Covid-19 Social Study

Results Release 24

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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-FOURTH report, we focus on psychological responses to the first thirty-two weeks since just before the UK lockdown was first announced (21/03 to 1/11). 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***** Confidence in essentials and healthcare service, 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

Findings

- Compliance has continued to remain stable over the last two weeks, with no further signs of decreases for now. There have been indications of slight improvements in "complete" compliance amongst adults aged 30 and above as cases have begun to rise again. "Complete" compliance is currently around 45%, but is just 20-25% in adults under the age of 30, 40-45% in adults aged 30-50 and 50-55% in adults over the age of 60. "Majority" compliance remains around 90% overall, but is lowest (around 80%) amongst adults under 30.

- Majority compliance with the measures to reduce the spread of the virus (broadly following the rules but with some modifications) is no different by education or income, but people with higher educational qualifications and higher household income are making more modifications to the rules ("majority" compliance). These groups also have lower confidence in the government to handle the pandemic and are more worried about the ability of the health service to cope (for education only) and the impact on their jobs. However, they are psychologically coping better, with better mental health.

- Depression, anxiety, happiness, life satisfaction and loneliness levels have stayed relatively constant in the past two weeks but are all worse than over the summer.

- Women have found the pandemic psychologically more challenging than men, with higher levels of depression, anxiety and loneliness and lower levels of life satisfaction and happiness. Women have also been more stressed about catching or becoming seriously ill from the virus and more worried about the ability of the health service to cope. But they are no different in their stress levels on finance, employment or access to food compared to men. Thoughts of death or self-harm, reported self-harming and reported abuse are similar across genders.

- 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. Confidence that access to essentials will be maintained is lower than it was over the summer, as is confidence in the ability of the health service to cope, with decreases in September as cases increased and again in October. It is now on a par with confidence in April.

- People from BAME backgrounds have lower confidence in the government to handle the pandemic, lower confidence that access to essentials will be maintained, and lower confidence in the health service that they will be able to cope with the demand. They also have worse mental health across every measure, with higher depression, anxiety, concerns about employment, financial stress, thoughts of death or self-harm, reported abuse and loneliness, and lower life satisfaction and happiness.

- People with a long-term physical health conditions are complying more with the rules, with higher overall majority and complete compliance. However, they are more concerned about catching and becoming seriously ill from the virus and are experiencing higher depression and anxiety levels and lower life satisfaction and happiness. More people with long-term physical health conditions are thinking about death or self-harm, or actually self-harming and their loneliness levels are higher. They are also more worried about accessing food but less worried about access to essentials being maintained and they have the same levels of confidence in the health service to cope as people without a physical health condition.

1. Compliance and confidence

1.1 Compliance with guidelines

Figure 1 Compliance with guidelines
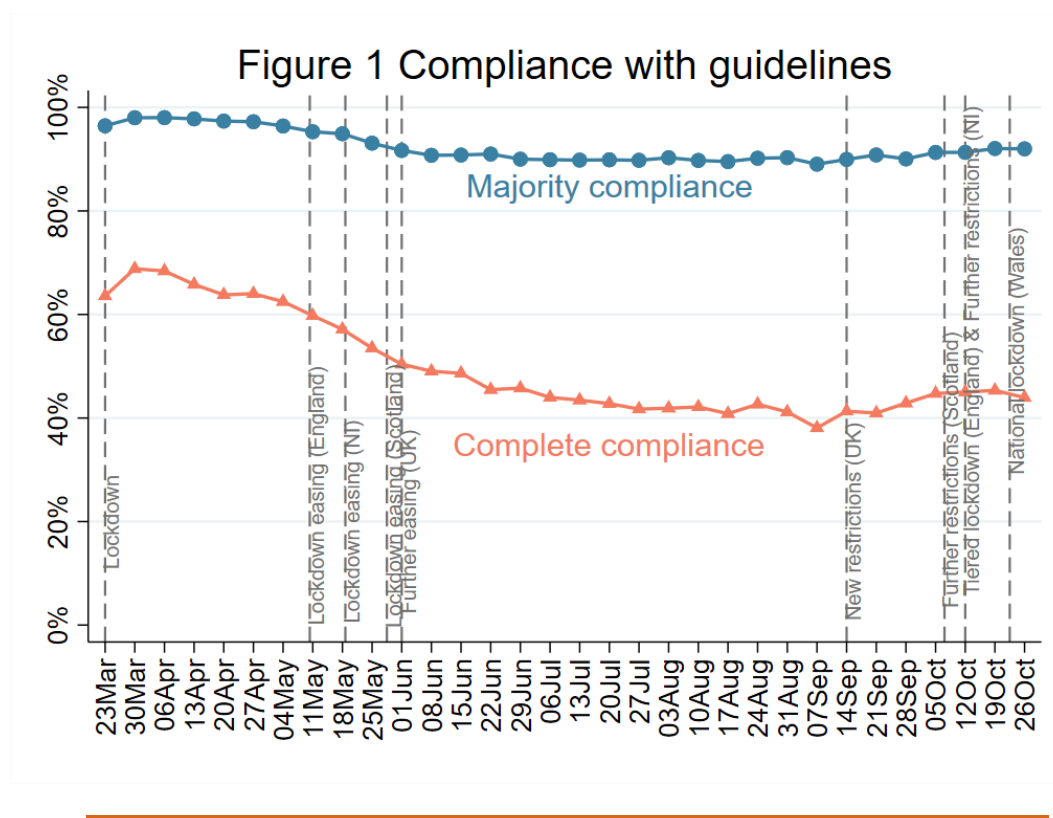
FINDINGS

Respondents were asked to what extent they are following the recommendations from government 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 continued to remain stable over the last two weeks, with no further signs of decreases for now. There have been indications of slight improvements in "complete" compliance amongst adults aged 30 and above as cases have begun to rise again. "Complete" compliance is currently around 45%, but is just 20-25% in adults under the age of 30, 40-45% in adults aged 30-50 and 50-55% in adults over the age of 60. "Majority" compliance remains around 90% overall, but is lowest (around 80%) amongst adults under 30. Compliance is lower in higher income households, in England, in urban areas, and amongst adults living with children compared to adults not living with children.

Majority compliance (broadly following the rules but with some modifications) is no different by gender or education, and people from white ethnic backgrounds are only showing slightly higher levels of majority compliance. However, men, people from BAME backgrounds, and people with higher educational qualifications are showing lower "complete compliance". Notably, people with a long-term physical health conditions are complying more with the rules, with higher overall majority and complete compliance.

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
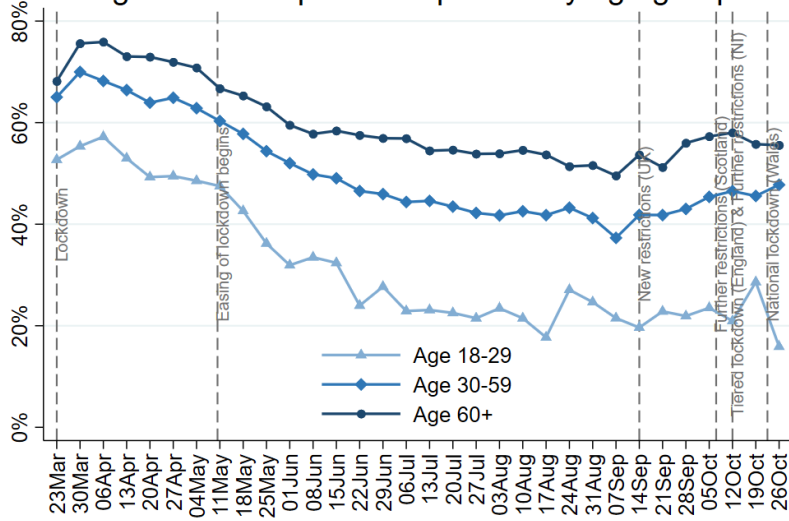
Figure 2b Complete compliance by living arrangement
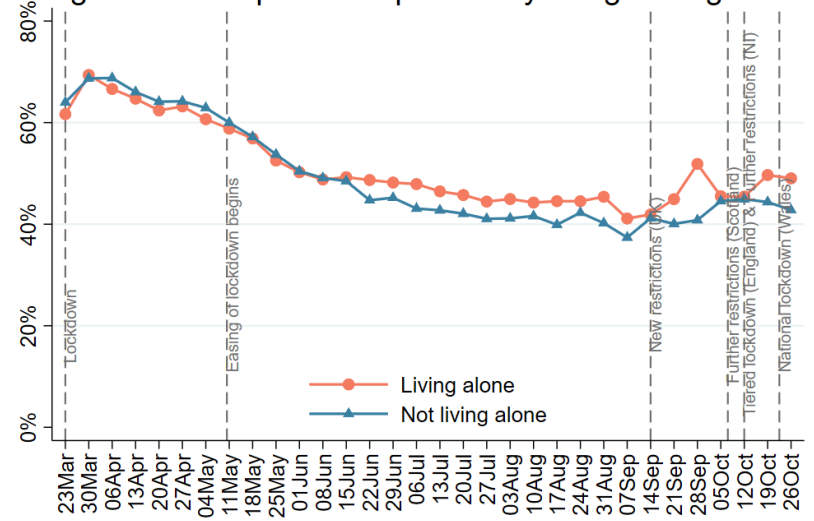
Figure 2c Complete compliance by household income
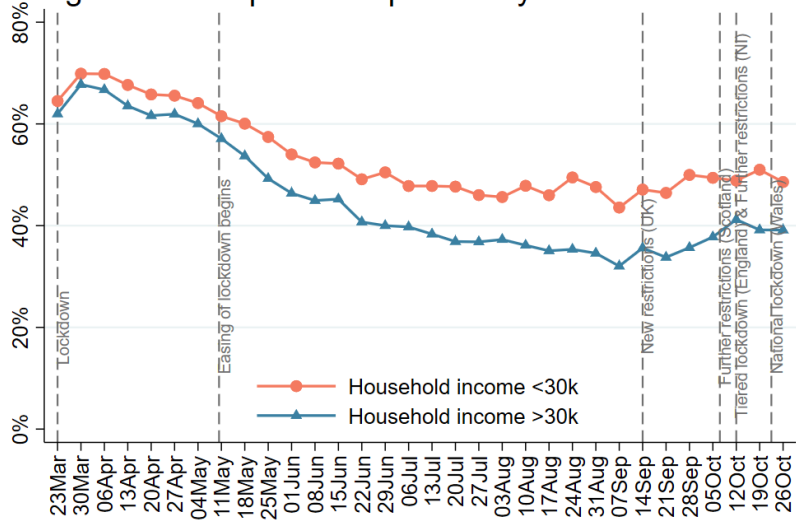
Figure 2d Complete compliance by mental health
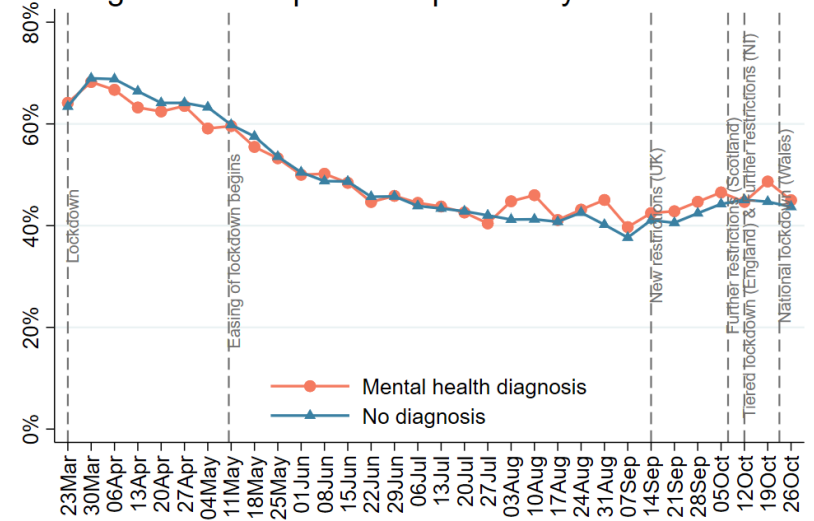
Figure 2e Complete compliance by nations
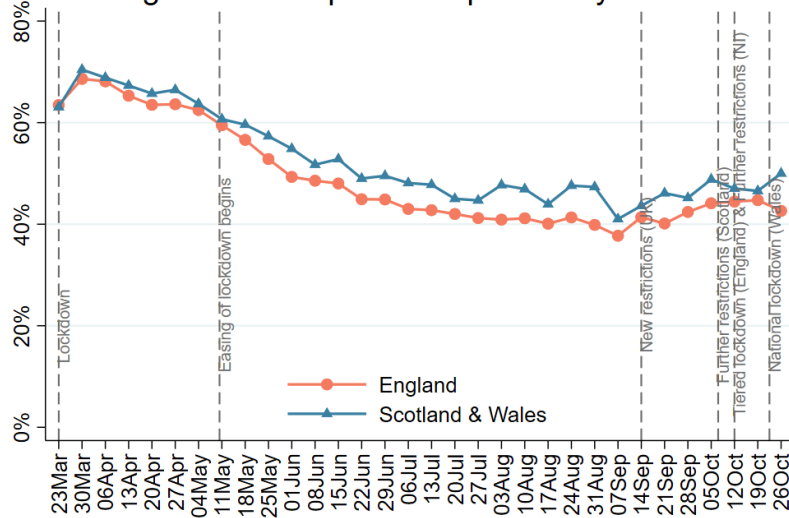
Figure 2f Complete compliance by keyworker status
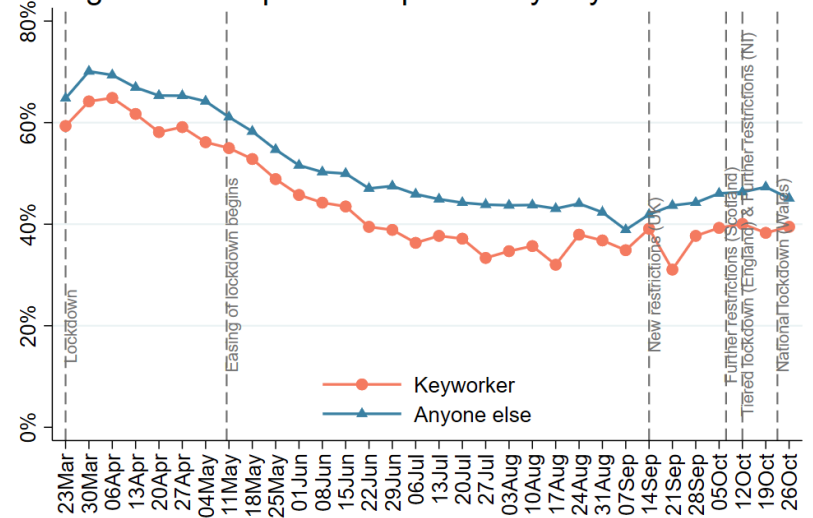
Figure 2g Complete compliance by living with children
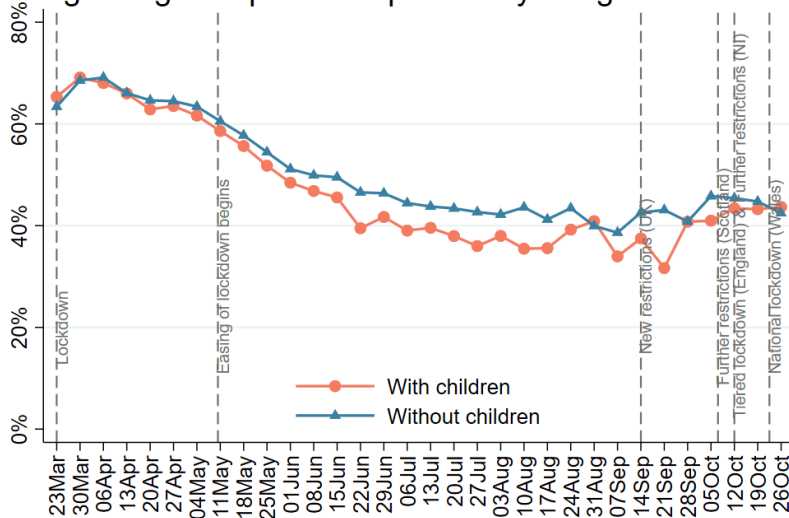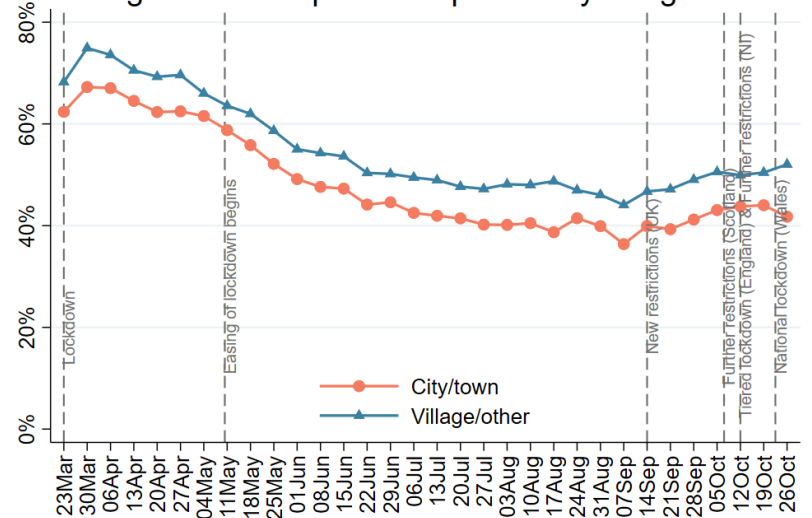

Figure 2h Complete compliance by living area
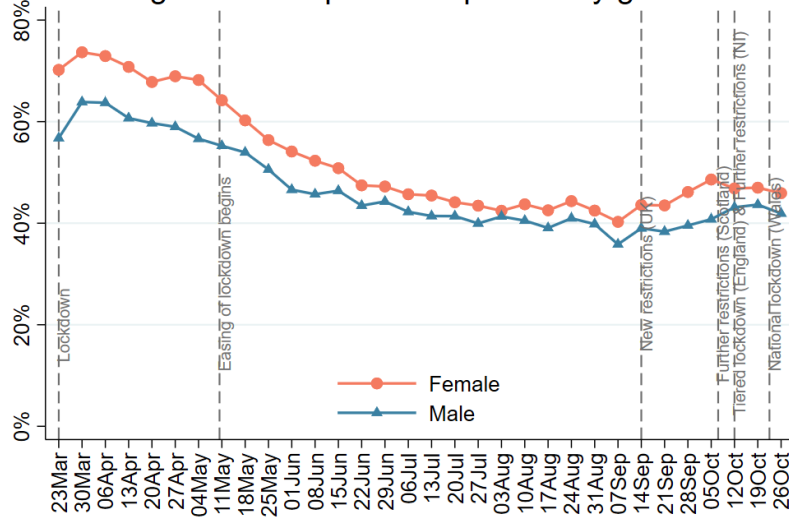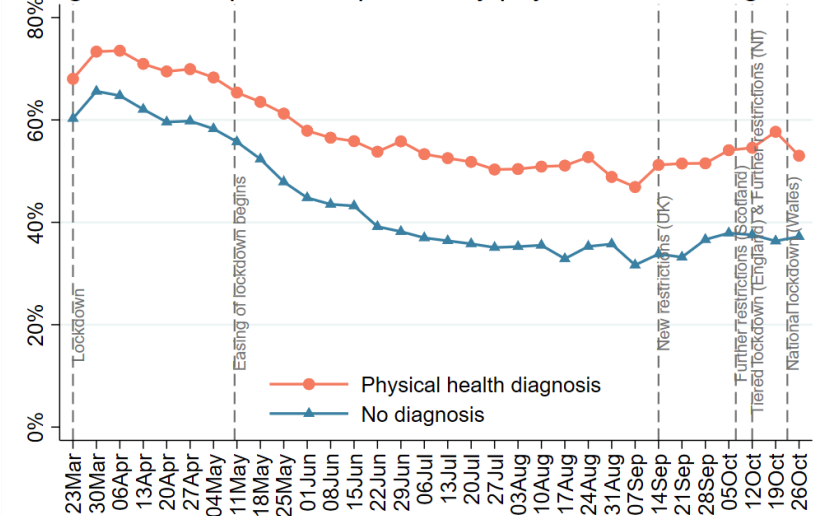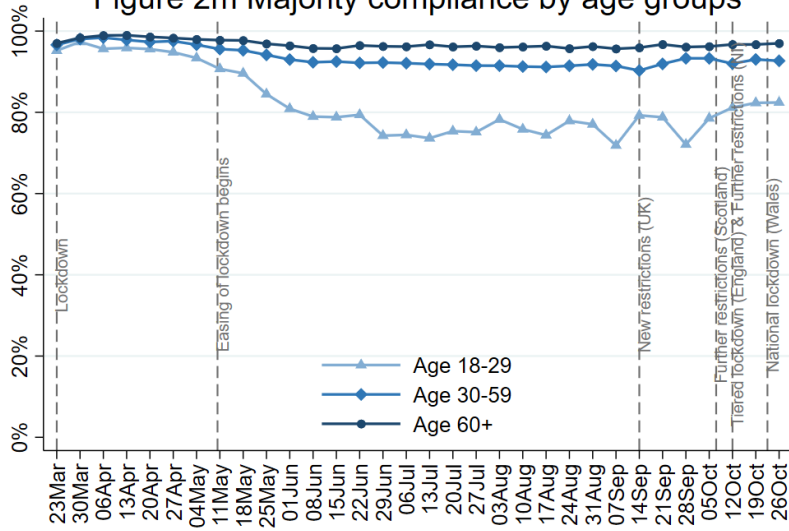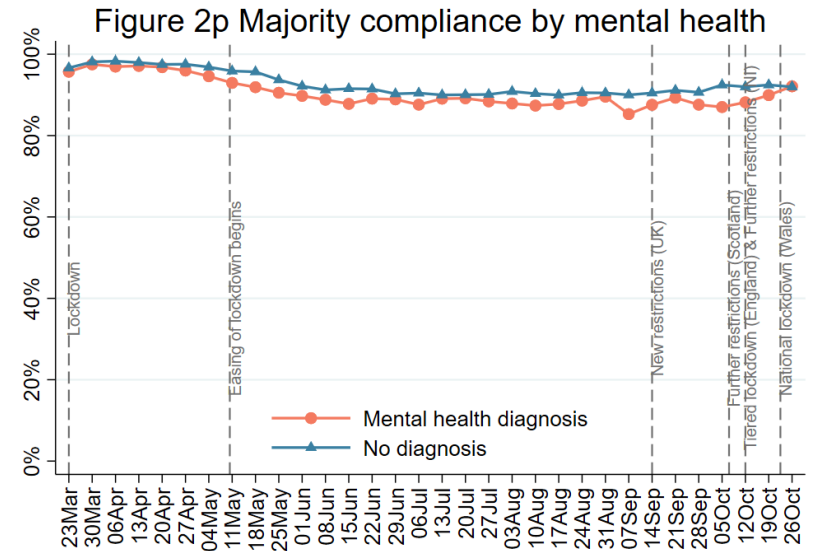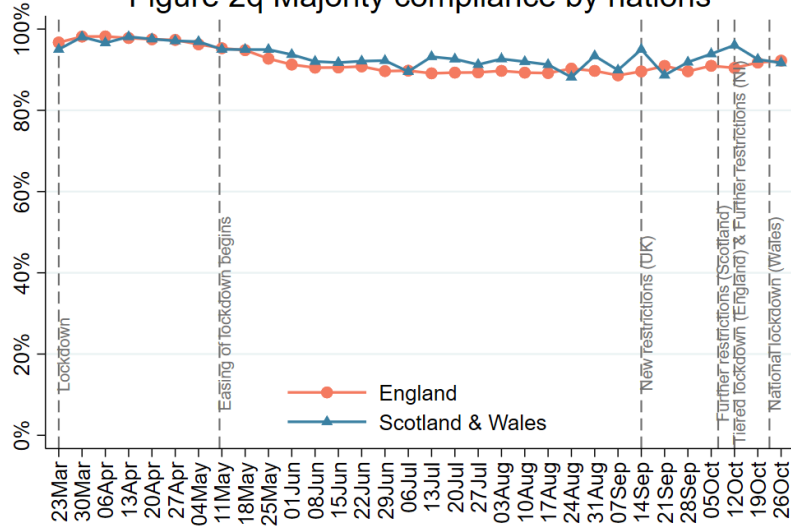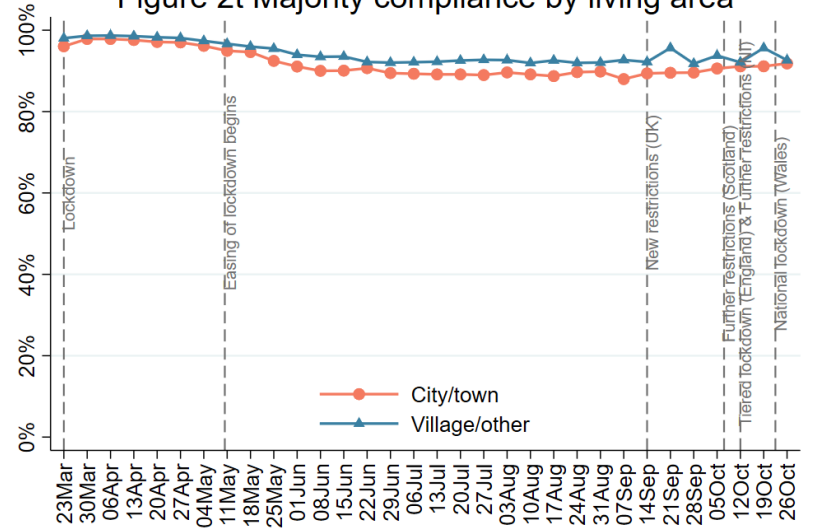
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Figure 2i Complete compliance by gender

Figure 2j Complete compliance by ethnicity
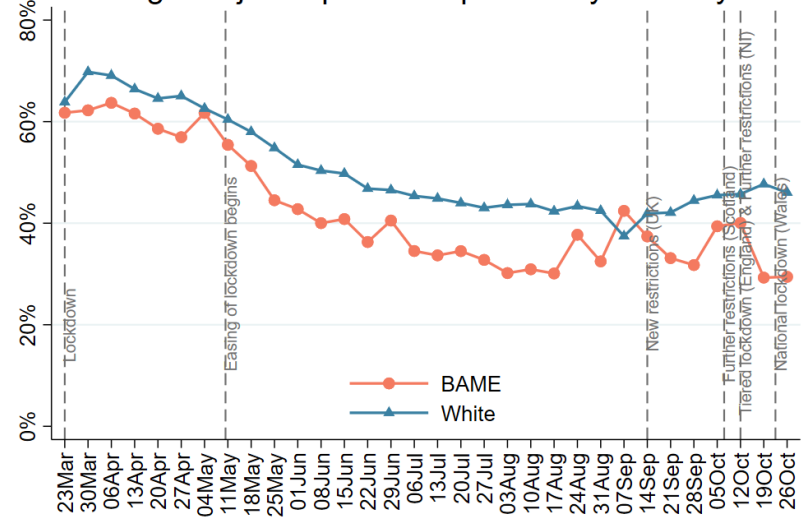
Figure 2k Complete compliance by educational levels
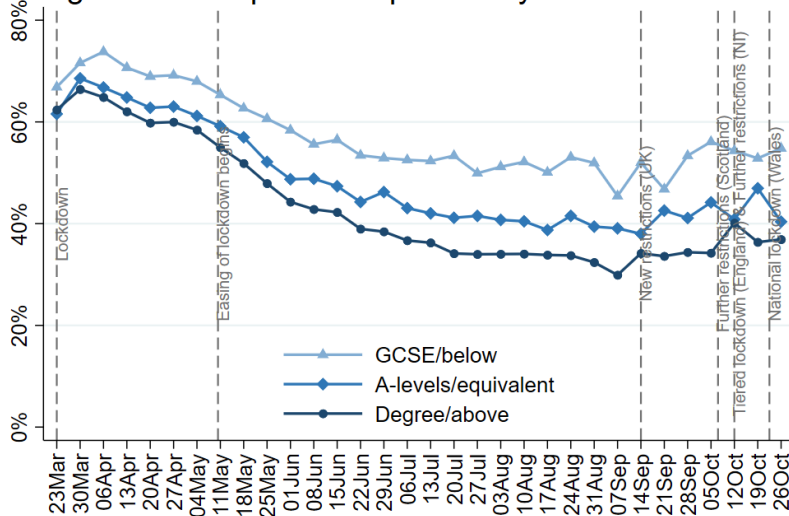
Figure 2l Complete compliance by physical health diagnosis

Figure 2m Majority compliance by age groups

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

Figure 2n Majority compliance by living arrangement

Legend:
- Living alone
- Not living alone
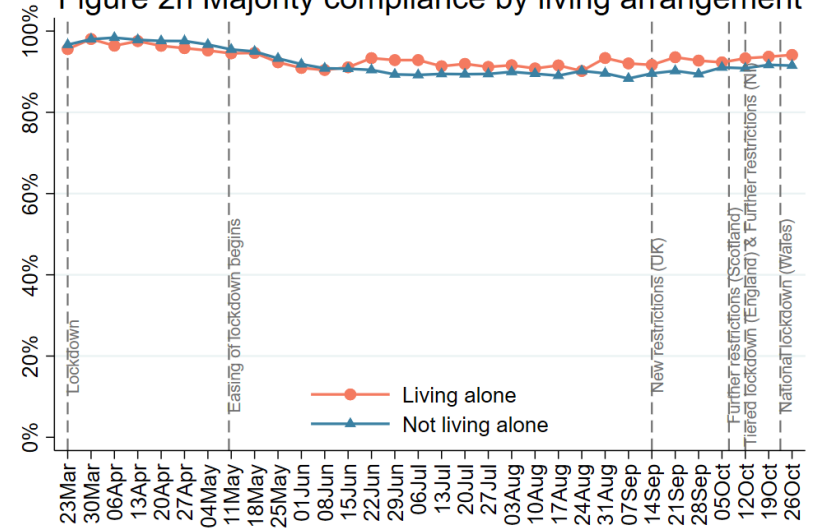
Figure 2o Majority compliance by household income

Legend:
- Household income <30k
- Household income >30k
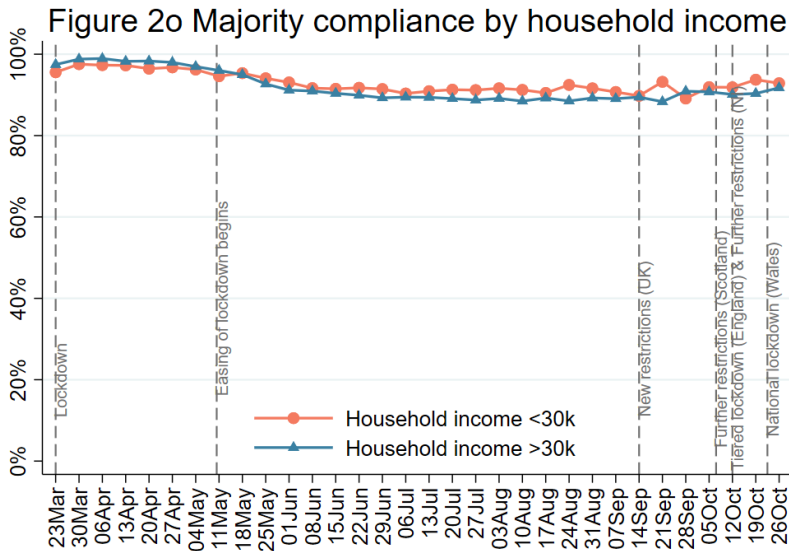
Figure 2p Majority compliance by mental health

Legend:
- Mental health diagnosis
- No diagnosis

Figure 2q Majority compliance by nations

Figure 2r Majority compliance by keyworker status
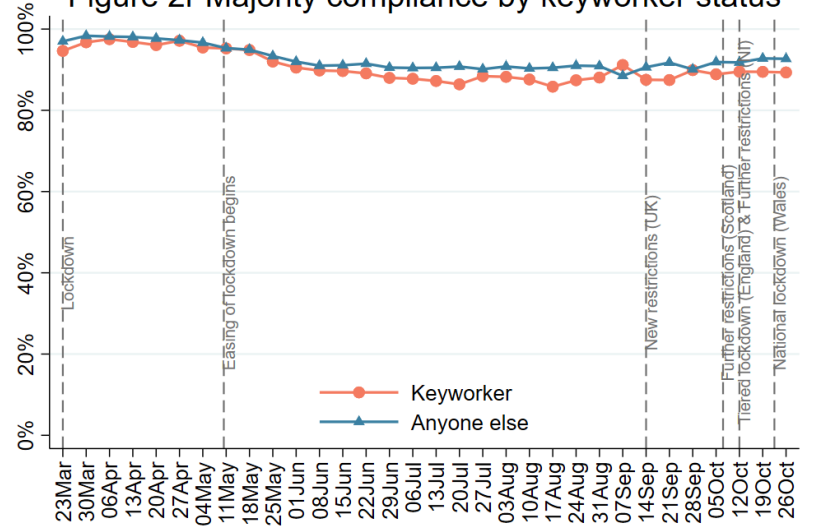
Figure 2s Majority compliance by living with children
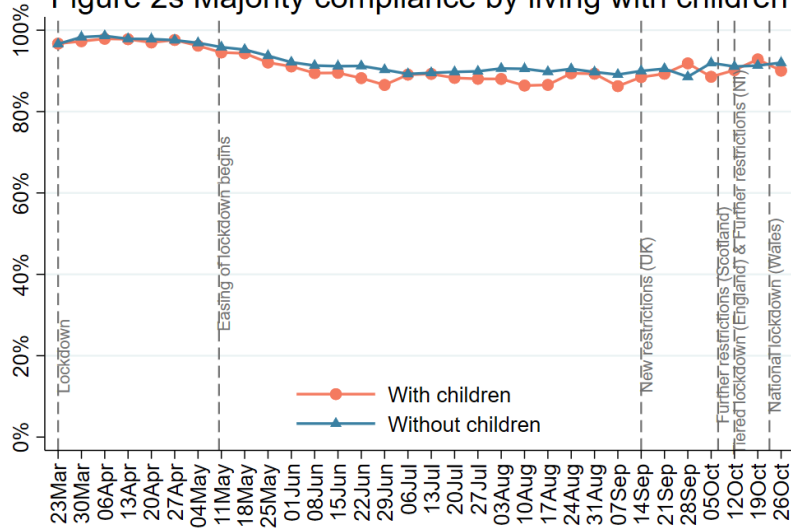
Figure 2t Majority compliance by living area

Figure 2u Majority compliance by gender
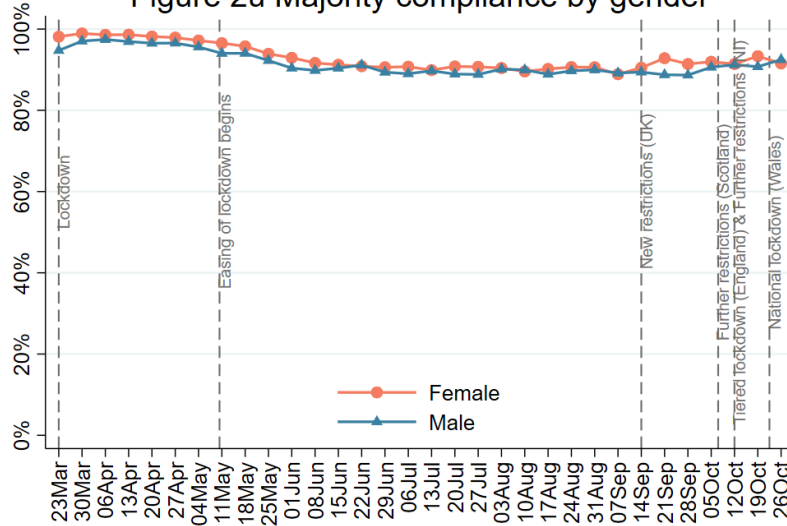
Figure 2v Majority compliance by ethnicity
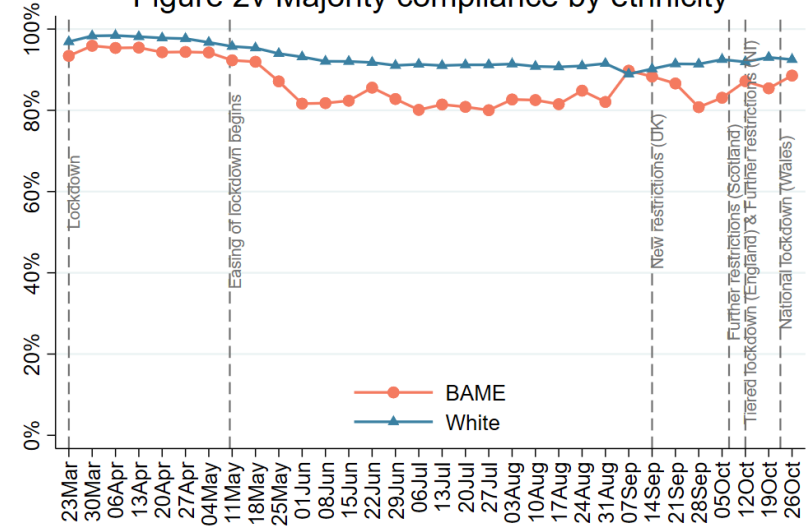
Figure 2w Majority compliance by educational levels
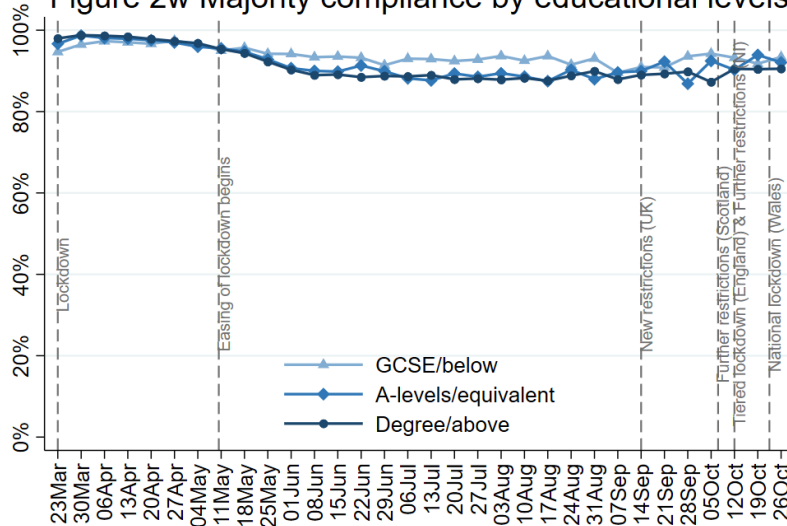
Figure 2x Majority compliance by physical health diagnosis

1.2 Confidence in Government
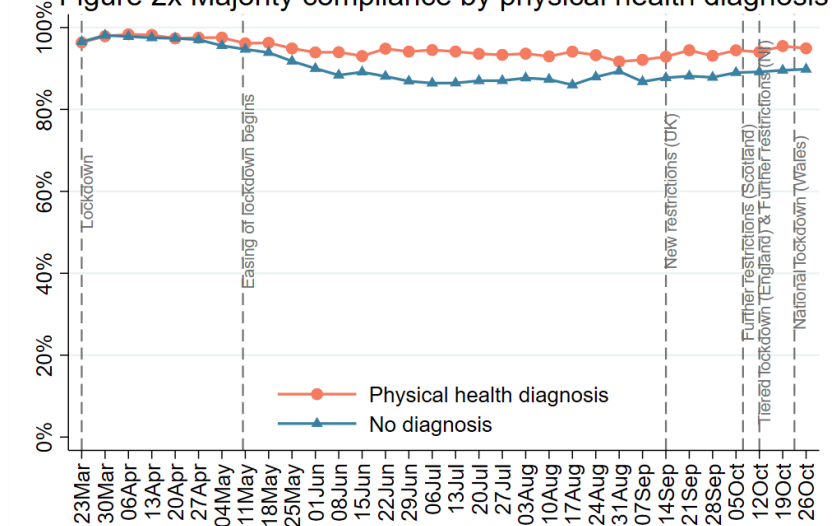
Figure 3 Confidence in government
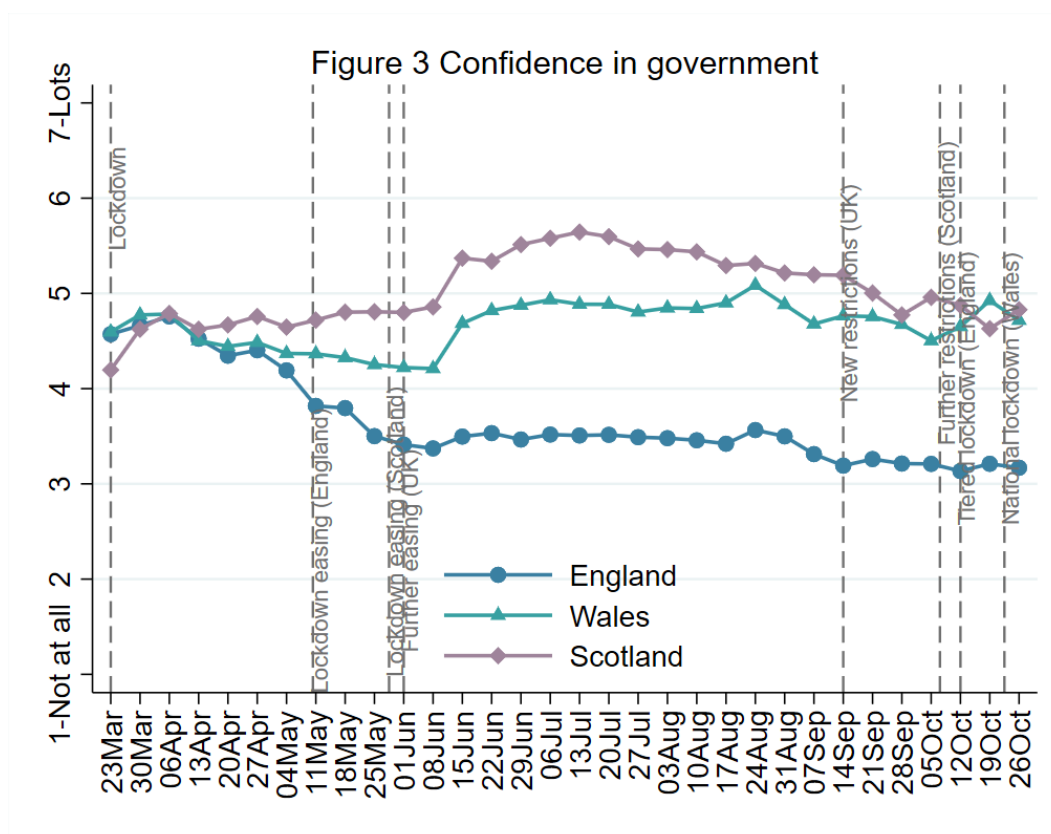
FINDINGS

Respondents were asked how much confidence they had in the government to handle the Covid-19 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.[1]

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 and in people with a mental health diagnosis. Confidence is also slightly lower in people of higher household income.

