



Covid-19 Social Study

Results Release 5

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22nd April 2020

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Executive summary

Background

This report provides data from Week 5 of the UK COVID-Mind Study run by University College London: a panel study of over 75,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this FIFTH report, we focus on psychological responses to the first two weeks of government measures requiring people to stay at home. We present simple descriptive results on the experiences of adults in the UK who are not keyworkers and are therefore being asked to stay at home. 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 and physical abuse
4. Psychological and social wellbeing including life satisfaction and loneliness

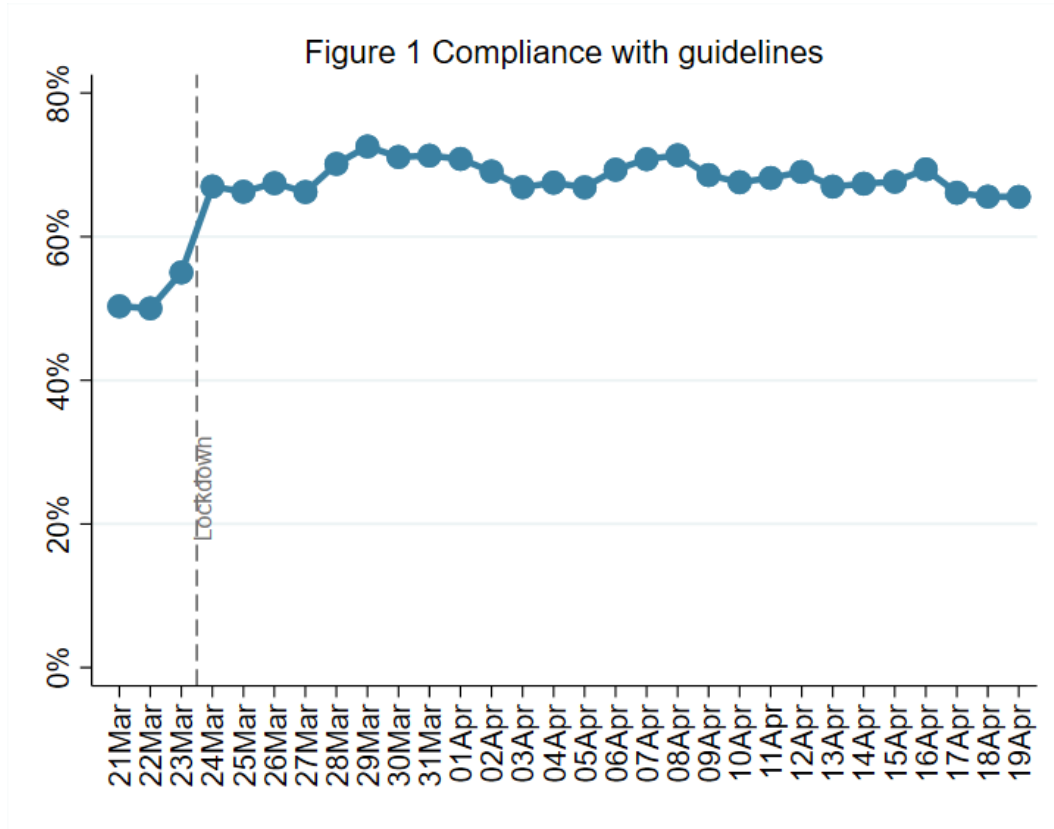
This study is not representative of the UK population but instead was designed to have good stratification across a wide range of socio-demographic factors enabling meaningful subgroup analyses to understand the experience of Covid-19 for different groups within society. Data are weighted using auxiliary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

Findings

- Compliance with government advice remains very high. There are signs of a slight decrease in “complete” adherence amongst adults aged 30-59, but the numbers showing overall high adherence remain unchanged.
- Confidence in government remains relatively stable, although there has been a slight decrease from levels two weeks ago.
- Depression levels appear relatively constant since lockdown, and anxiety levels appear to have stabilised. But individuals with existing mental health diagnoses are still reporting consistently high levels.
- Stress relating to Covid-19 (both catching and becoming seriously ill from Covid-19) has continued to decrease. Worries about money, employment, and access to food appear to have stabilised.
- Thoughts of death or self-harm remain relatively stable but are higher amongst younger people, those living alone, those with a lower household income, and people with a diagnosed mental health condition.
- Self-harm levels may have been increasing in the past week amongst younger adults, but it remains too soon to confirm this pattern.
- Abuse is reported to be higher amongst younger adults, those living alone, those with lower household income, and those with a diagnosed mental health condition. Levels reported here are expected to be under-estimations of experiences.
- Wellbeing decreased prior to lockdown coming in according to data from YouGov, but our data suggest it has been gradually increasing since, with some stabilisation in the last week.
- Loneliness levels continue to be relatively stable since lockdown started, even amongst high-risk groups.

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). Figure 1 shows the percentage of people who followed the recommendations “completely” (with a score of 7). “Complete” compliance remains stable over the past week. Results suggest there may have been a slight decrease amongst adults age 30-59 and those with household incomes above £30,000, but these trajectories remain to be confirmed over the following week or so (see Figs 2).

However, it should be noted that these graphs show self-reported “complete” compliance: a perfect score of 7 out of 7. When we look at scores of 5-7 out of 7, it becomes clear that compliance overall is very high, with over 98% of respondents scoring in this group. Less than 0.1% of respondents reported not complying at all with the guidelines.

Figure 2a Compliance by age groups

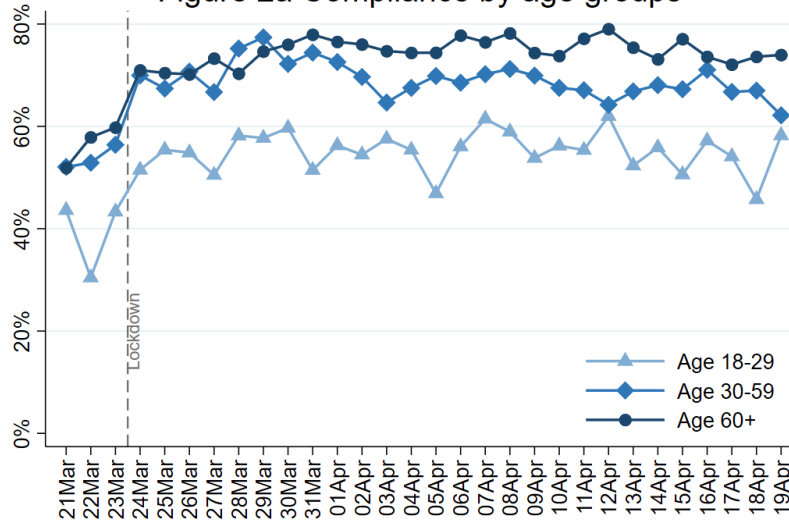


Figure 2b Compliance by living arrangement

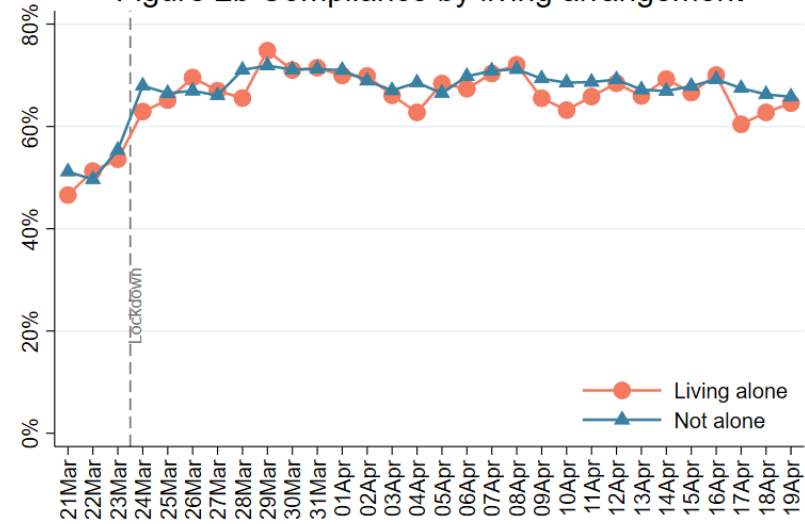


Figure 2c Compliance by household income

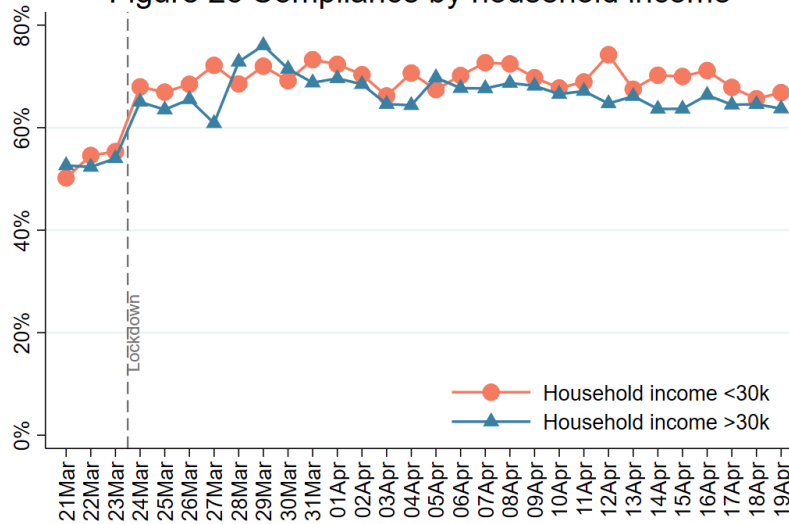
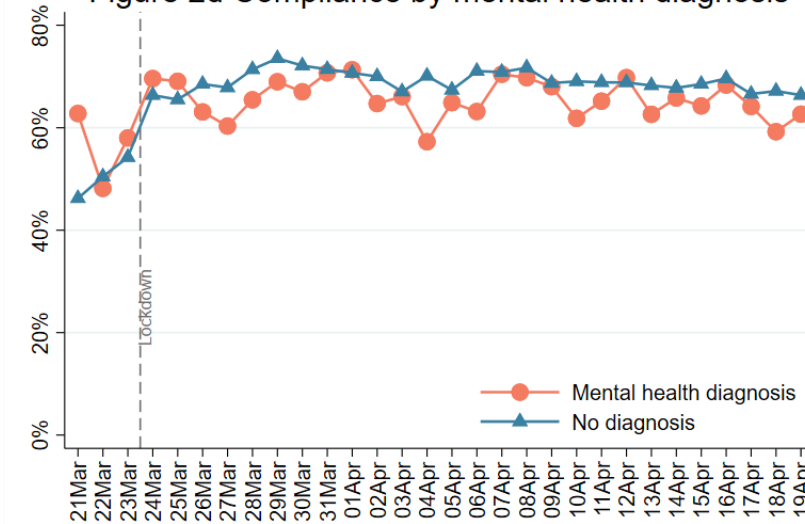
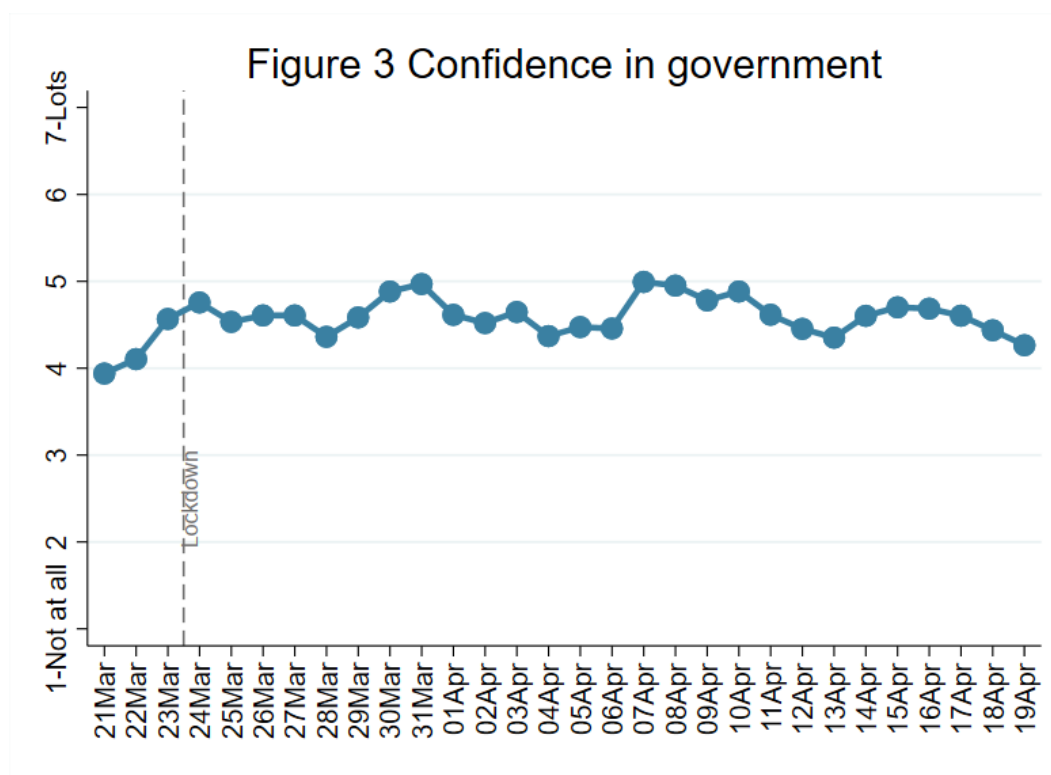


