Covid-19 Social Study

Results Release 7

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Executive summary

Background

This report provides data from Week 7 of the UK COVID-19 Social Study run by University College London: a panel study of over 85,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this SEVENTH report, we focus on psychological responses to the first six weeks of government measures requiring people to stay at home. We present simple descriptive results on the experiences of adults in the UK. **Crucially, in this report we include keyworkers within our main sample and present sub-group analyses for more socio-demographic groups.** Measures include:
1. Reported compliance with government guidelines and confidence in the government
2. Mental health including depression, anxiety and stress
3. Harm including thoughts of death or self-harm, self-harm and both psychological and physical abuse
4. Psychological and social wellbeing including life satisfaction and loneliness

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

Findings

*   Compliance with government advice remains very high. Although there is little change in overall compliance levels, there is a slight decrease in 'complete' compliance, suggesting a small proportion of adults are only partially following the social distancing rules. Compliance is higher in women and people living in rural areas.
*   Confidence in government remains relatively stable but is lower than it was at the start of lockdown. It is lower in urban areas.
*   Anxiety levels appear to have stabilised, although depression levels are similar to when lockdown started, with both above average levels. Levels remain highest in individuals with existing mental health diagnoses, women, people living with children, and people living in urban areas.
*   Stress relating to Covid-19 (both catching and becoming seriously ill from Covid-19) has increased slightly in the past week as discussions on the end of lockdown have begun.
*   1 in 12 people are now worried about access to food, and this figure is higher amongst people with a mental health diagnosis, people living with children, and people with a low household income.
*   Thoughts of death or self-harm remain relatively stable but are higher amongst younger people and those living alone, with low household income, with a mental health condition, and living in urban areas.
*   Self-harm and abuse remain relatively stable since lockdown began, but are reportedly higher amongst younger adults, those living alone, those with low household income, those with a mental health condition, women, and people living in urban areas. Levels reported here are expected to be under-estimations of experiences.
*   Life satisfaction is still noticeably lower than usual levels but is higher than when lockdown started. Life satisfaction is lower in women, people living with children, and people living in urban areas.
*   Loneliness levels continue to be stable since lockdown started, even amongst high-risk groups. Levels are higher in women, people living with children, and people living in urban areas.

1. Compliance and confidence

1.1 Compliance with guidelines

Figure 1 Compliance with guidelines
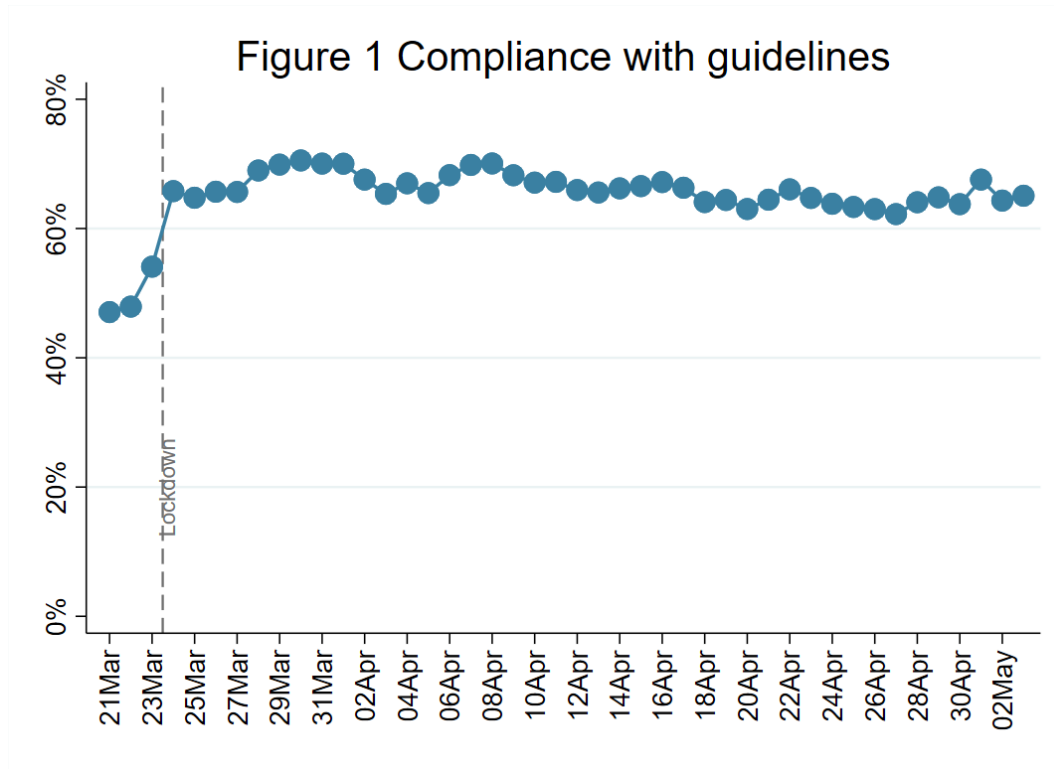
FINDINGS

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 (completely). Figure 1 shows the percentage of people who followed the recommendations "completely" (with a score of 7).

"Complete" compliance remains high but with a slight decrease evident since lockdown began. It remains lower in younger adults, and is also lower in men, and people living in cities and towns compared to people living in more rural areas (see Figs 2). Compliance is recorded as lower in keyworkers, but this is likely due to them being unable to follow the rules due to the demands of their work. There is little difference depending on whether people are living with children or not[1].

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

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

Figure 2a Compliance by age groups
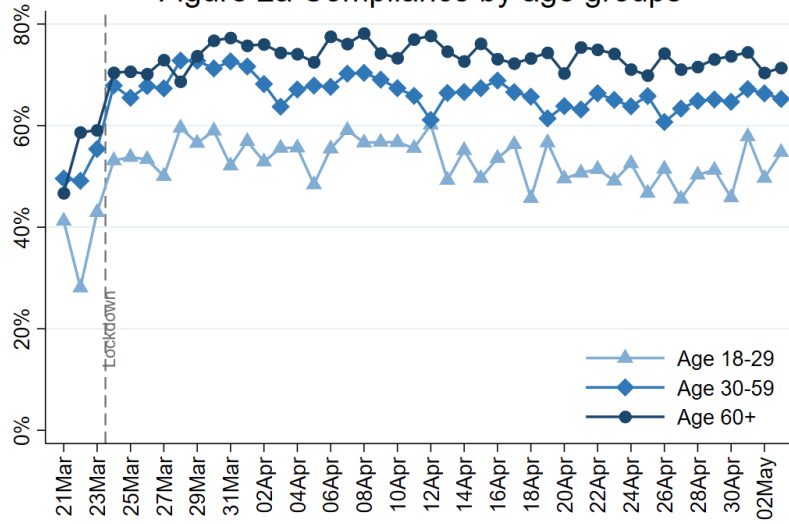
Figure 2b Compliance by living arrangement
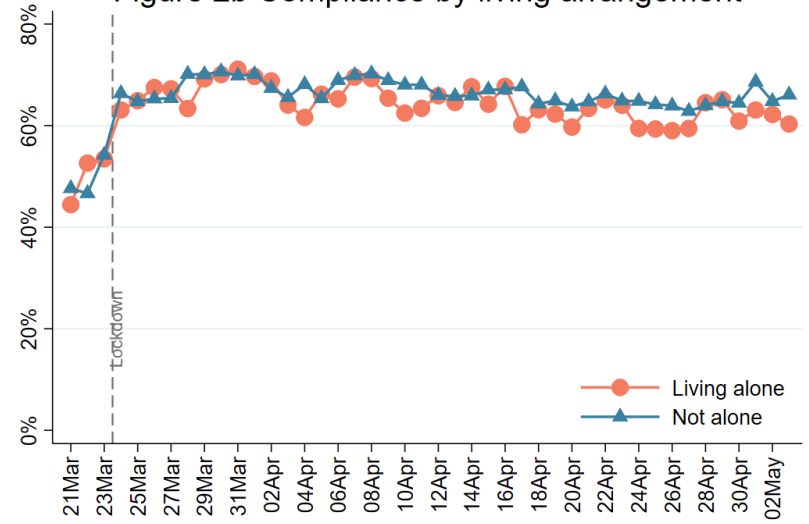
Figure 2c Compliance by household income
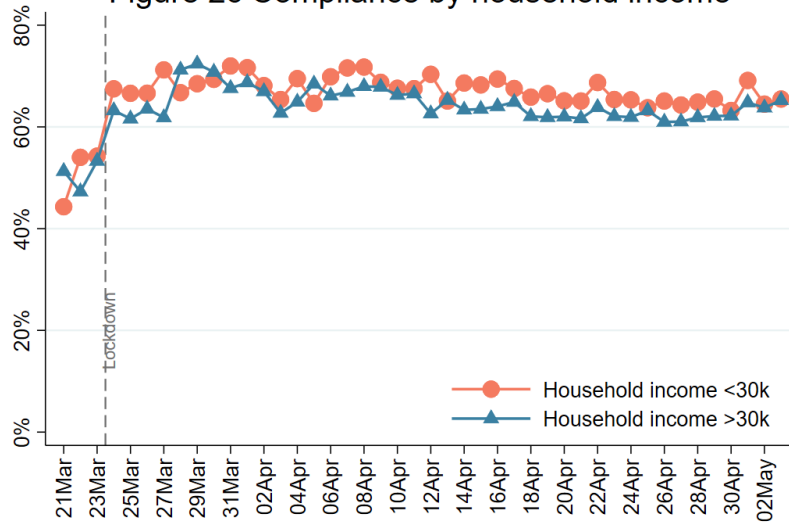
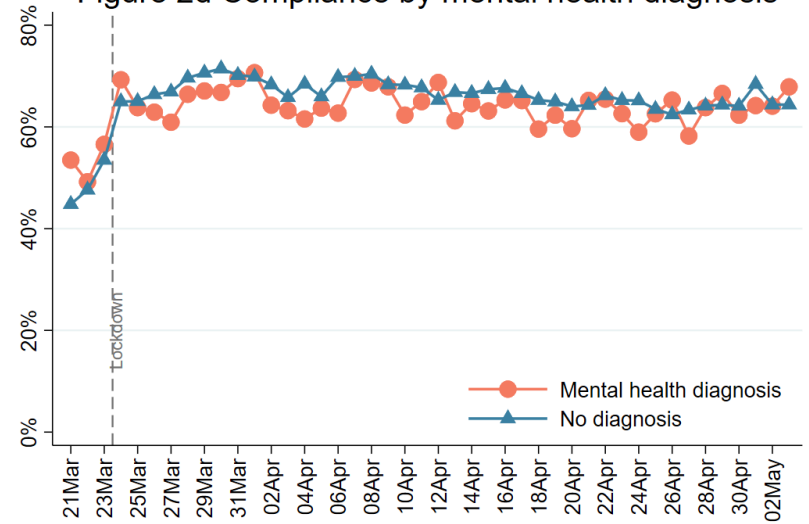Figure 2d Compliance by mental health diagnosis
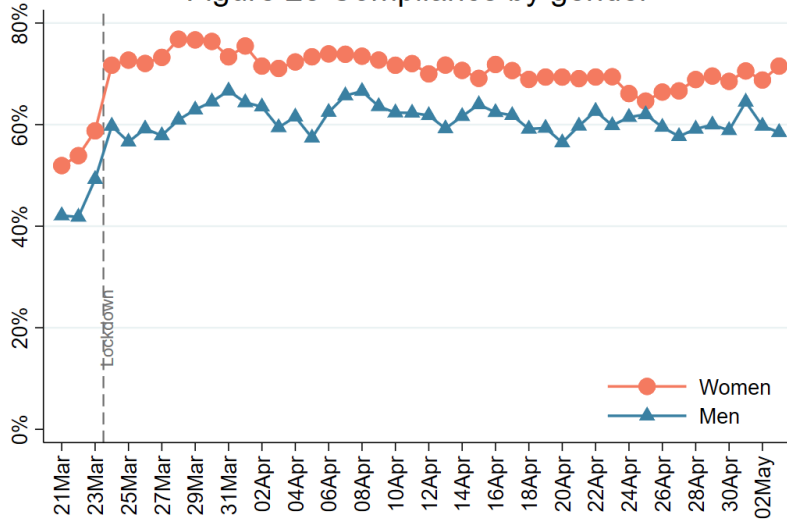
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Figure 2e Compliance by gender
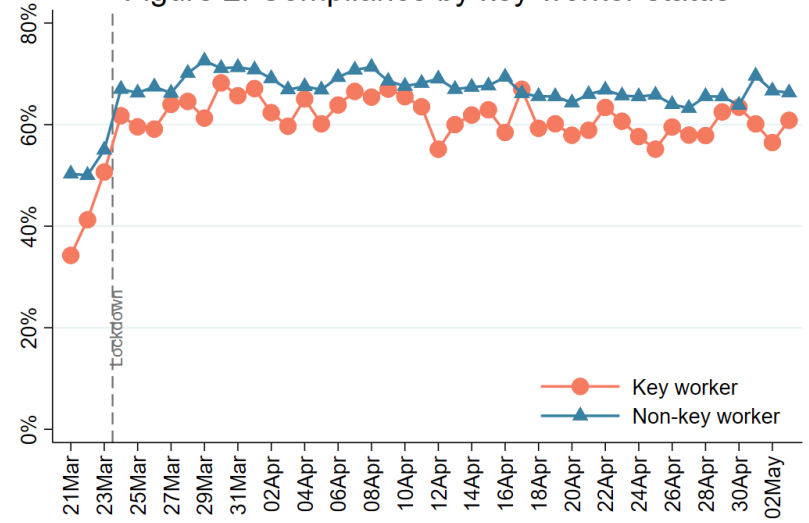
Figure 2f Compliance by key-worker status

Figure 2g Compliance by living with children

Figure 2h Compliance by living area
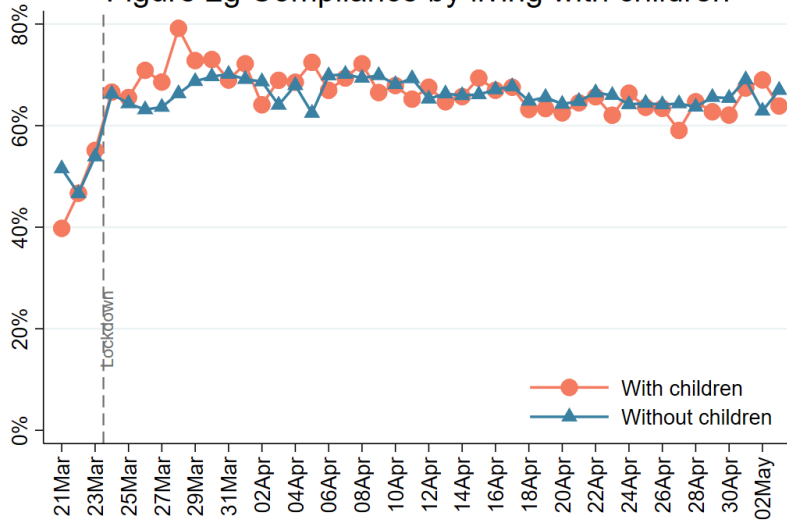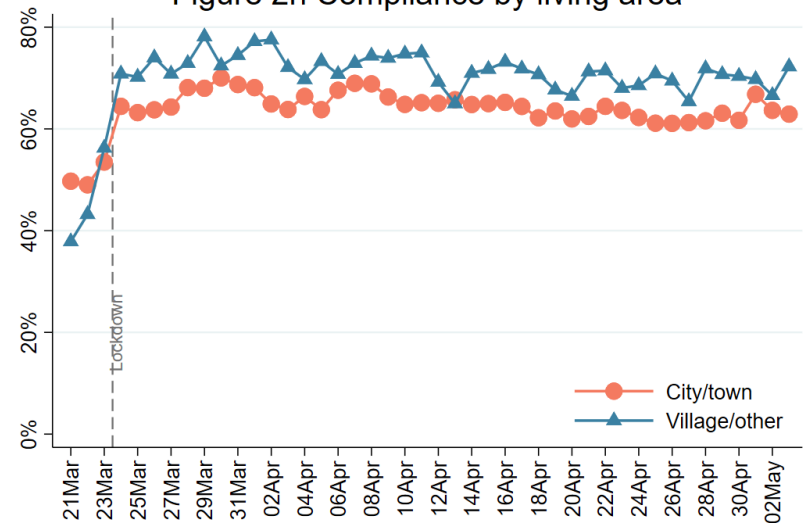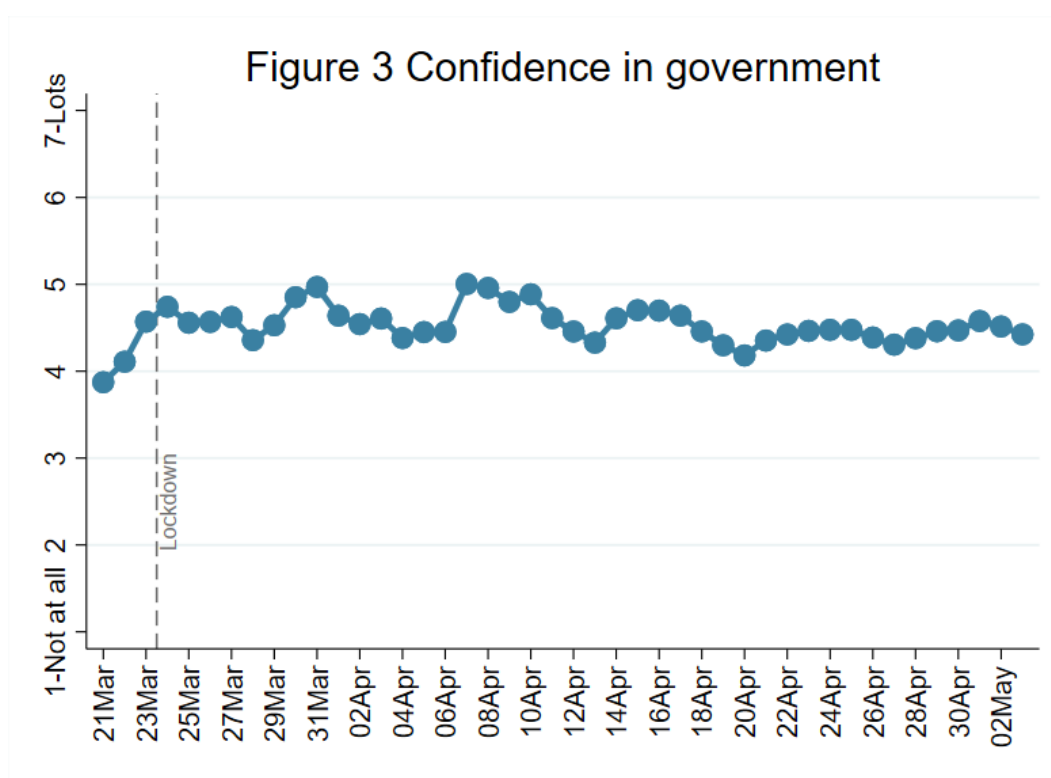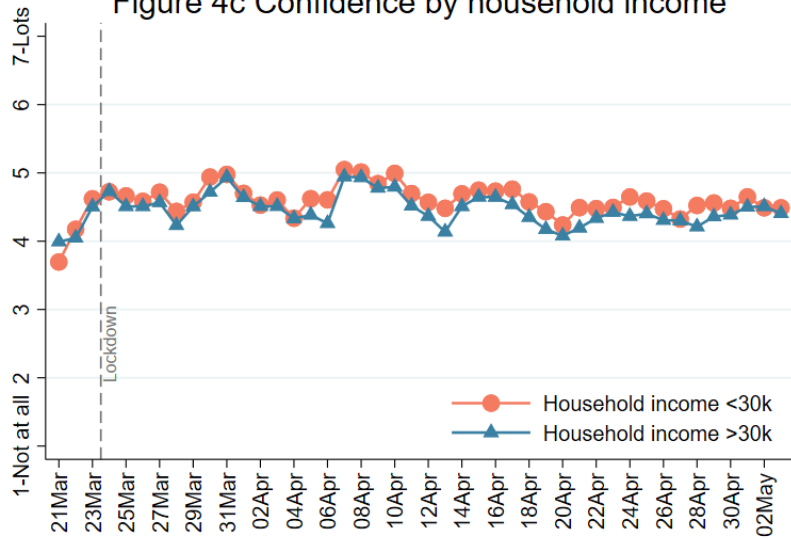
1.2 Confidence in Government (England)

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). We restrict our analyses here to respondents living in England, although future analyses will be able to look at confidence in devolved nations.

Confidence in government is lower than in the early weeks of lockdown, but appears stable in the last fortnight. It remains higher in older adults but lower in people with a mental health diagnosis and people living in urban areas. There appears to be no difference by gender, by household income, or amongst people living with children or just living with other adults.

