Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown: longitudinal analyses of the UK Household Longitudinal Study

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ABSTRACT
Background There are concerns that COVID-19 mitigation measures, including the ‘lockdown’, may have unintended health consequences. We examined trends in mental health and health behaviours in the UK before and during the initial phase of the COVID-19 lockdown and differences across population subgroups.

Methods Repeated cross-sectional and longitudinal analysis of the UK Household Longitudinal Study, including representative samples of over 27,000 adults (aged 18+) interviewed in four survey waves between 2015 and 2020. A total of 9748 adults had complete data for longitudinal analyses. Outcomes included psychological distress (General Health Questionnaire-12), loneliness, current cigarette smoking, use of e-cigarettes and alcohol consumption. Cross-sectional prevalence estimates were calculated and multilevel Poisson regression assessed associations between time period and the outcomes of interest, as well as differential associations by age, gender, education level and ethnicity.

Results Psychological distress increased 1 month into lockdown with the prevalence rising from 19.4% (95% CI 18.7% to 20.1%) in 2017–2019 to 30.6% (95% CI 29.1% to 32.3%) in April 2020 (RR=1.3, 95% CI 1.2 to 1.4). Groups most adversely affected included women, young adults, people from an Asian background and those who were degree educated. Loneliness remained stable overall (RR=0.9, 95% CI 0.6 to 1.5). Smoking declined (RR=0.9, 95% CI=0.8,1.0) and the proportion of people drinking four or more times per week increased (RR=1.4, 95% CI 1.3 to 1.5), as did binge drinking (RR=1.5, 95% CI 1.3 to 1.7).

Conclusions Psychological distress increased 1 month into lockdown, particularly among women and young adults. Smoking declined, but adverse alcohol use generally increased. Effective measures are required to mitigate negative impacts on health.

INTRODUCTION
The coronavirus disease 2019 (COVID-19) pandemic has led to large-scale societal changes in many countries. Governments have introduced substantial restrictions to people’s movement, including limiting the potential to attend work and school, or see friends and family.1–2 Such ‘lockdown’ measures could have large impacts on health and health inequalities.3–4 While some impacts could arise from reduced access to healthcare during lockdown,2 lockdown measures themselves could have direct consequences on mental health and health-related behaviours.

Research prior to the pandemic has suggested quarantine is linked to several negative psychological outcomes.6 During the COVID-19 pandemic, concerns have been repeatedly raised about potentially long-lasting harms to mental health.7 Similarly, health-related behaviours such as alcohol consumption and smoking could be subject to rapid change in either direction. Increased stress during lockdown could increase consumption,8,9 while greater awareness of health risks, reduced availability and socialising could reduce consumption.

The UK Government introduced strict physical distancing measures, or ‘lockdown’ on the 23 March 2020, with other mitigation measures being introduced throughout March (online appendix S1).10 This restricted the general population to staying at home, unless required to leave for the purposes of carrying out an essential job (referred to as a ‘keyworker’, such as transport, education, food and health and social care workers), to buy necessary items or to take exercise.

Understanding the impact of lockdown is important as further periods of physical distancing are likely to be necessary in many countries for some time, especially as the possibility of further waves of infection remain. These impacts may disproportionately affect specific population subgroups, with concerns that young people, women and disadvantaged socioeconomic groups may be at greater risk.

We investigated the impact of the UK’s COVID-19 lockdown on mental health and health behaviours, as well as whether any observed impacts differed by age, gender, ethnicity and education level.

METHODS
Data source The UK Household Longitudinal Study (also referred to as ‘Understanding Society’) is a nationally representative longitudinal household panel study, based on a clustered-stratified probability sample of UK households, described in detail previously.11 All adults (aged 16+ years) in chosen households are invited to participate. Data
collection for each ‘wave’ usually spans 24 months, with participants re-interviewed annually by online, face-to-face or telephone survey. We used pre-pandemic data from wave 7 (2015–2017), wave 8 (2016–2018) and wave 9 (2017–2019), with household response rates of 81–84%. Following the pandemic’s onset, an additional wave of data was collected via online survey between 24th and 30th April 2020 (referred to as the COVID-19 wave A henceforth the ‘CA wave’). The response rate for the CA wave was 48.6% of those who took part in wave 9. We analysed data from all adults aged 18+ years who participated in each wave for repeated cross-sectional analysis (excluding proxy interviews). When analysing educational inequalities we restricted analyses to adults aged 25+ years as educational attainment tends to be stable from that age onwards. For longitudinal analysis, we included participants with complete data from all four waves and aged 18+ years during wave 9.