Figure 2d Compliance by mental health diagnosis



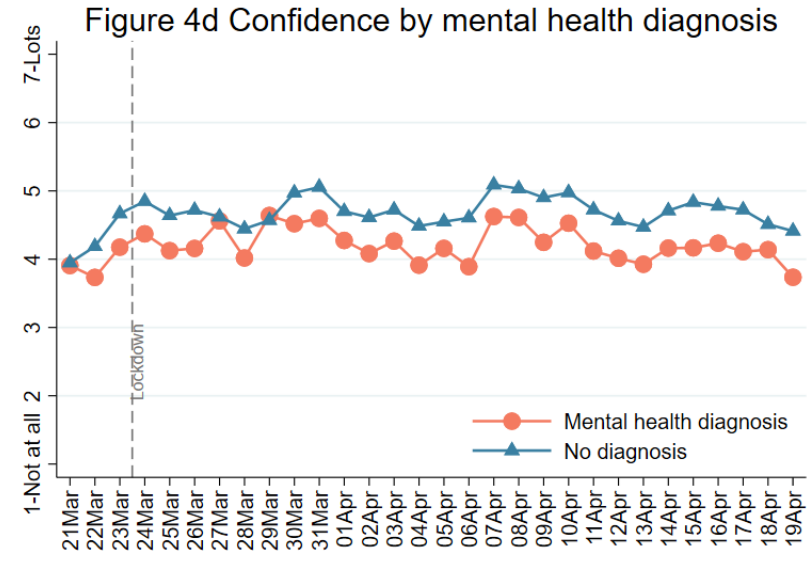
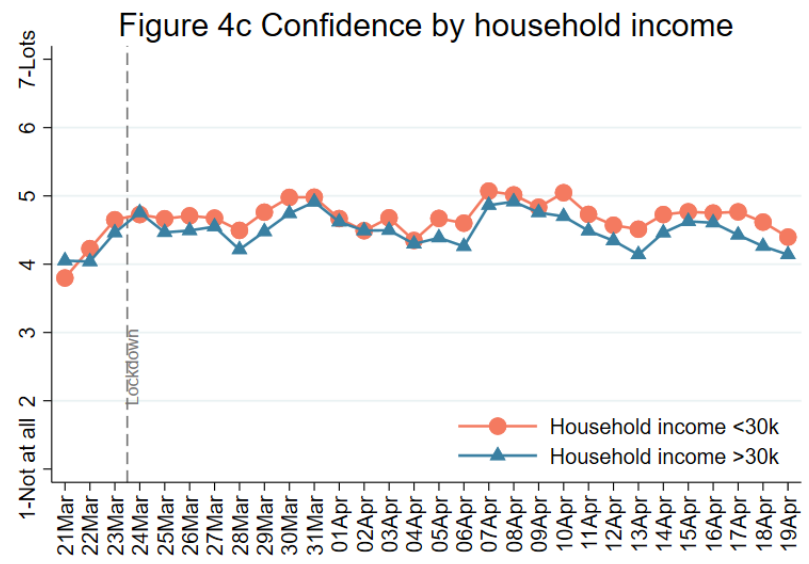
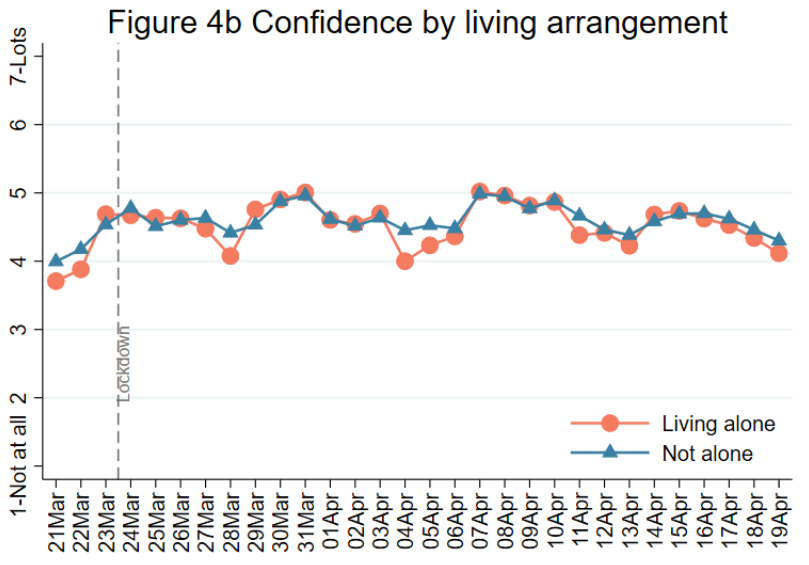
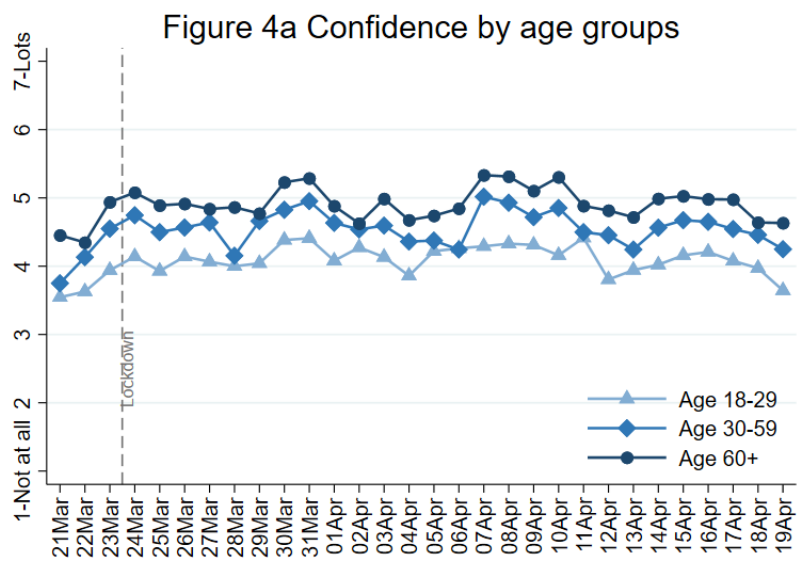
1.2 Confidence in Government (England)



FINDINGS

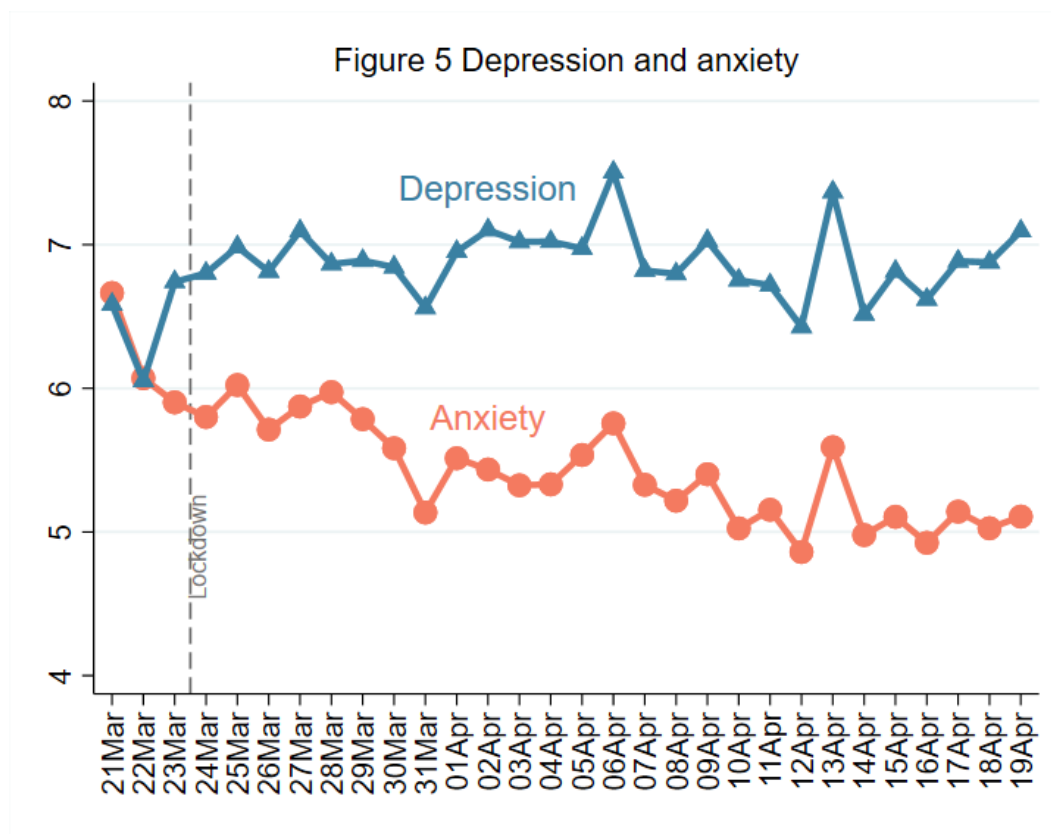
Respondents were asked how much confidence they had in the government to handle the Covid-19 epidemic from 1 (not at all) to 7 (lots). We restrict our analyses here to respondents living in England.

Results show that confidence in government has increased since the lockdown was announced, and has stayed relatively stable since, although there has been a slight decrease from levels two weeks ago. There are suggestions of cyclical patterns of confidence, with higher levels early in the week and lower levels at the end of the week. Confidence in government continues to be patterned by age groups and mental health diagnoses.



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); a standard instrument for diagnosing depression in primary care. There are 9 items with 4-point responses ranging from “not at all” to “nearly every day”, with higher overall scores indicating more depressive symptoms. Scores of higher than 10 can indicate major depression. Respondents were asked about anxiety levels during the past week using Generalised Anxiety Disorder assessment (GAD-7); a well-validated tool used to screen and diagnose generalised anxiety disorder in clinical practice and research. There are 7 items with 4-point responses ranging from “not at all” to “nearly every day”, with higher overall scores indicating more symptoms of anxiety. Categorical scales suggest that scores of higher than 5 are mild, higher than 10 are moderate, and higher than 15 are severe.

Anxiety levels appear to have stabilised in the past week and depression levels remain similar. Both depression and anxiety levels have been higher in younger adults, those living alone, those with lower household income, and those with an existing mental health diagnosis. As anticipated, people with an existing mental health diagnosis have levels above the threshold indicative of clinical depression and anxiety.

