Health Inequalities Policy Programme:
Briefing Paper

Themes from available data

The importance of ethnicity for understanding young people's experiences of health inequalities

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Contents

Acknowledgements

We would like to express our sincere thanks to Tracey Bignall (Race Equality Foundation) and Dr Darren Sharpe (University of East London) for their insight and expertise in informing the drafting of this report.

A note on language

Throughout this report, we have used the labels and terms as they appear within the original datasets or research to which it refers. We have capitalised all ethnicities, as per recommendations from the Commission on Race and Ethnic Disparities (UK Government, 2021).

Introduction

Covid-19 revealed stark health inequalities along the lines of ethnicity. People from all minority ethnic groups were at greater risk of death and hospitalisation from the illness in comparison to White British groups (SAGE, 2022). Wider research has also found that ethnic minority groups generally have worse health outcomes compared to the overall population (Parliamentary Office of Science and Technology, 2007). These worrying statistics have rightly directed thinking on health inequalities to consider the impact of ethnicity on health.

In the population as a whole more young people than older people fall into ethnic minority groups (AYPH, 2021). Yet little is understood about how health outcomes vary by ethnic groups for young people aged 10-25 in the UK. In this report we have collated a range of publicly available data sources in order to examine the level of ethnic health inequalities experienced by young people. The structure of the report considers the drivers, levers and outcomes of health inequalities in turn. This builds upon earlier work developing a conceptual model for understanding the pathways of young people's health inequalities (McKeown & Hagell, 2021).

Interpreting ethnic health inequalities

Given the variation between different ethnic groups, we recognise the importance of presenting a comprehensive breakdown where it is available. For data that are available, we have presented the ethnic categories as they appear within the data sets, meaning different categories are reported for some charts. Similarly, where we refer to other research sources we have used the categorisations and ethnicity labels used in the literature. Most data are available by the categories used in the 2011 census (although these themselves are now out of date[1]). For health data it is not always clear whether ethnicity is self-reported by the patient (either at the time or via the patient's health record) or whether it is defined externally by others. It is also worth noting that ethnicity is a subjective concept and cannot always be clearly categorised. It has been suggested that miscoding in hospital settings has led to an increase in patient ethnicity recorded as "unknown" or "other" (Scobie et al, 2021). In addition, not all health data are broken down by ethnicity *and* age, which means the data presented in this report cannot provide a full picture of the range and breadth of health inequalities experienced by young people separate from other age groups.

Ethnicity of young people in the UK

21.5%

of 10-19 year olds in England and Wales classify themselves as belonging to an ethnic category other than White British. This compares to 19.5% for the wider population in England and Wales.

The largest groups are Mixed ethnicity, Pakistani, Indian and Black (Black African/ Caribbean/Black British).

Source: ONS, 2012

1 At the time of writing, the 2021 census results do not provide population breakdowns by ethnicity. These are due to be published later in 2023.

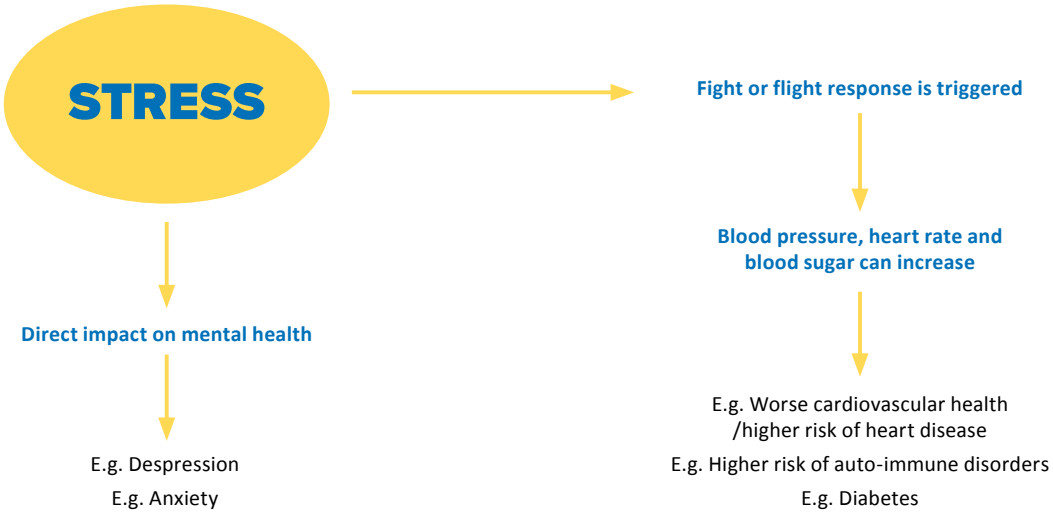
Drivers of ethnic health inequalities

Health inequalities may result from economic inequalities which impact the social determinants of health. Looking specifically at differences in health outcomes by ethnicity, there are a number of additional causes of inequity. These include racism, discrimination and bias, poverty and deprivation, all potentially leading to accessibility issues and poorer experiences of healthcare and preventative services. Elsewhere, the drivers of ethnic health inequalities have been categorised as structural racism, interpersonal racism and institutional racism (Nazroo, 2022).

The NHS Race and Health Observatory have uncovered a number of ethnic inequalities in healthcare, including poor quality treatment from healthcare staff and lack of appropriate treatment for health conditions (Kapadia et al, 2022). Incidents of racism have both direct and indirect impacts on an individual's health via physiological pathways, as explored in Box 1. Minority stress theory describes how repeated experiences of prejudice and discrimination can lead to poorer mental and physical health outcomes for minority groups.

How does racism impact health? (Williams & Whitfield, 2004)

Racism can take many forms including discrimination, prejudice, bias and micro-aggressions. These events can have direct or indirect impacts on an individual's health by triggering stress within the body. There may be a direct impact on a person's mental health and wellbeing. Indirectly, the stress event can trigger the "fight or flight" bodily response, which can have physical implications. Repeated or continued experiences are called "toxic stress", leading to a wear and tear effect on the body which increases risk over time (Shonkoff, 2022).



Racism or micro-aggressions (e.g. staring in public or asking to touch someone's hair) may also have insidious impacts on a young person's health. By not providing racially inclusive services professional practice runs the risk of discriminating against patients from different ethnic minority backgrounds, who might struggle with accessing standard levels of care. In health and social care settings, for example, professionals may favour some patients over others by offering longer consultations or different treatments based on bias judgements on the person's lifestyle and culture. Additionally, medical education / training may not teach health professionals about the different ways in which conditions can present by ethnicity. Individuals may or may not be aware if these scenarios are occurring and the direct impact this may have on their health.

As well as interpersonal racism, structural racism is a key factor that impacts on the ways in which young people from different ethnic minority backgrounds experience social determinants as either risk or protective factors for their health and wellbeing. Racism influences employment status, housing status/ condition and education level, amongst other factors. These in turn shape the wealth and income afforded to different individuals and groups and thus their deprivation level. It is for this reason that ethnicity and socio-economic status are so closely connected. Michael Marmot (2020) recently updated his core recommendations for reducing health inequalities to include "tackling discrimination, racism and their outcomes". It is vitally important to recognise the role racism plays in understanding ethnic health outcomes.

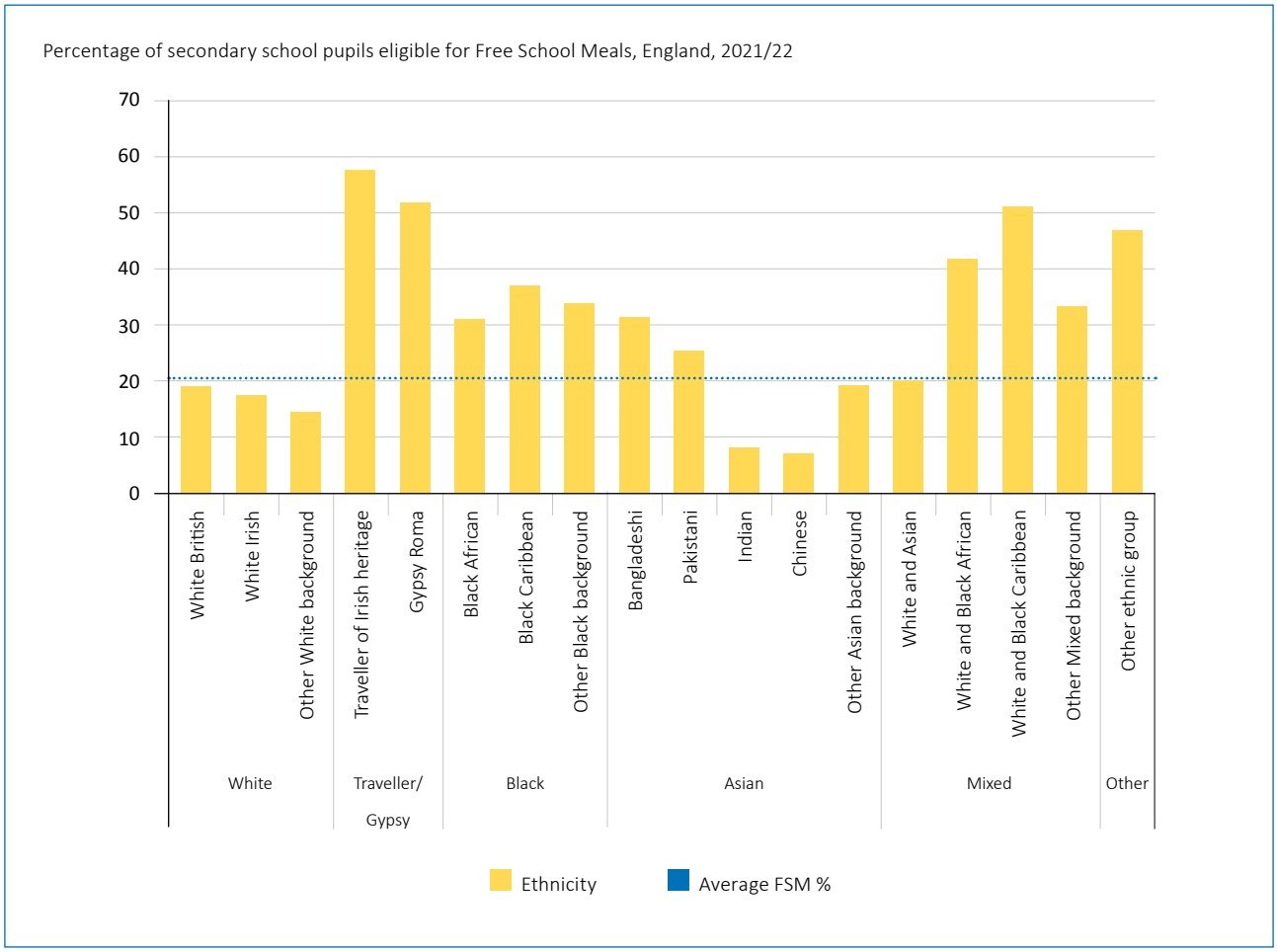
It is important to note that some of the disparities in health outcomes that we see for different ethnic minority groups are not necessarily driven by racism or socioeconomic circumstance. The prevalence of some health conditions are higher for certain ethnic minority groups as a result of genetic causes, such as sickle cell anaemia which is more common for Black African and Black Caribbean individuals.

