and drug misuse. Such an approach would call for increased attention from sociologists, economists, clergy, educators and governments. In the defence of psychiatrists, in the psychiatric literature there is considerable interest in suicide prevention among people with mental illnesses.

De Leo sees promise for suicide prevention in antidepressants, functional neuroimaging and psychometric testing, but surely this would apply only in the clinical setting. It is important to reveal the alternative to identifying and intervening with people at high risk (which has been described as ineffective and even wasteful), that is, the public health approach, in which efforts are made to reduce the risk of suicide across the community (Rosenman, 1998).

De Leo, D. (2002) Why are we not getting any closer to preventing suicide? *British Journal of Psychiatry*, **181**, 372–374.

Durkheim, E. (1897) *Suicide*. Republished (1952) as *Suicide: A Study in Sociology* (transl. J. A. Spaulding & E. Simpson; ed. G. Simpson). London: Routledge and Kegan Paul.

La Vecchia, C., Lucchini, F. & Levi, F. (1994) Worldwide trends in suicide mortality, 1955–1989. *Acta Psychiatrica Scandinavica*, **90**, 53–64.

Rosenman, S. (1998) Preventing suicide: what will work and what will not. *Medical Journal of Australia*, **169**, 100–102.

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Author's reply: Sociocultural factors are of great importance in suicide, and the deliberate manipulation of the sociocultural milieu (social engineering?) would evoke a meaningful change in suicide mortality. However, this concept is theoretical and, like most approaches to suicide prevention among high-risk individuals, lacks rigorous scientific evidence. It is important to point out that while Emile Durkheim's theories have never been effectively refuted, neither have they been supported by convincing empirical evidence.

My main contention is that the prevention of suicide, like other types of preventable death, requires a multifaceted approach that should incorporate interventions specific to high-risk individuals as well as public health approaches. As far as I am aware, this principle guides all existing national strategies, including the recently launched National Plan in England (September 2002). There is little doubt that strategies exclusively targeting high-risk subjects would produce only minimal reductions in mortality rates. Dr Pridmore maintains that counteracting unemployment and drug misuse, and improving community cohesiveness, would be profitable approaches to population-based suicide-prevention tactics. Once more, although shareable on the basis of common sense, convincing evidence for the effectiveness of these interventions is non-existent. For example, I recently reported in this journal on the impact of a telephone support service on suicide mortality among the elderly (De Leo *et al*, 2002). The supportive environment provided by that service had a significant impact only among female clients. Elderly men, who suffer from far higher rates of suicide than women, reported very little benefit. Similarly, full employment would surely positively affect suicide attempt rates, but maybe not suicide mortality.

The multi-disciplinary approach to suicide seems to me the *conditio sine qua non* under which prevention of this human tragedy can be effectively pursued. Given their professional exposure to suicidal individuals, psychiatrists are often in a privileged position to positively interfere with a suicidal process. To do it more consistently and on a larger scale, they should contribute more to suicide research, particularly within multi-disciplinary teams in collaboration with psychologists and sociologists, demographers and anthropologists. Complexity of causes requires complexity of remedies; there are no short cuts.

De Leo, D., Dello Buono, M. & Dwyer, J. (2002) Suicide among the elderly: the long-term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry*, **181**, 226–229.

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I read De Leo's (2002) editorial on preventing suicide with interest. However, I would like to raise a few concerns. In spite of much development and understanding in both biological and psychological causes for suicide, the prevention of suicide remains an imperfect art. However, the comparison of suicide prevention with that of ischaemic heart disease seems inappropriate. The risk factors for ischaemic heart disease are well known, stable and quantifiable. Ideally, risk factors used for predictive purpose should be stable, whereas in suicide, clearly, most are not (Hawton, 1987). Therefore, when risk factors are not stable it will be difficult to apply the same analogy to suicide prevention.

The risk factors for suicide are different for community- and hospital-based populations. We have made progress in pharmacological interventions in hospital-based populations with lithium in bipolar disorders (Kallner *et al*, 2000) and clozapine in schizophrenia (Meltzer & Okayli, 1995), which have been shown to reduce suicide rates. However, the risk factors in community-based populations are different and a number of psychosocial risk factors have been reported to be significantly associated with the risk of suicide. We need to understand local perspectives and regional factors that influence suicide rates. There is a need for qualitative studies to examine these issues; the factors thus identified should then be explored in epidemiological studies.

De Leo, D. (2002) Why are we not getting any closer to preventing suicide? *British Journal of Psychiatry*, **181**, 372–374.

Hawton, K. (1987) Assessment of suicide risk. *British Journal of Psychiatry*, **150**, 145–153.

Kallner, G., Lindelius, R., Petterson, U., *et al* (2000) Mortality in 497 patients with affective disorders attending a lithium clinic or after having left it. *Pharmacopsychiatry*, **33**, 8–13

Meltzer, H. Y. & Okayli, G. O. (1995) Reduction of suicidality during clozapine treatment of neuroleptic-resistant schizophrenia: impact on risk–benefit assessment. *American Journal of Psychiatry*, **152**, 183–190.

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Author's reply: While the ability to prevent suicide is far less advanced than the prevention of heart disease, in my editorial the analogy highlighted the need for a multifaceted approach to anti-suicide strategies. I made the point that a single preventive measure would not be effective in reducing suicide mortality, as evidenced through the prevention of other types of death such as ischaemic heart disease. In the case of suicide, for example, the worldwide optimal treatment of depression would bring only a minimal reduction in suicide rates (further details available from the author upon request). None the less, fighting depression is generally perceived as the K constant of suicide prevention in existing national

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