Te Mauri

THE LIFE FORCE

# Rangatahi suicide report

# Te pūrongo mō te mate whakamomori o te rangatahi

Ngā Pou Arawhenua

Child and Youth Mortality Review Committee

Suicide Mortality Review Committee

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Suicide Mortality Review Committee

Child and Youth Mortality Review Committee

# Whakaohongia te mauri ora, te punga o te wairua.

# Awaken the life force of one's being that becalms the inner soul.

The flowing shape of the pattern represents one's spirit, one's strength, one's energy and one's love as it binds the niho taniwha pattern within. The niho taniwha pattern represents whakapapa (genealogy line), guardianship and protection for all people.

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## The concept:

We have brought the idea of water to life using abstract water images. The images feel hand painted, touched by human hands.

There are different styles of imagery and a mix will be used throughout the report – from peaceful watercolours, to acrylic canvases where you can see the thick strokes of paint.

Texture is an important element of the design and we can use this to evoke, dial up or dial down feelings. The watercolour paintings feel calm and the texture of the canvas and the brush strokes in the acrylic paintings are rough and imperfect.

## Colours:

Our colour palette is: blue, gold and white.

The blues connect with our abstract water theme. Pale blues can be used to portray a sense of calm, thoughtfulness, peacefulness. Cyan blue feels active and energetic. Darker blues can capture turbulence, sadness, grief and a mixture of all blues can represent a spectrum of emotions and feelings.

The gold adds warmth and richness and is a subtle acknowledgement that our rangatahi are vibrant, unique and special. It is also a tribute to rangatahi who have passed, with the gold being reminiscent of the sun and stars.

# Te Mauri

## THE LIFE FORCE

# Winner of the Pei Te Hurinui Jones Senior Māori Speech Competition, Wellington region, May 2019

# Te Toa o Te Whakataetae Pei Te Hurinui, te rohe o Te Whanganui-a-Tara, Haratua 2019

**Paige Scruton Nepe-Apatu**[1]
Ngāti Kahungunu, ko Ngā Rauru ki Tahi ko Rangitāne
Year 13 | Tau 13

## Te Kura Kaupapa Māori o Ngā Mokopuna

### Mihi, Whakatakotoranga

Ka mihia ngā atua Māori, mō ngā āhuatanga o tō tātau taiao. Ka mihia ngā tini mate, rātau kua whetūrangitia okioki atu ki ngā rekereke o Hinenuitepō, moe ai. Ka mutu rā, kai aku whakakai marihi ki te rangi, aku whakatamarahi ki te whenua koutou ngā kaipupuri mauri o te ahi kā i ō āhuru mōwai, ka nui ana ngā whakamiha ki a tātau.

Ka whātika ake nei taku kaupapa kōrero i te tihi o Te Toi a Uru; Kua pokea te motu e te mate hinengaro. He tika! Ka kore ana ā mātau rautaki whakarauora anō i a tātau, ka mutu ana i tō tātau wairua. Ka pokea tonutia tō tātau iwi e tēnei mate, ka tō tonu ana te rā ki a tātau. Ka rere ana taku kaahu ki te maunga hirahira ake nei ko Ruahine, ka tīwē taku kaupapa matatahi; he aha tēnei mea te mate hinengaro. Ka topa, ka tiu taku kaahu e whai nei i ngā wai hōriri, i ngā wai whitawhita o Manawatū, ka kē atu taku kaupapa matarua; tēnei taniwha te whakamomori. Ka hāro taku kaahu ki runga i Te Moana Tāpokopoko a Tāwhaki, ka tīoro taku kaupapa matatoru; he rongoā, e tika ai tēnei mate? Ka mutu, taku kaahu ka okioki ki runga i ngā tātahi o Kirikiritatangi, ka waiho ana mā taku whakakōpani au e kōrerohia aku whakaaro ki te kaupapa. Ma te haerenga o taku kaahu, e tutuki ai taku whakatakotoranga whakaaro, wero anō hoki hai whakaarotanga mō tātau.

### Mate Hinengaro

Ka rere ana taku kaahu, ka tau ki te maunga hirahira ake nei ko Ruahine, ka tīwē taku kaupapa matatahi; he aha tēnei mea te mate hinengaro? Ka pātai ana ki te Papakupu o Te Aka mō te 'mate hinengaro', ko tāna he 'psychiatric disorder, he mental illness rānei'. Engari, he aha tana pūtake? He pēhea tētahi e tau ki tēnei mate? He aha tāna ki tō tātau iwi? Ka mutu, kai te aha rawa tēnei mate pokotiwha ki tō tātau iwi?

Tēnei mea te mate hinengaro, he mate ka tau ki ngā tāngata katoa. Ahakoa te wā, ahakoa te rā, ahakoa te poto, ahakoa te roa ka tau tēnei mate ki a tātau ahakoa te aha.

Tēnei mate ka hua mai i ngā āhuatanga maha, he rerekē ki ngā tāngata katoa. Engari, ko te mate e kaha pokea ana e te motu, ko te hinapōuri. I ngā wā ka pōuri rawa. I ngā wā e tino taupatupatu ana ngā whakaaro. I ngā wā kāore e tino moe. I ngā wā e kaha āwangawanga ana, e kaha āmaimai ana, ko ēnei ngā āhuatanga ka kīia ko te hinapōuri.

Ko tētahi anō āhuatanga e kaha kitea ana ko te kīanga nei 'kurī mangumangu'. He kupu whakarite te 'kurī mangumangu' ki tētahi āhua e waipukehia ana tō ao ki te pōuritanga. Ka kaha whakamahi, ka kaha whakataurite te ira tāne i tēnei momo kīanga, kia whakamārama, kia whakaāhua i tō rātau pōuritanga e whakataikaha nei i a rātau. Ehara i te mea ka pā tēnei momo mate ki ngā tāne anake, engari he uaua ake mā ngā tāne ki te whakaputa i ō rātau kare-ā-roto, ki tō ngā kare-ā-roto o ngā wahine.

[1] Paige has asked that the speech not be translated into English, to privilege te reo Māori.

Ka kīia ko tā te kuri mangumangu he whaiwhai haere i a koe, kia ruku rētō ai koe ki te ao o Whiro. Ki reira waiho ai mā te kurī mangumangu koe e arahi, e pēhi, ki ngā whakaaro o Te Rewera. Ka kite koe i te hinātore e whiti mai ana, ka whakatata atu koe ki taua hinātore, ka kumea anō koe ki raro, kia noho rangatira ai te kurī mangumangu māu, haere ake nei.

Ēnei mate, e kaha tāmi ana i te wairua o te tangata. Nō reira tātau, ki te rongo i ngā tohu o tēnei mate hianga nei. Tēna ōrerohia, wānangahia e ora ai anō koe, e ora ai anō tāua.

### Whakamomori

Ka topa, ka tiu taku kaahu e whai nei i ngā wai hōriri, i ngā wai whitawhita o Manawatū, ka kē atu taku kaupapa matarua; tēnei taniwha te whakamomori. Kātahi rā te āhuatanga kaiapo ko tēnei. Ko te ara ngāwari e whatungarongaro ai ō raru. Engari he āhuatanga me kōrero au.

E hoa mā, ko te whakamomori e kōkiri nei, e arahi nei i te waka ki ngā tatau o te pō. He aha pea te take nui e whāia ai ō tātau hoa, ō tātau whānau, ō tātau iwi i tēnei ara kore whai hua, kore whai aroha, kore whai whakaaro ki te ātaahuatanga o te tangata e mate huhua nei? Ko tērā kurī mangumangu anō pea te take, kua rētō ake nei tana ruku ki tō Whiro ao, karekau he hinātore e whiti mai ana, karekau he māramatanga i tua o ngā whakaaro whakamomori.

I tēnei tau i Te Matatini ki te Ao, i aro atu te kapa haka o Te Waka Huia ki tēnei kaupapa i tā rātau mōteatea. Ko te kaupapa nui ko te tamaiti e kōrero ana ki tana Pāpā, he aha i huri ai ia ki te taniwha whakamomori. Hai tā Te Waka Huia, i whakapōkēao te taniwha nei i te ao o te Pāpā. 'Tīwha ana te pō i ngā kupu whakaweti, uriuri ana te pō i ngā mate whaiāipo, kere ana te pō i te pōtinitini e'. Ka mihia a Te Waka Huia i tā rātau whakaāhua i te aweawetanga o te whakamomori ki tā te tamaiti tirohanga.

He aweawetanga nui tā te whakamomori ki a tātau katoa. Nā reira tātau mā, kia kaha tā tātau toro atu i ō tātau ringa ki a rātau mā e ngaua ana e ngā tāmitanga, e nga pēhinga o tōna ao. Ka ngata ana a whakamomori, i tō tātau noho ngū. E hoa mā, kai kōnei ahau, kai kōnei mātau hai taringa rahirahi mā koutou. Ko tātau ngā waha, ngā ringa, hai poipoi, hai kūmanu i a tātau anō. Ahakoa ngā tāmitanga o te tangata, ki te kore tātau e toro atu, ka kore tātau e mōhio nā te aha rātau e huri kanohi atu ai. Taringa rahirahi mā, me noho tūwhera te ngākau me te hinengaro ki a tātau e noho pōuri ana.

Rātau mā, kua maunu e te taniwha pokotiwha nei. E muri ahiahi ngā tai roimata ki a rātau, e mua tai aroha e kore e motu.

### Rongoā

Ka hāro taku kaahu ki runga i Te Moana Tāpokopoko a Tāwhaki, ka tīoro taku kaupapa matatoru; he rongoā e tika ai tēnei mate? Ki a au nei, ko tētahi rongoā e tāea ana. Ko te whakatō ki roto i ngā kura, ko ngā mātauranga o te hauoratanga o te wairua.

Ka whakaako ana ki ngā taitamariki i te tika o te kūmanu i tōna wairua i a ia e tamariki tonu ana, ka tae ki tana taiohitanga, ki tana pāketanga ka mōhio ia ki ngā tika, ki ngā hē mōna, ka mutu mō tana wairua. Mā te hauoratanga o tōna wairua e mimiti ai ngā tūponotanga ki tēnei mate hianga nei o te mate hinengaro.Ko tāku e āwangawanga nei, kāre i a tātau ngā pukenga kia mākoi i ngā tāmitanga o tō tātau ao, i ngā tāmitanga o ngā whānaungatanga, i ngā tāmitanga o te kura. Engari ka kaha whakapono ana au, mā te whakatō i ēnei mātauranga ki ngā kura he wāhanga nui tōna te ārahi i a tātau te mauminamina, te mākoi anō hoki i ngā wero ka hua mai mō tātau. Mā ēnei mātauranga hoki pea e tāea te whakautu i ētahi pātai i roto anō i a tātau, pēnei; ka pēhea au e mākoi i te parahako? I te mate? I taku rerekētanga? Nā te aha taku whānau e kore ai e arohanuitia au? Katoa ēnei he pātai ka hua ake i ia rā, he pātai e kaha tāmi ana i a tātau anō.

Mā ēnei mātauranga e whakautu ai ēnei pātai. Mā ēnei mātauranga e whanake ai te hauoratanga o ō tātau wairua. Ki te hauora te wairua, ka hauora te hinengaro, te whatumanawa ka kore ana te motu e pōkea ki ngā tāmitanga o te mate hinengaro, ki ngā tāmitanga o te hinapōuri.

Hai tā Aotearoa he whakatinana i ngā momo rongoā rerekē a tēnā, a tēnā mo te oranga o ngāi tātau te tangata. Ki te kore, ka pokea tonutia tātau e te hinapōuri, e te mate hinengaro.

### Whakakapi

Ka tau taku kaahu ki runga i ngā tātahi o Kirikiritatangi, ki konei ōku whakaaro ka whakakōpani ake ki tēnei kaupapa; 'Kua pokea te motu e te mate hinengaro'. He aha tā tātau ki te kaupapa nei?

Ko tāku, he tū hai tākuta mate hinengaro, hai taupā i ngā mate whakamomori huhua nei i waenga i tō tātau iwi Māori, i waenga hoki i ngā iwi o te Moana nui a Kiwa. Ko tāku he mahi i ngā tikanga, i ngā mātāpono o Te Ao Māori, ā-tirohanga nei, ā-taiao nei anō hoki. Engari, kotahi noa tēnei, ki tō tātau iwi whānui.

He aha tā Aotearoa ki te kaupapa? Nō tētahi tau, kua kaha ake tā Aotearoa aro ki te kaupapa nei. Nō te Aperira tonu i tū te rā kamupūtu, hai kohi pūtea mō te hunga e mate hinapōuri ana. Ka mihia te taraheti nāna anō tēnei kaupapa hirahira ake nei i whakatū.

Engari he āhuatanga anō e tāea ana tātau, kia mōhio whānuitia ki tēnei mate. Hai tauira; te parekura i Ōtautahi. Tuatahi ake ka mihia ngā Muhirama, i ō rātau mate, haere atu rā koutou, ka hoki ora mai anō ki a tātau ngā waihotanga ō rātau mā kia kōrerohia tēnei pāhuatanga. He pōuri, engari, tēnā i ētahi tāngata, kāore au e tino aro atu ana ki tēnei kaupapa. He pēnei rawa aku whakapono, i te mea tōna rima rau tāngata ka whakamomori i ia tau, ā, nō tēnei tau tonu ka kitea i tā Aotearoa aronga atu ki tēnei mate. Engari anō mō te pāhuatanga i Ōtautahi, ka tau a Aotearoa, hai tautoko i tēnei kaupapa mō ngā tāngata rima tēkau mā aha nei. Karekau he māramatanga mō te take e pēnei ana tātau. Ko te māramatanga e pūrangiaho ana, ka pēnei tonu ana tā tātau waiaro ki te mate pokotiwha nei, ka pokea tonutia te motu e te mate hinengaro, ko tātau ka hinga.

**Koia taku iti i tēnei wā, kai raro taku kaahu, ka tau.**

# Committee members*

## Ngā mema o te komiti

### Ngā Pou Arawhenua (Māori Caucus of the mortality review committees)

| | | |
|---|---|---|
| Dr Fiona Cram (Chair) | Ngāti Pahauwera | (Family Violence) |
| Denis Grennell | Ngāti Maniapoto | |
| Dr Alayne Mikahere-Hall | Ngāti Whatua, Te Rarawa, Tainui | (Child and Youth) |
| Dr Hinemoa Elder | Ngāti Kuri, Te Rarawa, Te Aupōuri, Ngāpuhi | (Child and Youth) |
| Tania Papali'i | Ngāpuhi, Ngāi Tai ki Tamaki | (Suicide) |
| Dr Maria Baker | Ngāpuhi, Te Rarawa | (Suicide) |
| Lisa Paraku | Ngāti Tamaterā, Ngāti Porou | (Perinatal and Maternal) |
| Louise Kuraia | Ngāpuhi, Ngāti Manu, Kōhatu Taka, Ngāi Tai ki Tainui | (Perinatal and Maternal) |
| Dr Donna Cormack | Kāti Māmoe, Kāi Tahu | (Perinatal and Maternal) |
| Dr Michael Roguski | Te Āti Awa, Ngāti Tūwharetoa | (Family Violence) |
| Shayne Walker | Ngāi Tahu, Kāti Māmoe, Waitaha, Ngāti Kahungunu | (Family Violence) |
| Kiriana Tan | Ngāti Ranginui, Ngāti Mutunga | (Family Violence) |
| Dianne Cooze | Ngāti Porou | (Family Violence) |
| Keri Parata-Pearse | Ngāti Toarangatira, Ngāti Raukawa, Ngāti Awa | (Perioperative) |
| Dr Maxine Ronald | Ngā Puhi, Ngāti Wai | (Perioperative) |
| Sheldon Ngatai | Ngāti Rahiri, Ngāti Mutunga, Te Atiawa, Taranaki, Ngāti Maniapoto, Ngāti Mutunga o Whare Kauri | (Perioperative) |

| Child and Youth Mortality Review Committee | Suicide Mortality Review Committee |
|---|---|
| Dr Felicity Dumble (Chair) | Dr Sarah Fortune (Chair) |
| Dr Arran Culver (Deputy Chair) | Taimi Allan |
| Dr Hinemoa Elder | Tania Papali'i |
| Dr Alayne Mikahere-Hall | Dr Maria Baker |
| Andrew Lesa | Denise Kingi-Ulu'ave |
| Dr Colette Muir | David Cairns |
| Dr Rebecca Hayman | Professor Roger Mulder |
| Dr Matthew Reid | |

*Members current at 31 December 2019.

# Acknowledgements

## He mihi

Ngā Pou Arawhenua (the Māori Caucus of the mortality review committees), the Child and Youth Mortality Review Committee and the Suicide Mortality Review Committee would like to acknowledge Witi Ashby (Ngāti Hine, Ngāti Kawa) and Professor Denise Wilson (Ngāti Tahinga – Tainui) for their guidance in the development of the report.

We give special thanks to Professor Rob Kydd (former Chair, Suicide Mortality Review Committee) for his ongoing commitment and leadership in reducing the great harm that suicide causes, and his desire for a health system that is compassionate, connected and equitable.

We would like to thank Paige Scruton Nepe-Apatu (Ngāti Kahungunu, ko Ngā Rauru ki Tahi, ko Rangitāne) for sharing her speech; and the following providers who have shared their examples of promising practice in delivering prevention and postvention initiatives.

| | |
|---|---|
| The Aroha Project | Fusion, Te Tai Tokerau |
| LifeKeepers, Le Va | Te Ha O Ngā Rangatahi |
| Takerei Ruha Whānau Trust | Te Taitimu Trust |

The committees would also like to recognise and thank Len Hetet for his inspirational talent in designing the tohu and whakataukī for this report.

Finally, we would like to acknowledge the support and work of the mortality review secretariat within the Health Quality & Safety Commission.

# When reading this report on suicide

## Te pānui i tēnei pūrongo mō te mate whakamomori

If any of the issues in this report are personal for you and you want to talk to someone, please contact any of the agencies and services below.

- Need to Talk? **1737** call or text (mental health, depression and anxiety counselling)
- Lifeline: **0800 543 354**
- Suicide Crisis Helpline: **0508 828 865 | 0508 TAUTOKO**; 12 noon to 12 midnight (for people in distress, or people who are concerned about the wellbeing of someone else)
- Kidsline (for children up to 14 years): **0800 543 754 (0800 KIDSLINE)** | 4.00–6.00 pm weekdays
- Youthline: **0800 376 633 | free text 234 | talk@youthline.co.nz**
- Supporting Families (support for whānau bereaved by suicide): **supportingfamilies.org.nz**
- Skylight **(www.skylight.org.nz)** for those facing loss, trauma and grief.
- Mental Health Foundation: **www.mentalhealth.org.nz** offers a list of resources (including videos) (www.mentalhealth.org.nz/get-help/a-z/resource/52/suicide-bereavement) and the bereavement handbook, with updated support information, which you can download (www.mentalhealth.org.nz/assets/Suicide/Bereavement-Handbook-Online-Sept.pdf)
- Le Va: **www.leva.co.nz**
- LifeKeepers National Suicide Prevention Training Programme (Le Va): **www.lifekeepers.nz**
- Waka Hourua: **teaumaori.com/support/waka-hourua**
- Aunty Dee: **www.auntydee.co.nz** offers a free online tool for anyone who needs some help working through a problem or problems: a systematic approach to decision-making that is based on structured problem solving.
- You can also talk to your GP or another local health professional, friends, whānau or someone you trust.

# Reporting

## Pūrongo

The Suicide Mortality Review Committee provides useful guidance on reporting on suicide for journalists and the media. We recommend reviewing this guidance before reporting data and discussion included in this report:

www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/3612/

# Foreword from chairs

## Whakapuakitanga a ngā heamana

Any information – data, stories, the tears shed by whānau – about the lives of rangatahi who have been lost to suicide is about knowing that these young people have passed too soon.

Their lives, their potential and the generations that may have borne their whakapapa have been foreshortened. Those left behind inevitably have questions about the lives and circumstances of those they have lost, and questions about what drove their beloved whānau member to the point of believing that their best option was to end their own life.

In mortality review, we are charged with looking back to understand what was going on for rangatahi who have died by suicide. Guiding this work is the hope that, going forward, we – the communities and the institutions responsible for their care – can be at our most helpful and supportive.

We hope that we will be able to metaphorically and perhaps literally take the hands of other rangatahi in similar situations and guide them along different pathways that enable them to live.

The chairs would like to thank all those involved in producing this report. We acknowledge the advice of the peer reviewers, Dr Cameron Lacey (University of Otago), Associate Professor Sarah Hetrick (University of Auckland), Dr Tepora Emery (Toi Ohomai Institute of Technology) and Elana Curtis (Taikura Consultants Ltd).

**Dr Fiona Cram,** Chair Ngā Pou Arawhenua

**Dr Sarah Fortune,** Chair Suicide Mortality Review Committee

**Dr Felicity Dumble,** Chair Child and Youth Mortality Review Committee

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# Executive summary | Whakarāpopototanga matua

Suicide is a complex issue with many contributing causes, and the solutions required to prevent it are broad and far-reaching. *Te Mauri*[2] *(The Life Force): Rangatahi*[3] *suicide report* steps into this complexity and asks why rangatahi, compared with non-Māori young people, have higher rates of death by suicide and what Aotearoa New Zealand is doing, and what else we could do, to prevent rangatahi from taking their lives by suicide.

