



**ADVISORY REPORT OF THE SUPERIOR HEALTH COUNCIL
no.9662**

**Psychosocial care during the Covid-19 pandemic
Children & Young people**

In this scientific advisory report, which offers guidance to public health policy-makers, the Superior Health Council of Belgium provides recommendations on psychosocial care during the Covid-19 pandemic for children and young people.

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Keywords and MeSH *descriptor terms*¹

Mesh terms*	Keywords	Sleutelwoorden	Mots clés	Schlüsselwörter
Covid-19	Covid-19	<i>Covid-19</i>	<i>Covid-19</i>	<i>Covid-19</i>
Pandemic	Pandemic	<i>Pandemie</i>	<i>Pandémie</i>	
Mental Health	Mental Health	<i>Geestelijke gezondheid</i>	<i>Santé mentale</i>	<i>Psychische Gesundheit</i>
Children	Children	<i>Kinderen</i>	<i>Enfants</i>	
Young people	Young people	<i>Jongeren</i>	<i>Jeunes</i>	

MeSH (Medical Subject Headings) is de thesaurus van de NLM (National Library of Medicine) met gecontroleerde trefwoorden die worden gebruikt voor het indexeren van artikelen voor PubMed <http://www.ncbi.nlm.nih.gov/mesh>

¹ The Council wishes to clarify that the MeSH terms and keywords are used for referencing purposes as well as to provide an easy definition of the scope of the advisory report. For more information, see the section entitled "methodology".

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List of abbreviations used

BMHDR	Belgian mental health (care) data repository
SHC	Superior Health Council

I INTRODUCTION AND QUESTION

In May 2020 and February 2021, the Superior Health Council (SHC) published two advisory reports on psychosocial care during the COVID-19 pandemic (SHC 9589, 2020 and SHC 9610, 2021). They did not have the specific aim of making recommendations for children and adolescents. Nonetheless, they have included as much of the available data as possible for this target group. For example, as early as May 2020 the SHC highlighted young people as a group particularly at risk for the mental health impact of the pandemic. In the second advisory report, the SHC highlighted that, according to the international literature: "Children and young people are particularly affected by the duration of the lockdown measures, which severely disrupts their social life (Loades et al, 2020; Fong & Larocci, 2020; Dubey et al, 2020; Ramalho, 2020; Marques de Miranda et al, 2020; Imran et al, 2020). They are confronted with anxiety, depression and restlessness. One element that may contribute to their restlessness is increased screen time (Imran et al, 2020). Moreover, the elderly and children are more likely to be victims of violence during the pandemic (Guessoum et al, 2020; Mazza et al, 2020; Hossain et al, 2020; Ramalho, 2020; Que et al, 2020)." In the second advisory report, the SHC also mentioned that according to several Belgian studies: "The situation of children in Belgium and particularly that of our adolescents or young adults is very worrying both in terms of their school, academic and social development and in terms of their mental health (Braet, 2020; Gaugue, Rossignol & Ris, 2020; Glowacz, 2020). While they are not particularly vulnerable to COVID-19, they are disproportionately vulnerable to the negative effects of the current restrictions put in place to combat the virus:

- social interaction and social relations with peers, which has currently been taken away from them, are indeed a fundamental requirement for their development;
- social support and good social skills make a significant contribution to the mental health of young people;
- for students in higher education, social relationships and interactions are also crucial to their academic success."

As a result of these two reports, the SHC also set up the [Belgian mental health \(care\) data repository](#) (BMHDR). This inventory brings together Belgian studies on the impact of the pandemic on mental health and aims to provide easy access to these studies and to promote systematic analysis. The analyses show that being young is a risk factor for a greater impact of the pandemic on mental health, and that there is currently few research on children and young people.

Alongside the scientific reviews, the SHC had the opportunity to hear from several representatives of professionals in the field, whose testimonies demonstrate the very problematic situation of young people.

Alongside all the COVID-19 related knowledge, we need to emphasize that most mental health problems develop in adolescence and young adulthood (average age = 14; Solmi et al., 2021) and these problems often remain until far in adulthood jeopardising participation and workability.

Taking this into account, the SHC deemed it necessary to provide a specific review of the available data for children and has developed specific recommendations.

II METHODOLOGY

After analysing the request, the Board and the Chair of the working group identified the necessary expertise. On this basis, an ad hoc working group was set up, which included experts in psychology, psychiatry, child psychiatry, occupational medicine and virology. The Paediatric Task Force was also consulted. In addition, various experts were invited to present their research results, data and projects in the form of hearings. The experts of this working

group provided a general and an *ad hoc* declaration of interests and the Committee on Deontology assessed the potential risk of conflicts of interest.

This advisory report is based on an analysis of the international literature, an inventory of Belgian data (the *Belgian mental health (care) data repository*), feedback from professionals in the field and discussions within the working group.

Once the advisory report was endorsed by the working group, it was ultimately validated by the Board.

III ELABORATION AND ARGUMENTATION

1 Review of the international literature

Sprang and Silman reported in 2013 that the psychosocial responses of parents and their children to pandemics attest to the traumatic nature of lockdown measures, with 30 % of children and 25 % of parents showing post-traumatic stress symptoms following isolation or quarantine. They also found that average post-traumatic stress scores were four times higher in children who had experienced a quarantine than in children who had not.