Figure 4a Confidence by age groups
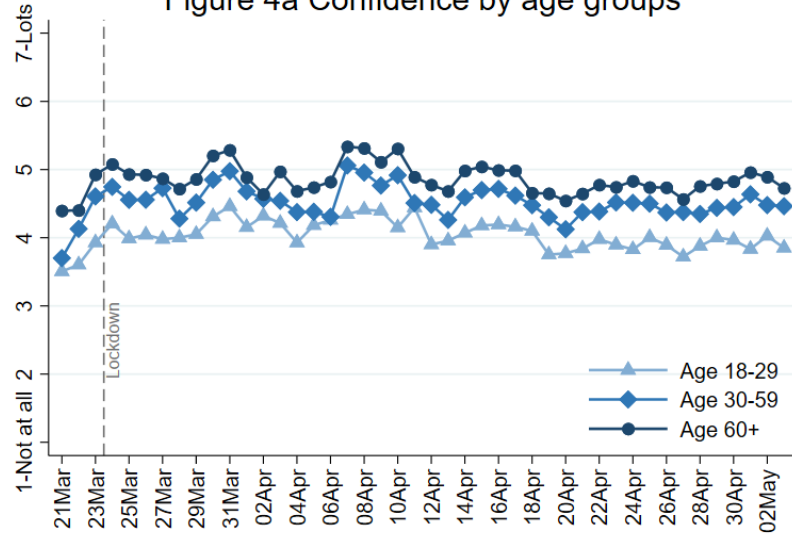
Figure 4b Confidence by living arrangement
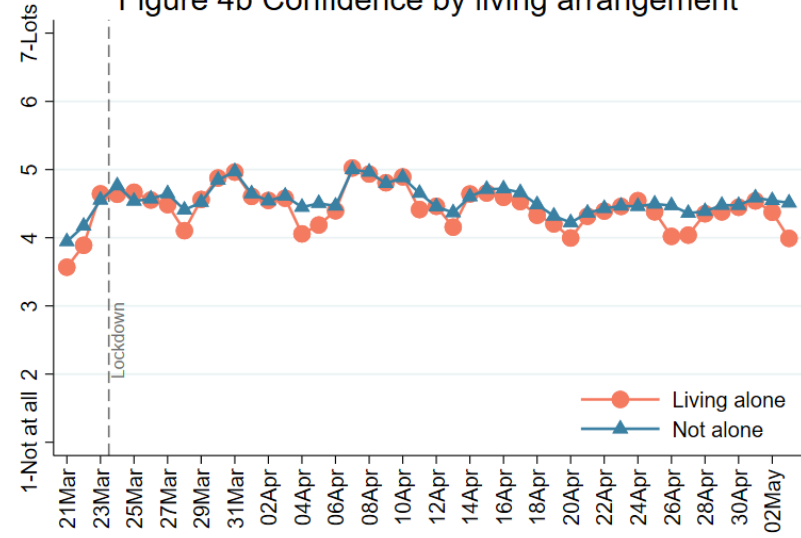
Figure 4c Confidence by household income

Figure 4d Confidence by mental health diagnosis

Figure 4e Confidence by gender

Figure 4f Confidence by key-worker status

Figure 4g Confidence by living with children

Figure 4h Confidence by living area
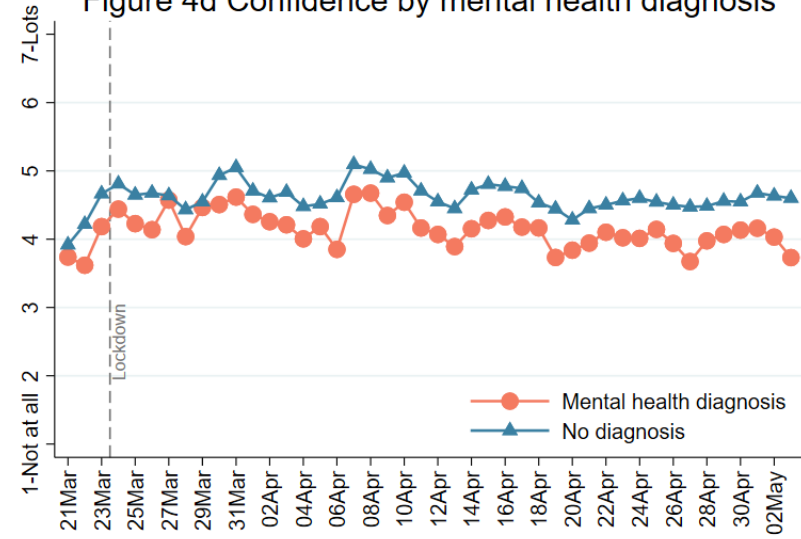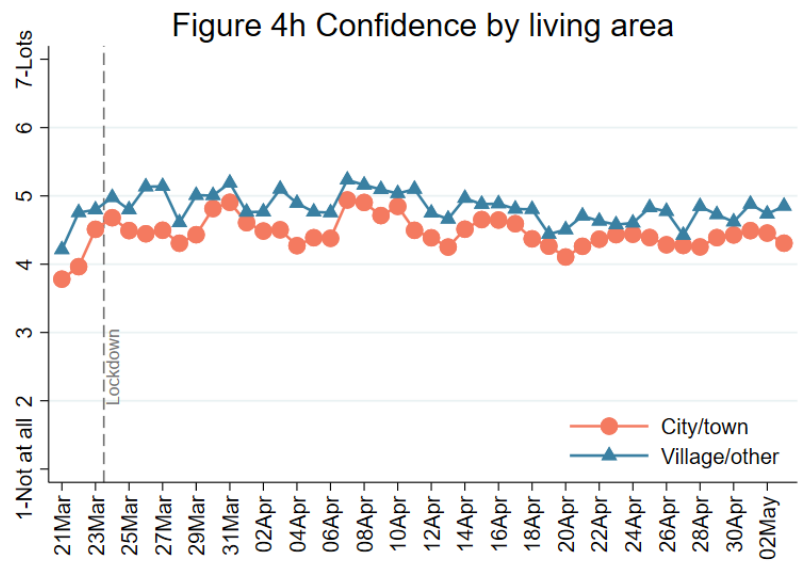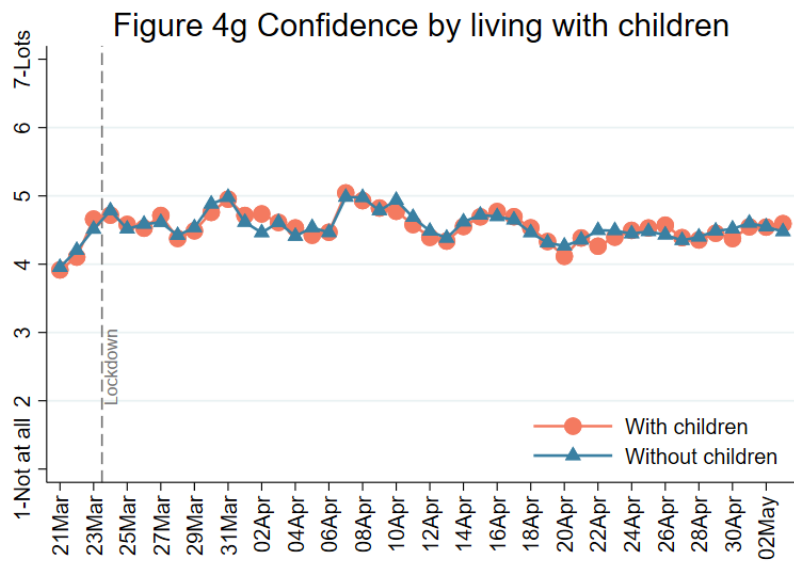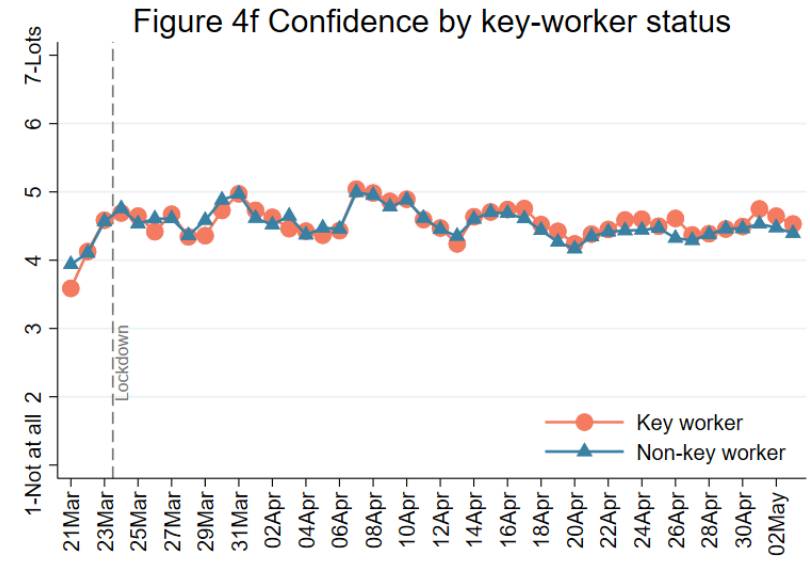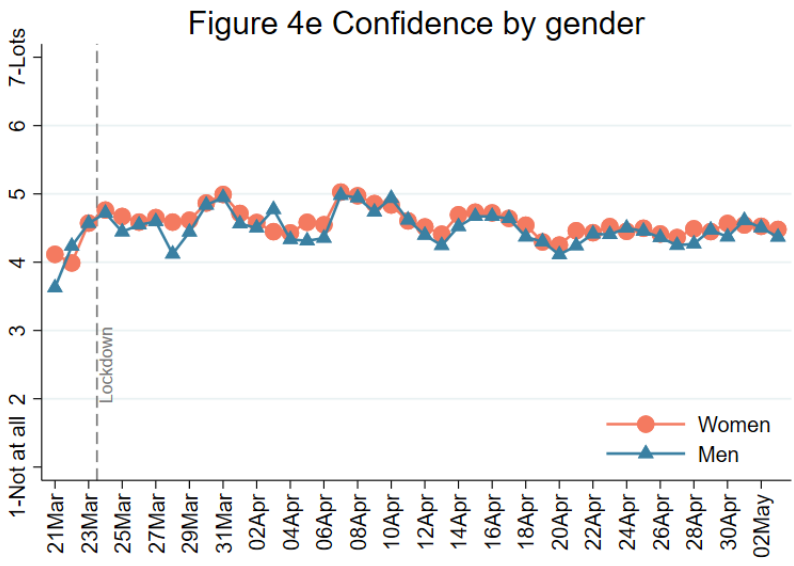
2. Mental Health

2.1 Depression and anxiety

Figure 5 Depression and anxiety
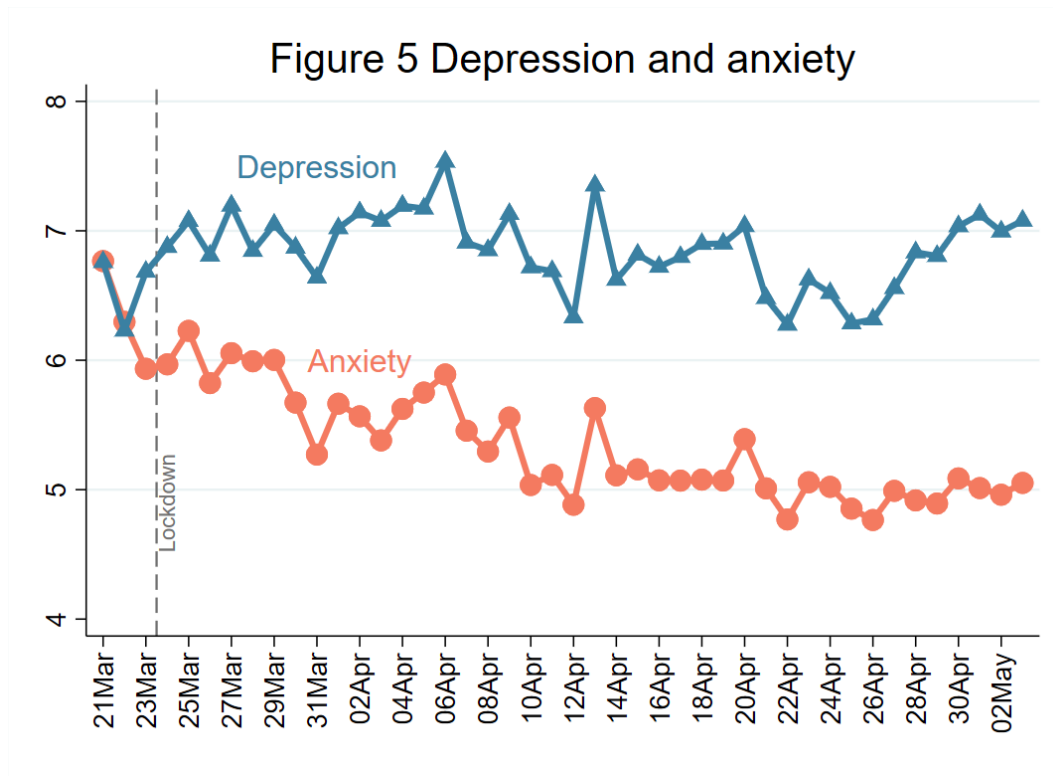
Respondents were asked about depression levels during the past week using the Patient Health Questionnaire (PHQ-9) and anxiety using the Generalised Anxiety Disorder assessment (GAD-7); standard instruments for diagnosing depression and anxiety in primary care. There are 9 and 7 items respectively with 4-point responses ranging from "not at all" to "nearly every day", with higher overall scores indicating more symptoms. Scores of higher than 10 can indicate major depression or moderate anxiety.

Anxiety levels have stabilised in the past week at a lower level than when lockdown began, although depression levels appear to have increased in the past week. The levels overall are higher than usual reported averages (2.7-3.2 for anxiety and 2.7-3.7 for depression[2]). Both depression and anxiety levels have been higher in younger adults, those living alone, those with lower household income, and those with an existing mental health diagnosis. They have also been higher in women than men, in those living in urban areas, and in people living with children compared to those living just with adults.

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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

Figure 6a Depression by age groups
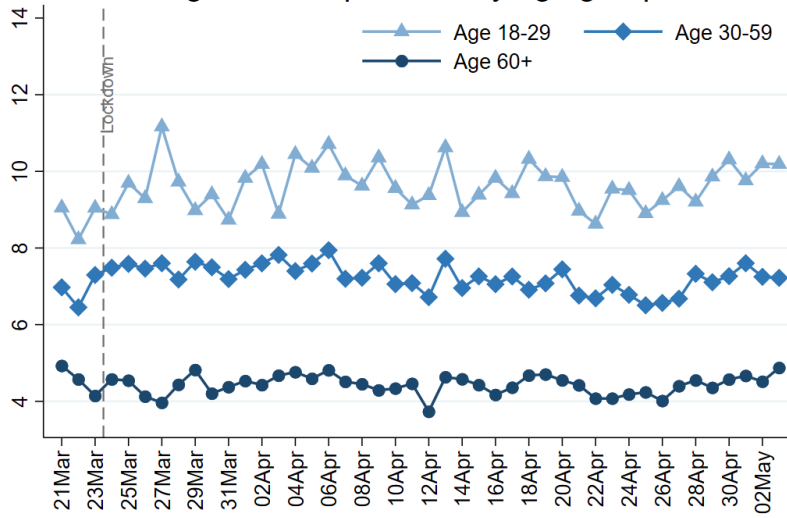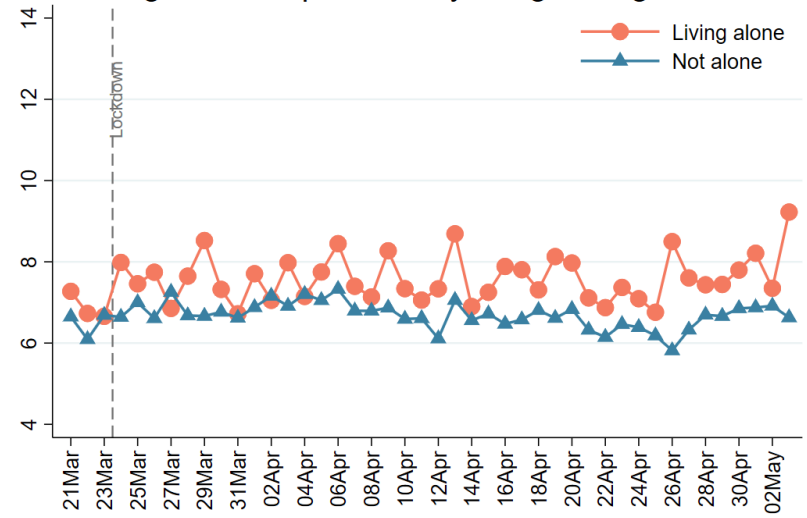
Figure 6b Depression by living arrangement

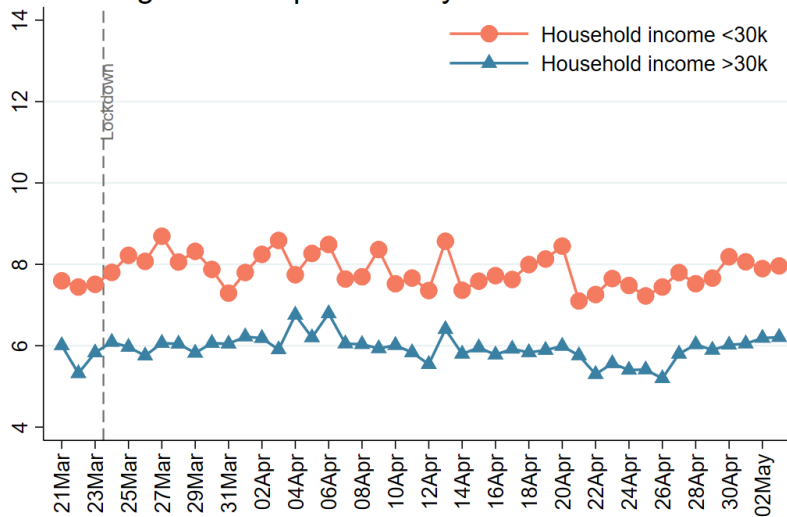Figure 6c Depression by household income
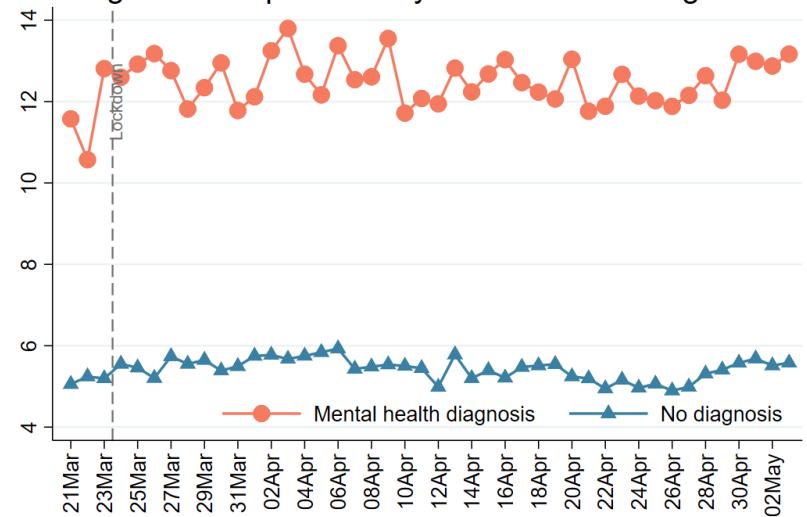
Figure 6d Depression by mental health diagnosis

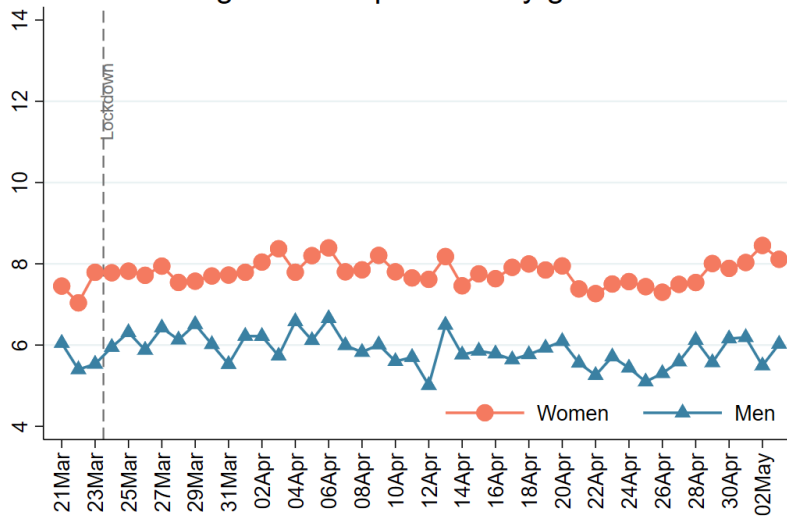Figure 6e Depression by gender

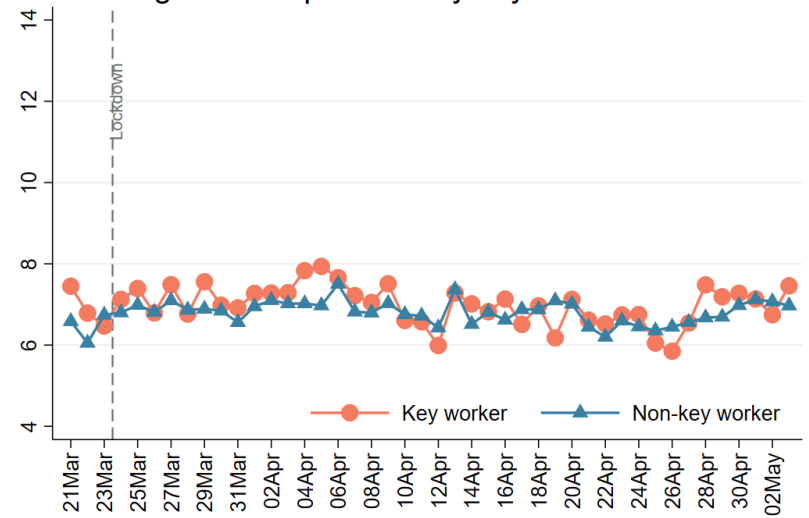Figure 6f Depression by key-worker status

