THE PARLIAMENTARY STANDING COMMITTEE OF COMMUNITY DEVELOPMENT MET IN PARLIAMENT HOUSE, BRISBANE ON TUESDAY 15 NOVEMBER 2005.

INQUIRY INTO STRATEGIES FOR THE PREVENTION OF SUICIDE

PROFESSOR DIEGO DE LEO, PROFESSOR OF PSYCHOPATHOLOGY AND SUICIDOLOGY AND DIRECTOR OF THE AUSTRALIAN INSTITE FOR SUICIDE RESEARCH AND PREVENTION, GRIFFITH UNIVERSITY, BRISBANE, WAS CALLED AND EXAMINED.

CHAIR (Ms Thorp) - Welcome, Professor De Leo. Some of us were at a conference that you gave an address to. Given the terms of reference for our committee, which I am sure you are familiar with, we thought it appropriate that we meet with you and get your perspective on what we are trying to achieve with our committee. The outcome of our deliberations will go into a report with recommendations to the State Government about what action should be taken to try to make some impact on suicide prevention in Tasmania. I think if you could just give us the benefit of your expertise that would be appreciated.

Prof. DE LEO - You have to choose the style first - which button you want to press: the political or the scientific one.

CHAIR - The scientific one.

Mr WILKINSON - The sensible one.

Prof. DE LEO - The sensible one may be more political than scientific, so which one?

Ms HAY - We want to know how we can help, how we can be of the most use to the people of Tasmania. We don't want to hear what you think we might want to hear; we want to hear the truth.

Prof. DE LEO - The truth is that there is no truth, in the sense that research is vastly insufficient to draw conclusions and research so far has been very inconsistently funded and mostly medical, which gives you two biases. The first is that only the rich countries have done some research and that, of those rich countries involved, researchers were coming from the medical environment, which is mainly psychiatrists. I am a psychiatrist. What these could bring into the picture is a distortion in the sense that you are using a magnifying lens, which is a psychiatric lens, so you will find only psychiatric results. All other results will be undetectable to you, simply because we are ignorant in other fields. Even if there were striking evidences coming from the social, anthropological, cultural or whatever other environments, we were unequipped to clearly pick up these scenarios. Having said that, we need to be prudent and cautious in approaching a topic that is still substantially uncontrollable. We are certainly preventing cases of suicide because in our

work we are improving evolution, services and clinical and social expertise but we rarely know if we are really preventing cases of suicide because for us cases are dead individuals; live individuals make no numbers.

We have been unable so far to provide such research as to really be able to capture a rare phenomenon - because suicide is still a rare phenomenon, fortunately - that was needed to control if an intervention was by any chance more effective than another. To give you a dimension of the amount required, if you wanted to intervene on the general population level, which includes certainly cases at higher risk, you would need dimensions of 14 million or 15 million people.

CHAIR - The population of Australia.

Prof. DE LEO - Exactly. So nearly three-quarters of the population of Australia should be compared to a similar population - if your intervention to see whether your information would have provided a given result, which is unfeasible. Nobody does that. What very few, if any, have really done so far is choose high-risk people in relatively big numbers who are psychiatric patients. This is implicitly an assumption that we are making. We are changing in our work consideration of suicide in the evolution of humankind. Suicide was a merit a couple of thousand years ago, then became a scene and then a disease. So we have attributed to the same act Profoundly different meanings. Today's 'disease', which I personally doubt - it is more appropriate to say that it is associated frequently with a disease - but in itself suicide is a behaviour; it is not a disease or anything like that.

Ms HAY - You said something about it turning from a scene and then into a disease? What was the first perception?

Prof. DE LEO - It was an act of dignity, of heroism and even something permitted to dignitaries or priests - a person with religious capacities.

CHAIR - Is that where you would fit the Japanese?

Prof. DE LEO - The Japanese are still a different culture from ours. Their conception of suicide is quite different from ours. For example, if you want to rehabilitate your family for the misconduct that you were perpetrating before, suicide is an honourable choice and you have the rehabilitation of your family. You are certainly familiar that with the Japanese Mafia when you want to be forgiven for something, you give your small finger and put it in a silk handkerchief and give it to the boss or the person who has been injured by your behaviour. It is a different culture; it is very interesting. In our society suicide unavoidably brings stigma to the family. In the Japanese culture is starting to bring stigma, but in many cases suicide is still rehabilitating the family or the group of individuals from the fact of that bad behaviour. This is why suicide has been for a long time an act publicly performed. We certainly have read the reports of people making harakiri in a public square, or near a metro station or a train station. The public suffering - harakiri is incredibly painful - had a very important cathartic effect, something that may clean and clear all the problems in the family due to previous misbehaviour. So in anthropological terms there is clearly still a vast difference in meaning and attributions that can be given to suicide.

Mr PARKINSON - Can you just explain to me further the thinking behind your saying it is not a disease, it is a behaviour?

Prof. DE LEO - It is a behaviour, suicide. There are no diseases that directly involve or cause suicide. For example, this is one of the most common distortions that we have. In psychiatry we have at least two conditions. One is major depression, and the other is borderline personality disorders in which suicidal behaviour is quoted as one of the most recurring symptoms. But in major depression suicidal ideation is included as one of the most frequent symptoms. In borderline personality disorders, non-fatal suicidal behaviour, self-mutilating or repeatedly self-harming is one of the most common features. Now, in different societies these conditions do not even exist, so there is enough evidence to claim, for example, that in China, which is changing dramatically and is possibly one of the fastest running, progressing countries today, the prevalence of depression is much less, and still the majority of disorders are categorised as neurostanic forms, a definition that has disappeared from our glossary, which also means that in China there is much less attribution to mental disorders in the genesis of suicidal behaviour. I am not talking about Papua-New Guinea or another African or whatever aggregation, but I am talking about an important country with important differences.

Now, back to your question. There are no proofs, no scientific evidence literally, that any condition directly causes suicide. The idea that I just expressed, that it could be a medical distortion, is grounded on the fact that the vast majority of major depressed individuals do not commit suicide, do not even attempt suicide. The vast majority of borderline personality disorders do not commit suicide. So they are what we call false positives. On the other hand, there are quite a number of individuals free from any psychiatric conditions who in an instant commit suicide and they are false negative. We have not sorted it out as yet; we are still wondering how to better to categorise this. But it is reasonable to maintain today that in the light of these and many other considerations, it is simply a behaviour, it is an act. It can be impulsive, can be premeditated, but still it is an act that can be originated with many different intentions and with many different woes. Is that more clear now?

