

Using data from the Medical Birth Register, we identified 2,777,045 babies born to 1,417,903 mothers during the study period. Of those 9,334 were born to women with CH. Maternal CH were recorded using ICD-8, ICD-9 and ICD-10. Outcome measures were pre-eclampsia (PE), emergency and elective caesarean sections (CS), spontaneous preterm birth (PTB<37 weeks' gestation), medically indicated PTB, stillbirth and small for gestational age. Multivariate logistic regression models were performed using Stata 16 and adjusting for several socio-demographic and perinatal confounders.

**Results** Compared to normotensive women, we found higher odds among hypertensive women of the following outcomes: PE adjusted odds ratio [aOR (95% confidence intervals)]: [4.60 (4.31, 4.92)]; emergency CS [1.64 (1.53, 1.77)]; elective CS [1.63 (1.51, 1.76)]; medically indicated PTB [3.36 (3.11, 3.63)]; stillbirth [1.62 (1.26, 2.08)] and SGA [2.33 (2.13, 2.54)]. Moreover, Women of advanced maternal age were more likely to have emergency CS [aOR: 1.82 (1.61, 2.05)]; elective CS [1.83 (1.64, 2.04)]; medically indicated PTB [4.01 (3.54, 4.54)] and SGA [2.61 (2.24, 3.04)] compared to younger normotensive women. However, the magnitude of these associations appears to decrease over time apart of the association with PE which appears to have remained almost constant over time.

**Conclusion** Women with chronic hypertension are at increased risk of adverse maternal, fetal and neonatal outcomes and the risk differs according to maternal age. However, the effect of antihypertensive treatment and severity of hypertension have not been taken into account in this study.

#### P43 EXPERIENCE OF CHILD WELFARE SERVICES AND LONG-TERM ADULT MENTAL HEALTH OUTCOMES: A SCOPING REVIEW

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**Background** Research consistently suggests that children in care have higher rates of mental ill-health compared to their peers in the community, however, studies exploring the long-term adult mental health outcomes have shown mixed results. The proliferation of research in this area is challenging and to date no comprehensive overview exists. This study synthesised the literature on the mental health outcomes of adults with a history of child welfare involvement.

**Methods** A systematic scoping review methodology was used to search five electronic databases (MEDLINE, EMBASE, PsychINFO, IBSS, Social Policy and Practice). Two reviewers screened all papers independently. Studies were included if they examined any child welfare exposure (including being known to social services and remaining at home or being removed from the home and placed in foster care or residential care) and adult mental health status.

**Results** In total 4,591 records were retrieved, of which 53 met the eligibility criteria. Four major themes of child welfare and adult mental health research were identified based broadly on service type: 35 studies examined out-of-home care (OHC) without specifying outcomes by placement type; eleven studies of OHC examined specific placement types; four studies examined both in-home care (IHC) and OHC; and three studies examined IHC services only. Overall, both OHC and IHC

were associated with an increased risk of adult mental ill-health, suicide attempt and completed suicide. Potential moderating factors such as gender and care related experiences have been explored but produced conflicting results. Reason for becoming known to child welfare services and experience of abuse or neglect have not been widely explored, nor have outcomes in those who received child welfare services but remained in their own home. Mental health was defined and measured heterogeneously and detail on welfare services received was lacking.

**Conclusion** This is the first review to systematically map the available evidence on child welfare exposure and adult mental health. There is a need for detailed, longitudinal studies to better understand the aetiology of mental ill health amongst adults with a childhood history of welfare service exposure, with more standardised measures of mental ill-health and more detail from authors on specific care exposure.

#### P44 DIFFERENT PATTERNS OF FAMILY ADVERSITY IN EARLY CHILDHOOD AND MIDDLE CHILDHOOD MENTAL HEALTH: WHEN DOES CHILDCARE HAVE A PROTECTIVE EFFECT? RESEARCH USING THE GROWING UP IN SCOTLAND STUDY

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**Background** Various patterns of early childhood family adversity characterised by poverty and/or other stressors are major risk factors for middle childhood mental health. Efforts to reduce mental health inequalities would benefit from understanding whether childcare moderates effects of different adversity patterns. This study examined hypotheses regarding centre-based (eg nursery) and non-centre (eg grandparent, childminder) childcare in: (1) buffering effects of adversity mainly characterised by poverty; (2) potentiating effects of adversity characterised by multiple stressors.

**Methods** We used the Growing Up in Scotland first birth cohort (born in 2004/5, n=5217), selecting families with a singleton birth, where mothers provided information on adversity and childcare at child age 10, 22 and 34 months, and where there was parent-reported information on children's externalizing and internalizing problems at 46, 58, 70, 94, 122 and/or 152 months (n=3419). Using Mplus, latent class analysis of 19 indicators identified four adversity subtypes: Low (66%), Health-related (20%), Poverty/discord (9%), Multiple (5%). Growth mixture modelling identified five childcare patterns: Low (28%), Moderate Non-Centre (30%), High Non-Centre (16%), High Centre (12%), High Combined (13%). Latent growth models of problem trajectories (approximate ages 4 to 12 years) on adversity, childcare and interaction terms controlled for child gender, low birth weight, mothers' age, ethnicity, education, smoking in pregnancy, family type and number of children at baseline.

**Results** Compared to the Low adversity subtype, children from higher-risk subtypes had higher 8.25-year intercepts of externalizing problems (coefficients with 95% confidence intervals: Health-related 1.46, 1.15–1.78; Poverty/discord 1.34, 0.82–1.87; Multiple 2.56, 1.86–3.26) and internalizing problems (Health-related 1.20, 0.93–1.47; Poverty/discord 1.16, 0.70–1.61; Multiple 2.60, 2.02–3.17); and steeper linear growth in