



# Covid-19 Social Study

## Results Release 25

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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

## Background

This report provides data from the last 30 weeks of the UK COVID-19 Social Study run by University College London: a panel study of over 70,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this TWENTY-FIFTH report, we focus on psychological responses to the first thirty-four weeks since just before the UK lockdown was first announced (21/03 to 15/11). 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\*\*\*** Maintaining social distancing and financial situation since lockdown, and with an additional focus on gender, ethnicity, educational levels and physical health conditions

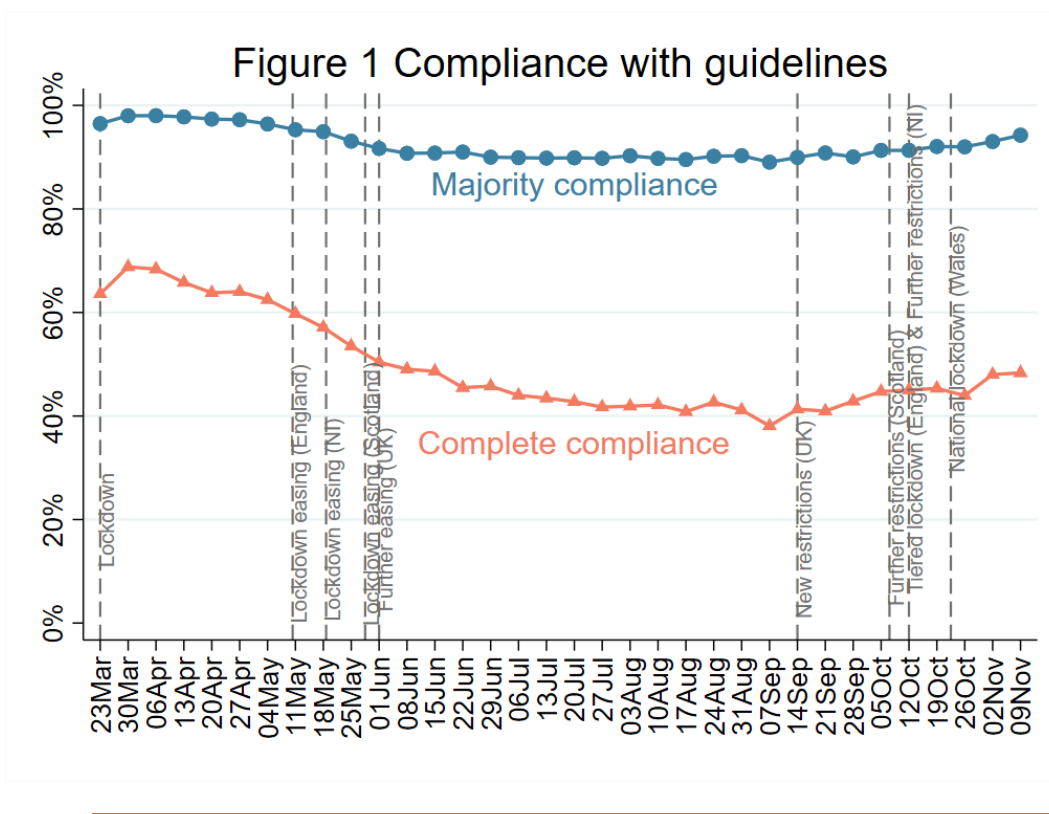
This study is not representative of the UK population but instead was designed to have good stratification across a wide range of socio-demographic factors enabling meaningful subgroup analyses to understand the experience of Covid-19 for different groups within society. Data are weighted using auxiliary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

## Findings

- Data suggest there are widening financial inequalities within society as a result of the pandemic. Amongst people finding things financially very difficult before the pandemic, 70% are now reporting that things are even worse for them. This is a deterioration in experiences since July when only 57% of the same group said things were even worse for them. It is also 3.5 times higher than the number of people reporting they are worse off amongst those who were comfortably off before the pandemic (20%).
- The worsening financial position has been felt most by people living in the North East of England, where there have been particularly strong restrictions in the past few months and 39% of all adults (regardless of their financial position before the pandemic) say things are now worse for them.
- There are suggestions that even for those who are comfortably off, economic benefits of the pandemic have diminished, with just 27% reporting they are better off now compared to before the pandemic (down from 33% in July). Amongst those who were financially finding things quite or very difficult before the pandemic, only 7-10% think their financial situation has improved.
- In the week commencing 9<sup>th</sup> November, 41% reported maintaining social distancing completely, with a further 49% reporting that they were maintaining it to a large extent. However, 8% reported not always maintaining social distancing, and 2% reported not following it at all. This is an improvement on the summer, when 3% reported not following it at all, over twice as many people (18%) reported not always following it, and nearly 50% fewer people reported following social distancing completely (28%).
- Both men and women have been maintaining social distancing to a very similar extent, as have people living alone compared to people living with others. But younger adults have been maintaining it less consistently. For example, in the past week, only 18% of adults aged 18-29 reported following social distancing completely (5% not at all), compared to 43% of adults aged 30-59 maintaining it completely (2% not at all), and 55% of adults over the age of 60 maintaining it completely (<1% not at all). Further, people with higher household income have been maintaining social distancing less effectively: 40% of people earning more than £30,000 a year have been maintaining social distancing completely compared to 44% of people earning less than £30,000 a year.
- Compliance has improved slightly in the past few weeks as cases of the virus have increased and stricter restrictions have been brought in. Levels of “complete” compliance are now around 47% (21% higher than they were at the end of August) and “majority” compliance is at 94% (5% higher than the end of August). The patterns of compliance remain as they were for the last few months though, with compliance lower in higher income households, in England, in urban areas, amongst women, amongst people with a physical health condition, and amongst adults living with children compared to adults not living with children.
- Depression and anxiety levels have stayed relatively constant in the past two weeks. Depression and anxiety levels are worse than they were in mid-August, but better lower than they were at the start of lockdown in March.
- But wellbeing has worsened since new restrictions were brought in in mid-September. Life satisfaction is 8% lower than it was at the start of September but still 11% higher than it was at the start of the first lockdown in March. Further, happiness levels are now 5% lower than they were before more restrictions were brought in in mid-September, but 5% higher than during first lockdown in April. The decrease in recent weeks has been particularly evident amongst older adults (although they remain higher in this age group compared to younger adults).

# 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 who followed the recommendations “completely” (with a score of 7) or to a large extent (with a score of 5-7; described below as “majority” compliance).

Compliance has improved slightly in the past few weeks as cases of the virus have increased and stricter restrictions have been brought in. Levels of “complete” compliance are now around 47% (21% higher than they were at the end of August) and “majority” compliance is at 94% (5% higher than the end of August). The patterns of compliance remain as they were for the last few months though, with compliance lower in higher income households, in England, in urban areas, amongst women, amongst people with a physical health condition, and amongst adults living with children compared to adults not living with children.

Figures 2a-2l show “complete” compliance by demographic factors, while Figures 2m-2x show “majority” compliance by demographic factors.

Figure 2a Complete compliance by age groups

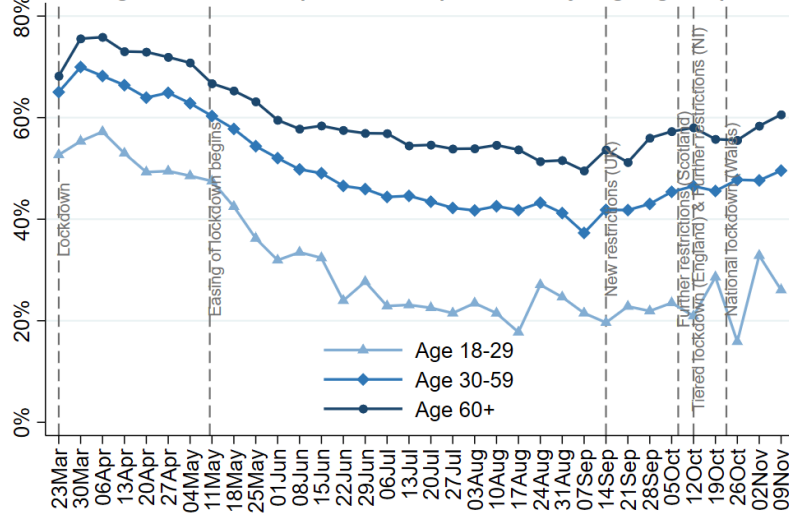


Figure 2b Complete compliance by living arrangement

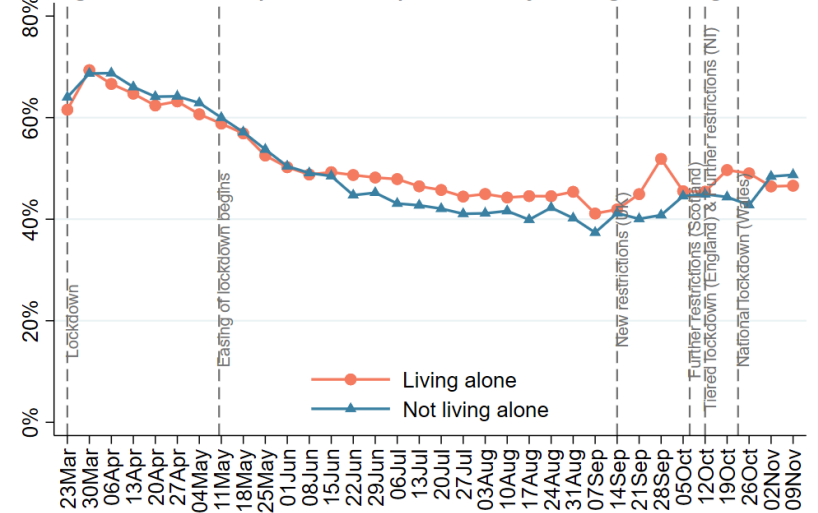


Figure 2c Complete compliance by household income

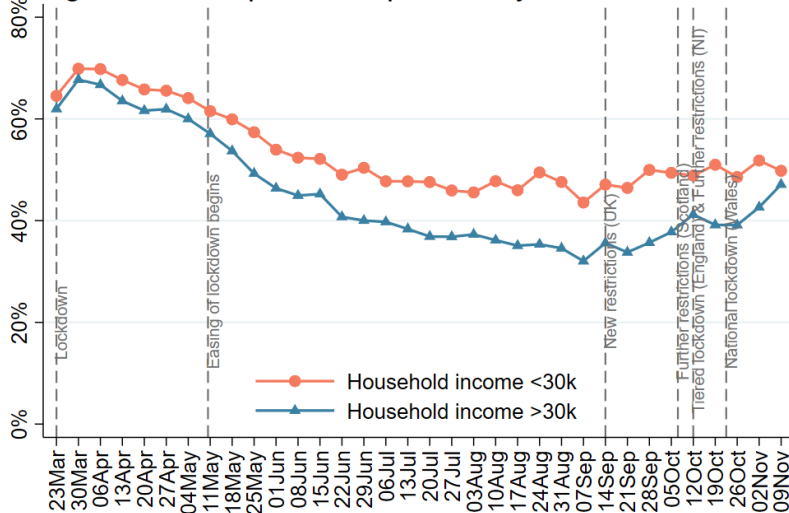


Figure 2d Complete compliance by mental health

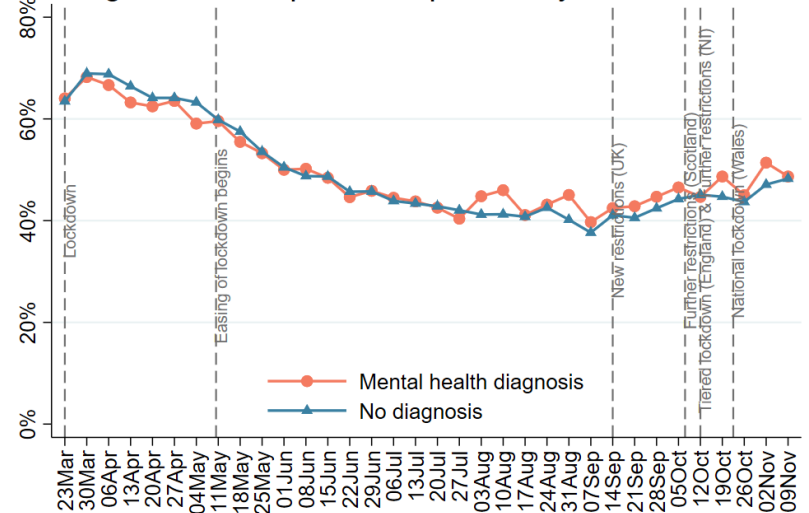


Figure 2e Complete compliance by nations

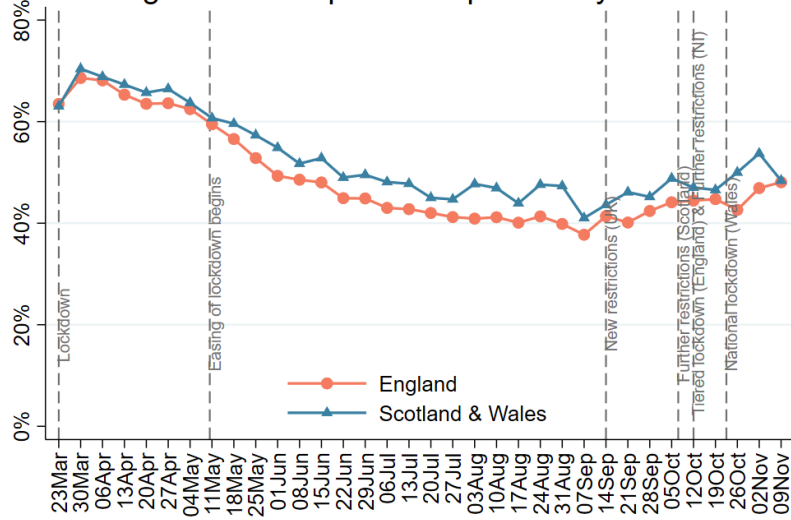


Figure 2f Complete compliance by keyworker status

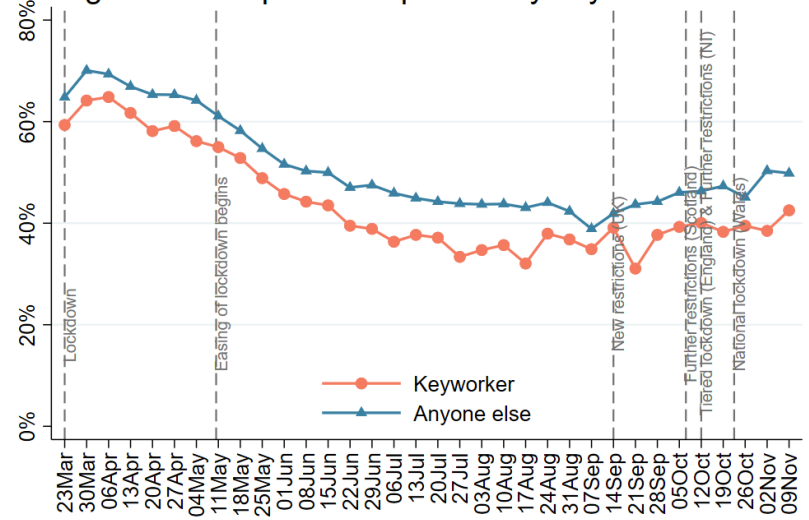


Figure 2g Complete compliance by living with children

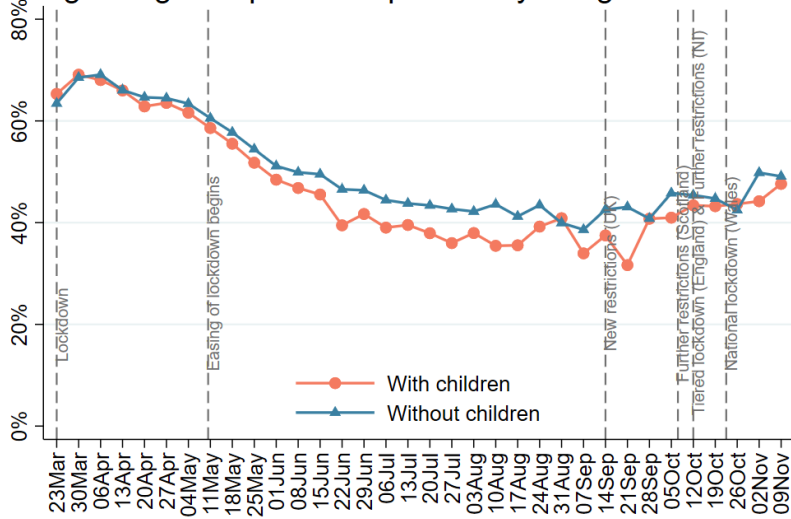


Figure 2h Complete compliance by living area

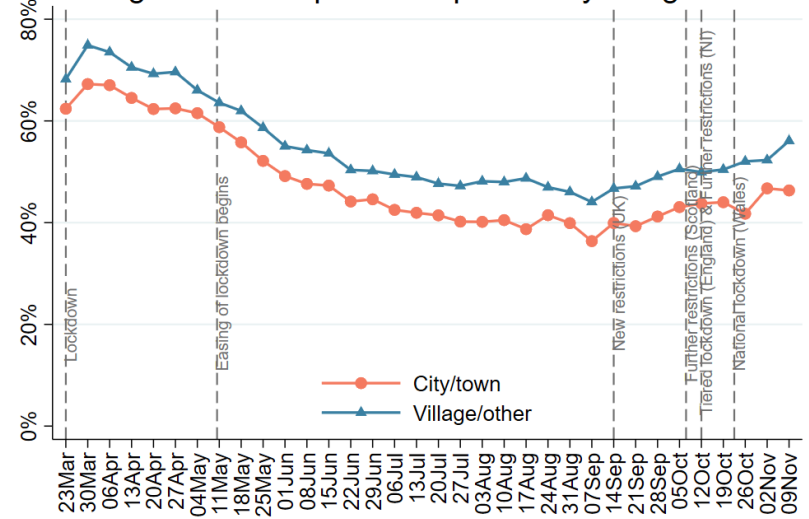


Figure 2i Complete compliance by gender

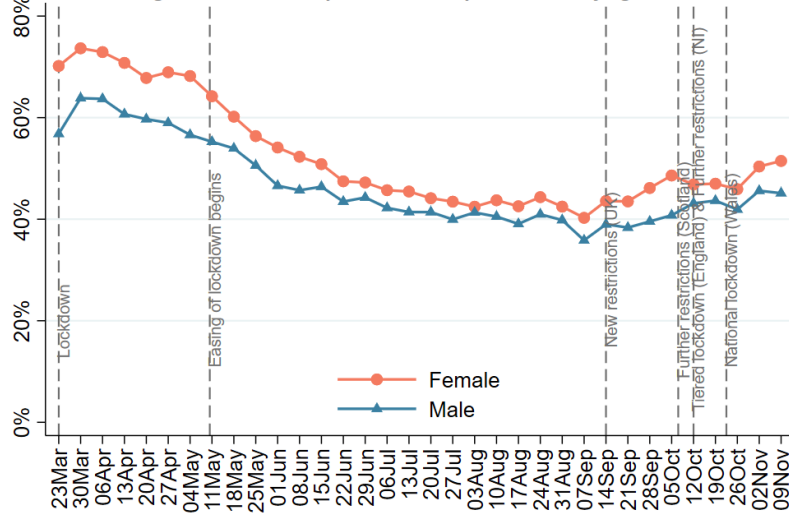


Figure 2j Complete compliance by ethnicity

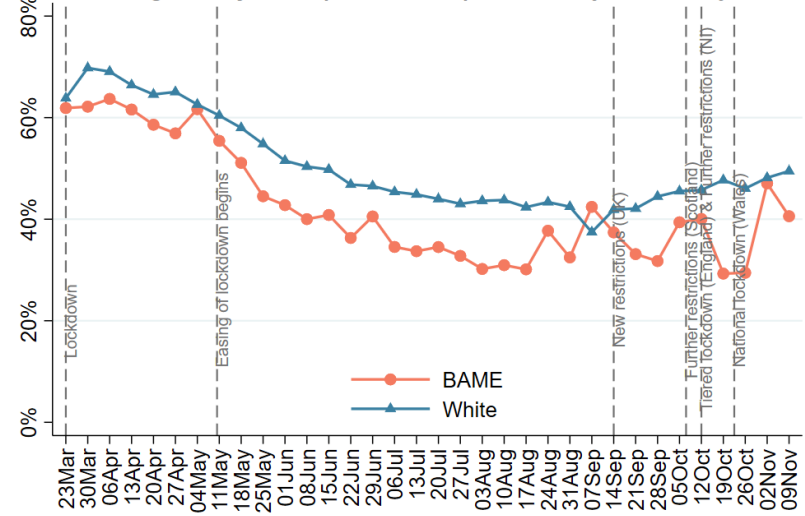


Figure 2k Complete compliance by educational levels

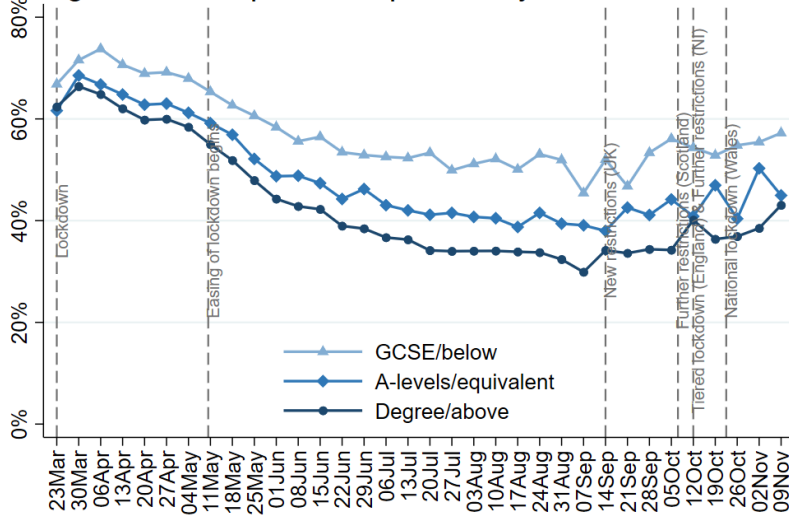


Figure 2l Complete compliance by physical health diagnosis

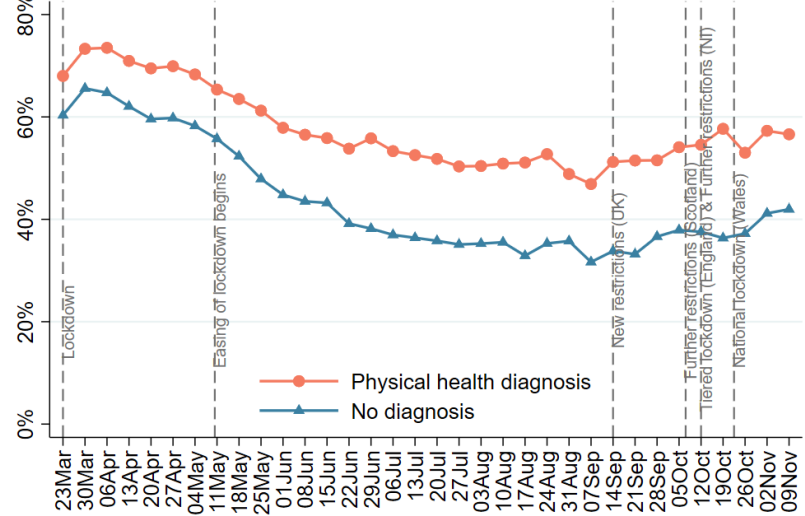


Figure 2m Majority compliance by age groups

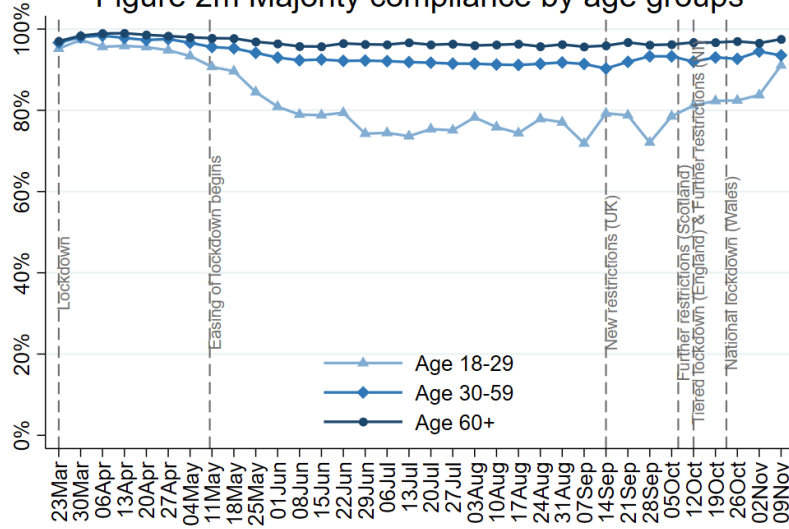


Figure 2n Majority compliance by living arrangement

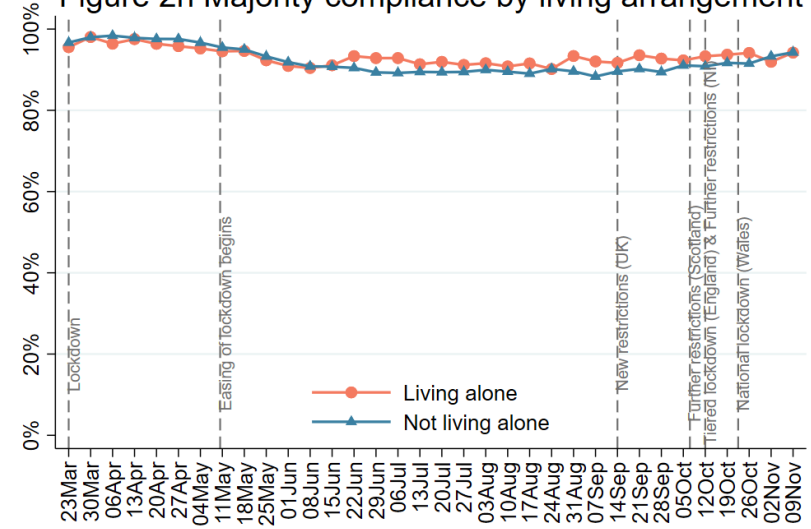


Figure 2o Majority compliance by household income

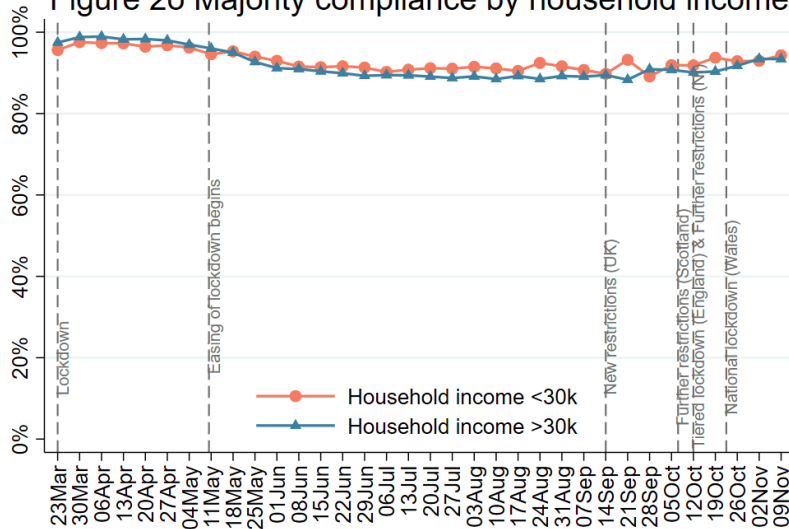
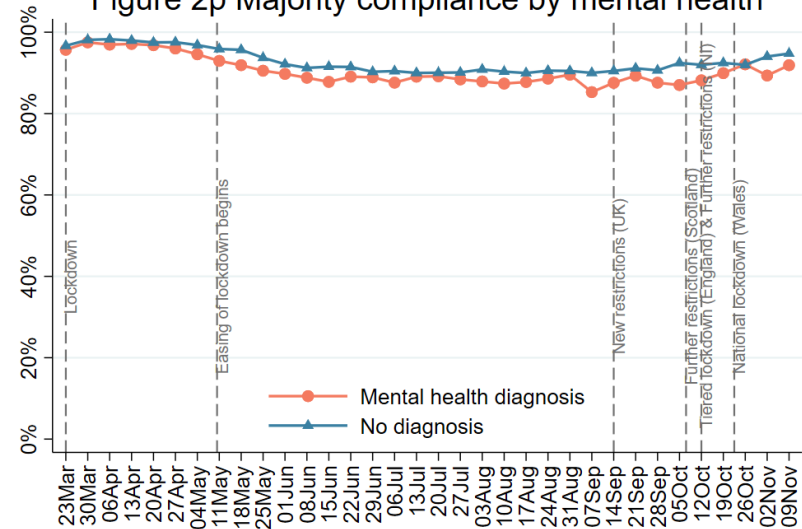
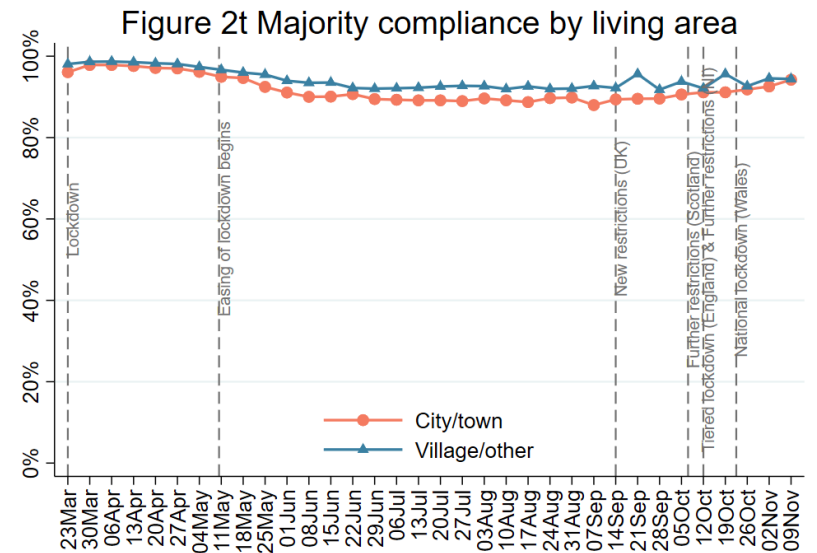
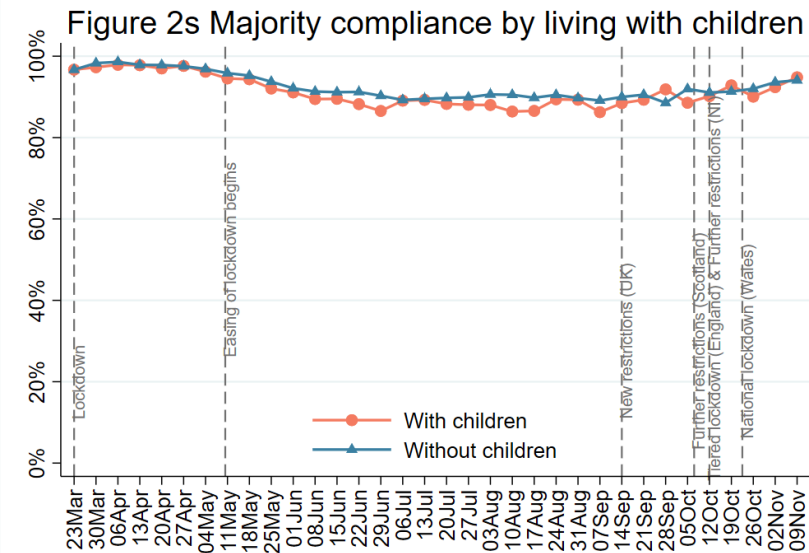
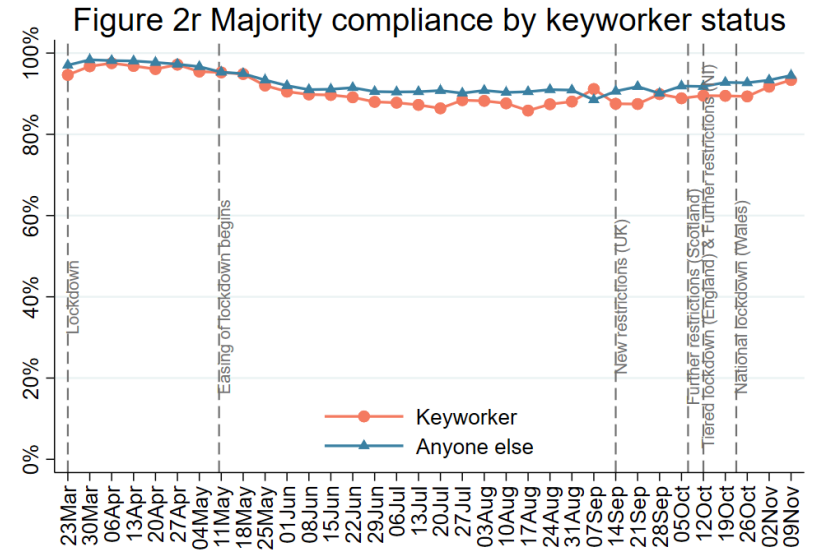
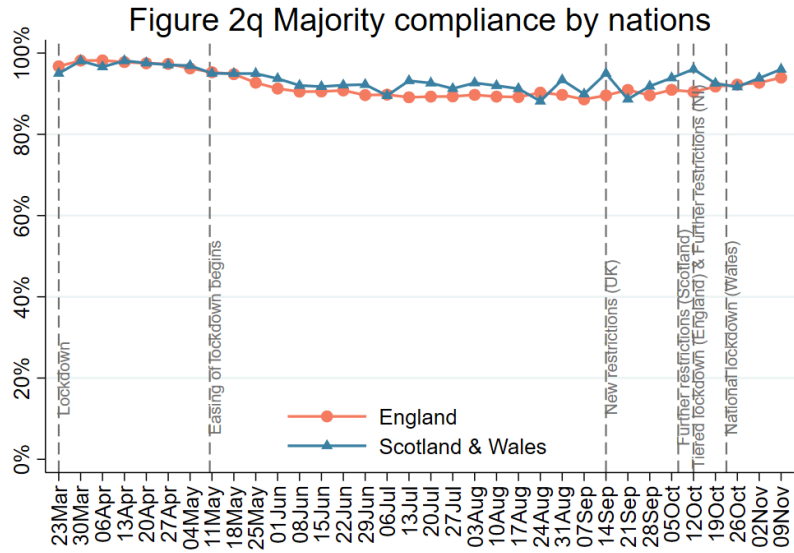
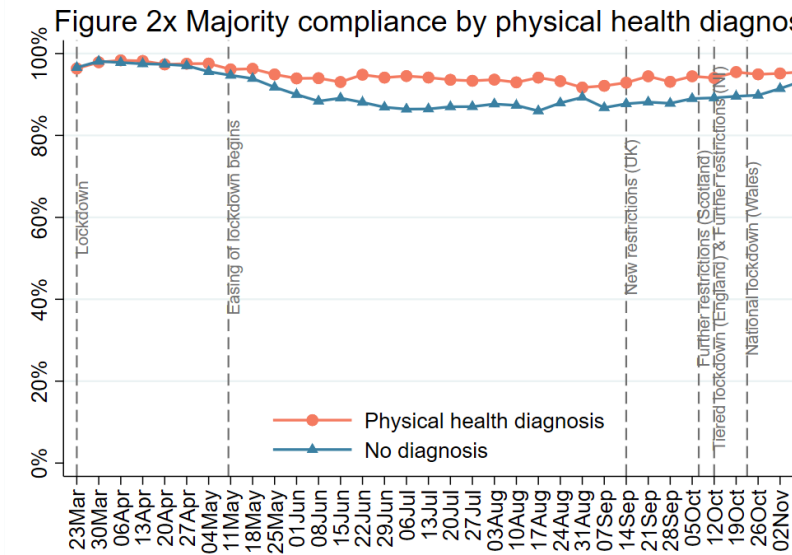
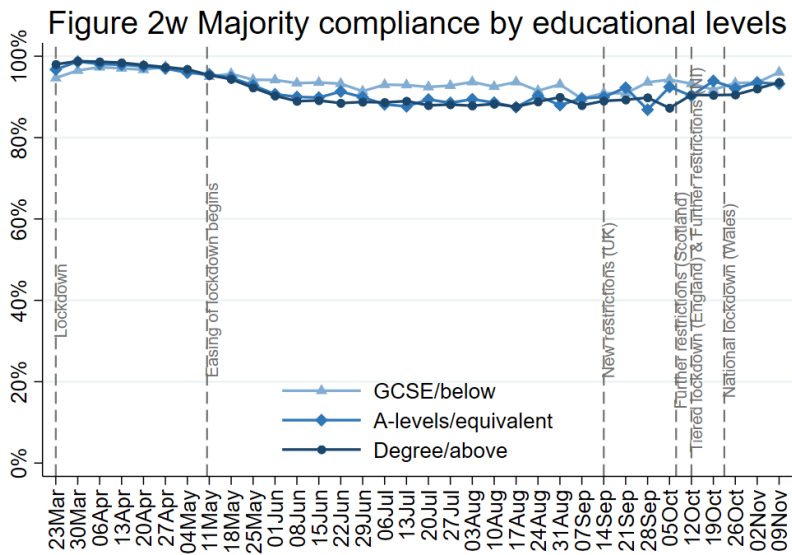
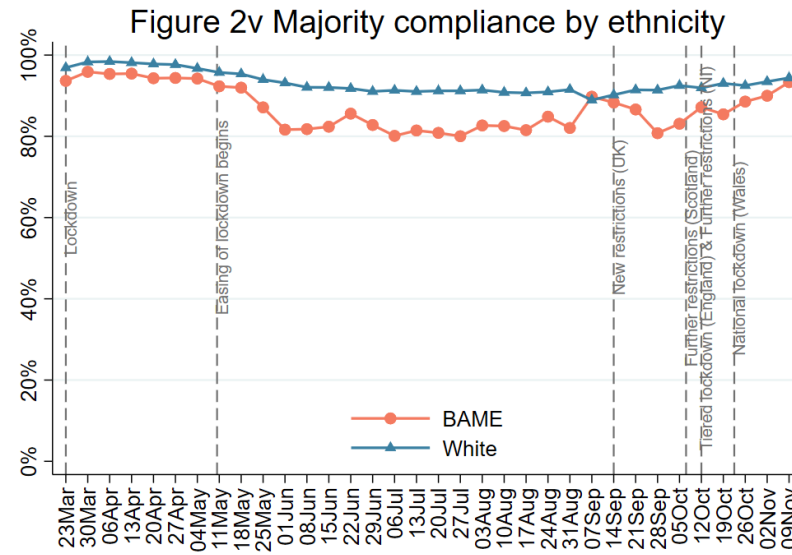
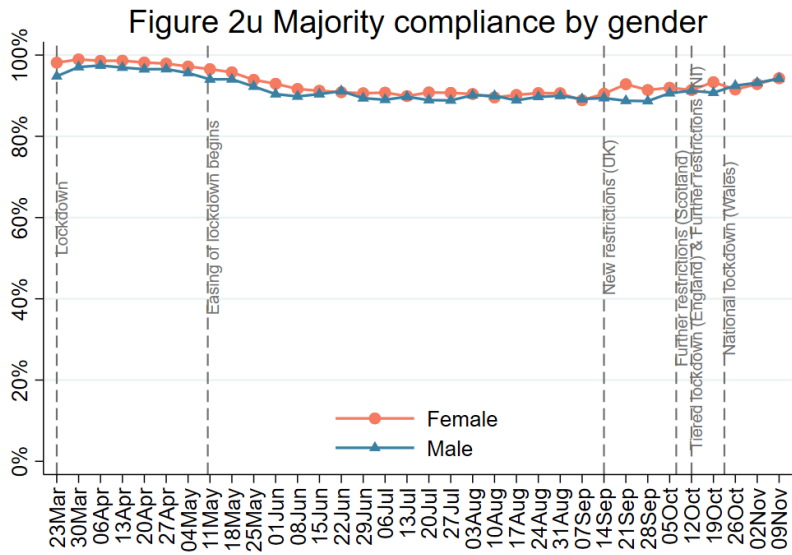


