Covid-19 Social Study
Results Release 21

Dr Daisy Fancourt, Dr Feifei Bu, Dr Hei Wan Mak, Prof Andrew Steptoe
Department of Behavioural Science & Health

23rd September 2020
Table of Contents

Executive summary................................................................. 3
Background................................................................................. 3
Findings .................................................................................... 3
1. Compliance and confidence .................................................. 4
   1.1 Compliance with guidelines ............................................. 4
   1.2 Confidence in Government .............................................. 9
2. Mental Health ....................................................................... 12
   2.1 Depression and anxiety .................................................. 12
   2.2 Stress ............................................................................. 17
3. Self-harm and abuse ............................................................. 26
   3.1 Thoughts of death or self-harm ....................................... 26
   3.2 Self-harm ....................................................................... 29
   3.3 Abuse ............................................................................ 32
4. General well-being ............................................................... 35
   4.1 Life satisfaction ............................................................ 35
   4.2 Loneliness ..................................................................... 38
   4.3 Happiness ..................................................................... 41
5. Vaccination .......................................................................... 44
   5.1 Vaccine attitudes .......................................................... 44
   5.2 Vaccine intentions ......................................................... 48
Appendix .................................................................................... 53
Methods .................................................................................... 53
Demographics of respondents included in this report ................. 53

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.

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 26 weeks of the UK COVID-19 Social Study run by University College London: a panel study of over 70,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this TWENTY-FIRST report, we focus on psychological responses to the first twenty-six weeks since just before the UK lockdown was first announced (21/03 to 20/09). 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*** Vaccine attitudes and flu & Covid-19 vaccine intentions

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

- We asked participants about their attitudes towards vaccines (focusing on vaccines in general rather than a Covid-19 vaccine specifically). Results suggest substantial levels of misinformation amongst the general public about vaccines.
- 53% report believing to varying degrees that vaccines can cause unforeseen effects, with 30% showing substantial beliefs that there can be future problems for adults or children in the future not yet discovered.
- 38% report believing to varying degrees that natural immunity is better than immunity from vaccines, with 4% strongly believing that natural immunity is safer and lasts longer. 25% report believing to varying degrees that vaccines are used for commercial profiteering, with 4% strongly believing that vaccination programmes are a con from pharmaceutical companies and authorities promote vaccination for financial gain. 15% report believing to varying degrees that vaccines do not work, with 4% strongly believing that vaccines do not provide protection.
- Older adults are more likely to display worries about unforeseen effects, preferences for natural immunity, concerns about commercial profiteering, and mistrust of vaccine benefits, as are people from lower-income households.
- On balance, 78% of adults felt they were likely to get a Covid-19 vaccine when one is approved, with 49% saying they were very likely, 15% moderately likely and 13% on balance more likely than unlikely. But 8% felt they were on balance more unlikely than likely to get the vaccine, 4% felt they were moderately unlikely to get it, and 10% very unlikely.
- 64% of adults felt they were likely to get a flu vaccine this winter. Older adults felt they were more likely to get the flu vaccine (73%) than a Covid-19 vaccine (58%). But younger adults felt they were more likely to get the Covid-19 vaccine (46% vs 25% getting the flu vaccine).
- 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.
- Levels of confidence in the central government to handle the Covid-19 epidemic have remained relatively stable over the past fortnight, although there are some indications that levels in England have decreased further.
- In the past fortnight, depression and anxiety levels, life satisfaction, happiness, and loneliness have stayed stable or shown only slight improvements. However, levels are still better than at the start of lockdown. There has still been little change in people reporting major or minor stress due to catching Covid-19, unemployment, finance, or getting food.
1. Compliance and confidence

1.1 Compliance with guidelines

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

 Compliance has continued to remain stable over the last two weeks, with no further signs of decreases for now. “Majority” compliance remains around 90% overall, but is lowest (70-80%) amongst adults under 30. “Complete” compliance remains around 40%, but is 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.¹

 These findings should be interpreted in light of the results in Report 17 showing that understanding of the current guidelines, though, is low. As such, these figures reflect people’s belief that they are complying rather than necessarily actual compliance levels.