The first part of this report adopts a Māori lens to examine suicide. This lens looks to mātauranga Māori (Māori knowledge). It locates Māori understandings of suicide within the colonial history of Aotearoa New Zealand and explores how that has had ongoing impacts through marginalising Māori within their own lands.

It then looks at what we need to do to prevent the suicide deaths of rangatahi. As well as describing Māori approaches to suicide prevention, it reports on what Māori whānau and communities say they need to prevent suicide in rangatahi. This discussion highlights the need for a multi-layered explanation of suicide that takes account of the colonial history of this country.

[2] **Mauri** is the Māori term for the life force or essence of a person. Mauri is both dynamic and relational. It is constantly changing; it shapes one's spirit (wairua), balances the mind and body, and shapes how a person relates to themselves, others and the wider environment (Durie 2001).

[3] In this report 'rangatahi' refers to Māori young people aged 10–24 years.

The second part of this report builds on the need for a structural response, informed by Te Tiriti o Waitangi (Te Tiriti), to the suicide deaths of rangatahi through evidence-informed policy advice. It makes four major system-level recommendations for all of government.

1. Embed and enact Te Tiriti into all policy and practice to support mana motuhake, accelerating this process for rangatahi within the education and health sectors.
2. Urgently address the impact of socioeconomic determinants of health on whānau, including poverty, alcohol, racism, housing and unemployment.
3. Invest in what works for Māori, iwi, hapū and whānau – invest in, fund and build communities to lead initiatives that support communities in suicide prevention and postvention.
4. Work collectively, nationally and locally to leverage government investment in what works for Māori.

Within each of these recommendations is a range of more specific actions recommended for individual government agencies.

Contributing to the understanding of rangatahi suicide are data findings for the period 2002 to 2016.[4]

**Key findings for rangatahi aged 10–24 years:**

**Over the 15-year period covered in this report,** 727 rangatahi (25.3 per 100,000) and 876 non-Māori, non-Pacific children and young people (9.13 per 100,000) died by suicide.

**Suicide was the cause of one-third (33.8 percent) of all deaths in rangatahi,** compared with just over one-quarter (26.1 percent) of all deaths in non-Māori, non-Pacific children and young people; for every non-Māori, non-Pacific person aged 10–24 years who died by suicide there were approximately three rangatahi who died by suicide.

**The rate of suicide in rangatahi varied from 18.8 per 100,000 (in 2002) to 38.4 per 100,000 (in 2012),** compared with a variation between 7.2 per 100,000 and 10.7 per 100,000 for non-Māori, non-Pacific children and young people.

**In the five-year period, 2012 to 2016** nearly two-thirds (61.7 percent) of the rangatahi aged 10–24 years who died by suicide had accessed secondary mental health and addictions service and for non-Māori, non-Pacific children and young people it was 63.2 percent.

**Forty-six percent of the rangatahi who died by suicide** had had a Child, Youth and Family (CYF) notification at some point in their lives, compared with 23 percent of non-Māori, non-Pacific children and young people who died by suicide.

**Forty-three percent of rangatahi had been stood down from school,** compared with 22 percent of non-Māori, non-Pacific children and young people.

A consistent message drawn from this report is that enacting Te Tiriti across all our government systems is an essential component of stopping rangatahi deaths by suicide. Making improvements to these systems firmly based on Te Tiriti is key to enhancing mauri ora (wellbeing) for rangatahi, their whānau and all Māori.

[4] See Appendix 1 for the full data report.

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# Introduction | Kupu whakataki

The whānau, kaimahi and iwi who made submissions to the 2018 Mental Health and Addiction Inquiry Panel called for transformational change to the health system to achieve optimal wellbeing for Māori. The report dedicated to their submissions – *Oranga Tāngata, Oranga Whānau* (Inquiry into Mental Health and Addiction 2019) – spoke to their vision:

> The dream articulated by submitters is for a flourishing Pae Ora society where whānau have ready access to all the determinants of good health: quality housing; education; employment; and to the practises handed down from tūpuna. It is a society where a kaupapa Māori approach is normalised, and reo, tikanga and interactions with the natural environment play a part in daily life. It is one where Māori are able to participate in practices and pursuits in order to maintain hauora; it is where there are strong connections between whānau, marae and whenua, and where society is grounded in the kaupapa of tino rangatiratanga, manaakitanga, mana, whanaungatanga and whānau ora; it is where whānau have hope and are empowered to determine their own futures. Such a society is centred on whānau wellbeing where time with whānau is valued and intergenerational connections are strong. (p 2)

While this message is intended for the mental health system, the vision it encapsulates goes far beyond mental health and far beyond health more generally. It stretches across government and society as a whole, as a vision of what should be aspired to as a country.

When we think of the loss of rangatahi lives to suicide in the context of this vision, we realise that as a country and as a people we are far away from realising our potential. While youth suicide rates as a whole are unacceptably high – even one life lost is one life too many – the suicide rates for rangatahi are much higher than for their non-Māori peers.

Suicide has many causes; in other words, it is the result of a complex interaction of factors that relate to systems, society and the individual. Like the vision above, solutions and prevention opportunities are broad and far-reaching and are about nurturing mauri ora, the fully energised life force of rangatahi.

*Te Mauri (The Life Force): Rangatahi suicide report* enquires into rangatahi suicide using a Māori lens. It asks what is going on, what is being done and what further actions are needed at a governmental level to help stem this loss of life and potential. *Te Mauri* is a collaboration between the Child and Youth Mortality Review Committee, the Suicide Mortality Review Committee and Ngā Pou Arawhenua (the Māori Caucus of the mortality review committees).

This report aims to prompt discussion and policy development that will lead to system improvement to enhance mauri ora for rangatahi and for all Māori.

The first part is dedicated to understanding how Māori understand and frame suicide within te ao Māori (the Māori world/a Māori worldview). An important aspect of this is understanding the impacts of Aotearoa New Zealand's history of colonisation and the ongoing impacts of institutional racism on Māori. Part 1 also considers Māori approaches to suicide prevention, and what Māori whānau and communities say they need to prevent suicide in rangatahi.

Part 2 highlights the urgent need to reconfigure current government consulting, planning and funding models of services and systems for rangatahi. It provides evidence-informed advice to government agencies about their role in reducing rangatahi deaths by suicide. Central to this advice is the need for Te Tiriti o Waitangi (Te Tiriti) to underpin all systems, structures, operating models and resourcing approaches.

*Te Mauri* therefore aligns with the government's aim to meet its responsibilities to Te Tiriti (Office of Treaty Settlements 2018) and to address systemic racial inequity affecting Māori, their rangatahi and whānau (Ministry of Health 2018a). Multiple streams of work across government are providing guidance and advice, and offering solutions to the systemic issues Māori face. The Wellbeing Budget prioritises wellbeing alongside economic goals, creating a good platform for change. The government Inquiry into Mental Health and Addiction,[5] the wider Health and Disability System Review,[6] Hāpaitia te Oranga Tangata – Safe and Effective Justice cross-sector initiative, the Tomorrow's Schools Review conversation,[7] the work of the Welfare Expert Advisory Group,[8] Oranga Tamariki National Care Standards and the Wai 2575 Health Services and Outcomes Inquiry[9] will all provide useful guidance. In addition, models are emerging across government that show aligned and integrated work that can also be drawn on, including the Whānau Ora initiative[10] and the Joint Venture for Family and Sexual Violence.[11]

*Appendix 2 contains a glossary of terms used in this report.*

5 https://mentalhealth.inquiry.govt.nz/
6 https://systemreview.health.govt.nz/
7 https://conversation.education.govt.nz/conversations/tomorrows-schools-review/
8 http://www.weag.govt.nz/
9 https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/
10 https://www.tpk.govt.nz/en/whakamahia/whanau-ora
11 https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/family-and-sexual-violence/ministerial.html

# PART 1 | WĀHANGA 1

## Māori views of suicide and approaches to prevention

## Ngā whakaaro Māori mō te mate whakamomori me ngā ara hei ārai i tēnei mate

This part draws on literature and commentary from Māori researchers and community leaders to provide an overview of Māori understandings of suicide. It discusses the impact of the losses Māori have experienced because of colonisation and how this historical trauma has passed across generations.

While we review individual and institutional risk factors for rangatahi suicide, we also introduce the concepts of resistance and resilience to demonstrate that Māori are not passive recipients of colonisation and continue to strive for the wellbeing of rangatahi and whānau.

Te Mauri
THE LIFE FORCE

## 1.1 Understanding suicide within Māori whānau and communities

As Māori scholars see it, the root causes of disproportionately high rangatahi suicide rates within Māori communities are the wider economic, political and social systems that structure society for Māori, which, in turn, stem from the colonisation of Aotearoa New Zealand (Coupe 2005; Durie 2001; Hirini and Collings 2005; Lawson-Te Aho 1998). Colonisation has fragmented Māori social structures and disconnected Māori from their tribal lands. The loss of land has undermined mana whenua (land-based prestige) and negatively impacted people's tūrangawaewae – their place to stand – where Māori feel empowered and connected to their whakapapa (cultural genealogy, lineage and related kinship structures). These widespread disconnections have created a legacy of harm that is devastating for Māori individuals and communities. These structural determinants are reflected in the contemporary challenges that Māori face, including institutional racism, multiple social disadvantage, poverty, trauma and cultural disconnection.

Professor Sir Mason Durie (2001, 2017) divides the risk factors for Indigenous suicide into two main types: personal and collective. Collective risk factors reflect the realities of Māori and Indigenous peoples over time; these set the foundation on which personal risk factors are built. Examples of collective risk factors for suicide include: loss of culture (eg, language), insecure cultural identity, spiritual disconnection and colonisation (eg, oppression, alienation from ancestral lands and loss of self-determination). Examples of personal risk factors include: material hardship, unemployment, family adversity (eg, marital disharmony, foster care), mental health and addictions issues (eg, substance abuse, depression), stress, bullying and relationship breakdowns. These personal risk factors arise from and are expressed within the context of collective or structural risk factors (WHO 2014).[12]

While aspects of Māori culture can protect people against suicide, it is important to understand that no single cultural factor alone will prevent suicide. Some rangatahi who have relatively strong connections with their culture (eg, involvement in kapa haka groups) may still die by suicide. This is because suicide usually has many underlying causes that interact in a way that increases the overall risk of suicide. The analyses presented in this report highlight the multiple, overlapping nature of the issues that rangatahi who die by suicide frequently face over their life course (Cram et al 2019).

This structural framing has flow-on effects for how we understand rangatahi suicide and how we can prevent it. *Te Mauri* draws on this framing.

Before we examine this framing in more depth, it is important to canvas Māori understanding of suicide and how this understanding changed with the colonisation of Aotearoa New Zealand.

[12] The World Health Organization (WHO) has identified similar risk factors associated with suicide but does not acknowledge the colonial context of many Indigenous people. These are linked to health systems (eg, barriers to health care), social practices (eg, inappropriate media reporting of suicide), community tensions including discrimination and stresses of acculturation, relationships (eg, conflict, discord and loss) and individual factors (including previous suicide attempts, mental disorders, job loss and family history). In contrast, the three broad groupings of protective factors encompass strong personal relationships, religious or spiritual beliefs, and positive coping strategies and wellbeing (WHO 2014).

## Māori understanding of suicide

**Mauri** is the Māori term for the life force or essence of a person. Mauri is both dynamic and relational. It is constantly changing; it shapes one's spirit (wairua), balances the mind and body, and shapes how a person relates to themselves, others and the wider environment (Durie 2001). The concept of mauri is important to how Māori communities understand suicide (Durie 2001).

**Mauri ora** (flourishing, wellbeing) is the optimal state of mauri. With mauri ora, Māori move through life invigorated by positivity, hope and a sense of purpose and meaning. At the same time, they experience positive states of being such as: optimism, cultural engagement, vitality, having physical and mental energy, having positive relationships, and participating in society and engaging with others (Durie 2017).

By contrast, a state of **mauri moe** and **mauri noho** (languishing) refers to a state in which one's mauri is weakened. It is characterised by a range of painful feelings and behaviours, such as fear, sadness, guilt, gloom, mistrust, lack of mental and physical energy, isolation, non-participation, cultural alienation and harmful relationships, which can become overwhelming and lead to a loss of spirit and a loss of will to live (Durie 2017).

A related state, **kahupō** (hopelessness, spiritual blindness) is characterised by a loss of hope, meaning and purpose and by lasting despair. Kahupō involves a disconnection or separation of the physical from the spiritual as well as a psychological separation of the individual from the collective (Lawson-Te Aho 2017; Lawson-Te Aho and Liu 2010). Both mauri moe and kahupō represent the end of the Māori wellbeing spectrum, where individuals are at increased risk from suicide.

**Whakamomori** is the Māori term for thoughts, feelings and actions that can build up and lead to the act of suicide (Ihimaera and MacDonald 2009; Lawson-Te Aho 1998). Whakamomori is often used as a direct translation for suicide, although it is broader than Western concepts of suicide because whakamomori also acknowledges the cultural and spiritual impact of suicide on whānau (extended families), hapū (subtribes) and iwi (tribes) (Coupe 2005; Ihimaera and MacDonald 2009). Whakamomori is experienced both by the individual and the collective. On an individual level, whakamomori can severely impact a person's mauri and wairua. On the collective level, whakamomori can disrupt whakapapa within Māori whānau and the wider community (Ihimaera and MacDonald 2009).

Tēnei taniwha te whakamomori.
Kātahi rā te āhuatanga kaiapo ko tēnei.
**Paige Scruton Nepe-Apatu**

## Suicide among Māori before colonisation

Traditional Māori pūrākau (ancient legends or stories), waiata (songs) and mōteatea (laments or chants) demonstrate that suicide in traditional Māori society was rare, that it occurred mainly among Māori adults and that the circumstances underpinning it were different from those seen in contemporary Māori communities (Lawson-Te Aho 1998). For example, suicide sometimes occurred among adults who had committed serious transgressions against others and caused significant whakamā (shame) to their whānau, hapū and iwi.[13] Suicide also occurred during periods of mourning among bereaved widows who had lost a husband, although this was less likely if they had tamariki (children) to care for (Durie 2001; Lawson-Te Aho 2013). In addition, because Māori lived collectively and shared responsibility for the wellbeing and protection of mokopuna (grandchildren), suicide among tamariki and rangatahi did not exist (Kingi 2005). Māori enjoyed positive and healthy relationships that contributed to the health and wellbeing of individuals and of whānau (Jenkins et al 2011).

In contrast to a Māori worldview, in which suicide was not forbidden, early colonial law is likely to have been responsible for introducing the concept of suicide as morally wrong, by making it a criminal offence to die by suicide – leading to the term 'commit suicide' (Cameron et al 2017; Emery et al 2015). It was only in colonial times that Māori who died by suicide began to be excluded from burial in urupā (burial grounds) and Māori use of tangihanga practices (ceremonies to mourn the dead) decreased. At this stage, too, the suicide deaths of rangatahi began (Durie 2001).

Next, we position these changes in Māori views about suicide within the broader context of the colonisation of Aotearoa New Zealand, and the breaches of Te Tiriti that this colonisation signals.

[13] Emery et al (2015) give an example of Te Matapihi o Rehua, a Te Arawa chieftain, who was ordered by his koro (grandfather), the paramount chief Pūkaki, to go into battle. Te Matapihi refused because going into battle would mean he would have to kill a close friend in a neighbouring tribe. Instead, Te Matapihi's brother took his place in the battle and completed the task. Te Matapihi experienced great distress and shame because he was unable to forewarn his friend and his mana waned after the battle while the mana of his brother soared. Eventually, Te Matapihi became consumed by despair and he paddled his canoe out onto the lake and drowned.

## Māori individual and collective loss

As the process of colonisation unfolded, legislation and war dispossessed Māori of their lands. This loss of lands, in turn, contributed to the fragmentation of Māori communities as whānau, hapū and iwi were stripped of the ability to nourish and protect one another as a collective unit. The disconnection from tribal lands had consequences for Māori that were much broader than economic losses. This is because Māori culture, identity and wellbeing are inseparable from Māori whenua (lands) (Cram et al 2019).

> Loss of land had more than economic implications. Personal and tribal identity were inextricably linked to Papatūānuku – the mother earth – and quite apart from loss of income and livelihood, alienation from land carried with it a severe psychological toll.
>
> **(Durie 2001)**

As well as being alienated from their land, Māori caught new infectious diseases, which devastated the population, and a series of colonial governments introduced a wide range of policies aimed first at the assimilation and then at the integration of Māori. One result of these experiences was that young Māori had fewer opportunities to learn mātauranga Māori (Māori knowledge), tikanga (customs, traditions) and te ao Māori (the Māori world).

Over time, therefore, Māori social structures gradually fragmented and collective Māori cultural identity eroded through the disruption of whakapapa (Lawson-Te Aho 2013). These experiences had an impact on the mental health and wellbeing of individuals because, for Māori, a person's individual cultural identity cannot be separated from the identity of the collective (Durie 2001).

Policies and practices in the second half of the 20th century helped to break down Māori collectivity further. Some policies actively aimed to relocate Māori, who had mainly been living in rural areas, to larger towns and cities. Other influences were more passive: the welfare of Māori was neglected, and the Crown's and colonisers' activities had unintended consequences.

These events, together with the growth of post-war industrialisation in Aotearoa New Zealand, drove large numbers of Māori to migrate away from rural hapū and iwi to live and work in urban centres, especially in the two decades from 1945 to 1965 (Kukutai 2011).

More recent colonial events that have impacted on Māori include the downturn in employment in state-run utility companies in the 1980s and in primary industries in the 1990s, along with a harsher economic and welfare environment from the late 1980s. Although before this era Māori had briefly made some health gains (eg, lower child mortality), such conditions ensured these gains were short-lived. Then, when Māori were beginning to recover from the legacy of the 1990s but had not yet benefited from the economic gains of the earlier part of the 2000s, the 2008 global financial crisis hit, and whānau were pushed further into the social and economic margins of our society (Te Puni Kōkiri, online).

The impacts of colonisation may differ across whānau. In Te Whare Tapa Whā (Durie 1994), a Māori model of health, markers of whānau wellbeing include the heritage, wealth, capability, cohesion, connectedness and resilience of the whānau. While indicating the extent to which a whānau is flourishing, the markers also reflect the capacities of whānau to carry out their expected roles and functions.

Whānau with high-capacity reserves are more likely to be able to withstand adverse impacts, whereas whānau who have low reserves are more vulnerable to external influences and are less likely to have favourable outcomes (Kingi et al 2018). Low reserves can create an environment that makes it difficult to see and to address some stressors that may contribute to suicide.

Next, we begin to explore this idea by examining recent thinking about historical trauma and its intergenerational impacts on whānau.

## Historical trauma: Growing harm across generations

Historical trauma refers to harm that is inflicted on an entire population. The cause of this harm is a large-scale destructive event, such as colonisation, and its effects are typically so catastrophic and widespread that it is experienced both collectively by the whole population and individually by members of that population. If unresolved, historical trauma is then passed on through the generations that follow (see Braveheart 1998; Walters et al 2011).

Historical trauma theory has increasingly been adopted to frame Māori health inequities and help promote wellbeing in Māori communities (eg, Borell et al 2018; Cameron et al 2017; Farrelly et al 2006; Pihama et al 2014, 2017; Wirihana and Smith 2014).

> Ka kore ana ā mātau rautaki whakarauora anō i a tātau, ka mutu ana i tō tātau wairua.
>
> **Paige Scruton Nepe-Apatu**

Because historical trauma has passed from generation to generation, Māori have disproportionate rates of negative personal and interpersonal behaviours (eg, alcoholism, violence). Many of these have become normalised over time (Dobbs and Eruera 2014; Kruger et al 2004; Lawson-Te Aho 1998).

Lawson-Te Aho (2013) draws from Duran and Duran's (1995) theory of historical trauma to describe how high rates of suicide are the physical manifestation of the wounding of Māori spirits and the decimation of cultures, since colonisation began. Disproportionately high rates of Indigenous youth suicide in some other colonised countries provide further evidence that the hallmark acts of colonisation – land confiscation, oppression of traditional cultural healing practices and language, unjust legislation and widespread racial discrimination – have a pervasive and persistent impact on Indigenous young people (Dudgeon et al 2018). As we describe next, colonisation is not a historical event – it persists and continues to be a root cause of rangatahi suicide.

> Ka whakaako ana ki ngā taitamariki i te tika o te kūmanu i tōna wairua i a ia e tamariki tonu ana, ka tae ki tana taiohitanga, ki tana pāketanga ka mōhio ia ki ngā tika, ki ngā hē mō na, ka mutu mō tana wairua. Mā te hauoratanga o tōna wairua e mimiti ai ngā tūponotanga ki tēnei mate hianga nei o te mate hinengaro.
>
> **Paige Scruton Nepe-Apatu**

## How colonisation continues today

As Aotearoa New Zealand is founded on structures and systems that privilege whiteness, colonisation continues unabated. It is not an event from the distant past (Reid and Robson 2007). Contemporary forms of colonisation marginalise Māori, restrict Māori tino rangatiratanga (self-determination) and limit Māori prosperity. Acknowledging that the trauma of colonisation is ongoing for Māori is central to healing and eliminating Māori health inequities.

