



# Covid-19 Social Study

## Results Release 17

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## Executive summary

### Background

This report provides data from the last 19 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 SEVENTEENTH report, we focus on psychological responses to the first nineteen weeks since just before the UK lockdown was first announced (21/03-26/07). 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\*\*\*** Understanding of lockdown guidelines & barriers to health care

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](http://www.COVIDSocialStudy.org)

### Findings

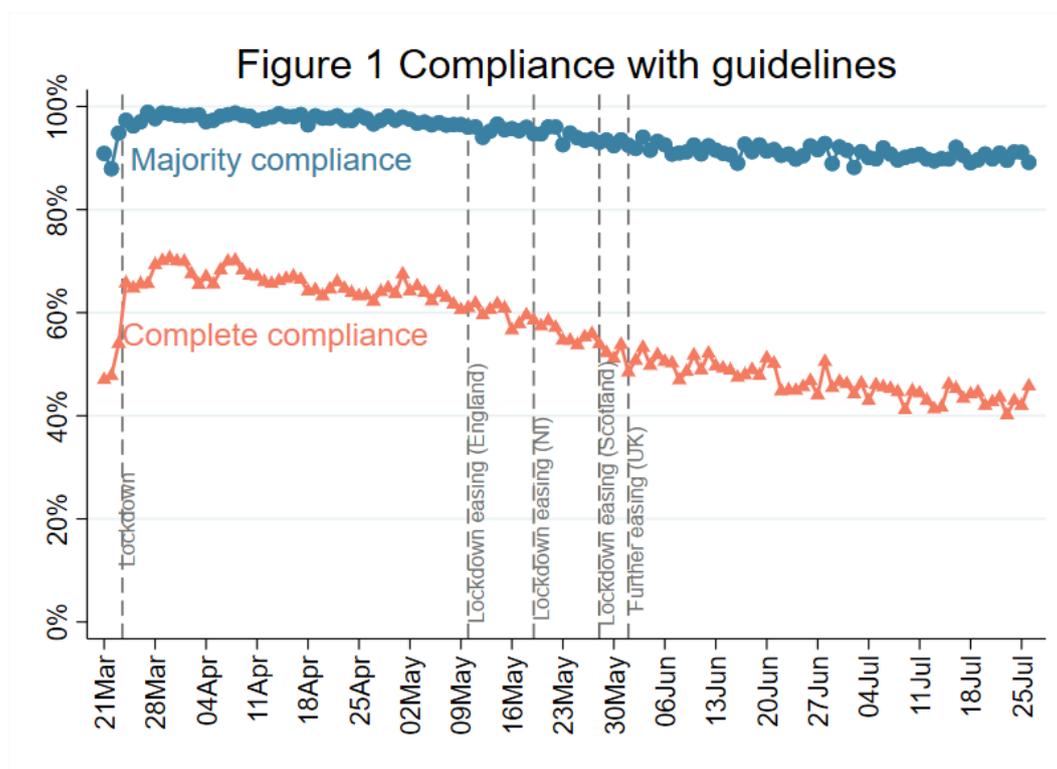
- 1 in 10 people reported being unable to see or speak with a GP about their physical health since lockdown began, along with 1 in 20 being unable to speak with a professional about their mental health. 1 in 6 adults reported having tests postponed or cancelled, and 1 in 10 reported having treatment postponed or cancelled. Nearly 1 in 6 reported other types of challenges related to accessing healthcare.
- Even when healthcare was available, 1 in 5 people reported not telling a GP about symptoms of an illness when they would usually have done, while 1 in 12 reported not speaking to a health professional about mental health when they would usually have done. 2.8% of people reported stopping taking medication due to difficulties in accessing it (e.g. being unable to collect the prescription), and 1 in 25 people reported not going for tests even though they were available.
- Groups who faced most barriers or who did not access healthcare included younger adults, women, individuals from BAME backgrounds, and people with physical and mental health conditions. 1 in 5 people with a diagnosed mental health condition reported being unable to access professional mental health support during lockdown. People from BAME backgrounds were 1.5 times more likely not to have gone for tests even though they were available (5.8% vs 3.9% from white backgrounds).
- During strict lockdown (before easing measures came in), 9 in 10 people reported understanding the rules about what they should be doing to prevent the spread of the virus and 6 in 10 people reported a very high understanding. Comprehension of the rules in strict lockdown was highest amongst adults aged over 30, with just over 3 in 5 adults understanding the rules completely, compared to only around 1 in 2 adults under 30.
- As lockdown eased (and each nation set its own rules), understanding of the rules was reported to be highest in Scotland (75% reporting they understood them, and 27% reporting they understood them 'very much') but lower in Wales (61% reporting understanding, and 18% 'very much so'), and lowest in England (45% reporting understanding and 14% 'very much so'). This is notable as compliance has been lower in England compared to Scotland and Wales.
- Compliance has remained relatively constant over the last two weeks. "Complete" compliance remains just 20%-30% 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 (70-80%) amongst adults under 30.
- In the past fortnight, depression and anxiety levels, life satisfaction, and happiness have shown further improvements across every socio-demographic subgroup examined. Loneliness levels have decreased further, showing the first clear pattern of decrease in 19 weeks. There has still been little change in people reporting major or minor stress due to catching COVID-19, unemployment, finance, or getting food.
- Levels of confidence in the central government to handle the Covid-19 epidemic have remained constant over the past fortnight, with highest levels in Scotland and Wales and lowest levels in England.<sup>1</sup>

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<sup>1</sup> 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.

# 1. Compliance and confidence

## 1.1 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 remained relatively constant over the last two weeks, with no further signs of decreases for now. “Complete” compliance remains just 20%-30% in adults under the age of 30, 40-45% in adults aged 30-50 and 50-55% in adults over the age of 60. “Complete” 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 remains around 90% overall, but is lowest (70-80%) amongst adults under 30.

Figures 2a-2h show “complete” compliance by demographic factors, while Figures 2i-2p show “majority” compliance by demographic factors.

Figure 2a Complete compliance by age groups

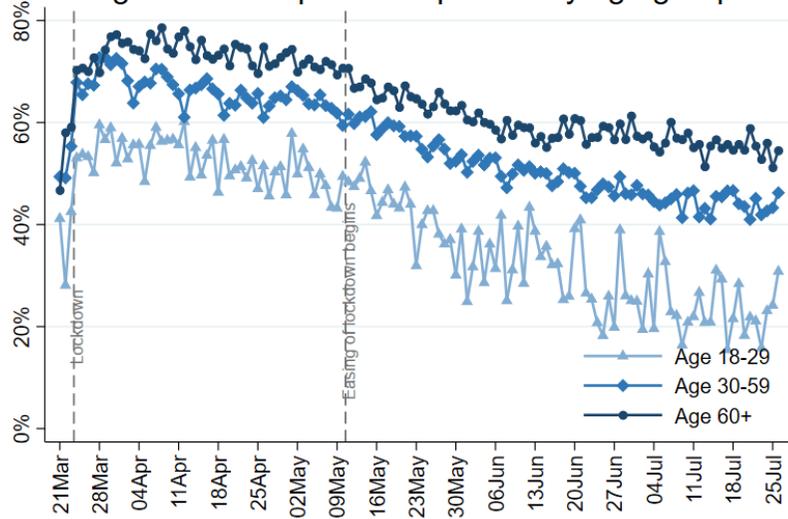


Figure 2b Complete compliance by living arrangement

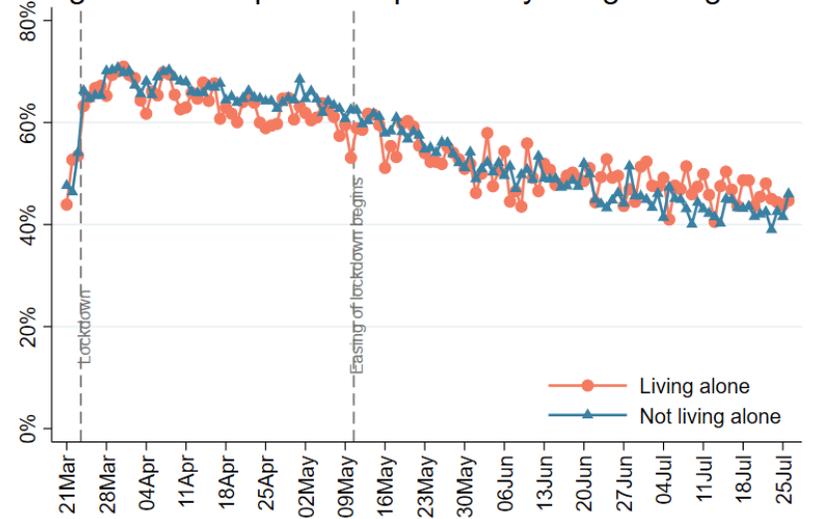


Figure 2c Complete compliance by household income

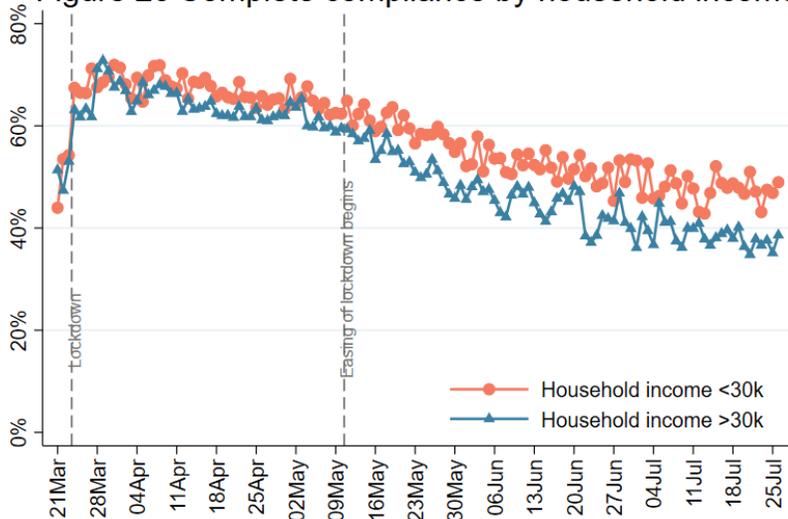


Figure 2d Complete compliance by mental health

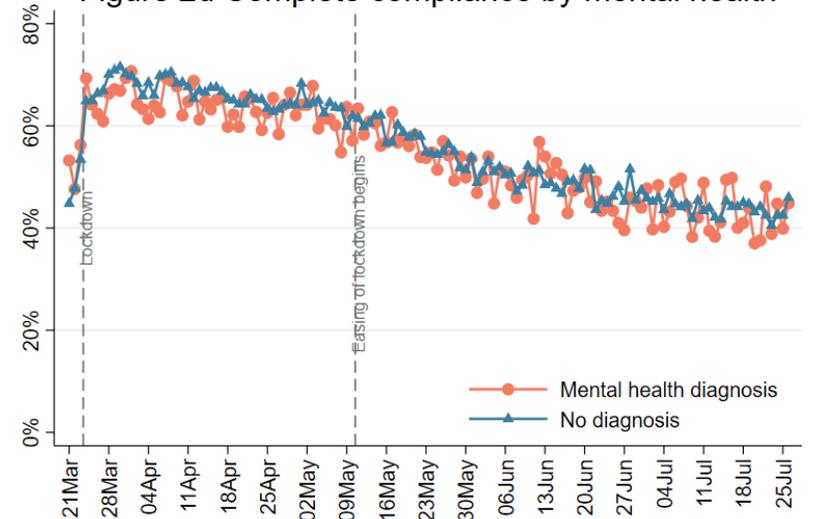


Figure 2e Complete compliance by nations

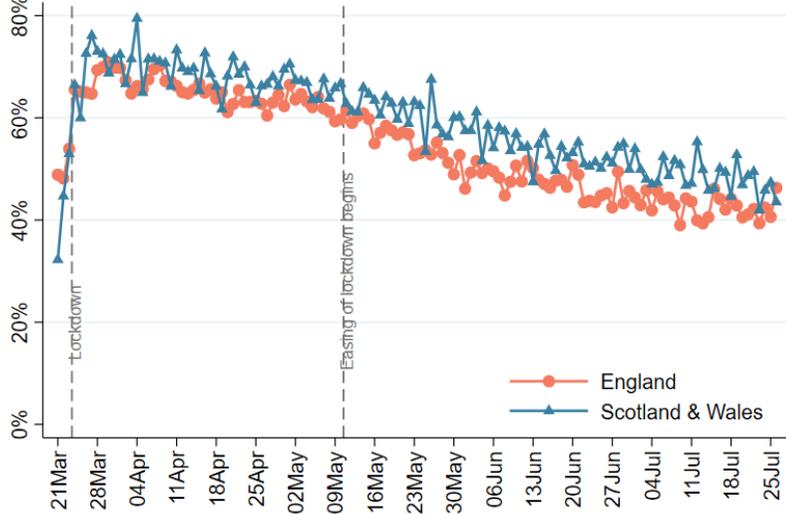


Figure 2f Complete compliance by keyworker status

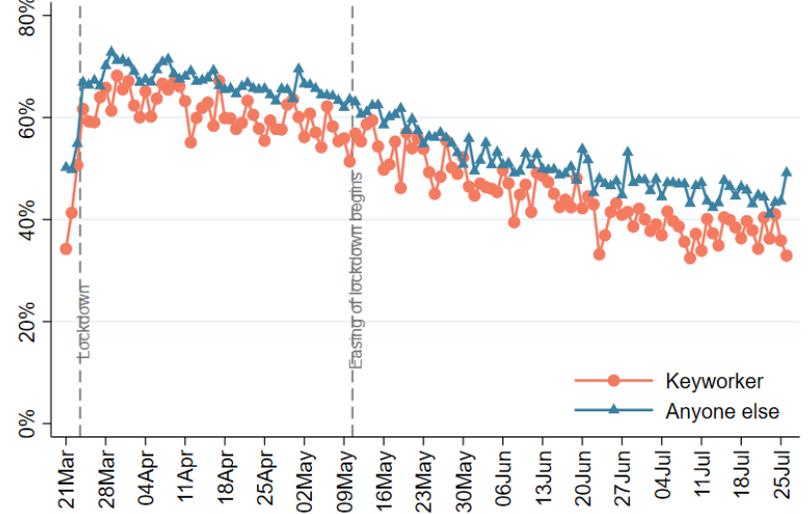


Figure 2g Complete compliance by living with children

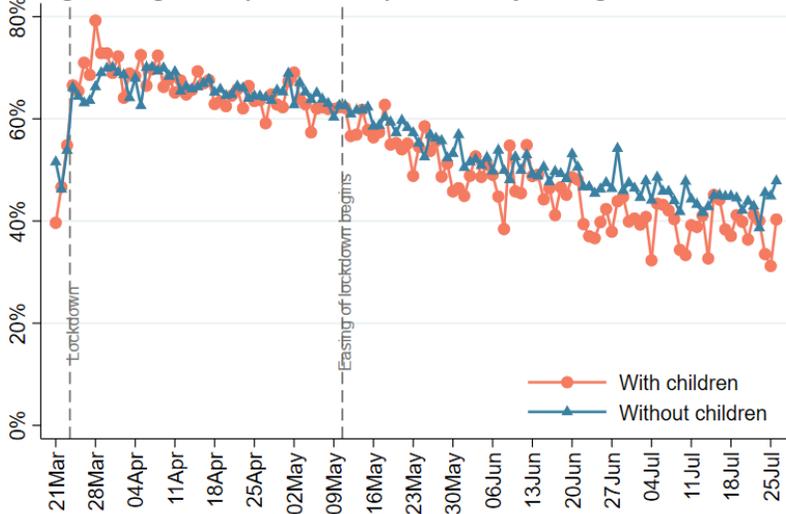
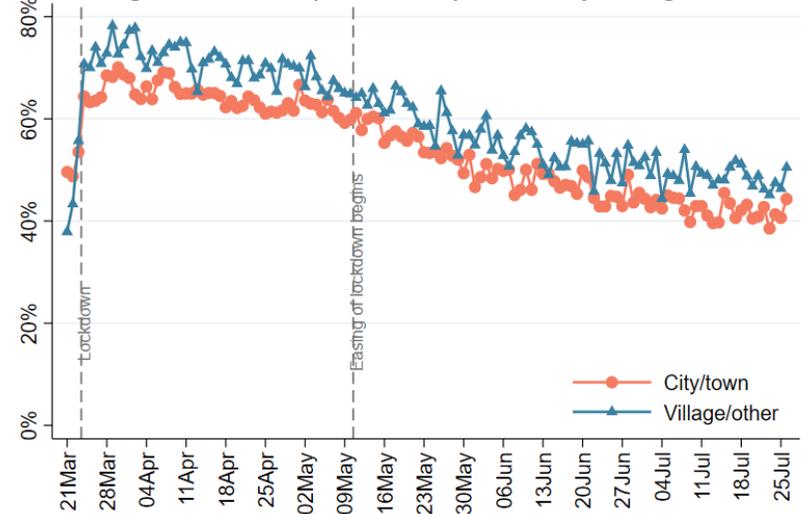


Figure 2h Complete compliance by living area



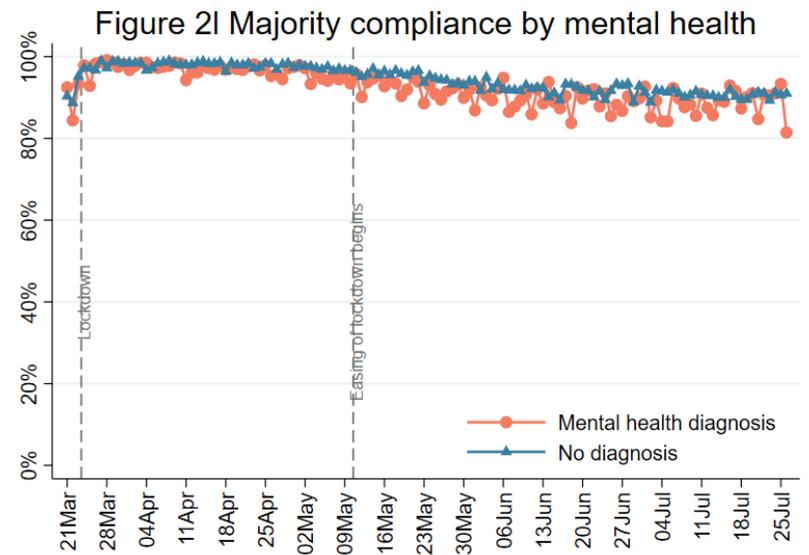
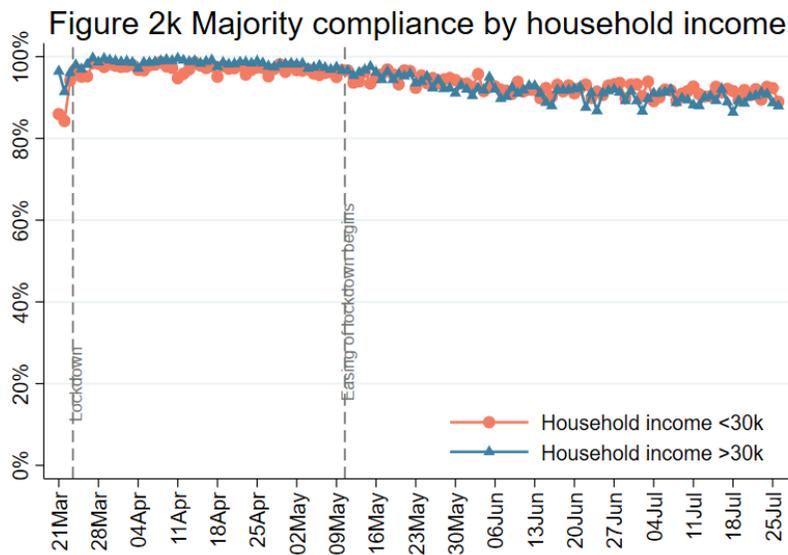
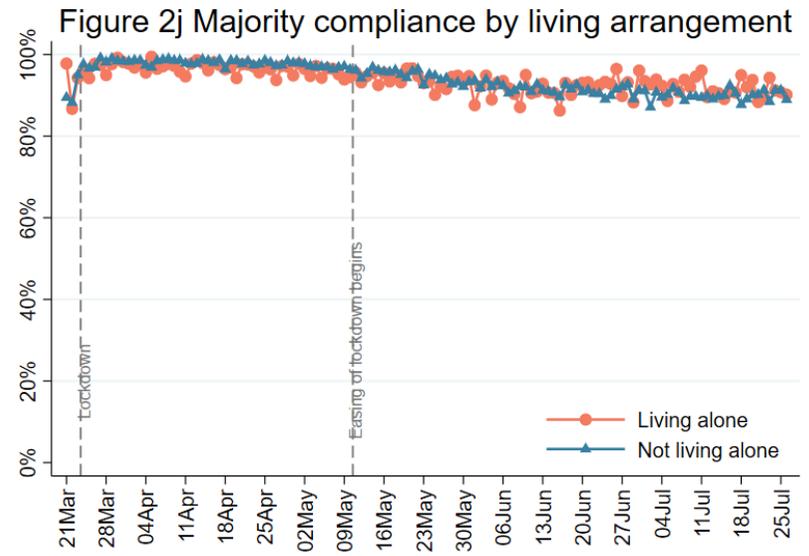
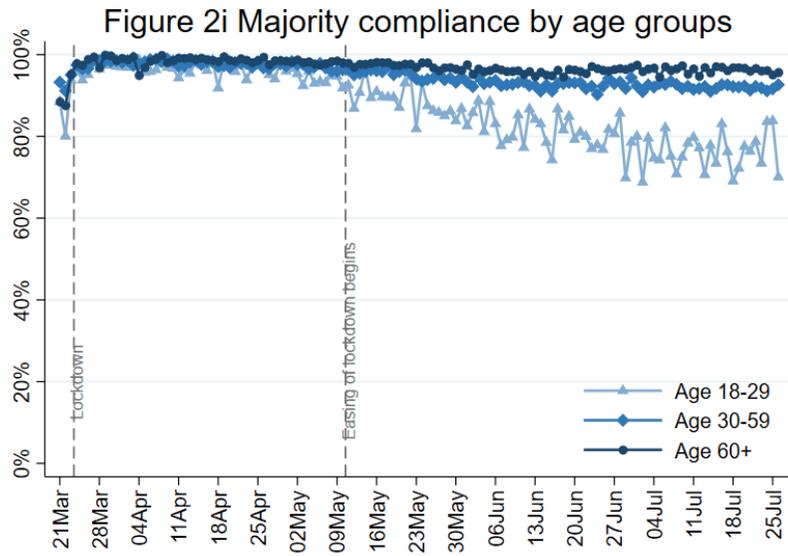


Figure 2m Majority compliance by nations

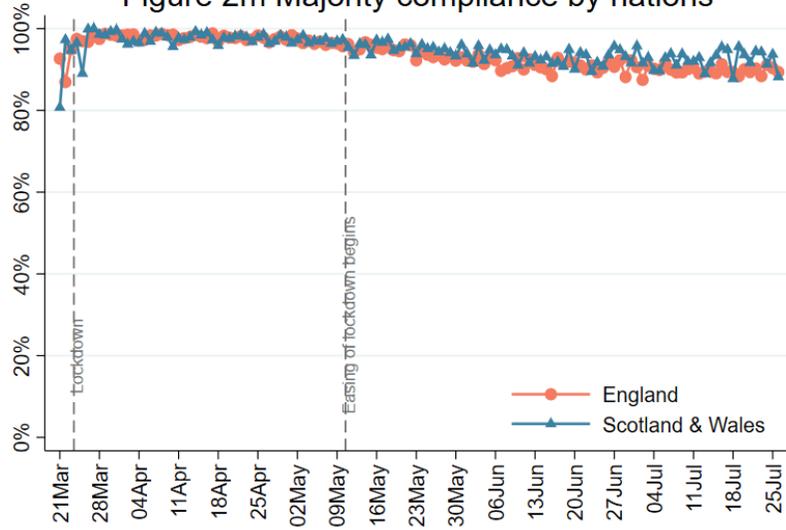


Figure 2n Majority compliance by keyworker status

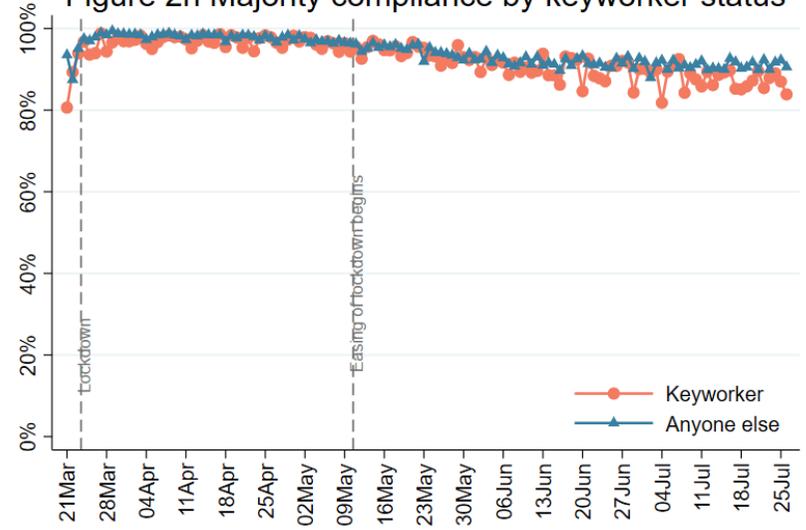


Figure 2o Majority compliance by living with children

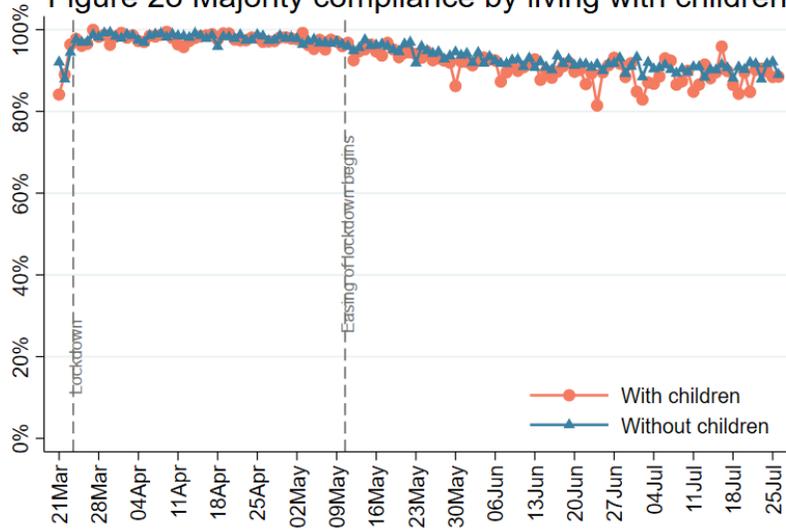
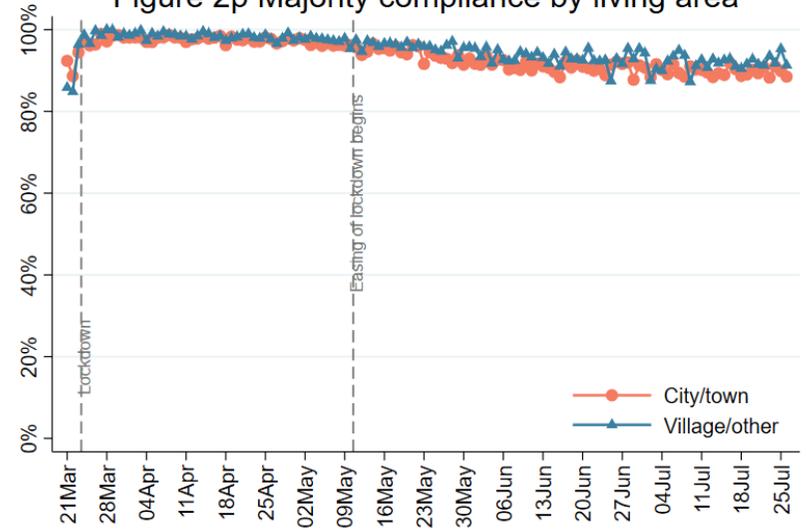
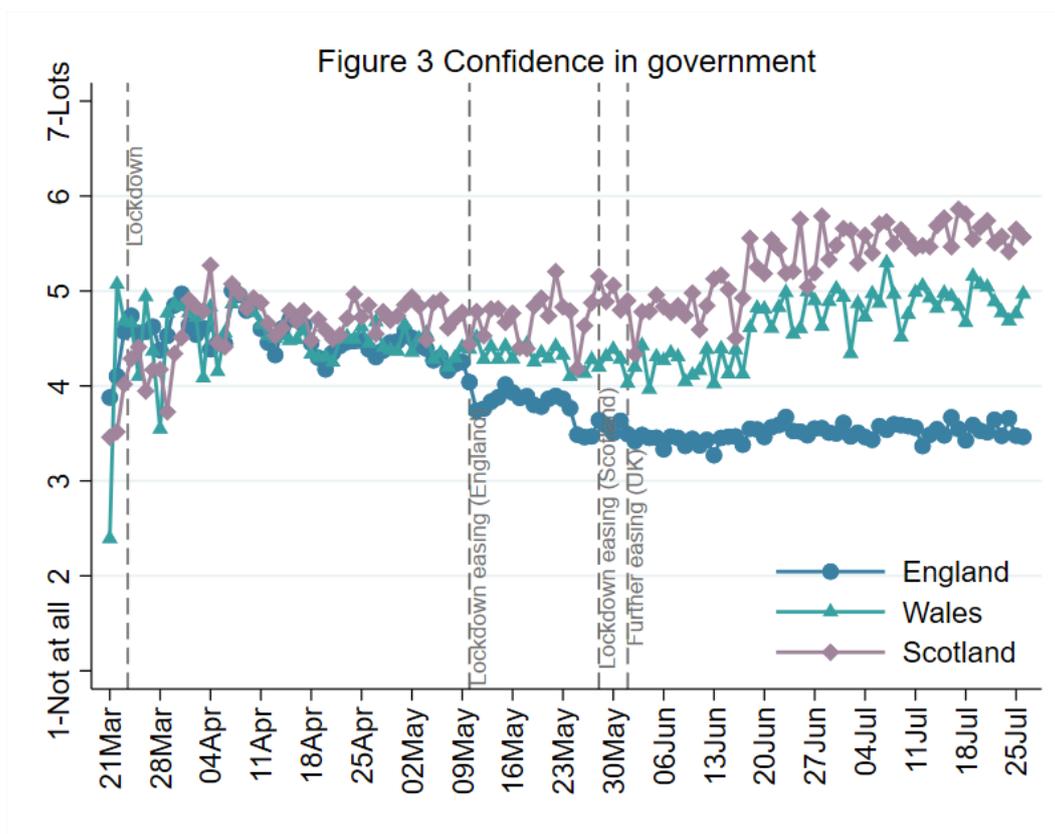