Notably, there is no difference in confidence in government by gender and little evidence of a difference amongst people with and without a long-term physical health condition, but people from BAME backgrounds have consistently had lower confidence in the government across the pandemic, as have people with higher educational qualifications.

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[1] 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.
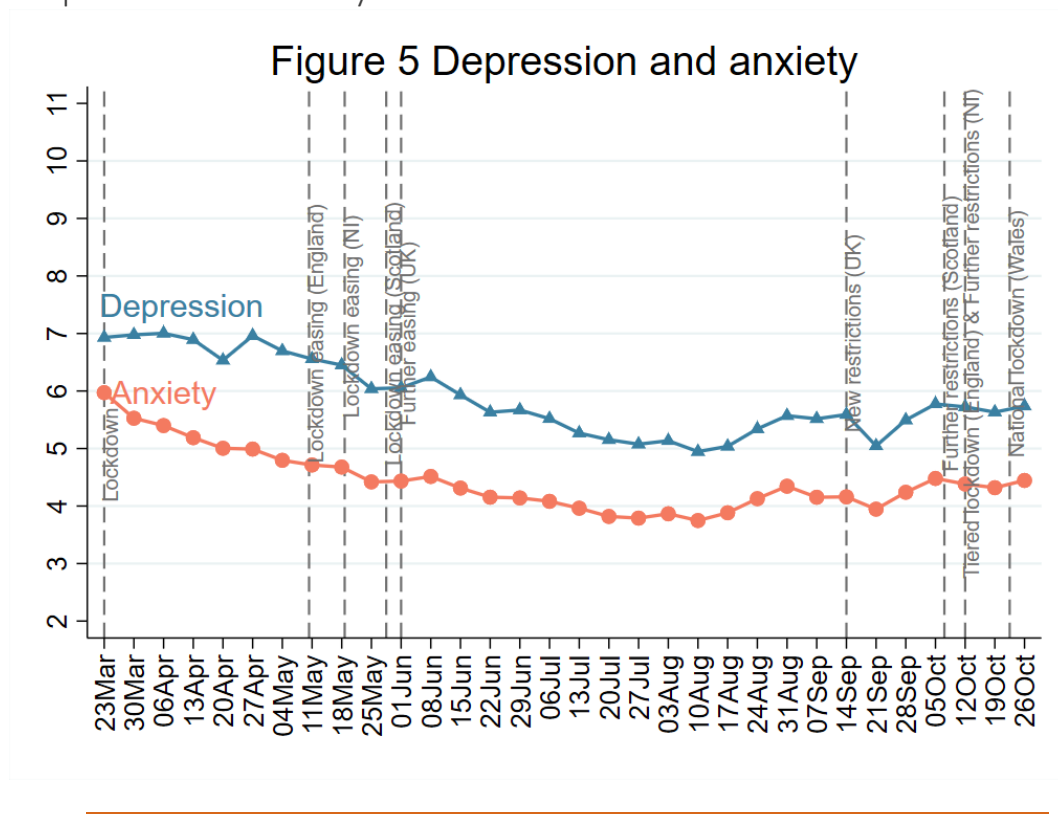
Figure 4a Confidence by age groups

Legend: Age 18-29, Age 30-59, Age 60+

Figure 4b Confidence by living arrangement

Legend: Living alone, Not living alone

Figure 4c Confidence by household income

Legend: Household income <30k, Household income >30k

Figure 4d Confidence by mental health diagnosis

Legend: 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

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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

The chart plots two lines over time (23 Mar to 26 Oct). A blue line labelled "Depression" starts around 7 and declines to about 5 before rising again to near 6. An orange line labelled "Anxiety" starts around 6 and declines to about 4 before rising slightly. Vertical dashed lines mark: Lockdown, Lockdown easing (England), Lockdown easing (NI), Lockdown easing (Scotland), Further easing (UK), New restrictions (UK), Further restrictions (Scotland), Tiered lockdown (England) & Further restrictions (NI), National lockdown (Wales).

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. 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[2]).

Depression and anxiety are still highest in young adults, people living alone, people with lower household income, 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).

Depression and anxiety have been consistently higher throughout the pandemic amongst women, people with a long-term physical health condition, people with lower educational qualifications, and people from BAME backgrounds.

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[2] 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
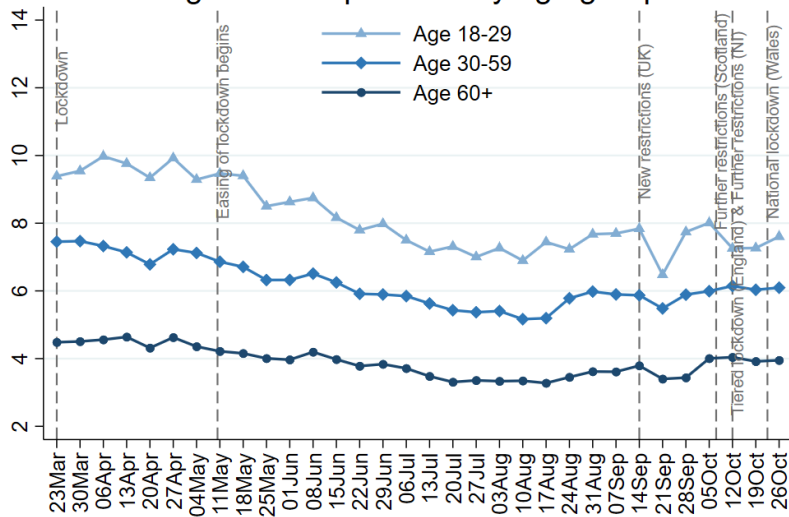
Figure 6b Depression by living arrangement
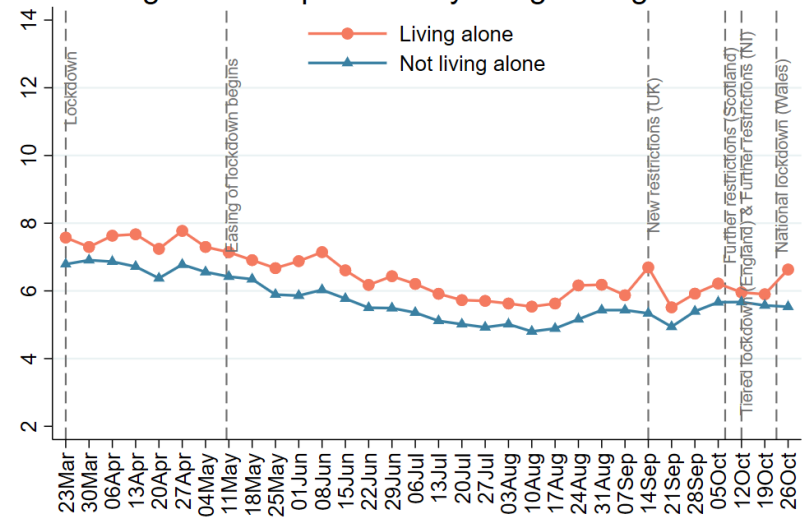
Figure 6c Depression by household income
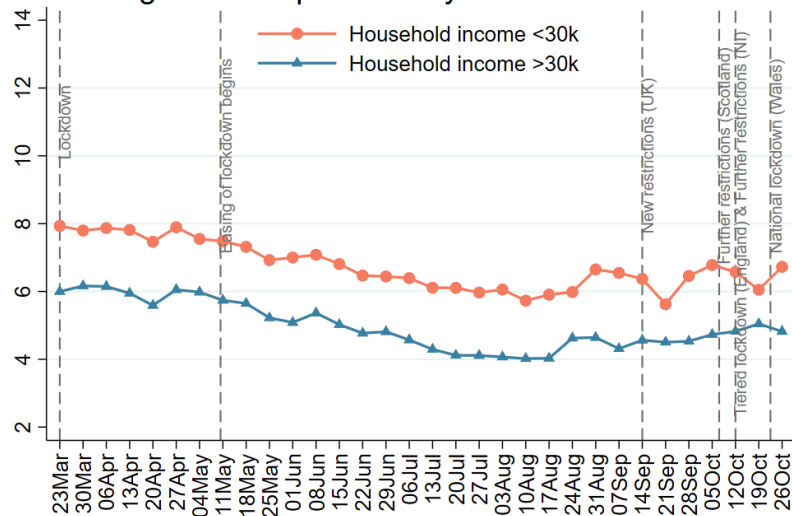
Figure 6d Depression by mental health diagnosis
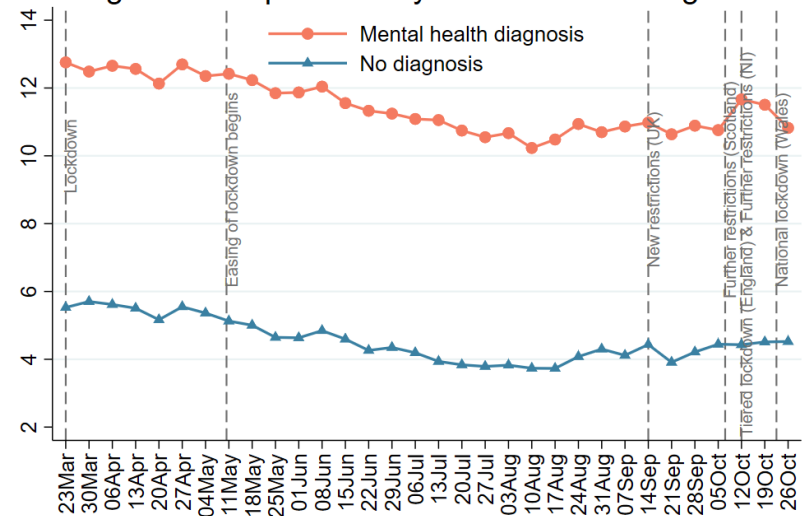
Figure 6e Depression by nations
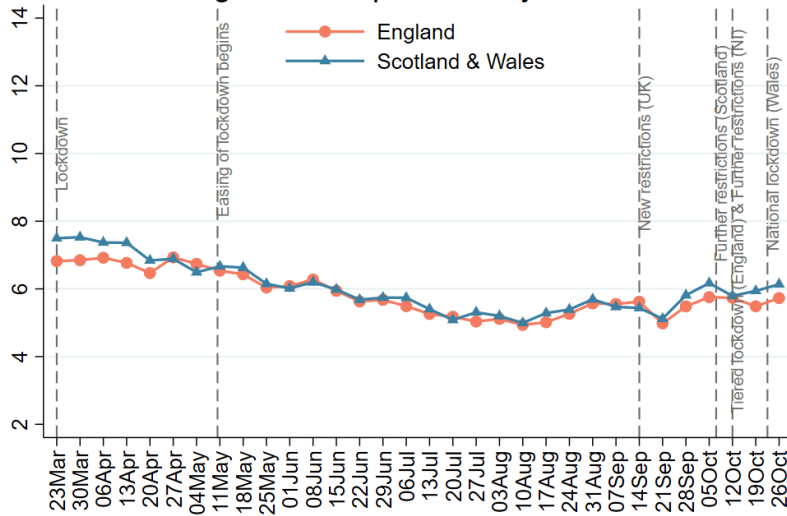
Figure 6f Depression by keyworker status
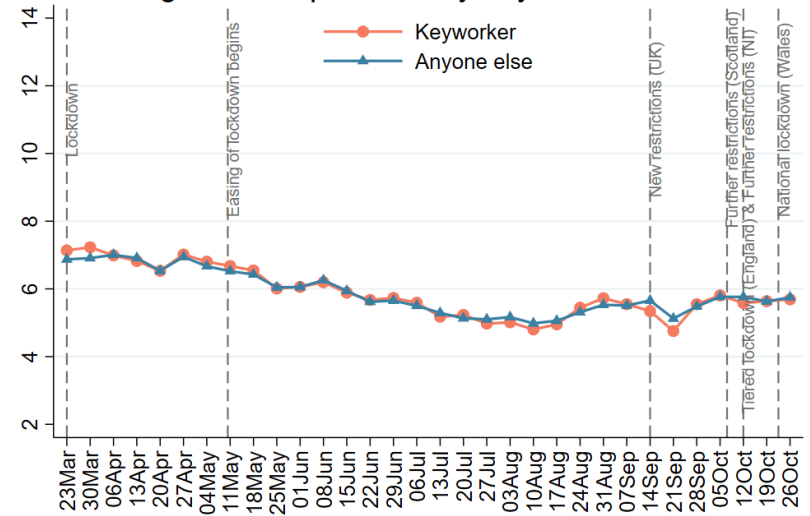
Figure 6g Depression by living with children
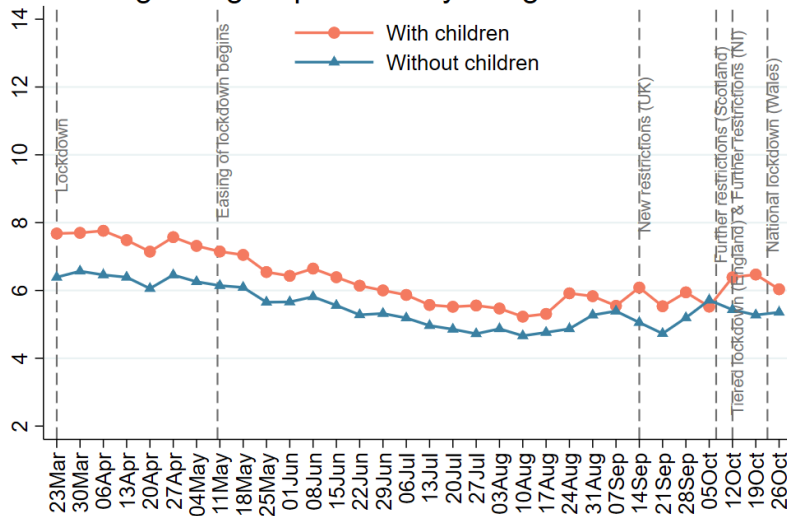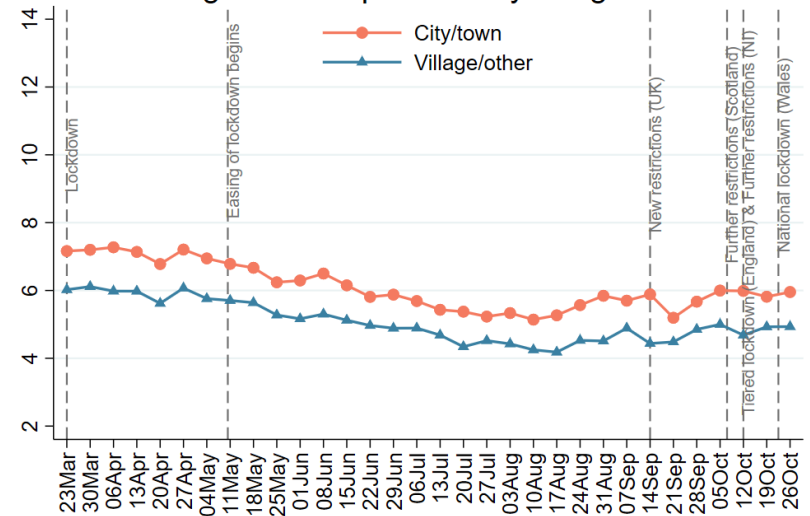

Figure 6h Depression by living area

Figure 6i Depression by gender
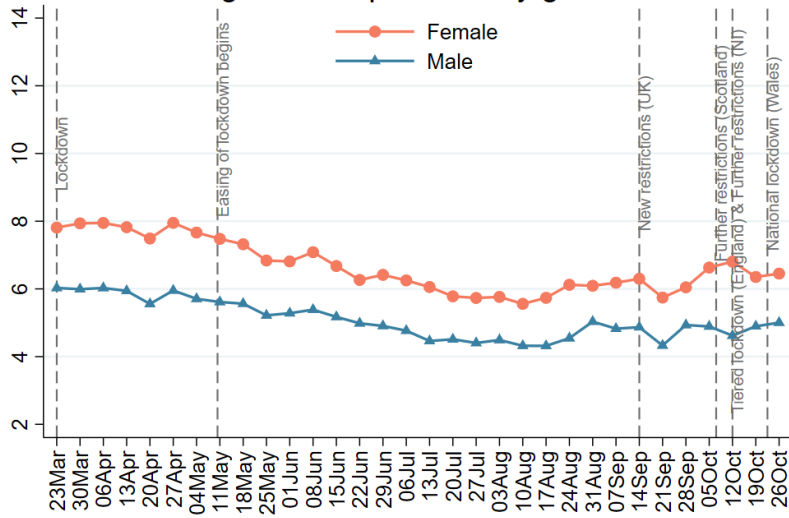
Figure 6j Depression by ethnicity
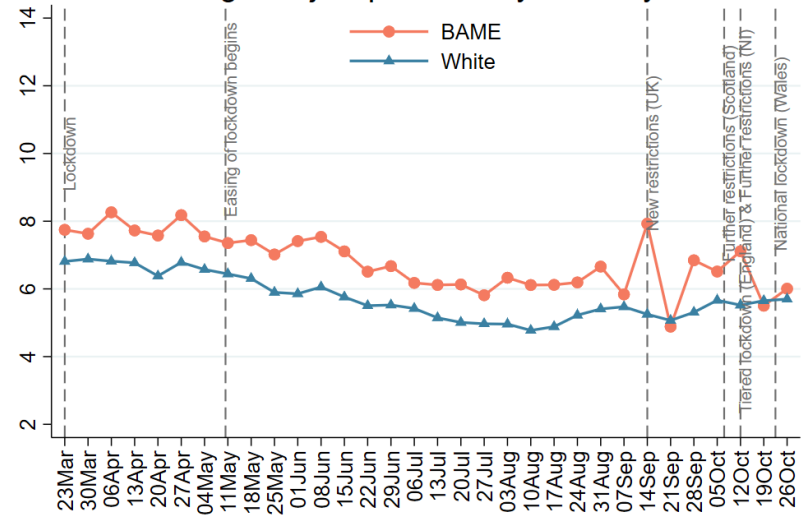
Figure 6k Depression by educational levels
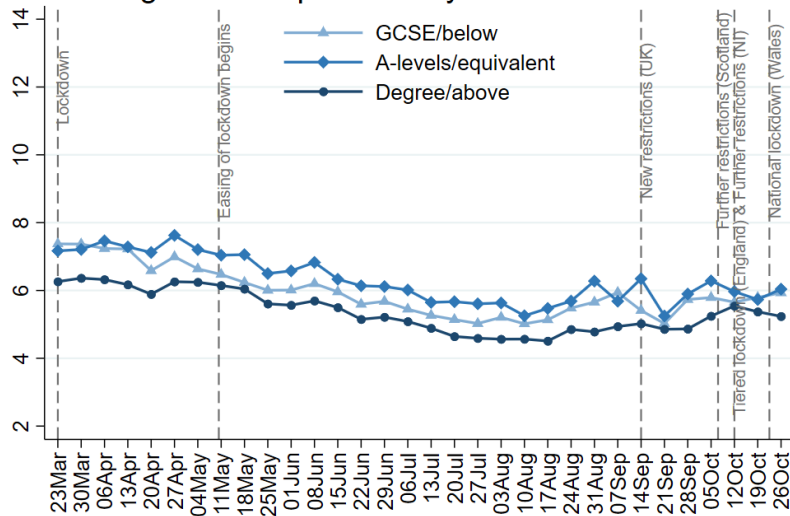
Figure 6l Depression by physical health diagnosis
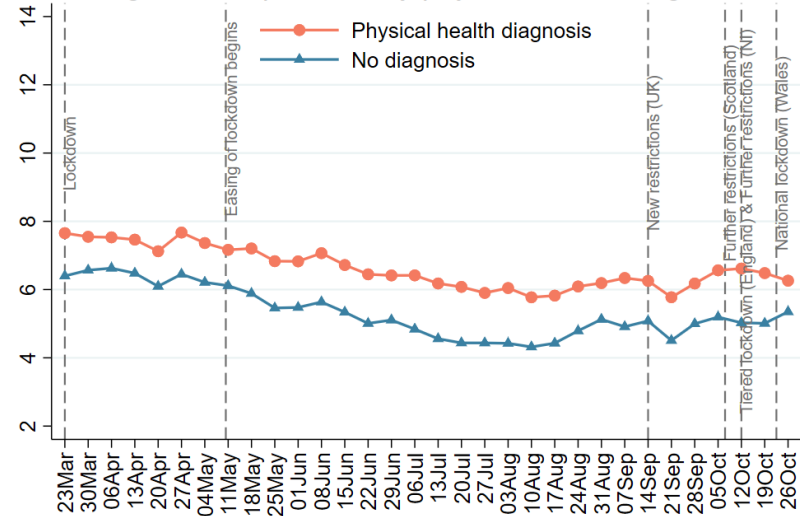
Figure 7a Anxiety by age groups
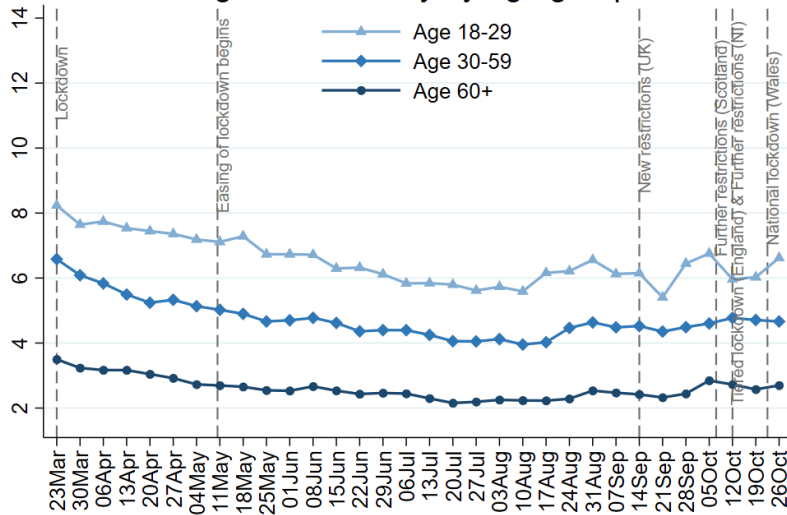
Figure 7b Anxiety by living arrangement
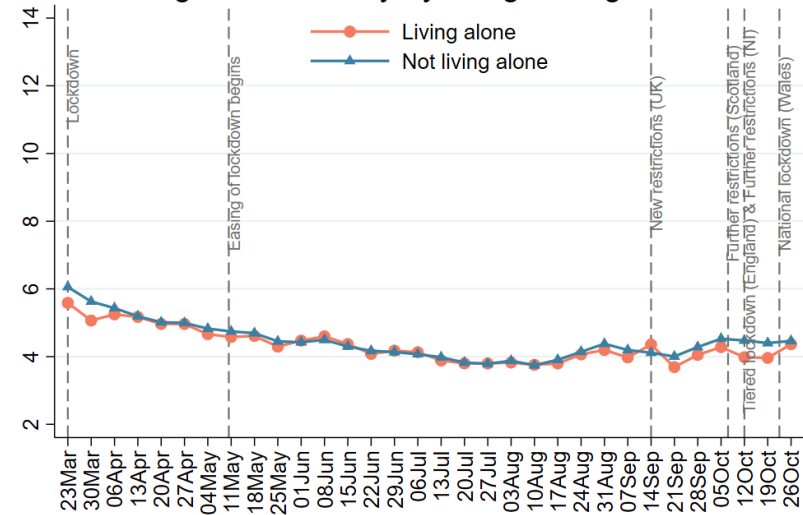
Figure 7c Anxiety by household income
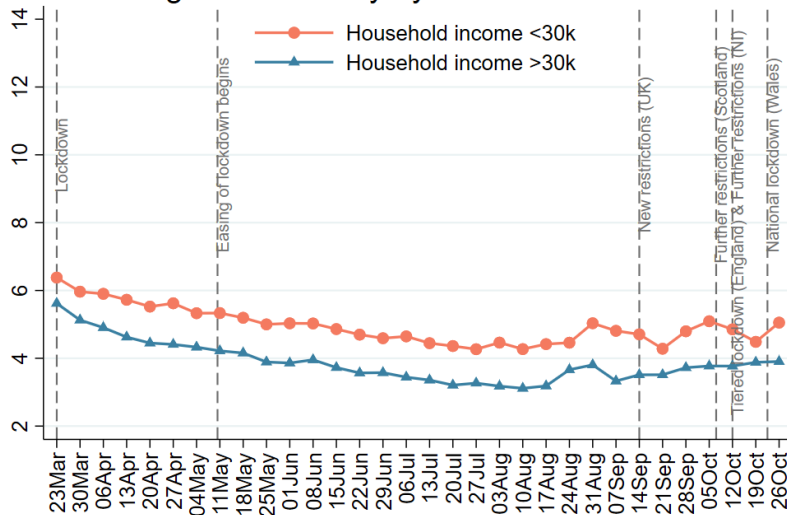
Figure 7d Anxiety by mental health diagnosis
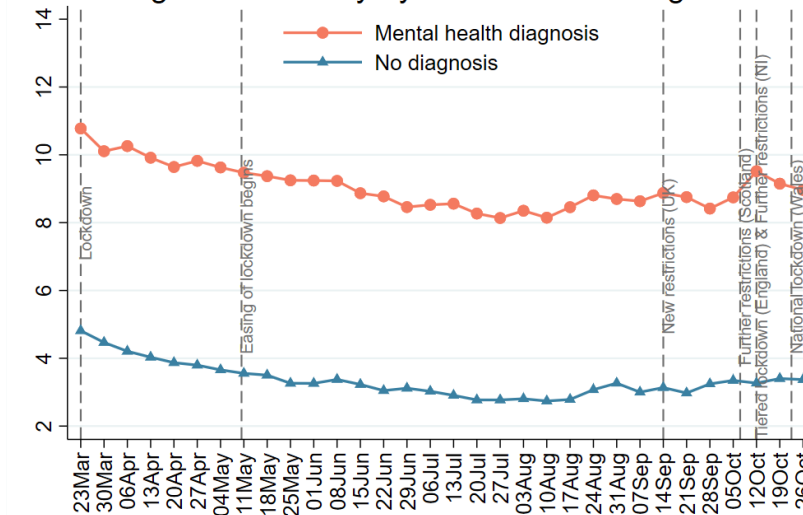
Figure 7e Anxiety by nations
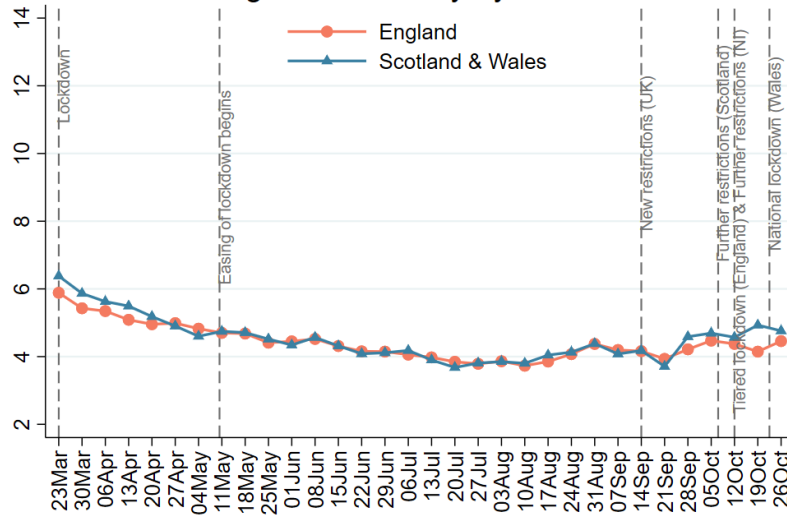
Figure 7f Anxiety by keyworker status
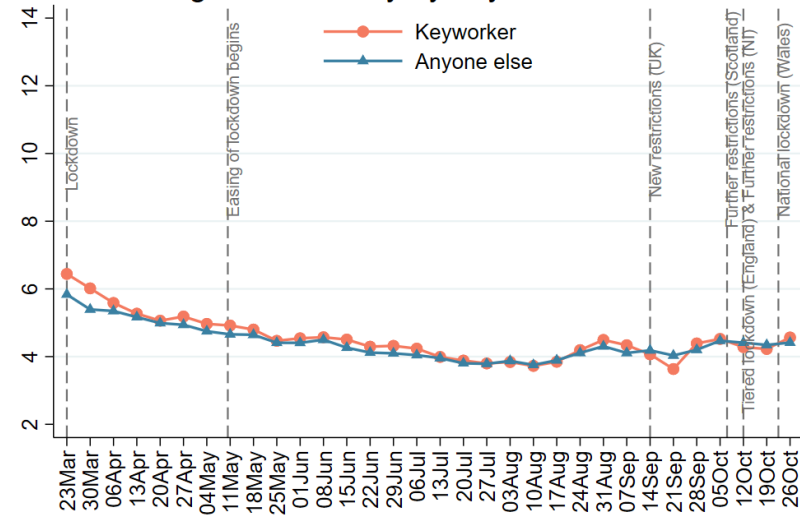
Figure 7g Anxiety by living with children
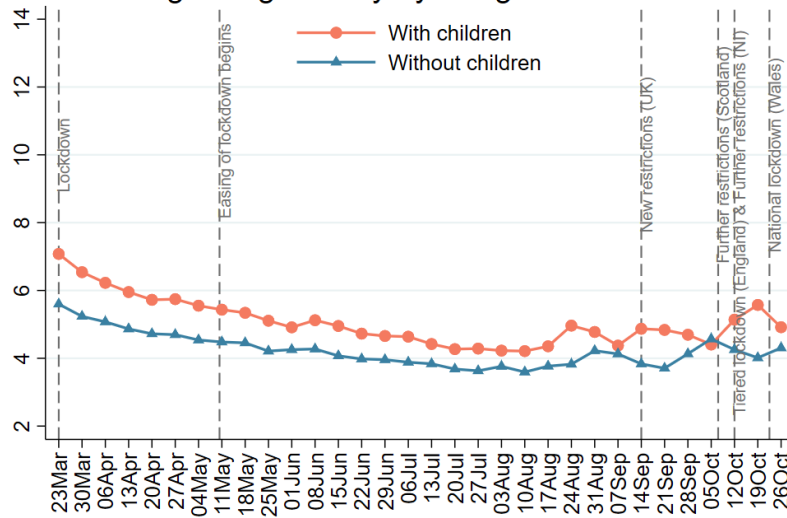
Figure 7h Anxiety by living area
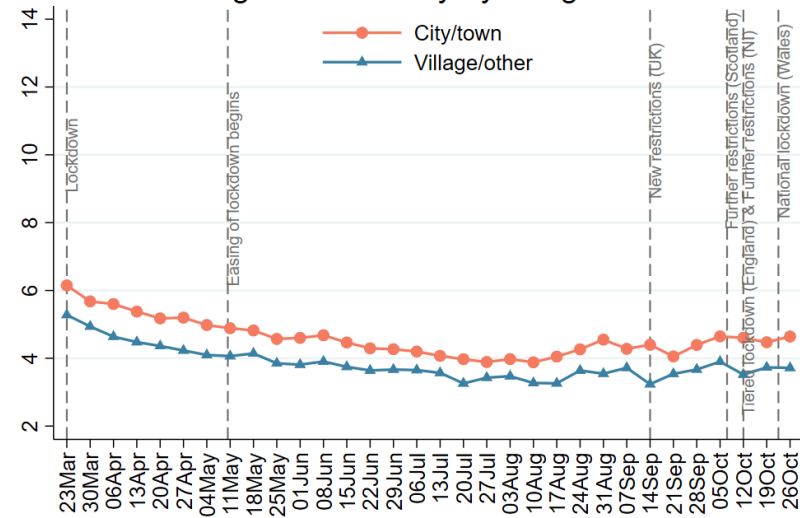
Figure 7i Anxiety by gender
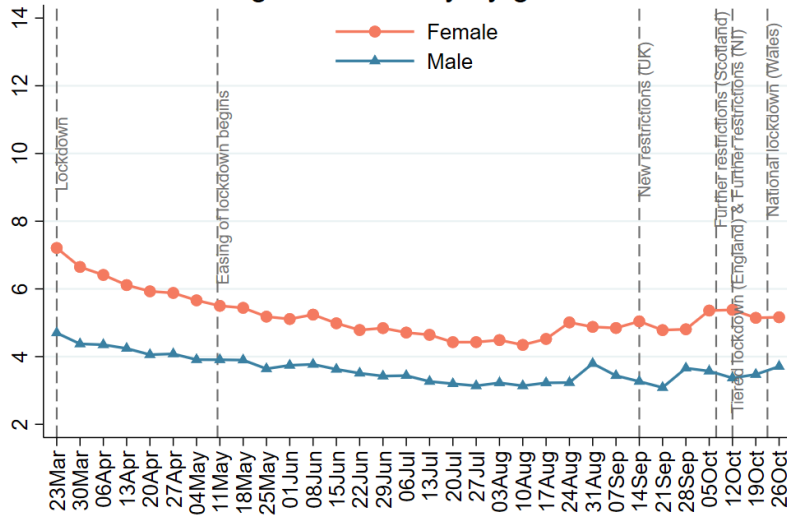
Figure 7j Anxiety by ethnicity
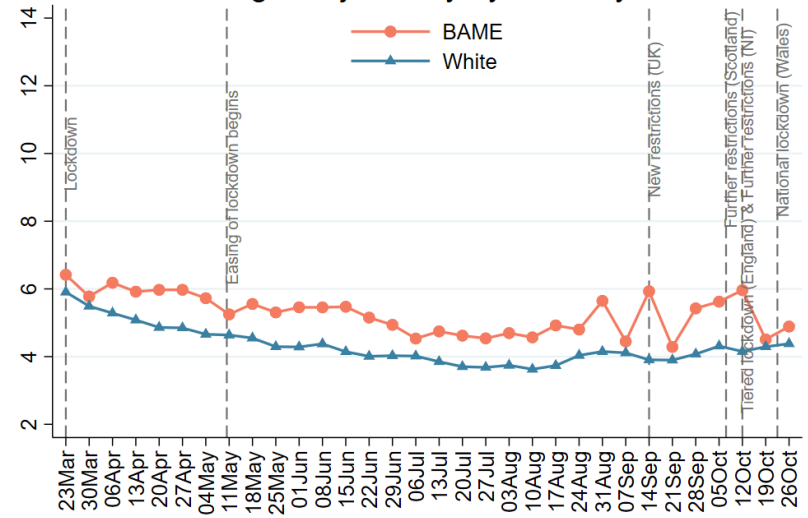
Figure 7k Anxiety by educational levels
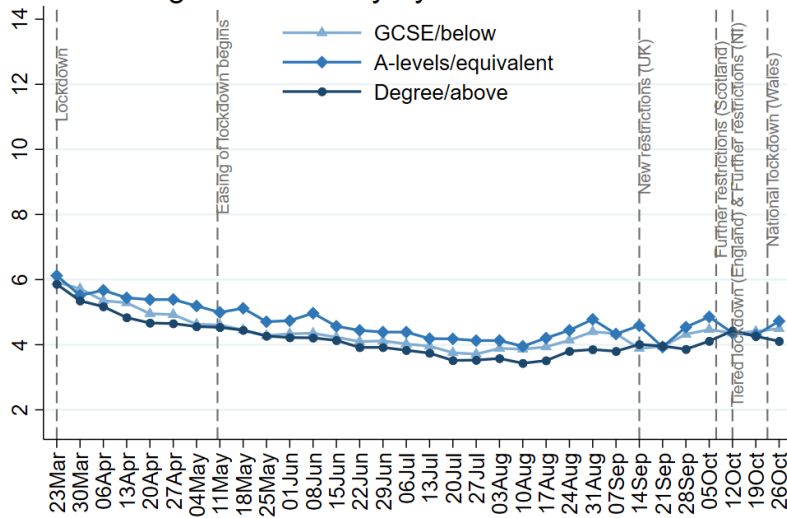
Figure 7l Anxiety by physical health diagnosis

2.2 Stress

Figure 8 Stressors
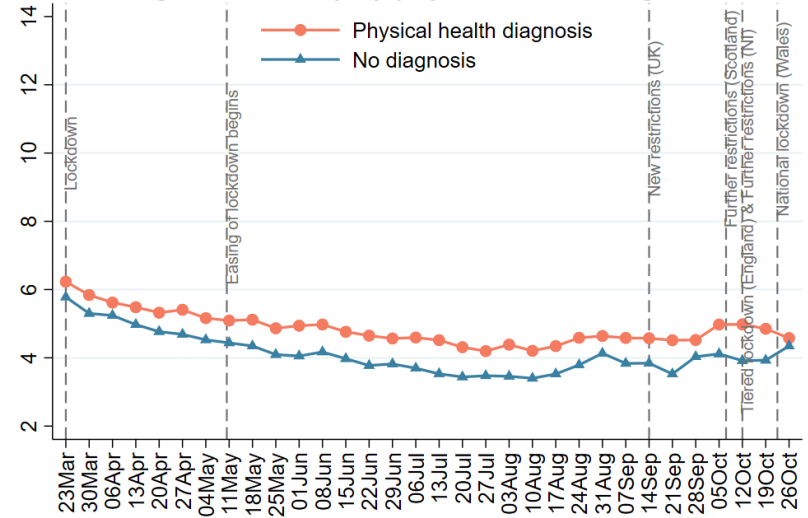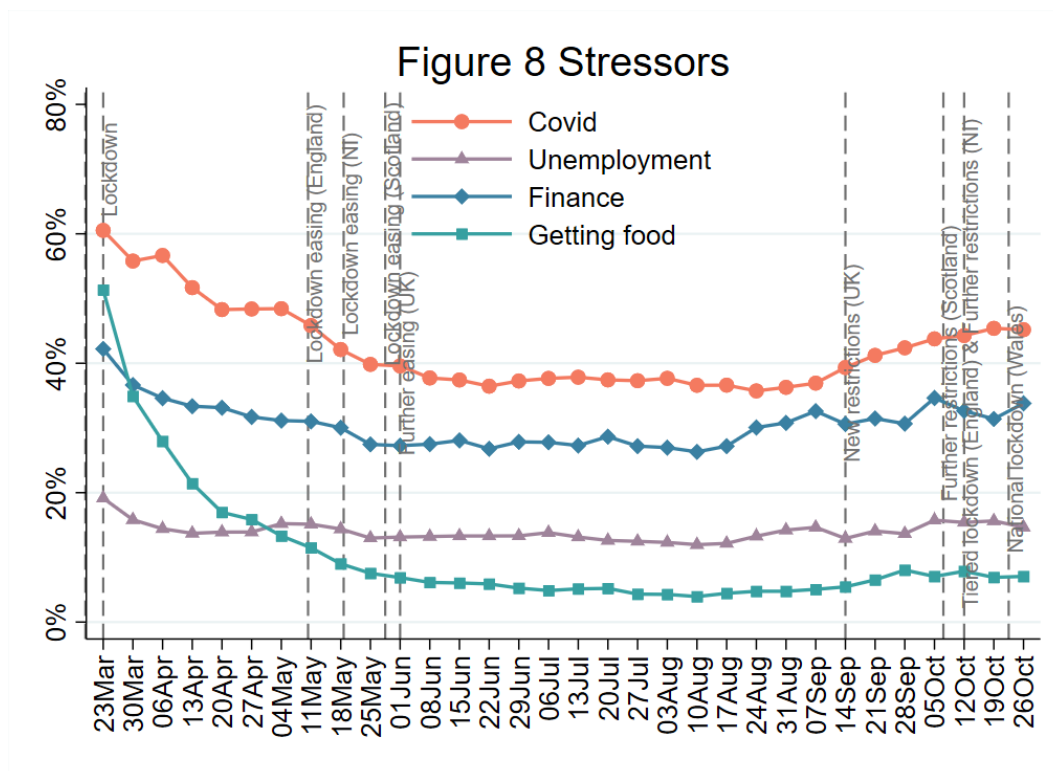
We asked participants to report which factors were causing them stress in the last week, either minor stress or major stress (which was defined as stress that was constantly on their mind or kept them awake at night).