Mr PARKINSON - Yes, it is. Well, it is and it isn't. As you were speaking I was thinking of a couple of instances of people with whom I have been associated over a long period of time. One committed suicide after a long period of depression and treatment by psychiatrists which involved the administration of drug treatments - I think he even had that shock treatment they used to use. I don't know whether they still use that, but it did not seem to do him any good. Anyway, that is one case and I knew him personally. Another one in more recent times was a young fellow, whom I guess you would categorise as a major depressive type. He just seemed to be a young troubled fellow, who had has his ups and downs, was occupied in a job and was right for a while but then, for no particular reason, seemed to go off again into his own little depressive shell. That is why I asked that question.

Prof. DE LEO - There is no doubt that it is more frequent. Suicide is 10 times more frequent in the psychiatric population than in the general population. There is no doubt about that and clearly we are talking about the present society and a western society. In a normal western society these ratios are different.

Mr WILKINSON - Interestingly enough, I was in Fiji recently and I read an article in the *Fiji Times* where they were talking about suicide and looking into the same type of thing that we are looking into. The suicide rates in Fiji seem to be quite high, especially in the Indian population.

Prof. DE LEO - It is nearly 10 times higher than the native.

Mr WILKINSON - Yes. They are talking about the same things that we are. It was in the paper a couple of months ago.

Prof. DE LEO - That is the situation in Fiji, a group of islands - a beautiful example of a tourist paradise. The Indians have been there at least three centuries now and certainly you cannot claim that the prevalence of schizophrenia or, for example, another disorder is different in the two groups. Schizophrenia, for example, is present in every culture. Nevertheless, the prognosis of the disorder is different and paradoxically it is much better to be schizophrenic in Nigeria than in Australia because in Nigeria you would be supported by your family. Sometimes you will even be acknowledged as having magical powers and the capacity to predict the future and to foresee events but in any case there is a much better cohesion around you and the support that you receive is remarkable. In Australia you end up by being on the front page as a simple criminal or a dangerous person and so the stigma around you is immense. There are studies; these are not personal opinions. There is quite robust literature internationally.

CHAIR - If I understand you correctly, you are saying that diseases such as schizophrenia are ubiquitous so that they exist throughout all cultural groups all over the world -

Prof. DE LEO - They exist in every part of the world.

CHAIR - and whilst people with schizophrenia or other mental diseases may end up committing suicide -

Prof. DE LEO - Yes, but suicide amongst schizophrenics here is quite frequent.

CHAIR - it sounds more like the way people are treated than the disease.

Prof. DE LEO - Yes, exactly and suicide or schizophrenia in Indians of India or suicide in Nigeria - I am quoting Nigeria because it compares to an international standard - is much less frequent. So back to your point: it is not the disease that causes the behaviour necessarily; there are many other combinations that we should control in trying to contain or eliminate it. For example, to be very striking with regard to that, the available literature tabled by us is rich enough and convincing enough to show that when you are a member of the general community, the general population, the rate of suicide is 0.001. When you are a member of the psychiatric community so to speak, you have to multiply this number by 10 but when you are discharged from a psychiatric ward your risk of suicide becomes 200 times higher.

CHAIR - When the support mechanisms are no longer there?

Prof. DE LEO - No. I am leading a study funded by the Commonwealth now on examining the post discharge period for example and the rationale for doing this study is trying to

improve, with the available funding, the system and the many problems that there are in the post discharge period, so imagine this sequence: you are affected by something and you enter psychiatric care, which means that the prevention efforts and the community care, GPs, your family, et cetera, were unable to keep you in the community. You have some mental condition so your risk goes from one to 10, let us imagine for simplicity.

Then you enter into the psychiatric hospital ward, whatever, clinic, and you are treated properly and you are discharged because you are recovering. I am not being political. I am being very open and frank. Then you are dismissed but paradoxically instead of having your risk decreased to something closer to the one of the general population or at least to the previous level of general risk, your risk increases by 20 times, so what happens in between? Is it the disease that becomes much more dangerous? Not at all. What happens after the discharge are all psychological and environmental factors that can then become extremely powerful, much more powerful than the condition that brought them to the hospital. These elements are, 'Gosh, being in a psychiatric ward, what will people think of me now? How will they consider me? What about my family members? What about my mates at work? How will I be considered? What will be the outcomes of my staying in psychiatric care? Do I still have friends? Do I still make money? Do I still have a personal relationship? Do I still have sex? Do I still enjoy life? Are these diseases?' Not at all, these are simply manifestations of the living of an individual but they are incredibly important.

Ms HAY - Over what period of time does that thinking last?

Prof. DE LEO - It is very acute in the first month, it is very acute in the first three months and decreases. It remains acute for one year, which is the adaptation period. This is very unpopular. It is very politically incorrect to be told but this is the reality is.

Mr WILKINSON - What is needed? Obviously that is occurring Australia-wide.

Prof. DE LEO - This is the UK, the United States -

Mr WILKINSON - Western countries.

Prof. DE LEO - Yes. It is much less in the Latin countries but still very present.

Mr WILKINSON - Are you saying that no matter what support mechanisms you can put in place to assist, these people are still going to have those thoughts, or are there support mechanisms that you believe we can put in place to assist those people through the three months especially and then -

CHAIR - Post discharge.

Mr WILKINSON - Yes.

Prof. DE LEO - Well, clearly if the motives that I briefly explained to you are credible to your eyes, then the real change has to take place in the psycho-social environment, so what we call destigmatising mental disorders should be the imperative and certainly it is but how to do it, that is a different cup of tea. But clearly this would be the really important strategy. Personally, I don't believe we are able to do so in the foreseeable

future so the project that I am performing is: this is the money available; this is the mentality; this is the real world, let us try to implement correctives in the real world if it is possible. I have two chosen simple and apparently non-costly strategies.

One is to take care that the same case manager follows the patients for at least one year with face-to-face meetings at least once per week. Regarding the other, as I read in your agenda, the people at risk in Australia are indeed males aged from 25 to 44. These individuals, especially when suicidal, do not call Lifeline - zero. There are no calls from these people. Lifeline can claim the contrary but they don't call Lifeline, so 1 per cent of the calls relate to this particular population of people, so why not ask Lifeline people to call them, the patients? I come from a long experience. I believe Tasmania is doing one of my projects, the one with elderly people.

CHAIR - Yes.

Prof. DE LEO - Okay. I am coming from 15 years of experience with this. It has been very successful, not costly, et cetera so I convinced Lifeline on the Gold Coast to accept being given the names of the patients discharged from the psychiatric ward and to make two phone calls routinely to them. Instead of waiting for a phone call, the operator calls them.

CHAIR - Are those two calls weekly?

Prof. DE LEO - Weekly. These people need to have contact. They need, not a glossy brochure, but to be contacted, to listen to a human voice, be seen by a human face, someone that takes care of the mess that is normally in their homes and environment and helps them to reconstruct some sort of future. This has randomised control, which means that the patients are randomly allocated to the treatment as usual or to this intensive case management. There is no additional funding to this project, just more intervention. I am not claiming that it is miraculous, but at least I am saying it is possible.