Figure 2p Majority compliance by living area



## 1.2 Confidence in Government



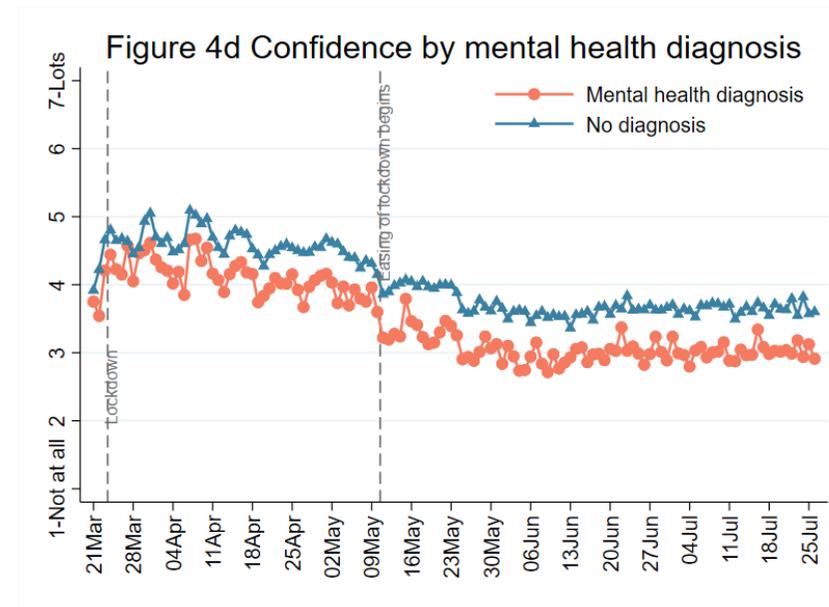
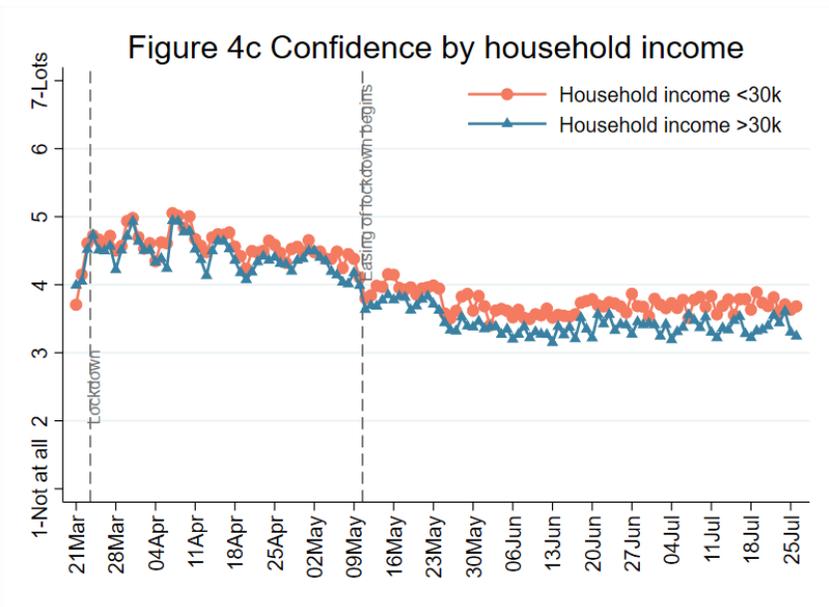
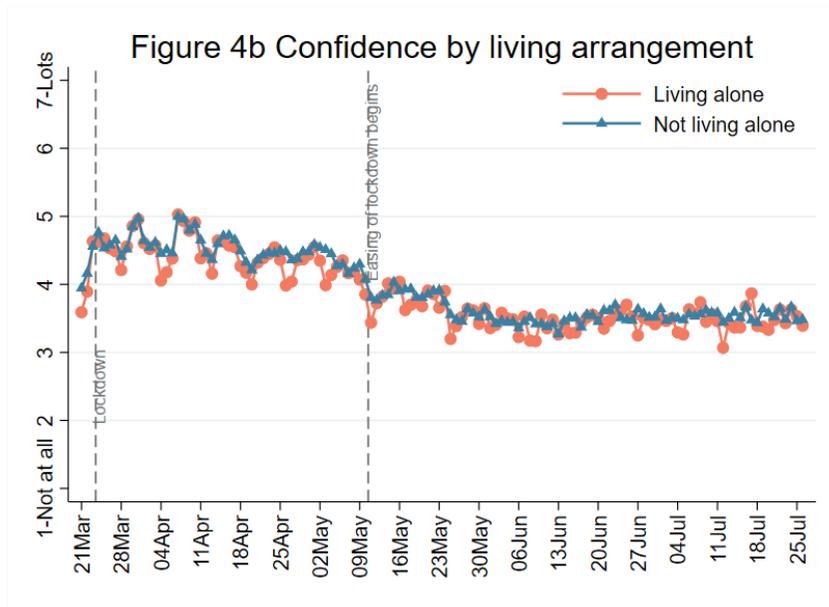
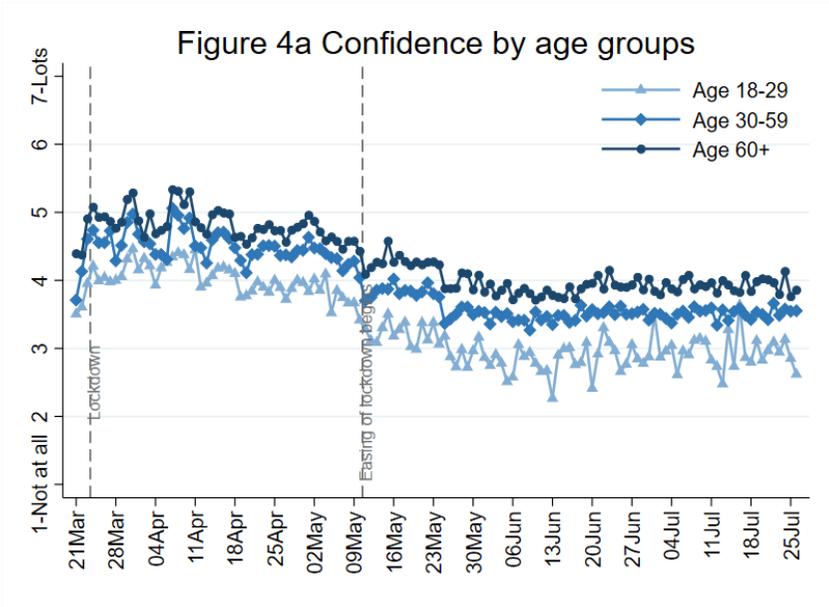
### FINDINGS

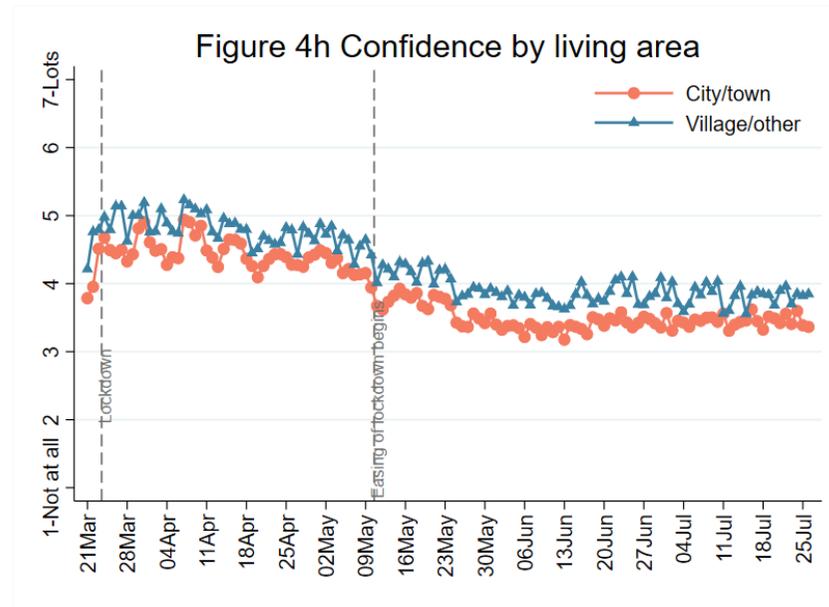
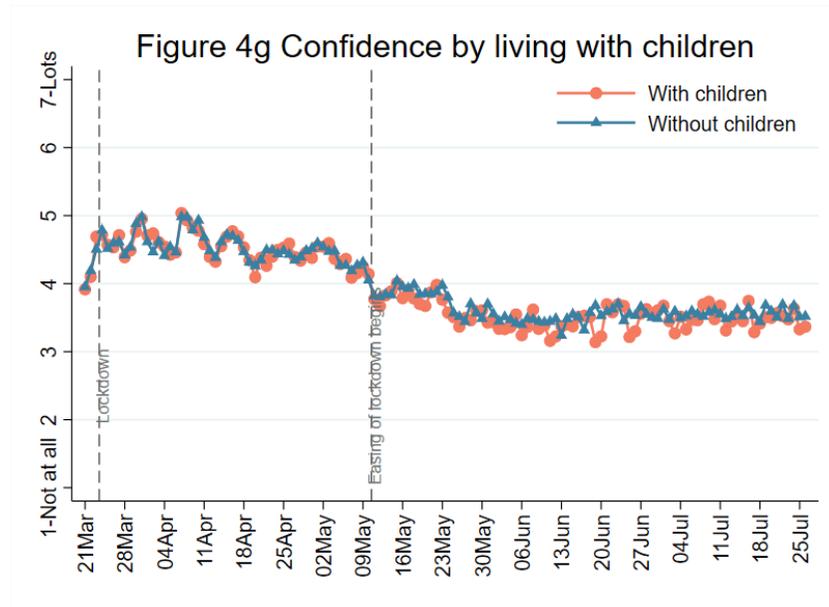
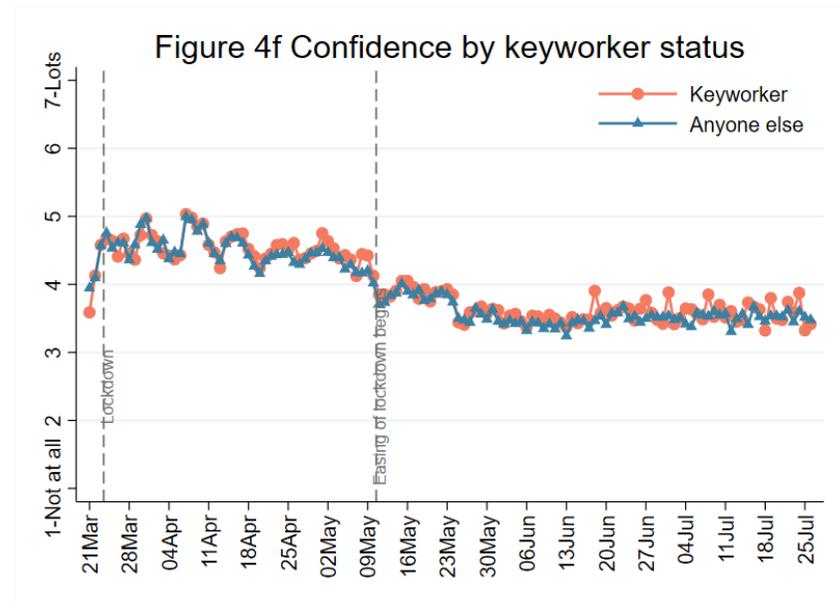
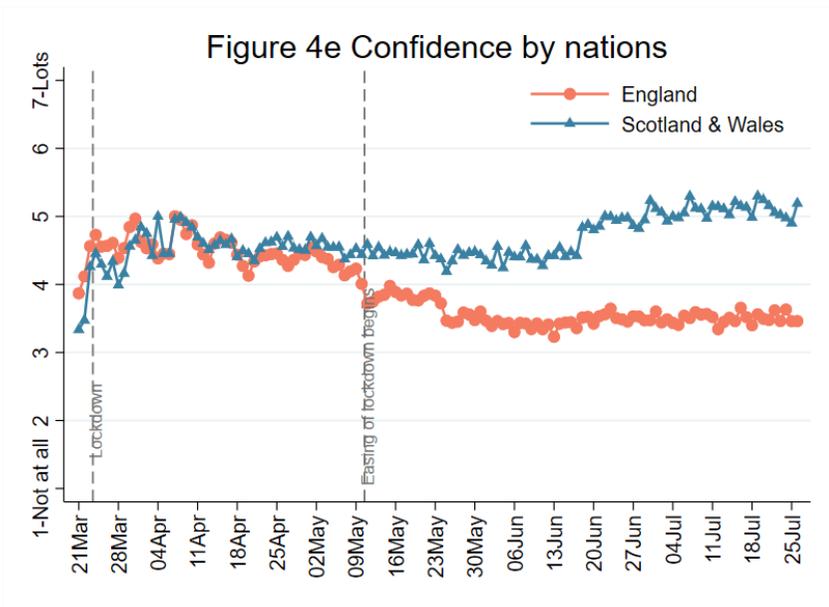
Respondents were asked how much confidence they had in the government to handle the Covid-19 epidemic from 1 (not at all) to 7 (lots). People living in devolved nations were asked to report their confidence in their own devolved governments.

Levels of confidence in the central government to handle the Covid-19 epidemic have remained constant over the past fortnight, with highest levels in Scotland and Wales and lowest levels in England.<sup>2</sup>

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 focusing on weekly rather than daily tracking will look at 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.

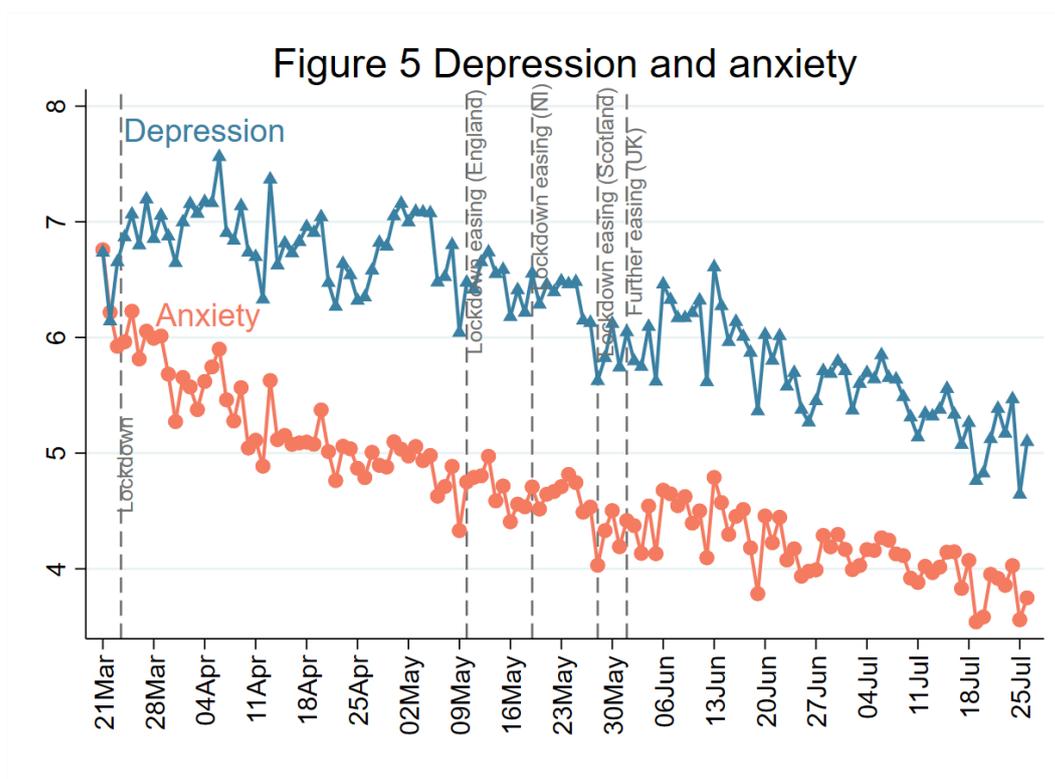
<sup>2</sup> Figures for Northern Ireland have now been removed from our daily tracker graphs due to a small sample size that makes extrapolation even with statistical weighting unreliable. These data are being analysed in other papers and reports.





## 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 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 fortnight, depression and anxiety levels have shown further improvements. 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<sup>3</sup>), but are returning towards these usual averages.

Decreases in depression and anxiety have occurred across every subgroup. However, 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), but they have on average experienced greater improvements in the past fortnight in depressive symptoms, starting to narrow the gap in experiences compared to individuals without a diagnosed mental illness.

