Covid-19 Social Study
Results Release 38

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Executive summary

Background

This report provides data from the last 76 weeks of the UK Covid-19 Social Study run by University College London: a panel study of over 70,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this THIRTY-EIGHTIETH report, we focus on psychological responses to the first seventy-six weeks since just before the first UK lockdown was announced (21/03/2020 to 05/09/2021). We present simple descriptive results on the experiences of adults in the UK. Measures include:

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

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

Findings

- Nearly half of adults (44%) reported having experienced some kind of discrimination (e.g., due to gender, age, race/ethnicity, or some other characteristic) since the start of the pandemic. Having been treated with less courtesy or respect than others was the most common type of discrimination (28%), followed by having been threatened or harassed (14%), having had people act as if they were afraid of them (13%), and having received poorer service for deliveries/in stores (12%) or in a medical setting (11%).
- People from ethnic minority groups (61% vs 41% of people with white ethnicity) and younger adults (60% aged 18-30 vs 29% of people aged 60+) were most likely to have experienced discrimination. Such experiences were also slightly higher amongst women (48% vs men 39%) and more common in urban areas (45% vs 40% reported in rural areas).
- Across the pandemic, levels of social support (e.g., the extent to which participants have experienced understanding and support from others, whether emotional or physical) have been relatively constant. There has been a slight increase since the end of April 2021, perhaps as people have been able to move around more and receive in-person support more easily.
- However, people living alone, those with lower household income, and people with a mental or physical health diagnosis have consistently experienced much lower levels of social support. Support has also been slightly lower amongst people in urban areas, people from ethnic minority groups, and people with lower educational qualifications, but with no differences related to age, living in different countries, being a keyworker, or whether or not people live with children.
- Depression and anxiety symptoms have generally continued to decrease as they have been since the end of February 2021. However, depression and anxiety symptoms are still highest in young adults, people living alone, people with lower household income, people living with children, women, people from ethnic minority groups, and those with a physical or mental health diagnosis.
- The proportion of people concerned about catching or becoming seriously ill from Covid-19 increased over the month preceding the ending of the latest restrictions in England but appears to have levelled off. It is now similar to what it was in late February 2021.
- Confidence in government to handle the pandemic remains lower in England than in Wales and Scotland, as it has been since the end of April 2020.

1. Compliance and confidence

1.1 Compliance with guidelines

Figure 1 Compliance with guidelines
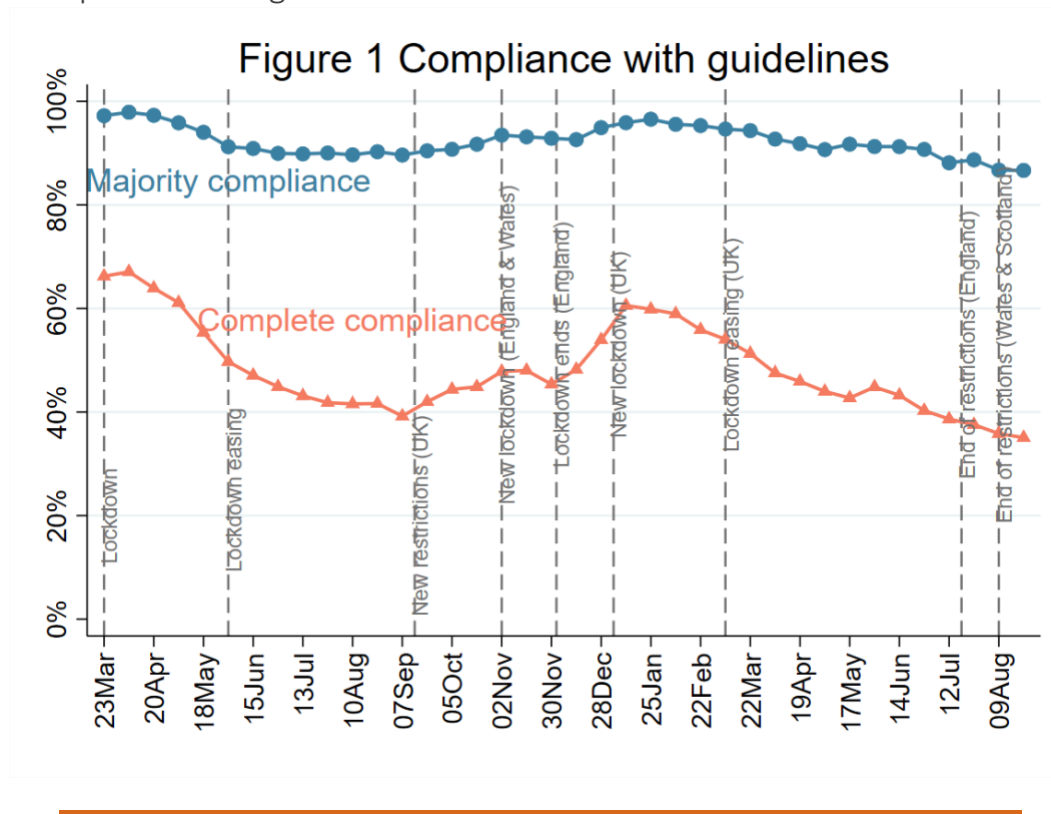
FINDINGS

Respondents were asked to what extent they are following the recommendations from government to prevent spread of Covid-19, ranging from 1 (not at all) to 7 (very much so). Of note, we ask participants to self-report their compliance, which relies on participants understanding the regulations. Figure 1 shows the percentage of people across the whole of the UK who followed the recommendations "completely" (with a score of 7) or to a large extent (with a score of 5-7; described below as "majority" compliance).

Majority compliance has continued to decline since the easing of restrictions for the latest lockdown and is now slightly lower than what it was in the summer of 2020.

Complete compliance (i.e., following rules and recommendations with no bending or even minor infringements) has been decreasing since the start of the new year and is now as low as it ever has been, around 35%.

Nevertheless, this means that around one third of participants reported that they are still following the rules to the letter. Across demographic groups, patterns of complete compliance remain as they have been since the start of the year, with compliance lower in higher income households, amongst young adults, amongst keyworkers, in urban areas, amongst men, and amongst people in good physical health. Although compliance has been lower in people from ethnic minority groups[1], this trend appears to have stopped.

Majority compliance has been reported by just under 9 in 10 (86%) people in the last month, with consistent patterns since the beginning of the year present in all major demographic groups (Figures 2m-2x).

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

Figure 2a Complete compliance by age groups

Figure 2b Complete compliance by living arrangement

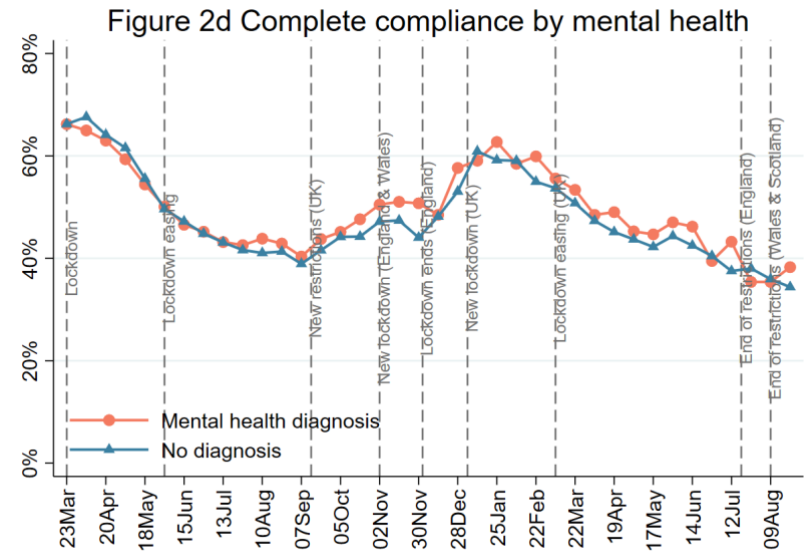Figure 2c Complete compliance by household income
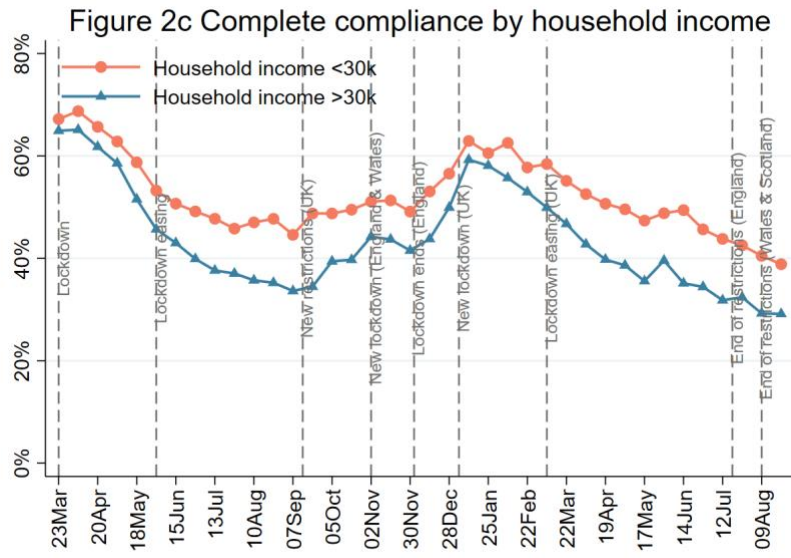

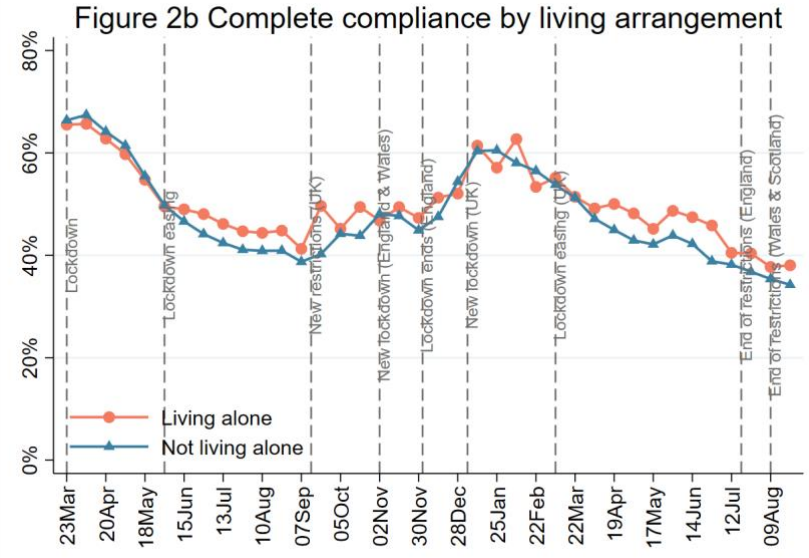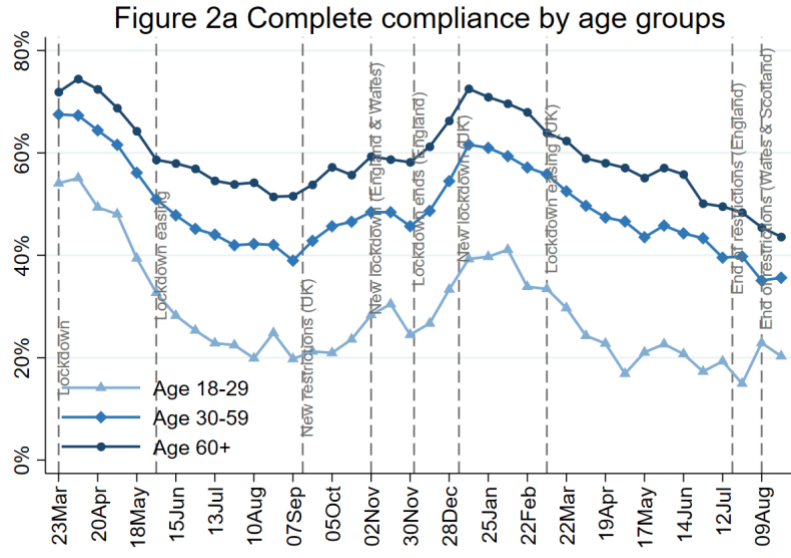Figure 2d Complete compliance by mental health

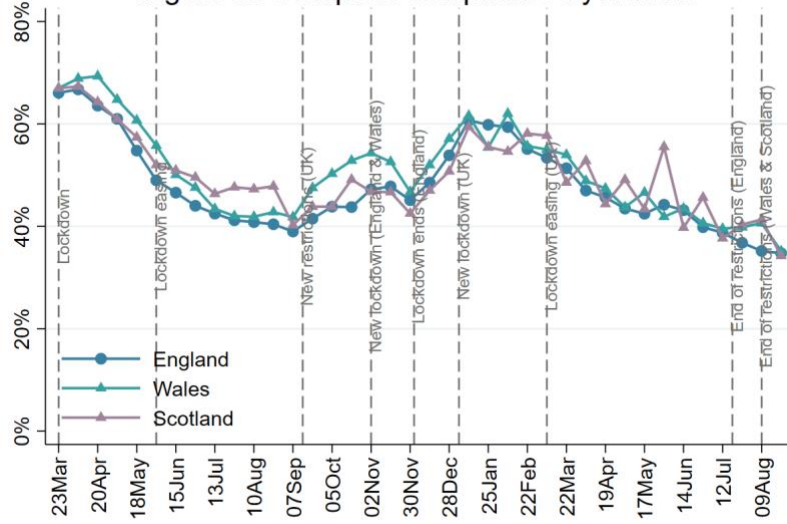Figure 2e Complete compliance by nations
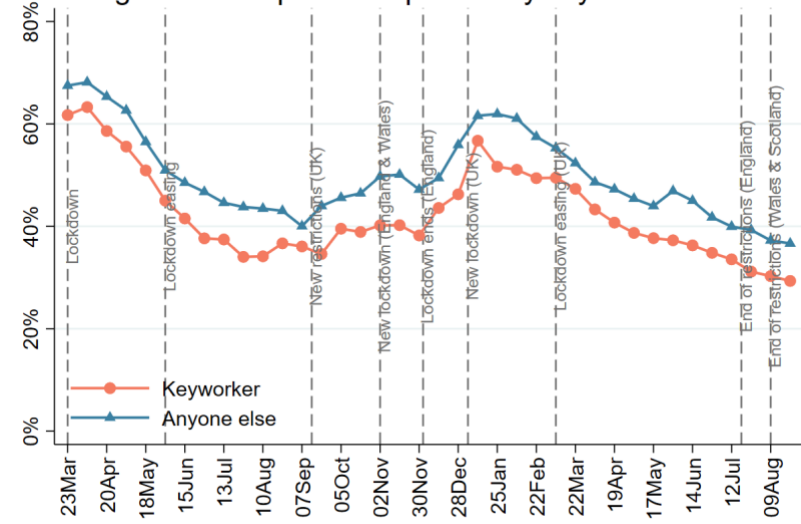

Figure 2f Complete compliance by keyworker status
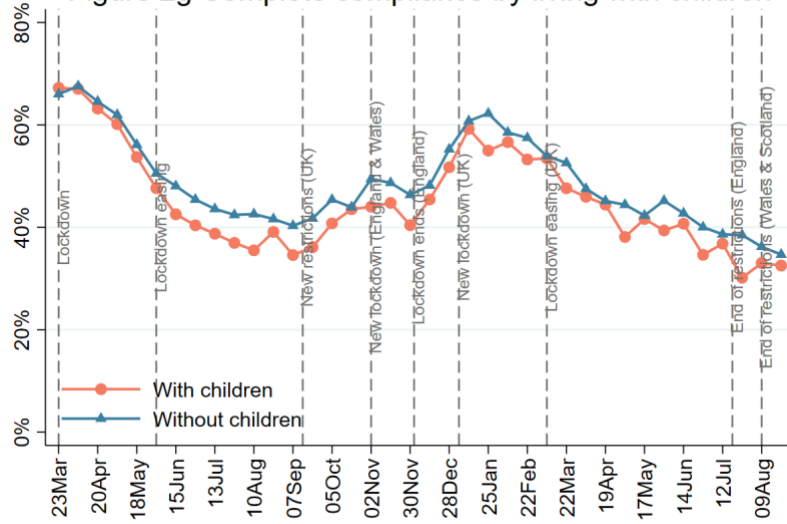

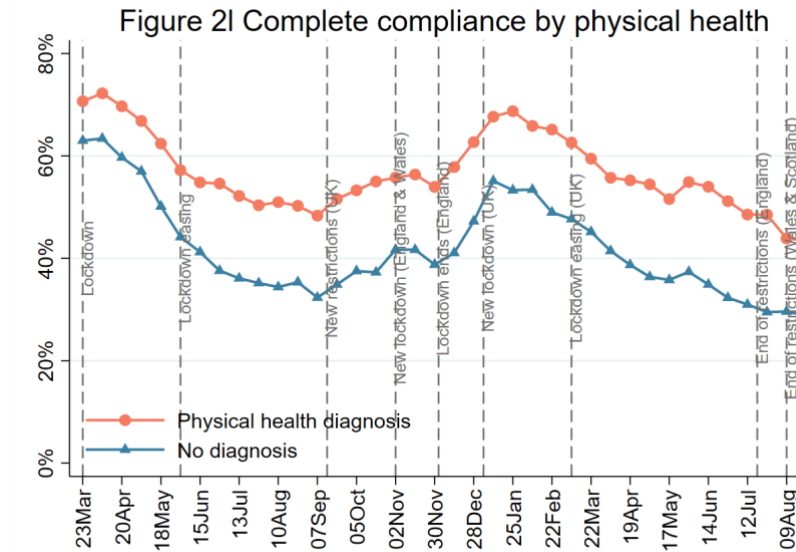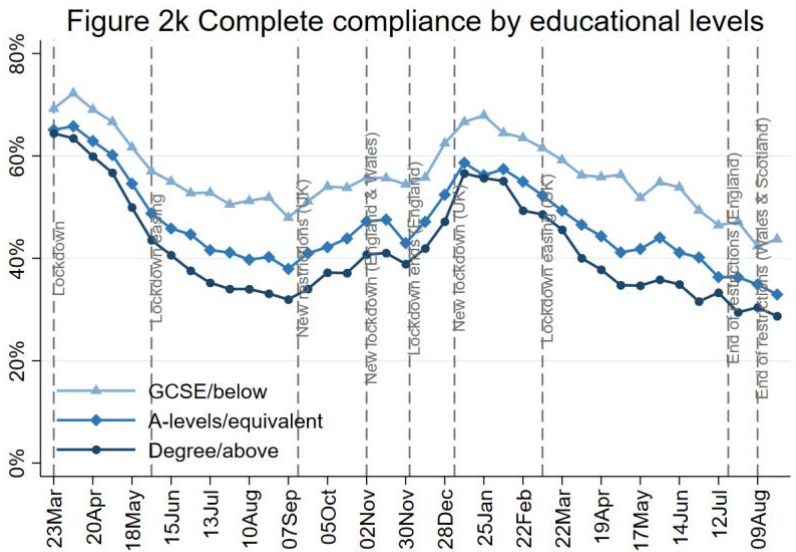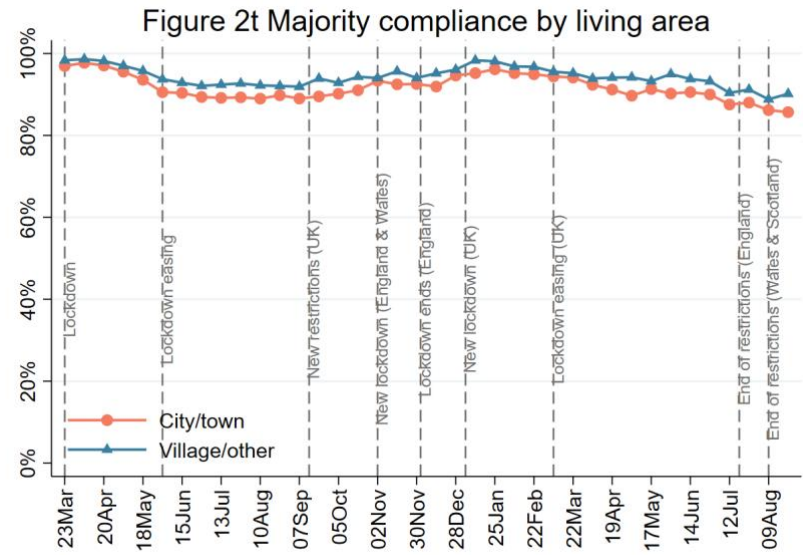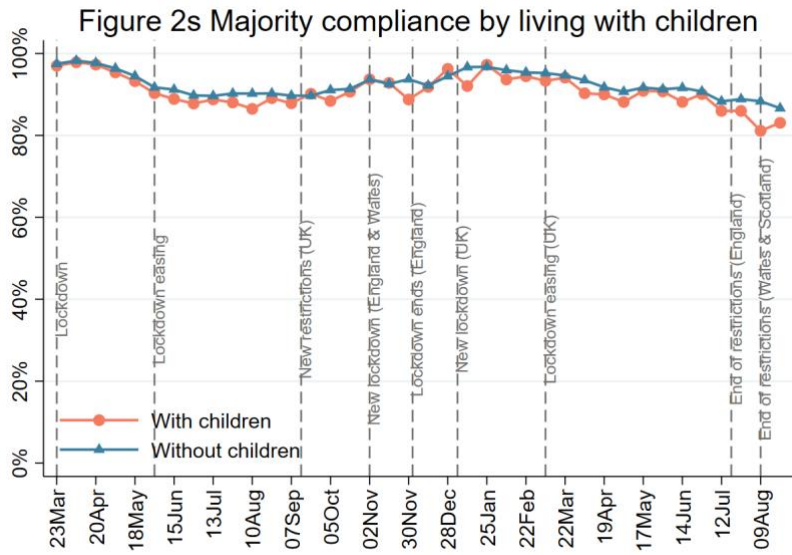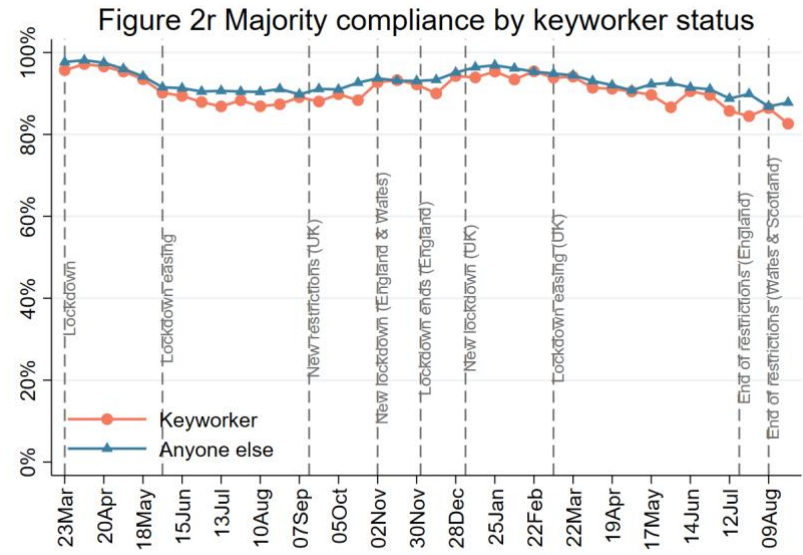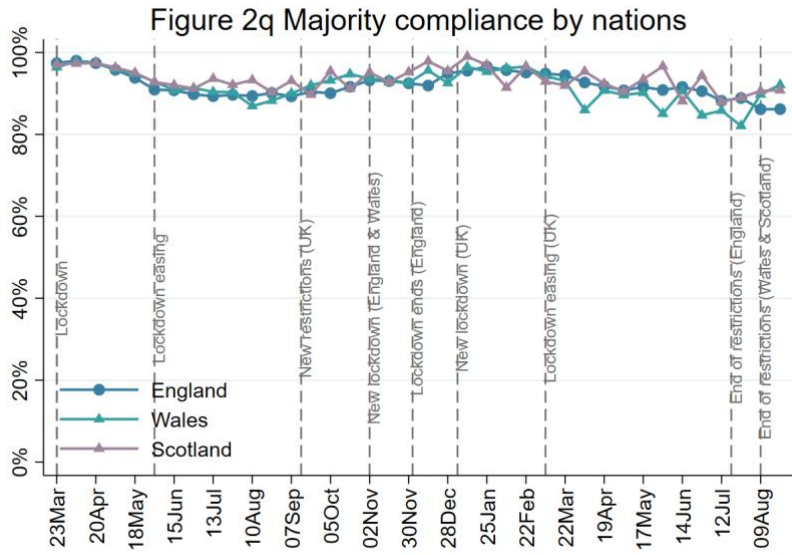Figure 2g Complete compliance by living with children

Figure 2h Complete compliance by living area

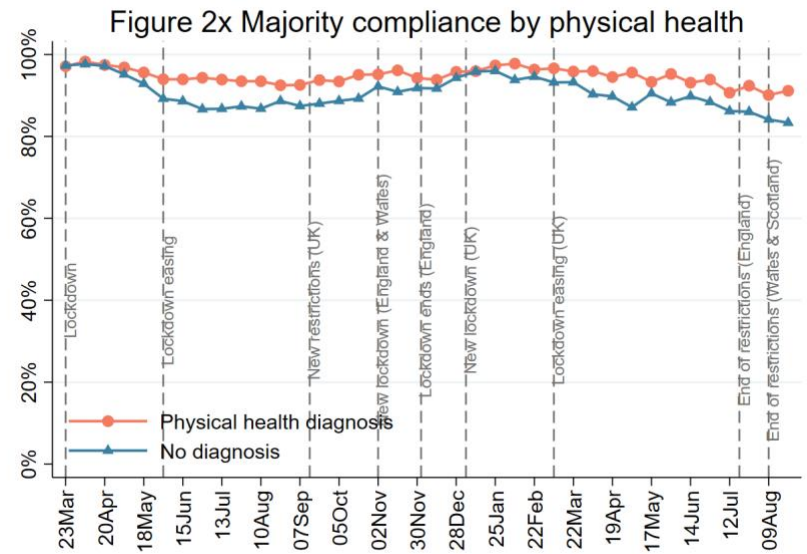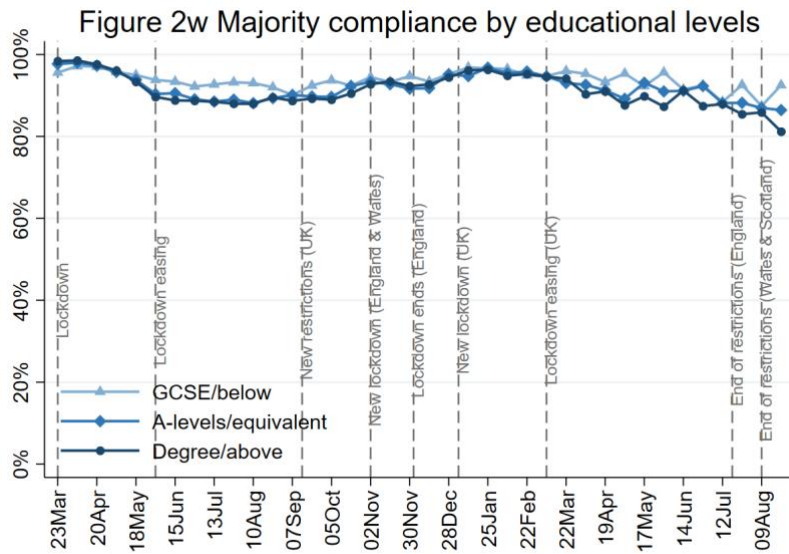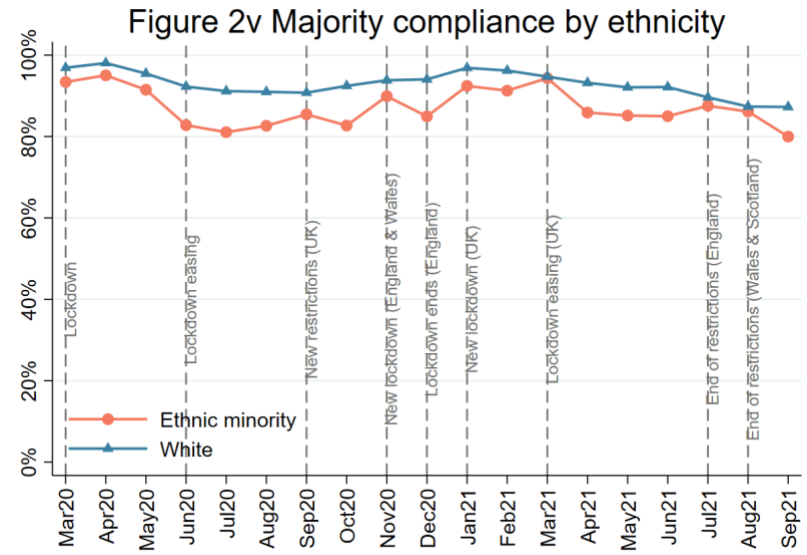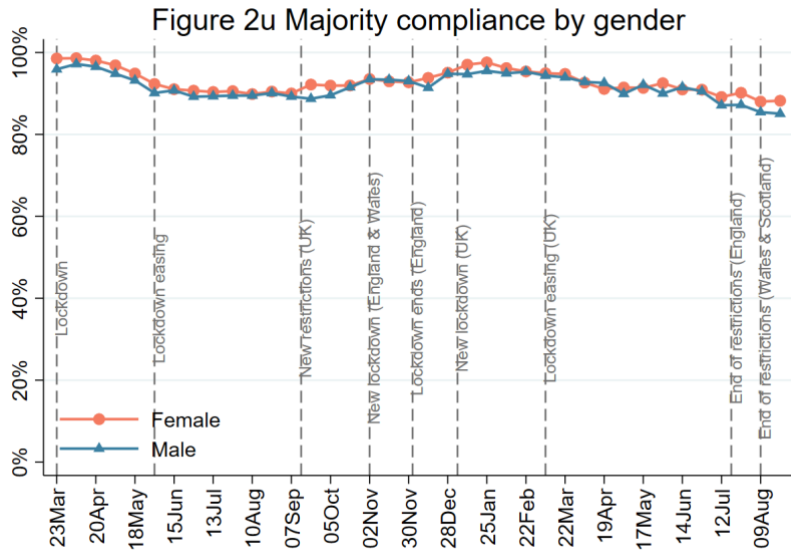Figure 2i Complete compliance by gender

Figure 2j Complete compliance by ethnicity

Figure 2k Complete compliance by educational levels

Figure 2l Complete compliance by physical health

Figure 2m Majority compliance by age groups

Figure 2n Majority compliance by living arrangement

Figure 2o Majority compliance by household income

Figure 2p Majority compliance by mental health

Figure 2q Majority compliance by nations

Legend: England, Wales, Scotland

Event markers: Lockdown, Lockdown easing, New restrictions (UK), New lockdown (England & Wales), Lockdown ends (England), New lockdown (UK), Lockdown easing (UK), End of restrictions (England), End of restrictions (Wales & Scotland)

Figure 2r Majority compliance by keyworker status

Legend: Keyworker, Anyone else

Event markers: Lockdown, Lockdown easing, New restrictions (UK), New lockdown (England & Wales), Lockdown ends (England), New lockdown (UK), Lockdown easing (UK), End of restrictions (England), End of restrictions (Wales & Scotland)

Figure 2s Majority compliance by living with children

Legend: With children, Without children

Event markers: Lockdown, Lockdown easing, New restrictions (UK), New lockdown (England & Wales), Lockdown ends (England), New lockdown (UK), Lockdown easing (UK), End of restrictions (England), End of restrictions (Wales & Scotland)

Figure 2t Majority compliance by living area

Legend: City/town, Village/other

Event markers: Lockdown, Lockdown easing, New restrictions (UK), New lockdown (England & Wales), Lockdown ends (England), New lockdown (UK), Lockdown easing (UK), End of restrictions (England), End of restrictions (Wales & Scotland)

Figure 2u Majority compliance by gender

Figure 2v Majority compliance by ethnicity

Figure 2w Majority compliance by educational levels

Figure 2x Majority compliance by physical health

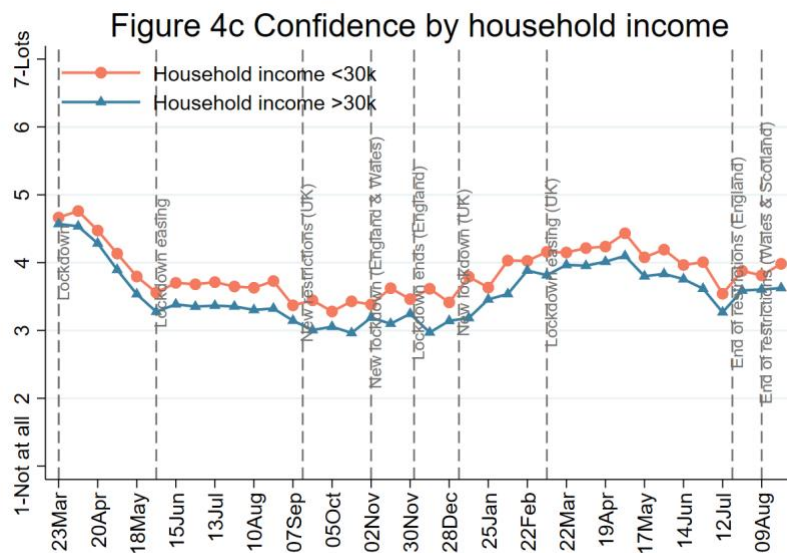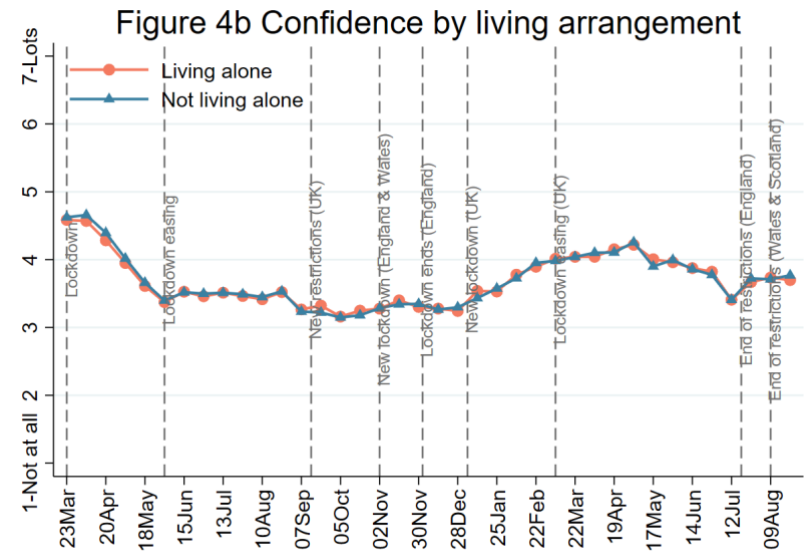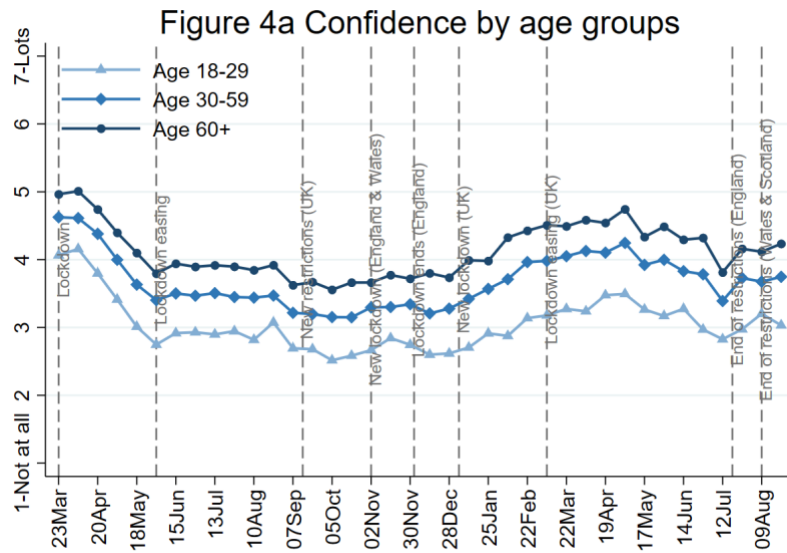## 1.2   Confidence in government

Figure 3 Confidence in government

FINDINGS

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

Confidence in government to handle the Covid-19 pandemic remains lower in England than devolved nations[2]. Levels of confidence increased somewhat in England over the month of July 2021 but then levelled off in August.

For subgroup analyses in Figures 4a-d and 4f-h, we restrict our results to respondents living in England in order to have sufficient sample sizes for meaningful subgroup analyses. In England, confidence in government is still lowest in those under the age of 30. Confidence also remains lower in urban areas, amongst people from ethnic minority groups, in people with a mental health diagnosis, people with higher household incomes, and amongst people with higher educational qualifications.