The University of Essex Ethics Committee has approved all data collection for the Understanding Society main study and COVID wave. No additional ethical approval was necessary for this secondary data analysis.

Outcomes
Mental health was assessed at all four waves using the General Health Questionnaire-12 (GHQ-12), which is a screening tool for psychological distress that has been validated for use in epidemiological studies. Respondents scoring 4 or more (out of a possible total of 12) are likely to be experiencing anxiety and/or depression. To better understand the driving symptoms of any change in psychological distress we also considered each individual GHQ item in subsidiary analyses, investigating trends in the proportion of respondents who selected the two most adverse response categories for each question. We also conducted sensitivity analyses with the item on enjoyment of day-to-day activities removed (since this could be affected by lockdown restrictions without necessarily indicating poor mental health), and with the cut-off point reduced to 3 or more symptoms, as a way of examining increases in less severe psychological distress and to enable comparison with other studies using this definition. Loneliness was assessed at wave 9 and the CA wave by asking participants: ‘in the last 4 weeks, how often did you feel lonely?’ and respondents were able to answer hardly ever or never, some of the time, or often. In the statistical models, this was converted to a binary variable (often felt lonely vs all other responses).

We also assessed three health behaviour outcomes: cigarette smoking, e-cigarette use and alcohol consumption. Participants were asked ‘do you smoke cigarettes? Please do not include electronic cigarettes (e-cigarettes)’ and those who answered ‘yes’ were then asked, ‘approximately how many cigarettes a day do you usually smoke, including those you roll yourself?’. We defined cigarette smoking (excluding e-cigarettes) as current smoker versus non-smoker and the number of cigarettes per day was calculated (<10, 10–19, 20+ cigarettes per day) for subsidiary analyses. Current e-cigarette use was defined on the basis of having used e-cigarettes at least once a week (waves 8, 9 and CA wave). Information about alcohol consumption was collected (waves 7, 9 and CA wave) using the Alcohol Use Disorders Identification Test for Consumption (AUDIT-C) instrument. However, the CA wave contained some modifications including asking about drinking behaviour over the last 4 weeks, rather than the last year. We therefore looked at three key outcomes: binge drinking (6+ drinks in a single sitting on a weekly basis), frequency of alcohol consumption (4+ times per week) and heavy drinking (5+ drinks on a typical day when drinking).

Covariates
We adjusted for a range of potential confounders that were likely causes of the outcomes and that did not lie on the causal pathway between lockdown and the outcomes: age group (18–24, 25–44, 45–64, 65+ years at wave 9) and self-reported gender (male/female). Highest education level was coded as: degree-level or equivalent qualifications, A-level/AS-level or equivalent, General Certificate of Secondary Education (GCSE) or equivalent, and no qualifications. Race/ethnicity was categorised as: white, Asian, black, mixed and other, but recoded to binary (white and non-white) for the statistical models due to small numbers within specific ethnic minority groups. Interview year as a continuous variable accounted for temporal trends.

Statistical analysis
Prevalence estimates (with 95% CIs) for each outcome were calculated in repeated cross-sectional analyses using all complete sets of responses from waves 7 to 9 and the CA wave. Cross-sectional inverse probability weights provided with the data were used to adjust for attrition and to create estimates that were representative of the general population over time (see online appendix 1 for details of the weights). This was supplemented with additional weighting for differences in outcome non-response by age, gender, ethnicity and education. We repeated cross-sectional analyses stratified by gender, age group, ethnicity and education level.