<sup>3</sup> 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

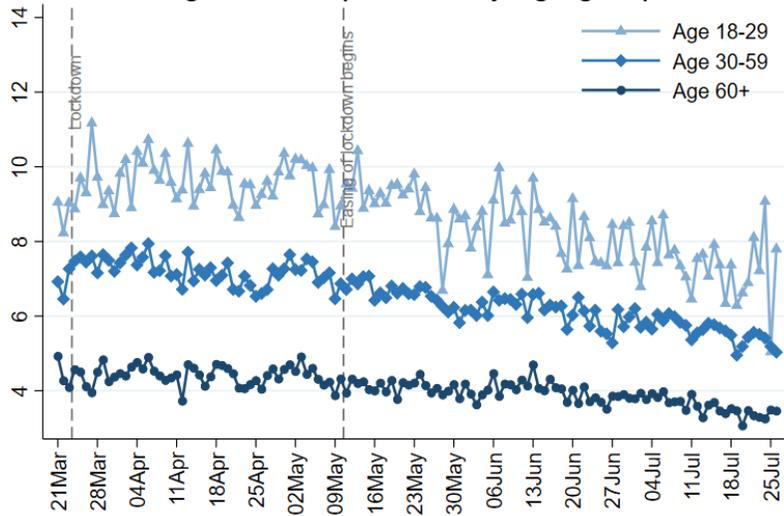


Figure 6b Depression by living arrangement

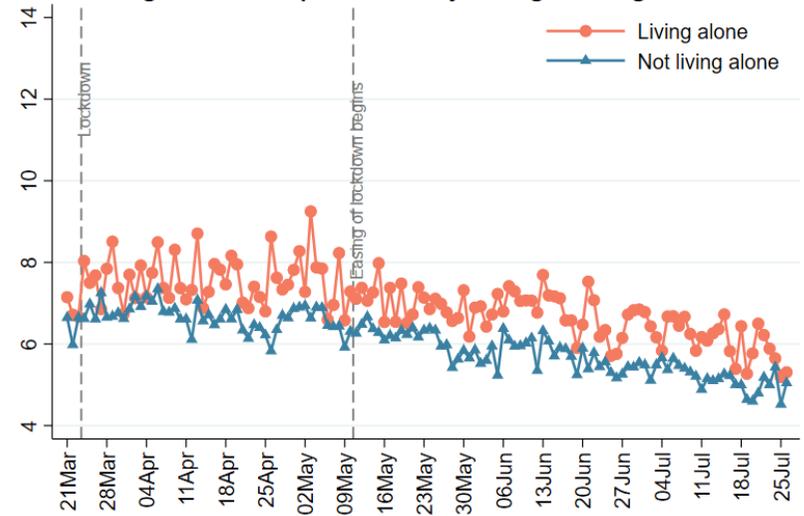


Figure 6c Depression by household income

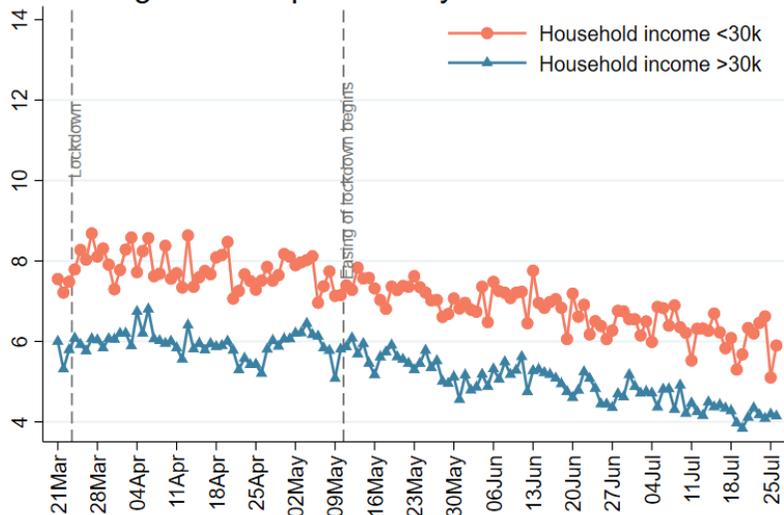


Figure 6d Depression by mental health diagnosis

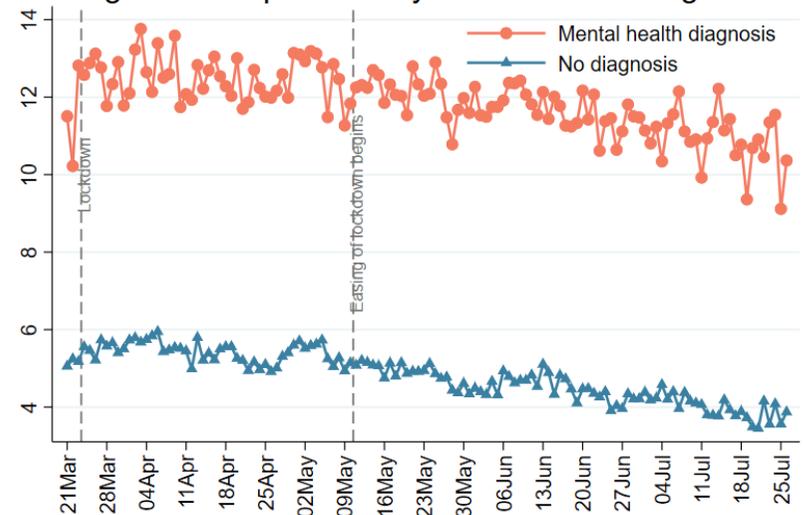


Figure 6e Depression by nations

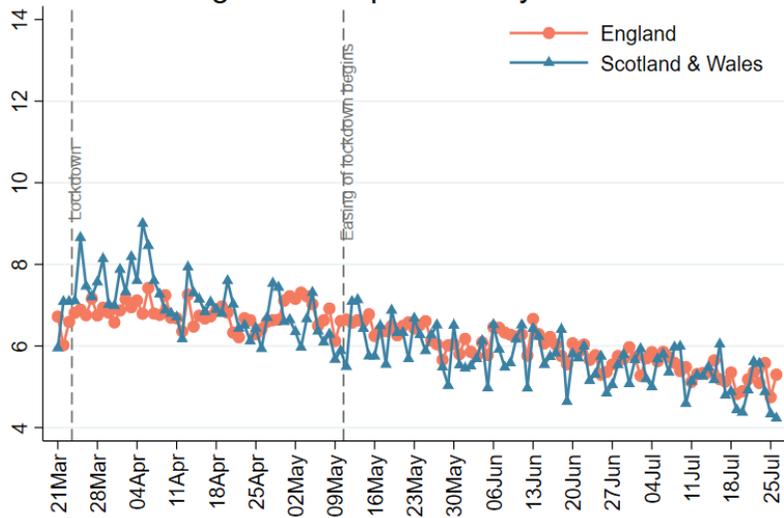


Figure 6f Depression by keyworker status

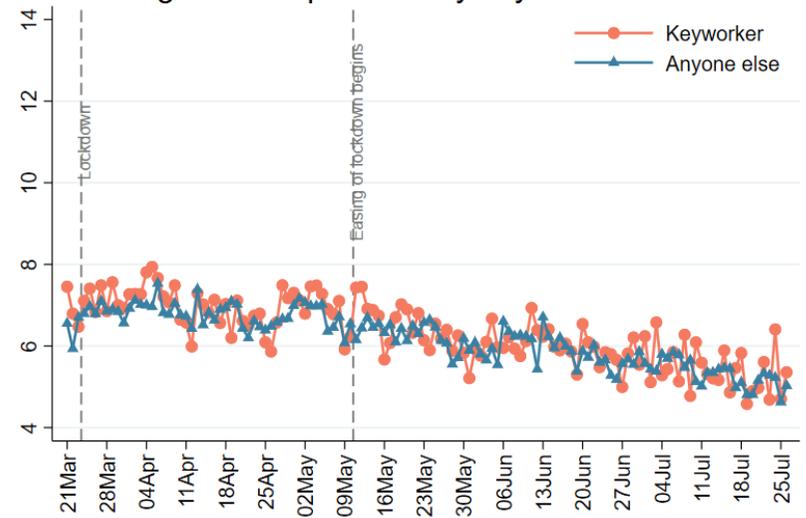


Figure 6g Depression by living with children

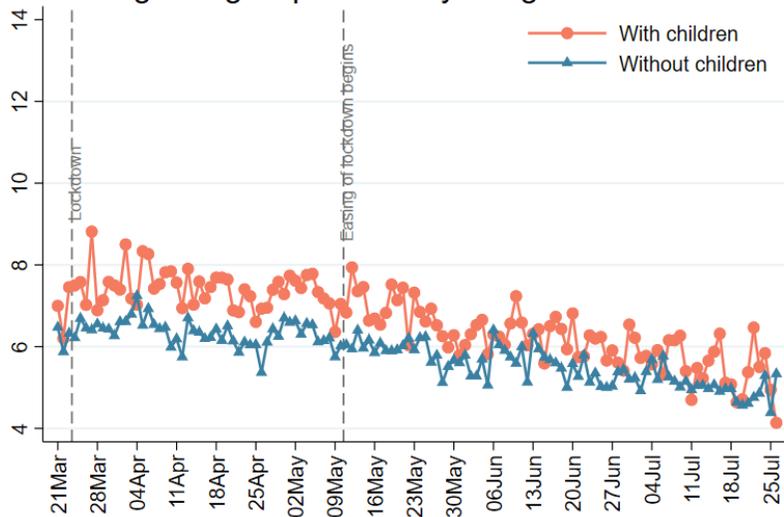


Figure 6h Depression by living area

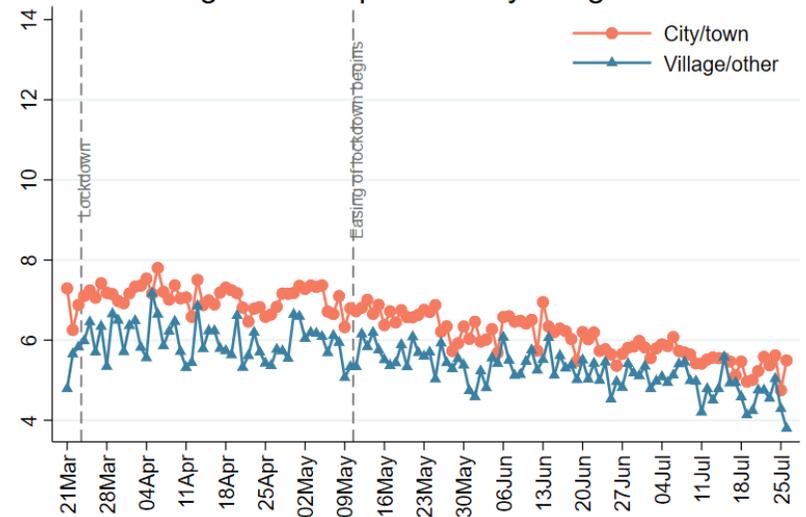


Figure 7a Anxiety by age groups

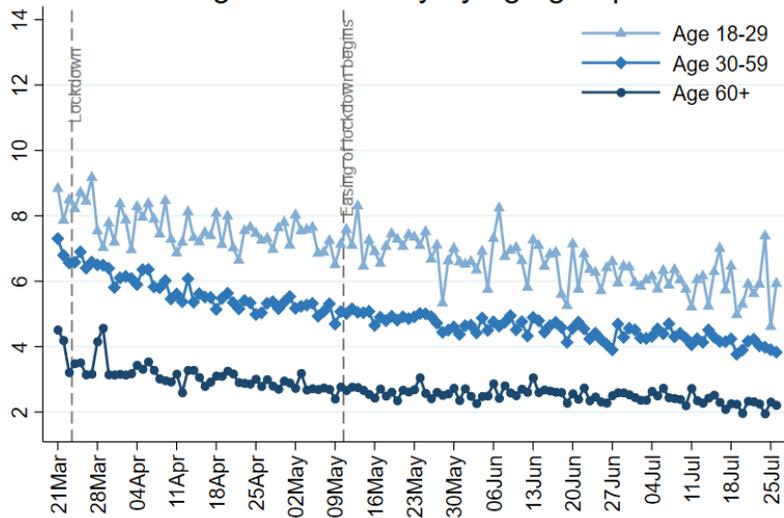


Figure 7b Anxiety by living arrangement

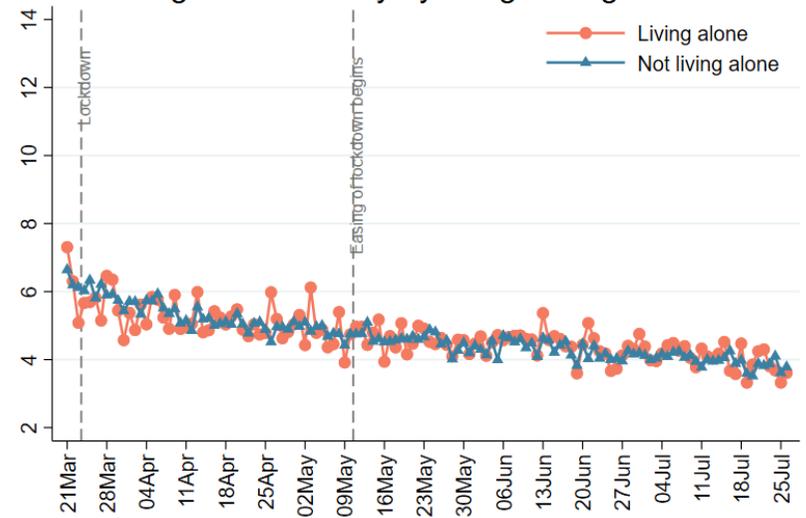


Figure 7c Anxiety by household income

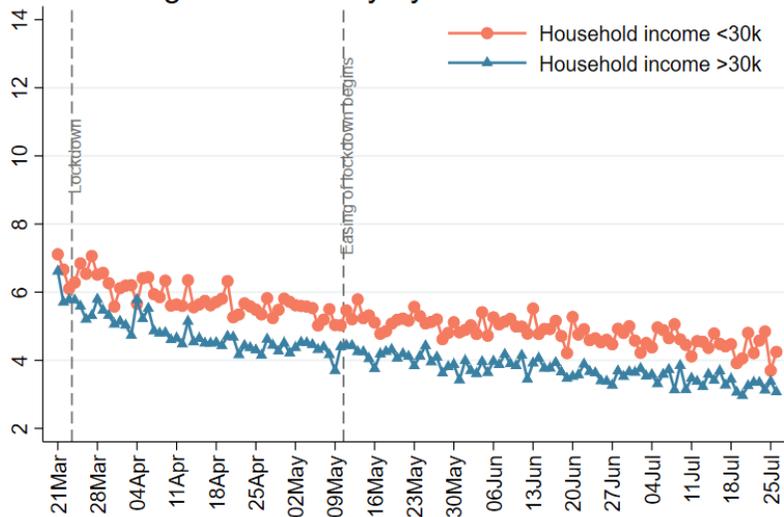


Figure 7d Anxiety by mental health diagnosis

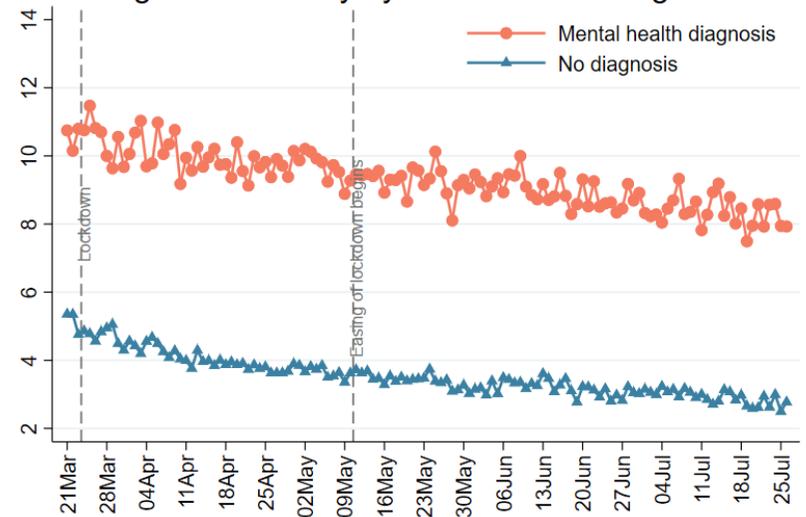


Figure 7e Anxiety by nations

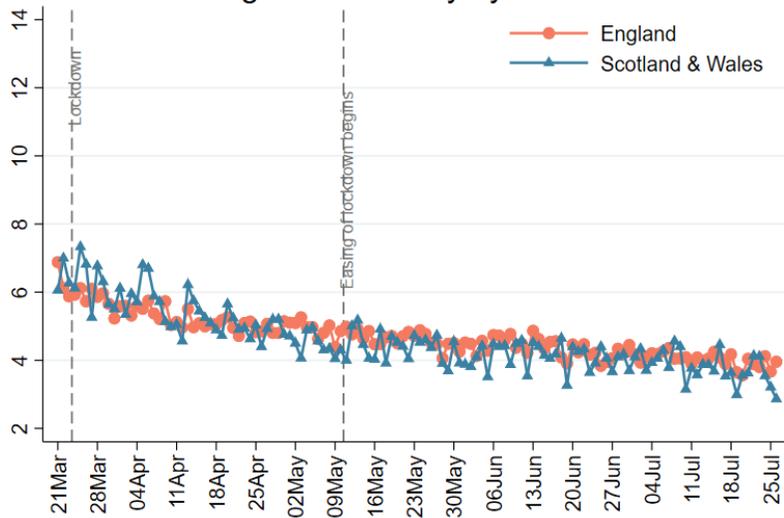


Figure 7f Anxiety by keyworker status

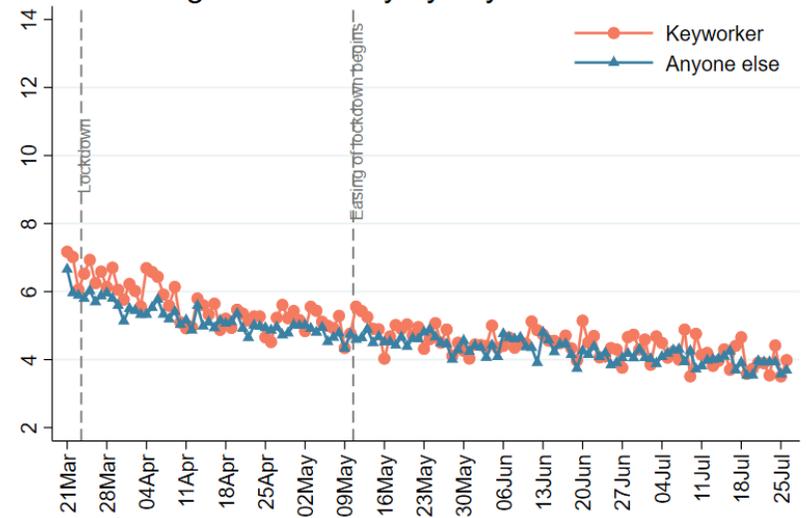


Figure 7g Anxiety by living with children

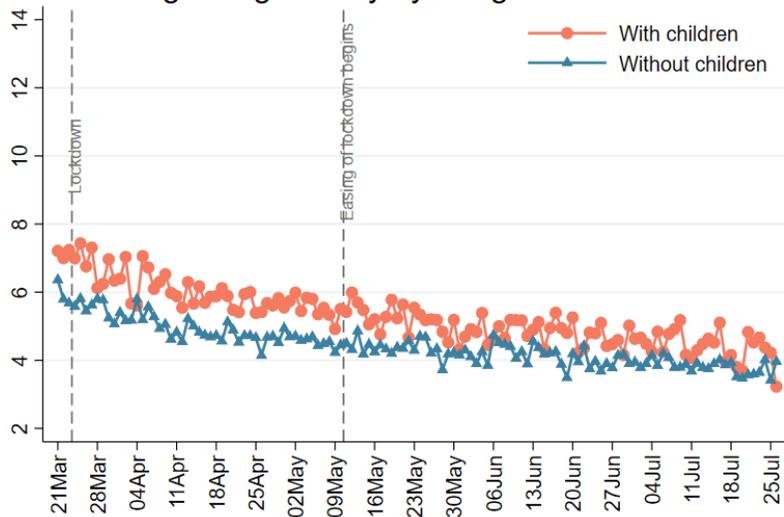
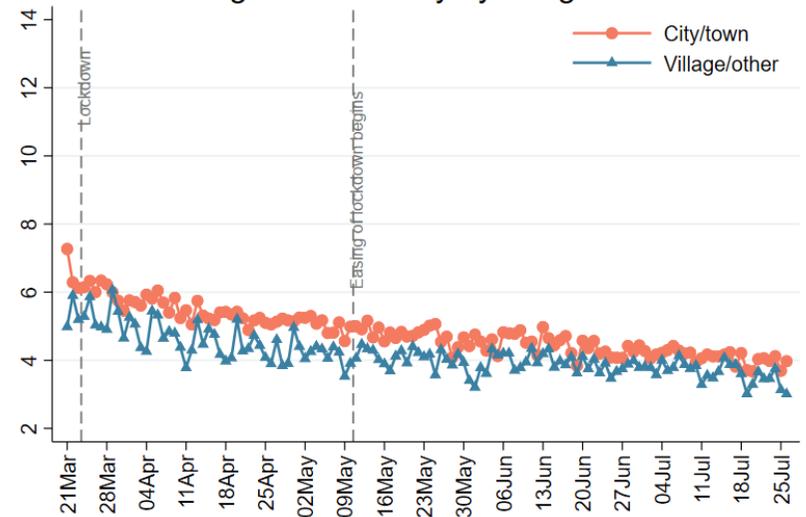
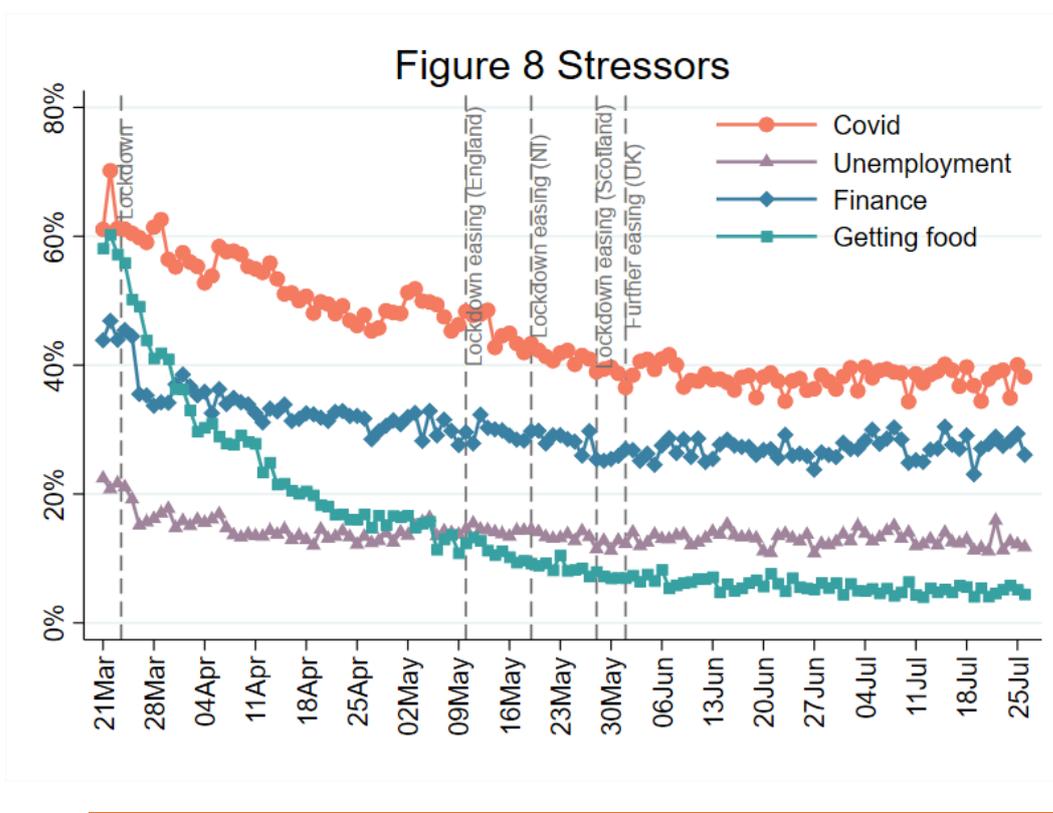


Figure 7h Anxiety by living area



## 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).

There has still been little change in people reporting major or minor stress due to catching COVID-19, unemployment, finance, or getting food in the past fortnight. Stress relating to Covid-19 (both catching Covid-19 and becoming seriously ill from Covid-19) remains the most prevalent stressor, but is still not affecting the majority of people, with fewer than 40% reporting it. Notably, worries about finance and unemployment have not risen for individuals, despite the end of furlough schemes nearing and more companies discussing redundancy measures. Just 1 in 4 people report being worried about finance and 1 in 6 worried about unemployment. Worries about access to food are still only affecting around 1 in 20 people, but this residual worry is remaining.

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. People living with children have worried more about all factors, but the differences on worries relating to Covid-19 and food access have diminished as lockdown has eased. Older adults have worried less about unemployment and food. Unemployment has worried people in England and in urban areas more.