Stress about catching Covid-19 has continued to increase in the past month, now with nearly half of adults worried either about catching Covid-19 or becoming seriously ill from it. This stress has increased in all groups.

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
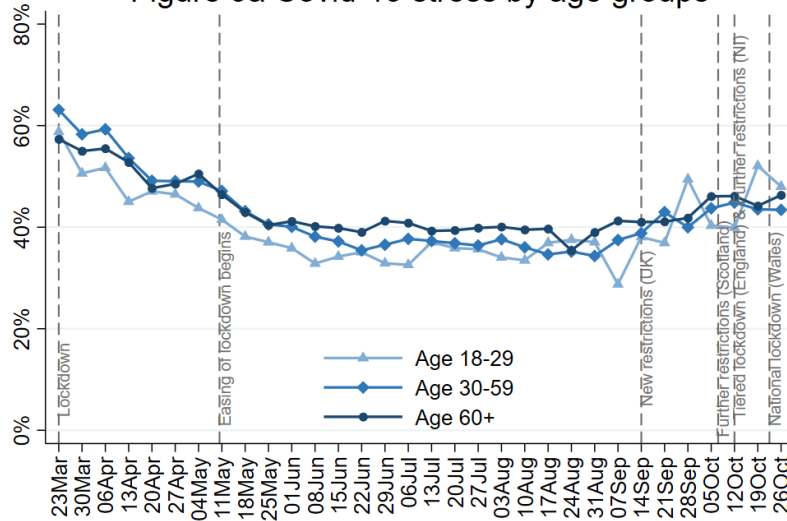
Figure 9b Covid-19 stress by living arrangement
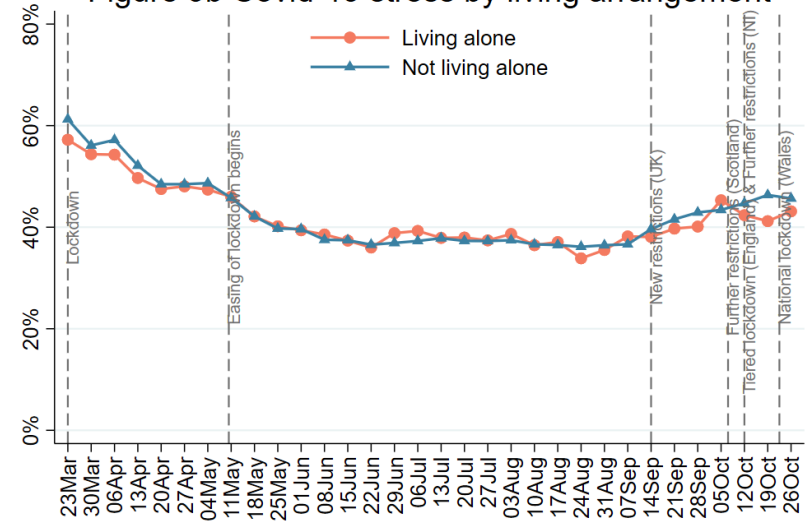
Figure 9c Covid-19 stress by household income
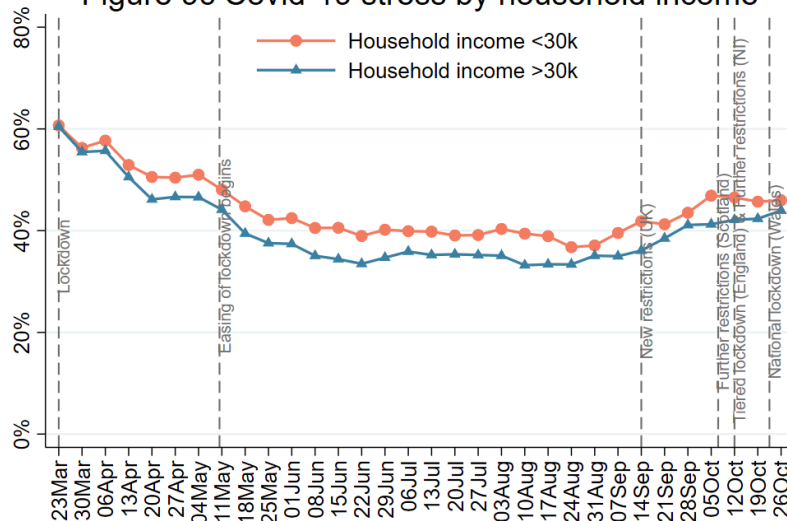
Figure 9d Covid-19 stress by mental health diagnosis

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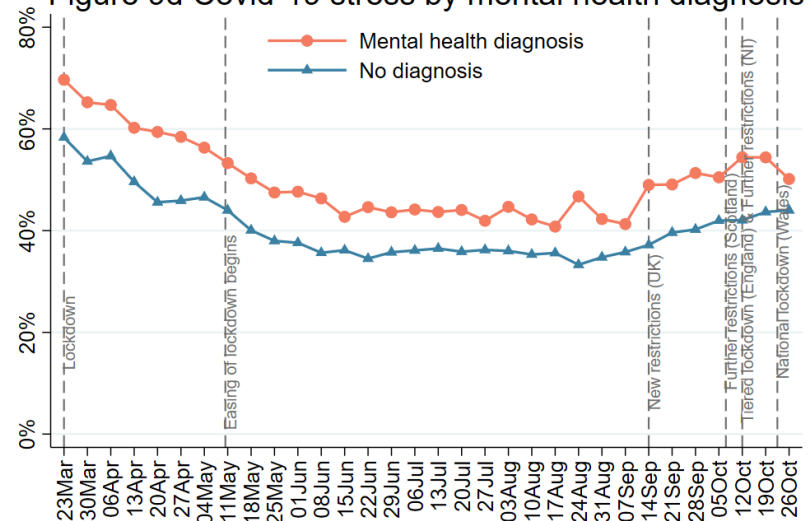
Figure 9e Covid-19 stress by nations
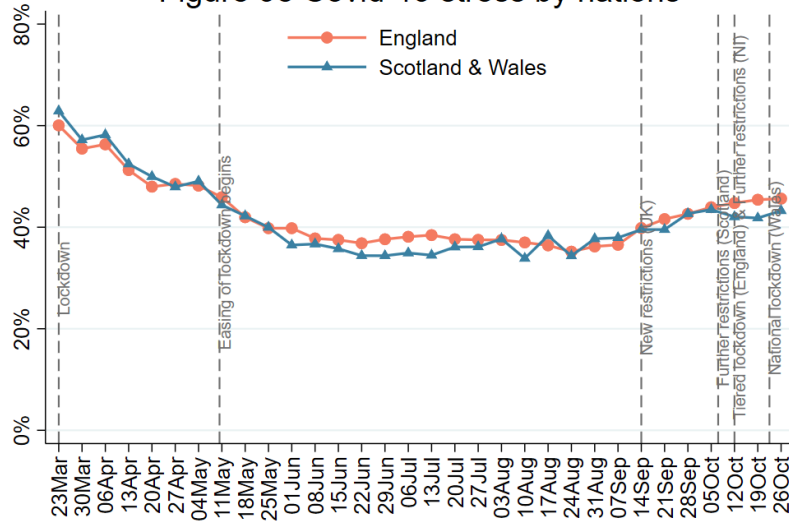
Figure 9f Covid-19 stress by keyworker status
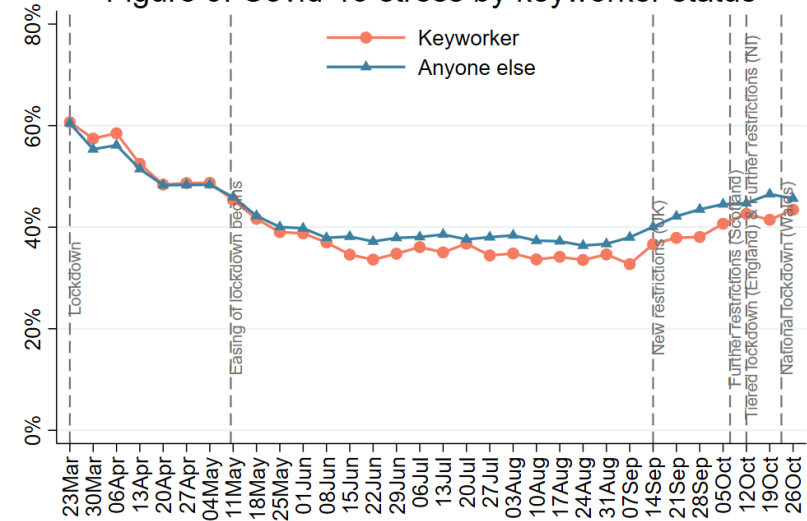
Figure 9g Covid-19 stress by living with children
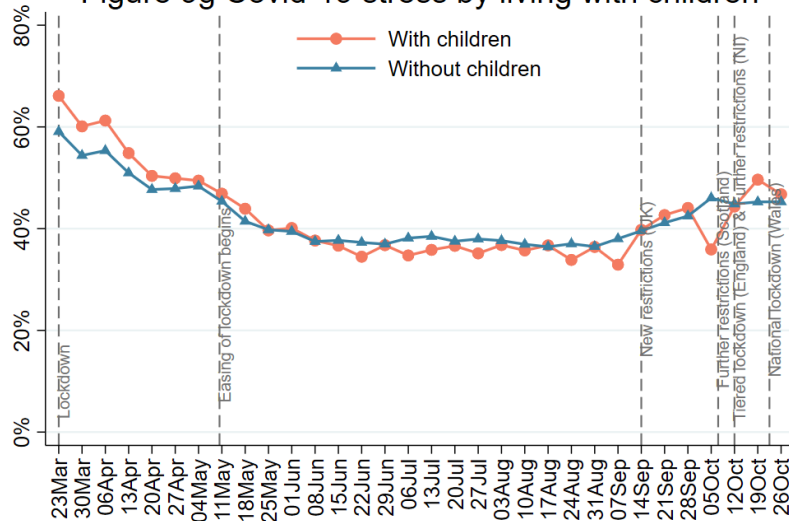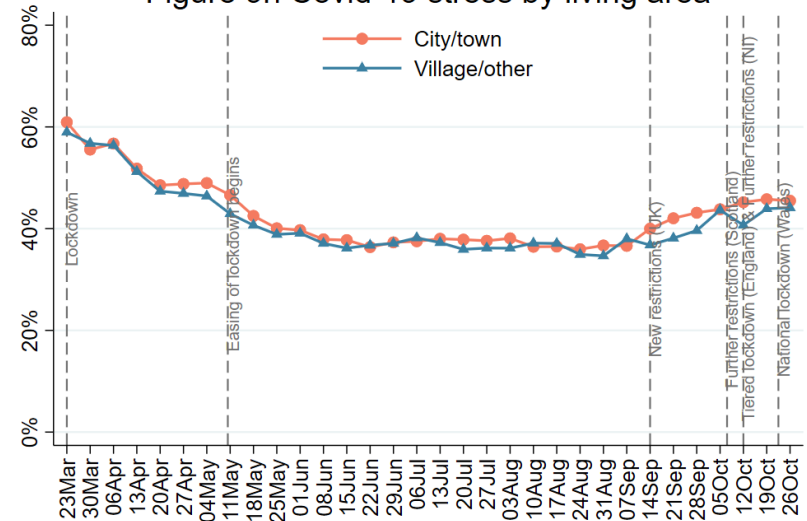

Figure 9h Covid-19 stress by living area
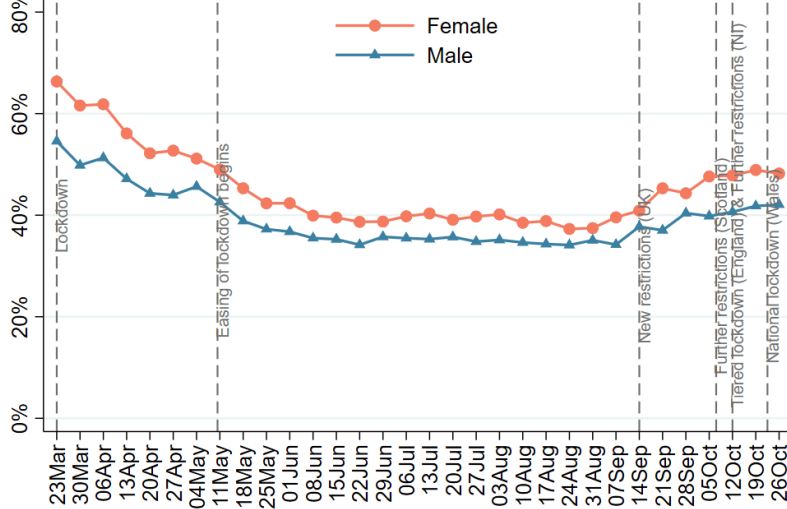
Figure 9i Covid-19 stress by gender

Figure 9j Covid-19 stress by ethnicity
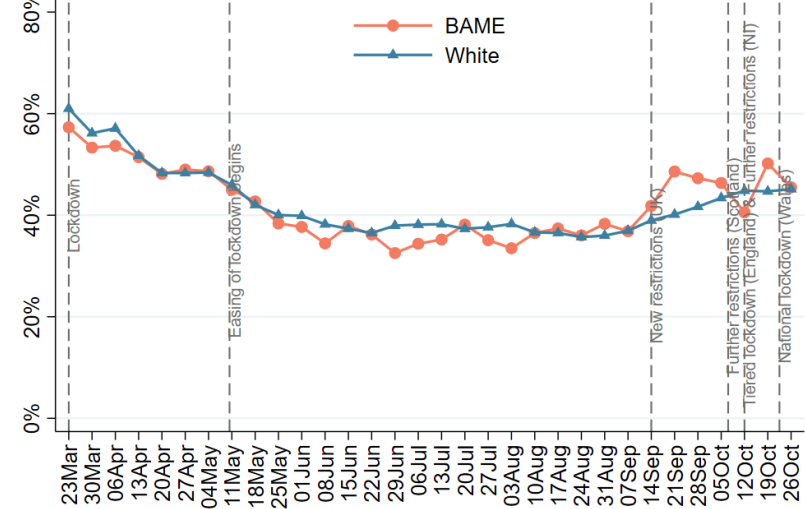
Figure 9k Covid-19 stress by educational levels
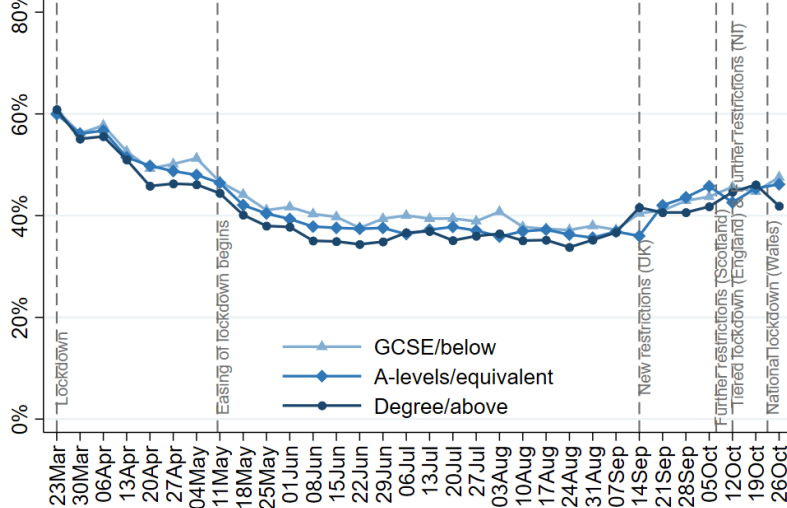
Figure 9l Covid-19 stress by physical health diagnosis
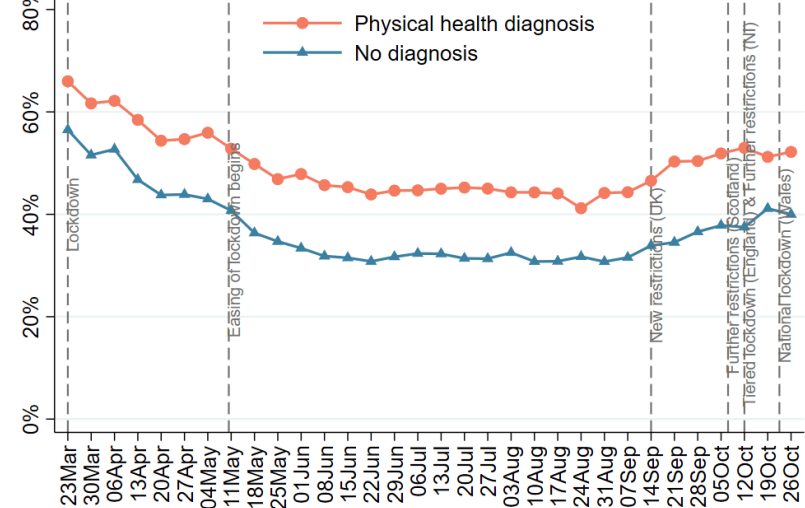
Figure 10a Unemployment stress by age groups
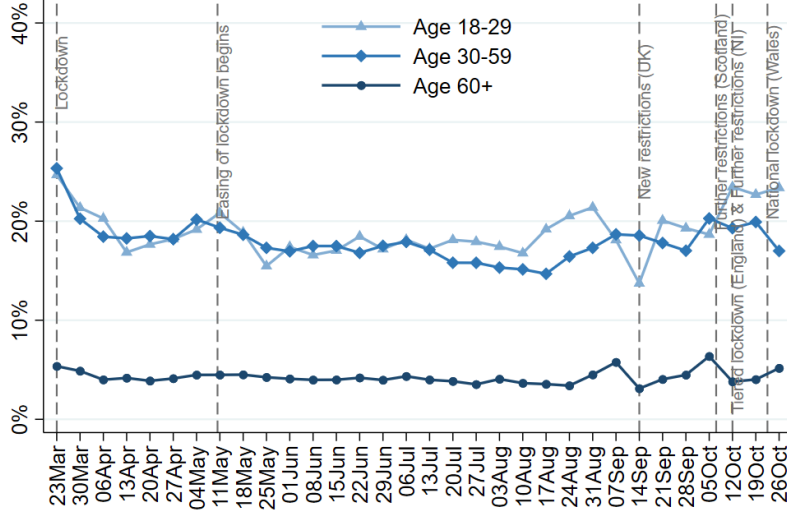
Figure 10b Unemployment stress by living arrangement
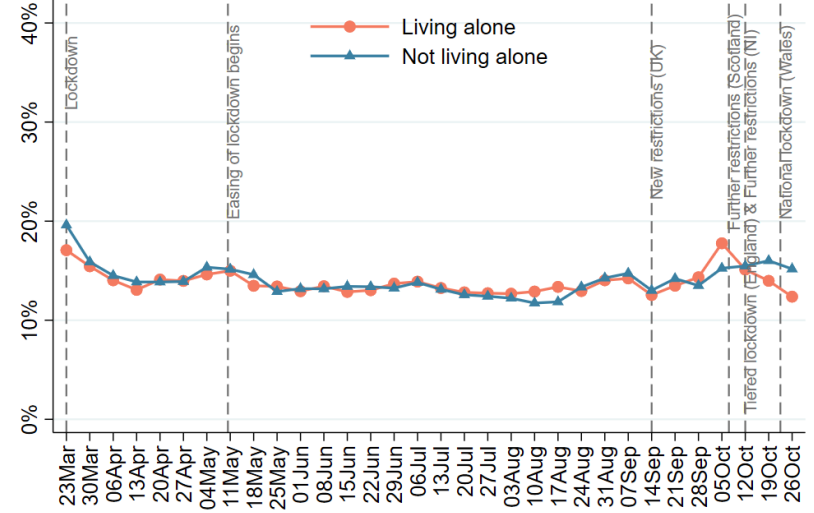
Figure 10c Unemployment stress by household income
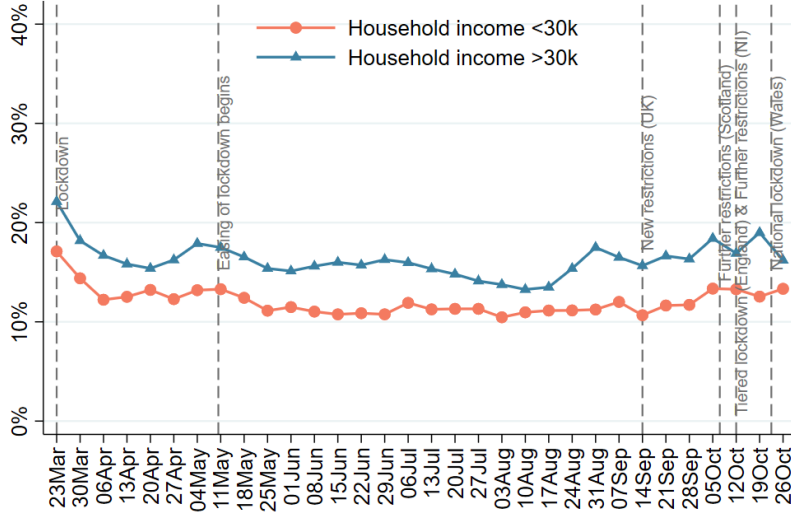
Figure 10d Unemployment stress by mental health
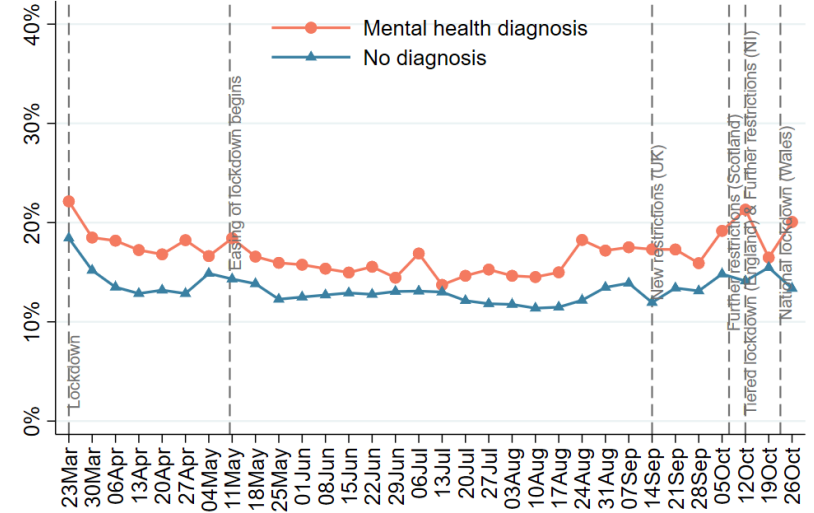
Figure 10e Unemployment stress by nations
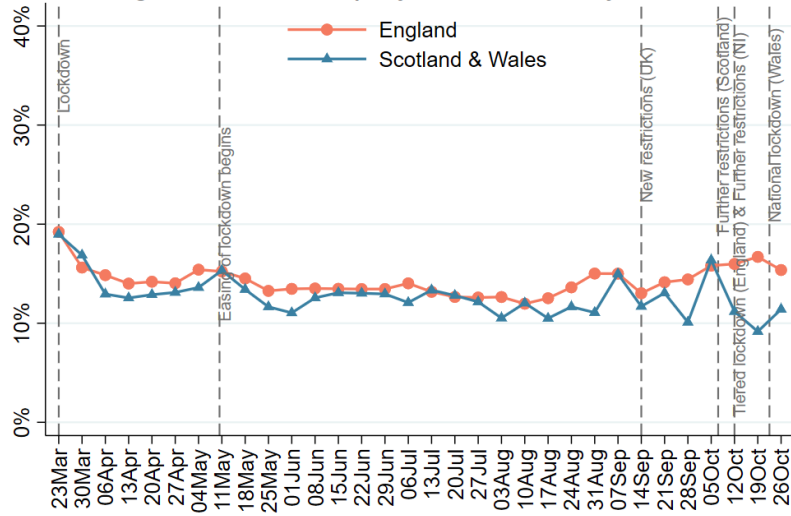
Figure 10f Unemployment stress by keyworker status
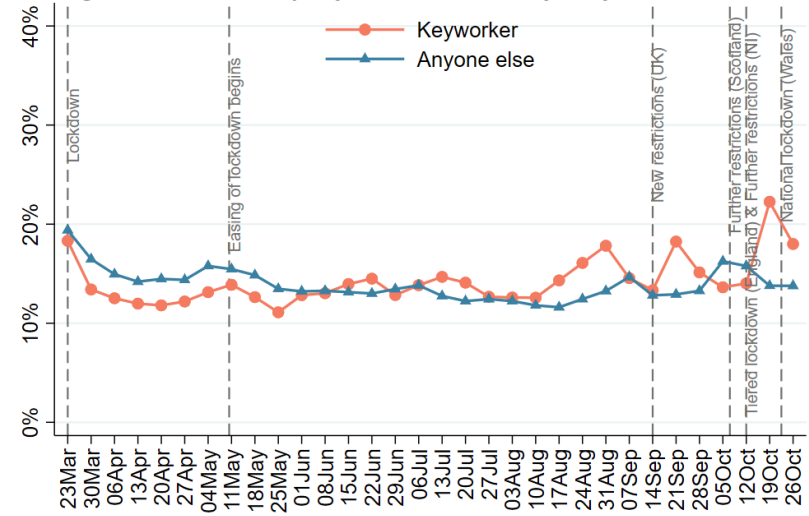
Figure 10g Unemployment stress by living with children
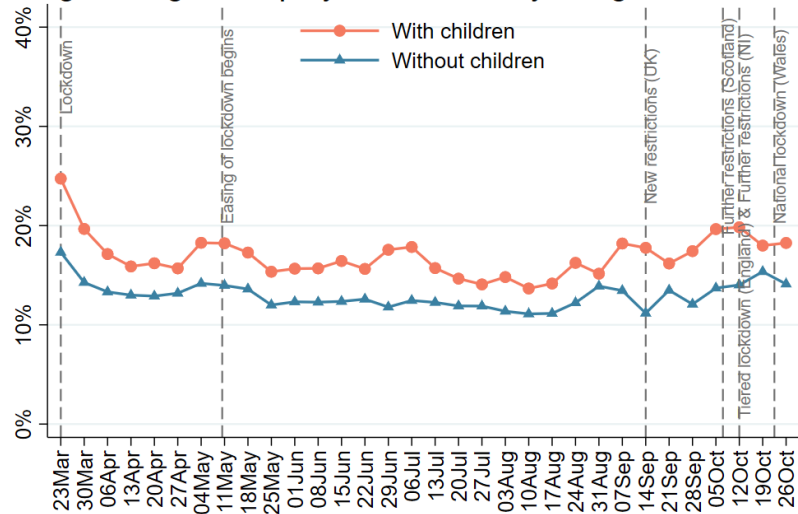
Figure 10h Unemployment stress by living area
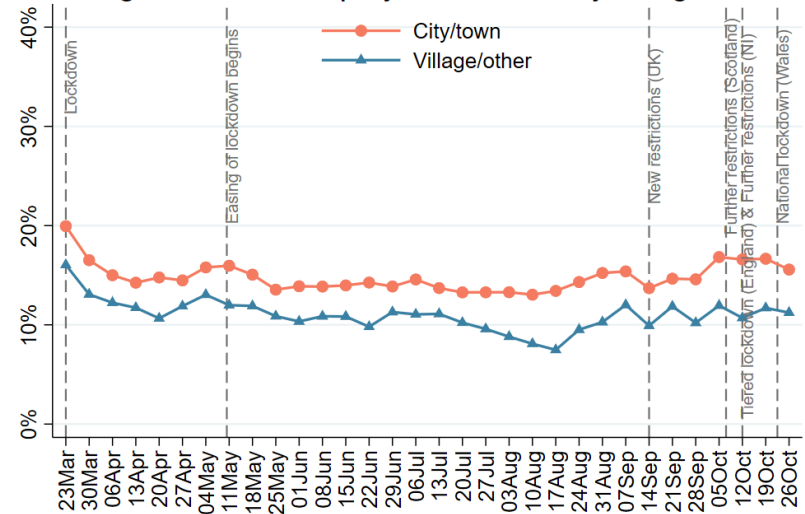
Figure 10i Unemployment stress by gender
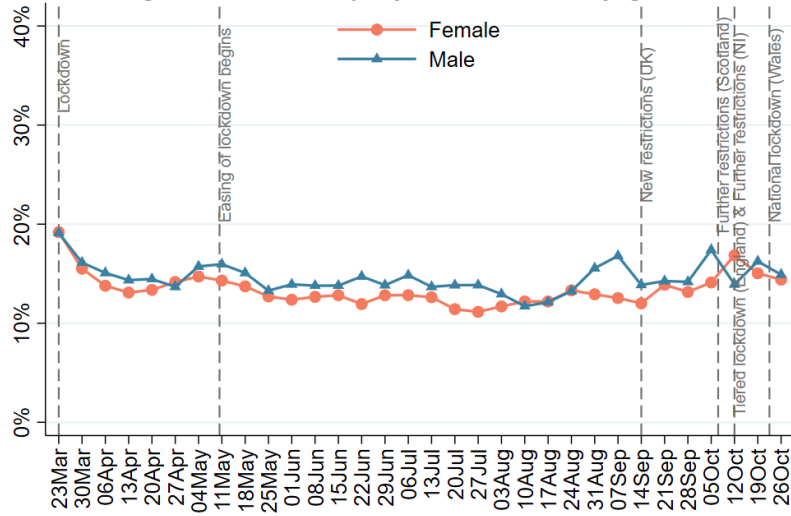
Figure 10j Unemployment stress by ethnicity
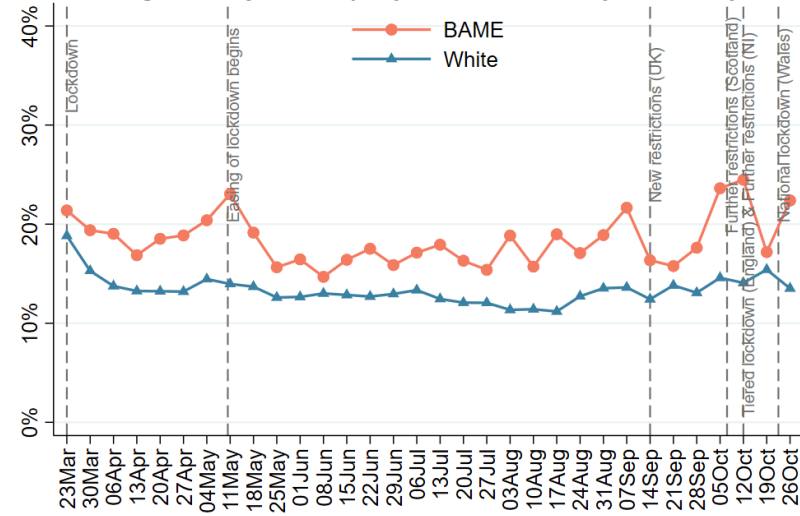
Figure 10k Unemployment stress by educational levels
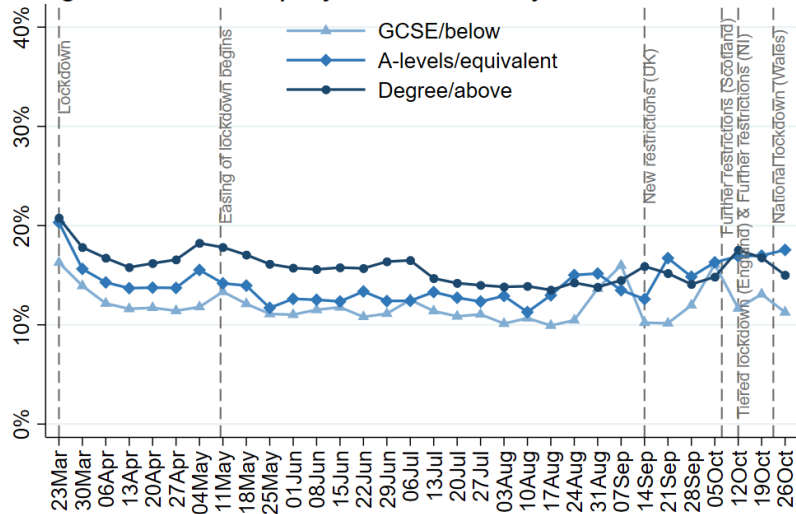
Figure 10l Unemployment stress by physical health diagnosis
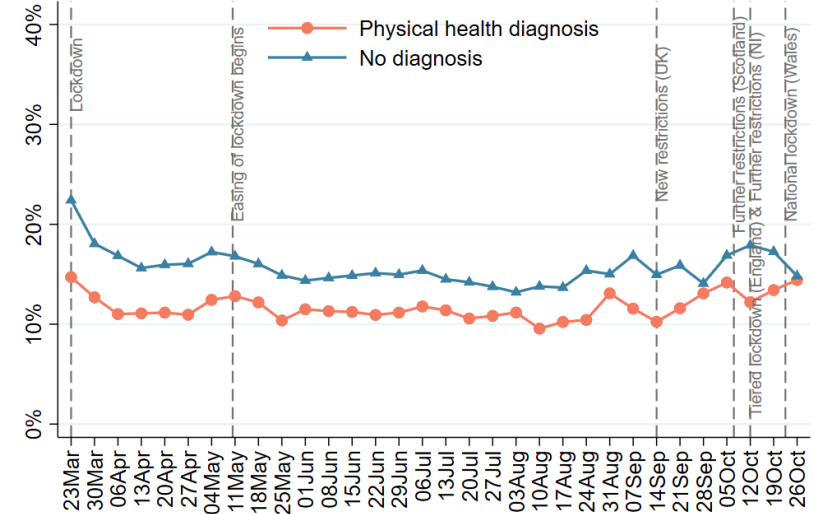
Figure 11a Financial stress by age groups
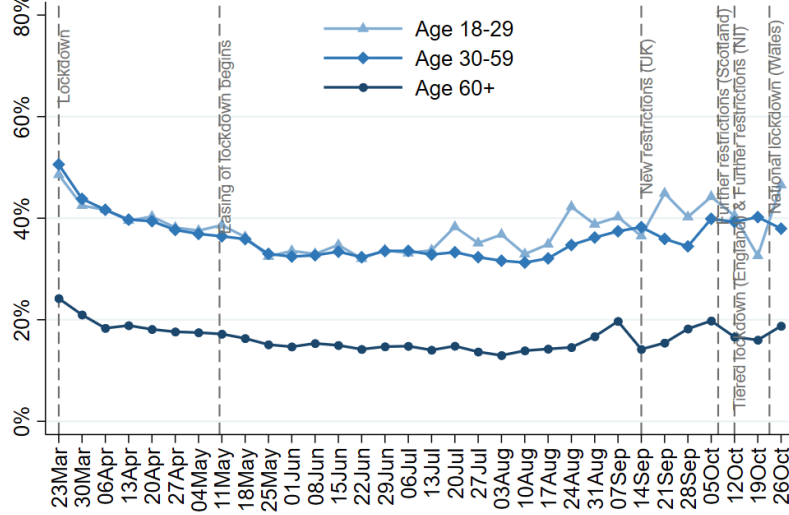
Figure 11b Financial stress by living arrangement
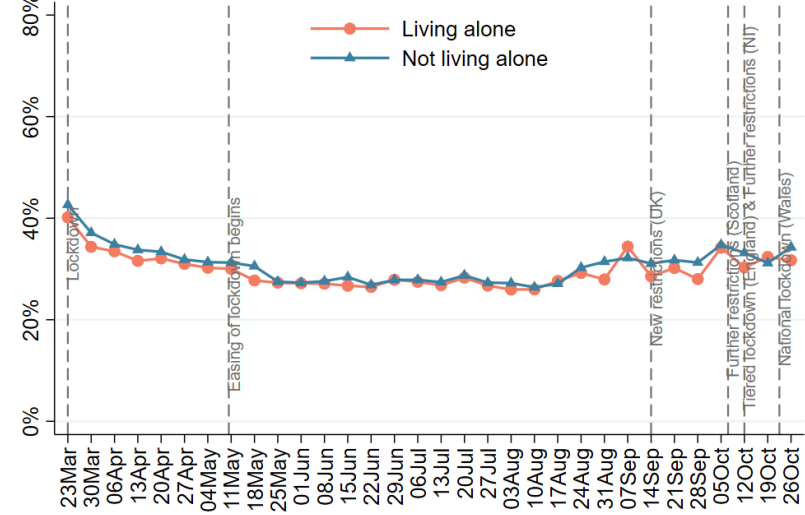
Figure 11c Financial stress by household income
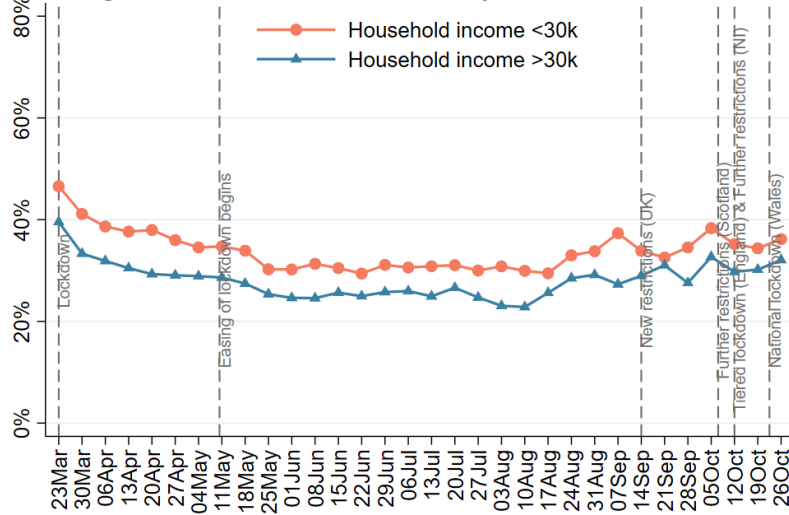
Figure 11d Financial stress by mental health diagnosis
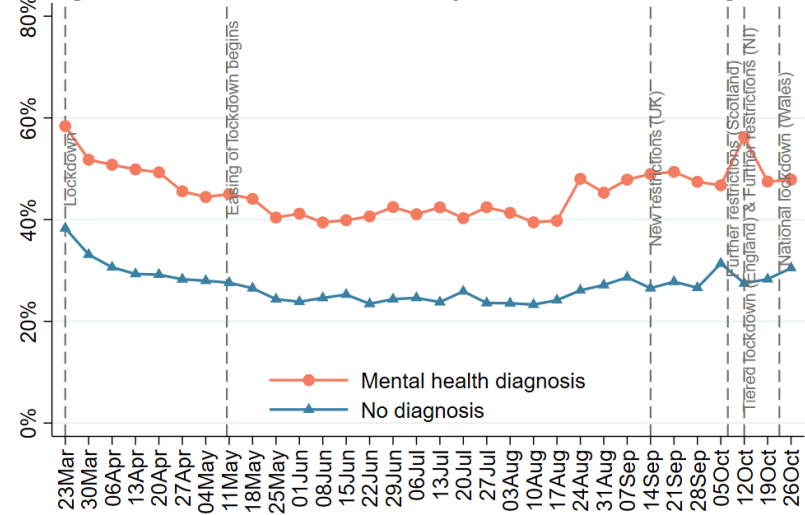
Figure 11e Financial stress by nations
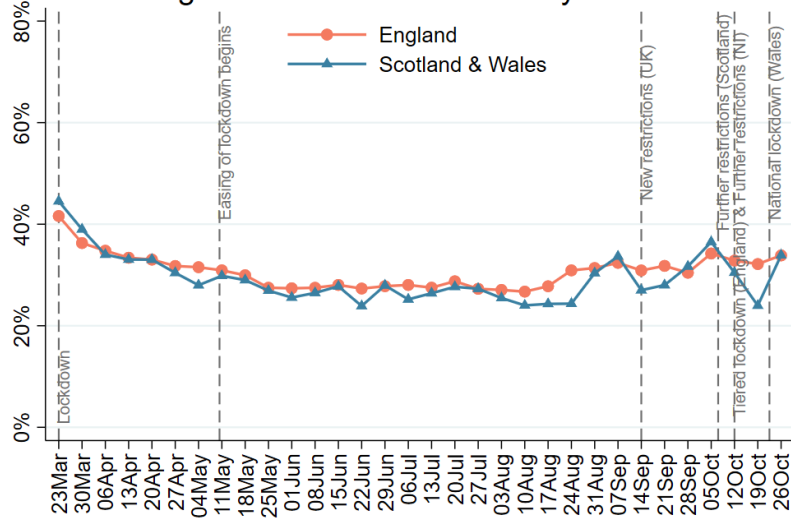
Figure 11f Financial stress by keyworker status
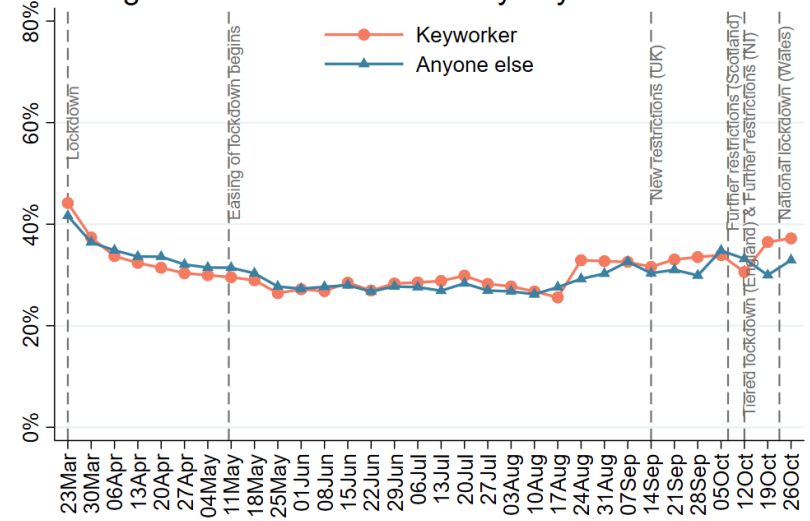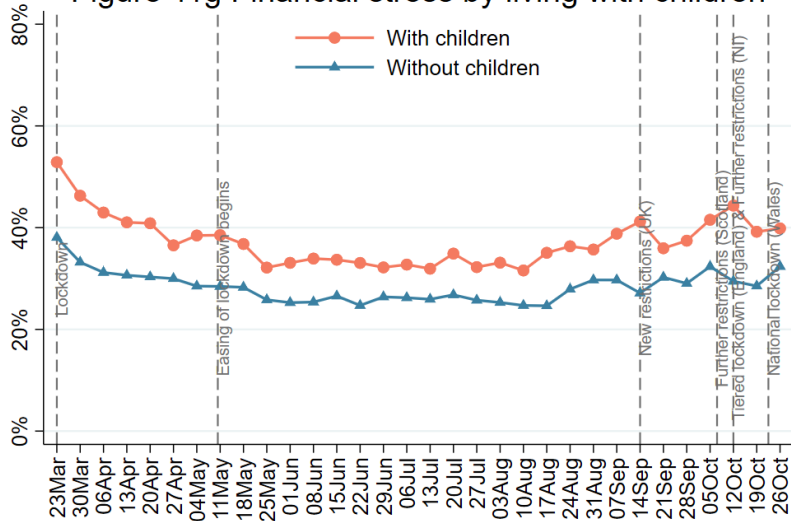

