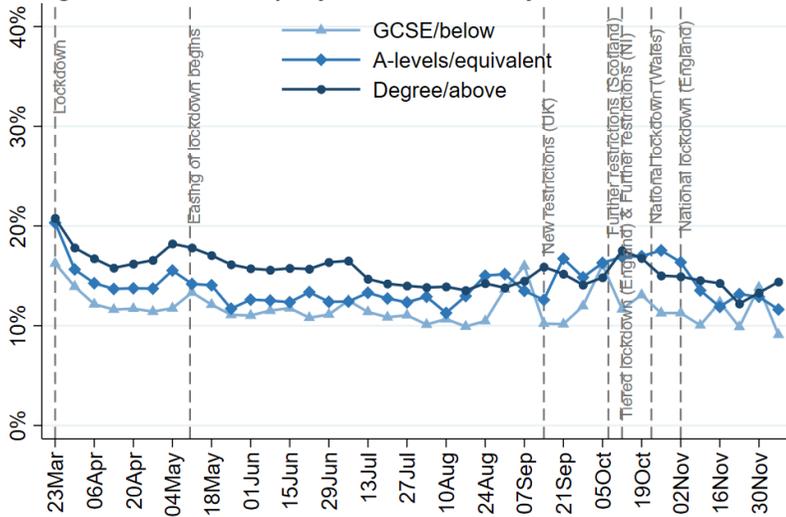


Figure 10l Unemployment stress by physical health diagnosis

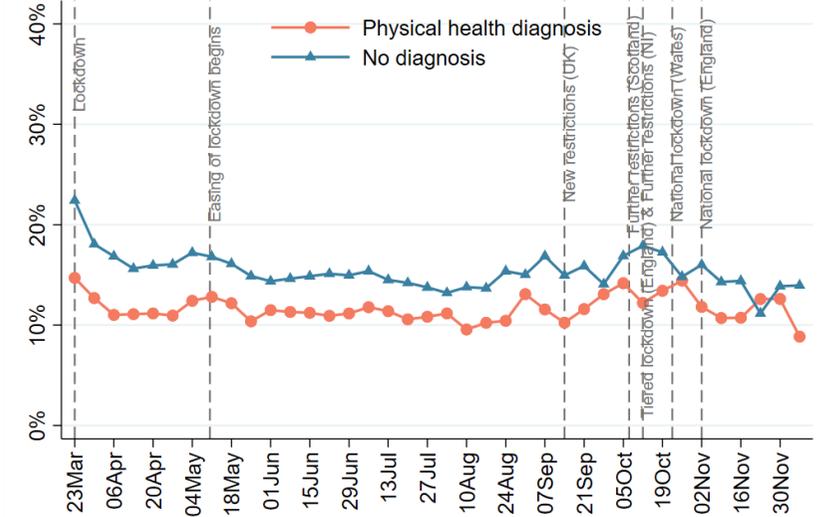


Figure 11a Financial stress by age groups

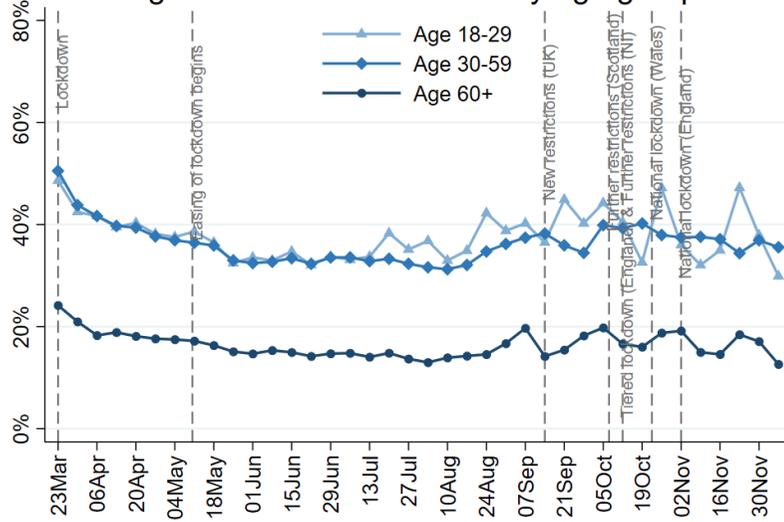


Figure 11b Financial stress by living arrangement

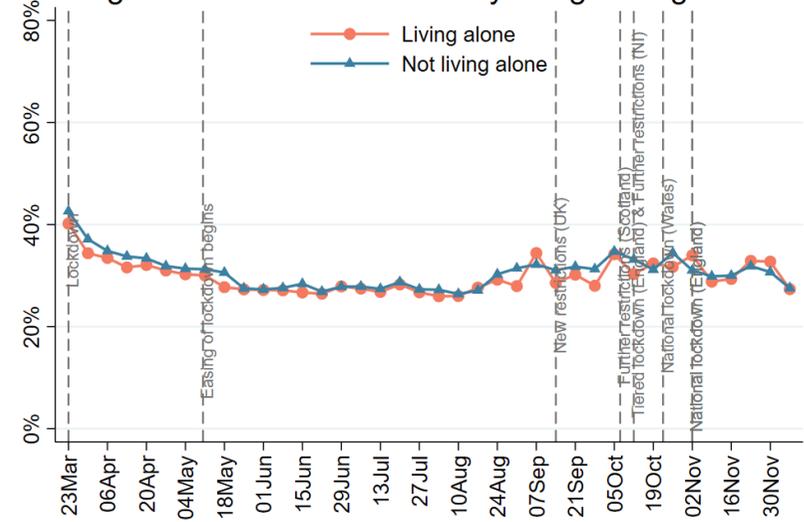


Figure 11c Financial stress by household income

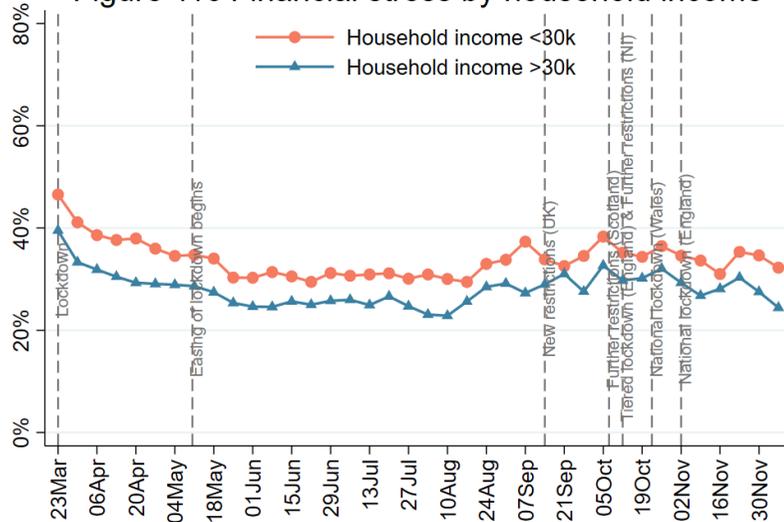


Figure 11d Financial stress by mental health diagnosis

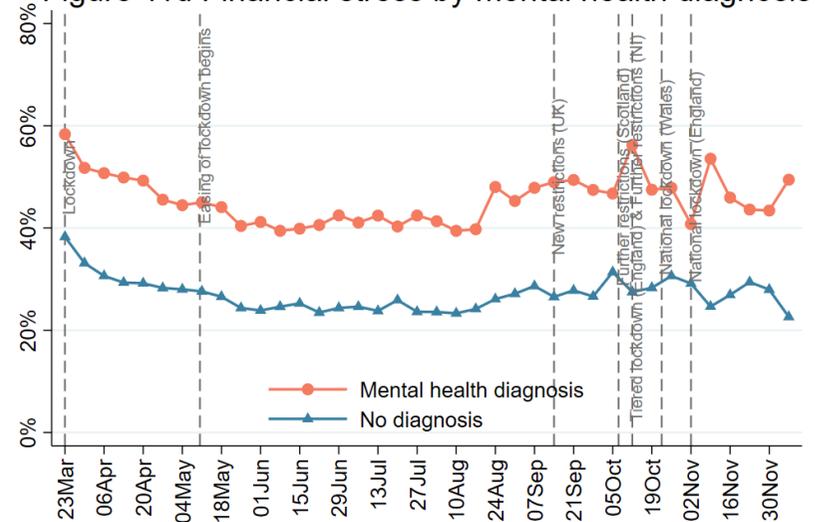


Figure 11e Financial stress by nations

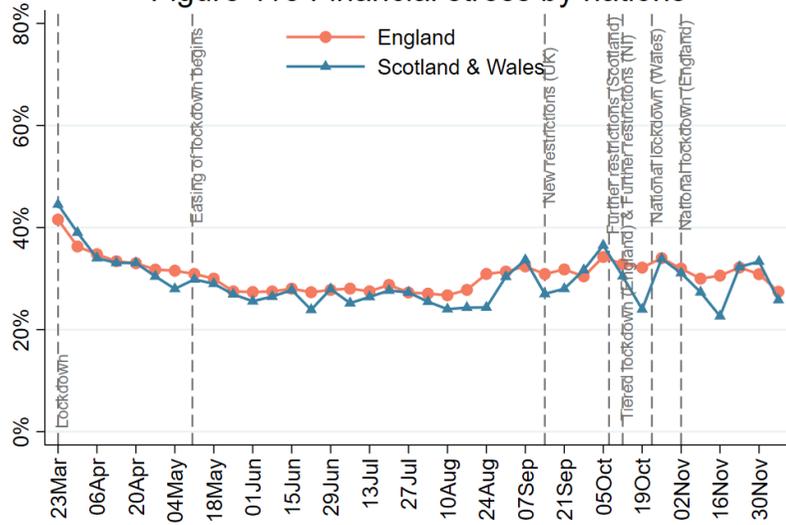


Figure 11f Financial stress by keyworker status

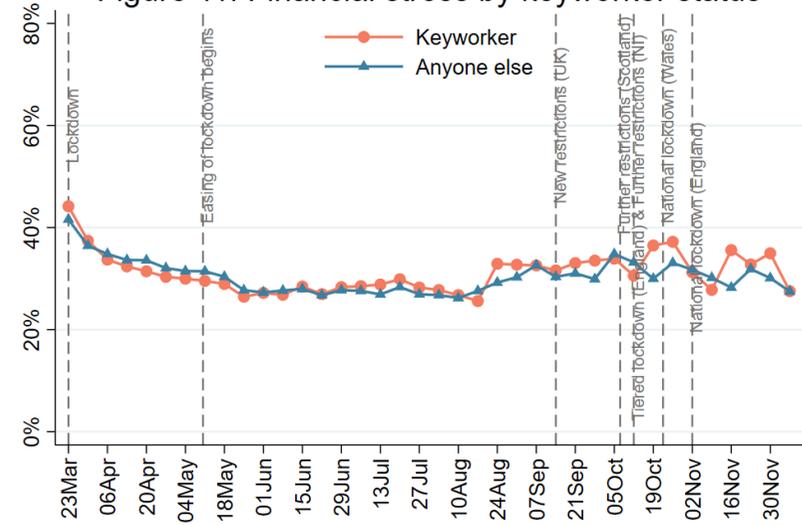


Figure 11g Financial stress by living with children

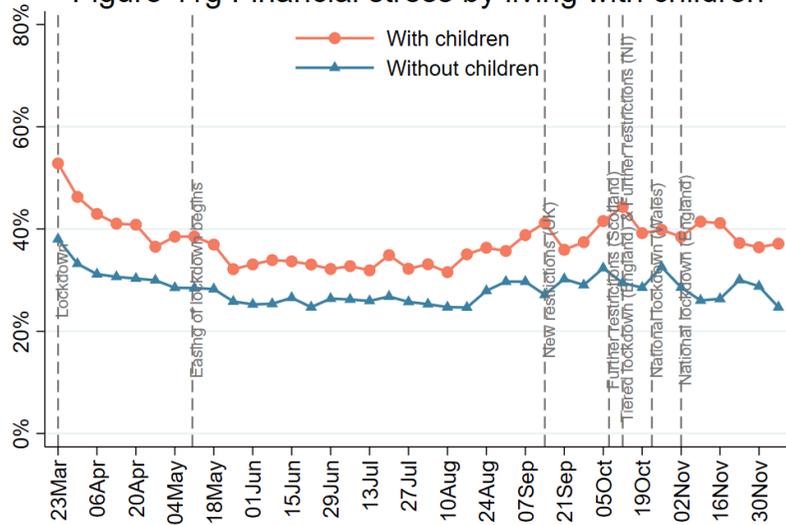


Figure 11h Financial stress by living area

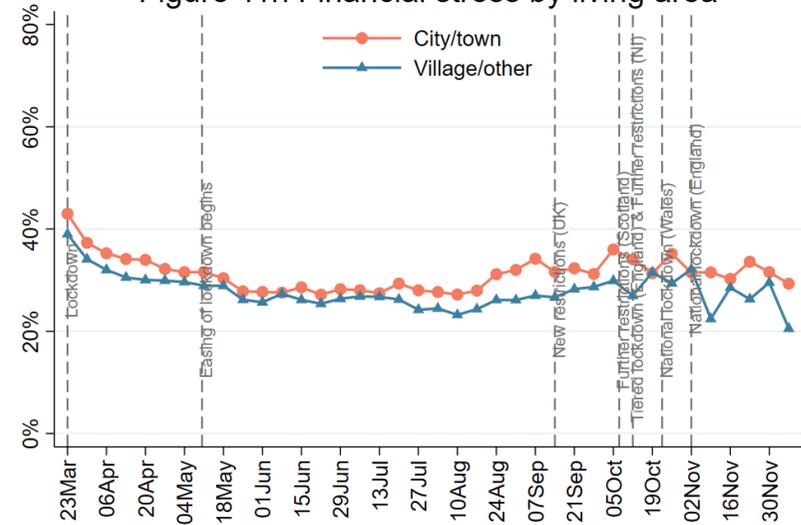


Figure 11i Financial stress by gender

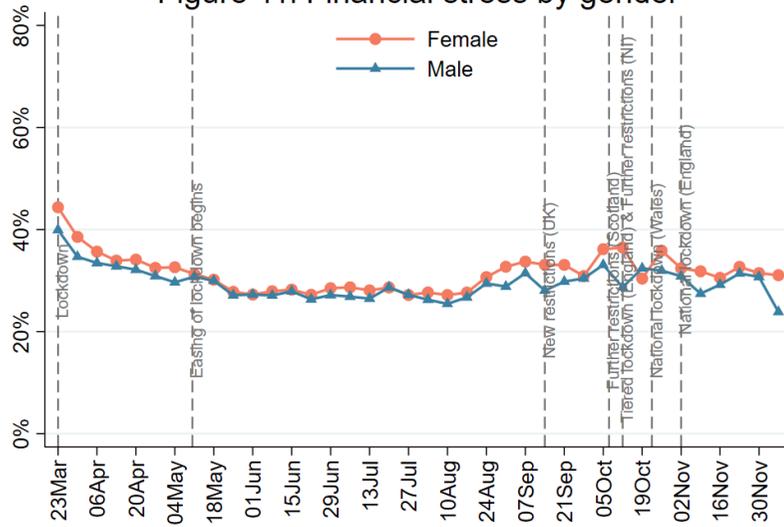


Figure 11j Financial stress by ethnicity

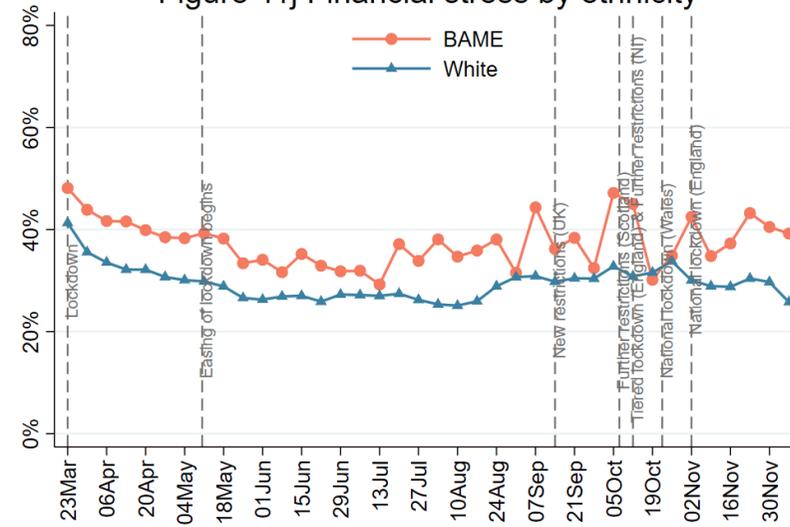


Figure 11k Financial stress by educational levels

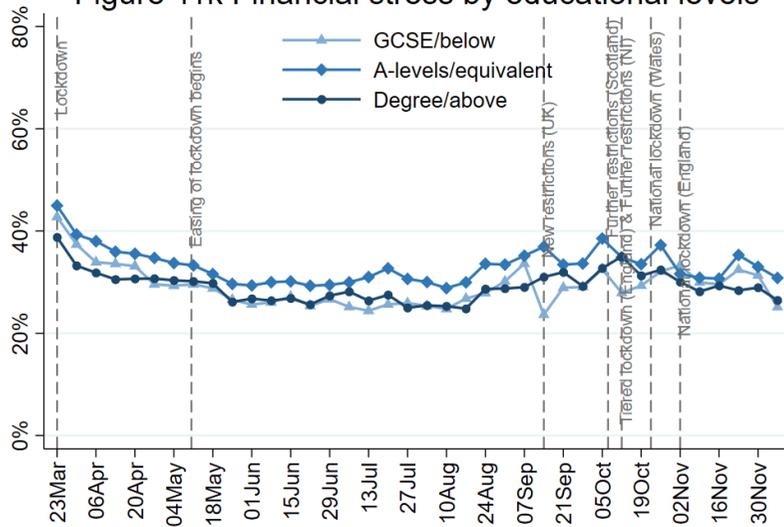


Figure 11l Financial stress by physical health diagnosis

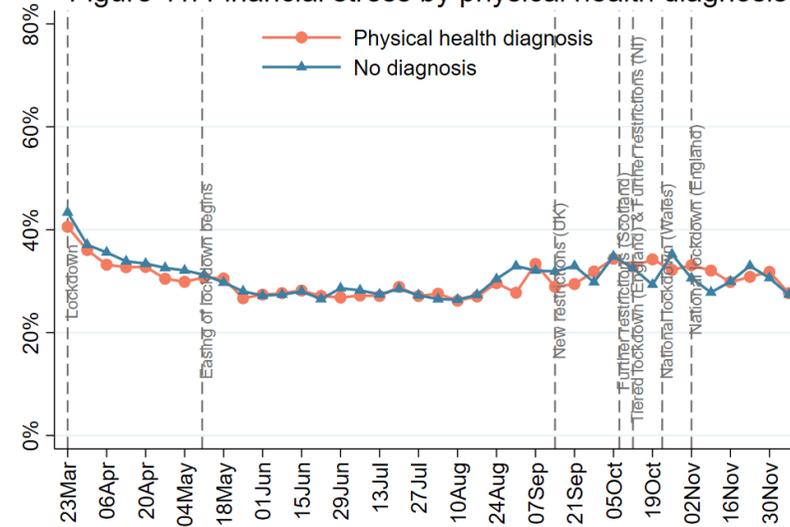


Figure 12a Food security stress by age groups

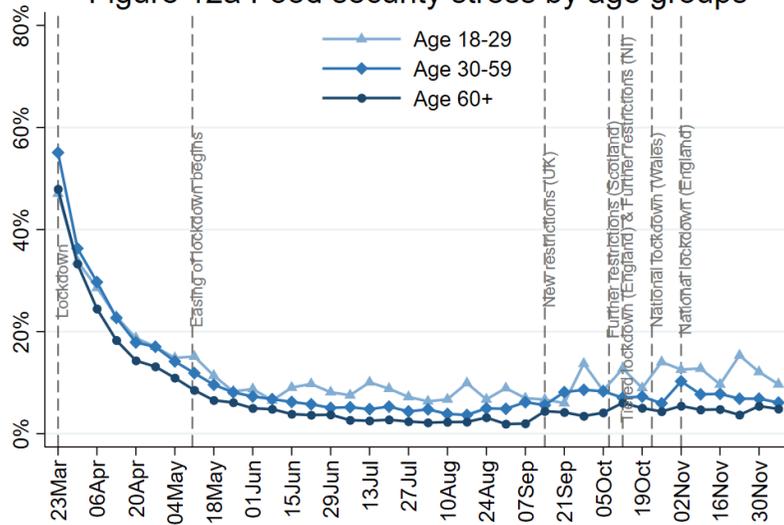


Figure 12b Food security stress by living arrangement

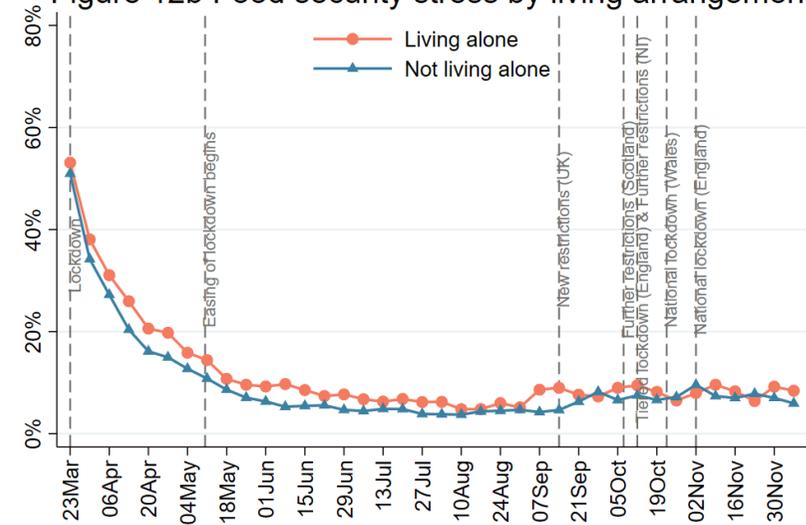


Figure 12c Food security stress by household income

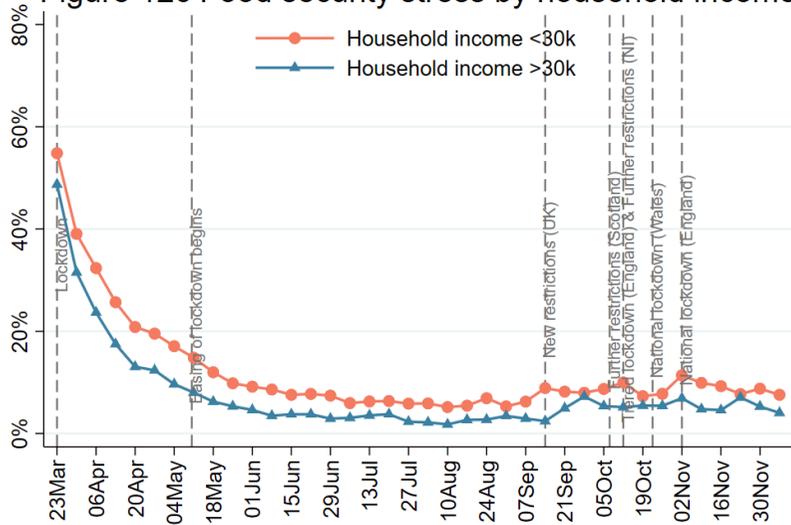


Figure 12d Food security stress by mental health

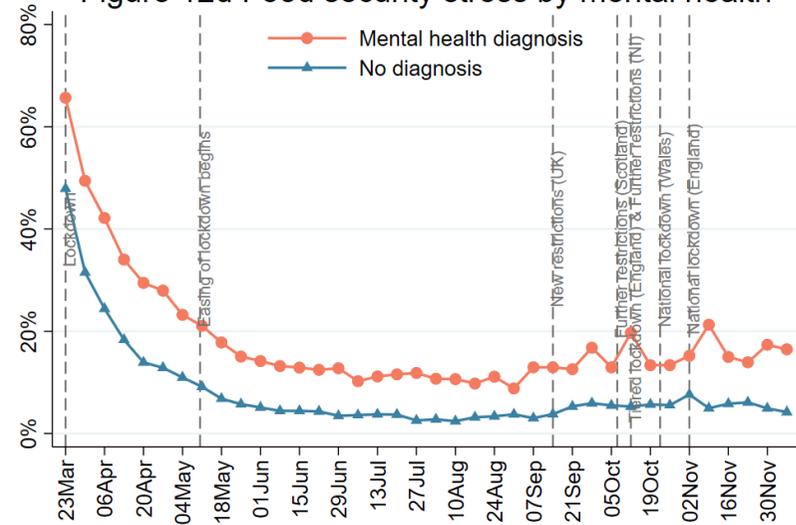


Figure 12e Food security stress by nations

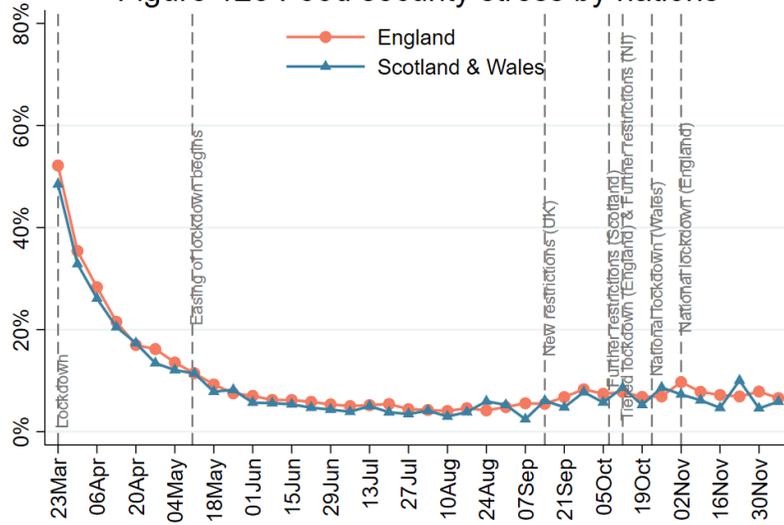


Figure 12f Food security stress by keyworker status

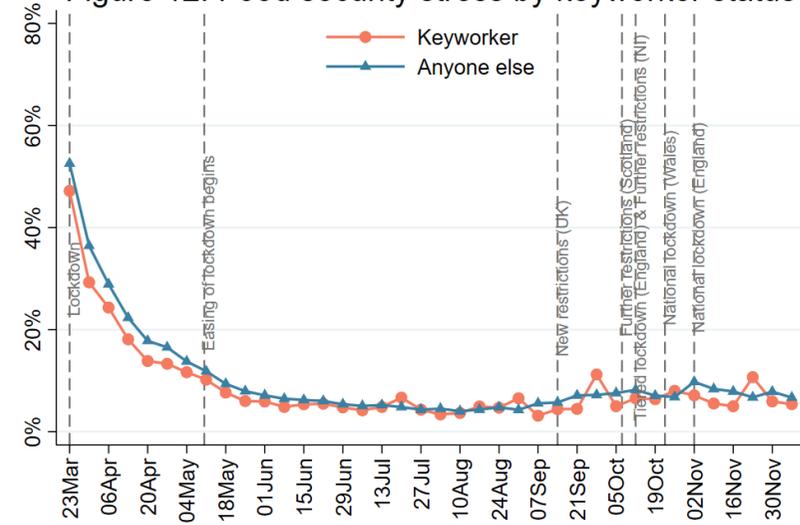


Figure 12g Food security stress by living with children

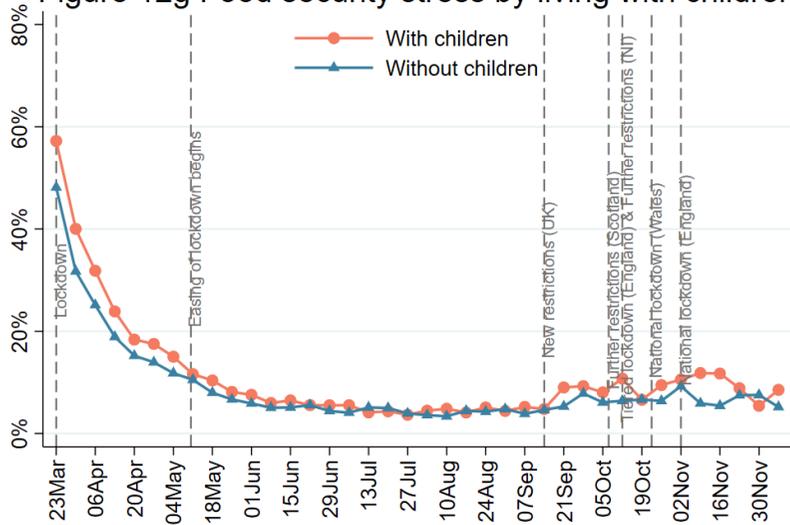


Figure 12h Food security stress by living area

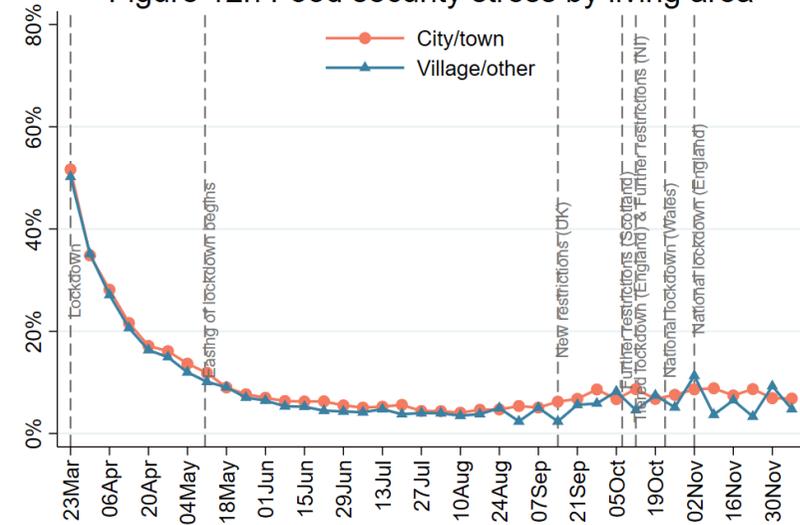


Figure 12i Food security stress by gender

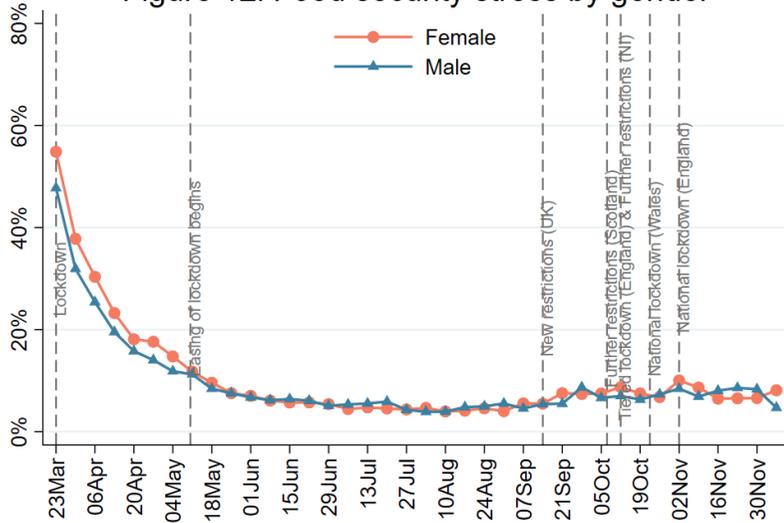


Figure 12j Food security stress by ethnicity

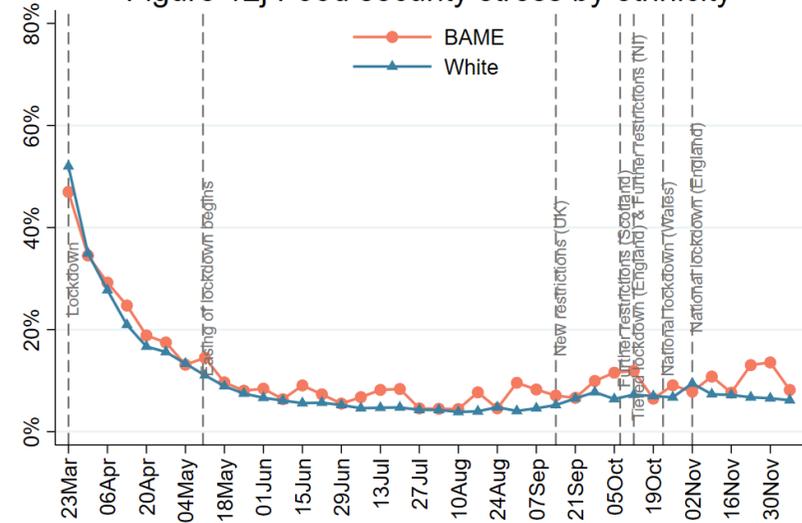


Figure 12k Food security stress by educational levels

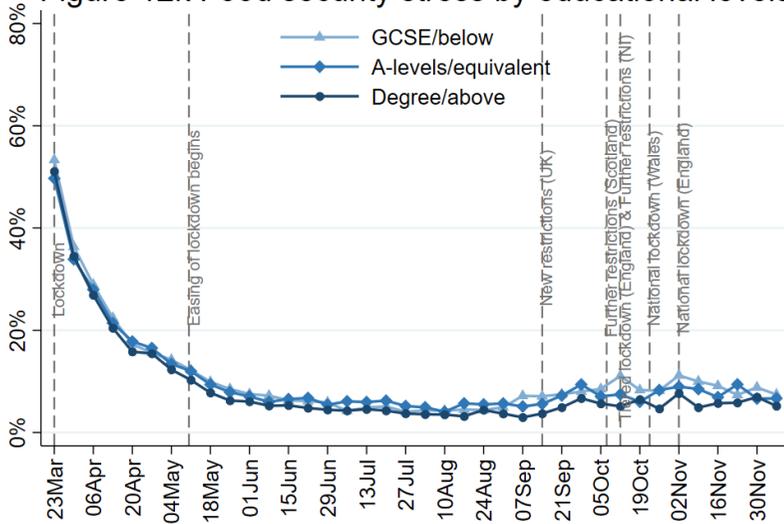
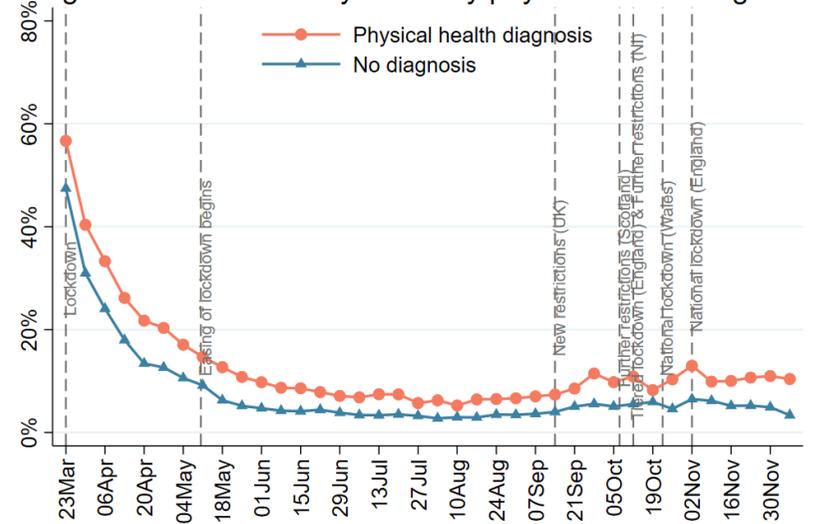
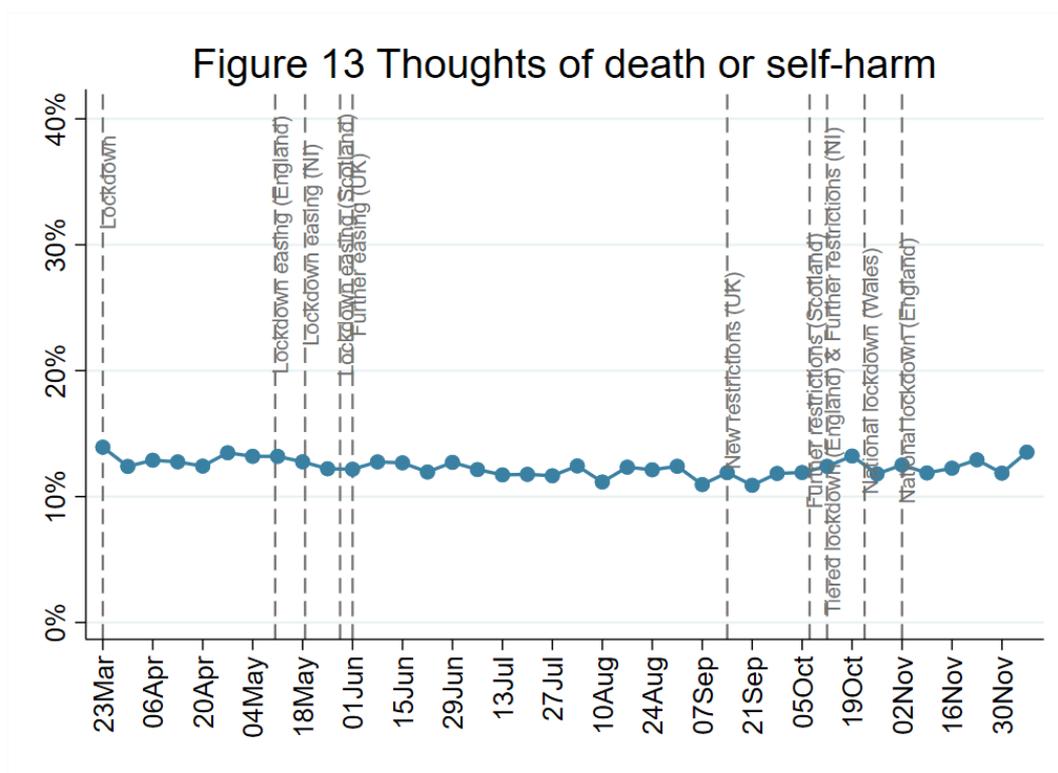


Figure 12l Food security stress by physical health diagnosis



