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Background Male suicide rates increased remarkably in Scotland in the 1980s and 1990s, with higher rates in more deprived areas. We examine trends in male suicide in Scotland from 1980 to 2015 by method of suicide and individual socioeconomic position. We also explore trends in inequalities by individual socioeconomic position and the extent to which this may be attributable to suicide method.

Methods Suicide deaths for 1980–2015 were obtained from National Records Scotland. Inequalities were assessed using National Statistics socio-economic classification (NS-SEC) for ages 20–59 in 2000–2002 and 2010–2012. Standardised death rates were calculated by age with European population 2013 as reference, and Poisson regression was used to assess trend significance. Inequalities were assessed using Slope of Index of Inequality (SII).

Results There were 12,281 suicide deaths between 1980 and 2013. No significant linear trend was observed over time for all ages, but suicide rates per 100,000 person-years increased from 21 to 27 between 1980 and 2002 (p<0.001), and decreased from 27 to 20 from 2002 to 2015 (p<0.001). No significant trend was observed for poisoning, but suicide rate by hanging, suffocation and strangulation increased over time (p<0.001), and decreased for other suicide (p<0.001). There were significant differences in suicide rates between the NS-SEC groups, and by suicide method (p-values<0.001). SII: 85 (95% CI, 77 to 92) in 2000–01 and 62 (95% CI, 55 to 68) in 2010–12 per 100,000 person-years, indicated that inequalities between social class extremes were significantly higher in 2000–02 than 2010–12. Suicide by hanging, suffocation and strangulation accounted for 44% of inequalities in 2000–02 (SII=37 (95% CI, 33 to 42)) and 49% in 2010–2012 (SII=30 (95% CI, 25 to 34)).

Conclusion The decline in male suicide rates may be attributed to suicide prevention strategies introduced by the Scottish Government from 2002 such as Choose Life. Despite decreasing trends of male suicide, suicide by hanging, suffocation, and strangulation increased over time. Inequalities by individual deprivation decreased between 2000–02 and 2010–12. Limitations are that NS-SEC categories, never worked and long term unemployed and not classified, were excluded from the analysis assessing inequalities since the interpretation of results for this group was ambiguous. What effect this omission would have on the estimation of inequalities is unclear. Caution should be taken when comparing inequalities by NS-SEC 2001 and 2011 as in 2011 NS-SEC category was estimated for those without occupation. Policy should be directed at reducing deaths from hanging, suffocation, and strangulation.
OP64 IMPACT OF POVERTY TRAJECTORIES ON CHILDREN’S HEALTH AND MATERNAL MENTAL HEALTH: EVIDENCE FROM THE UK MILLENNIUM COHORT STUDY

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Background The number of children living in poverty in the United Kingdom (UK) is rising. Child poverty has been shown to cause poor mental and physical health outcomes that last into adulthood. Poverty also puts families in distress. The aim of the study was to understand the prevalence of different poverty trajectories for UK children, and their associations with multiple child health and maternal mental health outcomes.

Methods We analysed data on 11,565 children who participated in sweeps of the UK Millennium Cohort Study from ages 9 months to 14 years. Outcomes were: (i) mental health at age 14, measured by the Strengths and Difficulties Questionnaire (SDQ); (ii) physical health at age 14, measured by overweight/obese and any longstanding illness; and (iii) maternal mental health, measured by Kessler 6 scale. The main exposure of interest was relative poverty (less than 60% of median of equivalised household income). Poverty trajectories measured at 9 months, 3, 5, 7, 11 and 14 years were characterised using latent class analysis. Odds ratios (ORs) and 95% confidence intervals (CIs) were estimated using multivariable logistic regression models, adjusted for child sex, maternal mental health and alcohol consumption, parenting at 3 y, and puberty reported at 11 y. Sample design and attrition were accounted for with weights and item missingness with multiple imputation.

Results Four poverty trajectories were identified: class 1 (61.2% of children) (stable never-poor, reference group), class 2 (14.2%) (poverty in early childhood), class 3 (5.2%) (poverty in late childhood) and class 4 (19.4%) (persistent poverty). Any exposure to poverty was associated with increased risk of longstanding illness, and worse mental health outcomes for both mothers and children, with the largest effects for (iii) maternal mental health and alcohol consumption, parenting at 3 y, and puberty reported at 11 y. Sample design and attrition were accounted for with weights and item missingness with multiple imputation.

Results 17% of CMs had ever tried smoking cigarettes and 18% had ever tried e-cigarettes. 49% of CMs had consumed alcohol, including 11% binge-drinking. Trying illegal drugs, displaying anti-social behaviours and having sexual contact were less prevalent (6%-10%). Compared to CMs with High MHC, those with Low, Moderate, or High-Moderate MHC at age 11 were more likely to have taken part in risk-taking behaviours. After adjustment for potential confounding, elevated risks remained for Low MHC in relation to binge drinking (RRR: 1.6 [95% CI 1.3 to 2.3]), having tried smoking cigarettes (OR: 2.1 [1.5–2.9]), e-cigarettes (OR: 1.4 [1.0–2.0]), illegal drugs (OR: 1.9 [1.3–2.9]), and anti-social behaviour (OR: 1.8 [1.2–2.6]) but not sexual contact (OR: 1.1 [0.7–1.6]).

Conclusion MHC at the end of childhood was associated with risk-taking behaviours in mid-adolescence in a representative UK cohort. Interventions that improve MHC skills in childhood may help reduce risk-taking behaviours at this crucial stage in the life course, improving wellbeing in adolescence and into adulthood.

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