Figure 11g Financial stress by living with children
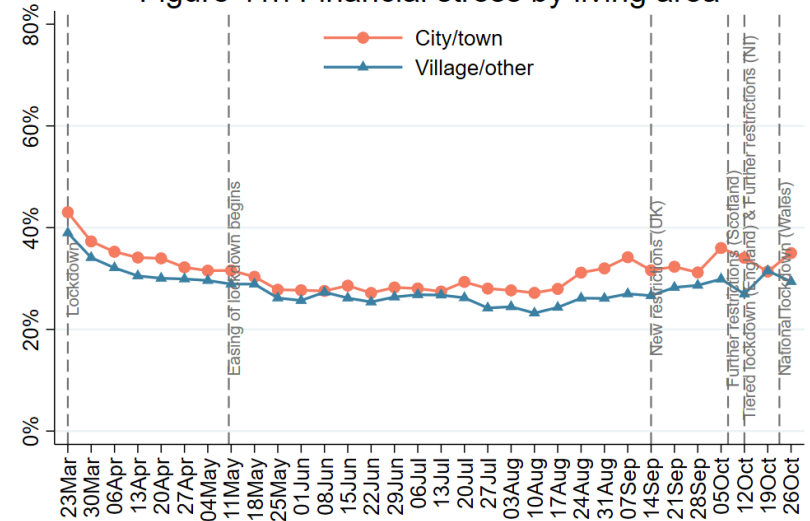

Figure 11h Financial stress by living area
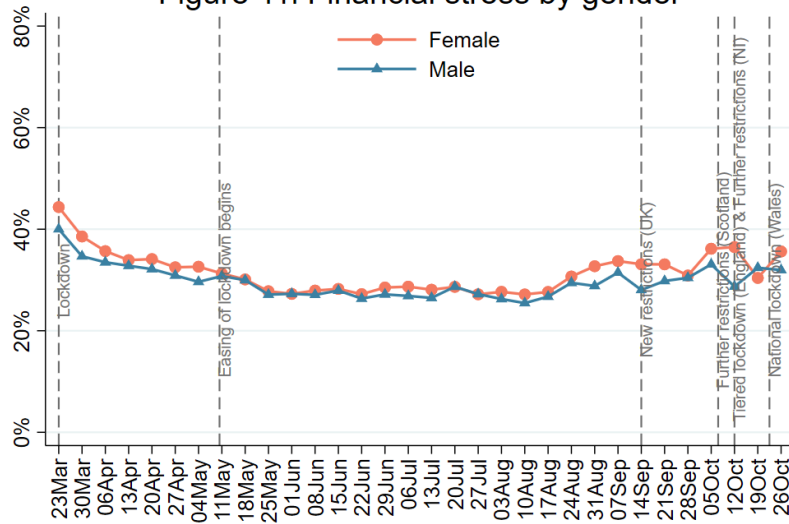
Figure 11i Financial stress by gender

Legend: Female, Male

Figure 11j Financial stress by ethnicity

Legend: BAME, White
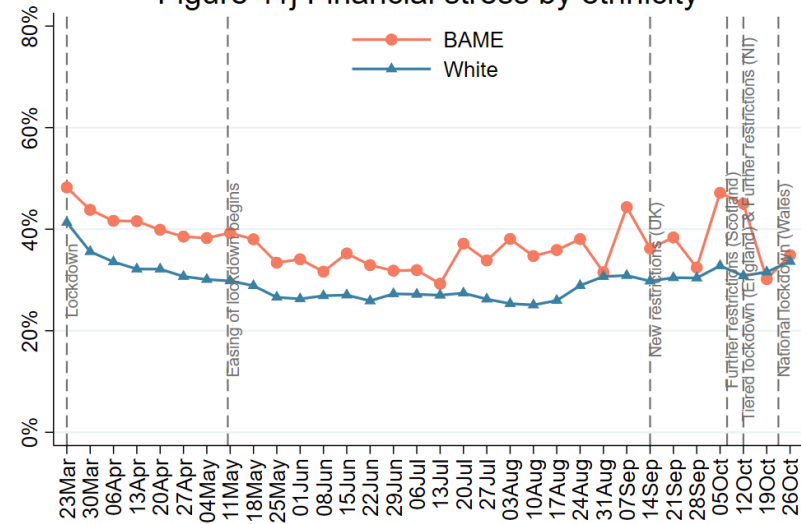
Figure 11k Financial stress by educational levels

Legend: GCSE/below, A-levels/equivalent, Degree/above
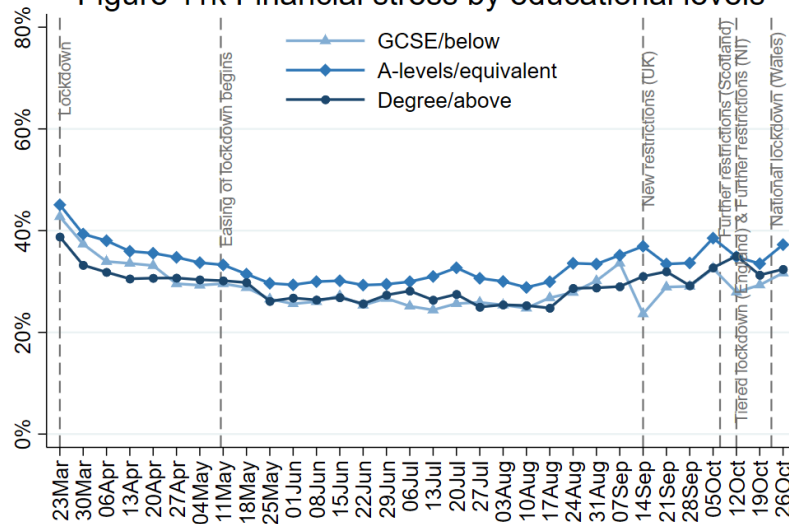
Figure 11l Financial stress by physical health diagnosis
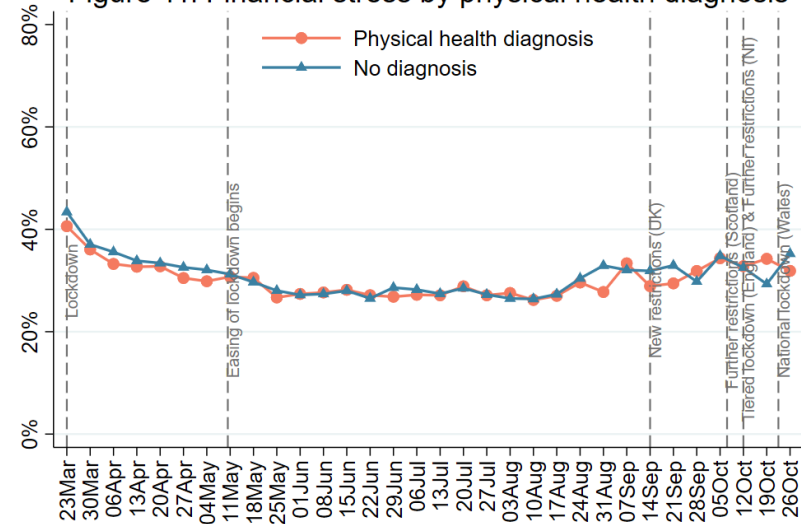
Legend: Physical health diagnosis, No diagnosis

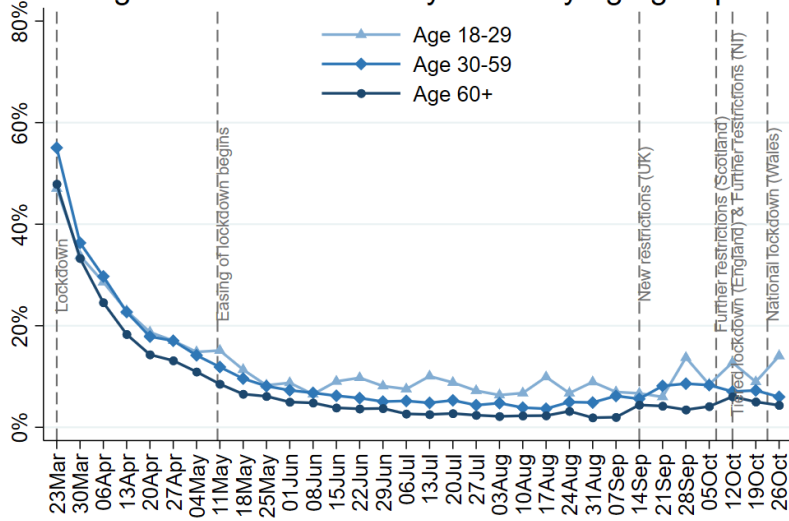Figure 12a Food security stress by age groups

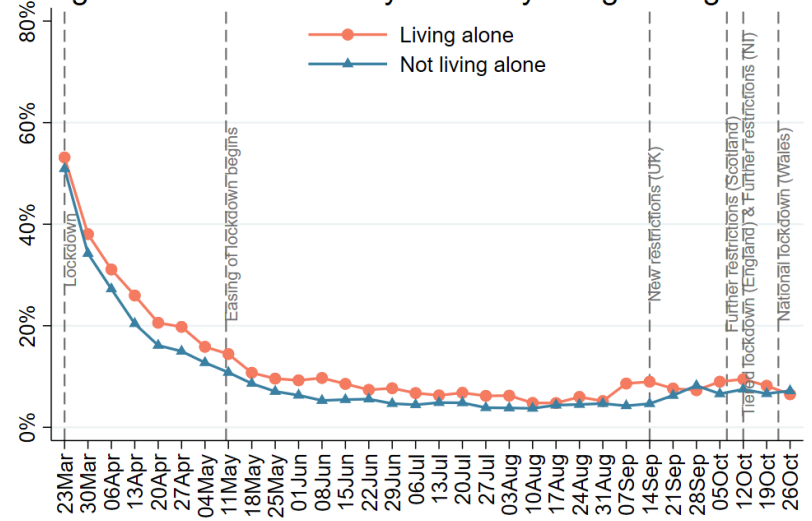Figure 12b Food security stress by living arrangement

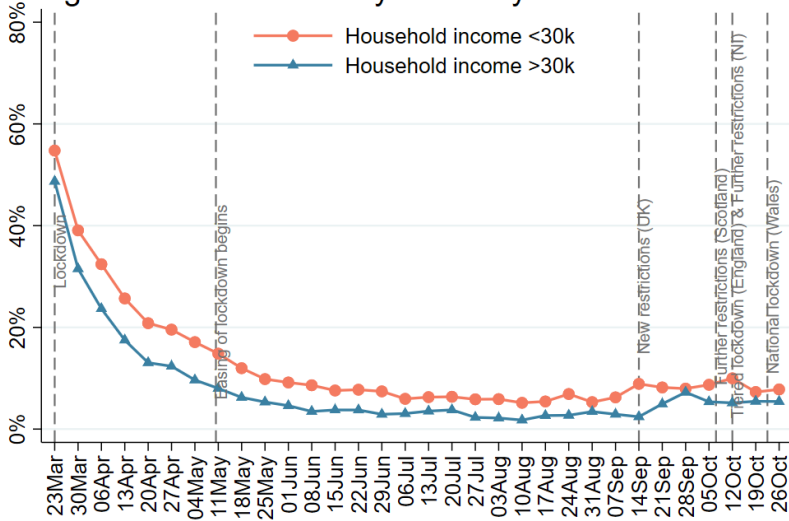Figure 12c Food security stress by household income

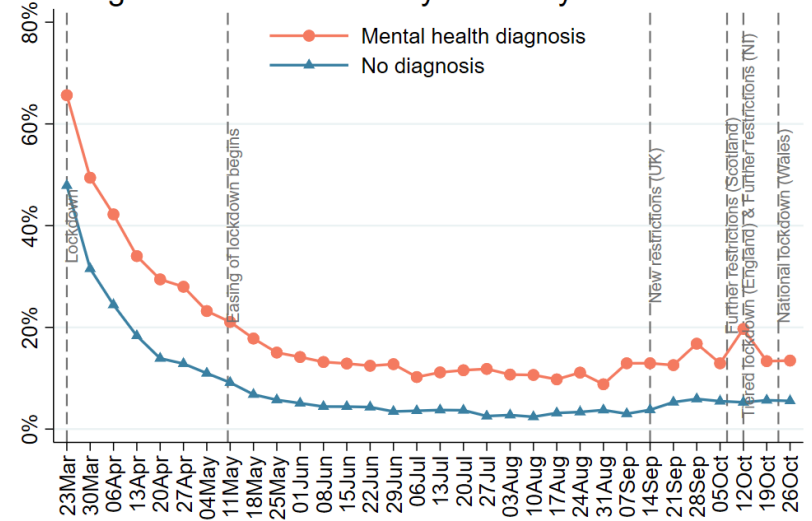Figure 12d Food security stress by mental health

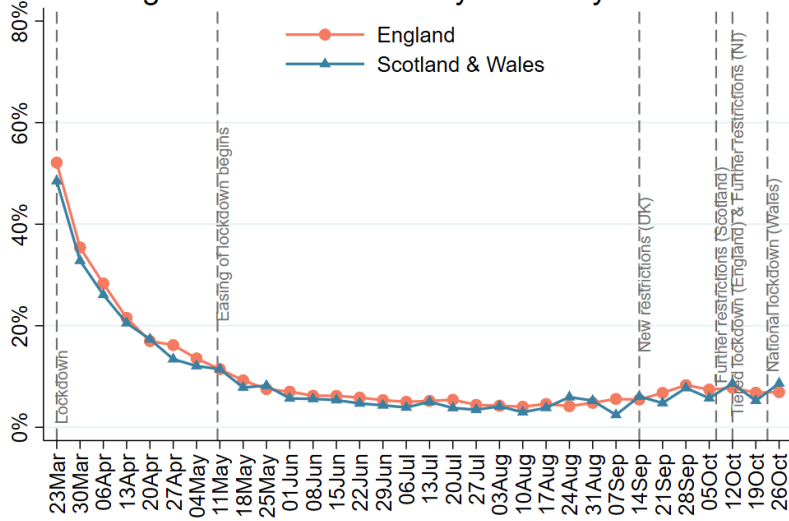Figure 12e Food security stress by nations

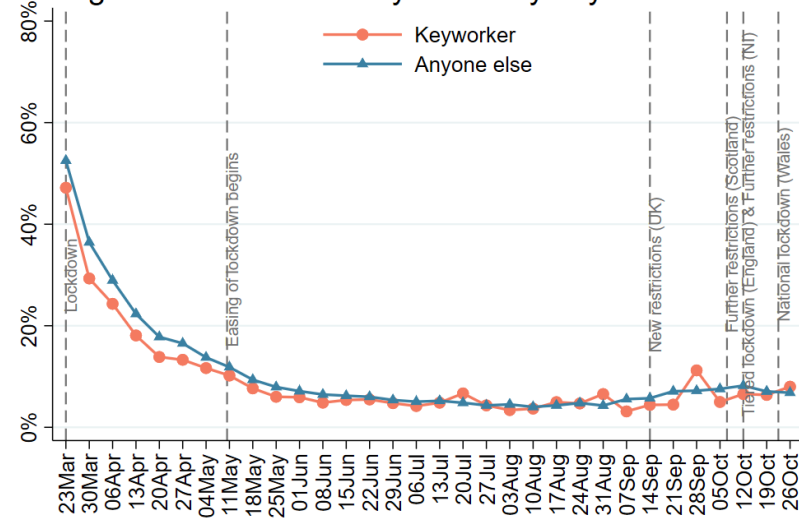Figure 12f Food security stress by keyworker status

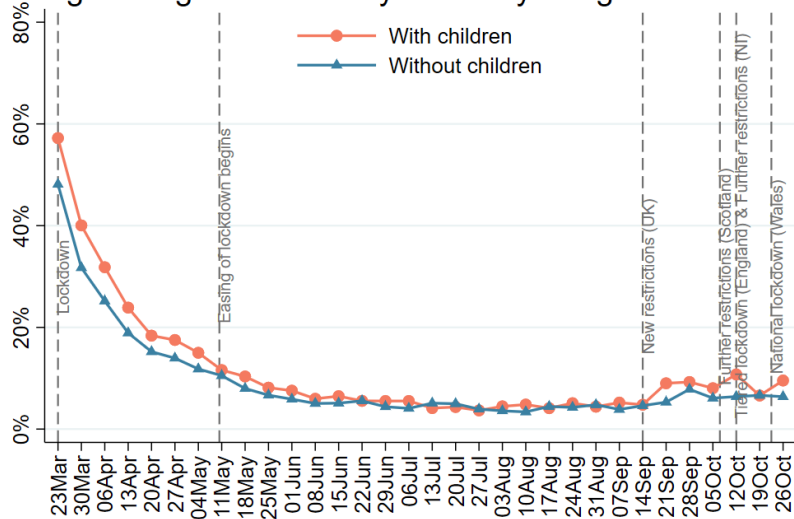Figure 12g Food security stress by living with children

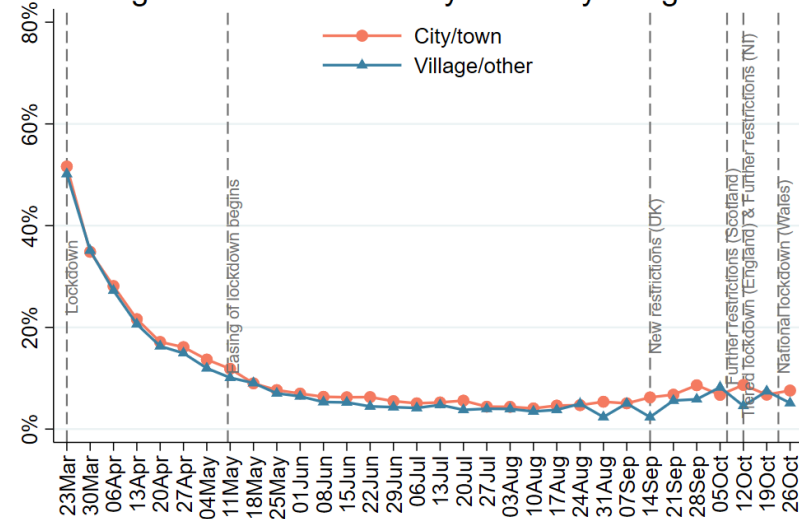Figure 12h Food security stress by living area
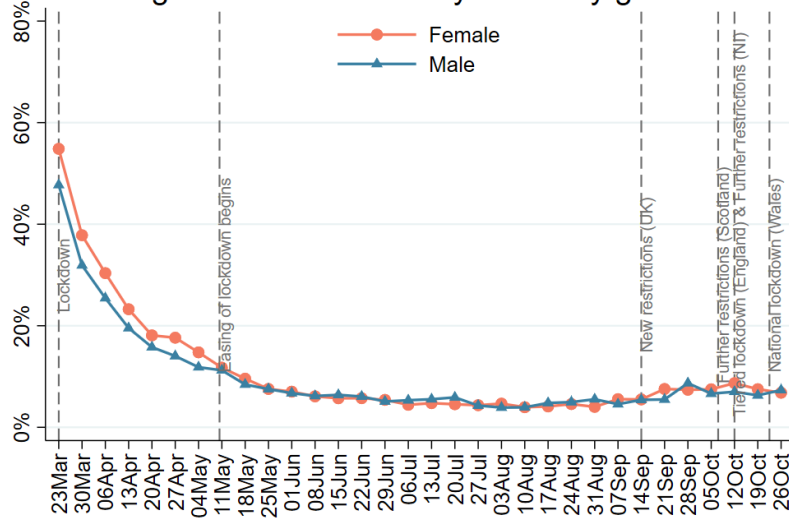
Figure 12i Food security stress by gender
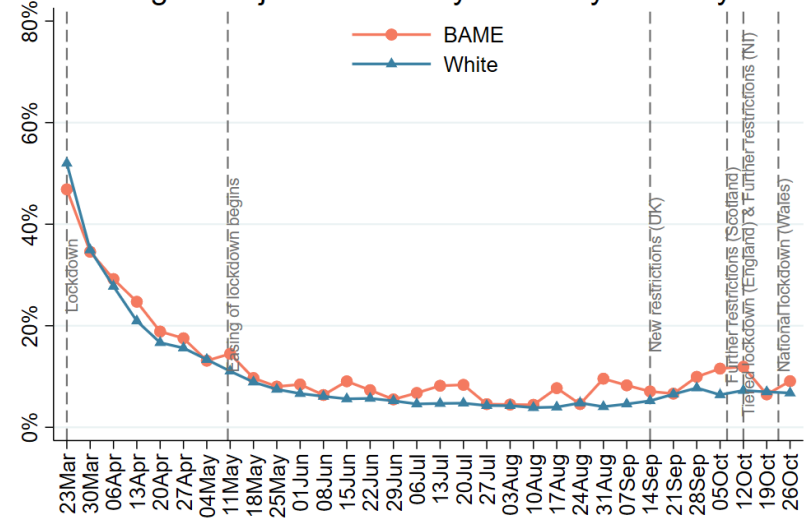

Figure 12j Food security stress by ethnicity
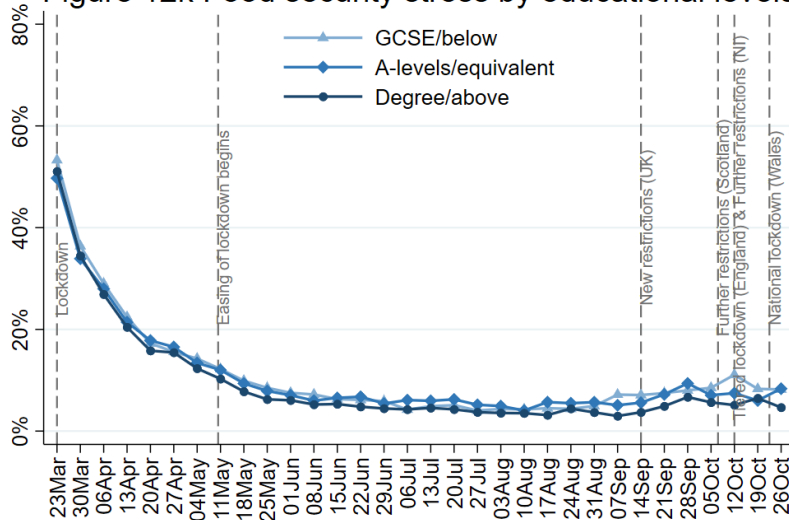

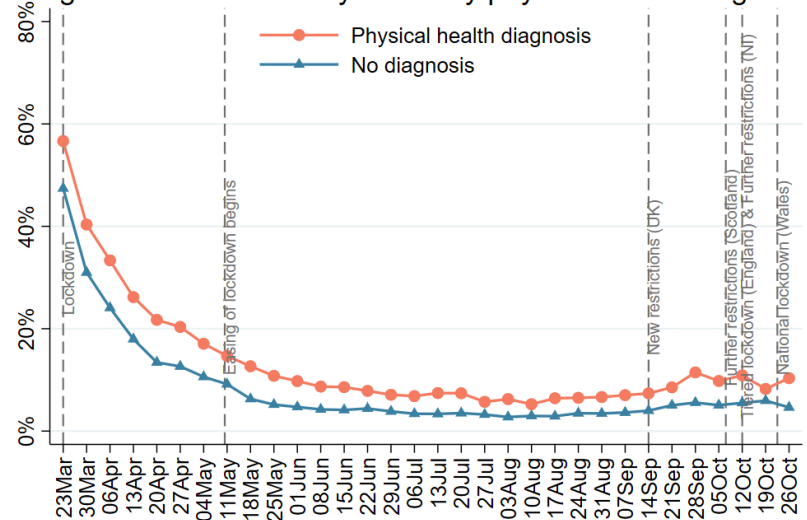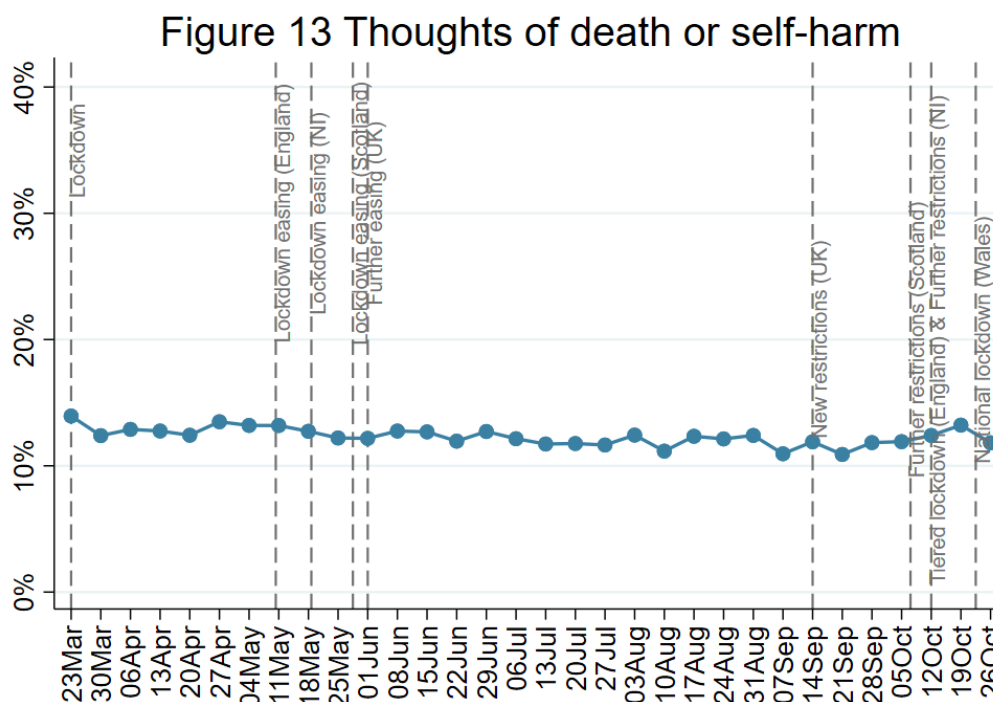Figure 12k Food security stress by educational levels

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, 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 35 weeks. They remain higher amongst younger adults, those with lower household income, and people with a diagnosed mental health condition. They are also higher in people living alone and those living in urban areas.