[2] Figures for Northern Ireland have now been removed from our daily tracker graphs due to a small sample size that makes extrapolation even with statistical weighting unreliable. These data are being analysed in other papers and reports.
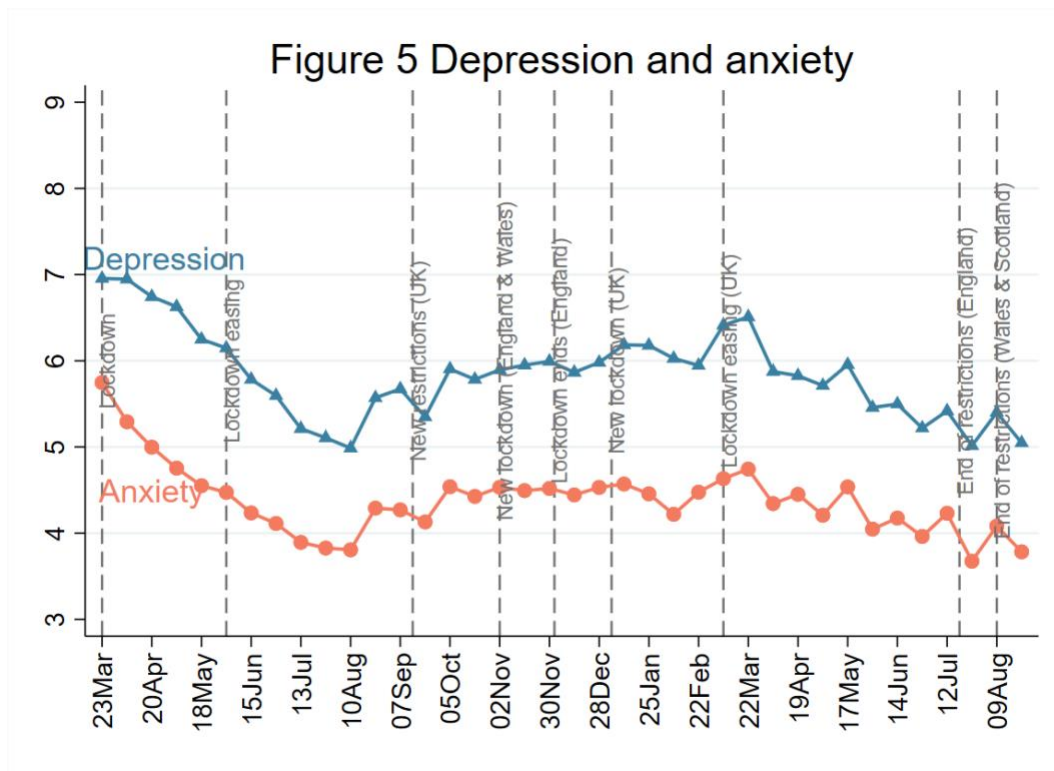
Figure 4a Confidence by age groups

- Age 18-29
- Age 30-59
- Age 60+

Figure 4b Confidence by living arrangement

- Living alone
- Not living alone

Figure 4c Confidence by household income

- Household income <30k
- Household income >30k

Figure 4d Confidence by mental health diagnosis

- Mental health diagnosis
- No diagnosis

Figure 4e Confidence by nations

Figure 4f Confidence by keyworker status

Figure 4g Confidence by living with children

Figure 4h Confidence by living area

Figure 4i Confidence in government by gender

Figure 4j Confidence in government by ethnicity

Figure 4k Confidence in government by educational levels

Figure 4l Confidence in government by physical health

2. Mental Health

2.1 Depression and anxiety

Figure 5 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 screening for depression and anxiety in primary care. There are 9 and 7 items respectively with 4-point responses ranging from "not at all" to "nearly every day", with higher overall scores indicating more symptoms. Scores higher than 10 can indicate major depression or moderate anxiety.

Depression and anxiety symptoms have generally continued to decrease over the past month as they have been since the end of February and are now similar to what they were in the summer of 2020.

Although this study focuses on trajectories rather than prevalence, the levels overall are higher than usual reported averages using the same scales (2.7-3.2 for anxiety and 2.7-3.7 for depression[3]).

Depression and anxiety are still highest in young adults, people living alone, people with lower household income, people living with children, those living in urban areas, women, people from ethnic minority groups, and those with a physical health diagnosis. People with a mental health diagnosis continue to report higher levels of depression and anxiety symptoms (as might be expected) (see Figures 6d and 7d). None of these differences appear to be narrowing as the pandemic continues.

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[3] Löwe B, Decker O, Müller S, Brähler E, Schellberg D, Herzog W, et al. Validation and Standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the General Population. Medical Care. 2008;46(3):266–74. | Tomitaka S, Kawasaki Y, Ide K, Akutagawa M, Ono Y, Furukawa TA. Stability of the Distribution of Patient Health Questionnaire-9 Scores Against Age in the General Population: Data From the National Health and Nutrition Examination Survey. Front Psychiatry.

NB in the absence of identified directly comparable prevalence estimates in the UK, these studies look at prevalence in the US in the general population.

Figure 6a Depression by age groups
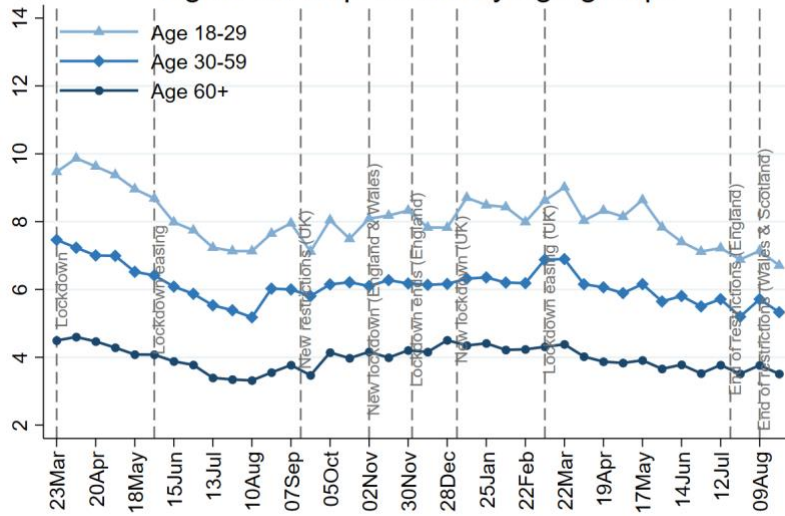
Figure 6b Depression by living arrangement
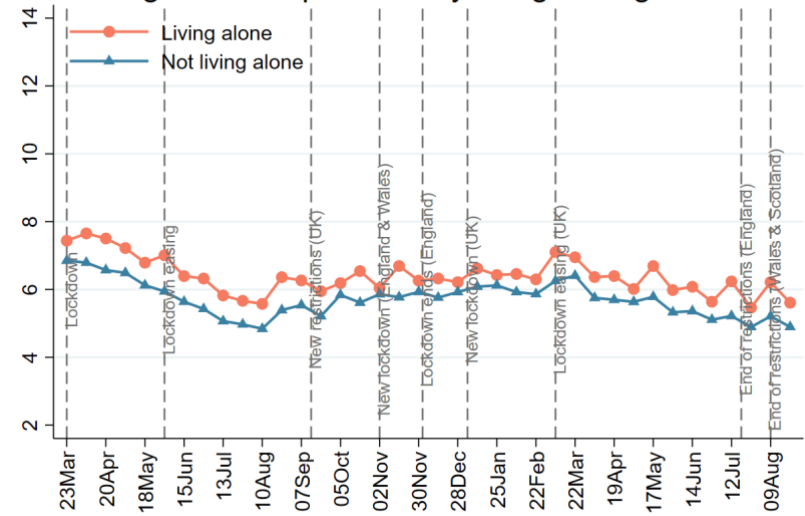
Figure 6c Depression by household income
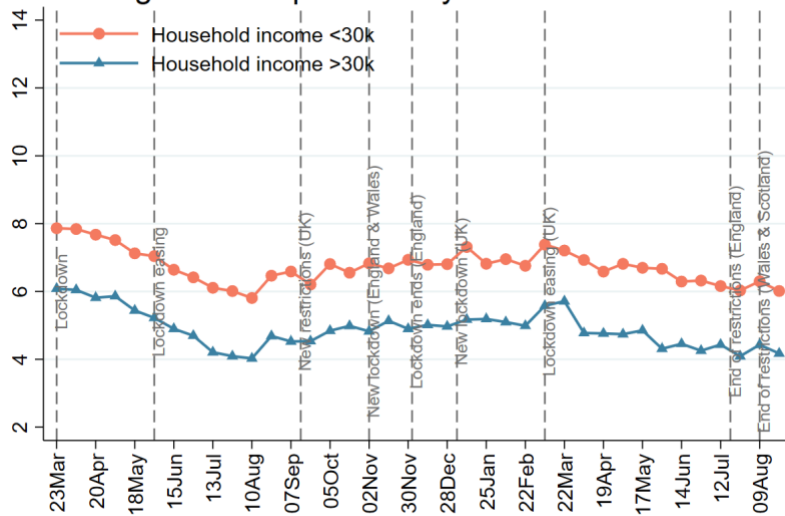
Figure 6d Depression by mental health diagnosis
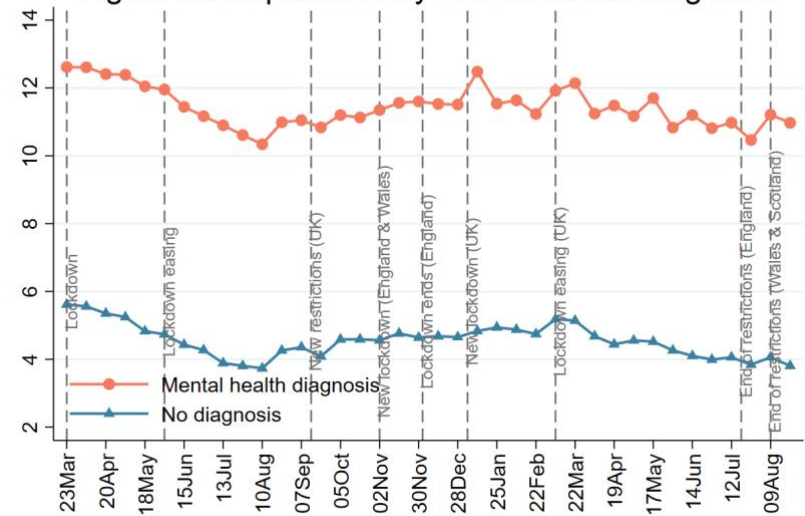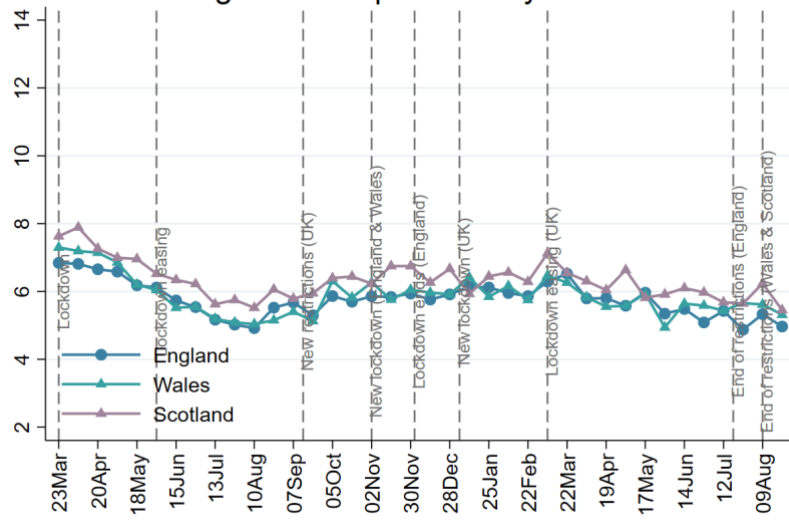
Figure 6e Depression by nations
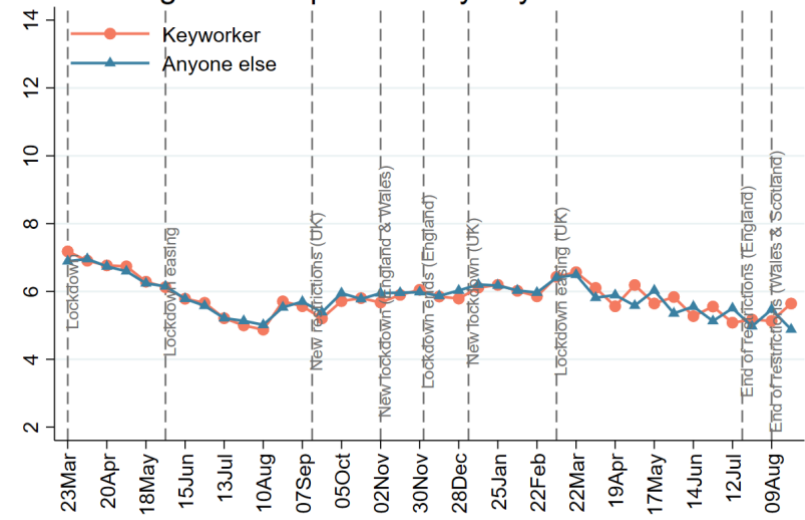

Figure 6f Depression by keyworker status

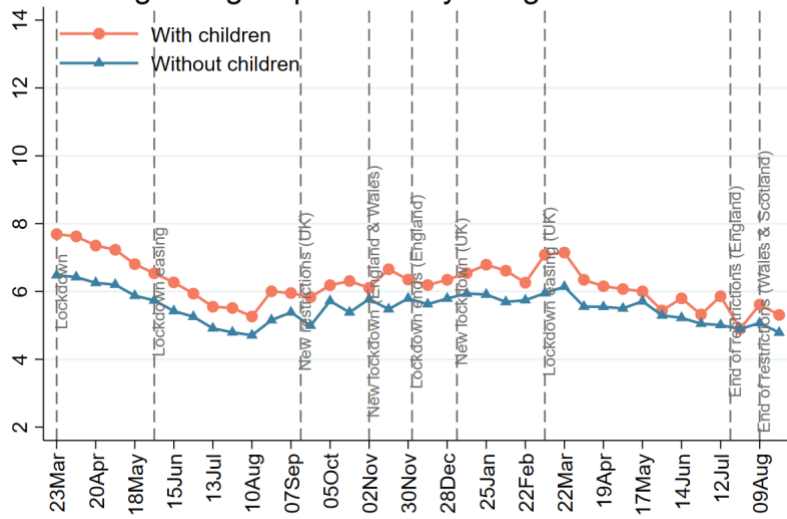Figure 6g Depression by living with children
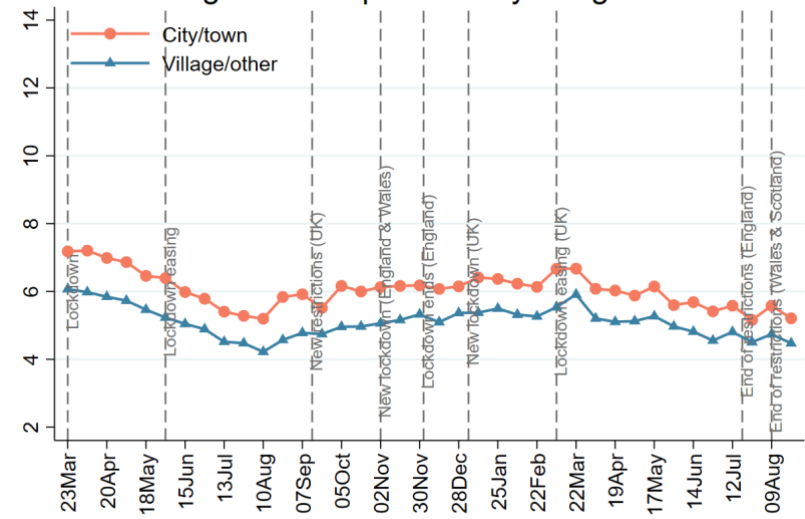

Figure 6h Depression by living area

Figure 6i Depression by gender
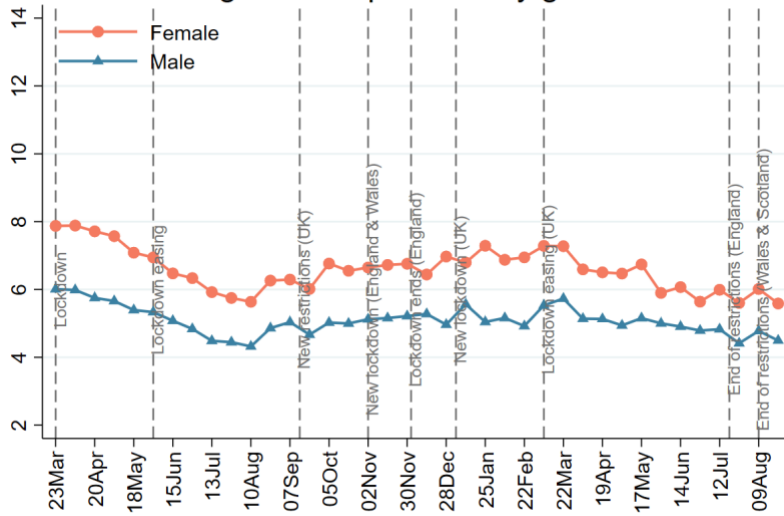
Figure 6j Depression by ethnicity
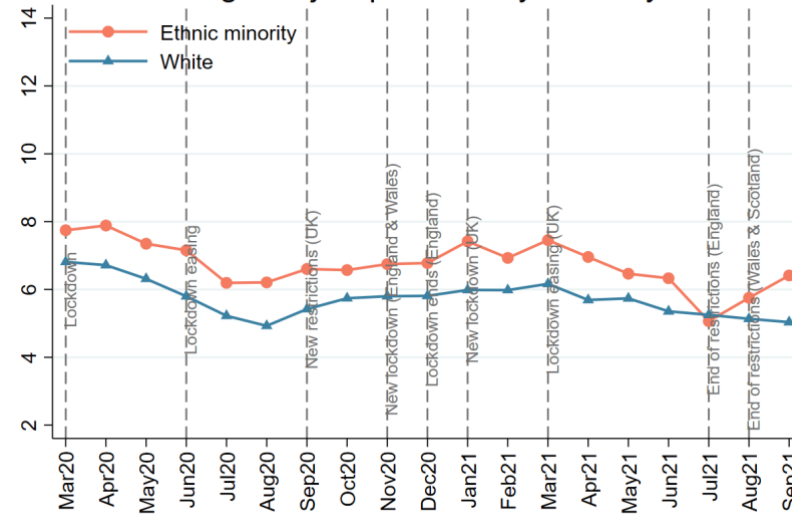
Figure 6k Depression by educational levels
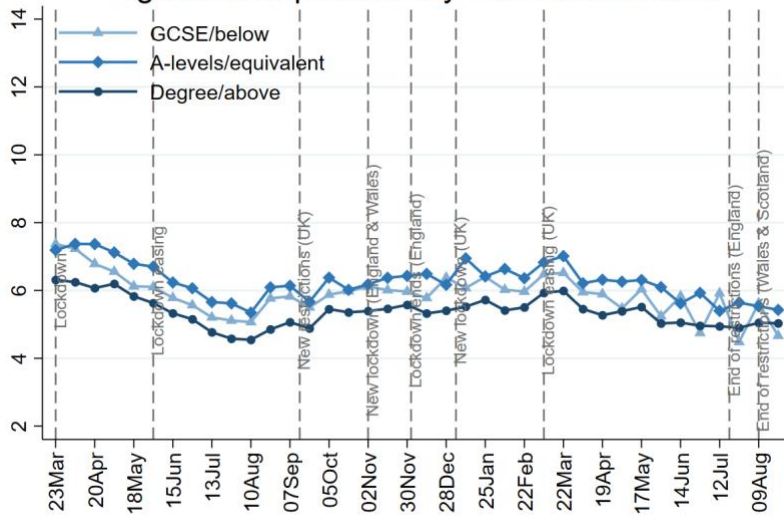
Figure 6l Depression by physical health diagnosis
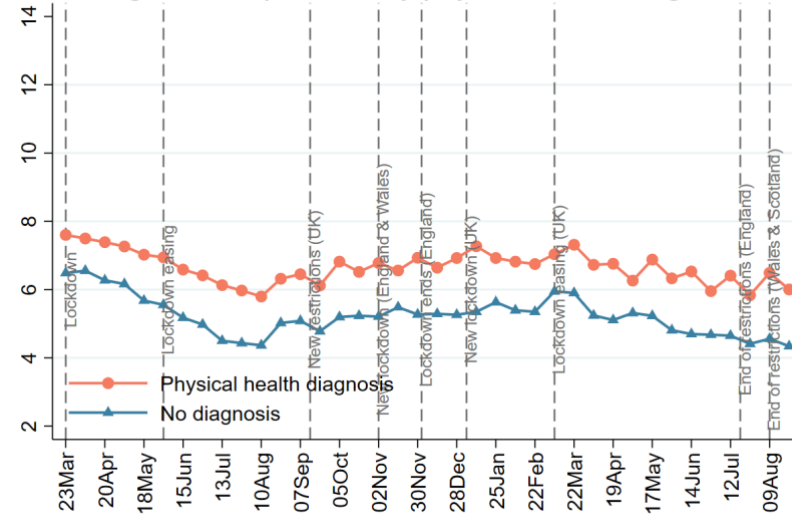
Figure 7a Anxiety by age groups

Age 18-29
Age 30-59
Age 60+
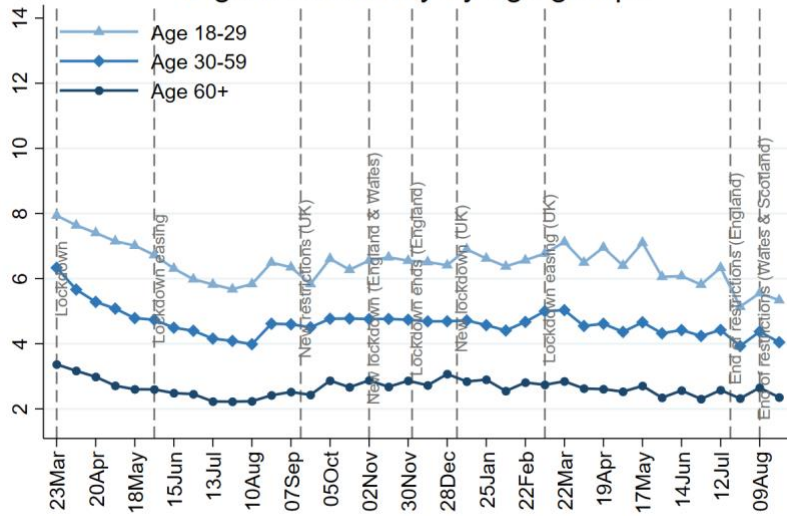
Figure 7b Anxiety by living arrangement

Living alone
Not living alone
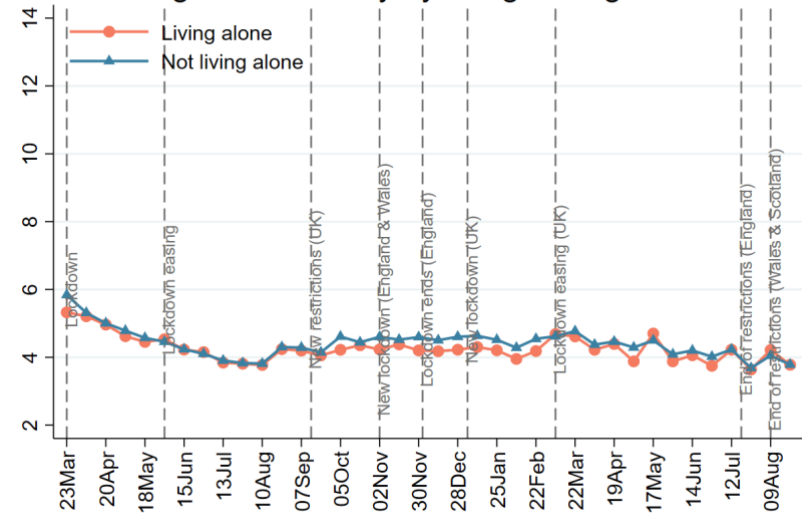
Figure 7c Anxiety by household income

Household income <30k
Household income >30k
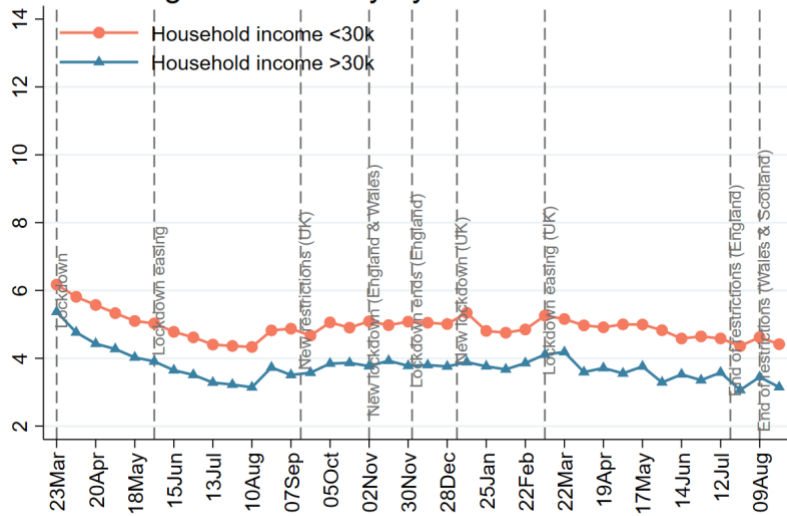
Figure 7d Anxiety by mental health diagnosis

Mental health diagnosis
No diagnosis
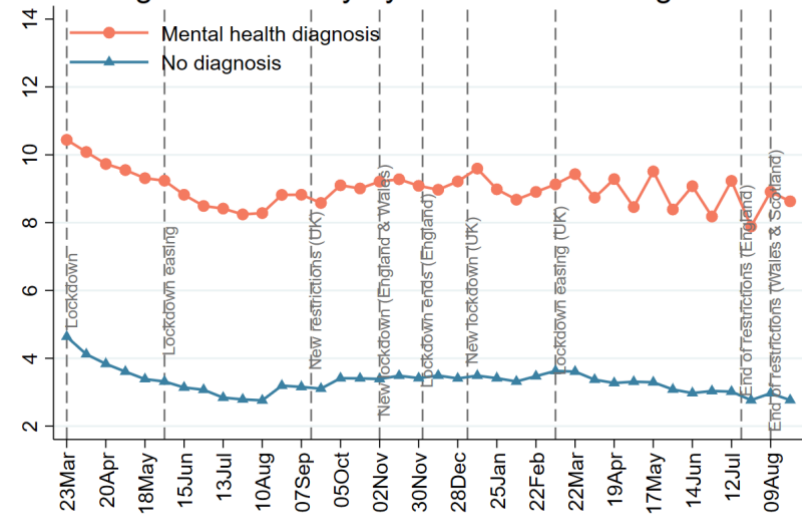
Figure 7e Anxiety by nations
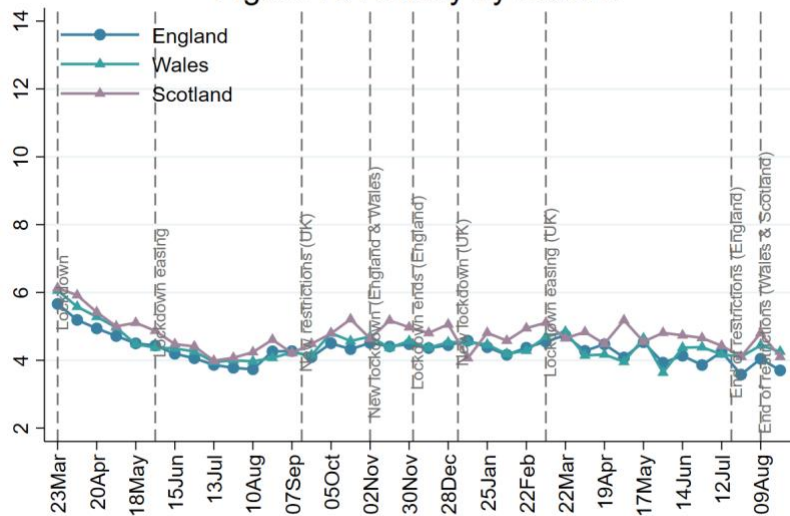
Figure 7f Anxiety by keyworker status
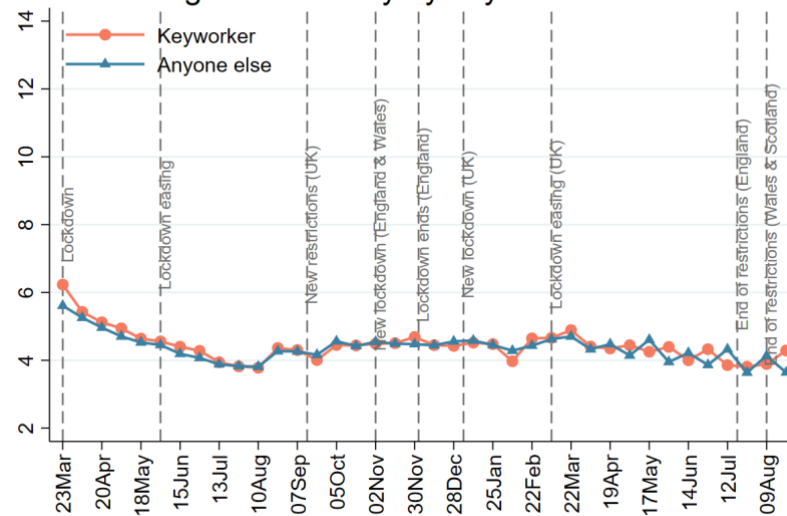
Figure 7g Anxiety by living with children
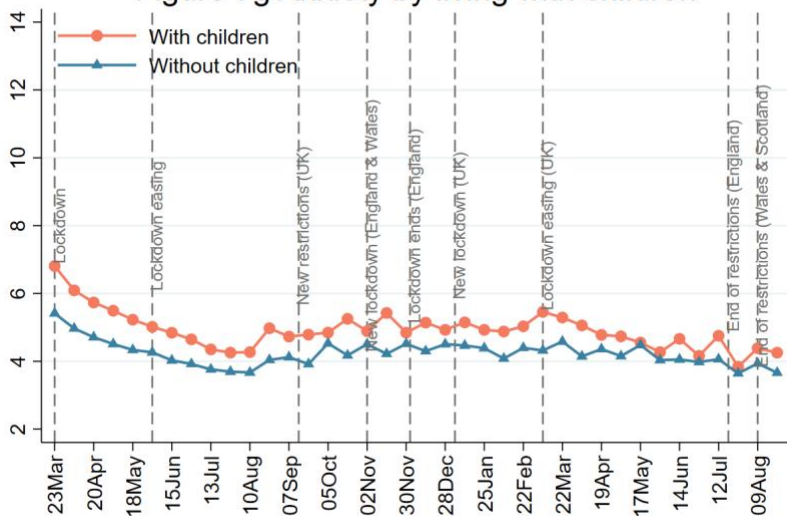
Figure 7h Anxiety by living area
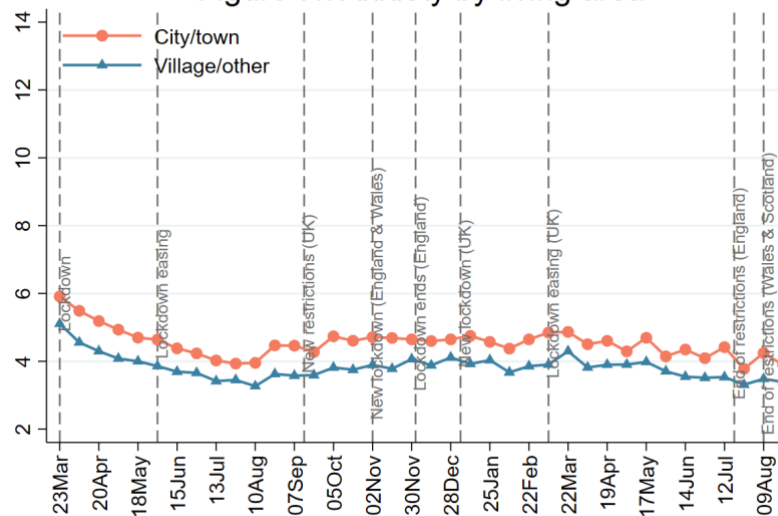
Figure 7i Anxiety by gender
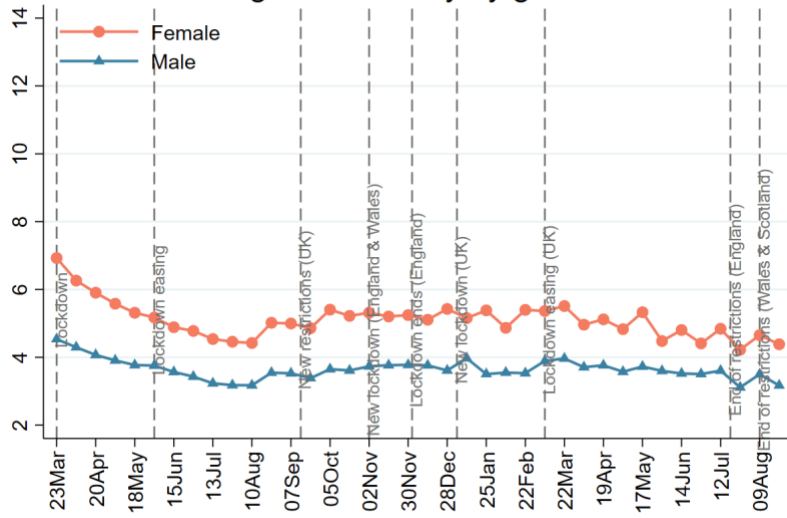
Figure 7j Anxiety by ethnicity
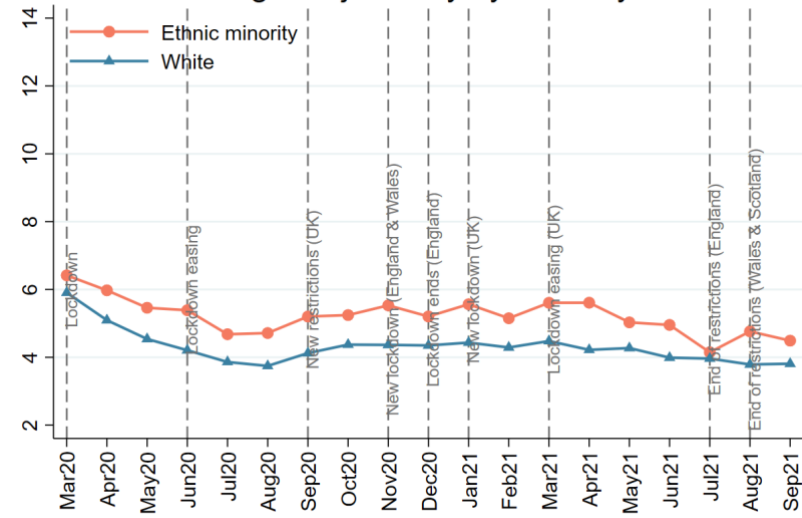
Figure 7k Anxiety by educational levels
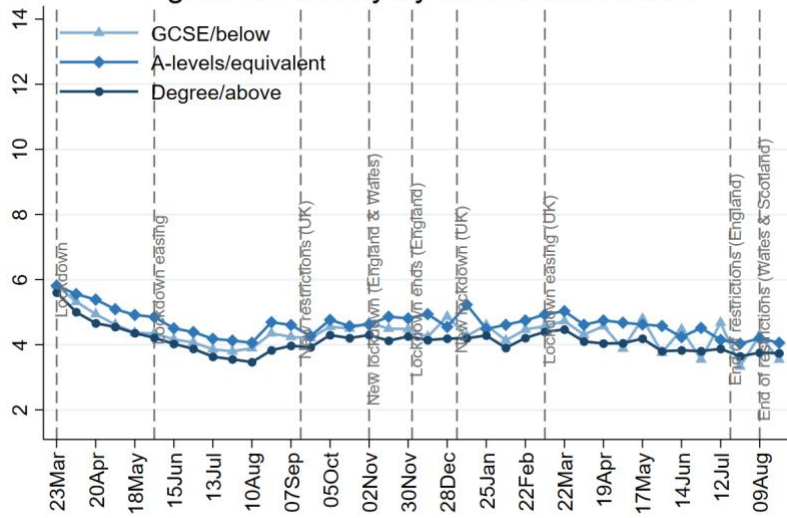
Figure 7l Anxiety by physical health diagnosis
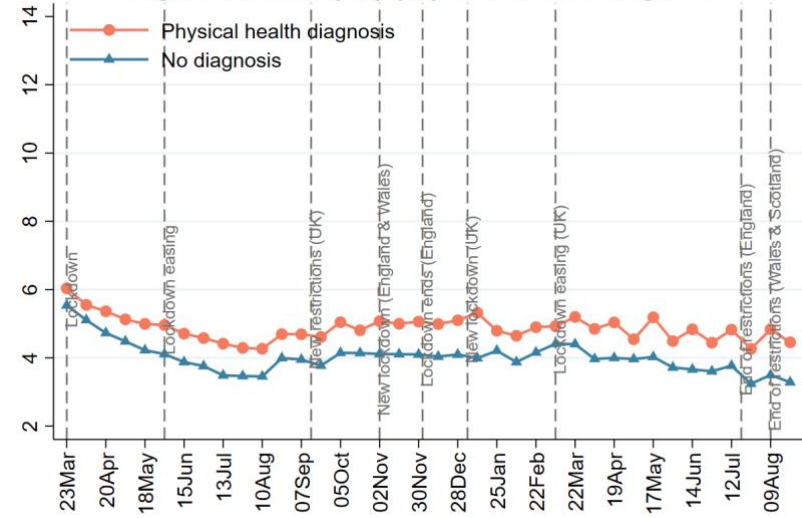
2.2 Stress

Figure 8 Stressors
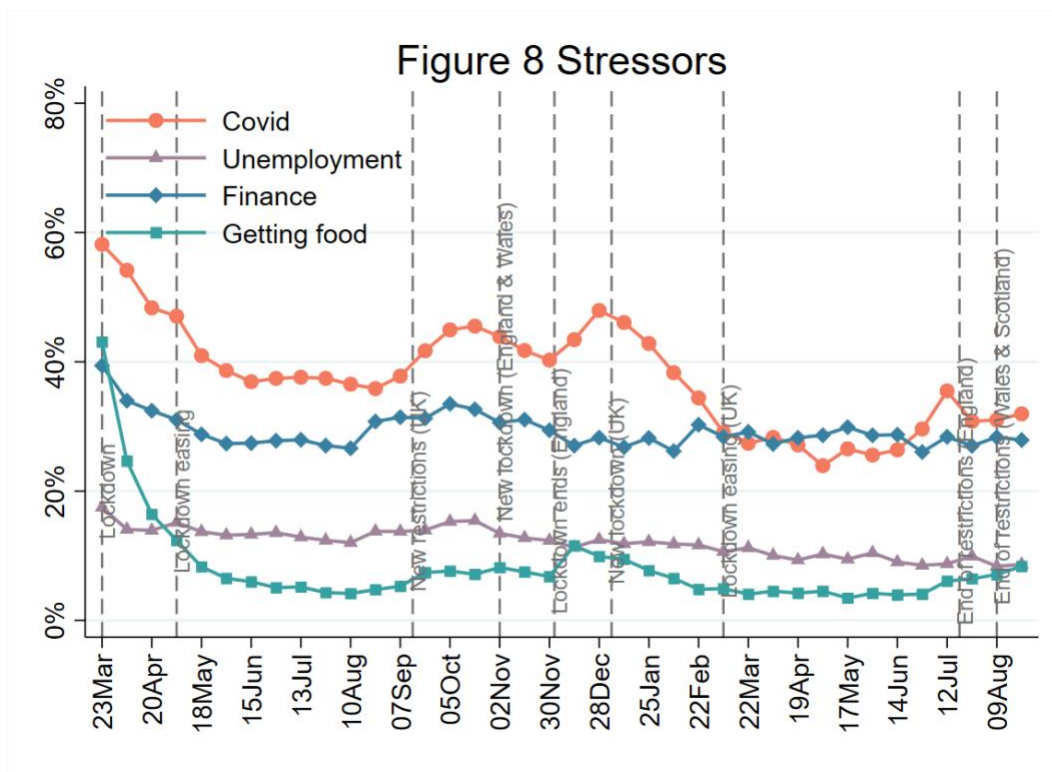
FINDINGS

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).