Figure 9a Covid-19 stress by age groups

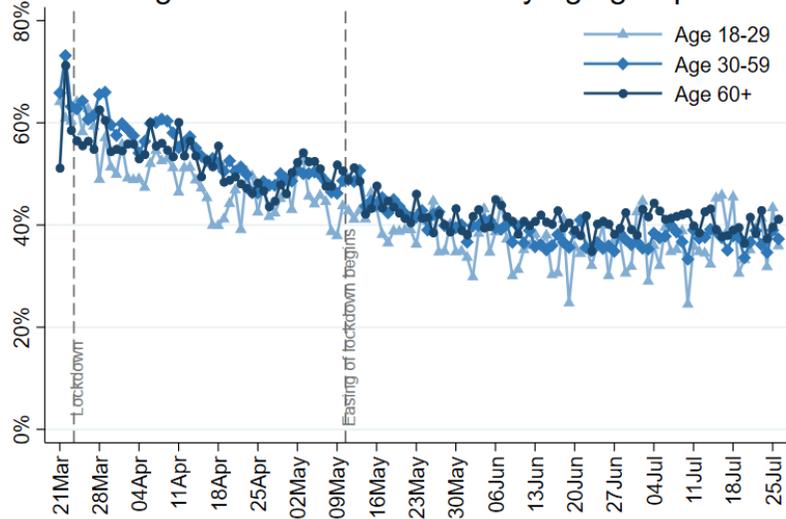


Figure 9b Covid-19 stress by living arrangement

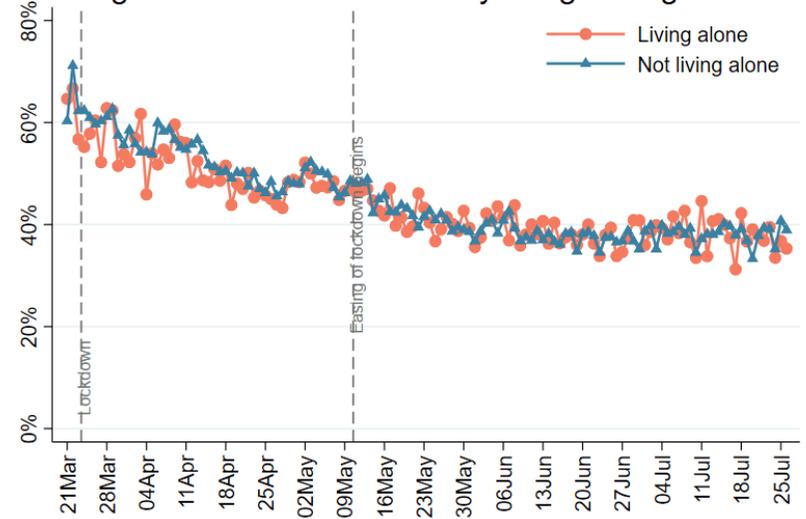


Figure 9c Covid-19 stress by household income

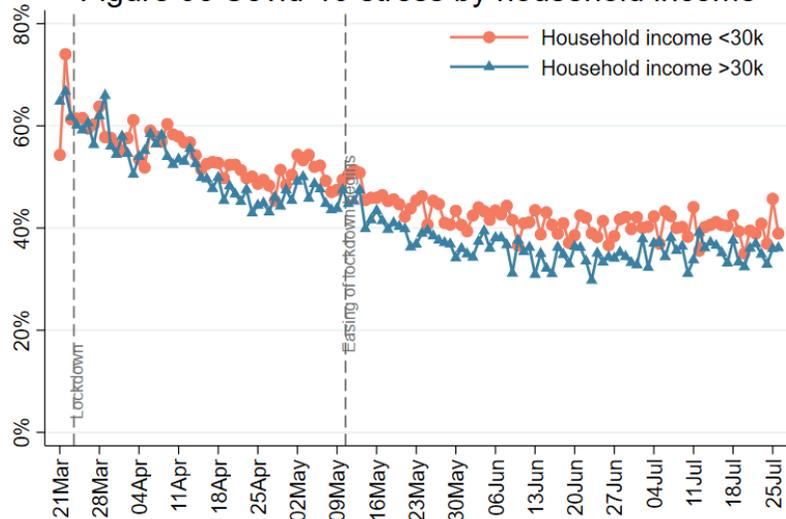


Figure 9d Covid-19 stress by mental health diagnosis

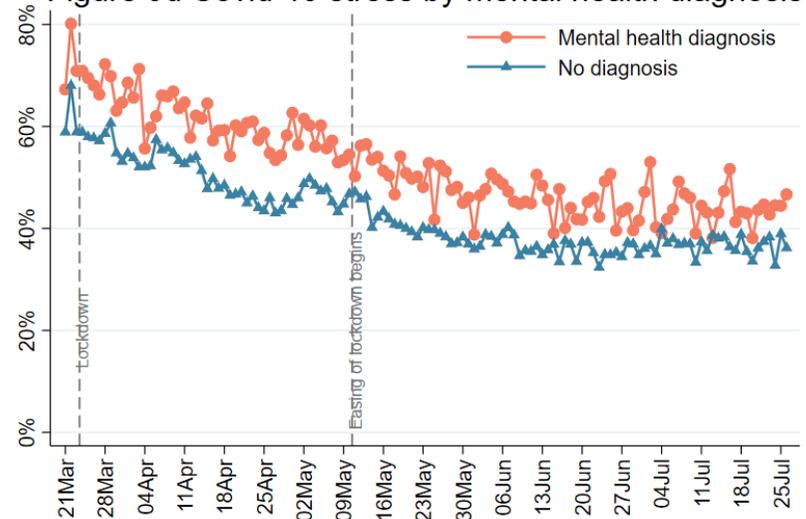


Figure 9e Covid-19 stress by nations

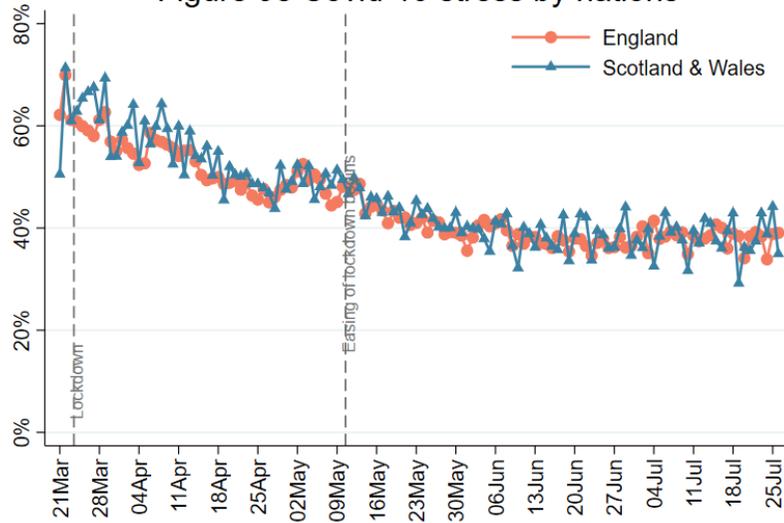


Figure 9f Covid-19 stress by keyworker status

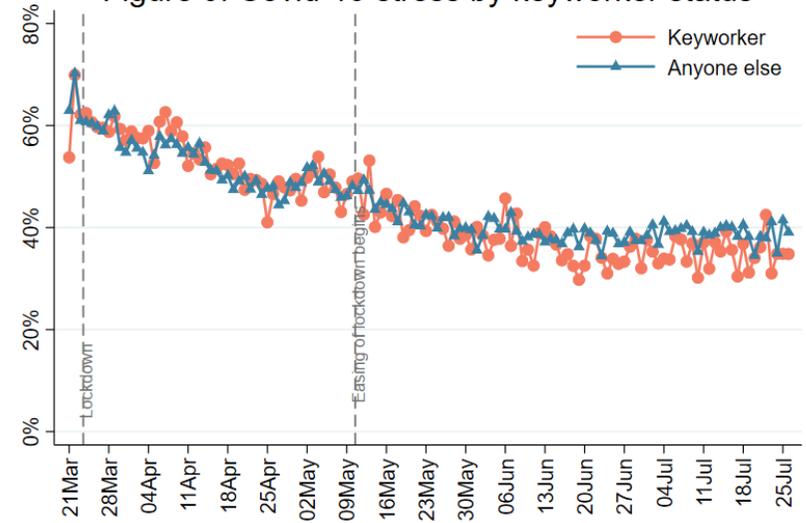


Figure 9g Covid-19 stress by living with children

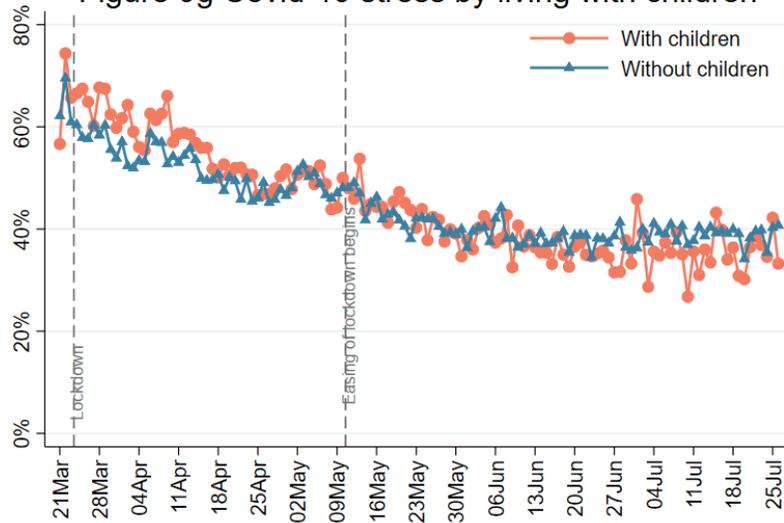


Figure 9h Covid-19 stress by living area

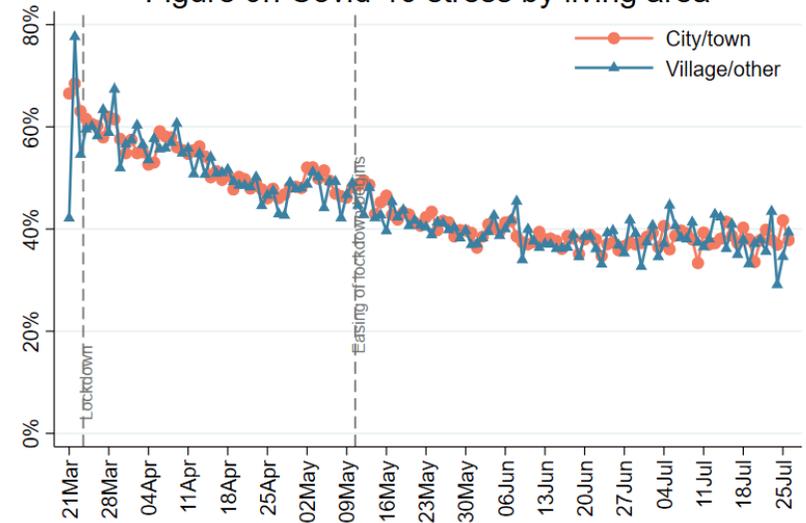


Figure 10a Unemployment stress by age groups

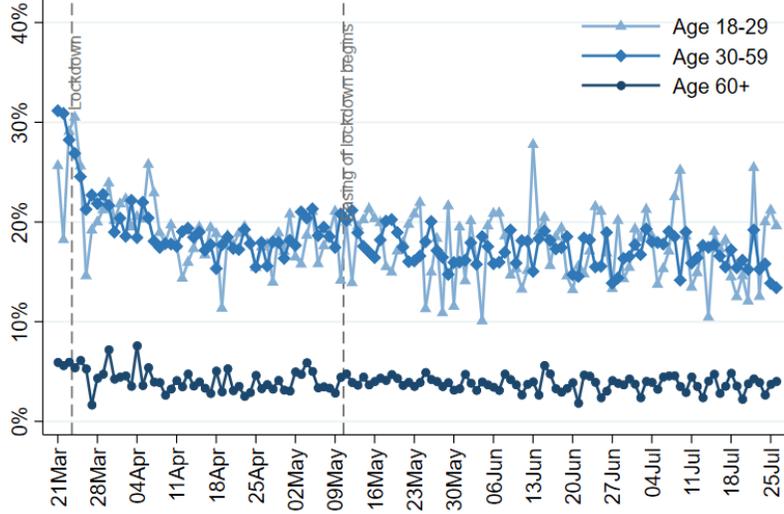


Figure 10b Unemployment stress by living arrangement

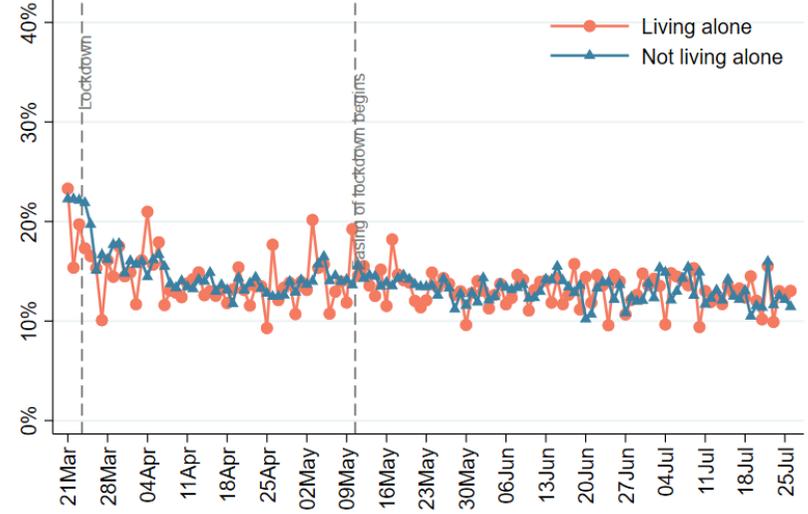


Figure 10c Unemployment stress by household income

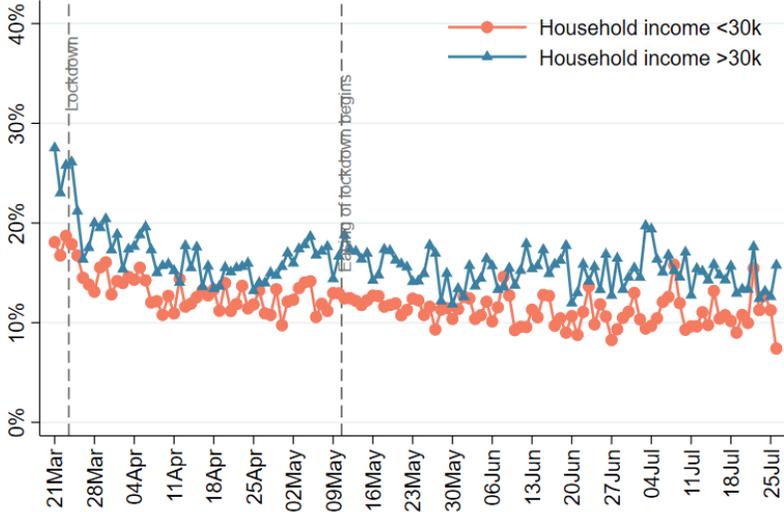


Figure 10d Unemployment stress by mental health

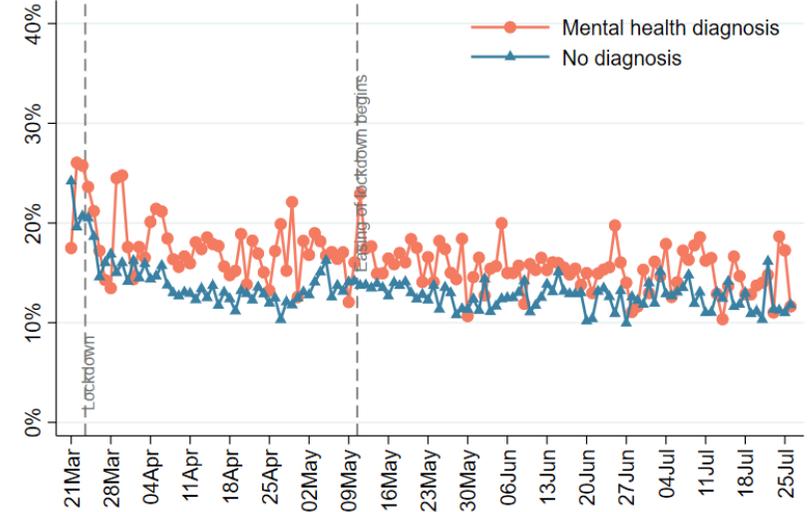


Figure 10e Unemployment stress by nations

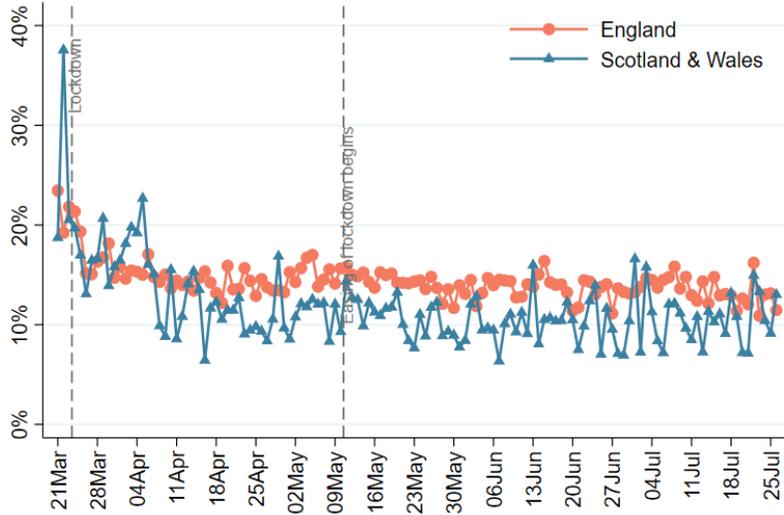


Figure 10f Unemployment stress by keyworker status

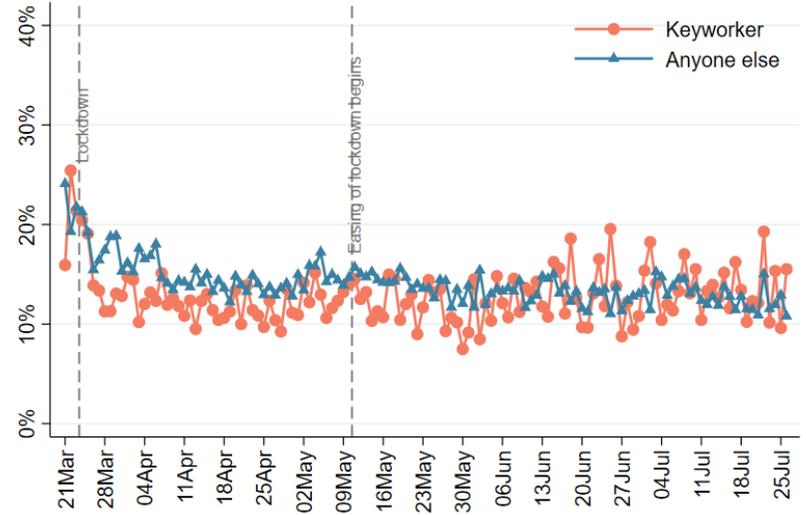


Figure 10g Unemployment stress by living with children

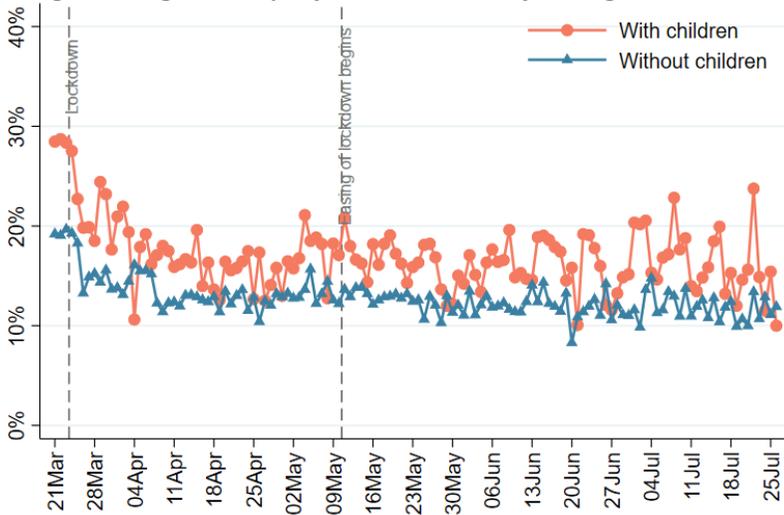


Figure 10h Unemployment stress by living area

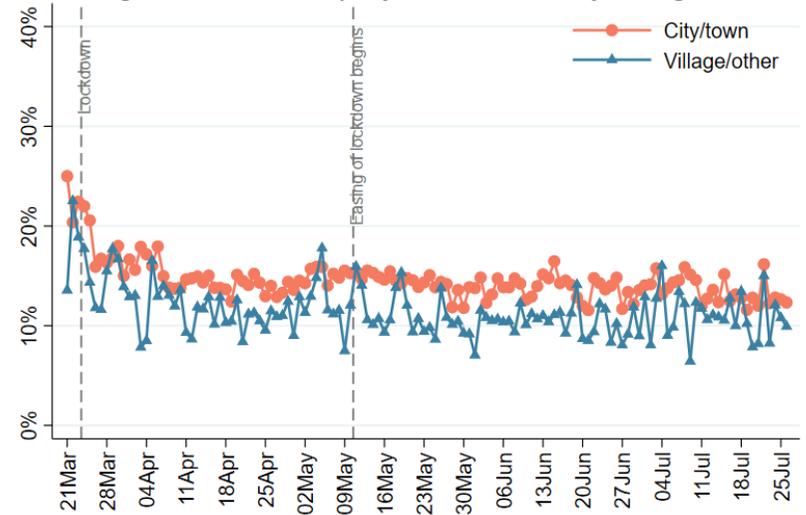


Figure 11a Financial stress by age groups

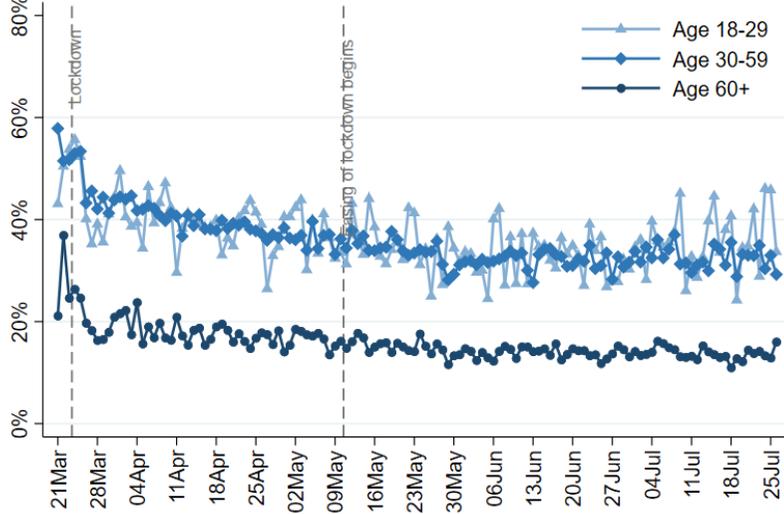


Figure 11b Financial stress by living arrangement

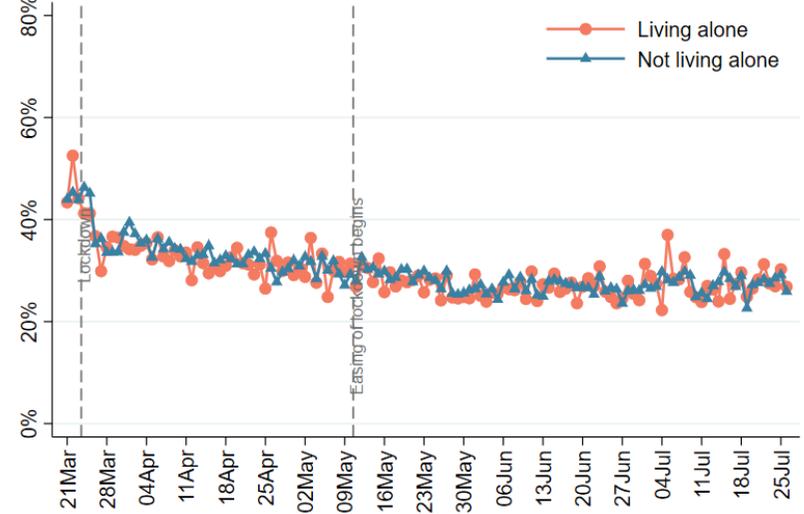


Figure 11c Financial stress by household income

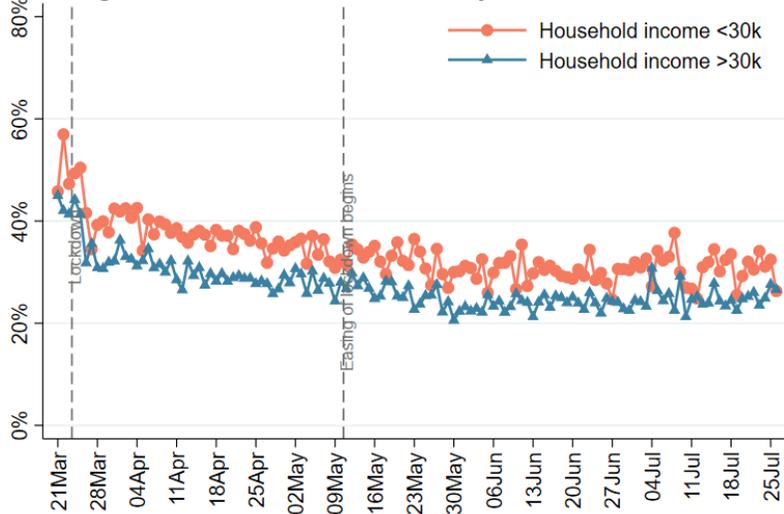


Figure 11d Financial stress by mental health diagnosis

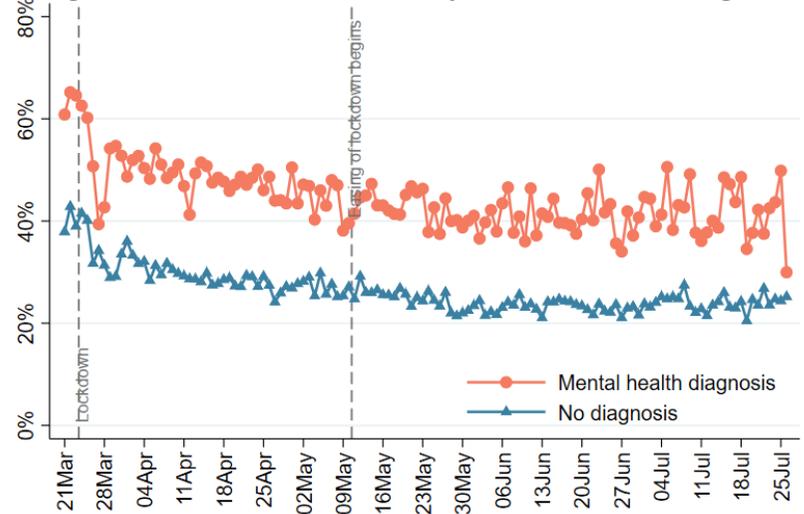


Figure 11e Financial stress by nations

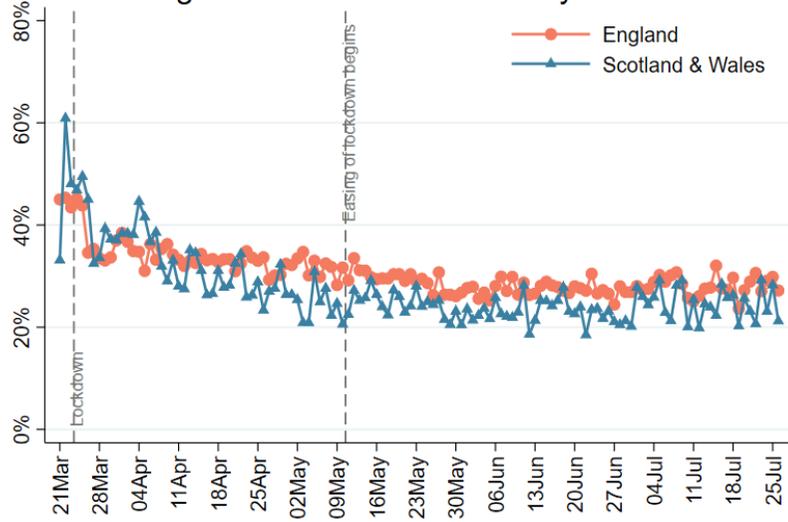


Figure 11f Financial stress by keyworker status

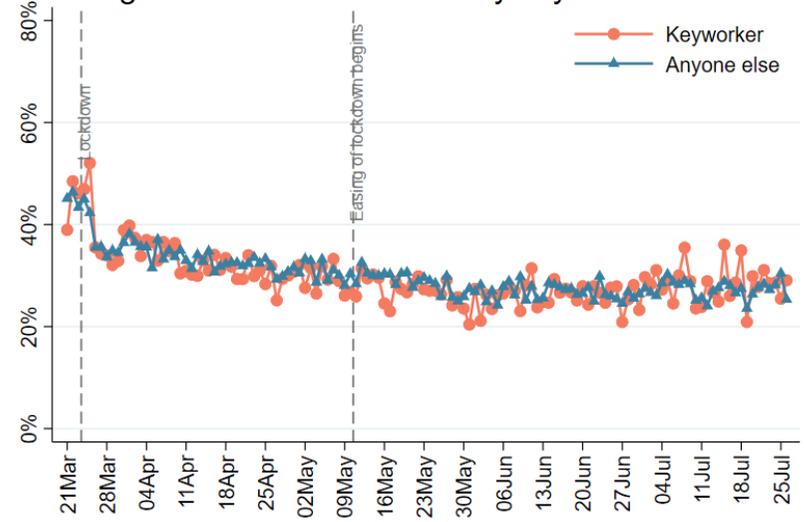


Figure 11g Financial stress by living with children

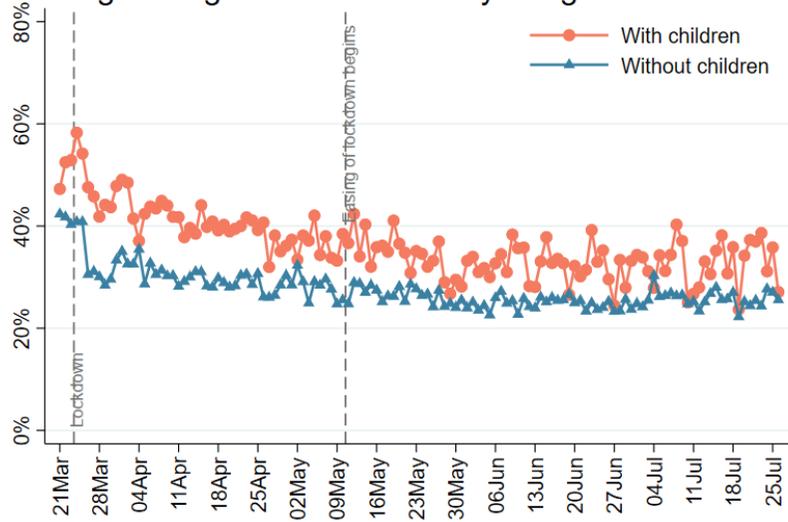
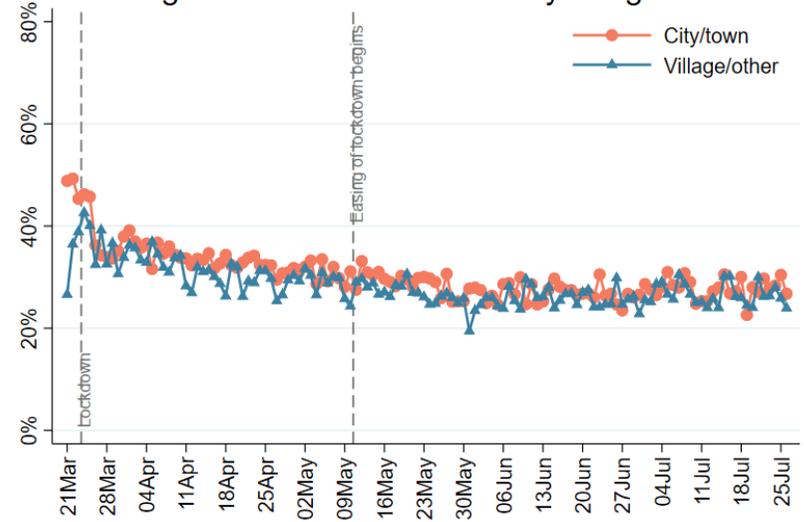


Figure 11h Financial stress by living area



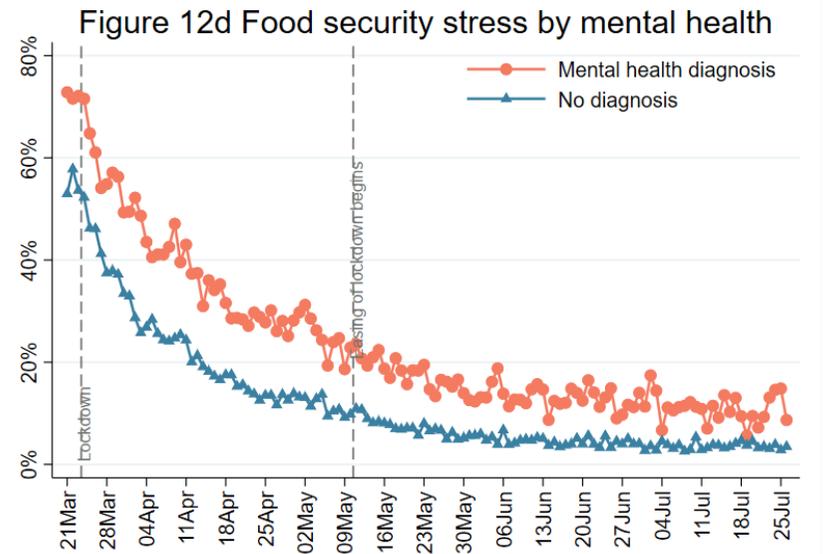
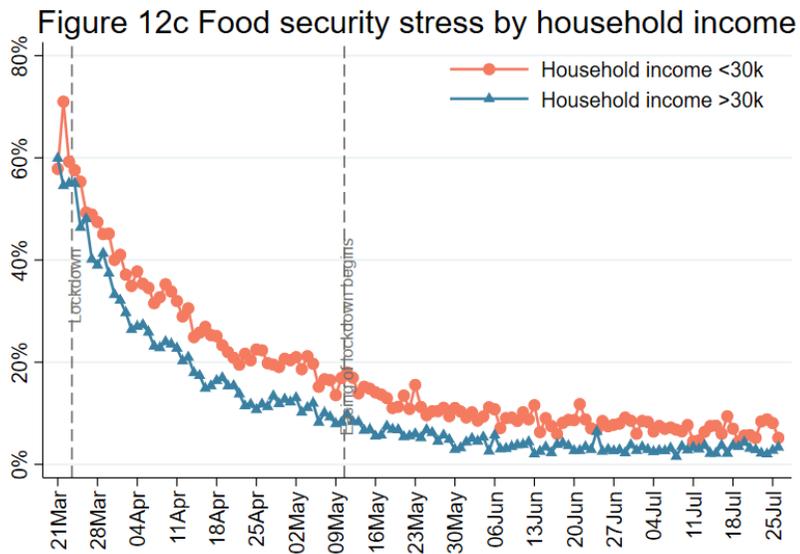
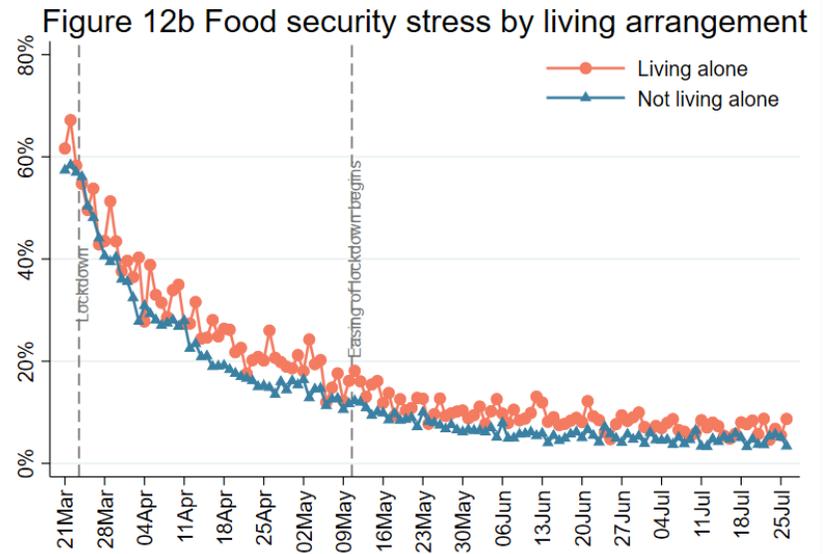
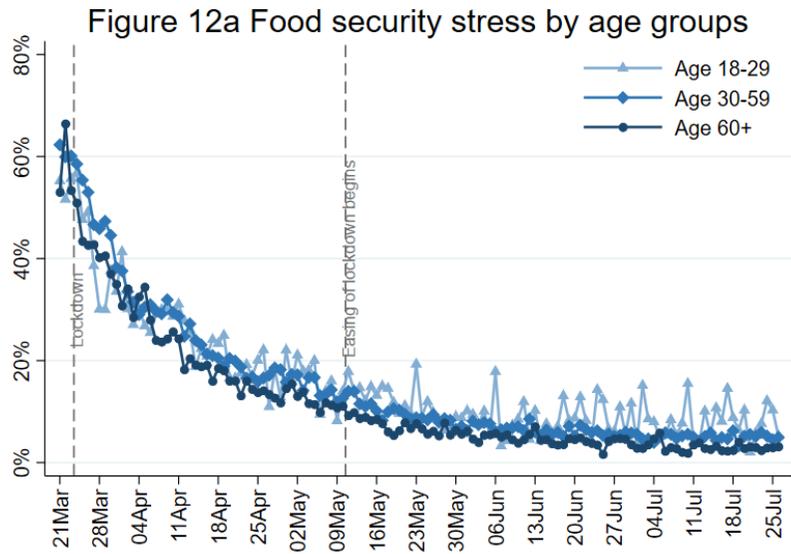


Figure 12e Food security stress by nations

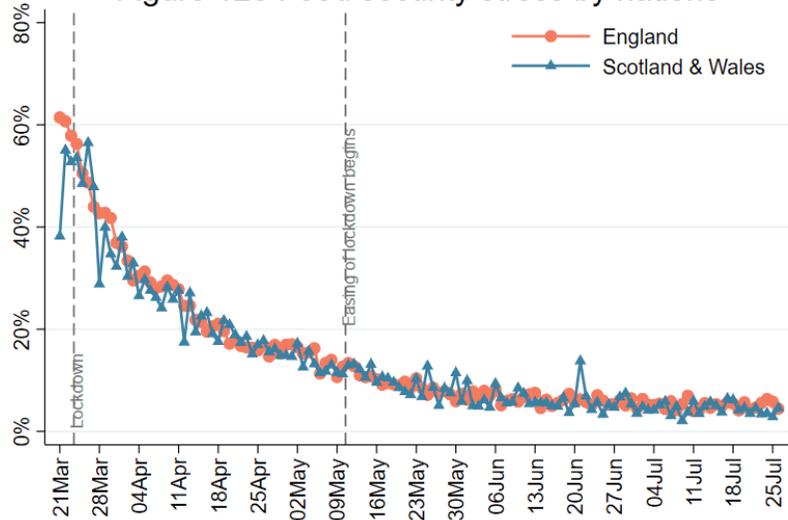


Figure 12f Food security stress by keyworker status

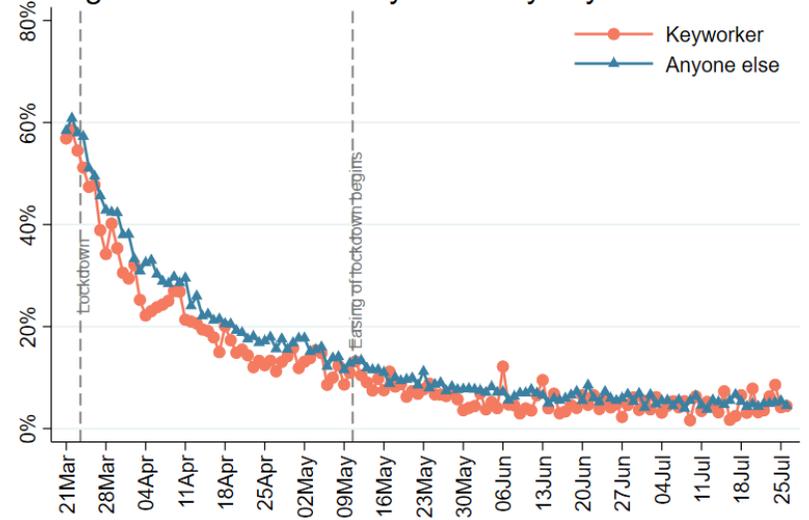


Figure 12g Food security stress by living with children

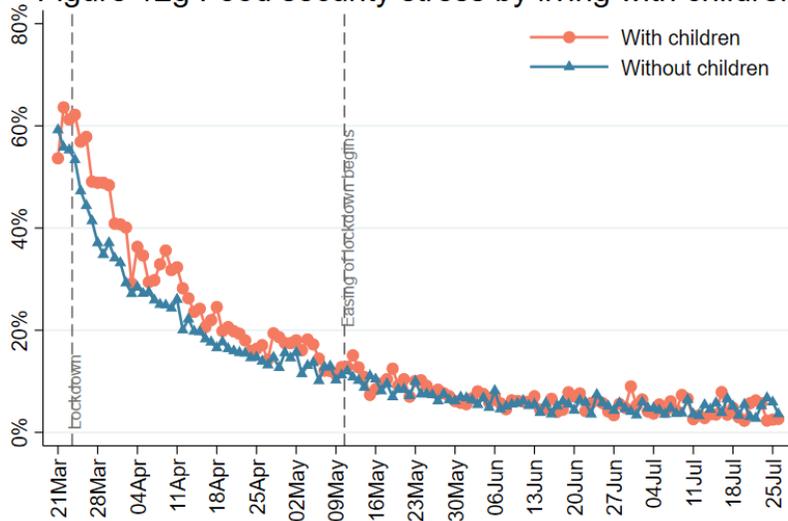
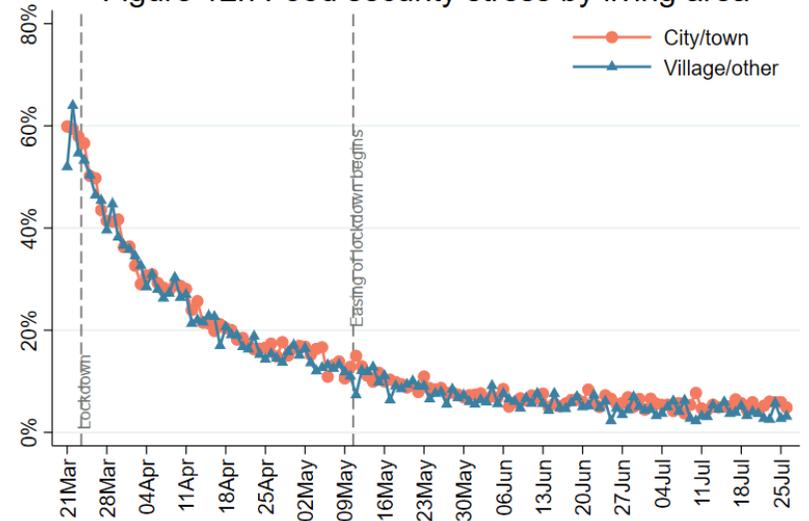
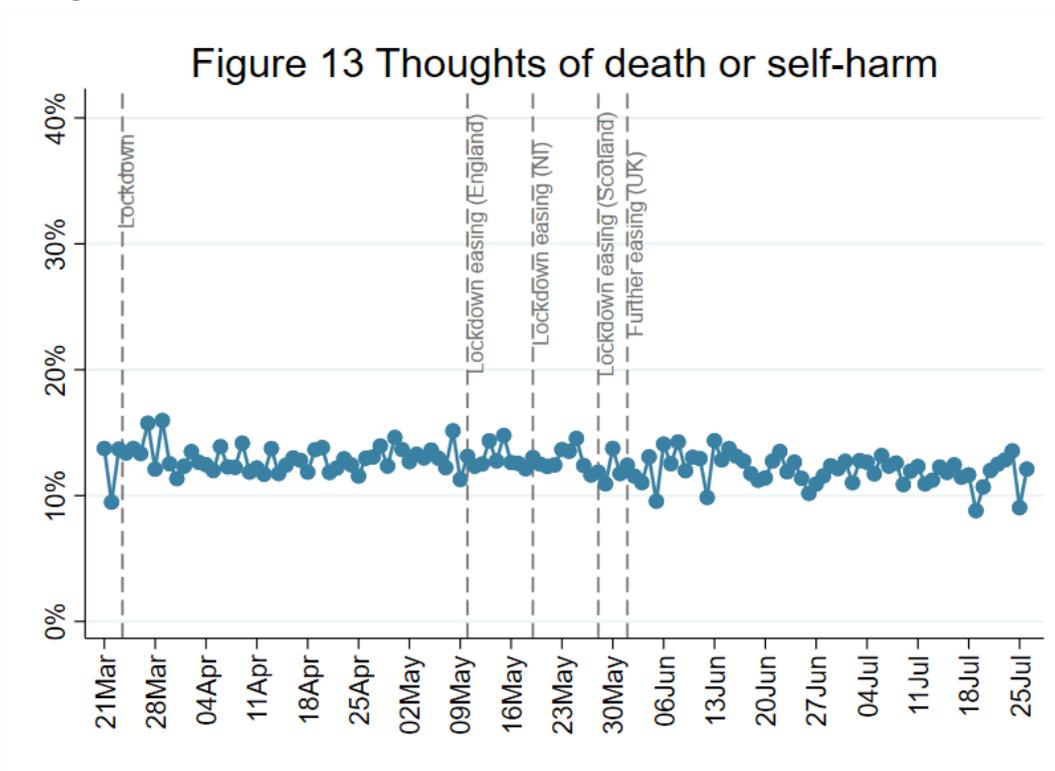


Figure 12h Food security stress by living area



### 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, 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 since the easing of lockdown was announced. Percentages of people having thoughts of death or self-harm have been relatively stable throughout the past 19 weeks. They remain higher amongst younger adults, 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.

