



**Superior  
Health Council**

**PSYCHOSOCIAL CARE DURING  
THE COVID-19 PANDEMIC  
REVISION**

**FEBRUARY 2020  
SHC № 9610**



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Federal Public Service Health, Food Chain Safety  
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## **ADVISORY REPORT OF THE SUPERIOR HEALTH COUNCIL no. 9610**

### **Psychosocial care during the Covid-19 pandemic Revision**

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 health care providers and authorities.

This version was validated by the Board on  
February 3<sup>rd</sup> - 2021

#### **SUMMARY**

This opinion is an update of opinion no. 9589 concerning possible psychological complaints related to the Covid-19 crisis. This revision consists of several parts:

- An update of the international literature.
- An inventory of the available (but as yet unpublished) national data and studies on the impact on the well-being of the population, in order to take the specific Belgian context into consideration.
- The minutes of presentations by various experts and stakeholders in the working group.
- A survey of health professionals and representatives of patients and caregivers.

This opinion is incomplete. As long as the pandemic continues, the available Belgian literature and data on the mental impact will be monitored.

Between the first opinion published in May 2020 and the present update, the group of experts has been expanded to reflect the mental health situation in Belgium. In addition to scientists, professional organisations, patient representatives and policy makers were invited.

This revision of opinion no. 9589 underscores the fact that the essential thrust of the original opinion is still valid after the most recent scientific documents have been processed, and then verified by a large group of experts.

As already stated in the first opinion, the resilience and adaptive capacity of the population must be safeguarded as much as possible.

Compared to previous crises, the **duration of this pandemic** and the measures that need to be taken pose an additional challenge. This pandemic is a marathon, not a sprint. The population will be asked repeatedly to adapt its behaviour (rapidly). This requires additional resilience and adaptability. Various studies have also highlighted the economic uncertainty and financial impact, which in turn have a negative impact on the mental health and resilience of the population (in particular certain target groups: the self-employed, organisations/services affected by the lockdown, etc.). Social isolation, and especially the duration of that isolation,

is also detrimental to mental well-being, especially among young people. The measures designed to limit social contact affect the well-being of the population as a whole, and call for creative solutions.

Although the responses to the crisis situation vary significantly from one person to another, it is clear that in this long-term crisis, the entire population will face stress reactions, usually transitory in nature. In order to prevent problems further down the line, but also to improve compliance with the measures to tackle the virus, the focus should be on building autonomy and resilience. The key aspect in this regard is to maintain the process of adaptation, rather than achieving some sort of ideal level of resilience.

In particular, it is essential to create and stimulate a sense of belonging.

The SHC recommends **acknowledging the importance of mental health** at all levels of pandemic management, in order to increase both the efficiency of managing the pandemic and its consequences, and to minimise the harmful effects of the chronic mental strain on the population. For example, this acknowledgement can be achieved by actively integrating mental health professionals into all sections managing the pandemic.

Recognition of mental health also requires an additional effort in mental health budgets and the mental health care system. The mental health effort should also be longer than the actual duration of the pandemic, as the impact of impaired well-being following the pandemic will have longer consequences than infection itself. Early and broad-based interventions will ensure that adverse psychological effects are limited in the long term. In this context, it is therefore advisable to take **an effective stepwise approach (staged care)**, starting with the most accessible help that people can rely on if necessary (including online interventions, self-help interventions). Psychosocial support should, above all, focus on encouraging the development of personal resources and autonomy, but also on identifying and orienting the people in need of treatment (monitoring/identifying/sorting/orienting). It is important to detect the alarm signals as early as possible and to adequately address them. Easy-to-use, high quality mental health support tools need to be developed. Sections of society may have trauma symptoms, which in turn need to be treated by professionals.

Moreover, deferring treatment also needs to be avoided at all times. The problem is that routine care was interrupted in several cases during the first wave, which caused problems for patients, whether hospitalised or not, but also for their relatives. These interruptions must absolutely be avoided in the future.

**Vulnerable groups**, already identified in the 1<sup>st</sup> opinion, need to be actively monitored for the long term: health professionals (with a particular focus on those directly confronted with Covid patients), patients/victims of Covid-19 and their relatives, the elderly and children, adolescents and young people (especially at pivotal ages) and vulnerable or discriminated groups, especially those with pre-existing physical and mental conditions, and detainees.

Evidence also suggests that the care sector, and mental health care in particular, merits special attention not only because caregivers are a high-risk population, but also because the sector (including mental health care), already under pressure before the pandemic, made additional efforts to adapt during the pandemic. Recognising this problem is highlighted, both during and also after the pandemic.

There is also a need to **invest in work** as an essential lever for maintaining and promoting mental health. Optimising the existing workplace health services could be part of this.

Finally, there is also a need to **develop an effective and aligned communication strategy** on promoting mental health. Tackling “infodemia” (the oversupply of information from various sources, often consisting of contradictory messages and sometimes even misleading information) is also crucial. It is essential to have accurate, coherent and transparent information, which is accessible and tailored to the different target groups.

### Keywords and MeSH descriptor terms<sup>1</sup>

<b>Mesh terms*</b>	<b>Keywords</b>	<b>Sleutelwoorden</b>	<b>Mots clés</b>	<b>Schlüsselwörter</b>
Disease Outbreak	Epidemic	<i>Epidemie</i>	<i>Epidémie</i>	<i>Epidemie</i>
Mental Health	Mental Health	<i>Geestelijke gezondheid</i>	<i>Santé mentale</i>	<i>Psychische Gesundheit</i>
Psychological trauma	Psychotraumatology	<i>Psychotraumatologie</i>	<i>Psychotraumatologie</i>	<i>Psychotraumatologie</i>
	Reintegration	<i>Werkhervatting</i>	<i>Réintégration</i>	<i>Wiedereingliederung</i>
Health Personnel	Health Care Providers	<i>Zorgverleners</i>	<i>Prestataires de soins</i>	<i>Leistungserbringer im Gesundheitswesen</i>
	Psychosocial intervention	<i>psychosociale interventies</i>	<i>Intervention psychosociale</i>	<i>Psychosoziale Intervention</i>
Resilience, Psychological	Resilience	<i>Veerkracht</i>	<i>Résilience</i>	<i>Belastbarkeit</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>.

<sup>1</sup> 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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## I INTRODUCTION AND ISSUE

In May 2020, the SHC published an opinion on the psychological impact of the Covid-19 pandemic, its likely evolution and the then current knowledge on the means to be implemented to tackle it in the medium and long term. The purpose of this opinion was to sketch a situational analysis of the relevant literature and the literature on collective emergency situations, with a view to informing the authorities on the measures to be taken in order to optimise psychosocial care.

The recommendations related to both the general population and caregivers and other support services.

The SHC recommended that psychosocial aspects be considered during the pandemic in accordance with the biopsychosocial model, not only to safeguard resilience as much as possible and reduce mental health problems in the general population and vulnerable groups, but also to promote better observance of the guidelines by the general population. It was also recommended that this opinion be reviewed in the light of developments, and new data and available literature.

The SHC therefore continued its work after the publication in May 2020.

This document is not a manual on the actions the government needs to take during and after the coronavirus crisis, but a deeper exploration of the existing literature and knowledge on the subject.

## II METHODOLOGY

After analysing the request, the College 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, occupational medicine and virology. Patients' and carers' associations, as well as various mental health associations and the RIZIV were also consulted. In addition, various experts were invited to present their research results, data and projects in the form of hearings. An overview of these is given in part 2 (2.2) of this report. Finally, the various authorities (federal, regional and community) responsible for public health were regularly informed of the progress of the work. The experts in this group have completed a general ad hoc declaration of interests and the Ethics Committee has evaluated the potential risk of conflicts of interest.

The opinion is based on a review of the scientific literature, published both in scientific journals and reports of national and international organisations competent in the field (peer-reviewed), as well as on the opinion of experts.

This revision consists of several parts:

- An update of the international literature.
- An inventory of the available (but as yet unpublished) national data and studies on the impact on the well-being of the population. In addition to published international studies, it is of course important to take into account the data available in Belgium, given that the health contexts, the care systems and the prevention and protection measures differ significantly from one country to another.
- Various hearings of experts and stakeholders.
- A survey of health professionals and representatives of patients and carers. The SHC wanted to ask them (1) about how the pandemic has been experienced thus far in their discipline and sector, and (2) about the good practices they felt had been developed.

After approval of the opinion by the working group, the College took a final decision on the opinion.

A few remarks concerning this report:

- These recommendations apply to all adults (including the elderly). For each of these potentially implicated groups, adapted implementation is necessary based on the rationales underlying these recommendations; this is not the subject of this report. It was not the purpose of this opinion to make specific recommendations for children, adolescents and young adults. Nevertheless, the scientific literature and available data have been included wherever possible.
- These recommendations and the systematic research carried out can form the basis of an evaluation. This does not fall under the remit of the working group, but the authors are available for further consultation during the evaluation phase.
- The recommendations apply to both the general population and psychosocial care staff who show specific characteristics during this pandemic. "Care sector" refers to both social workers and health care workers, including bereavement counsellors, funeral directors and family carers. There is no distinction between the different (support) services within this sector, as there is no evidence to suggest that the impact is different. The general rule also applies in the care sector: the more the individual is confronted with the impact and consequences of the coronavirus crisis, the higher the risk of acute stress reactions and long-term consequences.
- This report does not explicitly address a given number of factors that make certain groups more vulnerable to the effects of the coronavirus crisis, such as housing, their financial situation and any complex family situations; although these factors are known to have an impact on mental health and observance of (possible) measures.
- A collective emergency often generates victims. In the context of the coronavirus pandemic, an important distinction needs to be made between:
  - The direct or indirect **victims**, who are the people who contracted Covid-19, and their relatives;
  - And **affected people**, who are the persons who have suffered the consequences of the coronavirus crisis. Unlike other collective emergencies, in the coronavirus crisis, all Belgians were affected by the strict measures imposed during lockdown. The victims are, of course, also affected people.

This opinion is incomplete. As long as the pandemic persists, the available Belgian literature and data on the mental impact will be followed up.

### III ELABORATION AND ARGUMENTATION

#### 1 Review of the international literature

In contrast to the original opinion, this literature update does not focus on the anticipated phasing of the pandemic, but on the important focus points during the pandemic. The first opinion examined the predictions made regarding the impact on mental health, based on the available literature on traumatic events (one-off events and mass events). At the time, there was virtually no scientific literature on Covid-19 itself. The new literature currently being published focuses primarily on the experiences of the first wave of the Covid-19 pandemic. Consequently, the literature update will be reflected in the thematic topics which will be covered and which are important in terms of their impact on mental health.

The references used here are to published and peer-reviewed international studies. Point 2 takes stock of the studies still in progress in Belgium, so that a translation can be made for the Belgian context.

The working group organised a systematic review of the literature in scientific databases, based on predefined inclusion and exclusion criteria. The Cochrane Library and PubMed were used for this study. In order to maximise the validity of the results, priority was given to

selecting systematic reviews and peer-reviewed reviews published from May 2020 to November 2020 (following the first opinion) which covered the psychological impact of Covid-19. Anecdotal evidence (e.g. letters to the editor) was not included, although it is extensive. A detail of the search terms used and the process followed by the working group is presented in the annex.