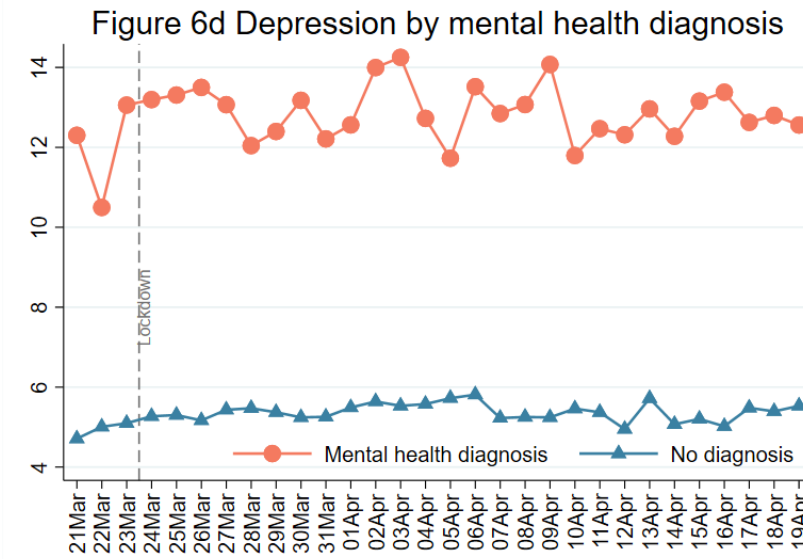
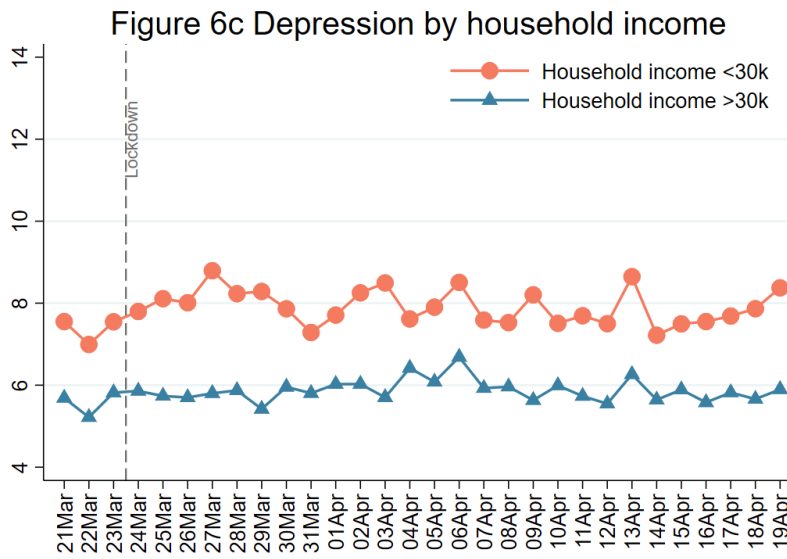
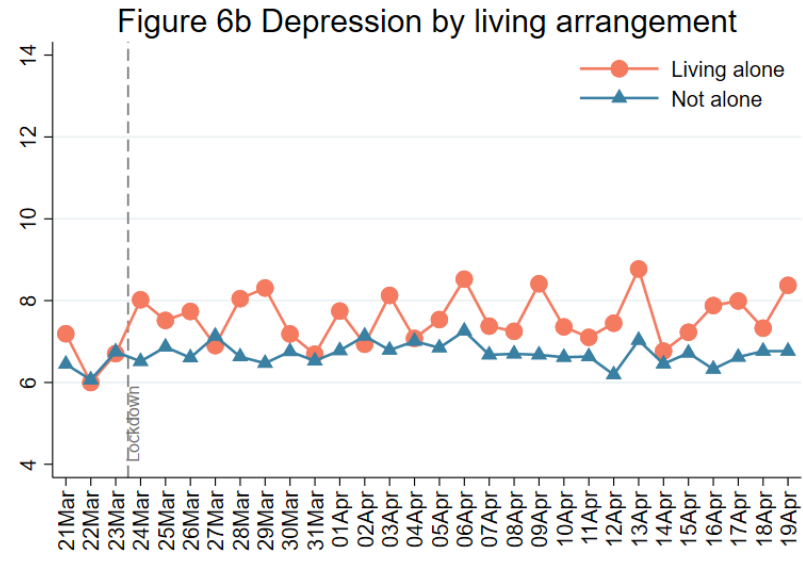
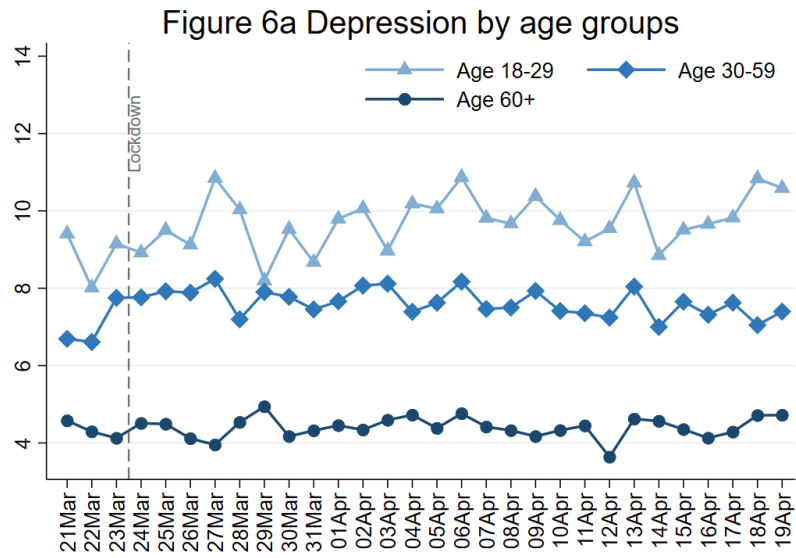


Figure 7a Anxiety by age groups

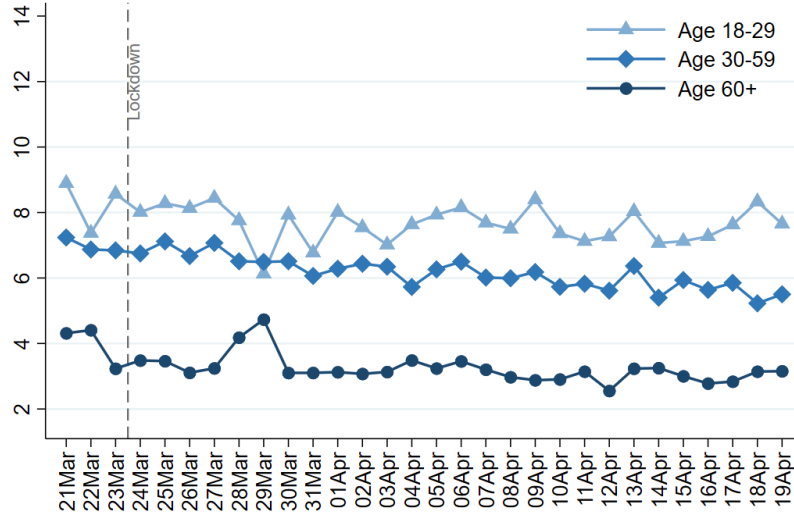


Figure 7b Anxiety by living arrangement

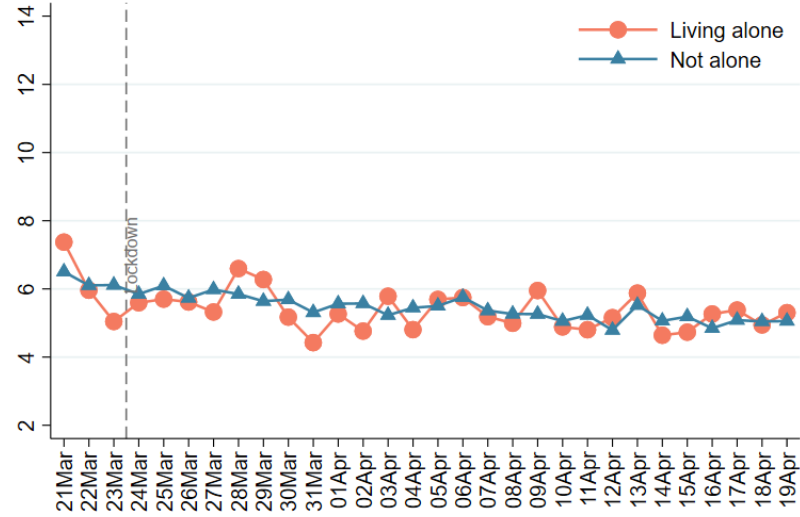


Figure 7c Anxiety by household income

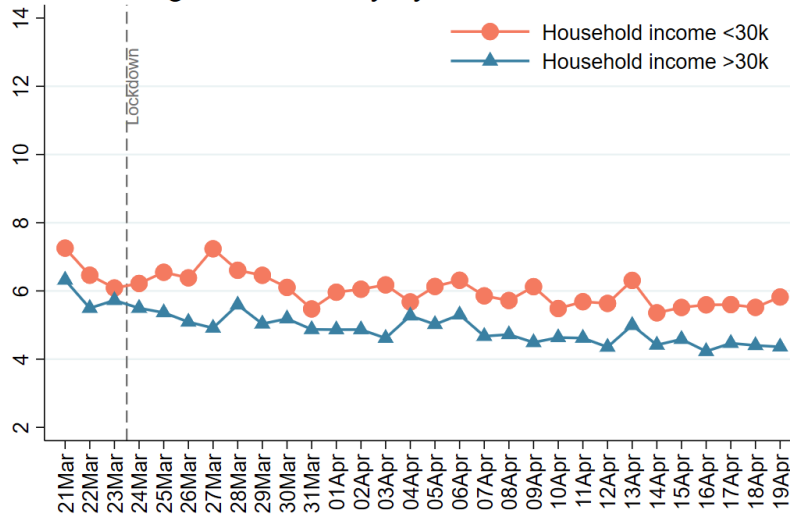
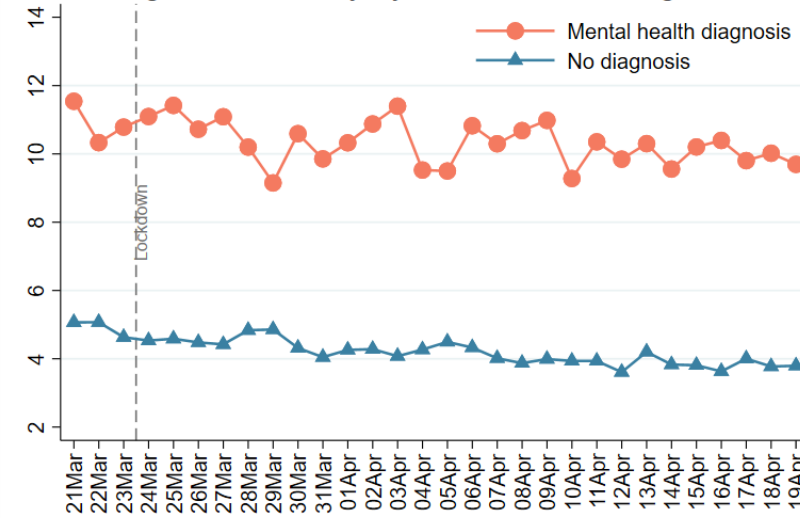
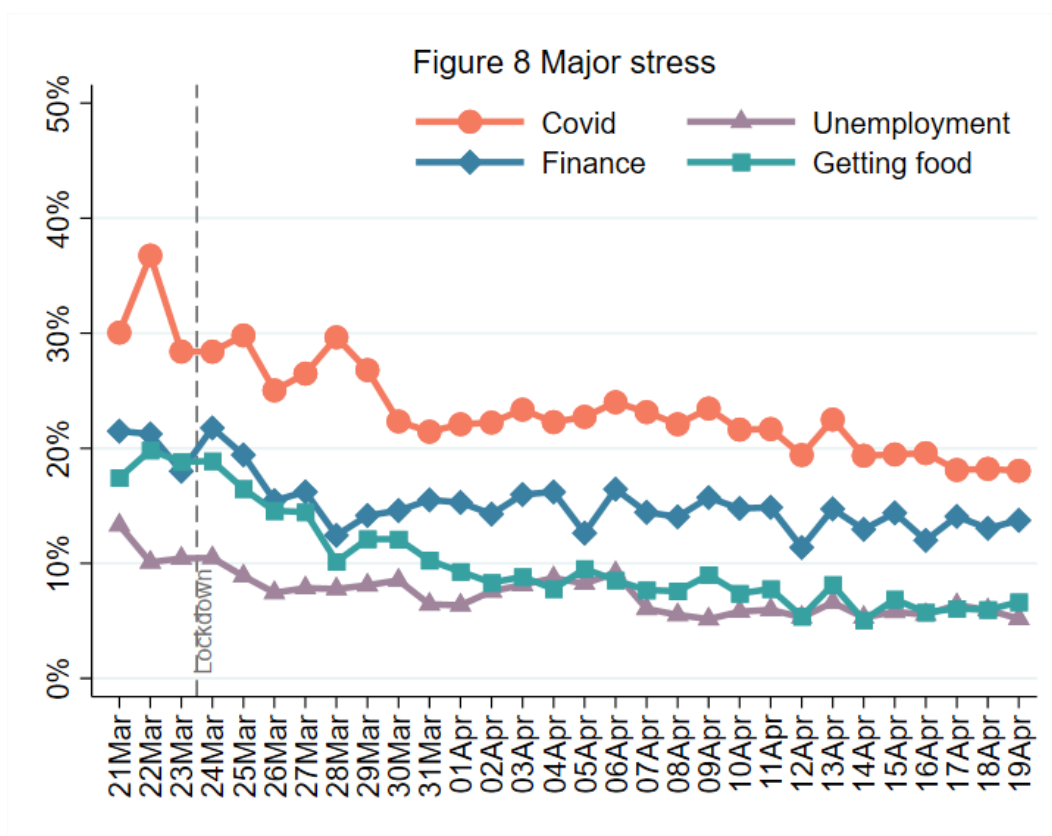


Figure 7d Anxiety by mental health diagnosis



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 decreased since lockdown began and continues to decrease. But Covid-related stress is still being reported by a greater number of people than stresses relating to finance, unemployment, or accessing food. Stressors relating to finance and food have stabilised over the past fortnight.

Stress relating to Covid-19 continues to be highest amongst those aged 30-59, but has continued to decline in all groups. It is still a more volatile worry amongst people living alone and a greater worry amongst people with a lower household income or a diagnosed mental health condition. Stress relating to unemployment and finance has remained relatively stable over the past week, although these stressors are still greater amongst people under the age of 60 and people with a diagnosed mental health condition. Financial stressors are also greater amongst people with lower household income. Stress relating to accessing food (food security) have stabilised over the past week. But worries remain higher for people living alone, with lower household incomes, and with a diagnosed mental health condition. People with a diagnosed mental health condition have had the steepest decrease.