The proportion of people concerned about catching or becoming seriously ill from Covid-19 increased during the month of July 2021 but appears to have levelled off. A greater proportion of young adults have been expressing this concern than adults over the age of 30 over the past few months. Women and people with a physical or mental health diagnosis remain more worried about catching or becoming seriously ill from Covid-19.

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

Worries about finance have remained relatively stable since the beginning of the year and are comparable to their lowest levels of around 1 in 3 people over the summer of 2020. Concerns about finances remain highest amongst adults of working age (18-59 years), people with low household incomes, those with a mental health diagnosis, people living with children, and people from ethnic minority groups. Financial stress has been higher in young adults than in other age groups since the end of March 2021.

Worries about being able to access sufficient food have been increasing slightly over the past two months and are now similar to what they were at the end of 2020 (in line with current news on potential upcoming food shortages). Most groups are reporting similar concern about accessing food, although these concerns are higher in people with a mental health diagnosis and people with lower household incomes. People with physical health conditions are also more concerned about accessing food, which may be due to greater concerns about going to supermarkets.

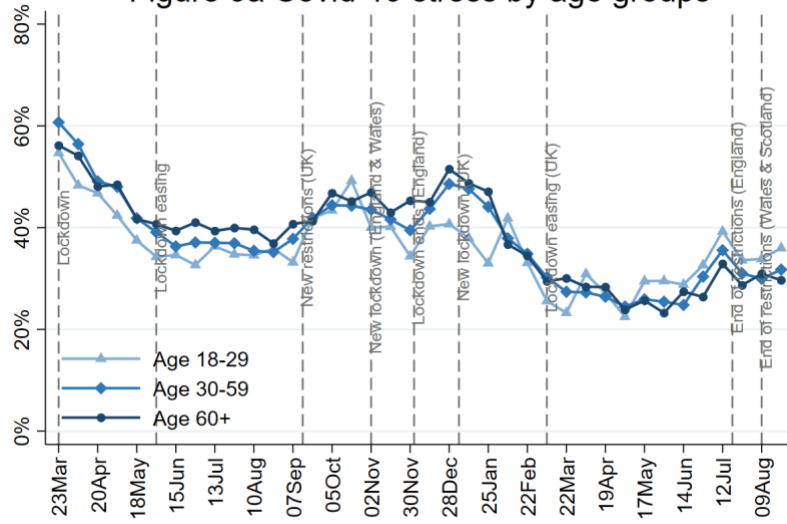Figure 9a Covid-19 stress by age groups

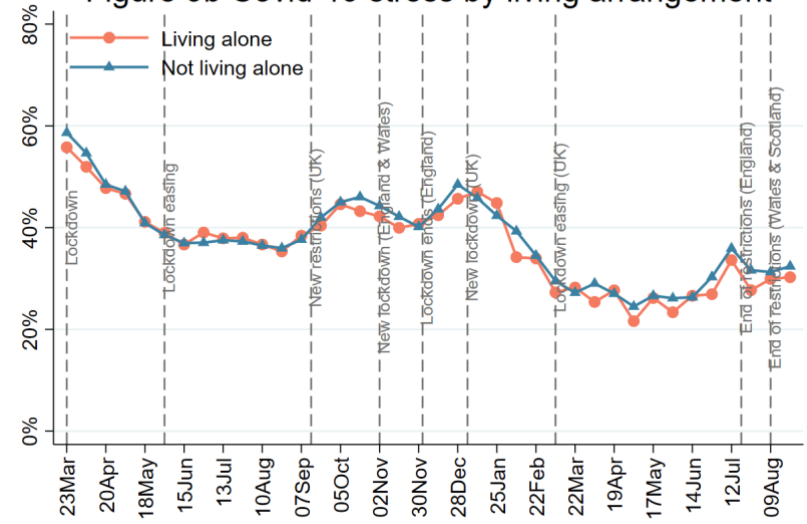Figure 9b Covid-19 stress by living arrangement
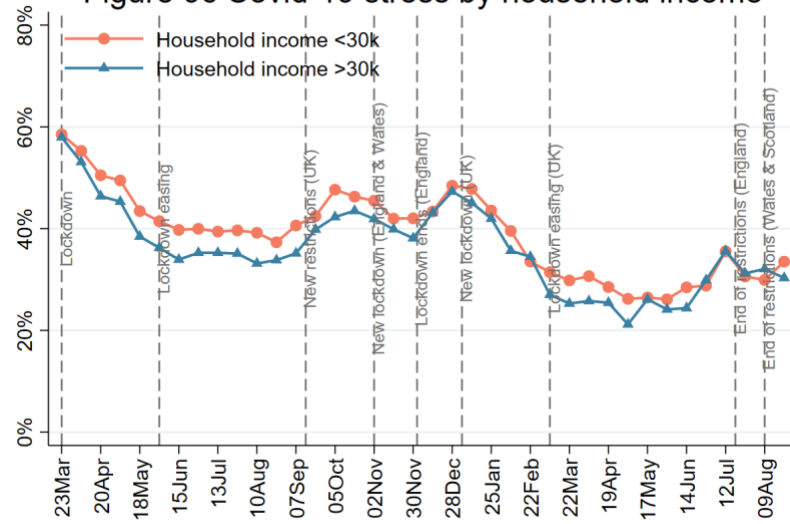

Figure 9c Covid-19 stress by household income

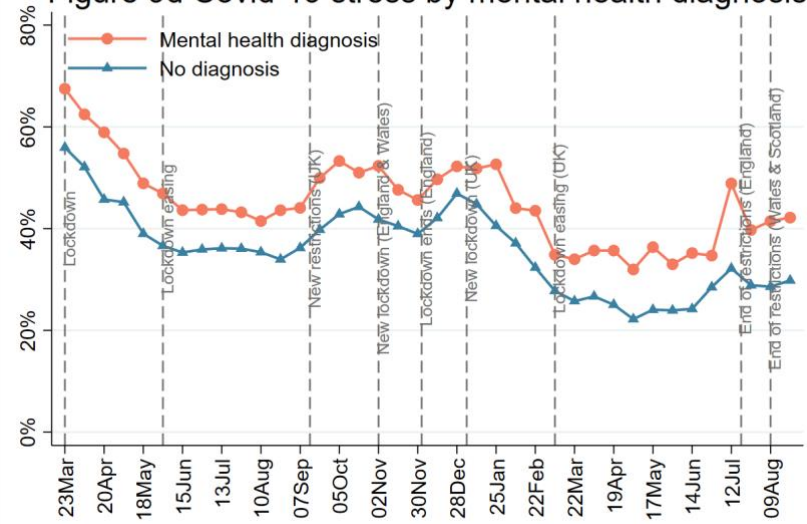Figure 9d Covid-19 stress by mental health diagnosis

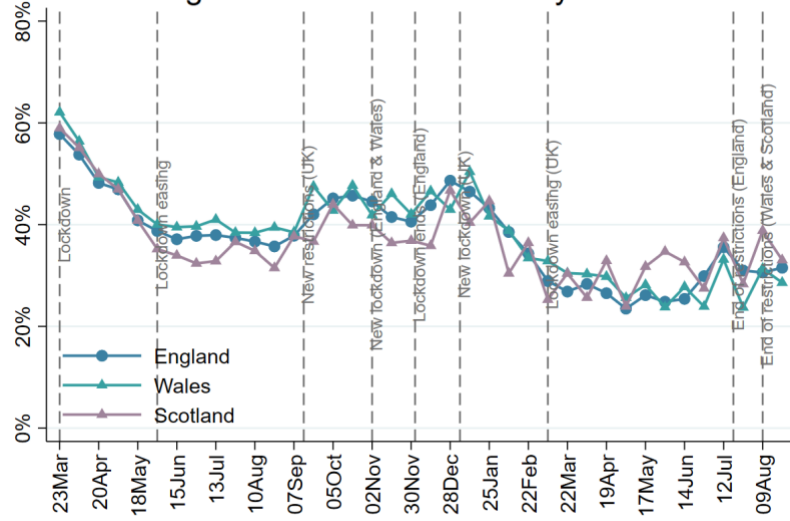Figure 9e Covid-19 stress by nations

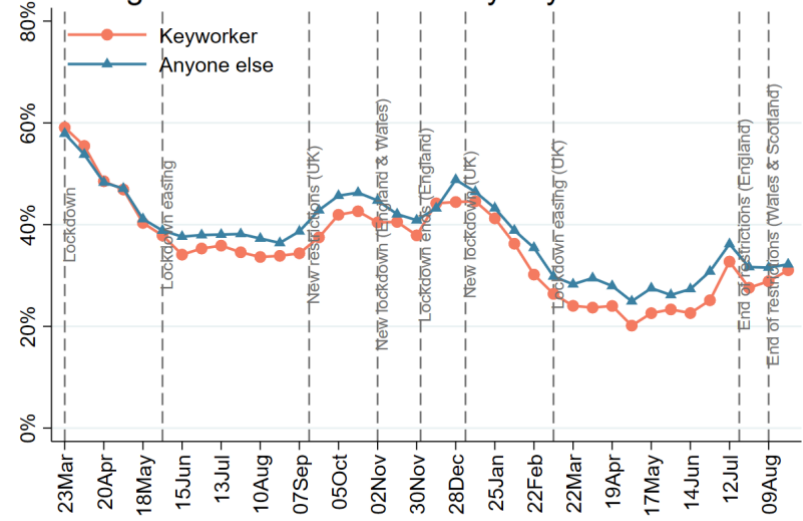Figure 9f Covid-19 stress by keyworker status

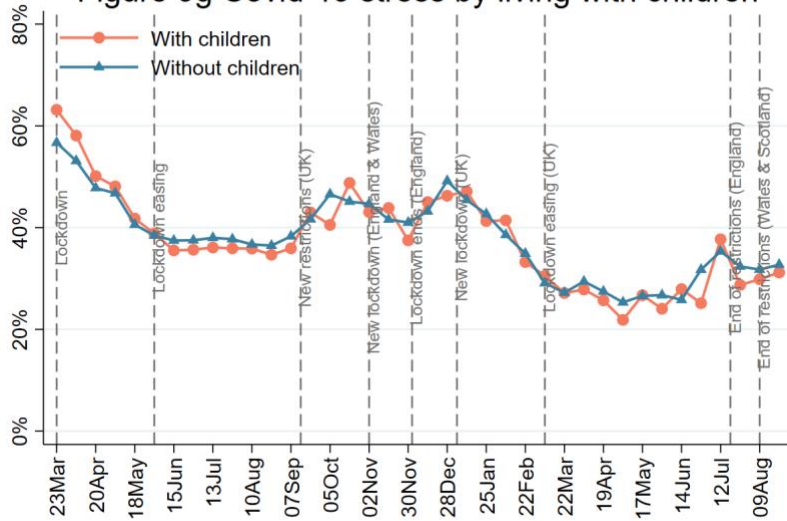

Figure 9g Covid-19 stress by living with children

Figure 9h Covid-19 stress by living area

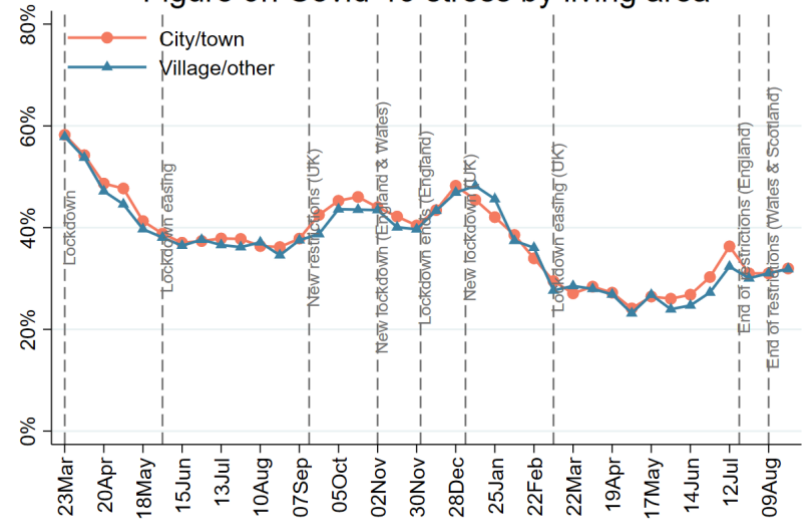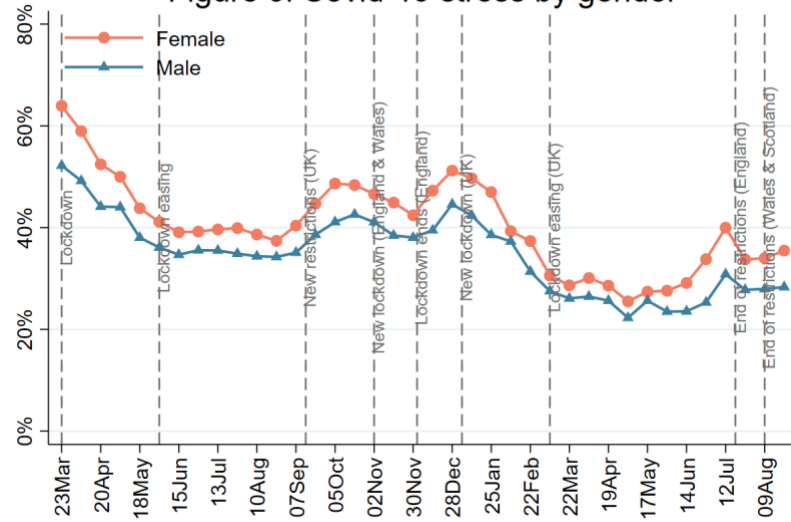Figure 9i Covid-19 stress by gender
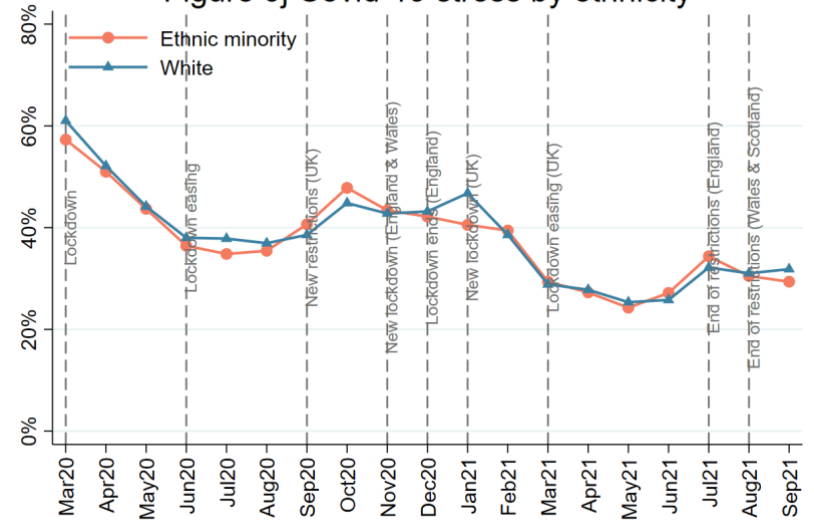

Figure 9j Covid-19 stress by ethnicity

Figure 9k Covid-19 stress by educational levels
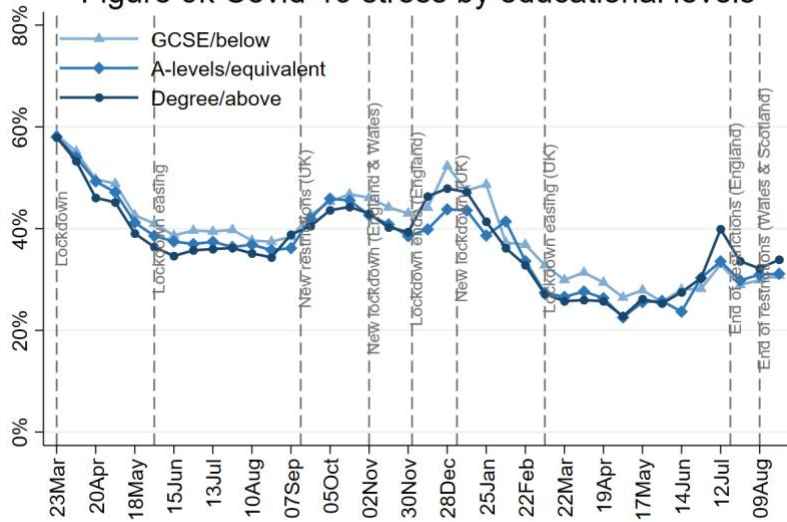
Figure 9l Covid-19 stress by physical health diagnosis
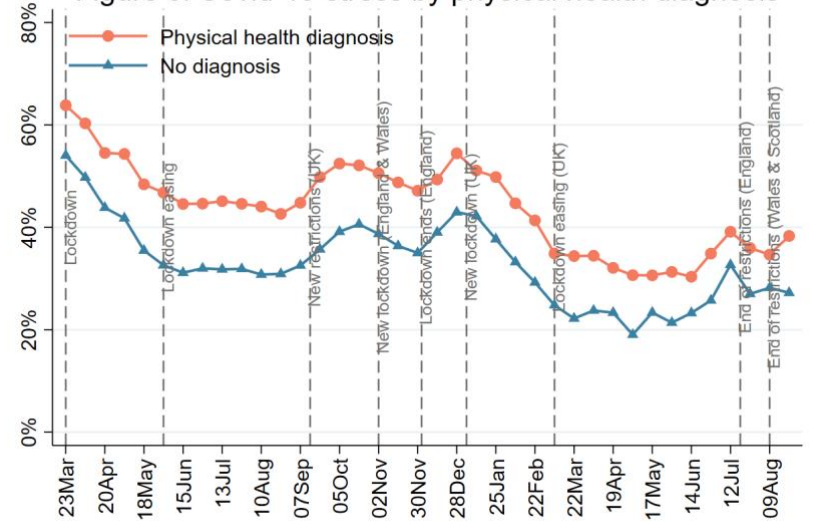
Figure 10a Unemployment stress by age groups
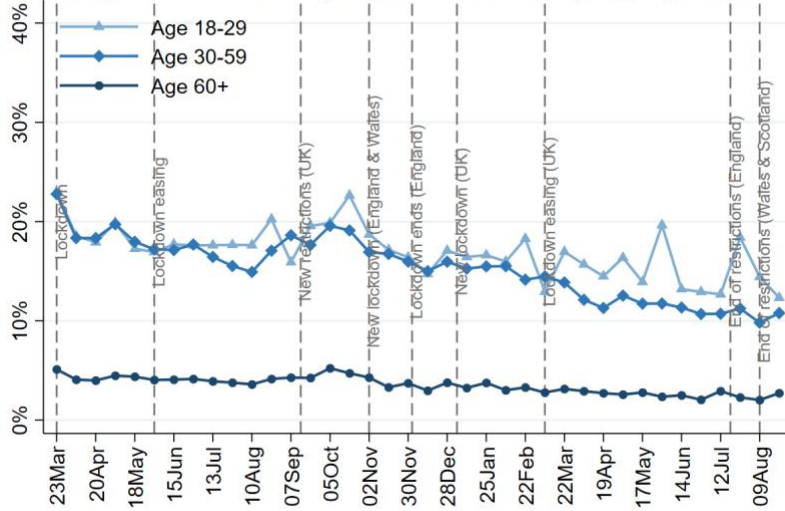
Figure 10b Unemployment stress by living arrangement
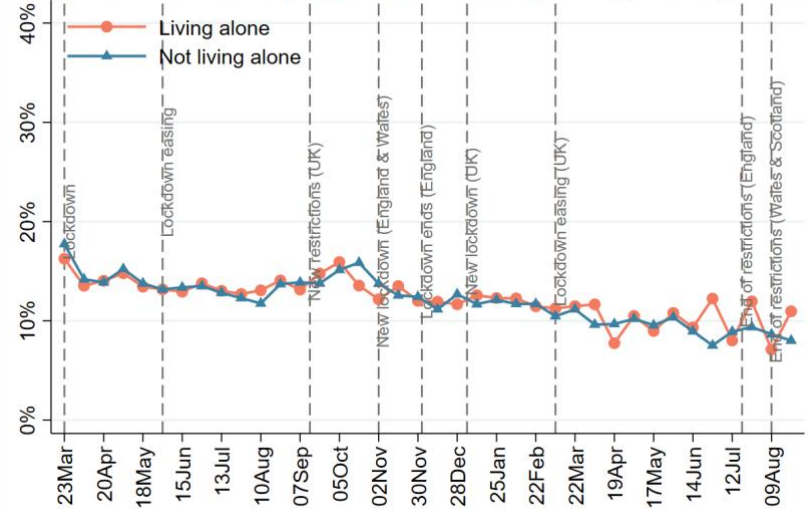
Figure 10c Unemployment stress by household income
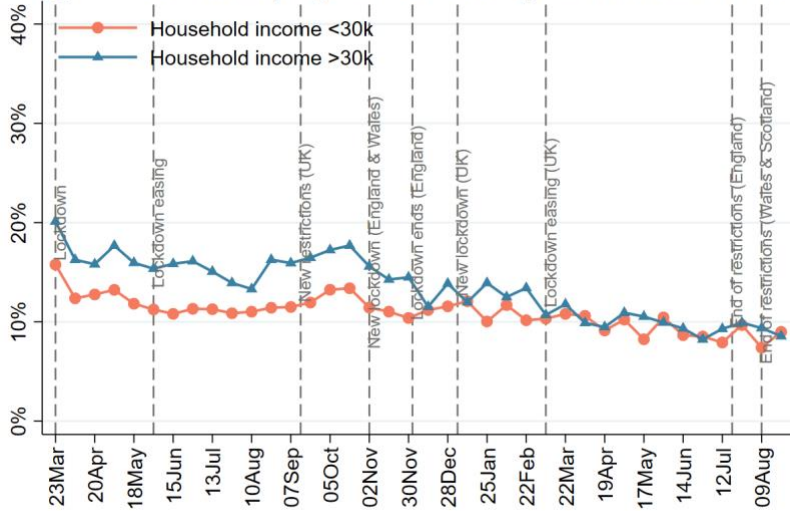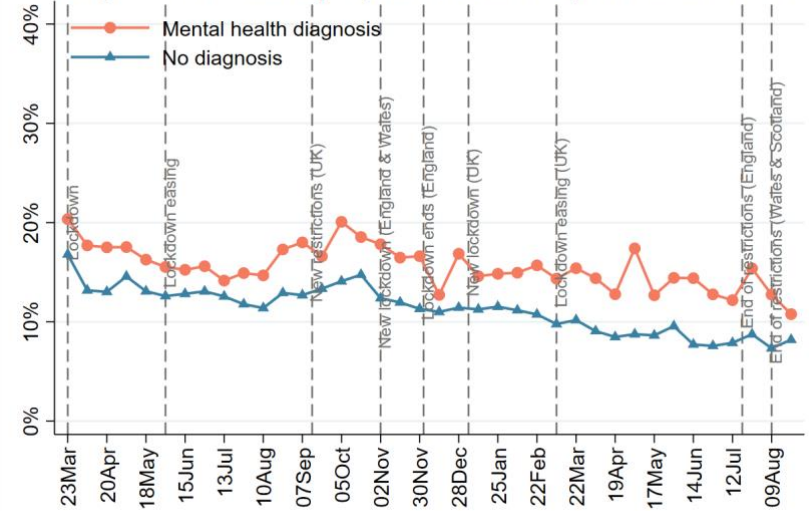

Figure 10d Unemployment stress by mental health
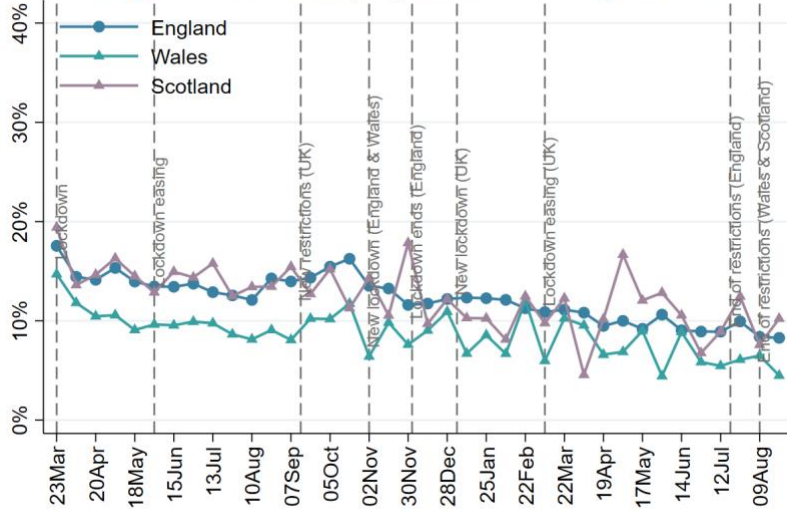
Figure 10e Unemployment stress by nations

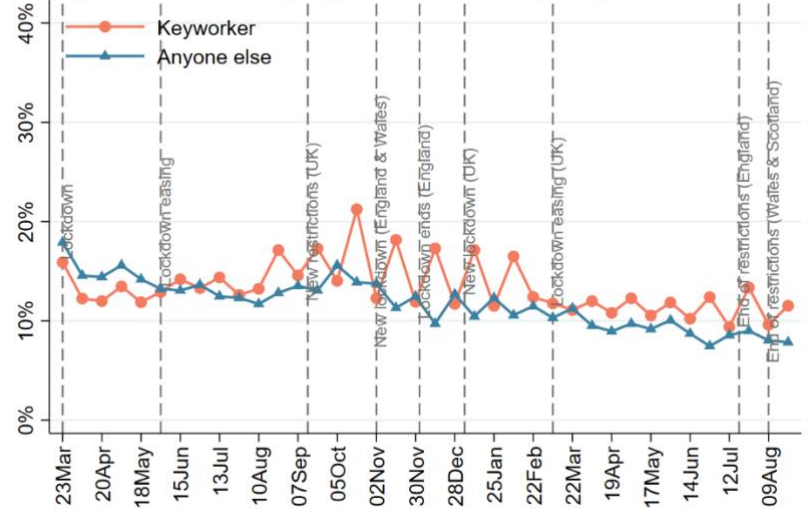
Figure 10f Unemployment stress by keyworker status

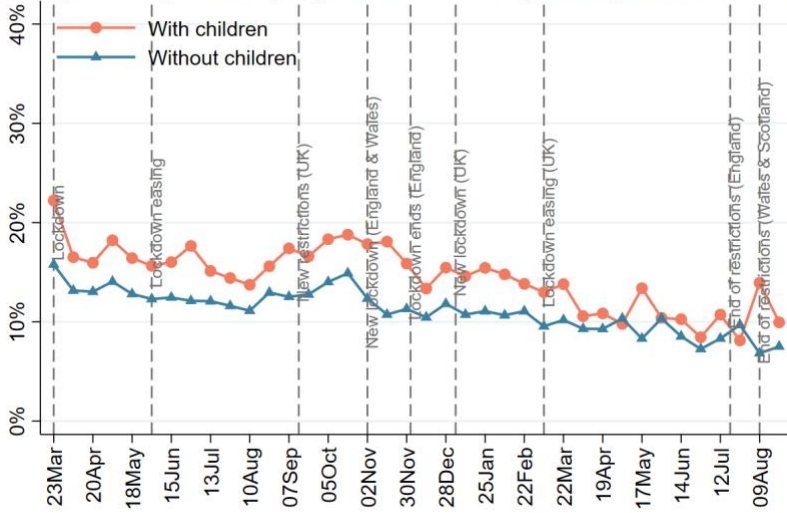Figure 10g Unemployment stress by living with children

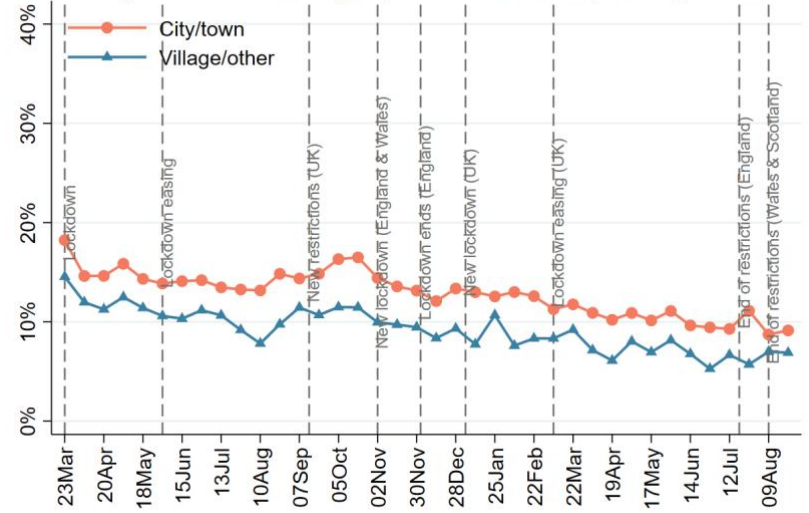Figure 10h Unemployment stress by living area
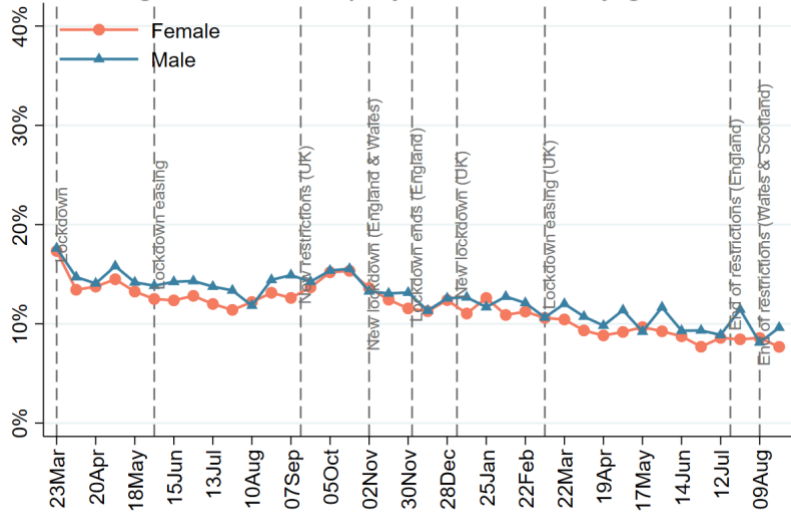
Figure 10i Unemployment stress by gender

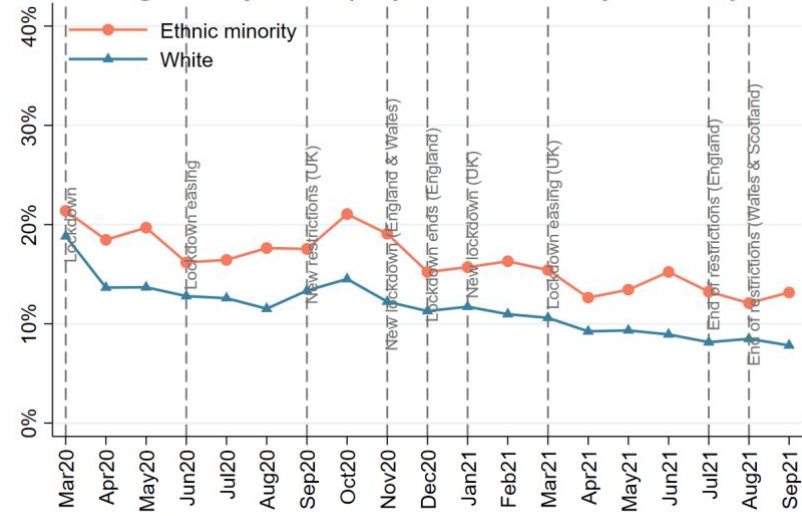Figure 10j Unemployment stress by ethnicity

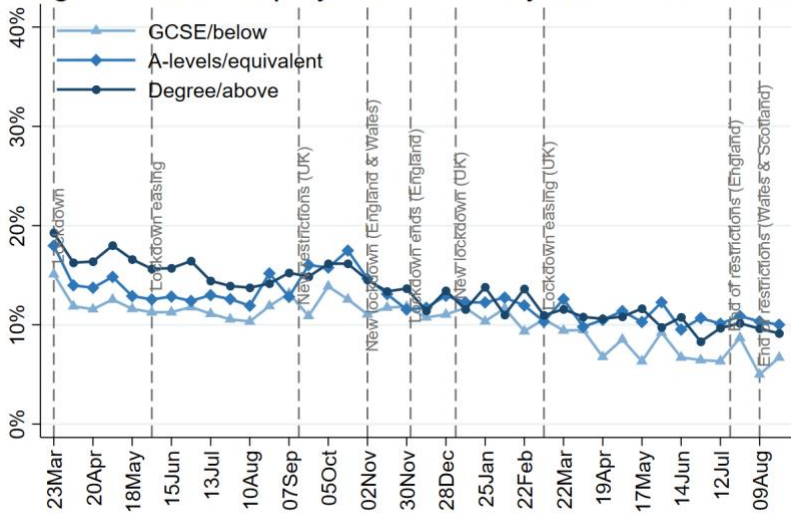Figure 10k Unemployment stress by educational levels

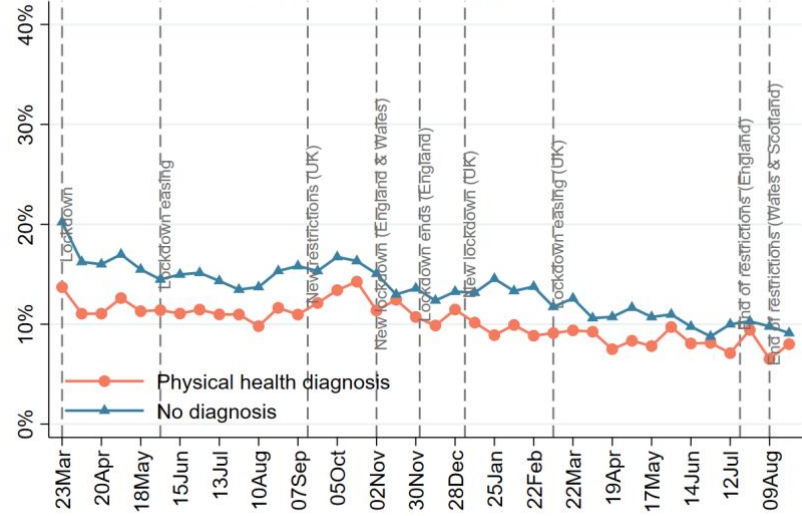Figure 10l Unemployment stress by physical health diagnosis