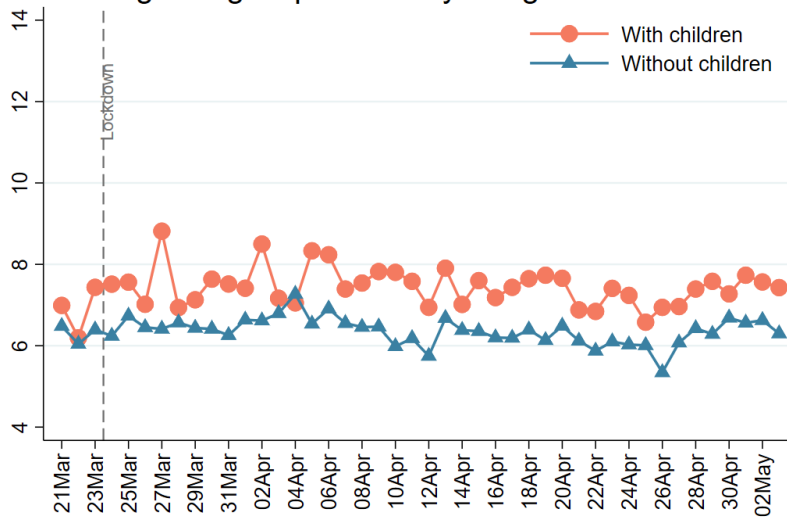Figure 6g Depression by living with children
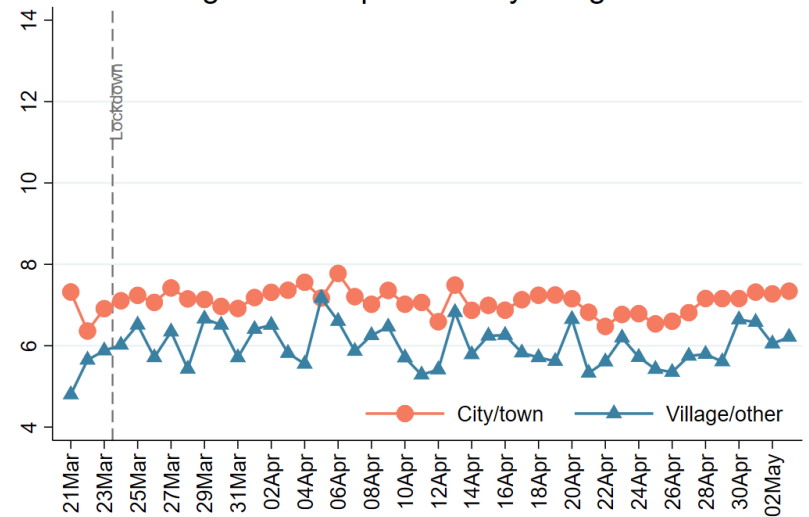
Figure 6h Depression by living area

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Figure 7a Anxiety by age groups
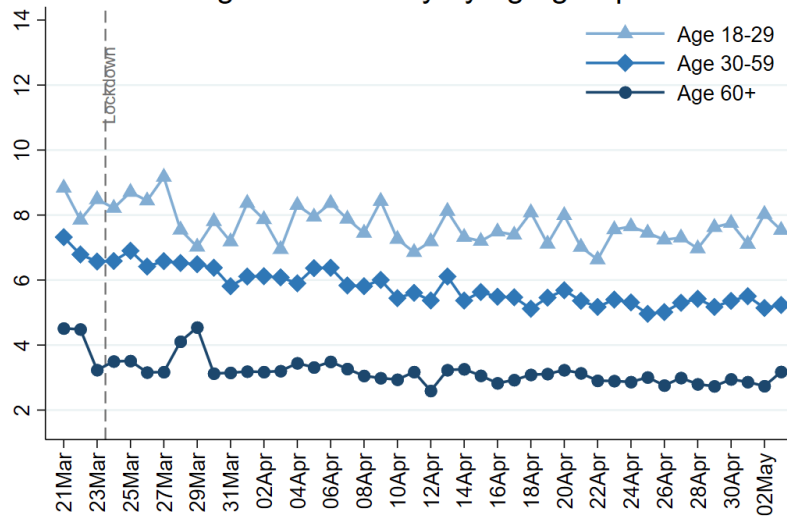
Figure 7b Anxiety by living arrangement
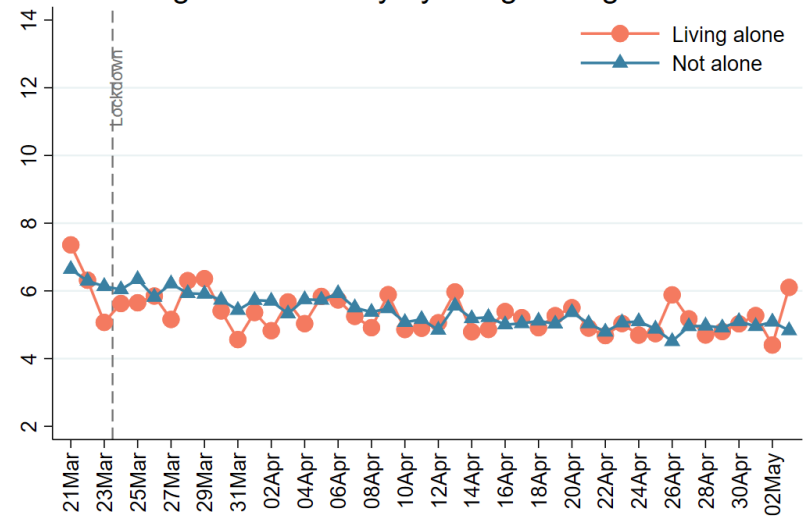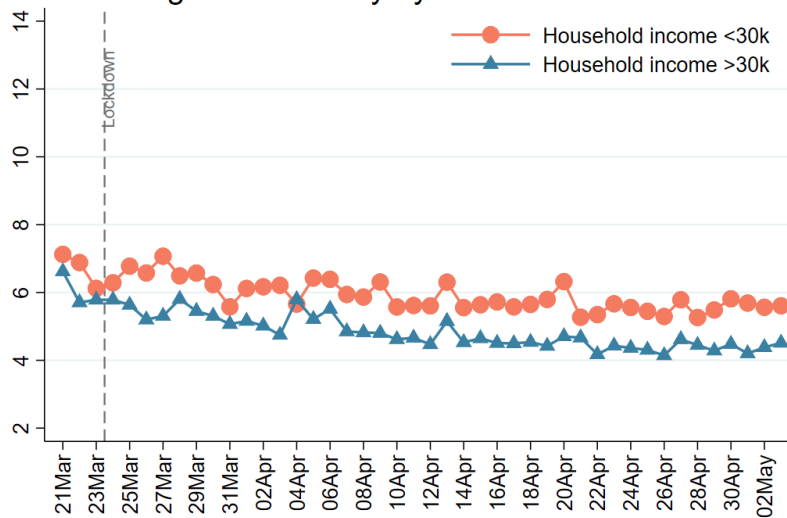
Figure 7c Anxiety by household income

Figure 7d Anxiety by mental health diagnosis
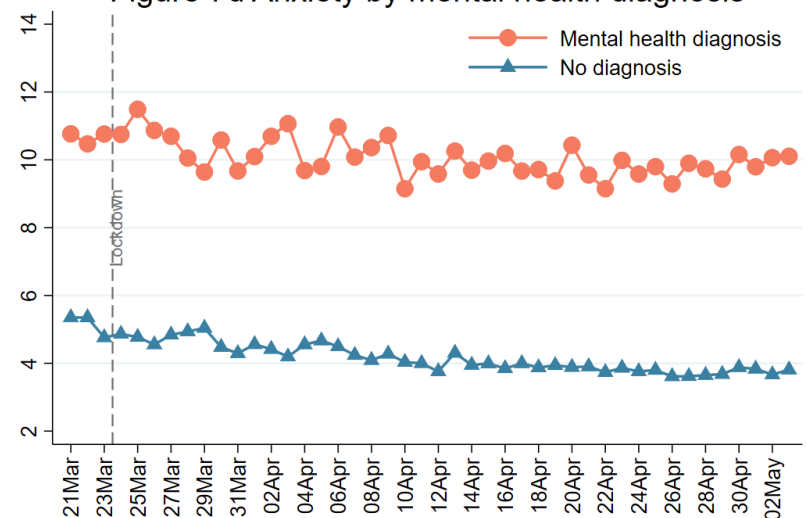
Figure 7e Anxiety by gender
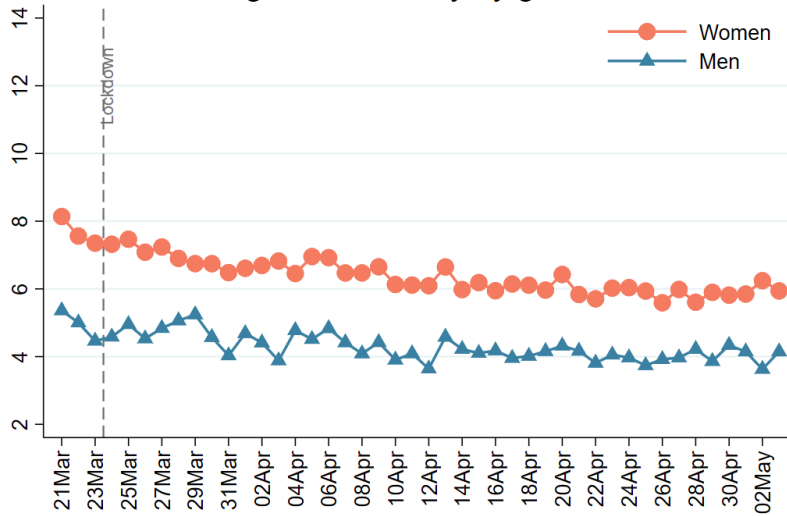
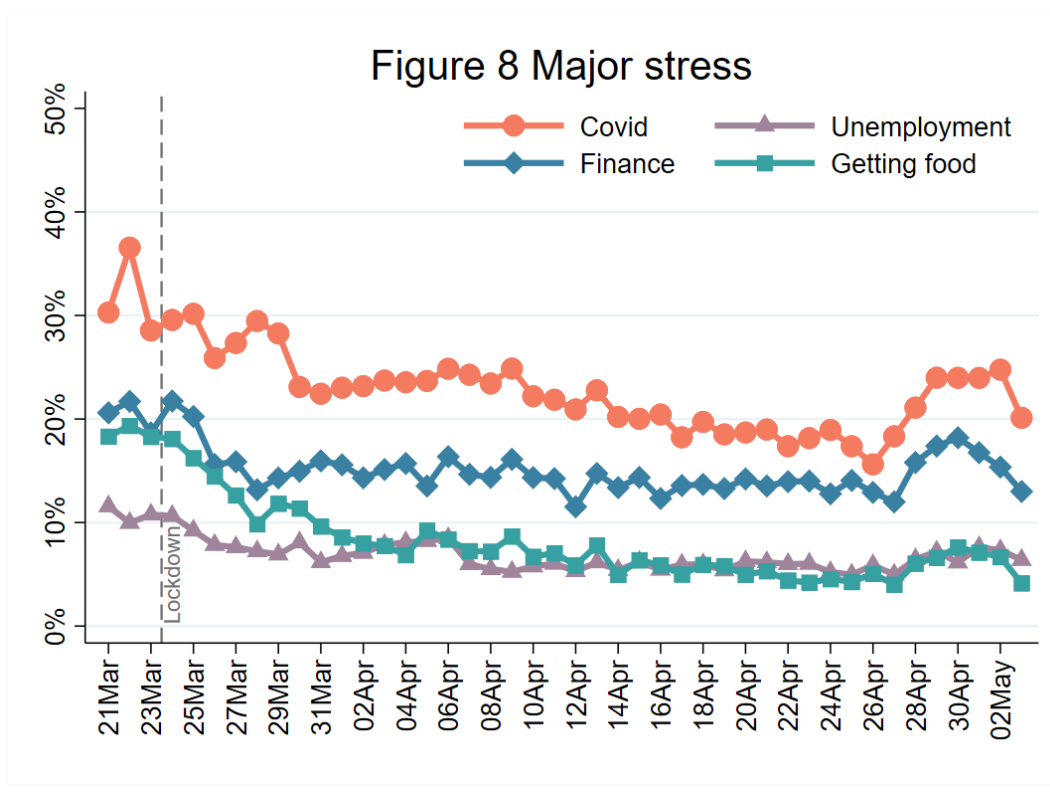Figure 7f Anxiety by key-worker status
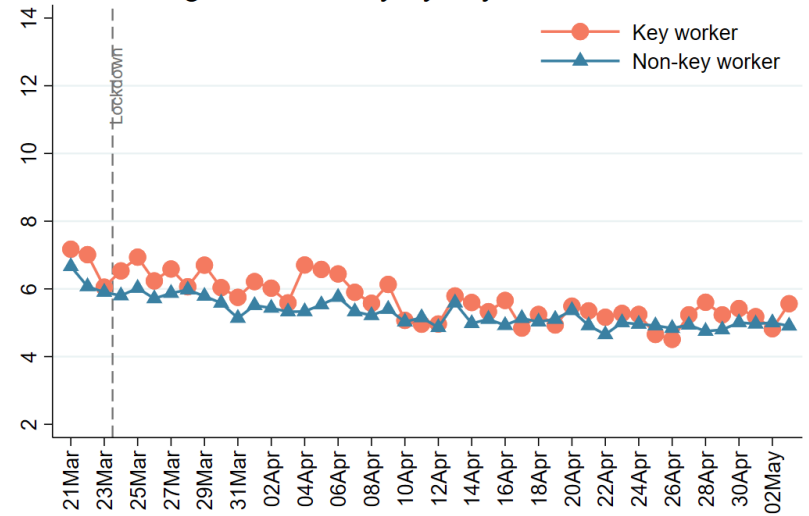
Figure 7g Anxiety by living with children
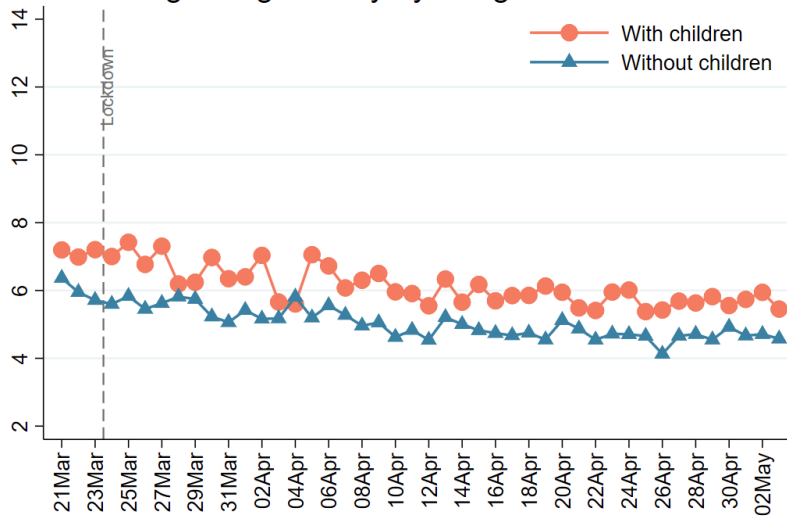
Figure 7h Anxiety by living area
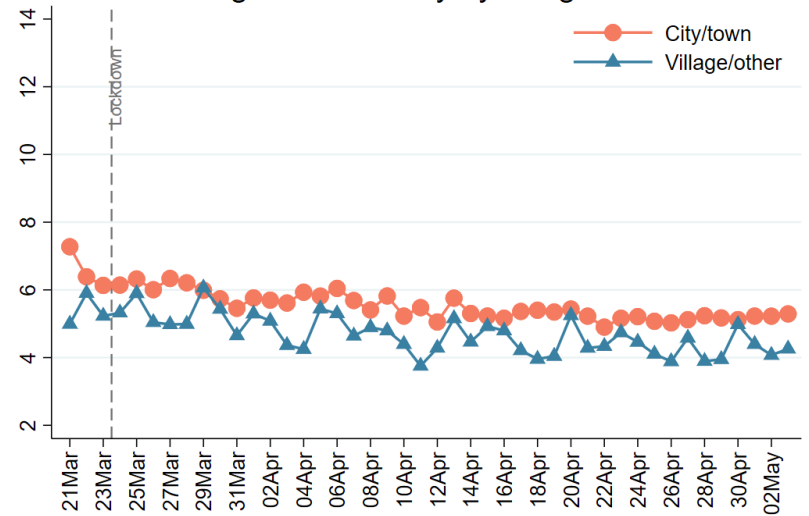
2.2 Stress

Figure 8 Major stress

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

Stress relating to Covid-19 (both catching Covid-19 and becoming seriously ill from Covid-19) has increased in the past week as discussions around lockdown ending have begun, with 1 in 4 people now worried about it. Worries about catching the virus are higher in women, people with children, keyworkers, people with a mental health diagnosis, and people with a lower household income.

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

Around 1 in 6 people are worried about finances, with these levels higher in people under the age of 60, with lower household incomes, living with children, and with a mental health diagnosis.

Stress relating to accessing food (food security) has stayed low over the past week, with only around 1 in 12 people now worried about it, although this rises to around 1 in 8 amongst people with a mental health condition and 1 in 10 for people with an annual household income lower than £30,000. It is slightly higher in people living with children.
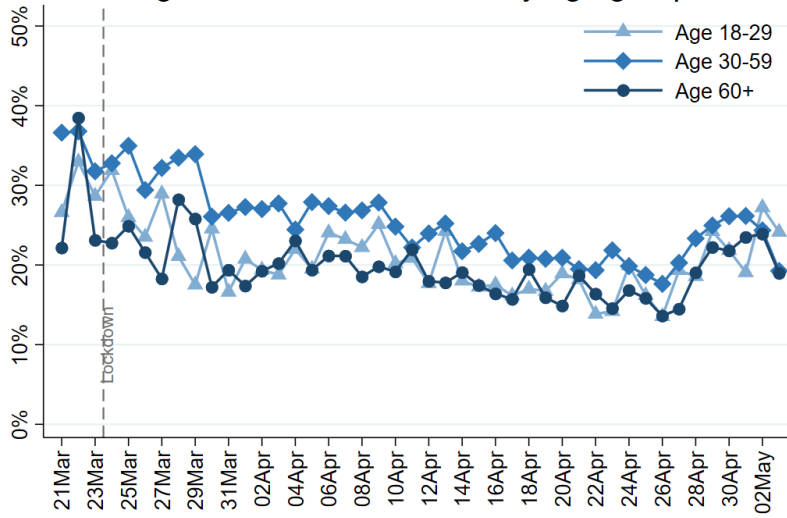
Figure 9a Covid-19 stress by age groups

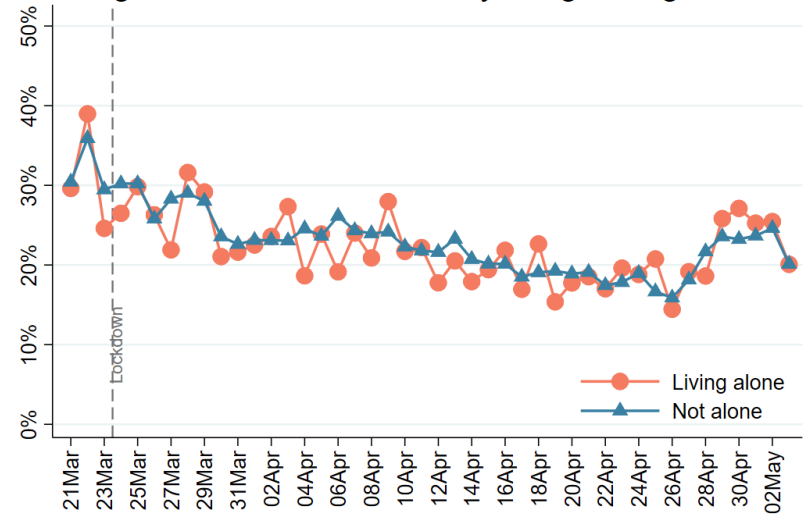Figure 9b Covid-19 stress by living arrangement
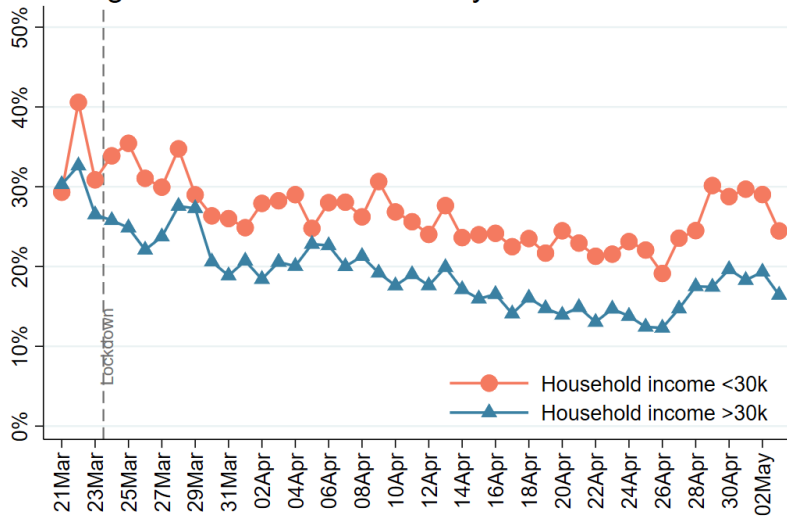
Figure 9c Covid-19 stress by household income

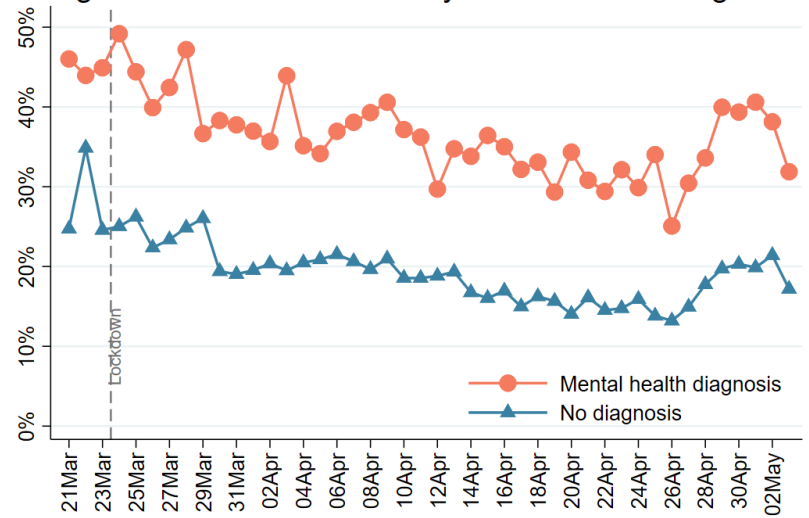Figure 9d Covid-19 stress by mental health diagnosis
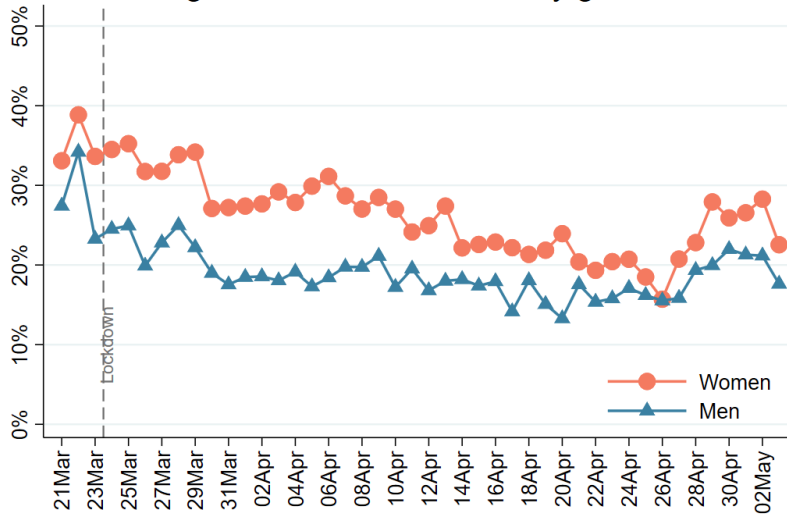
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Figure 9e Covid-19 stress by gender