This report is not a meta-analysis and there was no complete determination of the level of evidence for each recommendation.

Moreover, the unique character of the current pandemic should be kept in mind, and the working group therefore requests that these recommendations be re-examined as the situation evolves. The data that are used the most are based on the lessons learnt from the first wave of Covid-19 and the concrete impact of the chronicity of the pandemic is currently not sufficiently clear.

### 1.1 Expected impact of Covid-19 on mental health

The current literature review confirms the expected impact on mental health, namely that Covid-19 appears to have both direct and indirect consequences for mental well-being.

#### 1.1.1 *General population*

In the general population, **lower psychological well-being and a higher number of complaints related to stress, anxiety, depressive feelings** are highlighted (Vindegard & Benros, 2020; Rajkumar, 2020; Xiong et al, 2020; Salari et al, 2020; Luo et al, 2020; Krishnamoorthy et al, 2020; Lakhan et al, 2020; Talevi et al, 2020; Dubey et al, 2020; Hossain et al, 2020; Cooke et al, 2020; Silva et al, 2020; Carbrera et al, 2020; Mayland et al, 2020). This situation is partly related to disturbed sleep (insomnia), which, in addition to reduced immunity, also has an impact on well-being and mental functioning (Vindegard & Benros, 2020; Rajkumar, 2020; Pappa et al, 2020; Krishnamoorthy et al, 2020; Lakhan et al, 2020; Hossain et al, 2020; Silva et al, 2020). In the majority of the population, these complaints normalise over time, but in a limited number of cases they become psychopathological complaints which require professional help, particularly in cases of post-traumatic stress disorder (PTSD), depression and anxiety disorders (see 1.1.2 for at-risk groups).

Research shows that the impact of the pandemic on the mental health of the population **can also be seen in behaviour**. For example, it appears that there is an increase in problematic behaviours among a number of individuals, including alcohol consumption, aggression and violence (both domestic, intergenerational and general violence between individuals) that can manifest itself in various forms and in various domains (e.g. psychological, physical, sexual) (Guessoum et al, 2020; Mazza et al, 2020; Hossain et al, 2020; Ramalho, 2020; Que et al, 2020). The experience of a lockdown has a negative impact in this regard (Talevi et al, 2020; Guessoum et al, 2020); the duration of the lockdown has more impact than its intensity. Another critical indicator is an increase in the number of suicides in the population (Ramalho, 2020; Que et al, 2020).

Furthermore, various studies show that the pandemic also has indirect effects on mental well-being. For example, the economic impact and possible loss of employment can have an impact on mental health in the short and long term, both because of the loss of a sense of purpose following unemployment, and the financial consequences (Fong & Larocci, 2020; Luo et al, 2020; Chevance et al, 2020).

### 1.1.2 Specific risk groups

Various risk factors are decisive for the emergence and development of psychological problems:

- 1) Predisposing factors: age, female gender, low socio-economic status, low social support, low perception of control, pre-existing psychological and/or physical problems, etc.
- 2) Trigger factors: fear of the pandemic, fear of contagion from oneself and others, quarantine, prolonged uncertainty, risks to one's life, etc.
- 3) Maintenance factors: duration of the lockdown (not necessarily its intensity), personal factors such as autonomy, social support, community response and recognition, trust in the information provided, financial support, revalidation, media attention, etc.

The literature shows that risk factors have a cumulative and multiplying impact on the risk of developing mental problems (Hossain et al, 2020; Chevance et al, 2020; Carmassi et al, 2020). In other words, the risk of psychological problems increases with the number of risk factors.

In the first opinion, the following groups were identified as being at a higher risk of developing long-term problems:

- Persons who are very scared of Covid-19;
- Persons (who have been) admitted to intensive care;
- Persons who feel threatened / overwhelmed by the situation;
- Persons who are not sure whether they can keep their jobs or their income;
- Persons with pre-existing<sup>2</sup> higher vulnerability to the impact of Covid-19 ;
- Parents of young children;
- Women;
- Young people;
- Single people;
- People who have little or no social contact;
- Low-skilled people.

Recent data in the literature confirms that certain groups appear to be at higher risk of a negative impact on their mental health:

In the first instance, **patients with Covid-19** are at risk of a long-term negative impact on their physical and mental health that should not be underestimated (Rogers et al, 2020; Luo et al, 2020; Krishnamoorthy et al, 2020). For a very limited number of these individuals, neurological damage will also result in permanent psychopathological disorders (Rogers et al, 2020). It goes without saying that this also has a negative impact on their loved-ones (Fong & Larocci, 2020; Kisely et al, 2020).

**Older people and young people** (especially in the pivotal years - moving on to secondary school, university, graduation) have suffered in particular from social isolation. 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

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<sup>2</sup> We also refer here to patients who already had (severe) psychiatric disorders. There may be an exacerbation of existing problems in these cases, as well as the onset of new ones. Adapted check-ups, diagnoses and follow-up are called-for in this regard.

is increased screen time (Imran et al, 2020) (see 1.3 importance of communication). 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).

Most publications cover the impact of Covid-19 on the mental health of **health care workers**, and show that exposure to Covid-19 causes damage that exceeds normal psychological and emotional tolerance, thereby leading to stress, anxiety and depressive tendencies (Vindegaard & Benros, 2020; Pappa et al, 2020; Loades et al, 2020; Alazar de Pablo et al, 2020; da Silva & Neto, 2021; Serrano-Ripoll et al, 2020; Luo et al, 2020; Kisely et al, 2020; Krishnamoorthy et al, 2020; Galli et al, 2020; Cabarkapa et al, 2020; Spoorthy et al, 2020; Dubey et al, 2020; Preti et al, 2020; Chevance et al, 2020; Carmassi et al, 2020; Carbrera et al, 2020).

The highest risk of negative impact among health care workers is found among those with the most direct contact with Covid-19 patients, less experienced health care workers, women (perhaps related to the fact that there are more female nurses), those who take on a caregiving role in the home (children or informal care), and those who do not feel supported or who suffer from a lack of a social network (da Silva & Neto, 2021; Serrano-Ripoll et al, 2020; Kisely et al, 2020). There is therefore a strong call for support from this target group.

Furthermore, there is a special focus on people with **pre-existing mental and/or physical problems**, in particular psychiatric patients whose symptoms worsened during the pandemic due to the additional mental pressures they experienced (anxiety, stress) (Vindegaard & Benros, 2020; Rajkumar, 2020; Xiong et al, 2020; Dubey et al, 2020; Hossain et al, 2020; Bojdani et al, 2020; Chevance et al, 2020; Cabrera et al, 2020). The latter group of individuals is considered vulnerable as they are associated with a higher risk of medical risk factors (co-morbidity), lack of good physical and mental hygiene, homelessness and/or living conditions which are more conducive to the spread of the virus (Bojdani et al, 2020; Ramalho, 2020). Specific attention should be given to people in detention (psychiatric institution or prison) (Chevance et al, 2020).

In the first wave of Covid-19, the lockdown had negative effects on the evolution of pre-existing conditions and increased the risk of additional and/or secondary problems/pathologies. The continuity of care for people with psychiatric disorders has been under particular pressure. This has had a negative impact on patients, but also on their carers (Guessoum et al, 2020; Bojdani et al, 2020; Chevance et al, 2020).

## 1.2 The principle of the need for staged care: from resilience to professional care

Research shows that it is important to recognise that the impact of the pandemic on mental health differs from one person to another, and over time. However, it is clear that in this pandemic, almost everyone will be impacted (see 1.1. General population). Above all, a clear vision and the organisation of a staged care policy with targeted interventions are therefore necessary (Rajkumar, 2020; Pappa et al, 2020; Loades et al, 2020; Salari et al, 2020; Kisely et al, 2020; Cabarkapa et al, 2020; Spoorthy et al, 2020; Guessoum et al, 2020; Dubey et al, 2020; Preti et al, 2020; Mukhtar, 2020; Hossain et al, 2020; Carbrera et al, 2020; Etkind et al, 2020; Mayland et al, 2020; Harrop et al, 2020). The most accessible and efficient care should always be opted for, structures that are already known and/or reliable should be relied upon.

It is important to focus on the general bolstering of the resilience and coping styles of individuals, as they are the first buffer in preventing psychopathological complaints and can preserve the well-being of the general population during the pandemic (Rajkumar, 2020; Preti et al, 2020; Hossain et al, 2020; Mayland et al, 2020). Moreover, early, preventive and above all targeted interventions need to be put in place (Pappa et al, 2020; Loades et al, 2020). Finally, a follow-up system that can detect the needs early is crucial, so that individuals can

be efficiently referred to professional help when needed (Spoorthy et al, 2020; Dubey et al, 2020; Preti et al, 2020; Etkind et al, 2020).

There is a need to strengthen the provision of low-threshold care, so that professional help is accessible (including financially) to all without increasing the risk of infection. This may include an online offering, but there should also be a special focus on the most vulnerable groups who may not always have the necessary access to it (Salari et al, 2020; Talevi et al, 2020). A mixed approach is therefore the preference, staying as much as possible face-to-face (especially with vulnerable groups) and online if necessary.

The continuity of service provision also needs to be ensured, as this is crucial for the well-being of the population and in particular the most vulnerable target groups (e.g. psychiatric patients). However, standard care has come under pressure due to the preventive measures and challenges posed by the pandemic. The research points to the extreme adaptations and innovations that have taken place in mental health care during the pandemic. This is an exceptional achievement for a sector whose organisation was not set up to meet the challenges of the pandemic and which was already under strain in different areas (organisation, equipment, HR and funding), irrespective of the pandemic, which has only been exacerbated (Guessoum et al, 2020; Chevance et al, 2020).

### 1.3 Importance of communication

During the first wave of Covid-19, an infodemia phenomenon emerged, with an oversupply of communication and information, sometimes contradictory (Talevi et al, 2020; Guessoum et al, 2020; Dubey et al, 2020; Mukhtar, 2020; Hossain et al, 2020; Que et al, 2020). Correct and up-to-date information regarding the disease, the course of the pandemic in society and the future prospects have a crucial impact on the mental state of the population. There is a clear need for clear dissemination of reliable information (Kisley et al, 2020; Cabarkapa et al, 2020). Research suggests that the negative effects on mental health are amplified by the infodemia that has emerged. Excessive confrontation with an oversupply of Covid-19 communication at uncertain levels, reinforced by (in)formal social media channels, is associated with an increased risk of mental problems and even suicidal behaviour (Dubey et al, 2020; Hossain et al, 2020; Que et al, 2020).

