Covid-19 Social Study

Results Release 41

Dr Daisy Fancourt, Dr Feifei Bu, Dr Hei Wan Mak, Dr Elise Paul, Prof Andrew Steptoe

Department of Behavioural Science & Health

9 December 2021

Nuffield Foundation

wellcome

Table of Contents

Executive summary

Background

This report provides data from the last 88 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 FORTY-FIRST report, we focus on psychological responses to the first eighty-eight weeks since just before the first UK lockdown was announced (21/03/2020 to 28/11/2021). We present simple descriptive results on the experiences of adults in the UK. Measures include:

1.   Reported compliance with government guidelines and confidence in the government
2.   Mental health including depression, anxiety and stress
3.   Harm including thoughts of death or self-harm, self-harm and both psychological & physical abuse
4.   Psychological and social wellbeing including life satisfaction, loneliness and happiness
5.   *****New in this report***** Life changes and Covid-19 booster 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

- Compliance with government guidelines is at an all-time low for the pandemic. Since the start of the autumn complete compliance (following the guidelines to the letter) has been down to just 1 in 3 people, although majority compliance remains above 80%.
- Although attitudes to Covid-19 booster vaccine intentions were mostly favourable, 5% were hesitant about receiving a booster vaccine (scores of 3-4 on a scale from 1 [very unlikely]–6 [very likely]), and 7% said they were unwilling (scores of 1-2).
- *Booster unwillingness* (scores of 1-2 on a scale 1-6) was reported amongst 12% of young adults compared to 8% of adults aged 30-59 and 3% of adults aged 60+. Unwillingness was twice as high in people with lower household incomes (10%) compared to those with higher household incomes (5%), and in people with education levels up to a GCSE (10%) compared to those with a degree or higher (5%).
- *Booster hesitancy* (scores of 3-4 on a scale 1-6) was more common amongst people living with children (7% vs 3% in those not living with children), people in good physical health (6% vs 3% of people with a physical health diagnosis), and in young adults (10% vs 5% ages 30-59 and 2% ages 60+).
- Only 12% of people currently say that once the pandemic is over, they will return to living exactly as they did before Covid-19, whilst 1 in 5 (20%) feel they are likely to make changes to their lives and 27% are undecided.
- In general, people have reported being less likely to make changes to most domains they were asked about, with the exceptions of plans to work more from home (24% in 2021 and 2020), commuting by public transport more (2% in 2021 compared to 1% in 2020) and looking after their mental health (24% in 2021 compared to 21% in 2020).
- Plans to support local businesses more after the pandemic have decreased since 2020 (40% to 31%), as have plans to save money (35% to 25%), talk to neighbours more (20% to 15%), and exercise more (33% to 25%).
- Worries about finance have been increasing since mid-summer 2021. Concerns about finances remain highest amongst adults of working age (18-59 years), in particular young adults (age 18-29). Financial stress has also been higher amongst people with lower household incomes, keyworkers, in urban areas, those with a mental health diagnosis, people living with children, and people from ethnic minority groups.

1. Compliance and confidence

1.1 Compliance with guidelines

Figure 1 Compliance with guidelines
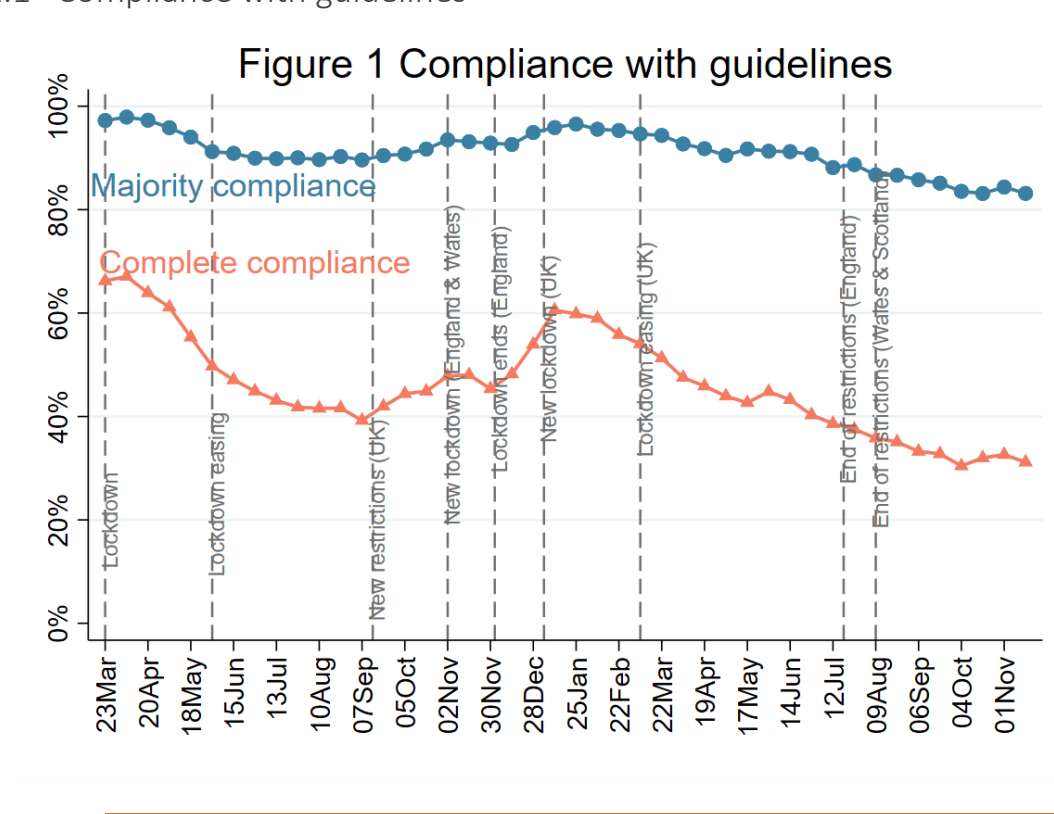
FINDINGS

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

Compliance with government guidelines is at an all-time low for the pandemic. Since the start of the autumn complete compliance (following the guidelines to the letter) has been down to just 1 in 3 people, although majority compliance remains above 80%.

Across demographic groups[1], patterns of complete compliance remain as they have been since the start of the year, with compliance lower in higher income households, amongst young adults, amongst keyworkers, in urban areas, amongst men, and amongst people in good physical health.

[1] Figures for ethnicity sub-groups are analysed by month rather than by week for the duration of the study to maximise sample size.

Figure 2a Complete compliance by age groups
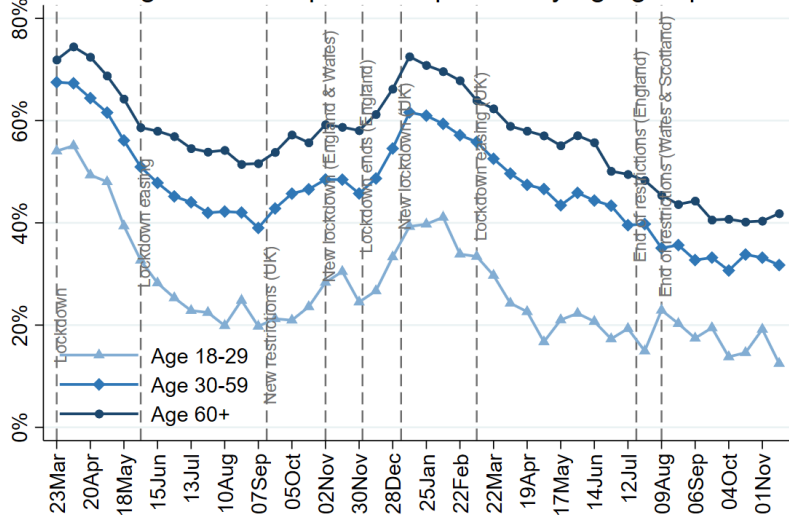
Figure 2b Complete compliance by living arrangement
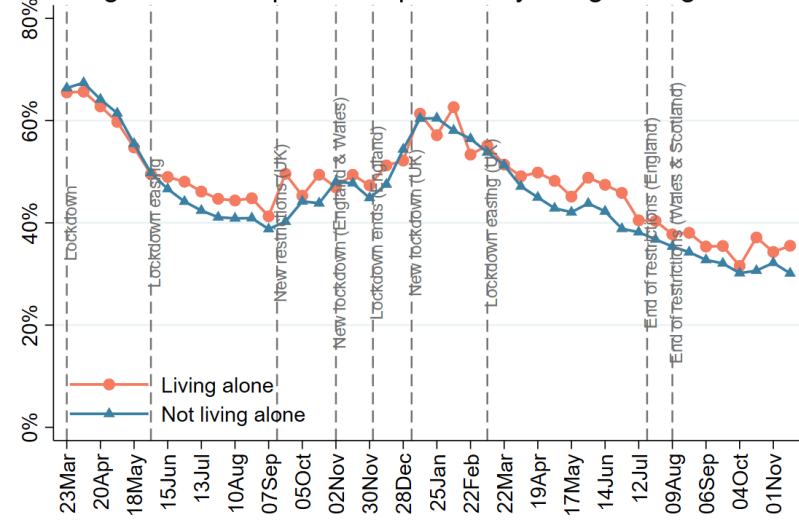
Figure 2c Complete compliance by household income
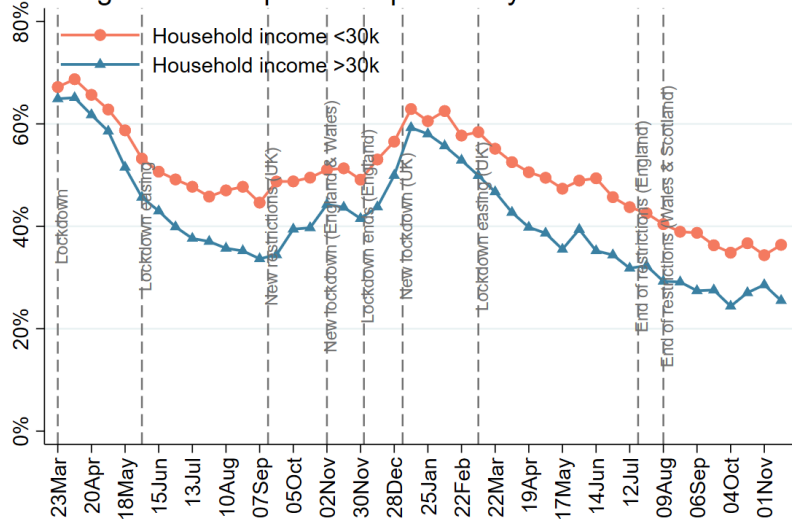
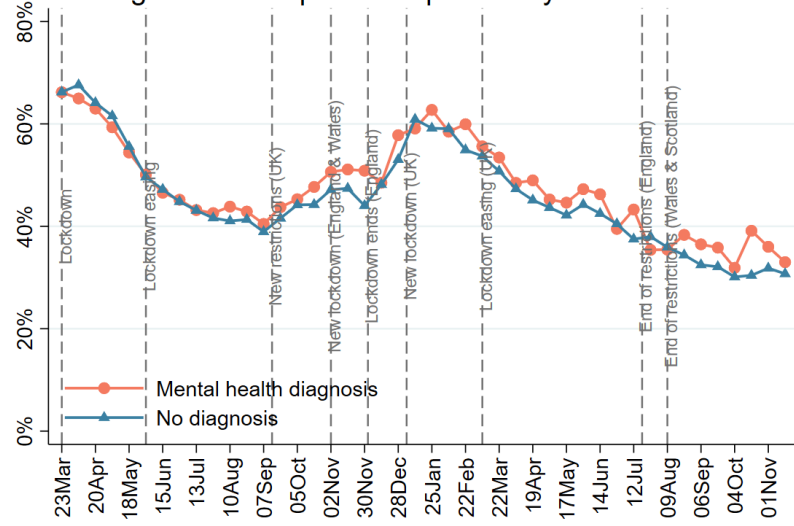Figure 2d Complete compliance by mental health

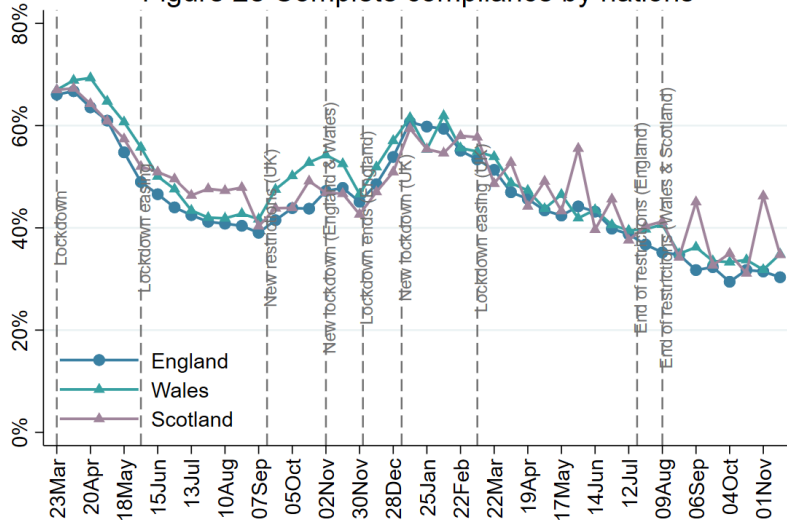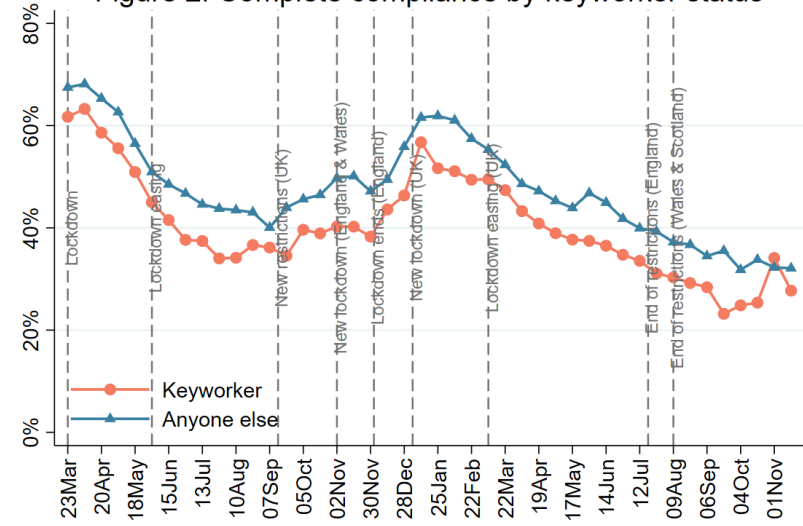Figure 2e Complete compliance by nations

Figure 2f Complete compliance by keyworker status
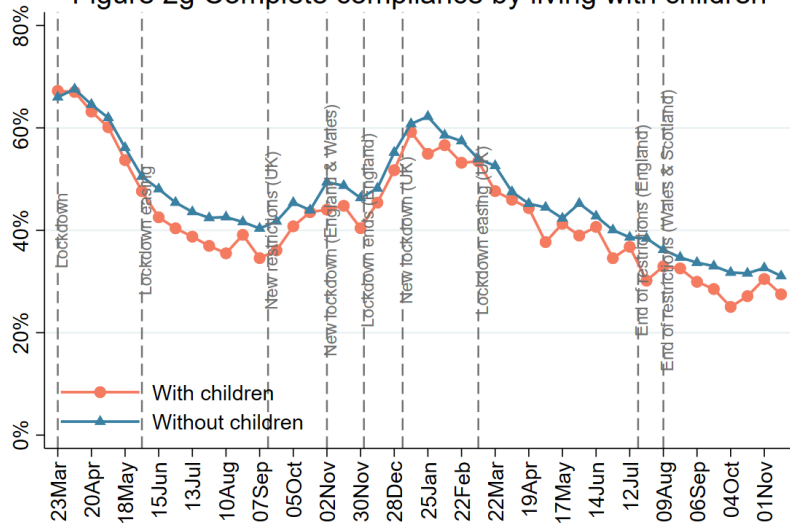

Figure 2g Complete compliance by living with children

Figure 2h Complete compliance by living area
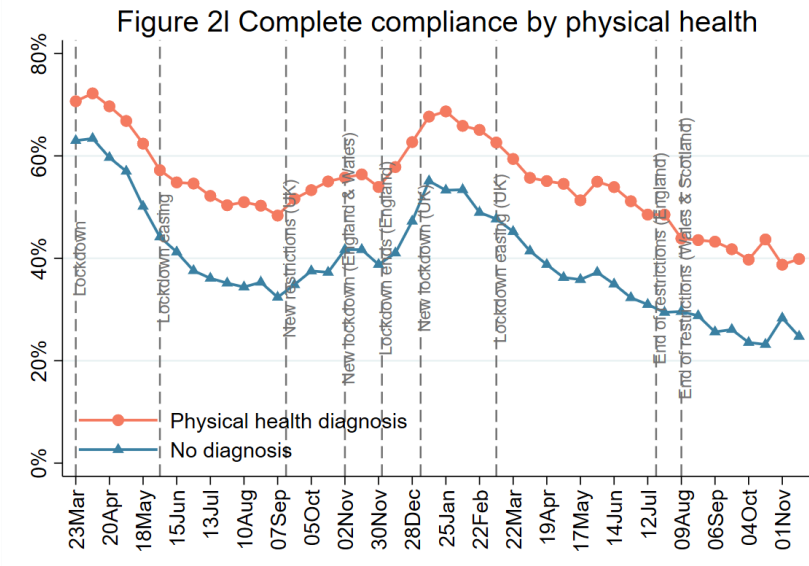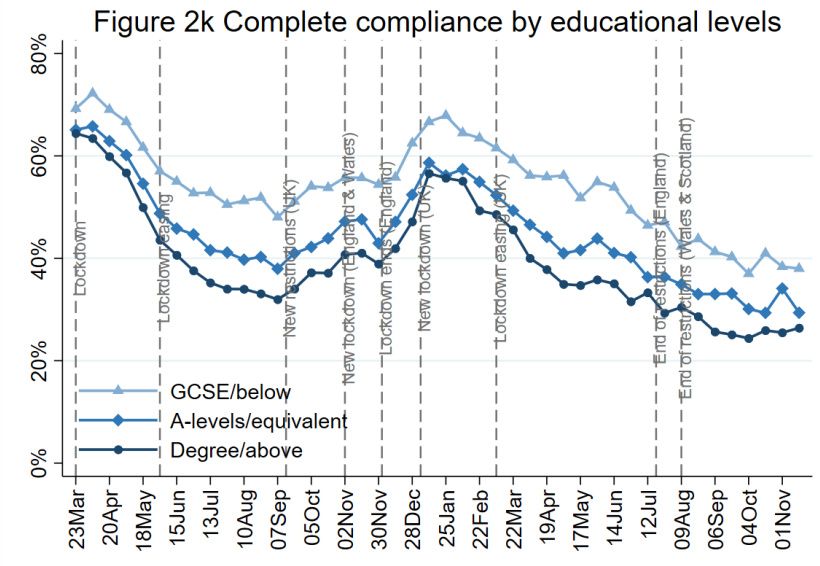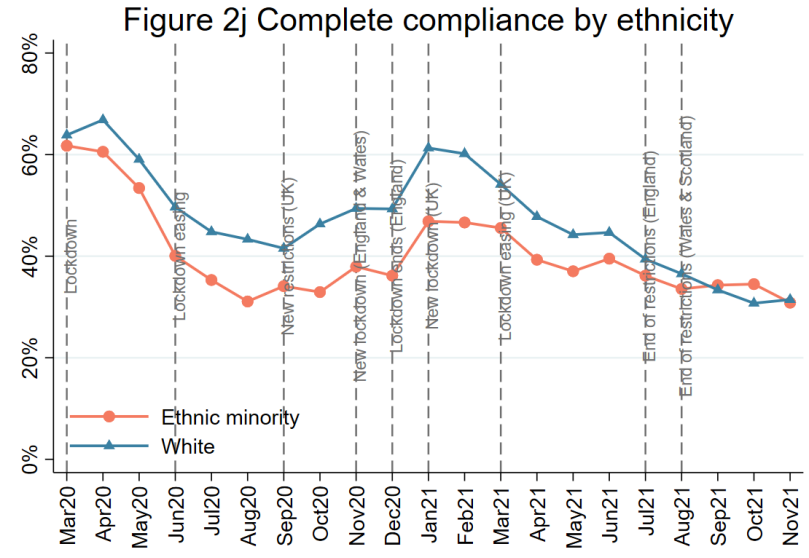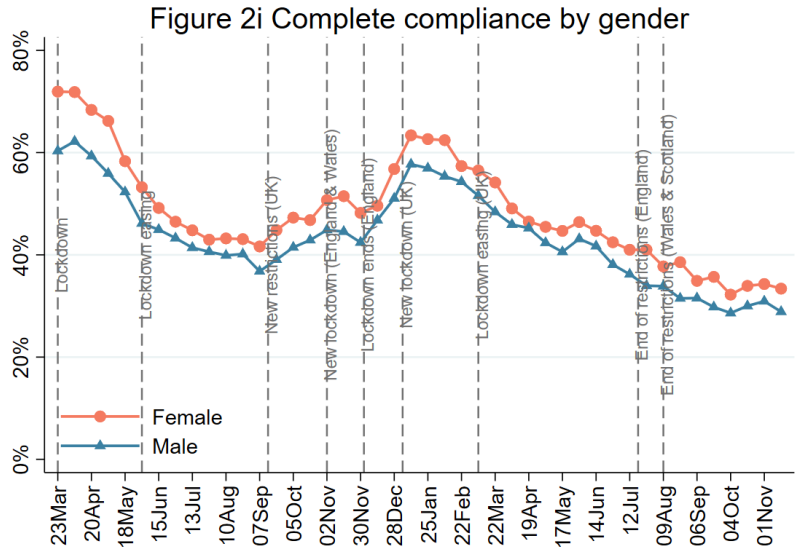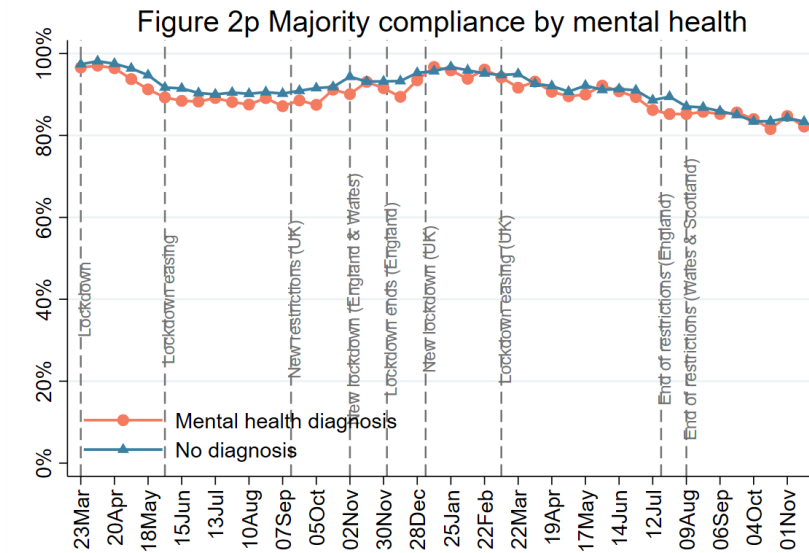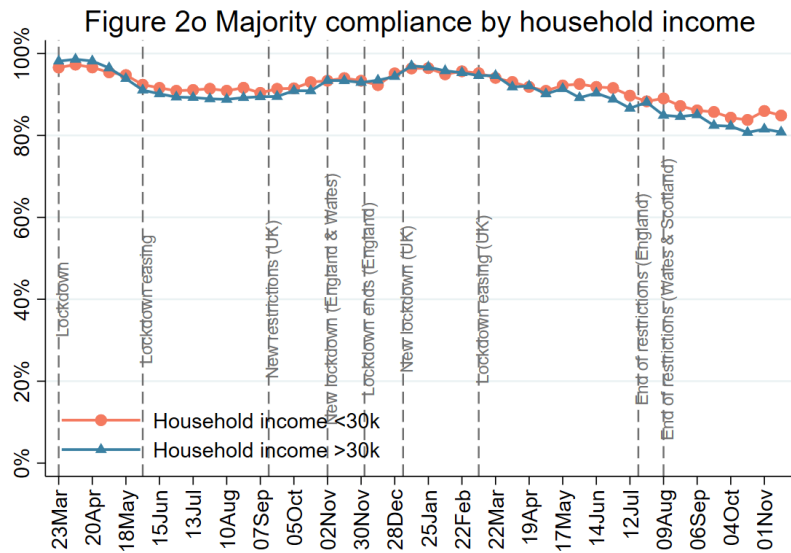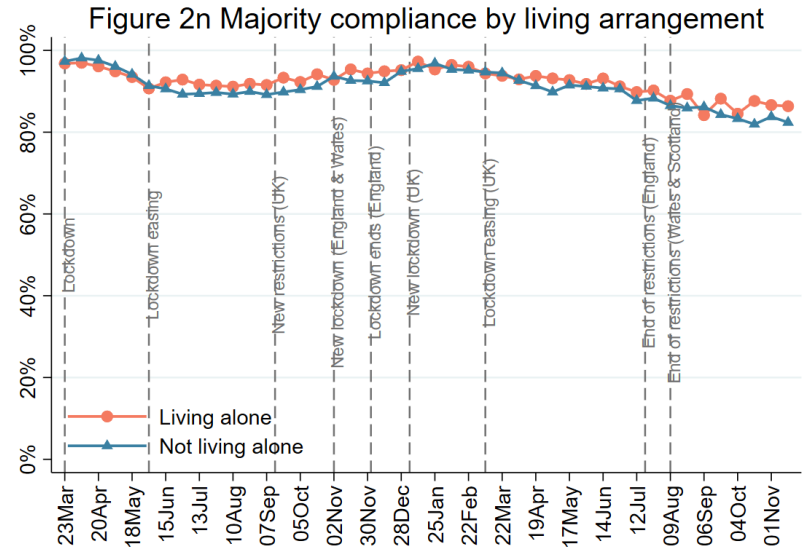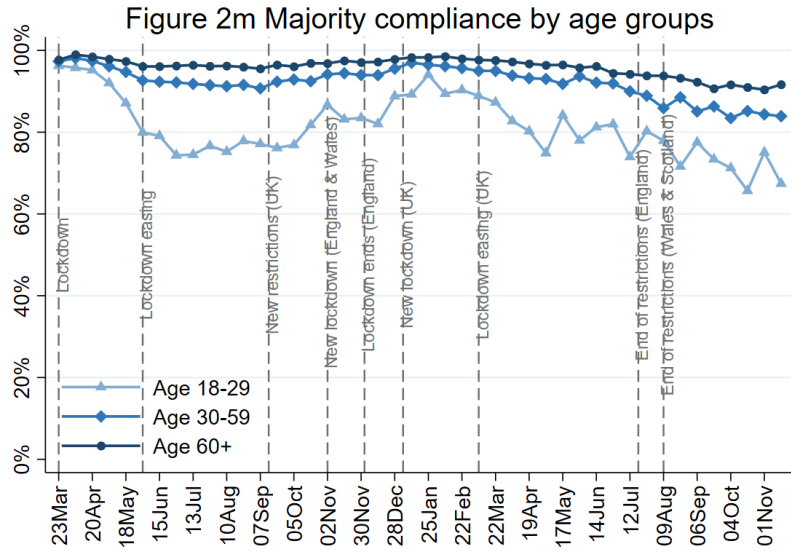
Figure 2i Complete compliance by gender

Figure 2j Complete compliance by ethnicity

Figure 2k Complete compliance by educational levels

Figure 2l Complete compliance by physical health

Figure 2m Majority compliance by age groups

Figure 2n Majority compliance by living arrangement

Figure 2o Majority compliance by household income

Figure 2p Majority compliance by mental health

Figure 2q Majority compliance by nations
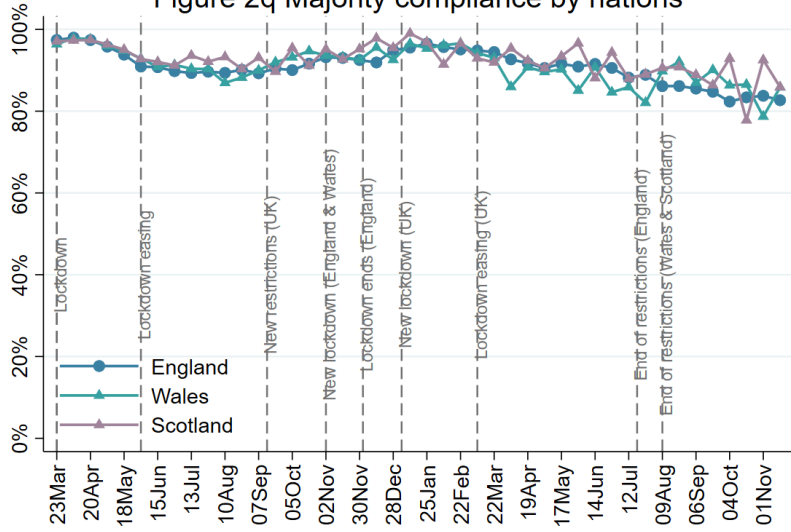
Figure 2r Majority compliance by keyworker status
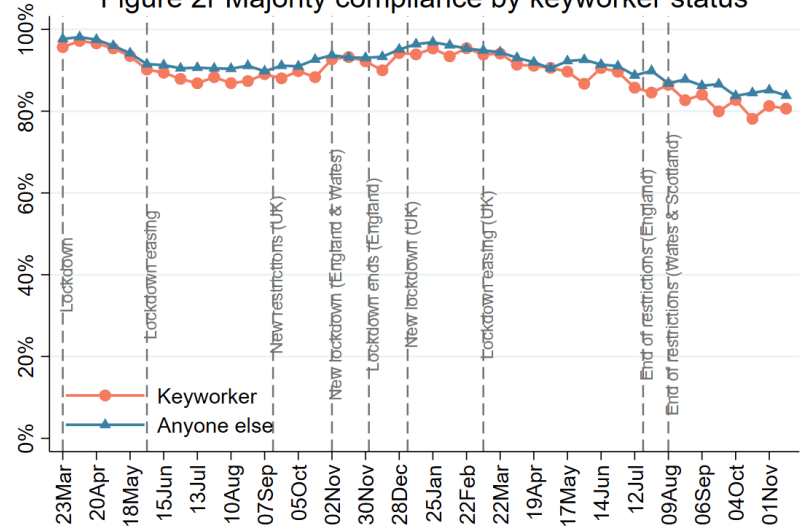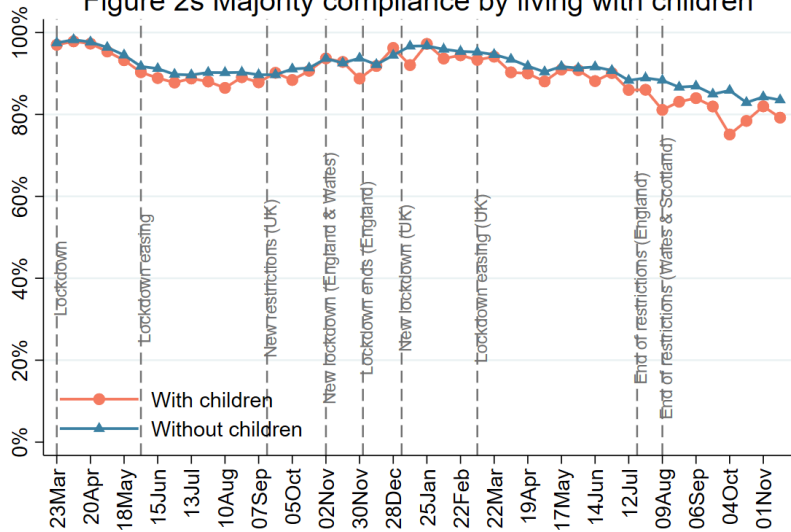
Figure 2s Majority compliance by living with children

Figure 2t Majority compliance by living area
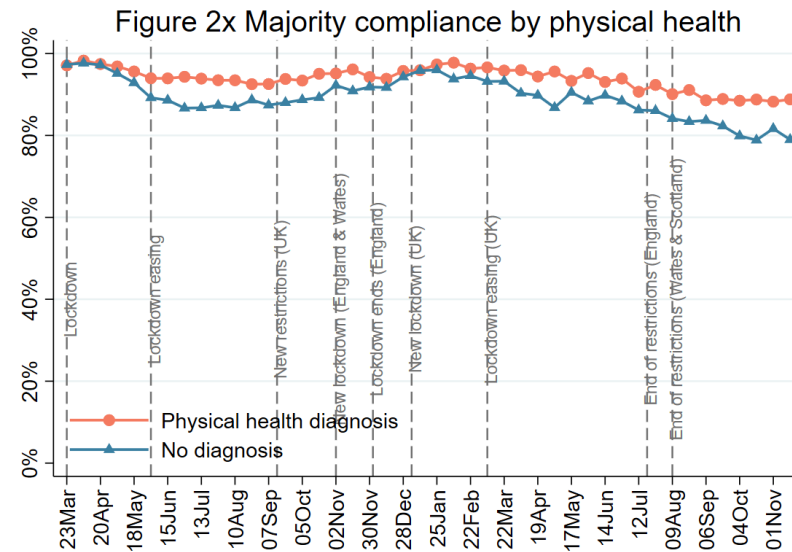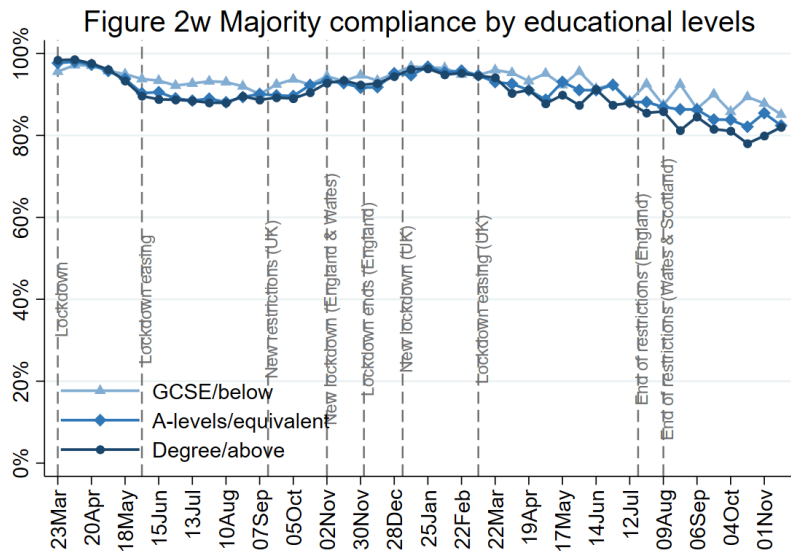
Figure 2u Majority compliance by gender

Figure 2v Majority compliance by ethnicity

Figure 2w Majority compliance by educational levels

Figure 2x Majority compliance by physical health

1.2 Confidence in government
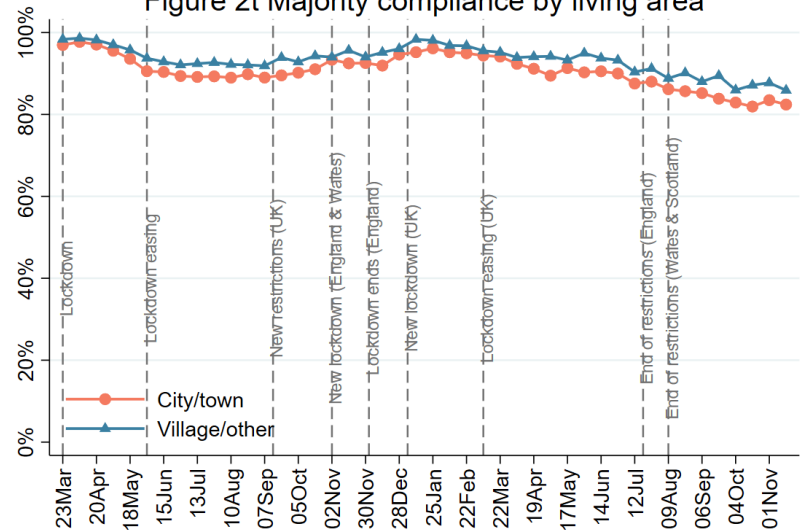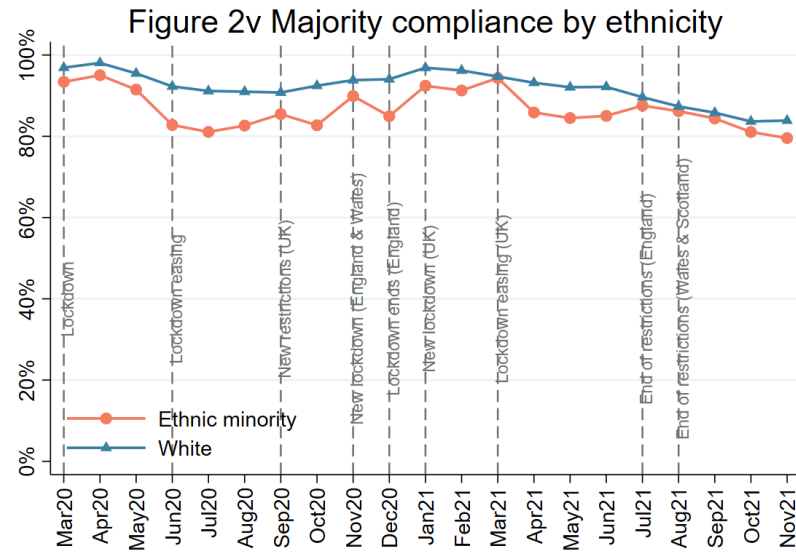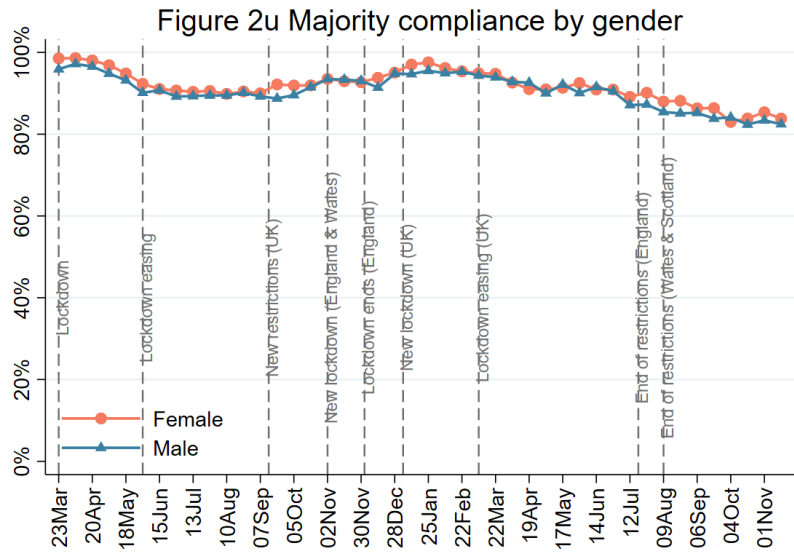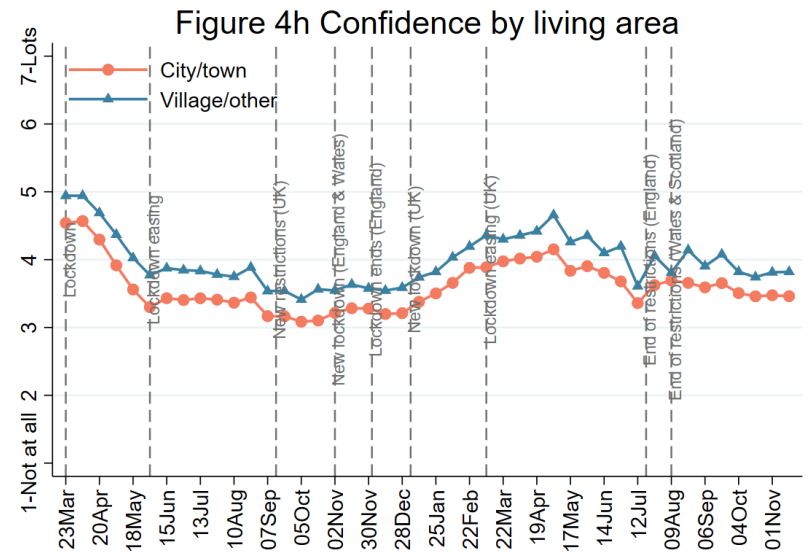