Figure 11a Financial stress by age groups
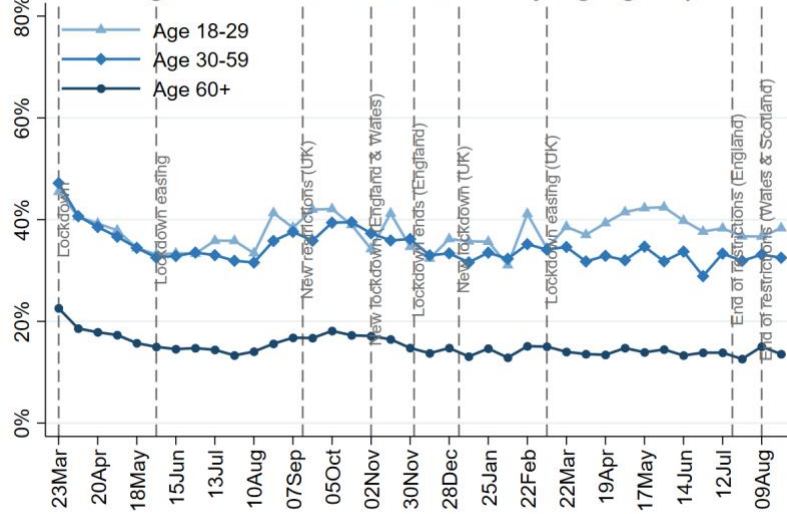

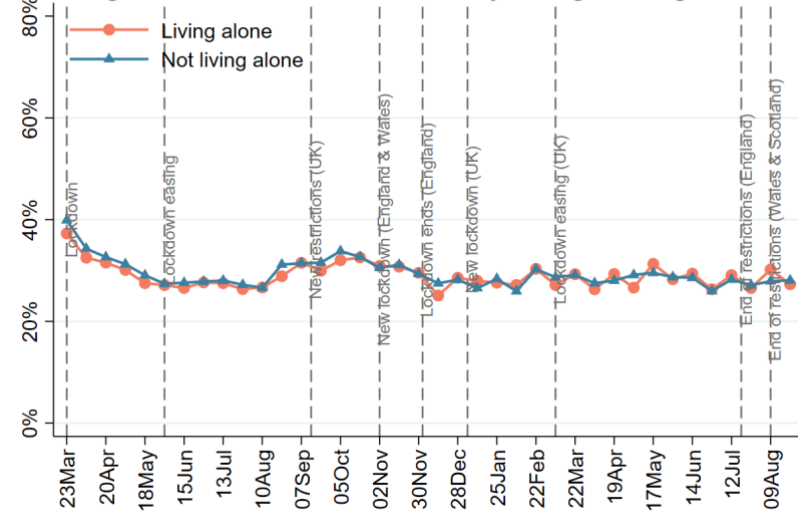Figure 11b Financial stress by living arrangement

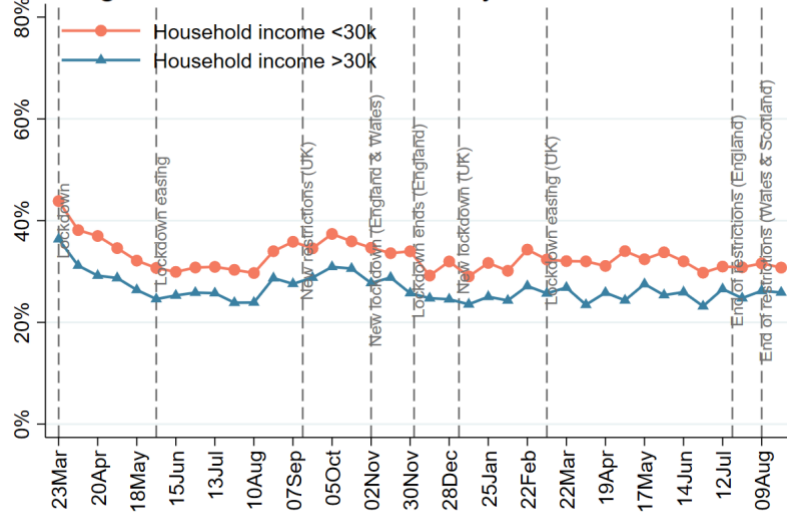Figure 11c Financial stress by household income

Figure 11d Financial stress by mental health diagnosis
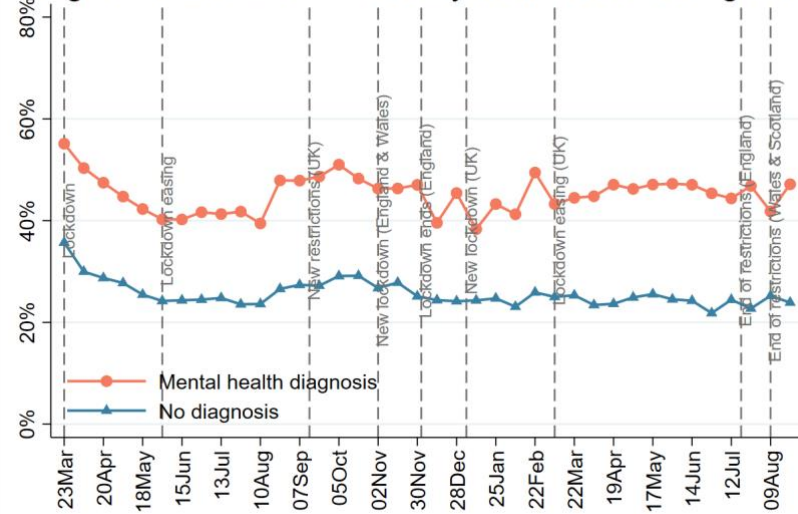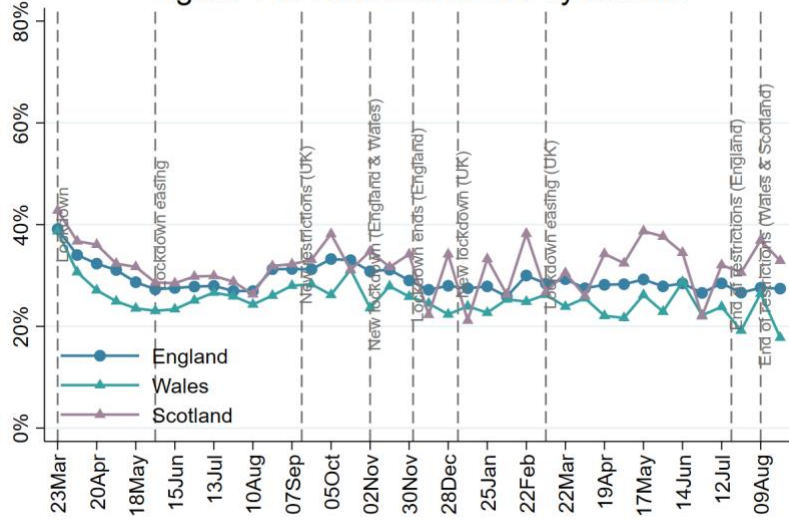
Figure 11e Financial stress by nations

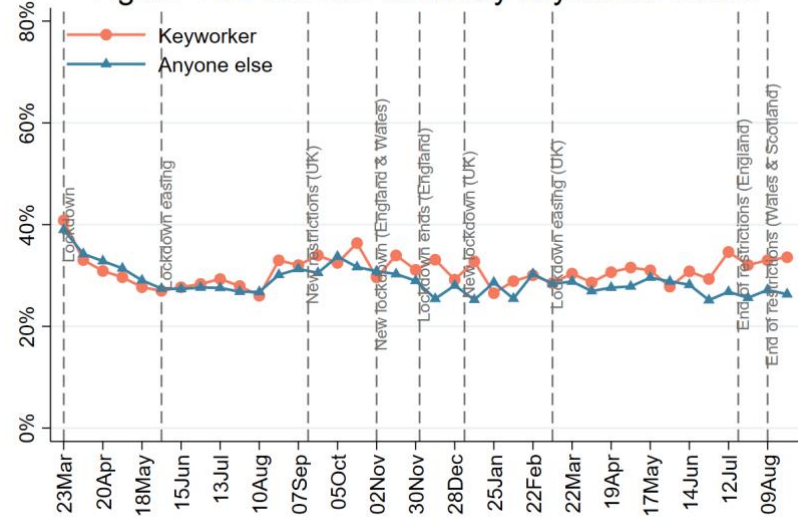Figure 11f Financial stress by keyworker status

Figure 11g Financial stress by living with children
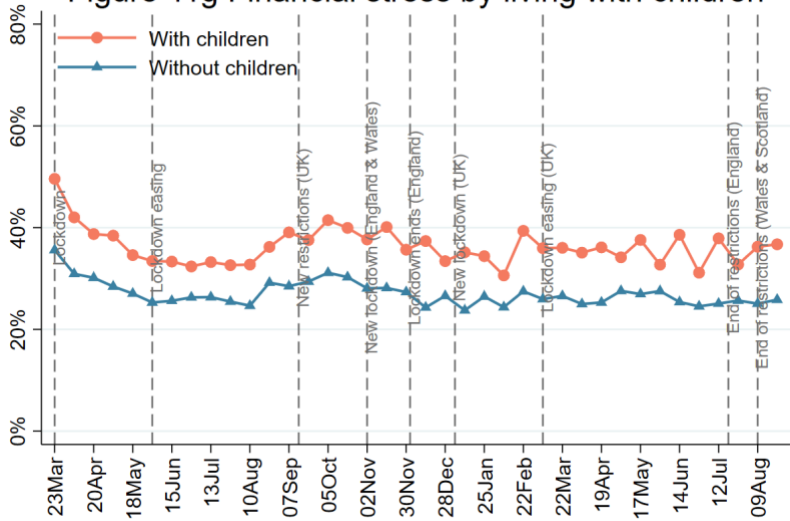
Figure 11h Financial stress by living area

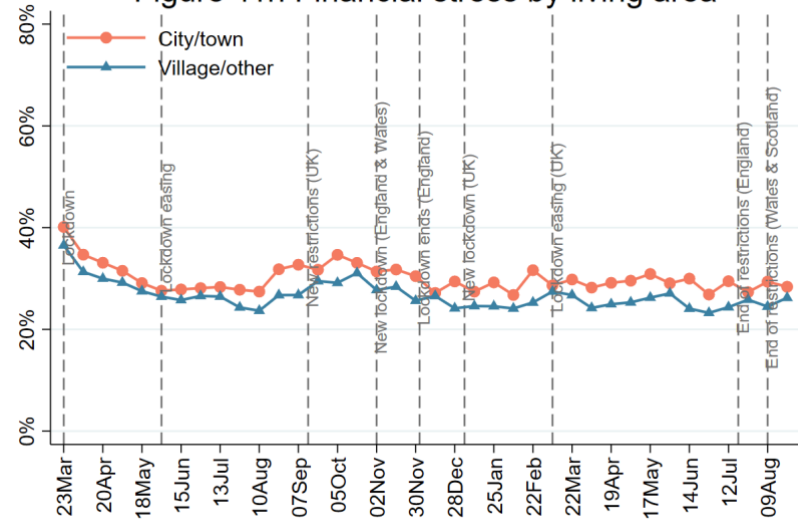Figure 11i Financial stress by gender
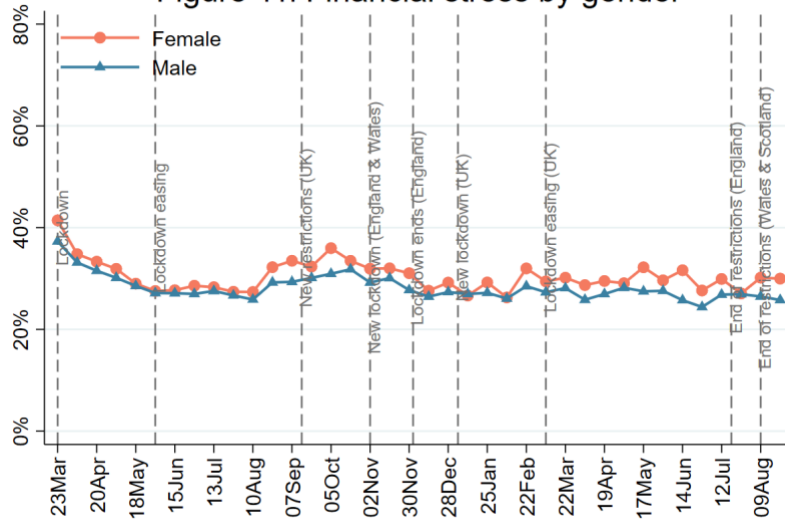
Figure 11j Financial stress by ethnicity
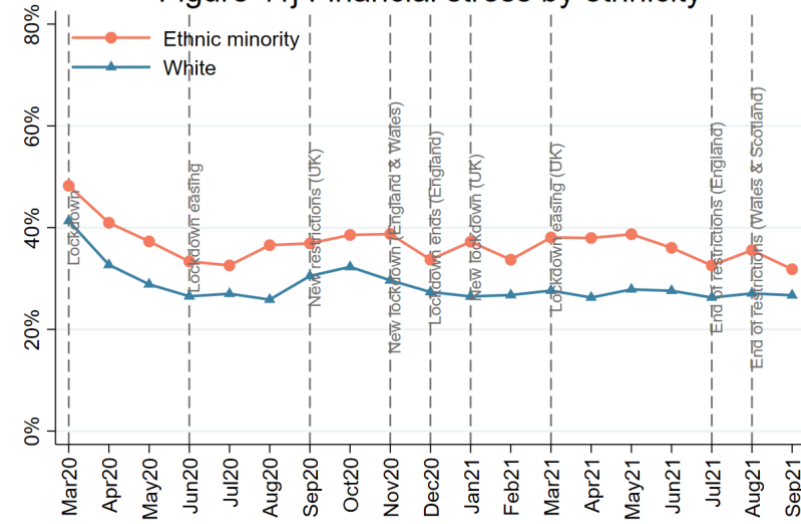
Figure 11k Financial stress by educational levels
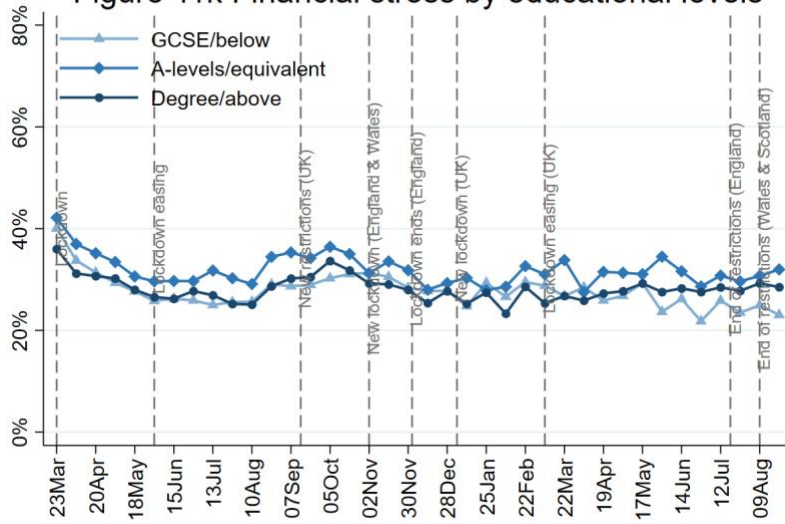
Figure 11l Financial stress by physical health diagnosis
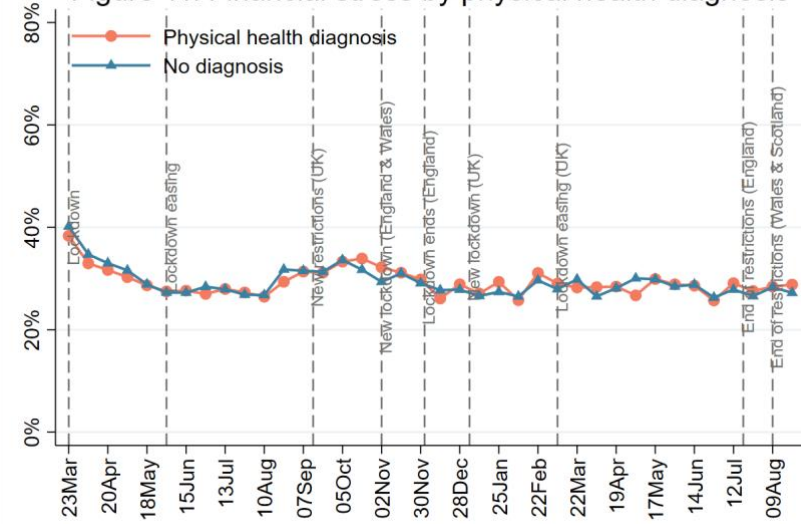
Figure 12a Food security stress by age groups

Figure 12b Food security stress by living arrangement
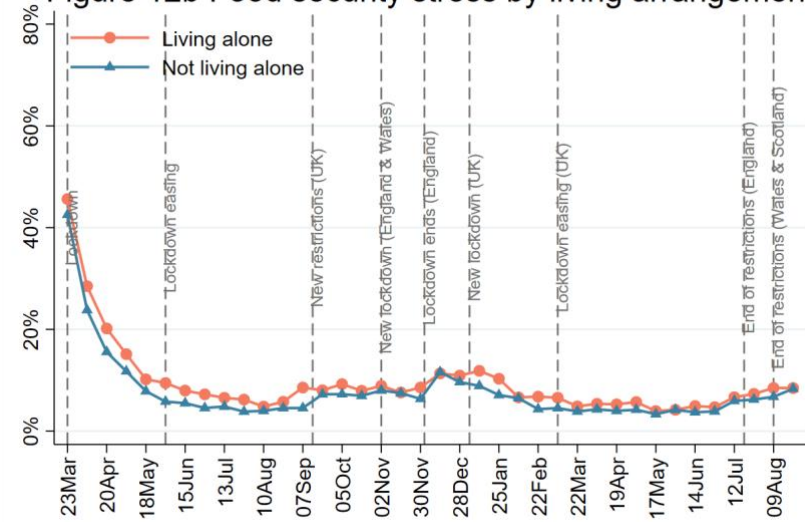
Figure 12c Food security stress by household income
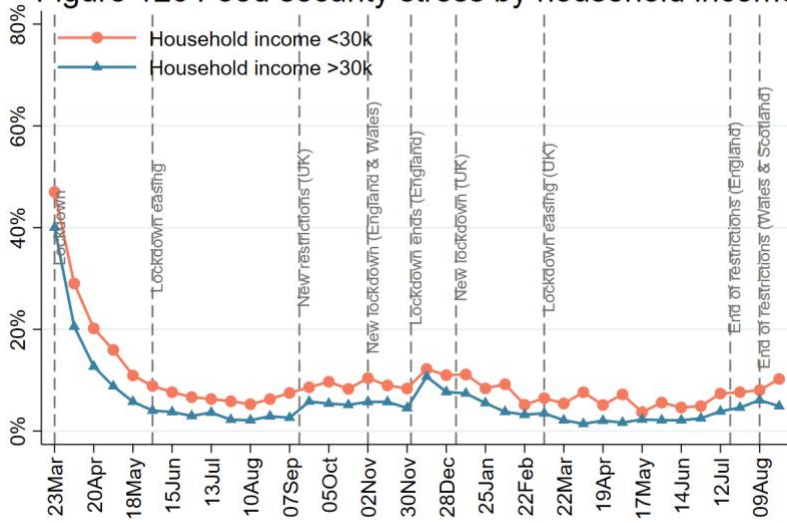
Figure 12d Food security stress by mental health

Figure 12e Food security stress by nations

Figure 12f Food security stress by keyworker status
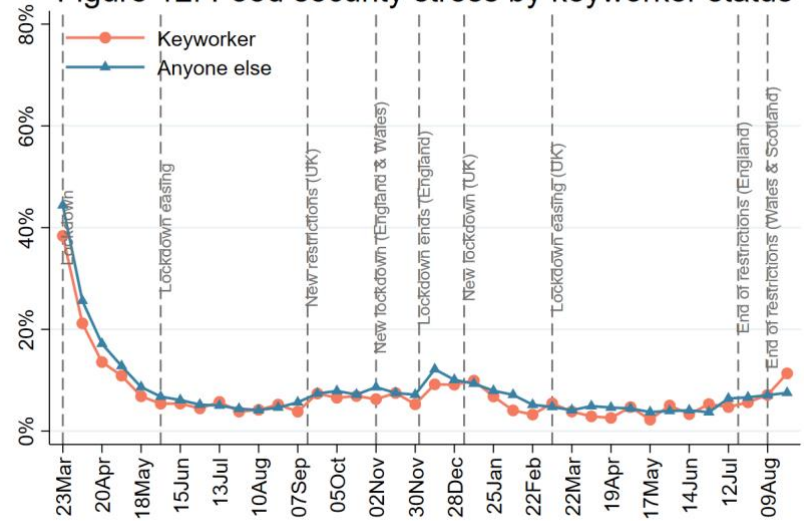
Figure 12g Food security stress by living with children
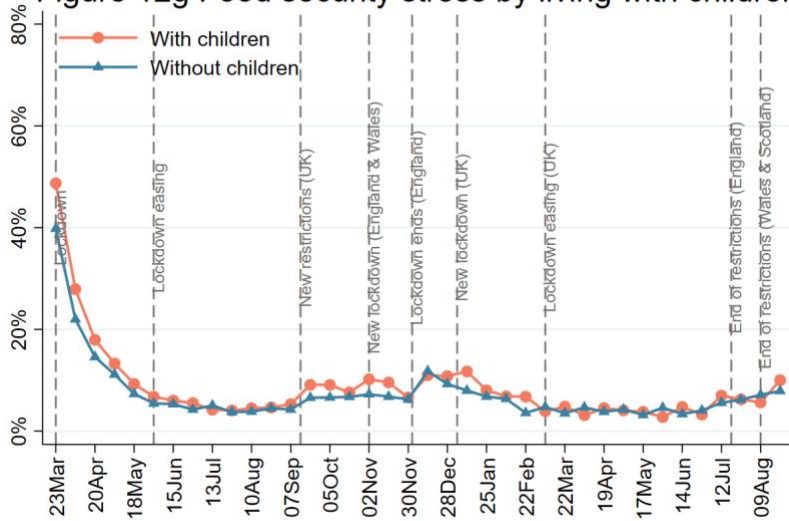
Figure 12h Food security stress by living area
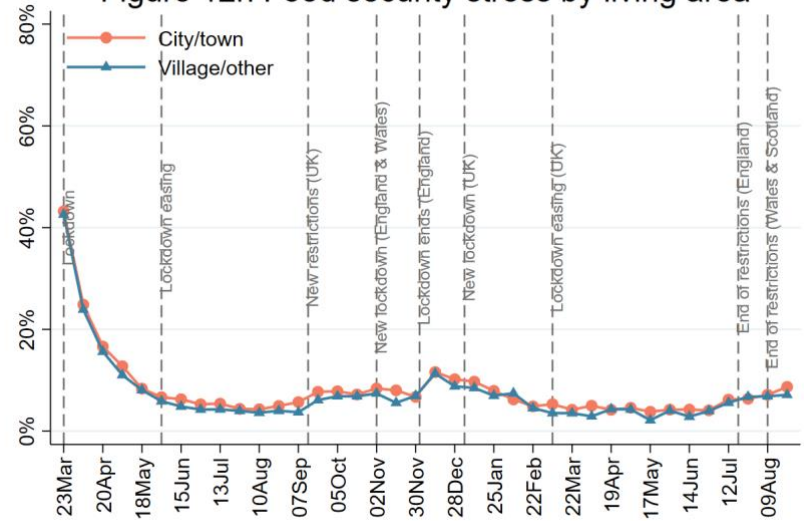
Figure 12i Food security stress by gender
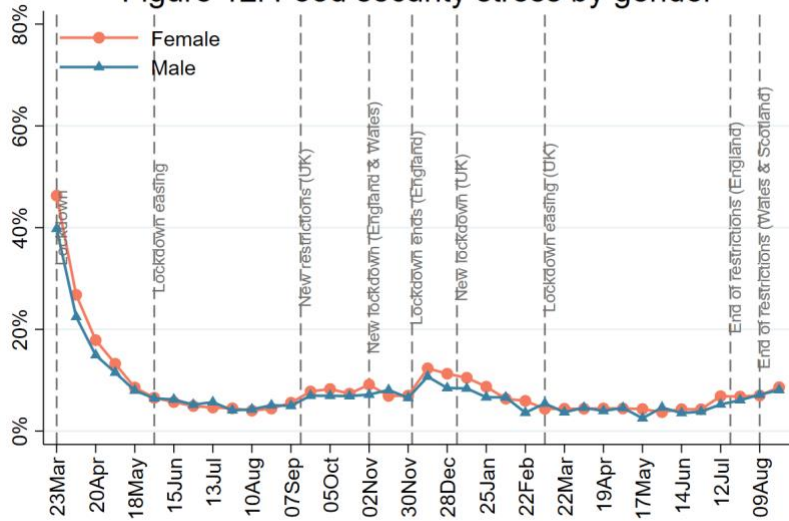
Figure 12j Food security stress by ethnicity
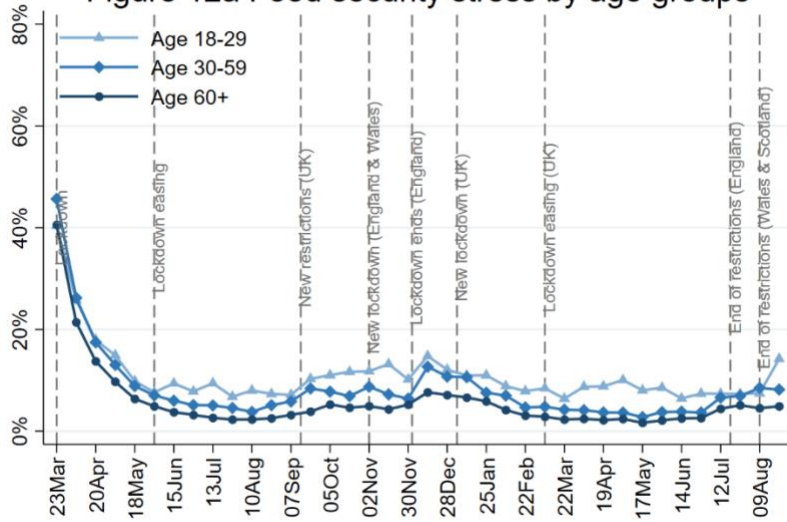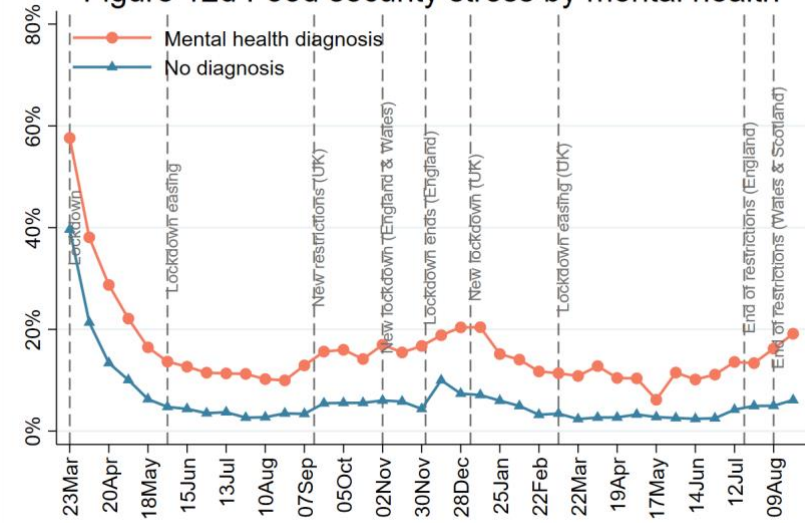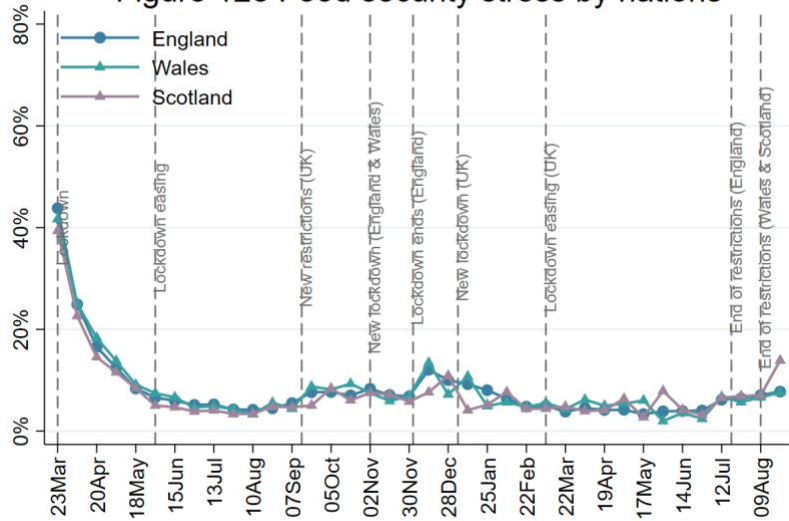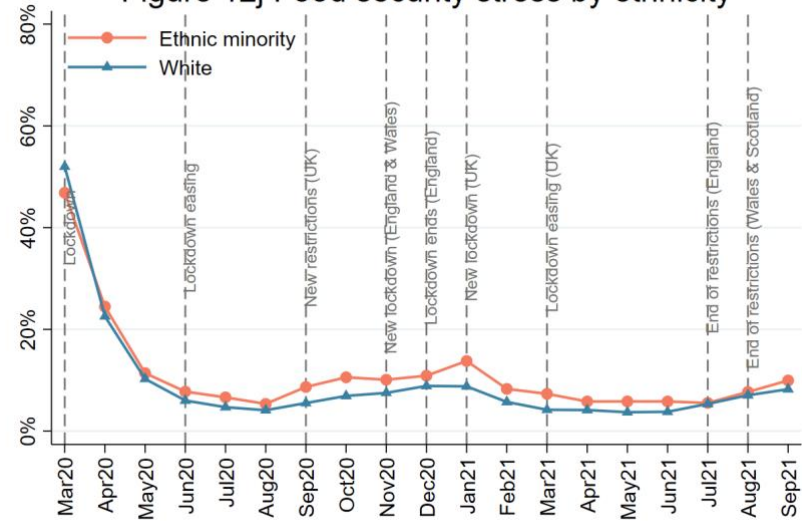

Figure 12k Food security stress by educational levels
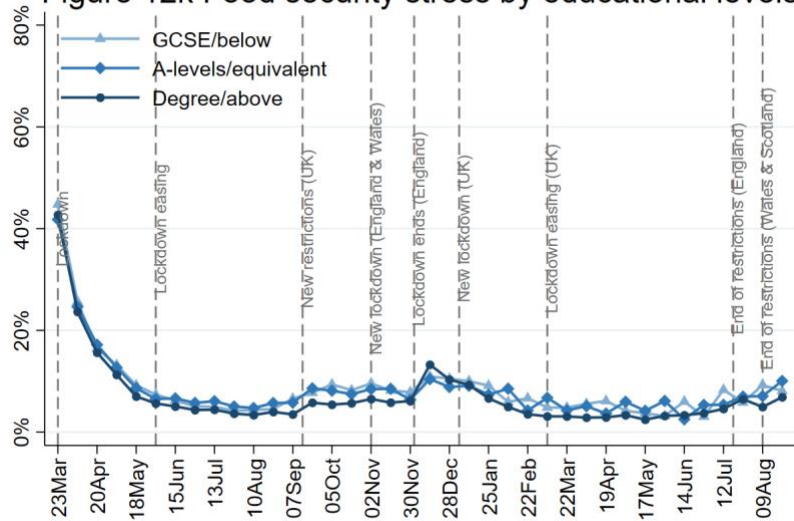
Figure 12l Food security stress by physical health diagnosis
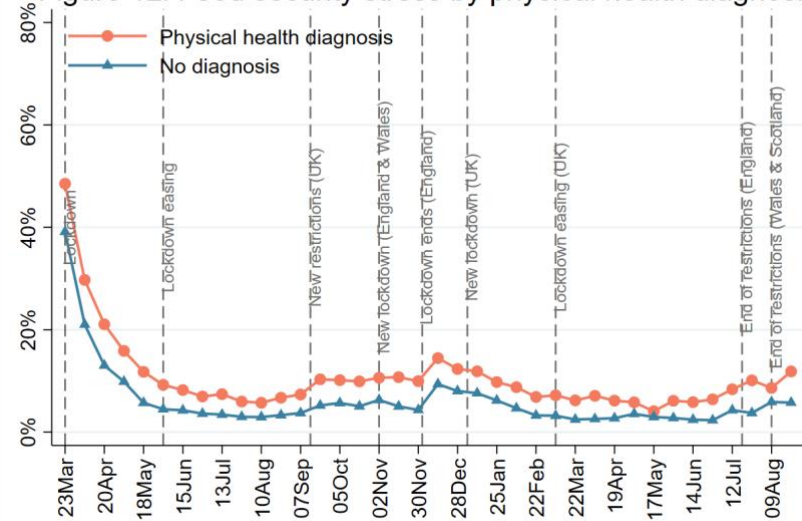
3. Self-harm and abuse

3.1 Thoughts of death or self-harm

Figure 13 Thoughts of death or self-harm
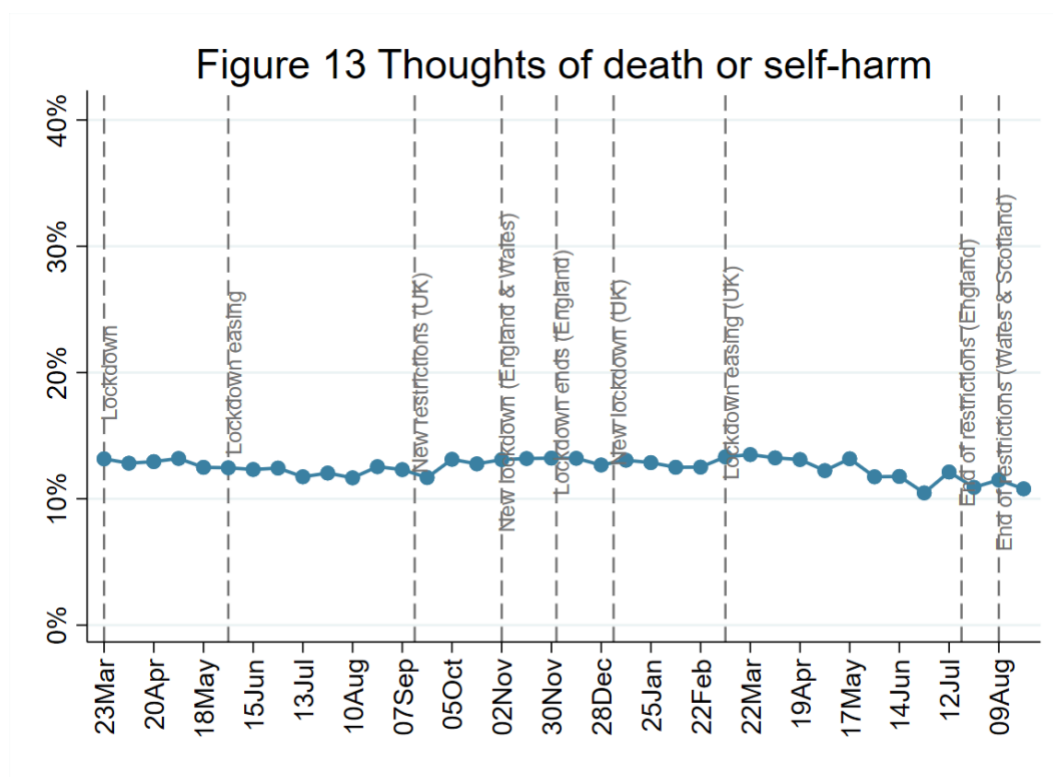
FINDINGS

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

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

People with a mental health diagnosis, people living alone, those with lower incomes, and people with a physical health diagnosis continue to report thoughts of death or self-harm in greater proportions. Thoughts of death or self-harm remain higher than in adults under the age of 30.

