PD-1104-20 Evidence- based online face-to-face tele-health stop smoking service to reduce health inequality

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Background and challenges to implementation: The challenge is to be able to deliver low cost & innovative ways to help people to quit smoking from the comfort of their home or workplace, who are unable to access regular stop smoking clinics through live face to face video consultation being delivered using an evidence based model. This appeals to people from all background particular those who are disabled, housebound and require support in multiple languages including support in Sign Language for deaf or hard of hearing. In these cases traditional telephone quitline support has not been possible.

Intervention or response: We have developed a unique digital platform through which service users can actually see & talk to a healthcare provider from the comfort of their homes, making the conversation feel very personal. The provider is able to review the patient's clinical information, discuss symptoms, diagnose, & prescribe medications as appropriate, for anything from common illnesses such as colds, flu, and sinus infections to chronic care management, smoking cessation, behavioural health or nutrition. At the end of the consultation, the user can share a full record of the conversation with his or her primary care physician, maintaining continuity of care.

Results and lessons learnt: This is currently being rolled out to a a geographical region of approx. 6 million people in Cities & Towns in England. Today we believe the use of online health services will grow quickly in the targeted sections of the population. With social networking & media at double digit growth rates, video chat will become a normal way of communicating between service providers & customers - The platform has been created to take advantage of this trend & reach out to more sections of society to improve health inequalities & deliver more personable & effective health services.

Conclusions and key recommendations: Having demonstrated this in the UK, we are keen to replicate this in other Countries, and help reduce the cost of smoking cessation intervention and at the same time appeal to a wider target population group. This solution will provide support in many different languages, including sign language.

PD-1005-20 Independent association between parental smoking and non-authoritative parenting style as reported by Chinese adolescents in Hong Kong

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Background: Both parental smoking and non-authoritative parenting style predict adolescent smoking, but the association between the two risk factors was seldom studied. We investigated this association in Chinese parents of adolescents in Hong Kong, where smoking is socially undesirable, especially in females.

Design/Methods: In the Hong Kong Student Obesity Surveillance project 2006/07, 33692 adolescents aged 11-18 (44.9% boys, mean age 14.8, SD 1.9 years) from 42 randomly selected schools reported smoking status (yes vs no) and the level (frequent/sometimes as high; seldom/none as low) of care and control of each parent. Parenting style (dependent variable) was defined as authoritative for high care and high control, and non-authoritative otherwise. Logistic regression was used to compute adjusted odds ratio (AOR) of (i) parental care (low vs high), (ii) parental control (low vs high), and (iii) non-authoritative parenting (vs authoritative) for parental smoking (study factor) in separate models and for each parent, adjusting for perceived family affluence, the parent's age and education level, the other parent's smoking status, and school clustering.

Results: Smoking was reported in 39.6% of fathers and 10.3% of mothers. In fathers, smokers were more likely than non-smokers to be classified as low care (26.3% vs 20.9%), low control (38.8% vs 35.3%) and non-authoritative (51.3% vs 45.1%) (all $P<0.001$), with AORs (95% CI) of 1.23 (1.15-1.32) for low care, 1.15 (1.08-1.23) for low control and 1.23 (1.14-1.31) for non-authoritative parenting. Similarly, in mothers, smokers were more likely than non-smokers to be classified as low care (24.3% vs 12.8%), low control (34.1% vs 24.4%) and non-authoritative (46.6% vs 31.9%) (all $P<0.001$), with AORs (95% CI) of 2.08 (1.86-2.32), 1.59 (1.45-1.74) and 1.81 (1.64-2.00), respectively. Stronger associations were observed in mothers than fathers (all $P <0.001$).

Conclusion: In both fathers and mothers, smoking was associated with low levels of care and control, and non-authoritative parenting style independent of socio-demographic characteristics. Smoking, as a negative role-modeling behaviour, might undermine parenting functions especially in smoking mothers in Hong Kong.