THE EFFECTS OF THE NAMASTE CARE FAMILY PROGRAM ON QUALITY OF LIFE OF PEOPLE WITH ADVANCED DEMENTIA

Jenny T. van der Steen,[1] Karlijn J. Joling,[2] Anneke L. Francke,[2] Wilco P. Achterberg,[3] and Hanneke J.A. Smaling[2], *1. Leiden University Medical Center, Leiden, Netherlands, 2. Amsterdam University Medical Centers, Amsterdam, Netherlands, 3. Leiden University Medical Center, Leiden, Netherlands*

People with advanced dementia often die in nursing homes. Family caregivers frequently feel that their loved one's quality of life and dying is suboptimal. The daily Namaste Care Family program -derived from the US Namaste Care program- involves family caregivers and integrates personalized care with meaningful activities for people with advanced dementia. A cluster-randomized controlled trial (December 2016 - December 2018) examined effects of the Namaste Care Family program on resident and family caregiver outcomes. Ten Dutch nursing homes implemented Namaste Care Family for 117 residents, while nine nursing homes provided usual care for 114 residents in the study. Nursing staff assessed quality of life over the last week with the Quality of Life in Late-Stage Dementia (QUALID, the primary resident outcome measure). Research assistants observed discomfort during the sessions with the Discomfort Scale-Dementia of Alzheimer Type (DS-DAT). Assessments were at baseline and after 1, 3, 6, and 12 months. We found a significant difference in QUALID score at 12 months favoring quality of life in the intervention group. Further, the intervention group showed less signs of discomfort at 3, 6, and 12 months compared with the control group. The Namaste Care Family program can improve quality of life of people with advanced dementia in the long run. These study findings support sustained implementation of the daily program in nursing homes. Further analyses of effects on the other outcomes will include blinded DS-DAT assessments, more secondary outcome measures and family caregiver outcomes.

SESSION 4140 (SYMPOSIUM)

LATE-LIFE SUICIDE: IDENTIFYING PREVENTION TARGETS AND MOBILIZING COMMUNITIES TO MANAGE RISK

Chair: Alexandria R. Ebert, *West Virginia University, Morgantown, United States*
Co-Chair: Emily S. Bower, *VISN Center of Excellence for Suicide Prevention, Canandaigua, New York, United States*
Discussant: Yeates Conwell, *University of Rochester School of Medicine, Rochester, New York, United States*

Adults aged 70 and older have the highest suicide rates in most countries across the globe (World Health Organization, 2014). Prevalence may increase as the Baby Boomers transition into older adulthood (Phillips, 2014). Disease and disability increase risk for late-life suicide, thus identifying opportunities to intervene within the network of services utilized by older adults with illness and disability could reduce suicide risk. This symposium will explore the impact of disease and disability on late-life suicide risk, and present novel ideas for intervention and prevention. Emphasizing the conference theme, we will discuss prevention points spanning networks of care, including mental health and social services, and long-term care. Dr. Bower will frame the scope of the problem by presenting findings of age-stratified associations between physical illness and suicide attempt among older veterans using secondary data from a retrospective case-control study of veterans. Ms. Lutz will present findings on the relationship between disability and suicidal thoughts from a clinical trial of problem-solving therapy. Dr. Lane will discuss management and identification of suicide risk factors during the transition from independent living to long-term care through the lens of a case-series. Dr. Fullen will present preliminary findings from a novel, randomized controlled trial of a community-based suicide prevention training program for nutrition service volunteers. Dr. Yeates Conwell, Co-Director of the Center for the Study and Prevention of Suicide and Director of the Geriatric Psychiatry Program at the University of Rochester Medical Center, will serve as the discussant.

PHYSICAL CONDITIONS ASSOCIATED WITH SUICIDE ATTEMPTS: DO RISKS DIFFER AMONG OUR OLDER VETERANS?

Emily S. Bower,[1] Kelsey Simons,[1] Patrick G. Walsh,[1] Lisham Ashrafioun,[1] Kimberly A. Van Orden,[2] and Todd M. Bishop[1], *1. VISN Center of Excellence for Suicide Prevention, Canandaigua, New York, United States, 2. University of Rochester School of Medicine, Rochester, New York, United States*

Physical illness confers risk for late-life suicide, yet few studies report whether risks differ with older age and among Veterans. We examined age-stratified associations between physical illness and suicide attempt among Veterans 65+ years (n=8452, 97% male) from a larger retrospective case-control study that utilized secondary data from the Veterans Affairs Corporate Data Warehouse and Suicide Prevention Applications Network. Controls were matched by age, sex, and mental health treatment utilization. Risk estimates for 15 conditions and a combined comorbidity score were stratified by young-old (65-74), middle-old (75-84), and oldest-old (85+), adjusting for age and sex within strata. Neurodegenerative disorder (ORs=4.5, 6.0, 6.5) or dementia (ORs=5.0, 5.7, 4.4) diagnosis within 180 days conferred the highest risks across young-, middle-, and oldest-old. Cerebrovascular disorder was associated with higher risk among the oldest-old versus young-old (ORs=6.1 vs 2.2). Findings differ from reported risks for suicide death. Illness may be experienced differently across later-life.

UTILIZING NUTRITION SERVICES PROVIDERS TO PREVENT LATE-LIFE SUICIDE: IMPLEMENTING A RANDOMIZED, CONTROLLED TRIAL

Matthew C. Fullen,[1] Mary Chase Mize,[2] and Laura R. Shannonhouse[2], *1. Virginia Tech, Blacksburg, Virginia, United States, 2. Georgia State University, Atlanta, Georgia, United States*

A challenge in preventing late-life suicide is identifying and responding to persons-at-risk prior to a suicide attempt. Distressed older adults are less likely to turn to a mental health professional, meaning that community-based prevention strategies are vitally important to comprehensive prevention frameworks. Due to their "natural helper" role,