Figure 14a Thoughts of death by age groups

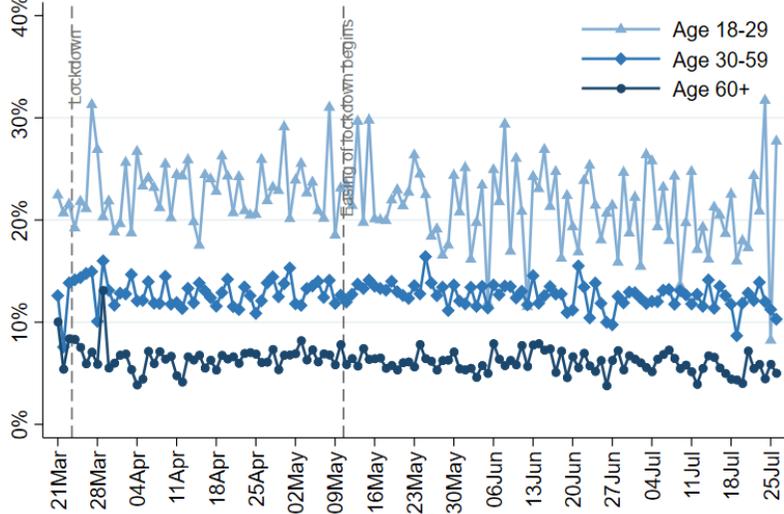


Figure 14b Thoughts of death by living arrangement

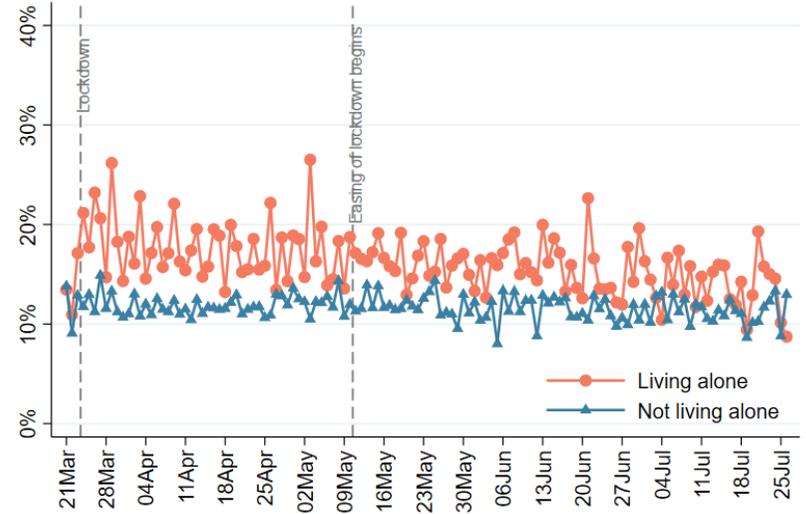


Figure 14c Thoughts of death by household income

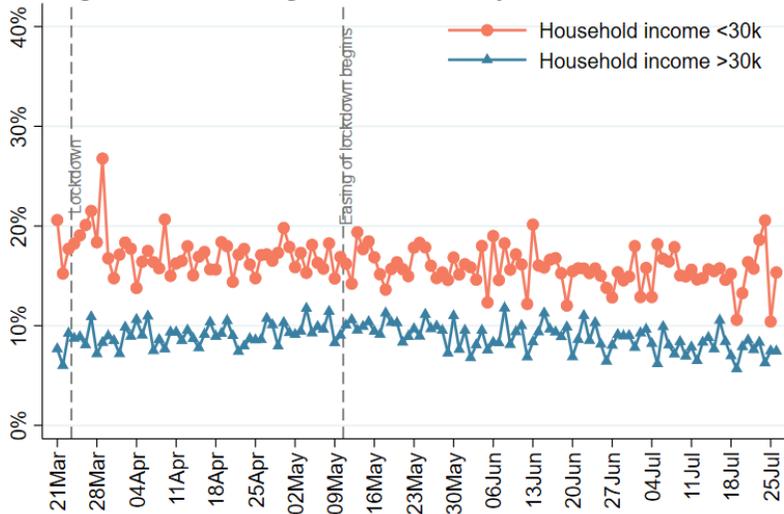


Figure 14d Thoughts of death by mental health diagnosis

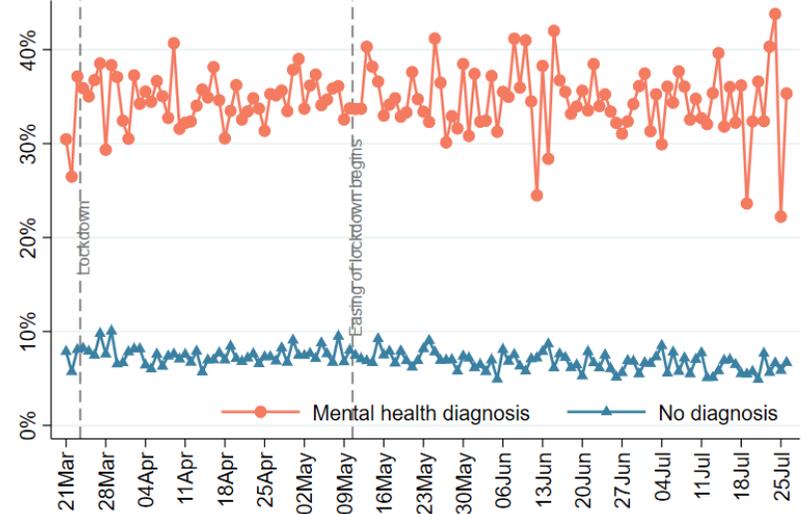


Figure 14e Thoughts of death by nations

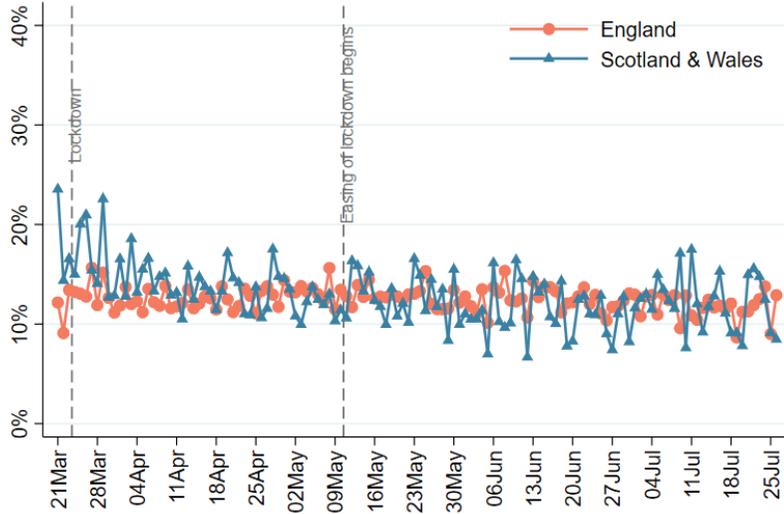


Figure 14f Thoughts of death by keyworker status

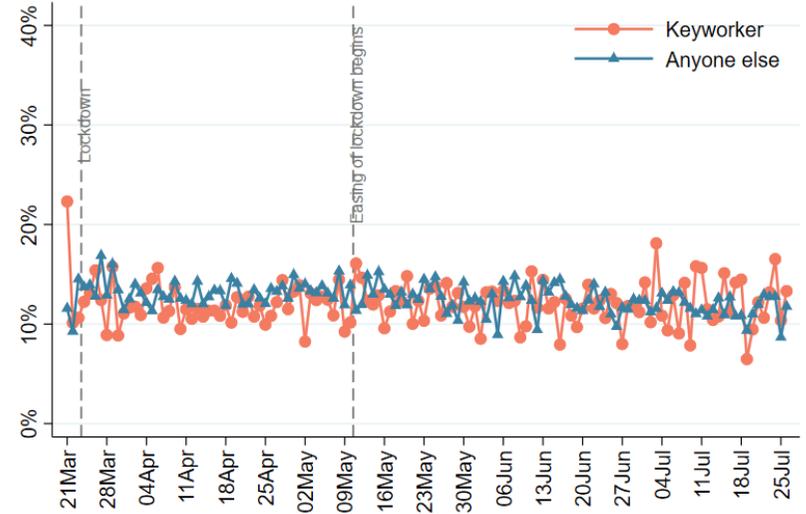


Figure 14g Thoughts of death by living with children

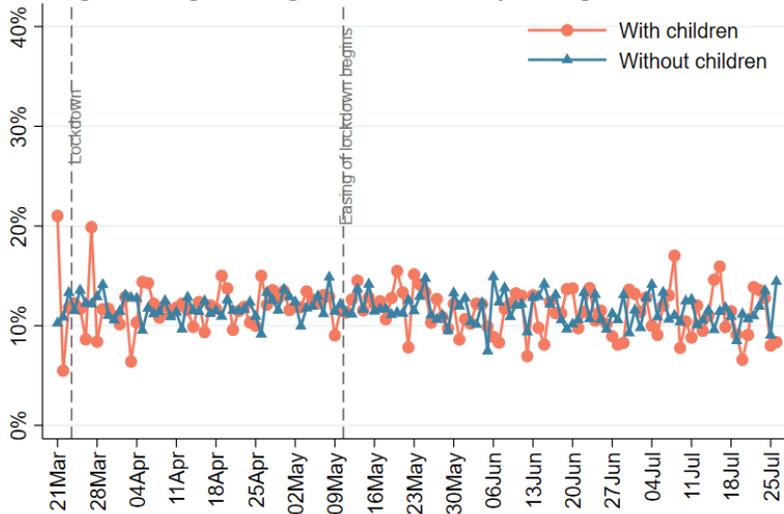
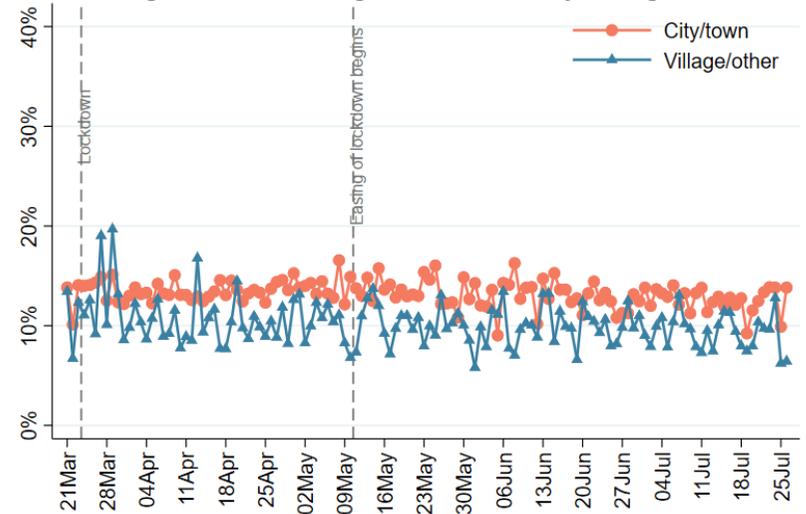
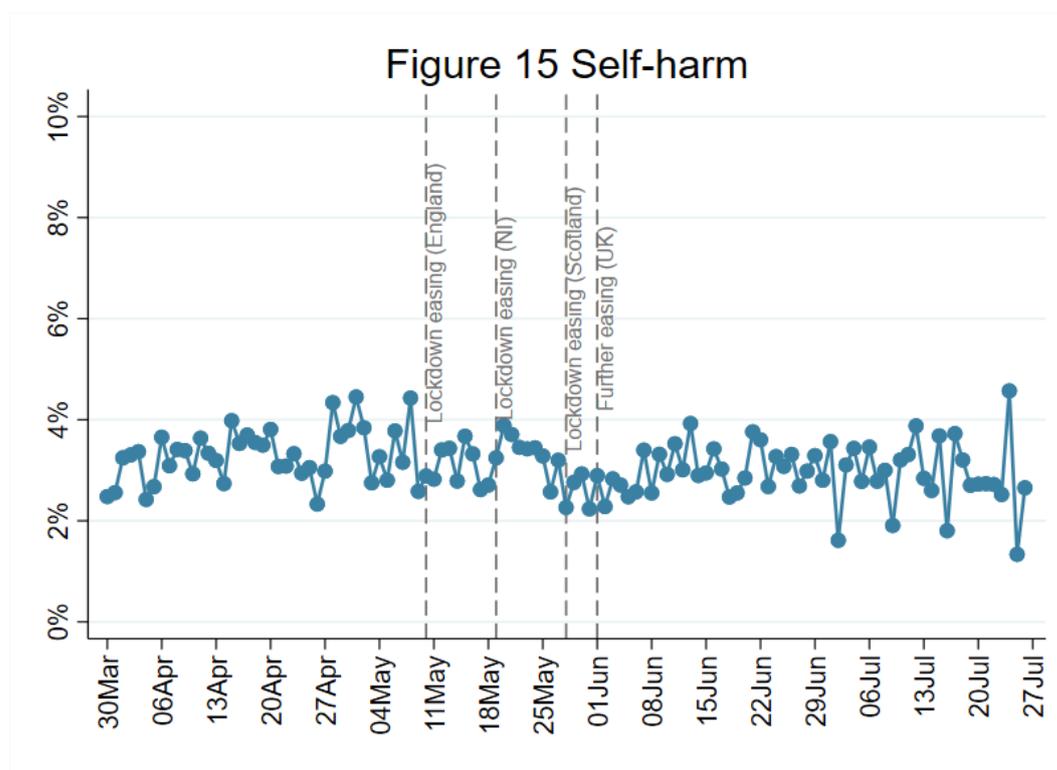


Figure 14h Thoughts of death by living area



## 3.2 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 since the easing of lockdown was announced. Consistently across lockdown, 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.<sup>4</sup>

<sup>4</sup> 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

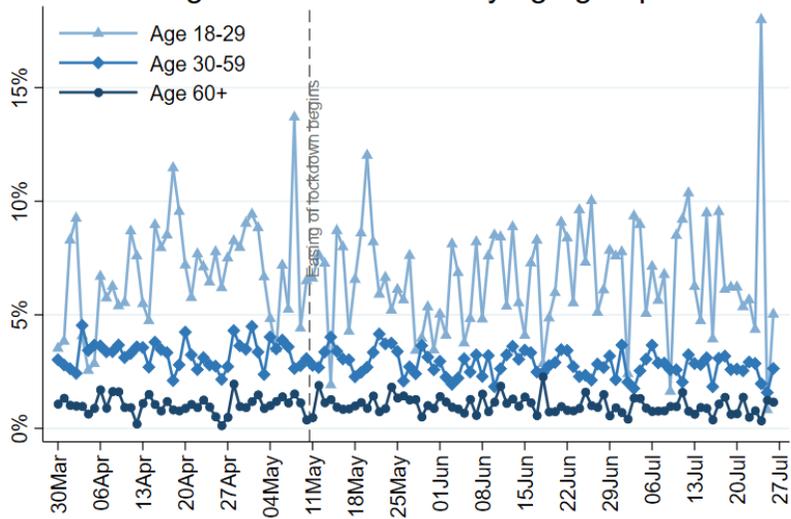


Figure 16b Self-harm by living arrangement

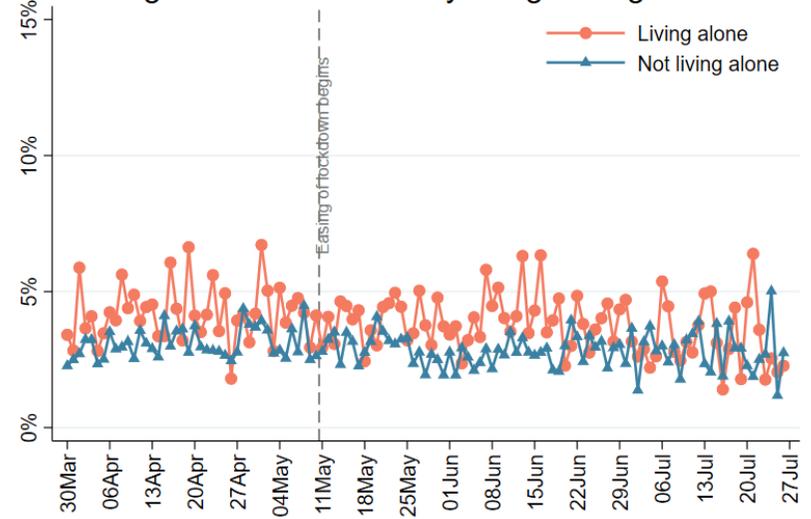


Figure 16c Self-harm by household income

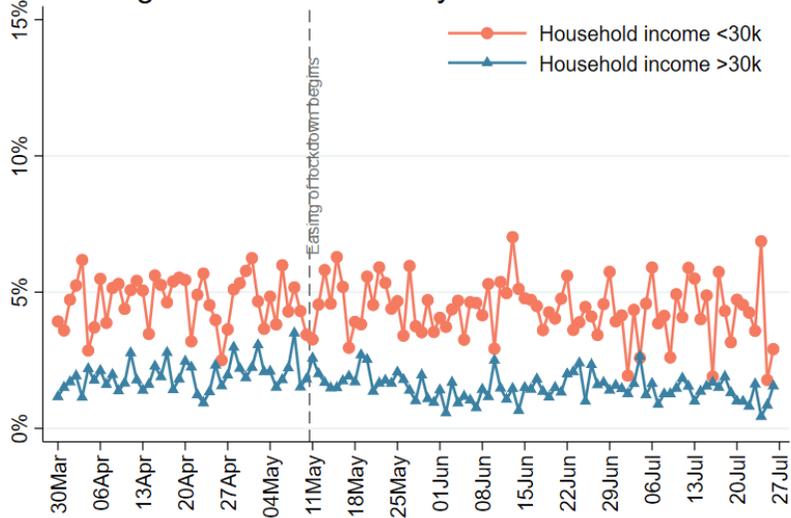


Figure 16d Self-harm by mental health diagnosis

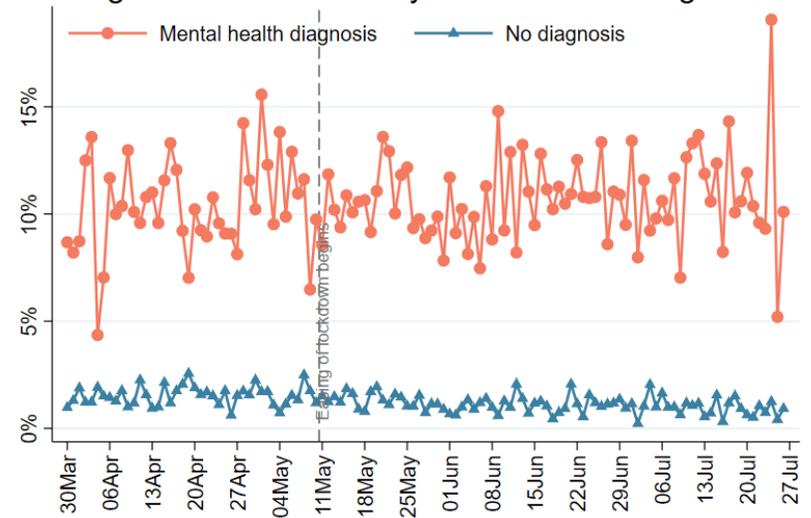


Figure 16e Self-harm by nations

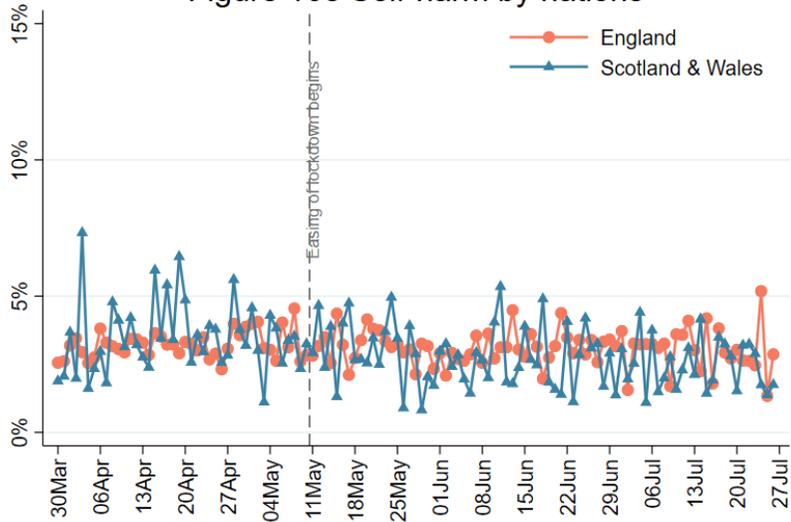


Figure 16f Self-harm by keyworker status

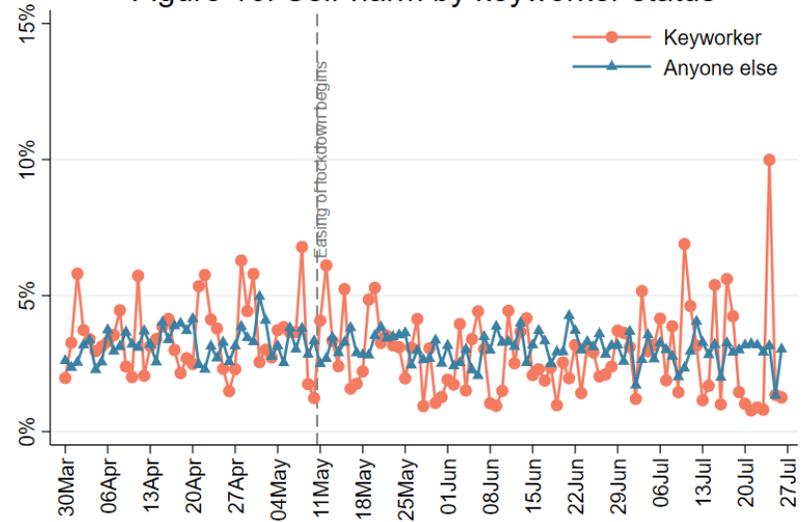


Figure 16g Self-harm by living with children

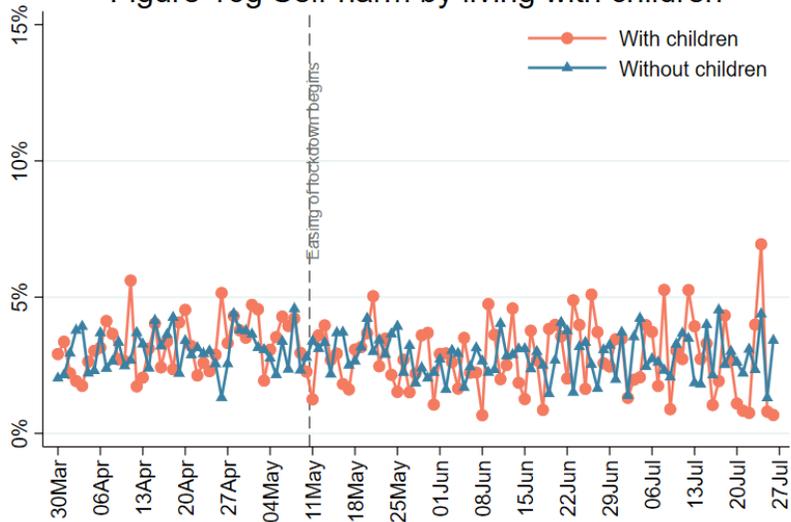
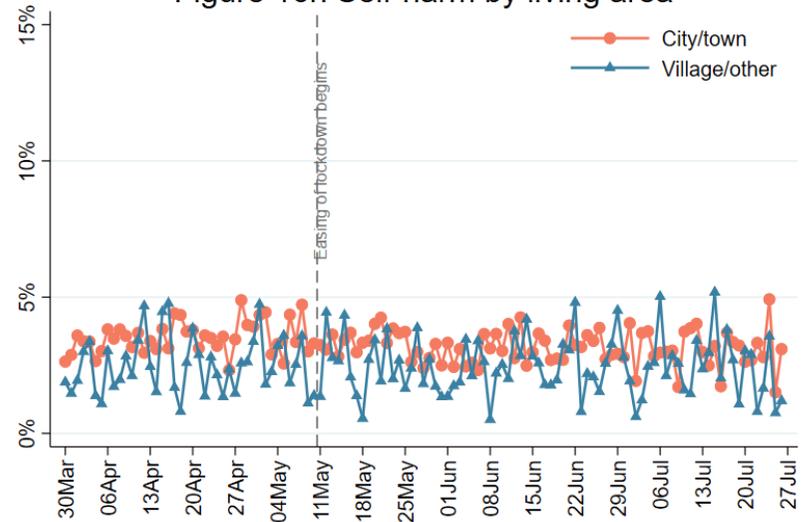
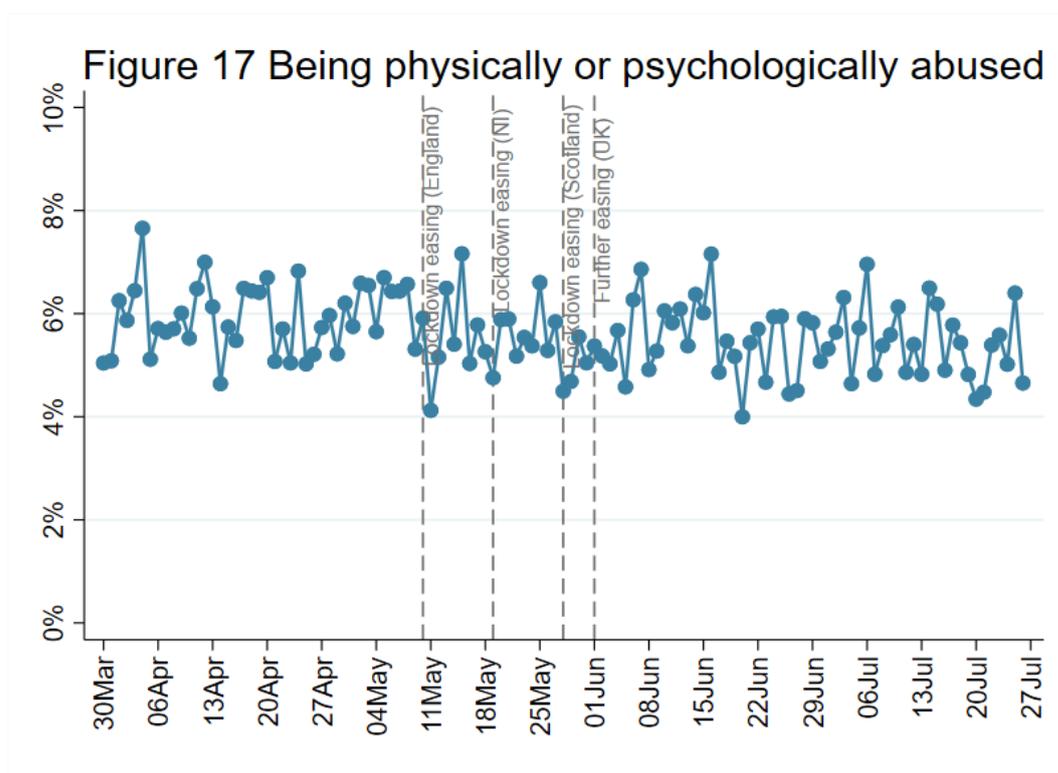


Figure 16h Self-harm by living area



### 3.3 Abuse



#### 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 remained relatively stable since the easing of lockdown was announced. 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.

Figure 18a Abuse by age groups

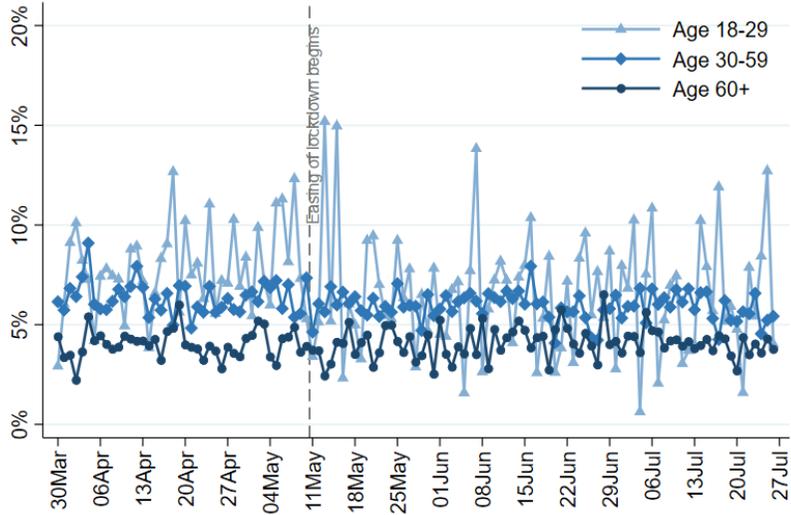


Figure 18b Abuse by living arrangement

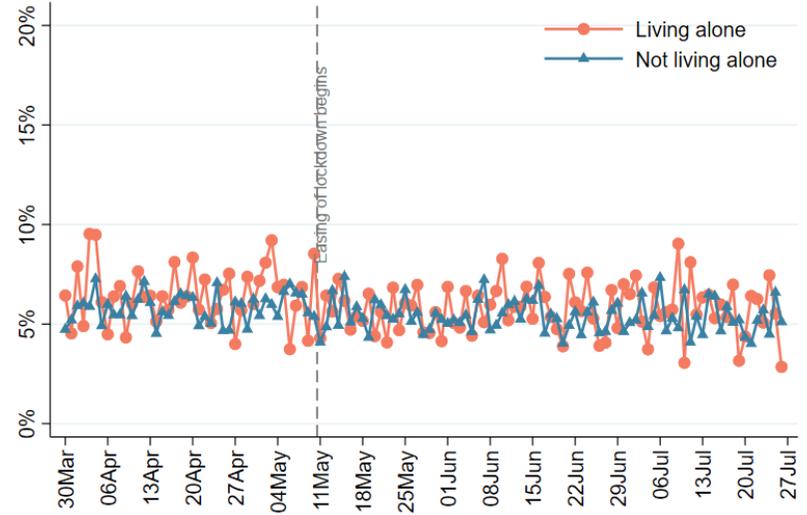


Figure 18c Abuse by household income

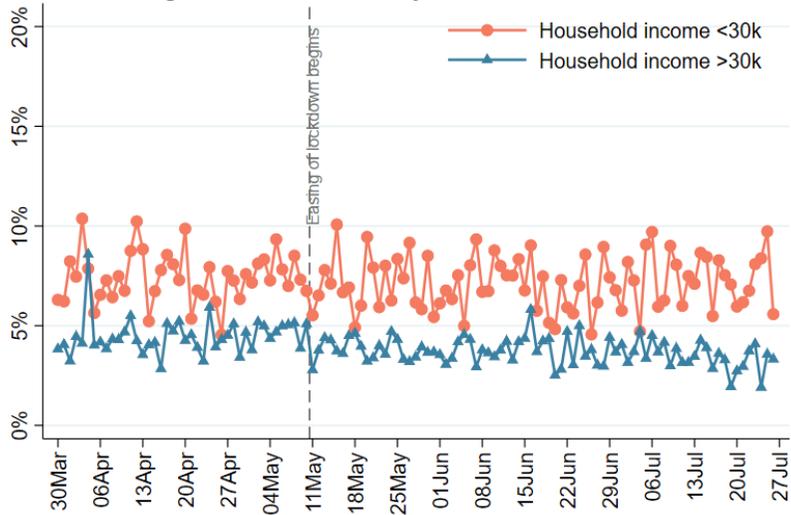


Figure 18d Abuse by mental health diagnosis

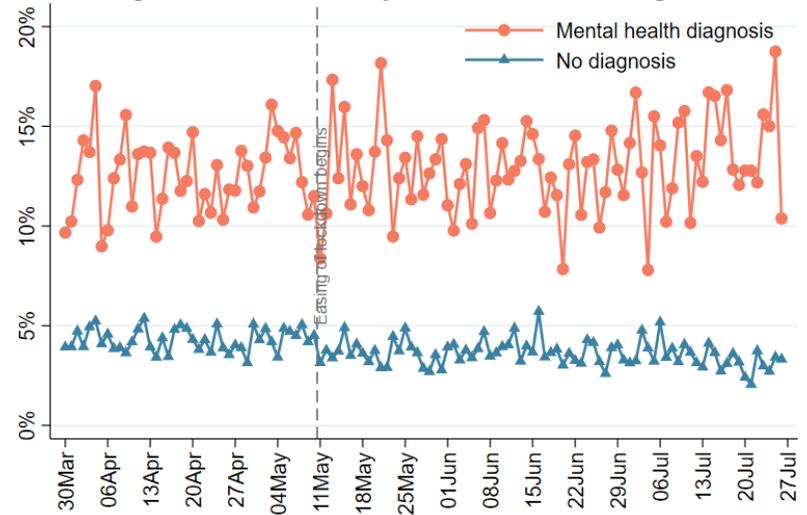


Figure 18e Abuse by nations

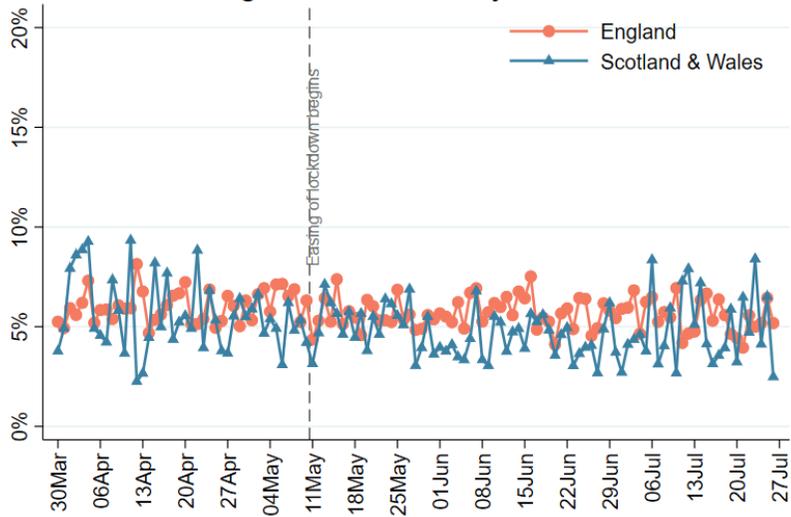


Figure 18f Abuse by keyworker status

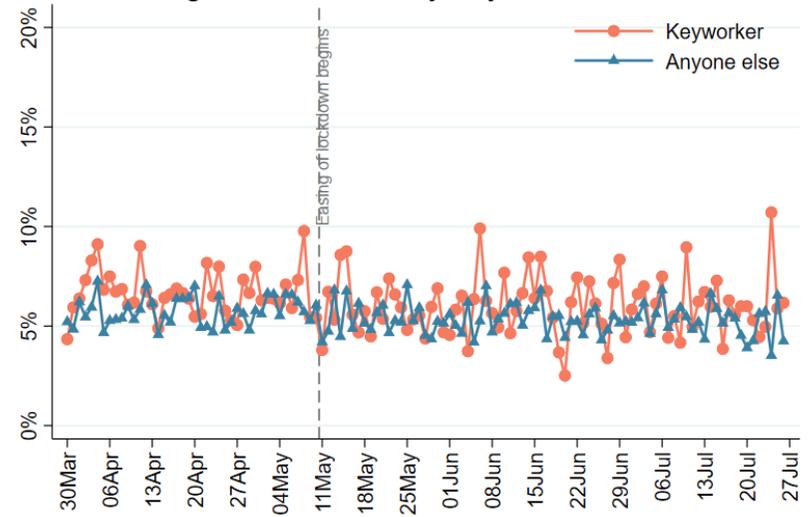


Figure 18g Abuse by living with children

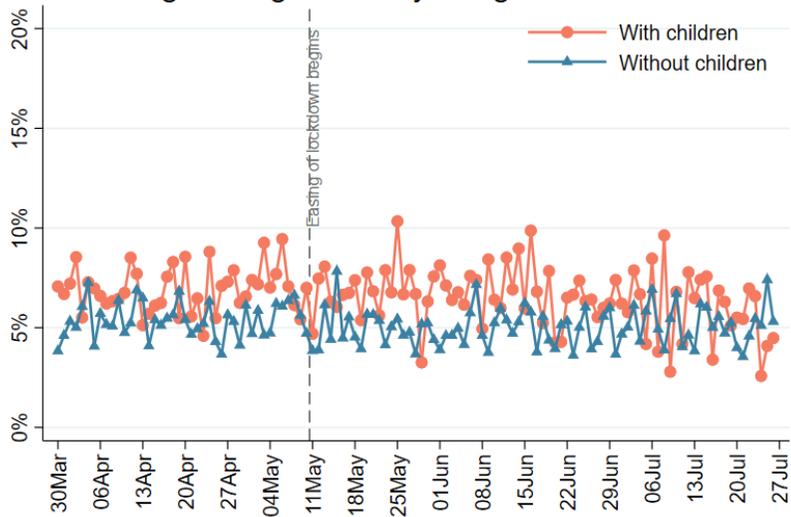
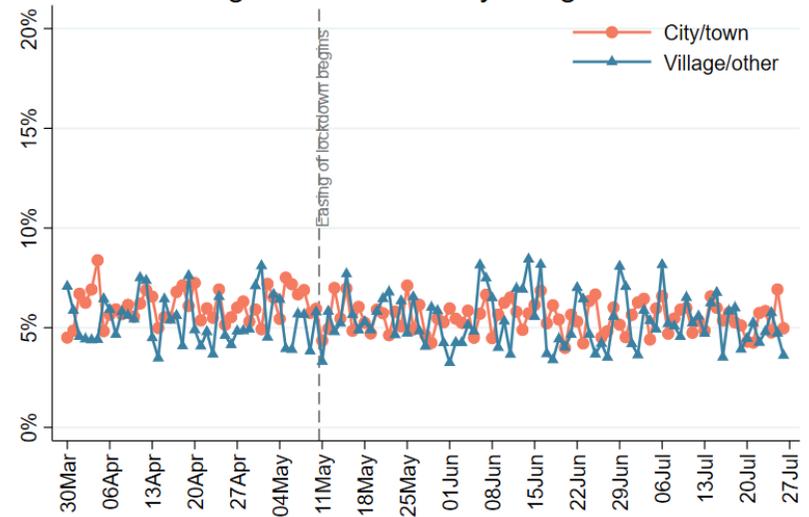
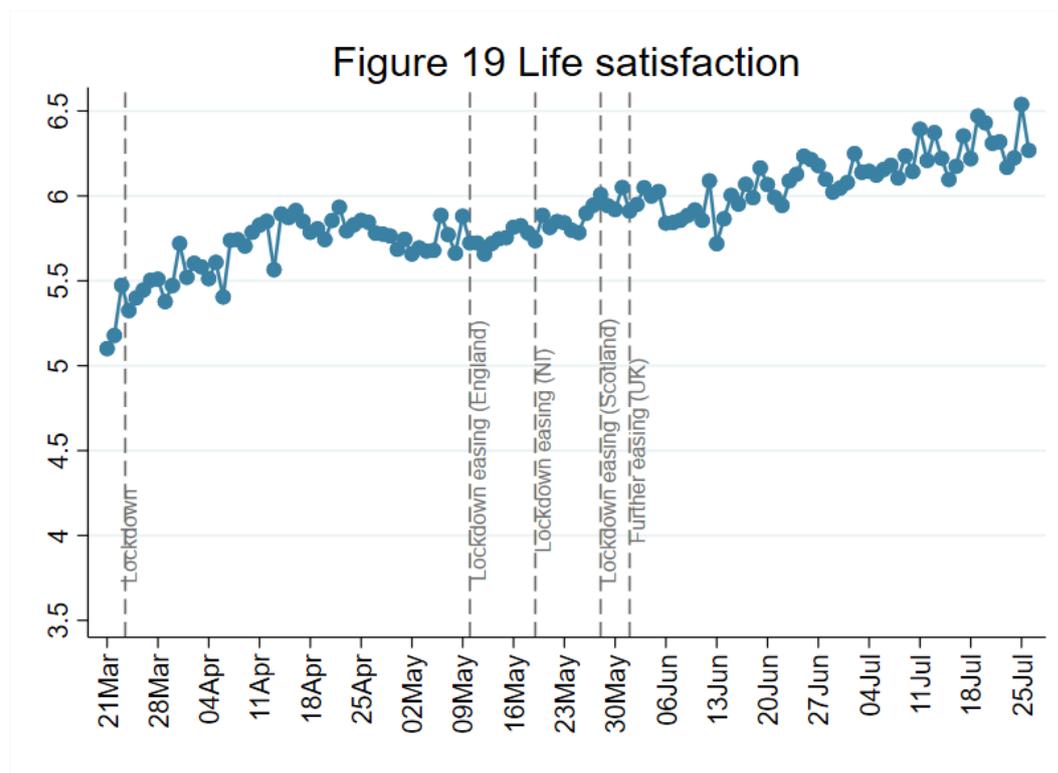


Figure 18h Abuse by living area



## 4. General well-being

### 4.1 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 has continued to improve further in the past two weeks. Whilst it was lower amongst people with children during lockdown, this difference has disappeared as lockdown has eased. It remains lowest in younger adults, people living alone, people with lower household income, people with diagnosed mental health conditions, and people living in urban areas (although the gap in differences between urban and rural areas has narrowed as further lockdown easing has taken place). It is similar across UK nations and amongst key workers.

