



# Covid-19 Social Study

## Results Release 14

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# Table of Contents

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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 Thought 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. Experience of lockdown .....	44
5.1 Enjoy the lockdown .....	44
5.2 Miss being in lockdown .....	47
5.3 Feelings about future lockdowns .....	50
6. Health behaviours .....	53
6.1 Health behaviours .....	53
Appendix .....	59
Methods .....	59
Demographics of respondents included in this report .....	59

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*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

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## Background

This report provides data from Week 14 of the UK COVID-19 Social Study run by University College London: a panel study of over 90,000 respondents focusing on the psychological and social experiences of adults living in the UK during the Covid-19 pandemic.

In this FOURTEENTH report, we focus on psychological responses to the first thirteen weeks of government measures requiring people to stay at home (21/03-21/06). 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\*\*\* Experience of lockdown and health behaviours

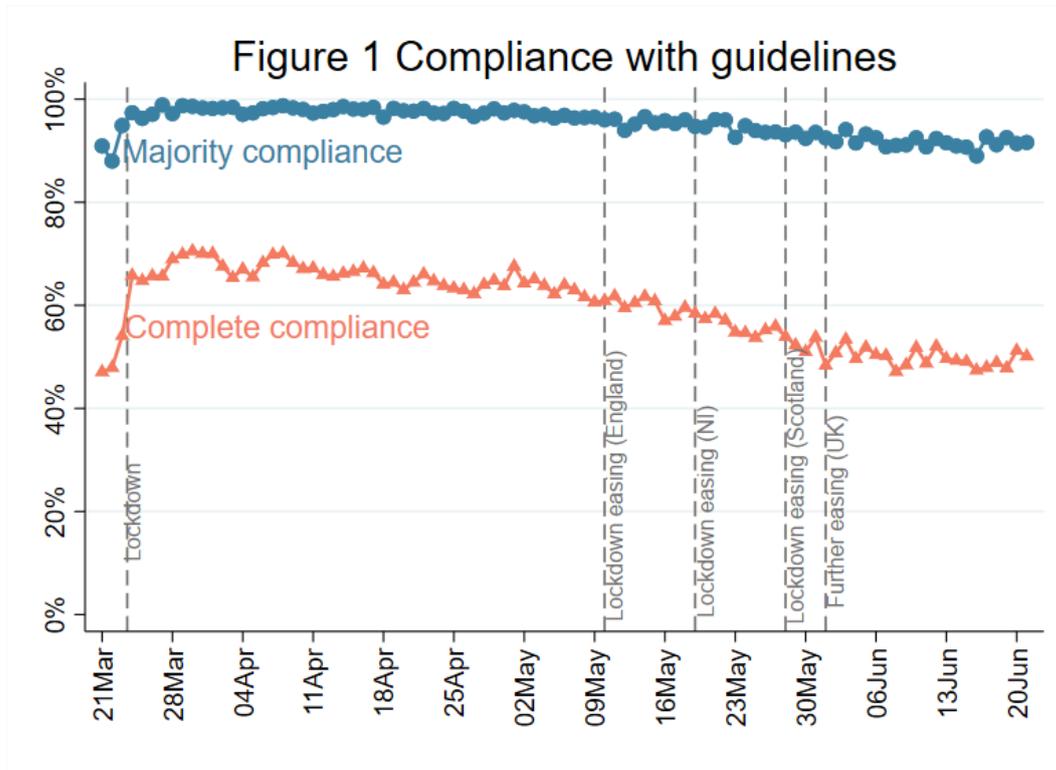
This study is not representative of the UK population but instead was designed to have good stratification across a wide range of socio-demographic factors enabling meaningful subgroup analyses to understand the experience of Covid-19 for different groups within society. Data are weighted using auxiliary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

## Findings

- 32% of adults reported that they have been enjoying being in lockdown more than not enjoying it, while 46% reported not enjoying it. Adults aged 30-59 have been enjoying lockdown the most, as have people living with others, people with higher incomes, and people living with children. There has been little difference by ethnicity.
- 26% of adults feel they will miss lockdown, while 61% feel they will not miss it overall. Adults aged 30-59 are most likely to feel they will miss it, as are people with a diagnosed mental illness.
- 50% feel they will overall not look forward to another potential lockdown, while 22% feel they would look forward to it. People aged 30-59 are most likely to look forward to another lockdown.
- Health behaviours have stayed constant across lockdown for the majority of respondents, but some adults have reported engaging more in less healthy behaviours, including 17% of adults reporting eating more than usual, 23% reporting eating less healthily than normal, 40% reporting gaining weight (4% reporting gaining lots of weight), 17% reporting drinking more than normal, 33% reporting smoking more than usual, and 11% reporting gambling more than usual.
- Young people have been most likely to change their eating and diet behaviours, as have women and people from Black and minority ethnic (BAME) groups. Adults aged 30-59 and women are most likely to have gained weight, whilst adults under the age of 30 and people from BAME groups are most likely to have lost weight. Younger adults, women and people from BAME groups are more likely to have drunk less than usual, although cigarette usage has gone up more in these groups. Men are more likely to have been gambling less than usual, although younger adults have changed their gambling behaviours most in both directions, with some increasing and some decreasing.
- Compliance with government guidelines has plateaued over the last two weeks. Levels of confidence in the central government to handle the Covid-19 epidemic remain lower in England than in other nations, but have not decreased any further in the past week.
- This past week, mental health has remained relatively stable across all measures.

# 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 (completely). Of note, we ask participants to self-report their compliance, which relies on participants understanding the regulations. Figure 1 shows the percentage of people who followed the recommendations “completely” (with a score of 7) or to a large extent (with a score of 5-7; described below as “majority” compliance).

Compliance behaviours have plateaued over the last two weeks. Both “complete” and “majority” compliance have, for now, stopped decreasing, perhaps as new rules being introduced across UK nations have started to align more with behaviours that people are already engaging in. Levels of “majority” compliance differ only by age (with lower levels amongst younger adults) while “complete” compliance remain lowest amongst young people, people with higher household incomes, people in England, and people living in urban areas.

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

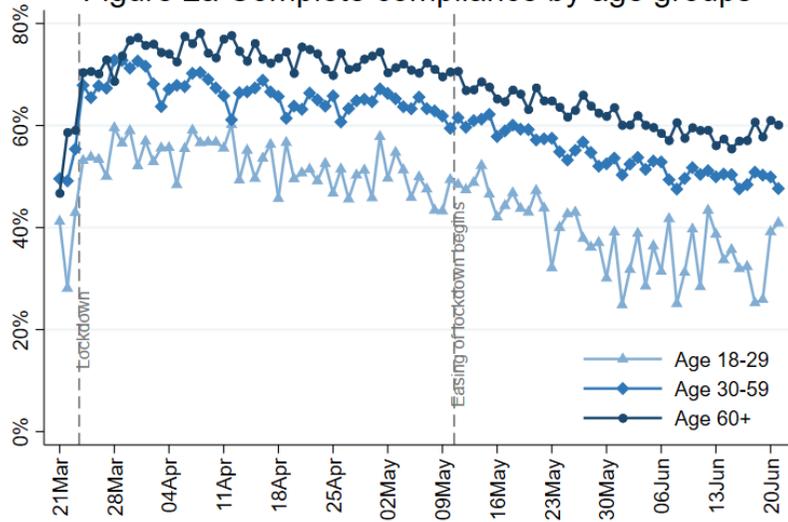


Figure 2b Complete compliance by living arrangement

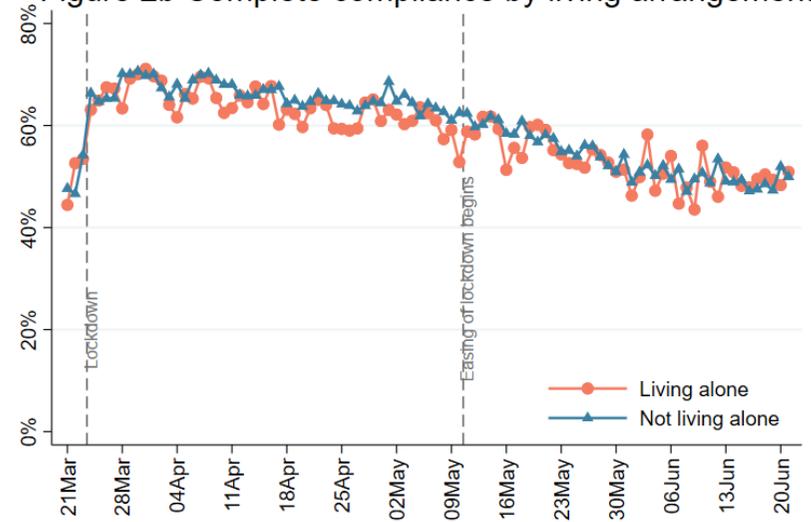


Figure 2c Complete compliance by household income

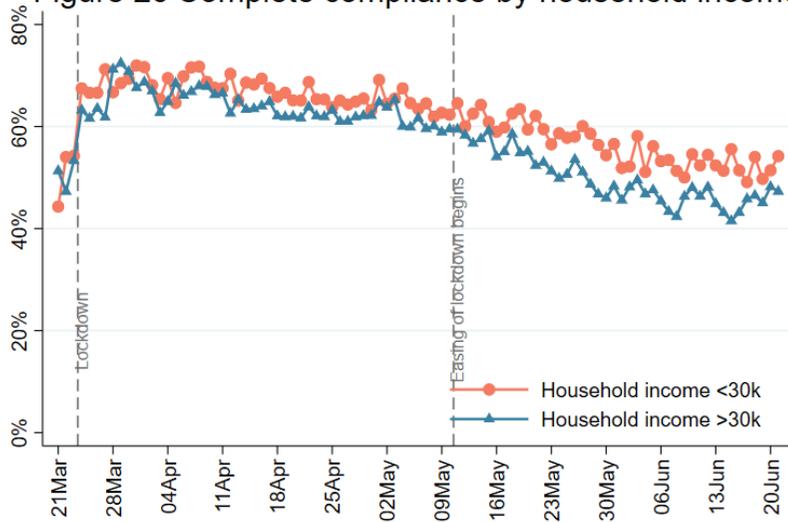


Figure 2d Complete compliance by mental health

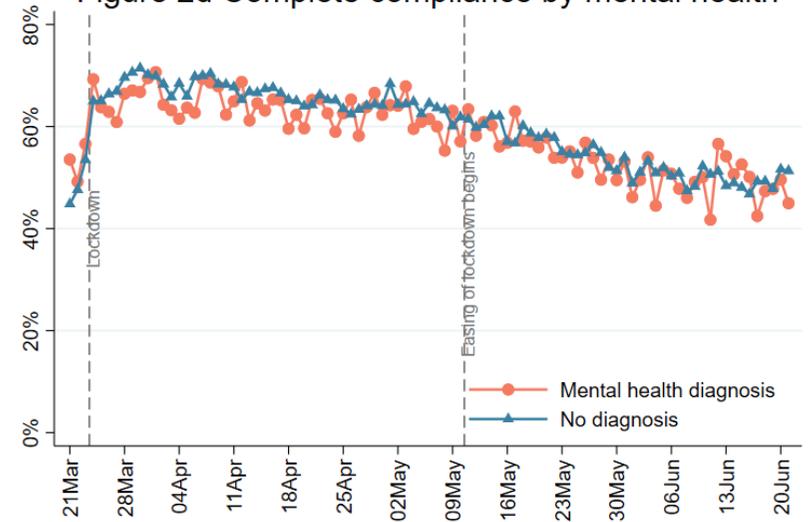


Figure 2e Complete compliance by nations

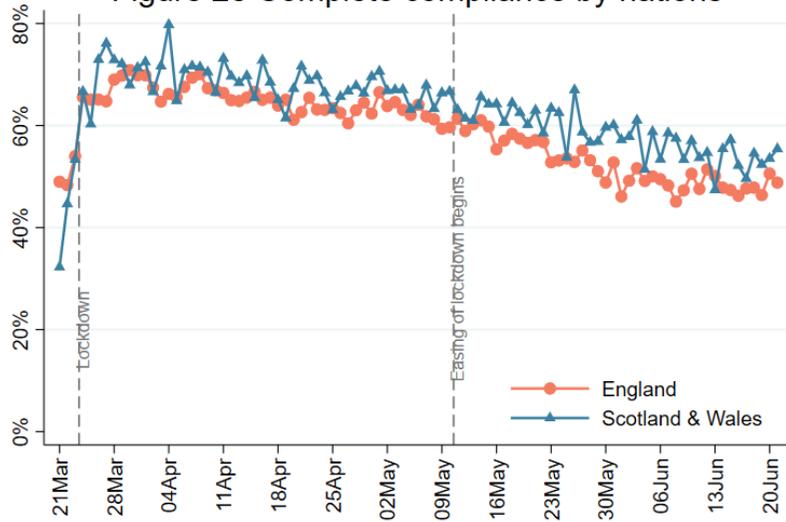


Figure 2f Complete compliance by keyworker status

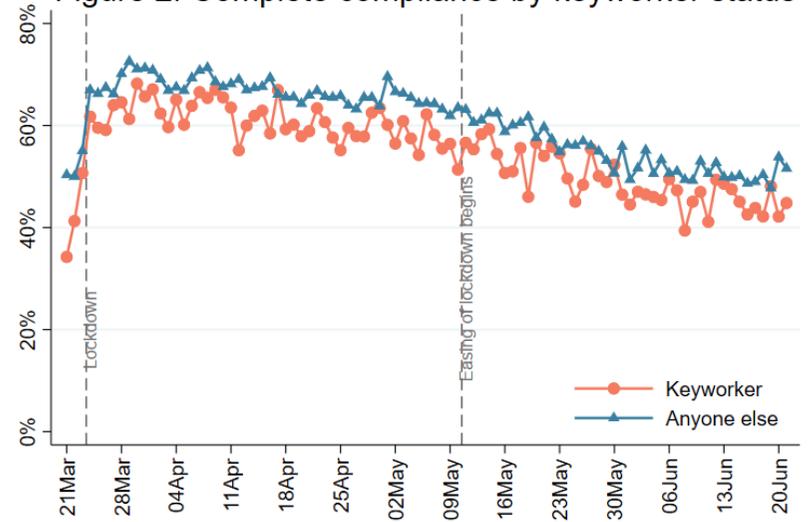


Figure 2g Complete compliance by living with children

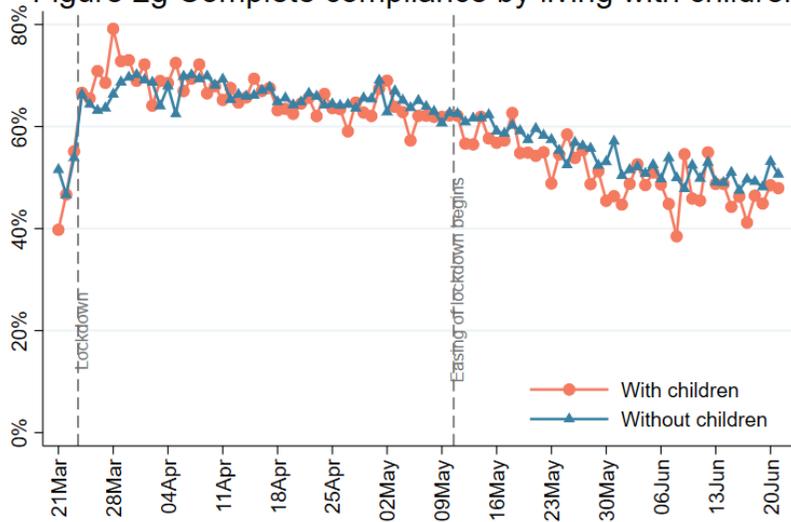
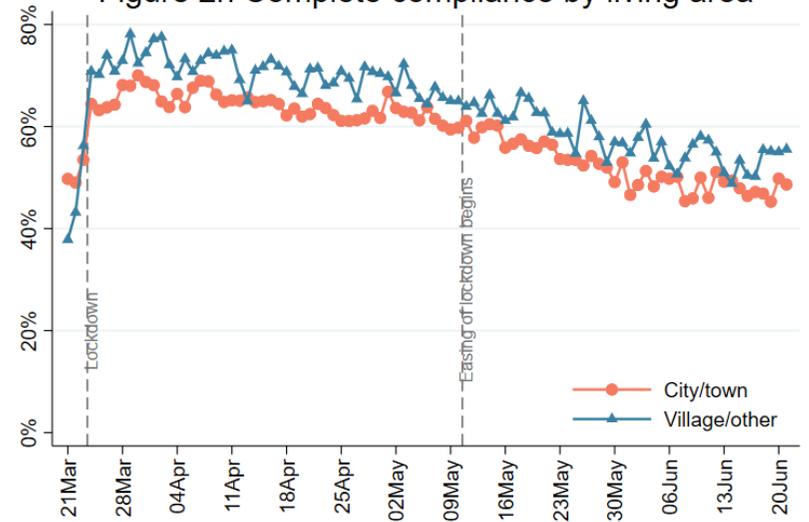
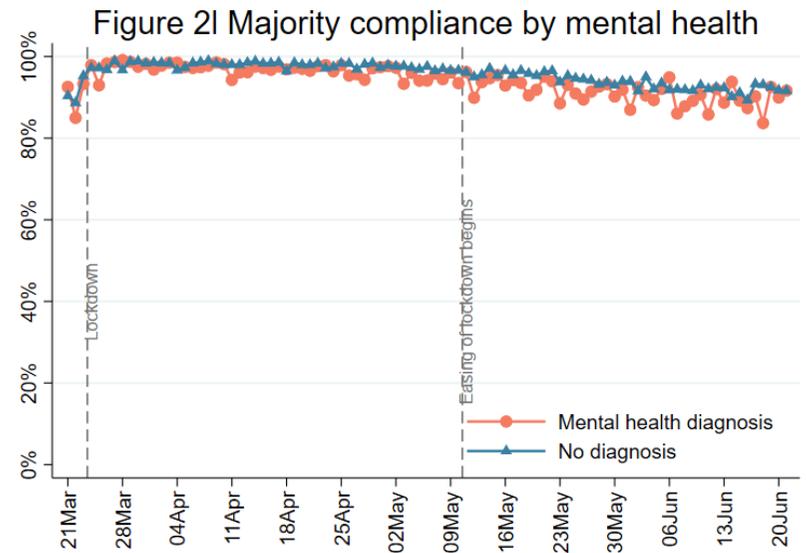
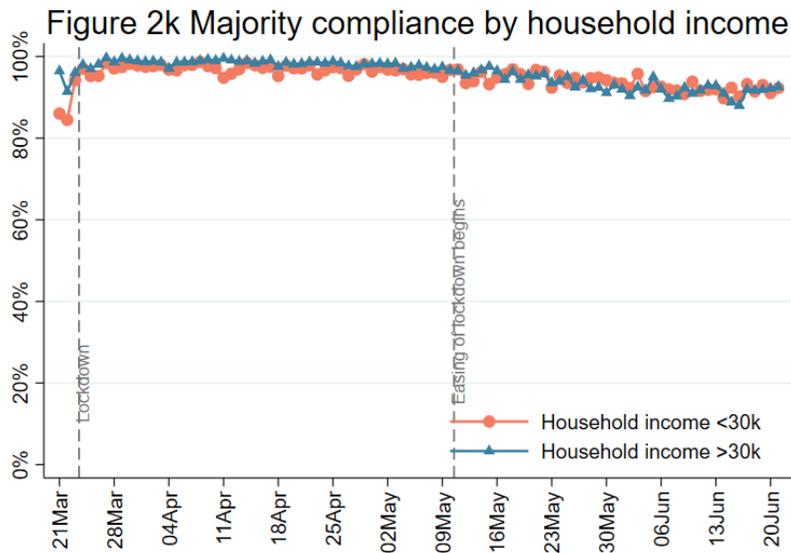
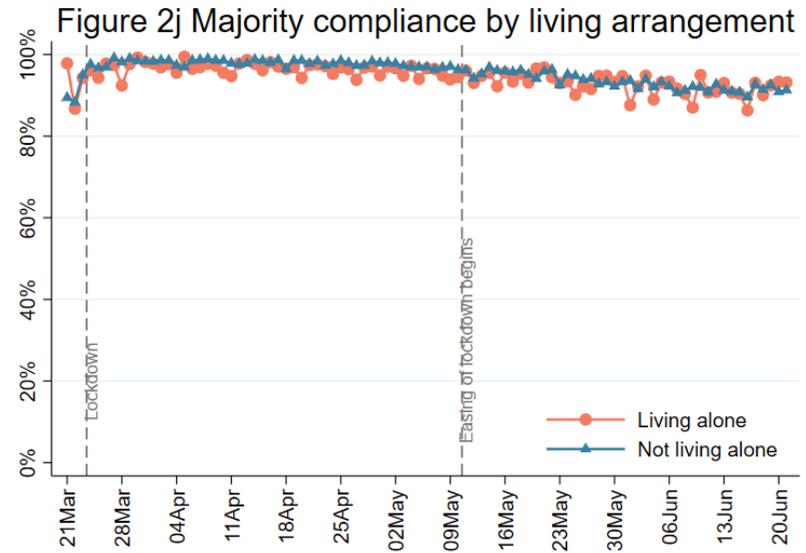
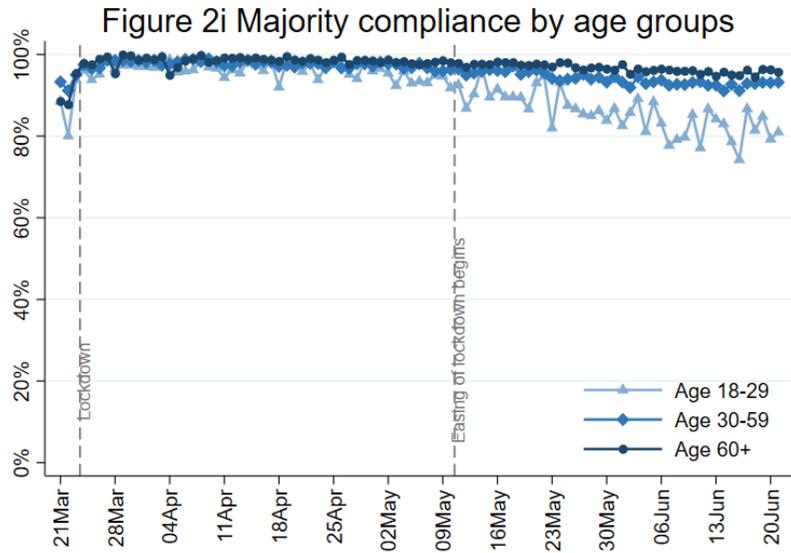
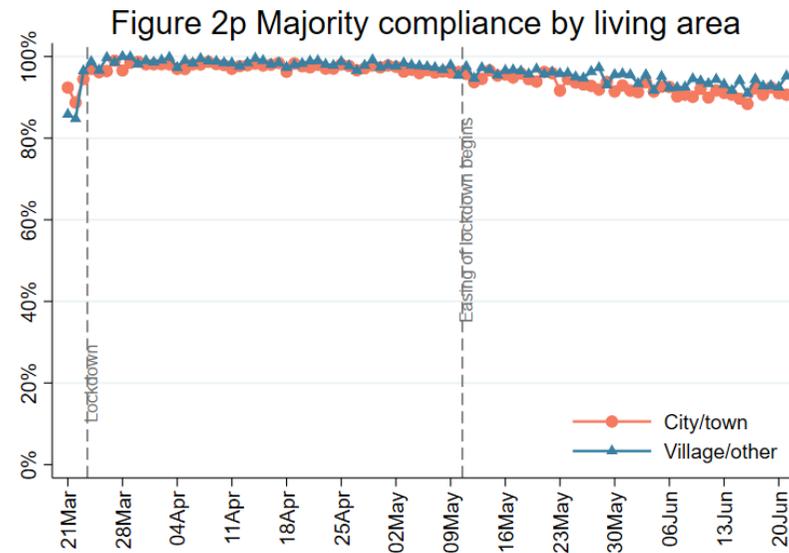
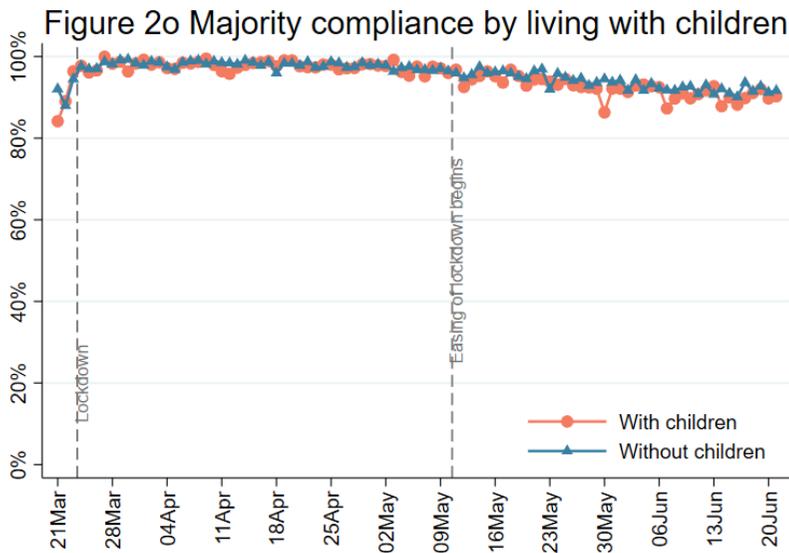
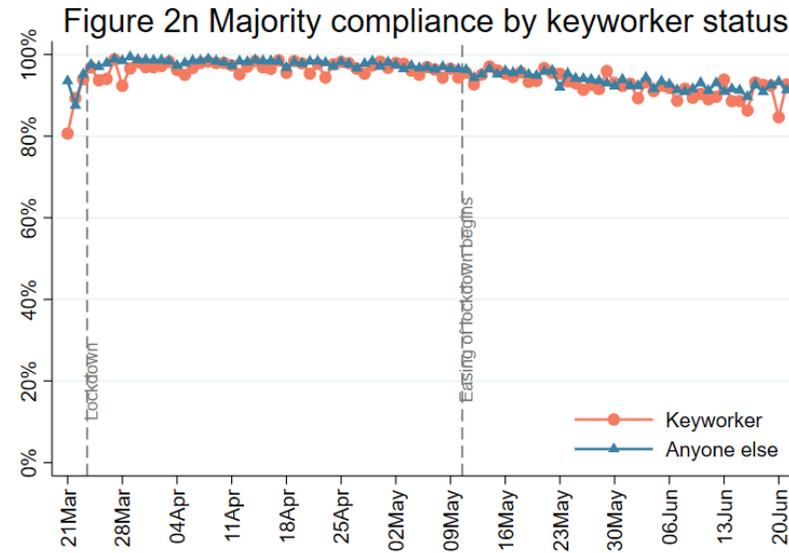
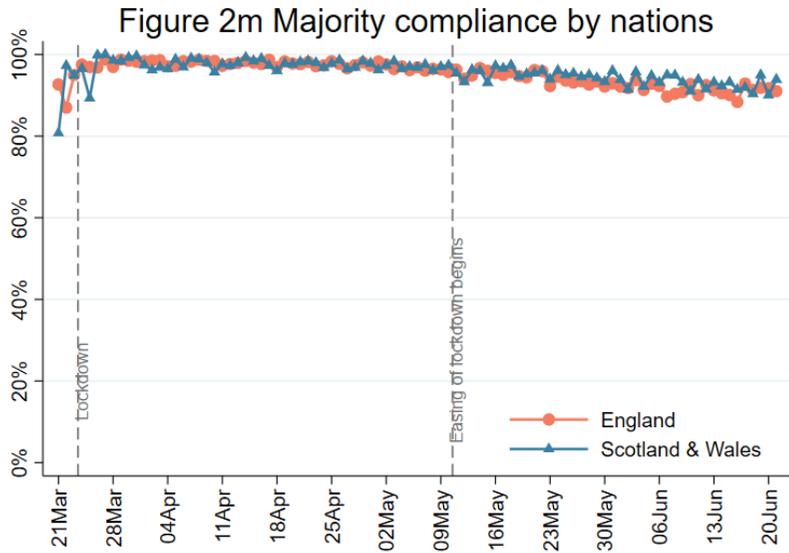


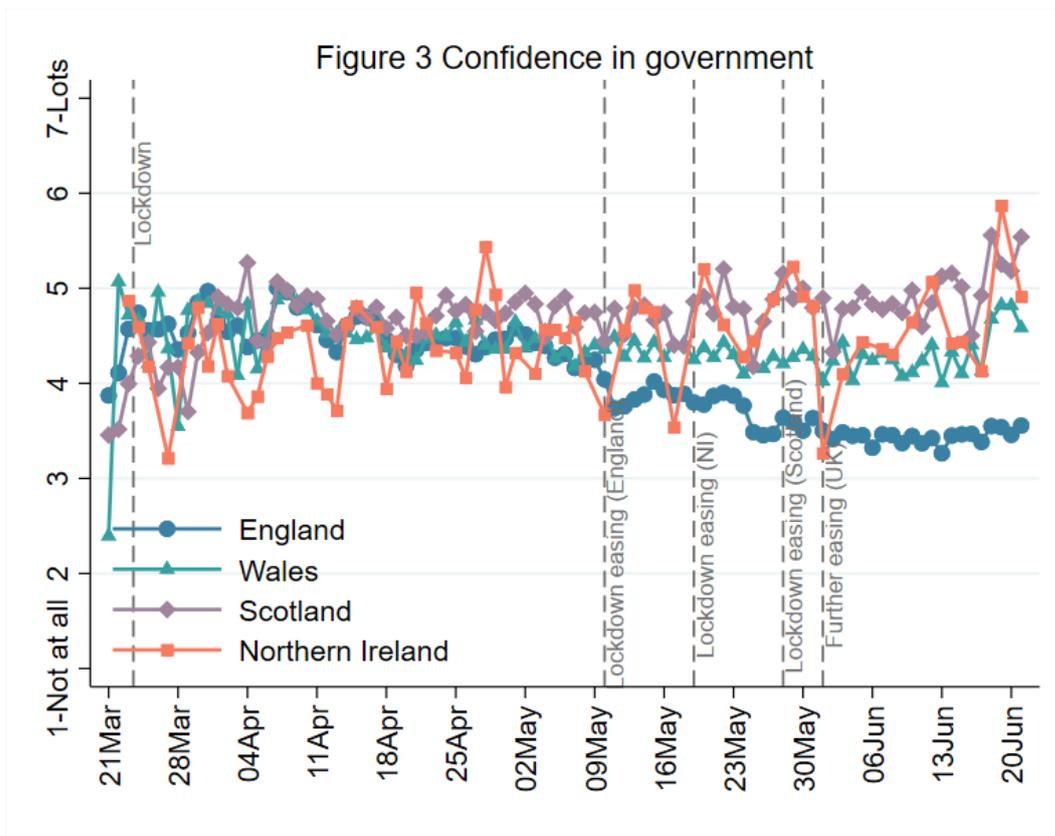
Figure 2h Complete compliance by living area







## 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 remain lower in England than in other nations, but have not decreased any further in the past week. However, levels of confidence in devolved governments in other UK nations have increased in the past week.<sup>1</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 will look at subgroups in devolved nations). In England, confidence in government is still lowest in those under the age of 30, with average scores of 2.6 out of 7. Scores amongst adults over the age of 30 are around 3.5-4. 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>1</sup> Figures for Northern Ireland show greater volatility but this is likely a function of the sample size in Northern Ireland being smaller than for other countries.

