



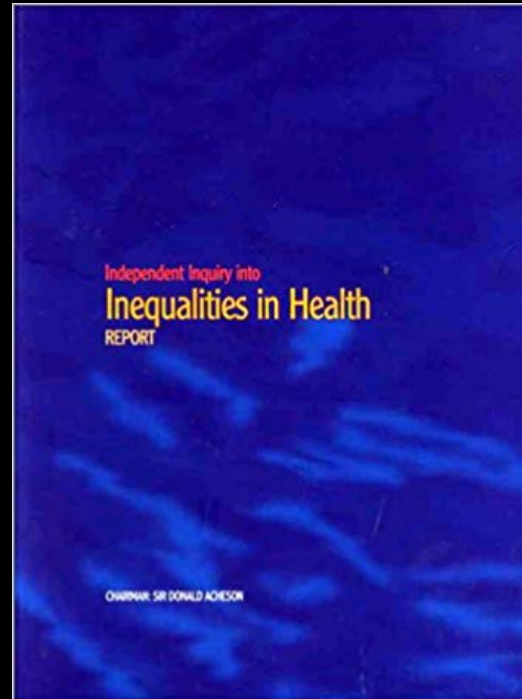
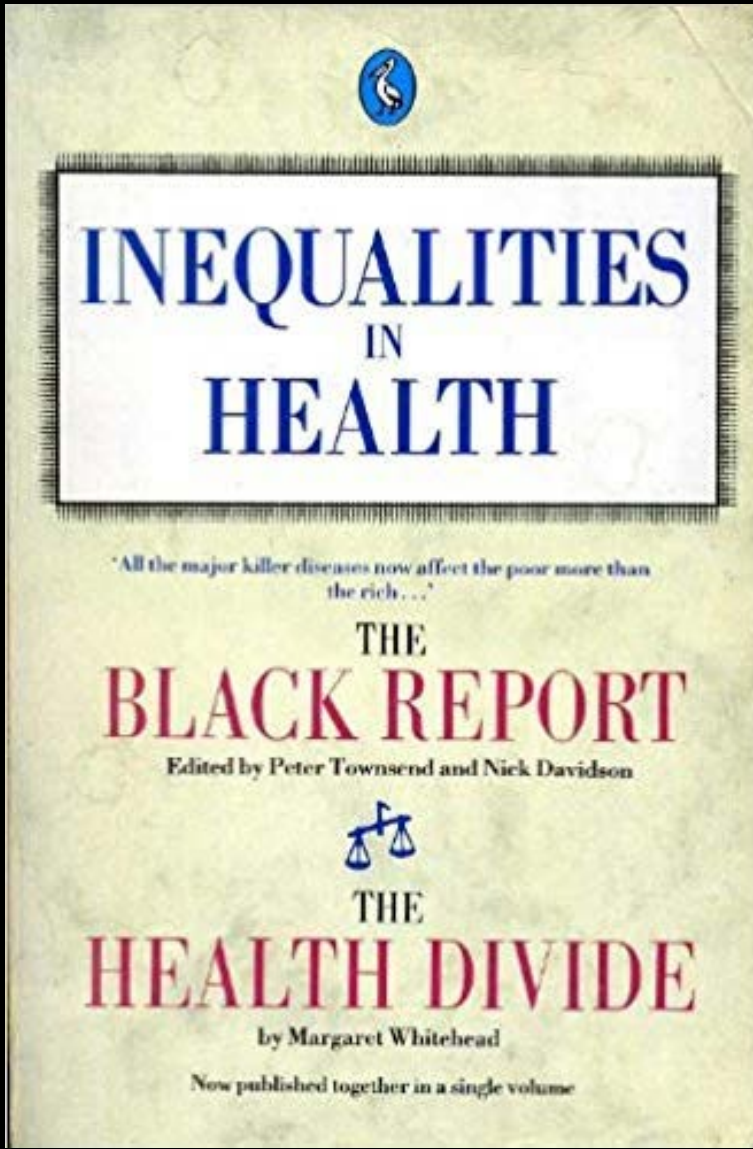
Public Health
England

Protecting and improving the nation's health

CYP Health Inequalities and the impact of COVID-19

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State of Child Health in the UK

Our landmark report into the health and wellbeing of children and young people looks at the evidence on child health outcomes and data trends across the UK.

[Read the evidence at a glance](#)

Child poverty has increased for those aged 0-18 in working families after housing costs.

Mental health prevalence in aged 5-15 and suicide rate per 100,000 in aged 15-24 is increasing.

