

did not significantly improve depression (SMD=-0.23 [95%CI-0.59,0.13], p-value=0.21), distress (SMD=0.00 [95%CI-0.15,0.16], p-value=0.96) or wellbeing (SMD=0.00 [95%CI-0.01,0.02], p-value=0.50) (no data for anxiety). Trials' risk of bias is generally high.

**Conclusion** Preliminary results suggest that implementing MBPs for non-clinical populations improve wellbeing; other effects depend on contextual factors to be explored further. We found evidence of MBPs' specific effects on depression only, and no indication of MBPs' superiority to similar interventions. Low trial quality limits evidence strength.

## Thursday 10 September

### Tobacco: Behaviours

OP63

#### 'I DON'T DO IT IN FRONT OF THE CHILDREN; IT'S THE WORST KEPT SECRET IN THE FAMILY': SECONDARY QUALITATIVE ANALYSIS OF ELECTRONIC CIGARETTE USERS' VIEWS AND REPORTED EXPERIENCES OF VAPING AROUND CHILDREN

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**Background** There is widespread concern about youth uptake of electronic cigarettes. Regulation and education campaigns exist which aim to protect children from initiating use, yet it is likely that children will be primarily influenced by the vaping/smoking behaviour of people in their immediate environment. This is the first known study exploring e-cigarette users' views and reported experiences of vaping around children.

**Methods** Following informed consent, semi-structured qualitative interviews with adults recruited from England, who had attempted to give up smoking by vaping, were conducted as part of a wider study into e-cigarette use trajectories and smoking relapse (Ectra study). Data relating to vaping around children were extracted from 28 interviews and thematically analysed taking a secondary data analysis approach.

**Results** Analysis indicated that vaping behaviour in the presence of children in public appeared to be governed by replicating smoking norms, whilst vaping in the home appeared to be determined by caregivers' need to reconcile vaping behaviour so that it was congruent with parental identity as responsible caregiver. Participant perspectives reflected existing diametrically opposed moral discourses applied to e-cigarette use of 'harm reduction for smokers' and 'potential for youth harm'.

**Conclusion** Vaping is being role modelled within the community and home, despite attempts to hide the behaviour by many e-cigarette users. The ambivalent contextualisation of e-cigarettes means that e-cigarette users may lack a clear narrative to draw on when discussing vaping with children. Public Health guidance for vaping around children, including discussing vaping in the context of smoking cessation, could be helpful.

OP64

#### CHANGE IN MATERNAL SMOKING BEHAVIOUR BETWEEN TWO PREGNANCIES AND SMALL FOR GESTATIONAL AGE BIRTH: ANALYSIS OF A UK POPULATION-BASED COHORT

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**Background** Maternal smoking during pregnancy is linked to small for gestational age (SGA) birth (< 10th percentile). We examined inter-pregnancy changes in maternal smoking and the odds of SGA in the second child.

**Methods** A population-based cohort of prospectively collected anonymised antenatal and birth healthcare data (2003–2018) recorded by University Hospital Southampton, Hampshire, UK (SLOPE study) was used. The first two singleton pregnancies resulting in live births were analysed (n=15,525 women) using logistic regression to examine changes in self-reported maternal smoking in relation to whether the second child was SGA. We adjusted for maternal age, ethnicity, body mass index, educational attainment, employment status, partnership status, folate supplementation, infertility treatment, gestational diabetes and gestational hypertension at the first pregnancy (P1), length of the interpregnancy interval and previous SGA birth.

**Results** SGA occurred in 15.7% of all pregnancy 2 (P2) births in mothers smoking at both pregnancies, compared to 5.7% in never-smokers (reference group). Smoking at the start of both pregnancies was associated with higher odds of 2nd child SGA (adjusted Odds Ratio (aOR) 2.88 [95% CI 2.32, 3.56]). The aOR of 2nd child SGA were also higher in women who smoked only at the start of either P2 (2.02 [1.41, 2.89]) or P1 (1.52 [1.10, 2.09]). The aOR of 2nd child SGA were similar to never-smokers in those who quit when each pregnancy was confirmed (1.23 [0.81, 1.85]), smoked between pregnancies but quit up to P2 confirmation (0.82 [0.59, 1.15]), or quit by P1 confirmation and maintained cessation (0.91 [0.74, 1.11]). The odds of SGA birth for women with no previous SGA followed a similar pattern. Among women whose 1st baby was SGA (n=1,903), the aOR of recurrent SGA were higher in those smoking at the start of both pregnancies (2.62 [1.84, 3.72]), or at P2 only (1.82 [1.00, 3.30]). However, those who were P1 smokers and stopped by P2 were not more likely to have recurrent SGA (aOR 1.08 [0.62, 1.88]).

**Conclusion** Mothers who smoked at the start of either one or both of their first two pregnancies had increased odds of SGA birth compared to never-smokers. However, the odds of recurrent SGA with smoking in the first pregnancy and quitting at any point up to confirmation of the second pregnancy were similar to never-smokers. The time between pregnancies is an opportunity to intervene on modifiable risk factors such as smoking, particularly in those with previous history of SGA babies.

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