



# Covid-19 Social Study

## Results Release 10

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28<sup>th</sup> May 2020



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*The project has also benefitted from funding from UK Research and Innovation and the Wellcome Trust. The researchers are grateful for the support of a number of organisations with their recruitment efforts including: the UKRI Mental Health Networks, Find Out Now, UCL BioResource, HealthWise Wales, SEO Works, FieldworkHub, and Optimal Workshop.*

# Executive summary

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## Background

This report provides data from Week 10 of the UK COVID-19 Social Study run by University College London: a panel study of over 90,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this TENTH report, we focus on psychological responses to the first nine weeks of government measures requiring people to stay at home (21/03-25/05). We present simple descriptive results on the experiences of adults in the UK. **Crucially, in this report we include keyworkers within our main sample and present sub-group analyses for more socio-demographic groups.** 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 and loneliness
5. \*\*\*New in this report\*\*\* Dysfunctional anxiety relating to COVID-19

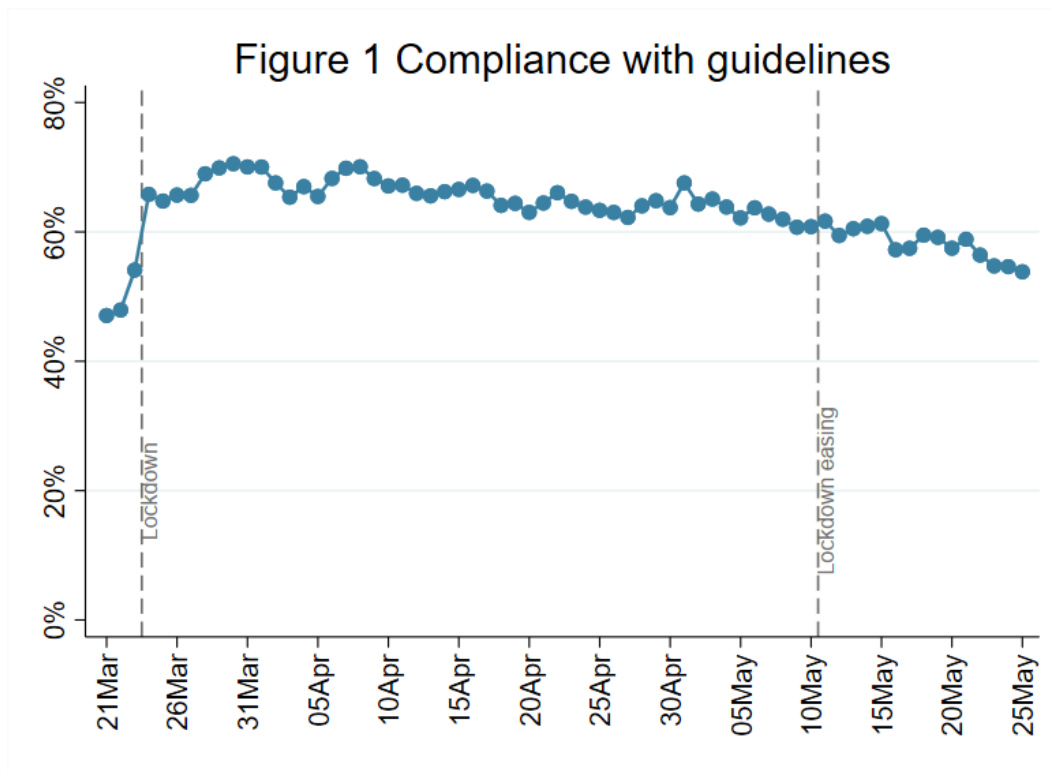
This study is not representative of the UK population but instead was designed to have good stratification across a wide range of socio-demographic factors enabling meaningful subgroup analyses to understand the experience of Covid-19 for different groups within society. Data are weighted using auxiliary 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. The study is still recruiting and people can take part by visiting [www.COVIDSocialStudy.org](http://www.COVIDSocialStudy.org)

## Findings

- There is still no evidence of any changes in mental health in response to the first stage of the easing of lockdown two weeks ago in England.
- However, compliance with government advice has decreased yet further, with just 40% of young people in the study now reporting complete adherence to guidelines.
- Confidence in government to handle the pandemic has fallen in England since the easing of lockdown was announced but not in devolved nations, and in particular over the bank holiday weekend.
- Anxiety levels and depression levels remain relatively stable. Both appear higher than usual reported averages.
- Stressors relating to Covid-19 (both catching Covid-19 and becoming seriously ill from Covid-19, accessing food, finance and unemployment remain relatively low and stable.
- Care keyworkers (those working in health and social care) are showing similar experiences to people in lockdown at home, although they are less worried about unemployment.
- The majority of people (69%) are not experiencing physiological symptoms of anxiety when thinking about Covid-19 (such as loss of appetite, nausea, dizziness or sleep disturbance). However, 29% are experiencing some physiological anxiety symptoms, and 2% are experiencing symptoms indicative of dysfunctional anxiety. Physiological anxiety is worse in younger adults, people with mental illness, and those living with children.
- Thoughts of death or self-harm, experience of self-harm or abuse, and loneliness remain relatively stable but are higher amongst younger people and also amongst those who live alone.
- Life satisfaction is still lower than usual levels but is higher than when lockdown started and has plateaued over the past month following an increase after lockdown commenced.

# 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 (completely). Of note, we ask participants to self-report their compliance, which relies on participants understanding the regulations. Figure 1 shows the percentage of people who followed the recommendations “completely” (with a score of 7).

“Complete” compliance has decreased even further in the past week, moving from averages of 70% ‘completely’ adhering, to scores in the 50%. A higher majority of participants report overall ‘good’ compliance (scores 5-7 out of 7; not shown here). It remains lower in younger adults, where it is now down to 40% complete compliance (see Figs 2). There is little difference depending on whether people are living with children or not<sup>1</sup>.

Compliance is recorded as slightly lower in care keyworkers, but this is likely due to them being unable to follow the recommendations due to the demands of their work. **Of note we focus this week more specifically on “care keyworkers” (those working in health and social care) vs all other people.**

<sup>1</sup> NB for all figures on ‘living with children’ in the report (figures ‘g’), data are restricted to people living with others (i.e. excluding people living alone) such that comparisons show people living with children (with or without other adults) vs living just with adults.

Figure 2a Compliance by age groups

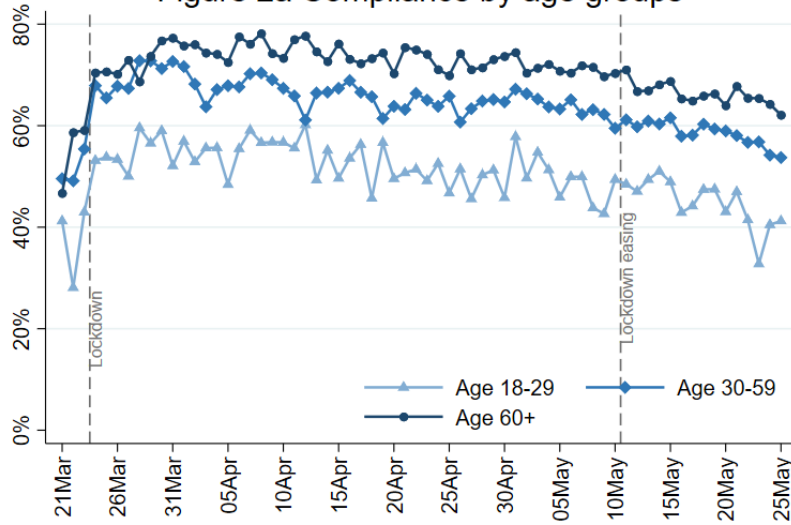


Figure 2b Compliance by living arrangement

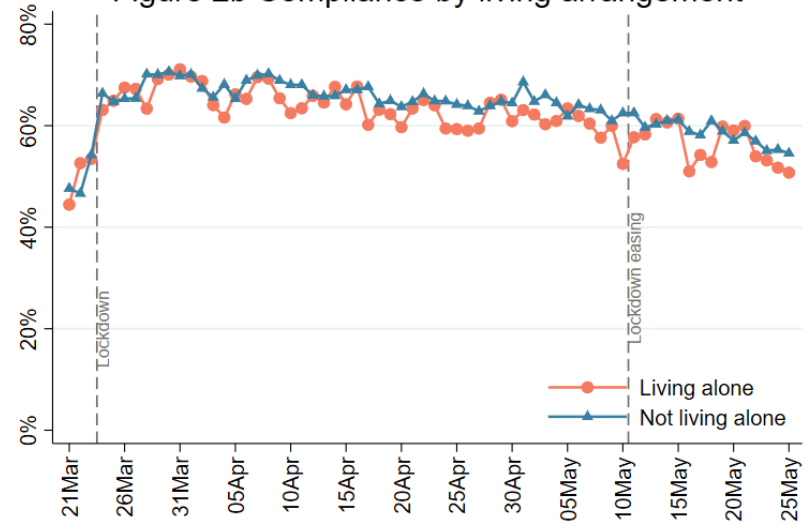


Figure 2c Compliance by household income

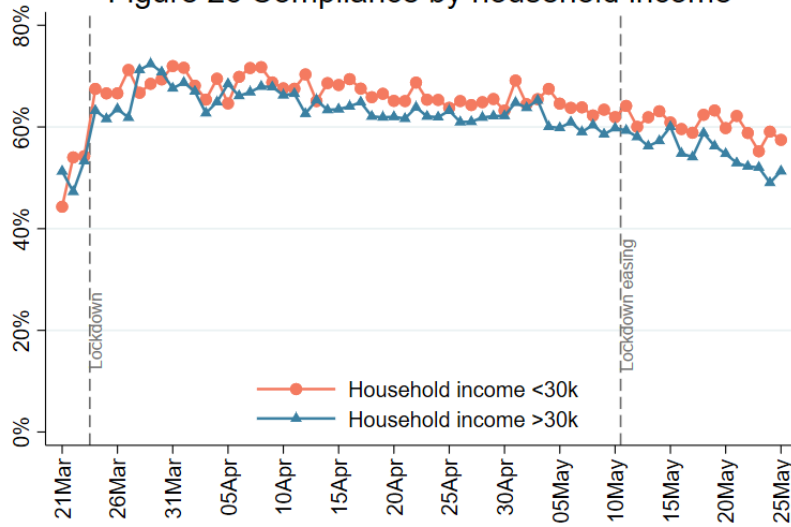


Figure 2d Compliance by mental health diagnosis

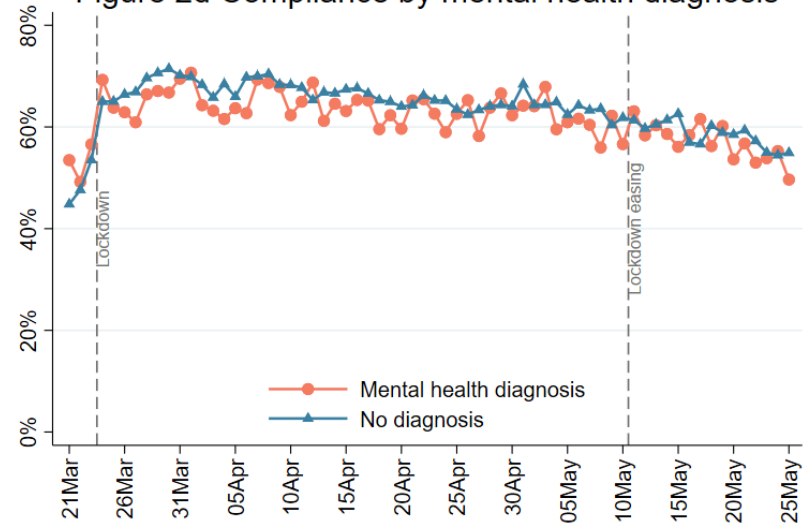


Figure 2e Compliance by nations

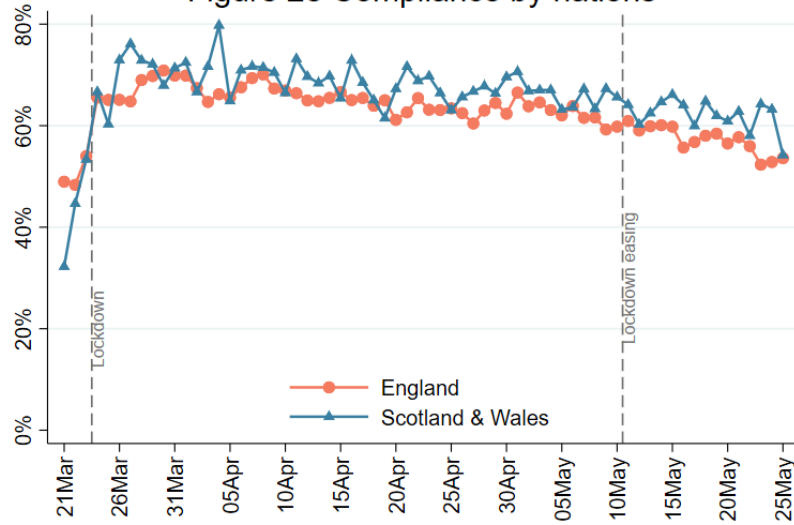


Figure 2f Compliance by care keyworker status

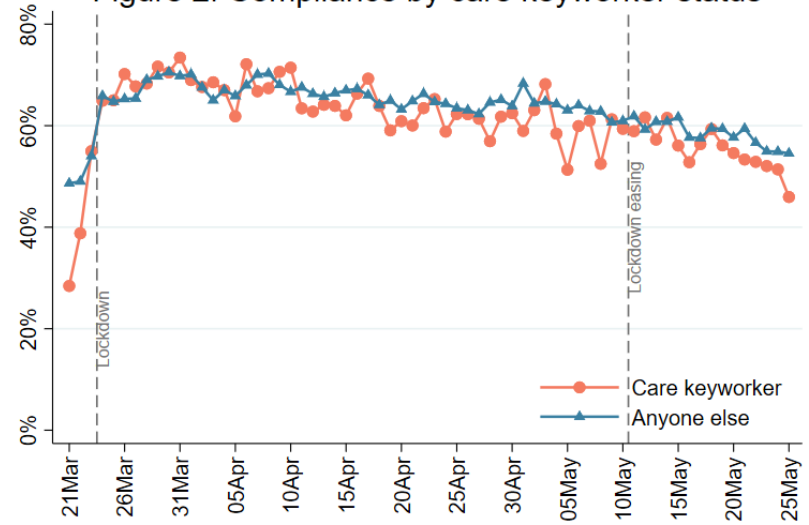


Figure 2g Compliance by living with children

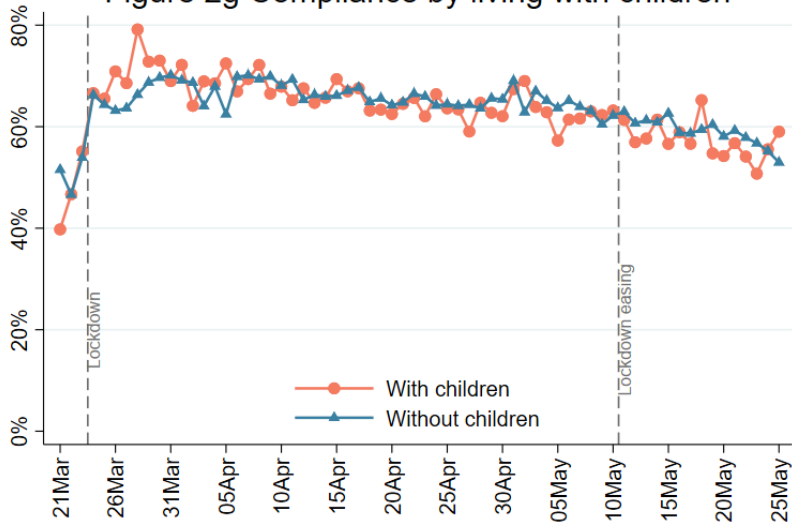
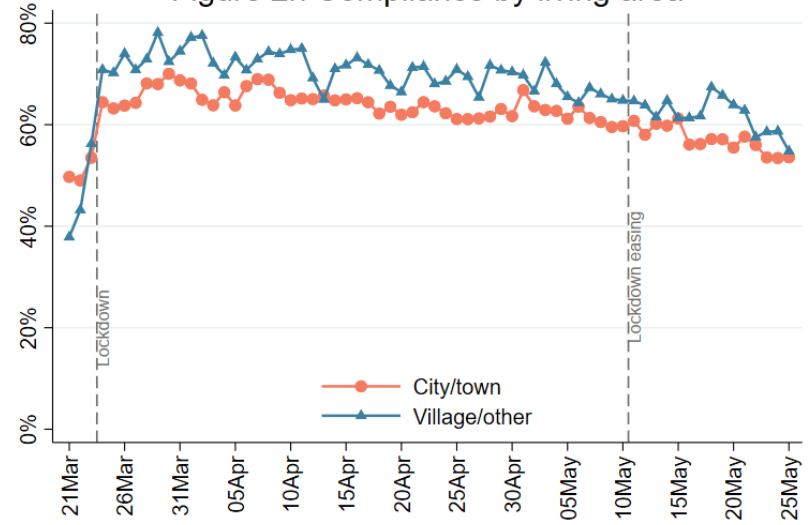
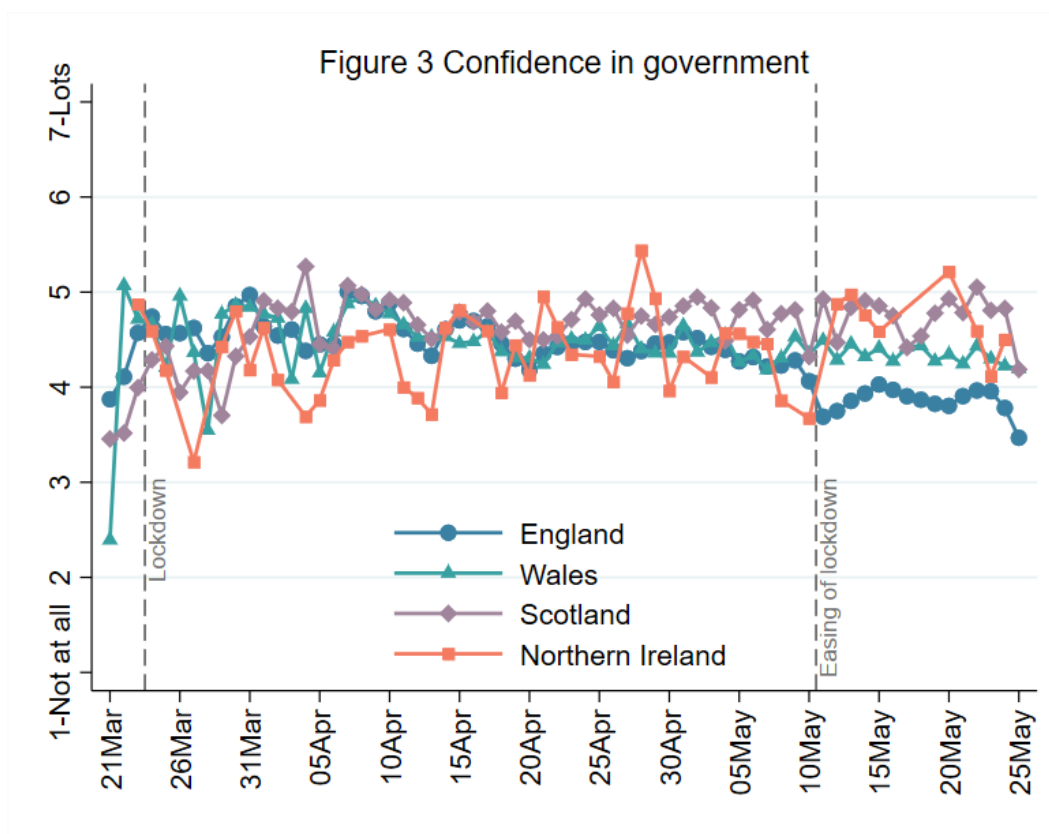


Figure 2h Compliance by living area



## 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.

There has been a further decrease in confidence in the central government to handle the Covid-19 epidemic over the bank holiday weekend (as shown by responses from participants in England). Confidence in government remains higher in devolved nations.<sup>2</sup> When comparing England (where lockdown has eased) to Scotland and Wales (Fig 4e), confidence in government was similar up to the easing of lockdown but has since declined in England and stayed lower even prior to the bank holiday weekend.

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 (future analyses will look at subgroups in devolved nations). In England, confidence in government has fallen most notably in younger adults, and is lowest in those under the age of 30. Confidence is also lower in urban areas and in people with a mental health diagnosis. There is not much difference in confidence level depending on living condition.

<sup>2</sup> Figures for Northern Ireland show greater volatility but this is likely a function of the sample size in Northern Ireland being smaller than for other countries.