Orgilés et al. (2020) present a study that examines the emotional impact of lockdown on children and adolescents in Spain and Italy, two countries that were highly affected by Covid-19 during the first lockdown. The results indicate that 85.7 % of the parents in the study, with children aged between 3 and 18, perceived changes in their children's emotional state and behaviour during lockdown. The study found symptoms related to difficulty concentrating (76.6 %), irritability (39 %), restlessness (38.8 %), nervousness (38 %), worry (30.1 %), boredom (52 %), feelings of loneliness (31.3 %) and uneasiness (30.4 %). The authors of this study explain that staying at home without being able to go out increases anxiety responses, sleep problems as well as family behaviour problems such as arguing. Several studies have found that children who were worried about being infected with Covid-19 were more likely to experience depressive symptoms compared to those with little or no worry about being infected (Xie et al., 2020; Zhou et al., 2020).

In addition, children were exposed to a lot of information containing high levels of stress and anxiety and were simultaneously observing their parents' anxiety-provoking reactions (Dalton et al., 2020; Danese et al., 2020). Parents who considered themselves more stressed by the situation felt that their children were more worried, agitated, anxious, sad, frustrated, bored, had more difficulty concentrating and sleeping, and were more dependent on them during lockdown (Orgilés et al., 2020). Lockdown is potentially traumatic (Allé et al., 2020) as the consequences of the pandemic felt by parents may be felt by their children (Larsen et al., 2021).

Bonanno (2004) argues that in emergency situations, many people are able to use resilience to maintain their mental health. However, the complexity and persistence of the effects of Covid-19 can undermine an individual's ability to respond in a resilient manner (Fiorillo & Gorwood, 2020). According to Gignoux-Froment et al. (2020), an individual's resilience capacities are enhanced in the face of lockdown if that individual has been educated to deal with frustration.

According to Prime et al. (2020), some families may experience resilience if family well-being is preserved or improved during this period. Thus, there seems to be a need to address family coexistence in times of lockdown (Orgilés et al., 2020).

During the first lockdown, the division of work and daily routines of families changed dramatically (Biroli et al., 2020). These changes within the family may have mitigated or amplified the effects of school closure on children (Larsen et al. 2021) and affected family routines, rituals and rules (Prime et al., 2020). The changes in the family were mainly related to children and parents spending more time at home due to home schooling and teleworking (Larsen et al., 2021). In addition to this there was the reassignment of household tasks,

changes in religious or cultural celebrations and, finally, the renegotiation by parents of the rules concerning the time spent away from home or home schooling (Prime et al., 2020). This has forced parents, with increased demand, to flexibly develop new rules, routines, and boundaries within the home (Prime et al., 2020). This increased demand on parenting resources combined with reductions in parenting capacity (due to mental health issues or coping behaviours for example) may have caused problems in parent-child interactions during the initial lockdown (Prime et al., 2020). The parent in this situation may react emotionally to a misbehaving child, which may lead to increased negativity from the child, conflict or avoidance of the child (Prime et al., 2020).

These disruptions in household functioning led to increased household tensions (Biroli et al., 2020) and increased inter-parental conflict (Bakken et al., 2020). After only two weeks of lockdown, in Paris, there was a 36 % increase in domestic violence as well as a 20 % increase in reports of domestic violence in Spain, 30 % in Cyprus and 50 % in Brazil (Tordjman et al., 2020). During the first lockdown, there was a significant increase in intra-family violence, psychological and physical marital violence, violence against children and violence between children (Neuburger, 2020). For example, in China, the number of children and women abused during the first lockdown tripled (Tordjman et al., 2020).

Orgilés et al. (2020), explain that family coexistence had an impact during lockdown, because if family coexistence became more difficult, stress levels became higher and parents tended to report more emotional problems in their children. However, in their study, Orgilés et al. (2020) added that only 11.4 % of parents reported that family coexistence during lockdown was difficult or very difficult, and more than half of the parents (61.8 %) reported that family coexistence was easy or very easy. According to Recchi et al. (2020), 21 % of the parents reported that the lockdown allowed them to focus on the most important things in life, such as family and according to Lades et al. (2020) some parents considered childcare a positive experience.

Although some children had problems sleeping and concentrating during the first confinement, they felt less sad, angry, or frightened than other children because they may have received more attention and support from their parents than usual due to the time they spent together as a family (Larsen et al., 2021). Indeed, children's adjustment is largely dependent on the overall climate and relationships within a family (Browne et al., 2015). Thus, if there are pre-existing vulnerabilities within a family, this may increase vulnerability to pandemic sequelae and social disruption (Prime and al., 2020).

During the first lockdown, the children had to work at home. Depending on the involvement of parents and the work space made available, pupils did not experience home schooling under the same conditions (Aupaix, 2021). Indeed, access to digital technology (Aupaix, 2021) was not the same for all families, as many of them had no computer, printer or photocopier (Luc & Rayou, 2020). During the lockdown, these families were worried and felt guilty about jeopardising their children's schooling because the parents could not buy such equipment (Luc & Rayou, 2020). Some cities have provided IT devices (tablets, laptop). However, some households do not even have an internet connection (Luc & Rayou, 2020). In fact, the health crisis has amplified social and learning inequalities (Jellab, 2021).