Poverty

There is a lack of official statistics on poverty by ethnicity, especially for this age group. Much of the available data are based on smaller scale research samples rather than population level data within official statistics. It is estimated that Black African or Caribbean or Black British children are more than twice as likely to grow up in poor households compared to White children (Labour Party research / The Guardian, 2022). Nearly two thirds (61%) of Bangladeshi children are classified as living within a poor household, representing the poorest ethnicity. The proportion of Black children living in poverty increased from 42% in 2010/11 to 53% in 2019/20 (Labour Party research / The Guardian, 2022). Research from the Social Metrics Commission (2019) indicated a similar finding, with 46% of Black households (African, Caribbean, Black British) in the UK living in poverty. The Joseph Rowntree Foundation (2022) have found that Black and other minority ethnic groups have the highest risk of "deep poverty" (below 40% of median income after housing costs), although these results are not specific to our age group.

Looking specifically at young people, the closest measure we have for determining poverty for secondary school aged children is eligibility for free school meals (FSM). This is not a wholly accurate indicator, since the threshold for being eligible is a household annual income of <£7,400, which is a relatively low annual income and households earning more than this may still experience poverty. As **Figure 1** shows, in the latest data from secondary school pupils in England all the groups with above average rates of FSMs are from ethnic minorities. Only White, Indian and Chinese young people fall below the overall FSM eligibility. Traveller and Gypsy Roma young people are much more likely to be eligible for FSM than other groups. Mobile Traveller and Gypsy Roma young people and/or those who have left the education system early (due to cultural beliefs relating to work and household responsibility) may not be recorded within the official statistics presented here.

Figure 1: Traveller and Gypsy young people are much more likely to be eligible for Free School Meals in England



Source: Department for Education (2022) *Schools, pupils and their characteristics*. UK Government.

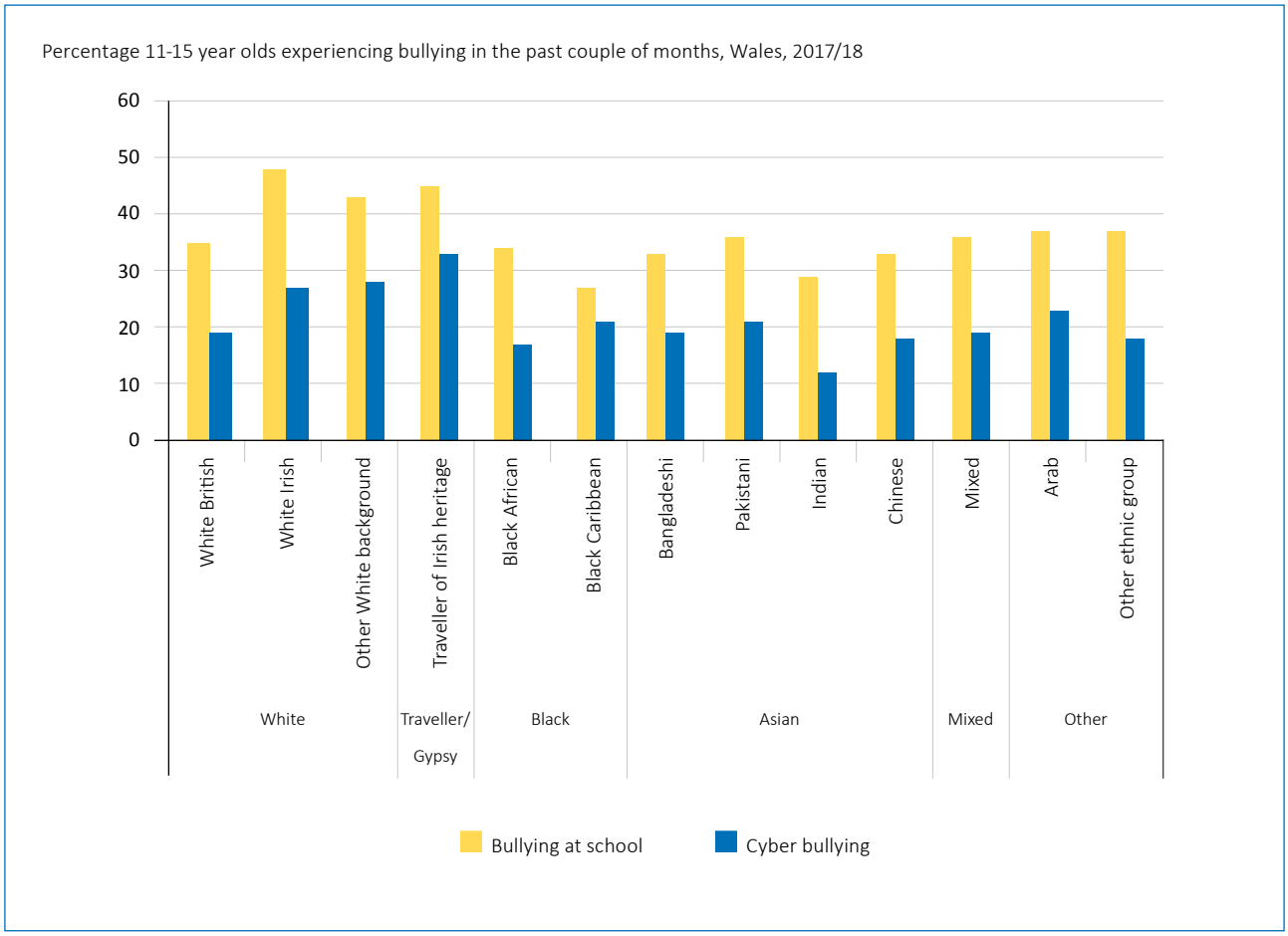
Experiences of school: racism and bullying

We have established that racism can have direct links to health outcomes. Research has found that schools are a common place for young people to experience racism and stigmatisation (Wright et al, 2009). Research and freedom of information requests have found that incidences of racism within schools have increased dramatically in recent years (Batty & Parveen, 2021). Interviews with Black[2] and Mixed ethnicity young people (aged 16-30 years) found 95% had heard or witnessed racist language at school, with 51% of young men hearing it "all the time" (YMCA, 2020).

Bullying has a huge impact on a young person's wellbeing and mental health and can also have implications for their physical health. More than a third (38%) of 10-11 year olds and nearly two thirds (63%) of 13-14 year olds believe that a person's skin colour makes them more likely to experience bullying within school (Department for Education NI, 2011). However, few representative survey data are available on bullying within school settings and those that do exist present a complex picture. **Figure 2** shows self-reported HBSC data from 11-15 year olds in Wales, with White and Traveller young people the most likely to report both in-person bullying and cyber-bullying. However, there are no particularly strong differences between many of the ethnic groups (Hewitt et al, 2019). Research from the National Children's Bureau (NCB) found higher levels of bullying for asylum seeker and refugee young people (Eilenberg, 2020). The same survey found that White children reported higher rates of bullying than those from Black Caribbean and Indian groups.

2 Defined as people who identify with one or more of the following demographics: Black African, Black British, Black Caribbean, Mixed White and Black African and Mixed White and Black Caribbean.

Figure 2: Black Caribbean young people are least likely to self-report experiencing bullying



Source: Hewitt, G., Anthony, R. & Moore, G. et al. (2019) *Student Health and Wellbeing in Wales: Report of the 2017/18 Health Behaviour in School-aged Children Survey and School Health Research Network Student Health and Wellbeing Survey.* Wales: HBSC.

