**In the aftermath of Covid-19, we must consider the mental health of children and young people with chronic respiratory illnesses**

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Children and young people have been, and remain, deeply affected by the Covid-19 pandemic 1,2. Lockdowns and new ways of living necessitated massive adjustments. Despite heroic efforts from teachers there was a huge impact on education, and children continue to lose the psychosocial benefits of being in school. News coverage is incessant, and polarised narratives and opinions are amplified in social media echo-chambers. In this paper, co-authored with an adolescent from our clinic, we discuss the psychological impact of the Covid-19 pandemic on children and young people with respiratory problems.

A systematic review identified that psychological problems in children during lockdowns include anxiety and fear, depression, irritability, and boredom3; lockdowns were also considered a contributing factor in some teenage suicides in the UK 4. Studies of children with chronic respiratory conditions are sparse: parents of children with asthma 5 and cystic fibrosis (CF)6,7 report heightened anxiety during the pandemic, but children themselves have been reported to have adjusted well– perhaps reflecting their adaptation to the usual restrictions placed on their daily lives.

In children and young people with chronic respiratory disorders, mental health issues are more complex than can be ascertained from isolated surveys, and there are certain additional considerations. They have received confusing, uncertain, and scary messaging. They were told that adults with respiratory illnesses are at risk of dying from Covid – and even though evidence suggests younger age groups are safe 8, those with chronic illnesses have been described using terms like “clinically extremely vulnerable”. They waited for a vaccine, to then not be prioritised to receive it, and subsequently heard constant speculation about its safety and effectiveness. Admission rates for asthma attacks are much lower than usual 9,10; children with asthma know that part of the reason for this is that they were protected from the usual milieu of viruses at school and so return to normal life may concern them. They are even made to feel like they are part of the problem. Proposals that people with chronic illness should remain at home while the world opens up for everyone else, and debate amongst adults about their civil liberties (for example to not wear a mask), unfairly place blame on these children for inconveniences experienced by the general population.

The usual resources these children would use have been less available, and they have become more isolated. They have been unable to meet friends as often as they would like, and contact with healthcare professionals has been disrupted. Although virtual clinic consultations have been necessary, and have advantages, they impair the ability to spot behavioural and emotional issues, and the nuances of the clinical consultation are clouded. As healthcare professionals we must be conscious of these problems and, in the return towards normality, re-evaluate what they mean for children and young people with respiratory conditions.

In clinic, we need to at least be mindful of these problems. It is of course important to be sympathetic and give time to families, who will be questioning the safety of holidays over the summer period, re-introducing social mixing outside school, and subsequently the return to school in autumn. For example, parents and children will share the concerns of healthcare professionals about recent disruption to the usual viral epidemics. Clear communication is more crucial than ever, and this includes being honest about what we do and do not know. Many people have lost faith in high-level communication strategies, and instead want personalised information relevant to their children and families. We must also consider psychological drivers for respiratory symptoms – particularly anxiety-induced breathlessness – and include these in our differential diagnoses for children with suboptimal disease control.

Mental health support for paediatric respiratory services before the pandemic was variable. For example, in the UK, most regional CF centres include a psychologist, but for other chronic respiratory conditions, and in District General Hospitals, this provision is sporadic. We would not run asthma clinics without specialist nurses – why, when we know that anxiety, depression, and suboptimal adherence with treatment regimes are common in young people with chronic respiratory conditions 11, would we not ‘build back better’ with more holistic care from teams that include psychologists? Alongside this, recovery from Covid-19 should stimulate more creative thinking, such as development of peer-support groups in which children and young people can share their lived experiences and coping strategies with each other – and it is important to remember the emotional well-being of parents and siblings as well.

Meaningful change requires investment. Health services have taken a financial hit, but we must prioritise high-quality psychological services for children and young people with respiratory conditions. On the backdrop of inadequate service provision for their needs they have been further sidelined by Covid-19 and, as the world recovers, we must ensure they are not left behind.

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