The closure of schools also led to a loss of academic learning for some pupils (Engzell et al., 2020), especially for pupils who were already academically weak before the lockdown, as they had the most difficulty organising their personal work outside the classroom (Jellab, 2021).

Moreover, school is a place of academic learning, but also a place where children can develop, socialize and benefit from the support of teachers, both at an emotional and academic level (Larsen et al., 2021). However, social bonds between children and between pupils and teachers were eroded during the lockdown (Aupaix, 2021). Children no longer had the opportunity to physically meet friends or peers (Brooks et al., 2020). Several studies link social isolation and loneliness to negative mental health outcomes in children (Loades et al., 2020; López-Bueano et al., 2020). Even at the beginning of the pandemic, several studies found that

children and adolescents had high levels of depressive and anxiety symptoms (Larsen et al., 2021).

According to Larsen et al. (2021), the lack of emotional support from friends and the absence of usual contacts due to social isolation led to increased emotional reactions in children. Finally, the closure of childcare facilities (schools, care facilities, etc.) and the loss of access to a safe environment were problematic because they could no longer avoid child abuse (Blain, 2020).

Secondly, the routines established at school allow children to have regular hours of sleep, physical activity and limit screen time (Brazendale et al., 2017). In this first lockdown, school closures were therefore associated with health risk behaviours in children such as reduced physical activity or sleep problems (López-Bueno et al., 2021).

However, some children were able to adapt to this new daily life and reported fewer emotional and somatic reactions. Home schooling thus gave children the opportunity to have more autonomy, although this required the child to have a high level of self-discipline and motivation to establish good routines (Larsen et al., 2021). In addition, the less 'formal' communication via the virtual, encouraged greater spontaneity and participation among the shyer pupils who, for example, were less restrained when asked for additional instructions (Lentz, 2021; Luc & Rayou, 2020). Ellis et al. (2020) report that time spent doing homework during lockdown was negatively associated with depression. Thus, according to them, doing homework served as a buffer for some children.

Many parents found it difficult to balance work and family. In Tremblay and Mathieu's (2020) survey, 46 % of parents preferred their children to continue with distance learning after the lockdown compared to 37 % who wanted to send their children back to school. In the study by Recchi et al (2020), only 39 % of parents were in favor of children returning to school.

During the second lockdown, keeping schools and communities open was essential, as opening schools can stop the deleterious effects of lockdown on certain children, such as those who have been abused or those who have experienced disruptions to medical care for a chronic illness (Delacourt et al., 2020). Opening schools provides children with a socio-educational environment beneficial to their development, unlike in the first lockdown when schools were closed, and can help limit school dropout (Delacourt et al., 2020).

According to Delacourt et al (2020), reopening schools is essential to stop the negative effects of lockdown on some children, such as children who are dropping-out of school and victims of abuse. Moreover, according to Dubet (2020): "One learns with others, sometimes against, but rarely alone. Homeschooling is not school, so it will not replace it."

For those students who did not return to class, Roux et al (2021) observed an increase in psychological disorders among students as a result of the negative effects of lockdown and of distance learning at university. Granjon (2021), in his survey, explains that students find that the time saved in transport and the freedom to study at their own pace are advantages of distance learning, whereas loss of motivation and difficulties in concentration affect a very large number of students.

Franck and Zante (2021) point out that the second confinement was difficult to live with as a result of the cumulative effect on the psychological level and the mental health consequences of confinement increase and worsen with its prolongation.

2 Research in Belgium

2.1 The Belgian mental health (care) data repository (BMHDR)

A large number of studies have been conducted in Belgium on the impact of the pandemic on mental health. In order to have a global overview of these and to be able to systematically review data, the SHC has set up the [BMHDR](#). For each study, the repository contains an overview of the authors, the status (ongoing, published...), the method (population, type of data collection ...) and a brief description of the study. It aims to provide researchers, authorities, health care providers and the general population with an accurate synthesis and

easier access to studies on mental health in Belgium. It also allows for cross-analysis between studies to gain a better understanding of the overall situation.

169 studies were initially included in the BMHDR. After applying the inclusion criteria (see 2nd update), 94 eligible studies remained. 22 new studies have recently been added. The current total is therefore 116 studies. Some studies concern children, adolescents or young adults (students).

It is clear from the BMHDR analysis that covid-19 has a negative impact on mental health. Although the general Belgian population seems to be quite resilient, some groups are more at risk of developing mental health problems, including children and young people. However, there is currently little research focused on this group in Belgium. Children and young people are identified as a gap in the available research.

Furthermore, many studies were carried out during the first lockdown (spring 2020) and do not provide sufficient information on the current situation. These data will need to be monitored further as the impact of the pandemic on mental health may change with the duration of the pandemic and the measures, and may be different now and in the coming months. Further informations concerning the Belgian situation can always be found in the next updates of the living document of the BMHDR.

2.2 Studies on children and their parents

The international literature (Griffith, 2020; Orgilés et al., 2020) shows that parents' anxiety has an impact on children, and that parents' reactions influence children's reactions.

In this context, a Belgian study (Chartier et al., 2021) assessed the impact of lockdown on the peritraumatic stress of parents and children. A questionnaire was completed by 287 parents and 161 children aged 8 to 18 during May, June, July and August 2020. At that time, parents had a lot of obligations: children at home, isolation (without the usual help), difficulties in managing the education of children; this can also lower the tolerance threshold and lead to more violence in some families.

