(n=22) and community workers working with Pakistani youth (n=8). Young Pakistanis were purposively selected across community settings: aged 16–25, born in UK and/or had been through UK secondary school. Interviews aimed to establish key life, social and cultural issues, with focus on relationship type and formation and perceived need/support. Interviews were recorded and transcribed verbatim. Analysis was thematic using “Framework” approach.

Results Many themes emerged which have a bearing on, and shape young Pakistanis’ experiences of, relationships. Most experience parental restrictions on socialising and mixing with the opposite sex. For girls, behaviour is further monitored by older brothers and for both sexes “community policing” is an extension of this. However, young people have developed creative strategies to circumvent these restrictions and despite faith and cultural norms, relationships do take place, primarily in secrecy. This presents what are described as “conflicting pressures”, “double worlds”, and “multiple realities”, which young people negotiate and move between, balancing different value systems. There were striking gender differences in perceptions and types of relationships and intimacy. For young women the ideal was a relationship for marriage. However, many described partners as “bad boys” and “gangster types” and some relationships were considered pressurised and “unhealthy”. The young men made distinctions between girls deemed “wifey material” and those for casual relationships. Older boys (18+) were sexually active with partners from a range of ethnic backgrounds. Condom use was inconsistent. Though not sexually active, some of the other young people had experienced mutual touching and/or oral sex. Few had good sexual health knowledge and would not know where to access help.

Conclusions The secrecy within which young Pakistanis have relationships and the pressures and gender roles they negotiate mean that many may not receive the support they need. This has implications for the delivery of appropriate preventative and curative sexual health services.

073 VARIATIONS IN THE USE OF PUBLICLY FUNDED ORAL CARE IN NORTHERN IRELAND: RESULTS FROM AN ANALYSIS OF ADOLESCENTS IN THE NORTHERN IRELAND LONGITUDINAL STUDY

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Background A socio-economic gradient in use of health care has been observed in a number of situations. These have been used to assess the performance of systems as well as frame discussion on system design. Examination of patterns at an aggregate level may mask important differences between types of care that could lead to different policy advice.

Aims To identify whether differences in registration and use related to socio-demographic characteristics exist in respect of publicly funded oral health care in Northern Ireland and if so to identify the nature of differences in care.

Methods NHS reimbursement data were linked to census and vital statistics data within the Northern Ireland Longitudinal Study. Data cover 28% of the population in Northern Ireland and in this study cover a period from 2003 to 2008. Data for individuals aged 11 or 12 in April 2003 that include registration status, reimbursement on a per item basis, gender, community background, siblings and also the social class and education of household reference person (HRP) were extracted. A series of multivariate analyses were used to examine the relationship between registration and use of care as a function of socio-demographic characteristics.

Results A clear socio-economic gradient was evident in respect of registration status. Adolescents whose HRP was long term unemployed or never worked were registered for 6 months (from a maximum of 54) less and consumed 8.3% less expenditure than those whose HRP was professional. While those from lower social backgrounds consumed 24.4% less expenditure on orthodontic services, with respect to extractions and conservative treatment, adolescents whose HRP was long term unemployed or never worked consumed 35.6% and 25.8%, respectively, more expenditure than those whose HRP was professional, other variables controlled for.

Conclusions A publicly funded demand led service can produce a pattern of service provision that disproportionately reflects the preferences of the affluent at the expense of the needs of the less affluent. This might be masked by analysis of data at an aggregate level. The pattern of service provision that results may from a societal perspective be neither efficient (cost effective) nor equitable. The disaggregated analysis of registration and utilisation patterns in this study highlights the potential for such distortion where public funds support demand led provision by for profit providers.

074 WHO THINKS TEENAGERS ARE A PROBLEM? CROSS-SECTIONAL EVIDENCE ON PERCEPTIONS OF ANTI-SOCIAL BEHAVIOUR, HEALTH AND PLACE

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Objective Perceptions of anti-social behaviour (PASB) are a policy priority and linked to numerous social harms including experience of ASB. National survey findings have associated PASB with individual and area level deprivation, potentially adding to the multiple disadvantages said to contribute to health inequalities. We ask whether PASB have independent associations with ill health compared to other individual and neighbourhood characteristics for residents of deprived inner-city neighbourhoods (Glasgow, UK).

Methods Randomly selected adult residents of 14 deprived neighbourhoods answered face-to-face structured questionnaires. A step-wise logistic regression (clustered by area) produced a multivariate model including self-rated measures of health, GP visits, psychosocial wellbeing, homes, neighbourhoods, and demographic characteristics. Perceiving teenagers hanging around to be a serious neighbourhood problem was the dependent variable.

Results 6008 adults participated (50% response). Regular annual GP visits (>6) were associated with PASB (OR 1.29; p=0.011; 95% CI 1.06 to 1.56), as was GP visits (>0) for mental health reasons (OR 1.44; p=0.020; 95% CI 1.06 to 1.96). PASB was inversely associated with self/collective efficacy (OR 1.25; p=0.028; 95% CI 1.02 to 1.53); self-esteem (OR 1.56; p<0.001; 95% CI 1.30 to 1.87); trust (OR 1.53; p<0.001; 95% CI 1.19 to 1.96); feeling safe (OR 1.71; p<0.001; 95% CI 1.41 to 2.06); social support (OR 1.94; p<0.001; 95% CI 1.45 to 2.59); age (OR 2.33; p<0.001; 95% CI 1.56 to 3.50); living with children (OR 1.20; p=0.001; 95% CI 1.06 to 1.37) home condition (OR 1.31; p=0.006; 95% CI 1.08 to 1.58); home security (OR 1.31; p=0.042; 95% CI 1.01 to 1.71); neighbourhood exposure (OR 1.60; p=0.015; 95% CI 1.09 to 2.34); rating of police (OR 1.65; p<0.001; 95% CI 1.34 to 2.02). PASB was positively associated with fuel poverty (OR 1.43; p=0.011; 95% CI 1.09 to 1.87); neighbour contacts (OR 1.60; p=0.005; 95% CI 1.10 to 1.71); neighbourhood decline (OR 2.42; p<0.001; 95% CI 1.84 to 3.89); noisy environment (OR 1.23; p=0.042; 95% CI 1.01 to 1.50), and area type (OR 1.59; p<0.001; 95% CI 1.33 to 1.91). General health and longstanding illness were not associated with PASB after adjustment (p>0.05).

Conclusion National surveys link PASB to socio-economic status but the deprived communities we surveyed have relatively little socio-