Figure 9a Covid-19 stress by age groups

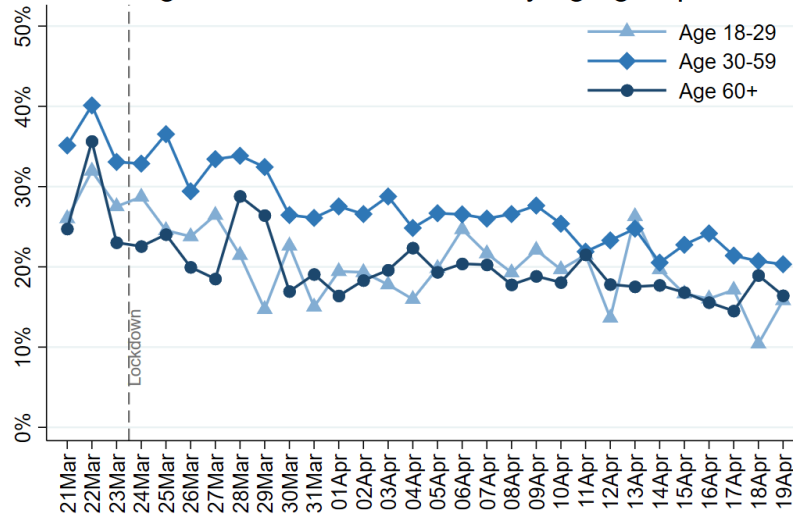


Figure 9b Covid-19 stress by living arrangement

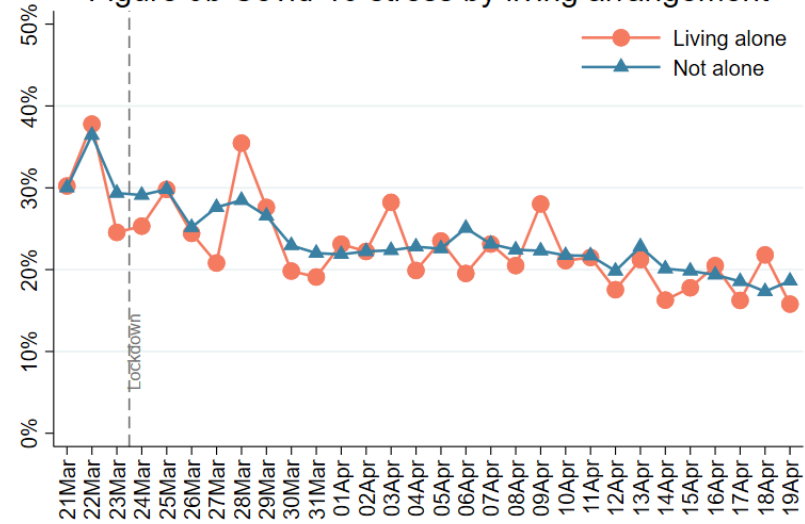


Figure 9c Covid-19 stress by household income

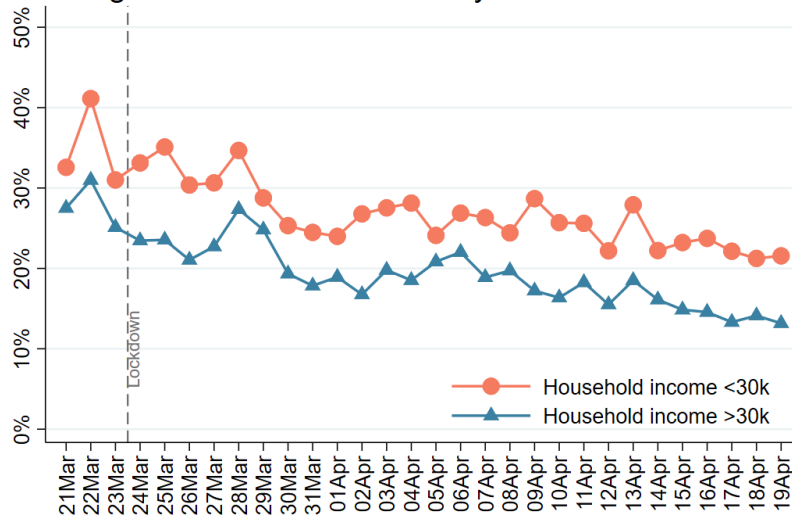


Figure 9d Covid-19 stress by mental health diagnosis

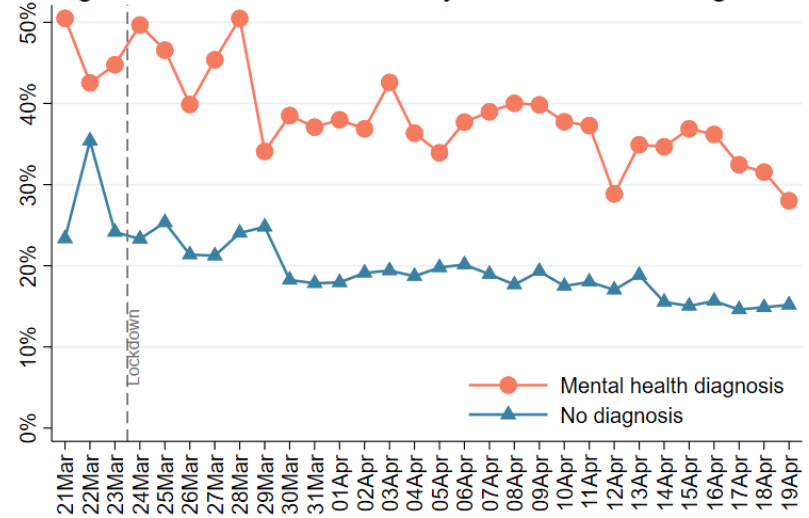


Figure 10a Unemployment stress by age groups

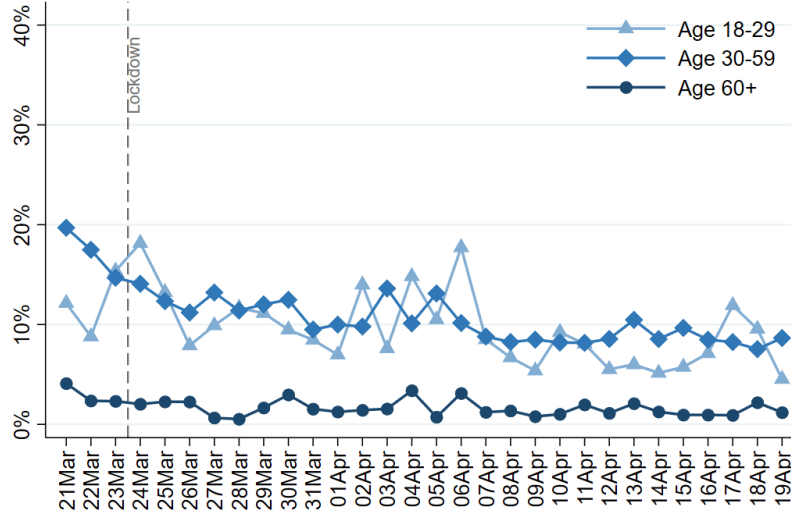


Figure 10b Unemployment stress by living arrangement

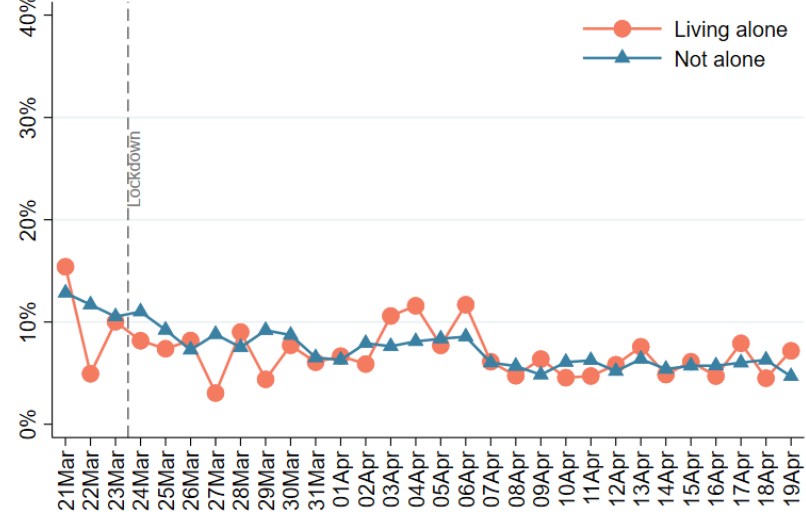


Figure 10c Unemployment stress by household income

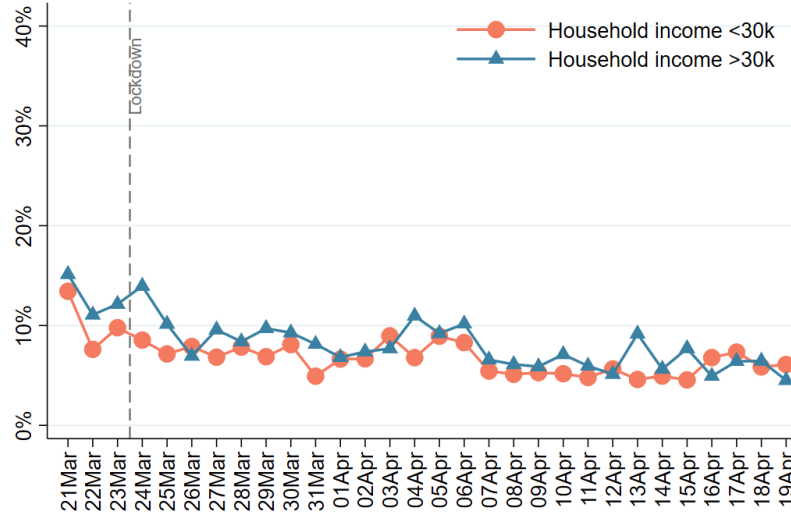


Figure 10d Unemployment stress by mental health

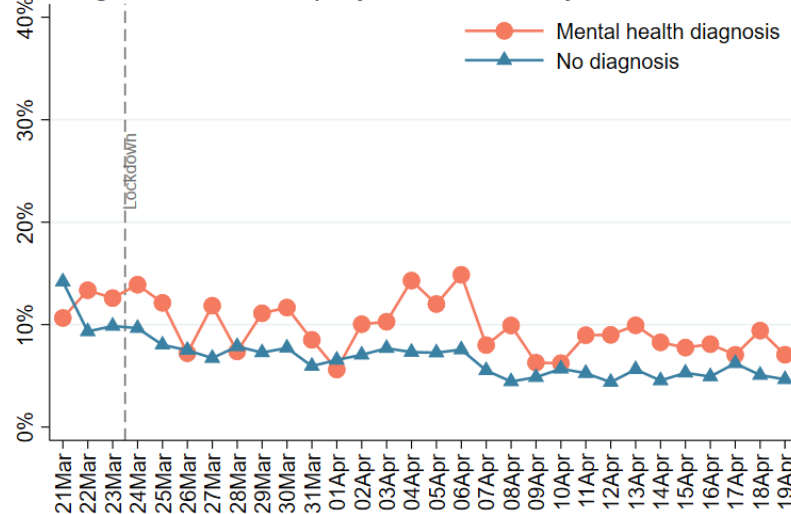


