

1 Coping with COVID-19: Young people's health in an age of disruption

While few people's lives have been unaffected by the COVID-19 pandemic, there have been concerns for the physical and mental health of young Europeans whose formative years have been marked by fear, uncertainty and disruption – particularly given the critical importance of early experiences in shaping health and well-being later in life. This chapter finds that those concerns are well-founded. The pandemic had a significant impact on young people's physical and mental health, with symptoms of depression amongst young people more than doubling in several countries, young people spending considerably less time engaged in physical activity, and many experiencing a worsening of their nutrition habits. Disruptions to care delivery and growing demand have also challenged already-stretched mental health services. Almost one in two young Europeans reported unmet needs for mental health care during the pandemic. European countries have implemented a range of measures to support young people's physical and mental health, but given the magnitude of the impacts, further action is needed.

1.1. Introduction

The pandemic and the measures implemented to contain it have had wide-reaching implications for young people's physical and mental health. Beyond the direct health impacts of the pandemic, fear, uncertainty, prolonged periods of social isolation and disruptions to education and employment seriously disrupted the lives and routines of young people at a critical time of their physical and social development. The alarm over mental health was sounded early and often. The pandemic exacerbated many of the risk factors associated with poor mental health and weakened many of the protective factors, leading to an unprecedented worsening of population mental health, particularly amongst young people (OECD, 2021^[1]). School closures, social isolation, disrupted routines and the suspension of sports programmes also had considerable implications for young people's physical health, with young people engaging in less physical activity and many experiencing a worsening of dietary habits.

Recognising the far-reaching consequences of the pandemic and the measures implemented to contain it, this chapter provides an overview of the impact of the COVID-19 crisis on young people's mental health, physical activity and nutrition, and the measures implemented across Europe to mitigate those impacts. It begins with a review of the evidence on the impact of the pandemic and associated containment measures on youth mental health and mental health care services, and then provides an overview of the policy measures adopted by European countries to mitigate them. It then reviews evidence on the impacts of the pandemic on young people's physical activity and nutrition, and consequences on overweight and obesity. This chapter focuses primarily on school-aged children and adolescents, and on young people aged up to 29 years old.

1.2. The pandemic has had a significant impact on young people's mental health and well-being

1.2.1. Symptoms of depression more than doubled in several European countries

Even before the pandemic, the burden of mental ill-health amongst young Europeans was significant. The prevalence of mental health issues is difficult to estimate as data obtained via population surveys often focus on a few specific mental health conditions or on the prevalence of conditions amongst specific age groups. Nevertheless, available evidence suggests mental health issues affect millions of young people across Europe every year. According to estimates from the Institute for Health Metrics and Evaluation (IHME), more than one in six young people in the EU – more than 14 million people – had a mental health issue in 2019 (17.4% of those aged 15-29 on average) (IHME, 2020^[2]).

Box 1.1. Defining and measuring the mental health of young people

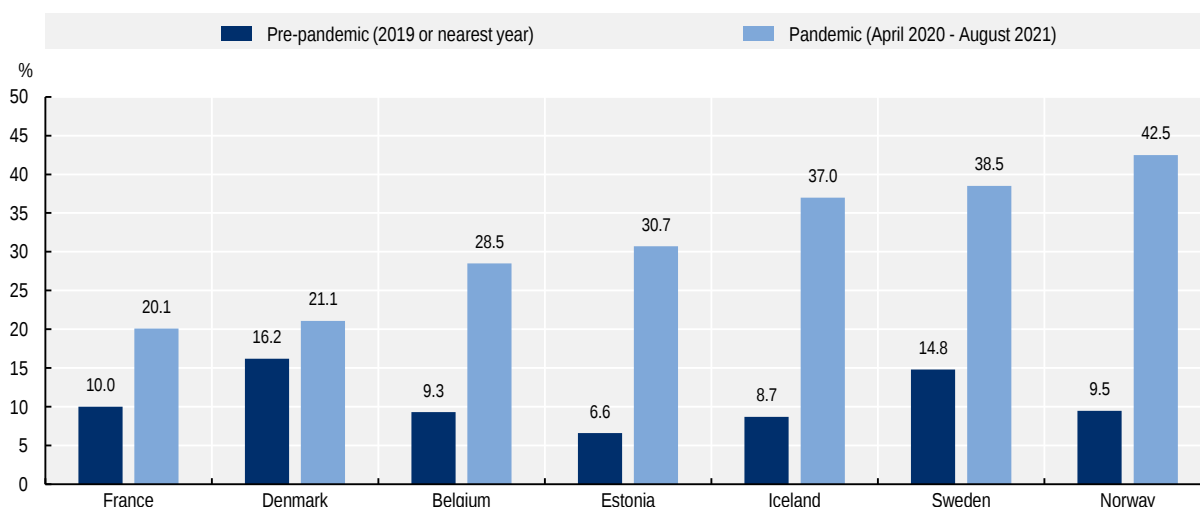
The terms “mental health conditions” and “mental health issues” are used in this brief, while the term “mental illness” is largely avoided. This is to ensure, where possible, language is person-centred, strengths-based, and recovery-focused, and reflects the differing experiences of mental health issues from individual to individual.

Age-stratified data on population mental health remain limited in quality and coverage, especially over the course of the pandemic. This chapter relies primarily on estimates of the prevalence of symptoms of anxiety and depression, obtained via self-reported surveys, as a proxy indicator for mental health. As far as possible, this chapter reports on data obtained through surveys using validated instruments, such as General Anxiety Disorder-7 (GAD-7) for anxiety and the Patient Health Questionnaire-9 (PHQ-9) for depression. A brief overview of the survey instruments referred to regularly in this chapter is contained in Annex 1.A. Samples are not necessarily representative, especially for surveys that were undertaken rapidly during the pandemic. Estimates of the share of people experiencing symptoms of mental health conditions are also affected by self-reporting rates, which can be influenced by different levels of mental health literacy or stigma within countries.

The pandemic and the measures implemented to contain it fuelled an unprecedented worsening of young people's mental health across Europe. In European countries where broadly comparable pre-pandemic data are available, the share of young people (typically 18-29) with symptoms of depression more than doubled in several countries (Figure 1.1). In three Nordic countries – Iceland, Sweden and Norway – more than one in three young people reported symptoms of depression in this period, compared to around one in nine prior to the pandemic (11% on average).

Figure 1.1. Symptoms of depression amongst young people more than doubled in several European countries

Share of young people with symptoms of depression



Note: Given the prevalence of symptoms of depression has fluctuated within countries over the course of the pandemic, prevalence estimates are pooled from longitudinal or repeated cross-sectional surveys within countries up to 12 August 2021. However, not all surveys are representative and the number and timing of surveys has varied across countries which hampers cross-country comparability. Symptoms of depression have been measured using PHQ-8 and PHQ-9 in all countries except France and Estonia. Some pre-pandemic and pandemic data are not strictly comparable due to differences in scoring methods, which could understate the increase in symptoms to some extent. Symptoms of depression in France during the pandemic have been measured using HADS-D which could lead to lower estimates of the share of young people with symptoms of depression compared to other countries using PHQ-8 and PHQ-9. The age groups used to refer to “young people” vary, limiting comparability. Pandemic data are for 18-29 year-olds in all countries except France, where it is for 18-24 year-olds. Pre-pandemic data are for 15-24 year-olds in all countries except Belgium, where it is for 18-29 year-olds.

Source (years and age groups): France: Eurostat (2021^[3]), <https://ec.europa.eu/eurostat/databrowser/> (2019, 15-24) and Santé publique France (2022^[4]), <https://www.santepubliquefrance.fr/etudes-et-enquetes/coviprev-une-enquete-pour-suivre-l-evolution-des-comportements-et-de-la-sante-mentale-pendant-l-epidemie-de-covid-19> (2020/21, 18-24); Belgium: Sciensano (2018^[5]), <https://www.sciensano.be/en/projects/health-interview-survey> and Sciensano (2022^[6]), <https://datastudio.google.com/embed/reporting/7e11980c-3350-4ee3-8291-3065cc4e90c2/page/ykUGC> (2018 and 2020/21, 18-29); Denmark, Estonia, Iceland, Sweden and Norway: Eurostat (2021^[3]), <https://ec.europa.eu/eurostat/databrowser/> (2019, 15-24) and Unnarsdóttir et al. (2021^[7]), <https://doi.org/10.1093/ije/dyab234> (2020/21, 18-29).

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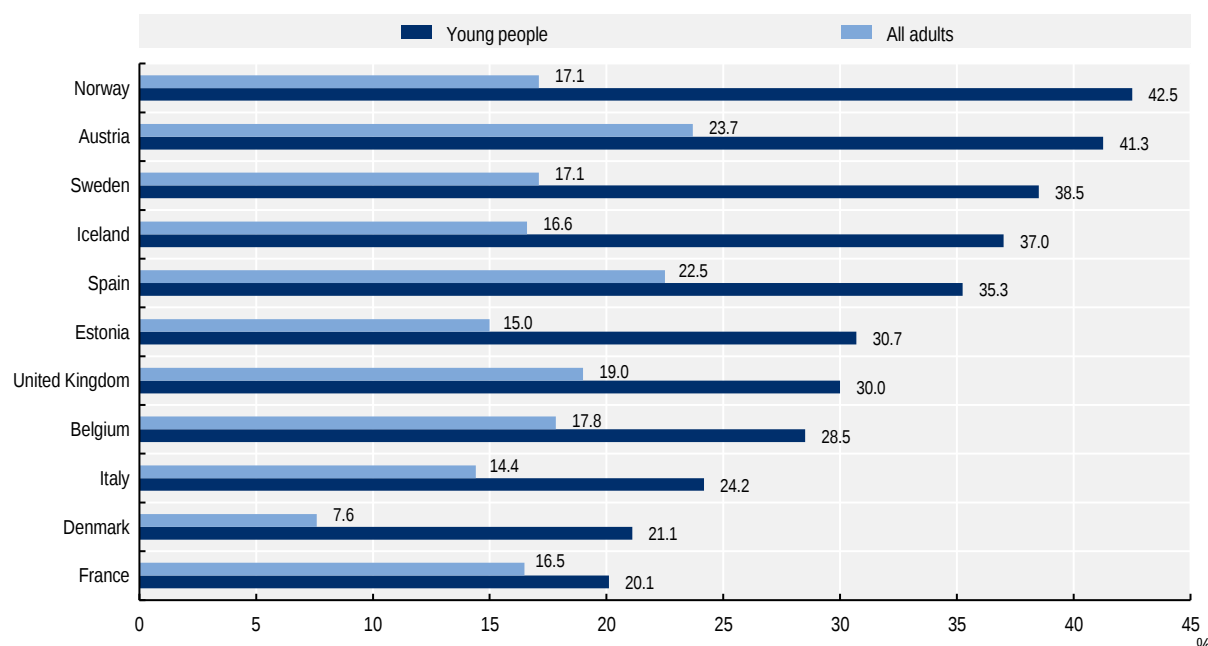
The share of young people with symptoms of anxiety also increased significantly in a number of European countries, in some cases doubling from pre-pandemic levels. For example in Belgium, the share of young people (18-29) reporting symptoms of anxiety more than doubled, climbing from 12% in 2018 to 28% between April 2020 and June 2022 (Sciensano, 2018^[5]; Sciensano, 2022^[6]). In Finland, the share of students (aged 14-20) reporting moderate or severe symptoms of anxiety increased by more than 50% between 2019 and 2021, from 12.6% to 19.2% (Finnish Institute for Health and Welfare, 2021^[8]). Symptoms of anxiety amongst young people have also been extraordinarily high in France, with almost one in three young people aged 18-24 (31%) reporting symptoms of anxiety in the period between March 2020 and September 2022 on average (Santé publique France, 2022^[4]).

While there is a paucity of pandemic data for children and adolescents, the available evidence also points to an increase in symptoms of anxiety and depression amongst this age group. Globally, a 2021 meta-analysis of studies reporting on symptoms of anxiety and depression amongst children and adolescents (up to 18 years old) – relying primarily on data collected in 2020 – found that symptoms were double that of pre-pandemic levels, with one in four experiencing symptoms of depression, and one in five experiencing symptoms of anxiety (Racine et al., 2021^[9]).