Thoughts of death or self-harm have been consistently higher amongst people with a long-term physical health condition but lower amongst people with post-18 qualifications. There has been no difference by gender.
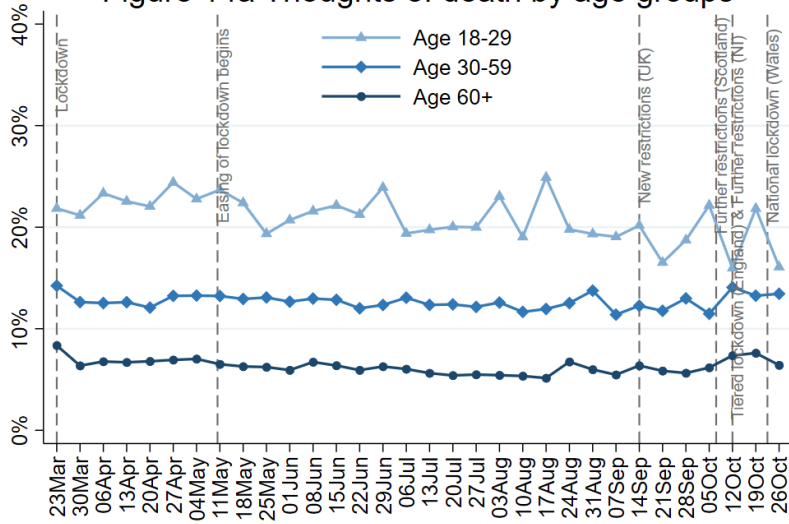
Figure 14a Thoughts of death by age groups

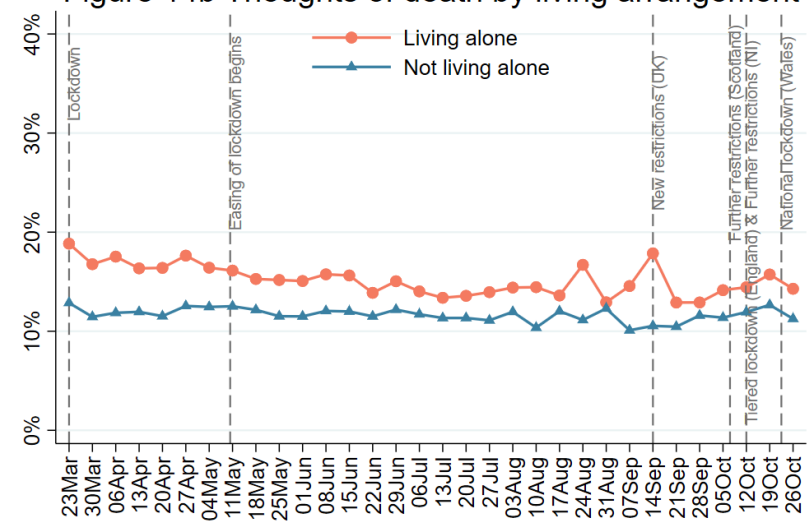Figure 14b Thoughts of death by living arrangement

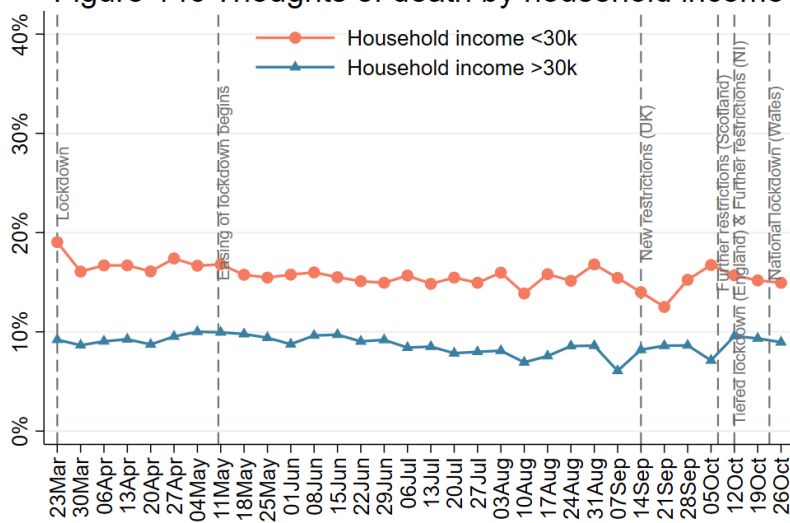Figure 14c Thoughts of death by household income

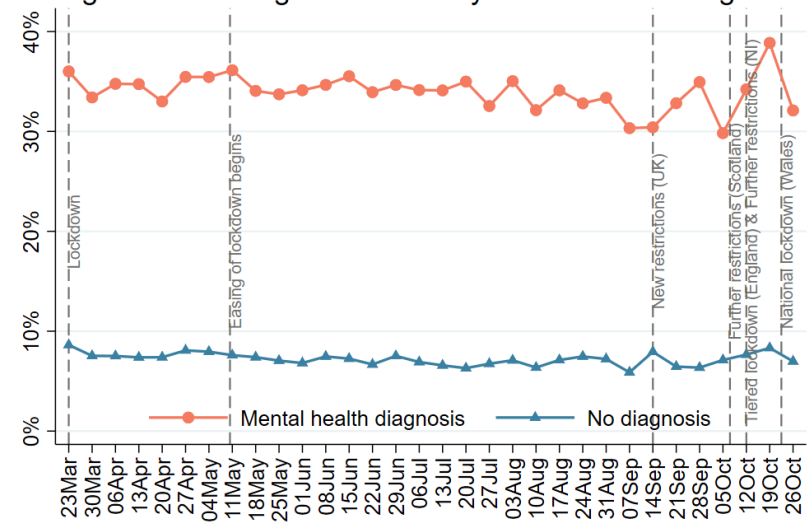Figure 14d Thoughts of death by mental health diagnosis

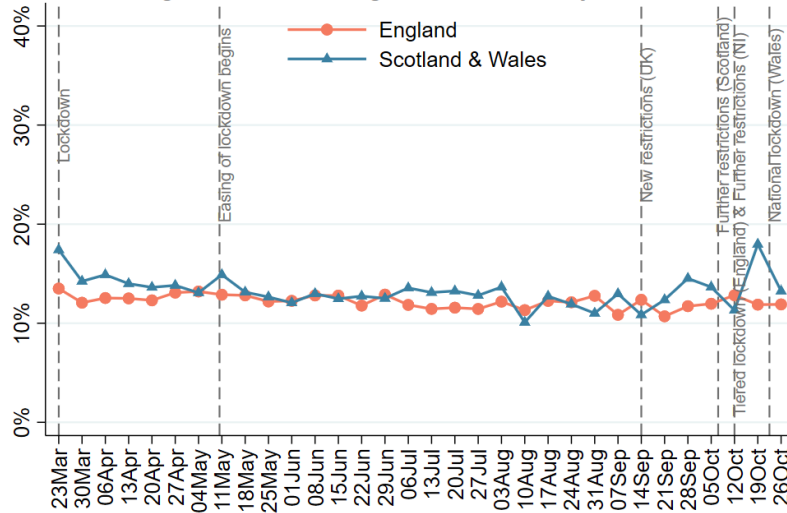Figure 14e Thoughts of death by nations

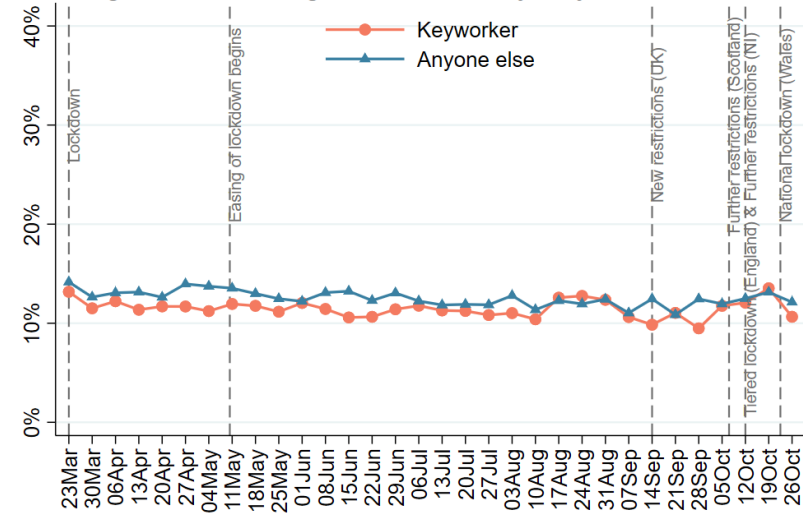Figure 14f Thoughts of death by keyworker status

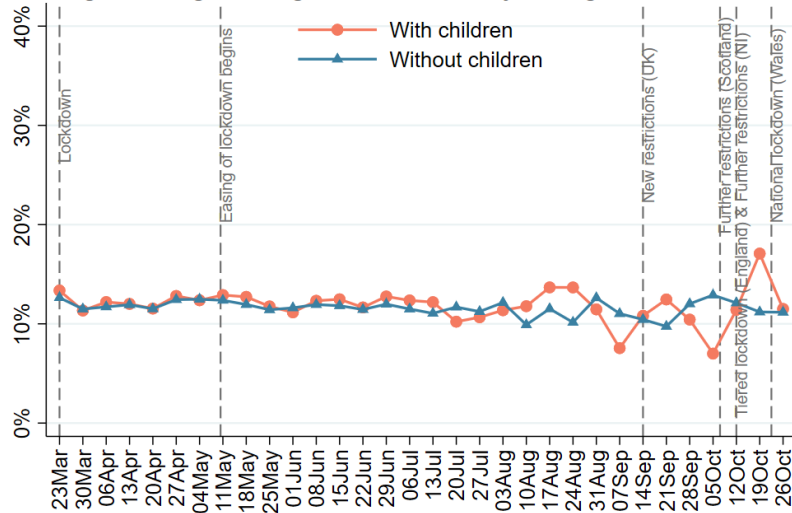Figure 14g Thoughts of death by living with children
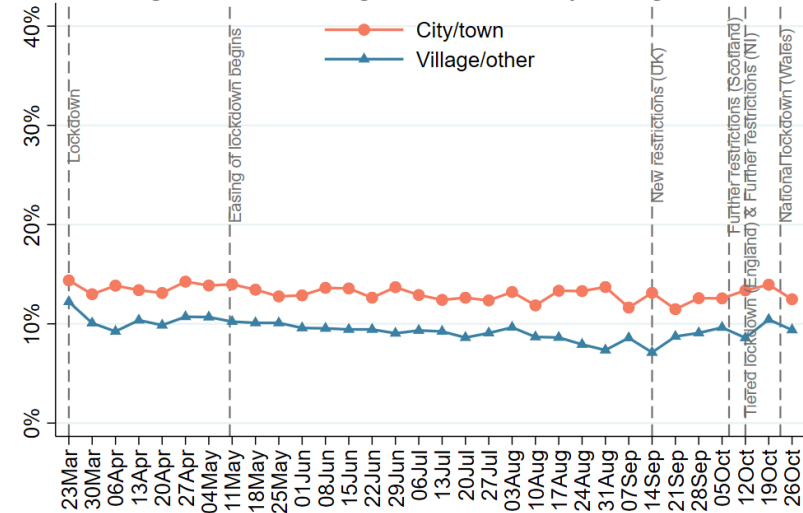

Figure 14h Thoughts of death by living area

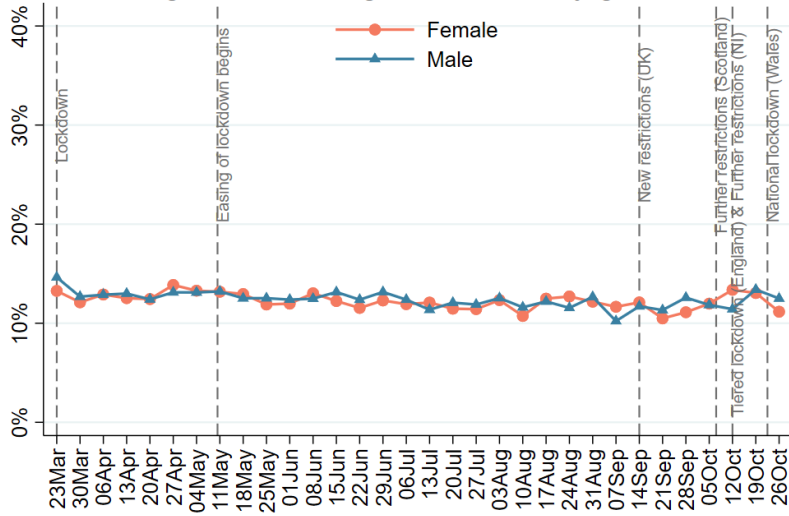Figure 14i Thoughts of death by gender

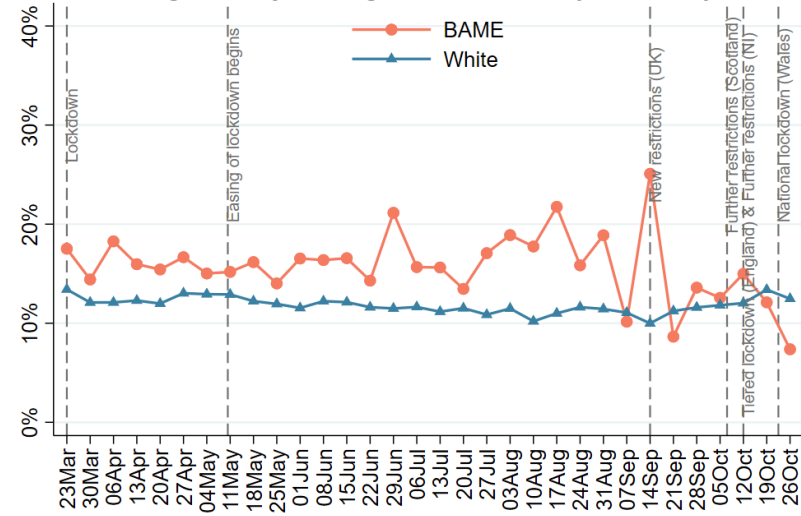
Figure 14j Thoughts of death by ethnicity
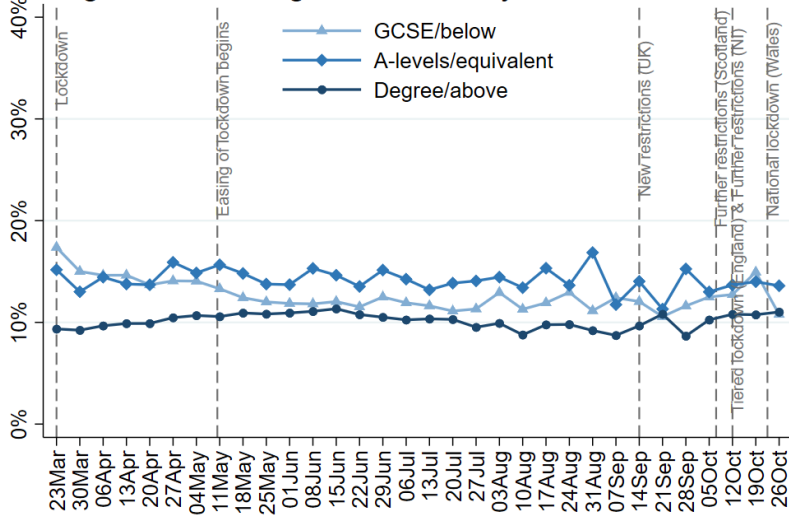

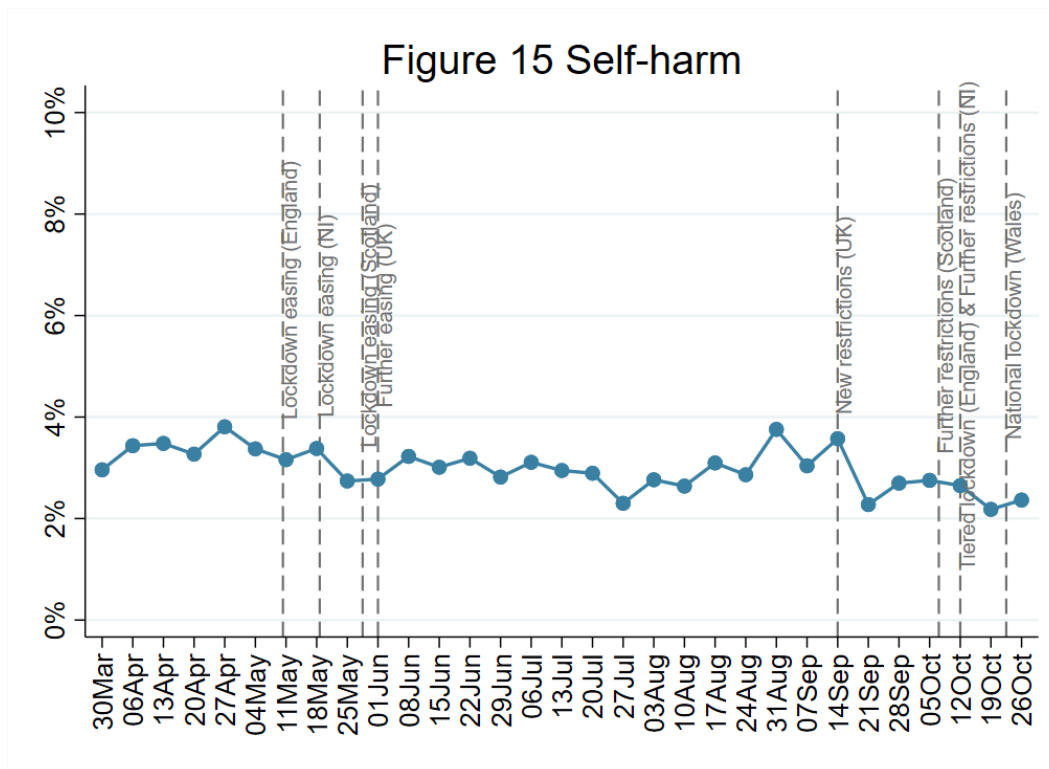Figure 14k Thoughts of death by educational levels

Figure 14l Thoughts of death by physical health diagnosis
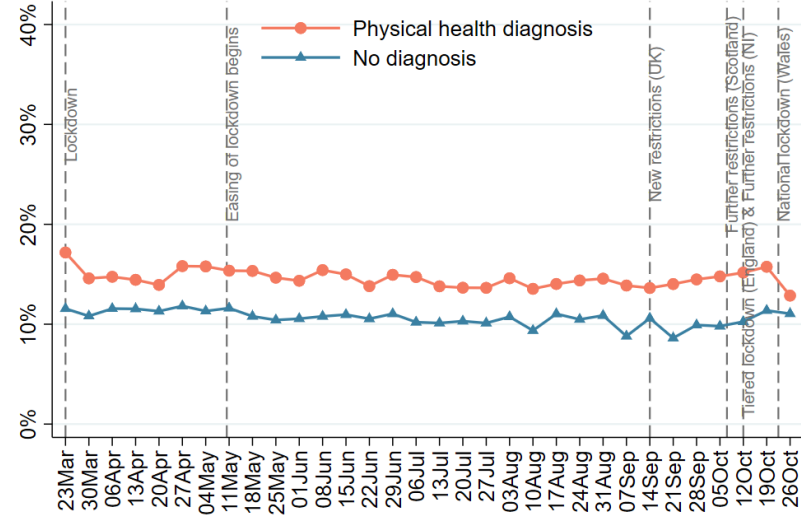
3.2 Self-harm

Figure 15 Self-harm

FINDINGS

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

Self-harm has remained relatively stable in the past few weeks. However, it 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.[3]

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[3] Spikes on particular days are likely due to variability in the data as opposed to indications of particularly adverse experiences on certain days.
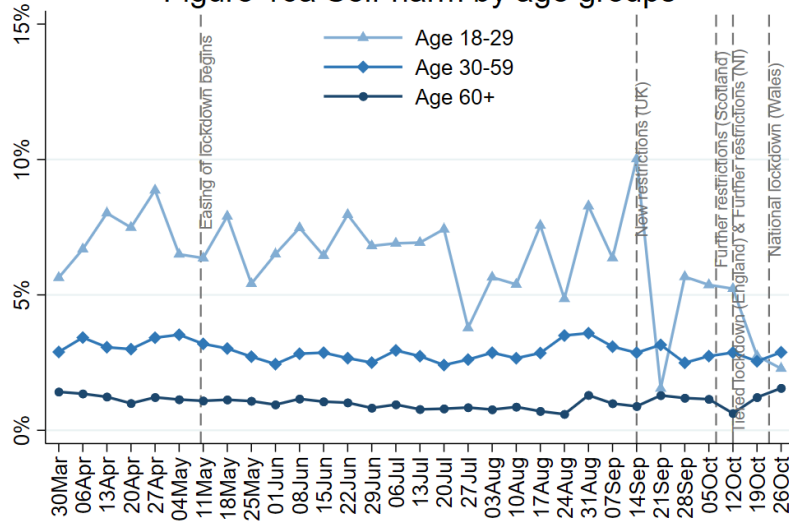
Figure 16a Self-harm by age groups

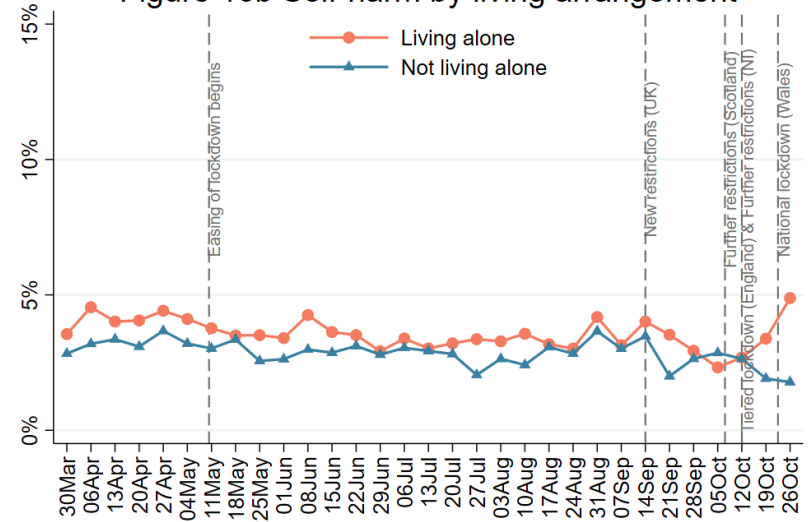Figure 16b Self-harm by living arrangement

Figure 16c Self-harm by household income
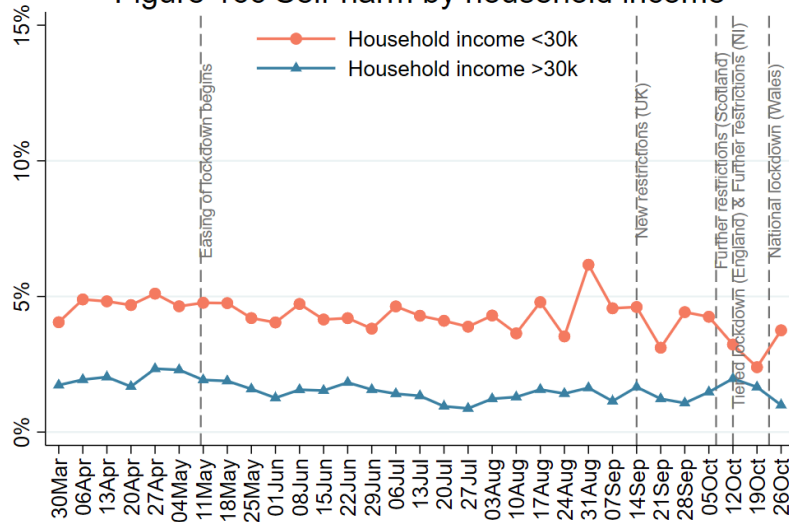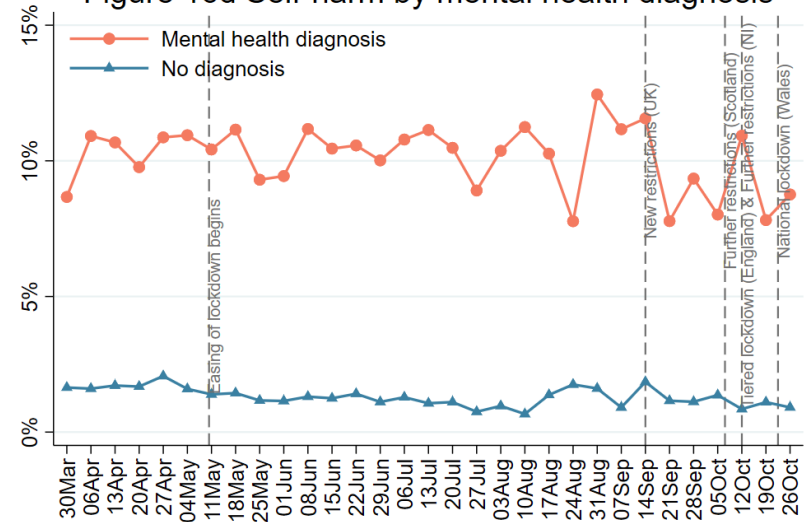
Figure 16d Self-harm by mental health diagnosis

Figure 16e Self-harm by nations

Figure 16f Self-harm by keyworker status

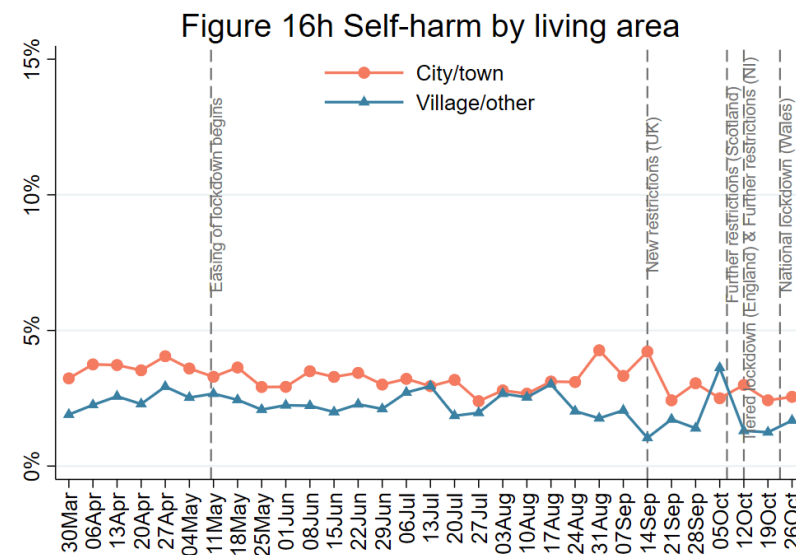## Figure 16g Self-harm by living with children
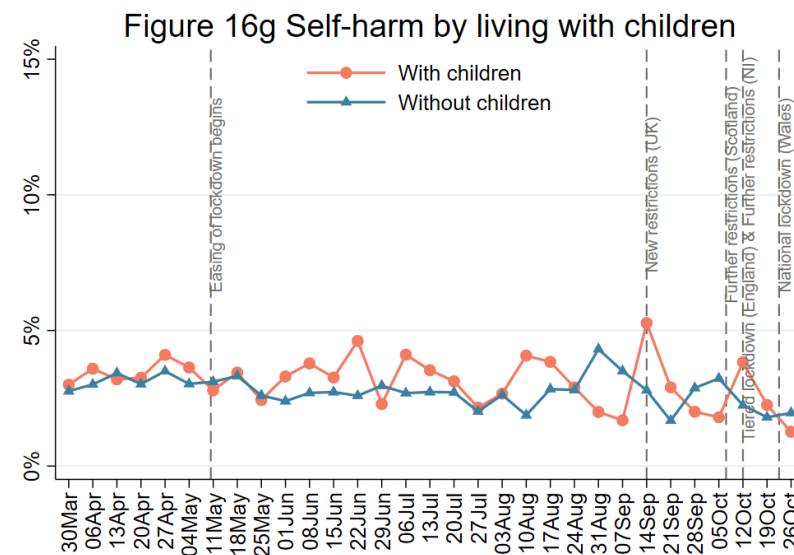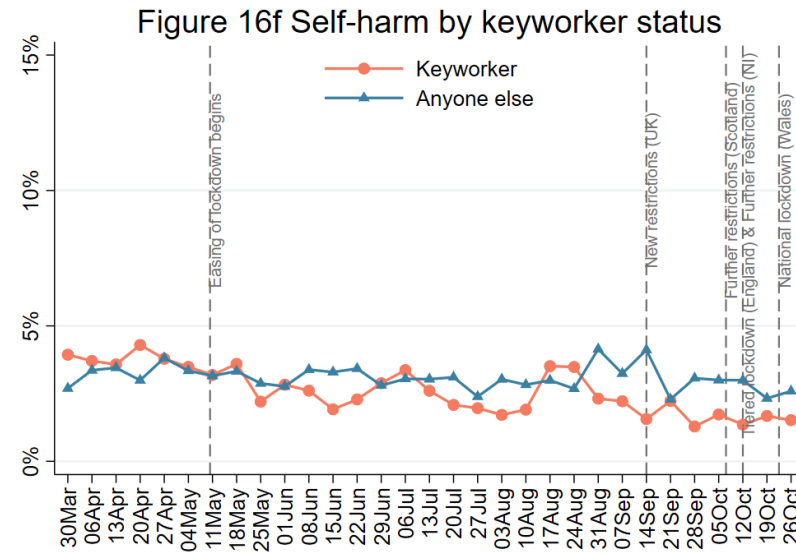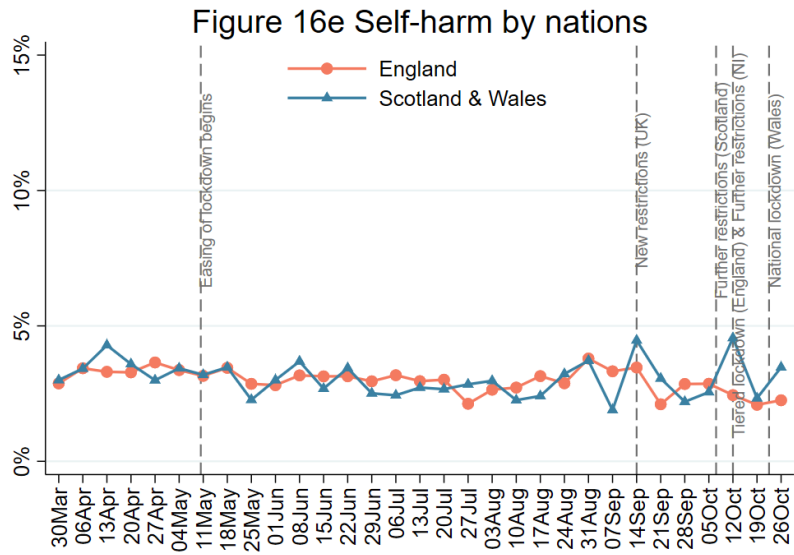

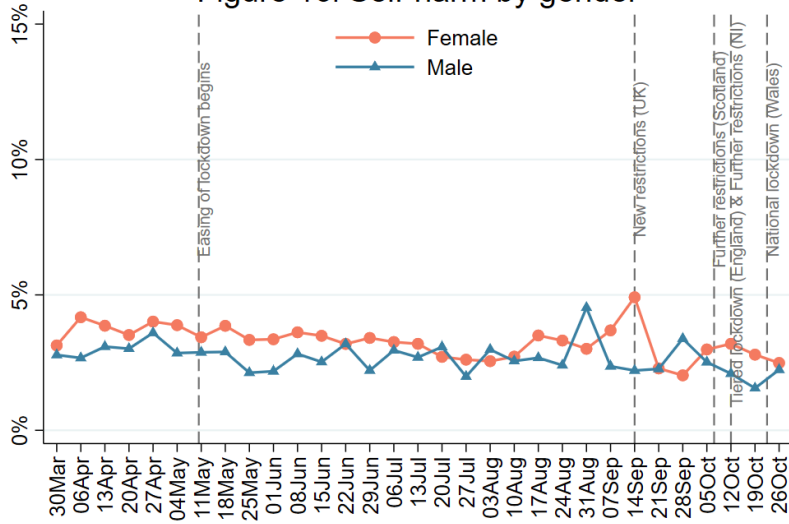## Figure 16h Self-harm by living area

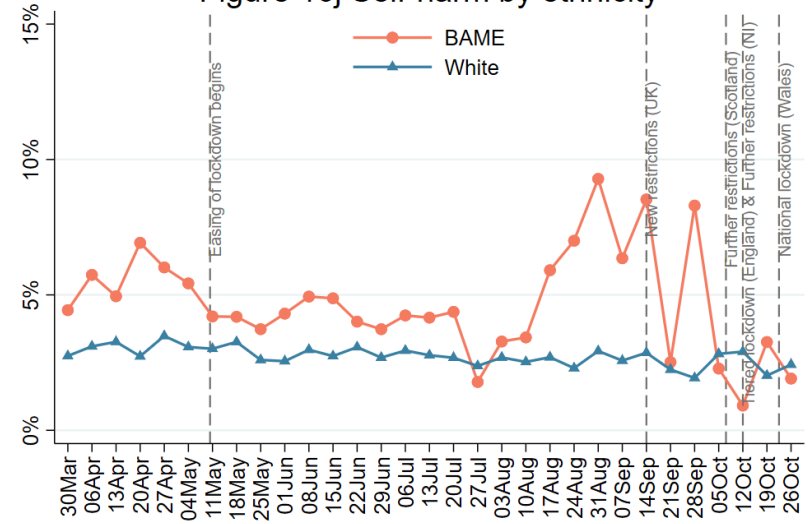Figure 16i Self-harm by gender

Figure 16j Self-harm by ethnicity
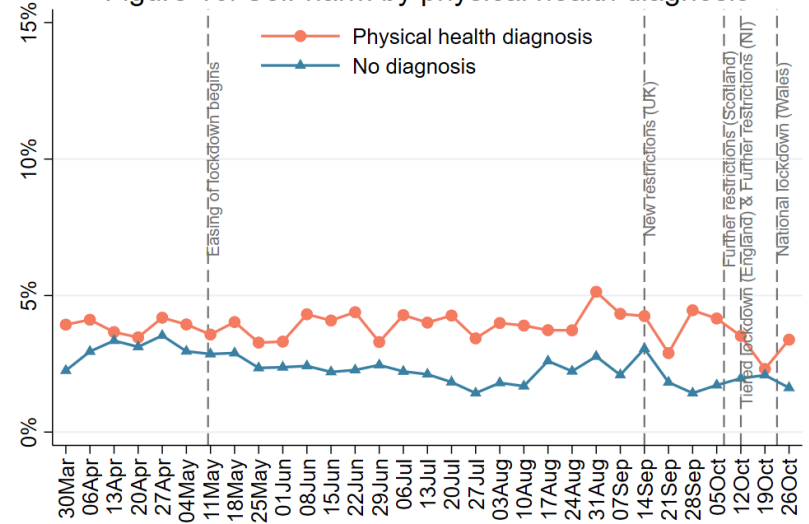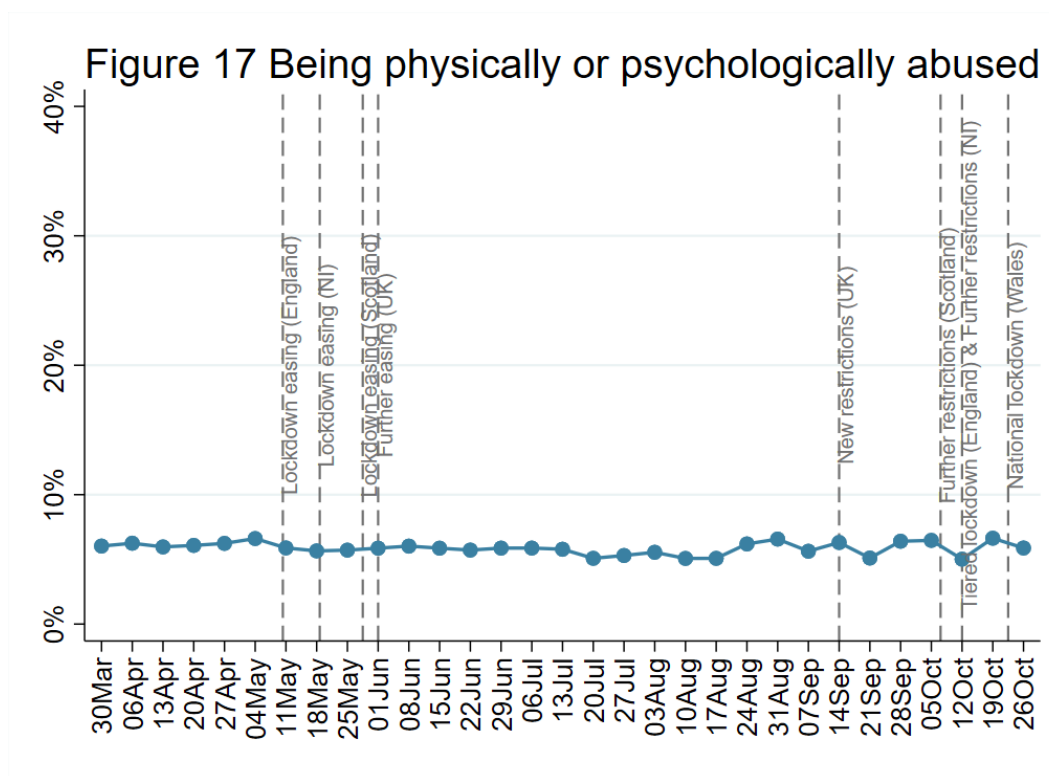

Figure 16k Self-harm by educational levels
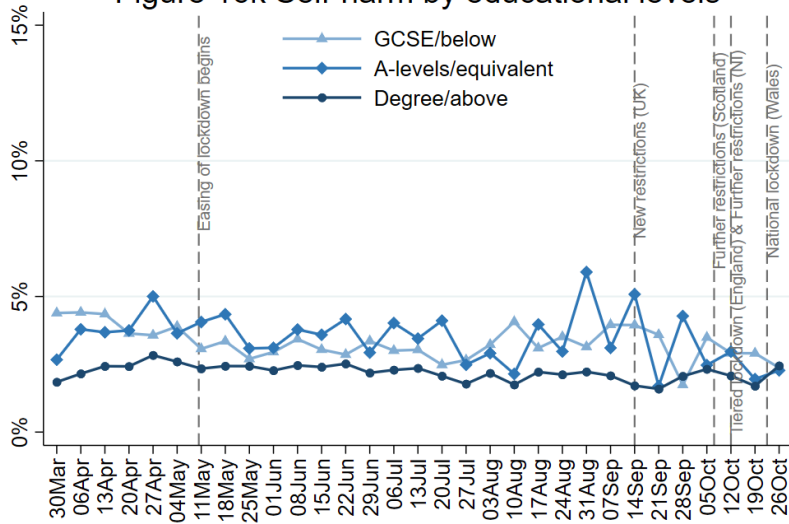
Figure 16l Self-harm by physical health diagnosis

3.3 Abuse

Figure 17 Being physically or psychologically abused

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.