Rate of young carers providing any unpaid care per week, per 1,000 young people aged 10-19 is increasing and so is the rate of LAC per 10,000 children aged 0-18

Source: <https://stateofchildhealth.rcpch.ac.uk/evidence/at-a-glance/>

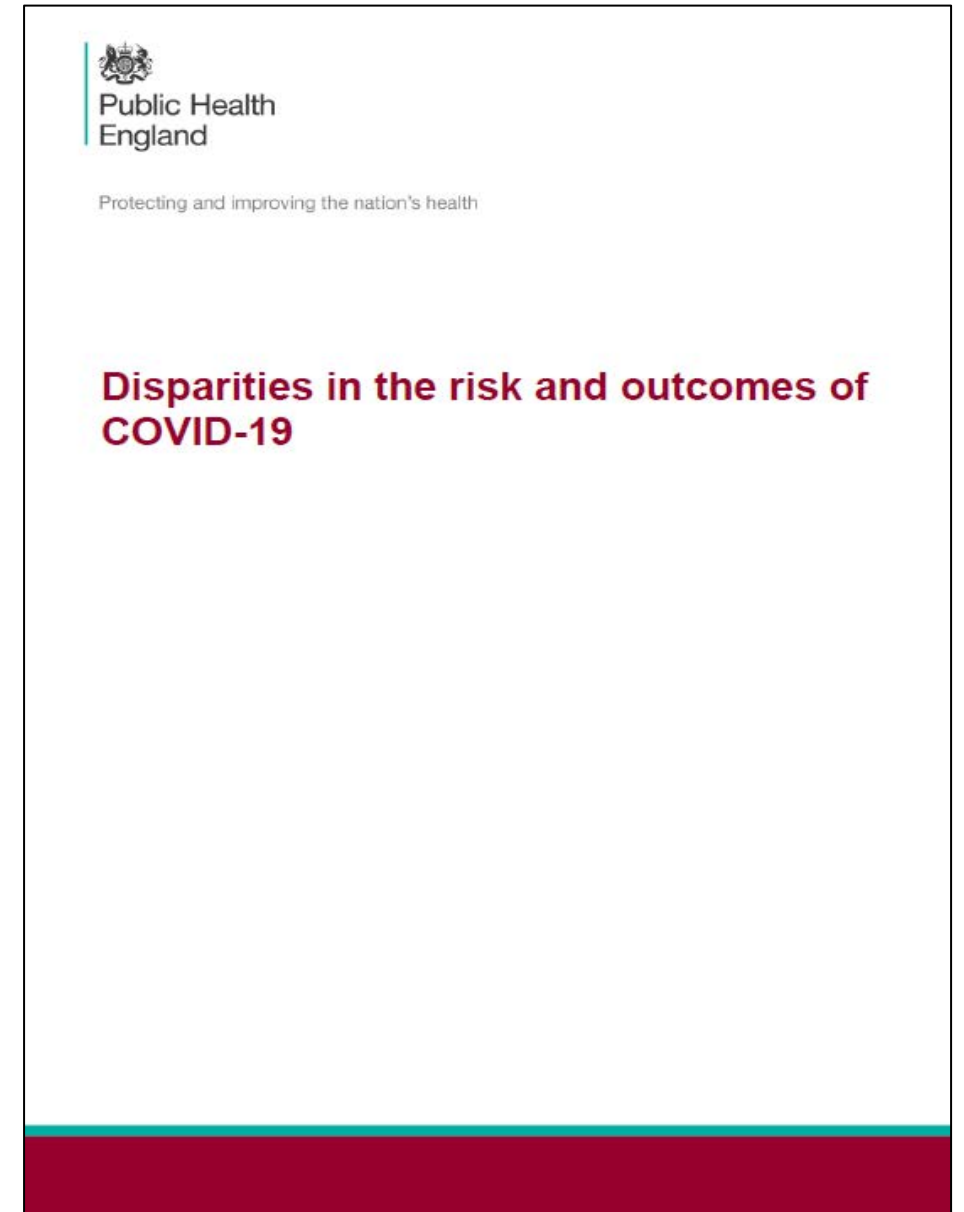
- Since 2010, progress has been made in early years development, as measured by children's readiness for school. Clear socioeconomic inequalities persist, with a graded relationship between these measures and level of deprivation.
- For low-income children, levels of good development are higher in more deprived areas than in less deprived areas.
- Rates of child poverty, a critical measure for early child development, have increased since 2010 and are now back to their pre-2010 levels with over four million children affected.
- Child poverty rates are highest for children living in workless families - in excess of 70 percent
- More deprived areas have lost more funding for children and youth services than less deprived areas, even as need has increased.
- The most deprived 10 percent of children are nearly twice as likely to die (5.3 per 1,000) as the most advantaged 10 percent of children (3.1 per 1,000)



In June 2020, PHE published the Disparities in the risk and outcomes of COVID-19 report.