Data from Europe similarly points to a worsening of mental health and well-being amongst children and adolescents, albeit with some variation across countries. In the Netherlands, the share of young people (12-18) considered “mentally unhealthy” (as measured using the Mental Health Inventory-5) increased by 50% during the pandemic, from 8.3% in 2019 to 12.6% in 2021 (CBS Netherlands, 2022^[10]). Similarly in Germany, a survey using the Screen for Child Anxiety Related Disorders (SCARED) found that the share of children and adolescents aged 11-17 with symptoms of anxiety more than doubled over the course of the pandemic, from 14.9% prior to the pandemic to 30.1% in December 2020/January 2021 (Ravens-Sieberer et al., 2022^[11]). However, in Sweden, a longitudinal study of 15-year-olds found no differences in psychosomatic symptoms and stress between adolescents sampled during the pandemic (between February and November 2020) compared to those sampled just before the pandemic (Chen et al., 2022^[12]). Variation in the intensity of the pandemic and the measures implemented to contain it is likely to explain some cross-country variations in mental distress amongst young people. While full school closures occurred in almost all European countries, this was not the case in Sweden and Iceland and the length of closures varied significantly (see Figure 1.12 below).

Figure 1.2. The share of young people with symptoms of depression was more than double that of the population average in several European countries

Share of people with symptoms of depression, 2020-21(or nearest year available)



Note: Data are not strictly comparable across countries as some estimates were collected at different points in time and are based on different survey instruments, but are presented to provide an indication of age gaps within countries. The data used in Figure 1.1 for France, Denmark, Belgium, Estonia, Iceland, Sweden and Norway have also been used in this figure and are therefore subject to the same comparability limitations. Data for the United Kingdom (Great Britain) are pooled averages for January to March 2021 and July to August 2021. Data for Austria are pooled averages for April 2020 and December 2020/January 2021. Data for Spain are for April-May 2020. Data for Italy are for June 2020. Symptoms of depression have been measured using PHQ-8 and PHQ-9 in all countries except France, Estonia and Italy.

Source and age groups (for young people): France: Santé publique France (2022^[4]), <https://www.santepubliquefrance.fr/etudes-et-enquetes/coviprev-une-enquete-pour-suivre-l-evolution-des-comportements-et-de-la-sante-mentale-pendant-l-epidemie-de-covid-19> (18-24); Belgium: Sciensano (2022^[6]) <https://datastudio.google.com/embed/reporting/7e11980c-3350-4ee3-8291-3065cc4e90c2/page/YkUGC> (18-29); Denmark, Estonia, Iceland, Sweden and Norway: Unnarsdóttir et al. (2021^[7]) (18-29); <https://doi.org/10.1093/ije/dyab234>; United Kingdom (Great Britain): Office for National Statistics (2021^[13]), <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/coronavirusanddepressioninadultsingreatbritain> (16-29); Austria: Pieh et al. (2020^[14]), <https://doi.org/10.1016/j.jpsychores.2020.110186>, Dale et al. (2021^[15]), <https://doi.org/10.3390/ijerph18073679> (18-24); Spain: Jacques-Aviñó et al. (2020^[16]), <https://doi.org/10.1136/bmjopen-2020-044617> (18-35); Italy: Delmastro and Zamariola (2020^[17]), <https://doi.org/10.1038/s41598-020-79850-6> (16-24).

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1.2.2. The pandemic had a disproportionate impact on young people's mental health

There is now overwhelming evidence that young people's mental health deteriorated disproportionately over the course of the pandemic. In virtually all European countries for which data are available, young people frequently reported poorer mental health than older age groups. This is a reversal of the pre-pandemic situation: in 2019, the share of young people reporting symptoms of depression was typically lower than the population average (6% of 15-24 year-olds, compared to 7% among all adults on average in the EU) (Eurostat, 2021^[3]). This reversal has been significant: during the pandemic, the share of young people reporting symptoms of depression was at least 50% higher than the population average in almost all European countries for which data are available, and in some countries even double that of the population average (Figure 1.2). The pandemic has clearly taken a heavy toll on young people.

1.2.3. Rates of suicidal ideation increased significantly, but there is not yet any indication of an increase in rates of death by suicide amongst young Europeans

The heavy toll of the pandemic on young people's mental health and well-being is further evidenced by an alarming increase in reported rates of suicidal ideation (suicidal thoughts). In Belgium and France, there was around a fivefold increase. In March 2021, one in four young Belgians aged 18-29 (25%) reported that they had seriously considered suicide in the past 12 months, compared to a pre-pandemic rate of around one in nineteen (5.2% in 2018) (Sciensano, 2021^[18]; Sciensano, 2018^[5]). Similarly in France, in September 2022 more than one in four young people aged 18-24 reported having considered suicide in the past 12 months, compared to a pre-pandemic prevalence of 4.6% in 2017 (Santé publique France, 2022^[4]; Baromètre de Santé publique France, 2017^[19]). High rates of suicidal ideation have also been reported in the Netherlands, where survey data for the period between April-June 2022 showed that around one in six young people (16% of those aged 12-25) reported serious thoughts of suicide in the past three months (Dutch National Institute for Public Health and the Environment, 2022^[20]).

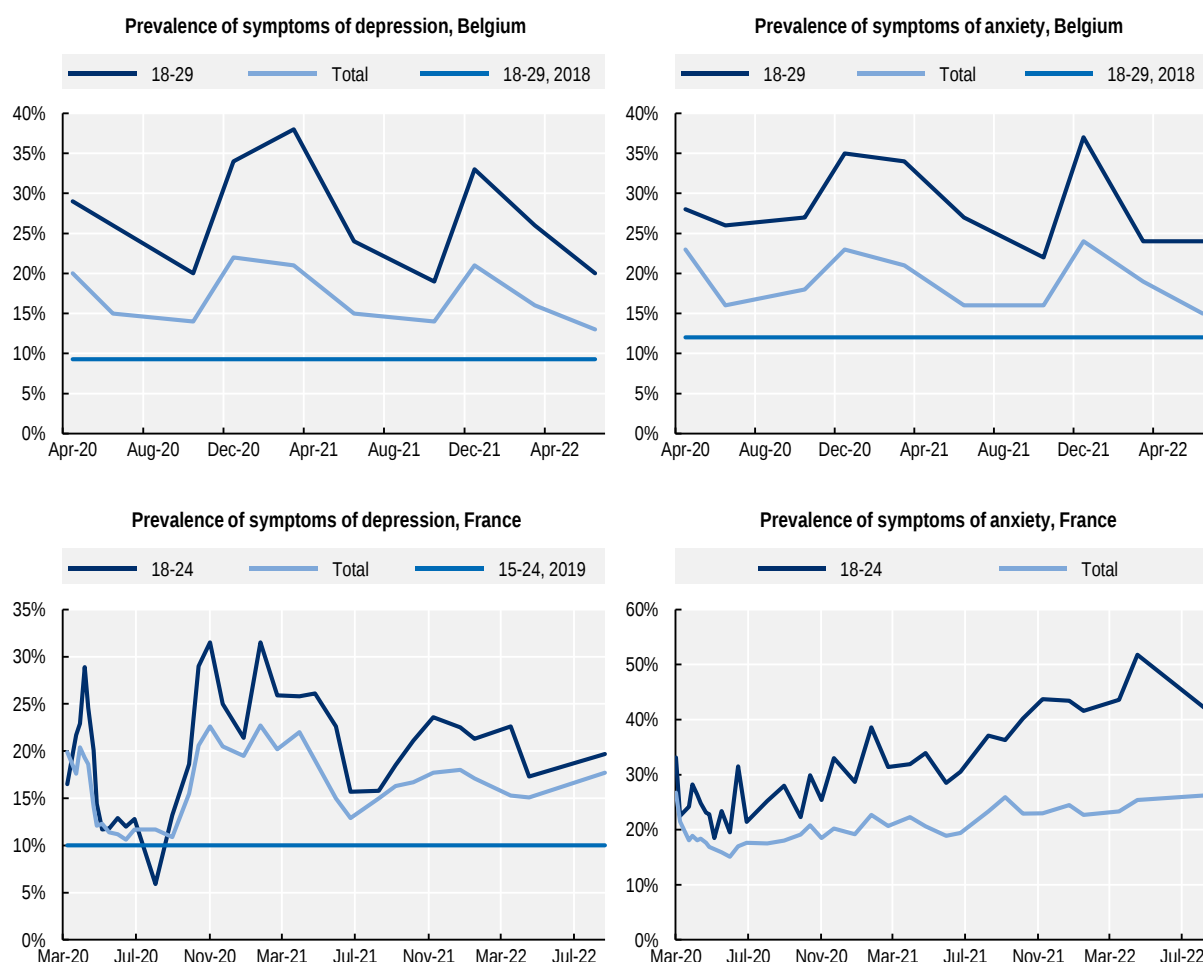
While there is as yet no indication that rates of death by suicide amongst young people have increased across Europe since the start of the pandemic, it is critically important that suicide prevention measures are strengthened and that rates of death by suicide are monitored closely.

1.3. Young people's mental health fluctuated with the intensity of the pandemic and the measures introduced to contain it

1.3.1. Population mental health was typically worst around pandemic "peaks", when infection and death rates were high, and uncertainty loomed large

Population mental health went up and down with pandemic "waves", typically worsening as the pandemic intensified. This is consistent with general population trends: in a number of European countries, high COVID-19 infection and death rates and stringent containment measures have generally been associated with increases in mental distress over the course of the pandemic, though the associations have varied by country and the type of mental health indicator (OECD, forthcoming^[21]). In Belgium and France, symptoms of anxiety and depression amongst young people were typically highest around pandemic peaks, though they remained significantly above pre-pandemic levels for almost the entirety of the pandemic (Figure 1.3). In France, symptoms of anxiety amongst young people (18-24) generally increased or remained stable between June 2021 and May 2022, before declining slightly in September 2022 (to 41%). Heightened symptoms of anxiety could to some extent reflect the emergence and confluence of multiple crises, such as Russia's war of aggression against Ukraine, the cost-of-living crisis, and the climate crisis.

Figure 1.3. Symptoms of anxiety and depression were typically highest around pandemic peaks in Belgium and France, but remained well above pre-pandemic levels for almost all of the pandemic



Note: Depression and anxiety have been measured using HADS-D and HADS-A in France and using PHQ-9 (depression) and GAD-7 (anxiety) in Belgium. An overview of the relevant survey methodologies is available in Annex 1.A. Pre-pandemic data for Belgium (2018) and France (2019) is provided where available. A pre-pandemic value for anxiety in France is not available. In France, confinement measures were in place in March-May 2020, November-December 2020, and April 2021. In Belgium, confinement measures were in place in March-May 2020 and from November 2020, with restrictions to June-August 2021.

Source: France: Eurostat (2021^[3]), <https://ec.europa.eu/eurostat/databrowser/> and Santé publique France (2022^[4]), <https://ec.europa.eu/eurostat/databrowser/>; Belgium: Sciensano (2018^[5]), <https://www.sciensano.be/en/projects/health-interview-survey>, Sciensano (2022^[6]), <https://datastudio.google.com/embed/reporting/7e11980c-3350-4ee3-8291-3065cc4e90c2/page/ykUGC>, OECD/European Observatory on Health Systems and Policies (2021^[22]), <https://doi.org/10.1787/57e3abb5-en>.

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1.3.2. Many young people with pre-existing and severe mental health issues reported a worsening of their symptoms during the pandemic

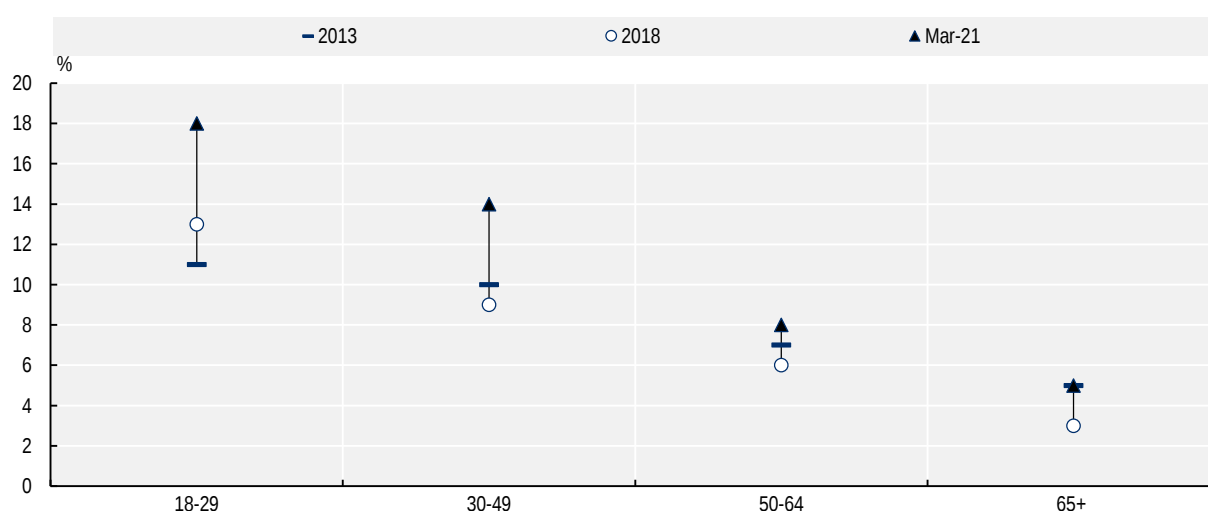
Alongside a sharp increase in the prevalence of mental distress, many young Europeans with pre-existing mental health issues reported a worsening of their mental health and well-being, though the evidence is somewhat mixed and varies across countries. A survey conducted in the United Kingdom (primarily England) between April and June 2020 found that three-quarters of young people with experience of mental health issues reported that their mental health had worsened during the first lockdown (Mind, 2020^[23]). Conversely in Denmark, a longitudinal survey of 18-24 year-olds found a deterioration in mental well-being amongst young people without pre-existing symptoms of depression during the first lockdown, but not amongst those with pre-existing symptoms (Joensen et al., 2022^[24]).