Figure 4a Confidence by age groups

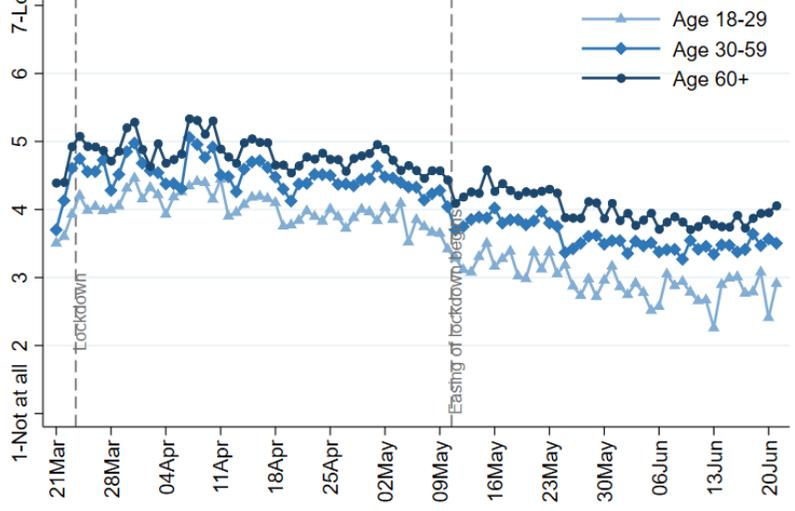


Figure 4b Confidence by living arrangement

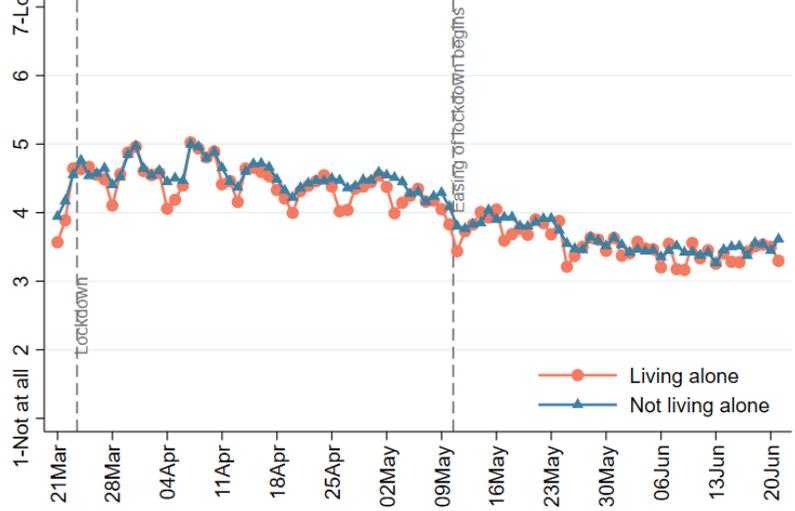


Figure 4c Confidence by household income

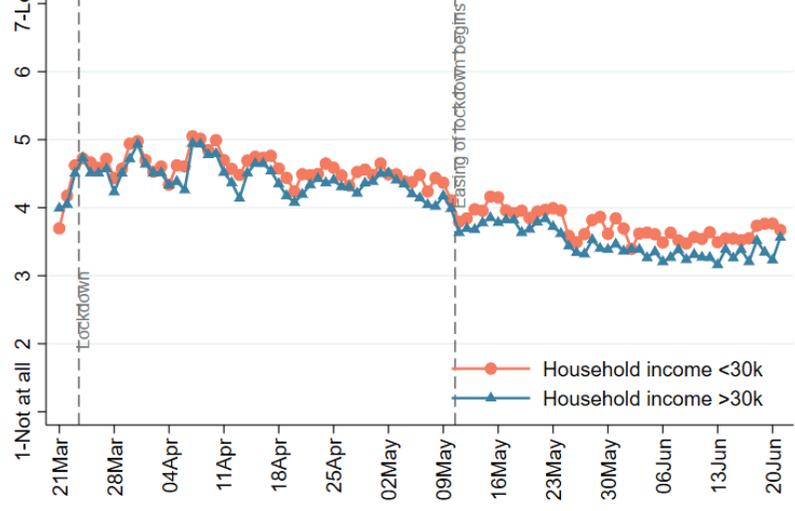
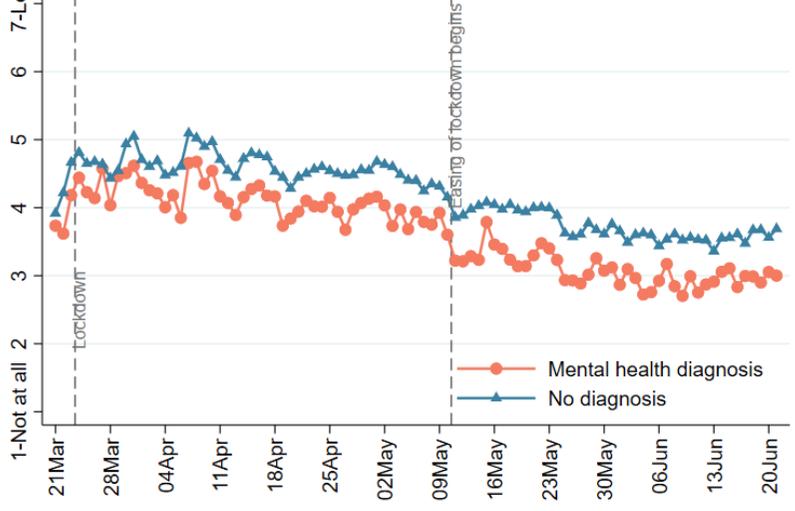
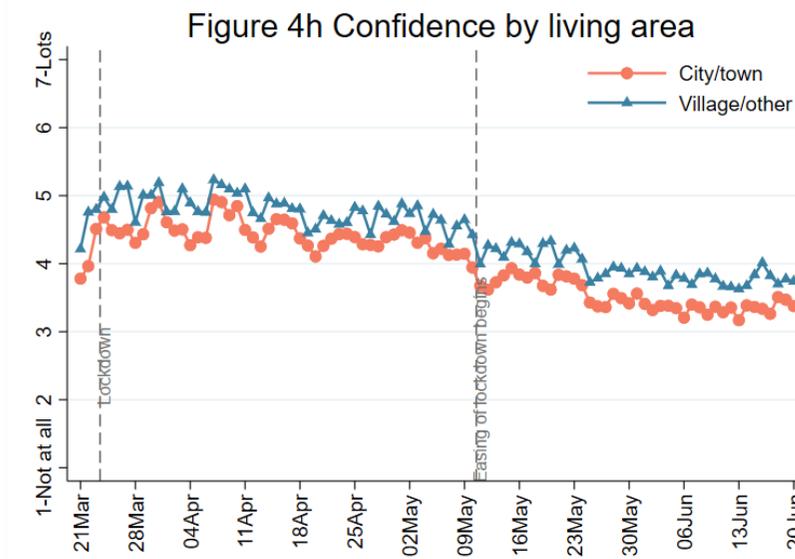
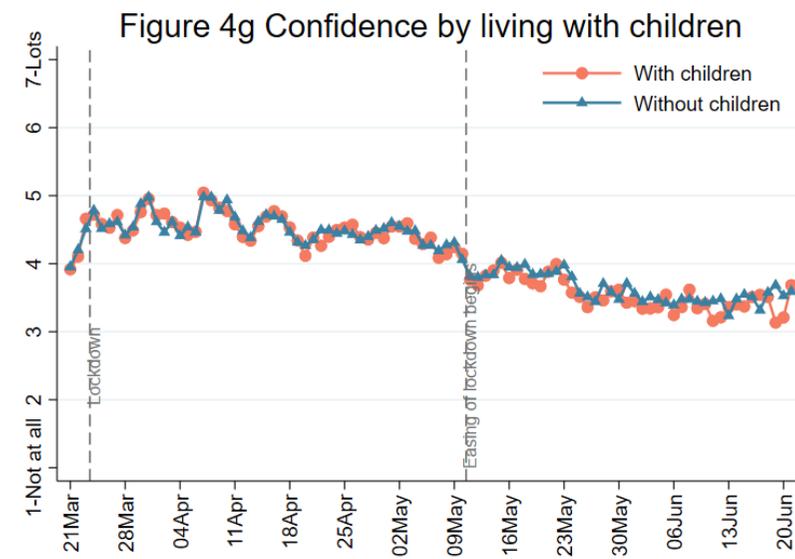
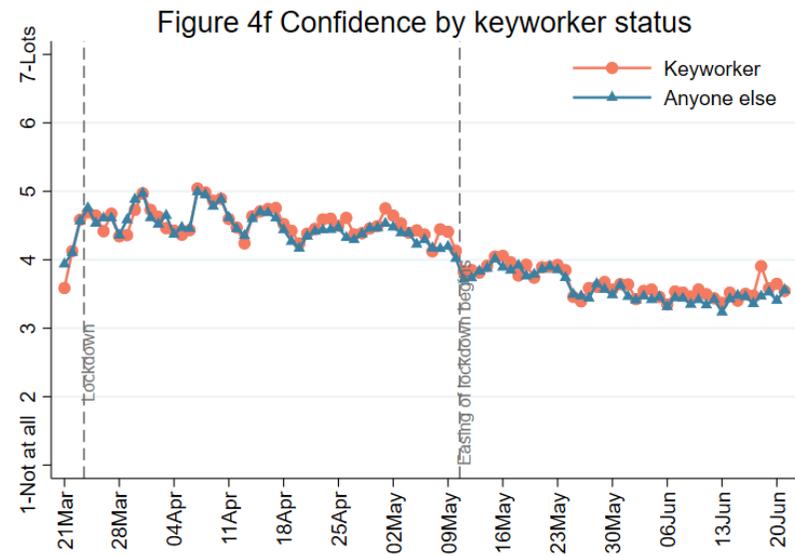
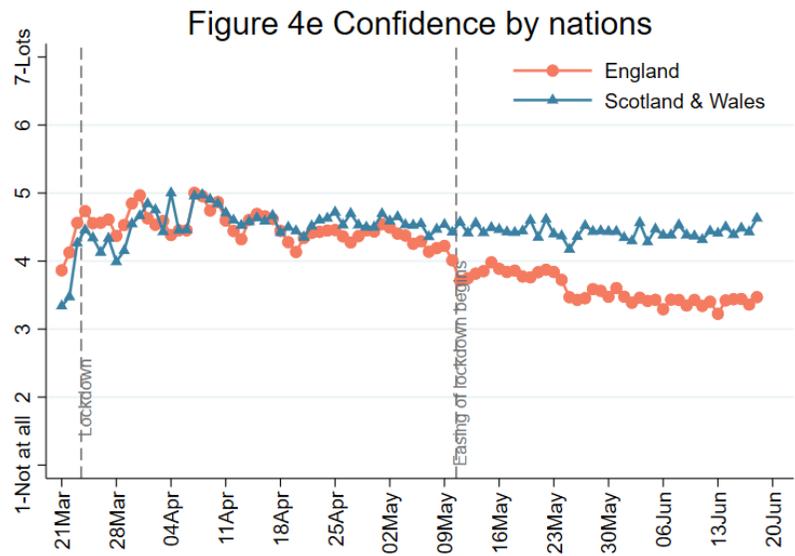


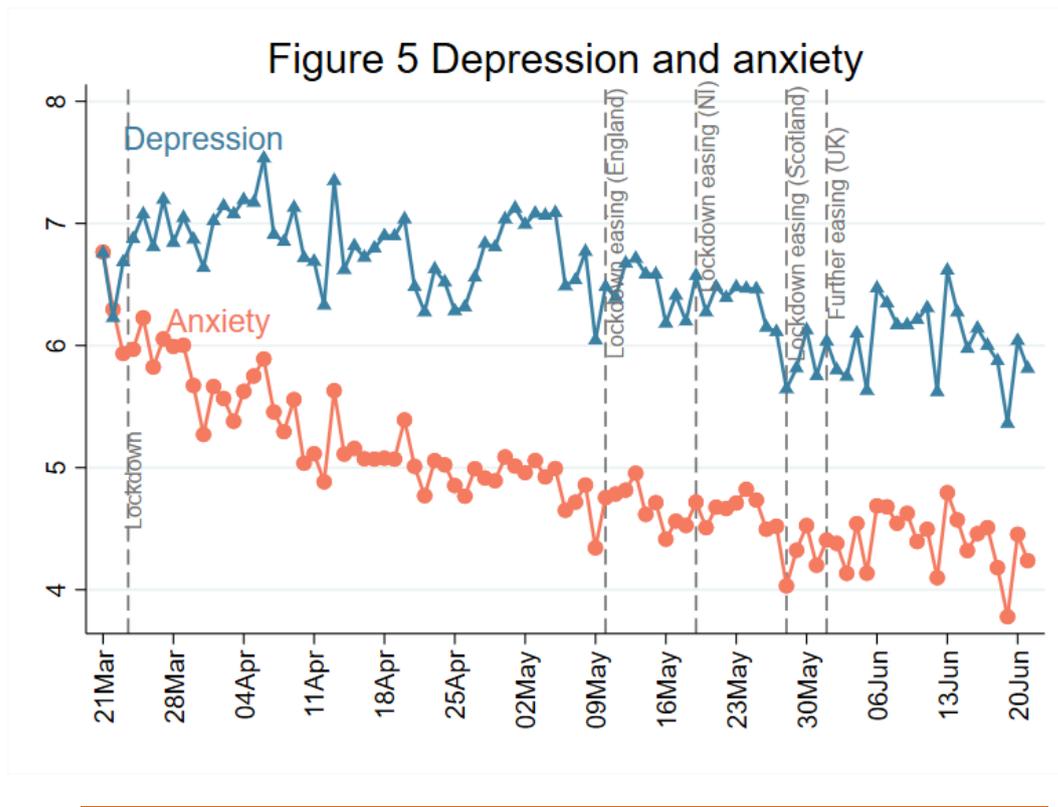
Figure 4d Confidence by mental health diagnosis





## 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 two weeks, depression and anxiety levels have remained relatively stable. 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>2</sup>). Depression and anxiety are still highest in young people, those living alone, those with lower household income, people with a diagnosed mental illness, people living with children, and people living in urban areas.