Summarises the findings of the descriptive review of data on disparities in the risk and outcomes from COVID-19.

It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them.

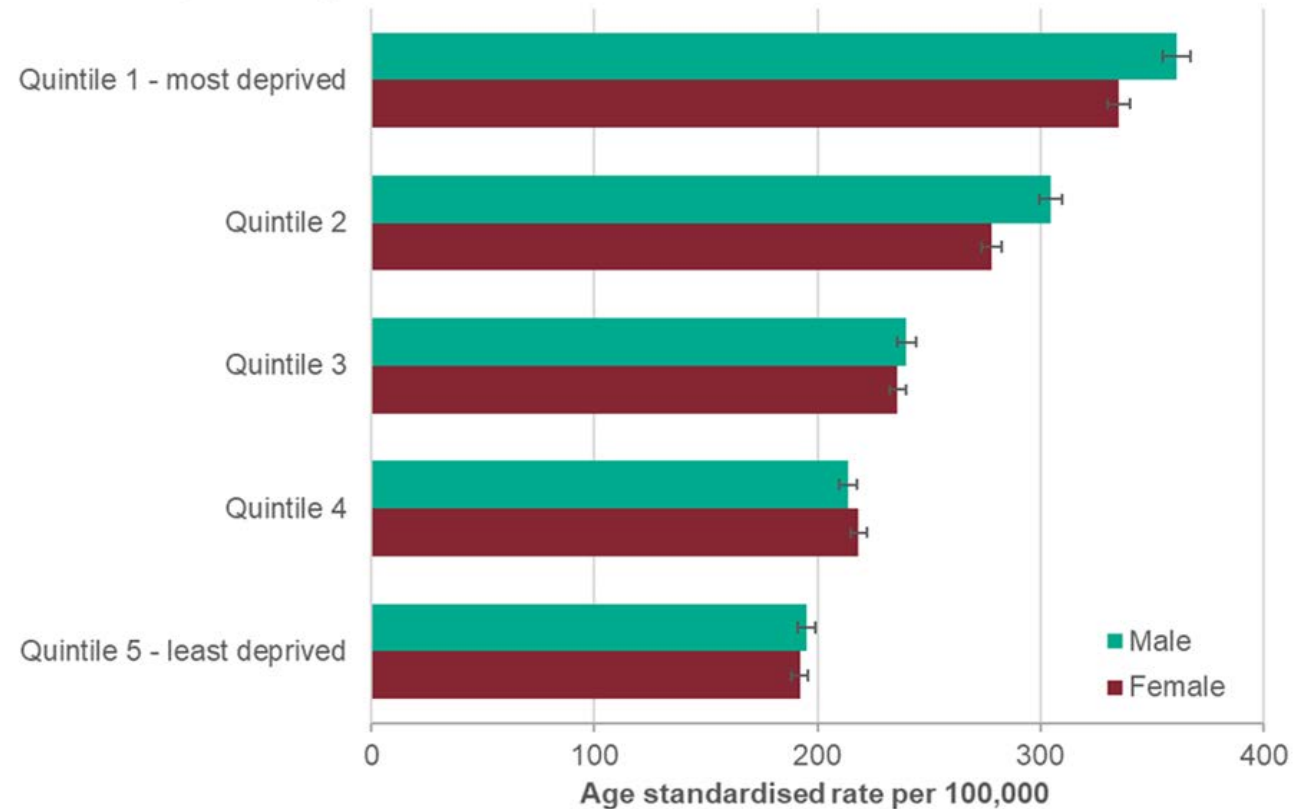


Cases - Deprivation

The rate in the most deprived quintile was 1.9 times the rate in the least deprived for males and 1.7 times the rate for females

Figure 3.2: Age standardised diagnosis rates by deprivation quintile and sex, as of 13 May 2020, England

IMD 2019 deprivation quintile



Source: Public Health England Second Generation Surveillance System

CORONAVIRUS INEQUALITIES AND MORTALITY RATES

Risk of dying among those diagnosed with COVID-19 **was higher** in those living in the **more deprived areas** than those living in the least deprived



The mortality rates from COVID-19 in the most deprived areas were **more than double** for both **males** and **females**

