

mental disorder. A precise presentation of the social disability shall improve the model of care offered to these persons. Any possible parallel studies in other countries, employing analogical methodology, could allow for a cross-national and cross-cultural comparison of the received outcomes.

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Psychotic symptoms in general population: Correlates in the Andalusian Province of Granada

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Introduction Several recent epidemiological studies have reported during the last few years that the prevalence of psychotic symptoms in the community is bigger than the previously thought. **Aims** Estimate the prevalence in our influence area, as there are no previous studies focused on this measure and its correlated factors in Andalusia population.

Methods Literature review was made about the prevalence reported in all continents as well as the found correlation. Then, a cross-sectional epidemiological study was designed (Granada). We present data from 809 Andalusian individuals taken from the Unified Data Base of the Andalusian Health System.

Results This poster presents a brief but updated systematic literature review of psychotic symptoms in the general population (i.e. delusions and hallucinations). We present also data from 809 individuals from our clinical catchment area. Prevalence of psychotic symptoms in Granada was of 10.3%. Hallucinations were reported in 6.1% and 7.4% reported delusions.

Conclusions The prevalence found was similar to other studies in the Spanish population such as the EsEMED Study performed in Catalonia where 11.2% of psychotic symptoms were reported, and similar to European studies like the BNS in Great Britain with a 10.9% of psychotic symptoms. Differences obtained in percentages could be due to different measure scales (PSQ, MINI, CIDI. . .) used in other studies made in the North American population such as the National Comorbidity Survey with a 28% of prevalence reported. Inter-interviewer differences and the potential risk factors for psychotic symptoms in each population seem to be the causes of such differences and similarities.

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Loneliness and mortality: A community-based prospective study

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Introduction Loneliness affects up to one in every third individual in the western population, and the prevalence is increasing. The literature suggests an increased mortality risk of about 26% when feeling lonely, and an association to some disorders of physical health.

Objectives To assess if loneliness increases the risk of mortality, and if so, if health indicators (hypertension, heart disease, tobacco use, alcoholism, diabetes, obesity, and depression) mediate the association.

Methods The design is a community-based prospective cohort study using data from the Swedish Lundby Study. Loneliness is measured in 1997 with a singleton question during interview of a psychiatrist. The outcome is death between 1997 and 2011. Survival analysis is used to estimate the relative risk of mortality. Stratification of potential explanatory covariates examines if any of the health indicators mediate the relationship.

Results Significant more females, unmarried, unemployed, and childless people feel lonely. Moreover, feeling lonely correlates to being smoker or alcoholic when adjusting for age and gender. The statistical work on the survival analysis is still in progress. However, we expect to find a positive correlation between loneliness and mortality corresponding to previous studies, and perhaps to reveal some of the health indicators to cause the association.

Conclusions With increasing prevalence, potential health consequences, and a neglected role in the society, loneliness is an important research area.

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More women are medicated while more men are talked out: Persistent gender disparities in mental health care

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Introduction Physician incentives have been shown in previous studies to help reduce socioeconomic disparities in health care. Its impact on gender disparities, however, has rarely been investigated.

Aim The impact of physician incentives on gender disparities in mental health care was investigated in this retrospective study.

Method De-identified health administrative data from physician claims, hospital separations, vital statistics, prescription database, and insurance plan registries were linked and examined. Monthly cohorts of individuals with depression who were residing in British Columbia, Canada were identified and their use of mental health services tracked for 12 months following receipt of initial diagnosis. Indicators that assess receipt of the following services were created:

- counseling/psychotherapy (CP);
- minimally adequate counseling/psychotherapy (MACP);
- antidepressant therapy (AT);
- minimally adequate antidepressant therapy (MAAT).

Interrupted time series analysis was used to estimate changes in these indicators before (01/2005–12/2007) and after (01/2008–12/2012) physician incentives were introduced.