3. Self-harm and abuse

3.1 Thoughts of death or self-harm



FINDINGS

Thoughts of death or self-harm are measured using a specific item within the PHQ-9 that asks whether, in the last week, someone has had “thoughts that you would be better off dead or of hurting yourself in some way”. Responses are on a 4-point scale ranging from “not at all” to “nearly every day”. We focused on any response that indicated having such thoughts.

There continues to be no clear change in thoughts of death or self-harm. Percentages of people having thoughts of death or self-harm have been relatively stable throughout the past 38 weeks. They remain higher amongst younger adults, those with lower household income, people with a long-term physical health condition, and people with a diagnosed mental health condition. They are also higher in people living alone and those living in urban areas. There is no difference by gender.

Figure 14a Thoughts of death by age groups

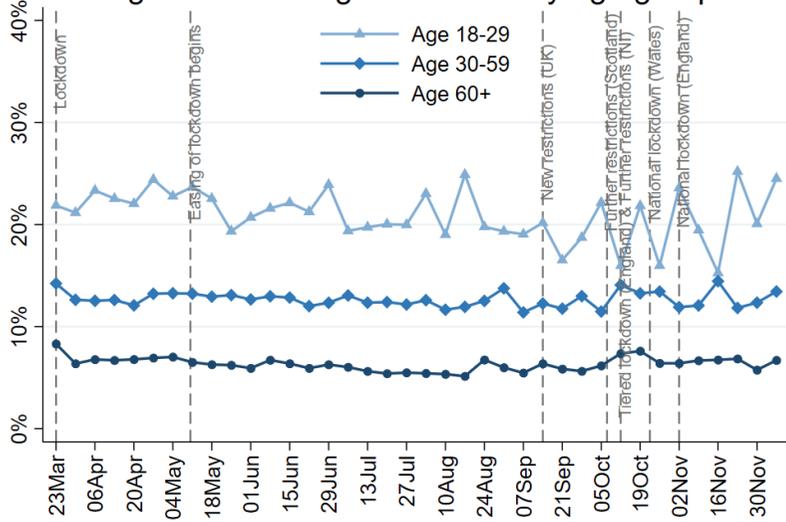


Figure 14b Thoughts of death by living arrangement

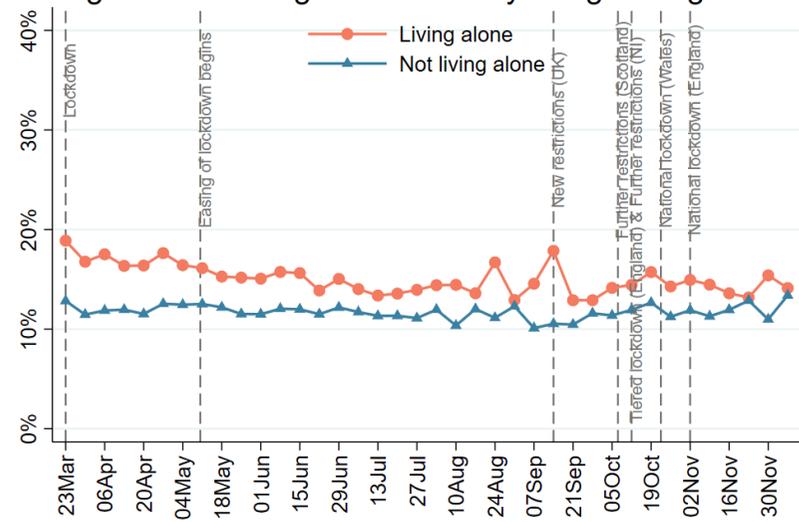


Figure 14c Thoughts of death by household income

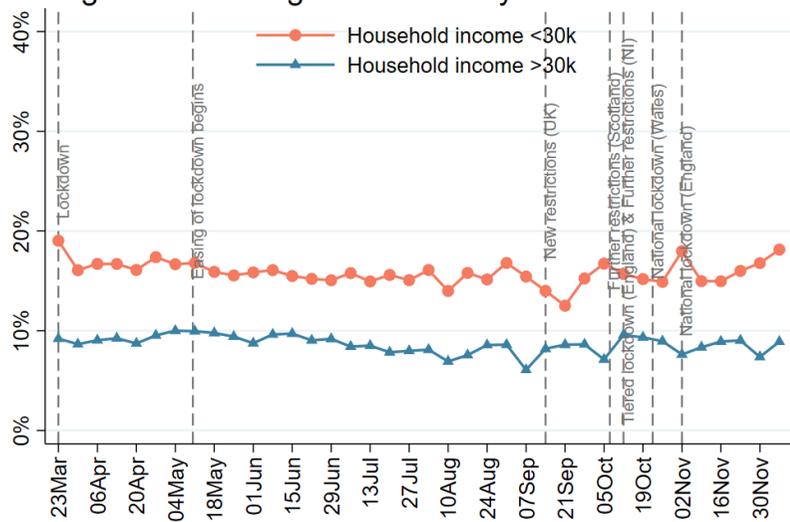


Figure 14d Thoughts of death by mental health diagnosis

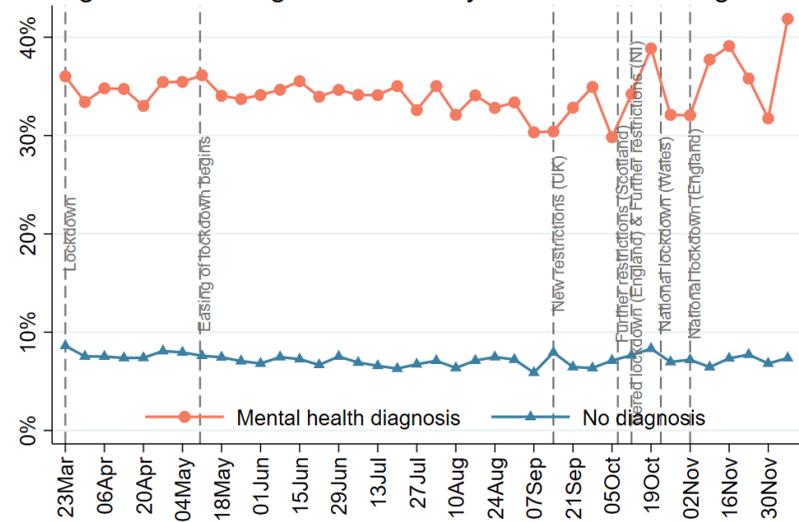


Figure 14e Thoughts of death by nations

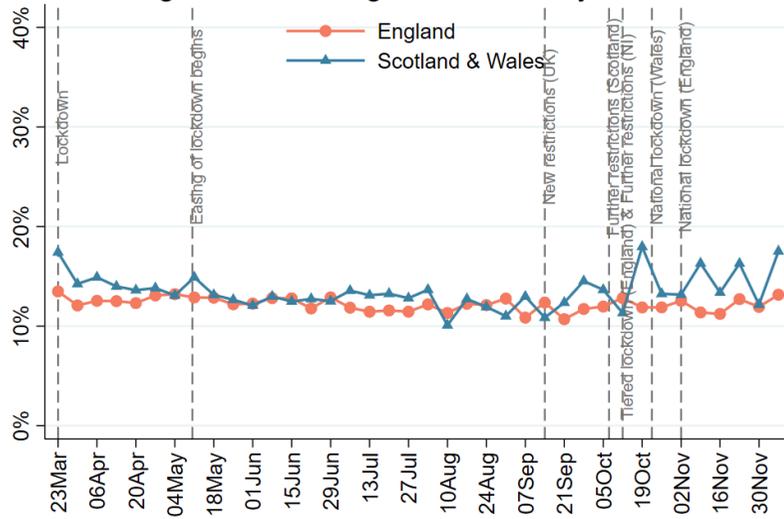


Figure 14f Thoughts of death by keyworker status

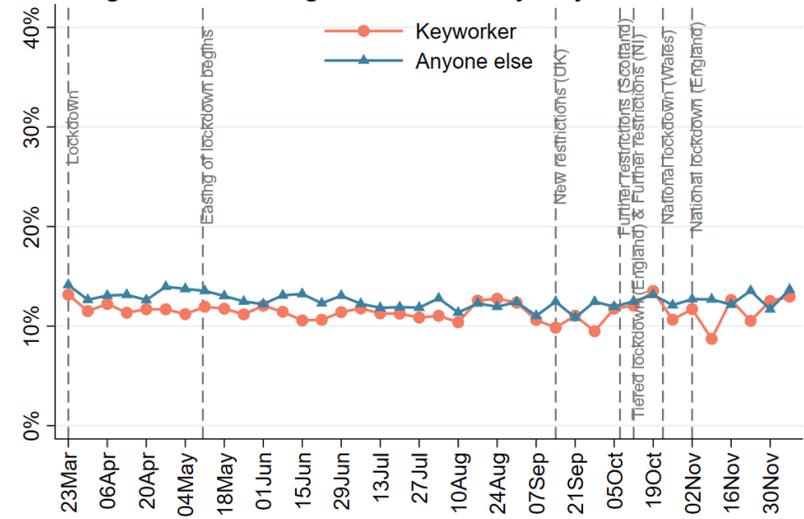


Figure 14g Thoughts of death by living with children

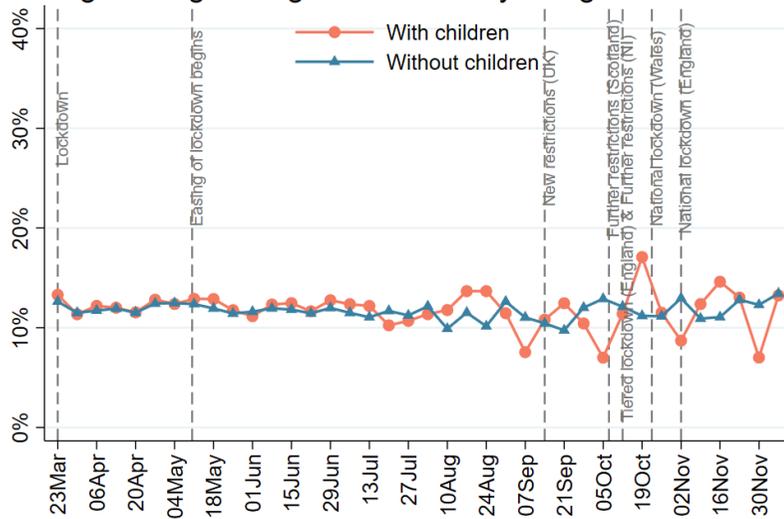


Figure 14h Thoughts of death by living area

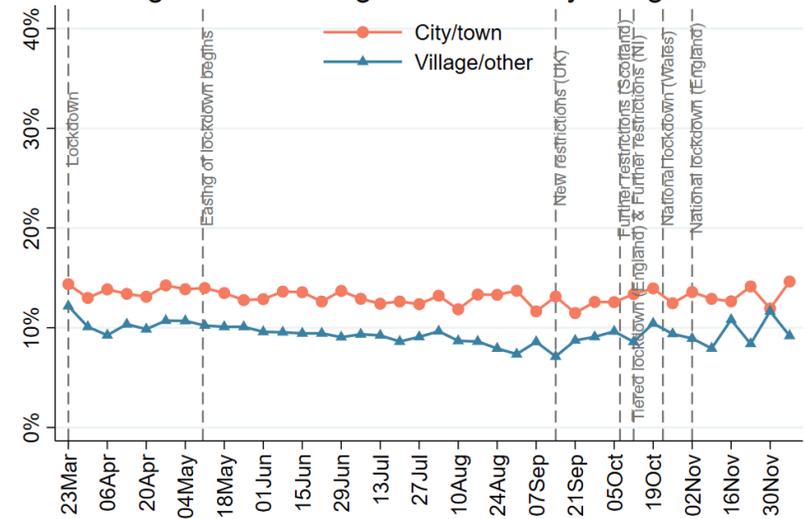


Figure 14i Thoughts of death by gender

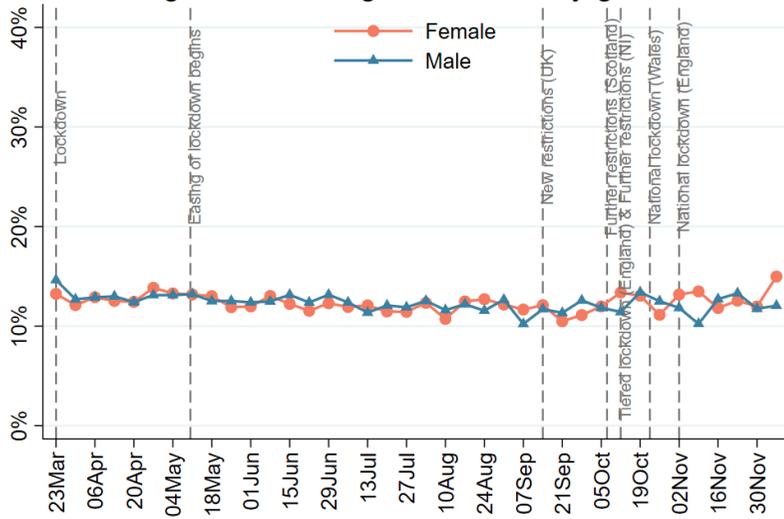


Figure 14j Thoughts of death by ethnicity

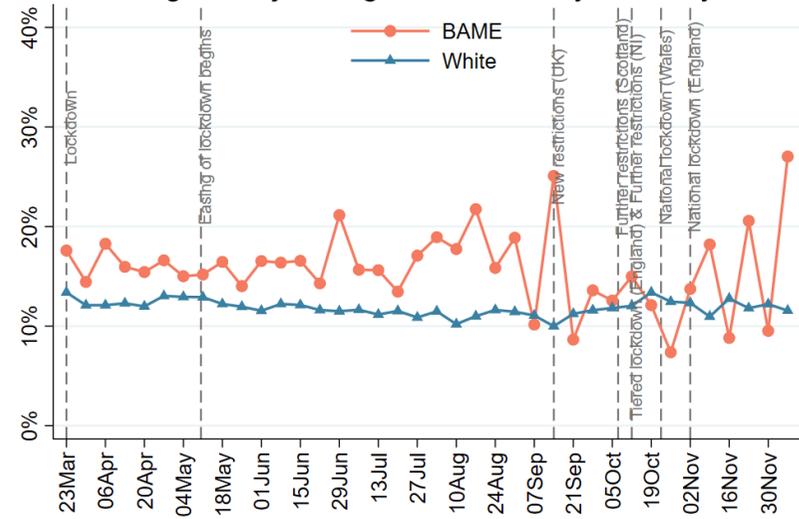


Figure 14k Thoughts of death by educational levels

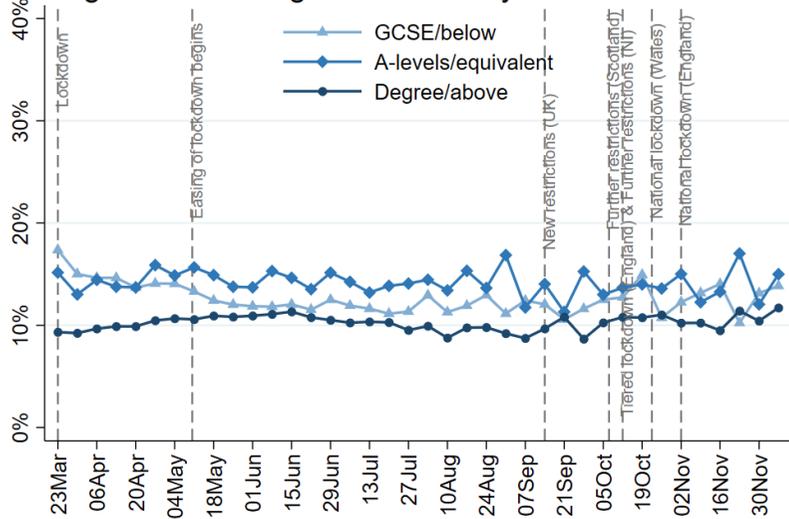
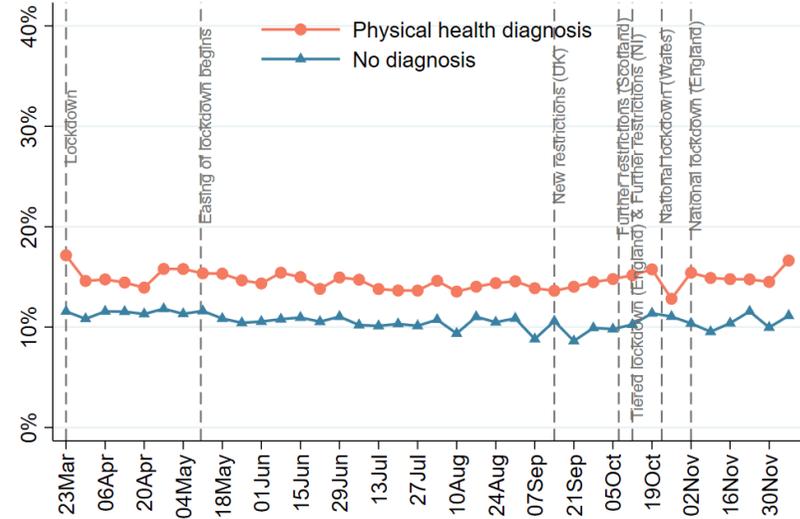
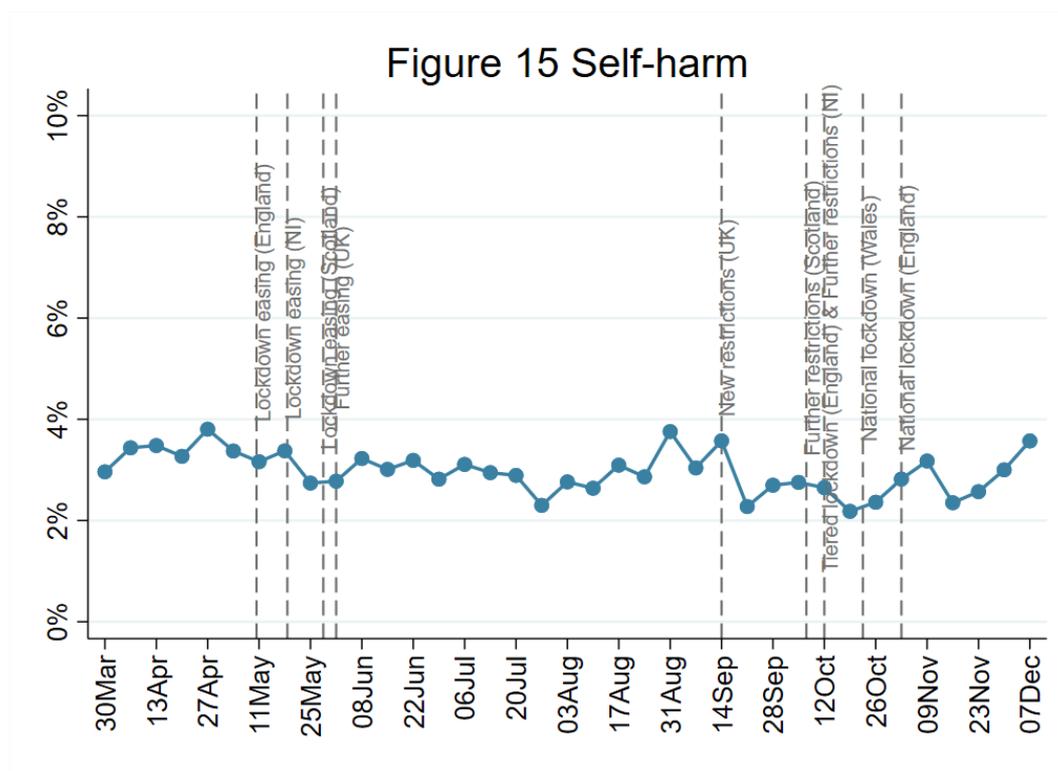


Figure 14l Thoughts of death by physical health diagnosis



3.2 Self-harm



FINDINGS

Self-harm was assessed using a question that asks whether someone in the last week has been “self-harming or deliberately hurting yourself”. Responses are on a 4-point scale ranging from “not at all” to “nearly every day”. We focused on any response that indicated any self-harming.