These mixed findings need some explanation and potentially contradict anecdotal evidence and teachers' observations. A recent survey of teachers found that 18% had witnessed bullying due to race or ethnicity either "often" or "very often" (Department for Education, 2020). This could be explained by cultural differences in acknowledging and reporting bullying (Eilenberg, 2020).

Experiences of school: suspension and exclusion

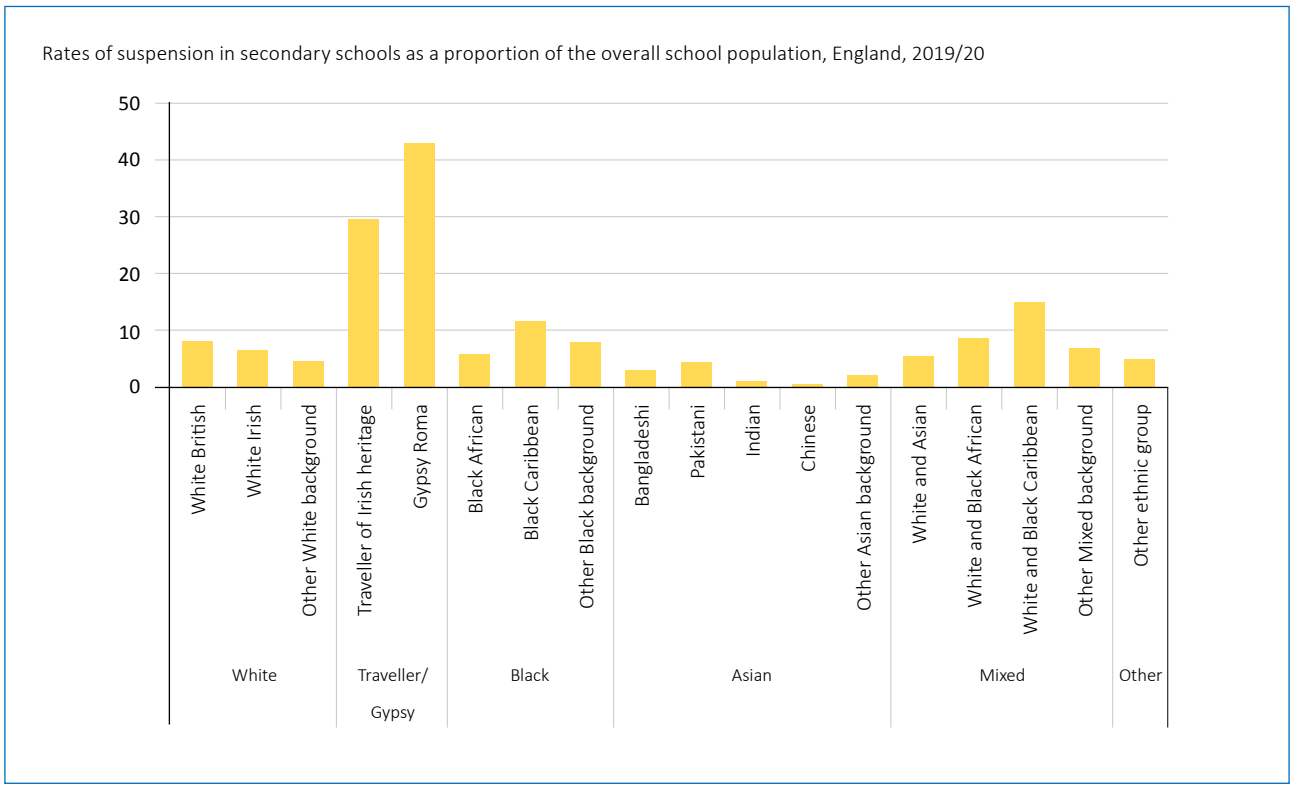
For the vast majority of young people, schools are a protective environment for their health and social and emotional wellbeing. The impacts of Covid-19 school closures on young people have been widely reported (Mansfield et al, 2021), demonstrating the protective effect of being in education. Schools provide a positive learning environment, opportunities to socialise with peers, regular and nutritious meals (for some), dedicated time and equipment for physical activity, and access to healthcare support. Being outside of school, young people lose access to these resources and opportunities to build resilience.

School suspensions and exclusions are a measure of a young person's experience of school, representing how well young people engage with their peers, teachers and the school system generally. Research has found that racism within school settings has had a disproportionate impact on behaviour management techniques such as detention and exclusions, with young Black people being less likely to receive a positive responsive to distress (Health and Social Care Scrutiny Commission, 2021). Again, these experiences may impact on a variety of different kinds of health outcomes, including mental health.

Figure 3 shows that Traveller and Gypsy Roma young people are much more likely to be suspended from secondary school compared to other ethnic groups. The suspension rate is the number of suspensions as a proportion of the overall school population in the academic year. By this measure, Gypsy Roma young people are five times more likely to be suspended compared to White British young people. Black Caribbean and White and Black Caribbean also have historically relatively high suspension rates.

The data on exclusion rates follow the same pattern as suspension rates (Department for Education, 2020). Research suggests that young people who have been excluded are 10 times more likely to go on to suffer from mental health problems later in life affecting their opportunities achieve wellbeing across the life course (Mind, 2021).

Figure 3: Suspension rates are higher for Traveller and Gypsy and Black Caribbean young people



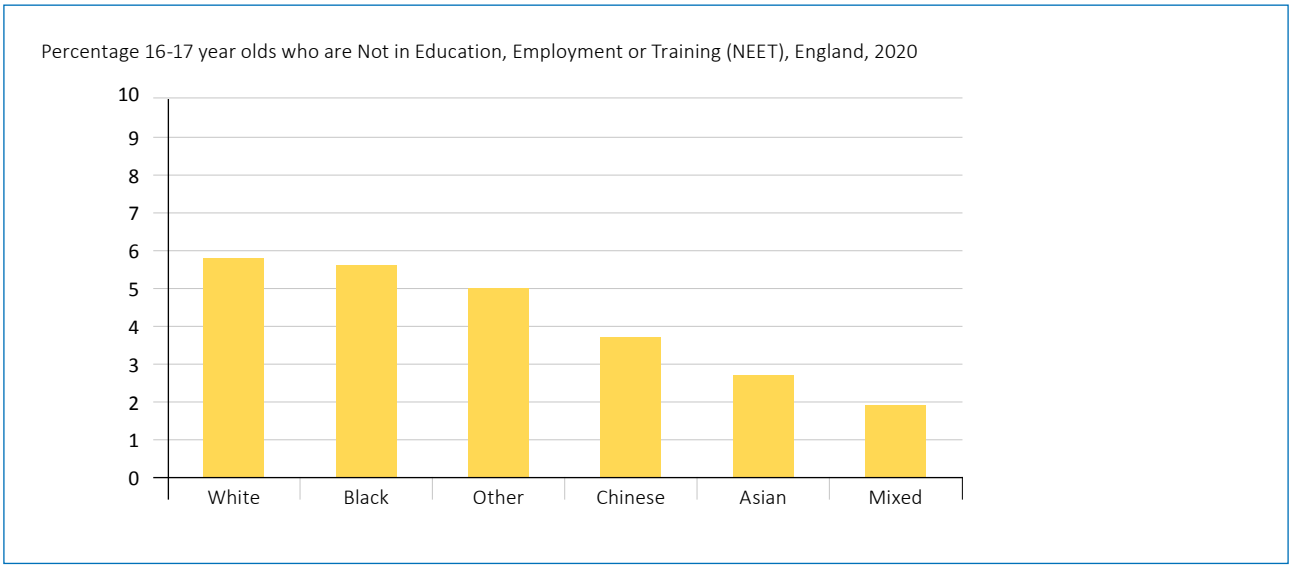
Source: Department for Education (2020) *Permanent exclusions and suspensions in England*. UK Government.

Not in Education, Employment or Training (NEET)

Education and employment status is a marker of future success and health status. Being Not in Education, Employment or Training (NEET) has been linked to poor health status, due to increased likelihood of unemployment, low wages and/or low quality work later in life. It is also linked to development of unhealthy habits and behaviours (Public Health England & UCL Institute for Health Equity, 2014).

Overall, in 2021, approximately 10% of 16-24 year olds in England were NEET. For 16-17 year olds, the overall NEET rate was approximately 6%. In **Figure 4** we can see that Black and White young people had similar, average, NEET levels. Asian and Mixed ethnicity young people had lower, below average NEET status. Interviews with Black and Mixed ethnicity young people (aged 16-30 years) found 54% felt that bias or prejudice is the main barrier to gaining meaningful employment, such as their name on their CV (YMCA, 2020).

Figure 4: Asian and Mixed ethnicity young people have below average NEET status



Source: Office for Health Improvement and Disparities (2022) *Fingertips – Child and Maternal Health*. UK Government.