Reported abuse has remained 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
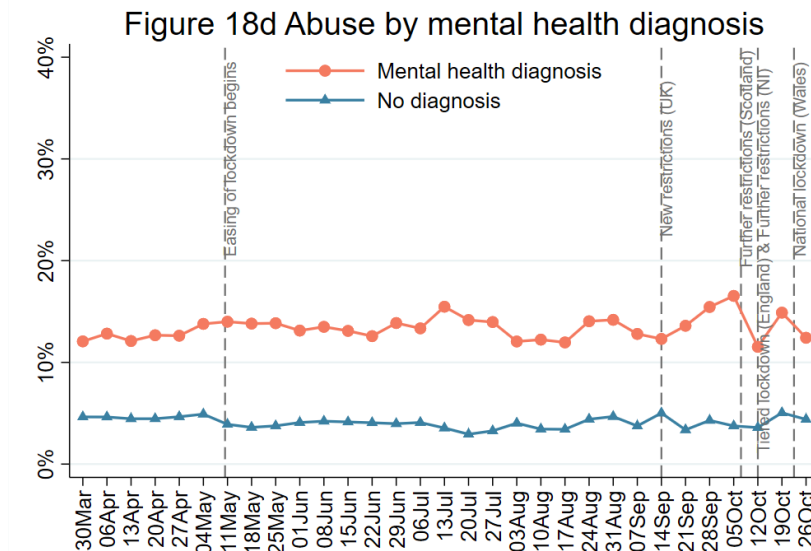

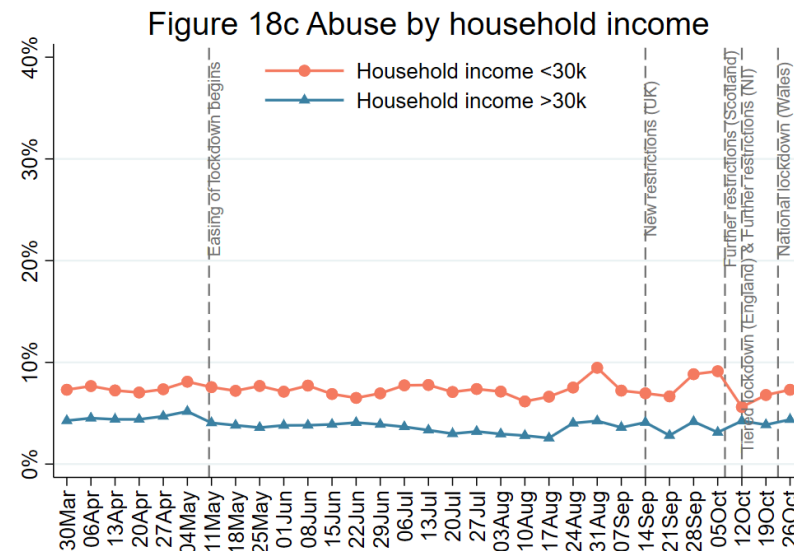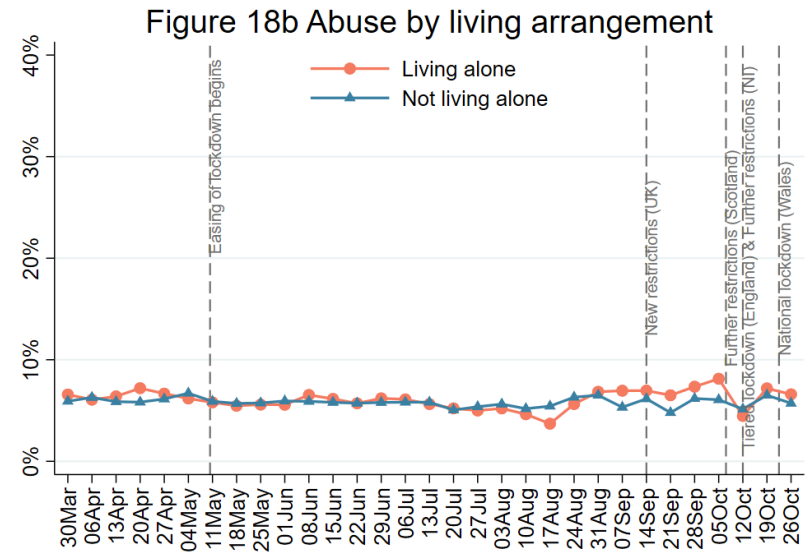Figure 18c Abuse by household income

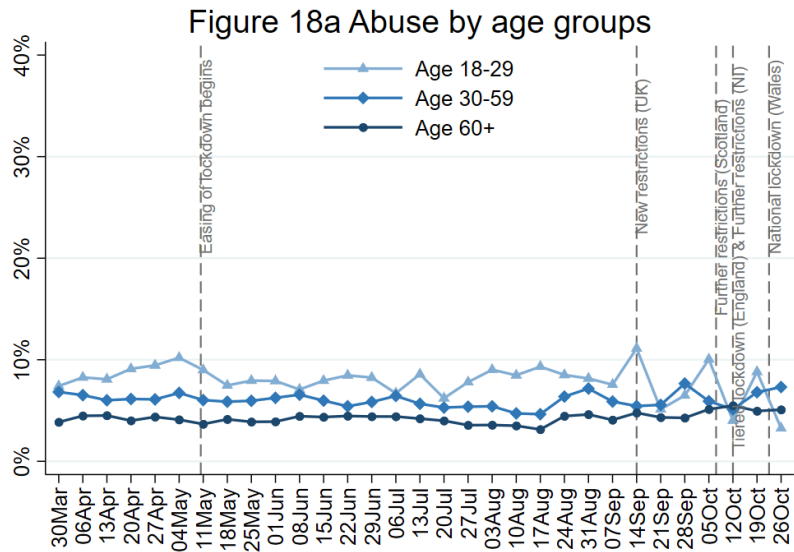Figure 18d Abuse by mental health diagnosis
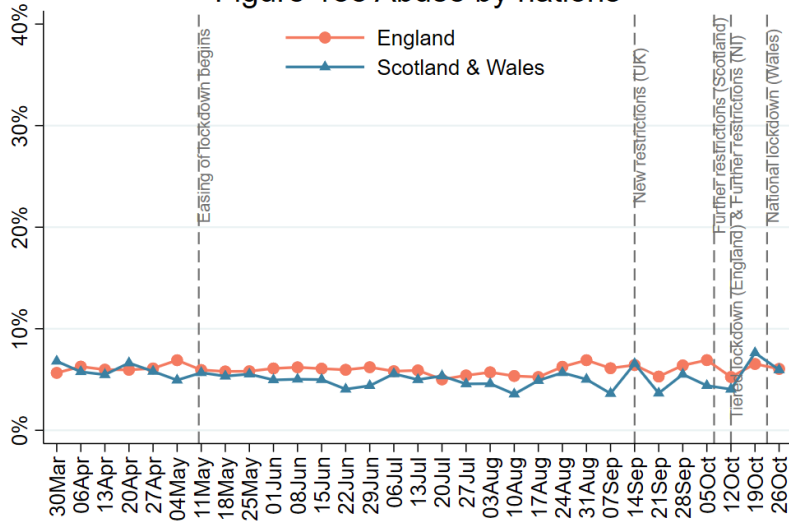
Figure 18e Abuse by nations
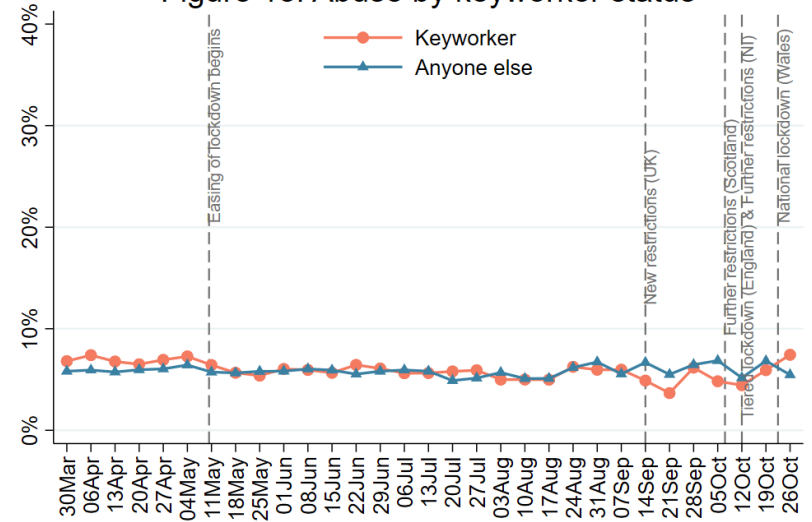

Figure 18f Abuse by keyworker status

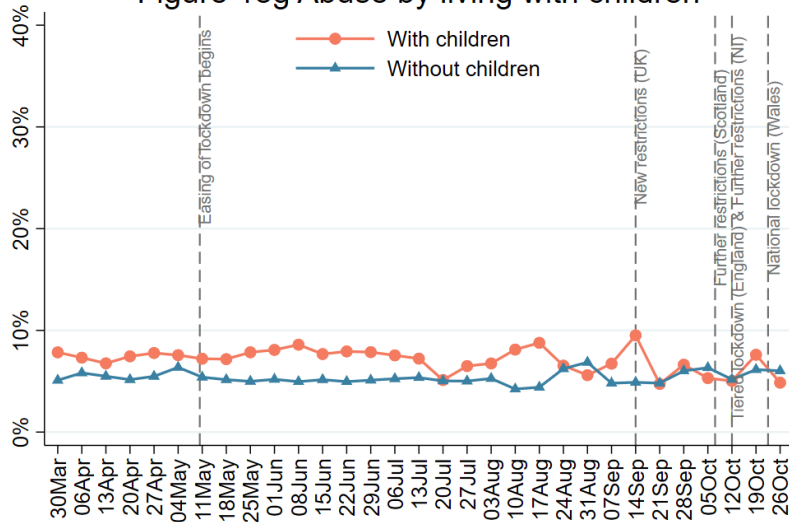Figure 18g Abuse by living with children
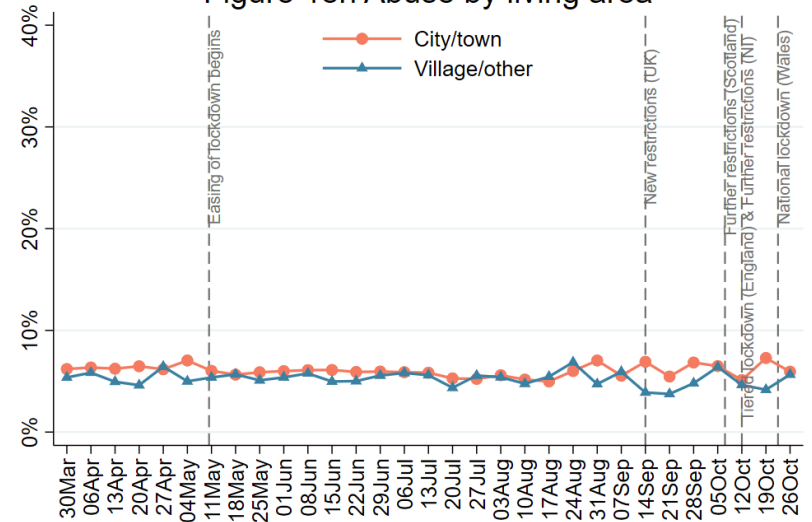

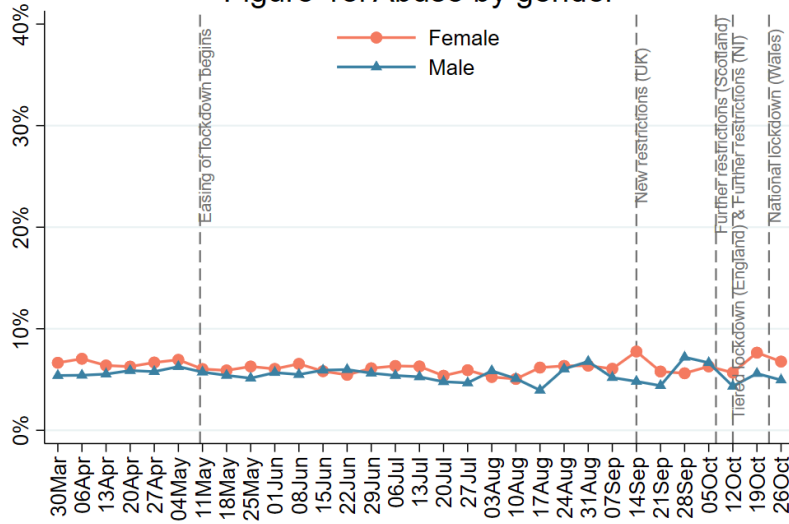Figure 18h Abuse by living area
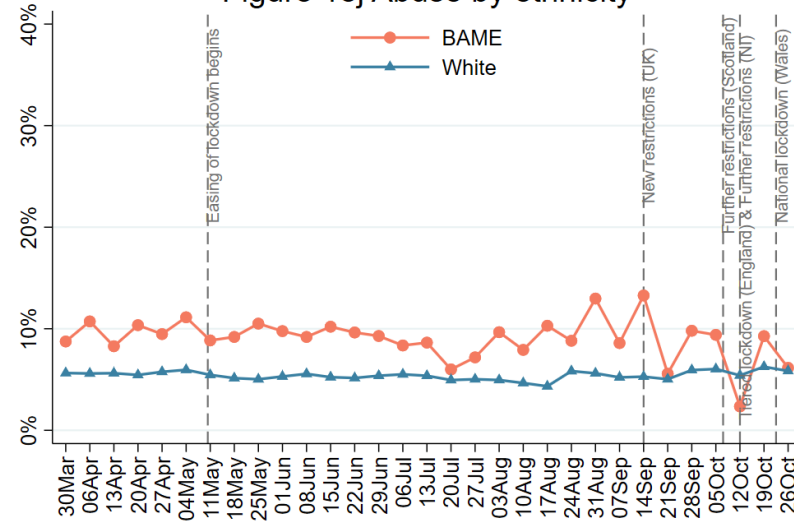
Figure 18i Abuse by gender

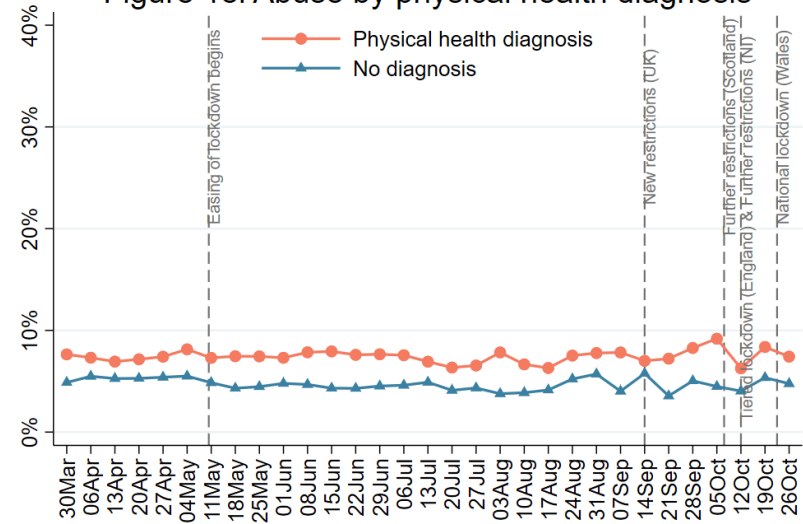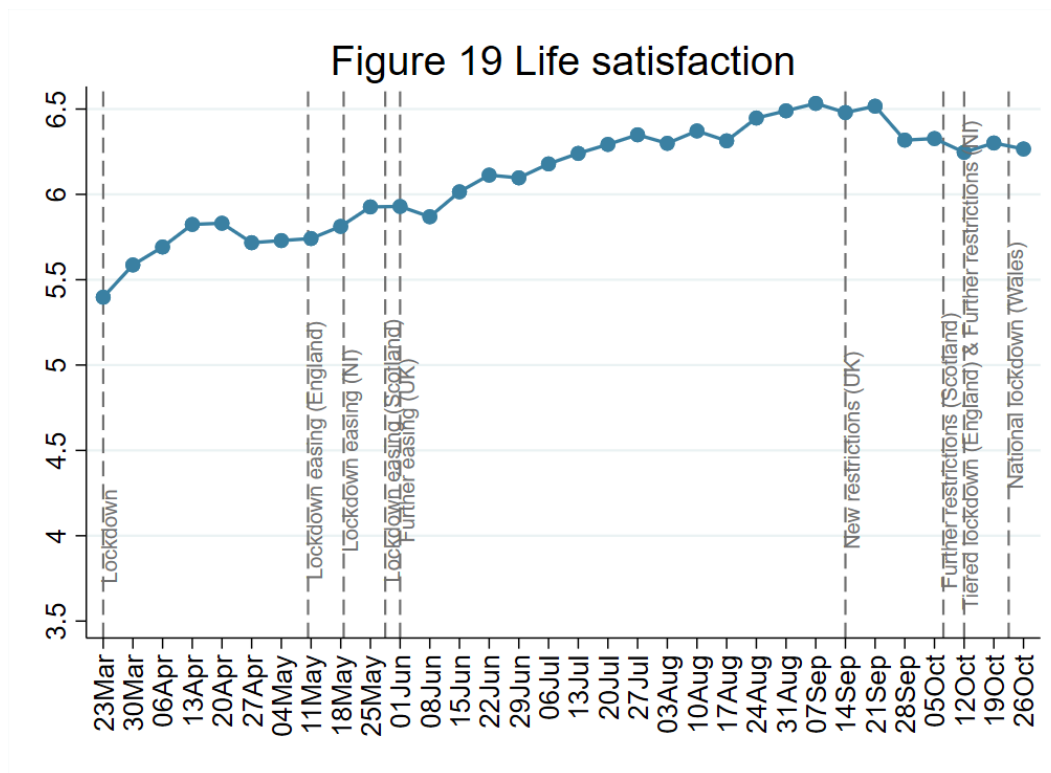Figure 18j Abuse by ethnicity

Figure 18k Abuse by educational levels
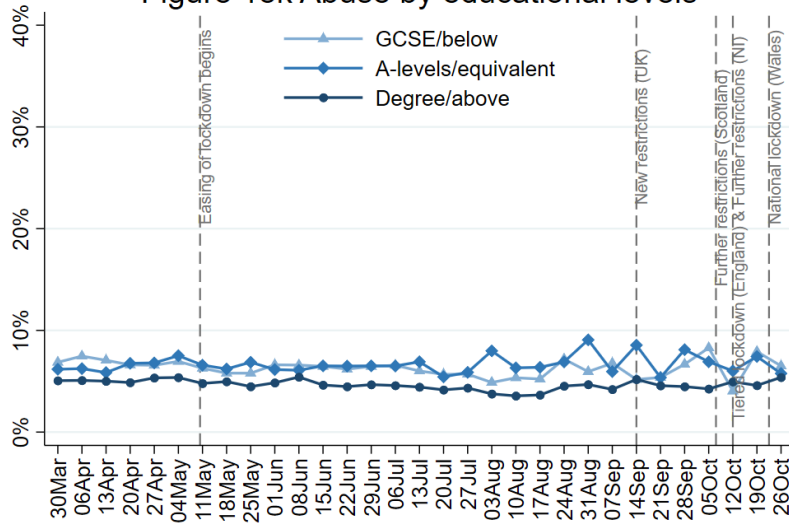
Figure 18l Abuse by physical health diagnosis

4. General well-being

4.1 Life satisfaction

Figure 19 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 continues to be lower than over the summer with no signs of improvements in the past fortnight. This decrease since August 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).

Life satisfaction is still noticeably lower than for the past 12 months (where usual averages are around 7.7), and wellbeing more generally appears to have decreased substantially in the weeks preceding lockdown[4].

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

Figure 20a Life satisfaction by age groups
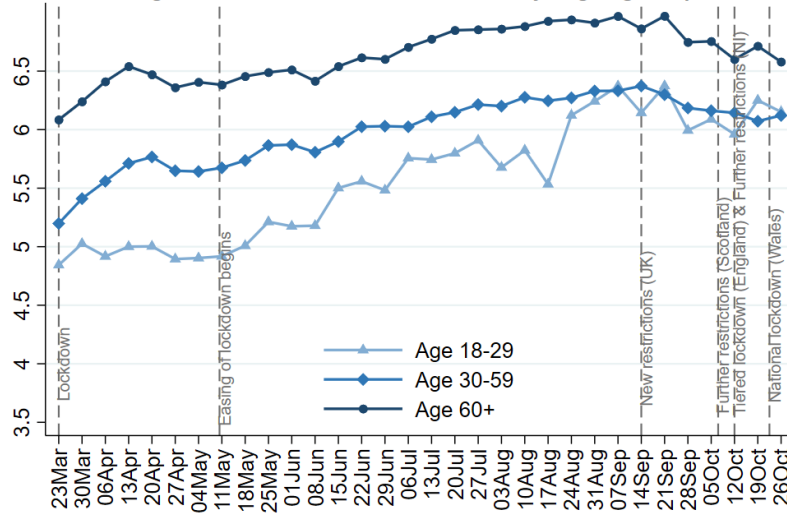
Figure 20b Life satisfaction by living arrangement
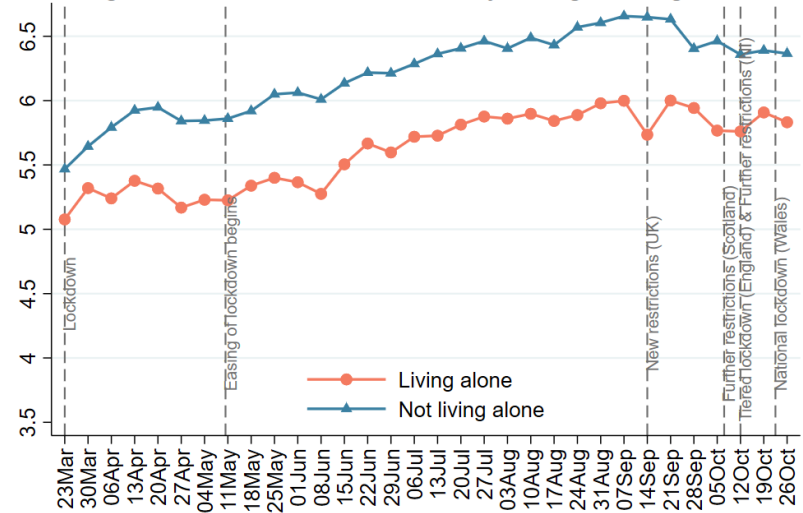
Figure 20c Life satisfaction by household income
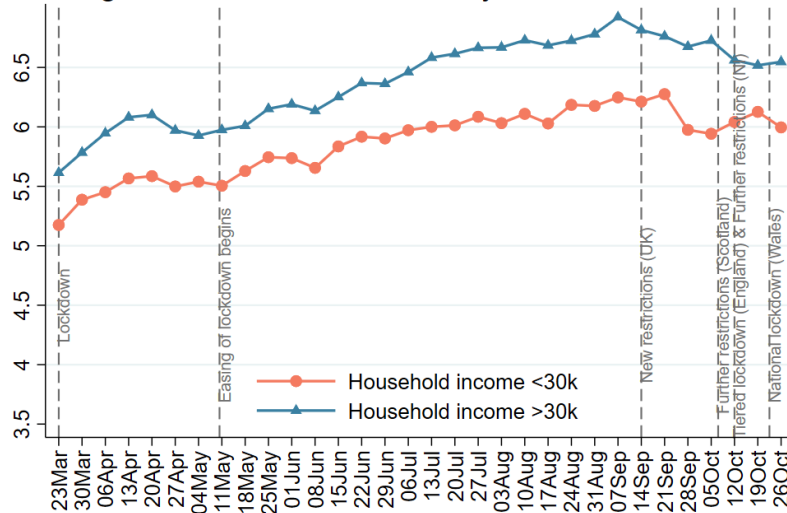
Figure 20d Life satisfaction by mental health diagnosis
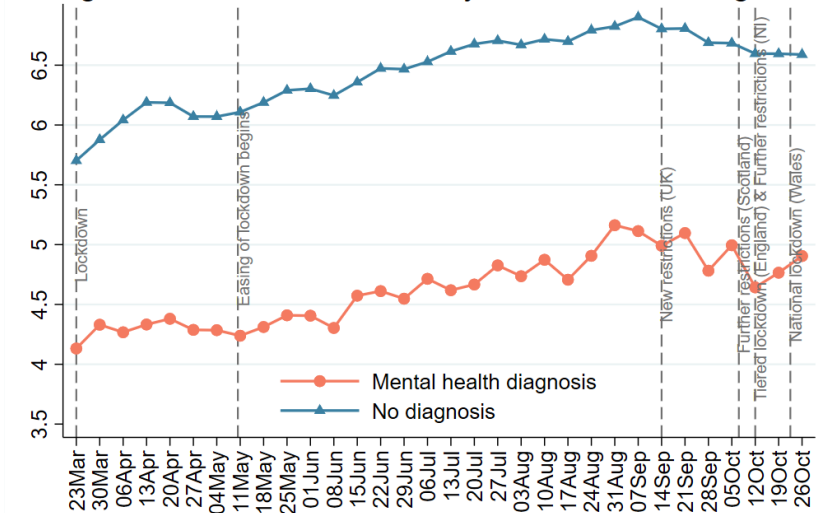
Figure 20e Life satisfaction by nations
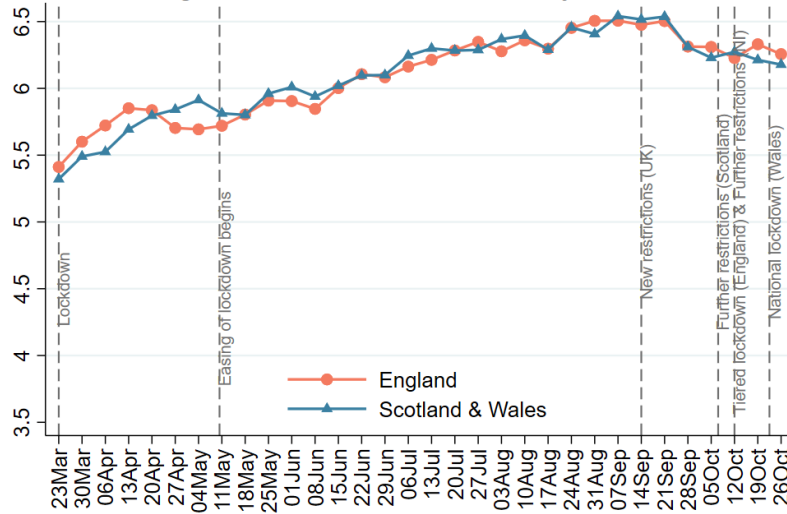
Figure 20f Life satisfaction by keyworker status
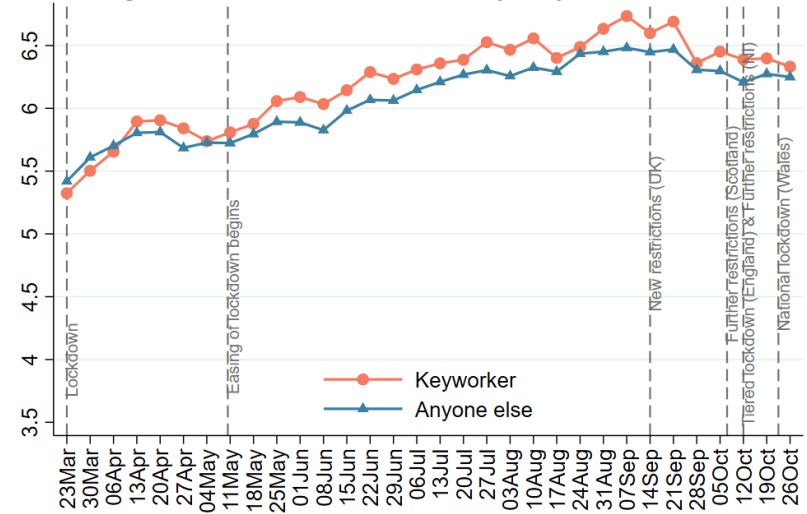
Figure 20g Life satisfaction by living with children
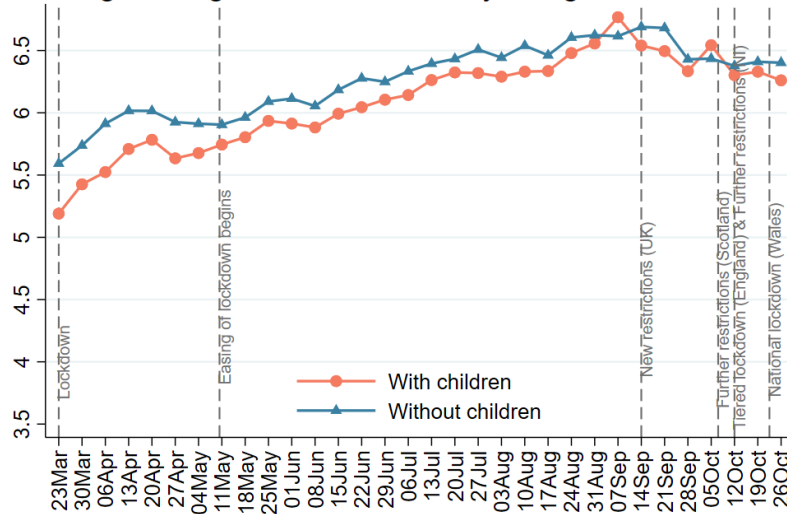
Figure 20h Life satisfaction by living area
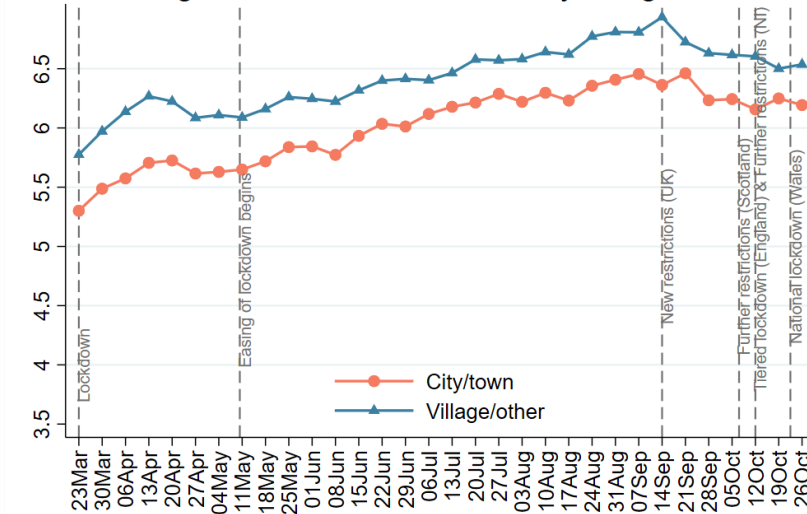
Figure 20i Life satisfaction by gender
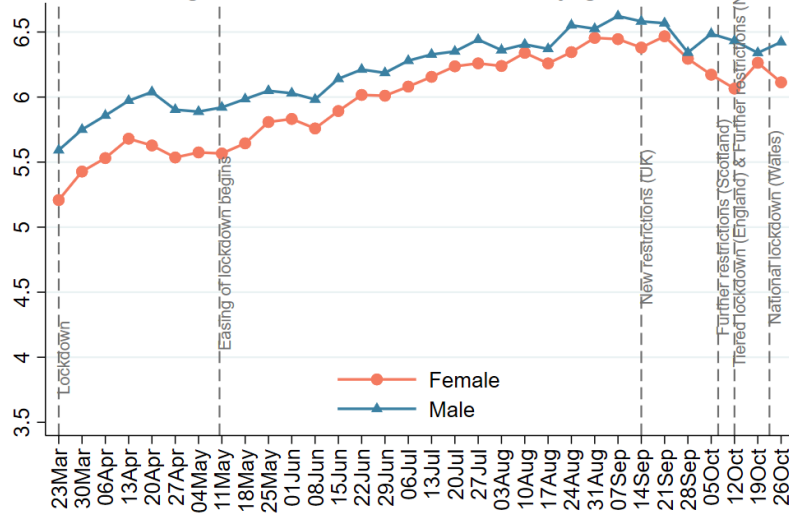
Figure 20j Life satisfaction by ethnicity
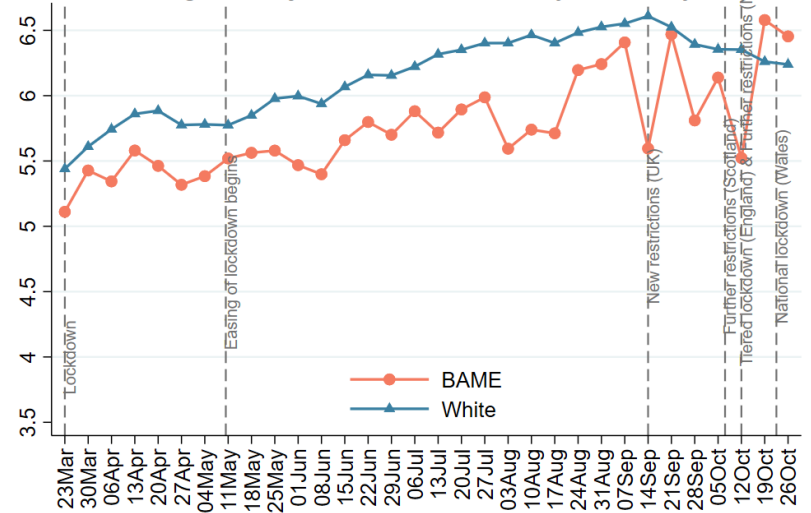
Figure 20k Life satisfaction by educational levels
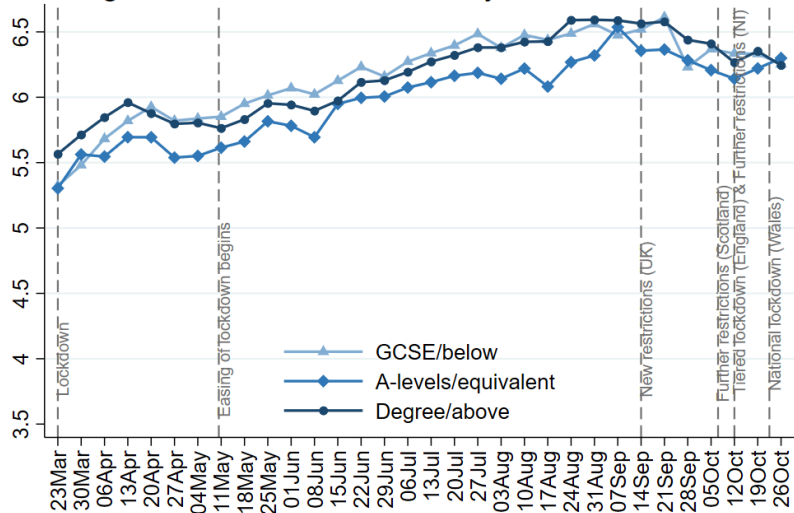
Figure 20l Life satisfaction by physical health diagnosis

4.2 Loneliness

Figure 21 Loneliness
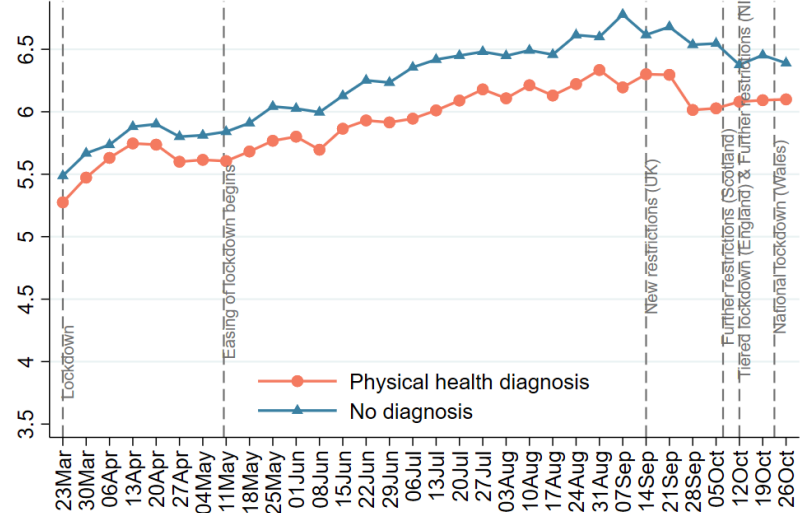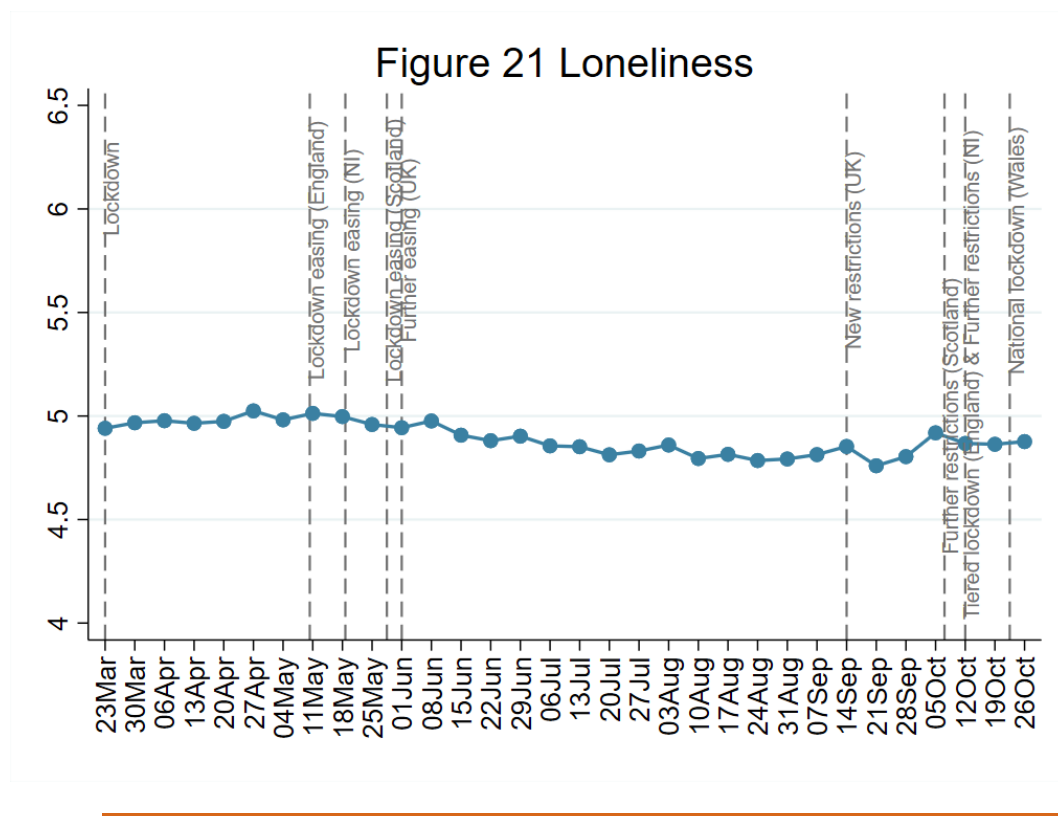
Respondents were asked about levels of loneliness using the 3-item UCLA-3 loneliness, a short form of the Revised UCLA Loneliness Scale (UCLA-R). Each item is rated with a 3-point rating scale, ranging from "never" to "always", with higher scores indicating greater loneliness.

Loneliness levels have been relatively stable in the past fortnight. They are still highest in younger adults, people living alone, people with lower household income, people living with children, people living in urban areas, and people with a diagnosed mental health condition. Loneliness levels have been higher amongst women, people from BAME backgrounds, and people with a long-term physical health condition.