Figure 11a Financial stress by age groups

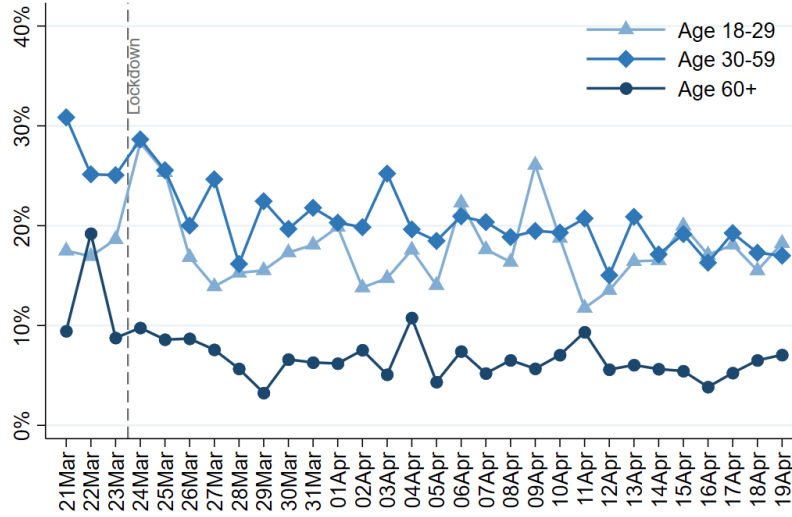


Figure 11b Financial stress by living arrangement

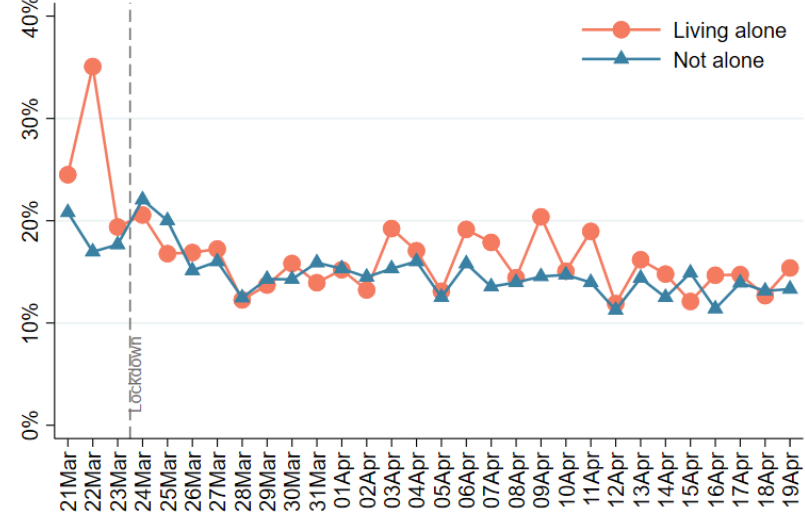


Figure 11c Financial stress by household income

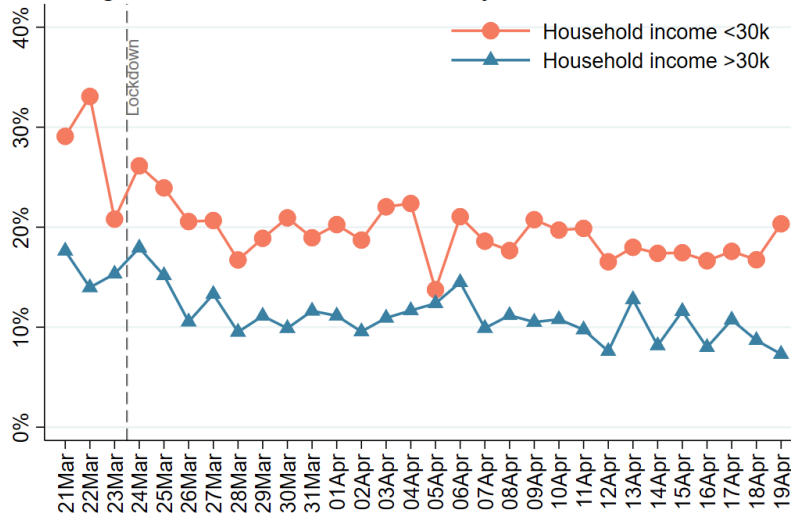


Figure 11d Financial stress by mental health diagnosis

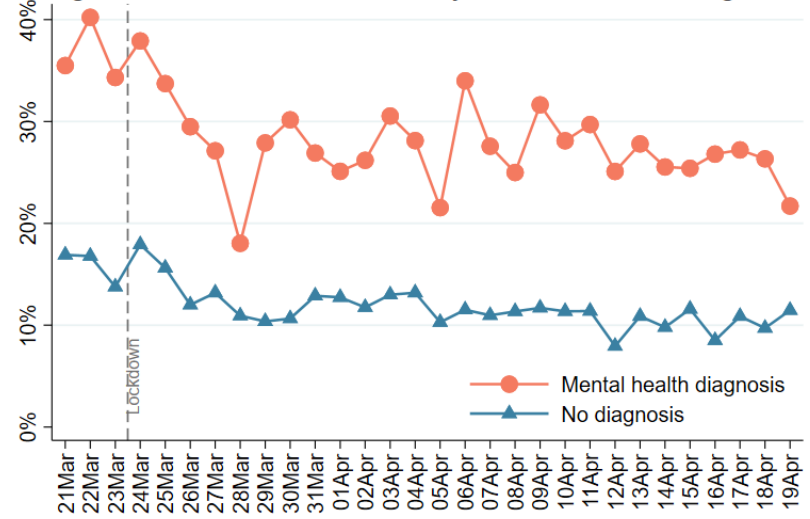


Figure 12a Food security stress by age groups

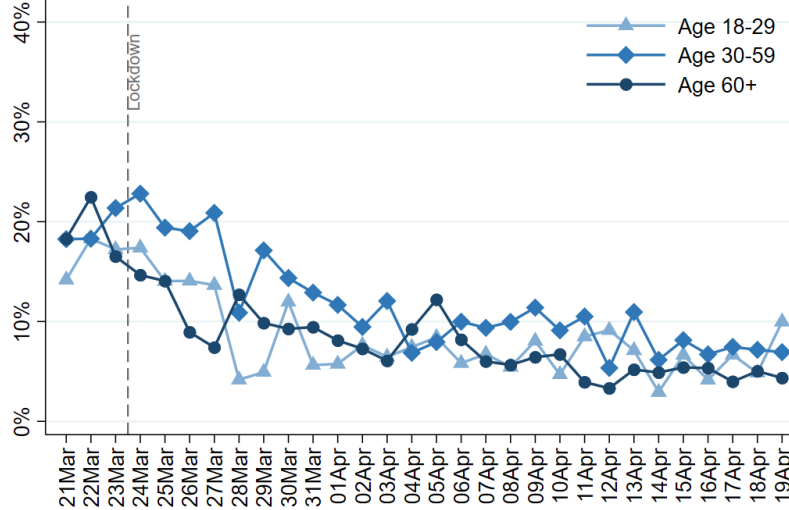


Figure 12b Food security stress by living arrangement

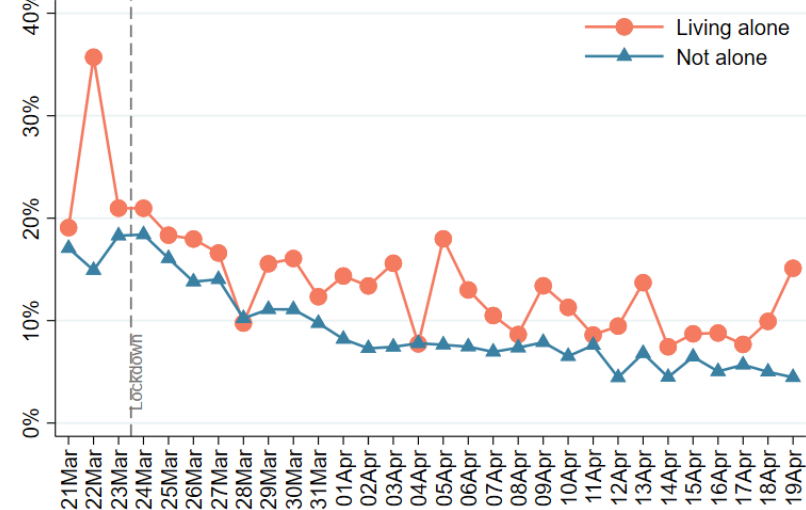


Figure 12c Food security stress by household income

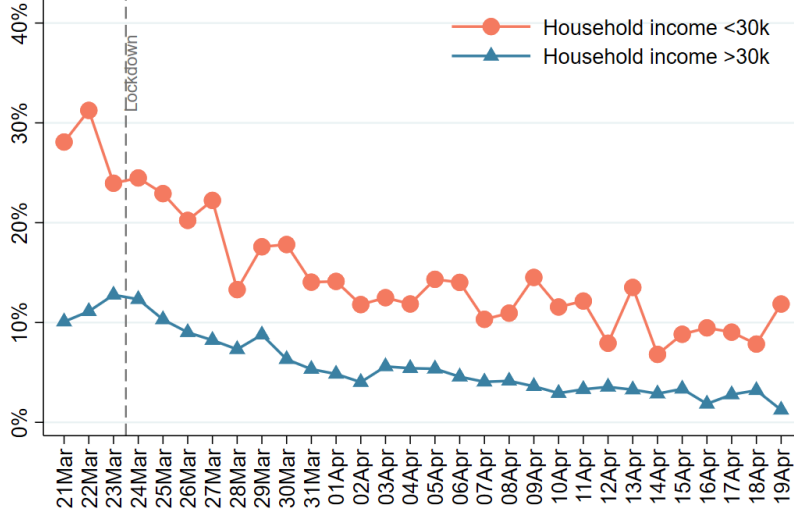
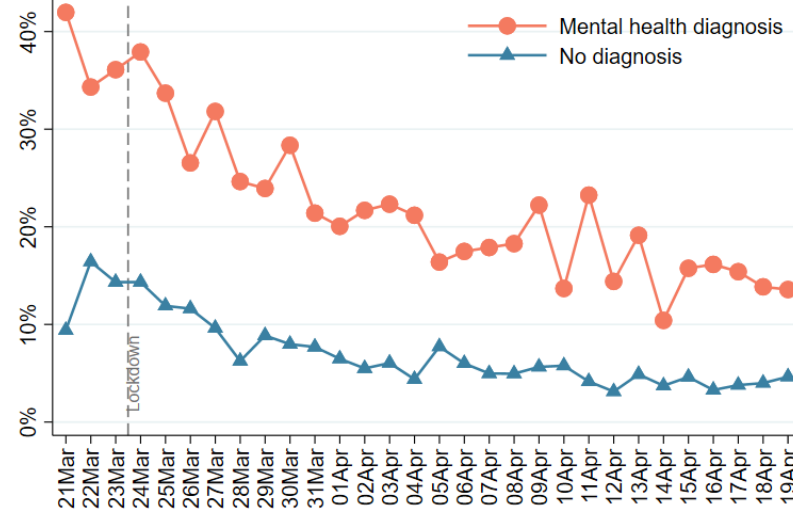
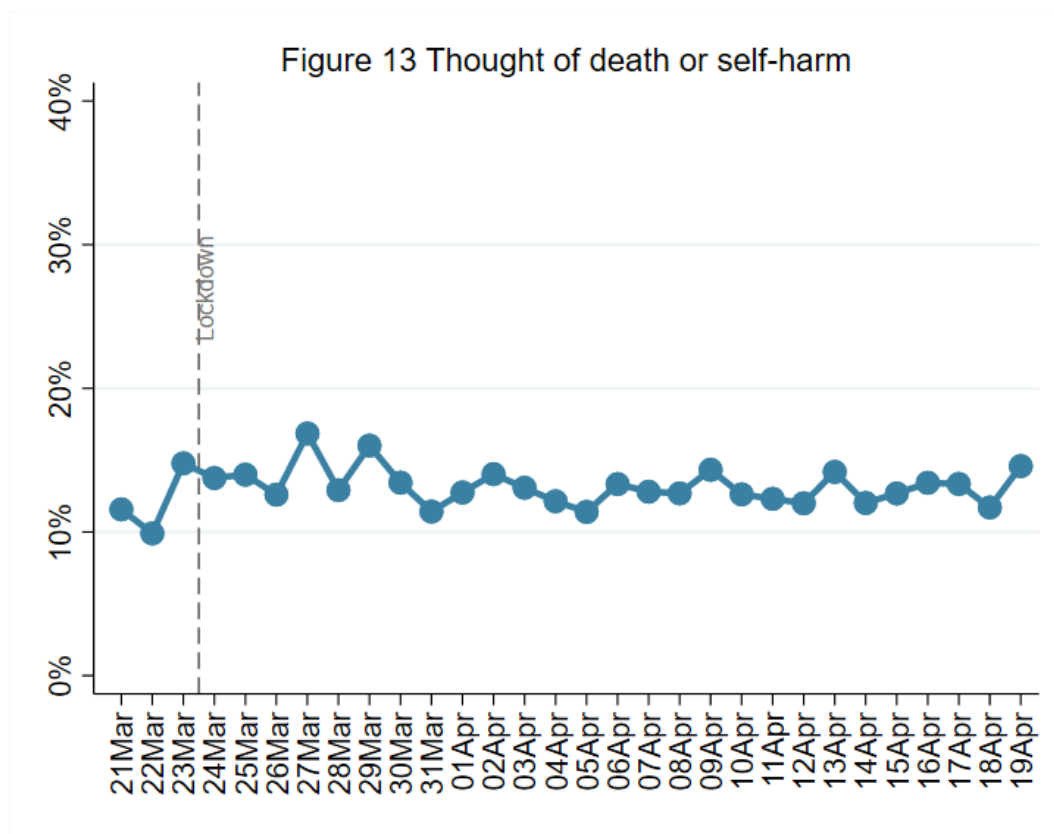


