


Places of living and places of dying: the case for preventing suicide in residential long-term care

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Abstract

This commentary addresses the increasing public health problem of suicide in later life and presents the case for preventing suicide in residential long-term care settings. We do so by examining this issue from the perspective of three levels of stakeholders – societal, organisational and individual – considering the relevant context, barriers and implications of each. We begin by discussing contemporary societal perspectives of ageing; the potential impact of ageism on prevention of late-life suicide; and the roles of gender and masculinity. This is followed by a historical analysis of the origin of residential long-term care; current organisational challenges; and person-centred care as a suicide prevention strategy. Finally, we consider suicide in long-term care from the perspective of individuals, including the experience of older adults living in residential care settings; the impact of suicide on residential care health professionals and other staff; and the impact of suicide bereavement on family, friends and other residents. We conclude with recommendations for policy reform and future research. This commentary aims to confront the often unspoken bias associated with preventing suicide among older adults, particularly those living with complex medical conditions, and invoke an open dialogue about suicide prevention in this population and setting.

Keywords: suicide; long-term care; prevention; ageism; person-centred care

Introduction

If we could prevent suicides of frail older adults, should we bother? This question does not serve as a provocation, rather an acknowledgement of the socially contested, often implicitly so, nature of late-life suicide. This commentary aims to invoke an open dialogue about suicide prevention among older adults. We suggest that a goal of zero suicides is as worthy a public health imperative as pursuing a goal of eliminating cancer. In both situations, we have only an incomplete understanding of the aetiology for individual cases, but have identified core factors that

contribute to elevated risk in the population as a whole (*e.g.* isolation and hopelessness, and tobacco and alcohol, respectively) and which can be mitigated through prevention initiatives. Unlike most public health campaigns, suicide prevention efforts among older adults, particularly those living in residential long-term care (LTC) (*e.g.* assisted living facilities, nursing homes) must contend with addressing the questions: Is this preventable? And if so, is it worthwhile preventing?

This issue is exemplified by media pieces from the United States of America (USA) and Australia (Donoghue, 2015). In 2014, *The Atlantic* ran a cover story entitled 'Why I hope to die at 75. An argument that society and families – and you – will be better off if nature takes its course swiftly and promptly' (Emanuel, 2014). This sentiment was also reflected in podcast entitled *Better Off Dead* by national media personality Andrew Denton (2015), who argued for the introduction of voluntary euthanasia laws in Australia. Evidently, the question of whether late-life suicide – particularly in the context of functional decline – is worth preventing is one of international relevance.

For the past decade, suicide has been among the top 15 causes of death worldwide (World Health Organization (WHO), 2015). It is among the top ten leading causes of death in the USA (Centers for Disease Control and Prevention, 2015) and is the 14th leading cause of death in Australia (Australian Bureau of Statistics, 2015). According to the WHO, older adults – particularly men aged 70 and older – have some of the highest suicide rates in countries with developed economies (WHO, 2014). For example, the 2014 rate of suicide for white men aged 75–80 years in the USA was 33.75 per 100,000 as compared to 24.73 per 100,000 for white men aged 25–30 years (Centers for Disease Control and Prevention, 2003–2015). In addition to the high suicide rate, this age group also faces high prevalence of physical health decline and cognitive impairments, often requiring LTC in a residential facility.

Residential LTC in the USA includes assisted living facilities and nursing homes. These facilities offer a location where adults, most aged >65, can receive non-medical support (in the case of assisted living) or continuous assistance (in the case of nursing homes) with activities of daily living, nursing care, medications, *etc.* In Australia LTC facilities are referred to as Residential Aged Care Services and include high care, low care and specialist services (Australian Institute of Health and Welfare (AIHW), 2017a). The demand for LTC is projected to increase steadily worldwide as a result of both demographic changes (*i.e.* ageing population) and socio-economic factors (*i.e.* reduced capacity for informal care-giving) (Colombo and Mercier, 2012). For example, an estimated 9 million US adults lived in LTC in 2014, a number that is projected to increase to 27 million by 2050 (Harris-Kojetin *et al.*, 2016).