<sup>2</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

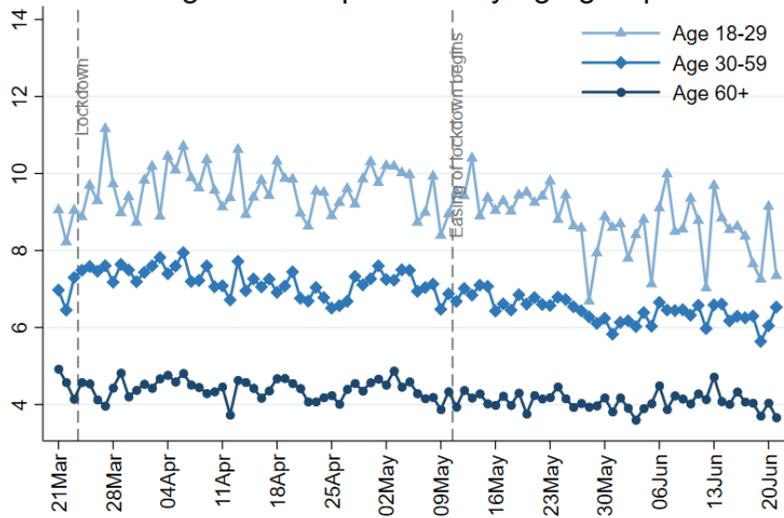


Figure 6b Depression by living arrangement

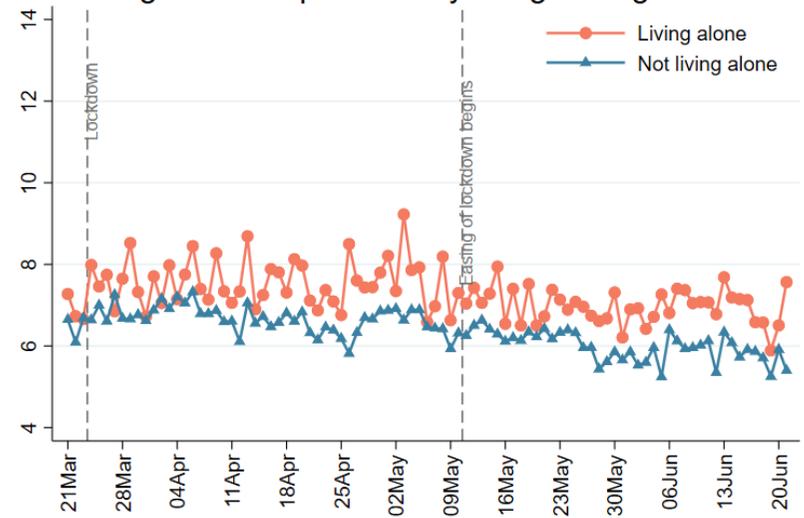


Figure 6c Depression by household income

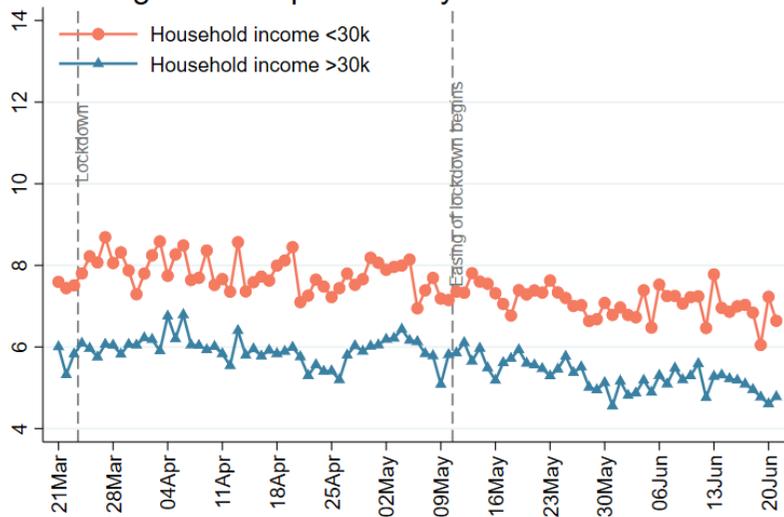


Figure 6d Depression by mental health diagnosis

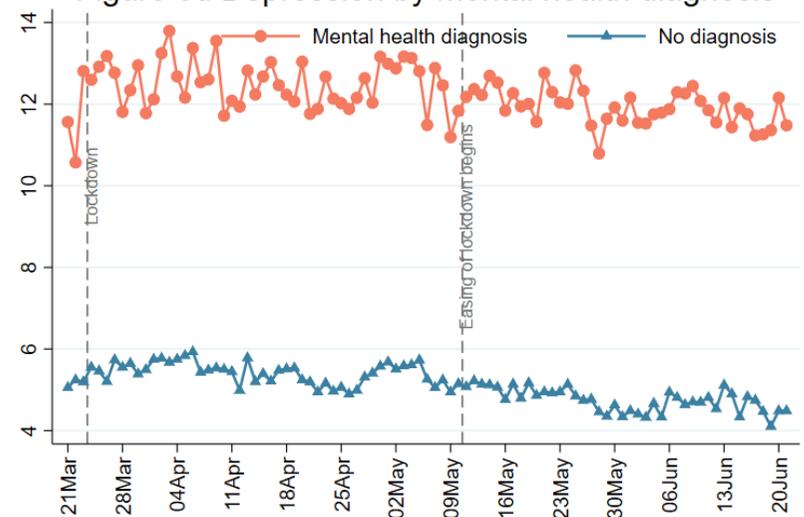


Figure 6e Depression by nations

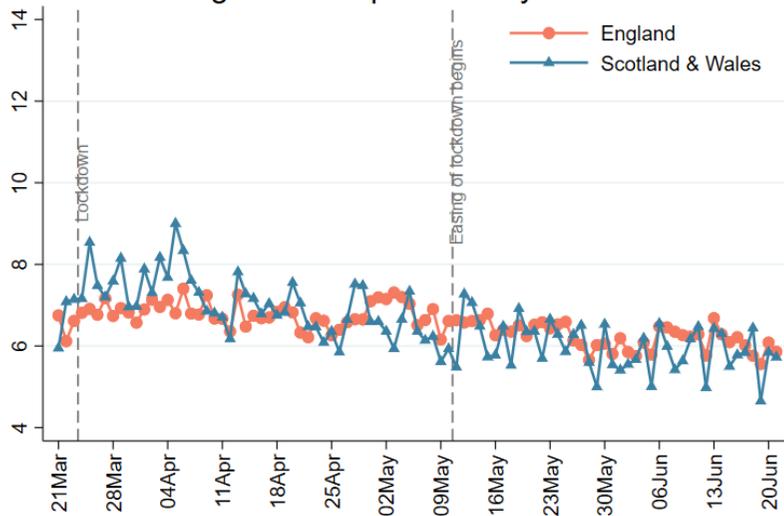


Figure 6f Depression by keyworker status

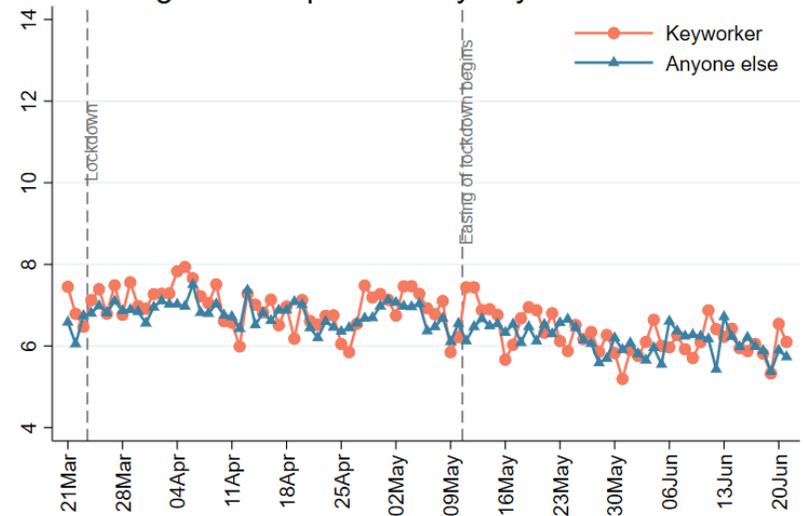


Figure 6g Depression by living with children

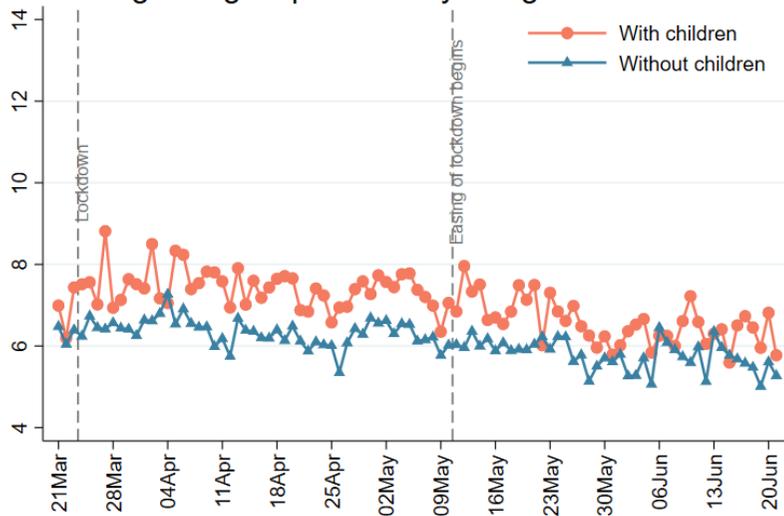


Figure 6h Depression by living area

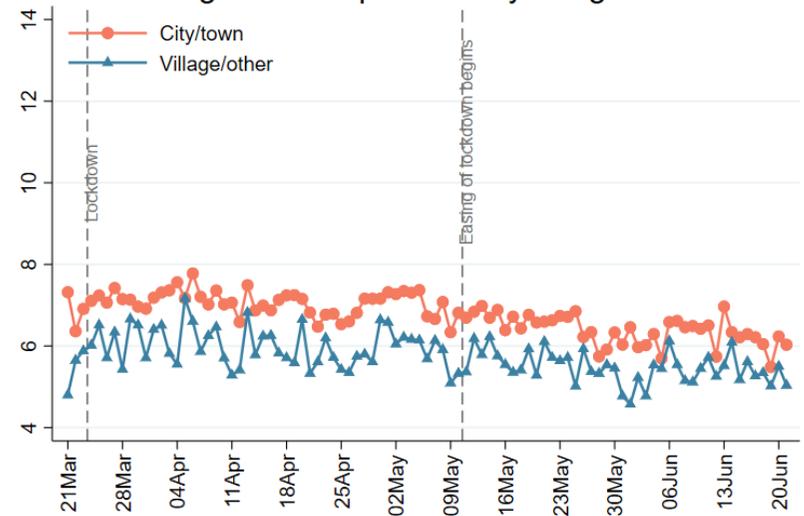


Figure 7a Anxiety by age groups

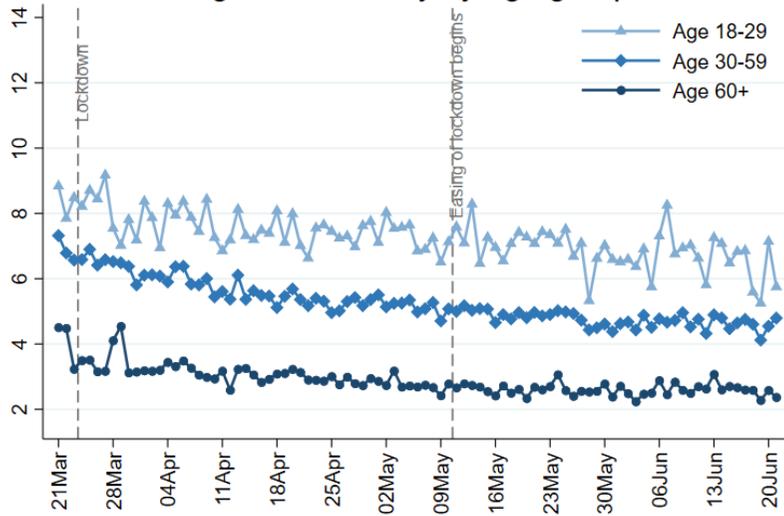


Figure 7b Anxiety by living arrangement

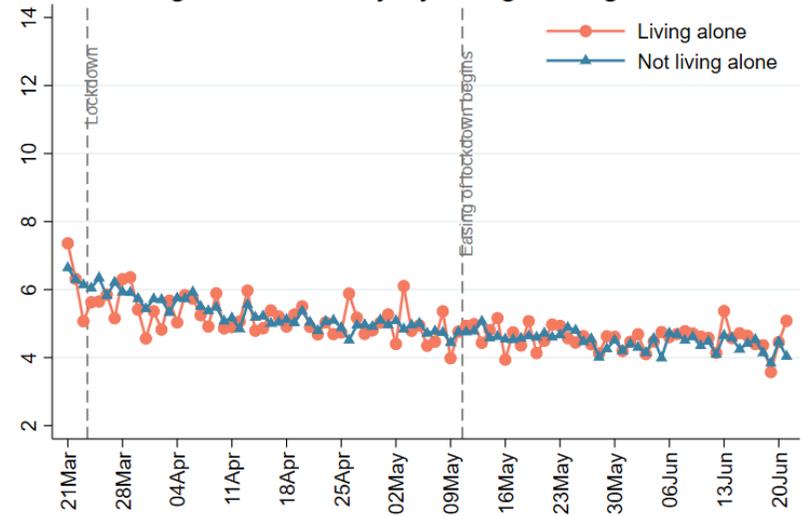


Figure 7c Anxiety by household income

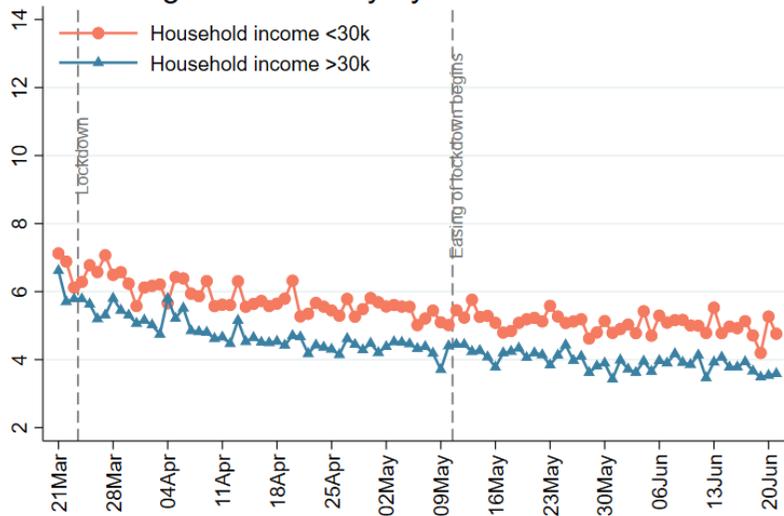


Figure 7d Anxiety by mental health diagnosis

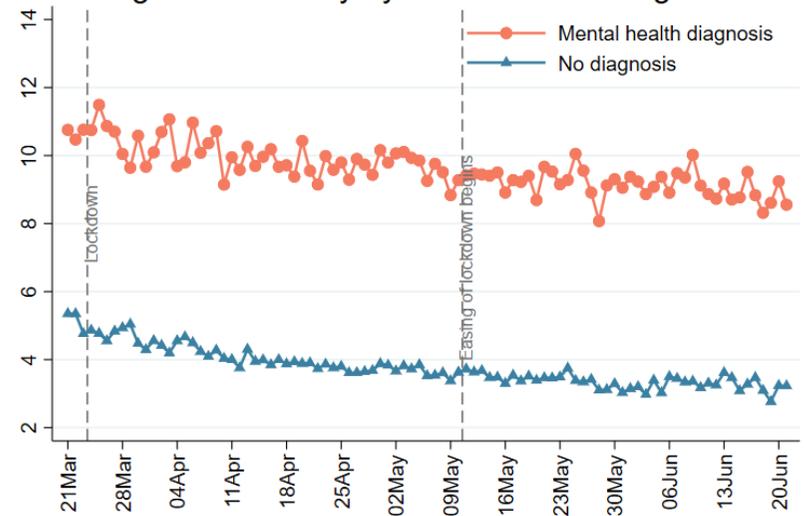


Figure 7e Anxiety by nations

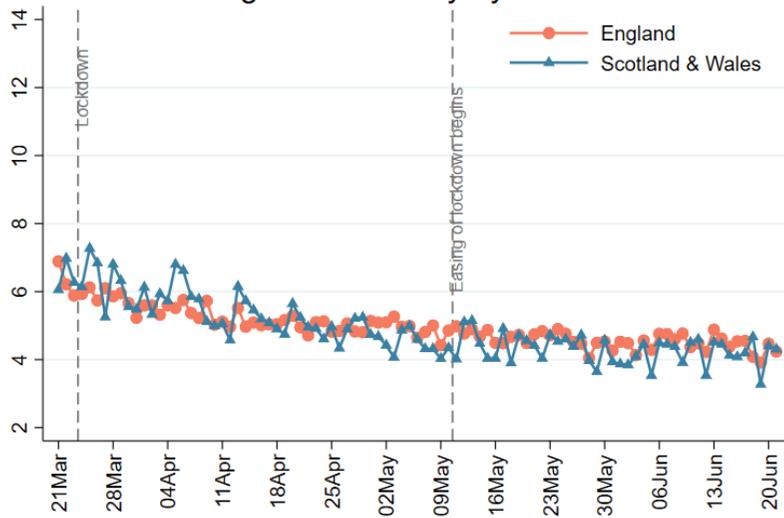


Figure 7f Anxiety by keyworker status

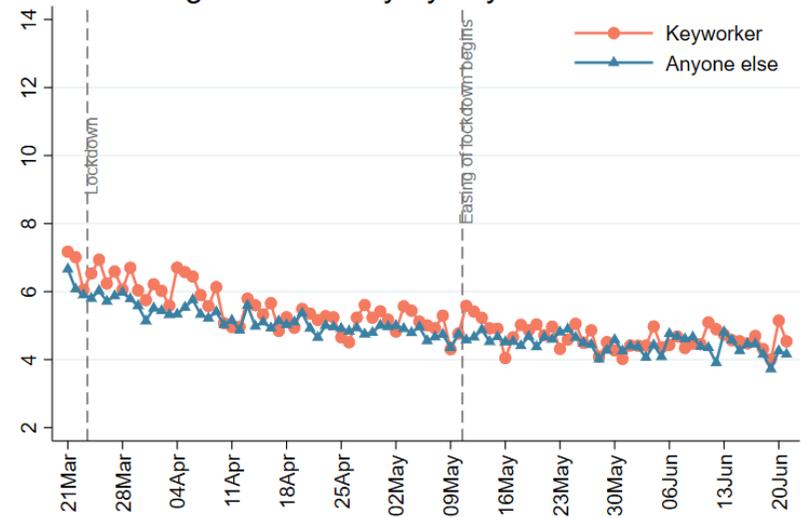


Figure 7g Anxiety by living with children

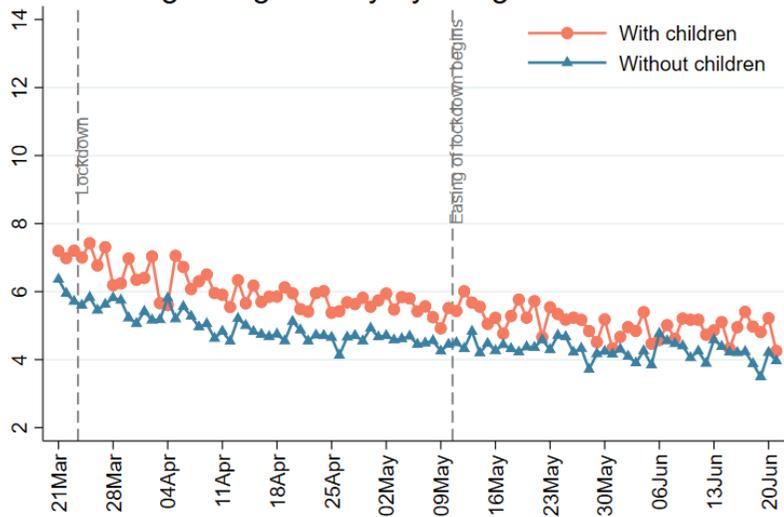
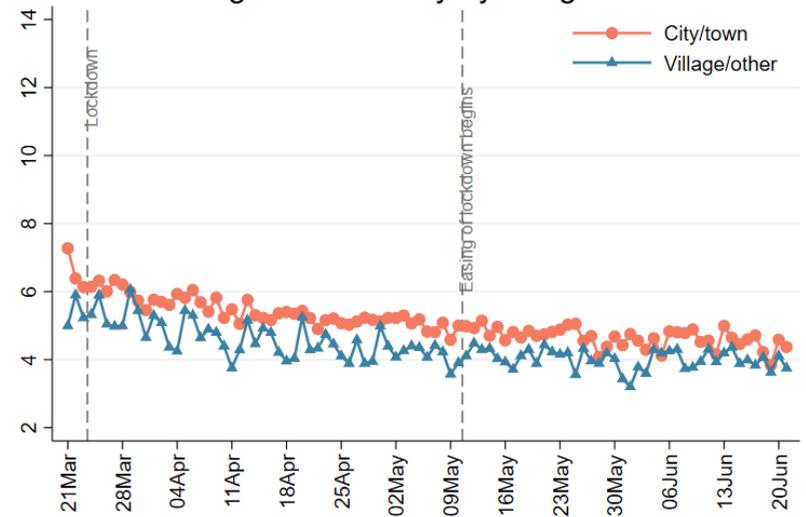
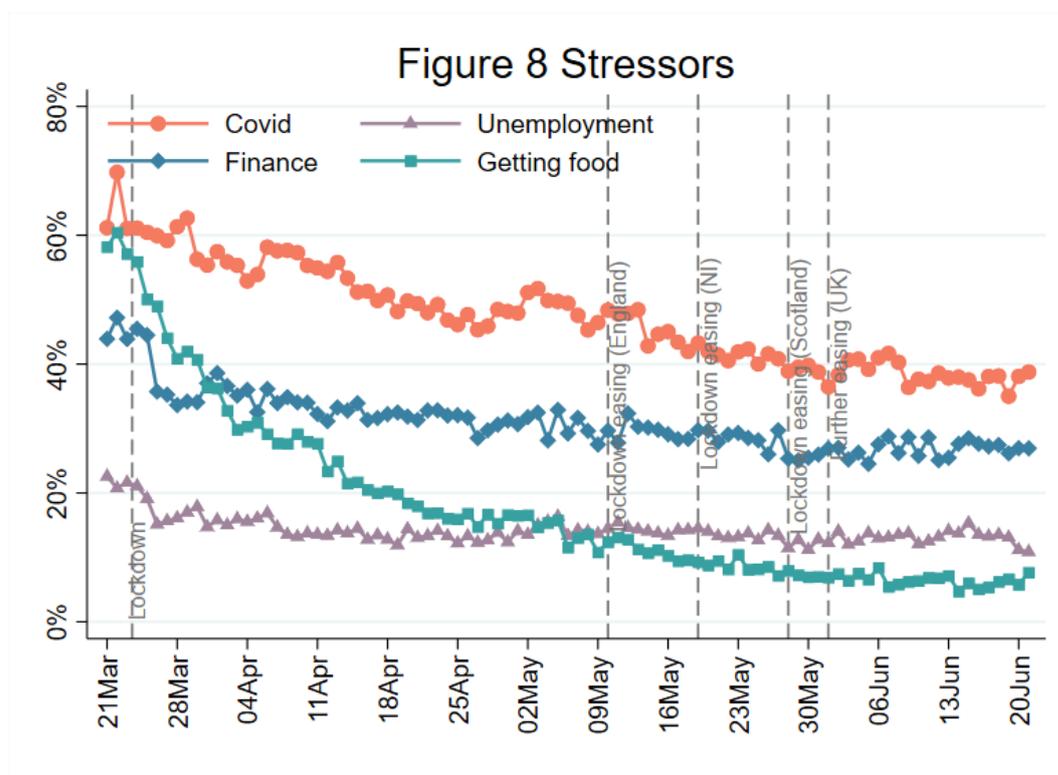


Figure 7h Anxiety by living area



## 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). **We present both minor and major stressors together to give a more detailed sense of how different factors are worrying people.**

There has been little change in people reporting major or minor stress due to catching COVID-19, unemployment, finance, or getting food in the past week. 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 only 40% reporting it. Worries about finance are affecting around 1 in 4 people, while worries about unemployment are only affecting 1 in 6 at present. Worries about access to food are only affecting around 1 in 15 people.

People with diagnosed mental illness have been more worried about all factors. But other predictors of stressors have varied. People with lower household income have worried more about Covid-19, finances and access to food, while people with higher household income have worried more about unemployment. People living with children have worried more about all factors, but the differences on worries relating to Covid-19 and food access has 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