Figure 12d Food security stress by mental health



3. Self-harm and abuse

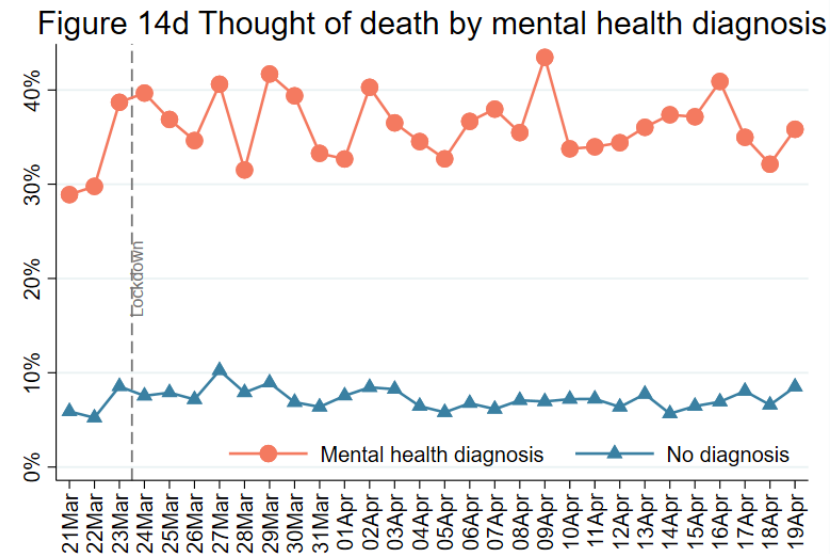
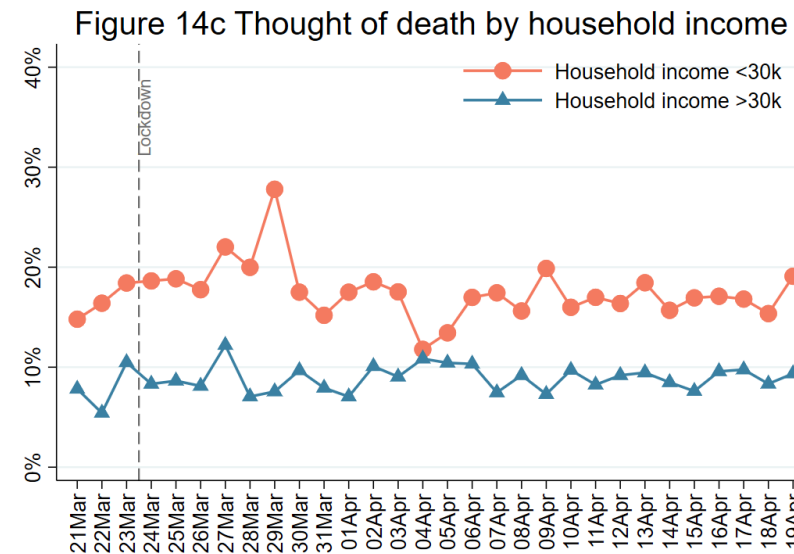
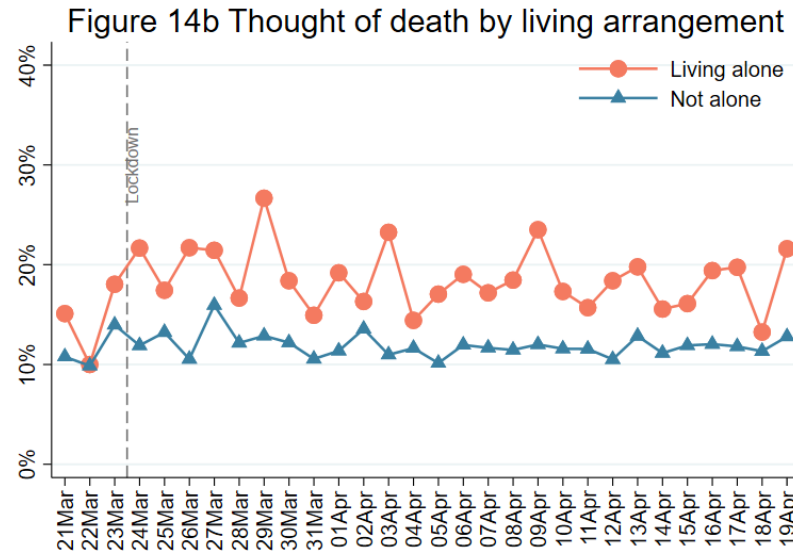
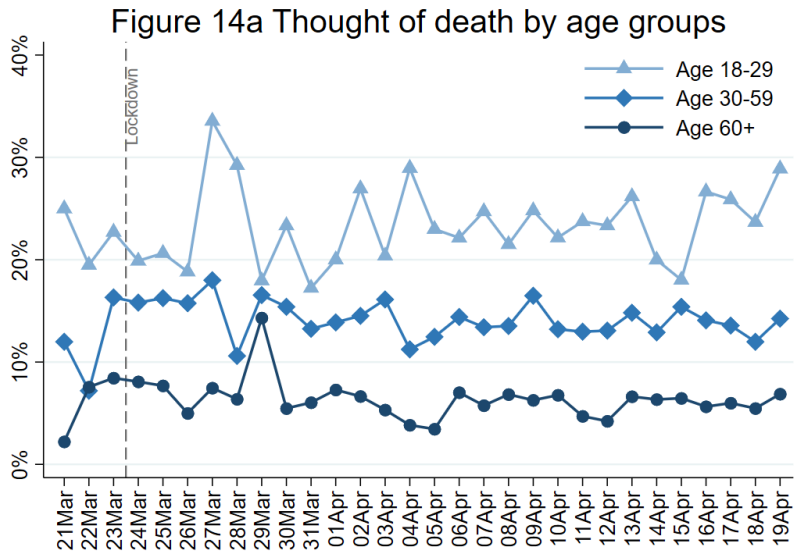
3.1 Thoughts of death or self-harm



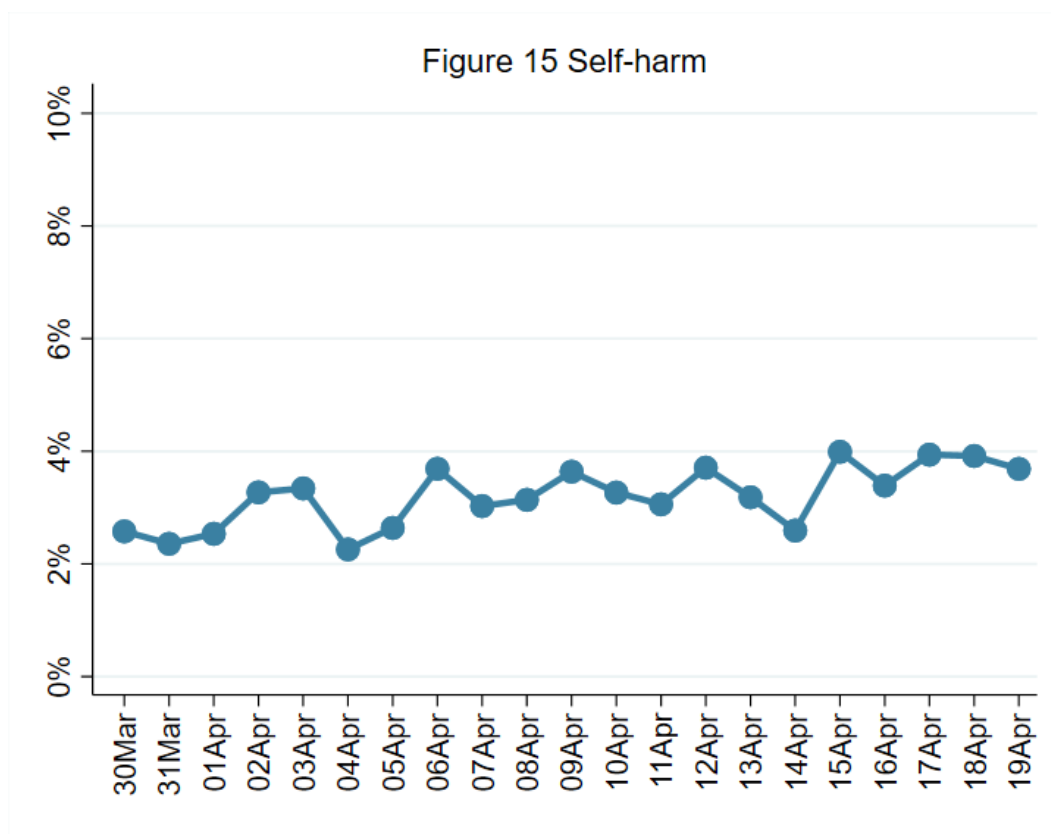
FINDINGS

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

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 living alone, those with a lower household income, and people with a diagnosed mental health condition. Thoughts have also been more volatile amongst these groups.



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 data are only available for the last week onwards.

Self-harm has been reported to be higher amongst younger adults, those living alone, those with lower household income, and those with a diagnosed mental health condition. There are suggestions that self-harm may be increasing amongst younger adults. However, this pattern remains to be confirmed with data in future weeks. 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.

Figure 16a Self-harm by age groups

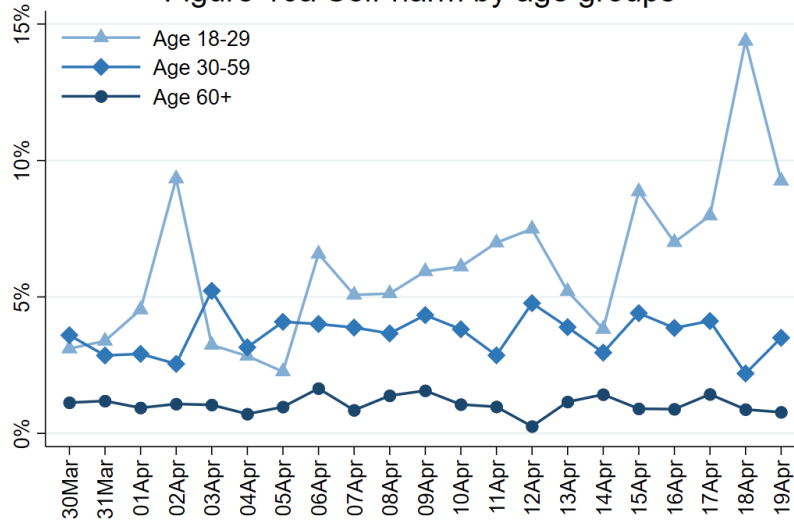


Figure 16b Self-harm by living arrangement

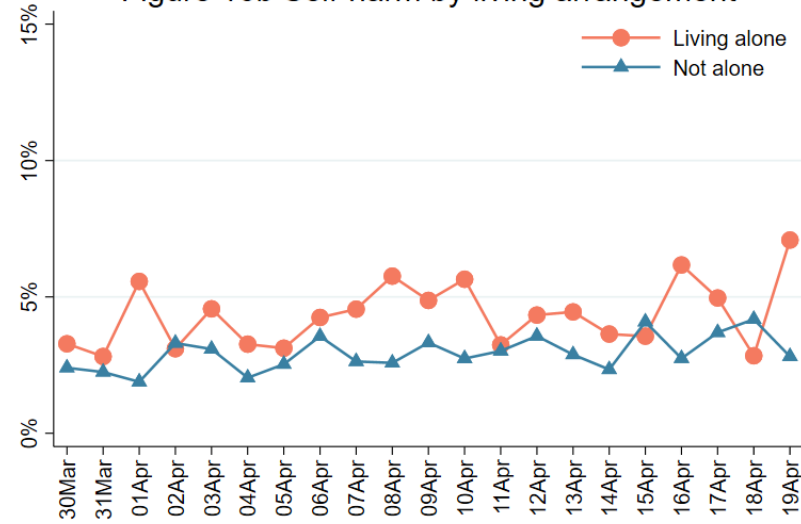


Figure 16c Self-harm by household income

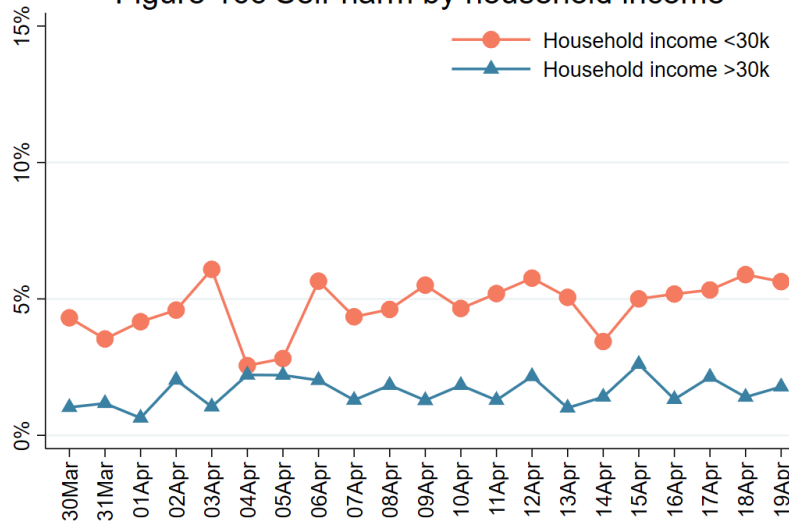
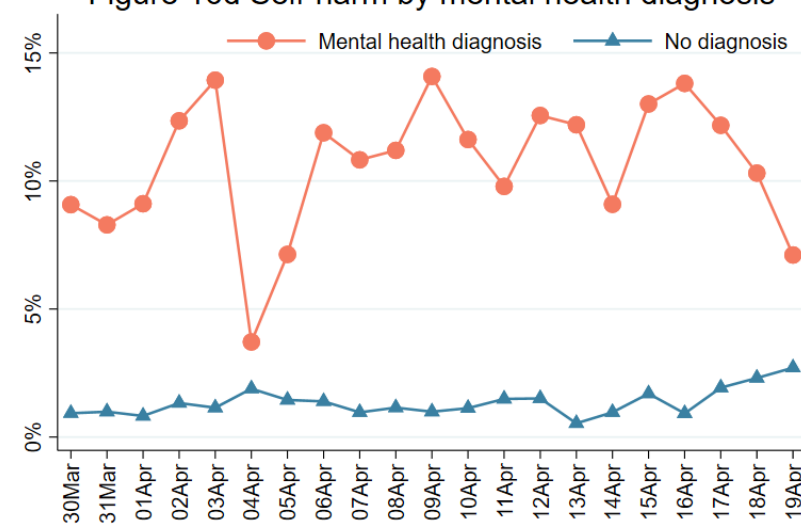
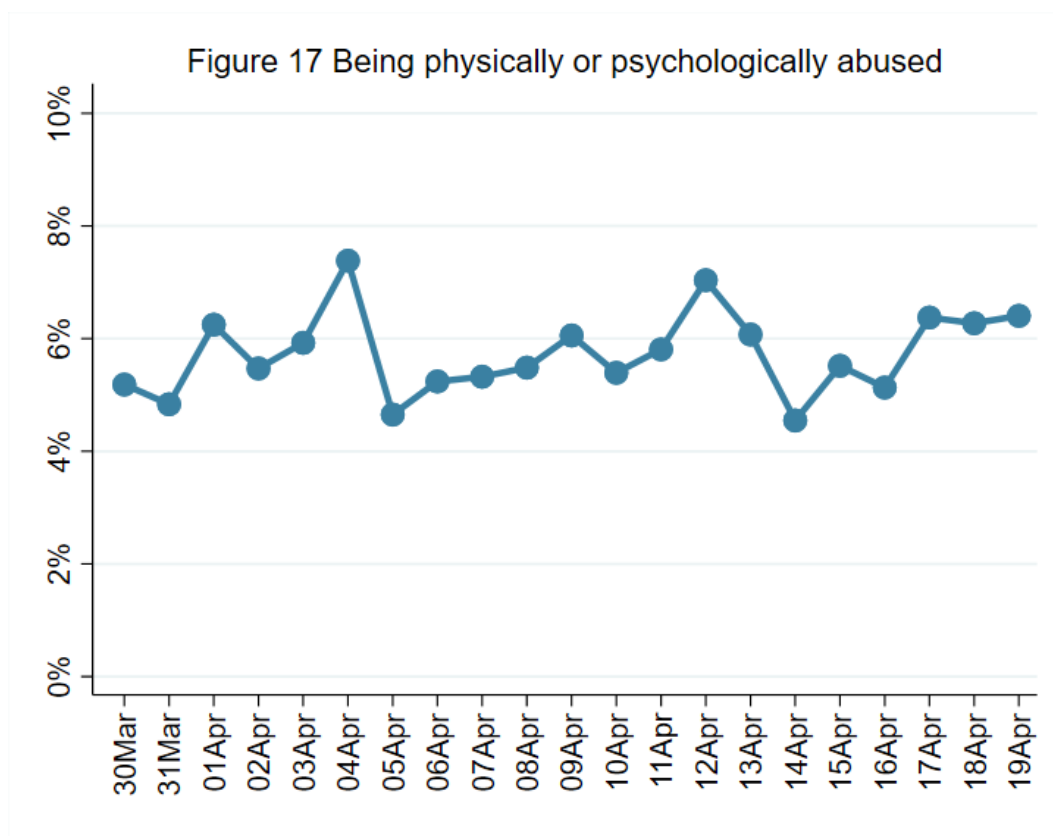


Figure 16d Self-harm by mental health diagnosis



3.2 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 abuse. Abuse data are only available for the last week onwards.