We then restricted our sample to individuals with repeated measures for all relevant waves for longitudinal analysis (n=9748). We conducted multi-level Poisson regression with robust SEs, to assess associations between outcomes and the time period an observation was taken in (CA wave or prior), adjusting for age, gender, race/ethnicity and interview year. Poisson regression was used to calculate relative risks. Robust SEs were used to improve the accuracy of estimated 95% CIs and p-values given the data are clustered. We carried out a complete case analysis, using longitudinal inverse probability weights constructed for these models to adjust for attrition and missing data (see online appendix 1 for further details). We tested for differential associations by fitting interaction terms for age group, gender, educational level and race/ethnicity. Statistical analysis was conducted using Stata/MP 15.1 and R version 3.6.0 for the figures.

RESULTS
Table 1 describes the individuals included in the repeated cross-sectional analysis by wave, after excluding participants with missing data (see supplemental figure S1 for STROBE diagram and online supplemental table S1 for details of the longitudinal sample). The sample at the CA wave in April 2020 was: 52.0% female, 36.8% were degree level educated, 9.2% were from ethnic minority groups and the mean age of participants was 49.5 (95% CI 48.7 to 50.2) years. Weighted prevalence estimates for the key outcomes before and during the COVID-19 pandemic are shown in figure 1 and online supplemental table S2 (online appendix 2 contains prevalences for each wave and outcome by subgroup).

Psychological distress
Psychological distress has steadily increased over time from 17.6% (95% CI 17.0 to 18.2) in 2015–2017 (wave 7) to 19.4%...
(95% CI 18.7 to 20.1) in 2017 to 34.9% (95% CI 27.3 to 43.2) during the pandemic period. Asian minority ethnic groups also experienced a large increase in psychological distress; from 13.3% (95% CI 11.6 to 15.3) to 20.2% (95% CI 16.0 to 25.2) during lockdown. Loneliness also slightly increased among women, but fell among men. In longitudinal analyses, differences by age were less apparent (although this analysis had less statistical power), but there was evidence for an interaction between gender and time period (online supplemental table S4).

Cigarette smoking and e-cigarette use
Current cigarette smoking decreased during lockdown (figure 1 and online supplemental table S2). The decrease in smoking was more apparent in younger age groups and among men (figure 3) and seems driven by a decline in lighter smokers (online supplemental table S2). Longitudinal models demonstrated that risk of smoking reduced during the pandemic (RR 0.9, 95% CI 0.8 to 1.0) (table 2), but there were no statistically significant (p<0.05) interactions with age group, gender, race/ethnicity or education level (online supplemental table S8). In the longitudinal analyses, risk of e-cigarette use was also lower during the pandemic (RR 0.7, 95% CI 0.5 to 0.9) (table 2), but no statistically significant interactions were found with the subgroups examined (online supplemental table S9).
DISCUSSION

Psychological distress substantially increased in the UK following the COVID-19 pandemic. Groups most adversely affected included women and younger people. The increase in psychological distress, measured after the first month of lockdown, appeared to be driven by a reduction in enjoyment of normal day-to-day activities, as well as increased difficulties...
Figure 3  Mental health and health behaviours before (2017–2019) and during the COVID-19 lockdown (April 2020) by subgroup.

with concentration and sleep, and feelings of unhappiness. Overall, loneliness remained relatively stable. Cigarette smoking declined, and this reduction appears to reflect cessation among lighter smokers. The frequency of drinking four or more times a week and binge drinking increased, particularly among those aged over 25 and white ethnic groups.

Our study has several strengths. We used a large nationally representative longitudinal dataset. We also checked the variation in our outcomes before the pandemic and found that secular trends tended to be small compared to changes observed during the pandemic. Some limitations should be noted. First, survey non-participation may have introduced bias in our estimates, especially as the response rate in the COVID survey was lower than usual. However, weights were used to reduce concerns about non-response and attrition. Second, there were changes to the questionnaire items about alcohol consumption, so that questions related to the pandemic period rather than the entire previous year. This meant that a modified version of the AUDIT-C scale was used, which is not strictly comparable with previous years and so these initial results should be interpreted with caution. Alcohol consumption is also known to be under-reported in surveys.23 24 The pandemic context may have also influenced participant reporting more broadly. For example, the increase in being less able to enjoy usual activities may not reflect anhedonia, but rather the reality of experiencing lockdown and could be considered a normal response. Relatedly, what people perceive as a ‘typical’ drinking day is likely to have changed, especially among younger people, which could explain the conflicting results for this measure of alcohol consumption.

