regression separately for 1996–2003 and 2004–2013 to account for non-linear trends. Regional person-linked data from the Oxford Region and WA were used to account for the effect of transfers and coronary procedure admissions on trends.

**Results** From 1996–2013, there were 4.9 million CHD hospitalisations in England and 2.6 million in Australia (67% men). From 1996–2003, there was between-country variation in the direction of trends in acute coronary syndromes (ACS) and chronic CHD hospitalisation rates (p<0.001). During 2004–2013, reductions in ACS hospitalisation rates were greater than for chronic CHD hospitalisation rates in both countries, with the largest subgroup declines in unstable angina [England: men -7.1%/year (95% CI -7.2 to -7.0), women -7.5%/year (-7.7 to -7.3); Australia: men -8.5%/year (-8.6 to -8.4), women -8.6%/year (-8.8 to -8.4)]. Age-specific trends generally reflected overall downward trends in each subgroup except for MI rates in women aged 35–54 years in 2004–2013, [England: 0%/year (-0.5 to +0.4); Australia: +1.9%/year (+1.1 to +2.4)]. Rates of ‘Other CHD’ increased in 75–84 year olds in both countries. Chronic CHD comprised half of all CHD admissions, with the majority involving angiography or revascularisation. Analysis of linked regional data found increasing MI rates in WA from 2004–2013 for men and women. In both regions, an increasing proportion of admissions for other CHD were for coronary procedures (mainly angiogram) in Oxford (71% in 1996; 84% in 2013) and WA (88% in 1996; 91% in 2013).

**Conclusion** Since 2004, rates of all CHD subgroups have fallen in both countries, with greater declines in acute than chronic presentations. The slower declines and high proportion of chronic CHD admissions involving coronary procedures require greater focus. Differing MI trends in younger women in both countries warrant further investigation.

**Abstracts**

**P62** HOW MUCH OF THE DISABILITY-RELATED INEQUALITIES IN HEALTH AND WELL-BEING ARE MEDIATED BY BARRIERS TO PARTICIPATION FACED BY PEOPLE WITH DISABILITIES? A CAUSAL MEDIATION ANALYSIS USING LONGITUDINAL DATA FROM WORKING AGE PEOPLE WITH AND WITHOUT DISABILITIES IN GREAT BRITAIN

1Z Aitken*, G Disney, L Knijacs, A Milner, E Emerson, AM Kavanagh. 1Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Australia; 2Centre for Disability Research, Faculty of Health and Medicine, Lancaster University, Lancaster, UK

**Background** Large health inequalities exist between people with and without disabilities, including many health conditions unrelated to the impairment causing the disability. There is some evidence that these health inequalities are, in part, due to the poor socio-economic circumstances experienced by people with disabilities, and therefore are amenable to public health intervention. In this study, we used a unique dataset to examine the relationship between disability acquisition and subsequent health outcomes using five different measures of health and wellbeing. We quantified the extent to which social barriers to participation explained the health inequalities between people with and without disability.

**Methods** We used data from three waves of the Life Opportunities Survey, a longitudinal study of disability in Great Britain with a strong focus on barriers to participation in society. We compared health and well-being outcomes between adults who recently acquired an impairment and those who remained disability-free, adjusting for baseline demographic, socio-economic
and health characteristics. Health and well-being outcomes included: self-rated health measured on a five-point scale, and life satisfaction, feeling that life is worthwhile, happiness, and anxiety, measured on eleven-point Likert scales. We conducted a causal mediation analysis to quantify natural indirect effects representing how much of the effect of disability acquisition on each outcome was explained by barriers to participation including employment, economic life, transport, leisure activities, social contact and accessibility. We used multiple imputation with 50 imputed datasets to account for missing data and conducted analyses in Stata/SE 15.

Results There was evidence that people who had recently acquired a disability had poorer health and well-being compared to people with no disability. Barriers to participation explained 13% (95% CI 11%, 14%) of inequalities in self-rated health, and were higher for all measures of well-being: life satisfaction (43%, 95% CI 39%, 47%), feeling that life is worthwhile (36%, 95% CI 31%, 40%), happiness (46%, 95% CI 39%, 53%) and anxiety (27%, 95% CI 24%, 31%).

Conclusion Despite methodological limitations including strong assumptions about confounding and potential selection bias from missing data, this is the first study to quantify how much of the inequalities in health and well-being between people with and without disabilities are explained by social barriers to participation. We found that a substantial proportion of the inequalities in health and well-being experienced by people with recently acquired disabilities were driven by social barriers to participation. The findings that some of these differences are socially produced have important policy implications, highlighting modifiable factors amenable to public health interventions to target the mechanisms causing the health inequalities.

P63 ADVERSE PREGNANCY OUTCOMES AND LONG-TERM RISK OF MATERNAL RENAL DISEASE: A SYSTEMATIC REVIEW AND META-ANALYSIS

1,2PM Barrett*, 1FP McCarthy, 1K Kubickiene, 3S Cormican, 4C Judge, 4M Evans, 5M Kubickias, 5U Perry, 5P Sterwinkel, 1,2AS Khankan, 6School of Public Health, University College Cork, Cork, Ireland; 6Inish Centre for Fetal and Neonatal Research (INFANT), University College Cork, Cork, Ireland; 5Department of Clinical Science, Intervention and Technology (CLINTEC), Karolinska Institutet, Stockholm, Sweden; 4Department of Neurology, University Hospital Galway, Galway, Ireland; 3Department of Obstetrics and Gynaecology, Karolinska Institutet, Stockholm, Sweden

Background Adverse pregnancy outcomes, like hypertensive disorders of pregnancy (HDP), gestational diabetes (GDM) and preterm delivery, are associated with increased risk of long-term maternal cardiovascular and cerebrovascular disease. Comparatively little is known about whether adverse pregnancy outcomes increase the risk of maternal renal disease. The purpose of this study was to quantify the burden of self-harm experienced by people with recently acquired disabilities and to assess factors associated with self-harm and repeated self-harm.

Methods Data on self-harm presentations to all 34 hospital emergency departments in Ireland were collected by the National Self-Harm Registry Ireland (NSHRI). Inequalities in self-harm were calculated using NSHRI data and national population estimates from the

P64 SELF-HARM AMONG THE HOMELESS POPULATION IN IRELAND: A NATIONAL REGISTRY-BASED STUDY OF INCIDENCE AND ASSOCIATED FACTORS

1PM Barrett*, 2E Griffin, 2P Cooran, 1MT O’Mahony, 2E Arensman. 1Department of Public Health, St. Finbarr’s Hospital, Cork, Ireland; 1National Suicide Research Foundation, University College Cork, Cork, Ireland

Background Suicide rates are higher among the homeless population than the general population, and the homeless are recognised as a priority group for suicide prevention. Self-harm is a strong predictor of future suicide, particularly repetition of self-harm. Little is known about the incidence of self-harm, and its associated predictive factors, among the homeless. The purpose of this study was to quantify the burden of self-harm among the homeless population in Ireland, and to assess factors associated with self-harm and repeated self-harm.

Methods Data on self-harm presentations to all 34 hospital emergency departments in Ireland were collected by the National Self-Harm Registry Ireland (NSHRI). Index and repeat presentations from 2010–2014 were included for the homeless and fixed residence populations. Individuals with no fixed abode, or who lived in recognised accommodation for the homeless, were recorded as being homeless. Age-standardised incidence rates (ASIR) of self-harm were calculated using NSHRI data and national population estimates from the