New data in the past month suggests an increase since mid-November. However, this still appears within the natural variation of responses across the past 38 weeks, so it is too early to say if this is indicative of a new trend. Self-harm remains higher amongst younger adults, those with lower household income, and those with a diagnosed mental health condition. It is also slightly higher amongst people living in urban areas. It is also higher amongst people with long-term physical health conditions.

It should be noted that not all people who self-harm will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels.³

³ Spikes on particular days are likely due to variability in the data as opposed to indications of particularly adverse experiences on certain days.

Figure 16a Self-harm by age groups

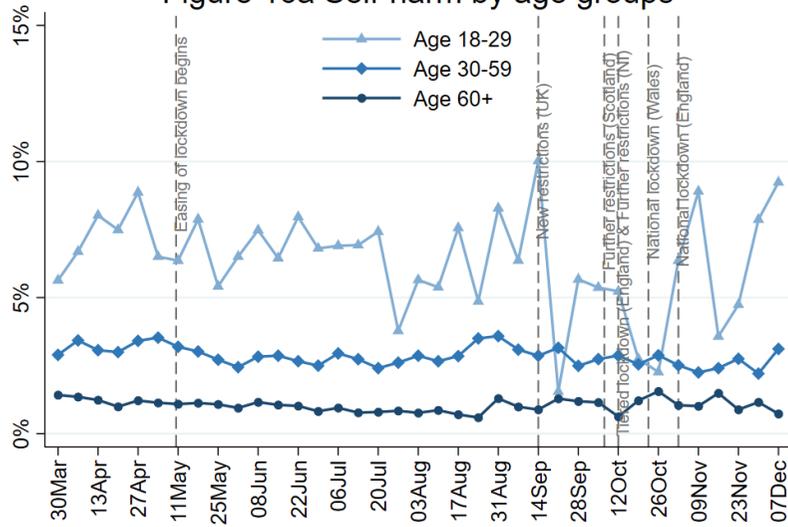


Figure 16b Self-harm by living arrangement

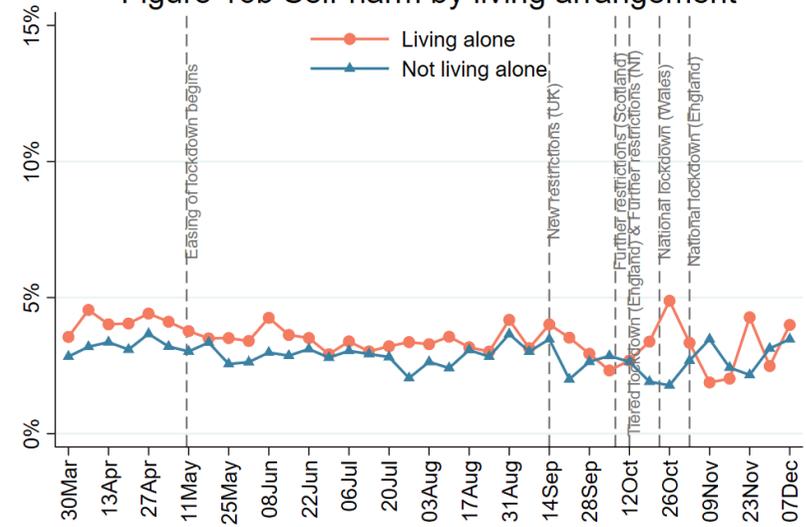


Figure 16c Self-harm by household income

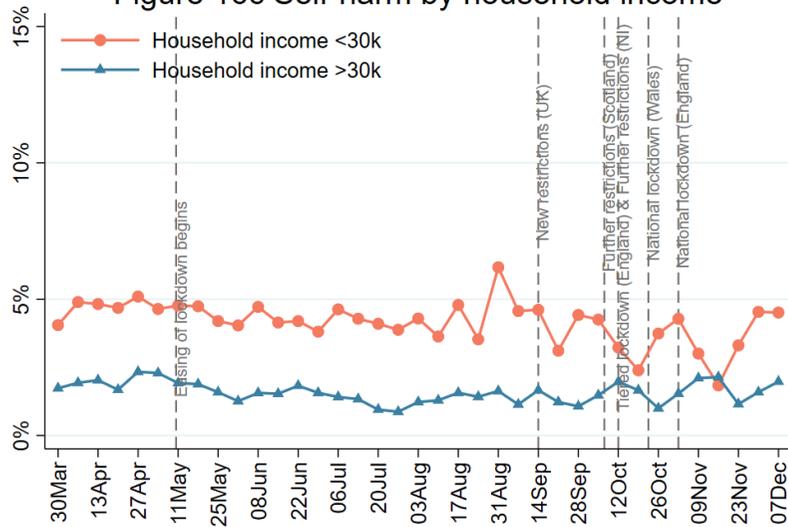


Figure 16d Self-harm by mental health diagnosis

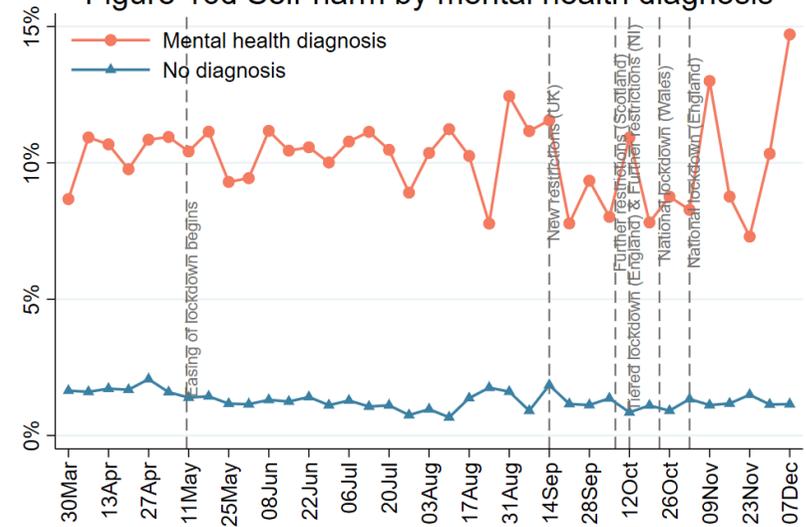


Figure 16e Self-harm by nations

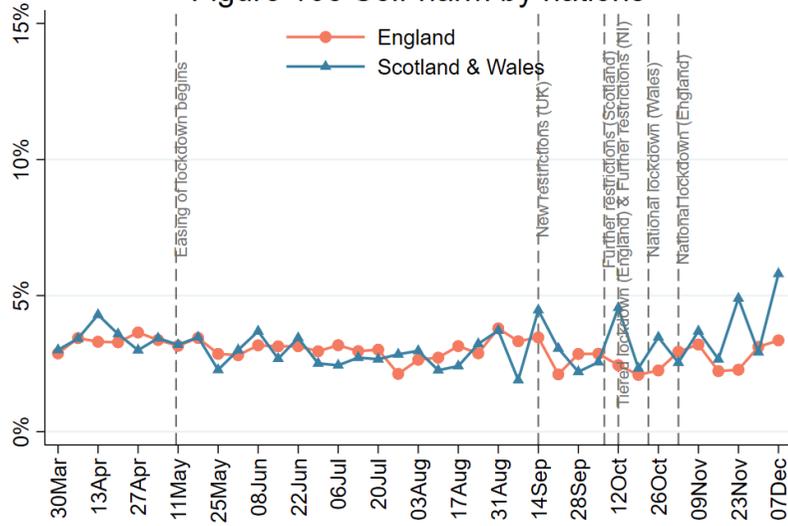


Figure 16f Self-harm by keyworker status

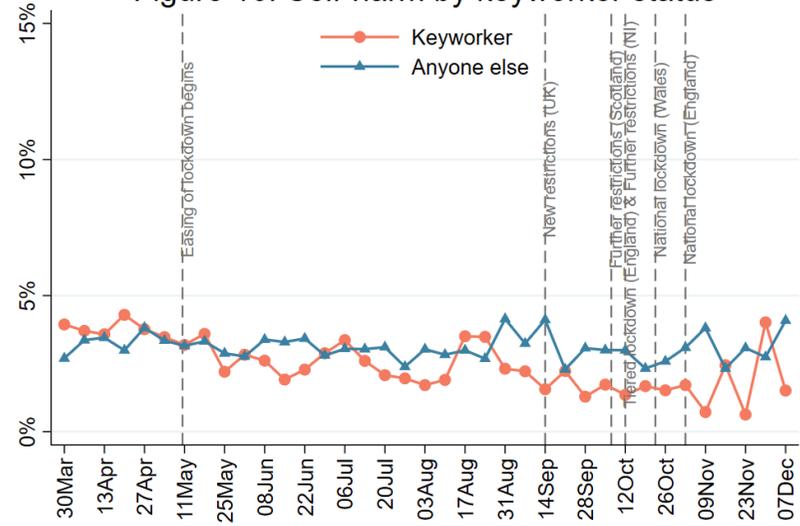


Figure 16g Self-harm by living with children

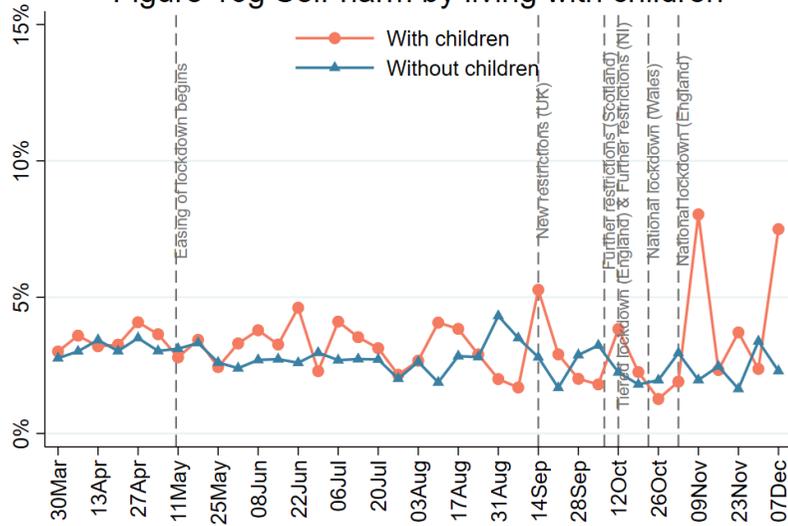


Figure 16h Self-harm by living area

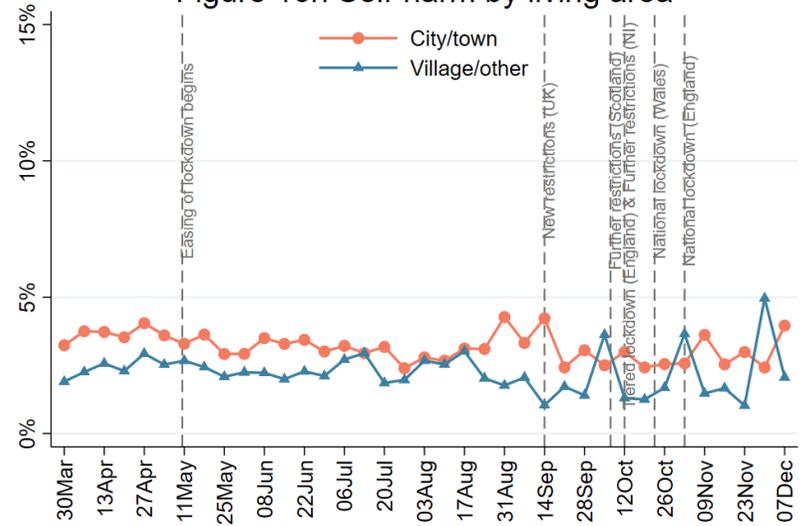


Figure 16i Self-harm by gender

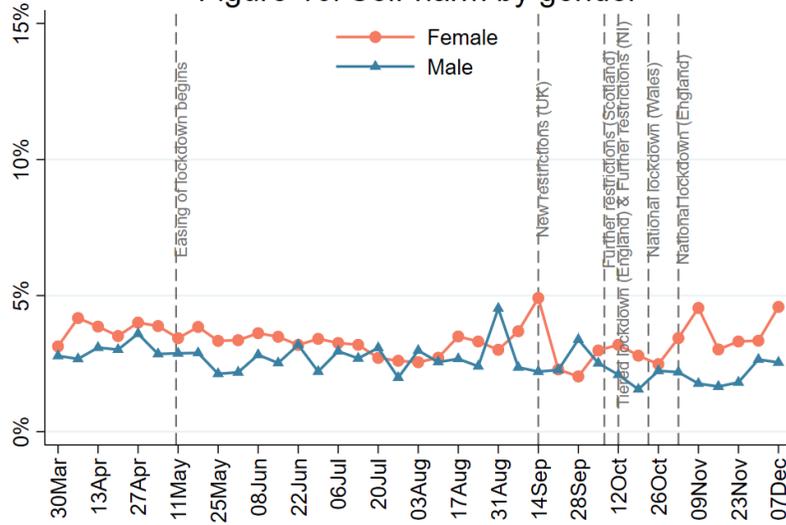


Figure 16j Self-harm by ethnicity

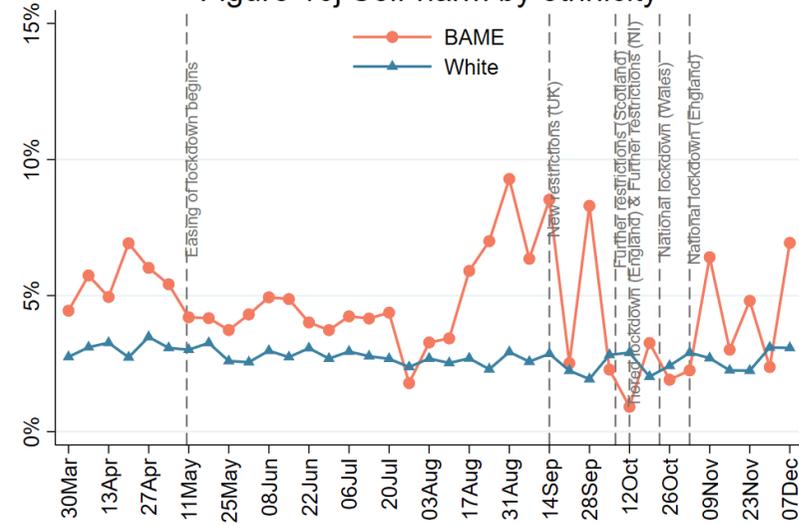


Figure 16k Self-harm by educational levels

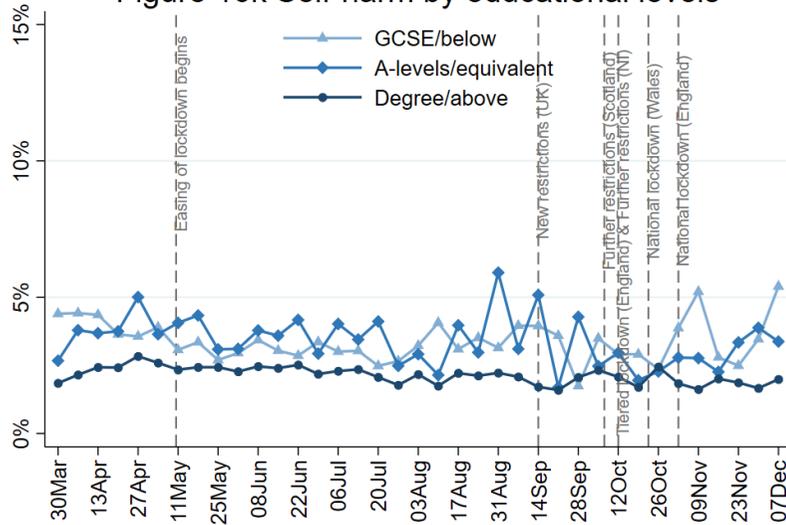
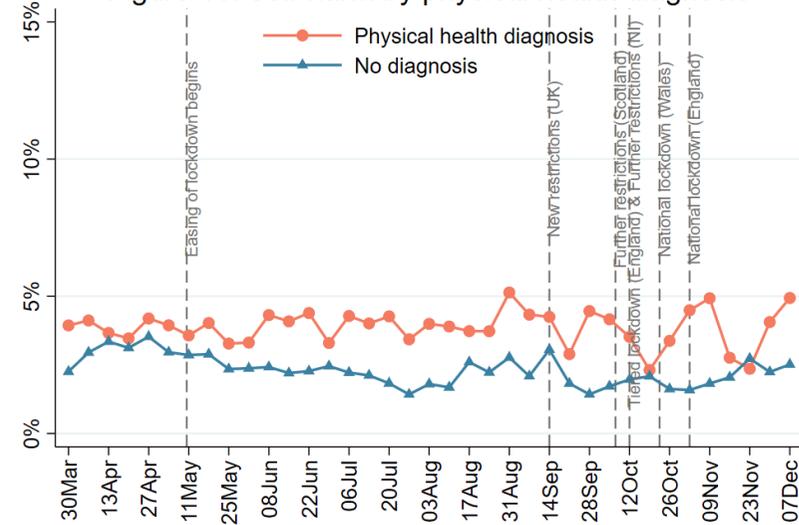
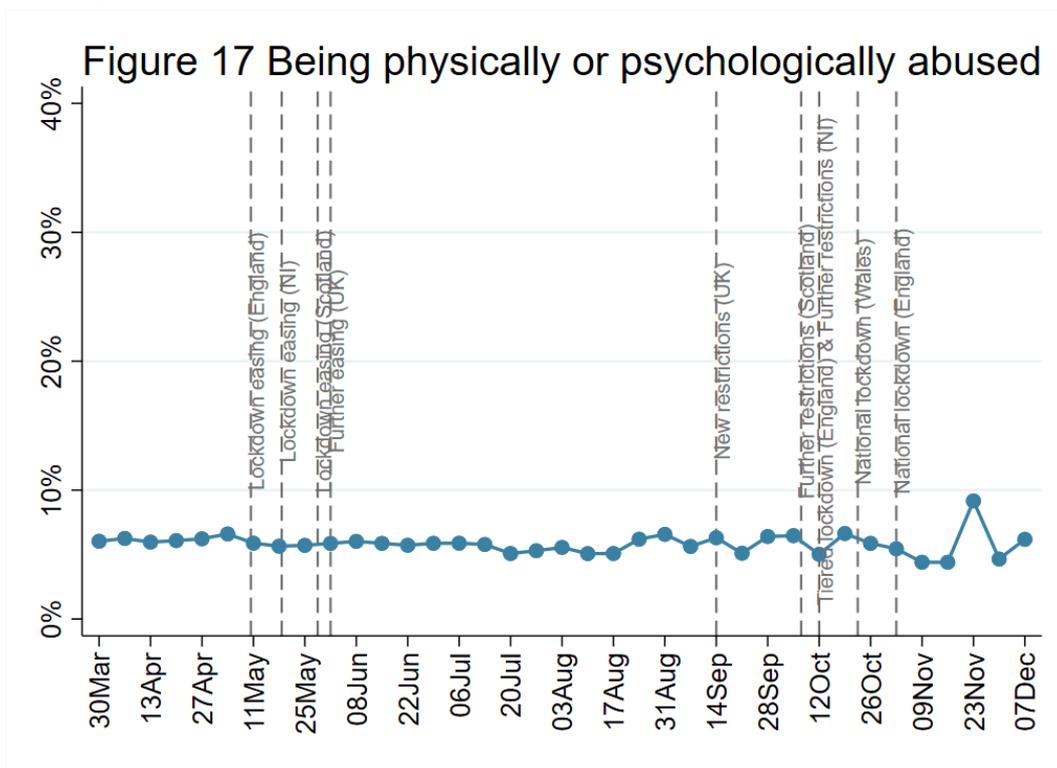


Figure 16l Self-harm by physical health diagnosis



3.3 Abuse



FINDINGS

Abuse was measured using two questions that ask if someone has experienced in the last week “being physically harmed or hurt by someone else” or “being bullied, controlled, intimidated, or psychologically hurt by someone else”. Responses are on a 4-point scale ranging from “not at all” to “nearly every day”. We focused on any response on either item that indicated any experience of physical or psychological abuse.

Abuse has remained relatively stable in the past few months. The data from 3 weeks ago now appear to be a statistical anomaly rather than an indication of a rise in levels since reports have returned to the same averages as in the past 38 weeks since.

Abuse remains higher amongst people with a diagnosed mental or physical health condition. It is also slightly higher amongst people with lower household income, those living in urban areas, and people from ethnic minority backgrounds.

It should be noted that not all people who experienced physical or psychological abuse will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels.⁴

⁴ Spikes on particular days are likely due to variability in the data as opposed to indications of particularly adverse experiences on certain days.