While a body of literature is developing to articulate the expected indirect impacts of the pandemic,3 7 25 empirical research on how mental health and health-related behaviours have changed remains limited and largely based on non-representative samples.26 A repeated cross-sectional analysis comparing results of two different representative surveys conducted before and during the pandemic in the USA found a marked increase in psychological distress among adults, from 3.9% to 13.6%.27 Furthermore, younger people experienced the greatest relative increase in poor mental health, echoing our findings. While longitudinal evidence on changes in consumption of tobacco and alcohol are limited, cross-sectional surveys have been conducted which asked about self-perceived changes in behaviour. A representative survey conducted on behalf of the charity Alcohol Change UK found that 21% of adults who normally drink alcohol self-reported increased consumption, but 3.5% reduced how often they drink or have stopped drinking altogether.28 Similarly, an online non-representative survey with data collection following the pandemic also found that
self-reported tobacco and e-cigarette use reduced by about one-quarter.39

Our study has important implications for public health policy. The substantial increase in psychological distress in the UK highlights the potential tension between implementing lockdown measures to control the pandemic and the risk of health harms that such action could have. By comparison, in England poor mental health after the Great Recession (assessed using the same GHQ outcome used in this study) increased from 13.7% to 16.4%—an effect size approximately one-quarter of that observed in this study. Finding that women have been disproportionately affected illustrates broader unequal power relations within society, with women more likely to experience the additional burden of childcare and more likely to work in sectors worst affected by the pandemic.31 It is worth noting that this more recent decline in mental health among women occurs after a period of austerity, during which women’s mental health had already been showing adverse trends.29–31

Observational evidence suggests that availability of unhealthy commodities drives consumption and contributes to health inequalities.35 The trends in alcohol consumption merit further exploration. The frequency of alcohol consumption and binge drinking appears to have increased, but the proportion of people drinking 5+ drinks on a typical day when drinking decreased. This may reflect the change in what a typical drinking day is (eg, going to the pub with friends compared with drinking at home) and the change in the frequency of alcohol consumption.

Further research is needed to understand mechanisms by which these impacts may be arising and whether the large increase in psychological distress remains following changes to the lockdown. As we did not investigate differences by country of the UK, future research should investigate whether there are differential trends over the longer-term course of the pandemic by country as the mitigation policies began to diverge. We also found psychological distress increased among the most educated groups, which may reflect that this group was more likely to move to remote working during the pandemic, and for some, this was combined with the home-schooling of children. Monitoring socioeconomic groups to see if they are able to recover from the initial shock of the lockdown will be important to understand the implications for mental health inequalities. While the UK Government introduced aggressive fiscal policies to minimise adverse economic risks, it is likely that at least some of these impacts reflect the start of a potentially long-lasting economic crisis.36 Understanding to what extent health is also being impacted by income and unemployment shocks will help inform decisions about ongoing support over the coming months and years.37 However, improved psychological support, including access to mental health services, may also be necessary. Our research provides an early picture of the broader consequences of the pandemic—clearly, longer-term monitoring will be necessary. Poor mental health is an important predictor of future mortality and several physical health conditions.38 39 Given this, further monitoring of the determinants of health, as well as health outcomes, are required.

