ation between employment status and time-to-first-contact with mental health services using survey data linked to electronic health records(EHR).
*Methods* SELCoH ($n = 1698$, 2008–2010) was a representative population survey of South East London, with a 71.9% household participation rate. Anonymised survey data for participants was linked with EHR, generating survival data for time-to-first-contact. Cox regression was used to assess associations between unemployment and time to first contact with mental health services.
*Results* The rate in the unemployed was 22.84 contacts per 1000 person-years, and in those not unemployed, it was 10 contacts per 1000 person-years. The crude (age-adjusted) hazard ratio (HR) for unemployment was 3.09 (95% CI: 1.66–5.75). The HR for contact for unemployment, after adjusting for age, gender, ethnicity and education, was 2.8 (95% CI: 1.44–5.47). On addition of symptoms of common mental disorder, post-traumatic stress, psychosis and suicide attempts, to the model, unemployed participants remained at elevated risk (HR:2.65, 95% CI: 1.33–5.27). Finally, illicit drugs and alcohol had minimal influence on estimates, giving a fully-adjusted estimate for the association between unemployment and rate of contact of 2.6 (95% CI: 1.31–5.14).
*Conclusions* Unemployment was associated with a greater than two-fold increase in risk of accessing mental health care for the first time within the observation time, after adjustment for sociodemographic confounders, psychopathology, and substance use. Explanations for this association could include unobserved confounding, health behaviours associated with unemployment or effects of unemployment on stress processing.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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**EW247**

## The evaluation of the effects of daytime sleepiness, anxiety and depression on the quality of life in 112 emergency medical staff

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*Introduction* One hundred and twelve emergency medical staff are faced with many physical and mental problems due to the deterioration of their sleep-wake cycle and getting out of their usual work and social life.
*Objectives* The aim of this study was to examine the effects of anxiety, depression, day time sleepiness on the quality of life in 112 emergency medical staff.
*Methods* Target population of this cross-sectional study was the 112 emergency medical staff in the province of Rize. We tried to obtain all the universe ($n = 154$), so the sample was not selected. One hundred and four people (67%) participated in the study. In the data form, Epworth sleepiness scale, Beck Anxiety Inventory, Beck Depression Inventory and the SF-36 quality of life questionnaire were applied.
*Results* The prevalence of pathological sleepiness was 14.4% ($n = 15$), the prevalence of anxiety was 39,8% ($n = 41$), the prevalence depression was 20,2% ($n = 21$), respectively (Table 1).
*Conclusion* Based on high levels of anxiety and depression that reduces quality of life compared to the general population in 112 emergency services workers, motivational programs, coping strategies, psychological counseling services are required. Also, against the psychosocial risk factors forming anxiety and depression in the working life, organizational measures must be taken.

*Table 1* The correlation between depression, anxiety and sleepiness scores with the subscores of the quality of life scale in 112 emergency medical staff.

| | Physical functioning | Role limitations due to physical health | Role limitations due to emotional problems | Energy/ fatigue | Emotional well being | Social functioning | Pain | General health |
|---|---|---|---|---|---|---|---|---|
| *Depression* | | | | | | | | |
| *r* | −0.12 | −0.32* | −0.39* | −0.47* | −0.44* | −0.32* | −0.31* | −0.44* |
| *p* | 0.234 | 0.001 | <0.001 | <0.001 | <0.001 | 0.001 | 0.002 | <0.001 |
| *Anxiety* | | | | | | | | |
| *r* | −0.22* | −0.33* | −0.35* | −0.31* | −0.32* | −0.27* | −0.39* | −0.25* |
| *p* | 0.027 | 0.001 | <0.001 | 0.002 | 0.002 | 0.007 | <0.001 | 0.014 |
| *Sleepiness* | | | | | | | | |
| *r* | −.024* | −0.22* | −0.12 | −0.24* | −0.11 | −0.27* | −0.30* | −0.06 |
| *p* | 0.019 | 0.035 | 0.268 | 0.019 | 0.305 | 0.008 | 0.003 | 0.592 |

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**EW248**

## Is body weight dissatisfaction associated with depression?

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*Introduction* Body image dissatisfaction is a risk factor for depression. Research has focused on female adolescents; yet little is known about sex and age differences.
*Objectives/aims* The aim of our study was to evaluate the association of body weight dissatisfaction, a component of body image, with depression overall, and for different sex and age-groups independent of body weight.
*Methods* We analyzed data of 15,975 individuals from the cross-sectional 2012 Swiss Health Survey. Participants were asked about their weight satisfaction. Patient Health Questionnaire (PHQ-9) was used to ascertain depression. Age was stratified in three groups ($\geq$ 18-29; $\geq$ 30-59; $\geq$ 60 years). Body mass index (BMI) was self-reported and categorized into normal weight (BMI: 18.5-24.9 kg/m$^2$), overweight (BMI: 25.0-29.9 kg/m$^2$), and obesity (BMI: $\geq$ 30 kg/m$^2$). The association between weight dissatisfaction and depression was assessed with logistic regression analyses and adjusted for known confounders (including BMI).
*Results* Weight dissatisfaction was associated with depression in the overall group (OR: 2.04, 95% CI: 1.66-2.50) and in men (1.85, 1.34-2.56) and women (2.25, 1.71-2.96) separately, independent of body weight (multivariable adjusted). Stratification by age groups revealed associations of weight dissatisfaction with depression in young (1.78, 1.16-2.74), middle-aged (2.1, 1.61-2.74) and old individuals (2.34, 1.30-4.23) independent of BMI. A sub-analysis in the overall group revealed statistically significant positive associations of weight dissatisfaction with depression in underweight, normal weight, overweight and obese individuals.
*Conclusion* Body weight dissatisfaction is associated with depression in men, women, young, middle-aged and old individuals independent of BMI.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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**EW253**