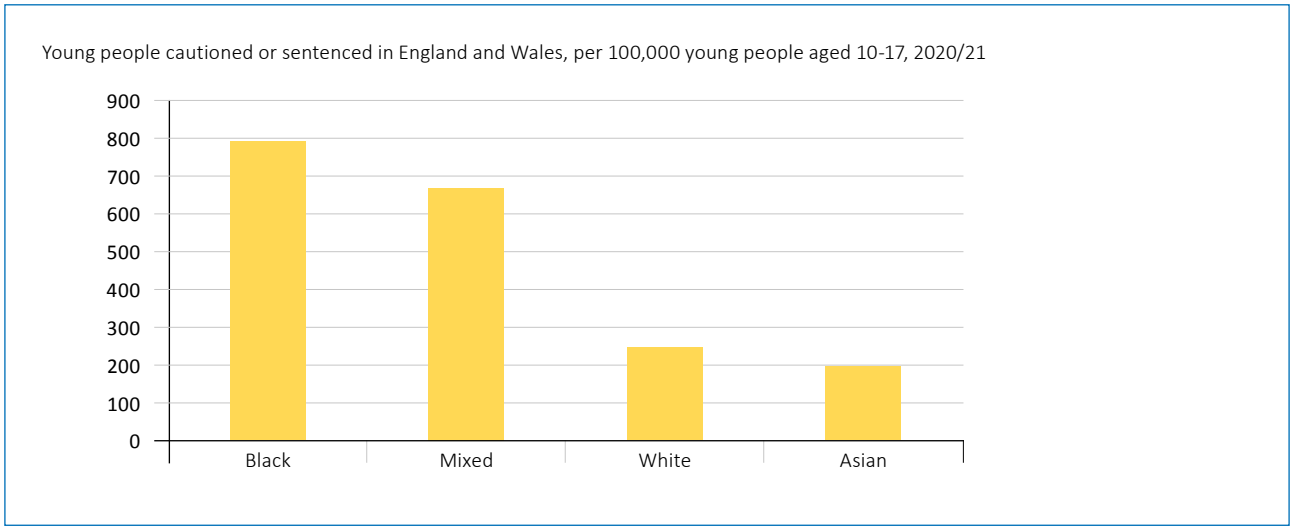
Criminal justice

Research has found policing in the UK to be systemically biased and racist in its practices, with stop and search being particularly criticised for racial profiling of Black communities. In 2021, Black people were seven times more likely to be stopped by police compared to White people (UK Home Office, 2022). During the Covid-19 lockdown periods, over 20,000 young Black men were stopped and searched in London, representing a quarter of all Black 15-24 year olds living in London (Grierson, 2020). In England and Wales, Black children were four times more likely to be arrested compared to White children in 2018/19 (Youth Justice Board & Ministry of Justice, 2020). The case of Child Q also demonstrated failings within policing, relating to racial profiling and inappropriate use of force.

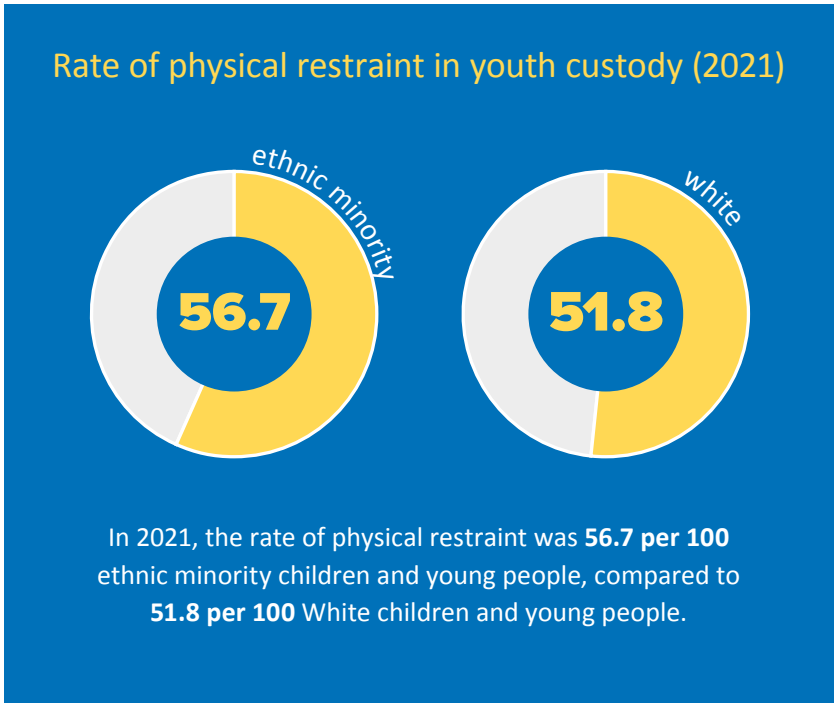
Figure 5 shows the number young people cautioned or sentenced in England and Wales by ethnic group, as a proportion of all young people aged 10-17. The population rates reveal that Black and Mixed ethnicity young people are overrepresented in the criminal justice system, with Black young people being three times more likely to be cautioned or sentenced compared to White young people. The National Audit Office (2022) have found that while the proportions of White children in youth custody has declined over time, the proportion of young people from minority ethnic backgrounds has increased dramatically between 2010/11 and 2020/21.

Data also reveal that, while being detained in custody settings, young people from ethnic minority backgrounds are more likely to be subject to restrictive physical restraint compared to White young people. In 2021, the rate of physical restraint was 56.7 per 100 ethnic minority children and young people, compared to 51.8 per 100 White children and young people (Youth Justice Board, 2022). Use of restrictive physical restraint can have an impact on the physical and mental health of young people. This can be compounded by the separation from family and support networks, which are protective factors to mental wellbeing. Young people's encounters with the criminal justice system will influence their later prospects in the job market and ultimately their future health and wellbeing outcomes. This is further undermined by poor educational experiences in custody, especially for those of secondary schooling age.

Figure 5[3]**:** Black and Mixed ethnicity young people aged 10-17 are more likely to be cautioned or sentenced in England and Wales



Source: Youth Justice Board (2022) *Youth Justice Statistics: 2020 to 2021*. UK Government.
Population data source: Office for National Statistics (2011) *2011 Census*. UK Government.



Source: Youth Justic Board, 2022

3 This chart combines two separate data sources, presented here as a population rate. We acknowledge that the cautioning / sentencing data are taken from the year 2020/21 and are compared against census population data from 2011 (latest available at the time of writing). In producing the population rate, we have assumed that both datasets have coded and recorded the ethnicity categories in the same way.

Levers for action

The social determinants of health are translated into health inequalities in a number of ways including, for example, by creating barriers in access to services. We've called these factors "levers for change" in our conceptual model for understanding young people's health inequalities (McKeown & Hagell, 2021). The "levers" represent either opportunities or obstacles to improving a young person's health and wellbeing.

Accessing services

Racism, discrimination and stigma may prevent young people from engaging with mainstream preventive services in their community. Research has found that the most important things for young people accessing healthcare settings are trusting relationships, having time to talk, empathy and taking concerns seriously (Appleton et al, 2022). Young people from ethnic minority backgrounds are more likely to experience barriers to healthcare settings which may delay them from getting the help they need at the time help is most needed. In a survey of 152 young people across England, 18% of Pakistani, Indian, African, Chinese, Mixed and Other young people reported a negative impact of ethnicity on their healthcare (NHS Youth Forum, 2022).

Evidence from 3,000 young people aged 16-25 revealed experiences of delays to accessing treatment for young people from ethnic minority backgrounds, with impacts on anxiety/stress, extreme pain, complications during medical procedures and lack of support (Leaders Unlocked, 2021).[4]

These experiences will influence the level of trust young people have in healthcare services, which can also be influenced by wider community and familial experiences and trust in services. Research from NHS West Yorkshire and Harrogate (2020) found that 39% of parents of children from Black, Asian or Minority Ethnic (BAME) backgrounds worried about taking their children into healthcare settings, compared to 31% of parents of White children.

Barriers to accessing services faced by young people from ethnic minority backgrounds

Individuals from ethnic minority backgrounds are more likely to experience barriers when accessing healthcare services, particularly for young people who face barriers relating to their age.

- Stigma around health issues within the community or family
- Lack of trust of professionals and services
- Previous experience of racist treatment or fear of racist/unfair treatment
- Language or communication barriers
- Services aren't culturally appropriate
- Health professionals and/or wider staff members aren't representative of a range of ethnicities and they "won't understand" if they are White
- Lack of awareness of where to go and how to access help and support
- Limited staff education and training
- Concerns around confidentiality

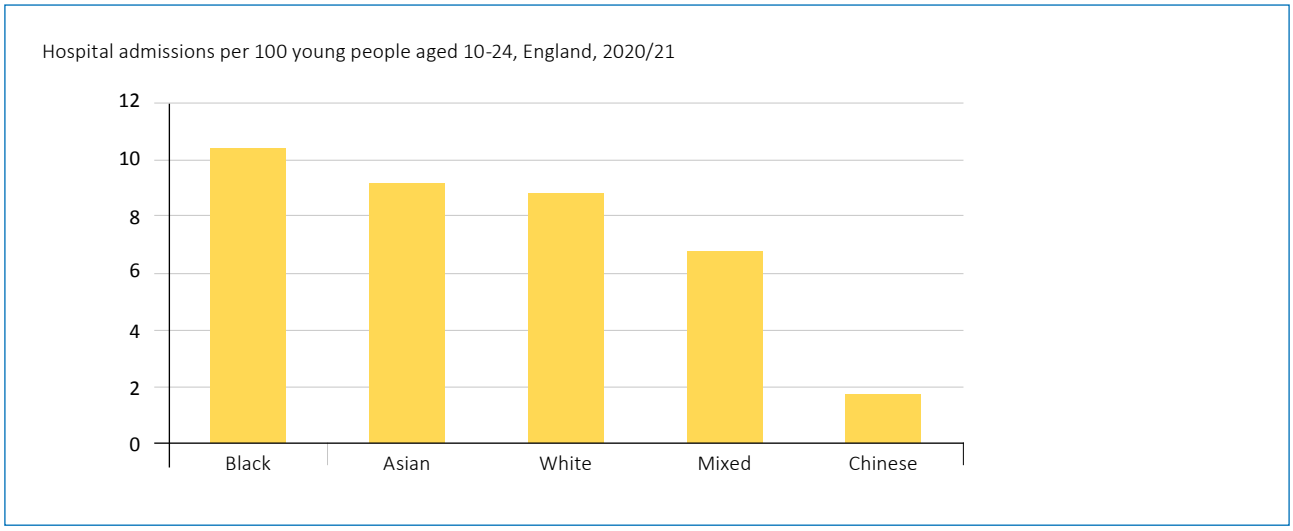
(Le et al, 2022; Kapadia et al, 2022; Street et al, 2005)

4 The sample of young people surveyed was not representative of the wider population, but 32% of respondents identified as Black, Asian or Minority Ethnic.