The results of this study show that 35 % of the children and 51.6 % of the parents showed distress, and that there was a significant association between the parents' peritraumatic stress and that of the children (the effect being more significant for the mothers). Children of older parents are more stressed. Older parents talk more about Covid with their children and watch more news. Younger parents show more traumatic symptoms. Older children feel more stress. Mothers were more affected than fathers by the lockdown, while there was no difference between girls and boys in the sample of children. There was also no link between having at-risk relatives and children's stress (but with parents' stress).

Another study (Roskam & Mikolajczak, 2020) conducted among 1212 French-speaking Belgian parents (90 % mothers) between March and May 2020 shows that the health crisis and the lockdown did not have a deleterious impact on all parents (for about a third of parents the lockdown was even an opportunity to spend more quality time with their children), but that it caused more stress for 15 % of fathers and 20 % of mothers. The risk is greater for parents with young children (under 4), teenagers (15+) or children with special needs; for parents who telework if they have a heavy workload or for parents who are not working. In fact, it is mainly the parents' perception of the impact of the health crisis and lockdown on their parenting that influences the level of burnout and resulting child abuse.

Several studies done at the University of Liège (not yet published) concerning frontline health workers have also analysed the situation of the children of these workers.

A first study in the summer of 2020 showed positive correlations between parental and child distress, especially for boys, and especially for neurovegetative hyperactivation.

The second study (November - January 2021) shows a correlation between parental and child posttraumatic stress disorder, especially with regard to anxiety, avoidance and intrusion. There is no difference between boys and girls.

2.3 Adolescents

The SIGMA study from KU Leuven is a longitudinal study on adolescent mental health, with baseline data on the mental health of almost 2000 adolescents in Flanders between the ages of 12 to 16, assessed pre-COVID in 2018 (Kirtley et al., 2021). During the first lockdown (May 2020), 173 adolescents were re-assessed and in spring 2021, a second wave of assessments were conducted with 400 adolescents from SIGMA Wave 1.

The SIGMA COVID study shows that there was no increase in general psychopathology symptoms in adolescents aged 13 to 20 during the first lockdown as compared to pre-COVID times (Achterhof et al., 2021). In fact, there was even a decrease in anxiety. Important to note, however is that pre-COVID about 1 in 5 adolescents reported moderate to severe mental health problems (Kirtley et al., 2019). Furthermore, this increased to more than 1 in 4 at the age of 16. In the SIGMA COVID study, a small increase in loneliness was found, but no increase in stress, and a decrease in irritability during daily life assessments (Janssen et al., 2021).

Furthermore, adolescents who experienced more COVID-related distress, reported the highest level of psychopathology symptoms. Crucially, however, those adolescents who maintained high-quality face-to-face interactions with family and peers were more resilient in terms of mental health. This is an important finding, also in light of the original SIGMA study, where it was shown that social support and good social skills were associated with better mental health. The original SIGMA study demonstrated that during adolescence, mental well-being is very closely related to social well-being, with higher levels of social isolation (Bamps et al., in prep) and lower quality of social interactions being associated with higher levels of psychopathology (Achterhof et al., 2020).

It therefore remains to be seen what the long-term effects will be of the enduring social deprivation in the current pandemic. The follow-up data from SIGMA (of spring 2021) will provide part of that answer. Whilst these initial results may provide a cause for optimism about the effects of the COVID-19 pandemic on adolescents' mental health, it is critical that we do not become complacent: longer term monitoring of adolescent mental health is essential.

2.4 Students

Social interaction is a basic need for adolescents and young adults. It is crucial for fulfilling developmental tasks: being independent, developing one's own identity, building lasting friendships, developing academically, developing romantic relationships. At the young adult level, interactions are also crucial for well-being and success in education.

During the first lockdown, Belgian studies (Braet, 2020; Gaugue, Rossignol & Ris, 2020; Glowacz, 2020) showed that 65 % of the young people reported distress (especially isolation). One study (Glowacz et al., 2020) indicated that in spring 2020, 33 % of respondents showed symptoms of anxiety, 35 % of respondents showed symptoms of depression and 9 % of respondents had thoughts of suicide or self-harm.

Another study (Baudoin et al., 2020) showed that many students were less happy in June 2020 than in June 2018, and that 2nd and 3rd grade students were less satisfied in September 2020 than in June 2020. The compulsory wearing of masks and the social distancing seem to make relationships with other students and teachers difficult (Baudoin et al., 2020).

A new study was carried out at the beginning of 2021 among Belgian students, in order to assess the experiences of students during the pandemic and to objectivise the psychological, financial, social and educational difficulties experienced.

This study (Glowacz et al., 2021) was conducted among 6 universities, 19 colleges and 16 higher arts schools. The data was collected online between 22 February and 5 March 2021. 23 307 students aged 18 to 25 responded, which is just over 10 % of the higher education population in the Belgian French Community.

The main difficulties encountered are

- financial difficulties: for 43 % the situation has deteriorated since the beginning of the crisis. During the last month, for 9 % it was difficult to meet basic needs (food, rent);
- online courses are difficult to live with: 80 % feel tired, lack motivation; for 65 % their studies require more time than before;
- we also see an increase in the feeling of dropping out (33 % in the last 6 months, and 40 % in February).

