poor mental health when data can be linked to them, even if their personal details are only used to help them access care. This may be particularly relevant because individuals who have a mental health problem are more likely to experience barriers to care and hold stigmatising beliefs. If that is the case, then mental health screening programmes where personal details are required may not be effective in detecting those most in need of care. We aimed to compare mental health symptom reporting when using an anonymous versus identifiable questionnaire among UK military personnel on deployment in Iraq (early 2009).

Methods This was a survey among UK military personnel using two questionnaires, one anonymous (n=315) and one identifiable (n=296). Questionnaires were distributed by alternative allocation. The questionnaire included the 12-item General Health Questionnaire (measuring symptoms of common mental disorder, CMD), the Post-Traumatic Stress Disorder (PTSD) Checklist Civilian Version (measuring probable PTSD) and 11 stigma statements relating to barriers of care and perceived social stigma.

Results Of 612 personnel approached to take part, 99.8% completed the survey. The overall prevalence of probable PTSD was 5.3% and 20.5% for symptoms of CMD. No significant difference in the reporting of symptoms of CMD was found (18.1% identifiable vs. 22.9% anonymous, P=0.150). Personnel were more likely to report borderline and probable PTSD when completing questionnaires anonymously (borderline PTSD: 2.4% identifiable vs. 5.8% anonymous; probable PTSD: 1.7% identifiable vs. 4.8% anonymous, P=0.022). Of the 11 barriers to care and perceived social stigma statements considered, those completing the anonymous questionnaire were more likely to endorse: “leaders discourage the use of mental health services” (9.3% vs. 4.6%, P=0.029), “it would be too embarrassing” (41.6% vs. 32.5%, P=0.025) and “I would be seen as weak” (46.6% vs. 34.2%, P=0.003).

Conclusion We found a significant effect on the reporting of PTSD and certain stigmatising beliefs (but not CMD) when using an anonymous compared to identifiable questionnaire. Our findings have implications for the current post-deployment screening policy used in the US military in which identifiable data are collected. We recommend a complete anonymisation against the use of non-anonymised but identifiable questionnaire among UK military personnel on deployment using the Post-Traumatic Stress Disorder (PTSD) Checklist Civilian Version (measuring probable PTSD) and 11 stigma statements relating to barriers of care and perceived social stigma.

Background There is considerable media, political and public interest on both sides of the Atlantic in an alleged rise in violence among military personnel returned from conflicts in Iraq and Afghanistan. This study explores violence among a large sample of UK military personnel, a proportion of whom had been deployed to Iraq/Afghanistan. The aims were to estimate the prevalence of self-reported violence, examine the impact of deployment and combat experiences on subsequent violence and the association with post-deployment mental health problems and alcohol misuse.

Methods This study formed part of a questionnaire-based cohort study established to explore the impact of deployment on mental health among UK military personnel. The sample was randomly selected from all military personnel serving in the UK Armed Forces between 2003 and 2007. A total of 9986 participants from all services were included, some had been deployed and some had been trained but not deployed. Special Forces were excluded. Data, collected by questionnaire, included information on deployment experiences, socio-demographic and military characteristics, pre-enlistment antisocial behaviour, and post-deployment health outcomes. The main violence outcomes were self-report measures of interpersonal violence.

Results 6.2% of the sample reported interpersonal violence in the last month. Deployment showed a stronger association with subsequent violence among reservists (OR=2.98 (1.50–5.93), P=0.002) than among regulars (OR=1.26 (0.96–1.67), P=0.098) when compared to their non-deployed counterparts. Performing a combat role whilst deployed was associated with a significantly increased likelihood of violence among regulars (OR=1.90 (1.38–2.75), P=0.001) and the risk of violence increased with the number of traumatic events experienced (P<0.001). Violence on homecoming was also associated with mental health problems such as PTSD (OR=4.8 (3.2–7.2) P<0.001) and alcohol misuse (OR=3.1 (2.5–3.9) P<0.001).

Conclusion Military deployment, in particular combat exposure, increased the risk of subsequent violence among military personnel and the risk of violence increased with increasing numbers of traumatic events experienced on deployment. Valuable information on risk factors for violence among military personnel is provided, especially regarding increased risk among deployed reservists and among personnel who report post-deployment mental health problems and alcohol misuse.
increased risk of liver events in the 90 days immediately prior to and post first Orlistat prescription, but no difference in risk between the pre and initial exposure periods. This suggests that Orlistat may be initiated during a period of time when adverse liver events are more likely due to poor underlying health, but does not suggest the risk increases with initiation of Orlistat.