> The current social status and general wellbeing of Māori have been deeply affected by historic acts of trauma and ongoing experiences of dispossession, denigration and discrimination. Acceptance is needed that those dire consequences for Māori have produced levels of advantage and privilege for the descendants of all settlers to Aotearoa, only possible through the ongoing process of colonisation.
>
> **(Borell et al 2018)**

We can see colonisation today in the form of institutional racism and the negative stereotyping of Māori (Paradies et al 2008). Below we describe these issues before introducing the notion of resistance – to both institutional racism and the wider forces of colonisation.

## Institutional racism and resistance

Institutional racism contributes to the persistent over-representation of rangatahi in suicide statistics because it leads rangatahi and their whānau to be unfairly marginalised – based on their ethnicity – from the goods and resources of our society (Reid et al 2019) and health care (Harris et al 2006b). In 2013, for example, 25 percent of Māori lived in decile 10 areas (areas with the greatest socioeconomic deprivation) compared with 7 percent of non-Māori, while 4 percent lived in decile 1 areas (with lowest deprivation) compared with 12 percent of non-Māori (Ministry of Health 2015b).

The poverty that many whānau experience is a major risk factor for suicide. Poverty during childhood and adolescence harms mental wellbeing, as it contributes to inadequate and insecure housing, poor nutrition and reduced education outcomes (Dale 2017). Poverty prevents whānau from participating fully in te ao Māori and in society more generally. As such, the poverty that Māori children experience is a breach of this country's responsibilities under the United Nations Convention on the Rights of the Child (Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty 2012).

An extreme form of institutional racism is when no action is taken to deal with obvious Māori health inequities. For example, no systematic national policy response followed the spike in Māori suicide numbers in 1960 and 1967 (Shahtahmasebi and Cassidy 2014).

However, despite evidence that shows living in more deprived areas is linked with poorer health, another finding is that areas with higher concentrations of ethnic minorities have protective effects on the health of ethnic minority residents. Reasons for such effects may be that enhanced social cohesion, social support and a stronger sense of community provide buffers against discrimination and racial harassment (Bécares et al 2013).

Resistance is a collective approach to exposing the inequitable distribution of power and opposing negative social, political and economic influences (Penehira et al 2014). Resistance involves making proactive and deliberate attempts to reclaim the position of Māori within Aotearoa New Zealand. As a concept, therefore, resistance is closely linked with tino rangatiratanga, and aims to achieve the rights of Māori to express self-determination in line with Te Tiriti.

Promoting resistance in communities should be a core part of suicide prevention initiatives. We can see resistance as a protective factor for rangatahi. Indigenous and minority children and young people do better when they are able to structurally analyse what they are experiencing in terms of racism (and other microaggressions).[14] This understanding helps individuals and groups to build resistance, as it gives them a voice and communal context to their experiences. In this way, it depersonalises the racism – that is, individuals can see it is not aimed at them personally (LaMothe 2012).

[14] Brief and common daily verbal, behavioural and environmental communications, whether intentional or unintentional, that transmit hostile, derogatory or negative messages to a target person because they belong to a stigmatised group.

## Protection through whānau resilience

**Resilience** is generally known as the ability to bounce back after adversity. Māori concepts of resilience are collective in that they emphasise whānau and whanaungatanga (networks and relationships) as well as connections with the broader environment.

In other words, individuals are more likely to be able to bounce back from adversity if they can draw on the strengths of and connectivity within whānau as well as wider whakapapa-based networks (Boulton and Gifford 2014). Cultural capacity (eg, knowledge of tikanga, cultural identity and cultural resources such as language) also plays an important role in helping whānau stay strong and optimistic during difficult times (Waiti and Kingi 2014). For these reasons, terms such as 'whānau resilience', 'community resilience' and 'cultural resilience' resonate more strongly with Māori communities than the term 'resilience' alone.[15] Whānau resilience may be key to protecting against rangatahi suicide.

Protective factors that guard against suicide can be grouped into three main types: personal, social and religious or spiritual (WHO 2014). Examples of protective factors include: educational achievement, financial security, meaningful employment, self-determination, access to health and social services, social inclusion, and sport and recreation (Durie 2017). While these are 'personal' risk factors, that does not mean they are the sole responsibility of the individual, rather, they are largely determined by structural factors that have a measurable impact at a person level. An increasing amount of evidence indicates that aspects of culture and cultural identity are important cultural protective factors for Indigenous peoples in North America, Alaska, Canada and Australia (Lalonde 2014).

Similarly, in Aotearoa New Zealand, aspects of Māori culture, such as a strong cultural identity, access to Māori cultural resources (eg, marae, te reo Māori, whakapapa, koroua and kuia) and strong connections with whānau, hapū and iwi, are seen as ways of protecting people against suicide (Ihimaera and MacDonald 2009). A strong, secure and positive cultural identity is a vital component of Māori mental health and wellbeing (Durie 2001). Recent evidence demonstrates that a strong cultural identity is associated with better overall wellbeing and fewer depressive symptoms in young Māori (Williams et al 2018).

The prominent discourse around the resilience of Indigenous communities implies that adaptation, vulnerability and care must be the building blocks of the Indigenous being. It reinforces the view that, as a collective, individuals have power and responsibility over their own fate. However, they have no power without resistance (Lindrotha and Sinevaara-Niskanenb 2016).

[15] Collective resilience concepts are similar to the more recent socioecological resilience concepts of resilience processes (eg, Ungar 2012, 2015). Socioecological resilience concepts consider the role broader aspects of one's social ecology play; they emphasise that, if an individual is to adapt in a positive way, the contextual factors (eg, relationships, families, schools, neighbourhoods and cultural worldviews) are just as important as psychological factors to help overcome stress and adversity.

## 1.2 Suicide prevention for rangatahi, whānau and Māori communities

He aweawetanga nui tā te whakamomori ki a tātau katoa. Nā reira tātau mā, kia kaha tā tātau toro atu iō tātau ringa ki a rātau mā e ngaua ana e ngā tāmitanga, e nga pēhinga o tōna ao. Ka ngata ana a whakamomori, i tō tātau noho ngū. E hoa mā, kai kōnei ahau, kai kōnei mātau hai taringa rahirahi mā koutou. Ko tātau ngāwaha, ngā ringa, hai poipoi, hai kūmanu i a tātau anō. Ahakoa ngā tāmitanga o te tangata, ki te kore tātau e toro atu, ka kore tātau e mōhio nā te aha rātau e huri kanohi atu ai.

**Paige Scruton Nepe-Apatu**

For decades, Māori have called for an integrated Indigenous response to suicide prevention. This response, based on kaupapa Māori (a Māori approach), would have multiple pathways that enable rangatahi to flourish wherever and however they live.

In practice, the response includes kaupapa Māori services and initiatives designed and implemented by the community, rohe (area) and iwi that rangatahi come from. It also includes mainstream services with the capacity to provide culturally safe services for rangatahi. Overall, this integrated response will promote positive rangatahi development and Māori wellbeing.

This section supports an integrated approach to suicide prevention. It presents examples of promising practice for suicide prevention and postvention that are already happening in both individual communities and centralised services. People have built these services by harnessing the values and connectivity of whānau, hapū, iwi and Māori communities.

For suicide prevention efforts to be effective, it is important to reduce the risk factors that make rangatahi vulnerable to suicide. Equally, efforts must strengthen the protective factors that safeguard rangatahi against suicide, which means strengthening whānau resilience alongside the ability of young people themselves to resist the devastating impact of ongoing colonisation. The following six approaches demonstrate promising suicide prevention practices for rangatahi, whānau and their communities that Māori providers and communities have designed and delivered.

## Strengthening support for whānau wellbeing – Te Ha O Ngā Rangatahi, Māori Youth Suicide Prevention

Whānau is essential to providing for the wellbeing of rangatahi. Whānau ora (family wellbeing) encapsulates the capability of whānau to realise their tino rangatiratanga to nurture each other and to flourish. Through the empowerment of whānau, the empowerment of rangatahi will be achieved.

Te Ha O Ngā Rangatahi was brought to life through the partnership of Te Hauora O Ngāti Rārua and Te Pūtahitanga o Te Waipounamu. The initiative was formed from the need to find a solution to the high youth suicide rate in the Marlborough region and to give rangatahi a voice so that others could hear their whakaaro (thoughts, opinions). The name of the initiative comes from the vision of this partnership: to instil and strengthen the sacred and precious 'breath of life' of our rangatahi. It was time to take a new approach so that suicide prevention efforts could have a more positive, empowering and sustainable impact on rangatahi and their whānau.

The aim of Te Ha O Ngā Rangatahi is to strengthen whanaungatanga and self-determination so whānau can identify issues within their own lives and then have the capacity and capabilities to address those issues. Its vision is to become a self-sustaining programme, driven by the aspirations of whānau and rangatahi. Its two guiding principles are whakarongo (listen) and mahia ngā whakaaro (put the ideas into action). Many rangatahi and whānau have had experiences in which they were engaged but others did not listen to them and/or did not take any action in response to the views they shared. When the programme showed it was following these principles through its actions, it became much easier to connect whānau with the programme.

There must be a real sense of caring for one another: not just at a whānau level but also at a community-wide level. There must be a sense of caring that surpasses the barriers of ethnicity, gender, age or socioeconomic standing. Te Ha O Ngā Rangatahi provides a kaupapa Māori approach to developing and delivering a programme that had been missing in the community. It was developed through focus group hui with whānau and rangatahi, at which the purpose was to gather their whakaaro, feelings and ideas around rangatahi suicide prevention. The partners used this knowledge and information to develop strategies, with input from whānau and rangatahi.

This initiative encouraged whānau to take a strength-based approach to finding solutions for rangatahi, which would include positive role-modelling at home and within the wider community. An advisory/consultation group of whānau and rangatahi was established from the focus group participants, with the aim of developing an education programme and strategies that the advisory group could use to share the insights and solutions from these hui with the wider whānau, rangatahi and community.

For rangatahi, a lot of stigma (perceived or real) was linked to accessing services from the health hub in Blenheim. They were afraid that other rangatahi and whānau knew why they were there and that their appointments would not be confidential. Rangatahi asked if counsellors could be co-located at other organisations so their access was not so public, making them feel more comfortable about going to appointments. Rangatahi also stated that they did not want 'sugar-coated' messages; instead, they wanted messages to be blunt and to the point because then they would be more likely to listen and take the information on board.

> While everyone is being nice about it, we have people dying around us.
>
> **Te Ha O Ngā Rangatahi, rangatahi**

Te Ha O Ngā Rangatahi has taken whakaaro from rangatahi and whānau, and developed them into a sequence of initiatives to empower rangatahi and whānau. It has delivered a series of community whānau events, including noho marae (overnight stay at a marae), day trips and a very successful 'Blackout' event where rangatahi supported whānau to organise a social/disco in Blenheim for rangatahi – similar to the 'Blue Light'[16] discos of past times. These events have provided additional opportunities to share messages with a wider audience in a way that is acceptable to rangatahi.

[16] Blue Light encourages healthy and safe socialisation at the community level for young people: all Blue Light events are alcohol, drug and violence free.

## Cultural (tikanga) development – Te Taitimu Trust, turning the tide

People who are developing policy and providing services need to better understand Māori sense of belonging and the value of cultural identity for Māori. Cultural alienation is a reality for many rangatahi today. The events and ongoing effects of colonisation, such as mass urbanisation and disconnection from whānau, hapū and iwi, have had an intergenerational impact on Māori communities. This makes it difficult for them to develop a strong Māori cultural identity (Hirini and Collings 2005). As a way of preventing suicide, Māori community approaches reconnect young Māori when they have been disconnected from their culture. Lawson-Te Aho (1998) calls these 'cultural (tikanga) development' approaches. The aim is to restore cultural connectedness by helping rangatahi learn about Māori cultural values and practices as well as Māori ways of relating to one another.

> Cultural development means teaching Māori youth about their identity as Māori, who they are, where they come from and how their whakapapa as Māori is a strength.
>
> **(Lawson-Te Aho 1998)**

Following the death of his own 15-year-old son 17 years ago, Hawke's Bay suicide prevention campaigner and Te Taitimu Trust director Zack Makoare has dedicated himself to battling the difficulties that young people face.

> I have been trying to spread the word of trust, commitment and aroha. It's about leadership within families – getting people supporting whānau and communities.
>
> **Zack Makoare, director, Te Taitimu Trust**

Knowing rangatahi face many challenges that they must deal with to live long, healthy, sustainable lives, the Trust engages with high-needs communities and key stakeholders while effectively coordinating and delivering high-quality services to support the development of healthier, happier rangatahi who become confident and connected citizens. The Trust's vision is to turn the tide of negative Māori health disparities by motivating rangatahi and whānau to navigate their own waka towards realising positive notions of whānau ora.

Toward this vision, Te Taitimu Trust coordinates and facilitates rangatahi wānanga (learning forum) with high-needs or high-risk Māori and Pacific rangatahi, whānau, groups and communities. Its aim is to engage with the hearts and minds of our rangatahi, motivating them to become our rangatira (leaders) for the future through engagement with the natural environment. The wānanga give young people the opportunity to come together and find out how they can become leaders. The Trust's philosophy on the marae is to teach rangatahi about being servants to their whānau.

> If we are to build connected and confident rangatahi we've got to teach them on the marae about being a servant to our whānau.
>
> **Zack Makoare, director, Te Taitimu Trust**

As well as being a forum for creating leadership, the natural environment has helped rangatahi with decision-making as they progress through adolescence. Te Taitimu Trust has found the method has proven successful to engage young people in wānanga, noho marae, weekend rangatahi workshops, weekend trips and other activities. Natural environment-based safety and skills development involving, for example, waka ama (outrigger canoes), snorkelling for kaimoana (seafood) and surfing, helps rangatahi to build resilience, confidence and self-esteem.

Leadership wānanga, te reo Māori, mahinga kai (gardening), whakamaoa (cooking) and experiencing nurturing tuakana–teina relationships[17] between rangatahi and kaitiaki are also offered, to enhance the taha wairua (spirituality) and cultural identity of rangatahi.

Through the delivery of wānanga, the programme can support healthier, happier rangatahi who will become confident, resilient and connected. The Trust values whakawhanaungatanga (building relationships) with support agencies and local communities, whānau and rangatahi.

> It's knowing how to grow and manage relationships.
>
> **Zack Makoare, director, Te Taitimu Trust**

The Trust continues to build opportunities for whānau to access the services of social and health professionals who they might not normally engage with, for support with budgeting, education and parenting, among other things. Again, the goal is to nurture self-reliant, self-sustainable whānau and communities.

[17] The tuakana–teina relationship, an integral part of traditional Māori society, provides a model for buddy systems. An older or more expert tuakana (brother, sister or cousin) helps and guides a younger or less-expert teina (originally a younger sibling or cousin of the same gender).

## Acknowledging the whakapapa of suicide and decolonisation – Takerei Ruha Whānau Trust

Decolonisation approaches look at Māori youth within the broader context of the history of Māori as an Indigenous colonised population and consider the outcomes of that history in the present (Lawson-Te Aho 1998). As decolonisation approaches are related to cultural (tikanga) development approaches and Māori-led suicide prevention, researchers commonly support using both approaches together (Cameron et al 2017).

Decolonisation is about knowing how colonisation has a lasting impact on mauri ora, whānau ora and your own whakapapa. This involves teaching young Māori about how the colonisation and settling of Aotearoa New Zealand impacted the wellbeing of Māori society and helping young Māori reclaim aspects of their culture that were lost because of colonisation (Lawson-Te Aho and Liu 2010). Importantly, this also includes teaching young Māori about how modern forms of colonisation, such as racism and negative stereotyping of Māori in media, impact their wellbeing.

The Takerei Ruha Whānau Trust began as a direct response to the crisis caused by suicide in Kawerau. Since then, the programme has worked closely with whānau and local providers to prevent suicide and promote health and wellbeing within the community.

> The whole whakaaro around whānau transformative praxis is about acknowledging the solutions that come from those learnings, our own stories.
>
> **Peta Ruha, director, Takerei Ruha Whānau Trust**

The programme is firmly based on tikanga principles of whanaungatanga, manaakitanga (showing respect, generosity and care for others) and aroha (love). It recognises the whānau is central to all aspects of the programme.

> When we are working with whānau we are calling on those traditional values that are left with us such as aroha because of the responsibility to address issues within our own whānau.
>
> **Peta Ruha, director, Takerei Ruha Whānau Trust**

A strong focus is on rangatahi, and their health and wellbeing. As such, rangatahi play a key leadership role in designing and implementing whānau initiatives to prevent suicide and to support and care for whānau affected by suicide. One example of a solution developed to address the spate of suicides in Kawerau is the whānau champion kaupapa, which the Trust mobilised with the support of Māori health provider Tūwharetoa ki Kawerau Hauora.

The marae-based nature of the Trust allows whānau and rangatahi to develop strong links with their whakapapa. The marae provides a space in which people can develop collaborative strategies to confront and overcome the multiple challenges to their health and wellbeing caused by suicide. Some of these challenges relate to the isolation and lack of support for whānau affected by suicide. The Trust uses a coordinated approach to supporting whānau to ensure their safety during their bereavement. It provides whānau with training in supporting people in need and dealing with trauma on an ongoing basis.

The programme recognises that solutions lie within the whānau and focuses strongly on developing relationships based on trust. It also recognises that whānau need to have support and resources to design and implement suicide prevention strategies. The programme works closely with whānau to build trust between whānau and providers, while recognising that whānau are storehouses of ancestral knowledge that is crucial in developing appropriate programmes that are responsive to the needs of whānau and rangatahi.

A sign of the importance of whānau-based relationships is the recognition that the Trust is the first point of contact for agencies in Kawerau when a suicide (or attempt) occurs. It is seen as a key link between police and affected whānau. The Trust has received one-off funding from the Ministry of Health and has sought funding from other sources to give its programme a secure base allowing it to can continue into the future.

## Strengthening points of intervention across the life course – LifeKeepers

An important part of effective suicide prevention is strengthening the key points of intervention: that is, ensuring that intervention occurs at multiple sites and at various points across an individual's life course, with more contact at times of increased risk. Aotearoa New Zealand has lacked a national policy to inform local early intervention initiatives for addressing adverse childhood experiences.

However, the Child and Youth Wellbeing Strategy has recently been launched and discusses the need to focus in on early intervention to reduce adverse child experiences. These initiatives need to be found within parenting programmes, schools, health care, the justice system, mental health services and wider community development (note that the Werry Workforce's Incredible Years programme, is taking this approach).

The more resources that can be filtered into suicide prevention, the better the outcomes for rangatahi and whānau. Preventing suicide requires a multifaceted approach, to address the many intersecting challenges rangatahi face.

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Kia hora te marino, kia papa pounamu te moana,
kia tere te karohirohi i mua i tou huarahi.

May calm and tranquillity be widespread, may the waters that you sail in glisten like greenstone, and may their shimmering light guide you safely on your journey.

**Māori blessing**

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LifeKeepers is a national programme that provides tailored training in suicide prevention for a wide range of people in face-to-face workshops and online e-learning modules. Participants are taught how to recognise and support whānau and friends in need. The programme is designed especially for those who work in communities or in frontline community roles, such as: support workers, sports coaches, emergency service personnel, church leaders, school counsellors, youth workers, Māori wardens, caregivers, kaumātua (an elder of status within the whānau) and community leaders.

The aim of LifeKeepers is to equip New Zealanders aged 18 years and over with the knowledge and skills to identify and support individuals at risk of suicide in their communities. Following training, participants will:

- know how to talk about suicide in a responsible way
- understand the risk and protective factors for suicide in New Zealand
- know how to identify warning signs that an individual may be at risk of suicide
- have increased skills and confidence to intervene safely with individuals at risk of suicide
- have new knowledge they can sustain and apply in practical ways
- be more aware of relevant local, regional and national support services
- know more about the cultural impact on suicide risk and how to consider cultural views in providing any help to individuals at risk of suicide.

LifeKeepers draws on local knowledge and experience, as well as international evidence and expertise. The programme is designed to be clinically safe and culturally responsive. It started out by working with key partners and organisations that have a common interest in preventing suicide among Pacific peoples.

LifeKeepers has also developed a stream specifically tailored to meet the needs of whānau Māori. Mana Akiaki: LifeKeepers is delivered through a Māori lens, weaving te reo Māori, tikanga, whakataukī (proverbs) and mātauranga Māori throughout the programme. Mana Akiaki was co-designed with leading experts in the field, those with lived experience, Māori suicide prevention stakeholder groups and Māori communities.

As a result, Mana Akiaki is strengths-based and draws on a wide range of Māori traditions that emphasise both holistic wellbeing and approaches to health that are family and community oriented. Māori in the community who are likely to be in contact with those at risk of suicide are a key priority group for the Mana Akiaki training, as they play an important role in preventing suicide. Targeted delivery of the training programme involves providing Māori with the skills and knowledge, in an authentic Māori approach, that they can use to create and sustain communities (CareNZ[18]) and help prevent suicide.

LifeKeepers has designed and is delivering its programme in collaboration with:

- its community partners – Te Rau Ora (formerly Te Rau Matatini), Homecare Medical and Walker Psychology
- an expert advisory group
- key national suicide prevention organisations such as Clinical Advisory Services Aotearoa, Rural Health Alliance Aotearoa New Zealand, He Waka Hourua, Skylight, Kia Piki Te Ora, the Mental Health Foundation and district health boards (DHBs)
- individual academics, people with lived experience of suicide, cultural knowledge holders and leaders in suicide prevention.

LifeKeepers is part of a wider group of national suicide prevention initiatives that operate across government, and national suicide prevention services funded by the Ministry of Health.