The survey also addressed mental health, with many students showing high levels of anxiety (50 % reporting actual symptoms) and depression (55 % reporting actual symptoms). These figures were 33 % and 35 % respectively in April 2020 in the Glowacz et al. study, with a smaller but comparable sample.

The survey also showed that a large number of students (60 %) suffer from insomnia, loss of appetite, and feel isolated, 57 % have lost hope in the future, and 20 % have thoughts of suicide.

The emotion most strongly felt is anger (almost half report being very angry). Only 13 % indicated that they felt strongly happy.

What affects the mental health of these students most of all is the lack of relationships, motivation, activities, and uncertainties about the future.

Concerning psychological help, 15 % have sought help and 18% would like to do so.

The study also assessed adherence to safety measures. The results are mixed, with much variation depending on the context. Regarding vaccination and saliva tests, many (75 %) were willing to have saliva tests to return to campus. But only 57 % were willing to be vaccinated, which is lower than the rest of the population (about 70 % for the similar time period).

Students reported that they have learned about different issues from the pandemic (solidarity, critical judgement...), and that they want to be actively involved in the fight against climate change (40 %).

The number of responses and written comments also showed a strong need to share their difficulties.

A new round of the survey (June 2021) includes an identical set of measures on mental health and new components on vaccination and educational adaptations for the start of the school year in September 2021.

Further data on students is also available via the KULeuven study, which has been tracking students in Leuven since 2012 (N~17,000). The longitudinal nature of these surveys makes it possible to measure the impact of different waves of covid19 on the psychological well-being of students. This study showed that 21 % of students reported a severe emotional impact (more morose, more anxious, more stressed) during the first wave of covid19. Specifically, this concerned students who already had anxiety problems as well as students whose home environment was characterised by less financial security. The psychological impact of the second wave of COVID-19 has also been measured and these results will be available soon.

The results of another large-scale survey of students at Flemish colleges and universities will also be available soon. Again, the potential emotional impact of the first and second waves of covid19 is specifically examined.

3 Data from the field

Godderis and Boets (2021) analysed the data of the Flemish agency “Opgroeien” (growing up), which is a Flemish organization that consists of “*Kind en Gezin*” (Child and family), “*Jongerenwelzijn*” (Youth welfare) and part of “*Vlaams Agentschap voor Personen met een Handicap*” (Flemish Agency for Persons with Disabilities). They provide advice, support, guidance, shelter or help for children and young adolescent while growing up. Every month they update the number of applications for crisis youth aid, youth support centres and other youth aid services. One of the steps in youth aid is crisis youth support for children, young adolescents, and their families when in crisis and urgent care is needed. The dispatch for crisis situations has been receiving more questions every month, and even more so since the beginning of the COVID-19 crisis. The dispatch centre first looks for a solution within the environment of the minor. If this is not possible, the dispatch centre decides to provide a consult. The number of consults has known a steep rise in 2021. During a consult, it is assessed if the situation needs further (crisis) youth support, mental health care support or both. Even before the COVID-19 crisis begun there were many applications, but recently the applications have never been higher. Most cases are about mental health problems, with a lot of questions about suicide. Especially complex situations that have been difficult for a while, now seem to go into crisis. When voluntary support is difficult or not possible, youth support centres can provide care for children, young adolescents, and their parents. With regard to the number of minors who applied for help at one of the youth support centres, in March 2021 they noted the second highest number of applications ever. Only in March 2020, right before the start of the COVID-19 crisis there was a higher number. In April 2021 the numbers seem to stabilize again to the numbers of 2019, but there are some regional differences.

The SHC also heard testimonies from a number of field professionals regarding the situation of children and young people. The Paediatric Taskforce, an informal structure of clinicians set up in March 2020, reported in particular its concerns about the situation of children, adolescents and young adults, who show a real need for social contacts.

In particular, since the beginning of 2021, they have noted a sharp increase in requests for hospitalisation.

Lengths of stay in child psychiatric hospitals are usually around 2-3 months, with fluctuating occupancy rates. After a usually quiet situation in September, admissions usually increase gradually in October, with the possibility of responding easily until December. The winter holidays normally clear the waiting lists, but after that it is often more difficult until March. At the end of the school year, it is usually very tense but this period is limited.

During the first lockdown in 2020, the hospitals emptied: most young people preferred to stay at home and continue care at home, or to continue without care. In November 2020, the pace returned to normal. By December, the units were full. From January onwards, there were waiting lists as usual. But after January, there was a huge increase in demand in hospitals. There is always an increase in demand at this time, but this year there was the cumulative effect of the school year and the lockdown. Mental health services were able to absorb some of the increase in demand, but they were also quickly saturated and new demands continued to arrive (decompensation of former patients and new problems).

A survey of Walloon child psychiatric services, carried out by the *Centre hospitalier le Domaine* in Braine-l'Alleud in February 2021, showed that at that time all the institutions had waiting lists that exceeded two months and numbered up to 30 patients, which is incompatible with the need for rapid care. From March onwards, they noted a gradual saturation of all consultation possibilities despite the reinforcement of the mobile child psychiatric teams. Requests for hospitalisation then decreased, but increased again in mid-May 2021, probably as a result of the return to schools. We know that the pressure of school at the end of the year can be very deleterious. The seasonal fluctuation in psychiatric hospitals shows that the pressure of school on the mental health of young people is high, even in normal times.

