Dear Elton Humphery,

Please accept this as a formal submission to your Inquiry. Should your Committee so wish, I am willing to appear for elaboration and questions about my work on Aboriginal youth suicide which began in 1989 and which continues.

1. A growing list of at-risk factors in youth suicide is not evidence, let alone proof, that we know *why* young people take their lives. We all wish to prevent what seems so wasteful, distasteful and injurious to bereaved families. To want to prevent such suicide is admirable, but the use of the term 'suicide prevention' suggests that we know the cause, as with measles or whooping cough, and by some formula (which we don't have) we can actually stop the behaviour. In this sense, prevention is a pretentious word. Prevention programs generally grope blindly because they guess at the reasons, because they equate at-risk factors with actual causality, and because they believe they can intervene successfully. Prevention strategies escalate, but so do the suicide rates — despite the plethora of glossy posters, 'feel good' messages and catchy slogans of the 'life-is-everything' variety. In my observations and research, suicide *alleviation* is a more realistic goal: to seek to deter, deflect or postpone the *overt act* of suicide. There is simply no way we can stop suicidal *thoughts.*

2. For historical reasons, suicide has become the domain of medicine, psychology and psychiatry and now of biology. The biomedicalization of suicide has resulted in a straitjacket: the would-be suicide must be depressed, depression is a clinical condition, therefore the right antidepressant drug is the answer. This approach has little or no time at all for the historical, geographical, cultural, social factors involved. It says that the subject is ill and the body/mind must be treated, not the contextual environments in which the patient lives and which all too often give rise to the desire for death. The circumstances and context of the 'illness' are either irrelevant or at the very margins. There is a simple response here: if 10 to 15 per cent of any population are 'depressed', then vast numbers should be attempting or committing suicide. Clearly this doesn't happen — and it doesn't happen because there is no direct or incontestable evidence that only the 'depressed' commit suicide. Most 'depressed' people don't. In my studies of Aboriginal youth suicide, virtually no cases of 'mental illness' or 'depression' were found to be present. Yet we persist in pursuing what we commonly but mistakenly believe is the *only* framework for understanding and treating the suicide phenomenon — the clinical psychological/psychotherapeutic model, soon, I believe, to be challenged or even supplanted by the genetic/biochemistry model. Strategies that now seek to employ more psychologists are bound to be disappointed: many in rural populations, especially Aborigines, are not 'psychology-oriented', are less likely to make an appointment with a resident clinical psychologist, are less likely to feel comfortable in a consulting room and less understanding when told after 45 minutes that 'our time is up'. Urban-trained clinical psychologists are not usually versed in the geography, culture, folkways of rural communities. As for the heavily-touted genetic theories, a 'suicide gene' is highly unlikely to appear; and in 'mixed-race' communities, so common in Australia, no 'science' can possibly uncover whose 'suicide genes' have prevailed. They also have to explain why Aboriginal suicide was virtually non-existent until 1960, why it is now amongst the highest rate in the world, and what it is that has 'awakened' the 'genes', or the chemical imbalances of the brain, since that recent date.

3. Dissemination of research material is, frankly, dismal. Lay people don't read articles in *Australasian Psychiatry;* nor do many of the health professionals, educators and community workers who seek to prevent suicide. Medical school curricula rarely pay attention to suicide, and there is evidence that even psychiatry registrars are not given sufficient exposure to the issues involved. Some ten years ago Professor Ernest Hunter, Professor Beverley Raphael and I were invited by such registrars to give a two-day workshop to 47 of their number: they claimed they weren't taught about the problems. What can we then say of the training given to lawyers, nurses, teachers, social workers, health educators, police, police liaison officers? Disseminating lists of at-risk factors is not realistic communication, especially when Aborigines are informed that one major risk factor in their suicide pattern is 'Aboriginality'—

an item that has appeared in several governmental and research publications. At the same time, the work of men like Brian McCoy on the mental health of desert men and of David Denborough on the use of narrative therapy is much less well known, and is seen as somehow 'unorthodox' because it lacks the medicalised basis at the root of most suicide strategies.