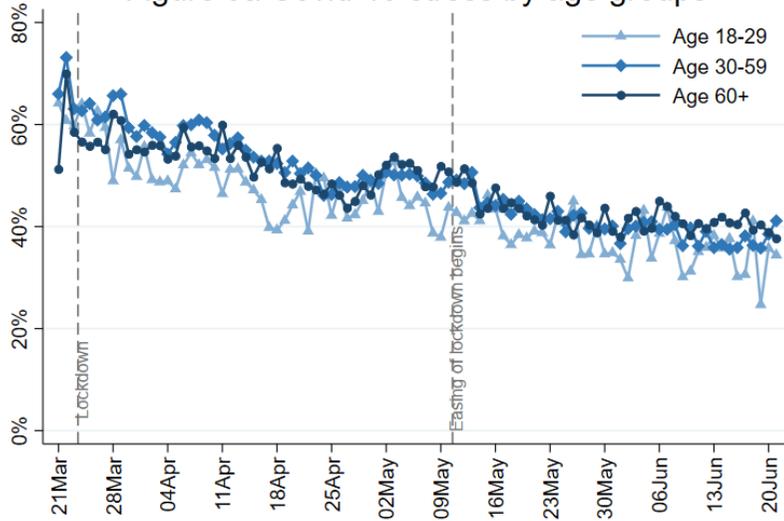


Figure 9b Covid-19 stress by living arrangement

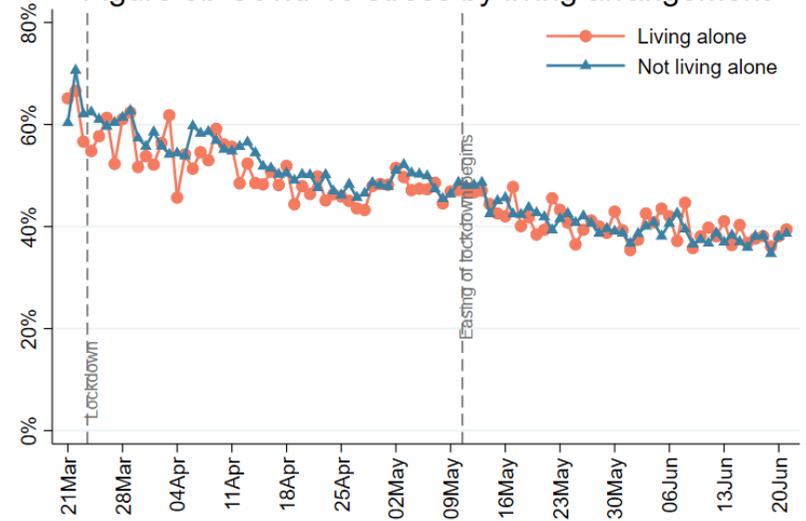


Figure 9c Covid-19 stress by household income

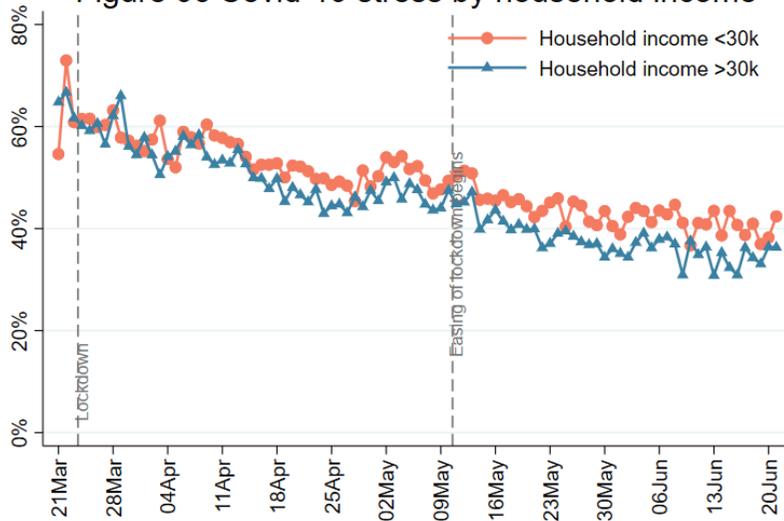


Figure 9d Covid-19 stress by mental health diagnosis

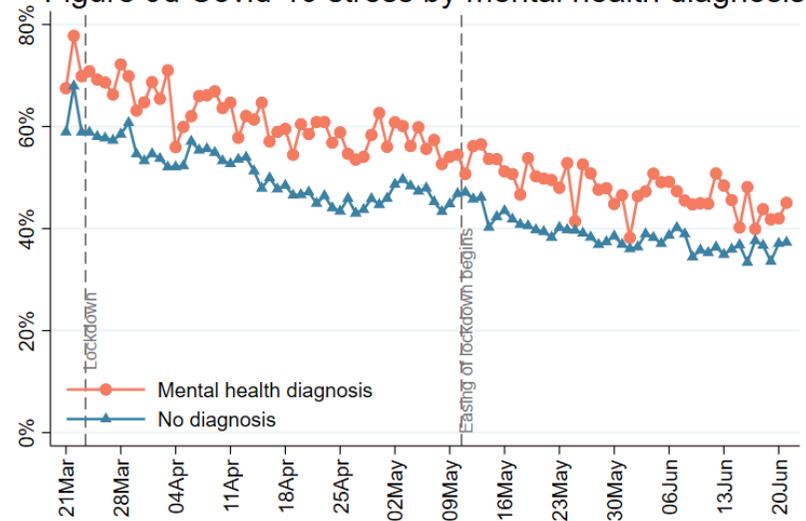


Figure 9e Covid-19 stress by nations

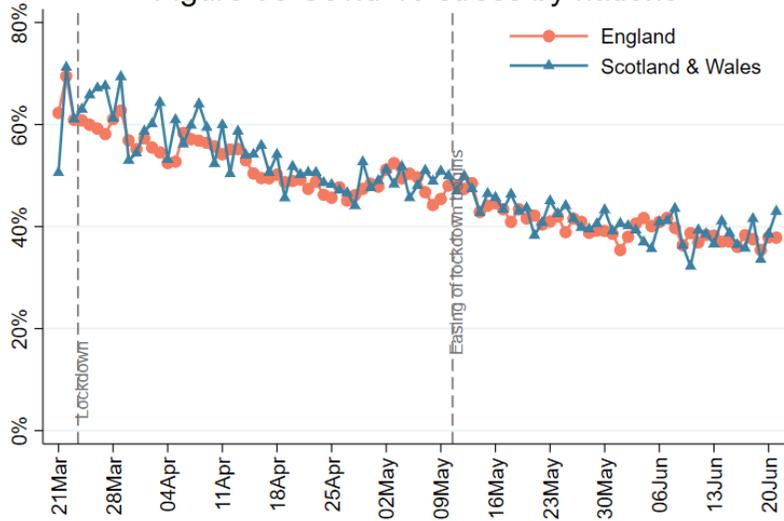


Figure 9f Covid-19 stress by keyworker status

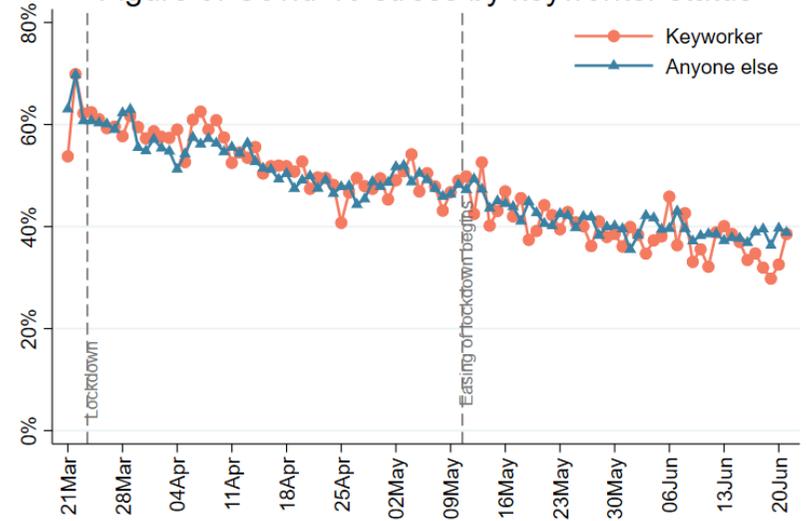


Figure 9g Covid-19 stress by living with children

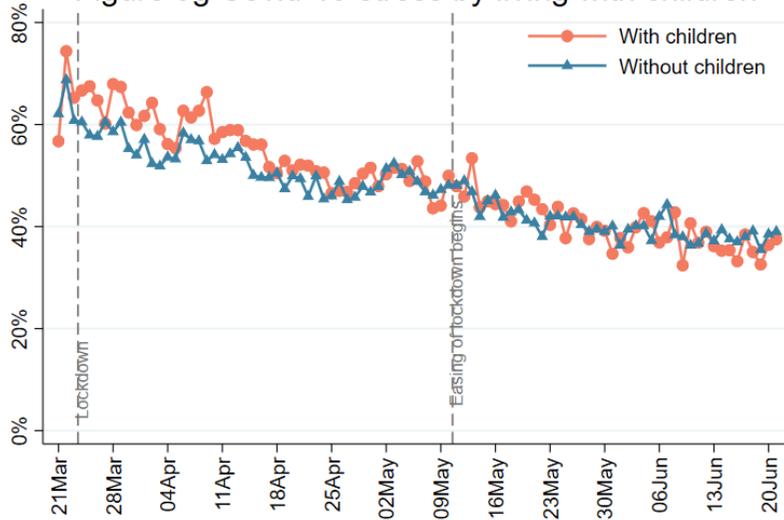


Figure 9h Covid-19 stress by living area

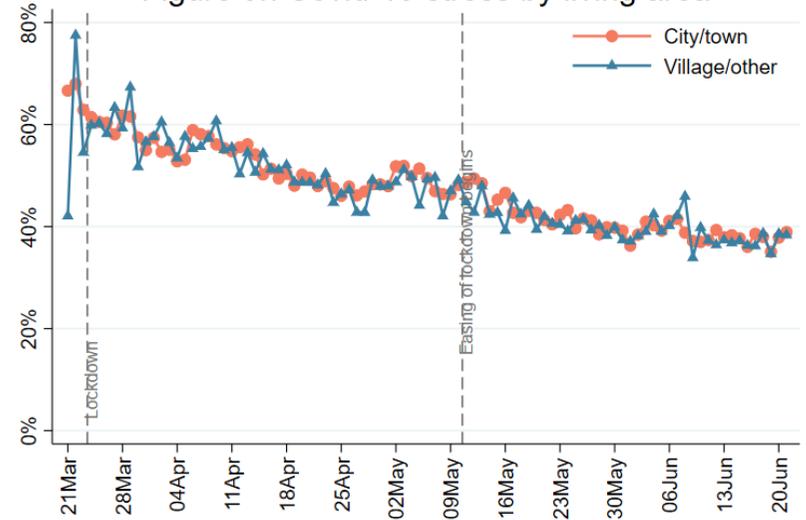


Figure 10a Unemployment stress by age groups

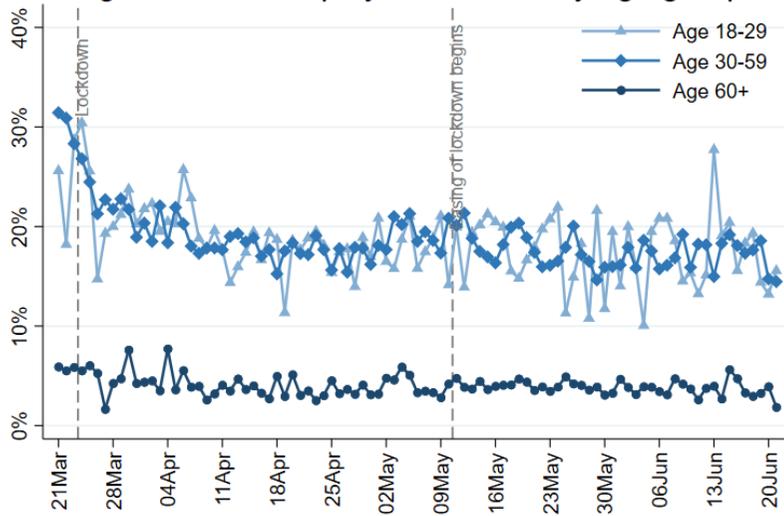


Figure 10b Unemployment stress by living arrangement

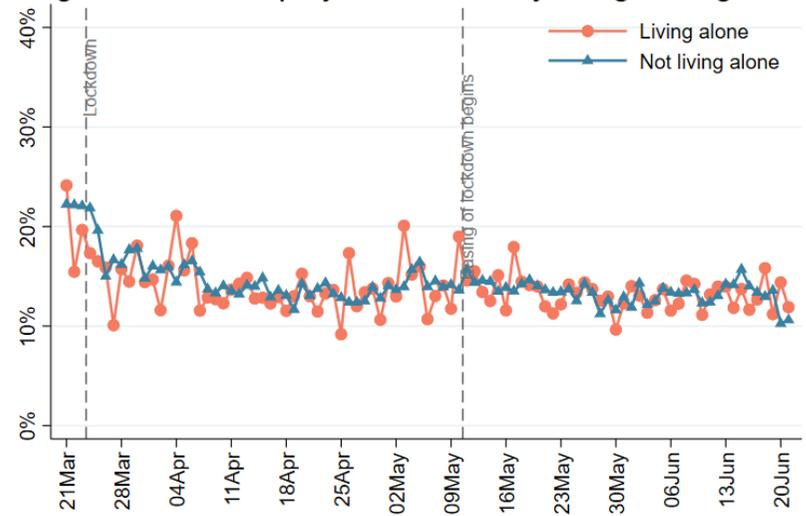


Figure 10c Unemployment stress by household income

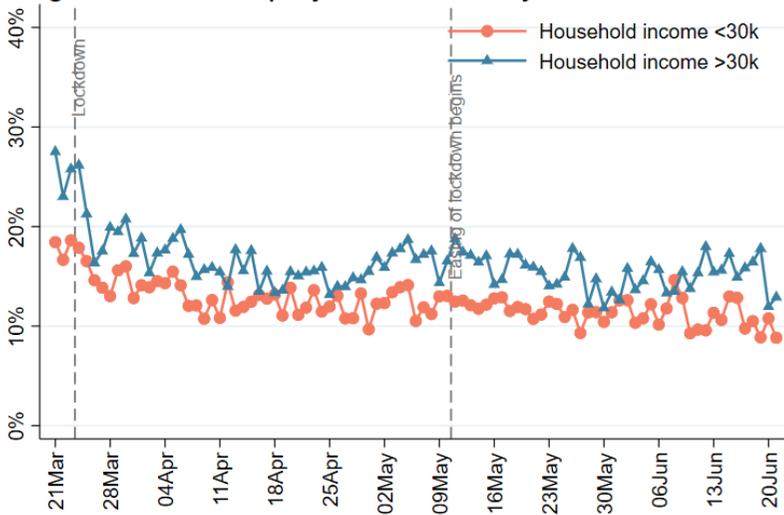


Figure 10d Unemployment stress by mental health

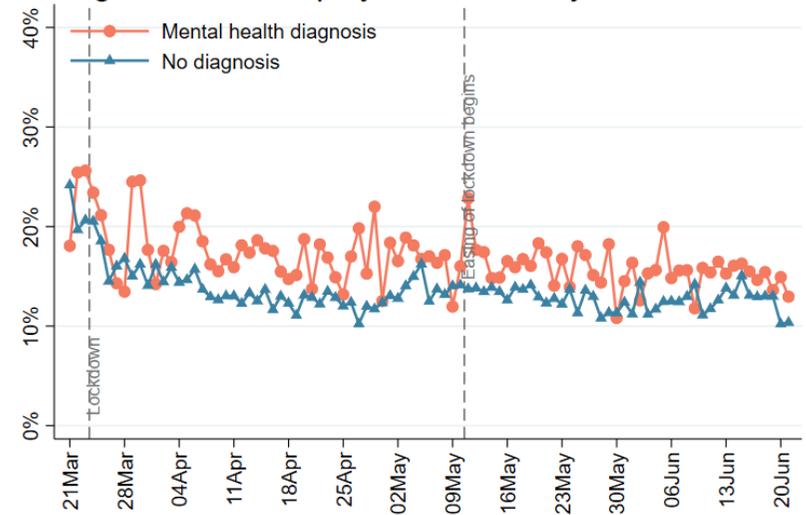


Figure 10e Unemployment stress by nations

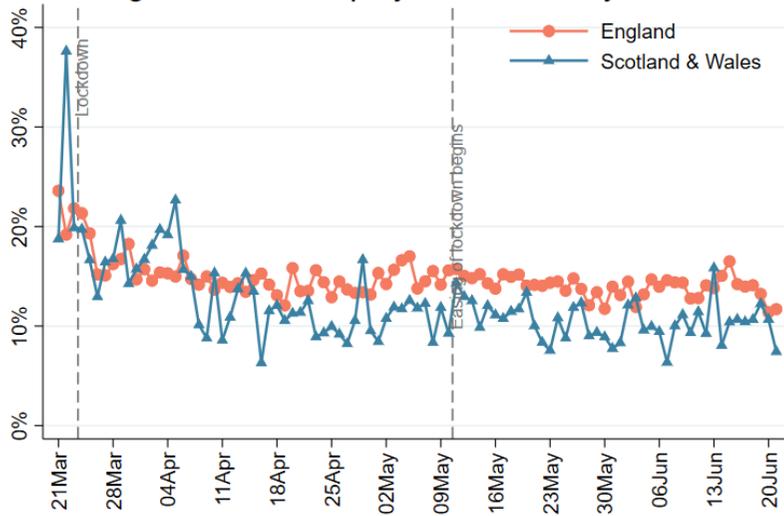


Figure 10f Unemployment stress by keyworker status

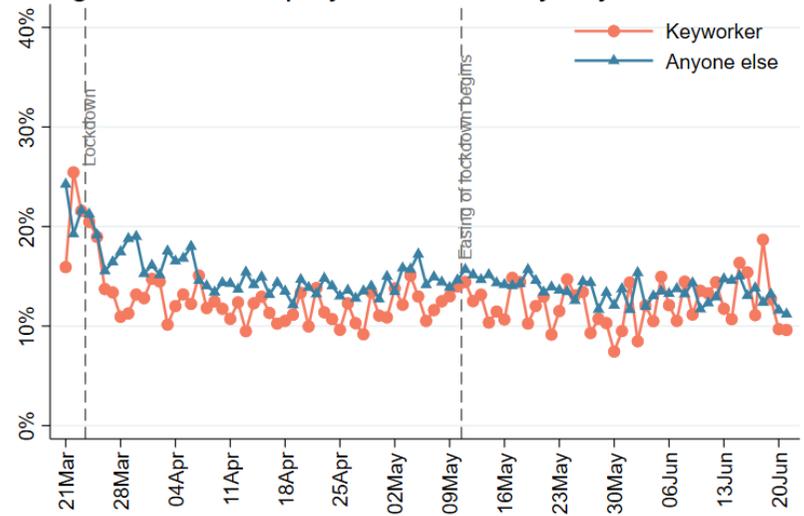


Figure 10g Unemployment stress by living with children

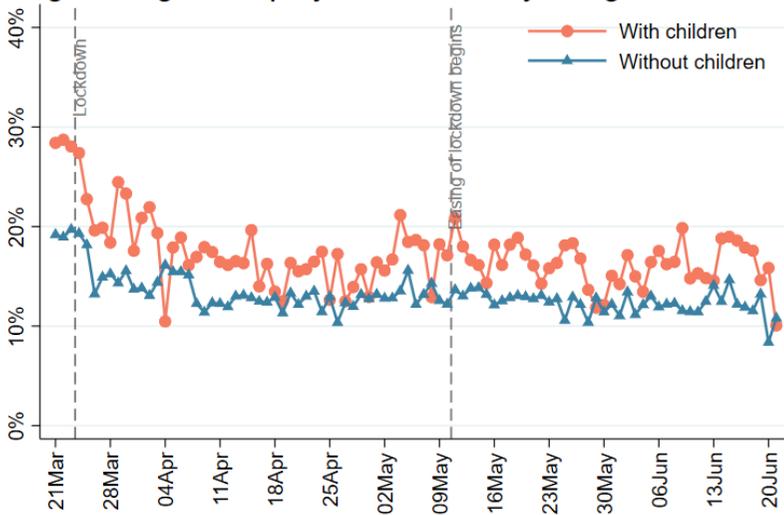


Figure 10h Unemployment stress by living area

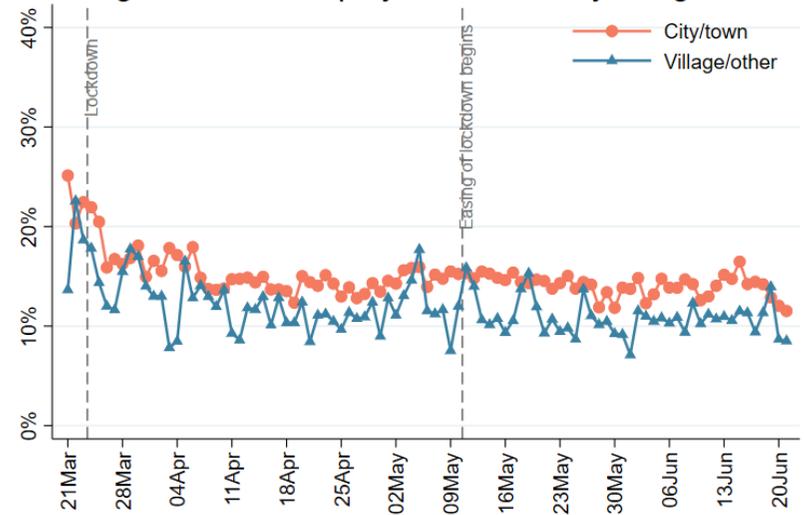


Figure 11a Financial stress by age groups

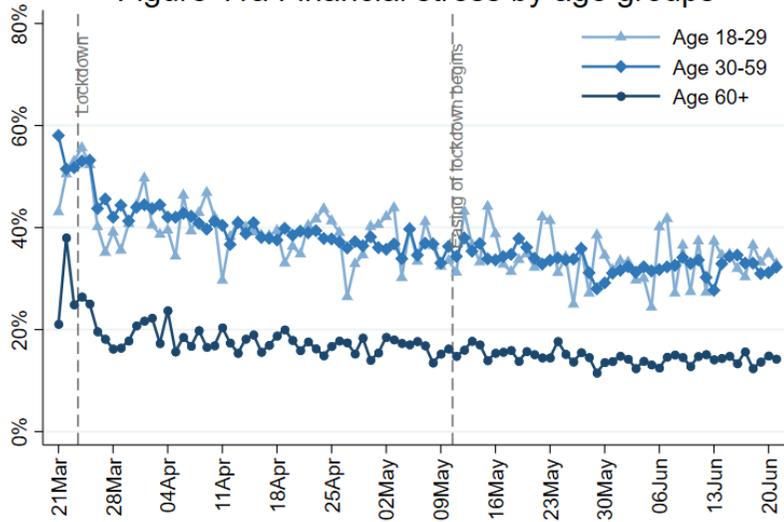


Figure 11b Financial stress by living arrangement

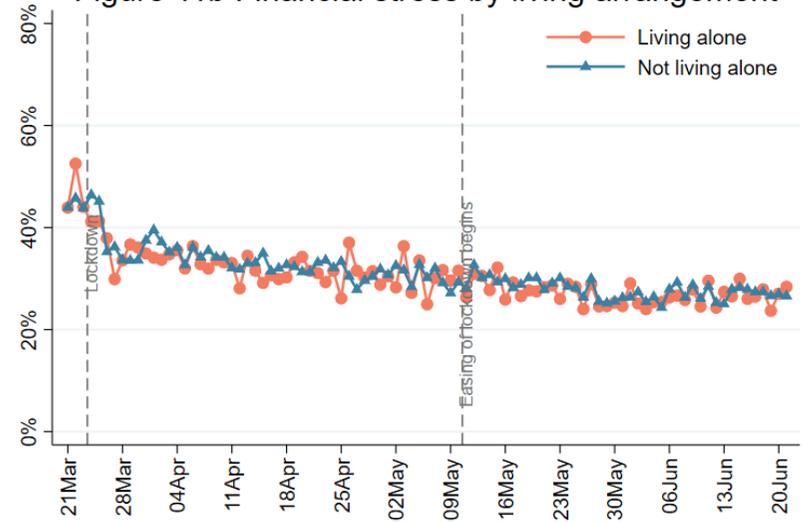


Figure 11c Financial stress by household income

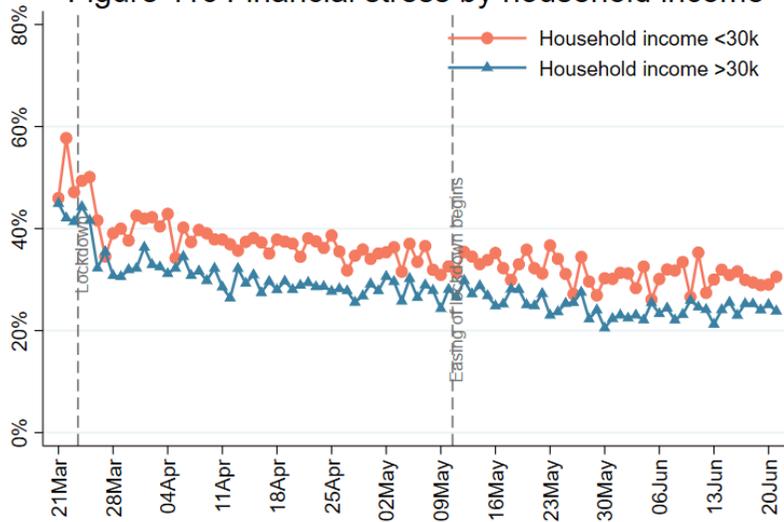


Figure 11d Financial stress by mental health diagnosis

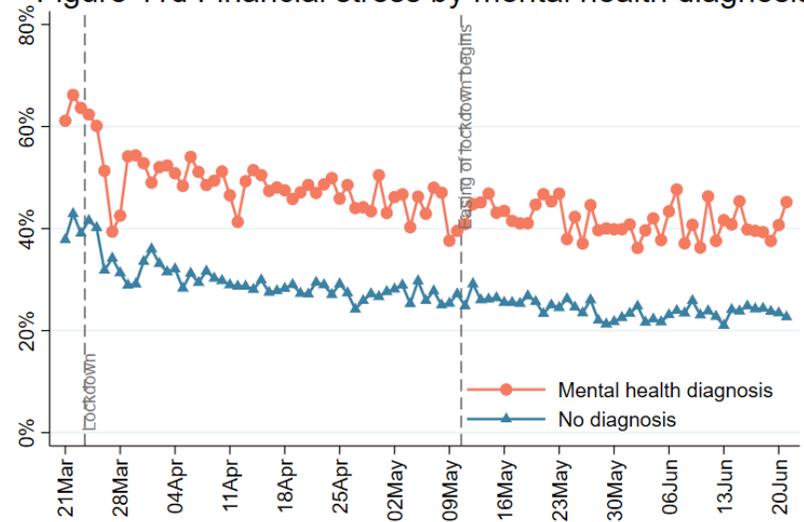


Figure 11e Financial stress by nations

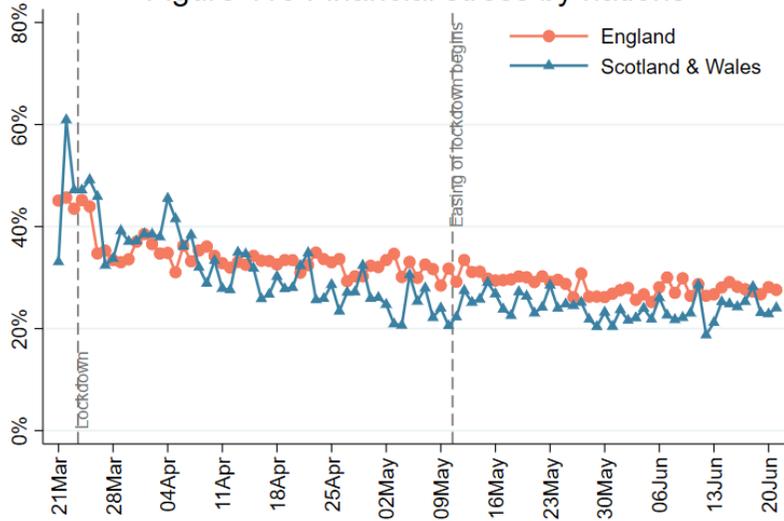


Figure 11f Financial stress by keyworker status

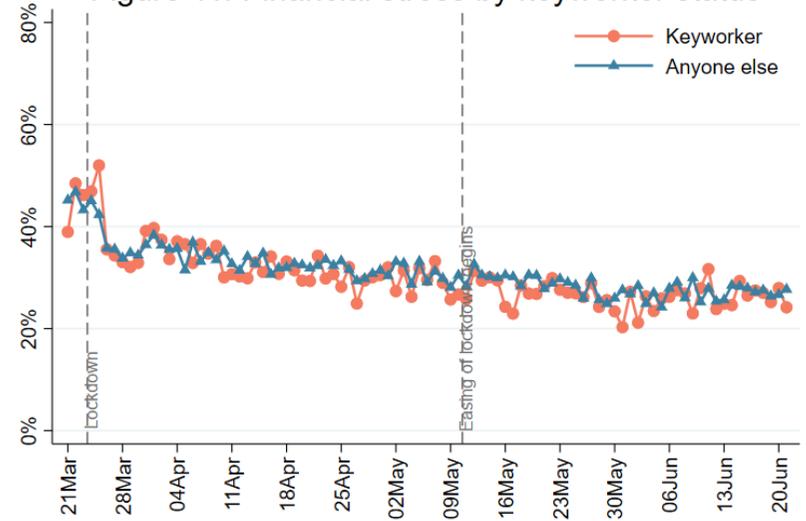


Figure 11g Financial stress by living with children

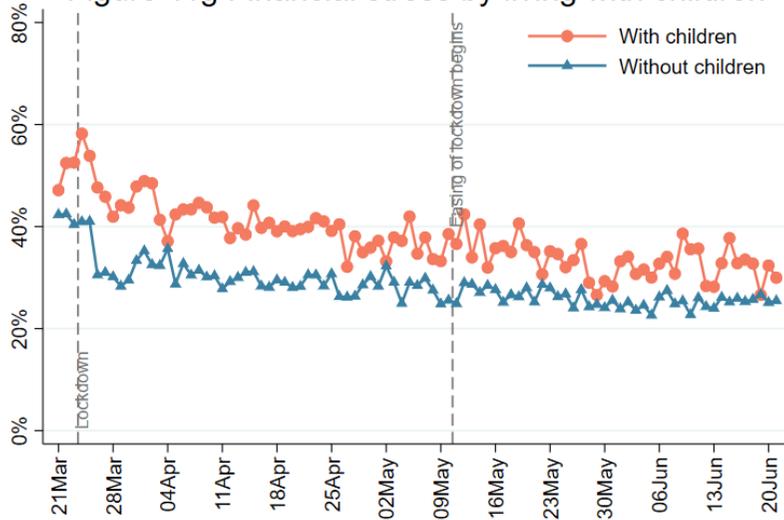


Figure 11h Financial stress by living area

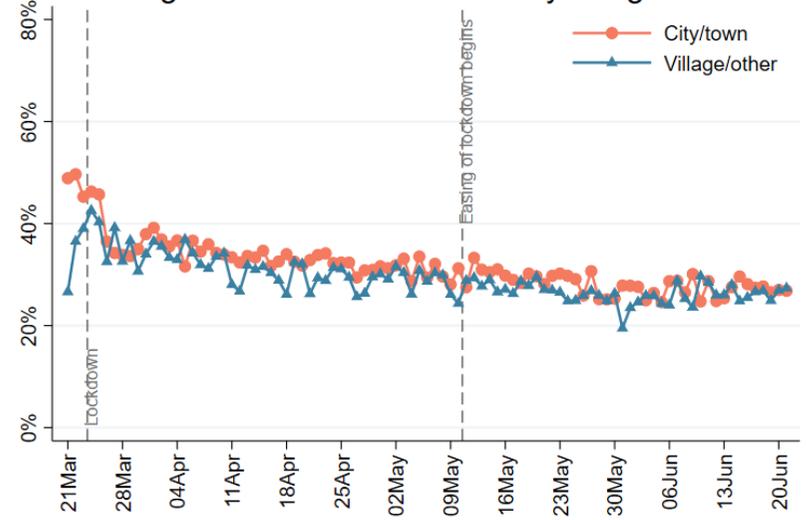


Figure 12a Food security stress by age groups

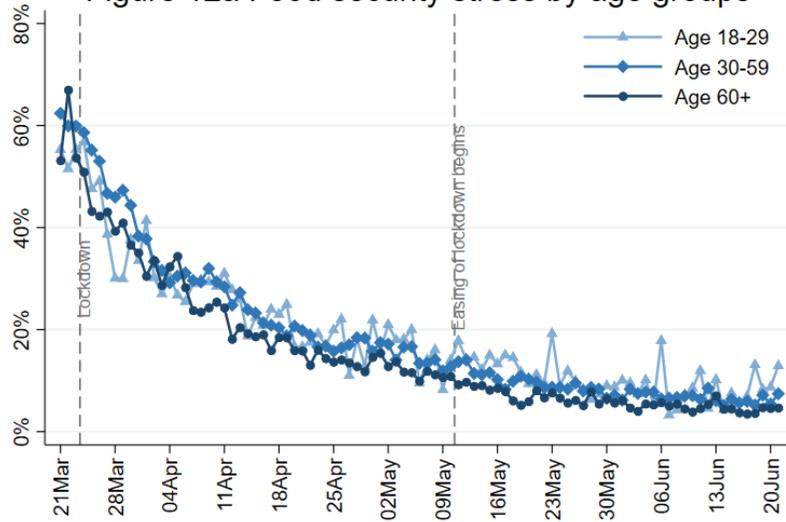


Figure 12b Food security stress by living arrangement

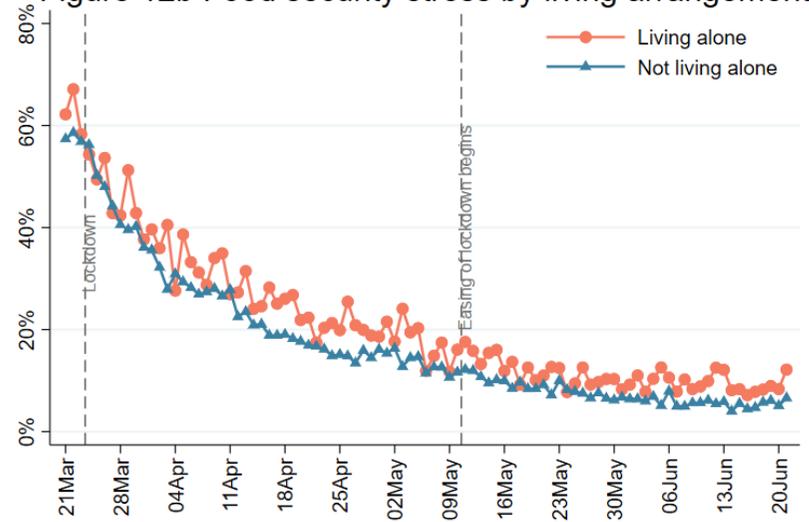


Figure 12c Food security stress by household income

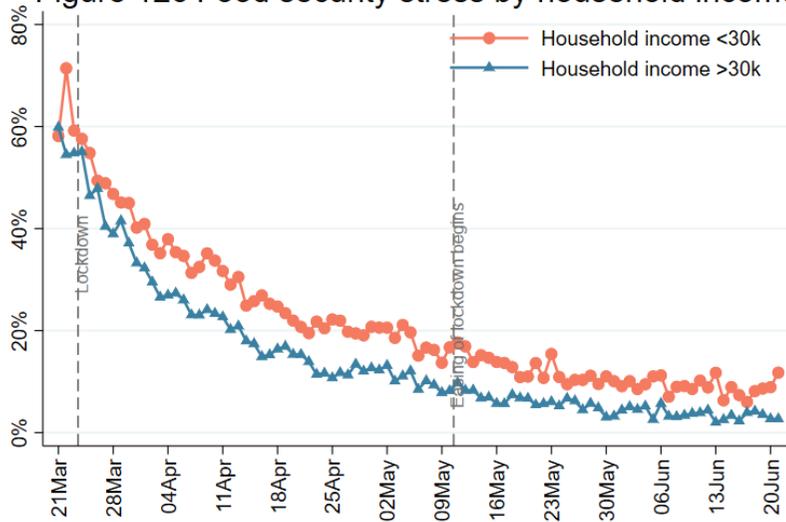


Figure 12d Food security stress by mental health

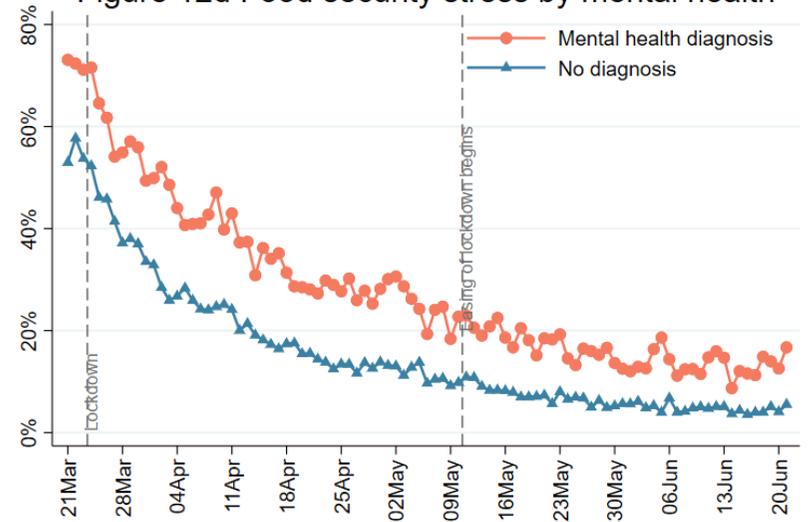


Figure 12e Food security stress by nations

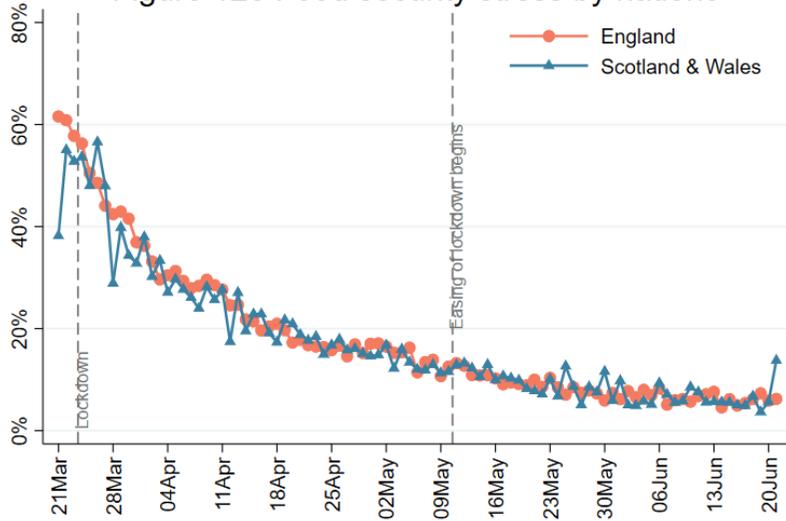


Figure 12f Food security stress by keyworker status

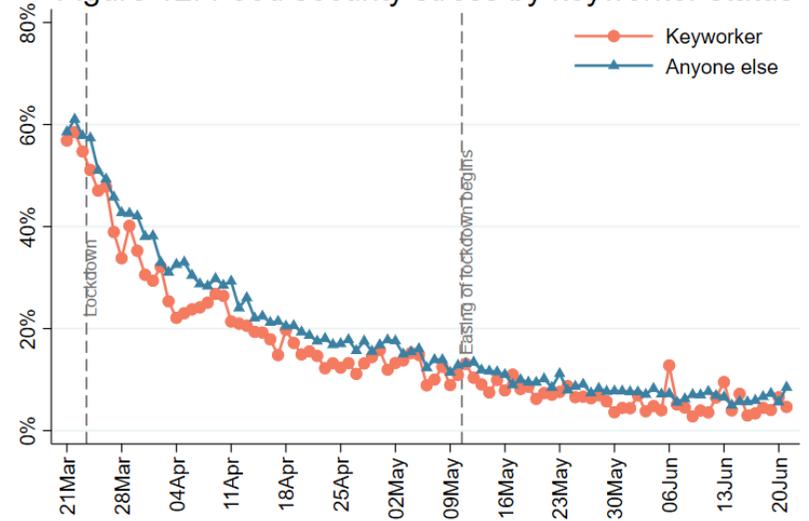


Figure 12g Food security stress by living with children

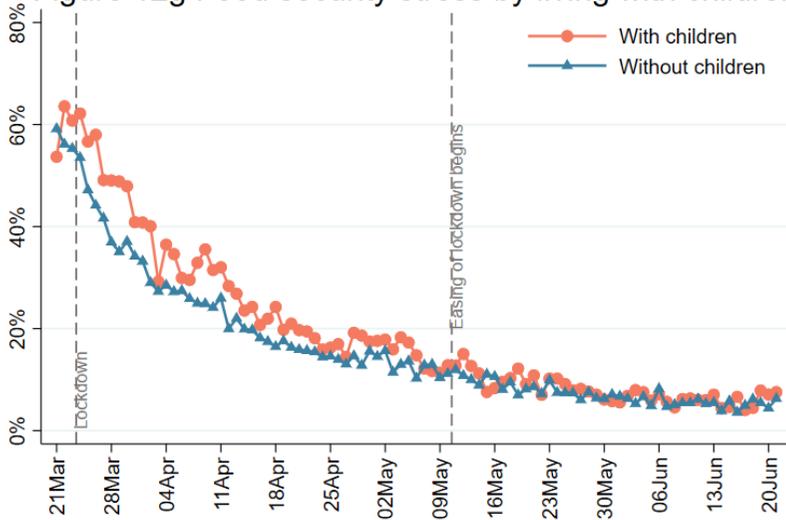
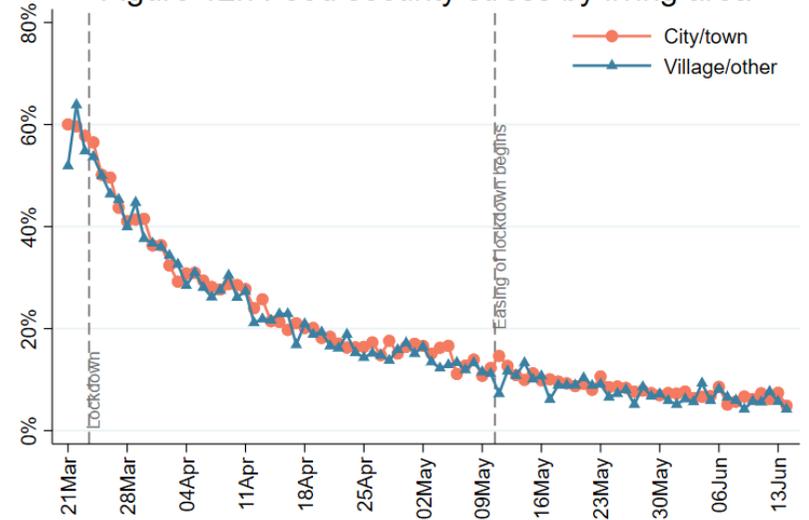
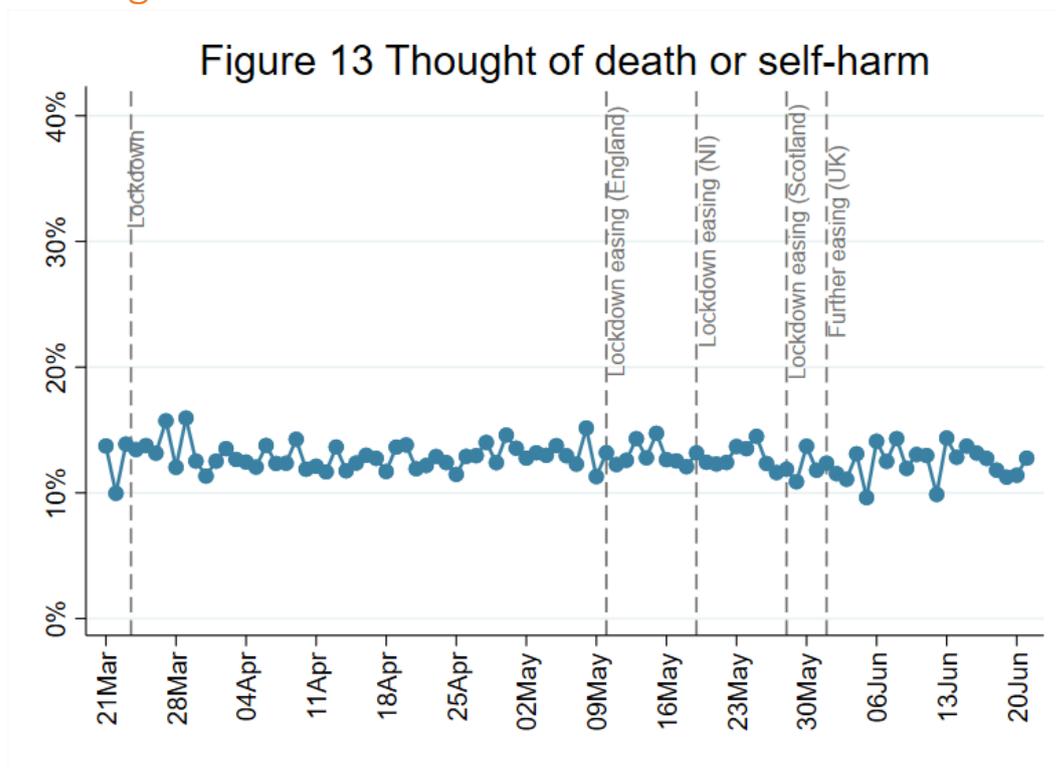


Figure 12h Food security stress by living area



### 3. Self-harm and abuse

#### 3.1 Thought of death or self-harm



#### FINDINGS

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

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 13 weeks. They remain higher amongst younger people, those with a lower household income, and people with a diagnosed mental health condition. They are also higher in people living alone and those living in urban areas.

Figure 14a Thought of death by age groups

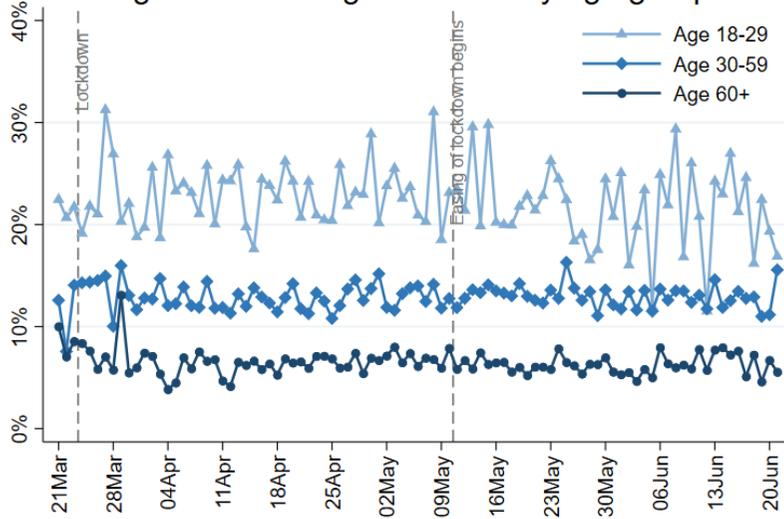


Figure 14b Thought of death by living arrangement

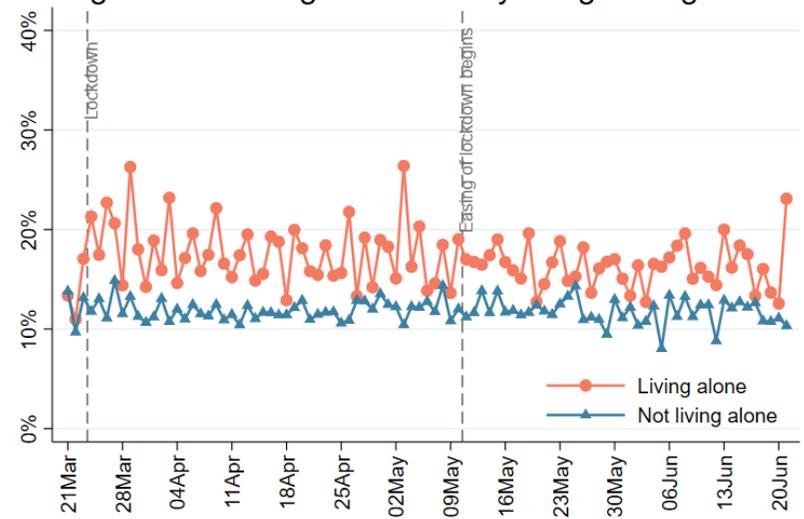


Figure 14c Thought of death by household income

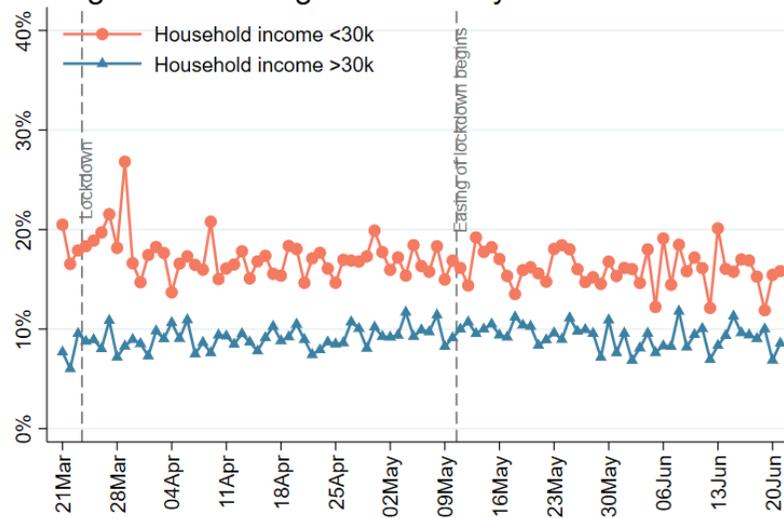


Figure 14d Thought of death by mental health diagnosis

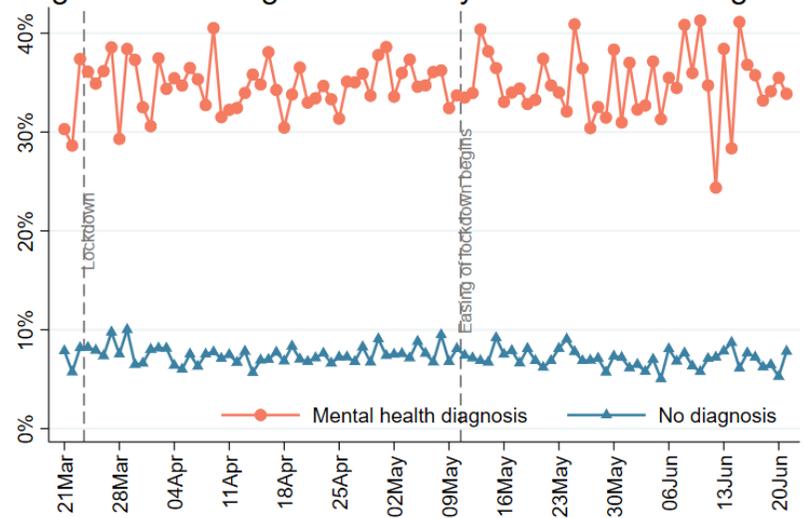


Figure 14e Thought of death by nations

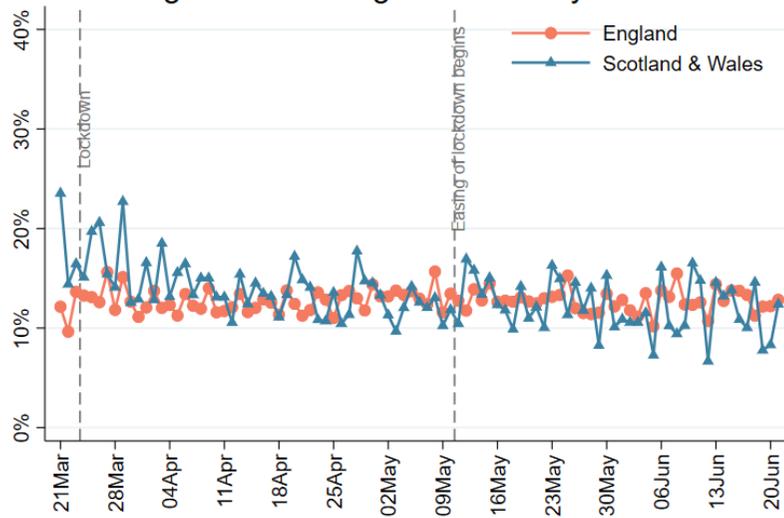


Figure 14f Thought of death by keyworker status

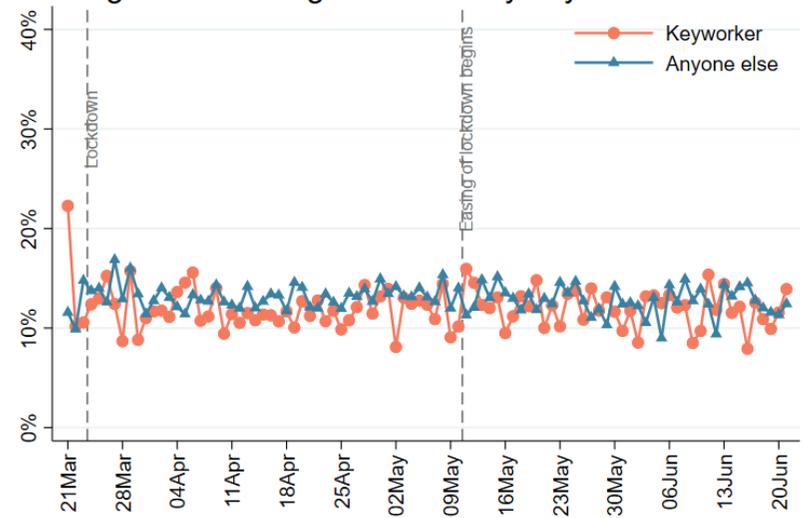
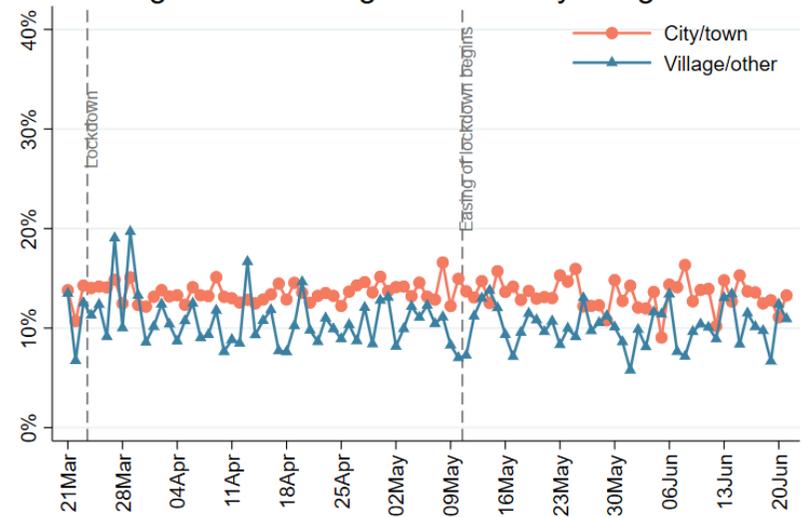


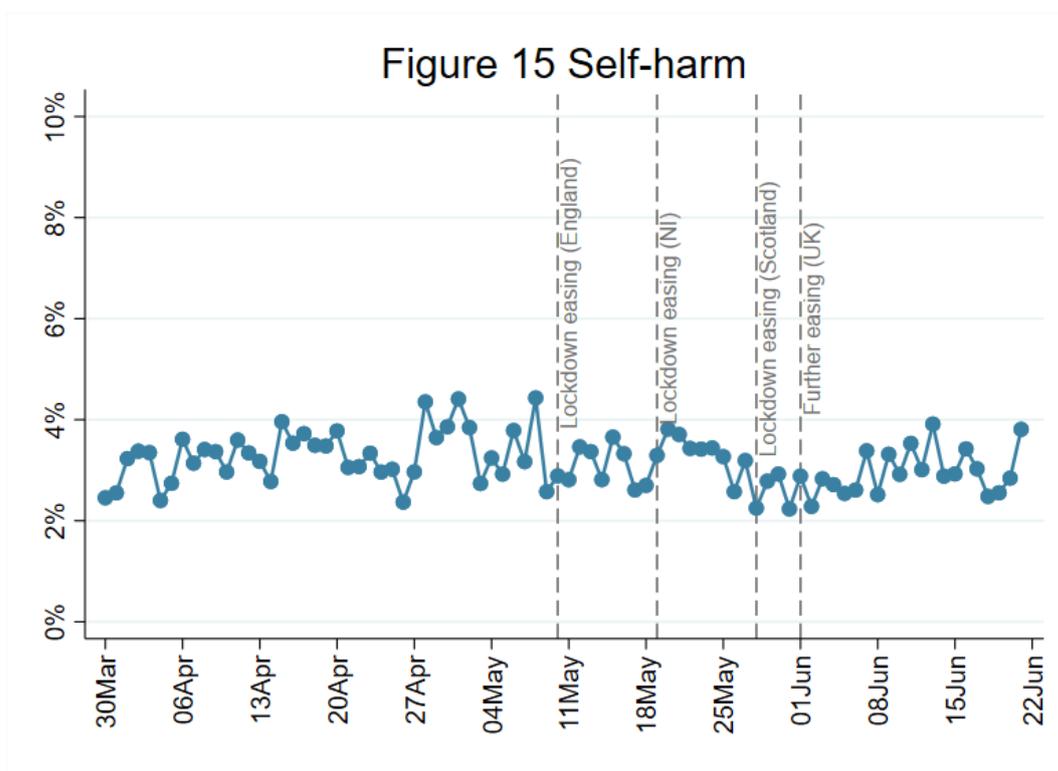
Figure 14g Thought of death by living with children



Figure 14h Thought 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.