Suicidal behaviour among residents in LTC is beginning to receive attention from public health researchers and practitioners (Mezuk *et al.*, 2014; Murphy *et al.*, 2015). Recent research has begun to uncover the prevalence and nature of suicide in LTC, identifying a range of risk factors specific to this population such as depression, health deterioration and duration of residence (Mezuk *et al.*, 2015; Murphy *et al.*, 2018). However, there has been only limited progress made in translating these emerging findings into suicide prevention and mental health promotion efforts on a broad scale for older adults living in, or transitioning into, LTC

(Substance Abuse and Mental Health Services Administration (SAMHSA), 2011). Oft-cited challenges to investigating suicide include under-reporting and misclassification of suicide deaths, limitations that apply to all work in this area. However, research and practice on preventing suicide among older adults, particularly those in LTC, must also contend with the often unspoken notion about whether this goal is worthy of pursuit (Draper, 2015; Murphy, 2016).

This commentary focuses on the public health problem of suicide in later life, particularly among individuals living in residential LTC. We describe how this unspoken bias permeates social structures and cognitive constructs with the result of shaping societal, organisational and individual perspectives on suicide prevention in later life. We close with recommendations for policy reform and future research to address ageism and improve outcomes for older adults in LTC.

Societal perspective

In Western cultures, beliefs about 'being old' are usually characterised by progressive loss of mental and physical functioning, productivity, autonomy and social connections (Whitbourne and Sneed, 2002; Stypinska and Turek, 2017). This negative cultural attitude towards ageing is pervasive and begins to be felt as early as the fourth decade of life (McConatha *et al.*, 2003; Kotter-Gruhn and Hess, 2012). This image of ageing is often reinforced by our cultural fascination with the youthful body and strength, which fosters a host of negative emotions around ageing, including fear, anxiety, denial and shame (McHugh, 2003; Sabik, 2015). Cherry *et al.* (2004) aptly describe this: 'as individuals and as a society, we are aged by our culture' (p. 631). The perpetuation of cultural narratives of ageism, in turn, normalises feelings of depression and sadness among older adults; renders suicidal behaviour 'rational'; and contributes to low screening rates of suicidal behaviour among older adults (Conwell, 1995; Uncapher and Arean, 2000).

Gender, masculinity and ageing

Suicide rates vary by age and gender, with significant differences between low/middle- and high-income countries (Nock *et al.*, 2008). According to the WHO (2014), the rates of suicide among men aged ≥ 70 years are consistently high in many countries around the world. Although women are twice as likely to attempt suicide, men are up to four times more likely to die by suicide (Blisker and White, 2011; Freeman *et al.*, 2017). In part, this is due to the higher lethality of means with which men attempt suicide (*e.g.* firearms *versus* poisoning) (Cibis *et al.*, 2012; Mergl *et al.*, 2015). Other explanations of these gender differences in suicidal behaviour implicate cultural narratives and norms of masculinity that emphasise strength, aggressiveness, financial success, lack of sympathy towards 'unsuccessful' suicidal behaviour or help-seeking among men (Gunn and Lester, 2011; Schrijvers *et al.*, 2012). The suicide death of journalist Hunter Thompson (1932–2005) serves as a case-in-point. Thompson allegedly shot himself while at home with his son and grandson and on the phone with his wife (Allen, 2005). Canetto (2017) writes that Thompson's family and friends originally accepted his suicide as a courageous and premeditated act of strength. This was later contested when his suicide note

revealed desperation and fear of a person 'unprepared' for the contingencies of ageing (Canetto, 2017). Arguably, this suicide of a journalist revered by many, exemplifies a painful tension between cultural norms of masculinity, personal fears of shame and stigma embedded within social perceptions of ageing. This is particularly relevant in LTC settings, where suicidal behaviour may be viewed as more acceptable or 'permissive', given that the majority of residents are living with multiple medical conditions and functional impairment (Winterrowd *et al.*, 2017).