Figure 2p Majority compliance by mental health

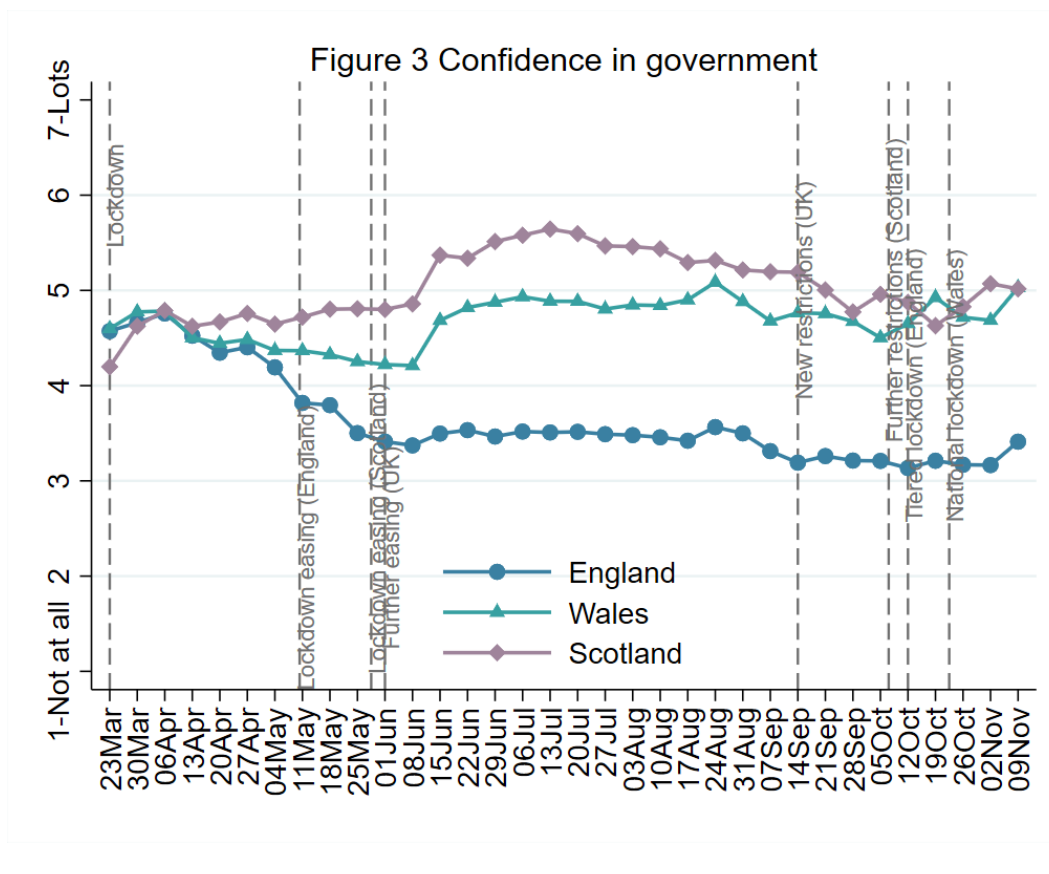








## 1.2 Confidence in Government



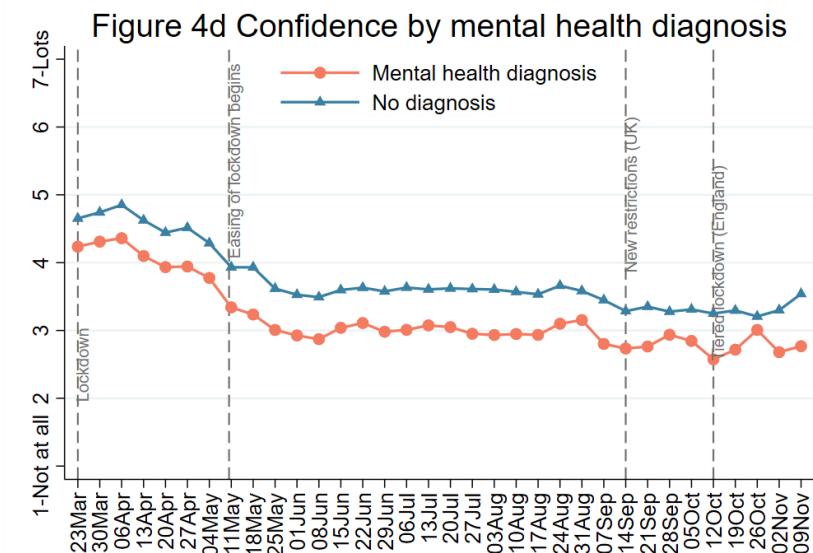
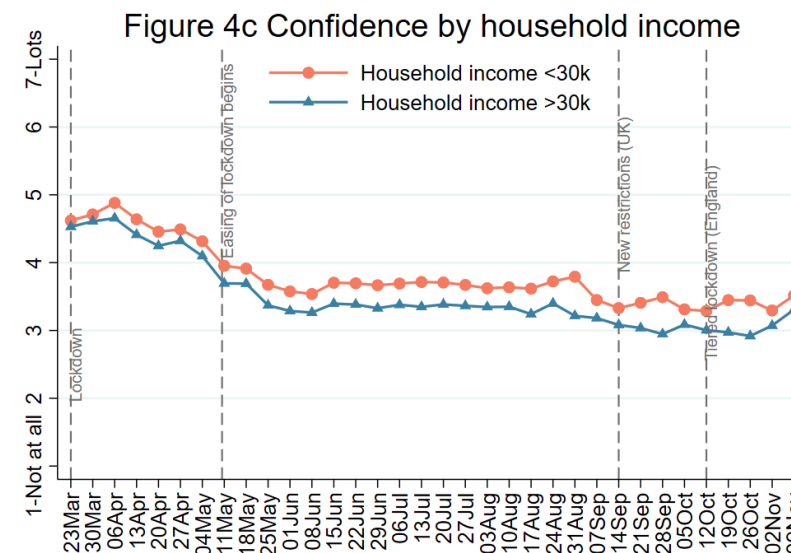
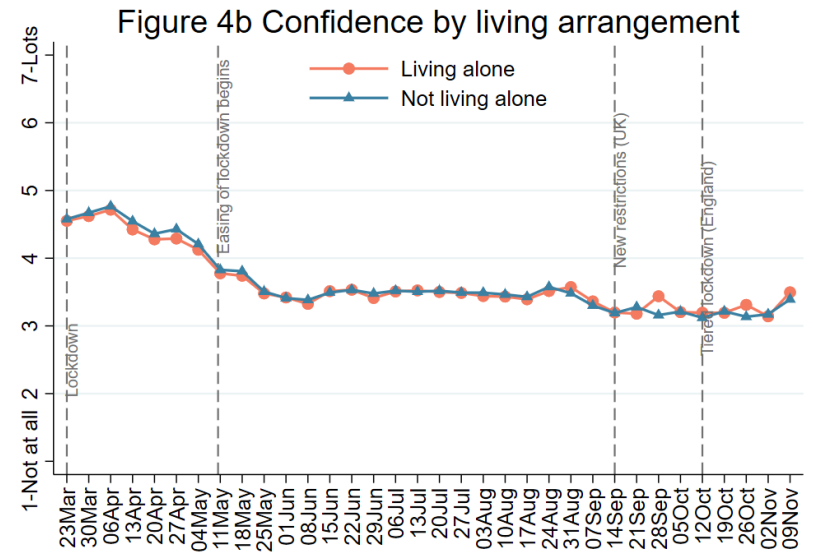
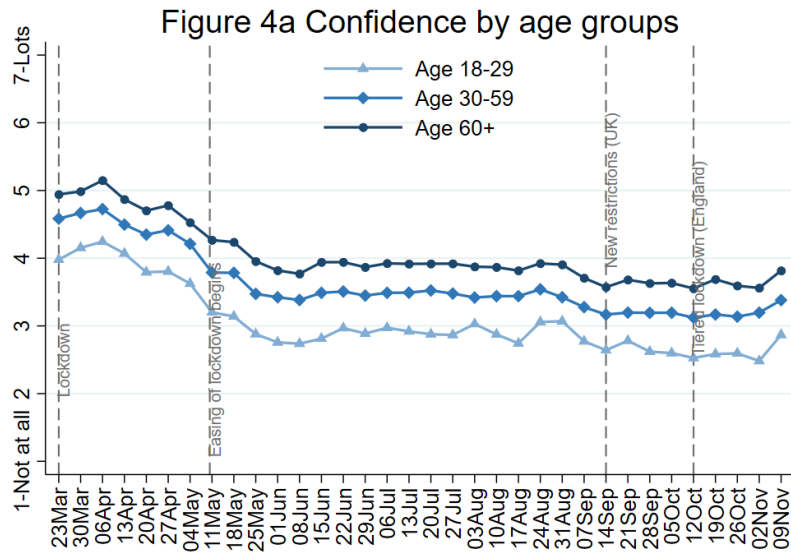
### FINDINGS

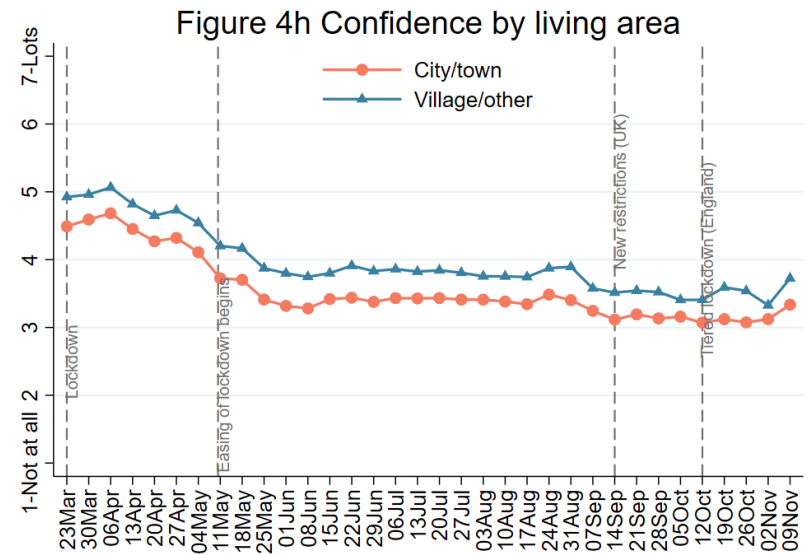
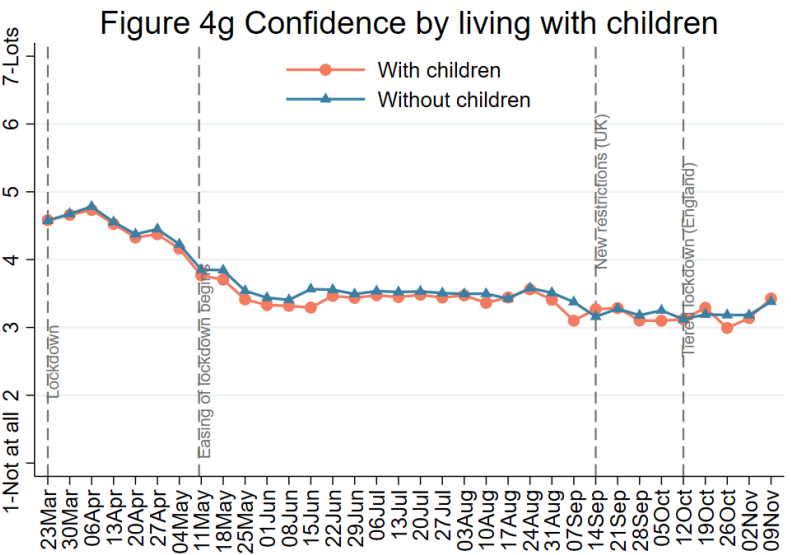
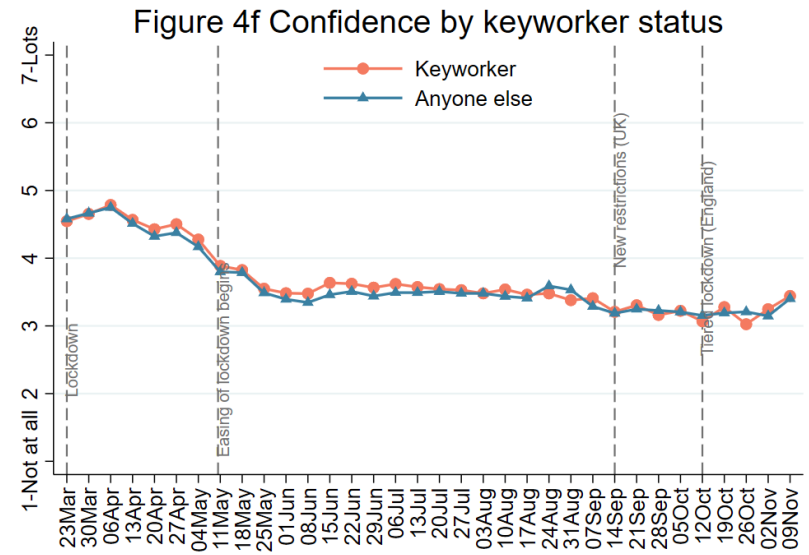
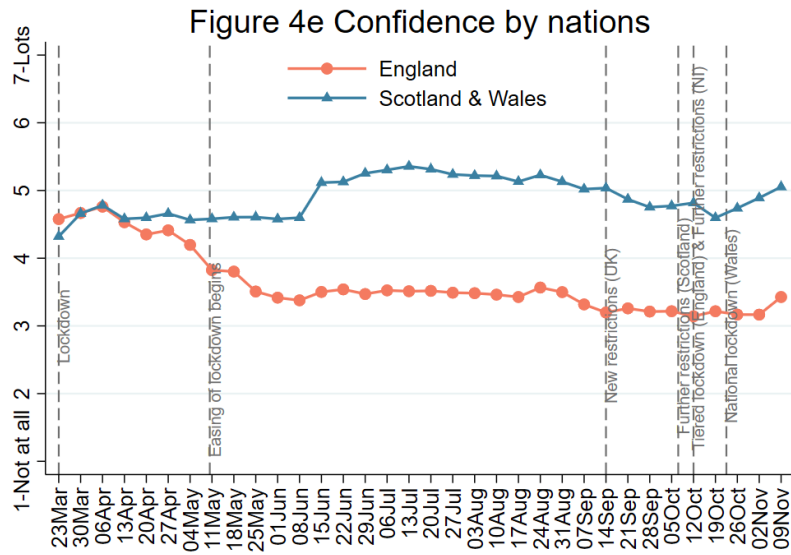
Respondents were asked how much confidence they had in the government to handle the Covid-19 epidemic from 1 (not at all) to 7 (lots). People living in devolved nations were asked to report their confidence in their own devolved governments.

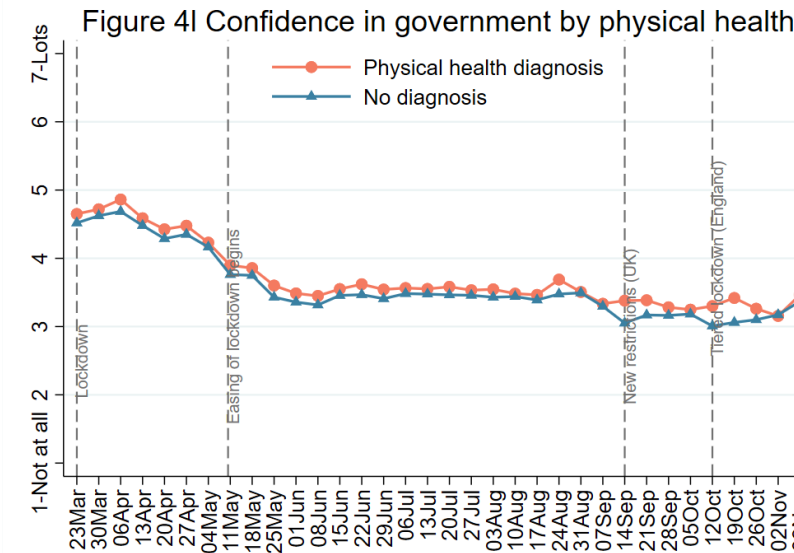
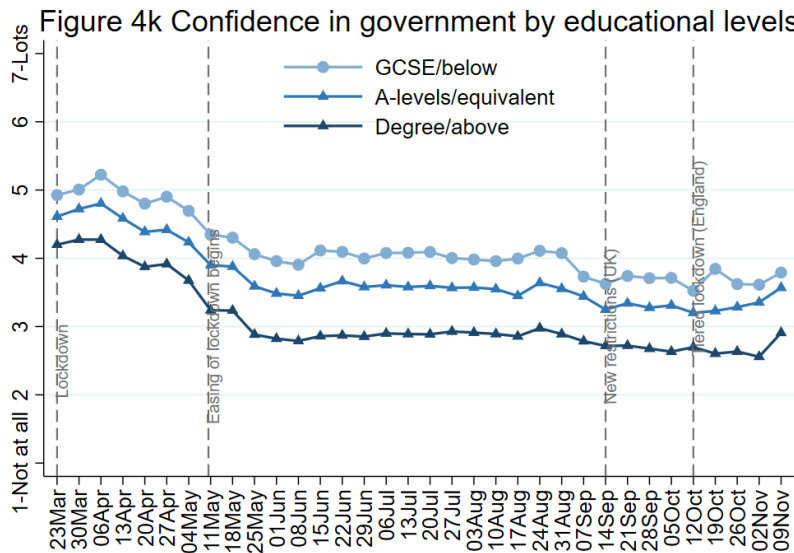
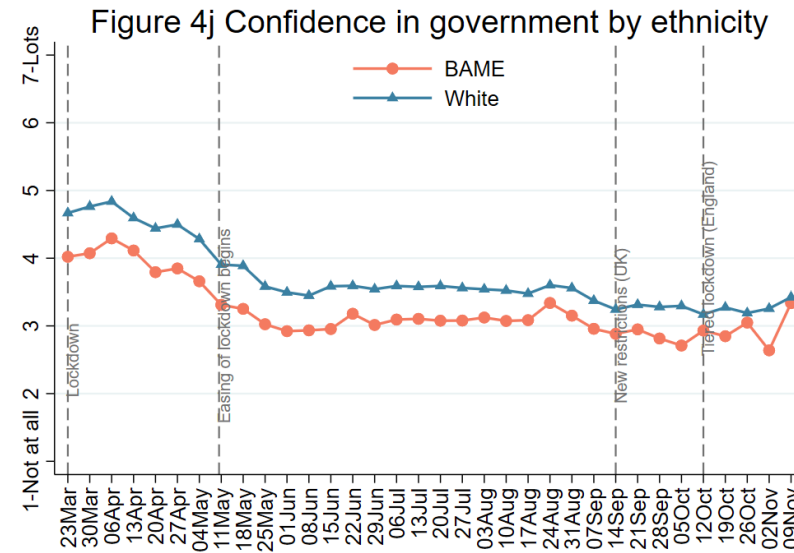
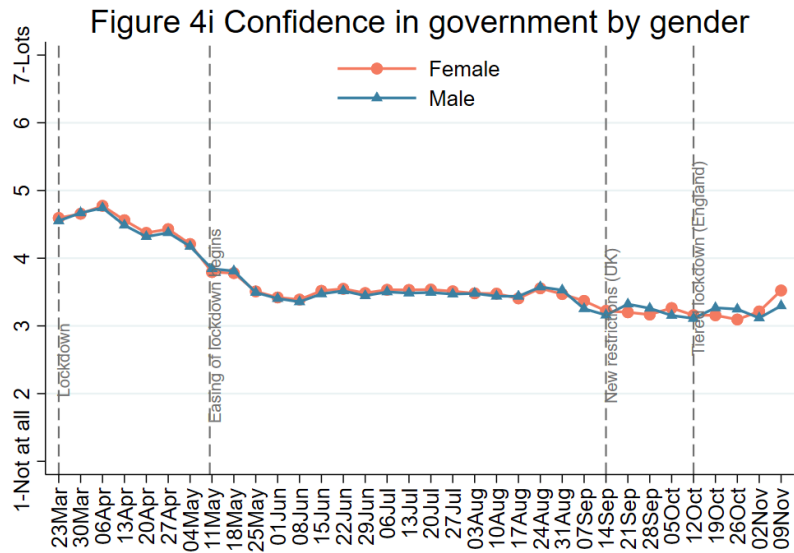
Levels of confidence in central and devolved governments to handle the Covid-19 epidemic have not changed substantially over the past fortnight. Levels remain highest in Scotland and Wales and lowest in England.<sup>1</sup>

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

<sup>1</sup> 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.

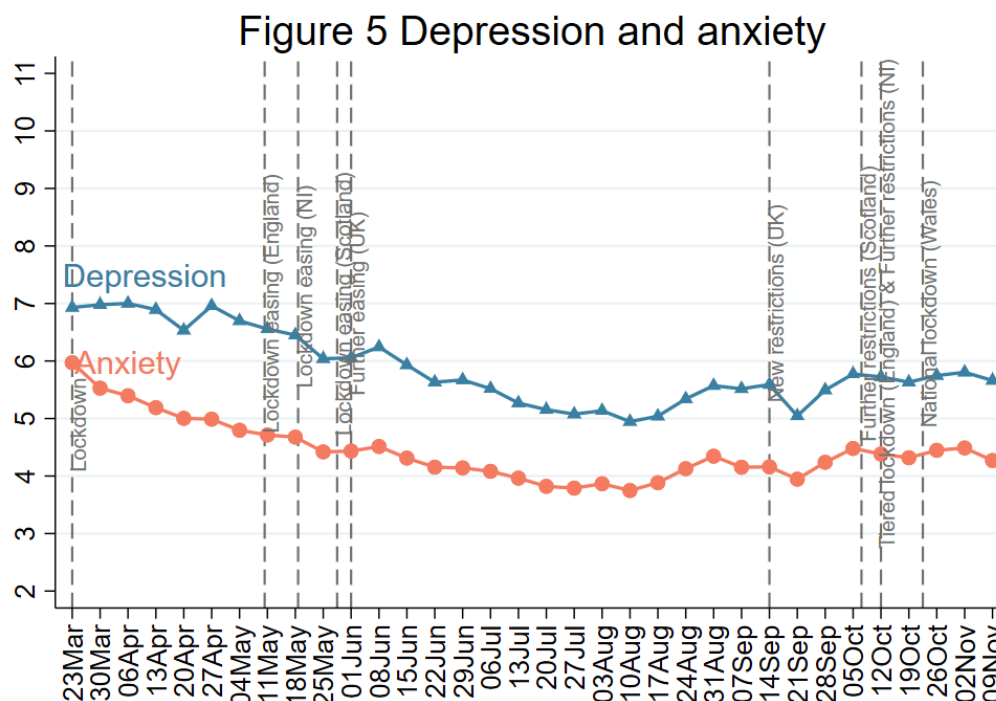






## 2. Mental Health

### 2.1 Depression and anxiety



#### FINDINGS

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

Depression and anxiety levels have stayed relatively constant in the past two weeks. Depression levels are 16% worse than they were in mid-August, but 17% better than they were at the start of lockdown in March. Similarly, anxiety levels are 16% worse than they were in mid-August, but 28% better than they were at the start of lockdown in March. 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 depression<sup>2</sup>).