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<sup>5</sup>.

<sup>5</sup> 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

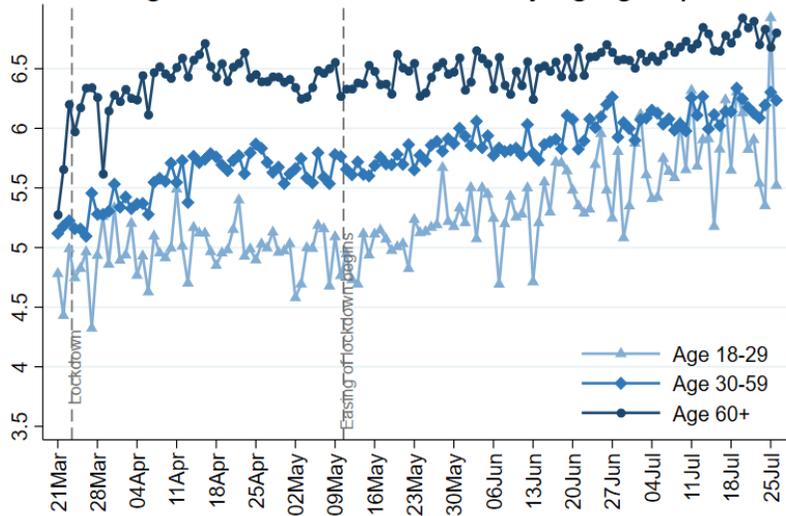


Figure 20b Life satisfaction by living arrangement

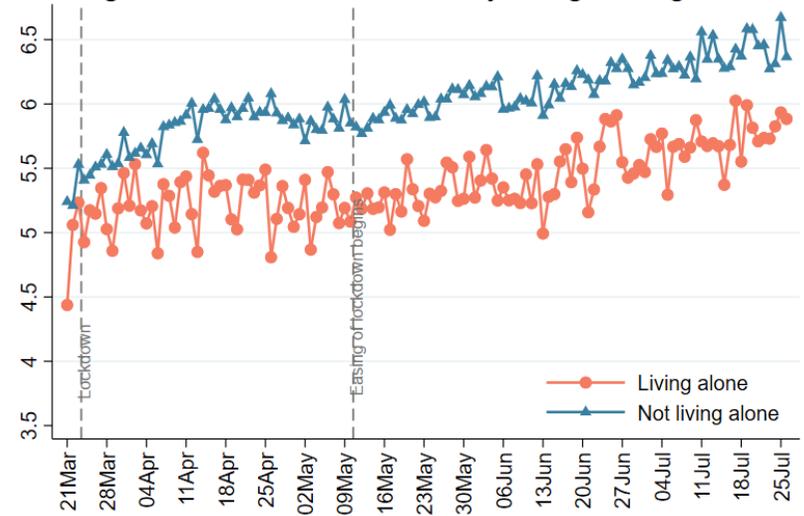


Figure 20c Life satisfaction by household income

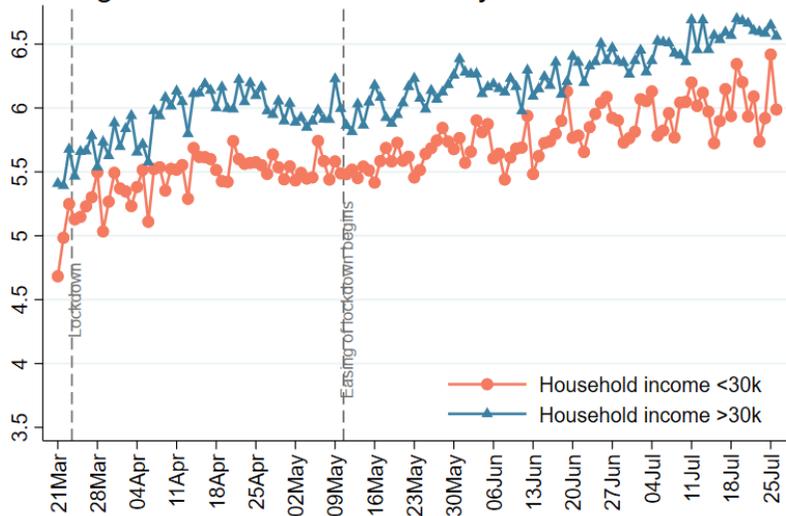


Figure 20d Life satisfaction by mental health diagnosis

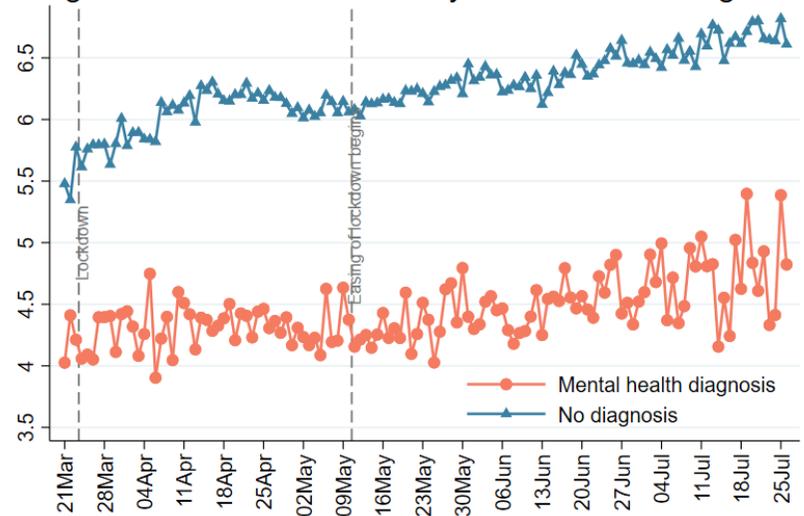


Figure 20e Life satisfaction by nations

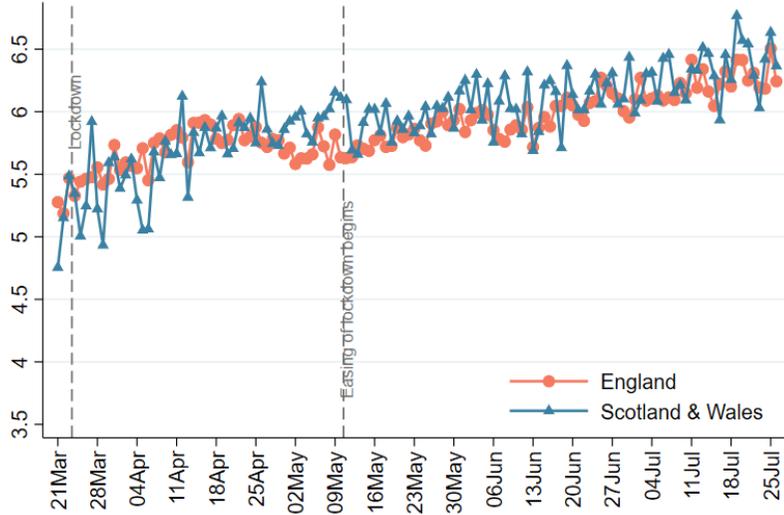


Figure 20f Life satisfaction by keyworker status

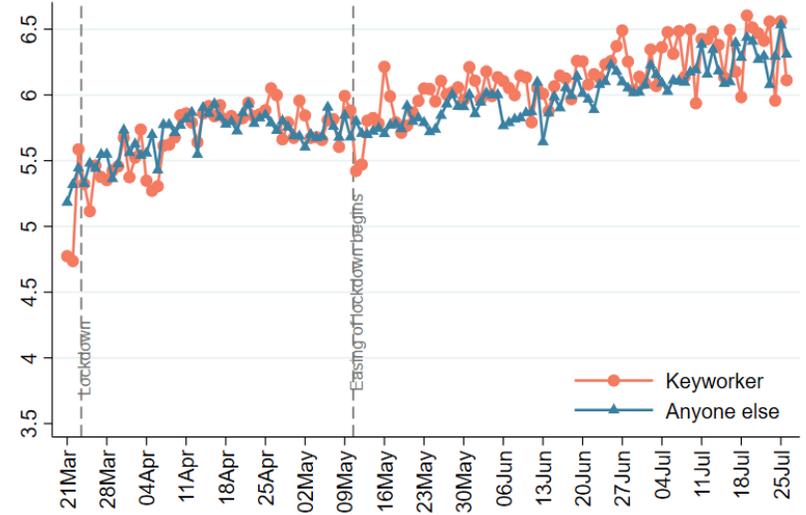


Figure 20g Life satisfaction by living with children

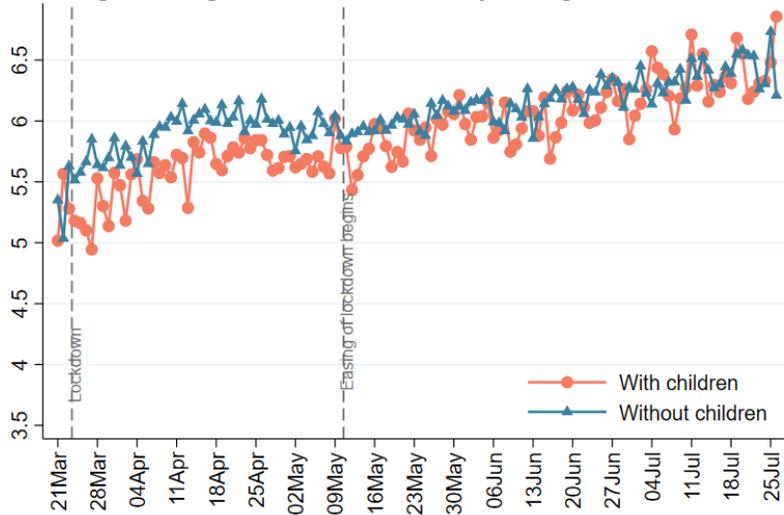
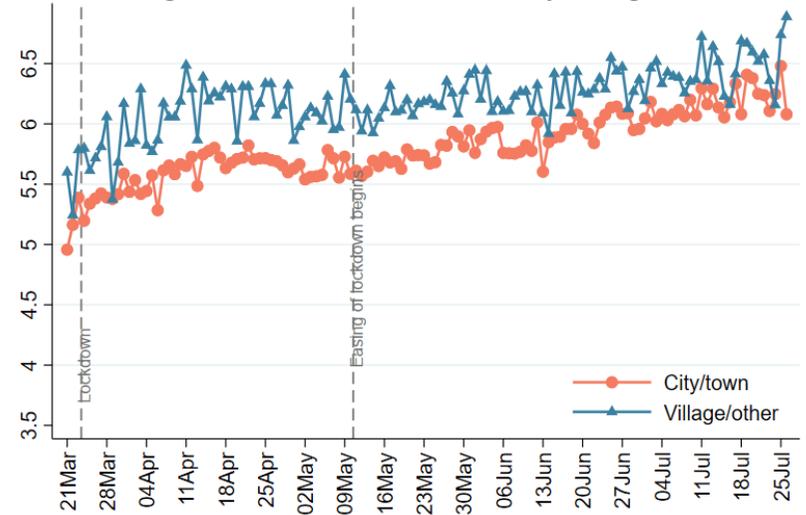
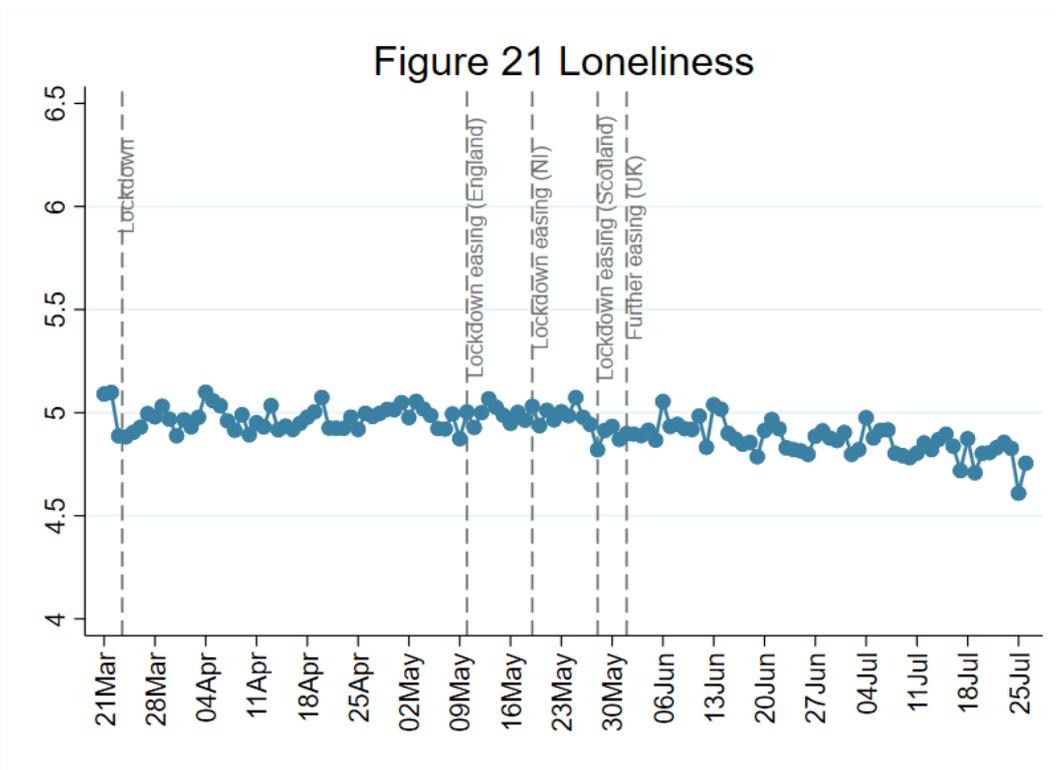


Figure 20h Life satisfaction by living area



## 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 rating scale, ranging from “never” to “always”, with higher scores indicating greater loneliness.

Loneliness levels have decreased further in the past fortnight, showing the first clear pattern of decrease in 19 weeks. Whilst this decrease is relatively small, it appears to be growing week on week and is most clearly apparent amongst younger adults (under 30), older adults (over 60), and people living alone.

Figure 22a Loneliness by age groups

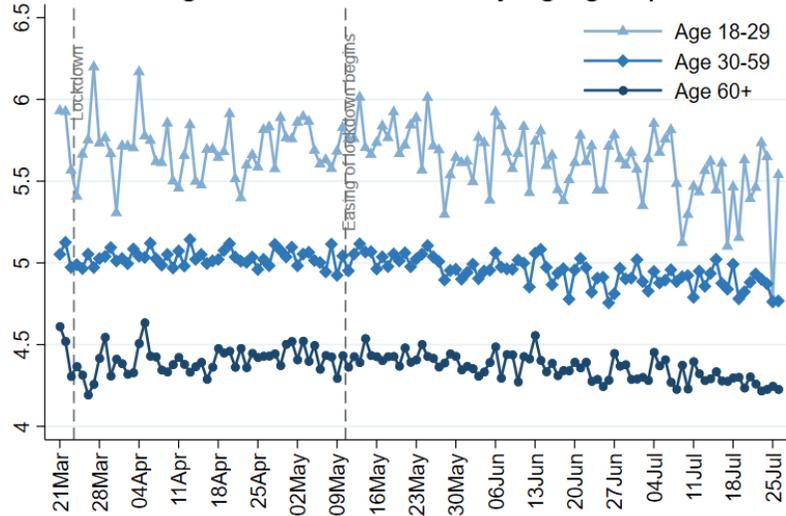


Figure 22b Loneliness by living arrangement

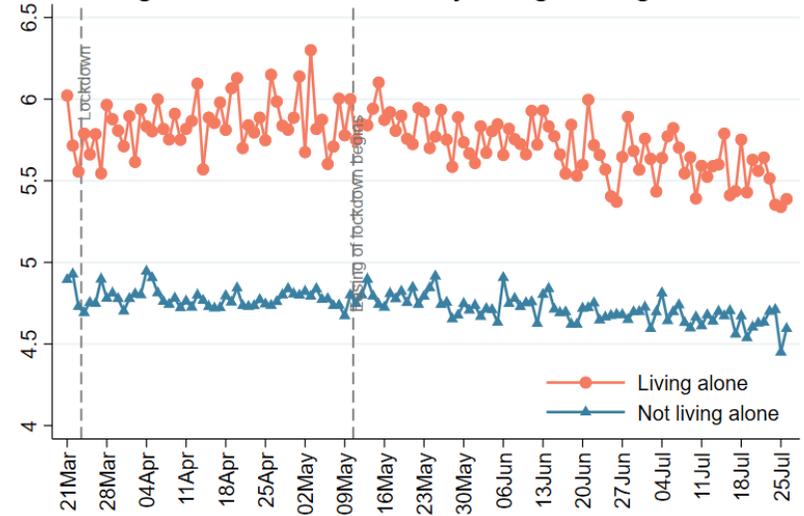


Figure 22c Loneliness by household income

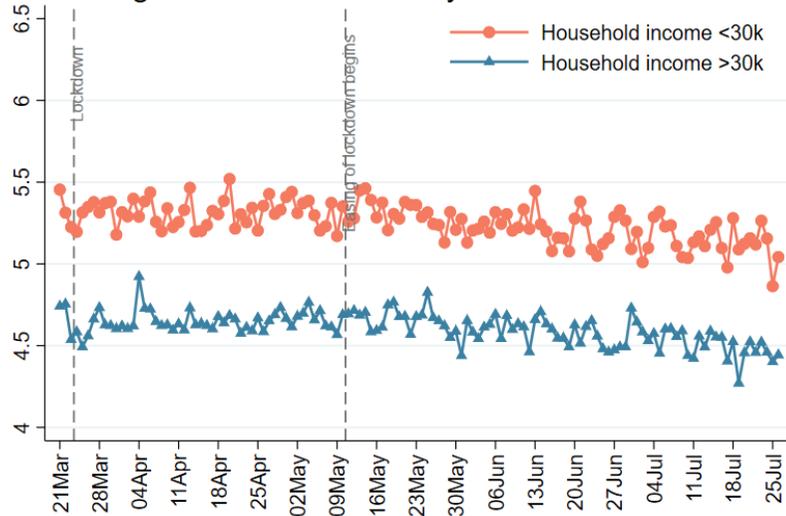


Figure 22d Loneliness by mental health diagnosis

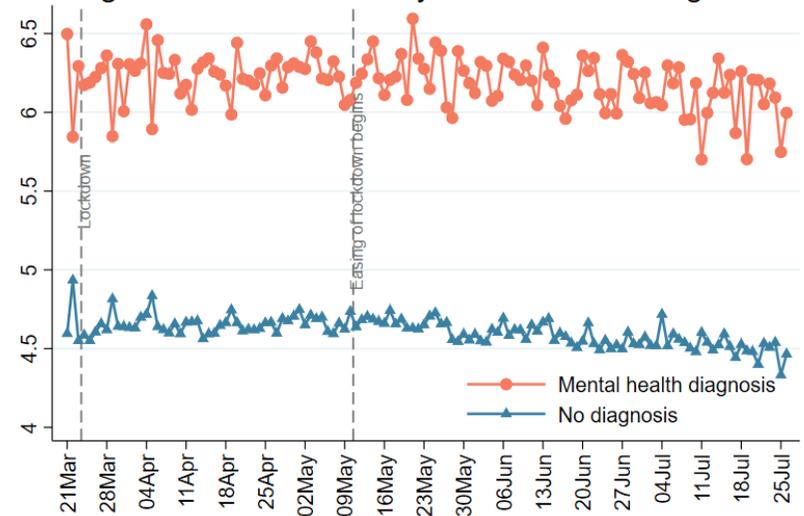


Figure 22e Loneliness by nations

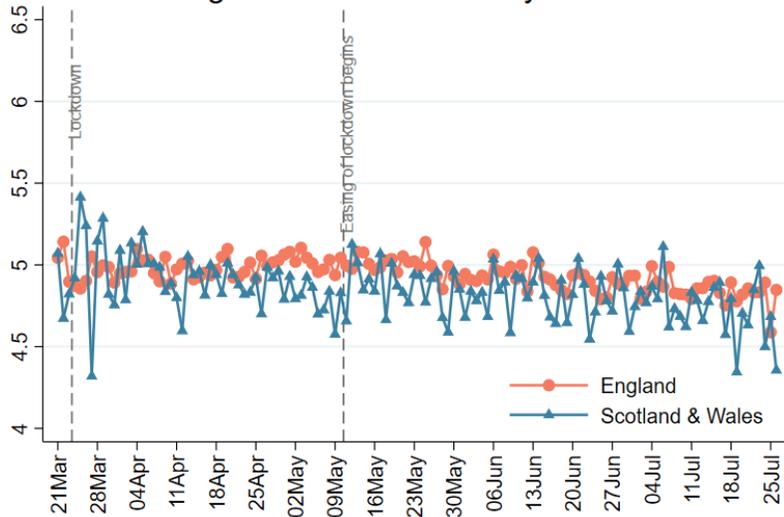


Figure 22f Loneliness by keyworker status

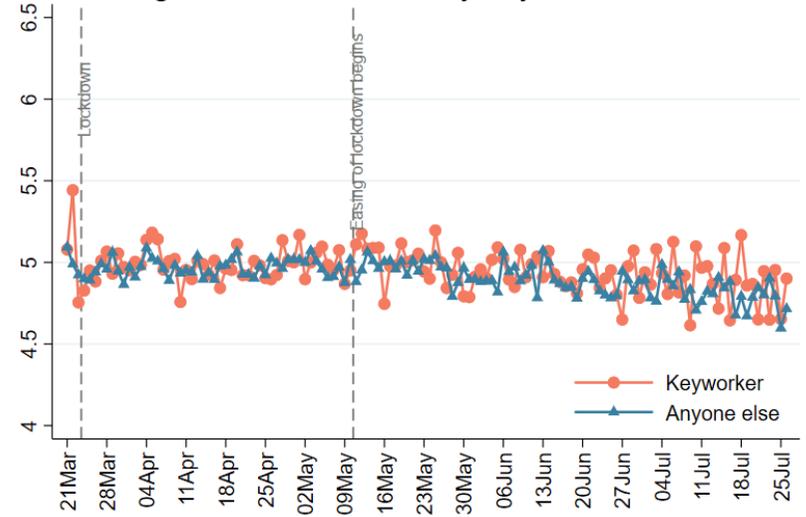


Figure 22g Loneliness by living with children

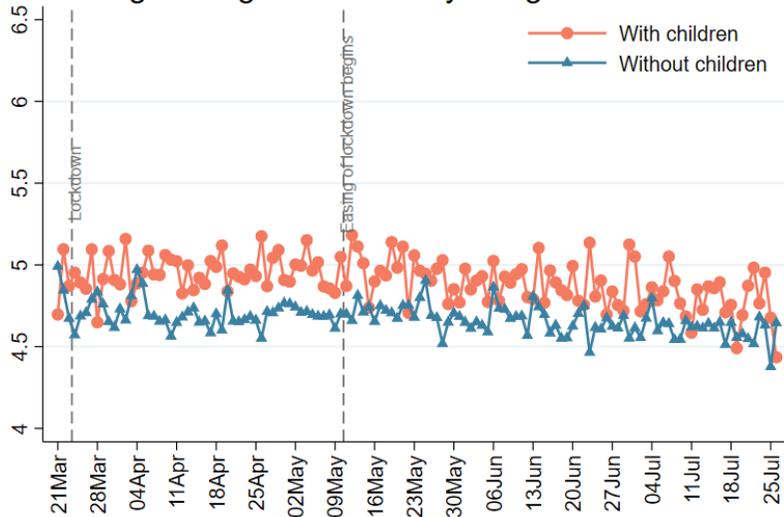
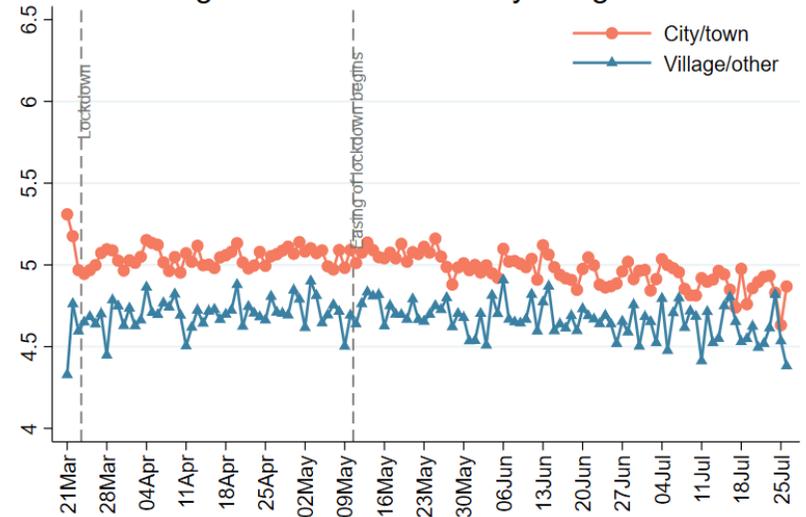
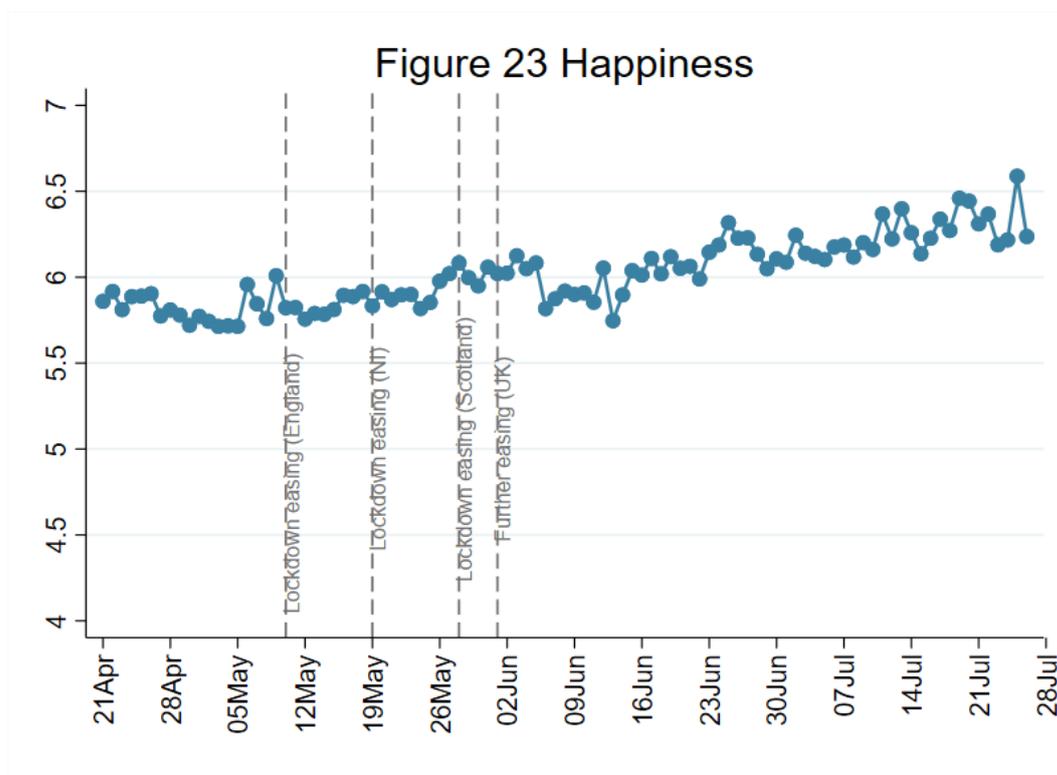


Figure 22h Loneliness by living area



### 4.3 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 21<sup>st</sup> April onwards.

Happiness levels have increased further in the past fortnight, most obviously in adults aged 18-29. Nevertheless, happiness levels remain lowest amongst younger adults, those living alone, those with lower household income, people with diagnosed mental health conditions, and people living in urban areas.