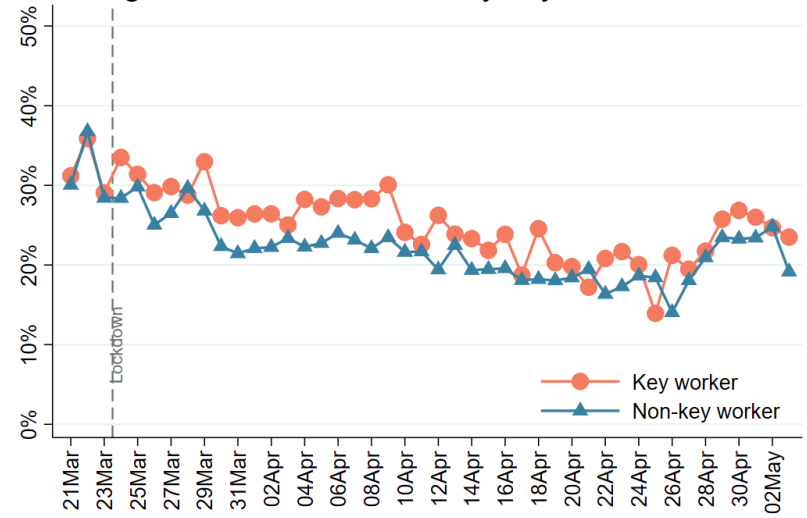Figure 9f Covid-19 stress by key-worker status
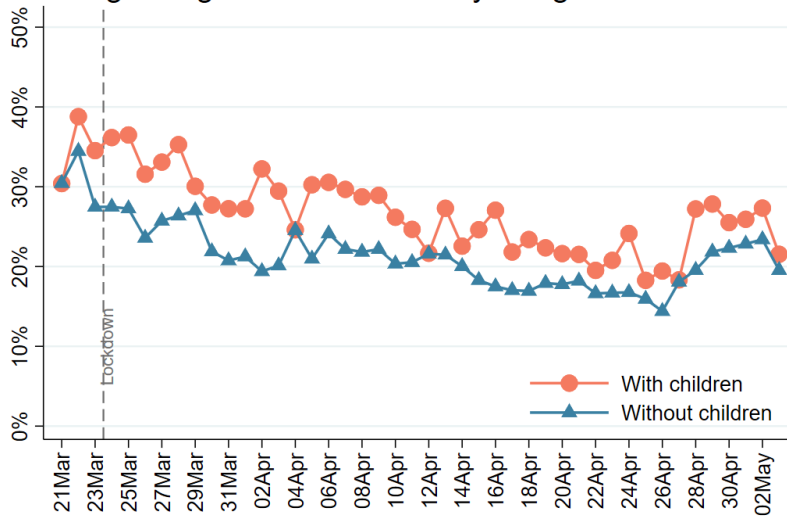
Figure 9g Covid-19 stress by living with children

Figure 9h Covid-19 stress by living area

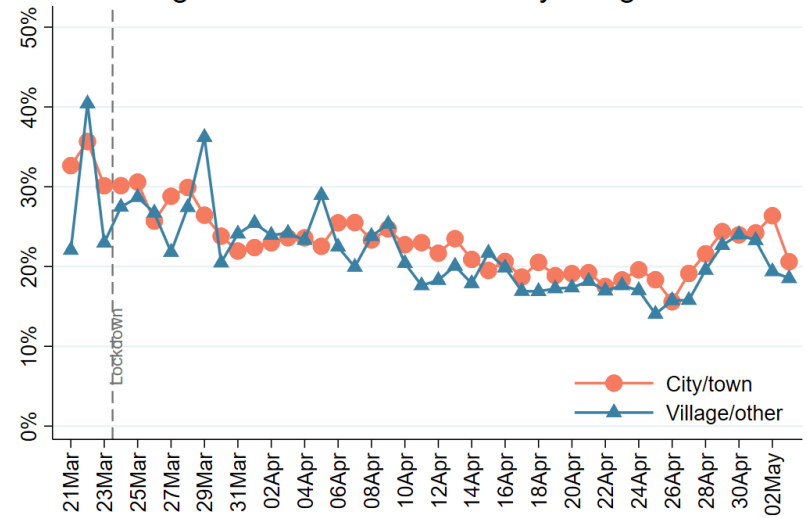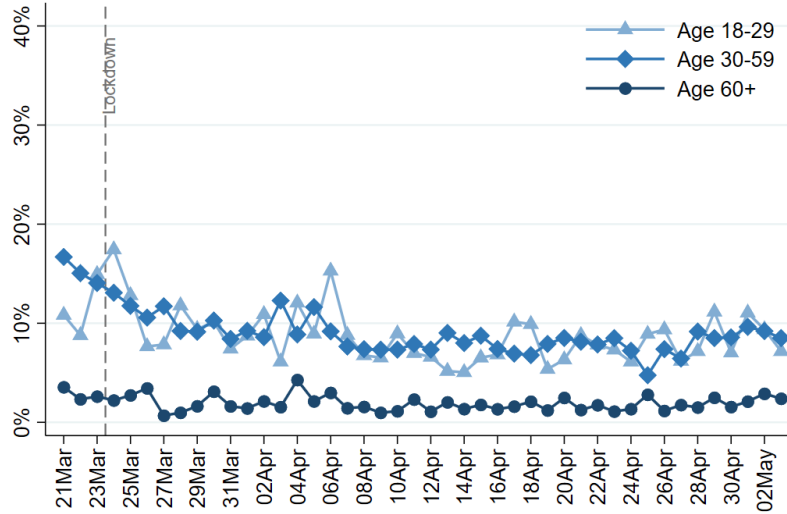Figure 10a Unemployment stress by age groups
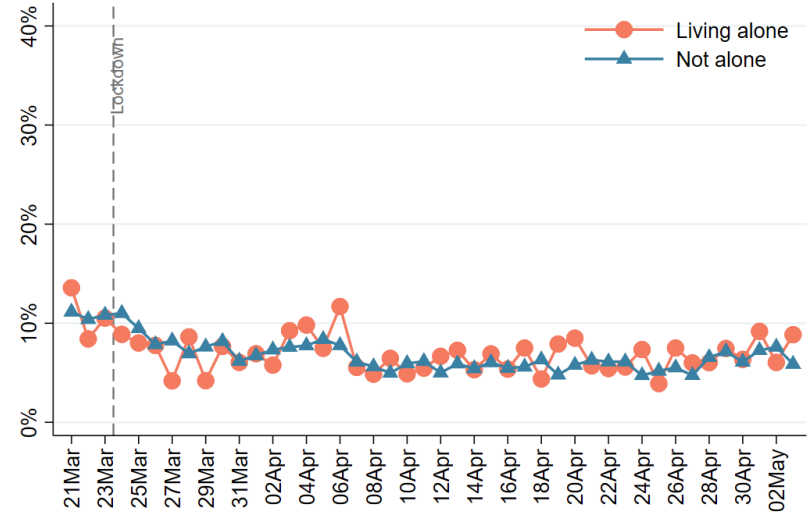
Figure 10b Unemployment stress by living arrangement

Figure 10c Unemployment stress by household income
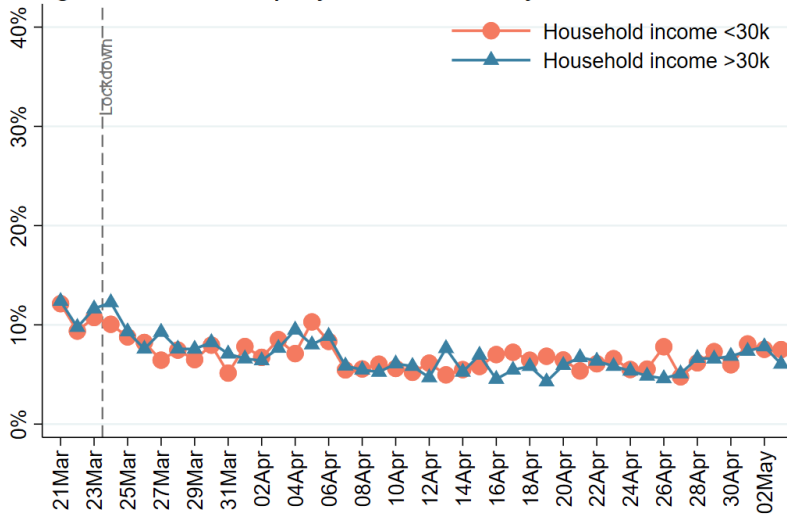
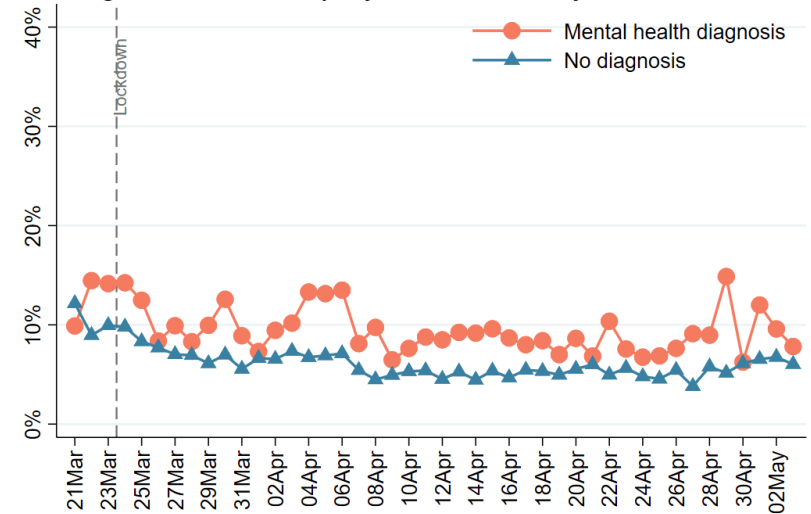Figure 10d Unemployment stress by mental health

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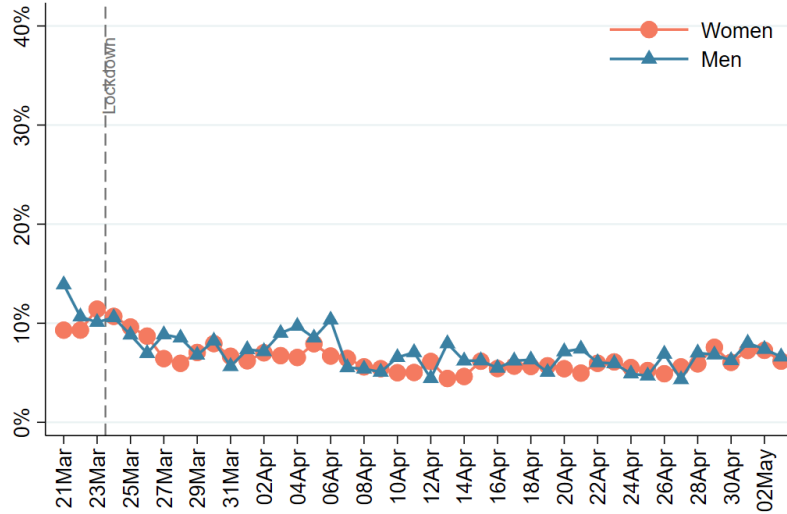
Figure 10e Unemployment stress by gender

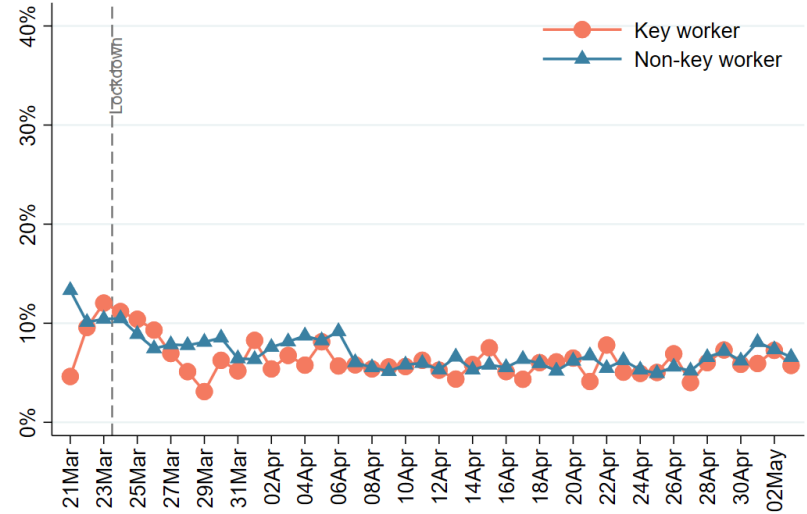## Figure 10f Unemployment stress by key-worker status

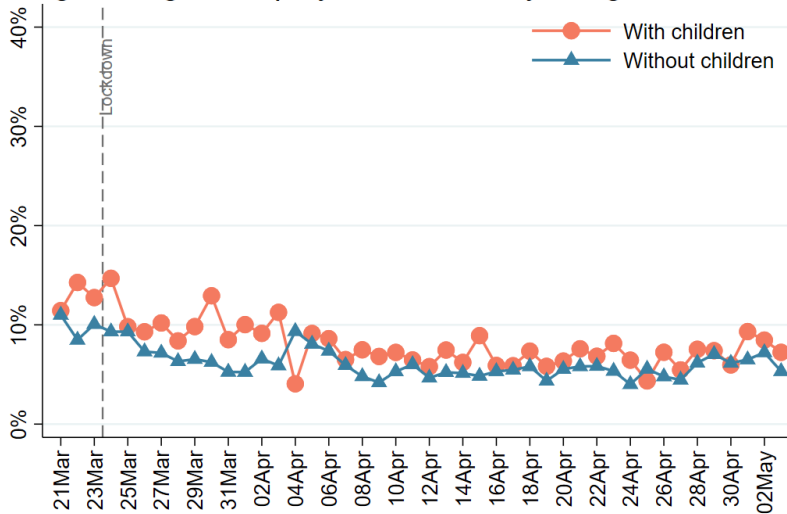## Figure 10g Unemployment stress by living with children

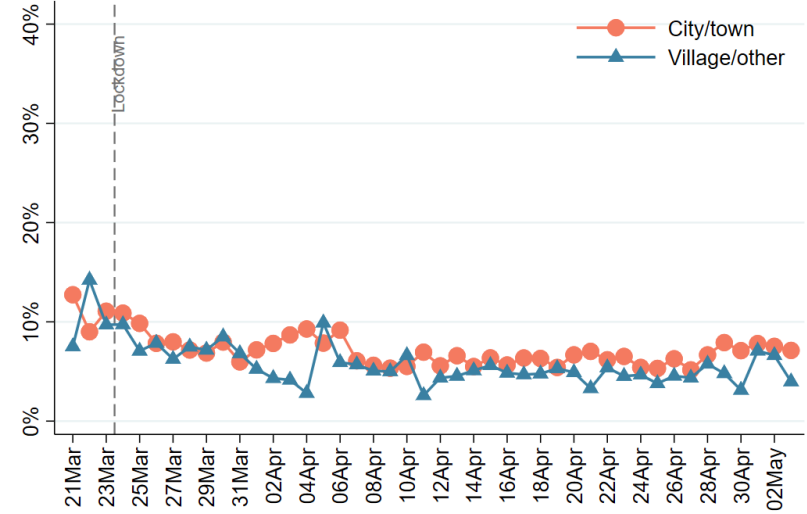## Figure 10h Unemployment stress by living area

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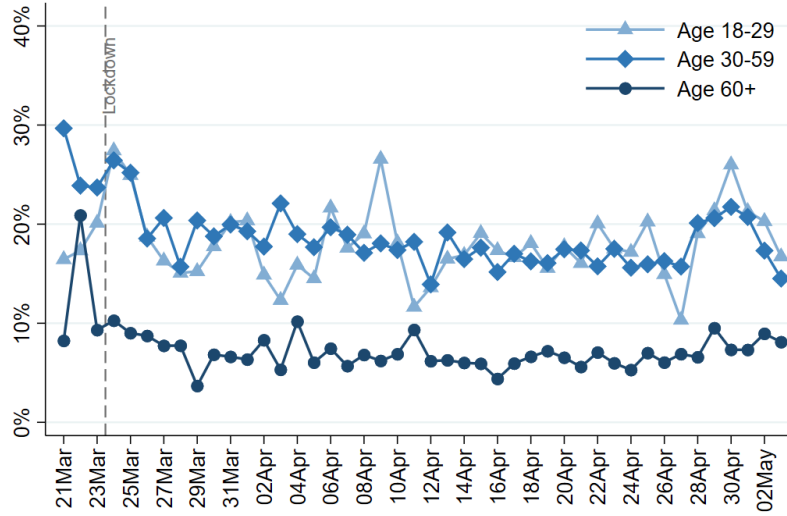## Figure 11a Financial stress by age groups

Figure 11b Financial stress by living arrangement
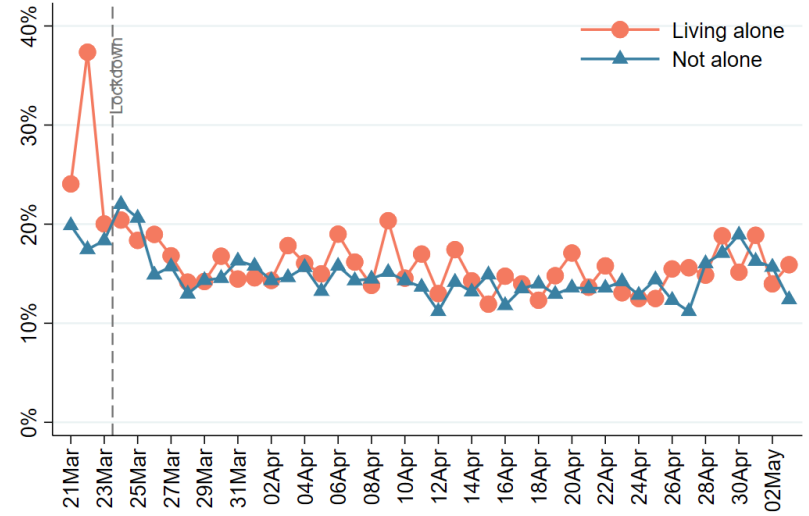

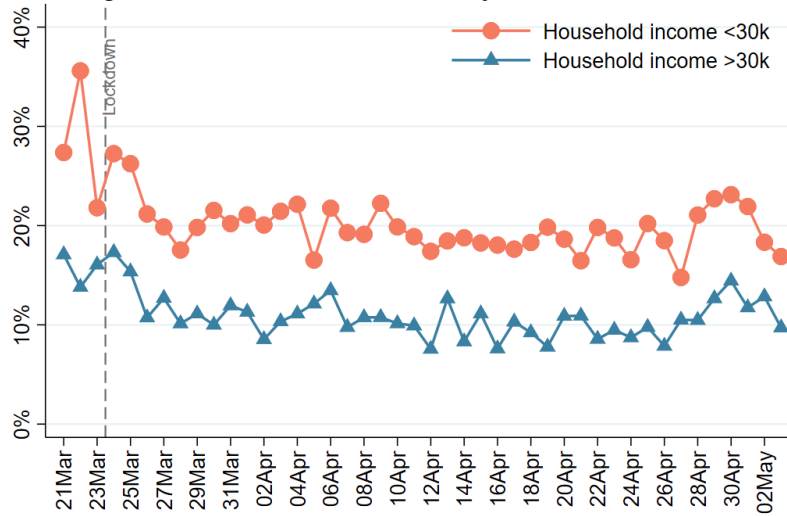## Figure 11c Financial stress by household income

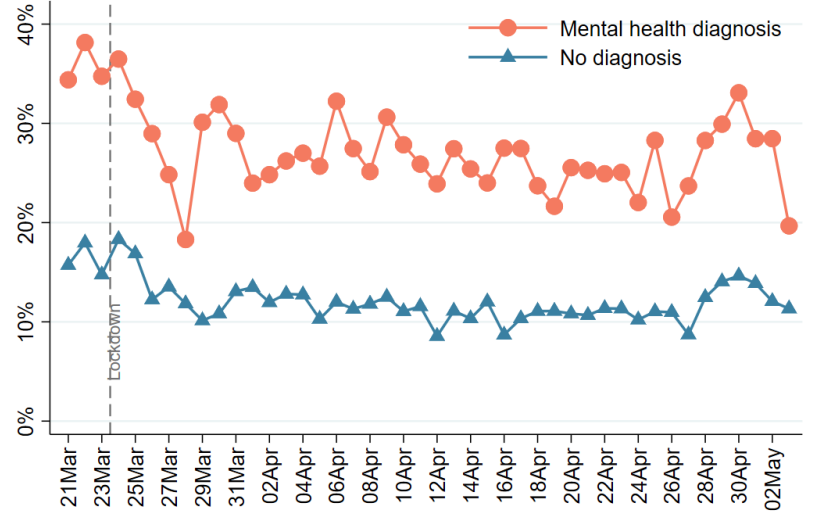## Figure 11d Financial stress by mental health diagnosis
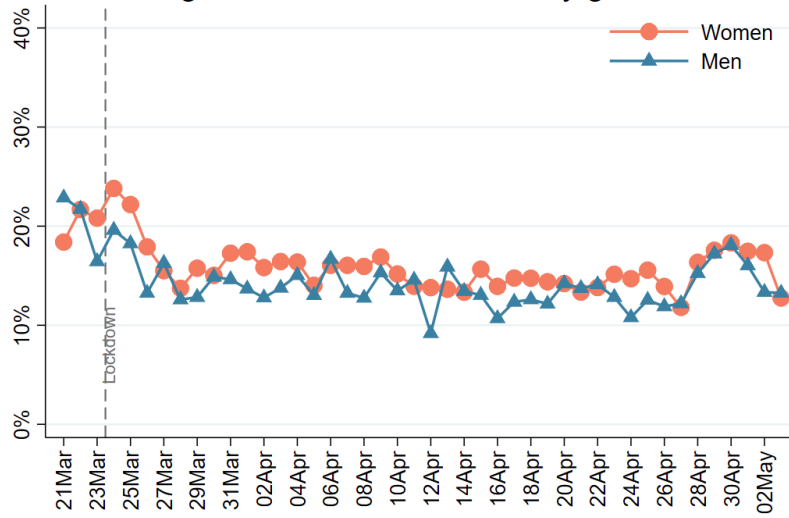

