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Background: Deinstitutionalization of nursing care in European counties relies profoundly on the mobilization of the caregivers and municipal homecare services. Yet, caring for home-dwelling people with dementia (PwD) can be stressful and resource demanding. The LIVE@Home.Path trial tailored, implemented, and evaluated the multicomponent LIVE intervention on informal caregivers' burden in dyads of home-dwelling PwDs and their families.

Method: From 2019 to 2021, we conducted a 24-month multicenter, multicomponent, stepped-wedge randomized control trial including dyads of people ≥ 65 years with mild to moderate dementia with minimum 1h/week contact with their informal caregiver. The user-developed Learning, Innovation, Volunteer support, and Empowerment (LIVE) intervention was implemented by municipal coordinators over 6 months periods. In an intention-to-treat analysis, we applied mixed-effect regression models accounting for time and confounding factors to evaluate the effect of the intervention on Relative Stress Scale (RSS), Resource Utilization in Dementia (RUD) and Clinical Global Impression of Change (CGIC).

Results: A total of 280 dyads were included at baseline, mean age of PwD was 82.2 years, 63% female, 43% lived alone, 36% had Alzheimer's dementia, median MMSE was 20 (range 0-30) and median FAST score 4 (range 1-7). Caregivers were on average 66 years, 64% female, 49% were the PwDs child. At baseline, 80 dyads were randomized to intervention sequence 1 of which 67 received the intervention, corresponding numbers for sequence 2 and 3 were 97/ 57 and 103/50. During the active intervention period, time spent in personal activities of daily living significantly increased with 2.8 hours/months compared to 1.2 hours/months increase in the control period, total score of RSS was stable in the intervention period (0.36 points) (range 0-60), while it increased significantly in the control period (27.0 points), CGIC increased significantly only in the intervention period (0.5 points) (range: -5 worsening, 5 improvement).

Conclusion: Although caregivers reported more care time during the intervention periods, they did not experience more stress which may be related to their increased understanding of dementia. Increase in reported care time might also reflect the increased understanding of dementia, leading to more realistic evaluation of own time contribution.

FC47: To use or not to use? Multiple perspectives on residents' alcohol and tobacco use in residential care facilities

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Objectives: Residential care facilities (RCFs) provide 24/7 care to older adults with cognitive and/or physical disabilities. RCFs aim to provide person-centred care (PCC) to enhance the quality of life (QoL) of residents. Residents are dependent on their environment to fulfil their needs and wishes, such as drinking alcohol or smoking tobacco. Although alcohol and tobacco use can be experienced as a part of QoL in the final phase of life

and the motivation to quit these substances is low, it can cause severe health problems in older adults. In RCFs this may cause a dilemma between the QoL of individual residents and the health and safety problems of all residents. This study aims to explore multiple perspectives on alcohol and tobacco use within the RCF.

Methods: A qualitative research design was chosen, and semi-structured interviews were conducted. A various sample was purposively selected in two organizations on two types of units (psychogeriatric units and units providing care for residents with mainly physical disabilities): residents who use alcohol and/or tobacco and those who do not. Subsequently, four of these 16 residents were invited to participate in an in-depth case study. To explore the dynamics of the social environment, both formal and informal caregivers were invited to participate.

Results: Residents are satisfied with their current use and value their autonomy regarding alcohol and tobacco use. Residents acknowledge that their use could cause a nuisance to others. Multiple caregivers are involved in their use and residents experience dependency on these caregivers to smoke tobacco or drink alcohol. There was limited interaction between the residents and their (in)formal caregivers and amongst the caregivers on this topic. Moreover, caregivers tended to act from their own perspectives, based on their professional expertise, knowledge, and attitudes towards residents' alcohol and tobacco use.

Conclusion: A dilemma arises between protecting residents from the adverse (health) outcomes of alcohol and tobacco use and sustaining their QoL by optimizing their autonomy. Future research could assess how to integrate providing PCC to residents by offering choices and autonomy, while considering the addictive component of these substances, health, and safety risks for all.

Posters

P9: Clinical and Sociodemographic Factors Associated with Suicidal Risk in Older Adults in Latin America

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Introduction: Suicidal behaviors represent a serious public health problem in terms of mortality, morbidity and social impact. Suicide in the elderly is a statistical reality little studied in the Latin American context. Method: It's an observational study where we reviewed the records of the patients seen between January 2018 and December 2019 at the Psychogeriatrics Clinic of the Ramón de la Fuente Muñiz National Institute of Psychiatry; collecting sociodemographic, clinical information and evaluating the suicidal risk by the SAD PERSONS Scale. With the information obtained, we correlated variables with suicidal risk based on the Pearson and Spearman correlation indices.

Results: A total of 404 files were reviewed, finding that in the last 5 years 1.4% of the patients had made a suicide attempt, what was directly related to a history of violence ($r=0.256$, $p=0.011$). Suicidal thoughts in the past year (15.4%) and increased suicidal risk were associated with PAS use ($r=0.123$, $p=0.037$) ($r=0.207$, $p=0.001$) and depressive disorder ($r=0.148$, $p=0.012$) ($r=0.27$, $p=0.000$).

Conclusions: In the older adult population, some of the clinical and sociodemographic factors associated with suicidal risk described for the general population could continue to be considered risk factors, among them: being male, low level of education, diagnosis of depressive disorder, having medical comorbidities and the use of SPA.