



Covid-19 Social Study

Results Release 36

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Executive summary

Background

This report provides data from the last 68 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 THIRTY-SIXTH report, we focus on psychological responses to the first sixty-eight weeks since just before the first UK lockdown was announced (21/03/2020 to 11/07/2021). 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***** In-depth Covid-19 rules compliance and following the news on Covid-19

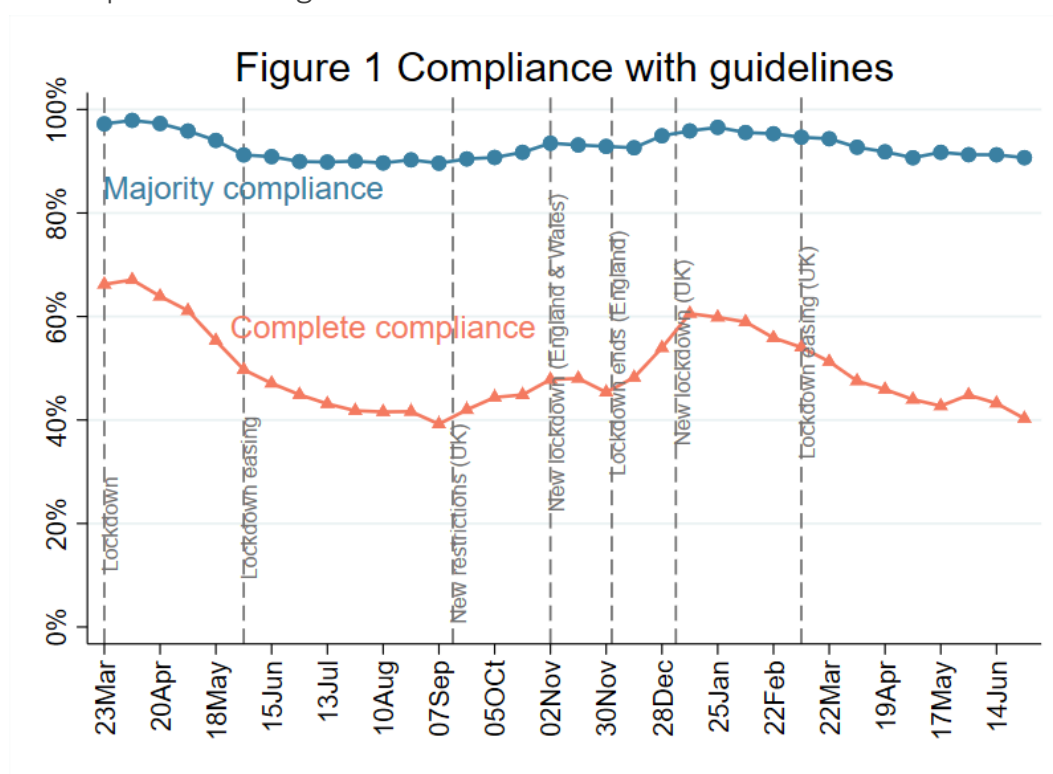
This study is not representative of the UK population but instead was designed to have good stratification across a wide range of socio-demographic factors enabling meaningful subgroup analyses to understand the experience of Covid-19 for different groups within society. Data are weighted using auxiliary 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

- Majority compliance with the rules and guidelines continues to be high and is currently at 90%. Complete compliance with the rules, has, however been decreasing since restrictions have started to lift and is now being reported by fewer than 1 in 2 people (40%). Note that these data were collected before the changes in rules that came into force in England on 19th July 2021.
- Regarding compliance with specific rules, just over 1 in 3 (35%) currently say they always maintain the recommended distance from people not in their household or bubble, compared to 1 in 2 (50%) who said they always did this at the end of 2020. Compliance with maintaining the recommended distance from people is highest amongst older adults (47% always do it) compared with 37% of adults aged 30-59 and just 15% of adults aged 18-29.
- Fewer than half (44%) of adults say they always wash their hands thoroughly with soap and water or use hand sanitiser after coming into contact with others outside of their household or with surfaces that could be contaminated, compared with 55% who said they always did this at the end of 2020. Complete compliance with handwashing is lowest in young adults, with just 1 in 3 (33%) saying they always do this (vs 48% of older adults and 46% of adults aged 30-59).
- The vast majority of people report always meeting up with no more than the recommended number of people outdoors and indoors (77% and 79%). However, these are the rules that people report breaking most often.
- Most adults (64%) say they currently follow the news on Covid-19, which is similar to the proportion this time last year (62%). At the start of the pandemic, over 9 in 10 adults in our study (96%) said they had followed the news on Covid-19, compared to 71% one year later in March 2021. Greater proportions of people with higher household incomes, those without a mental health condition, people who are not keyworkers, people who do not live with children, those living in remote areas, men, people with a physical health condition, older adults, people of white ethnic background, and people with progressively higher levels of education reported having followed accessed news on Covid-19 in the past four months.
- The sharp decline in the proportion of people who say they are worried about catching or becoming seriously ill from Covid-19 that was observed from the start of the new year has now ended and may even have reversed, although more data will be needed to confirm this trend.
- Confidence in government to handle the pandemic remains lower in England than in Scotland or Wales, and despite having increased over the first four months of the year, confidence levels in England now appear to be decreasing again.

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).

Majority compliance has declined somewhat since the easing of restrictions for the latest lockdown and is now what it was in the summer of 2020.

Complete compliance (i.e., following rules and recommendations with no bending or even minor infringements) has been decreasing since the start of the new year and is what it was at the end summer of 2020, around 40%. Across demographic groups, patterns of complete compliance remain as they have been since the start of the year, with compliance lower in higher income households, amongst young adults, amongst keyworkers, in urban areas, amongst men, amongst those in ethnic minority groups¹, and amongst people in good physical health.

Majority compliance has been reported by around 90% of people in the last month, with consistent patterns across the latest lockdown present in all major demographic groups (Figures 2m-2x).

¹ Figures for ethnicity sub-groups are analysed by month rather than by week for the duration of the study to maximise sample size.

Figure 2a Complete compliance by age groups

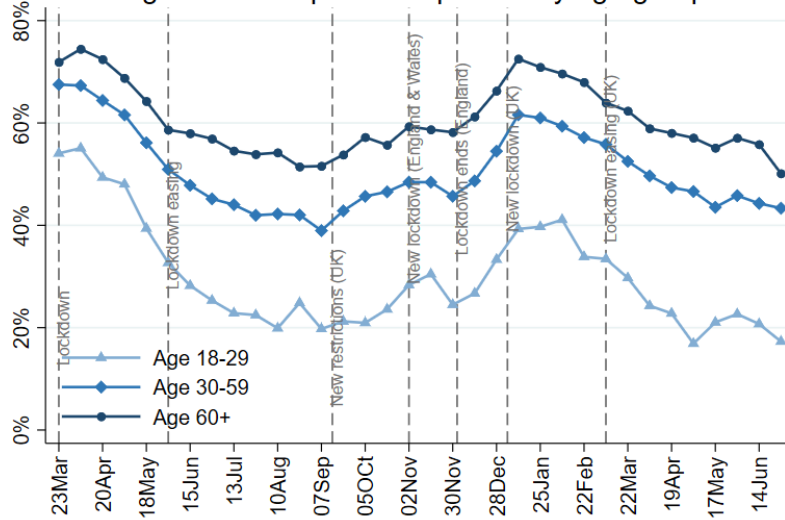


Figure 2b Complete compliance by living arrangement

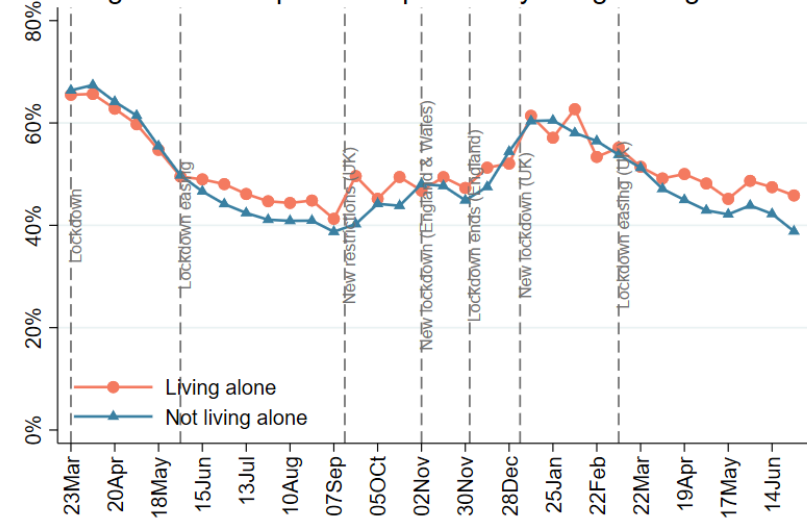


Figure 2c Complete compliance by household income

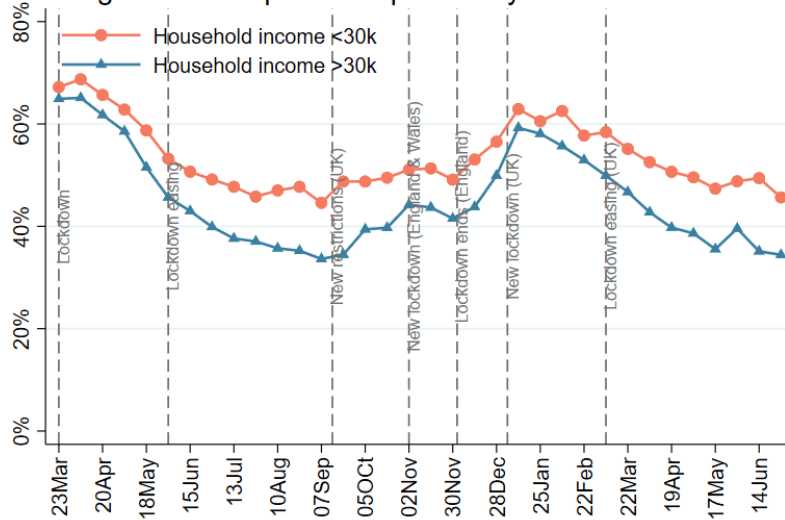


Figure 2d Complete compliance by mental health

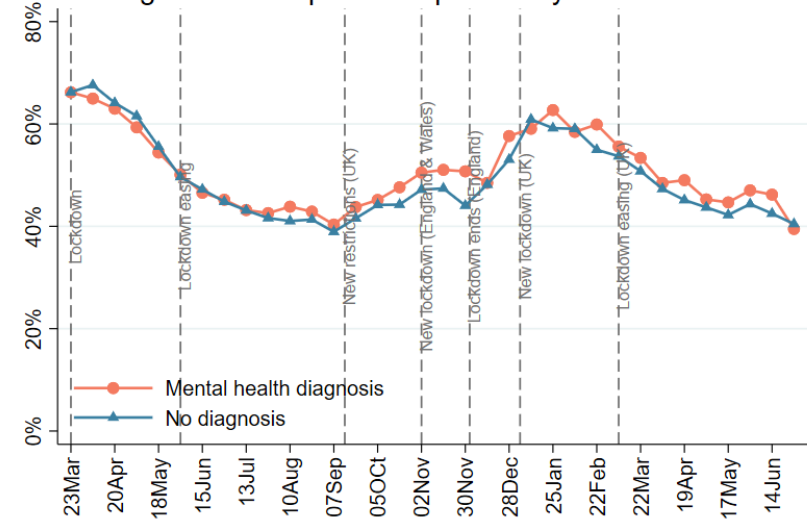


Figure 2e Complete compliance by nations

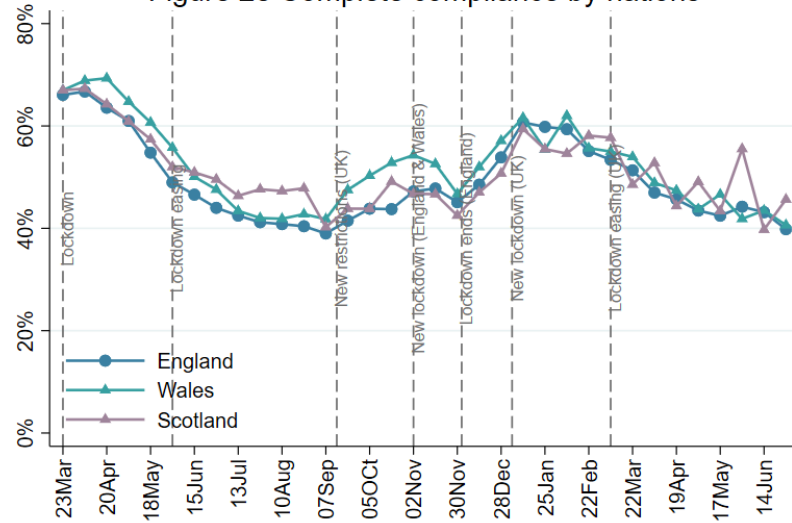


Figure 2f Complete compliance by keyworker status

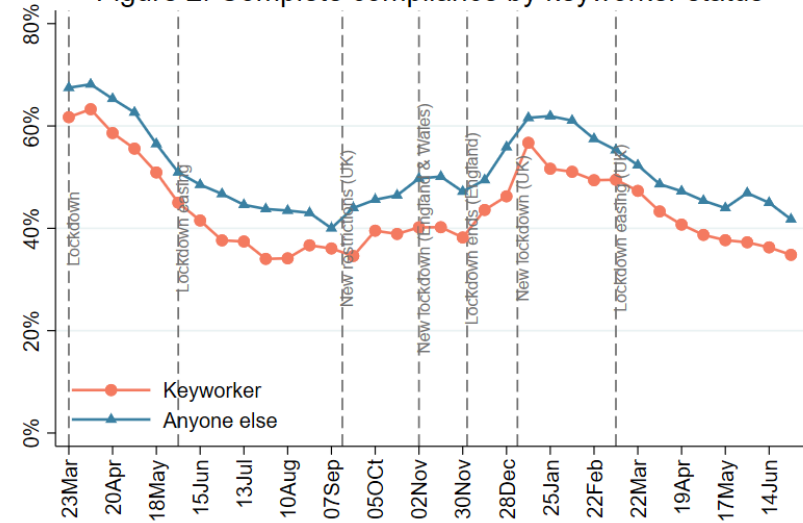


Figure 2g Complete compliance by living with children

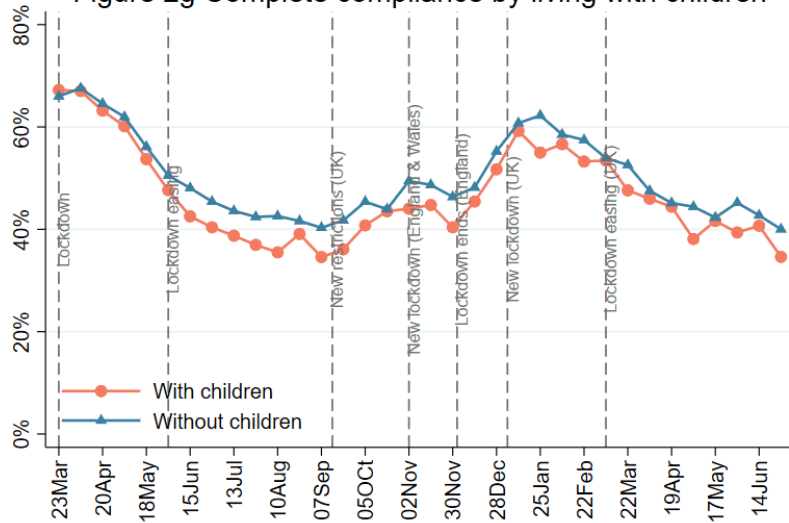


Figure 2h Complete compliance by living area

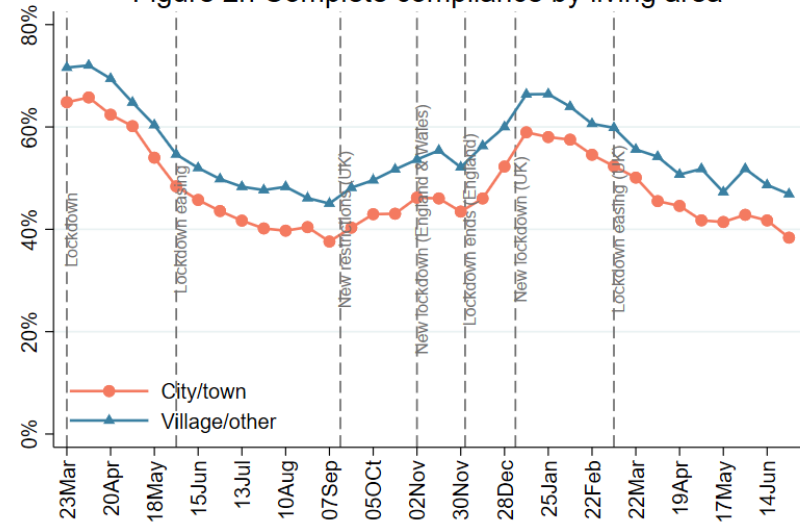


Figure 2i Complete compliance by gender

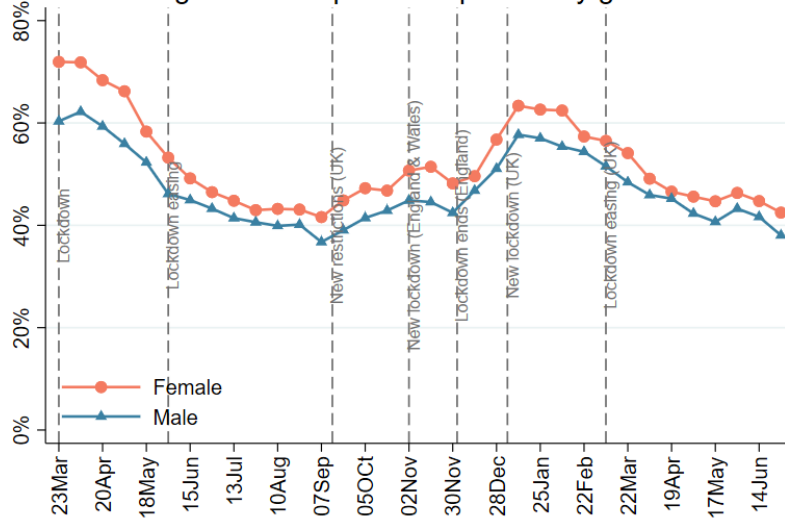


Figure 2j Complete compliance by ethnicity

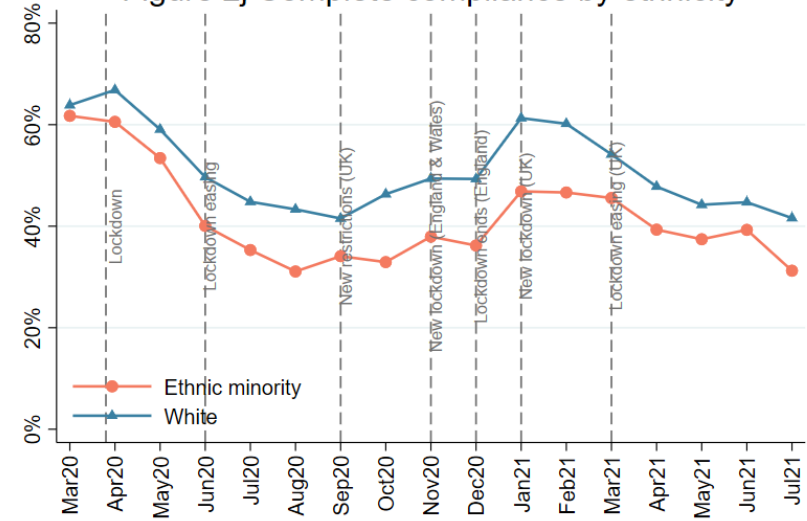


Figure 2k Complete compliance by educational levels

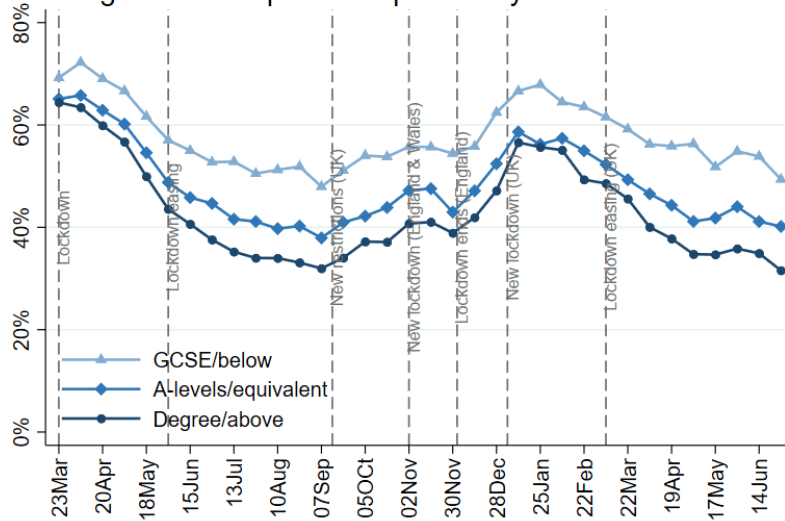


Figure 2l Complete compliance by physical health

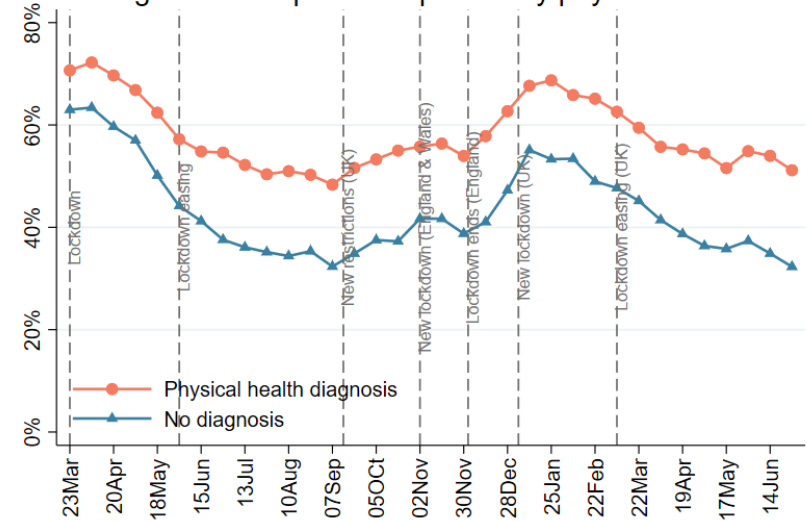


Figure 2m Majority compliance by age groups

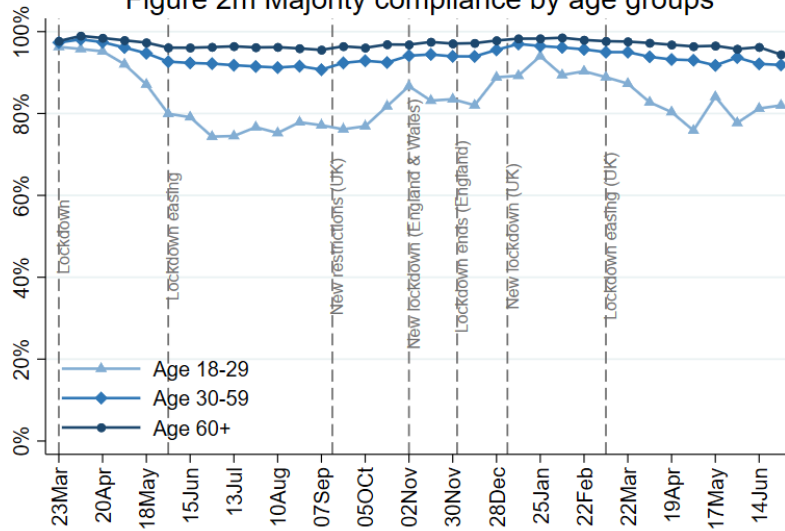


Figure 2n Majority compliance by living arrangement

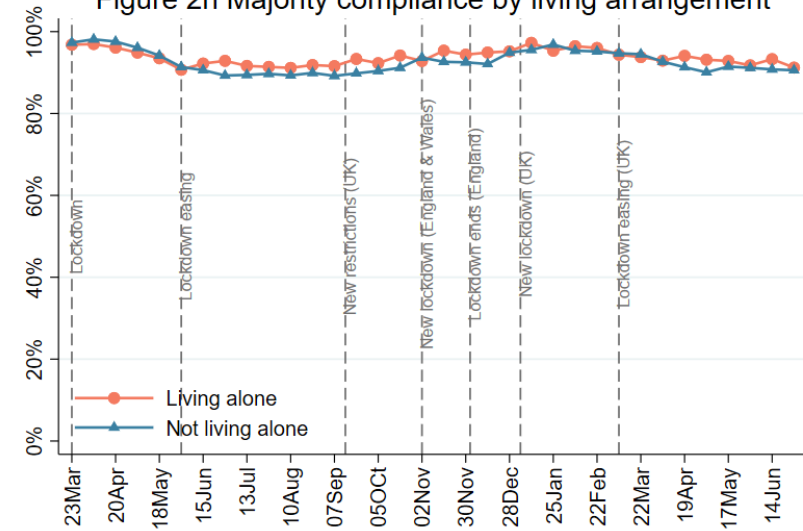


Figure 2o Majority compliance by household income

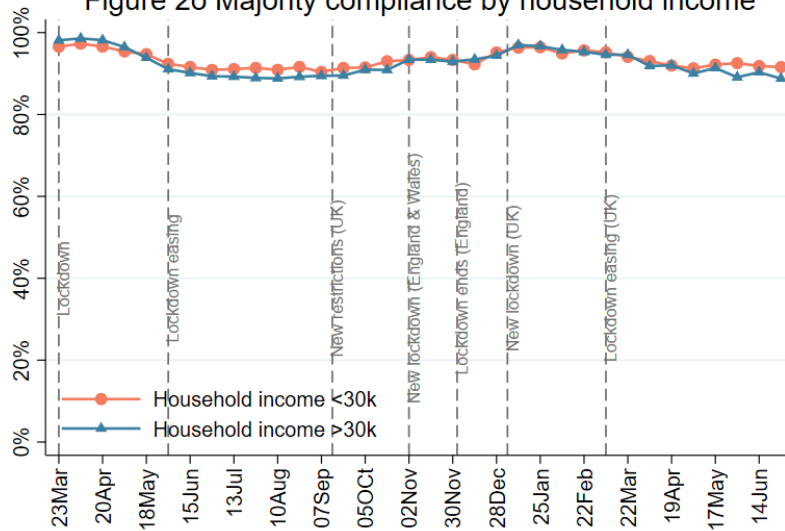
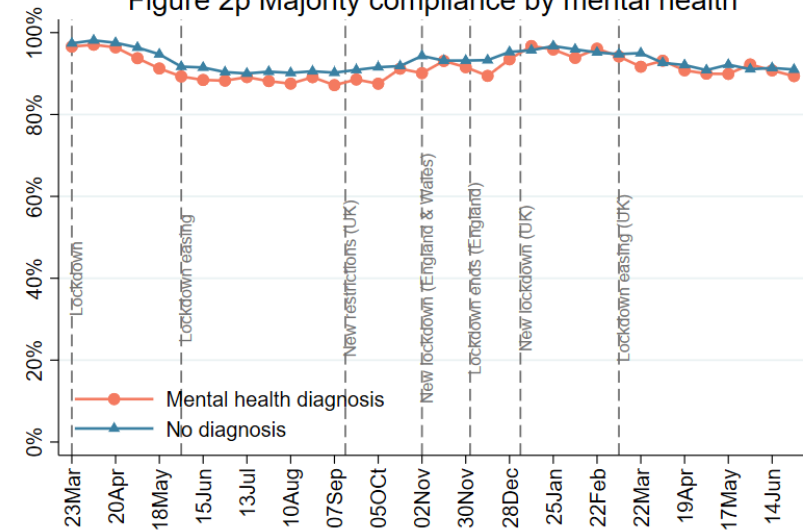
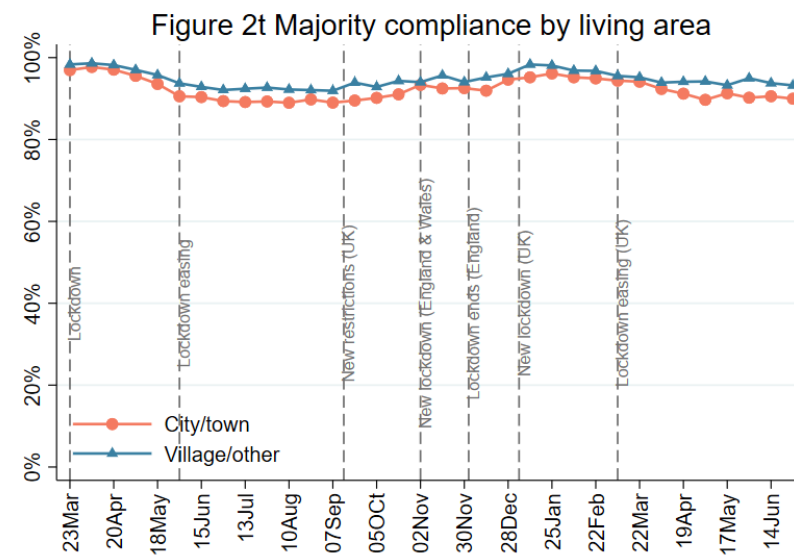
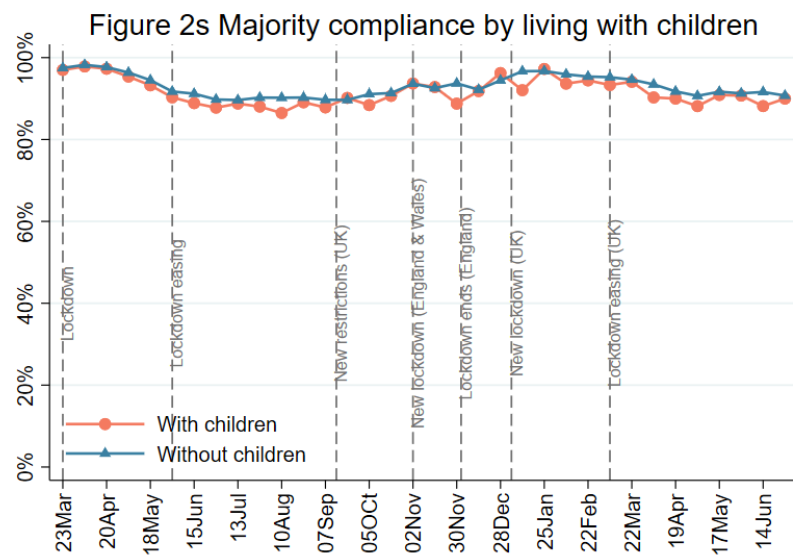
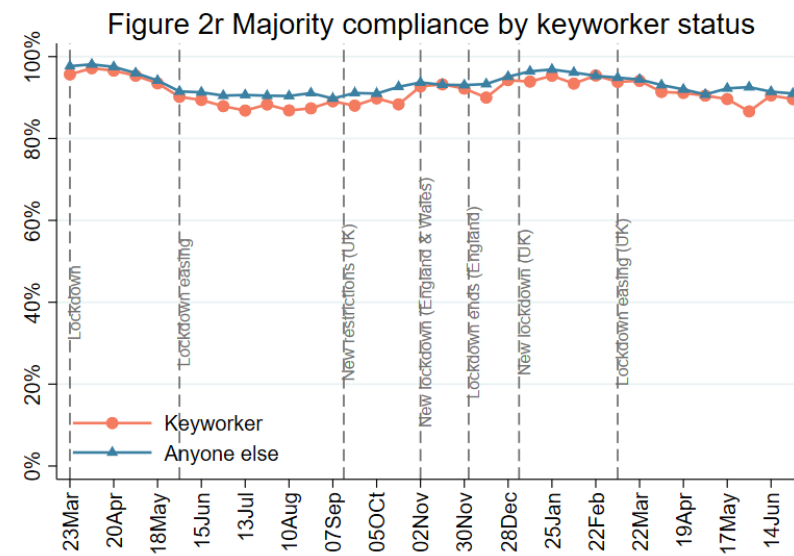
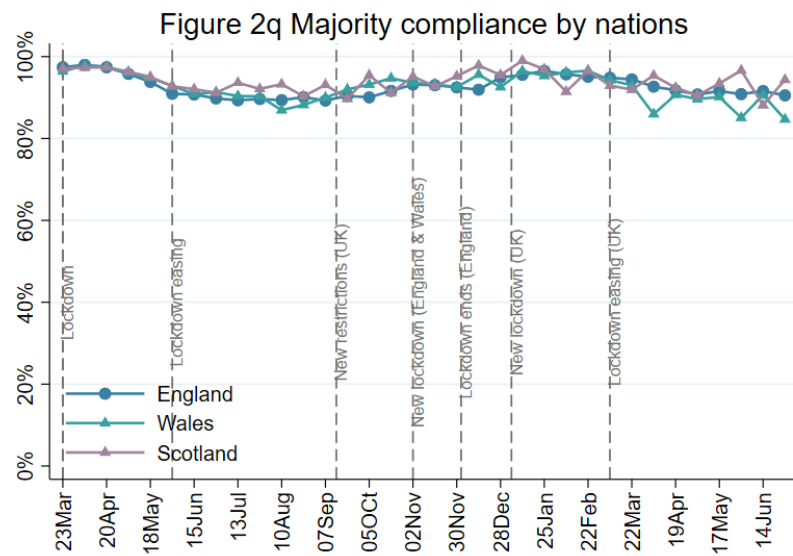
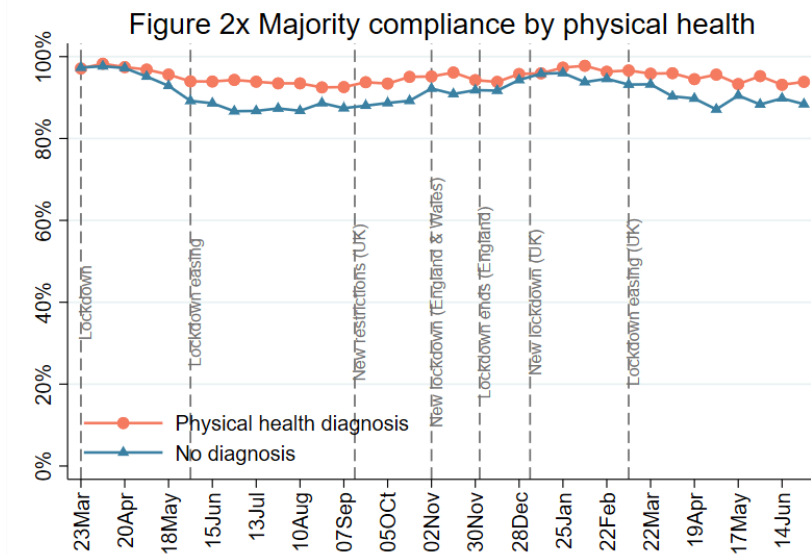
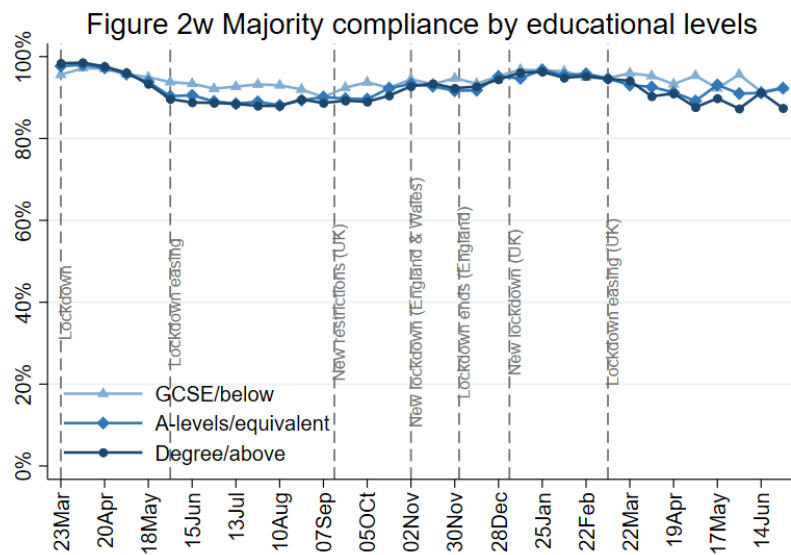
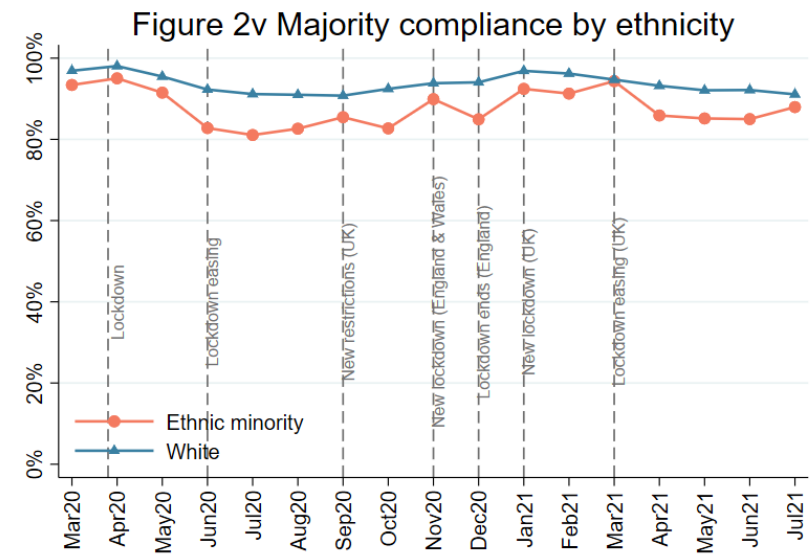
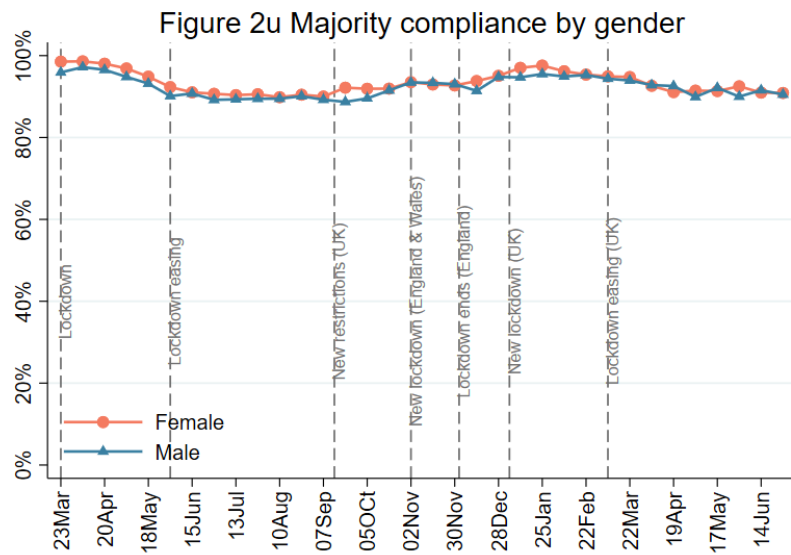


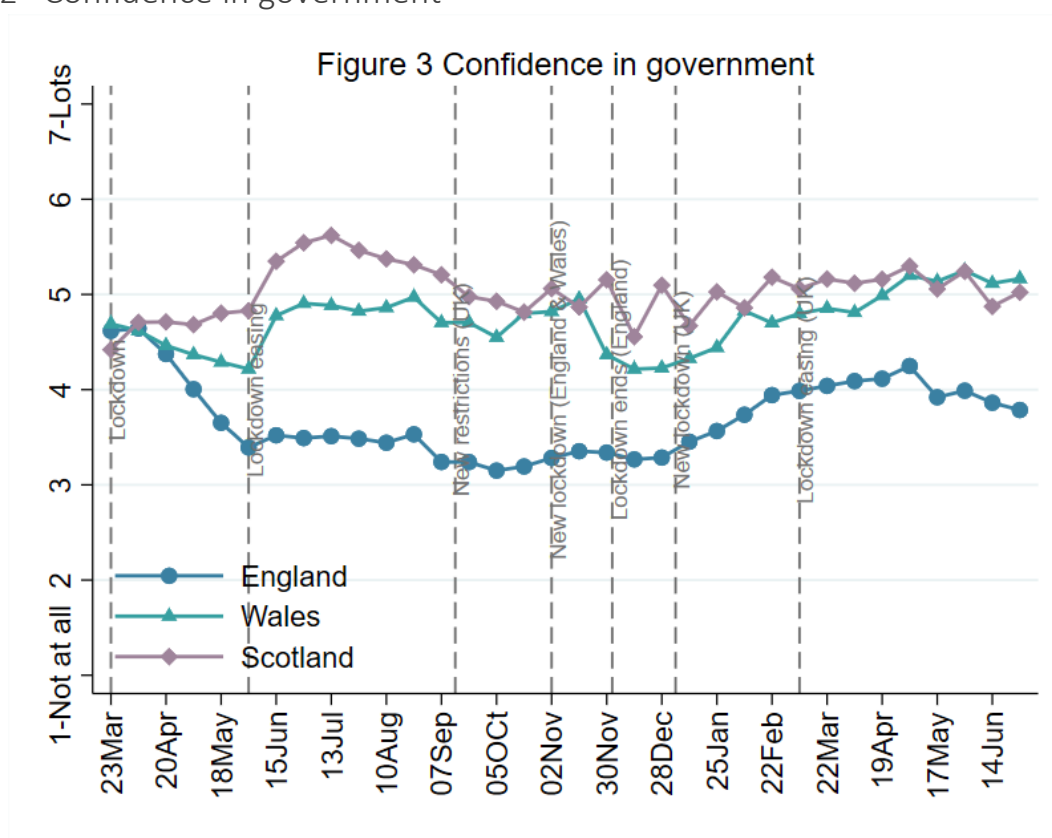
Figure 2p Majority compliance by mental health