Figure 18a Abuse by age groups

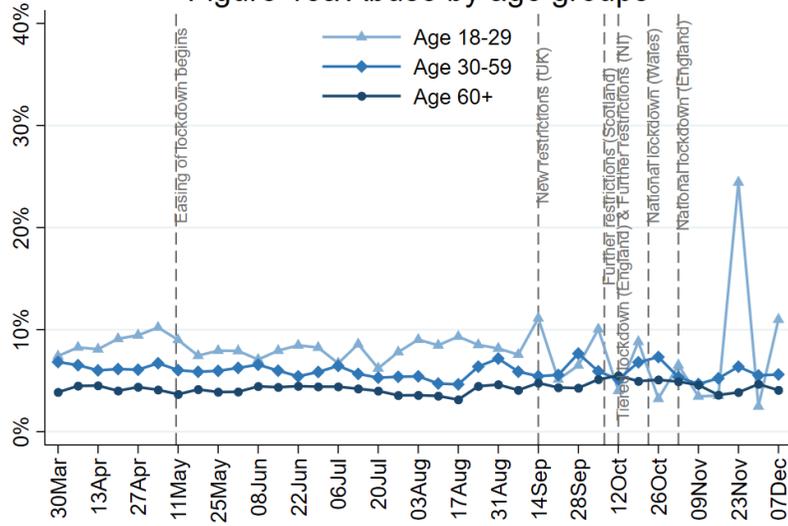


Figure 18b Abuse by living arrangement

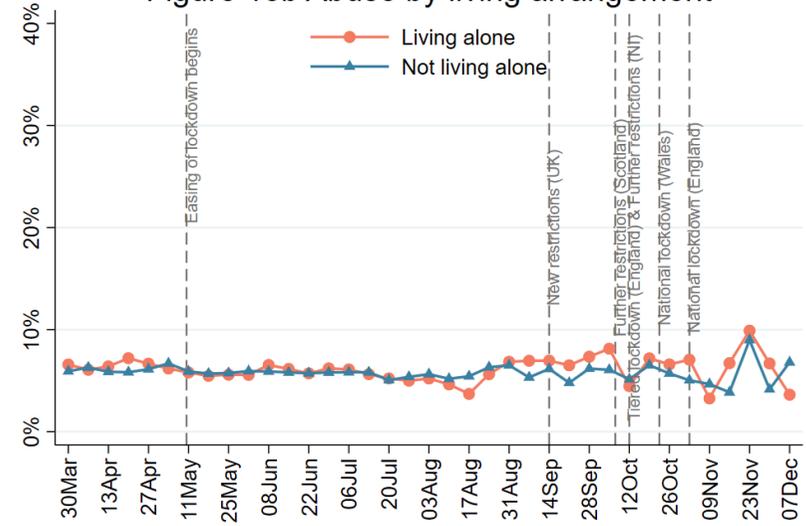


Figure 18c Abuse by household income

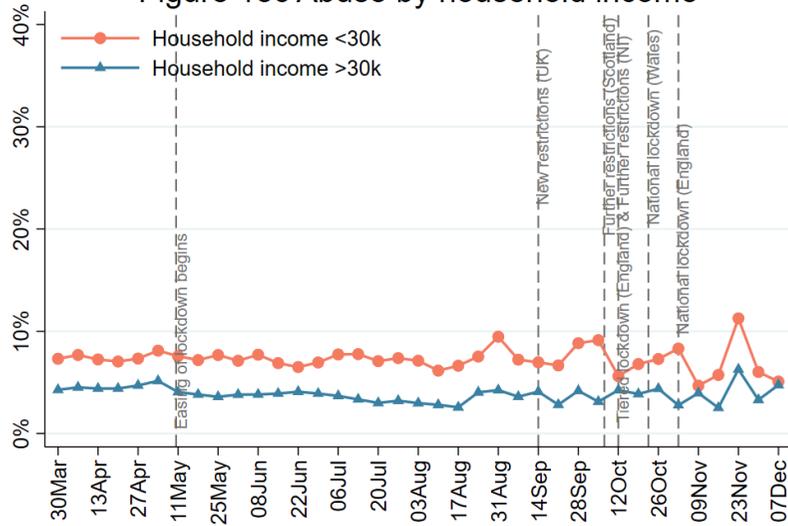


Figure 18d Abuse by mental health diagnosis

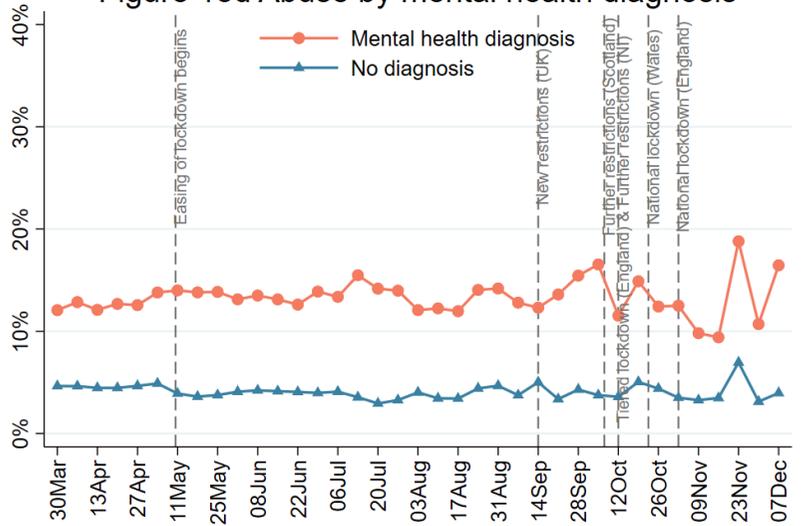


Figure 18e Abuse by nations

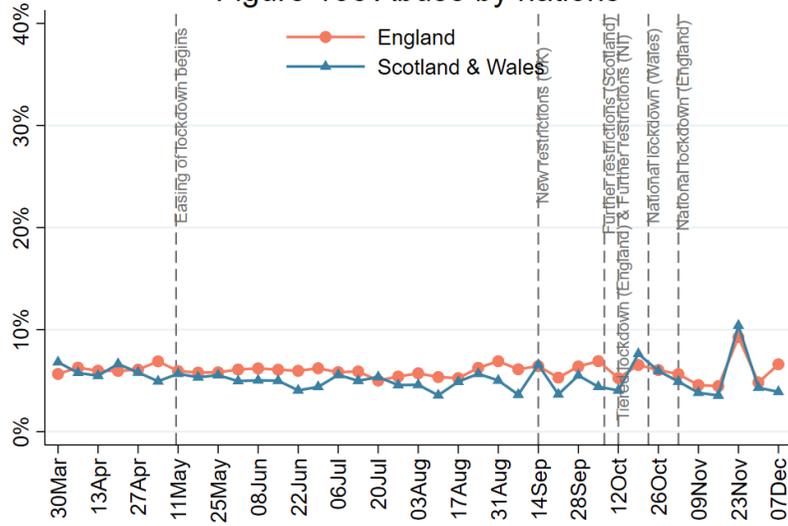


Figure 18f Abuse by keyworker status

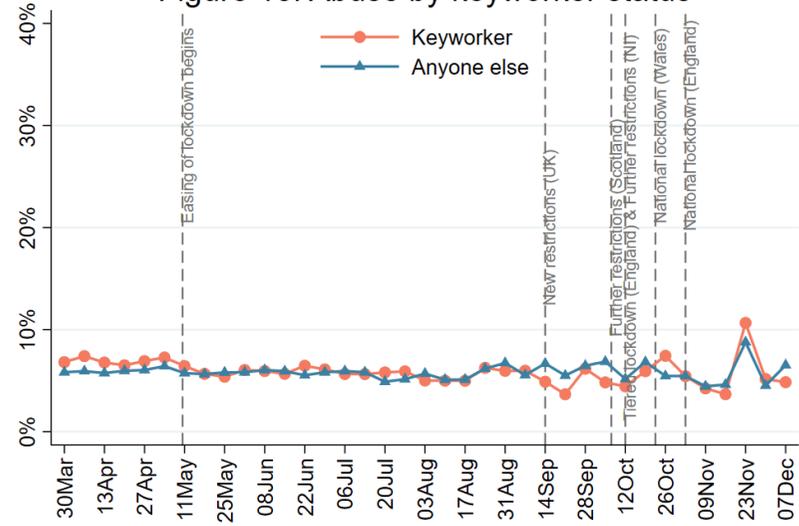


Figure 18g Abuse by living with children

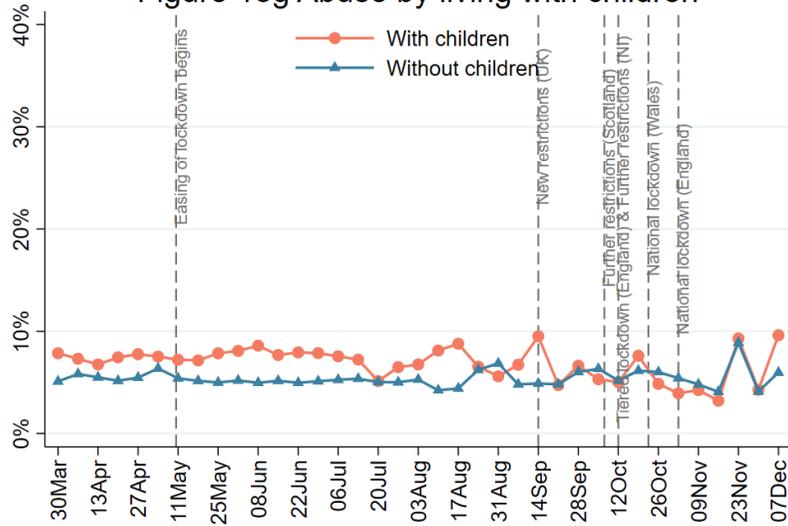


Figure 18h Abuse by living area

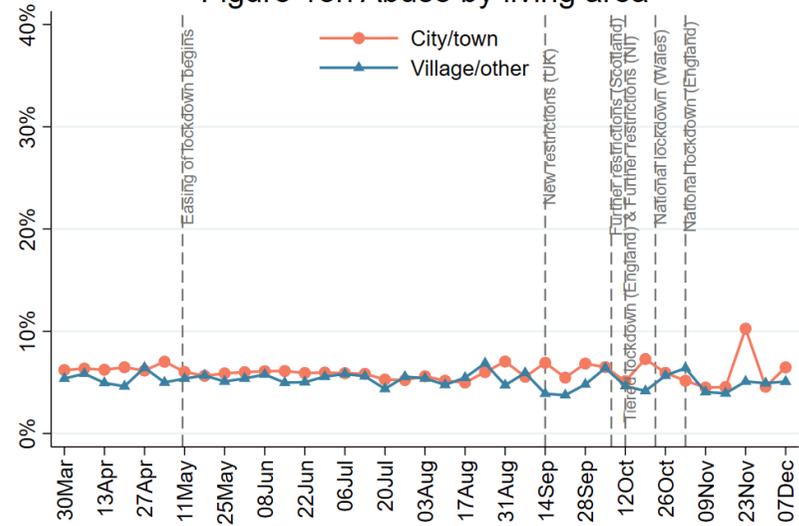


Figure 18i Abuse by gender

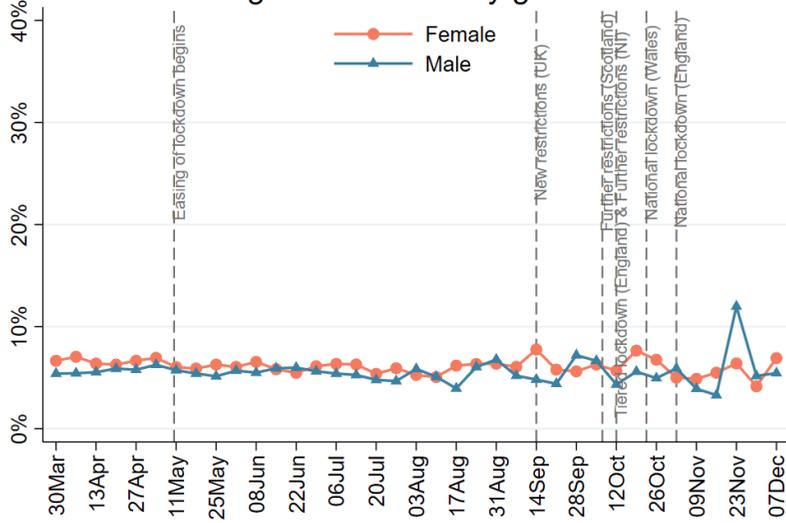


Figure 18j Abuse by ethnicity

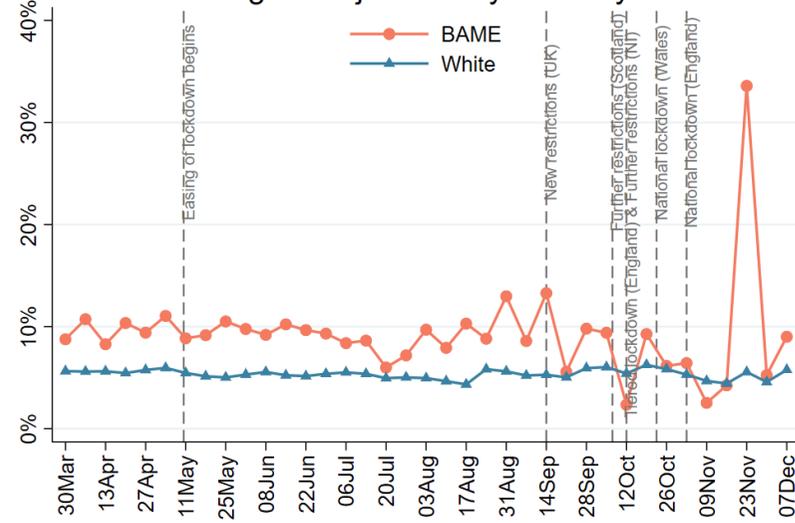


Figure 18k Abuse by educational levels

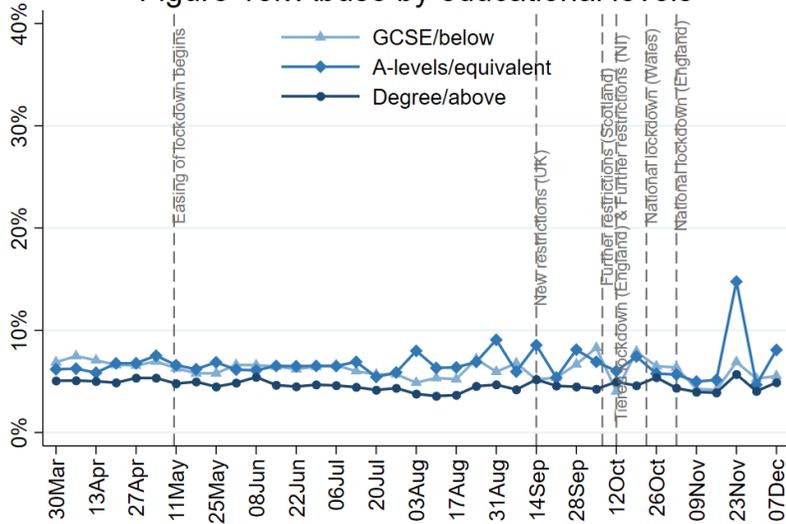
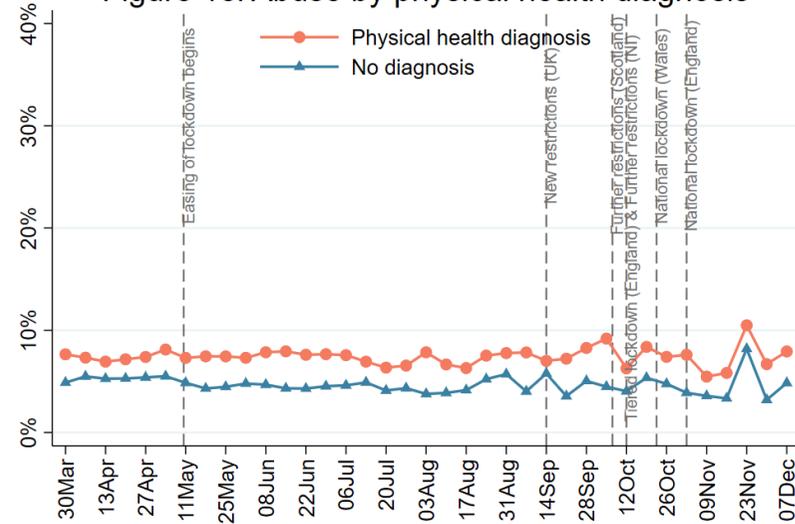
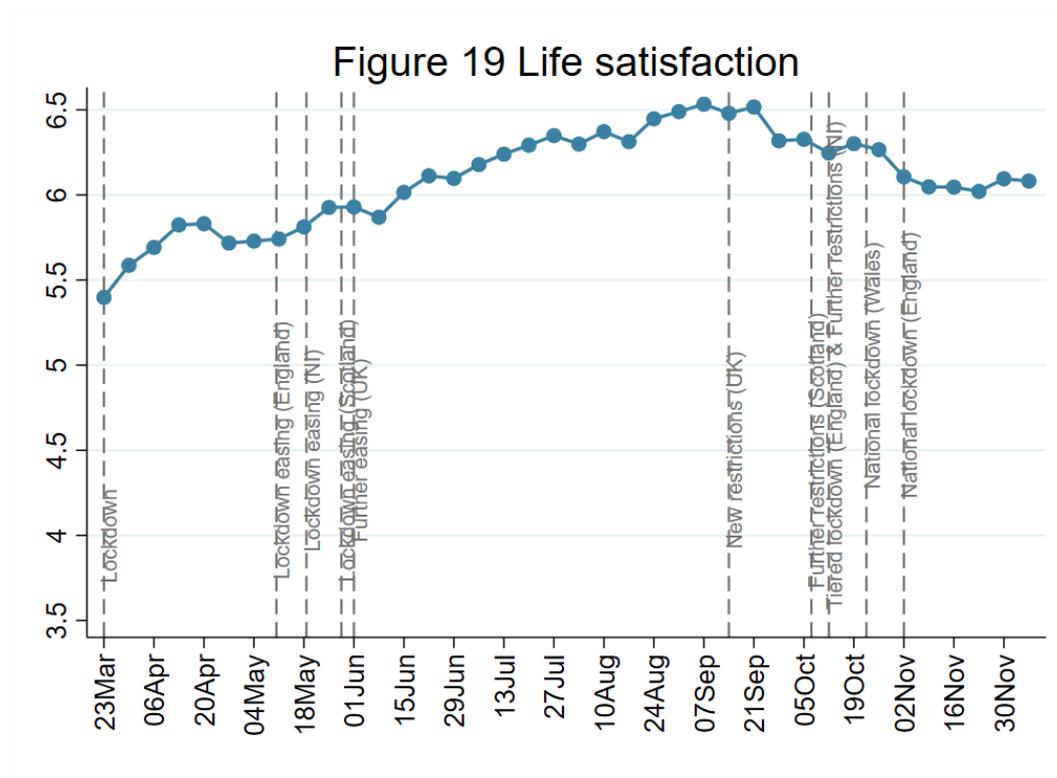


Figure 18l Abuse by physical health diagnosis



4. General well-being

4.1 Life satisfaction



FINDINGS

Respondents were asked to rate their life satisfaction during the past week using the ONS wellbeing scale, which asks respondents about how satisfied they are with their life, using a scale from 0 (not at all) to 10 (completely).

Life satisfaction continues to be lower than over the summer with no signs of improvements in the past fortnight. This decrease since August appears to have occurred across all age groups, although adults under the age of 60 have lowest levels of life satisfaction. It is also lower in people living alone, people with lower household income, people with a diagnosed mental health condition, and people living in urban areas. It is similar across UK nations and amongst key workers. Women have lower levels of life satisfaction, as do people with a long-term physical health condition and people from BAME backgrounds (although smaller sample sizes compared to people with white ethnicity mean there has been greater volatility in these data).

Life satisfaction is still noticeably lower than for the past 12 months (where usual averages are around 7.7), and wellbeing more generally appears to have decreased substantially in the weeks preceding lockdown⁵.

⁵ Layard R, Clark A, De Neve J-E, Kregel C, Fancourt D, Hey N, et al. When to release the lockdown: A wellbeing framework for analysing costs and benefits. Centre for Economic Performance, London School of Economics; 2020 Apr. Report No.: 49.