Figure 16a Self-harm by age groups

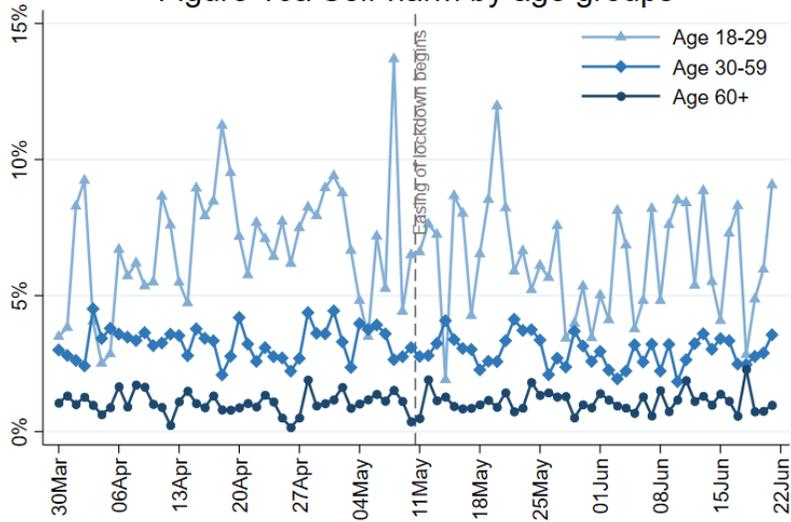


Figure 16b Self-harm by living arrangement

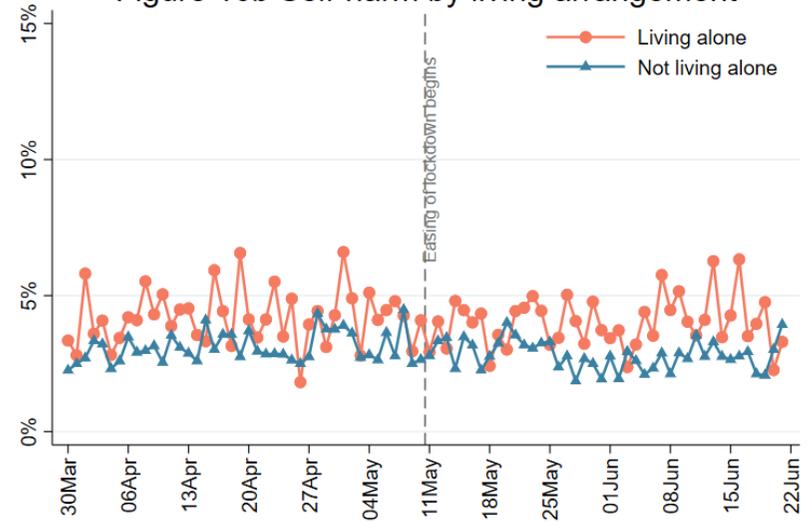


Figure 16c Self-harm by household income

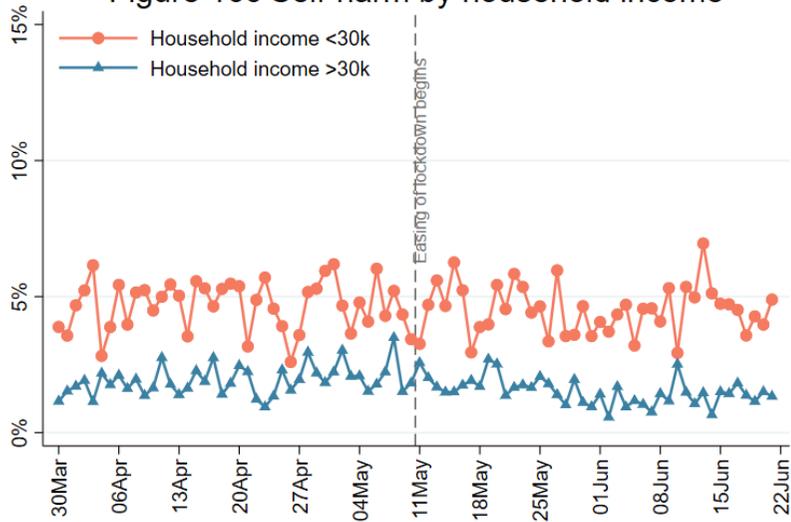


Figure 16d Self-harm by mental health diagnosis

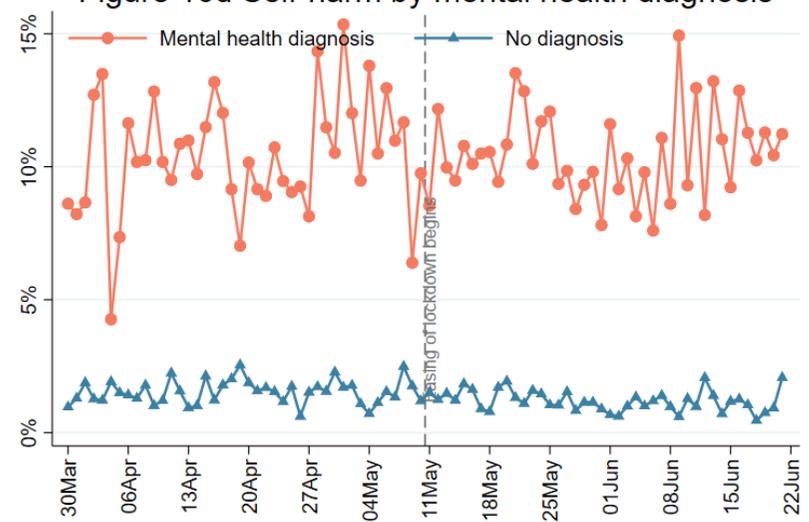


Figure 16e Self-harm by nations

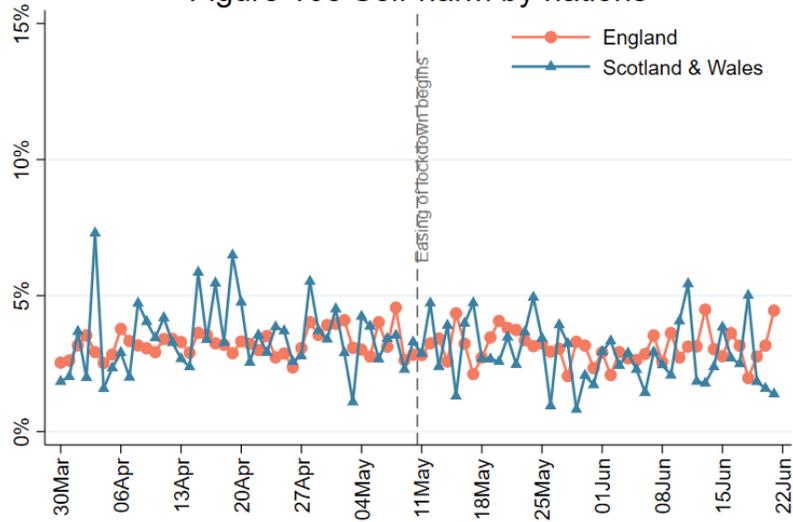


Figure 16f Self-harm by keyworker status

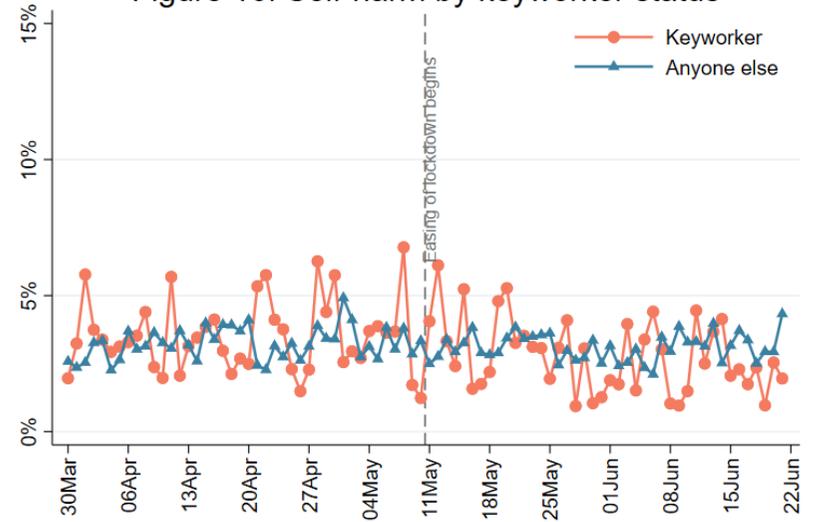


Figure 16g Self-harm by living with children

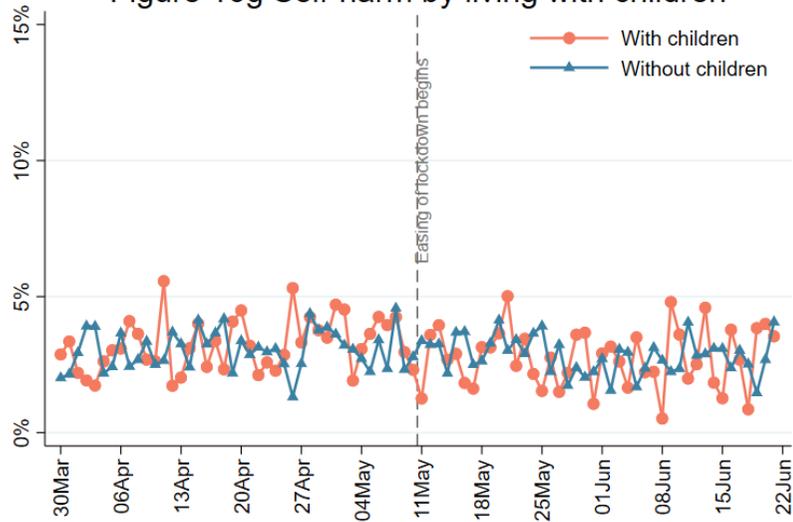
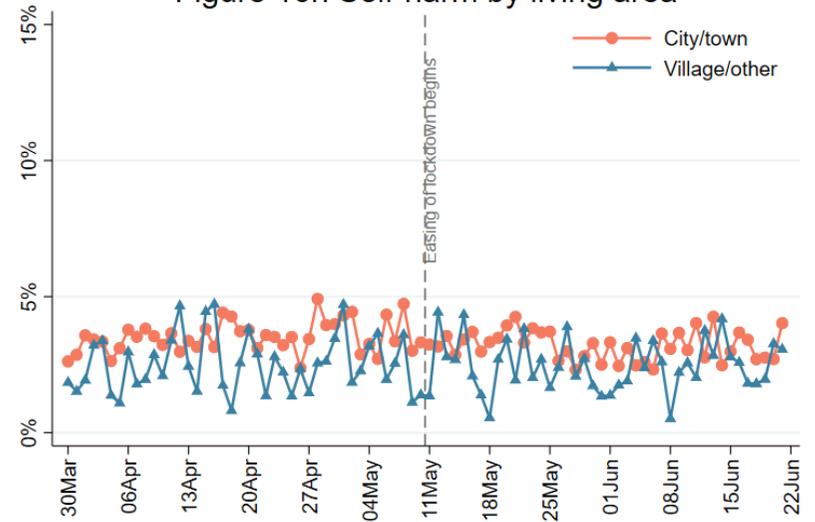
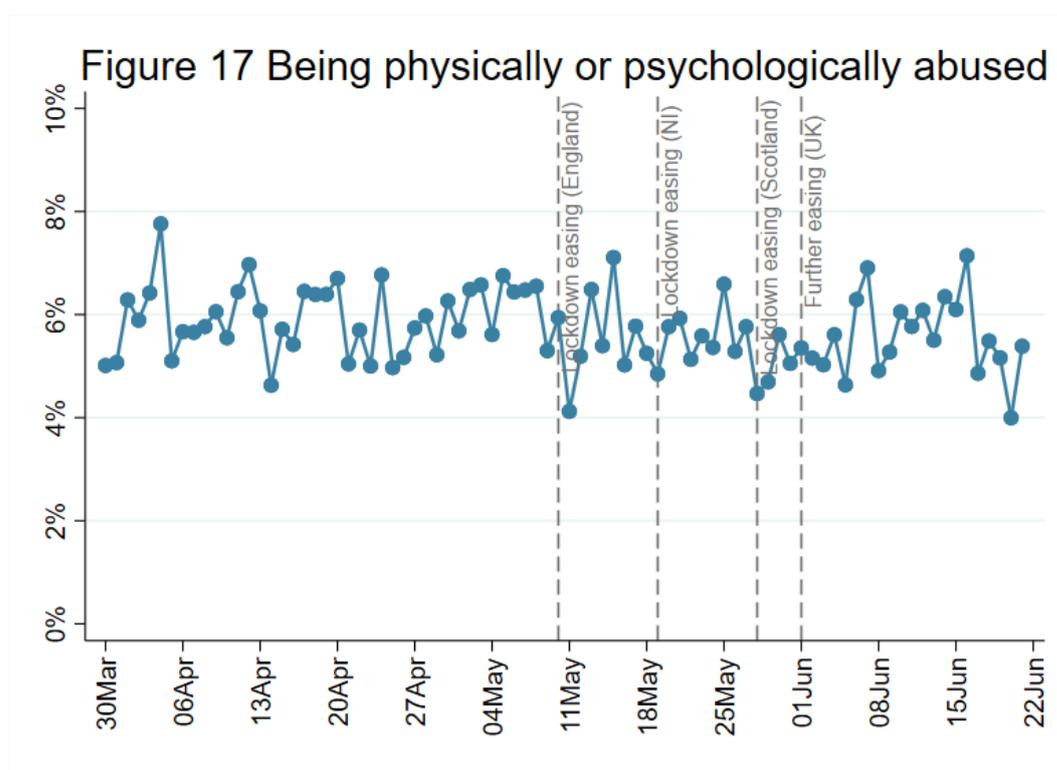


Figure 16h Self-harm by living area



### 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

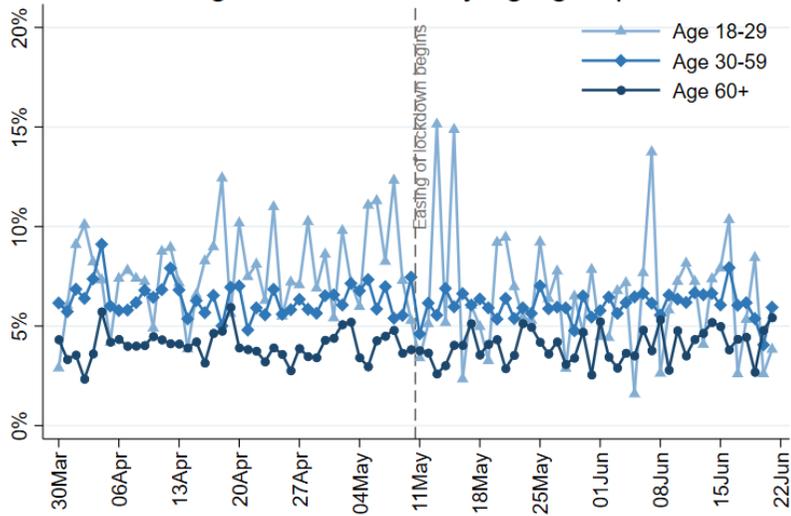


Figure 18b Abuse by living arrangement

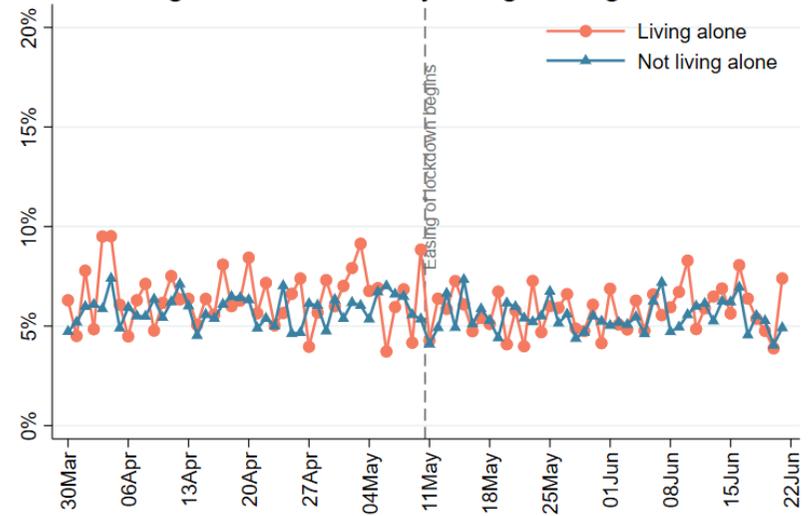


Figure 18c Abuse by household income

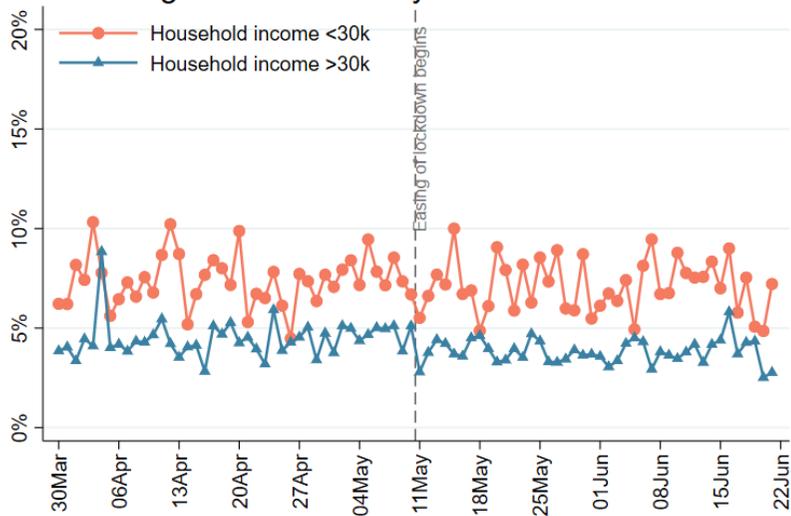


Figure 18d Abuse by mental health diagnosis

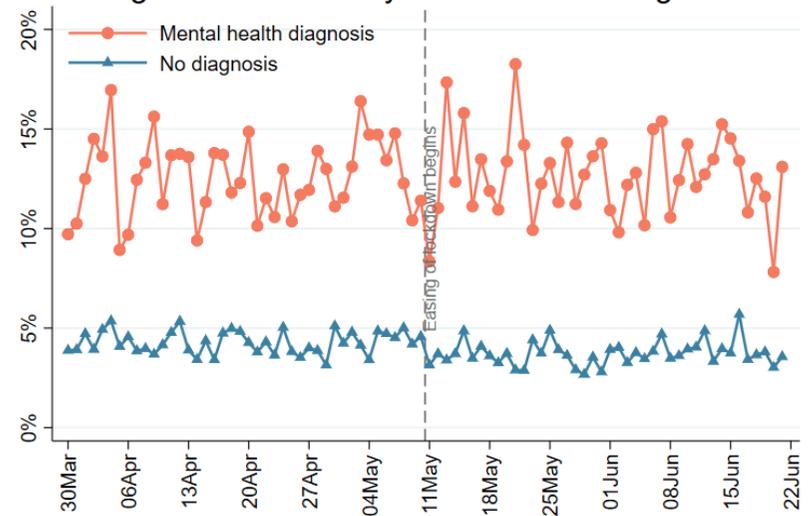


Figure 18e Abuse by nations

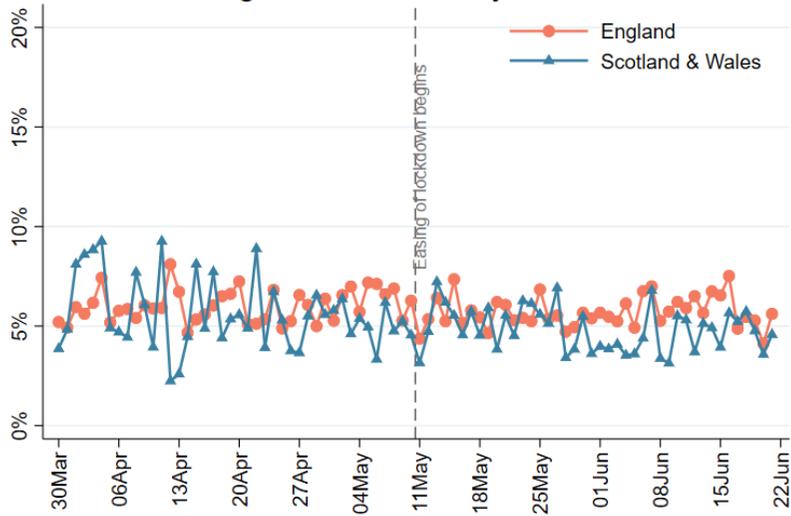


Figure 18f Abuse by keyworker status

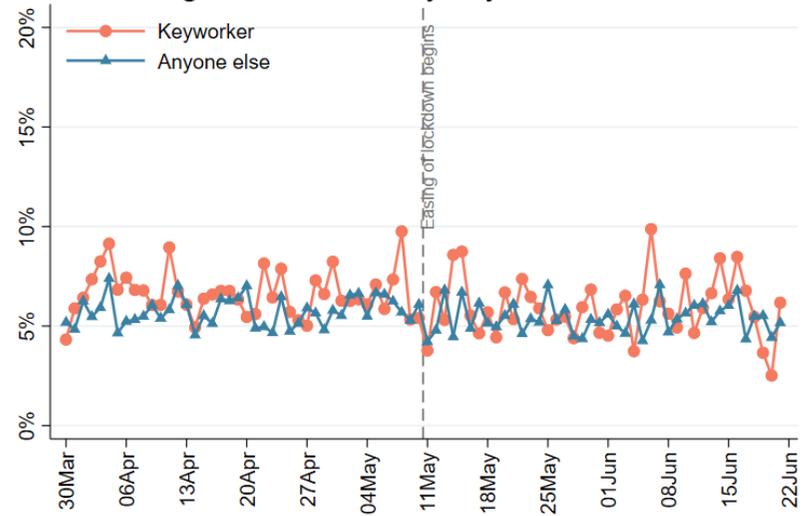


Figure 18g Abuse by living with children

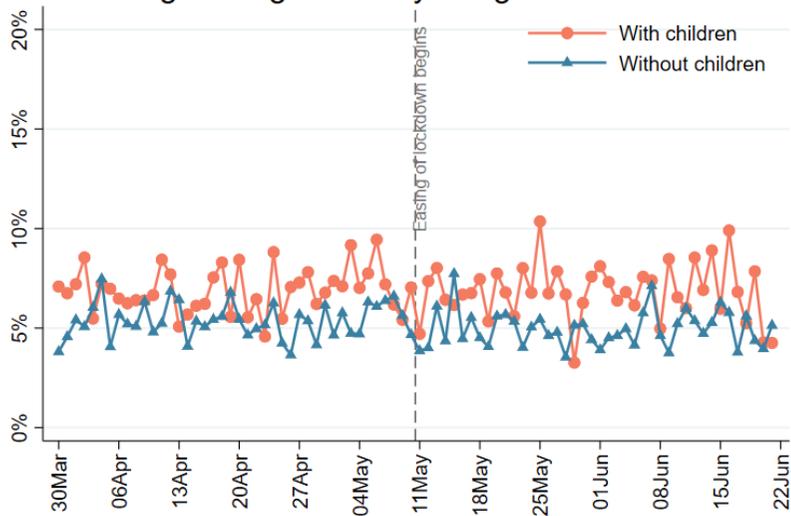
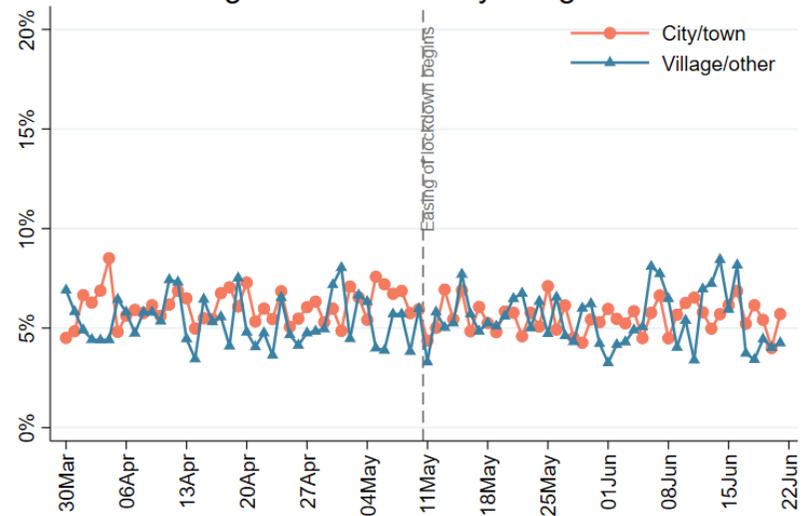
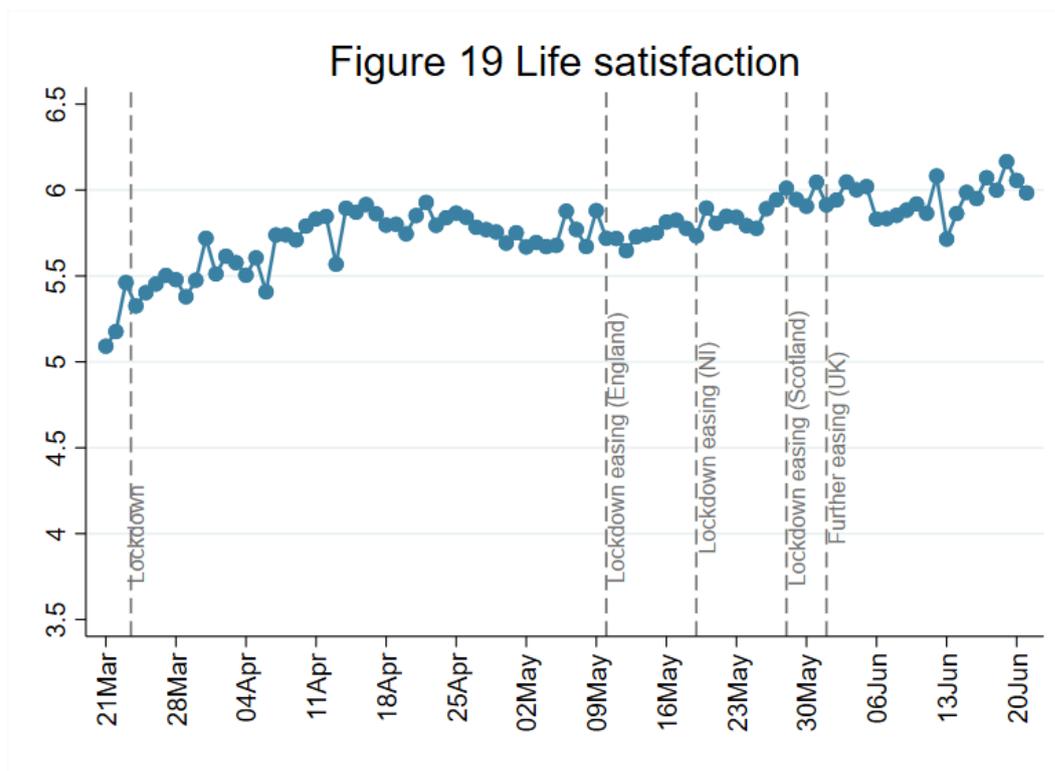


Figure 18h Abuse by living area



## 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 shown suggestions of further slight improvements in the past week, but this remains to be confirmed in future reports and may simply represent minor data variation.

Whilst life satisfaction 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. But 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>3</sup>.