1.2 Confidence in government



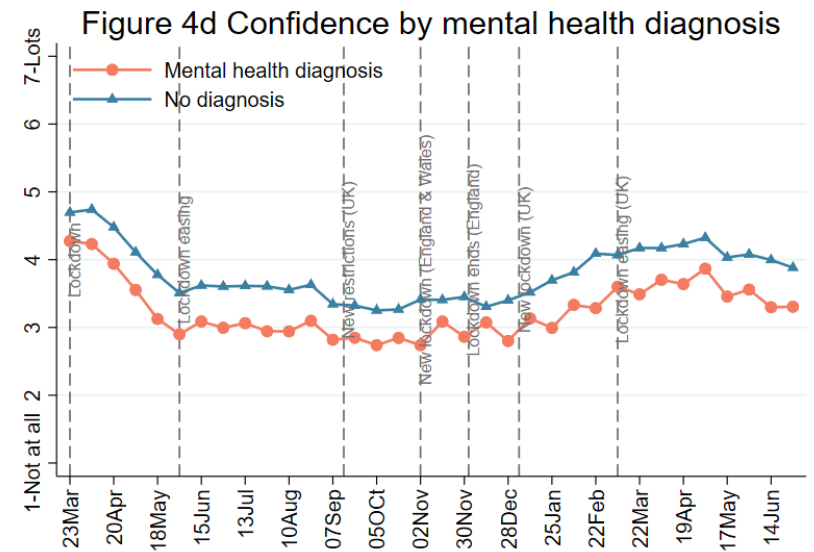
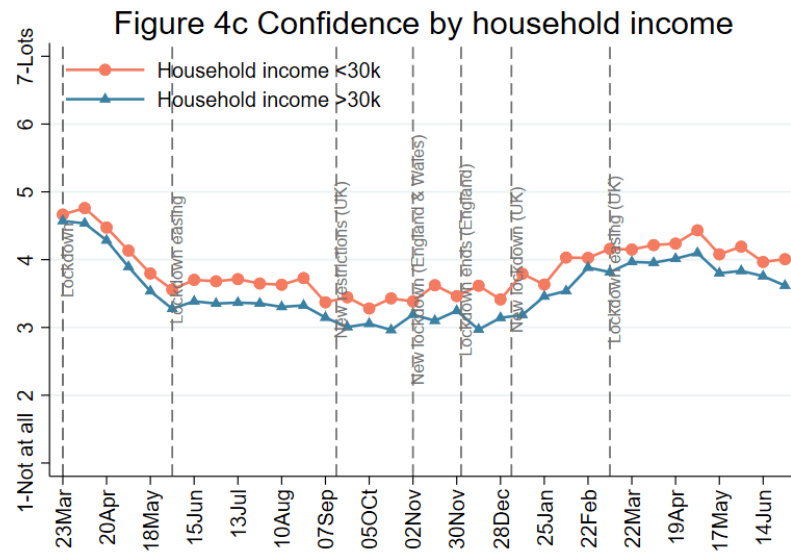
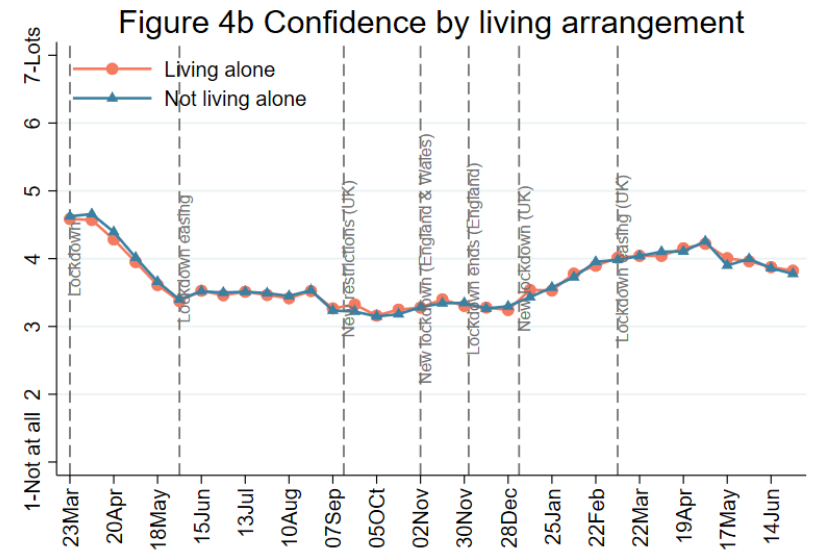
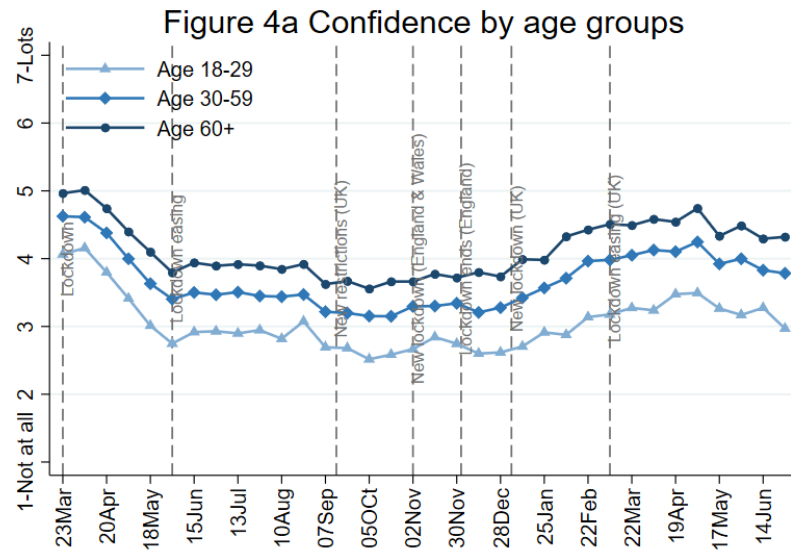
FINDINGS

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

Confidence in government to handle the Covid-19 pandemic increased from the start of the new year through to the end of April in England, Wales, and Scotland, and then levelled off in the latter two countries. Confidence levels remain lower in England than devolved nations and have been decreasing since the end of April.²

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. In England, confidence in government is still lowest in those under the age of 30. Confidence also remains lower in urban areas, amongst people from ethnic minority groups, in people with a mental health diagnosis, people with higher household incomes, and amongst people with higher educational qualifications.

² 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.



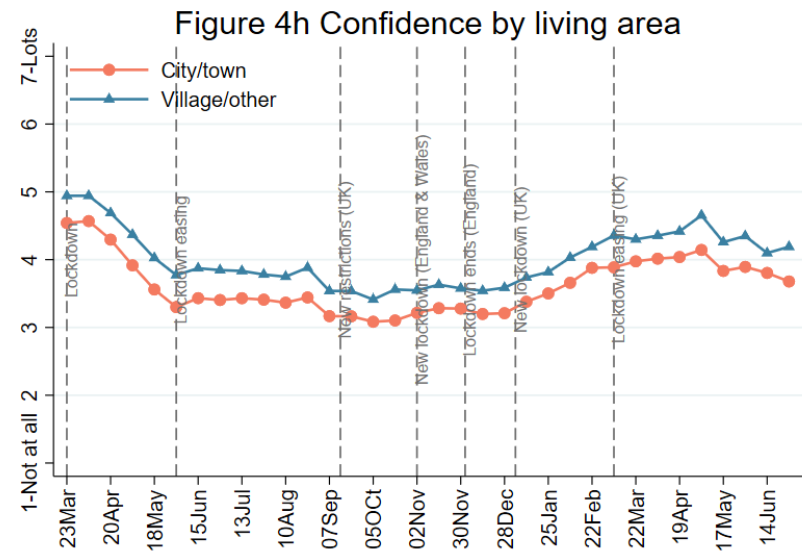
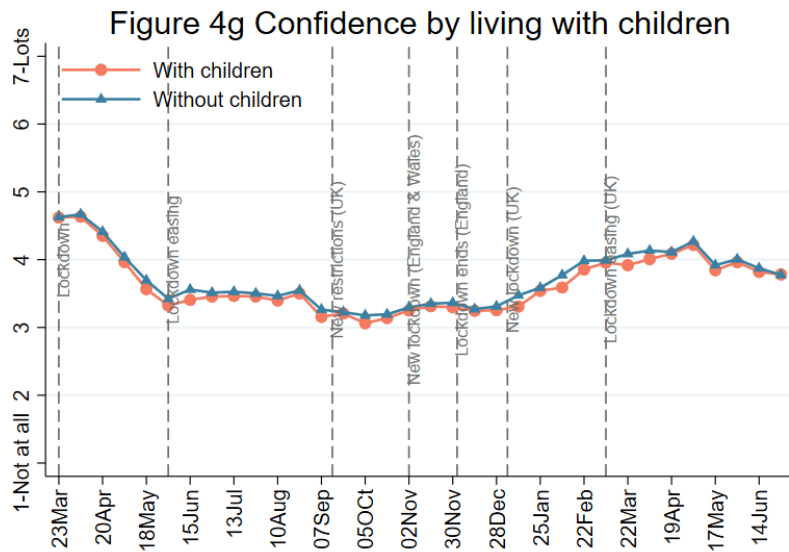
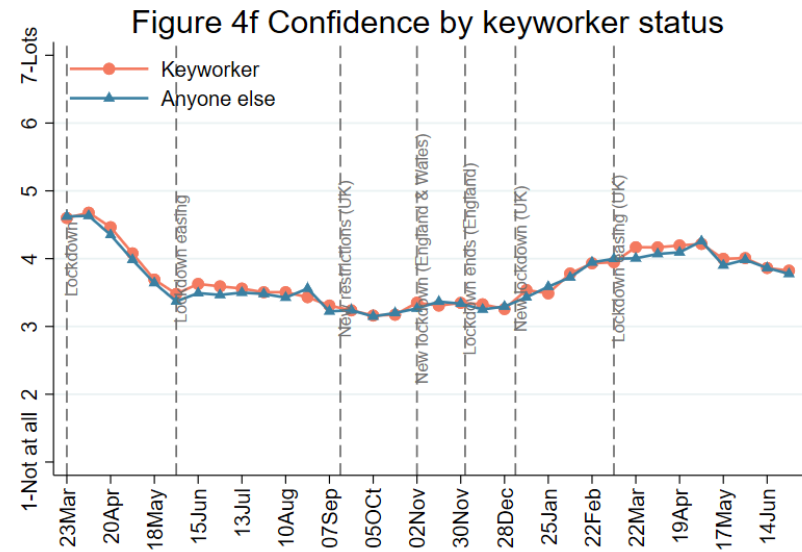
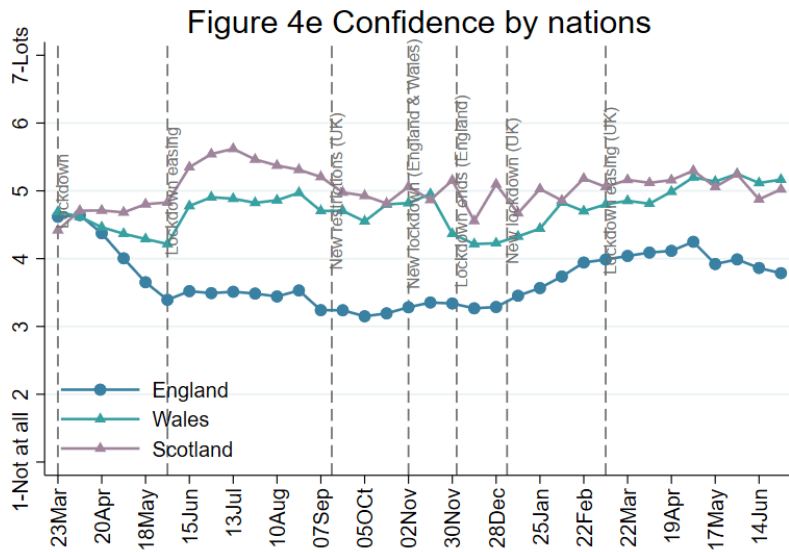


Figure 4i Confidence in government by gender

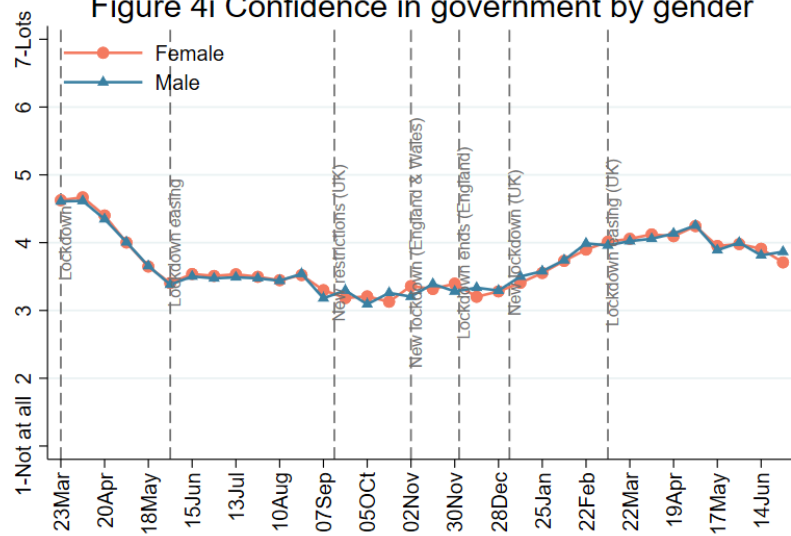


Figure 4j Confidence in government by ethnicity

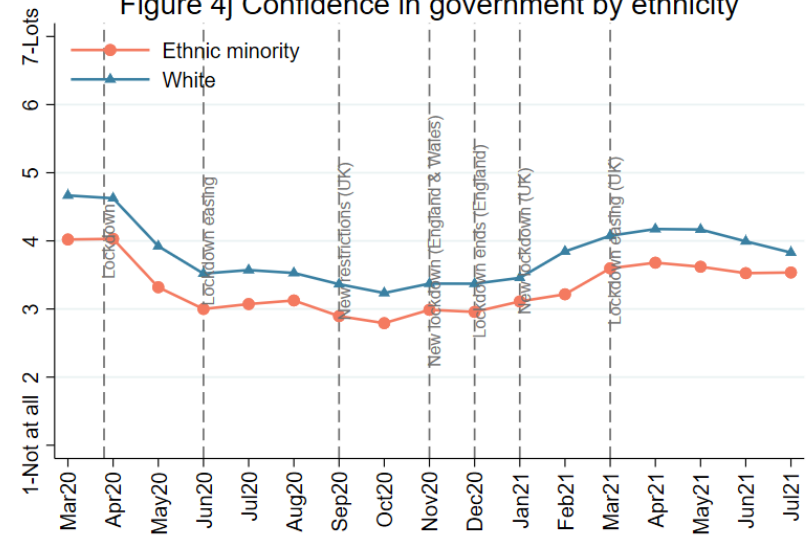


Figure 4k Confidence in government by educational levels

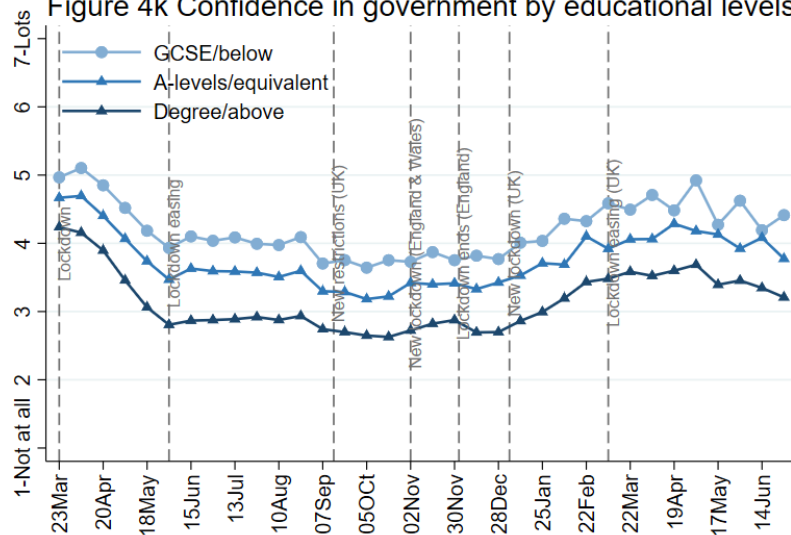
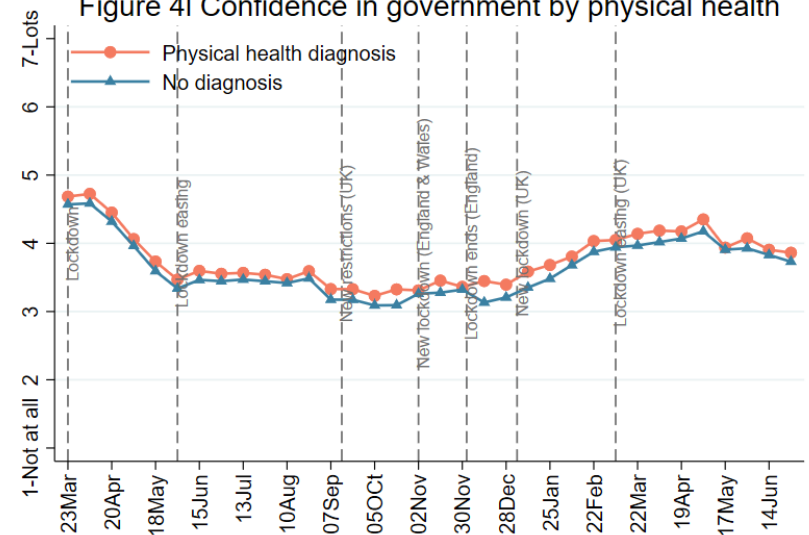
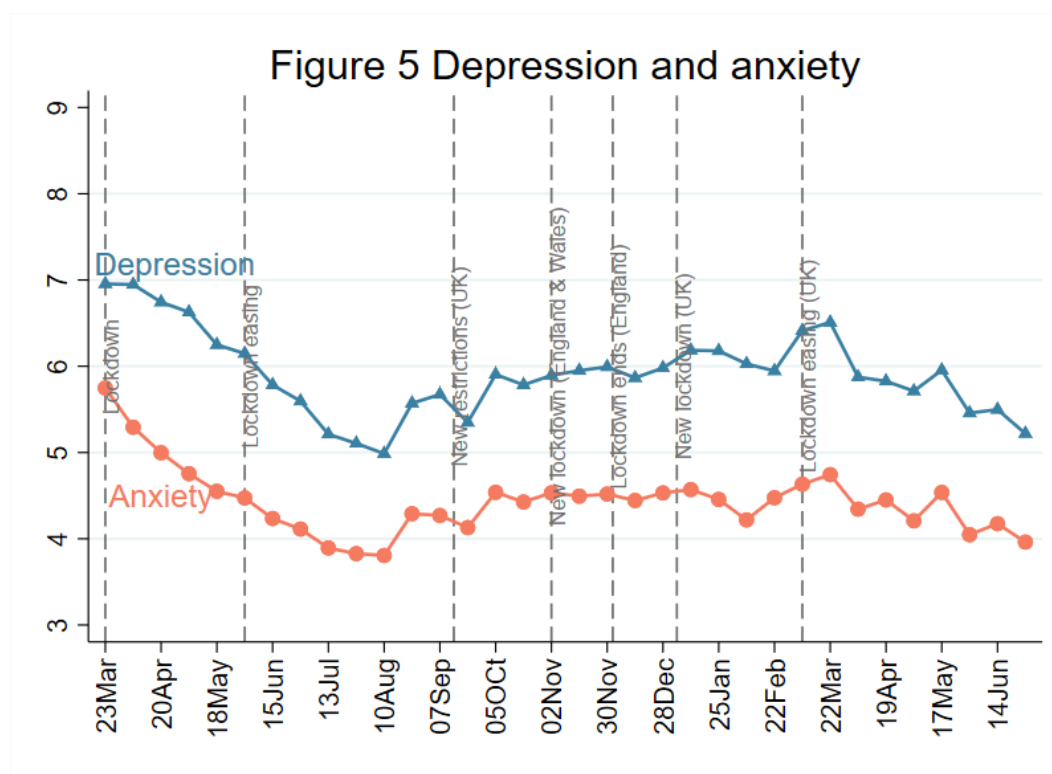


Figure 4l Confidence in government by physical health



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 higher than 10 can indicate major depression or moderate anxiety.

Depression and anxiety symptoms have generally continued to decrease over the past month as they have been since the easing of restrictions for the latest lockdown but remain similar to what they were in the autumn of 2020.

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 depression³).

Depression and anxiety are still highest in young adults, women, people with lower household income, people from ethnic minority backgrounds, those with a physical health condition, and people living with children. People with a diagnosed mental illness are still reporting higher levels of depression and anxiety symptoms (as might be expected) (see Figures 6d and 7d).