The *Vlaamse Vereniging voor Kinder- en Jeugdpsychiatrie* (Flemish Association for Child and Youth Psychiatry) also conducted a quick survey among Dutch-speaking professionals via social networks. This questionnaire made it possible to collect responses from a large number of professionals very quickly (one week): 290 doctors, 143 child psychiatrists, 44 paediatricians, 32 psychiatrists, 18 CLB doctors, and 56 others.

According to this survey, all professionals agreed that there was (much) more demand for care and longer waiting lists (the survey specifically asked to consider only severe problems). 37 % had seen a young person with suicidal thoughts in the week before the survey. Most of the doctors had seen young people with problems assessed as serious. And most of the time, it was not possible to put in place the necessary support, even in emergency or crisis services. There would also be an increase in forced hospitalisations (which would be linked to the lack of access to care, as this would be the only way to access care).

General practitioners had an average of 2.7 young people with acute mental health needs in the previous month, but only 15 % of them received the help they needed. According to 19 % of the doctors, these young people will have to wait more than 6 months before receiving the necessary help.

Finally, according to a survey carried out by the *Association Professionnelle des Psychiatres Infanto-Juveniles Francophones* (professional association of French-speaking child psychiatrists) between March and April 2021 among French-speaking child psychiatrists (154), almost 50 % of patients had to wait more than 3 months to obtain an appointment (which for 43.17 % of child psychiatrists is longer than usual for 43.17 % of child psychiatrists and much longer than usual for 33.81 %). 58.82 % also consider that there are "many more new requests than usual" and for 92.85 % the situations are (much) more worrying than usual. The child psychiatrists mainly report the saturation of the network and the heaviness or complexity of clinical situations as problems. They believe that, in order to better respond to needs, existing structures (especially outpatient teams and crisis beds) must be refinanced and new projects must be created, mainly focusing on emergency and crisis intervention, the creation of social links and the setting up of discussion groups. In addition to mental health care, they also felt it was important to work on funding or collaboration with education, youth support and the disability sector.

An online survey was also conducted in February 2021, as part of the "*Staten-Generaal van de Geestelijke Gezondheidszorg*" (<https://www.statengeneraalggz.be/wp-content/uploads/2021/06/Wachttijden-in-Vlaamse-privepraktijken-DEF.pdf>), asking Flemish private practitioners (psychologists, psychotherapists, orthopedagogists and psychiatrists) about their waiting lists. The survey shows that waiting lists are a problem in private practice, especially for psychiatrists, and especially for children and adolescents: only 35.8 % of practitioners for children and 42.2 % of those for young people have a waiting list of less than one month (compared to 53.3 % for adults). 15.3 % of practitioners for children have a waiting list of more than 6 months. Moreover, a majority of practitioners (71.9 %) note a (strong) increase in the need for help following the pandemic, both in the severity as in the complexity of the problems. Another patients survey published in December 2020 (https://test.statengeneraalggz.be/wp-content/uploads/2020/12/Uitgebreid-rapport-wachttijden_Def.pdf) also shows that waiting list problems are more important for children and young people (especially for developmental disorders).

Even though there are no precise numbers on waiting lists in Belgium, it is clear from the field that it is not currently possible to offer all young people the care they need.

Furthermore, if the mental health impact takes time to manifest itself, it will take time to address it as well. It is therefore to be expected that the need for care will increase for some time to come.

IV RECOMMANDATIONS

1. Prevention

Most young people including children have strong capacities for resilience. But, conditions must be created to support them, especially the more vulnerable ones like young people with mental health problems, with difficult familial or economic situation, with academic difficulties, or with poor social-emotional skills, and families with young children. The BMHDR defines some **risk factors, vulnerability factors as well as protective factors** which need to be taken into account when defining the needs and allocating resources. All the factors of the BMHDR are cumulative and multiplicative: the more of these factors with a negative impact, the higher the risk of suffering from long-term psychological problems.

Social support and social interactions have been identified as crucial factors in maintaining good mental health, especially in young people.

It is therefore especially important to put in place preventive measures and restore social networks, which aim to increase resilience.

This must be done through **positive and motivating communication**. The health discourse has been deleterious to young people. They are being stigmatised, in a context where they themselves are not largely at risk, but pose a danger to others. Moreover, at present they do not have the prospect of a vaccine. They must therefore be given meaning, other perspectives, and in particular recognition. It is important to recognise that it is difficult for them since they are making special efforts not for themselves but for society, and to give positive feedback on the results of their efforts.

As long as vaccination is not yet available for them, there should be **free PCR tests** for young people aged 12 to 25. This is important for their social life, but also their freedom and autonomy, which are important conditions for resilience. Two free tests are not enough for this group², which has made a lot of sacrifices, also financially (loss of student jobs). More free tests are advisable (which would allow one social event per week during the summer); and these tests should be easily accessible (e.g. via centres in universities). After all, it cannot be the intention to restrict children and young people's social interaction.