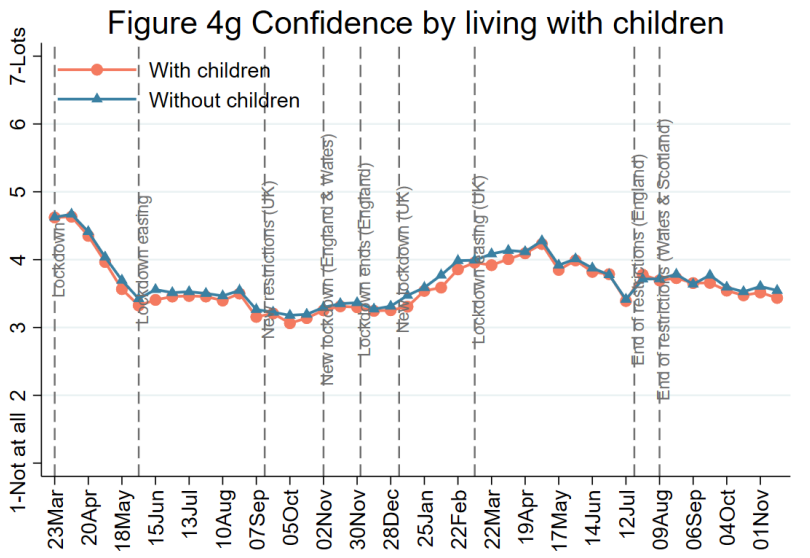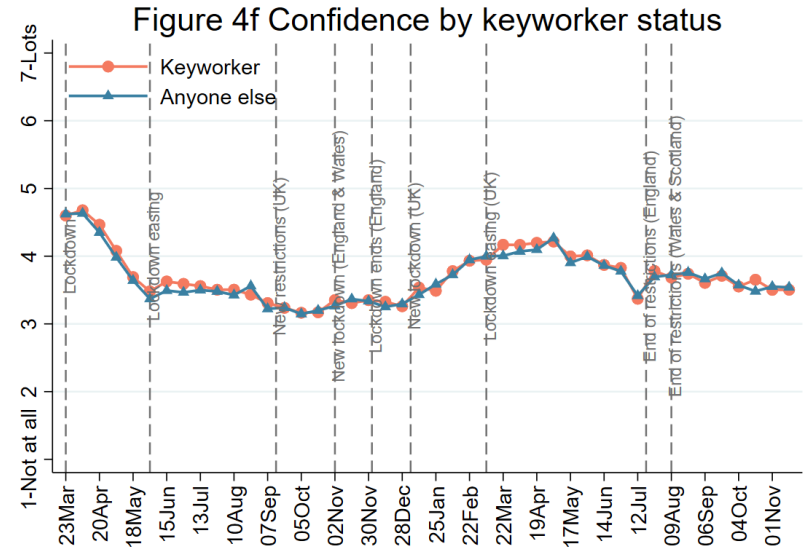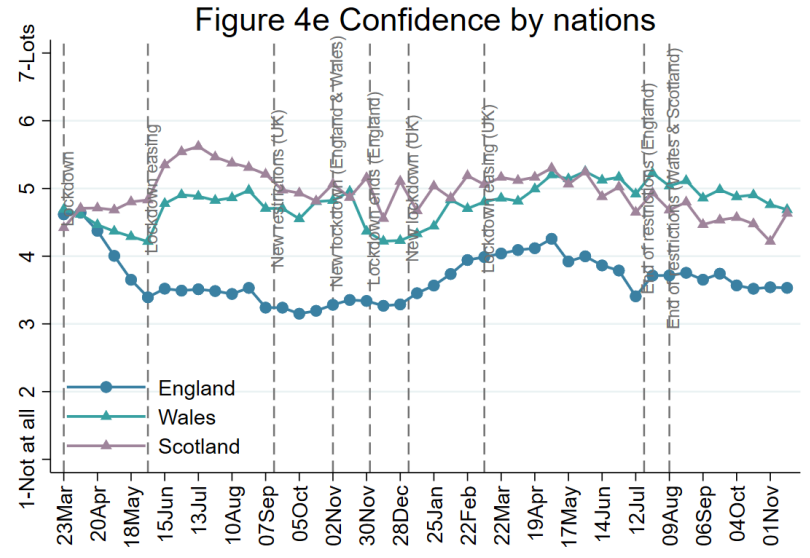Figure 3 Confidence in government

---
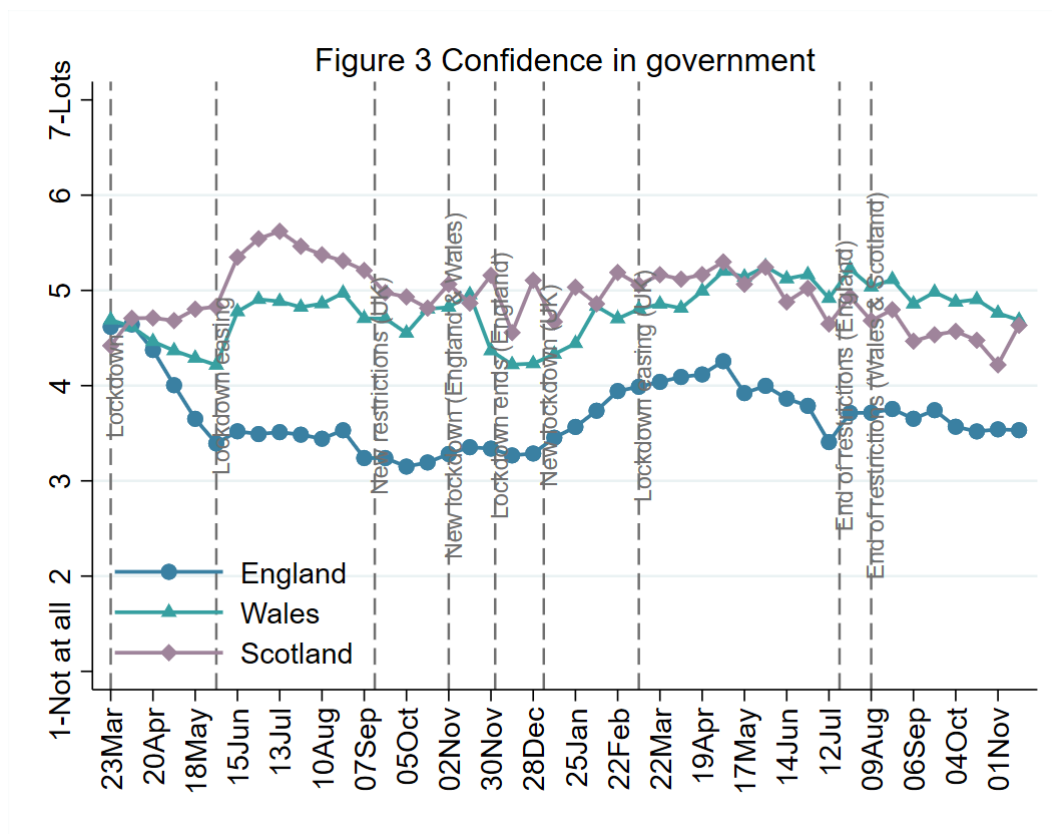
FINDINGS

Respondents were asked how much confidence they had in the government to handle the Covid-19 pandemic from 1 (not at all) to 7 (lots). People living in devolved nations were asked to report their confidence in their own devolved governments.
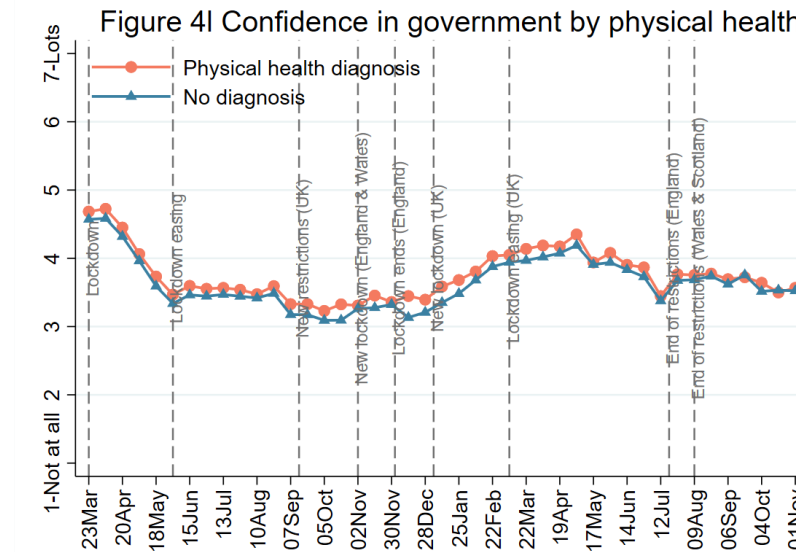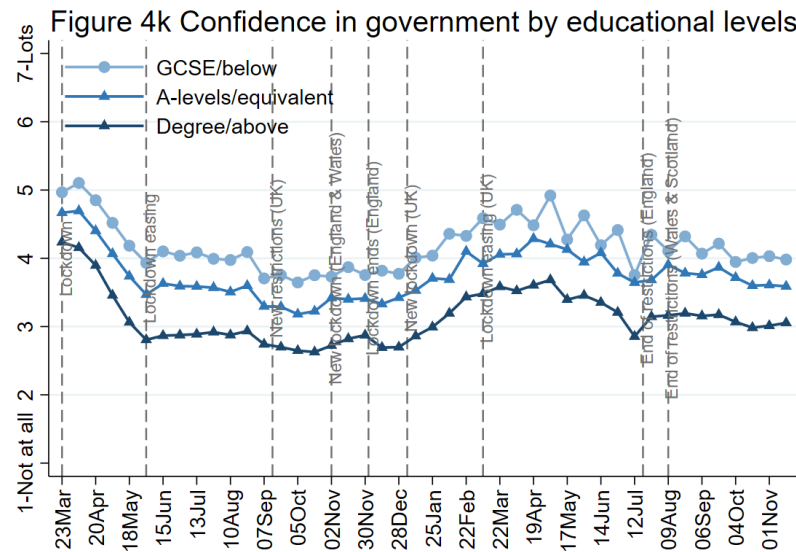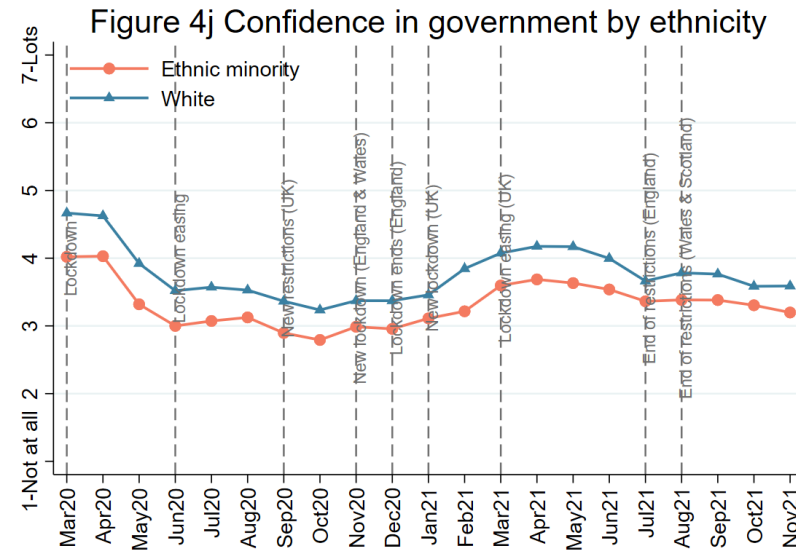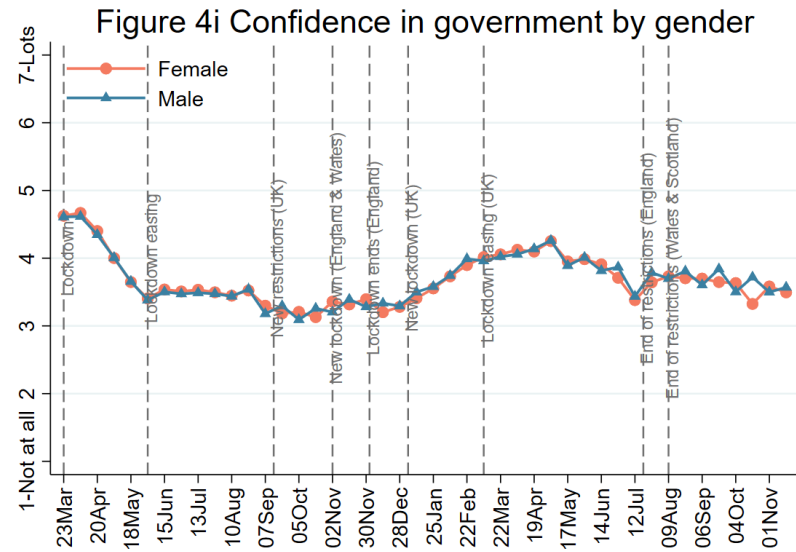
Confidence in government to handle the Covid-19 pandemic remains lower in England than in devolved nations[2]. In England, levels of confidence are on a par with May of 2020, when news of Dominic Cummings breaking the rules was announced. **However, it is noted that this report covers data from before the latest news about further government breaches of the rules was announced in the press.**

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

---

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

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

Figure 4e Confidence by nations

Figure 4f Confidence by keyworker status

Figure 4g Confidence by living with children

Figure 4h Confidence by living area

Figure 4i Confidence in government by gender

Figure 4j Confidence in government by ethnicity

Figure 4k Confidence in government by educational levels

Figure 4l Confidence in government by physical health
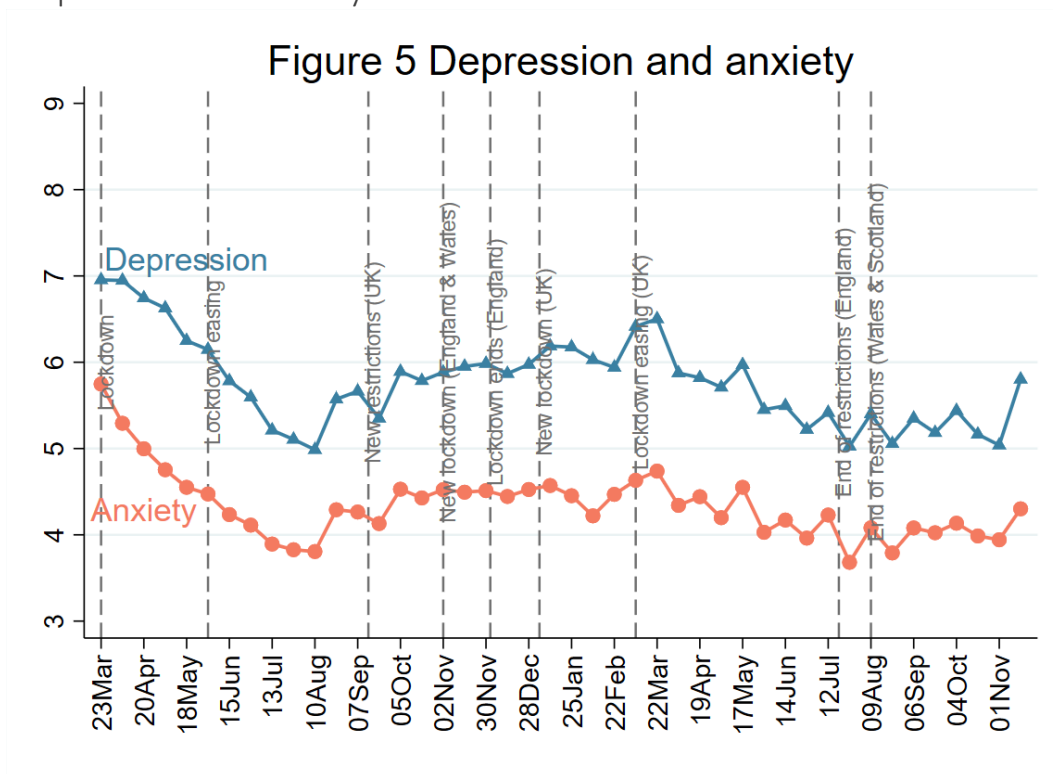
2. Mental Health

2.1 Depression and anxiety

Figure 5 Depression and anxiety

FINDINGS

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

Depression and anxiety symptoms remain lower than at the start of this year and slightly better than this time last year. But the inclusion of more participants in this wave of data collection (as original participants were given a further chance to re-join the study) suggests that levels are on average slightly higher than anticipated in the last report. Although this study focuses on trajectories rather than prevalence, the levels overall remain higher than the averages usually reported with these same scales (2.7-3.2 for anxiety and 2.7-3.7 for depression[3]).

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

---

[3] 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.
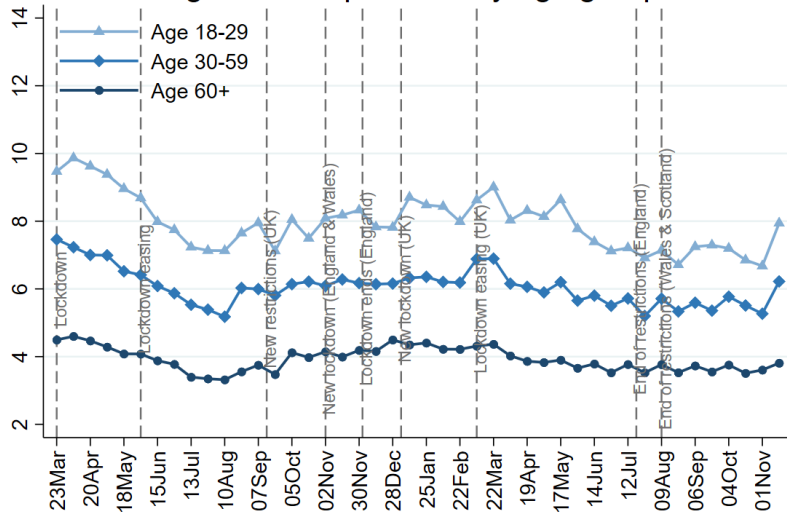
Figure 6a Depression by age groups

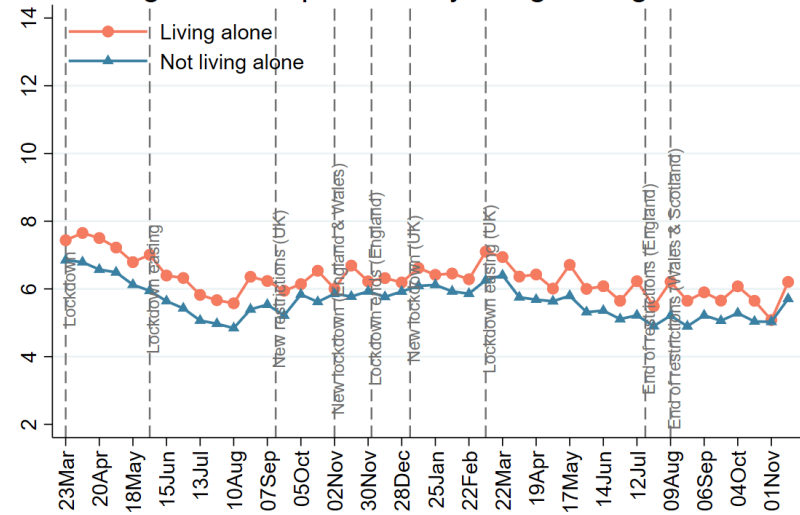Figure 6b Depression by living arrangement
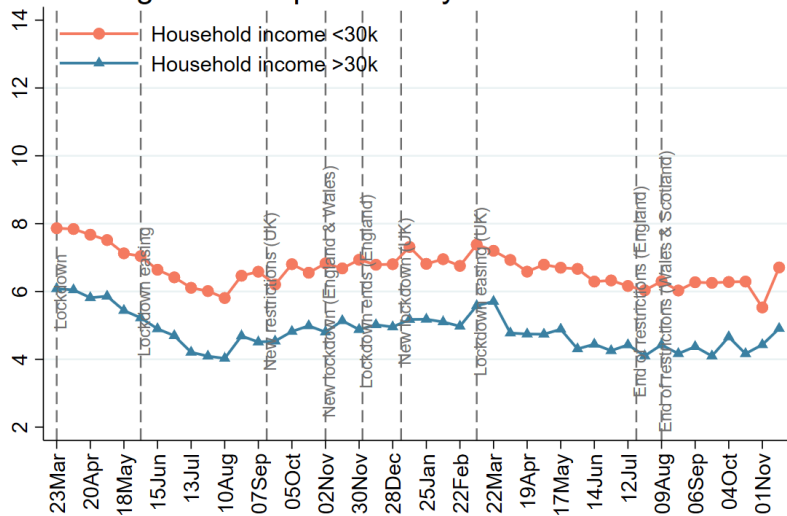

Figure 6c Depression by household income

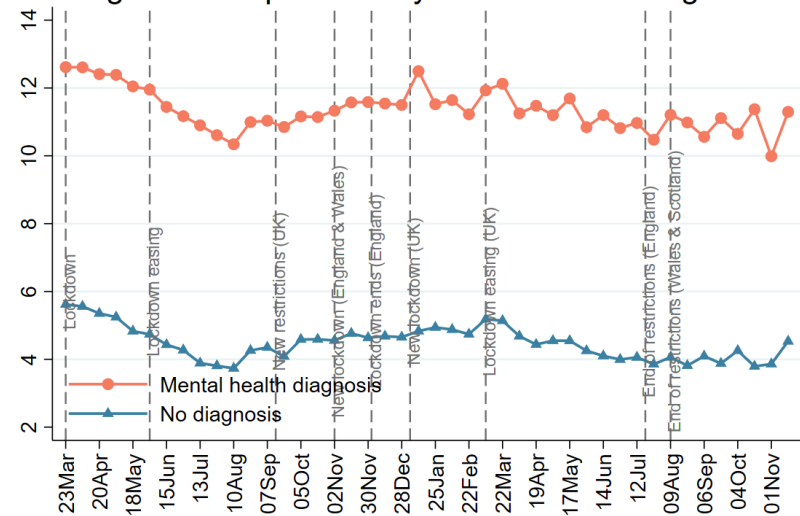Figure 6d Depression by mental health diagnosis
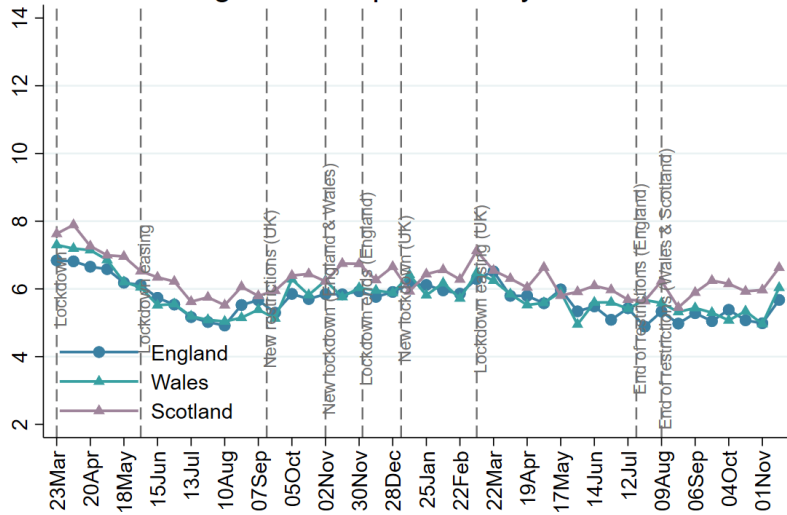
16

Figure 6e Depression by nations

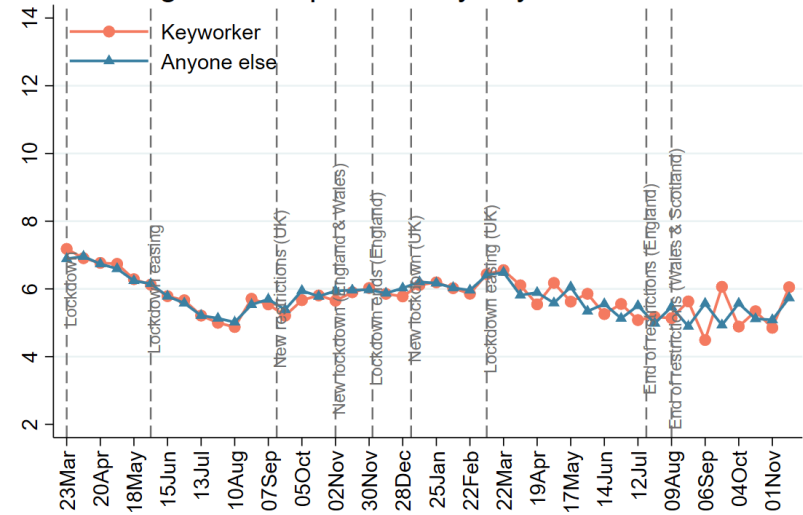Figure 6f Depression by keyworker status

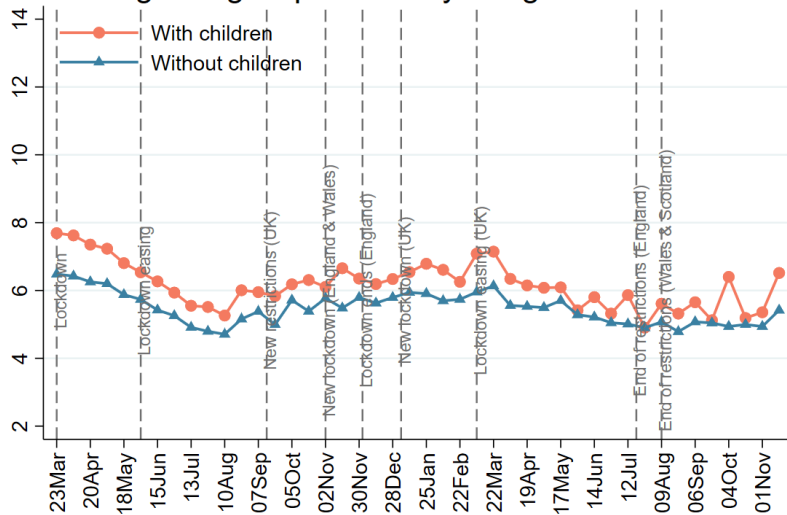Figure 6g Depression by living with children
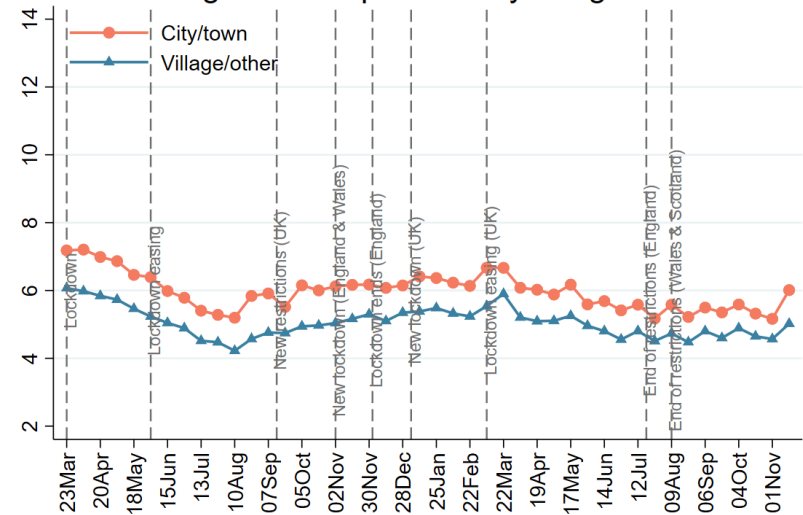

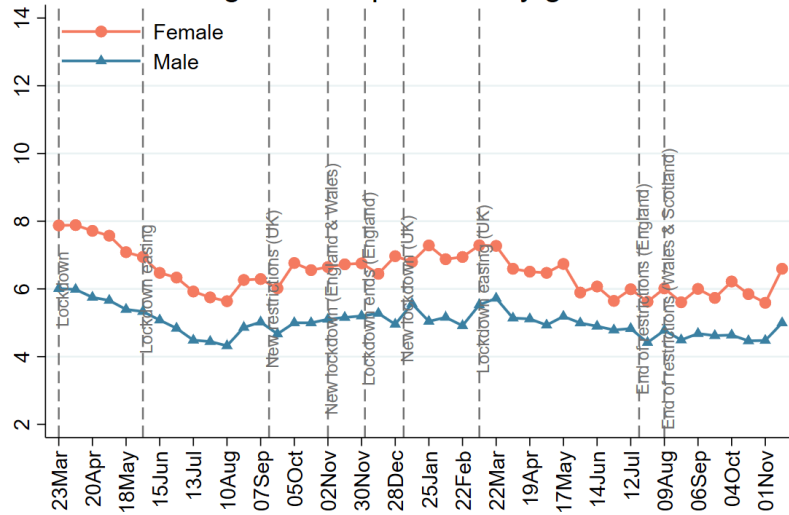Figure 6h Depression by living area

Figure 6i Depression by gender

Figure 6j Depression by ethnicity
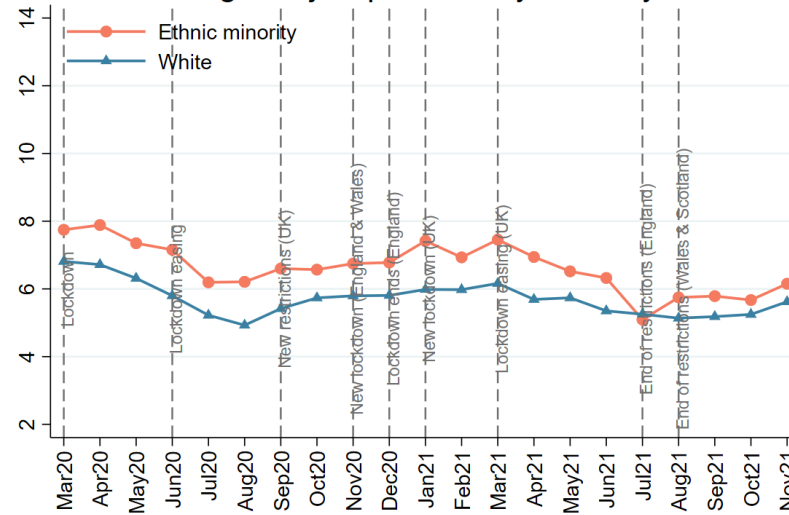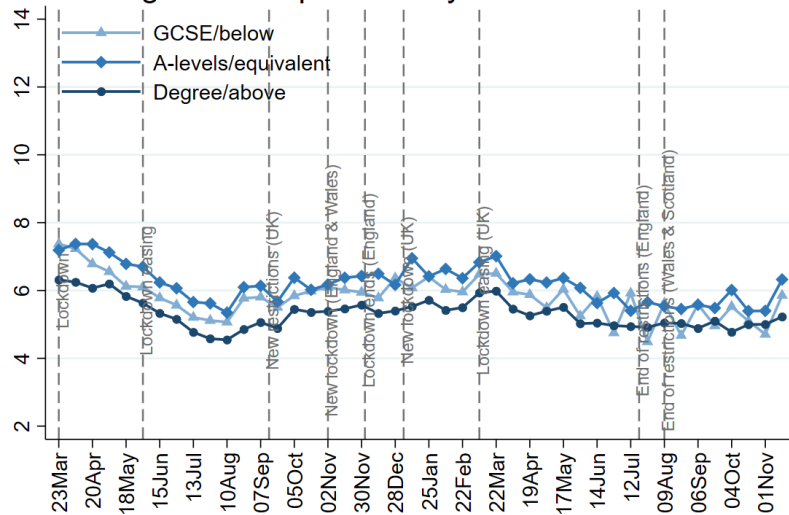
Figure 6k Depression by educational levels

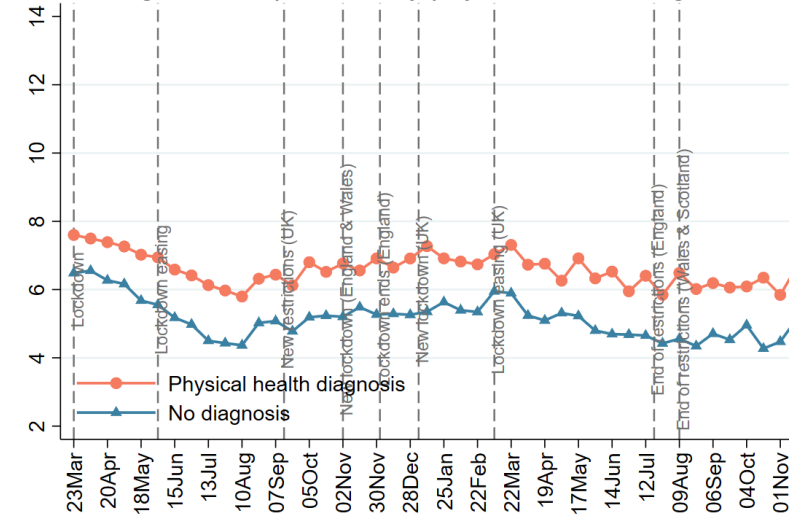Figure 6l Depression by physical health diagnosis

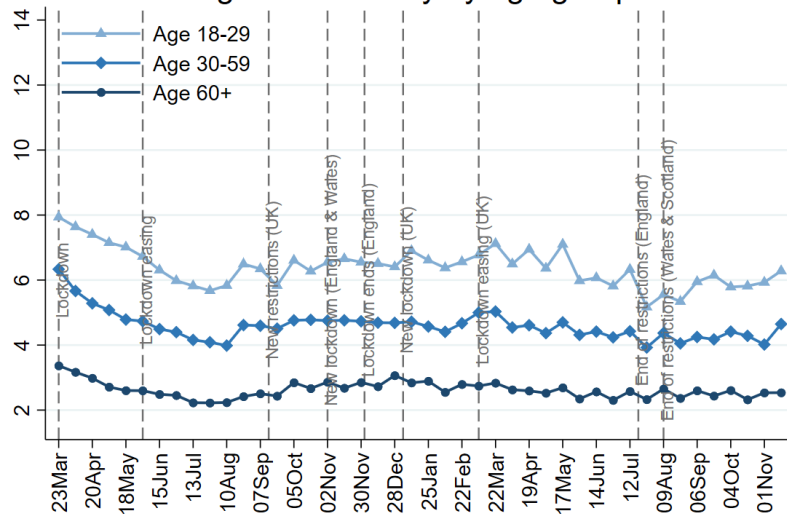Figure 7a Anxiety by age groups

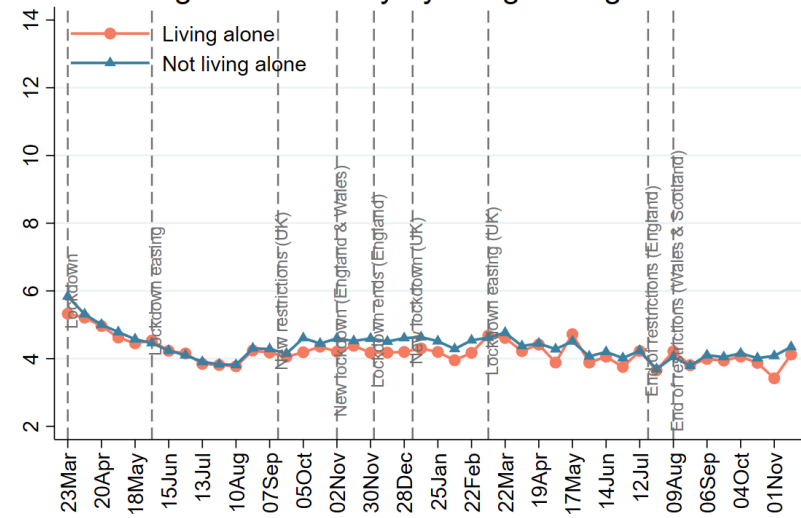Figure 7b Anxiety by living arrangement

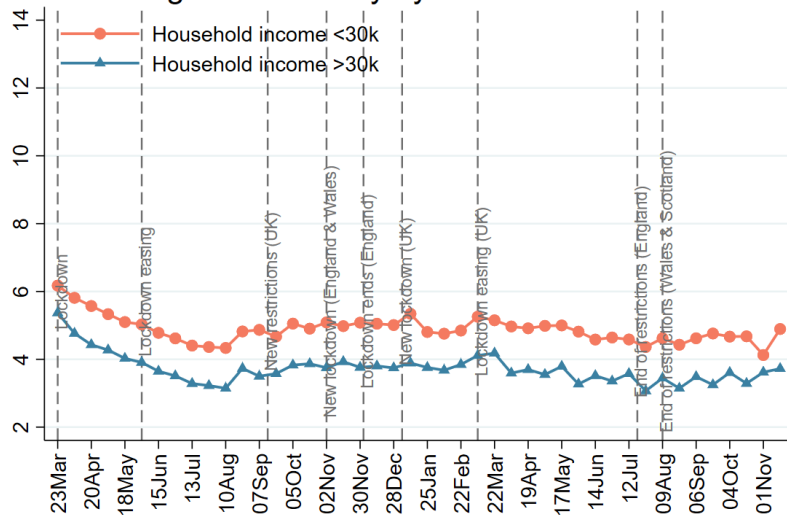Figure 7c Anxiety by household income

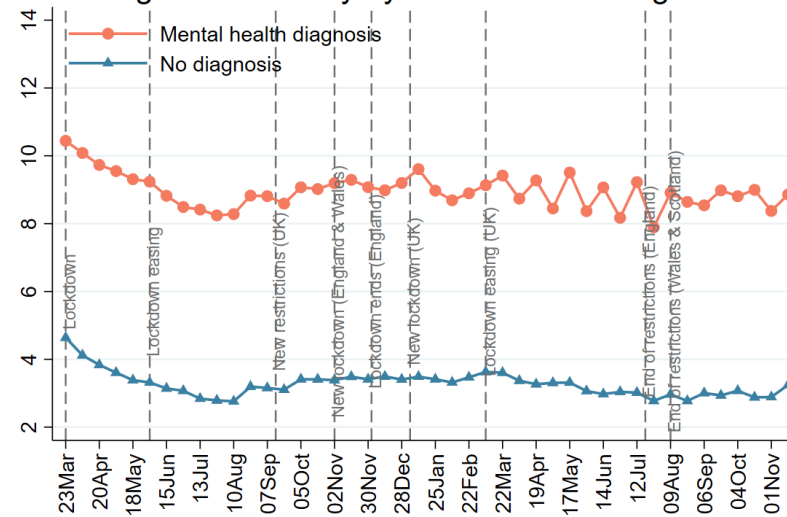Figure 7d Anxiety by mental health diagnosis
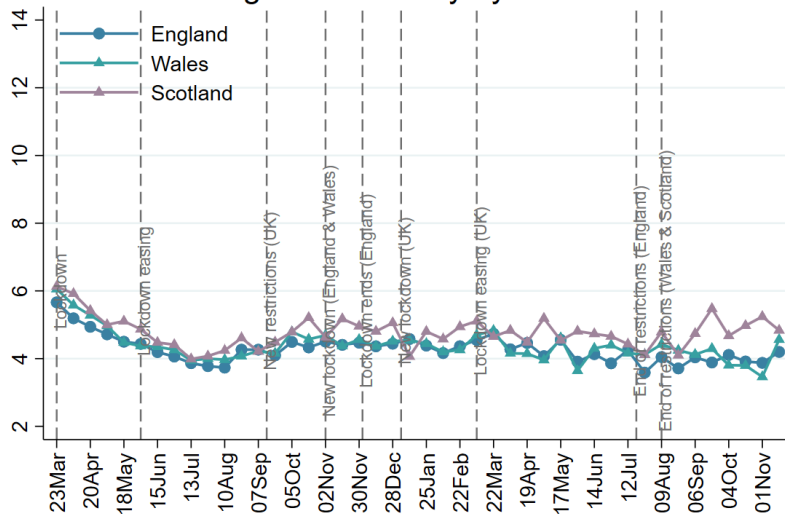
19