## Positive Youth Development – the Aroha Project

Positive Youth Development (PYD) is a strengths-based approach to development that works to enhance the wellbeing of young people by supporting them to develop positive relationships with their environments. It focuses on the potential of young people, rather than viewing them as problems to be fixed (Damon 2004). Māori PYD approaches are based on the understanding that an individual's social and cultural context is an important determinant of health behaviours and health outcomes (Hirini and Collings 2005).

'Te Kete Whanaketanga – Rangatahi' (The Developmental Kit – for Youth) is a PYD framework for Indigenous and minority youth. It identifies seven key PYD features: positive relationships, activities, cultural factors, education, healthy lifestyles, sociohistorical factors and personal characteristics. In Aotearoa New Zealand, the Ministry of Youth Development – Te Manatū Whakahiato Taiohi currently funds a range of programmes that use PYD approaches to strengthen the wellbeing of rangatahi aged 12–24 years so they are better able to 'succeed, contribute to and enjoy life' (Ministry of Youth Development – Te Manatū Whakahiato Taiohi 2019).

The Aroha Project is based in Auckland and hosted by the Mika Haka Foundation. The project supports the needs and aspirations of rangatahi by providing them with hands-on practical training in life skills and professional development.

> It took years of struggling to find myself and find a sense of belonging in this world, and now that I've discovered myself, I'm not afraid to show the world exactly who I am.
>
> **Aroha Project rangatahi**

[18] https://www.carenz.co.nz/

The Aroha Project began as a community-based response to bullying, alienation and suicide risk, and is focused on the needs of lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI or takatāpui) communities in Aotearoa New Zealand. Recognising that young people from these communities are at increased risk and are more vulnerable, the project works closely with these communities to reduce the risk of suicide and attempted suicide. People of all genders are accepted and welcomed into the programme.

The core principle of the Aroha Project is for young people to move on to great, holistic, vibrant lives. The fundamentals of the project are respect, tikanga and mōteatea. Rangatahi, pakeke (adults) and kaumātua play important roles in helping to determine the direction of the project. By participating, rangatahi build networks and strengthen connections and attachments to friends, whānau and communities.

The Aroha Project recognises that whānau and communities have their own approaches and plans in place and are actively building resilience to and reducing risks of suicide.

The Aroha Project involves a series of trans-media, multimedia projects to reach out to, and create discussion among, Māori and Pacific youth to tackle issues related to suicide in an innovative way. Its aims are to provide:

- people in need with information and access to services
- whānau and communities with resources to build strong relationships
- a context that builds people's confidence and enables them to talk about challenges in their lives and identify solutions.

> Poverty stops a young person having access – services need to be free, and we need to go to them.
>
> **Mika Haka, founder, Mika Haka Foundation**

The programme is designed and structured in a way that allows rangatahi to grow and develop in a safe environment where skilled and experienced teachers and mentors nurture and guide them. The mentors draw on the skills and expertise of rangatahi who have participated in the programme.

> There's nothing like seeing rangatahi succeed... when their dreams are allowed to be listened to and encouraged.
>
> **Mika Haka, founder, Mika Haka Foundation**

**The key messages of this programme include:**

- positive self-expression of diversity
- smokefree, drug-free events for rangatahi
- the fact that learning is continuous
- stories of hope and wellbeing
- smashing bullying, self-harm and suicide
- positive self-expression through creative dance and the arts
- good self-care, physical fitness, secure identity and positive self-esteem.

The Aroha Project draws on the strengths of community members and groups such as writers, performers, youth organisations, Lifeline and Youthline. Through these networks and relationships, rangatahi who participate in the programme learn more about services, including suicide prevention services and LGBTQI awareness programmes.

## Postvention as a suicide prevention approach – Fusion

Suicide has a profound effect on whānau and rangatahi. It is critical to give whānau effective support after a suicide and uphold their right to choose their own processes for healing. Whānau bereaved by suicide are a vulnerable, priority population requiring meaningful support. For some, the experience engenders suicidal thoughts within themselves, and they experience responses such as self-blame, guilt and potentially self-destructive coping mechanisms.

> You're working with people first, before you're working with what happened.
>
> **Fusion member**

Māori-centred postvention tools use narrative techniques to help bereaved whānau heal and emphasise the removal of stigma and restoring the mana (prestige, status) of the deceased (Emery et al 2015). The stigma attached to suicide is a major reason why rangatahi and whānau hold back from seeking help. Historically, Māori have been less likely to discuss suicide because of a silencing on the topic within communities and the whakamā around it. There is a need to create safe spaces and discourse around suicide. This discourse needs to include lifting the mana of the deceased to foster healing and learn from past experiences.

Fusion is a multi-sector collaboration in Tai Tokerau ki Muriwhenua. It works to reduce suicide and reduce the harm caused by suicide by using whanaungatanga, proactive analysis and intervention, kotahitanga (unity, togetherness) and a tailored response to the ongoing challenges facing vulnerable children, youth and families in Northland.

The Fusion team was formed in March 2012 after two suicide deaths occurring two weeks apart prompted individuals from local agencies to get together to respond. The group included Child, Youth and Family (now Oranga Tamariki), the Ministry of Education, the DHB's child and adolescent mental health service Te Roopu Kimiora and non-governmental organisations Ngāti Hine Health Trust and Ki A Ora Ngātiwai. While the group was forming, further deaths by suicide and suicidal behaviour (ideation, threats, attempts) occurred.

By April 2012, the group was aware it was dealing with a cluster of suicides and contagion. More rangatahi were dying by suicide: some were known to each other (sometimes related) or knew of the suicides. This cluster was unprecedented in Te Tai Tokerau.

A significant turning point occurred when the work of the group came to the notice of the Ministry of Health and the Director-General of Mental Health, who subsequently visited. The Ministry agreed to provide funding to establish a suicide prevention coordinator in the DHB, who was then welcomed into the Fusion group.

> What I remember most about what mattered back in that time, and still today, is the value of whanaungatanga.
>
> **Fusion member**

The key element of Fusion's success is the trust built from whanaungatanga. Without the initial intent to share information quickly, which then occurred despite previous organisational barriers to rapid information exchange, life-saving interventions would not have been possible. The networks made through whakawhanaungatanga and whakapapa are enduring, not just for the life of a project. Through Fusion it is possible to coordinate important information held separately by government agencies relating to vulnerable and at-risk children, youth and whānau.

The Fusion process can be triggered by a sudden death or suspected suicide, suicide attempt or threat of suicide from information gained as part of the police response. With timely updates on this information, Fusion members can rapidly follow up the next day with whānau and schools, as the agencies and people involved provide appropriate services that wrap around the community.

Growing tino rangatiratanga in whānau is critical to the work of the Fusion team; it is essential that the team uphold mana in the whānau it is supporting, so whānau members can regain the confidence of their existing skills, knowledge and strengths.

Over time, schools have become a critical partner in successful postvention work. The school setting has the potential to be a 'caretaking' environment and a supportive place for rangatahi. At first, the group had to do much work to engage the schools, gain their trust and encourage them to see the value in the Fusion model. Now the group receives proactive calls and referrals from principals about rangatahi they are worried about, especially those who have been affected by suicide in the past. The schools are responding more appropriately now when advice is offered. They are more confident, have processes in place and have a high level of trust in their partners.

While Fusion deals with crises, its postvention work is also about longer-term support for whānau to develop skills to understand their rangatahi, along with signs and risks of suicide and how to manage them. The team checks in with whānau when they need it and also proactively. Postvention support in the community continues for at least 14 months beyond the first anniversary of the death.

> The solutions for Māori are within Māori – embedded at the root of it, people first, tikanga, te reo, whakapapa and then it's everything else.
>
> **Fusion member**

The Fusion team still shares and responds to information relating to suicide risk within the Te Tai Tokerau community daily and has strong governance over it to ensure confidentiality. The team continues to monitor those they consider to be at risk after a suicide and acts immediately as a group when needed. It retains a huge commitment to this approach, because its members have seen it work.

# PART 2 | WĀHANGA 2

## Recommendations for government

## Ngā tūtohutanga mā te kāwanatanga

Hai tā Aotearoa he whakatinana i ngā momo rongoā rerekē a tēnā, a tēnā mo te oranga o ngāi tātau te tangata. Ki te kore, ka pokea tonutia tātau e te hinapōuri, e te mate hinengaro.

**Paige Scruton Nepe-Apatu**

This part summarises the explanatory framework and evidence presented in Part 1, and together with the findings from the data analysis (Appendix 1), it builds the case for the recommendations it makes for policy change for government. At the core of these recommendations is the need to address structural racism, with the underpinning theme that the responsibility is on government, as a Te Tiriti partner, to address the institutional racism that is putting all rangatahi at risk.

Te Mauri
THE LIFE FORCE

**To achieve the policy changes needed, all of government must:**

1. embed and enact Te Tiriti into all policy and practice to support mana motuhake (autonomy, self-determination, sovereignty, self-government), accelerating this process for rangatahi within the education and health sectors
2. urgently address the impact of socioeconomic determinants of health on whānau, including poverty, alcohol, racism, housing and unemployment
3. invest in what works for Māori, iwi, hapū and whānau – invest in, fund and build communities to lead initiatives that support communities in suicide prevention and postvention
4. work collectively, nationally and locally to leverage government investment in what works for Māori.

## 2.1 Embed and enact te Tiriti into all policy and practice to support mana motuhake, accelerating this process for rangatahi within the education and health sectors

### Te Tiriti in education

One of the key findings of this report is that stand-downs are more common among rangatahi than among non-Māori, non-Pacific children and young people. The Aroha Project identified bullying has a relationship to suicide and suicide attempts in rangatahi. Although behavioural issues and truancy are often the more visible reasons for stand-downs and exclusions, these behaviours are usually driven by challenges that young people face both inside and outside of school, including poverty, violence, learning difficulties and bullying. Such adversities can manifest in anger, fighting, truancy, substance misuse and mental health challenges. When rangatahi seriously misbehave in schools, they can be referred to alternative education, which can ultimately lead to them completely disengaging from education. Disengagement from school needs to be a signal to the school that students may be facing challenges to their wellbeing, either in their home or at school.

Schools have the potential to be sites of safety, stability and security for young people and to play a strong role in supporting student wellbeing. Providing the appropriate intervention at the right time can prevent behaviour from escalating into disengagement (Ministry of Education 2017a). Rangatahi aged 16–18 years are particularly vulnerable because the education system is not obliged to find these students another school if they are expelled. Because the social welfare system provides insufficient financial or social support for them until they are 18 years old and they have little work experience, people of this age remain particularly vulnerable and struggle to find employment.[19]

Increasingly, both nationally and internationally, schools are following restorative approaches (Gonzalez, Sattler, Buth 2018). These involve focusing less on punishment to deal with behavioural issues and more on building positive relationships across schools and communities. The Ka Hikitia (Ministry of Education 2013) strategy identifies key elements that need to be in place for the success of Māori students in mainstream schools: strong and respectful engagement with whānau, hapū and iwi; affirming Māori identity, language and culture; and validating Māori students as Māori.

Effective pastoral care,[20] guidance and counselling provided in schools can help support students to overcome challenges. This can help improve their engagement and achievement, as well as reduce suicide risk among young students (Ministry of Education 2017a).

Evidence also shows that school-based health services, particularly those with on-site health professionals, can help support mental wellbeing and reduce suicide risk (Denny et al 2014). Schools have the potential to play a strong role in improving rangatahi wellbeing.

[19] Note that the Ministry of Development does provide, to young people under the age of 18, a youth payment, young parent payment and support for young people not in education, employment or training (NEET).

[20] Pastoral care often describes the work of the school deans, guidance counsellors, youth workers, school nurses and other staff involved in supporting student wellbeing (Ministry of Education 2017a).

## Recommendations for education

1. The **Ministry of Education** improves engagement of rangatahi in education through creating an inclusive school culture and reducing stand-downs and suspensions. It creates this culture by:
    - treating truancy as an indicator of rangatahi need, not as a compliance or punitive issue
    - strengthening restorative practices to improve the way schools see and address behavioural issues; supporting students who are stood down, and having appropriate and adequate support systems in place to protect and care for students excluded from school
    - enhancing teacher training and education so that teachers are aware of the broader issues behind and reasons why students develop or exhibit behavioural difficulties
    - engaging effectively with whānau with the aim of restoration when addressing rangatahi disciplinary issues
    - tailoring Positive Behaviour for Learning (PB4L) approaches to the needs of rangatahi and whānau
    - evaluating the existence and quality of policies on bullying in schools
    - encouraging schools to take proactive measures to provide a safe environment for rangatahi with diverse sexual orientations and gender identity expressions (SOGIE), including positive information regarding SOGIE to all students
    - providing more support for primary schools to identify learning difficulties in tamariki early and provide education support that engages fully with their whānau
    - co-designing programmes with rangatahi and involving them in reviewing the implementation and effectiveness of those programmes.

2. The **Ministry of Education** partners with the **Secondary Principals' Association of New Zealand** and **Ministry of Social Development** (through its Youth Service) on the pathways for school leavers as they transition from school into the community, employment and independent housing.

3. The **Secondary Principals' Association of New Zealand** works to create safe spaces and processes for postvention management in schools by ensuring a safe balance between avoiding any discussion of suicide and over-responding, and ensuring those who are most affected, and who most need it, are supported to talk.

4. The **Ministry of Education** works with the **Secondary Principals' Association of New Zealand** to:

   - support schools to demonstrate tikanga and validate Māori students by acknowledging their tangata whenua status, as well as encouraging schools to develop knowledge of the local area's history and support the implementation and teaching of te reo Māori
   - take the lead in confirming best practice training for schools in suicide prevention education to students and staff, founded on evidence-based, clinical and public health approaches to suicide.

5. The **Ministry of Education** partners with the **Ministry of Health** to design and deliver school-based wellbeing services in all low-decile primary and secondary schools to promote wellbeing and school engagement among all tamariki and rangatahi. These services include:

   - on-site social workers, and nurses in schools, who are skilled in assessing the psycho-social needs of tamariki and rangatahi, and linking their whānau with the appropriate care
   - a mauri ora (wellbeing) nest where tamariki and rangatahi can access cultural advice and expertise to help them connect to their whakapapa and strengthen their cultural identity in every region
   - maintaining contact with students who are stood down or excluded to enable them to receive a complete psycho-social wellbeing assessment (eg, HEEADSSS[21] assessment) and ensure that any issues are referred to social workers and school mental health support workers
   - collaborating with health and social services providing support to rangatahi and whānau.

[21] A HEEADSSS assessment is carried out for all year 9 students. This helps assess youth wellbeing through a series of questions relating to home, education/employment, eating, activities, drugs, sexuality, suicide and depression, and safety (HEEADSSS). Any medical or mental health issues can be identified at an early stage, and students can be referred for treatment (https://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project/youth-mental-health-project-initiatives/expanded-school-based-health-services-making-difference).

## Te Tiriti in health

The report findings highlight two key issues: that many rangatahi who died by suicide had not had any engagement with secondary mental health services, and that very few of those who did engage with mental health services had a specific diagnosis recorded.

Several reasons may help to explain these findings: an unmet need for mental health services, difficulties with making a clear psychiatric diagnosis in this age group, or an issue with recording diagnoses for young people. It is also possible that some of the underuse of mental health services among rangatahi is driven by common care access and quality issues that Māori communities face. These include barriers to accessing care (eg, cost) as well as a lack of culturally effective models of care, and a gap in the response to behavioural and psychological distress.

Culturally effective models of mental health care for rangatahi include those that are based on Māori worldviews and concepts of mental health and wellbeing (eg, spiritual concepts such as 'mauri ora'). Similarly, there is an increasing need for Māori mental health services to provide 'trauma-informed' approaches to care – that is, approaches that are familiar with te ao Māori and recognise that Māori experience trauma in unique ways that are linked to their experience of colonisation, racism, negative stereotyping and resulting intergenerational whānau poverty and violence (McClintock et al 2018; Pihama et al 2017). It is crucial to remove these barriers so that rangatahi seeking mental health care can access it in a culturally safe manner and at a time and place that is appropriate for them.

It is important to acknowledge that many rangatahi needing help don't meet criteria for mental health services because they are suffering from severe distress, and do not have a mental illness, therefore increasing access to mental health service will not benefit those rangatahi. This challenges the common misconception that suicide is a result of mental illness, particularly depression (Shahtahmasebi 2018). Many of the rangatahi who have died would not have been considered to require specialist mental health intervention before their death. Therefore, although the health sector plays an extremely important part in addressing suicide, it is only one component of what is needed to solve this complex issue, which involves wider society and ongoing systemic problems.

## Recommendations for health

6. The **Ministry of Health** and **Suicide Prevention Office:**

   - resource community capability and capacity for postvention responses to suicide, ensuring they know about and can easily access the existing best evidence-based information available
   - fund development of resources that promote safe, non-stigmatising conversations among the health and social sectors
   - ensure rangatahi co-design programmes and are involved in reviewing their implementation.

7. The **Ministry of Health** partners with the **Ministry of Social Development** or **Ministry of Youth Development** to strengthen and sustain Youth One Stop Shops (YOSS). The ministries use YOSSs as a key pathway to support all rangatahi by:

   - broadening the scope of YOSSs to give rangatahi access to the full range of services they need, including: sexual, physical and mental health services; peer vocational and cultural support; and access to social workers to secure financial and housing support as well as help them navigate through social services
   - addressing the current gaps in timely, responsive and culturally appropriate rural services, especially to respond to potential crises.

8. The **Ministry of Health** actively supports increases to the accessibility and cultural appropriateness of mental health services in DHBs and the community delivered to tamariki, rangatahi and their whānau by:

   - ensuring Māori mental health services provide 'trauma-informed' approaches to care that take account of, and accommodate, Māori worldviews
   - expanding service response to recognise psychological distress and safety concerns
   - prioritising Māori-specific concepts of suicide and wellbeing in care and prevention, and expanding options to include kaupapa Māori providers
   - supporting improvements in hospital and community Māori maternal mental health services
   - training DHB staff to deliver culturally responsive care to rangatahi and their whānau
   - ensuring access to services for those in remote locations.

9. The **Ministry of Health** with **DHBs** resource, plan and fund suicide prevention and postvention work by:

- the Ministry of Health supporting DHBs to resource staff and systems for postvention work, recognising this service demands a 24/7 response
- DHBs ensuring that postvention staff have competencies, capability and experience to do this work; are local experts in their field; are compassionate and trusted; and work within a networked community
- creating discrete roles committed to postvention work, and by taking a succession planning and team approach within each DHB so DHBs can develop sustainable relationships with communities
- understanding the cultural context of suicide, that there is a whakapapa to suicide and that whānau need support, a space and time to grieve properly, during pani (bereavement period)
- the Ministry coordinating suicide postvention work, tools and resources nationally, encouraging local development to suit local issues and populations, supporting postvention work with timely, accurate intelligence
- ensuring whanaungatanga, whakapapa and other te ao Māori values are the basis of any postvention initiative, regardless of its size or location
- recognising that rangatahi are affected by adult suicides in their communities and factoring this into postvention work (currently focused on the suicides of young people only)
- evaluating current postvention work nationally, building in resources to reflect lessons learnt and developing an evaluations outcomes framework
- continuing postvention support for those bereaved by suicide for at least 14 months, to include and go beyond the first anniversary of the death
- attracting postvention staff who are embedded in the community they serve and providing them with ongoing supervision and professional development.

10. The **Ministry of Health** and **Suicide Prevention Office** form a cross-sector suicide prevention group to provide sustained leadership and governance of national suicide prevention approaches for rangatahi and whānau. These approaches include:

- developing a national suicide prevention action plan specifically for Māori that is founded in Te Tiriti and addresses the root causes of inequities for rangatahi and their whānau
- forming strategic partnerships with Māori communities and providers to develop and deliver culturally informed initiatives
- rolling out the national Suicide Prevention Strategy and Action Plan with workshops, including suicide prevention coordinators and the Ministry of Education and schools, to ensure all relevant sectors take up the strategy; and involving whānau, iwi and community in the implementation and evaluation
- including representatives from rangatahi leadership on the cross-sector group.

## 2.2 Urgently address the impact of determinants of health on whānau, including poverty, alcohol, racism, housing and unemployment

When deprivation increases, rangatahi suicide deaths also increase. At a population level, deprivation is a significant risk factor for rangatahi suicide in particular. The same clear socioeconomic trend is not evident for non-Māori, non-Pacific children and young people, for whom the number of suicide deaths remains relatively stable across all levels of deprivation.

For effective rangatahi suicide prevention, it is crucial to address poverty for Māori whānau and to enhance protective factors unique to Māori. This means strengthening intersectoral initiatives that support whānau wellbeing and giving Māori access to initiatives and programmes that help them build a Māori-centred foundation from which they can flourish.

### Recommendations to address socio-economic determinants of health

11. The **Department of the Prime Minister and Cabinet** ensures its Child and Youth Wellbeing Strategy addresses the social and cultural determinants of health that underpin rangatahi suicide inequities, improve living conditions and help reduce whānau poverty. This will involve specifically focusing on:
    - developing sustainable and secure housing models for whānau
    - embedding cultural determinants specific to Māori (cultural connectedness, whakapapa, mātauranga, tikanga and cultural identity) throughout the strategy
    - ensuring that tamariki and rangatahi co-design implementation activities.