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

 ¹ NB there is some variation in compliance amongst younger age groups in the past month, but this may be due to statistical noise rather than specific fluctuations in compliance.
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 2i Majority compliance by age groups

Figure 2j Majority compliance by living arrangement

Figure 2k Majority compliance by household income

Figure 2l Majority compliance by mental health
1.2 Confidence in Government

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

Levels of confidence in the central government to handle the Covid-19 epidemic have remained relatively constant over the past fortnight, with highest levels in Scotland and Wales and lowest levels in England. There are some suggestions that confidence in the government in England may be decreasing again, but this pattern remains to be explored further as more data are collected.

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.

---

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

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

Depression and anxiety levels are similar to two weeks ago. 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\(^3\)), but appear to be 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.

Figure 7a Anxiety by age groups

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

Figure 7b Anxiety by living arrangement

- Living alone
- Not living alone

Figure 7c Anxiety by household income

- Household income <30k
- Household income >30k

Figure 7d Anxiety by mental health diagnosis

- Mental health diagnosis
- No diagnosis
2.2 Stress

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 substantially 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.

NB data on stress relating to unemployment in the last four weeks show some fluctuations amongst younger adults. However, it is unclear if this is due to natural variations in data reporting or new trends and will be explored further in future weeks.
3. Self-harm and abuse

3.1 Thoughts of death or self-harm

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

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

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.\(^5\)

\(^5\) Spikes on particular days are likely due to variability in the data as opposed to indications of particularly adverse experiences on certain days.
3.3 Abuse

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

Abuse has 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.

There appears to be a slight downward trend in reports since the start of lockdown, but this is only very small. Further, 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.
4. General well-being

4.1 Life satisfaction

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

Life satisfaction is similar to levels two weeks ago, but this remains substantially higher than when lockdown came in. There is some indication that it has decreased slightly amongst younger adults in the past week, but this remains to be confirmed with future data. 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 a diagnosed mental health condition, 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 lockdown⁶.

---

4.2 Loneliness

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

Loneliness levels have been stable in the past fortnight, but are noticeably lower than 22 weeks ago. Loneliness levels are still highest in younger adults, people living alone, people with lower household income, people living with children, people living in urban areas, and people with a diagnosed mental health condition.
Respondents were asked to rate to what extent they felt happy during the past week using the Office for National Statistics wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April onwards.

Happiness levels have remained stable in the past fortnight, but are still substantially higher than early in lockdown. There is some indication that happiness has decreased slightly amongst younger adults in the past two weeks, but this remains to be confirmed with future data. Happiness levels remain lowest amongst younger adults, those living alone, those with lower household income, people with a diagnosed mental health condition, and people living in urban areas.
5. Vaccination
5.1 Vaccine attitudes

We asked participants about their attitudes towards vaccines (focusing on vaccines in general rather than a Covid-19 vaccine specifically). Attitudes were measured using the 12-item Vaccination Attitudes Examination (VAX) Scale, with responses ranging from 1 “strongly agree” to 6 “strongly disagree.” The scale contains four subscales covering the extent to which people agree or disagree with statements relating to mistrust of vaccine benefits, worries about unforeseen future effects, concerns about commercial profiteering, and preference for natural immunity. For each subscale, the average score was taken and rounded to the nearest whole number for descriptive reporting. More sophisticated analyses are currently underway.

47% of adults reported overall disagreeing that vaccines cause unforeseen effects (ranging from 5% strongly disagreeing, to 17% moderately disagreeing, to 25% slightly disagreeing). But 30% slightly agreed to statements that there could be unforeseen problems for adults or children in the future not yet discovered, 17% moderately agreed, and 6% strongly agreed.

62% of adults reported overall disagreeing that natural immunity is better than immunity from vaccines (ranging from 18% strongly disagreeing, to 21% moderately disagreeing, to 23% slightly disagreeing). But 26% slightly agreed to statements that natural immunity is safer and lasts longer, 9% moderately agreed, and 4% strongly agreed.

75% of adults reported overall disagreeing that vaccines are used for commercial profiteering (ranging from 30% strongly disagreeing, to 25% moderately disagreeing, to 20% slightly disagreeing). But 15% slightly agreed to statements that vaccination programmes are a con from pharmaceutical companies and authorities promote vaccination for financial gain, 7% moderately agreed, and 4% strongly agreed.