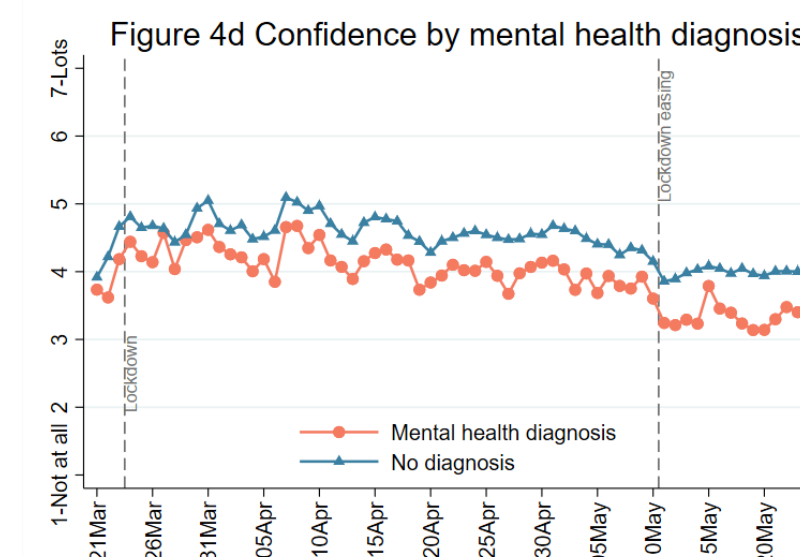
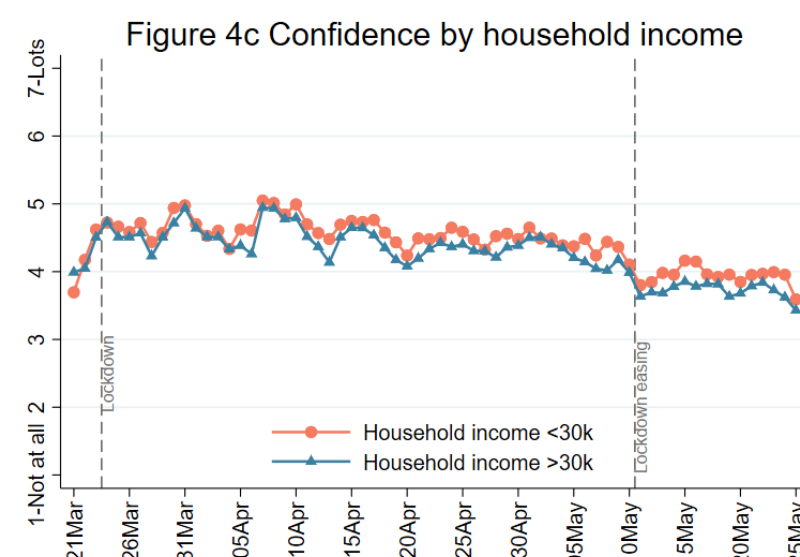
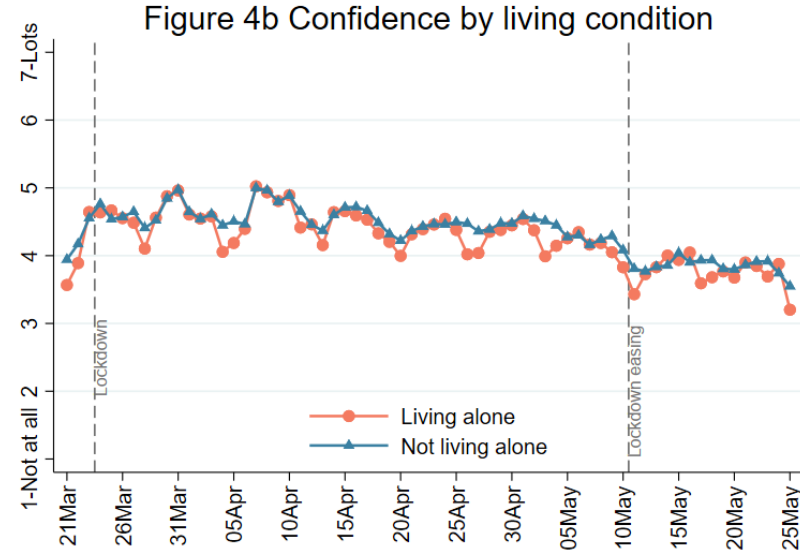
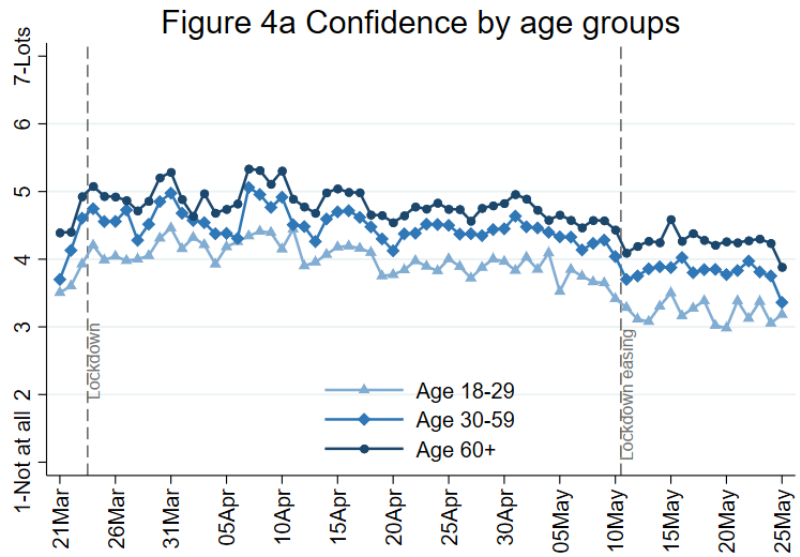




Figure 4e Confidence by nations

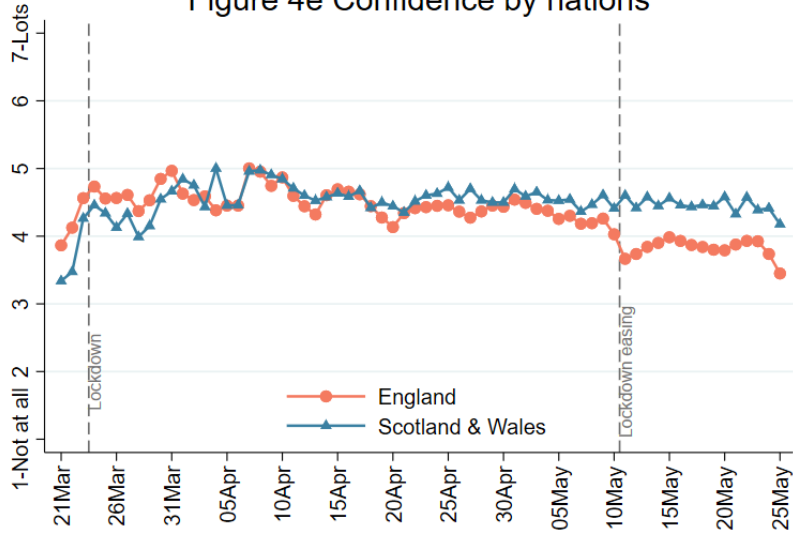


Figure 4f Confidence by key-worker status

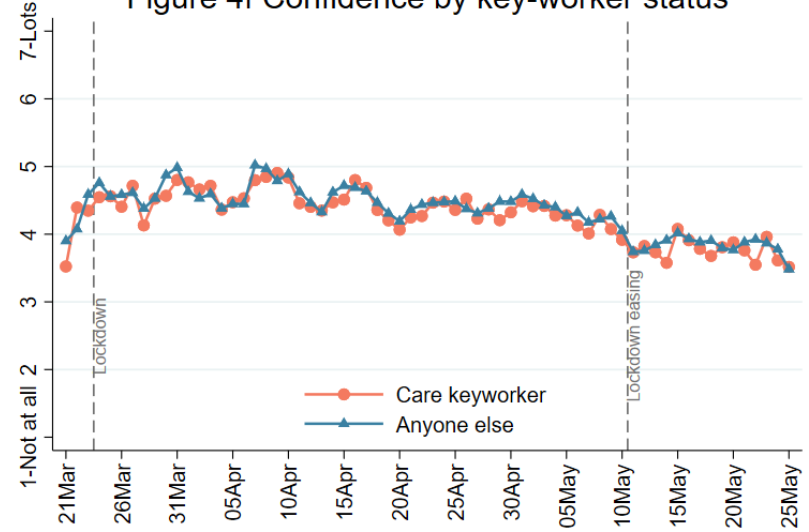


Figure 4g Confidence by living with children

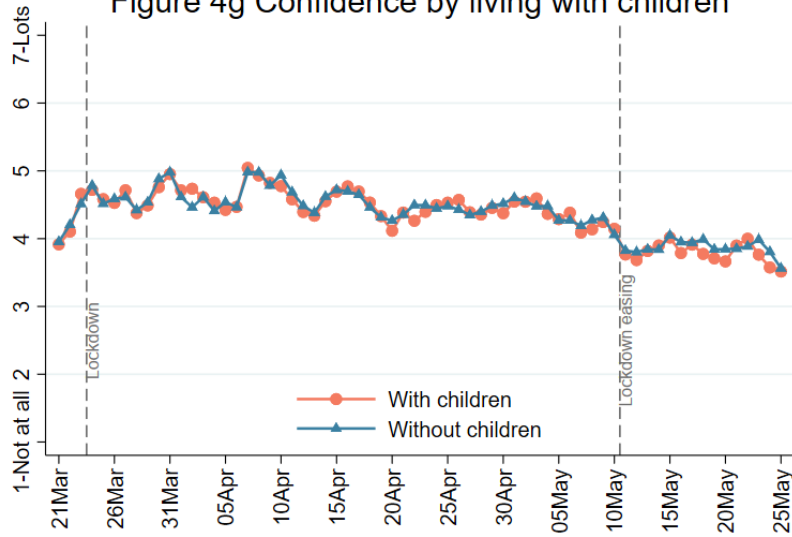
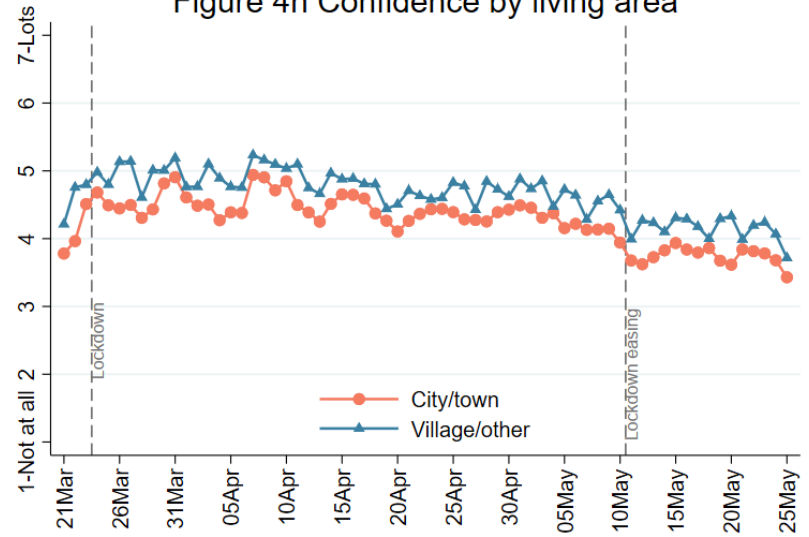
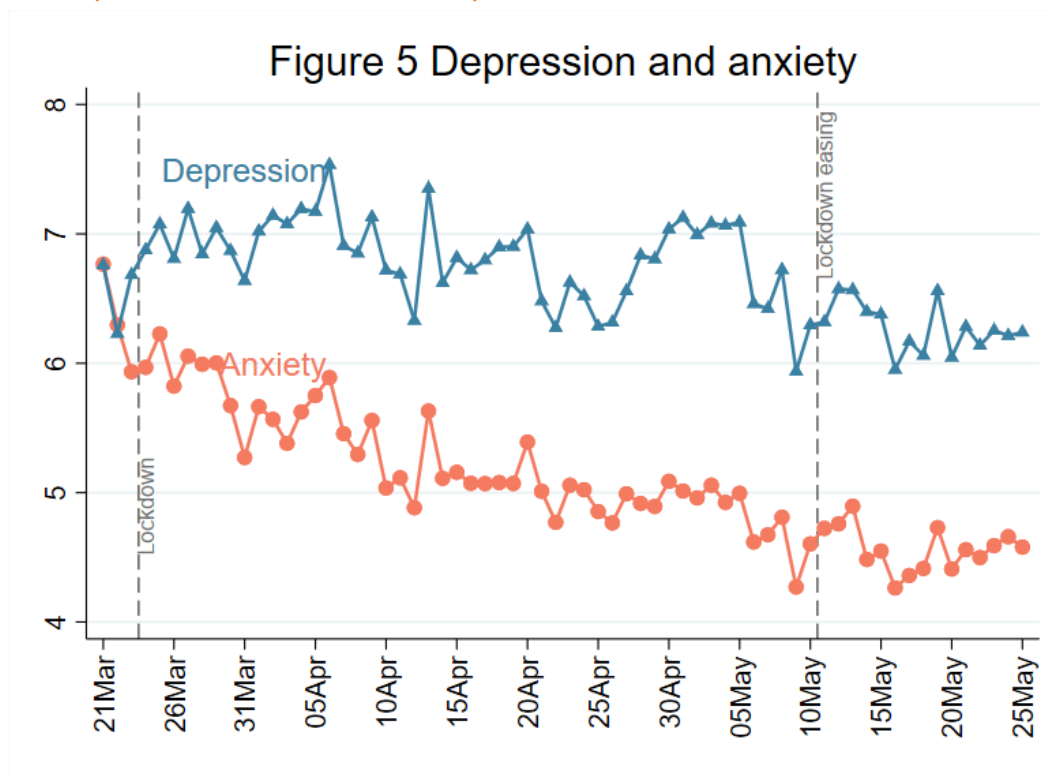


Figure 4h Confidence by living area



## 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.

There remain no changes in anxiety or depression since the first easing of lockdown. Although this study focuses on trajectories rather than prevalence, it is noted that 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 depression<sup>3</sup>). Depression and anxiety are highest still in young people, those living alone, those with lower household income, people with a diagnosed mental illness, people living with children, and people living in urban areas.