However there is a lack of regular and accurate population level data to monitor ethnic variation in the use of NHS services (Parliamentary Office of Science and Technology, 2007). The data we have available to use are on hospital admissions, as shown in **Figure 6**, which only reflect who actually received a service, not who needed one and did not get it.

We can see rates of hospital attendance for Black and Asian young people are highest while there are fewer Chinese and Mixed ethnicity young people attending hospital. These data are difficult to interpret but one explanation might be that, by missing out on preventative services, young people from ethnic minority groups might be more likely to have to be admitted with problems that have reached a more serious level.

Figure 6[5]: Fewer Chinese and Mixed ethnicity young people are being admitted to hospital compared to Black and Asian young people



Source: NHS Digital (2022) *Hospital Admitted Patient Care Activity – England*. NHS Digital: National Statistics.
Population data source: Office for National Statistics (2011) *2011 Census*. UK Government.

Experiences of services

It is important that young people have positive experiences of healthcare settings as this will influence their future re-engagement with healthcare or preventative services. In general, young people are more likely than older ages to say that they received poor communication from healthcare staff and that they did not feel their symptoms were believed. Some young people from ethnic minority groups have reported being dismissed by professionals and not being believed, being patronised by healthcare staff members and having rushed appointments (Leaders Unlocked, 2021).

Patient satisfaction is not routinely captured across NHS settings and services. Where experiences are recorded, it is more likely that satisfaction surveys are aimed at adult patients rather than children and young people. We therefore do not have an accurate picture of children and young people's experiences of healthcare services.

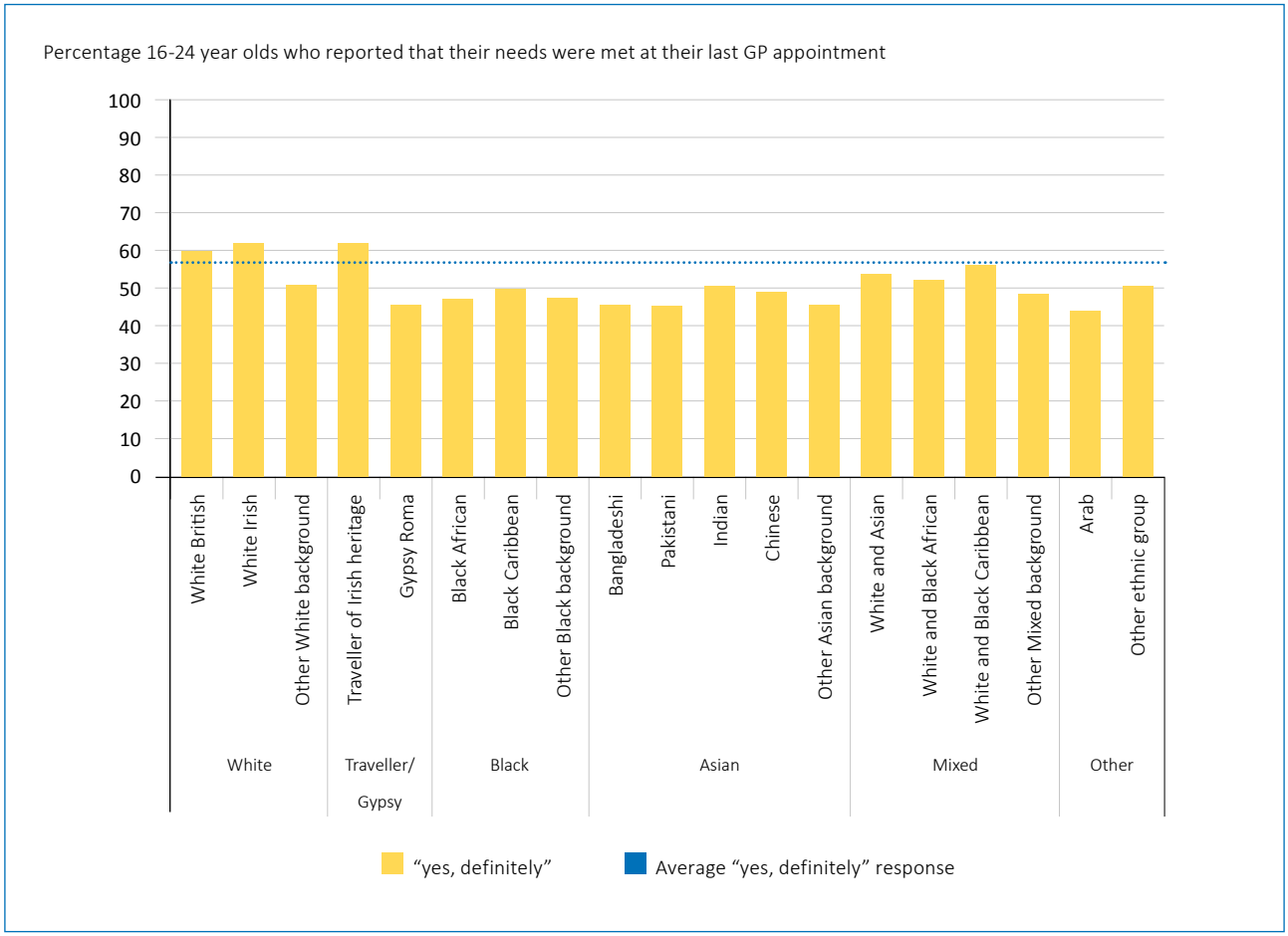
Figure 7 presents data from the England GP patient survey, which includes people aged 16 and above. On average, 56.7% of respondents aged 16-24 stated that they "definitely" felt their needs were met in their last GP appointment. Only White British, White Irish, Gypsy or Irish Traveller and White and Black

5 This chart combines two separate data sources, presented here as a population rate. We acknowledge that the hospital admissions data are taken from the year 2020/21 and are compared against census population data from 2011 (latest available at the time of writing). In producing the population rate, we have assumed that both datasets have coded and recorded the ethnicity categories in the same way.

Caribbean young people had an average or higher than average experience. All other ethnicities fell below the average experience of whether needs were met. However, the chart shows limited variation between the different groups, all reporting fairly similar experiences.

These data represent the views of young people who made it to their GP appointment and who have then reflected on their experience. We do not have good data on the experiences of young people who haven't attended, or for young people under the age of 16. It is important to note that 70% of the respondents to this survey question were White British and, for comparison, just 0.05% of question respondents were Gypsy or Irish Traveller. Did Not Attend (DNA) rates are typically higher among young people from ethnic minority communities, which can contribute to racial bias if they are construed as being a "problem" by healthcare staff, weakening the already low levels of trust in services. Research on older age groups has found that individuals from ethnic minority groups are more likely to report experiencing worse treatment at the GP compared to White people (Watkinson et al, 2021).

Figure 7: Most young people from ethnic minority backgrounds have below average GP experiences



Source: NHS England (2022) *GP Patient Survey 2022*. Ipsos Mori. Shared with AYPH.