Figure 22a Loneliness by age groups

Figure 22b Loneliness by living arrangement

Figure 22c Loneliness by household income

Figure 22d Loneliness by mental health diagnosis

Figure 22e Loneliness by nations

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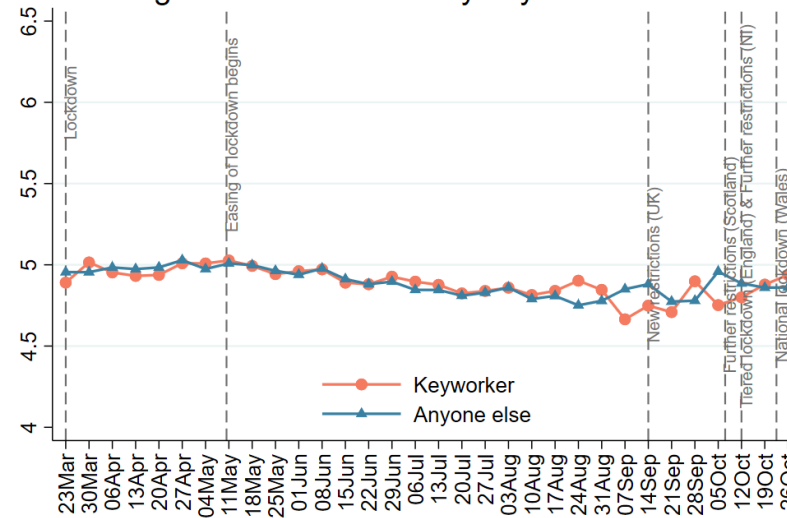
Figure 22g Loneliness by living with children
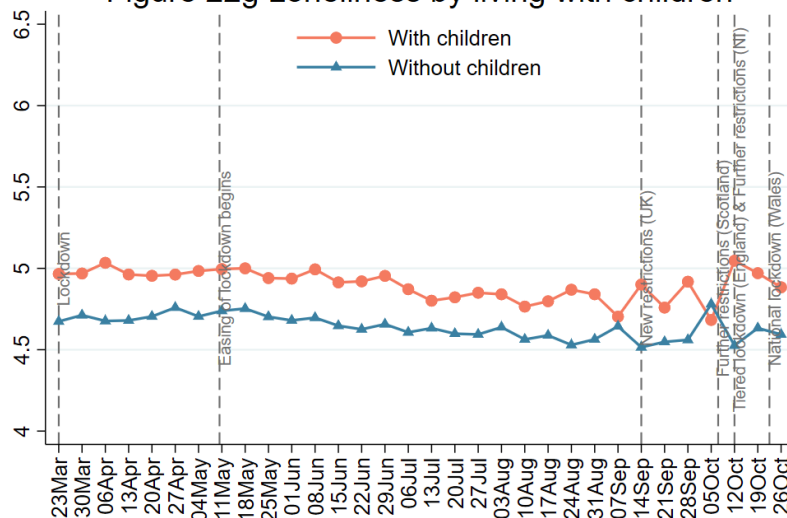
Figure 22h Loneliness by living area
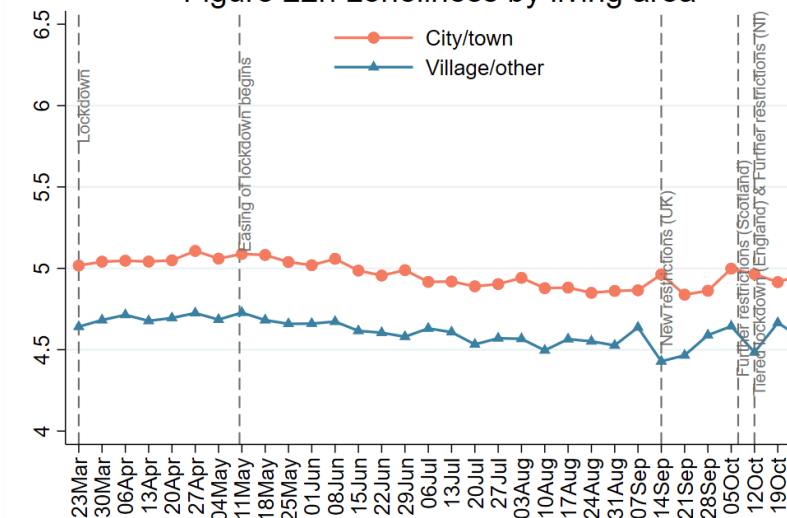
Figure 22i Loneliness by gender
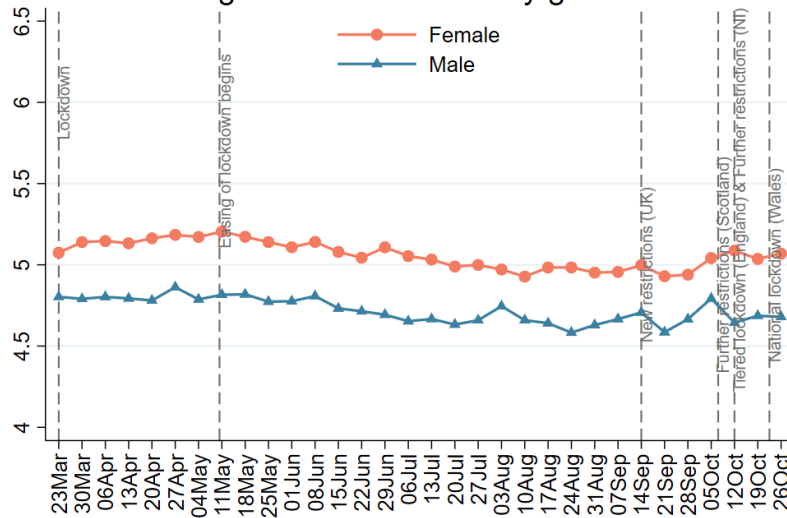
Figure 22j Loneliness by ethnicity
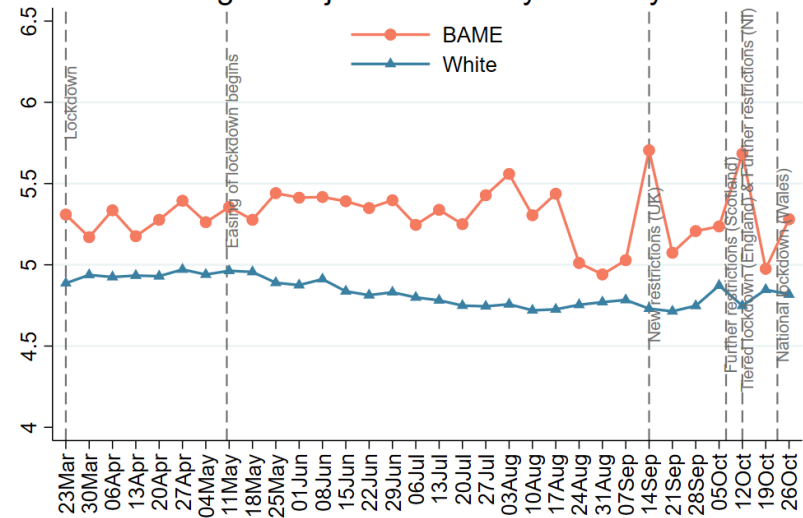
Figure 22k Loneliness by educational levels
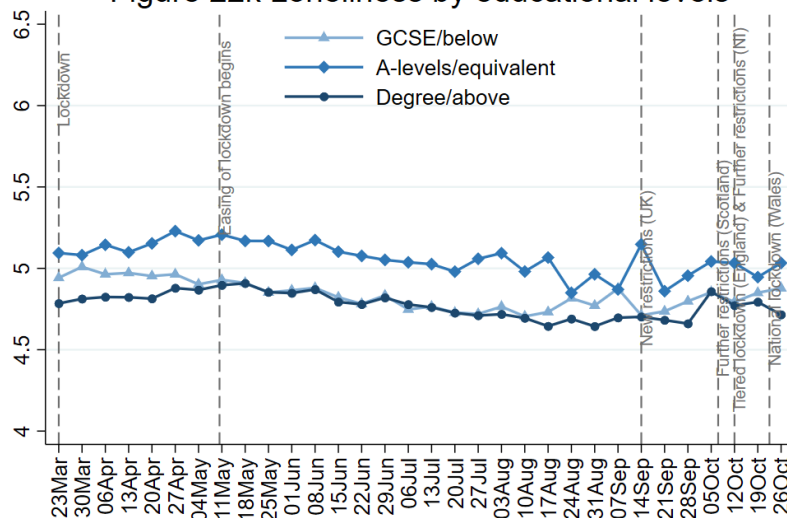
Figure 22l Loneliness by physical health diagnosis

4.3 Happiness
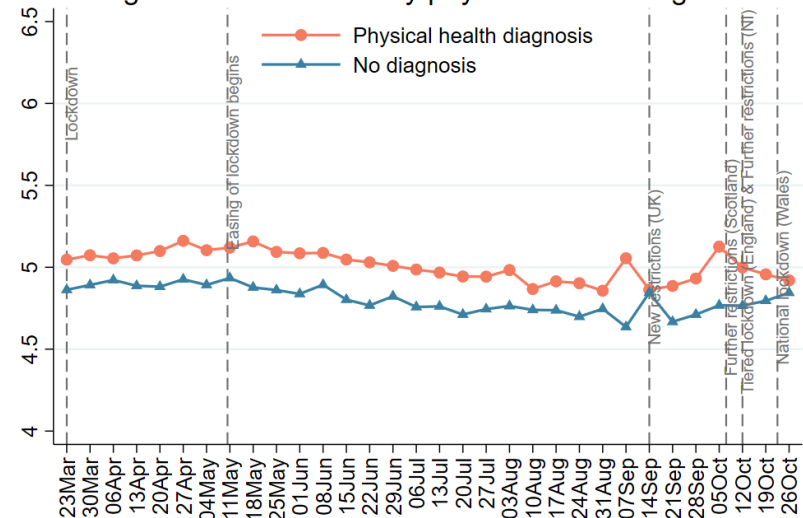
Figure 23 Happiness
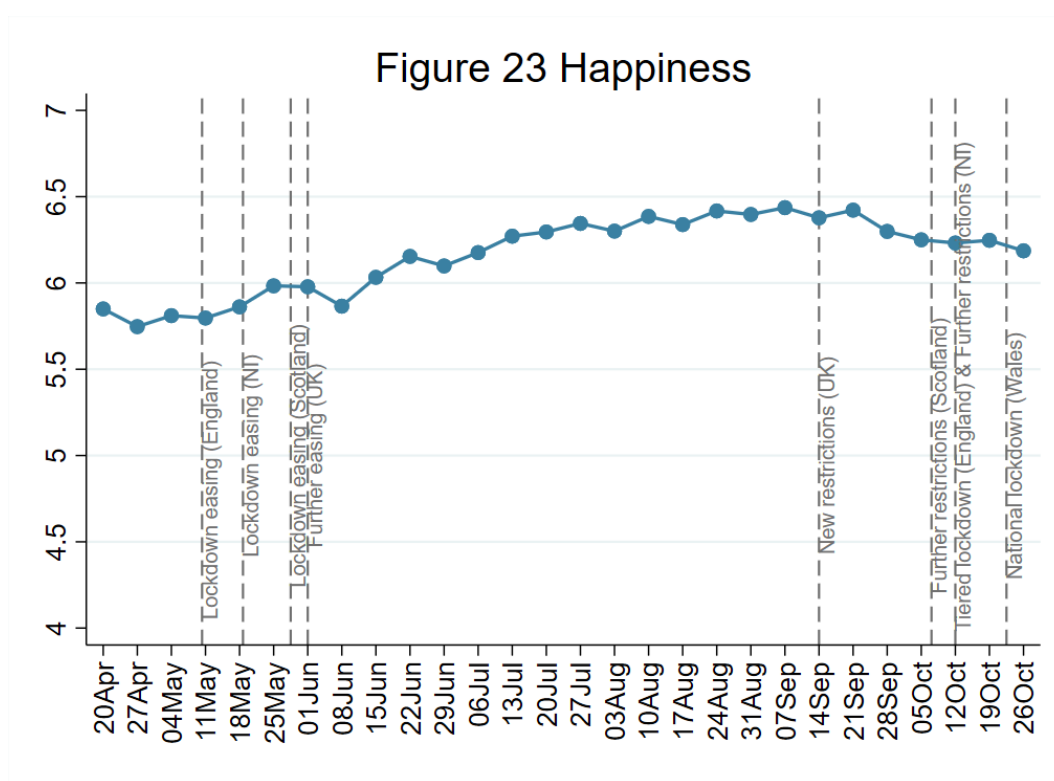
FINDINGS

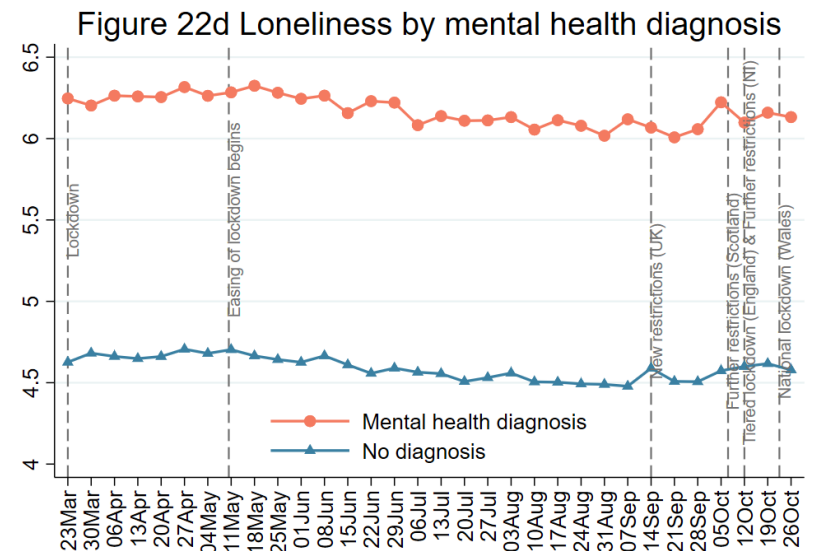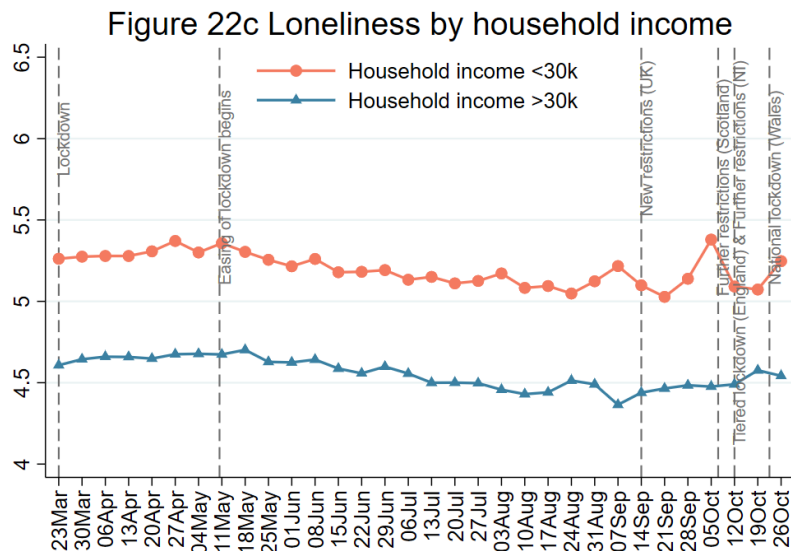Respondents were asked to rate to what extent they felt happy during the past week using the Office for National Statistics wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April onwards.

Happiness levels have further decreased in the past few weeks, particularly 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 health condition, and people living in urban areas. Happiness levels have been higher amongst women, people from BAME backgrounds, and people with a long-term physical health condition.

Figure 24a Happiness by age groups
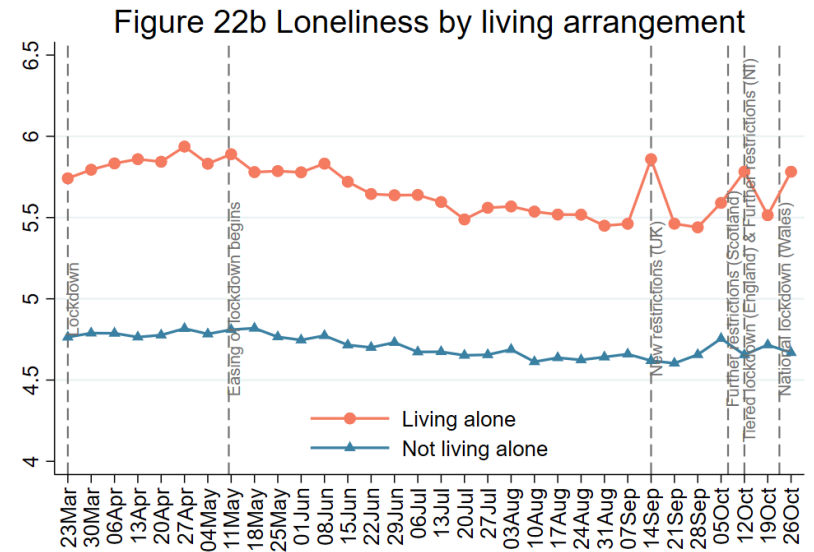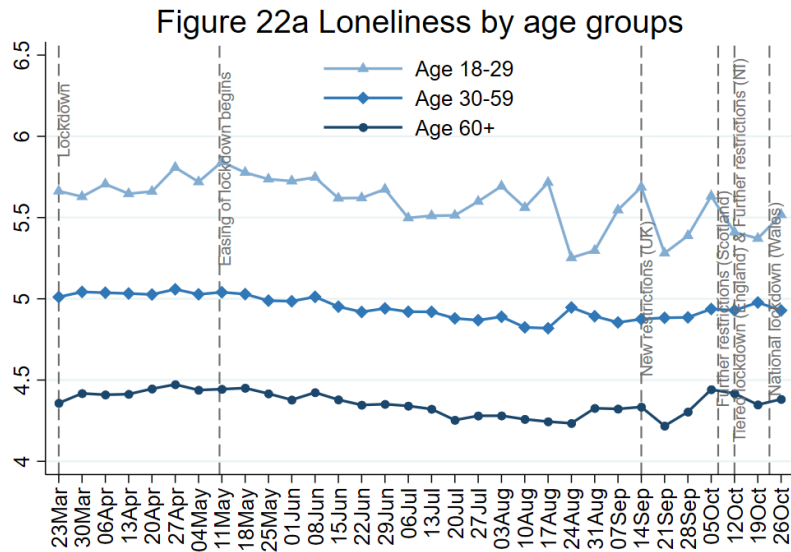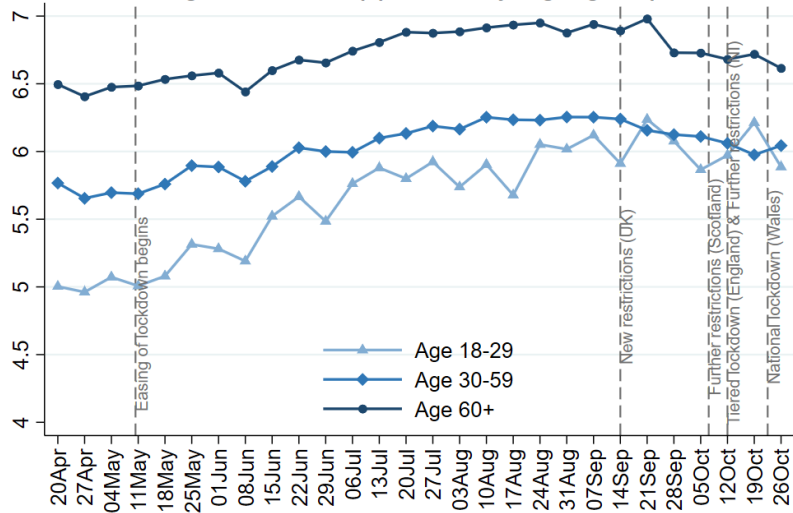

Figure 24b Happiness by living arrangement

Figure 24c Happiness by household income

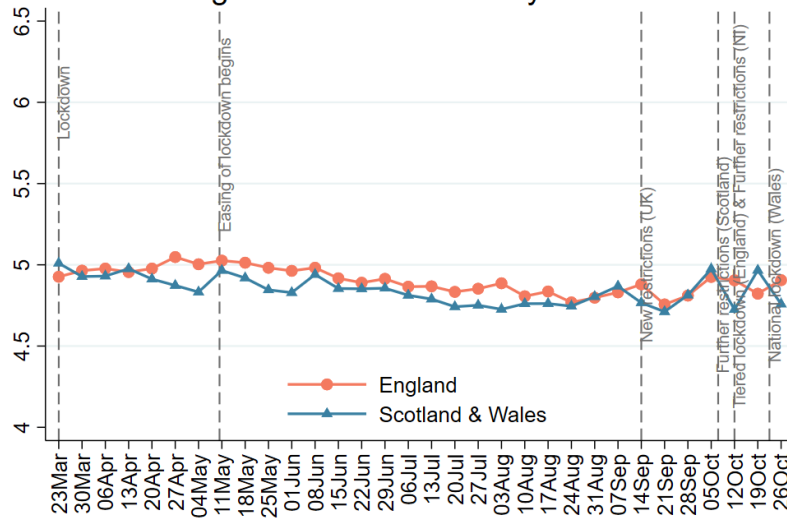Figure 24d Happiness by mental health

Figure 24e Happiness by nations
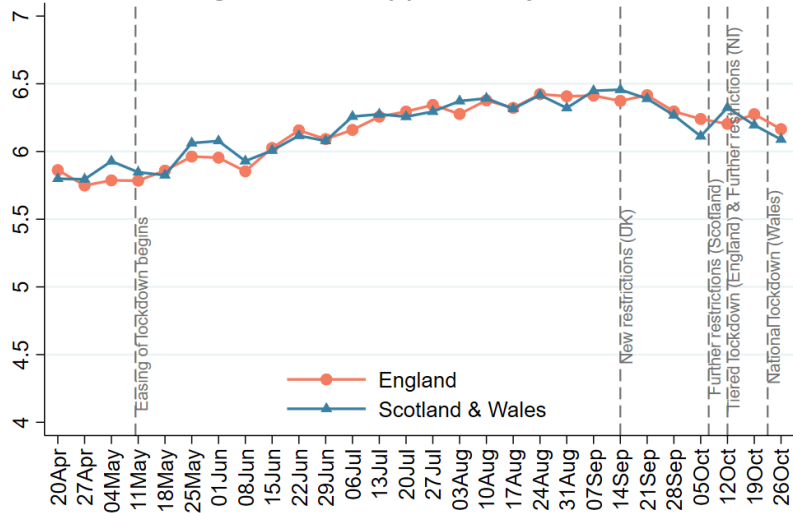
Figure 24f Happiness by keyworker status
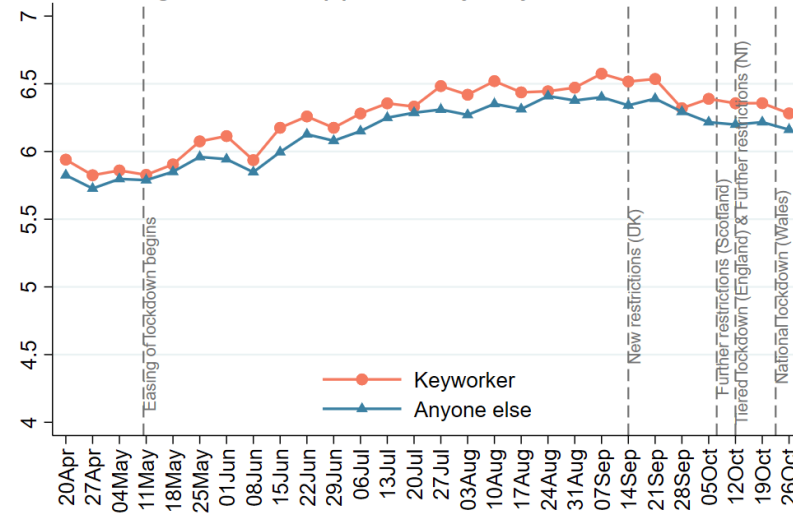
Figure 24g Happiness by living with children
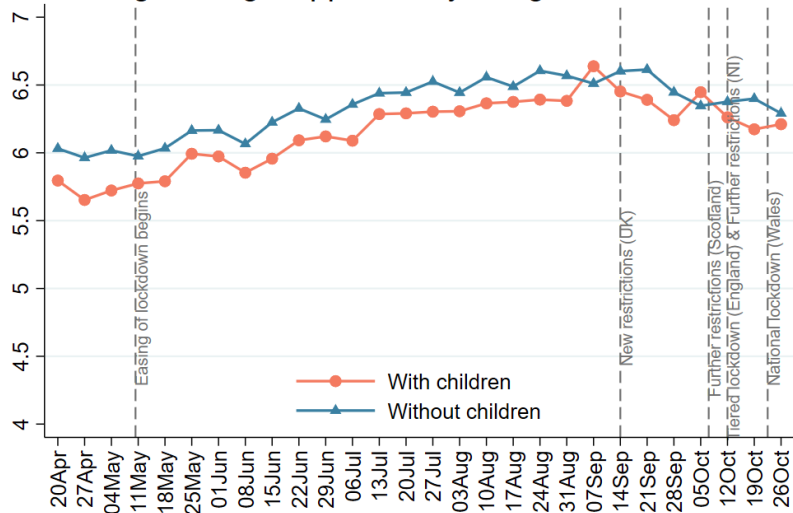
Figure 24h Happiness by living area
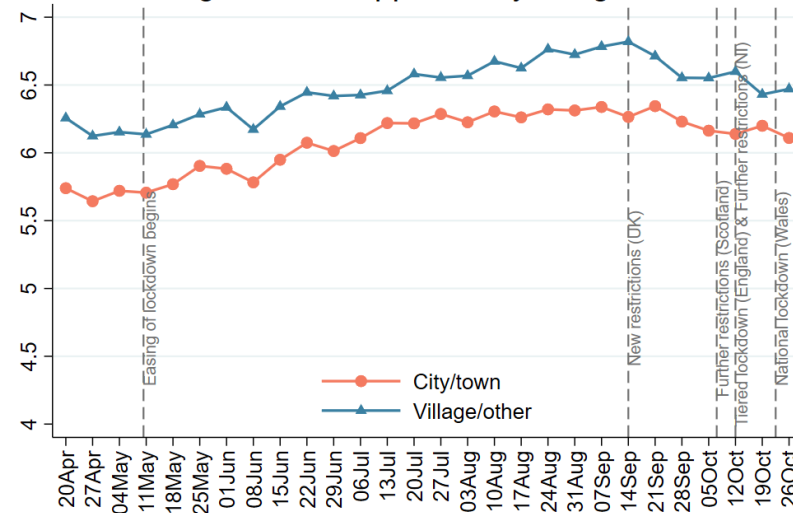
Figure 24i Happiness by gender
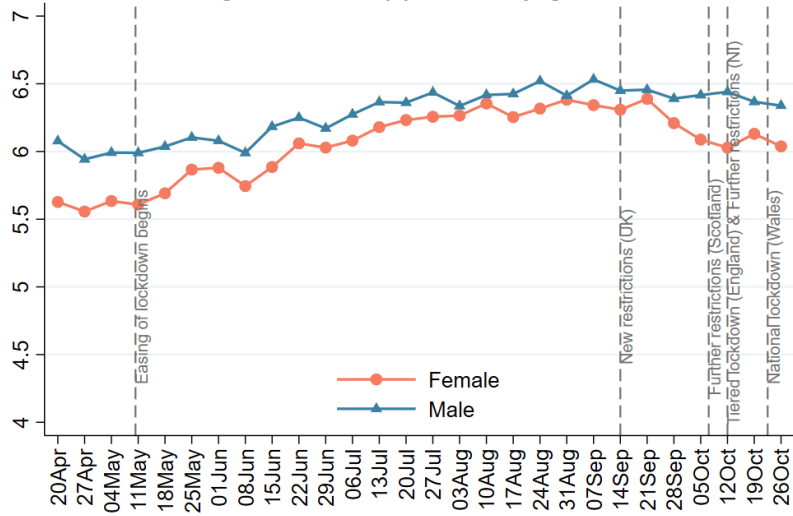
Figure 24j Happiness by ethnicity
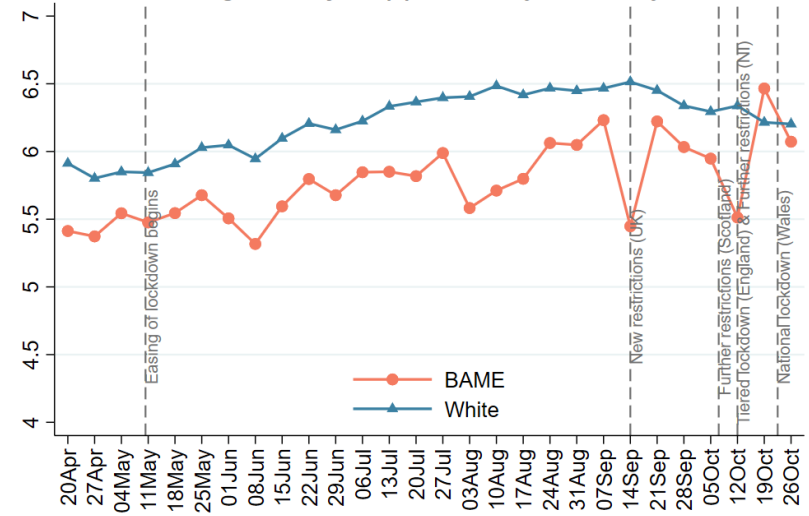
Figure 24k Happiness by educational levels

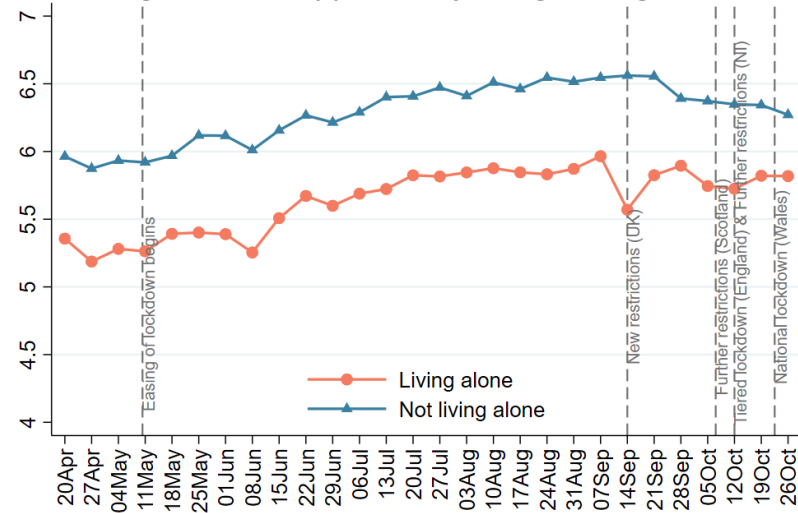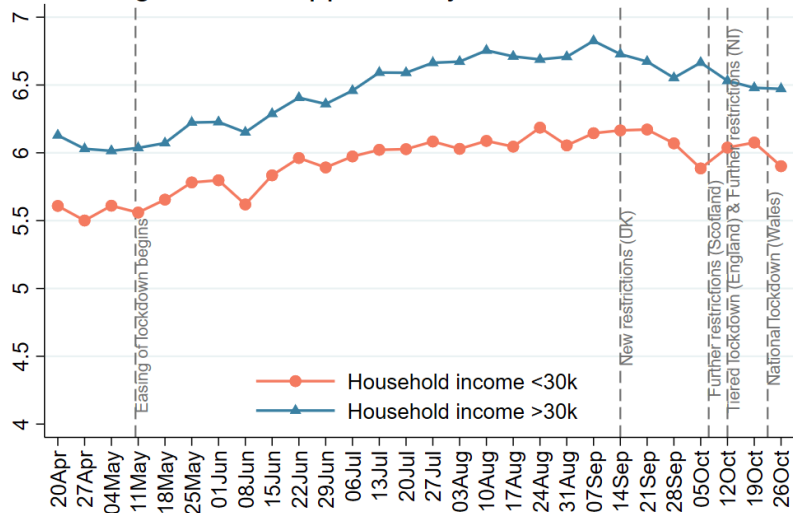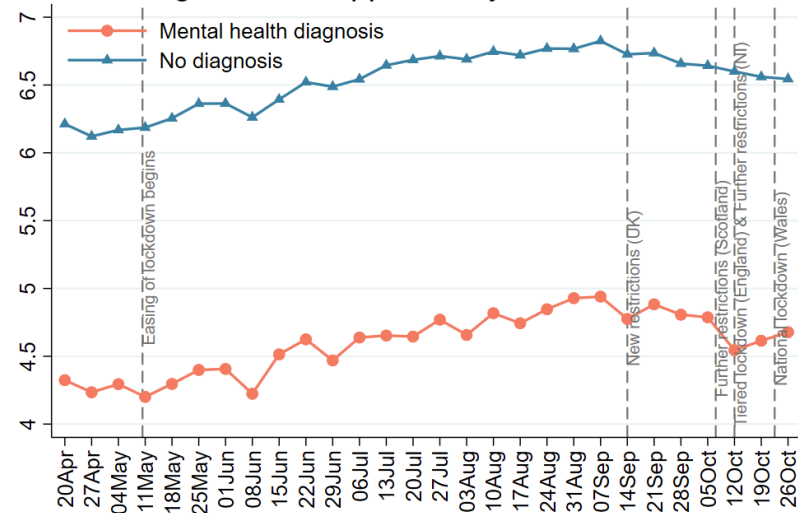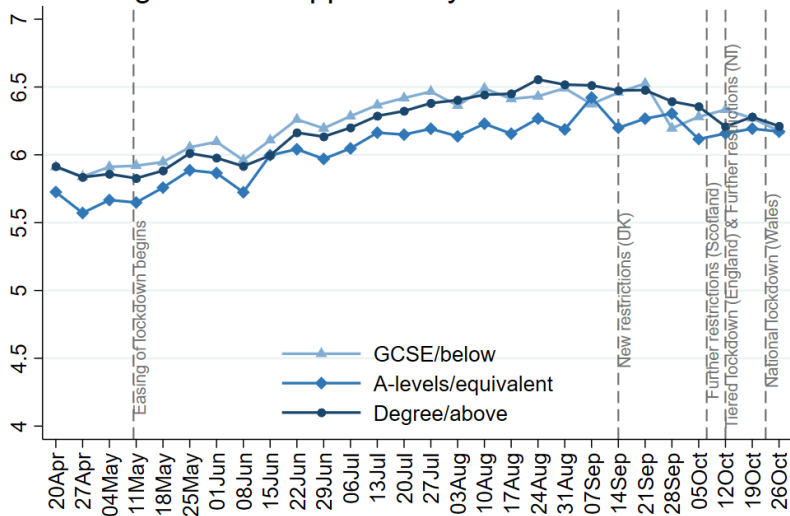## Figure 24l Happiness by physical health diagnosis

5. Confidence in essentials
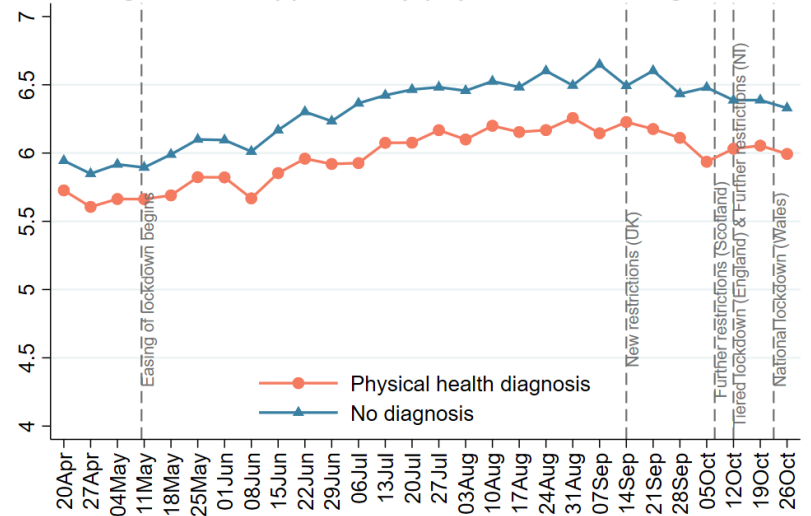
Figure 25 Confidence in essentials
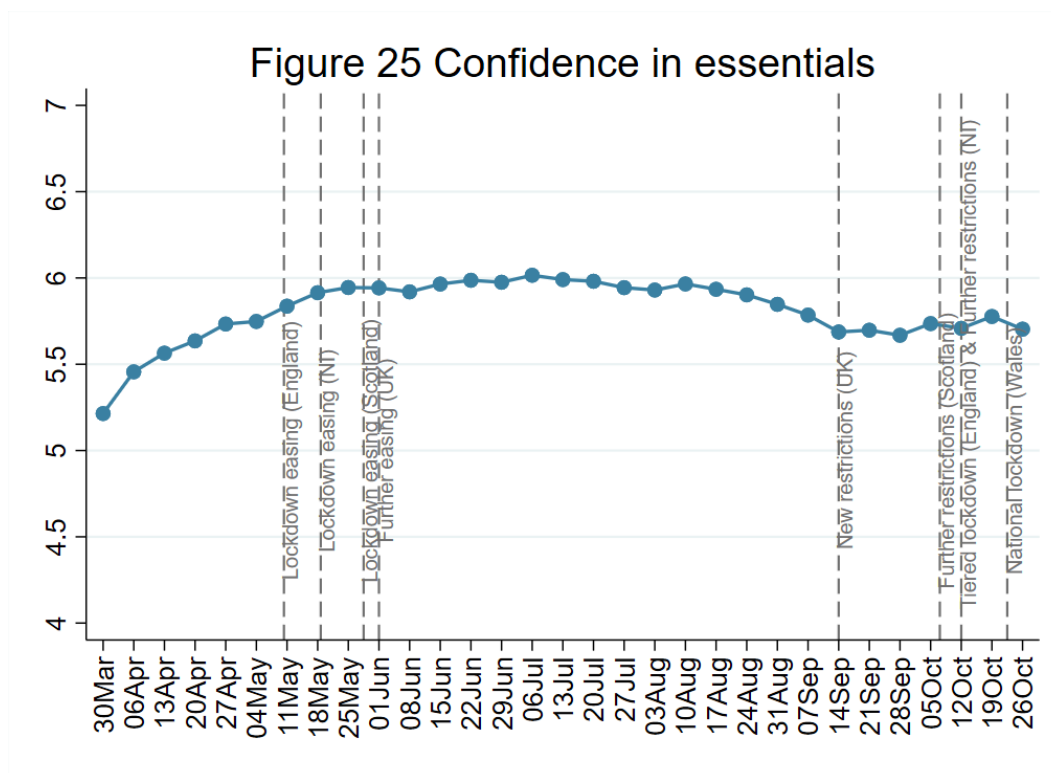
FINDINGS

We asked participants about their confidence in whether essentials (e.g. access to food, electricity, water etc) would be maintained during the pandemic from 1 (none at all) to 7 (lots). Confidence in access to essentials was low when lockdown started, with 20% of people on balance not having confidence that access to essentials would be maintained (score 1-3 out of 7), although 61% felt confident essentials would continue (score 5-7 out of 7; the remainder were undecided). This improved as lockdown continued and by mid-June, 91% of people thought access to essentials would be maintained and just 4% were concerned they would not be (see Report 22). However, across August and September as cases have started to increase again, confidence has decreased, although it has stabilised across October.

Confidence in access to essentials has decreased across all age groups. It has been consistently slightly lower in people living alone, people with lower household income, and people with a diagnosed mental health condition. It is similar across nations, amongst keyworkers and non-keyworkers, amongst people with and without children, and amongst people living in urban and rural areas. Confidence in access to essentials is lower amongst people from BAME backgrounds and people with long-term physical health conditions, but no different by gender or education.

