individuals, they had significantly more depressive symptoms (P = .019), higher emotional component of hopelessness (P = .037), and higher dysrhythmicity of sleep (P = .009), activities (P = .048), and social life (P = .019). Passive and active suicidal ideation and suicidal plans were best predicted by dysrhythmicity of sleep and social life. Dysrhythmicity of sleep and social life mediated the direct effect of depressive symptoms on passive and active suicidal ideation and also of active ideation on suicidal plans. The emotional component of hopelessness was related to dysrhythmicity of social life and mediated its effect on suicidal plans (P = .010).
Conclusions: Chronobiological alterations directly contributed to passive and active suicidal ideation and to suicidal preparation, with a key role of circadian rhythm alteration of sleep, activities, and social life. Chronobiological alterations also impacted the emotional component of hopelessness, hence indirectly contributing to suicidal ideations and plans. These findings call for the systematic screening of these dysrhythmicity dimensions when considering suicidal risk in individuals with BD.

Disclosure of Interest: None Declared

O0062

Suicide Deaths Before and During the COVID 19 Pandemic

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doi: 10.1192/j.eurpsy.2023.267

Introduction: With stressors that are often associated with suicide increasing during the coronavirus disease 2019 (COVID-19) pandemic, there has been concern that suicide mortality rates may also be increasing. Our objective was to determine whether suicide mortality rates increased during the COVID-19 pandemic.
With stressors that are often associated with suicideincreasing during the coronavirus disease 2019 (COVID-19) pandemic,there has been concern that suicide mortality rates may alsobe increasing.
Objectives: Our objective was to determine whether suicidemortality rates increased during the COVID-19 pandemic.
Methods: We conducted an interrupted time-series study using data from January 2019 through December 2020 from 2 large integrated health care systems. The population at risk included all patients or individuals enrolled in a health plan at HealthPartners in Minnesota or Henry Ford Health in Michigan. The primary outcome was change in suicide mortality rates, expressed as annualized crude rates of suicide death per 100,000 people in 10 months following the start of the pandemic in March 2020 compared with the 14 months prior. We conducted an interrupted time-series study using data fromJanuary 2019 through December 2020 from 2 large integrated health care systems. The population at risk included all patients or individuals enrolledin a health plan at HealthPartners in Minnesota or Henry Ford HealthSystem in Michigan. The primary outcome was change in suicide mortality rates, expressed as annualized crude rates of suicide death per 100,000 people in 10 months following the start of the pandemic in March2020 compared with the 14 months prior.
Results: There were 6,434,675 people at risk in the sample, with 55% women and a diverse sample across ages, race/ethnicity, and insurance type. From January 2019 through February 2020, there was a slow increase in the suicide mortality rate, with rates then decreasing by 0.45 per 100,000 people per month from March 2020 through December 2020 (SE= 0.19, P=0.03). There were 6,434,675 people at risk in the sample, with 55% women and a diverse sample across ages, race/ethnicity, and insurance type. From January 2019 through February 2020, there was a slow increase in the suicide mortality rate, with rates then decreasing by 0.45 per 100,000 people per month from March 2020 through December 2020 (SE= 0.19, P=0.03).
Conclusions: Overall suicide mortality rates did not increase with the pandemic, and in fact slightly declined from March to December 2020. Our findings should be confirmed across other settings and, when available, using final adjudicated state mortality data. Overall suicide mortality rates did not increase with the pandemic, and in fact slightly declined from March to December 2020. Our findings should be confirmed across other settings and,when available, using final adjudicated state mortality data.

Disclosure of Interest: None Declared

Depressive and Anxiety Disorders

O0063

2. Predictors of Generalized Anxiety Disorder Symptoms in Residents of Fort McMurray Five Years after the Devastating Wildfires.

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doi: 10.1192/j.eurpsy.2023.268

Introduction: Natural disasters adversely impact individuals living in places where they occur, resulting in emotional distress. The wildfire that occurred in Fort McMurray (FMM), Alberta in 2016 is no different.
Objectives: This study aims to identify the prevalence and predictors of Generalized Anxiety Disorder (GAD) symptoms in residents of FMM five years after the devastating wildfires.
Methods: Data for the study were collected through a cross-sectional survey conducted online from the 24th of April to the 2nd of June 2021. A validated instrument, the GAD-7 scale, was used to collect information on anxiety.
Results: Of the total number of 186 residents who took part in the study, the majority were females (85.5%), employed (94.1%), working at school boards (50.0%), and were either married, cohabiting, or partnered (71.0%). The prevalence of likely GAD among the study sample was 42.5%. Unemployed respondents were seventeen times more likely to develop GAD symptoms (OR = 16.62; 95% C.I. 1.23-223.67) while respondents who would like to receive mental health counseling were five times more likely to experience

GAD symptoms (OR = 5.35; 95% C.I. 2.03-14.15). Respondents who suffered a loss of property because of the wildfire were two times more likely to develop GAD symptoms (OR = 2.36; 95% C.I. 1.01-22.62).
Conclusions: Formulators of policy may mitigate GAD symptoms, particularly after natural disasters, by making long-term mental health counseling available and a key component of post-disaster management, and by investing in the social capital of the people to build resilience and support to deal with the post-disaster mental health effects.