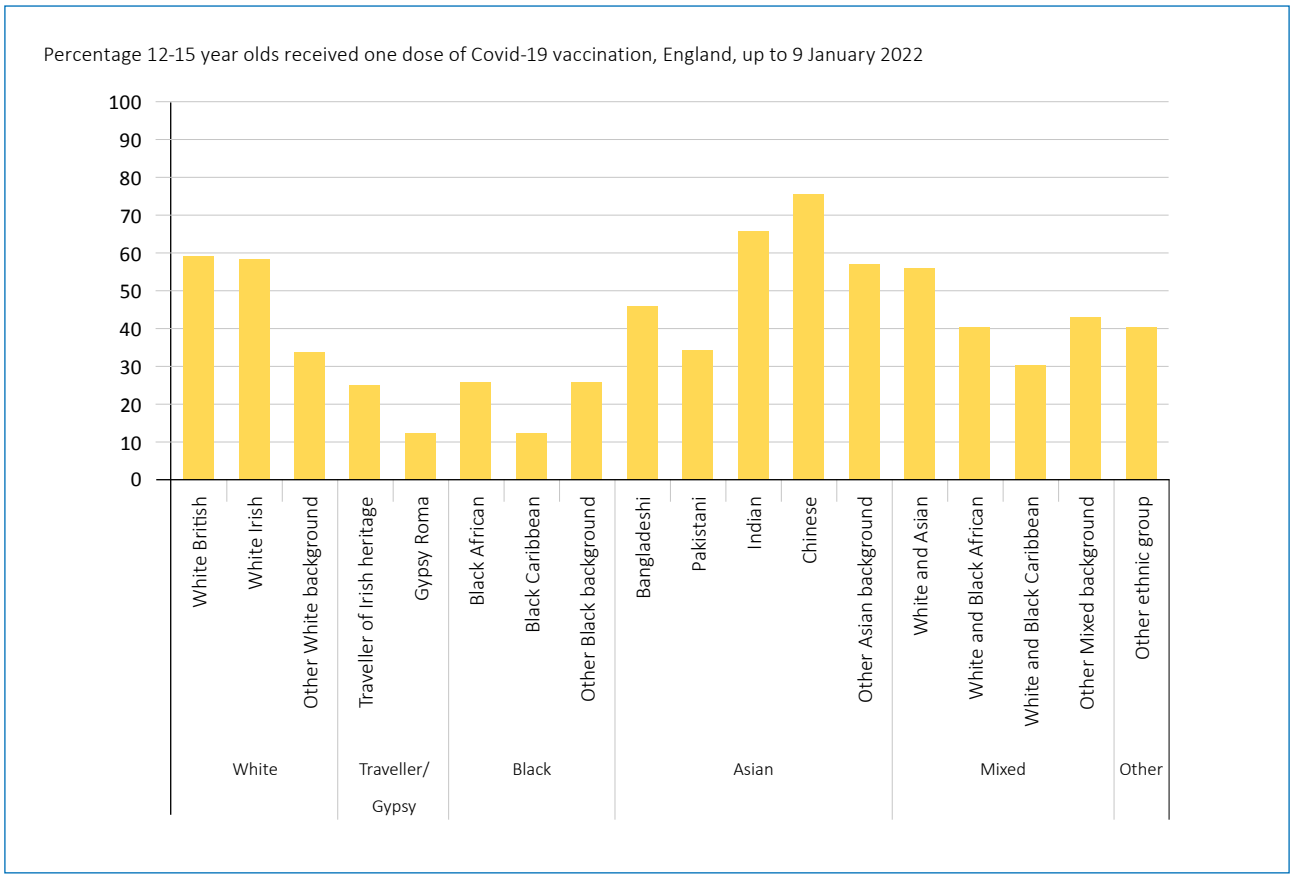
Public health screening and interventions: vaccinations

Public health screening and interventions, such as vaccines, are important for maintaining health. They are preventative measures which will improve or prevent ill health in later life. It is important young people engage in these measures as a method of health protection. There are limited data available on public health screening and vaccinations by ethnicity and age together.

Figure 8 shows the rate of Covid-19 vaccine uptake among teenagers (aged 12-15) as of January 2022, representing the latest data available at the time of writing. Generally, there are low levels of vaccine uptake among young people – with particularly low levels for Gypsy Roma and Black Caribbean young people (both at 12.4%). Chinese young people have the highest rates of Covid-19 vaccine uptake at 75.5%.

Reasons for vaccine uptake are complex and multi-faceted. It is likely to be connected to levels of trust in services and information spread among families and communities. Research suggests low levels of GP registration among migrant and refugee families due to lack of knowledge on how to access UK health services (Stagg et al, 2012), which has impacted access to Covid-19 vaccines. Separate research has found that racism is the main cause of ethnic inequities in Covid-19 vaccine hesitancy in the UK (Becares et al , 2022).

Figure 8: Black Caribbean and Gypsy Roma young people are the least likely to be vaccinated for Covid-19



Source: Office for National Statistics (2022) Coronavirus (Covid-19) vaccination uptake in school pupils, England: up to 9 January 2022.

Health outcomes

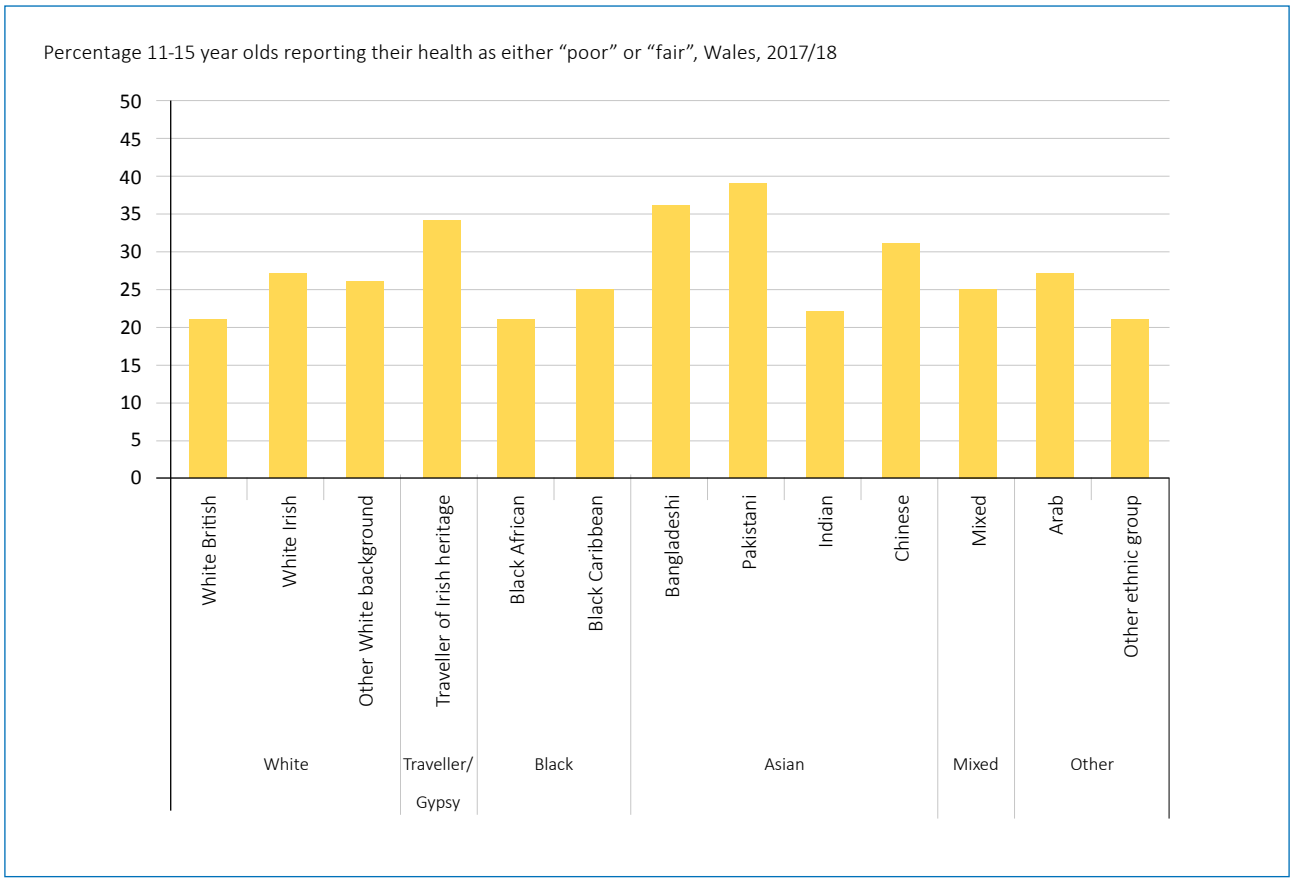
When thinking about young people, health outcomes can be thought of as health "now" – in the present – and also as the "foundations for the future" in terms of ensuring they go on to live healthy lives as they age (Patton et al, 2016; McKeown & Hagell, 2021). Mortality is often used as a general measure of health within a population group. Ethnicity is not routinely captured within death registrations and so we have not been able to include mortality as a measure within this report. Instead we have drawn on other measures of overall health where ethnicity and age have both been recorded.

Overall health

Self-reported health is one way of discerning the overall health status of different groups. However, it is worth noting that it will never be a wholly comparable measure due to subjectivity in determining how healthy we are. There also may be stigma and shame for some ethnicities in reporting health concerns, which we have touched upon in this report.

Figure 9 presents HBSC data from Welsh students on reported negative health status (indicated as either "poor" or "fair" health) by ethnicity. Pakistani (39%), Bangladeshi (36%) and Traveller (34%) young people are most likely to self-report that they have poor health (Hewitt et al, 2019). This finding aligns with other research that finds Pakistani, Bangladeshi and Black Caribbean people (of all ages) are most likely to report the poorest health (Parliamentary Office of Science and Technology, 2007). Nazroo (2022) has found that Bangladeshi adults are three times as likely to report their health to be fair or bad, rather than good, compared to White adults.