85% of adults reported overall agreeing that vaccines work (ranging from 38% strongly trusting vaccines, to 34% moderately trusting them, to 13% still showing trust on balance). But 7% reported not feeling completely sure that vaccines work and provide protection, 5% expressed more mistrust, and 4% strongly reported mistrusting vaccines.

Older adults were more likely to display worries about unforeseen effects, preferences for natural immunity, concerns about commercial profiteering, and mistrust of vaccine benefits, as were people from lower-income households. But there was no evidence of any differences by gender.

---

Figure 26a Vaccine attitudes amongst younger adults (aged 18-29)

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects

Figure 26b Vaccine attitudes amongst adults (aged 30-59)

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects

Figure 26c Vaccine attitudes amongst older adults (aged 60+)

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects
Figure 26d Vaccine attitudes amongst females

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects

Figure 26e Vaccine attitudes amongst males

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects
Figure 26f Vaccine attitudes amongst people with lower household income

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects

Figure 26g Vaccine attitudes amongst people with higher household income

- Mistrust of vaccine benefit
- Concerns about commercial profiteering
- Preference for natural immunity
- Worries about unforeseen future effects
Participants were asked about their intent to vaccinate either against the flu or against Covid-19 once a vaccine becomes available. The two questions asked “How likely to do you think you are to get a flu vaccine this year?” and “How likely to do you think you are to get a Covid-19 vaccine when one is approved?” Response options ranged from “1- very unlikely” to “6 – very likely”.

On balance, 78% of adults felt they were likely to get a Covid-19 vaccine when one is approved, with 49% saying they were very likely, 15% moderately likely and 13% on balance more likely than unlikely. But 8% felt they were on balance more unlikely than likely to get the vaccine, 4% felt they were moderately unlikely to get it, and 10% very unlikely.

People felt they were more likely to get a Covid-19 vaccine than a flu vaccine, with just 64% reporting that they would be likely to get a flu vaccine this winter. A similar proportion of people reported being very likely to get the flu vaccine (48%) to the Covid-19 vaccine, but twice as many people (21%) felt they were very unlikely to get the vaccine than the Covid-19 vaccine. Nevertheless, these figures are a potential increase on behaviours in the same sample of adults last year, when just 50% of the sample said they had had a flu vaccine.

Intending to get the flu vaccine was heavily patterned by age, with older adults nearly three times more likely to report strongly on intentions to get a flu vaccine (73% of over 60 year olds very likely vs 25% of 18-29 year olds; the same kind of patterning usually exhibited in the UK for the flu vaccine). However, there was not such a clear patterning by age for intention towards the Covid-19 vaccine, with adults aged 18-59 showing similar intentions (45-46%) and older adults only showing slightly higher levels (58%). Moreover, older adults felt they were more likely to get the flu vaccine (73%) than a Covid-19 vaccine (58%). But younger adults felt they were more likely to get the Covid-19 vaccine (46% vs 25% getting the flu vaccine).

Further, adults in lower income households were slightly more likely to show strong intentions towards getting the flu vaccine (51% under £30,000 vs 46% over £30,000), but less likely to show strong intentions towards a potential Covid-19 vaccine (46% under £30,000 vs 53% over £30,000). Keyworkers and people with children showed slightly lower likelihood of strong intentions towards getting either vaccine, which could be indicative of a belief of higher natural immunity through prior exposure. People in Scotland and Wales also showed slightly higher intentions than people in England (50% vs 47% for flu vaccination and 53% vs 49% for Covid-19 vaccination. There was little difference in intentions to get a Covid-19 vaccine based on living arrangement, presence of a diagnosed mental health condition, or geographical location.
Figure 28e Flu vaccine intentions by nations

England
Scotland/Wales

0% 20% 40% 60% 80% 100%
1-Very unlikely 2 3 4 5 6-Very likely

Figure 28f Flu vaccine intentions by keyworker status

Keyworker
Anyone else

0% 20% 40% 60% 80% 100%
1-Very unlikely 2 3 4 5 6-Very likely

Figure 28g Flu vaccine intentions by living with children

With children
Without children

0% 20% 40% 60% 80% 100%
1-Very unlikely 2 3 4 5 6-Very likely

Figure 28h Flu vaccine intentions by living area

City/town
Village/other

0% 20% 40% 60% 80% 100%
1-Very unlikely 2 3 4 5 6-Very likely
Figure 29a Covid-19 vaccine intentions by age groups