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

<sup>2</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

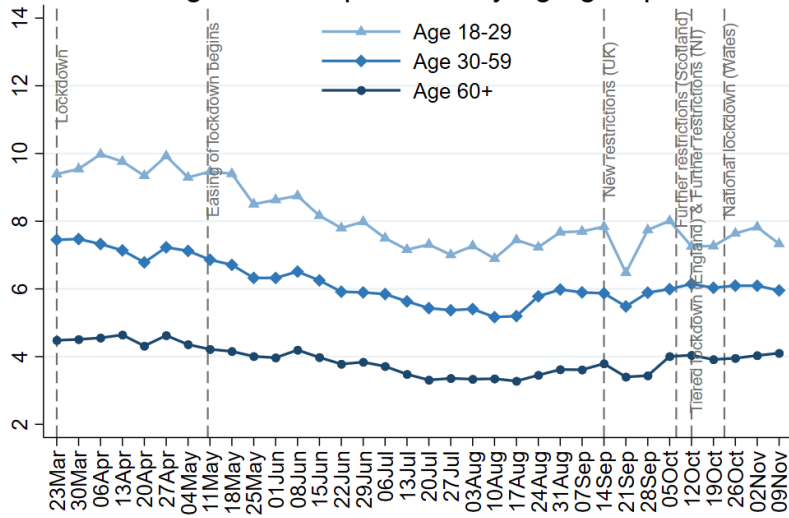


Figure 6b Depression by living arrangement

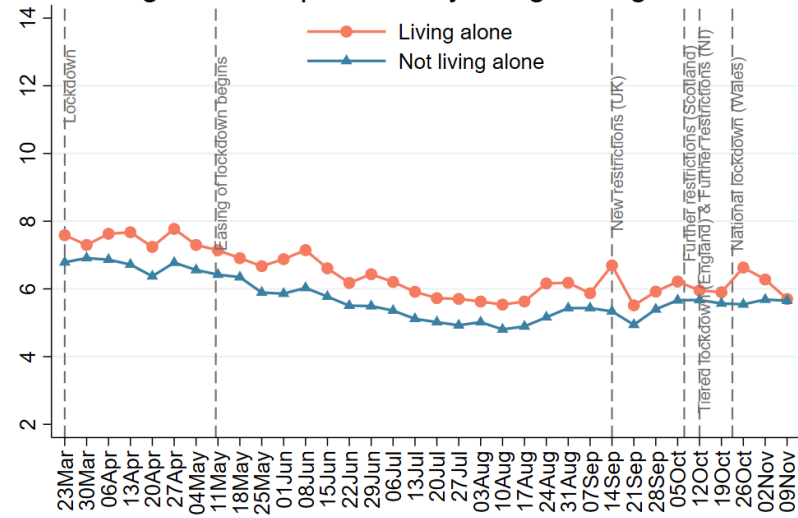


Figure 6c Depression by household income

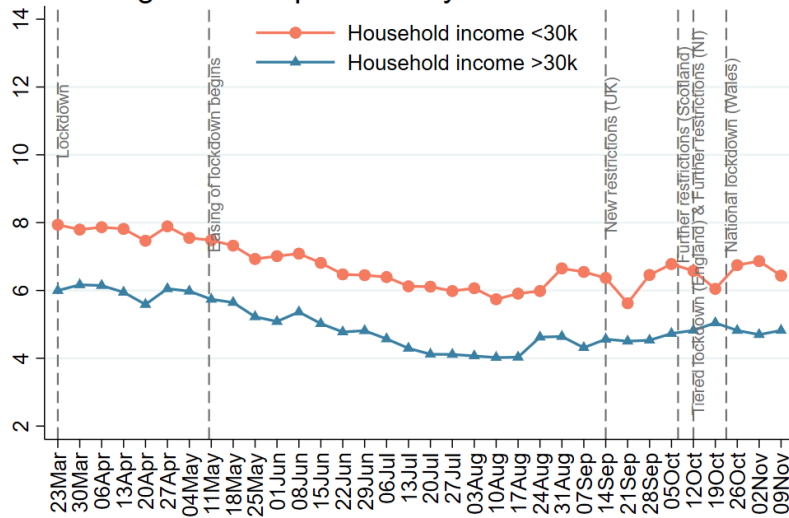


Figure 6d Depression by mental health diagnosis

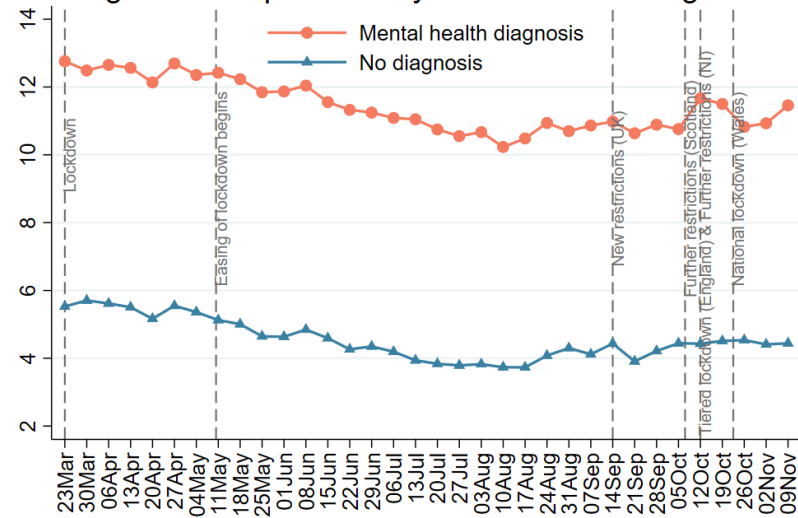




Figure 6e Depression by nations

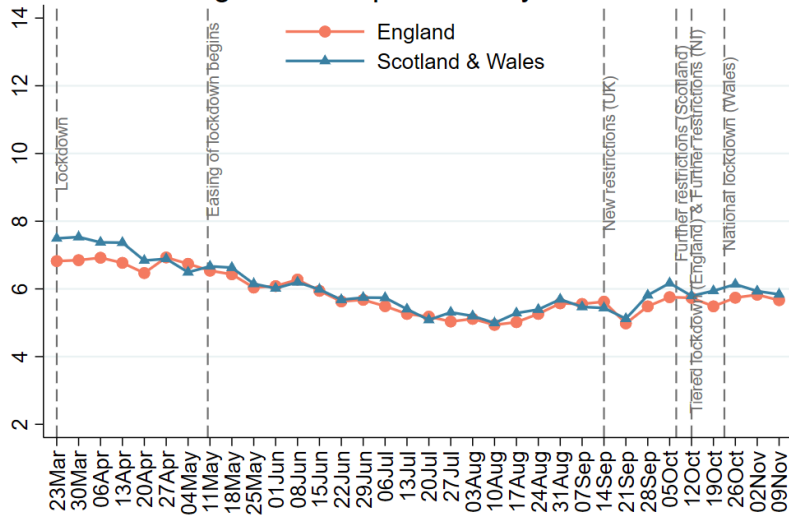


Figure 6f Depression by keyworker status

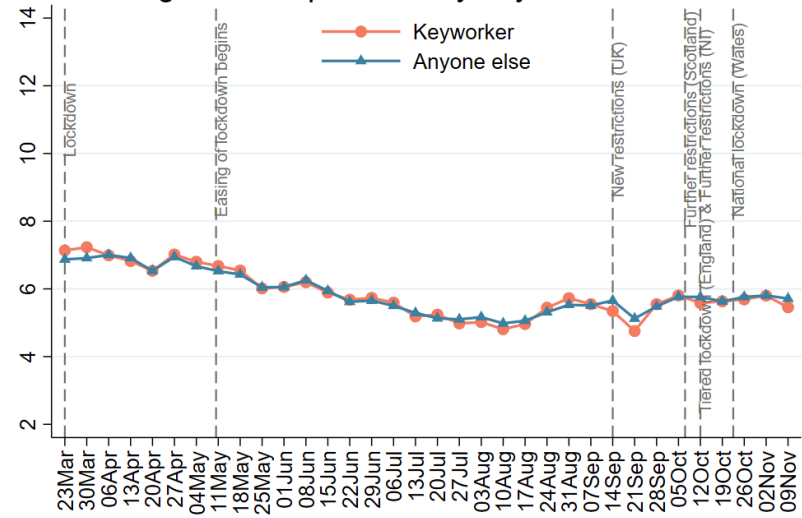


Figure 6g Depression by living with children

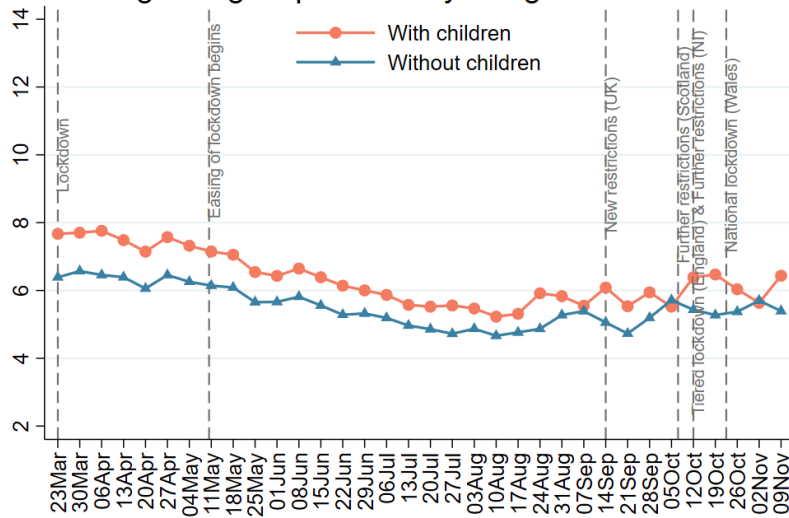


Figure 6h Depression by living area

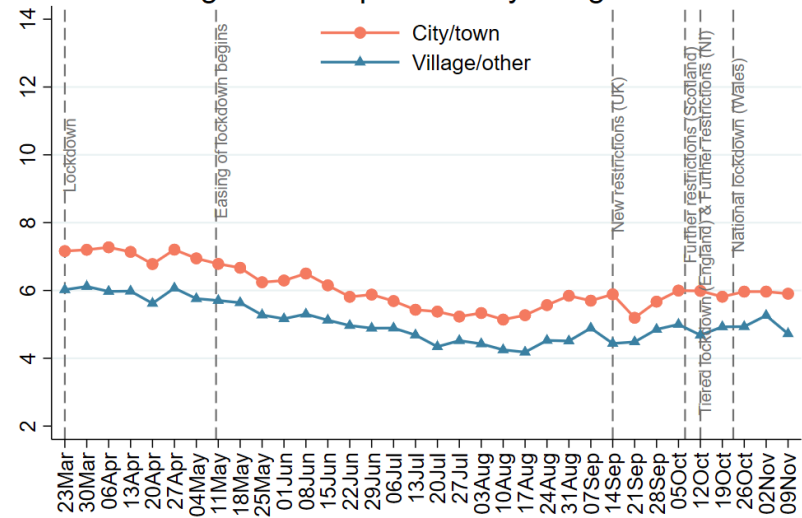


Figure 6i Depression by gender

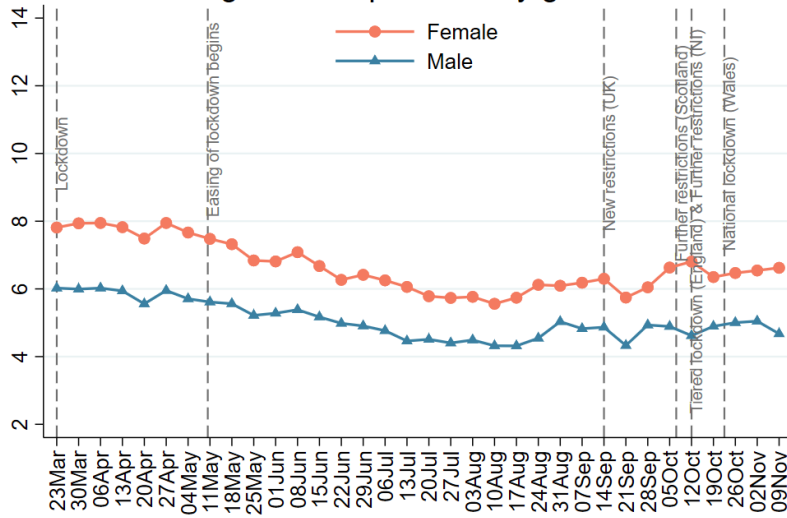


Figure 6j Depression by ethnicity

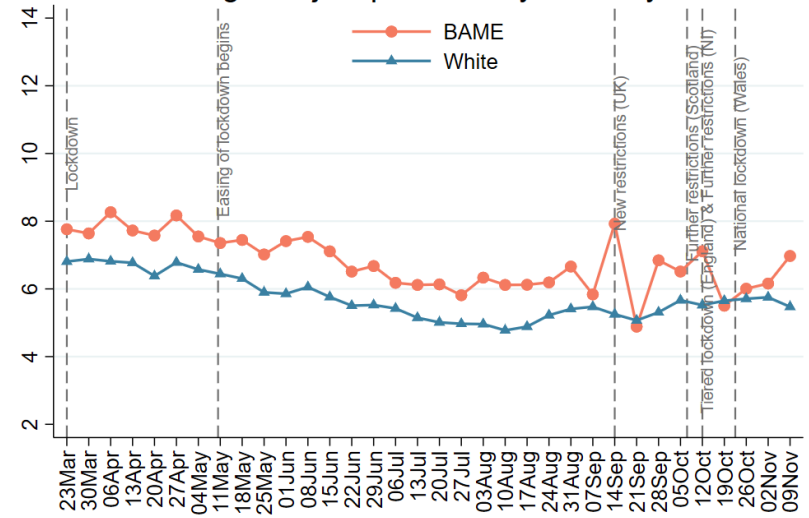


Figure 6k Depression by educational levels

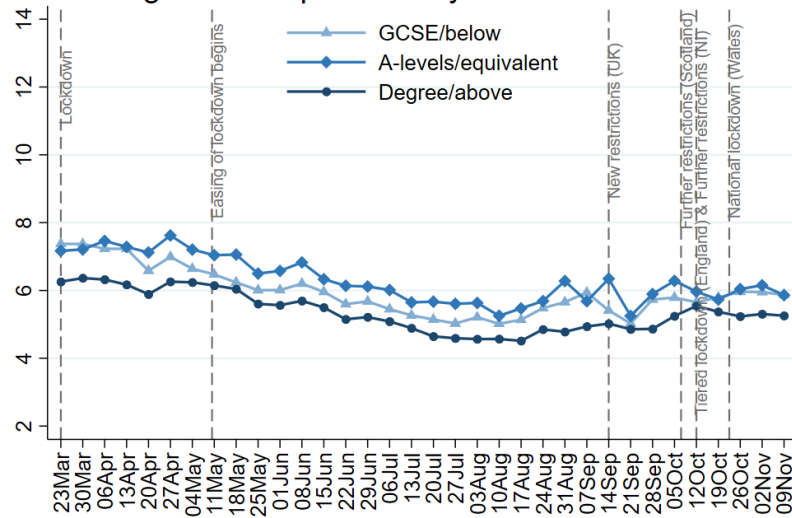


Figure 6l Depression by physical health diagnosis

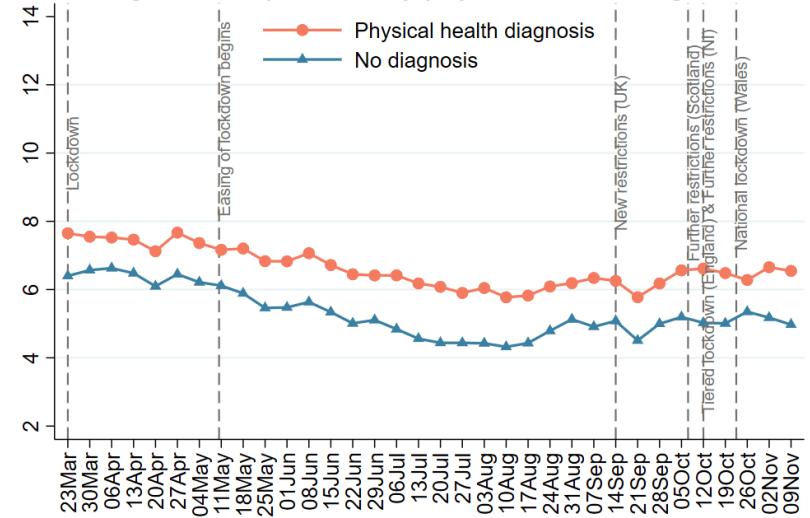


Figure 7a Anxiety by age groups

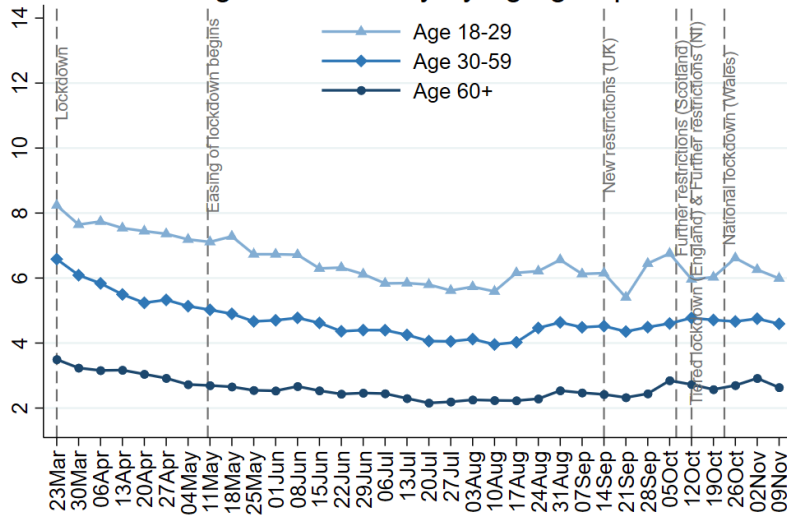


Figure 7b Anxiety by living arrangement

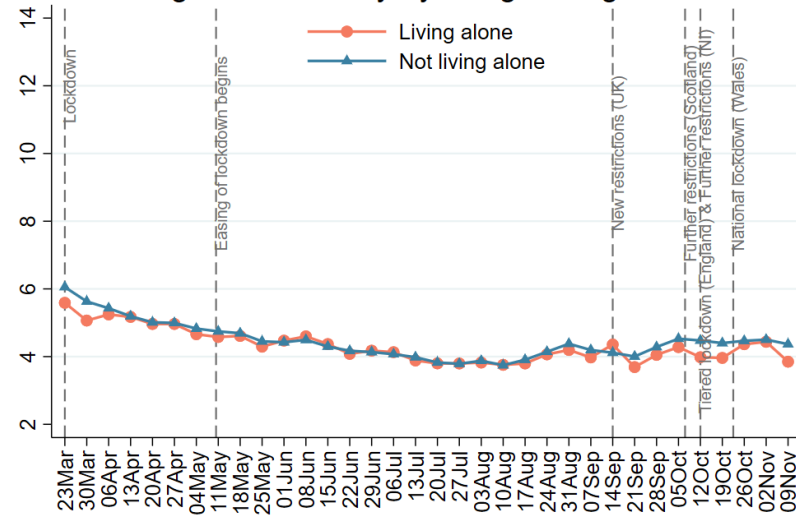


Figure 7c Anxiety by household income

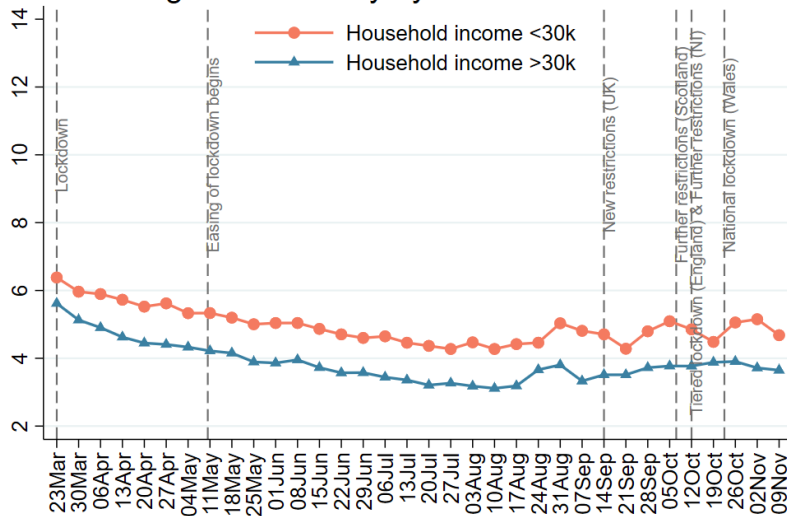


Figure 7d Anxiety by mental health diagnosis

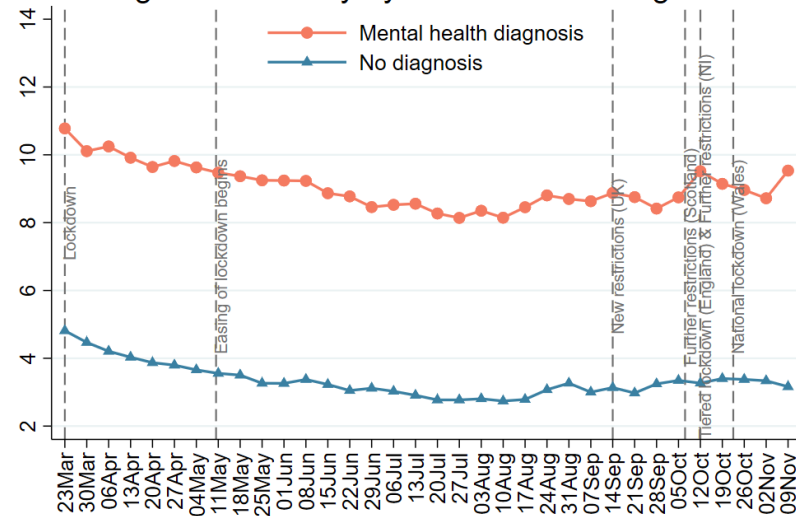


Figure 7e Anxiety by nations

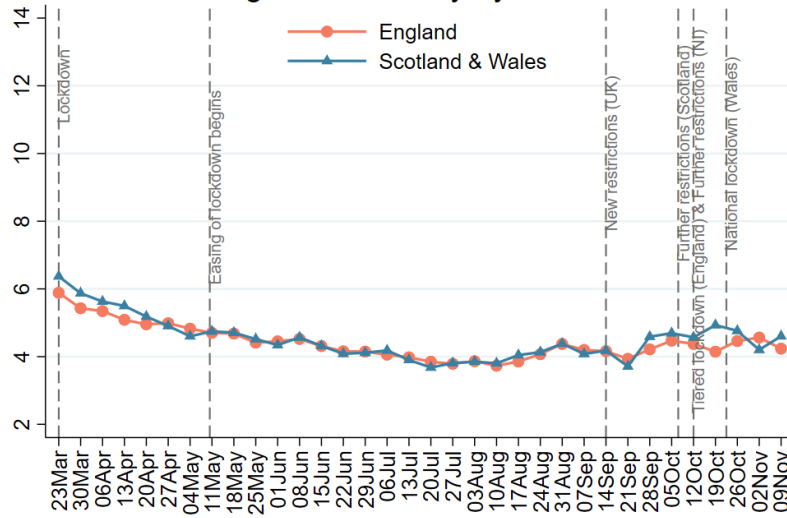


Figure 7f Anxiety by keyworker status

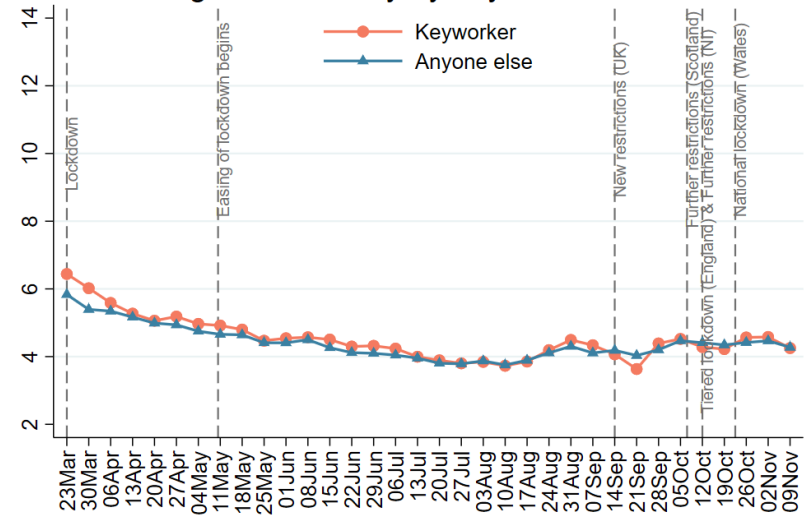


Figure 7g Anxiety by living with children

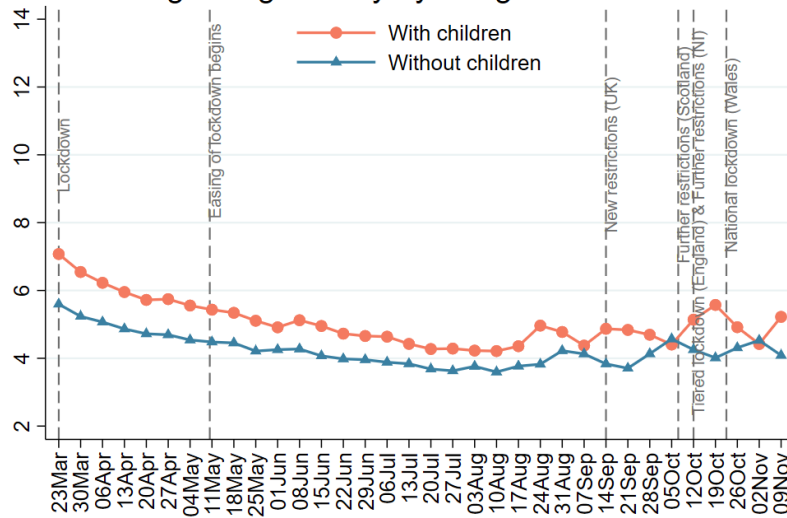


Figure 7h Anxiety by living area

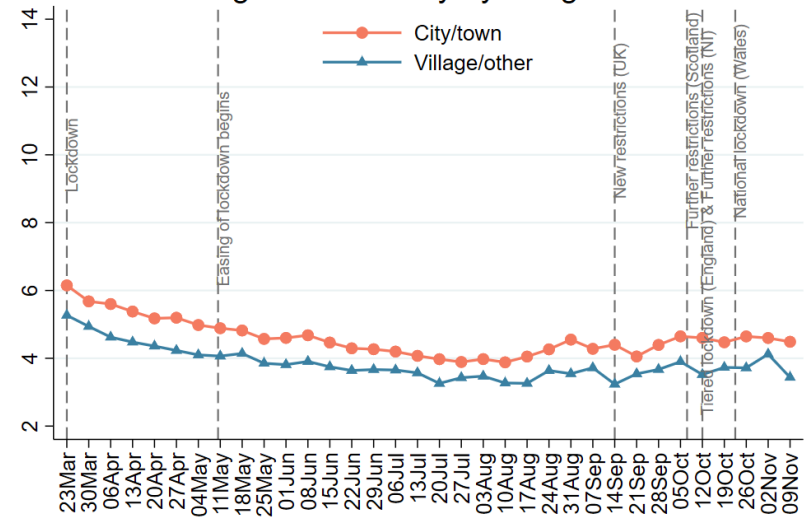


Figure 7i Anxiety by gender

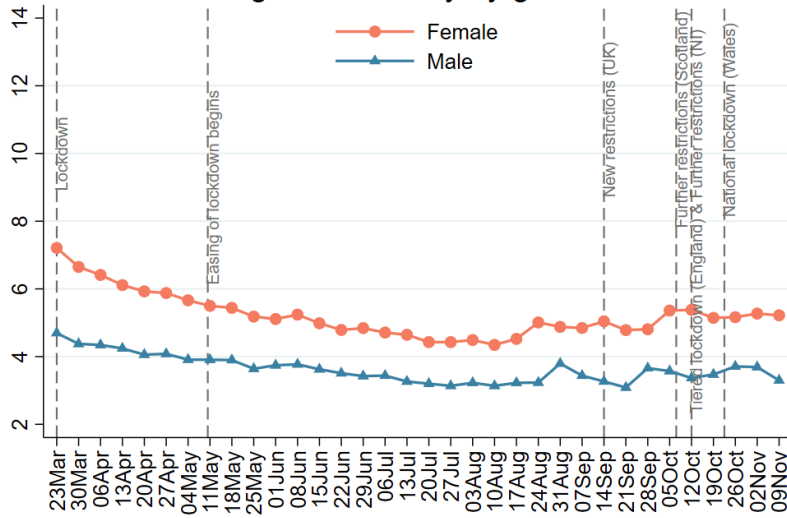


Figure 7j Anxiety by ethnicity

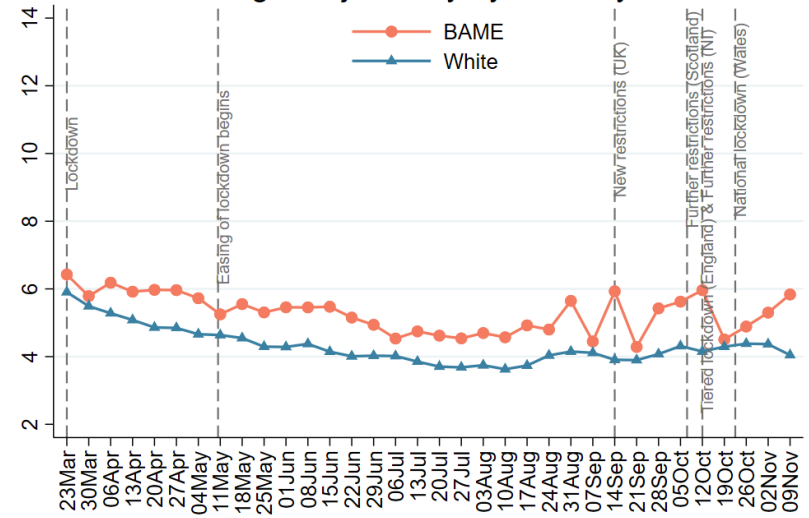


Figure 7k Anxiety by educational levels

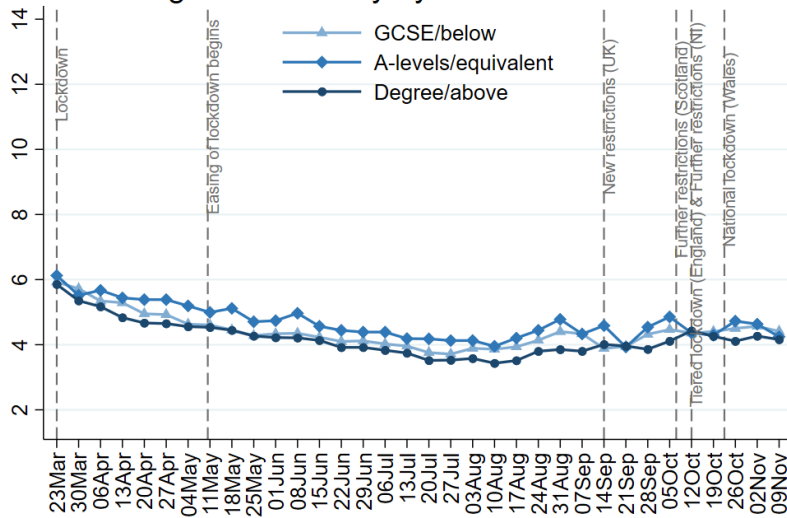
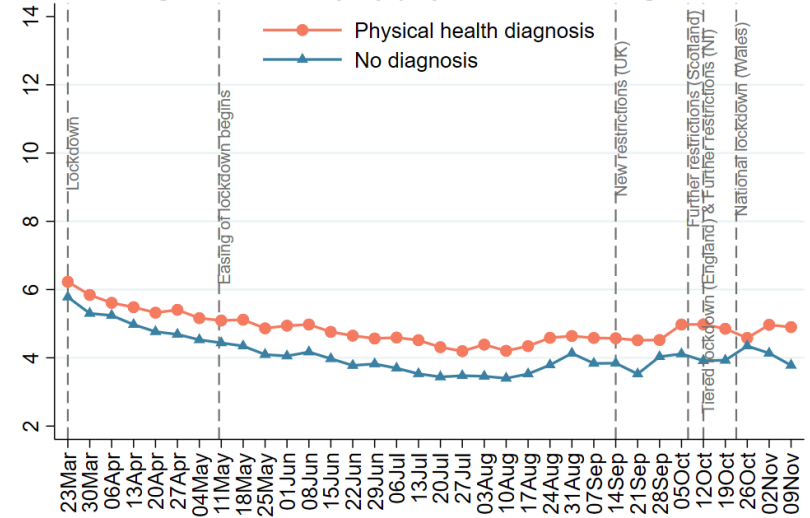
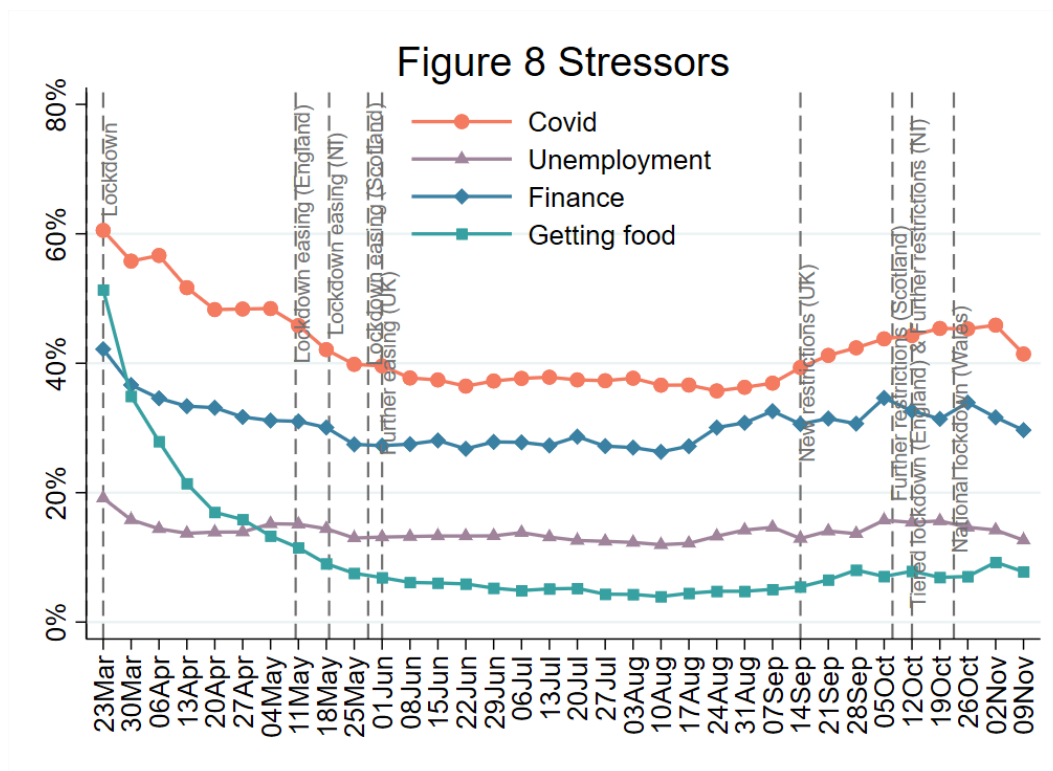


Figure 7l Anxiety by physical health diagnosis



## 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 has continued to increase in the past month with the exception of the past week commencing 9<sup>th</sup> November. It remains to be seen whether this is indicative of a new trend in the data or merely variation.

Other worries, though, remain relatively constant: around 1 in 3 people report being worried about finances (up from 1 in 4 over the summer); around 1 in 6 are worried about unemployment; and around 1 in 12 people are worried about access to food.