### Table 2 Risk ratios (RR) derived from the multilevel Poisson models for mental health and health behaviour outcomes

<table>
<thead>
<tr>
<th></th>
<th>Psychological distress (GHQ-12, 4+ cut-off)</th>
<th>Psychological distress (GHQ-12, 3+ cut-off)</th>
<th>Loneliness</th>
<th>Binge drinking (weekly or more)</th>
<th>Alcohol frequency (4+ times per week)</th>
<th>5+ drinks on typical drinking day</th>
<th>Current cigarette smoking</th>
<th>Regular e-cigarettes</th>
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<tr>
<td></td>
<td>RR [95% CI]</td>
<td>RR [95% CI]</td>
<td>RR [95% CI]</td>
<td>RR [95% CI]</td>
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<td>Interview year</td>
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<tr>
<td>18–24</td>
<td>1.06***[1.03,1.09]</td>
<td>1.05***[1.02,1.07]</td>
<td>1.00</td>
<td>1.02</td>
<td>1.05***[1.03,1.08]</td>
<td>1.02[0.98,1.06]</td>
<td>1.11***[1.00,1.22]</td>
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<tr>
<td>Age group: 18–24</td>
<td></td>
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<tr>
<td>25–44</td>
<td>2.33***[2.03,2.67]</td>
<td>2.08***[1.85,2.34]</td>
<td>4.76***</td>
<td>3.55,639</td>
<td>1.59***[1.25,2.01]</td>
<td>0.17***[0.12,0.23]</td>
<td>15.29***[11.73,19.93]</td>
<td>2.85***[2.47,3.31]</td>
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<td>45–64</td>
<td>1.01***[1.00,1.02]</td>
<td>1.05***[1.00,1.00]</td>
<td>1.73***</td>
<td>2.73,466</td>
<td>0.48***[0.40,0.54]</td>
<td>7.62***[6.09,9.59]</td>
<td>6.59***[4.42,9.75]</td>
<td>6.32***[4.14,9.37]</td>
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<tr>
<td>Gender: Women (ref)</td>
<td>1.58***[1.48,1.69]</td>
<td>1.51***[1.43,1.60]</td>
<td>1.64***</td>
<td>1.41,191</td>
<td>0.53***[0.49,0.59]</td>
<td>0.62***[0.57,0.67]</td>
<td>0.52***[0.46,0.59]</td>
<td>1.60***[1.12,2.22]</td>
</tr>
<tr>
<td>Race/ethnicity: White (ref)</td>
<td>1.14*[1.02,1.27]</td>
<td>1.08[0.98,1.19]</td>
<td>1.12</td>
<td>0.88,144</td>
<td>0.27***[0.20,0.36]</td>
<td>0.34***[0.26,0.43]</td>
<td>0.30***[0.22,0.40]</td>
<td>1.19[0.88,1.61]</td>
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<tr>
<td>Period: Pre-COVID-19</td>
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<tr>
<td>During COVID-19</td>
<td>1.28***[1.15,1.42]</td>
<td>1.38***[1.25,1.51]</td>
<td>0.90</td>
<td>0.55,147</td>
<td>1.48***[1.27,1.73]</td>
<td>1.38***[1.26,1.51]</td>
<td>0.40***[0.33,0.47]</td>
<td>0.89**[0.82,0.97]</td>
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<tr>
<td>Observations</td>
<td>38 992</td>
<td>38 992</td>
<td>19 496</td>
<td>29 244</td>
<td>29 244</td>
<td>29 244</td>
<td>38 992</td>
<td>29 244</td>
</tr>
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*p<0.05, **p<0.01, ***p<0.001. 95% CIs in brackets.
What this study adds

- In the UK, psychological distress markedly increased during lockdown, with women particularly adversely affected.
- Cigarette smoking fell, but adverse drinking behaviour generally increased.

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Contributors SVK and CLN conceived the idea for the study. CLN, MIG and SVK conducted the analysis, drafted the manuscript and had full access to the study datasets and act as guarantors; CLN, MIG, MB, DCC, PC, ED, AHP, AMT, EW and SVK contributed to the study design, interpretation of the findings and critically revised the manuscript. All authors approved the final version of the paper.

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Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Understanding Society de-identified survey participant data are available through the UK Data Service (URLs: http://doi.org/10.5255/UKDA-SN-6641-13; http://doi.org/10.5255/UKDA-SN-8644-3). Researchers who wish to use Understanding Society need to register with the UK Data Service (URL: https://ukdataservice.ac.uk/) before being allowed to download datasets.

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