Age 60+
Age 30-59
Age 18-29

0% 20% 40% 60% 80% 100%

1-Very unlikely 2 3 4 5 6-Very likely

Figure 29b Covid-19 vaccine intentions by living arrangement

Living alone
Not living alone

0% 20% 40% 60% 80% 100%

1-Very unlikely 2 3 4 5 6-Very likely

Figure 29c Covid-19 vaccine intentions by household income

Household income <30k
Household income >30k

0% 20% 40% 60% 80% 100%

1-Very unlikely 2 3 4 5 6-Very likely

Figure 29d Covid-19 vaccine intentions by mental health diagnosis

Mental health diagnosis
No diagnosis

0% 20% 40% 60% 80% 100%

1-Very unlikely 2 3 4 5 6-Very likely
Figure 29e Covid-19 vaccine intentions by nations

England
Scotland/Wales

Figure 29f Covid-19 vaccine intentions by keyworker status

Keyworker
Anyone else

Figure 29g Covid-19 vaccine intentions by living with children

With children
Without children

Figure 29h Covid-19 vaccine intentions by living area

City/town
Village/other
Appendix

Methods

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

Specifically, in the analyses presented here we included adults in the UK. We used new cross-sectional data from individuals as they entered the study and also included weekly longitudinal data as participants received their routine follow-up. In this report, we treated the data as repeated cross-sectional data collected daily from the 21st March to the 20th September (the latest data available). Aiming at a representative sample of the population, we weighted the data for each day to the proportions of gender, age, ethnicity, education and country of living obtained from the Office for National Statistics (ONS, 2018). Where results for subgroups show volatility, this could be a product of the sample size being smaller so caution in interpreting these results is encouraged.

The study is focusing specifically on the following questions:

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

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

Demographics of respondents included in this report

Table: Demographics of observations from participants in the pooled raw data (unweighted; data are weighted for analyses)
For full demographics weighted to population proportions, see the User Guide at www.covidsocialstudy.org/results

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of observations</th>
<th>%</th>
<th>Any diagnosed mental health conditions</th>
<th>Number of observations</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>43,393</td>
<td>6.14</td>
<td>No</td>
<td>586,746</td>
<td>83.0</td>
</tr>
<tr>
<td>30-59</td>
<td>393,768</td>
<td>55.7</td>
<td>Yes</td>
<td>120,200</td>
<td>17.0</td>
</tr>
<tr>
<td>60+</td>
<td>269,785</td>
<td>38.2</td>
<td>Keyworker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>177,372</td>
<td>25.2</td>
<td>No</td>
<td>557,920</td>
<td>78.9</td>
</tr>
<tr>
<td>Female</td>
<td>526,715</td>
<td>74.8</td>
<td>Yes</td>
<td>149,026</td>
<td>21.1</td>
</tr>
<tr>
<td>Living area</td>
<td></td>
<td></td>
<td>Living with children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>571,745</td>
<td>81.7</td>
<td>No (excluding those who live alone)</td>
<td>399,262</td>
<td>71.3</td>
</tr>
<tr>
<td>Wales</td>
<td>83,985</td>
<td>12.0</td>
<td>Yes</td>
<td>160,587</td>
<td>28.7</td>
</tr>
<tr>
<td>Scotland</td>
<td>44,318</td>
<td>6.33</td>
<td>Village/hamlet/isolated dwelling</td>
<td>175,382</td>
<td>24.8</td>
</tr>
<tr>
<td>Living arrangement</td>
<td></td>
<td></td>
<td>City/large town/small town</td>
<td>531,564</td>
<td>75.2</td>
</tr>
<tr>
<td>Not living alone</td>
<td>559,849</td>
<td>79.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living alone</td>
<td>147,097</td>
<td>20.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual household income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;30k</td>
<td>381,791</td>
<td>59.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30k</td>
<td>255,888</td>
<td>40.1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>