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

Figure 9a Covid-19 stress by age groups

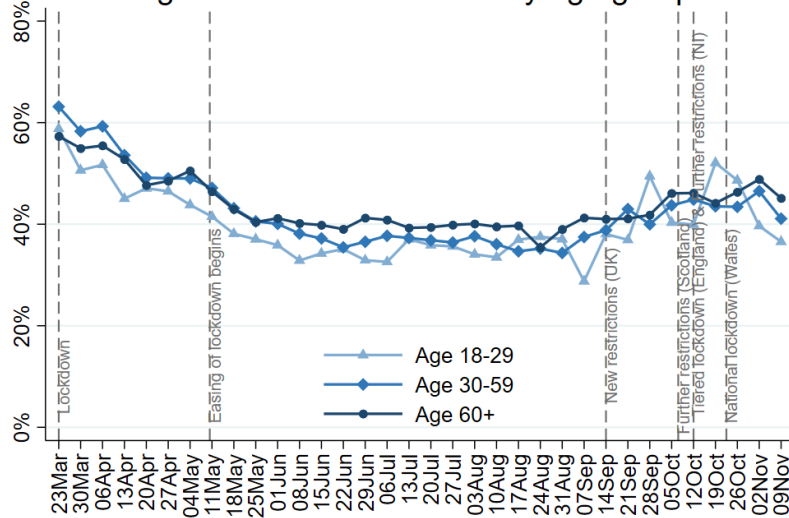


Figure 9b Covid-19 stress by living arrangement

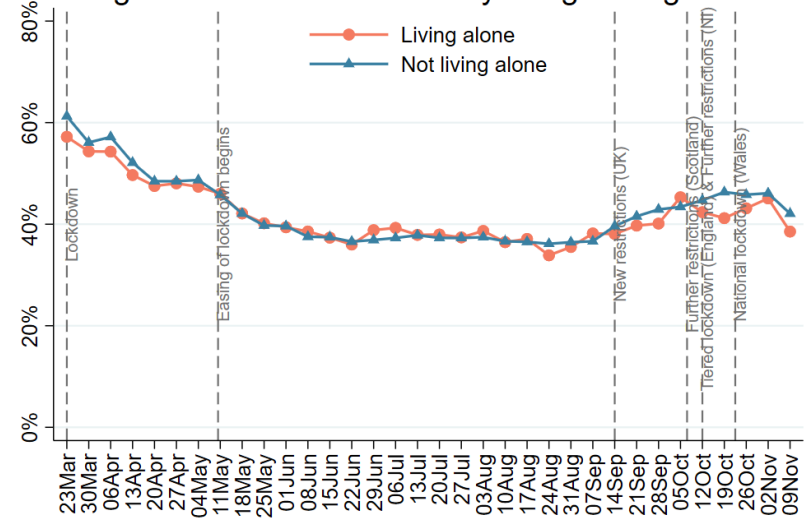


Figure 9c Covid-19 stress by household income

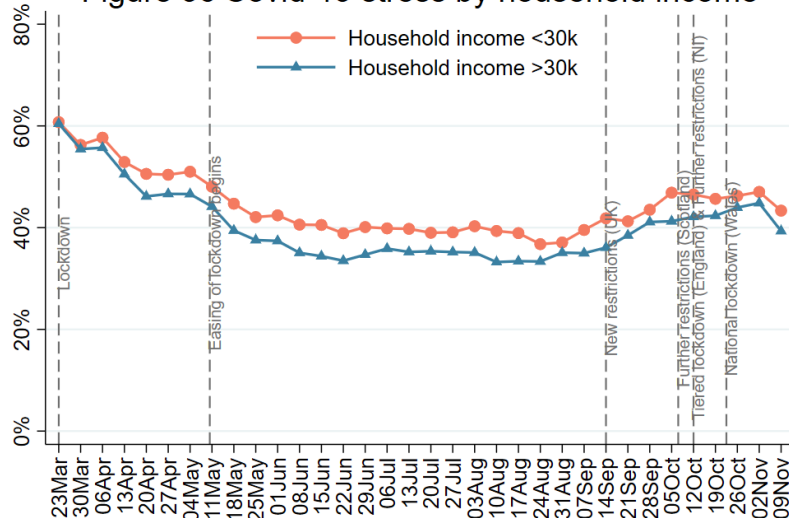


Figure 9d Covid-19 stress by mental health diagnosis

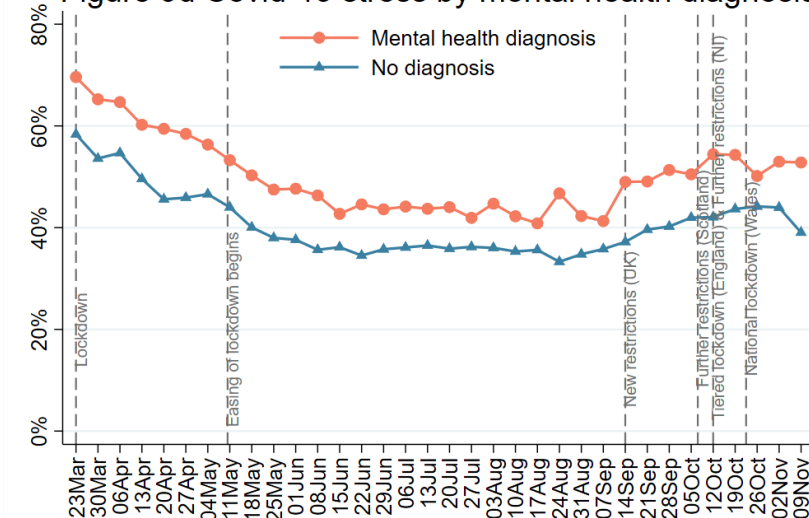


Figure 9e Covid-19 stress by nations

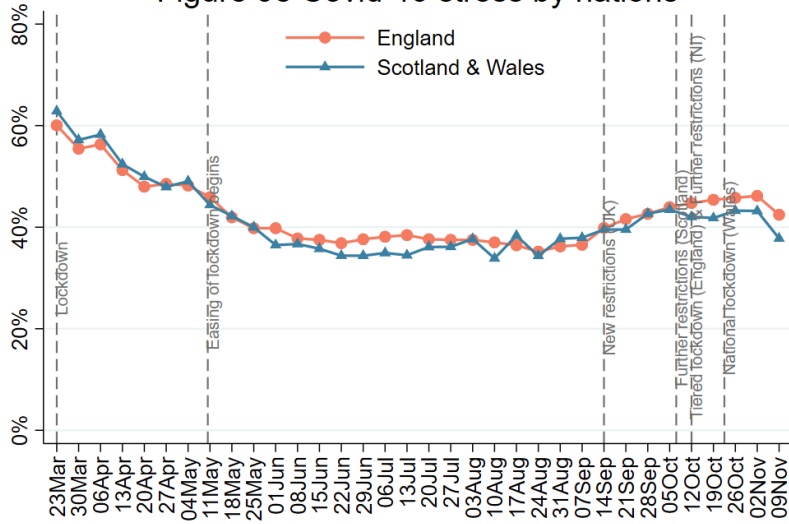


Figure 9f Covid-19 stress by keyworker status

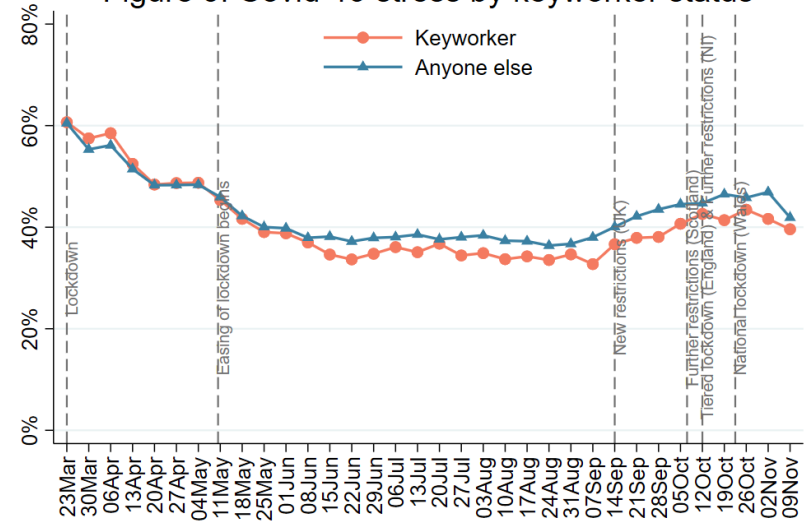


Figure 9g Covid-19 stress by living with children

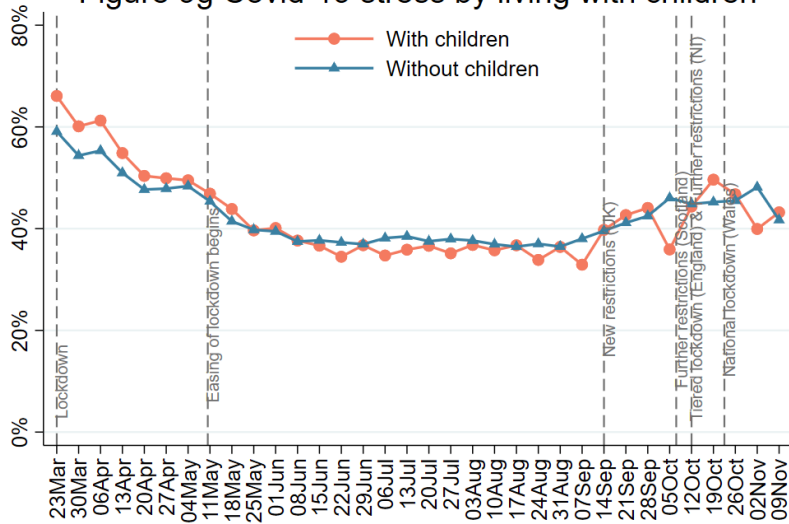


Figure 9h Covid-19 stress by living area

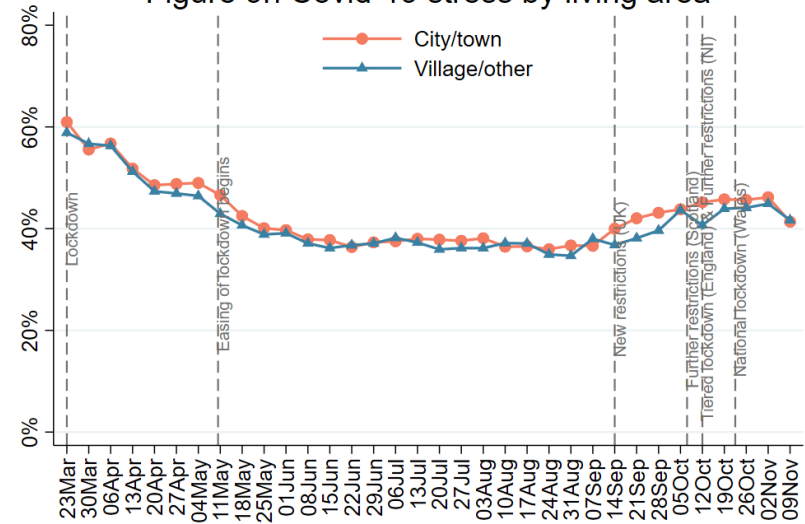




Figure 9i Covid-19 stress by gender

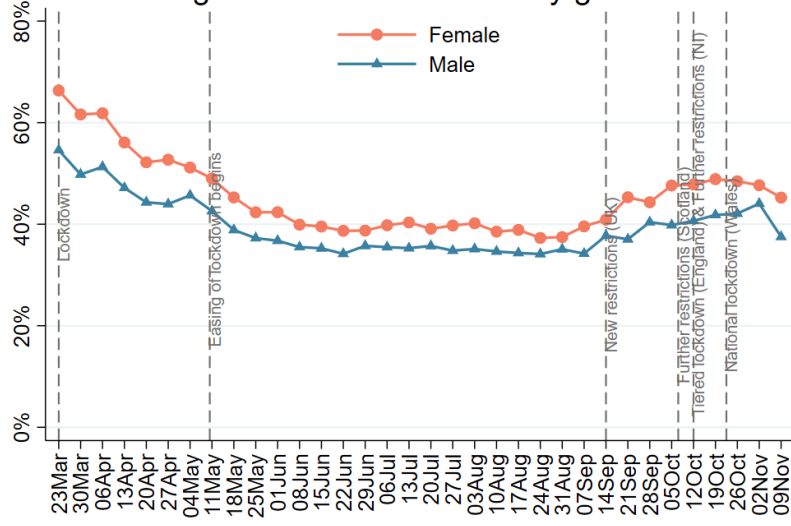


Figure 9j Covid-19 stress by ethnicity

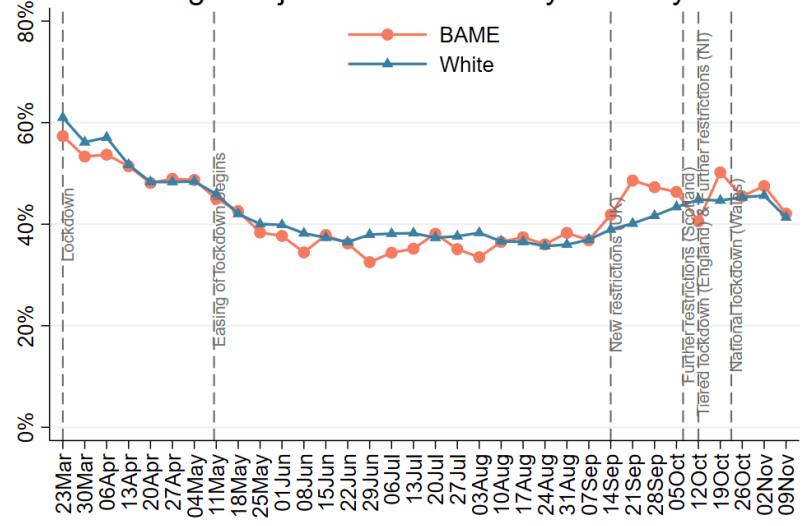


Figure 9k Covid-19 stress by educational levels

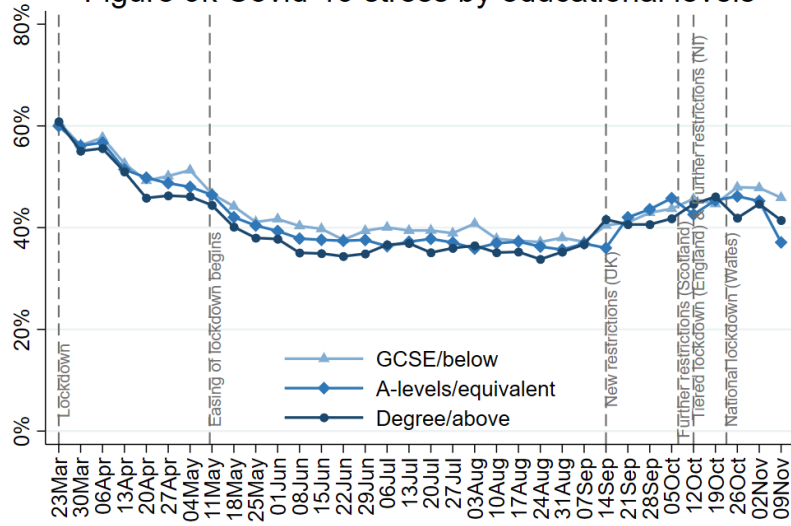


Figure 9l Covid-19 stress by physical health diagnosis

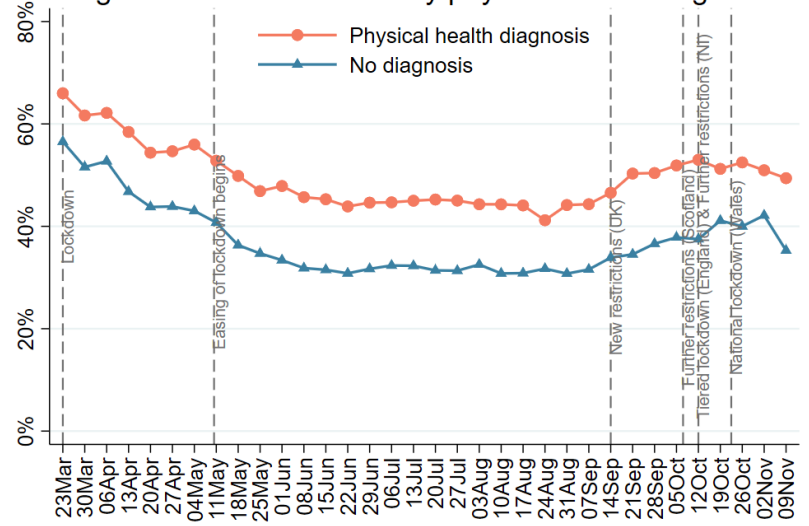


Figure 10a Unemployment stress by age groups

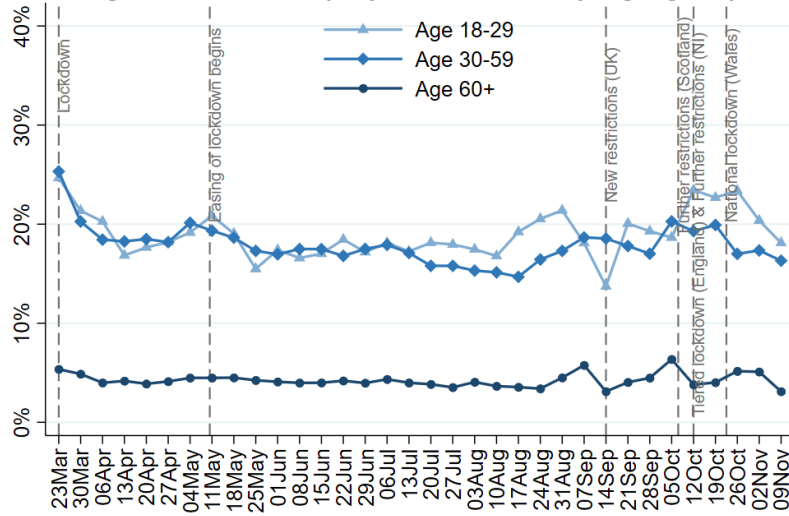


Figure 10b Unemployment stress by living arrangement

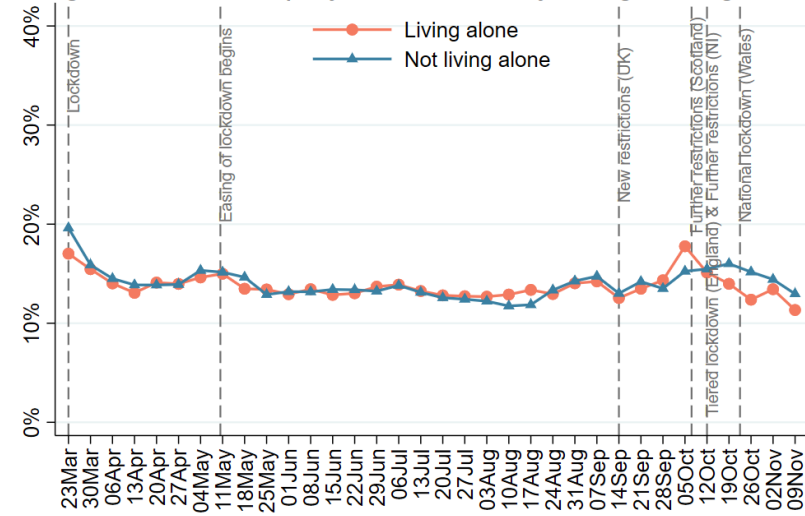


Figure 10c Unemployment stress by household income

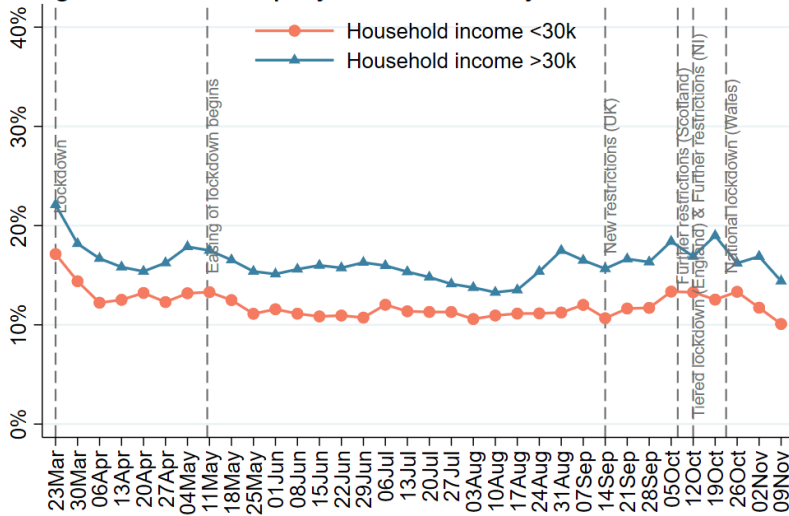


Figure 10d Unemployment stress by mental health

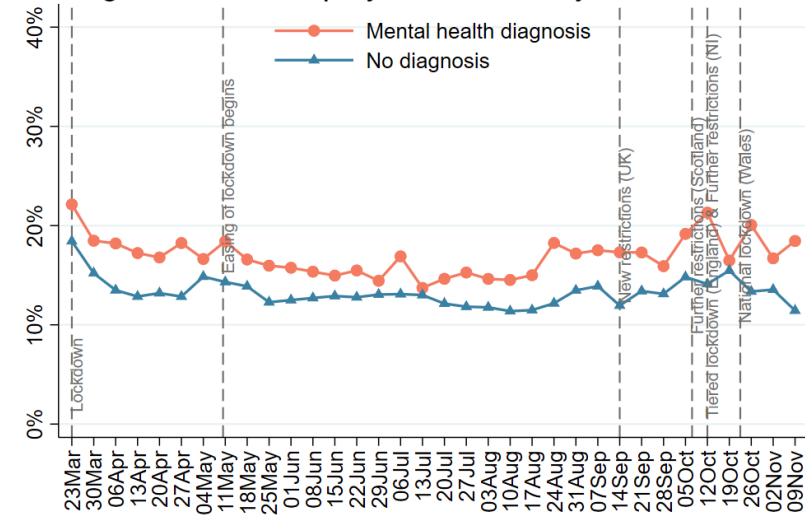


Figure 10e Unemployment stress by nations

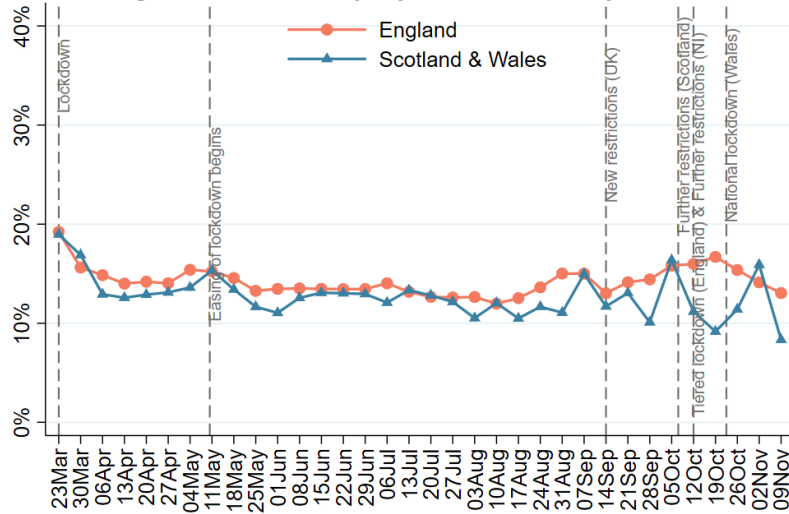


Figure 10f Unemployment stress by keyworker status

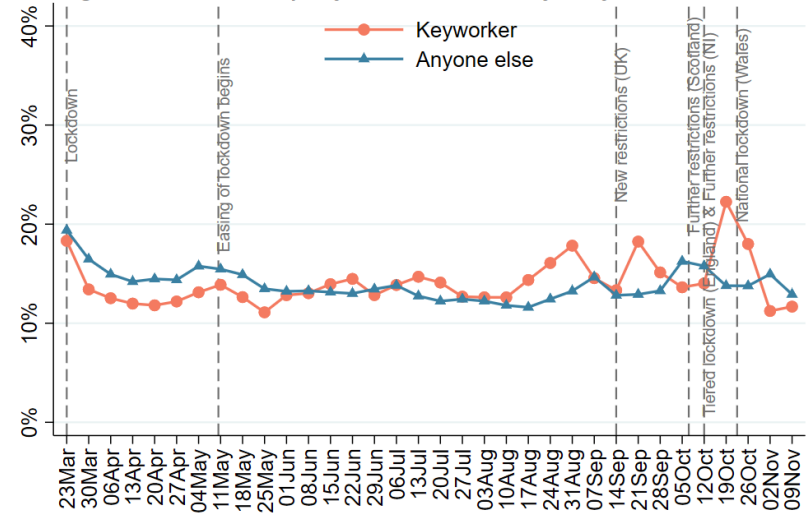


Figure 10g Unemployment stress by living with children

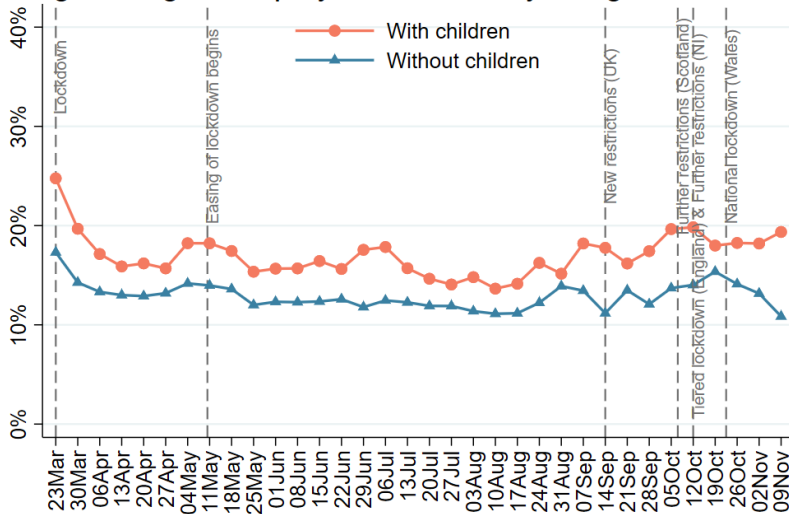


Figure 10h Unemployment stress by living area

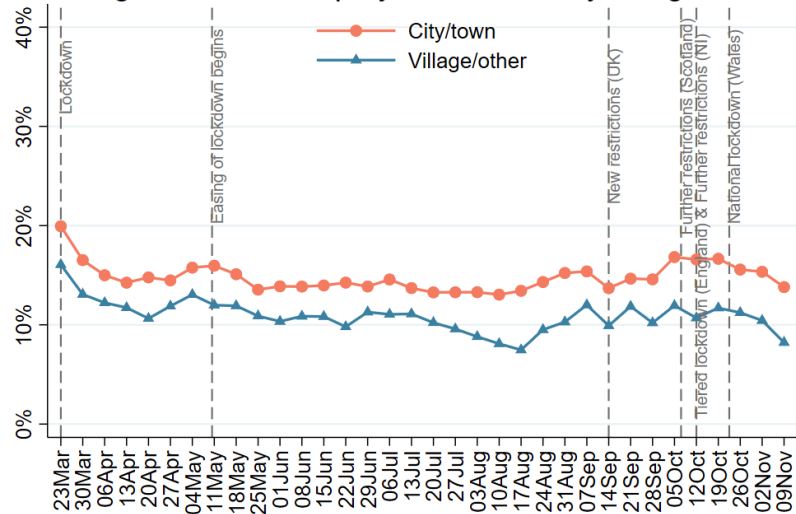


Figure 10i Unemployment stress by gender

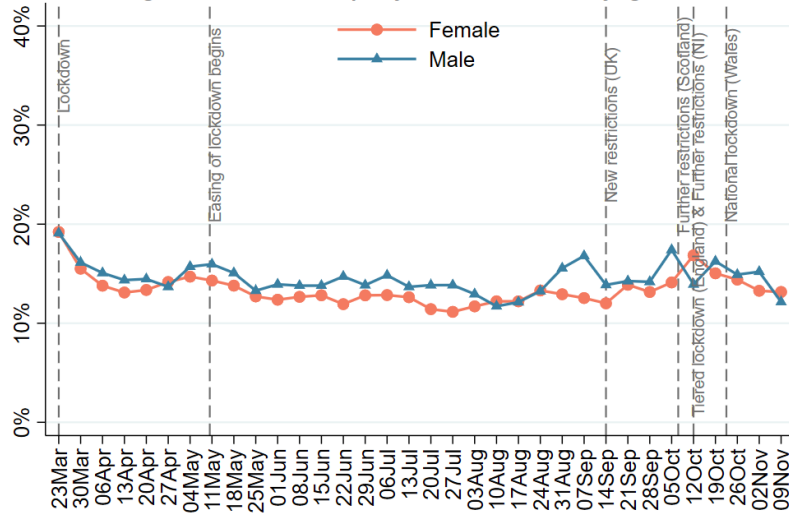


Figure 10j Unemployment stress by ethnicity

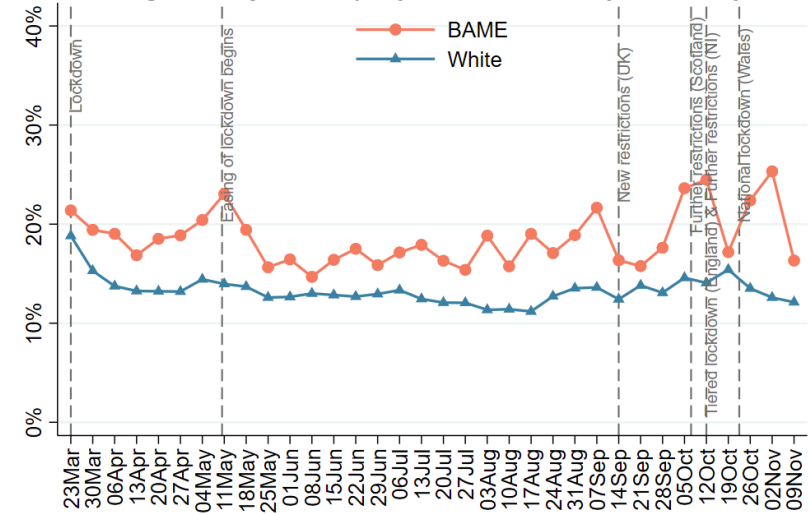


Figure 10k Unemployment stress by educational levels

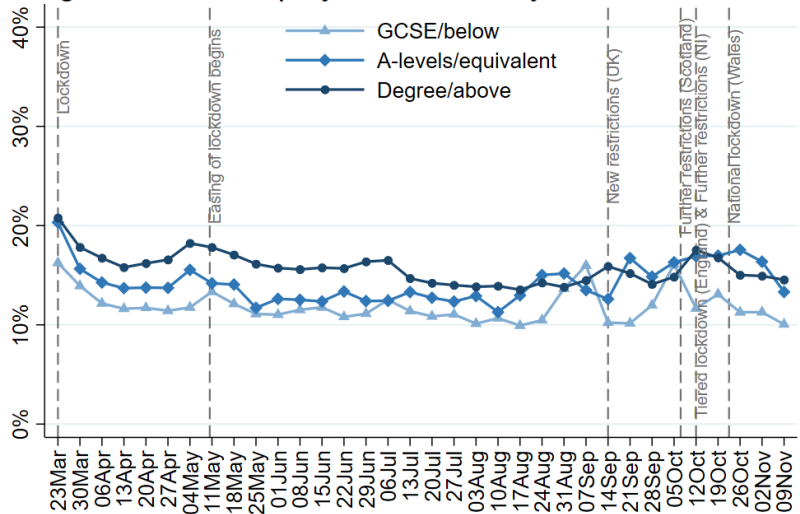


Figure 10l Unemployment stress by physical health diagnosis

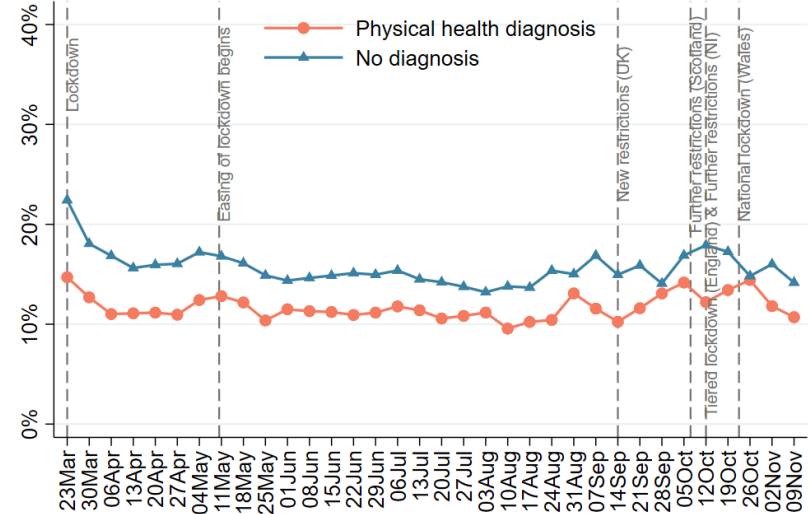


Figure 11a Financial stress by age groups

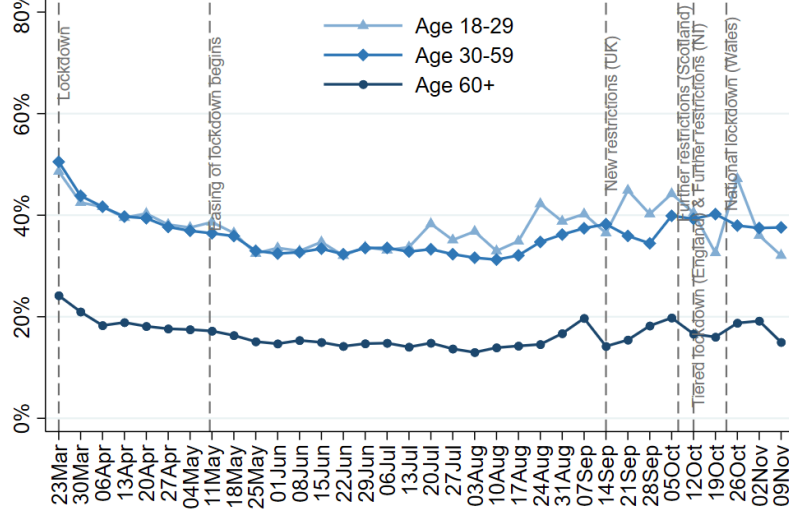


Figure 11b Financial stress by living arrangement

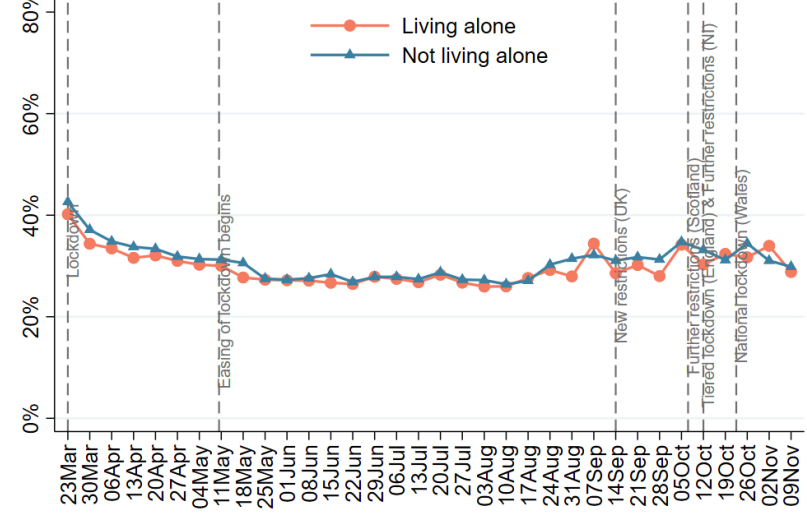


Figure 11c Financial stress by household income

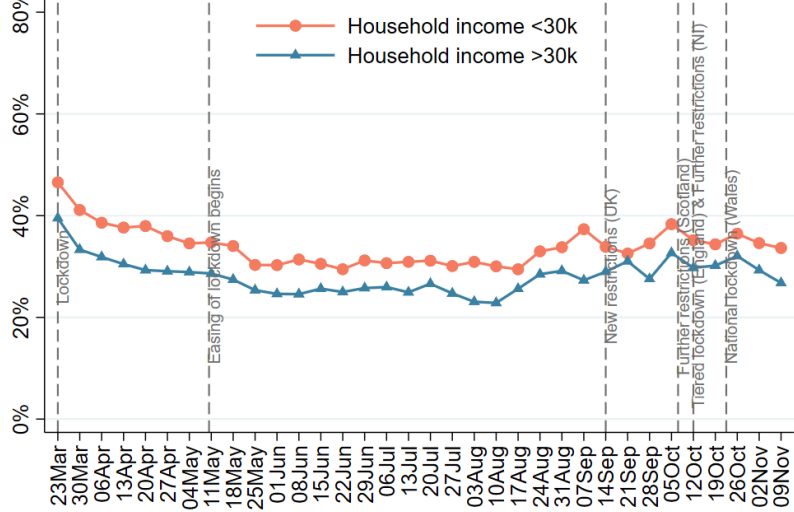


Figure 11d Financial stress by mental health diagnosis

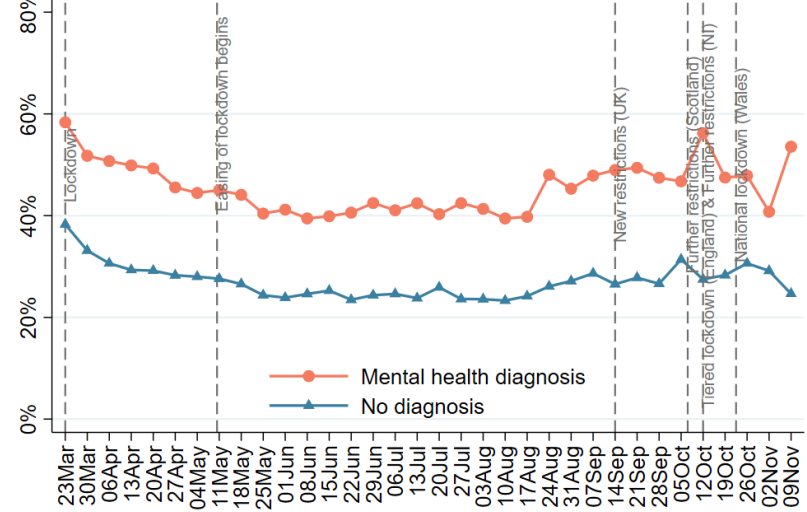


Figure 11e Financial stress by nations

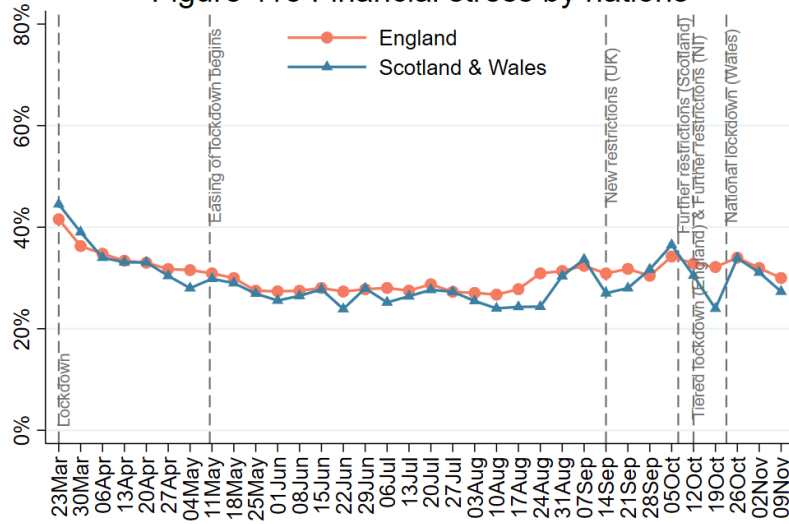


Figure 11f Financial stress by keyworker status

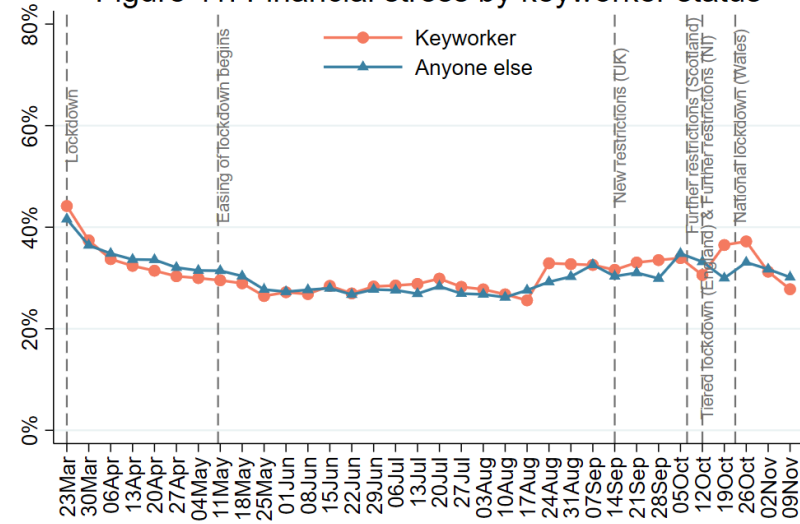


Figure 11g Financial stress by living with children

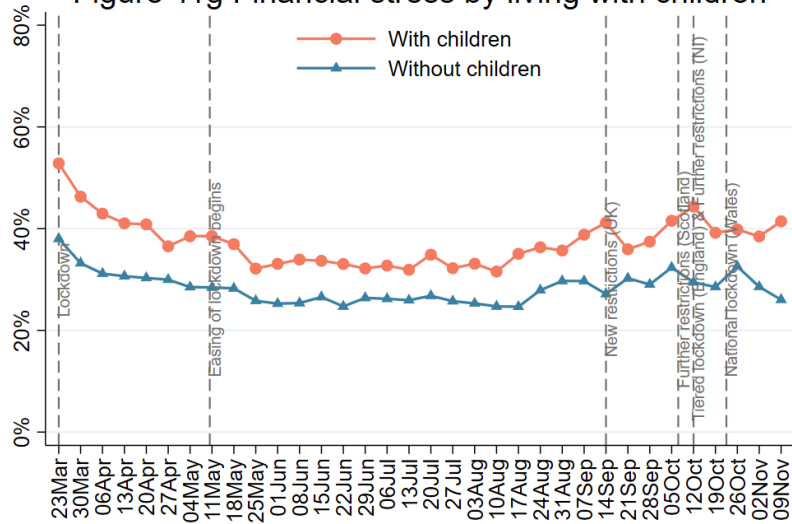


Figure 11h Financial stress by living area

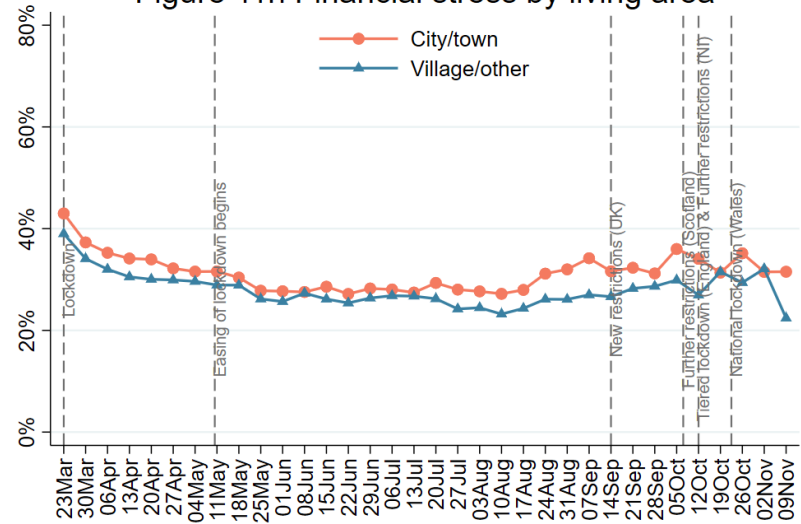


Figure 11i Financial stress by gender

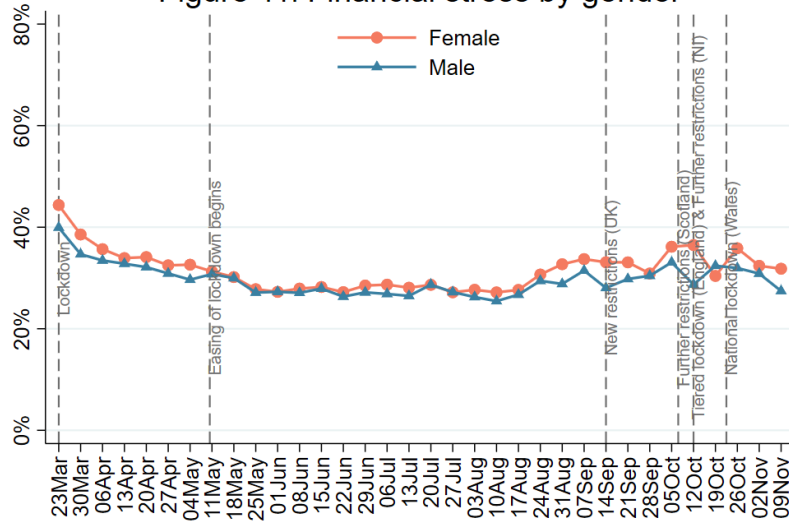


Figure 11j Financial stress by ethnicity

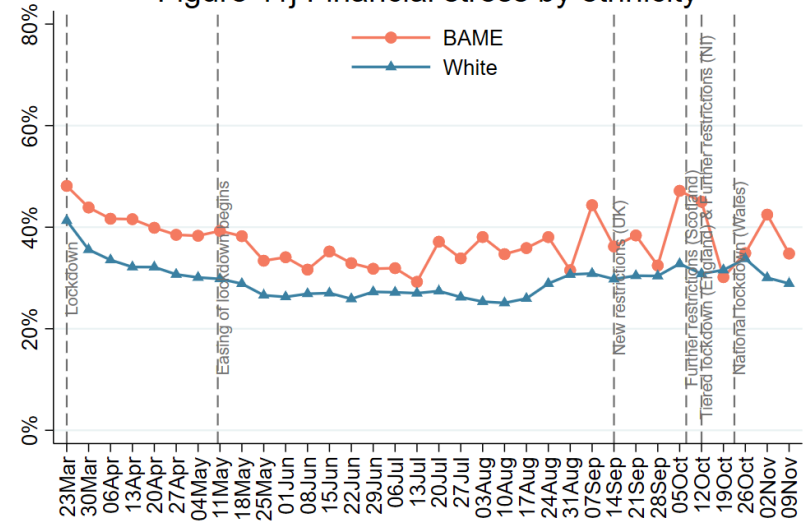


Figure 11k Financial stress by educational levels

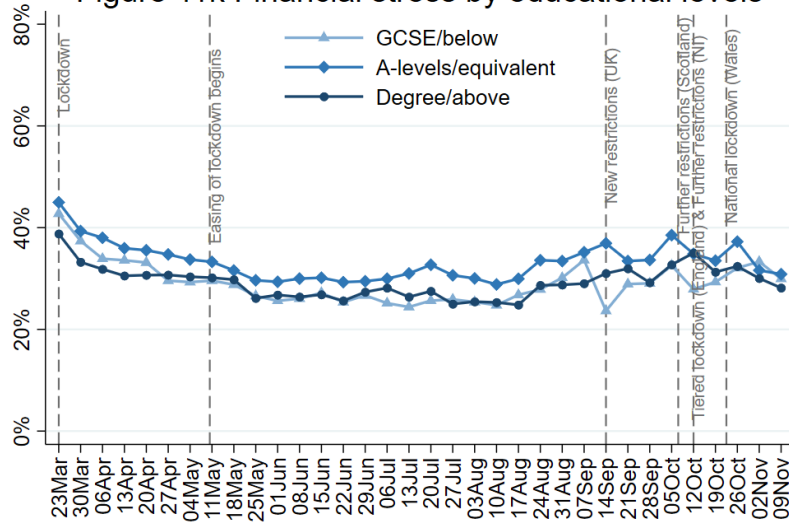


Figure 11l Financial stress by physical health diagnosis

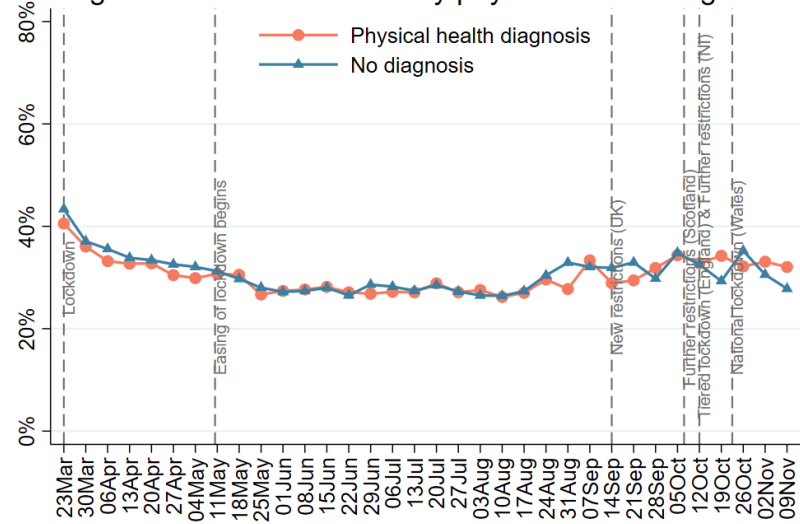


Figure 12a Food security stress by age groups

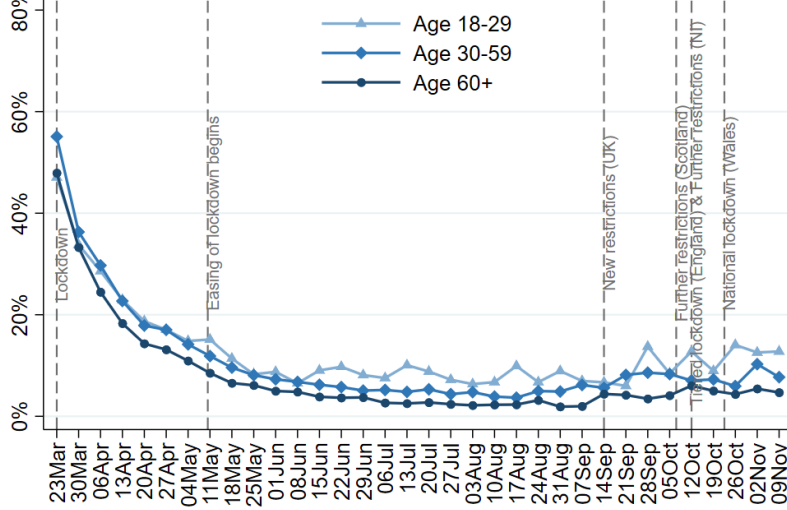


Figure 12b Food security stress by living arrangement

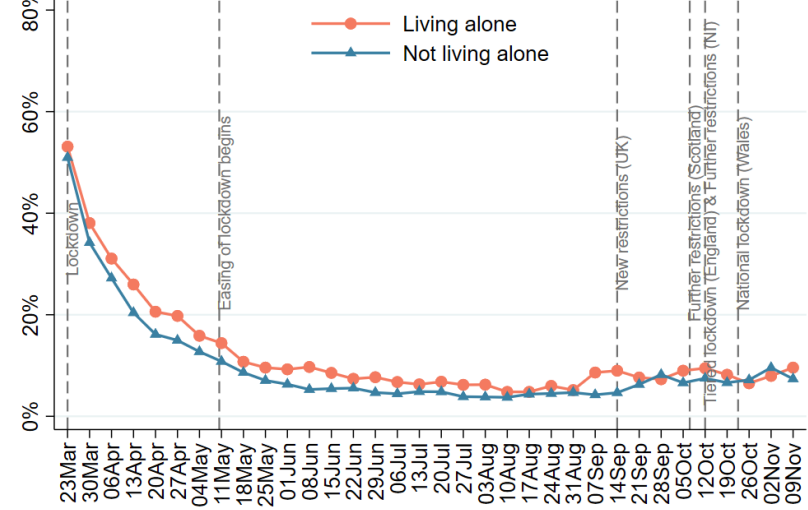


Figure 12c Food security stress by household income

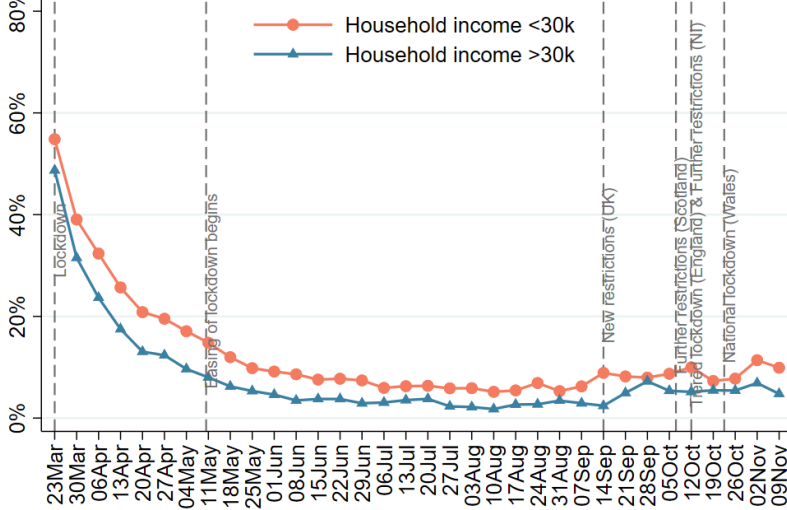
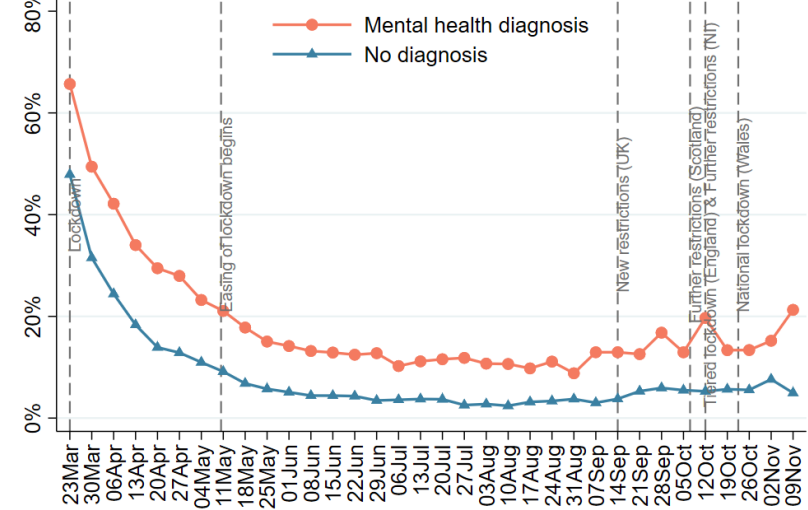


Figure 12d Food security stress by mental health





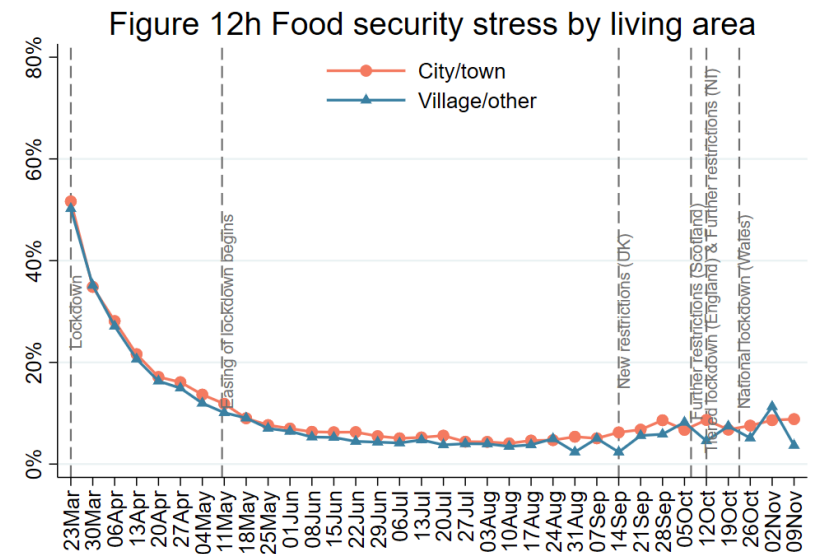
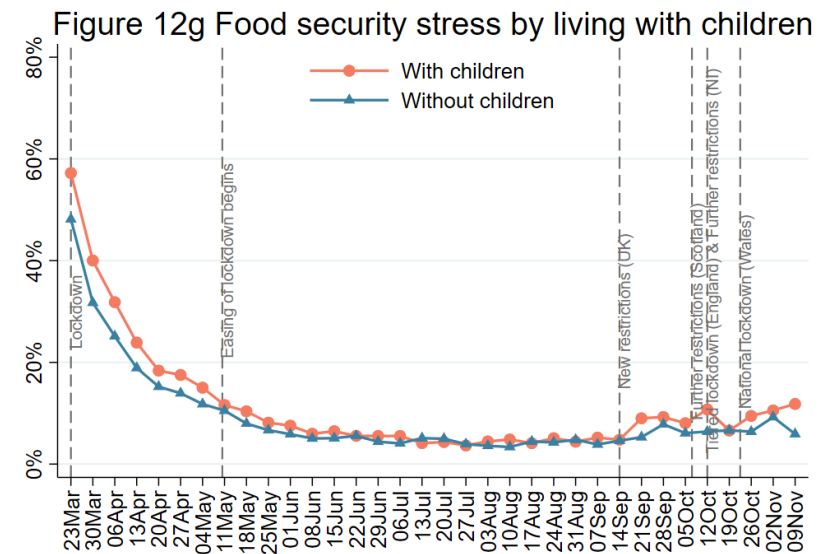
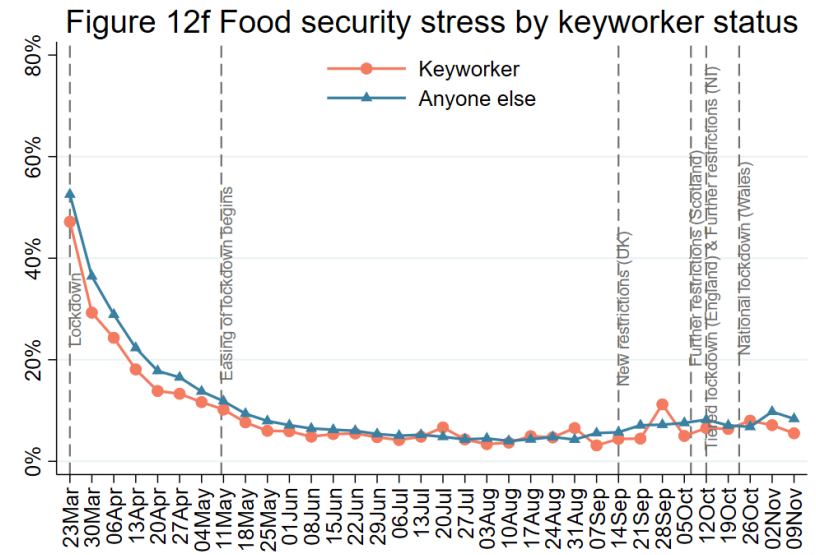
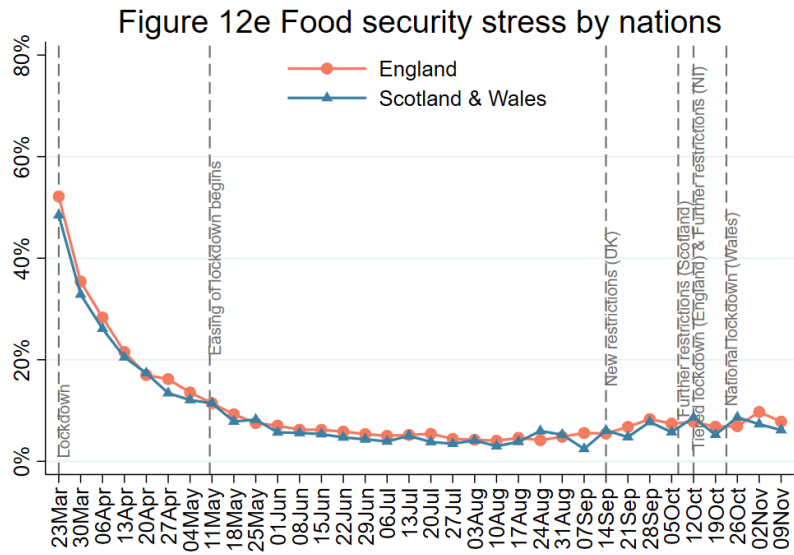