This is greater than the inequality seen in mortality rates in previous years

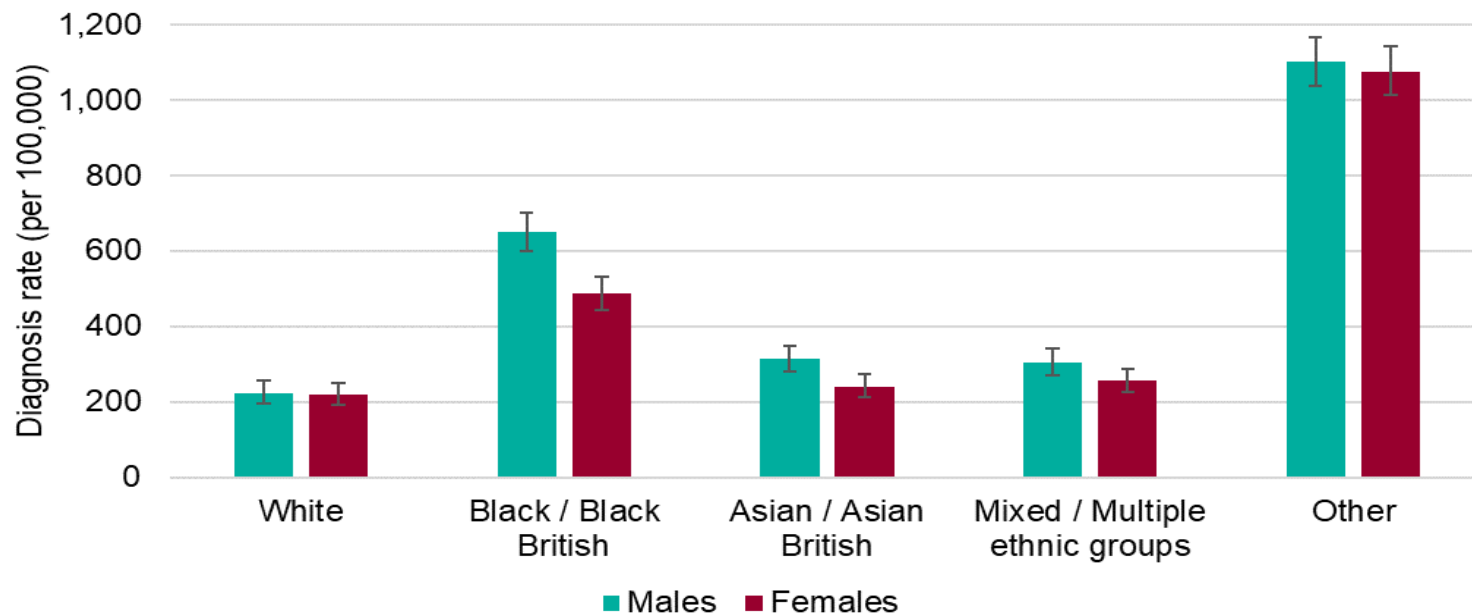
STAY ALERT ▶ CONTROL THE VIRUS ▶ SAVE LIVES

GOV.UK/coronavirus
NHS.UK/coronavirus

Cases- Ethnicity

The highest age standardised diagnosis rates of COVID-19 were in people in the Other and Black ethnic groups, and the lowest rates were in the White ethnic groups

Figure 4.2: Age standardised diagnosis rates by ethnicity and sex, as of 13 May 2020, England



Source: Public Health England Second Generation Surveillance System

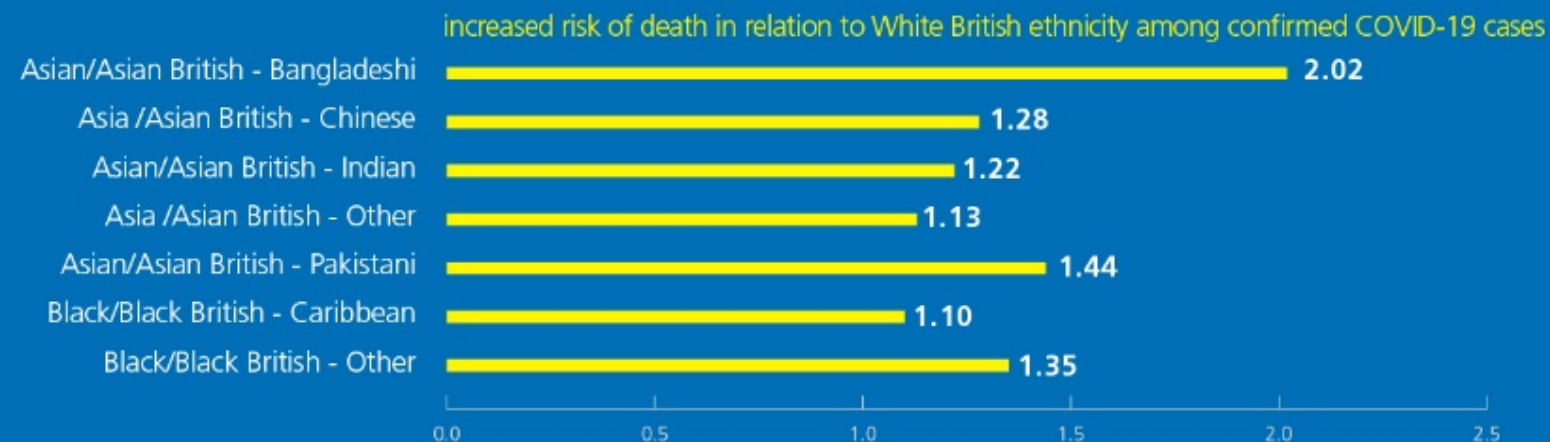
The rates in the Other ethnic group are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases data and the population data used to calculate the rates