There is also growing evidence that many young people with specific conditions, such as eating disorders, experienced a worsening of their symptoms. The pandemic – and particularly prolonged and repeated periods of confinement – may have exacerbated eating disorders through heightened mental distress, disrupted routines, reduced access to care and treatment, and restrictions to physical activity (Rodgers et al., 2020^[25]).

Some country-specific evidence points not only to a worsening of symptoms but also potentially to an increase in the incidence of eating disorders, though evidence for the latter is mixed. In Belgium, the share of young people aged 18-29 with symptoms of an eating disorder was almost 40% higher in March 2021 than in 2018 (Sciensano, 2021^[18]). While the share of young people with symptoms of an eating disorder had already been increasing in the years leading up to the pandemic, this trend accelerated (Figure 1.4). However in Italy, an April-June 2020 survey conducted during and after lockdown found that students with a history of an eating disorder reported an increase in symptoms following lockdowns, but there appeared to be no increase amongst students who did not have a previous history of an eating disorder (Meda et al., 2021^[26]).

Figure 1.4. The pandemic accelerated a growth in eating disorders amongst young people in Belgium

Share of people in Belgium with symptoms of an eating disorder by age, 2013-21



Note: Symptoms of an eating disorder were measured using SCOFF, a five-item questionnaire. Each “yes” response equals one point, and a cut-off of ≥ 2 has been used to indicate symptoms of anorexia, bulimia, or another eating disorder.

Source: Sciensano (2021^[18]), “Sixth COVID-19 Health Survey. First results”, <https://doi.org/10.25608/r4f5-1365>.

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1.4. While available data suggest some improvement in early 2022, mental distress remains very high

1.4.1. Young people’s mental health appears to have improved in early 2022, but symptoms of anxiety and depression are still double pre-pandemic levels in some countries

A limited set of country-specific evidence suggests that young people’s mental health and well-being improved somewhat in the first half of 2022 as infection and death rates fell and restrictions continued to be eased across Europe (see Figure 1.3). At a European level, data from Eurofound’s *Living, working and COVID-19 e-survey* point to some improvement in mental well-being, with the share of 18-29 year-olds at risk of depression in spring 2022 declining from spring 2021, but remaining higher than in the spring of 2020 (Eurofound, 2022^[27]). However, in Belgium and France, latest data show that symptoms of anxiety and depression remain elevated, and in some cases prevalence is still double that of pre-pandemic levels. In Belgium, in June 2022 the prevalence of symptoms of anxiety and depression amongst 18-29 year-olds stood at 24% and 20% respectively, double the pre-pandemic levels of 12% and 9% (in 2018). In France, data from September 2022 show that the share of 18-24 year-olds with symptoms of depression was also double that of pre-pandemic levels (19.7% compared to 10.0% for 15-24 year-olds in 2019).

It is too early to say what the long-term impact of the pandemic will be on the mental health and well-being of “the COVID-19 generation” – the young people whose formative years have been marked by the pandemic. Elevated mental distress can to some extent be considered an “expected” response to the stresses of the pandemic, and with appropriate support young people may be able to bounce back from the crisis. Yet, what little data there is shows that as of mid-2022, mental health and well-being remains affected. The potential long-term consequences of the pandemic on young people’s mental health are concerning, not least of which to young people themselves: in a July/August 2021 OECD survey, 151 youth organisations rated the areas where young people were finding it most challenging to mitigate the effects of the COVID-19 crisis, and mental health was the number one concern (OECD, 2022^[28]).

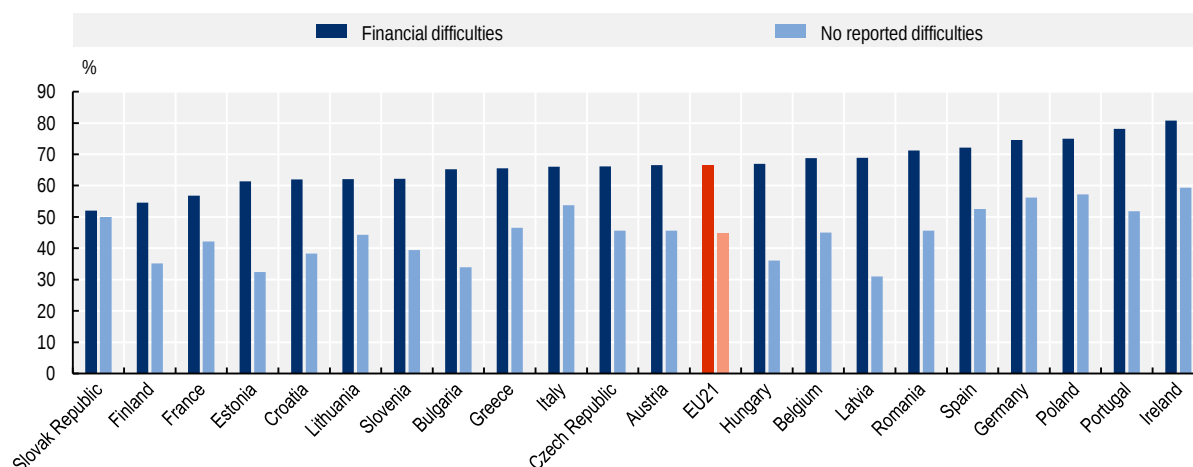
1.4.2. The pandemic has highlighted the links between income, inequality and mental health

The links between income, inequality and mental health were once more brought into sharp relief during the pandemic. Young people’s exposure to the health, social and economic shocks of the pandemic – and their ability to buffer those shocks – was shaped by their background and resources. While the risk of poor mental health has always had a social gradient, this trend has persisted or widened over the course of the pandemic. Young people in precarious financial circumstances, young women, and young people at risk of exclusion (by sexual orientation, migration status and race/ethnicity) were at heightened risk of mental health issues over the course of the pandemic.

Low income has long been associated with an increased risk of poor mental health, and this trend has continued during the COVID-19 pandemic. Data from Eurofound’s *Living, working and COVID-19 e-survey* found that young people aged 18-29 who perceived their household to have financial difficulties were significantly more likely to be at risk of depression over the course of the pandemic (Figure 1.5). On average across countries, two-thirds of young people who reported financial difficulties could be considered to be at risk of depression during the pandemic (67%), compared to just under half (45%) of those who did not report financial difficulties.

Figure 1.5. Young people in precarious financial circumstances were at heightened risk of depression over the course of the pandemic

Share of young people aged 18-29 at risk of depression (WHO-5 score <50 out of 100), by self-perceived difficulty to make ends meet, 2020-21



Note: Data from the first, second and third waves of Eurofound’s *Living, working and COVID-19 e-survey*, conducted in spring 2020, summer 2020 and spring 2021, have been pooled (weighted averages are presented). The share of respondents reporting financial difficulties are those who responded that their households had “difficulty” or “great difficulty” making ends meet. Data for Cyprus, Denmark, Luxembourg, Malta, the Netherlands and Sweden have been excluded due to small sample sizes.

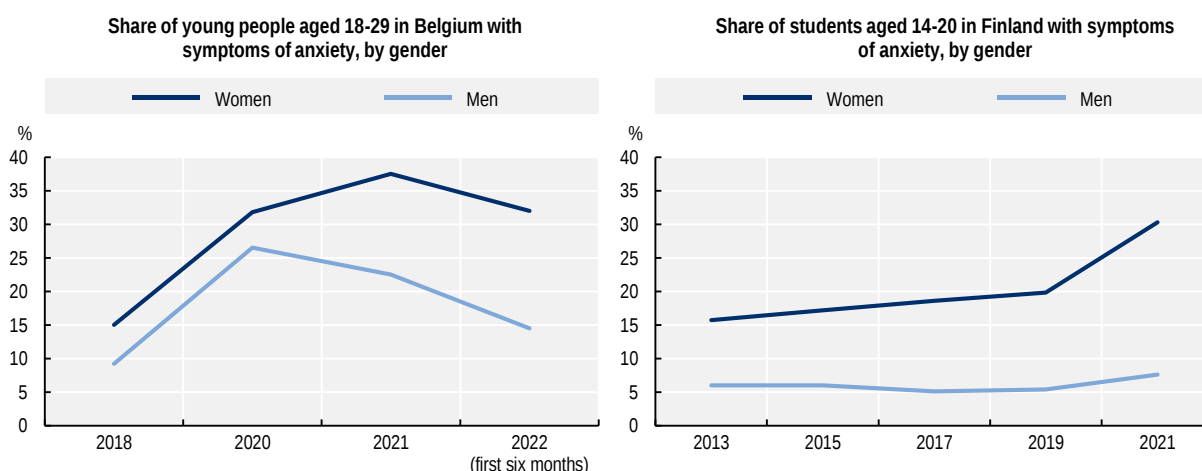
Source: OECD calculations, based on Eurofound (2021^[29]), *Living, working and COVID-19 dataset*, <http://eurofound.link/covid19data>.

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Young people at risk of exclusion were also at heightened risk of mental health issues. In the United Kingdom, LGBTIQ+ young people were more likely to report symptoms of anxiety and depression, findings echoed in Belgium (albeit amongst adults) where survey research suggests that the pandemic exacerbated mental health disparities by sexual orientation (Just Like Us, 2021^[30]; Reyniers et al., 2022^[31]). A survey of under-18s in the United Kingdom found that ethnic minority young people were significantly more likely to report symptoms of anxiety or depression and have suicidal thoughts than their white counterparts (Kooth, 2021^[32]). Survey data from Austria suggests that migration status has also been a risk factor for poorer mental health over the course of the pandemic, at least in some countries. In Austria, high school students with a first or second-generation migration background were more likely to report symptoms of anxiety and depression in February 2021 than those with no migration background (Pieh et al., 2022^[33]).

Inequalities in mental health by gender have also persisted – and in some cases widened – over the course of the pandemic. Young women were more likely to report symptoms of anxiety and depression even before the pandemic, but in a number of European countries – Belgium and Finland – there was a widening of gender gaps in some indicators of mental health, particularly so for anxiety (Figure 1.6).

Figure 1.6. Gender gaps in the share of young people with symptoms of anxiety have widened over the course of the pandemic in Belgium and Finland



Note: Symptoms of anxiety in Belgium and Finland have been measured using the General Anxiety Disorder-7 (GAD-7) scale, with a cut-off of ≥ 10 . Data for Belgium refers to 18-29 year-olds. Data for Finland cover students in grades 8 and 9 of basic education, 1st and 2nd year students in upper secondary school, and 1st and 2nd year students in vocational institutions (data restricted here to ages 14 to 20).

Source: Belgium: Sciensano (2022^[6]), <https://datastudio.google.com/embed/reporting/7e11980c-3350-4ee3-8291-3065cc4e90c2/page/ykUGC>; Finland: Finnish Institute for Health and Welfare (2021^[8]), <https://thl.fi/fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/kouluterveyskysely/kouluterveyskyselytulokset>.

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1.5. The pandemic heavily disrupted mental health care

1.5.1. The pandemic heavily disrupted mental health care, particularly during the first wave

In the early stages of the pandemic, traditional identification, referral and treatment routes for mental health conditions were heavily disrupted. The closure of schools and subsequent suspension of school mental health programmes posed a particular challenge to the prevention and timely identification of mental health issues amongst young people. Schools serve as a primary site of both mental health promotion and access to mental health services, and frontline workers such as teachers are often well-placed to identify early symptoms of mental health issues. The scale of the disruption was significant: a WHO survey in June-August 2020 found that approximately three-quarters of school mental health programmes globally were fully or partially disrupted (WHO, 2020^[35]). This disruption has meant that mental health issues amongst young people have risked going unidentified (OECD, 2021^[11]).