³ 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

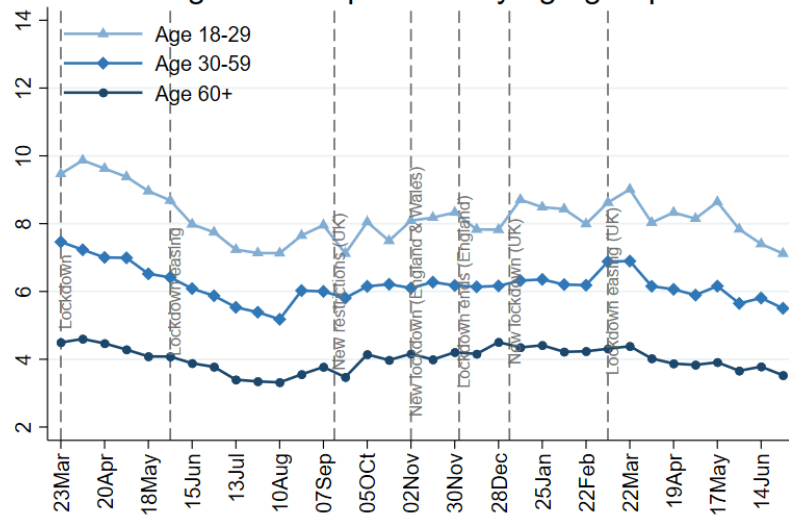


Figure 6b Depression by living arrangement

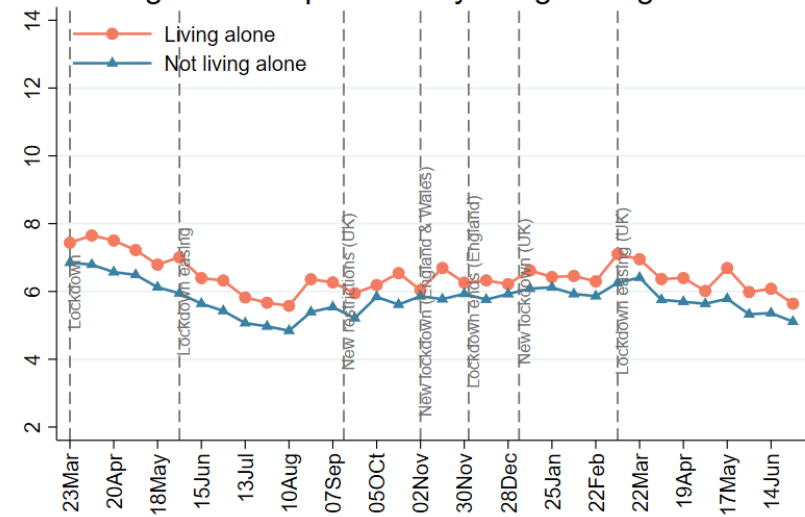


Figure 6c Depression by household income

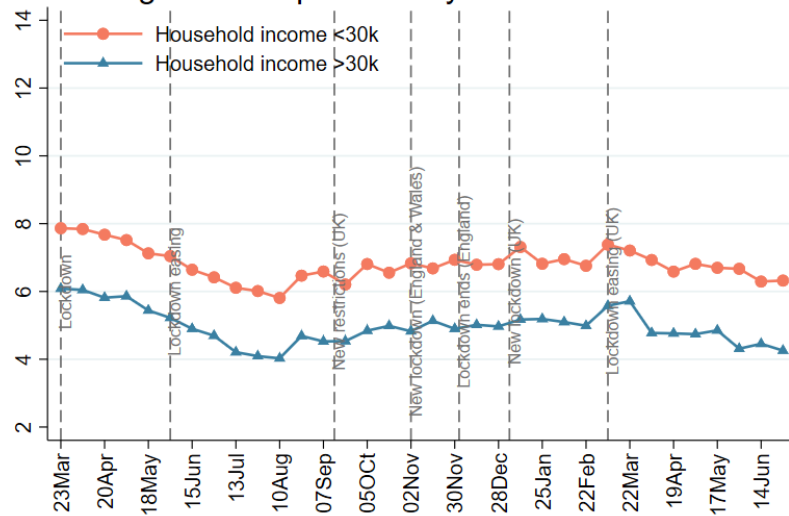


Figure 6d Depression by mental health diagnosis

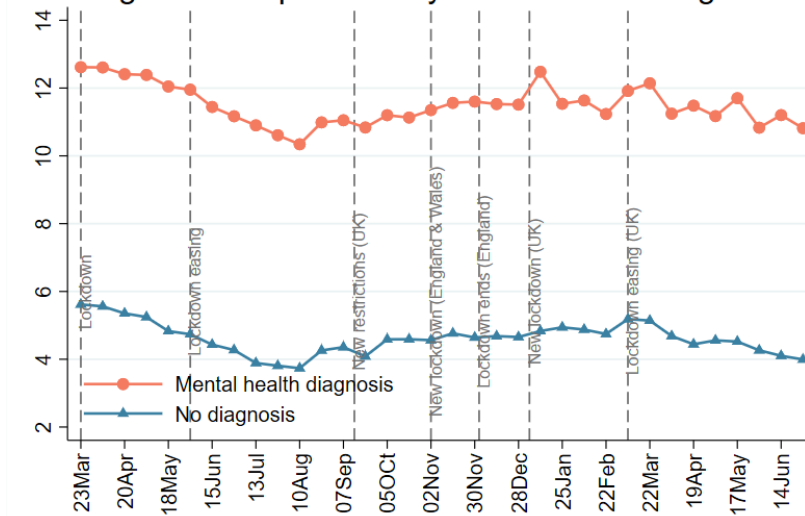


Figure 6e Depression by nations

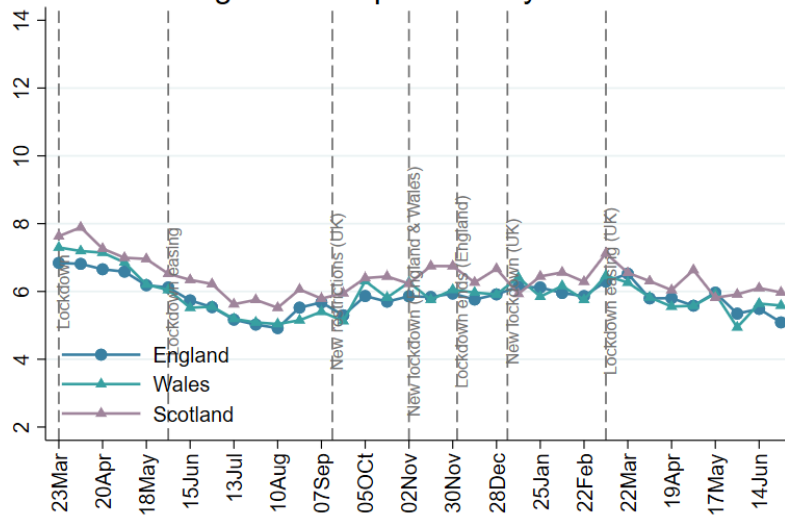


Figure 6f Depression by keyworker status

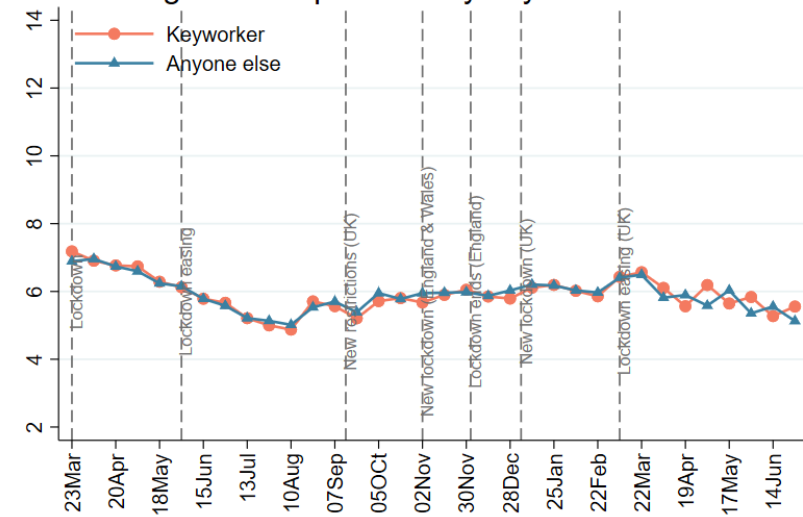


Figure 6g Depression by living with children

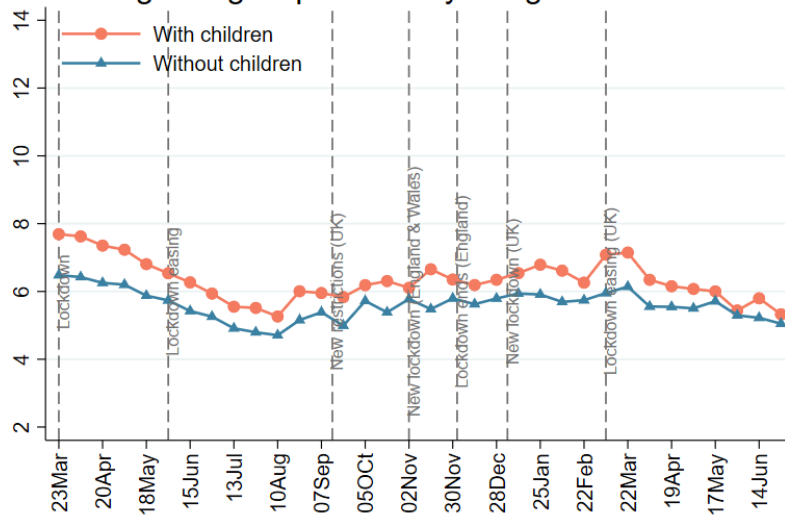


Figure 6h Depression by living area

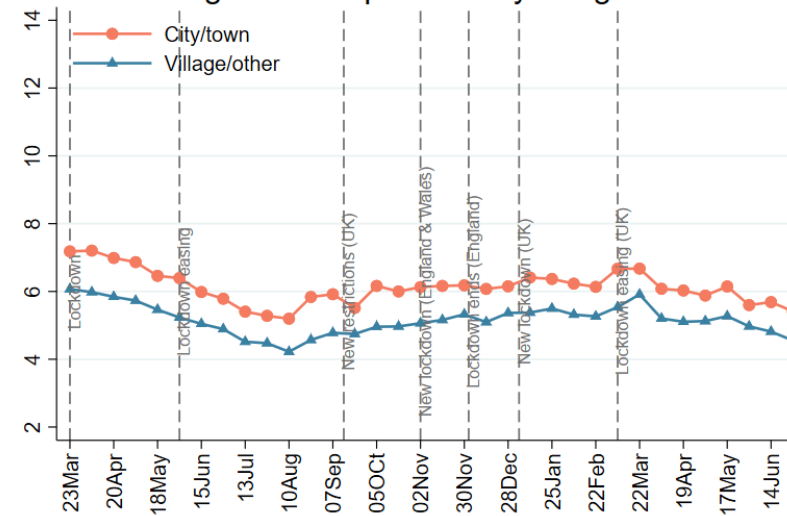


Figure 6i Depression by gender

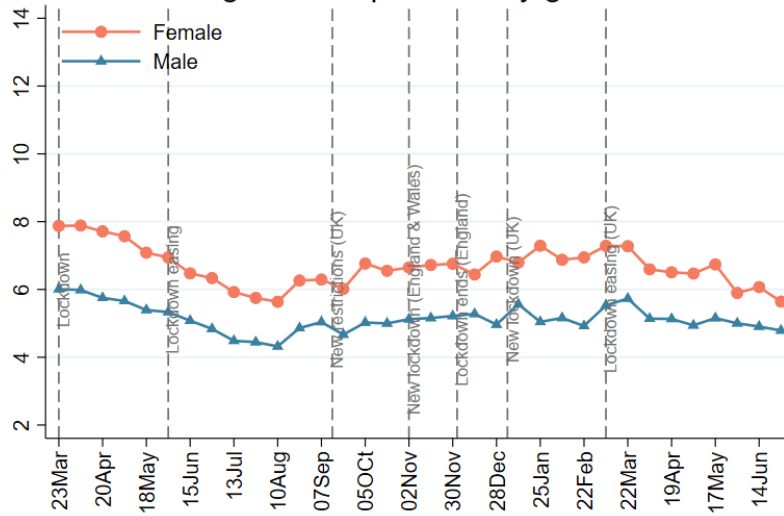


Figure 6j Depression by ethnicity

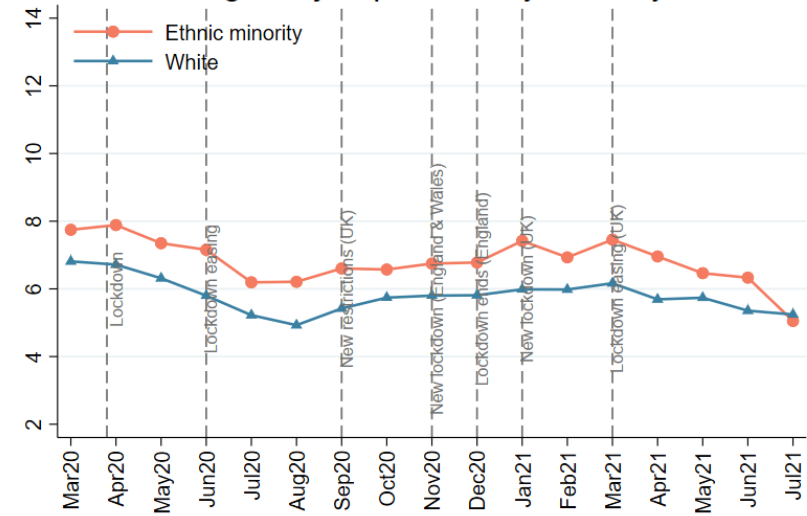


Figure 6k Depression by educational levels

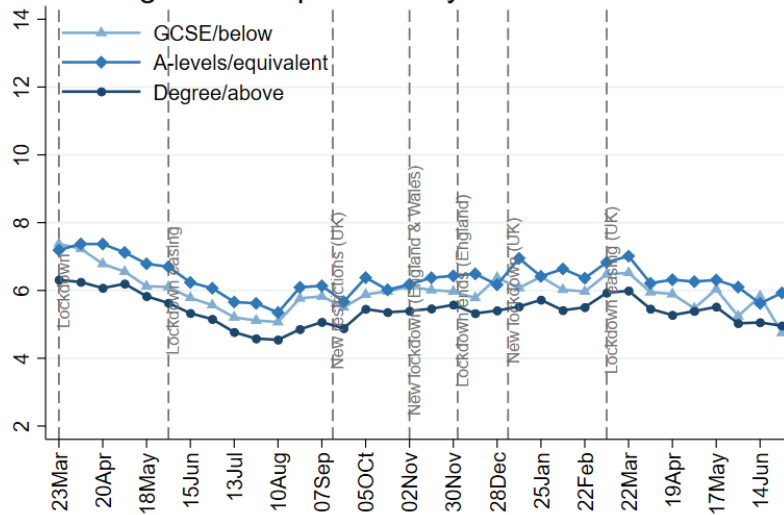


Figure 6l Depression by physical health diagnosis

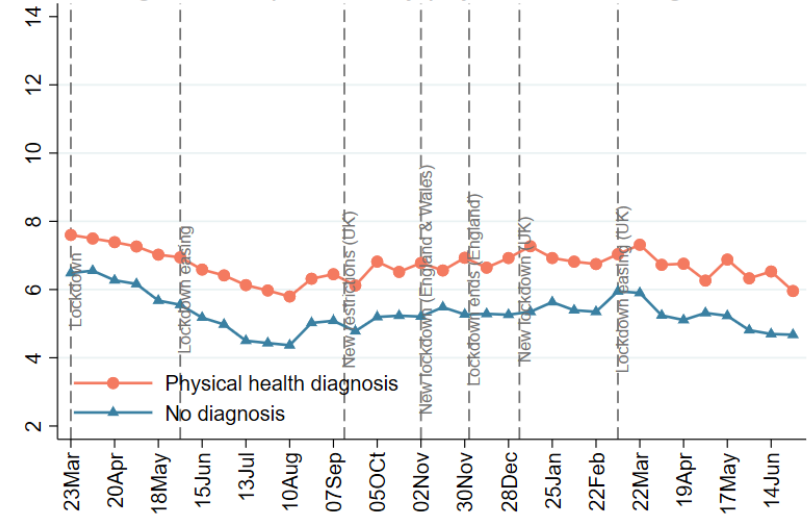


Figure 7a Anxiety by age groups

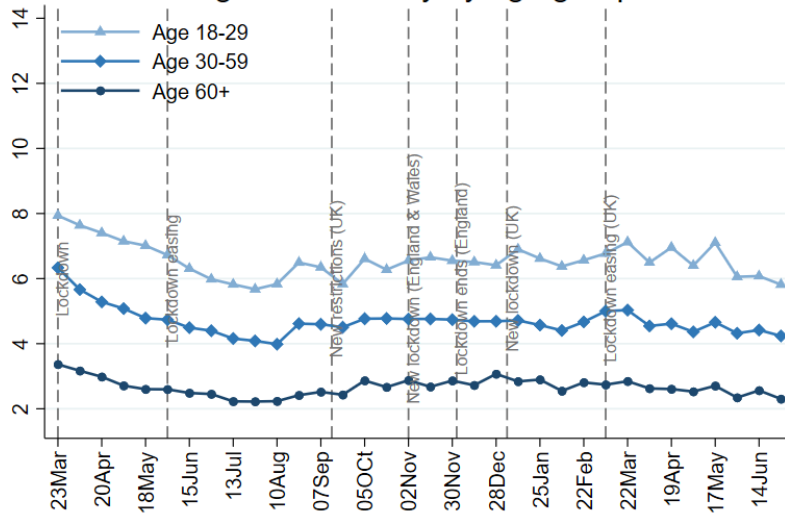


Figure 7b Anxiety by living arrangement

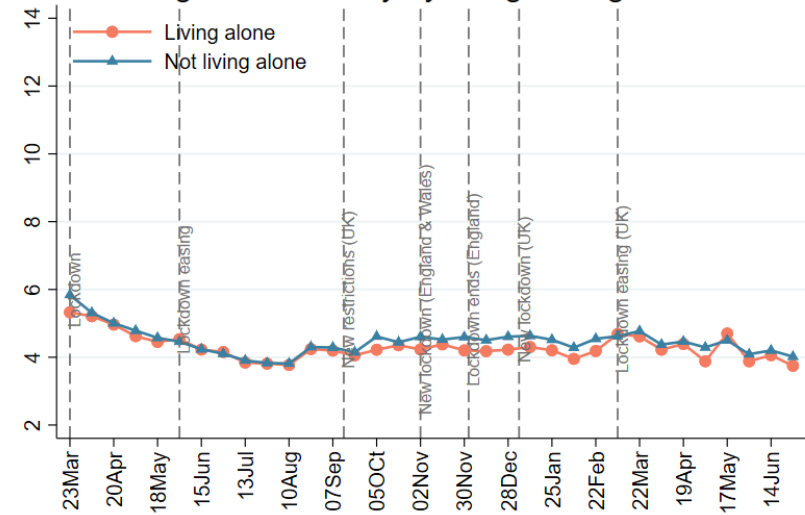


Figure 7c Anxiety by household income

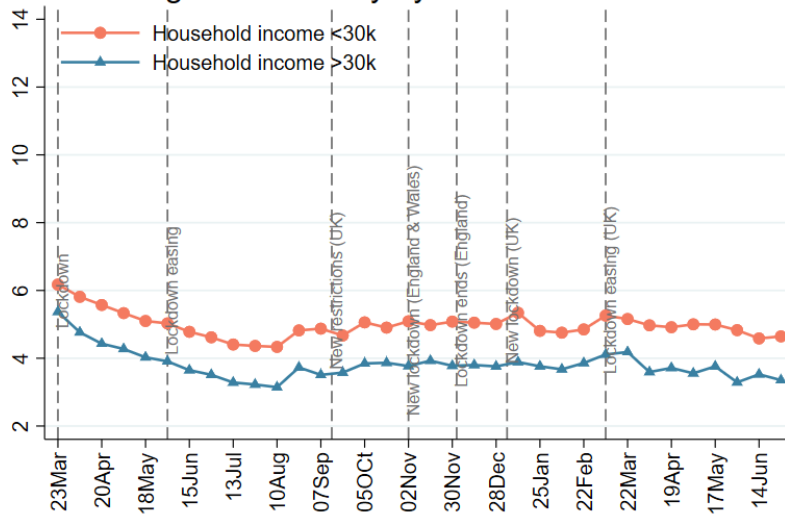


Figure 7d Anxiety by mental health diagnosis

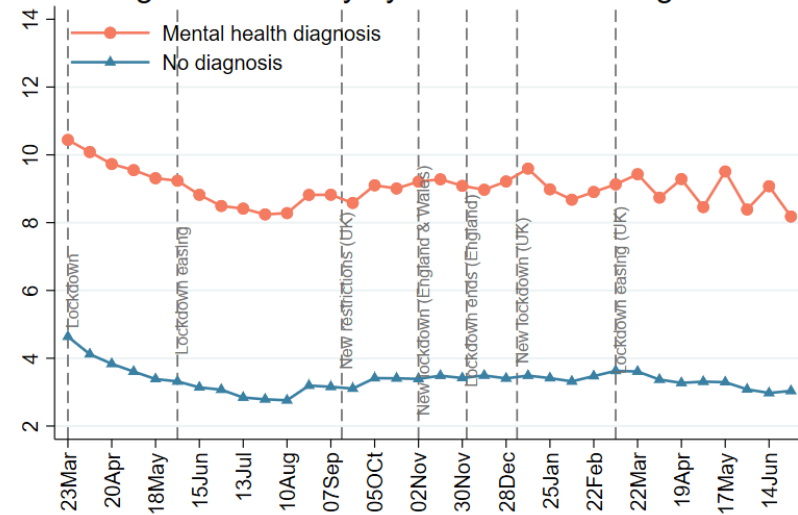


Figure 7e Anxiety by nations

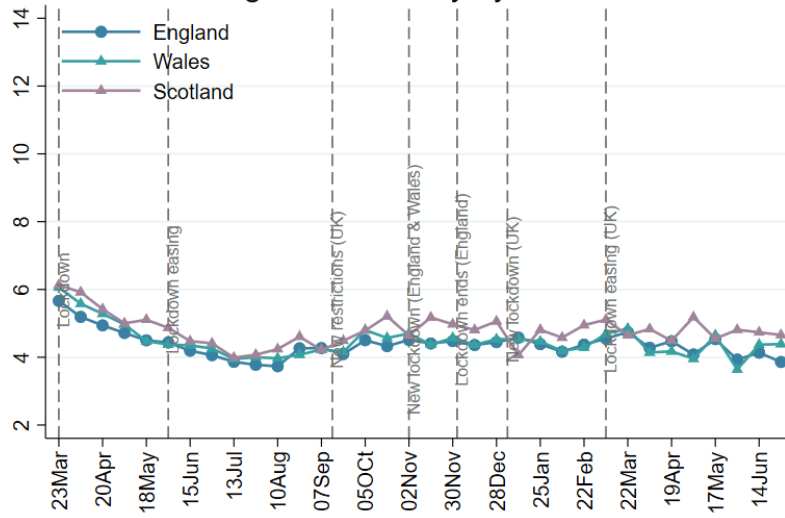


Figure 7f Anxiety by keyworker status

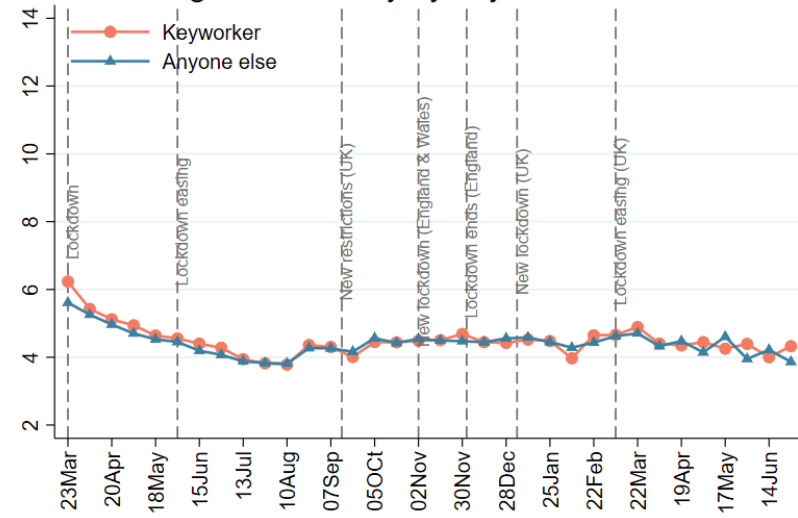


Figure 7g Anxiety by living with children

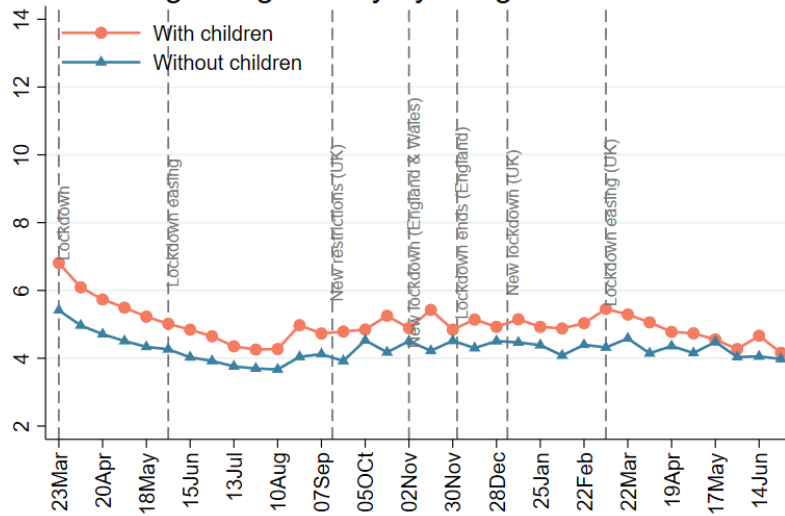


Figure 7h Anxiety by living area

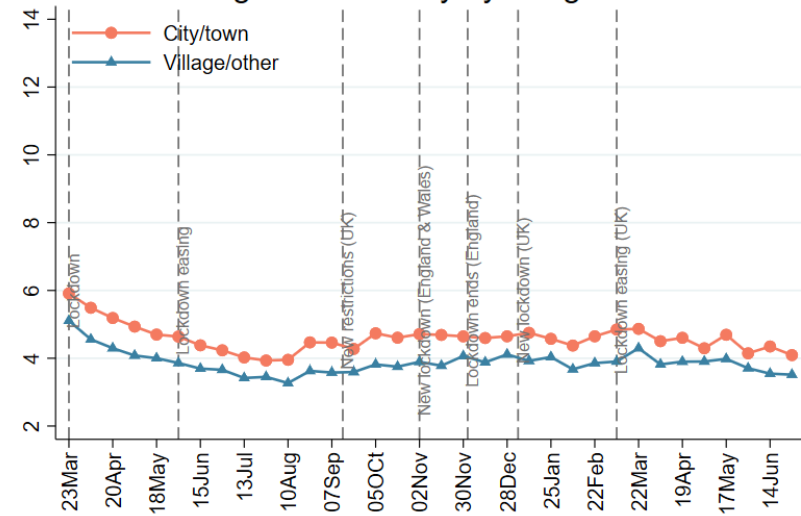


Figure 7i Anxiety by gender

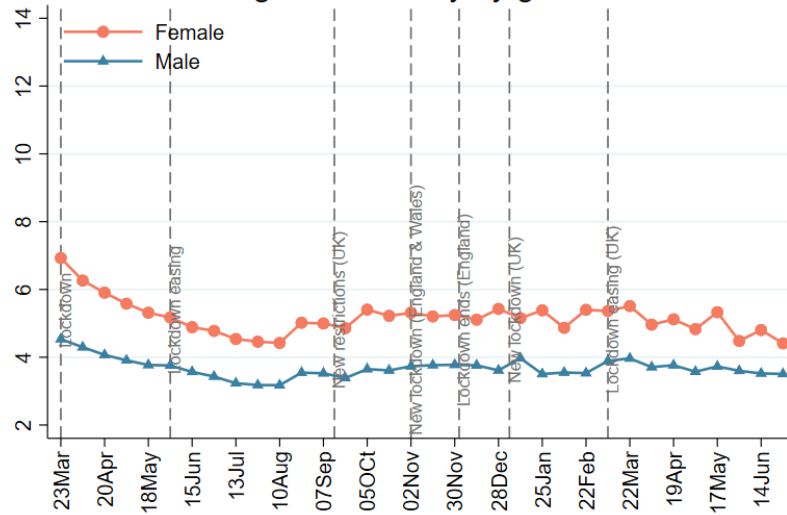


Figure 7j Anxiety by ethnicity

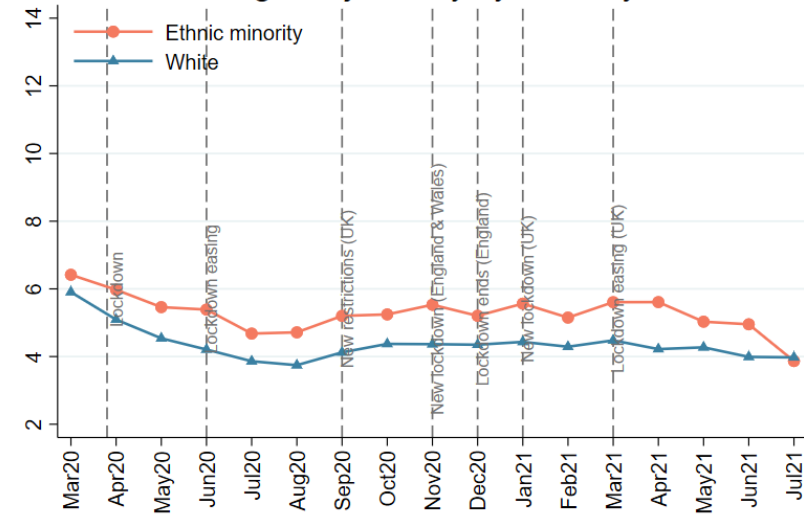


Figure 7k Anxiety by educational levels

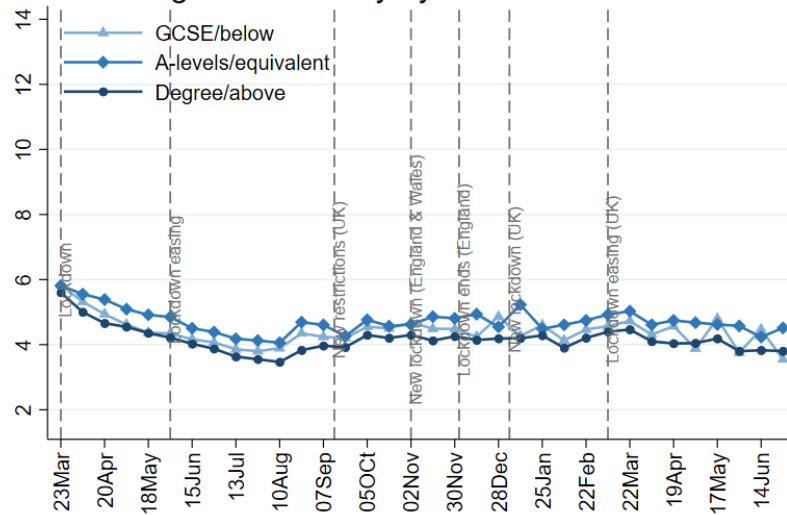
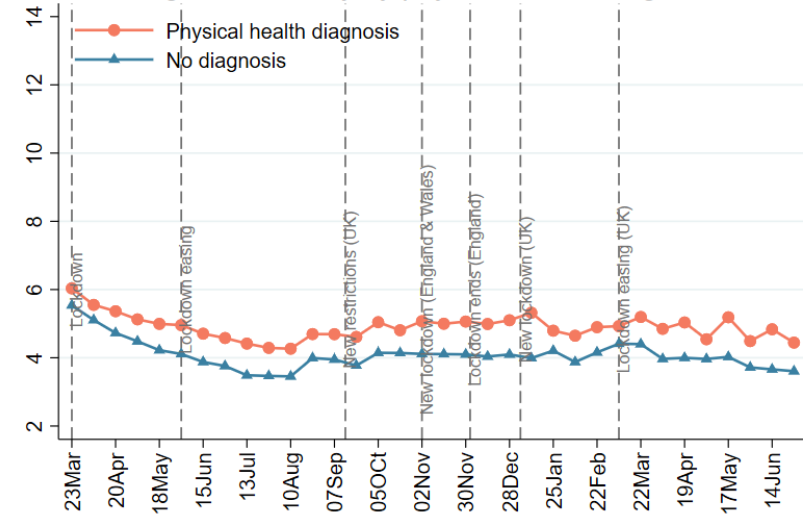
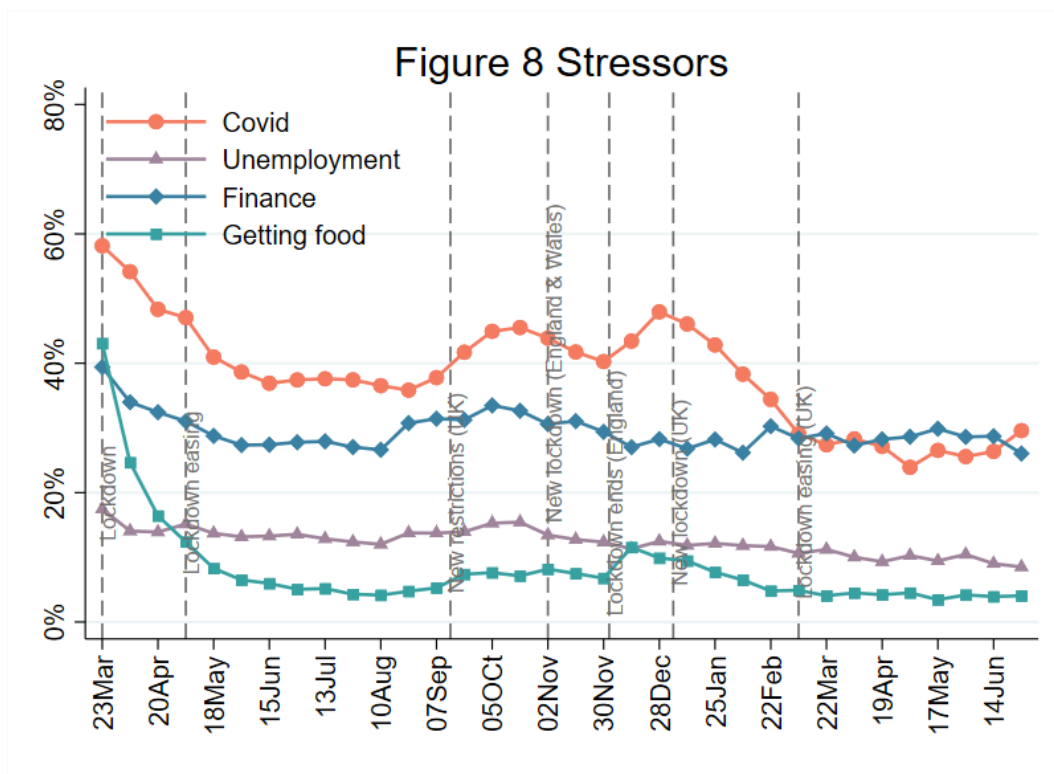


Figure 7l Anxiety by physical health diagnosis



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 decreased from the end of 2020 to the beginning of March when restrictions for the latest lockdown started to ease, but then levelled off. Though more data will be needed to confirm this trend, the proportion of people concerned about catching or becoming seriously ill from Covid-19 has increased slightly over the past month, as the number of cases has increased. A greater proportion of young adults have been expressing this concern than adults over the age of 30 over the past few months. Women and people with a physical or mental health diagnosis remain more worried about catching or becoming seriously ill from Covid-19.

Worries about finance have remained relatively stable since the latest lockdown started and are comparable to their lowest levels of around 1 in 3 people over the summer of 2020. Concerns about finances remain highest amongst people with low household incomes, those with a mental health condition, people living with kids, people from ethnic minority groups, and adults of working age (18-59 years). Worries about finance increased in young adults from the end of March to the end of May and remain higher in this group than adults over the age of 30.

Worries about unemployment continue to concern 1 in 10 people. Unemployment stress is higher in people living with children, people with a mental health diagnosis, amongst people from ethnic minority groups, in people under the age of 60, and in urban areas.

Worries about accessing food have been stable since the end of 2020 and are affecting approximately 5% of people; comparable to early summer 2020. Most groups are showing similar concern about accessing food, although these concerns are higher in people with a diagnosed mental health condition and people with lower household incomes. People with physical health conditions are also more concerned about accessing food, which may be due to greater concerns about going to supermarkets.