Disclosure of Interest: None Declared

O0064

A Pilot Study Comparing a Community of Practice Group Therapy Program with and without Concurrent Ketamine-assisted Therapy

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doi: 10.1192/j.eurpsy.2023.269

Introduction: Healthcare practitioners (HCPs) are facing a mental health crisis. Group therapies have long been used to treat symptoms associated with PTSD, anxiety and/or depression, however no studies have investigated the role of implementing group therapy with and without ketamine-assisted therapies (KaT).
Objectives: The current study investigated the effects of the Roots to Thrive (RTT) group therapy intervention both with and without adjunctive KaT.
Methods: In the present study we conduct a secondary analysis of data derived from the 12-week group psychotherapy program to that of the same program with adjunct KaT. Participants were administered a series of validated psychiatric assessment tools before and after the 12-weeks. Inclusion criteria included a diagnosis of treatment resistant mental health condition (depression, PTSD and/or generalized anxiety disorder) and a score of 15 or greater on the PTSD Checklist for DSM-5 (PCL-5). To assess the effects of time x group interaction and calculate differences between the RTT only and RTT-KaT subgroups, a repeated measures ANOVA was conducted. Effect sizes were calculated through partial eta-squared.
Results: Forty-nine HCPs with treatment-resistant PTSD, anxiety and/or depression were treated with the RTT group therapy model to target their symptoms. A total of 49 individuals (34 female, 10 male, 3 other) with a median age of 47 years old (SD 14.19) participated in the study. There were no statistically significant differences between RTT only (n=14) and RTT KaT (n=35) subgroups across gender [X2 (1, N=44) = 2.84, ns] or age [F (1, 36) = .257, p = .615]. From pre- to post-treatment, all patients showed significant reductions in scores of PTSD (from 39.3 to 20.99), depression (from 15.5 to 7.7) and anxiety (from 15.5 to 6.2). Two-way repeated measures ANOVA did not reveal any significant between-group differences between the RTT and RTT-KaT subgroups.
Conclusions: This observational study provides preliminary support for the potential of the RTT community of care model of group therapy and adds to a small but growing body of knowledge on the integration of group therapy and the broad category of psychedelic psychotherapies. Given the rapid proliferation and expansion of KaT clinics throughout North America, the finding that KaT did not appear to impact changes related to the RTT intervention suggests the need for further research to better explain the potential impacts of relational transference between the two groups, and the distinct contributions of ketamine administration in a group therapy context.

Disclosure of Interest: None Declared

O0065

Childhood trauma and anger in adults with and without depressive and anxiety disorders

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doi: 10.1192/j.eurpsy.2023.270

Introduction: Childhood trauma (CT) is associated with severe sequelae, including personality disorders and stress-related mental health disorders that can perpetuate long into adulthood.
Objectives: We aimed to investigate (1) whether childhood trauma is associated with anger in adulthood, and, if so, (2) to explore which types of childhood trauma predominate in the prediction of anger, and (3) to explore whether the association is independent of psychopathology in a cohort that included participants without lifetime psychiatric disorders, with current or remitted depressive and anxiety disorders, or comorbid depressive and anxiety disorders.
Methods: In the Netherlands Study of Depression and Anxiety (NESDA), childhood trauma was assessed with a semi-structured Childhood Trauma Interview (CTI) at baseline, and analyzed in relation to anger as measured at 4-year follow-up with the Spielberger Trait Anger Subscale (STAS), the Anger Attacks Questionnaire, and cluster B personality traits (i.e., borderline, antisocial) of the Personality Disorder Questionnaire 4 (PDQ-4), using analysis of covariance (ANCOVA) and multivariable logistic regression analyses. Post-hoc analyses comprised cross-sectional regression analyses, using the Childhood Trauma Questionnaire – Short Form (CTQ-SF) obtained at 4-year follow-up.
Results: Participants (n = 2,276) were on average 42.1 years (SD = 13.1), and 66.3% were female. Childhood trauma showed a dose-response association with all anger constructs. Zooming in, all types of childhood trauma except for sexual abuse were associated with higher levels of trait anger, and a higher prevalence of anger attacks and antisocial personality traits in adulthood, independently of depression and anxiety. Additionally, all types of childhood trauma were significantly associated with borderline personality traits. Cross-sectionally, the effect sizes were larger compared to the analyses with the childhood trauma measured four years prior to the anger measures.