EVIDENCE FOR THE EFFECTIVENESS OF OPIOATE SUBSTITUTION TREATMENT IN RELATION TO HIV TRANSMISSION IN PEOPLE WHO INJECT DRUGS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background Injecting drug use is a major risk factor for the acquisition and transmission of HIV among people who inject drugs (PWID), and between PWID and the wider community. Worldwide there are an estimated 15.9 million PWID of whom 3 million may be HIV-positive. Methadone and buprenorphine (opiate substitution treatments, OST) reduce heroin use, injecting risk behaviour, and drug related mortality and are included in the World Health Organization list of essential medicines. A small number of individual cohort studies and a Cochrane narrative systematic review suggest that OST may reduce HIV incidence, but no pooled quantitative synthesis has been carried out. We have undertaken a systematic review and meta-analysis of published and unpublished studies to quantify the effect of OST on HIV transmission.

Methods Medline, EMBASE and PsychINFO were searched to identify studies that examined the effectiveness of OST in relation to HIV transmission. Authors of prospective studies that assessed HIV incidence in PWID were contacted to obtain unpublished data.

Results Fifteen studies conducted in seven countries were relevant for inclusion. Data from ten of the studies were pooled, two of which were unpublished. Analysis included over 22,000 person-years of follow-up and 738 incident HIV infections. Preliminary random effects meta-analysis demonstrates that OST reduces risk of HIV transmission among PWID by 49% (RR 0.51, 95% CI 0.57–0.71, p<0.001) although there was significant heterogeneity between studies (I² 59.5%, χ² 22.2, p=0.008). Study-level covariates including publication year, gender, median age, and ethnicity of participants did not significantly influence the impact of OST in meta-regression analyses. However, sub-group analysis demonstrated that whilst continuous OST significantly reduced risk of HIV infection, the effectiveness of interrupted or detoxification treatment was less clear (RR 1.26, 95% CI 0.77–2.07, p=0.360).

Conclusion These preliminary data provide further evidence that OST can reduce the risk of HIV infection among PWID and for the first time quantify the effect. Ensuring sufficient coverage of OST as part of a package of harm reduction interventions is critical to reduce the burden of HIV among PWID and to prevent onward transmission between PWID and to the wider community.

SURVEY OF USE AND APPLICATION OF TEST ACCURACY MEASURES FOR DECISION MAKING IN PRIMARY CARE

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Background Venous thromboembolism (VTE) remains one of the leading causes of maternal mortality in high income countries. A lack of robust data on women’s risk factors for antepartum and postpartum VTE limit potential prevention. There is a need for estimates of absolute risks at population level according to recognised risk factors.

Methods Using a large primary care database, we analysed 376,154 pregnancies ending in live births or stillbirths from women 15–44 years of age between 1995 and 2009. We assessed the impact of risk factors on the absolute and relative incidence of VTE for antepartum and postpartum periods using Poisson regression.

Results Postpartum, the strongest risk factor was stillbirth (Absolute VTE Rate=2,444/100,000 person-years) followed by varicose veins, BMI >30kg/m2, obstetric haemorrhage, preterm delivery, medical co-morbidities (either SLE, IBD, nephrotic syndrome or cancer) and caesarean section (AR=657/100,000 person-years or higher). BMI >30kg/m2 conferred a substantial increase in postpartum risk (ARs=926/100,000 person-years) but only a modest increase antepartum (AR=109/100,000 person-years). Women aged ≥55 years, current smokers, and those with acute systemic infections had small relative increases in antepartum and postpartum VTE to those without such risk factors.

Conclusion Antepartum VTE varies modestly by recognised risk factors, yet women with stillbirths, preterm births, obstetric haemorrhage, caesarean section delivery, co-morbidities or BMI >30kg/m2 are most likely to benefit from thromboprophylaxis postnatally. For example, we estimate that up to 17 to 19 annual VTEs could be avoided annually if all women with stillbirth, preterm birth or caesarean section in the UK received appropriate thromboprophylaxis.