Figure 9a Covid-19 stress by age groups

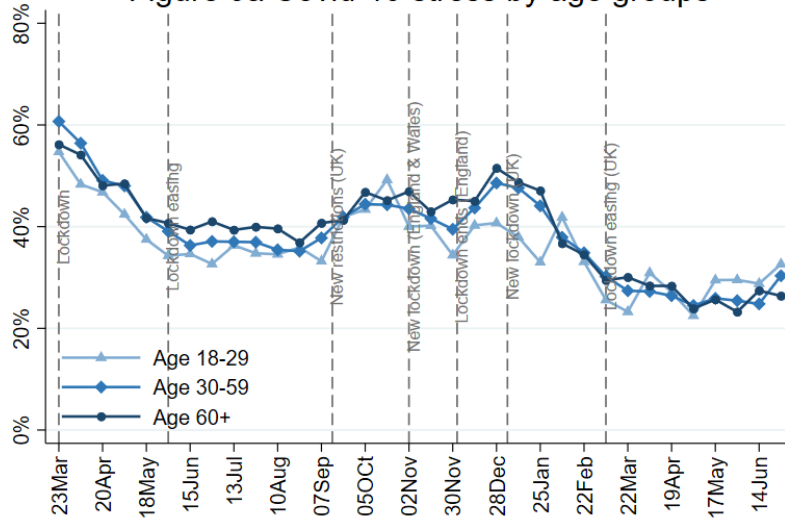


Figure 9b Covid-19 stress by living arrangement

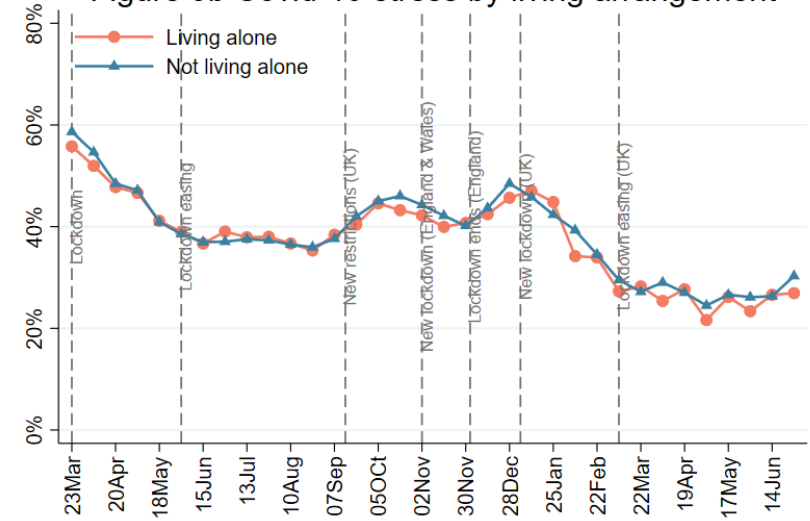


Figure 9c Covid-19 stress by household income

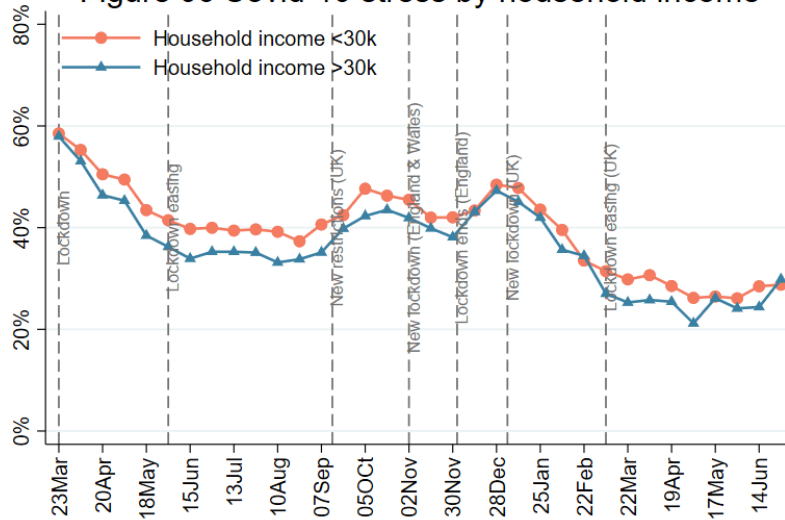


Figure 9d Covid-19 stress by mental health diagnosis

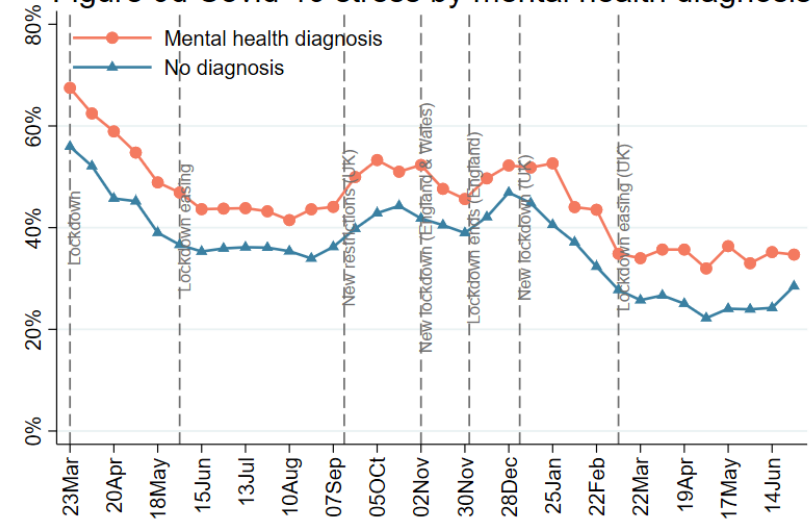


Figure 9e Covid-19 stress by nations

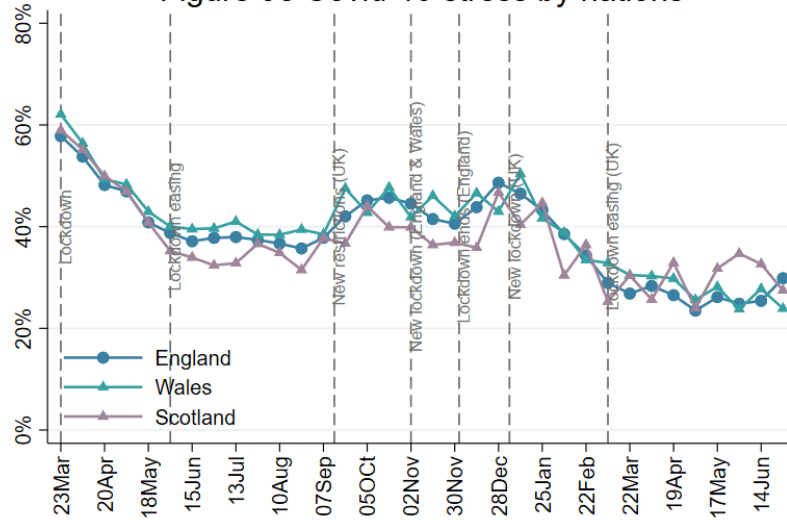


Figure 9f Covid-19 stress by keyworker status

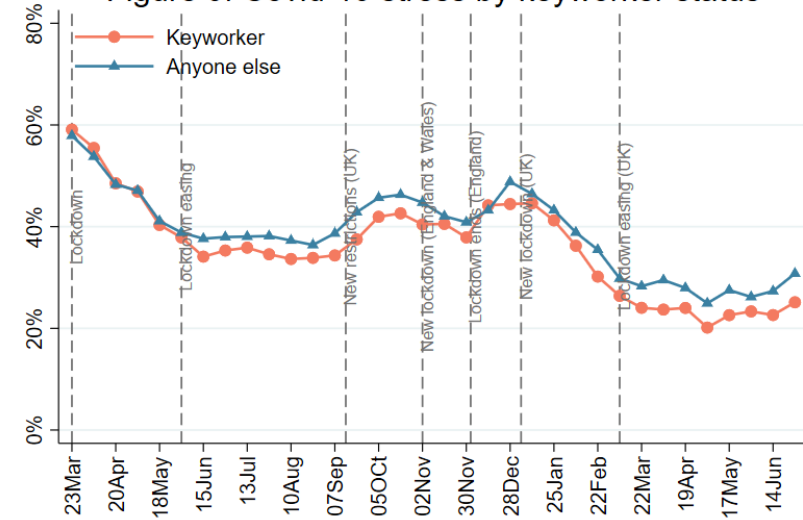


Figure 9g Covid-19 stress by living with children

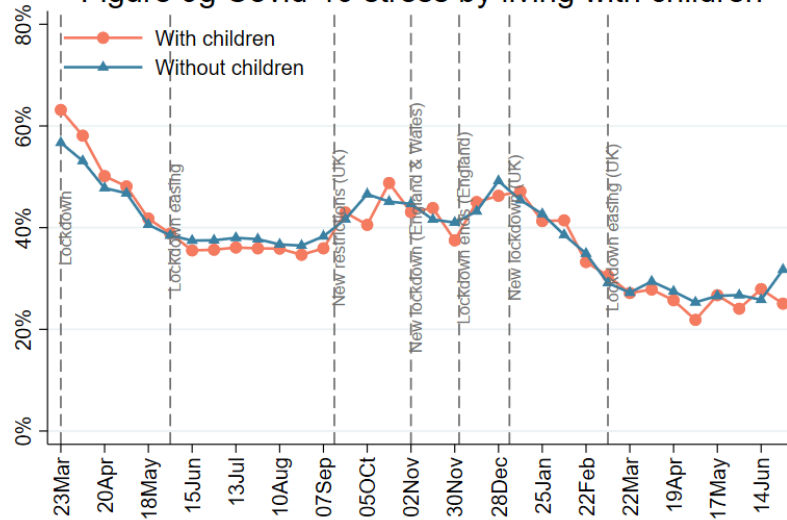


Figure 9h Covid-19 stress by living area

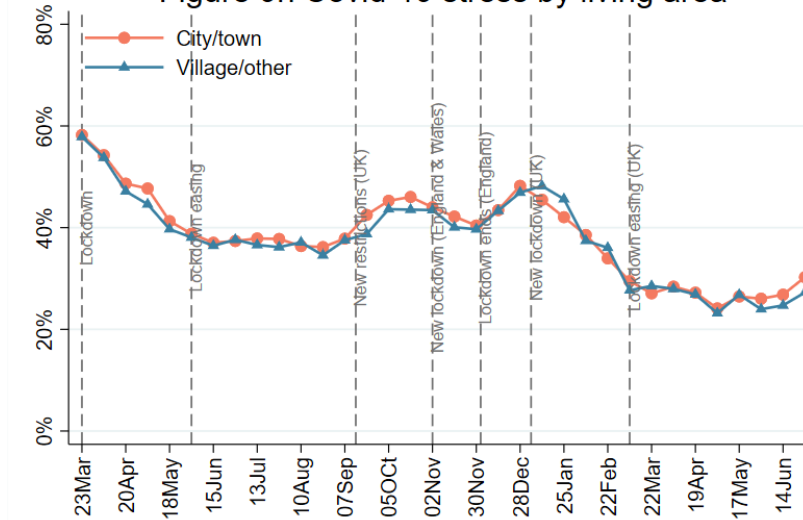


Figure 9i Covid-19 stress by gender

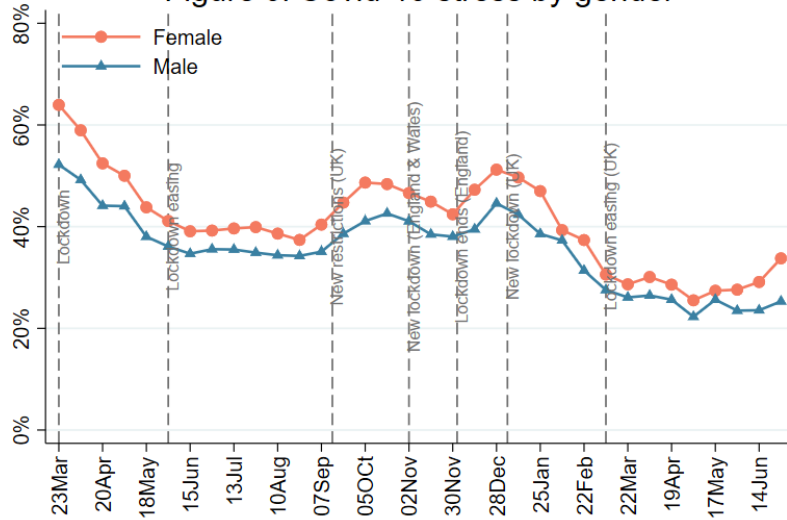


Figure 9j Covid-19 stress by ethnicity

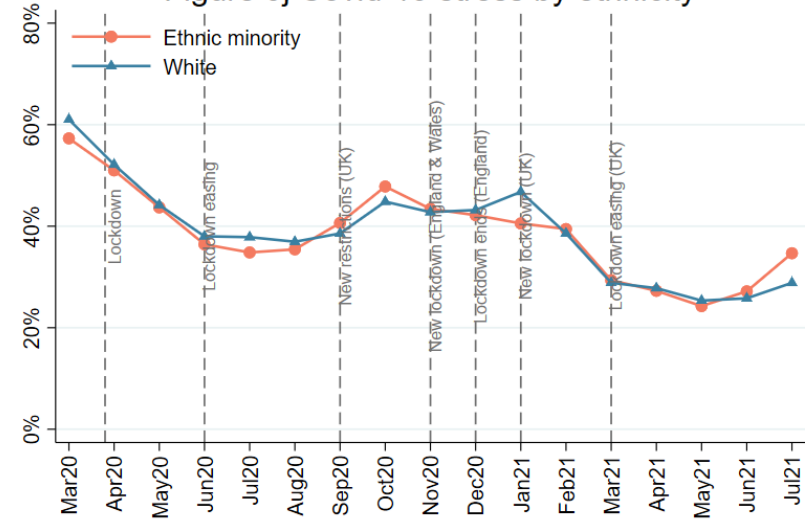


Figure 9k Covid-19 stress by educational levels

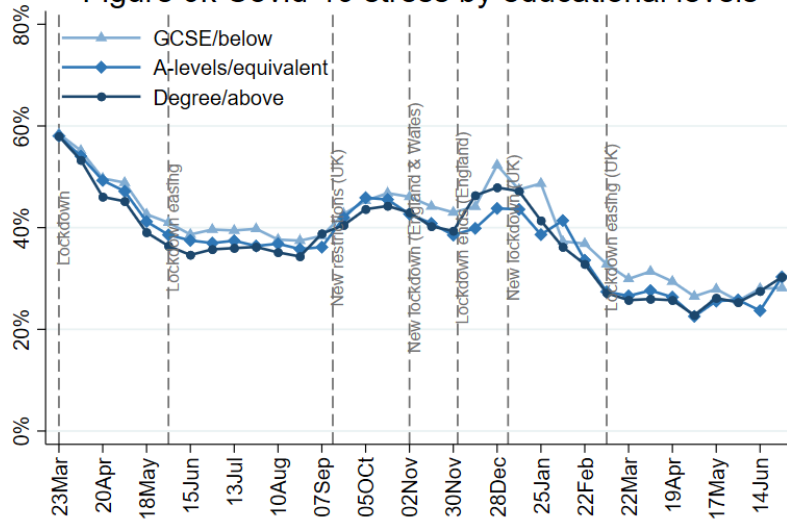


Figure 9l Covid-19 stress by physical health diagnosis

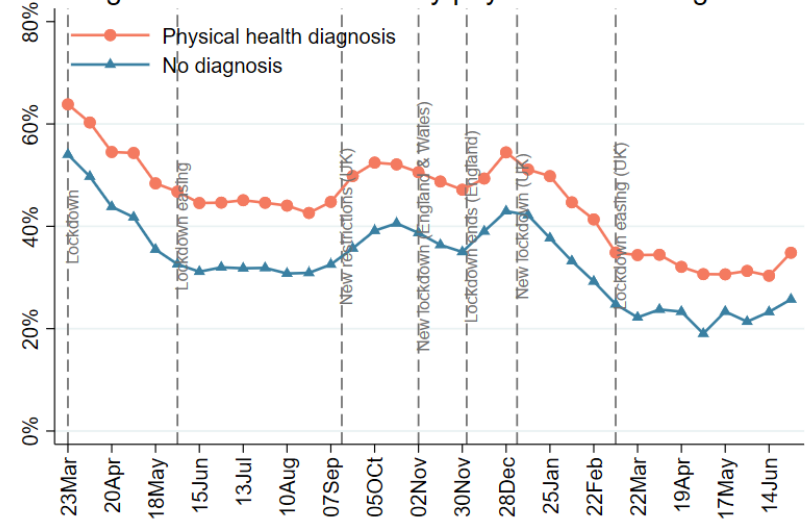


Figure 10a Unemployment stress by age groups

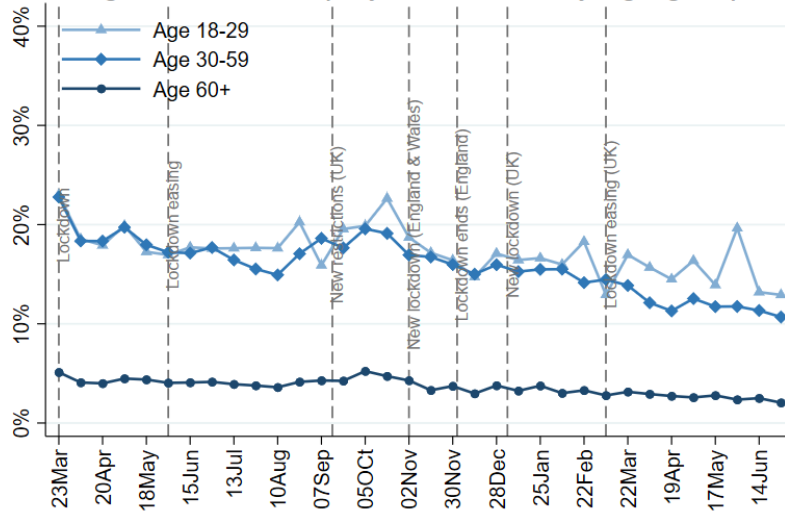


Figure 10b Unemployment stress by living arrangement

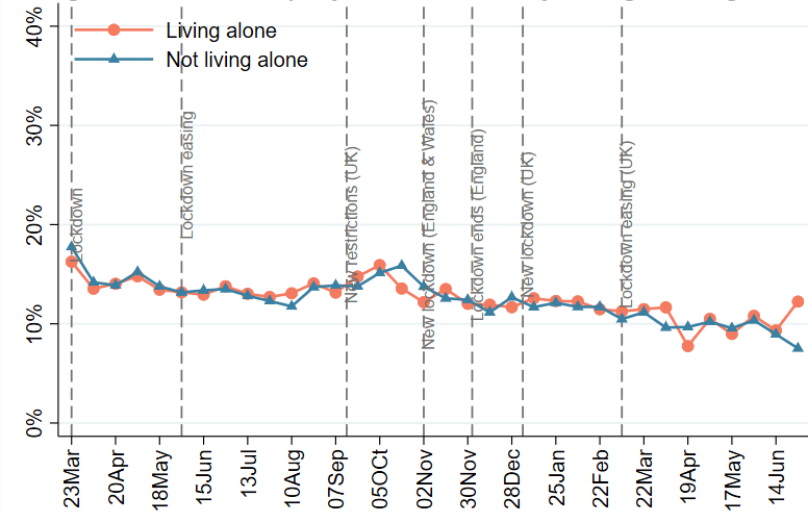


Figure 10c Unemployment stress by household income

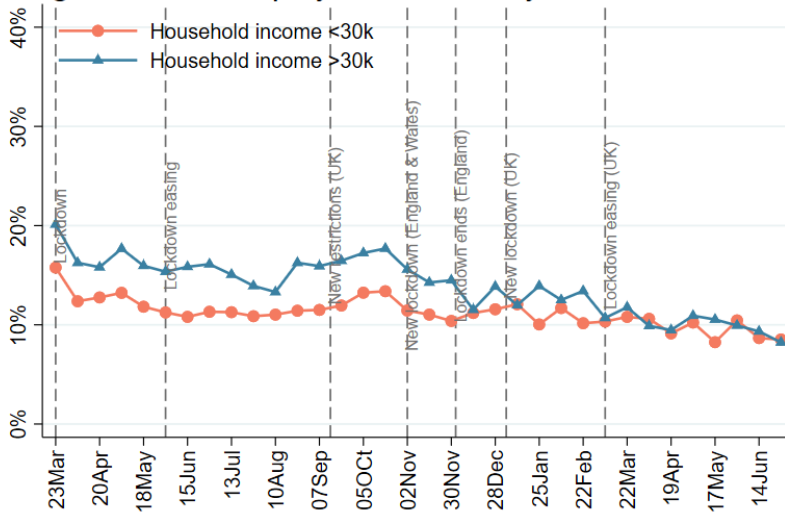


Figure 10d Unemployment stress by mental health

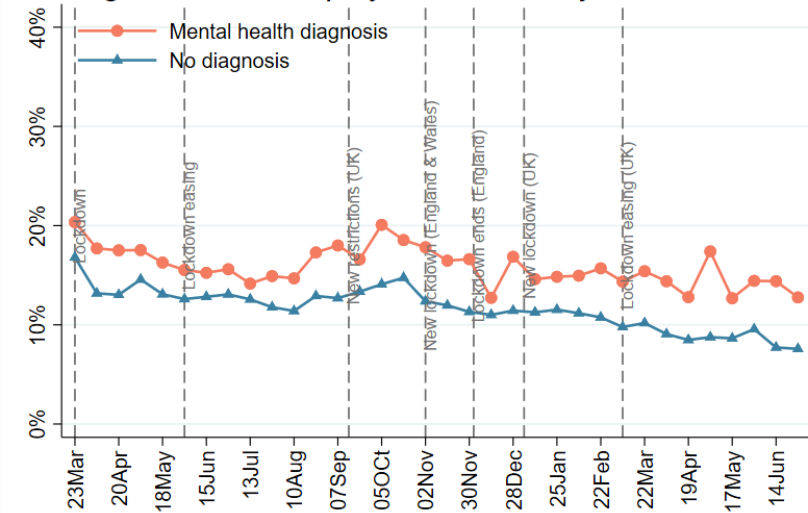


Figure 10e Unemployment stress by nations

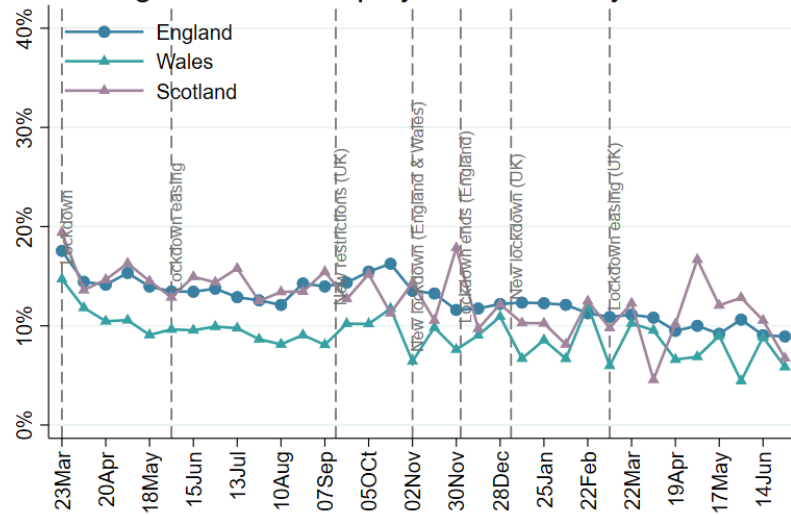


Figure 10f Unemployment stress by keyworker status

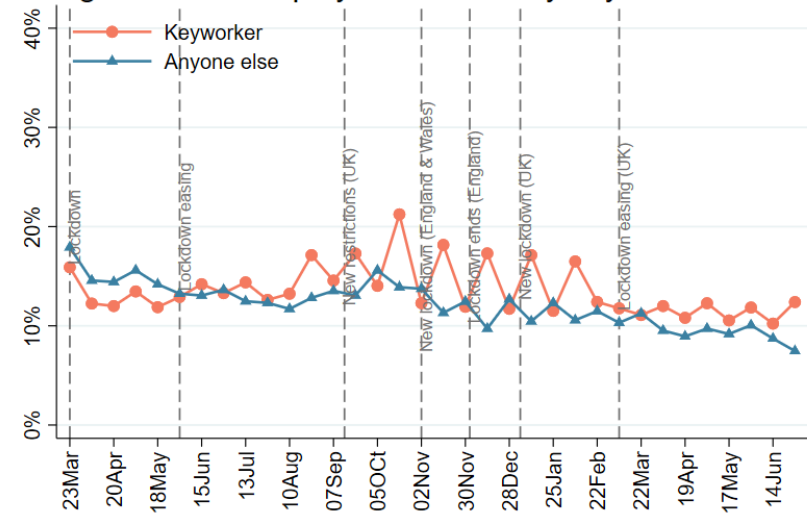


Figure 10g Unemployment stress by living with children

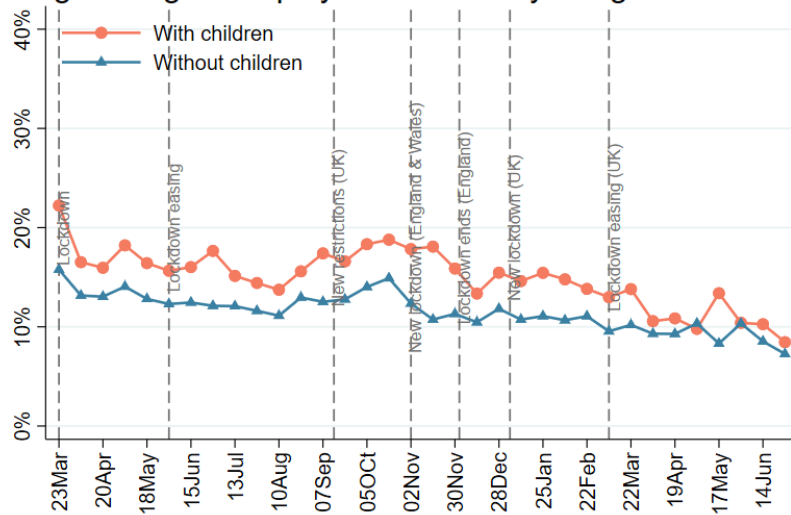


Figure 10h Unemployment stress by living area

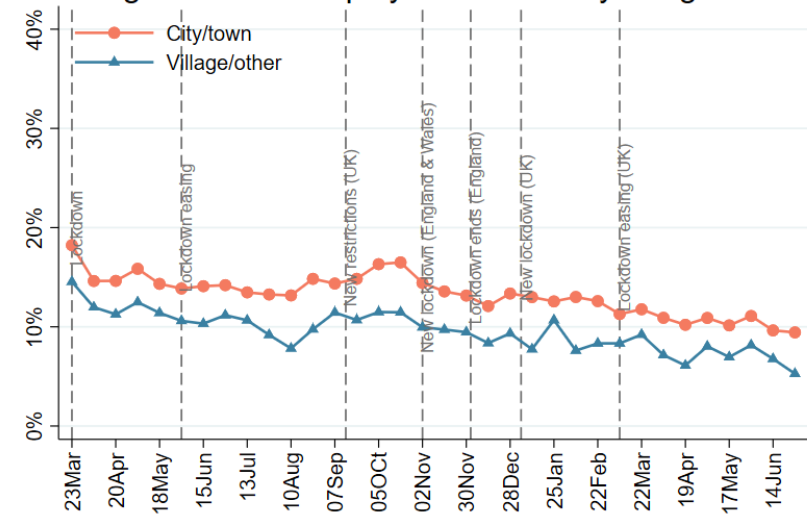


Figure 10i Unemployment stress by gender

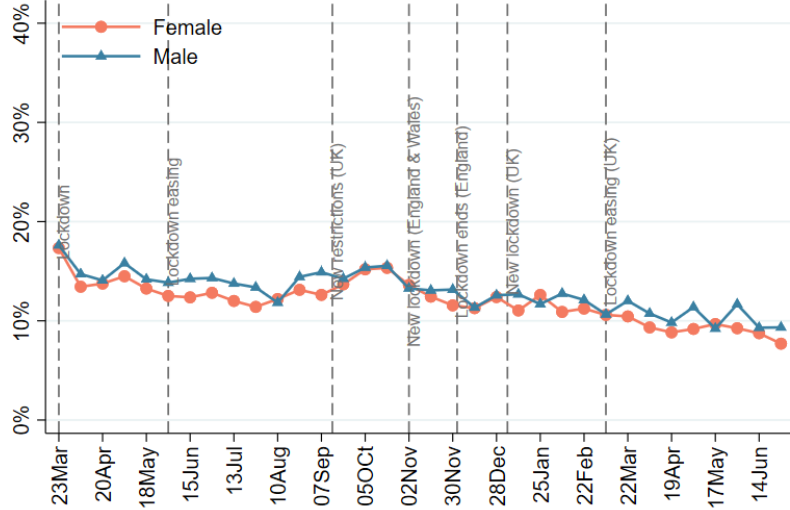


Figure 10j Unemployment stress by ethnicity

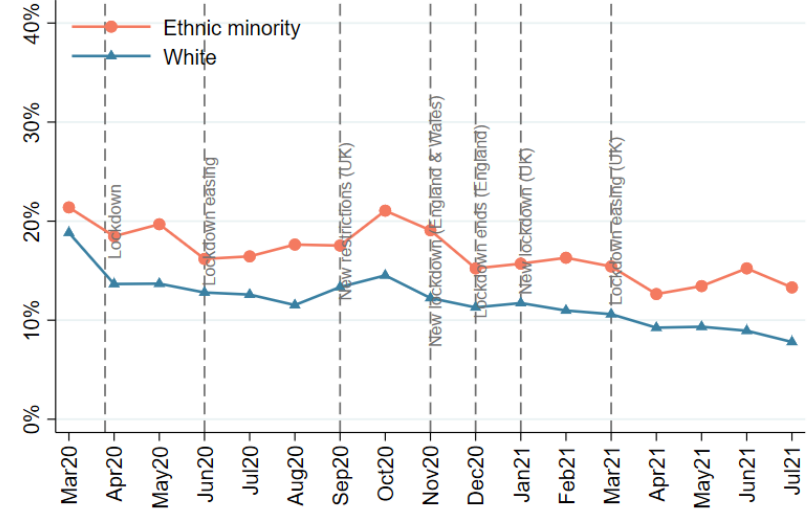


Figure 10k Unemployment stress by educational levels

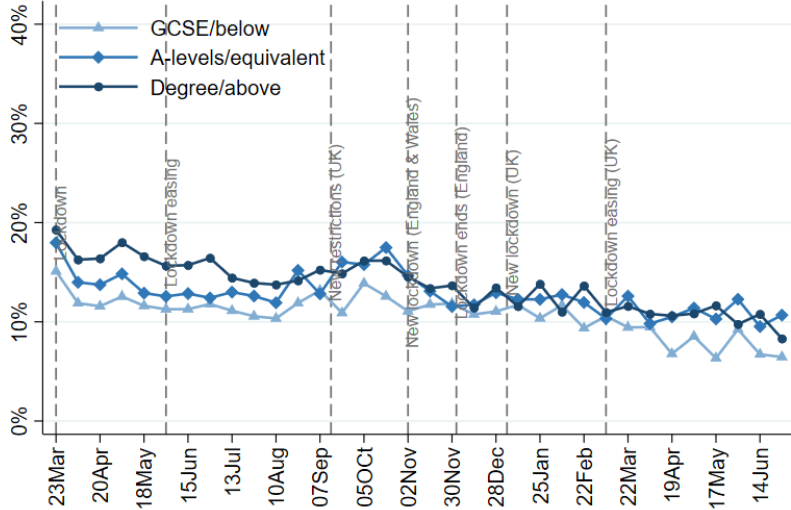


Figure 10l Unemployment stress by physical health diagnosis

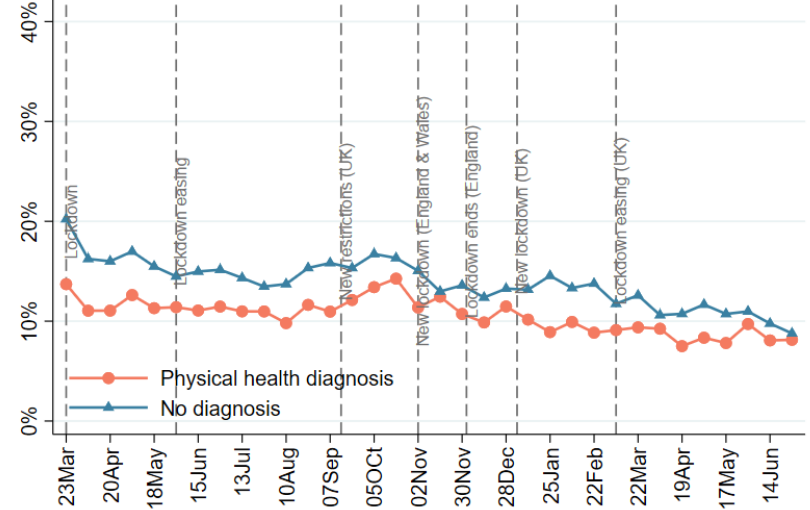


Figure 11a Financial stress by age groups

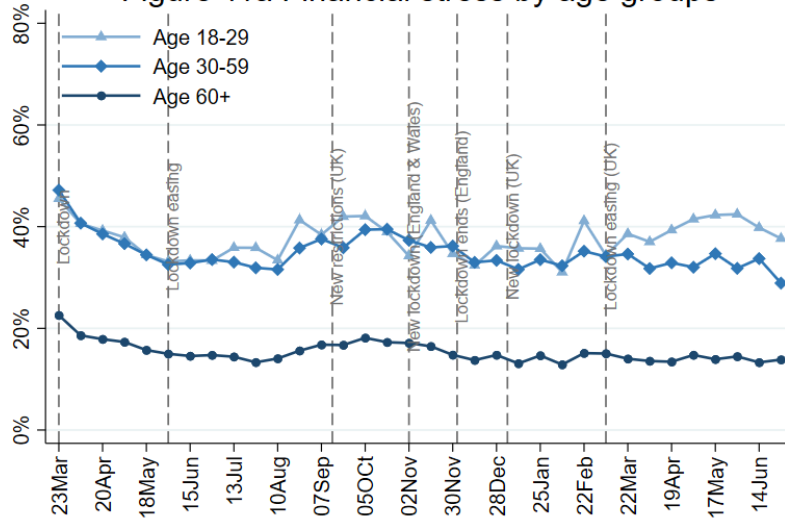


Figure 11b Financial stress by living arrangement

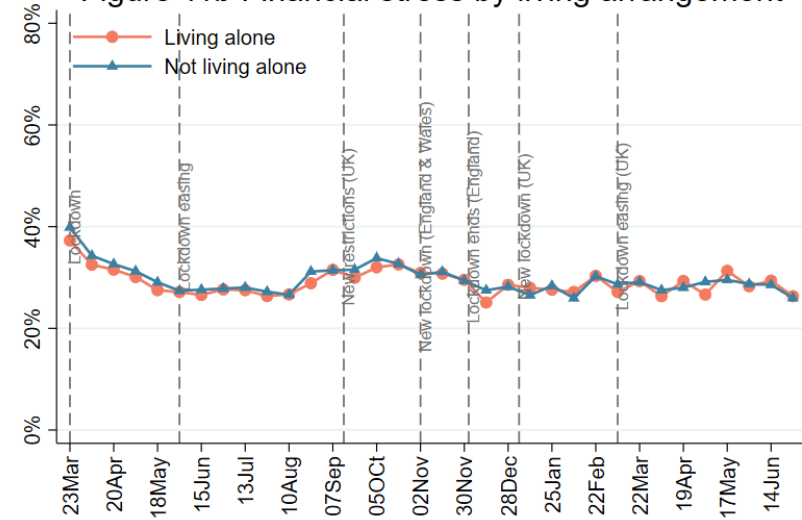


Figure 11c Financial stress by household income

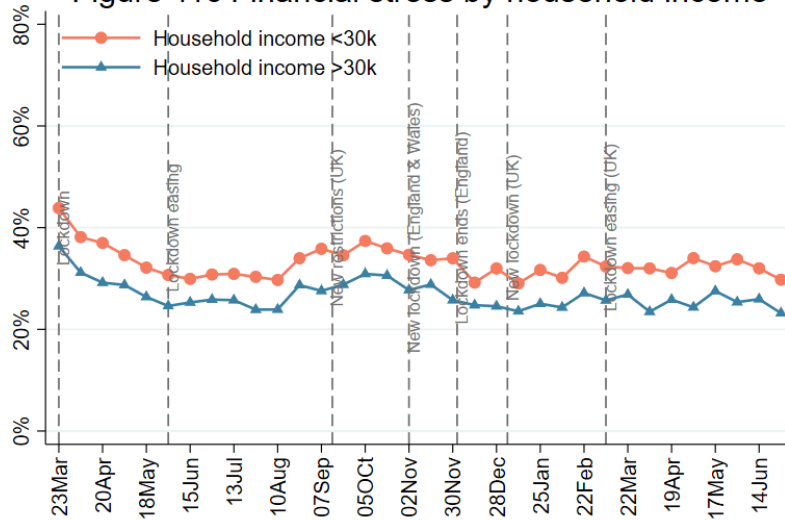


Figure 11d Financial stress by mental health diagnosis

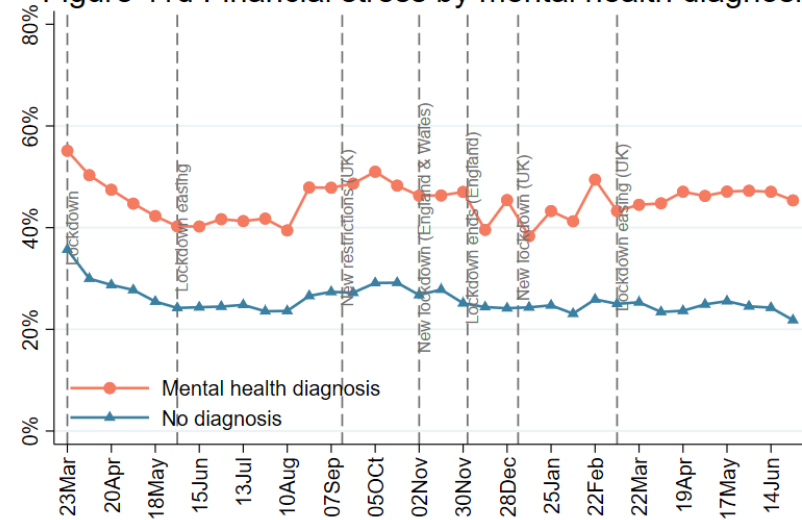


Figure 11e Financial stress by nations

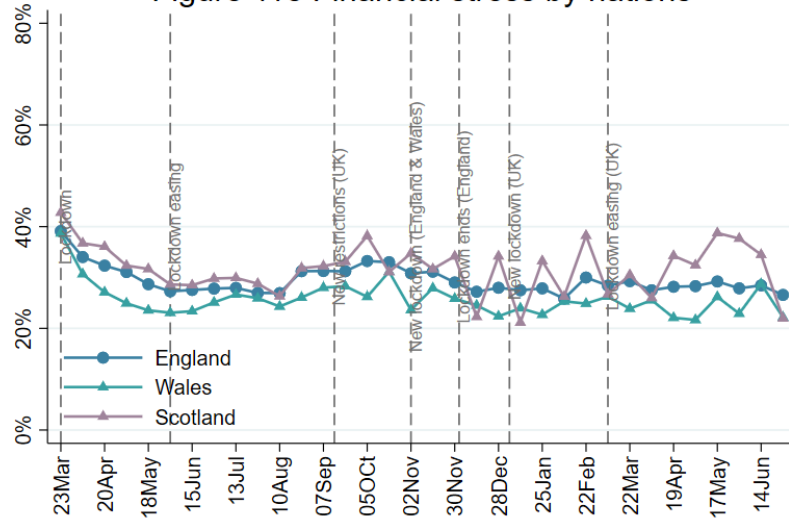


Figure 11f Financial stress by keyworker status

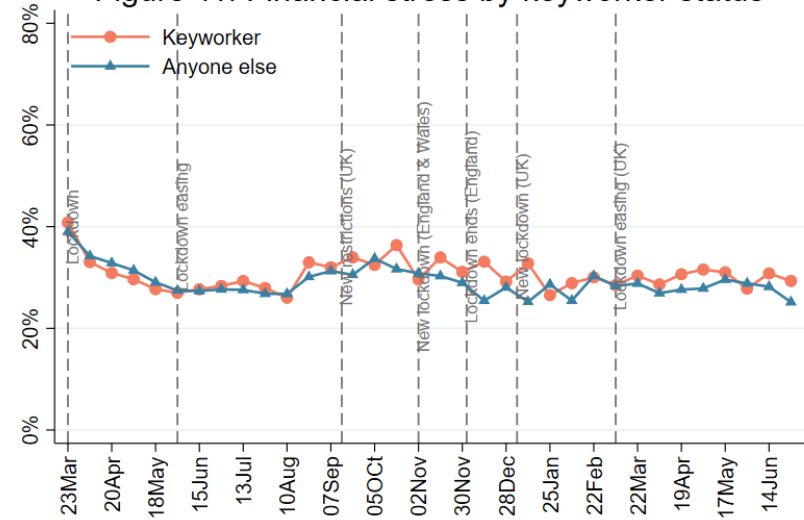


Figure 11g Financial stress by living with children

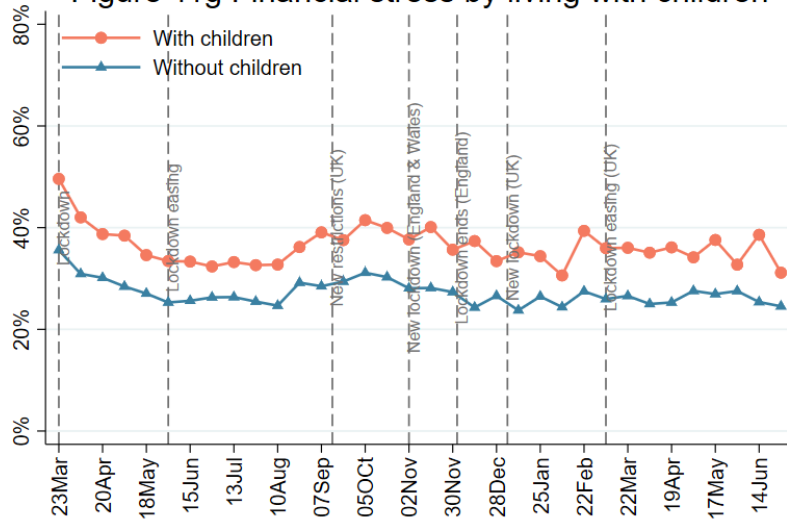


Figure 11h Financial stress by living area

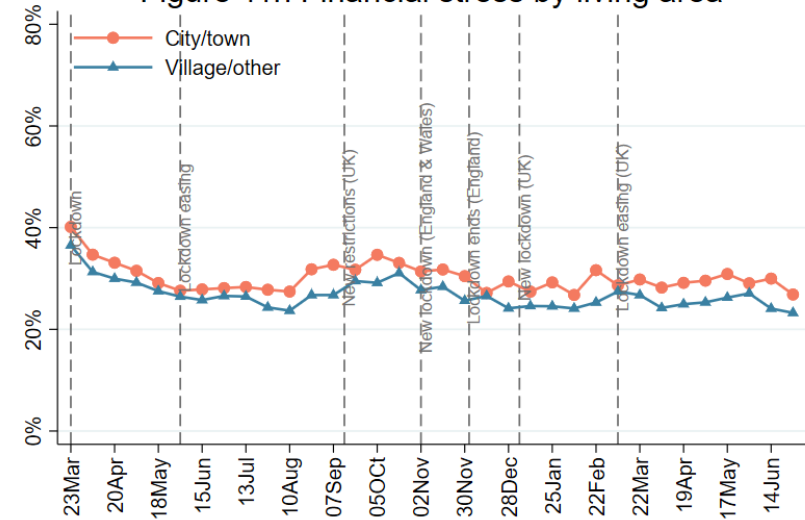


Figure 11i Financial stress by gender

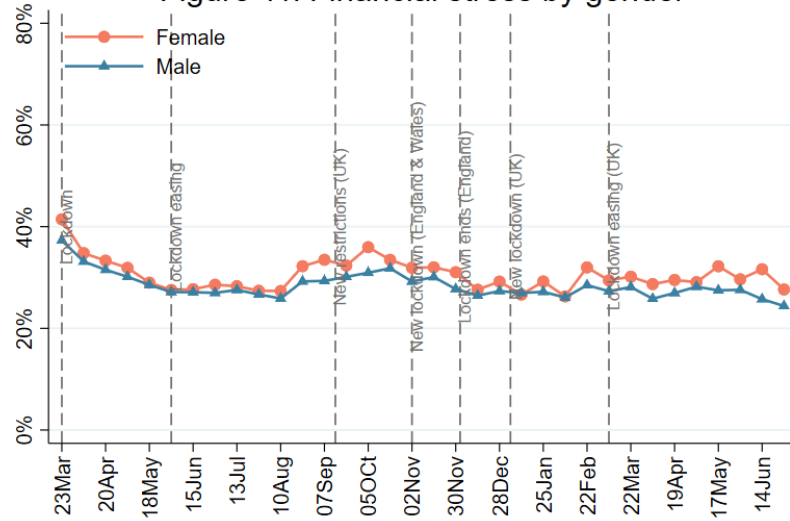


Figure 11j Financial stress by ethnicity

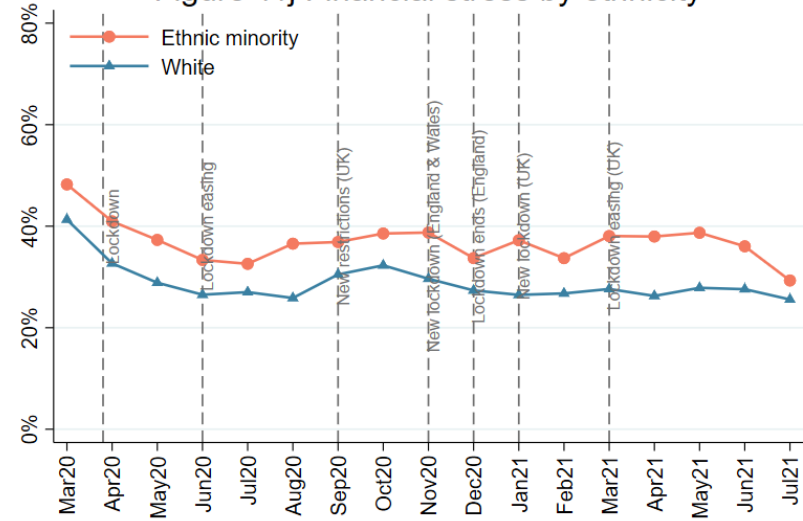


Figure 11k Financial stress by educational levels

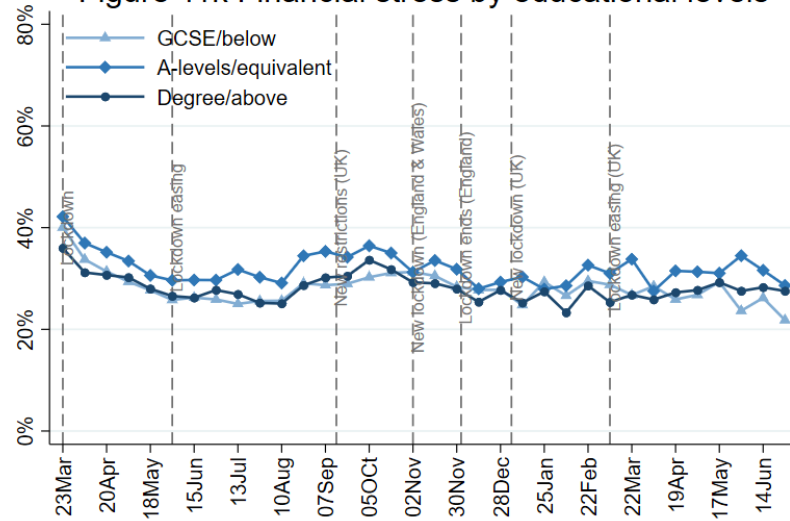


Figure 11l Financial stress by physical health diagnosis

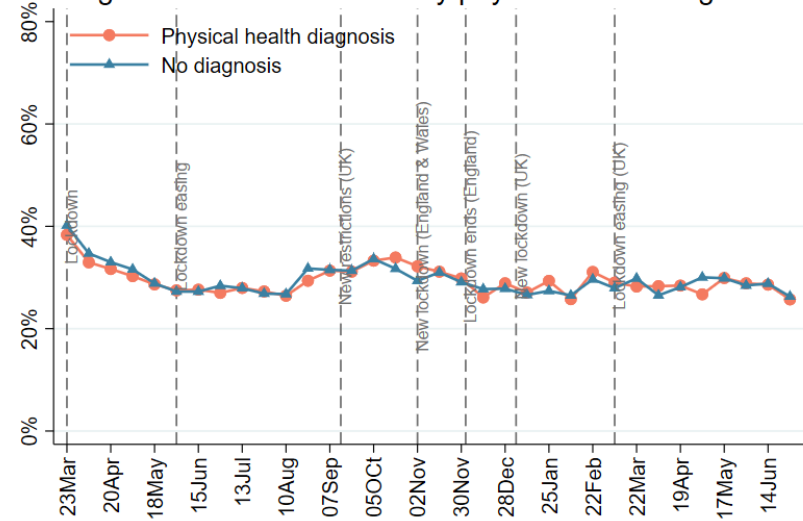


Figure 12a Food security stress by age groups

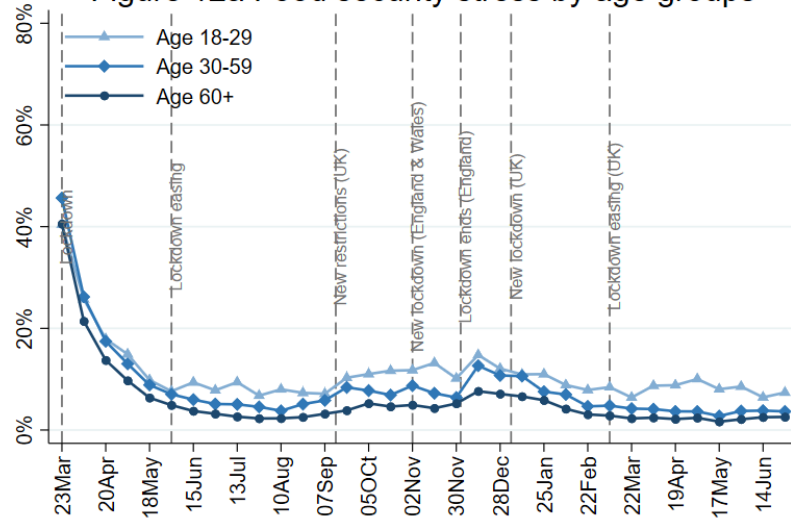


Figure 12b Food security stress by living arrangement

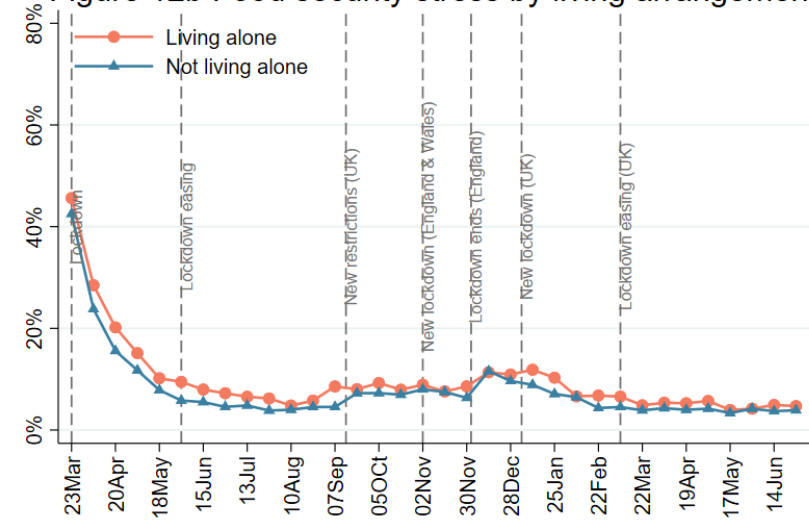


Figure 12c Food security stress by household income

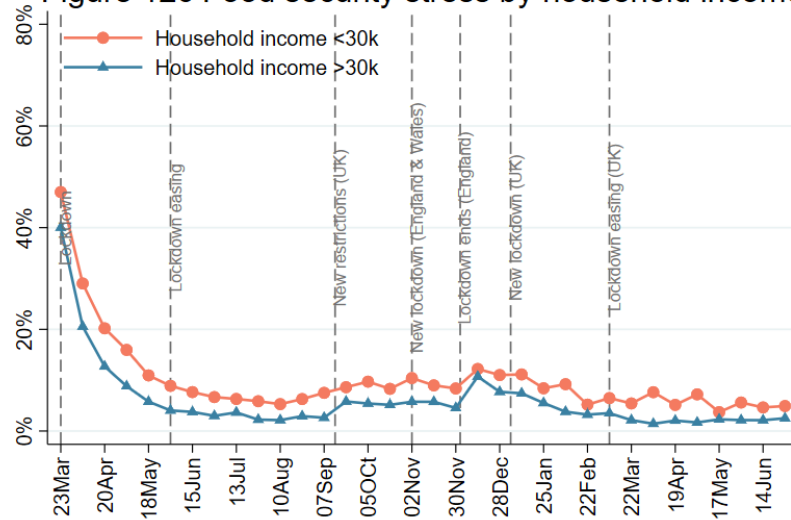


Figure 12d Food security stress by mental health

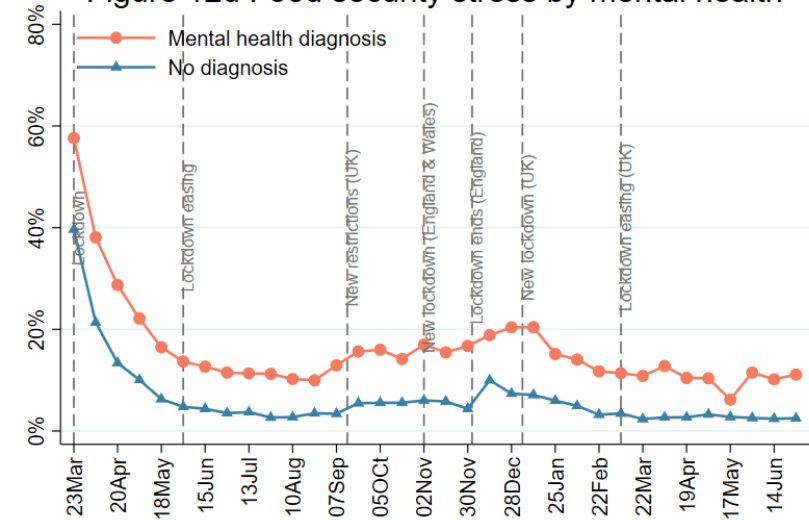


Figure 12e Food security stress by nations

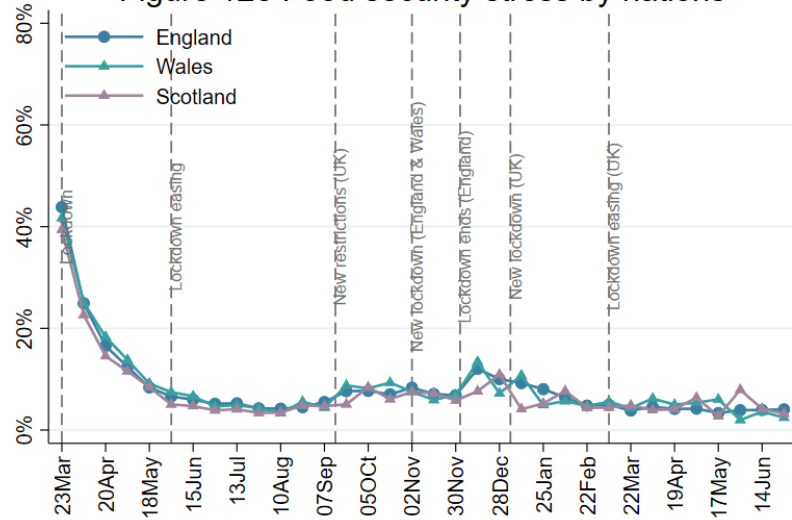


Figure 12f Food security stress by keyworker status

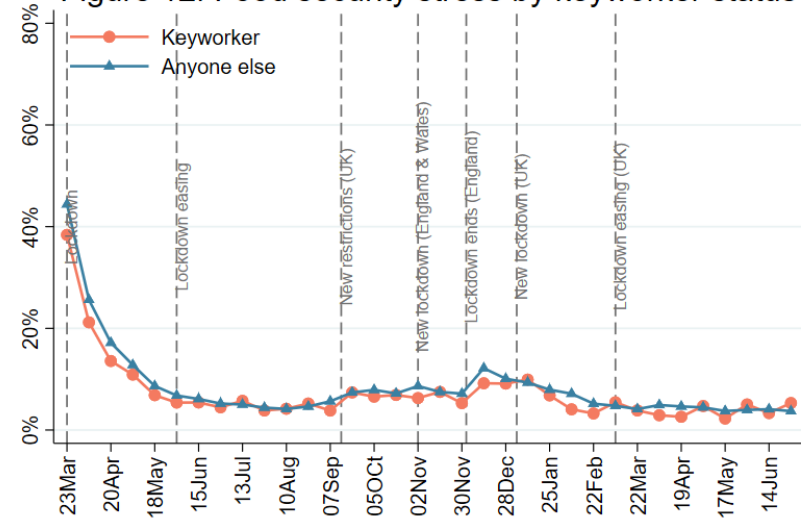


Figure 12g Food security stress by living with children

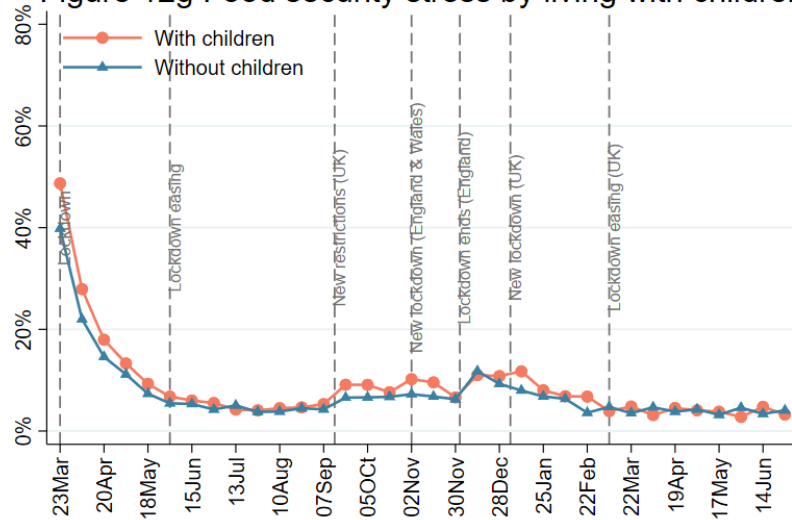


Figure 12h Food security stress by living area

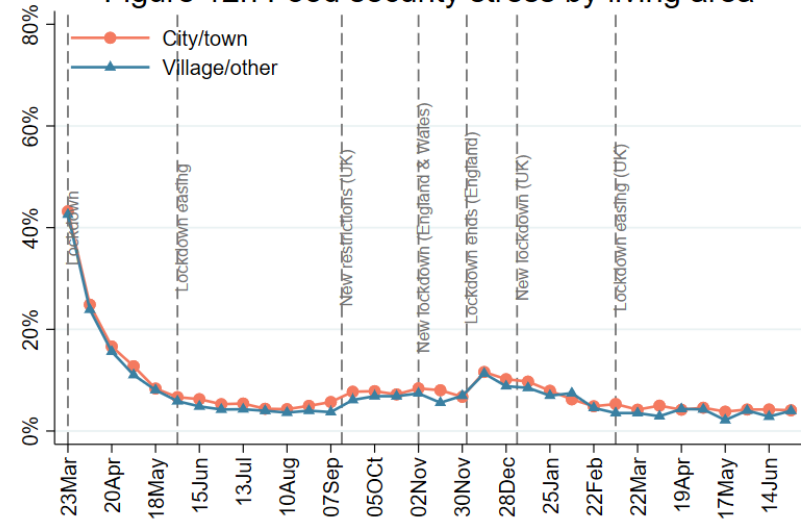


Figure 12i Food security stress by gender

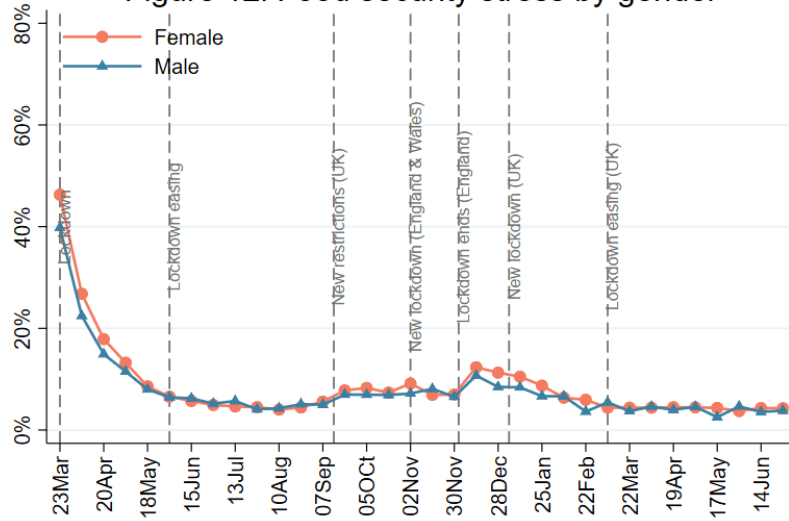


Figure 12j Food security stress by ethnicity

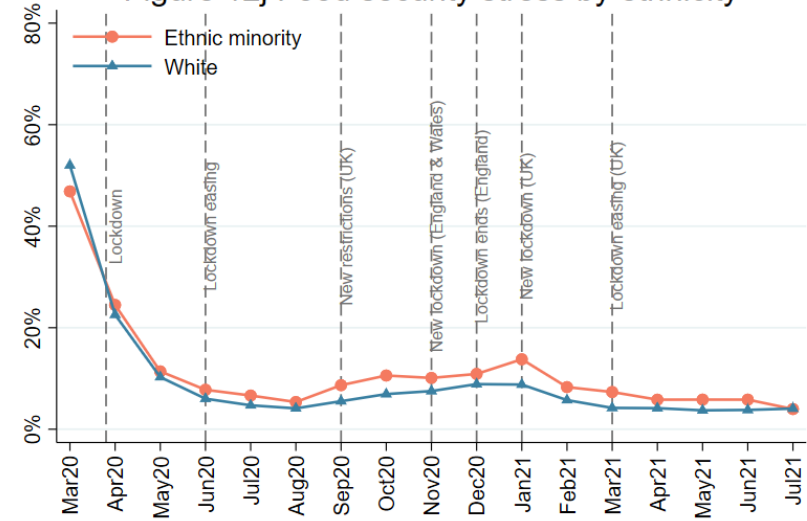


Figure 12k Food security stress by educational levels

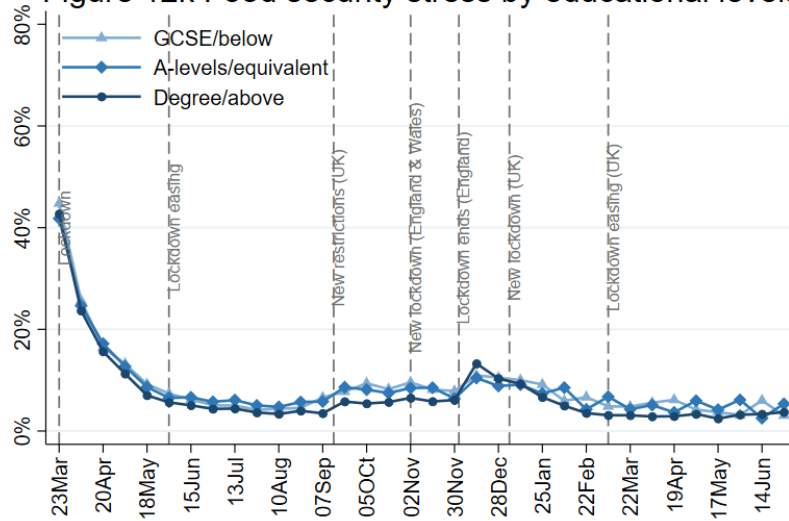
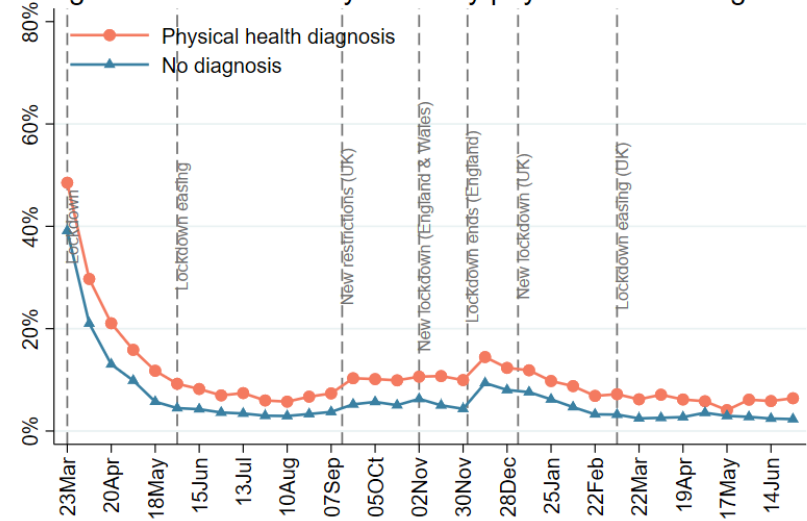
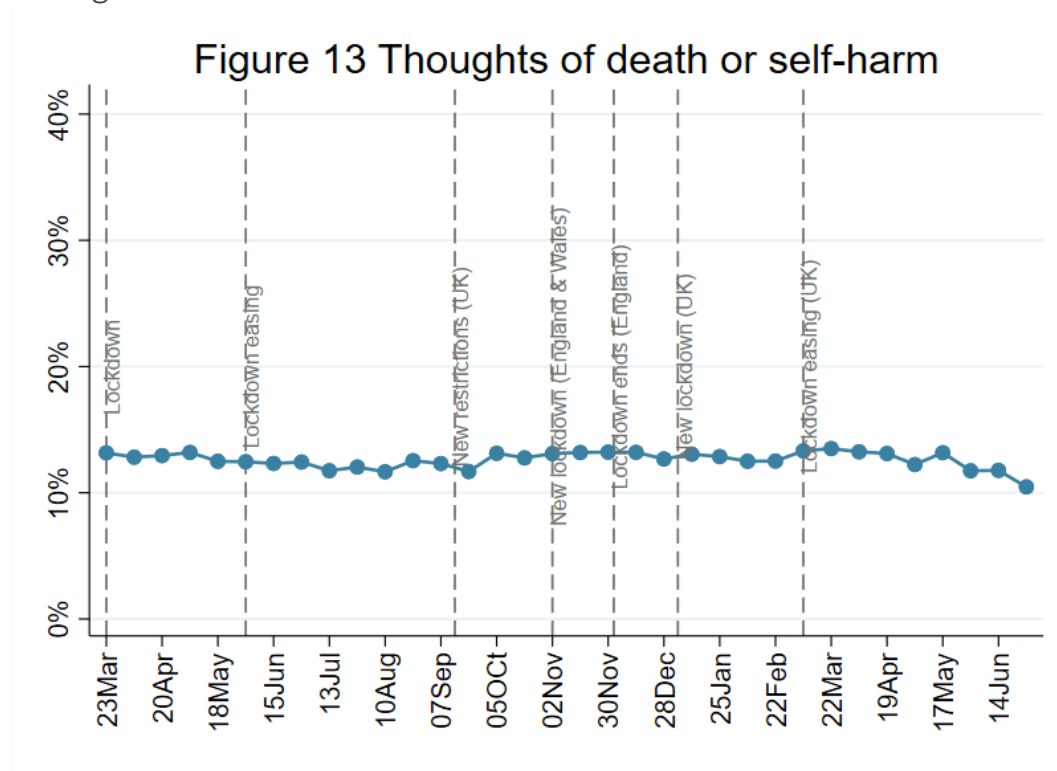


Figure 12l Food security stress by physical health diagnosis



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, the respondent 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.