It is essential that rumours, misinformation and fake news are counteracted with effective and regularly updated communication, adapted to the different target groups that need to be reached (Talevi et al, 2020; Guessoum et al, 2020; Que et al, 2020). Knowing what is going on helps people regain a sense of control/autonomy. The model by Beverley Raphael (1986) could become an explanatory model for the general population. In the face of divided opinion, the tendency is to build explanatory presentations or models that give the feeling of control over what is happening. Usually, scientific knowledge is used as the basis, but if there is little or no clear scientific literature, all available literature and personal experiences are drawn on. Lay theories have the major disadvantage of being uncontrollable. Once they are in the public domain, they are difficult to counteract, in part because they have little scientific basis (Furnham, 1988; Plaks et al, 2005). They are primarily used to make sense of everyday reality, are less explicit than scientific theories, can be ambiguous and incoherent, confuse correlation and causality, fulfil a purpose (social or psychological) and seek confirmation rather than refutation (Furnham, 1988; Hong et al, 2001; Levy et al, 2006; Lickel et al, 2001; Plaks et al, 2005). Proposing an explanatory model such as that of Beverley Raphael (1986) that describes how we adapt to a crisis (or in this case a pandemic) can fill the gap in scientific knowledge without ambiguity. This is one possible method of countering polarisation, thereby having indirect positive effects on the observance of guidelines and/or measures.

## 1.4 Bereavement

Research shows that society is confronted with multiple experiences of loss. On the one hand, literally because of the number of deaths, but also figuratively in the context of the loss of normality, customs and standard rituals (Etkind et al, 2020; Mayland et al, 2020; Harrop et al, 2020; Menzies et al, 2020). Almost daily, we are confronted with signals that reiterate our vulnerability and mortality (discussions and conversations on television or social media, preventive measures, confrontation with mortality rates, infections of people we know, etc.). (Menzies et al, 2020). Bereavement experts therefore point to a possible risk of augmented pathological reactions resulting from this complex and incomplete bereavement (Stroebe & Schut, 2020).

The research calls for a focus on bereavement in this specific period, where the main challenge is to find innovative ways to connect with each other and make new rituals possible without increasing the risk of contamination. Indeed, rituals help process bereavement; the absence of such rituals erodes the process of dealing with emotions, and can lead to a loss of meaning and connection with society. These initiatives can be managed at the federal level, but there must always be room for interpretation and deployment at the local level (Mayland et al, 2020; Harrop et al, 2020; Menzies et al, 2020; Stroebe & Schut, 2020; Zech, 2020). Psycho-educational interventions on the subject of bereavement at this particular time are advisable.

## 1.5 Conclusions and recommendations

Covid-19 has long-term health consequences, not only on account of the coronavirus infection, but also the stress, frustration and isolation due to quarantine or lockdown.

An update of the international literature reveals that:

- Loneliness, lack of contact and social isolation are risk factors for mental problems, illness and even death, whether by suicide or otherwise. People who are currently living apart from family or friends are at higher risk of developing mental health problems such as depression, anxiety or suicidal thoughts. It is highly likely that during and after the coronavirus pandemic, the general population will assess its own well-being less positively than under normal circumstances, partly on account of the strict measures imposed as regards social contact. This is particularly the case for the young and the elderly.
- The duration (chronicity) of the pandemic and the duration of the preventive measures are more decisive for mental health than the intensity of the measures. This requires additional resilience and adaptability on the part of the population. The resilience and adaptability of the population must therefore be monitored. This can be done by developing an indicator of the capacities still within the population.
- Rapid detection of problematic behaviours and warning signals of reduced resilience in society requires adequate follow-up. There are currently various data sources and studies (generally convenient samples). Linkages should be created between these data in order to maximise their use.
- A model built around detection, linking, sorting and monitoring within a staged care model is necessary. The SHC recommends proceeding with a proactive contact approach, and not sticking to a wait-and-see approach (waiting for the person seeking help to reach out to care workers), while relying on existing structures.
- Job insecurity and loss of income can lead to psychological problems that will manifest themselves over a long period of time, including for the self-employed and those directly affected by the coronavirus crisis.
- Belonging to one or more of the identified risk groups has a cumulative and multiplier effect.

- It is crucial to explain to the population what is happening and why. This would give a sense of control in the absence of (as yet) unequivocal scientific knowledge.

Taking into account the review of the international literature, the SHC confirms the validity of the main recommendations made in the first opinion:

- Align psychosocial care with the phases of the pandemic. Be proactive, not reactive. Adapt the communication strategies when necessary.
- Strengthen natural adaptation processes by activating the resources already within an individual and/or system.
- Monitor the psychosocial impact (until at least 6 months after the pandemic to ensure that delayed psychosocial responses are taken into account).
- Treat psychosocial problems as rapidly as possible.
- Offer high quality treatment. Provide training to ensure adequate resources to address the psychosocial issues.
- Put in place a monitoring/distribution system to ensure adequate distribution, (impact) assessment and monitoring.
- Target at-risk persons/groups.
- Use familiar channels or persons of trust to provide assistance to individuals.
- Do not minimise the impact of quarantine, lockdown or fear of Covid-19.
- Break the social isolation and focus on facilitating a sense of social cohesion.

The following recommendations are made to the authorities:

#### **Mental health as an integral part of public health:**

- Prevention, detection and treatment of mental health problems must be an important component of the public health approach. In the approach to a pandemic, the psychosocial component must also be approached strategically.
- An indicator needs to be developed to monitor what the population (and any vulnerable groups) can still bear.
- An adequate approach to mental health has an impact both on the course of the pandemic (e.g. the observance of Covid-related guidelines) and on the mental health of the population (in the short and long term).
- It is necessary to reinforce the provision of care that is as accessible as possible, making mental health care accessible to all without increasing the risk of infection. Preference is given to a mixed approach: online if possible and face-to-face if necessary or preferable (especially for vulnerable groups).

#### **Focus points as regards communication:**

- In addition to a pandemic, an infodemic is currently ongoing. There is an oversupply of information emanating from various channels, information that is not always correct and sometimes even misleading (infox). This infodemic must be counteracted.
- Trust in the information disseminated, in the experts and in the authorities will have a positive influence on the recovery. (Re-)gaining and maintaining the trust of individuals must therefore be a priority for the authorities.
- There is a general need for clear, correct, transparent and coordinated communication. Trustworthy communication that leaves room for humility in the face of uncertainty must be the priority, even in a context of complexity and/or partial and progressive understanding of the pandemic (e.g. risk gradient of contamination).
- Conflicting communication and discussion regarding policy decisions taken or the mere perception of such contradictions reinforces the sense of anxiety prevalent in society. It is therefore crucial to communicate in an unequivocal and consistent manner, with consideration for specific communication-related challenges such as avoiding stigma and discrimination, and differences in media literacy and the media preferences of

individuals. A clear division of roles between the federated entities and the experts involved in the area of communication is also essential.

- In order to reach as many people as possible in a uniform manner, the communication strategy needs to diversify the media used and the target audiences.
- The media can play an important role, both positive and negative, in disseminating information about the consequences of a collective emergency. Significant media focus on the dramatic aspects of a collective emergency can increase compassion for the victims on the part of society, but can also reinforce fear. The media has a role to play in communicating in a more positive and less anxiety-inducing way about the adoption of protective health-related behaviour.
- Although social media offer a form of connection, they are also a source of (over)information, sometimes fake, and stress, especially for people who are alone and are less able to talk about themselves with others.
- In the absence of clear scientific data, an explanatory model can be used to restore the population's sense of control/autonomy (model by Beverley Raphael, 1986).

#### **Focus on the chronicity of the pandemic:**

- The longer the pandemic and related measures last, the greater the risk that society will be overwhelmed. The chronicity of this pandemic is an exceptional element, different from previous crises, and the duration of the measures has a greater impact on mental health than their intensity.
- Monitoring and adequately following-up the indicators of mental overload in society are of paramount importance. For example, a rise in alcoholism, domestic violence, expressions of loneliness, etc. are important signals that need to be picked up and dealt with in good time. There is a need to develop a comprehensive monitoring, detection and orientation system that links the existing data (possibly by filling in gaps).
- The risk of possible secondary trauma increases with the duration of the pandemic.

#### **Strengthen individual and collective resilience:**

- Resilience plays an important role in reducing the risk of toxic stress and associated health problems, both in the general population and in specific target groups.
- Most of the individuals concerned generally regain their equilibrium without professional help. However, given the chronicity of this pandemic and the measures taken, reinforcing resilience and autonomy is a necessary preventive measure to reduce the proportion of the population that will need professional help.
- The way in which the community to which an individual belongs responds to the collective emergency is crucial. Indeed, support, consideration, recognition and respect are different protective effects for mental health. In this perspective, it is important to support families as the first social buffer.

#### **Effective deployment and optimal organisation of mental health care:**

- An evaluation and a psychological needs assessment adapted to the currently available resources is necessary. Following the first acute confrontation with the impact of the pandemic, it remains crucial to further facilitate the expansion and strengthening of psychosocial care.
- Psychological interventions must remain available in a targeted and adapted manner.
- Certain groups are particularly vulnerable due to a variety of factors, and therefore deserve special attention.
- Easily accessible, stage-by-stage care, including online help and emergency psychological assistance provided by front-line professionals that citizens can consult themselves when they deem it necessary, must be put in place to find a balance between the focus on psychological and psychiatric needs, without falling into the trap of providing forced generalised treatment (see resilience above).

**Support for the care sector:**

- The care sector deserves special attention with regard to the impact of the coronavirus pandemic.
- The care sector, and in particular mental health care, is under pressure. Regular and routine care is sometimes interrupted, which has a negative effect on the health of society. The sector has made incredible efforts during this pandemic, and was not set up for the challenges posed by this pandemic.
- The individuals on the front line need to be monitored from the outset for stress, the mental workload and avoidance behaviours. It is advisable to limit the known stress factors as much as possible. Preventive psychosocial support is also essential. Care providers need accurate information and a clear definition of their roles. Back-up systems need to be put in place and special care must be taken to ensure their physical and mental safety.
- In the health care sector, training and development must be fully deployed to ensure that this crucial sector is ready to respond to crisis situations.

**Promote social protection:**

- Investing in job-related recovery, managing workloads, career guidance and providing a social safety net are important investments that promote health in times of recession and at the same time help revitalise the economy. When affected people receive no financial assistance and rebuilding is difficult, their recovery falters.
- Previous pandemics and recessions lead us to conclude that a return to work and work in general are important for the recovery of society. Moreover, the professional activity is also an important factor in preventing mental health and other health problems.
- The SHC therefore advises investing in training (and upskilling) of workers, and in programs that increase the likelihood of finding employment if returning to work is not possible after the protective measures are eased.

**Commitment to an intelligently-designed, staged bereavement process:**

- It is advisable to work towards an intelligently-designed and staged bereavement process for the loved ones of those who die, patients who were in the services, and health care and social assistance workers.
- In the first instance and as soon as medically possible, individuals should be offered the opportunity to organise memorials with their loved ones in private, and national recognition of the special way in which their loved ones have experienced their bereavement in these exceptional circumstances should be envisaged.
- There is a need to find innovative ways to make connections and allow new rituals, without increasing the risk of contamination. These initiatives can be managed centrally, while leaving room for interpretation and roll-out at the local level.