Figure 12i Food security stress by gender

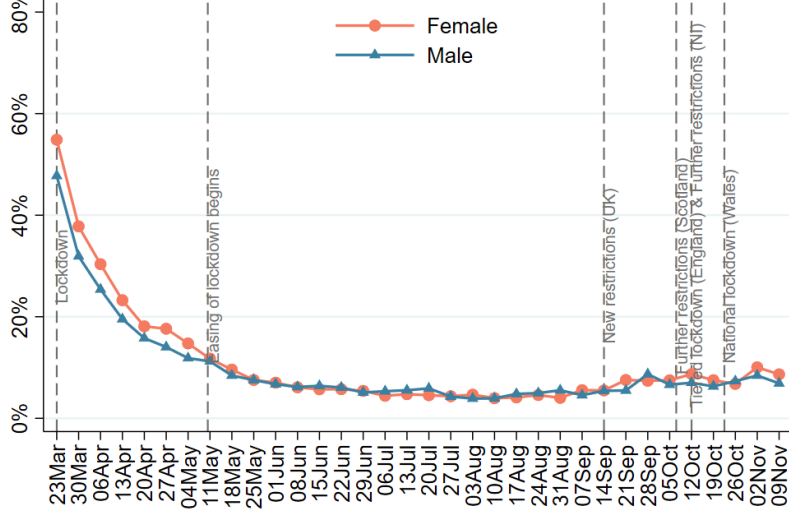


Figure 12j Food security stress by ethnicity

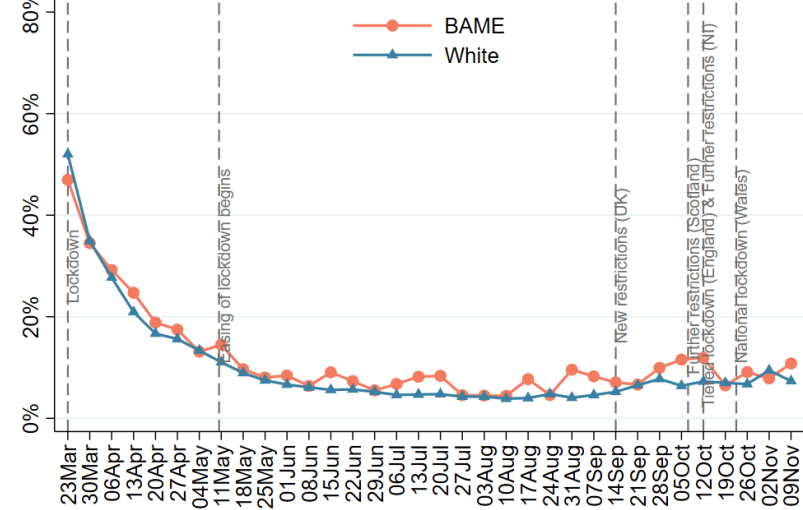


Figure 12k Food security stress by educational levels

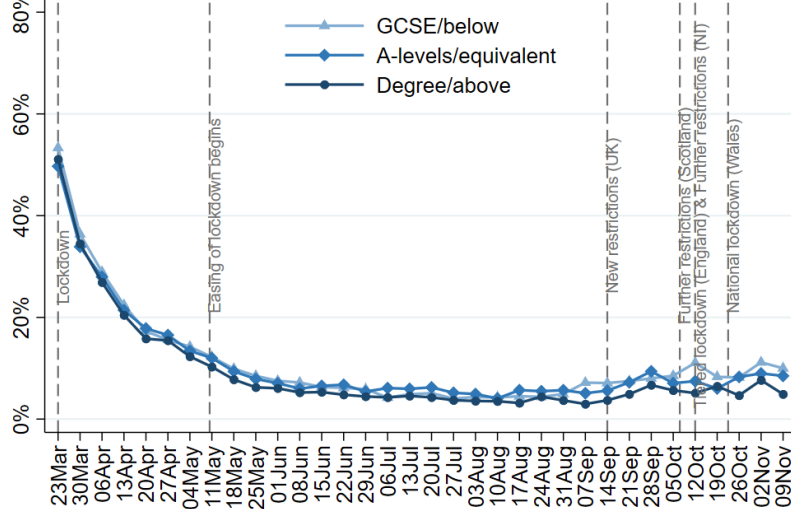
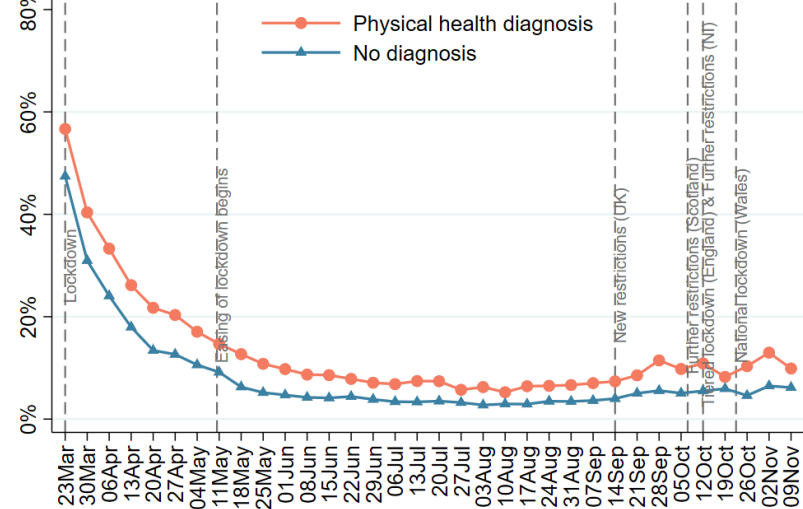
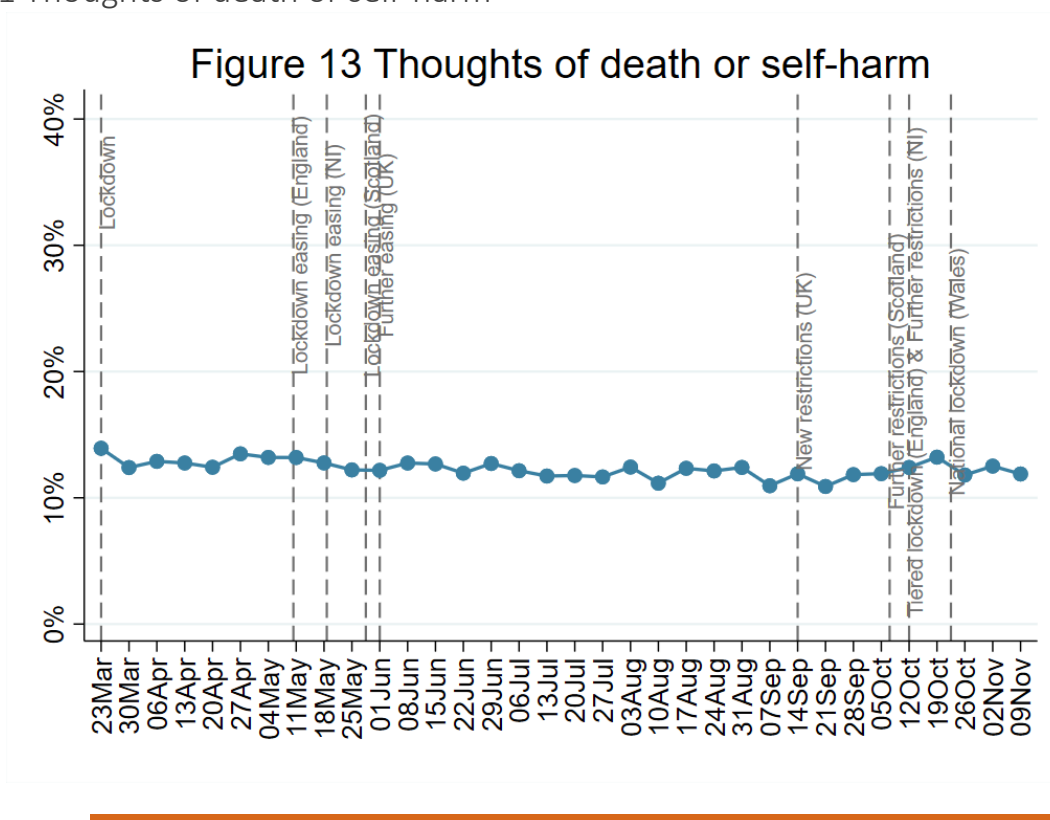


Figure 12l Food security stress by physical health diagnosis



### 3. Self-harm and abuse

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



#### FINDINGS

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

There continues to be no clear change in thoughts of death or self-harm. Percentages of people having thoughts of death or self-harm have been relatively stable throughout the past 32 weeks. They remain higher amongst younger adults, those with lower household income, people with a long-term physical health condition, and people with a diagnosed mental health condition. They are also higher in people living alone and those living in urban areas. There is no difference by gender.

Figure 14a Thoughts of death by age groups

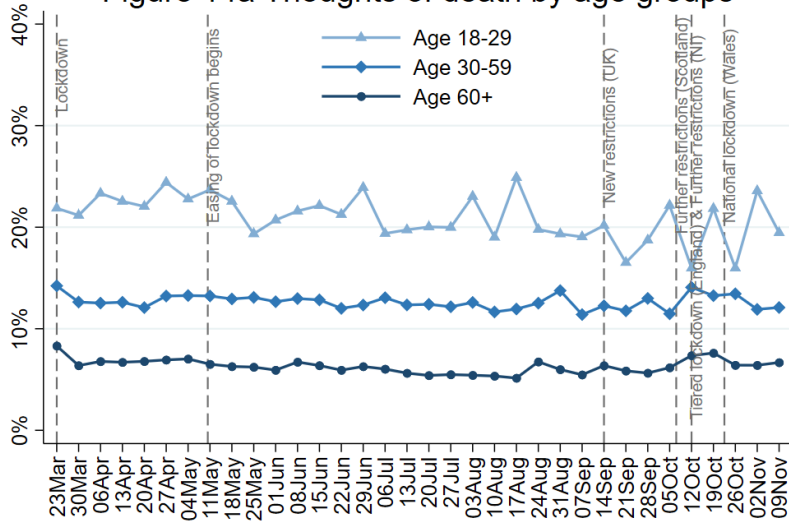


Figure 14b Thoughts of death by living arrangement

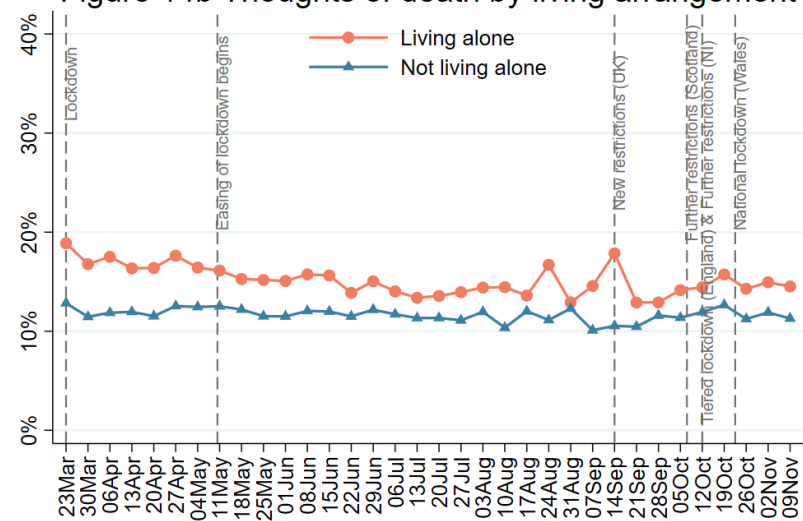


Figure 14c Thoughts of death by household income

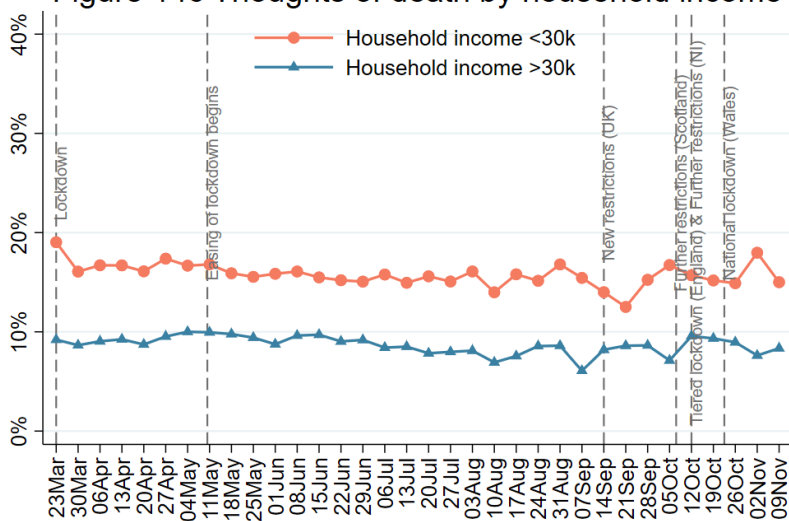


Figure 14d Thoughts of death by mental health diagnosis

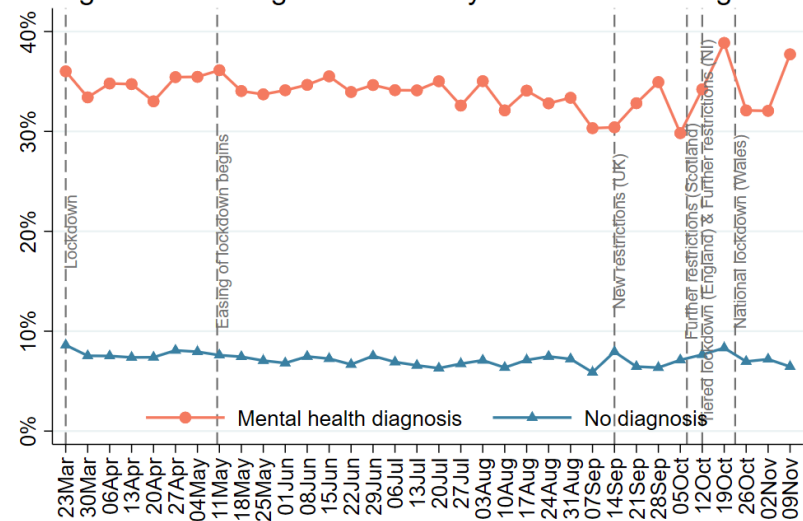


Figure 14e Thoughts of death by nations

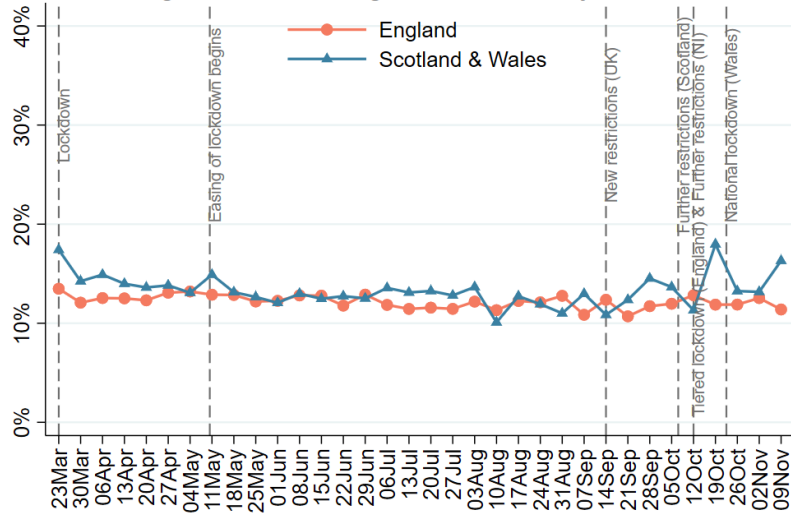


Figure 14f Thoughts of death by keyworker status

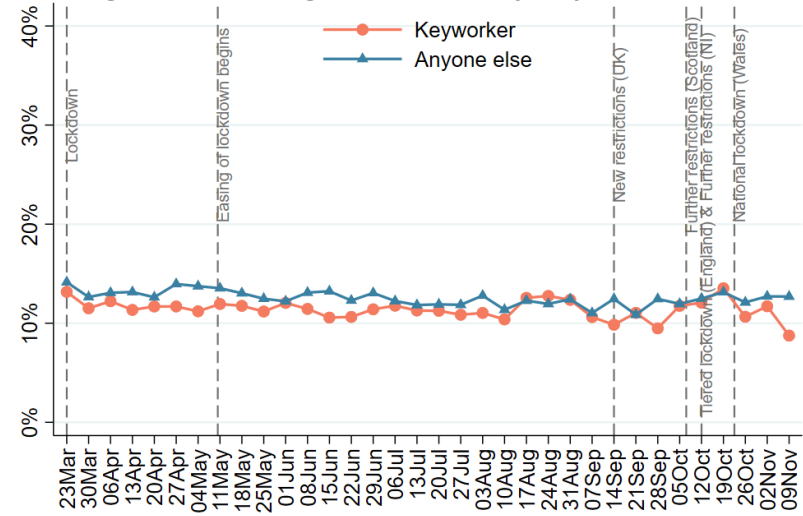


Figure 14g Thoughts of death by living with children

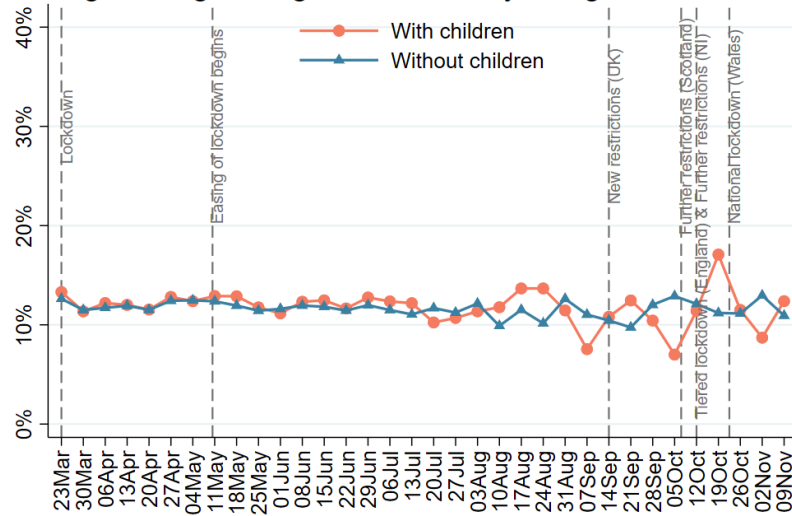


Figure 14h Thoughts of death by living area

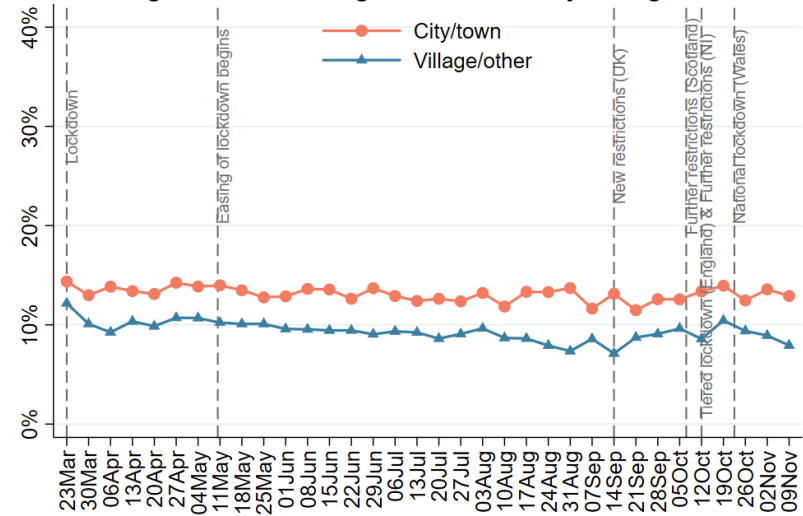


Figure 14i Thoughts of death by gender

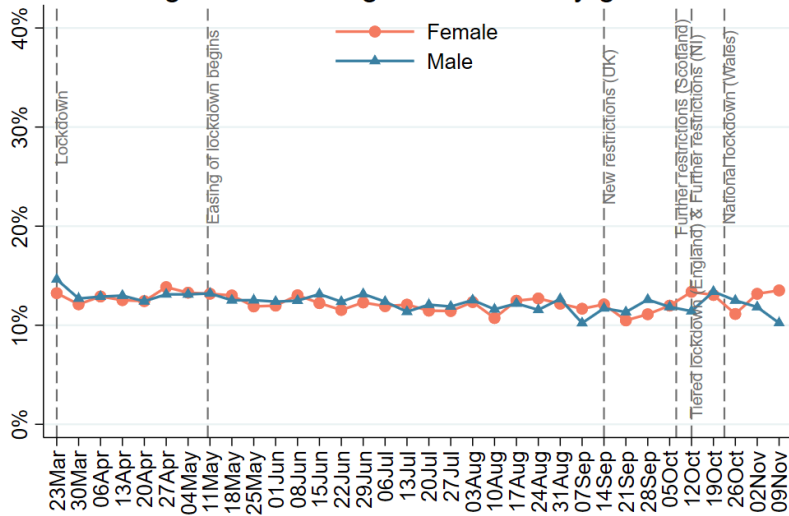


Figure 14j Thoughts of death by ethnicity

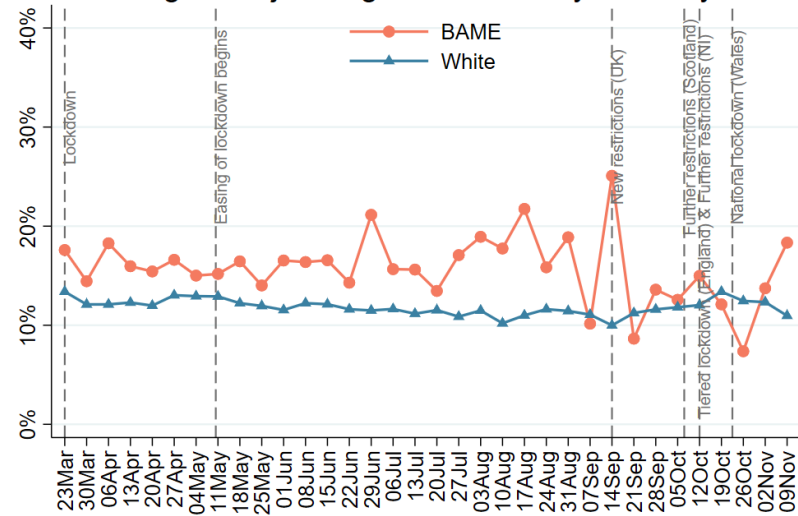


Figure 14k Thoughts of death by educational levels

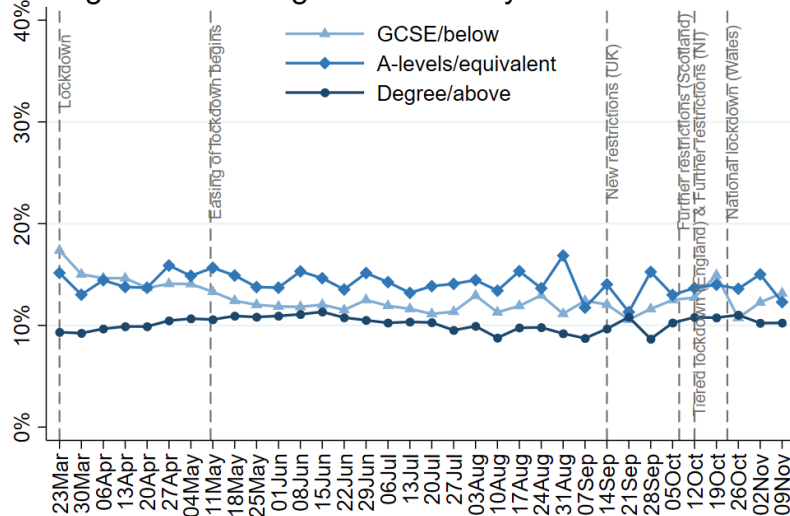
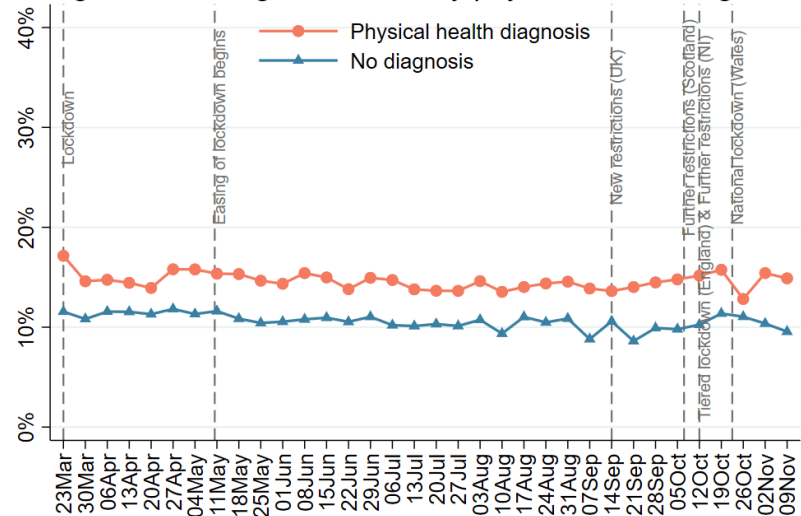
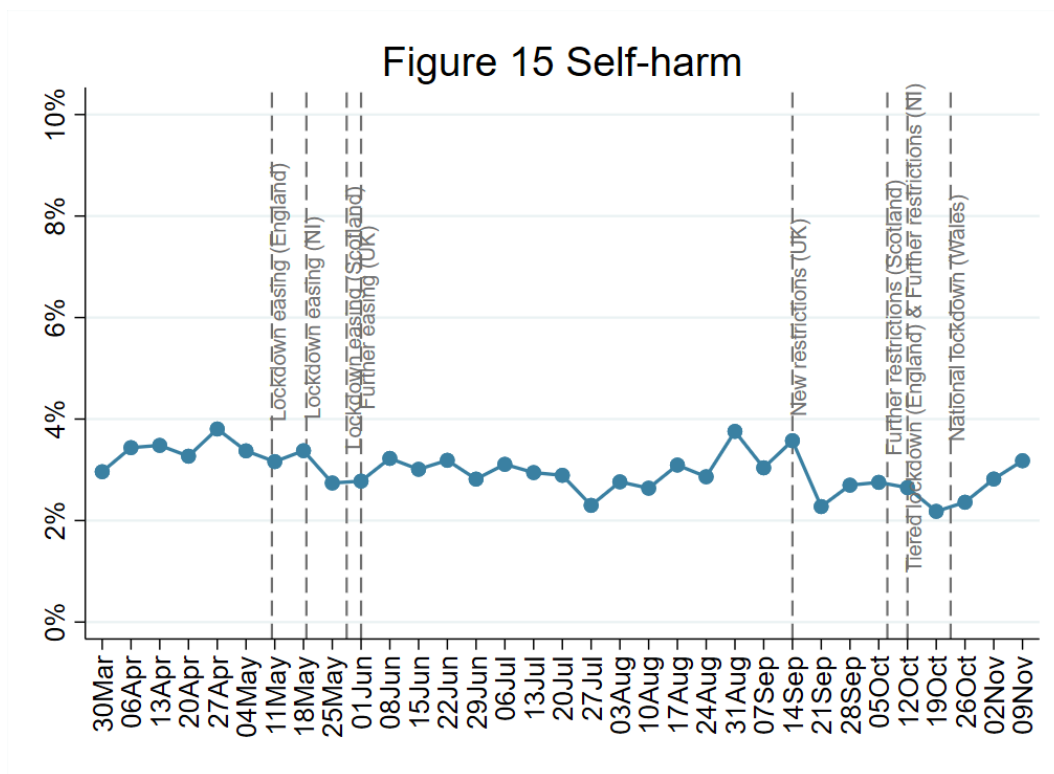


Figure 14l Thoughts of death by physical health diagnosis



### 3.2 Self-harm



#### FINDINGS

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

There may be indications that self-harm has increased since more restrictions came in around mid-October. But the variations are between 2% and 2.6%, so are not currently indicative of substantial rises, and averages are easily skewed. However, this pattern will be monitored to see if further patterns emerge in coming weeks.

Self-harm remains higher amongst younger adults, those with lower household income, and those with a diagnosed mental health condition. It is also slightly higher amongst people living in urban areas. It is also higher amongst people with long-term physical health conditions.