Before starting this project, and being still very Italian in my thinking, apart from my accent, I was very astonished when doing the feasibility part of the study. I went through a number of the clinical dossiers of these patients. I noticed on a sample of 80 to 90 random patients, with 10 years of disease or at least of psychiatric stories on average, and just focusing on the 25 to 44 group - something in between, say 35 - on average of these patients received 18 case managers in their psychiatric life - 15 psychiatrists and 18 different case managers.

Mr FINCH - That is per patient?

Prof. DE LEO - Per patient. You have everything in this country; it is a fantastic country and we have first class assistants, first class public health et cetera. Certainly I can confirm that in this country there are beautiful documents, first class programs but the application is terrible. There are problems so entrenched with the culture that they are not immediately solvable. In Queensland - I don't know about Tasmania - you have 92 per cent of psychiatrists in private practice, so what do you do?

And then you have psychiatrists like me with a funny accent, and many others in public hospitals. I work one day in a public hospital to follow up my research projects and also

to understand the environment. The staff turnaround continues; people change positions -

Mr WILKINSON - Is that because of the job, though? We spoke with a psychiatrist in Hobart last week, or the week before, who really gave a very depressing overview of the situation in the Royal Hobart Hospital department of psychiatry. There was lack of numbers, lack of psychiatrists, lack of support staff, it seemed to me. The psychiatric patients are in an area which is certainly -

CHAIR - Less than salubrious.

Mr WILKINSON - Yes, it is not the Rolls-Royce of the hospital. It is a very poor area. And it just seemed to be this whole story of hopelessness, really. It was quite marked, wasn't it?

CHAIR - Yes.

Mr WILKINSON - I feel it has to change.

Prof. DE LEO - I don't know about Tasmania, but that certainly is true here.

CHAIR - Actually, when you said that, of your two interventions, one was to have consistent case management for 12 months, I thought, 'How on earth did you organise that?'

Prof. DE LEO - How?

CHAIR - Yes, because I come from an educational background -

Prof. DE LEO - I recruit the case managers -

CHAIR - And you make sure they stay?

Prof. DE LEO - Yes.

CHAIR - Yes. That is the difficulty, isn't it? When you are dealing with children, child abuse or even children having trouble at school for any reason, the staff turnover is such that that kind of continuity is very difficult to achieve, in my experience.

Prof. DE LEO - Yes; but the reality is that nobody monitors you. When you are discharged from hospital you are given the telephone number of a GP or maybe some psychiatric consultants - a private one, someone bulk-billing you, whatever - but still there is no one person who guides you or controls the process. You are told that there are case managers and they are well-prepared - I have nothing to complain about, they are beautiful people - but they change their position very often. And in any case the so-called treatment, as usual, is made up normally of three or four in-sequence encounters at the domicile of the patient. The contacts are via phone. Appearance at the domicile of the patient occurs only when there is an emergency. The public hospital clients are quite a different clientele from that of private hospitals, to be very frank. The most disadvantaged people going to the hospital: dirty, bad-smelling, of low education or whatever, but psychiatrists want to have blonde young girls, intelligent, witty, funny and making a lot

of money with easy patients. In the public hospital you have a tough job; you have very hard patients, very tough, sometimes very violent patients, but not because they are mad and bad, but because they are scared. A schizophrenic patient is terrorised, is full of fears. Then he becomes violent because the way you are acting increases his terror and his fear, so you are confrontational. With a dangerous schizophrenic patient, basically you should offer your throat and lay down and be absolutely calm and quiet with no fear, which is very difficult, I must admit. This is the way of dealing with them, because everything that you do otherwise is potentially dangerous because that is the way it is perceived by them. But anyway this is another topic. Yes, the problem is the management of public mental health. The big numbers of suicide in this psychiatric sphere comes from the public psychiatric sphere.

Mr WILKINSON - And because of that, is that why there is such a big turnover in your case managers? When you look at your family support case managers, they are fairly consistent. I know in Tasmania again there are support people in the family services who have been there for a long time, but in the psychiatric field there is this turnover, and you have probably just explained one of the reasons why.

Prof. DE LEO - Sure. You're more easily burnt out, you want to be there temporarily because the environment is not rewarding and the first occasion that you have, you go away. Being very clear about this, in community service at the Gold Coast Hospital there is not one Australian doctor.

CHAIR - Not one?

Prof. DE LEO - Zero. There are a couple of South Africans, which is better than being English -

Laughter.

Prof. DE LEO - a couple of Pakistanis, a Sri Lankan.

I am not claiming that you don't understand patients - this may be the case, by the way - or that the patient doesn't understand you, which is more often the case, I believe; the problem is that you have real problems in understanding the culture and in understanding the environment and the origins of a condition and so your reading of the situation of the patient may be very insufficient because of that. It is not just the medical skills. It is not ideal but this is the practice. Even in the hospital I am not aware that there are any Australians. So in the acute unit I am thinking, 'If we all became Australians', but we are not. The boss is a German and the other boss is a Russian. They are good doctors but nevertheless, success in the profession is choosing your patients, treating the easier cases and having a lovely lifestyle, which I understand. But, still, it is not ideal.

Mr WILKINSON - Do a lot of people do, like yourself, spend a week in the public system and have four days private or do the majority of the private practitioners spend all their time in private practice? What happens in Queensland?

Prof. DE LEO - As I said, more than 90 per cent are in private practice.

Mr WILKINSON - But do they still do a day in a public hospital?

Prof. DE LEO - No. If you are really successful, you don't even touch the public environment. It is habit more than the culture.

The other issue is that traditionally Queensland has been very modest in scientific activity in mental health. There are a few newcomers who have a reputation, but it has been really modest compared to Melbourne or even Sydney. Melbourne is the capital of psychiatry. Maybe the weather is too nice, the beaches too beautiful. I do not know what it is but this is what it has been so far.

Ms HAY - With the study that you're doing - the case study officer staying with the person for a year and making two phone calls a week - has that started?

Prof. DE LEO - No. You have the guarantee that the same case manager will follow that patient for one year. The guarantee comes from the fact that we are providing the funding and we have recruited the case manager on the basis of this commitment. Then the Lifeline people receive the name of the person to be called by the Mental Health people. They commit themselves to call this given person at least twice a week.

Ms HAY - So that can be a different person each week or each month who is making the call?

Prof. DE LEO - It could be, but they have to pay attention that this doesn't happen. I must admit that this is the part that is not very functional.

Ms HAY - At first I thought it was the actual case study officer who made the phone calls and that year-long commitment to one patient might be in November and then there is another one in December so all the patients do not come in the same month so it could actually lead to an 18-month stint and then there is holiday time and family time. I am wondering how someone else can be inserted there to fill that void and to keep the rapport with the patient or the person who needs the assistance.