Figure 7e Anxiety by nations
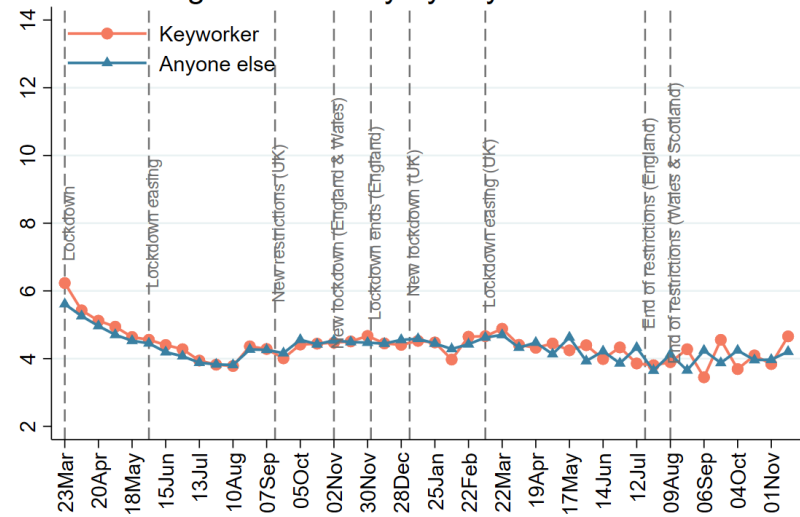

Figure 7f Anxiety by keyworker status

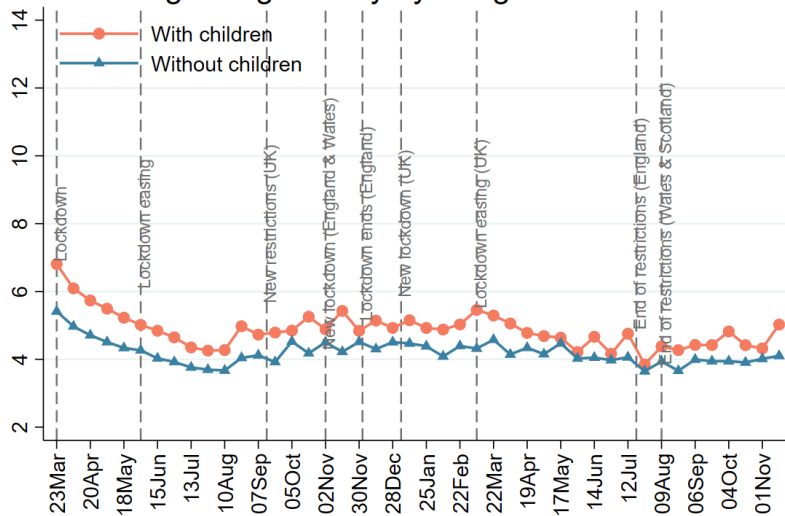Figure 7g Anxiety by living with children
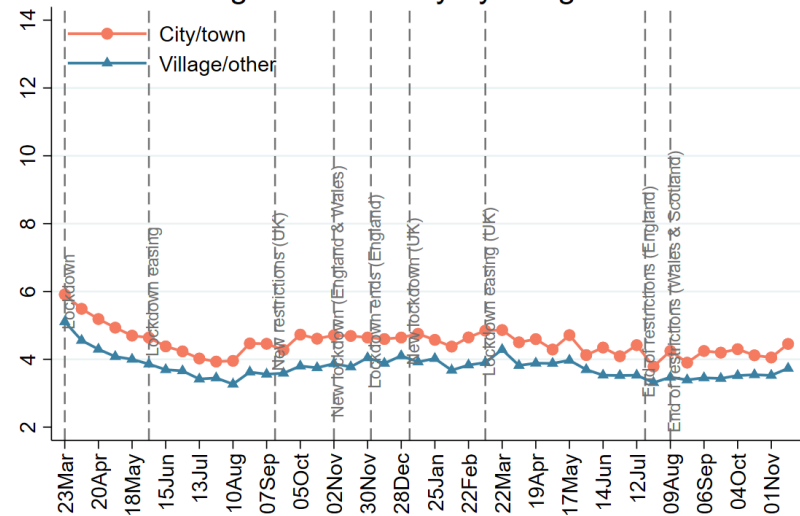

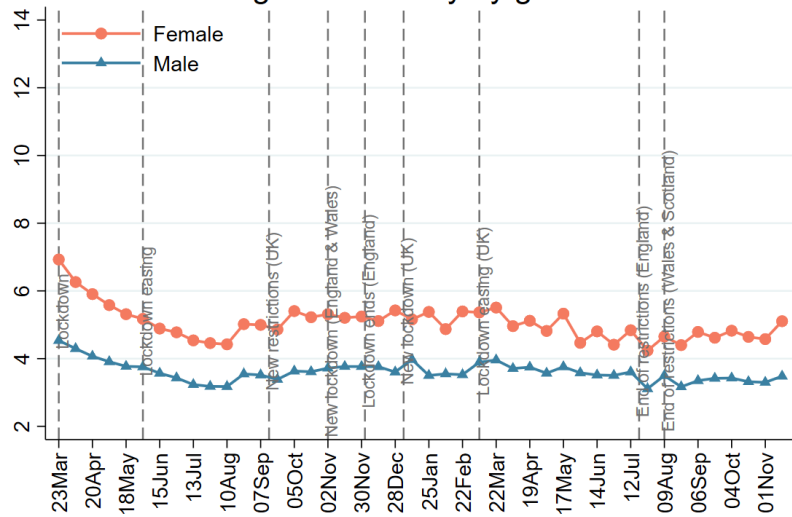
Figure 7h Anxiety by living area
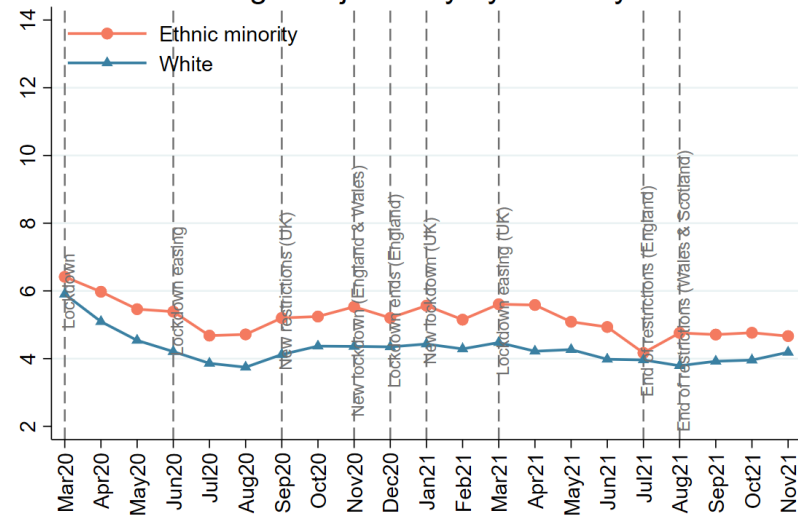
Figure 7i Anxiety by gender

Figure 7j Anxiety by ethnicity
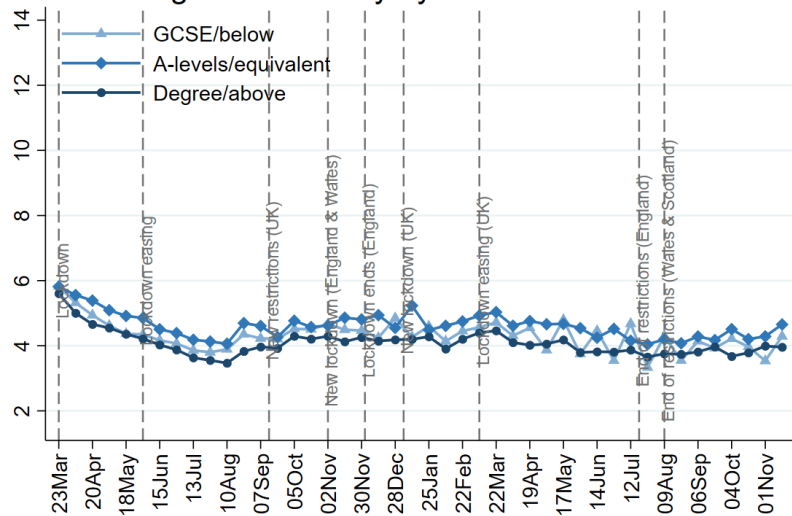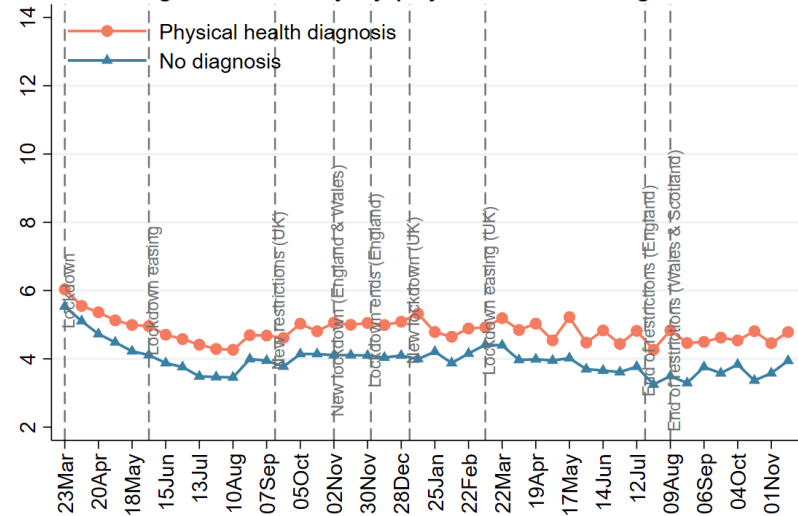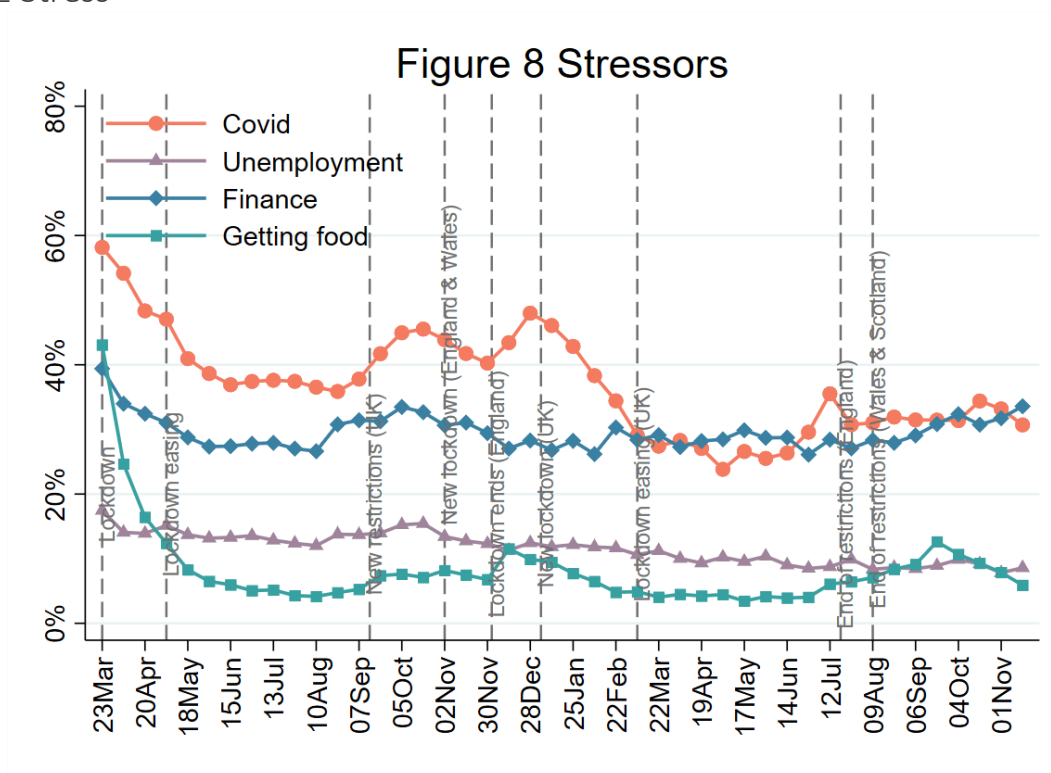
Figure 7k Anxiety by educational levels

Figure 7l Anxiety by physical health diagnosis

2.2 Stress

Figure 8 Stressors

FINDINGS

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

The proportion of people concerned about catching or becoming seriously ill from Covid-19 is higher than it was in the spring but has not shown a substantial increase in recent weeks, despite cases being so high. **Notably, news about the Omicron variant has gained in prominence since the last wave of data collection in late November.** A greater proportion of women and people with a physical or mental health diagnosis continue to be more worried about catching or becoming seriously ill from Covid-19.

Worries about unemployment continue to concern around 1 in 12 people. Unemployment stress has been higher in people under the age of 60, people with a mental health diagnosis, keyworkers, in urban areas and amongst people from ethnic minority groups over the last several months.

Worries about finance have been increasing since mid-summer 2021. Concerns about finances remain highest amongst adults of working age (18-59 years), in particular young adults (age 18-29). Financial stress has also been higher amongst people with low household incomes, keyworkers, in urban areas, those with a mental health diagnosis, people living with children, and people from ethnic minority groups.

Worries about being able to access sufficient food increased from mid-summer 2021 to early autumn (in line with problems with food supply), but this proportion has since been decreasing. Most groups continue to report similar levels of concern about accessing food, although these concerns are higher in people with a mental or physical health diagnosis and people with lower household incomes.
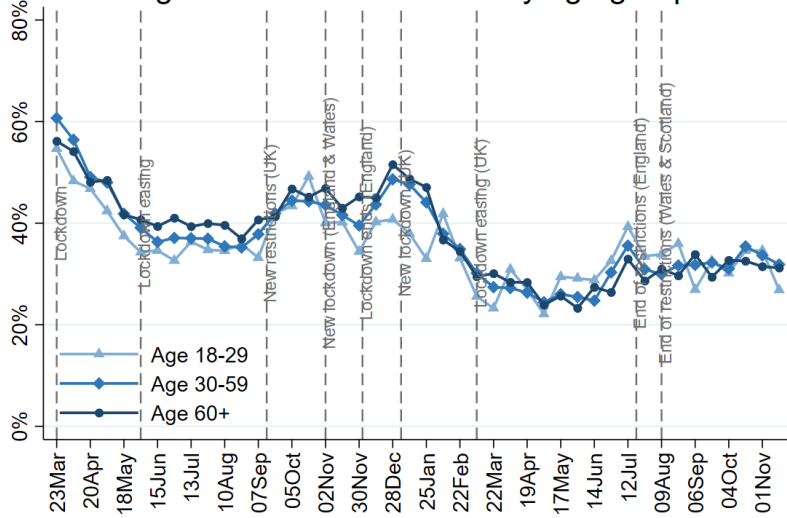
Figure 9a Covid-19 stress by age groups

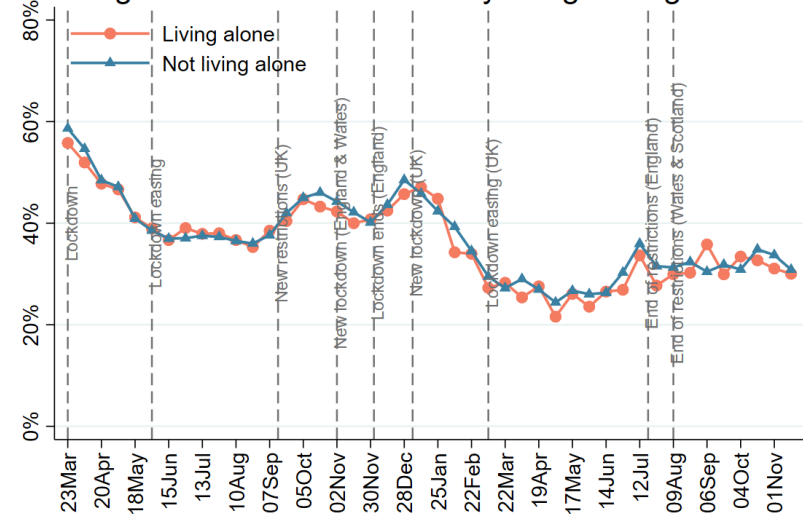Figure 9b Covid-19 stress by living arrangement

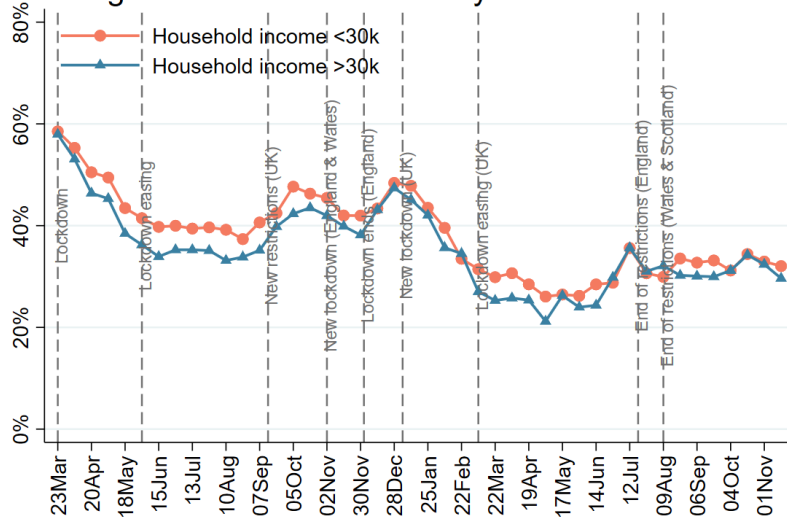Figure 9c Covid-19 stress by household income

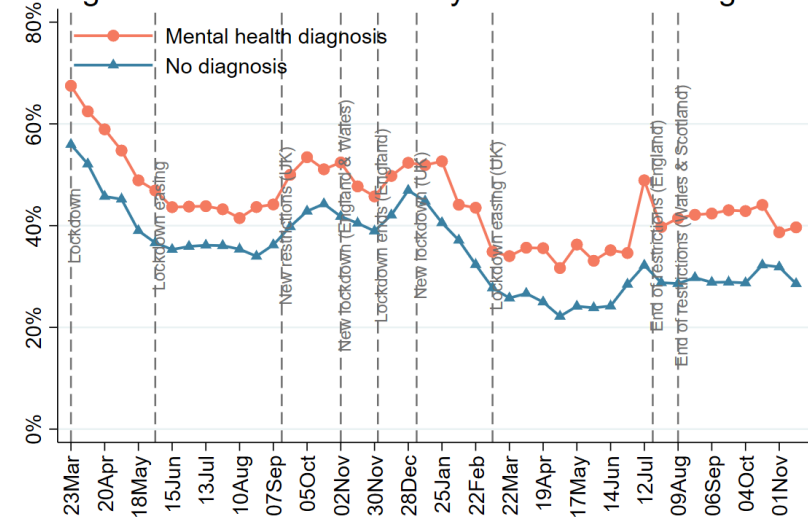Figure 9d Covid-19 stress by mental health diagnosis
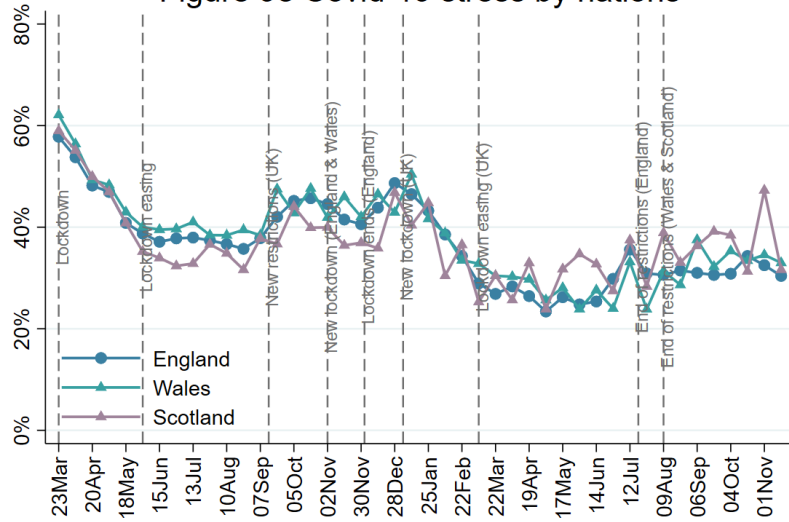
Figure 9e Covid-19 stress by nations

Figure 9f Covid-19 stress by keyworker status
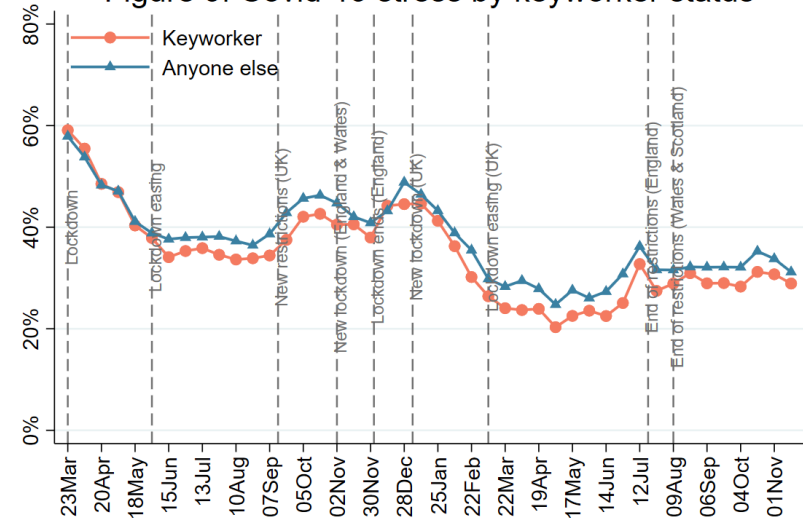

Figure 9g Covid-19 stress by living with children
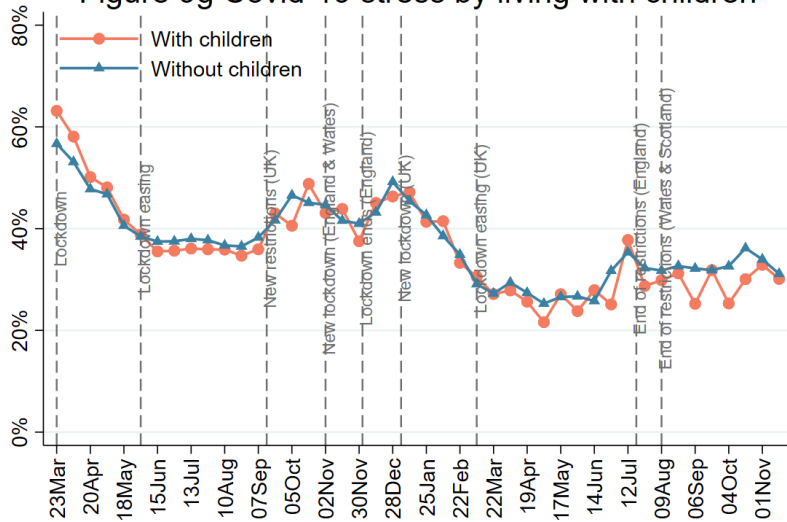
Figure 9h Covid-19 stress by living area
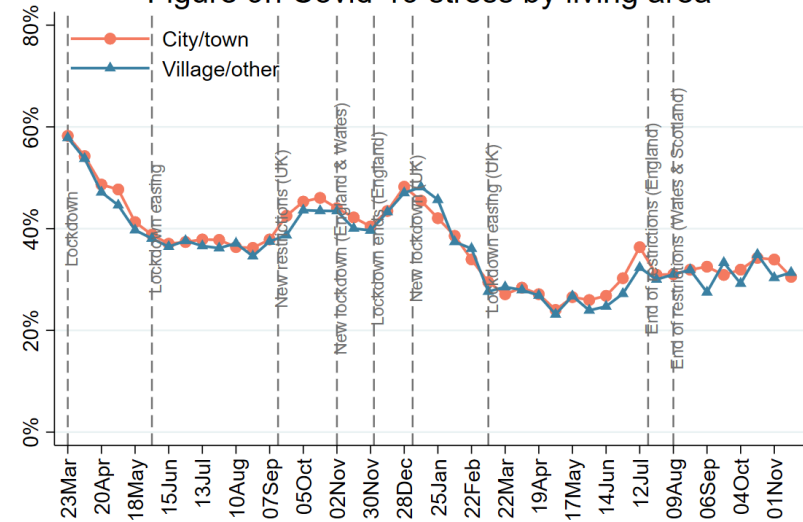
Figure 9i Covid-19 stress by gender
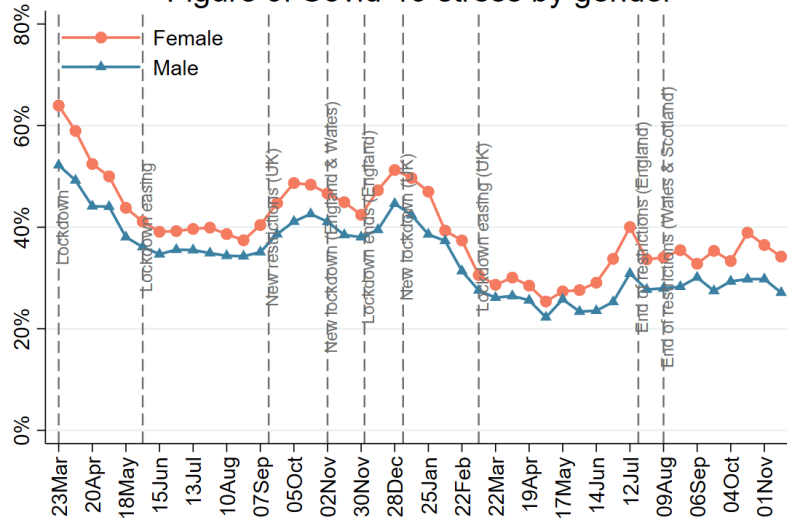
Figure 9j Covid-19 stress by ethnicity
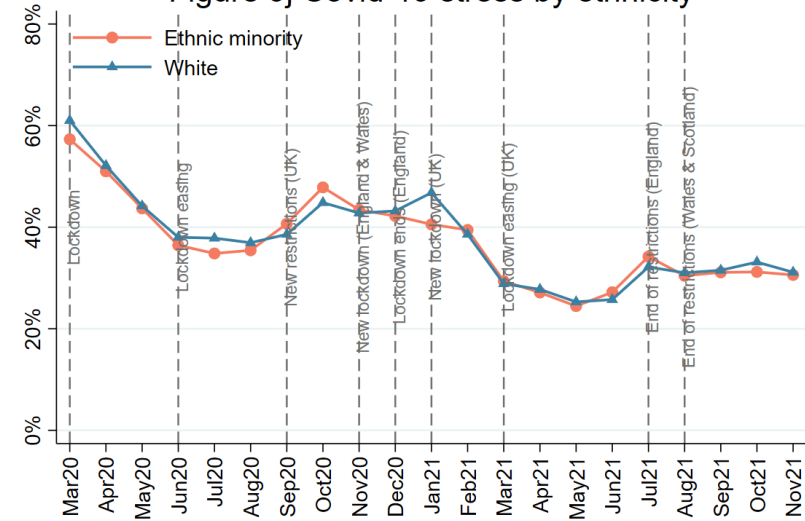
Figure 9k Covid-19 stress by educational levels
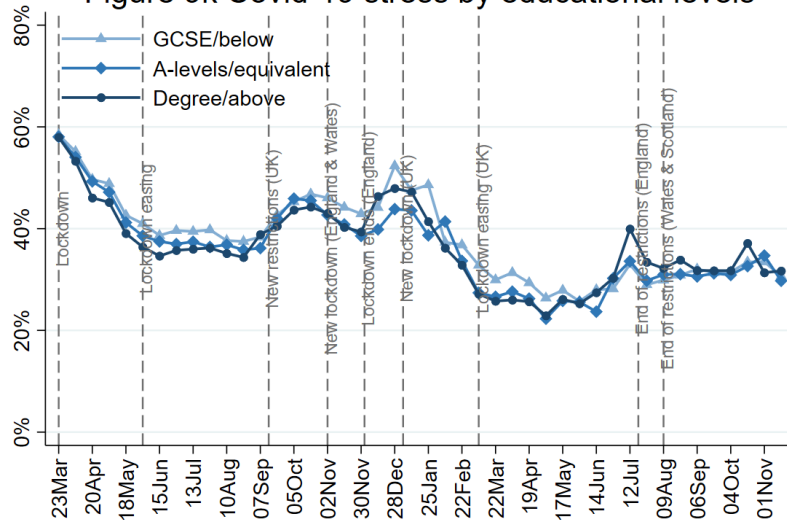
Figure 9l Covid-19 stress by physical health diagnosis
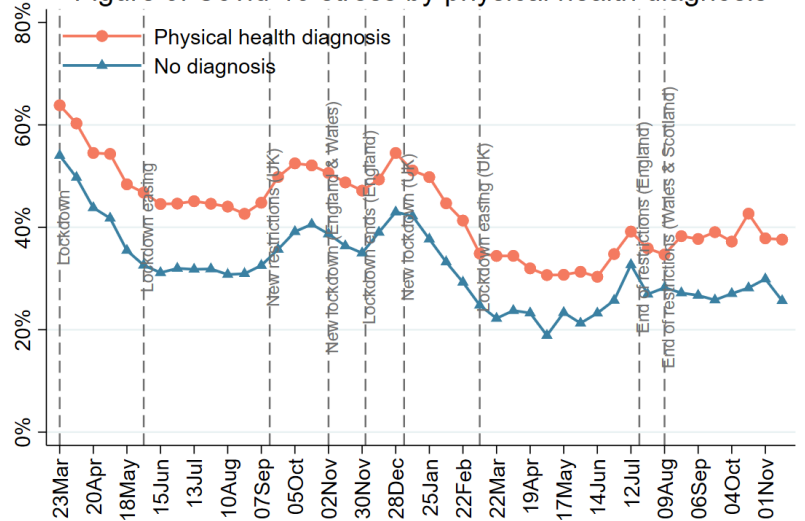
Figure 10a Unemployment stress by age groups

Figure 10b Unemployment stress by living arrangement
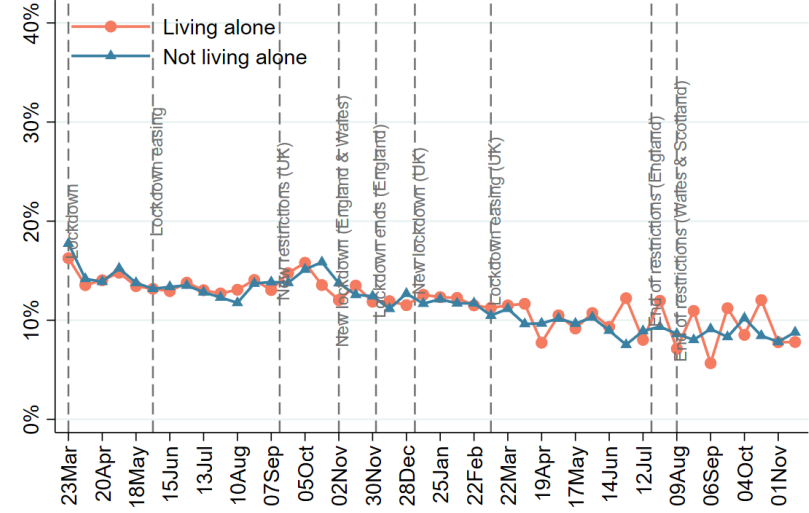
Figure 10c Unemployment stress by household income
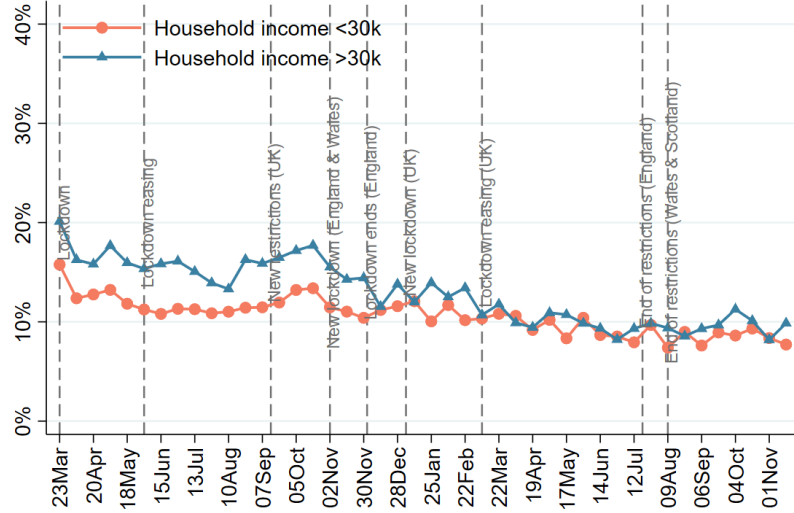
Figure 10d Unemployment stress by mental health
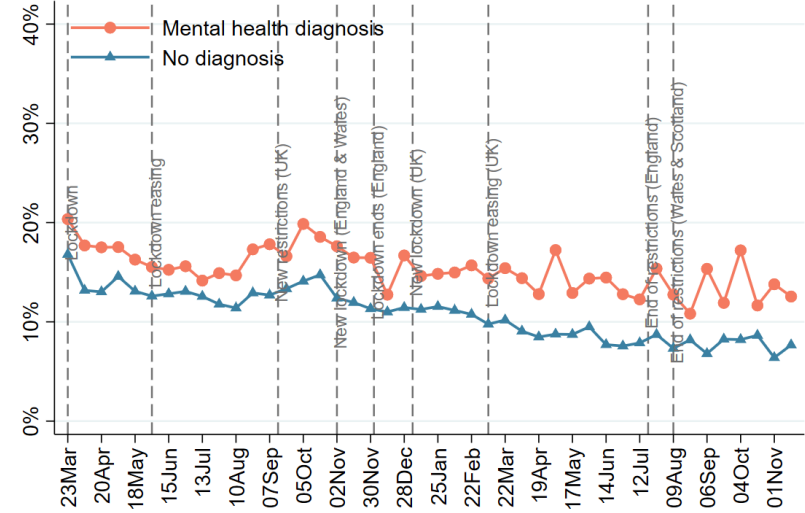
Figure 10e Unemployment stress by nations
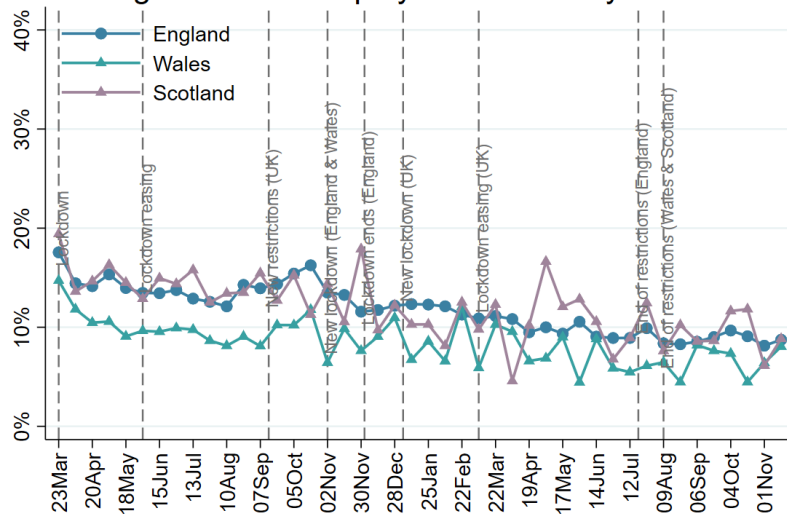
Figure 10f Unemployment stress by keyworker status
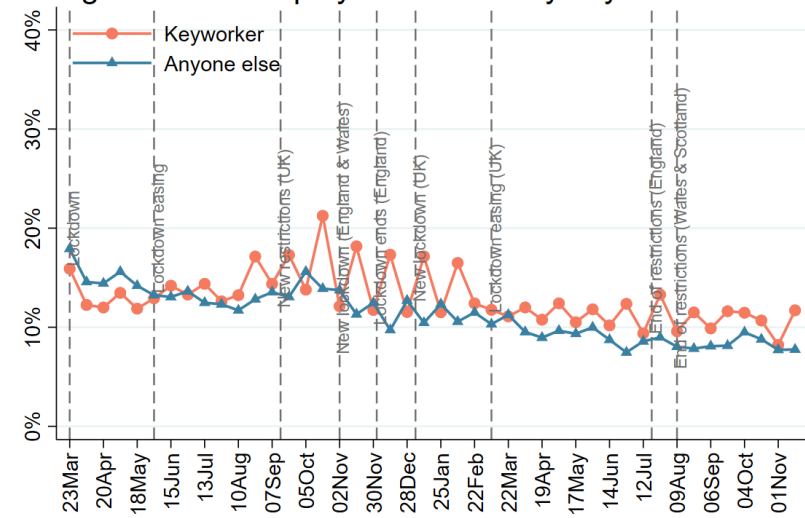
Figure 10g Unemployment stress by living with children
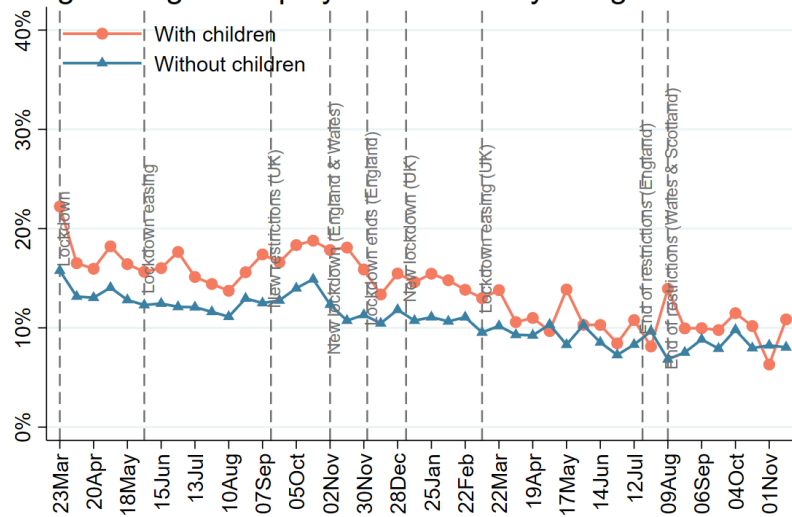
Figure 10h Unemployment stress by living area
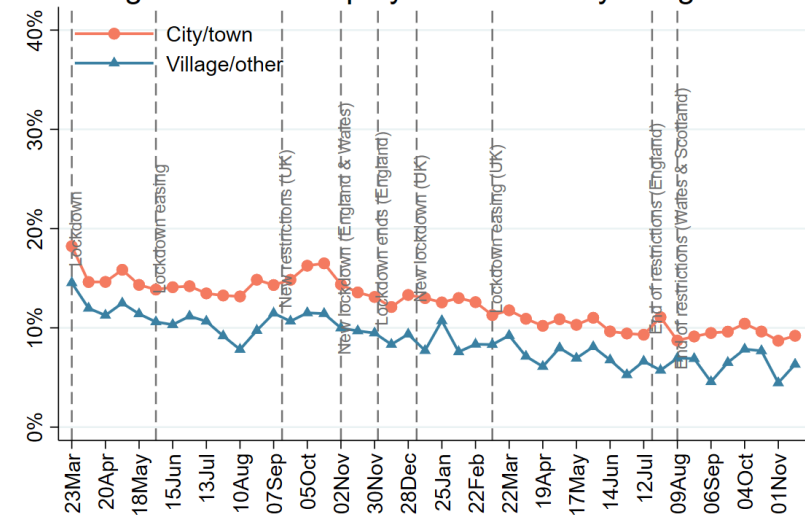
Figure 10i Unemployment stress by gender