The measures implemented to contain the pandemic not only disrupted the prevention and identification of mental health issues, but also affected their treatment. Mental health care services – those for the general population and for children and adolescents – were heavily disrupted in European countries, particularly in spring 2020 during the first lockdowns. Social distancing and confinement measures limited the capacity to provide face-to-face services, health care efforts were focused on combatting rising infection and hospitalisation rates, and fear of infection meant that many avoided contact with care providers. Many countries quickly reconfigured care delivery to remote formats to ensure the continuity of care, with mental health services increasingly delivered online or by telephone (OECD, 2021^[35]).

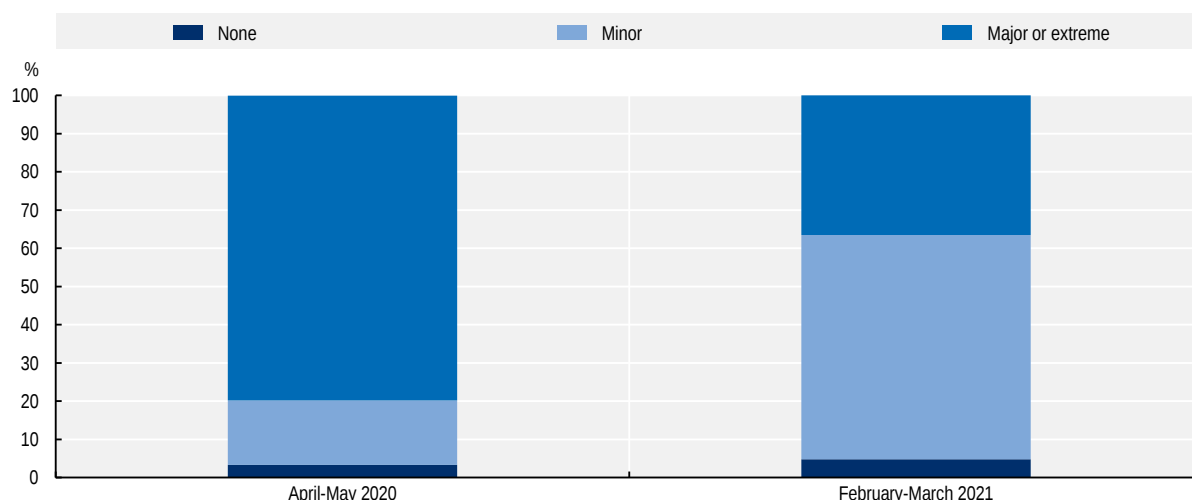
While services were quickly adapted to remote delivery, there were nonetheless significant disruptions during the first wave of the pandemic. A 2020 WHO survey found that almost 40% of participating European countries reported disruption to at least 75% of mental, neurological and substance use services/interventions, and that globally over 70% of services for children and adolescents were partially or completely disrupted (WHO, 2020^[34]). In a survey of heads of child and adolescent psychiatry in university hospitals across Europe in April/May 2020, 80% reported that the pandemic was affecting services “extremely” or “to a major degree”, 79% reported a decrease in inpatient service use and 83% reported a decrease in outpatient service use compared to pre-pandemic levels (Revet et al., 2021^[36]).

1.5.2. Following initial disruption, demand for mental health care appears to have increased in many European countries, challenging already-stretched mental health care systems

The extensive disruption to mental health care services during the first lockdowns eased with the relaxation of confinement measures, albeit at varying speeds across countries. In Ireland, for instance, it took some time for referral volumes for child and adolescent services to return to pre-pandemic levels (referrals saw an initial decline for six months) (McNicholas et al., 2021^[37]). Child and adolescent services were also disrupted as the second wave of the pandemic swept through Europe, though not as severely as during the first wave (Figure 1.7).

Figure 1.7. Heads of child and adolescent services across Europe reported the most significant disruptions to services in spring 2020, though disruptions persisted in early 2021

Share of survey respondents who reported disruptions to the provision of services to patients and their families



Note: The ESCAP's survey was distributed to the heads of child and adolescent psychiatry services in university hospitals across Europe in two waves. Responses were received from 22 European countries. Multiple responses were received from some countries and responses were aggregated, meaning that the results may be more representative of particular European countries than others. The same respondents did not necessarily respond to both waves, limiting comparability of the data across waves. Nevertheless, the results provide some insights into the perceived impact of the pandemic on mental health care services.

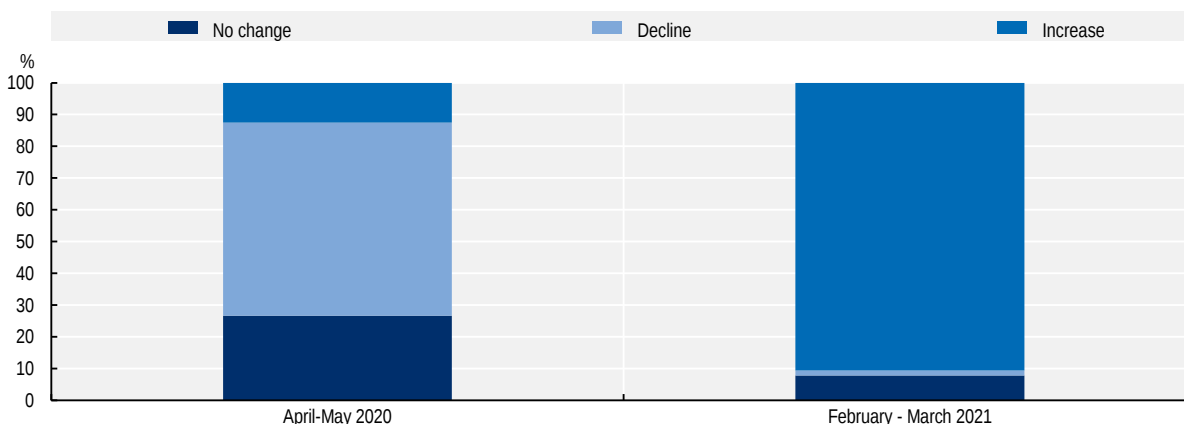
Source: Revet et al. (2021^[36]), “Perceived impact of the COVID-19 pandemic on child and adolescent psychiatric services after 1 year (February/March 2021): ESCAP CovCAP survey”, <https://doi.org/10.1007/s00787-021-01851-1>.

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There are signs that demand for mental health care increased across many European countries as service disruptions eased. While 61% of respondents to the first round of the ESCAP survey in April-May 2020 reported a decline in referrals for child and adolescent mental health care, by February-March 2021 over nine out of ten respondents reported an increase in referrals or requests for assessments compared to pre-pandemic levels (Figure 1.8). In Ireland, routine and urgent referrals for child and adolescent mental health care increased between 50-180% between September-November 2020 compared to pre-pandemic levels (McNicholas et al., 2021^[37]).

Figure 1.8. Over nine out of ten heads of child and adolescent services across Europe reported an increase in referrals for mental health care in 2021 compared to pre-pandemic levels

Share of survey respondents who reported no change, a decline or an increase in the number of referrals or requests for assessments compared to pre-pandemic levels, 2020 and 2021



Note: The ESCAP's survey was distributed to the heads of child and adolescent psychiatry services in university hospitals across Europe in two waves. Responses were received from 22 European countries. Multiple responses were received from some countries and responses were aggregated, meaning that the results may be more representative of particular European countries than others. The same respondents did not necessarily respond to both waves, limiting comparability of the data across waves. Nevertheless, the results provide some insights into the perceived impact of the pandemic on demand for mental health care.

Source: Revet et al. (2021^[36]), Perceived impact of the COVID-19 pandemic on child and adolescent psychiatric services after 1 year (February/March 2021): ESCAP CovCAP survey, <https://doi.org/10.1007/s00787-021-01851-1>.

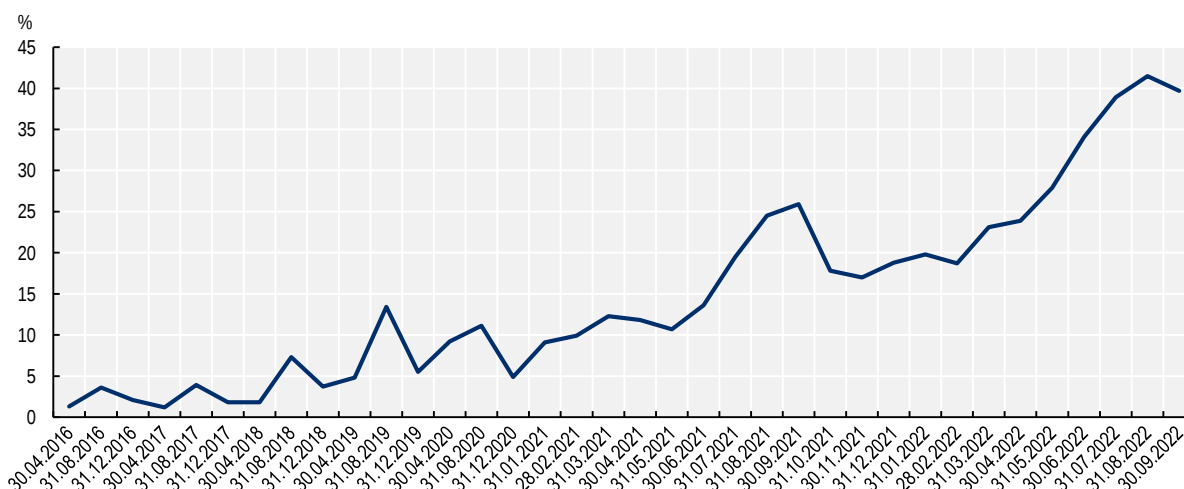
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Care complexity also increased, at least to the extent that the number of young people requiring mental health care for suicidal ideation increased. In the second wave of the ESCAP survey in February-March 2021, more than eight out of ten respondents reported an increase in the number of cases related to suicidal crises amongst children and adolescents (Revet et al., 2021^[36]). In France, this challenge appears to have persisted into 2022: between January and September 2022, the weekly number of emergency visits for suicidal ideation amongst young people (aged 15-24) was consistently higher than any other pandemic year, and at times three to four times higher than pre-pandemic levels (Santé publique France, 2022^[38]). Similarly in the Netherlands, data for April-June 2022 indicate that the number of GP visits related to suicidal ideation or attempts amongst young people were more than one-third higher (39%) than for the same period in 2019 (Dutch National Institute for Public Health and the Environment, 2022^[39]).

The pandemic has challenged already stretched mental health care services, with reports that waiting times increased in a number of European countries. In Belgium and Switzerland, care providers reported increased waiting times for mental health care during the pandemic (Belgian Federal Public Service Health Food Chain Safety and Environment, 2021^[40]; Werling et al., 2022^[41]). A March 2021 review in the Netherlands similarly reported an increase in both waiting times and waiting lists for young people, with waiting times in some inspected institutions reported to have doubled (Dutch Health and Youth Care Inspectorate, 2021^[42]). More recent data from Finland indicate that these challenges persisted in 2022: in September 2022, 40% of children and young people had to wait more than 90 days for specialised mental health care, up from 13% in August 2019 (Figure 1.9).

Figure 1.9. Waiting times for specialised mental health care for children and young people increased significantly in Finland in 2021 and 2022

Share of children and young people waiting more than 90 days for non-urgent specialised mental health care, hospital districts



Note: The Finnish Institute for Health and Welfare does not conduct monthly quality checks on this data, so it should be interpreted with caution.

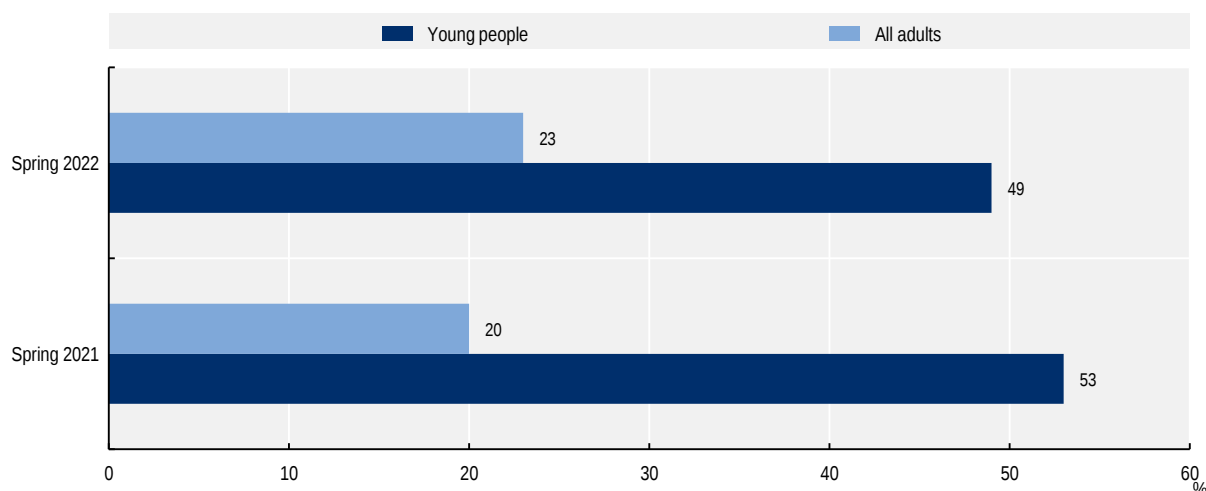
Source: Finnish Institute for Health and Welfare (2022^[43]), Access to treatment in specialised medical care, <https://thl.fi/fi/tilastot-ja-data/tilastot-aiheittain/terveyspalvelut/hoitoonpaasy-erikoissairaanhoidossa>.