Figure 20a Life satisfaction by age groups

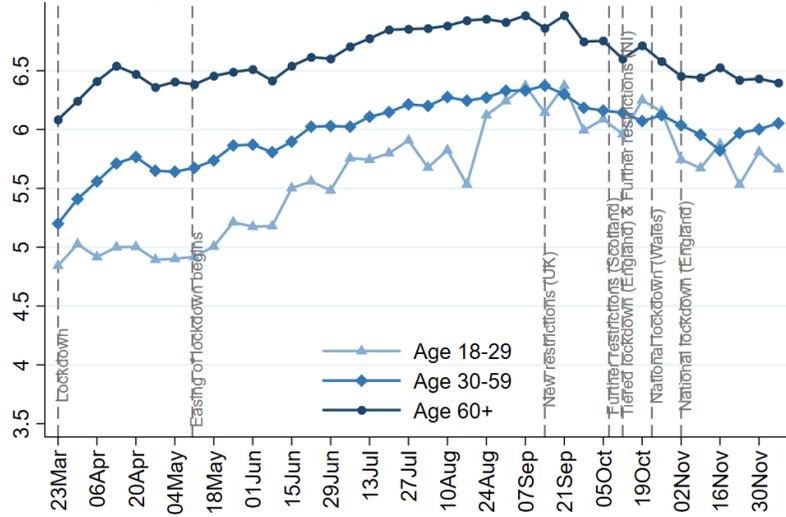


Figure 20b Life satisfaction by living arrangement

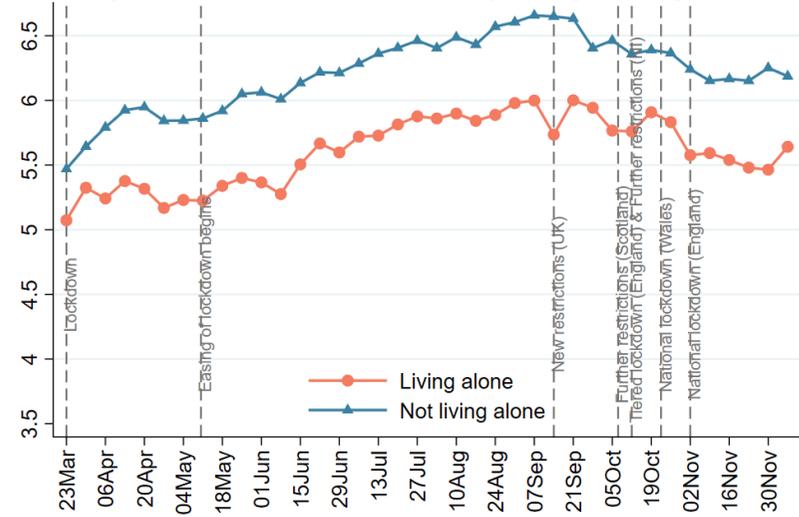


Figure 20c Life satisfaction by household income

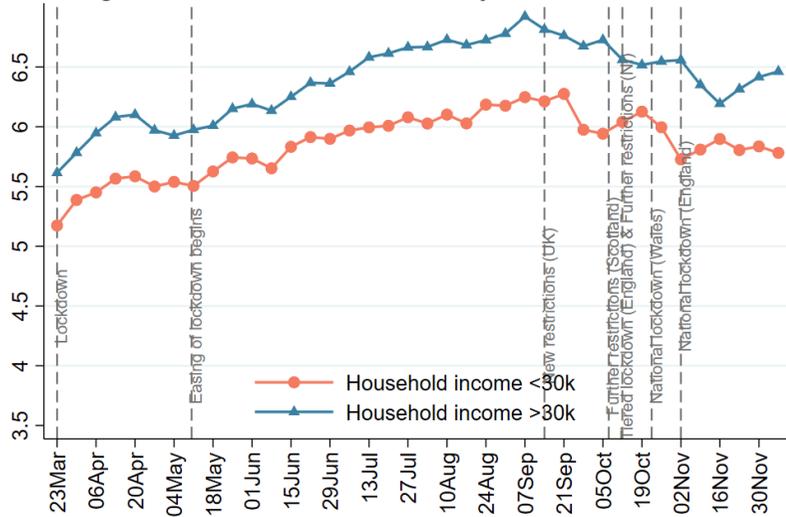


Figure 20d Life satisfaction by mental health diagnosis

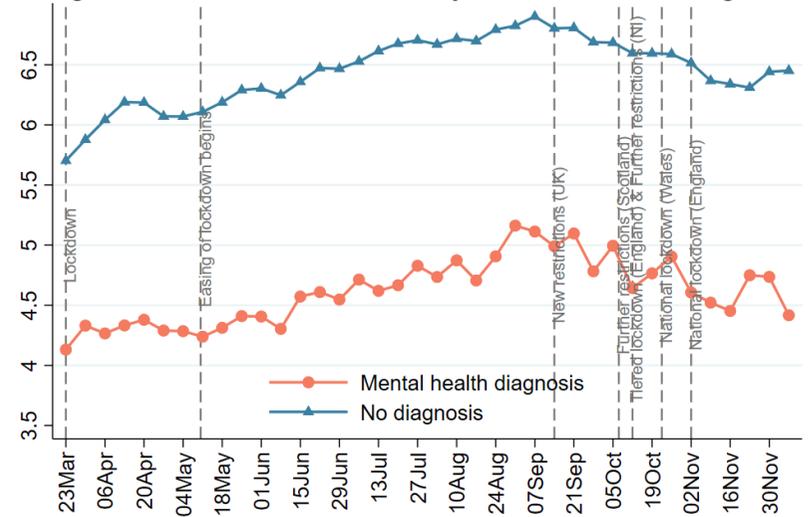


Figure 20e Life satisfaction by nations

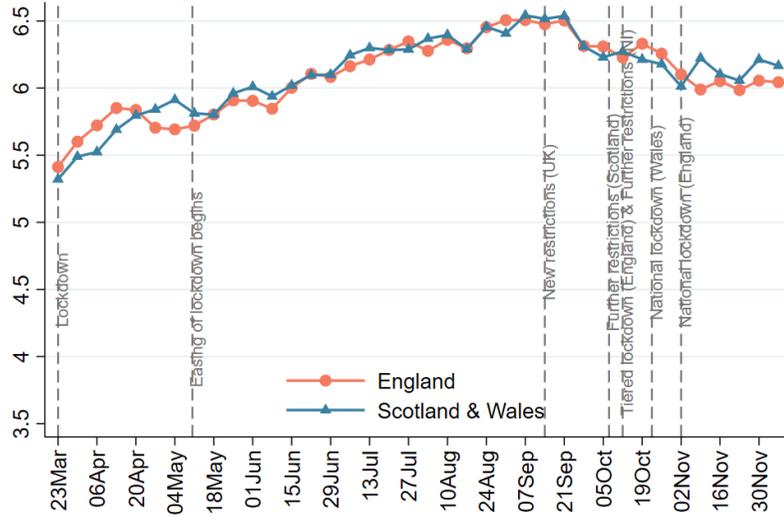


Figure 20f Life satisfaction by keyworker status

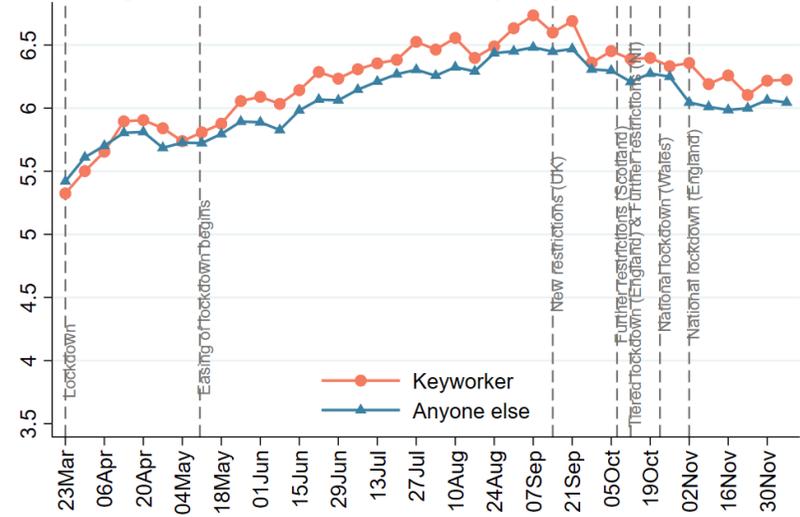


Figure 20g Life satisfaction by living with children

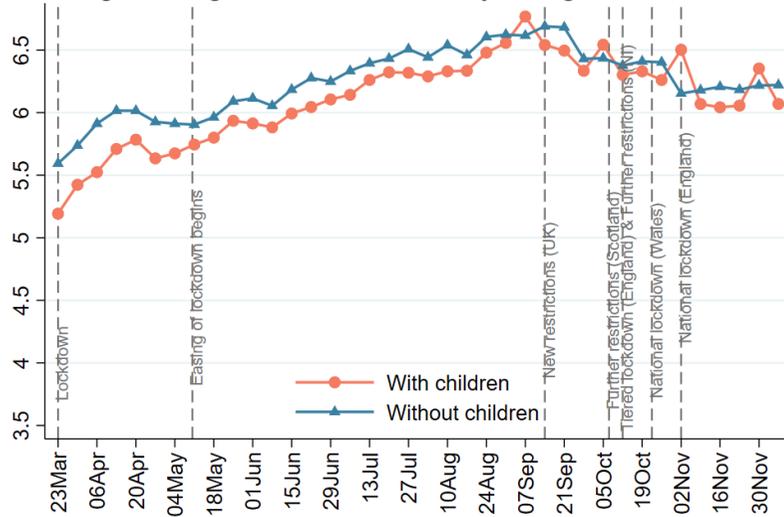


Figure 20h Life satisfaction by living area

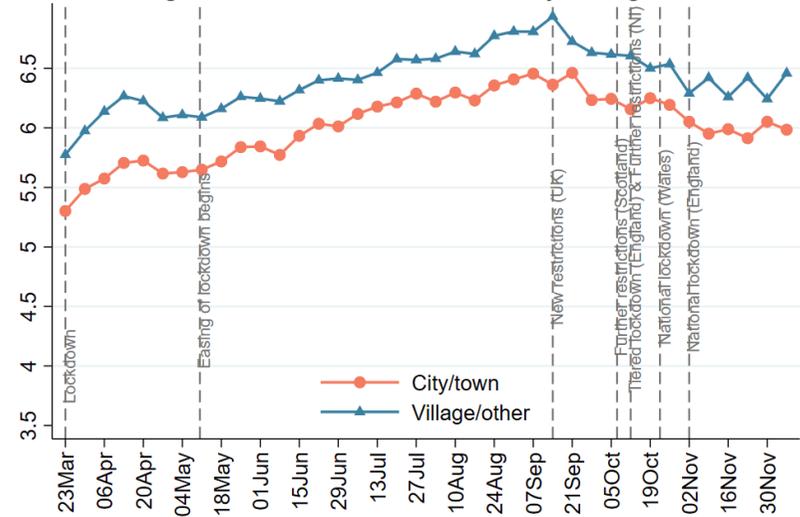


Figure 20i Life satisfaction by gender

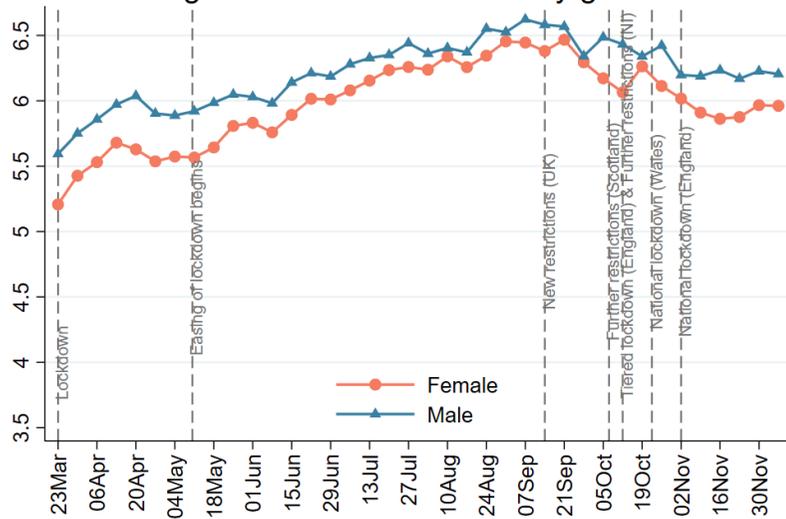


Figure 20j Life satisfaction by ethnicity

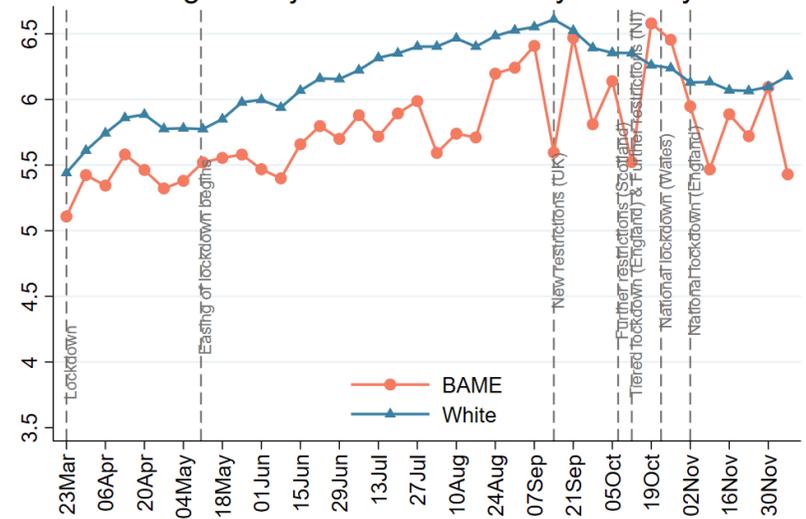


Figure 20k Life satisfaction by educational levels

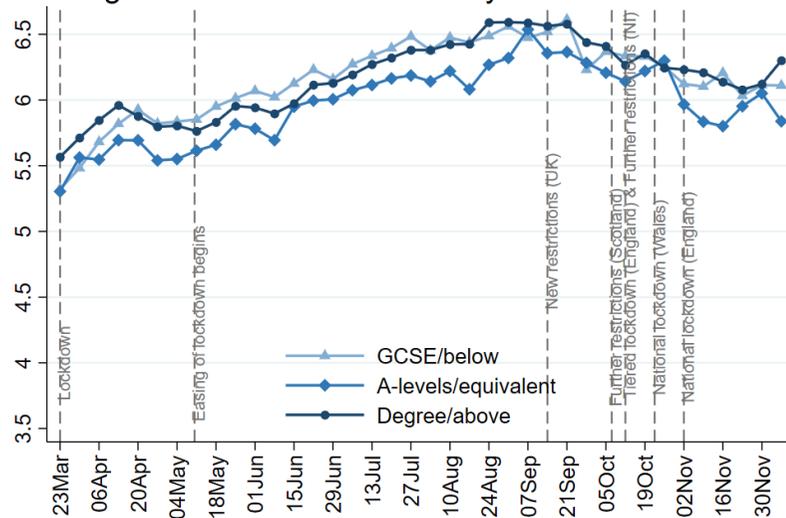
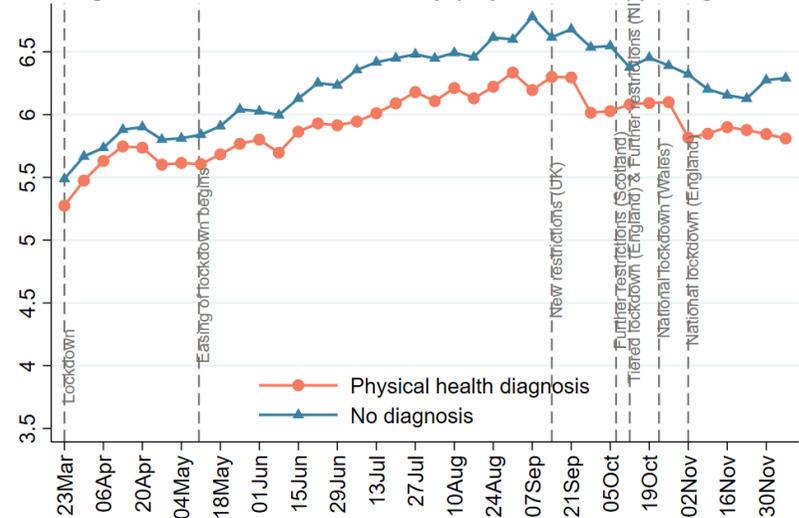
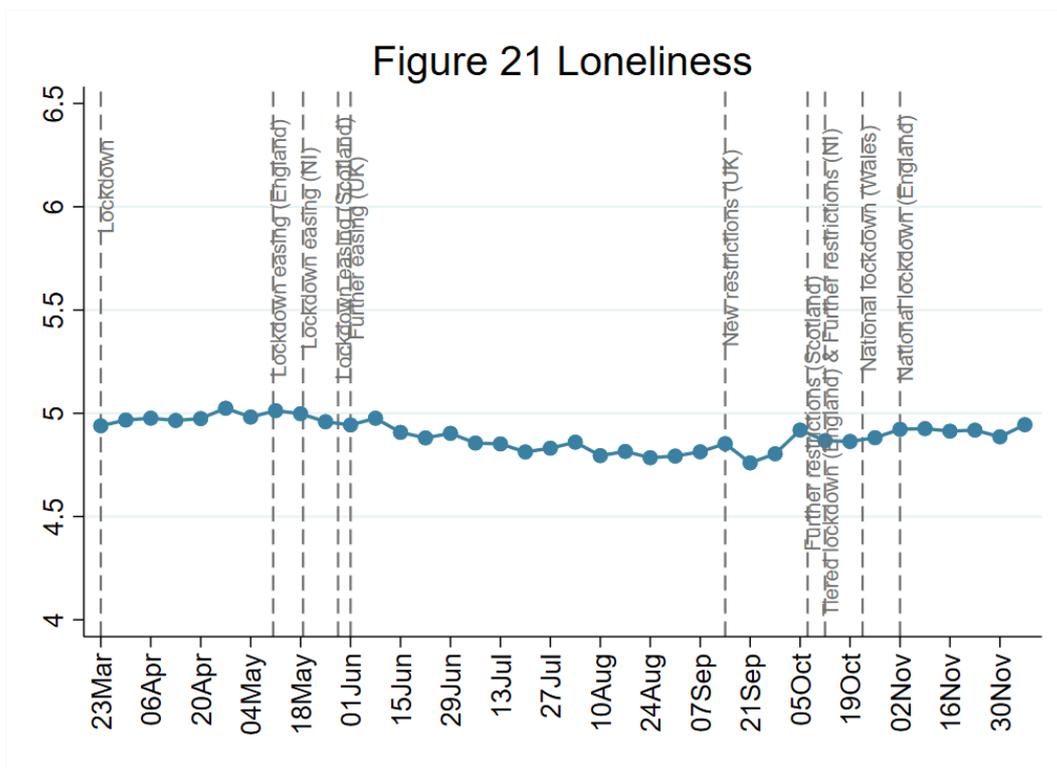


Figure 20l Life satisfaction by physical health diagnosis



4.2 Loneliness



FINDINGS

Respondents were asked about levels of loneliness using the 3-item UCLA-3 loneliness, a short form of the Revised UCLA Loneliness Scale (UCLA-R). Each item is rated with a 3-point rating scale, ranging from “never” to “always”, with higher scores indicating greater loneliness.

Loneliness levels have been relatively stable in the past fortnight but are very slightly higher (2%) than they were over the summer before new restrictions were brought in. The greatest increase in recent weeks has occurred in people living alone. Levels are still highest in younger adults, women, people from BAME backgrounds, people with lower household income, people living with children, people living in urban areas, and people with a diagnosed mental or physical health condition.

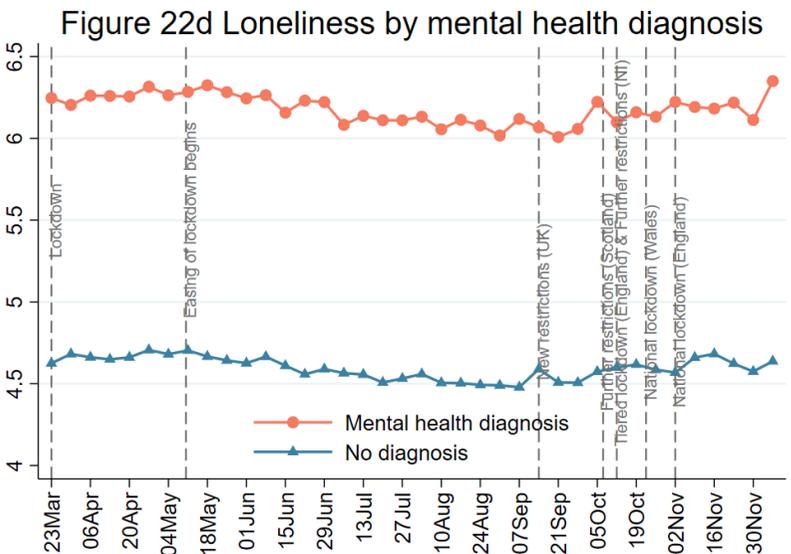
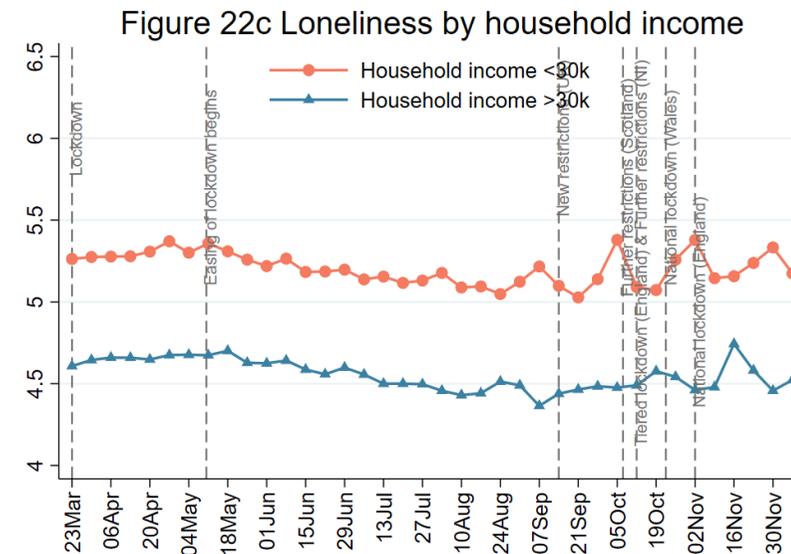
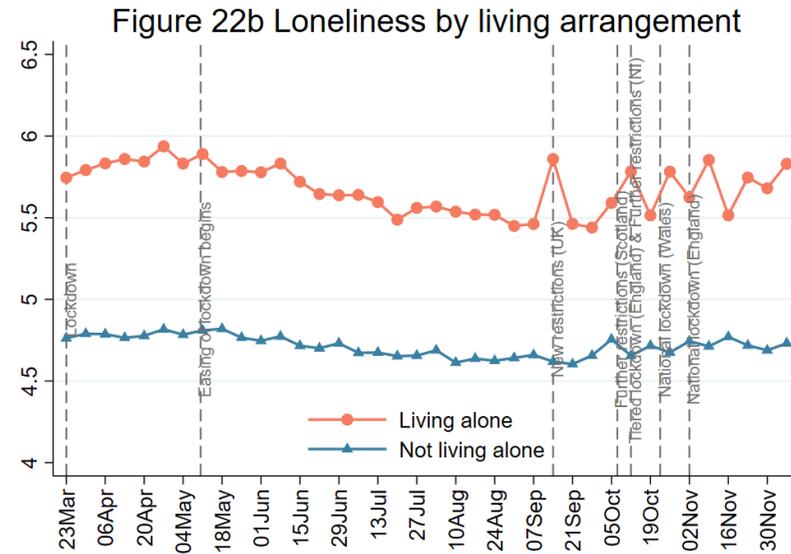
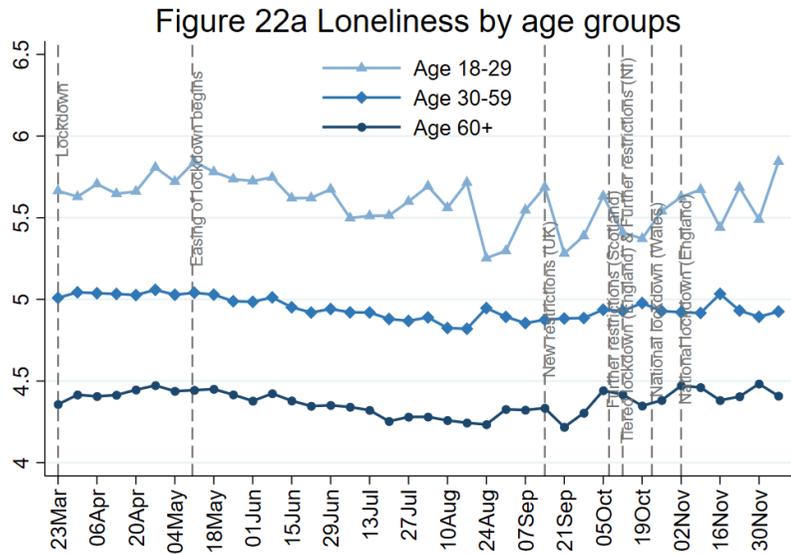


Figure 22e Loneliness by nations

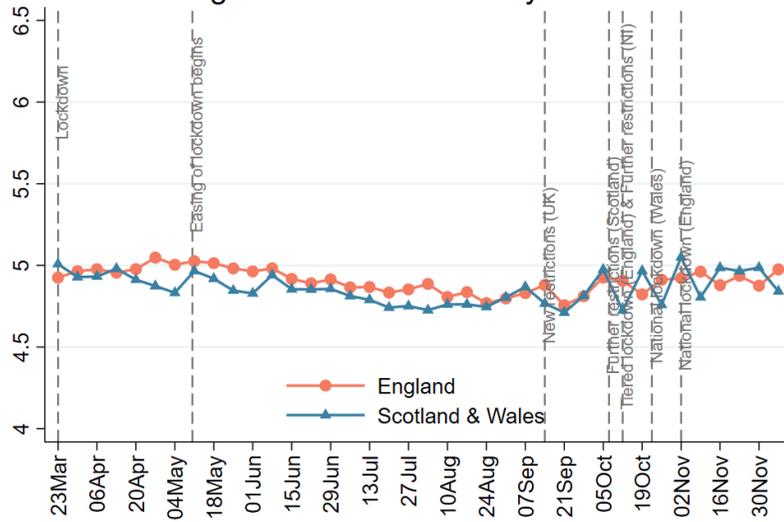


Figure 22f Loneliness by keyworker status

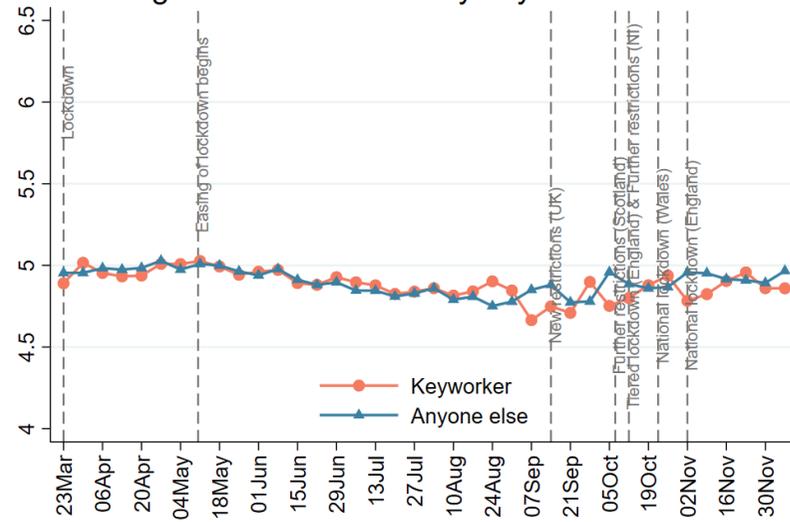


Figure 22g Loneliness by living with children

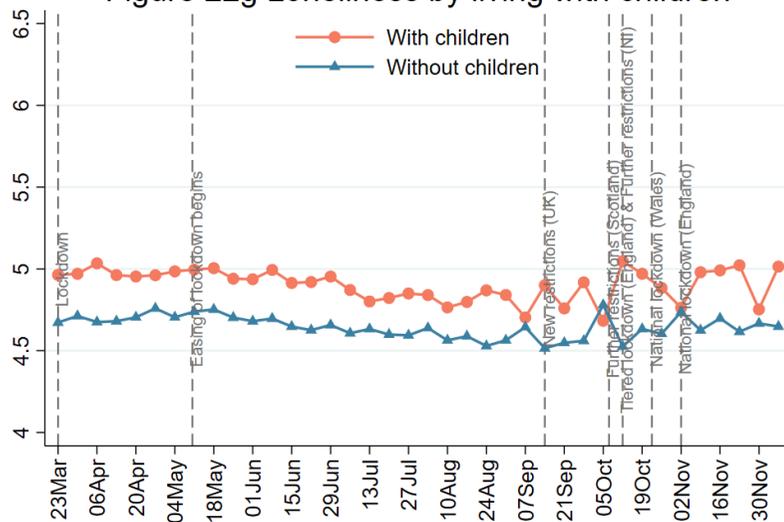


Figure 22h Loneliness by living area

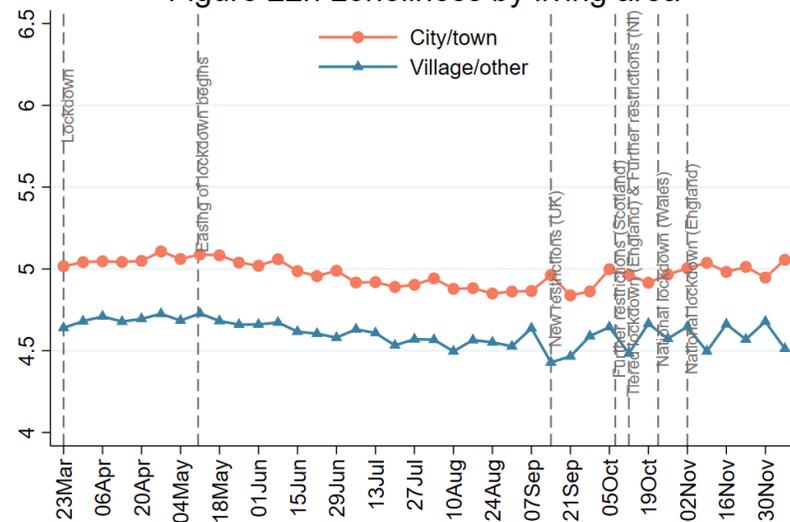


Figure 22i Loneliness by gender

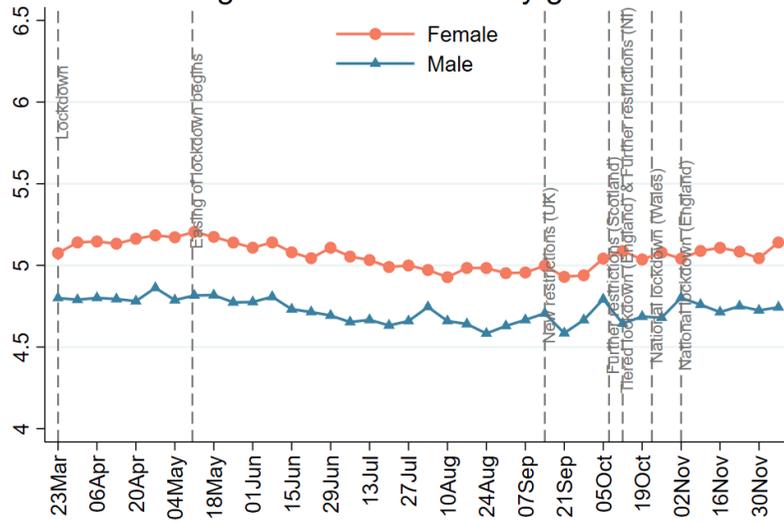


Figure 22j Loneliness by ethnicity

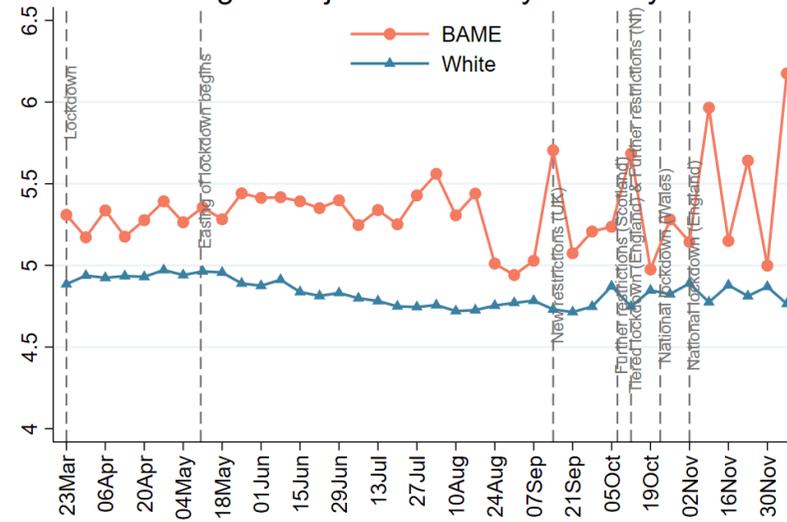


Figure 22k Loneliness by educational levels

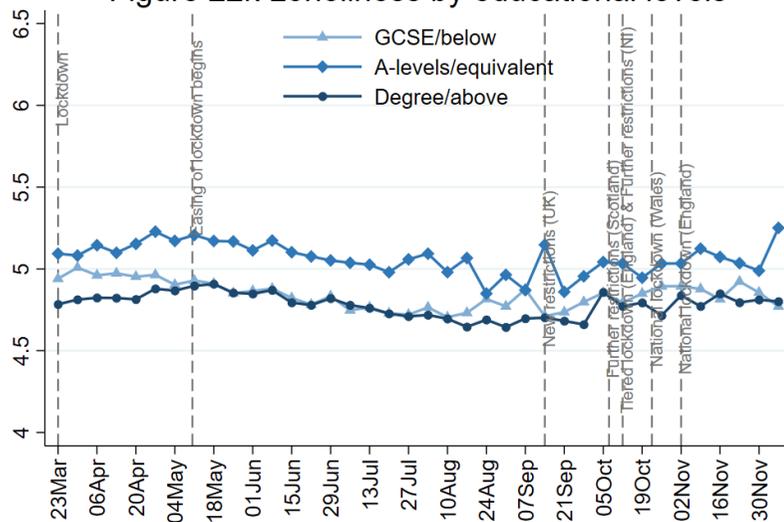
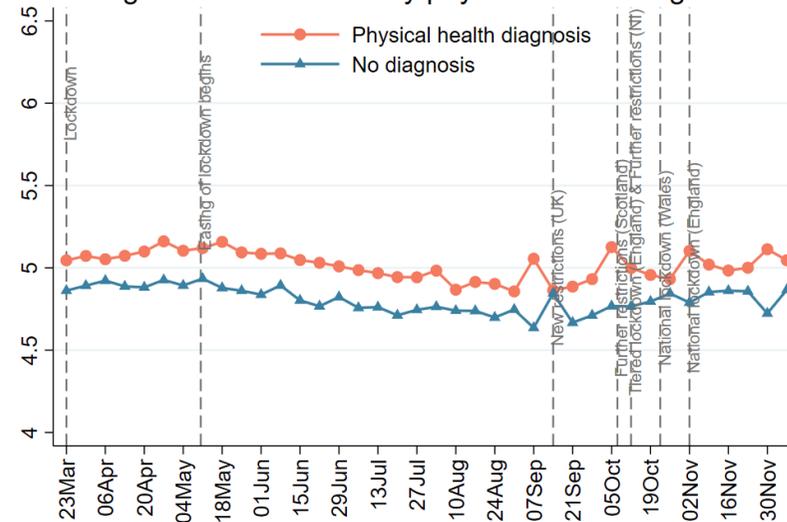
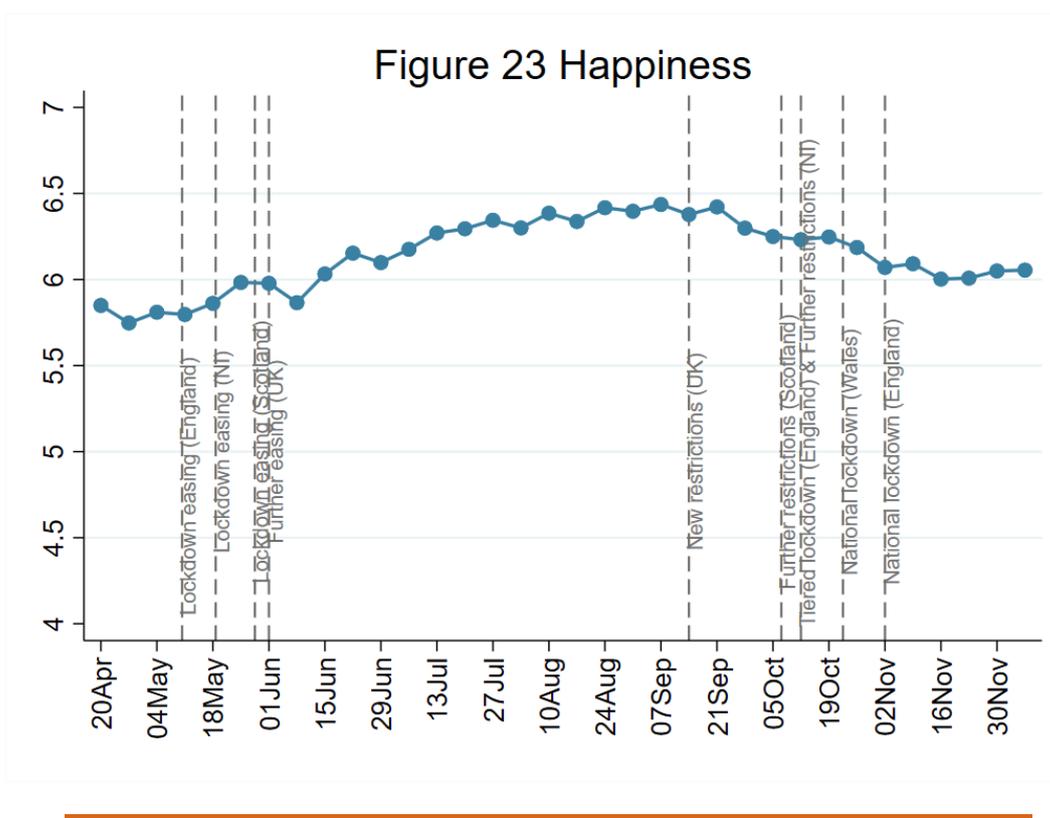


Figure 22l Loneliness by physical health diagnosis



4.3 Happiness



FINDINGS

Respondents were asked to rate to what extent they felt happy during the past week using the Office for National Statistics wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April onwards.