The proportion of people reporting thoughts of death or self-harm was relatively stable throughout the pandemic but appears to have been decreasing slightly over the past two months. More data will be needed to confirm this trend.

People with a diagnosed mental health condition, people with a physical health diagnosis, people living alone, those with lower incomes, and in urban areas continue to report thoughts of death or self-harm in greater proportions. They have decreased noticeably in young adults over the past two months but remain higher than in adults over the age of 30.

Figure 14a Thoughts of death by age groups

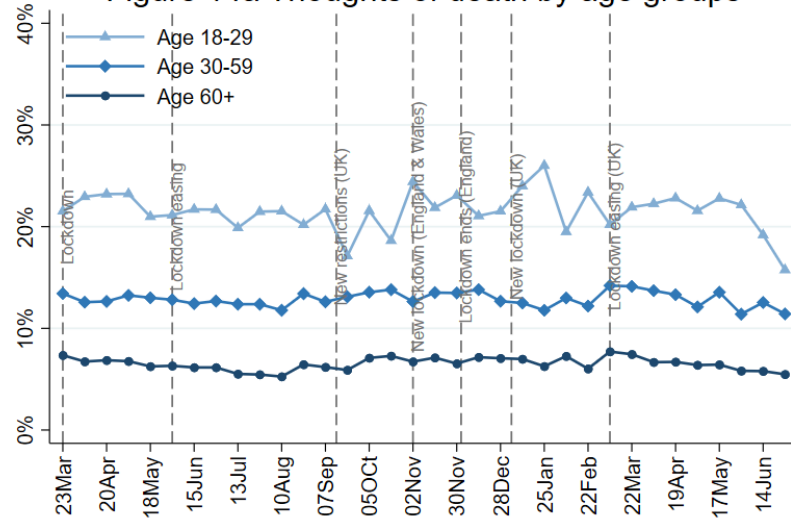


Figure 14b Thoughts of death by living arrangement

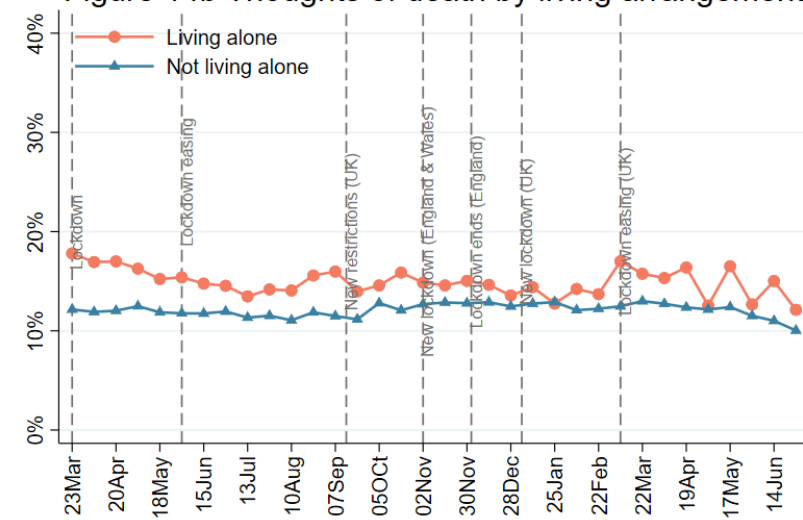


Figure 14c Thoughts of death by household income

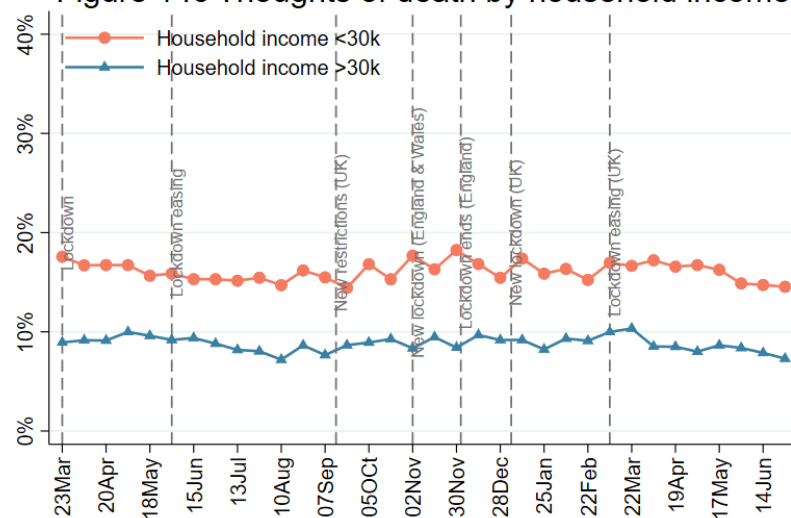


Figure 14d Thoughts of death by mental health diagnosis

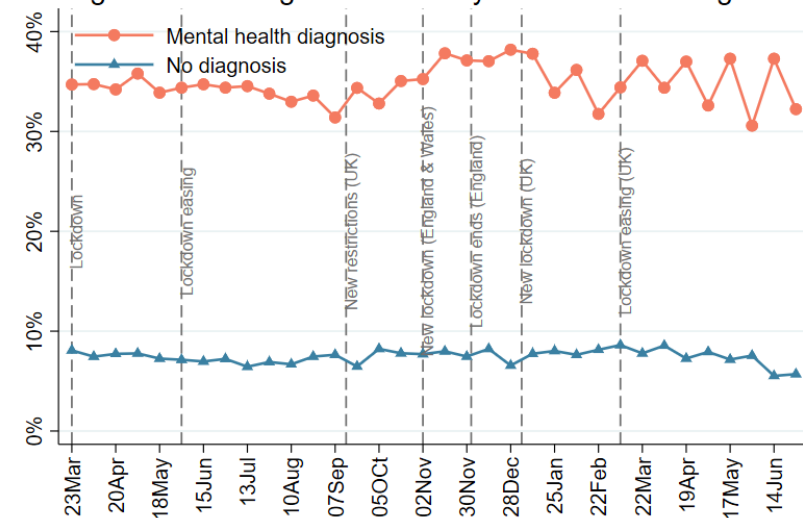


Figure 14e Thoughts of death by nations

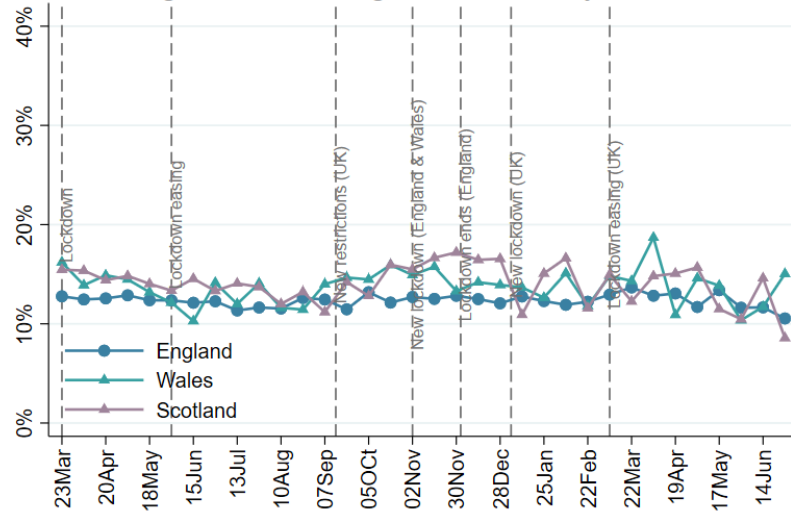


Figure 14f Thoughts of death by keyworker status

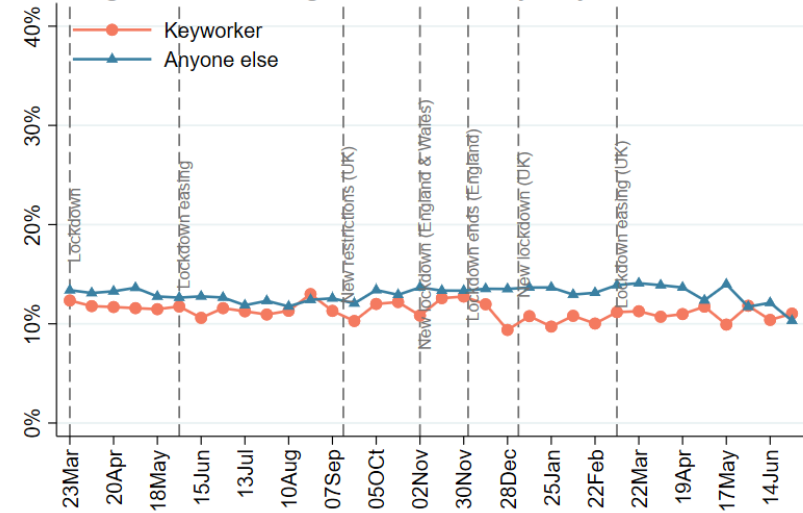


Figure 14g Thoughts of death by living with children

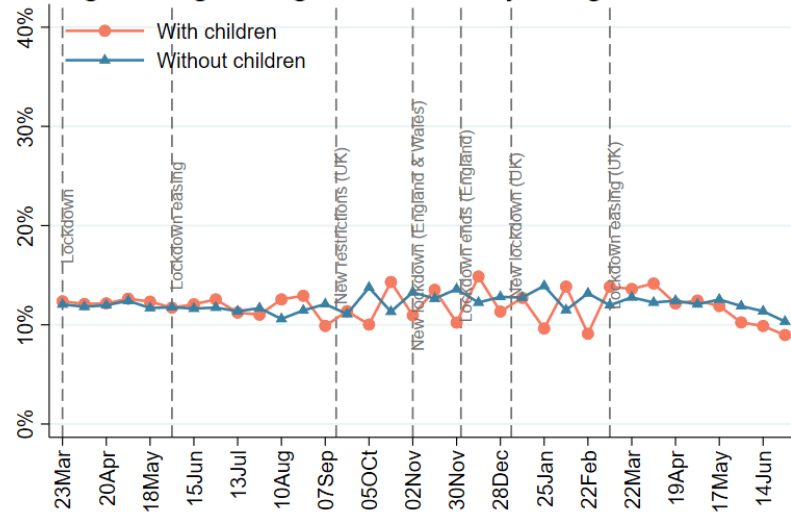


Figure 14h Thoughts of death by living area

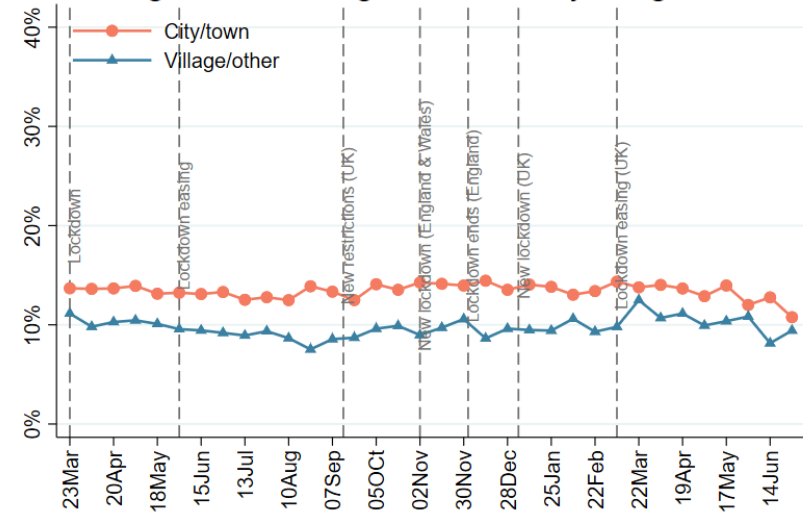


Figure 14i Thoughts of death by gender

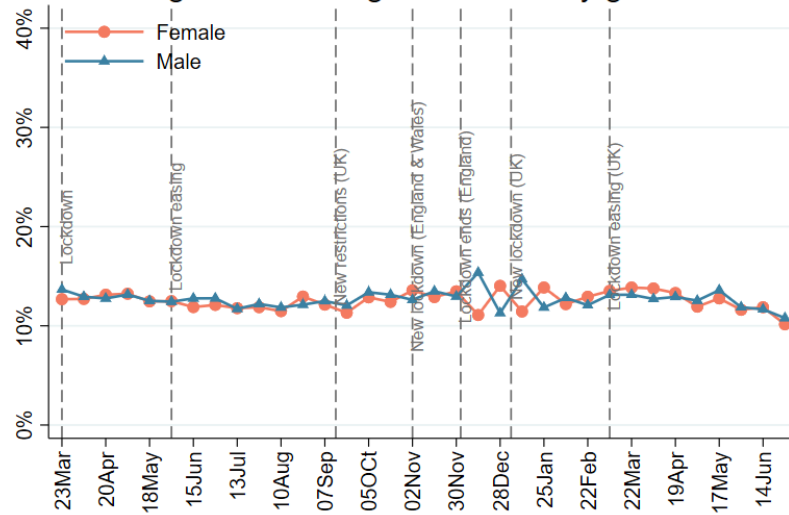


Figure 14j Thoughts of death by ethnicity

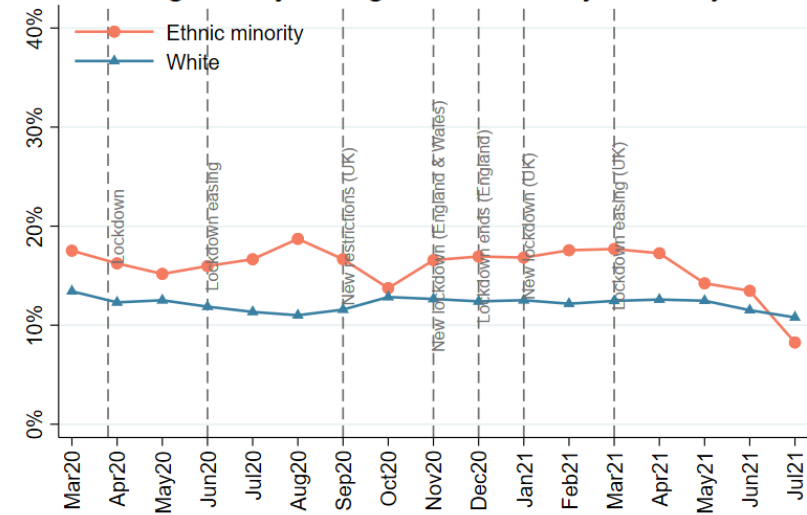


Figure 14k Thoughts of death by educational levels

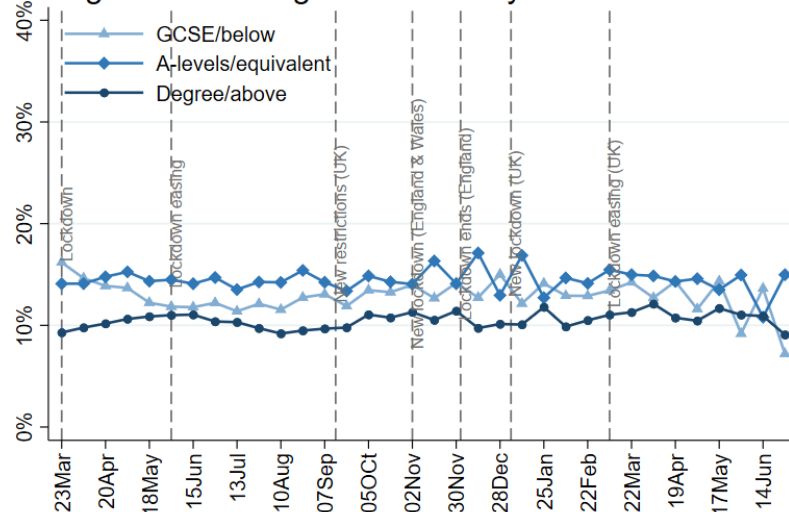
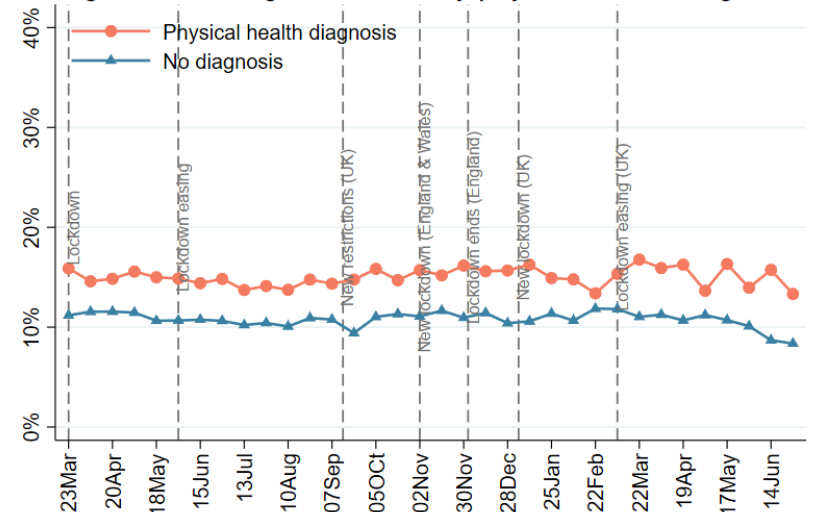
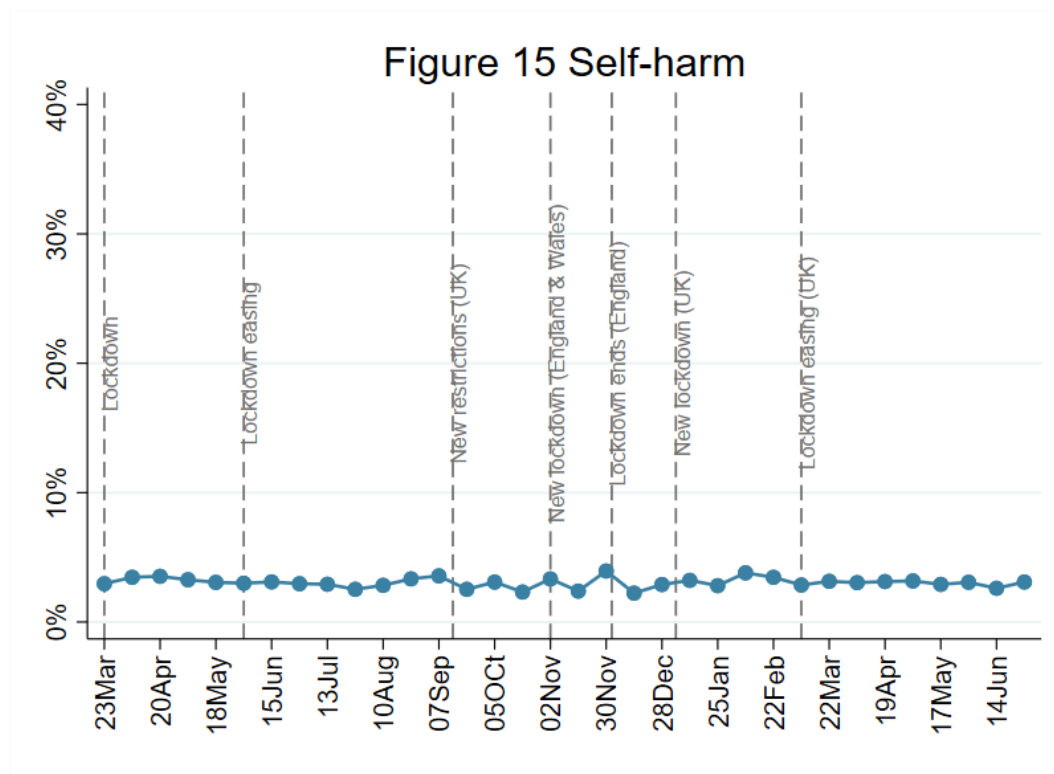


Figure 14l Thoughts of death by physical health diagnosis



3.2 Self-harm



FINDINGS

Self-harm was assessed using a question that asks whether in the last week the respondent 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.

Self-harm continues to remain relatively stable over the course of the pandemic. Throughout most of the pandemic, self-harm has been higher amongst younger adults, people with lower household incomes, those with a mental health condition, and in those with a physical health condition.

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 levels⁴.

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

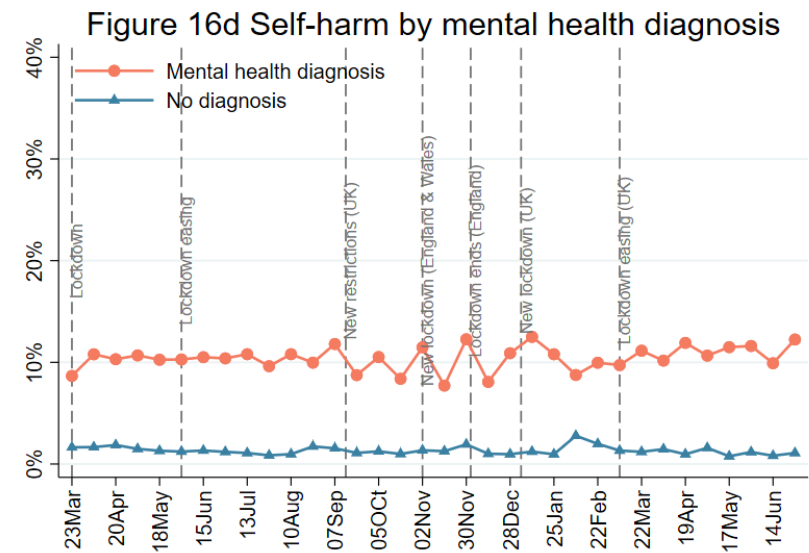
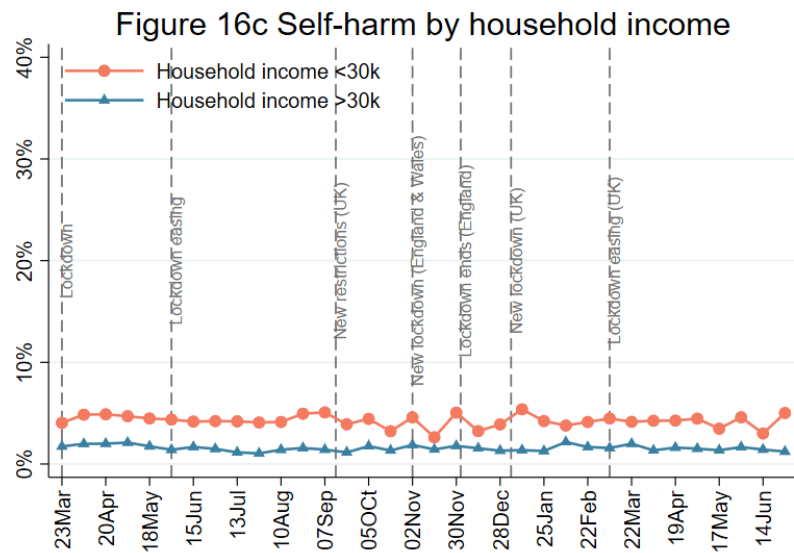
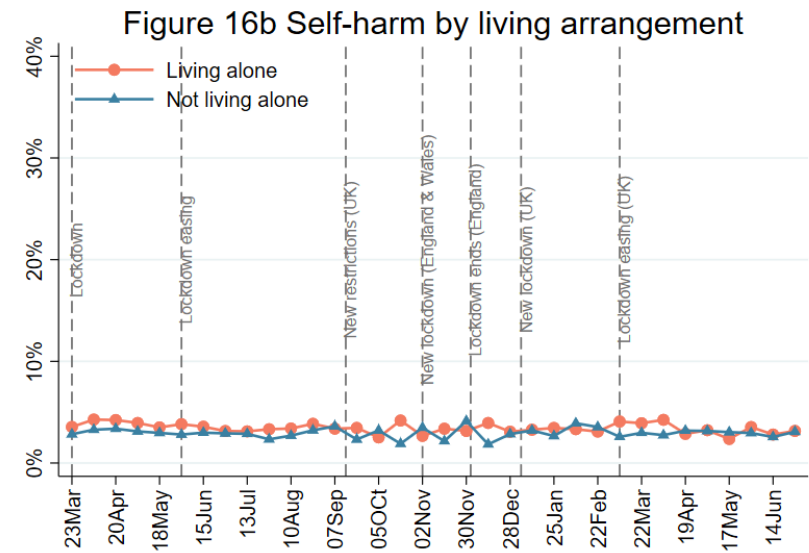
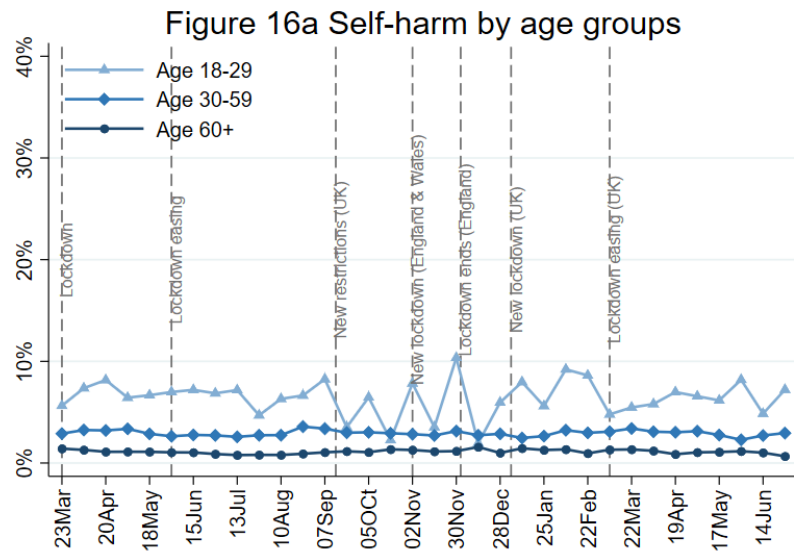


Figure 16e Self-harm by nations

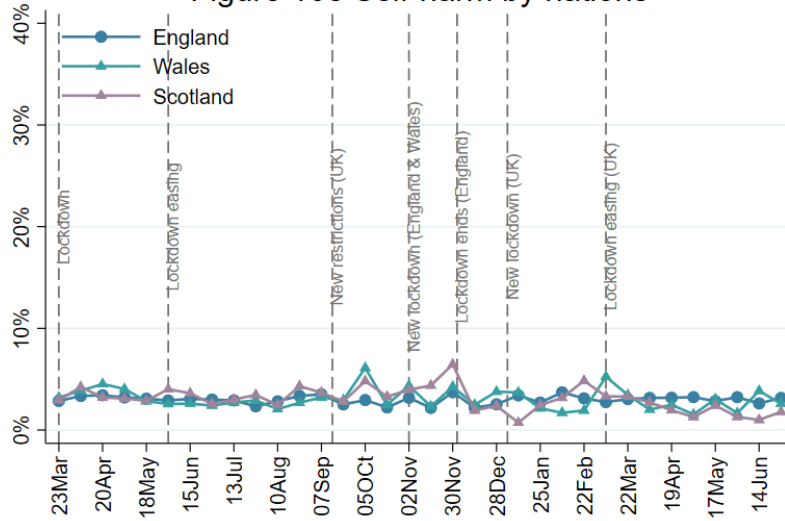


Figure 16f Self-harm by keyworker status

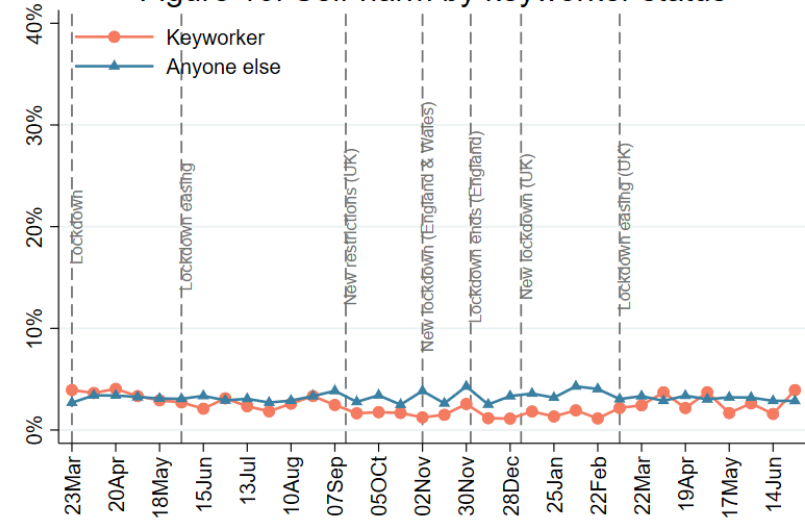


Figure 16g Self-harm by living with children

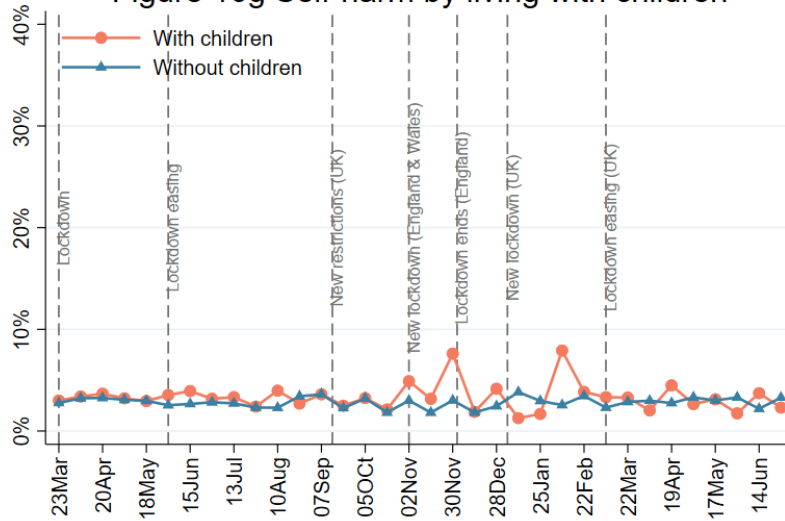


Figure 16h Self-harm by living area

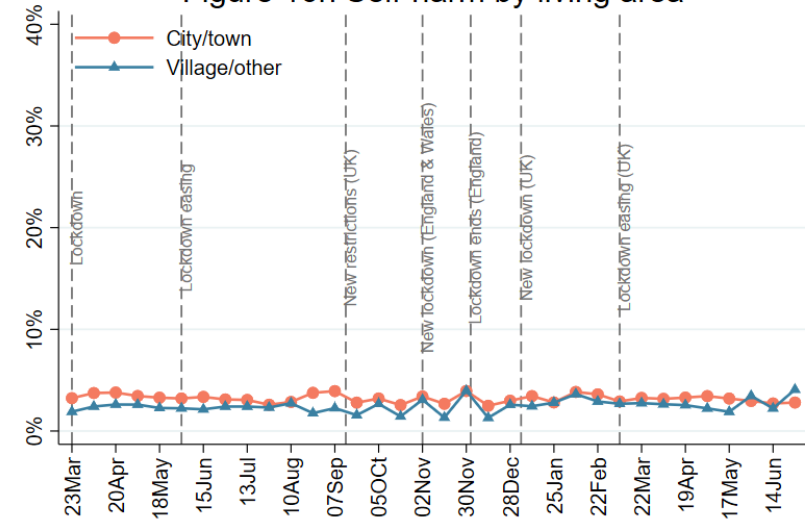


Figure 16i Self-harm by gender

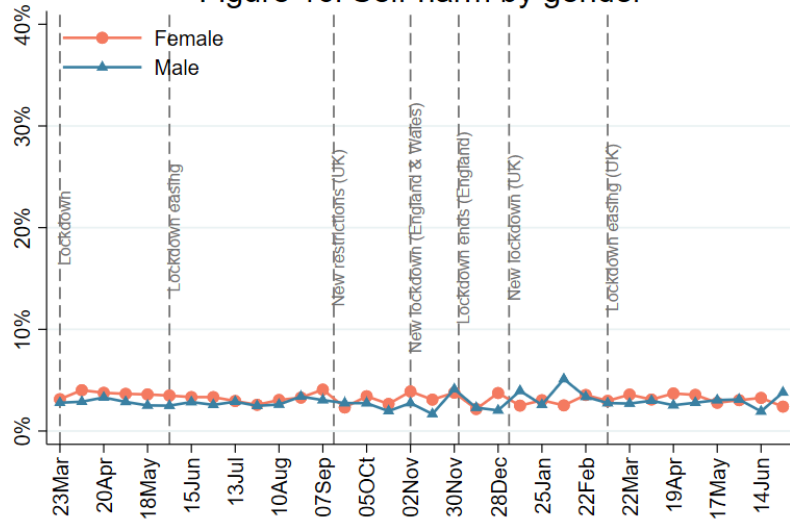


Figure 16j Self-harm by ethnicity

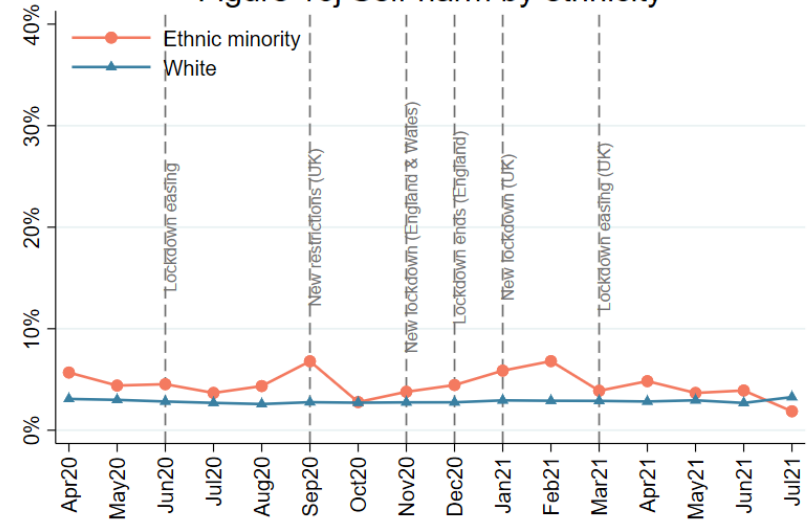


Figure 16k Self-harm by educational levels

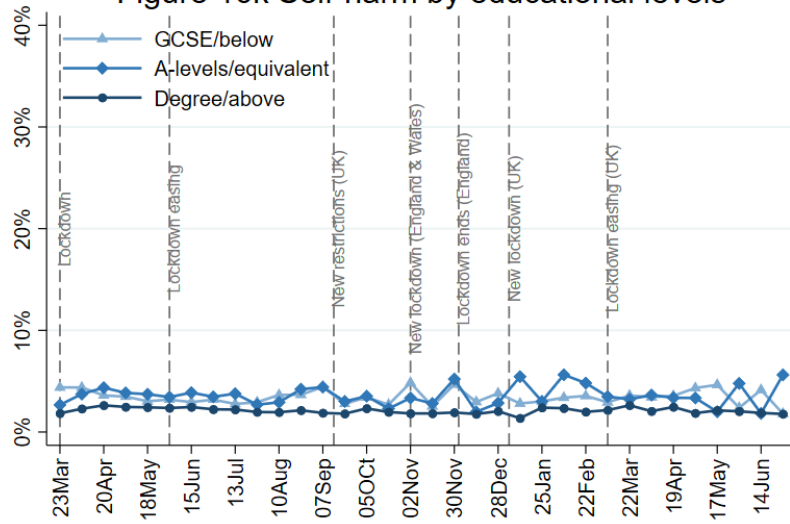
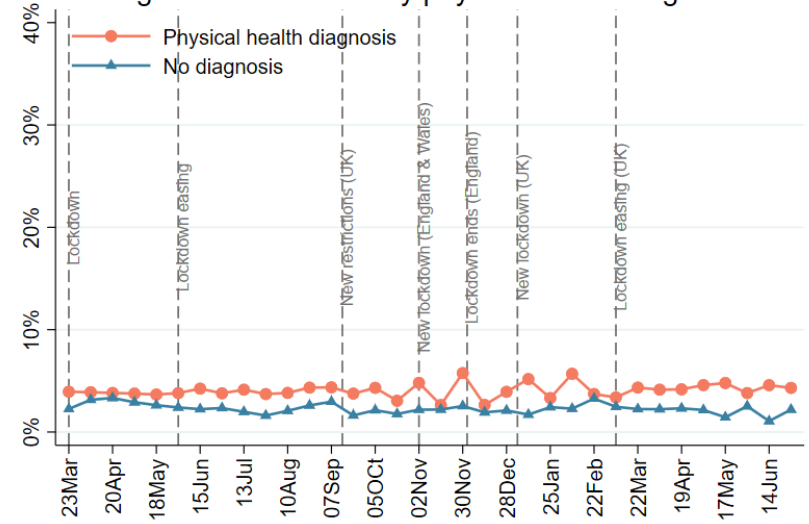
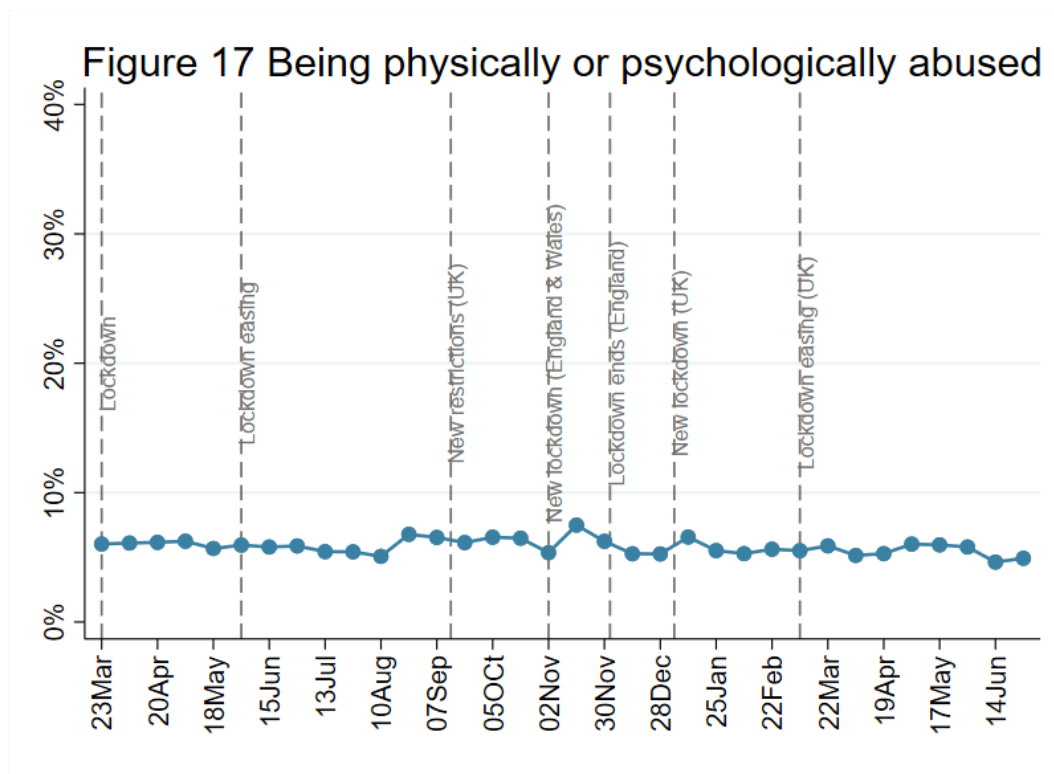


Figure 16l Self-harm by physical health diagnosis



3.3 Abuse



FINDINGS

Abuse was measured using two questions that ask if the respondent 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 psychological or physical abuse.