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A worrying number of young Europeans now report unmet needs for mental health care. In spring 2021, more than one in two young Europeans aged 18-29 (53%) reported unmet needs for mental health care (Figure 1.10). While the share of young people reporting unmet mental health care needs decreased slightly in spring 2022, almost one in two young Europeans continued to report unmet needs (49%), more than double the share of the adult population (23%).

Figure 1.10. Almost one in two young Europeans reported unmet needs for mental health care in spring 2022

Share of people in the EU reporting unmet needs for mental health care, young people (18-29) compared with all adults, spring 2021 and spring 2022



Note: Respondents were asked about types of medical examinations or treatments that they needed but were currently unable to receive, including mental health care. The data relate to the population who reported current unmet health care needs (14% of 18-29 year-old respondents reported current unmet healthcare needs in spring 2022).

Source: Eurofound (2022^[27]), *Fifth round of the Living, working and COVID-19 e-survey: living in a new era of uncertainty*, <https://doi.org/10.2806/190361>.

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While there are indications that the need for mental health care has increased in some countries, it is not yet known whether and to what extent heightened mental distress will translate to increased effective demand for mental health care amongst young people in the years to come. Given significant gaps between the need for and availability of support even before the pandemic, the implications would be significant. New and extended sources of uncertainty across Europe – Russia's war of aggression against Ukraine, the cost-of-living crisis and the climate crisis – could also compound the challenges presented by the pandemic years. Given the extent of the impact of the pandemic on young people's mental health, the serious disruptions to mental health care and indications that need for care is growing in some countries, it will be critical that countries ensure appropriate support is available to those who need it.

1.6. European countries stepped up efforts on youth mental health

European countries have taken actions to mitigate the consequences of the pandemic on young people's mental health, typically by strengthening prevention and promotion efforts, and/or expanding mental health support.

1.6.1. Countries scaled up prevention and promotion measures

Preventing mental ill-health and promoting good mental health has taken on a new urgency as a result of the pandemic. Many European countries have stepped up prevention and promotion measures, often including youth-oriented or youth-targeted measures. Awareness campaigns have been common. For example, in June 2021, France launched "*J'en parle à*" ("*I talk to*"), a prevention campaign targeted to adolescents to encourage them to talk about mental health and take up remote support services if needed. An evaluation of the campaign suggested it had been well received, with over nine out of ten (94%) teenagers finding the campaign useful, and evaluations finding increased use of "*Fil Santé Jeunes*" ("*Youth Health Threads*"), the digital and telephone support platform for young people throughout the campaign (Santé publique France, 2022^[44]). Similarly, Lithuania launched "*Pagalba Sau*" ("*Self-help*"), a national mental health platform designed to provide information on how to maintain good emotional health during the pandemic, with a dedicated section for teenagers. Targeted awareness-raising campaigns for young people were also launched in Portugal, Germany and the Netherlands (OECD, 2021^[45]).

Beyond awareness campaigns, a range of interventions have been deployed across European countries to protect and promote young people's mental health. At the European level, a new EU initiative on mental health was announced in the 2022 EU State of the Union address. A number of flagship initiatives have also been launched within the context of 2022 being designated the European Year of Youth. In February 2022, the European Commission launched a call for proposals as part of the *EU4Health* Programme, allocating EUR 8 million to support – amongst other things – interventions to promote the mental health and well-being of young people and their families in vulnerable situations.

National initiatives have also been common. For example, Latvia allocated EUR 3 million to support young people's mental health in April 2021, by encouraging activities such as youth summer camps and local pupil council initiatives (OECD, 2021^[45]). In Hungary, the Snétberger Music Talent Centre provided online music teaching and mentoring to disadvantaged students to promote social inclusion (Eurofound, 2021^[46]). The European Commission's 2021 EU Health Award recognised a number of pioneering initiatives by local authorities and non-governmental organisations across Europe to protect and promote young people's mental health during the pandemic, such as "*Action Suricate*" ("*Action Meerkat*"), a local initiative by the French municipality of Toulouse to protect young people's mental health through peer-to-peer exchanges and support (European Commission, 2022^[47]).

1.6.2. European countries expanded mental health support for young people

Many European countries have expanded access to mental health support for young people in response to the COVID-19 crisis. For example, many European countries expanded or developed new mental health information and support platforms (typically by telephone or online) to provide crisis support to young people during the pandemic. In Germany, the digital and telephone counselling services offered to young people by "*Nummer gegen Kummer*" ("*Number against grief*") were expanded. In Austria, additional funding was made available to expand access to "*Rat auf Draht*", the national crisis telephone service for children and young people, alongside the expansion of an online suicide-prevention programme for young migrants (OECD, 2021^[48]).

Some European countries also expanded low-threshold mental health support. In Finland, the government expanded its programme to provide psychosocial support through one-stop youth centres called "*Ohjaamo/Navigator*", which offer integrated agency interventions to young people (OECD, 2021^[48]). In the Netherlands, in December 2020 the central government provided municipalities EUR 58 million funding to support young people, including EUR 3.5 million allocated specifically to provide low-threshold preventative support to young people, including through "*Join Us*", an initiative to provide information and guidance on loneliness to young people and their parents (Dutch Central Government, 2020^[49]).

Most European countries also bolstered psychosocial and mental health support for young people in schools. In a 2022 OECD survey, 15 out of 22 surveyed European countries indicated that they had newly implemented or reinforced existing psychosocial and mental health support for students in response to the pandemic in the 2021/2022 school year, with a number of other European countries indicating that such measures were planned for the 2022/2023 school year (Table 1.1). Most support was provided for students in primary and secondary schools, with over half (55%) of countries indicating that they implemented support at primary and secondary level in the 2021/2022 school year, compared to 32% at the tertiary level and 18% at pre-primary level (Table 1.1).

Table 1.1. Many European countries bolstered psychosocial and mental health support for students in response to the COVID-19 pandemic, typically in primary and secondary schools

Country	Implemented in school year 2021/2022			Plans for implementation in school year 2022/2023		
	Pre-primary	Primary to upper secondary	Tertiary	Pre-primary	Primary to upper secondary	Tertiary
Austria	-	✓	✓	-	✓	✓
Belgium	✓	✓	✓	-	-	✓
Denmark	-	-	-	-	-	✗
Estonia	-	✓	-	-	✓	-
Finland	-	-	-	-	-	-
France	✗	✗	✓	✗	✗	✓
Germany	-	-	✓	-	-	✓
Iceland	✗	-	-	✗	✗	✗
Italy	✓	✓	-	-	-	-
Latvia	✗	✓	-	✗	✓	-
Lithuania	✗	✓	✗	✗	✓	✗
Luxembourg	-	-	✓	✓	✓	-
Netherlands	-	-	-	-	-	-
Norway	✗	-	✗	✗	-	-
Poland	✓	✓	✗	✓	✓	✗
Portugal	✓	✓	-	✓	✓	-
Slovak Republic	✗	✓	✓	✓	✓	-
Slovenia	-	✓	✗	-	-	✗
Spain	-	-	-	-	-	-
Sweden	✗	✓	-	✗	✓	-
Switzerland	-	-	-	-	-	-
United Kingdom	✗	✓	✓	✗	✓	✓

Note: Data refer to measures that have been or will be newly implemented or reinforced in response to the COVID-19 pandemic.

Legend: (✓) where existing national measures have been reinforced or new measures have been introduced as a result of the crisis; (✗) where no new national measures were introduced or existing measures were not reinforced; (-) where countries could not answer, or where Schools/Districts/the most local level of governance could decide to implement measures at their own discretion.

Source: OECD (2022^[50]), *Education at a Glance 2022: OECD indicators*, <https://doi.org/10.1787/3197152b-en>.

A number of European countries have also bolstered funding to strengthen mental health care services for young people. In Denmark, DKK 100 million (EUR 13 million) was allocated for the period 2020-22 to promote easier treatment and support for children and young people experiencing mental health issues. In Romania, child and adolescent community mental health services were developed and reinforced as part of the Open Minds project (European Education and Culture Executive Agency, 2022^[51]). Austria, Poland and France also increased funding for mental health care either to develop new services (Austria and Poland) or extend access to existing services (France) (OECD, 2021^[35]).

The COVID-19 pandemic has underscored the importance of an inter-sectoral approach to protect and care for young people's mental health. Many of the protective factors for good mental health go beyond the scope of health systems, and employment, education and social protection policies all play an important role in promoting good mental health. While interest in inter-sectoral approaches to mental health was growing before the pandemic, it may have served as

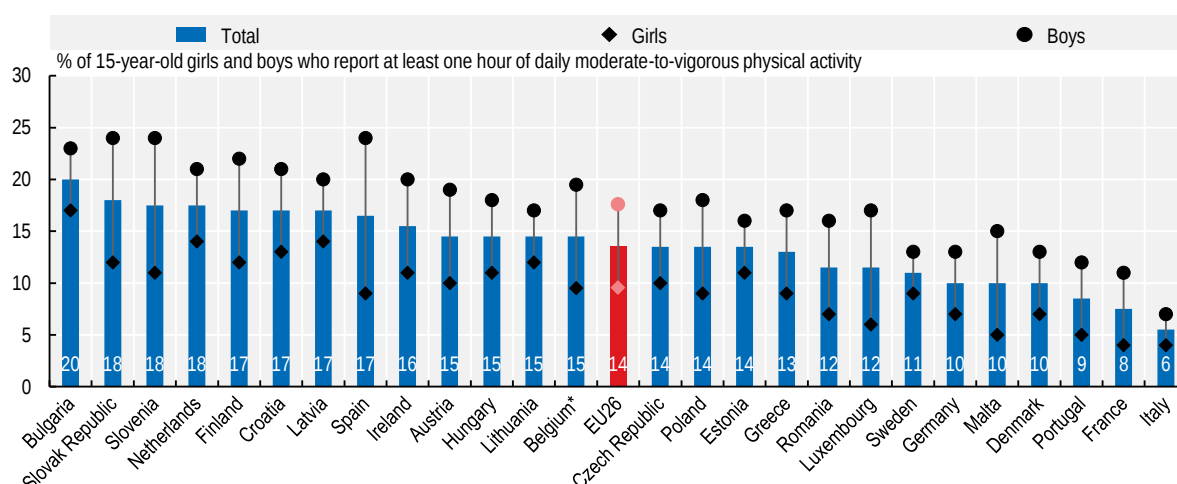
a catalyst. In June 2022, the Ministries of Health, Education and Social Affairs in the Netherlands announced an inter-sectoral “movement for mental health” with a specific focus on young people, and a strong emphasis on prevention and promotion in neighbourhoods, workplaces, schools and online (Government of the Netherlands, 2022^[52]). Given the scale of the impact, and the interrelatedness of the health, social and economic impacts of the pandemic, a whole-of-society approach to mental health will be critical to prevent permanent scarring.

1.7. Physical activity among children and adolescents decreased during the pandemic

Physical and mental health are closely related; physical activity is a protective factor for good mental health, and low physical activity can contribute to mental health issues in children and adolescents.

Evidence from a number of European countries shows that physical activity amongst children and adolescents declined during the pandemic, from an already low level before the pandemic. Prior to the pandemic, only about one in seven (14%) adolescents aged 15 years old reported doing at least one hour of moderate-to-vigorous physical activity every day as recommended by the WHO (Figure 1.11). Boys were more physically active than girls: 18% of 15-year-old boys on average reported at least one hour of moderate to vigorous physical activity every day, compared with 10% only of 15-year-old girls. Italy, France and Portugal had the lowest proportion of boys and girls meeting the WHO recommendation (HBSC, 2022^[53]).