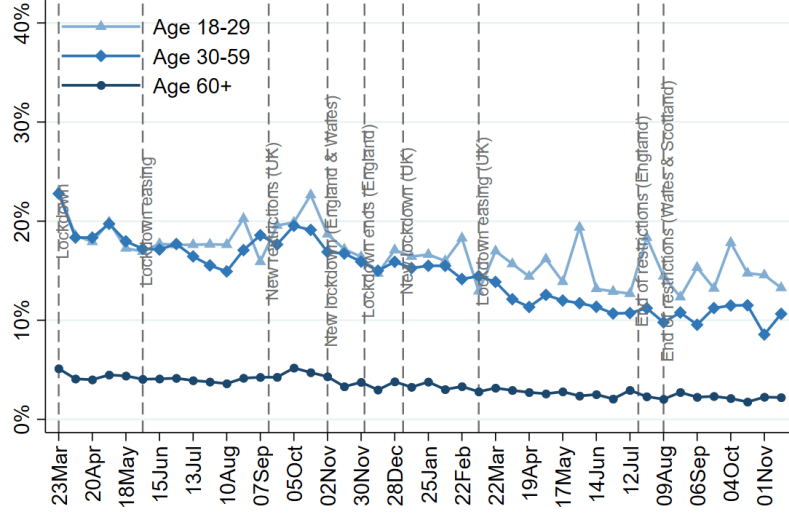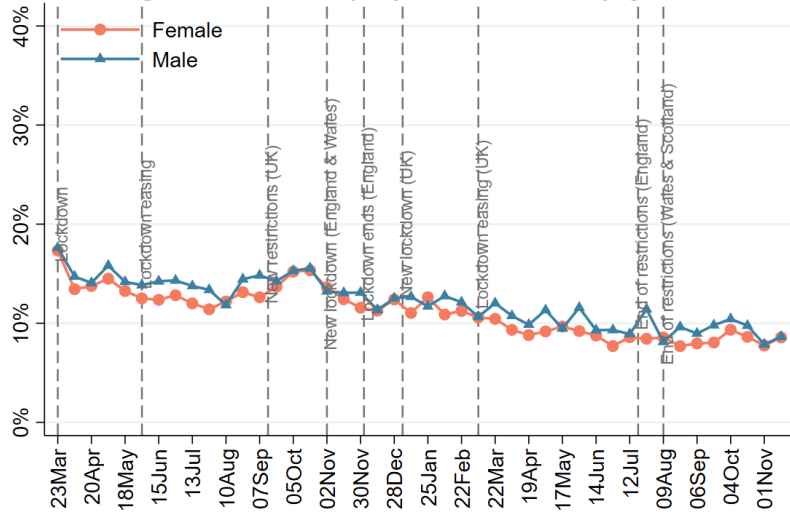Figure 10j Unemployment stress by ethnicity
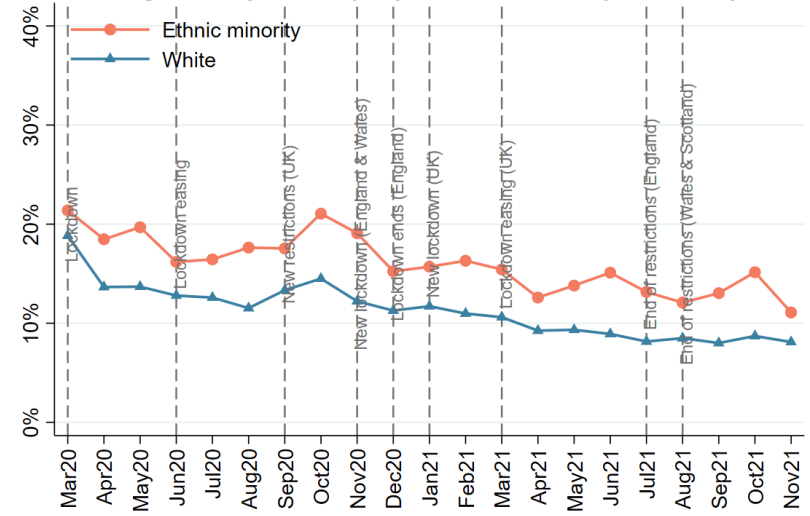
Figure 10k Unemployment stress by educational levels
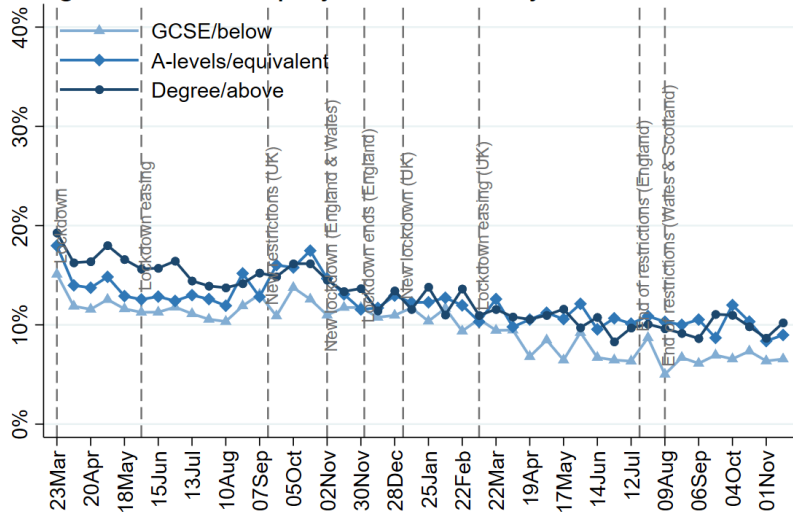
Figure 10l Unemployment stress by physical health diagnosis

28
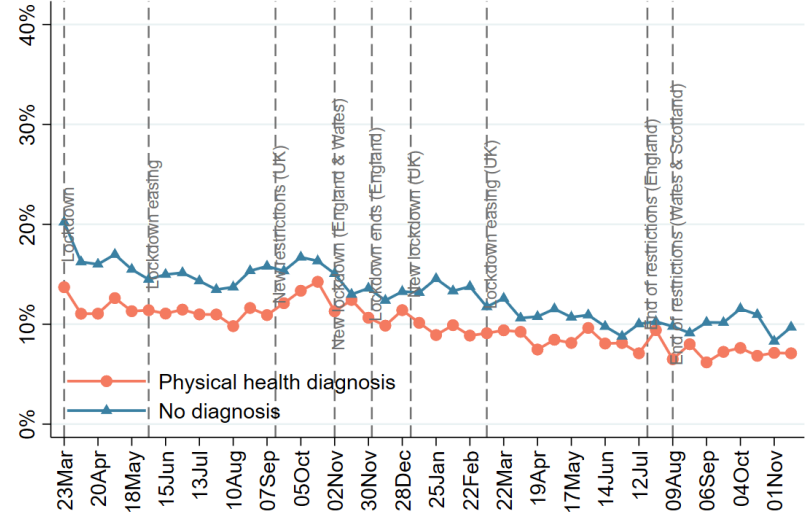
Figure 11a Financial stress by age groups

Age 18-29
Age 30-59
Age 60+
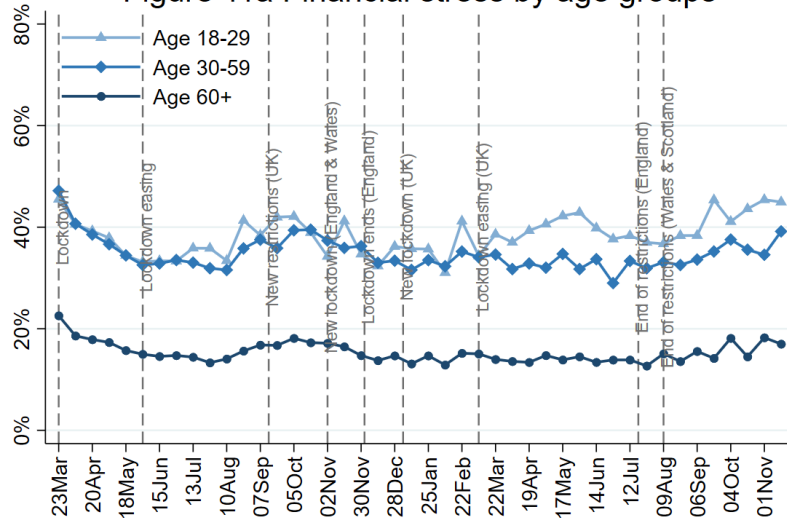
Figure 11b Financial stress by living arrangement

Living alone
Not living alone
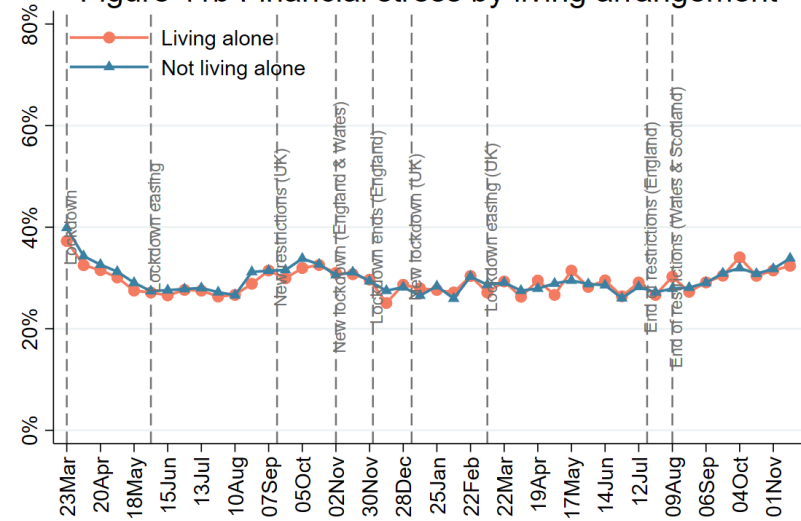
Figure 11c Financial stress by household income

Household income <30k
Household income >30k
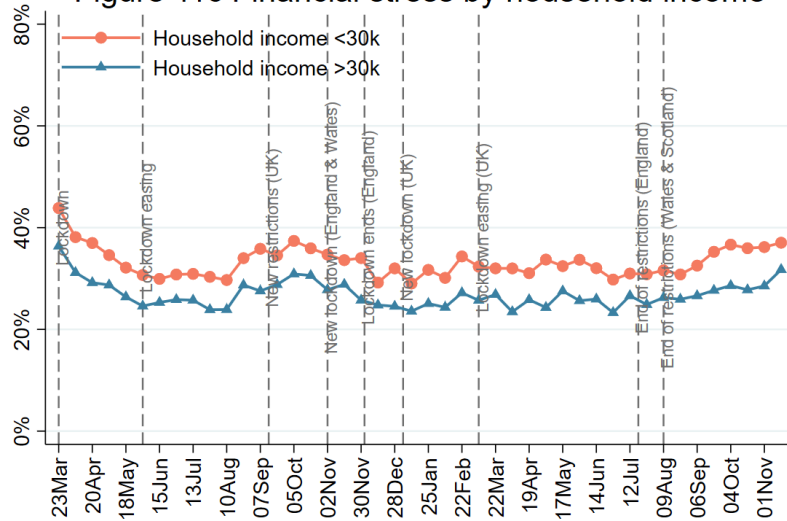
Figure 11d Financial stress by mental health diagnosis

Mental health diagnosis
No diagnosis
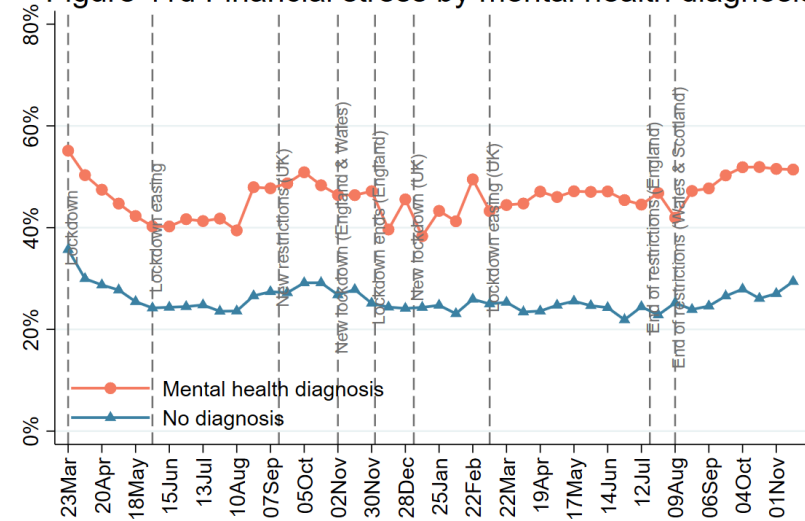
Figure 11e Financial stress by nations
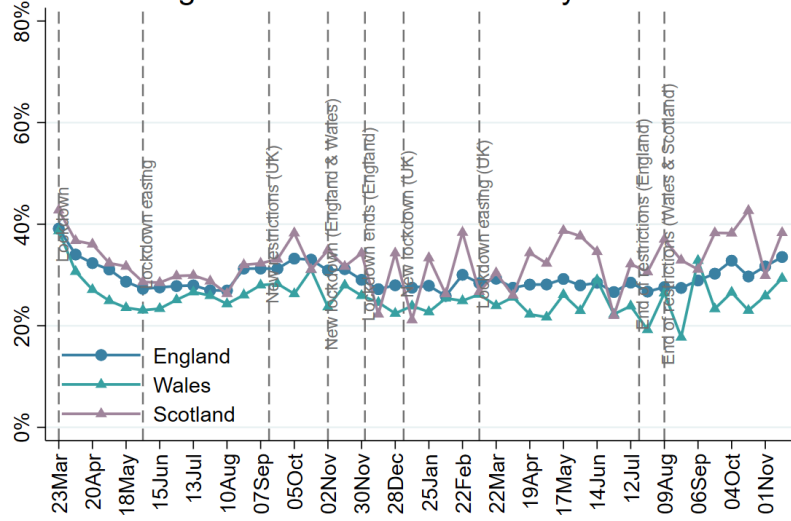
Figure 11f Financial stress by keyworker status
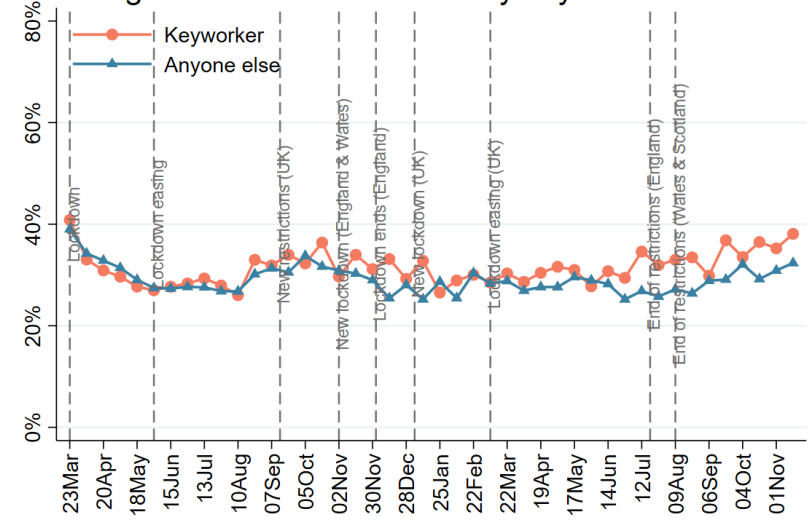
Figure 11g Financial stress by living with children
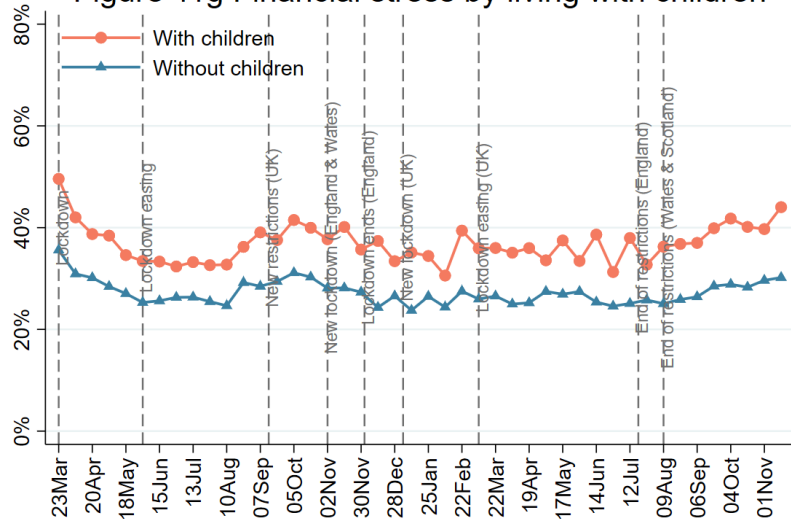
Figure 11h Financial stress by living area

30

Figure 11i Financial stress by gender

Figure 11j Financial stress by ethnicity

Figure 11k Financial stress by educational levels

Figure 11l Financial stress by physical health diagnosis
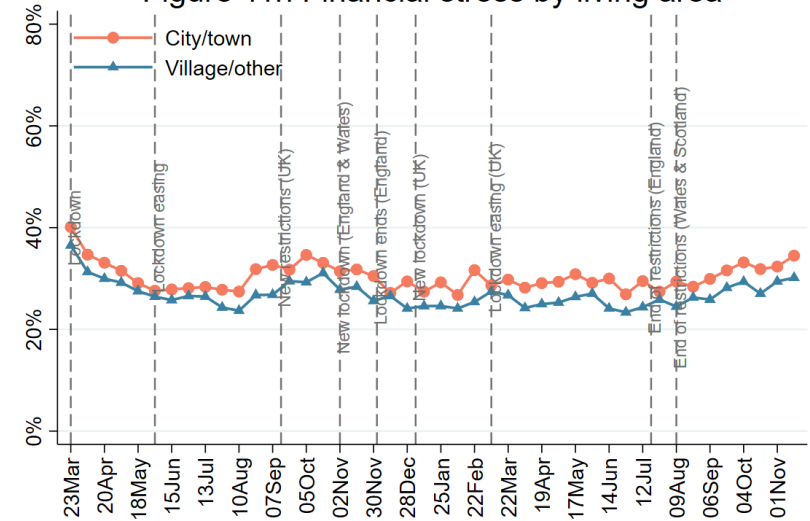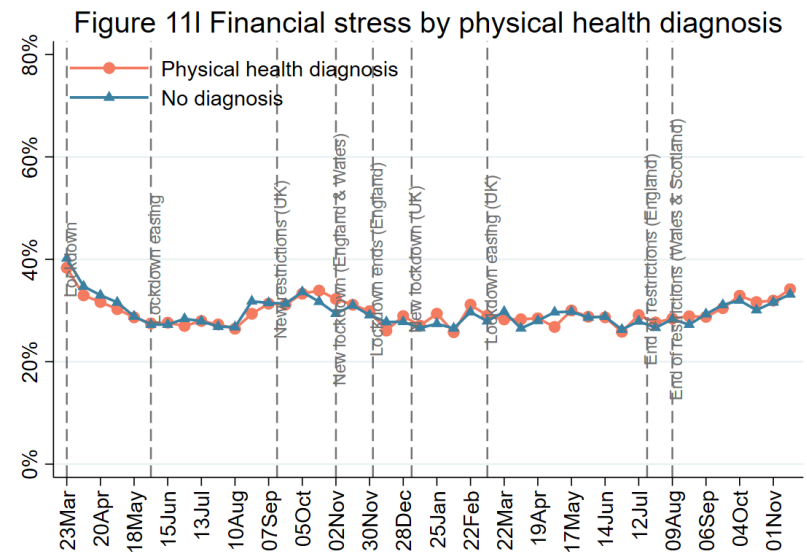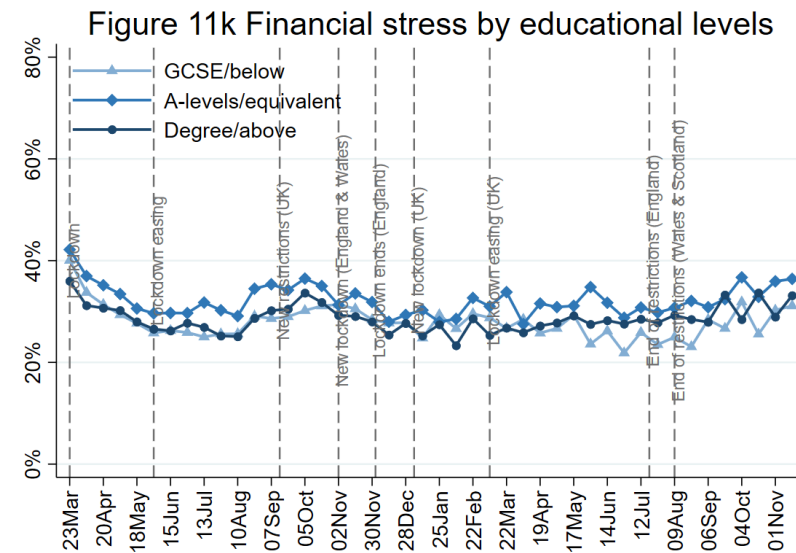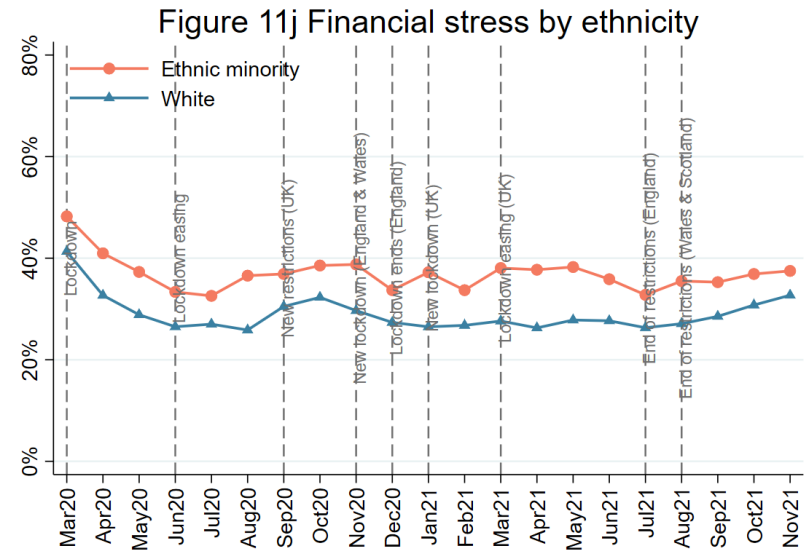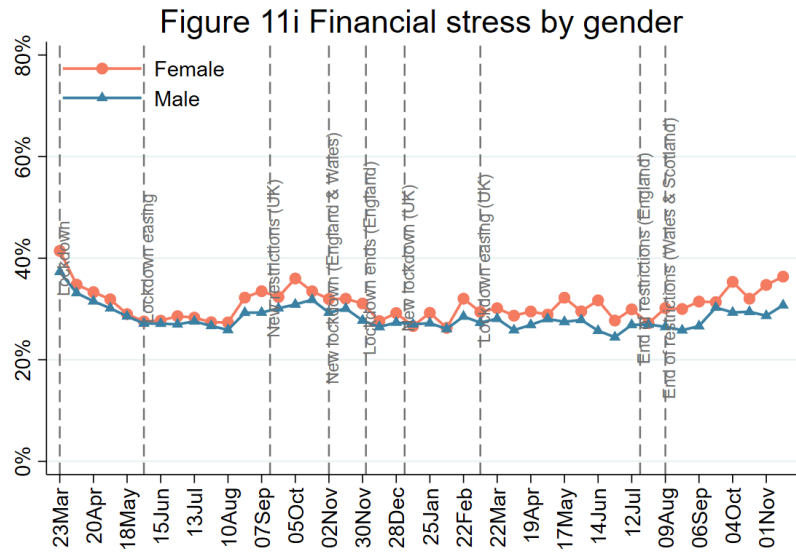
Figure 12a Food security stress by age groups
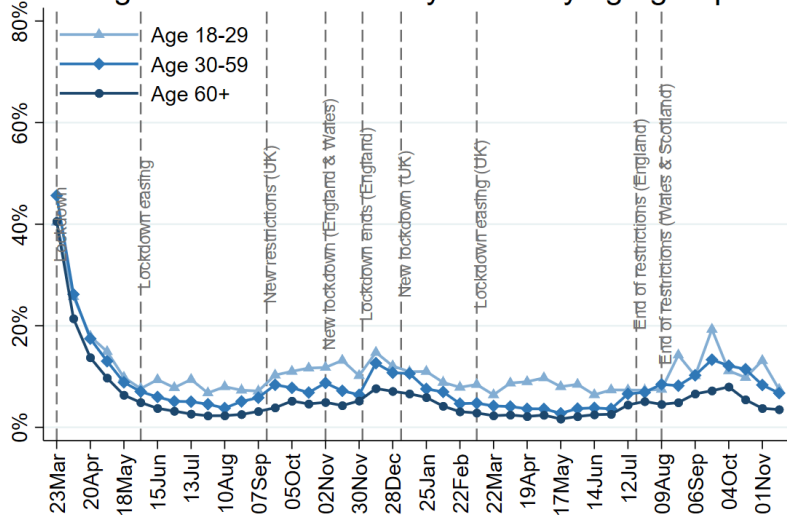
Figure 12b Food security stress by living arrangement
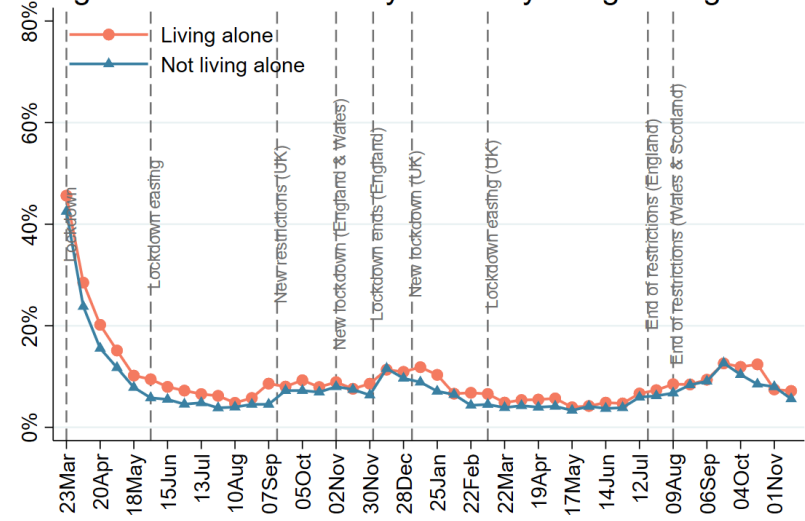
Figure 12c Food security stress by household income
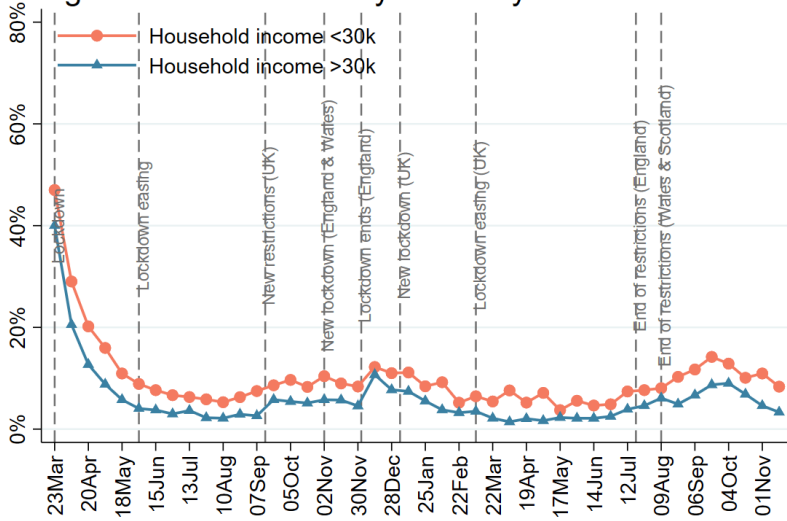
Figure 12d Food security stress by mental health
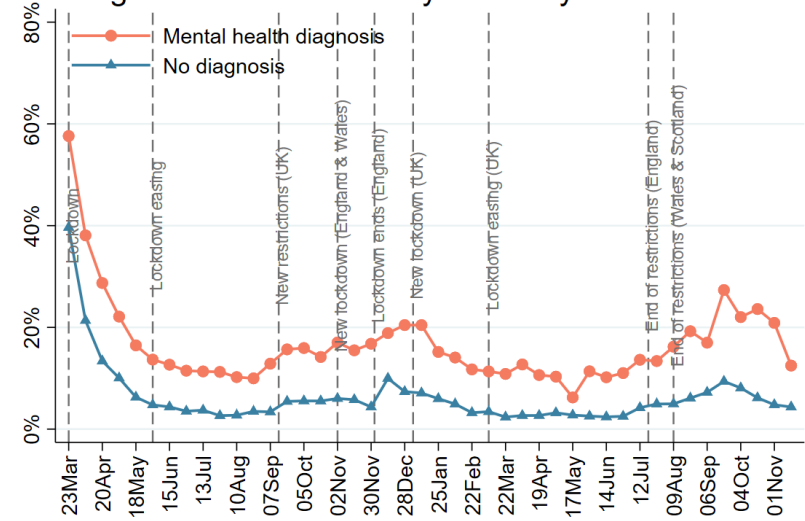
Figure 12e Food security stress by nations
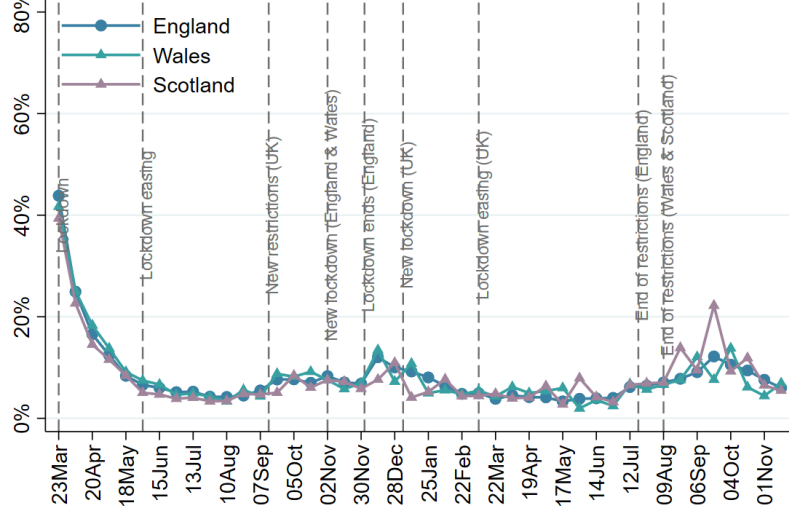
Figure 12f Food security stress by keyworker status
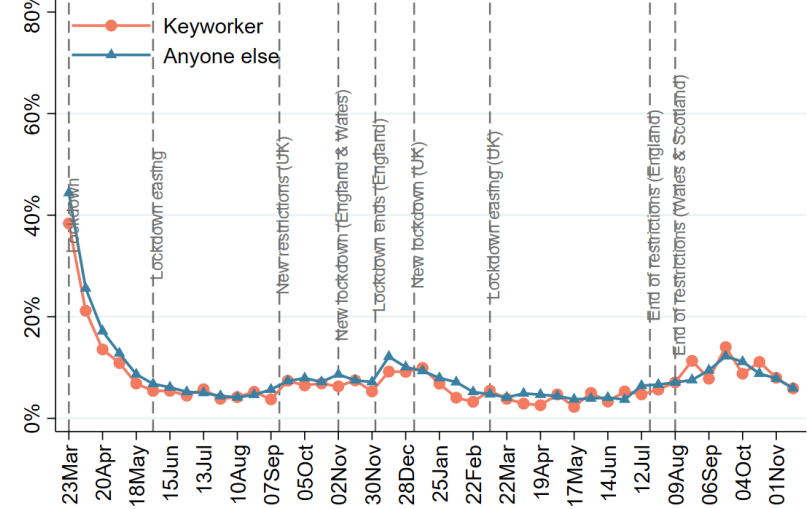
Figure 12g Food security stress by living with children
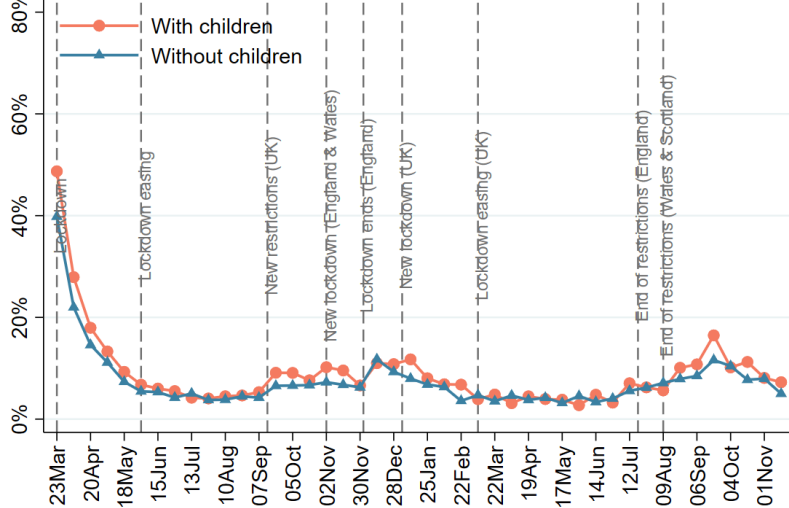
Figure 12h Food security stress by living area
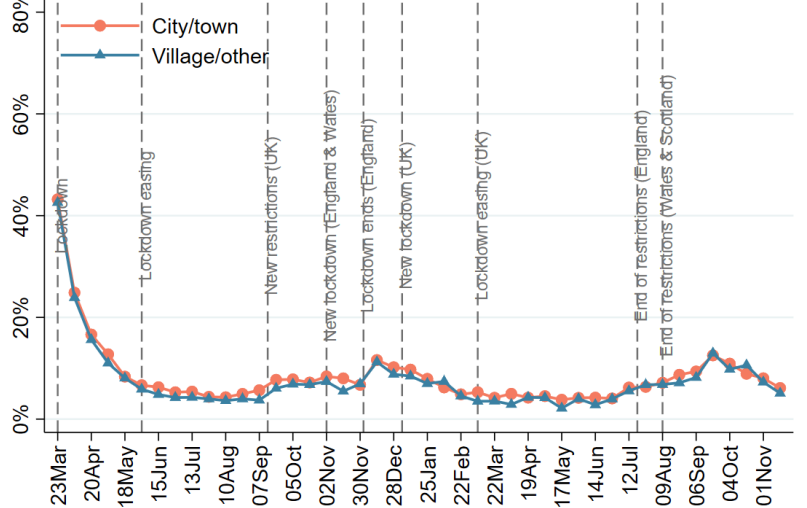
Figure 12i Food security stress by gender
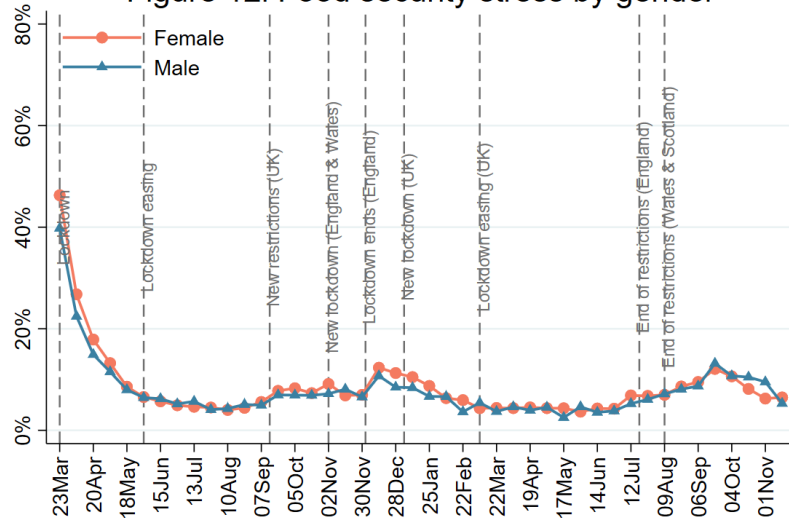
Figure 12j Food security stress by ethnicity
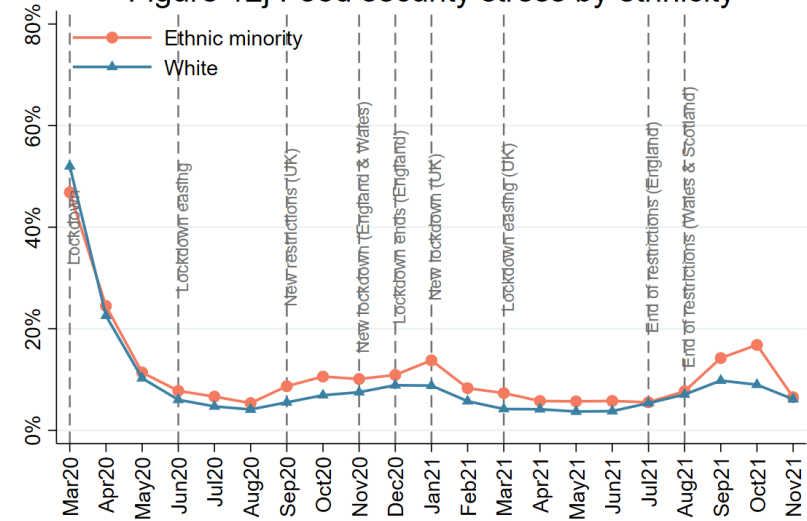
Figure 12k Food security stress by educational levels
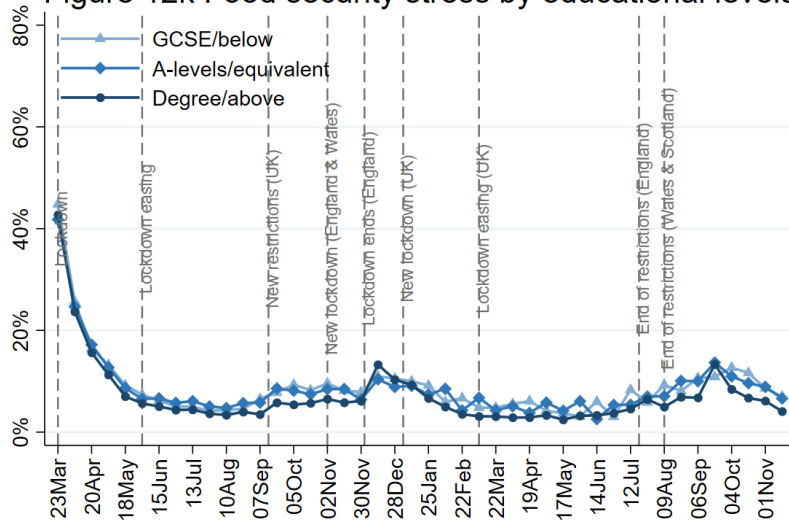
Figure 12l Food security stress by physical health diagnosis
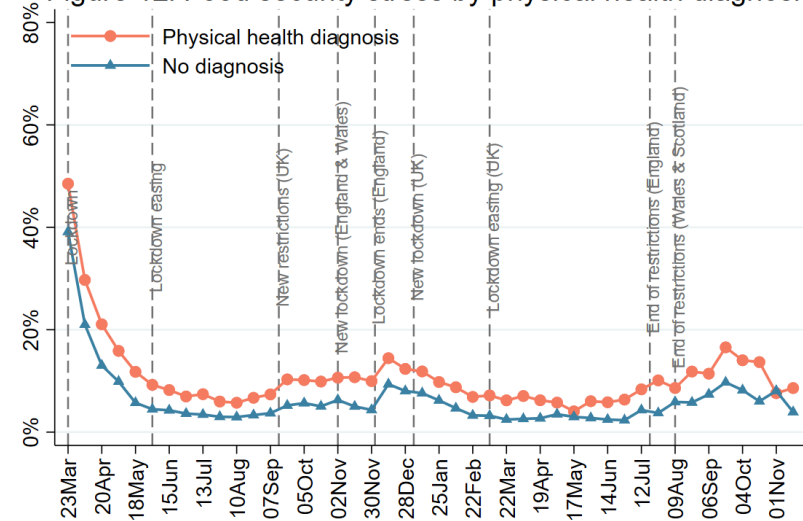
3. Self-harm and abuse

3.1 Thoughts of death or self-harm

Figure 13 Thoughts of death or self-harm
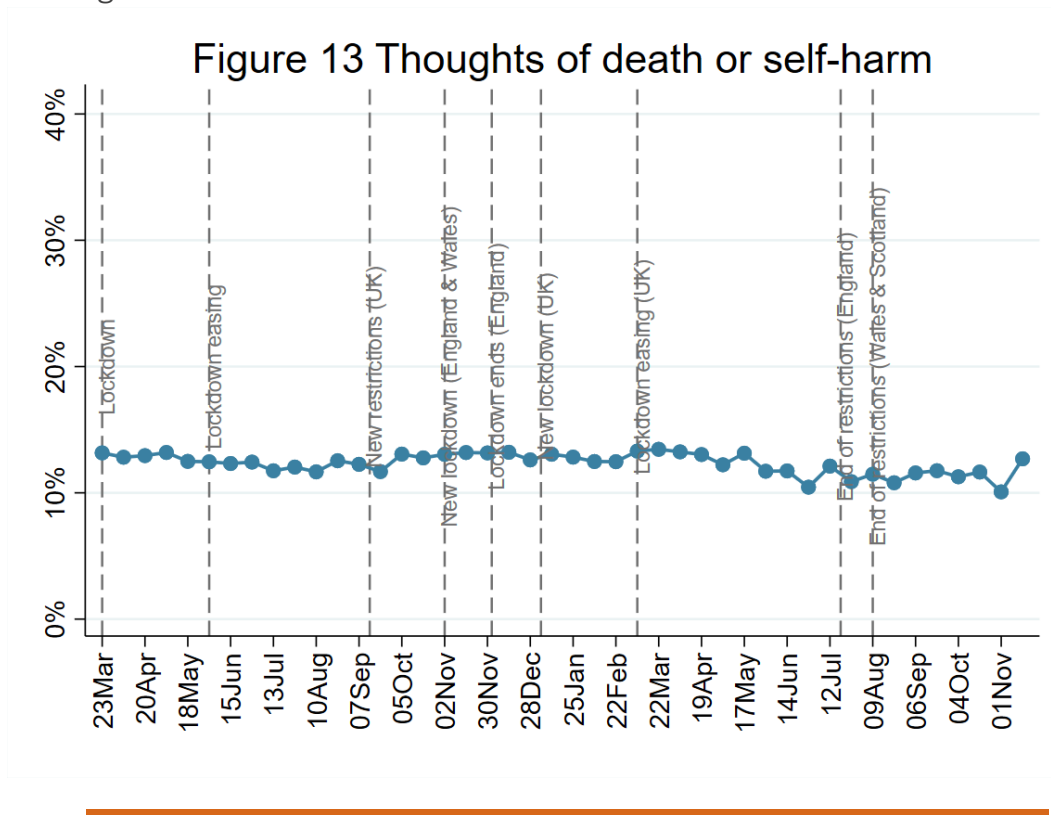
FINDINGS

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

The proportion of people reporting thoughts of death or self-harm was relatively stable throughout the pandemic and then decreased slightly throughout the months of May and June 2021. Rates remain relatively consistent since.