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 noted that people living alone are still reporting abuse, which could refer to physical abuse by people visiting them in their homes, or psychological abuse through other modes of contact. 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.

Figure 18a Abuse by age groups

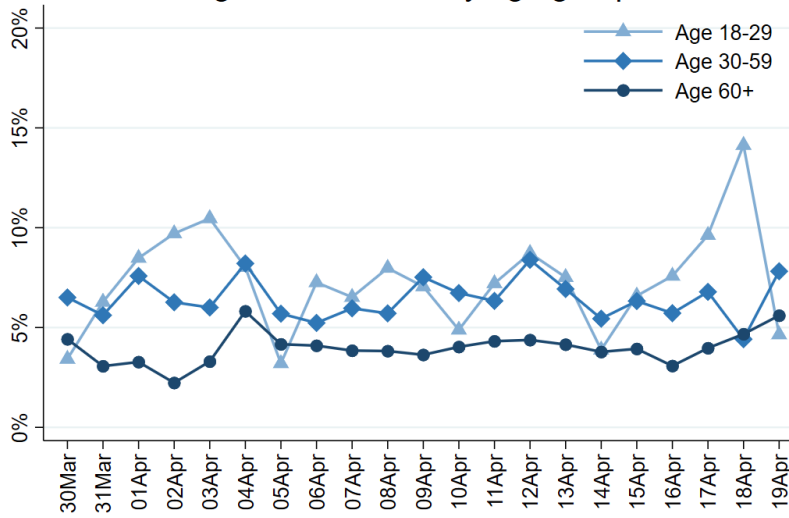


Figure 18b Abuse by living arrangement

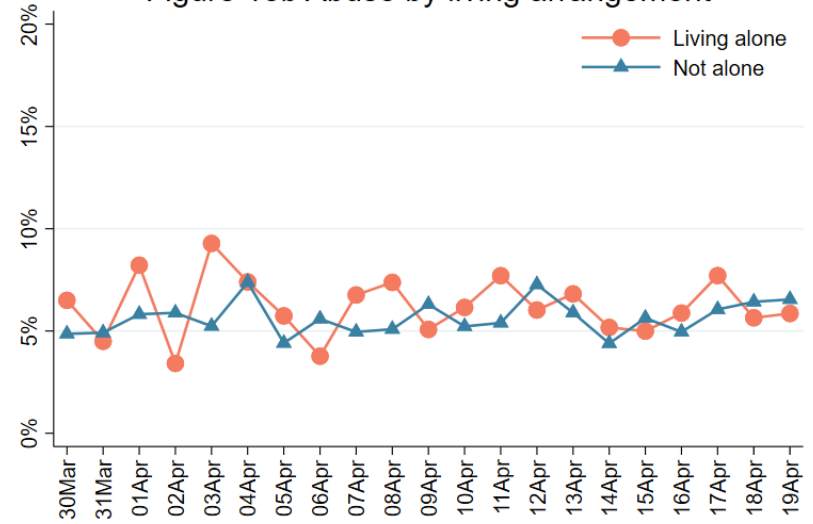


Figure 18c Abuse by household income

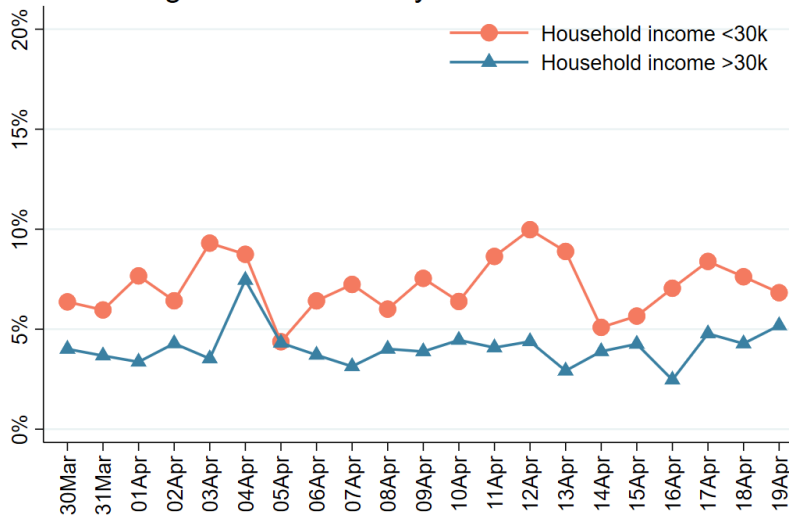
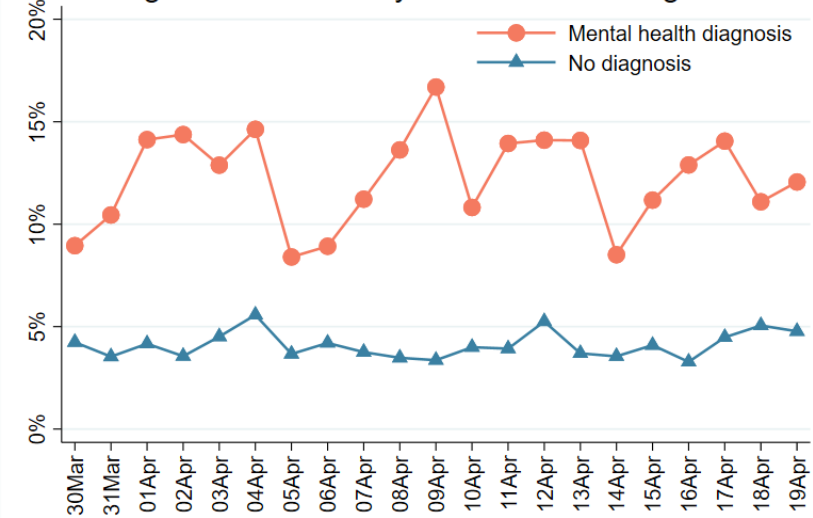
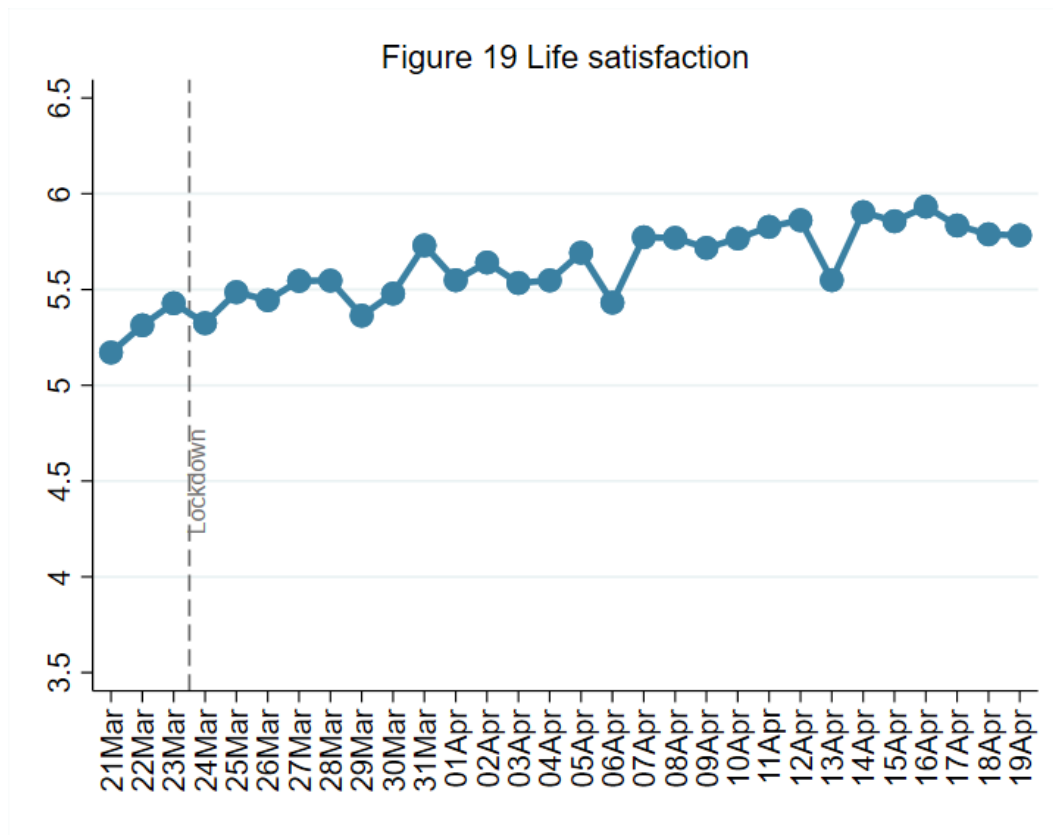