Prof. DE LEO - You know that Lifeline is made up mainly of volunteers so there are people who are genuinely interested in the study and want to be part of it, so they try their best to be the same caller for that individual patient. But the problem of the turnaround is of course affecting patients also - many patients move, change address et cetera - and we have agreed that the Lifeline callers make three attempts per patient. After that they are passed to the subsequent scheduled telephone caller. It is not the ideal. They are not making 100 phone calls, desperately trying to retrieve the patients, but still, it is what we agreed.

Of course we have all different motivations so you cannot pretend that people have your own motivation or share your visions.

CHAIR - It strikes me that you have got a group, if you like, someone has come into psychiatric care because of an illness, whether it be schizophrenia or whatever, they have been identified and the work that you are doing is about trying to find out the factors that may lead that person to suicide post their psychiatric treatment. They have been identified. What about all the people out in the community who do not have a factor like a diagnosis of schizophrenia that alerts people to that potential?

Prof. DE LEO - You mean when there are warning signs, what to do with these people who are not psychiatrically affected?

CHAIR - There are people who have had a psychiatric illness and have been identified as someone who may potentially suicide if the conditions after post discharge are not good, so you can see a possibility there, but it seems that people almost randomly in the whole community sometimes commit suicide.

Prof. DE LEO - Yes, absolutely.

CHAIR - I am wondering about that.

Prof. DE LEO - How to pick up these people?

CHAIR - Yes.

Mr WILKINSON - There have to be some signs though, do there not? Not with everybody, I accept that, but do you believe that the majority of people who do commit suicide have a sign that if people were better educated they would be able to pick up on?

Prof. DE LEO - Of course we have all worked on the so-called warning signs and we have made also educational programs. We have even made public campaigns with this in mind but I am not sure that the results are convincing. First of all warning signs are post-talk warning signs in the sense that they are much more detectable after the events than before.

CHAIR - Hindsight is a wonderful thing.

Prof. DE LEO - Yes. The second fact is that there is a risk of talking too much about suicide but still the dimension of this risk is not unequivocal; it may change from environment to environment. So there may be societies in which it is better not to talk about it and other societies which are different or even favour talking about it.

Ms THORP - And age groups, I imagine, too.

Prof. DE LEO - And also age groups and also genders.

Ms HAY - It is hard to destigmatise it then, isn't if, if we don't want to talk about it?

Prof. DE LEO - Well -

Ms HAY - If it is to be.

Prof. DE LEO - The problem is that it is very difficult controlling, for example, the media because the media are commercial enterprises. They want to have success, which means attention, copy sold broadcasting, being seen by people et cetera. You have seen the package that the Commonwealth has created - this beautiful first-class document - but it has changed all this in the country? I doubt it. You will see on the front page the place from where the young fellow jumped or the tree, then the face, then the house and then

the friends mourning et cetera. The only success was that at the end of each article now there is something about Lifeline - a helpline who are ready to listen at those numbers. This was a step ahead, by the way, but it will be a very long process to use the media in such a way that they can favour suicide prevention. Of course they are powerful for the negative but they must be powerful also for the positive, and the positive should be, for example, defusing - creating the mentality that suicide is the solution found for a temporary crisis. So suicide prevention is based on the idea that suicide is a crisis in the life of individuals. Once the crisis has gone or has been successfully counteracted then the danger decreases. So there is an acme, an acute stage in which an individual is acutely dangerous, but then if you are able to intervene and pull through, the crisis expires and the danger goes down again.

We may even conceptualise different models, of course, but this is the most common model. If there is a message that there are people out there able to understand and to help, that there are many other options cognitively, that there are alternatives, that there are other solutions, that there are places where all sad persons may meet and stay together and share their despair or sadness, that there are places in which are people who do not believe in anything in their life and feel are hopeless may meet and go and help each other - self-help grouping - then you offer powerful messages to prevent suicide.

For example, one exercise that people who approach this build-up should do at the very beginning would be just considering the listing of countries from WHO to see the rates of suicide that the different countries have. This is amazing because there are huge differences from country to country in the rates of suicide.

Ms THORP - That suggests that in different cultures, when someone - and it could happen to anyone - has that acme, that crisis moment when suicide is considered as an option, then it is differential as to whether or not that option is taken up, if that person has other supports or other options or there is an intervention right then and there which says 'No, you don't have to do this. There is something which you can do.' Am I hearing you correctly.

Prof. DE LEO - Yes.

Ms THORP - There was a fellow we spoke to in Launceston a while ago who works very much as a youth worker, and he suggested that if someone had someone to love, something to look forward to, something to do and something to believe in, then they were much less likely during that crisis situation to consider suicide an option. Would you go along with that?

Prof. DE LEO - I agree with that, sure.

Ms THORP - So it really comes down to that person and their own strengths, weaknesses, supports, family, job and where they are as a person, whether or not they jump over that crisis moment and go on or whether they say, 'There's no way out. I may as well suicide.' So really we are not dealing with suicide, are we? We are dealing with people's personalities, their social life, their home life and whether they are happy people.

Prof. DE LEO - Yes, but you are all politicians, all in charge of community, so the question that you would need to answer is what can be done in our position in this culture, with

this human material and with the existing loads and environmental factors, because certainly we cannot convince people to love each other. We cannot convince people to get married and have children. Children are a very powerful protective factor, but if people do not have children, what do you do? One of the missing issues in suicide research is the role of protective factors. For example, what is really important? Is it important to have a vast social network? Apparently, yes, but what should be the intensity of liaisons? To banalise the issue, is it more important to have 15 acquaintances or one good friend? There are no mathematical rules for those things. And is it more important to have a couple of good hobbies, or a rewarding profession, et cetera? It is complex. That is why we are not progressing very much in this domain, because we are continuing with the same line of research, and adding other disciplines to this line of research is quite difficult. Honestly, for me to work with a sociologist is difficult, but I have a PhD in social sciences, so despite my condition, for me reading a sociological article is still something difficult, and reading a psychiatric article or a psychological article is normalcy. Again it is necessary that I marry up with some sociologists, anthropologists, ethicists and theologists et cetera, because we need to conceive an environment that fills the many gaps that we have in our society, at least in conceptualising models.

So if you read some projections for sociology for the future, you would be amazed by what is predicted for future society. Talking about 2050 on, for example, people are divided into major clans and major tribal aggregations, so that the traditional model of family is the first thing to end in some way. The clan model is something that attracts most of the attention. There are other sociologists that think that we will have aggregation of 100, 150, 200 individuals with internal leaders et cetera, in order to cover the costs to live in a society that is much more flattering - but these are models.

CHAIR - I always knew the hippies would rule!