Figure 9: Pakistani, Bangladeshi and Traveller young people are most likely to report that they have poor health



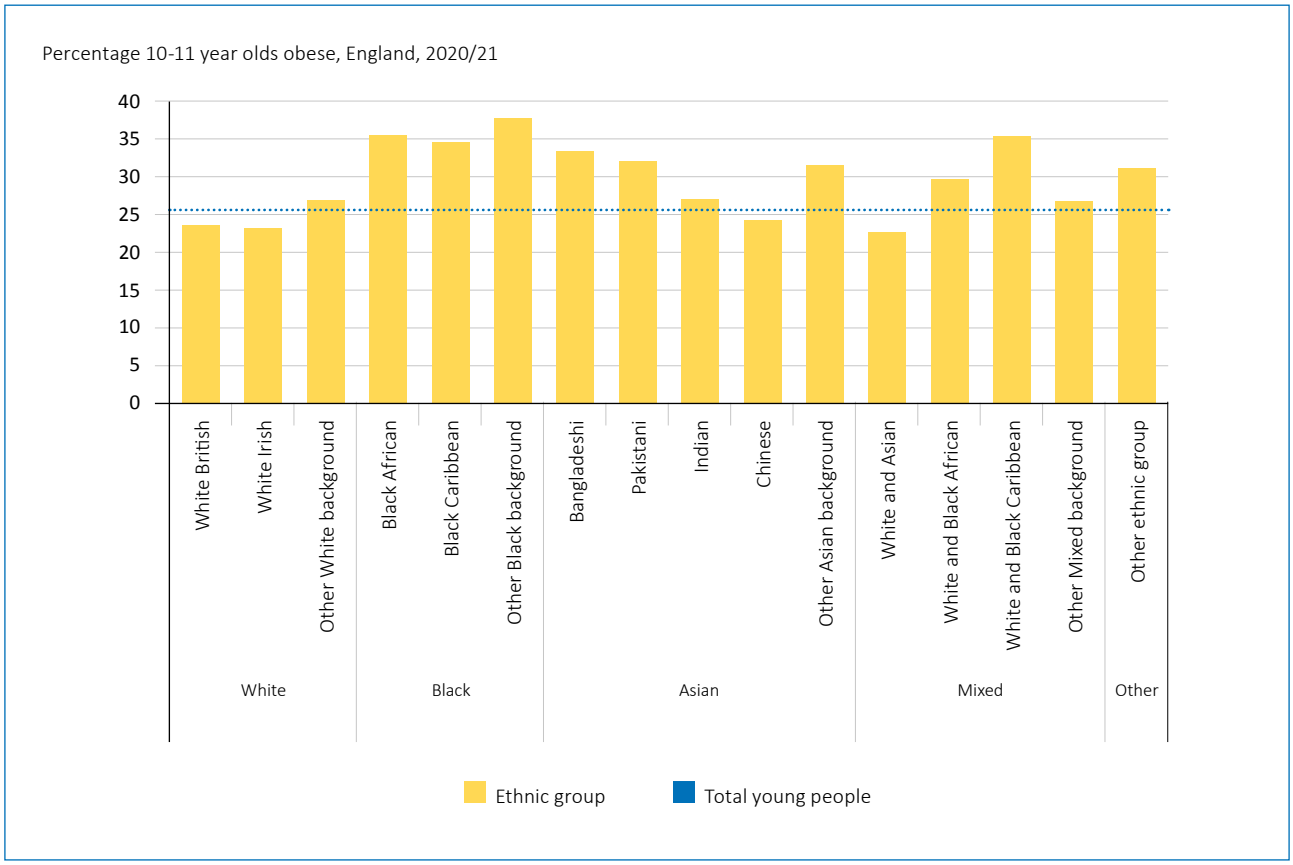
Source: Hewitt, G., Anthony, R. & Moore, G. et al. (2019) *Student Health and Wellbeing in Wales: Report of the 2017/18 Health Behaviour in School-aged Children Survey and School Health Research Network Student Health and Wellbeing Survey.* Wales: HBSC.

Obesity

Adolescent nutrition and obesity are of increasing concern. Habits of a lifetime can be formed at this stage and poor nutrition has implications for both current and future health status. Obesity rates among young people are rising over time and the increasing health inequalities by deprivation have been widely reported (AYPH, 2022). Less is known about obesity trends by ethnicity, although ethnicity is linked to deprivation (Jivraj & Khan, 2013).

A quarter (25.5%) of young people aged 10-11 in England were classified as obese in 2020/21. **Figure 10** presents obesity rates by different ethnic groups, which shows that White British, White Irish, Chinese and White and Asian young people are the only groups that fall below the average obesity rate. Black young people are most likely to be classified as obese, particularly young people from Other Black backgrounds (37.8%).

Figure 10: Black young people are more likely to be obese



Source: NHS Digital (2021) *National Child Measurement Programme, England 2020/21 School Year.* NHS Digital: National Statistics.

Mental health

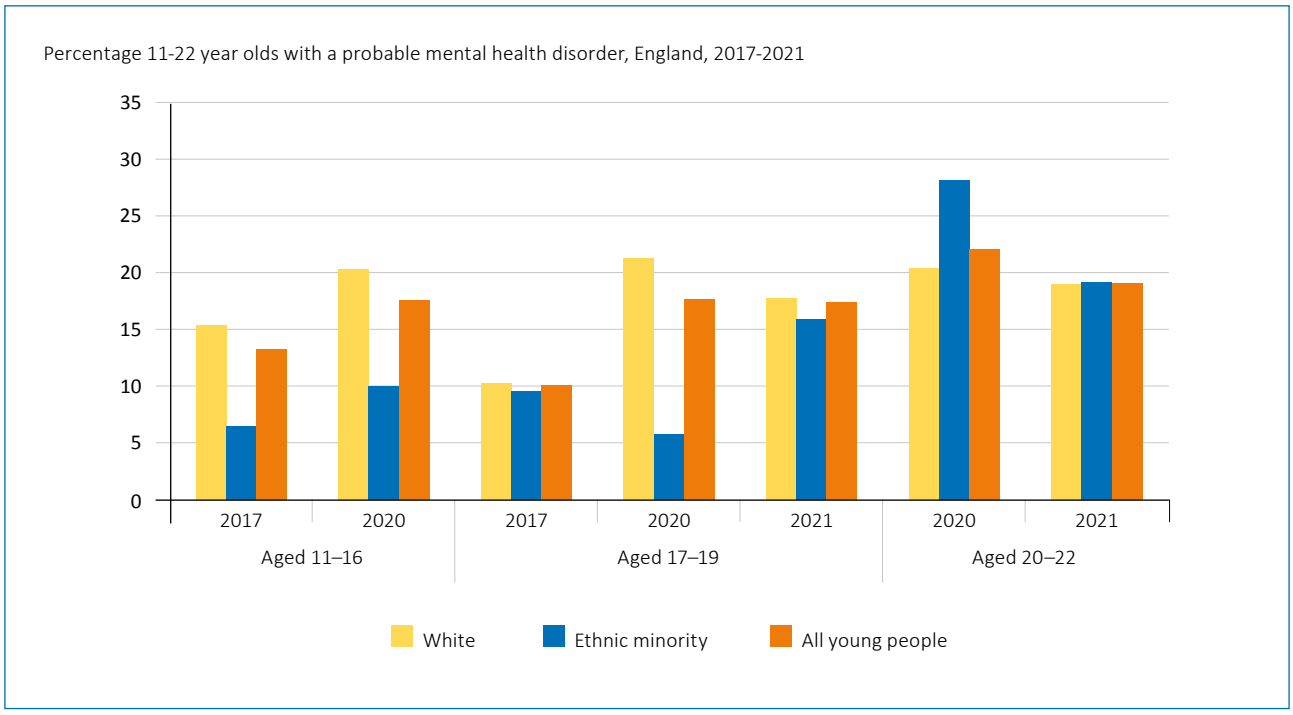
Alongside obesity, mental health is another area of increasing public health concern. Earlier in this report we have discussed how racist events and structural racism can have negative impacts on a young person's mental health and wellbeing.

Young people from ethnic minority backgrounds may also experience stigma surrounding the understanding and reporting of mental health conditions, which may prevent them from seeking help and support. A survey of young people from Somerset found that 57% of respondents from ethnic minority backgrounds thought that their racial or religious community's views about mental health differed from those of other communities (Diverse Young Somerset, 2022). This could be due to intra-group cultural taboos and prejudices overlaid by inter-group bias and prejudices.

Additionally, research has suggested that psychiatric diagnoses of mental health symptoms vary depending on the ethnicity of the patient (Parliamentary Office of Science and Technology, 2007). And Black and minority ethnic people are less likely to be referred to talking therapies and are more likely to be medicated (Bignall et al, 2019) due in the large part to the delay in seeking help, for reasons outlined here. These factors may impact the available data on mental health by ethnicity. In the adult population, research has found that Black men are more likely to have experienced a psychotic episode compared to White men and South Asian women are an at-risk group for suicide (Mental Health Foundation, 2021).

Figure 11 presents data from the most recent Mental Health of Children and Young People Survey in England. The data are presented as White and 'ethnic minority' only, which does not show the variation of experience between different ethnic groups. This may be why the data are hard to interpret, and we cannot see a clear trend or pattern. Generally, White young people aged 11-19 are more likely to have a probable mental health disorder compared to ethnic minority young people and total young people. This shifts for the older age group, with ethnic minority young people aged 20-22 more likely to have a probable mental health diagnosis compared to White young people and total young people. There have been increases in mental health diagnoses over time for young people aged 11-16 and 17-19 in both ethnic groups, however there have been declines for young people aged 20-22 in both ethnic groups.