Reports of abuse have continued to remain relatively stable over the course of the pandemic. They are more common amongst people with a diagnosed mental health condition, amongst people with lower household income, and in those with a physical health condition.

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 levels⁵.

⁵ 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

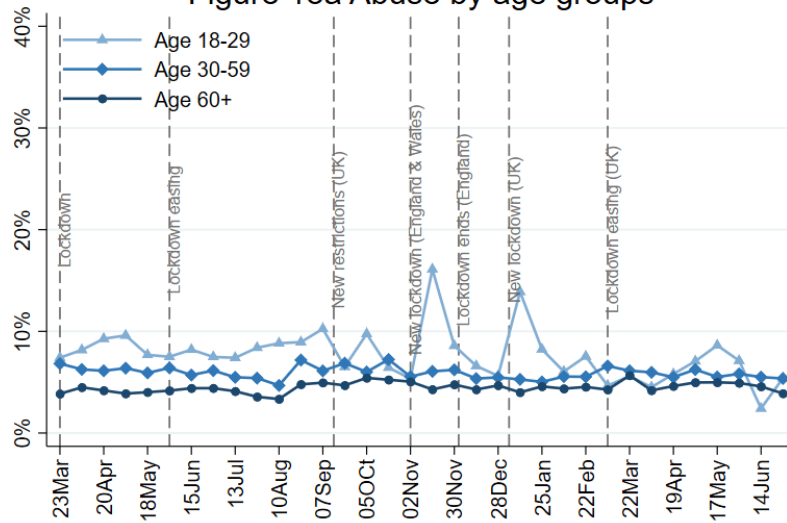


Figure 18b Abuse by living arrangement

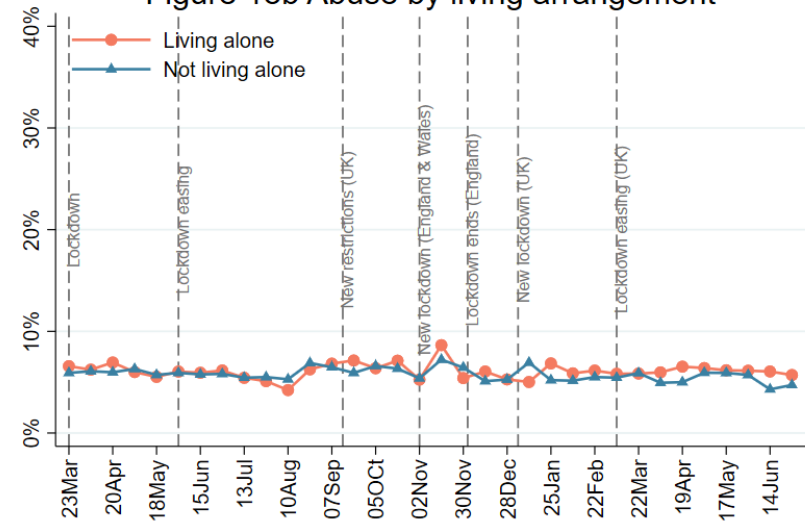


Figure 18c Abuse by household income

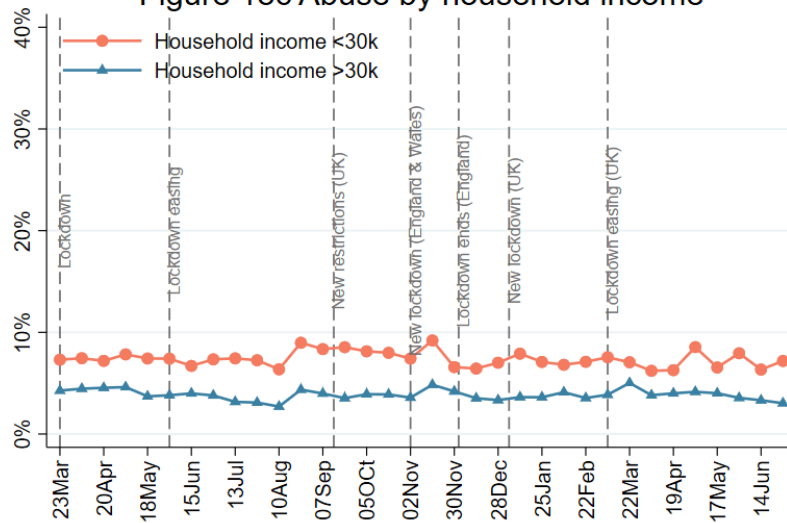


Figure 18d Abuse by mental health diagnosis

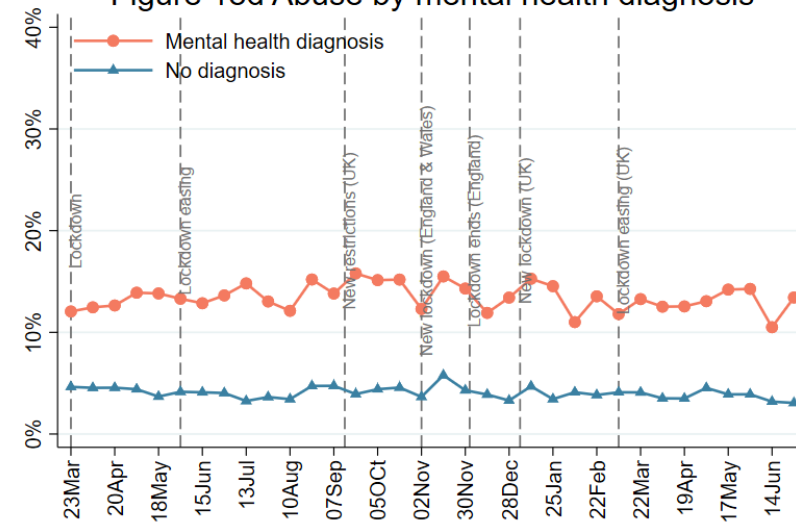


Figure 18e Abuse by nations

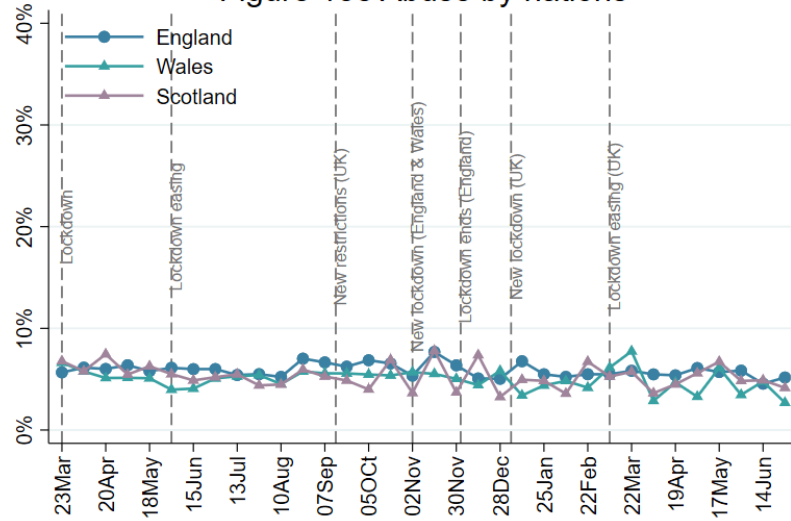


Figure 18f Abuse by keyworker status

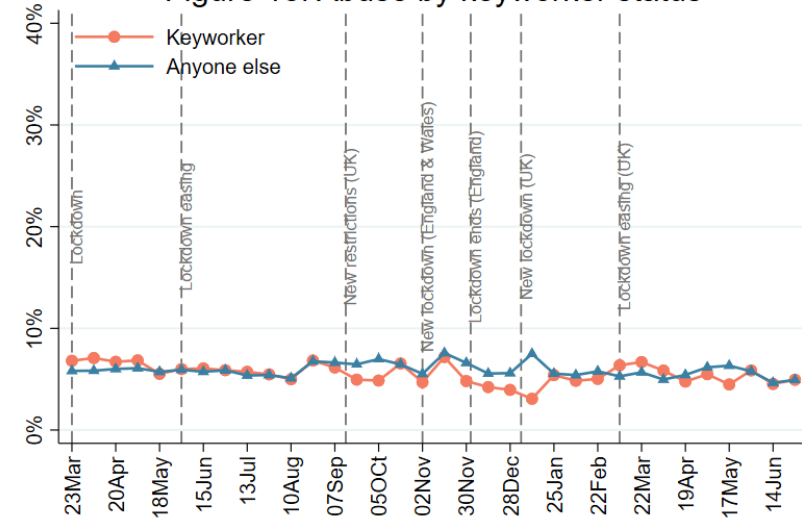


Figure 18g Abuse by living with children

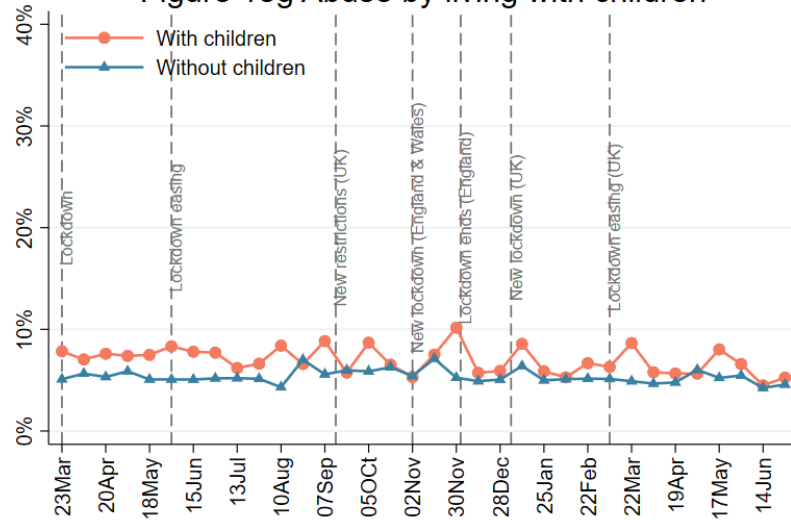


Figure 18h Abuse by living area

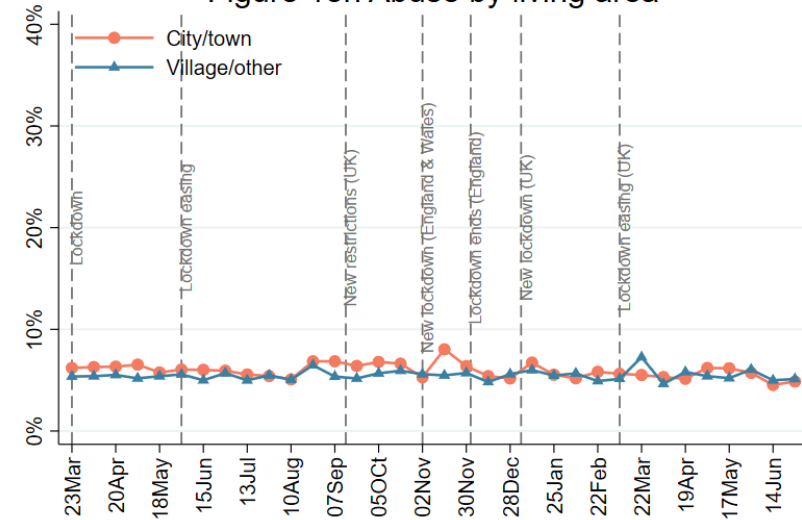


Figure 18i Abuse by gender

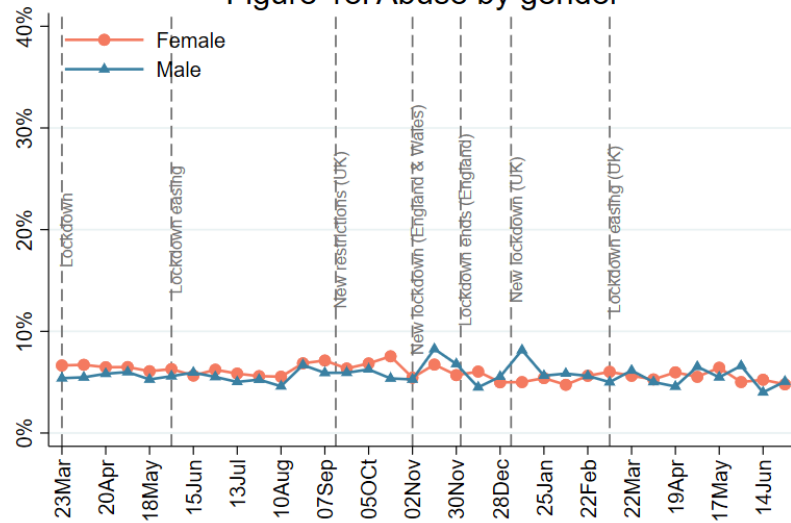


Figure 18j Abuse by ethnicity

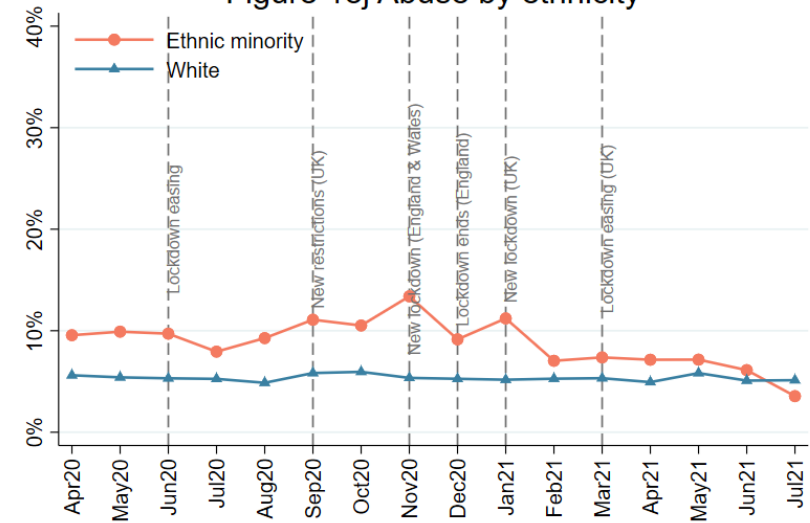


Figure 18k Abuse by educational levels

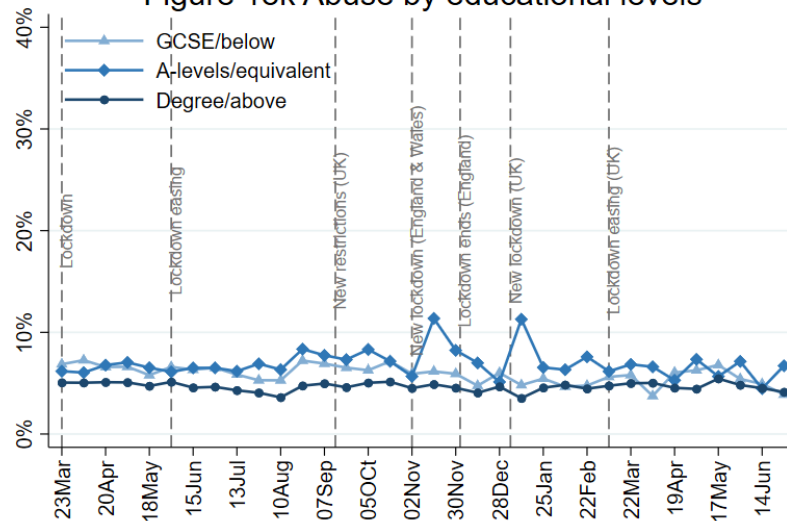
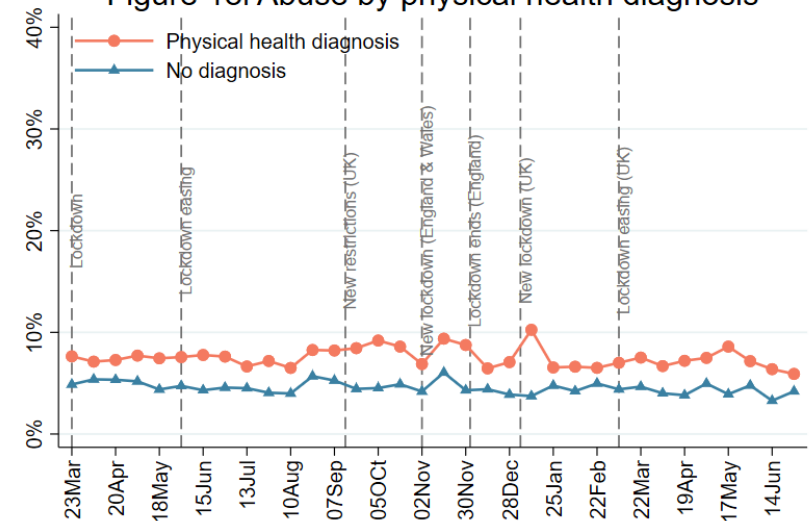
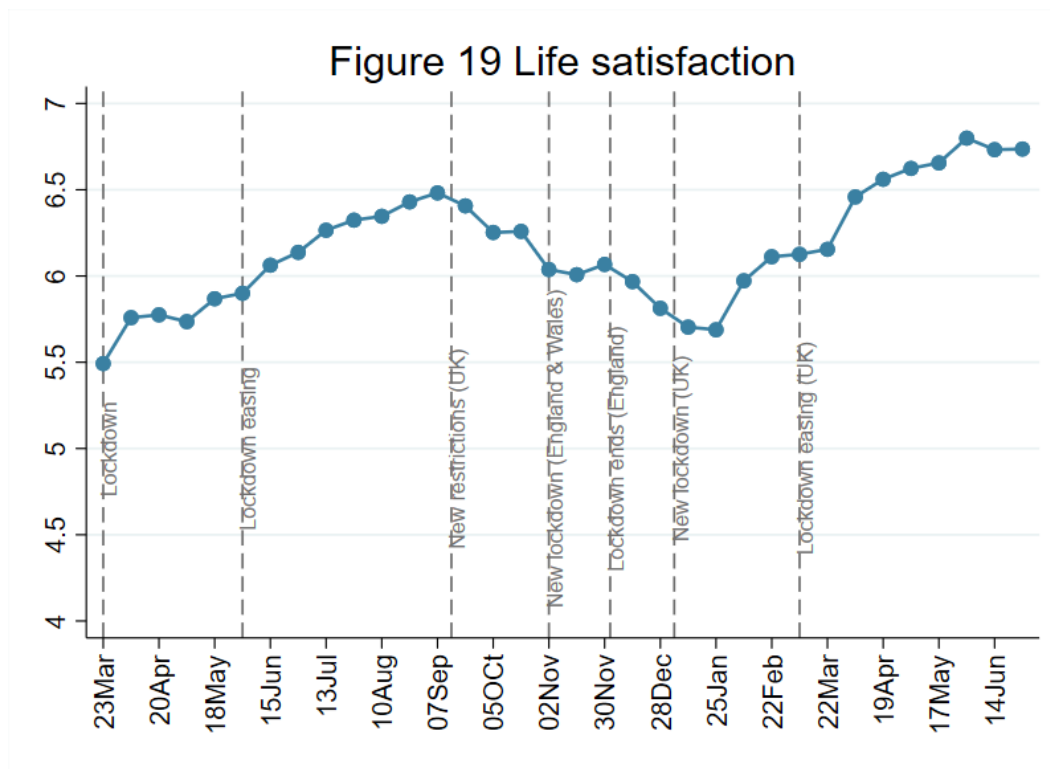


Figure 18l Abuse by physical health diagnosis



4. General well-being

4.1 Life satisfaction



FINDINGS

Respondents were asked to rate their life satisfaction during the past week using the Office of National Statistics (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 increased steadily from the start of the new year to the beginning of May but has since levelled off over the past two months. This increase in life satisfaction was generally seen across all demographic groups. Although difficult to interpret due to small biweekly sample sizes, life satisfaction appears to have been decreasing in young adults over the last two weeks. More data will be required to confirm the trend.

Women, people living alone, those with a mental health condition, those with lower household incomes, people living in cities/towns, people with a long-term physical health condition, and people from ethnic minority groups (although smaller sample sizes compared to people with white ethnicity mean there has been greater volatility in these data) continue to report lower levels of life satisfaction.

Although this study focuses on trajectories rather than prevalence, the levels of life satisfaction remain lower than usual reported averages using the same scale (7.7)⁶.

⁶ Layard R, Clark A, De Neve J-E, Krekel 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

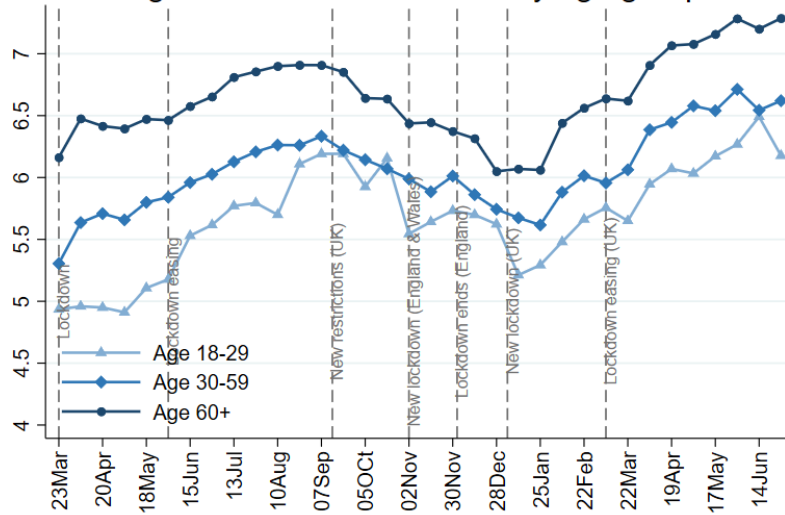


Figure 20b Life satisfaction by living arrangement

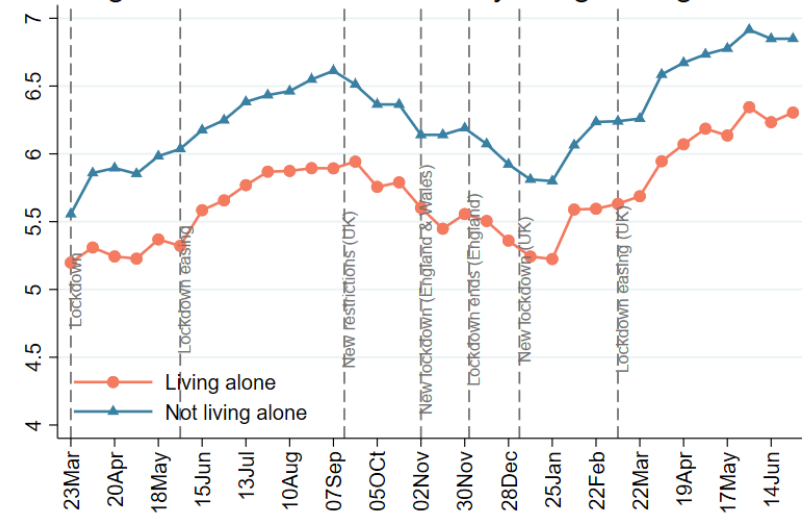


Figure 20c Life satisfaction by household income

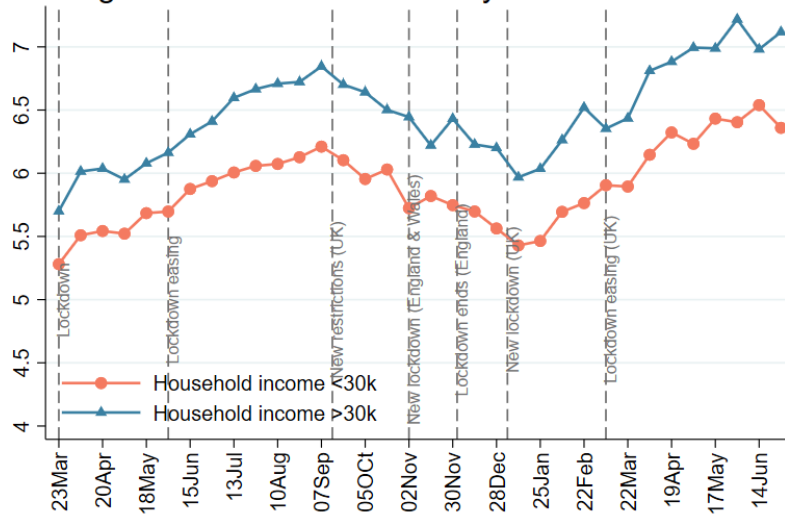


Figure 20d Life satisfaction by mental health diagnosis

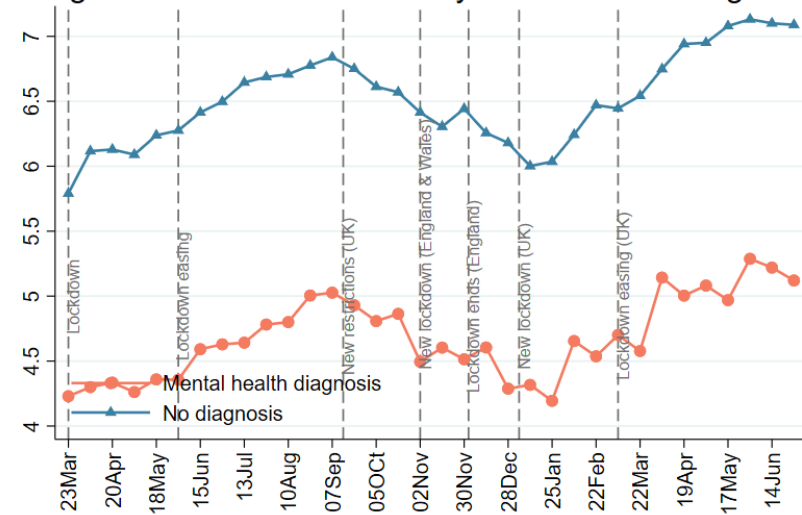


Figure 20e Life satisfaction by nations

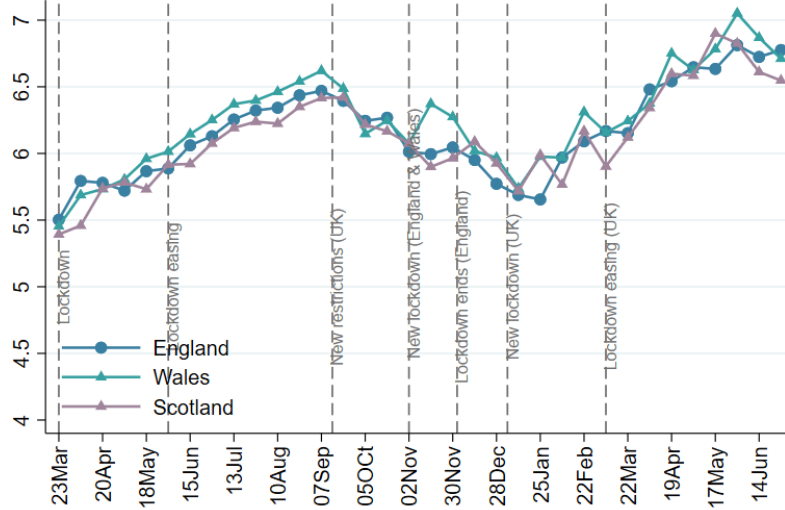


Figure 20f Life satisfaction by keyworker status

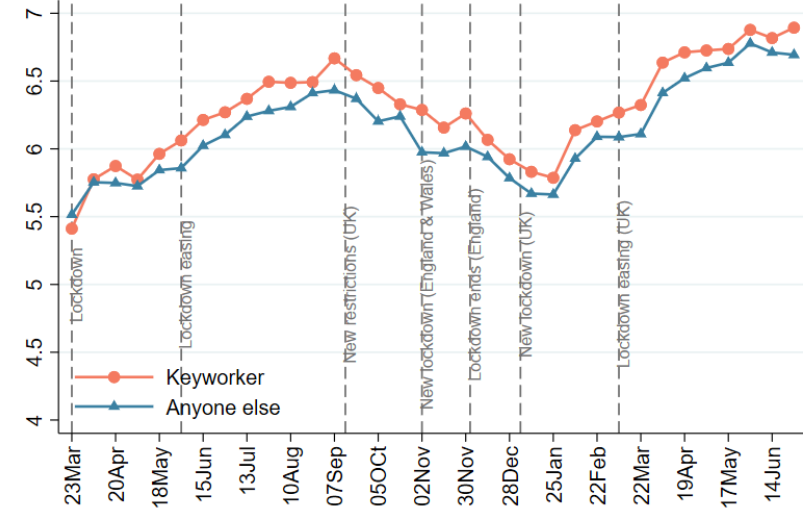


Figure 20g Life satisfaction by living with children

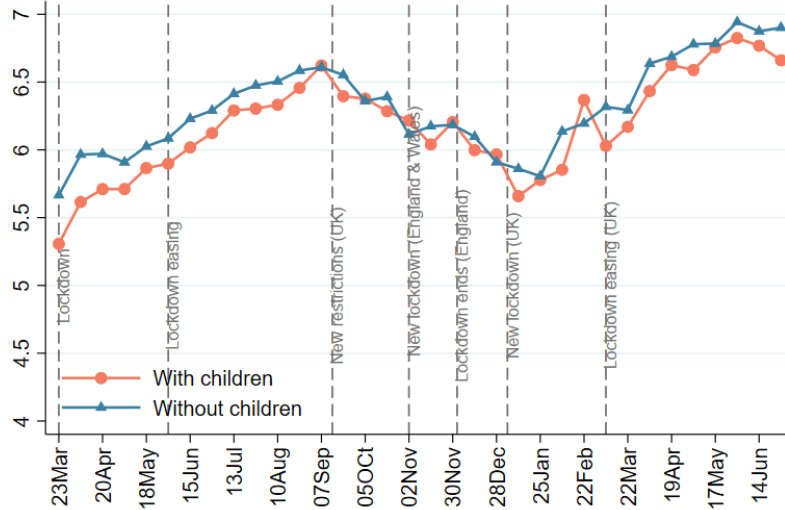


Figure 20h Life satisfaction by living area

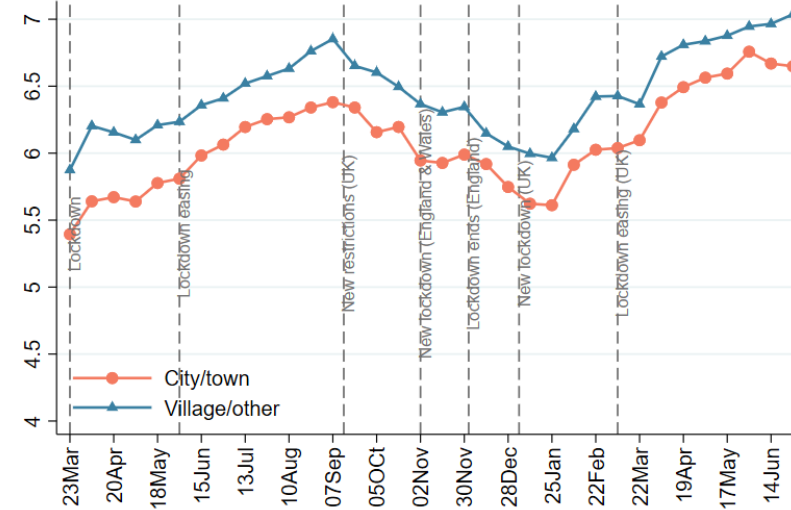


Figure 20i Life satisfaction by gender

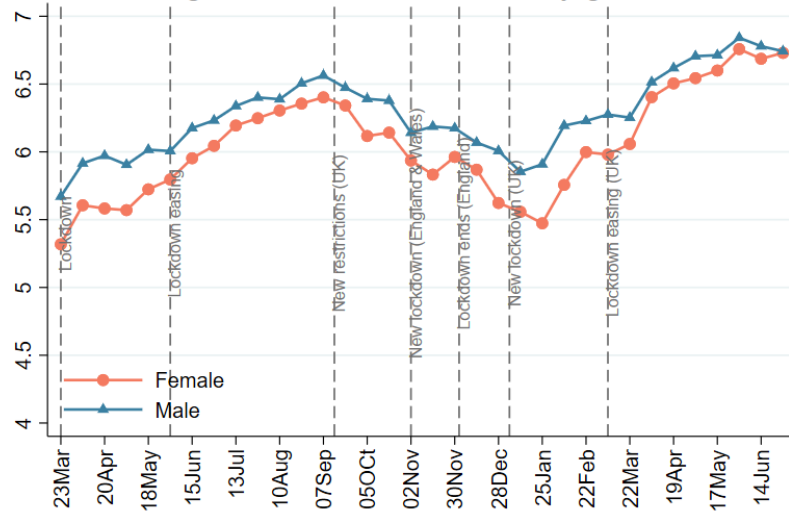


Figure 20j Life satisfaction by ethnicity

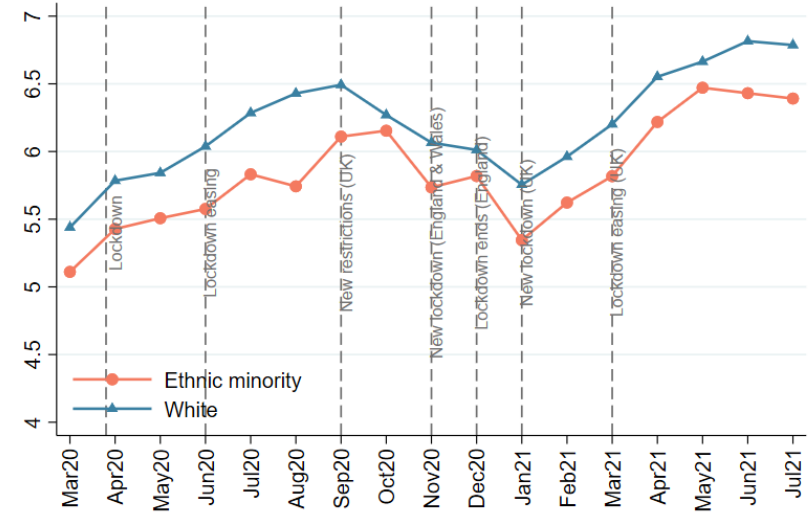


Figure 20k Life satisfaction by educational levels

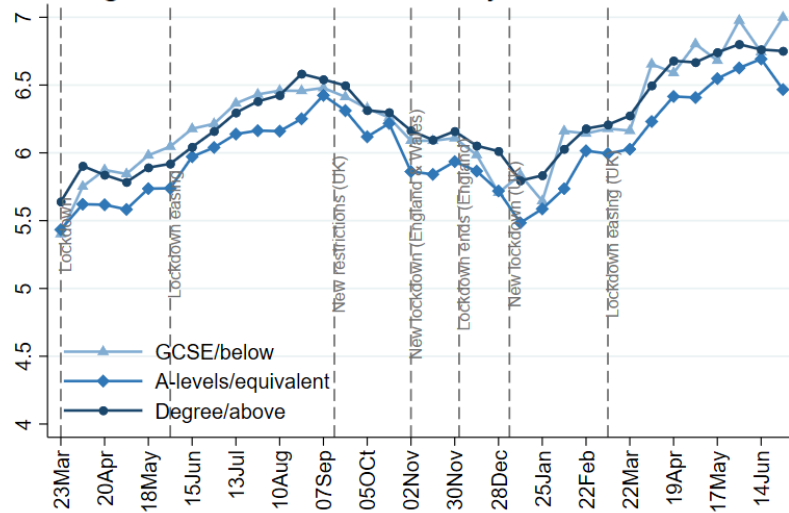
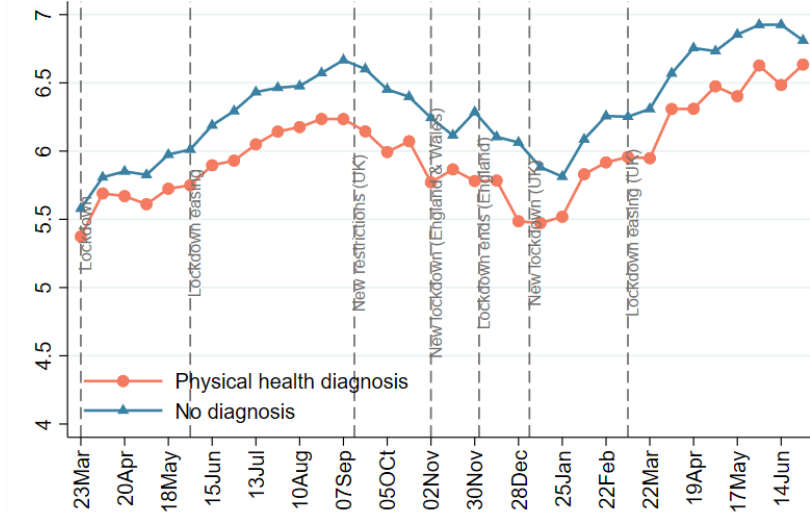
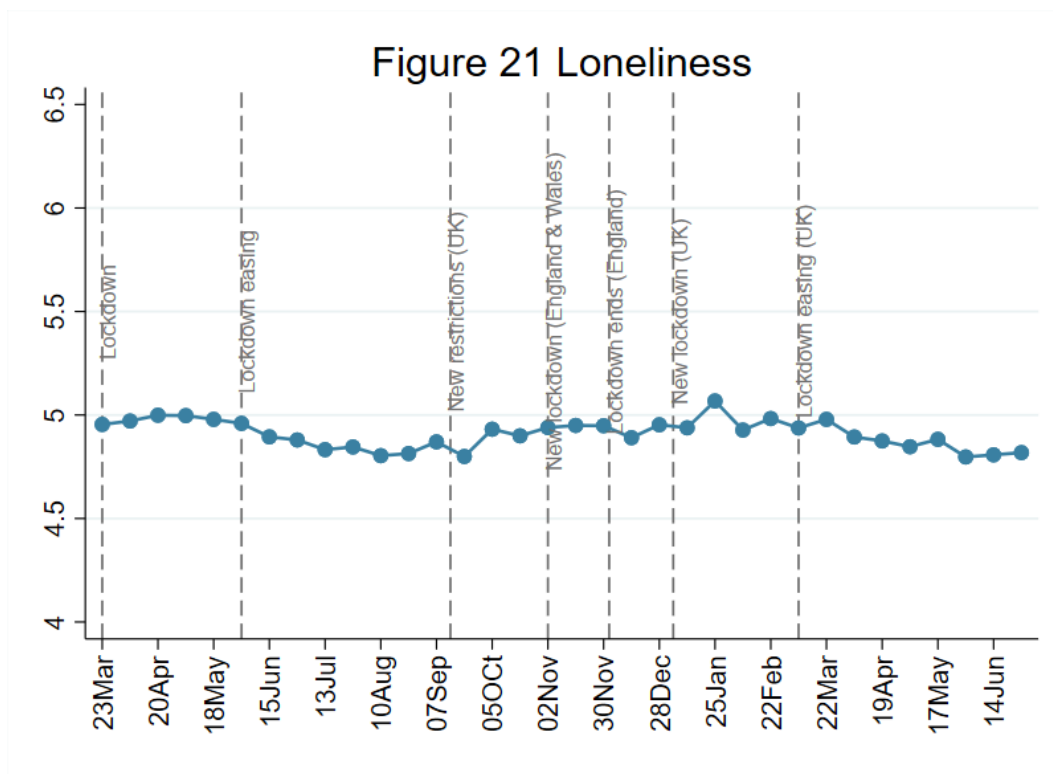


Figure 20l Life satisfaction by physical health diagnosis



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 scale, ranging from “never” to “always”, with higher scores indicating greater loneliness.