<sup>3</sup> 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

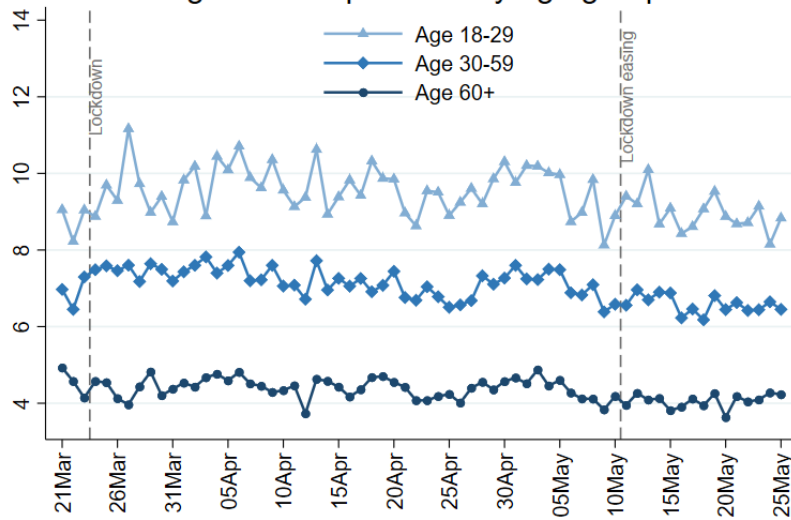


Figure 6b Depression by living arrangement

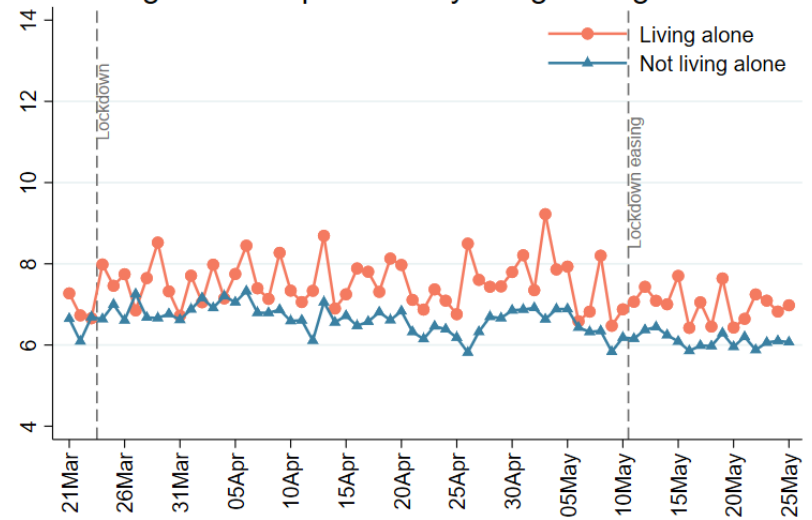


Figure 6c Depression by household income

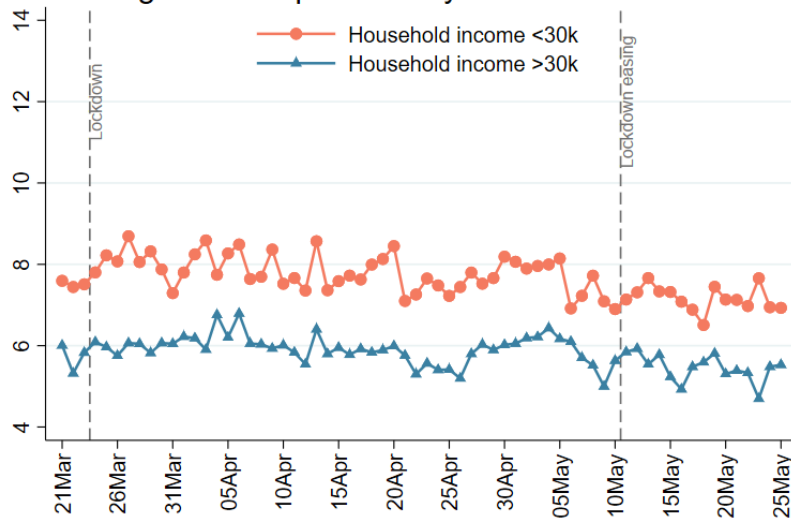


Figure 6d Depression by mental health diagnosis

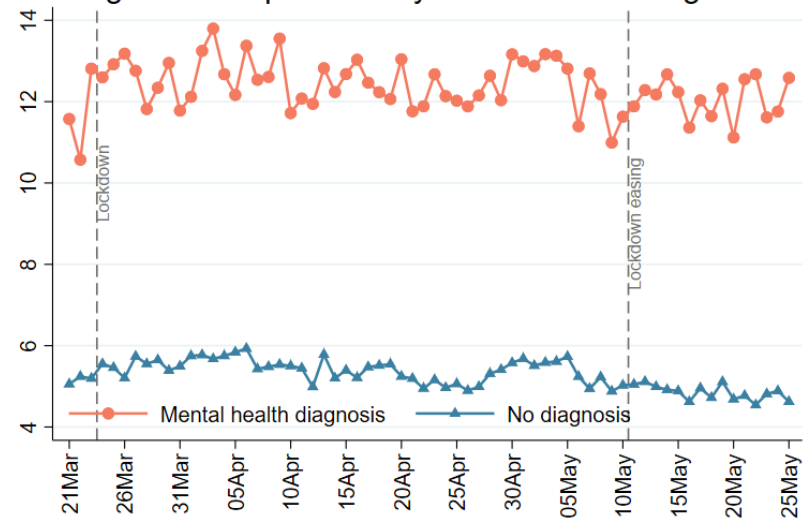


Figure 6e Depression by nations

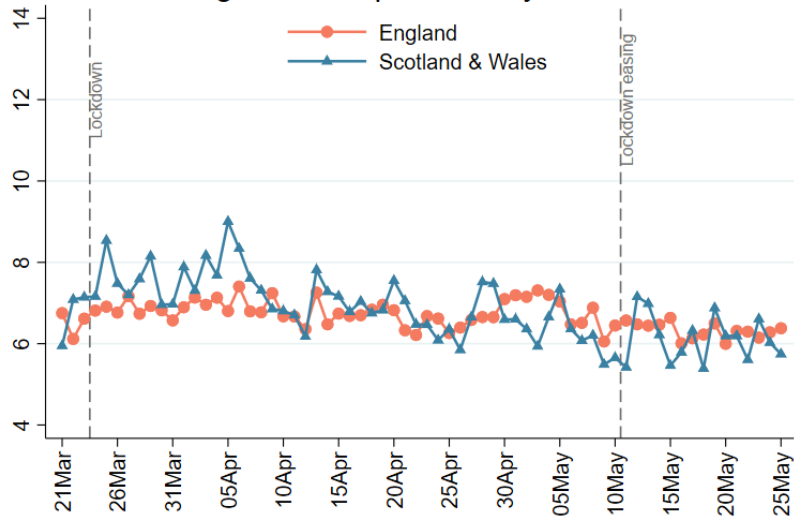


Figure 6f Depression by care keyworker status

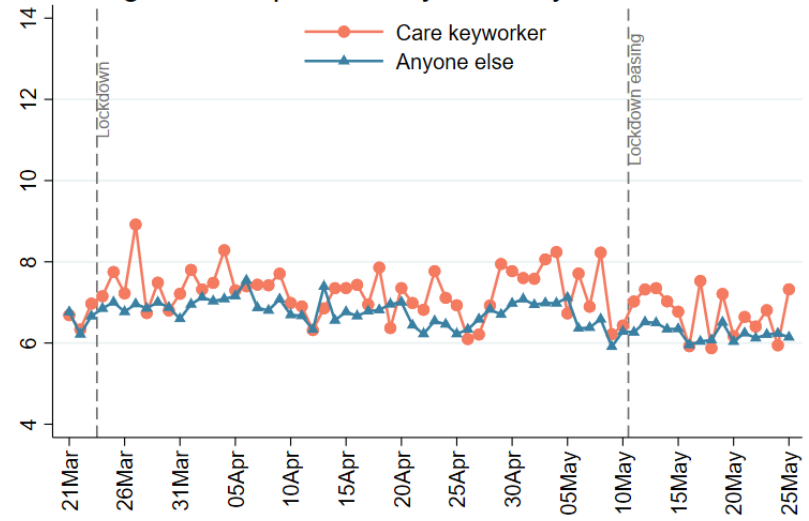


Figure 6g Depression by living with children

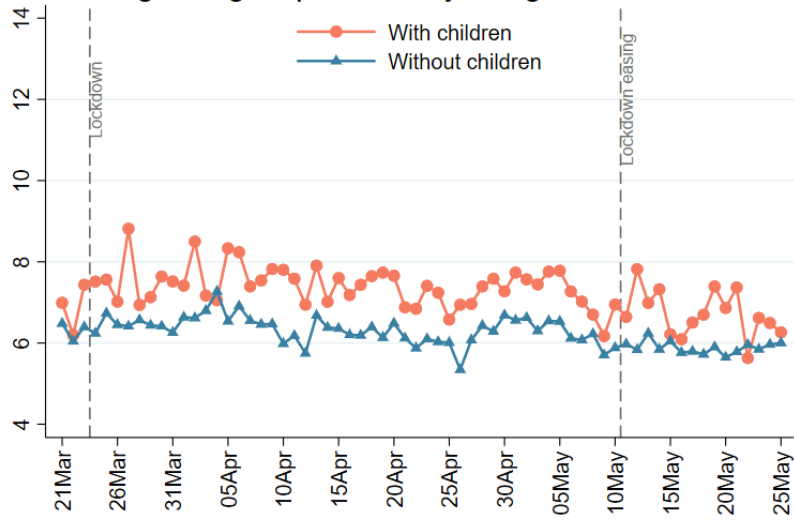


Figure 6h Depression by living area

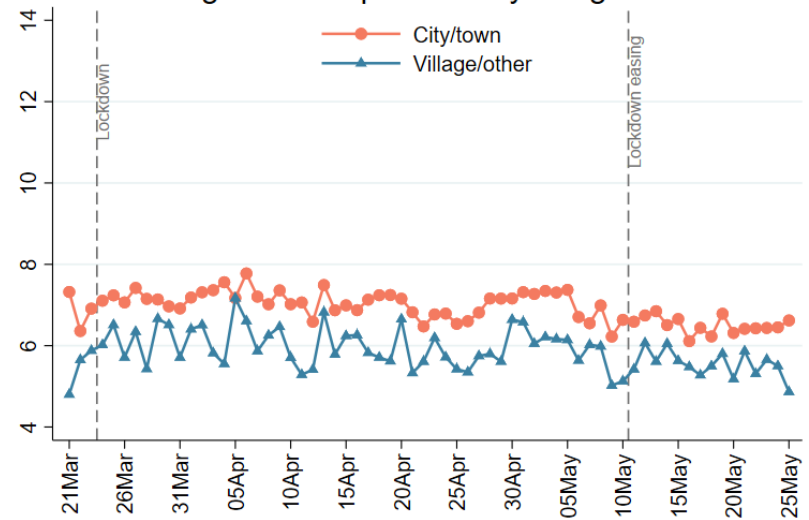


Figure 7a Anxiety by age groups

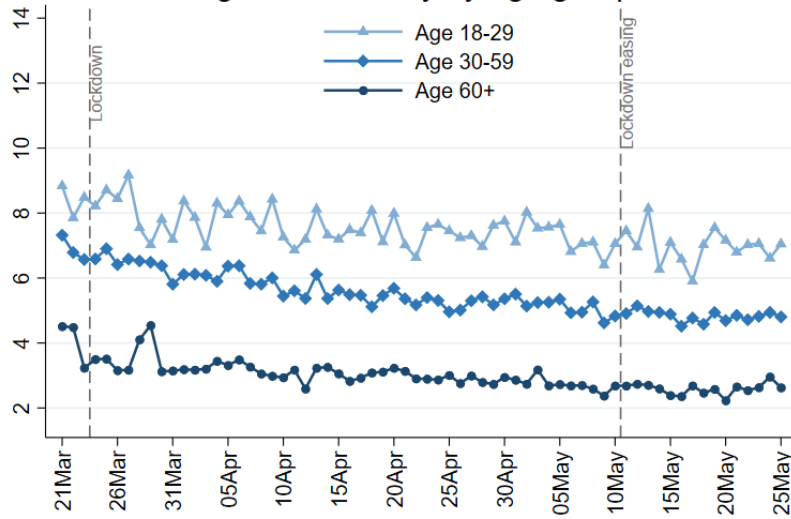


Figure 7b Anxiety by living arrangement

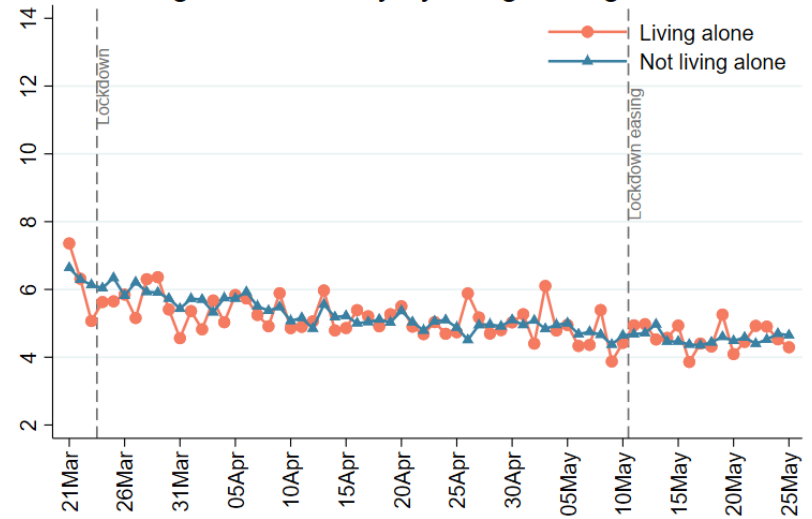


Figure 7c Anxiety by household income

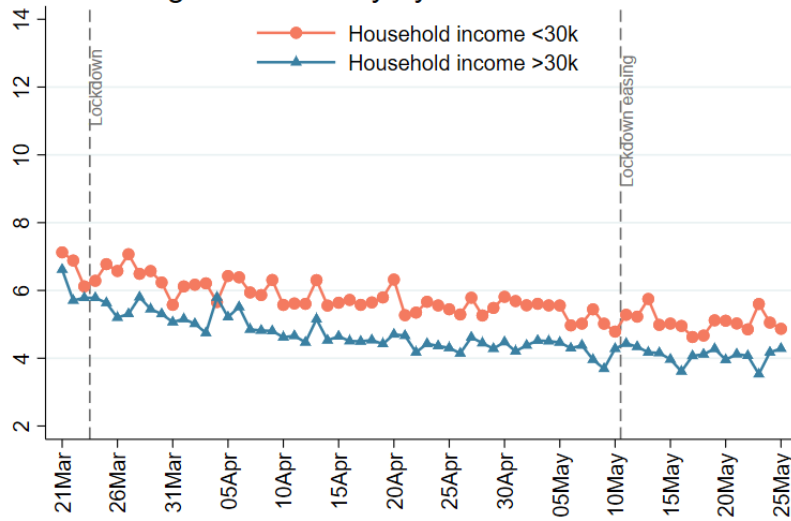


Figure 7d Anxiety by mental health diagnosis

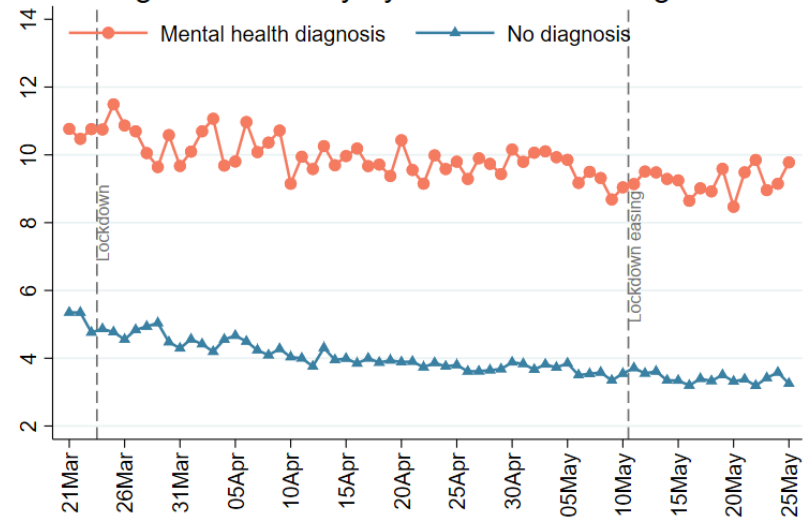


Figure 7e Anxiety by nations

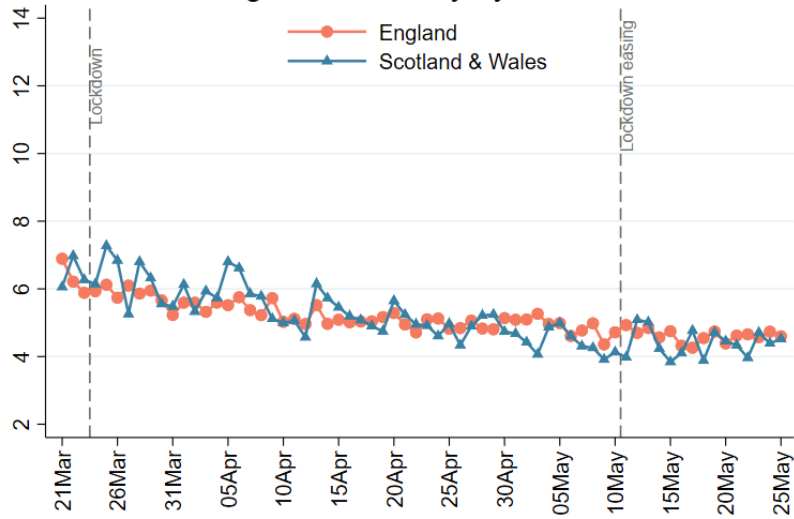


Figure 7f Anxiety by care keyworker status

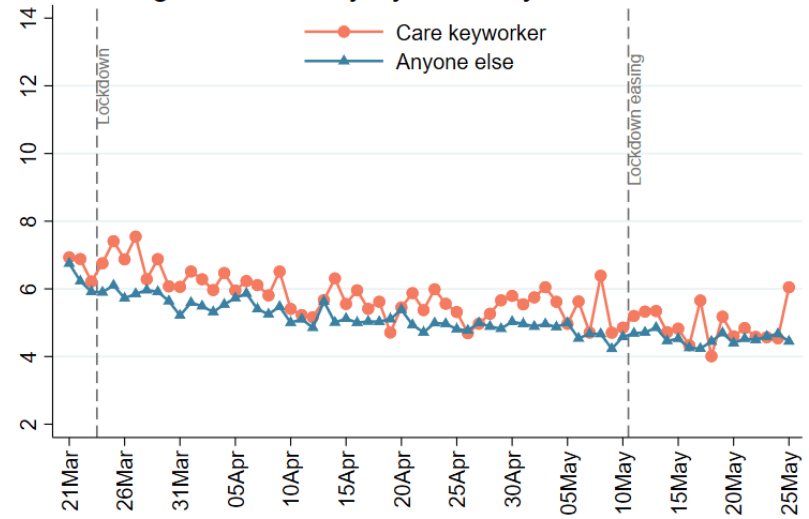


Figure 7g Anxiety by living with children

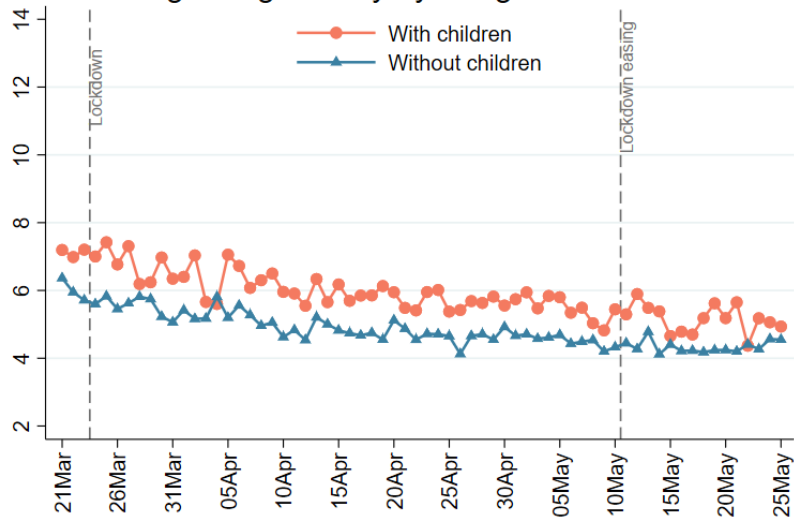
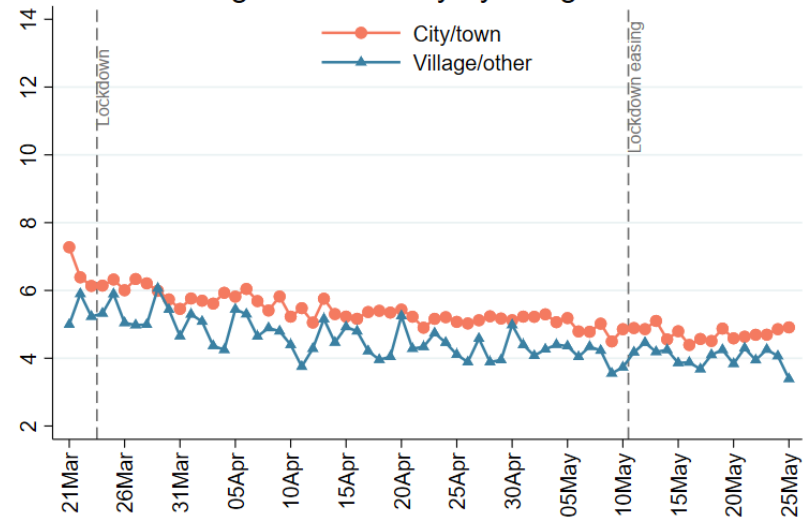
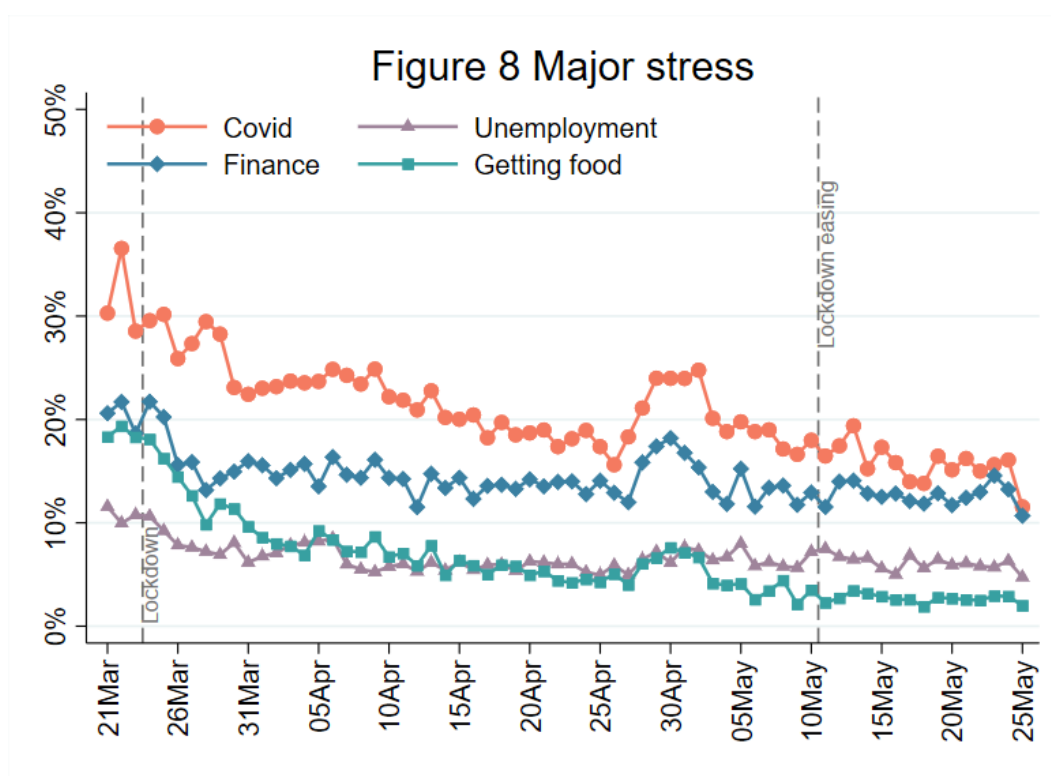


Figure 7h Anxiety by living area



## 2.2 Stress



### FINDINGS

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

Stress relating to Covid-19 (both catching Covid-19 and becoming seriously ill from Covid-19) has stayed low in the past week, with only 1 in 6 people now worried about it.

Worries about unemployment remain relatively stable, with around 1 in 12 people worried. These levels are similar across most demographics, although higher in those under 60 and those with a mental health diagnosis.

Around 1 in 8 people are worried about finances, with these levels higher in people under the age of 60, with lower household incomes, living with children, and with a mental health diagnosis.

Stress relating to accessing food (food security) has stabilised in the past week, with fewer than 1 in 20 people now worried about it.

**There continues to be no change in stressors since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figures 9e-12e).**