Figure 14a Thoughts of death by age groups

Legend:
- Age 18-29
- Age 30-59
- Age 60+
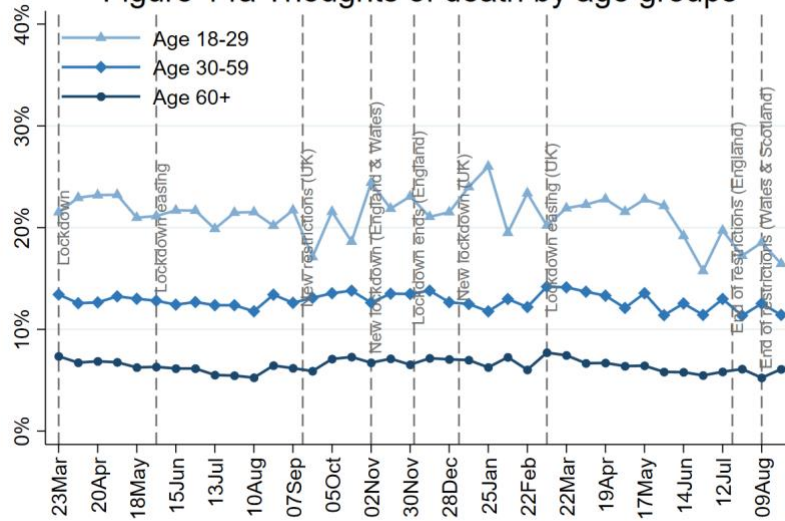
Figure 14b Thoughts of death by living arrangement

Legend:
- Living alone
- Not living alone
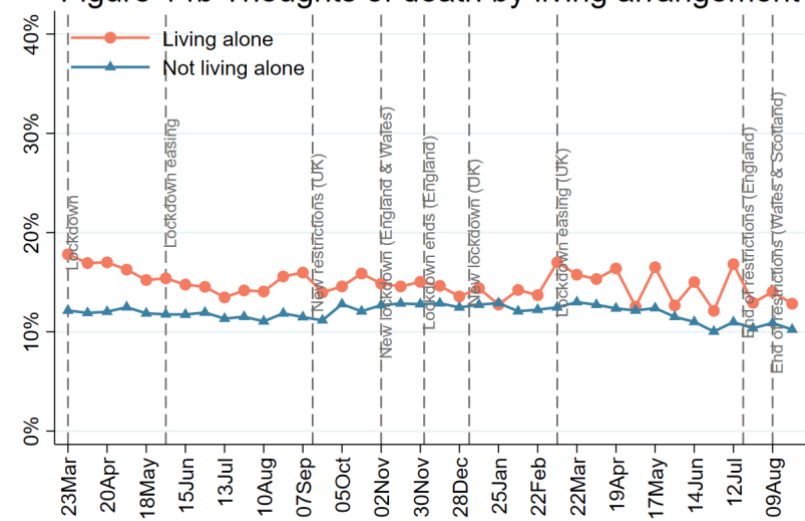
Figure 14c Thoughts of death by household income

Legend:
- Household income <30k
- Household income >30k
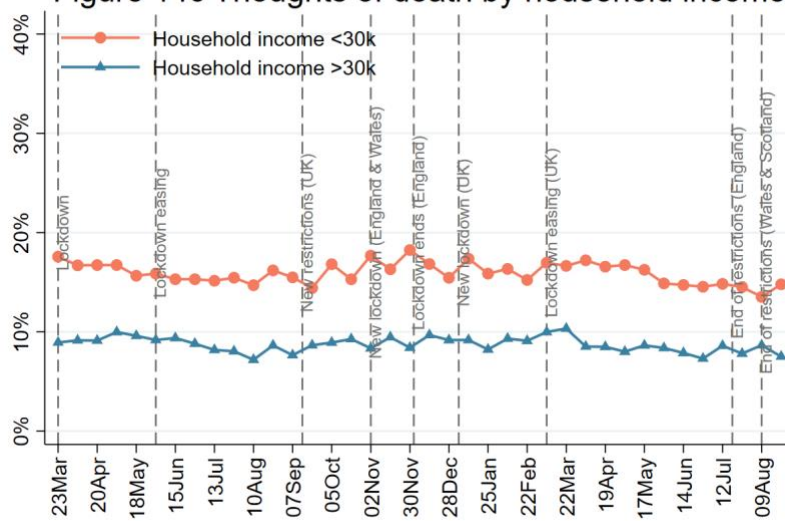
Figure 14d Thoughts of death by mental health diagnosis

Legend:
- Mental health diagnosis
- No diagnosis
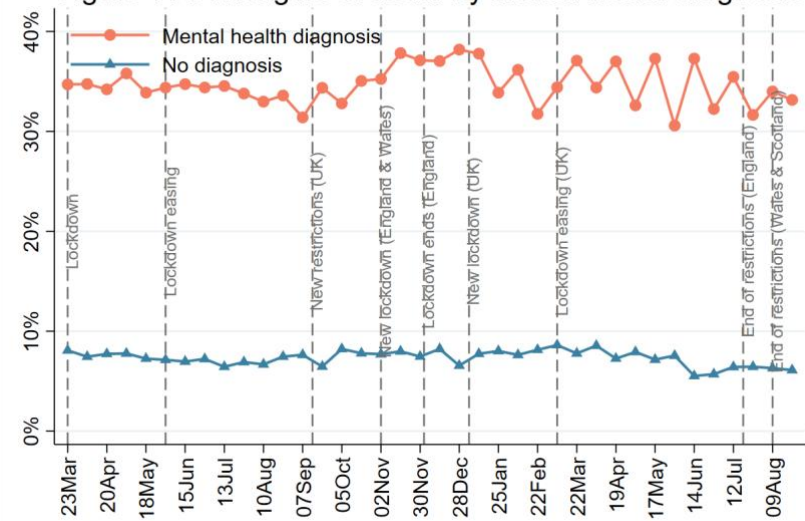
Figure 14e Thoughts of death by nations
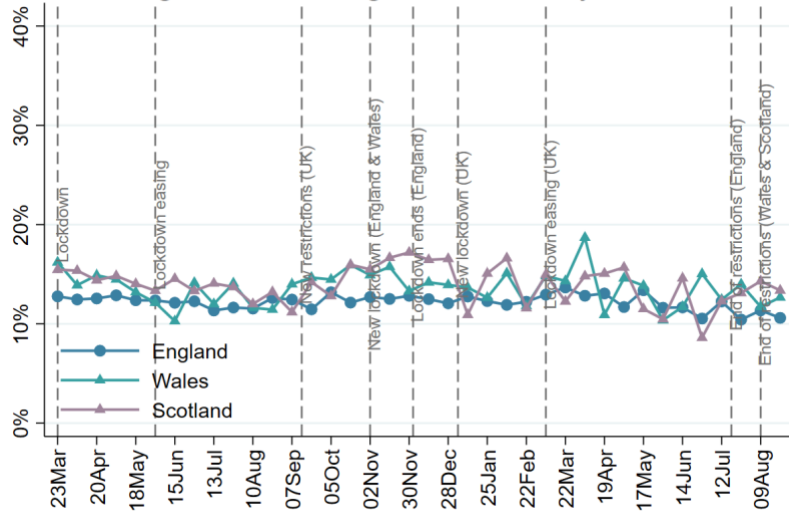
Figure 14f Thoughts of death by keyworker status
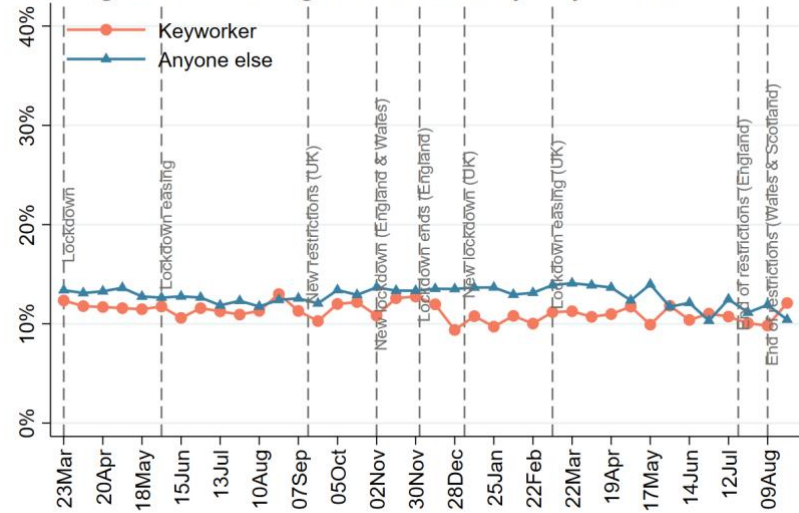
Figure 14g Thoughts of death by living with children
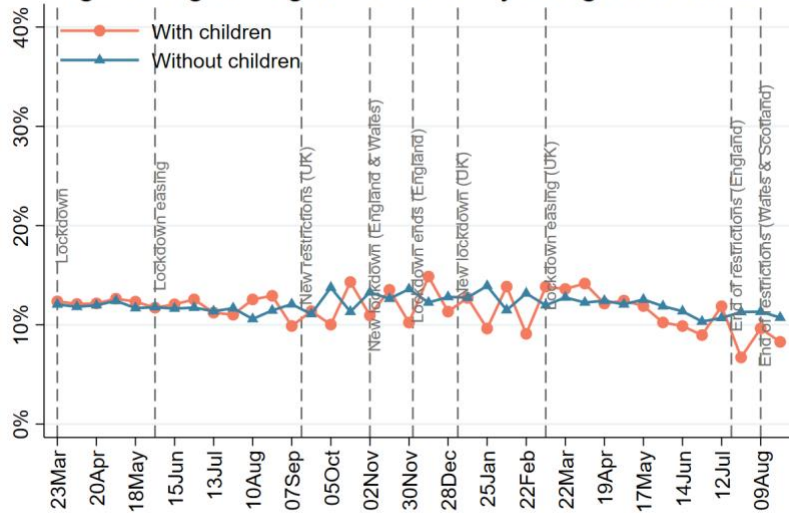
Figure 14h Thoughts of death by living area
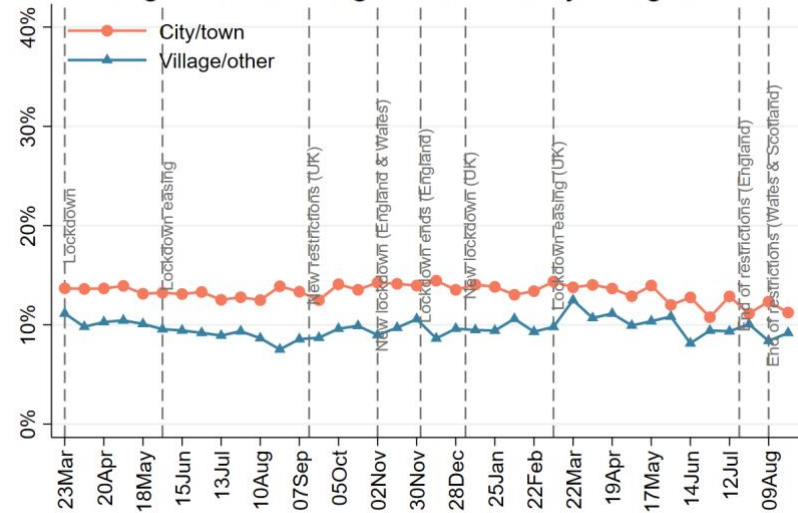
Figure 14i Thoughts of death by gender
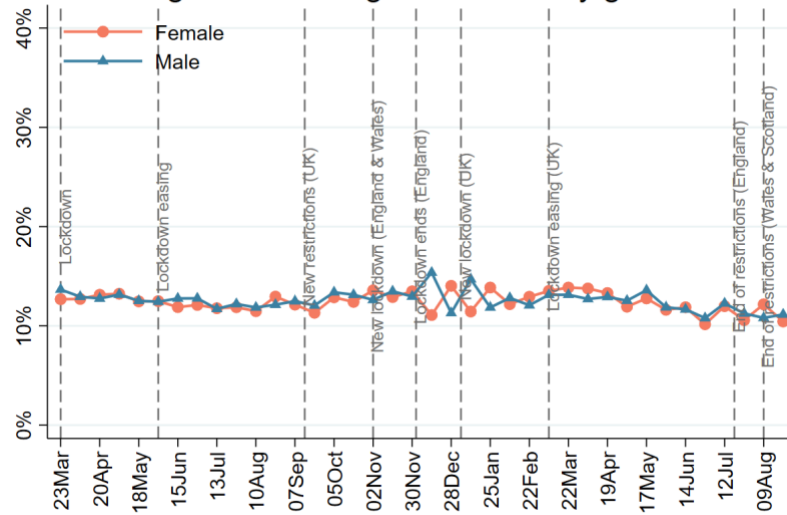
Figure 14j Thoughts of death by ethnicity
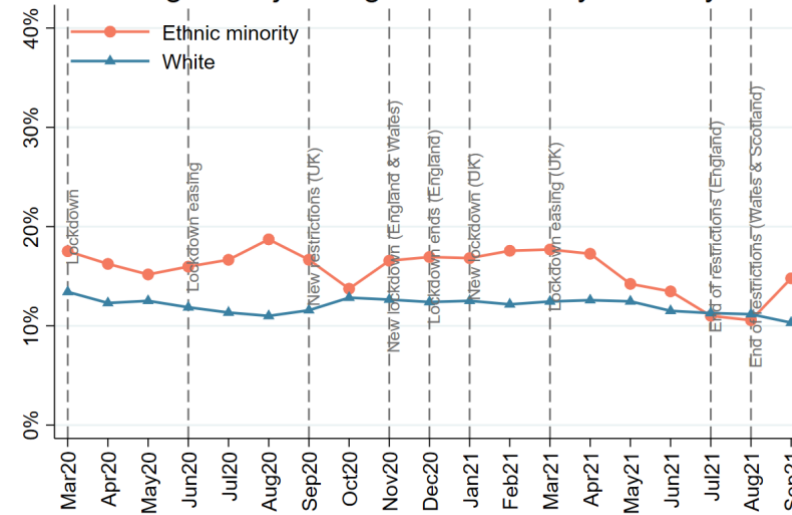
Figure 14k Thoughts of death by educational levels
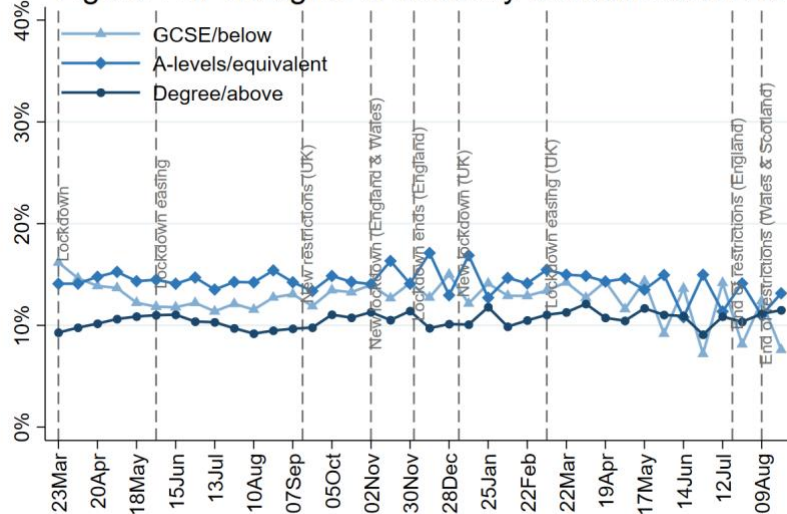
Figure 14l Thoughts of death by physical health diagnosis
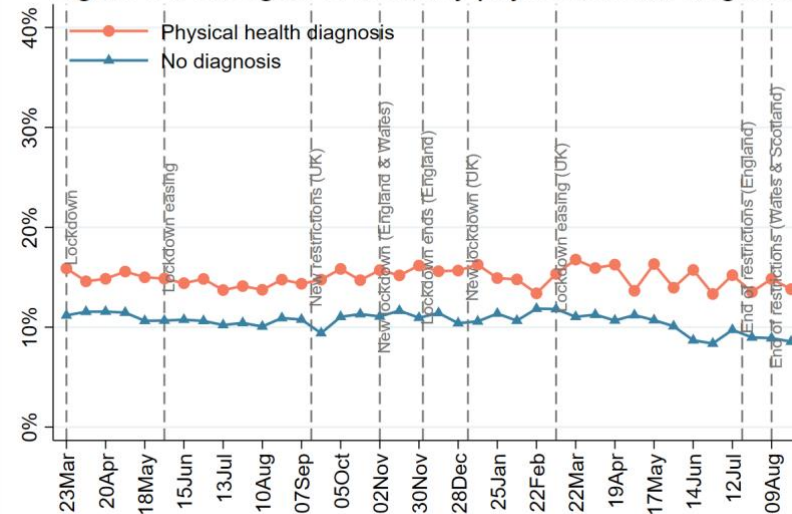
3.2 Self-harm

Figure 15 Self-harm
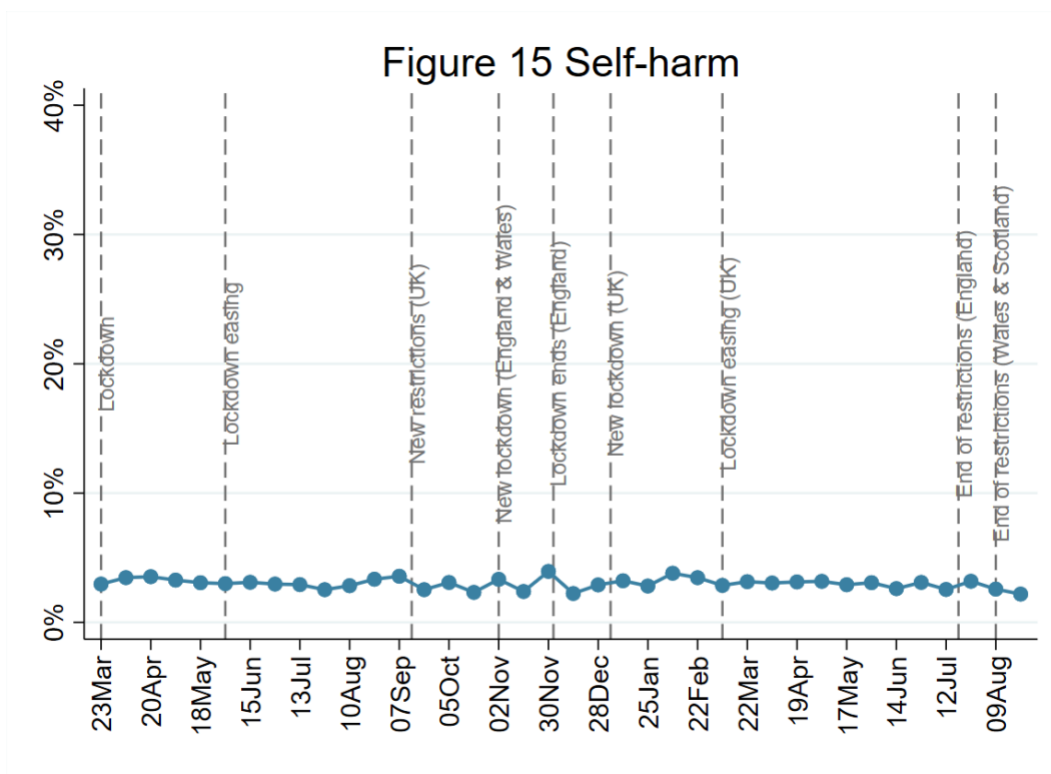
FINDINGS

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

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

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[4].

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

Figure 16a Self-harm by age groups
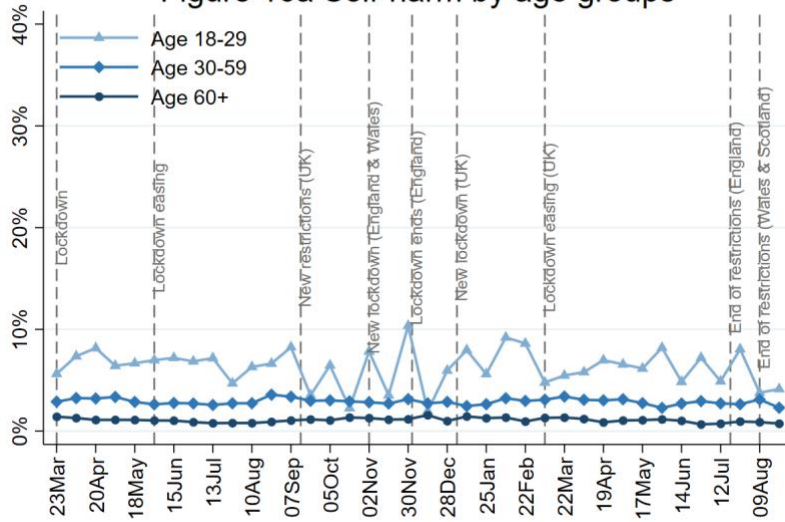
Figure 16b Self-harm by living arrangement
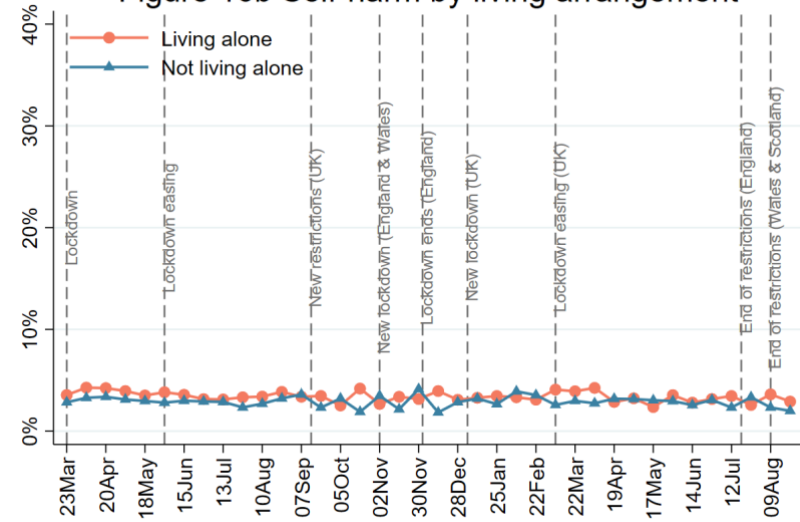
Figure 16c Self-harm by household income
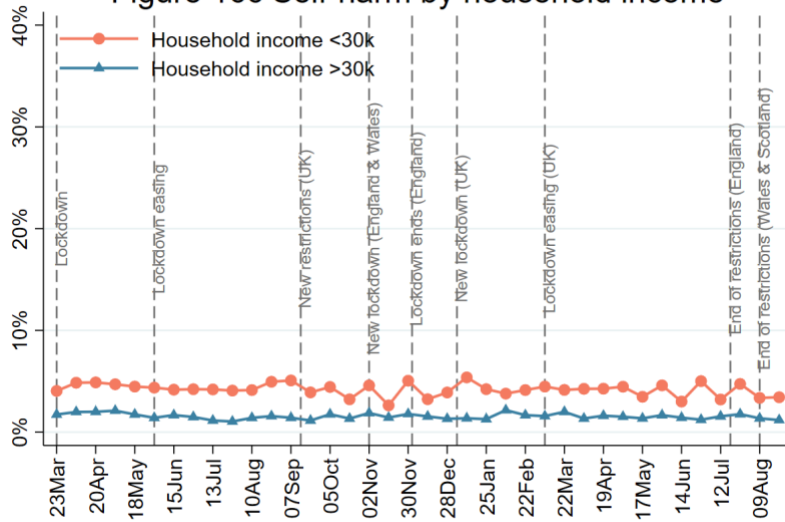
Figure 16d Self-harm by mental health diagnosis

40
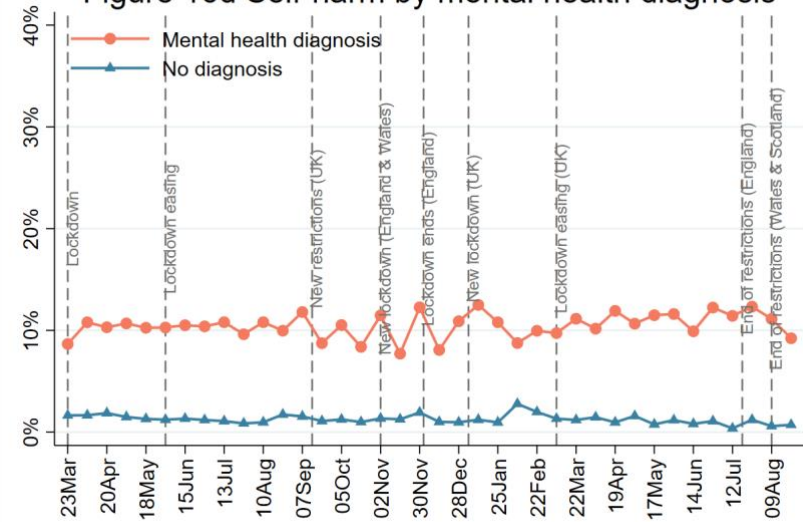
Figure 16e Self-harm by nations
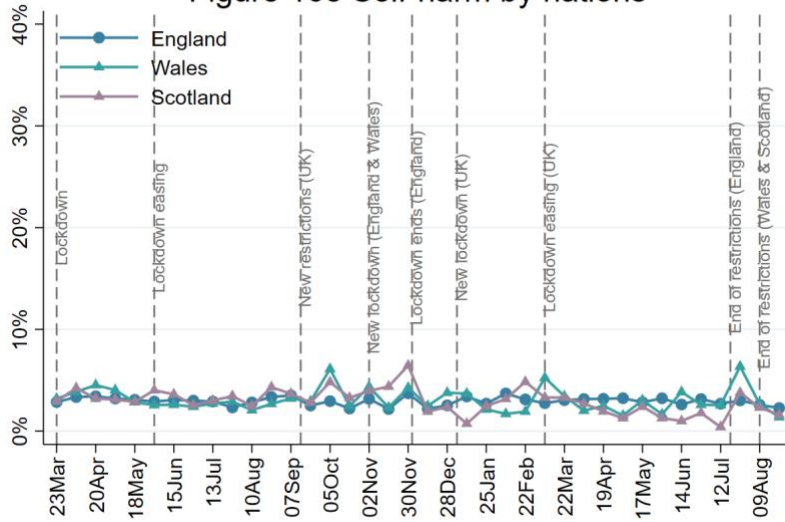
Figure 16f Self-harm by keyworker status
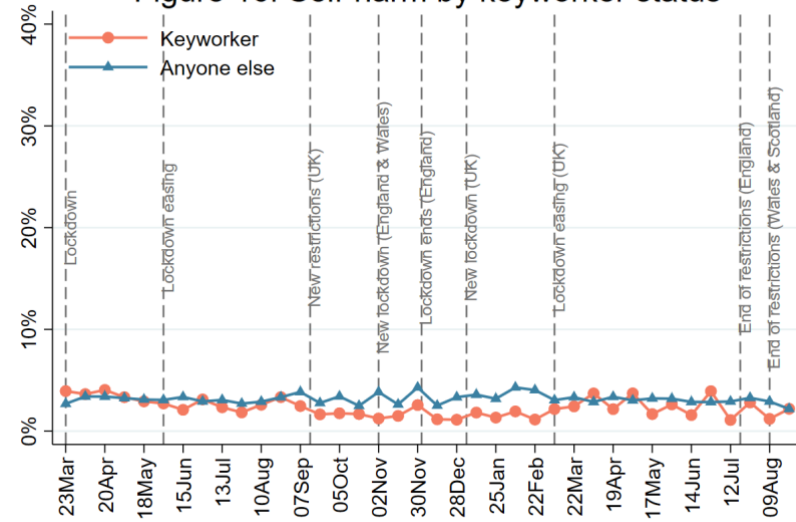
Figure 16g Self-harm by living with children
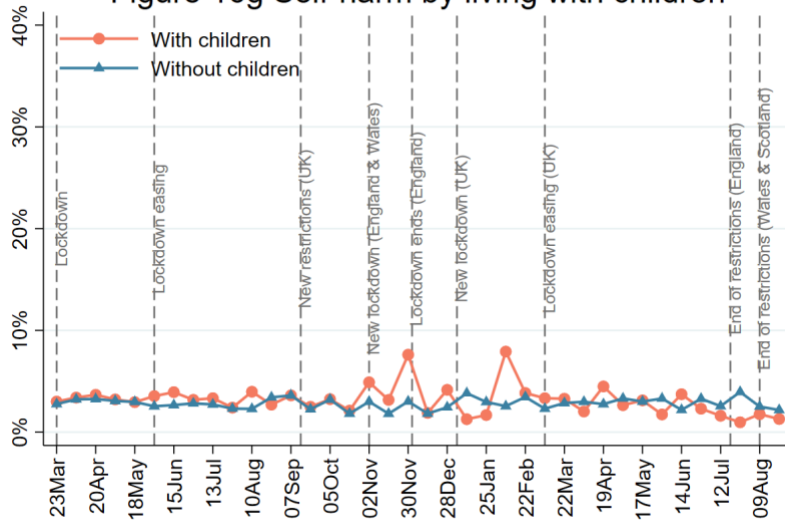
Figure 16h Self-harm by living area
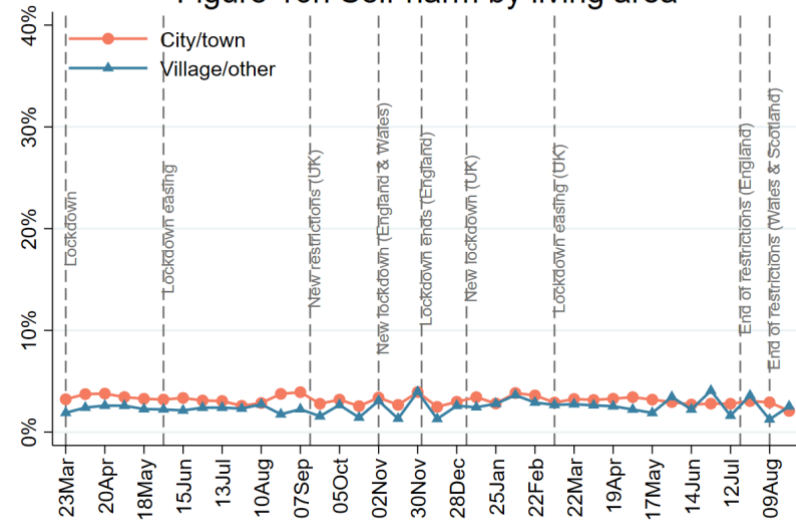
Figure 16i Self-harm by gender
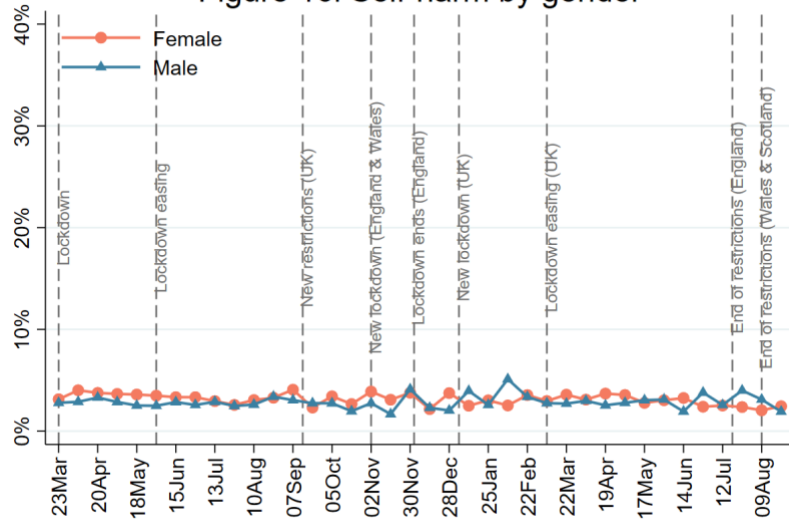
Figure 16j Self-harm by ethnicity
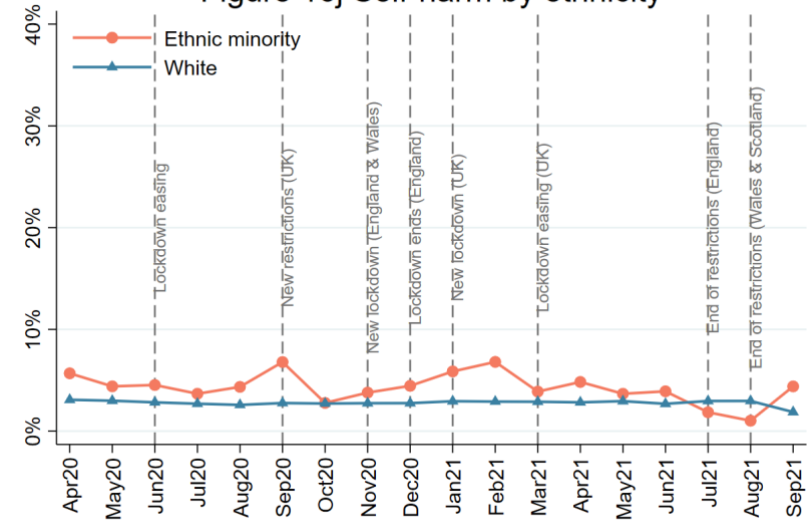
Figure 16k Self-harm by educational levels
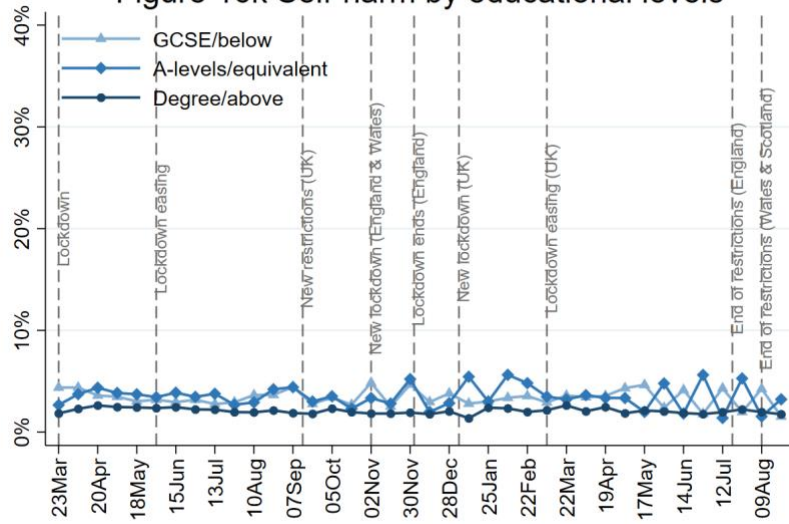
Figure 16l Self-harm by physical health diagnosis

3.3 Abuse

Figure 17 Being physically or psychologically abused
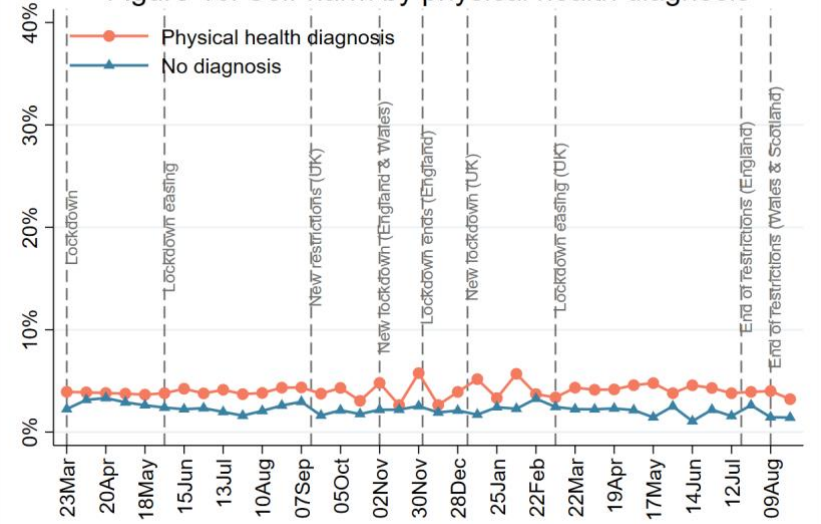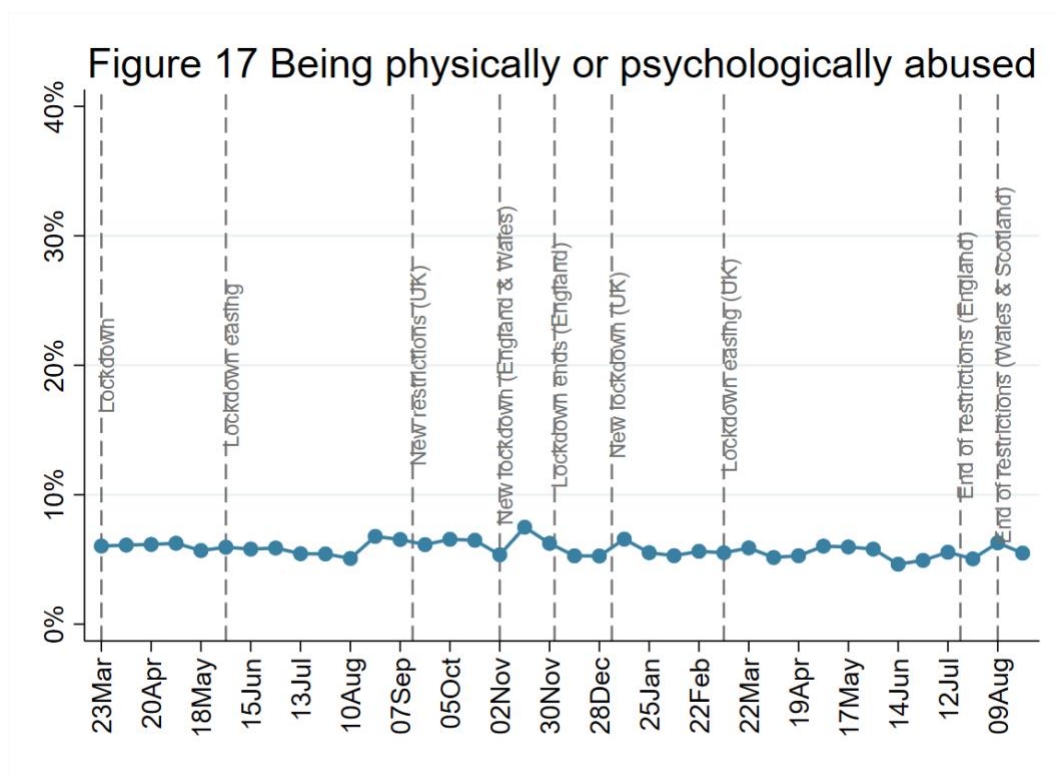
FINDINGS

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

Reports of abuse have continued to remain relatively stable over the course of the pandemic, although there have been small fluctuations over the past three months. They are more common amongst people with lower household income, and in people with a mental or physical health diagnosis.