Happiness levels have further decreased in the past few weeks. They are now 5% lower than they were before more restrictions were brought in in mid-September, but 5% higher than during first lockdown in April. The decrease in recent weeks has been particularly evident amongst older adults (although they remain higher in this age group compared to younger adults). Happiness levels are also lower amongst those living alone, those with lower household income, people with a diagnosed mental or physical health condition, people living in urban areas, women, and people from BAME backgrounds.

Figure 24a Happiness by age groups

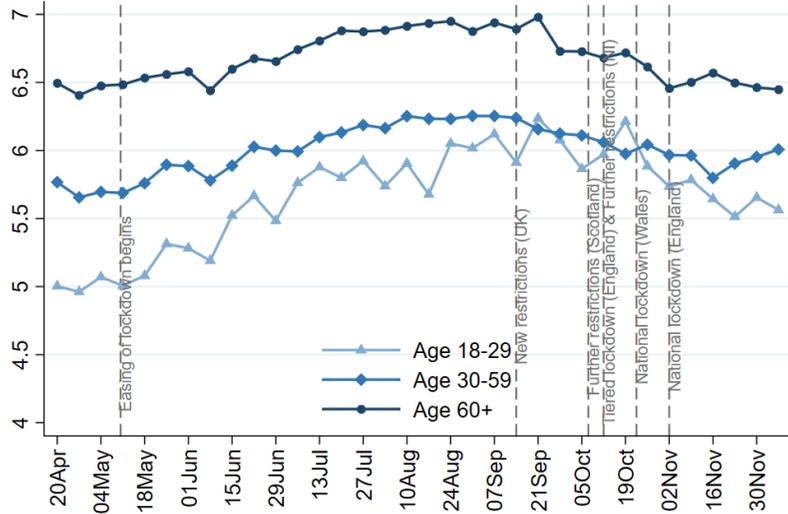


Figure 24b Happiness by living arrangement

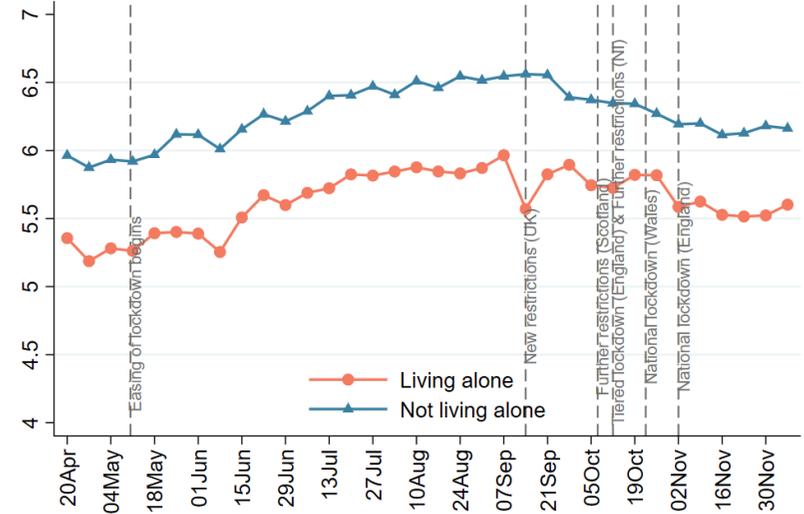


Figure 24c Happiness by household income

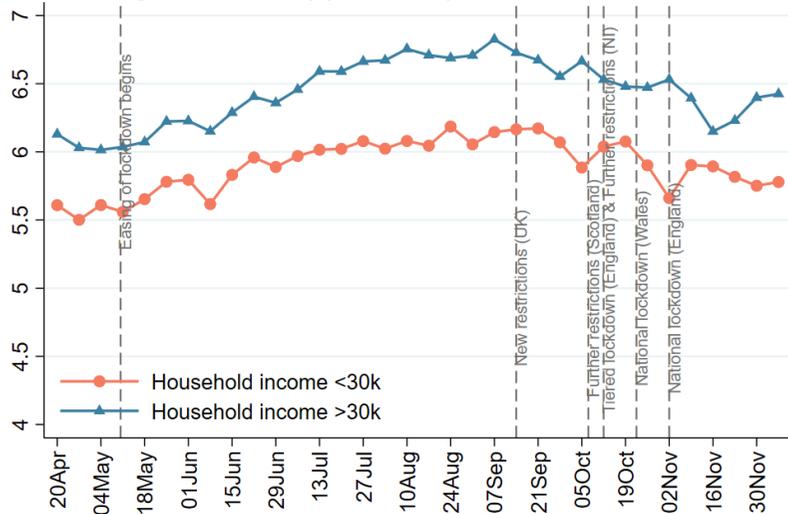


Figure 24d Happiness by mental health

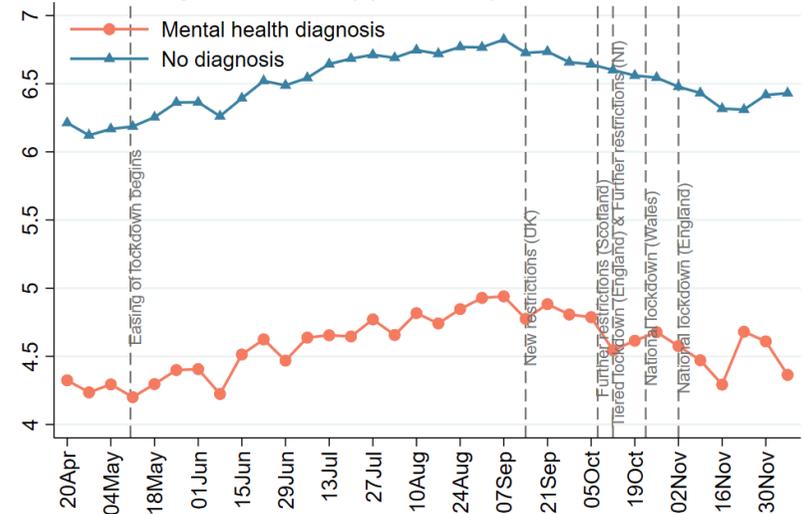


Figure 24e Happiness by nations

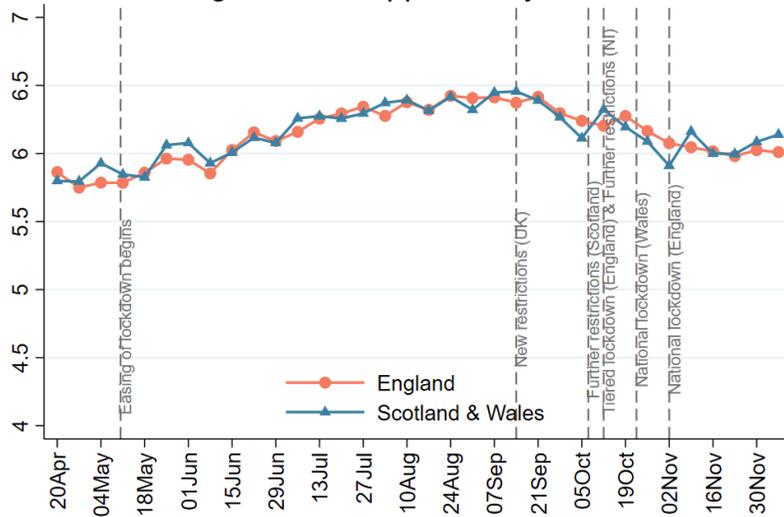


Figure 24f Happiness by keyworker status

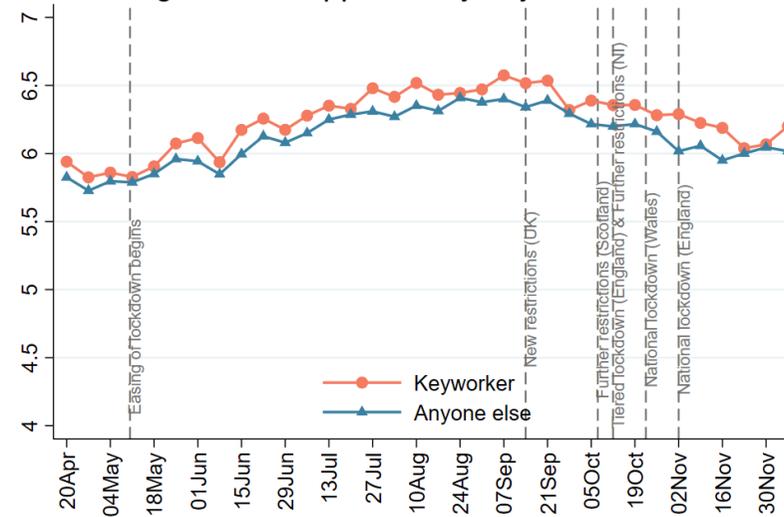


Figure 24g Happiness by living with children

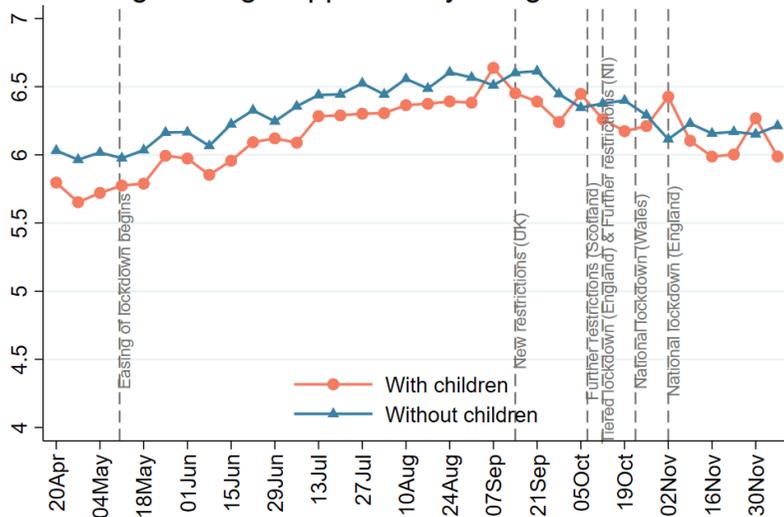


Figure 24h Happiness by living area

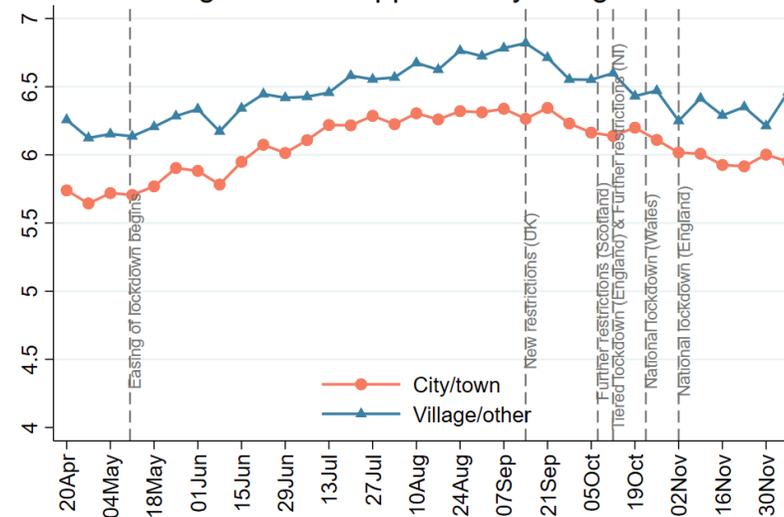


Figure 24i Happiness by gender

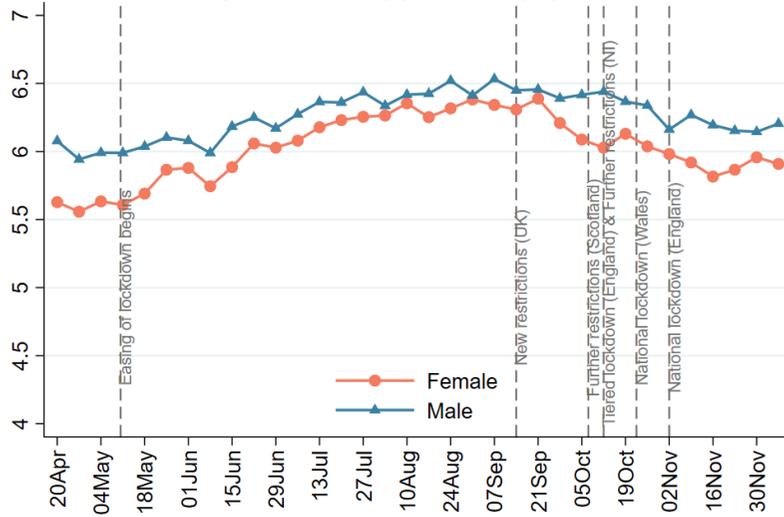


Figure 24j Happiness by ethnicity

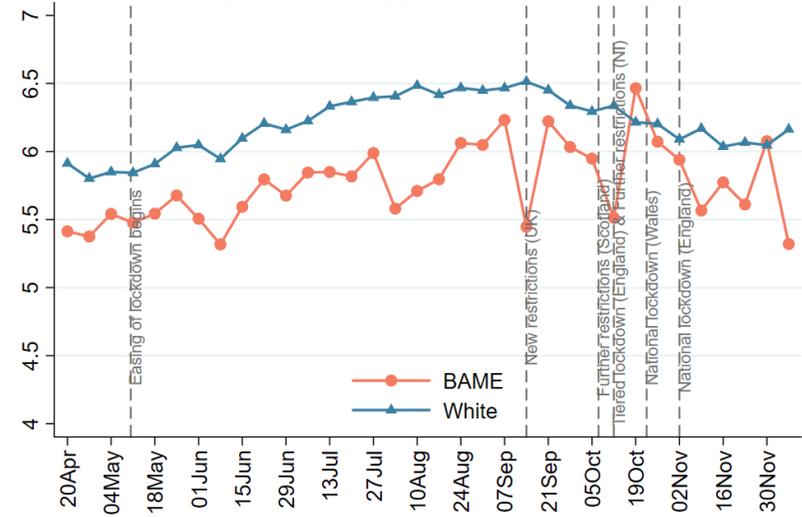


Figure 24k Happiness by educational levels

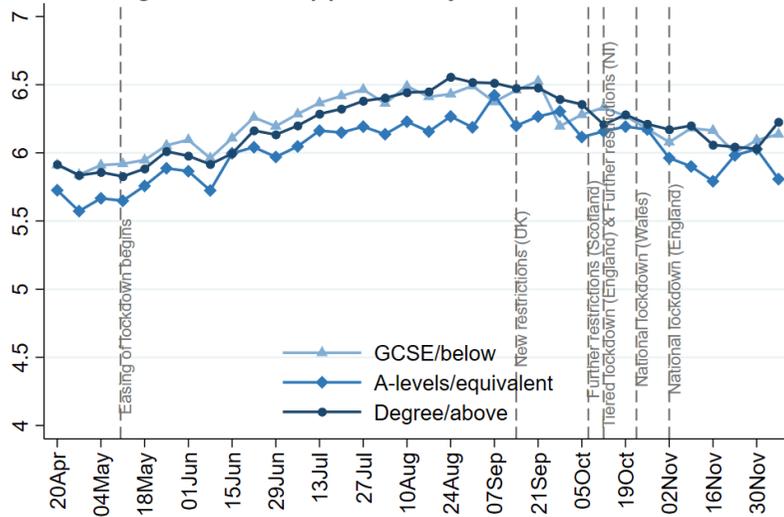
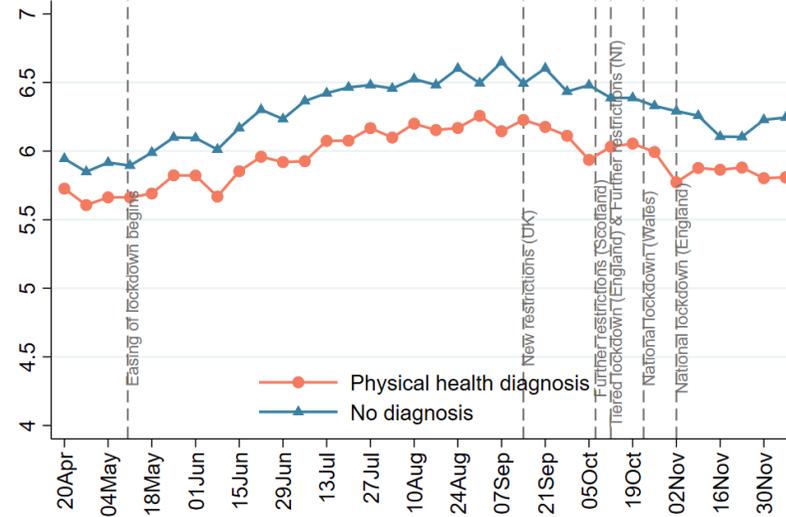
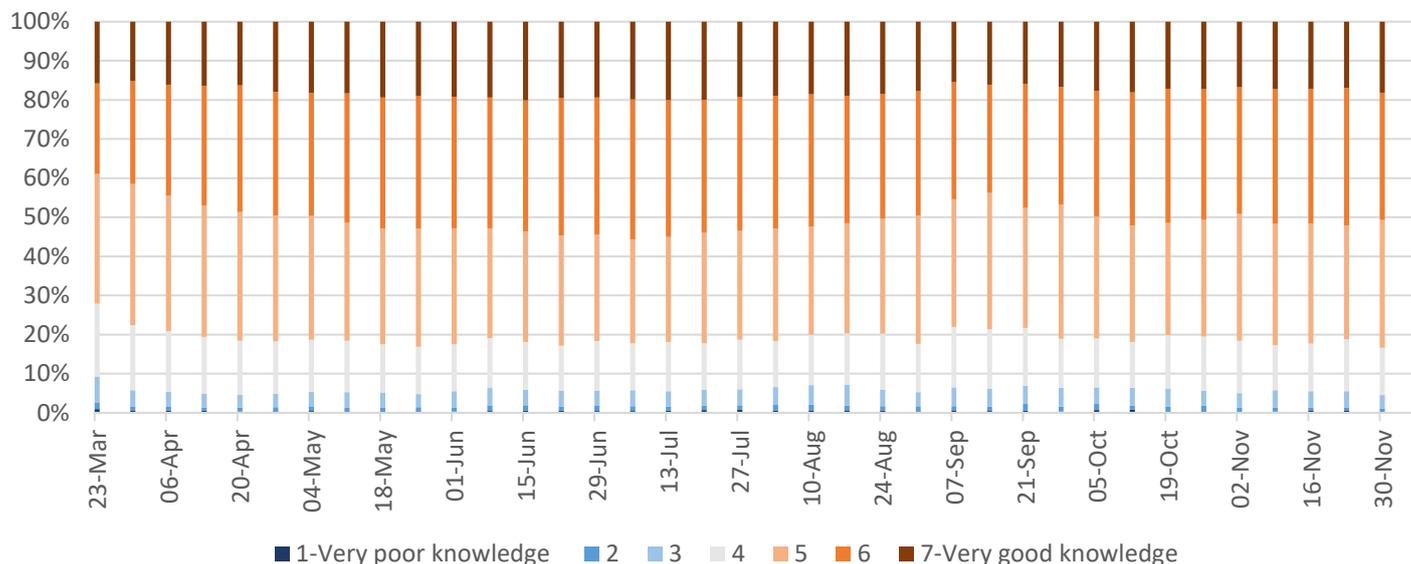


Figure 24l Happiness by physical health diagnosis



5. Self-rated knowledge of COVID-19

Figure 25 Self-rated knowledge of COVID-19



FINDINGS

Respondents were asked to rate how good they felt their self-rated knowledge of COVID-19 was, ranging from 1 (very poor knowledge) to 7 (very good knowledge).

On average, self-rated knowledge about Covid-19 is relatively high amongst our survey sample and higher than it was in March when the first lockdown came in. Only 5% of people currently think they have very poor or poor knowledge (scores 1-3; down from 10% in March). The percentage who think they have good or very good knowledge (scores 5-7) has increased since March from 72% to 85%.

Average self-rated knowledge scores are presented in Figures 26. Across the pandemic, self-rated knowledge has consistently been highest amongst adults over the age of 30 and slightly higher amongst people with physical health conditions, who may feel they are more at risk from the virus and therefore want to understand it more. But levels are slightly lower amongst people from minority ethnic backgrounds. There is no difference in self-rated knowledge about the virus by gender, educational attainment, nation, area of living, living status or household income. There is also no difference amongst keyworkers and non-keyworkers. However, “keyworkers” included a range of occupations not just including health and social care, where levels of knowledge are expected to be higher. Further this measure is of self-reported knowledge, so some people may rate their knowledge levels as higher despite not understanding details about the virus.