12. The **Ministry of Health:**
    - supports the establishment of alcohol and drug addiction services for those aged under 14 years
    - uses health data to influence the wider system to take a stricter regulatory approach to the sale and supply of alcohol (as advised by the Mental Health and Addiction Inquiry Panel 2018, 2010 Law Commission review, 2014 Ministerial Forum on Alcohol Advertising and Sponsorship and 2014 Ministry of Justice report on alcohol pricing).

13. **Oranga Tamariki – Ministry for Children:**
    - provide trauma-informed and oranga-focused approaches to care that centre te ao Māori world views, enhance mana tamaiti and support whakapapa and whanaungatanga connections
    - increase support and opportunities for tamariki and rangatahi in care to connect and reconnect to whānau and important people, places and events
    - identify and support the full range of needs for tamariki and rangatahi in care and during changes in care arrangements and transitions towards independence
    - partners with the **Ministry of Education** to engage with communities to share information about children in care with schools, and work with schools to enable them to safely discuss information on wellbeing at school

- support placement decisions that prioritise keeping tamariki in the same school to help them stay connected to their peers, social groups and the school's pastoral care; where this is not possible, work with schools to plan for and manage transition
- partners with the **Ministry of Education** and **Ministry of Health** to ensure social work services delivered in schools are complementary to school-based wellbeing services
- provides whānau-centric programmes to pregnant wāhine and their partners, as well as new parents, supporting them to develop healthy relationships with each other and their communities.

14. The **Suicide Mortality Review Committee** investigates the extent to which alcohol and other drugs are involved in suicide events, the life of the person who has died and whānau, and population health.

15. The **Ministry of Social Development:**

- boosts core benefits significantly in line with the Welfare Expert Advisory Group's recommendation
- provides the full Working for Families package to all low-income families, lifts the earning threshold and ensures all children supported by a benefit receive the full Working for Families package.

16. The **Ministry of Social Development** and **Ministry of Housing and Urban Development** in partnership with the **Māori Housing Network, Kāinga Ora - Homes and Communities** and other housing providers[22] deliver on:

- partnering with **Oranga Tamariki** to help older rangatahi find accommodation and housing
- ensuring that accommodation is safe, warm, dry, affordable and secure
- encouraging the **Community Housing Regulatory Authority** to support regular audits.[23]

## 2.3 Invest in what works for Māori, iwi, hapū and whānau – invest in, fund and build communities to lead initiatives that support communities in suicide prevention and postvention

Part 1 of this report demonstrates that many positive initiatives for Māori rangatahi are already underway. These provide models of effective engagement and support with and for rangatahi, such as:

- whānau-centred support for whānau wellbeing
- cultural (tikanga) development approaches and Māori-led suicide prevention
- programmes of intervention at multiple sites and at various points across the life course, including when individuals are at increased risk
- strengths-based Positive Youth Development approaches that enhance the wellbeing of young people by supporting them to develop positive relationships with their environments
- postvention support for bereaved whānau with the aim of healing and preventing further suicide.

[22] Includes local councils, churches, iwi organisations and housing trusts and foundations.

[23] The Community Housing Regulatory Authority supervises and monitors community housing providers annually for each organisation, checking them against the performance standards. It also investigates complaints from tenants and can suspend or revoke an organisation's registration, if appropriate.

Cultural alienation is a reality for many rangatahi in today's society. The impacts of colonisation, such as mass urbanisation and disconnection from whānau, hapū and iwi, have had an intergenerational impact on Māori communities. For this reason, many tamariki and rangatahi now lack the opportunity to connect with their culture. This makes it difficult for them to develop a strong Māori cultural identity (Hirini and Collings 2005). Services need a better understanding of Māori sense of belonging and other indicators of cultural identity for Māori.

Listening to whānau and rangatahi is crucial. Tamariki and rangatahi have already said it is important to them to feel contented, have supportive family and friends and have their basic needs met, be mentally healthy, feel safe, have a good education and feel valued and respected (Office of the Children's Commissioner and Oranga Tamariki 2019). Feedback from postvention groups and to the Mental Health and Addiction Inquiry Panel indicates that initiatives must respond to the local context so that they are relevant to rangatahi and whānau. A top-down, national, one-size-fits-all approach does not empower communities to take control of the situation or create sustainable solutions; instead, agencies need to listen to communities (Government Inquiry into Mental Health and Addiction 2018).

## Recommendations to support flourishing Māori initiatives

17. **Whole of government** explicitly demonstrates its support of kaupapa Māori approaches. Actions that show such support include:
    - describing and providing evidence of government engagement with Māori providers, iwi and communities
    - evidence that Māori have co-designed funding and planning activities
    - further funding to ensure monitoring and evaluation are part of all initiatives.

18. The **Ministries of Health, Education** and **Social Development** invest collectively and individually to prioritise and support whānau-centred approaches to service design and delivery. Their investments focus on:
    - supporting whānau in the community (eg, community connectors and Whānau Ora navigators)
    - increasing funding so that monitoring and evaluation are supported to be part of all initiatives and not a burden on providers
    - supporting whānau-centric training that takes a Māori worldview (eg, Mana Ake)[24]
    - supporting Whānau Ora commissioning agencies and their providers
    - including the voices of rangatahi when commissioning or evaluating programmes.

[24] http://ccn.health.nz/FocusAreas/ManaAke-StrongerforTomorrow.aspx

## 2.4 Work collectively, nationally and locally to leverage government investment in what works for Māori

### Recommendations across government

19. The **Suicide Prevention Office:**
    - creates a cross-government joint venture for suicide prevention and postvention
    - develops an all-agency agreement on information-sharing to ensure privacy concerns that individual agencies have at the practice level do not prevent best practice in saving lives
    - learns from evidence of effectiveness of postvention initiatives.

20. **Oranga Tamariki:**
    - improves processes for working with rangatahi and their whānau to understand care and protection concerns
    - gathers information from schools, mental health and addiction services and other agencies
    - uses this information to guide rangatahi and whānau-led decision-making and planning.

21. The **Mental Health and Wellbeing Commission** leads discussion, with representation from all relevant health, social and justice ministries, to:
    - improve the quality of Māori-centric information and data on whānau and Māori communities
    - gather and disseminate information that reflects te ao Māori concepts of wellbeing.

22. The **Mental Health and Wellbeing Commission** partners with **Te Puni Kōkiri** and the **Ministry of Health** to:
    - promote investment strategies and solutions supported in communities and investment in new systems and practices for Māori and by Māori
    - promote long-term contracting periods, to support provider assurance and sustainability and provide additional opportunity for long-term investment by provider agencies

23. **All government agencies** significantly upskill their competency concerning te ao Māori, Crown responsibilities under Te Tiriti and the cultural safety of their workforce through examining their own biases (Curtis 2019). This upskilling includes:
    - developing trusting, effective and valued relationships with iwi, hapū and whānau
    - having Māori present to work with Māori clients where possible
    - developing a workforce that functions in a way that respects Māori customs, cultural beliefs, values and practices, along with mātauranga Māori
    - demonstrating how the above changes have improved access to health and social care and services for whānau.

# Conclusion

## Whakakapi

Above all, effective suicide prevention involves supporting tamariki and rangatahi by enhancing the protective factors that provide wellbeing and reducing risk factors. Māori rangatiratanga and mana motuhake cultural concepts, values and practices need to be central to this protection, as guaranteed under Te Tiriti, including ensuring health equity for rangatahi, Māori whānau and communities.

Māori must be able to lead, develop and inform the decision-making, planning and funding of whānau wellbeing and suicide prevention initiatives. Māori are best placed to understand the root causes of suicide and system inequities that impact tamariki, rangatahi, whānau and their communities.

Te Mauri
THE LIFE FORCE

This report has presented core components, approaches and highlights of promising initiatives based on kaupapa Māori, along with frameworks to help develop both kaupapa Māori and mainstream suicide prevention services. These are successful because they have been informed by rangatahi and whānau, are based within the community and are strengths-based. They are also underpinned by a set of values that are intrinsic to te ao Māori and therefore mauri ora.

Throughout the past 30 years, Indigenous scholars and practitioners have repeatedly pointed to these same common themes. Culturally anchored approaches will not be successful on their own.

Whānau and service providers alike have expressed considerable concerns about a system that is difficult to navigate, is colonising and racist, and does not respond to needs in a timely or effective manner. Current services that are provided within a kaupapa Māori context are overburdened and under-resourced. Further, they operate within a system that conflicts directly with the principles and values the services are based on.

Inequities in rangatahi suicide persist because the systems and ways in which society is structured privilege New Zealand Europeans and marginalise Māori (Reid et al 2019). As a result, the way in which the system is configured and delivered needs to change immediately.

Urgent attention is required to address poverty as one of the major drivers of suicidality and poor mental health. More than that, meaningful initiatives to reduce poverty can work against the cascading effects of colonialism, racism, sexism, poverty and violence – which all threaten the wellbeing of rangatahi (Clark et al 2018).

To continue to grow understanding of the mauri mate and whakamomori that afflicts some rangatahi, the next steps are to weave the experiences of whānau more firmly into the review process.

Kia kaha, kia maia, kia manawanui –
be strong, be steadfast, be willing.

Rātau mā, kua maunu e te taniwha pokotiwha nei. E muri ahiahi ngātai roimata ki a rātau, e mua ai aroha e kore e motu.

**Paige Scruton Nepe-Apatu**

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Te Mauri

THE LIFE FORCE

# Appendices

## Ngā āpitihanga

# Appendix 1: Data

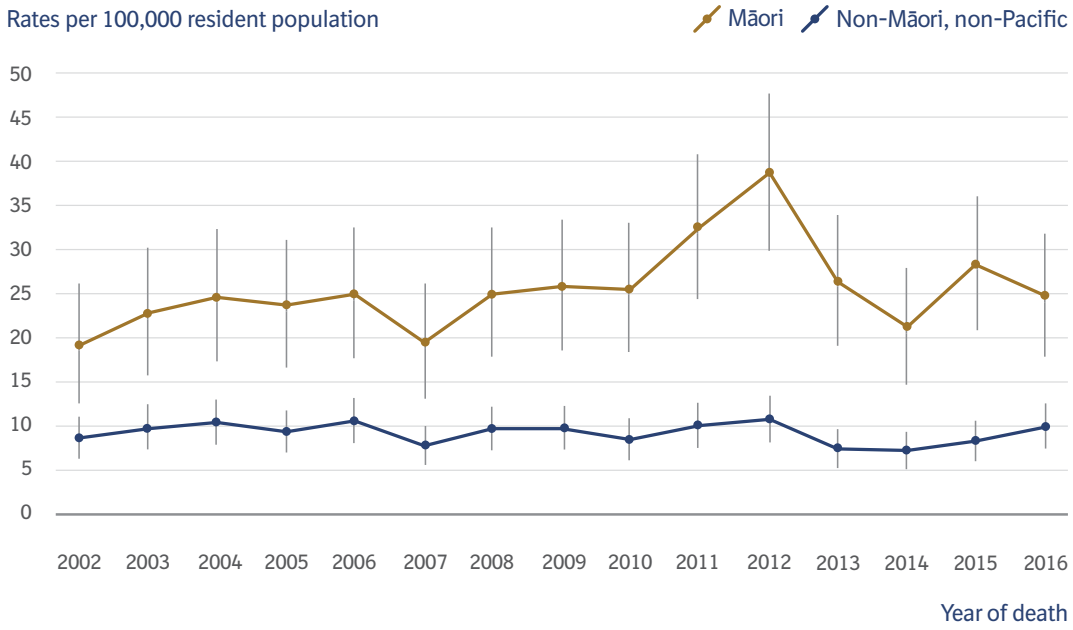
## Āpitihanga 1: Ngā raraunga

In recognition of the different stages of life covered by the age span of the rangatahi in this report, the analyses examine suicide deaths across three age bands: 10–14 years, 15–19 years and 20–24 years.

Key findings on rangatahi aged 10–24 years who died from suicide, 2002–16:

- Suicide was the cause of 33.8 percent of all deaths in rangatahi, compared with 26.1 percent of all deaths in non-Māori, non-Pacific children and young people; rates for rangatahi were consistently higher than those among non-Māori, non-Pacific children and young people (Figure 1), with an overall Māori/non-Māori, non-Pacific rate ratio of 2.8 (95 percent CI 2.5–3.1).
- Among those aged 10–24 years, 727 rangatahi (25.3 per 100,000) and 876 non-Māori, non-Pacific children and young people (9.13 per 100,000) died by suicide.
- The rate of suicide in rangatahi varied from 18.8 per 100,000 (in 2002) to 38.4 per 100,000 (in 2012), compared with a variation between 7.2 per 100,000 (in 2014) and 10.7 per 100,000 (in 2012) for non-Māori, non-Pacific children and young people aged 10–24 years. Regardless of this variation, there is a consistent outcome gap between rangatahi and non-Māori, non-Pacific children and young people, and that this difference has increased during 2002–12.

Figure 1 Suicide mortality (rates per 100,000 resident population with 95 percent confidence intervals) in rangatahi aged 10–24 years, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 (n=1,603 deaths)




Sources: Numerator: Mortality Review Database; denominator: NZ MRDG estimated resident population 2002–16, 10–24 years.

## Previous research on the history of rangatahi suicide trends

Between the 1960s and the 1990s, suicide rates for New Zealand males in their late teens and early 20s increased threefold. This pattern is similar among young New Zealand females (Snowden 2017).

Suicide rates in Aotearoa New Zealand have fluctuated over time and vary significantly by age, sex and ethnicity. The high rangatahi suicide rate has been a feature of suicide mortality in New Zealand since the 1990s (Ferguson et al 2005). Although it is not possible to reliably compare suicide rates by ethnicity before 1995, suicide rates were disproportionately higher for rangatahi (aged 15–24 years) compared with their non-Māori peers for every year from 1996 to 2002 (Beautrais and Fergusson 2006).

In 2002, the suicide rate for rangatahi aged 15–24 years was 43.7 per 100,000 for males and 18.8 per 100,000 for females, compared with non-Māori rates of 18.0 per 100,000 for males and 9.1 per 100,000 for females (Beautrais and Fergusson 2006). These patterns suggest that factors influencing suicide are not identical for all population groups. They also raise the possibility that the unique social position of Māori in Aotearoa New Zealand – as a disenfranchised Indigenous population – may be an important cause of rangatahi suicide rates.

Recent national data for 1996 to 2016 showed suicide mortality rates for Māori rangatahi aged 15–24 years were consistently higher than rates for non-Māori young people in the same age group; it also showed that, in that age group, the female rangatahi suicide rate was increasing compared with a relative decline for non-Māori females over the same time period (Ministry of Health 2019c).

## Service access and engagement

- During 2012–16, 46 percent of the rangatahi who died by suicide had had a Child, Youth and Family (CYF) notification[25] at some point in their lives, compared with 23 percent of non-Māori, non-Pacific children and young people who died by suicide.
- Nearly two-thirds (61.7 percent) of the rangatahi aged 10–24 years who died by suicide had accessed secondary mental health and addictions service at some point in their lives, and for non-Māori, non-Pacific young people it was 63.2 percent. Mental health and addictions service use was higher among rangatahi who died by suicide than rangatahi who died by other (non-suicide) causes.
- Where rangatahi who died by suicide had previously seen a secondary mental health and addictions service, many did not have a specific diagnosis recorded. A specific diagnosis was recorded for only 23 percent of the rangatahi in this group, and only 34 percent of non-Māori, non-Pacific who died by suicide had a specific diagnosis recorded.
- Stand-downs from school were more frequent among rangatahi who died by suicide than among non-Māori, non-Pacific children and young people who died by suicide. In total, 42.9 percent of these rangatahi had been stood down from school, compared with 21.6 percent of non-Māori, non-Pacific children and young people.

[25] 'Notifications' are now called 'reports of concern'. Since 2017, Oranga Tamariki – Ministry for Children has replaced Child, Youth and Family. See the later section on Child, Youth and Family data for further details.

## Rural rangatahi and suicide

- The suicide rates were higher for rangatahi than non-Māori, non-Pacific children and young people for both rural and urban areas.
- For rangatahi aged 10–24 years who died by causes other than suicide ('non-suicide' deaths), the pattern by urban or rural status was similar to those who died by suicide.

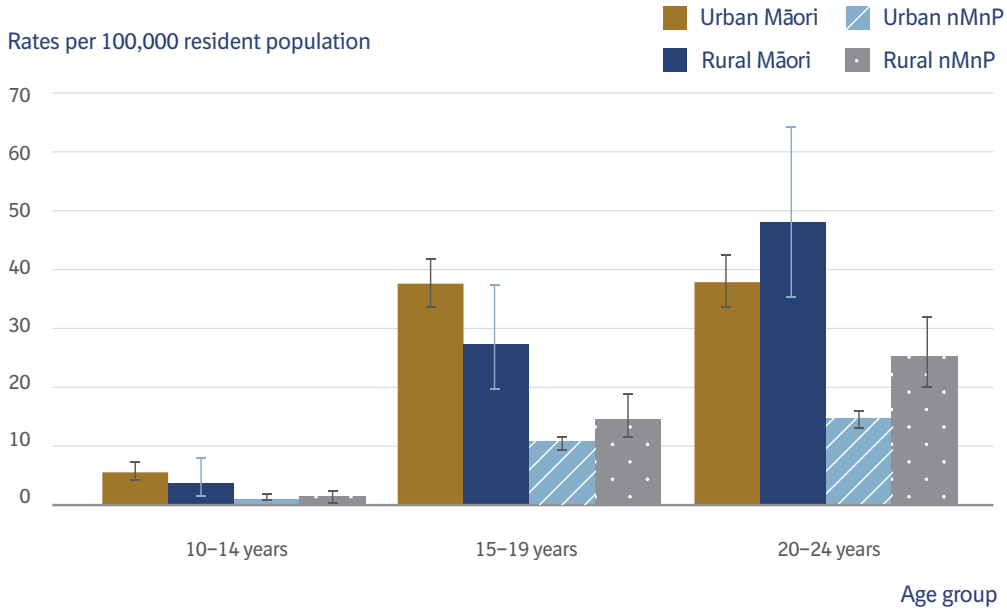
A wide range of issues is likely to impact rural children and young people. For example, the data may reflect young people's poorer access to social support and health services in rural areas, underlying differences in the population of young people who remain in rural areas after leaving school, or a combination of both.

The following Ministry of Health findings are relevant to rural rangatahi (Ministry of Health 2012).

The overall suicide rate for rural Māori aged 10–24 years was not significantly higher than the rate for rural non-Māori. However, for Māori living in urban centres, the suicide rate was twice the rate of non-Māori, which was mostly due to the large differences between the rates for Māori and non-Māori, non-Pacific aged 15–24 years and 25–44 years (Ministry of Health 2012).

- A higher proportion of Māori 'overall' live in rural areas compared with non-Māori (ie, 15.5 percent versus 13.8 percent).
- A lower proportion of Māori 'overall' live in urban areas compared with non-Māori (ie, 69 percent versus 76 percent).
- However, more Māori rangatahi live in urban areas compared with rural areas (ie, 19 percent versus 16 percent).
- Māori rangatahi living rurally are less likely to have secondary school qualifications higher than Level 2 NCEA and have lower personal incomes than Māori rangatahi living in urban areas; and are more likely to live in households without telecommunications than Māori rangatahi living in urban areas.

Figure 2 Suicide mortality (rates per 100,000 resident population with 95 percent confidence intervals) in rangatahi aged 10–24 years, by urban/rural status and age group, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 (n=1,599* deaths)




Sources: Numerator: Mortality Review Database; denominator: Stats NZ, 2002–16, 10–24 years.
Notes: * Excludes four deaths with no available rurality data.
nMnP = non-Māori, non-Pacific.

## Structural influences of inequity: employment, deprivation and poverty

Suicide mortality rates are patterned by socioeconomic factors (Ajwani et al 2003; Blakely et al 2003; Curtis et al 2013; Kerr et al 2017; Whitley et al 1999). In Aotearoa New Zealand, lower socioeconomic status has been associated with higher suicide rates (Ministry of Health 2015a) and is thought to contribute to suicide risk, particularly among young Māori men (Collings et al 2005). In the 10 years from 2003 to 2013, the gap in median weekly income between Māori and European increased (Marriott and Sim 2015).

Māori (and Pacific) children aged 0–17 years are at least twice as likely as New Zealand European children to be living in severe and persistent poverty (Imlach Gunasekara and Carter 2012). The persistent poverty that Māori children and whānau experience should always be considered within the context of the ongoing impact of colonisation; that is, we need to understand that alienation from land and resources led to the loss of an economic, spiritual and cultural base for Māori (Cram 2011; Dale 2017) and the contemporary insults of colonisation (ie, benefit cuts/restrictions, lack of employment and educational opportunities, over-representation in the criminal justice system, etc). Poverty severely limits the opportunities and aspirations of children (Dale et al 2011; Henare et al 2011).

Māori whānau continue to experience disproportionate rates of poverty, which in turn constrains their health and education as well as their ability to accumulate wealth (Dale 2017).

### Employment

Recent statistics demonstrate that Māori unemployment rates remain double the national unemployment rate. In recent years the largest gains in Māori employment were among young Māori aged 20–29 years (Stats NZ 2018).