It should be noted that not all people who experienced physical or psychological abuse will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels[5].

---

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

Figure 18a Abuse by age groups

Legend: Age 18-29, Age 30-59, Age 60+
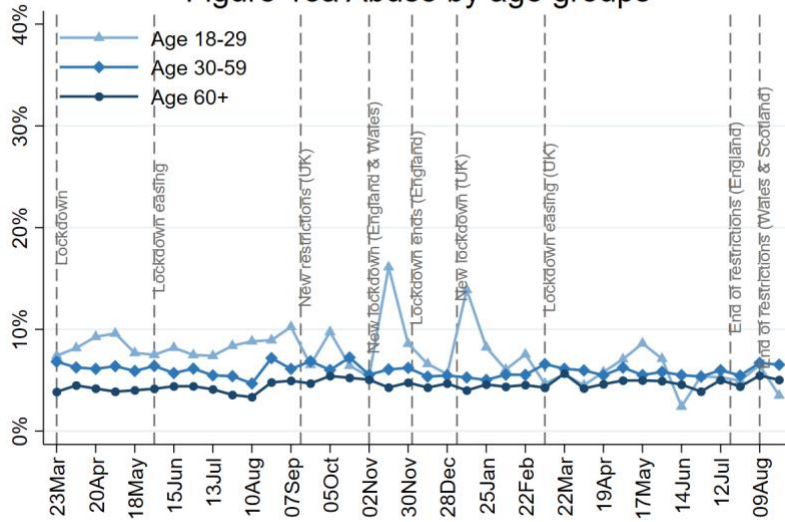
Figure 18b Abuse by living arrangement

Legend: Living alone, Not living alone
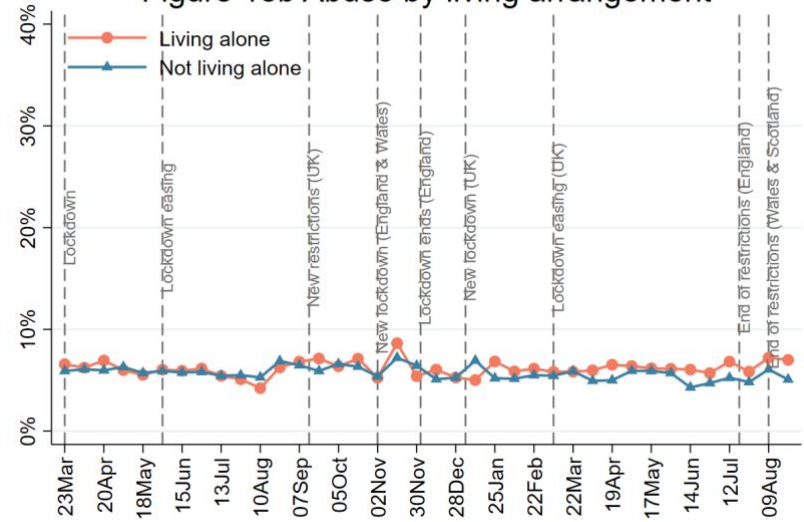
Figure 18c Abuse by household income

Legend: Household income <30k, Household income >30k
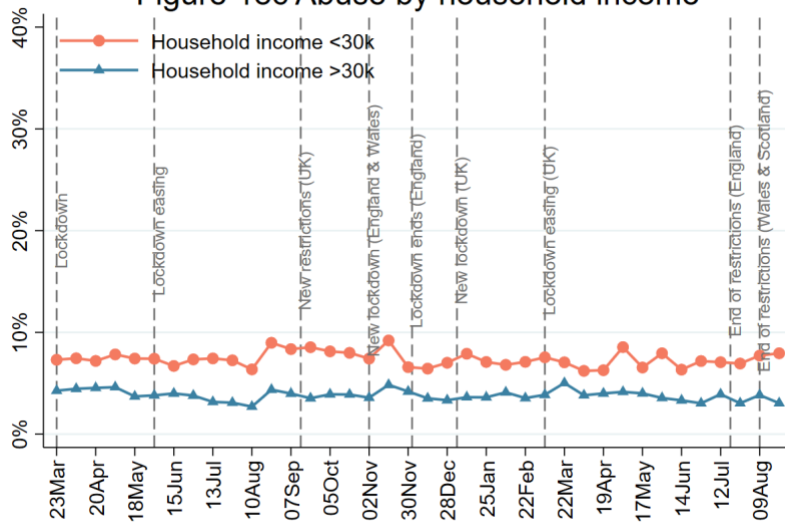
Figure 18d Abuse by mental health diagnosis

Legend: Mental health diagnosis, No diagnosis

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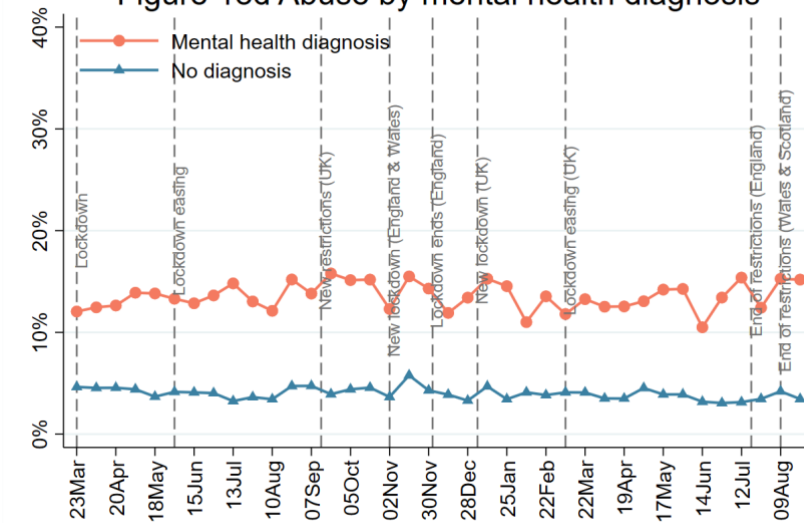
Figure 18e Abuse by nations
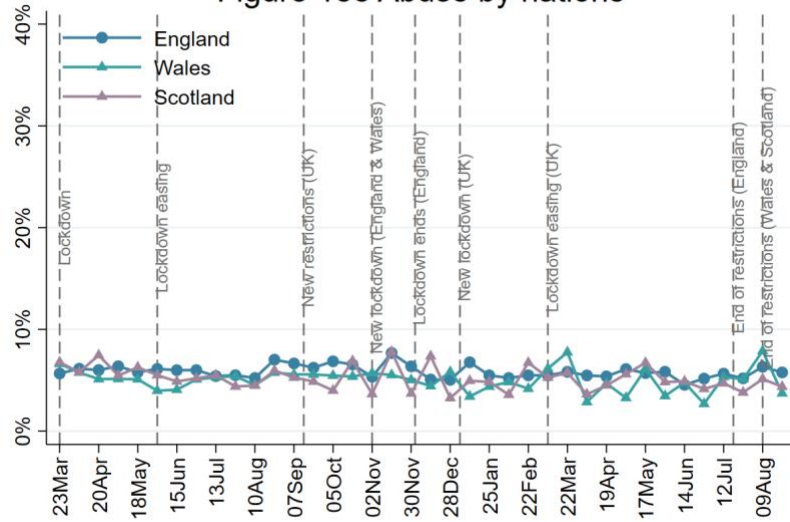
Figure 18f Abuse by keyworker status
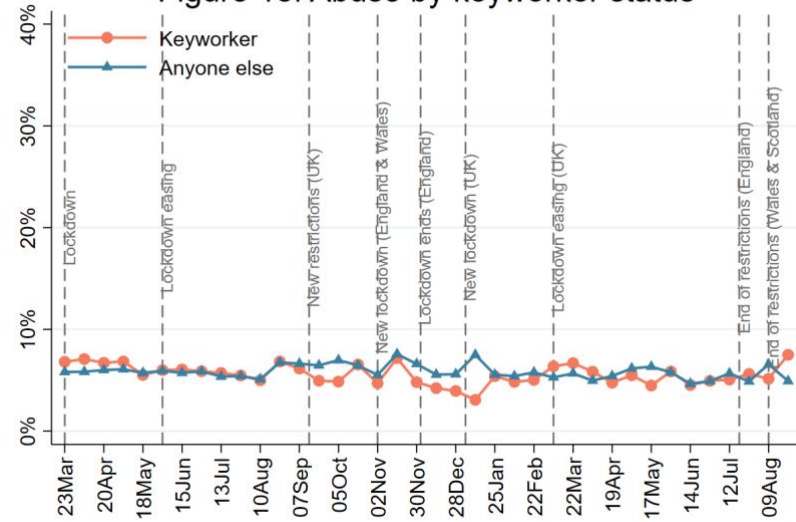
Figure 18g Abuse by living with children
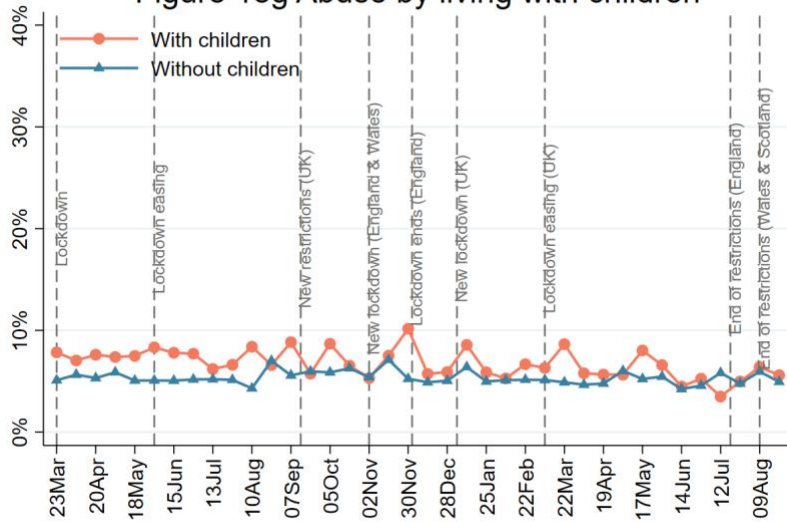
Figure 18h Abuse by living area
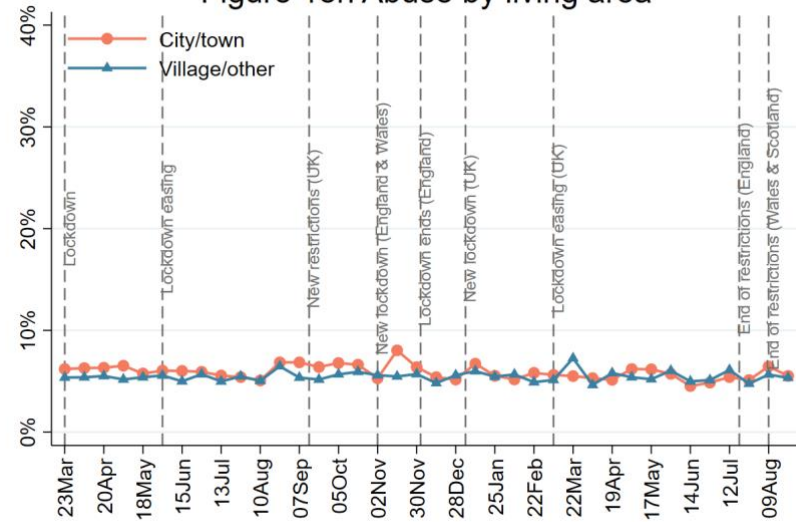
Figure 18i Abuse by gender
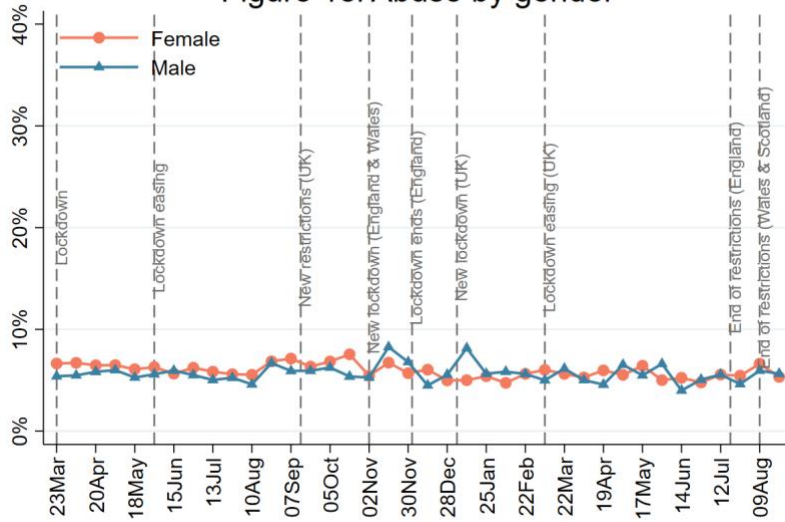
Figure 18j Abuse by ethnicity
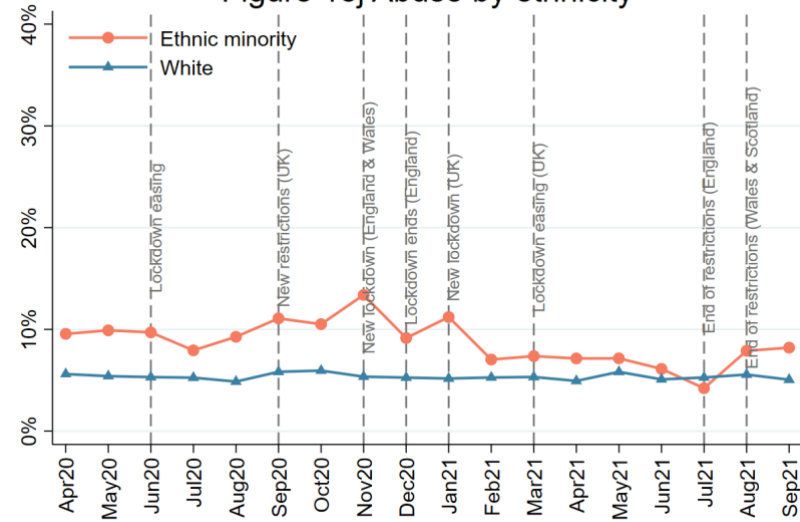
Figure 18k Abuse by educational levels
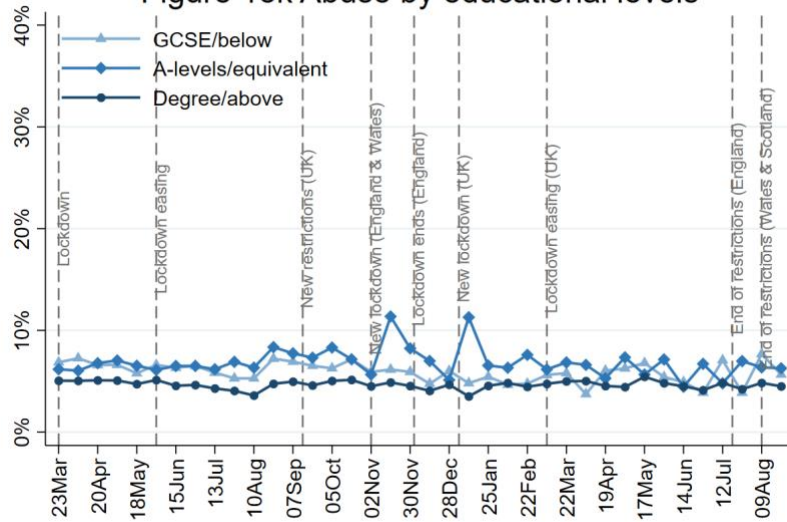
Figure 18l Abuse by physical health diagnosis
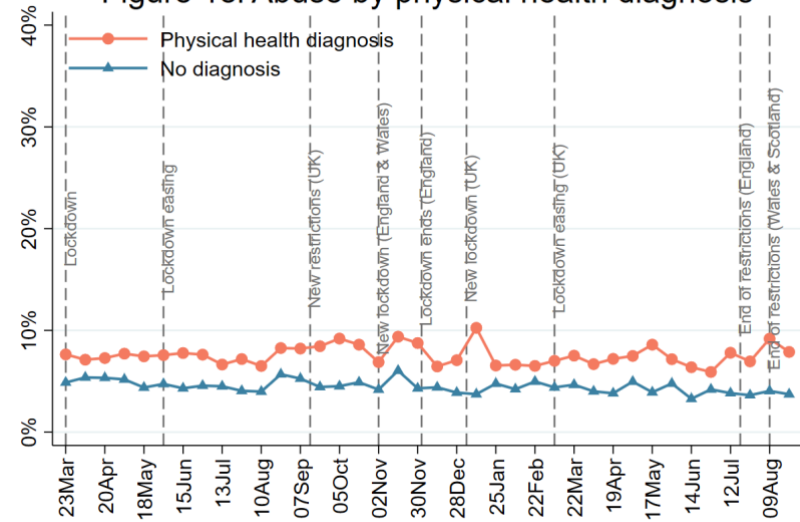
4. General well-being

4.1 Life satisfaction

Figure 19 Life satisfaction
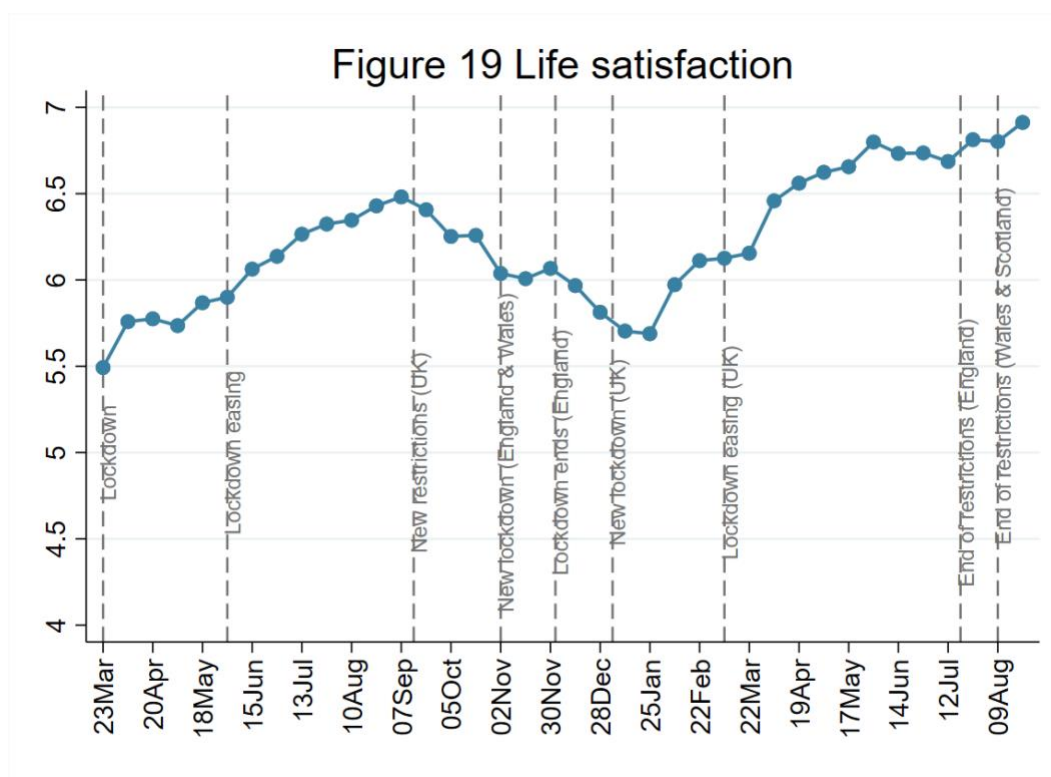
FINDINGS

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

Life satisfaction has been increasing since the ending of restrictions in July of 2020 and is now higher than it ever has been during this study. These increases in life satisfaction have generally been seen across all demographic groups.

People living alone, young adults, those with a mental health diagnosis, those with lower household incomes, people living in urban areas, people with a physical health diagnosis, and those from ethnic minority groups (although smaller sample sizes compared to people with white ethnicity mean there has been greater volatility in these data) continue to report lower levels of life satisfaction.

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

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

Figure 20a Life satisfaction by age groups

Legend:
- Age 18-29
- Age 30-59
- Age 60+
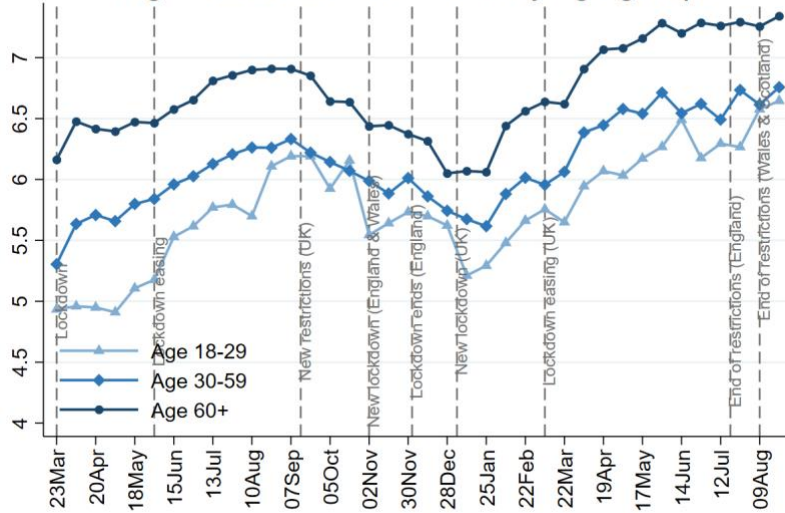
Figure 20b Life satisfaction by living arrangement

Legend:
- Living alone
- Not living alone
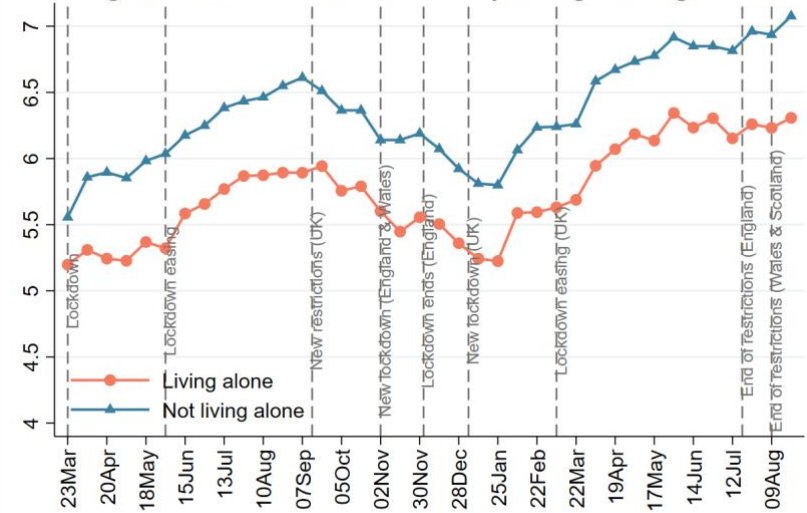
Figure 20c Life satisfaction by household income

Legend:
- Household income <30k
- Household income >30k
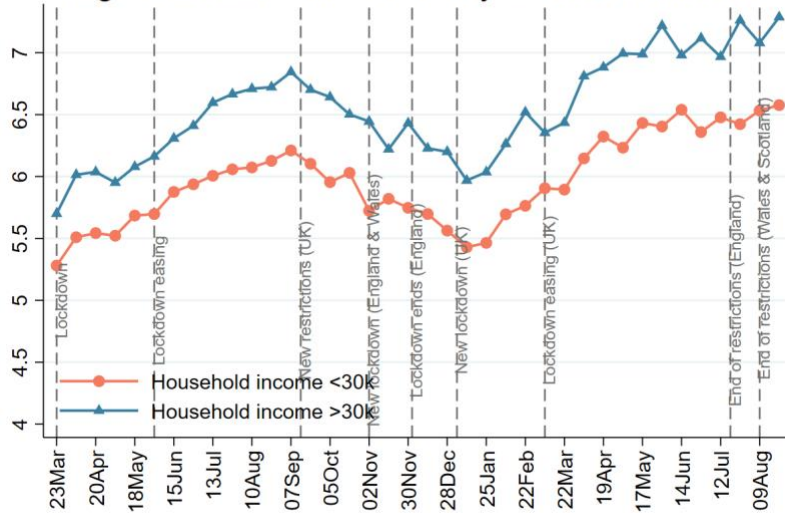
Figure 20d Life satisfaction by mental health diagnosis

Legend:
- Mental health diagnosis
- No diagnosis
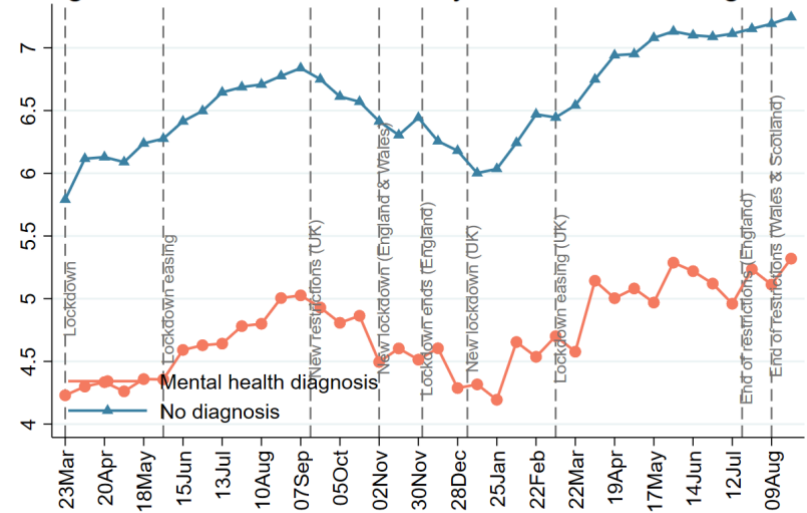
Figure 20e Life satisfaction by nations
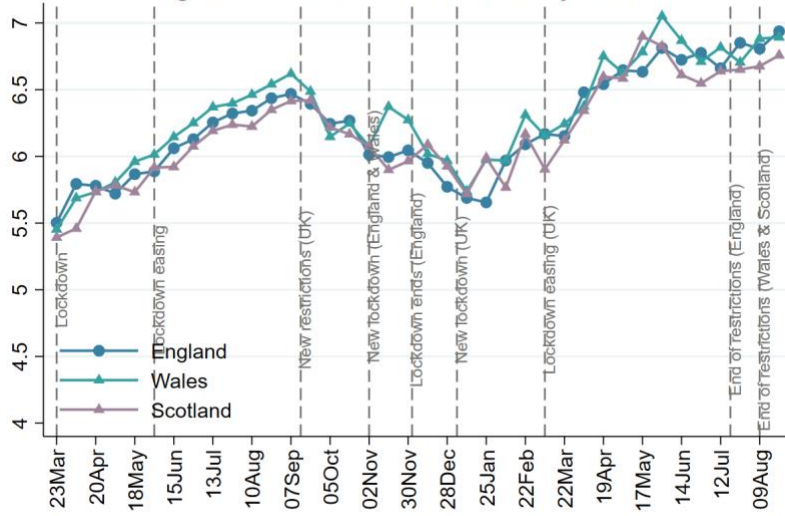
Figure 20f Life satisfaction by keyworker status
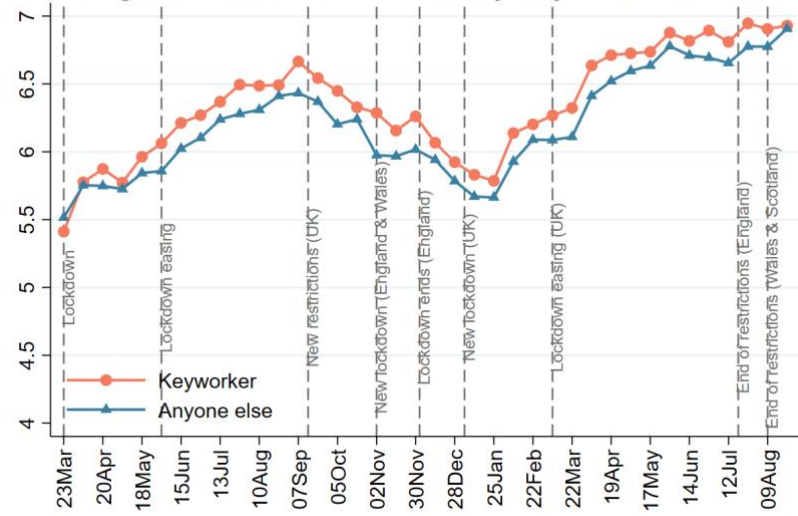
Figure 20g Life satisfaction by living with children
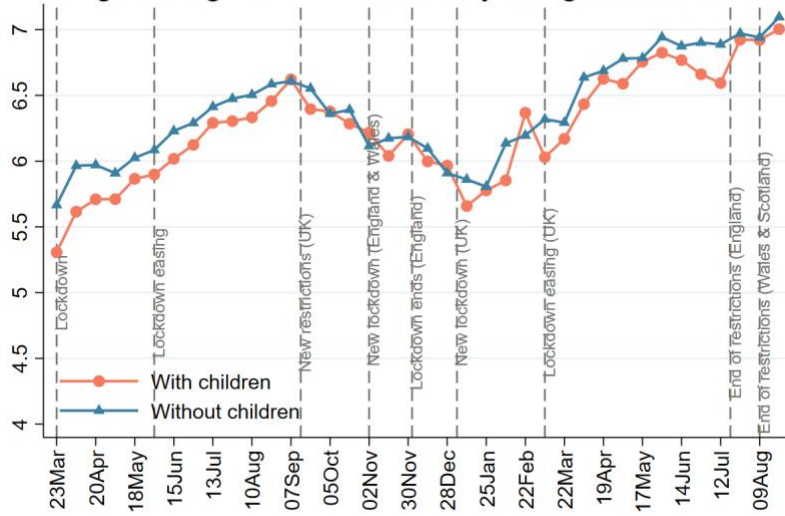
Figure 20h Life satisfaction by living area
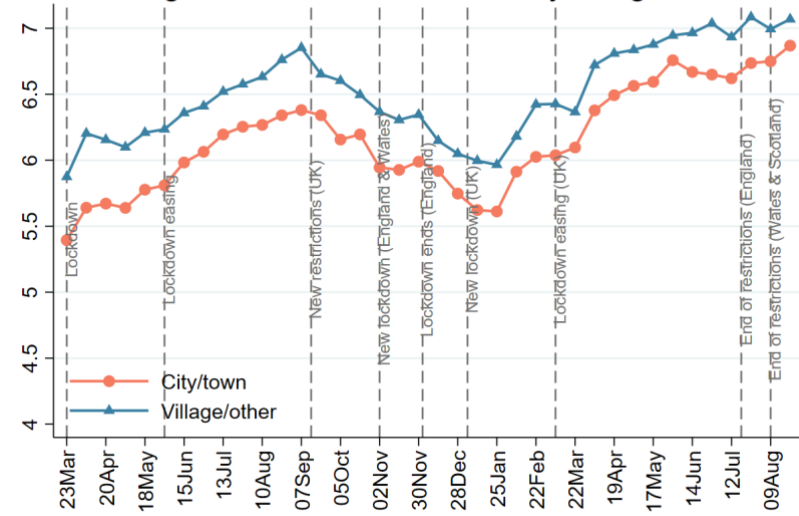
Figure 20i Life satisfaction by gender
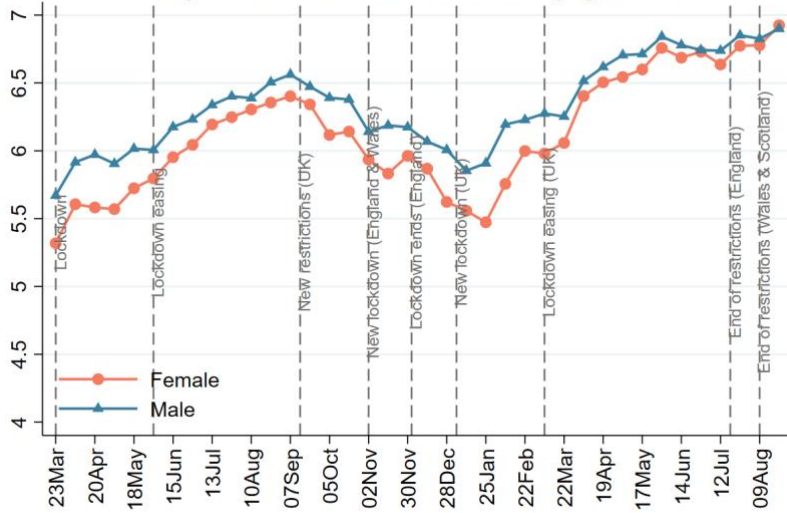
Figure 20j Life satisfaction by ethnicity
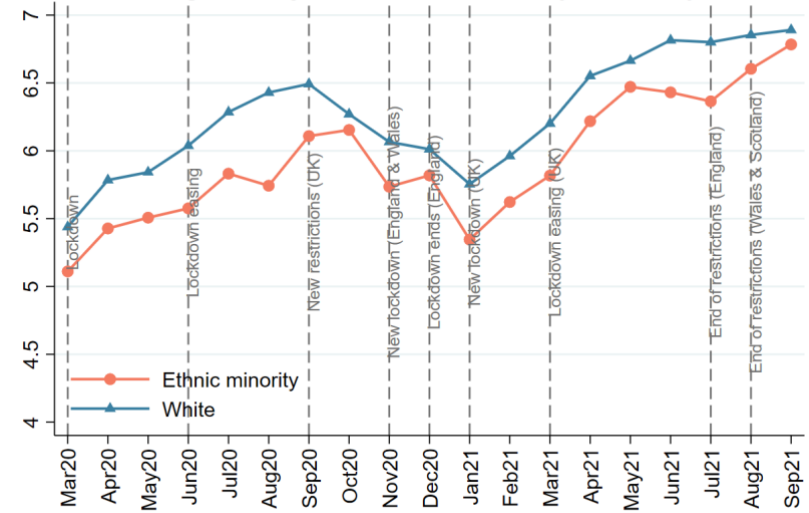
Figure 20k Life satisfaction by educational levels
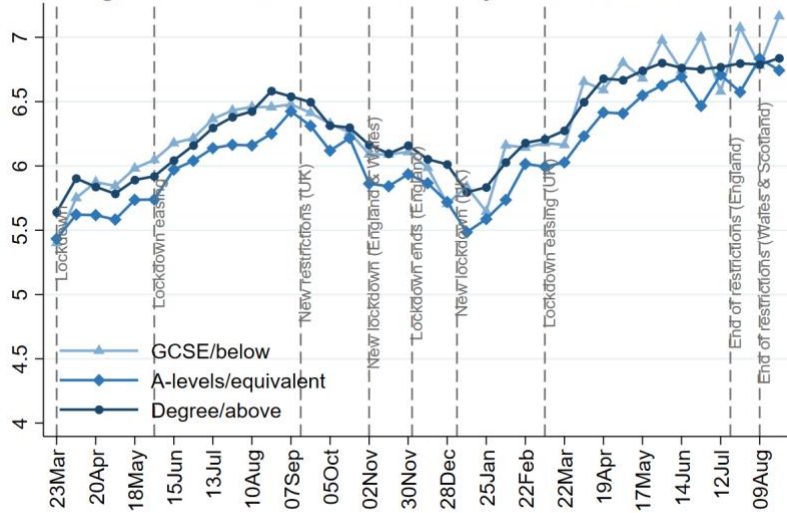
Figure 20l Life satisfaction by physical health diagnosis

4.2 Loneliness
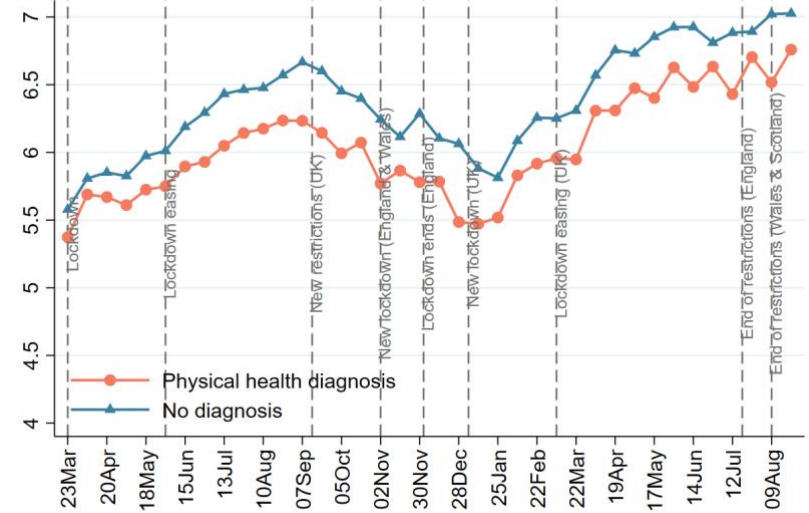
Figure 21 Loneliness
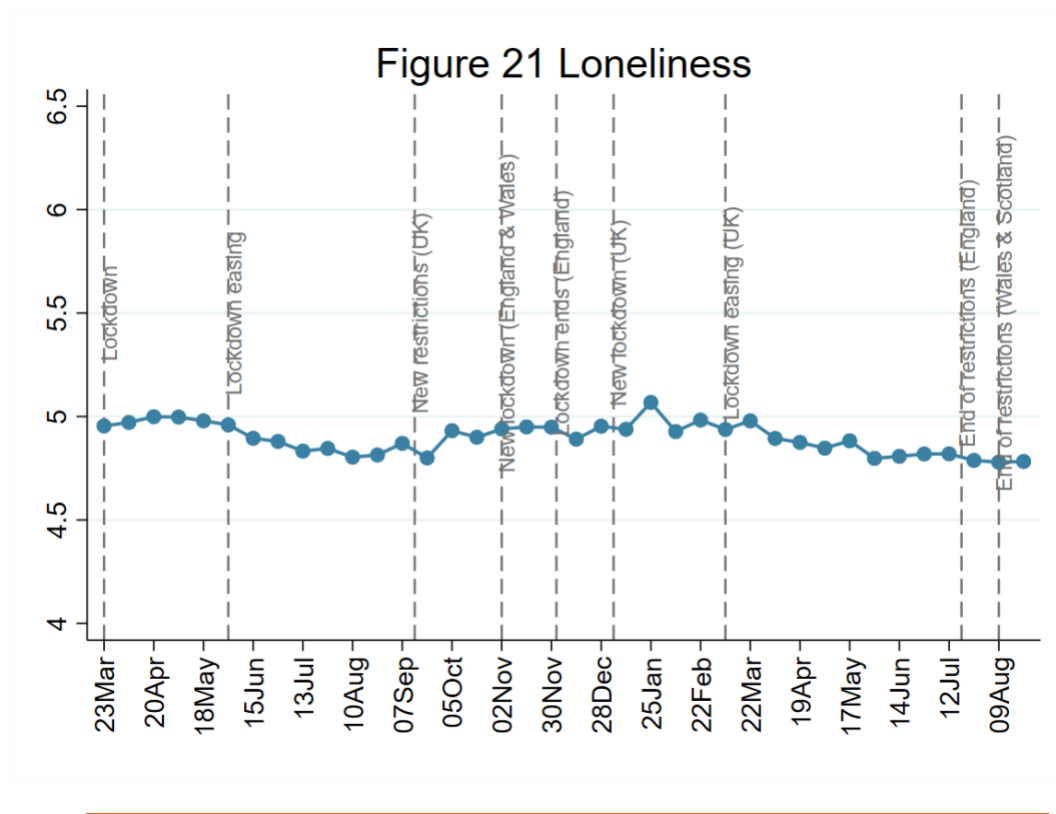
FINDINGS

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

Loneliness levels have been decreasing steadily since the beginning of March 2021 and are now slightly lower than what they were in the summer of 2020. Loneliness remains highest in young adults, people living alone, those with a mental health diagnosis, people with lower household income, amongst those from ethnic minority groups, women, and those living in urban areas.