Figure 9a Covid-19 stress by age groups

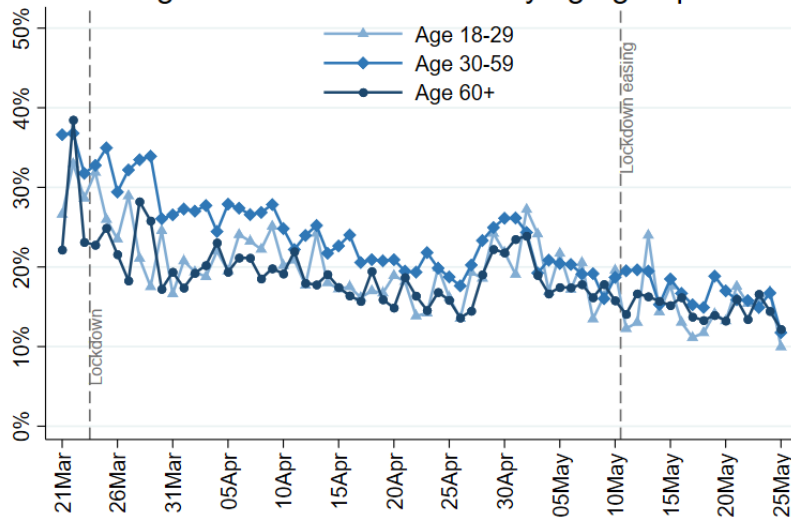


Figure 9b Covid-19 stress by living arrangement

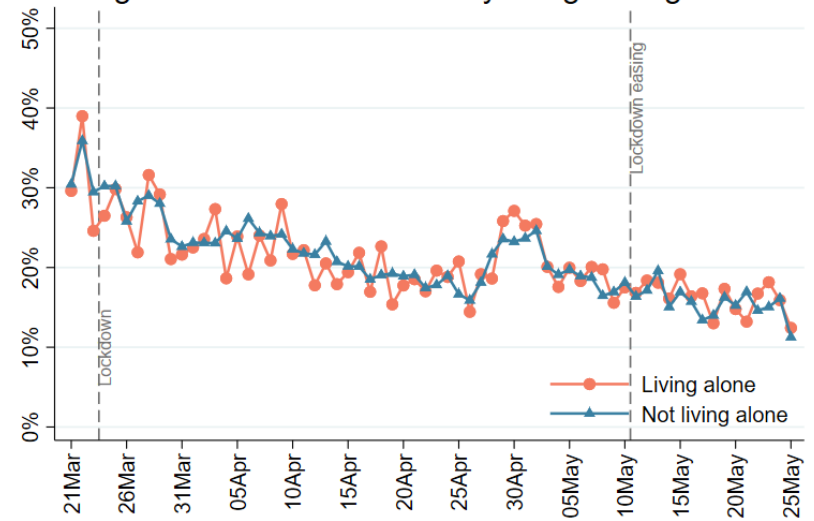


Figure 9c Covid-19 stress by household income

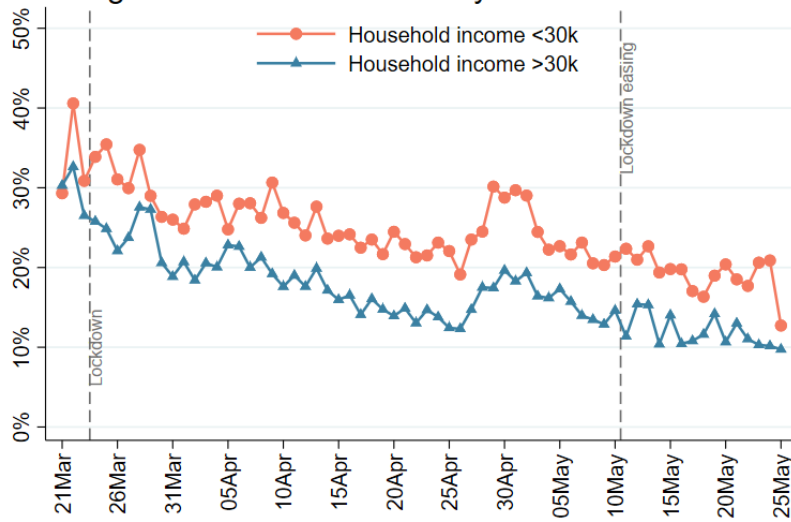


Figure 9d Covid-19 stress by mental health diagnosis

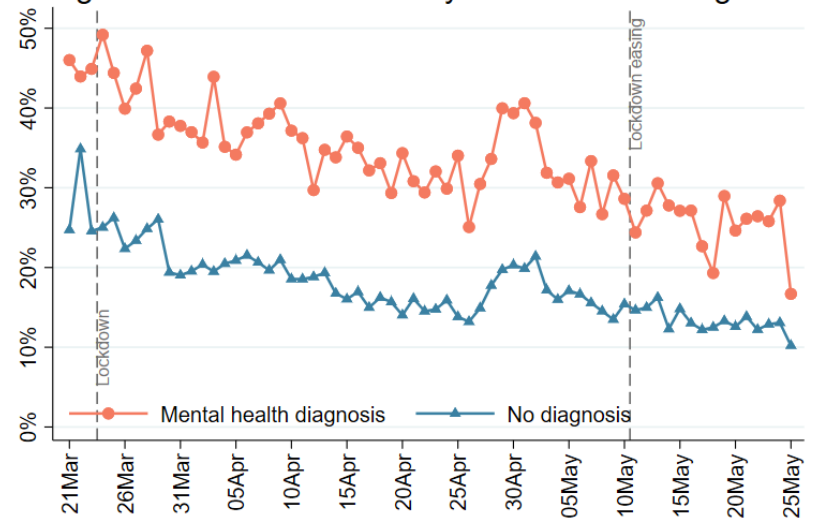




Figure 9e Covid-19 stress by nations

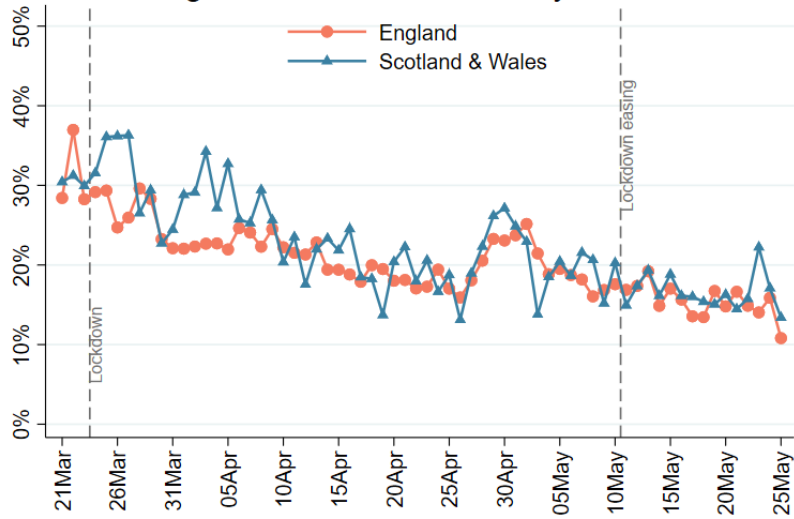


Figure 9f Covid-19 stress by care keyworker status

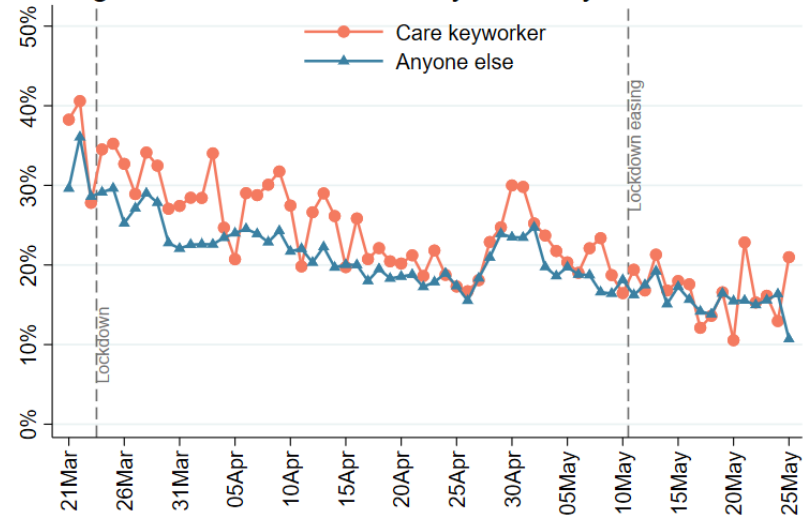


Figure 9g Covid-19 stress by living with children

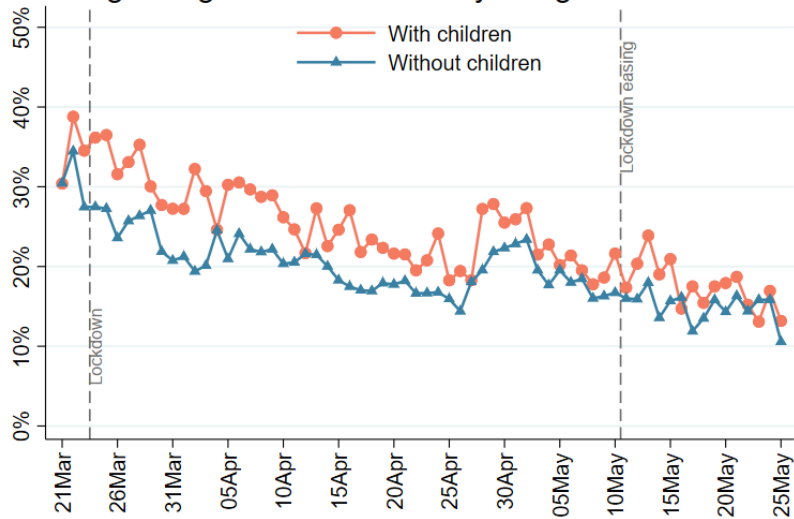


Figure 9h Covid-19 stress by living area

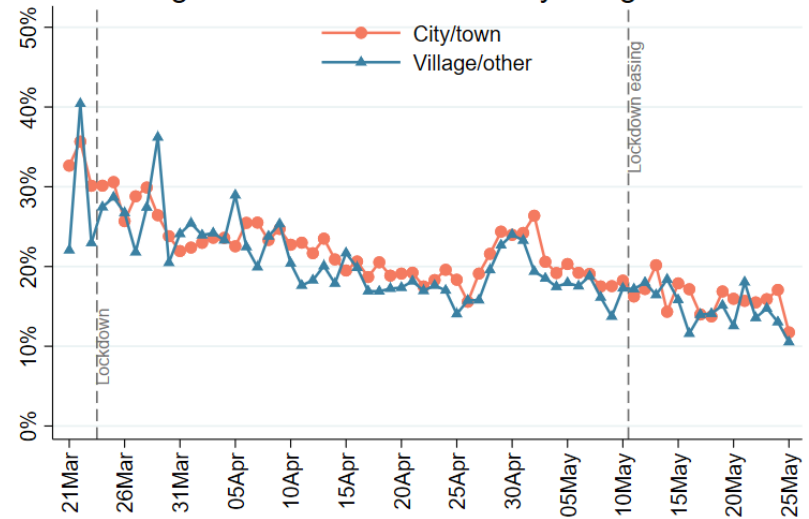


Figure 10a Unemployment stress by age groups

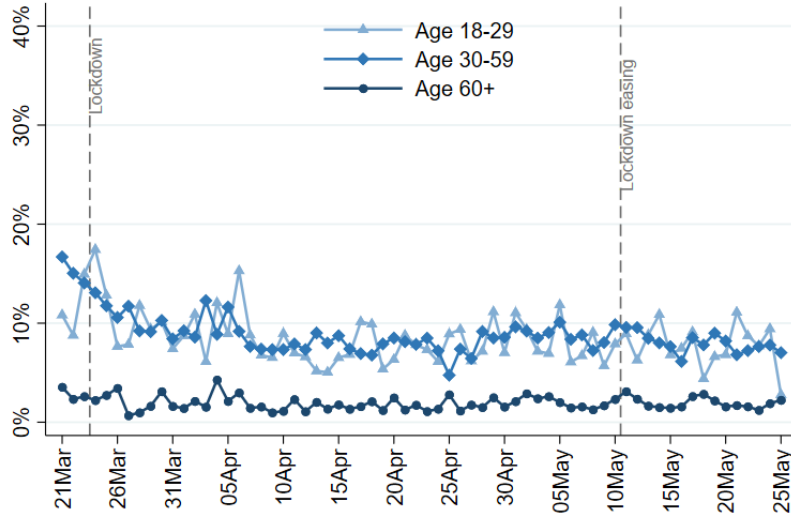


Figure 10b Unemployment stress by living arrangement

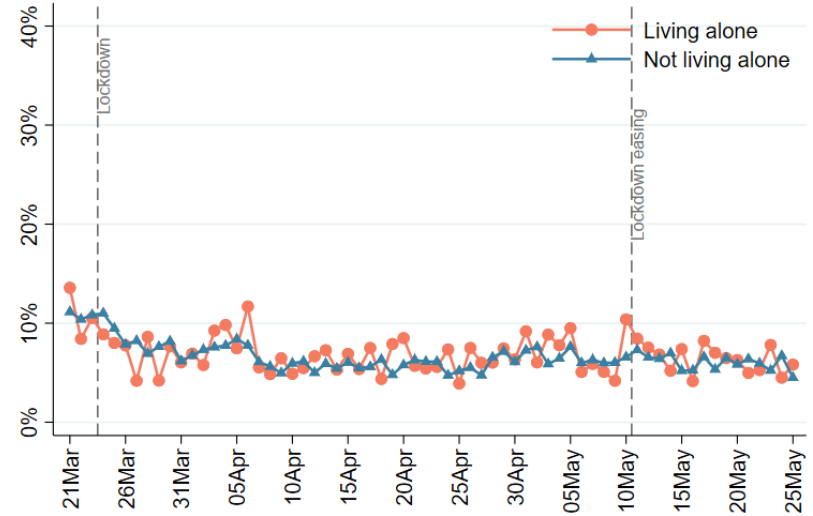


Figure 10c Unemployment stress by household income

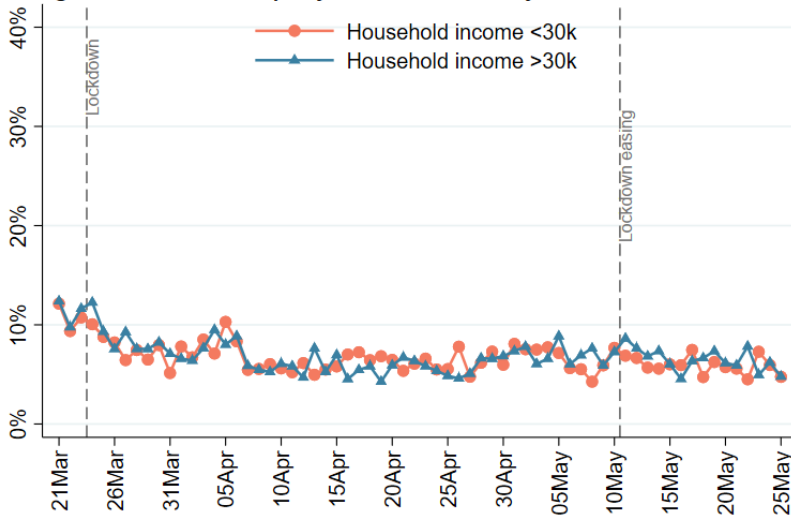


Figure 10d Unemployment stress by mental health

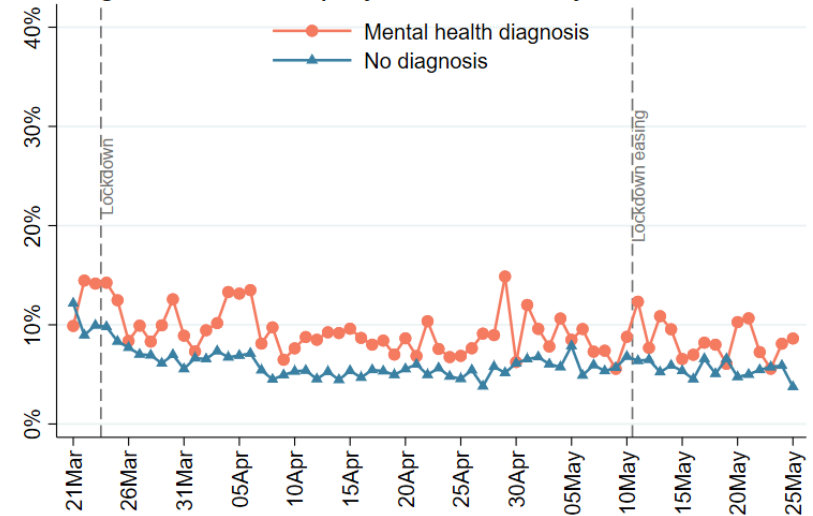


Figure 10e Unemployment stress by nations

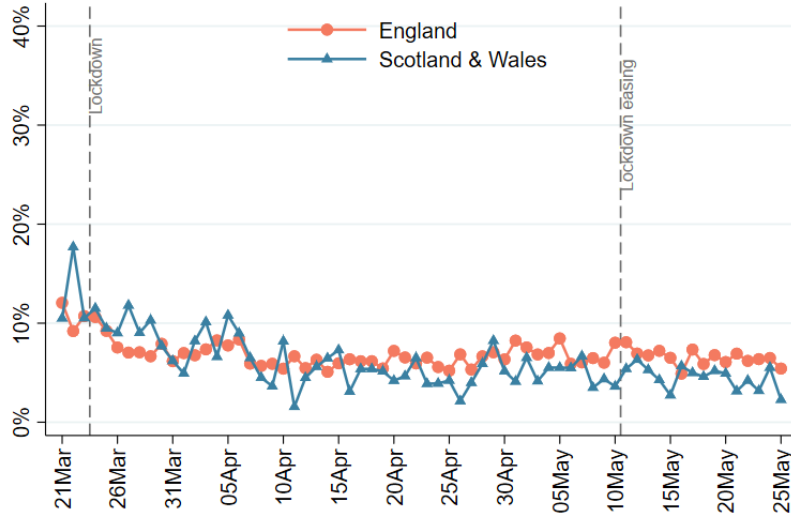


Figure 10f Unemployment stress by keyworker status

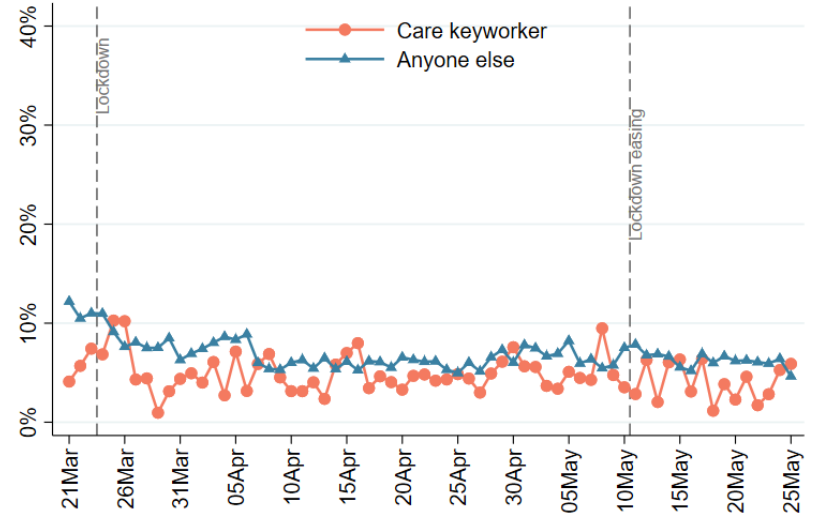


Figure 10g Unemployment stress by living with children

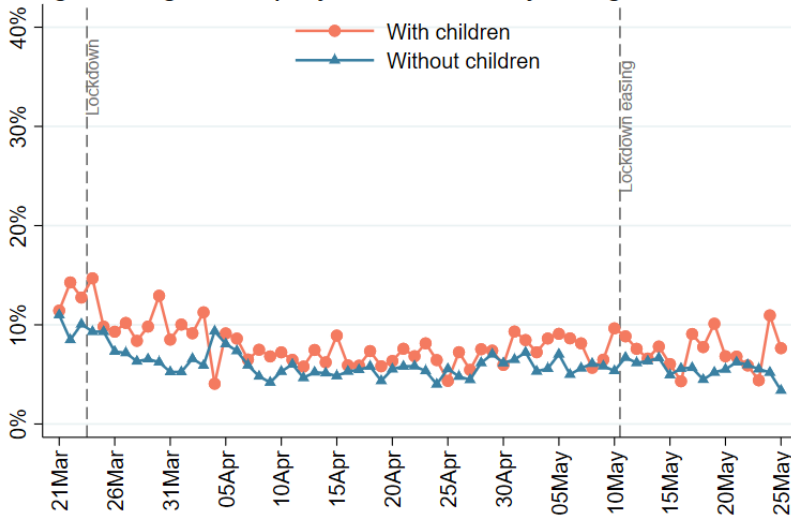


Figure 10h Unemployment stress by living area

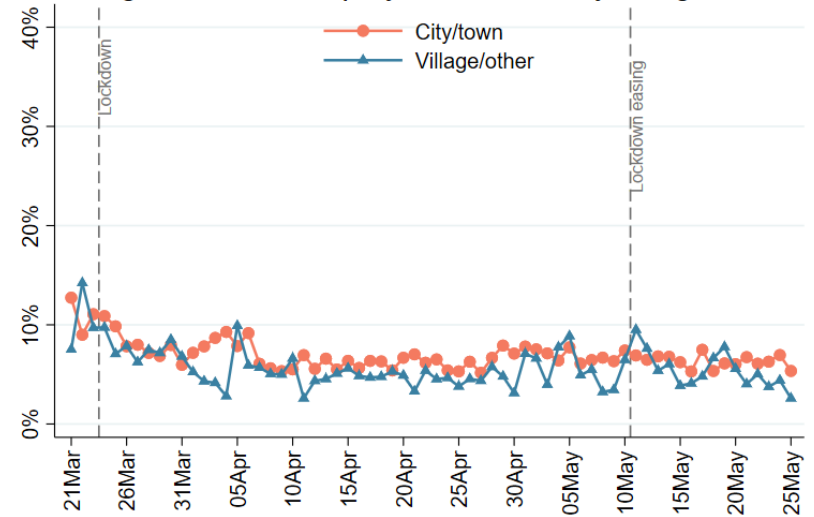


Figure 11a Financial stress by age groups

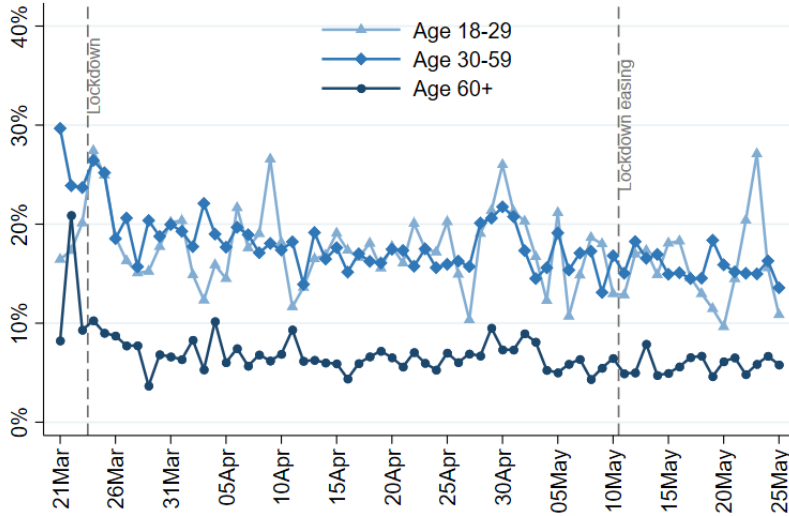


Figure 11b Financial stress by living arrangement

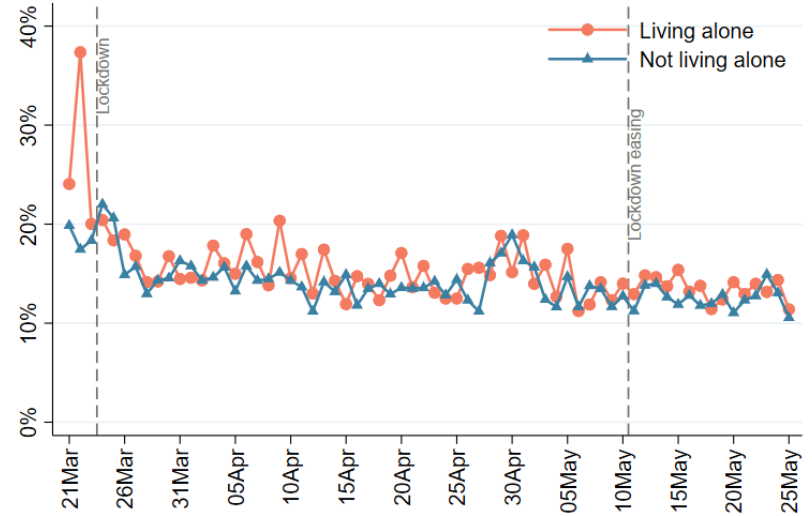


Figure 11c Financial stress by household income

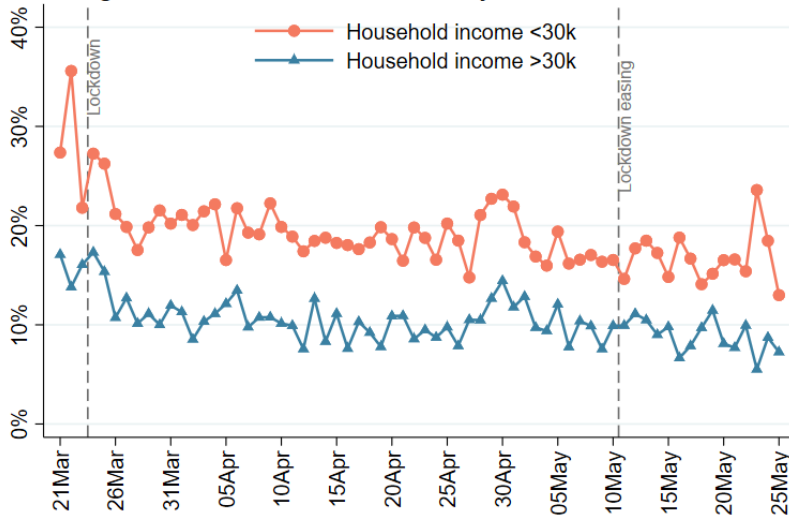


Figure 11d Financial stress by mental health diagnosis

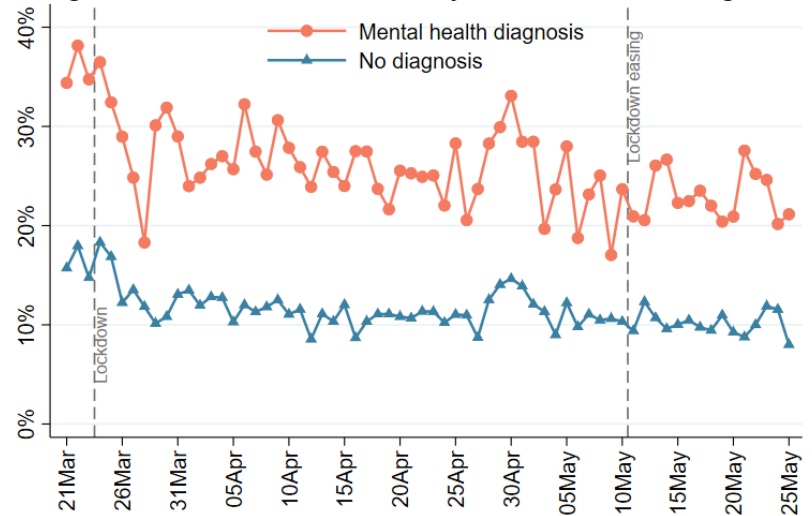


Figure 11e Financial stress by nations

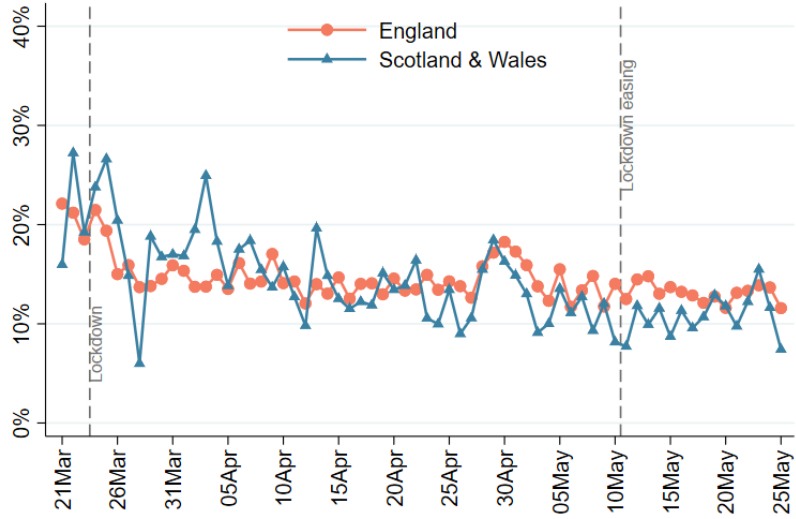


Figure 11f Financial stress by care keyworker status

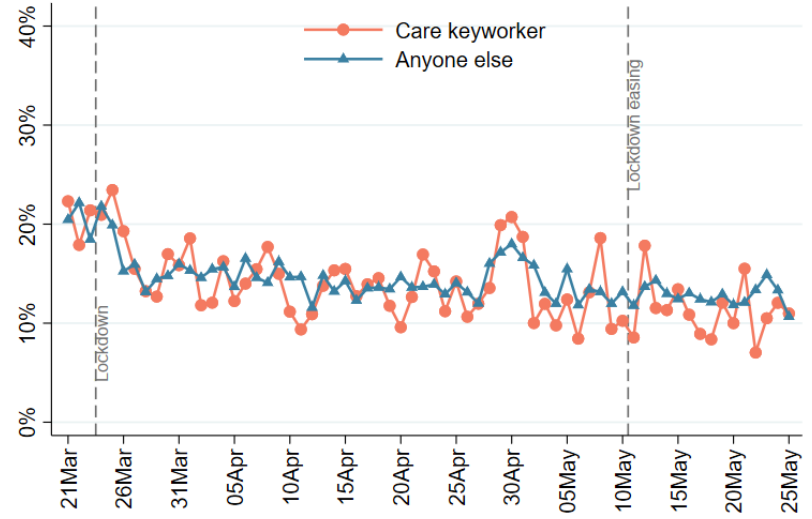


Figure 11g Financial stress by living with children

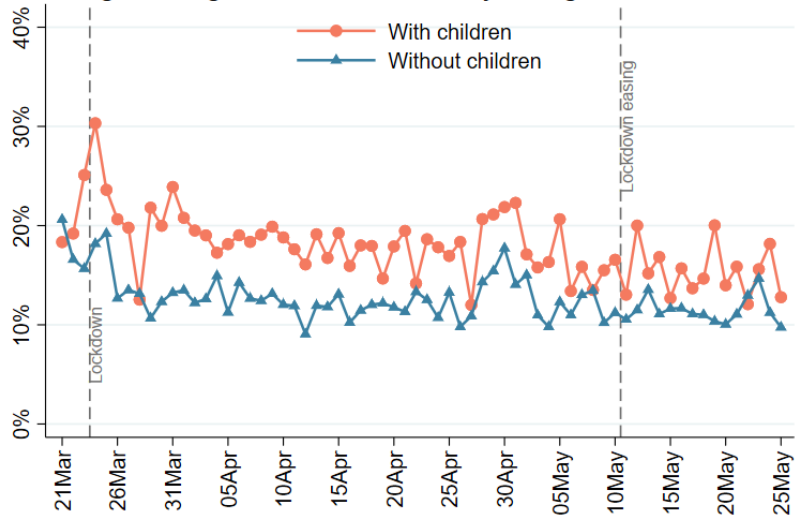


Figure 11h Financial stress by living area

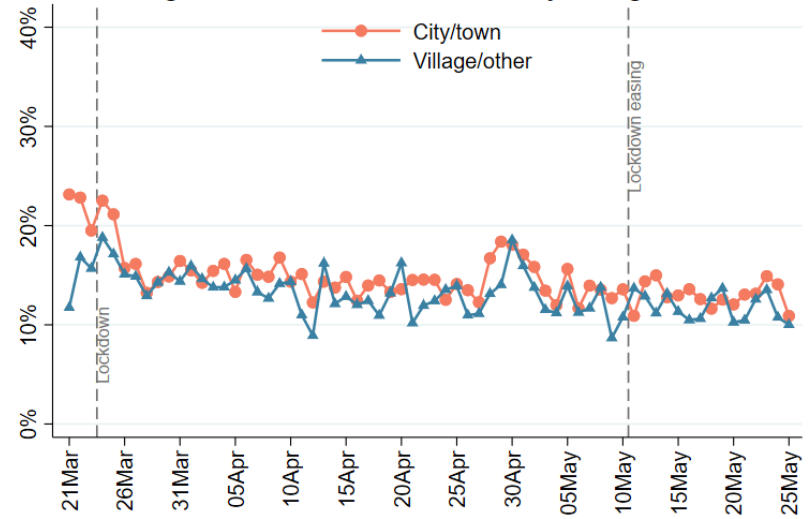


Figure 12a Food security stress by age groups

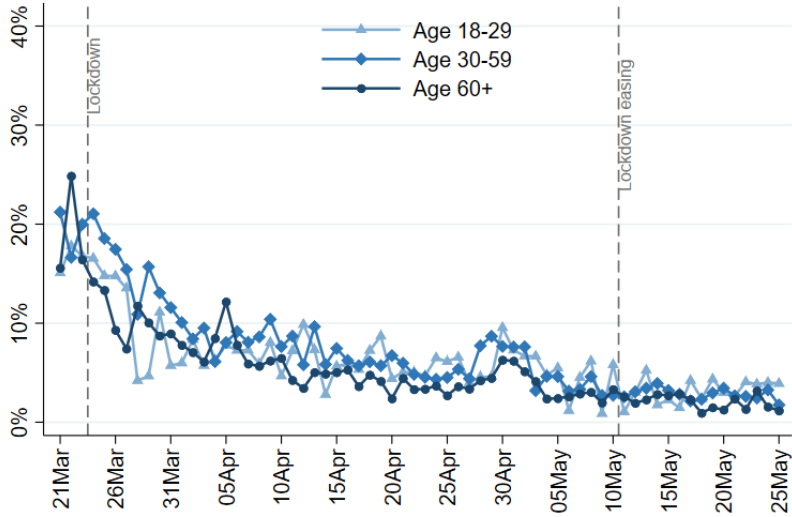