Figure 18d Abuse by mental health diagnosis



4. General well-being

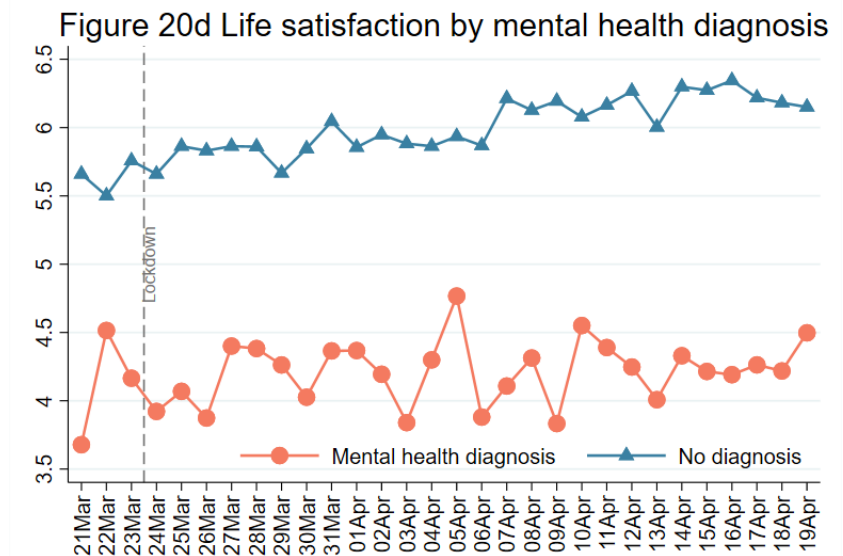
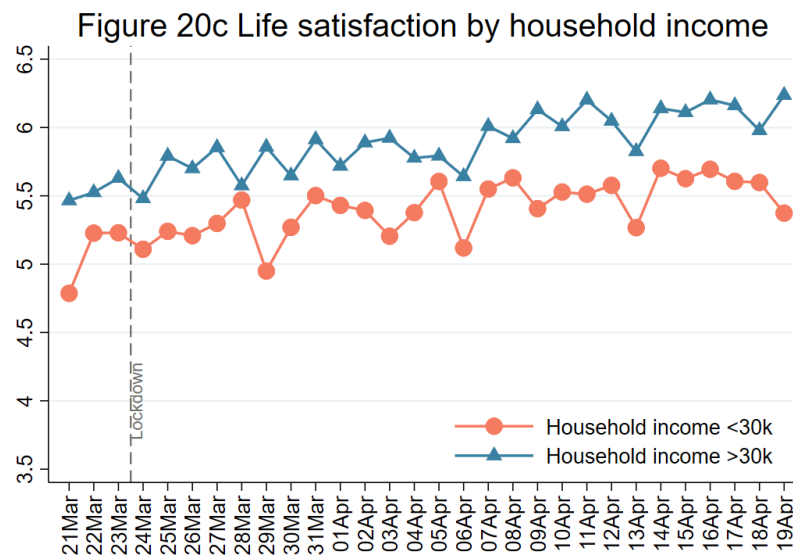
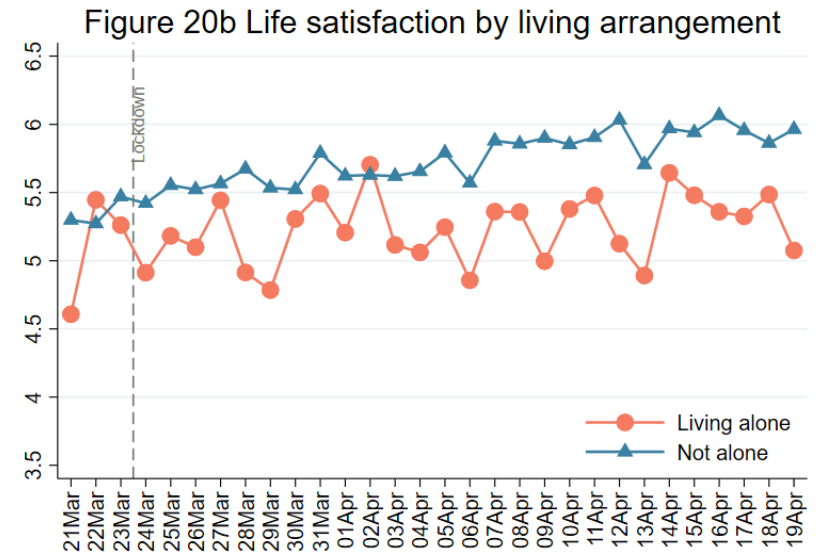
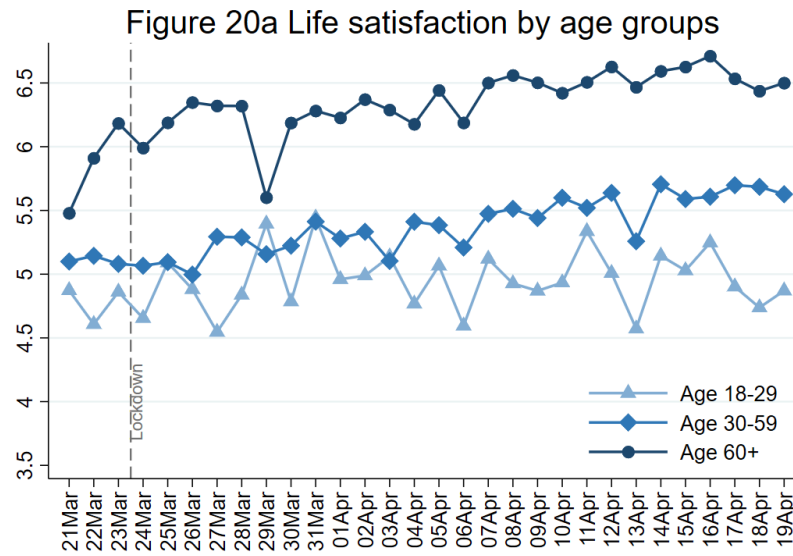
4.1 Life Satisfaction



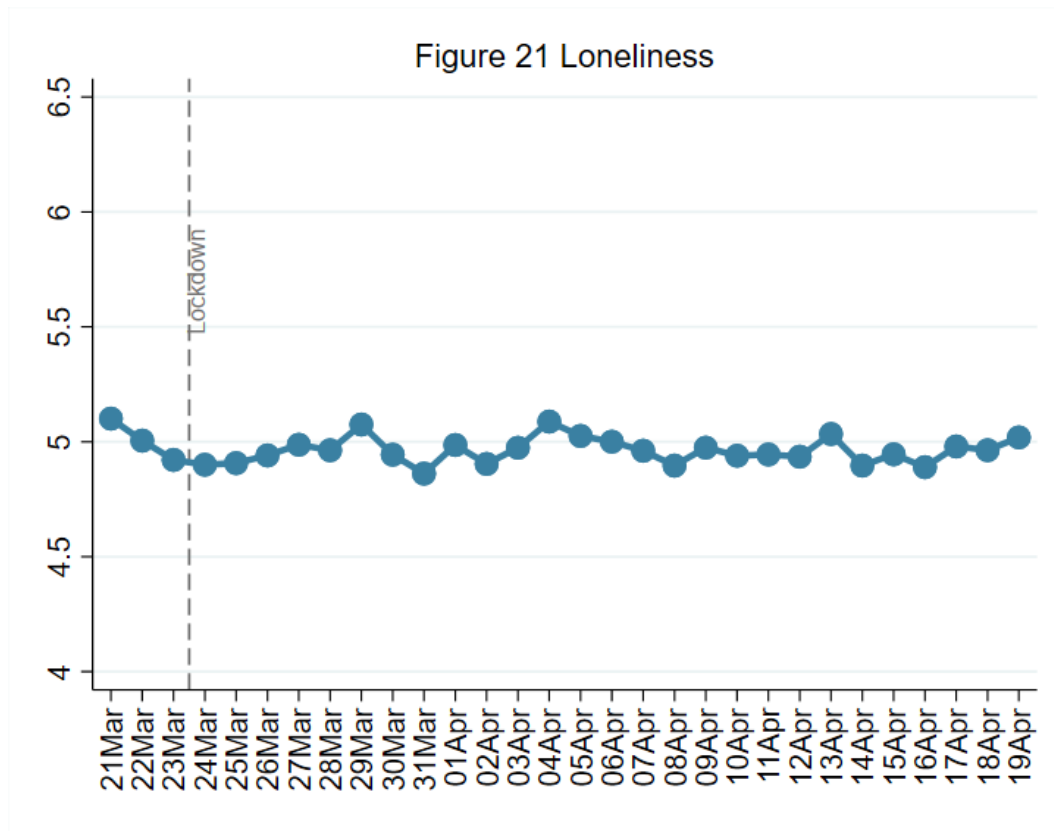
FINDINGS

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).

Wellbeing is still noticeably lower than for the past 12 months as reported by YouGov, where it appears a decrease took place prior to lockdown coming in. Since then, our sample shows that life satisfaction (one component of wellbeing) has been increasing gradually. This appears to have stabilised in the past week, but this remains to be confirmed with future data. It remains more volatile amongst younger adults (those aged 18-29) and people living alone. There is less evidence of an improvement amongst adults aged 18-29 or amongst individuals with a diagnosed mental health condition.



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 “hardly ever” to “often”, with higher scores indicating greater loneliness.

Loneliness levels continue to remain relatively stable. They are still higher amongst younger adults, those living alone, those with lower household income levels, and those with an existing diagnosed mental health condition.

Figure 22a Loneliness by age groups

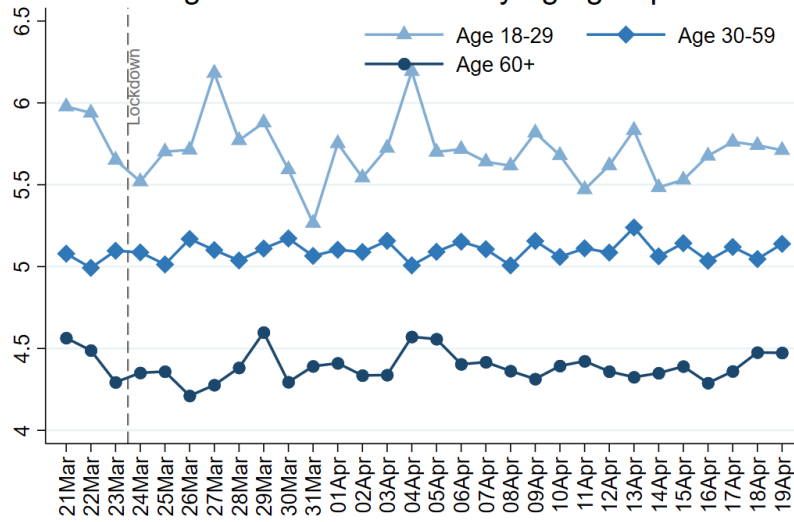


Figure 22b Loneliness by living arrangement

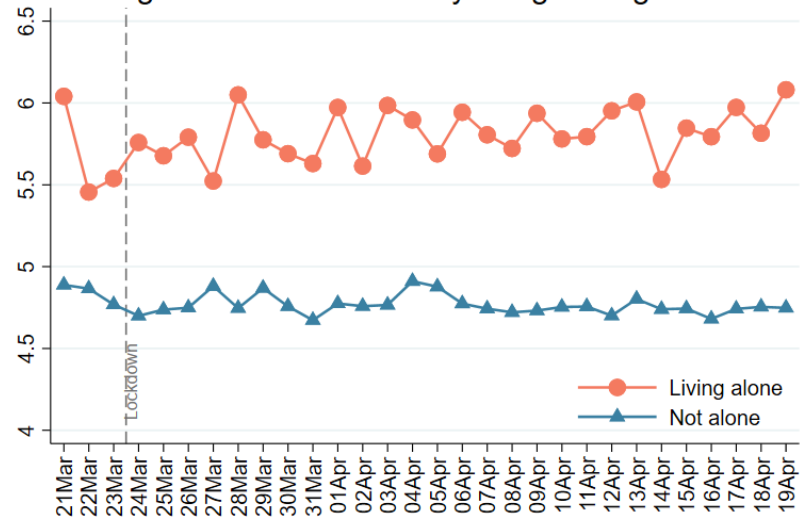


Figure 22c Loneliness by household income

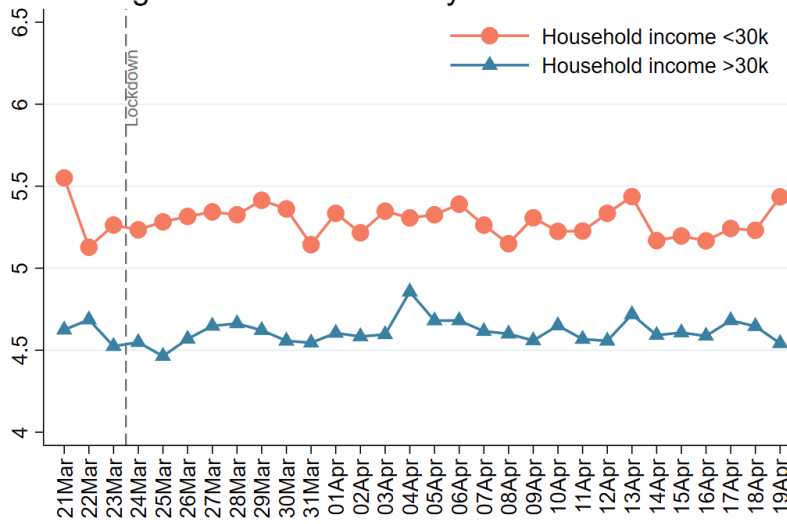
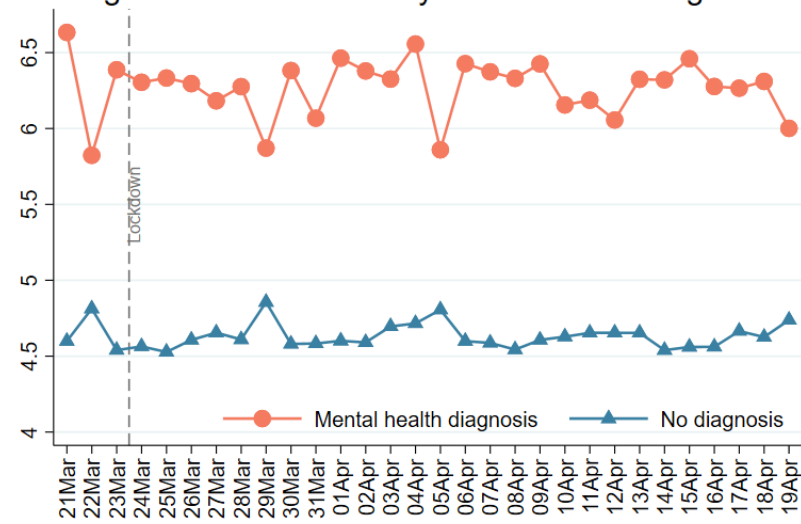


Figure 22d Loneliness by mental health diagnosis



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. To date, over 75,000 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 does not aim to be representative of the UK population, but instead 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 who were not designated as keyworkers and who therefore are requested to stay at home by the government. 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 of March to the 19th of April (the latest data available). Aiming at a representative sample of the population for each sub-dataset, we weighted the data for each day to the proportions of age group, gender and educational level on the basis of ONS population estimates and Annual Population Survey (2018).

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 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, visit www.MARCHNetwork.org/research

Demographics of respondents included in this report

NB In this report, we only included respondents who were not keyworkers.

Table A1 Demographics of participants in the pooled raw data (unweighted)

	Number of observations	%
Age		
18-29	9,314	8.74
30-59	60,098	56.4
60+	37,108	34.8
Gender		
Men	35,222	25.4
Women	103,391	74.6
Living alone		
No	85,372	80.2
Yes	21,148	19.9
Annual household income		
>30k	56,655	59.1
<30k	39,284	41.0
Any diagnosed mental health conditions		
No	86,690	81.4
Yes	19,830	18.6