Figure 1.11. Only one in seven 15-year-olds met the WHO recommendation on minimum amount of physical activity each day before the pandemic across EU countries



Note: Data refer to 2018. The EU average is unweighted. *The data for Belgium is the unweighted average of Wallonia and Flanders.

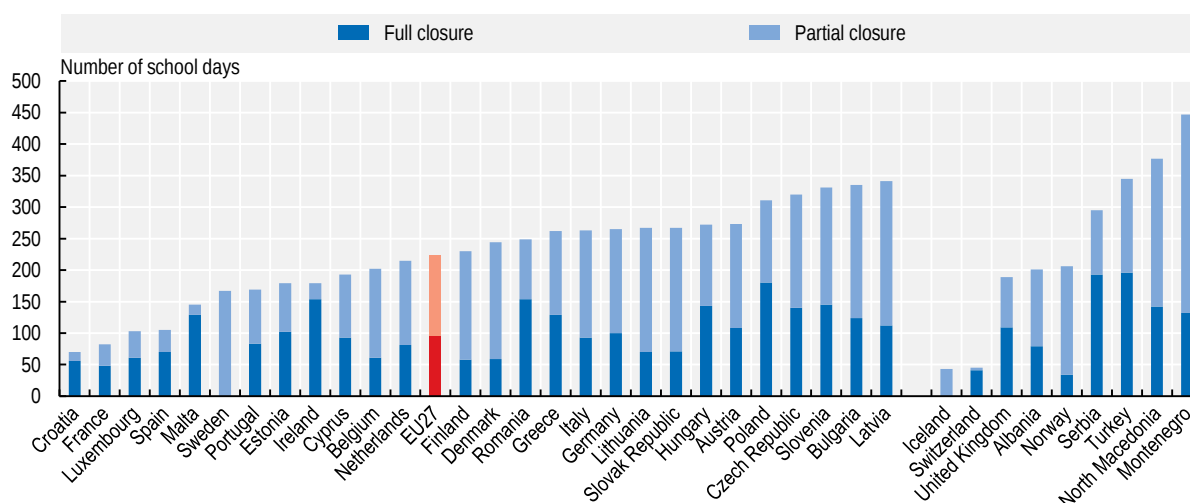
Source: HSBC (2022^[53]), Health Behaviour in School-aged Children (HBSC) survey 2017/18, <https://hbcs.org/data/>.

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School closures, the closure of sports facilities and other mobility restrictions were associated with a reduction in physical activity amongst children and adolescents in virtually all European countries with available data. Full school closures occurred in all European countries, with the exception of Sweden and Iceland, although the number of days of closure varied widely (Figure 1.12).

Evidence from a number of countries shows that physical activity among children and adolescents reduced substantially during the pandemic. In Italy, Spain and Portugal, a survey found that the share of children and adolescents aged 3-18 years old that did not meet the WHO recommendation of at least one hour of daily physical activity increased markedly during the first lockdown in March and April 2020: it rose from 53% to 85% in Italy, from 34% to 86% in Spain and from 46% to 86% in Portugal (Francisco et al., 2020^[54]). Another study in 10 European countries (Belgium, France, Germany, Hungary, Italy, Poland, Portugal, Romania, Slovenia and Spain) also found that over 80% (81%) of children aged 6-18 years old did not meet WHO recommendations in May-June 2020 (Kovacs et al., 2021^[55]).

Figure 1.12. Full school closures occurred in nearly all EU countries during the pandemic, but for various lengths



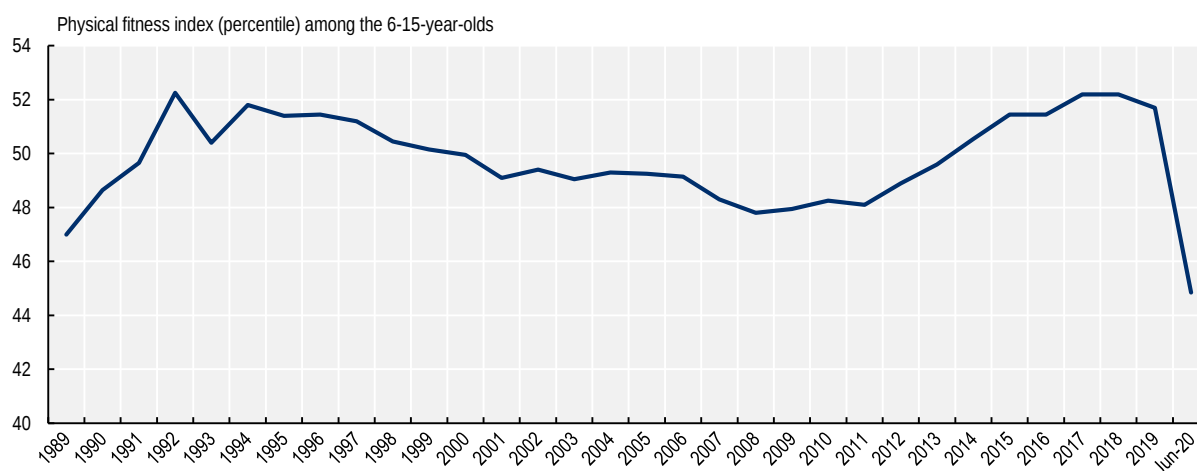
Note: Data available for 775 school days from 16-02-2020 until 31-03-2022. Full school closures refer to situations where all schools were closed at the national level due to COVID-19, accompanied by distance-learning to ensure education continuity. Partial school closures refer to school closures in some regions or for some grades, or with reduced in-person classes.

Source: UNESCO 2022, adapted from European Education and Culture Executive Agency (2022^[51]), "The impact of the COVID-19 pandemic on the mental health of young people. Policy responses in European countries", <https://doi.org/10.2797/547518>.

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In Slovenia, physical fitness of school-aged children from 6 to 15 years old fell by about 13% in June 2020, compared with 2019. It was the lowest level ever measured since the first data were available more than 30 years ago (Figure 1.13).

Figure 1.13. In Slovenia, physical fitness among school children fell sharply in June 2020 compared with previous years



Note: The physical fitness index covers the standardised results of 8 fitness measures: 20-s arm-plate tapping, standing long jump, backwards obstacle course, 60-s sit-ups, stand and reach, bent arm-hang, 60m dash and 600m run. This survey was usually carried out in April, except in 2020 when it was carried out in June as students were gradually returning to school after the first lockdown. Data for 2020 included about 15% of Slovenian children aged 6- to 15-year-olds.

Source: SLOfit Database; Jurak et al., (2021^[56]), "A COVID-19 Crisis in Child Physical Fitness: Creating a Barometric Tool of Public Health Engagement for the Republic of Slovenia", <https://doi.org/10.3389/fpubh.2021.644235>.

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However, some other surveys show relatively less dramatic reductions in physical activity during the pandemic. In Germany, a representative study of 4-17 year-olds found that children and adolescents engaged in less sport activities, but increased other physical activities (playing outside, walking and cycling, gardening and doing housework) during the first lockdown (Schmidt et al., 2020^[57]). In Lithuania, a small survey found that physical activity remained relatively unchanged during the first lockdown: about one-third (34%) of children did not meet the WHO recommendation in March-June 2020, about the same rate as before the pandemic (Braidokienė et al., 2021^[58]).

Several factors affected levels of physical activity during the pandemic:

- School-based physical activities came to a halt during school closures and often remain limited even when schools re-opened;
- Organised sports were also interrupted and playgrounds, parks and other public green spaces were closed at least during lockdown periods;
- However, home-based physical activities partly offset the impacts of these restrictions, even though these activities were limited by indoor and outdoor space;
- Young people who used to do sport regularly before the pandemic were more likely to remain physically active during the pandemic and resume their sport routine after the pandemic;
- Having a structured daily routine during the lockdowns contributed to maintaining a certain level of physical activity;
- In general, older children and adolescents were less likely to remain physically active.

During the lockdown periods, home-based physical activities typically increased, even though the opportunities to do physical activities at home were limited by home features. Children and adolescents living in houses reported less reduction in physical activity compared with those living in apartments, and this was also the case for children who could go outside (e.g. with access to a garden) (Paterson et al., 2021^[59]). A Spanish study of children aged 2-12 years old showed that those with outdoor space engaged in more physical activities compared with children without such space (Berasategi Sancho et al., 2021^[60]). Children and adolescents living in urban areas reduced their physical activity more than those living outside cities and towns, as shown for example in a Croatian study of 16-year-olds (Zenic et al., 2020^[61]).

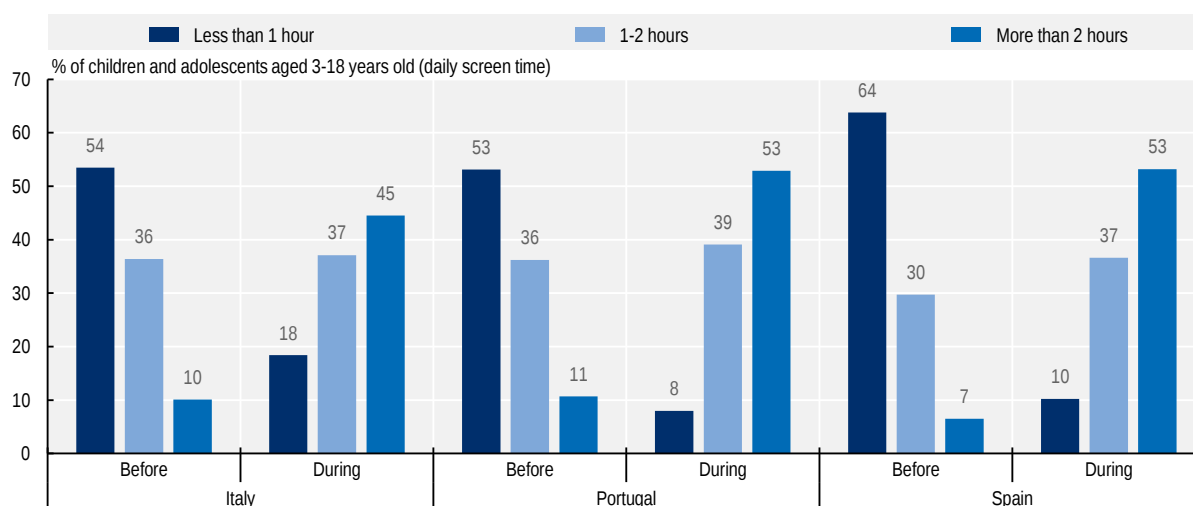
The effect of containment measures on physical activity during the pandemic was consistently more marked for older adolescents than for younger children (Paterson et al., 2021^[59]), reinforcing the typical decrease in physical activity as children get older. For example, a study of children aged 2-11 years old in Italy showed that 65% of the 2-5 year-olds reduced their usual physical activity during the first lockdown, but this proportion reached 87% among the 6-11 year-olds (Censi et al., 2021^[62]).

Having a structured daily routine contributed to continuing to be physically active, and parental guidance and support was helpful to maintain a certain level of physical activity (Kovacs et al., 2021^[55]; Censi et al., 2021^[62]). In Italy, among the 40% of children aged 2-11 years old who maintained some physical activity every day during the first lockdown, three-quarters practiced this physical activity with their parents (Censi et al., 2021^[62]).

Those who used to do sport out of home before the pandemic were also more likely to remain physically active or resume their sport routine. A survey in Greece showed that 12-17 year-olds who participated in organised sport before the pandemic reported higher levels of physical activity during the pandemic, even though their physical activity decreased (Morres et al., 2021^[63]).

Alongside a decline in physical activity, sedentary behaviour such as staying seated and screen time typically increased during the pandemic (Paterson et al., 2021^[59]). For example, a survey found that the share of children and adolescents aged 3-18 years old spending two hours or more in front of a screen every day was almost six times higher on average in Italy, Portugal and Spain during the first lockdown in March and April 2020 than before the pandemic (Figure 1.14).