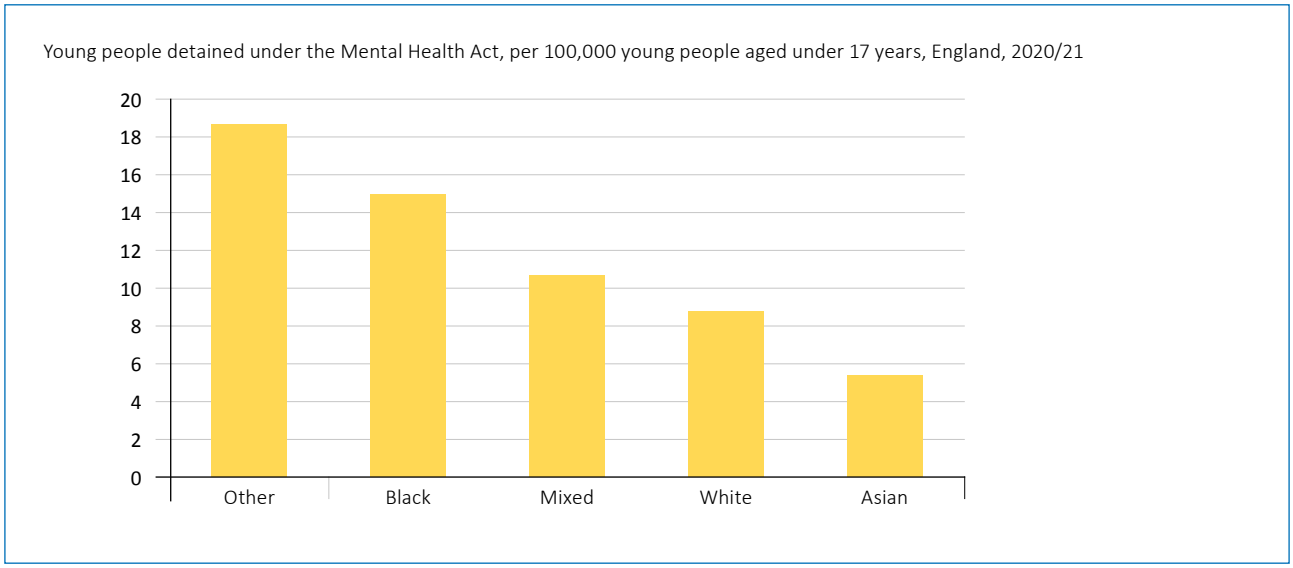
Figure 11: The mental health inequalities by ethnicity are unclear



Source: NHS Digital (2021) *Mental Health of Children and Young People in England 2021*. NHS Digital: National Statistics.

Other data have indicated that Black young people represent only 5% of the total population in Child and Adolescent Mental Health Services (CAMHS) (Thomas, 2022), when they represent nearly a fifth of the general population of this age. Mental health services are often not racially inclusive or representative of different ethnic minorities. Yet NHS Benchmarking data have revealed that Black and mixed-race young people represent 36% of the population detained in acute mental health services (Thomas, 2022). Other research has also found that Black and minority ethnic groups are more likely to end up in crisis care. **Figure 12** shows that Other, Black and Mixed young people are most likely to be detained under the Mental Health Act (i.e. "sectioned"). The Other category here is hard to interpret; as noted previously these are likely to be staff ratings of client ethnicity rather than self-report.

Figure 12[6]: White young people are much less likely to be detained under the Mental Health Act



Source: NHS Digital (2021) Mental Health Act Statistics, Annual Figures 2020-21.
Population data source: Office for National Statistics (2011) *2011 Census*. UK Government.

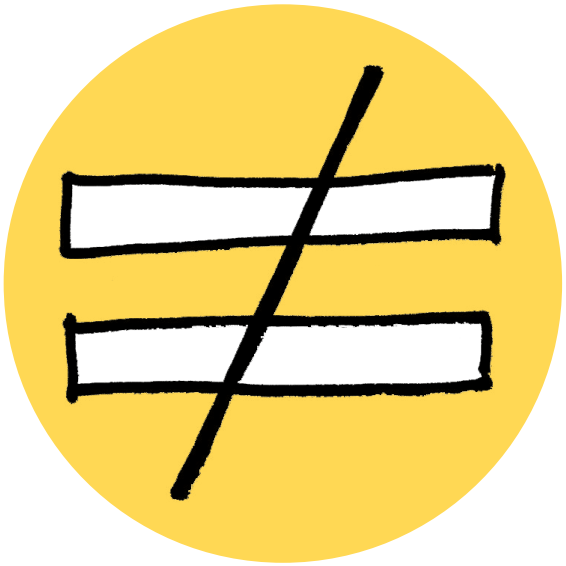
Finally, Black young people are 10 times more likely to be referred to CAMHS via social services, rather than via the GP, compared to White young people (Kapadia et al, 2022). Other research has also found that, in comparison to White young people, Black and Asian young people are more likely to be referred into mental health services via social care and justice routes rather than primary care (Edbrooke-Childs & Patalay, 2019).

6 This chart combines two separate data sources, presented here as a population rate. We acknowledge that the hospital admissions data are taken from the year 2020/21 and are compared against census population data from 2011 (latest available at the time of writing). In producing the population rate, we have assumed that both datasets have coded and recorded the ethnicity categories in the same way.

Limitations of the data

There is a diversity and complexity inherent when examining health by ethnicity. Although the data suggest overall that ethnic groups are more likely to have poorer health compared to the overall population, there remains considerable variation between ethnicities and by different indicators of health. While we may see a disparity in one area of health, this may not be replicated in other areas. Gender, education and housing all play a role in addressing risk and protective factors.

We also acknowledge the multiple and interconnected causes of ethnic health inequalities. The data presented here do not provide multi-variate regression accounting for all the possible different factors at play, they simply present descriptive outcomes by different ethnicities. The analysis presented here is unable to examine the connections between deprivation, ethnicity and health status, although there are bound to be complex relationships between these variables. All of these factors should be considered when analysing and interpreting the data presented in this report.



Conclusions

The data presented in this report demonstrate that young people aged 10-25 from ethnic minority groups are likely to face inequalities in a range of health outcomes and within the social determinants that are related to health outcomes. Though the patterns are not always clear and consistent, White British young people in the UK tend to be in better health and are living within healthier environments than their peers from ethnic minority backgrounds. There are particular concerns arising for the disparities faced by Gypsy and Traveller young people and Black young people.

Young people from Gypsy and Traveller backgrounds have higher rates of poverty and school exclusions and are least likely to have familial support available. These factors place them at a high risk of poor health outcomes in the present and the future. Black young people are least likely to engage with preventative public health measures such as vaccination. They are also more likely to be obese and have negative routes into mental health care. They are over-represented in the criminal justice system, which can constrain young people's ability to lead healthy lifestyles.

It is apparent that the needs of young people from ethnic minority groups must be appropriately planned and considered within health service design and delivery, with targeted support available. We have identified a range of barriers facing ethnic minority young people from engaging with healthcare and preventative services. Efforts must be taken to work with healthcare systems, education, criminal justice systems and communities to overcome these barriers and build up trust between young people and professionals. There must also be increased training and education of healthcare staff on ethnic health inequalities, unconscious bias and prejudice to provide racially inclusive and equitable healthcare services.

As we have shown in this report, there is a clear need for better data on ethnicity and health. The data we need to understand ethnic health inequalities is not routinely available, especially for our age group. Where it is reported in official statistics, the ethnic groups are not consistent and do not always account for the variation of experience between ethnicities. Without good quality data on ethnicity, efforts to understand and reduce health inequalities are weakened.

We join in calls others have made to eradicate racism from UK society. In acknowledging the role that racism plays in causing ethnic health inequalities, policy solutions must be focused in tackling racism head on (Nazroo, 2022).

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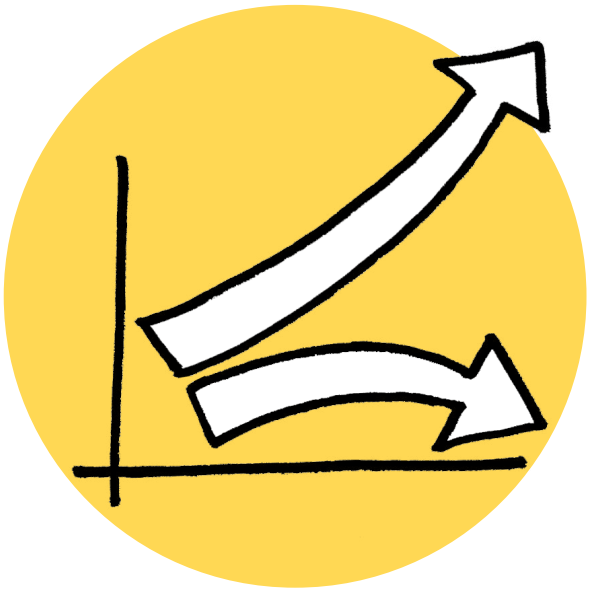

More information

About the Health Inequalities Policy Programme

This AYPH Health Inequalities Policy Programme aims to shine a light on young people's specific experiences of health inequalities and how this is a unique experience for the 12-24 age group, which hasn't previously been given due attention. Covid-19 has exposed both inequalities within society and has revealed a disproportionate impact on the lives of young people specifically. The project will seek to understand what the data and evidence says on the topic and will speak to specific groups of young people about their lived experiences. We plan to work with key, influential stakeholders who have the power to help make a difference, to learn from their experiences and work together on developing solutions. The project will develop useful guidance, tools and resources to deliver changes within both policy and practice.

The project is part of the action phase of the Young people's future health inquiry, which is funding work across a range of organisations to build the policy agenda and amplify the voices of young people. Other projects include the RSA on economic insecurity, UWE and Sustrans on transport, and projects at the Resolution Foundation and the IES exploring different aspects of youth employment.

Association for Young People's Health

AYPH is the leading independent voice for young people's health in the UK.
To find out more about our work visit www.ayph.org.uk

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