Figure 22a Loneliness by age groups

Figure 22b Loneliness by living arrangement

Figure 22c Loneliness by household income

Figure 22d Loneliness by mental health diagnosis
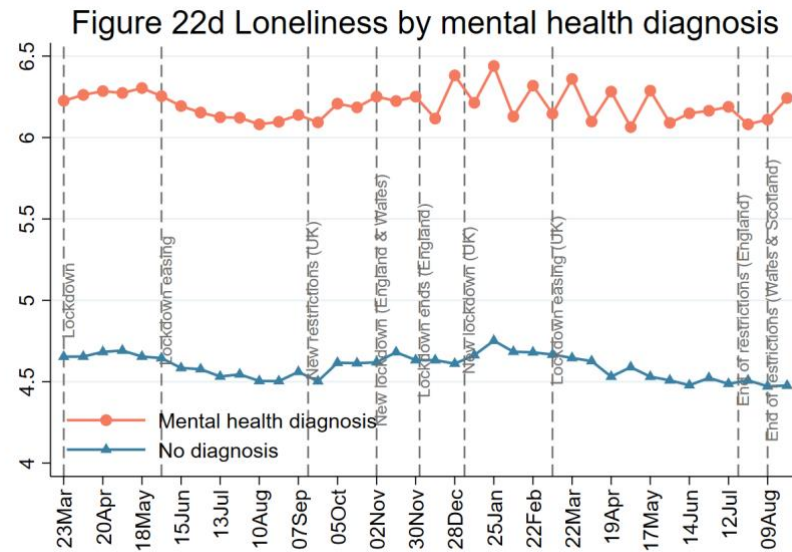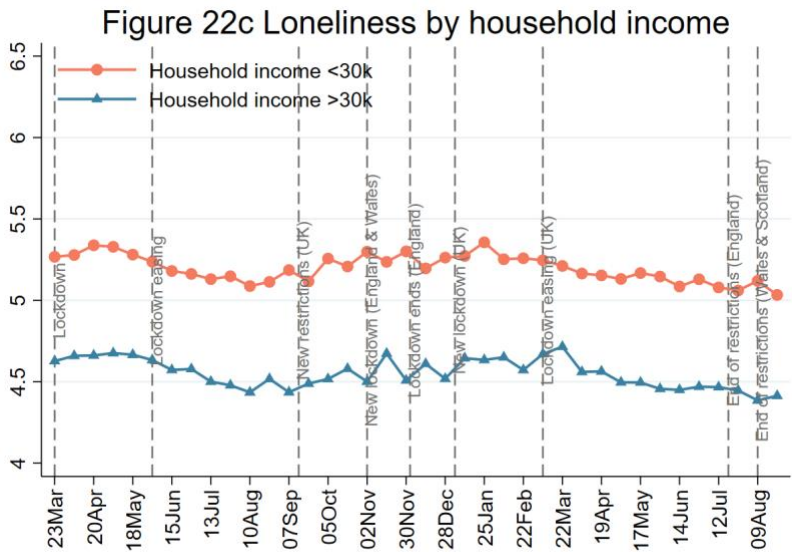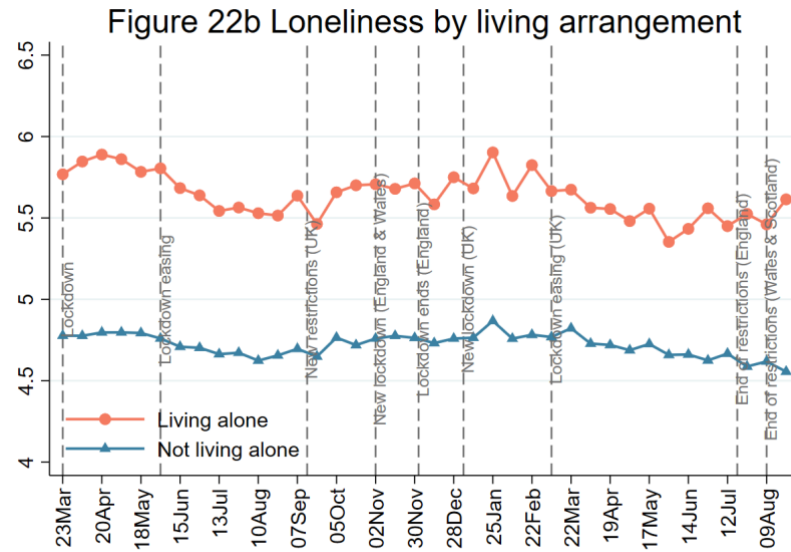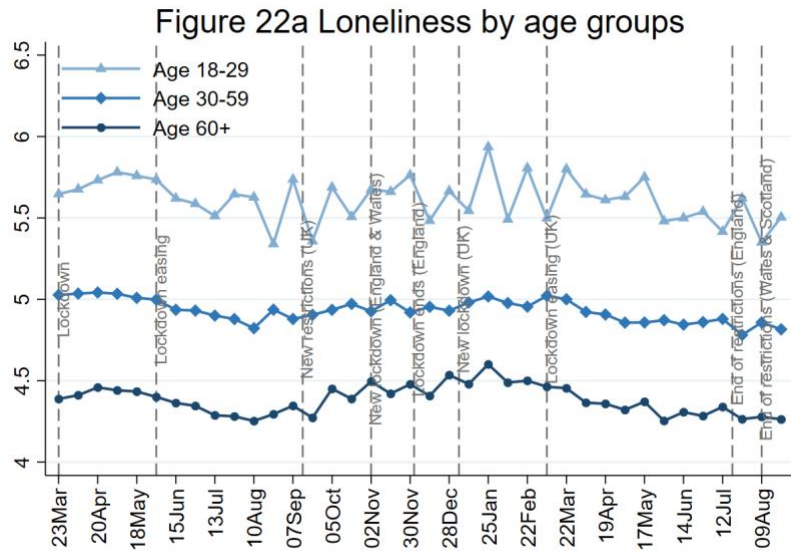
Figure 22e Loneliness by nations
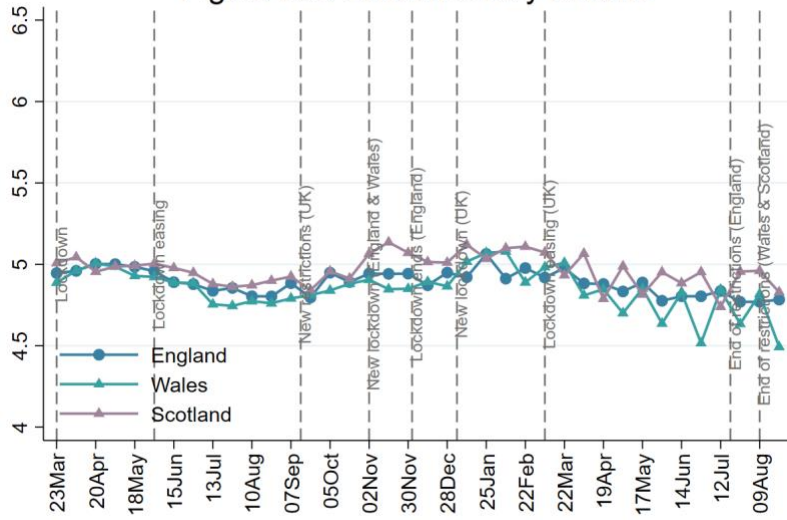
Figure 22f Loneliness by keyworker status
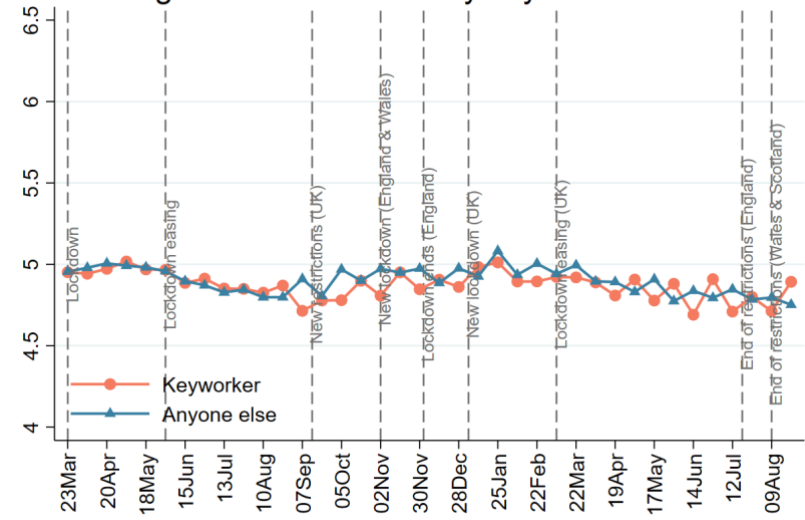
Figure 22g Loneliness by living with children
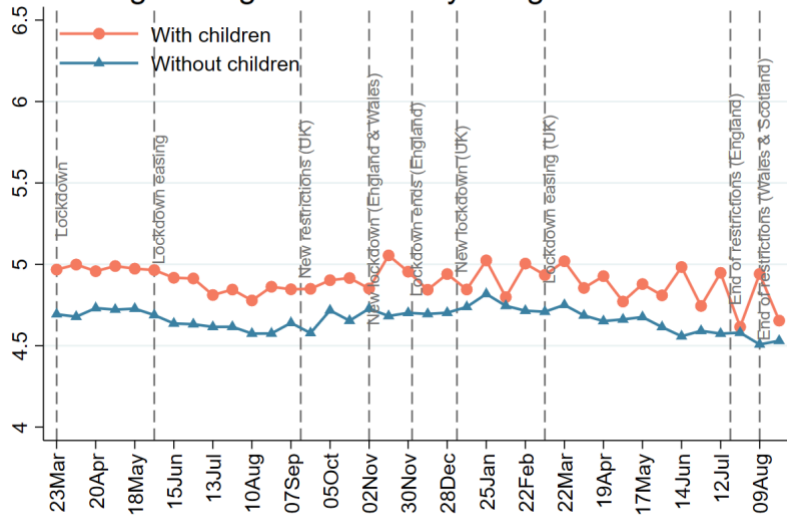
Figure 22h Loneliness by living area
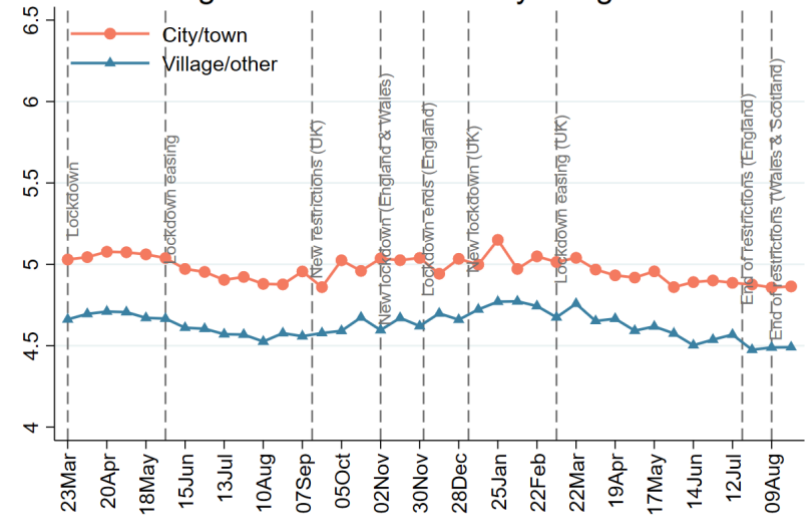
Figure 22i Loneliness by gender
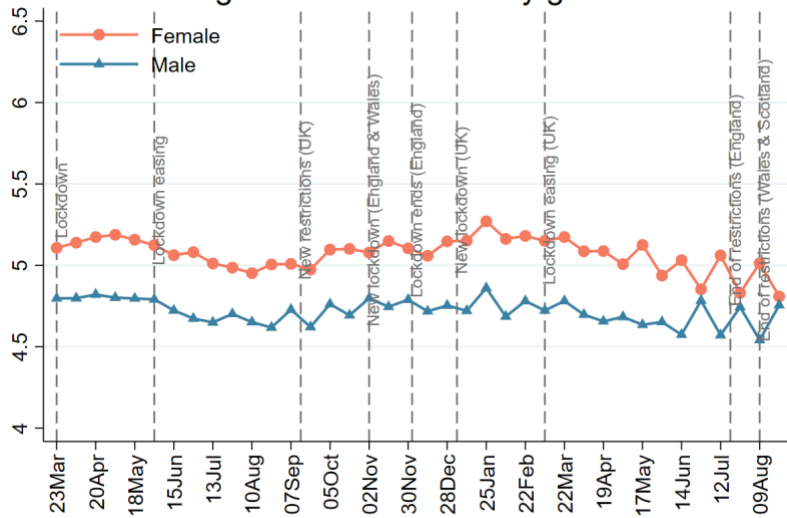
Figure 22j Loneliness by ethnicity
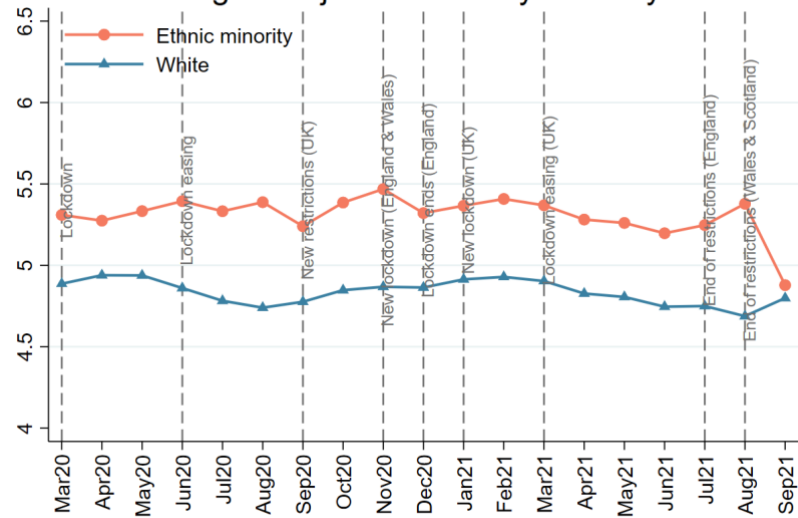
Figure 22k Loneliness by educational levels
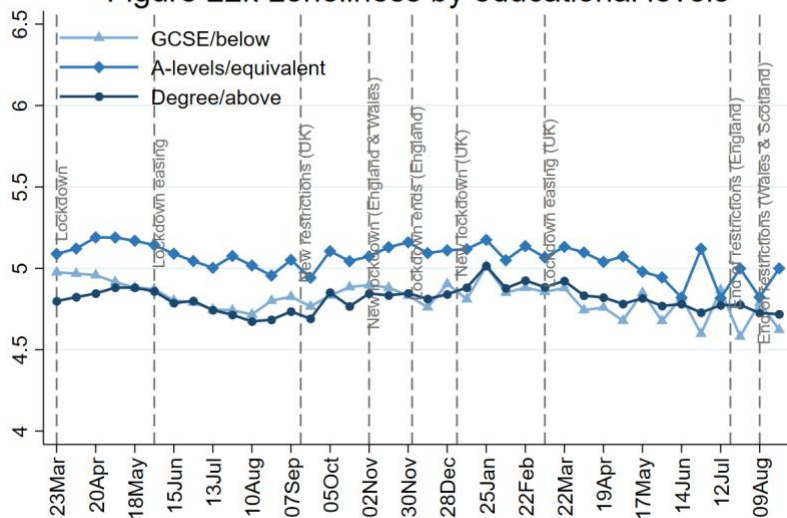
Figure 22l Loneliness by physical health diagnosis

4.3 Happiness
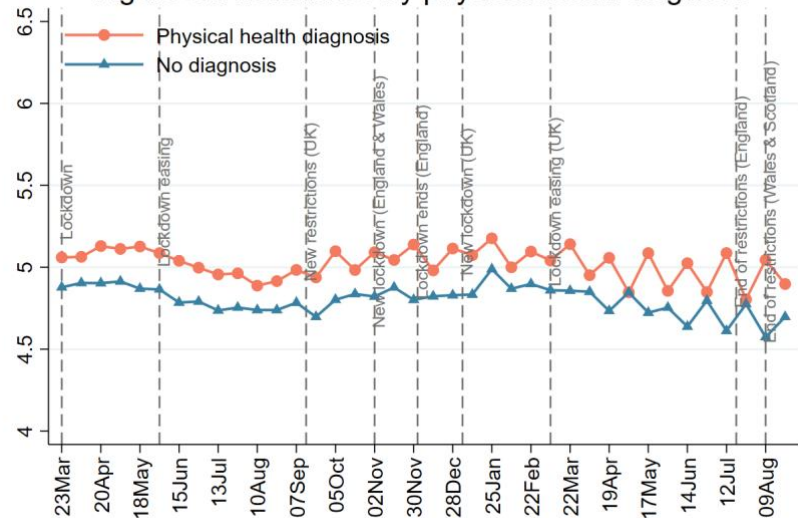
Figure 23 Happiness
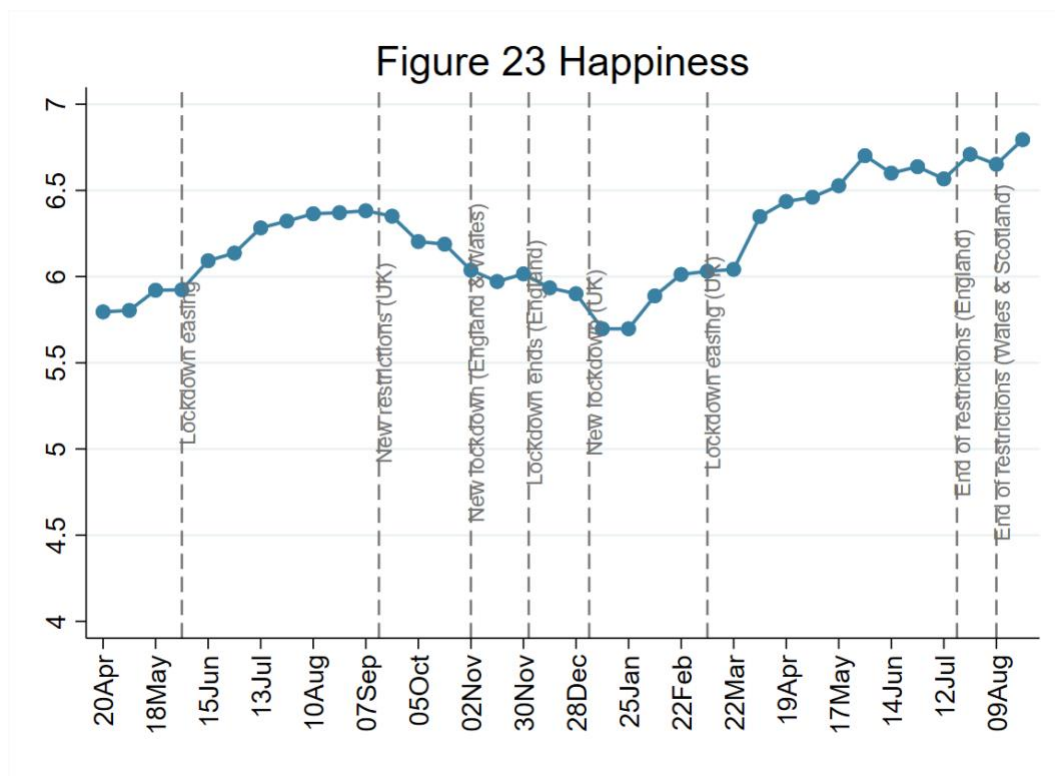
FINDINGS

Respondents were asked to rate to what extent they felt happy during the past week using the Office for National Statistics (ONS) wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April 2020 onwards.

Happiness levels have generally been increasing since the end of March 2021 and are now higher than they ever have been during this study.

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

Figure 24a Happiness by age groups

Age 18-29
Age 30-59
Age 60+
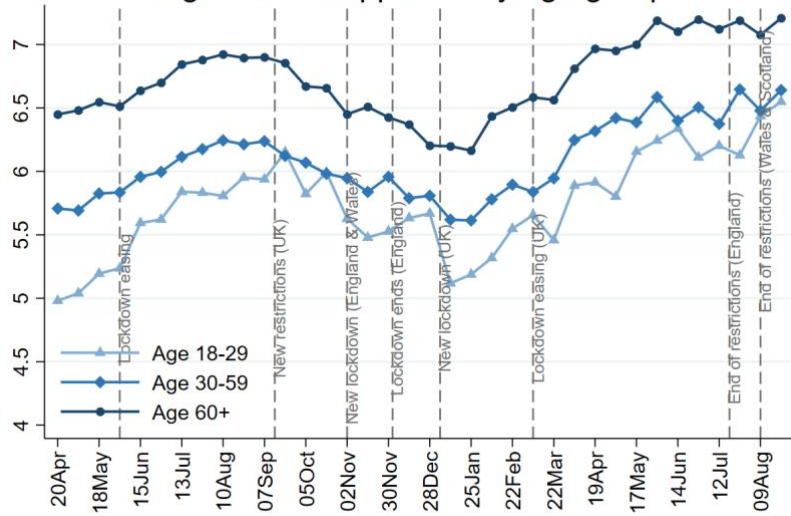
Figure 24b Happiness by living arrangement

Living alone
Not living alone
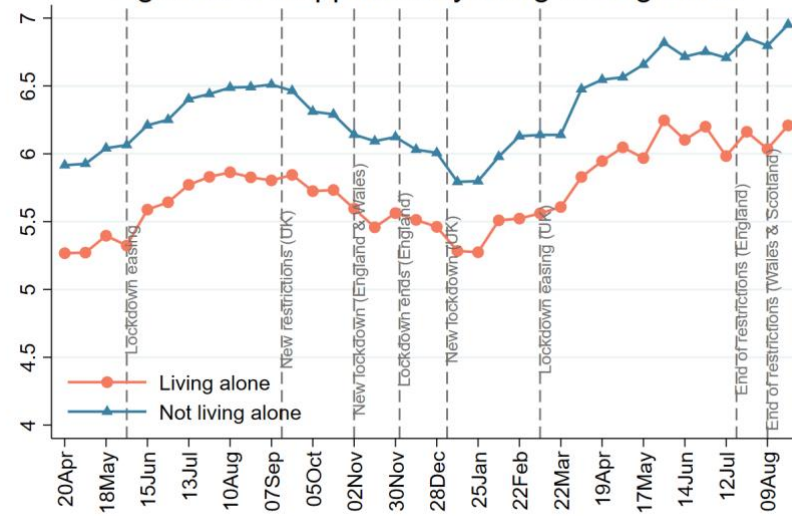
Figure 24c Happiness by household income

Household income <30k
Household income >30k
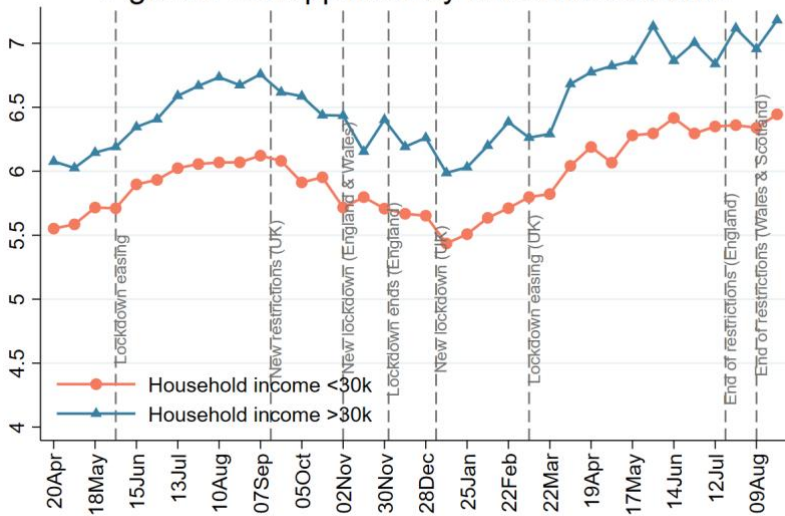
Figure 24d Happiness by mental health

Mental health diagnosis
No diagnosis
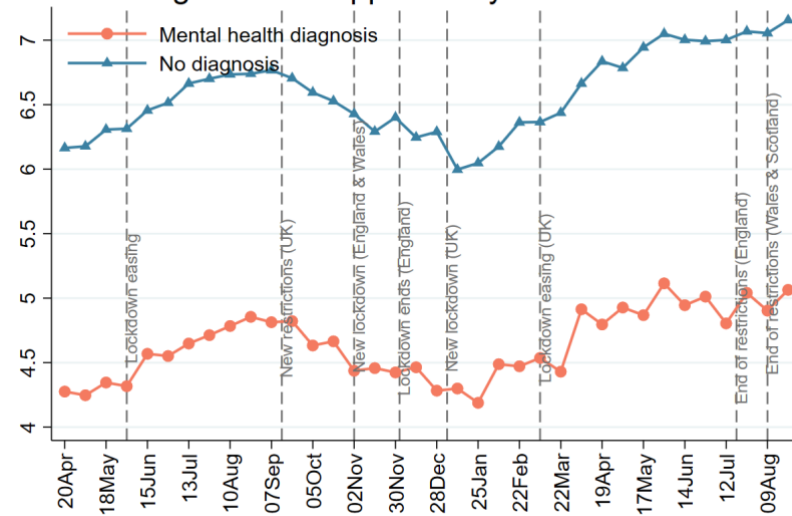
Figure 24e Happiness by nations
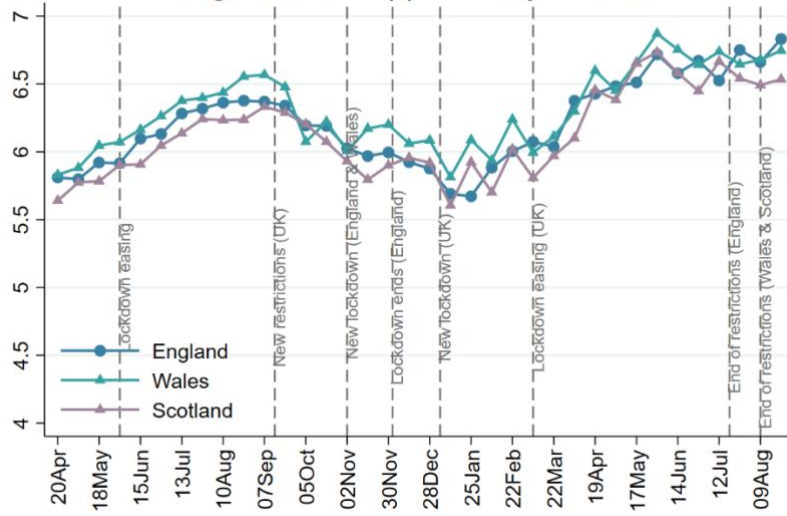
Figure 24f Happiness by keyworker status
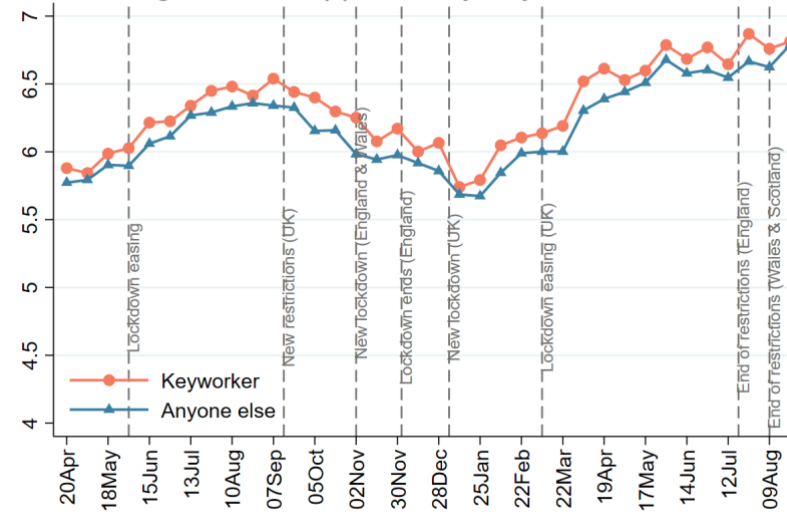
Figure 24g Happiness by living with children
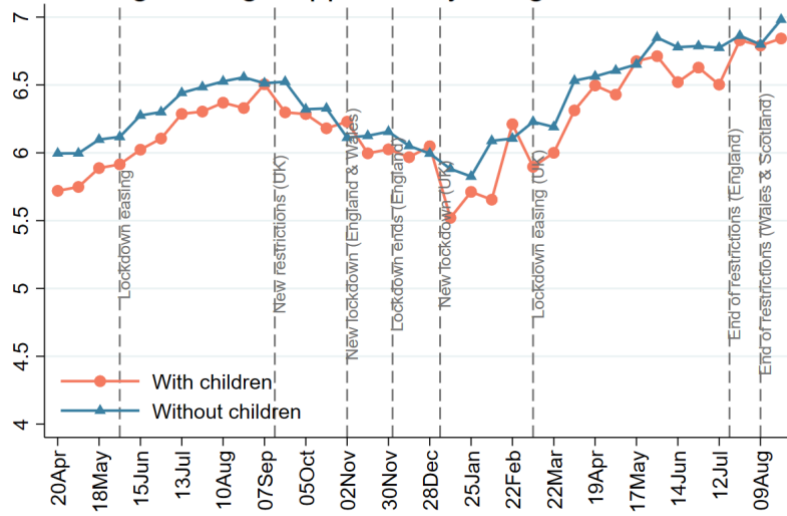
Figure 24h Happiness by living area
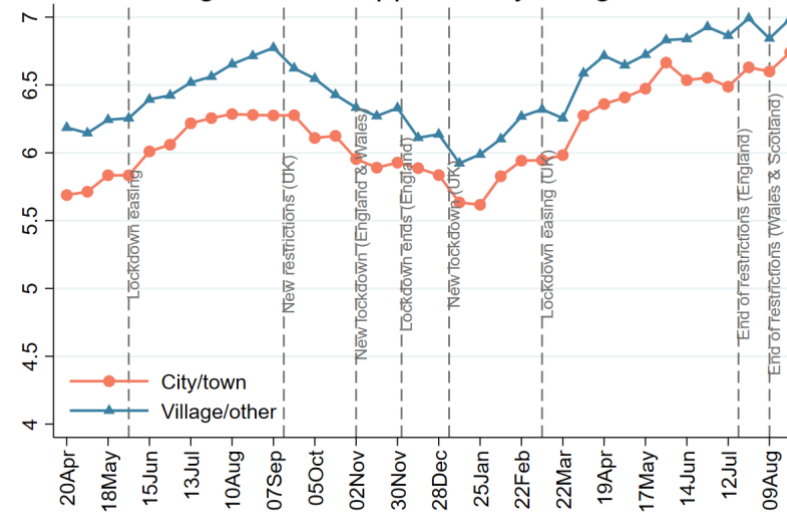
Figure 24i Happiness by gender
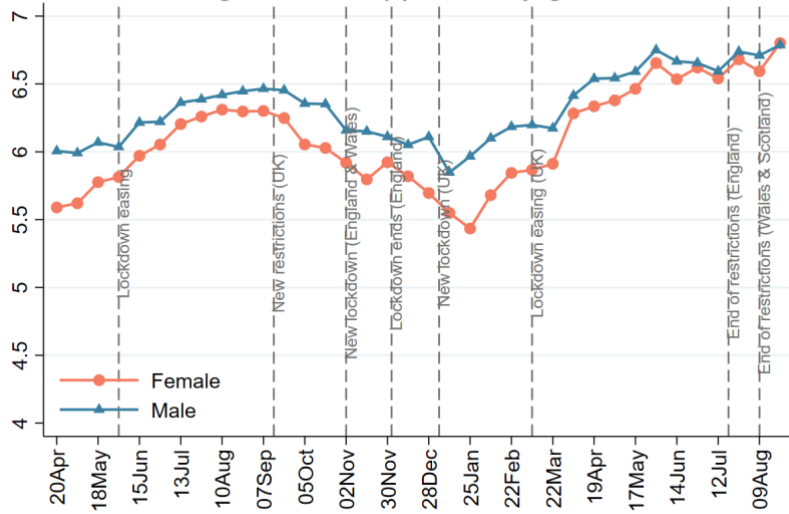
Figure 24j Happiness by ethnicity
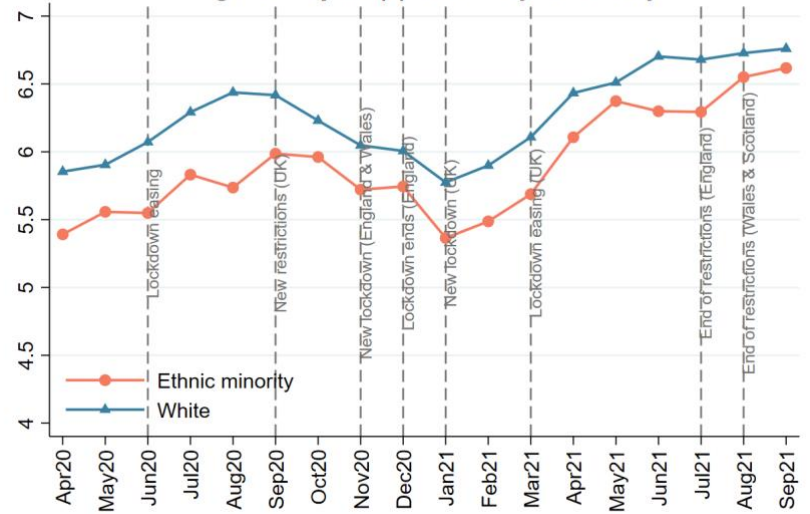
Figure 24k Happiness by educational levels
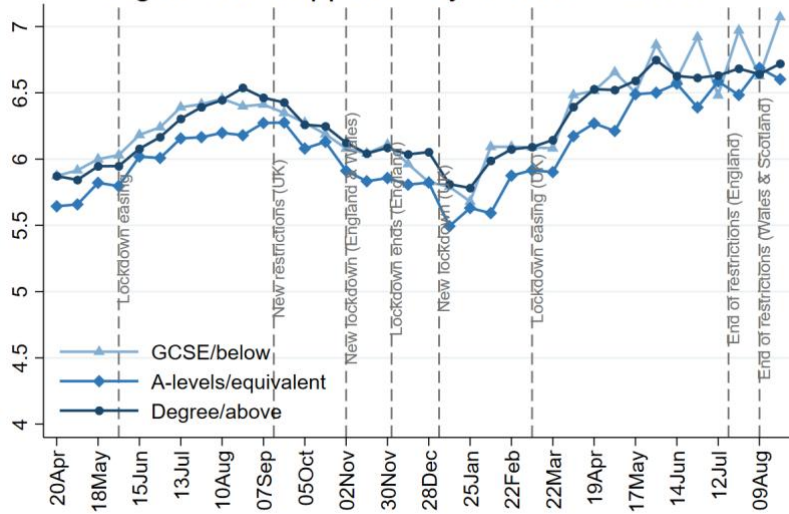
Figure 24l Happiness by physical health diagnosis