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Figure 11e Financial stress by gender

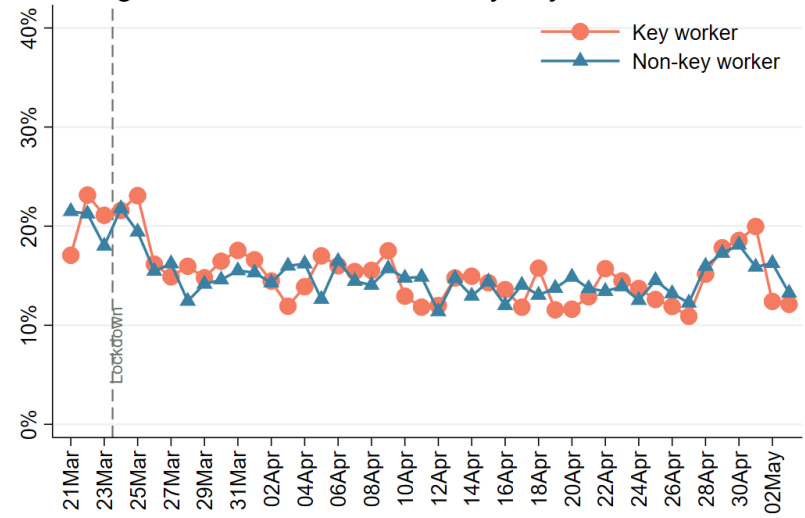Figure 11f Financial stress by key-worker status

Figure 11g Financial stress by living with children

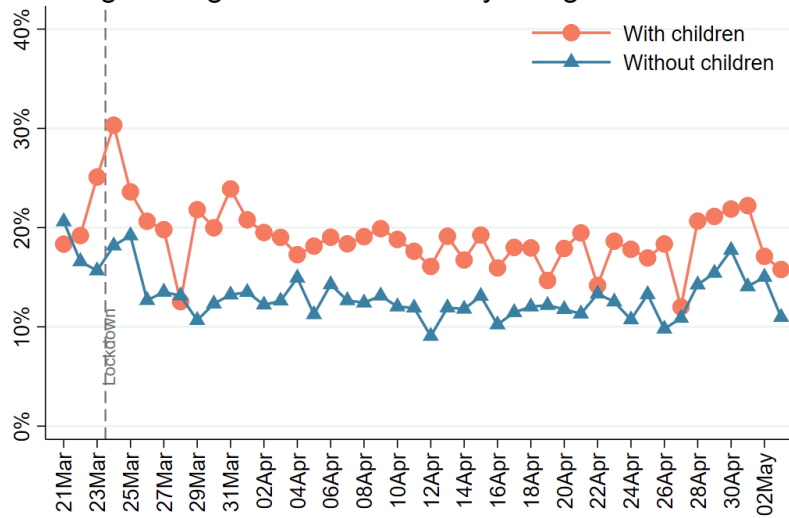Figure 11h Financial stress by living area

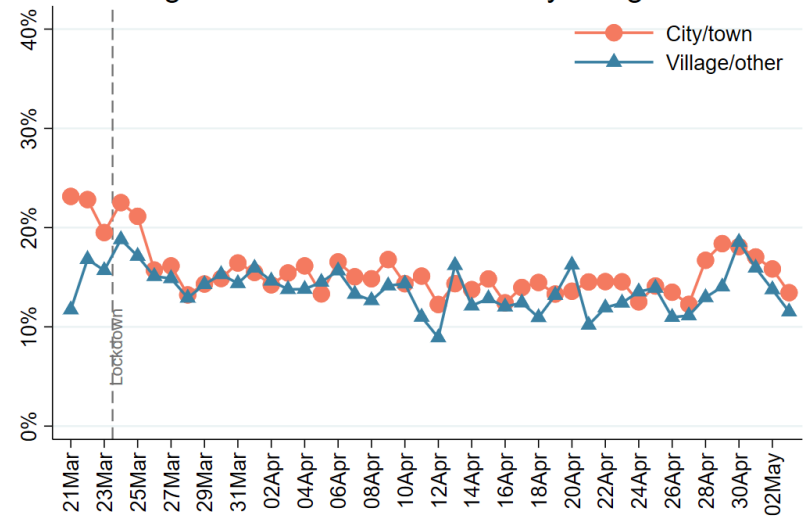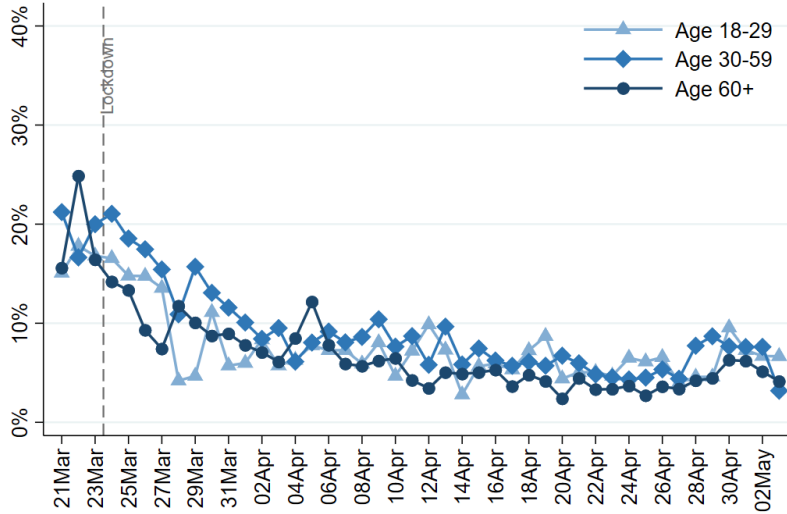## Figure 12a Food security stress by age groups

Figure 12b Food security stress by living arrangement
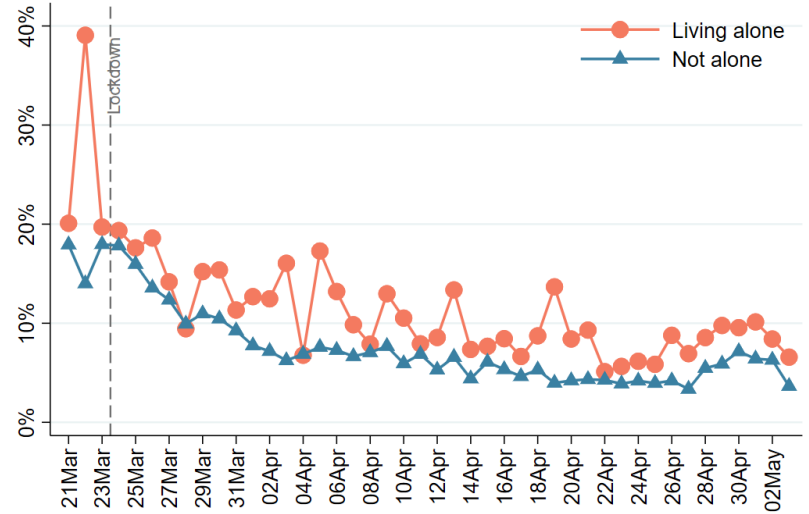
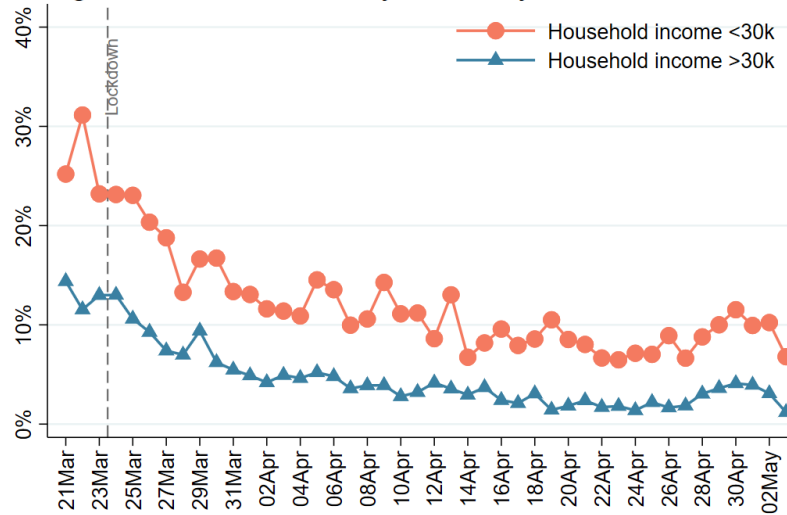## Figure 12c Food security stress by household income

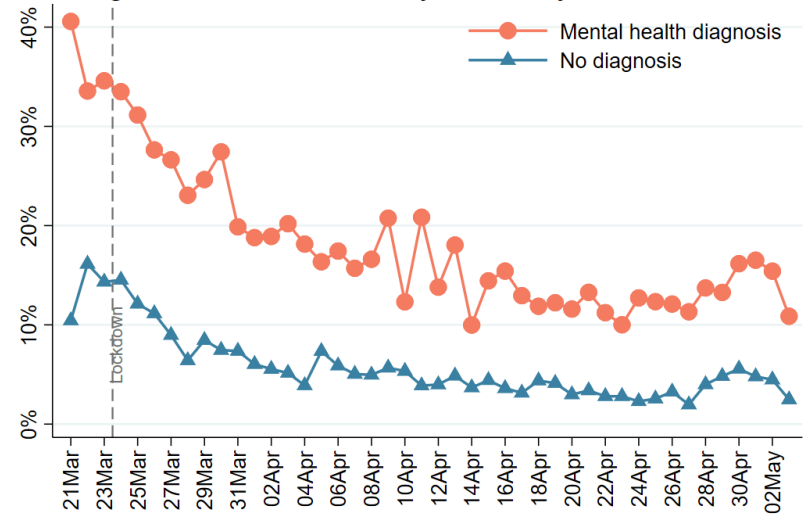## Figure 12d Food security stress by mental health

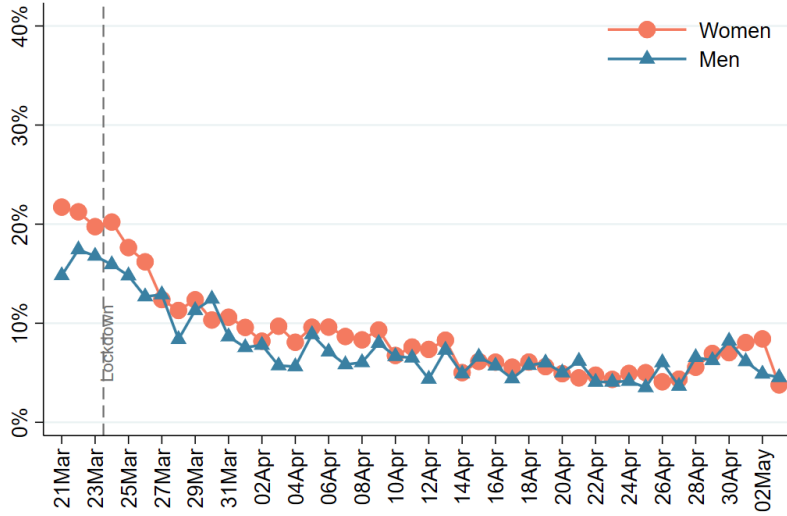Figure 12e Food security stress by gender

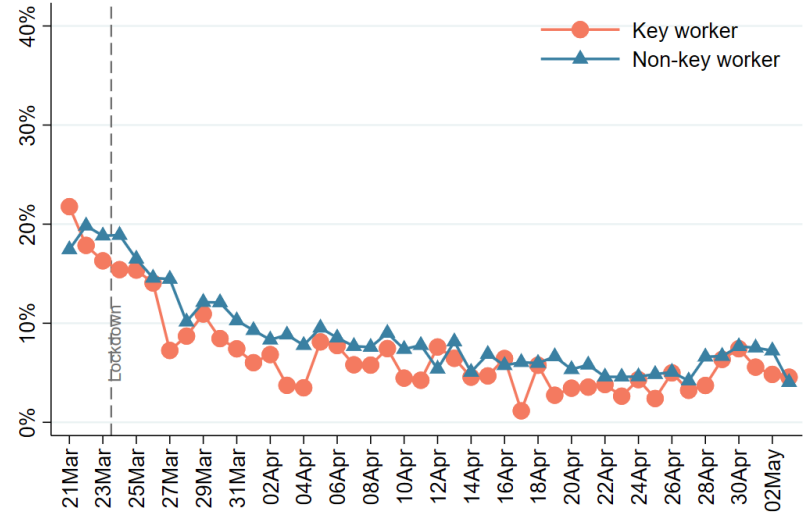Figure 12f Food security stress by key-worker status

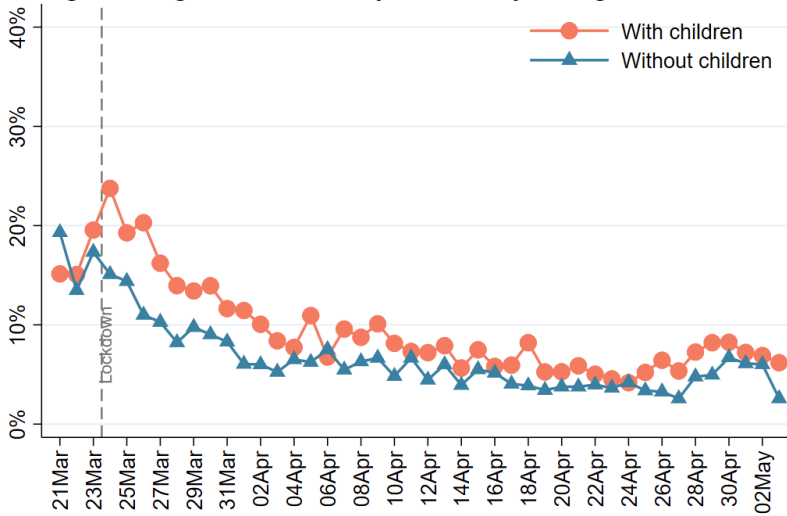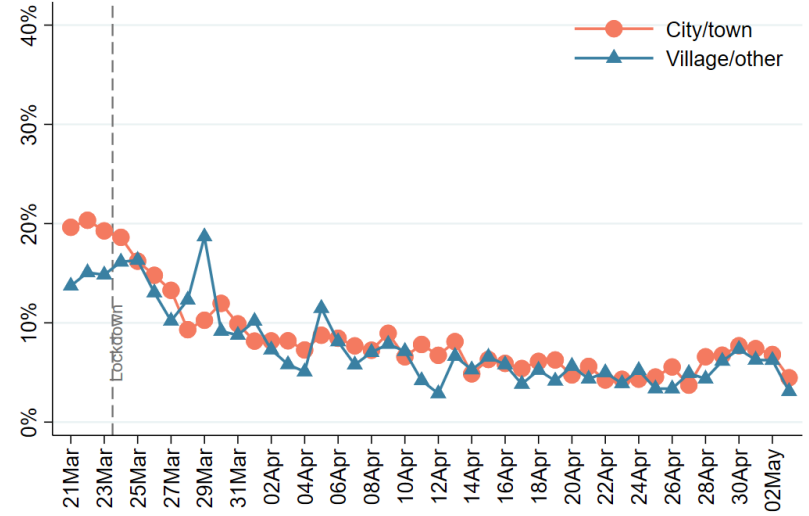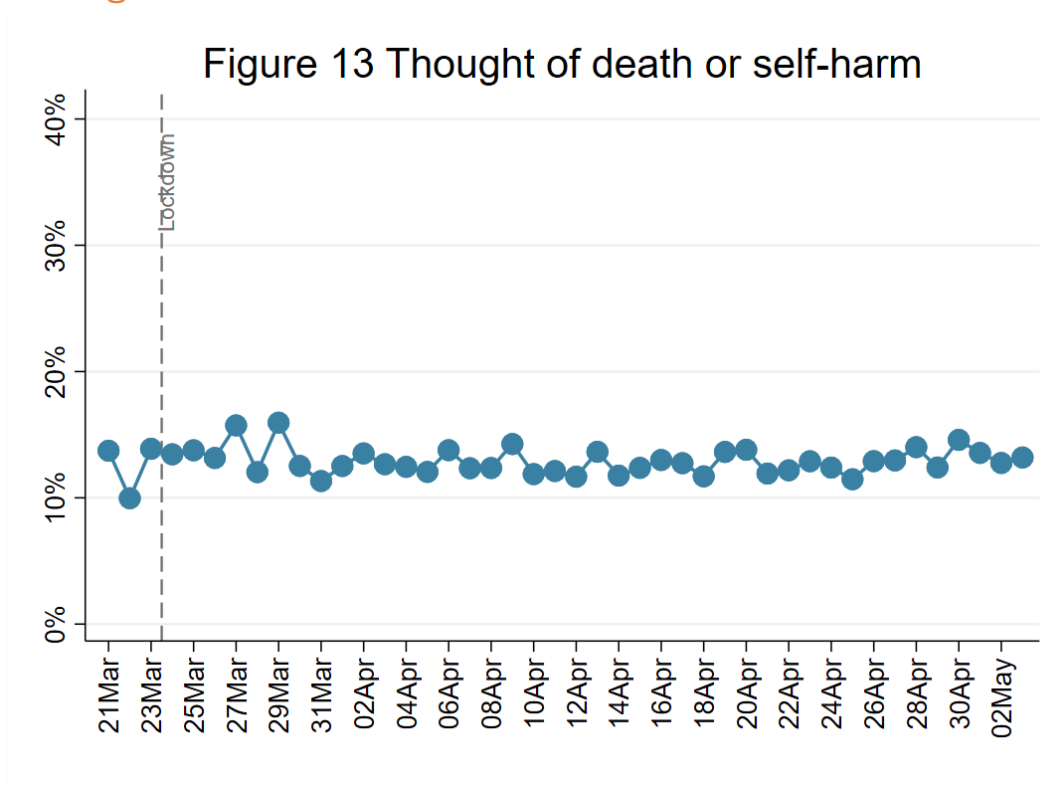Figure 12g Food security stress by living with children

Figure 12h Food security stress by living area

3. Self-harm and abuse

3.1 Thought of death or self-harm

Figure 13 Thought of death or self-harm

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

Percentages of people having thoughts of death or self-harm have been relatively stable since lockdown was announced in our sample. They remain higher amongst younger people, those living alone, those with a lower household income, and people with a diagnosed mental health condition. Reporting of thoughts of death and self-harm have also been more volatile amongst these groups. They are also higher in people living in urban areas, although there is no difference between men and women.
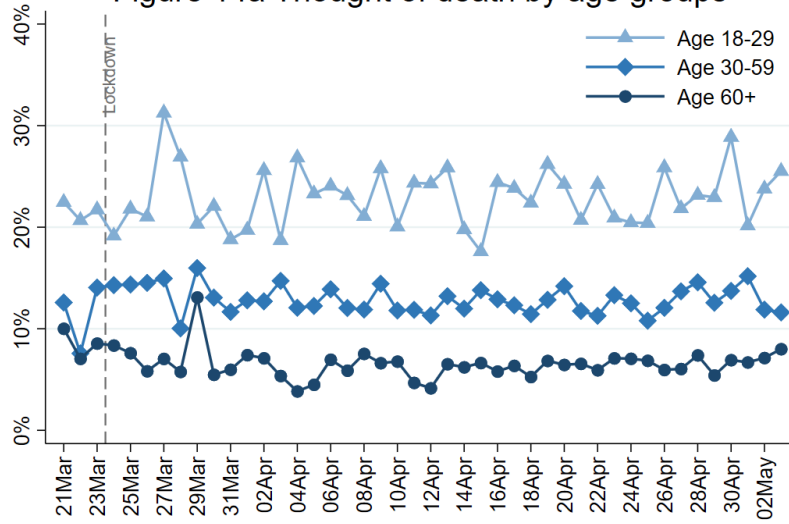
Figure 14a Thought of death by age groups

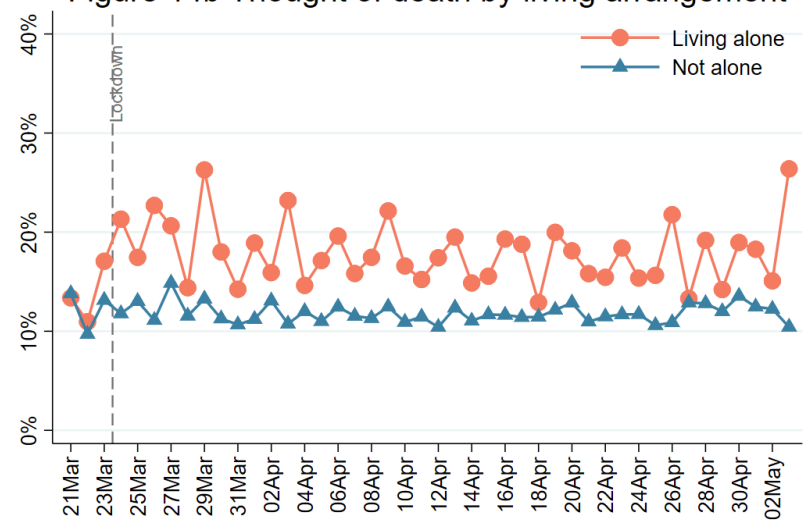Figure 14b Thought of death by living arrangement