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

Figure 14a Thoughts of death by age groups

Legend: Age 18-29, Age 30-59, Age 60+
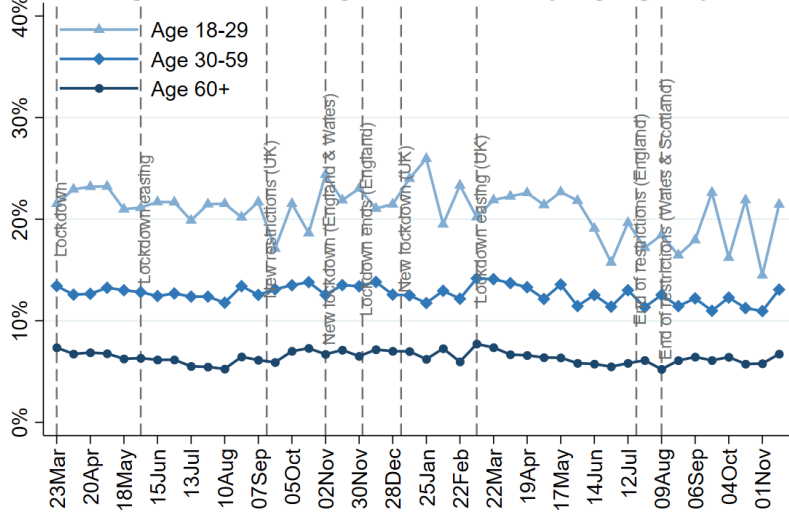
Figure 14b Thoughts of death by living arrangement

Legend: Living alone, Not living alone
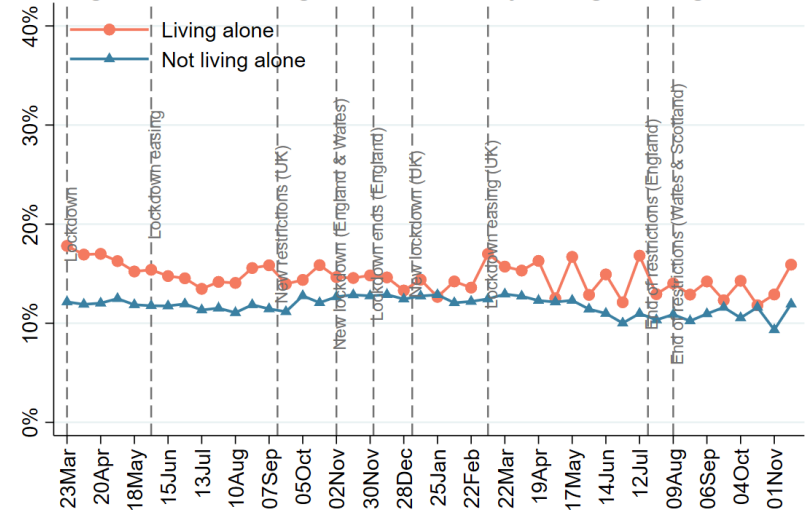
Figure 14c Thoughts of death by household income

Legend: Household income <30k, Household income >30k
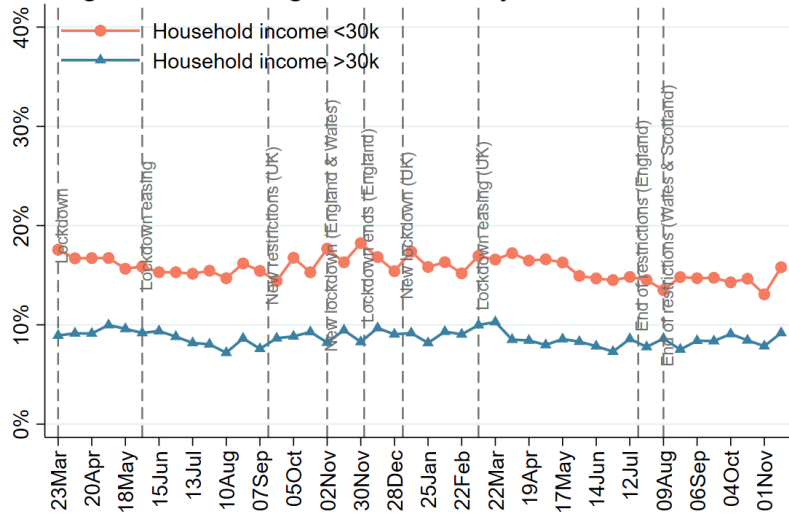
Figure 14d Thoughts of death by mental health diagnosis

Legend: Mental health diagnosis, No diagnosis
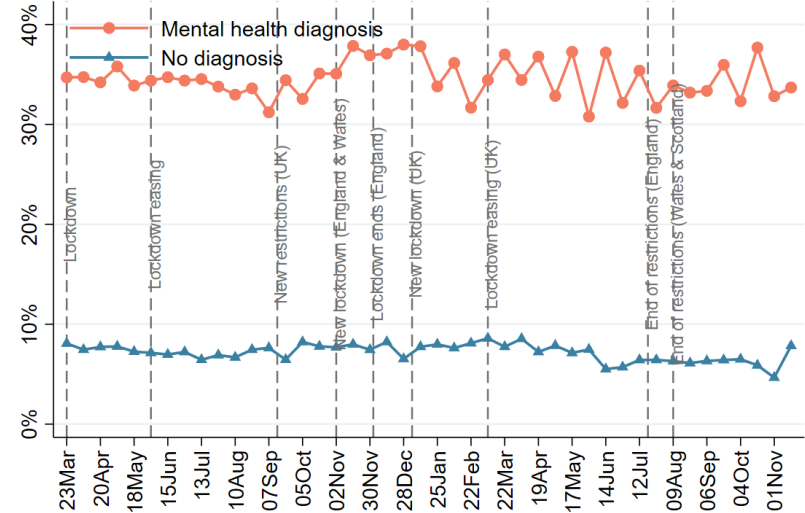
Figure 14e Thoughts of death by nations
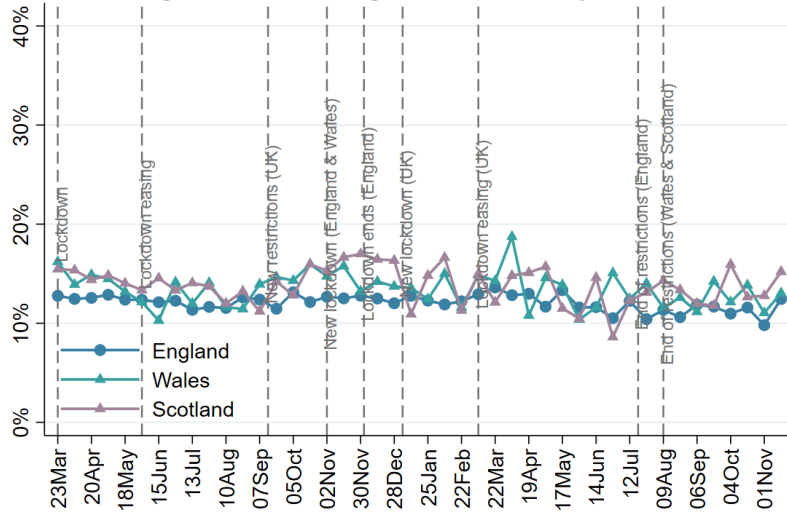
Figure 14f Thoughts of death by keyworker status
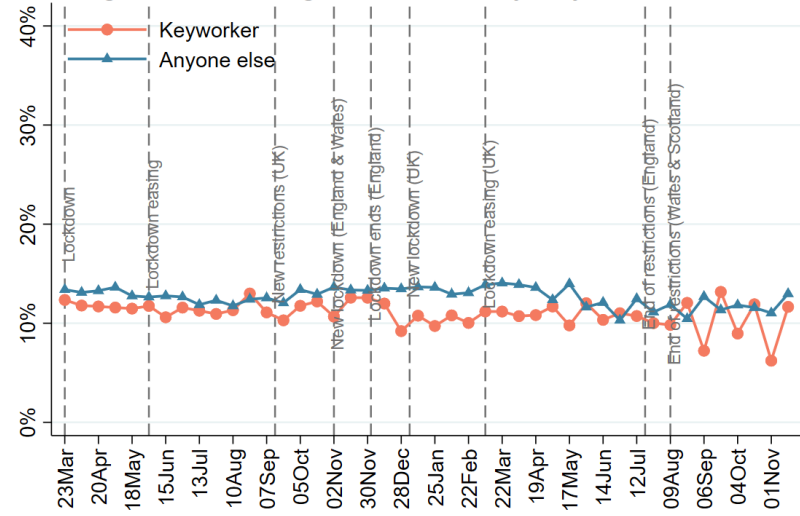
Figure 14g Thoughts of death by living with children
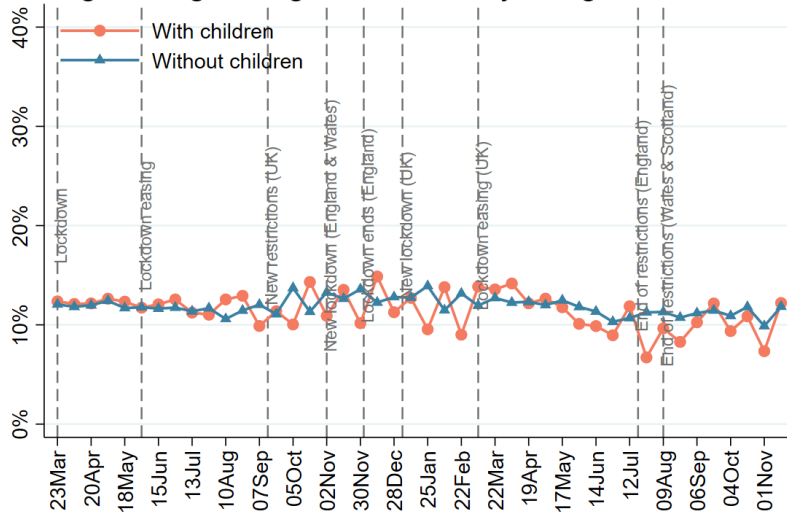
Figure 14h Thoughts of death by living area
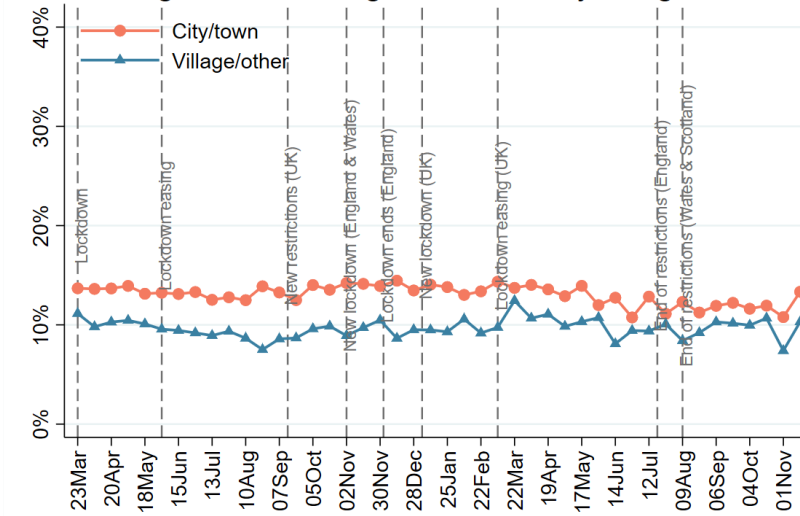
Figure 14i Thoughts of death by gender
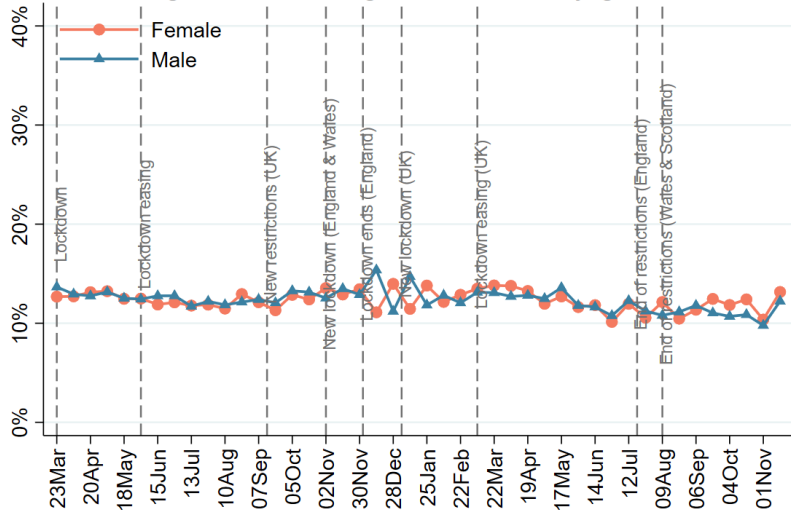
Figure 14j Thoughts of death by ethnicity
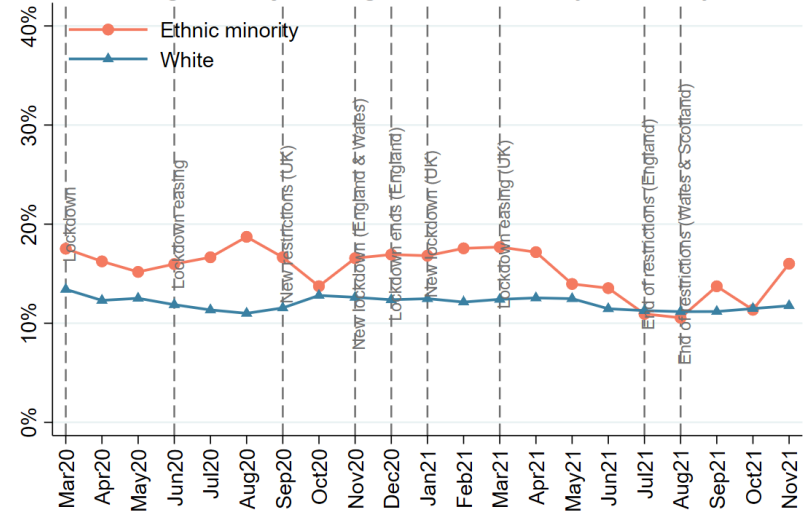
Figure 14k Thoughts of death by educational levels
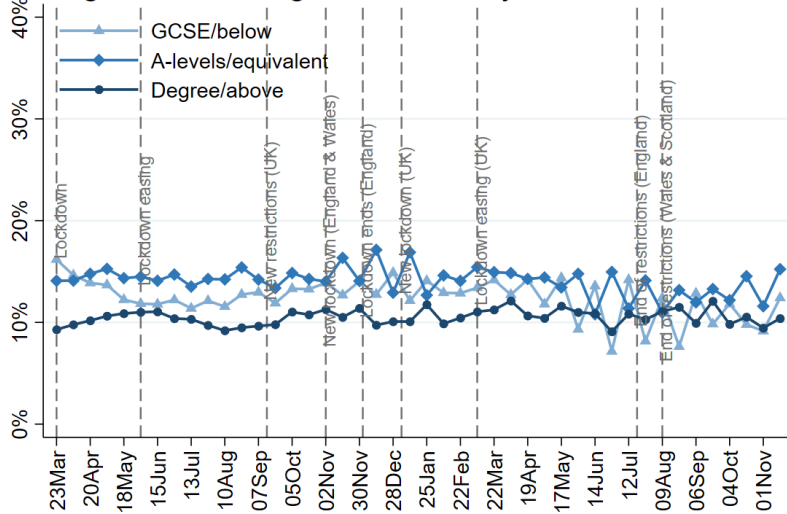
Figure 14l Thoughts of death by physical health diagnosis

3.2 Self-harm

Figure 15 Self-harm
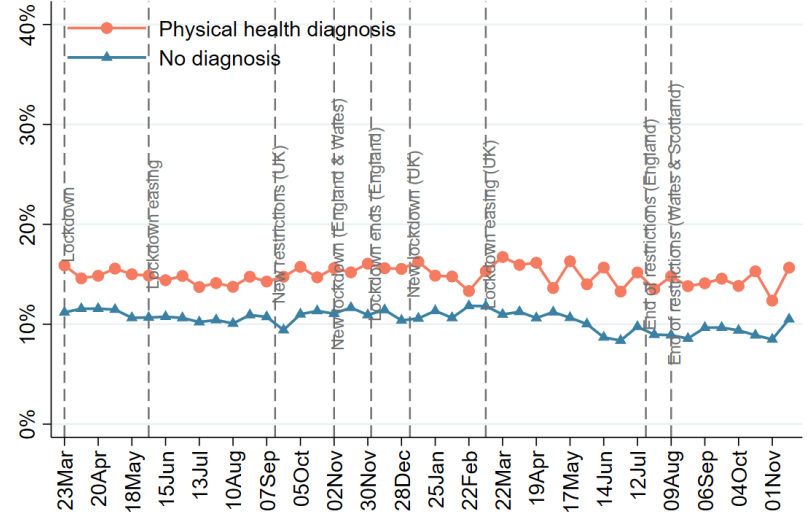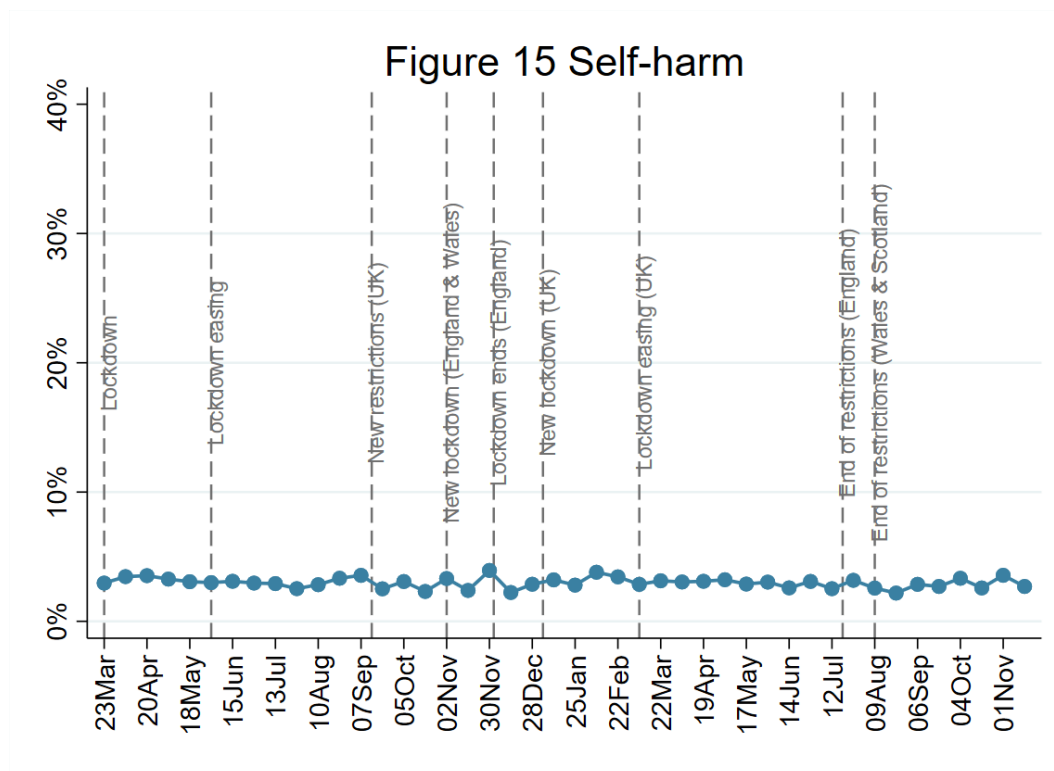
Self-harm was assessed using a question that asks whether in the last week the respondent has been "self-harming or deliberately hurting yourself". Responses are on a 4-point scale ranging from "not at all" to "nearly every day". We focused on any response that indicated any self-harming.

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

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

Figure 16a Self-harm by age groups
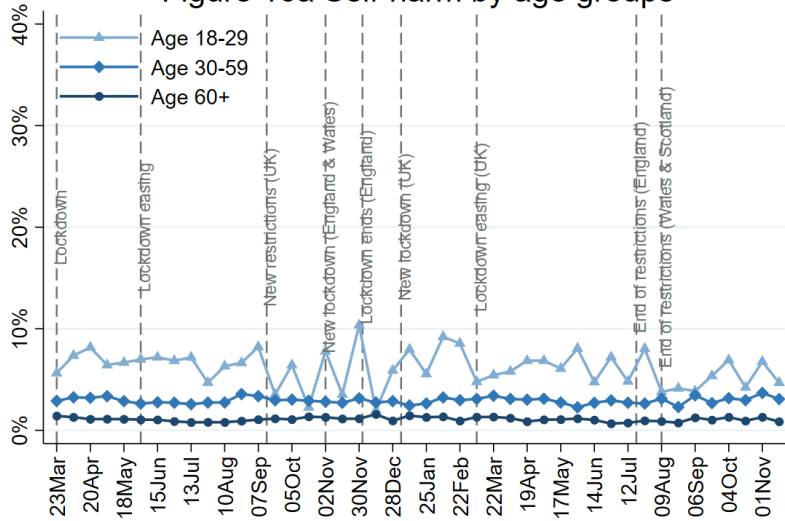
Figure 16b Self-harm by living arrangement
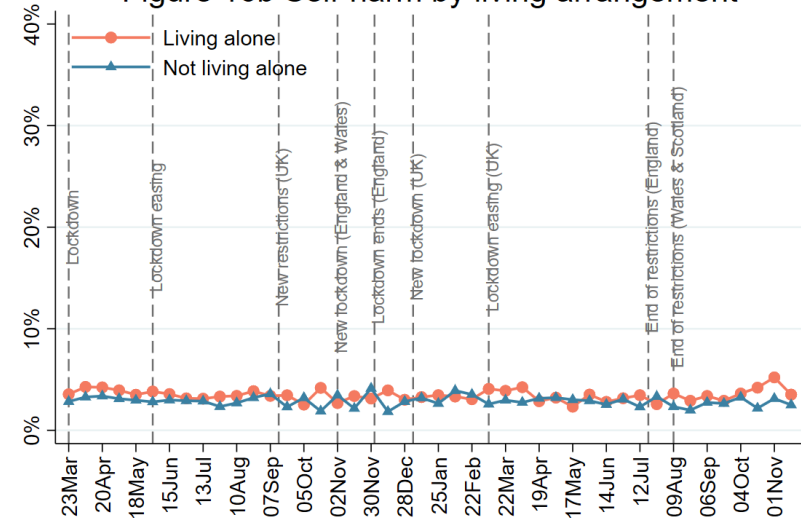
Figure 16c Self-harm by household income
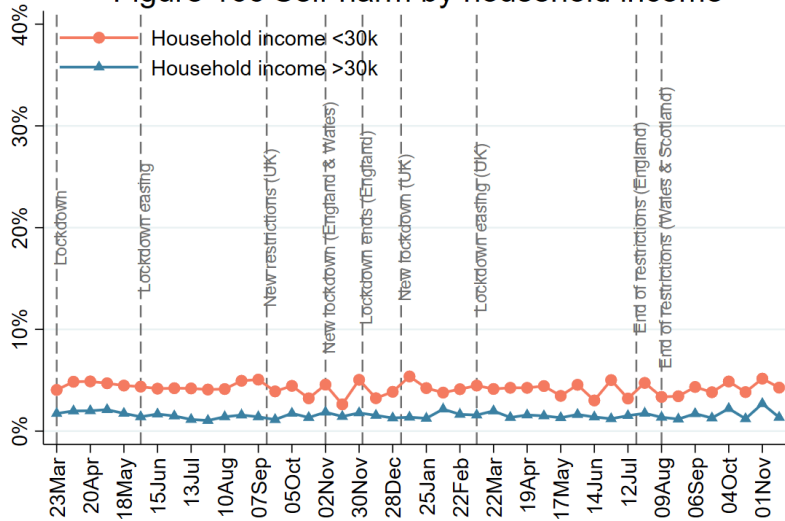
Figure 16d Self-harm by mental health diagnosis
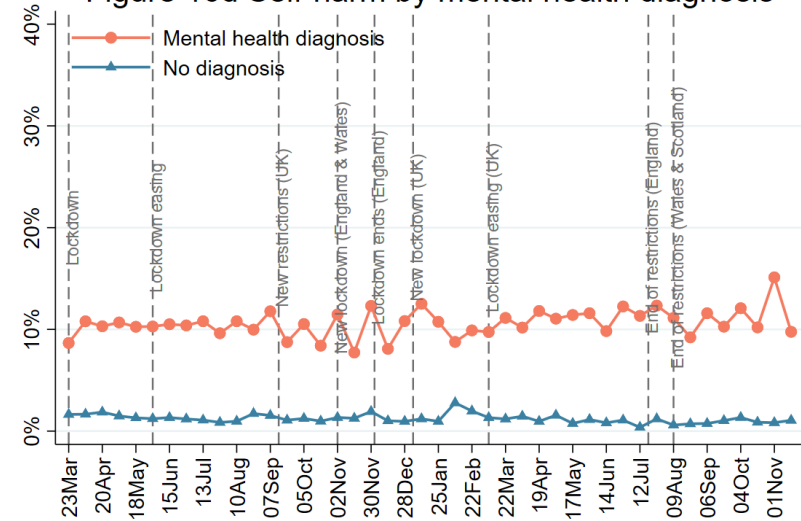
Figure 16e Self-harm by nations
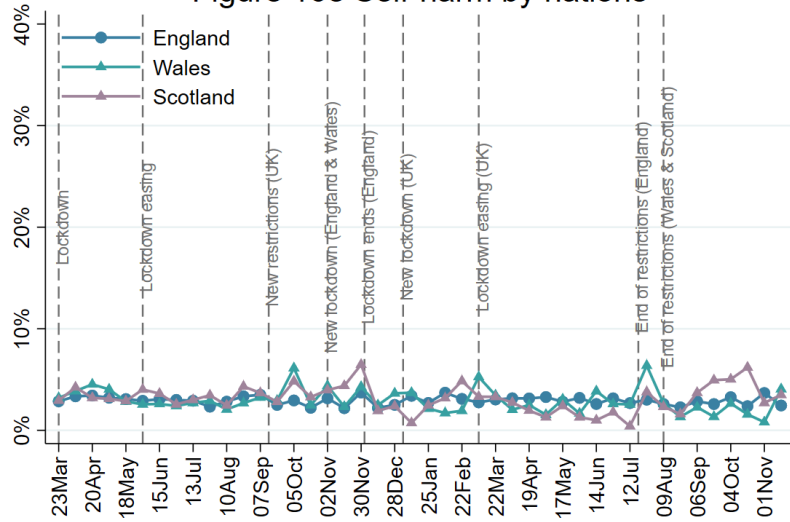
Figure 16f Self-harm by keyworker status
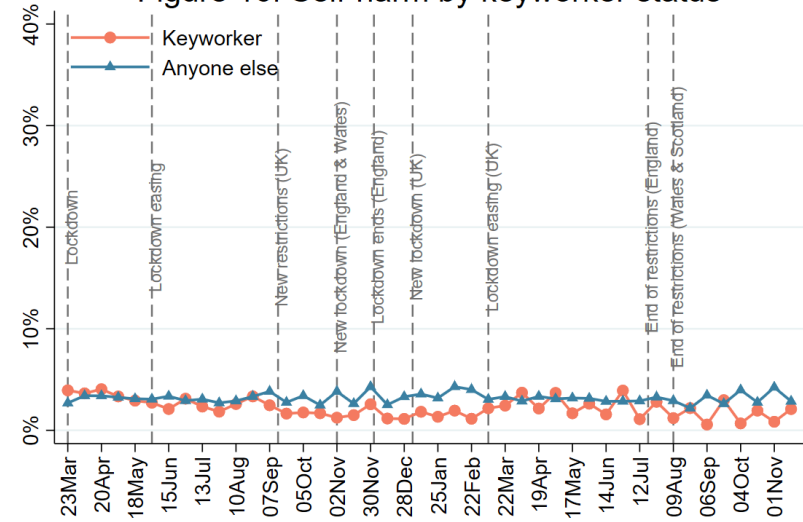
Figure 16g Self-harm by living with children
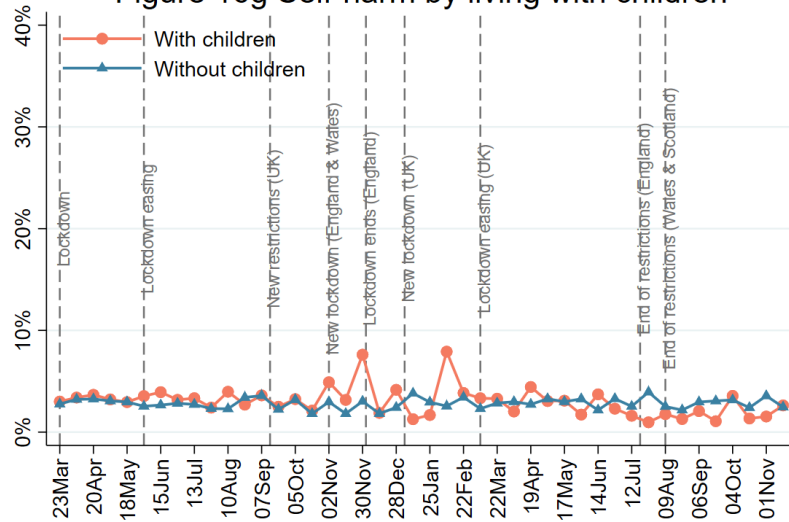
Figure 16h Self-harm by living area
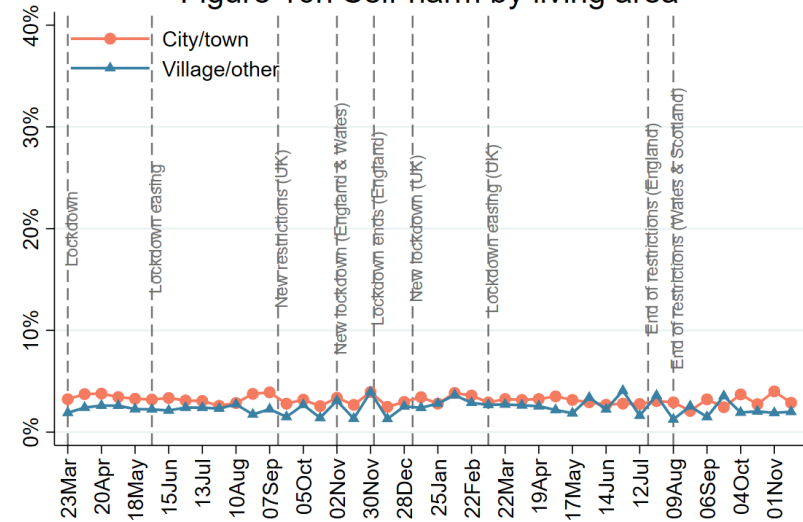
Figure 16i Self-harm by gender
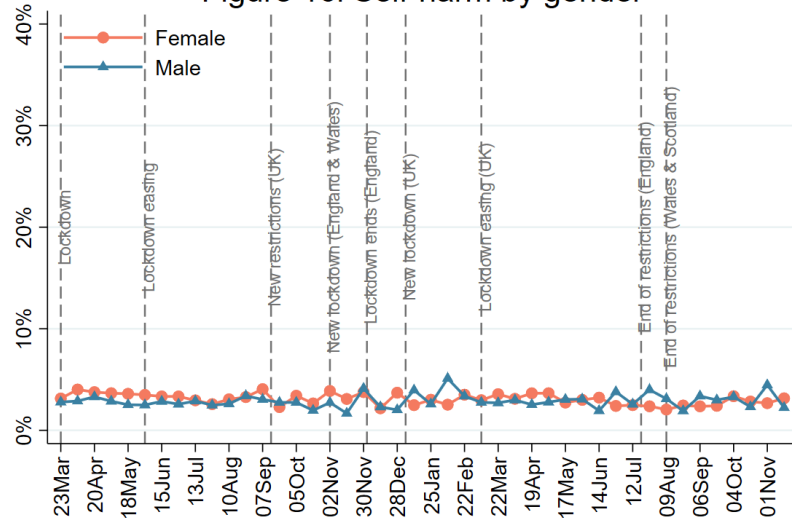
Figure 16j Self-harm by ethnicity
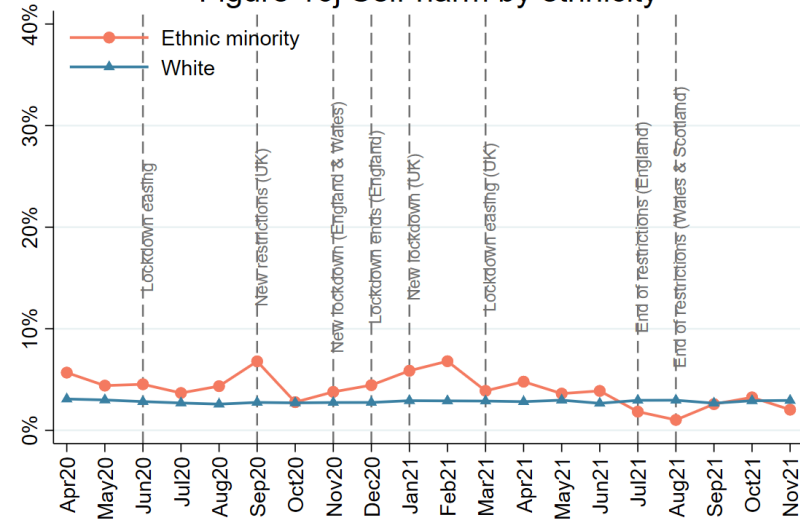
Figure 16k Self-harm by educational levels
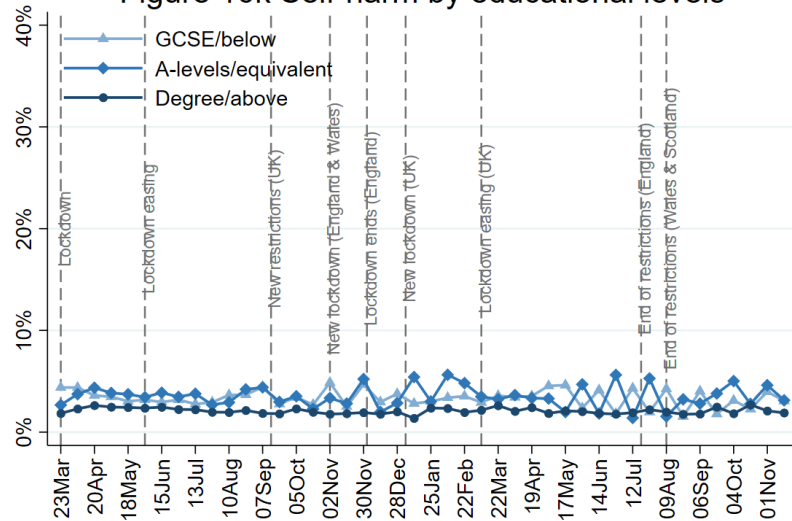
Figure 16l Self-harm by physical health diagnosis

3.3 Abuse

Figure 17 Being physically or psychologically abused
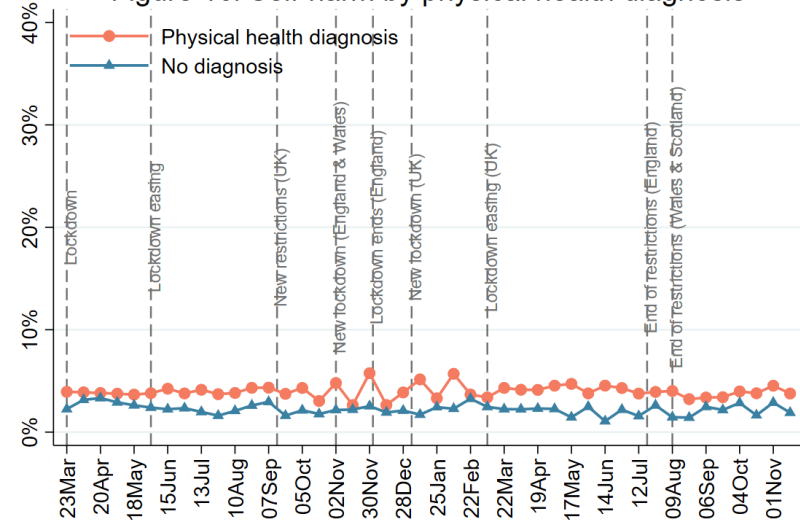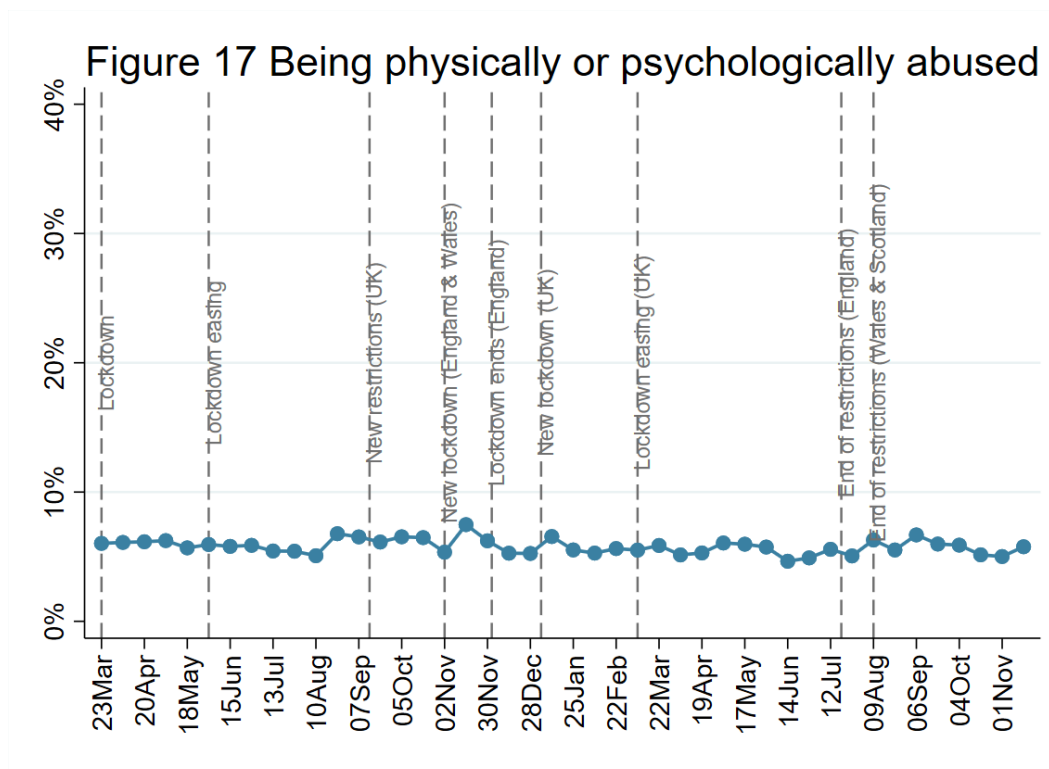
Abuse was measured using two questions that ask if the respondent has experienced in the last week "being physically harmed or hurt by someone else" or "being bullied, controlled, intimidated, or psychologically hurt by someone else". Responses are on a 4-point scale ranging from "not at all" to "nearly every day". We focused on any response on either item that indicated any experience of psychological or physical abuse.

Reports of abuse have remained relatively stable over the pandemic. Abuse is more common amongst people with lower household income, in people with a mental or physical health diagnosis, and in people from ethnic minority groups.

