and £5,505, respectively). Regression analysis demonstrated that this increased spending for White British patients holds after accounting for age, gender, deprivation, LTC count, and primary care network (p=0.0002). Funnel plot analyses did not show significant patterns in GP practice-level variability in social care, emergency departments nor mental health service use. There was no clear individual-level relationship between primary care consumption and use of these other services.

Discussion These findings raise questions around ethnicity-based equity of care. Furthermore, they do not support the common narrative around differential access and gate-keeping at a GP practice-level affecting broader system costs. An increased focus on drivers of costs in social care rather than emergency or primary care settings may be needed for patients with SMI. However, the generalisability of these B&D results to the general population has not yet been explored.

OP12 MORTALITY RISK FOLLOWING SELF-HARM IN YOUNG PEOPLE: AN EXPLORATION OF SELF-HARM AND SUICIDE USING THE NORTHERN IRELAND REGISTRY OF SELF-HARM

[1]E Ross*, [1]D O'Reilly, [2]D O'Hagan, [1]A Maguire. *[1]Centre for Public Health, Queen's University Belfast, Belfast, UK; [2]Public Health Agency, Belfast, UK*

10.1136/jech-2020-SSMabstracts.12

Background Suicide is the second leading cause of death in young people worldwide. Self-harm is a recognised predictor of future suicide and is most common in young people under the age of 24 years. The aim of this study was to estimate the risk of mortality following self-harm in adolescents, including death by suicide, and to examine the factors associated with this outcome.

Methods The Northern Ireland Registry of Self-Harm (NIRSH) collects information on all self-harm presentations to all Emergency Departments (ED) in NI. NIRSH data from 2012–2015 was linked to centralised electronic data relating to primary care registration, prescribed medication and death records. Logistic regression was employed to examine the factors associated with increased likelihood of self-harm and Cox regression to estimate mortality risk following self-harm and to examine the factors associated with the greatest risk of mortality.

Results The cohort consisted of all 395,771 individuals aged 10–24 years who were resident in NI on 1st April 2012 followed up until 31st December 2019. During the study 4,513 (1.14%) young people presented with self-harm, 116 (2.6%) of whom died during follow-up with 49% (n=57) of those deaths being by suicide. Rates of self-harm were highest in females, those aged 20–24 years (OR=3.47, 95% CI 3.23–3.73), and those living in the most deprived areas (OR=3.10, 95% CI 2.80–3.42). Most individuals self-harmed via self-poisoning with psychotropic medications (68.6%), followed by self-injury with a sharp object (24.1%). Although only 57 of those who presented with self-harm went on to die by suicide they accounted for 28.8% of all deaths by suicide in this cohort. Those who presented with self-harm were 27 times more likely to die by suicide compared to those who did not present with self-harm after adjustment for age and sex (HR=27.20, 95% CI 19.86–37.25).

Conclusion This constitutes the first population-wide study of self-harm and suicide in young people in the UK and provides valuable information to inform suicide prevention strategies. Additional analysis is underway exploring variation in mortality risk based on ED care intervention and will be complete by the time of the conference.

The authors would like to acknowledge the help provided by the staff of the Honest Broker Service (HBS) within the Business Services Organisation Northern Ireland (BSO). The HBS is funded by the BSO and the Department of Health (DoH). The authors alone are responsible for the interpretation of the data and any views or opinions presented are solely those of the author and do not necessarily represent those of the BSO.

Wednesday 9 September

Smoking: Cessation Services to Policy

OP13 WE CAN QUIT2 – PRELIMINARY RESULTS OF A PILOT CLUSTER RANDOMISED CONTROLLED TRIAL OF A COMMUNITY-BASED INTERVENTION ON SMOKING CESSATION FOR WOMEN LIVING IN DISADVANTAGED AREAS OF IRELAND

[1]CB Hayes*, [2]J Patterson, [1]E Burke, [1]N O'Connell, [3]F Dobble, [4]J Vance, [1]C Darker, [5]D Devane, [3]L Bauld, [3]N Dougall. *[1]Public Health and Primary Care, Institute of Population Health, Trinity College Dublin, Dublin, Ireland; [2]School of Health and Social Care, Edinburgh Napier University, Edinburgh, UK; [3]Usher Institute, College of Medicine and Veterinary Science, University of Edinburgh, Edinburgh, UK; [4]Irish Cancer Society, Dublin, Ireland; [5]HRB Trials Methodology Research Network, NUI Galway, Galway, Ireland*

10.1136/jech-2020-SSMabstracts.13

Background Tobacco use is the leading cause of preventable death worldwide. In Ireland almost 6000 smokers dye each year from smoking-related diseases. 'We Can Quit2' (WCQ2 is a pilot pragmatic two-arm, parallel group, cluster randomised trial of a community-based peer-led smoking cessation intervention for women living in disadvantaged areas. The aim is to explore feasibility and acceptability of trial processes including recruitment and retention rates. A future trial will assess the effectiveness on short and medium-term cessation rates.

Methods Four matched pairs of districts (eight clusters) selected by area level of deprivation, geographical proximity, and eligibility for free medical services were randomised to receive either WCQ (behavioural support + access to Nicotine Replacement Therapy (NRT)) delivered over 12 weeks by trained Community Facilitators (CFs) or to a one-to-one smoking cessation service delivered by health professionals from Ireland's Health Service Executive (HSE). Recruitment target: 24–25 women per cluster (97 per arm; 194 in total) in four waves with consent obtained prior to randomisation. Primary outcome: achievement of recruitment target. Secondary outcomes included retention and data completion rates at 12 weeks(w) and 6 months(m) post-quit date and proportion continuously absent from smoking at 12w (primary outcome for a future DT) and at 6m, (self-report +biochemical validation). Acceptability of trial processes and intervention delivery was assessed by interview with participants and community facilitators.