Employment data sourced for local Child and Youth Mortality Review Committee (CYMRC) reviews[26] was available for 456 cases (82 percent) of all children and young people aged 10–24 years who died by suicide during 2012–16. Of these:

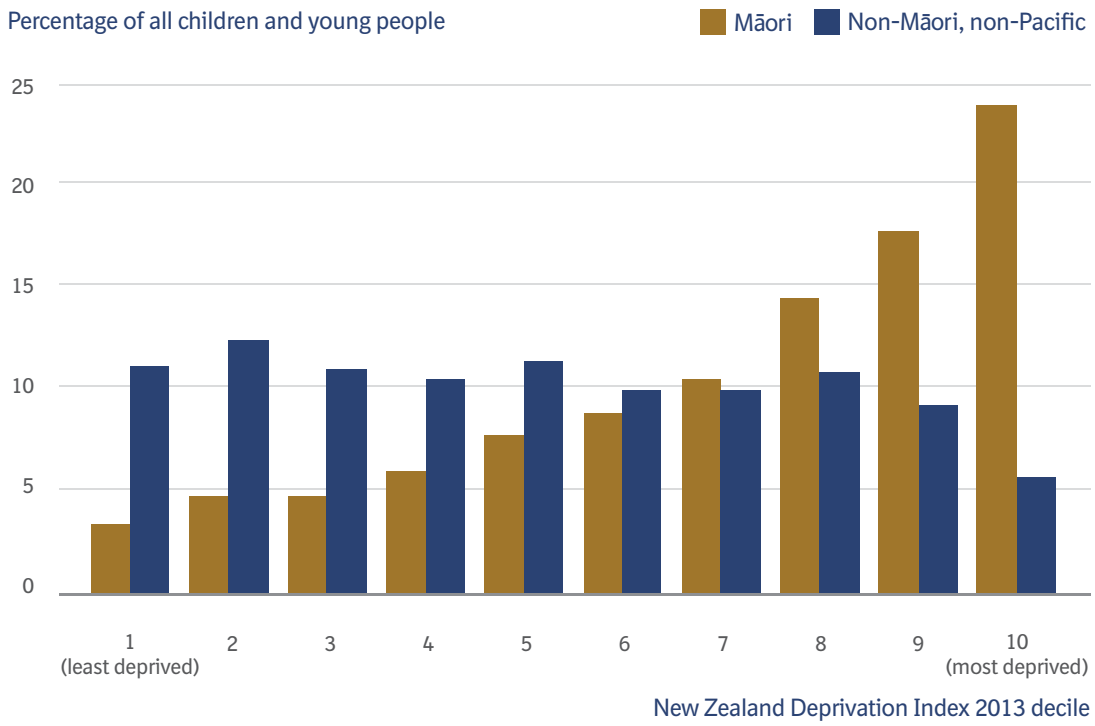
- 88 percent of rangatahi aged 10–14 years were students, compared with 100 percent of non-Māori, non-Pacific children aged 10–14 years
- one-quarter of rangatahi (25 percent) aged 15–24 years were studying, either full or part time, compared with 32 percent of non-Māori, non-Pacific young people aged 15–24 years
- over one-quarter (26 percent) of rangatahi aged 15–24 years were employed either full or part time at the time of their death, compared with 36 percent of non-Māori, non-Pacific young people aged 15–24 years
- 13 percent of rangatahi and 7 percent of non-Māori, non-Pacific young people were unemployed
- 19 percent of rangatahi and 12 percent of non-Māori, non-Pacific young people were on a benefit
- length of unemployment for rangatahi and non-Māori, non-Pacific young people varied from a few days to several years
- rangatahi aged 15–19 years and 20–24 years had similar rates of unemployment, whereas, for non-Māori, non-Pacific young people, unemployment was lower among those aged 15–19 years than among those aged 20–24 years.

[26] Based on CYMRC local reviews data. See the 'Limitations of the data' section (page 87) on the completeness of local review data.

## Deprivation and poverty

- Higher proportions of all rangatahi lived in the most deprived areas of Aotearoa New Zealand, according to the New Zealand Index of Deprivation (NZDep2013). Among those aged 0–24 years, 41 percent of all tamariki and rangatahi, compared with 15 percent of all non-Māori, non-Pacific children and young people, lived in the areas rated as having the highest levels of deprivation (NZDep deciles 9 and 10) in 2002–16 (Figure 3).
- The distribution of rangatahi was heavily skewed to the most deprived NZDep2013 deciles, whereas non-Māori, non-Pacific children and young people showed a pattern of lower distribution in deciles 9 and 10 for non-Māori, non-Pacific.

Figure 3 Percentage of all children and young people aged 0–24 years, by New Zealand Deprivation Index 2013 decile and prioritised ethnic category, Aotearoa New Zealand, 2002–16



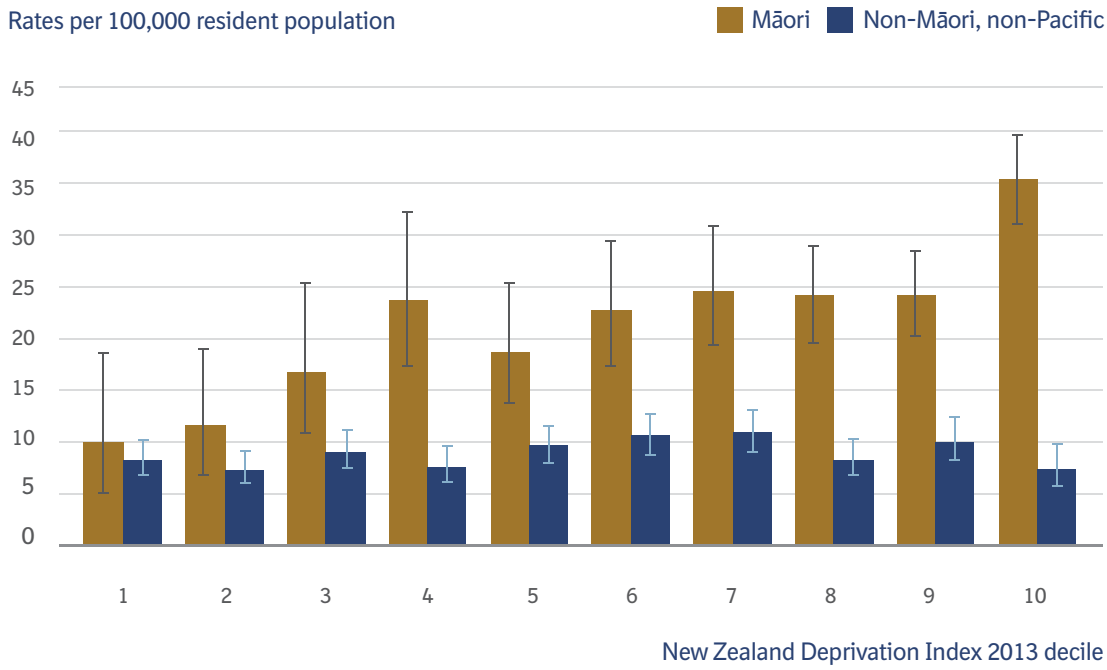

Source: NZ MRDG estimated resident population 2002–16, 0–24 years.

- Rangatahi deaths by suicide increased as deprivation increased (Figure 4).
- In general, as deprivation increased, the size of the inequity between Māori and non-Māori, non-Pacific children and young people also increased (ie, the Māori:non-Māori, non-Pacific rate ratio increased).
- From NZDep2013 decile 4 to decile 10, rangatahi suicide mortality rates were higher than the rates of their non-Māori, non-Pacific peers living in areas of the same decile (Figure 4).[27]
- Rangatahi aged 10–24 years living in the most deprived areas (NZDep2013 deciles 9 and 10) were 3.4 times more likely to die by suicide than non-Māori, non-Pacific children and young people living in areas of similar deprivation (95 percent CI 2.79–4.12) (Figure 4).

[27] The rate ratio for Māori compared with non-Māori, non-Pacific at NZDep2013 decile 3 was 1.86, 95 percent CI 1.18–2.93.

The poverty experienced by Māori whānau is evident at the community level. Māori are more likely to live in residential areas characterised by high levels of deprivation than non-Māori (measured by NZDep2013). Deprivation at the community level impacts schooling and employment opportunities for Māori as well as access to goods and services (Cram 2011).

Figure 4 Suicide mortality (rates per 100,000 with 95 percent confidence intervals) in rangatahi aged 10–24 years, by New Zealand Deprivation Index 2013, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 (n=1,599 deaths*)




Sources: Numerator: Mortality Review Database; denominator: NZ MRDG estimated resident population 2002–16, 10–24 years.
* Excludes four deaths with no available deprivation data.

## Child, Youth and Family (now Oranga Tamariki)[28]

The NZ MRDG received information from Child, Youth and Family (CYF) on all cases of children and young people who had died and could be matched to individuals in its system. 'Notifications'[29] refers to the number of notifications CYF received for the child or young person (the deceased) or for any other children in their family. Note that data provided on CYF notifications does not include any further level of detail; for example, on the reasons for notifications, or which notifications progressed to care and protection. Because notifications can be made for any reason ranging from low to high risk of harm, data on numbers of notifications should be interpreted with some caution.

- During 2012–16, of the 277 rangatahi suicide deaths, 128 (46.2 percent) had at least one recorded notification to CYF at some time in their life, compared with 63 of 277 deaths (22.7 percent) among non-Māori, non-Pacific children and young people who died by suicide (Table 1).
- For those with a CYF record, the number of notifications for each child or young person ranged from one to 32, except for one case who had substantially more notifications than this.
- The most common number of notifications was one: 23 percent of rangatahi and 34 percent of non-Māori, non-Pacific children and young people were in this group.

The Suicide Mortality Review Committee trial found that during 2007–11, of rangatahi aged 15–24 years who died by suicide (n=194), approximately 45 percent had had some contact with CYF; 40 percent had reports of concern (notifications) made on their behalf and 12 percent had been placed under legal status for care and protection at some stage in their lives (Suicide Mortality Review Committee 2016).

Oranga Tamariki noted that at the end of June 2017, 69 percent of all children aged under 18 years in state care (ie, those subject to a custodial order or legal agreement under the Oranga Tamariki Act 1989) identified as Māori (Ministry for Vulnerable Children, Oranga Tamariki 2017).

Table 1 Notifications with Child, Youth and Family, by cause of death for rangatahi aged 10–24 years, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2012–16 combined (n=1,540 deaths)

| Child, Youth and Family notification | Māori | | | | Non-Māori, non-Pacific | | | |
|---|---|---|---|---|---|---|---|---|
| | Suicide deaths | | Non-suicide deaths | | Suicide deaths | | Non-suicide deaths | |
| | Number | % | Number | % | Number | % | Number | % |
| Yes | 128 | 46.2 | 118 | 31.0 | 63 | 22.7 | 73 | 12.1 |
| No | 70 | 25.3 | 108 | 28.3 | 163 | 58.8 | 325 | 53.7 |
| Unknown | 9 | 3.2 | 22 | 5.8 | 11 | 4.0 | 22 | 3.6 |
| Missing data | 70 | 25.3 | 133 | 34.9 | 40 | 14.4 | 185 | 30.6 |
| **Total** | **277** | **100.0** | **381** | **100.0** | **277** | **100.0** | **605** | **100.0** |

Source: Mortality Review Database.

[28] Since 2017, Oranga Tamariki has replaced Child, Youth and Family.

[29] 'Notifications' are now called 'reports of concern'. These are generated from any people – such as police, health and education professionals, social service providers, whānau, friends and members of the public – who are worried about the care and protection of a child. When someone makes a report of concern, Oranga Tamariki conducts an initial assessment about the child and whānau to establish the level of risk or harm and whether any further action is necessary to ensure the child is safe. In many cases, whānau just need some advice, or to be connected with the right support services. In some cases, Oranga Tamariki care and protection teams need to undertake more intensive work to identify the issues and find a solution that is in the best interest of the child. This may include carrying out a formal investigation with police and taking actions against perpetrators when abuse is substantiated.

The association between mental illness and suicide is not as strong in young people as it is in adults. Furthermore, rather than seeing mental illness as a risk factor for suicide, it is more appropriate to consider both suicide and mental illness in the context of the life course: factors and adverse experiences that contribute to mental illness in children and young people also contribute to the risk of suicide.

To find out more about how strongly mental illness is linked with suicide, the national mental health and addictions data stored in the Ministry of Health's PRIMHD data set was examined. PRIMHD data is collected on secondary mental health and alcohol and drug services provided by DHBs and non-governmental organisations (NGOs). DHBs have been reporting to PRIMHD since 1 July 2008; NGOs have started reporting gradually; over 80 percent were doing so by November 2011 (Ministry of Health 2012b).

The information presented in this section uses PRIMHD to identify children and young people who have had contact with any secondary mental health and alcohol and drug services. 'Contact' in this context might be as minor as a phone call, or could include a face-to-face consultation, with or without treatment. PRIMHD does not include records of children and young people who have been seen solely in primary care (eg, at their general practitioner (GP)) or children who have been seen by general paediatric services (eg, for attention deficit hyperactivity disorder). The analysis also did not include data from NGO mental health services.

## Contact with mental health services

- Of the 1,540 children and young people who died of all causes during the five-year period 2012–16, 700 (45.5 percent) had had contact with DHB mental health services at some point in their lives (Table 2).
- Among those who died by suicide, the percentage of rangatahi who had accessed secondary mental health and addictions services overall was 61.7 percent, and for non-Māori, non-Pacific children and young people it was 63.2 percent. For Māori the figures ranged from 35 percent for those aged 10–14 years to 68.3 percent for 20–24-year-olds, and for non-Māori, non-Pacific children and young people 55.6 percent for 10–14-year-olds to 63.5 percent for those aged 15–19 years. This includes contact that could have been years prior to death and may have been for conditions such as attention deficit hyperactivity disorder (ADHD) or similar.

About half of the total population of Māori mental health service users in 2017 was aged under 25 years. Many of these young people lived in areas of high community deprivation (Ministry of Health 2019).

Māori have higher rates of compulsory mental health treatment orders (community and inpatient treatment ordered under the Mental Health (Compulsory Assessment and Treatment) Act 1992) and higher rates of seclusion when receiving inpatient mental health treatment (Ministry of Health 2019b).

Table 2 Contact with mental health services for rangatahi aged 10–24 years, by cause of death, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2012–16 (n=700 deaths)

| Age group (years) | Māori | | | | Non-Māori, non-Pacific | | | |
|---|---|---|---|---|---|---|---|---|
| | Suicide deaths | | Non-suicide deaths | | Suicide deaths | | Non-suicide deaths | |
| | Number | % | Number | % | Number | % | Number | % |
| 10–14 | 7 | 35.0 | 15 | 28.3 | 5 | 55.6 | 10 | 15.6 |
| 15–19 | 82 | 59.9 | 75 | 43.6 | 66 | 63.5 | 63 | 29.0 |
| 20–24 | 82 | 68.3 | 86 | 55.1 | 104 | 63.4 | 105 | 32.4 |
| **Total** | 171 | 61.7 | 176 | 46.2 | 175 | 63.2 | 178 | 29.4 |

Source: Mortality Review Database.

Analysis of mental health service use by cause of death shows the general pattern that people who died by suicide were more likely to have had contact with mental health services than those whose deaths were not from suicide. This pattern is true for both rangatahi and non-Māori, non-Pacific children and young people.

Overall there was no significant difference between Māori rangatahi (61.7 percent) and non-Māori, non-Pacific children and young people (63.2 percent) who died by suicide and had contact with mental health services (Table 2). However, there was a difference between Māori (46.2 percent) and non-Māori, non-Pacific (29.4 percent) deaths that were not due to suicide, and mental health service contact; this finding needs further analysis.

Children and young people may not have accessed secondary mental health and addictions services because they had poor access to those services, or they or their whānau preferred to have treatment for mental health issues in primary care. In addition, many young people who die by suicide do not have mental health illnesses requiring clinical treatment, therefore these mental health services are not necessarily appropriate for all rangatahi who die by suicide.

## Mental illness

Mental illness may increase the risk of suicide among adolescents. One systematic review estimated that up to 89 percent of young people who die by suicide have a major psychiatric disorder at the time of their death (Fleischmann et al 2005). One case-control study on a small sample (n=129) of young people in Aotearoa New Zealand found a high prevalence of current mental disorders (89.5 percent) among those who had made serious suicide attempts (Beautrais et al 1998). An earlier review of records from the CYMRC database found reference to mental illness in 41 percent of the rangatahi (n=194) aged 15–24 years who died by suicide during 2007–11. Of these 194 rangatahi, 40 percent had had no interaction with specialist mental health services during their lifetime (Suicide Mortality Review Committee 2016).

Although studies such as these demonstrate mental illness is correlated with suicide, it is important to note that the psychological-autopsy study methods they use are often associated with high levels of bias (Shahtahmasebi and Cassidy 2014).

## Diagnostic data

This section presents data from PRIMHD on all cases where diagnostic information was available.

Of those who died by suicide, and had been seen by secondary mental health services, 68 percent of Māori rangatahi and 75 percent of non-Māori, non-Pacific children and young people had a diagnosis recorded.

For a large proportion of the cases where diagnostic information was available, a specific diagnosis was not recorded. Two non-specific diagnostic codes were commonly used: R69 'Unknown and unspecified causes of morbidity' and Z032 'Observation for suspected mental and behavioural disorders'.

For the most recent contact:

- Of those who died by suicide, R69 or Z032 was recorded as the 'diagnosis' code for 60 percent of rangatahi and 50 percent of non-Māori, non-Pacific children and young people.
- No children aged 10–14 years who died by suicide had a specific diagnosis recorded.

The specific diagnoses recorded were wide-ranging. They covered most common psychiatric diagnoses, including those to do with addiction, mood disorders, psychotic disorders and behavioural disorders (such as ADHD). While many diagnostic and technical issues make it difficult to assign a diagnosis, and rangatahi may be being treated for mental illness in services outside DHBs, this data challenges the assumption that depression is a significant driver of suicide in rangatahi and young people.

It is likely that factors and experiences throughout the life course of this population of young people have contributed both to their risk of having a diagnosed mental illness and their risk of dying by suicide. This highlights the complex nature of suicide among rangatahi and illustrates that mental health issues comprise one of the many factors that place rangatahi at risk of suicide.

## Education

Data on qualifications, stand-downs, and suspensions and exclusions (see information below in this section for relevant definitions) relates to young people who had a Ministry of Education record and died during the years 2012–16 inclusive (n=1,302 deaths).

## Qualifications

An analysis of records of the highest qualification[30] gained among those aged 15 years or over who had died by suicide found that 49 percent of rangatahi had completed any qualification, compared with 68 percent of non-Māori, non-Pacific young people.

## Stand-downs

A stand-down is when a principal or acting principal removes a student from school or kura for a short period (no more than 5 days per school term or 10 days per school year). Stand-downs are only used where a student is displaying continual disobedience, gross misconduct or any other behaviour that is likely to cause serious harm to the person or others (Ministry of Education 2018).

- Among young people who died between 2012 and 2016, rangatahi were stood down from school more frequently than non-Māori, non-Pacific children and young people.
- Among those who died by suicide, 42.9 percent of rangatahi were stood down, compared with 21.6 percent of non-Māori, non-Pacific children and young people (Table 3).

Table 3* Stand-downs (number and percentage) for rangatahi aged 10–24 years, by cause of death, compared with non-Māori, non-Pacific children and young people who died by suicide, Aotearoa New Zealand, 2012–16 combined (n=347 deaths**)

| Ethnic group | Suicide deaths | | Non-suicide deaths | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Māori | 102 | 42.9 | 113 | 35.5 |
| Non-Māori, non-Pacific | 53 | 21.6 | 79 | 15.8 |

Source: Mortality Review Database.

*There were 215 Māori who were stood down. Of these, 102 died from suicide, 113 died from other causes. There were 238 Māori who died from suicide (who had a Ministry of Education record), so 102/238=42.9 percent. Of those who died from other causes (n=318 total), 113 were stood down, so 113/318=35.5 percent. There were 132 non-Māori, non-Pacific who were stood down. Of these, 53 died from suicide, 79 died from other causes. There were 245 non-Māori, non-Pacific who died from suicide (who had a Ministry of Education record), so 53/245=21.6 percent. Of those who died from other causes (n= 501 total), 79 were stood down, so 79/501=15.8 percent.

**This analysis excludes 238 cases for which no Ministry of Education record was available.

[30] A qualification refers to any formal qualification gained, including NCEA Levels 1–3, national certificates and tertiary qualifications.

## Suspensions and exclusions[31]

A suspension is the formal removal of a student from school or kura by the principal until the board of trustees meets to decide how to handle the case. Suspensions can lead to exclusions (for those under 16 years) or expulsions (for those over 16 years), depending on the board's decisions.

An exclusion is when a student aged under 16 years is formally removed from school or kura and must enrol at another school (with the assistance of either the current school principal or the Ministry of Education).

An expulsion is the formal removal of a student aged over 16 years from school or kura. Schools and kura are not required to accept students who have been expelled from another school (for more information, see Ministry of Education 2018).

- Among rangatahi and non-Māori, non-Pacific children and young people who died by suicide, 17 percent had ever been suspended from school.
- Just over 7 percent of rangatahi who died by suicide had been excluded from school, compared with 6 percent of non-Māori, non-Pacific children and young people. Of these rangatahi who had been stood down, suspended or excluded, only 23 percent transferred to another school. Forty percent ended their schooling, 16 percent were recorded as 'continuously absent' and 5 percent were granted an early exemption.