Loneliness levels have been decreasing slightly since the easing of restrictions for the latest lockdown but remain similar to what they were in summer 2020. Loneliness remains highest in young adults, people living alone, those with a mental health condition, amongst those from ethnic minority groups, people living with children, people with lower household income, women, and those living in cities/towns.

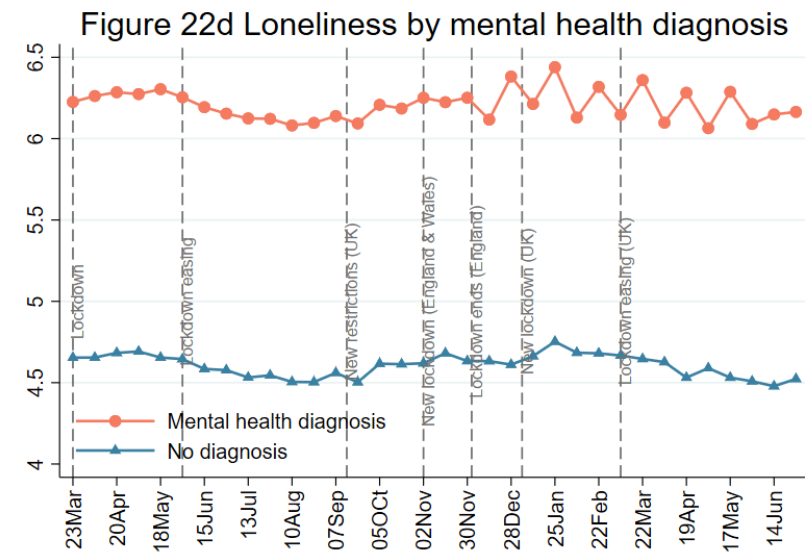
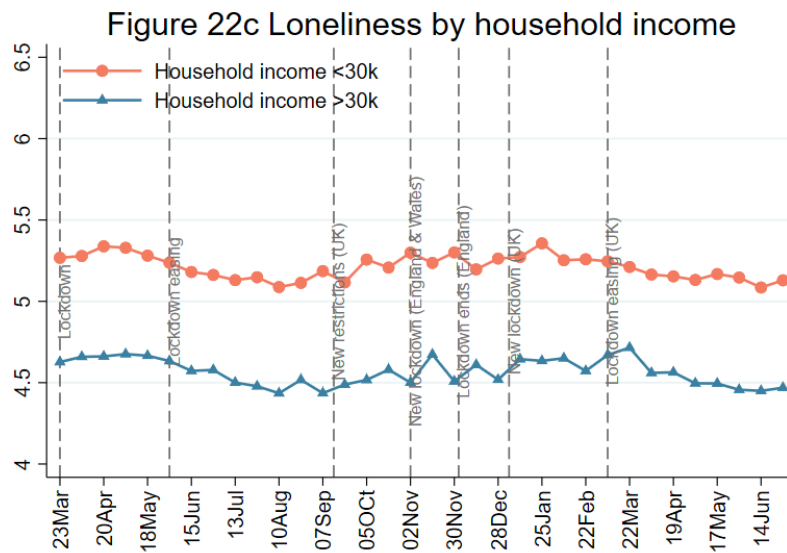
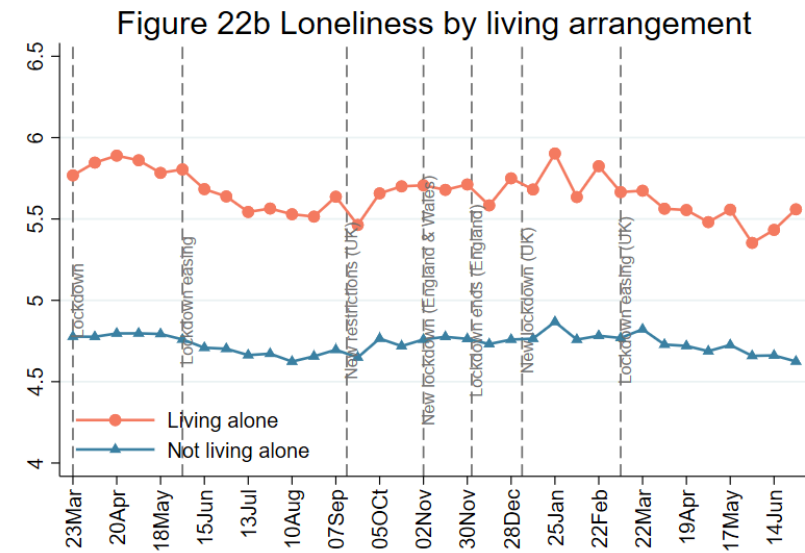
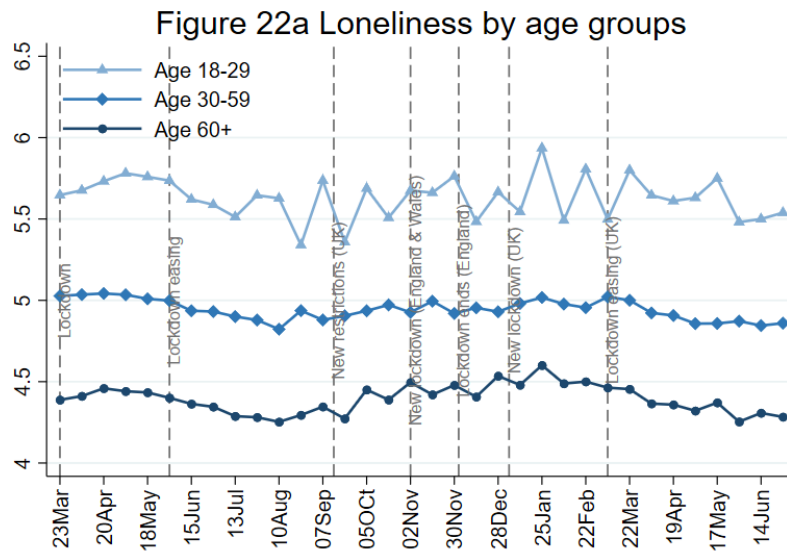


Figure 22e Loneliness by nations

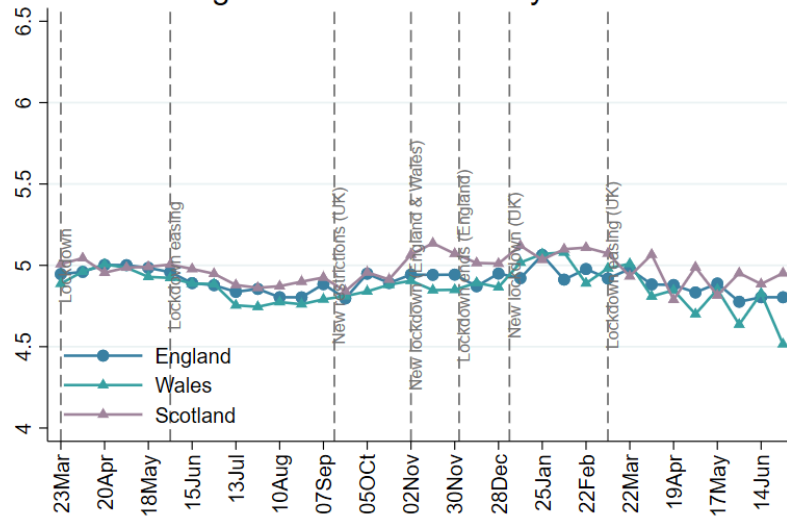


Figure 22f Loneliness by keyworker status

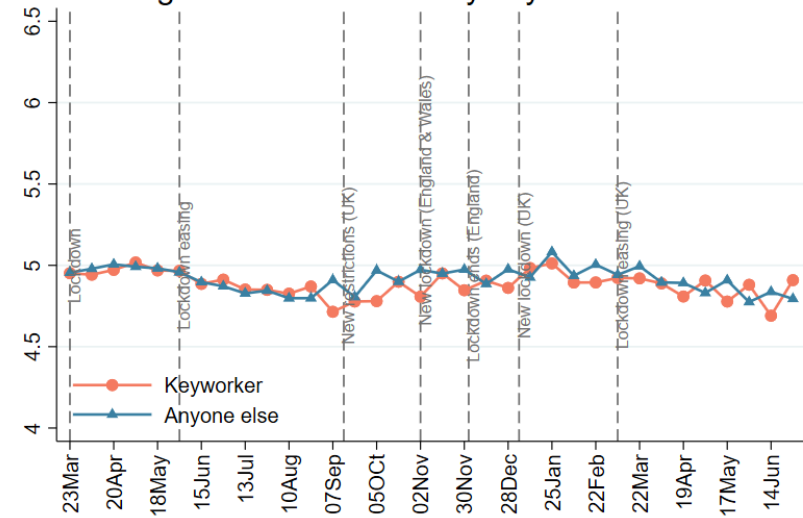


Figure 22g Loneliness by living with children

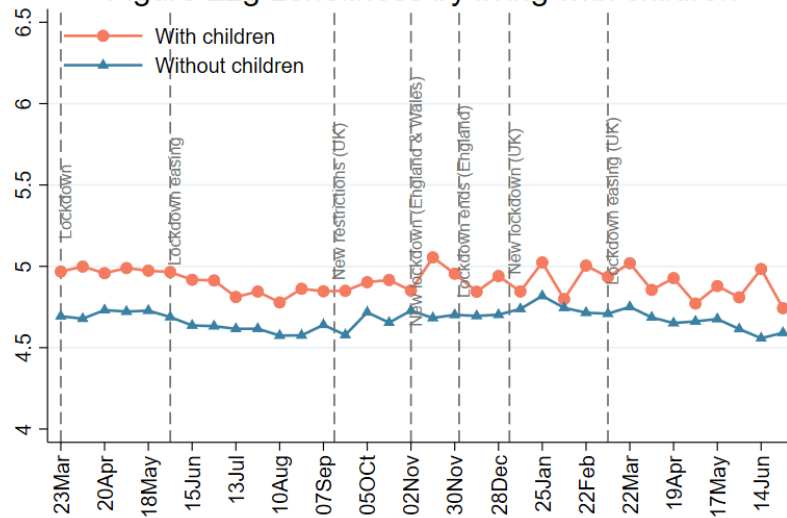


Figure 22h Loneliness by living area

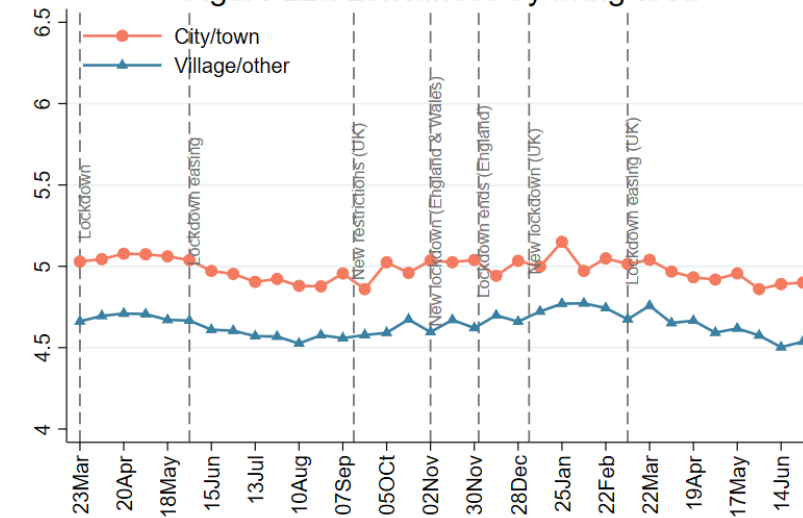


Figure 22i Loneliness by gender

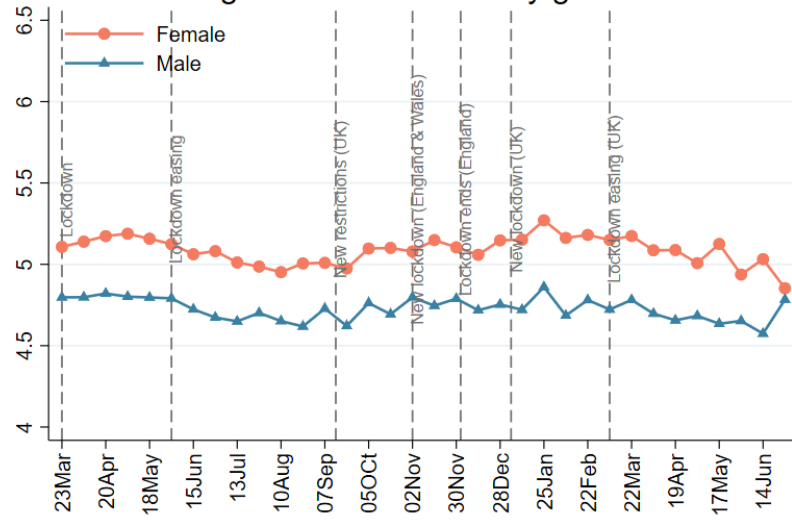


Figure 22j Loneliness by ethnicity

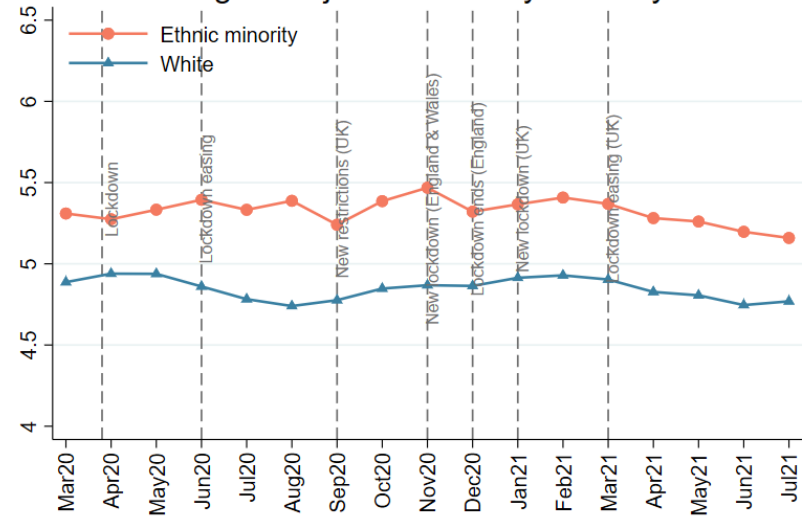


Figure 22k Loneliness by educational levels

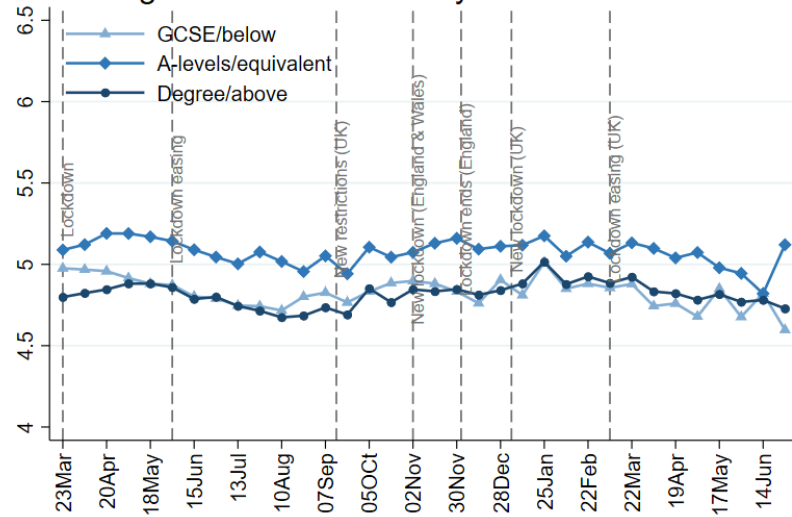
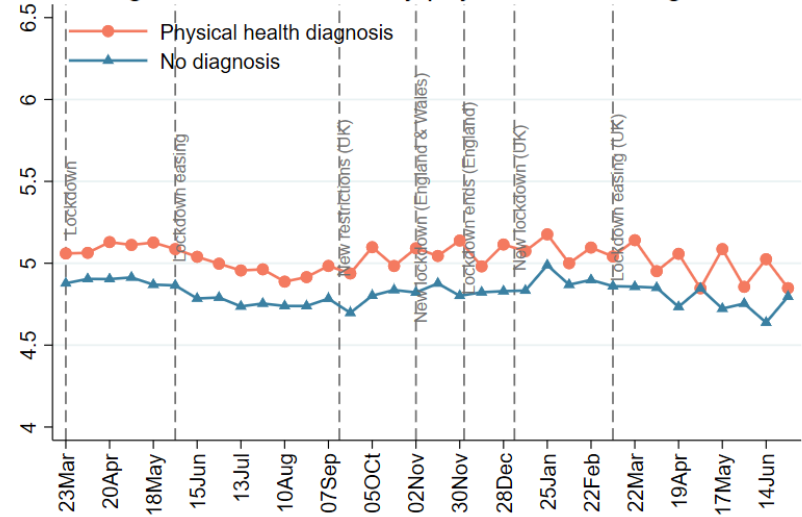
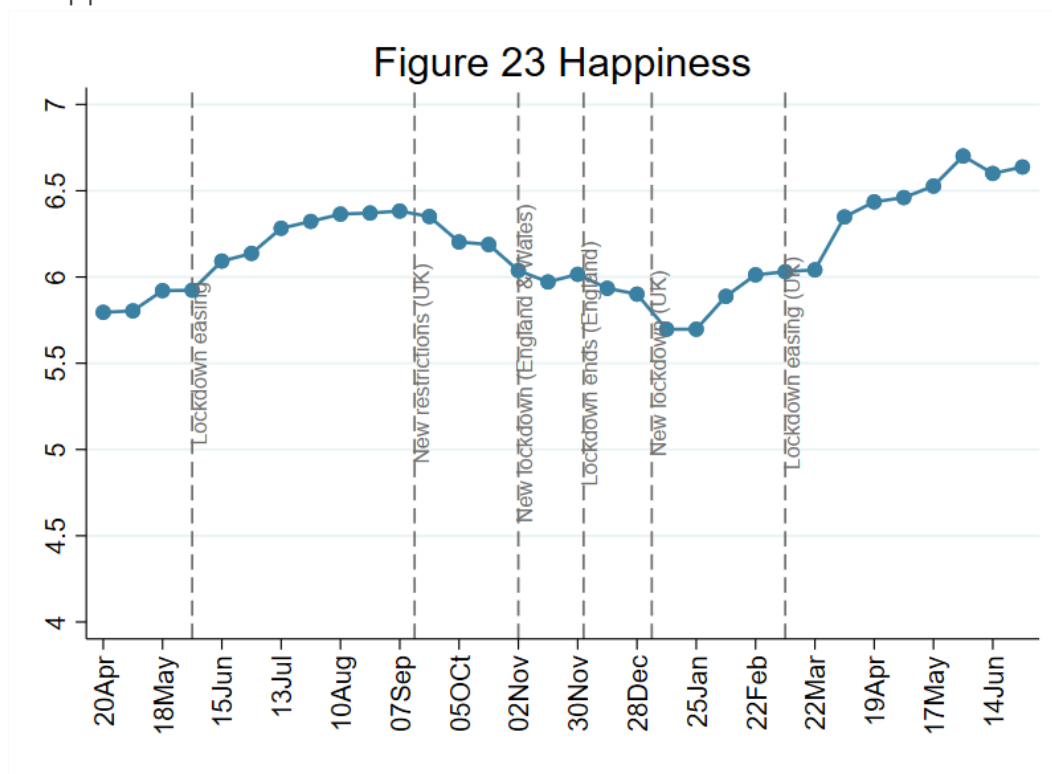


Figure 22l Loneliness by physical health diagnosis



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 (ONS) wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April 2020 onwards.

Happiness levels increased with the easing of restrictions for the latest lockdown but appear to have levelled off over the past month.

There continue to be differences in reported levels of happiness across demographic groups. Levels of happiness remain lower in adults under the age of 60, people living alone, people with lower household incomes, people with a diagnosed mental or physical health condition, in urban areas, in women, and people from ethnic minority groups.

Figure 24a Happiness by age groups

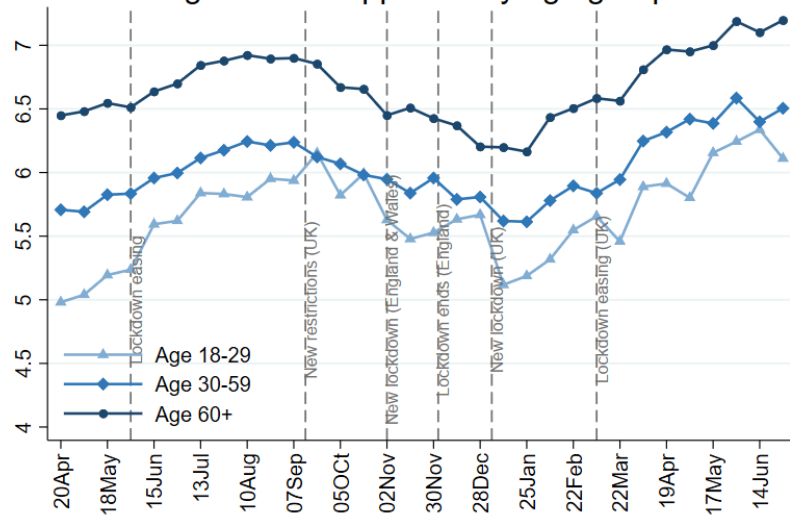


Figure 24b Happiness by living arrangement

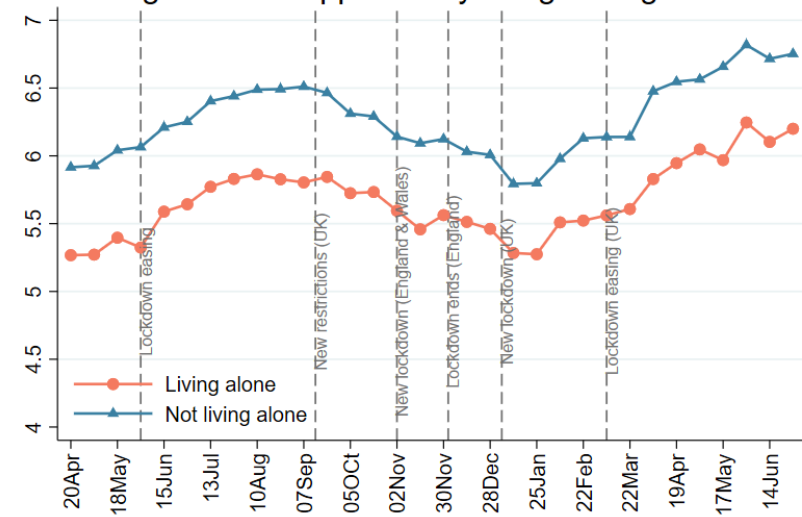


Figure 24c Happiness by household income

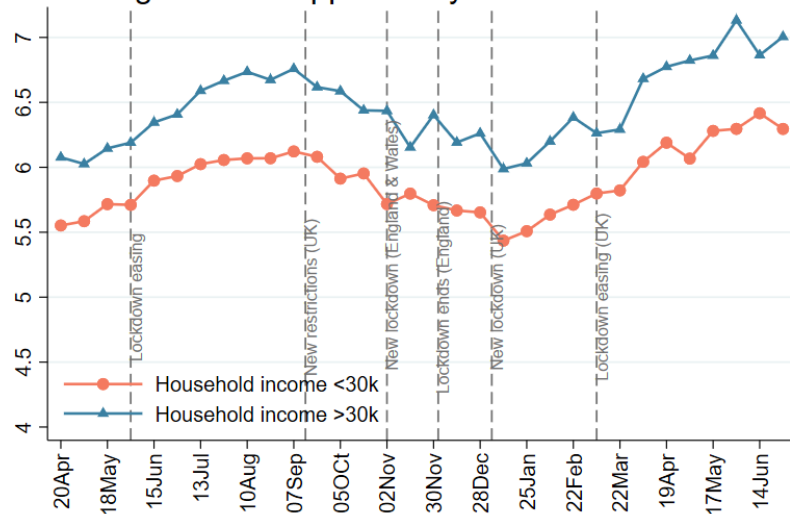


Figure 24d Happiness by mental health

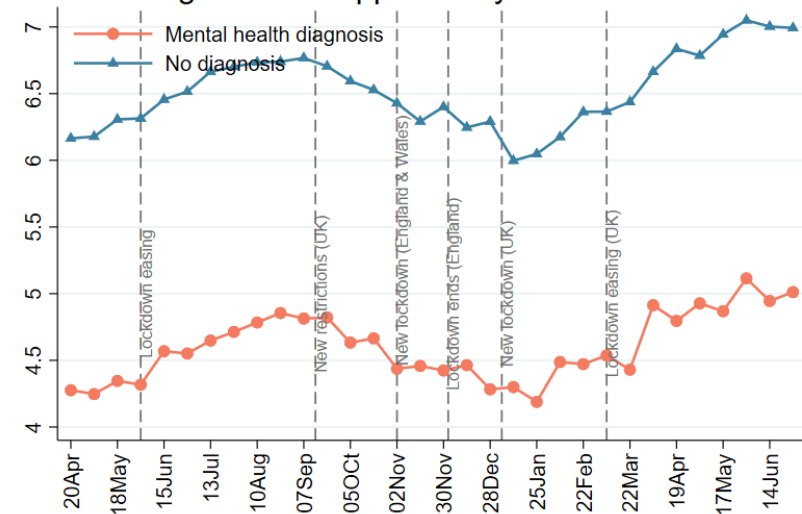


Figure 24e Happiness by nations

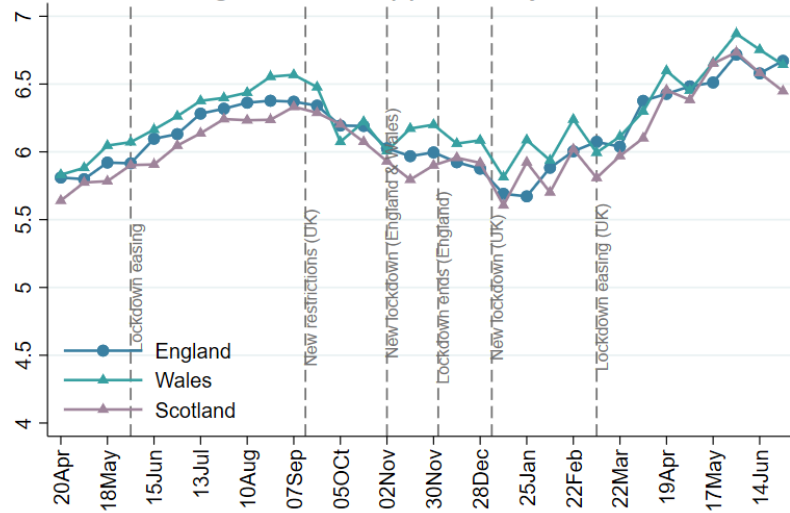


Figure 24f Happiness by keyworker status

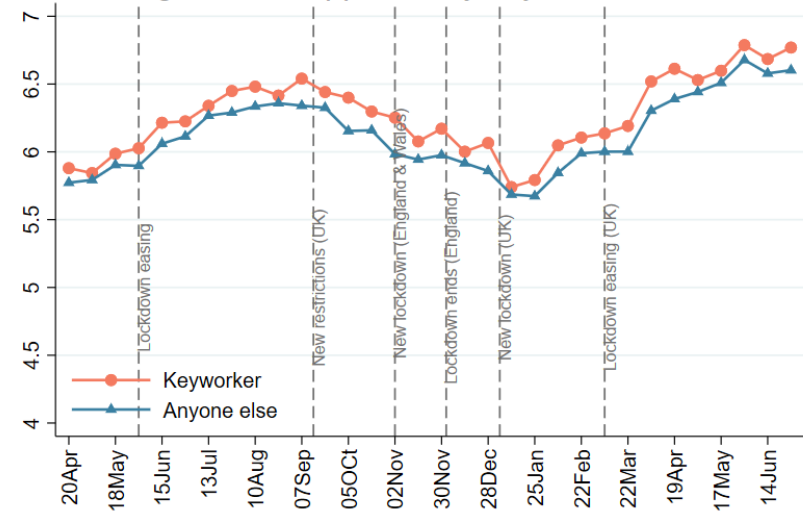


Figure 24g Happiness by living with children

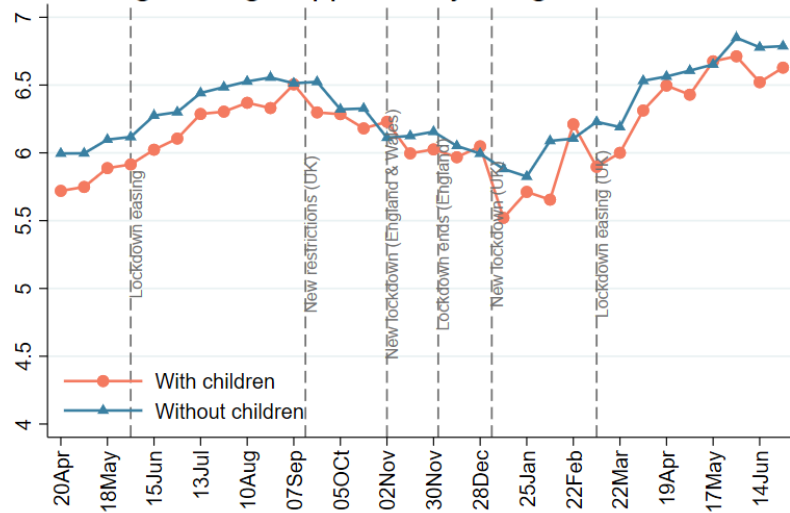


Figure 24h Happiness by living area

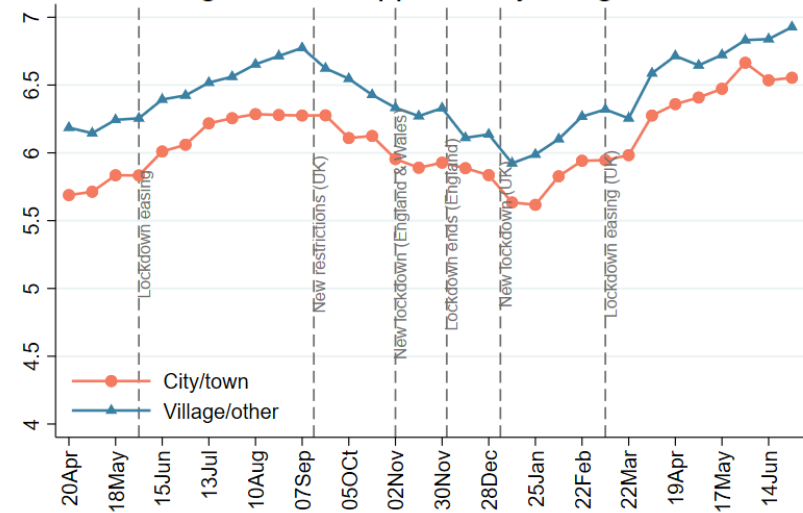


Figure 24i Happiness by gender

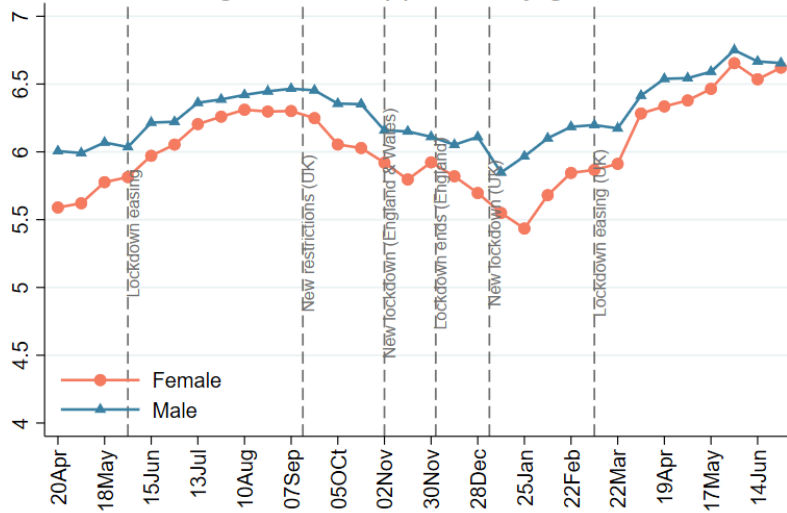


Figure 24j Happiness by ethnicity

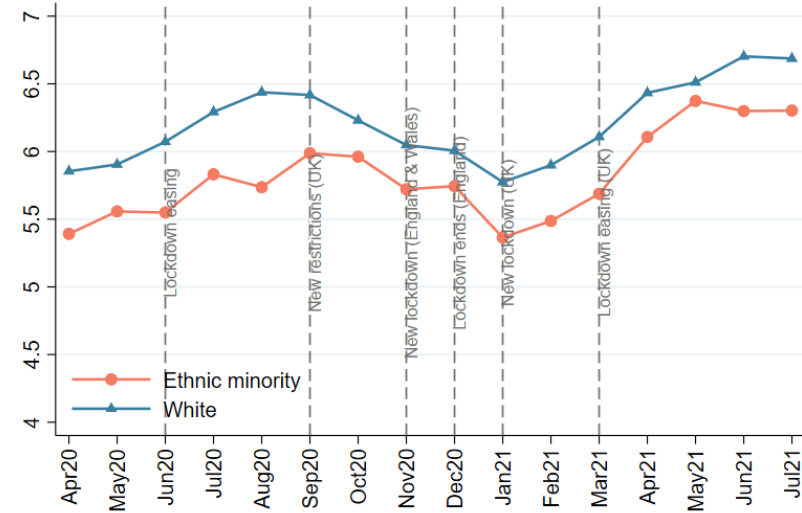


Figure 24k Happiness by educational levels

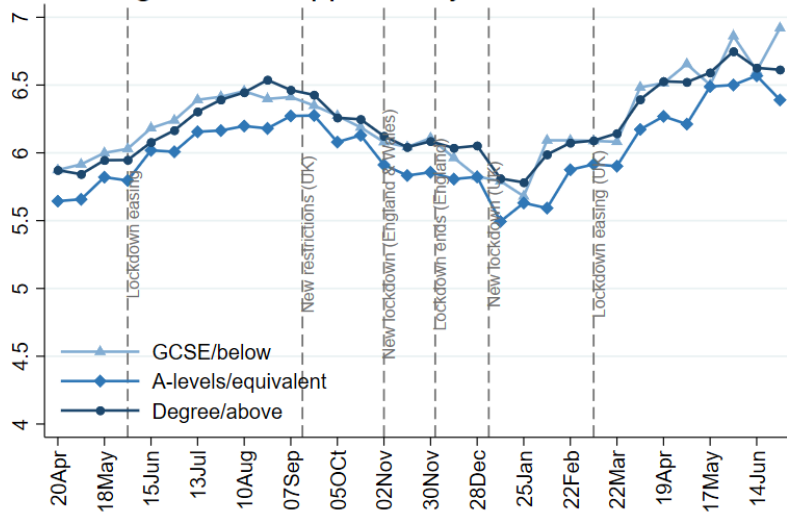
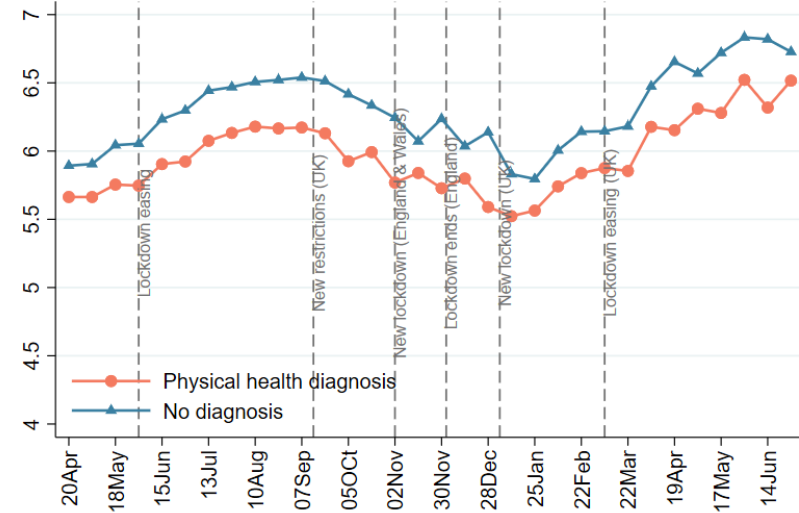


Figure 24l Happiness by physical health diagnosis



5. Covid-19 rules compliance

Figure 25a Covid-19 rules compliance in Nov/Dec 2020

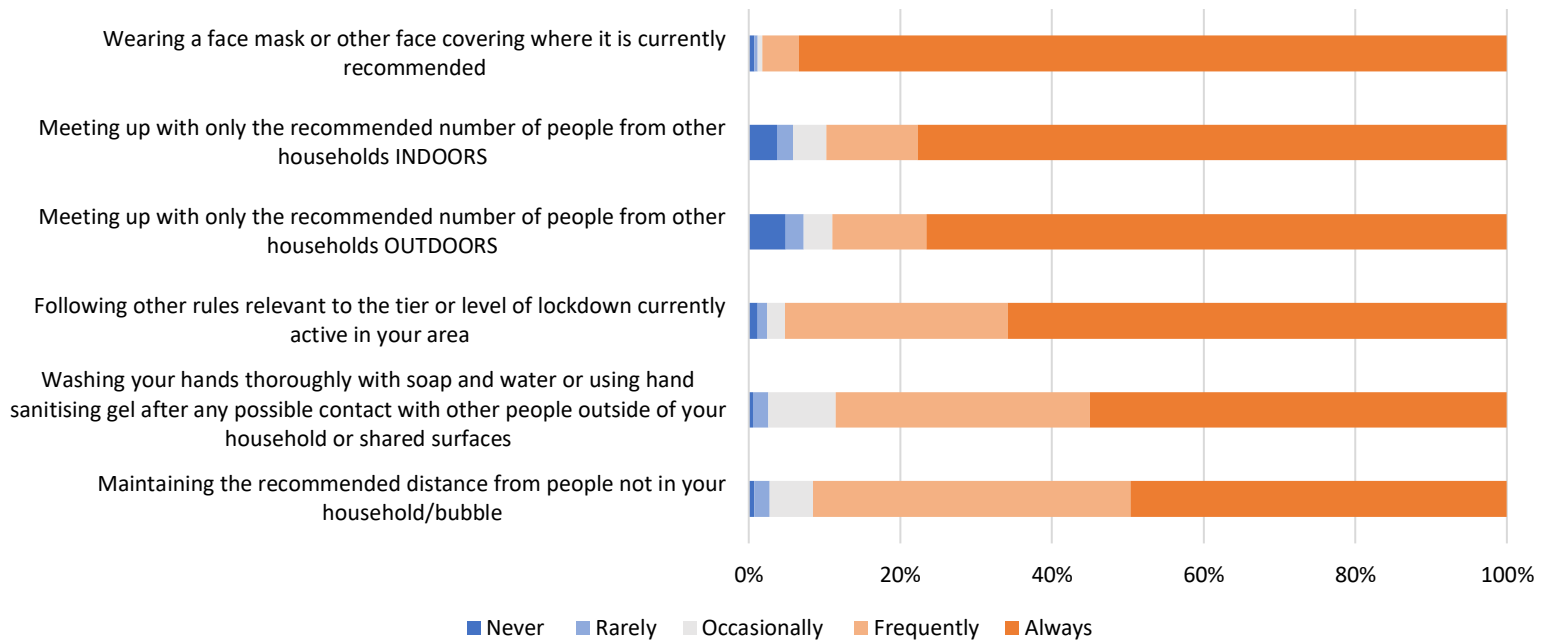
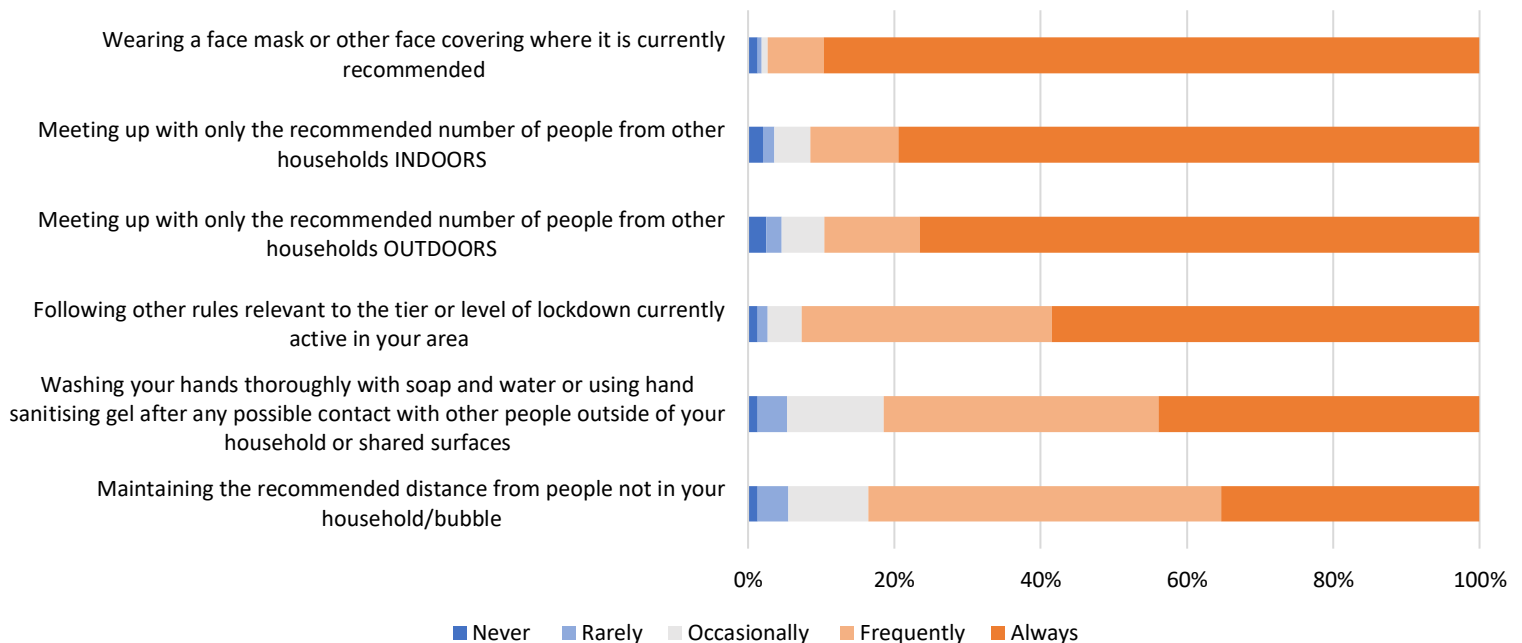


Figure 25b Covid-19 rules compliance in May-Jul 2021



FINDINGS

Throughout the month of December 2020 and from the end of May to mid-July 2021, we asked people which rules specifically they had been following in relation to controlling the spread of the Covid-19 virus. These included wearing face masks, washing their hands, maintaining the recommended distance from others, and

meeting up with only the allowed number of people indoors and outdoors. A summary comparison of these two time periods is shown in Figures 25a and 25b, but the results for subgroups (Figures 26) are presented only for data collected in 2021.

