OP20 SHAME: EXPERIENCES OF FOOD AND POVERTY AMONG WHITE BRITISH AND PAKISTANI LOW-INCOME WOMEN

¹MS Power*, ²N Small, ¹KE Pickett. ¹Department of Health Sciences, University of York, York, UK; ²Faculty of Health Studies, University of Bradford, Bradford, UK

10.1136/jech-2017-SSMAbstracts.20

Background Food bank use has increased sharply in the UK since 2010, however, qualitative research with food aid providers has found very low use of food banks by members of Bradford's Pakistani community, a large minority community in Bradford. Despite this, quantitative research has shown a substantial prevalence of food insecurity among Pakistani households (10%), albeit a lower prevalence than in White British (WB) households (18%).

The study aims to understand how low-income women understand and experience food insecurity, and how this differs between WB and Pakistani women; and to explore access to and experiences of food aid among WB and Pakistani low-income women.

Methods In light of potential recruitment difficulties and language and capacity restrictions, focus groups were used. With the assistance of the Better Start Bradford Innovation Hub, we identified existing group activities in Bradford where it would be appropriate to hold focus groups. Members of these groups were invited to participate in the study. Four semi-structured focus groups (n=16) were conducted in three low-income wards in Bradford. A three-stage analysis process was used and the data was analysed thematically.

Results The sample included eight Pakistani women and eight WB women living in three deprived wards in Bradford. Seven Pakistani women were married to men in employment. Only one Pakistani woman was in employment. Six WB women were married or cohabiting; one was employed; four had partners who were employed and three were solely reliant on social security.

Only one Pakistani women reported struggling to afford food, compared with five WB women. However, only three of the latter had used food aid; no Pakistani women had used food aid. All women described a sense of shame around not being to provide enough food for family members, particularly children. This was felt most acutely among Pakistani women. It was explained that food insecurity was experienced but concealed among Bradford's Pakistani community; support with food was sought not from food aid but from immediate family members and, occasionally, the wider Pakistani community.

Conclusion This is small scale study of low income women in one city, however it does suggest that Pakistani and WB women in Bradford experience food insecurity differently, with the latter much more likely to use food banks. Shame around food insecurity may not only deter low-income women from accessing food aid but cause food insecurity to be concealed entirely, this is most pronounced in the Pakistani community.

Children and mental health

OP21 ASSESSING THE IMPACT OF CHILDHOOD SOCIO-ECONOMIC CONDITIONS ON CHILD MENTAL HEALTH: FINDINGS FROM THE WIRRAL CHILD HEALTH AND DEVELOPMENT STUDY

¹C Rutherford*, ²J Hill, ³H Sharp, ¹D Taylor-Robinson. ¹Department of Public Health and Policy, University of Liverpool, Liverpool, UK; ²School of Psychology and Clinical Language Sciences, University of Reading, Reading, UK; ³Department of Psychological Sciences, University of Liverpool, Liverpool, UK

10.1136/jech-2017-SSMAbstracts.21

Background There is increasing recognition that the early-years of a child's life are critical periods in which social inequalities in mental health can develop. A systematic review has shown that a socio-economic gradient exists in child and adolescent (5–18 years) mental health outcomes, but few studies have assessed the early emergence of inequalities in child mental health. The aim of this study was to assess the impact of childhood SECs on child mental health outcomes in preschool children and to identify potentially modifiable early life factors.

Methods Analysis of the Wirral Child Health and Development Study, a longitudinal study of the early origins of child mental health, following 1233 children from a wide range of socio-economic backgrounds on the Wirral, North West England. The mental health outcome measure was parent reported child externalising problems, as measured by the Child Behaviour Checklist at 4.5 years. Maternal education at 20 weeks gestation, a measure of SECs in pregnancy, was the main exposure. We assessed the association of SECs with child mental health outcomes (log CBCL T-score) in sequential linear models adjusting for pre- and post-natal risk factors (e.g. parental mental health and perinatal factors). Exponentiated coefficients and 95% confidence intervals are presented as geometric means, using R (version X).

Results Children of mothers in the most educated quintile scored 11.0% (95% CI 3.5–18) lower for externalising problems compared to children of mothers in the least educated quintile, after adjusting for sex and ethnicity. Male sex, prenatal maternal depression at 20 weeks, and postnatal depression at 3.5 years were independently associated with an increased risk of child mental health problems. Adjusting for prenatal maternal depression attenuated the association of maternal education with child mental health to 9% (95%CI 1–16) comparing the most educated to the least). Further adjustment for perinatal factors and post-natal mental health did little to further attenuate the association of SECs with child mental health.

Conclusion In a study of early child mental health we found that social disadvantage is associated with worse child mental health outcomes at age 5. This was partially explained by adjusting for maternal mental health during pregnancy, but not postnatal measures of maternal mental health. Policies

supporting maternal mental health in pregnancy are important to address the early emergence of inequalities in child mental health. Parent-reported child mental health, and cohort attrition are limitations of this study.

OP22 UNDERSTANDING SOCIAL INEQUALITIES IN BEING BULLIED IN CHILDHOOD: FINDINGS FROM THE UK MILLENNIUM COHORT STUDY

M Campbell*, V Straatmann, D Taylor-Robinson. *Department of Public Health and Policy, University of Liverpool, Liverpool, UK*

10.1136/jech-2017-SSMAbstracts.22

Background Childhood bullying is an important policy concern. Nearly half of victims of bullying report thoughts about suicide and self-harm with negative impacts extending across the life-course. Being bullied in childhood is common, socially patterned, however, factors explaining social inequalities in being bullied are unclear. Using a contemporary United Kingdom (U.K.) birth cohort, we aimed to assess and explain social inequalities in the risk of being bullied.