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

Figure 18a Abuse by age groups
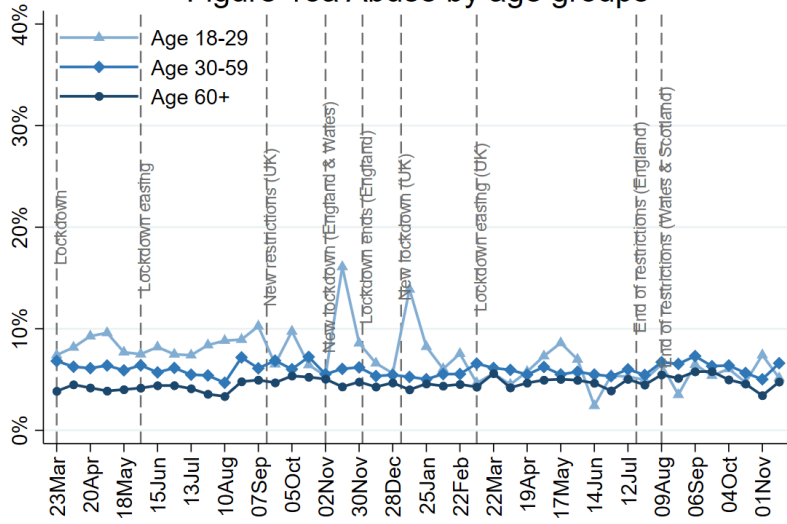
Figure 18b Abuse by living arrangement
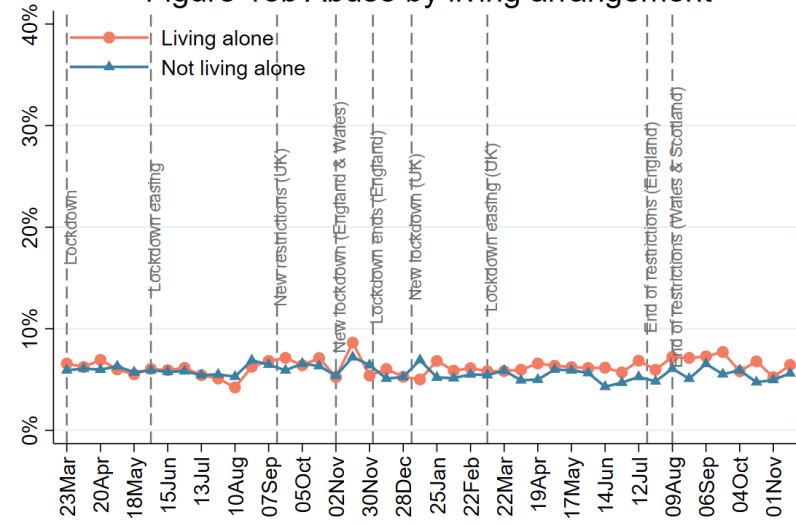
Figure 18c Abuse by household income
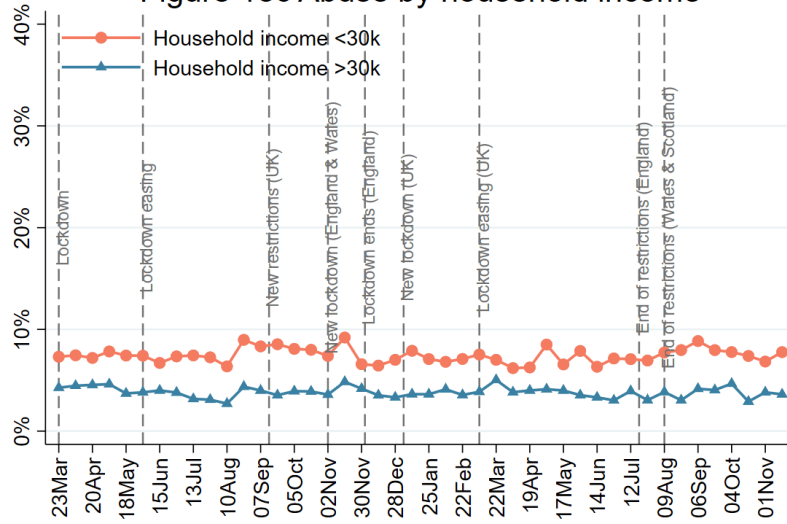
Figure 18d Abuse by mental health diagnosis
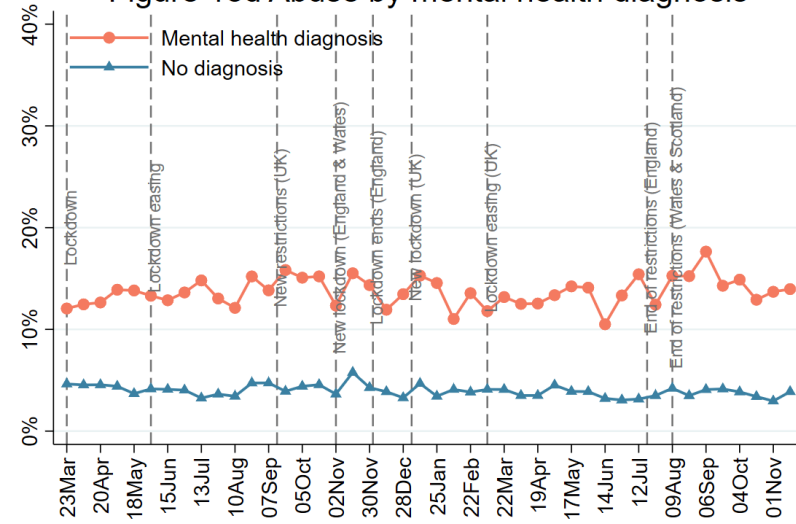
Figure 18e Abuse by nations
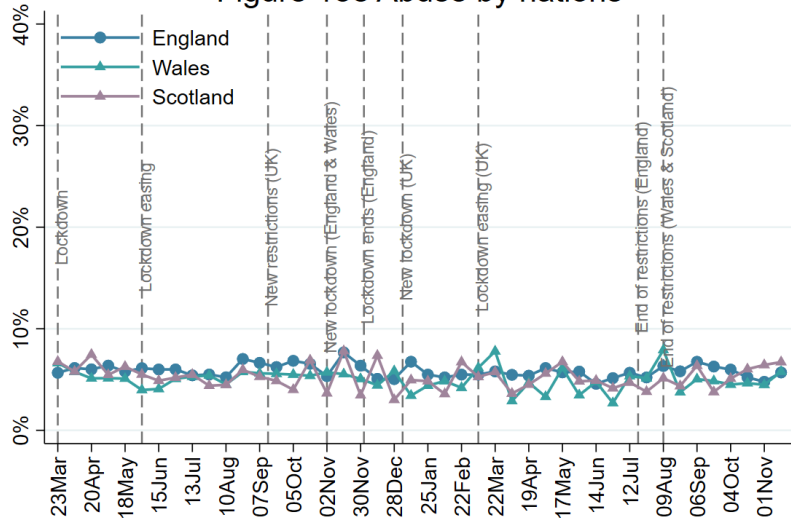
Figure 18f Abuse by keyworker status
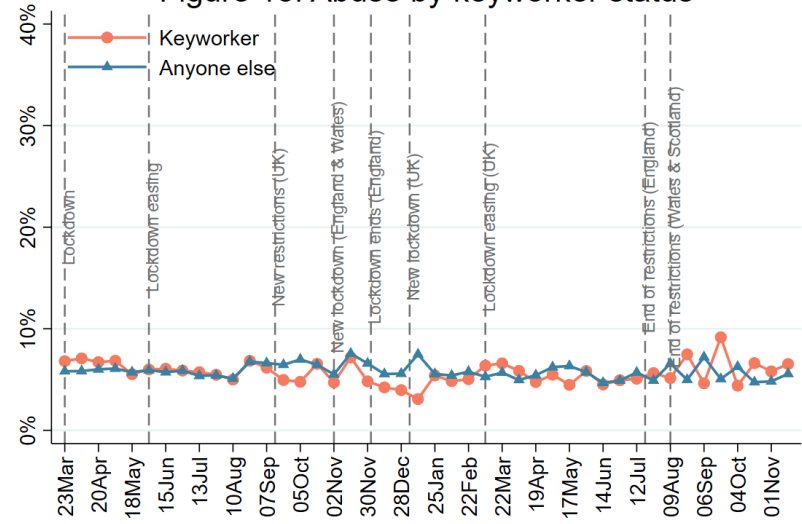
Figure 18g Abuse by living with children
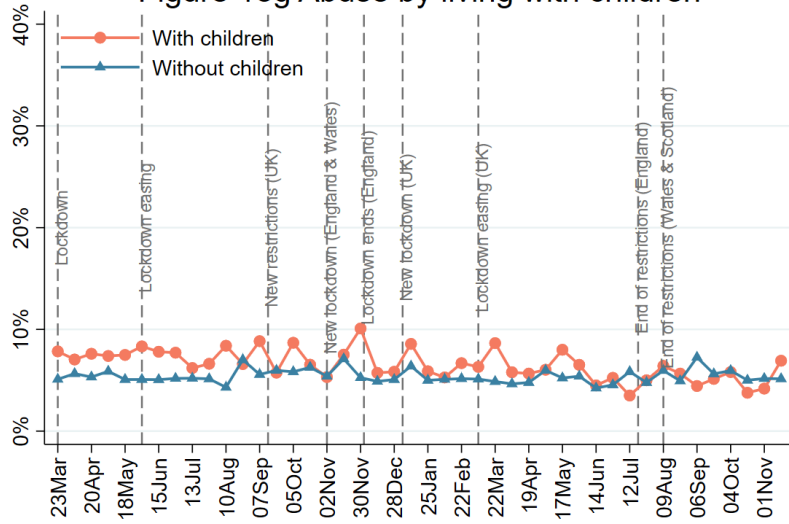
Figure 18h Abuse by living area
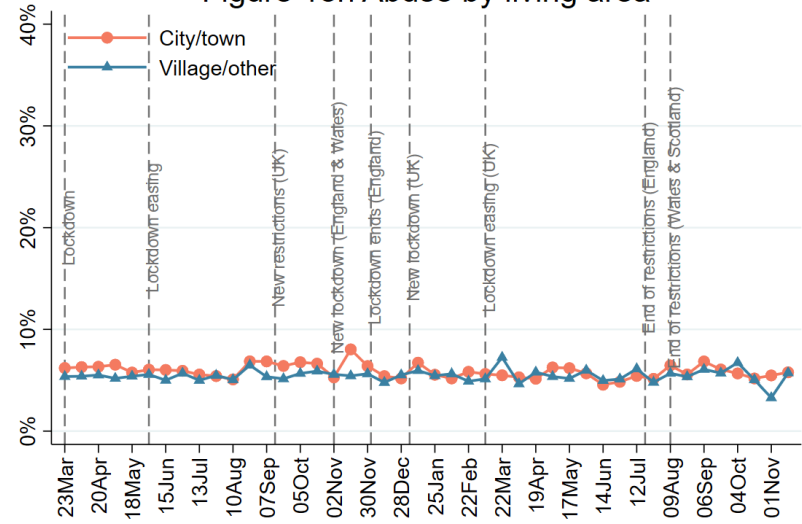
Figure 18i Abuse by gender
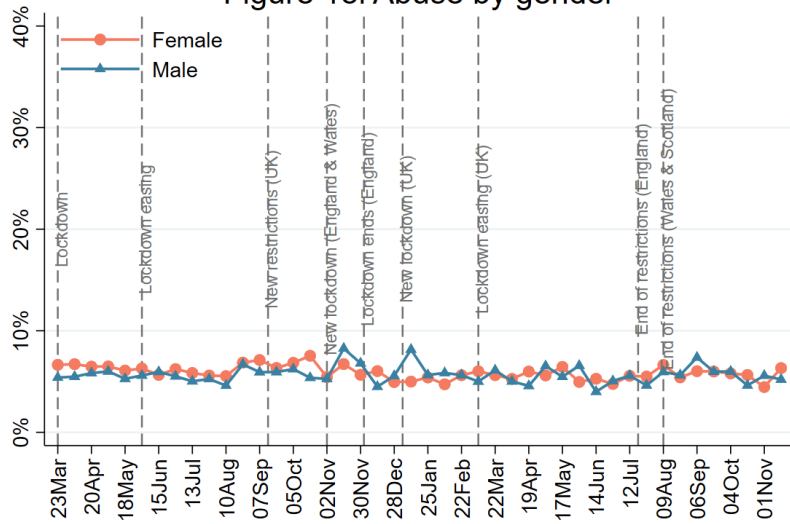
Figure 18j Abuse by ethnicity
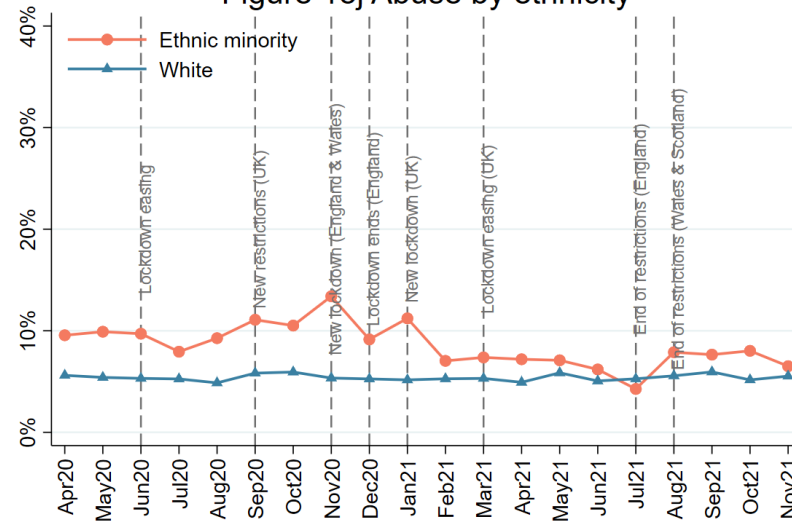
Figure 18k Abuse by educational levels
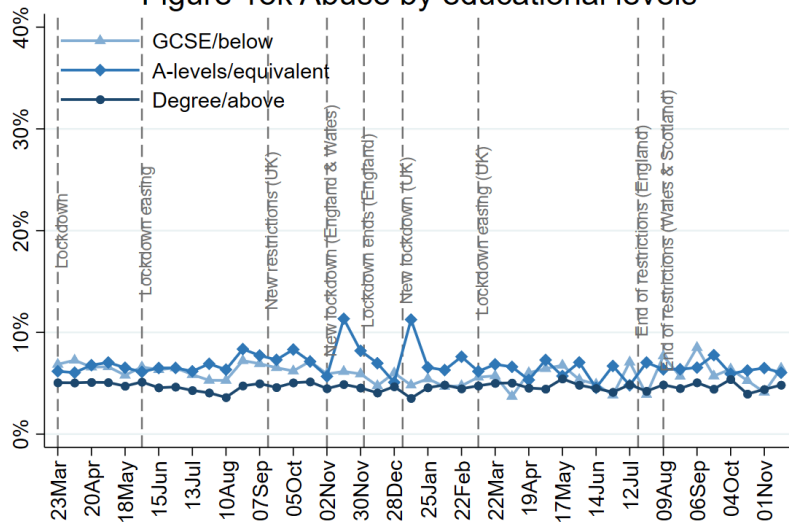
Figure 18l Abuse by physical health diagnosis
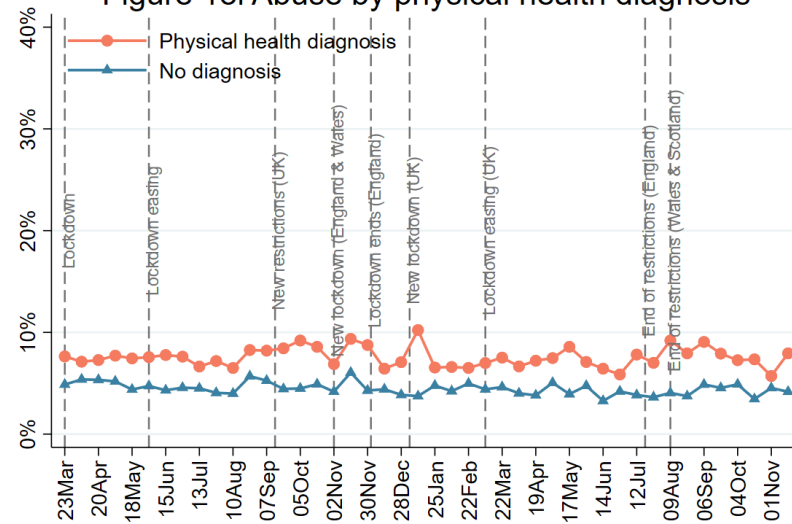
4. General well-being

4.1 Life satisfaction

Figure 19 Life satisfaction
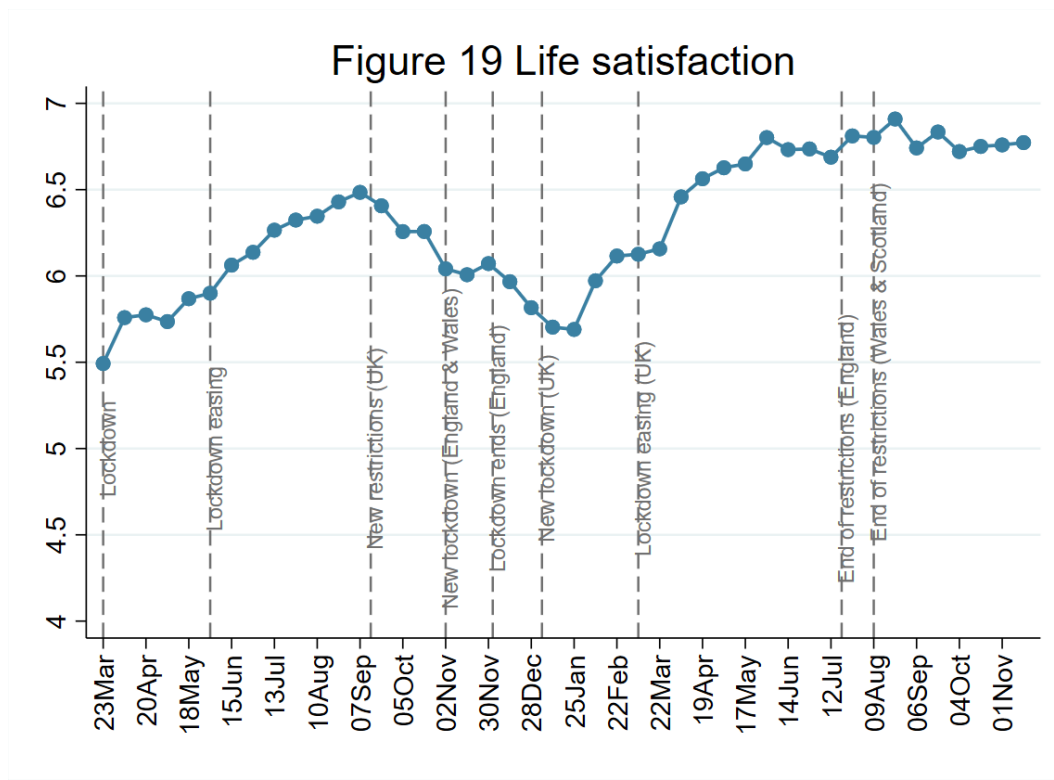
FINDINGS

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

Levels of life satisfaction have been relatively stable over the past several months following an increase over the spring and summer 2021. Although this study focuses on trajectories rather than prevalence, the levels of life satisfaction remain slightly lower than usual reported averages using the same scale (7.7)[6].

People living alone, young adults, those with a mental health diagnosis, those with lower household incomes, people living in urban areas, people with a physical health diagnosis, and those from ethnic minority groups (although smaller sample sizes compared to people with white ethnicity mean there has been greater volatility in these data) continue to report lower levels of life satisfaction. Notably, the gap in life satisfaction between older and younger adults appears to be increasing, with older adults reporting substantially higher levels than other age groups.

[6] 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
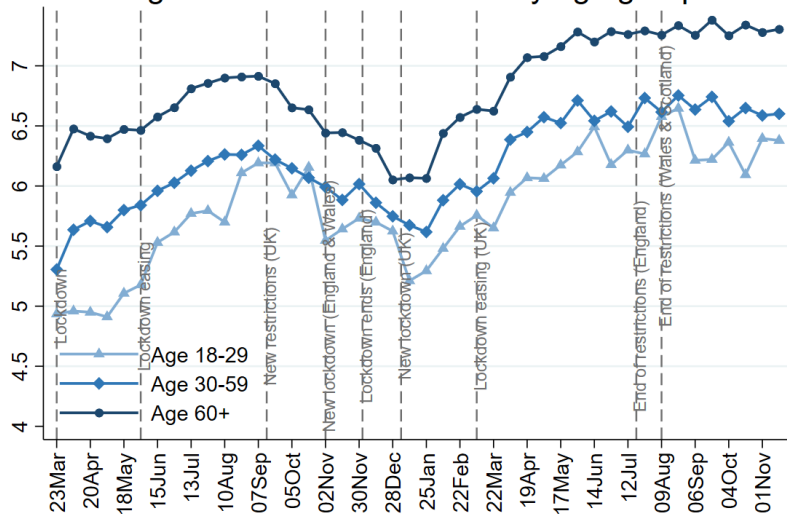
Figure 20b Life satisfaction by living arrangement
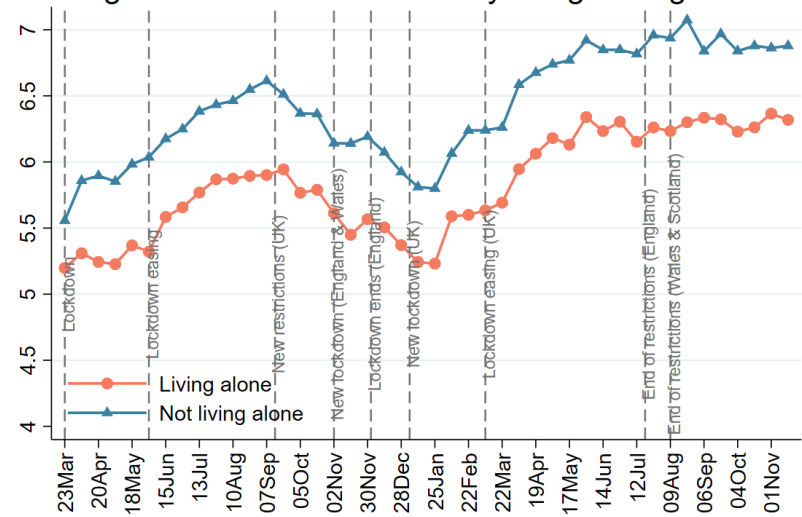
Figure 20c Life satisfaction by household income
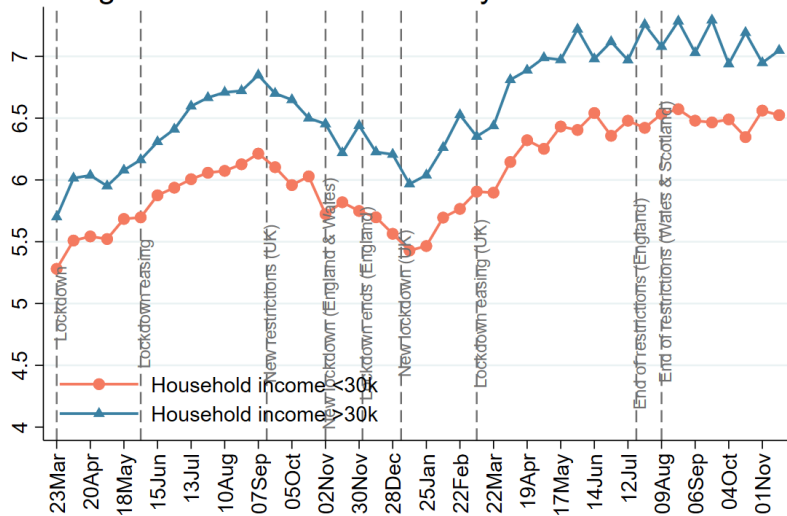
Figure 20d Life satisfaction by mental health diagnosis
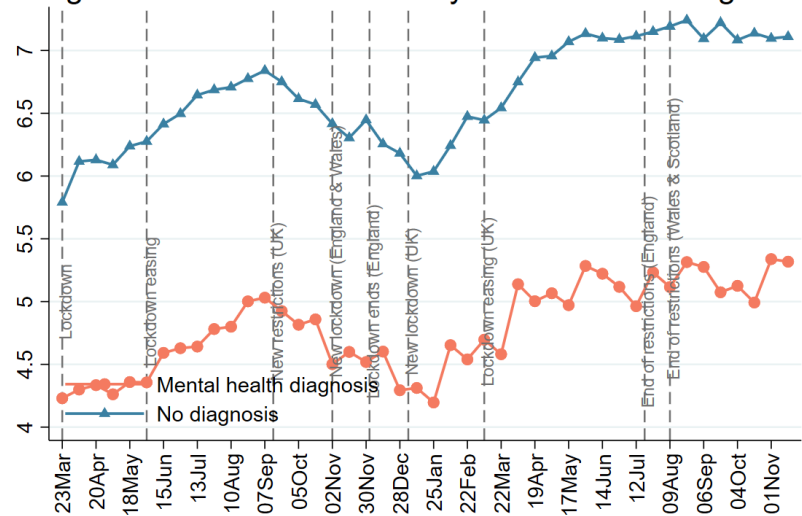
Figure 20e Life satisfaction by nations
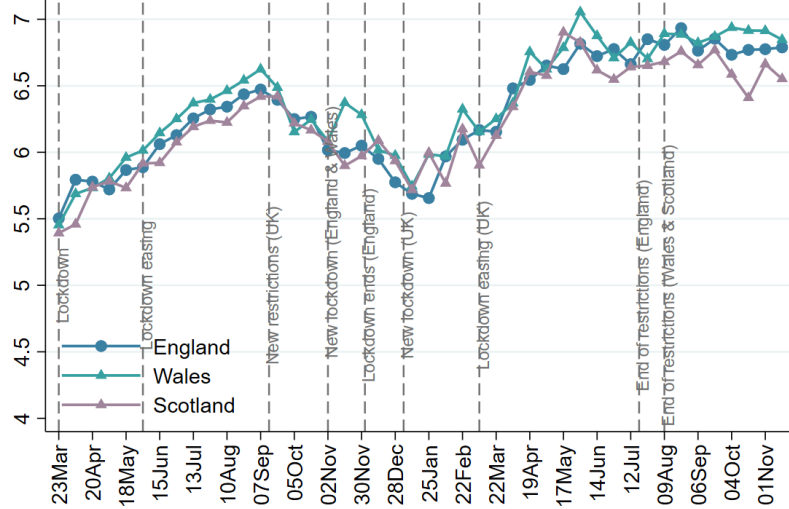
Figure 20f Life satisfaction by keyworker status
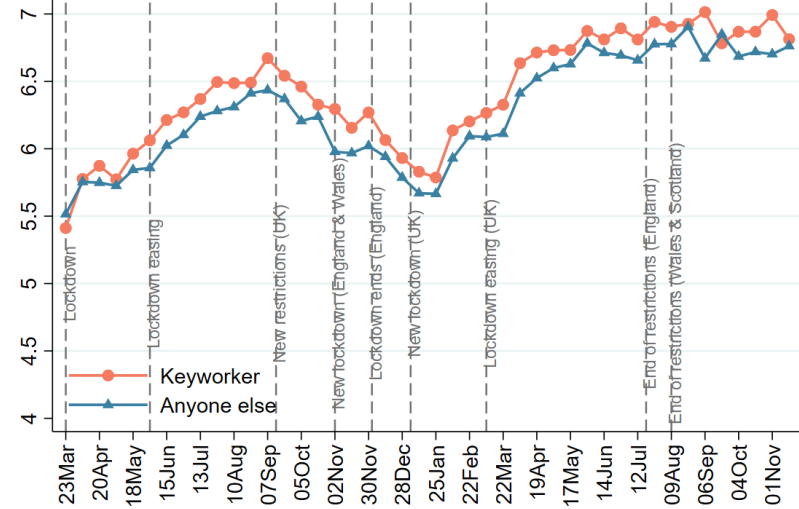
Figure 20g Life satisfaction by living with children
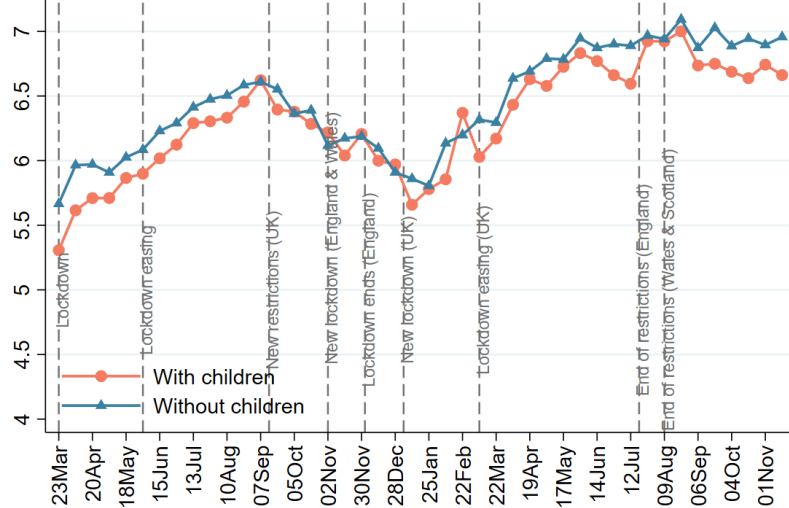
Figure 20h Life satisfaction by living area
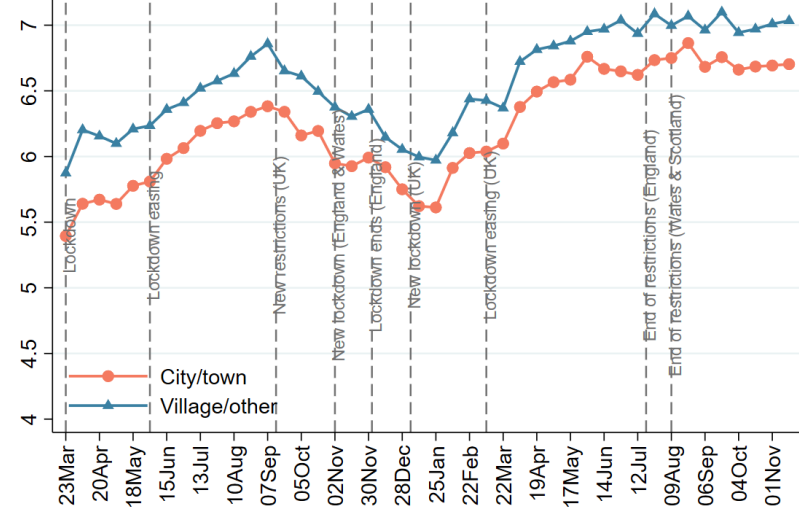
Figure 20i Life satisfaction by gender
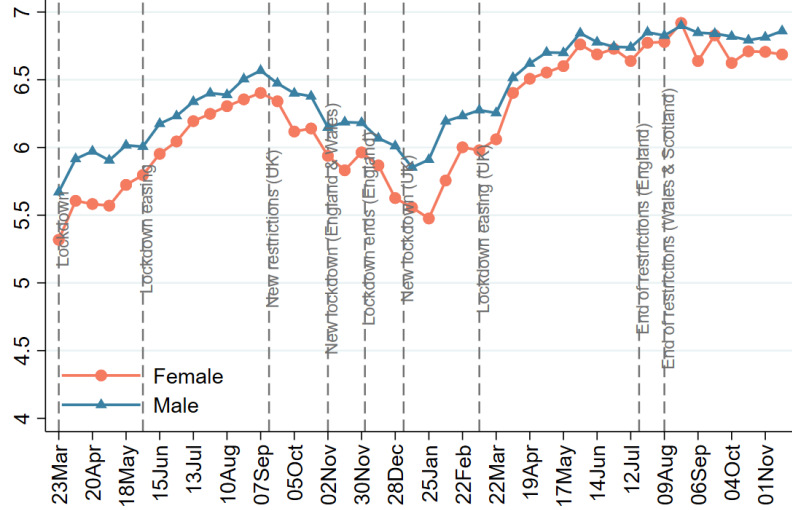
Figure 20j Life satisfaction by ethnicity
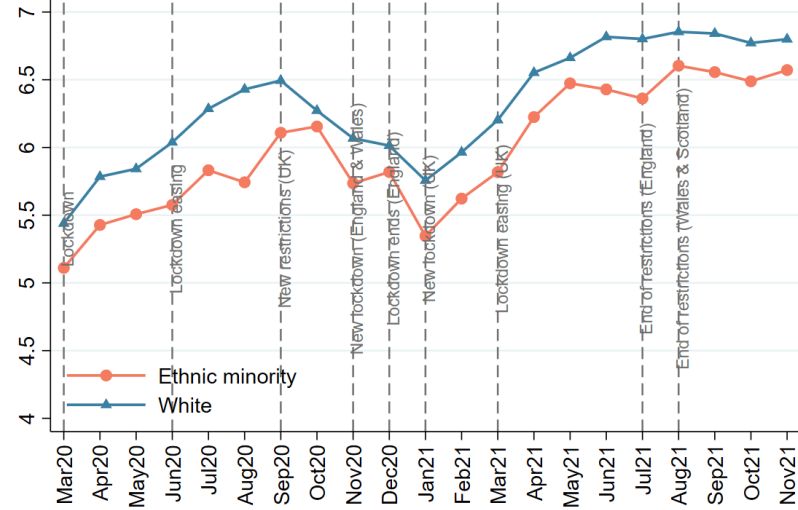
Figure 20k Life satisfaction by educational levels
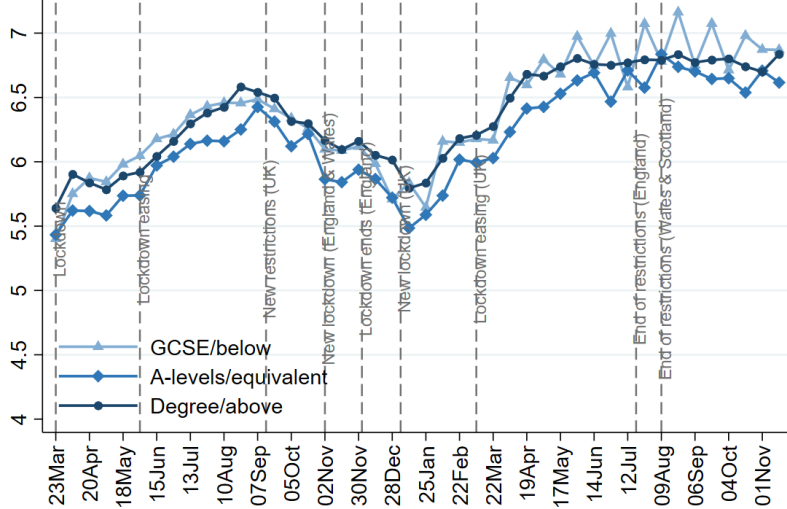
Figure 20l Life satisfaction by physical health diagnosis

4.2 Loneliness
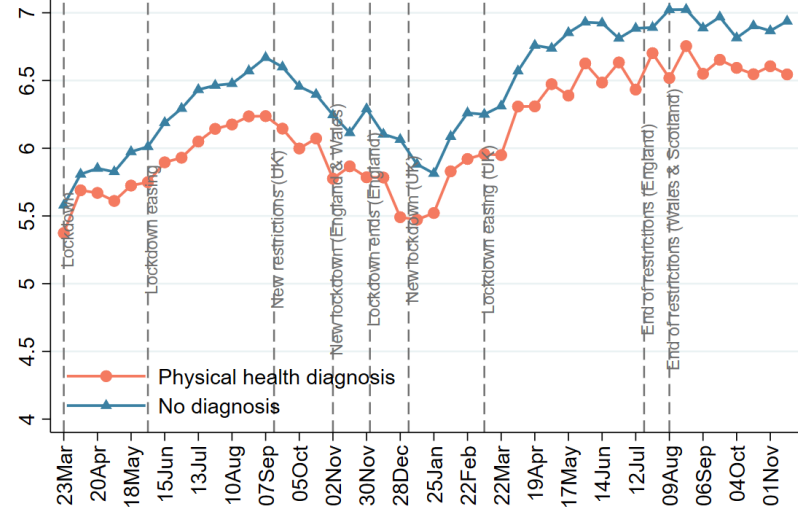
Figure 21 Loneliness
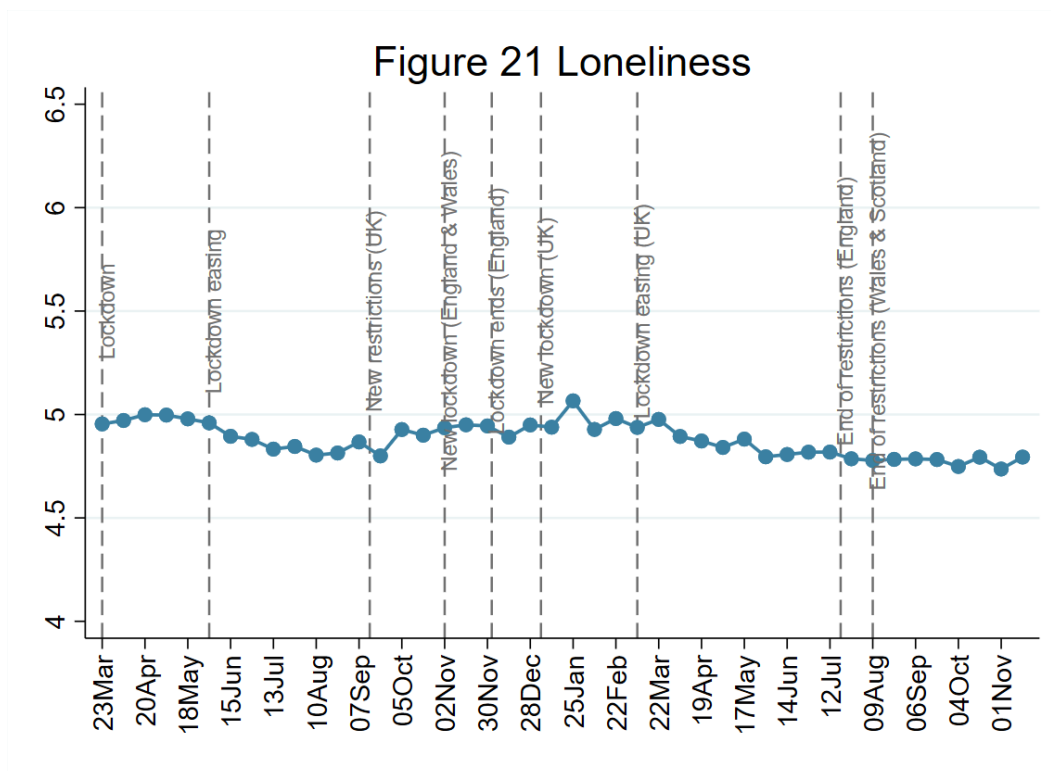
FINDINGS

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

Loneliness levels had been decreasing slightly from the beginning of March 2021 to early summer, but levels have since been relatively stable. Loneliness remains highest in young adults, people living alone, those with a mental or physical health diagnosis, people with lower household income, those living with children, amongst those from ethnic minority groups, women, and those 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