Figure 12b Food security stress by living arrangement

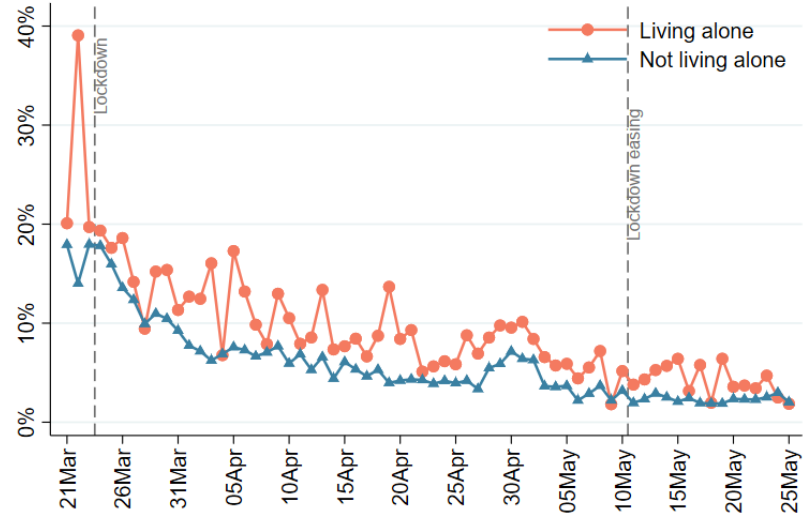


Figure 12c Food security stress by household income

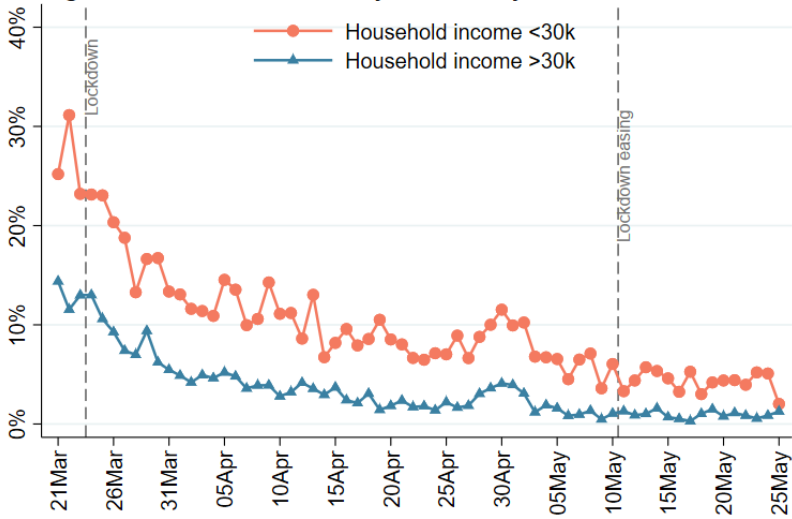


Figure 12d Food security stress by mental health

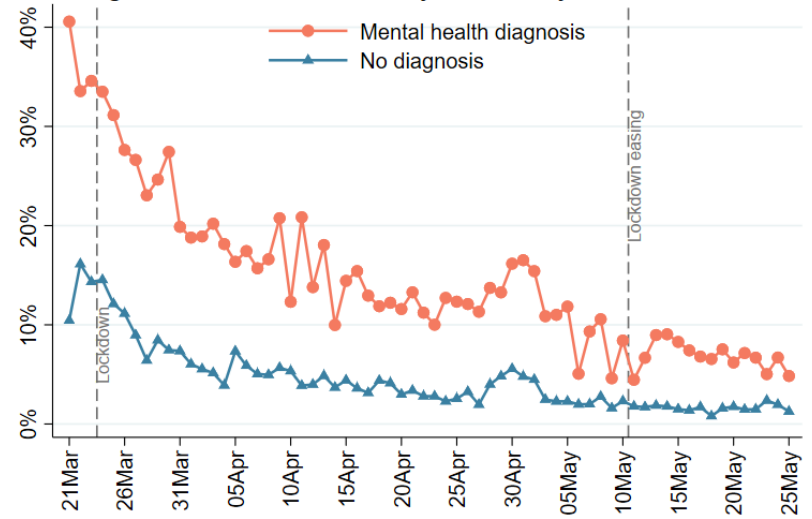


Figure 12e Food security stress by nations

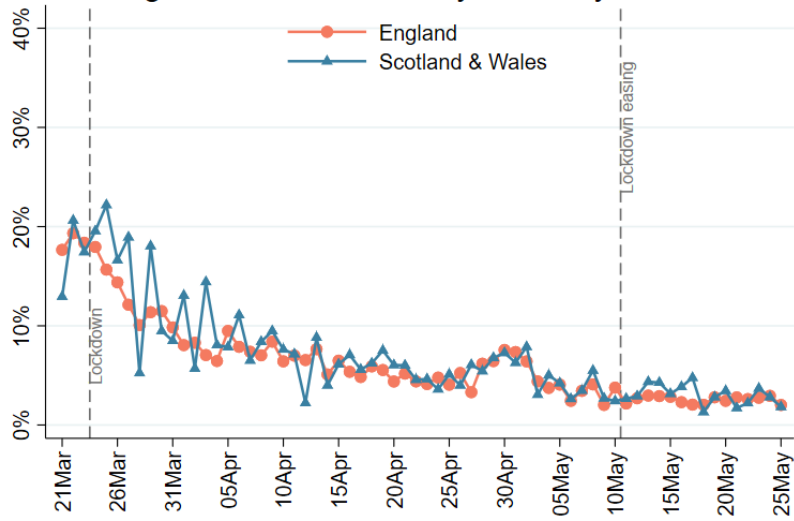


Figure 12f Food security stress by keyworker status

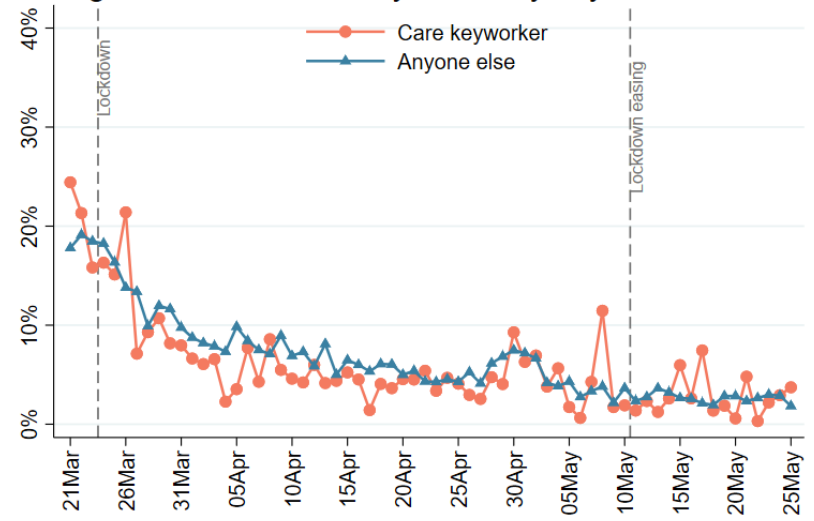


Figure 12g Food security stress by living with children

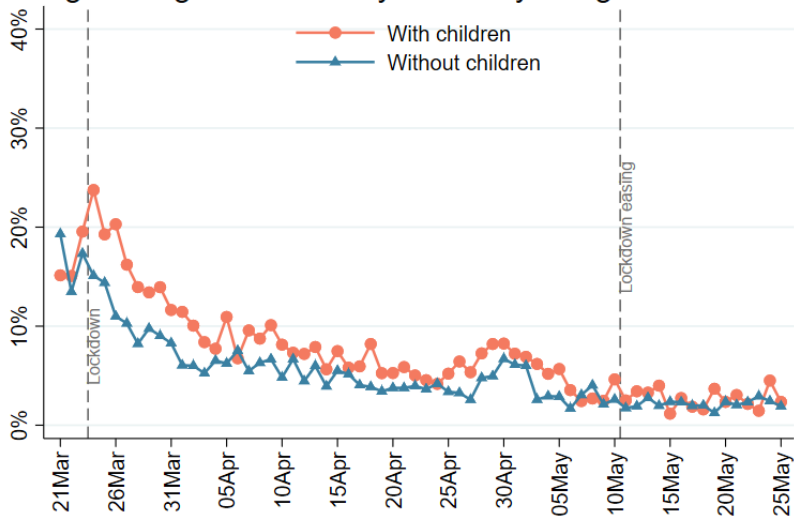
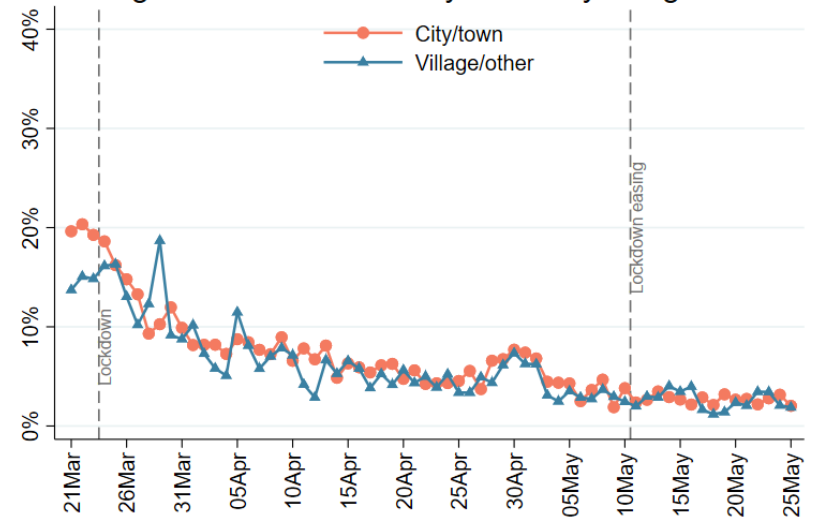
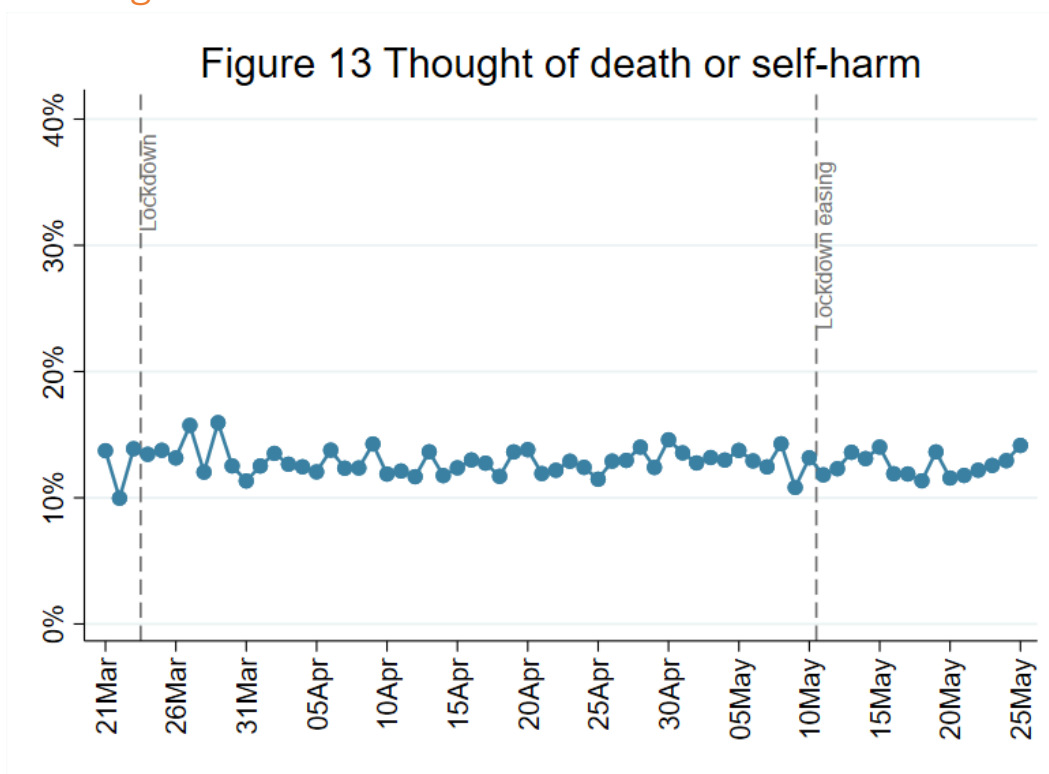


Figure 12h Food security stress by living area



### 3. Self-harm and abuse

#### 3.1 Thought of death or self-harm



#### FINDINGS

Thought 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.

Percentages of people having thoughts of death or self-harm have been relatively stable since lockdown was announced in our sample. They remain higher amongst younger people, those with a lower household income, and people with a diagnosed mental health condition. They are also higher in people living in urban areas.

**There continues to be no clear change in thoughts of death since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figure 14e).**



Figure 14a Thought of death by age groups

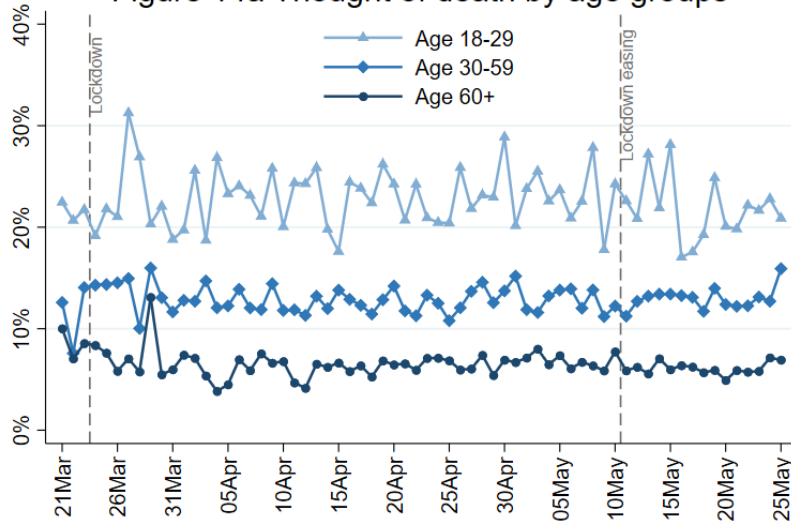


Figure 14b Thought of death by living arrangement

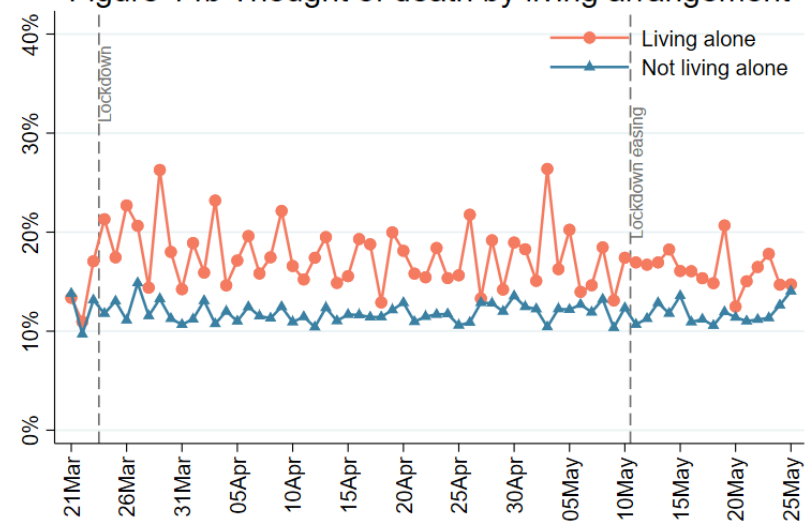


Figure 14c Thought of death by household income

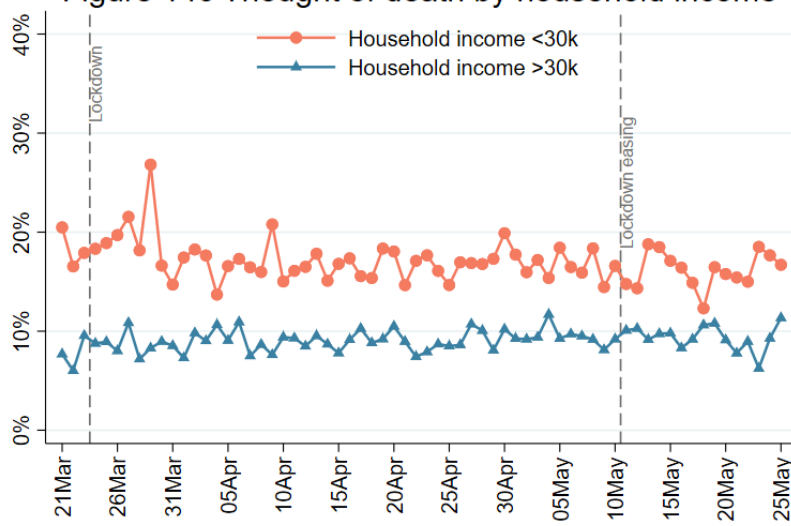


Figure 14d Thought of death by mental health diagnosis

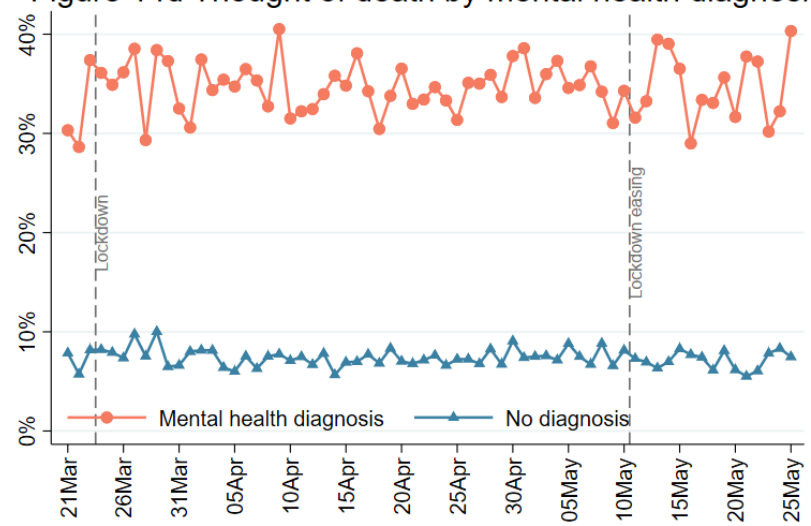


Figure 14e Thought of death by nations

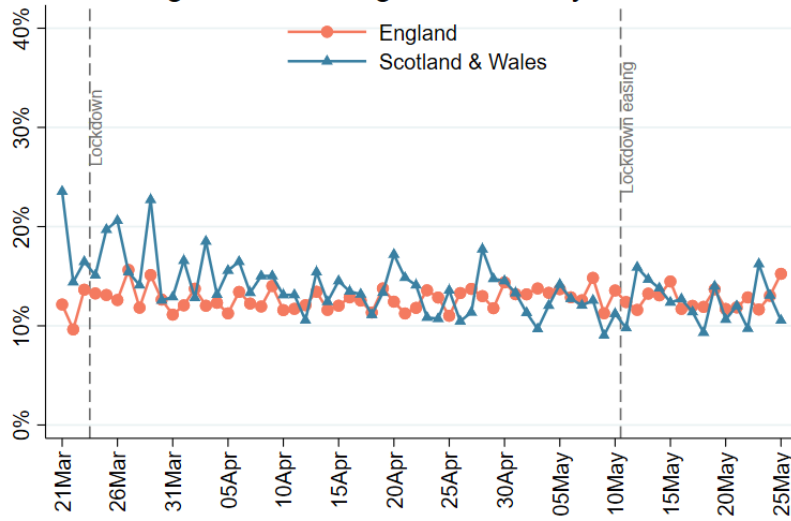


Figure 14f Thought of death by care keyworker status

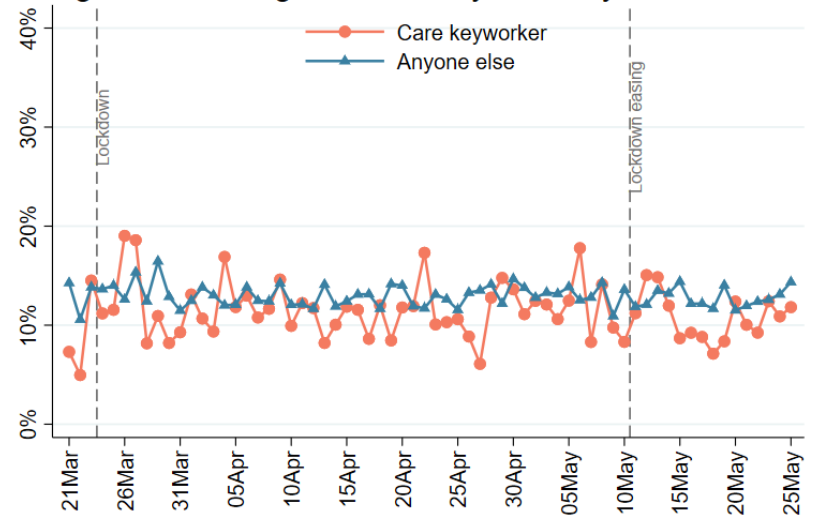


Figure 14g Thought of death by living with children

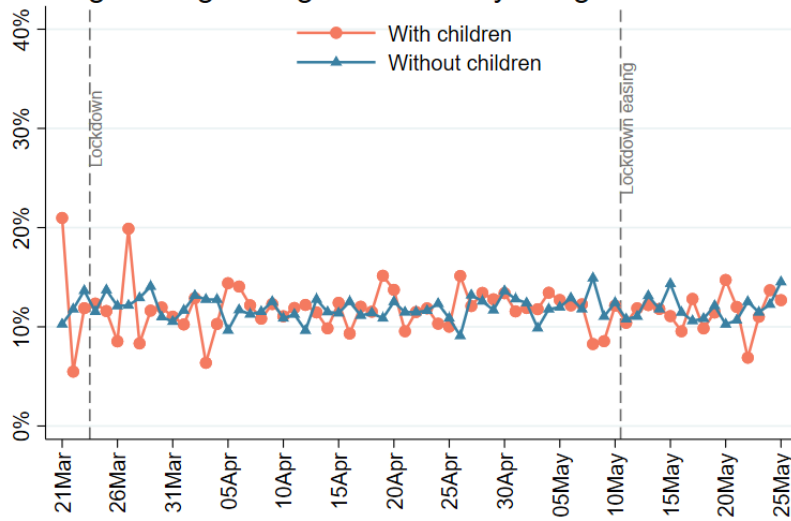
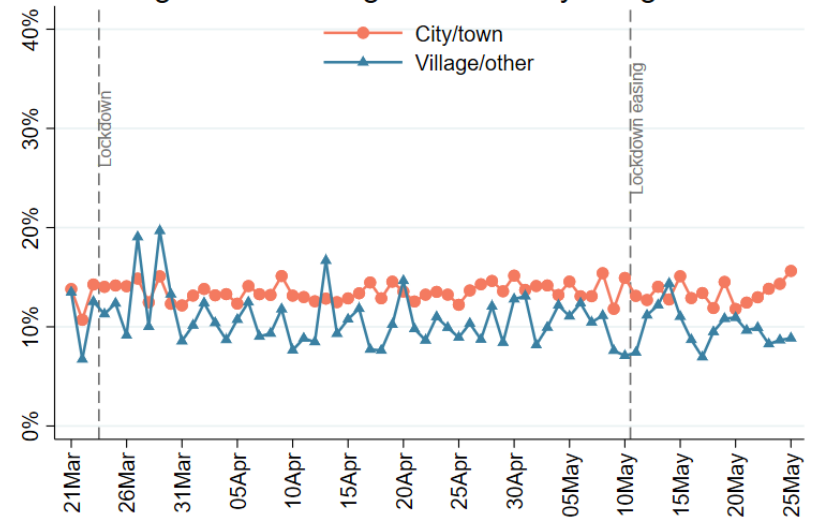
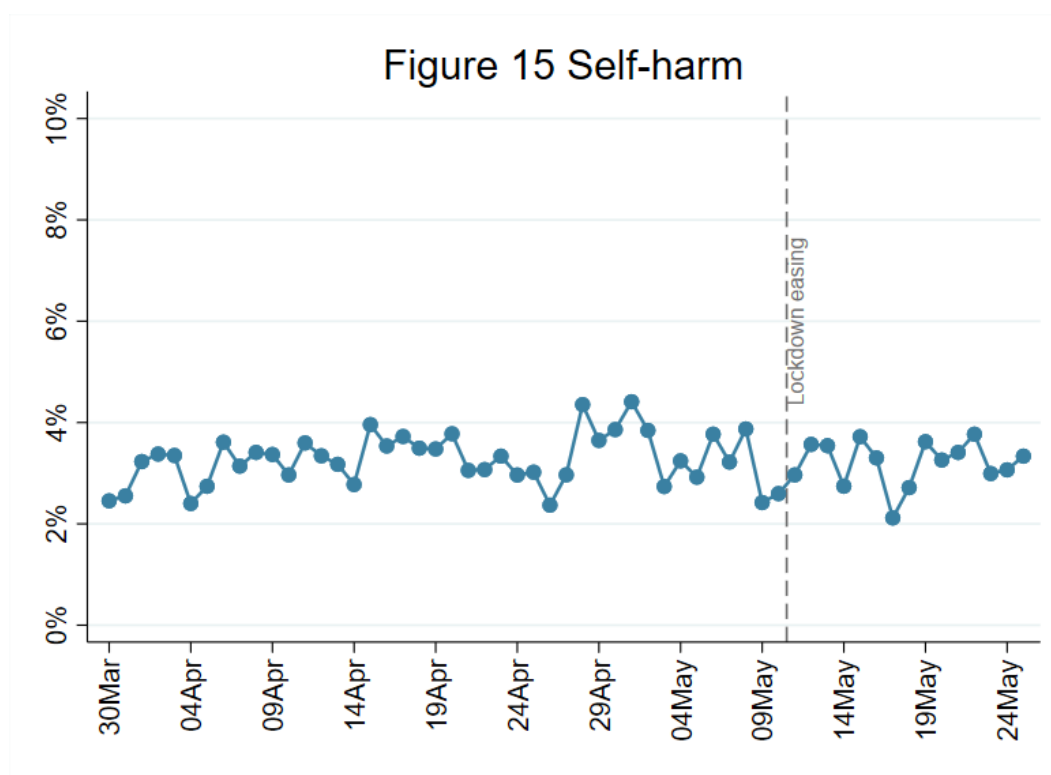


Figure 14h Thought of death by living area



## 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.

Self-harm has been reported to be 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 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.