Organisational perspective

There is a growing demand worldwide for residential and home-based LTC due to population ageing, changing norms and demands regarding work (*e.g.* increasing role of women in the labour force and dual-earning households), and cultural expectations regarding the importance of individual relative to family or community needs (Fung, 2013; Bengtson and DeLiema, 2016). Given this increased demand for aged care (Buckinx *et al.*, 2015; Pickard, 2015), LTC can be considered a potentially viable intervention source or a 'point of engagement' (Conwell *et al.*, 2011) for addressing suicide risk among older adults prior to suicidal crisis (Reiss and Tishler, 2008; Mezuk *et al.*, 2015). However, before considering LTC as an intervention setting, it is important to understand the social and historical context of LTC settings as a 'normal' space for ageing. That is, why does LTC take the form that it does today? What types of policies, designs and strategies are currently used to provide care for older persons, and how do those intersect with suicidal behaviour?

The origin of residential LTC in Euro-American settings

Up until the early 19th century, primary care for the elderly was mostly provided by close relatives and family, which was partially an artefact of 'filial statutes' enacted in 16th-century England and the American colonies (Pearson, 2013). The unfortunate few, mostly poor or sick, whose families could not care for them, were forced to share residency with other indigent populations (*i.e.* orphan children, poor and sick, mentally ill or vagabonds) (Rothman, 1971). The functional forms of such outside-home residential care varied between Europe and the USA, ranging between outhouses and almshouses, asylums and hospital-based institutions (Rothman, 1971; van Leeuwen *et al.*, 2014). These discrepancies were due to sweeping socio-economic and cultural changes happening at different times in Europe and the USA (Haber, 2015).

With the advent of 19th- and early 20th-century industrialisation in the USA, the first public institutions dedicated to care for specific populations began to emerge (*e.g.* orphanages, lunatic asylums), although older people in need of nursing care were still sent to the public asylums (Luchins, 1988; Haber and Gratton, 1993). Founded on the principles of social rehabilitation and moral character, these asylums were largely designed to reform their residents through explicit surveillance and denial of individual autonomy (Rothman, 1971). These 'total institutions' hid the problems of poverty and neglect behind the prison-like walls and further

fuelled growing fears and distrust among the public (Rothman, 1971; Noelker and Harel, 2001).

The enactment of the Social Security Act of 1935 in the USA marked an important turning point towards building an economic safety net for older adults through federal and state government (Haber and Gratton, 1993). However, the Act also revealed an implicit societal prejudice against the use of public funds for institutional care of the elderly (Institute of Medicine (US) Committee on Nursing Home Regulation, 1986). The Act initiated a public Old Age Assistance programme designed to distribute cash grants to community-dwelling older adults (Institute of Medicine (US) Committee on Nursing Home Regulation, 1986; Noelker and Harel, 2001). It was not until the passing of the 1965 Medicare Act that the eligibility for public funds expanded to include the residents of public institutions (Institute of Medicine (US) Committee on Nursing Home Regulation, 1986). The Medicare Act also established the Federal government as a regulatory body of residential LTC, with a hospital model as a blueprint for managing LTC functional operations (Singh, 2014; Erlyana *et al.*, 2016). Thus, in order to comply with Federal regulations, residential LTC had to resemble a hospital – rather than an orphanage, prison or halfway house – in its environment, operations and goals. These changes largely eliminated moral prejudice towards the reliance on LTC facilities for late-life care. However, in a place where care was provided by medical professionals and oriented towards safety and life preservation, the recourse to personal freedom and autonomy remained limited (Agich, 2003).

LTC as an institutional site for suicide prevention?