Figure 26a Knowledge of COVID-19 by age groups

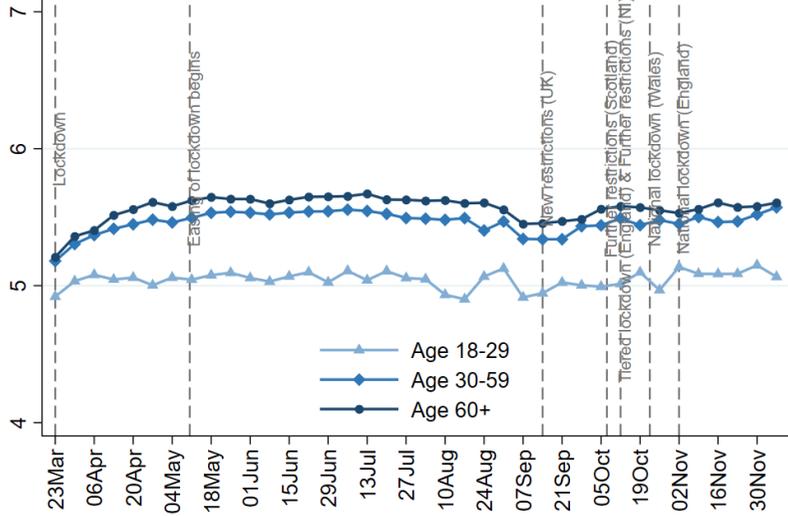


Figure 26b Knowledge of COVID-19 by living arrangement

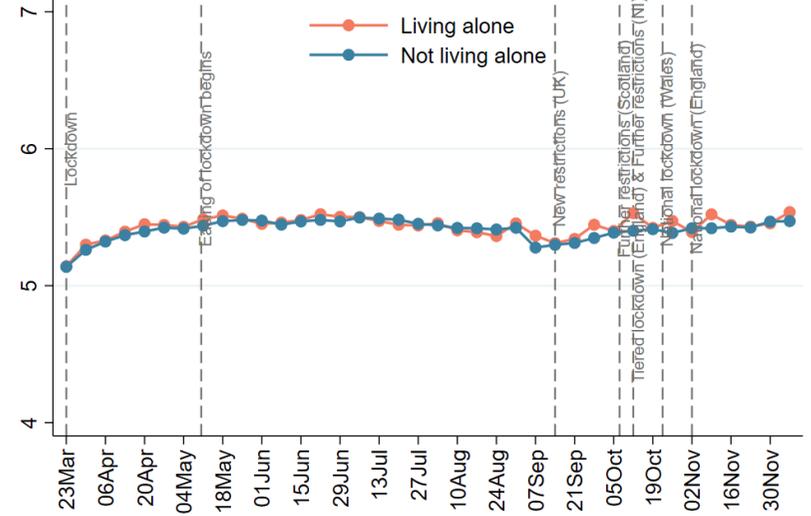


Figure 26c Knowledge of COVID-19 by household income

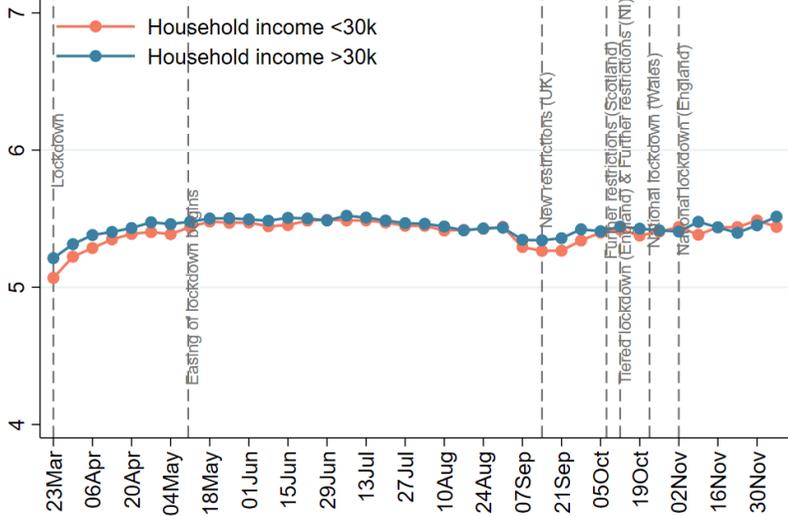


Figure 26d Knowledge of COVID-19 by mental health

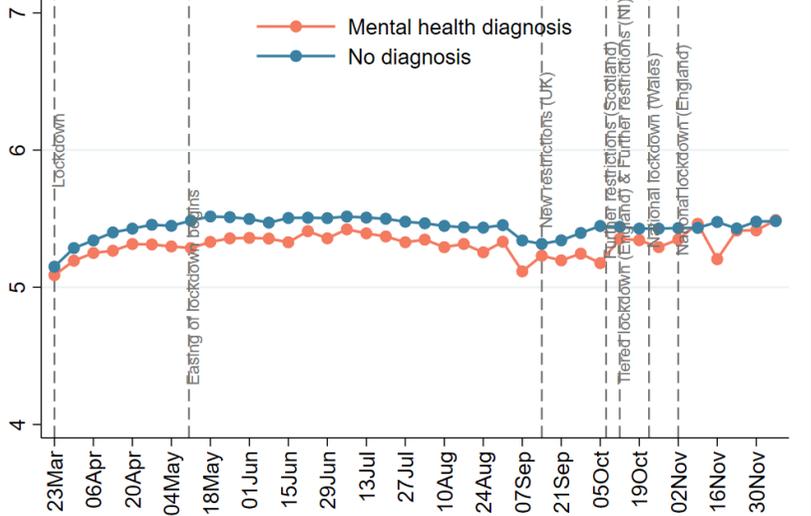


Figure 26e Knowledge of COVID-19 by nations

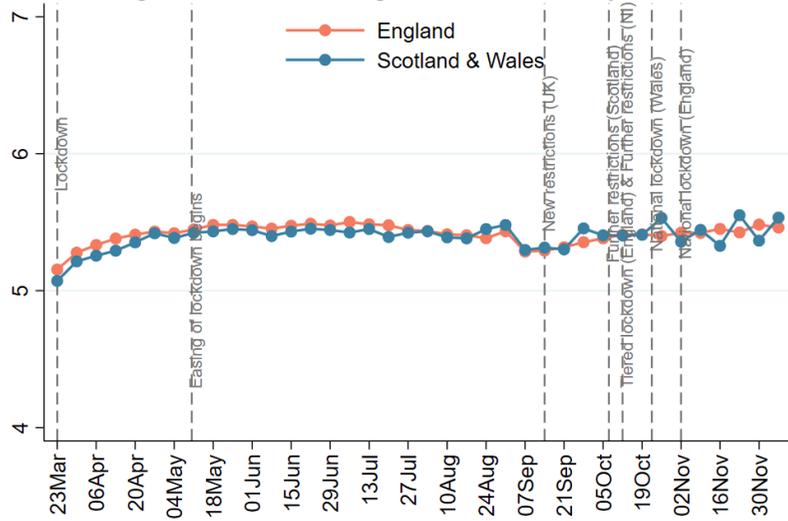


Figure 26f Knowledge of COVID-19 by keyworker status

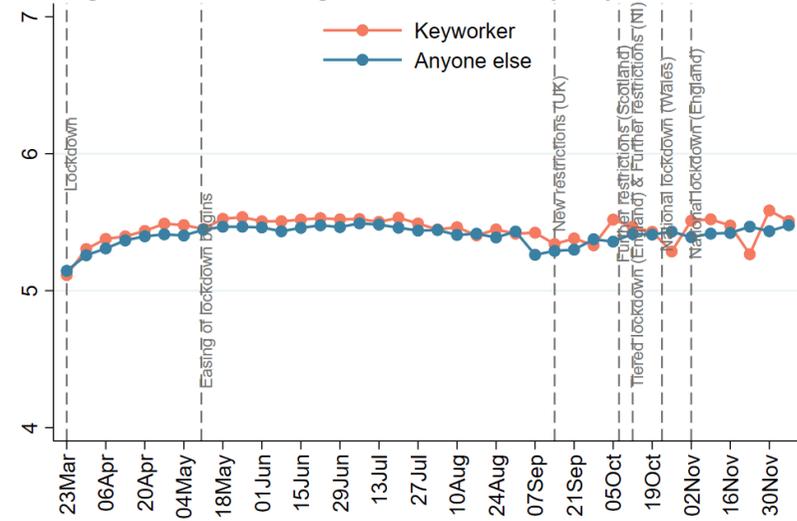


Figure 26g Knowledge of COVID-19 by living with children

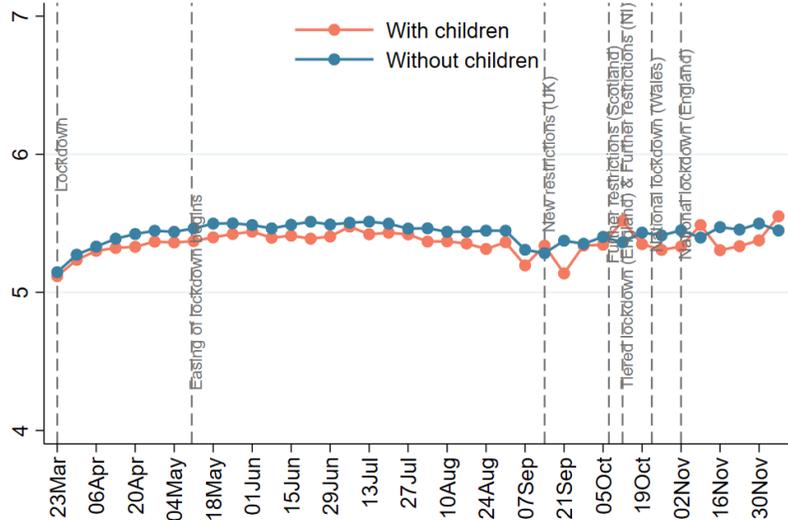


Figure 26h Knowledge of COVID-19 by living area

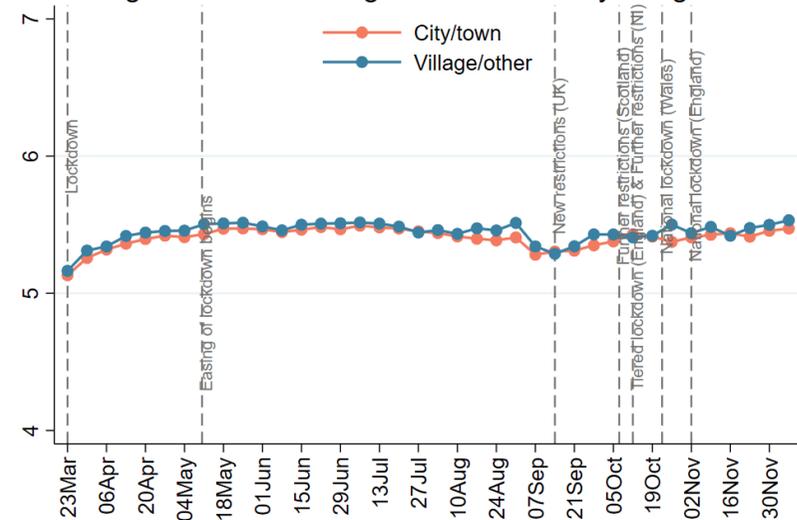


Figure 26i Knowledge of COVID-19 by gender

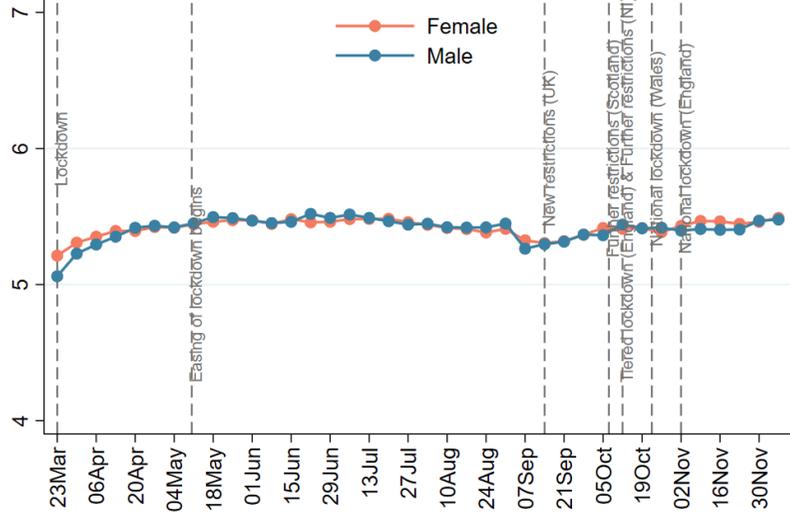


Figure 26j Knowledge of COVID-19 by ethnicity

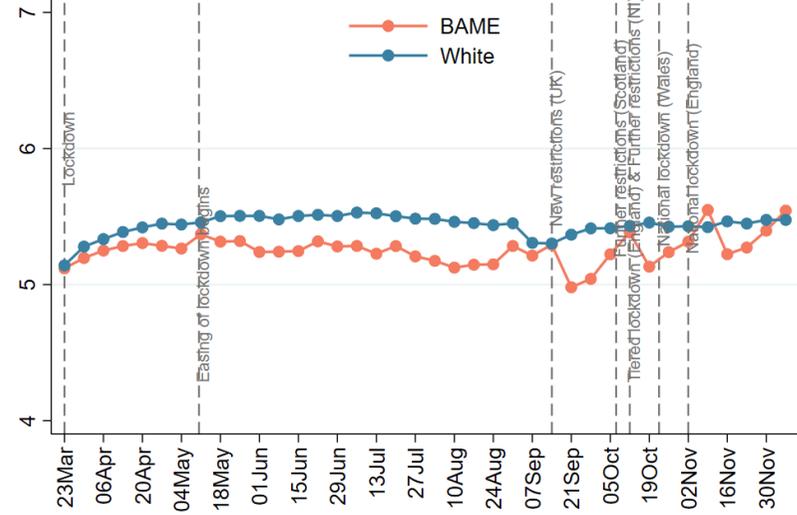


Figure 26k Knowledge of COVID-19 by educational levels

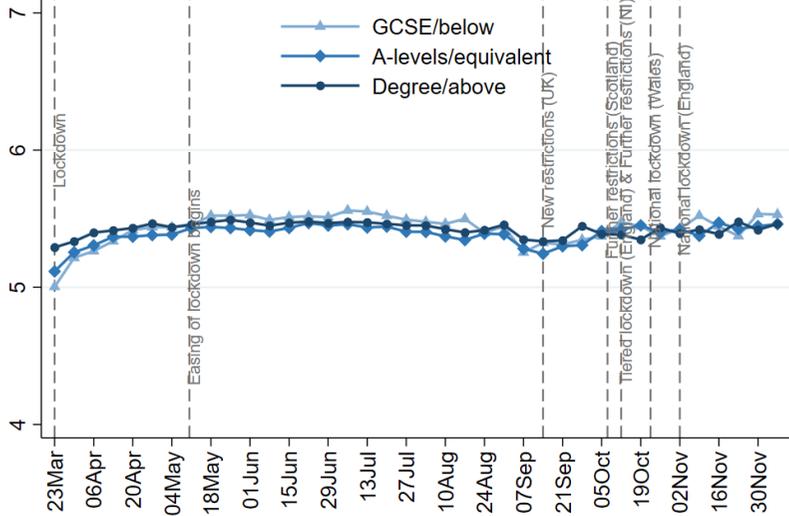
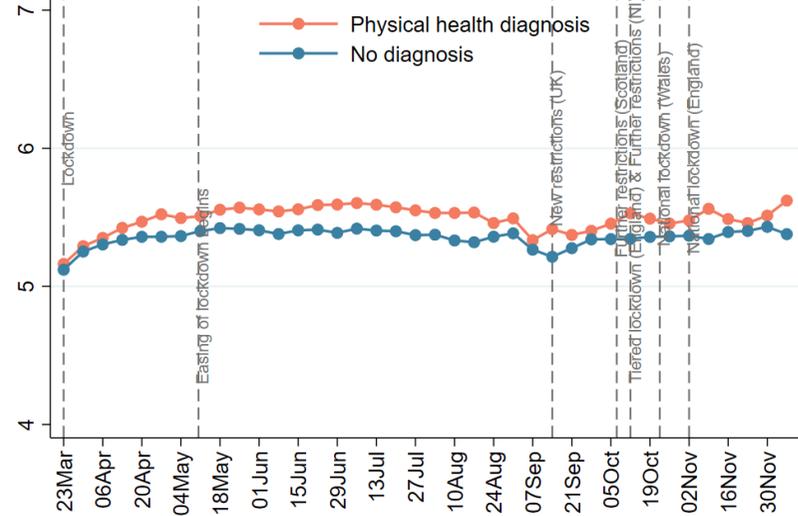
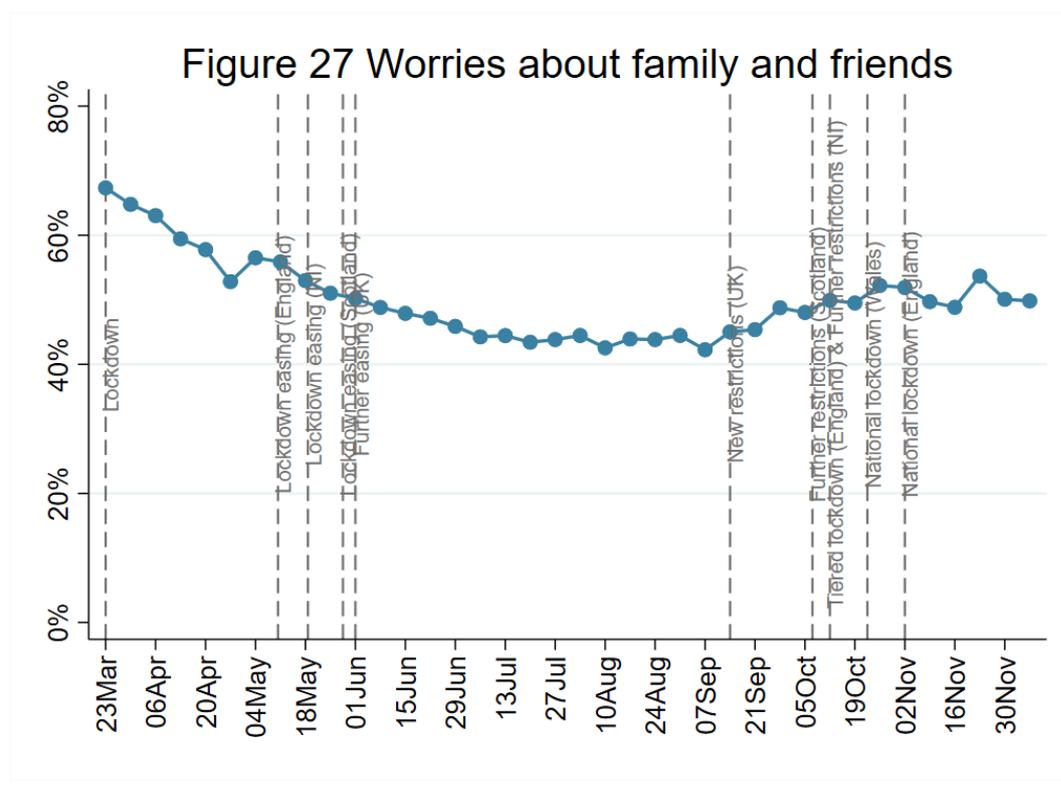


Figure 26l Knowledge of COVID-19 by physical health diagnosis



6. Worries and social support

6.1 Worries about family and friends

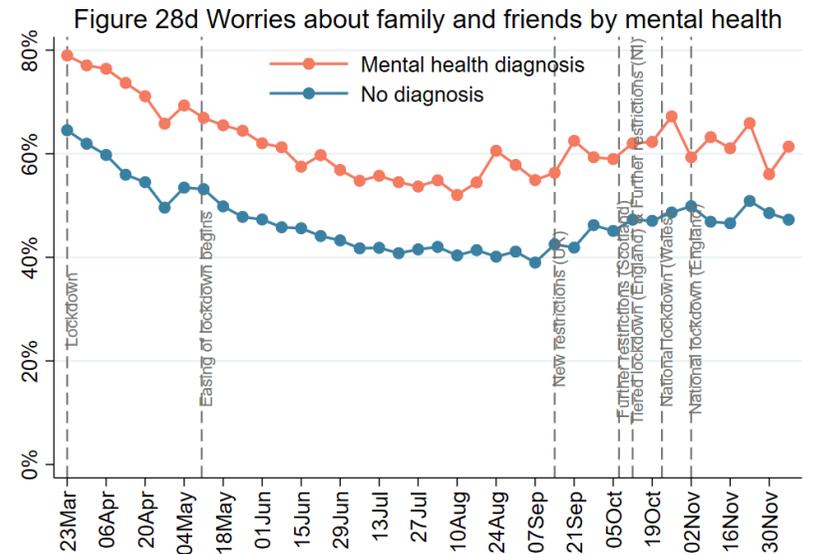
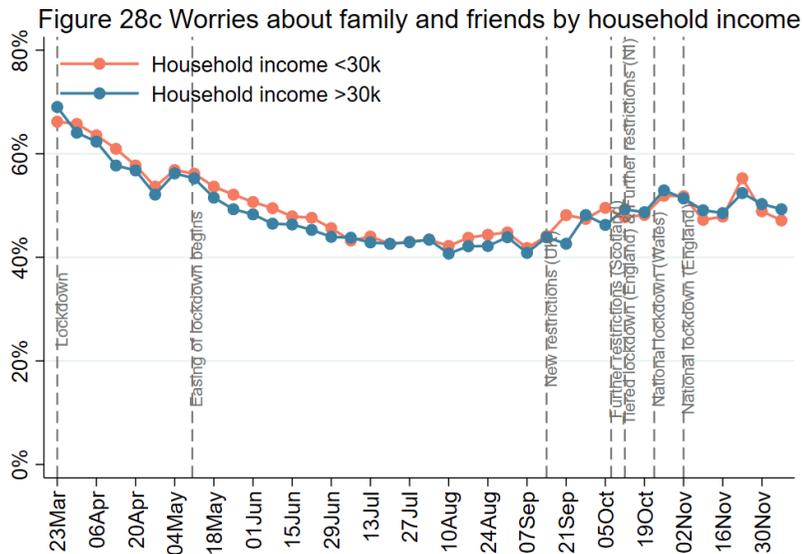
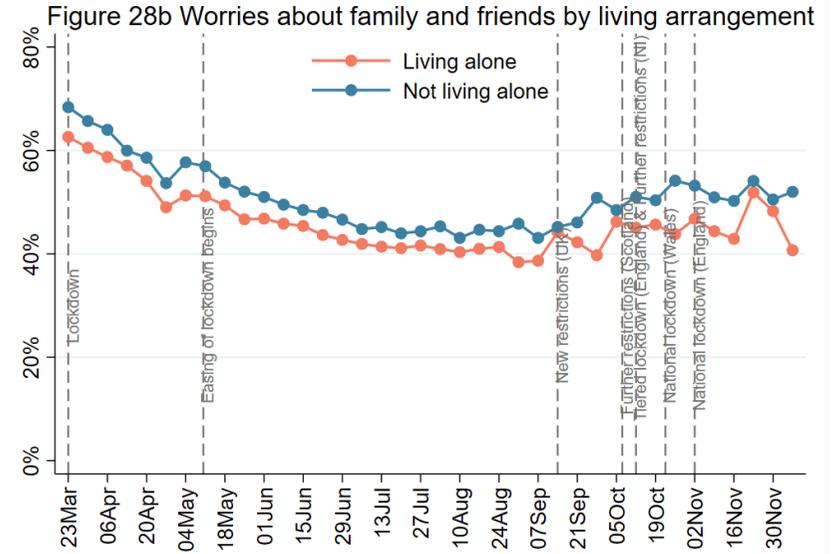
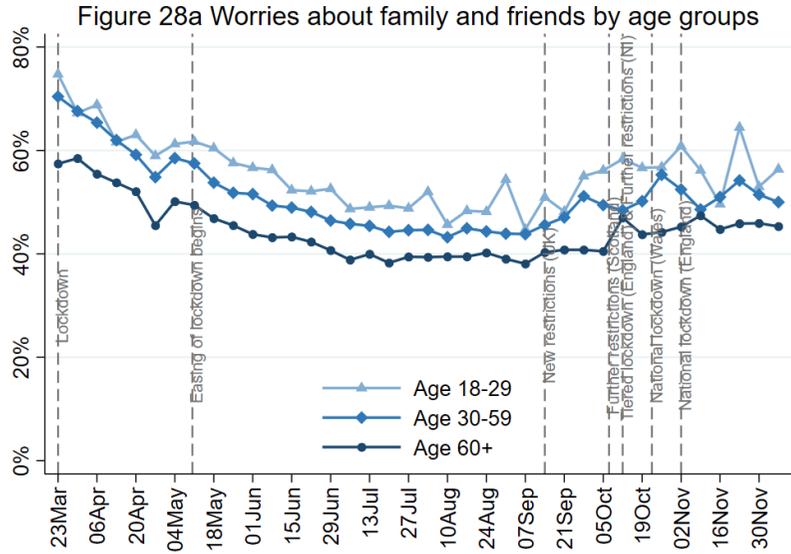


FINDINGS

We asked participants if they had been stressed (either in a minor or a major way) about either family or friends living in their home or family or friends outside of their household.

At the start of lockdown, 67% of adults were worried about family or friends. Over the summer, these numbers decreased to around 43%. However, as virus cases have increased and new restrictions have been brought in, levels have risen again to 49%.

Worries have been higher amongst people with a diagnosed mental illness, of whom 61% are currently worried about family and friends outside of the household compared to 47% of people without a mental illness. Women have also been more concerned, with 59% currently reporting that they are worried compared to 41% of men. Younger adults have been more worried about family and friends than older adults, as have people with higher educational qualifications, people living with others, and people with a diagnosed physical health condition. But there has been no difference in worries by nation, area of living, ethnicity, keyworker status, living with children, or household income.



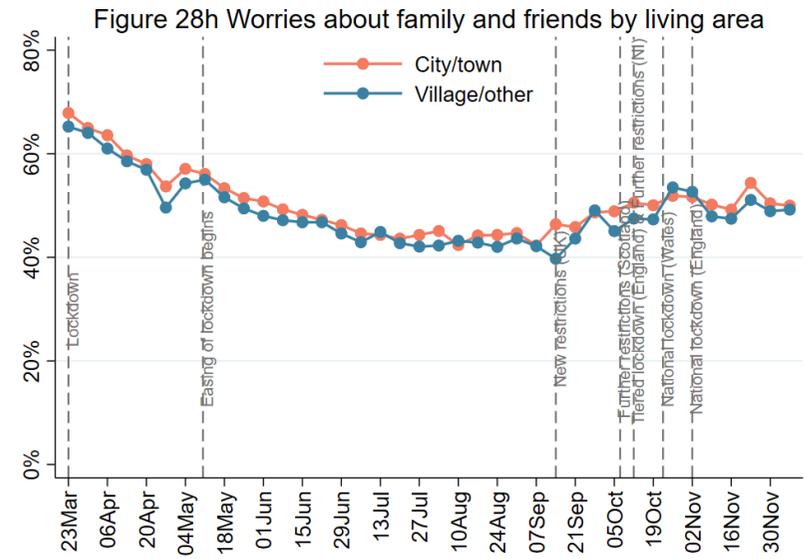
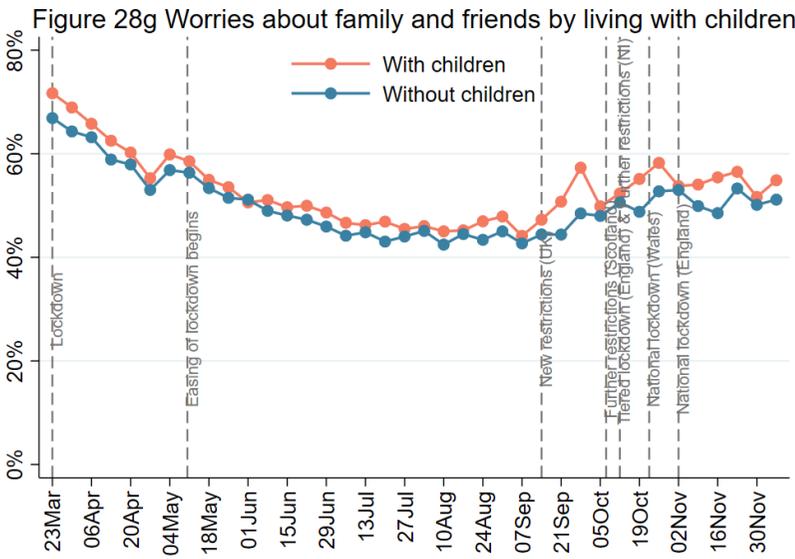
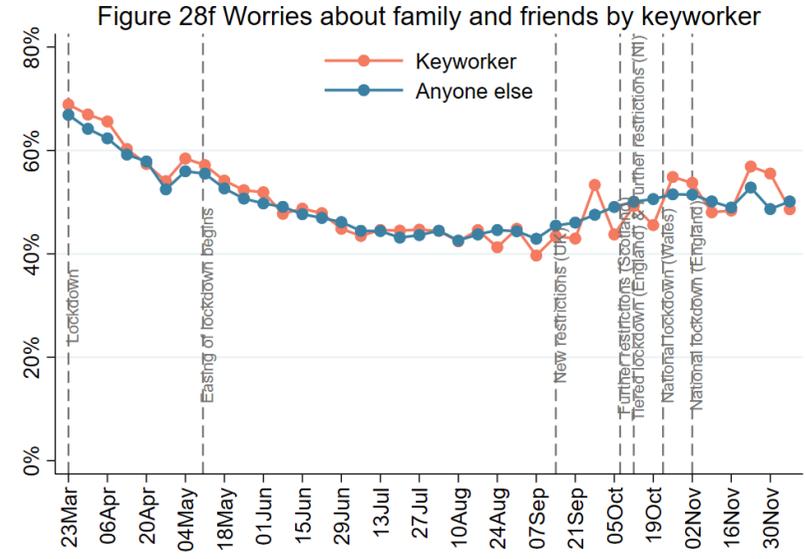
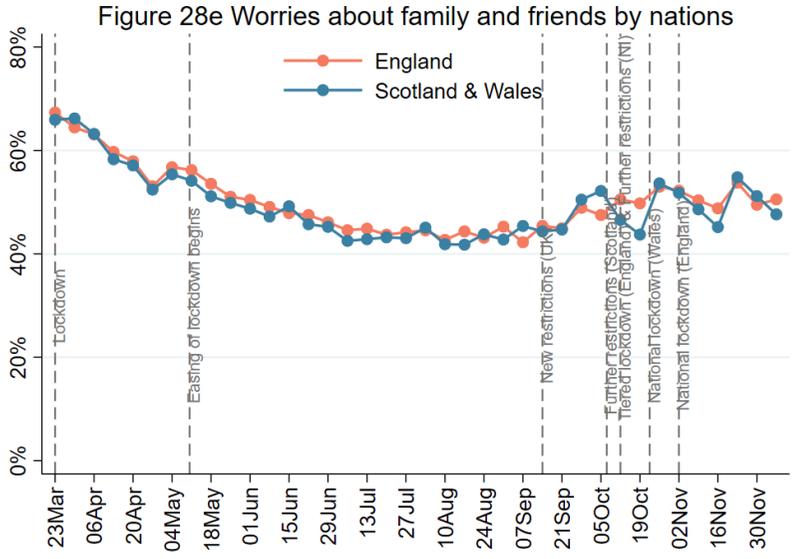