Figure 24a Happiness by age groups

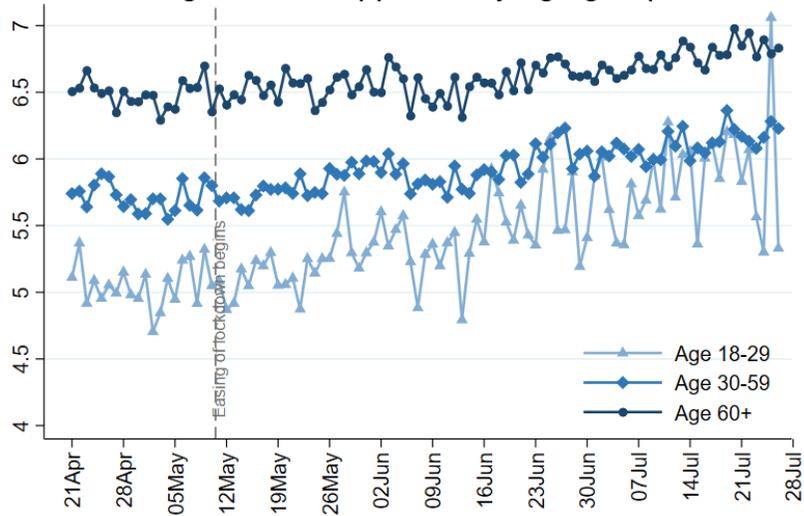


Figure 24b Happiness by living arrangement

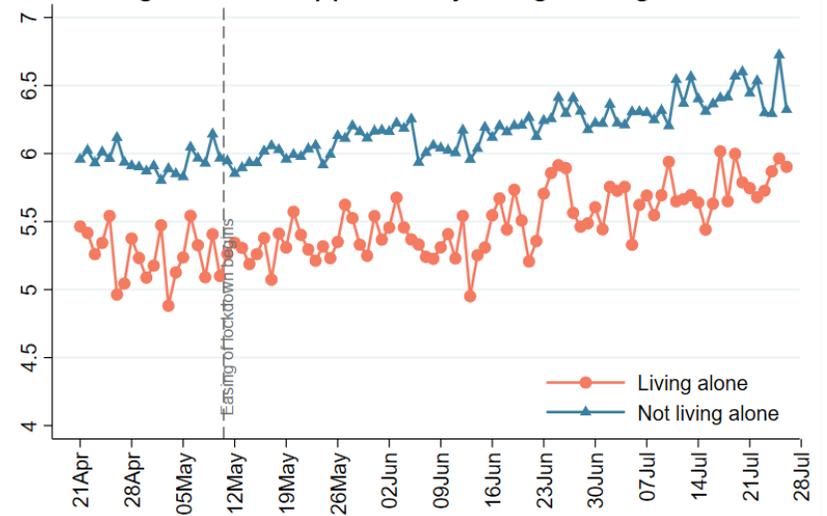


Figure 24c Happiness by household income

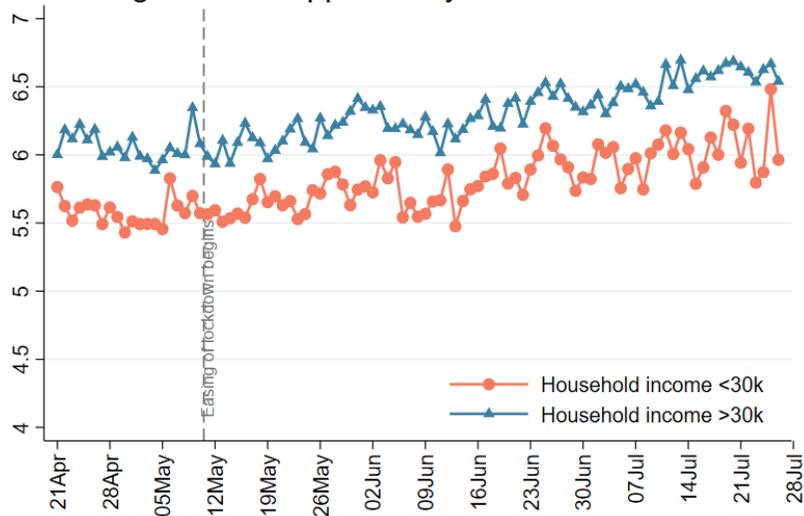


Figure 24d Happiness by mental health

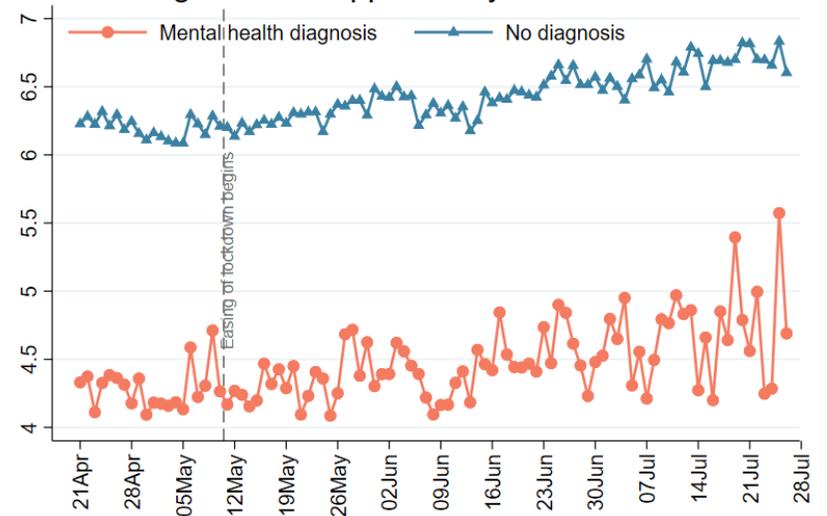


Figure 24e Happiness by nations

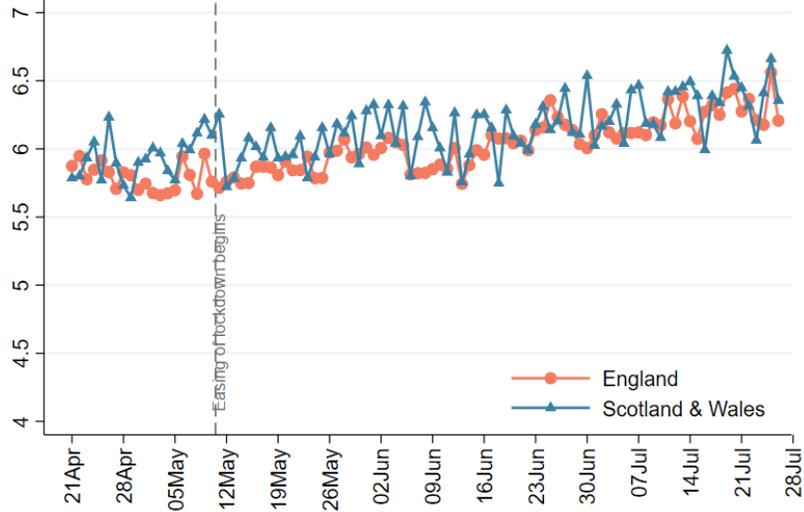


Figure 24f Happiness by keyworker status

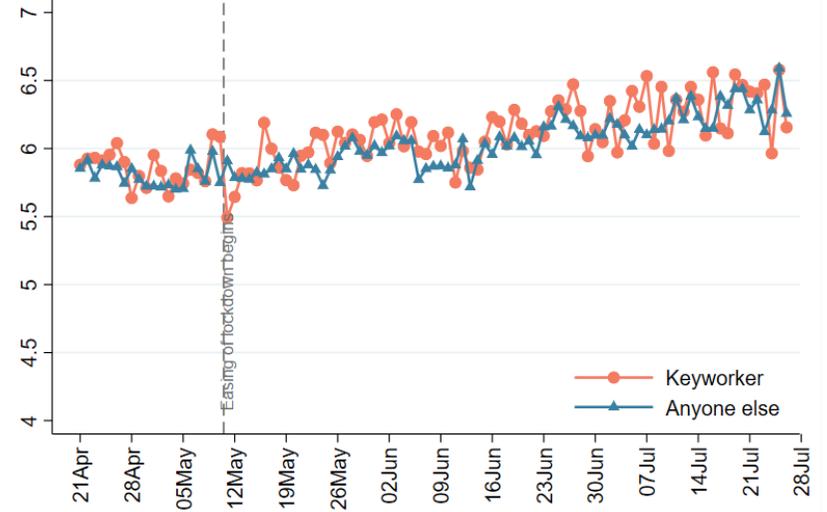


Figure 24g Happiness by living with children

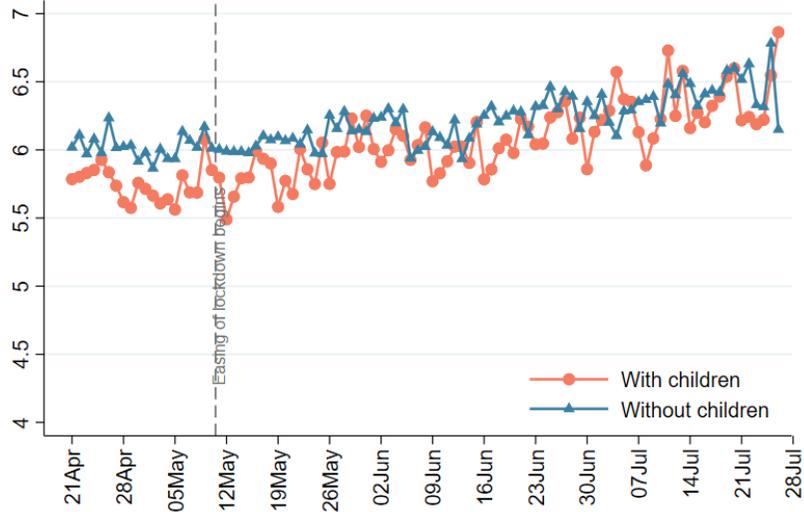
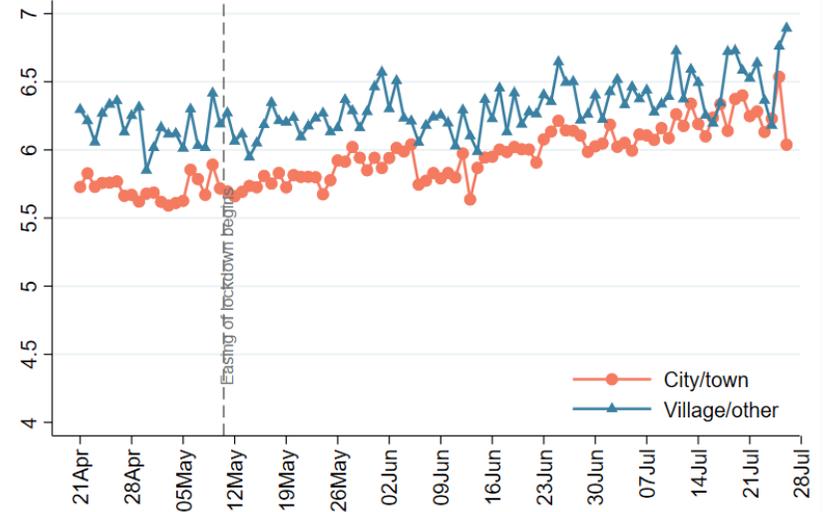
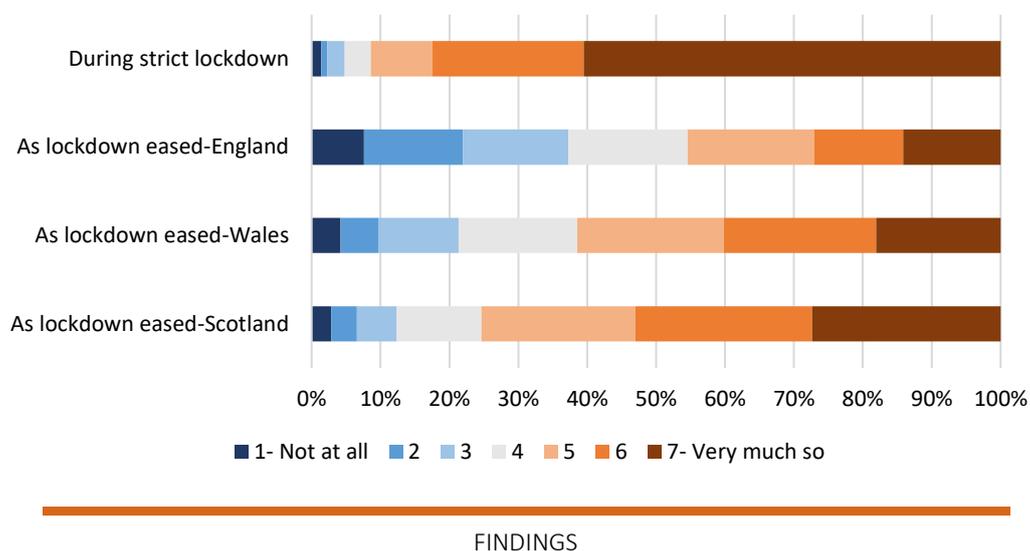


Figure 24h Happiness by living area



## 5. Understanding of rules

Figure 25 Understanding of rules



Respondents were asked how much they feel they understood the rules brought in by the government during (a) the ‘full’ or ‘strict’ lockdown period, and (b) as lockdown easing was announced. Responses ranged from 1 (not at all) to 7 (very much so), with scores above 4 indicating broad understanding and below 4 implying poor understanding. Participants were asked to respond about the government in their own country (so if they live in a devolved nation, they were asked to answer on their devolved government).

During strict lockdown (when the same rules were applied across the UK), levels of understanding were reported by individuals to be very high, with 9 in 10 people saying they understood the rules and 6 in 10 people saying they had a very high level of understanding. However, there was much poorer comprehension of the rules after lockdown easing began. As the rules for lockdown easing were different in devolved nations, we present here the findings for England, Wales and Scotland separately<sup>6</sup>. In England fewer than half of adults reported broad understanding of the rules (45%), with just 14% understanding them ‘very much’. This compared to 61% reporting a broad understanding in Wales and 18% reporting understanding the rules ‘very much’. In Scotland, 75% of people still reported a broad understanding, but only 27% reported understanding the rules ‘very much’.

Comprehension of the rules in strict lockdown was reported as highest amongst adults over the age of 30, with just over 3 in 5 adults over 30 understanding the rules completely, compared with only around 1 in 2 adults under 30. Following the easing of lockdown, comprehension of the rules dropped most amongst younger adults in all nations. Fewer than 1 in 10 adults in England reported understanding the rules completely as lockdown eased, and fewer than 1 in 20 in Wales. This compared to around 1 in 5 adults over the age of 60 in the two countries. This could possibly reflect difficulties in applying the rules to more complex life scenarios amongst younger adults, or may be reflective of the differential amounts of time spent following the news on Covid-19 amongst different age groups. During strict lockdown, the rules were equally understood by adults regardless of educational attainment. However, rules on the easing of lockdown were less well understood by adults with higher educational qualifications. This could reflect greater scrutiny of the consistency and applicability of the rules.

<sup>6</sup> The sample size for Northern Ireland was not large enough for a reliable calculation but the data from NI are being used in other analyses.

Figure 26a Understanding of rules (young adults aged 18-29)

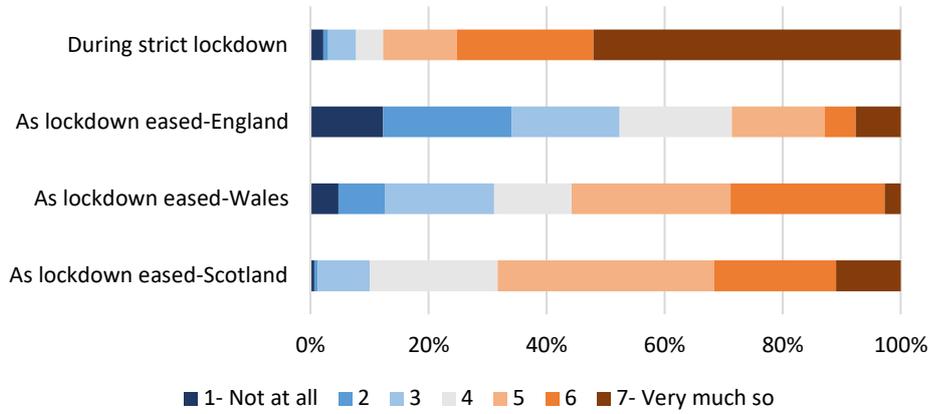


Figure 26b Understanding of rules (adults aged 30-59)

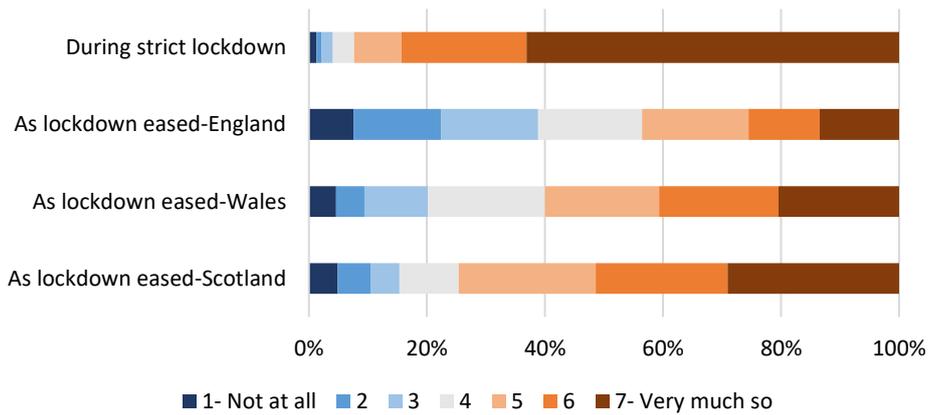


Figure 26c Understanding of rules (older adults aged 60+)

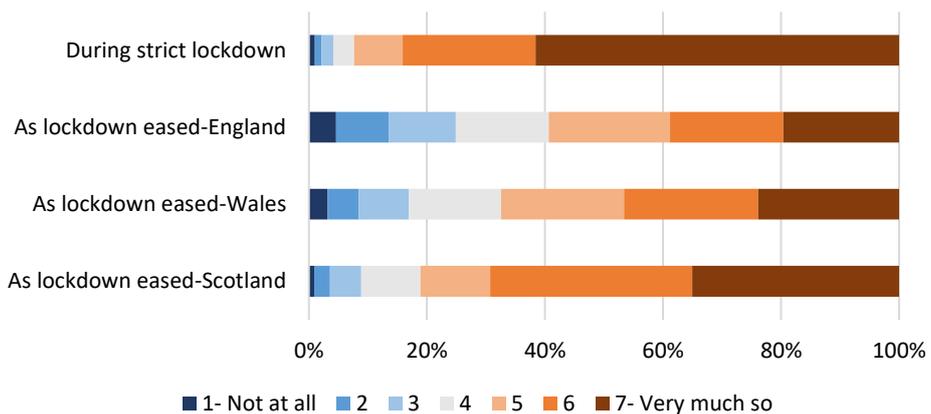


Figure 26d Understanding of rules (education level=GCSE or below)

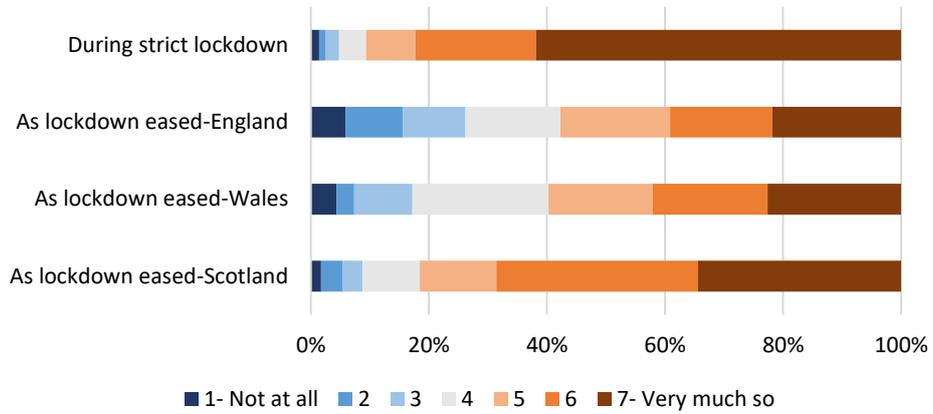


Figure 26e Understanding of rules (education level=A-levels or equivalent)

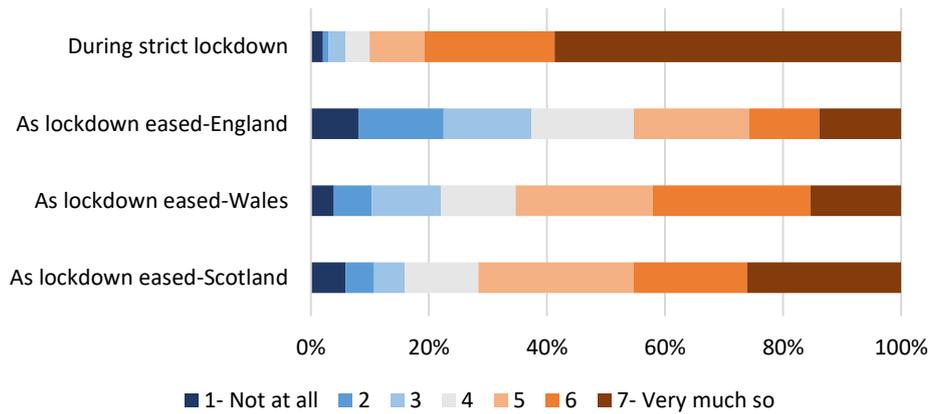
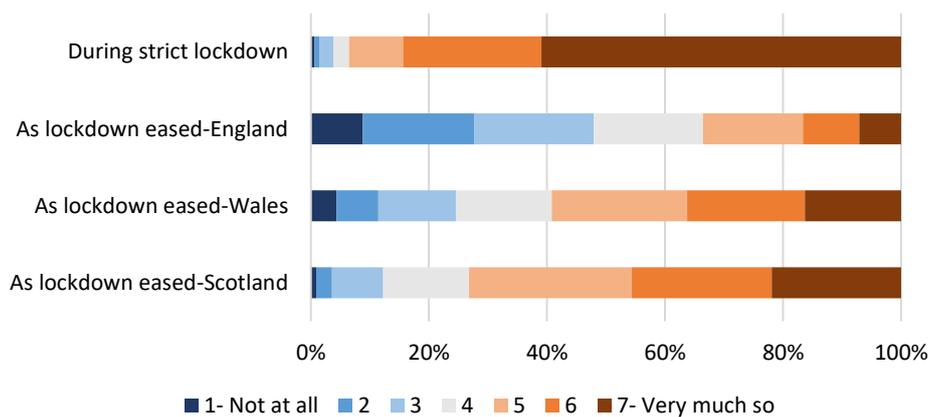
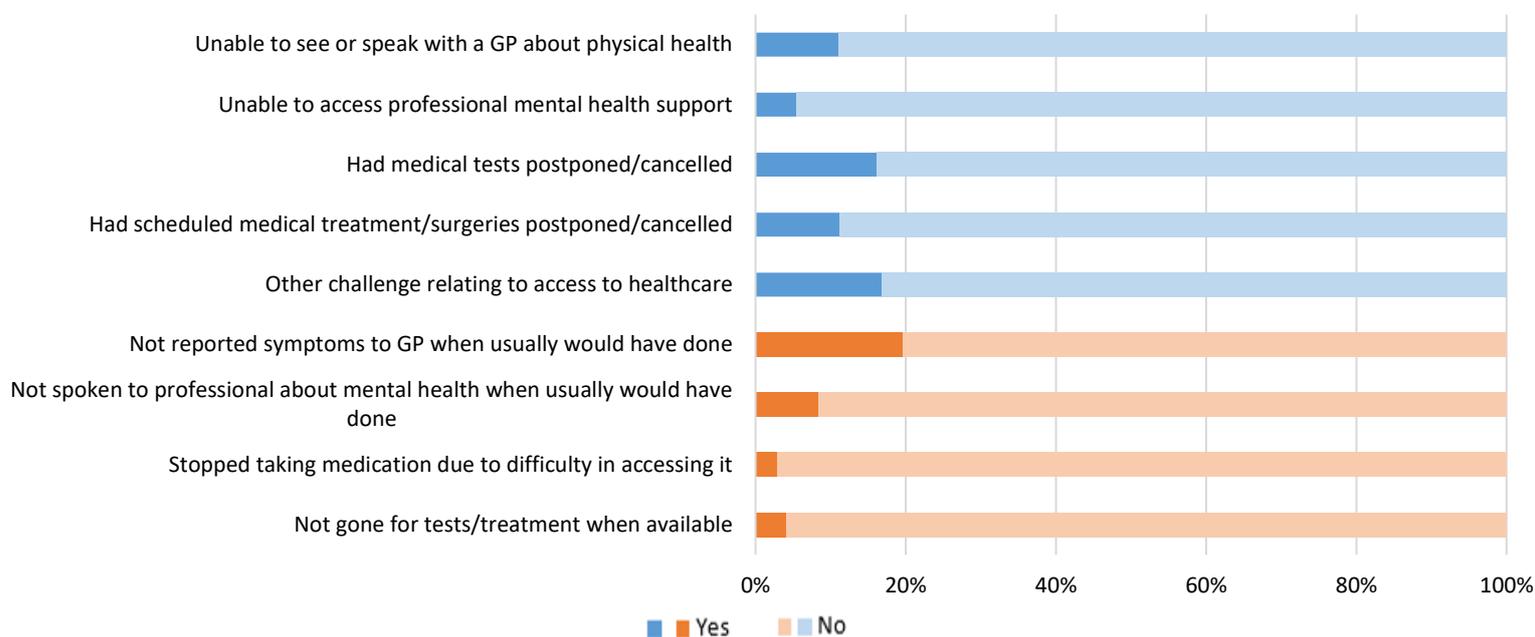


Figure 26f Understanding of rules (education level=Degree or above)



## 6. Barriers to health care

Figure 27 Health barriers and care



### FINDINGS

Respondents were asked if they had experienced any barriers to accessing healthcare since lockdown began, including seeing or speaking with a GP, accessing professional mental health support, having tests or treatment postponed or cancelled, or any other challenges (all shown above as blue bars). Further, they were also asked if they had not accessed any healthcare even when it was available, when they usually would have done so, including reporting symptoms to a GP, speaking with a professional about their mental health, stopping their medication, or not going for tests even when they were available (shown above as orange bars)

39% of people reported facing one or more challenges in accessing healthcare (the top 5 bars in Figure 27). 1 in 10 people reported being unable to see or speak with a GP about their physical health since lockdown began, along with 1 in 20 being unable to speak with a professional about their mental health. 1 in 6 adults reported having tests postponed or cancelled, and 1 in 10 reported having treatment postponed or cancelled. Nearly 1 in 6 reported other types of challenges related to accessing healthcare.

Further, 26% of people reported not accessing healthcare even when it was available (the bottom 4 bars in Figure 27). 1 in 5 people reported not telling a GP about symptoms of an illness when they would usually have done, while 1 in 12 reported not speaking to a health professional about mental health when they would usually have done. Further, 2.8% of people reported stopping taking medication due to difficulties in accessing it (e.g. due to not being able to collect the prescription), and 1 in 25 people reported not going for tests even though they were available.

In general, barriers were more of a problem for younger adults, but challenges relating to tests or treatment being cancelled were similarly felt across age groups. Women were more likely to report barriers to accessing healthcare, or not accessing healthcare even when it was available than men, with the exception of accessing mental health support, where levels were similar. People from BAME backgrounds also faced more barriers or did not access available healthcare, for example being 1.5 times more likely not to have gone for tests even though they were available (5.8% vs 3.9% from white backgrounds). People with a physical health condition were more likely not to have reported symptoms to a GP when they usually would have done. Similarly, people with a mental health condition were nearly twice as likely not to have reported symptoms to a GP than people without a mental health condition (17% vs 32%) and nearly 7 times more likely not to have spoken to a mental health professional when they usually would have done than people without a mental health condition (28% vs 3.7%). Further, 1 in 5 people with a diagnosed mental health condition reported being unable to access professional mental health support during lockdown.