Residential LTC facilities can be viewed as organisations nested within social structures designed to serve a particular social function, in this case, caring for older adults. They are institutions much like schools, prisons and hospitals, in that each occupies a physical place where individuals are voluntarily or involuntarily admitted, often for a prolonged period of time. Many effective suicide prevention programmes have been implemented within institutions such as the United States Air Force Suicide Prevention Program, or the Signs of Suicide (SOS) programme for middle and high school students (<http://www.sprc.org/resources-programs>). As such, LTC organisations offer potentially key settings for developing cost-effective and evidence-based suicide prevention strategies, specifically tailored for the particular risk factors and needs of the institutionalised population (SAMHSA, 2011; Jobes *et al.*, 2018).

Like other social institutions, LTC organisations have a responsibility and duty not only to the individuals they serve (whether these are residents, students, patients or inmates) but also to the broader community (families, community, governments, investors, *etc.*) What differentiates LTC from other institutions is that instead of individuals graduating or being released or discharged, those residing in LTC often only leave when they die (81% of nursing home residents in Australia (AIHW, 2017b) and 70% of nursing home residents in the USA (Temkin-Greener *et al.*, 2013)) making LTC ‘the last stop’ for the majority of residents (Ball *et al.*, 2014). This may contribute to the reluctance to prevent suicide in these settings: why bother to act if death is imminent? However, this attitude is

contrary to the original social function LTC organisations are designed to serve: caring for older adults. Moreover, LTC is not hospice care: residents may not be able to live independently, but that does not equate to being in the active stages of dying. Indeed, while the average length of stay in a US nursing home may be relatively brief (approximately nine months) (Statista, 2015), the average length of stay in an assisted living facility in the USA is much longer at 28 months (Byala *et al.*, 2009), and the average length of stay in a residential aged care service in Australia is 2.9 years (AIHW, 2017b). These are not simply places where people die, but where people live for a substantial period of time, in most cases equivalent to the period of time spent in university or college accommodation.

Main challenges to preventing suicide in residential LTC

Reforms in the USA such as the Omnibus Reconciliation Act of 1987, and subsequent similar laws, were designed to develop a regulatory framework through standardised measures of quality assessment and accountability (*i.e.* readmissions, staffing ratios, medication costs and errors, unplanned discharges, falls and emergency hospitalisations, *etc.*) with the intent of improving co-ordination and quality of care. These measures were criticised as insufficient to capture the intended quality of care as they focus predominantly on outcomes rather than processes of care (Walshe and Harrington, 2002). Critics say these quantitative measures of compliance fail to address fundamental psycho-social aspects of quality of care, such as life and work satisfaction among staff, social connectedness (of residents and staff, of residents and their broader community), and sense of 'home' and belonging (Gloth and Gloth, 2011; Haque and Waytz, 2012). Furthermore, despite stringent regulatory practices enacted in LTC, evidence suggests that LTC residents were less likely to always have been treated with respect at the end of life (68.2%) compared to those cared for in hospitals (79.6%) or home hospice services (96.2%) (Teno *et al.*, 2004).

Is person-centred care a suicide prevention strategy in LTC?

In parallel with global processes of dismantling of welfare institutions under the auspice of deinstitutionalisation, person-centred care (PCC) initiatives began to emerge in the USA and have been the dominant model since the 1990s. While the deinstitutionalisation movement focused on transitioning to community-centred care and away from large-scale institutions, the PCC model was focused on the culture change within LTC and other health-care institutions. The person-centred movement was buoyed by a 1986 report by the US Institute of Medicine which emphasised the need for change in regulatory practices (Institute of Medicine (US) Committee on Nursing Home Regulation, 1986). Subsequent changes in policy triggered a grassroots movement that focused on small-scale, family-like and individualised nursing care (McCormack and McCance, 2006; Koren, 2010). Among others, these initiatives include The Pioneer Network (Fagan, 2003), Eden Alternative (Barba *et al.*, 2002), Green House Project (Rabig *et al.*, 2006) and Wellspring Model (Kehoe and Van Heesch, 2003). A common theme of these models of care pertains to their orientation towards promoting

personal autonomy through meaningful participation in one's care and improving quality of life in the LTC setting (White-Chu *et al.*, 2009). These innovative care models aim to embody features of social support and individual autonomy (Brownie and Nancarrow, 2013; Boelsma *et al.*, 2014). These features include the adaptation of the institutional built environment to resemble personal homes, introduction of spiritual practices and selection of geriatric nurses, trained to offer care-giving, guided by collaborative engagement between staff and residents (Puchalski, 2013; Miller *et al.*, 2016).