**Prepare for possible future waves and/or a new pandemic:**

- It is crucial to learn lessons from the current situation and prepare for a possible next wave and/or new pandemic. Based on an evaluation, improvements need to be made in the strategy of approaching the pandemic, policy and also in the training of professionals (if useful and relevant).
- A coherent crisis prevention plan and an action plan for the next pandemic need to be developed. Mental health must be a fundamental part of this plan.
- Moreover, the unique character of the current pandemic needs to be borne in mind, and the working group therefore requests that these recommendations be re-examined as the situation evolves.

In the first opinion, the SHC also made specific recommendations for care workers, which are still valid:

- **Promote the personal and collective resources of individuals.** The way in which an individual is able to assess their own ability to cope with a situation greatly influences how things develop. An active approach to problems protects against psychological symptoms. It is therefore recommended that the interventions should always result in stimulating the persons concerned.
- Caregivers must be attentive **to those who need therapeutic treatment** and show them the correct path to take. A number of groups (see above) have a higher risk of long-term problems.
- The goal of interventions is above all to **reduce stress symptoms, acute stress disorders and the risk of post-traumatic stress disorder.** The existing guidelines from the World Health Organization (WHO), the American Psychiatric Association (APA), the National Institute for Health and Care Excellence (NICE), the International Society for Traumatic Stress Studies (ISTSS) and the National Health and Medical Research Council (NHMRC) recommend Trauma-Focused Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing (EMDR) as techniques for treating acute stress disorders. The guidelines of the NICE and WHO recommend that in situations where face-to-face psychological counselling is not possible, alternatives such as online counselling or group interventions should be creatively sought. In China, experiments have already been carried out with the development of online psychological care in the context of Covid. Treating toxic stress reactions reduces the risk of problems at a later stage. Moreover, in such cases, people are more likely to comply with the measures imposed to contain the spread of the virus. Traumatic experiences must be treated by trained and competent health professionals who meet a certain profile (see opinion SHC 9403).
- **Specific attention** must be given to **traumatic experiences of loss**, which are a mental challenge that many people will be confronted with during this pandemic. Only a minority of the relatives or affected people seek professional help. Nonetheless, this is recommended in cases of complicated bereavement, when an individual experiences intense grief reactions for six months, accompanied by serious problems in day-to-day functioning. Examples include an intense and destabilising longing for the person who has died, difficulty accepting the loss, and a feeling that life is empty and meaningless.

## 2 Belgian data inventories and studies

### 2.1 Submission of Belgian studies on mental health in connection with Covid-19

In order to transpose the findings of the systematic review to the Belgian context, the working group was asked to draw up a list of available data flows that could provide insight into the impact on mental health. The analysis and interpretation of the data collected can be used to pinpoint trends and forecasts.

This project is ongoing and will be incorporated into a document that will be updated at regular intervals: <https://doi.org/10.5281/zenodo.4555102>

### 2.2 Hearings within the working group of the SHC

In addition to the inventory of Belgian research and the submission of data, the working group of the SHC also had the opportunity, during hearings, to learn more about some of these studies, which concerned both the general population and health care workers or other target groups.

### 2.2.1 General population

The group therefore heard about the (sometimes provisional) results of various studies aimed at the general population:

- A recurrent online survey of the University of Antwerp (conducted with the support of UHasselt, KU Leuven and ULB), which assessed the well-being of the population during lockdown. The results of this survey showed (as of June 2020) an impact of the lockdown measures on well-being (and an evolution of this impact according to the measures taken or their easing). This study also identified certain risk factors. The results of this study (still ongoing) are available at: <https://www.uantwerpen.be/en/projects/etude-corona/>.

- A study by Idewe/KU Leuven on the well-being of employees, their psychological feelings, and the effect of various resources of employers and employees. This was a cohort study, with 4 measures (in March, April, May and June 2020). The results (see also on: <https://www.idewe.be/-/eerste-resultaten-coronastudie>) suggest an impact on the well-being of workers, and in particular an impact on their perception of safety. Indeed, essential sectors, which have remained open, show the most fear and the lowest job satisfaction. Satisfaction has increased in particular among people who are not working from home, probably due to the perception of safety that has increased over the weeks, as protective equipment has become more available. Teachers also expressed significant anxiety about the reopening of schools. Prioritising the health and safety of workers therefore seems to be an important factor in enhancing well-being.

This study also confirms the fact that the family situation has had an impact on an individual's experience (single parents have suffered the most); and that the impact of private life on work has decreased with the reopening of schools.

Social support from managers and colleagues is also important. Another important resource highlighted by the study is to provide clear information on procedures.

- The “motivation barometer” of Ghent University (which since December has been carried out in collaboration with UCLouvain and ULB) shows that the motivation to comply with health measures (e.g. hand washing, wearing a mask, social distancing and reducing social contacts) fluctuates over time, and that there are certain pivotal moments.

This research also highlighted the impact of the type of communication of the crisis centre on the motivation of citizens (an authoritarian approach has a negative impact on individuals whose motivation is already fragile). It was therefore clear from this data that it is important to invest in a campaign that will raise motivation, by emphasising social ties, shared identity, new rituals, etc., and strengthen accountability, particularly by being transparent in decision-making. The results are available at: <https://www.ugent.be/epg/nl/onderzoek/coronastudie>.

- With regard to children, adolescents and young adults, the group also heard a representative of researchers from several Belgian universities (UGent, UCLouvain, ULiège and UMONS) who proposed recommendations to improve the mental health of children and adolescents in Belgium. The research conducted by these universities shows that 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.

### 2.2.2 Health care workers

The SHC also heard about studies being conducted among health care workers:

- The barometer (<https://www.dezorgsammen.be/power-to-care/>) of "De Zorg Samen" (Care Together) (a consortium set up with the help of *Zorgnet* Icuuro to help health care workers), which aims to assess the personal, professional and physical reactions and support mechanisms. This survey was carried out among health care workers (nurses, doctors; on the front line, in hospitals, in institutions, etc.); 4 times (early April - at the peak of the first wave; early May and early June; then early October - just before the start of the second wave), with a total of 9 630 participants (different participants each time).

The results of this study should be interpreted with caution, but in general they show that the pandemic has had an impact on several personal symptoms (stress, fatigue, sleep problems, fear, difficulty concentrating, etc.), and professional symptoms (doubts about one's abilities, etc.). The highest scores were found in the "30 - 49" age group (probably due to a more difficult work-life balance with (young) children); as well as among women, nurses and in residential settings (who experienced the most problems in the first wave).

Professionals also show high scores on certain symptoms before the Covid period, suggesting that they were already under a lot of pressure in normal times.

The scores also show that fear and anxiety (symptoms of acute stress) were highest in April (at the peak of the first wave); and that guilt and shame were highest in May (fear and guilt of spreading the virus within the organisation, or bringing it home to their family). In October, longer-term symptoms (fatigue, sleep problems, etc.) were still significant and certain professional symptoms (the number of professionals thinking of quitting their job for example) were also more observable. There were also various significant physical problems (migraines, muscular pains, intestinal problems, etc.) in October, suggesting that summer was not long enough for them to recharge their batteries.

This research also shows that partners, colleagues, and friends are among the most important sources of support. Nonetheless, many also feel that they need to talk to people outside the home, not just their partner or family.

- A longitudinal study by the KUL (*Recovering Emotionally COVID-19 - RECOVID*, Bruffaerts et al, 2021) which specifically studied the impact on the mental health issues of health care workers. This study is the only one to identify the impact at the level of the issue (rather than symptoms) and benefited from international collaboration. The results were weighted to be representative of Belgian health care. It was conducted among 4 hospitals and 4 professional organisations, as well as the organisation *Zorgnet* Icuuro; twice in 2020 (April - June and October - December); and will be followed by a follow-up in April - June 2021 and October - December 2021 in order to study the long-term effects. It brought together the responses of more than 6 000 respondents during the first period. The results of this study show that 30 % of health care workers had at least one mental health issue in the previous month (23 % of those who had no issues previously). For 5 % of those with no previous problems, it was a severe mental health issue. In terms of risk factors, we see that previous anxiety problems have a significant impact, as well as working conditions, particularly the work-life balance and the lack of financial means. It is therefore important to take action on these factors to mitigate work-related problems during a pandemic. The study also highlighted the fact that a number of professionals who were being treated for a

psychological disorder stopped their treatment during the pandemic, and that the unmet need for care grew during the crisis.

Another result of this study relates to resilience and shows that health care workers, although they have more emotional problems, show as much resilience as the general population.

The data from this research was also backed up by other, more qualitative testimonies. This was highlighted in particular in the "*Schouder aan Schouder*" (Shoulder to Shoulder) project, launched by *Zorgnet* Icuro and supported by the Daniël De Coninck Fund of the King Baudouin Foundation, which proposed interventions to the directors of rest homes, shows in particular that the workers experienced considerable pressure in this context. The meaningfulness of their work was severely impacted, it was difficult to perform high-quality work, and it took a lot of creativity to build resilience among workers.

Similarly, Vincent Liévin, author of the book "*Les Héros du coronavirus*", (The heroes of the coronavirus) which he wrote after meeting various professionals from different sectors (nurses, firefighters, home carers, etc.) on the front line during the first wave, told the group about the feeling of abandonment among many caregivers, who had to be resourceful and creative to invent new ways of working. It is clear from these testimonies that mental health problems are expected to increase in the coming years, both for health care workers and the general population.

### 2.2.3 *Limitations*

The studies presented in the group have two significant limitations:

- They primarily focus on the first wave. Less data are available for the second wave, even though the impact is expected to be different, with the effect of the season, the duration of the measures, the difficult outlook for the end-of-year season, etc. People working from home, for example, are increasingly suffering from isolation and their work is gradually losing its meaningfulness. All these aspects may also have an impact on people's observance of the measures, and it is important to take this into account. The psychosocial impact will also need to continue being monitored as the financial support measures are scaled back.
- These were predominantly made online, which de facto excludes various target groups that are more difficult to reach.
- The SHC has identified different mental health research projects and surveys addressing mental health problems through different indicators. However, there is no strategic link between the different sets which could help generate better understanding of the specific impact of Covid-19 on mental health in Belgium. None of this data provides a complete picture of the situation. The principle of convenience samples also poses several methodological problems. Faced with the virus, and its rapid spread, it was necessary to adapt and react as effectively as possible. The data, which aim to be reproducible, trustworthy, predictable and translatable for different groups, are generally used to understand the situation, respond to uncertainties and make recommendations based on undisputed information; but it must be accepted in this regard that the data collected thus far cover only part of the reality and that scientists are also learning more as the pandemic evolves. The combined effect of different studies appears to make it possible to more accurately predict what is to come, and better guide policy decisions for the future.

### 2.2.4 *Conclusions and recommendations*

In general, the results of these studies are fairly consistent with each other, and often converge with the conclusions of the international literature review and expert opinion. In particular, they are in line with those of the "Psychology & corona" group, which brings together experts in psychology from several Belgian universities, and which also presented its recommendations

to the SHC (concerning changes in the behaviour of the population with a view to promoting better compliance with the safety measures).