Prof. DE LEO - It will be quite different, we will need more protecting perhaps. Who knows? To draw a line on this again if you continue to seek just in one direction you miss the entire picture so you cannot control. You have heard about social engineering, for example. Social engineering means more defined, something in society with well targeted actions. This is possible. The information behaviour science is something that is used by the market companies to influence you to buy this or that product, to create a trend and then to oblige you to buy that bag instead of the other, that make-up instead of the other and so on. This is the product, certainly not of a random action but of a strategic line of development. Why do we not do it in suicidology which is much more important than anything else?

For example, why we have in this country males committing suicide four times more than females or nine or 10 times more when they are very old or five or six times more when they are very young. We have men relatively unsettled and females oceanically pacific - in the real sense because women are winning. They are dominating, believe it or not, which means that women are much stronger than men. This is a personal opinion; these trends are really visible for a newcomer in this country. Also visible is the difficulty that men have in this country which are not common at all in my country of origin for example or most European countries, so you have these extremes in the suicide rates that probably are shared.

In Tasmania you have traditionally quite high rates of suicide but you have a smaller population than Queensland. Your rates are normally 20 or 30 per cent higher than the average Australian population. I am not sure about your men in Tasmania but I was told that there is the same problem that we have here in Queensland and so youth is a critical age, very critical. Old age, particularly extreme old age, is another critical age but these are not making the big numbers. These are a few cases. The big numbers are here in the 25 to 34 age group. Here are the big difficulties which means separation, unreached financial success, isolation, shame, sense of diversity, sense of failure, all this stuff. The difference for a culture such as the Anglo is that you do not talk to any one so you are not communicating. You can talk, you can ring a friend only if you have something good to tell to this friend but if you feel a mess, if you feel a failure, if your girlfriend or wife or whatever has left you and if you have difficulties with payments, if you gamble, if you drink et cetera, and you are not talking to anyone, then suicide becomes a very attractive option because it is an escape from an unbearable situation. People are not trying to prevent suicide at that level because these would be an intrusion in the life of another individual. The framework is the 'non-catch' culture, which is very respectful of the other people's space, so we have to be realistic and go back to the physical things. In my view, some social engineering, targeting these main aspects, can be done. I don't think that it is the word of God that we don't have to embrace each other, for example. I don't think that it is the word of God that we don't have to tell others that we are a failure, that we feel horrible, that we are unable to do anything good, that we have no worth, et cetera. We can say these things to people and people may accept us anyway. We don't all need to be successful, beautiful, rich, full of muscles, et cetera. We don't need these things and we can have a life that is equally rewarding.

Ms THORP - So working very hard with the perception of young people as they are growing up would be a good idea, encouraging communication or trying to break down some of the gender stereotypes in school, things like that could be useful, I would imagine.

Mr WILKINSON - In my old uni days I always used to look for the nutshell versions of books or whatever, which were a really good assistance to me in writing papers because you hear the overall picture and then they normally used to target the areas that you had to write about in exams. We have to write this report, so can I just run you through the terms of reference to have nutshell picture on each of the terms reference? The first one is the role of non-government organisations and other community and business partners in progressing suicide prevention in Tasmania. What would you say to that?

Prof. DE LEO - They are crucially important in the scenario. Who else is doing this job? It can be a men's association, Relationships Australia, Lifeline or it can be whoever, but otherwise who else is doing things?

Mr WILKINSON - Would the first step be to identify the groups out there in the community doing those things to make sure you don't duplicate what they are already doing?

Prof. DE LEO - Look, we are not doing too much so we can stand the risk of duplicating things, honestly.

Mr FINCH - Where do you work on the Gold Coast - with Lifeline - how many clients would you be dealing with in that program?

Prof. DE LEO - 120 at the completion; 60 per group.

Mr FINCH - Is it too early in your studies for us to make a recommendation that that should be duplicated? Do we need to have a look at your studies and see the results that you are trying to achieve there, or is that a recommendation that we could go to Lifelink or Lifeline in Tasmania with?

Prof. DE LEO - We have sent an intermediate paper to a journal two weeks ago and it contains 60 cases. The paper is not conclusive in regard to the real impact of the study but it provides some interesting indication. The interest in this particular study is justified by the fact that one of the limits of research into suicide is that normally it does not include serious cases of suicidality, because you never obtain ethical approval for them. For example, even with drug trials, you don't include in your trial people who are seriously suicidal, so this basic element of research is missing. I am not sure if you are aware of that. One of the reasons why we are so laid back in the research is that there are ethical implications. One of the good aspects of this post-discharge therapy that I mentioned to you is that it is a real-world study. They could not avoid giving me the ethical approval because this is what happens in real life. We are taking the patients unselected, so all classifications are included. The patients we are not enrolling in these studies are mentally or physically impaired. We have severely psychotic, severely manic, severely depressed patients in the real world of a public hospital.

The other side of the coin says - and this is one of the interesting parts of the study - that the majority of these real-world people drop out from your care. One of the motives for this dropping out is investigated in the paper. There are many different factors: moving closer to family members or friends; the prospect of a job; no money; better marijuana; less control; a secluded environment - whatever motive. There are many motives. I did not consider before that someone might move because there is more available marijuana, or because there is no-one around, for example, which is hard to believe for an overcrowded country like Italy where it is impossible to be alone. Quite a number of people move to the cottage that is there, where there is no-one to complain or control them. They can scream, shout and do anything, so that is one of the motives. In some regard it provides a picture of the clientele of the services, which is really a difficult clientele. They are extremely difficult and very diverse from the ones in private practice where your patient is clean, well-dressed and going to the nice office with their car et cetera. At the public hospital there are people without cars, no money, no food in the fridge, drinking a lot, sharing premises, sexual promiscuity et cetera. These are the majority of our clients.

Mr FINCH - Can we get a copy of that report?

Prof. DE LEO - I sent it to a journal, understanding that they wanted to publish it. Do you want a copy of the paper?

CHAIR - That would be great.

It seems to me that we are dealing with two quite discrete groups here. One is the group of people who may or may not commit suicide after psychiatric treatment, which you are dealing with specifically with in your research, and then there is that amorphous group in the community who may or may not, for whatever reason at some time in your life have

a crisis situation and consider suicide the only option. It is quite distinct, isn't it really, in a way?

Prof. DE LEO - It can be the same actually. As I said before, unfortunately it is very difficult to predict suicide so you have all types of people committing suicide, that is why there is no profile for suicide, and even if you reason in microterms so we choose the epidemiological characteristics that are most frequent in individuals, your main area, for example, is that it is characteristic to a group of elderly males who are depressed, widowed, alcoholic, who have the highest concentration of risk factors, the problem is that if you have five of these people you know that statistically one will commit suicide. The problem is that we don't know which one of the five and these are the limits of our knowledge.

Ms HAY - In Tasmania we have a network called Women Tasmania. It is more or less a place where women can go for a whole host of reasons and be referred to other services, or just to talk, but we don't have a Men's Tasmania and a few people have mentioned this. Mary and Chris have been in Launceston for years and years so they have a great rapport with the people coming in. If we had two people, possibly men, who had a business like that, do you think that people who are close to suicide might - because Women Tasmania is well known - walk in and have a conversation with somebody and maybe then be referred; do you think they would take that first step to seek help before trying to commit suicide?