**There continues to be no change in self-harm since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figure 16e).**

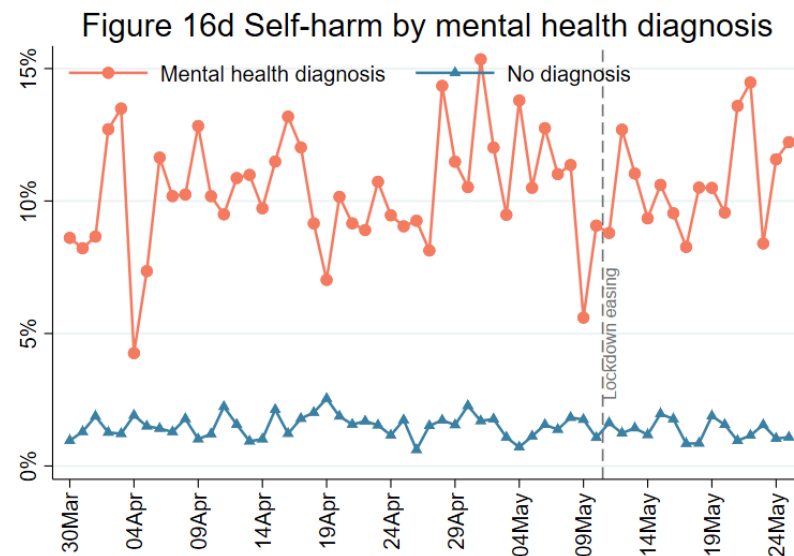
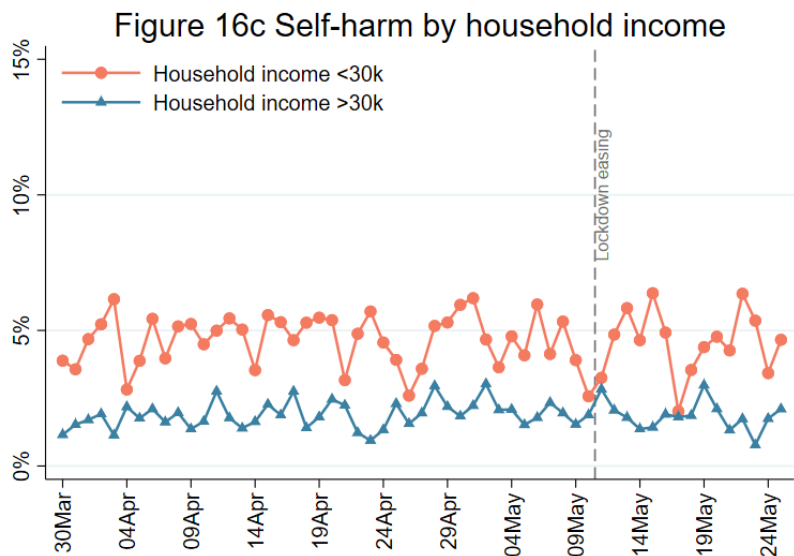
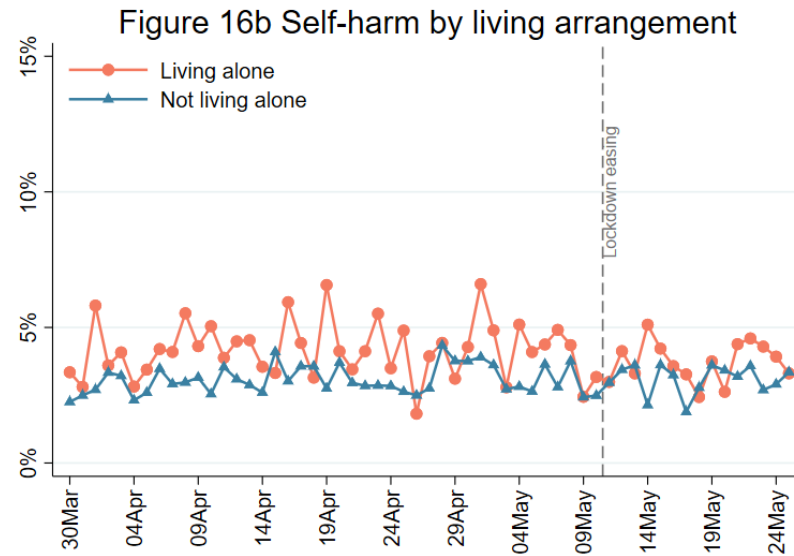
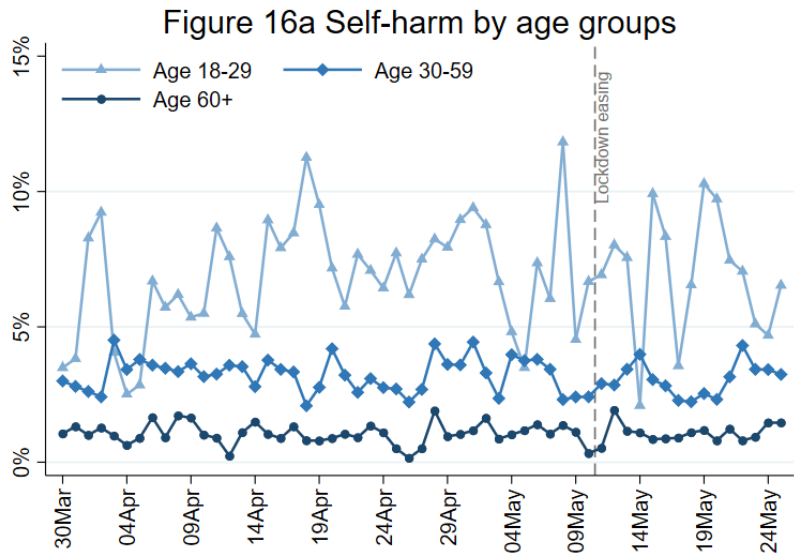


Figure 16e Self-harm by nations

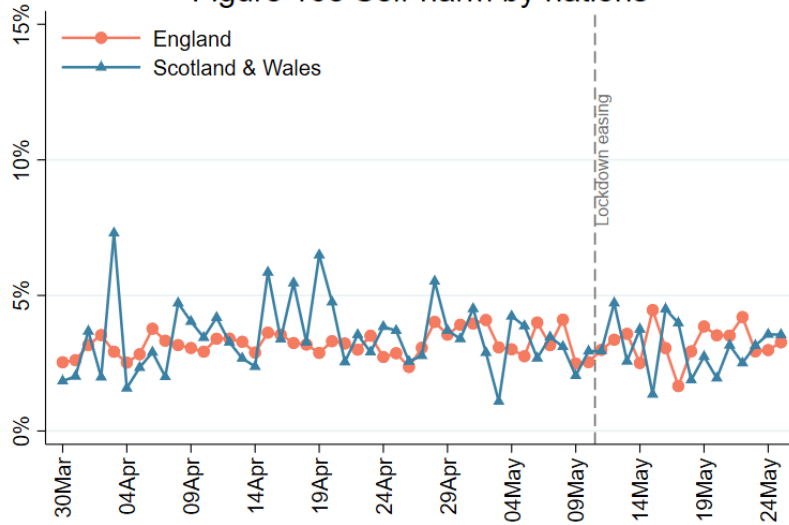


Figure 16f Self-harm by care keyworker status

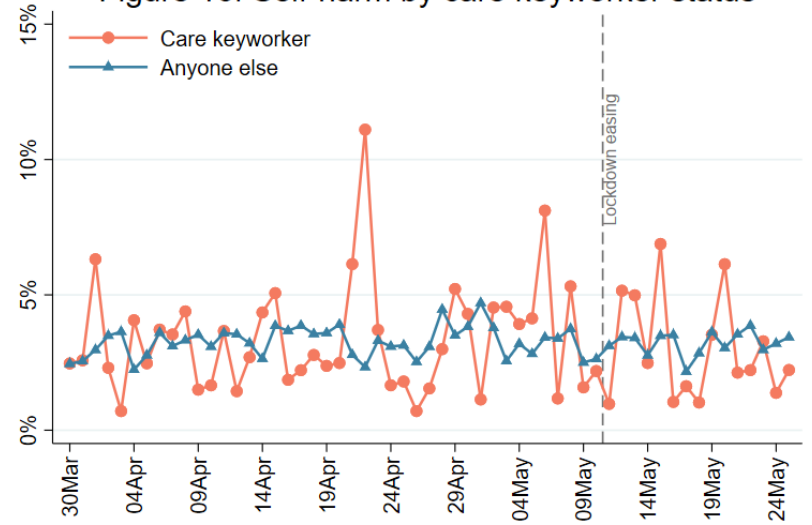


Figure 16g Self-harm by living with children

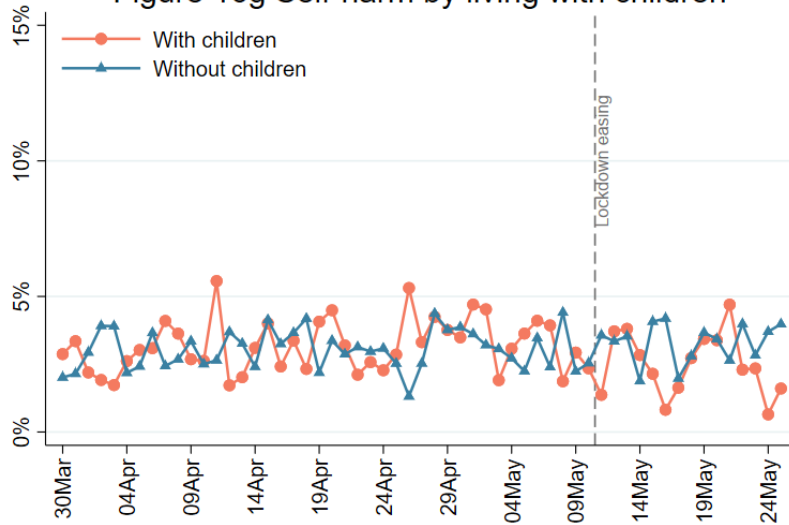
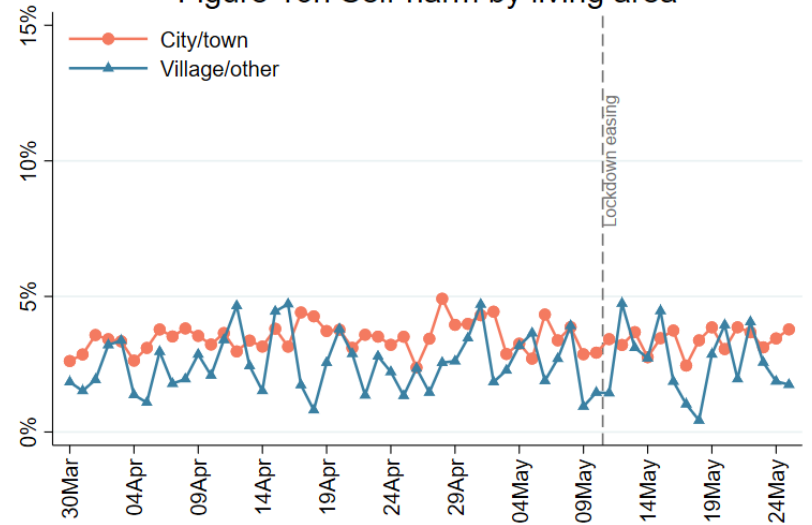
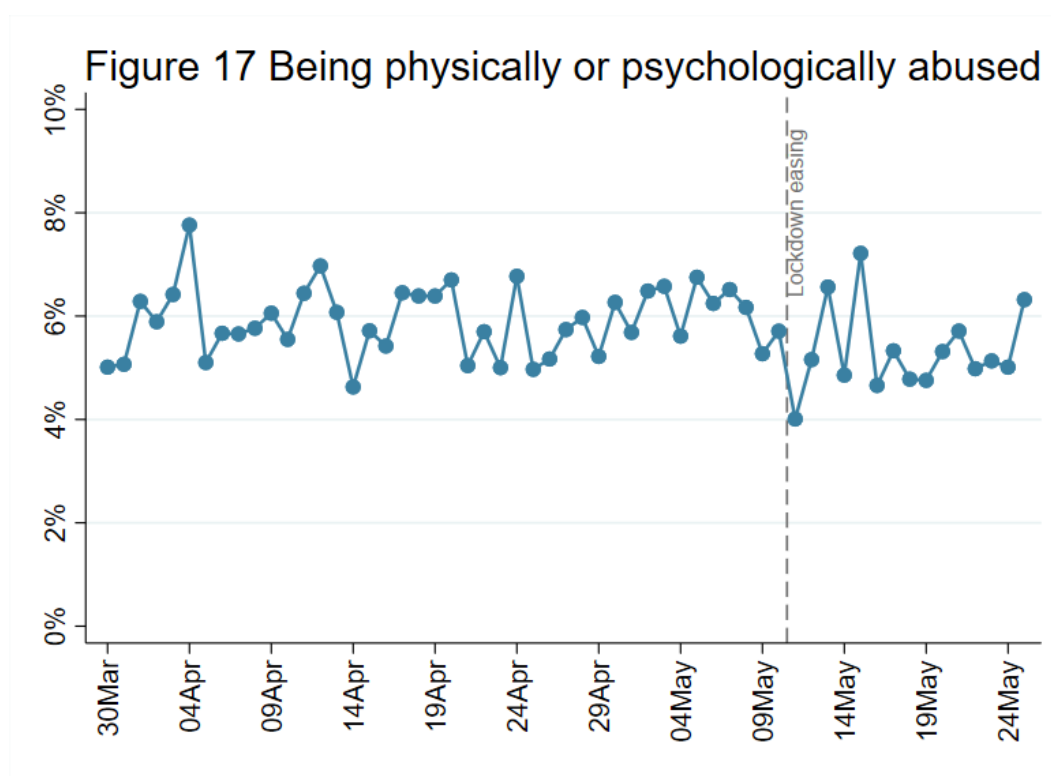


Figure 16h Self-harm by living area



### 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 psychological or physical abuse.

Abuse has been reported to be higher amongst adults under the age of 60, those with lower household income and those with existing mental health conditions. It is also slightly higher in people living with children compared to those living with just other adults. It should be noted that not all people who are experiencing abuse will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels.

**There continues to be no change in reports of abuse since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figure 18e).**