Figure 26a Confidence in essentials by age groups
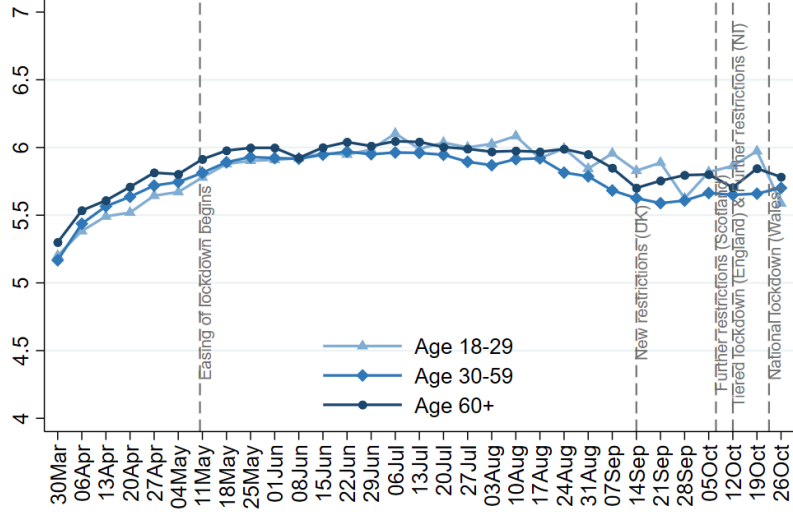
Figure 26b Confidence in essentials by living arrangement
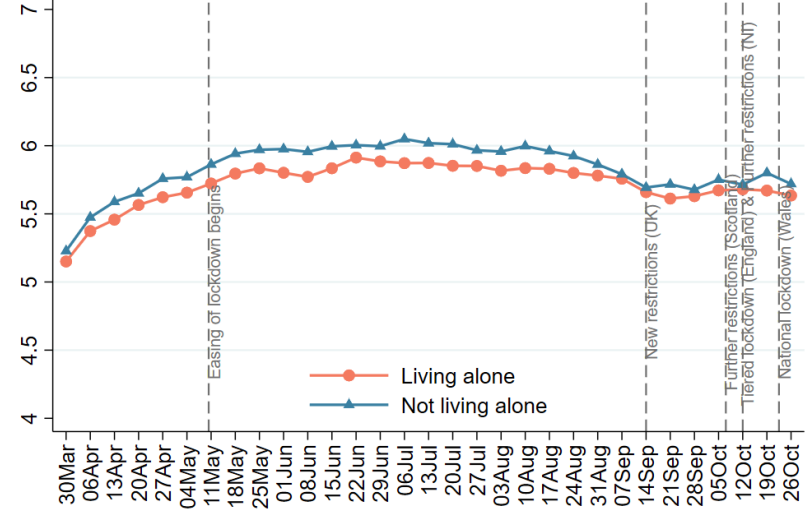
Figure 26c Confidence in essentials by household income
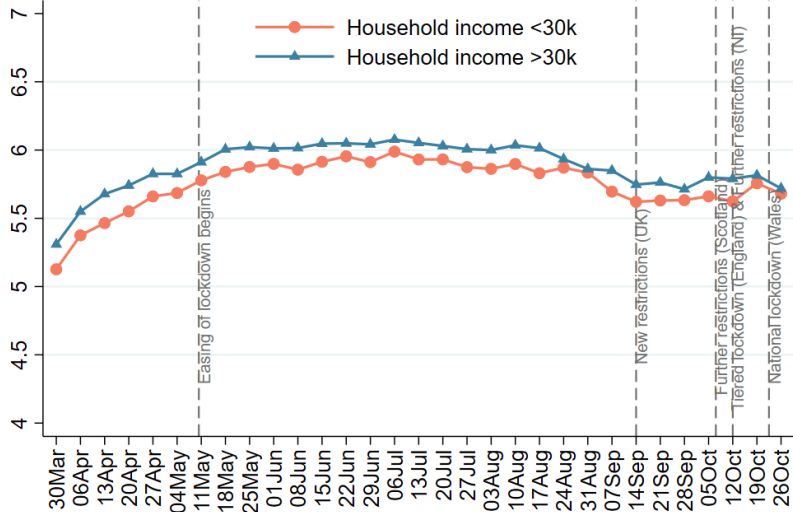
Figure 26d Confidence in essentials by mental health
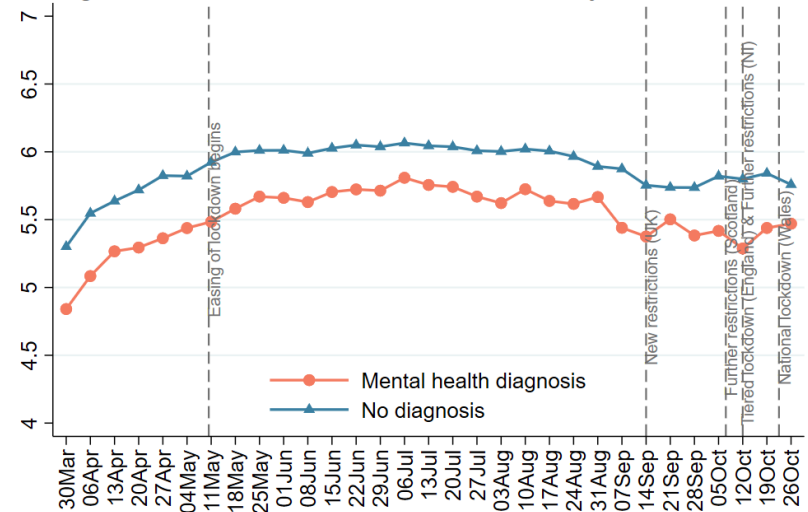
Figure 26e Confidence in essentials by nations

Figure 26f Confidence in essentials by keyworker status
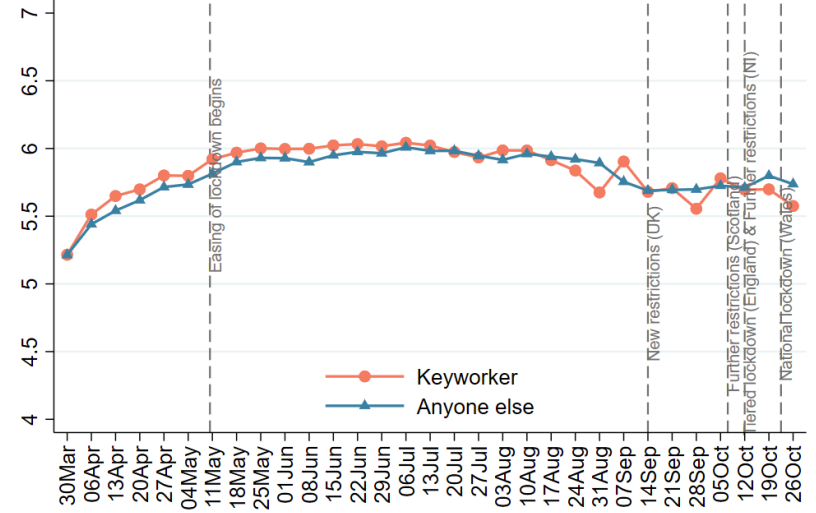
Figure 26g Confidence in essentials by living with children
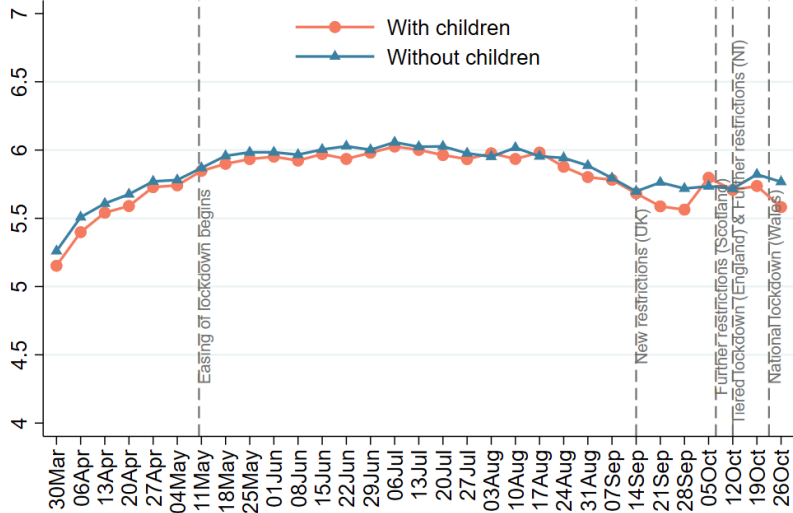
Figure 26h Confidence in essentials by living area
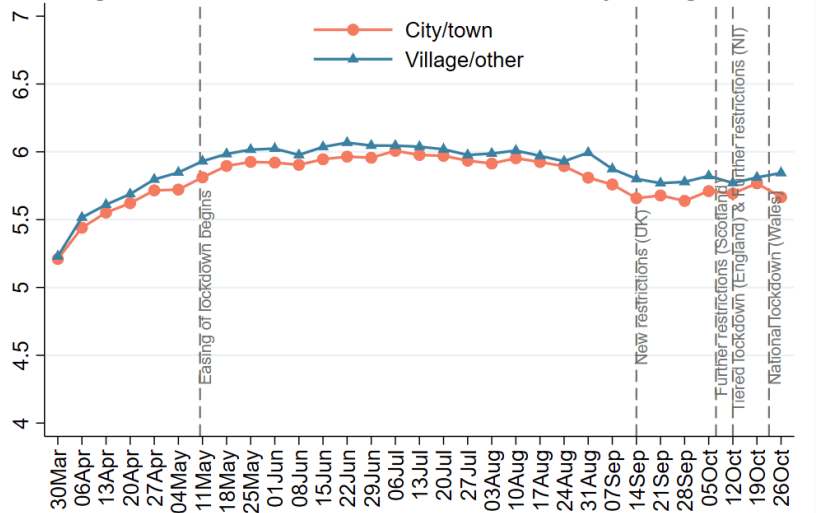
Figure 26i Confidence in essentials by gender
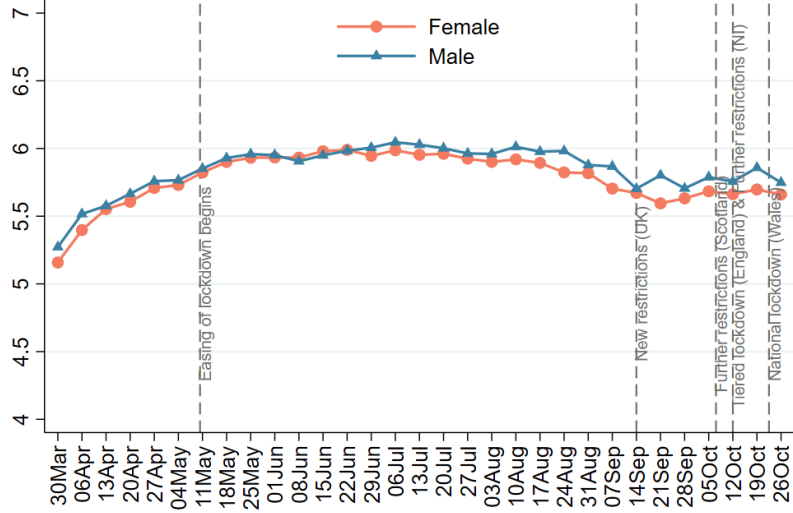
Figure 26j Confidence in essentials by ethnicity
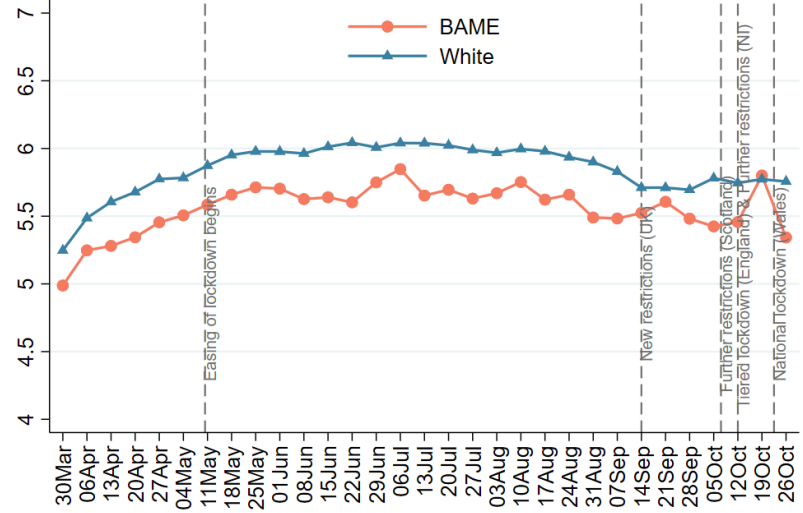
Figure 26k Confidence in essentials by educational levels
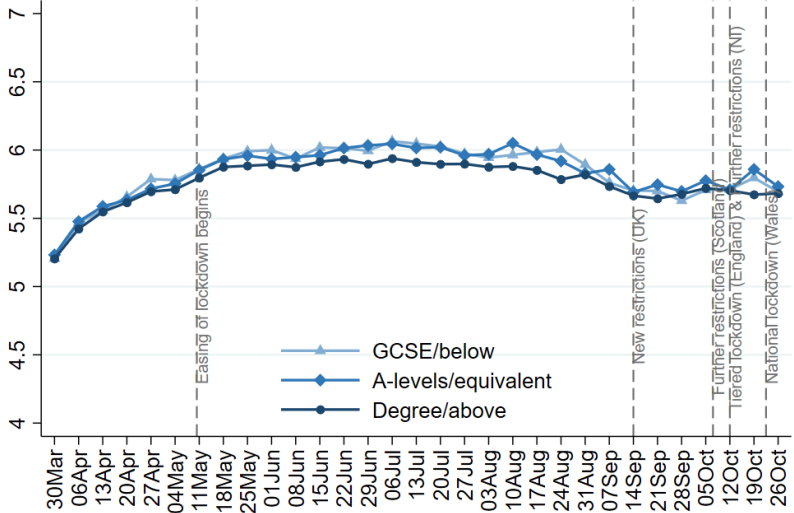
Figure 26l Confidence in essentials by physical health

6. Confidence in healthcare service
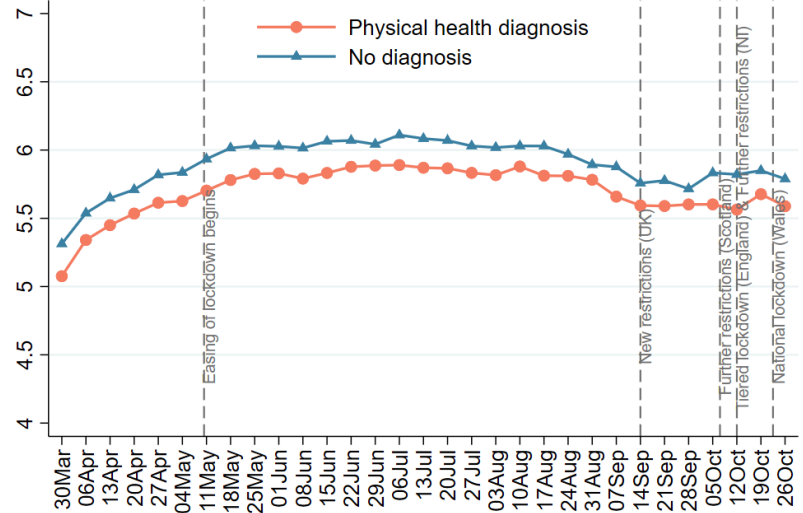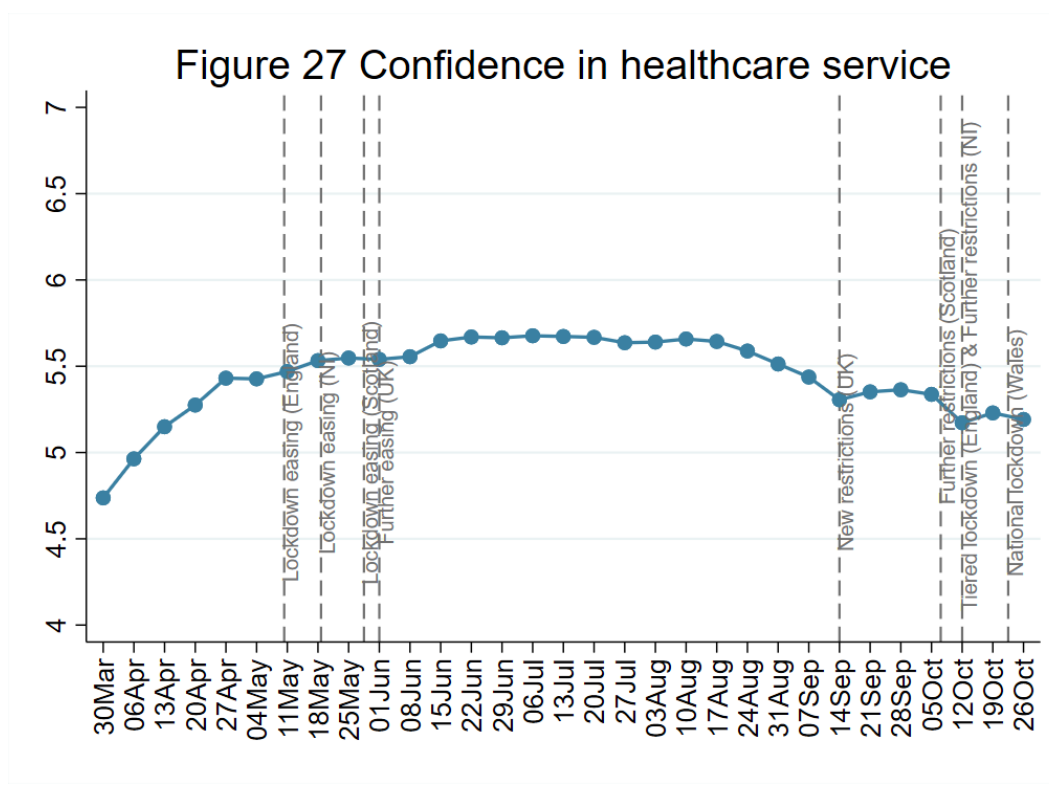

Figure 27 Confidence in healthcare service

FINDINGS

We asked participants about their confidence in the ability of the health service to cope during the pandemic from 1 (none at all) to 7 (lots). People living in devolved nations were asked to report their confidence in their own health service. Confidence in the ability of the health service to cope was low when lockdown started, with 20% of people on balance not thinking the health service would be able to cope (score of 1-3 out of 7) and 60% thinking it would cope (score of 5-7 out of 7; the remainder of participants were unsure). This improved as lockdown continued, stabilising in late April before increasing slightly more from mid-June when more restrictions were eased. At this point, on balance only 8% felt the health service would not cope but 83% felt it would (see Report 22). However, across later August and September as cases started to increase and confidence decreased and this pattern has continued across October.

Confidence in the ability of the health service to cope is higher amongst older adults and people living in rural areas, but lower amongst people with a pre-existing mental health condition. There has been little difference depending on factors such as household income, being a keyworker, living with children, or living alone and also no material difference by country. Confidence in the ability of the health service to cope is lower amongst women, people from BAME backgrounds and people with higher educational attainment, but no different amongst people with and without long-term physical health conditions.

Figure 28a Confidence in healthcare service by age groups
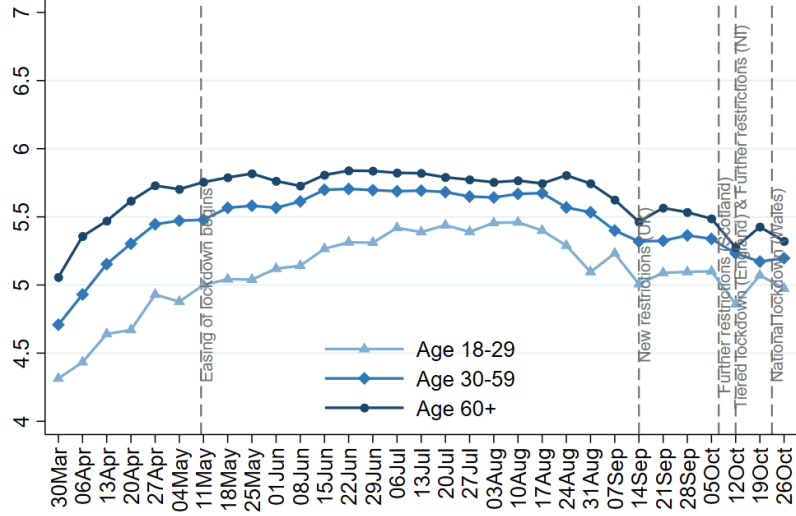
Figure 28b Confidence in healthcare by living arrangement
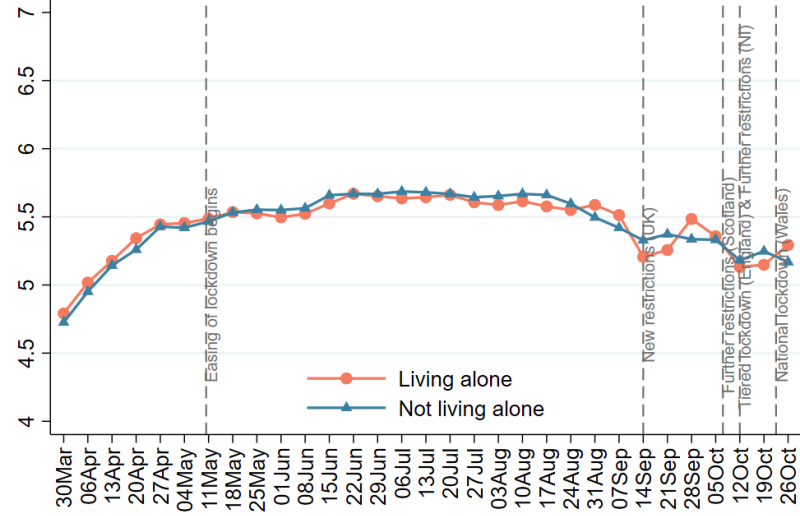
Figure 28c Confidence in healthcare by household income
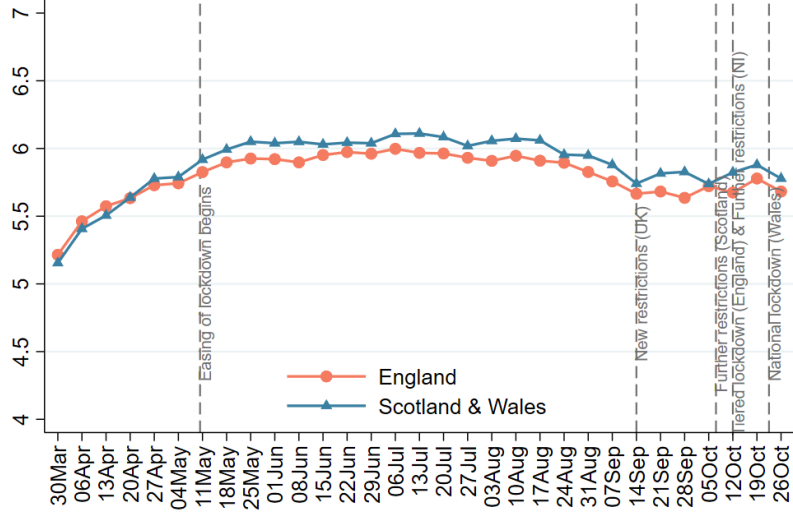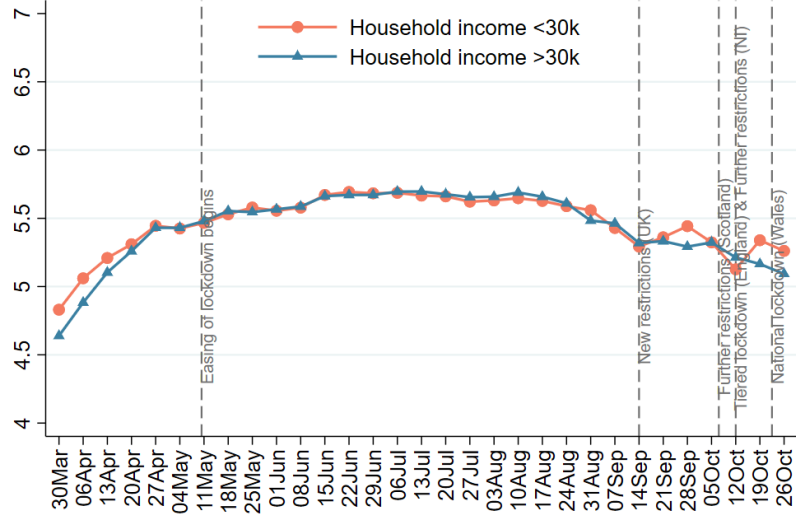
Figure 28d Confidence in healthcare by mental health
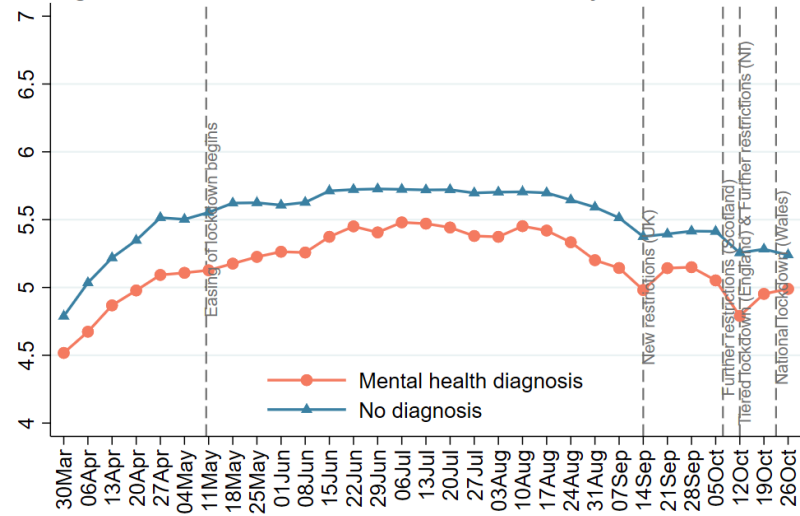
Figure 28e Confidence in healthcare service by nations
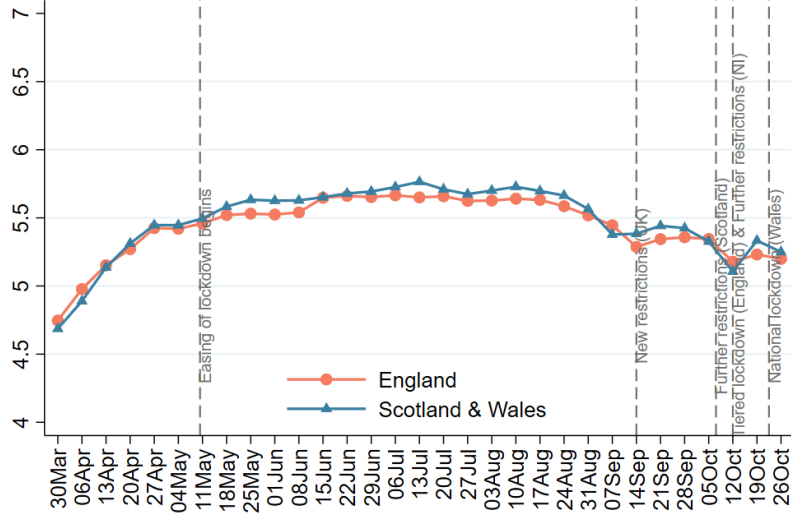
Figure 28f Confidence in healthcare by keyworker status
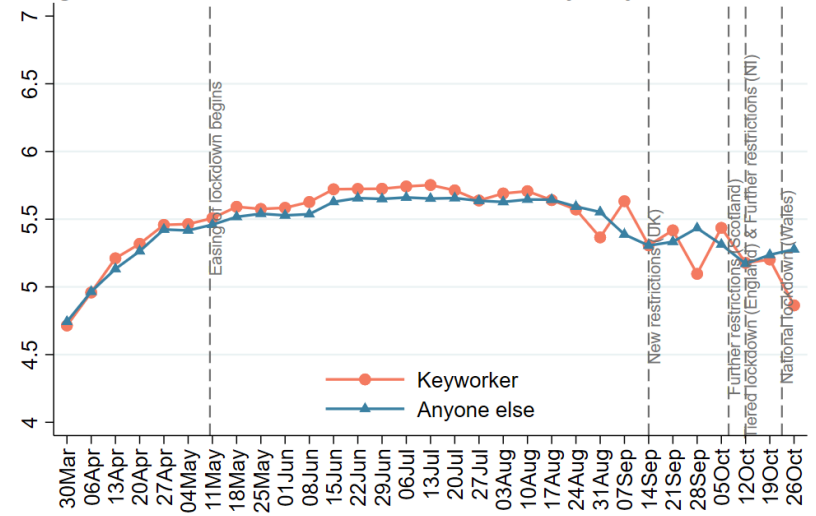
Figure 28g Confidence in healthcare by living with children

Figure 28h Confidence in healthcare service by living area
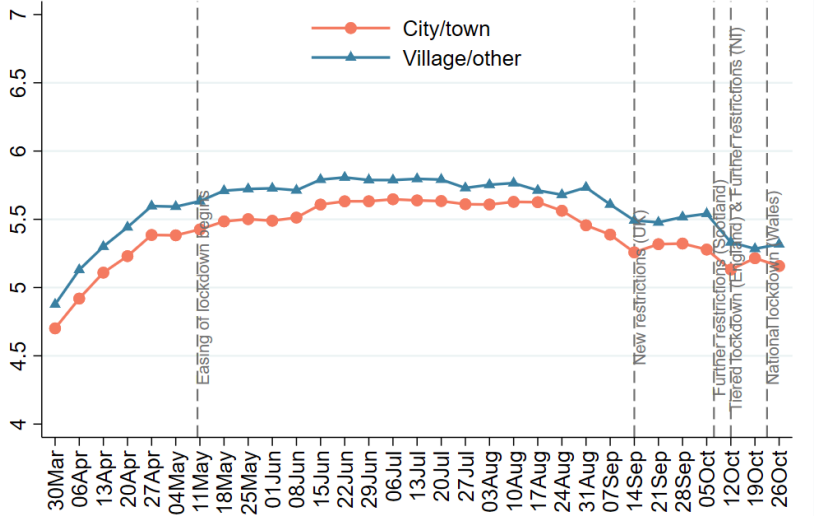
Figure 28i Confidence in healthcare service by gender

Female
Male

Figure 28j Confidence in healthcare service by ethnicity

BAME
White

Figure 28k Confidence in healthcare by educational levels

GCSE/below
A-levels/equivalent
Degree/above

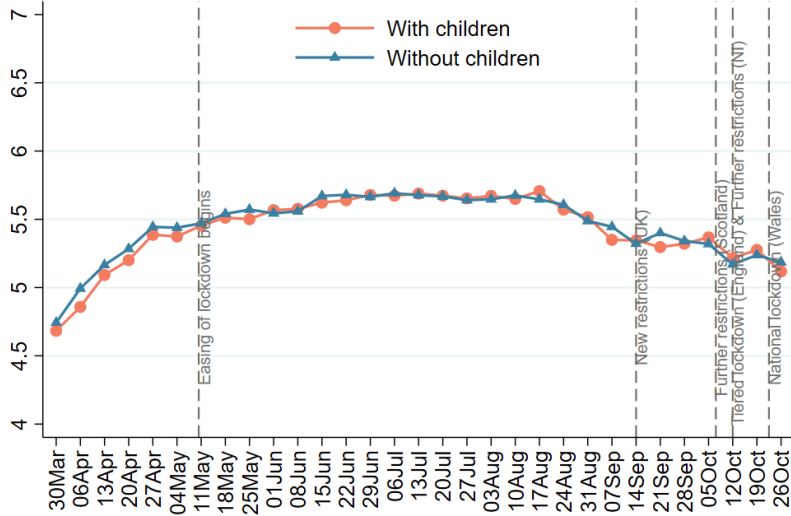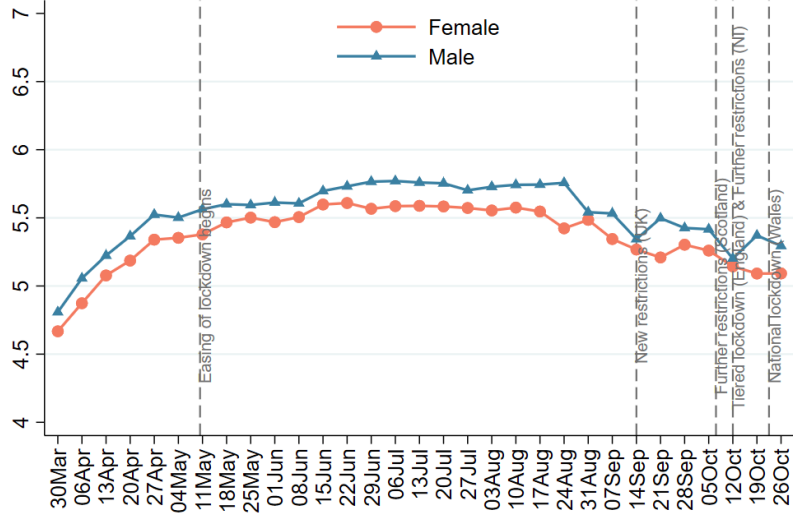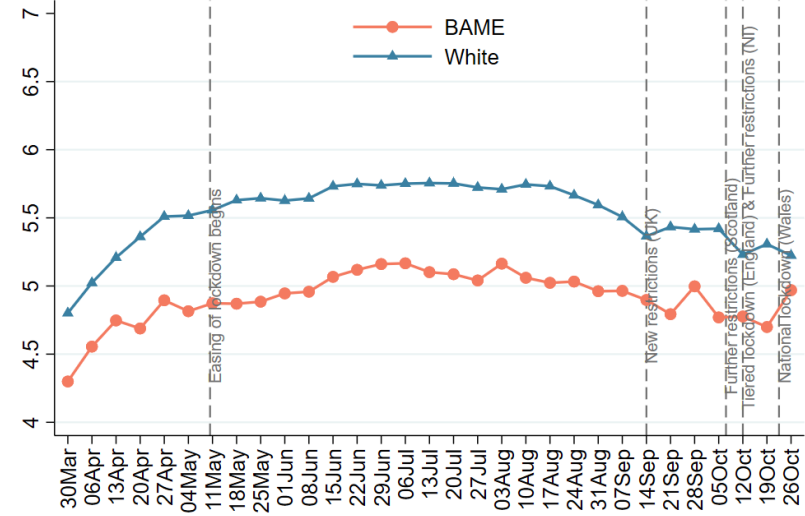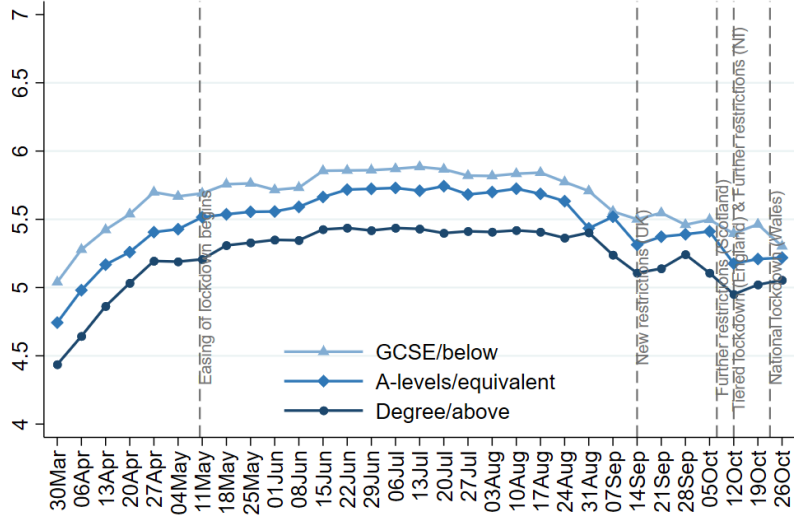## Figure 28l Confidence in healthcare by physical health

Physical health diagnosis
No diagnosis
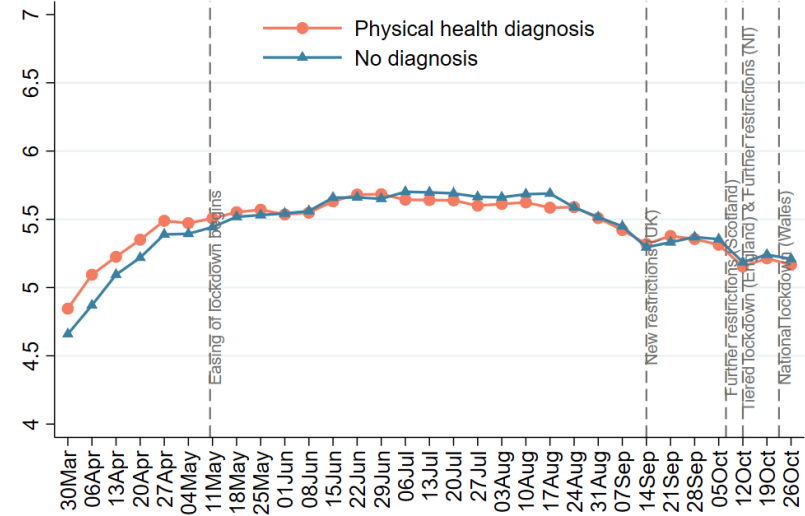
Appendix

Methods

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

Specifically, in the analyses presented here we included adults in the UK. We used new cross-sectional data from individuals as they entered the study and also included weekly longitudinal data as participants received their routine follow-up. In this report, we treated the data as repeated cross-sectional data collected daily from the 21st March to the 1st 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. 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	45,455	6.05	**GCSE or below**	105,295	14.0
30-59	417,151	55.6	**A-levels of equivalent**	129,952	17.3
60+	288,229	38.4	**Degree or above**	515,588	68.7
Gender			**Any diagnosed mental health conditions**		
Male	188,400	25.2	**No**	623,717	83.1
Female	559,402	74.8	**Yes**	127,118	16.9
Ethnicity			**Any diagnosed physical health conditions**		
White	718,372	96.0	**No**	434,312	57.8
BAME	30,124	4.02	**Yes**	316,523	42.2
UK nations			**Keyworker**		
England	606,570	81.6	**No**	592,993	79.0
Wales	89,921	12.1	**Yes**	157,842	21.0
Scotland	47,018	6.32	**Living with children**		
Living arrangement			**No (excluding those who live alone)**	424,554	71.4
Not living alone	594,390	79.2	**Yes**	169,836	28.6
Living alone	156,445	20.8	**Living area**		
Annual household income			**Village/hamlet/isolated dwelling**	186,694	24.9
>30k	405,047	59.8	**City/large town/small town**	564,141	75.1
<30k	272,075	40.2			