Indeed, the same trends emerge from the literature, the data presented and the discussions in the working group: the Covid-19 crisis, and the measures taken, are having an impact on the well-being of the population. It also emerged from the group's discussions that the impact on mental health is expected to be felt for several years (see, for example, an article in The Guardian on this subject in December 2020<sup>3</sup>, which predicts the effects over several years). Certain target groups are also more vulnerable, in particular adolescents and young adults, and health care workers. Consequently, it is crucial to monitor this impact and bolster the mental health care sector, which was already under pressure before the crisis; by paying particular attention to these more vulnerable groups.

Taking this impact into account is essential, not only to reduce mental health problems, but also to promote better compliance of the measures.

These data and the discussions in the group have already resulted in various avenues for action:

- It is crucial to support security (physical, but also financial) in order to promote well-being: it was therefore essential to provide protective equipment to health care workers during the first wave. It will also be important to continue guaranteeing financial security.
- Social support (family, friends, colleagues) is also crucial and must also be encouraged. Families, which are often the first line of support, need to be supported in this regard. It is crucial in particular for the young people themselves and for the future of our society to maintain and/or restore as much as possible the social fabric of young people, in spite of the current circumstances.
- It is also important to take these aspects on board as regards communication, which needs to be clear, transparent and coherent and tailored to the different target groups. Communication also needs to emphasise the positive actions, for example solidarity. It is also important to recognise the significant efforts made by health care workers. In any case, communication must be professionalised, careful thought must be given to the way messages are conveyed, and psychologists must be involved from the onset of a crisis, so that these psychosocial aspects can be taken into consideration alongside the medical aspects. In particular, the group highlighted the challenge of vaccination.
- Not all psychosocial issues are currently visible, and these disorders will last longer than the rate of coronavirus infection (delayed effect). It is therefore necessary to continue (in the long term) monitoring the mental health of the population, and of vulnerable groups, particularly with regard to the risks of post-traumatic stress and suicide (the most recent figures on suicides in Belgium date from 2018; it is therefore impossible for the moment to say whether the pandemic has prompted an increase in suicides). At present, it is crucial to monitor the impact and analyse existing data in order to have an overview of the past, but also to try to predict the future (simulations).
- Furthermore, mental health care must always remain accessible, and the continuity of care must be guaranteed, from the "zero line" to specialised care, with a special focus on the groups in precarious situations (including new groups).
- There is a need to raise awareness of mental health, and offer a clear vision for mental health care: put in place a comprehensive approach that shows where we are going, rather than isolated initiatives that are difficult to put in context. In effect, the SHC has identified a wide range of mental health services which were set up during the pandemic, originating from different sources (volunteers, private and public sector) and

<sup>3</sup>[https://www.theguardian.com/society/2020/dec/27/covid-poses-greatest-threat-to-mental-health-since-second-world-war?utm\\_term=.98965406ea28795acfee2f515961e853&utm\\_campaign=GuardianTodayUK&utm\\_source=esp&utm\\_medium=Email&CMP=GTUK\\_email](https://www.theguardian.com/society/2020/dec/27/covid-poses-greatest-threat-to-mental-health-since-second-world-war?utm_term=.98965406ea28795acfee2f515961e853&utm_campaign=GuardianTodayUK&utm_source=esp&utm_medium=Email&CMP=GTUK_email)

targeting different groups (general public, target groups). The origin and reasons for the setting-up of these services and projects are not always known, nor is the quality of these services. The sheer amount of services offered also reduces the likelihood of people effectively finding the help they need, and even leads to fatigue regarding potentially necessary support. It also makes it difficult to gain insight into the uptake and effectiveness of these measures.

### **3 Perspective of health care workers and patients - Delphi study<sup>4</sup>**

#### **3.1 Introduction**

In order to glean the perspective on the ground, the SHC set up a study among mental health care workers and patients and caregivers, using the Delphi method. This method is designed to systematically collect and process the opinions of the persons involved and/or experts on a given topic. It is in fact an interactive communication protocol between the researcher and the participants. With a Delphi study, a common opinion is created without the interaction influencing the process and the results. It is a highly structured form of group interview in qualitative research.

In the first phase, a question is put individually to the experts, with a request for a written response. The researcher summarises the responses, and draws up a proposal for a conclusion. This report and proposal are returned to the participants for feedback. In the report, the researcher can still send a number of more in-depth questions. This iterative process is repeated until a certain consensus is reached or a clear answer is found to the research question.

The study therefore progressed in several stages:

1. Invitation and selection of participants;
2. Opening of the Delphi with a definition of the problem;
3. The participants formulate an initial response;
4. A working group gathers the responses and summarises them;
5. The summary is circulated;
6. The participants react;
7. The working group summarises the reactions of the participants;
8. The summary report is sent to the participants for feedback;
9. Final report.

#### **3.2 Stage 1: Collection of qualitative information**

An initial invitation was sent to all the contacts of the Superior Health Council in the area of mental health (3 752 people), asking them to register if they wanted to take part in the study.

The first questionnaire was drafted and sent to the 221 people who had registered. They had 10 days to react (from 19/10 to 28/10).

The questions were as follows (translated):

*How has the Covid-19 pandemic changed your professional practice?  
What are the consequences of the pandemic on the population you care for?  
Have you identified particularly vulnerable target groups?  
What difficulties have you encountered as a professional?  
What resources have helped you as a professional?*

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<sup>4</sup> Under the leadership of Elke Van Hoof and in collaboration with Sylvie Gérard, Frédérique Van Leuven, Nele Van den Cruyce and Lode Godderis.

*What difficulties have you encountered on a personal level?*  
*What has helped you on a personal level?*  
*What are the needs that you identify as a professional?*  
*Do you have examples of innovative practices, good practices and positive examples that could help?*  
*Would you like to add anything?*

A modified questionnaire was also sent to patients' and carers' associations for distribution to their members, with the following questions (translated):

*What difficulties have you encountered?*  
*What has helped you on a personal level?*  
*What are the needs that you identify?*  
*Do you have examples of innovative practices, good practices and positive examples that could help?*  
*Would you like to add anything?*

The responses to 195 questionnaires were collected:

- 149 professionals (86 French-speaking and 63 Dutch-speaking);
- 46 patients and carers (14 French-speaking and 32 Dutch-speaking).

The professionals came from different categories:

**45 members of service staff:**

15 members of staff of a mental health care service (speech therapists, psychologists, psychiatrists, nurses);  
5 members of staff of a hospital (nurses, social workers, psychologists, psychiatrists);  
6 members of staff of a mobile team (educators, psychiatrists);  
6 members of staff of a medical clinic (social workers, nurses, psychologists);  
13 members of staff from other services (mediation, PMS [medical, psychological and social assistance], family planning, addiction, etc.).

**36 liberal professions:**

9 (paedo-)psychiatrists;  
24 independent psychologists;  
3 independent others (sexologist, doctor, developmental therapy).

**26 directors – coordinators:**

13 mental health care directors/coordinators;  
5 network coordinators;  
8 other directors (non-profit association, red cross, informal care, etc.).

**11 researchers – academics:**

**25 well-being at work (prevention services, coaches, HR, etc.):**

Including 3 in hospitals.

**6 not specified.**

The data were analysed separately by 4 researchers (2 French-speaking and 2 Dutch-speaking), who made an ethnographic encryption as follows:

1. Data mining;
2. Identification of codes;
3. Identification of quotations illustrating the codes;
4. Identification of categories and sub-categories;

5. Research into potential relationships;
6. Research into main categories;
7. Integration of categories;
8. Triangulation/consultation with other researchers;
9. Decision on the final framework.

This first analysis revealed that:

- The 4 researchers conducted a similar analysis.
- There is no significant difference in the French-speaking and Dutch-speaking content.
- There is no significant difference in the data from patients versus the data from professionals.

The analysis was therefore performed on all the data.

The themes identified in this analysis are presented below, combined with examples taken directly from the comments made by the participants:

### 1) Unmet mental health needs

- Insufficient recognition of mental health and mental health care workers:
  - Emphasis on biomedical aspects only.  
*"Mental health is given short shrift at the political and societal level, and mental health care is not put on the same level as somatic care."*
  - Lack of recognition of the excessive workload of mental health care workers.  
*"I am also irked by the lack of recognition of the work that has been done for years in an ambulatory sector that is overwhelmed and underfunded, but nevertheless highly effective in terms of mental health care in the environment where people live, closest to their day-to-day lives."  
"During this seven-month period, from March to October, we tried to adapt, be patient, reassure ourselves, while still being under the illusion that the government was looking out for our safety with decisions justified by the general interest. But gradually, at the same time, a lot of nonsense has emerged, making analysis difficult and confusing."*
  - Lack of financial support for mental health care workers.  
*"I am in financial difficulty, and am drawing on my savings because I am self-employed. Between financial security and my professional conscience, I chose to do the right thing by my conscience."*
- Lack of resources at the practical level (IT, protective equipment, workspace, etc.), in particular for people in precarious situations and the elderly.
 

Professionals:  
*"The fact that we had to improvise in order to get hold of masks and disinfectant gel."*

Patients/carers:  
*"With free wi-fi no longer accessible, many families have found themselves cut off from the world."*
- Lack of information and clear communication: guidelines that change too often, lack of vision, etc.

*"I have to adapt continuously and sometimes have little time or means to acquire and master given skills."*

*"Conflicting information, too little information or data too late."*

*"Living with changing and sometimes contradictory rules, loss of bearing points, which leads to anxiety."*

- Lack of accessibility of services (including support services) and difficulty in referral: many services closed.

*"Closure of most of the collective institutions that receive our patients during the day and which are one of the elements of their psychological stability."*

*"The fact that we needed to cover in some cases for the lack of availability and presence of the usual assistance (medication, arrangements with pharmacies)."*

*"The difficulty or impossibility, due to technical or financial reasons, of contacting a range of previously accessible social services."*

## **2) Impact on mental health**

It can be seen in this first phase that the impact of Covid-19 on mental health has been multifaceted. Below we present the responses given, broken down into three categories: the general population, excluding psychopathological disorders, the psychopathological disorders as such, and the impact on health care workers.

### **- General population:**

- Difficulties related to lack of freedom, prospects, plans, uncertainties and incoherent communication, and insecurity.

*"The impression of being deprived of a certain form of freedom of choice, because government decisions have been imposed without seeking the opinion of citizens and questioning the choices of each individual."*

*"The inability to say when the pandemic will end and a quasi-normal life will be possible again."*

*"Difficulties due to lack of clarity in the Covid-related recommendations."*

*"I fully understand the reasons behind them, but the lack of clarity on the scientific sources used by politicians for making decisions results in incomprehension as regards the measures. This leads to an array of extreme emotions including anxiety, anger, feelings of powerlessness and even invisibility in some patients. Others feel a need to rebel and go more into conspiracy theories, which readily emerge given the incomprehension as regards a lot of information and/or measures. Of course, this is highly detrimental to mental health and risks causing medium or even long-term consequences for certain more fragile populations."*

- Insufficient opportunities to recharge one's batteries, personal resources impacted by Covid (sport, culture, family, friends, colleagues, etc.).

*"During the lockdown, I stopped exercising at my normal level because of the Covid rules."*

*"The only lack is related to the restriction of contact with relatives (family, friends)."*

- Impact perceived as bigger, and lower perceived solidarity/social cohesion in the second wave.