### Education sector findings

Poor school attendance, stand-downs and suspensions are signs that students are not accessing education. Māori tamariki and rangatahi have the lowest levels of regular school attendance of all ethnic groups, and their attendance levels are lower than those of non-Māori at every year level. By year 13, only 28 percent of Māori are attending regularly, compared with 50 percent of non-Māori (Ministry of Education 2017b).

The age-standardised stand-down rate for Māori students in 2018 was 44.3 per 1000 students; two times higher than European/Pākehā students (20.9 stand-downs per 1000 students). Across all ethnic groups the age standardised rate of suspensions has decreased since 2001. The greatest reduction was for Māori students where the rate decreased from almost 18 suspensions per 1,000 students to 7.9 per 1,000 students. However, Māori students continue to be suspended at a higher rate than any other ethnic group; twice as likely to be suspended as European/Pākehā students (3.0 per 1,000 students) (Ministry of Education 2019b).

The SuMRC Feasibility Study analysed education data for 162 rangatahi aged 15–24 years who died by suicide during 2007–11. It found about one-third had attained at least one school qualification; 19 percent had non-enrolment notifications (ie, notifications of absence from school for 20 consecutive days); 27 percent had been stood down; 11 percent had been suspended; and 7 percent had been expelled from school at some point (Suicide Mortality Review Committee 2016).

In 2008, 43 percent of all male students and 34 percent of all female students who left school in Year 10 were Māori, and Māori made up the lowest proportion of students (48 percent) who left school attaining at least NCEA Level 2 or University Entrance (20 percent) (Ministry of Education 2011a, 2011b). More Māori are now leaving school achieving NCEA Level 2 than in 2001. Despite such improvements, however, achievement inequities between Māori and non-Māori school leavers remain (Dale 2017).

Alternative education students are among those at greatest risk of poor achievement in the education system (Education Review Office 2011). The majority of students in alternative education are Māori. An evaluation of all alternative education schools showed that, in 2010, 63 percent of all 3,500 alternative education students were Māori, compared with 9 percent who were Pacific peoples and 25 percent who were Pākehā/European students (Education Review Office 2011).

Outcomes from alternative education schools vary widely; not all students who attend such schools successfully transition back into mainstream education or employment. Just under 40 percent of all alternative education students who left school in 2009 took up further education or employment (Education Review Office 2011).

[31] Information on expulsions was not included in the data set provided for this report.

## Criminal justice system

Rangatahi are over-represented in the criminal justice system. The extent of this over-representation increases the further rangatahi move along the youth justice pathway, from police apprehension to Youth Court appearance and finally to supervision in residence (Modernising Child, Youth and Family Expert Panel 2016).

### Corrections data

The Department of Corrections provided the data presented here to the SuMRC. It includes young people aged 17–24 years who died during 2007–11 and had a cause of death in the Mortality Collection of suicide as at 2016.[32] This is a subset of the cases that the rest of this report covers.

- Of the 134 people for whom the Department of Corrections submitted records to SuMRC, 63 had served a sentence.[33] Within this group, 40 (63 percent) were rangatahi.
- Of those who had served a sentence, 37 rangatahi and 21 non-Māori, non-Pacific young people had served one or more community-based sentences, including community work, community detention and supervision.
- Sixteen rangatahi and five non-Māori, non-Pacific young people had served one or more prison sentences. All but five of them had also served one or more community sentences.

### Facing criminal charges – CYMRC local review data

Information was available for pending criminal charges for 438 (79 percent) of all 554 rangatahi and young people who died by suicide during 2012–16.

- Of all rangatahi who died by suicide, 11 percent were facing criminal charges before their death.
- A similar proportion of non-Māori, non-Pacific young people (13 percent) who died by suicide were facing criminal charges.

### Referred to Youth Justice – CYMRC local review data

CYMRC local reviews provided information on referrals to Youth Justice for 387 (70 percent) of all 554 rangatahi, children and young people who died by suicide during 2012–16.

- Among rangatahi who died by suicide, 17 percent had been referred to Youth Justice at some point in their lives compared with 13 percent of non-Māori, non-Pacific children and young people who died by suicide.

### Police

The SuMRC Feasibility Study found that, of the 194 rangatahi aged 15–24 years who died by suicide during 2007–11, 119 (61 percent) had police records for alleged offences in the 10 years before their death. Over half of the 119 had come to the attention of police in the year before they died (Suicide Mortality Review Committee 2016).

[32] In the SuMRC Feasibility Study, some cases in the CYMRC database who had a cause of death in the Mortality Collection of suicide did not appear in the Ministry of Health records. Therefore, of the 155 cases of suicide in rangatahi aged 17–24 years, only 134 were at that stage in the Ministry of Health data set that was sent to Corrections.

[33] These analyses exclude people who identified as being of Pacific but not Māori ethnicity.

## Alcohol and drug intoxication in rangatahi who died by suicide

Results from the SuMRC Feasibility Study showed that, of the 105 rangatahi aged 15–24 years who died by suicide during 2007–11, and where data was available, about half (n=55) tested positive for alcohol at the time of their death. However, for 18 of these rangatahi only traces of alcohol were registered in their blood. Toxicology reports were positive for the presence of cannabis in approximately 10 percent of these rangatahi.

However, due to the high level of missing or unknown alcohol and drug data, these proportions were thought to be significantly undercounted (Suicide Mortality Review Committee 2016).

For this study, alcohol was considered to be involved in a death, both in cases where the individual was acutely intoxicated at the time of their death and cases where the individual had a history of early and harmful alcohol use.[34] Use of alcohol, both in the short term and chronically, is a risk factor for suicide. Without the influence of alcohol, it is likely that many of these deaths would not have occurred.

Information around alcohol was available for 400 of the 554 children and young people who died by suicide during 2012–16. CYMRC local reviews found that alcohol was a factor in the death for 164 individuals (41 percent) of those for whom information was available. By ethnicity, alcohol was considered to contribute to 42 percent of suicide deaths in rangatahi and 40 percent of deaths in non-Māori, non-Pacific children and young people. The proportions varied by age: where there was information available on alcohol, for rangatahi, alcohol was involved in very few deaths in those aged 10–14 years, 37 percent of deaths in those aged 15–19 years and 54 percent of deaths in those aged 20–24 years. These percentages were similar for non-Māori, non-Pacific children and young people.

- Information was available about whether drugs were involved in the deaths of 388 (70 percent) of the 554 children and young people who died by suicide during 2012–16. Within this total, drugs were involved in the deaths of 34 percent of the rangatahi who died by suicide.
- Information about drug use, including short-term and long-term use, was available for 400 (72 percent) of the 554 cases of children and young people who died by suicide during 2012–16. Within this total, over one-half (65 percent) of the rangatahi who died by suicide had used drugs.
- For both rangatahi and non-Māori, non-Pacific children and young people, those who died by suicide had a much greater history of drug use than those who died from other causes. However, this information was much more likely to be complete for those who died by suicide, which makes comparisons difficult.

Substance abuse presents a significant risk for teenage suicide. Alcohol and drugs are linked with many youth suicide behaviours, attempts and deaths (King et al 2001; Norström and Rossow 2016). Alcohol use among adolescents, especially when it began in a person's pre-teen years, is an important risk factor for both suicidal ideation and suicide attempts (Swahn and Bossarte 2007).

Data from *Te Rau Hinengaro* revealed that, among Aotearoa New Zealand young people aged 15–24 years, alcohol was the most common substance of abuse and dependence and a contributing factor in the majority of suicides in New Zealand (Oakley-Browne et al 2006).

[34] Data relating to the influence of alcohol comes from CYMRC local reviews. The reviews themselves may have gained this information from post-mortem toxicology results or other sources.

Alcohol intoxication or a history of alcohol abuse has been shown to be more strongly associated with suicidal behaviour in males than females (Norström and Rossow 2016). Evidence also indicates an elevated risk of suicide in adolescents whose parents, both mothers and fathers, are heavy drinkers (Rossow and Moan 2012).

A study on the means and location of suicide in Aotearoa New Zealand found inconsistencies in the reporting on alcohol intoxication and the recording of the presence of alcohol in the body (Taylor and Collings 2010). Part of the study involved reviewing coroners' files from 2005–06 to examine the role of alcohol in suicide deaths.

The review revealed the information provided was highly variable, both in the level of detail and the use of standard forms. Alcohol was only mentioned in the coroner's notes on 4.8 percent of the 972 deaths reviewed. Coroners' files and pathology reports did not contain a standardised approach to considering or reporting on alcohol ingestion in the hours leading up to the suicide. This made it impossible to draw any conclusions about possible links between alcohol intoxication and suicide (Taylor and Collings 2010).

## Individual attempt

CYMRC local reviews contained information on suicide attempts over the past year for 444 cases (80 percent) of children and young people aged 10–24 years who died by suicide during 2012–16. Of these:

- 206 were rangatahi and 238 were non-Māori, non-Pacific children and young people
- 185 (42 percent) had made a previous suicide attempt in the year leading up to their suicide
- of the rangatahi aged 20–24 years who died by suicide, 40 percent had made a suicide attempt in the past year, compared with 47 percent of non-Māori, non-Pacific young people
- the percentage of children and young people who had made a suicide attempt in the year before their death increased with age. Those aged 10–14 years had very few known past suicide attempts. Those aged 15–19 years and 20–24 years had a similar percentage of known attempts within their respective ethnic groups.

## Youth'12 results: suicide and risk factors

The results of the Youth'12 health and wellbeing survey demonstrated Māori students aged 12–18 years were more likely than non-Māori, non-Pacific students to report a previous suicide attempt (Crengle et al 2013).

Specific risk factors associated with a suicide attempt in the past year for Māori students included depressive symptoms, having a close family member or friend die by suicide, having anxiety symptoms, witnessing an adult hit another child in the home, and being uncomfortable in New Zealand European social surroundings (Clark et al 2011).

Some areas had improved since the first Youth2000 series survey in 2001. Compared with 2001, in the 2012 survey fewer Māori reported they had attempted suicide, been hit or harmed on purpose, witnessed adults hitting children (or each other) in their home or used substances. However, compared with New Zealand European students, Māori students continued to experience inequities for these outcomes (Crengle et al 2013).

## Whānau history of suicide

CYMRC local reviews contained information on whānau history of suicide for 363 (66 percent) children and young people who died by suicide during 2012–16. Of these:

- a higher proportion of rangatahi had one or more whānau members who had also died by suicide, compared with non-Māori, non-Pacific children and young people
- among the rangatahi, 35 (19 percent) had a whānau history of suicide, compared with 15 (8 percent) non-Māori, non-Pacific children and young people.

## Location of death

During 2002–16, most deaths by suicide in rangatahi (77 percent) and non-Māori, non-Pacific (68 percent) children and young people aged 10–24 years occurred at home (Table 4).

Table 4 Suicide mortality (number and percentage) in rangatahi aged 10–24 years, by location of death, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 combined (n=1,603 deaths)

| Location of death | Māori | | Non-Māori, non-Pacific | | Total | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Home | 556 | 76.5 | 591 | 67.5 | 1,147 | 71.6 |
| School/institution/other | 23 | 3.2 | 24 | 2.7 | 47 | 2.9 |
| Residential institution | 14 | 1.9 | 11 | 1.3 | 25 | 1.6 |
| Street | 10 | 1.4 | 50 | 5.7 | 60 | 3.7 |
| Industrial/construction | 7 | 1.0 | 17 | 1.9 | 24 | 1.5 |
| Farm | 5 | 0.7 | 8 | 0.9 | 13 | 0.8 |
| Other | 82 | 11.3 | 137 | 15.6 | 219 | 13.7 |
| Unspecified | 29 | 4.0 | 35 | 4.0 | 64 | 4.0 |
| Unknown | 1 | 0.1 | 3 | 0.3 | 4 | 0.2 |
| **Total** | **727** | **100.0** | **876** | **100.0** | **1,603** | **100.0** |

Source: Mortality Review Database.

Most of the deaths involved means that are readily available. Reducing access to means is a cornerstone of national suicide prevention strategies around the world, with proven benefit (WHO 2014, 2018). Given that most deaths in Aotearoa New Zealand occur in the home using items that cannot be restricted legally, we need to consider other ways to restrict access to means commonly associated with suicide.

## Violence

CYMRC local reviews found information about whether violence had occurred within the whānau for 70 percent of the 277 cases of rangatahi who died by suicide during 2012–16.

Of these, 34 percent of rangatahi had a mother who had been a victim of violence within whānau, and 35 percent of rangatahi had been physically abused (either alleged or confirmed).

## Forensic examination of electronic devices

CYMRC local reviews found information on the use of electronic devices for 298 (54 percent) of the 554 children and young people who died by suicide during 2012–16.

- Examination of young people's devices showed that a small number had been looking at 'how to' suicide websites (6 rangatahi and 10 non-Māori, non-Pacific children and young people).
- There were very few situations within the data in which contagion through electronic media had played an obvious part in the suicide.
- Some had clearly been bullied online (9 rangatahi and 10 non-Māori, non-Pacific children and young people).
- Twenty-two rangatahi and 26 non-Māori, non-Pacific children and young people had made threats electronically to kill themselves.

## Sexual orientation, gender identity and gender expression

The CYMRC local reviews included limited information on the sexual orientation, gender identity and gender expression (SOGIE)[35] for 280 (51 percent) of all 554 children and young people who died by suicide during 2012–16.

Among those who died by suicide, records indicated there were 11 SOGIE rangatahi (4 percent). The proportion was similar among non-Māori, non-Pacific children and young people.

In the SuMRC Feasibility Study, issues surrounding sexuality were significant for about 7 percent of the rangatahi who died by suicide during 2007–11. This study found that the stigma associated with being LGBTI was particularly difficult for Māori males who had been bullied about their sexual orientation (Suicide Mortality Review Committee 2016). The Aroha Project also noted a connection with bullying and suicide risk in relation to a person's sexual orientation, gender identity or gender expression.

The Youth'12 results showed that:

- high school students who identified as sexual minority (lesbian, gay or bisexual) were more likely to have been bullied and had an increased risk of suicide attempts than those who identified as heterosexual
- increased risk of suicide attempts was particularly prominent in male sexual minority students with the risk being over seven times greater than in heterosexual students (Lucassen et al 2014)
- transgender students showed they were more likely to have significant depressive symptoms and report previous suicide attempts and being bullied at school than their non-transgender peers. Over one-half reported being afraid that someone at school would bully or bother them and one in five transgender students reported they were bullied at school at least weekly (Clark et al 2014).

Analysis of data from the 2007 survey wave demonstrated that sexual minority students had consistently higher estimated prevalence of self-reported depressive symptoms, self-harm, serious thoughts about suicide and suicide attempts than those exclusively attracted to the opposite sex (Lucassen et al 2011).

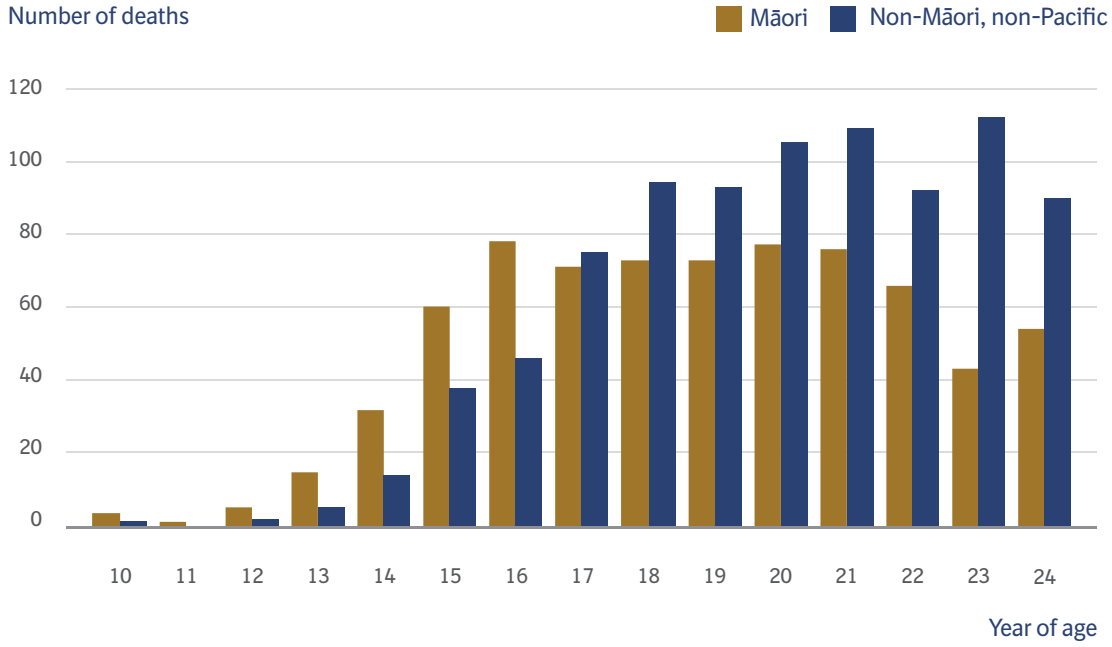
To advance knowledge and understanding of SOGIE suicide and suicide risk, new ways of determining sexual orientation and gender identity among people who die by suicide are needed (Haas et al 2011), including new collection methods and more comprehensive collection.

[35] SOGIE is an all-embracing term that acknowledges the diversity of sexual orientation, gender identity and expression, and includes people who identify as LGBTQI+.

## Age and sex

- For the age grouping 12–16 years, the number of rangatahi deaths by suicide were increasingly higher than non-Māori, non-Pacific children and young people suicides. Over the 17–24-year age grouping, non-Māori, non-Pacific young people died in greater numbers than rangatahi.
- Deaths by suicide occurred with both tamariki and children as young as 10 years of age.
- The number of suicides by rangatahi peaked at 16 years of age (levelling out through the 16–21-year age range), whereas the number of suicides for non-Māori, non-Pacific children and young people peaked much later, at 23 years of age (Figure 5).

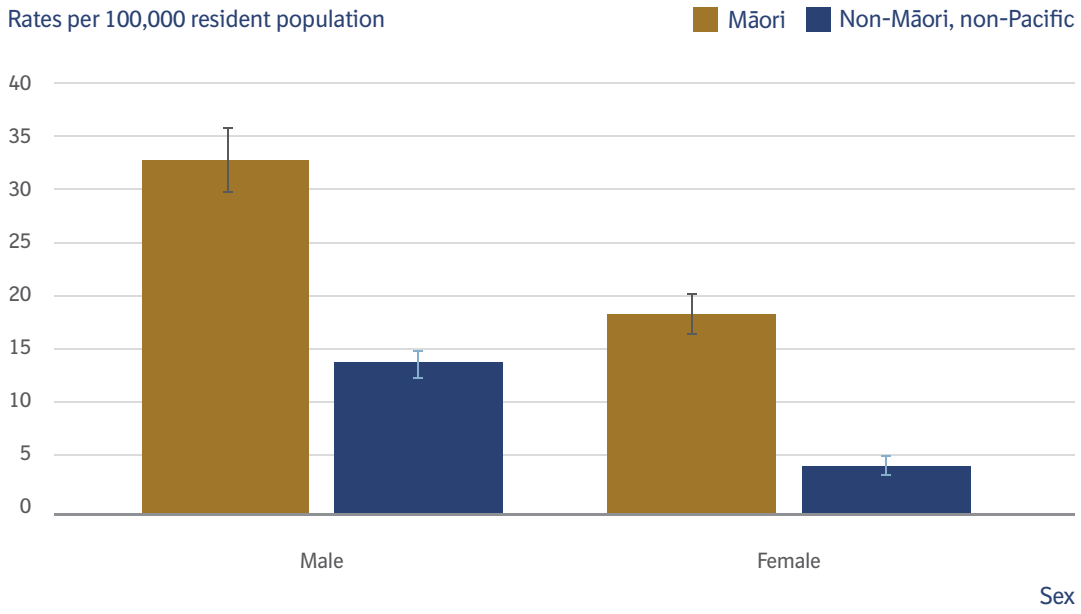
Figure 5 Suicide mortality (number of deaths) in rangatahi aged 10–24 years, by year of age, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 (n=1,603 deaths)




Source: Mortality Review Database.

- Consistent with international findings, the rate of rangatahi suicide among males was higher than the rate for females (Figure 6).
- Among rangatahi males aged 10–24 years, the suicide mortality rate over the period 2002–16 was 32.6 per 100,000: more than double that of non-Māori, non-Pacific males (Figure 7).
- For rangatahi females, the suicide rate was 18.0 per 100,000: more than four times that of non-Māori, non-Pacific females.
- Overall, the male:female ratio of suicides was lower for rangatahi (1.8; 95 percent CI 1.6–2.1) compared with non-Māori, non-Pacific children and young people (3.2; 95 percent CI 2.7–3.7).

Figure 6 Suicide mortality (rates per 100,000 resident population with 95 percent confidence intervals) in rangatahi aged 10–24 years, by sex, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 (n=1,603 deaths)




Sources: Numerator: Mortality Review Database; denominator: NZ MRDG estimated resident population 2002–16, 10–24 years.

Ministry of Health data shows that suicide rates for Māori rangatahi aged 15–24 years were higher for males from 2006 to 2014; however, suicide has been increasing among female rangatahi, from 13.6 per 100,000 in 2006 to 35.3 per 100,000 in 2015 (Ministry of Health 2015a).