Figure 14c Thought of death by household income

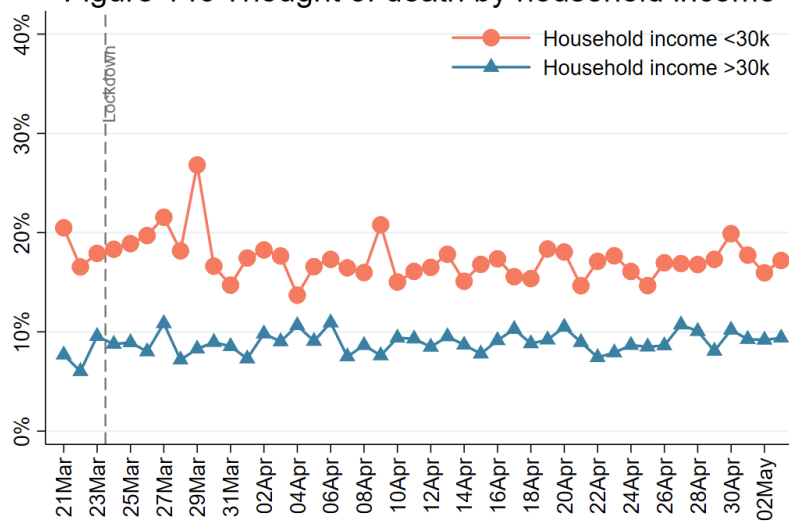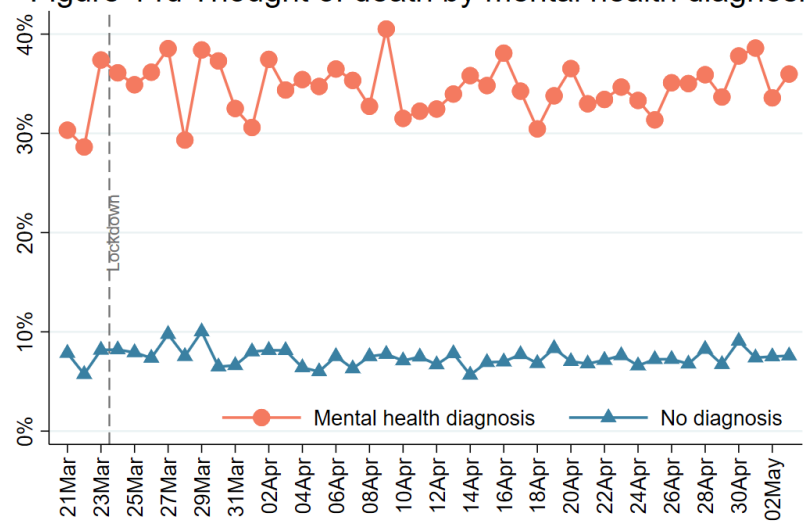Figure 14d Thought of death by mental health diagnosis

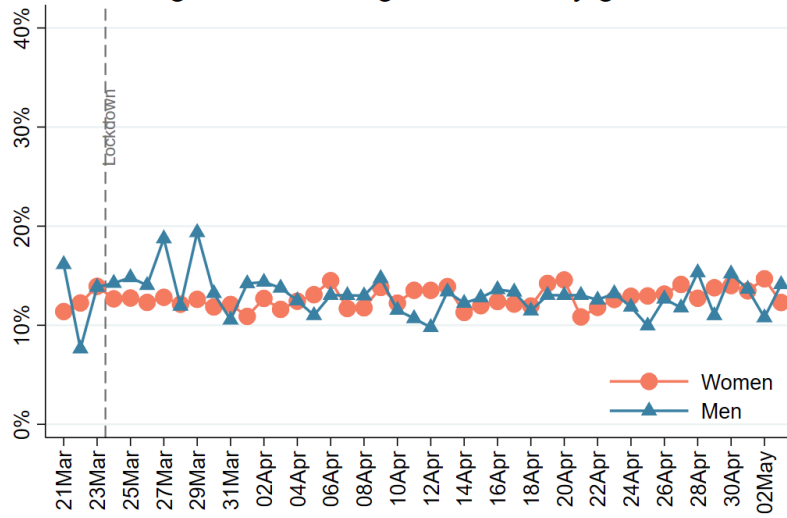## Figure 14e Thought of death by gender
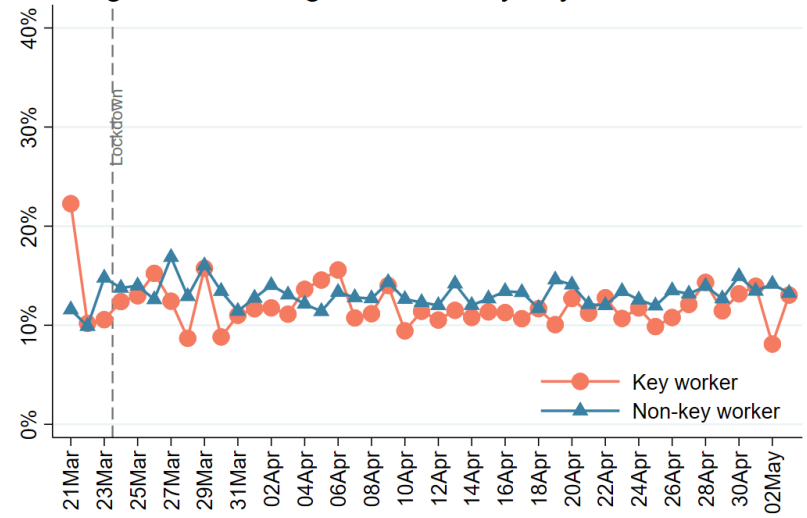
Figure 14f Thought of death by key-worker status

Figure 14g Thought of death by living with children
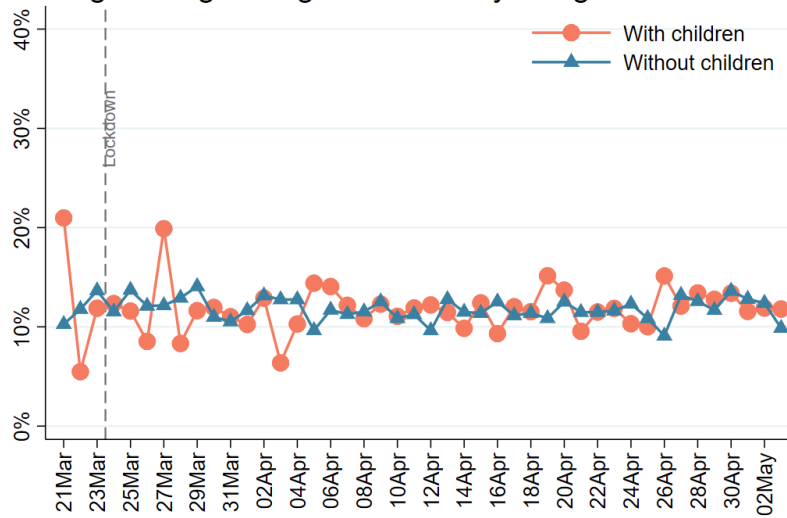
Figure 14h Thought of death by living area

3.2 Self-harm

Figure 15 Self-harm
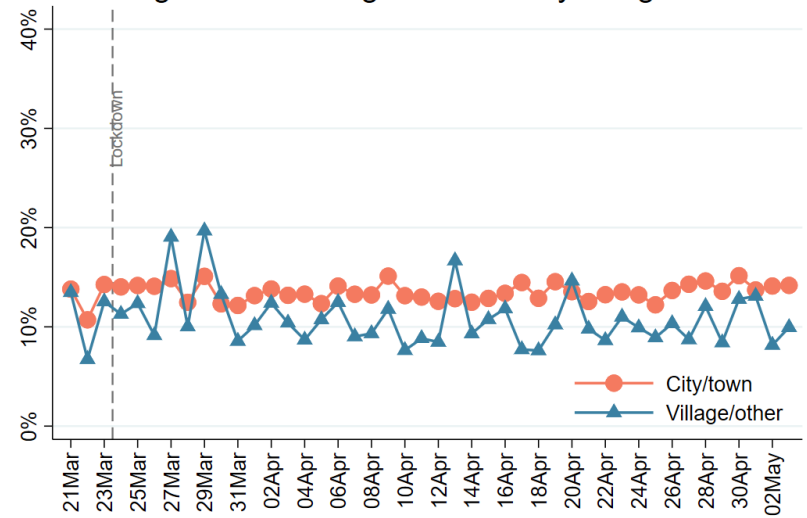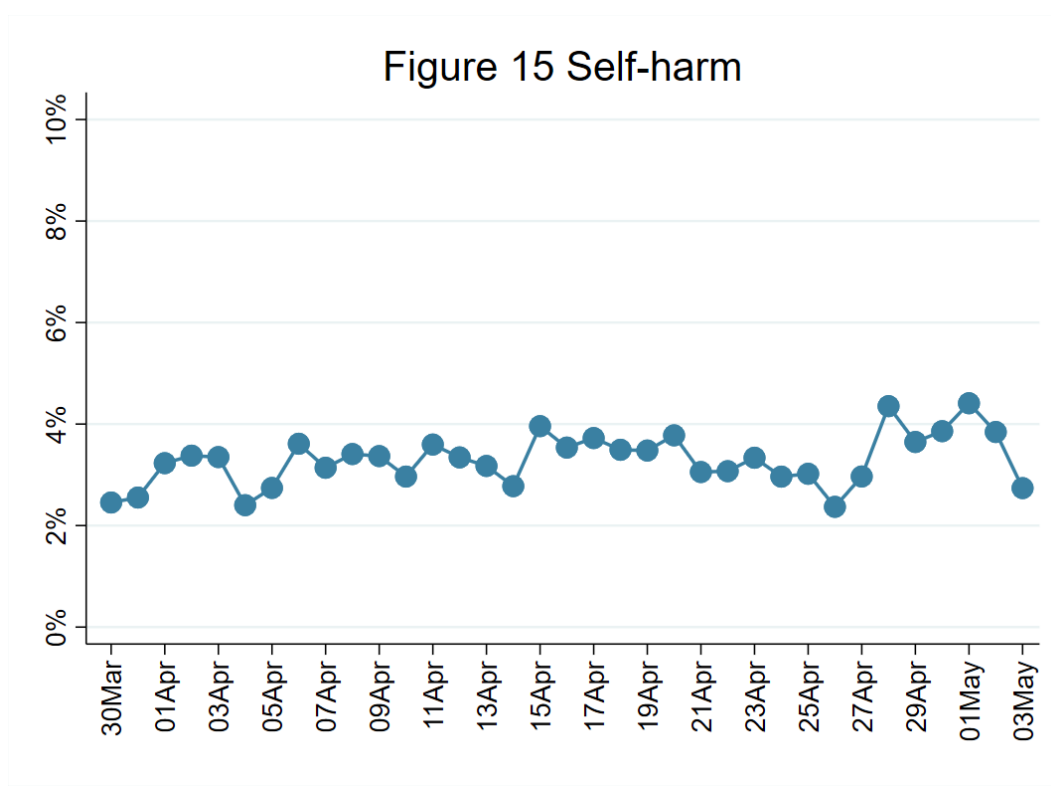
Self-harm was assessed using a question that asks whether someone in the last week has been "self-harming or deliberately hurting yourself". Responses are on a 4-point scale ranging from "not at all" to "nearly every day". We focused on any response that indicated any self-harming.

Self-harm has been reported to be higher amongst younger adults, those living alone, those with lower household income, and those with a diagnosed mental health condition. It is also slightly higher amongst women than men and amongst people living in urban areas. It should be noted that not all people who self-harm will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels.

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 gender

Figure 16f Self-harm by key-worker status
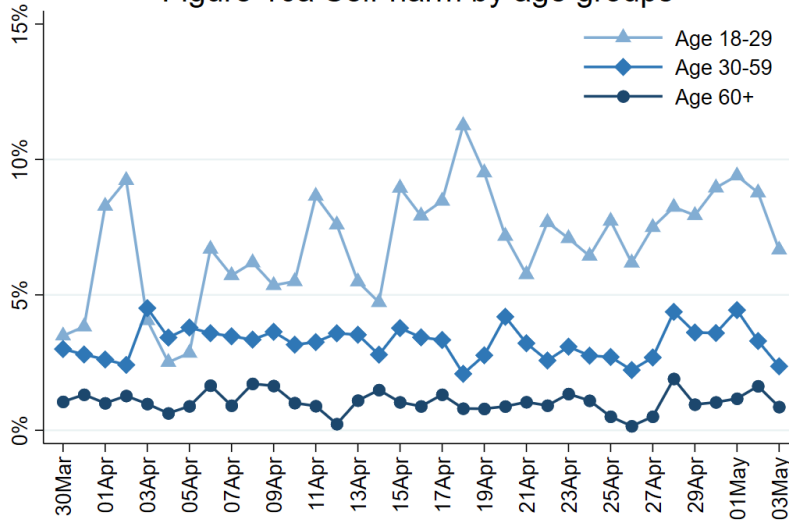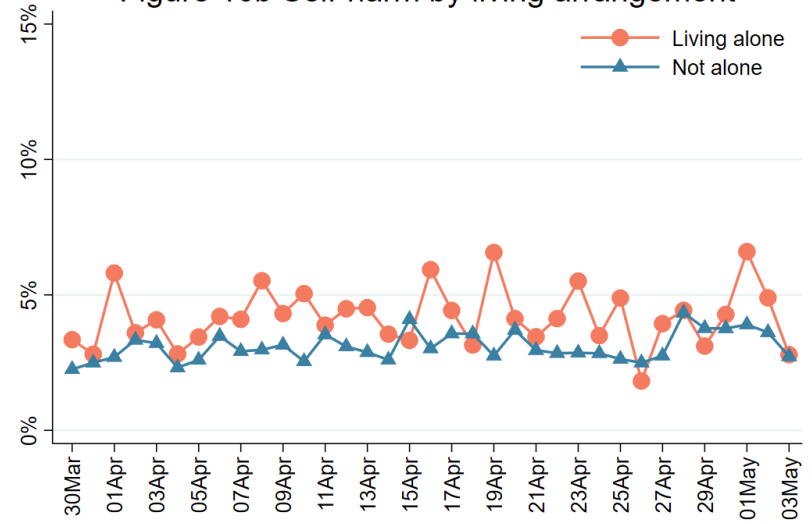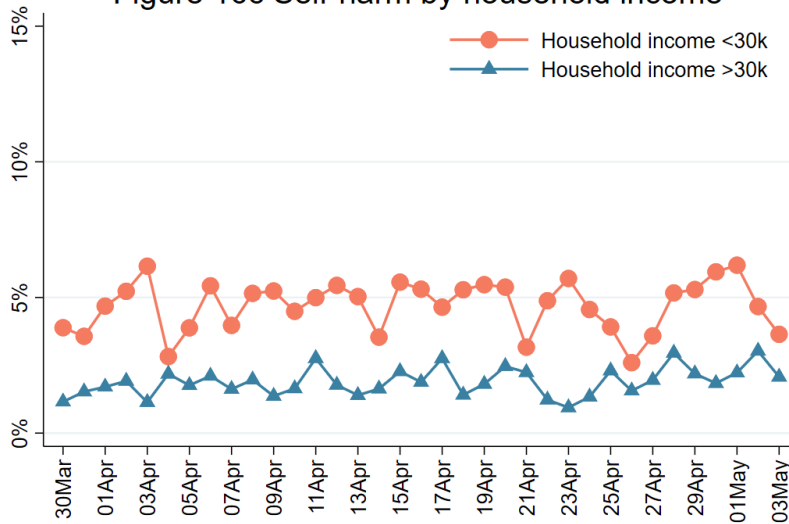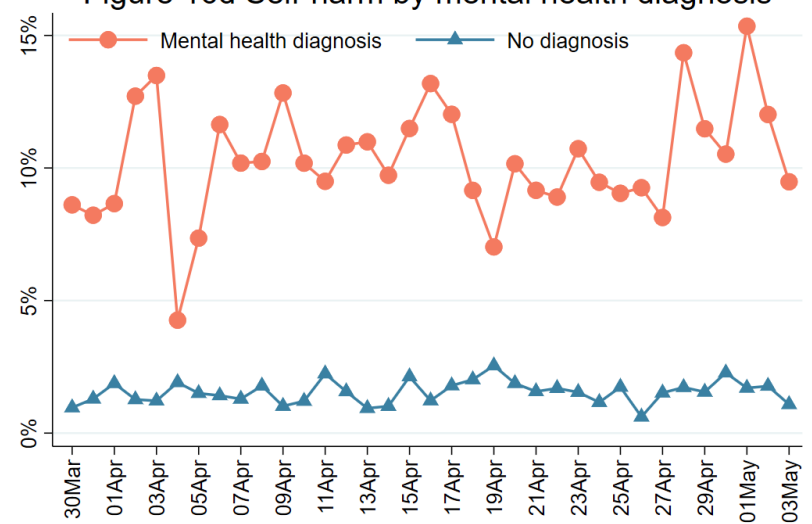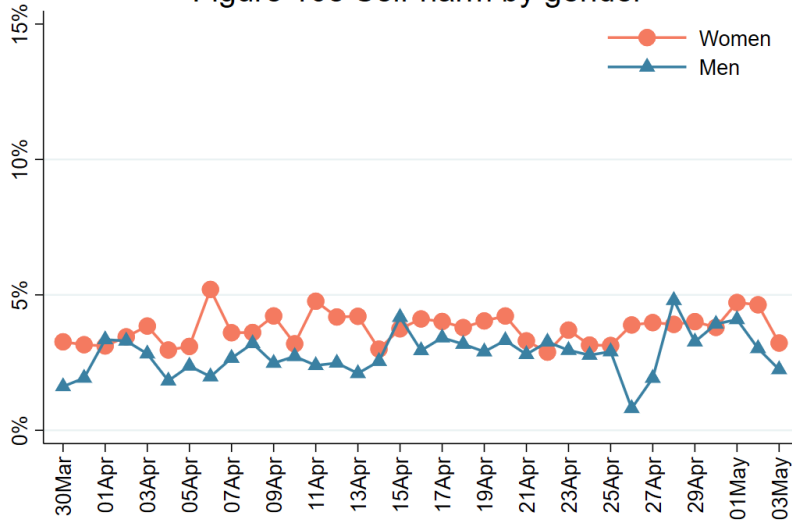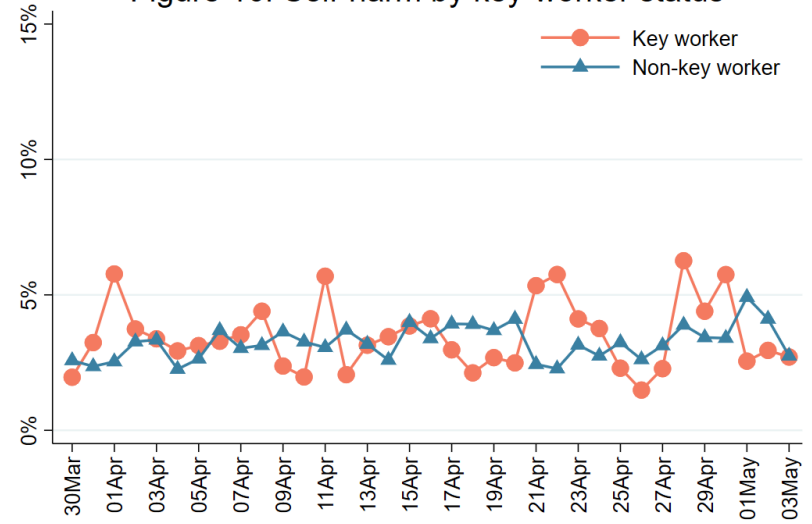
Figure 16g Self-harm by living with children
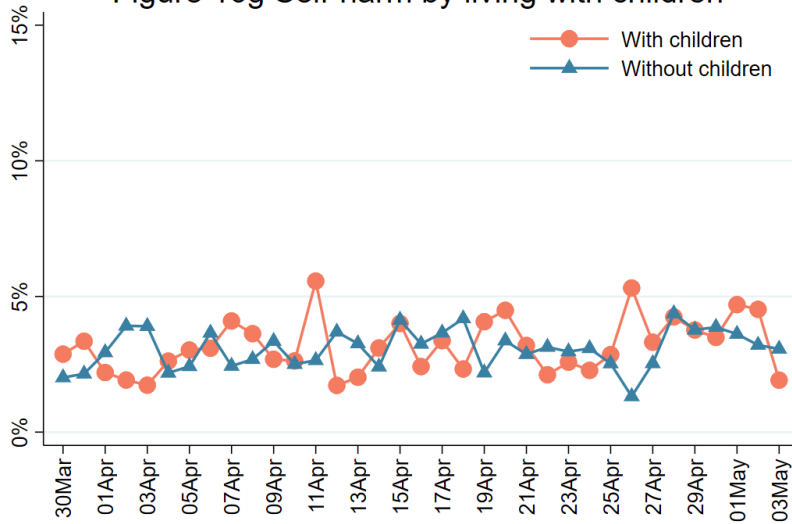
Figure 16h Self-harm by living area