Prof. DE LEO - Surely not because they will be people from this culture and this environment. What you can hope to achieve is to create a network of informants, collectors that is able to push those individuals towards accepting groups of people. You need to create gatekeepers who may collect information around those individuals at risk or in need and may address them and channel them towards these groups, for example, or these centres or these aggregations of whatever colour, kind or religion. It doesn't matter.

Ms HAY - It is always open; it is very casual. You just go in there and chat. So you are saying that a man, possibly between 25 and 44, wouldn't be likely to wander past and see what help is out there? They wouldn't access that?

Prof. DE LEO - No.

CHAIR - What about educating existing networks that men have, like the pub, the football club, and possibly identifying people who are interested in finding out more about suicide prevention?

Prof. DE LEO - You can do it. For example, in Scotland they have created mats for the beer glasses with a logo for an association for suicide prevention. A number of pubs have these and you drink and you see what is written on the mat and may discuss that.

Certainly the pub is the place where people go to learn about strong people, not to learn about weak people, so the shift in the culture should be an insistent and continued stimulation to reverse slightly the culture or at least to instigate some different way of thinking.

For a couple of years I am dedicating some of my time to information behaviour, which is completely new to me and very fascinating. All public campaigns that last six or eight spots are doomed to fail, so to have success you need to bomb people for ages. Then you can obtain something, and possibly with different means, not just television, but television must be accompanied by the press, and the press by some poster, and the poster by some talk or some event et cetera, so it must be a constellation of stimuli that bring individuals to feel that they are part of the system that is normal. Otherwise it is perceived like an isolated experience that you can accept or deny. These are standard rules for everything, be it a detergent or suicide prevention.

We spent $3 million or $4 million for the domestic violence campaign, but it was a series of television spots, period. Not much more has been done on that, and that is an important issue. This type of behaviour should be avoided in the future, not that we do not need to talk about domestic violence, but better, in a more articulated way, in a more comprehensive way, and certainly we need to do a better anti-suicide strategy, because we are spending money on that, but I believe that very few people have the idea of what is really happening with this national strategy and what could be a legitimate expectation out of the strategy, because the strategy is touching very few people.

Mr WILKINSON - I am still searching for the best way out for Tasmania. If I was, let us say, the Premier of Tasmania and came to you and said I want you to devise an anti-suicide strategy for Tasmania, what would you do?

Ms HAY - At least the wording was different.

Prof. DE LEO - Sorry?

Ms HAY - Jim asks the fix-it question every time.

Laughter.

Prof. DE LEO - I think that I would spend a lot of time in studying Tasmania first and studying the positive and negative characteristics of Tasmania, the future that Tasmania offers and all these things which I am not really aware of at the moment, and then the peculiarity of Tasmania and the differences between several other States or comparable States around, even geographically. It could be, for example, that Tasmania is very similar to Chile, and you may say this Professor De Leo is really crazy -

Mr WILKINSON - My son is going out with a Chilean girl.

Prof. DE LEO - The comparability is important, because there are geophysical phenomena that still have a role, believe it or not, and there are also geomagnetic phenomena that surely have a role but we are absolutely not controlling them. So there are factors beyond everything that we control that have an influence that is not detected. After that, I would like to know how many people are really interested in that, how many people are forced to be interested, and how many people regret being forced to be interested, because every application or every implementation could be well received or rejected and then you have to fix a target in your strategy. A target may have a duration well beyond your particular mandate, which is one of the traditional obstacles in suicide prevention. For example, you want to last 300 years but you can't and the strategy has a

duration of 500 years. Then you say, 'It is better that I pay attention to trees or fisheries because they are more worthy or more physical? Because you implement something today, you see the fruits of what you have done in a 10-year period, and particularly if your intervention is at the social level, which is clearly of crucial importance, you have to wait for what you have implemented, you have to monitor what you have implemented and evaluate - which is something that is never done properly. Then basically you have to create a routine out of that, which is something that takes time, particularly if you wanted, for example, to conceive something like a men's club or men's institution, before it has been accepted, been in operation as a positive element for asking people takes a substantial amount of time. As a general principle, you have to frame your mind in a way in which you need to be serious, you need not to be in a hurry but to be deep with what you do. You need to know your territory very well, which means knowing where the devils are -

Mr WILKINSON - It's getting harder to find the devils.

Prof. DE LEO - and then act in such a way that envisages from the very beginning a certain time frame with a number of procedures which are a correct implementation, an evaluation of the process if correctly implemented, an evaluation of the initial results, continuous monitoring of the results to assess the effectiveness of the measures which takes time. First of all, you have 50 cases of suicide on average per year. That is a very small number; an unbearable number of course but still it is a small number in epidemiological terms. To verify that your trend diverges from the other trends, it takes quite a lot of time - at least five years. This is the minimum amount of time necessary for this operation.

In general, you need to act on two levels. You need to act on the general population level and high-risk people. The general population is the most effective level; the high-risk people is ethically unavoidable, so you have to intervene on those people as well. You have to choose well your high-risk group well, knowing that you are not looking for big numbers. The big numbers will come from the general community but, nevertheless, clearly identifying your youths, elderly, jail inmates, gays and lesbians, unemployed, psychiatric patients, post-discharge patients, alcohol-abusers, drug abusers, gamblers et cetera. So you have a number of targets and then you have to control these people by mapping them and making expectations. Mapping means literally I have, for example, 25 out of 50 patients of a psychiatric condition in my 50 cases per year. How many psychiatric patients do I have? And you have to know that. When did they start their psychiatric career? What are the events that create more of these coming forward in the community? Is it possible to control them at the entry of the school system, for example? This is something that we should do. We should have screening in schools because it costs nothing and is very effective. You should train your school teachers to - I wouldn't say 'identify mental disorders' because that is not their role - at least identify signs of deviancy in broad terms. 'These scholars are not performing well because I have the impression that there is this and that'. Then you have the school counsellors who normally do very little. They can be trained better to cope with these problems and rescreen subjects when it is appropriate.

So you have a way of controlling people. It is bad word 'controlling' but you have a monitoring of people and you put them in the condition of learning by themselves, for example, what is happening to them and what is positive or negative. Then you have

people who enter the autonomous line of society with a background that is already controlled, so they may be assessed as requiring extra attention and extra support for example, with people who understand and are in the position of helping others.