<sup>3</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

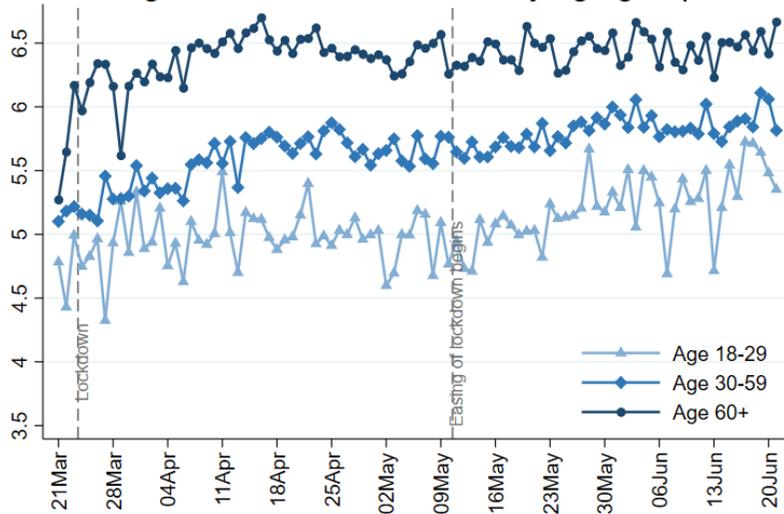


Figure 20b Life satisfaction by living arrangement

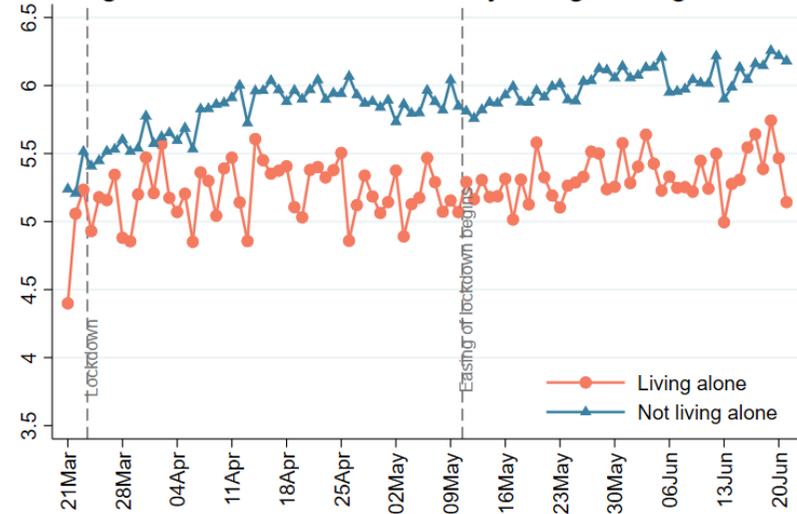


Figure 20c Life satisfaction by household income

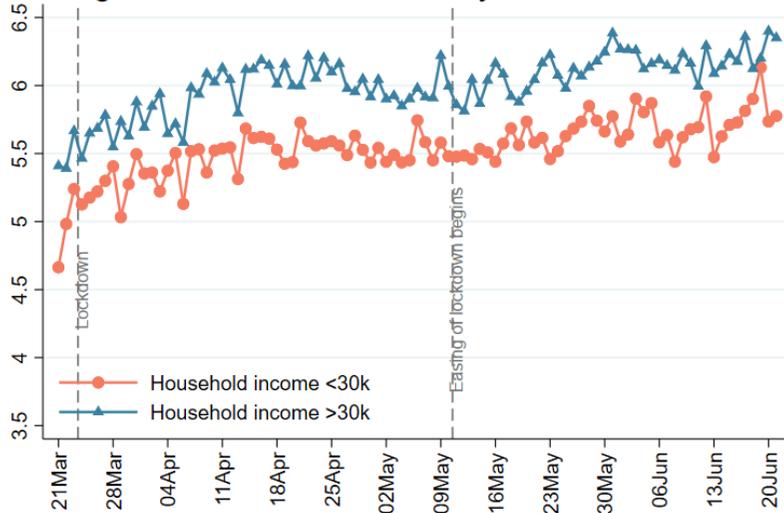


Figure 20d Life satisfaction by mental health diagnosis

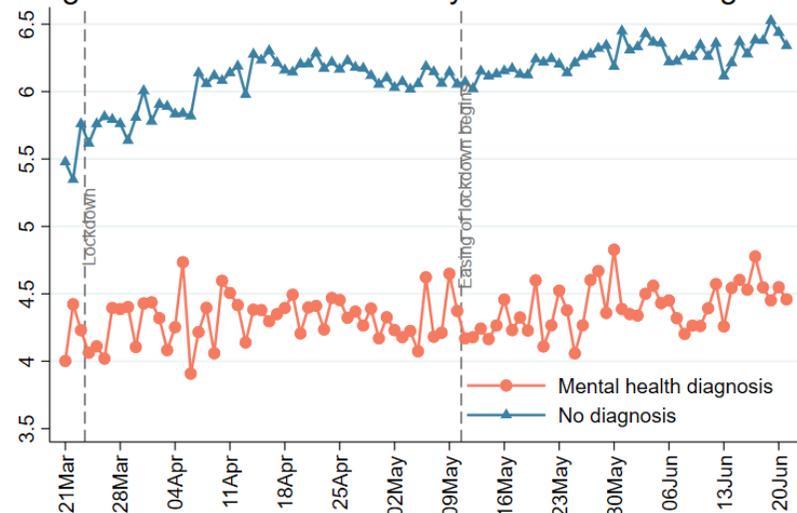


Figure 20e Life satisfaction by nations

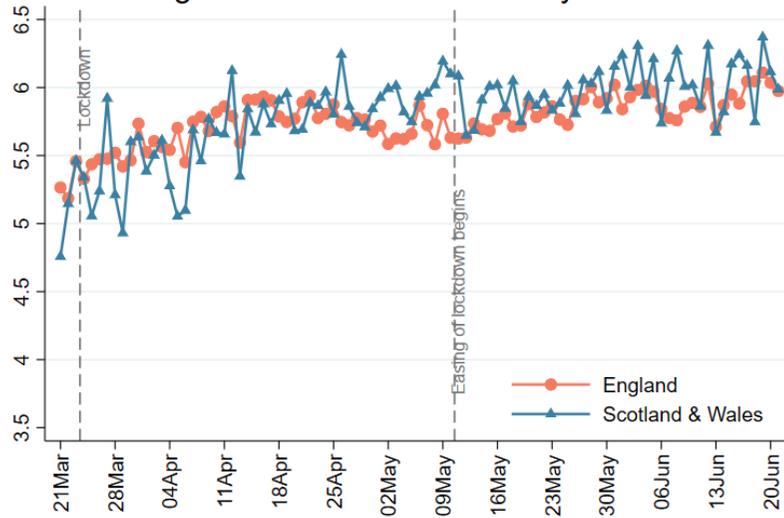


Figure 20f Life satisfaction by keyworker status

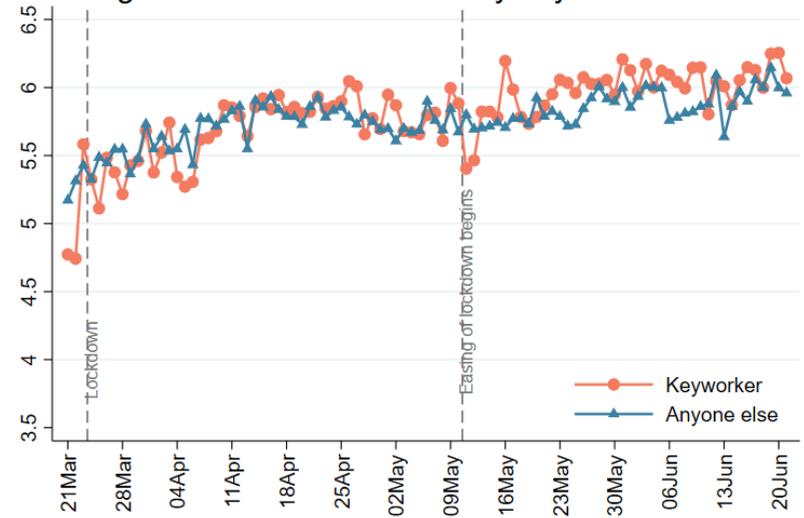


Figure 20g Life satisfaction by living with children

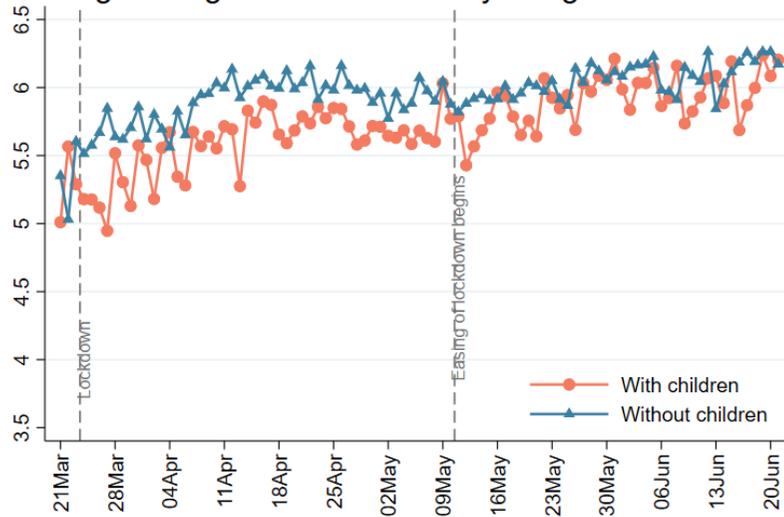
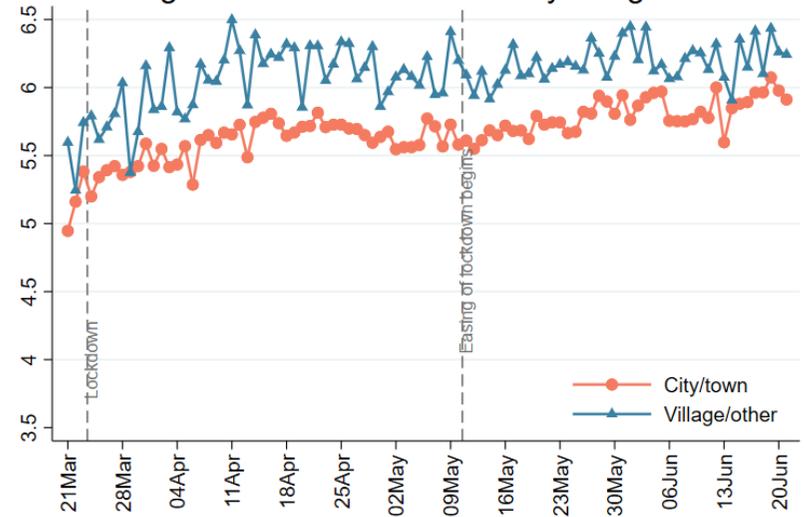
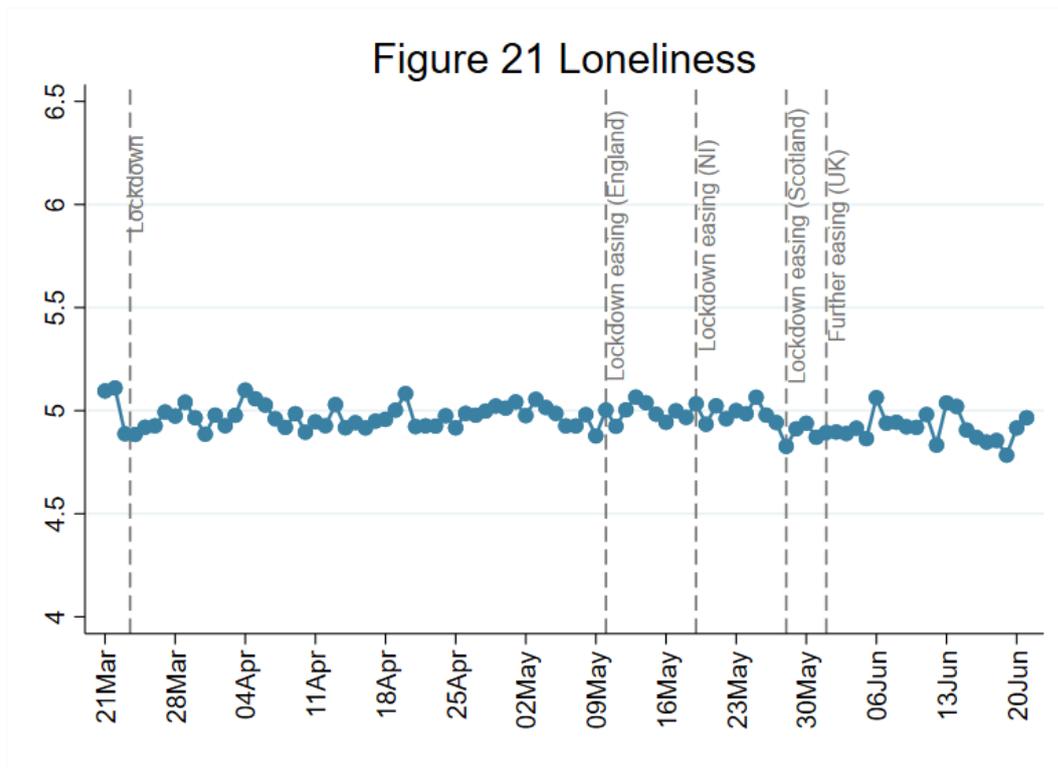


Figure 20h Life satisfaction by living area



## 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 continue to remain relatively consistent and have notably not decreased since lockdown easing began. This is notable given that opportunities for socialising in person are now greater than over the past 13 weeks.

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

Figure 22a Loneliness by age groups

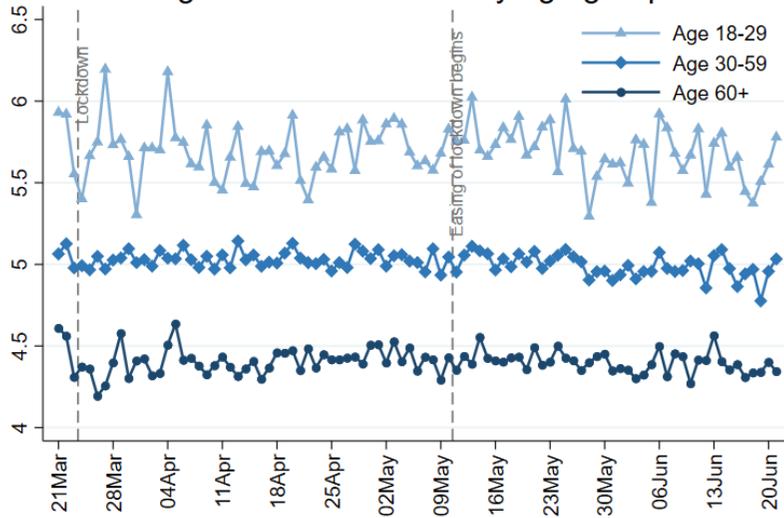


Figure 22b Loneliness by living arrangement

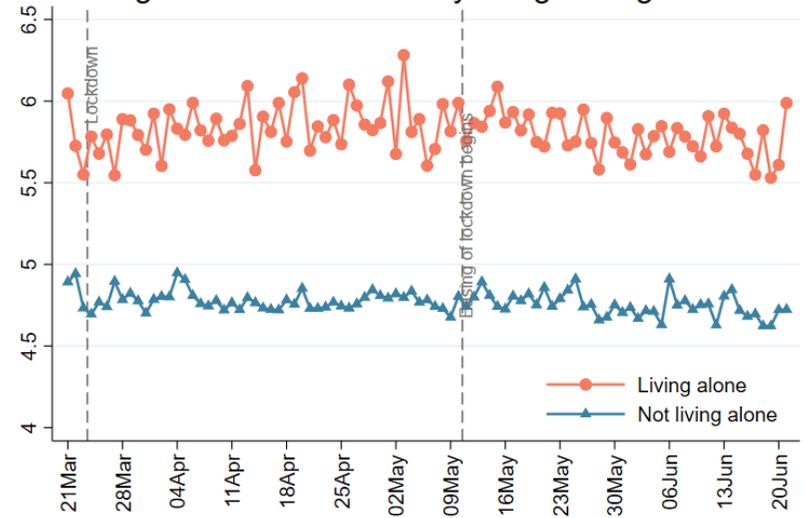


Figure 22c Loneliness by household income

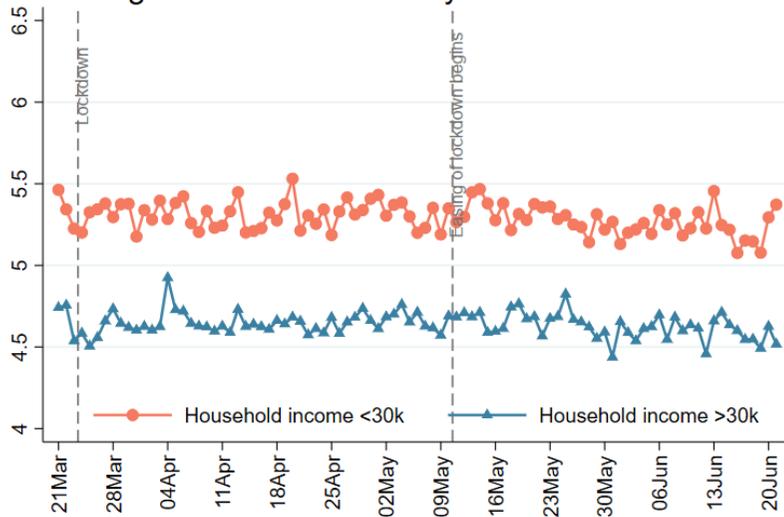


Figure 22d Loneliness by mental health diagnosis

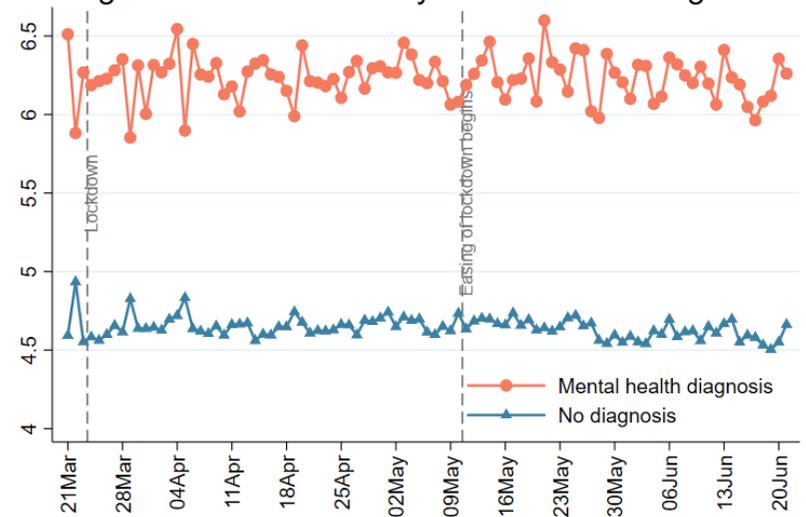


Figure 22e Loneliness by nations

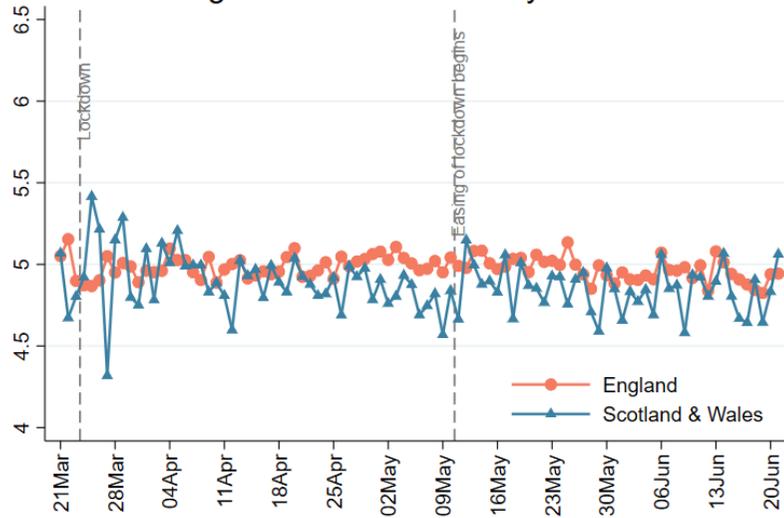


Figure 22f Loneliness by keyworker status

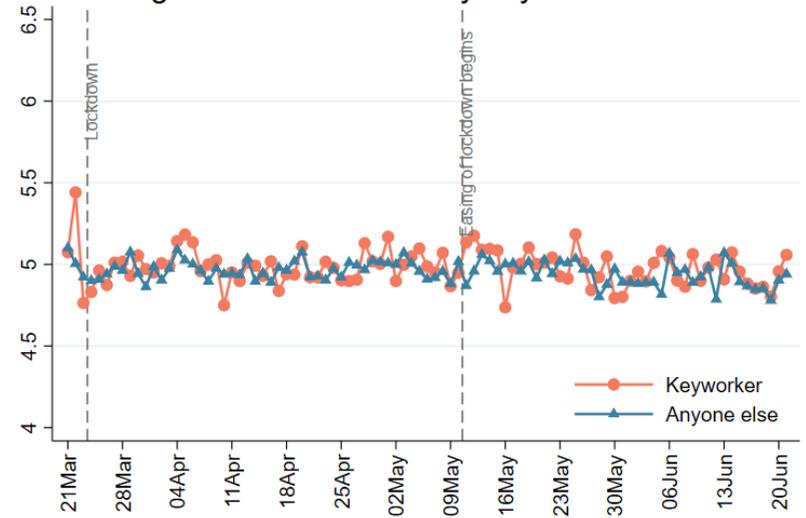


Figure 22g Loneliness by living with children

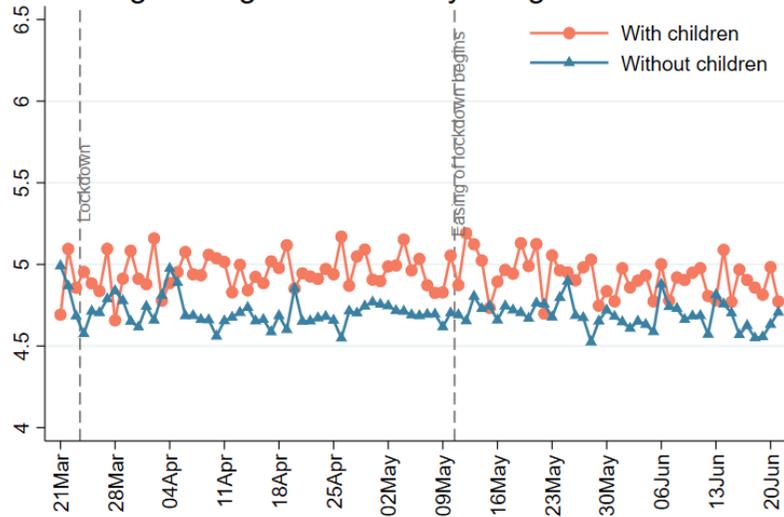
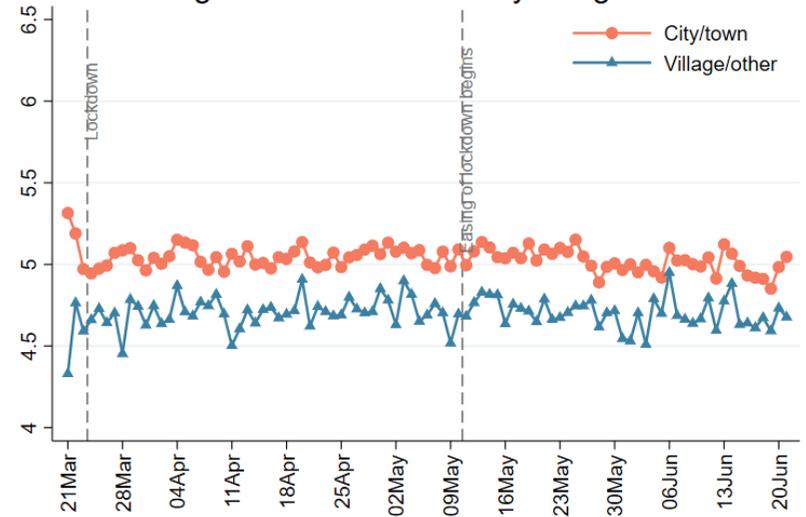
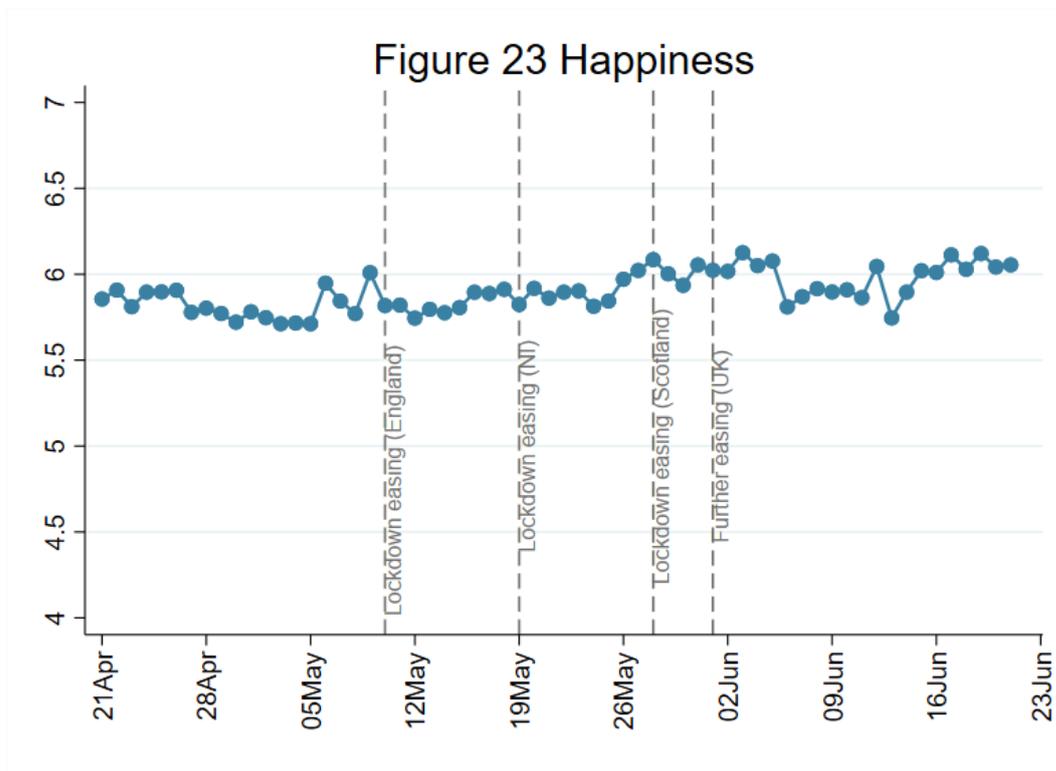


Figure 22h Loneliness by living area



## 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 was relatively stable across the second part of lockdown, but increased slightly as lockdown restrictions began to be lifted. Levels seem to have plateaued for now. Happiness levels have been lowest across lockdown 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

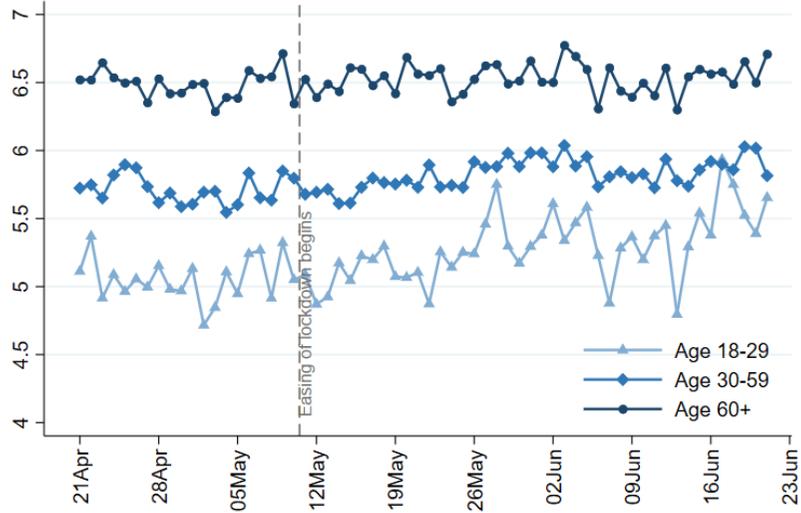


Figure 24b Happiness by living arrangement

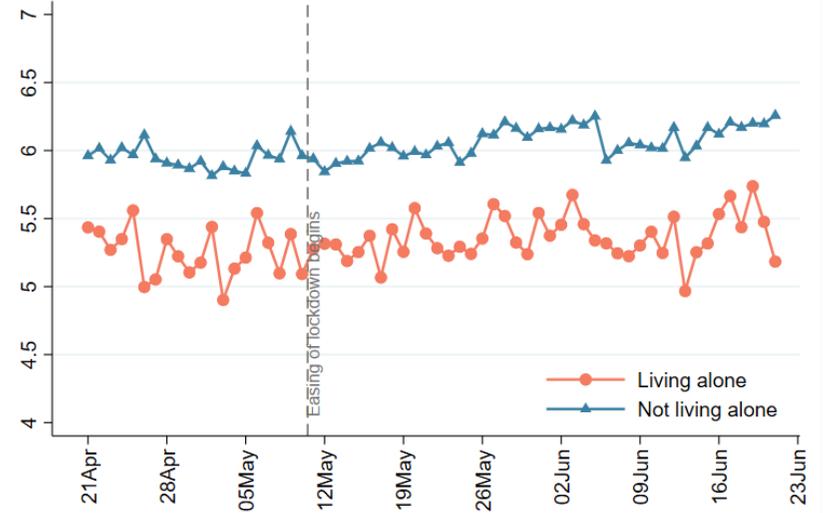


Figure 24c Happiness by household income

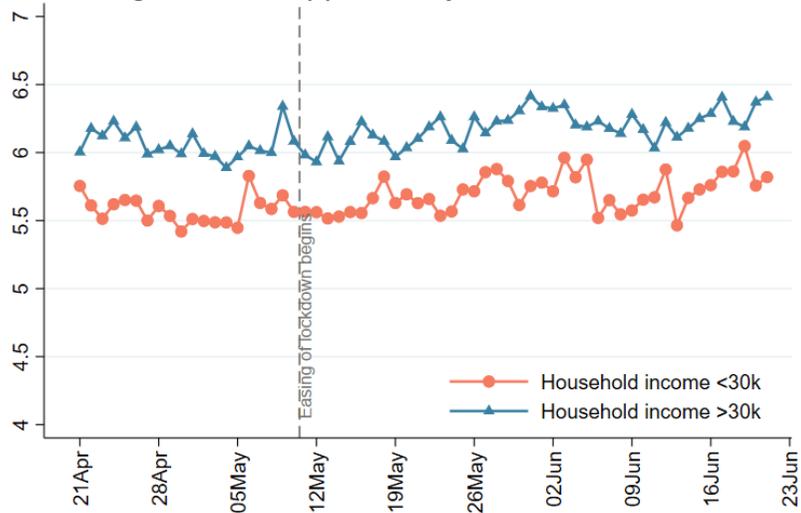


Figure 24d Happiness by mental health

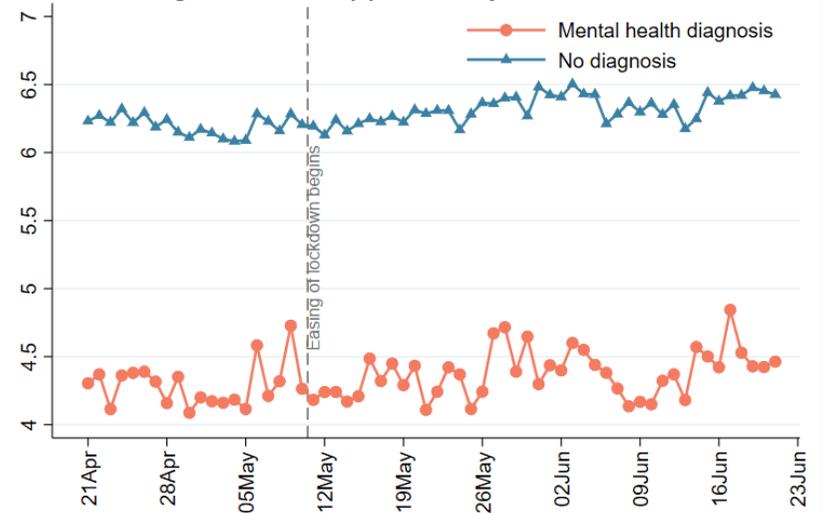


Figure 24e Happiness by nations

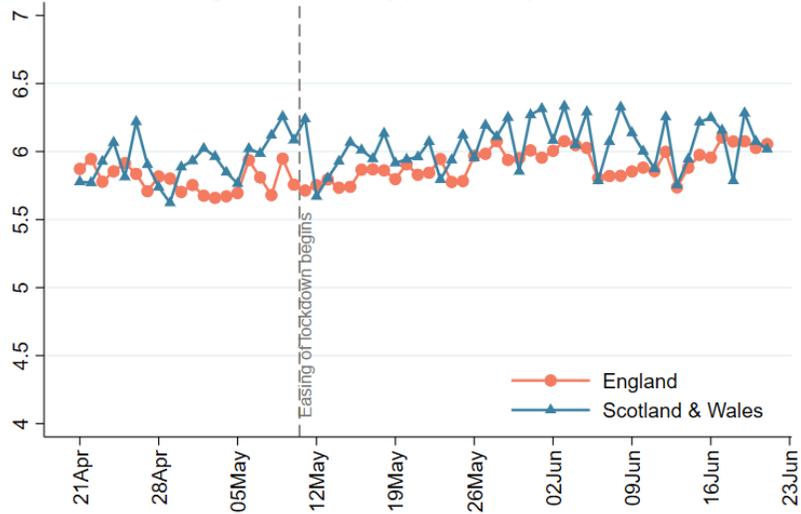


Figure 24f Happiness by keyworker status

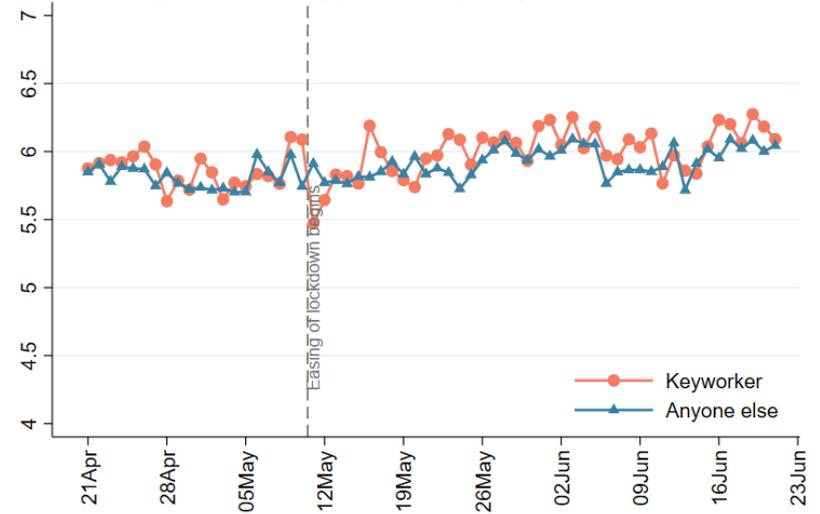


Figure 24g Happiness by living with children

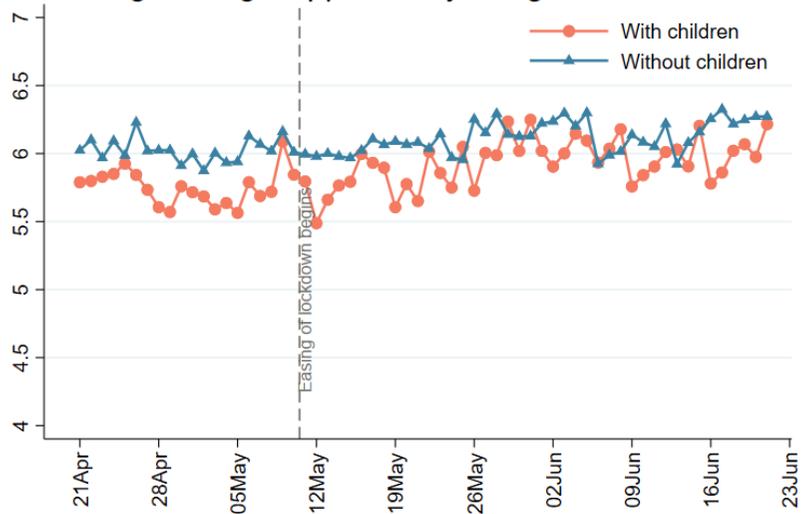
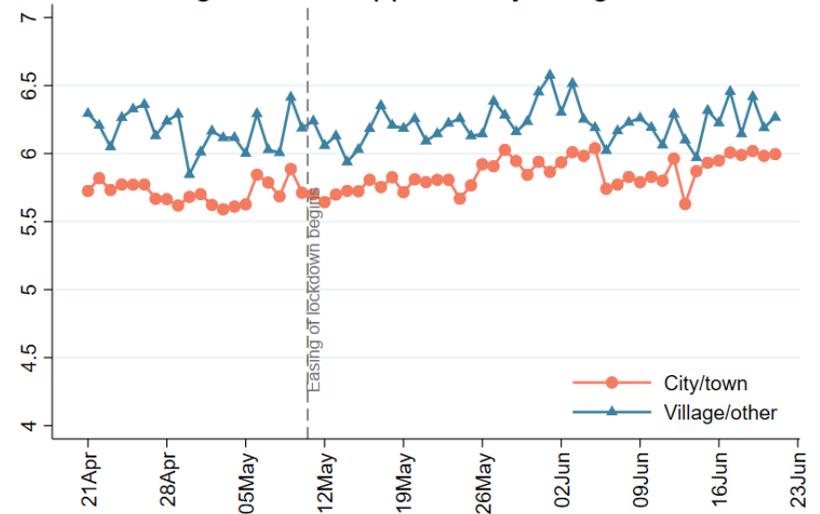
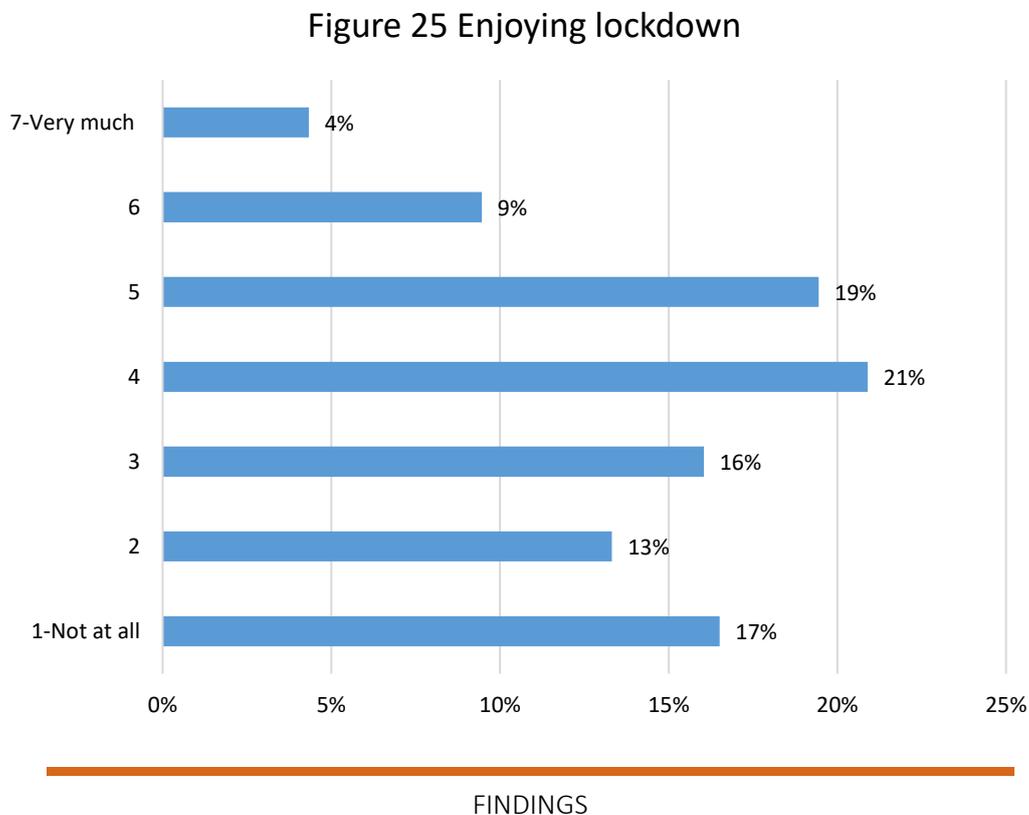


Figure 24h Happiness by living area



## 5. Experience of lockdown

### 5.1 Enjoying lockdown



We asked participants to report how much they have been enjoying lockdown on a scale from 1 (not at all) to 7 (very much). 17% of respondents reported not enjoying lockdown at all, and only 4% reported enjoying it very much. When looking at the balance of responses, 32% of the respondents reported overall enjoying lockdown (scores 5-7) while 46% reported overall not enjoying it (scores 1-3). 21% of respondents were uncertain about their feelings.