3.3 Abuse

Figure 17 Being physically or psychologically abused
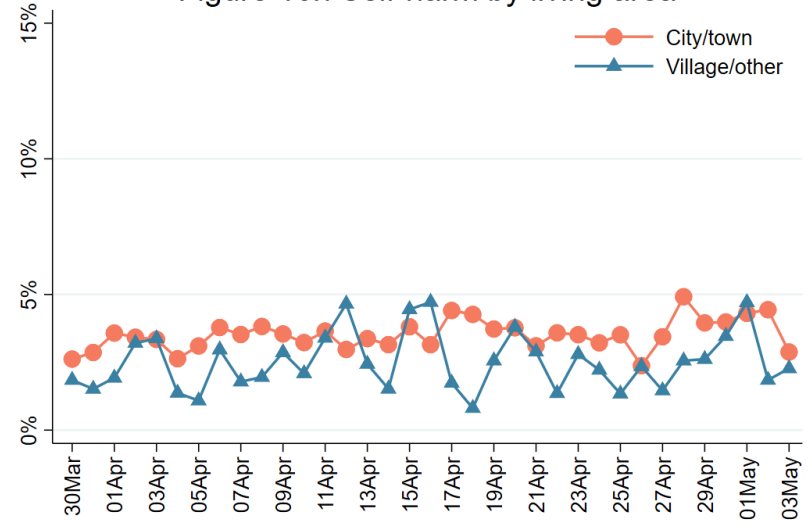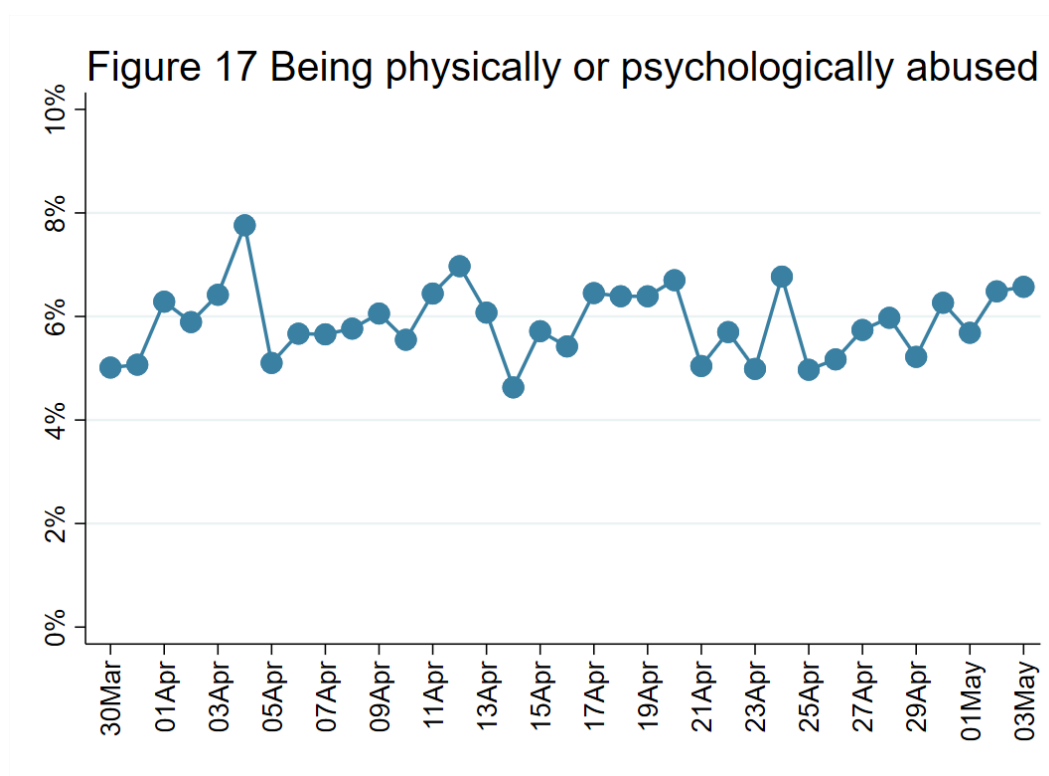
FINDINGS

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

Abuse has been reported to be higher amongst adults under the age of 60, those with lower household income and those with existing mental health conditions. Some people living alone are still reporting abuse, which could refer to physical abuse by people visiting them in their homes, or psychological abuse through other modes of contact. It is also slightly higher in women than men, and also in people living with children compared to those living with just other adults. It should be noted that not all people who are experiencing abuse will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels.

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 gender

Figure 18f Abuse by key-worker status
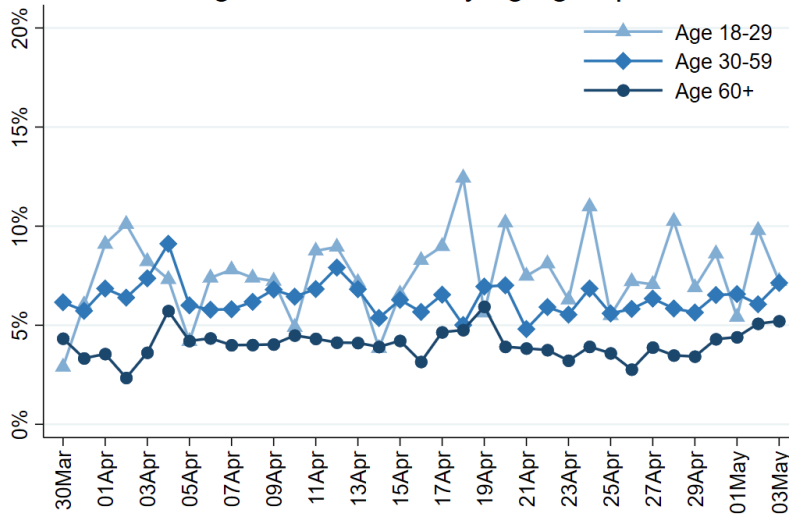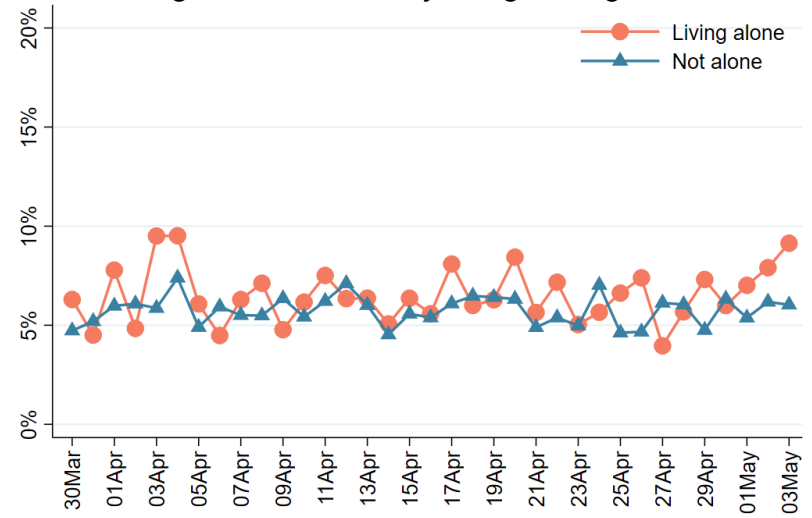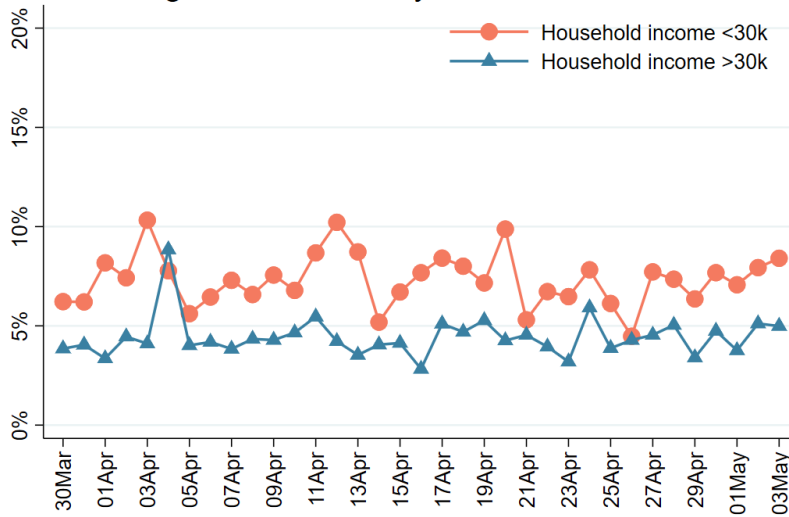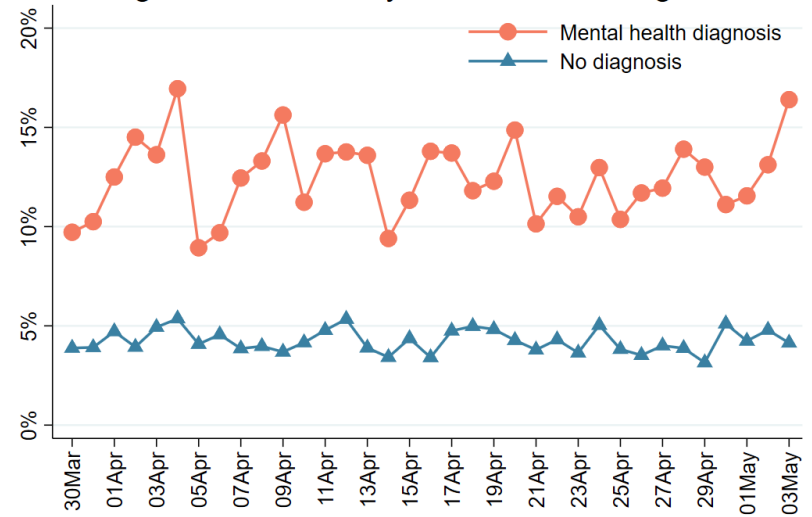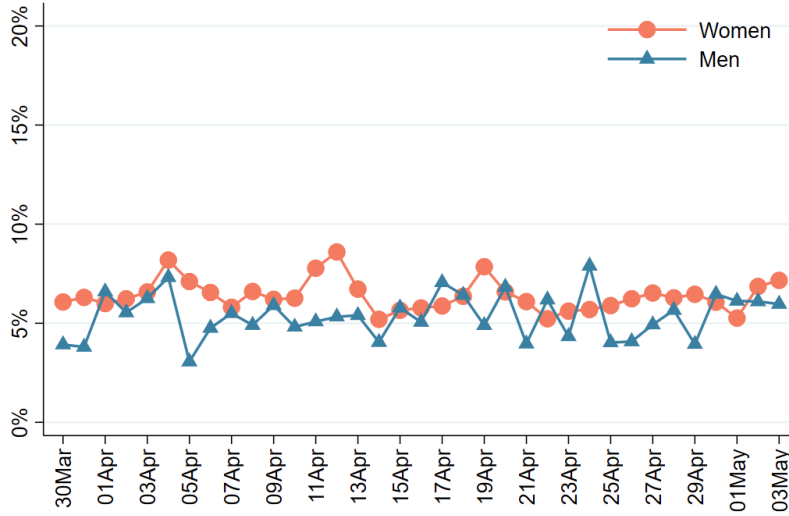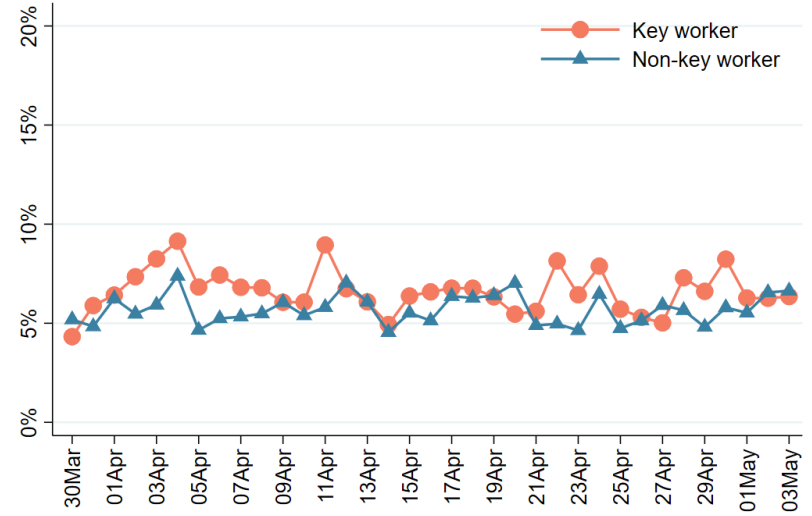
Figure 18g Abuse by living with children
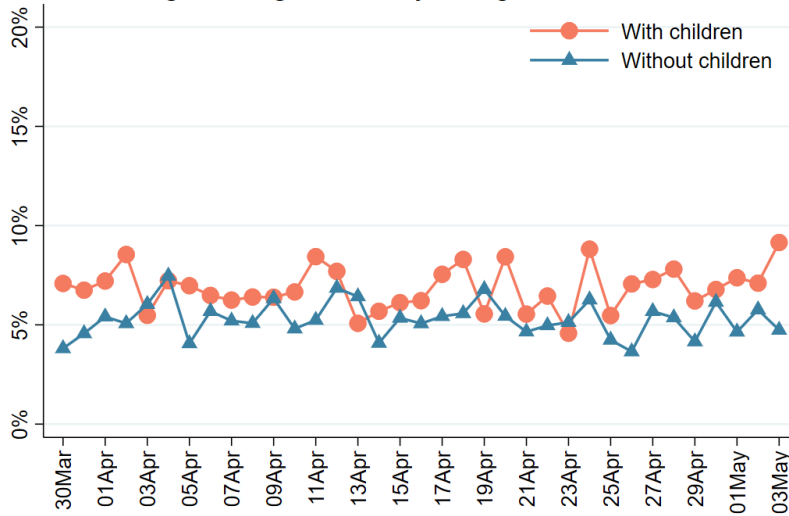
Figure 18h Abuse by living area
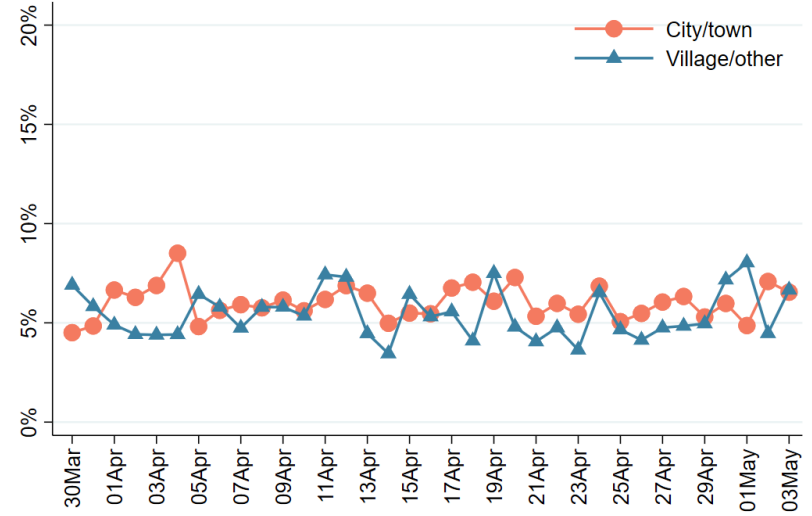
4. General well-being

4.1 Life Satisfaction

Figure 19 Life satisfaction
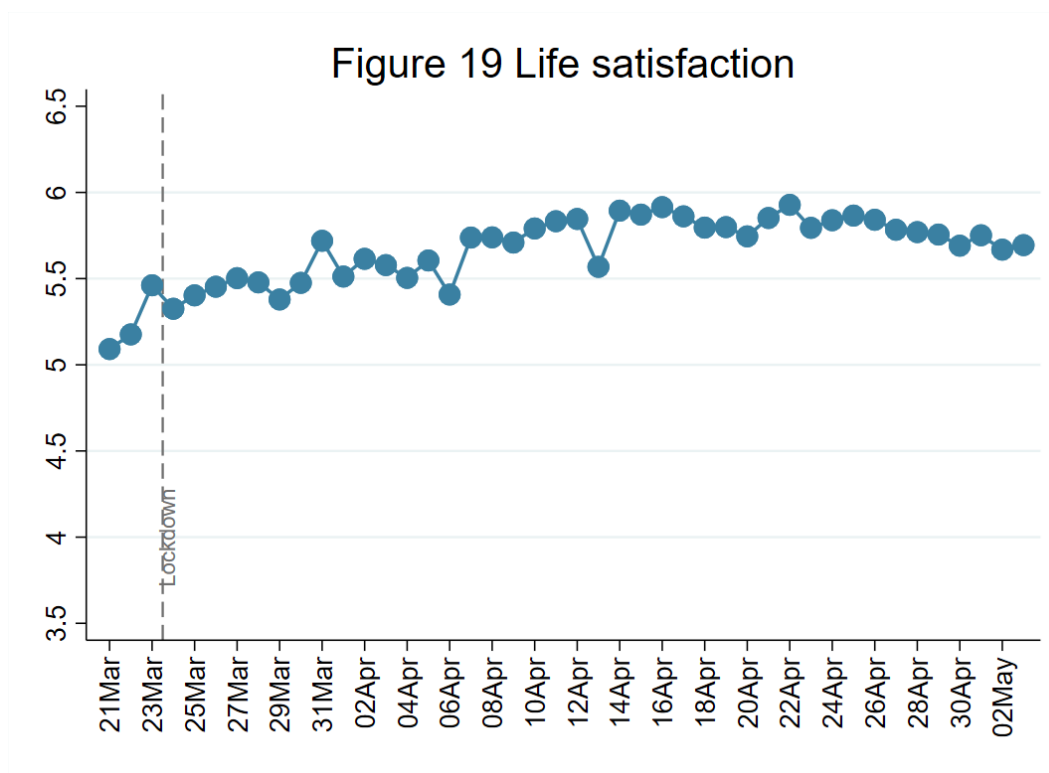
FINDINGS

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 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 [3]. In our sample life satisfaction increased after lockdown was announced but appears to have stabilised. It remains more volatile amongst younger adults (those aged 18-29) and people living alone. There is less evidence of an improvement amongst adults aged 18-29 or amongst individuals with a diagnosed mental health condition. Levels are higher in men and people living in rural areas, and lower in people living with children.