## Type A personality and its association with mortality: Considering different analysis approaches of the Bortner Scale

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*Introduction* Type A behaviour pattern (TABP) is defined as the combination of competitive need for achievement, sense of time urgency, aggressiveness, and hostility. Studies raised evidence for an association between TABP and cardiovascular disease. Recent studies on its association with mortality showed contradicting results and used different methods to measure TABP.
*Objectives/aims* Investigating the association between TABP and all-cause, CVD, and all-cancer mortality.
*Methods* We used data of the MONICA and the NRP1A studies that were linked with the Swiss National Cohort (SNC) ($n = 7997$). Essentially, the SNC is an anonymous record linkage of census, migration and mortality data. TABP was measured by the Bortner Scale. To determine the all-cause, CVD, and cancer mortality risk a Cox regression was performed. Following Edwards et al. (1990), we analysed the Bortner Scale in two different ways: all items and its two dimensions (speed and competitiveness) separately.
*Results* We found a significant association of the Bortner Scale with all-cause mortality in women (adjusted for sociodemographic factors HR 1.02, 95% CI 1.00–1.03, additionally adjusted for lifestyle factors–smoking, alcohol intake, physical activity, BMI category–1.01, 1.00–1.03). The subscale of competitiveness was associated with all-cause and CVD mortality in women. Interestingly, stratifying for lifestyle variables revealed that the association was only present in those having a healthy lifestyle, e.g. non-smoking or non-hazardous alcohol intake.
*Conclusions* The Bortner Scale and its subscale of competitiveness were associated with mortality in women. In those having great health awareness, this might offer potential for further reduction of mortality risk.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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**EW254**

## Social withdrawal and suicide risk: A descriptive study

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*Introduction* Social withdrawal is a major health problem that has been related with higher morbidity and mortality rates. There are few studies about the relationship between suicidal behavior and social isolation.
*Aim* To describe the existence of suicidal risk in subjects with social isolation.
*Method* Participants were 187 subjects referred to a Crisis Resolution Home Treatment because of social isolation. The inclusion criteria were: home isolation, avoiding of social situations and relationships, for at least 6 months. Suicide risk was assessed by the item of the Severity of Psychiatric Illness, dividing in four groups (from absence to high suicide risk). Socio-demographic and clinical data were also analysed.
*Results* Most cases ($n = 132$, 70.5%) had absence of suicide risk. They were predominantly young males in all groups. There were no statistically significant differences in sociodemographic or clinical variables. The mean age at onset of social isolation was lower in the high suicide risk group, having lower socially withdrawn period. This group had also lower rates of child abuse and suicide attempt history. The more frequent diagnosis in all groups was psychotic, affective and anxiety disorders. Those cases with mild and high suicide risk needed more frequently hospitalization.
*Conclusions* Social isolated people attended by CRHT do not have high frequency of suicide risk. Cases with higher suicide risk are younger and have a shorter period of isolation. The absence of child abuse history or previous suicide attempts contrasts with previous suicidal behavior research. These data can be influenced by the characteristics of functioning of CRHT and the small sample size.
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**EW255**

## Diagnosed depression and utilization of healthcare and preventive services in the general adult population in Germany

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*Introduction* Depressive disorders have been related to increased health service utilization, but specific information about associations between health professional-diagnosed depression and the utilization of health care and preventive services in the general population is limited.
*Objectives* To compare the use of health care and preventive services among men and women with and without diagnosed depression in the general population in Germany.
*Aims* To examine the association of diagnosed depression with the utilization of healthcare and preventive services.
*Methods* Cross-sectional analysis of data from the representative telephone survey German Health Update (GEDA) 2009 and 2010 ($n = 43.312$ residents in private households 18 years and older). We analyzed associations between self-reported health professional-diagnosed depression (past 12 months) and the use of a range of healthcare services and preventive services covered by statutory health insurances using multivariable regressions adjusted for age, socio-economic status, marital status, employment and number of chronic somatic conditions.
*Results* Twelve-month diagnosed depression was associated with increased health care service utilization (physician contacts, hospital admissions, rehabilitation) in both sexes. Of the preventive services, diagnosed depression was associated with increased use of general health check-ups, cancer screening and flu vaccination among women, while there was no association with dental check-up and tetanus and pertussis vaccination. Among men, no association of diagnosed depression with any preventive service was found except for cancer screening.
*Conclusions* Health professional-diagnosed depression is associated with increased health service utilization independent of somatic comorbidity and socio-demographic confounders. This includes some preventive services in women and only one preventive service in men.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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