5. Social support
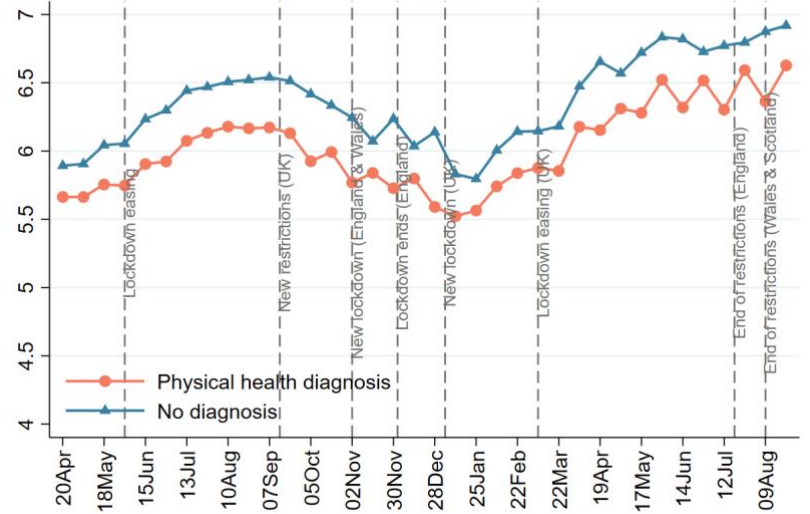
Figure 25 Social support
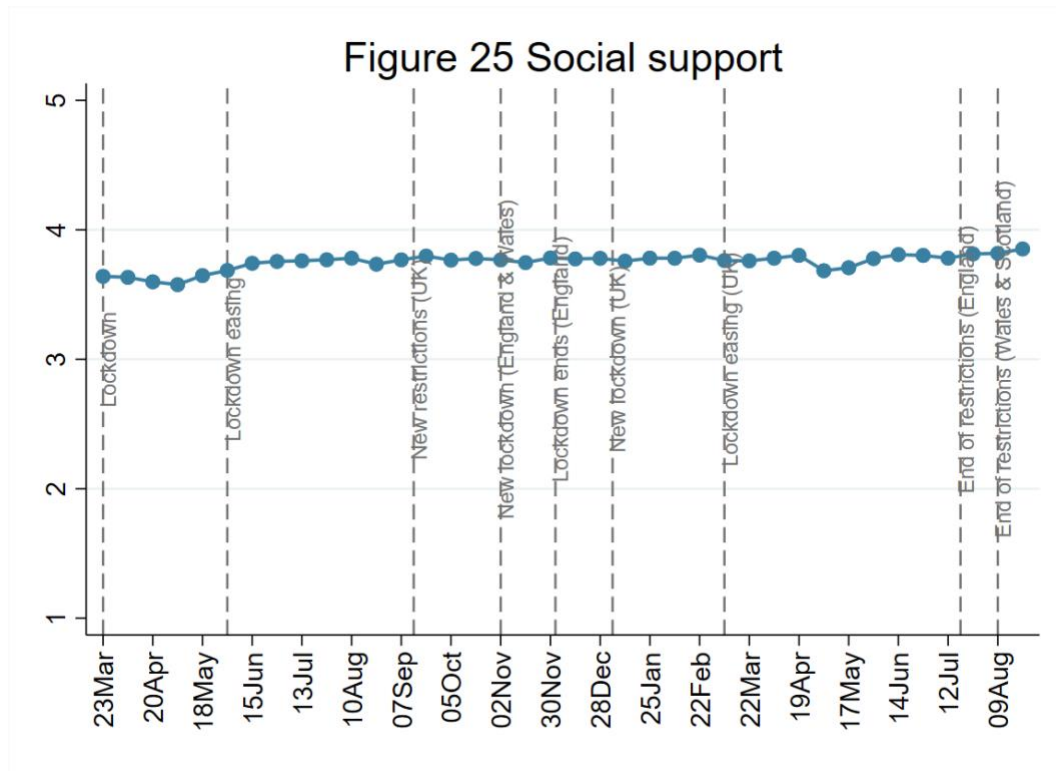
FINDINGS

Social support during the past week was measured using an adapted version of the six-item short form of Perceived Social Support Questionnaire (F-SozU K-6)[7]. This measures the extent to which participants have experienced understanding and support from others, whether emotional or physical. Each item is rated on a 5-point scale from "not true at all" to "very true", with scores averaged and higher scores indicating higher levels of perceived social support (range 1-5).

Levels of social support have been relatively constant across the pandemic. There has been a slight increasing trend since the end of April 2021, perhaps as people have been able to move around more and receive in-person support more easily.

However, some groups have experienced much lower levels of social support than others. People living alone, with lower household income, and with a mental or physical health diagnosis have consistently reported lower support. Support has also been slightly lower amongst people in urban areas, people from ethnic minority groups, and people with lower educational qualifications but no differences have been present by age groups, different nations, by keyworkers status, or whether or not people are living with children.

[7] Kliem S, Mößle T, Rehbein F, Hellmann DF, Zenger M, Brähler E. A brief form of the Perceived Social Support Questionnaire (F-SozU) was developed, validated, and standardized. Journal of Clinical Epidemiology 2015;68(5):551-562.

Figure 26a Social support by age groups
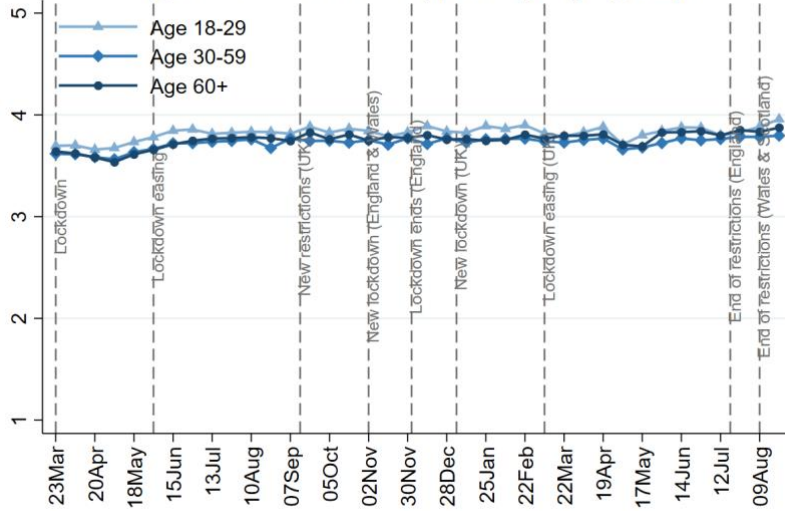
Figure 26b Social support by living arrangement
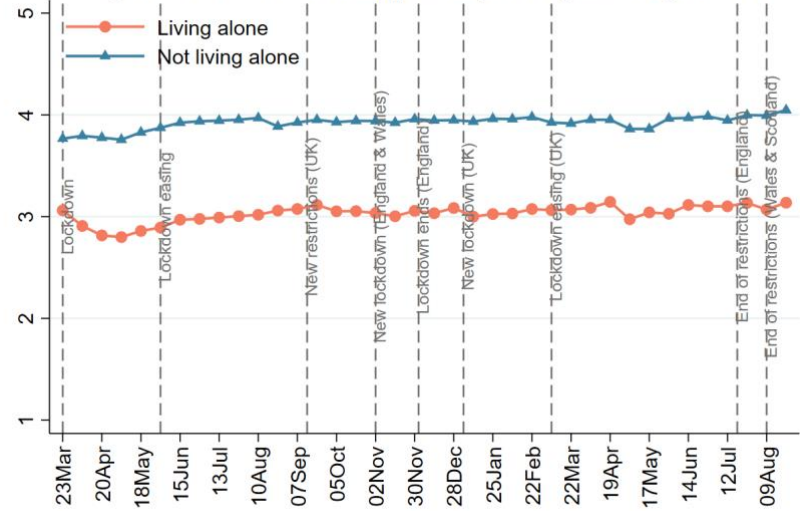
Figure 26c Social support by household income
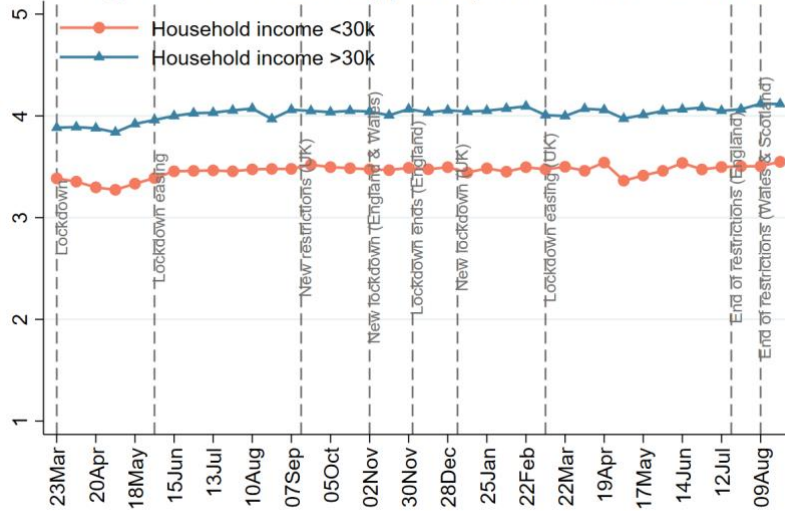
Figure 26d Social support by mental health diagnosis
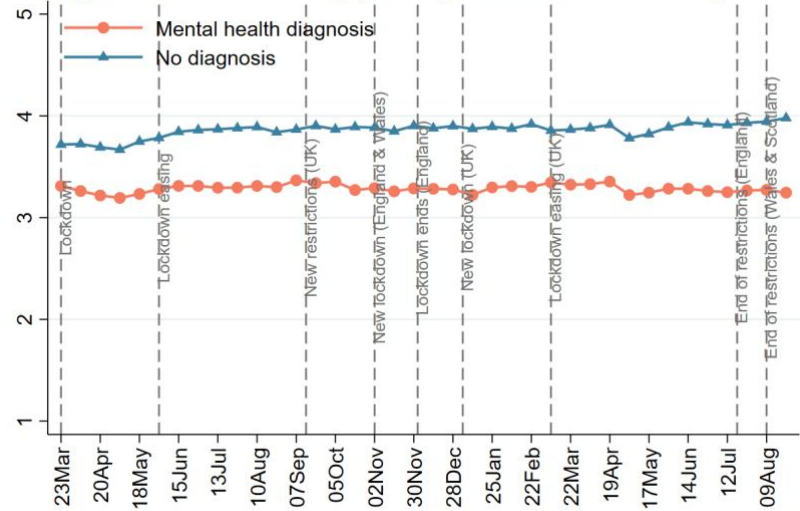
Figure 26e Social support by nations
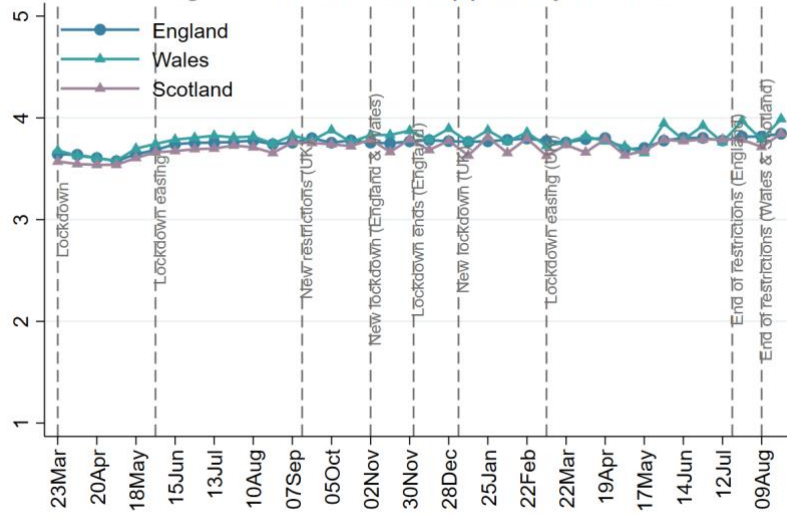
Figure 26f Social support by keyworker status
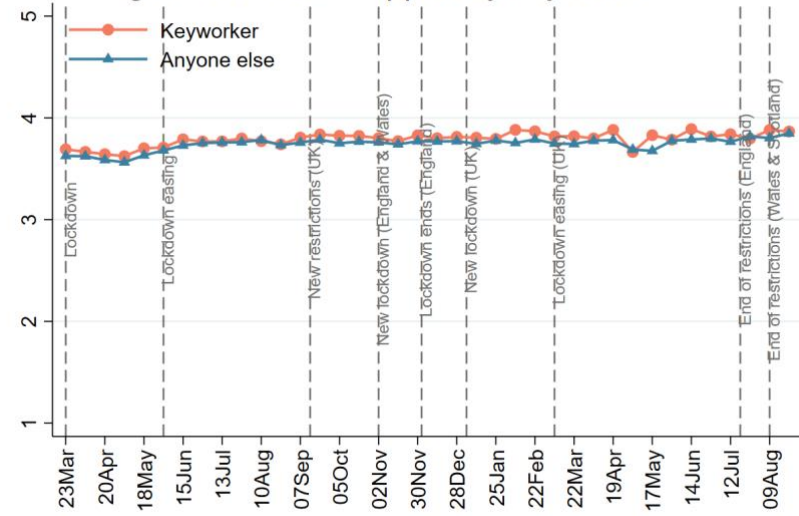
Figure 26g Social support by living with children
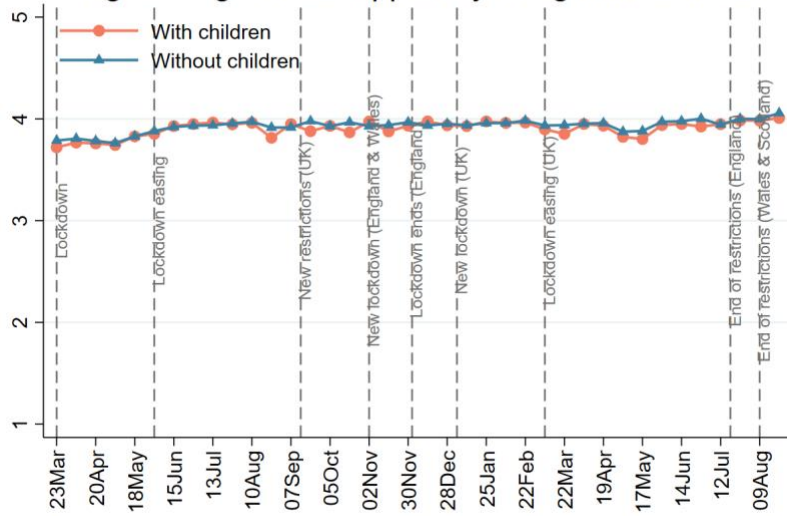
Figure 26h Social support by living area
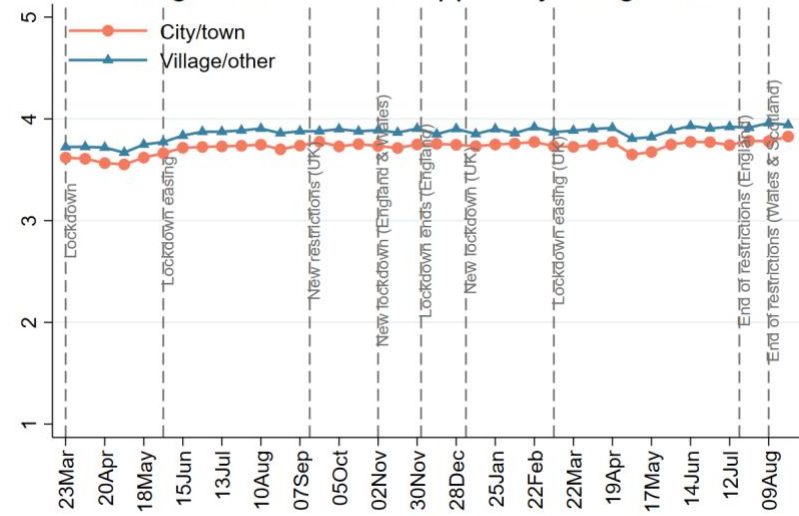
Figure 26i Social support by gender
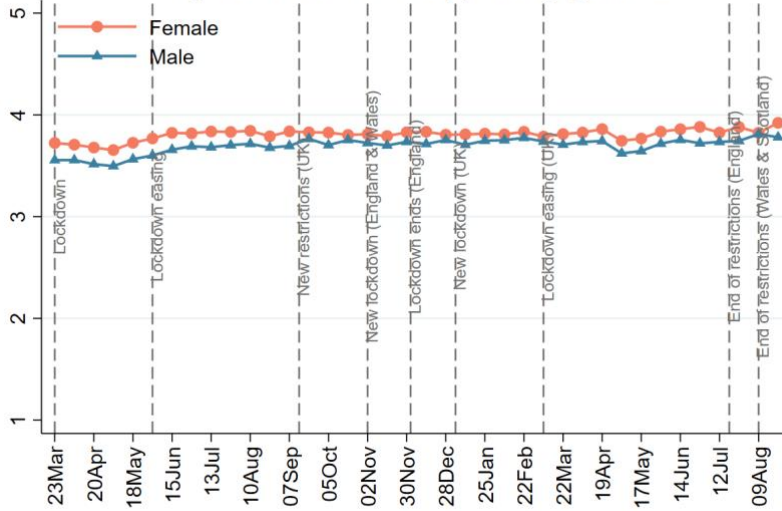
Figure 26j Social support by ethnicity
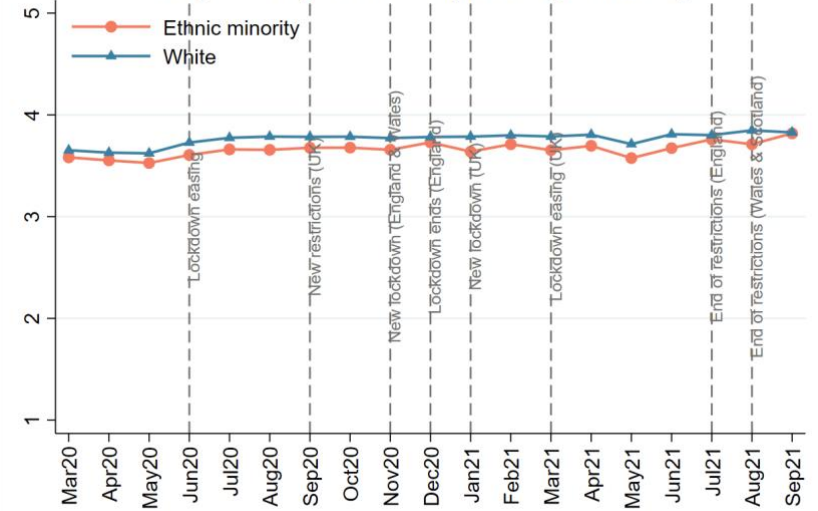
Figure 26k Social support by educational levels
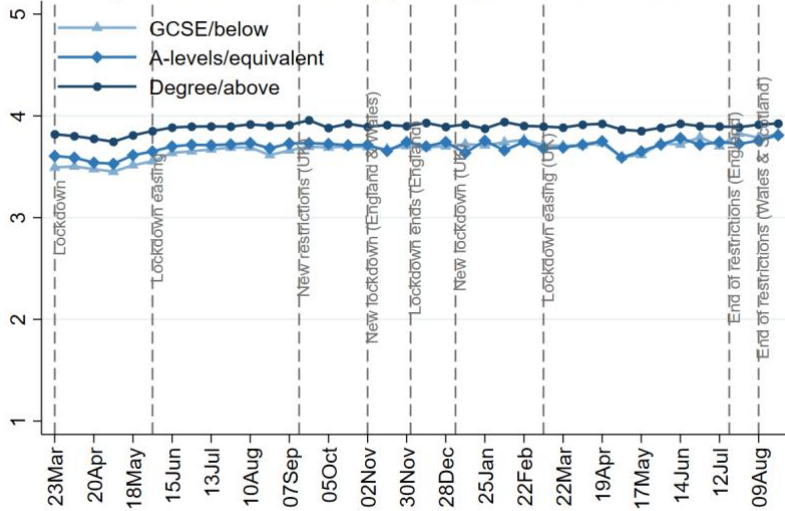
Figure 26l Social support by physical health diagnosis
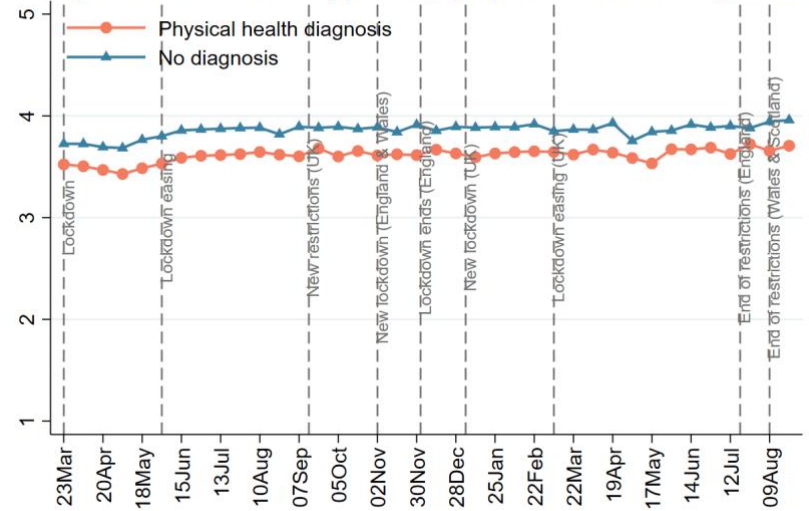
6. Discrimination

Figure 27 Discrimination experienced between 2020-2021

Category	Percentage
Any discrimination	44%
Been treated with less courtesy or respect than other people	28%
Been threatened or harassed	14%
People have acted as if they were afraid of you	13%
Experienced some other kind of discrimination	13%
Received poorer service than other people (e.g. for deliveries or in stores)	12%
Received poorer service or treatment than other people from doctors or hospitals	11%
People have acted as if they think you are dishonest	7%

FINDINGS

In July 2020, respondents were asked whether they had experienced discrimination since lockdown came in, either due to their age, gender, race/ethnicity, or any other characteristics. Respondents were allowed to choose multiple characteristics. One year later, participants were asked this same set of questions but were asked to focus on discrimination they had experienced over the past year. We focus here on any response that indicated discrimination experiences at either timepoint.

In total, 44% of people reported experiencing some form of discrimination since the start of the pandemic. When looking at what type of discrimination people had experienced, over 1 in 4 (28%) reported having been treated with less courtesy or respect than others, whilst more than 1 in 10 reported that they had been threatened or harassed (14%), had people act as if they were afraid of them (13%), had experienced some other form of discrimination (13%), or had received poorer service than others for deliveries/in stores (12%) or from doctors or in hospitals (11%).

In total, 12% reported that they felt their discrimination experiences were due to their age, 11% to their gender, 6% to their race/ethnicity, and 32% to other reasons.

When looking at subgroups, total discrimination experiences were highest amongst people from ethnic minority groups (61% vs 41% of people with white ethnicity) and younger adults (60% aged 18-30 vs 29% of people aged 60+). They were also slightly higher amongst women (48% vs men 39%) and more common in urban areas (45% vs 40% reported in rural areas).

Figure 28a Any discrimination by age group
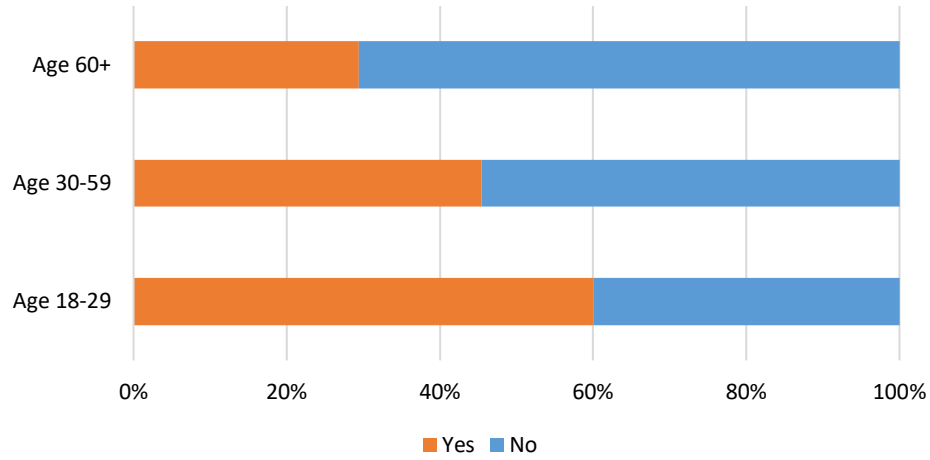
Figure 28b Any discimination by gender
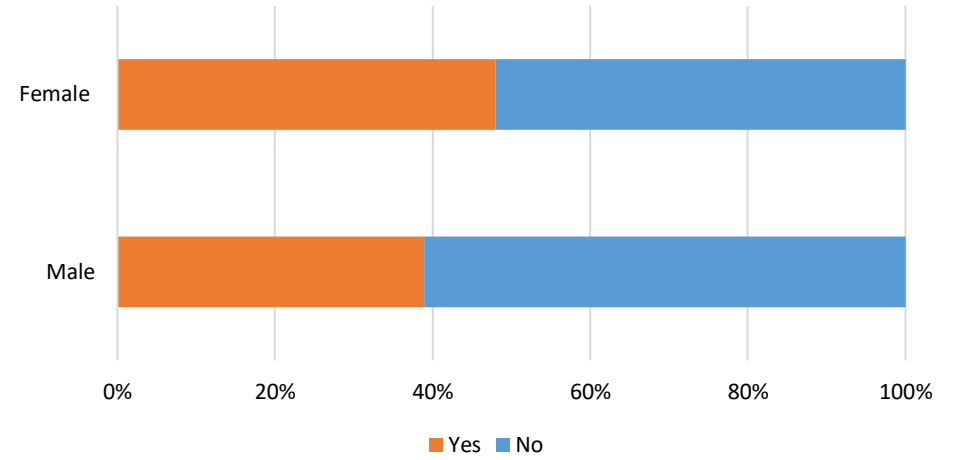
Figure 28c Any discrimination by ethnicity
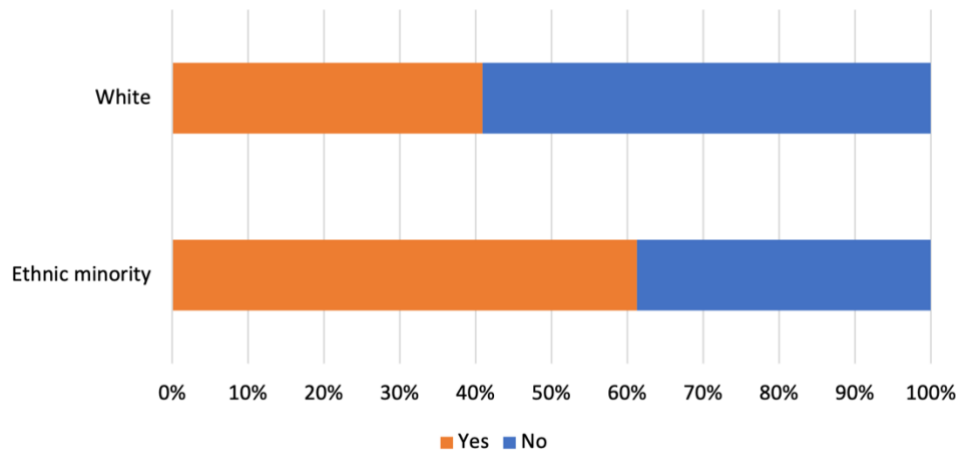
Figure 28d Any discrimination by living area
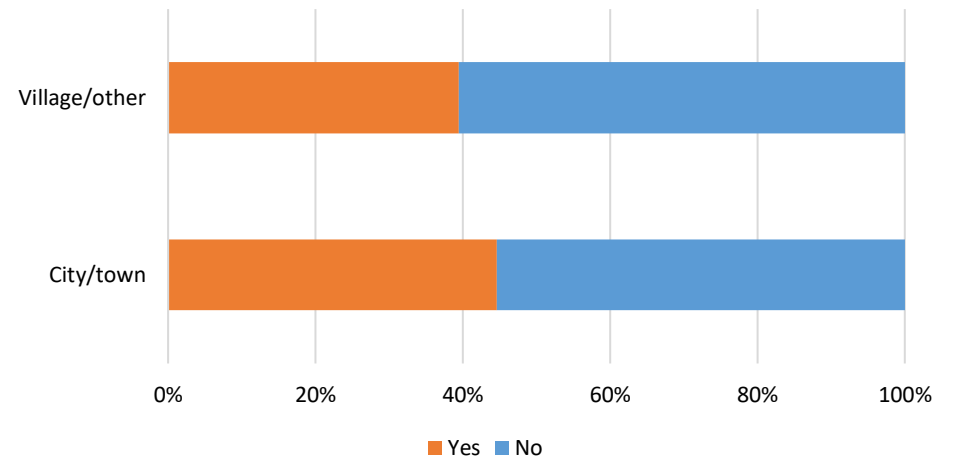
Appendix

Methods

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

Specifically, in the analyses presented here we included adults in the UK. We used new cross-sectional data from individuals as they entered the study and also included weekly longitudinal data as participants received their routine follow-up. In this report, we treated the data as repeated cross-sectional data collected daily from the 21st of March 2020 to the 5th of September 2021 (the latest data available). Aiming at a representative sample of the population, we weighted the data for each day to the proportions of gender, age, ethnicity, education, and country of living obtained from the Office for National Statistics (ONS, 2018). Where results for subgroups show volatility, this could be a product of the sample size being smaller so caution in interpreting these results is encouraged.

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

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

Demographics of respondents included in this report

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

	Number of observations	%		Number of observations	%
Age			**Education levels**		
18-29	57,947	5.51	**GCSE or below**	148,880	14.2
30-59	571,134	54.3	**A-levels of equivalent**	181,486	17.3
60+	423,161	40.2	**Degree or above**	721,876	68.6
Gender			**Any diagnosed mental health conditions**		
Male	264,918	25.3	**No**	878,443	83.5
Female	783,154	74.7	**Yes**	173,799	16.5
Ethnicity			**Any diagnosed physical health conditions**		
White	1,008,200	96.1	**No**	602,443	57.3
Ethnic minority	40,730	3.88	**Yes**	449,799	42.8
UK nations			**Keyworker**		
England	848,690	81.4	**No**	835,161	79.4
Wales	128,943	12.4	**Yes**	217,081	20.6
Scotland	64,468	6.19	**Living with children**		
Living arrangement			**No (excluding those who live alone)**	600,546	72.5
Not living alone	828,245	78.7	**Yes**	227,699	27.5
Living alone	223,997	21.3	**Living area**		
Annual household income			**Village/hamlet/isolated dwelling**	265,557	25.2
>30k	561,760	59.3	**City/large town/small town**	786,685	74.8
<30k	385,410	40.7			

Peer reviewed publications

For readers of this report who are interested in following up some of the findings in more detail, a selected list of articles published in scientific journals that are based on the COVID-19 Social Study is listed below. Readers can access the full listing, including articles published as preprints, on our website www.COVIDSocialStudy.org/results.

Bu, F., Bone, J. K., Mitchell, J. J., Steptoe, A., & Fancourt, D. (2021). Longitudinal changes in physical activity during and after the first national lockdown due to the COVID-19 pandemic in England. *Scientific Reports*, *11*(1), 17723. https://doi.org/10.1038/s41598-021-97065-1

Bu, F., Mak, H. W., & Fancourt, D. (2021). Rates and predictors of uptake of mental health support during the COVID-19 pandemic: An analysis of 26,720 adults in the UK in lockdown. *Social Psychiatry and Psychiatric Epidemiology*. https://doi.org/10.1007/s00127-021-02105-w

Bu, F., Steptoe, A., & Fancourt, D. (2020). Who is lonely in lockdown? Cross-cohort analyses of predictors of loneliness before and during the COVID-19 pandemic. *Public Health*, *186*, 31–34. https://doi.org/10.1016/j.puhe.2020.06.036

Bu, F., Steptoe, A., Mak, H. W., & Fancourt, D. (2021). Time use and mental health in UK adults during an 11-week COVID-19 lockdown: A panel analysis. *The British Journal of Psychiatry*, 1–6. https://doi.org/10.1192/bjp.2021.44

Fancourt, D., Steptoe, A., & Bu, F. (2021). Trajectories of anxiety and depressive symptoms during enforced isolation due to COVID-19 in England: A longitudinal observational study. *The Lancet Psychiatry*, *8*(2), 141–149. https://doi.org/10.1016/S2215-0366(20)30482-X

Fancourt, D., Steptoe, A., & Wright, L. (2020). The Cummings effect: Politics, trust, and behaviours during the COVID-19 pandemic. *The Lancet*, *396*(10249), 464–465. https://doi.org/10.1016/S0140-6736(20)31690-1

Fluharty, M., Bu, F., Steptoe, A., & Fancourt, D. (2021). Coping strategies and mental health trajectories during the first 21 weeks of COVID-19 lockdown in the United Kingdom. *Social Science & Medicine*, *279*, 113958. https://doi.org/10.1016/j.socscimed.2021.113958

Garnett, C., Jackson, S., Oldham, M., Brown, J., Steptoe, A., & Fancourt, D. (2021). Factors associated with drinking behaviour during COVID-19 social distancing and lockdown among adults in the UK. *Drug and Alcohol Dependence*, *219*, 108461. https://doi.org/10.1016/j.drugalcdep.2020.108461

Iob, E., Frank, P., Steptoe, A., & Fancourt, D. (2020). Levels of severity of depressive symptoms among at-risk groups in the UK during the COVID-19 pandemic. *JAMA Network Open*, *3*(10), e2026064–e2026064. https://doi.org/10.1001/jamanetworkopen.2020.26064

Mak, H. W., Fluharty, M., & Fancourt, D. (2021). Predictors and impact of arts engagement during the COVID-19 pandemic: Analyses of data from 19,384 adults in the COVID-19 Social Study. *Frontiers in Psychology*, *12*, 1335. https://doi.org/10.3389/fpsyg.2021.626263

Wright, L., Steptoe, A., & Fancourt, D. (2020). Are we all in this together? Longitudinal assessment of cumulative adversities by socioeconomic position in the first 3 weeks of lockdown in the UK. *Journal of Epidemiology and Community Health, 74*(9), 683–688. https://doi.org/10.1136/jech-2020-214475

Wright, L., Steptoe, A., & Fancourt, D. (2021a). Predictors of self-reported adherence to COVID-19 guidelines. A longitudinal observational study of 51,600 UK adults. *The Lancet Regional Health - Europe*, *4*, 100061. https://doi.org/10.1016/j.lanepe.2021.100061

Wright, L., Steptoe, A., & Fancourt, D. (2021b). Does thinking make it so? Differential associations between adversity worries and experiences and mental health during the COVID-19 pandemic. *Journal of Epidemiology and Community Health*, *75*(9), 817–823. https://doi.org/10.1136/jech-2020-215598