Figure 1.14. Screen time increased starkly during the first lockdown in March-April 2020 in Italy, Portugal and Spain

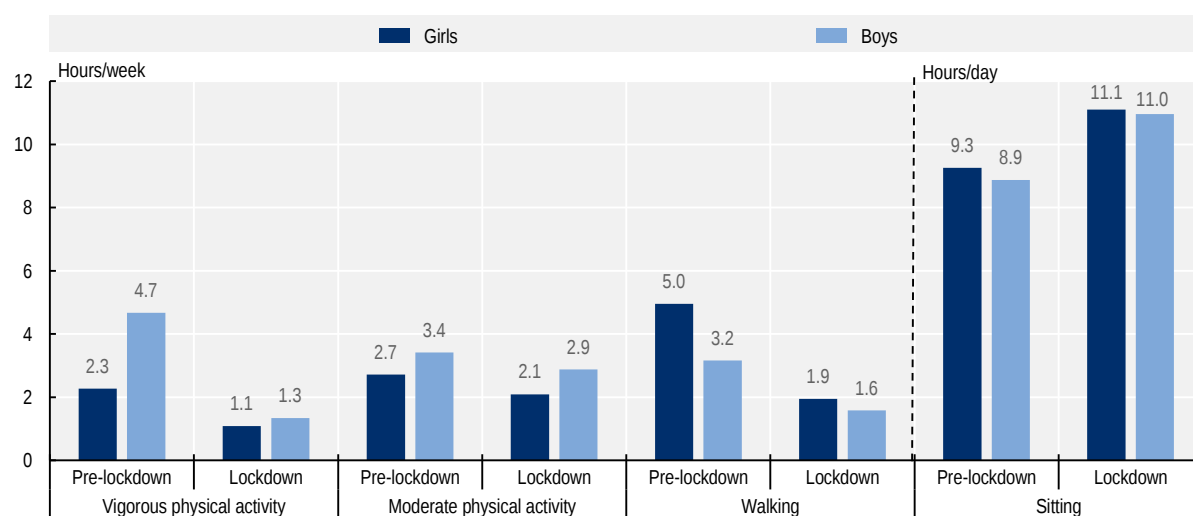


Source: Adapted from Francisco et al. (2020^[54]), "Psychological Symptoms and Behavioral Changes in Children and Adolescents During the Early Phase of COVID-19 Quarantine in Three European Countries", <https://doi.org/10.3389/fpsy.2020.570164>.

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In the Austrian city of Innsbruck, a study showed that the containment measures implemented during the second lockdown (from mid-November 2020 to mid-January 2021) greatly reduced various physical activities among high-school teenagers in Fall/Winter 2020/21 (Figure 1.15). There was a steep reduction in sport and other vigorous physical activity among boys, while time spent walking decreased much more for girls. Boys and girls reported staying seated longer – about 11 hours every day (University of Innsbruck, 2021^[64]).

Figure 1.15. In Innsbruck (Austria), time spent on physical activities decreased significantly among adolescents during the lockdown at the end of 2020 and early 2021



Note: Total hours per week for physical activities and total hours per day for sitting.

Source: University of Innsbruck (2021^[64]), "Physical activity and sitting time prior to and during COVID-19 lockdown in Austrian high-school students", <https://doi.org/10.3934/publichealth.2021043>.

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1.7.1. Several countries have introduced new policies and programmes to promote greater physical activity among children and adolescents

In response to already low levels of physical activity before the pandemic and the further reduction during the pandemic, several countries have taken actions to promote greater physical activity among children and adolescents to avoid any long-lasting impacts of physical inactivity on young people's physical and mental health. While each policy can have its own benefits, it is unlikely that any single policy will have a major impact as many behavioural, social and environmental factors influencing physical activity.

New policies and programmes have focused on three main areas:

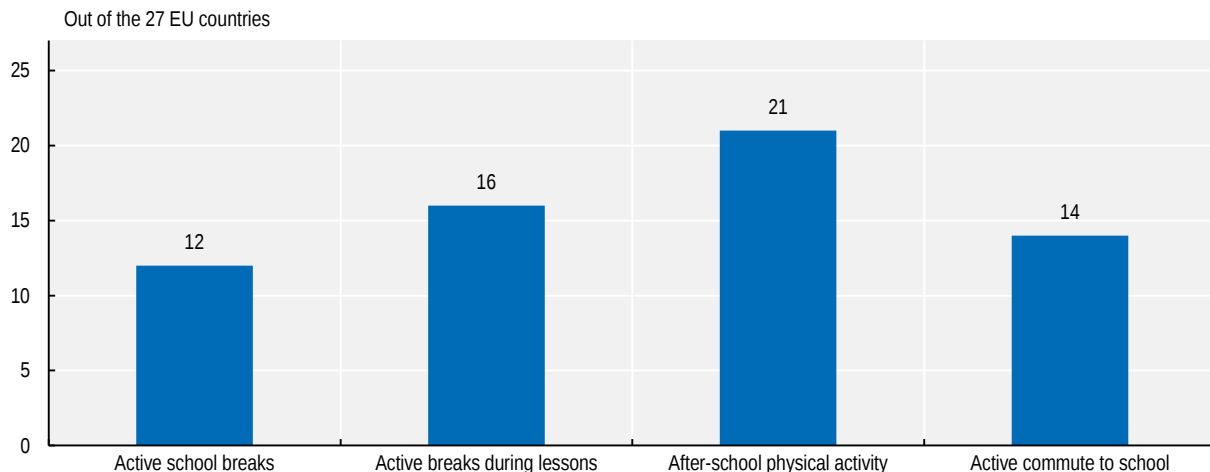
- programmes in schools
- policies to increase access to sports facilities; and
- public awareness campaigns

Programmes in, or with, schools can play an important role in increasing physical activity amongst children. Some school programmes were adjusted to promote physical activity during the pandemic, despite the lockdowns. In Ireland, for example, the “active school week” was transformed into an “active home week”.

Some initiatives have encouraged a return to physical activity following the confinements. For example, Denmark supported schools in organising a day of sports to promote physical activity and well-being in primary and lower secondary schools in the Summer 2021 (WHO, 2021^[65]).

In all EU countries, all schools are required by law to provide physical education classes. In 2021, programmes to encourage active school breaks were implemented in 12 EU countries, active breaks during lessons in 16 countries, after-school physical activity programmes in 21 countries and programmes to encourage active commute to school in 14 EU countries (Figure 1.16) (WHO, 2021^[65]). However, school programmes and initiatives often remain voluntary, with varying take-up rates.

Figure 1.16. A number of school-based programmes were implemented in EU countries to promote physical activity among children and adolescents in 2021



Note: Active school breaks include opportunities for physical activity (e.g. playground) whereas active breaks during school lessons consist of brief, structured physical activity during lessons to break up periods of sitting.

Source: WHO (2021^[65]), Physical activity factsheets for the European Union Member States in the WHO European Region.

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Many countries have also developed initiatives with sports facilities and sports clubs because they can play a major role in enabling and promoting physical activity among children and adolescents. In France, the label *Generation 2024* encourages schools and universities to strengthen the sports offer and allow local sports clubs to use schools and universities' sports facilities. Over 2 840 schools and universities have already been awarded the label. France aims to label 20% of schools and universities by 2024, the year of the Olympic Games.

Initiatives to increase physical activity also included public awareness campaigns. In 2021, 23 EU countries reported to have clearly-formulated national campaigns to raise public awareness about physical activity, targeting in some cases children and adolescents specifically (WHO, 2021^[65]). For example, during the pandemic, Healthy Ireland's public information campaigns were re-purposed and re-branded into the "*In This Together*" and "*Keep Well*" campaigns to highlight physical activity and sports that could be maintained during the COVID-19 restrictions, including for children and adolescents (such as exercise at home, online classes, walking, running, cycling, and outdoor swimming). In late 2021, a partnership between Sport Ireland and Healthy Ireland forged the "*Let's Get Back*" campaign, which encouraged a return to organised sport. Similarly, Germany, France and many other EU countries launched national or local initiatives with Olympic Committees or sports clubs to promote a return to organised sport among children and adolescents in 2021 and 2022.

At the EU level, the campaign *HealthyLifestyle4All* (HL4A) was launched in 2021 to increase awareness of a healthy lifestyle across all generations and facilitate access to sport, physical activity and healthy diets (European Commission, 2021^[66]). It encourages all organisations to carry out an initiative, activity or campaign to promote healthy lifestyles across all generations and social groups. About 90 organisations pledged an initiative as part of the *HealthyLifestyle4All* campaign by November 2022.

1.8. The pandemic and containment measures also affected the nutrition of children and adolescents, with mixed impacts

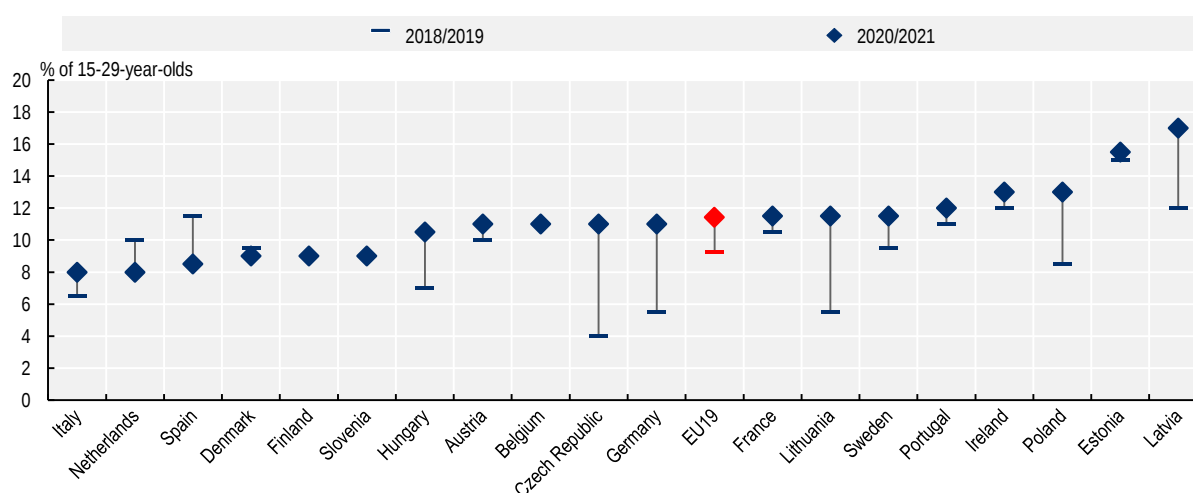
School closures and other mobility restrictions affected young people's nutrition habits in different ways. Food consumption increased for a substantial number of children and adolescents in EU countries during the pandemic, though it is unclear to what extent food choices were healthier or not. In Germany, a study found that increased food intake was mostly related to increased intake of bread, but also of sweet and processed food (Huber et al., 2020^[67]). By contrast, in Poland, a study amongst 10-16 year-olds showed that the consumption of fruit and vegetables increased on average (Kołota and Głąbska, 2021^[68]). A study covering Italy, Spain and South American countries (Chile, Colombia and Brazil) found that the consumption of fried food and sweet food as well as fruit and vegetables increased among 10-19 year-olds during the lockdown in April and May 2020 (Ruiz-Roso et al., 2020^[69]).

Children and adolescents share, to some extent, the same eating habits as their parents. Parents had a particular influence over food choices, especially during lockdowns. For example, a small survey in France found that 42% of parents reported that their children asked for food more often, sometimes out of boredom. While over two-thirds of parents reported cooking more at home, a similar proportion also reported that they had relaxed rules around food consumption and meals, being less strict on meal times and places where to have meals at home (CERIN, 2020^[70]).

School closures led a number of children and adolescents to lose access to healthy and free (or low-cost) school meals. Some countries took exceptional measures to maintain school meals for children in need even when schools were closed. For example, Lithuania supported municipalities to provide food rations to children who received free school meals before the pandemic.

The pandemic also affected young adults' access to nutrition, with those on low incomes reporting more difficulties buying food during the pandemic, especially healthy food. On average across EU countries, one in nine (11%) 15-29 year-olds reported going through times when they did not have enough money to buy food for them or their families in 2020/2021 (Figure 1.17). This rate was greater than before the pandemic (9% in 2018/2019).

Figure 1.17. Over 10% of young adults in several countries did not always have enough money to buy food in 2020/2021



Note: The question is “Have there been times in the past 12 months when you did not have enough money to buy food that you or your family needed?”. Source: Gallup Survey.

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1.8.1. Several countries have taken actions to improve nutrition among school-aged children and young people

Several interventions have been strengthened to encourage healthy nutrition among children and adolescents since the pandemic, particularly school-based programmes as well as initiatives to help parents and young adults on low incomes to buy food.

Many countries have expanded or launched new initiatives to provide healthy food at school when schools re-opened during the pandemic (including Denmark, Finland, France, Latvia, the Netherlands, and Portugal). France expanded an initiative to provide affordable school meals and free breakfast to children in need. About 100 000 French school children benefited from free breakfasts in the school year 2020-21 and nearly 300 000 school children were expected to benefit from this initiative in 2021-22. In addition, nearly 2.5 million meals were provided to school canteens in rural areas at a price below EUR 1 in 2020-21 (Ministère de l'Éducation nationale et de la Jeunesse, 2021^[71]).