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

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

Figure 16a Self-harm by age groups

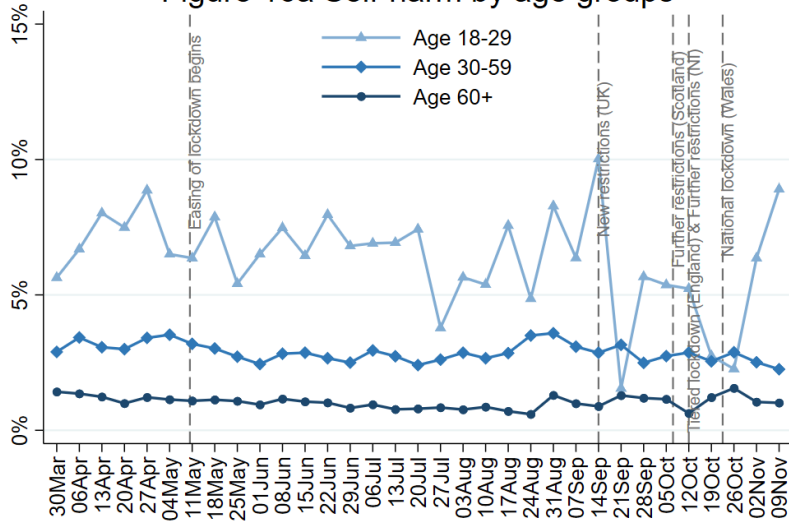


Figure 16b Self-harm by living arrangement

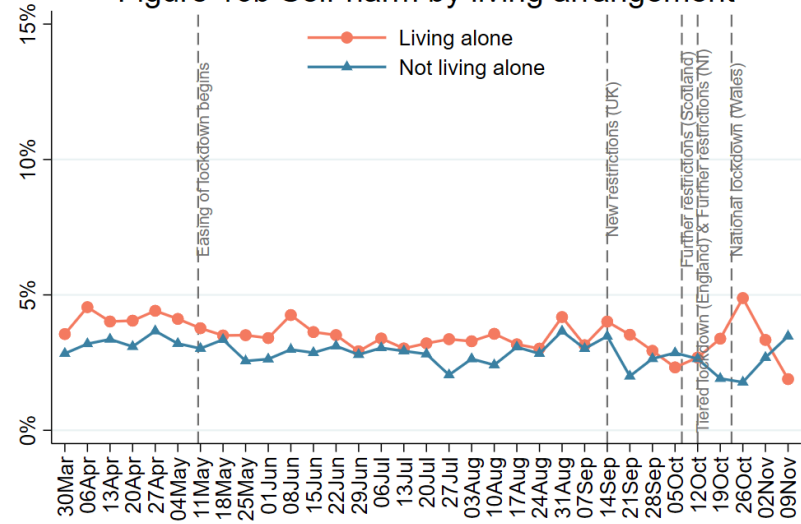


Figure 16c Self-harm by household income

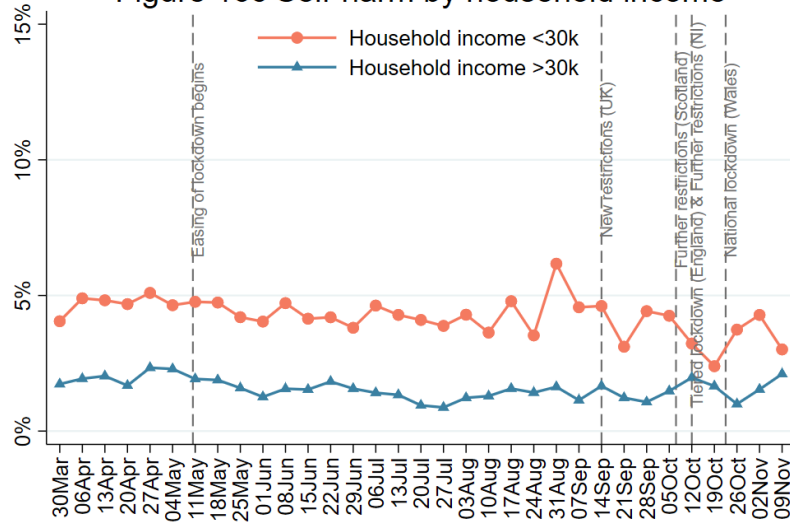


Figure 16d Self-harm by mental health diagnosis

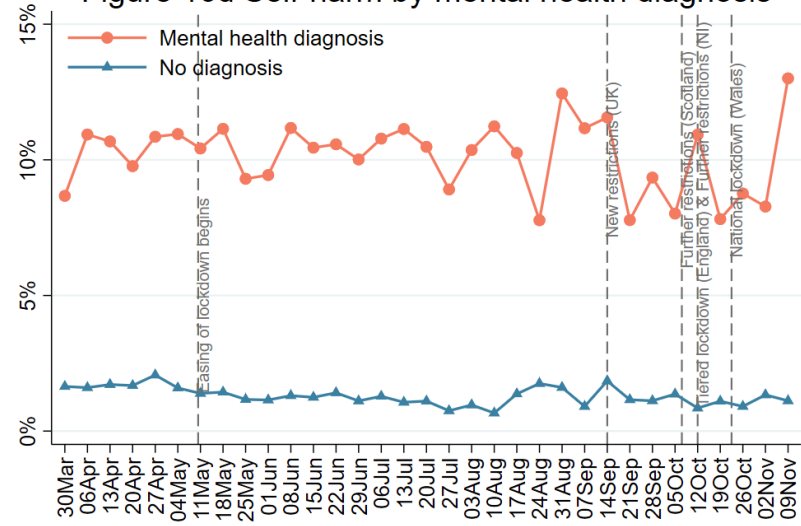




Figure 16e Self-harm by nations

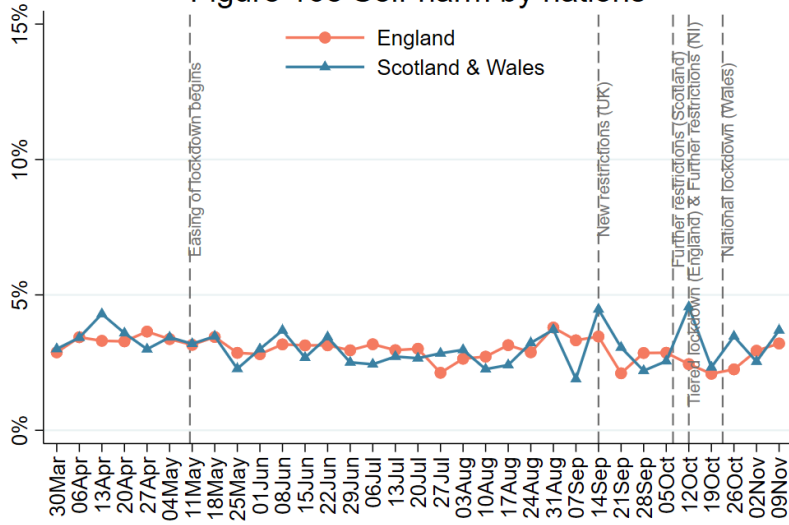


Figure 16f Self-harm by keyworker status

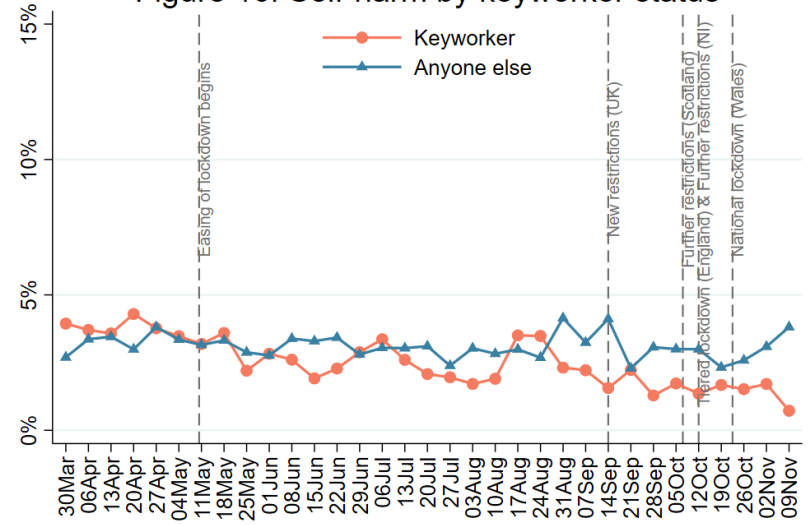


Figure 16g Self-harm by living with children

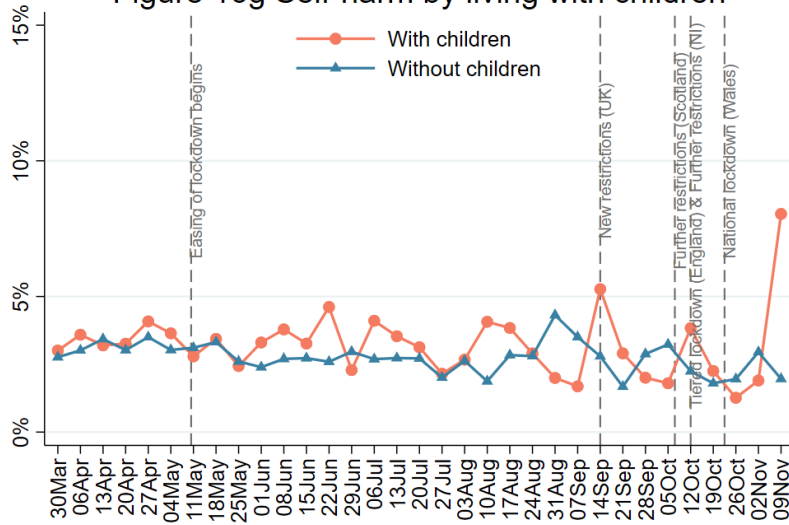


Figure 16h Self-harm by living area

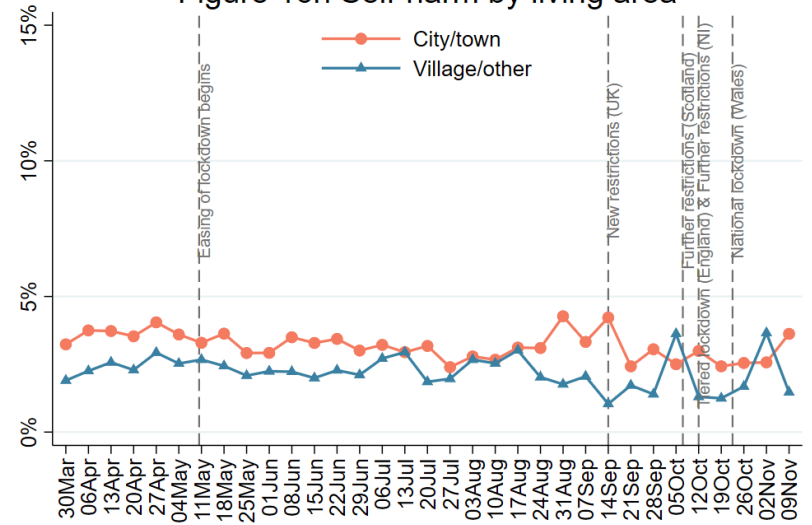


Figure 16i Self-harm by gender

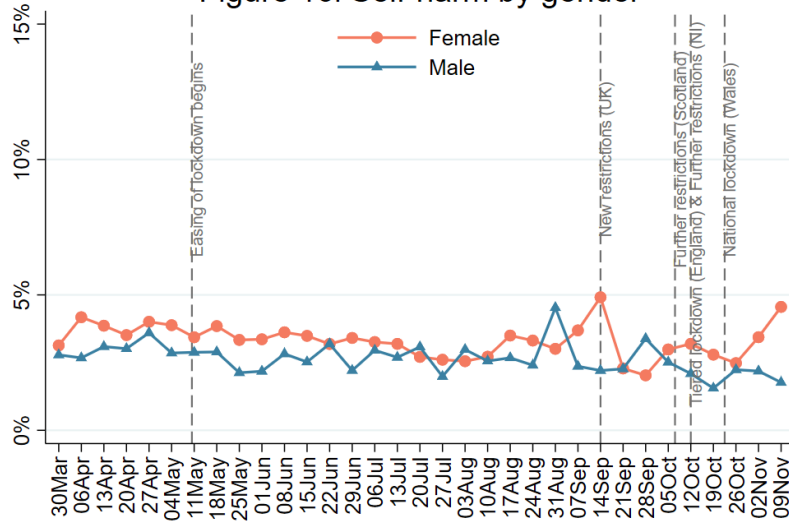


Figure 16j Self-harm by ethnicity

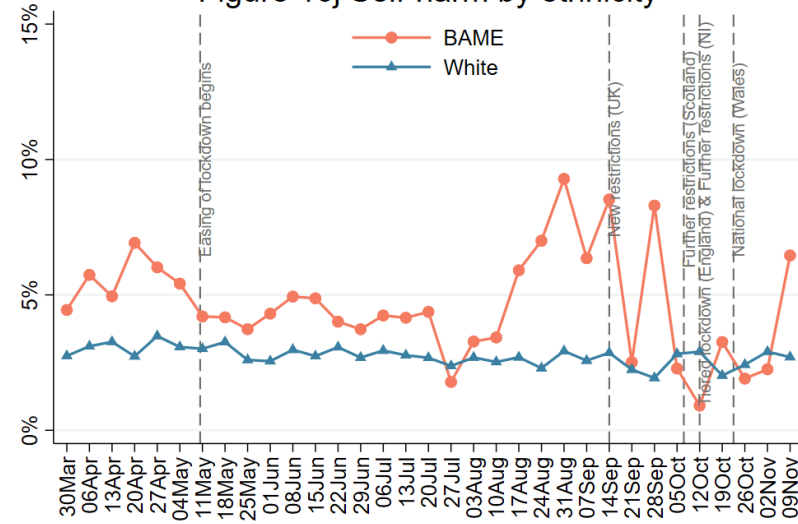


Figure 16k Self-harm by educational levels

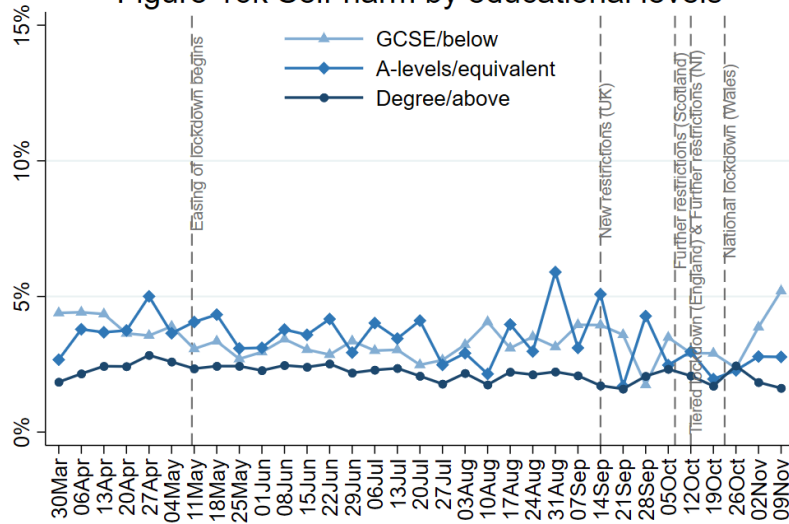
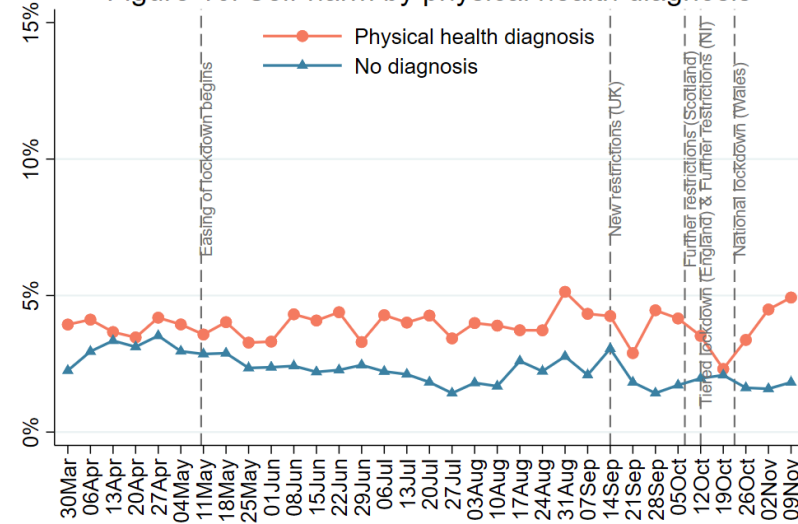
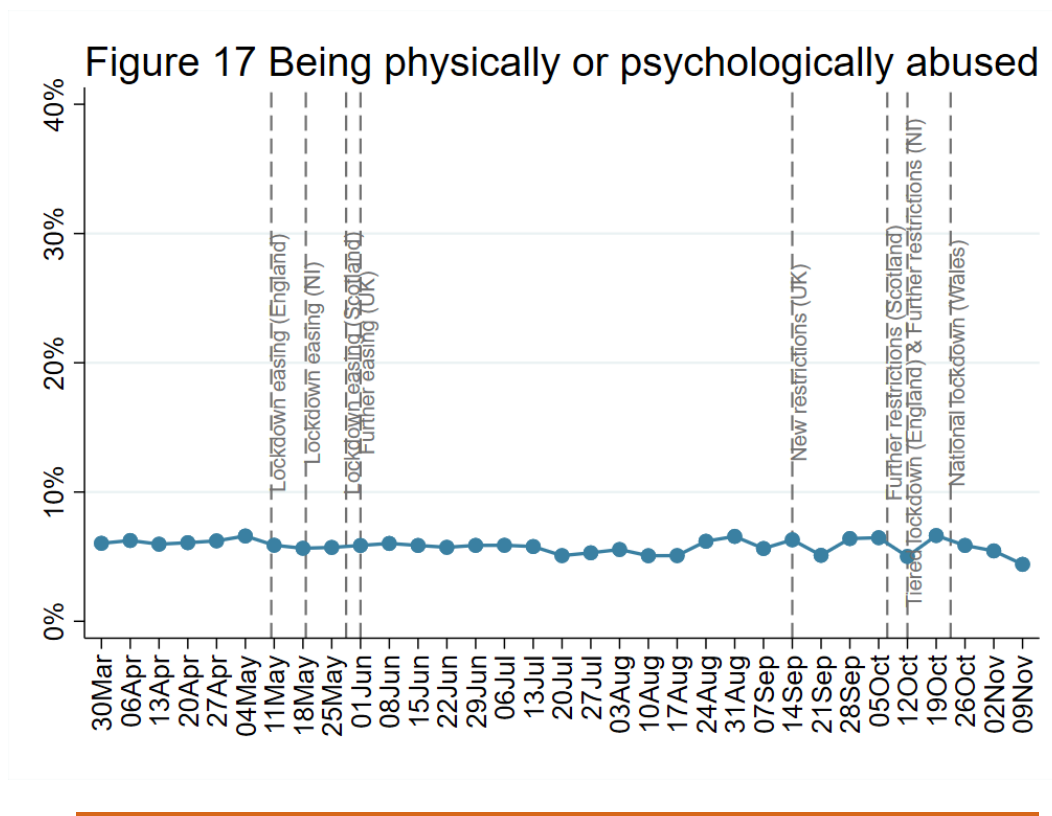


Figure 16l Self-harm by physical health diagnosis



### 3.3 Abuse



#### FINDINGS

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

Abuse has remained relatively stable in the past few months. 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. Abuse has also been higher amongst people with long-term physical health conditions and people from BAME backgrounds.

However, 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

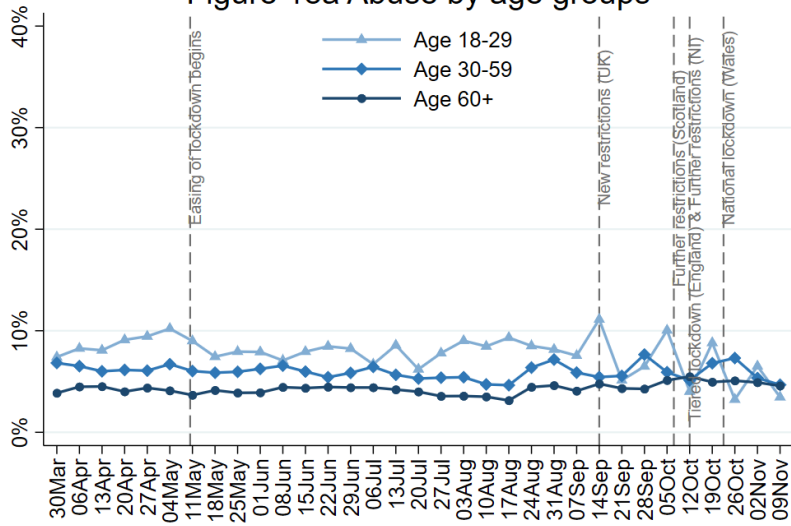


Figure 18b Abuse by living arrangement

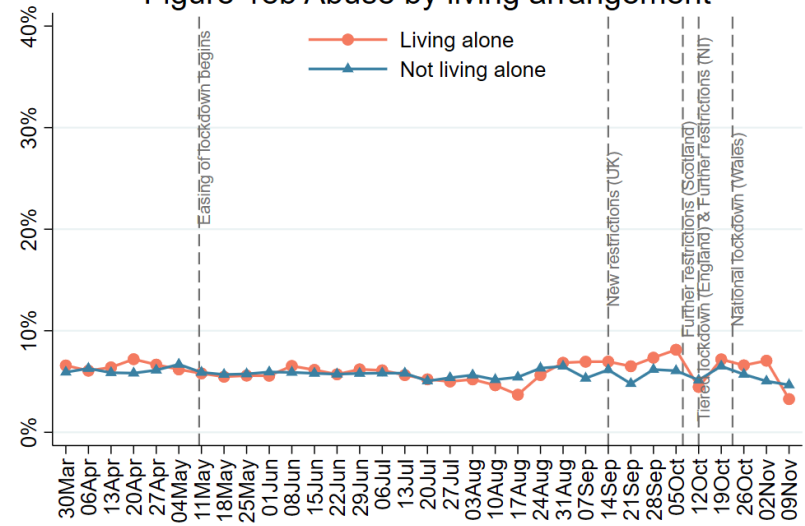


Figure 18c Abuse by household income

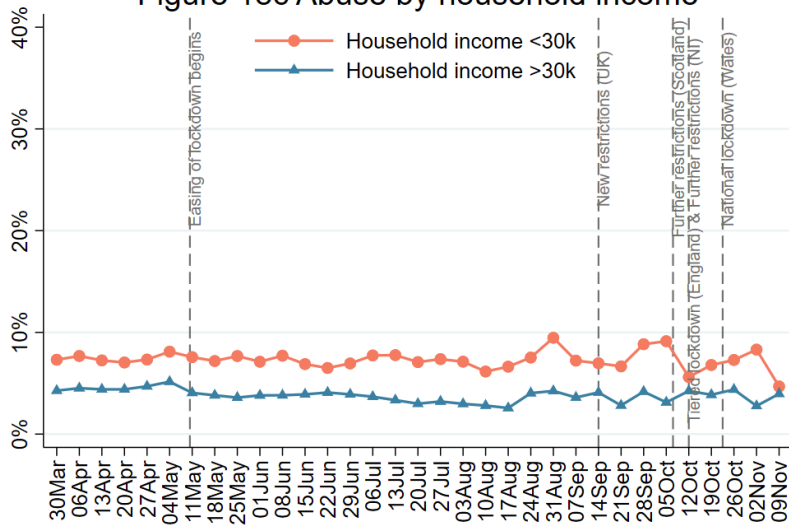


Figure 18d Abuse by mental health diagnosis

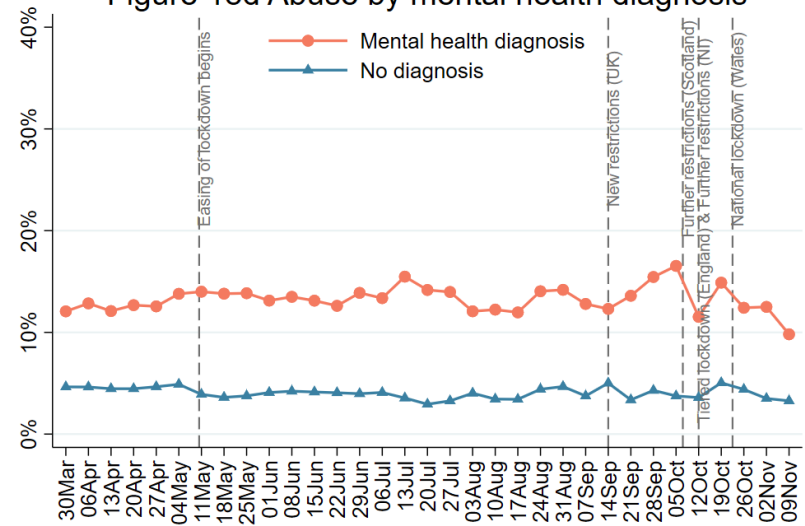


Figure 18e Abuse by nations

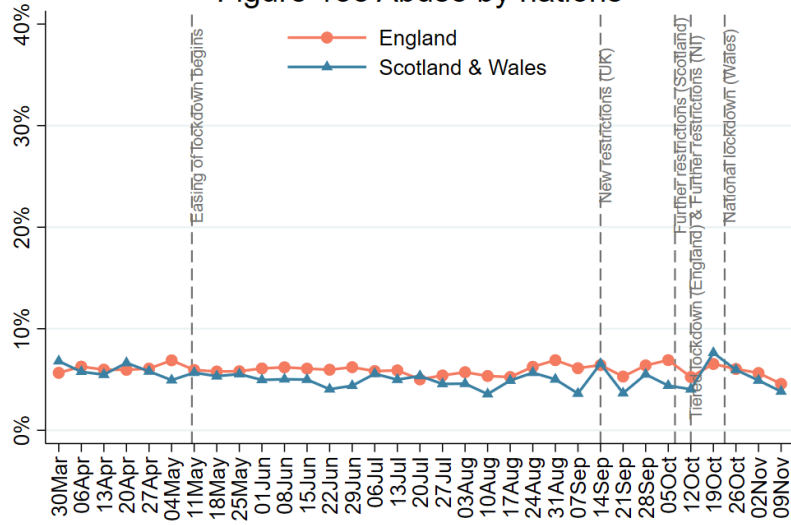


Figure 18f Abuse by keyworker status

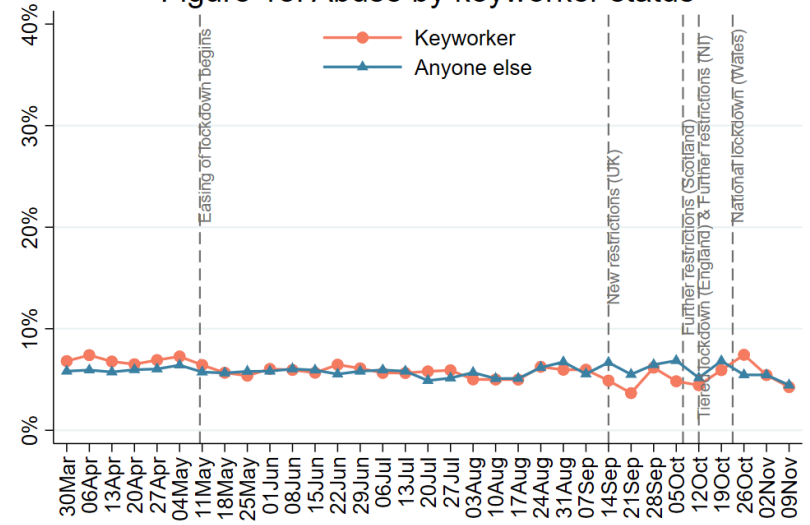


Figure 18g Abuse by living with children

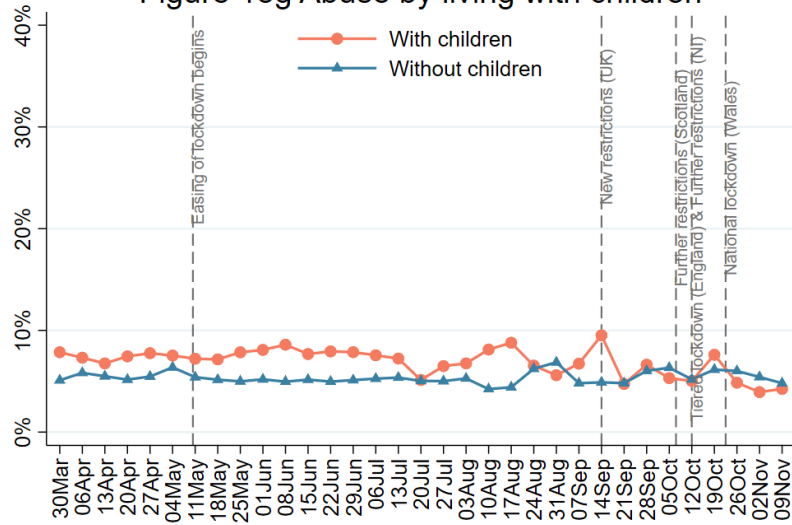


Figure 18h Abuse by living area

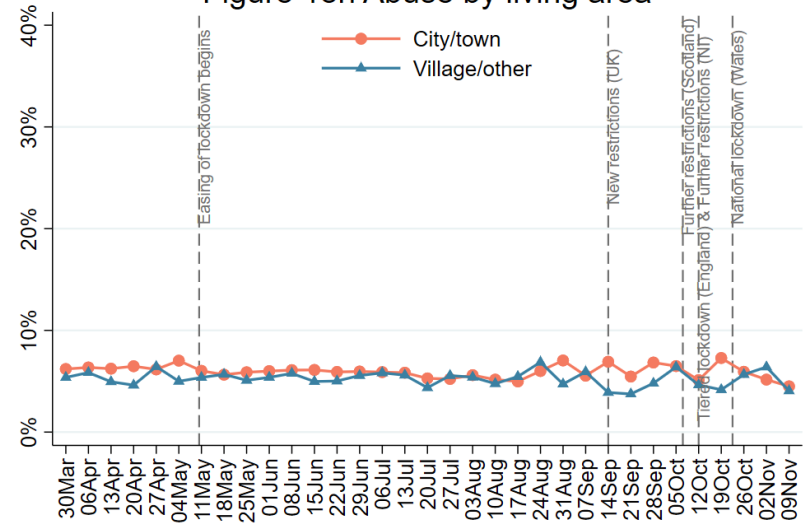


Figure 18i Abuse by gender

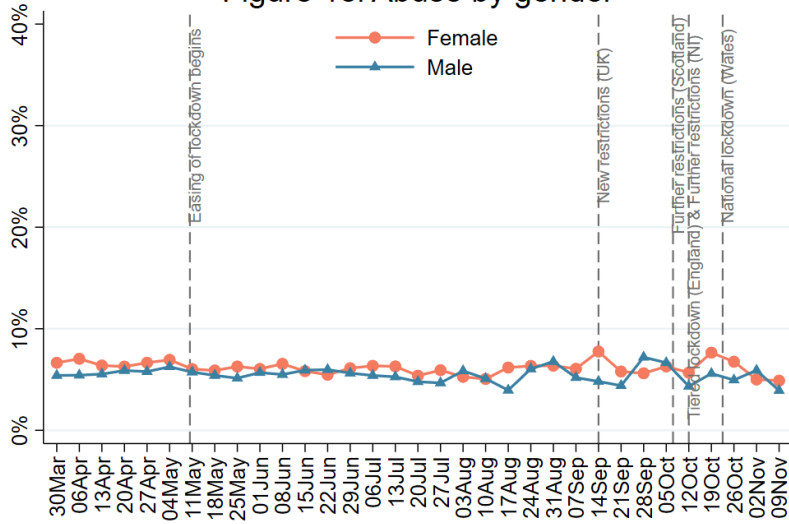


Figure 18j Abuse by ethnicity

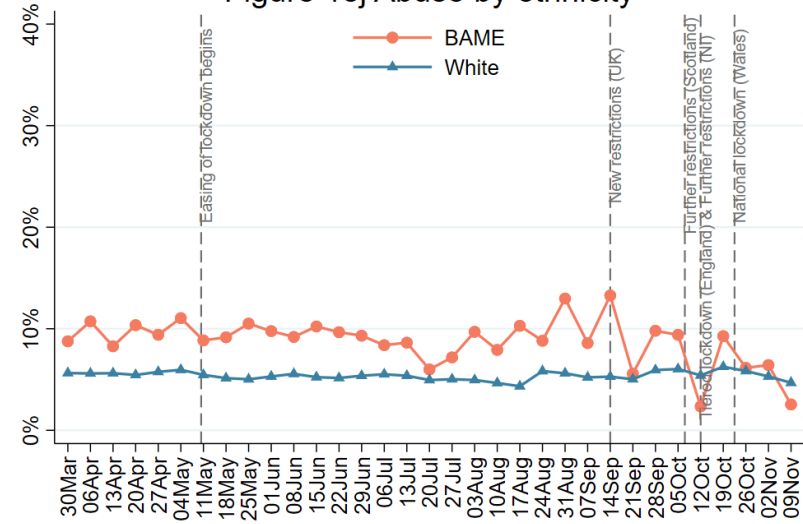


Figure 18k Abuse by educational levels

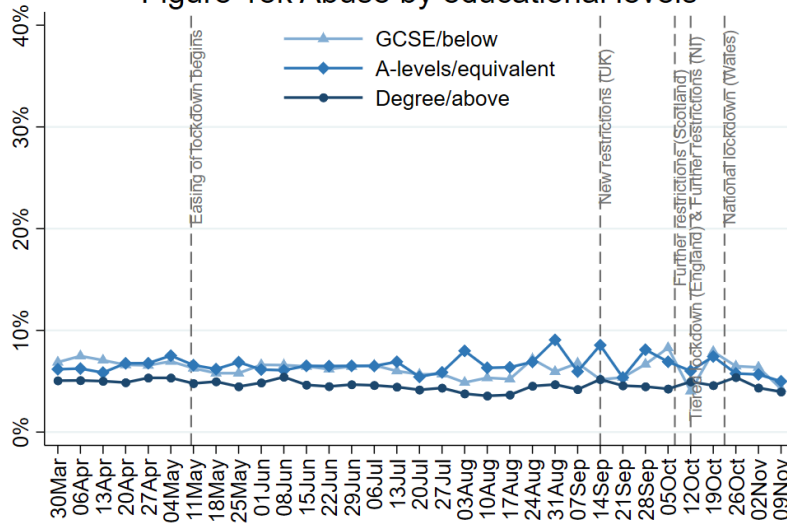
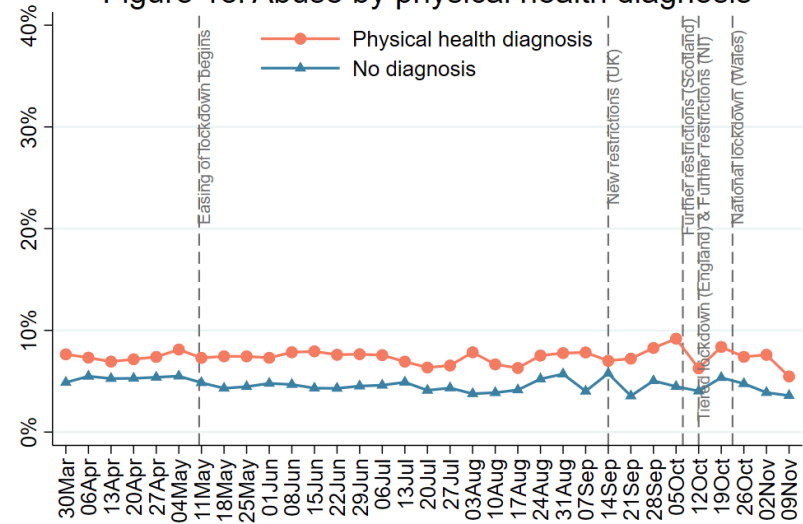
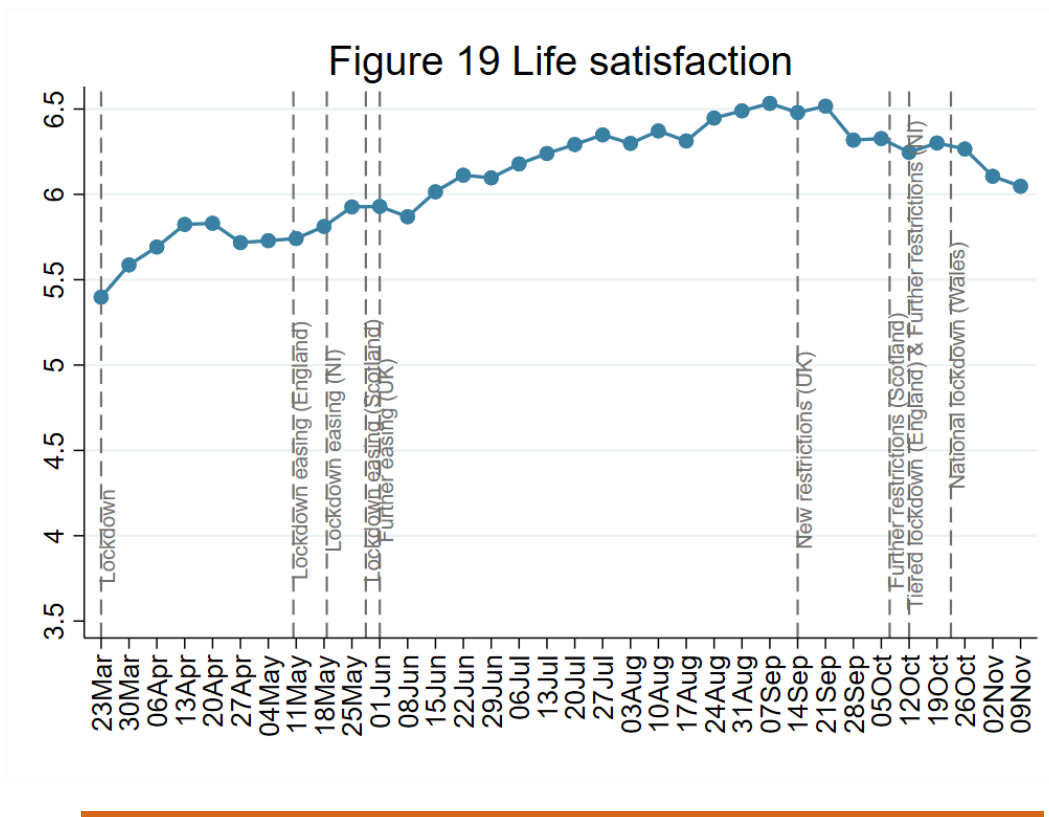


Figure 18l Abuse by physical health diagnosis



## 4. General well-being

### 4.1 Life satisfaction



#### FINDINGS

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

Life satisfaction has continued to decrease since new restrictions were brought in in mid-September. Life satisfaction is 8% lower than it was at the start of September but still 11% higher than it was at the start of the first lockdown in March.

The decrease over the past two months appears to have occurred across all age groups, although adults under the age of 60 have lowest levels of life satisfaction. It is also lower in people living alone, people with lower household income, people with a diagnosed mental health condition, and people living in urban areas. It is similar across UK nations and amongst key workers. Women have lower levels of life satisfaction, as do people with a long-term physical health condition and people from BAME backgrounds (although smaller sample sizes compared to people with white ethnicity mean there has been greater volatility in these data).

Whilst this study focuses on trajectories rather than prevalence, life satisfaction is still 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>.

<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

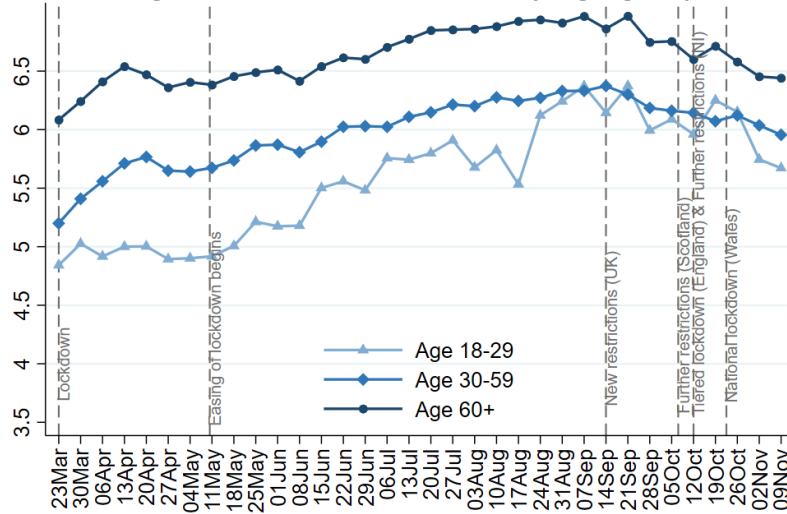


Figure 20b Life satisfaction by living arrangement

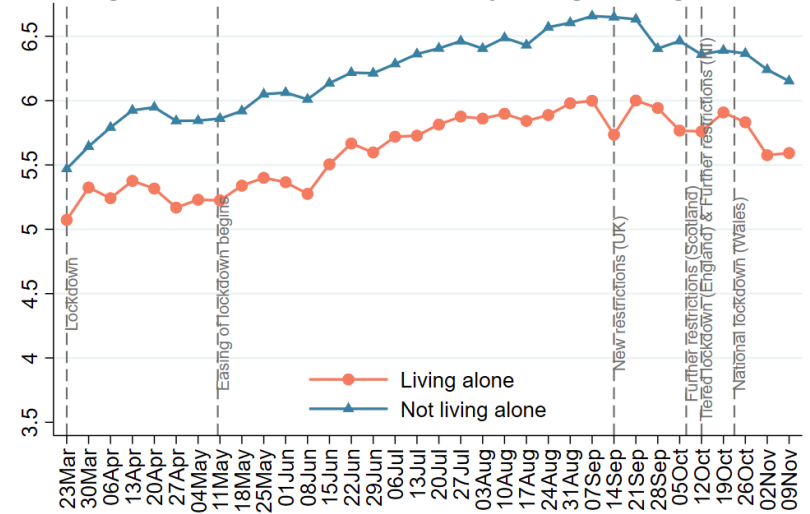


Figure 20c Life satisfaction by household income

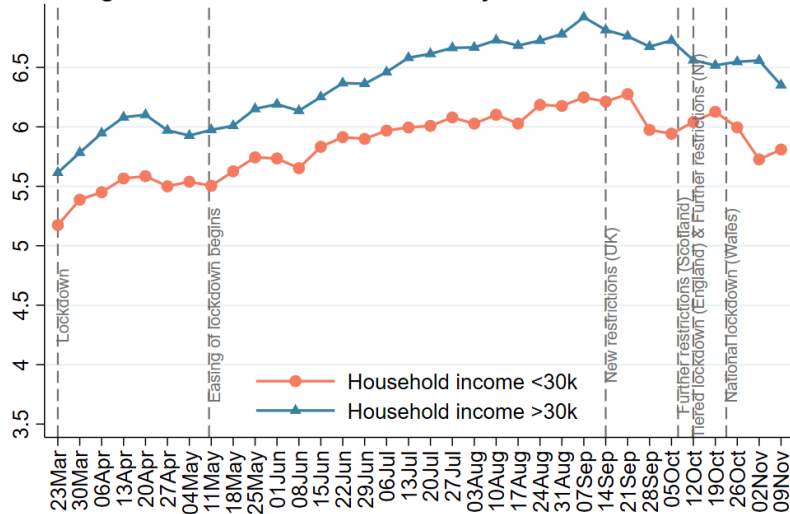


Figure 20d Life satisfaction by mental health diagnosis

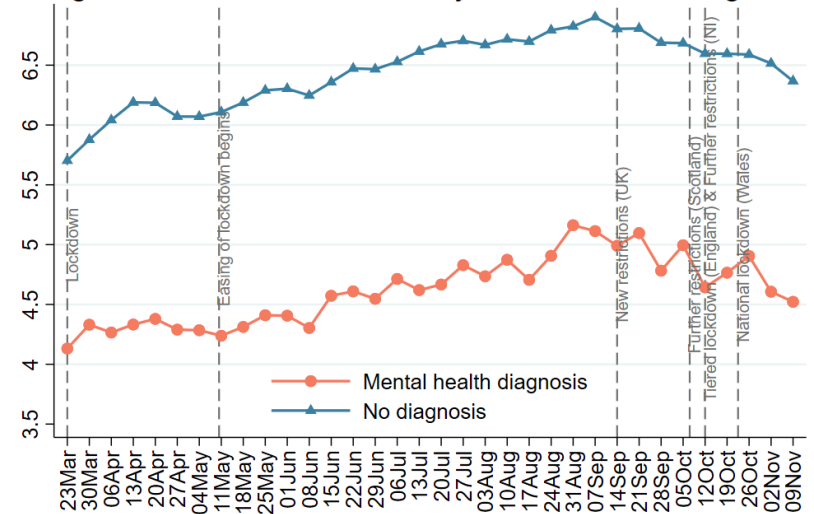




Figure 20e Life satisfaction by nations

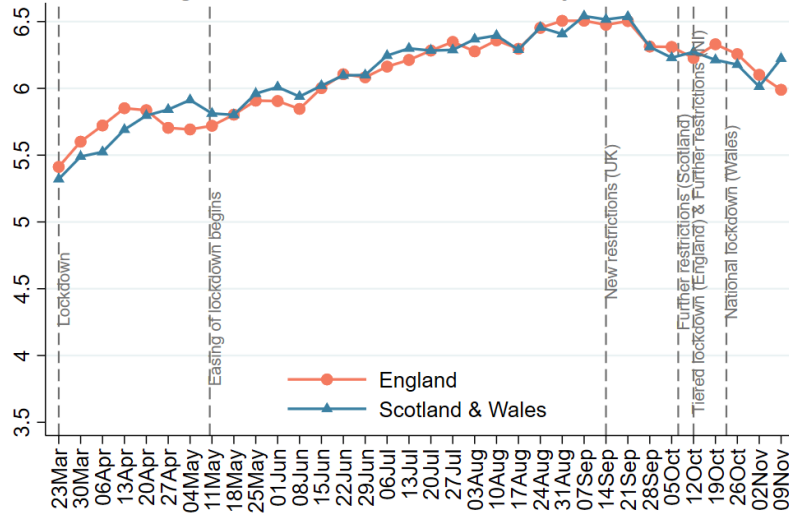


Figure 20f Life satisfaction by keyworker status

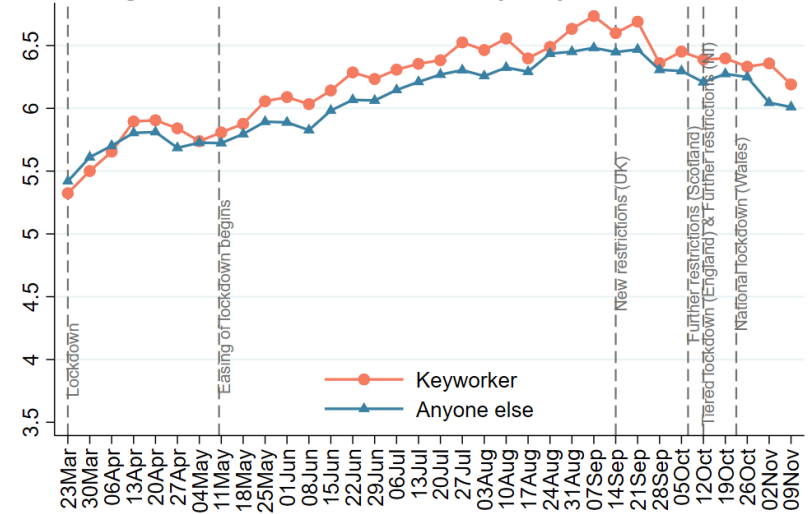


Figure 20g Life satisfaction by living with children

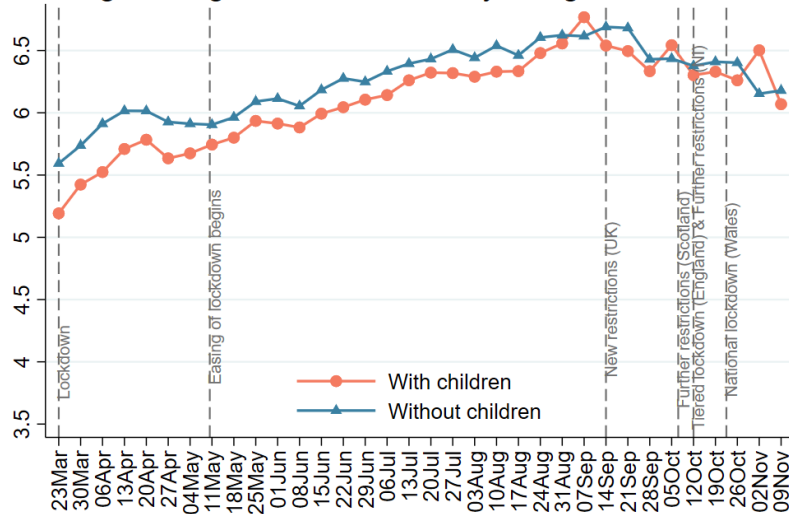


Figure 20h Life satisfaction by living area

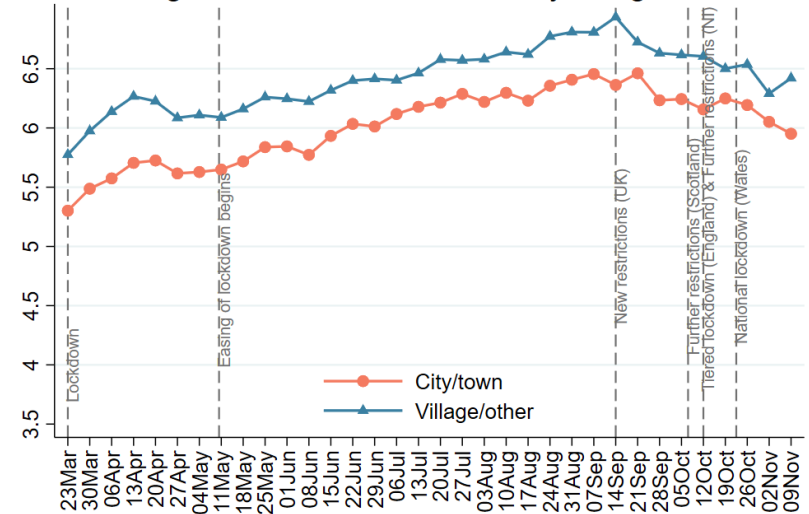


Figure 20i Life satisfaction by gender

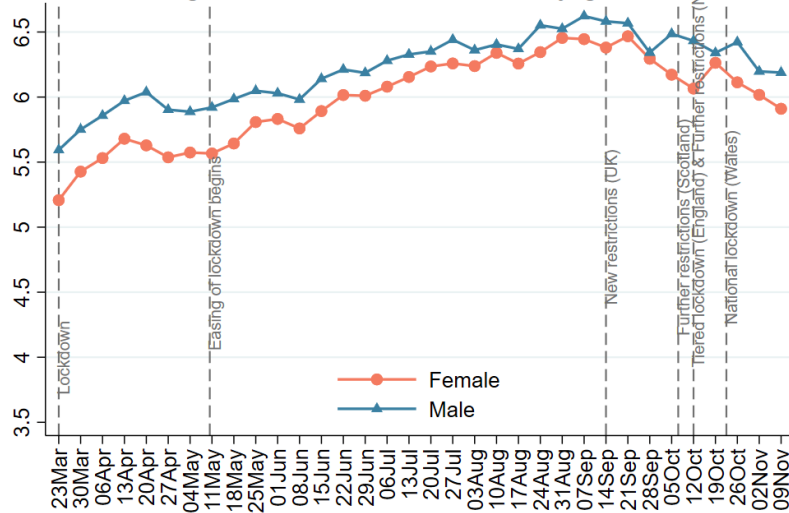


Figure 20j Life satisfaction by ethnicity

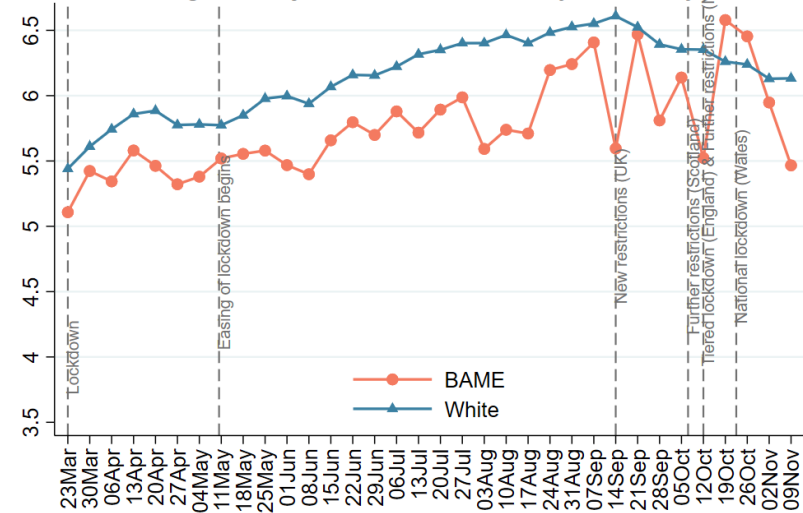


Figure 20k Life satisfaction by educational levels

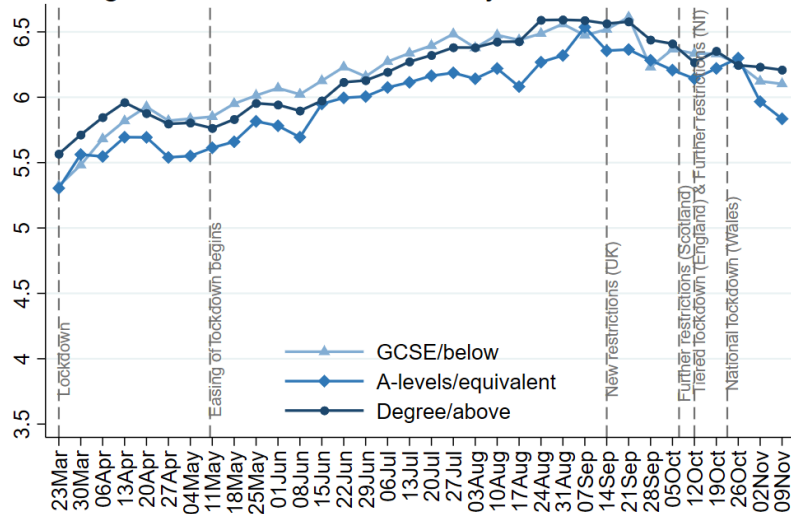
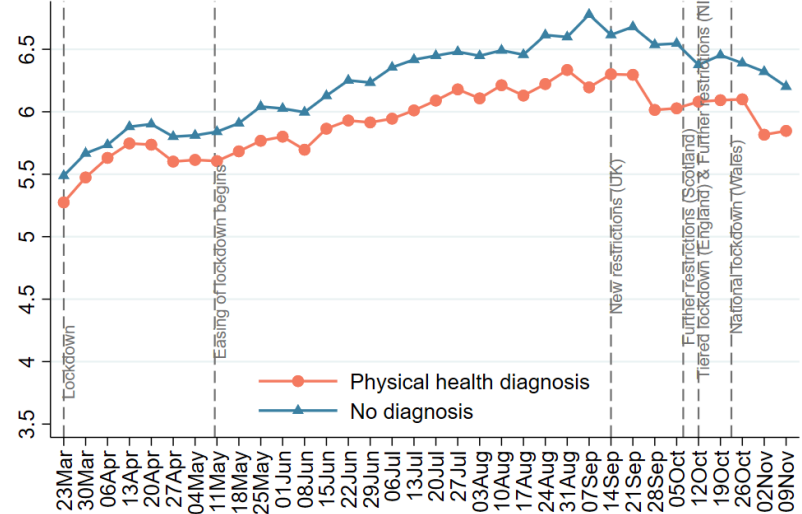
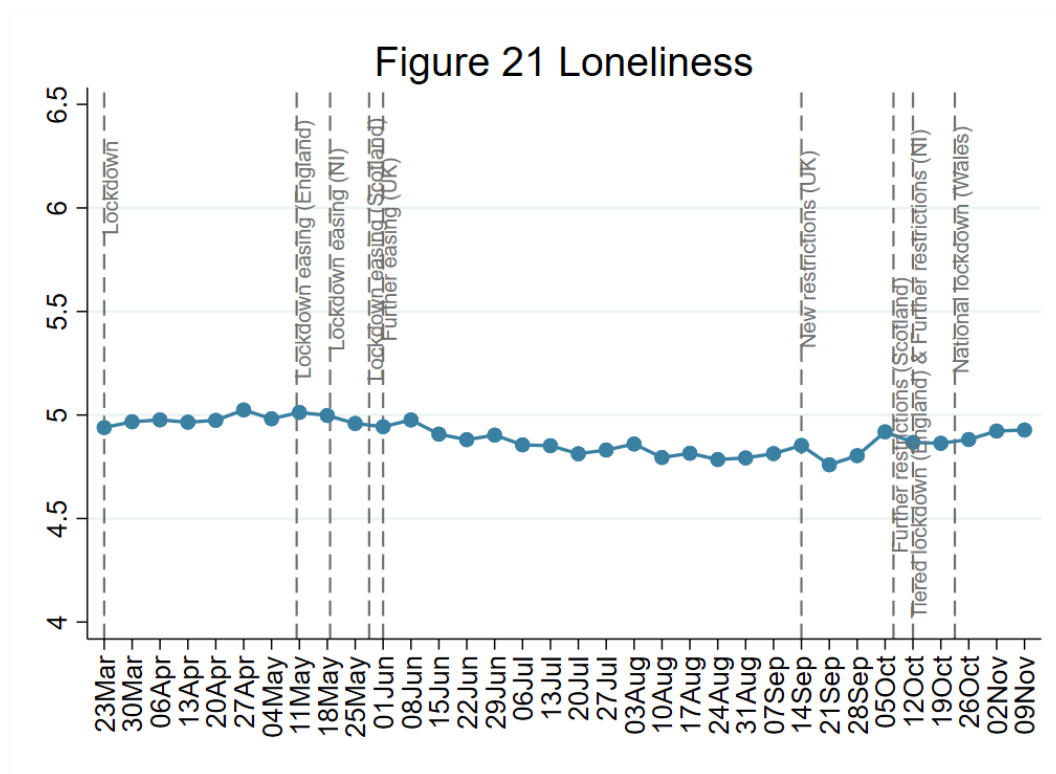


