Covid-19 Social Study

Results Release 11

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Executive summary

Background

This report provides data from Week 11 of the UK COVID-19 Social Study run by University College London: a panel study of over 90,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this ELEVENTH report, we focus on psychological responses to the first ten weeks of government measures requiring people to stay at home (21/03-31/05). 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 & physical abuse
4. Psychological and social wellbeing including life satisfaction and loneliness
5. ***New in this report*** Sense that life is worthwhile (‘meaning’ in life)

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.COVIDSocialStudy.org

Findings

- “Complete” compliance with government guidelines has decreased even further in the past week, but “majority” compliance is still high, with over 90% of people showing that they were still largely adhering to the guidelines. Nevertheless, lowest levels of compliance and the greatest decrease in compliance is occurring amongst younger adults, while people with higher household incomes are most likely to be ‘bending’ the rules (showing high but not complete compliance).
- Levels of confidence in the central government to handle the Covid-19 epidemic remains low since the dip experienced over the bank holiday weekend and differences between confidence in England compared to confidence in devolved governments has grown.
- There are some indications that mental health is improving as lockdown eases. In the past week, depression levels have shown some decrease, especially amongst adults under the age of 60, while anxiety levels are also lower. But levels are still higher than usual averages.
- Life satisfaction has also started to rise again since the easing of lockdown was announced, across all ages and across all demographic groups analysed, but most notably in younger people.
- Feeling that life is worthwhile has also shown some indications of improving since lockdown was eased. Notably, this feeling of ‘meaning’ in life has been higher throughout the lockdown amongst health and social care keyworkers compared to others.
- However, loneliness levels have not yet shown any clear changes. There are also no discernible changes in thoughts of death or self-harm, experience of self-harm or abuse.
- Surprisingly, stress relating to Covid-19 (both catching Covid-19 and becoming seriously ill from Covid-19) has stayed low in the past week, not showing any sign of increase despite lockdown easing, with fears over catching the virus half what they were when lockdown came in.

www.COVIDSocialStudy.org
1. Compliance and confidence

1.1 Compliance with guidelines

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). 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).

“Complete” compliance has decreased even further in the past week, but “majority” compliance is still high, with over 90% of people showing that they were still largely adhering to the guidelines. Figures 2a-2h show “complete” compliance by demographic factors, while Figures 2i-2p show “majority” compliance by demographic factors.

Compliance remains lower in younger adults, who have notably started to decrease in both “complete” and “majority” compliance. For “majority” compliance, there is no other evidence of difference by socio-demographic factors, but for “complete” compliance, there has been a greater decrease and lower levels in people with higher household incomes, people in England (compared to Scotland or Wales) and people in cities.
1.2 Confidence in Government

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 the central government to handle the Covid-19 epidemic remains low since the dip experienced over the bank holiday weekend and differences between confidence in England compared to confidence in devolved governments has grown.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 (future analyses will look at subgroups in devolved nations). In England, confidence in government has fallen most notably in younger adults, and is lowest in those under the age of 30. Confidence is also lower in urban areas and in people with a mental health diagnosis.

¹ Figures for Northern Ireland show greater volatility but this is likely a function of the sample size in Northern Ireland being smaller than for other countries.
2. Mental Health

2.1 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. 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.

In the past week, depression levels have shown some decrease, especially amongst adults under the age of 60. Although this study focuses on trajectories rather than prevalence, it is noted that 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\(^2\)). Anxiety levels are also a little lower but whether this is indicative of a decreasing trend remains to be confirmed in future data. Depression and anxiety are still highest in young people, those living alone, those with lower household income, people with a diagnosed mental illness, people living with children, and people living in urban areas.

2.2 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 stayed low in the past week, notably not showing any sign of increase despite lockdown easing.

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 8 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 stabilised in the past week, with fewer than 1 in 20 people now worried about it.

There continues to be no change in stressors since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figures 9e-12e).
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
3. Self-harm and abuse

3.1 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 with a 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.

There continues to be no clear change in thoughts of death since the easing of lockdown was announced, as shown when comparing data for England with data for Scotland and Wales (Figure 14e).
3.2 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.

There are indications of a slight decrease in self-harm in the last week, especially amongst younger adults and people with a mental health diagnosis. However, this is only tentative for now and could be within usual variation. So it remains to be confirmed with future data.

Self-harm has been reported to be 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 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.
3.3 Abuse

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. It is also slightly higher 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.

There continues to be no change in reports of abuse since the easing of lockdown was announced.
4. General well-being

4.1 Life satisfaction

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).

In our sample, life satisfaction increased after lockdown was announced but has stabilised in the past month. But it has started to rise again since the easing of lockdown was announced, across all ages but most notably in younger people.

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 lockdown3.

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4.2 Loneliness

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 with lower household income levels, and those with an existing diagnosed mental health condition. They are higher amongst people with children, and people living in urban areas.

There is not yet any clear pattern of change in loneliness levels since the easing of lockdown was announced, although it is noted that the opportunity to socialise with people from other households has only just come through in the different nations. So data should provide more insight into whether this has affected loneliness in the next week.
4.3 Sense of meaning

Respondents were asked to rate to what extent they felt the things they had been doing in their life during the past week were worthwhile using the Office for National Statistics wellbeing scale on a scale from 0 (not at all) to 10 (completely).

Feeling that life was worthwhile (has “meaning”) has been relatively stable across lockdown, but has begun to increase since lockdown restrictions began to be lifted. This sense of life being worthwhile has been higher across lockdown in older adults, those living with others, those with higher household incomes, those without any diagnosed mental health conditions and in people living in rural areas. It has also, notably, been higher in health and social care key workers than in people working in other professions. There has been no different depending on whether people live with children or if they live in devolved nations.
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 90,000 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 31st May (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.

Contrary to some 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.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)

<table>
<thead>
<tr>
<th>Number of observations</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>26,887</td>
</tr>
<tr>
<td>30-59</td>
<td>209,970</td>
</tr>
<tr>
<td>60+</td>
<td>120,435</td>
</tr>
<tr>
<td><strong>UK nations</strong></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>290,928</td>
</tr>
<tr>
<td>Scotland &amp; Wales</td>
<td>62,332</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>3,801</td>
</tr>
<tr>
<td><strong>Living arrangement</strong></td>
<td></td>
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<tr>
<td>Not living alone</td>
<td>286,906</td>
</tr>
<tr>
<td>Living alone</td>
<td>70,146</td>
</tr>
<tr>
<td><strong>Annual household income</strong></td>
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<td>&gt;30k</td>
<td>197,723</td>
</tr>
<tr>
<td>&lt;30k</td>
<td>125,692</td>
</tr>
<tr>
<td><strong>Any diagnosed mental health conditions</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>293,387</td>
</tr>
<tr>
<td>Yes</td>
<td>63,905</td>
</tr>
<tr>
<td><strong>Care keyworker [NB we show more specific data on care key workers this week rather than all keyworkers]</strong></td>
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</tr>
<tr>
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<tr>
<td>Yes</td>
<td>37,647</td>
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<tr>
<td><strong>Living with children</strong></td>
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<tr>
<td>No (excluding those who live alone)</td>
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<tr>
<td>Yes</td>
<td>90,247</td>
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<tr>
<td><strong>Living area</strong></td>
<td></td>
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<tr>
<td>Village/hamlet/isolated dwelling</td>
<td>85,222</td>
</tr>
<tr>
<td>City/large town/small town</td>
<td>271,839</td>
</tr>
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