Adults aged 30-59 have been enjoying lockdown the most, as have people living with others, people with higher household incomes, people without any prior mental health conditions, and people living with children. People living in England have also been enjoying lockdown more compared to people in Scotland and Wales. There has been little difference by ethnicity.

People who have been enjoying lockdown least include younger and older adults, people living alone, people with lower household income, and people with an existing diagnosed mental health condition; many of the same groups who have experienced poorest mental health across the last 14 weeks.

Figure 26a Enjoy lockdown by age groups

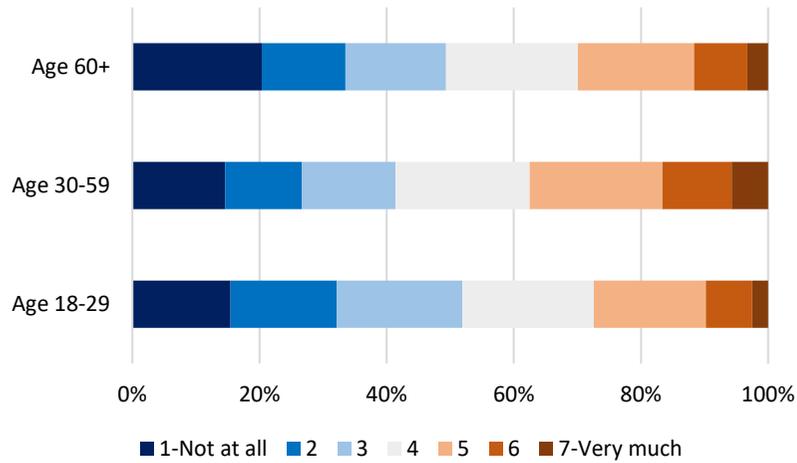


Figure 26b Enjoy lockdown by living arrangement

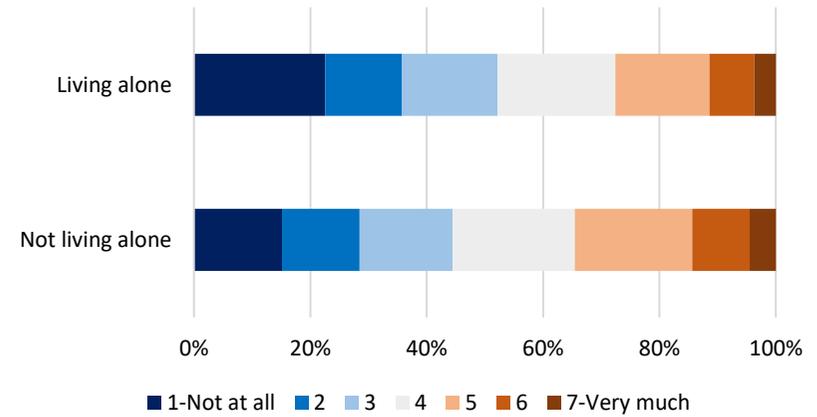


Figure 26c Enjoy lockdown by household income

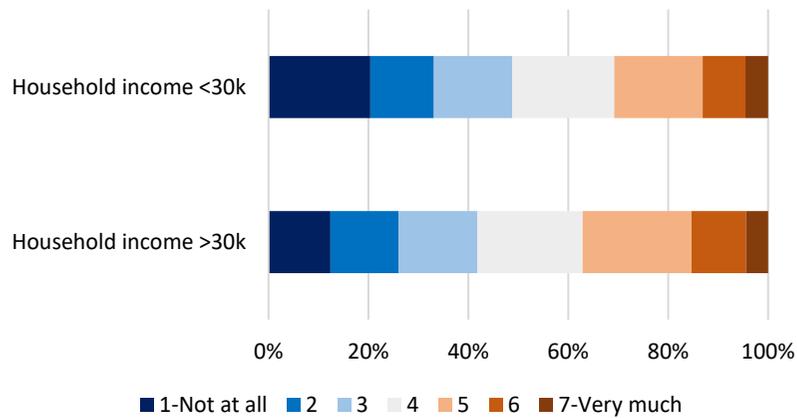


Figure 26d Enjoy lockdown by mental health diagnosis

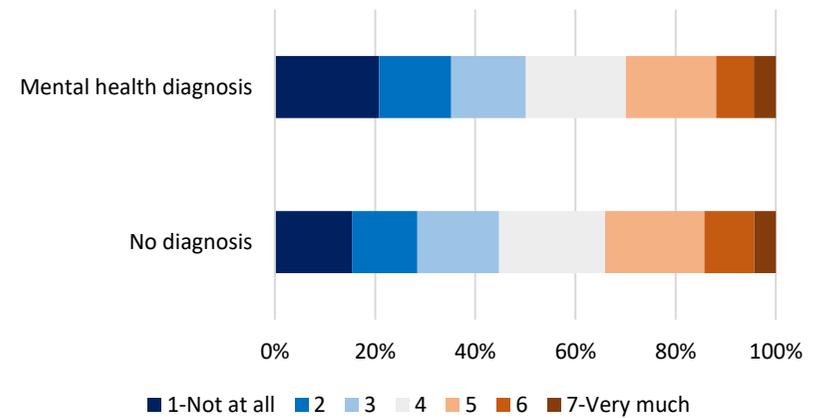


Figure 26e Enjoy lockdown by nations

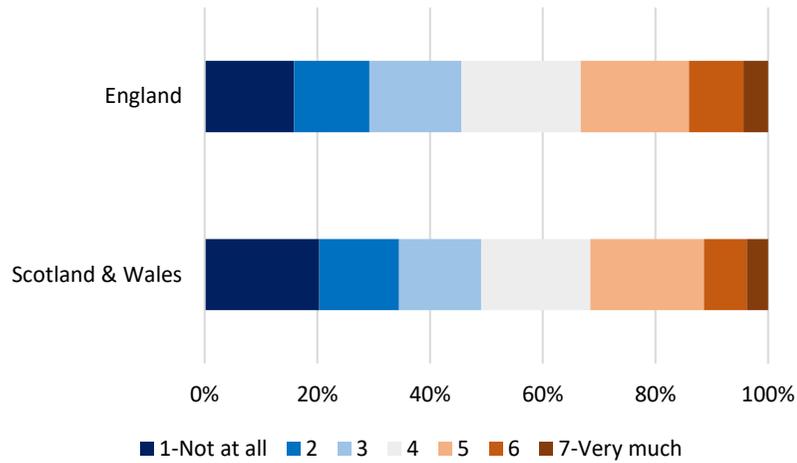


Figure 26f Enjoy lockdown by keyworker status

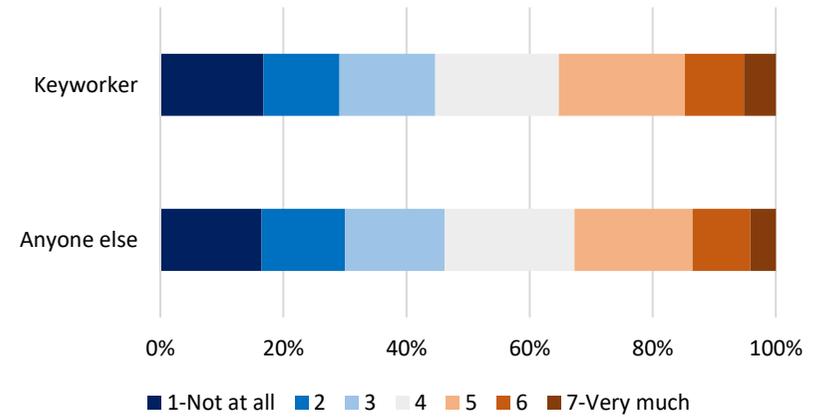


Figure 26g Enjoy lockdown by living with children

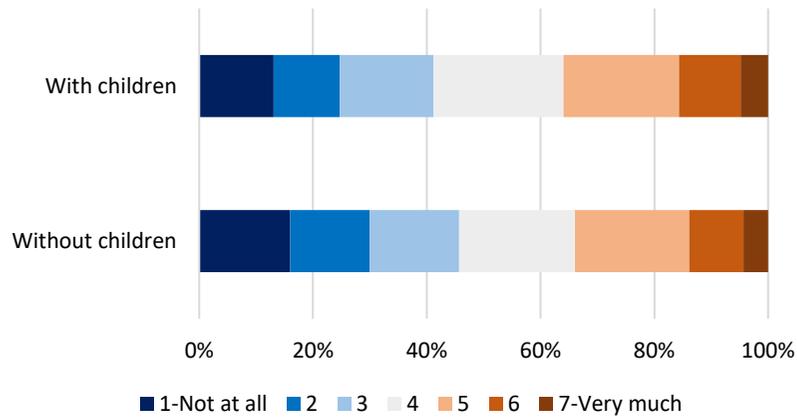
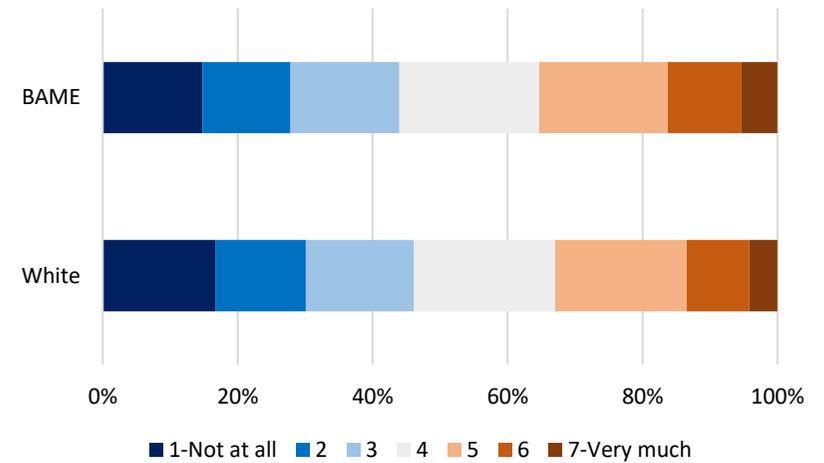
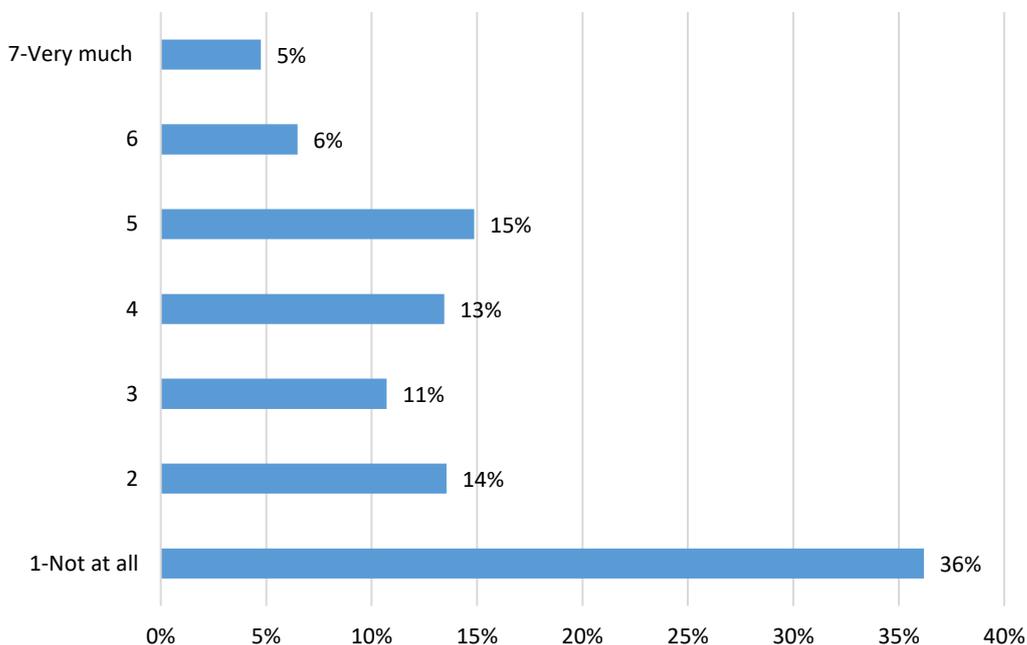


Figure 26h Enjoy lockdown by ethnicity



## 5.2 Miss being in lockdown

Figure 27 Miss being in lockdown



### FINDINGS

We asked participants to report how much they thought they would miss lockdown on a scale from 1 (not at all) to 7 (very much). 36% of people felt they would not miss it at all while just 5% said they would miss it very much. When looking at the balance of responses, 26% reported that overall they would miss lockdown (scores 5-7), while 61% felt overall they would not miss it at all (scores 1-3), and 13% were uncertain about their feelings.

Older adults, people living alone, and people with lower household income were most likely not to miss lockdown. However, adults aged 30-59 were most likely to miss it, as were people with a diagnosed mental illness and people from BAME groups. People living in England, keyworkers and people living with children were also more likely to miss being in lockdown.

Figure 28a Miss being in lockdown by age groups

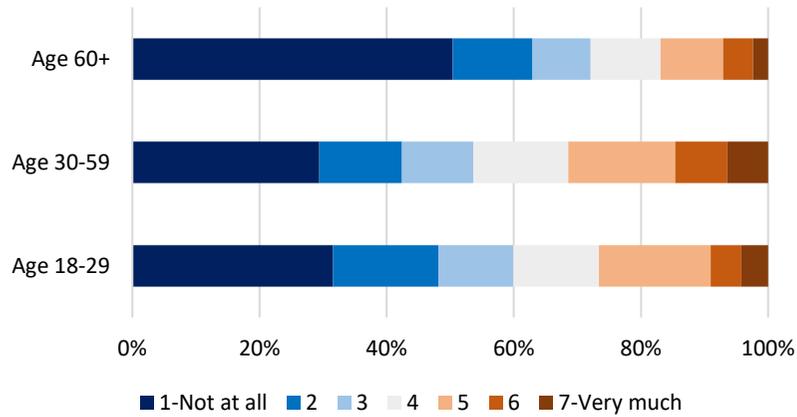


Figure 28b Miss being in lockdown by living arrangement

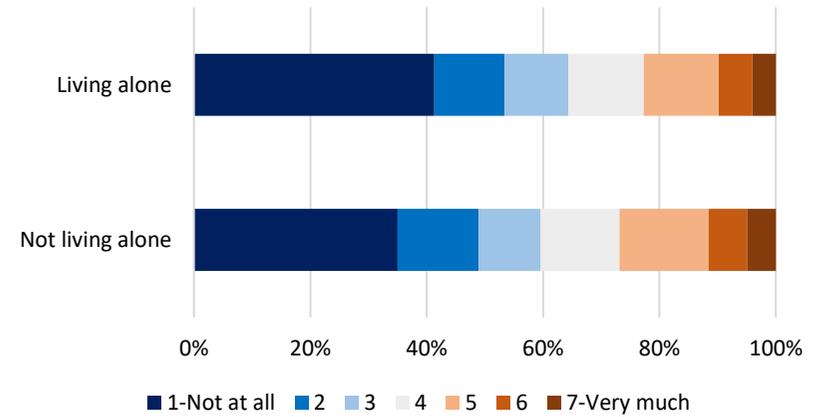


Figure 28c Miss being in lockdown by household income

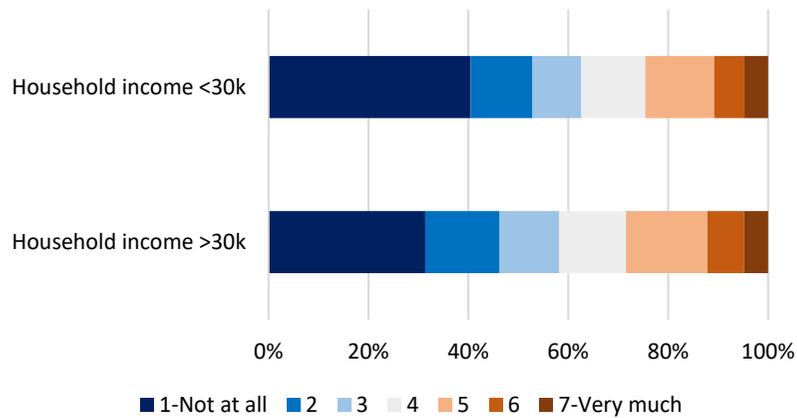


Figure 28d Miss being in lockdown by mental health diagnosis

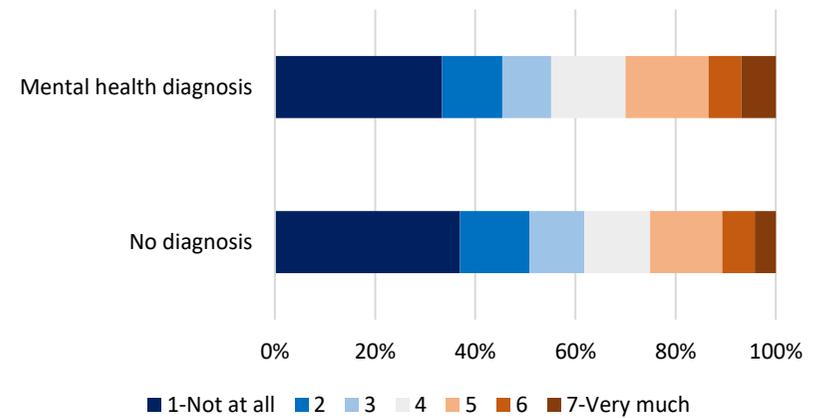


Figure 28e Miss being in lockdown by nations

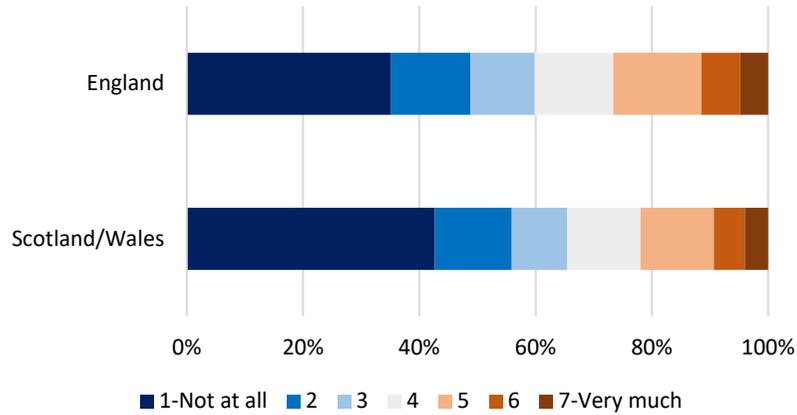


Figure 28f Miss being in lockdown by keyworker status

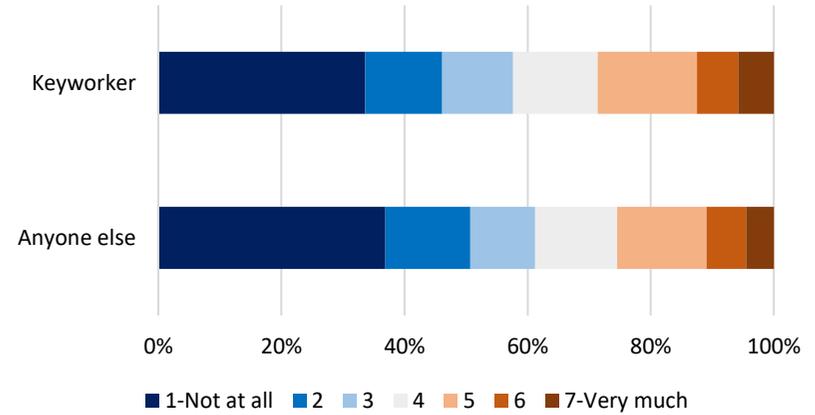


Figure 28g Miss being in lockdown by living with children

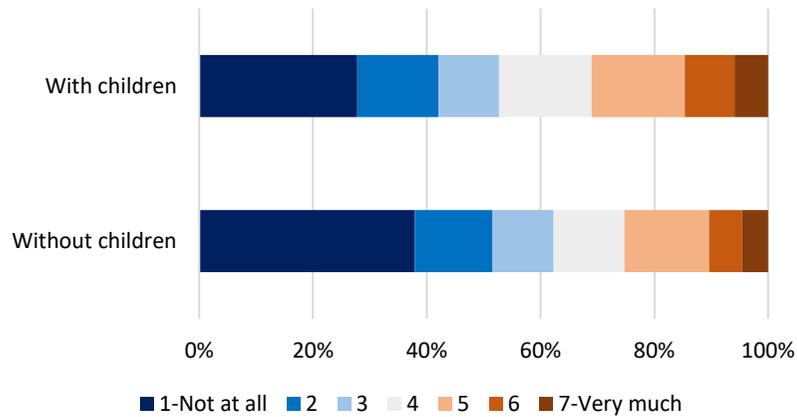
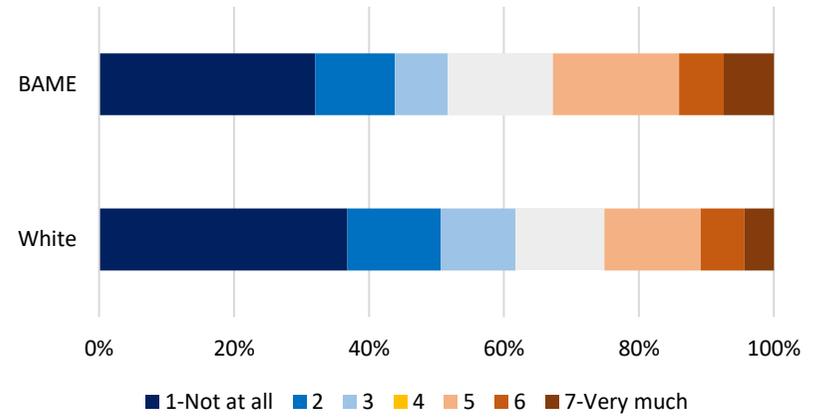
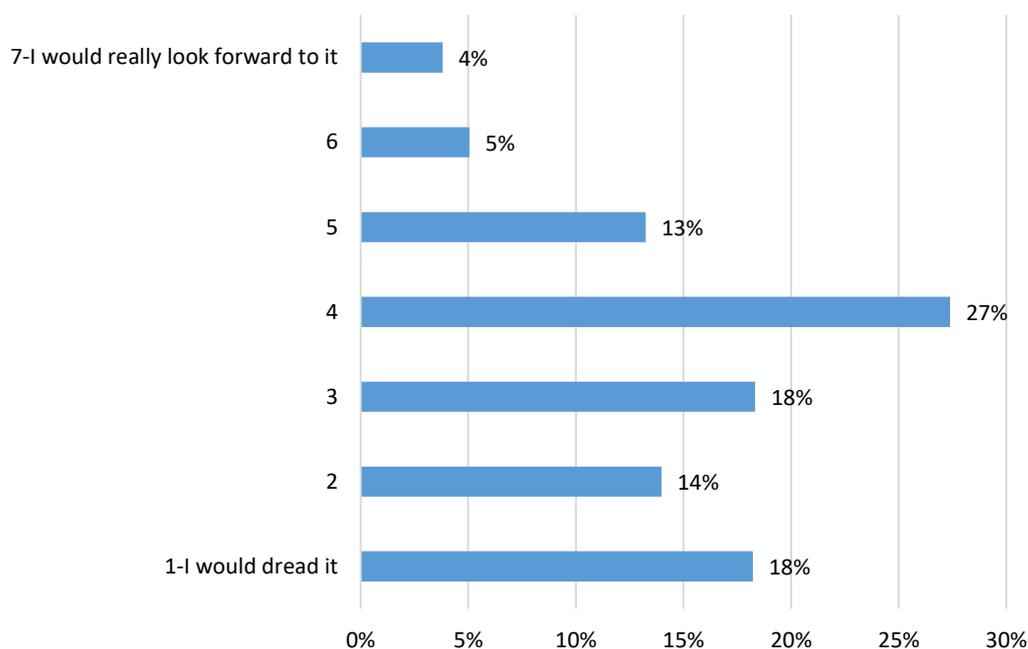


Figure 28h Miss being in lockdown by ethnicity



## 5.3 Feelings about future lockdowns

Figure 29 Feeling about future lockdowns



### FINDINGS

We asked participants to report how they would feel about a potential future lockdown on a scale from 1 (I would dread it) to 7 (I would really look forward to it). 18% of people felt they would dread it just 4% felt they would really look forward to it. When looking at the balance of responses, 50% felt they would overall not look forward to it (scores 1-3), while 22% felt they would overall look forward to it (scores 5-7), and 27% were mixed in their feelings.

People aged 30-59 were most likely to look forward to another lockdown, and there was a small indication that people living with others, people with higher household income, people living in England, keyworkers, people living with children, and people from BAME groups would also look forward to it slightly more or dread it slightly less. People with mental illness are more likely to dread a future lockdown, with 1 in 4 dreading it and 1 in 2 feeling overall negative about it, but a further 1 in 4 would still feel overall positive about it.