Similarly, **in schools**, the health discourse needs to be adapted. Health measures are sufficiently integrated, more attention now needs to be paid to mental health:

- Children with high psychosocial distress and therefore low participation rates at school should be supported towards the next school years. Children who are unable to take exams or attend school due to COVID-related psychosocial problems have an equal right to recharge during the summer holidays. An alternative way of testing knowledge and skills is needed.
- Caring and mental health promotion must be at the centre. School is a structuring, framing and socialising place for academic and psychosocial learning, where preventive assistance can reach all minors. School actors should be involved in mental health prevention and support resilience (e.g. learning to manage and express emotions), as young people are currently mainly in schools. The pandemic should be a learning experience, an opportunity to develop social-emotional skills.

² Only two tests means that this groups needs to choose and prioritize and will subsequently feel under severe restriction of freedom of choice once again.

- These actions to support resilience must be long-term, and become a part of the curriculum (learning the skills to take care of their own and others' well-being). The idea of well-being should be integrated in the entire academic process. Resilience should be included in the final attainment levels so that schools can also teach these 'life skills'. From childhood onwards, we should invest in learning mental health self-care.

Furthermore, it is important to **restore the social network (formal and informal)** as soon as possible. We need to find positive ways to recreate links, support actions that create links (at all levels including municipalities) and create spaces for informal socialisation. It will be important to reach out specifically to young people that experience difficulties to restore their social network, including young people with less developed social skills or young people who already had some mental health problems (about 20 % of the population). Specific initiatives should be taken to reach these youngsters. We may need to develop **specific programs to booster social development**, as especially for adolescents and young adults, social development was significantly hindered. We have to consider the holiday period as well, during which many young people will be alone again.

Finally, it is important to **include young people in decisions**, give them a voice and engage representatives in decision-making groups. In particular, the return to the campus will have to be well thought out in collaboration with the students. There will be many challenges to deal with, for instance because many students have only known distance learning since the beginning of their studies.

The means are available but we need to work together; collective intelligence and creativity are important.

2. Early detection and intervention

It is important to be proactive in providing psychosocial support, and to establish early detection and early intervention at a local level. All adults must be attentive to the psychosocial state of young people (*Centre Psycho-médico-social (PMS)* (Psycho-Medico-Social centre) or *Centrum voor Leerlingenbegeleiding (CLB)* (Pupil Guidance Centres), family planning, youth centres, homework schools, help in open setting, etc.). As adolescence and young adulthood is a crucial time for the development of psychological problems, it is crucial to detect mental health problems as soon as possible and to intervene at this early age. Therefore, very low threshold accessible support projects are needed, such as community houses, where young people can go and talk about their problems and where someone can identify whether more professional help is needed and guide them to this help, e.g. Patrick McGorry's Headspace' project (<https://www.orygen.org.au/>) in Australia, @ease in the Netherlands, Tejo houses or Over Kop houses in Flanders.

The Sentinel project - a project where people are trained to become "sentinels" who can identify vulnerable people in different settings (Snoeck & Leclercq, 2012) - can also be applied in schools: teenagers will more easily confide in other teenagers. These projects can be easily implemented.

Schools also have an important role in identifying the young people who have dropped out. It will indeed be necessary to reach out to those who are not seeking help.

We also have to make information on where to find possible help more visible for young people (on social media, tv,...) and direct them to help. An efficient **dispatching** tool is warranted, for example via an interface accessible to them, with chat, forum, helpline, triage which would allow them to be redirected according to their location.

3. Strengthening help

In addition to prevention measures, we must also be able to help those who need help now. It is indeed **not acceptable to have long waiting list** for young people in crisis.

This requires that care opportunities are better known, strengthened and more accessible to young people.

As mentioned above, young people do not always find the help that is available. The first step should be to raise awareness of the possibilities and to organise referral effectively. The previously mentioned low threshold care facilities could be important triage posts in this.

This crisis has increased the crisis in mental healthcare that was already there. Mental health should be put in front, there is a need for structural investment in mental health. We have to reflect on how to structurally strengthen the various forms of assistance (mental health services, mobile teams, crisis intervention, etc.). For example, the liaison projects set up to help paediatric services deal with mental health problems should be made structural. All professionals dealing with children should be better trained in mental health issues.

There is also a need for short-term solutions, which could be:

- Reimbursement of consultations for people younger than 25, in order to promote access to independent psychologists (as first line psychologists are only suitable for light pathologies and brief therapies).
- More support for child psychiatry, in particular to improve the working conditions of child psychiatrists
- The extension of COVID-19 reinforcements in mental health services beyond 30 June 2021, as well as in provincial, crisis and assertive mobile child psychiatry teams.

In any case, consultation and creativity must be encouraged in order to better meet the needs of young people in the coming months.

4. Research and monitoring

Research into mental health is worldwide structurally underfunded compared to somatic health. The global pandemic has underscored the need for more research in this domain, as next to the virological aspects of COVID-19, mental health was most affected. With regards to children and youth, we need more research and better numbers

- 1) to evaluate the prevalence of mental health problems;
- 2) to develop better early detection and intervention strategies;
- 3) to evaluate mental health care service;
- 4) to assess the use of care and identify any gaps;
- 5) to develop and evaluate new interventions including eHealth and mHealth services.

As already highlighted in the SHC's advisory reports 9589 and 9610, there is an urgent need for a national mental health barometer, especially for vulnerable groups such as children and young people. In particular, it is important to have better monitoring of suicides, so that these data can also be taken into account in public health policies.