The expansion of the person-centred paradigms of LTC created new challenges. This included challenges in defining and measuring quality of care (Shier *et al.*, 2014), and inability to examine the efficacy and effectiveness of the different person-centred models of care (Williams *et al.*, 2015). When evaluations are completed, these show large variations between facilities, and the impact of different models of PCC also vary (Desrosiers *et al.*, 2014; Yoon *et al.*, 2015). There is an overall lack of empirical evidence (Miller *et al.*, 2016), and what exists is inconsistent. Some commentators have even raised concerns about the safety of the PCC model in LTC settings (Brownie and Nancarrow, 2013; Low *et al.*, 2015). Fundamental challenges also lie in care implementation and operations. PCC requires differently trained staff managers and care-givers, who emphasise personal decision-making, engaged care, and social integration in a work or living environment; this type of professional is characterised by increased adaptability and ability to multi-task (Tellis-Nayak, 2007; Low *et al.*, 2015). At the same time, within the person-centred paradigms, staff who directly care for the residents (*e.g.* nurses, nursing aides) report gains in overall job satisfaction (Brownie & Nancarrow, 2013). Other studies show evidence that among LTC residents, person-centred care is associated with improved mental health (Hill *et al.*, 2011), spirituality (Puchalski *et al.*, 2014), higher life satisfaction (Roos *et al.*, 2016) and positive adjustment during the transition to LTC (Boelsma *et al.*, 2014; Yoon, 2018).

The inconsistencies in the current evidence about the impact of PCC may stem from the use of different definitions (Morgan and Yoder, 2012), and the degree to which implementation and adherence has occurred. This is due to the complexity of achieving larger structural changes at the institutional and policy levels (Epstein *et al.*, 2010), including administrators who understand and support the need for person-centred care, alongside new regulations and norms that support the change (Moore *et al.*, 2017; Jacobs *et al.*, 2018). In order to enact a much needed, but fairly radical (in light of all historical evidence) organisational change, a new training model for nursing care is needed (*e.g.* diversity training, cultural competence) (Low *et al.*, 2015; Meyer *et al.*, 2017). Other reasons might include the lack of appropriate measures of care quality, as well as limited availability of rigorous research evidence that shows clear effect of PCC to be used to guide new care practices (Edvardsson *et al.*, 2008; Li and Porock, 2014).

Individual perspective

The majority of literature on suicide among older adults has focused on identifying risk factors for suicidal behaviour such as depression, physical decline and lack of social connectedness (Conwell *et al.*, 2002; Harwood *et al.*, 2006). A systematic

review of suicide risk among LTC residents found that suicidal thoughts are common among residents (5–33% prevalence in the past month), and are correlated with depression, social isolation, loneliness and functional decline (Mezuk *et al.*, 2014). These risk factors are shared with suicide risk in non-LTC community settings. Few studies have explored suicidal behaviour from the perspective of older adults, an important area for future research (Crocker *et al.*, 2006; Deuter *et al.*, 2016). Qualitative studies, based on ethnographic observations and personal interviews with older adult suicide attempters, identified personal loss, loneliness and loss of control as themes preceding their suicide attempt (Bonnewyn *et al.*, 2014). Similarly, qualitative studies involving interviews with LTC residents about their reasons for wishing to die revealed common themes such as loneliness; tiredness; inability to express oneself; and loss of one's autonomy, dignity and independence (van Wijngaarden *et al.*, 2015, 2018). Theoretical work suggests that older adults, particularly those in LTC, may perceive themselves as 'burdensome' to others, and experience internal or external pressures to suicide as part of a moral obligation to reduce their burden on others (Joiner *et al.*, 2015).