In 2021, EU countries agreed that school-aged children in need – those at risk of poverty or social exclusion – should receive at least one healthy meal each school day under the new European Child Guarantee (Box 1.2).

Additionally, some European countries have introduced new programmes since the onset of the pandemic to help young adults and families on low incomes to buy food. For example, Italy announced a EUR 400 million Fund for food aid at the start of the first lockdown in February 2020. Local city councils were able to use COVID-19-specific social vouchers to help the most vulnerable groups buy food. Priority was given to families with young children, disabled people and the elderly. Italy decided to extend the scheme in early December 2020, with an additional fund of EUR 400 million (Edenred, 2021^[72]). A new programme in Slovenia entitled every university student to one e-coupon per day (EUR 2.63/coupon) to use in any restaurant. In France, 20% of university students who benefited from the existing food support scheme reported that the COVID-19 pandemic led them to seek greater food support. About 80% of all these university students are international students.

Other policies developed before the pandemic were strengthened to encourage healthy food choices for parents, adolescents and children, such as front-of-pack nutrition labelling. As part of the *Farm to Fork* strategy, the EU plans to harmonise mandatory front-of-pack nutrition labelling for food products to enable consumers to make healthier food choices, by the end of 2022. Several labelling schemes were developed across Europe before the pandemic. For example, since 2017 the French Government introduced a voluntary front-of-pack food label called *Nutri-Score*. This *Nutri-Score* provides easy-to-understand information on the overall nutritional quality of food products. In 2020, nearly 60% of the French population reported that they had modified their food purchasing behaviour with the help of *Nutri-Score* and 89% believed that *Nutri-Score* should be mandatory for all food products (Santé publique France, 2021^[73]). OECD analysis of *Nutri-Score* shows that it helps to improve the nutritional quality of the food put on the market by

producers and the food intake by consumers, leading to health benefits and health care savings (OECD, 2022^[74]). *Nutri-Score* has already been adopted in a number of other countries like Belgium, Germany, Luxembourg, the Netherlands and Switzerland.

Box 1.2. The European Child Guarantee

The European Child Guarantee, adopted in 2021, aims to break the intergenerational cycle of poverty and social exclusion by guaranteeing children and adolescents in need access to a set of health, education and other key services.

Free and effective access for children in need to:



early
childhood
education
and care



education
and school-
based
activities



at least
one healthy
meal each
school day



healthcare

Effective access for children in need to:



healthy
nutrition



adequate
housing

The European Child Guarantee builds on earlier EU efforts to support healthy food consumption at school. These include the EU school fruit and vegetables scheme, which was launched in 2009 to encourage healthy eating habits among children at school. In 2017, the programme was extended to incorporate the EU School Milk Subsidy Scheme. The EU annual budget for this broader scheme is EUR 250 million, including EUR 150 million for the provision of fresh fruit and vegetables in schools and EUR 100 million for milk.

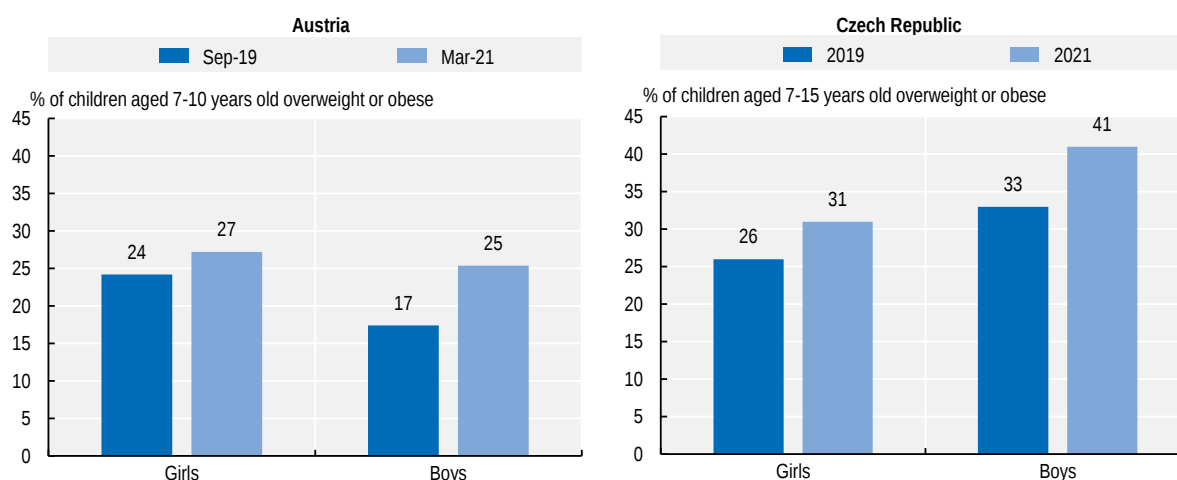
Source: European Commission (2021^[75]), <https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=10024&furtherNews=yes>.

1.9. The COVID-19 crisis made childhood overweight and obesity worse in many countries

The combination of lower physical activity and a worsening of nutrition habits amongst many children and adolescents during the pandemic led to at least a temporary increase in overweight and obesity rates in countries with available data. Not only more children and adolescents became overweight, but those already overweight or obese gained weight. All age groups were affected.

In Germany, the prevalence of obesity increased from 13.2% to 14.6% among the 6-12 year-olds and from 18.5% to 18.9% among the 12-18 year-olds during the first three months of the pandemic (Vogel et al., 2021^[76]). In Croatia, among the 10-15 year-olds, the prevalence of overweight increased from 14.5% before the first lockdown in 2020 to 17.2% during the lockdown, and the prevalence of obesity also increased slightly from 6.4% to 6.9% (Kendel J et al., 2021^[77]). In Austria, the proportion of children aged 7-10 years old overweight or obese increased to 26.2% in March 2021, up from 20.7% in September 2019 (Figure 1.18) (Jarnig et al., 2022^[78]). In the Czech Republic, the share of overweight and obesity among the 7-15 year-olds increased to 41% among boys and 31% among girls in 2021, up from 33% and 26% respectively in 2019 (Vážná et al., 2022^[79]).

Figure 1.18. In Austria and the Czech Republic, overweight and obesity among children was higher in 2021 than before the pandemic



Note: Measured overweight and obesity. In the Czech Republic, data refer to the unweighted average of children aged 7, 9, 11, 13 and 15 years old.
 Source: Jarnig et al. (2022^[78]), <https://doi.org/10.1111/ijpo.12890>; Vážná et al. (2022^[79]), <https://doi.org/10.3390/ijerph191911902>.

StatLink  <https://stat.link/yn10pd>

The childhood overweight and obesity “epidemic” was already a major public health concern before the pandemic in virtually all EU countries: nearly one in five (19%) of adolescents aged 15 years were overweight or obese on average across 26 EU countries in 2017-18, up from one in six (16%) in 2009-10 (OECD/European Union, 2020^[80]).

1.10. Conclusions

Alongside the millions of people directly affected by tragic losses of life and life-threatening illness during the pandemic, many more have been profoundly affected by the closures of schools and workplaces, disruptions to public services, and serious constraints on social contact that would hitherto have seemed unimaginable. Particular concerns have been raised for the health and well-being of the millions of young people whose formative years have been marked by prolonged periods of fear, social isolation, uncertainty and disruption. This chapter finds that those concerns are well-founded.

The pandemic and the measures implemented to contain it fuelled an unprecedented worsening of population mental health, with the prevalence of symptoms of depression amongst young people (18-29) more than doubling in several European countries. Young people in precarious financial circumstances and young people at risk of exclusion were at particularly high risk of mental distress. Moreover, there are signs that the pandemic accelerated a worsening of – and potentially a growth in – symptoms of eating disorders in some countries.

Young people’s mental health fluctuated with the pandemic, with symptoms of anxiety and depression typically highest around pandemic “peaks”, when infection and/or death rates were high. The mental health and well-being of young people (18-29) has generally improved slightly in European countries with available data as the pandemic situation has improved (in the first half of 2022), though the share of young people with symptoms of anxiety and depression remain double that of pre-pandemic levels in some countries. Ongoing elevated mental distress could reflect the emergence and confluence of multiple crises, such as Russia’s war of aggression against Ukraine, the cost-of-living crisis, and the climate crisis.

The pandemic has challenged already-stretched mental health care services, with waiting times increasing in some countries. Around one in two young people in the EU reported unmet needs for mental health care in the spring of 2021 and 2022, rates over double those of the general adult population. While the long-term implications of the pandemic on the need and demand for mental health care are yet to be seen, the pandemic has brought a new urgency to mental health prevention and promotion measures, and to ensuring that adequate support is available to those who need it.

The physical health impacts of the pandemic have also been significant. Physical activity amongst children and adolescents declined in almost all European countries with available data, particularly amongst older adolescents. Significantly more time was spent sitting and watching screens. Food consumption at home increased in many European countries, but it is not always clear whether food choices were healthy ones. The closure of schools meant that many children and adolescents lost access to free and healthy meals.

European countries have taken action to mitigate the impacts of the pandemic on young people, but given the magnitude of the impacts, further action is needed.

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Annex 1.A. Measuring mental health and well-being: A brief overview of survey instruments

This chapter reports indicators of mental health and well-being based on different survey instruments, which are briefly reviewed below.

Generalised Anxiety Disorder-7 (GAD-7) is a survey instrument commonly used to measure symptoms of anxiety. It is a seven-item questionnaire with a series of questions about the frequency with which respondents have experienced a range of negative symptoms over the past two weeks, such as “feeling nervous, anxious or on edge,” or “not being able to stop or control worrying.” Each response is assigned a score on a 4-point Likert scale, from 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day). All items are added together to calculate a total score, with a score of 10 or above typically used to indicate anxiety (with 0-4 indicating minimal symptoms, 5-9 mild, 10-14 moderate, and 15-21 severe symptoms of anxiety).

Patient Health Questionnaire-8 and 9 (**PHQ-8** and **PHQ-9**) are shortened versions of the **Patient Health Questionnaire (PHQ)** and are used to measure the presence and severity of symptoms of depression.

- **PHQ-9** is a nine-item questionnaire with a series of questions about the frequency with which respondents have experienced a range of negative symptoms over the past two weeks, such as “little interest or pleasure in doing things,” or “feeling down, depressed or hopeless.” Each response is assigned a score on a 4-point scale from 0 (not at all) to 3 (nearly every day), in the same way as GAD-7. **PHQ-8** is the same as PHQ-9, but removes a question about suicidal ideation (typically because it is considered too sensitive).
- There are two ways in which responses are typically scored: via an algorithm-based approach with classifications of “major depression” or “other depression”; or by adding the scores and applying different “cut-off” points for the severity of depression:
 - o The “algorithm diagnosis” is aligned to definitions contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Respondents have to report experiencing two specific symptoms – “little interest or pleasure in doing things,” or “feeling down, depressed or hopeless” – for more than half the time in the preceding two weeks. Respondents are categorised as having symptoms of “major depressive” or “other depression” if they also report a number of other symptoms (there are 6 to 7 others, depending on whether PHQ-8 or PHQ-9 is used): “Major depression” is when respondents also answer at least “more than half the days” to 5 or more of the other questions; or “other depression” is when respondents answer at least “more than half the days” to 2 to 4 other questions. The measure “any depression” (a combination of “other” and “major” depression) is typically used in this chapter where data have been scored using the algorithm diagnosis.
 - o In the “cut-off” approach, all of the scores are simply added together to provide a final score which indicates the severity of depression, ranging from 0-24 for the PHQ-8 and 0-27 for the PHQ-9: 0-4 none, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe depression, 20-24/27 severe depression. A score of ≥ 10 is typically used to indicate moderate to severe symptoms of depression.

The **WHO-5 Well-being Index (WHO-5)** is a questionnaire used to measure subjective well-being. It contains five questions about the frequency with which respondents have experienced a range of positive symptoms over the past two weeks, such as having felt “cheerful and in good spirits,” and “calm and relaxed.” The final score is calculated by summing the raw scores and multiplying them by 4. Respondents with a score of 50 or lower (out of 100) are sometimes considered to be at risk of depression.

The **Hospital Anxiety and Depression Scale (HADS)** is a 14-item survey with the first seven items on anxiety (HADS-A) and the latter seven on depression (HADS-D). The survey has a four-point scale for each item and total scores can range from 0 to 21.

The **Mental Health Inventory-5 (MHI-5)** contains five questions on the extent to which respondents experienced a range of positive and negative symptoms over the past four weeks, such as feeling nervous or feeling happy. Each response is assigned a score on a 6-point Likert scale ranging from 1 to 6. The overall score is converted to a score between 0 (psychologically unhealthy) and 100 (perfect mental health).



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