Figure 20l Life satisfaction by physical health diagnosis



## 4.2 Loneliness



### FINDINGS

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

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

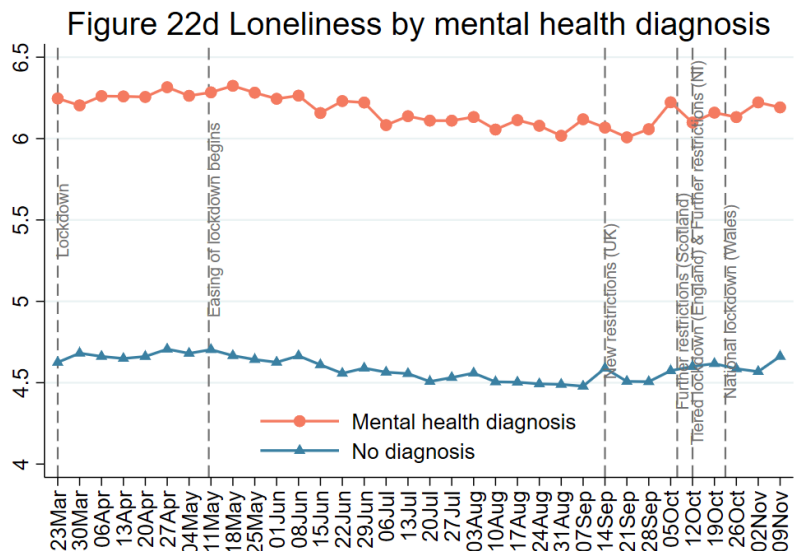
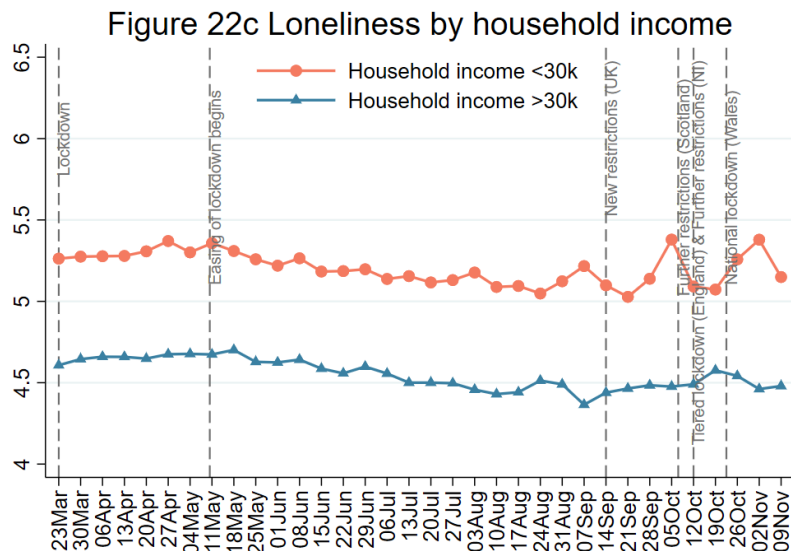
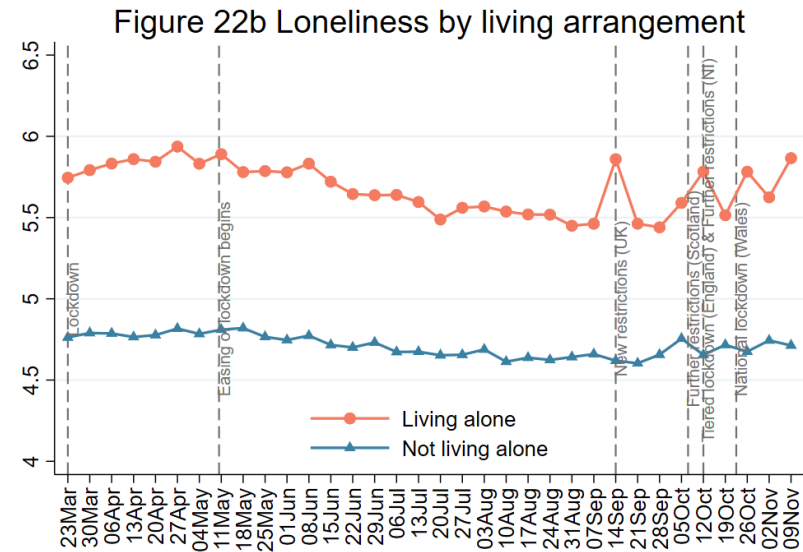
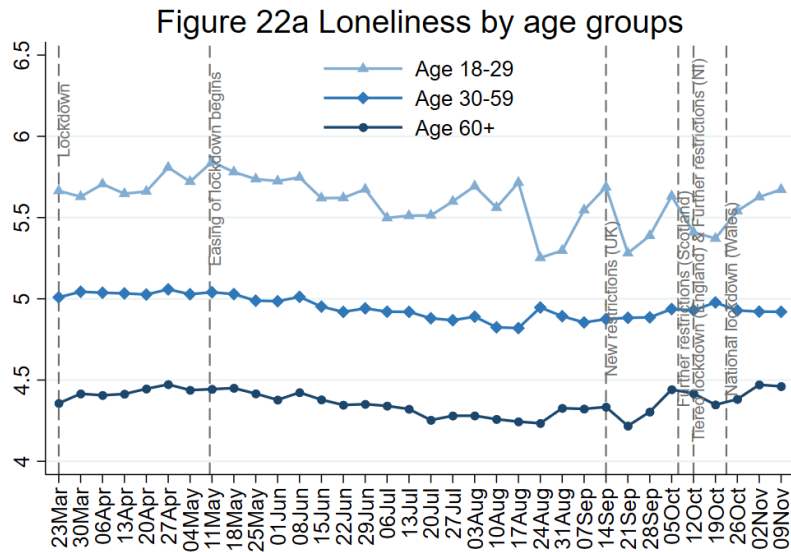


Figure 22e Loneliness by nations

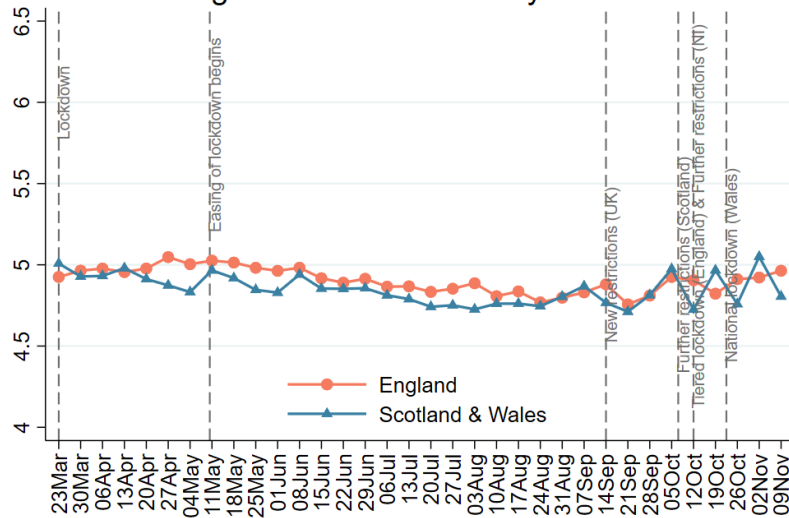


Figure 22f Loneliness by keyworker status

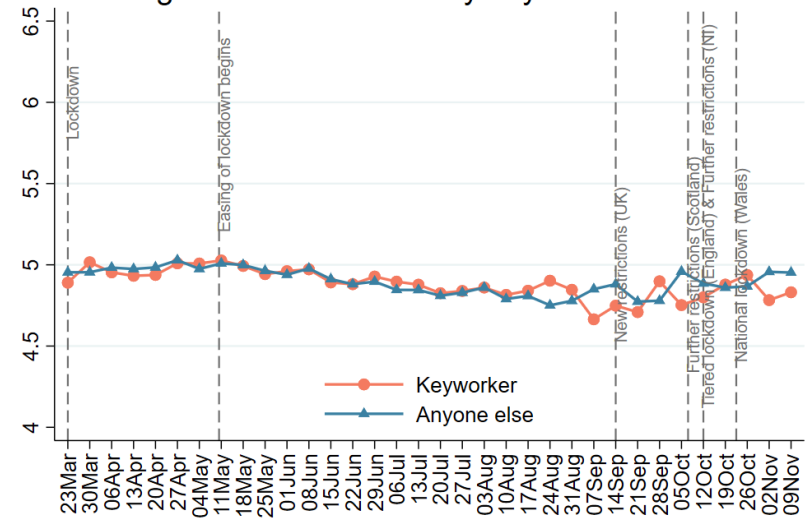


Figure 22g Loneliness by living with children

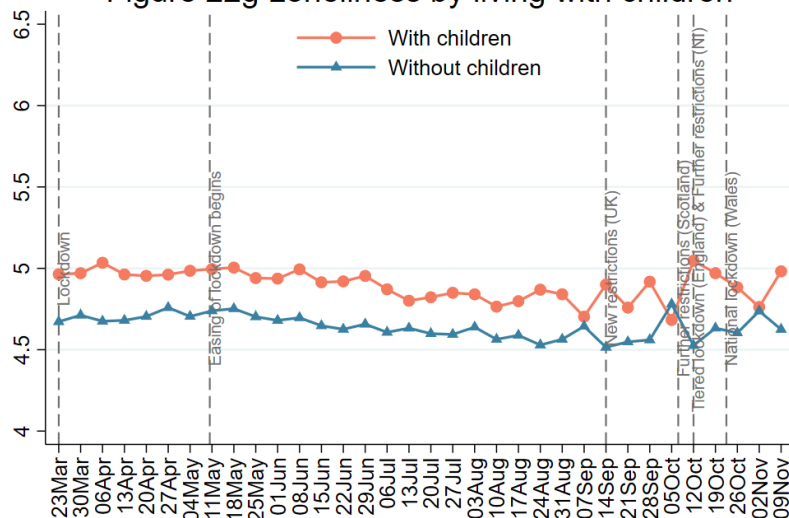
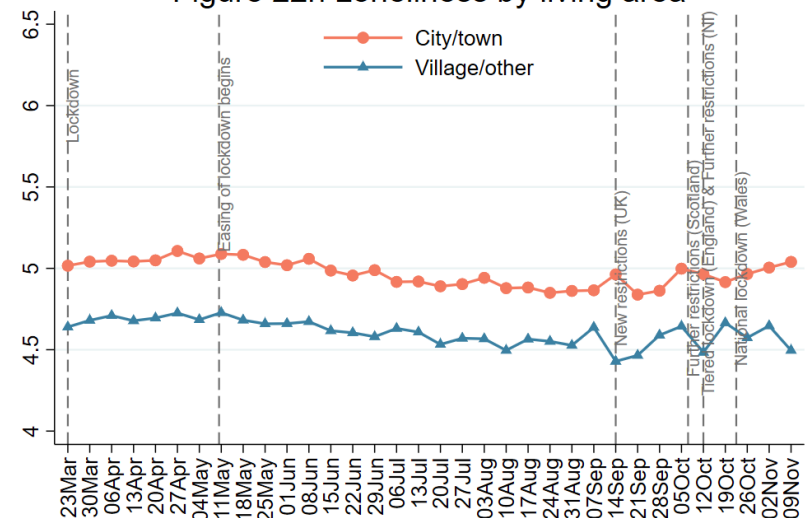
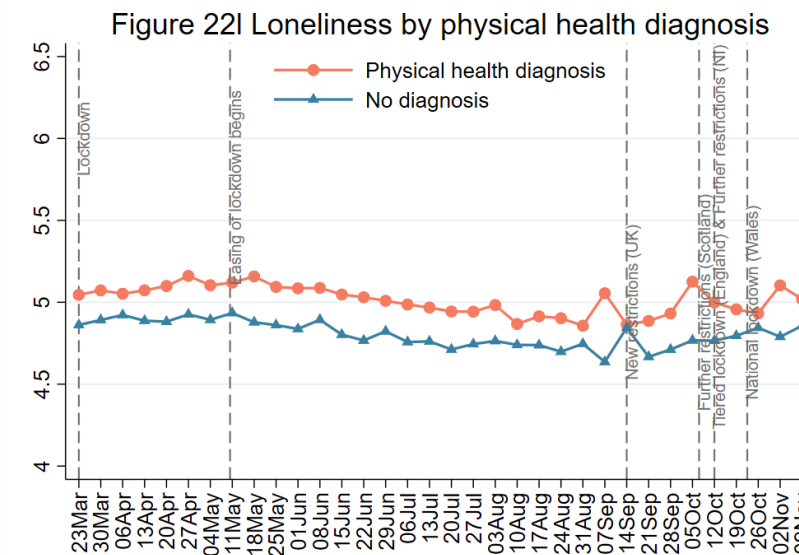
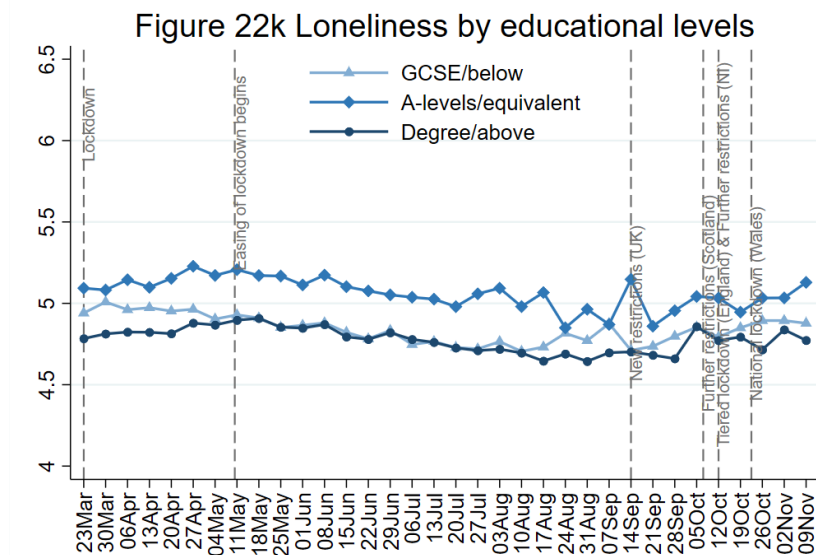
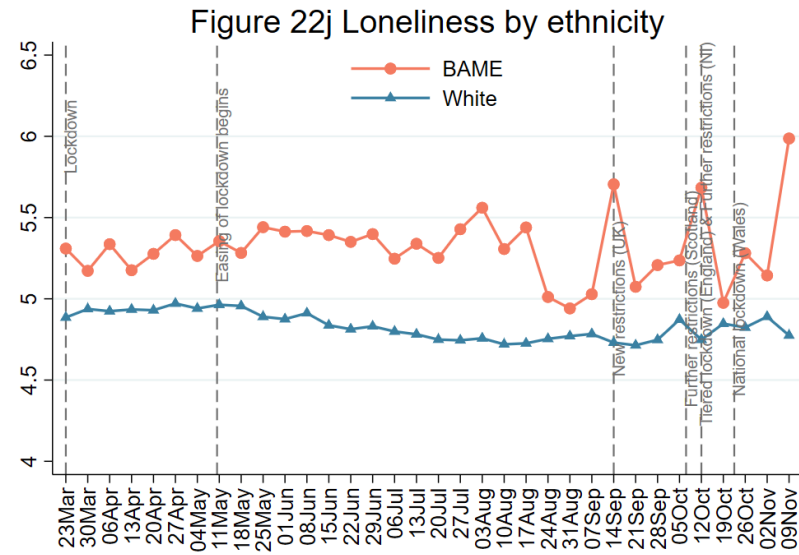
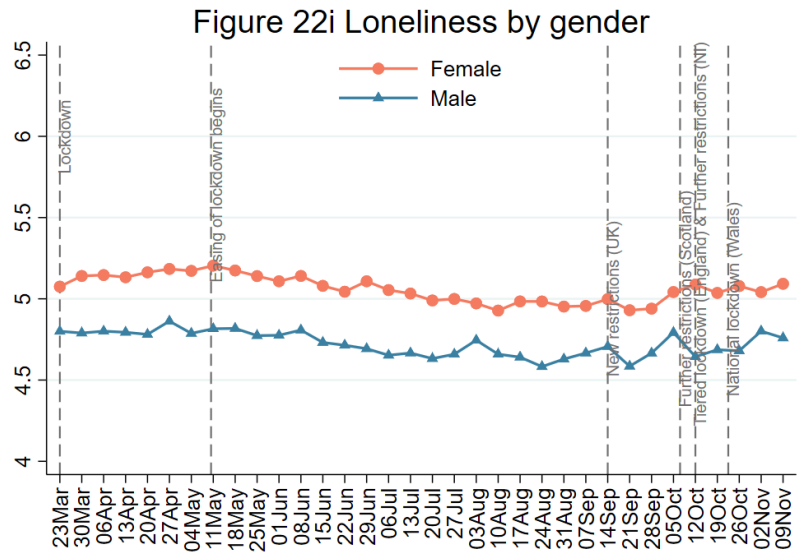
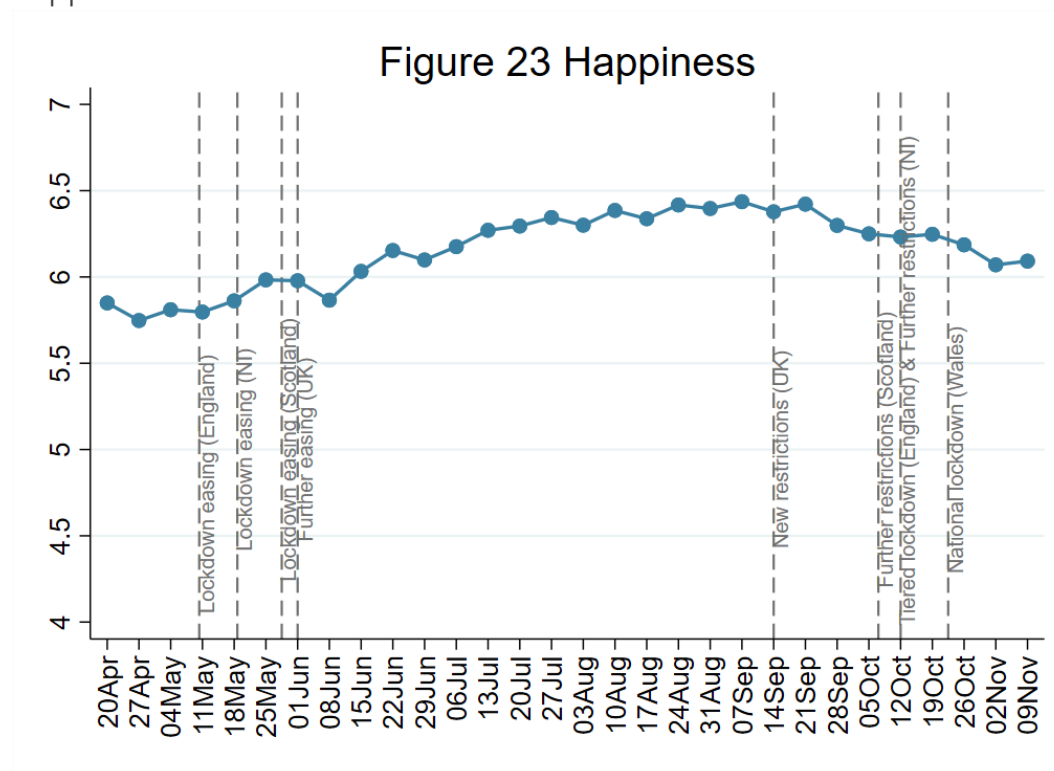


Figure 22h Loneliness by living area





### 4.3 Happiness



#### FINDINGS

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

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

Figure 24a Happiness by age groups

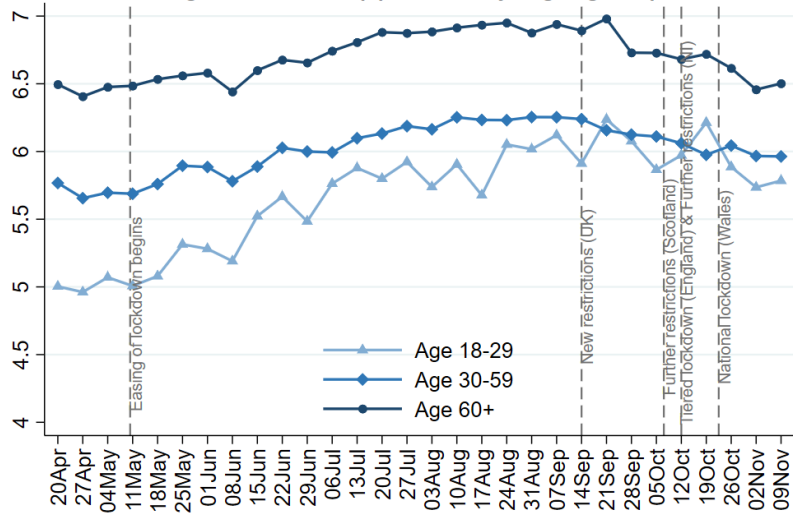


Figure 24b Happiness by living arrangement

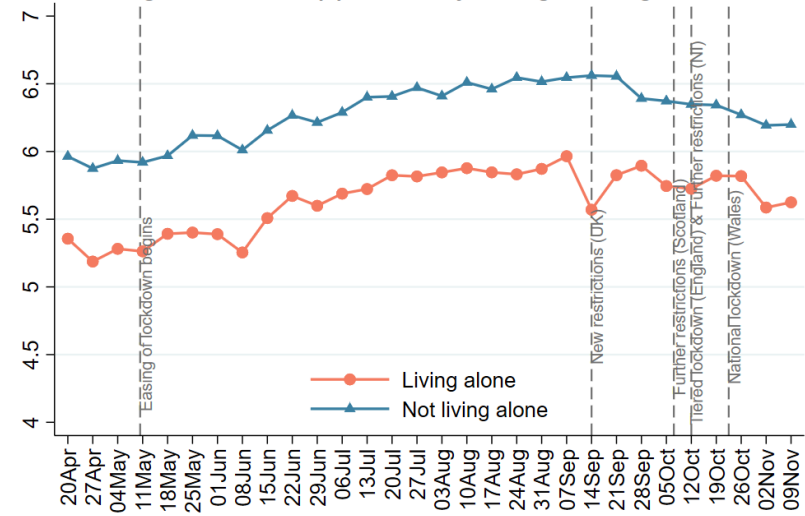


Figure 24c Happiness by household income

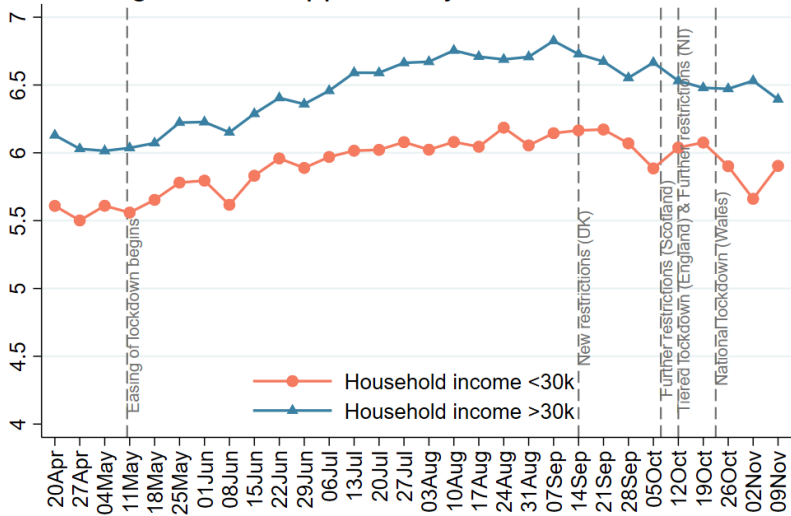


Figure 24d Happiness by mental health

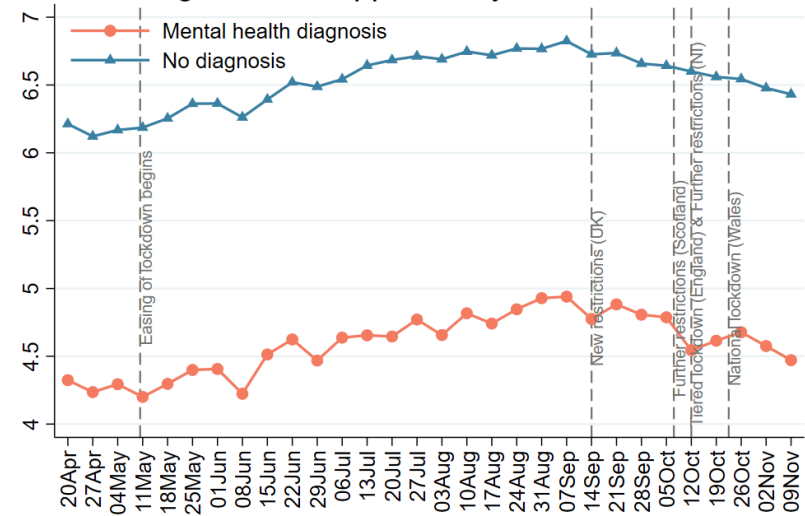




Figure 24e Happiness by nations

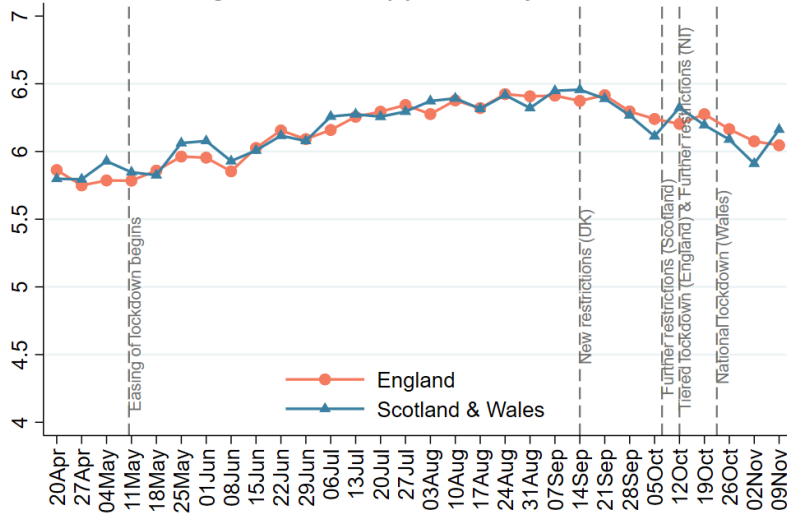


Figure 24f Happiness by keyworker status

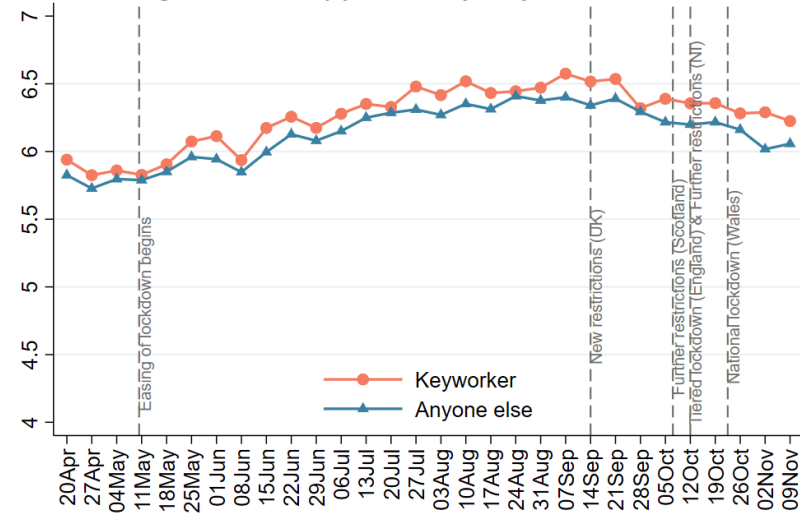


Figure 24g Happiness by living with children

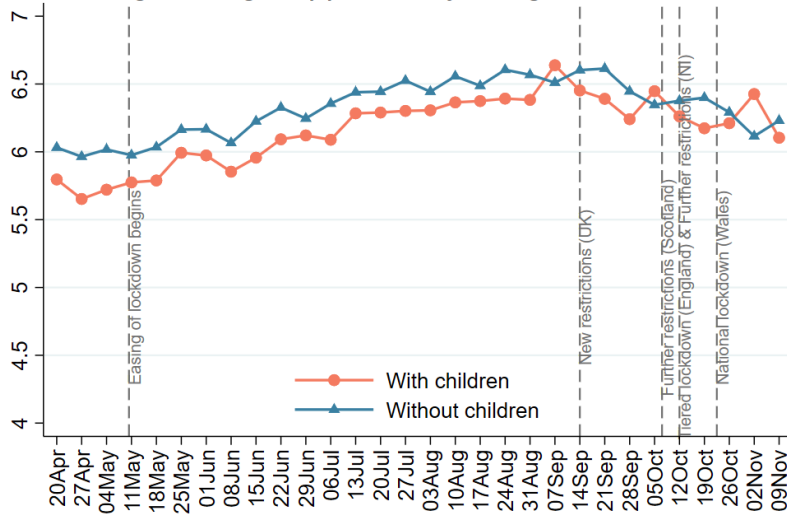


Figure 24h Happiness by living area

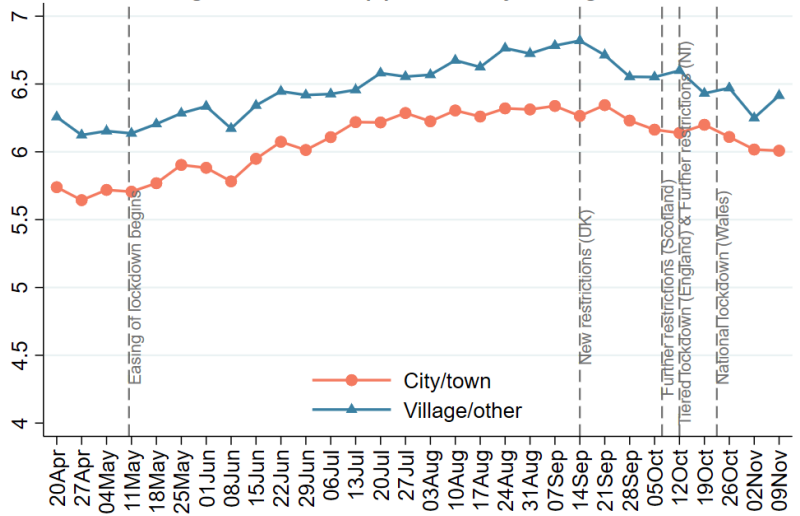


Figure 24i Happiness by gender

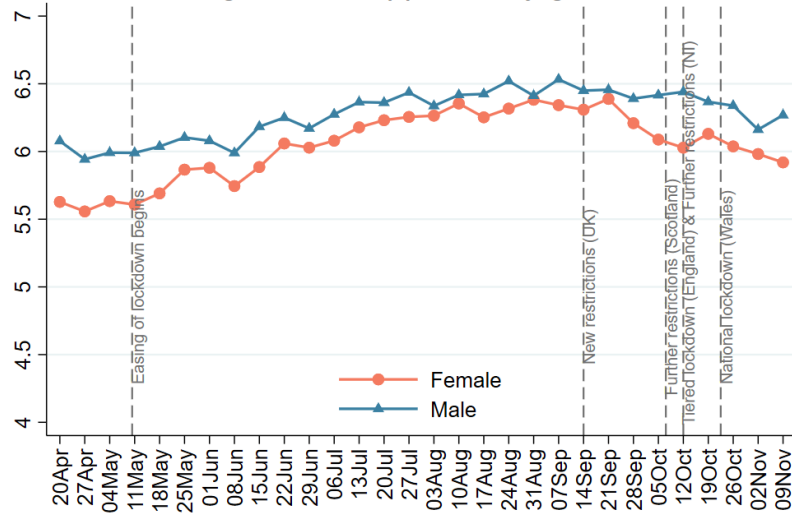


Figure 24j Happiness by ethnicity

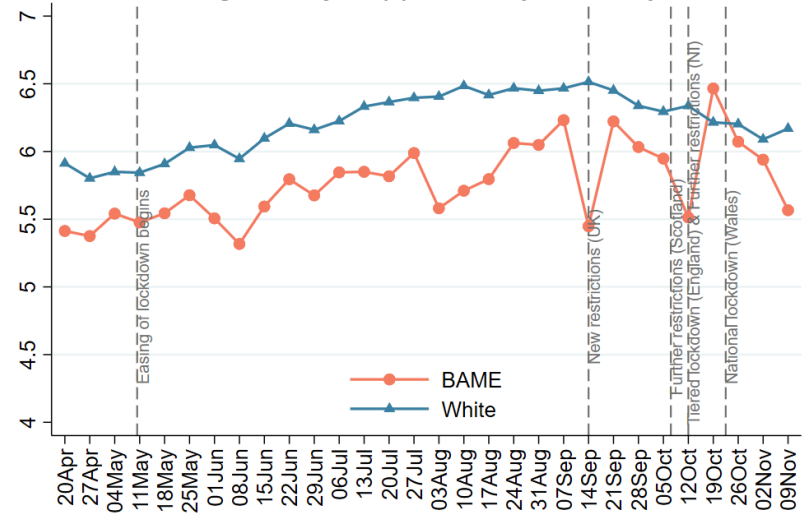


Figure 24k Happiness by educational levels

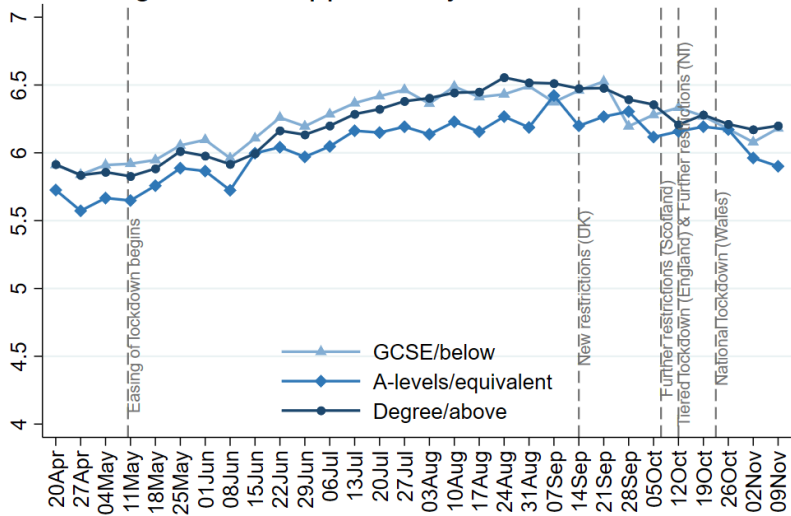
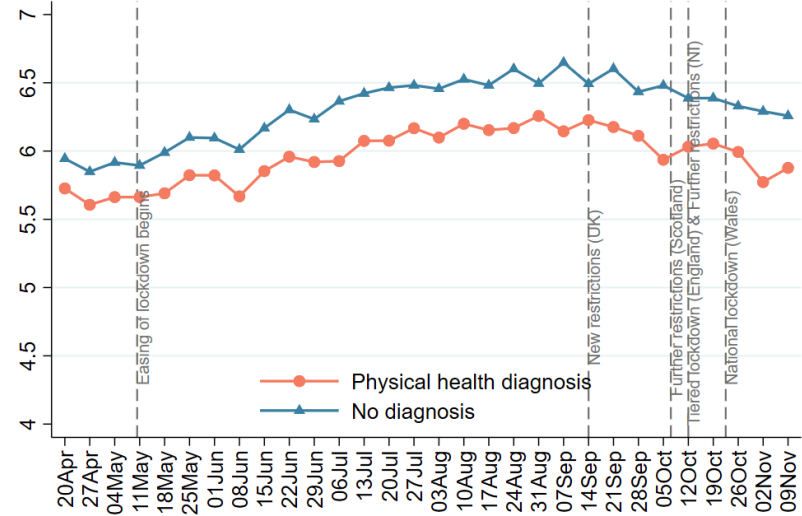
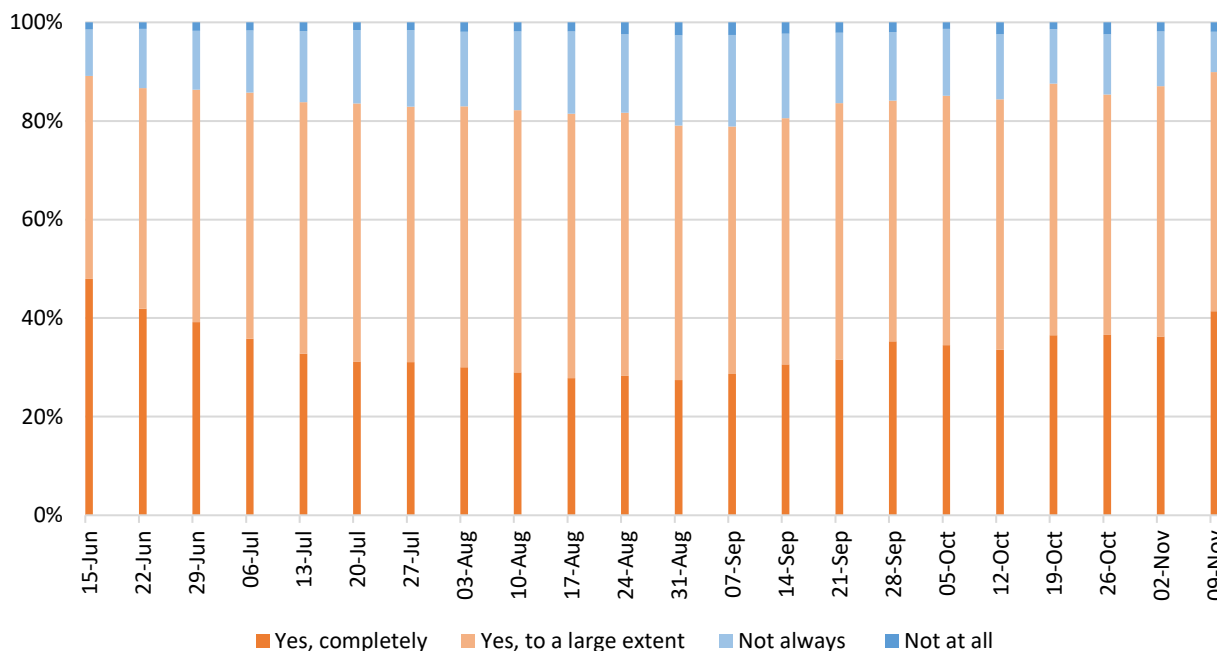


Figure 24l Happiness by physical health diagnosis



## 5. Maintaining social distancing

Figure 25 Maintaining social distancing



### FINDINGS

We asked participants about the extent to which they maintain social distancing from meeting with people not within their household or bubble.