Suicide of a LTC resident represents a challenging experience for health-care professionals (Draper *et al.*, 2014). Over the course of their career, psychiatrists and general practitioners are likely to have at least one patient die by suicide (Halligan and Corcoran, 2001; Rothes *et al.*, 2013), some as frequently as one every three years (Halligan and Corcoran, 2001). Health-care professionals may experience a range of reactions to a patient suicide, including surprise, shock or disappointment for being unaware of the patient's plans of suicide. For LTC staff as well, the experience of loss following the death of a resident can be traumatic (Gannon and Dowling, 2012). Based on the 115,000 residents who were discharged due to death from one of the 2,700 residential aged care facilities in Australia in 2015–2016, we can estimate that each facility would experience on average almost one death per week (AIHW, 2017b). Staff may experience grief symptoms similar to family members, particularly if they were close to the resident or if the death occurred suddenly (Boerner *et al.*, 2015). However, LTC staff are often overlooked as requiring grief and bereavement support as death is considered part of their job (Marcella and Kelley, 2015).

Social impact of suicide bereavement of older adults

Suicide bereavement is different from other types of mourning (Jordan, 2001). These differences are present in terms of both the personal emotional response and the impact on one's social network – which, for older adults in LTC, includes not only family and friends, but also other residents and staff (Cerel *et al.*, 2008, 2018). Individuals experiencing suicide bereavement may have strong feelings of confusion, guilt and anger not always associated with the loss of a loved one (Jordan, 2001). Empirical evidence on bereavement responses to older adult suicides is lacking, particularly in how this may differ from suicide of younger people. However, research has shown that bereaved relatives and friends of older adults who died from suicide experience higher levels of stigmatisation, shame and sense of rejection compared with those bereaved through natural death (Harwood *et al.*, 2002). Suicide can also impact family interactions, with a lack of open

communication about the death and a heightened risk of suicide among family members, friends and acquaintances (Jordan, 2001). Furthermore, interpersonal interaction and social support is often problematic following a death from suicide compared to other types of loss, due to the social stigma that still remains (Jordan, 2001).

LTC institutions, distinct from other residential settings, have to contend with the fact that death is not uncommon; nearly 40 per cent of Medicare beneficiaries die in a nursing home annually (Teno *et al.*, 2018). Just as with other causes of death, residents in LTC facilities are affected by suicide deaths. In practice, residents are often not told directly about the death of a fellow resident, but rather hear it informally through word-of-mouth (Ball *et al.*, 2014). This lack of communication about death has the potential to be confusing and traumatic for other residents (Rivolta *et al.*, 2014). SAMHSA encourages staff and residents affected by a suicide death to openly discuss the decedent and to support each other in their grief, and advises facilities to name a specific contact that residents and staff can reach out to help cope with suicide bereavement (SAMHSA, 2011). These types of efforts emphasise empathy and communication, and can have a positive impact on the sense of community in LTC settings.

Implications for public policy

The goal of this commentary was to examine the societal, organisational and individual perspectives through which late-life suicide in LTC settings can be understood. We close with a summary on what we see are the main challenges for policy makers in preventing suicide among older adults in LTC, and make recommendations for cultural shift, policy reform and future research.

Societal

Studies have shown that public perceptions of suicide are generally not consistent with the empirical epidemiologic data (Morgan *et al.*, 2018). Increased public discussions of suicide among older adults, including among those residing in LTC, is required to address this misconception. Such discussions could be informed by media reports; for example, CNN published a comprehensive and thoughtful article regarding the suicide death of an 82-year-old farmer (Ravitz, 2018). Another example of a constructive public dialogues can be found in the Men's Sheds initiative in Australia (<https://mensshed.org/>), an effort that supports mental health and psycho-social wellbeing for older men as they experience transitions in later life (*e.g.* retirement, development of physical limitations) (Taylor *et al.*, 2018).