Methods Analysis of the U.K. Millennium Cohort Study using a sample of 12 706 children surveyed at four sweeps (aged nine months, three, five and seven years). The main outcome was a binary, child-reported measure of being bullied at age 7. Household income quintile at birth was the main measure of socio-economic conditions. Relative risk (RR) and 95% confidence intervals (95% CI) for being bullied were estimated using Poisson regression, by household income quintile. Sequential models adjusted for risk factors for being bullied, including individual (e.g. emotional resilience, health status including obesity), parental (e.g. maternal mental health and discipline) and peer relationship (e.g. friends) factors. Analysis used Stata/SE with svy commands to account for the sampling design and attrition. Our sensitivity analysis will use parent and teacher reported outcome measures.

Results By age seven, 48.7% (95%CI 47.5%–49.9% [n=6183]) of children self-reported being bullied. There was a social gradient; 53.4% (95%CI 50.6%–56.1%) in the lowest income quintile reported having been bullied, compared to 43.9% (95%CI 41.5%–46.4%) in the highest (RR 1.21 [95% CI 1.10–1.33]). Male sex, young maternal age, higher child BMI and Strengths and Difficulties Questionnaire (SDQ) scores and worse maternal mental health were independently associated with an increased risk of being bullied, whilst having a good friend was protective. Controlling for these factors in the final model attenuated the RR for being bullied for children in the lowest income quintile, compared to the highest, rendering the association non-significant (RR 1.08 [95%CI 0.98–1.19]).

Conclusion Using a nationally representative cohort, about half of seven year olds reported being bullied, with a greater risk in children from the poorest homes. Increased risk was largely explained by social differences in other risk factors for bullying including friends, maternal mental health, and individual factors including emotional resilience and BMI. Interventions addressing these risks and promoting protective factors are likely to reduce social inequalities in being bullied, improving mental health outcomes for the most vulnerable U.K. children. Future research should investigate inequalities in being bullied in adolescents. The self-reported primary outcome is the main study limitation.

OP23 MODELLING THE POTENTIAL FOR PARENTING INTERVENTIONS TO REDUCE INEQUALITIES AND POPULATION PREVALENCE OF CHILDREN'S MENTAL HEALTH PROBLEMS: EVIDENCE FROM THE MILLENNIUM COHORT STUDY (MCS)

¹S Hope*, ¹A Pearce, ¹M Cortina-Borja, ²C Chittleborough, ¹C Law. ¹Population, Policy and Practice Programme, UCL Great Ormond Street Institute of Child Health, London, UK; ²School of Public Health, The University of Adelaide, Adelaide, Australia

10.1136/jech-2017-SSMAbstracts.23

Background Parenting programmes aim to support parents' skills and confidence, improving parenting and, in turn, children's mental health. Thus they have the potential to reduce population prevalence (and inequalities) in child mental health problems. We modelled the potential population impact of scale-up of parenting interventions in a national cohort. Based on review evidence, we simulated interventions with effect sizes of 0.9SD (intensive) and 0.4SD (standard).

Methods We used data from the UK Millennium Cohort Study, following 18 000 children born 2000–2002. Parenting was assessed by Child-Parent Relationship Scale (CPRS: Short-Form) score when the child was 3 years. Child mental health problems (CMHP) at 5 years were assessed by Strengths and Difficulties Questionnaire (SDQ) total score, dichotomised using an established cut-off. Socio-economic circumstances were represented by mother's highest academic qualifications (<GCSEs A-C; GCSEs A-C and above) at 9 months.

Predicted probabilities of CMHP were estimated, fitting marginal structural models to examine the mediating effect of parenting, accounting for confounding using inverse-probability-treatment-weights. Inequalities were assessed with Risk Ratios (RR [95% CIs]). A series of intervention scenarios were simulated by re-estimating predicted probabilities after modifying the CPRS score (to reflect effectiveness) for eligible children (targeting).

We analysed data from 14 540 children, using Stata 13.1. Survey weights and multiple imputation addressed missing data.

Results Overall prevalence of CMHP at 5 years was 10.8%, and children of mothers with low educational attainment had a greater risk of CMHP (RR=2.46 [95%CI:2.24–2.70]). Focusing on three parenting intervention scenarios, we showed changes in CMHP prevalence and inequalities compared to those observed: 1. Universal (standard support to all parents): prevalence change –2.5%; inequality RR=2.56[2.30–2.85]; 2. Targeted (intensive support to families receiving means-tested benefits): prevalence change –1.4%; inequality RR=2.11 [1.91–2.34]; 3. Progressive universal (intensive support for families receiving benefits and standard support for others): prevalence change –3.2%; inequality RR=2.35[2.10–2.62].

Conclusion Large inequalities in CMHP were apparent by age 5 years. In simulated scenarios, inequality was reduced through an intervention that explicitly set out to provide intensive support to disadvantaged families. In contrast, reductions in overall prevalence were more likely to be achieved by universal interventions. A progressive universal approach (combining intensive support for disadvantaged families with standard support for others) led to a reduction in both population prevalence and inequality. Nevertheless, in all intervention scenarios, inequalities in CMHP remained strong. These results suggest that parenting interventions may contribute to a reduction in CMHP inequalities, particularly when including targeted support for disadvantaged families.