Compliance was highest for wearing a facemask or other face covering where it is recommended in 2021 (90% saying they always do this) as it was in 2020 (93% said they always do this). Face mask compliance is currently somewhat lower in young adults (86%) than in adults aged 60+ (92%) and 30-59 (90%). A higher proportion of women (92%) than men (87%) report always following this rule.

The rules people are currently most often breaking are meeting up with more than the recommended number of people outdoors (11% saying they never, rarely, or only occasionally follow this) and indoors (9% saying they never, rarely, or only occasionally follow this). These two rules were also the most frequently broken at the end of 2020, and proportions who reported breaking them were similar in 2020 (outdoors: 11% said they never, rarely, or only occasionally follow this; indoors: 10% said they never, rarely, or only occasionally follow this). However, the vast majority of people (77% and 79%) currently report always following these rules.

Older adults have been slightly less strict on always following the outdoor (74%) rule than adults aged 30-59 (78%) and young adults (77%). However, the percentage of people always following the indoor rule indoors is lowest in young adults (70% vs 82% of adults aged 30+). Both indoors and outdoors, complete compliance is higher in women (81% indoors and 80% outdoors) than in men (78% indoors and 73% outdoors).

Fewer than half (44%) currently report always washing their hands, compared with 55% at the end of 2020. Nearly 1 in 5 (19%) report never, rarely, or only occasionally washing their hands after possible contact with others, which is higher than the 12% of people who said this rarely at the end of 2020.

Compliance with hand washing is highest amongst older adults (48% always do it) and adults aged 30-59 (46% always do it). Just 1 in 3 (33%) young adults report always washing their hands thoroughly with soap and water after contact with others outside of their household. More women (48%) than men (40%) and more people in lower income households (48%) than in higher income households (38%) report always complying with this rule.

Just over 1 in 3 (35%) say they always maintain the recommended distance from others, compared to 1 in 2 (50%) at the end of 2020. Compliance with maintaining the recommended distance from people is highest amongst older adults (47% always do it) compared with 37% of adults aged 30-59 and just 15% of adults aged 18-29. Proportions always complying with this rule are comparable amongst women (35%) and men (35%) but are higher in lower income households (42%) than higher income households (29%).

Note that these data were collected before the changes in rules that came into force in England on 19th July 2021.

Figure 26a Covid-19 rules compliance amongst younger adults aged 18-29

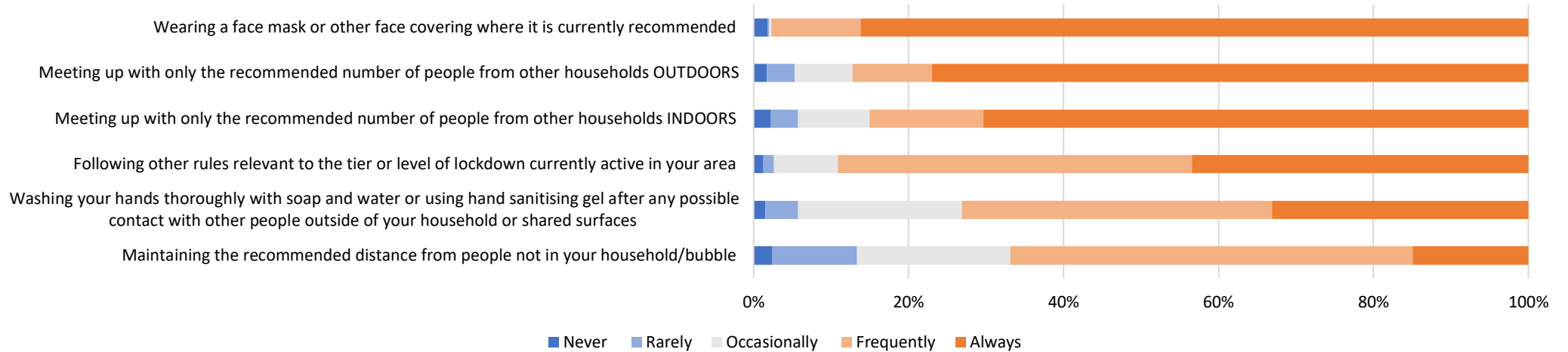


Figure 26b Covid-19 rules compliance amongst adults aged 30-59

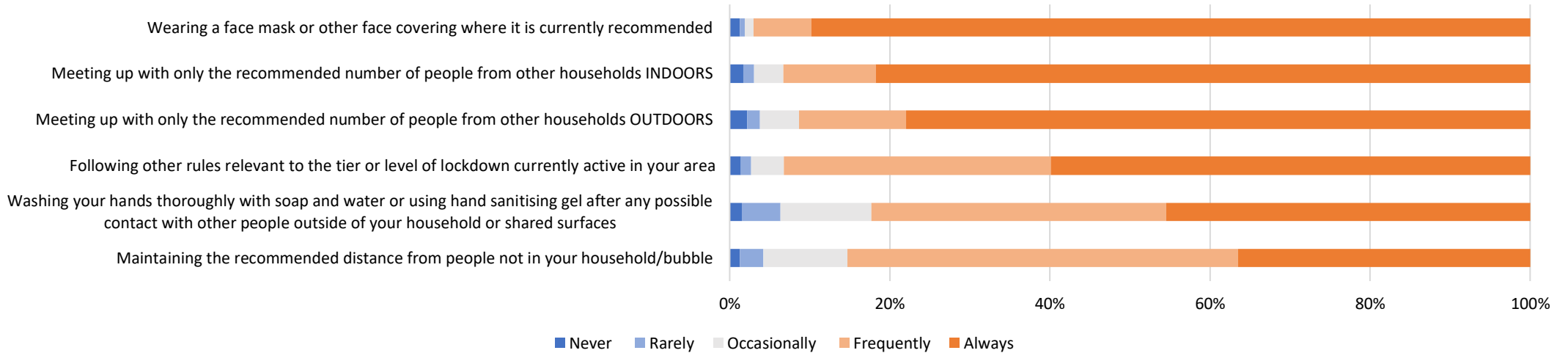


Figure 26c Covid-19 rules compliance amongst older adults aged 60+

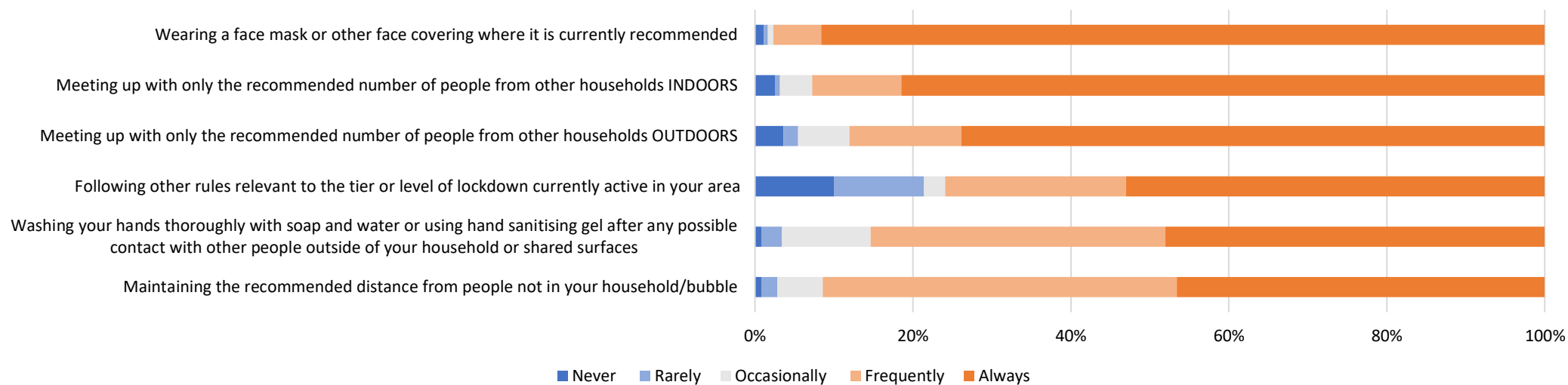


Figure 26d Covid-19 rules compliance amongst females

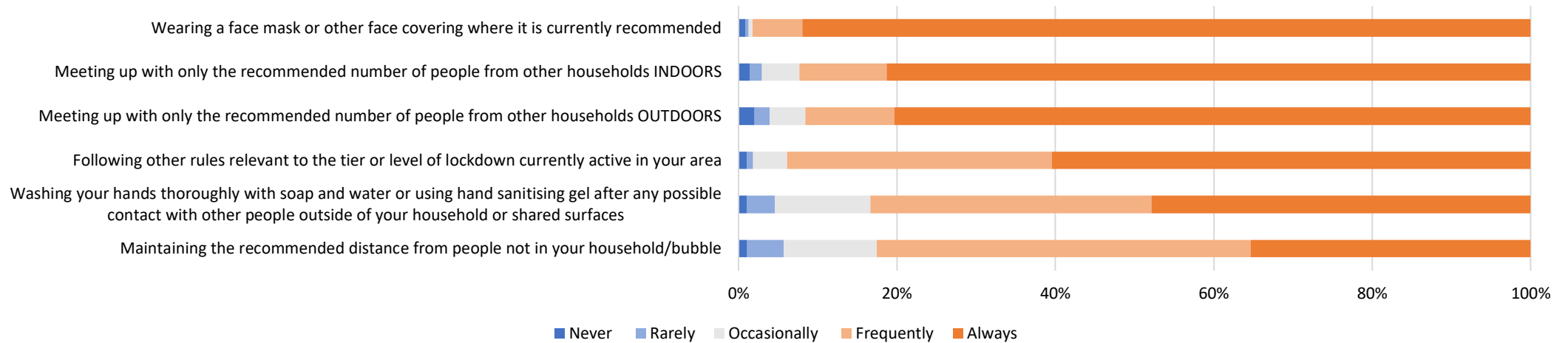


Figure 26e Covid-19 rules compliance amongst males

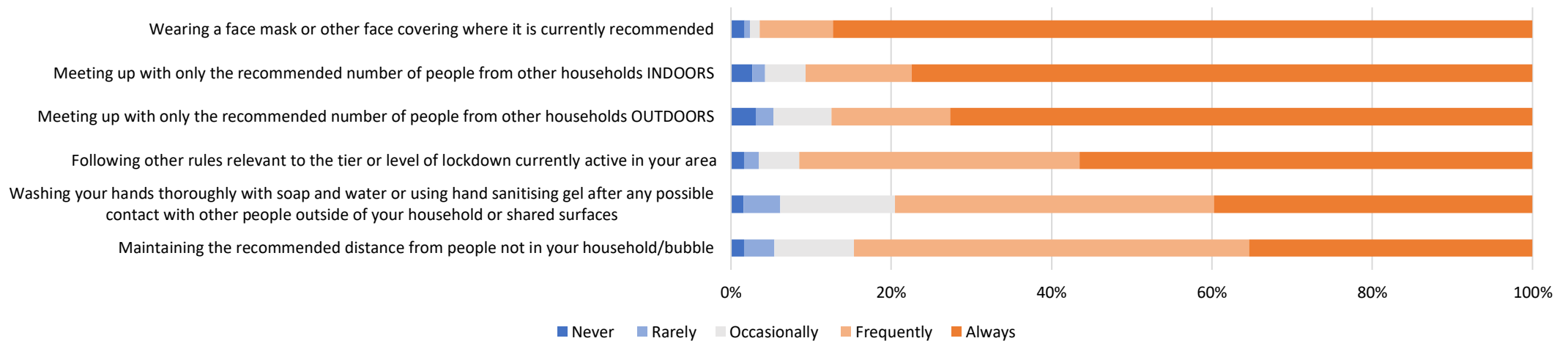


Figure 26f Covid-19 rules compliance amongst people with household income <30k

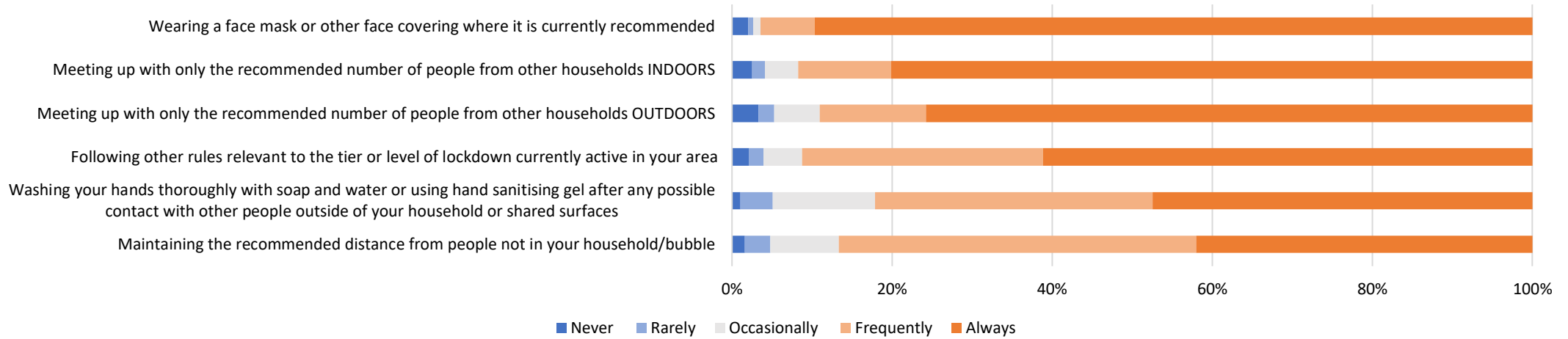
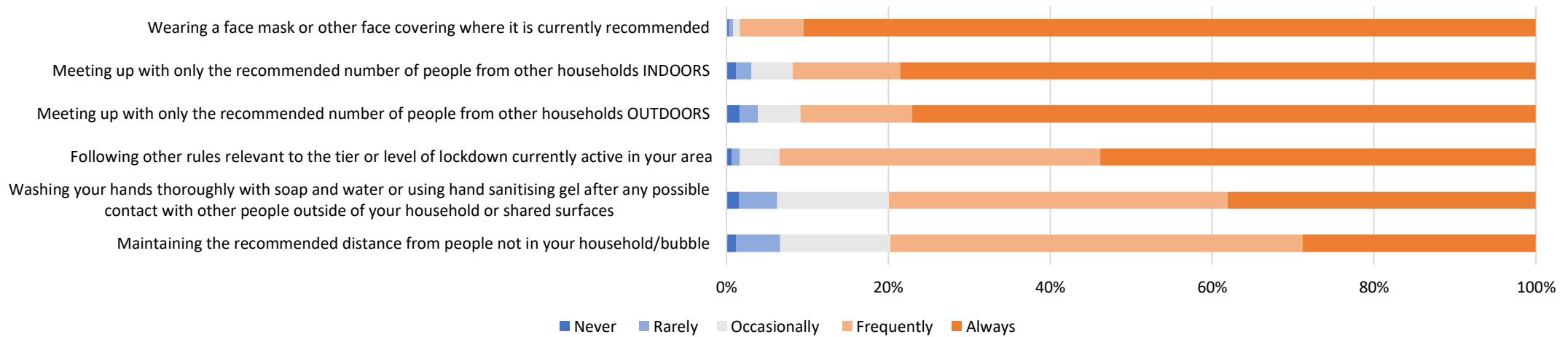
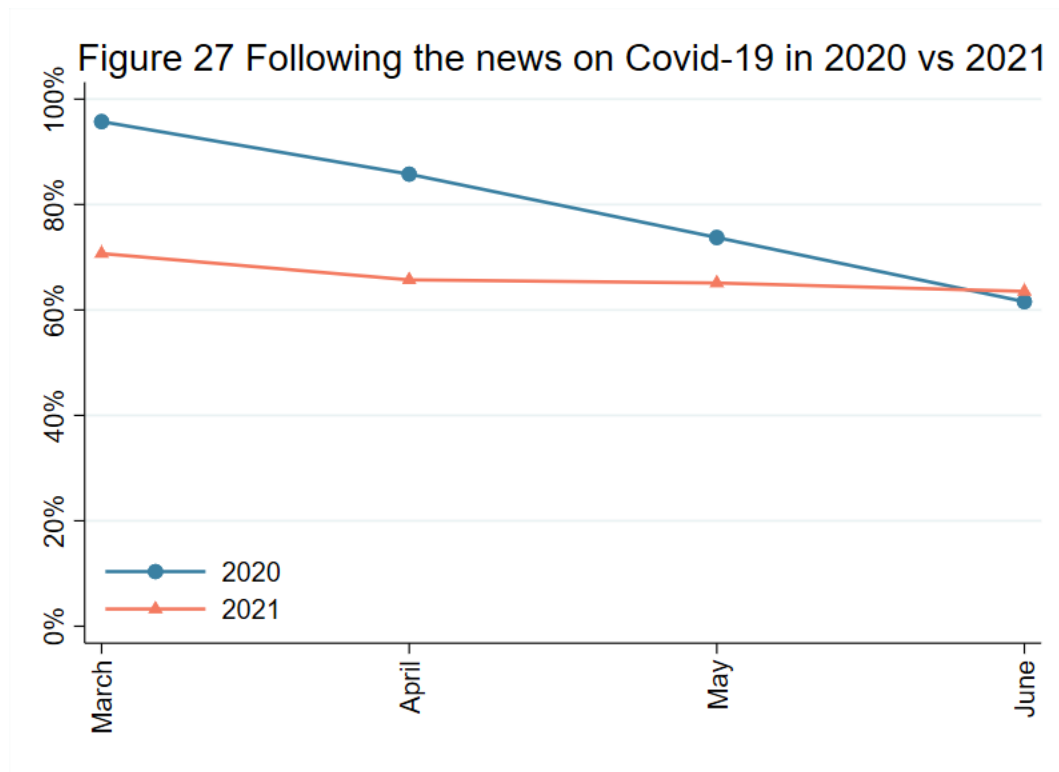


Figure 26g Covid-19 rules compliance amongst people with household income ≥ 30k



6. Following the news on Covid-19



FINDINGS

We asked participants how much time they had spent on the last weekday following the news on Covid-19. Response options ranged from 'did not do' to 6+ hours and for this report, responses are presented as any time spent following the news on Covid-19 versus none. The patterns in different subgroups of the population are presented for 2021.

The majority of adults report having accessed news on Covid-19 at each timepoint since the start of the pandemic. Currently, 64% report doing this, compared to 62% at this time last year. The proportion following Covid-19 news was highest at the start of the pandemic, when over 9 in 10 adults (96%) were doing this, compared to 71% one year later in March 2021.

Greater proportions of people with higher household incomes, those without a mental health condition, people who are not keyworkers, people who do not live with children, those living in remote areas, men, people with a physical health condition, older adults, people of white ethnic background, and people with progressively higher levels of education reported having followed accessed news on Covid-19 in the past four months.

Figure 28a Following Covid-19 news by age groups

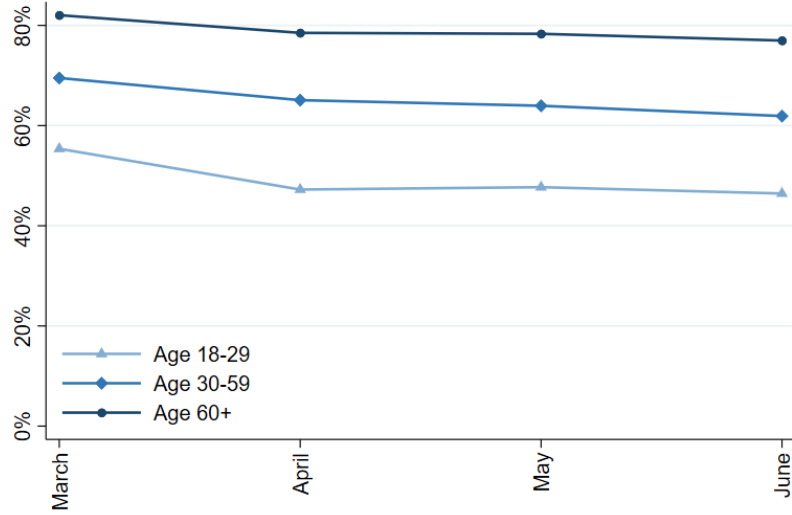


Figure 28b Following Covid-19 news by living arrangement

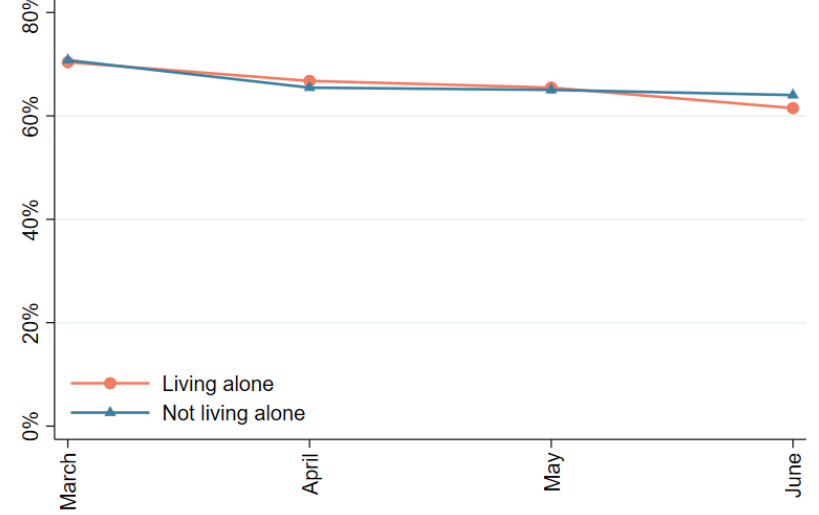


Figure 28c Following Covid-19 news by household income

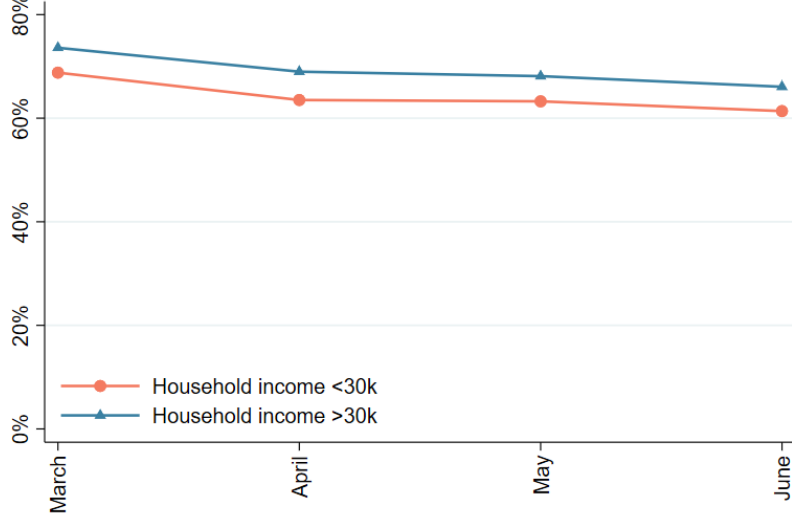


Figure 28d Following Covid-19 news by mental health

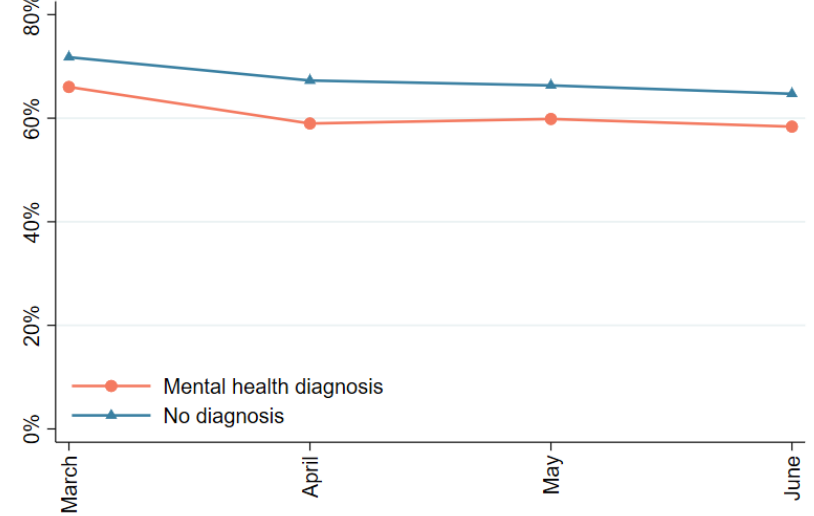


Figure 28e Following Covid-19 news by nations

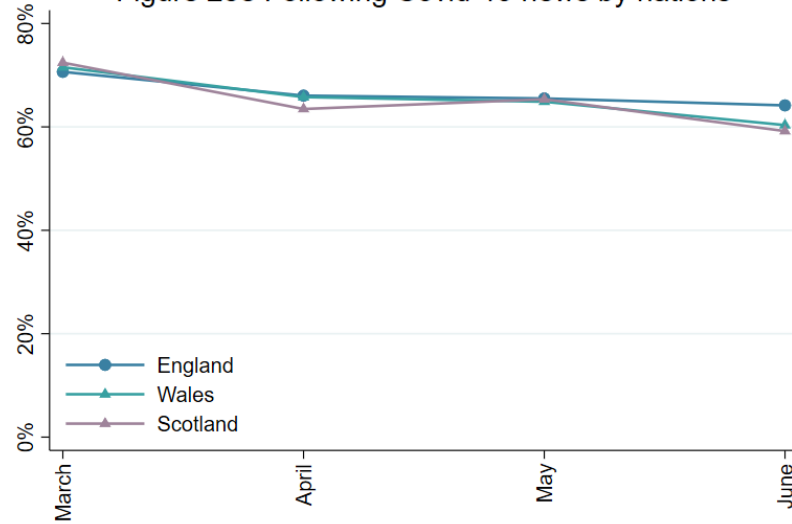


Figure 28f Following Covid-19 news by keyworker status

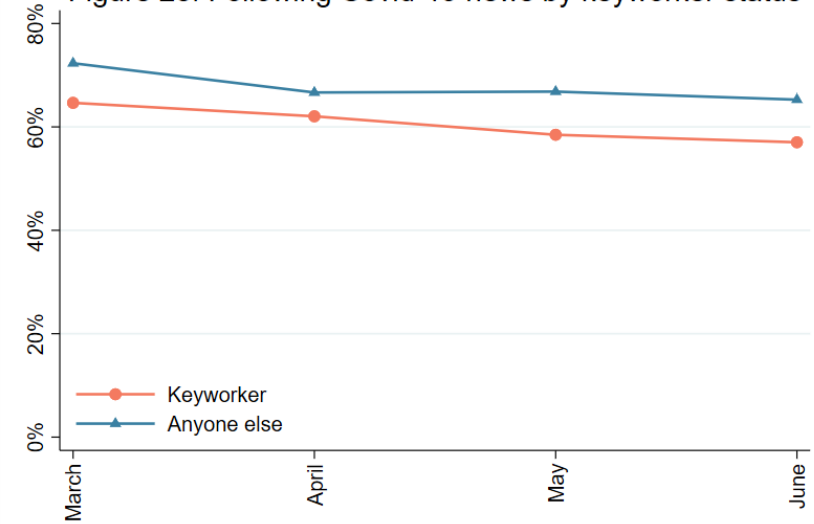


Figure 28g Following Covid-19 news by living with children

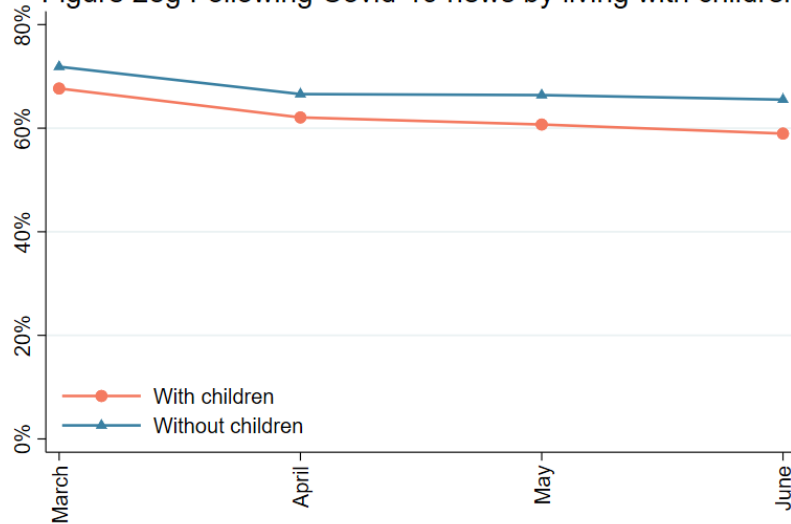


Figure 28h Following Covid-19 news by living area

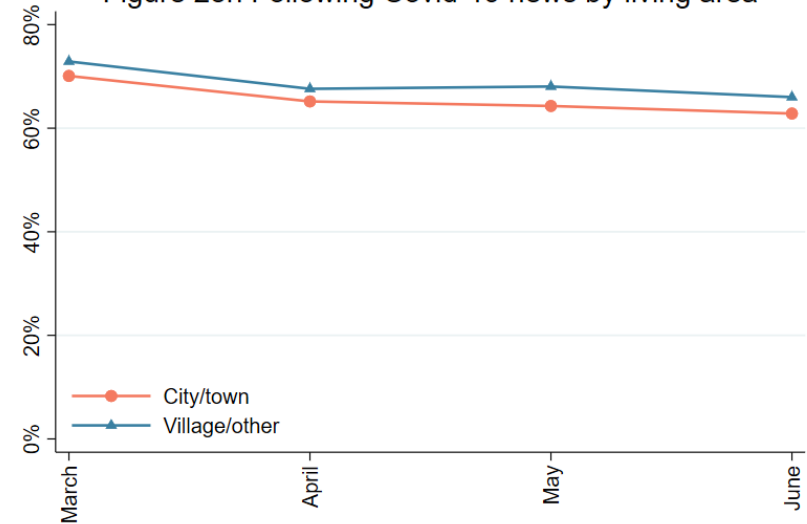


Figure 28i Following Covid-19 news by gender

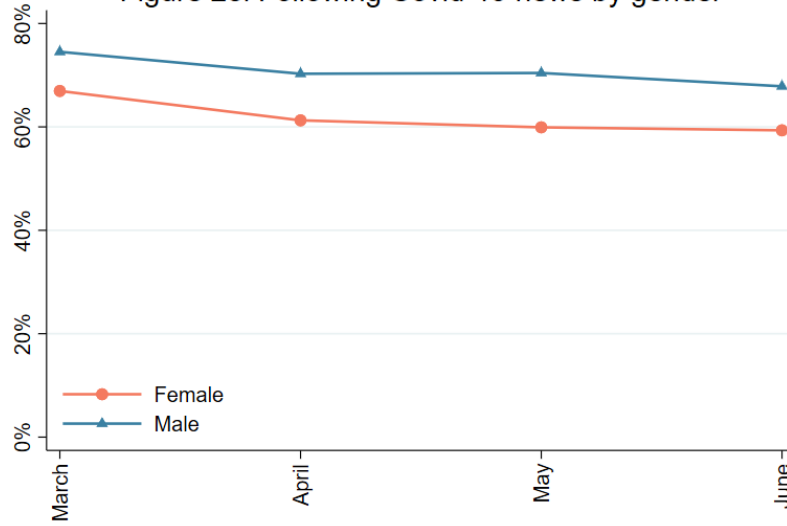


Figure 28j Following Covid-19 news by ethnicity

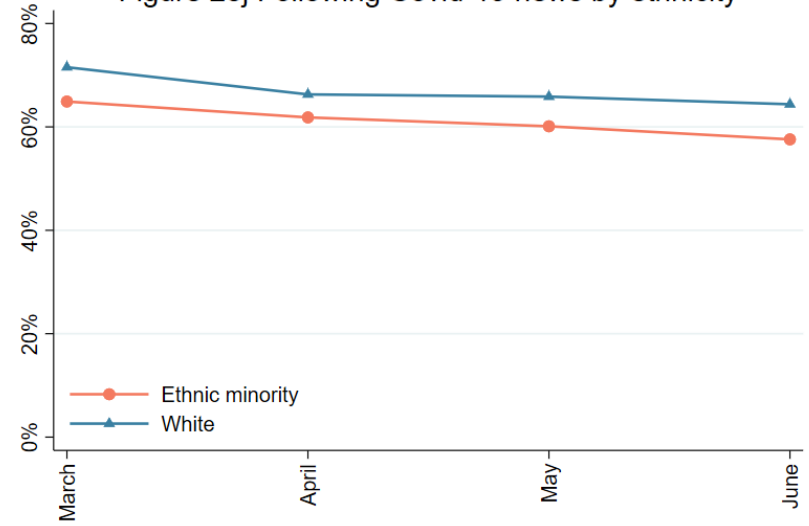


Figure 28k Following Covid-19 news by education levels

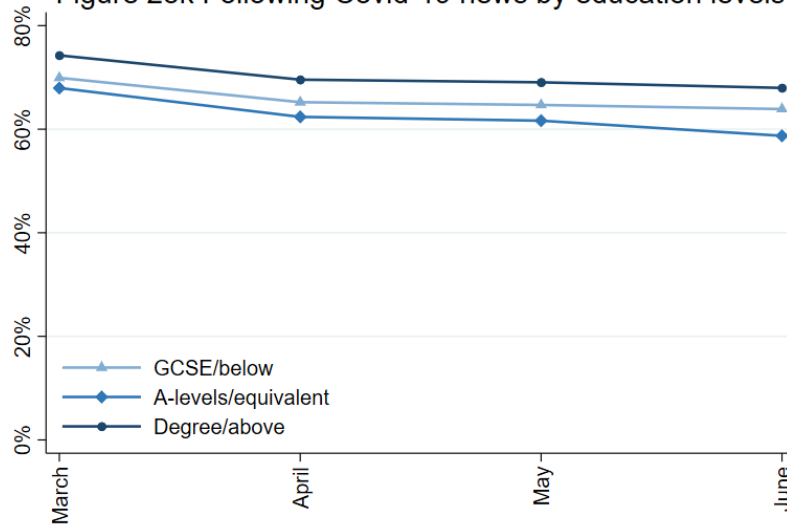
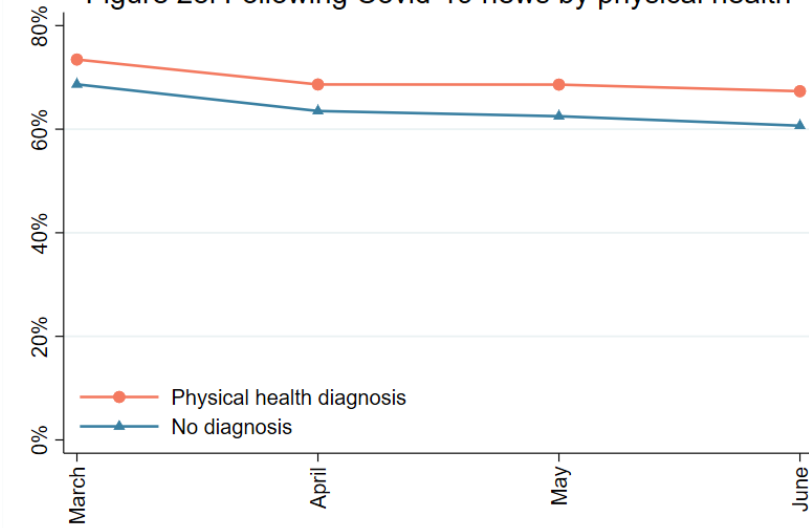


Figure 28l Following Covid-19 news by physical health



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 2020 to the 11th July 2021 (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	56,446	5.60	GCSE or below	142,381	14.1
30-59	549,818	54.5	A-levels of equivalent	173,946	17.3
60+	402,032	39.9	Degree or above	691,969	68.6
Gender			Any diagnosed mental health conditions		
Male	253,548	25.3	No	841,011	83.4
Female	750,742	74.8	Yes	167,285	16.6
Ethnicity			Any diagnosed physical health conditions		
White	965,781	96.1	No	578,312	57.4
Ethnic minority	39,338	3.91	Yes	429,984	42.6
UK nations			Keyworker		
England	813,738	81.5	No	799,428	79.3
Wales	122,912	12.3	Yes	208,868	20.7
Scotland	61,903	6.20	Living with children		
Living arrangement			No (excluding those who live alone)	574,413	72.3
Not living alone	794,580	78.8	Yes	220,167	27.7
Living alone	213,716	21.2	Living area		
Annual household income			Village/hamlet/isolated dwelling	253,799	25.2
>30k	539,457	59.4	City/large town/small town	754,497	74.8
<30k	368,420	40.6			