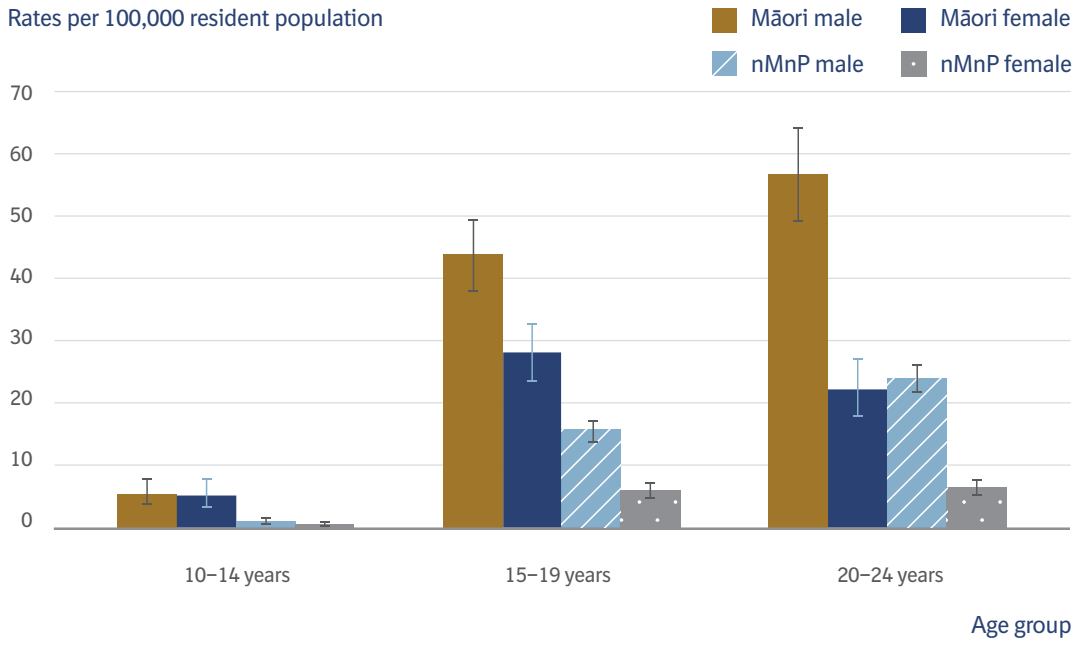
The term 'gender paradox' describes the pattern of higher rates of suicide mortality in males but higher rates of suicide attempts in females (Canetto and Sakinofsky 1998). This pattern is visible in adolescent and young adult populations worldwide, with the notable exceptions of China and India (McLoughlin et al 2015).

Higher suicide rates among males have been linked to the tendency among males to choose more lethal suicide methods and the higher prevalence among males of externalising disorders, such as conduct disorders, substance abuse, aggression and an inclination towards violence (Beautrais 2002; Bridge et al 2006; Kaess et al 2011; Stack 2000).

A recent meta-analysis of 67 studies showed several risk factors for suicide attempts and deaths that were specific to males and others specific to females aged 12–26 years (Miranda-Mendizabal et al 2019). For females, specific risk factors for suicide attempts included eating disorder, post-traumatic stress disorder, bipolar disorder, being a victim of dating violence, depressive symptoms, interpersonal problems and previous abortion. For males, specific risk factors for suicide attempts included disruptive behaviour/conduct problems, hopelessness, parental separation or divorce, friend/s with suicidal behaviour and access to means. Male-specific risk factors for suicide death included drug abuse, externalising disorders and access to means. The studies found no female-specific risk factors for suicide death; however, common risk factors for suicide deaths in both males and females included childhood maltreatment, negative life events and a family history of suicidal behaviour (Miranda-Mendizabal et al 2019).

- Only a small number of suicide deaths occur each year in tamariki Māori and non-Māori, non-Pacific children aged 10–14 years. Of these, 56 (29 male, 27 female) were tamariki Māori, alongside 22 non-Māori, non-Pacific children (15 male, 7 female). The suicide rate of Māori in this age group was over seven times higher (rate ratio 7.3:1 (95 percent CI 4.5–11.9) than that of non-Māori, non-Pacific children (Figure 7).
- The Māori to non-Māori, non-Pacific rate ratio was 3.4 (95 percent CI 2.9–3.9) for those aged 15–19 years and 2.5 (95 percent CI 2.2–2.9) for those aged 20–24 years (Figure 7).
- For rangatahi aged 10–24 years, suicide rates during 2002–16 increased as age increased overall. Rates were lowest in those aged 10–14 years and highest among those aged 20–24 years (Figure 7).

Figure 7 Suicide mortality (rates per 100,000 resident population with 95 percent confidence intervals) in rangatahi aged 10–24 years, by age group and sex, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 (n=1,603 deaths)




Sources: Numerator: Mortality Review Database; denominator: NZ MRDG estimated resident population 2002–16, 10–24 years.
nMnP = non-Māori, non-Pacific.

Table 5 Suicide mortality (number, rates per 100,000 population and rate ratios) in rangatahi aged 10–24 years, by age group, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 combined (n=1,603 deaths)

| Age group (years) | Māori | | | | | | | | Non-Māori, non-Pacific | | | | | | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | | Female | | Total | | | | Male | | Female | | Total | | | | | | | |
| | No. | Rate | No. | Rate | No. | Rate | Male: female rate ratio | 95% CI | No. | Rate | No. | Rate | No. | Rate | Male: female rate ratio | 95% CI | No. | Rate | Māori: nMnP rate ratio | 95% CI |
| 10–14 | 29 | 5.29 | 27 | 5.21 | 56 | 5.25 | 1.01 | 0.60–1.71 | 15 | 0.96 | 7 | 0.47 | 22 | 0.72 | 2.04 | 0.83–4.99 | 78 | 1.89 | 7.29 | 4.45–11.93 |
| 15–19 | 218 | 43.56 | 137 | 27.93 | 355 | 35.82 | 1.56 | 1.26–1.93 | 255 | 15.35 | 91 | 5.78 | 346 | 10.69 | 2.66 | 2.09–3.37 | 701 | 16.59 | 3.35 | 2.89–3.88 |
| 20–24 | 223 | 56.47 | 93 | 22.04 | 316 | 38.68 | 2.56 | 2.01–3.26 | 404 | 23.92 | 104 | 6.40 | 508 | 15.33 | 3.74 | 3.01–4.63 | 824 | 19.95 | 2.52 | 2.19–2.90 |
| **Total** | **470** | **32.56** | **257** | **17.97** | **727** | **25.30** | **1.81** | **1.56–2.11** | **674** | **13.71** | **202** | **4.31** | **876** | **9.13** | **3.18** | **2.72–3.72** | **1,603** | **12.85** | **2.77** | **2.51–3.06** |

Sources: Numerator: Mortality Review Database; denominator: NZ MRDG estimated resident population 2002–16, 10–24 years.
nMnP = non-Māori, non-Pacific.

Table 6 Suicide mortality in rangatahi aged 10–24 years, by New Zealand Deprivation Index 2013 decile, compared with non-Māori, non-Pacific children and young people, Aotearoa New Zealand, 2002–16 combined (n=1,599 deaths*)

| New Zealand Deprivation Index 2013 decile | Māori | | Non-Māori, non-Pacific | | Māori:nMnP rate ratio | 95% CI |
|---|---|---|---|---|---|---|
| | Number of deaths | Rate | Number of deaths | Rate | | |
| 1 | 10 | 10.25 | 84 | 8.37 | 1.23 | 0.64–2.36 |
| 2 | 16 | 11.82 | 84 | 7.39 | 1.6 | 0.94–2.73 |
| 3 | 23 | 17.18 | 93 | 9.26 | 1.86 | 1.18–2.93 |
| 4 | 42 | 24.20 | 75 | 7.74 | 3.13 | 2.14–4.56 |
| 5 | 42 | 19.11 | 103 | 9.87 | 1.94 | 1.35–2.77 |
| 6 | 58 | 23.18 | 101 | 10.8 | 2.15 | 1.55–2.96 |
| 7 | 73 | 24.96 | 103 | 11.2 | 2.23 | 1.65–3.01 |
| 8 | 100 | 24.63 | 88 | 8.38 | 2.94 | 2.21–3.92 |
| 9 | 124 | 24.71 | 96 | 10.22 | 2.42 | 1.85–3.15 |
| 10 | 239 | 36.03 | 45 | 7.53 | 4.78 | 3.48–6.58 |

Note the increasing Māori to non-Māori, non-Pacific ratio for suicide mortality with increasing deprivation decile.

Sources: Numerator: Mortality Review Database; denominator: NZ MRDG estimated resident population 2002–16, 10–24 years.
* Excludes four deaths with no available deprivation data.
nMnP = non-Māori, non-Pacific.

# Data methodology

## Sources of data

The results presented in this report come from an analysis of data held in the Mortality Review Database, a secure database containing information on all deaths of children and young people aged between 28 days and 24 years (from 1 January 2002). The New Zealand Mortality Review Data Group (NZ MRDG) collects and stores this information in the database for the CYMRC and provided the data and analysis for this report.

The results also reference the SuMRC Feasibility Study report of 2016.

Some of the results come from a variety of national sources, such as:

- Births, Deaths and Marriages (BDM), Department of Internal Affairs
- Ministry of Health, Mortality and PRIMHD (mental health) collections
- Oranga Tamariki – Ministry for Children
- coroners
- Coronial Services, Ministry of Justice.

In addition, local child and youth mortality review groups collect data to inform local reviews. Local reviews occur in the DHB in which the deceased child or young person lived. The purpose of a local review is to identify systems issues that can be improved to prevent future deaths.

## Cohort

This report includes all rangatahi aged 10–24 years who died by suicide between 2002 and 2016 (inclusive). There were 727 deaths in this group.

## Ethnic group comparisons

This data analysis compares suicide deaths in rangatahi against a non-Māori, non-Pacific reference group. A non-Māori, non-Pacific reference group was chosen as the most accurate way to present inequities for Māori, because Pacific children and young people also have high rates of suicide (ie, including Pacific peoples in the comparison group would minimise the extent of Māori suicide inequities).

The comparator group therefore includes all non-Māori, non-Pacific children and young people aged 10–24 years who died from suicide between 2002 and 2016 (n=876). Those who identified as being of Pacific ethnicity but not Māori were excluded from all analyses (152 were due to suicide), as were all those where ethnicity was unknown (n=18).

The use of a comparator group is to highlight the deficits of a society that creates, maintains and tolerates these differences, rather than to provide a commentary on the deficits of a particular group.

## Analysis and coding

### Mortality data

For the purposes of mortality review in Aotearoa New Zealand, children and young people are defined as those aged between 28 days and 14 years (children) and 15 and 24 years (adolescents). In all tables, the year of death relates to the calendar year in which the individual died, rather than the year the death was registered. This is different to some official collections, where the year the death is registered is used.

### Cause of death

Cause of death is ascribed in line with the Ministry of Health's Mortality Collection. Deaths are coded as being due to suicide when this is the ruling of the coroner who investigated the death.

### DHB of residence

DHB of residence is derived from a person's address as supplied by the coroner, police or BDM. This is based on the individual's self-identified 'usual' place of residence and does not necessarily reflect their legal residential status.

### The New Zealand Index of Deprivation (NZDep2013)

The NZDep2013 is an area-based measure of socioeconomic deprivation using variables from the Census of Population and Dwellings 2013. The measure combines census data on income, home ownership, employment, qualifications, family structure, housing, access to transport and communications, and provides a deprivation score for each meshblock in Aotearoa New Zealand.[36] In this report, NZDep2013 scores were assigned according to meshblock unit, derived from place

of residence of the deceased person's address (supplied from the coroner, police or BDM), and presented as deciles from least deprived (decile 1) to most deprived (decile 10).

### Urban and rural

This report uses the standard urban rural classification profile defined by Stats NZ.[37]

### Education data

The Ministry of Education was asked for data for all cases in the Mortality Review Database. Overall, 50 percent of the cases in the Mortality Review Database were matched to records in the Ministry of Education's database. Because the proportion of cases matched was considerably lower for the earlier years in the period under review, the analysis of education data was restricted to the most recent five years (for which at least 75 percent of cases were matched). There were no substantial differences between the proportions of those who matched by ethnic group or cause of death (suicide compared with all others).

### Statistics

The NZ MRDG computed data presented in this report from the Mortality Review Database. Percentages are expressed to one decimal point. In some cases, due to rounding, percentages do not sum to 100 exactly. The denominator used in the main analyses is a derived set based on data from Stats NZ's estimated resident population from census years 2001, 2006 and 2013. Linear extrapolation was undertaken to calculate the estimated resident population between 2001 and 2006, and 2006 and 2013. The 2006 to 2013 gradient was then used to extrapolate out to 2016. Rates in this report are presented as per 100,000 age-specific population.

Rates and confidence intervals are expressed to two decimal places. Rates were not calculated for numbers less than three. Due to differences in the way rates were calculated and the different denominators used, the rates presented in this report may vary from other published rates. The deaths of non-New Zealand residents were excluded from the report because the denominator in rate calculations (as above) excludes visitors from overseas.

The word 'significant' in relation to statistics that appear in this report indicates that a statistical test has provided sufficient evidence that the groups being compared are different (significance level 0.05; that is, the probability of the groups being the same is less than 5 percent).

## Limitations of the data

The CYMRC has collected the data and information used for this report over time, in keeping with strict legislative requirements. It includes administrative information from government departments that is transferred electronically for all cases, and information that CYMRC local coordinators collect during a cross-agency mortality case review process within DHBs. Many cases are reviewed by the local mortality review group, of which there is one per DHB. Information collected during this cross-agency mortality case review process is also entered into the database. Note that not all cases are reviewed at local level. However, administrative data is received for all, and most deaths due to suicide are reviewed.

For this reason, the quality and depth of the information the CYMRC has depended on:

1. the skills and experience of those following the recording, collection and coding processes that provide information
2. the quality of information shared within local CYMRC review processes, how well those at the review understand it and what is recorded in the mortality review record as a result
3. membership of the local CYMRC local review groups – some may have strong Māori participation, but CYMRC review groups do not engage directly with Māori whānau or with rangatahi, due to legislative constraints around dealing with personal information. A key limitation of the study is that it relies on the perspective of people who work primarily in government agencies. Another limitation is the lack of clear rangatahi and whānau voices, which would add significantly to this work. Mortality review committees are considering options for addressing this issue.

[36] A meshblock is both a geographic unit and a classification. It is the smallest geographic unit for which statistical data is reported by Stats NZ, defined geographic area, varying in size from part of a city block to large areas of rural land.

[37] http://archive.stats.govt.nz/methods/classifications-and-standards/classification-related-stats-standards/urban-area.aspx

# Te Mauri

## THE LIFE FORCE

# Appendix 2: Glossary

## Āpitihanga 2: Rārangi kupu

### Bereaved by suicide

The description 'bereaved by suicide' applies to all those close to an individual who died by suicide. This includes friends, whānau, caregivers, extended Māori tribal networks (hapū and iwi), professionals who worked with the deceased and any non-relative who had a close relationship with the person who died.

### Rangatahi

For the purposes of this report, 'rangatahi' are defined as young Māori aged 10–24 years. Tamariki Māori (Māori children) aged 10–14 years were included within the scope of this report because a significant proportion (61 percent) of all suicide deaths among those aged 10–14 years occur in tamariki Māori (Child and Youth Mortality Review Committee 2019).

### Suicide

Suicide includes all deaths resulting directly from acts of self-harm (Carter et al 2016; Hawton and Fortune 2008). In Aotearoa New Zealand, the classification of suicide deaths involves a coronial inquiry. The police report all suspected suicide deaths to the coroner. The coroner then conducts an inquiry into the circumstances surrounding the death. Suicide is the act of intentionally killing oneself, therefore, for the coroner to find that the death was a suicide, the decision must be made on the balance of probabilities that the person had the intent to die.

Most suicide inquiries are conducted in chambers by the coroner, without an inquest. For some suicide deaths, an inquest is held to investigate the circumstances surrounding the death and find out more about the person. These inquests help coroners make public recommendations and comments about the death to prevent similar deaths occurring in future.[38]

### Self-harm

Self-harm is any form of intentional, non-fatal self-poisoning or self-injury (eg, cutting, taking an overdose, hanging, self-strangulation and running into traffic), regardless of motivation or the degree of intention to die (Hawton et al 2012).

### Suicide ideation

The term 'suicide ideation' refers to thoughts about an act of self-harm or suicide, including: wishing to kill oneself; making plans of when, where and how to carry out the act; and considering the impact of suicidal actions on others.

### Suicide attempt

The term 'suicide attempt' refers to the range of actions where people make attempts at suicide that are non-fatal.

### Suicide prevention

The term 'suicide prevention' refers to a wide range of activities that aim to prevent and reduce the risk of suicide by enhancing protective factors and reducing risk factors associated with suicidal behaviour.

### Suicide postvention

The term 'suicide postvention' refers to a wide range of activities that take place directly after a suicide to help minimise any harmful impact of the suicide on others in the community. Suicide postvention is a form of suicide prevention because it reduces the subsequent risk of suicide and harm to those exposed.

For Māori communities, integral aspects of suicide postvention include: facilitating safe kōrero (conversation) around the suicide; acknowledging mātauranga Māori (Māori knowledge); respecting tikanga (protocols), funeral processes and the lifting of tapu (sacredness); and supporting cultural processes and sensitivities around treatment of the tūpapaku (deceased) in ways that help Māori whānau and friends grieve and heal (McClintock and Baker 2019).

[38] https://coronialservices.justice.govt.nz/suicide/

# Appendix 3: Guide to Māori terms

## Āpitihanga 3: He aratohu mō ngā kupu Māori

| | |
|---|---|
| Aotearoa | The Māori name for New Zealand |
| Aroha | Love, concern, compassion, empathy |
| Hapū | Subtribe |
| Hauora | Holistic health and wellbeing |
| Iwi | Tribal grouping |
| Kaimahi | Worker, employee, clerk, staff |
| Kapa haka | Māori performing arts |
| Kaupapa Māori | A Māori approach |
| Kōrero | Discussion, conversation |
| Koroua | Elderly male |
| kotahitanga | Unity, togetherness, solidarity, collective action |
| Kuia | Elderly female |
| Kura kaupapa | Māori immersion secondary schools |
| Mana | Prestige, authority, control, power, influence, status |
| Mana motuhake | Autonomy, self-determination, sovereignty, self-government |
| Manaakitanga | The process of showing respect, generosity and care for others |
| Māori | Indigenous people of Aotearoa |
| Mātauranga Māori | The Māori worldview, Māori knowledge, traditional knowledge. Original tribal teachings maintained by transmitting oral knowledge from generation to generation; used to nurture relationships within their environments and within the whānau and wider community |
| Mauri | The life force or essence of a person, both dynamic and relational. It is constantly changing; it shapes one's spirit (wairua), balances the mind and body, and shapes how a person relates to self, others and the wider environment (Durie 2001) |
| Mauri moe, mauri noho | Languishing; the state in which one's mauri is weakened; a range of painful emotions and behaviours are associated with these states, including: fear, sadness, guilt, gloom, pessimism, mistrust, lack of mental and physical energy, isolation, non-participation, cultural alienation and harmful relationships (Durie 2017) |
| Mauri ora | The state in which the mauri is fully energised; accompanied by positive states of being such as optimism, cultural engagement, vitality, having physical and mental energy, positive relationships, and participating in society (Durie 2017) |
| Mokopuna | Grandchild, grandchildren |
| Mōteatea | Laments, chants |

| | |
|---|---|
| Noho marae | Overnight stay at a marae |
| Rangatahi | See definition in glossary (Appendix 2) |
| Tamariki | Child, children |
| Tangata whenua | People of the land, local people |
| Tapu | To be sacred, sacredness |
| Te ao Māori | The Māori world |
| Te reo Māori | Māori language |
| Te Tiriti o Waitangi | Te Reo Māori version of The Treaty of Waitangi, first signed on 6 February 1840 by representatives of the British Crown and Māori chiefs (rangatira) from the North Island of New Zealand |
| Tikanga | Correct procedure/protocol; a system of values and practices |
| Tino rangatiratanga | The fullest expression of rangatiratanga, autonomy, self-determination, sovereignty, self-government |
| Tūrangawaewae | Place of family origin; a place to stand, where Māori feel empowered and connected to their whakapapa |
| Wairua | Spirit |
| Wānanga | Learning forum |
| Whakaaro | Thoughts, opinion |
| Whakamomori | Thoughts, emotions and behaviours that may escalate and result in self-harm if left unaddressed; the concept is broader than Western concepts of suicide because it acknowledges that suicide within Māori communities is experienced as a collective state of psychological and spiritual sadness |
| Whakapapa | Ancestral lineage, genealogical connections. Whakapapa in traditional Māori society formed the foundation of all Māori social and kinship relationships |
| Whānau | Extended family, family group |
| Whanaungatanga | Networks and relationships |
| Whakawhanaungatanga | Building relationships, process of establishing relationships, relating well to others |
| Whānau ora | Family (including extended family) wellbeing |
| Whānau Ora | A public policy approach to health and social service delivery underpinned by Māori values, announced in 2010. The Whānau Ora initiative places whānau as the experts in their own lives; as agents of change primed for success; and as carriers of identity, culture and belonging. Whānau Ora is aspirational, culturally grounded, empowering, emancipatory, strengths-based, mana-enhancing and whānau determined, rather than being system or service driven |
| Whenua | Land |