*"Staff are tired and exhausted and the second wave is only just beginning ... the public no longer respects white coats, there is more verbal and physical aggression."*

- Psychopathology (especially for vulnerable groups):
  - Routine care under pressure and sometimes even suspended (continuity of care not assured).  
*"No continuity of treatment and follow-up both psychiatric and somatic => increase in relapses of patients who were stabilised."*  
*"No placement decision by youth services in cases of maltreatment."*
  - Existing pathologies getting worse.  
*"we have observed a psychological deterioration in some of our patients, especially in adults suffering from pre-existing pathologies (anxiety disorders, phobias, abandonment disorders, etc.)."*  
*"Many people waking up with trauma as a result of the lockdown and anxiety associated with the pandemic in various patients."*  
*"Emergence of suicidal tendencies in the most isolated people."*
  - Need for a staged approach, adapted to the needs.  
*"Impossible to use the full range of psychotherapeutic tools."*
- Healthcare workers:
  - Difficulties maintaining quality work (maintaining the therapeutic link remotely; constant adaptations, etc.).  
*"Social distancing measures, masks, plexiglas, consultations by video: lower-quality patient interactions, decreased ability to assess patient emotions, difficulty for hearing impaired patients to read lips."*  
*"Working at home (in my bedroom to be away from my children) has made it very difficult to keep a professional approach."*  
*"There are a lot of relevant requests, so you have to make choices and prioritise (even more than usual). The overriding feeling is that we cannot do the job properly and that our efforts are inadequate for the needs of our target audience."*
  - Fear of contamination causing emotional overload.  
*"Fear of infecting one's own family."*  
*"Difficulties dealing with the anxiety of my family, who feared that I would be exposed to Covid."*  
*"Work under stress due to Covid-related risks in the workplace."*
  - Workplace well-being impacted (teleworking, stress, work-life balance).  
*"I'm exhausted."*  
*"Difficult to maintain a comfortable environment, by telephone or videoconference (people tend to think that you should be available 24 hours a day, much more than in a face-to-face setting); difficulty disconnecting from client situations (harassment, violence, death, suicidal urges) due to being constantly in the same place as the workplace and no possibility of changing rooms because there aren't any."*  
*"Burnout associated with so many video conference meetings."*

### 3) Identified risk groups

- Children and adolescents and the elderly (notably risk of domestic violence);
- People in precarious situations;
- People with pre-existing conditions:
  - Mental
  - Physical
  - Addiction/substance abuse

- Disabled
- Front line health care workers;
- Caregivers;
- Self-employed;
- People who have recovered from Covid-19;
- Families of people infected with Covid-19 (in particular close relatives).

#### 4) Resources that helped

##### On a personal level:

- Healthy lifestyle (walks, rest, etc.);
- Mental attitude (positive psychology, mindfulness, etc.);
- Work-life balance (both mental and physical, e.g. in terms of time and space);
- Leisure, sports, etc.;
- Outlook (in practice, and also plans, but also philosophical);
- Feeling of financial security;
- Information (clear communication; reference point - trusted information);
- Physical social contacts.

##### At the institutional level:

- Social contacts and connections with colleagues;  
*"The support of close colleagues and new collaborations with other co-workers."*
- The feeling of being useful, of having a role to play;  
*"The feeling of being useful for something, in the context of work during this corona period."*
- Knowledge sharing practices;
- Open management capable of flexibility and innovation;
- New practices (walking consultations, new roles, etc.);
- Supervision in the network (care for caregivers);
- Participation in decisions.

##### At society level:

- Prevention campaigns;
- Collective and spontaneous initiatives (applause, volunteering, etc.).

#### 3.3 Stage 2: Quantitative feedback on the responses

The collected themes were summarised in 21 statements (see annex). The analysis of the qualitative responses and the drafting of these statements was reviewed by two other researchers (one French-speaking and one Dutch-speaking), who were not involved in the initial study (external referees to the study to ensure validity) and who ensured that the methodology was applied and that the statements were consistent with the results of the analysis. These statements were then submitted to the 195 participants in the first part. They were asked to indicate for each statement how much they agreed, using a 7-point Likert scale (from "Strongly disagree" to "Strongly agree").

They were also asked to indicate the extent to which they agreed (Likert scale) with the definition of the 10 risk groups that were identified in the first phase as being particularly at risk of developing Covid-related mental health problems:

*Children / adolescents;*

*Elderly people;*

*People with a precarious socio-economic status (in poverty, isolated, etc.);*

*Pre-existing conditions (mental, physical, etc.);*

*Detainees;*

*Front line health care providers;*

Caregivers;  
 Self-employed;  
 People who have recovered from Covid-19;  
 Families of survivors/victims/deceased of Covid-19.

Finally, they were asked to say to what extent 11 resources identified in the first phase had helped them, and to what extent these resources should be structurally reinforced (from "Not at all" to "Significantly"):

*A healthy lifestyle (leisure, work/life balance, sleep, etc.);*  
*The feeling of having prospects: practical (e.g. projects) and philosophical (e.g. reading books);*  
*Feeling of financial security;*  
*Information (clear, trustworthy and up-to-date);*  
*Physical social contacts (relatives, psychosocial services, peers, etc.);*  
*Virtual social contacts (relatives, psychosocial services, peers, etc.);*  
*Knowledge sharing practices (no silos);*  
*Management open to/capable of flexibility/facilitating innovation;*  
*A clear vision that generates a sense of usefulness through roles, staying busy, being useful, helping;*  
*Prevention campaigns/messages (e.g. mental health);*  
*Collective and social initiatives (applause at 8.00 pm, volunteering, etc.).*

Of the 195 questionnaires sent out, 113 responses were received (60 Dutch-speaking and 53 French-speaking). The smaller number of participants is partly explained by the fact that the patient questionnaire had been sent to patient associations, who were asked to forward it to their members, who then had the choice of whether or not to provide their contact information; and not all patients who completed the first part provided their email address. Similarly for the questionnaire for professionals, some participants participated via a link and did not leave their email address.

Moreover, some participants in the first study simply did not respond to the second study. As can be seen in the following table, the missing responses are relatively evenly distributed among the different professional categories:

	No. of responses 1st	No. received 2nd	% received 2nd	N without resp. 2nd	% without resp. 2nd
Patients and caregivers	46	27	59	6	22
Psychologists	24	21	88	10	48
HR/Prevention advisor	25	23	92	6	26
Coordinator/Director	22	17	77	5	29
Staff institution SM	45	32	71	7	22
Doctor - Psychiatrists	12	7	58	3	43
Network coordinator	5	5	100	2	40
Researchers - Academics	11	11	100	0	0
No info	5	5	100	0	0
Total	195	148	76	39	26

Analysis of the results (see annex for details) of this survey indicates that participants largely agree with all the statements. Moreover, there is no difference between the responses of the French and Dutch speakers (the responses of the French speakers are slightly more pronounced, but still point in the same direction).

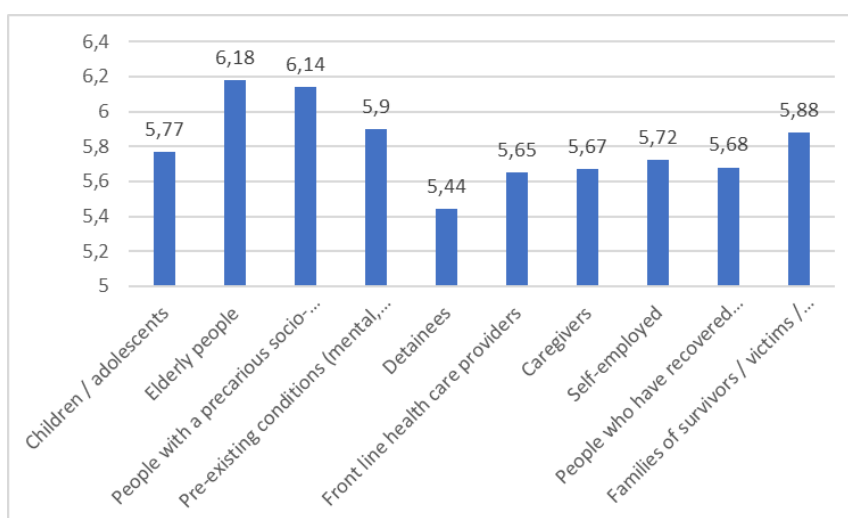
The score is between 5.18 and 6.07 out of 7 (1 being "Strongly disagree" and 7 being "Strongly agree"), except for the following statements:

- Teleconsultations have opened up mental health services to people who did not previously consult them. (3.99)
- For the general population, the impact of Covid-19 on mental health is primarily visible in the workplace. (3.94)
- Innovations to the mental health system in the first wave have made care more accessible in the second wave (e.g. hybrid care). (4.84)

The most convergence was reached on the following statements:

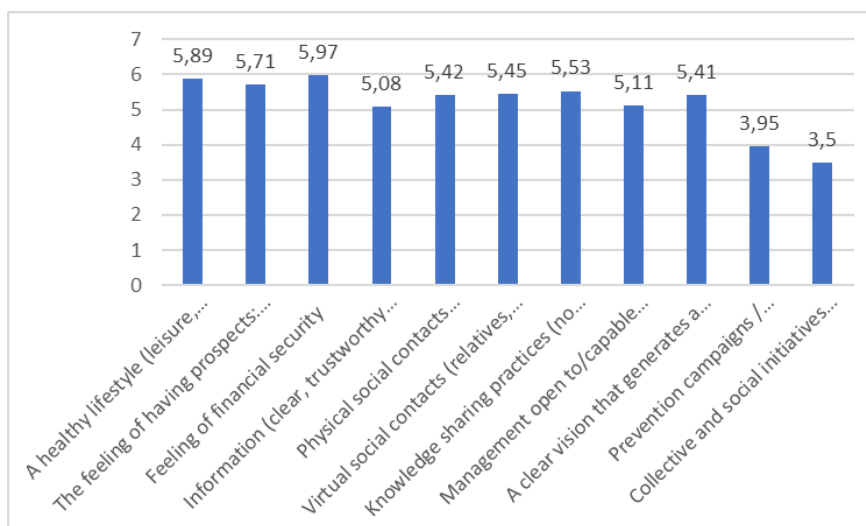
- Lack of strategic vision on mental health care and the importance of mental health in society. (5.92)
- The fear of contaminating oneself and the fear of contaminating others (relatives, patients, etc.) create additional emotional pressure. (5.95)
- The impact of Covid-19 has heightened social inequalities, which in turn may also increase mental health problems. (6.07)

As regards vulnerable groups, the participants also strongly agreed with the assertions, particularly for the elderly and people with a precarious socio-economic status.



