

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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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 suicide increasing during the coronavirus disease 2019 (COVID-19) pandemic, there has been concern that suicide mortality rates may also be increasing.

Objectives: Our objective was to determine whether suicide mortality 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 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 System 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.

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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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