One of the projects we started to get involved in is with pupils acting as ambassadors. There are many beautiful young boys and girls who have prominence for social interaction, social attention and social soul and these people can act as the detector of suffering and match, for example, the role of the counsellor in schools. They would not be spying but becoming a point of reference in their class, being the one with whom it is possible to speak - because one of the traditional problems is that you have a youth having a problem but not talking to you. They are talking to another youth but not to you, not to their counsellor. So the introduction of these school ambassadors is grounded in research clearly indicating that self-harming people - just to tell you what I know in my field but there may be many others - talk with their peers but not with their GPs, very little with their family members and not at all with help lines or other institutions.

So here in Queensland in a large centre of 4 000 individuals, we have 82 or 83 per cent of people talking only with their peers on important matters, those connected with the self-harm behaviour. So it would be at least unwise to neglect this dynamic and then we will need to adapt our intervention knowing the territory. The territory is based on that relationship. But then if you follow your individual from the school system on and if you create an appropriate network of detection, of gate-keeping et cetera then you have the possibility, in due time, to pick up good results. Islands have big chances because they are more controllable. The size of the Tasmanian population is ideal with half a million inhabitants.

Mr WILKINSON - Should there be funding for research like you have spoken about within Tasmania because, as you say, it can be a litmus test -

CHAIR - What sort of answer do you expect to that?

Laughter.

Mr WILKINSON - Obviously, yes, there should be more funding, but what would be the approximate cost of that funding, in your experience?

Prof. DE LEO - It depends on what you want to achieve. Do you want to compare, for example, a community which is the treated versus a community which is not treated? That is possible, so the Commonwealth has been examining a proposal for three years now of a community-controlled trial. I haven't understood why they are so lazy and making delays but a community could be, for example, targeted by all interventions which have been funded within the current national strategy.

CHAIR - Who came up with the concept? Whose idea is this proposal?

Prof. DE LEO - It was mine.

CHAIR - Okay.

Prof. DE LEO - That is why it is still there.

CHAIR - So where is the proposal? Where has it gone to?

Prof. DE LEO - The national board.

CHAIR - Okay. Is this the NHMRC?

Prof. DE LEO - No, it is the National Council for Suicide Prevention. We have declining rates of suicide in Australia and of course this is a very fortunate circumstance because there is a national strategy and there is automatically a decline in the rates of suicide. It is fantastic for politicians. What about next increases in rates of suicide? That is where we risk it.

CHAIR - We blame George Bush for that. It is quite feasible, isn't it, that with this current environment of fear and the rest of it that there would be that kind of rise.

Prof. DE LEO - Okay. I have no political mind so I don't know about things of this kind but I understand that it is an excellent idea. In any case, the proposal is this: imagine that some of you are claiming that the strategy was effective, so let us measure this information in a controlled environment. We have interventions for the elderly, for indigenous people, for youth, for gays and lesbians, for the unemployed et cetera. All this kind of information is concentrated in a controlled community. Then look outside at another community that is free from intervention unless already in operation. Then, after one year or two, you see if there are differences in terms of completed suicide, attempted suicide and suicide ideation in the population. How can you do that? Through a community survey. The cost of this operation was $1.7 million for two communities of 260 000 inhabitants, so that is not an unbearable cost if you consider that we are investing $10 million per year in suicide prevention.

Ms THORP - Had you identified the communities?

Prof. DE LEO - I have proposed several communities, but for one reason or another the study is still there.

Ms THORP - You would be aware that Tasmania is considered a really good spot for epidemiological work, wouldn't you?

Prof. DE LEO - Yes. I was in contact with one of your fellows, Martin Harris, and I believe that he is involved in the study of the elderly, that he is interested also in this kind of study, but you can identify the communities. This has been approved by the members of the board but not funded. But you need to do these things, otherwise you will continue to spend money and you do not know if you are doing any good, if you are wasting time and taxpayers' money et cetera, or even if you are harmful. You do not even know that. If you don't rigorously control what you are doing, you may repeat old mistakes and continue to do so for the sake of doing something.

Mr WILKINSON - I would like to have as a recommendation, and it is only a minor tip of the iceberg, I suppose, but you need more experts in the area. That is my belief, that is why I have been travelling from one end of the country to the other, to get your advice, and that is not to say there are not the experts in Tasmania. But it would seem a good

idea, I think, if a scholarship was offered for somebody - and I am just putting up a name now - like Renee Woodhouse, who works with Wendy Quinn in Tasmania, who seems to have an interest in the field. What I would like to see is a scholarship, say, for her to come up here if possible and be involved with your at the university for a period, whatever it might be, one or two semesters, I do not know, but I think that would be of assistance. Do you believe it would?

Prof. DE LEO - Absolutely.

Mr WILKINSON - As you know, now there is the intervention into society of those people - in Tasmania we had the Royal Derwent Hospital - but there would appear to be some need, from the evidence that we have already, of not a Royal Derwent Hospital-type facility but some type of facility to house these people for a period of time, maybe as a post-intervention thing after they leave the Royal Hobart Hospital, after they have been an inmate for a short time to get treatment. There seems to be a need for a place to house these people for a period to make sure they have -

CHAIR - There is no halfway house set-up. You're in the psychiatric ward and then you're out.

Mr WILKINSON - Yes, to make sure they take their medicine, that they do have the support, that they can ask questions if need be, or people can ask them how they are feeling et cetera. Do you think you need that halfway house and, if so, how would you set it up?

Prof. DE LEO - I am Italian, which means that I had only one year of a psychiatric hospital in my career. I graduated in 1977, I spent one year as a doctor in the local psychiatric hospital, and I will never forget it. It was a huge psychiatric hospital in Padua, northern Italy, which has a very famous university and a huge 3-000 bed psychiatric hospital.

Prof. DE LEO - We had the reform in 1978. The reform was to shut down the psychiatric hospital and start with community services. It was traumatic, particularly in a city like Padua, which promoted 'democratic psychiatry', as it was called at that moment, this revolution in the practice of psychiatry. Of course, any time that you change things there are people who are enthusiastic and people who are very opposed. Of course it takes time to enter into the mentality of it. The first years were characterised by a very strong debate - you have increased the number of suicides, who takes care of these people, they are sleeping in parks, and all this and that. But after a few years, Italy suddenly became not only the country where you eat well and there are beautiful women and cars, but also the country in which there are beautiful psychiatric patients, so we were being visited by an enormous number of incredible scholars.

The community saw this and, as articulated at many different levels, one of the crucial steps, which has not yet been received properly here, was to construct houses for these people. These special houses, 'protected nests' as we called them at the beginning, need to be serviced by someone - controlling compliance to treatment, controlling the general characteristics of the environment, the hygiene, proper manners et cetera. This is of crucial importance, particularly in the transitional phase when you have old patients in a new reform of an old environment for an old audience, an audience that is reluctant not to

marginalise these patients but to accept them back into the community because they are potentially causing troubles, or so they believe.