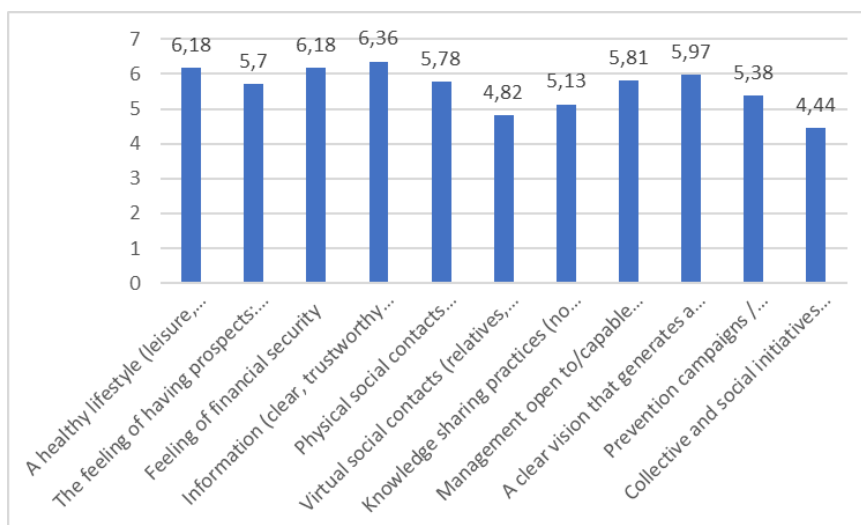
In terms of resources, we see that it was primarily a healthy lifestyle, financial security, a clear vision and outlook, and physical social contacts that helped.

Collective and social initiatives and prevention campaigns were less helpful for the respondents.



The participants felt that it is important to develop most of the resources, and especially information, a feeling of financial security, a healthy lifestyle and a clear vision that creates a sense of usefulness.

The consensus was slightly weaker on the need to develop virtual social contacts and collective and social initiatives.



### 3.4 Stage 3: Feedback on the summary report

The summary report was sent to the 113 participants in the second phase, asking them to state whether they agreed with the conclusions and whether they had anything to add.

50 participants responded. All responses were positive (they were well reflected in the report's conclusions). 19 participants added comments.

In summary, these comments highlight the significant impact of the pandemic on mental health due to lack of prospects, a lack of security, stress, reduced social contact and cohesion, difficult bereavements, and the duration of the crisis. Pre-existing problems were exacerbated. And these effects will last for the foreseeable future.

The needs particularly highlighted in these comments relate to:

- The need for new resources: the need to provide positive messages, foster autonomy, participation, and promote personal resources to build resilience are all highlighted.
- Recognition of difficulties and raising awareness of mental health: people need to feel recognised in their difficulties and feel legitimate in asking for help.
- Strengthening mental health care: the crisis has primarily highlighted shortcomings that already existed in this sector. Mental health care needs to be further recognised and strengthened (from the front line), in terms of staff (including management), but also in terms of infrastructure and supervision possibilities; building on what already exists. Professionals often felt helpless in the face of exacerbated problems and the workload. There is also a need for data (on suicide in particular).

Finally, the comments stressed the vulnerability of groups in a situation of socio-economic precariousness, who need to be supported financially (growing inequalities); but also groups in a situation of "psychological" precariousness, which should be taken more into account. Children (especially those with developmental disorders or mental retardation) and young people (adolescents, students) are not sufficiently represented in the at-risk groups, even though they suffered in particular during the lockdown.

### 3.5 Conclusions

The results show that, in general, the participants agreed with the statements and that the analysis of the first stage therefore allowed a correct translation of their responses. We can see that they agree in particular with the lack of strategic vision on mental health care, the emotional pressure due to fear of lockdown, and the impact of Covid-19 on inequalities in society. On the other hand, there was less agreement on the assumptions regarding the added value and potential of teleconsultation (opening up to new target groups, better access during the second wave) and the assumption that mental health problems in the general population would manifest themselves primarily at work.

In terms of resources, we can see that financial security and prospects, and a clear vision are important resources. Virtual contacts are deemed to be less important than physical contacts.

It is important to note that these results reflect the impressions of survey participants based on their reality on the ground and therefore cannot be generalised. Nevertheless, several conclusions can be drawn from this study:

- During the crisis, mental health was not adequately taken into account by the authorities. It is necessary to recognise the **importance of mental health** and psychological well-being in the same way as for physical health. In particular, the continuity of care and the opening up of services (including the zero line, low-threshold services and social services such as youth care, family planning, etc.) must always be guaranteed.
- It is important to propose a **clear vision**, future prospects, and have a global approach that shows everyone where we are going. Isolated initiatives are not enough, it needs to go further than simply implementing one or other recommendation without rethinking the entire framework. For example, it is clearly not enough to provide online consultation tools. Even though such initiatives need to be taken and may have added value for certain target groups, hybrid forms of care need to be envisaged. Using the pre-existing services is also necessary, and these need to be reinforced rather than creating new, disparate initiatives.
- It is also important to **recognise the work** done by mental health care workers. They have given so much of themselves to meet the needs of the population as effectively as possible, and have felt abandoned; this while their sector is historically underfunded, and the context was particularly difficult and anxiety-provoking. Health care workers have suffered from fear of contamination, a lack of financial security, and a difficult

work-life balance. These efforts need to be recognised and protected more adequately. For this to happen, various actions can be put in place (which will also improve the accessibility of care):

- Provide mental health care workers with the necessary resources (protective equipment, IT equipment, etc.).
- Encourage training (in using teleconsultation tools, for example), supervision, information exchange and provide tools and support to facilitate collaboration.
- Guarantee their financial security.
- Reinforce staff to an adequate level in order for them to meet the demands.
- Involve professionals in decision-making processes and organise participatory processes that give them a sense of purpose.
- Every effort must also be made to provide professionals with **adequate, clear, coherent and reliable information**. Being able to access reliable information has been an important resource for many; while there have been constant changes in procedures, instructions, and inconsistencies and contradictions among experts have been a source of significant stress. Providing information clearly needs to be a priority. This communication should also be available to the general population, adapted to the different groups and intended to inform rather than sow fear and guilt.
- Mental health care workers have made it clear that various **vulnerable groups** require special attention. In particular, it is clear that the Covid-19 crisis has heightened social inequalities in society, which in turn have an impact on mental health; and that groups with a lower socio-economic status are particularly at risk and need multidisciplinary support to mitigate these risks. Groups with other pre-existing vulnerabilities (psychological in particular) also need to receive special attention, as well as children, adolescents and students.
- For the general population, it is necessary to focus on **prevention** (building resilience and autonomy, raising awareness of personal resources, positive messages, participation, raising awareness of mental health, etc.) to mitigate adaptation problems. The approaches therefore need to be staggered (monitoring, sorting, orientation) and adapted to the different target groups.
- There is a need for tools to **objectively assess** the mental health situation and the mental health needs of the population, in order to anticipate and monitor the actions. Various initiatives are currently in place in this regard, but there is a lack of articulation and coordination between these data.

#### IV GENERAL RECOMMENDATIONS

The data from the review of the international literature, the survey among health care workers, patients and family carers, the consultation of research carried out in Belgium and the hearings and discussions within the working group overlap to a significant extent, and allow the SHC to make the following general recommendations:

##### 1) **Acknowledge the importance of mental health in the preparation, management and consequences of a pandemic, and long-term support for the mental health sector.**

The SHC explicitly reaffirms the importance of recognising the fact that the Covid-19 pandemic is not solely a medical challenge, but a psychosocial crisis as well. Mental health is not just an aspect of overall health, it requires specific attention, for various reasons:

- Compliance with the prevention measures is directly related to various psychosocial factors (e.g. psychosocial and economic vulnerability, motivation, fatigue, resilience, and adaptability). The possible outcome of the pandemic and its consequences can, therefore, benefit from psychosocial expertise.
- Due to the chronicity of the pandemic and the nature of the protective measures, the strain on mental health has increased within the general population. Social isolation in particular

appears to have taken a heavy toll, in particular among adolescents and young adults. The duration of the measures is more significant than the measures themselves.

- Different resources highlight an increase in behaviours which are indicative of deteriorating mental health (e.g. alcoholism, violence, suicide, etc.) which reflect increasing psychological pressure.
- The indirect effects (e.g. financial insecurity) will continue to take full effect after the pandemic, and many mental health issues have a delayed effect. We can therefore expect a further increase in mental health issues in the longer term. These issues will outlive the coronavirus infection rate.
- The SHC has also identified different groups at a greater risk than the rest of society of developing mental health issues during and even after the pandemic: children and young people in particular, older adults and people with multi-morbidities, people with mental health problems, health workers on the front line, family carers, socially excluded groups (including detainees, the homeless, refugees, undocumented migrants and people with a migrant background), and people facing occupational and/or financial insecurity.

## ACTIONS:

- a. This recognition of mental health can be accomplished by actively integrating mental health care workers into the coronavirus pandemic management staff.
- b. The mental health care system itself was not adequately equipped to deal with this pandemic and is still experiencing a significant amount of stress. In order to be able to provide the best care possible, also in the future, the sector as a whole needs to be supported (ex. financially, in terms of staff, organisationally, etc.) for many years. The time scale for investment in mental health care needs to be much longer than the end of the pandemic.
- c. Consolidate a **proactive, staged approach** to mental health care that includes monitoring, setting priorities, and providing orientation when and where needed. For this, the SHC recommends:
  - Focusing on effectively stimulating people's resilience and natural resources (e.g. quality self-help programmes, civic participation, raising awareness of mental health, etc., and restoring social contacts, especially of young people, and financial security, as rapidly as possible).
  - Putting in place easy-to-use mental health support tools, and ensuring active coordination and quality control of these services, in order to ensure the best possible mental health care.
  - Centralise these resources on the website which provides the national information on the coronavirus.
  - When professional help is necessary, referral and care should follow as soon as possible, without any delay or interruption.
- d. The **monitoring of the impact of Covid-19** on mental health needs to be professionalised and continued over time, for many years after the pandemic:
  - Combine subjective indicators with more objective data like the number of sold (over-the-counter) psychotropic medication.
  - Pay special attention to already identified vulnerable groups (and children and young people in particular), and organise the active monitoring of new precarious situations.

- Elaborate a mental health data repository and create active links between the existing data sources, in order to maximise the potential usage of data in better monitoring and predicting the impact of this pandemic on mental health.
- Invest in research that provides insights on the impact on mental health and predict the consequences by combining subjective and objective indicators.

## **2) Develop an effective and aligned communication strategy on promoting mental health.**

The SHC wishes to stress the crucial importance of communication regarding the mental health impact of Covid-19:

- The pandemic has been accompanied by an infodemic, i.e. an overload of information of varying quality (including fake news) which is continuously being spread through a wide array of media. There is a need for a robust mental health communication plan, to counteract the negative effects of the infodemic.
- Given the chronicity of the pandemic, the population have great difficulty staying motivated and keeping a positive outlook. An aligned communication strategy can support people in their behaviour in adapting to the situation, and inspire them to adopt new coping strategies.

### **ACTIONS:**

- a) Combat the infodemic by an effective mental health communication strategy, in collaboration with the media and government bodies, which focuses on giving people trustworthy and transparent information, and a realistic, but positive, perspective that prompts them to adopt new coping strategies.
- b) This communication needs to avoid an authoritative tone, and focus on community, humanity, solidarity and togetherness.
- c) The communication also needs to be adapted to the different target groups, especially those with limited knowledge of health information or who are not reached by traditional media.
- d) The media has a role to play in communicating in a more positive and less anxiety-inducing way about the adoption of protective health-related behaviour.