CORONAVIRUS MORTALITY RATES BY ETHNICITY

Risk of dying among those diagnosed with COVID-19 **was higher** in those in **Black, Asian and Minority Ethnic (BAME)** groups than in **White ethnic** groups

In previous years, the mortality rates were lower in BAME groups when compared to White ethnic groups

An analysis of survival among confirmed COVID-19 cases, using more detailed ethnic groups and after accounting for the effect of sex, age, deprivation and region:



Among people who tested positive for COVID-19 Bangladeshi ethnicity had **around twice the risk of death** than people of White British ethnicity

People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had **between 10 and 50% higher risk of death** when compared to White British ethnicity

People of Black Caribbean ethnicity have **approximately 10% higher risk of death** than people of White British ethnicity

Disparities of Impact – Children & Young People

- **Deprivation:** the mortality rates from COVID-19 in the most deprived areas were more than double for both males and females – consider potential impact of increased mortality in deprived communities on Children and Young People.
- **Urbanisation:** Local authorities with the highest diagnoses and death rates are mostly urban/densely populated – impact on communities and children and young people in urban areas.
- **Ethnicity** - Risk of dying among those diagnosed with COVID-19 was higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups – consider impact on CYP – impact of cases, hospitalisation, mortality and increased fear and worry.

Disparities of Impact – Children & Young People

- **Occupation:** A total of 10,841 COVID-19 cases were identified in nurses, midwives and nursing associates registered with the Nursing and Midwifery Council – consideration for children of key workers.
- **Sex:** Working age males diagnosed with COVID-19 were twice as likely to die as females – consider the loss of parent on CYP MH.
- **Age:** Compared with those under 40, those who were 80 or older were seventy times more likely to die - loss of grandparents to consider and impact on CYP MH.

- **Longstanding inequalities exacerbated by COVID-19**
Structural and societal environments & socio economic factors.
- **Increased risk of exposure to and acquisition of COVID-19**
Key workers, higher use of public transport, multiple occupancy households.
- **Increased risk of complications and death from COVID-19**
Higher rates of MLTC, mental health, poorer uptake of prevention services and importance of risk factors such as diabetes, obesity and CVD.
- **Racism, discrimination, stigma, fear and trust**
Late presentation for treatment, access to PPE, Occupation risk assessment, role of faith and culture, need to rebuild trust.
- **Moving forward**
Act now, cross government action, sustainable change, communications culturally and faith specific, more research needed.

Beyond the data: Understanding the
impact of COVID-19 on BAME groups

Understanding the Impact on CYP: BAME Groups

- **Intergenerational living:** 30% of BAME groups live with a child under the age of 16 compared with only 11% of the white British population.
- **Social isolation and loneliness:** Ethnic minority groups also face particular risks of social isolation and loneliness, linked to higher levels of deprivation and potential exclusion from structures and processes that promote social connectedness and a sense of belonging.
- **Existing mental ill health:** Increased acquisition risk and poorer health outcomes for people with mental illness. This was especially compounded for BAME communities for whom problematic access to primary mental healthcare and mental health promotion have been well described.

Understanding the Impact on CYP: BAME Groups

- **Impact of lockdown restrictions on those with mental illness:** Social distancing measures place restrictions on access to social support networks which are a fundamental part of BAME communities' infrastructure and culture.
- **Barriers to accessing childcare:** The proportion of Black African and Black Caribbean households with dependent children and lone parents is high when compared to other groups; this may lead to difficulty arranging childcare in order to become economically active.

General Resources, Tools and Guides

Migrant Mental Health Guide

<https://www.gov.uk/guidance/mental-health-migrant-health-guide>

Fingertips Data – Shows mental health data by protected characteristics <http://fingertips.phe.org.uk/profile-group/mental-health>