4.i. Our society is spending a fair sum of money and a great deal of energy on suicide prevention. Yet we have no idea of the real dimension of the problem. Some argue that that doesn't matter, that we know enough to know that we have a growing problem; others contend that you can't tackle an issue like this unless you know its dimensions. There is serious under-reporting of suicide both in Australia and abroad, some of it deliberate, much of it well-intended. The deliberate is found in countries that are grounded in a religious faith which considers suicide a mortal sin and where any publication of suicide is frowned upon. Australia, or at least New South Wales (where I have done most of my research), is well-intended — for historical-religious, social and legal reasons. Wherever a coroner can, he or she brings in an open or accidental death verdict, even in the face of logic, reason and some pretty obvious circumstances. For example, the number of single-driver accidents occurring in broad daylight, in good driving conditions, with no skid marks, with the car hitting the only tree on the opposite side of the road and the driver clutching rosary beads, is remarkable. The verdict is, inevitably, 'accidental'. No malice is intended. The reverse: such verdicts spare the family the shame and chagrin, the agonising doubts and questions. Such under-reporting or misreporting occurs more often in country towns, places of higher suicide rates among the young, and places where coroners, police and the public know each other.

4.ii. Coroners in Australia are not coroners in the New Zealand, British or American senses. Chief and senior coroners in the major cities are usually lawyers or magistrates. Their assistants or deputies, at least in New South Wales, are Clerks of Petty Sessions, carrying the combined duties of coroner, land titles registrar, registrar of births, deaths and marriages, and other such duties. They are not formally trained in coronial work and few have any tertiary education. The new Coroners Act in New South Wales (2009) requires that all coroners be 'Australian lawyers' but it has a saving clause for the former Clerks of Petty Sessions: they all remain in office but are re-named as 'assistant coroners'.

4.iii. With the support of several colleagues, named in the attachment below, I will be researching comparative coronial policies and practices in several western societies during 2010. At the end of that year, or early in 2011, the Australian Institute of Aboriginal and Torres Strait Islander Studies will publish a research discussion paper on 'Presuming Suicide: the Aboriginal Case'. The outline of that study appears below in the attachment 'Presuming Suicide'. The essence is that the prohibition on coroners not to presume suicide is, especially in the Aboriginal case, a direct cause of under-reporting — by as much as 30 to 40 percent of actual cases. There is a major procedural problem in New South Wales, one which may also pertain to other jurisdictions. Anyone researching suicide rates examines the summary sheets held in State Coroner's headquarters, the ones sent by local coroners to head office. The real evidence for the circumstances of an unnatural death — the full family history, previous known attempts at suicide, risk-taking behaviour, school behaviour, substance abuse, conversations with friends and relatives, indications of alienation, medical and pharmaceutical histories — are to be found *only* in the full files held at the local coroner's office. In sum, to get a truer picture of the suicide patterns, one has to journey from town to town, something few researchers are willing, or have the time and resources, to do.

5. A key factor is the role of sport in deterring or deflecting suicide. The paper 'Aborigines, Sport and Suicide' is attached. It is to be presented at the Pathways to Reconciliation conference in Amman, Jordan in December 2009, and will be published as a book chapter in late 2010. There is enough convincing evidence of the efficacy of sport as a deterrent in the United States, New Zealand and here to warrant the major promotion of sport in suicide strategies. Quite remarkably, it is an activity that is totally ignored by both sports and suicide scholars in Australia.

6. My research in this field is to be found in 'Aboriginal Violence: A Return to Pessimism', *Australian Journal of Social Issues*, 25(4), November 1990, pp. 245–60; *Aborigines: Sport, Violence and Survival,* report to the Criminology Research Council, Project 18/1989, April 1994; *Aboriginal Suicide is Different: a Portrait of Life and Self-Destruction,* 1st edition 2001, 2nd edition, revised, 2005, Canberra, Aboriginal Studies Press; 'Aboriginal, Maori and Inuit Youth Suicide: Avenues to Alleviation?', *Australian Aboriginal Studies*, 2/2004, pp. 15–25.

Sincerely,
Professor Colin Tatz AO,
Visiting Fellow in Social Sciences, ANU; Honorary Visiting Fellow, AIATSIS.

PROPOSAL FOR AN AIATSIS RESEARCH DISCUSSION PAPER

Presuming suicide: the Aboriginal case

Colin Tatz

1. Soon after the initial publication of my book *Aboriginal Suicide is Different* in 2001, there was a surge in research projects, conference presentations, reports and papers on Aboriginal suicide, statistical analyses, concerns about the under-reporting of cases, calls for standardised reporting across all coronial systems, as well as major revisions to coroners' statutes, and revised suicide prevention strategies. The National Coroners Information System (NCIS) was launched in 2000; and in September 2009 the Australian Senate instigated an enquiry into the accuracy of suicide statistics, the effectiveness of prevention strategies and the social costs of suicide.