Figure 28i Worries about family and friends by gender

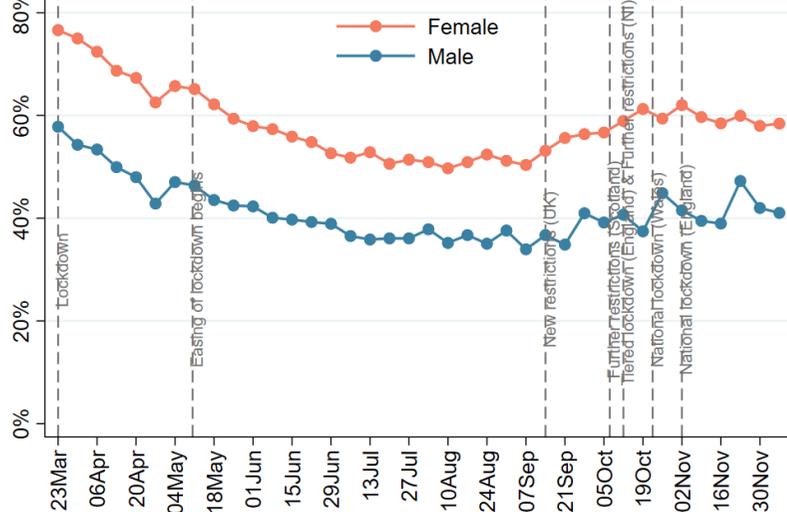


Figure 28j Worries about family and friends by ethnicity

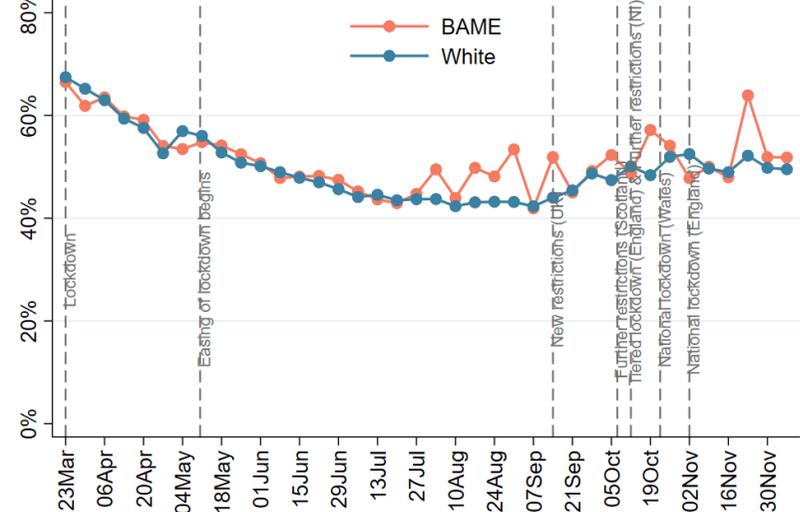


Figure 28k Worries about family and friends by educational levels

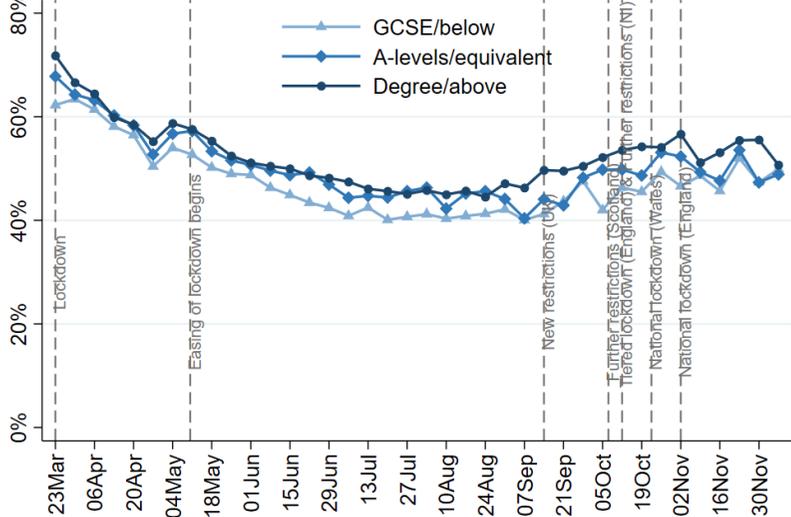
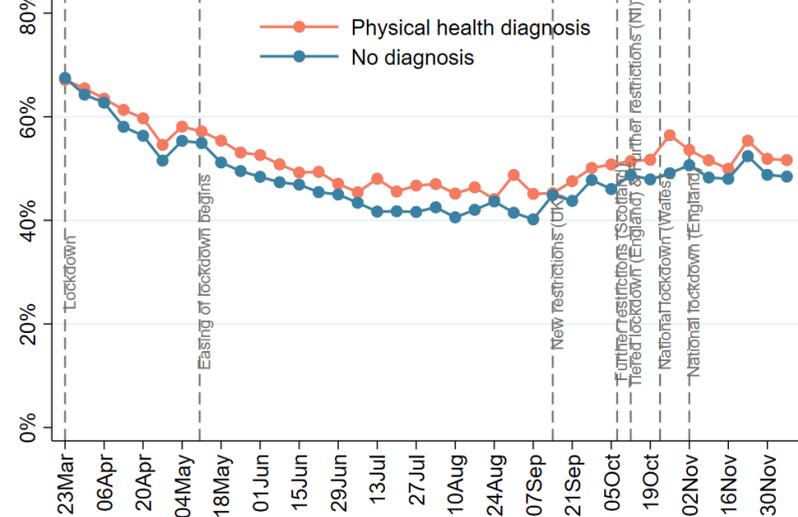
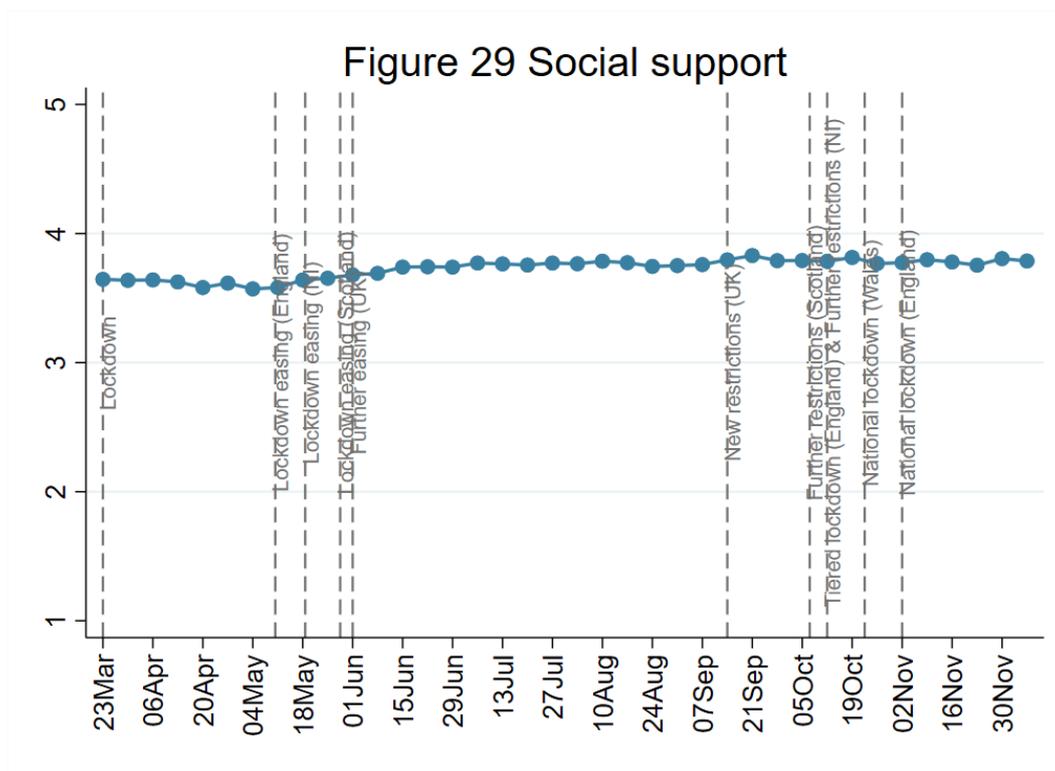


Figure 28l Worries about family and friends by physical health



6.2 Social support



FINDINGS

Social support was measured using an adapted version of the six-item short form of Perceived Social Support Questionnaire (F-SozU K-6). This measures the extent to which participants have experienced understanding and support from others, whether emotional or physical. Each item is rated on a 5-point scale from “not true at all” to “very true”, with scores averaged and higher scores indicating higher levels of perceived social support.

Levels of social support have been relatively constant across the pandemic. There has been a slight increase since first lockdown, perhaps as people have been able to move around more and provide in-person support to others more easily. However, some groups have experienced much lower levels of social support than others.

People living alone, with lower household income, and with a diagnosed mental or physical health condition have received consistently lower support. Support has also been slightly lower amongst men, people in urban areas, people from ethnic minority backgrounds, and people with lower educational qualifications but no difference amongst age groups, different nations, keyworkers status, amongst people living with children, and amongst BAME groups.

Figure 30a Social support by age groups

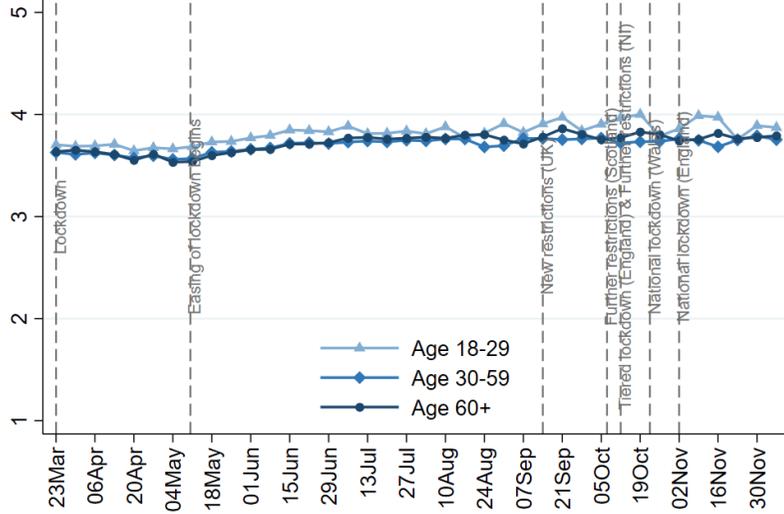


Figure 30b Social support by living arrangement

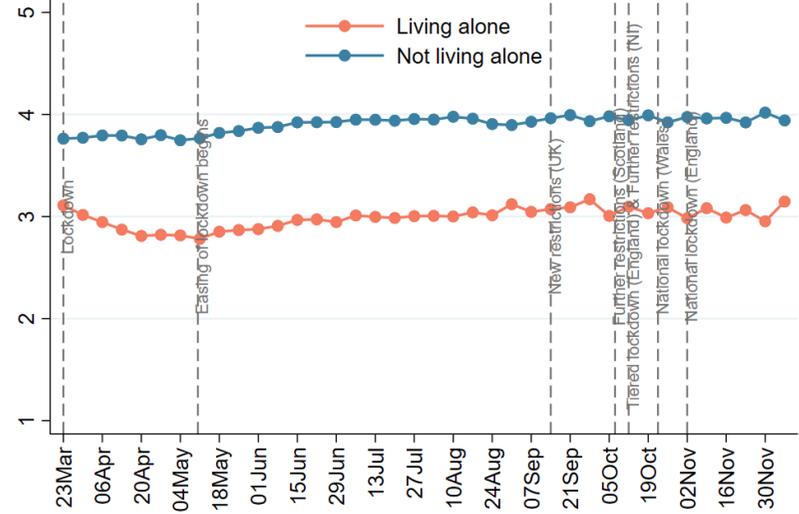


Figure 30c Social support by household income

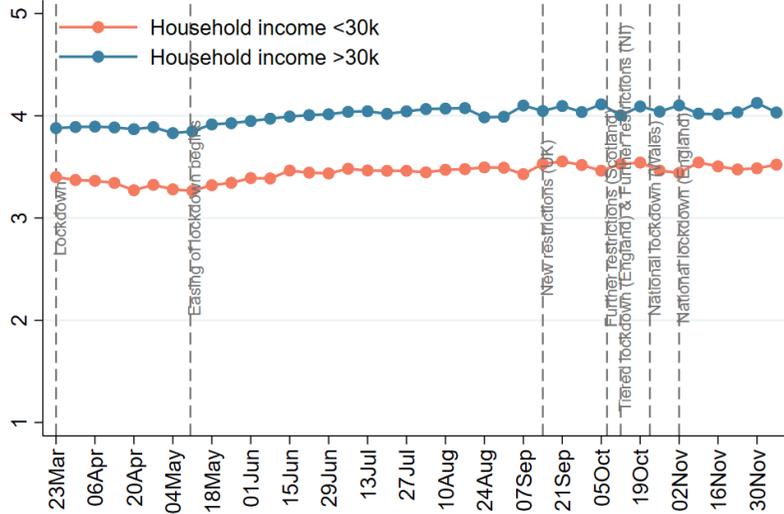


Figure 30d Social support by mental health diagnosis

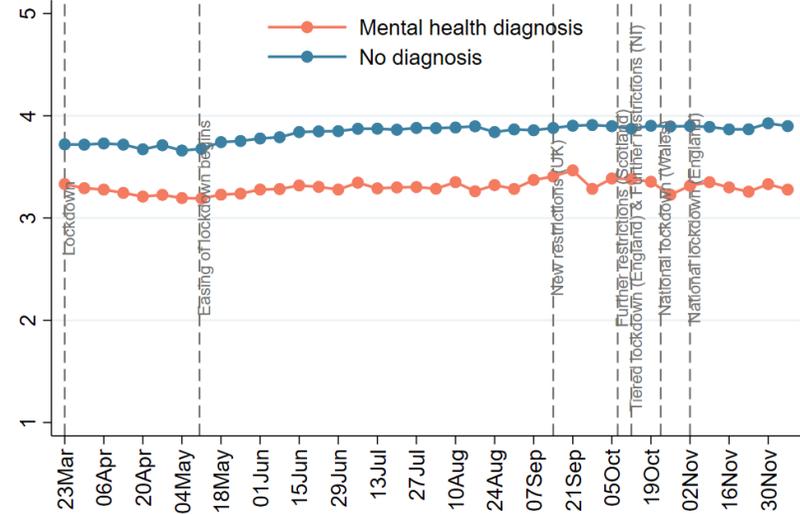


Figure 30e Social support by nations

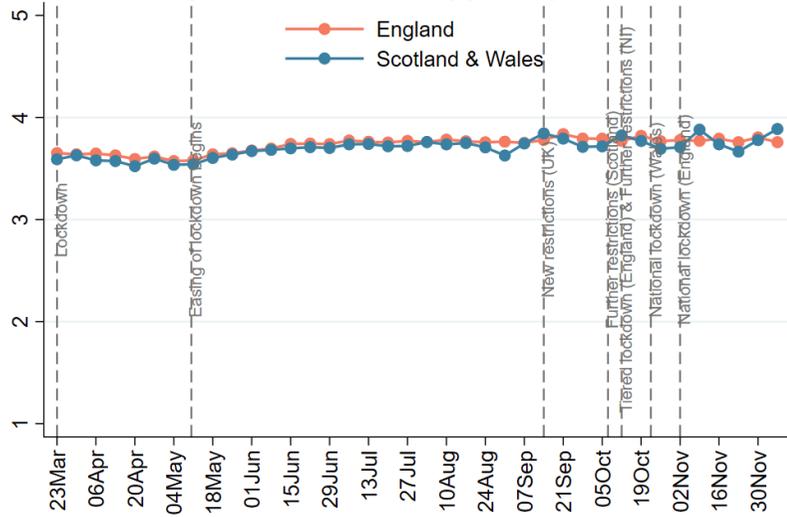


Figure 30f Social support by keyworker status

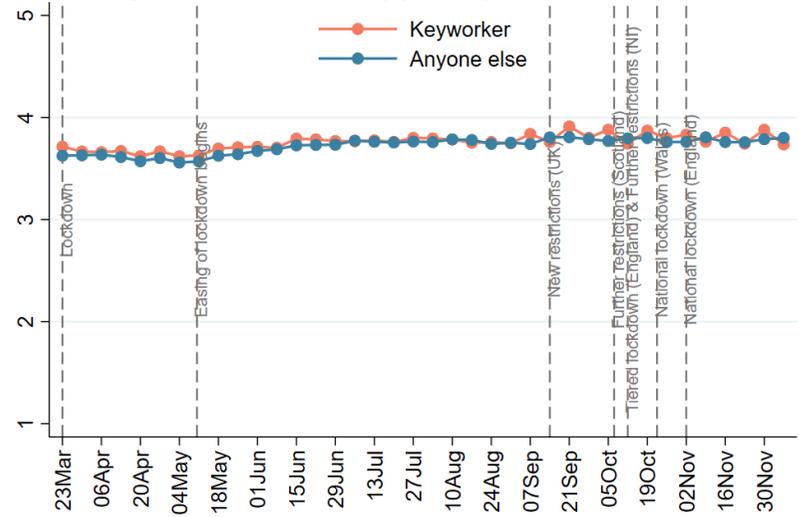


Figure 30g Social support by living with children

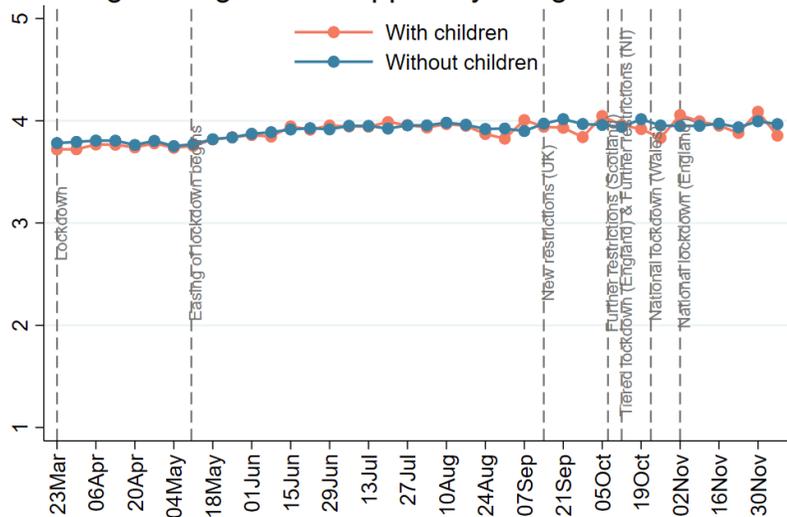


Figure 30h Social support by living area

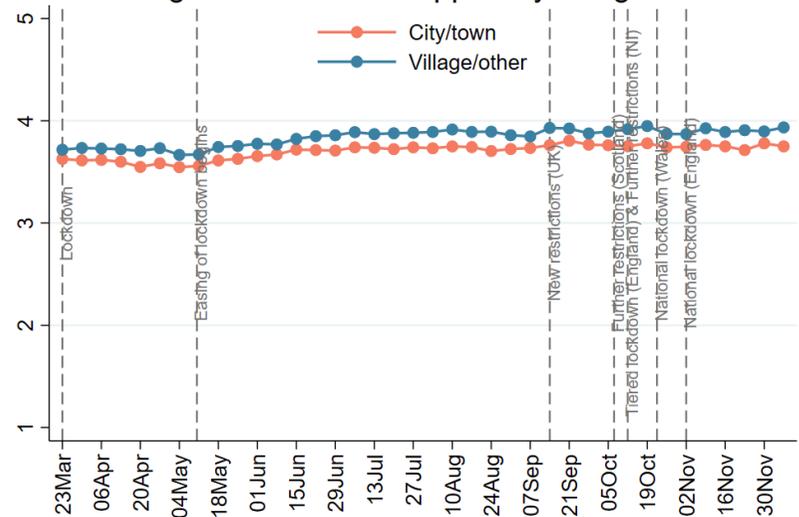


Figure 30i Social support by gender

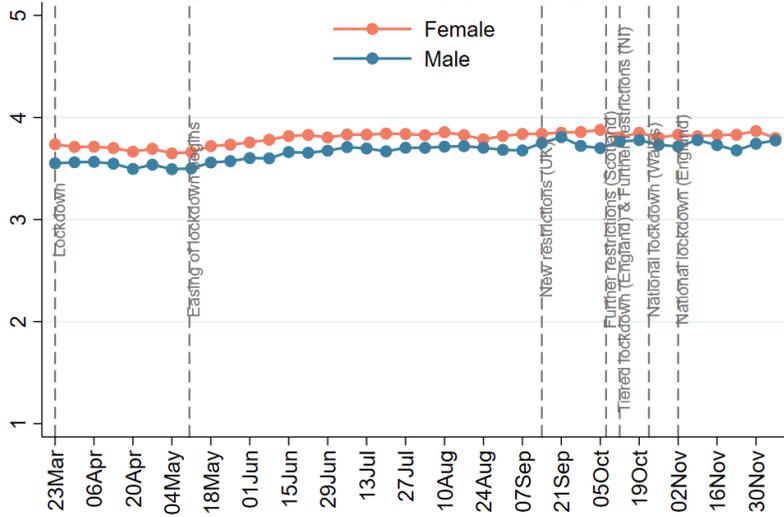


Figure 30j Social support by ethnicity

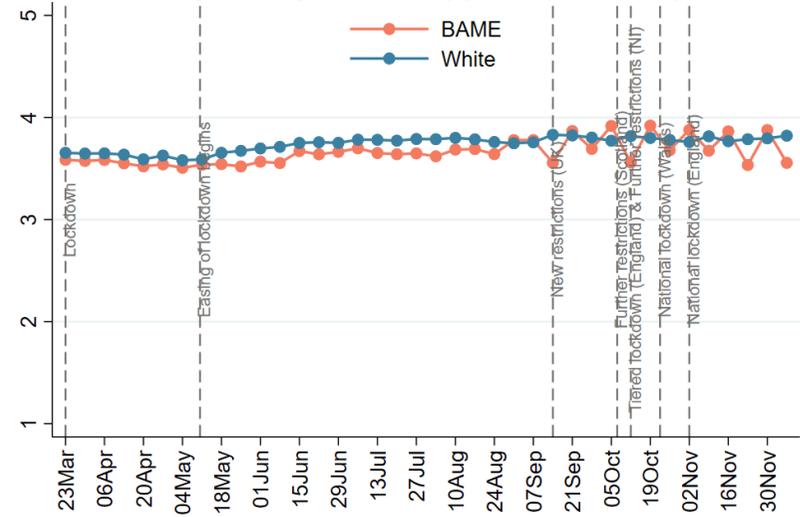


Figure 30k Social support by educational levels

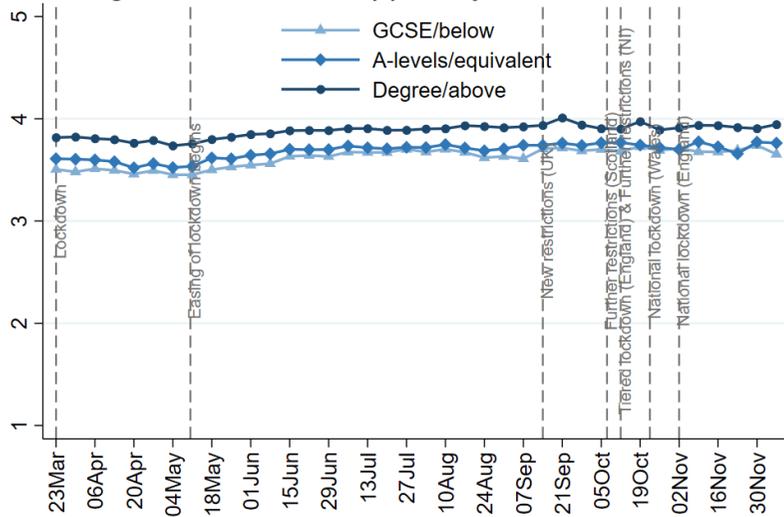
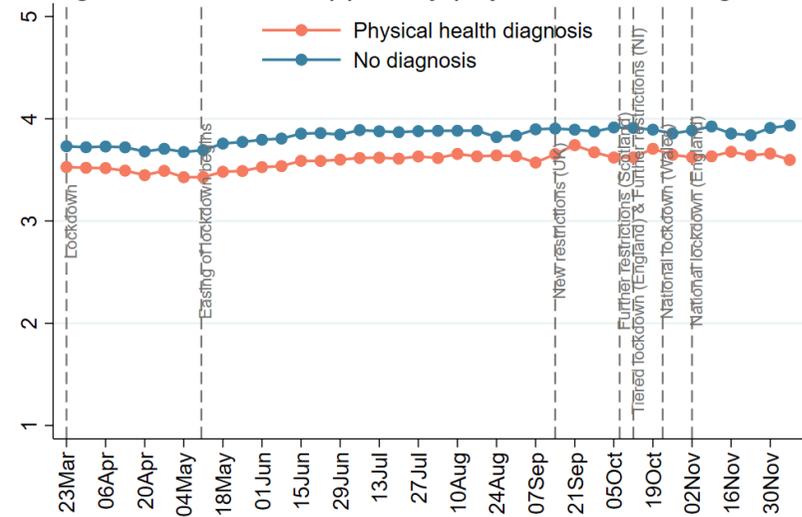


Figure 30l Social support by physical health diagnosis



Appendix

Methods

The Covid-19 Social Study is a panel study of the psychological and social experiences of adults in the UK during the outbreak of the novel coronavirus run by University College London and funded by the Nuffield Foundation, UKRI and the Wellcome Trust. To date, over 70,000 people have participated in the study, providing baseline socio-demographic and health data as well as answering questions on their mental health and wellbeing, the factors causing them stress, their levels of social interaction and loneliness, their adherence to and trust in government recommendations, and how they are spending their time. The study is not representative of the UK population, but instead it aims to have good representation across all major socio-demographic groups. The study sample has therefore been recruited through a variety of channels including through the media, through targeted advertising by online advertising companies offering pro-bono support to ensure this stratification, and through partnerships with organisations representing vulnerable groups, enabling meaningful subgroup analyses.

Specifically, in the analyses presented here we included adults in the UK. We used new cross-sectional data from individuals as they entered the study and also included weekly longitudinal data as participants received their routine follow-up. In this report, we treated the data as repeated cross-sectional data collected daily from the 21st March to the 13th December (the latest data available). Aiming at a representative sample of the population, we weighted the data for each day to the proportions of gender, age, ethnicity, education and country of living obtained from the Office for National Statistics (ONS, 2018). Where results for subgroups show volatility, this could be a product of the sample size being smaller so caution in interpreting these results is encouraged.

The study is focusing specifically on the following questions:

1. What are the psychosocial experiences of people in isolation?
2. How do trajectories of mental health and loneliness change over time for people in isolation?
3. Which groups are at greater risk of experiencing adverse effects of isolation than others?
4. How are individuals' health behaviours being affected?
5. Which activities help to buffer against the potential adverse effects of isolation?

The study has full ethical and data protection approval and is fully GDPR compliant. For further information or to request specific analyses, please contact Dr Daisy Fancourt d.fancourt@ucl.ac.uk. To participate or to sign up for the newsletter and receive monthly updates on the study findings, visit www.COVIDSocialStudy.org

Demographics of respondents included in this report

Table: Demographics of observations from participants in the pooled raw data (unweighted; **data are weighted for analyses**)
For full demographics weighted to population proportions, see the User Guide at www.covidsocialstudy.org/results

	Number of observations	%		Number of observations	%
Age			Education levels		
18-29	47,170	5.97	GCSE or below	111,003	14.0
30-59	437,680	55.4	A-levels of equivalent	136,680	17.3
60+	305,582	38.7	Degree or above	542,749	68.7
Gender			Any diagnosed mental health conditions		
Male	198,496	25.2	No	657,307	83.2
Female	588,740	74.8	Yes	133,125	16.8
Ethnicity			Any diagnosed physical health conditions		
White	756,509	96.0	No	456,562	57.8
BAME	31,470	3.99	Yes	333,870	42.2
UK nations			Keyworker		
England	637,960	81.5	No	624,718	79.0
Wales	95,333	12.2	Yes	165,714	21.0
Scotland	49,427	6.31	Living with children		
Living arrangement			No (excluding those who live alone)	447,740	71.6
Not living alone	625,424	79.1	Yes	177,684	28.4
Living alone	165,008	20.9	Living area		
Annual household income			Village/hamlet/isolated dwelling	197,169	24.9
>30k	425,911	59.8	City/large town/small town	593,263	75.1
<30k	286,767	40.2			