Figure 30a Feeling about future lockdowns by age groups

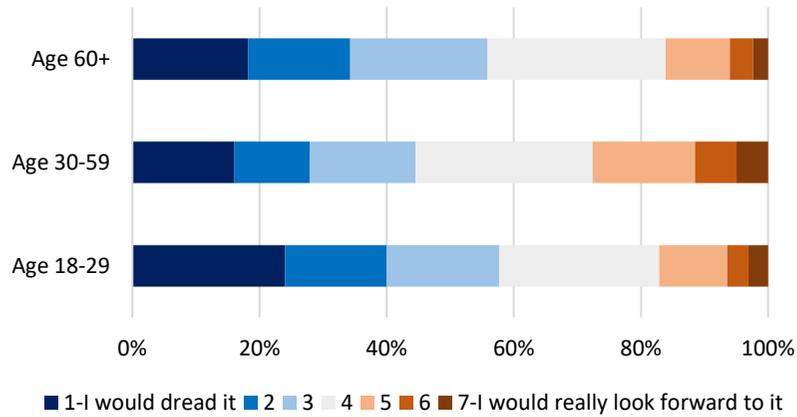


Figure 30b Feeling about future lockdowns by living arrangement

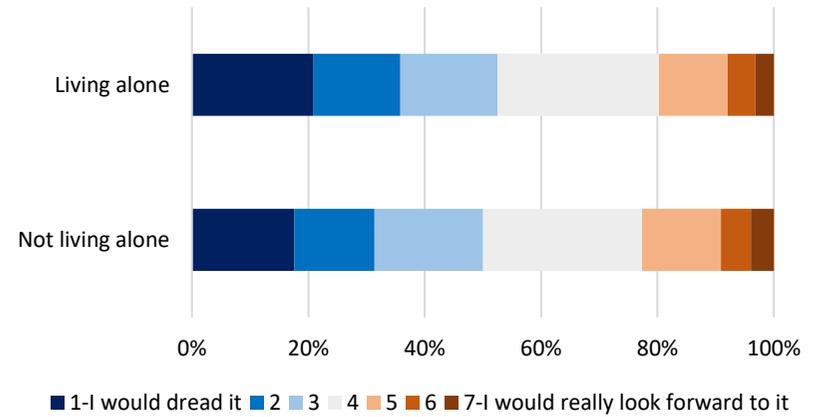


Figure 30c Feeling about future lockdowns by household income

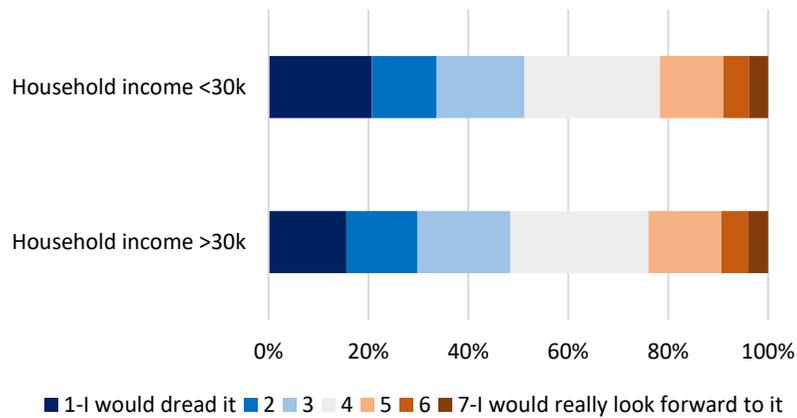


Figure 30d Feeling about future lockdowns by mental health diagnosis

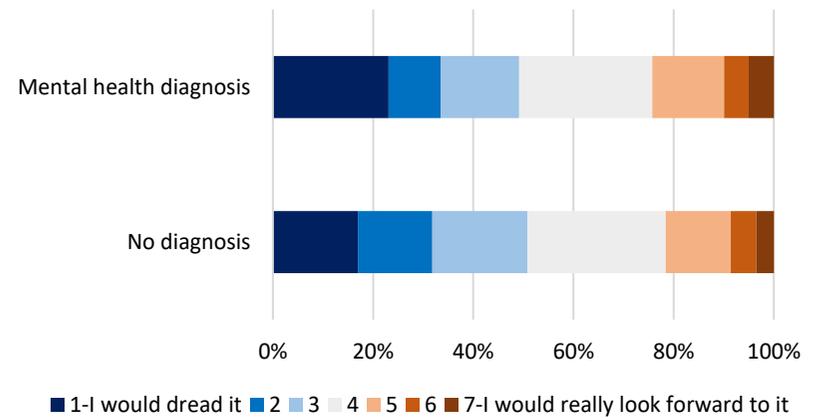


Figure 30e Feeling about future lockdowns by nations

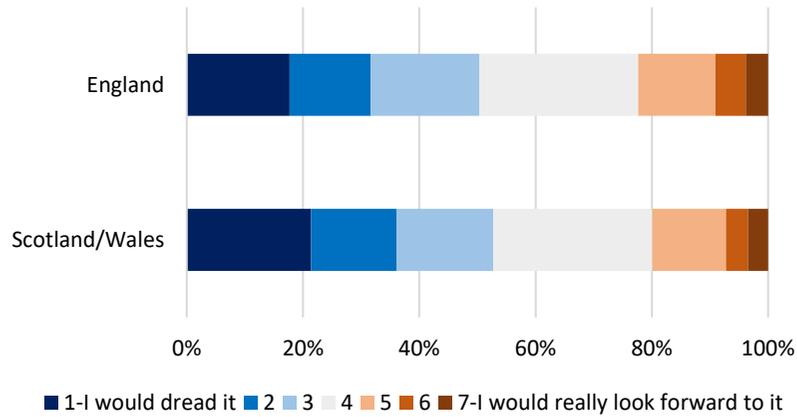


Figure 30f Feeling about future lockdowns by keyworker status

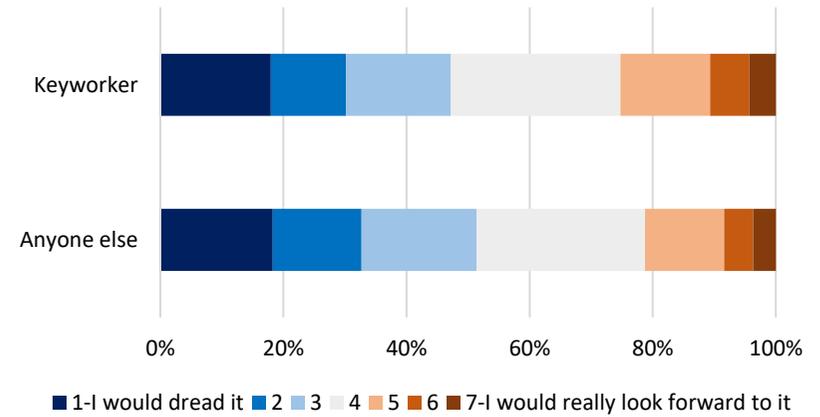


Figure 30g Feeling about future lockdowns by living with children

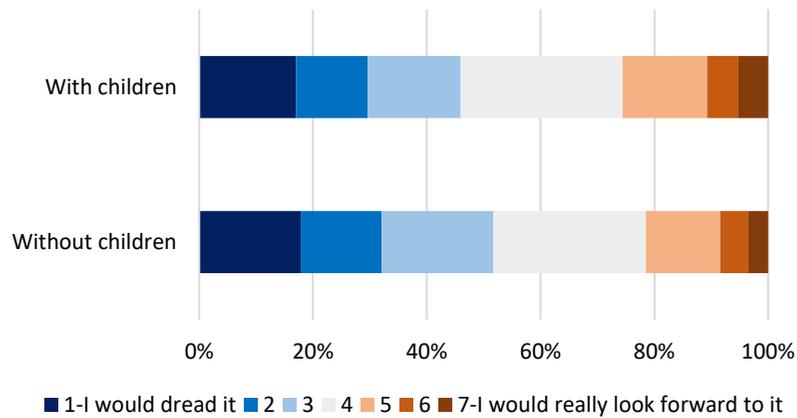
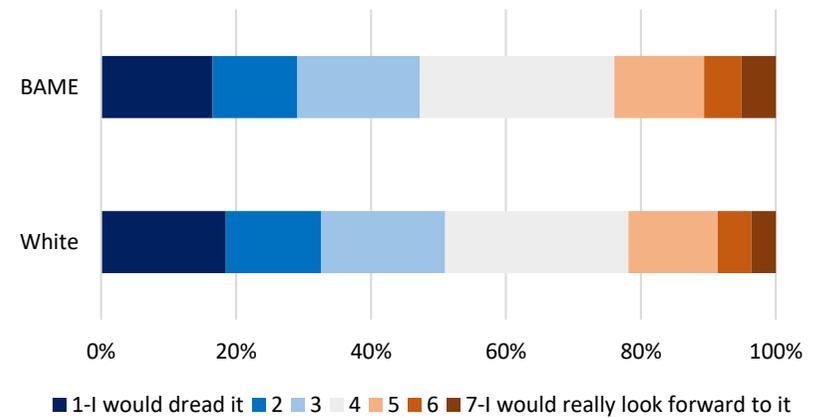


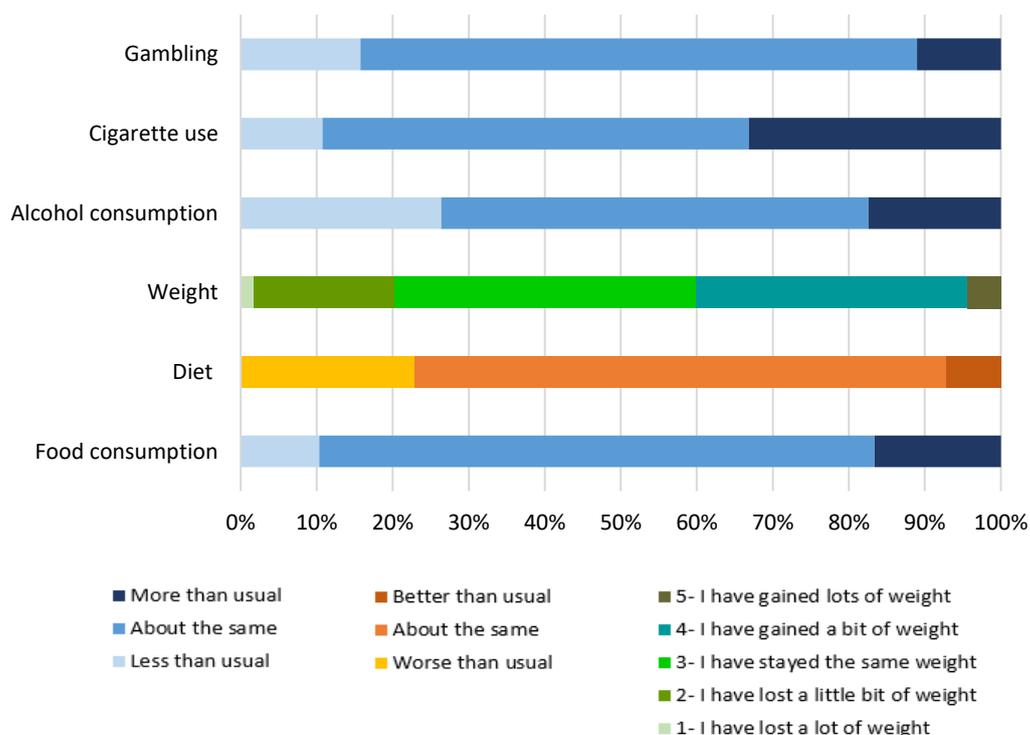
Figure 30h Feeling about lockdowns by ethnicity



## 6. Health behaviours

### 6.1 Health behaviours

Figure 31 Changes in health behaviours before and after lockdown



#### FINDINGS

Health behaviours have stayed constant across lockdown for the majority of respondents, with 73% reporting no change in volume of food consumption, 70% reporting no change in the healthiness of their diet, 40% reporting no change in their weight, 56% reporting no change in the amount of alcohol they drunk or the number of cigarettes they smoked, and 73% showing no change in the amount they gambled<sup>4</sup>.

However, some adults reported engaging more in less healthy behaviours, including 17% of adults reporting eating more than usual, 23% reporting eating less healthily than normal, 40% reporting gaining weight (4% reporting gaining lots of weight), 17% reporting drinking more than normal, 33% reporting smoking more than usual, and 11% reporting gambling more than usual.

Older adults have been least likely to change their eating and diet behaviours, while young people have been more likely to change their eating and diet behaviours, as have women and people from BAME groups. Adults aged 30-59 and women have been most likely to have gained weight, whilst adults under the age of 30 and people from BAME groups have been most likely to have lost weight. Younger adults, women and people from BAME groups have been more likely to have drunk less than usual, although cigarette usage has gone up more in these groups. Men have been more likely to have been gambling less than usual, although younger adults have changed their gambling behaviours most in both directions, with some increasing and some decreasing.

<sup>4</sup> Alcohol, cigarette use and gambling behaviours are only reported for people who said they usually engage in these behaviours. All results are subject to bias in participant reporting, which will be explored further in future statistical analyses, but should be considered in the interpretation of differences reported here.

Figure 32a Changes in food consumption by age groups

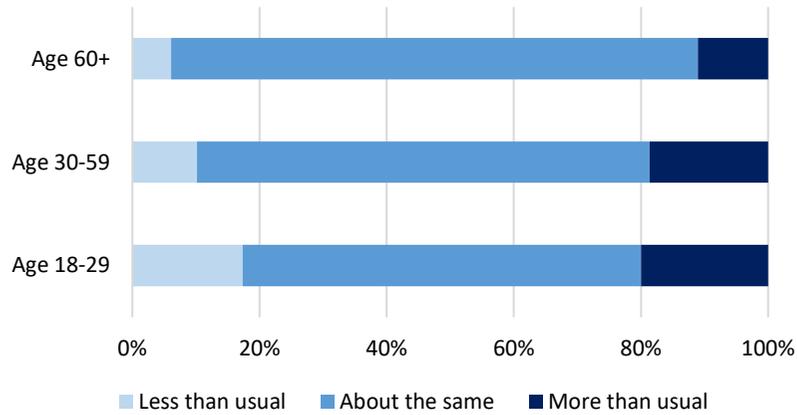


Figure 32b Changes in diet by age groups

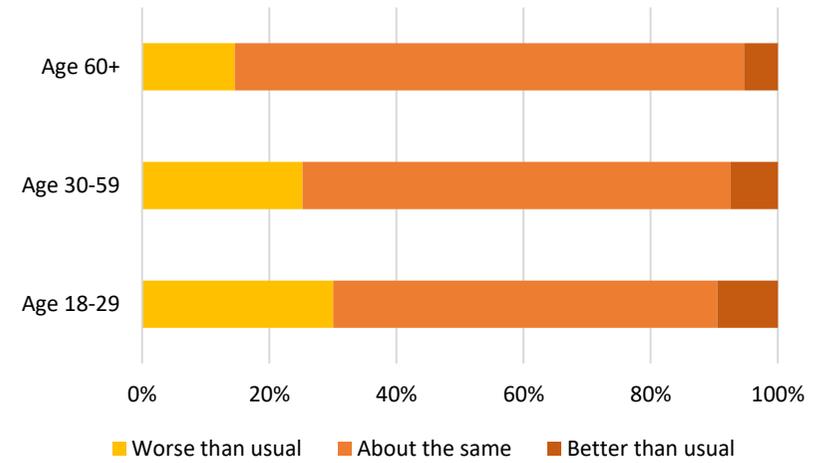


Figure 32c Changes in weight by age groups

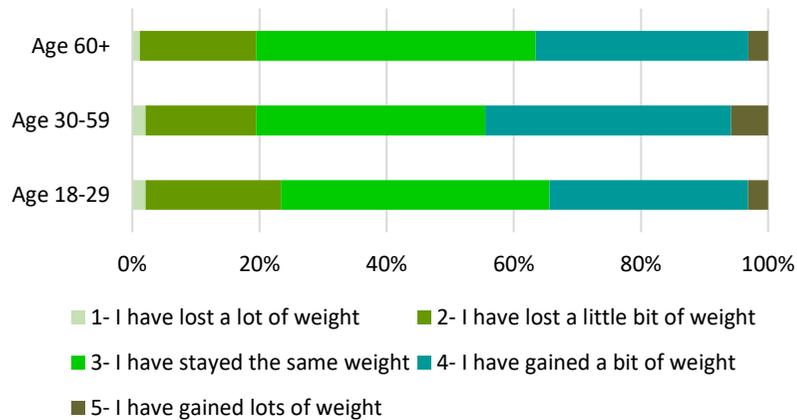


Figure 32d Changes in alcohol consumption by age groups

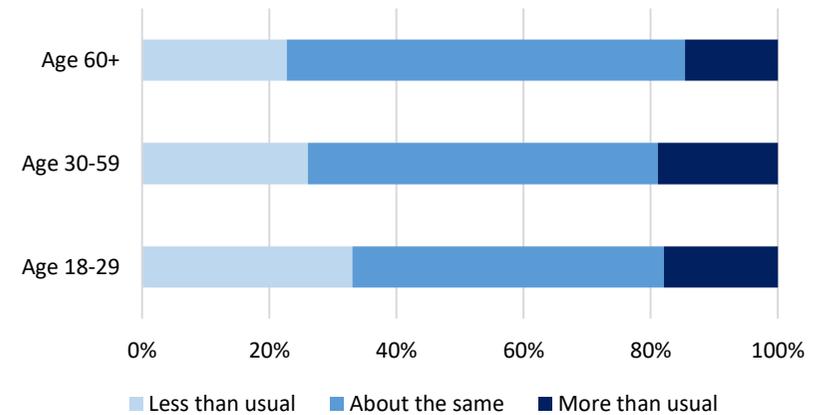


Figure 32e Changes in cigarette use by age groups

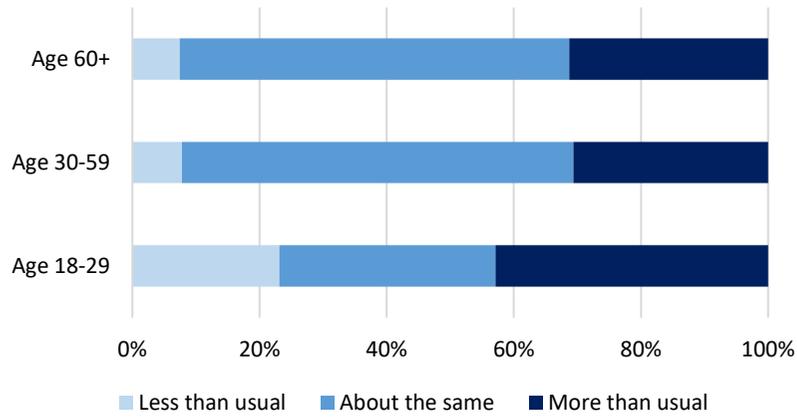


Figure 32f Changes in gambling by age groups

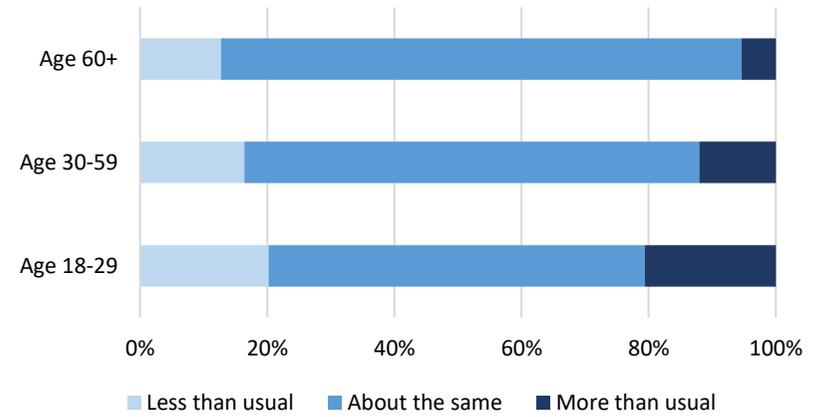


Figure 33a Changes in food consumption by gender

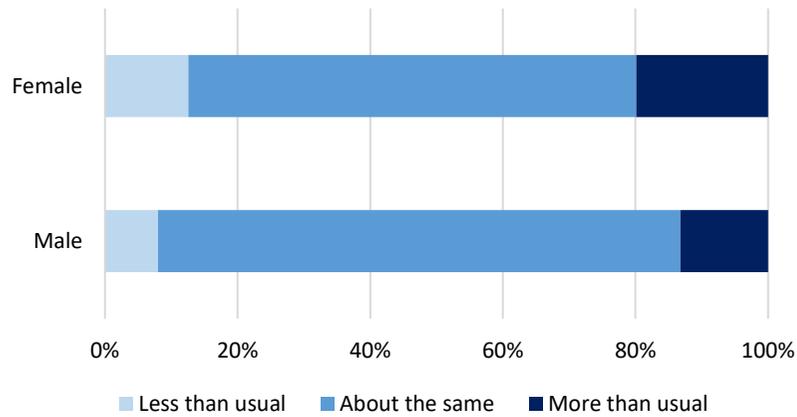


Figure 33b Changes in diet by gender

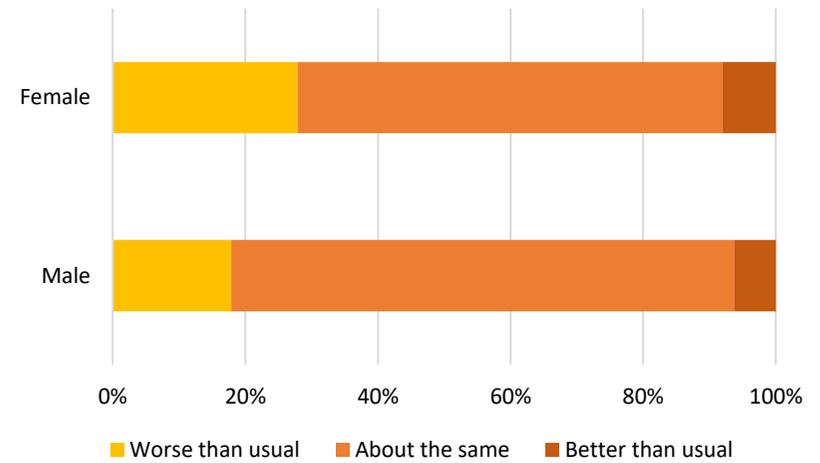


Figure 33c Changes in weight by gender

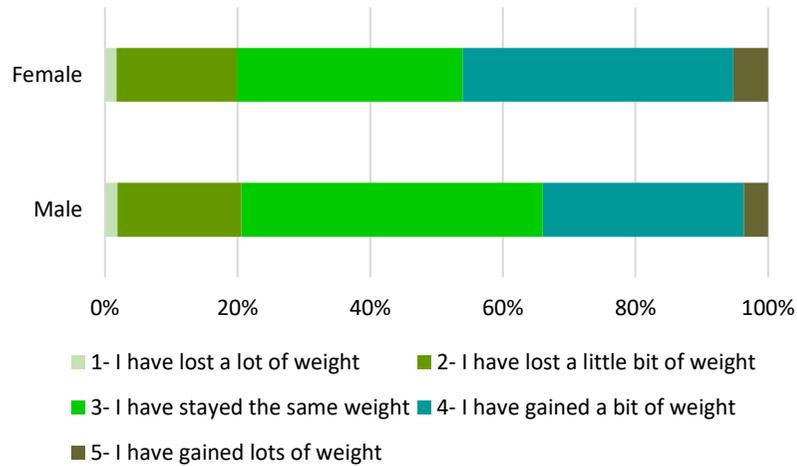


Figure 33d Changes in alcohol consumption by gender

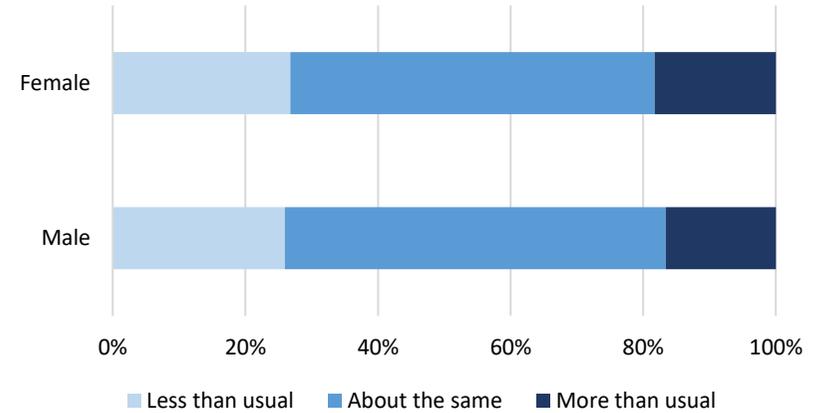


Figure 33e Changes in cigarette use by gender

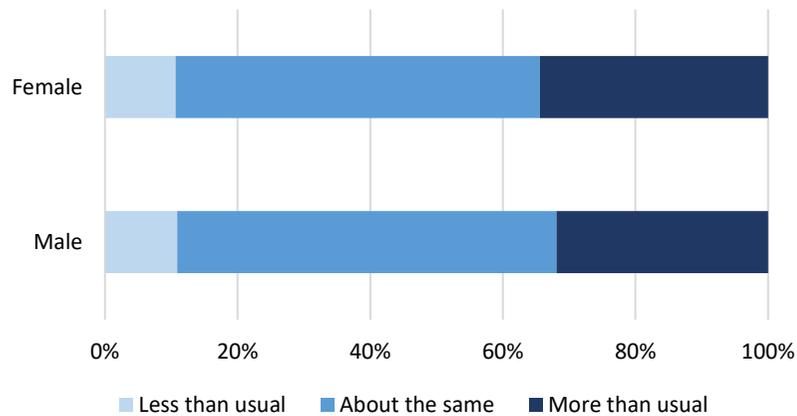


Figure 33f Changes in gambling by gender

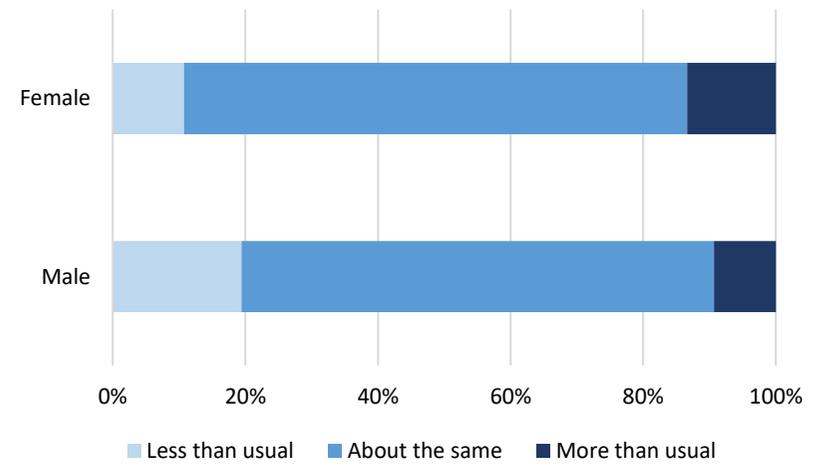


Figure 34a Changes in food consumption by ethnicity

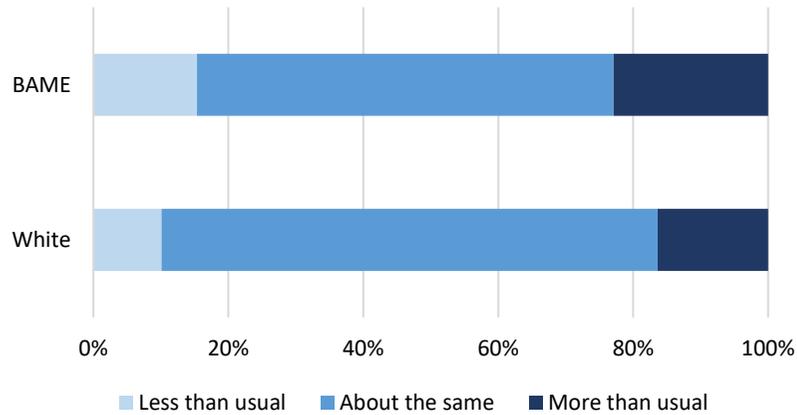


Figure 34b Changes in diet by ethnicity

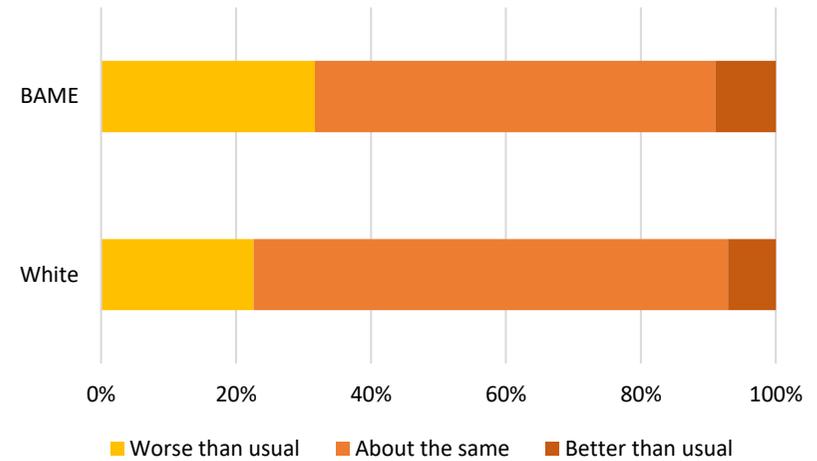


Figure 34c Changes in weight by ethnicity

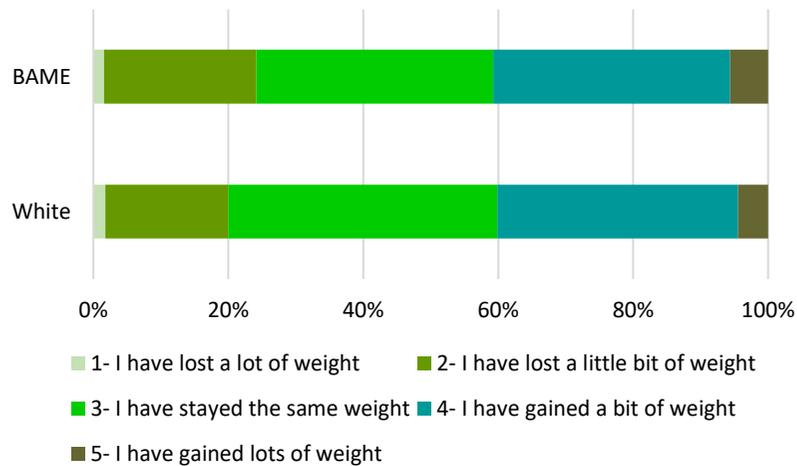


Figure 34d Changes in alcohol consumption by ethnicity

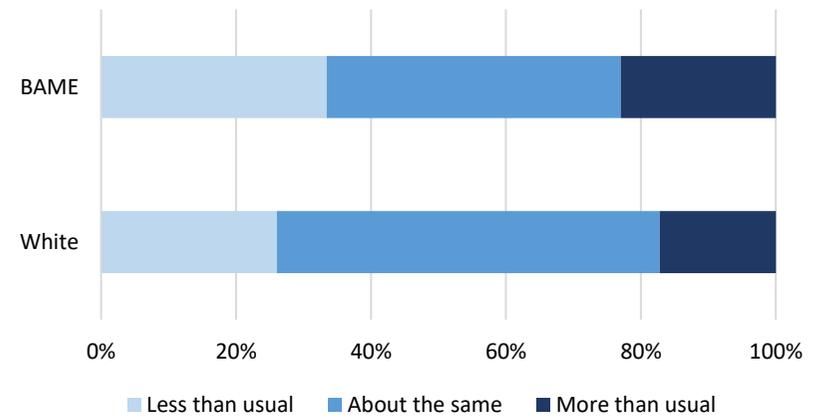


Figure 34e Changes in cigarette use by ethnicity

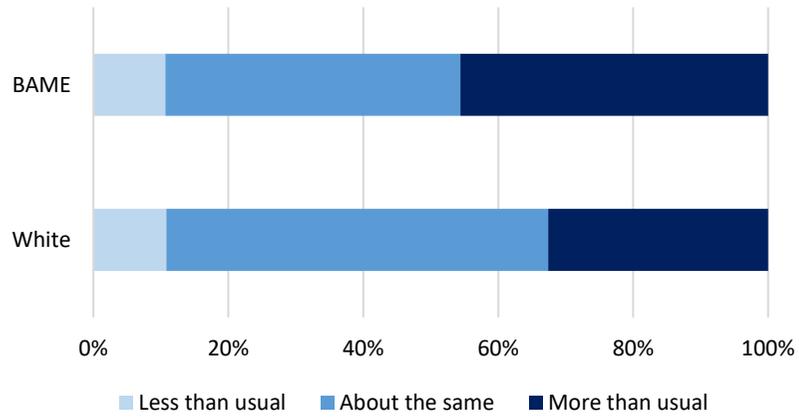
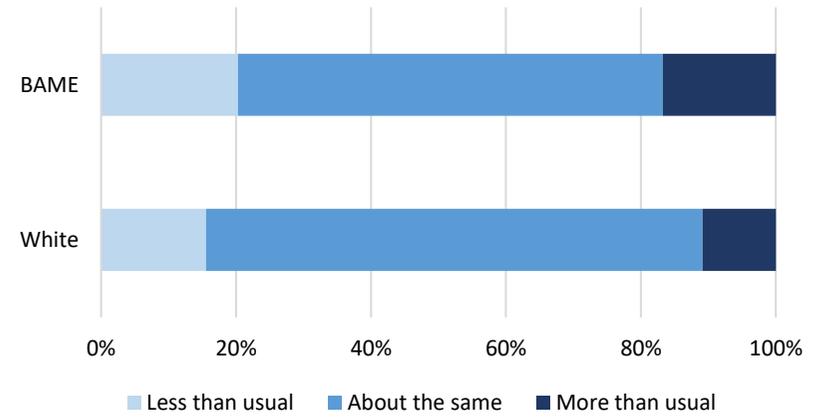


Figure 34f Changes in gambling by ethnicity



# 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.

In this report, we treated the data as repeated cross-sectional data collected daily from the 21<sup>st</sup> March to the 21<sup>st</sup> June (the latest data available) across baseline and follow-up surveys. 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, 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)

	Number of observations	%
Age		
18-29	31,966	7.1
30-59	260,365	57.8
60+	158,004	35.1
Gender		
Male	112,883	25.2
Female	335,537	74.8
Ethnicity		
White	429,391	95.7
BAME	19,524	4.35
UK nations		
England	365,889	81.3
Wales	50,145	11.2
Scotland	29,284	6.51
Northern Ireland	4,600	1.02
Living arrangement		
Not living alone	359,771	80.0
Living alone	90,129	20.0
Annual household income		
>30k	247,557	60.8
<30k	159,479	39.2
Any diagnosed mental health conditions		
No	371,058	82.4
Yes	79,277	17.6
Keyworker		
No	351,417	78.0
Yes	98,918	22.0
Living with children		
No (excluding those who live alone)	249,721	69.4
Yes	110,050	30.6
Living area		
Village/hamlet/isolated dwelling	108,692	24.2
City/large town/small town	341,226	75.8