2. The suicide literature shows a tension between two views: those who believe that suicide generally is under-reported, omissions that dilute or even mask the seriousness of the problem; and those who believe that despite under-reporting, enough is known to establish patterns, the dimensions of the phenomenon, additions to a growing list of at-risk factors, and to institute prevention programs.

3. My unchanged view, since my first research publication in this field in 1999, is that suicide generally, and that of Aboriginal youth in particular, is under-reported by a factor of 30 to 40 per cent. The first port of call for any unnatural or seemingly suspicious death is the police. The second, and vital, next step is the finding of a coroner, with or without post-mortem examination, with or without inquest. It is on that finding, and on that one alone, that all studies of suicidology rates are based.

4. Deriving from decisions of British courts, Australian coroners may not presume suicide. The case for non-presumption has always had much to do with personal, familial and social discomfort: the need 'to properly grieve', the avoidance of rumour, the creation of moral labels, the sense of stigma, the religious factor of sin, the possible legal consequences of such a finding, the hurt

at what looks like the ultimate rejection of one's society. In plain language, courts have ruled on 'the seriousness of the allegation of suicide' decades after the decriminalising of that act.

5. With encouragement from Dr David Ranson of the Victorian Institute of Forensic Medicine, Dr Michael Dudley, president of Suicide Prevention Australia, Michael Barnes, Chief Coroner of Queensland, Laurie Glanfield, chair of the Australian Criminology Council, Dr Alan Rosen of the Royal North Shore Hospital community psychiatry unit, John Mendoza, director of ConNetica Consulting, and David Crosbie of the Mental Health Council of Australia, I propose an analytical essay on comparative coronial systems, using jurisdictions in Australia, England, Ireland, Wales, New Zealand, selected states in the United States and selected provinces in Canada to examine the prohibition on the presumption of suicide. I hope to examine, briefly, presumption in two non-Christian societies, Jordan (Muslim) and Israel (Jewish). The research will also take account of cultural and religious attitudes towards autopsies and the attitudes of state systems to cultural sensitivities.

6. My general proposition is that while protection against 'insensitive' and 'discomforting' findings is sensible and desirable, there is a collective Aboriginal community need to know why so much self-inflicted death is occurring among their youth. In my experience, some Aboriginal families wish to avoid a public finding of suicide, but most want to know how the death occurred, and why. Accordingly, there needs to be some form of resolution between protecting reputation — stemming from the legacy of earlier centuries that a suicide was either bad or mad — and the need to document just how widespread self-inflicted death is among younger Aboriginal people. There is, indeed, mortification enough for Aborigines where some of the Australian reporting, both official and academic, lists 'Aboriginality' as an inherent at-risk factor for suicide.

7. My specific proposition is that while there is a professional system of coroners and deputy-coroners, and while there is soon likely to be an Australia-wide system which requires all coroners to be 'Australian lawyers', as in New South

Wales since mid-2009, there are still a great many assistant coroners who have no formal training in death investigation, in suicide studies, and in matters Aboriginal.

8. There is, I contend, a need for a Diploma in Coronial Studies in Australia. This would comprise a six-module syllabus, with a research project, aimed at formal training and certification of those currently classified as 'assistant coroners' and for those who see this field as a career path. Such a diploma would need to cover, inter alia, a conspectus of coronial history, the nature of death and its investigation, medico-legal aspects, suicide and culture, suicide in society, coroners and the problems posed by suicide, and analysis of contemporary Aboriginal and Islander societies.

9. Given my previous experience with Research Discussion Papers (on genocide in 1999 and uranium health hazards in 2006), this paper is likely to require between 13,000 and 16,000 words. There will be one or two tables or diagrams. I believe, as with the uranium RDP, that it should be published both on-line and in a small hard copy edition. John Mendoza has indicated his willingness to sponsor the cost of the latter form. The time-line is likely to be the end of 2010 or early 2011.

10. I ask for a discretionary grant of $2,500 towards the costs of visits to coroners in several country towns and capital cities. I will be asking the Mental Health Council of Australia to help me obtain a similar amount from institutions interested in this matter.