## **3) Invest in work as a lever for mental health and fully utilise the existing preventive structures.**

The SHC identified the work which would be of crucial importance in regard to well-being, both on a personal and social level, but also of crucial importance to preserve financial stability (identified as a possible indirect risk of the pandemic). Work gives meaning, purpose, social connection and financial stability. For the general public, the current mental health impact of the pandemic is mostly felt through adaptation challenges and is predominantly felt in the workplace.

### **ACTIONS:**

- a) Work must therefore be seen as a crucial and readily available lever to mental well-being in this pandemic.
- b) The prevention services, already active and operational within the work domain, can play a vital role in preventing and detecting mental health problems in the workplace. There is no need to reinvent the wheel, as these existing services can be easily strengthened and are up to the job.

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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 **Lode GODDERIS** and **Frederique VAN LEUVEN**; the scientific secretary was Sylvie GERARD.

<b>BAL Sarah</b>	Clinical psychology	UGent
<b>BAZAN Ariane</b>	Psychology	ULB
<b>BLAVIER Adélaïde</b>	Clinical psychology	ULG
<b>BRUFFAERTS Ronny</b>	Psychology	UZLeuven
<b>CALMEYN Marc</b>	Psychiatry, psychotherapy	<i>PZ Onze-Lieve-Vrouw-College</i>
<b>DE LAET Hannah</b>	Psychology	VUB
<b>DERLUYN Ilse</b>	Migration	UGent
<b>GODDERIS Lode</b>	Occupational medicine	KULeuven
<b>LORANT Vincent</b>	Public Health	UCLouvain
<b>LUMINET Olivier</b>	Health Psychology	UCLouvain
<b>MATTHYS Frieda</b>	Psychiatry	UZ Brussel, VUB
<b>MOMMERENCY Gijs</b>	Clinical psychology	UZ Gent
<b>PORTZKY Gwendolyn</b>	Psychology	UGent
<b>RESIBOIS Maxime</b>	Psychology	CRéSaM
<b>VAN DEN CRUYCE Nele</b>	Social sciences	VUB
<b>VAN GRAMBEREN Mieke</b>	Sociology	<i>Zorg Leuven</i>
<b>VAN HOOF Elke</b>	Clinical psychology	VUB
<b>VAN LEUVEN Frederique</b>	Psychiatry	<i>Centre Psychiatrique Saint-Bernard</i>
<b>VANDAMME Annemie (Anne-Mieke)</b>	Virology, epidemiology	<i>Rega Instituut (KU Leuven)</i>

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

<b>COLEMONT Patrick</b>	<i>Vlaams Patiëntenplatform</i>
<b>LAUREYS Greet</b>	Similes
<b>LOWET Koen</b>	VVKP
<b>LIÉVIN Vincent</b>	Freelance journalist
<b>MOENS Isabel</b>	<i>Zorgnet Icuro</i>
<b>NIEUWENHUYTS Céline</b>	Federation of Social Services
<b>PEPERMANS Koen</b>	<i>Universiteit Antwerpen</i>
<b>VAN DAELE Tom</b>	<i>Steunpunt GGZ</i>
<b>VANHAECHE Kris</b>	KU Leuven
<b>VANSTEENKISTE Maarten</b>	UGent

The following administrations and/or ministerial cabinets were heard:

CAUCHIE Martin	Cabinet Minister Maron
CUIGNET Deborah	Cabinet Minister Linard
DE BOCK Paul	FPS Public Health
FORTUIN Astrid	FPS Public Health
JACOB Bernard	FPS Public Health
LECLERCQ François	Cabinet Minister Morreale
MOENS Isabel	Cabinet Minister Vandenborucke
OOSTERLINCK Tineke	Cabinet Minister Beke
PERL François	RIZIV
PIRAPREZ Laura	Cabinet Minister Antoniadis
RABAU Ria	Cabinet Minister Van den Brandt
VANDENBROUCKE Elodie	Cabinet Minister Linard

This advisory report was translated by an external translation agency.

## VII APPENDIXES

### **Appendix 1: Search terminology used in Cochrane and Pubmed (title and/or abstract)**

*COVID-19/coronavirus/Covid*

**AND**

*Mental health (psychological distress)*

**AND**

*Children*

*elderly*

*resilience*

*bereavement*

#### ***Inclusion criteria***

*Systematic Review and reviews with clear methodological approach*

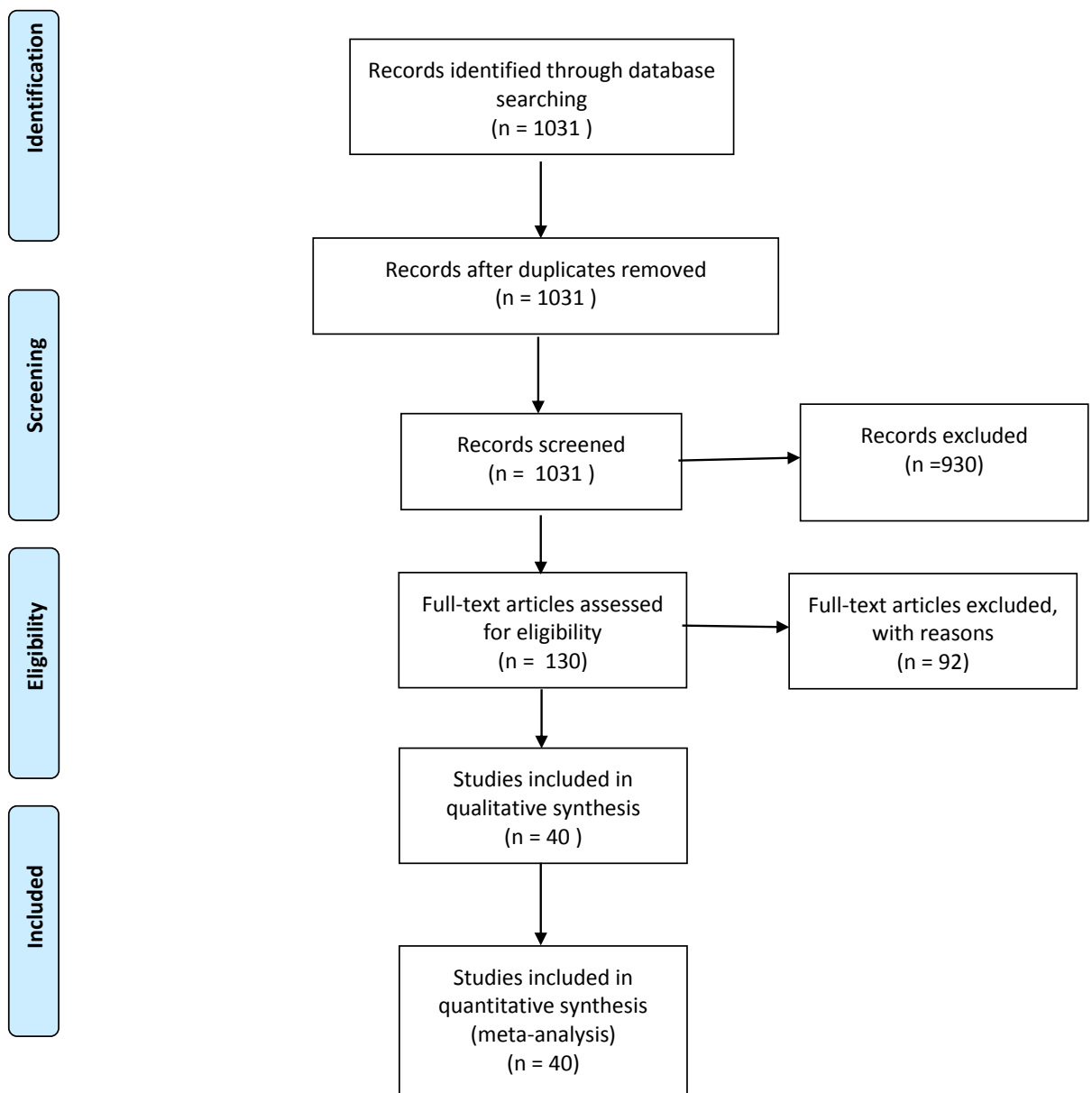
*May 2020 – November 2020 (follow up report I)*

*English/French*

#### **Exclusion criteria**

Non psychosocial impact

Non-human impact



## Appendix 2: Delphi study: Statement and average score per statement (out of 7)

The authorities are not paying sufficient attention to the psychosocial aspects of the pandemic. Not including the psychosocial aspects of Covid-19 will have a negative impact on the course and development of the consequences of the pandemic.	5,34
The mental health system was already under pressure before the crisis. The structurally insufficient support (e.g. financial, legal, organisational, etc.) for this sector is a significant element that explains why the sector was not adequately prepared for the challenges posed by the pandemic.	5,84
There is a lack of strategic vision on mental health care and the importance of mental health in society.	5,92
Mental health care has not received sufficient government support to address the lack of necessary resources (e.g. prevention equipment, IT needs, etc.).	5,49
During the pandemic, various mental health services were forced to close or reduce their availability, which had a negative impact on mental health.	5,81
The necessary preventive measures during the pandemic (e.g. social distancing, masks, teleworking) have a negative impact on the therapeutic relationship between the mental health care worker and the patient.	5,18
Teleconsultations have opened up mental health services to people who did not previously consult them.	3,99
There is a lack of communication and clear guidelines, which has a negative impact on mental health.	5,35
Due to the preventive measures, there is a dearth of options to recharge one's batteries, which impacts the basic principles of preventive mental health.	5,75
The fear of contaminating oneself and the fear of contaminating others (relatives, patients, etc.) create additional emotional pressure.	5,95
The impact of COVID-19 on the mental health of the general population is marked by difficulties in coping, and a significant mental burden.	5,84
For the general population, the impact of COVID-19 on mental health is primarily visible in the workplace.	3,94
In the long term, a rise in mental health issues in the general population is to be expected.	5,89
There is a need for more flexible working conditions (e.g. breaks) in recognising the mental overload in the workplace.	5,35
The duration of preventive measures is more testing for mental health than the preventive measures themselves.	5,48
There is less social cohesion/solidarity in the second wave compared to the first.	5,27
The impact of COVID-19 on the mental health of those with pre-existing vulnerabilities increased the severity and/or number of psychopathologies.	5,71
The impact of Covid-19 has heightened social inequalities, which in turn may also increase mental health problems.	6,07
Policy makers do not pay sufficient attention to the impact of the pandemic on the mental health of vulnerable or less represented groups (e.g. children and young people, people with disabilities, caregivers, etc.).	5,57
There is a need to set up a dispatching system, capable of rapidly identifying the psychosocial needs, sorting and orienting patients; this is to ensure continuity of care and to respond rapidly to (possibly variable) mental health needs (staged care).	5,50
The impact of Covid-19 on mental health is greater in the second wave than in the first.	5,69
There is a need for a better overview and linking of existing data and analysis on the impact of COVID-19 on mental health.	5,83

Innovations to the mental health system in the first wave have made care more accessible in the second wave (e.g. hybrid care).	4,84
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