So you have to create those opportunities in the situation that may guarantee that the transition is lived properly and successfully, but you do not have such houses or apartments here at all. There are private institutions or non-governmental entities that provide some logic to people and some good care, but they are cases, they are rare events and in any case people have to pay even if you go to the Salvation Army. So a few dollars but they need to be paid and in those places you don't have to pay anything so you are just a patient in the care of the public, the government, but you live better and you are given all the opportunities to handle the problem. So now in Italy we are now closing these nests because the new patients are much younger than those who entered in the system already prepared to figure out the community services required. They don't have to be transitional ones, you understand. It is now common, for example, for the psychiatric beds, of which there are 15 acute beds for 100 000 inhabitants, to be empty, which means that the network created at the community level works well enough. Of course there are differences in Italy because the north works in a very different way from the south of the country. There are differences and that is clear.

Mr FINCH - We don't have that problem in Tasmania.

Laughter.

Prof. DE LEO - I can't see any other options. I certainly am not in favour of reconstructing psychiatric hospitals. You want to go back to the community. You cannot put them in institutions again.

Mr PARKINSON - In your experience, how much actual research is done into the successful cases - that is, those who have suicided? How much analysis or research into individual causal factors is actually done?

Prof. DE LEO - I can send you a paper which describes the best research into suicide. You will see from this paper that nearly 100 per cent of research is done in two countries - the United States and the UK. The United States does two-thirds and the UK does the remaining third. This means that we know very little from other countries, including Australia, which has not produced much research into suicide. Australia is not the same as the United States, which means that you cannot transplant American projects directly to Australia. You need your local projects because your community is different. You cannot implement a British strategy in India or China, say. Despite this principle, it is widely accepted that there is always reluctance to fund research locally. The money available is limited because there are other priorities, personal agenda et cetera.

My personal opinion is that we are far from being considered serious in suicide prevention. If your question is how much research has been done in this domain here, it is very little.

Mr PARKINSON - This is not an area that I've ever thought much about. I am thinking in logical terms; if you don't know why people end their lives then it must be very difficult to develop a strategy to prevent the occurrence. If I can draw a parallel with road accident research, academic researchers in institutions such as Monash and all over the

world, researched individual road accidents to work out how it happened, why it happened, why this situation was different to another, and then out of that the general trend is to develop road accident prevention policies. I am not saying it is going to work exactly the same with suicide, but I think if we knew why in Tasmania, or even in parts of Tasmania, individuals were ending their lives then there might be a way of preventing it. I was just sitting here thinking that it would be valuable to know in a historical sense and to be able to group people. We have 100 people jumping off the bridge in Hobart every year -

CHAIR - No, that's a myth.

Mr PARKINSON - It is not a myth at all.

Mr FINCH - No, it is six since the bridge has been built.

Mr PARKINSON - That is not what the police tell me. You may have looked into it further than I have.

Mr FINCH - It is six that they know of.

CHAIR - We will argue about that later.

Mr PARKINSON - Anyway, I think I made the point. In other words, I have been sitting here wondering how much value there will be in a study of other cases to either try to work out -

Prof. DE LEO - Of existed cases?

Mr PARKINSON - Yes, the ones who have ended their lives. In other words, there are familial factors; there are all the factors you have been talking about really.

Prof. DE LEO - An historical reconstruction is always of value, I believe. I believe that you were visited last year by an American writer who was writing a book on the history of suicide and came to Tasmania because Tasmania for a long time has had quite a high rate of suicide. He wanted to understand a bit more and came to visit a colleague at the university, in the history department, so he had access to an archive. I don't know how it has done because I haven't seen it but there was a collection of cases. I should find the address of this man.

Certainly it is essential to know the territory and essential to know the stories of these people. One factor that should not be neglected is that in a place where there is a high number of suicides, there is the tendency for the suicide rate to remain high in that place because it is a tradition, so there is the acceptance of the fact or even the pushing towards a certain behaviour. Even in Australia there are a couple of places with very high rates of suicide but there is a very small population and it is clear if there is a modelling of the behaviour of members of the community or if there is some genetic or other influence but nevertheless there are still places in which the frequency is three, four, five times higher than the general population.

In every country of the world there are these places. We normally define them as places with a tradition of suicide, which means that this is a habit which is accepted. 'If I was in those circumstances I would commit suicide because this was done by my father and my uncle' or my grandfather and 'other people that I respect and they had a reputation and nothing happened' et cetera, and this perpetuates the behaviour.

Probably this is a component in the higher rates of suicide in Queensland and in Tasmania. The frequency of the event feeds further frequency and so to have a sustained effect we need to have prompt action.

CHAIR - We are looking at that age group, 25 to 44, and a previous witness suggested to us that there was some research showing that that cohort was growing older so it wasn't that people passed through the age group but that cohort was from 18 to 21 and now it was from 25 to 44 and that group was moving and that there may be some -

Prof. DE LEO - Cohort effect.

CHAIR - Yes.

Prof. DE LEO - It is possible. Basically they are not any longer the baby boomer generation for which a cohort fact or has been established in many countries in the world, not very much in Australia, but the baby boomers - I am a baby boomer -

CHAIR - We all are, except Kathryn, I think, and Charles perhaps.

Prof. DE LEO - Our generation was particularly exposed to suicide and we had a cohort effect in that. Then there can be period effects or there are specific historical moments in which suicide is fed by many environmental factors. Ireland is one of those countries that have incredibly suffered in terms of rates of suicide, and Croatia, Bosnia and Serbia, for different reasons but not that different, have suffered from similar issues and this creates moments in life in which for a specific period there is something that brings to a head these risks, or situation effects like the Vietnam veterans. They are sharing something and they have increased rates of suicide, in them and probably in their children, their families. These are all interesting. Sorry, I missed your question.

CHAIR - The reason I ask if you would basically confirm that is that that means that in five years time it is not 25 to 44, it is 30 to 49.

Prof. DE LEO - No, I don't think so, not for this specific historical time. It is that age because that age at this moment expresses the majority of the difficulties in life of individuals. What you are assuming is that historically these people are bringing ahead their age of risk.

CHAIR - Yes.

Prof. DE LEO - No. Here it is difficult because they are separating, having financial difficulties or failing their entrance to society and so it is a particularly tough time.

CHAIR - So it is likely that in 20 years' time that will still be the group?

Prof. DE LEO - Yes.

Mr WILKINSON - It is interesting, isn't it. Sir Edmund Hillary was asked the question, 'What is the best age group for people to climb with you?' and he said, 'Who do you think?' and the person said, '18 to 23, 24 year olds because they're fit, they're strong, they're at the prime of their life'. He said, 'No, 35 to 40.' And they said, 'Why do you say that?' and he said, 'Because they know what misery is all about.' That is a true story and it is a bit the same, isn't it?

CHAIR - Thank you very much, Professor. It has been really good of you to give us so much of your time. We really appreciate it and we will make sure we send you our report. You never know, you might find it interesting reading.

THE WITNESS WITHDREW.