In addition, there is a need for community mental health campaigns and increased funding for suicide research on older adult populations. Public campaigns and participatory research initiatives should focus on changing public perception that not only is suicide preventable in any age group, but that it is worth preventing for all persons, including older adults living in LTC. Does the public tend to accept late-life suicide as rational and expected? Do these perceptions influence the culture, policies and practices of care? These challenging questions must be voiced for changes to start taking root. Both research and policy efforts should aim to

identify the nature and extent of the impact of ageism on suicide prevention among older adults.

Organisational

Suicide prevention in LTC is particularly important from an organisational perspective. Aged care is a human-made institutional system created and continually developed to support a natural stage of human ageing with due dignity, comfort and integrity. As such, it is imperative that this system be structured and evaluated to ensure it is achieving its intended goal, and modified as warranted. LTC staff and managers have a duty of care to residents, akin to the duty that any institution has to its constituents.

In light of the evidence that poor social support is strongly associated with suicide among older adults (Duberstein *et al.*, 2004; Mezuk *et al.*, 2008), active implementation of the person-centred LTC alternatives which emphasise social engagement and personal autonomy are worth exploring as strategies that can promote mental health and quality of life of residents, and potentially reduce risk of suicide (Araujo *et al.*, 2016). Researchers, providers and policy makers should work together to develop evidence-based guidelines and implement suicide prevention strategies based on PCC models. For example, in 2013 O'Riley *et al.* proposed a framework for assessing and managing suicide risk in LTC settings (O'Riley *et al.*, 2013), and in 2017 the state of Illinois developed policies and procedures for assessing risk and responding when a LTC resident expresses suicidal ideation (Illinois Department on Aging, 2017); these are welcome first steps towards recognising the role of institutions in supporting the mental health of residents.

In addition, researchers and clinicians should consider ways to improve the measurement of mental health and psycho-social wellbeing of LTC residents by incorporating validated measures of social engagement, social satisfaction and connectedness into assessments of both residents and staff (Chan *et al.*, 2018). Better data are needed to understand the links between organisational policies and procedures and resident mental health.

Individual

From an individual perspective, it is important to continue to engage and communicate effectively with stakeholders around late-life suicide and its prevention in LTC. This should include assessing the gaps in care identified by residents, family members and staff. For example, previous research has identified several areas considered important by older adults when developing practice improvements in LTC; these include a balance between maintaining resident's independence and autonomy (*i.e.* feeling at home and maintaining own hobbies and lifestyle) and developing a sense of community through interpersonal conduct between residents and care-givers (Boelsma *et al.*, 2014). Any changes to LTC policy and practice to prevent suicide must take into account the wishes of older people who will be directly affected and who are the intended beneficiaries of such change. Another concrete step would be to establish suicide bereavement support for staff, family and other residents. Through enactment of appropriate bereavement

policies that promote transparency and dialogue, grief interventions facilitate mechanisms for coping, processing and understanding intense emotions and fears around death and dying (Katz *et al.*, 2001; Rickerson *et al.*, 2005; Marcella and Kelley, 2015).

Implications for public policy

Suicide prevention and improvement in life quality of older adults in residential care through service provisions require implementation of new budget and regulatory policies. To facilitate a shift in policies at federal and local settings, it is important to conduct stakeholder engagement with residents, family members, staff, management and policy makers to ensure that any measures identified will be appropriate and feasible in a real-world environment. This has been conducted to an extent by consulting with individuals in senior management and policy positions to develop recommendations for prevention of suicide in Australia (Ibrahim, 2017) and as a part of Zero Suicide Initiatives in the USA (Labouliere *et al.*, 2018), but requires further research engaging with residents, their family and staff. Intuitively, this would be followed by strategy and policy development to prepare selected and stakeholder-approved strategies ready for policy enactment. The final stages involve policy enactment, repeated evaluation and implementation (*i.e.* drafting and passing of new legislation or internal process documents). This is likely to be a slow and incremental process and is heavily reliant on changes in community attitudes towards late-life suicide and end-of-life care, but fertile seeds planted through small-scale initiatives, growing research evidence on PCC and clear need for continuous improvement show promise.

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