Covid-19 Social Study
Results Release 38

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The Nuffield Foundation is an independent charitable trust with a mission to advance social well-being. It funds research that informs social policy, primarily in Education, Welfare, and Justice. It also funds student programmes that provide opportunities for young people to develop skills in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Nuffield Council on Bioethics and the Ada Lovelace Institute. The Foundation has funded this project, but the views expressed are those of the authors and not necessarily the Foundation. Visit [www.nuffieldfoundation.org](http://www.nuffieldfoundation.org).

The project has also benefitted from funding from UK Research and Innovation and the Wellcome Trust. The researchers are grateful for the support of a number of organisations with their recruitment efforts including: the UKRI Mental Health Networks, Find Out Now, UCL BioResource, HealthWise Wales, SEO Works, FieldworkHub, and Optimal Workshop.
Executive summary

Background

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

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

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

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

Findings

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

1.1 Compliance with guidelines

FINDINGS

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

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

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

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

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

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3 Figures for ethnicity sub-groups are analysed by month rather than by week for the duration of the study to maximise sample size.
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
1.2 Confidence in government

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

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

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

\(^2\) Figures for Northern Ireland have now been removed from our daily tracker graphs due to a small sample size that makes extrapolation even with statistical weighting unreliable. These data are being analysed in other papers and reports.
2. Mental Health
2.1 Depression and anxiety

FINDINGS

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

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

Although this study focuses on trajectories rather than prevalence, the levels overall are higher than usual reported averages using the same scales (2.7-3.2 for anxiety and 2.7-3.7 for depression3).

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


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 6e Depression by nations

Figure 6f Depression by keyworker status

Figure 6g Depression by living with children

Figure 6h Depression by living area
2.2 Stress

FINDINGS

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

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

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

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

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

FINDINGS

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

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

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

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

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

It should be noted that not all people who self-harm will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels.⁴

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

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

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

It should be noted that not all people who experienced physical or psychological abuse will necessarily report it, so these levels are anticipated to be an under-estimation of actual levels⁵.

⁵Spikes on particular days are likely due to variability in the data as opposed to indications of particularly adverse experiences on certain days.
4. General well-being

4.1 Life satisfaction

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

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

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

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

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4.2 Loneliness

FINDINGS

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

Loneliness levels have been decreasing steadily since the beginning of March 2021 and are now slightly lower than what they were in the summer of 2020. Loneliness remains highest in young adults, people living alone, those with a mental health diagnosis, people with lower household income, amongst those from ethnic minority groups, women, and those living in urban areas.
Respondents were asked to rate to what extent they felt happy during the past week using the Office for National Statistics (ONS) wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April 2020 onwards.

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

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

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

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

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

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\(^7\) Kliem S, Mößle T, Rehbein F, Hellmann DF, Zenger M, Brähler E. A brief form of the Perceived Social Support Questionnaire (F-SozU) was developed, validated, and standardized. Journal of Clinical Epidemiology 2015;68(5):551-562.
Figure 26a Social support by age groups

Figure 26b Social support by living arrangement

Figure 26c Social support by household income

Figure 26d Social support by mental health diagnosis
6. Discrimination

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

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

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

When looking at subgroups, total discrimination experiences were highest amongst people from ethnic minority groups (61% vs 41% of people with white ethnicity) and younger adults (60% aged 18-30 vs 29% of people aged 60+). They were also slightly higher amongst women (48% vs men 39%) and more common in urban areas (45% vs 40% reported in rural areas).
Figure 28a Any discrimination by age group

- Age 60+: [Graph]
- Age 30-59: [Graph]
- Age 18-29: [Graph]

Figure 28b Any discrimination by gender

- Female: [Graph]
- Male: [Graph]

Figure 28c Any discrimination by ethnicity

- White: [Graph]
- Ethnic minority: [Graph]

Figure 28d Any discrimination by living area

- Village/other: [Graph]
- City/town: [Graph]
Appendix

Methods

The Covid-19 Social Study is a panel study of the psychological and social experiences of adults in the UK during the outbreak of the novel coronavirus run by University College London and funded by the Nuffield Foundation, UKRI and the Wellcome Trust. To date, over 70,000 people have participated in the study, providing baseline socio-demographic and health data as well as answering questions on their mental health and wellbeing, the factors causing them stress, their levels of social interaction and loneliness, their adherence to and trust in government recommendations, and how they are spending their time. The study is not representative of the UK population, but instead it aims to have good representation across all major socio-demographic groups.

The study sample has therefore been recruited through a variety of channels including through the media, through targeted advertising by online advertising companies offering pro-bono support to ensure this stratification, and through partnerships with organisations representing vulnerable groups, enabling meaningful subgroup analyses.

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

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

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

Demographics of respondents included in this report

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

<table>
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<th>Age</th>
<th>Number of observations</th>
<th>%</th>
<th>Education levels</th>
<th>Number of observations</th>
<th>%</th>
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<td>18-29</td>
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<td>GCSE or below</td>
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<td>30-59</td>
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<td>60+</td>
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<td>Degree or above</td>
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<td>Gender</td>
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<td></td>
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<td></td>
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<td>264,918</td>
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<td>878,443</td>
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<td></td>
<td>No (excluding those who live alone)</td>
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<td>Not living alone</td>
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Peer reviewed publications

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