52
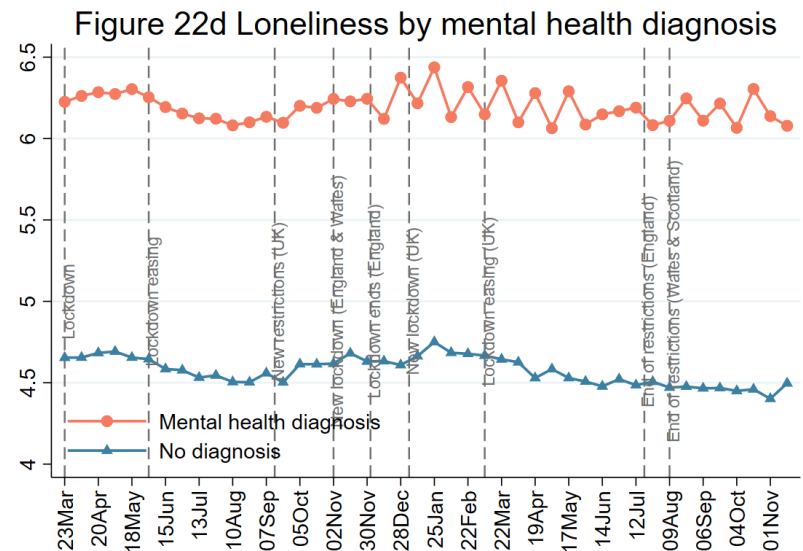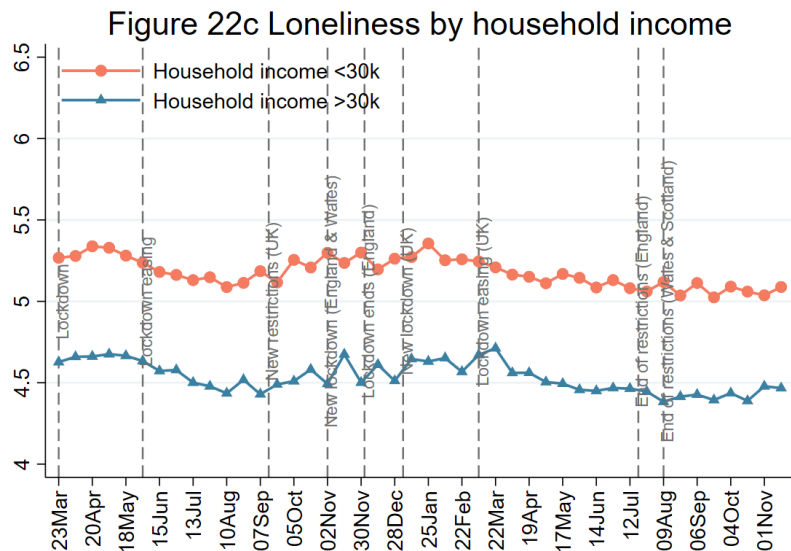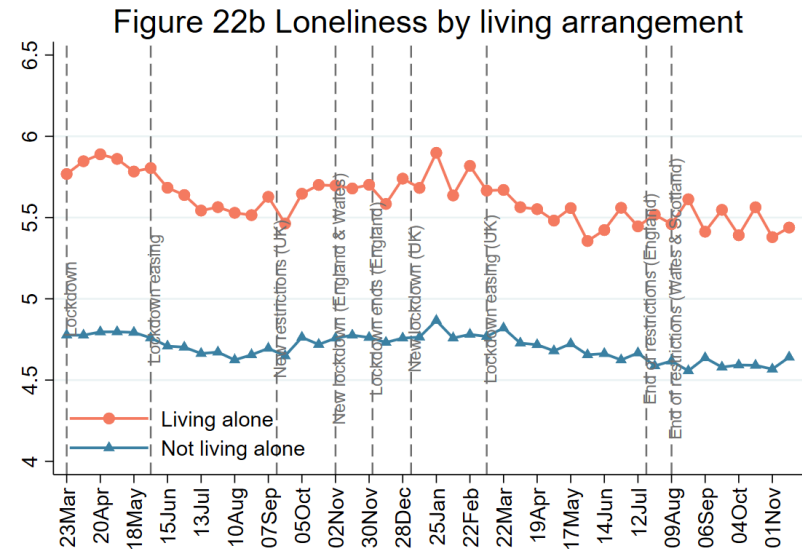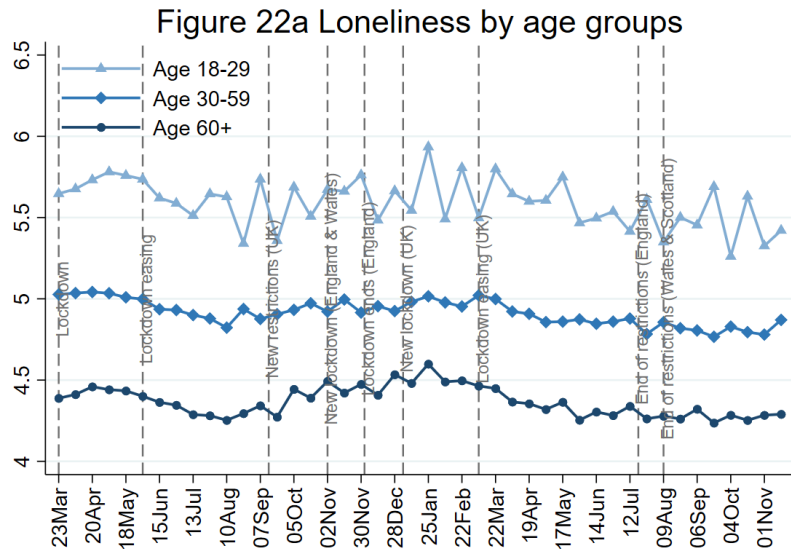
Figure 22e Loneliness by nations
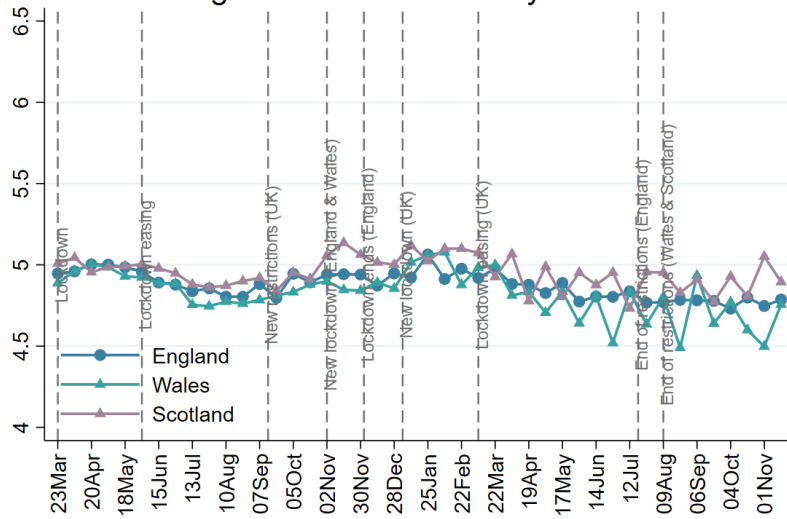
Figure 22f Loneliness by keyworker status
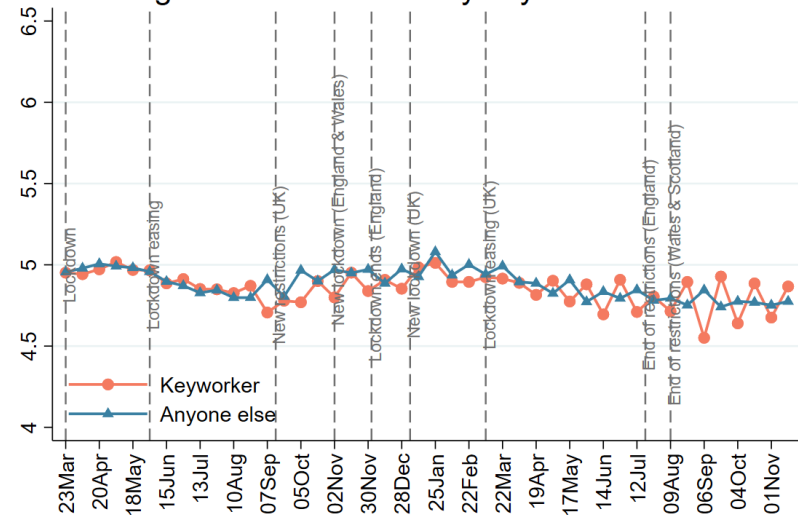
Figure 22g Loneliness by living with children
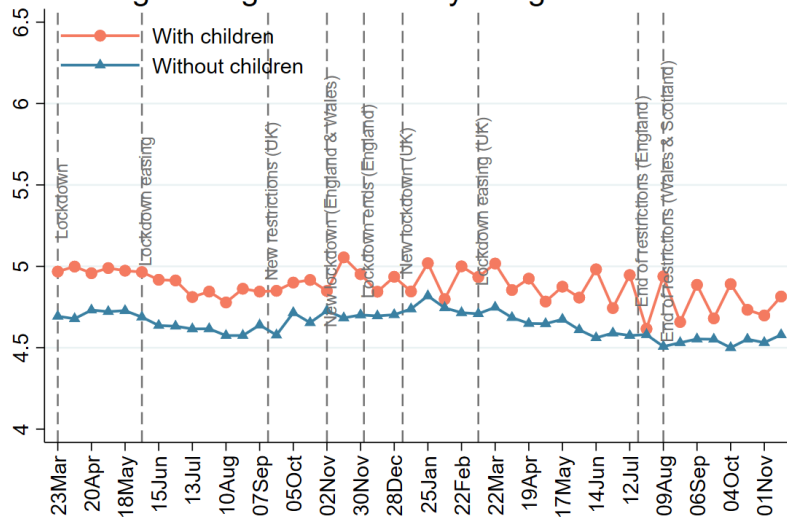
Figure 22h Loneliness by living area
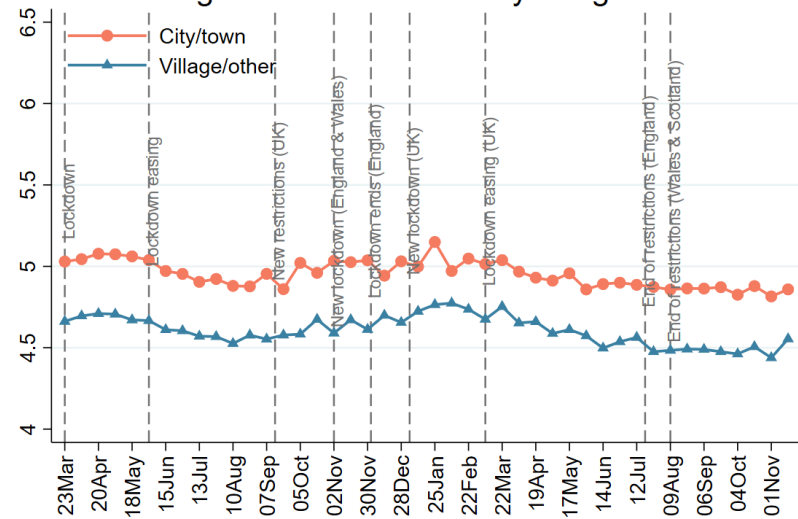
Figure 22i Loneliness by gender
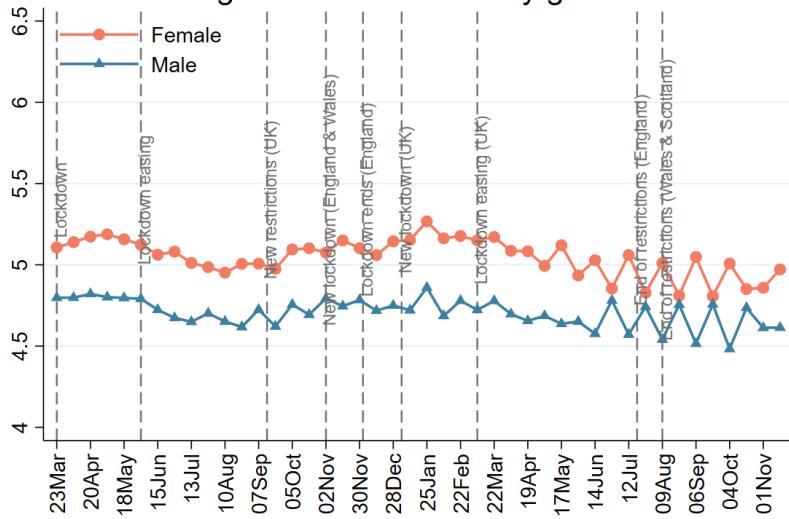
Figure 22j Loneliness by ethnicity
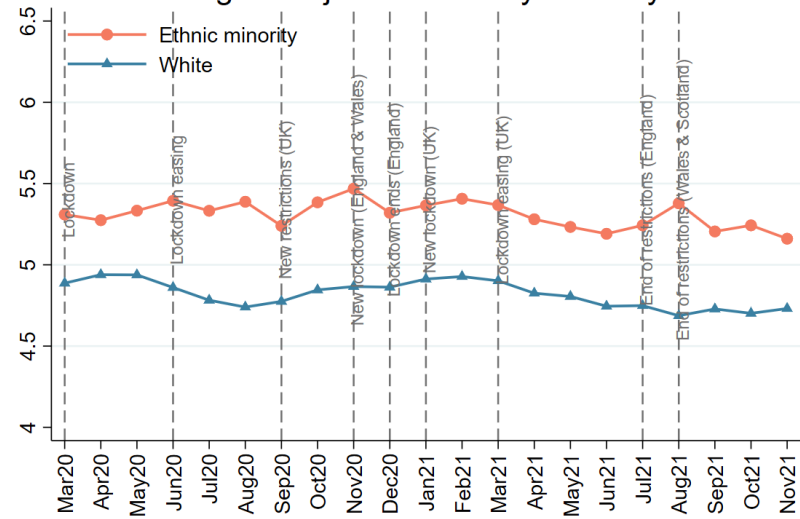
Figure 22k Loneliness by educational levels
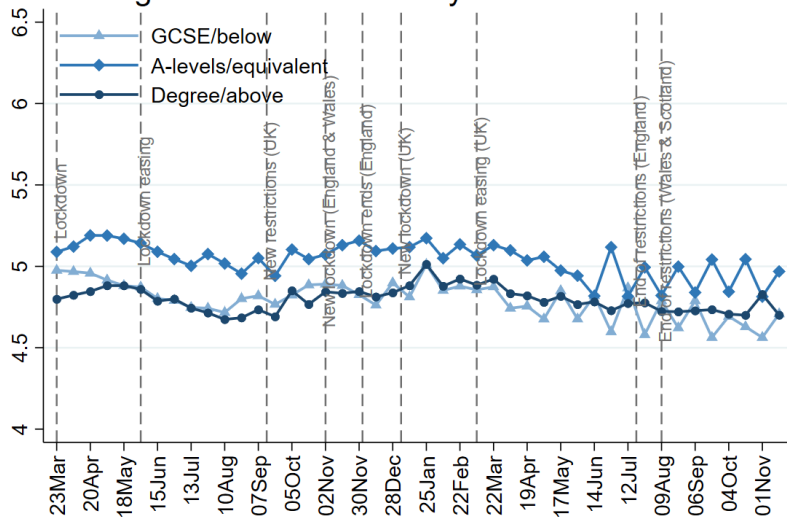
Figure 22l Loneliness by physical health diagnosis

4.3 Happiness
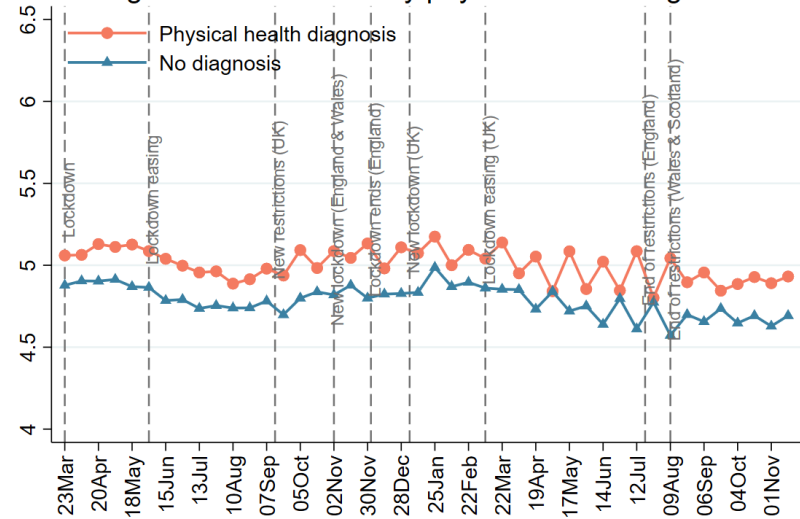
Figure 23 Happiness
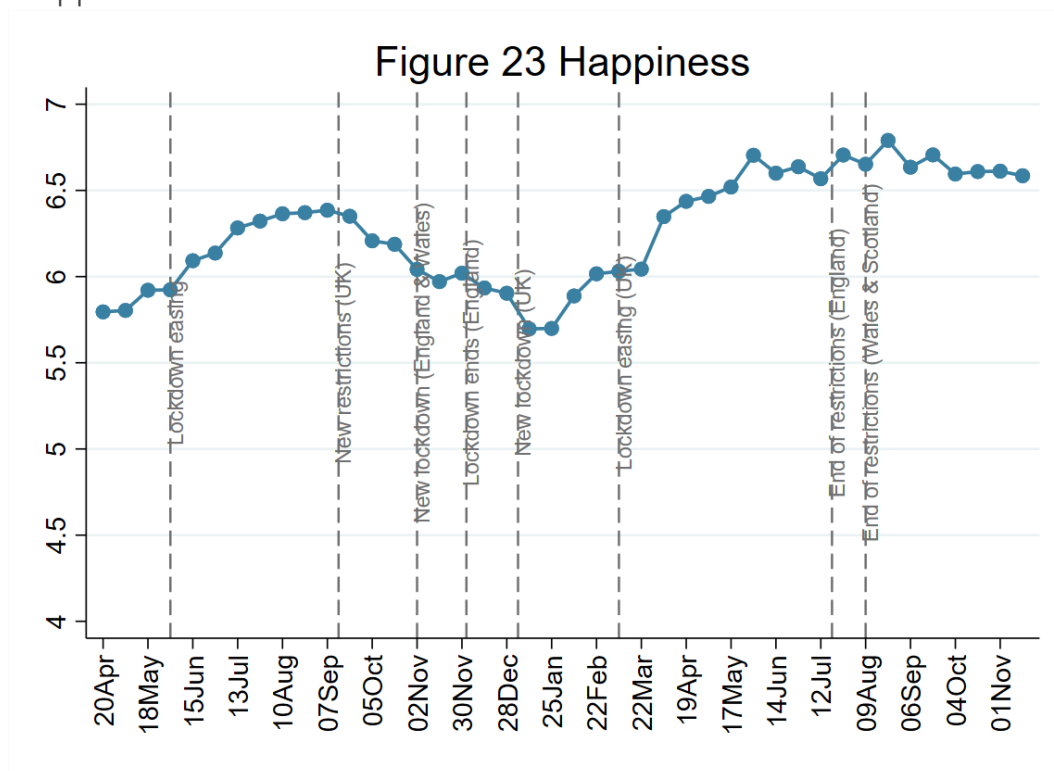
FINDINGS

Respondents were asked to rate to what extent they felt happy during the past week using the Office for National Statistics (ONS) wellbeing scale on a scale from 0 (not at all) to 10 (completely). Happiness ratings are only available from 21st April 2020 onwards.

Happiness levels generally increased from the end of March 2021 to the beginning of August but have since stabilised. Over the past several months, levels of happiness have been similar to what they were in early summer 2021.

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

Figure 24a Happiness by age groups
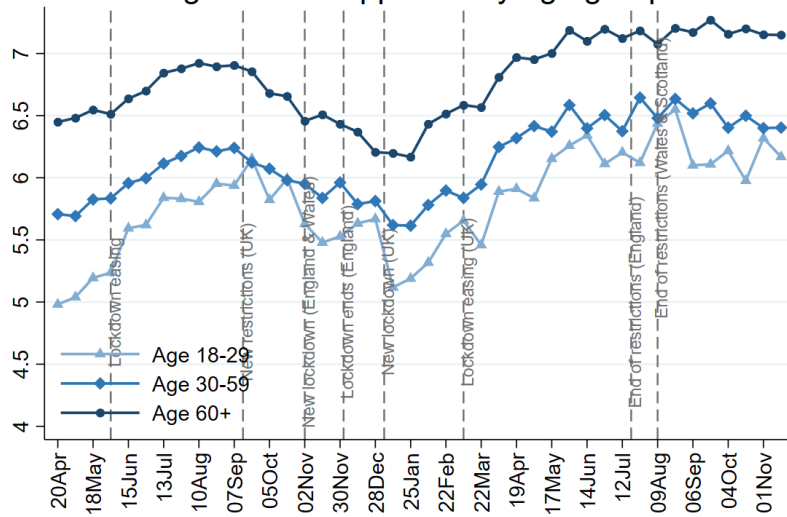
Figure 24b Happiness by living arrangement
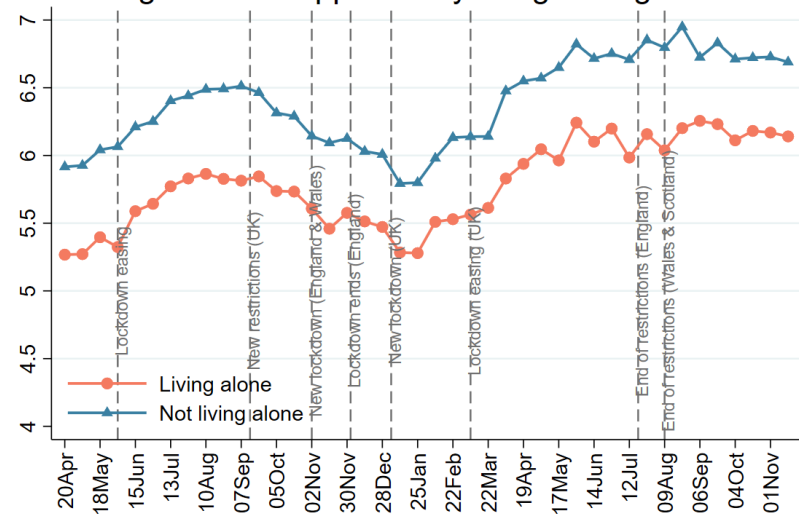
Figure 24c Happiness by household income
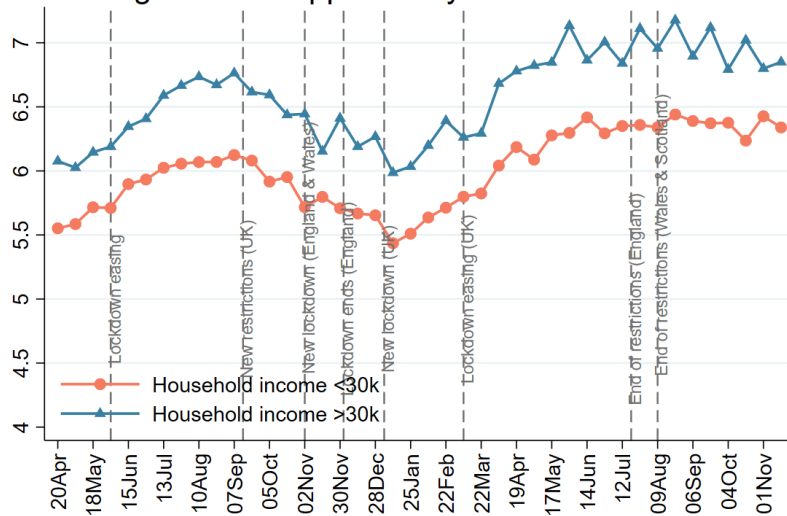
Figure 24d Happiness by mental health
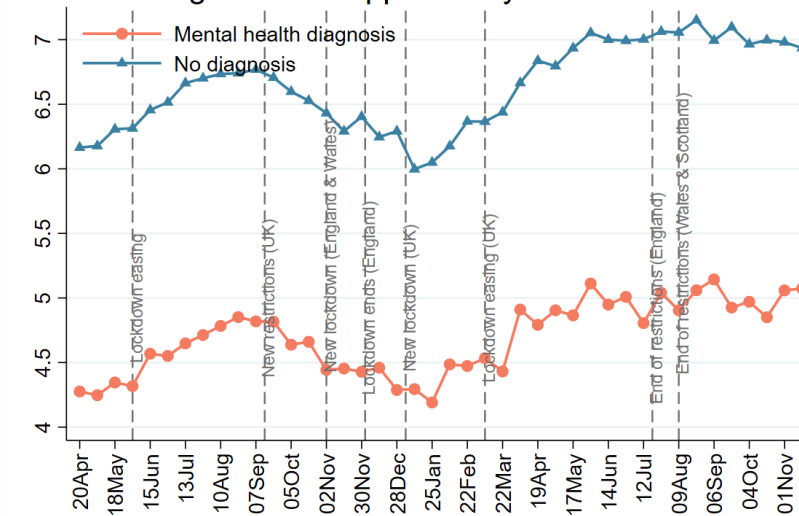
Figure 24e Happiness by nations
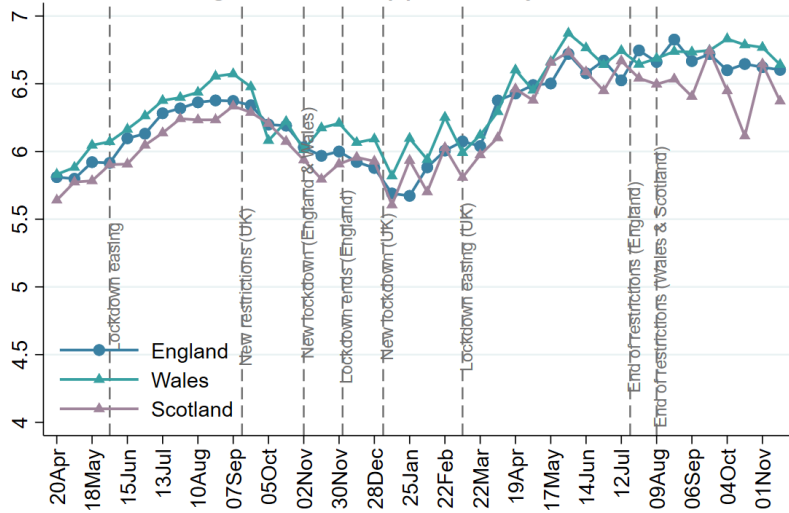
Figure 24f Happiness by keyworker status
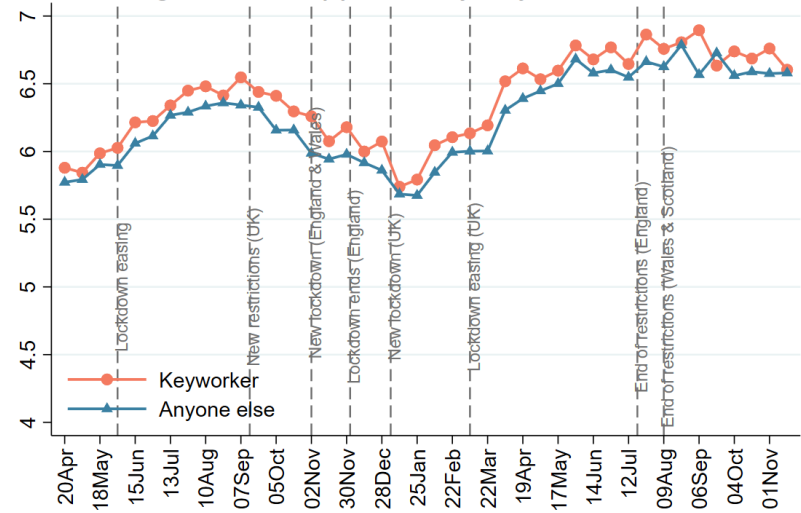
Figure 24g Happiness by living with children
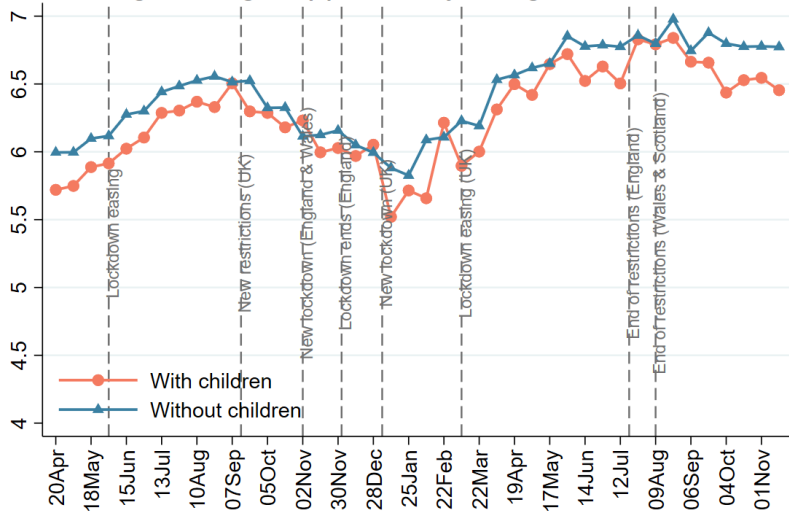
Figure 24h Happiness by living area
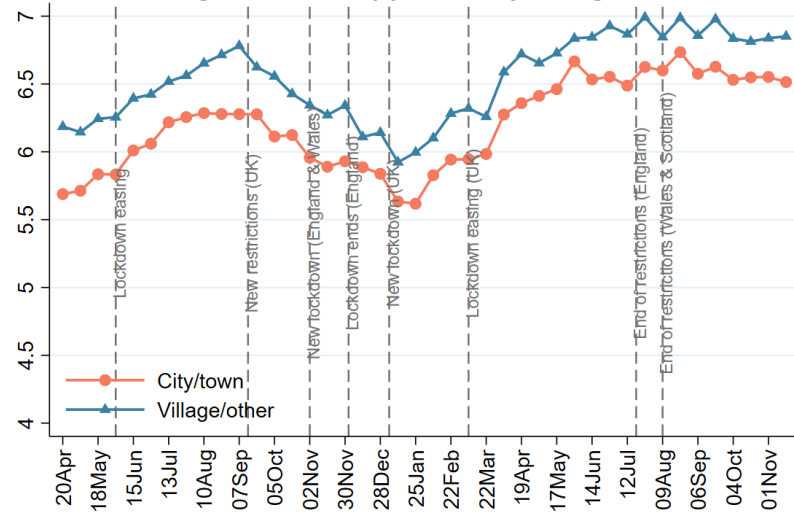
Figure 24i Happiness by gender
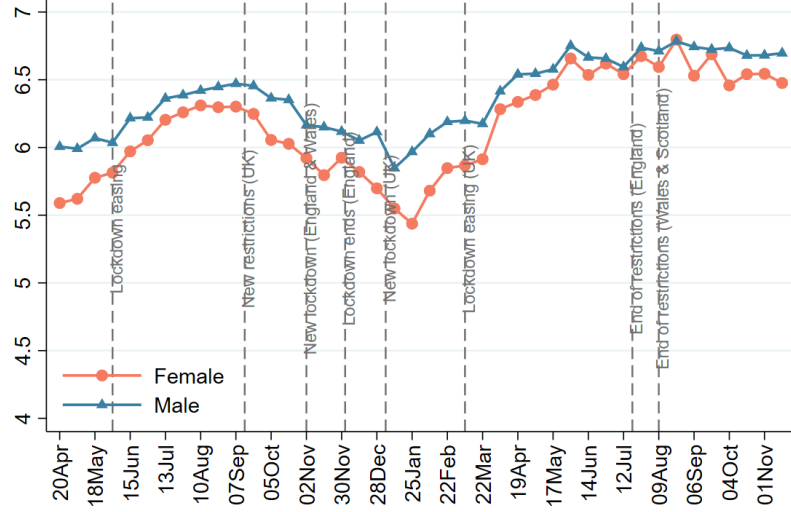
Figure 24j Happiness by ethnicity
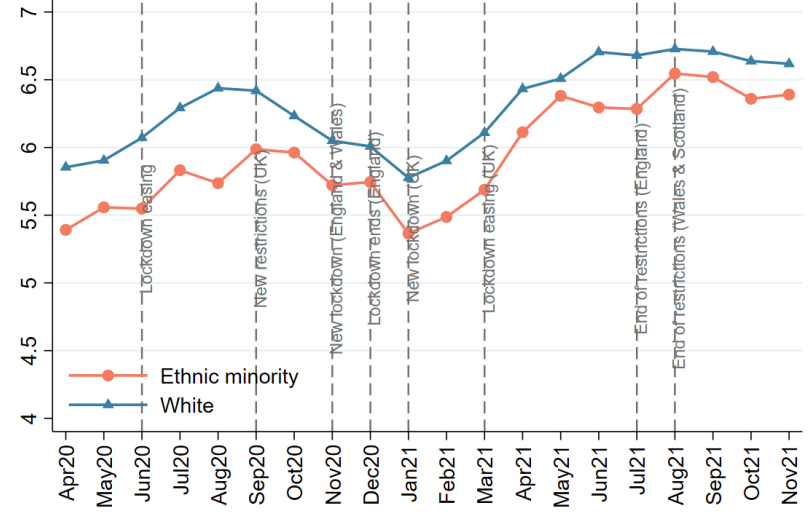
Figure 24k Happiness by educational levels
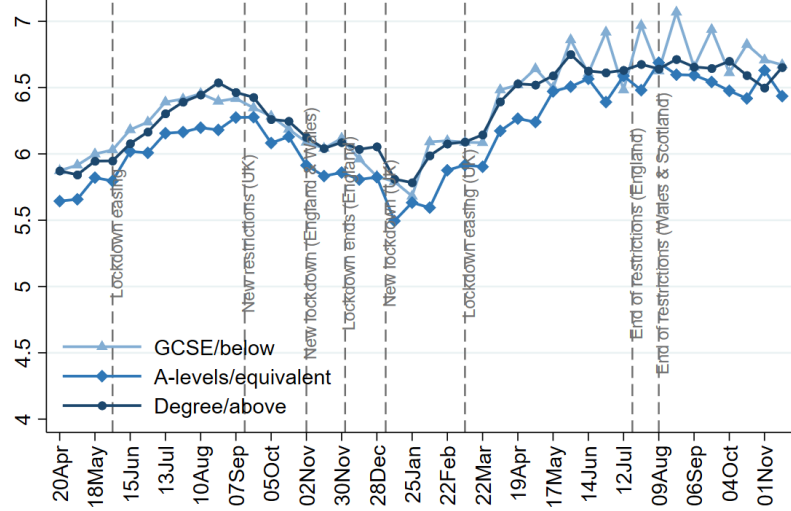
Figure 24l Happiness by physical health diagnosis
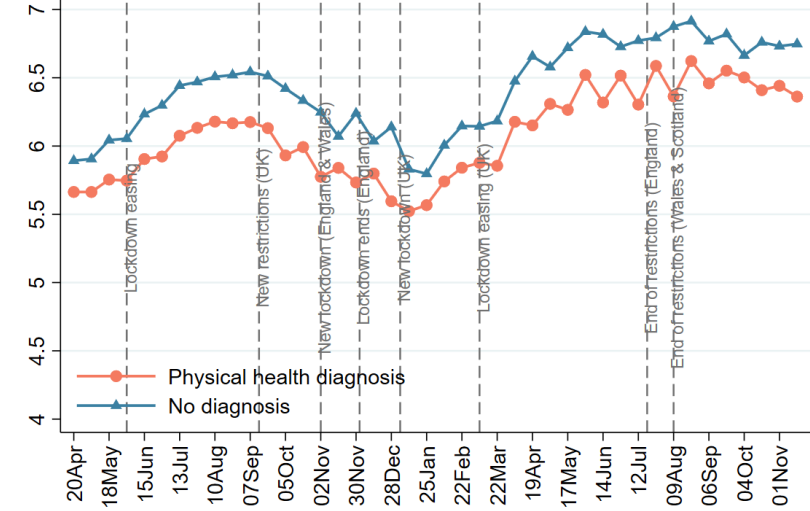
5. Life changes plan

5.1 Plans to make life changes

Figure 25 Plans to make life changes after Covid-19
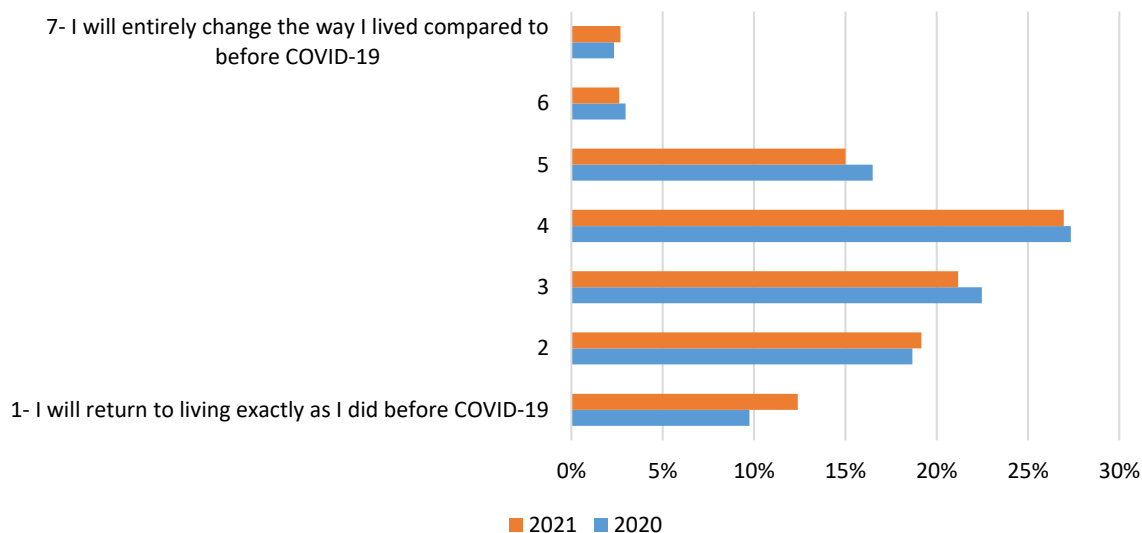
FINDINGS

In July 2020 and then again in November 2021, respondents were asked about the extent to which they feel they will change the way they live their lives once the pandemic is over compared to the way they were living before Covid-19. Respondents rated their feelings on a scale from 1 ("I will return to living exactly as I did before Covid-19") to 7 ("I will entirely change the way I lived compared to before Covid19").

Only 12% of people currently say that they will return to living exactly as they did before Covid-19, compared to 10% who said this in 2020. Just over half of people (53%) feel they are more likely on balance to return to how things were before (scores of 1-3) the pandemic, whilst 1 in 5 (20%) feel they are more likely to change things (scores of 5-7). 27% rated themselves in the middle. Differences in responses in 2020 vs 2021 were minimal.

When looking at subgroups for responses collected in 2021, adults aged 30-59 were most likely to report currently thinking that they will change their lives following the pandemic, with 24% saying they will on balance make changes compared to 17% of people aged 18-30 and aged 60+. 20% of people aged 60+ said they will return entirely to how they lived before, compared with just 5% of adults under 30.

People with a mental health diagnosis (23% vs 20% without a mental health diagnosis), people living alone (23% vs 20% living with others), people from ethnic minority groups (28% vs 19% from white backgrounds), and those living with children (24% vs 19% in those not living with children) were more likely to report that they would make changes to their lives after Covid-19.

People with lower household incomes were more likely to report that they would not make any changes to their lives (16% vs 8% in those with higher household incomes), as were people living alone (16% vs 11% not living alone).