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[3] 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
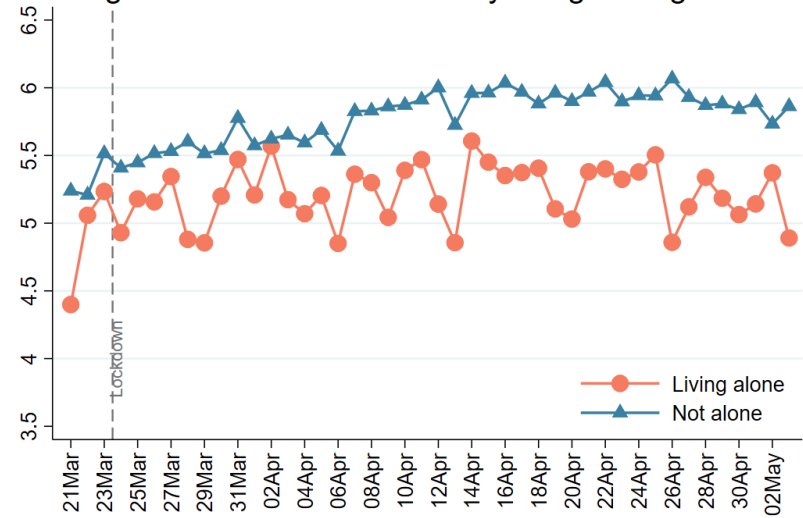
Figure 20c Life satisfaction by household income
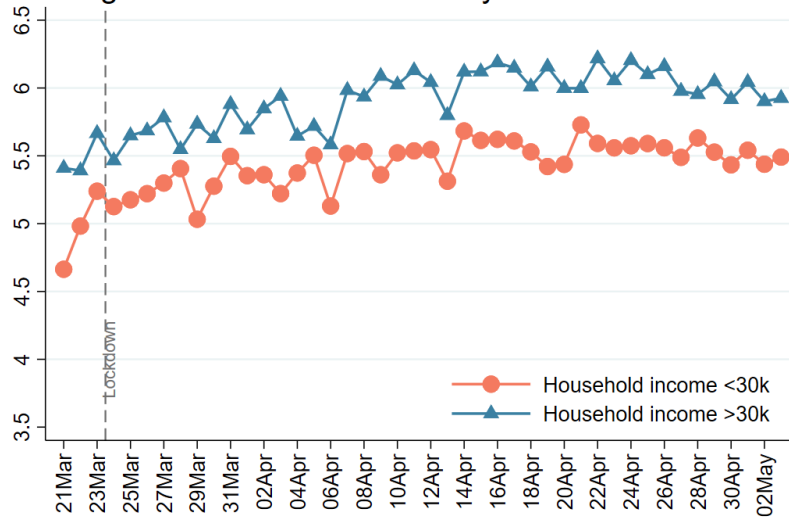
Figure 20d Life satisfaction by mental health diagnosis
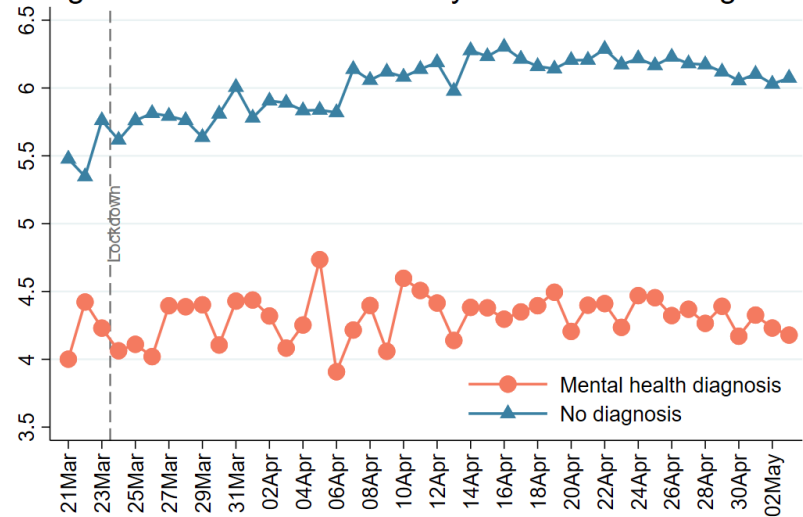
Figure 20e Life satisfaction by gender
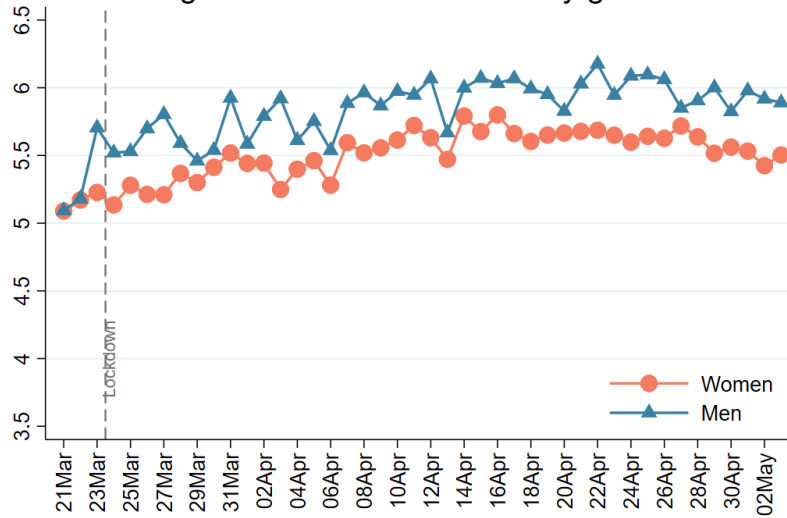
Figure 20f Life satisfaction by key-worker status
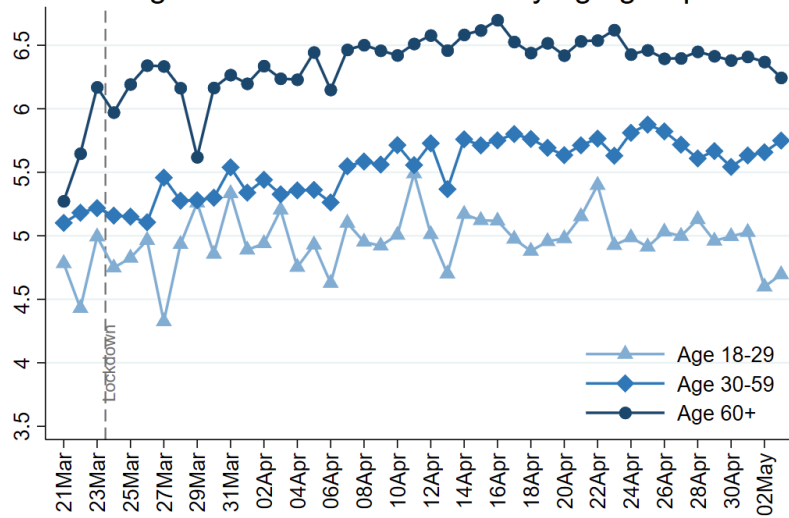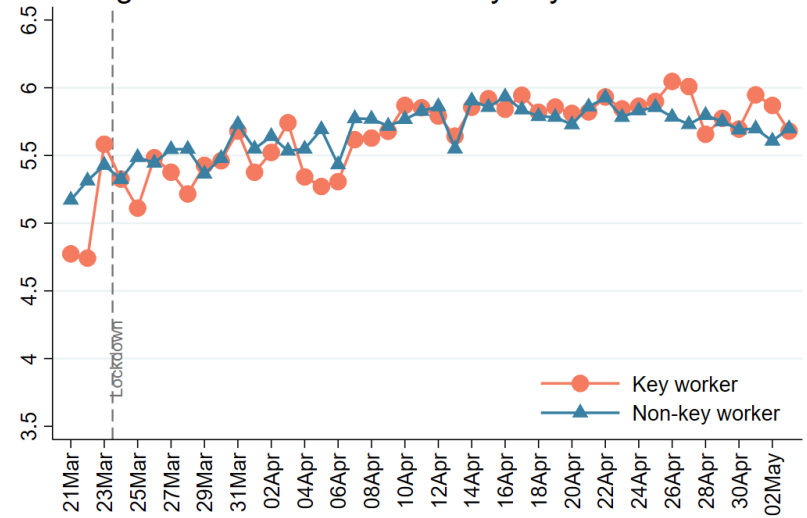
Figure 20g Life satisfaction by living with children
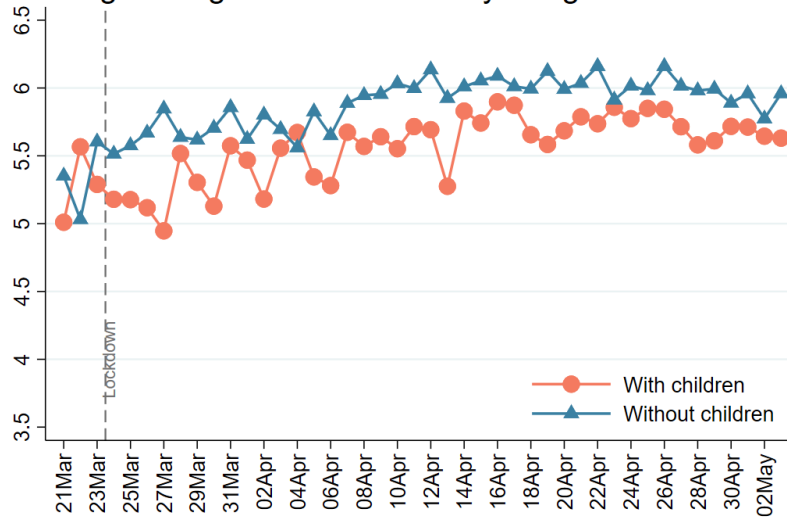
Figure 20h Life satisfaction by living area
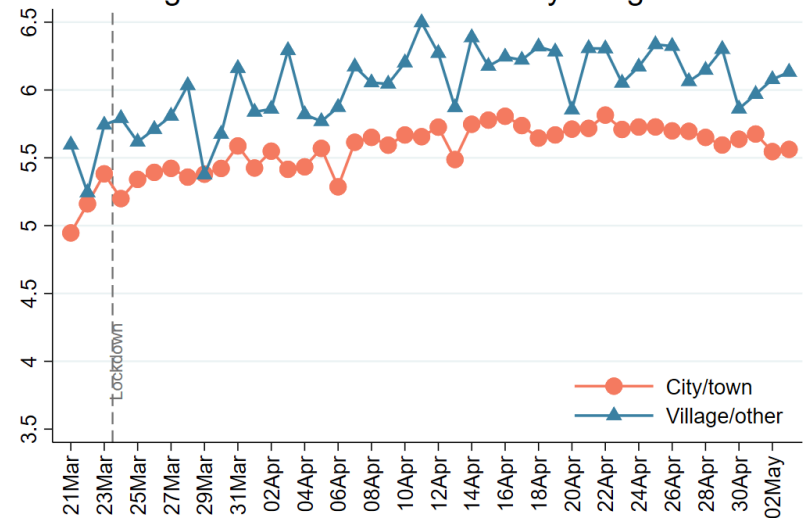
Figure 21 Loneliness
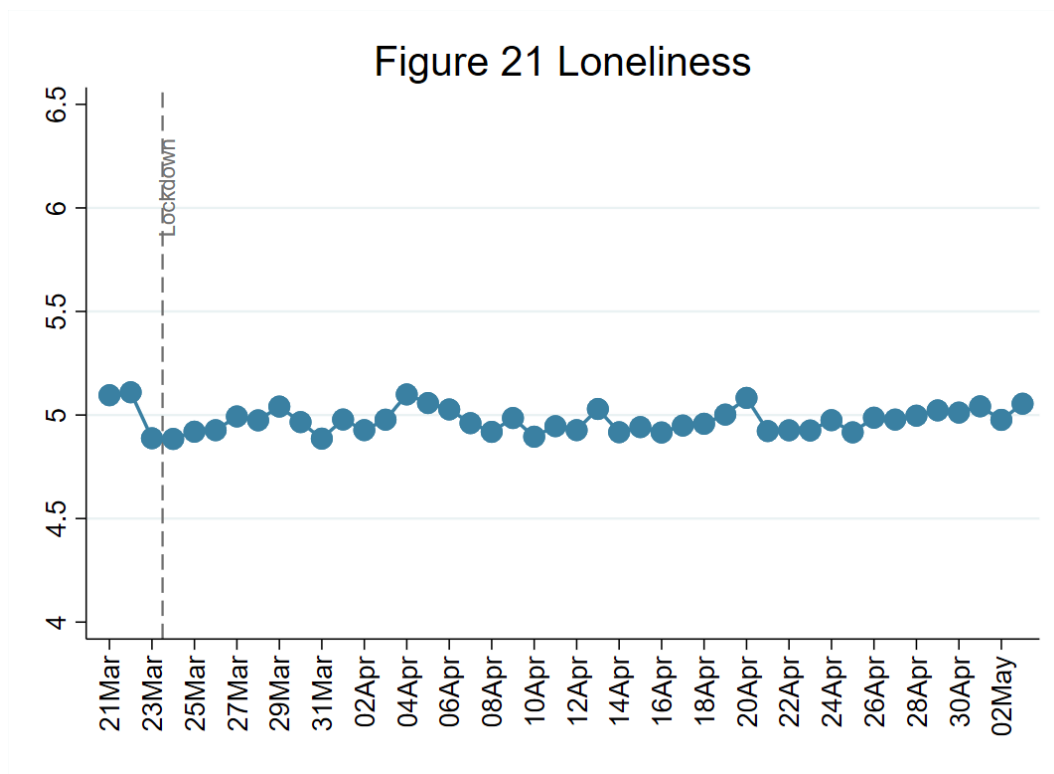
FINDINGS

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

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

Figure 22a Loneliness by age groups
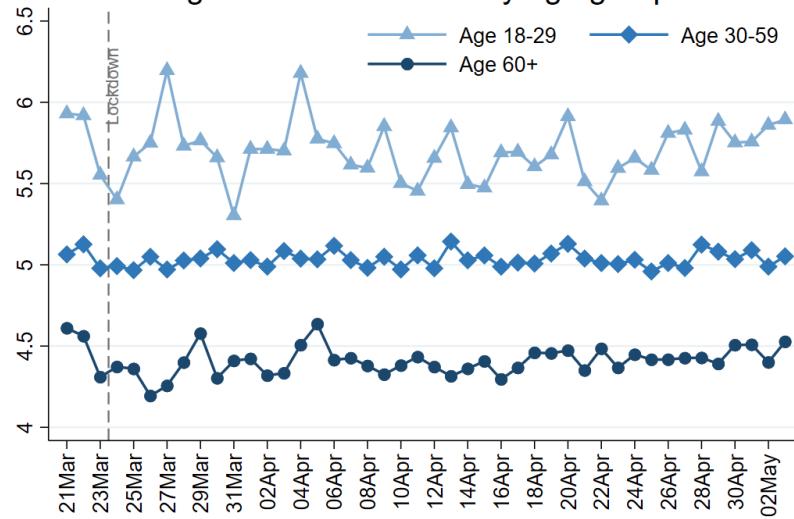
Figure 22b Loneliness by living arrangement
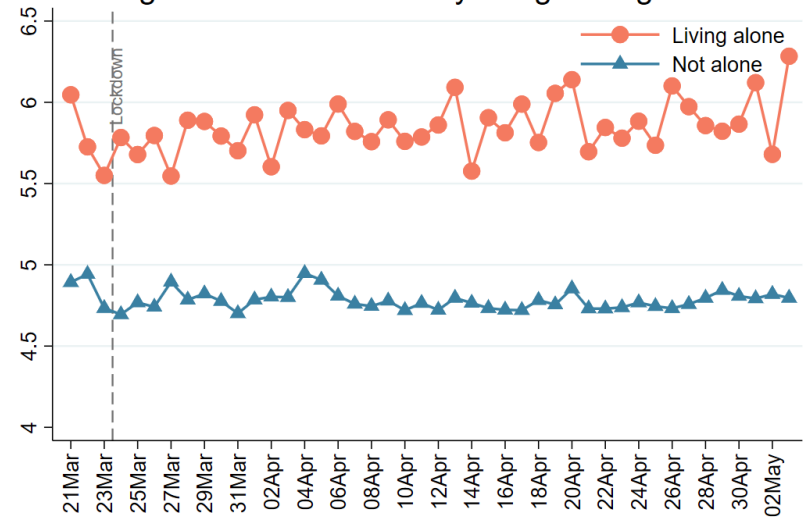
Figure 22c Loneliness by household income
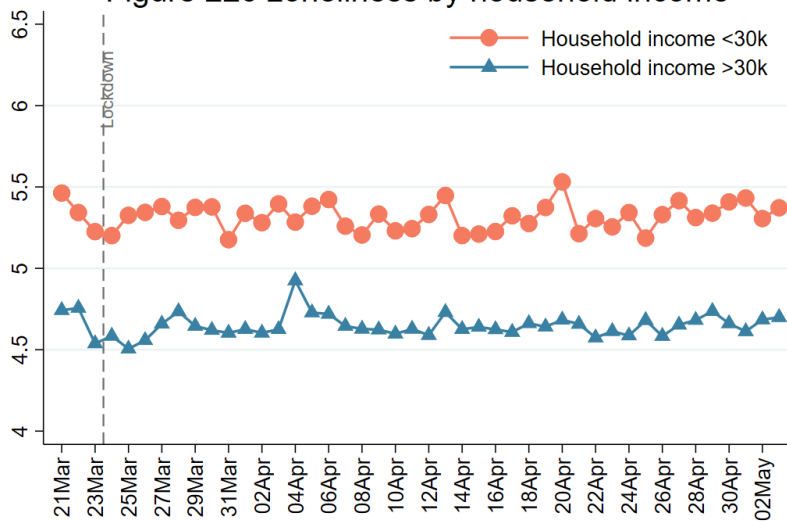
Figure 22d Loneliness by mental health diagnosis

Figure 22e Loneliness by gender

Figure 22f Loneliness by key-worker status

Figure 22g Loneliness by living with children

Figure 22h Loneliness 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 85,000 people have participated in the study, providing baseline socio-demographic and health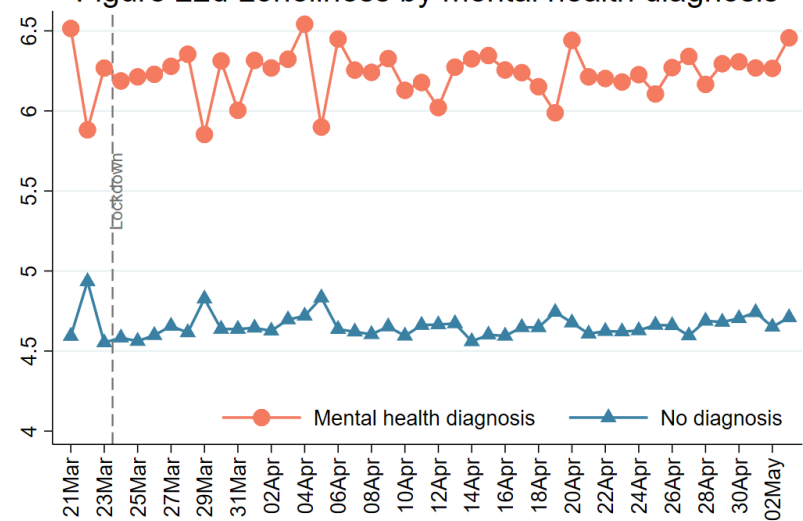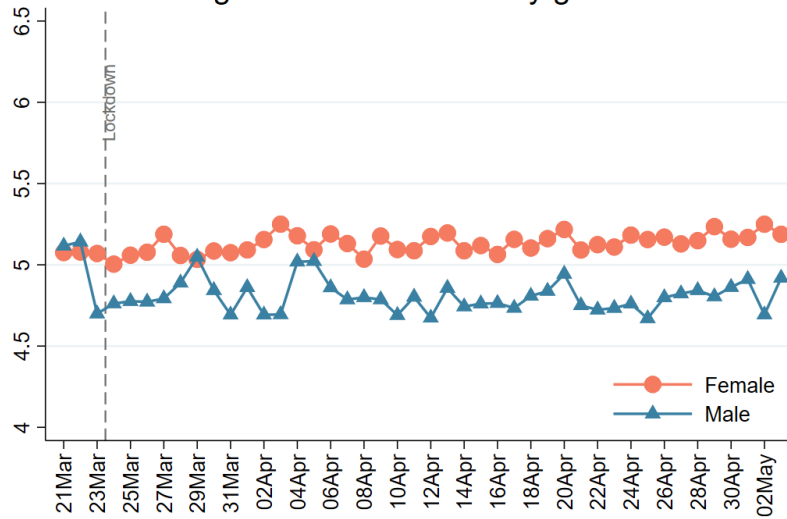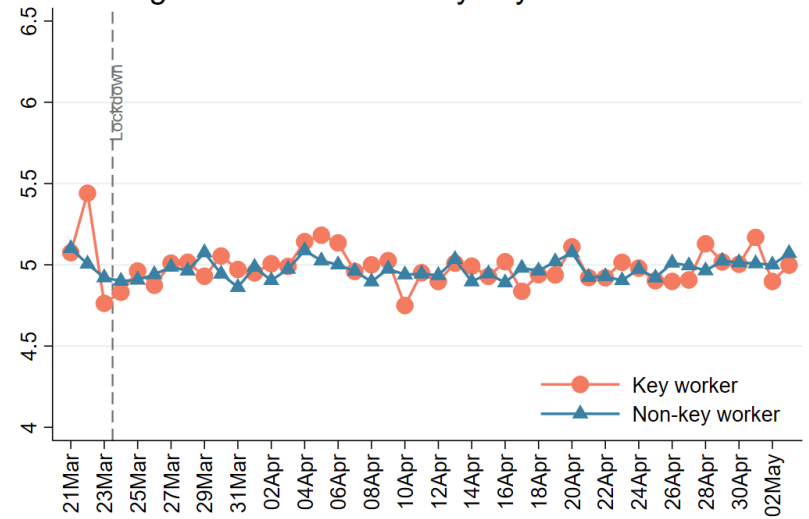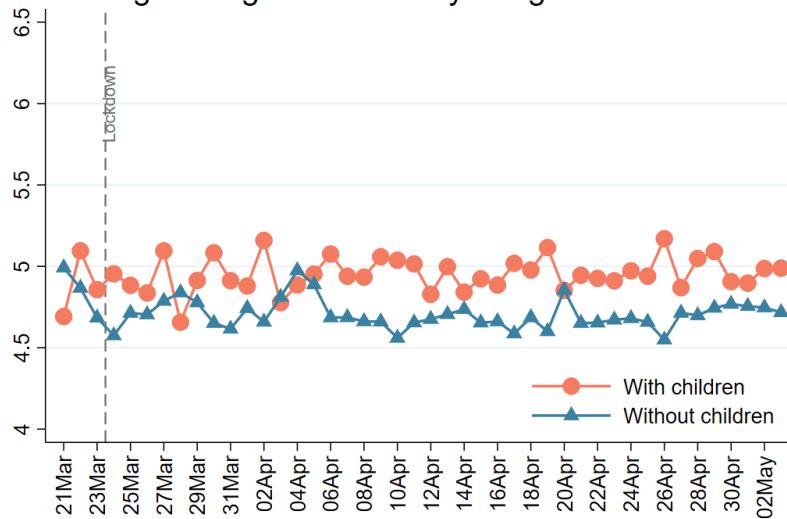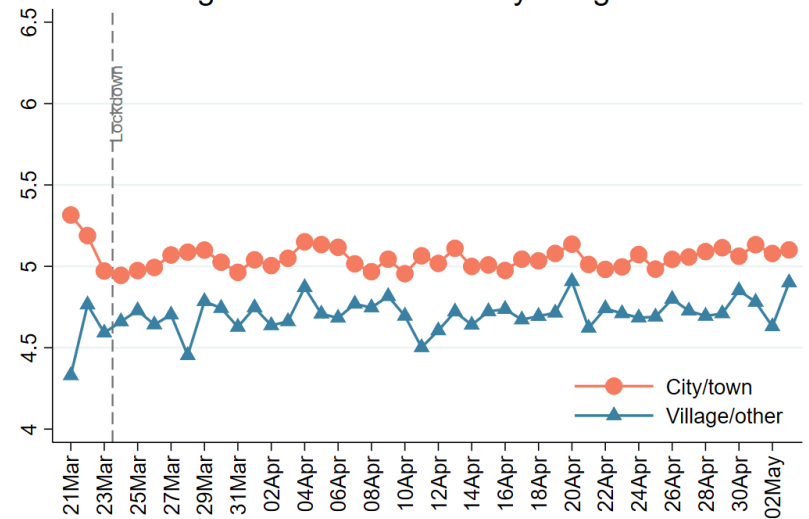 data as well as answering questions on their mental health and wellbeing, the factors causing them stress, their levels of social interaction and loneliness, their adherence to and trust in government recommendations, and how they are spending their time. The study does not aim to be representative of the UK population, but instead to have good representation across all major socio-demographic groups. The study sample has therefore been recruited through a variety of channels including through the media, through targeted advertising by online advertising companies offering pro-bono support to ensure this stratification, and through partnerships with organisations representing vulnerable groups, enabling meaningful subgroup analyses.

Specifically, in the analyses presented here we included adults in the UK. We used new cross-sectional data from individuals as they entered the study and also included weekly longitudinal data as participants received their routine follow-up. In this report, we treated the data as repeated cross-sectional data collected daily from the 21st of March to the 3rd May (the latest data available). Aiming at a representative sample of the population for each sub-dataset, we weighted the data for each day to the proportions of gender, age, ethnicity, education and country of living obtained from the Office for National Statistics (ONS, 2018). **Contrary to previous reports, we include keyworkers within our main analyses.**

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

The study has full ethical and data protection approval and is fully GDPR compliant. For further information or to request specific analyses, please contact Dr Daisy Fancourt d.fancourt@ucl.ac.uk.

To participate, visit **www.MARCHNetwork.org/research**

Demographics of respondents included in this report

Table: Demographics of observations from participants in the pooled raw data (unweighted; data are weighted for analyses)

	Number of observations	%
Age		
18-29	17,933	8.32
30-59	129,999	60.3
60+	67,521	31.3
Gender		
Men	54,528	25.4
Women	159,998	74.6
Living alone		
No	174,541	81.0
Yes	40,912	19.0
Annual household income		
>30k	119,994	61.4
<30k	75,460	38.6
Any diagnosed mental health conditions		
No	175,855	81.6
Yes	39,598	18.4
Key worker		
No	166,027	77.1
Yes	49,426	22.9
Living with children		
No (excluding those who live alone)	117,129	67.1
Yes	57,412	32.9
Living area		
Village/hamlet/isolated dwelling	50,441	23.4
City/large town/small town	165,012	76.6