Figure 28a Health barriers and care reported by young adults (age 18-29)

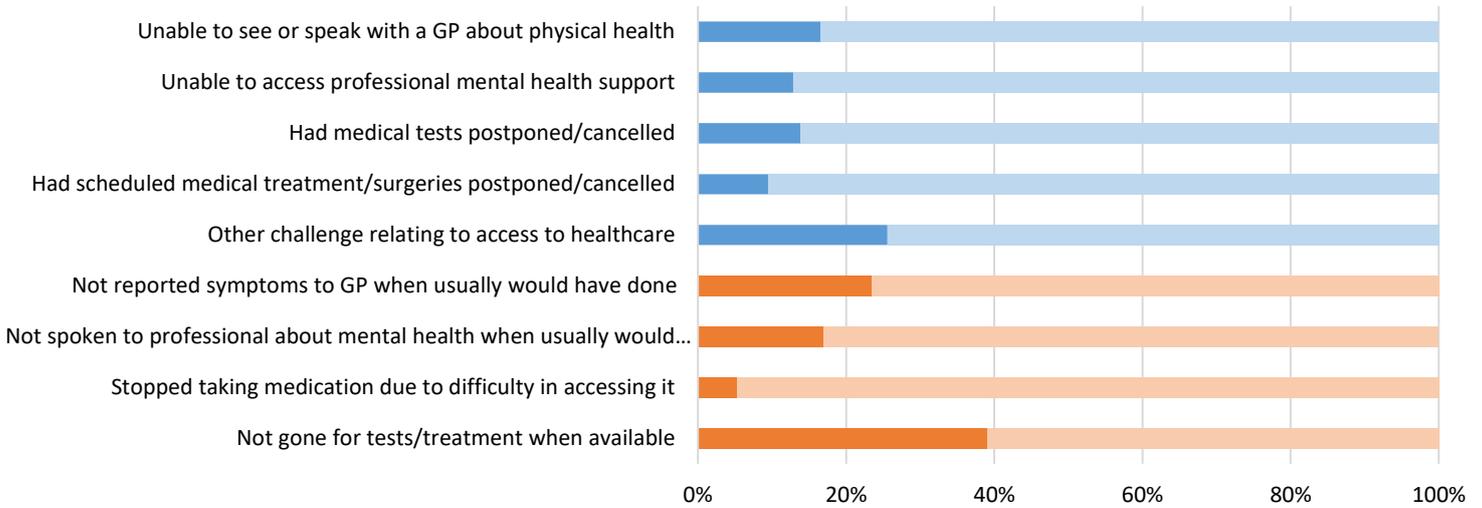


Figure 28b Health barriers and care reported by adults (age 30-59)

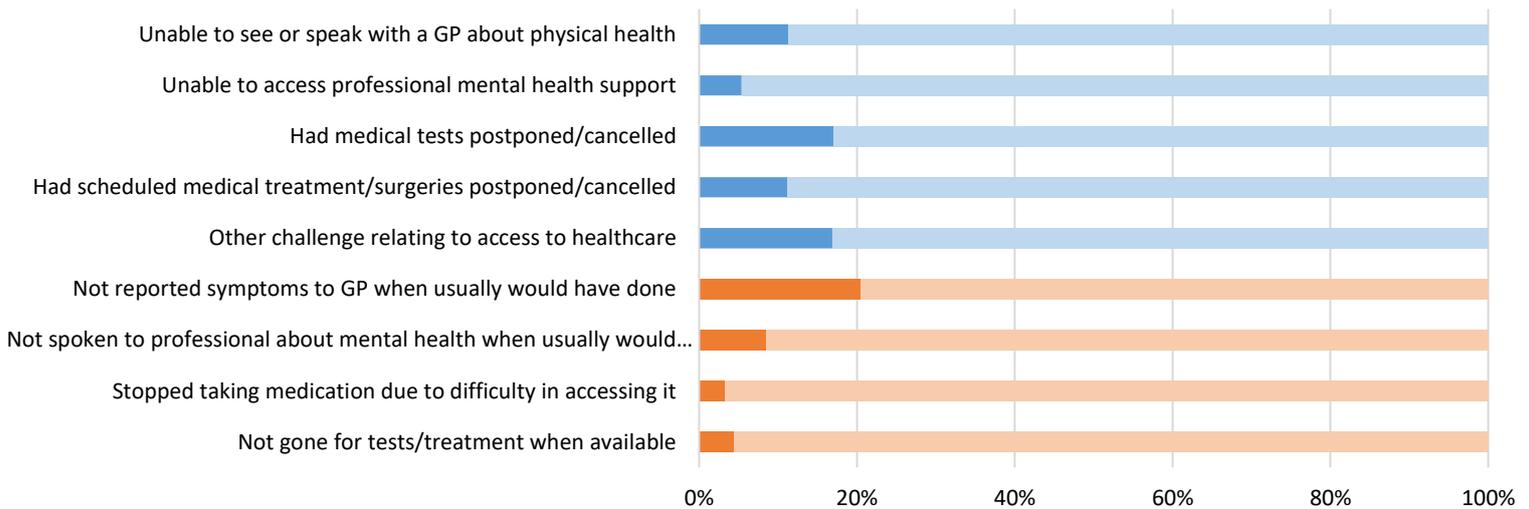


Figure 28c Health barriers and care reported by older adults (60+)

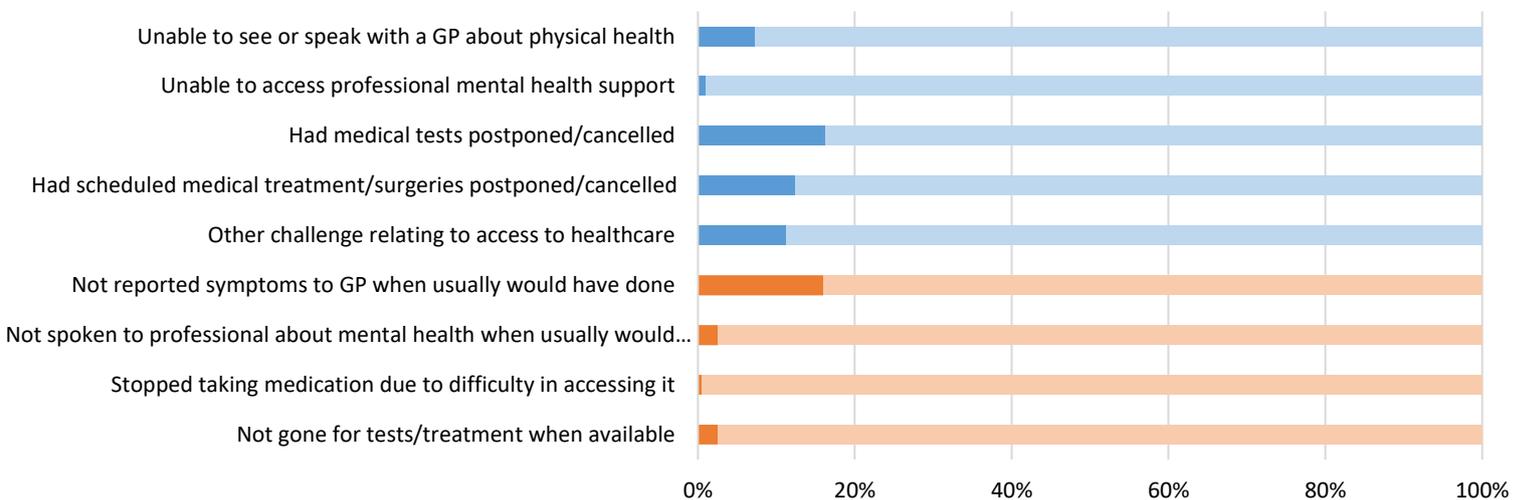


Figure 28d Health barriers and care reported by female

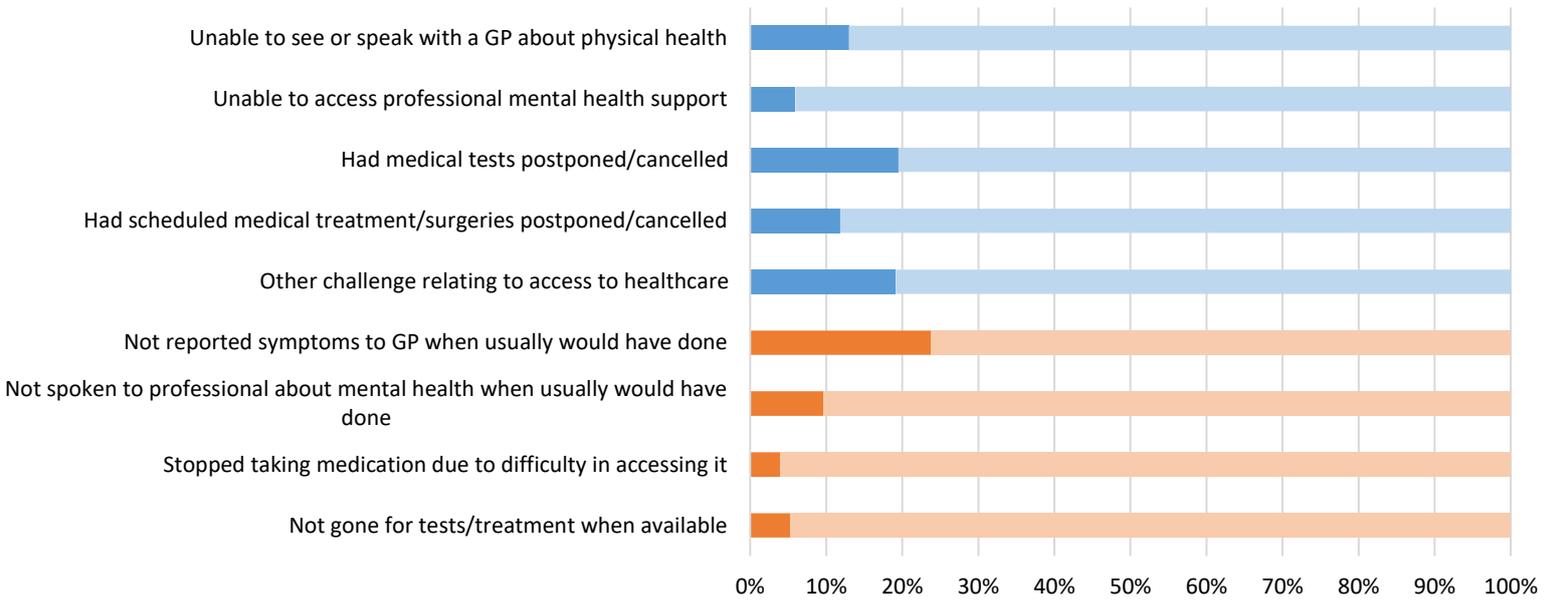


Figure 28e Health barriers and care reported by male

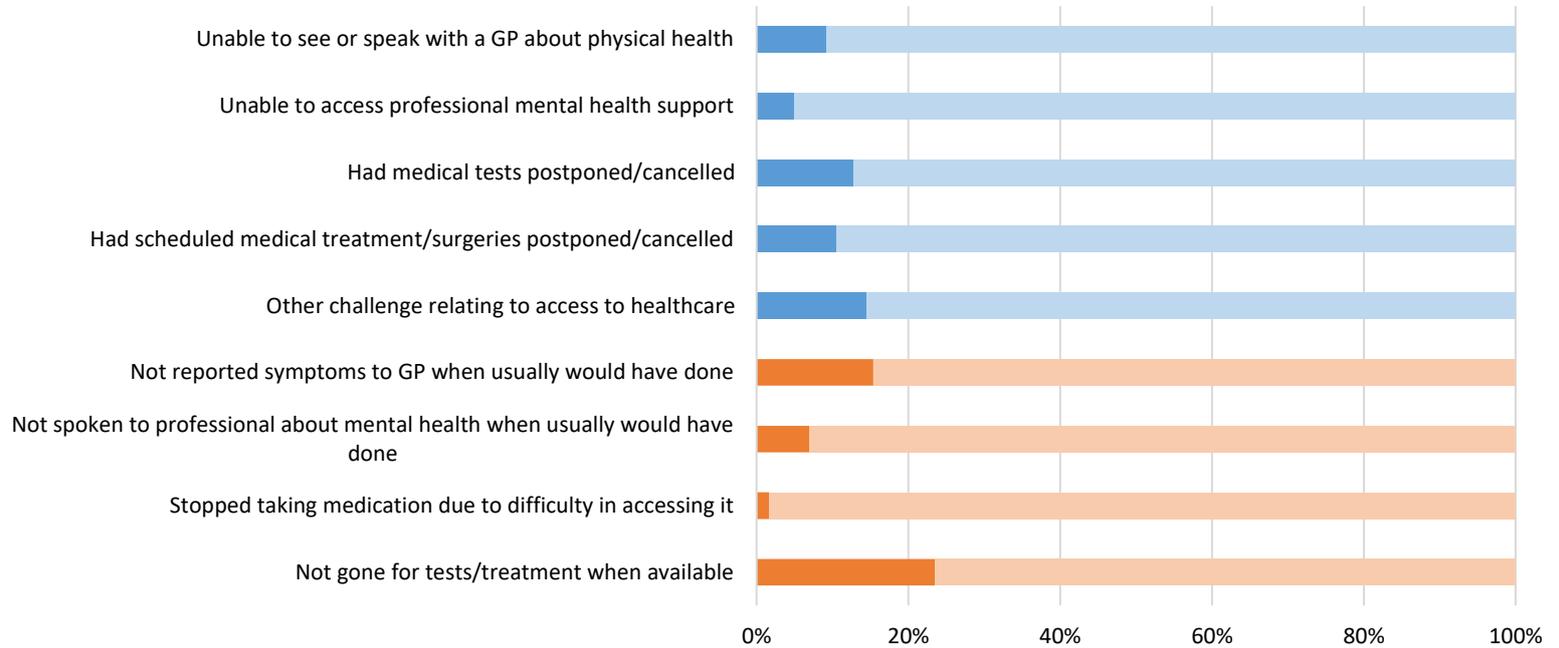


Figure 28f Health barriers and care reported by people of white ethnic background

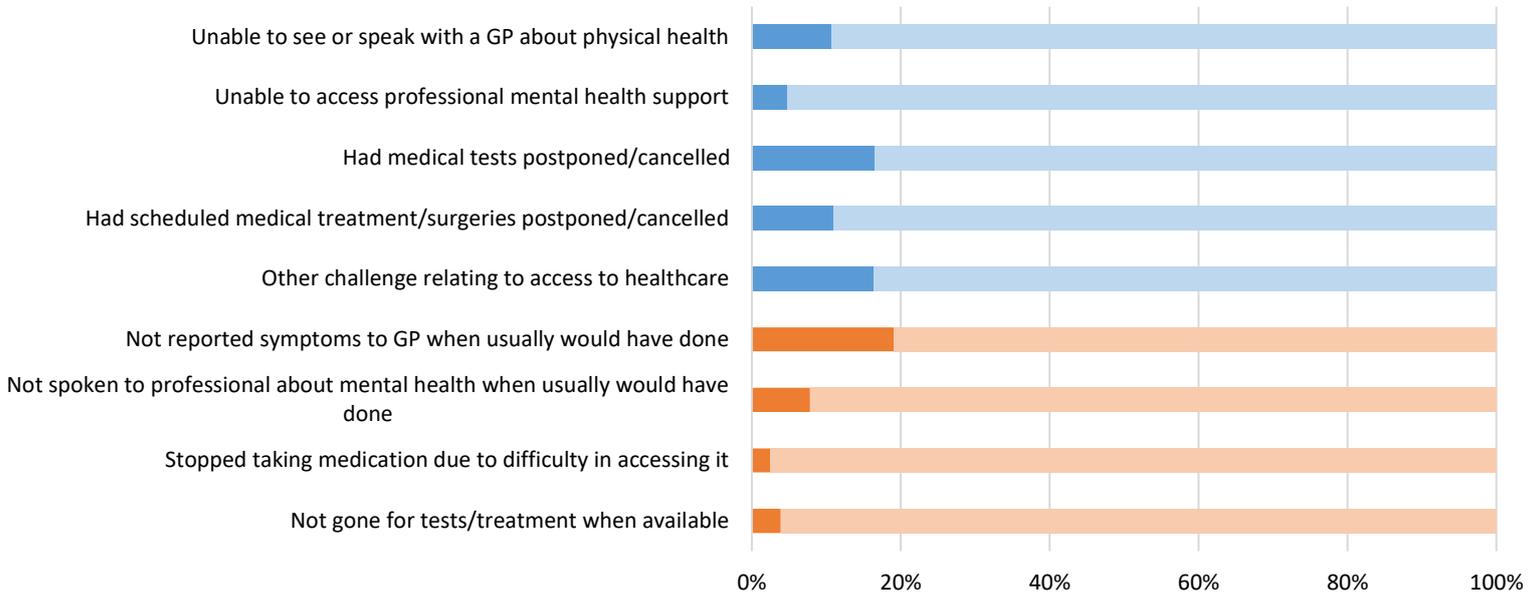


Figure 28g Health barriers and care reported by people of BAME background

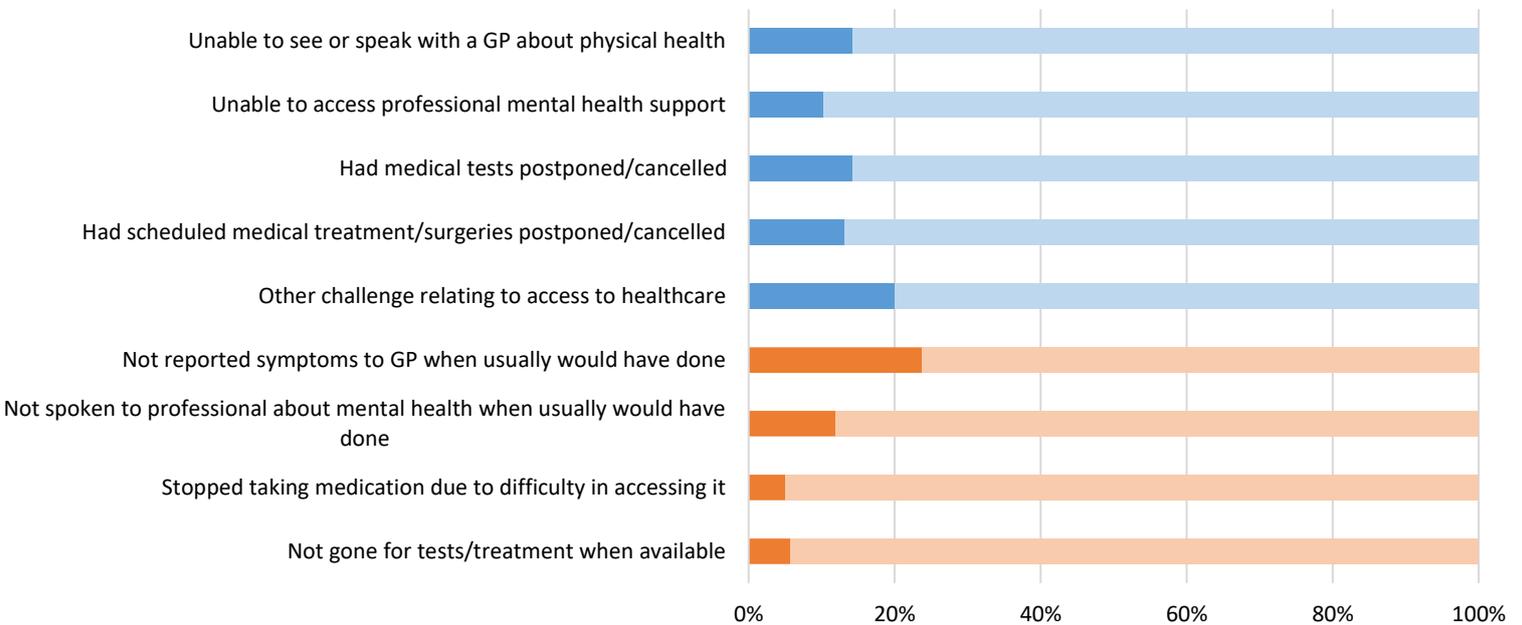


Figure 28h Health barriers and care reported by people without a physical health diagnosis

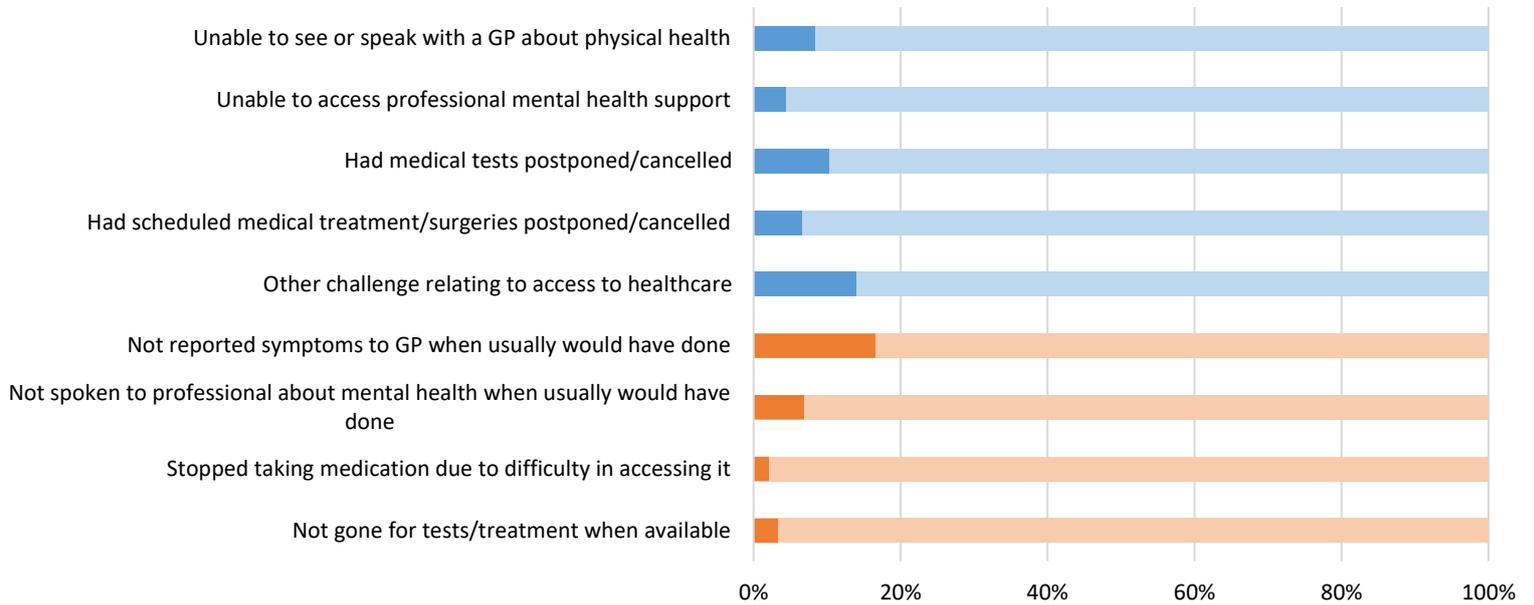


Figure 28i Health barriers and carer reported by people with a physical health diagnosis

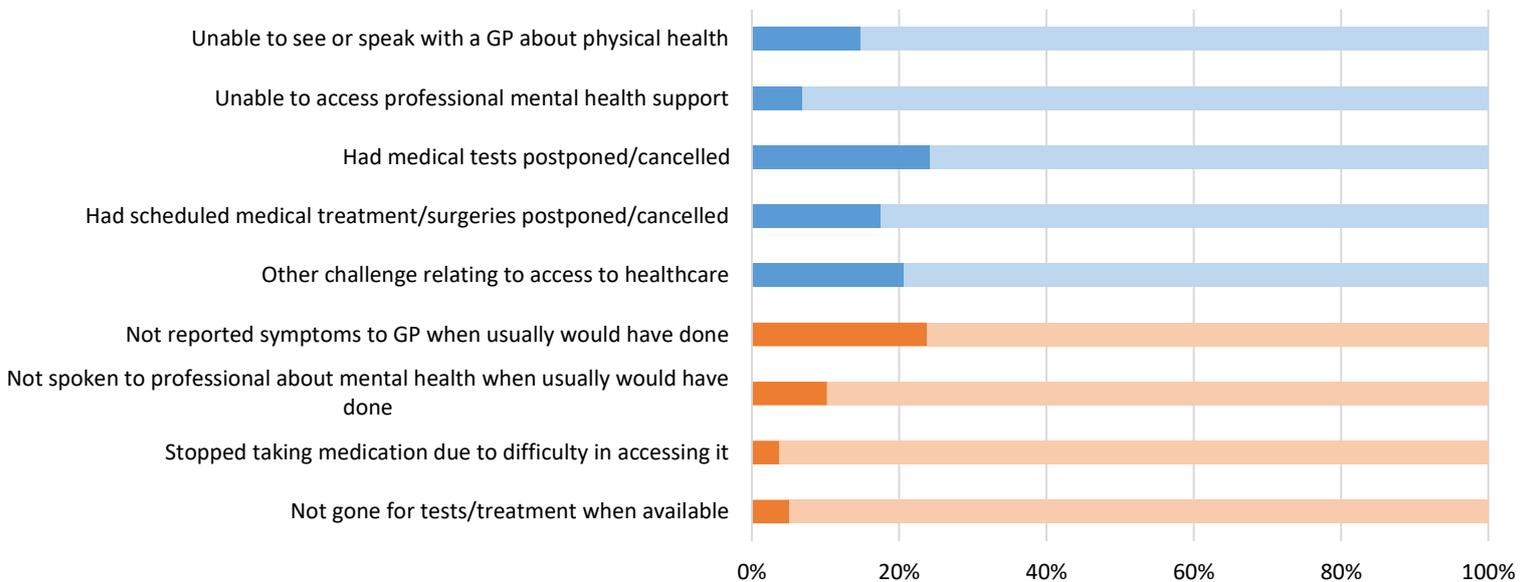


Figure 28j Health barriers and care reported by people without a mental health diagnosis

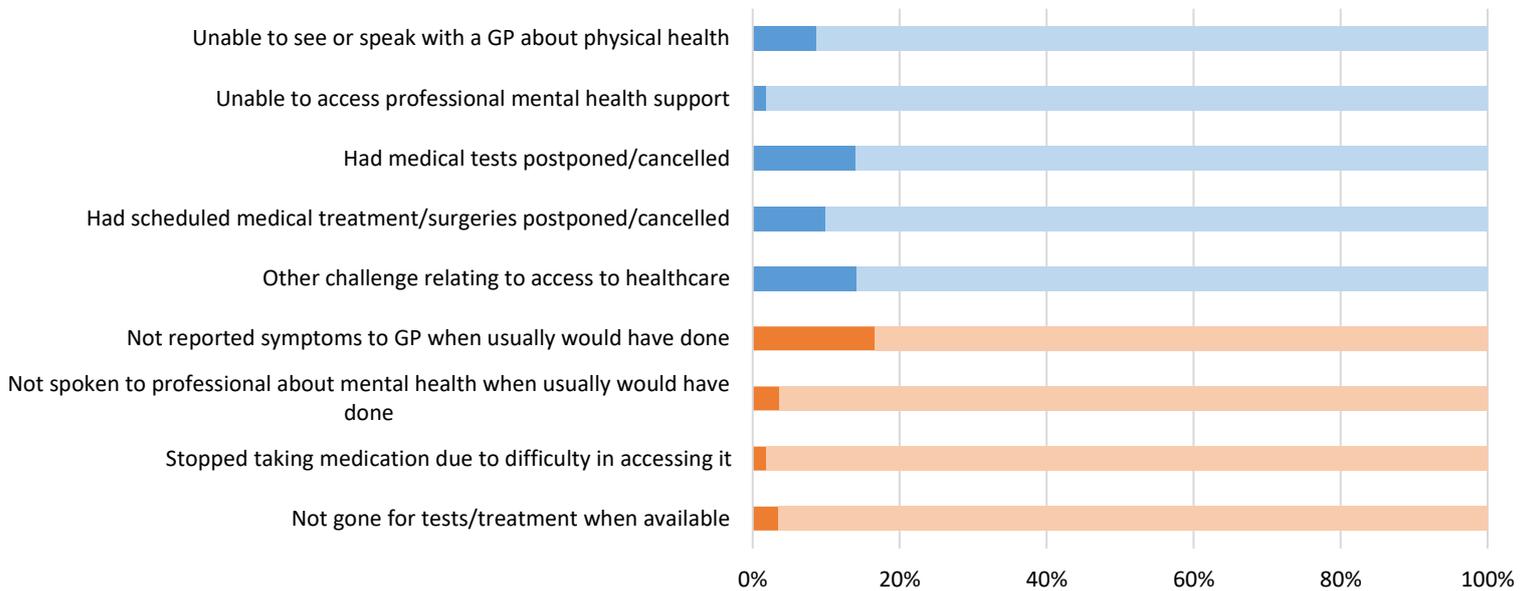
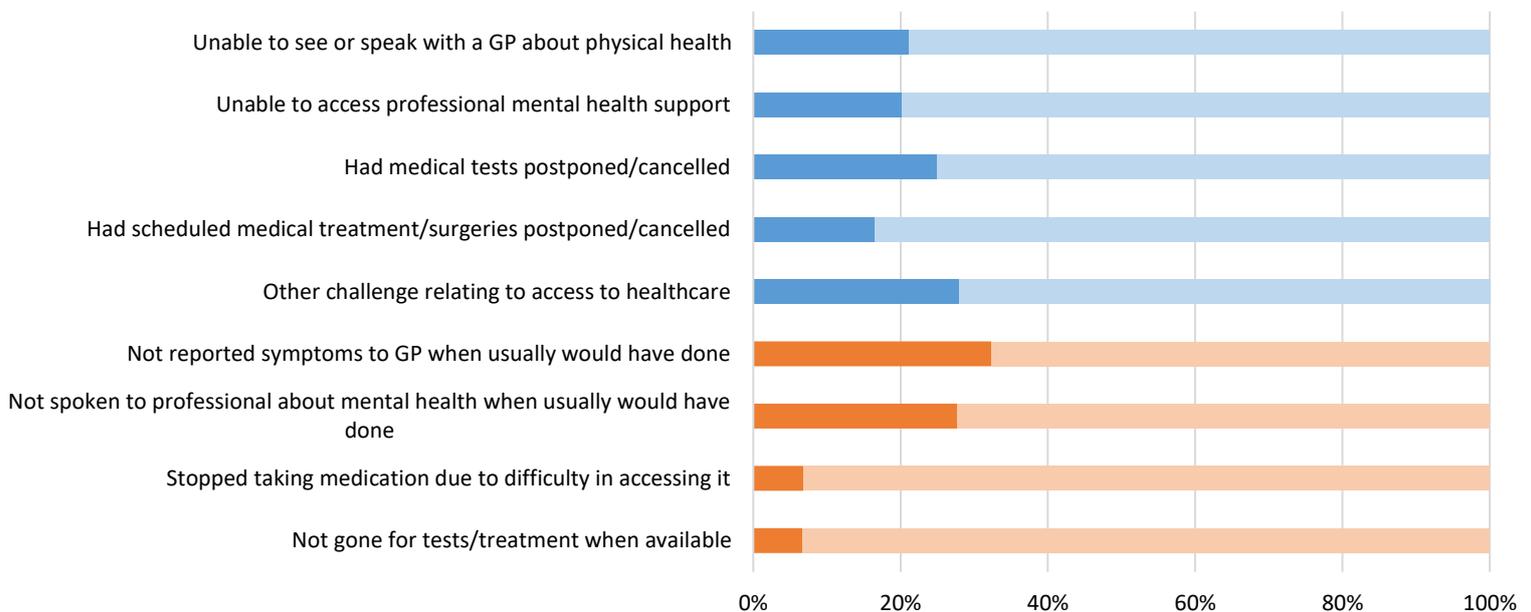


Figure 28k Health barriers and care reported by people with a mental health diagnosis



## 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 21<sup>st</sup> March to the 26<sup>th</sup> July (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](mailto: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](http://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](http://www.covidsocialstudy.org/results)

	Number of observations	%		Number of observations	%
<b>Age</b>			<b>Any diagnosed mental health conditions</b>		
18-29	38,293	6.55	No	483,734	82.7
30-59	330,981	56.6	Yes	100,941	17.3
60+	215,401	36.8	<b>Any diagnosed physical health conditions</b>		
<b>Gender</b>			No	341,357	58.4
Male	146,456	25.2	Yes	243,318	41.6
Female	435,793	74.9	<b>Keyworker</b>		
<b>Ethnicity</b>			No	459,343	78.6
White	558,491	95.8	Yes	125,332	21.4
BAME	24,352	4.18	<b>Living with children</b>		
<b>UK nations</b>			No (excluding those who live alone)	327,857	70.5
England	474,356	81.1	Yes	136,945	29.5
Wales	67,414	11.5	<b>Living area</b>		
Scotland	37,144	6.35	Village/hamlet/isolated dwelling	143,278	24.5
Northern Ireland	5,759	0.98	City/large town/small town	441,395	75.5
<b>Living arrangement</b>			<b>Education levels</b>		
Not living alone	464,802	79.5	GCSE or below	80,987	13.9
Living alone	119,873	20.5	A-levels or equivalent	100,891	17.3
<b>Annual household income</b>			Degree or above	402,797	68.9
>30k	318,678	60.3			
<30k	209,450	39.7			