Figure 26a Plans to make life changes by age groups
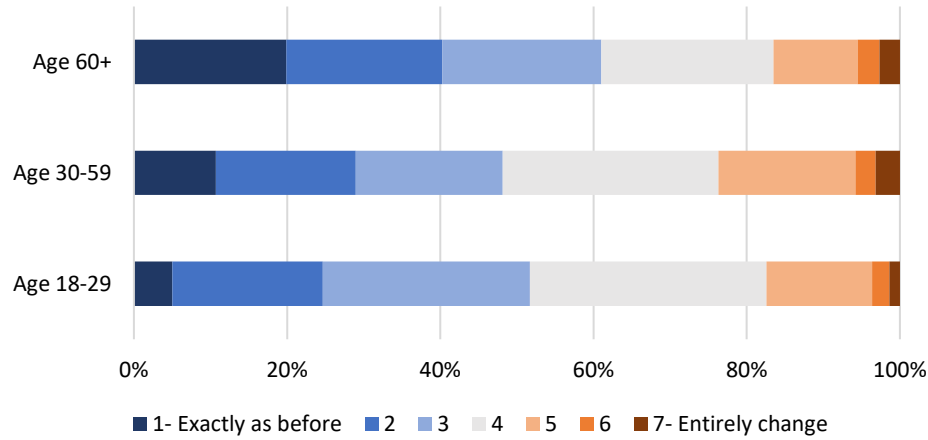
Figure 26b Plans to make life changes by living arrangement
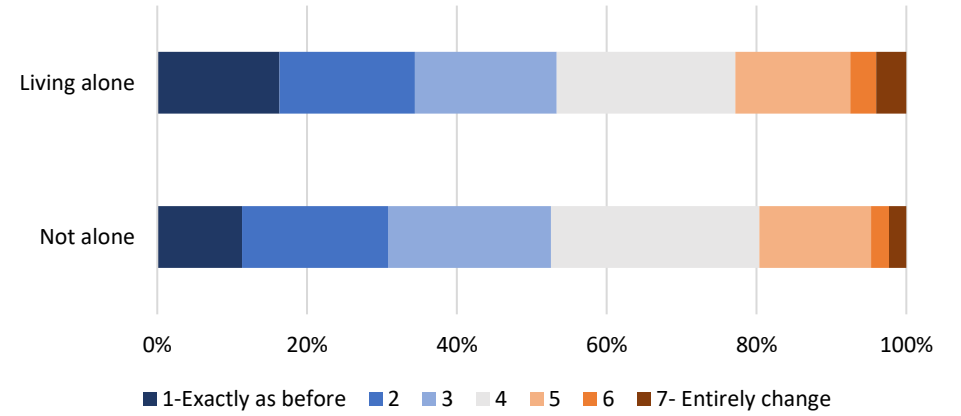
Figure 26c Plans to make life changes by household income
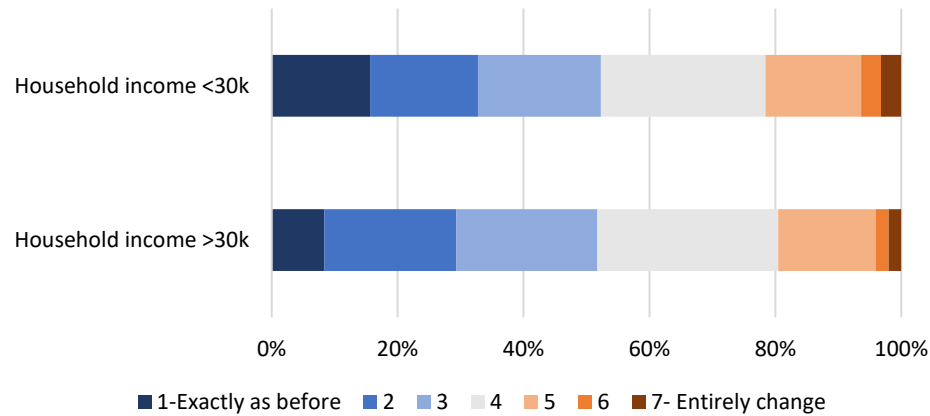
Figure 26d Plans to make life changes by mental health diagnosis
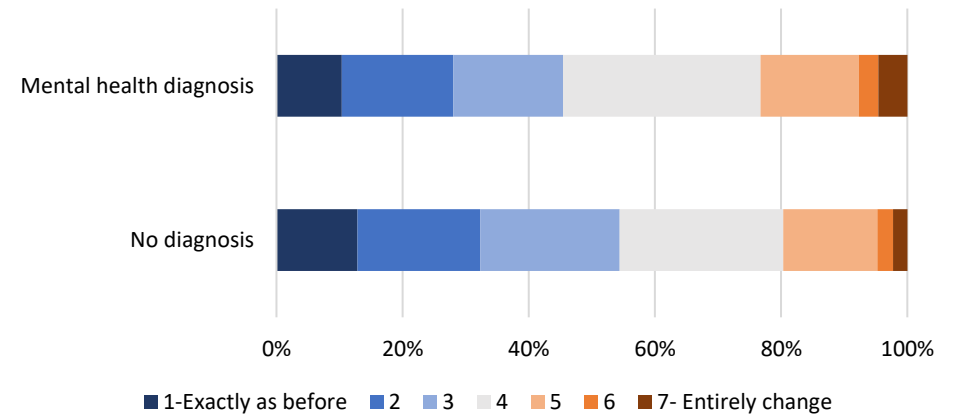
Figure 26e Plans to make life changes by ethnicity

Legend: 1-Exactly as before, 2, 3, 4, 5, 6, 7- Entirely change
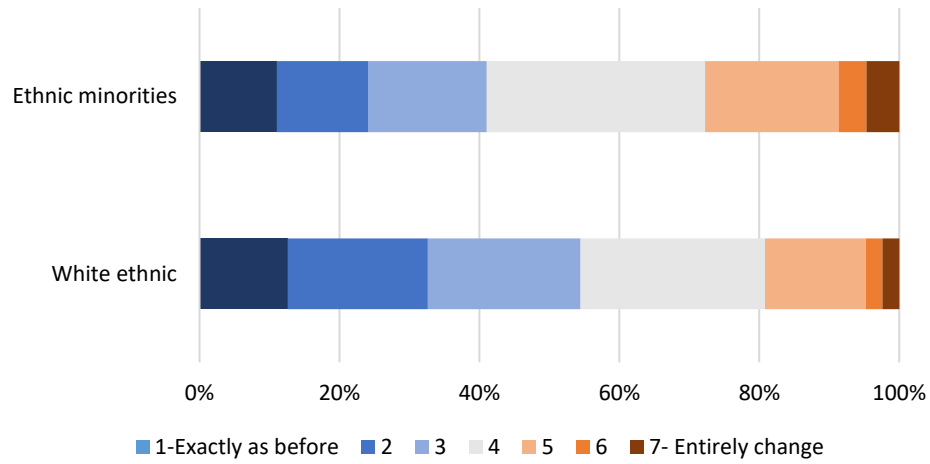
Figure 26f Plans to make life changes by keyworker status

Legend: 1-Exactly as before, 2, 3, 4, 5, 6, 7- Entirely change
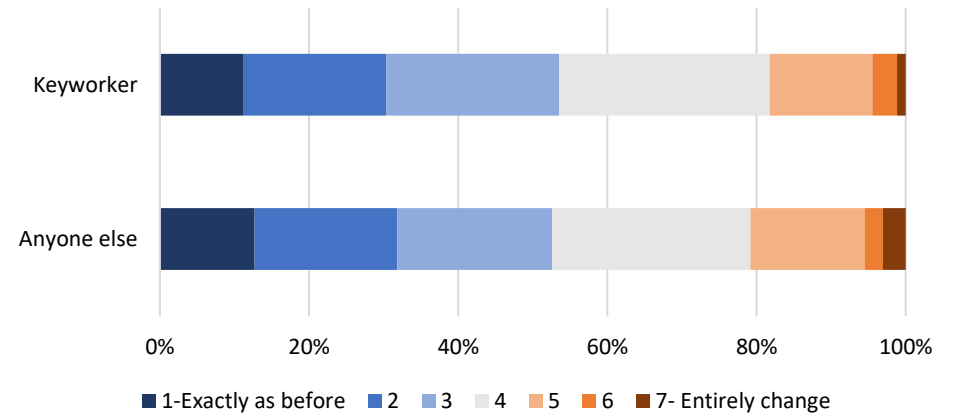
Figure 26g Plans to make life changes by living with children

Legend: 1-Exactly as before, 2, 3, 4, 5, 6, 7- Entirely change
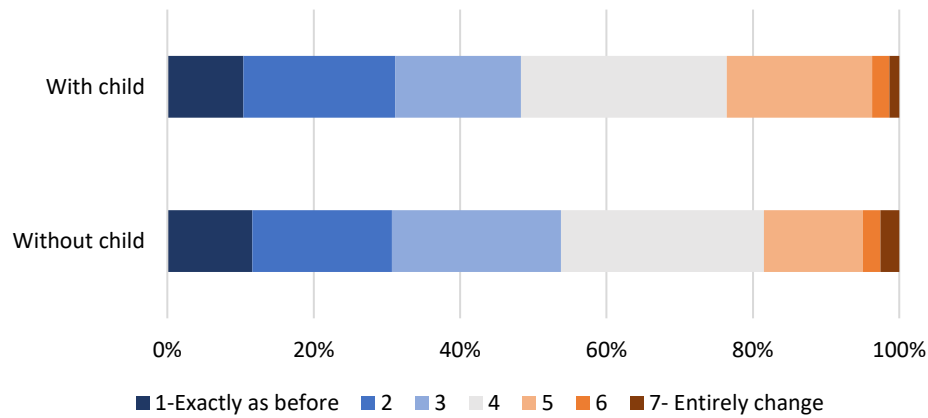
Figure 26h Plans to make life changes by living area

Legend: 1-Exactly as before, 2, 3, 4, 5, 6, 7- Entirely change
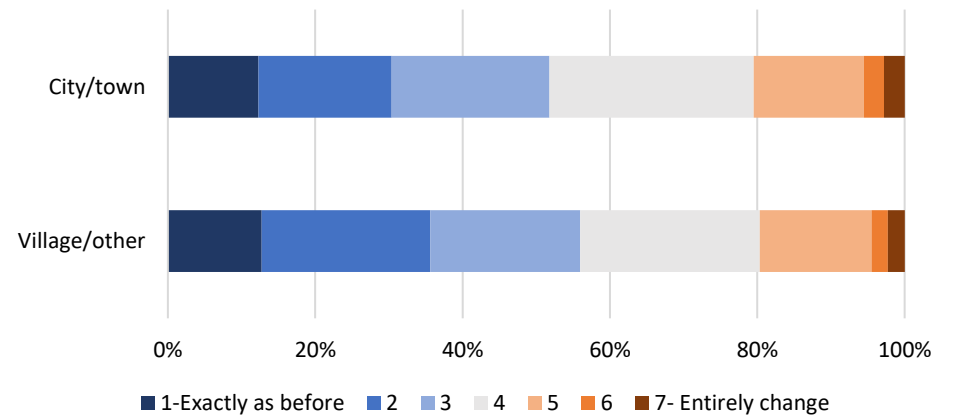
5.2 Specific planned changes after Covid-19

Figure 27 Specific planned changes after Covid-19
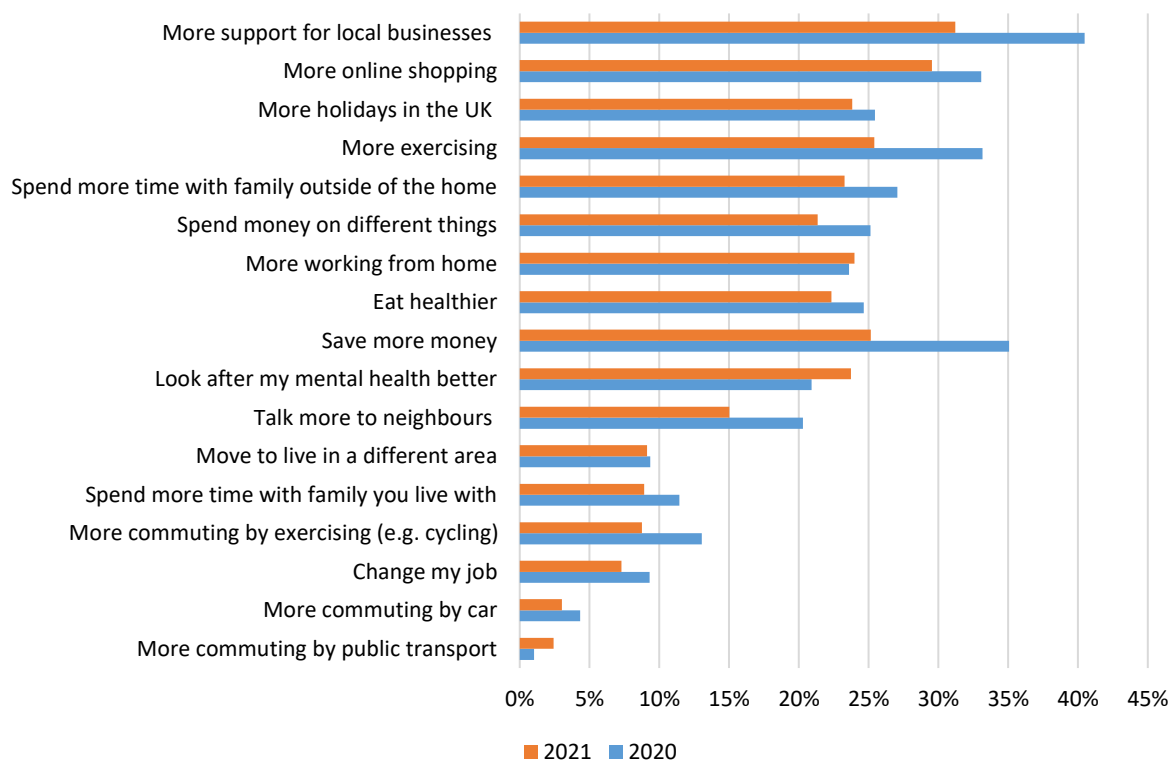
FINDINGS

In July 2020 and then again in November 2021, respondents were asked to select which things in their lives (from a list of 29) they felt they would change following the pandemic. In general, people have reported being less likely to make changes to most domains they were asked about, with the exceptions of plans to work from home (24% in 2021 and 2020), commuting by public transport more (2% in 2021 compared to 1% in 2020) and looking after their mental health (24% in 2021 compared to 21% in 2020).

Other changes people plan to make are more modest than in 2020. The factor that people reported they were most likely to change in 2020 and 2021 was increasing their support for local businesses, although this proportion fell from 40% to 31%. This was in the top 3 changes for all age groups (39% of 18–29-year-olds, 31% of 30–59-year-olds, and 27% of over 60s). Saving more money (25%), exercising more (25%), and making more use of online shopping (30%) were also high priorities for planned changes.

Saving more money was a higher priority amongst young adults (36%) than older adults (13%), whereas it was tied for 1st priority for 30–50-year-olds (28%) along with using more online shopping and working from home more often.

Slightly fewer people across all ages reported wanting to spend more time with family outside of their homes (23%) than in 2020 (27%), whereas more people said in 2021 (24%) than in 2020 (21%) that they would look after their mental health better. The latter was especially important to young adults (39% vs 25% of adults 30-59 and 12% of older adults).

Figure 28a Specific planned changes by age group

Age 60+ Age 30-59 Age 18-29
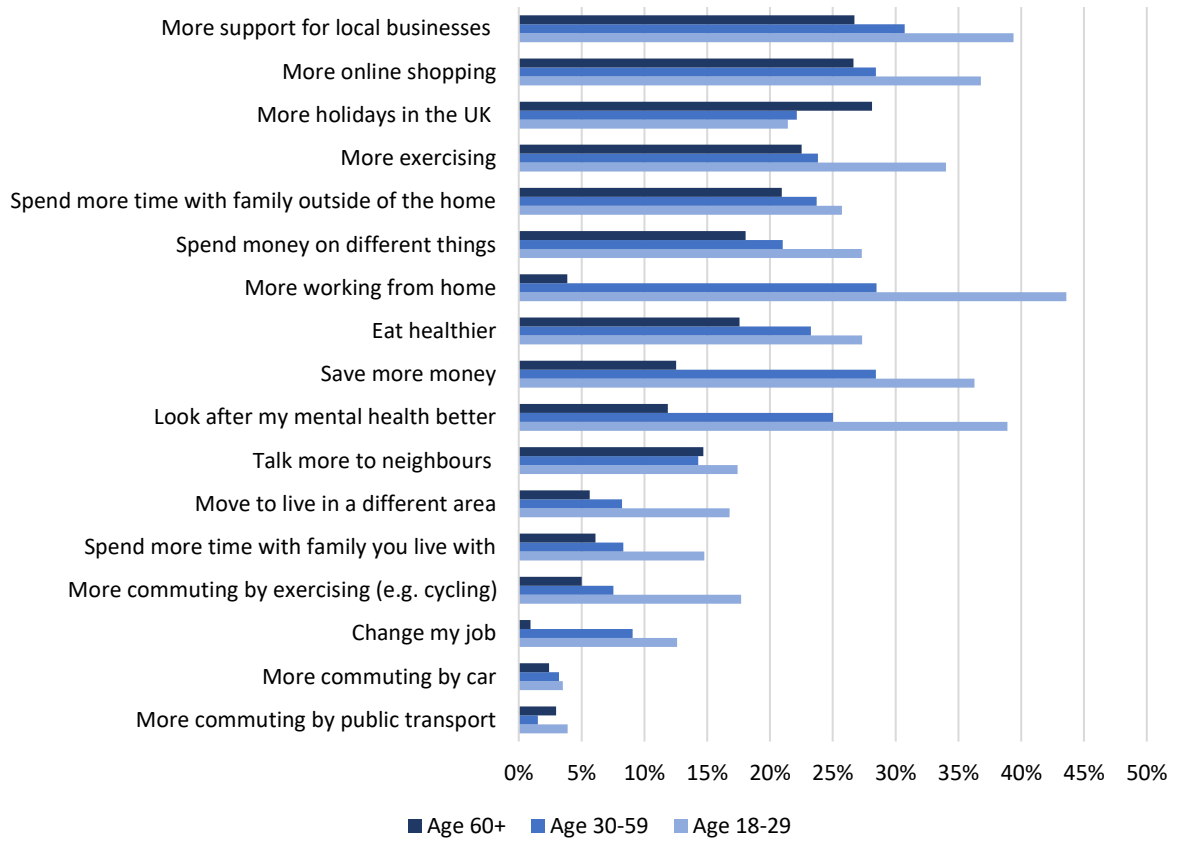
6. Covid-19 booster vaccine intentions

Figure 29 Likelihood of receiving a Covid-19 booster vaccine
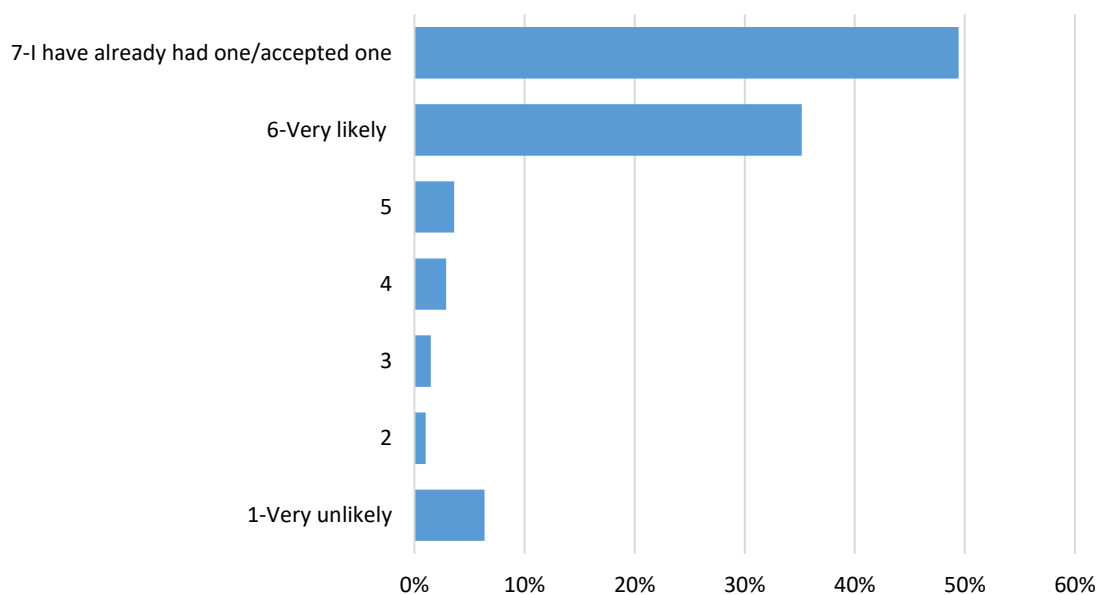
FINDINGS

Participants were asked, "We are interested in your thoughts on the booster vaccination. How likely to do you think you are to get a Covid-19 booster vaccine when offered?" Response options ranged from "1- very unlikely" to "6 – very likely" and "I have already had one/accepted one" in November 2021.

Nearly half of adults in our study (49%) said they had already received or accepted a Covid-19 booster vaccine. This is ahead of national figures (36% at the time of writing), but our data include people who have accepted a booster but not yet had it. The proportion of people who had already received a booster dose decreased with age, as expected. People living alone (56% vs 48% living with others), those without a mental health diagnosis (52% vs 41% of people with a mental health diagnosis), men (53% vs 46% of women), and people with a physical health condition (64% vs 39% of those without a physical health condition) were more likely to have already received a Covid-19 booster vaccine.

Although booster vaccine intentions were mostly favourable (39% of respondents said they were willing (scores of 5-6 on a scale of 1-6) to accept a vaccine when offered it), 5% were hesitant about receiving a Covid-19 booster vaccine (scores of 3-4) and 7% said they were unwilling (scores of 1-2).

Booster unwillingness (scores of 1-2) was reported amongst 12% of young adults compared to 8% of adults aged 30-59 and 3% of adults aged 60+. Unwillingness was twice as high in people with lower household incomes (10%) compared to those with higher household incomes (5%), and in people with education levels up to a GCSE (10%) compared to those with a degree or higher (5%).

Booster hesitancy (scores of 3-4 on a scale 1-6) was more common amongst people living with children (7% vs 3% in those not living with children), people in good physical health (6% vs 3% of people with a physical health diagnosis), and in young adults (10% vs 5% ages 30-59 and 2% ages 60+).

Figure 30a Covid-19 booster vaccine intent by age group

Legend: 1-Very unlikely | 2 | 3 | 4 | 5 | 6-Very likely | 7-I have already had one/accepted one
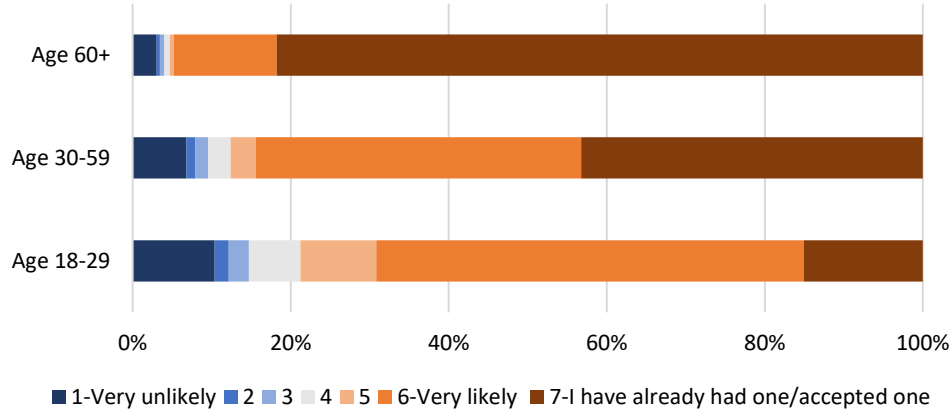
Figure 30b Covid-19 booster vaccine intent by living arrangement

Legend: 1-Very unlikely | 2 | 3 | 4 | 5 | 6-Very likely | 7-I have already had one/accepted one
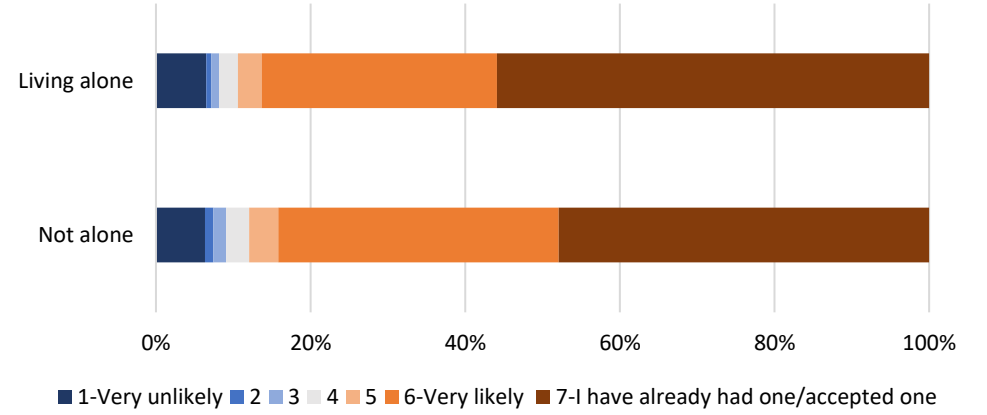
Figure 30c Covid-19 booster vaccine intent by household income

Legend: 1-Very unlikely | 2 | 3 | 4 | 5 | 6-Very likely | 7-I have already had one/accepted one
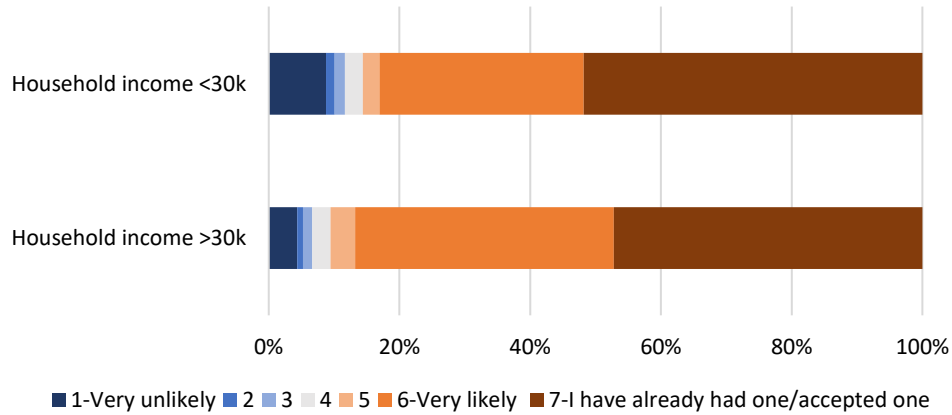
Figure 30d Covid-19 booster vaccine intent by mental health diagnosis

Legend: 1-Very unlikely | 2 | 3 | 4 | 5 | 6-Very likely | 7-I have already had one/accepted one
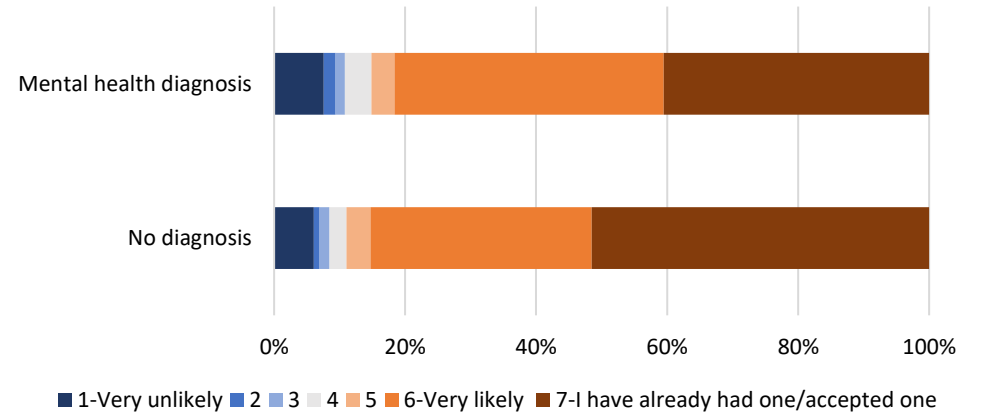
Figure 30e Covid-19 booster vaccine intent by nation

Legend: 1-Very unlikely, 2, 3, 4, 5, 6-Very likely, 7-I have already had one/accepted one
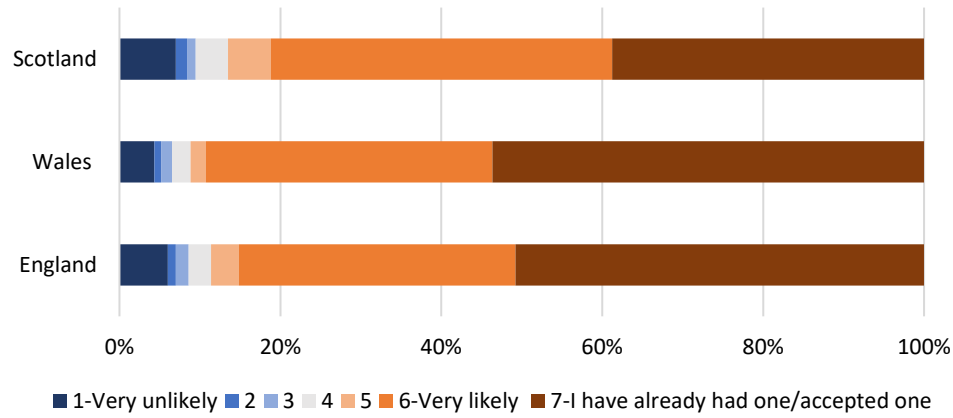
Figure 30f Covid-19 booster vaccine intent by keyworker status

Legend: 1-Very unlikely, 2, 3, 4, 5, 6-Very likely, 7-I have already had one/accepted one
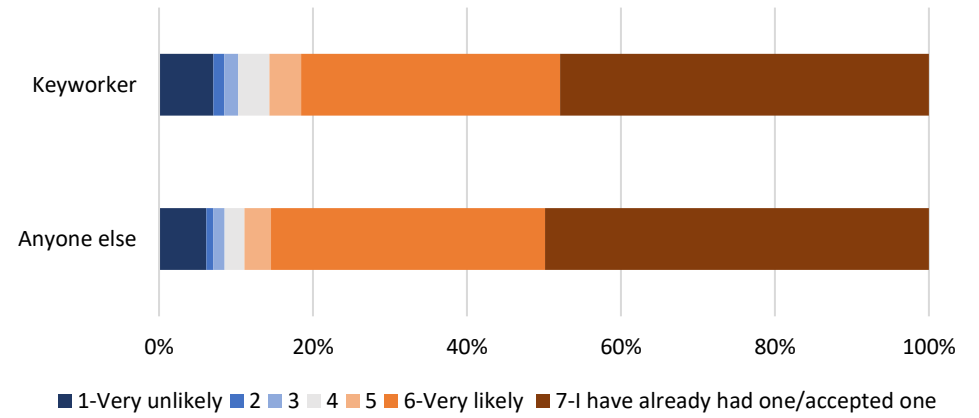
Figure 30g Covid-19 booster vaccine intent by living with children

Legend: 1-Very unlikely, 2, 3, 4, 5, 6-Very likely, 7-I have already had one/accepted one
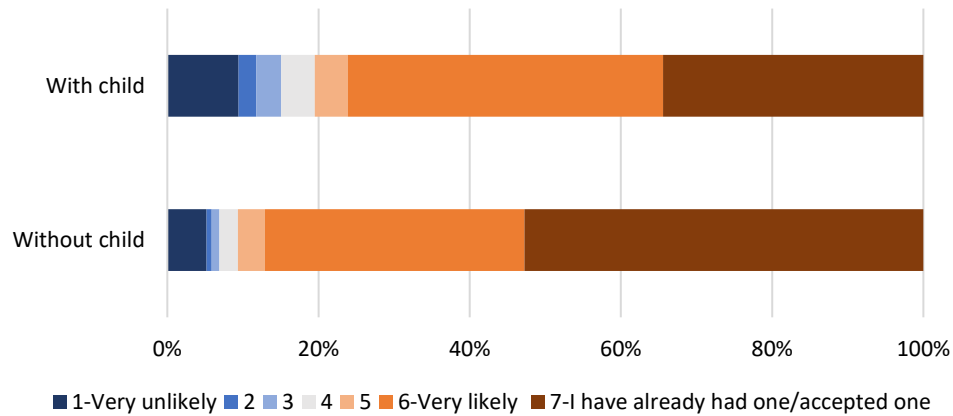
Figure 30h Covid-19 booster vaccine intent by living area

Legend: 1-Very unlikely, 2, 3, 4, 5, 6-Very likely, 7-I have already had one/accepted one
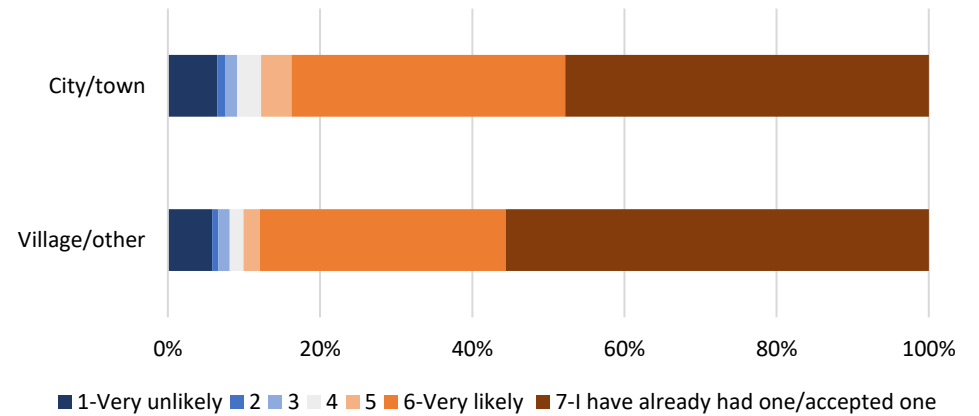
Figure 30i Covid-19 booster vaccine intent by gender

Legend: ■ 1-Very unlikely ■ 2 ■ 3 ■ 4 ■ 5 ■ 6-Very likely ■ 7-I have already had one/accepted one
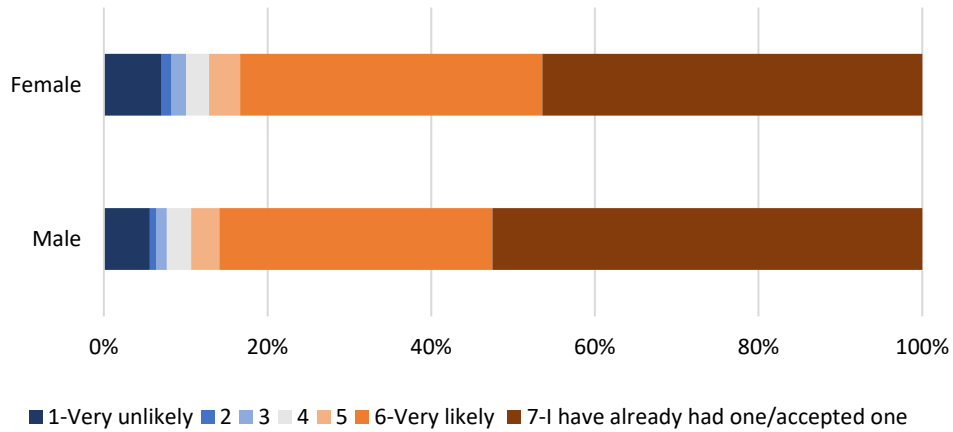
Figure 30j Covid-19 booster vaccine intent by ethnicity

Legend: ■ 1-Very unlikely ■ 2 ■ 3 ■ 4 ■ 5 ■ 6-Very likely ■ 7-I have already had one/accepted one
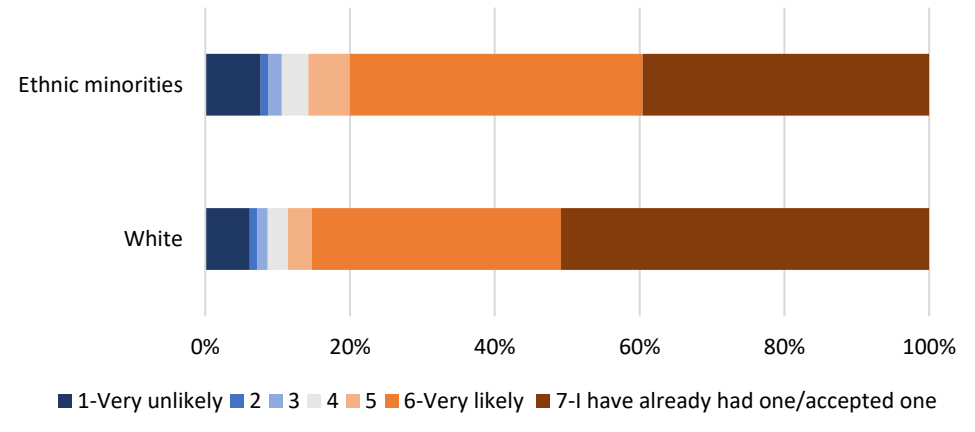
Figure 30k Covid-19 booster vaccine intent by educational level

Legend: ■ 1-Very unlikely ■ 2 ■ 3 ■ 4 ■ 5 ■ 6-Very likely ■ 7-I have already had one/accepted one
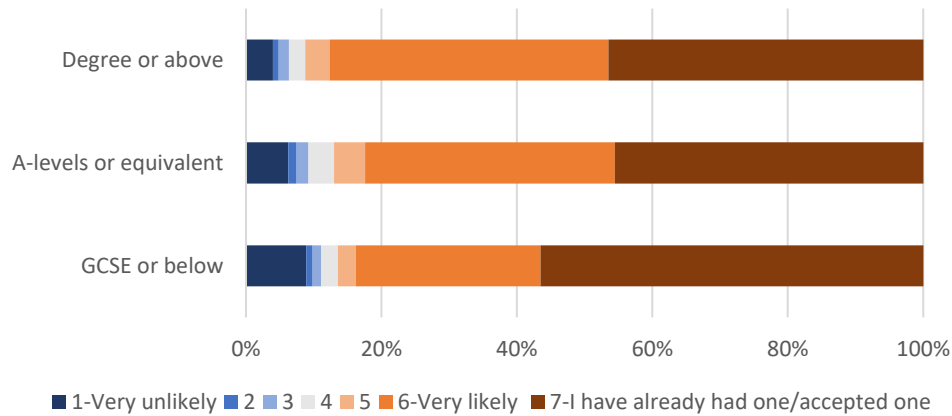
Figure 30l Covid-19 booster vaccine intent by physical health diagnosis

Legend: ■ 1-Very unlikely ■ 2 ■ 3 ■ 4 ■ 5 ■ 6-Very likely ■ 7-I have already had one/accepted one
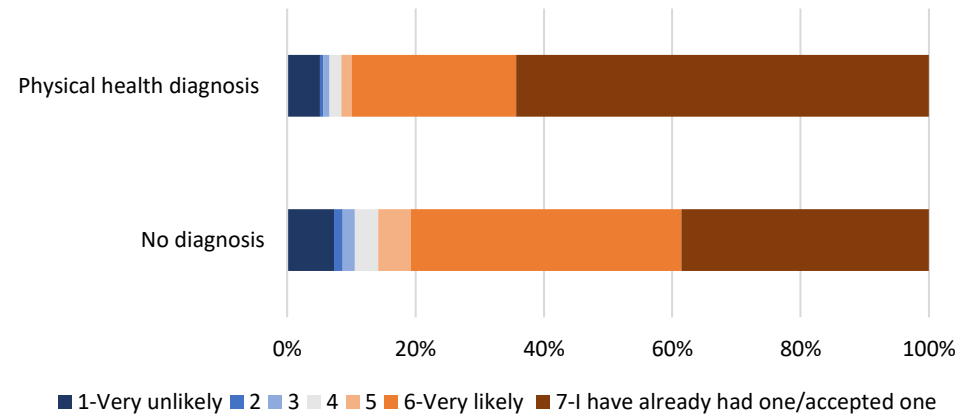
Appendix

Methods

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

Specifically, in the analyses presented here we included adults in the UK. We used new cross-sectional data from individuals as they entered the study and also included weekly longitudinal data as participants received their routine follow-up. In this report, we treated the data as repeated cross-sectional data collected daily from the 21st of March 2020 to the 28th of November 2021 (the latest data available). Aiming at a representative sample of the population, we weighted the data for each day to the proportions of gender, age, ethnicity, education and country of living obtained from the Office for National Statistics (ONS, 2018). Where results for subgroups show volatility, this could be a product of the sample size being smaller so caution in interpreting these results is encouraged.

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

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

Demographics of respondents included in this report

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

	Number of observations	%		Number of observations	%
Age			**Education levels**		
18-29	60,935	5.39	**GCSE or below**	160,210	14.2
30-59	610,351	54.0	**A-levels of equivalent**	194,851	17.3
60+	458,405	40.6	**Degree or above**	774,630	68.6
Gender			**Any diagnosed mental health conditions**		
Male	284,801	25.3	**No**	944,037	83.6
Female	840,433	74.7	**Yes**	185,654	16.4
Ethnicity			**Any diagnosed physical health conditions**		
White	1,082,773	96.2	**No**	645,538	57.1
Ethnic minority	43,371	3.85	**Yes**	484,153	42.9
UK nations			**Keyworker**		
England	910,340	81.4	**No**	897,376	79.4
Wales	139,277	12.5	**Yes**	232,315	20.6
Scotland	69,163	6.18	**Living with children**		
Living arrangement			**No (excluding those who live alone)**	645,904	72.7
Not living alone	888,225	78.6	**Yes**	242,321	27.3
Living alone	241,466	21.4	**Living area**		
Annual household income			**Village/hamlet/isolated dwelling**	285,829	25.3
>30k	601,575	59.2	**City/large town/small town**	843,862	74.7
<30k	414,956	40.8			

Peer reviewed publications

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

Bu, F., Bone, J. K., Mitchell, J. J., Steptoe, A., & Fancourt, D. (2021). Longitudinal changes in physical activity during and after the first national lockdown due to the COVID-19 pandemic in England. *Scientific Reports*, *11*(1), 17723. https://doi.org/10.1038/s41598-021-97065-1

Bu, F., Mak, H. W., & Fancourt, D. (2021). Rates and predictors of uptake of mental health support during the COVID-19 pandemic: An analysis of 26,720 adults in the UK in lockdown. *Social Psychiatry and Psychiatric Epidemiology*. https://doi.org/10.1007/s00127-021-02105-w

Bu, F., Steptoe, A., & Fancourt, D. (2020). Who is lonely in lockdown? Cross-cohort analyses of predictors of loneliness before and during the COVID-19 pandemic. *Public Health*, *186*, 31–34. https://doi.org/10.1016/j.puhe.2020.06.036

Bu, F., Steptoe, A., Mak, H. W., & Fancourt, D. (2021). Time use and mental health in UK adults during an 11-week COVID-19 lockdown: A panel analysis. *The British Journal of Psychiatry*, 1–6. https://doi.org/10.1192/bjp.2021.44

Fancourt, D., Steptoe, A., & Bu, F. (2021). Trajectories of anxiety and depressive symptoms during enforced isolation due to COVID-19 in England: A longitudinal observational study. *The Lancet Psychiatry*, *8*(2), 141–149. https://doi.org/10.1016/S2215-0366(20)30482-X

Fancourt, D., Steptoe, A., & Wright, L. (2020). The Cummings effect: Politics, trust, and behaviours during the COVID-19 pandemic. *The Lancet*, *396*(10249), 464–465. https://doi.org/10.1016/S0140-6736(20)31690-1

Fluharty, M., Bu, F., Steptoe, A., & Fancourt, D. (2021). Coping strategies and mental health trajectories during the first 21 weeks of COVID-19 lockdown in the United Kingdom. *Social Science & Medicine*, *279*, 113958. https://doi.org/10.1016/j.socscimed.2021.113958

Garnett, C., Jackson, S., Oldham, M., Brown, J., Steptoe, A., & Fancourt, D. (2021). Factors associated with drinking behaviour during COVID-19 social distancing and lockdown among adults in the UK. *Drug and Alcohol Dependence*, *219*, 108461. https://doi.org/10.1016/j.drugalcdep.2020.108461

Iob, E., Frank, P., Steptoe, A., & Fancourt, D. (2020). Levels of severity of depressive symptoms among at-risk groups in the UK during the COVID-19 pandemic. *JAMA Network Open*, *3*(10), e2026064–e2026064. https://doi.org/10.1001/jamanetworkopen.2020.26064

Mak, H. W., Fluharty, M., & Fancourt, D. (2021). Predictors and impact of arts engagement during the COVID-19 pandemic: Analyses of data from 19,384 adults in the COVID-19 Social Study. *Frontiers in Psychology*, *12*, 1335. https://doi.org/10.3389/fpsyg.2021.626263

Wright, L., Steptoe, A., & Fancourt, D. (2020). Are we all in this together? Longitudinal assessment of cumulative adversities by socioeconomic position in the first 3 weeks of lockdown in the UK. *Journal of Epidemiology and Community Health, 74*(9), 683–688. https://doi.org/10.1136/jech-2020-214475

Wright, L., Steptoe, A., & Fancourt, D. (2021a). Predictors of self-reported adherence to COVID-19 guidelines. A longitudinal observational study of 51,600 UK adults. *The Lancet Regional Health - Europe*, *4*, 100061. https://doi.org/10.1016/j.lanepe.2021.100061

Wright, L., Steptoe, A., & Fancourt, D. (2021b). Does thinking make it so? Differential associations between adversity worries and experiences and mental health during the COVID-19 pandemic. *Journal of Epidemiology and Community Health*, *75*(9), 817–823. https://doi.org/10.1136/jech-2020-215598