To this end, registration with professionals should be made as easy as possible. This is the time to invest in digitising and helping professionals in this respect.

The SHC will soon start a new project to consider how best to facilitate sharing of knowledge and data as well as streamlining the gathering of high quality data.

5. Keeping blind spots in sight

In the further management strategies of COVID-19 (including the aftermath) we should pay extra attention to some blind spots. At the moment we have no data on the pre-peri and post-natal period or the so-called 1.000 first days of a child (early infancy) nor on psychopathology and children/young people. These blind spots arise, on the one hand, from a historical launch, namely limited data collection within mental health care, but on the other hand also as a direct consequence of the higher complexity in the collection of data in this area. Indeed, we see an oversupply of data on 'regular' groups during the pandemic. Finally, we do not have accurate data on the demand for care in relation to the use and supply of care. This too has grown historically. We should always make sure that a lack of data does not result in a lack of attention. In other words, it is not necessarily the one who shouts the loudest who needs the most support. The centralisation of data on children and young people clearly shows that certain groups do not (yet) have a voice.

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VI COMPOSITION OF THE WORKING GROUP

The composition of the Committee and that of the Board as well as the list of experts appointed by Royal Decree are available on the following website: [About us](#).

All experts joined the working group *in a private capacity*. Their general declarations of interests as well as those of the members of the Committee and the Board can be viewed on the SHC website (site: [conflicts of interest](#)).

The following experts were involved in drawing up and endorsing this advisory report. The working group was chaired by **Elke VAN HOOF** in co-chair with **Adelaïde BLAVIER**, **Inez GERMEYS**, and **Lode GODERIS**; the scientific secretary was Sylvie GERARD.

BLAVIER Adélaïde	Clinical psychology	ULG
BRUFFAERTS Ronny	Psychology	UZLeuven
CALMEYN Marc	Psychiatry, psychotherapy	PZ Onze-Lieve-Vrouw-College
DE LAET Hannah	Psychology	VUB
GERMEYS Inez	Psychiatry	KULeuven
GODDERIS Lode	Occupational medicine	KULeuven
LUMINET Olivier	Health Psychology	UCLouvain
MATTHYS Frieda	Psychiatry	UZ Brussel, VUB
PORTZKY Gwendolyn	Psychology	UGent
RESIBOIS Maxime	Psychology	CRéSaM
VAN DEN CRUYCE Nele	Social sciences	VUB
VAN GRAMBEREN Mieke	Sociology	Zorg Leuven
VAN HOOF Elke	Clinical psychology	VUB
VAN LEUVEN Frederique	Psychiatry	Centre Psychiatrique Saint-Bernard
VANDAMME Annemie (Anne-Mieke)	Virology, epidemiology	Rega Instituut (KU Leuven)

The following experts were heard but did not take part in endorsing the advisory report:

COLEMONT Patrick	Vlaams Patiëntenplatform
JACOBS Delphine	Cliniques Universitaires St Luc, Belgian Pediatric task force
KIRTLEY Olivia	KULeuven
LAUREYS Greet	Similes
MAES Sophie	Centre hospitalier le Domaine (Braine l'Alleud)

The following administration were heard:

DE BOCK Paul	FPS Public Health
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This advisory report was translated by an external translation agency.

About the Superior Health Council (SHC)

The Superior Health Council is a federal advisory body. Its secretariat is provided by the Federal Public Service Health, Food Chain Safety and Environment. It was founded in 1849 and provides scientific advisory reports on public health issues to the Ministers of Public Health and the Environment, their administration, and a few agencies. These advisory reports are drawn up on request or on the SHC's own initiative. The SHC aims at giving guidance to political decision-makers on public health matters. It does this on the basis of the most recent scientific knowledge.

Apart from its 25-member internal secretariat, the Council draws upon a vast network of over 500 experts (university professors, staff members of scientific institutions, stakeholders in the field, etc.), 300 of whom are appointed experts of the Council by Royal Decree. These experts meet in multidisciplinary working groups in order to write the advisory reports.

As an official body, the Superior Health Council takes the view that it is of key importance to guarantee that the scientific advisory reports it issues are neutral and impartial. In order to do so, it has provided itself with a structure, rules and procedures with which these requirements can be met efficiently at each stage of the coming into being of the advisory reports. The key stages in the latter process are: 1) the preliminary analysis of the request, 2) the appointing of the experts within the working groups, 3) the implementation of the procedures for managing potential conflicts of interest (based on the declaration of interest, the analysis of possible conflicts of interest, and a Committee on Professional Conduct) as well as the final endorsement of the advisory reports by the Board (ultimate decision-making body of the SHC, which consists of 30 members from the pool of appointed experts). This coherent set of procedures aims at allowing the SHC to issue advisory reports that are based on the highest level of scientific expertise available whilst maintaining all possible impartiality.

Once they have been endorsed by the Board, the advisory reports are sent to those who requested them as well as to the Minister of Public Health and are subsequently published on the SHC website (www.hgr-css.be). Some of them are also communicated to the press and to specific target groups (healthcare professionals, universities, politicians, consumer organisations, etc.).

In order to receive notification about the activities and publications of the SHC, please contact: info.hgr-css@health.belgium.be