Figure 18a Abuse by age groups

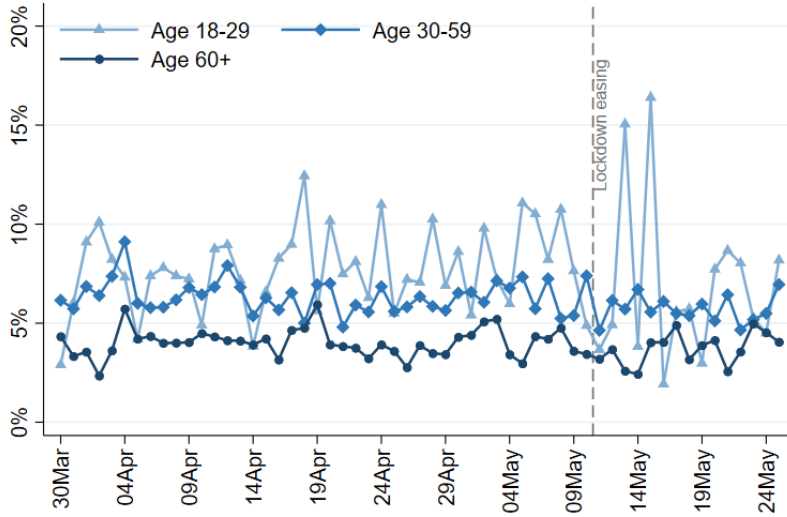


Figure 18b Abuse by living arrangement

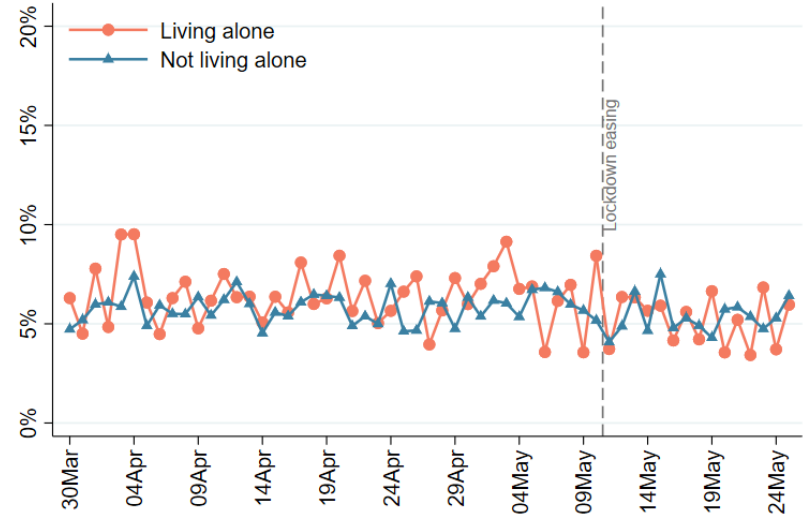


Figure 18c Abuse by household income

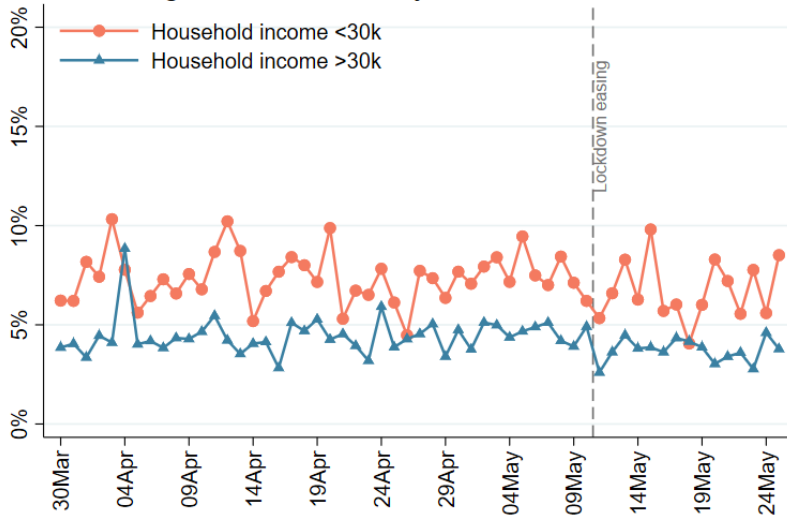


Figure 18d Abuse by mental health diagnosis

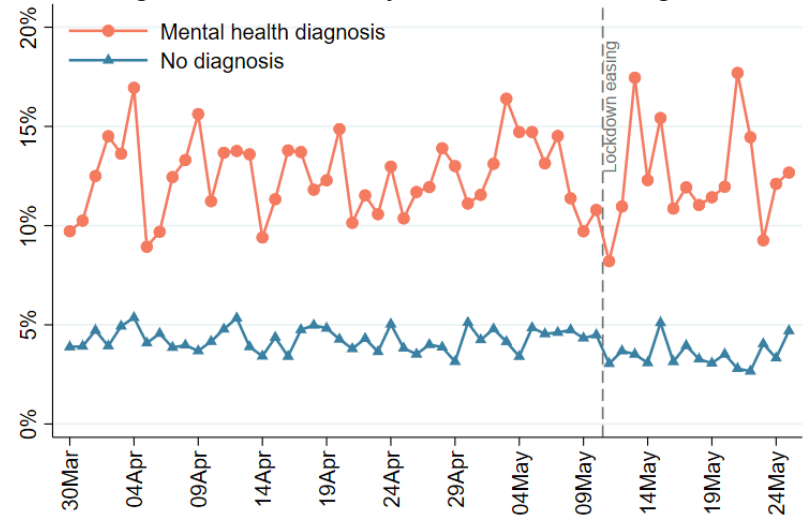


Figure 18e Abuse by nations

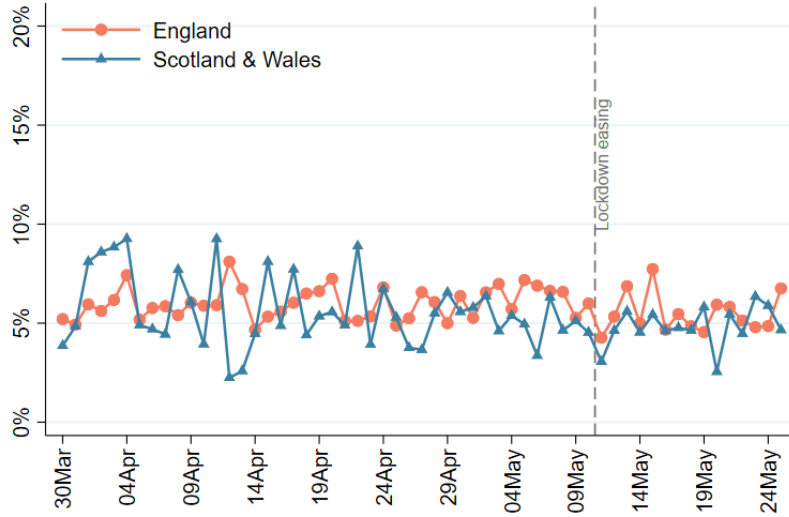


Figure 18f Abuse by care keyworker status

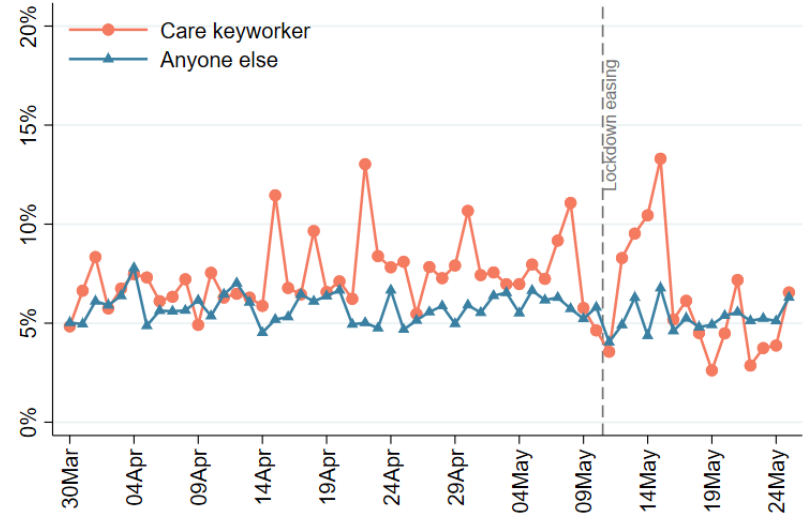


Figure 18g Abuse by living with children

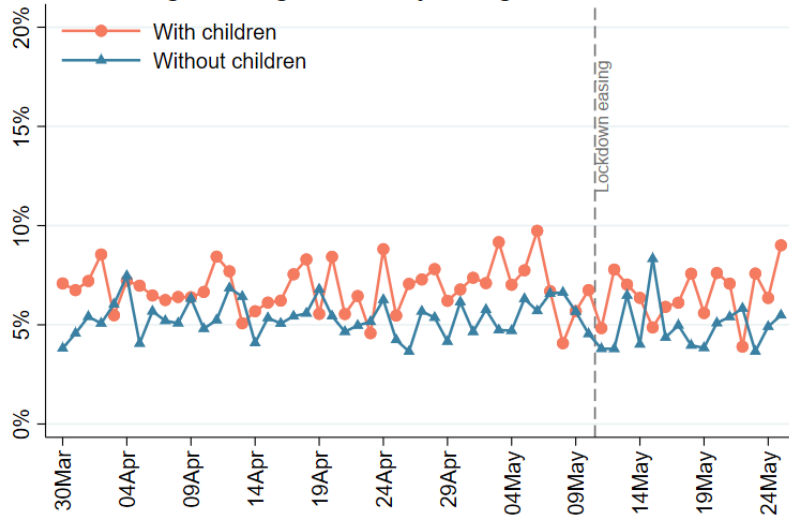
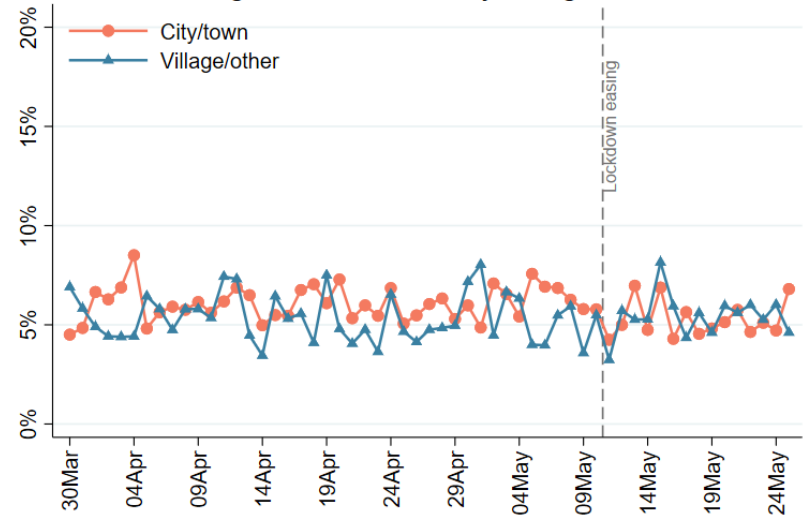


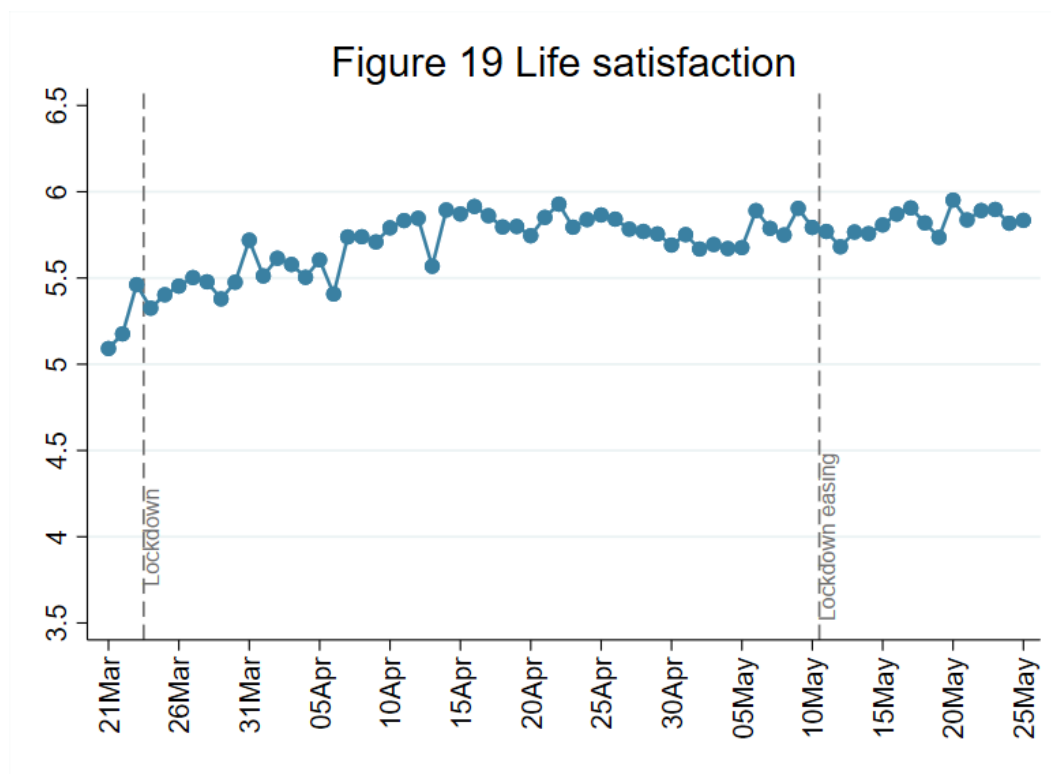
Figure 18h Abuse by living area





## 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 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 lockdown<sup>4</sup>. In our sample, life satisfaction increased after lockdown was announced but has stabilised in the past month. There is less evidence of an improvement amongst adults aged 18-29, such that differences compared to adults aged 30-59 have widened across lockdown. There is also less evidence of an improvement amongst people with a diagnosed mental health condition. Levels are higher in people living in rural areas, and lower in people living with children. **There continues to be no change in life satisfaction since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figure 20e).**

<sup>4</sup> 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

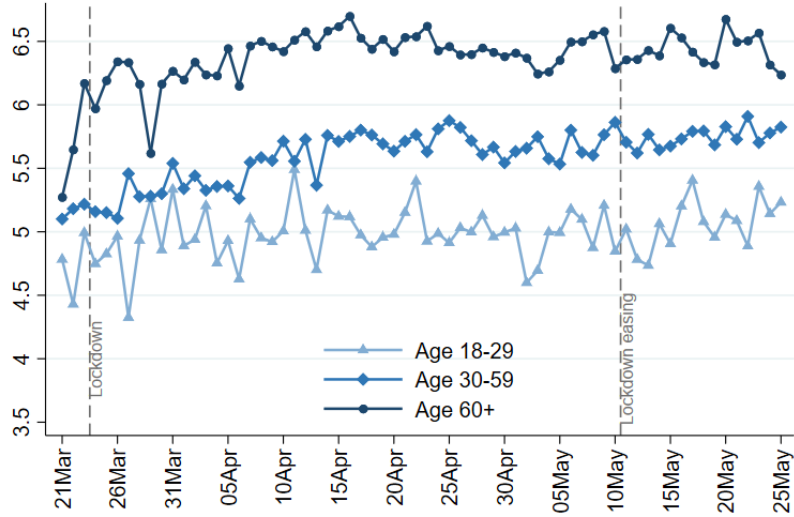


Figure 20b Life satisfaction by living arrangement

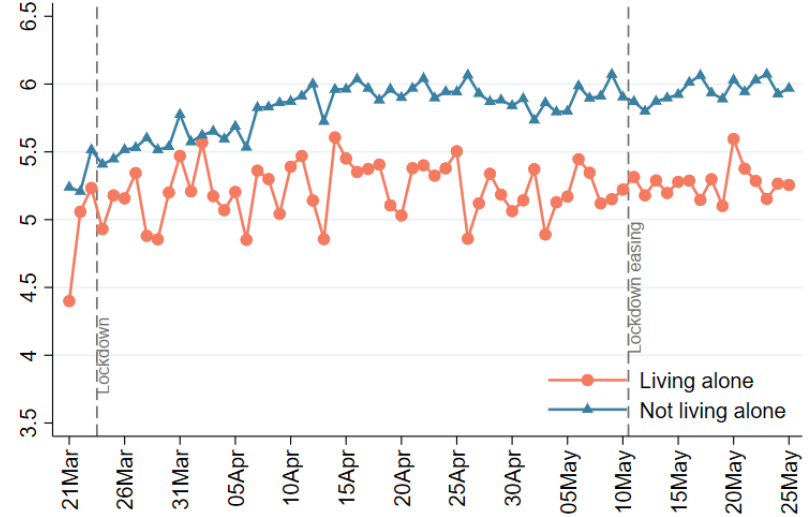


Figure 20c Life satisfaction by household income

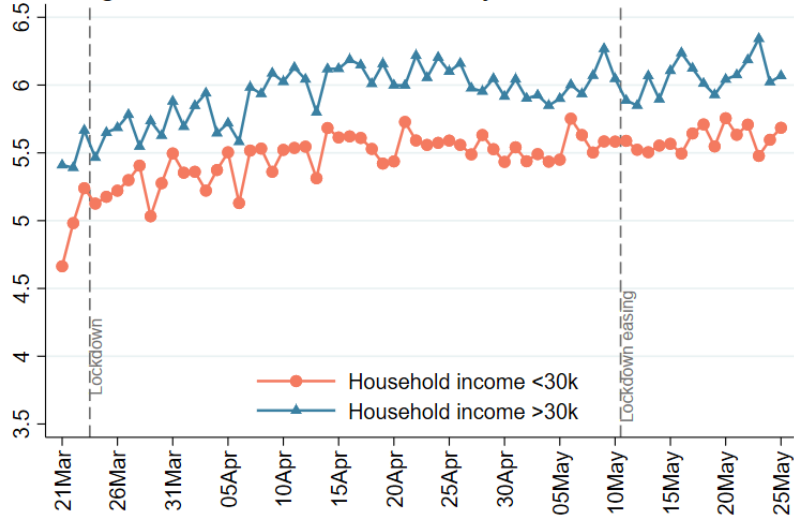


Figure 20d Life satisfaction by mental health diagnosis

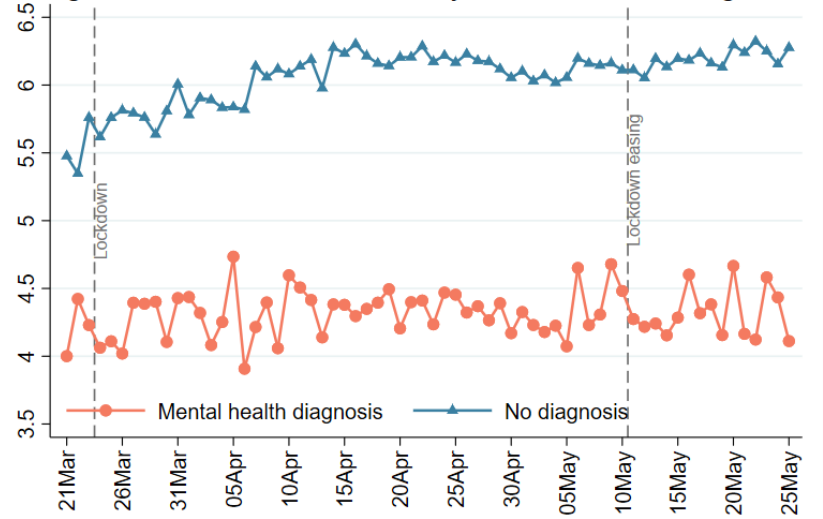


Figure 20e Life satisfaction by nations

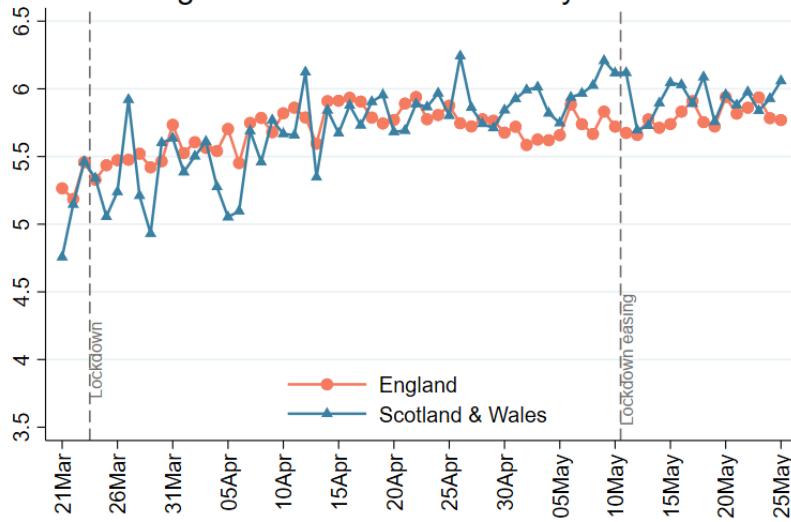


Figure 20f Life satisfaction by care keyworker status

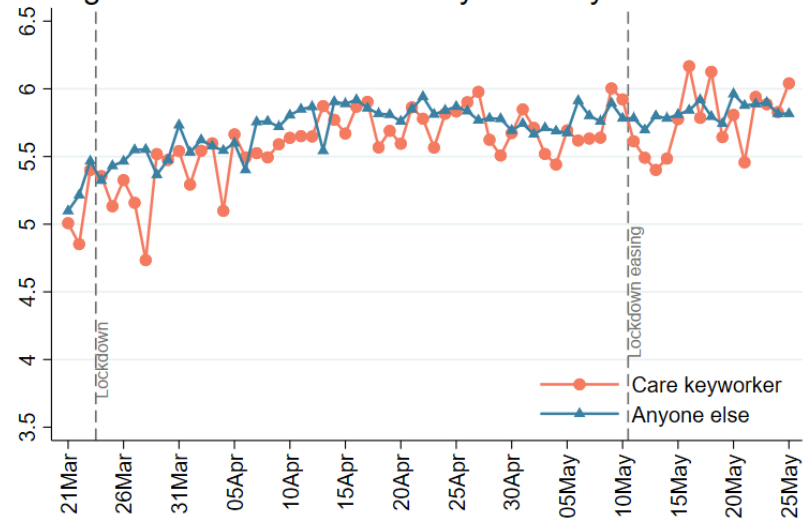


Figure 20g Life satisfaction by living with children

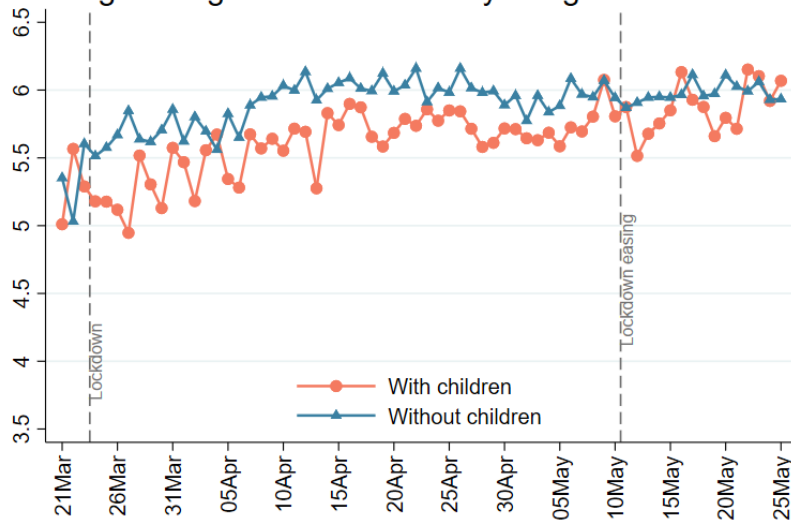
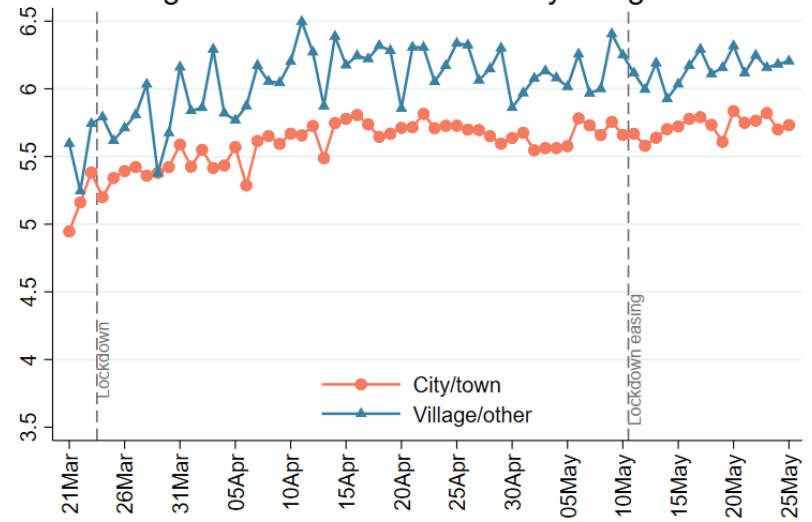
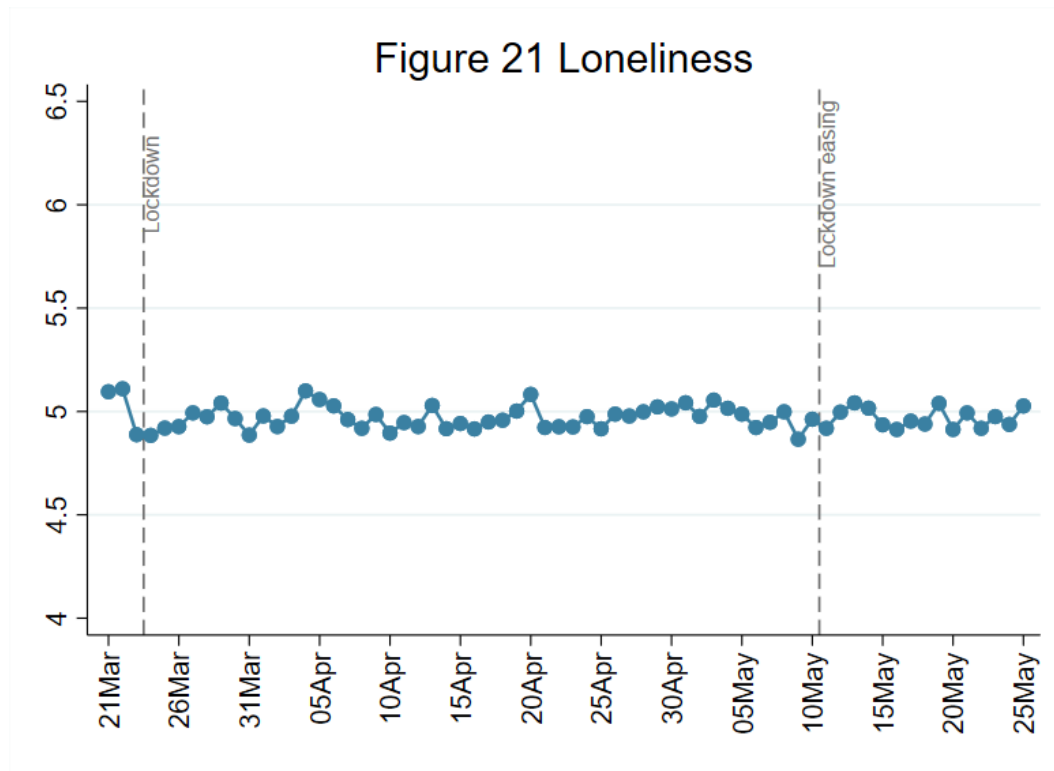


Figure 20h Life satisfaction by living area



## 4.2 Loneliness



### FINDINGS

Respondents were asked about levels of loneliness during the past week 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 continue to remain relatively stable. They are still higher amongst younger adults, those with lower household income levels, and those with an existing diagnosed mental health condition. They are higher amongst people with children, and people living in urban areas.