In the week commencing 9<sup>th</sup> November, 41% reported maintaining social distancing completely, with a further 49% reporting that they were maintaining it to a large extent. However, 8% reported not always maintaining social distancing, and 2% reported not following it at all. This is an improvement on the summer, when 3% reported not following it at all, over twice as many people (18%) reported not always following it, and nearly 50% fewer people reported following social distancing completely (28%).

Both men and women have been maintaining social distancing to a very similar extent, as have people living alone compared to people living with others. But younger adults have been maintaining it less consistently. For example, in the past week, only 18% of adults aged 18-29 reported following social distancing completely (5% not at all), compared to 43% of adults aged 30-59 maintaining it completely (2% not at all), and 55% of adults over the age of 60 maintaining it completely (<1% not at all). Further, people with higher household income have been maintaining social distancing less effectively: 40% of people earning more than £30,000 a year have been maintaining social distancing completely compared to 44% of people earning less than £30,000 a year.

Figure 26a Maintaining social distancing amongst younger adults (age 18-29)

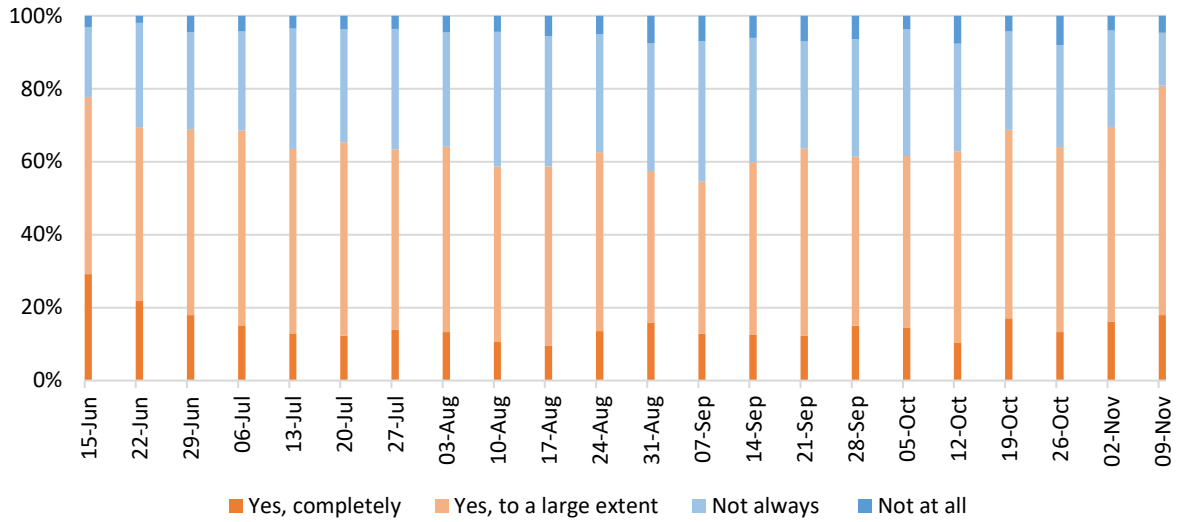


Figure 26b Maintaining social distancing amongst adults (age 30-59)

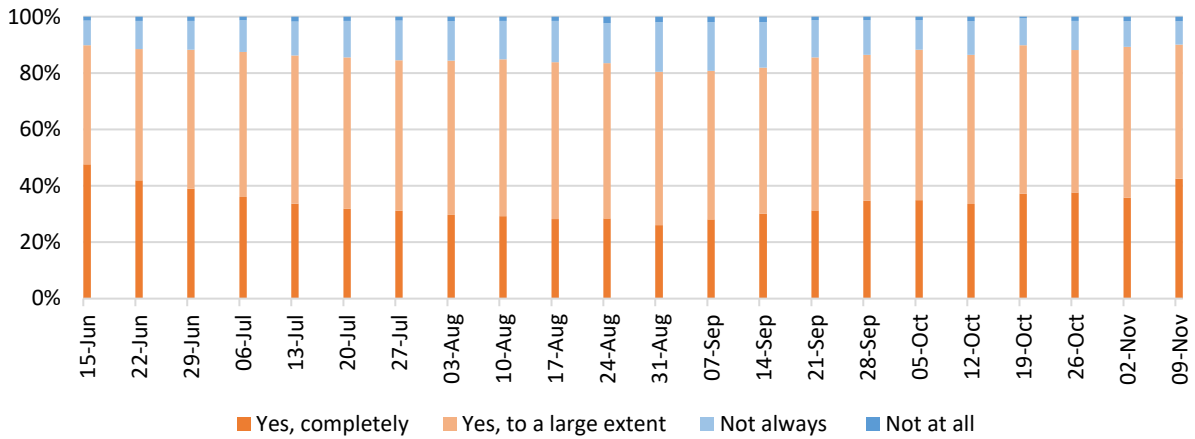


Figure 26c Maintaining social distancing amongst older adults (age 60+)

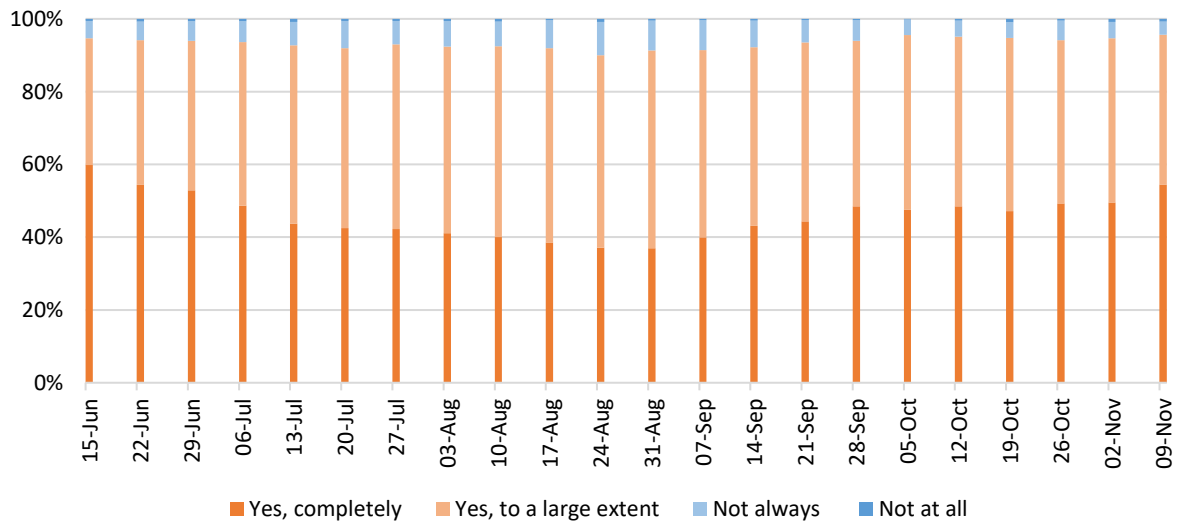


Figure 26d Maintaining social distancing amongst males

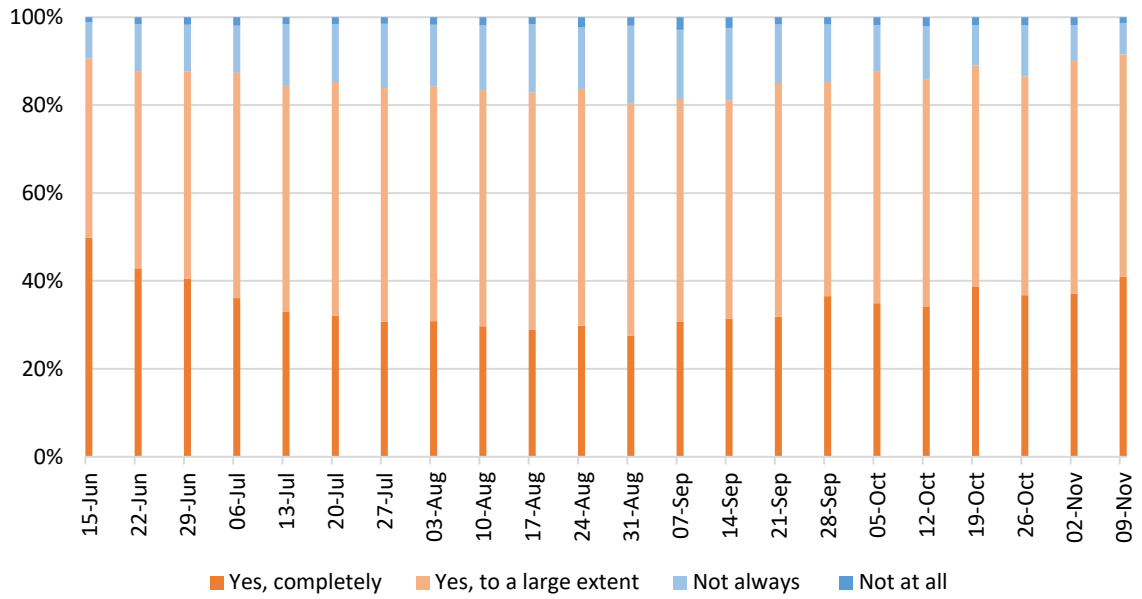


Figure 26e Maintaining social distancing amongst females

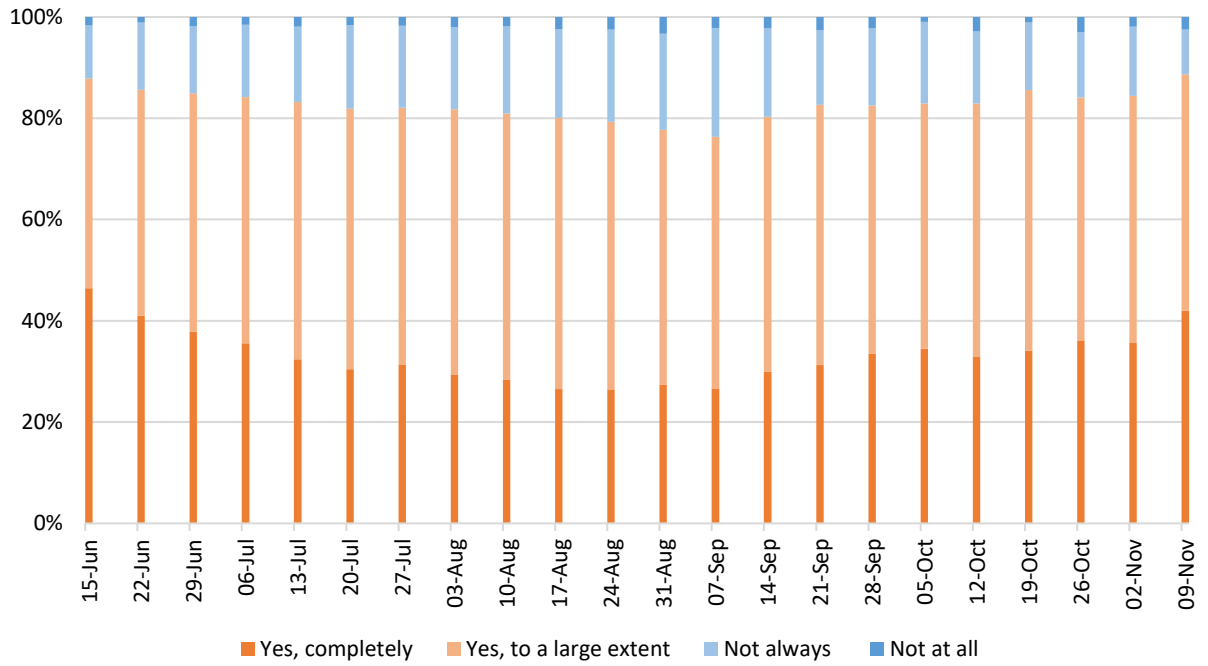


Figure 26f Maintaining social distancing amongst people with higher household income

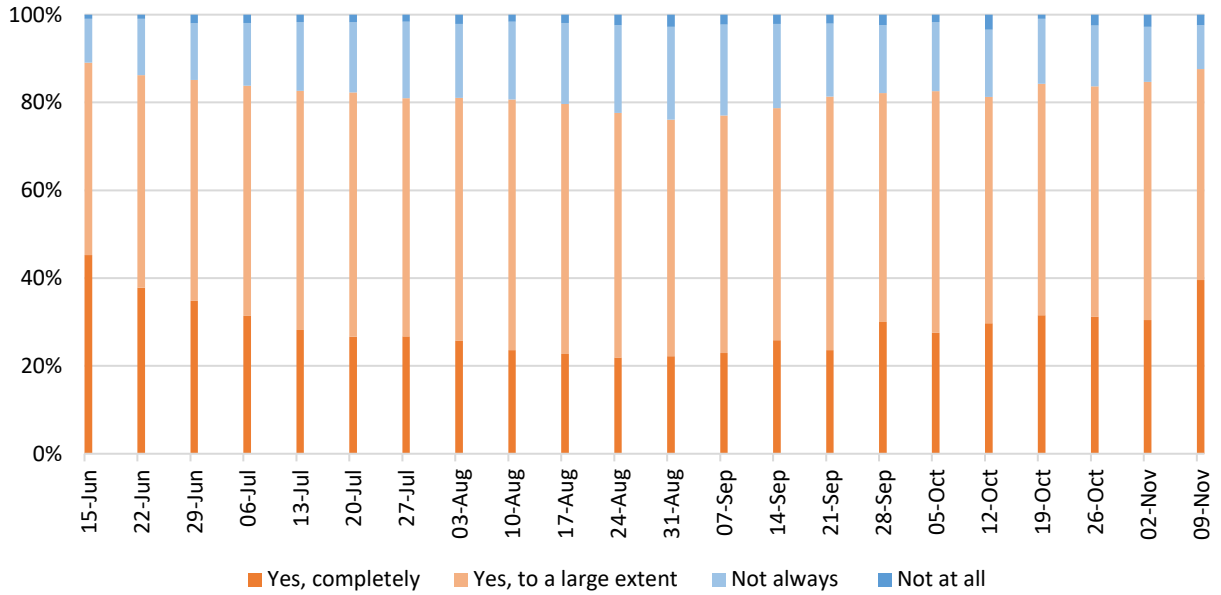


Figure 26g Maintaining social distancing amongst people with lower household income

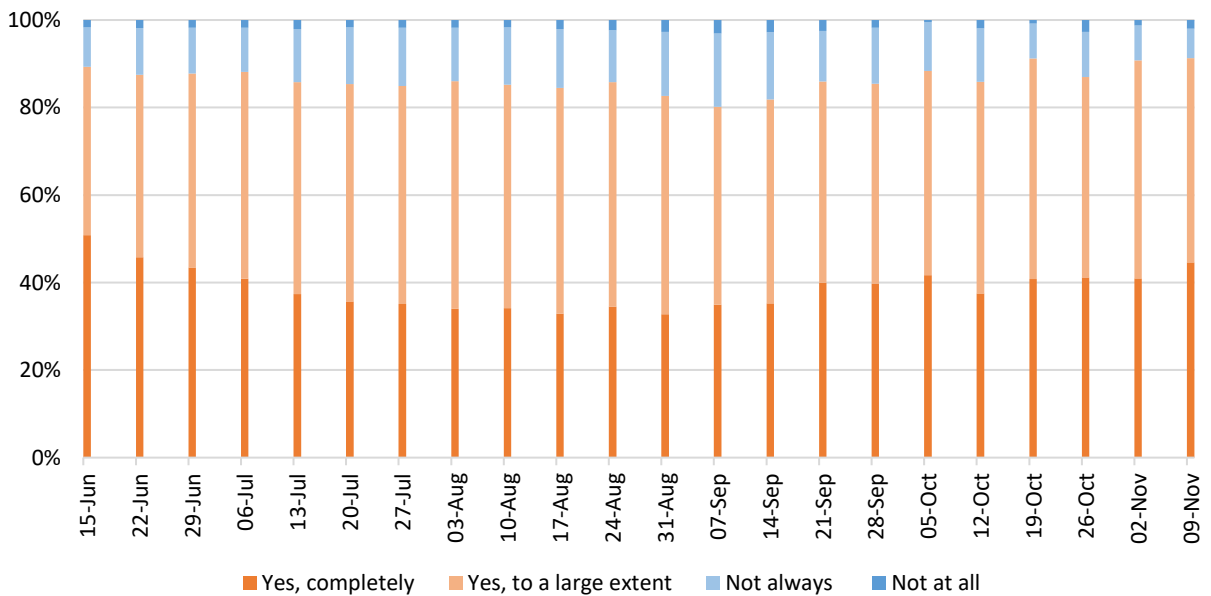


Figure 26h Maintaining social distancing amongst people who live with others

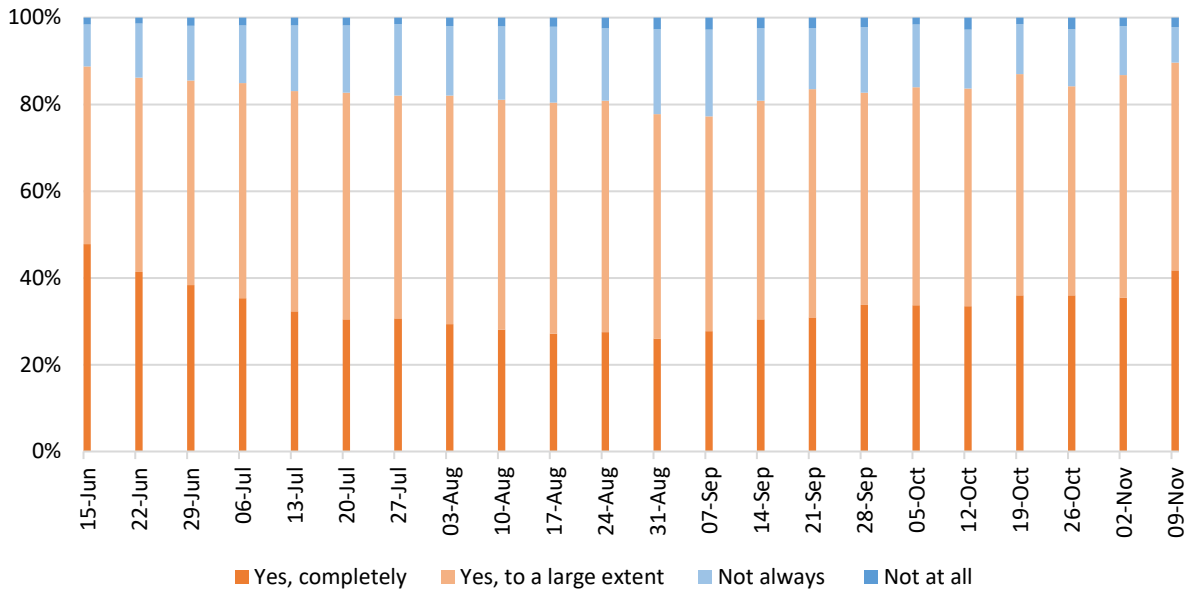
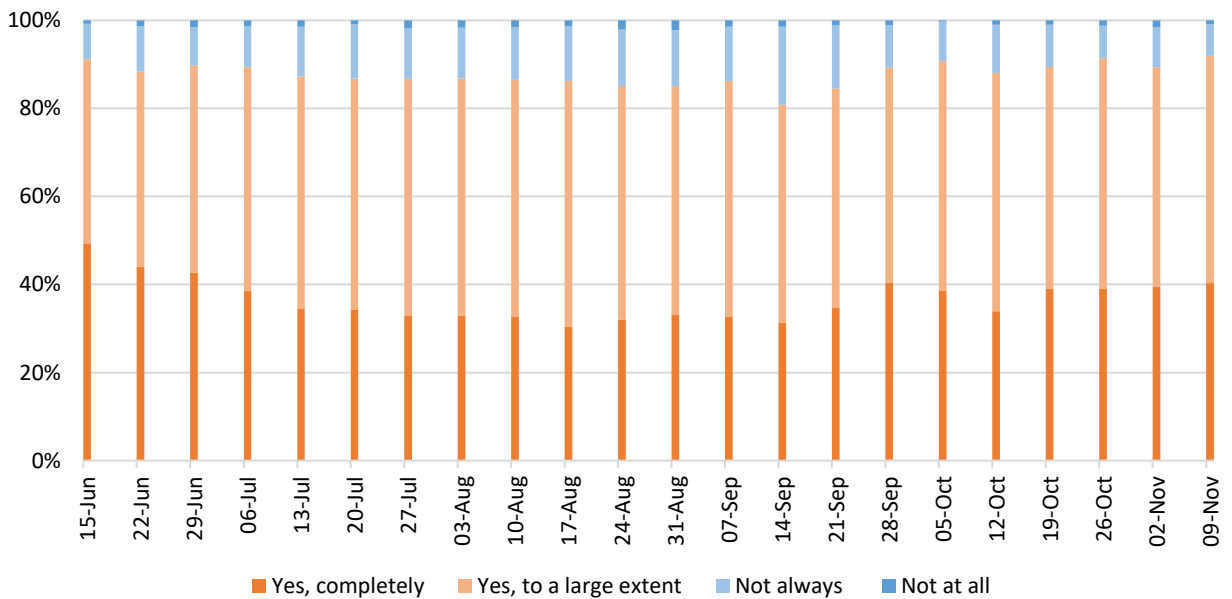
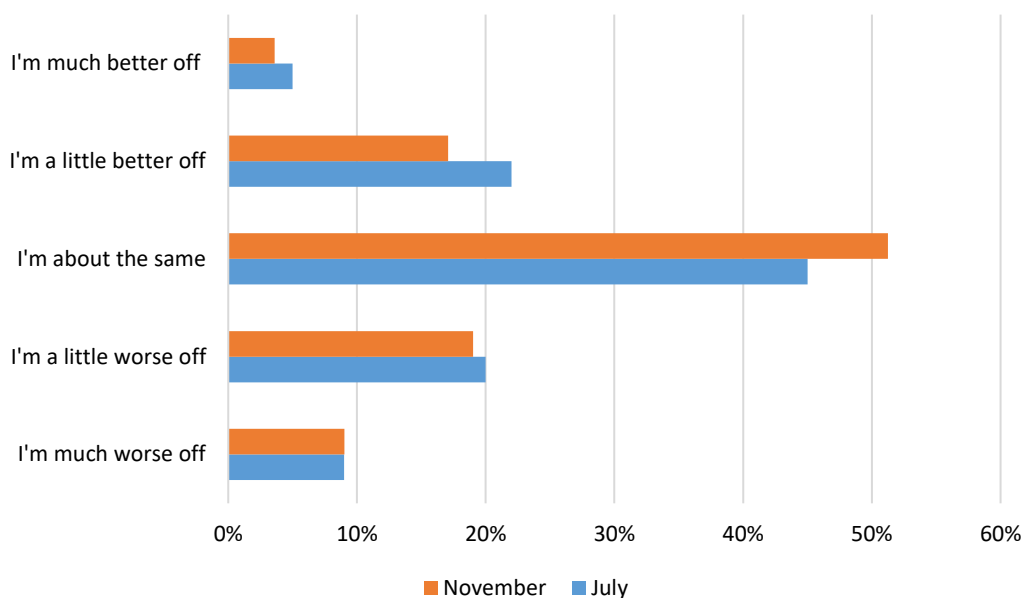


Figure 26i Maintaining social distancing amongst people who live alone



## 6. Financial situation

Figure 27 Changes in financial situation in July/November since lockdown



### FINDINGS

Respondents were asked how their financial situation had changed since before the pandemic from “much worse off” to “much better off”. These questions were asked in July and have now been repeated for November. Participants were also asked to report on their financial situation before the pandemic, from “living comfortably” to “finding it very difficult”.

In July, nearly half of respondents (45%) reported that they were about the same financially, with 27% reporting improvements in their financial situation and 29% reporting that things had got worse. These figures are similar now, with 28% reporting things have got worse, 51% reporting they are about the same, but only 21% now reporting things have got better since the spring.

However, when splitting responses by participants’ reported financial situation before the pandemic, clear differences emerged. Amongst people living comfortably before the pandemic, just 20% reported that things had got worse with 5% reporting things were “much worse” (very similar to the figures of 21% and 6% back in July). But amongst people finding it very difficult before the pandemic, there are now 70% of people reporting things are worse. This is 3.5 times the number compared to people who were comfortably off and substantially worse than in July (when the figure reporting things as worse was 57%). The figure reporting things as “much worse” is now 47% amongst those finding things very difficult before the pandemic (up from 38% in July and more than 9 times the number compared to people who are living comfortably).

The worsening financial position has been felt most by people living in the North East of England, where there have been particularly strong restrictions in the past few months.

There are suggestions that even for those who are comfortably off, economic benefits of the pandemic have diminished, with just 27% reporting they are better off now compared to in the spring (down from 33% in July). But this figure compares to just 7-10% of people who reported finding things quite or very difficult back in the spring.



Figure 28a Changes in financial status by previous financial management before COVID-19 crisis (July)

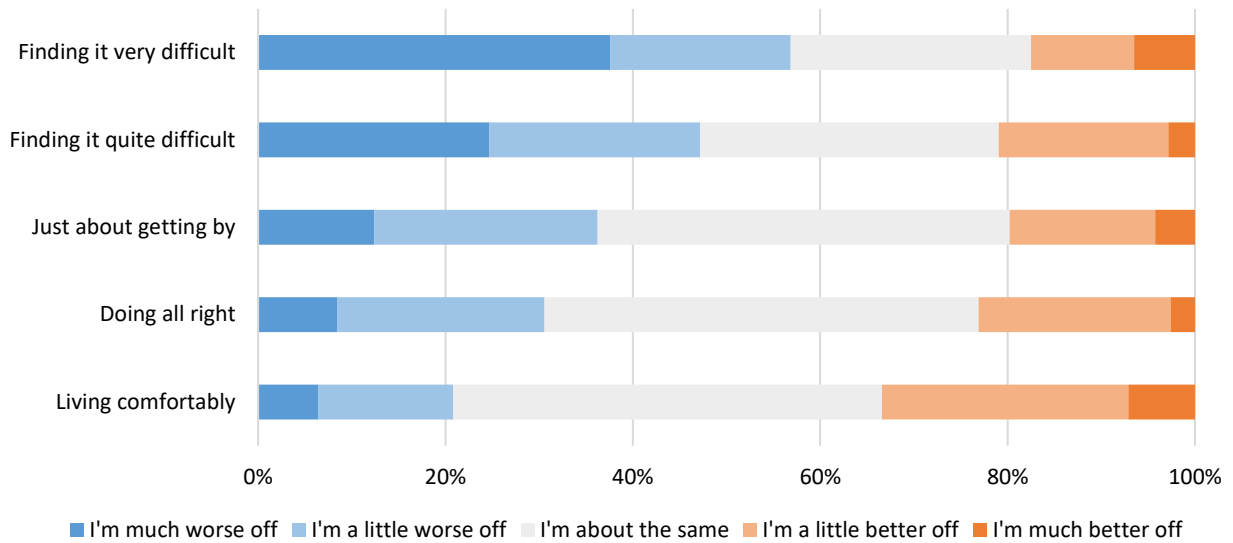


Figure 28b Changes in financial status by previous financial management before COVID-19 crisis (November)

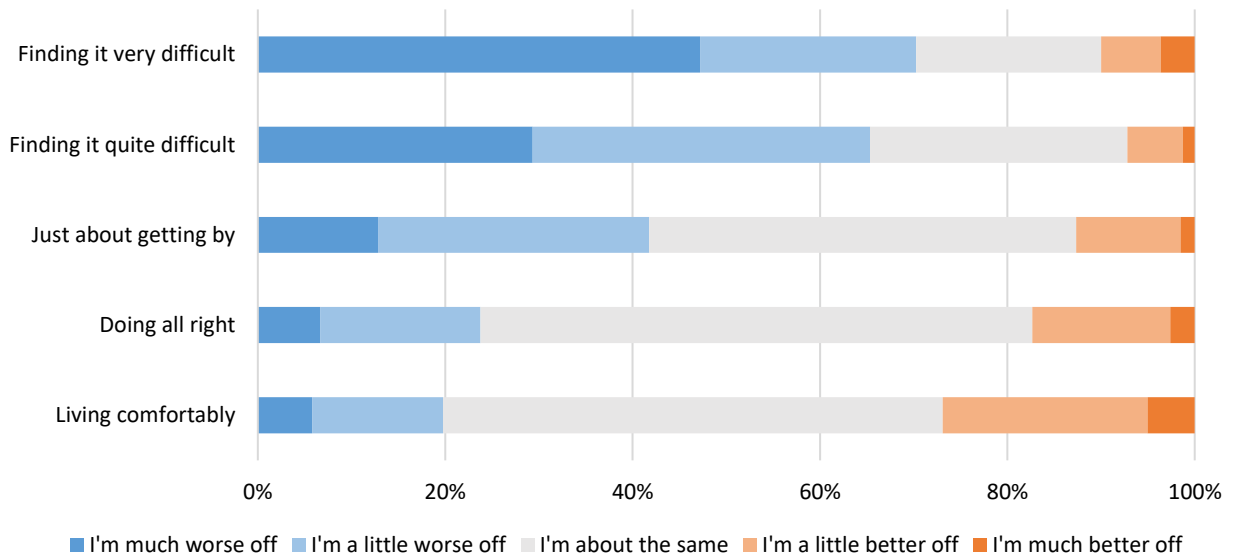


Figure 28c Changes in financial status by regional locations (July)

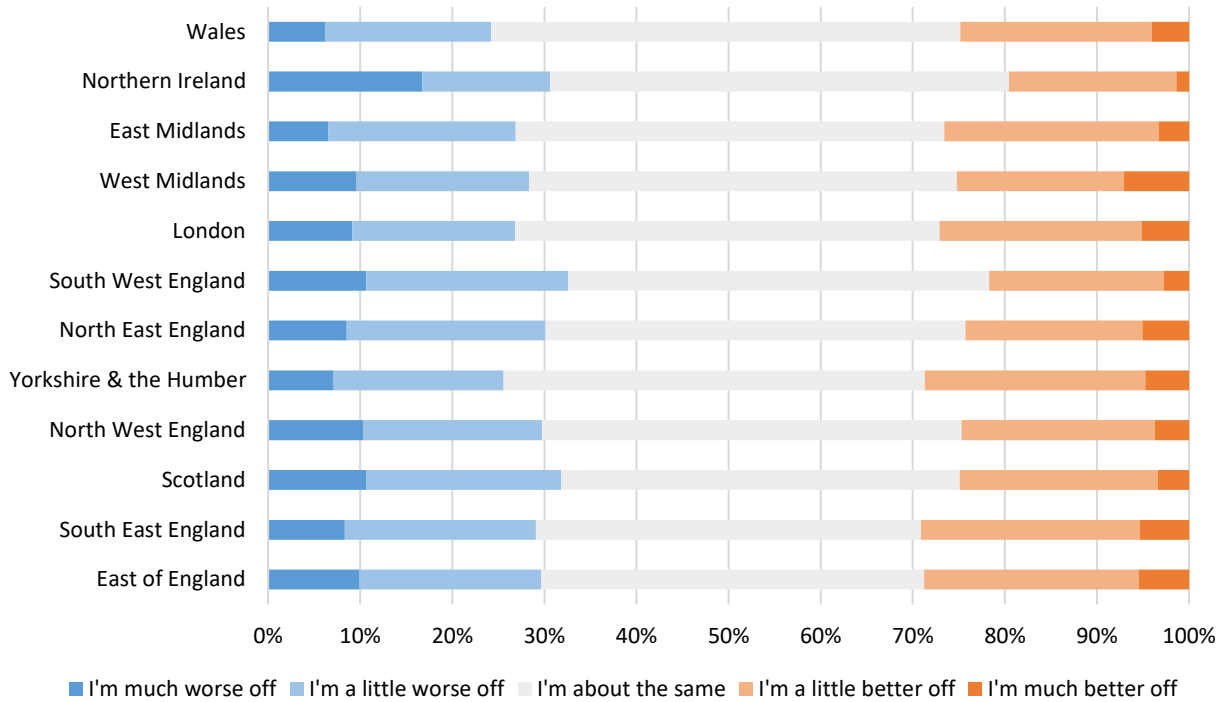
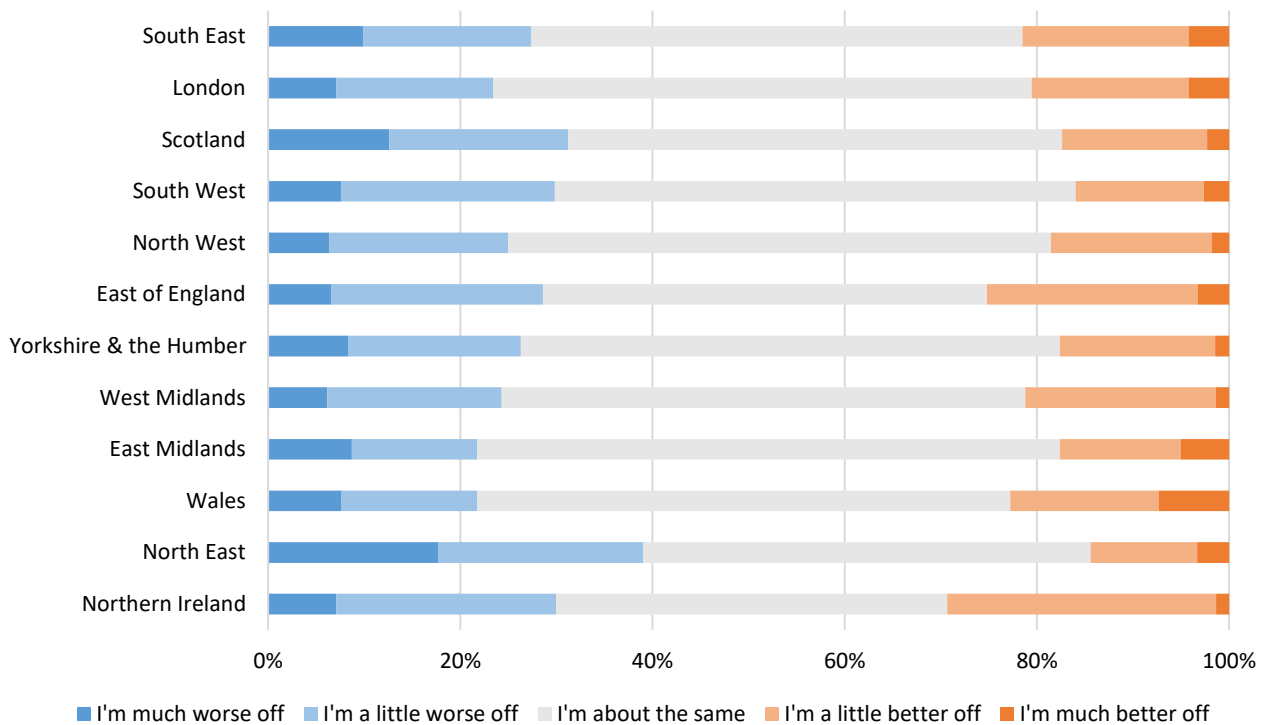


Figure 28d Changes in financial status by regional locations (November)



## 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 21<sup>st</sup> March to the 15<sup>th</sup> November (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](mailto: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](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**)  
For full demographics weighted to population proportions, see the User Guide at [www.covidsocialstudy.org/results](http://www.covidsocialstudy.org/results)

	Number of observations	%		Number of observations	%
<b>Age</b>			<b>Education levels</b>		
<b>18-29</b>	46,101	6.03	<b>GCSE or below</b>	107,245	14.0
<b>30-59</b>	424,506	55.5	<b>A-levels of equivalent</b>	132,279	17.3
<b>60+</b>	294,114	38.5	<b>Degree or above</b>	525,197	68.7
<b>Gender</b>			<b>Any diagnosed mental health conditions</b>		
<b>Male</b>	191,919	25.2	<b>No</b>	635,454	83.1
<b>Female</b>	569,706	74.8	<b>Yes</b>	129,267	16.9
<b>Ethnicity</b>			<b>Any diagnosed physical health conditions</b>		
<b>White</b>	731,723	96.0	<b>No</b>	442,147	57.8
<b>BAME</b>	30,620	4.02	<b>Yes</b>	322,574	42.2
<b>UK nations</b>			<b>Keyworker</b>		
<b>England</b>	617,621	81.6	<b>No</b>	603,999	79.0
<b>Wales</b>	91,766	12.1	<b>Yes</b>	160,722	21.0
<b>Scotland</b>	47,868	6.32	<b>Living with children</b>		
<b>Living arrangement</b>			<b>No (excluding those who live alone)</b>	432,673	71.5
<b>Not living alone</b>	605,361	79.2	<b>Yes</b>	172,688	28.5
<b>Living alone</b>	159,360	20.8	<b>Living area</b>		
<b>Annual household income</b>			<b>Village/hamlet/isolated dwelling</b>	190,390	24.9
<b>&gt;30k</b>	412,448	59.8	<b>City/large town/small town</b>	574,331	75.1
<b>&lt;30k</b>	277,170	40.2			