**There continues to be no change in loneliness since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figure 22e).**

Figure 22a Loneliness by age groups

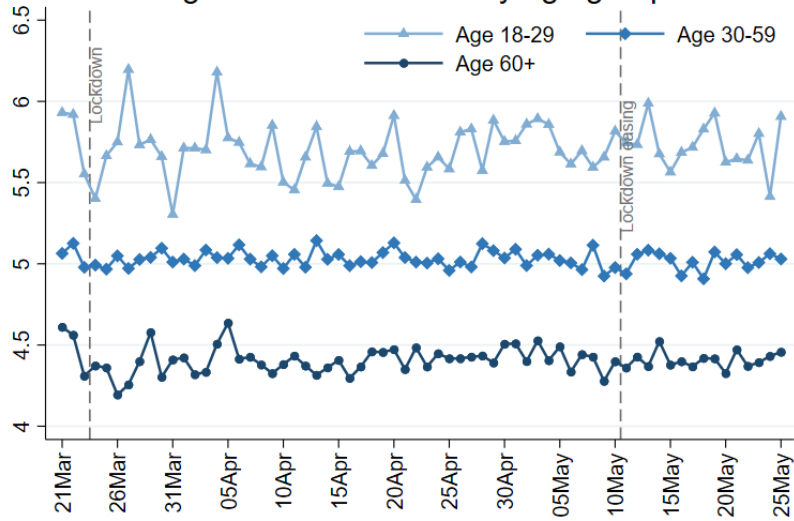


Figure 22b Loneliness by living arrangement

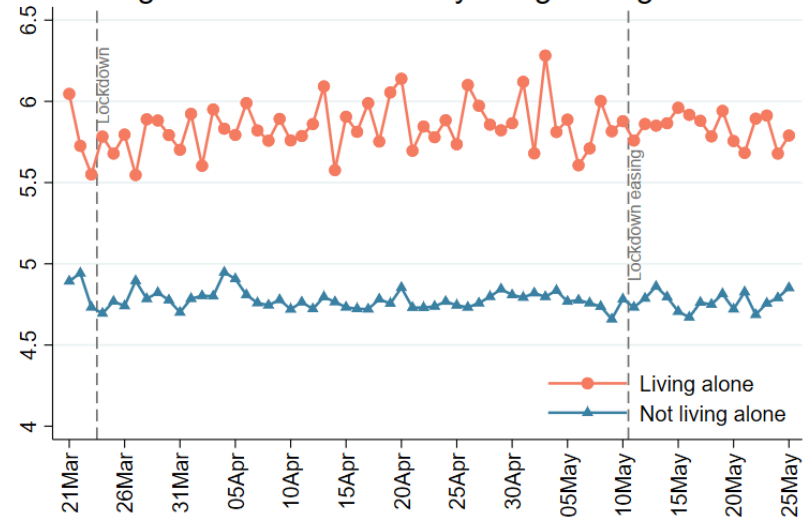


Figure 22c Loneliness by household income

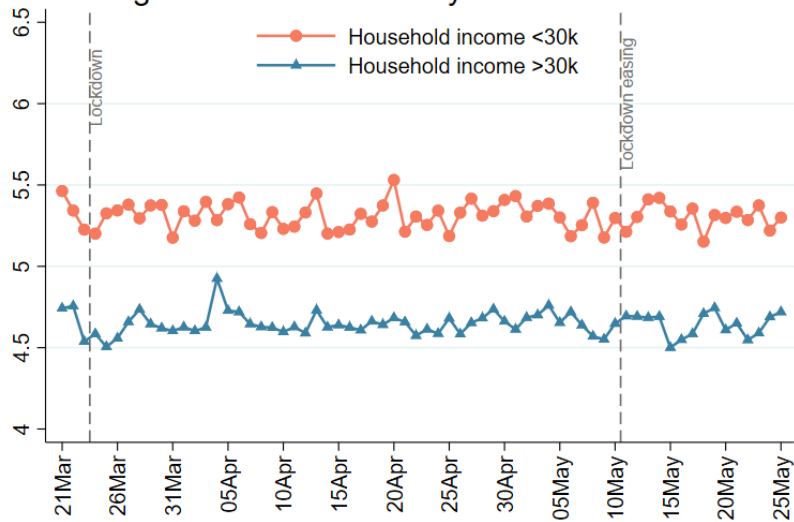


Figure 22d Loneliness by mental health diagnosis

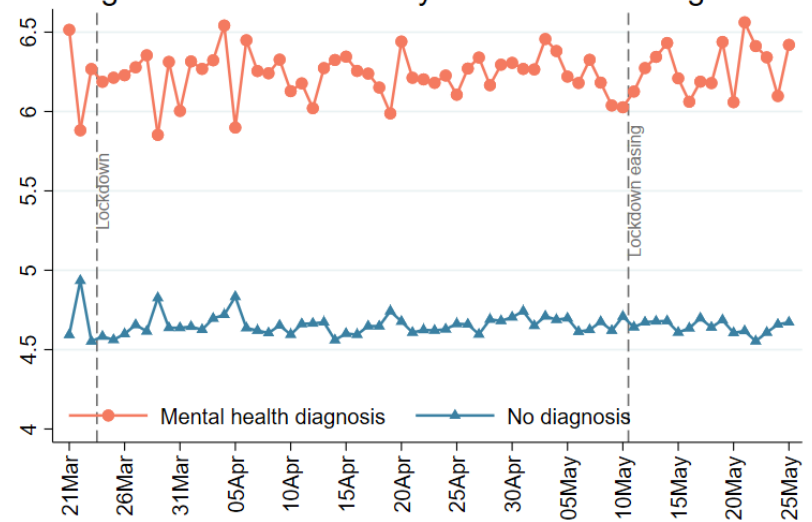


Figure 22e Loneliness by nations

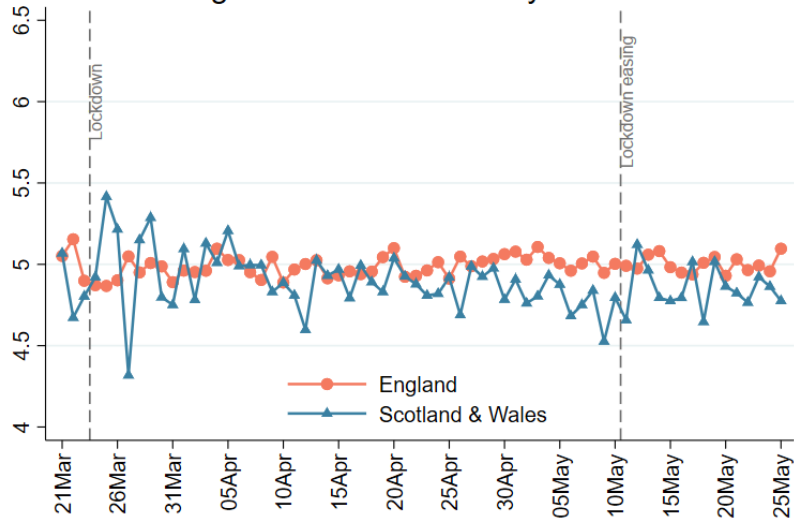


Figure 22f Loneliness by care keyworker status

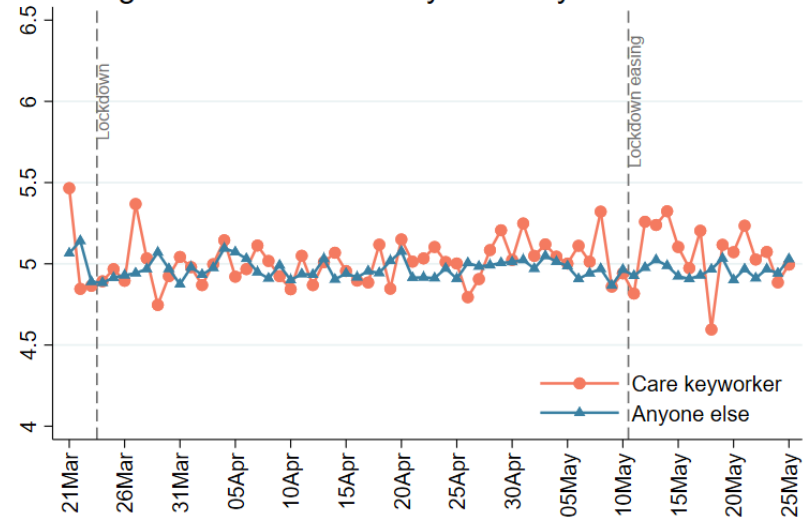


Figure 22g Loneliness by living with children

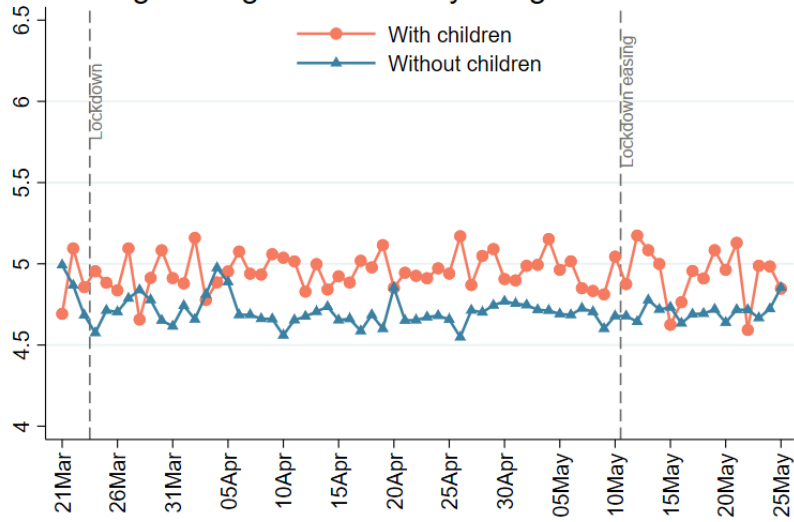
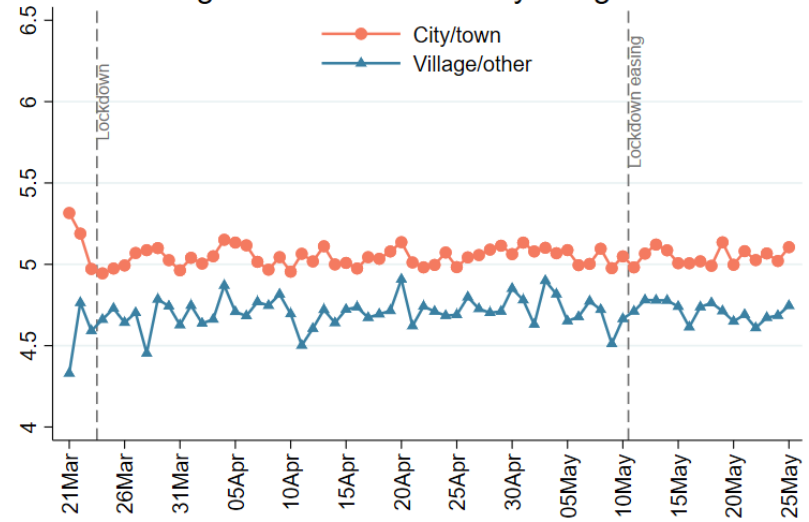


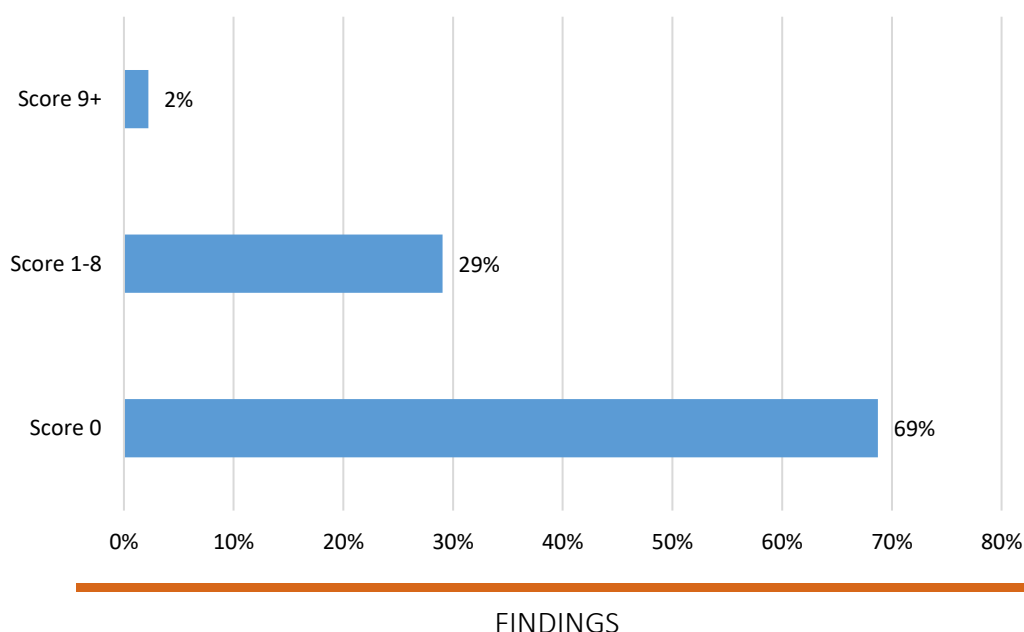
Figure 22h Loneliness by living area



## 5. Dysfunctional Coronavirus Anxiety Score

### 5.1 Dysfunctional Coronavirus Anxiety Score

Figure 23 Dysfunctional Coronavirus Anxiety Score (CAS)



This week, we also asked participants about their anxiety around Covid-19 using the newly-developed Coronavirus Anxiety Scale (CAS)<sup>5</sup>. CAS is a brief mental health screener that measures how anxious people are feeling about the virus itself (as opposed to its personal or societal implications). The scale includes five items that measure physiological features of anxiety including sleep disturbance (having trouble falling or staying asleep because of thinking about the virus), metabolic disturbance (loss of appetite when thinking about the virus or nausea or stomach problems), loss of balance (feeling dizzy, lightheaded or faint when thinking about the virus), and tonic immobility (feeling frozen or paralysed when thinking about the virus). Each item is scored from 'not at all' to 'nearly every day over the last 2 weeks', with scores ranging from 0 to 20 (higher scores indicating higher anxiety).

The majority of participants (69%) showed no physiological symptoms when thinking about Covid-19. However, 29% of participants showed some physiological anxiety symptoms, and 2% experienced symptoms that have been shown to indicate dysfunctional anxiety. Covid-19 anxiety is highest in younger adults, those living with other people (especially with children), people of lower household income, people with a diagnosed mental illness and people in urban areas. There is little difference amongst care keyworkers vs others or by nation.

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<sup>5</sup> Lee, S. A. (2020). Coronavirus Anxiety Scale: A brief mental health screener for COVID-19 related anxiety. *Death Studies*, 1-9.

Figure 24a CAS by age groups

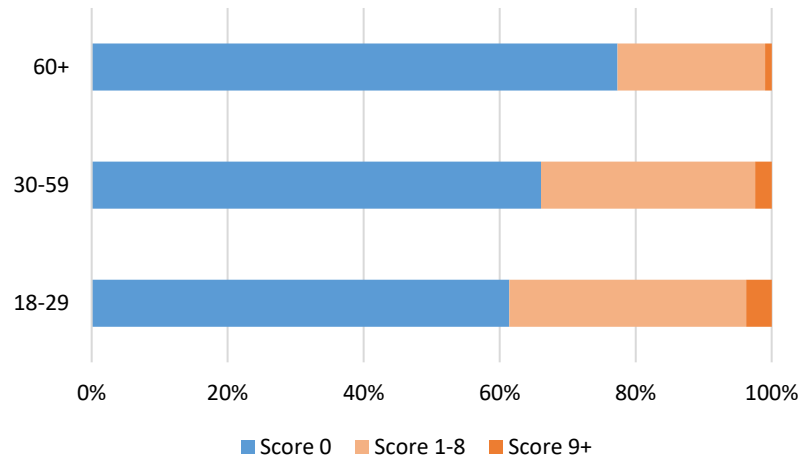


Figure 24b CAS by living arrangement

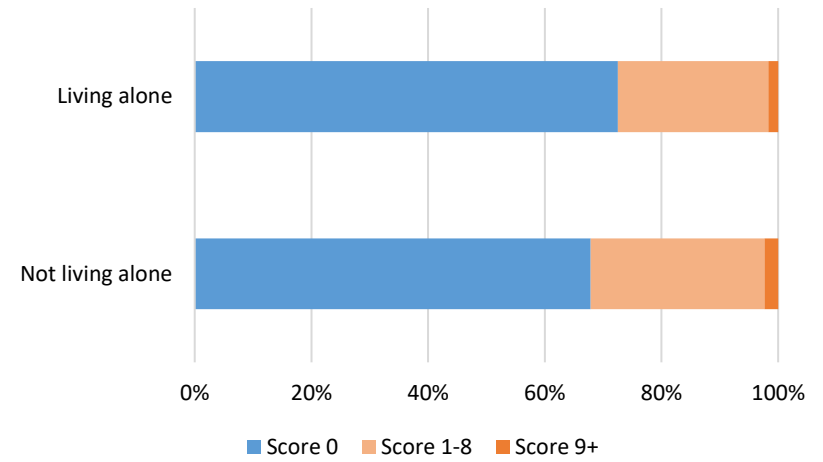


Figure 24c CAS by household income

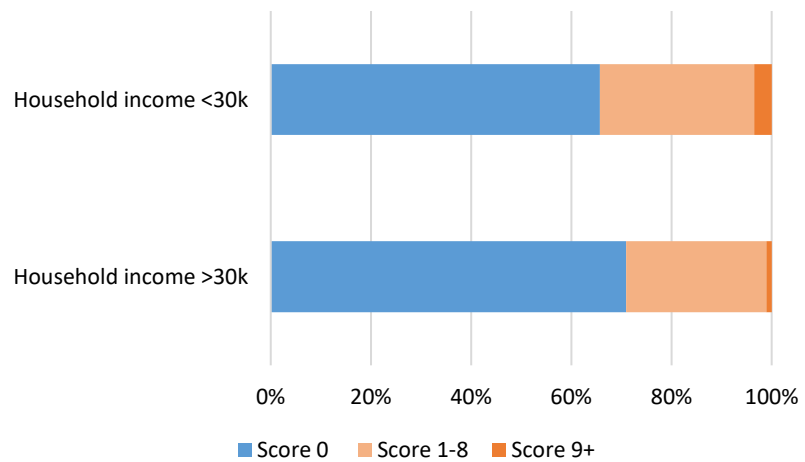


Figure 24d CAS by mental health diagnosis

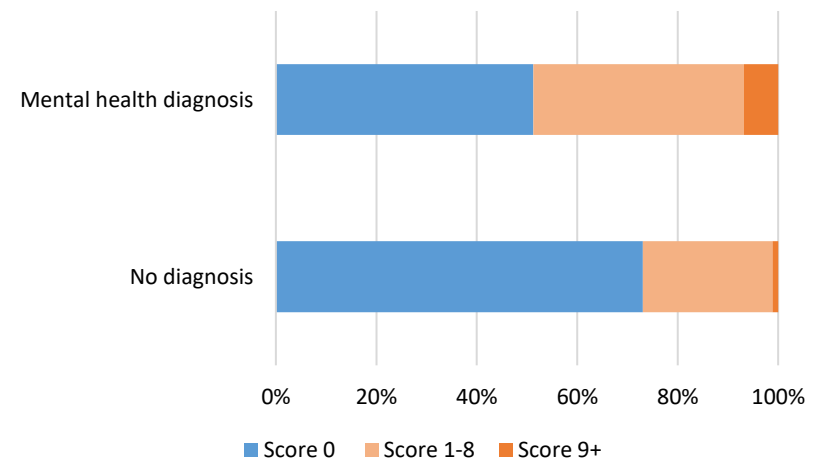




Figure 24e CAS by nations

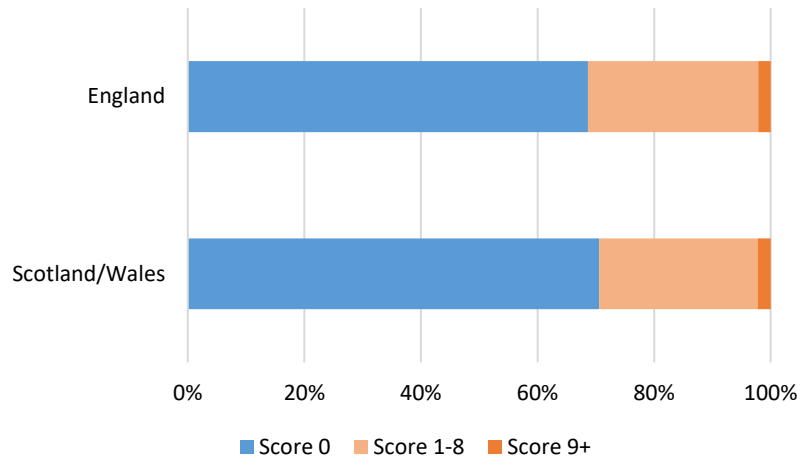


Figure 24f CAS by care keyworker status

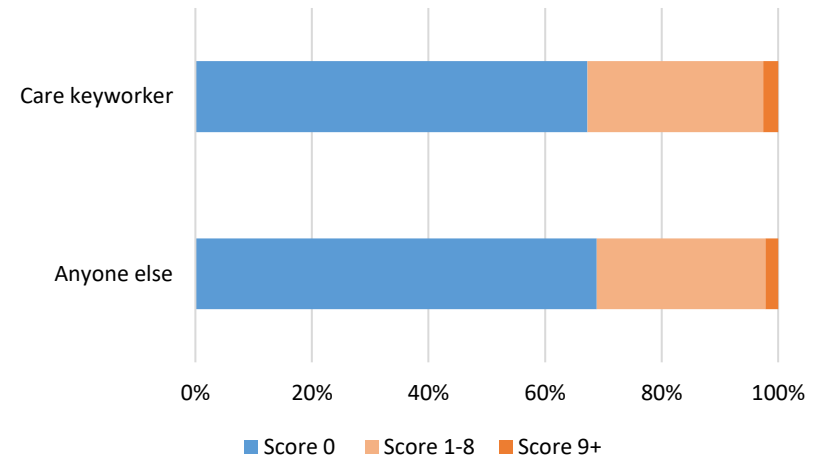


Figure 24g CAS by living with children

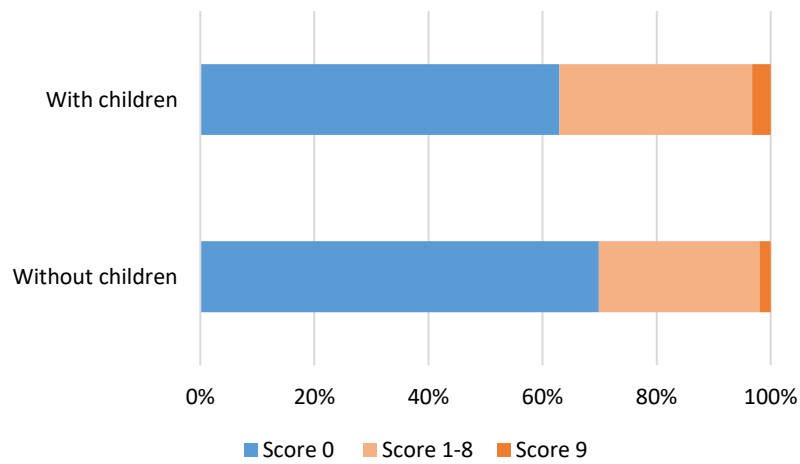
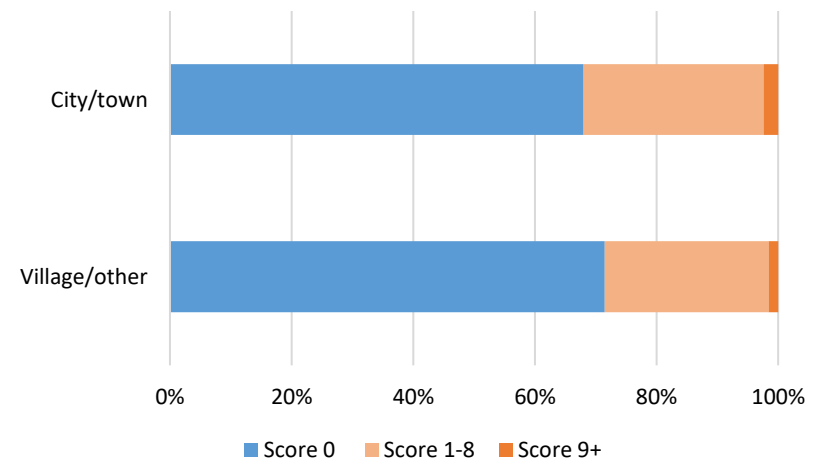


Figure 24h CAS by living area



# 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 90,000 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 21<sup>st</sup> March to the 25<sup>th</sup> May (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.

**Contrary to some previous reports, we include keyworkers within our main analyses.**

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](mailto:d.fancourt@ucl.ac.uk). To participate, visit [www.COVIDSocialStudy.org](http://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)

	Number of observations	%
Age		
18-29	24,466	7.64
30-59	188,969	59.0
60+	106,953	33.4
UK nations		
England	260,059	81.2
Scotland & Wales	56,676	17.7
Northern Ireland	3,653	1.1
Living arrangement		
Not living alone	257,600	80.5
Living alone	62,601	19.6
Annual household income		
>30k	177,358	61.1
<30k	112,773	38.9
Any diagnosed mental health conditions		
No	262,917	82.1
Yes	57,471	17.9
Care keyworker [NB we show more specific data on care keyworkers this week rather than all keyworkers]		
No	286,456	89.4
Yes	33,932	10.6
Living with children		
No (excluding those who live alone)	176,041	68.3
Yes	81,559	31.7
Living area		
Village/hamlet/isolated dwelling	76,384	23.9
City/large town/small town	243,823	76.2