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Indigenous suicide: The Turamarama Declaration

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Abstract

Across the globe suicide has become a major public health concern. Indigenous suicide rates have escalated over the past two decades and continue to exceed national rates. In 2016, a Māori tribal organisation, Ngāti Pikiao, convened an international conference, Turamarama ki te Ora, to discuss global approaches to the prevention of suicide. To bring together the many aspects of suicide prevention, a Declaration was presented and subsequently endorsed by Conference delegates. The Turamarama Declaration acknowledged the grief associated with suicide, recognised avenues to promote indigenous resilience, identified opportunities to decrease risks to suicide, and challenged local, national, and international authorities to take definitive measures to reduce indigenous suicide. The Declaration also encouraged indigenous people to work together to provide an integrated response and collective, networked leadership.

Keywords: Indigenous leadership, suicide prevention, global response, collective action.

Global Perspectives on Suicide

For more than two decades suicide has been a major global concern. In 1996, the United Nations published guidelines to assist and stimulate countries to develop national strategies aimed at reducing morbidity, mortality, and other consequences of suicidal behaviour (United Nations, 1996). The guidelines emphasised the need for across sector collaboration, multidisciplinary approaches, and continued evaluation and review. The United Nations identified several elements that could increase the effectiveness of suicide prevention strategies, including:

- Support from government policy.
- A conceptual framework.
- Well established aims and goals.
- Measurable objectives.
- Identification of organisations capable of implementing objectives.
- Ongoing monitoring and evaluation.

But by 2014, suicide remained a source of ongoing concern. Of the 800,000 people who commit suicide each year, rates were highest in people aged 70 years and over. In some countries, however, the highest rates were found among the young. Notably, suicide is the second leading cause of death globally in people between the ages of 15 and 29 years (World Health Organisation [WHO], 2014a).

Of particular concern, suicide rates are higher for indigenous populations than for non-indigenous populations in the same countries, a fact that has been known for more than two decades (De Leo, Sveticic, & Milner, 2011). In Australia, for example, suicide is the second leading cause of death for Aboriginal children aged 14 years and less–and they are eight times more likely to die by suicide than their non-Aboriginal peers. For young Aboriginal people aged 15 to 35 years, suicide is the leading cause of death–thirty percent of deaths in this age group are reported as suicides–therefore nearly one in three deaths in the 20 year age group are suicides (Georgatos, 2015).

In Canada, a similar trend is apparent. Suicide is five to six times as likely among First Nations youths aged 15 to 24 than non-Aboriginal youth in Canada (Kestler-D'Amours, 2017). Similarly, Inuit suicide rates are eleven times the Canadian average and are particularly high for youth (Chachamovich et al., 2015). The trend is repeated in the USA where in 2012-2013 the suicide rates were highest in the American Indian or Alaska Native (AIAN) population for both males and females (34.3 and 9.9 deaths per 100,000 population, respectively). AIAN males were more than twice as likely to commit suicide as most other gender, racial and ethnic subgroups (Jiang, Mitran, Miniño, & Ni, 2015).

Meanwhile, Māori suicide rates also remain significantly higher than for other ethnic groups in New Zealand. In 2014, the rate of suicide among Māori was higher than among non-Māori for both males and females. Among Māori males the suicide rate was 21.7 per 100,000; 1.4 times that of non-Māori. For Māori females, the suicide rate was 1.5 times that of non-Māori females (Ministry of Health, 2016).

Suicide cannot be explained by a single determinant acting in isolation. Instead sociological, cultural, historical and economic factors all contribute to the escalating rates (Hunter & Milroy, 2006). As well as sociological and societal explanations, suicide has also been discussed within a medical context–most often in connection with a depressive disorder but also in association with psychoses, postpartum disorders, and chronic debilitating illnesses. But not all people who commit suicide have been shown to have undergone psychiatric treatment or to have a mental disorder. Indeed, statistics in New Zealand show that less than 50 percent of people who commit suicide have been receiving psychiatric treatment (Suicide Mortality Review Committee, 2016). While some others may have had an undetected disorder, it is also probable that suicide is not always, or even not mostly, linked to a mental illness. Instead acute distress following a catastrophic event may be a fatal trigger point. A broken heart after the termination of a loving relationship, or intense fear following bullying tactics, or humiliation on social media have all been seen as precipitating factors for suicide.

But, in the wake of increasing suicide among indigenous peoples, the significance of generic understandings derived from western philosophies and experiences, have been found wanting. Suicides in indigenous peoples have been strongly linked to cultural identity–cultural alienation leading to an insecure identity and cultural confusion resulting in fragmented identity (Lawson-Te Aho, 2013).

Indigenous suicide has also been recognised as a consequence of group dispossession, alienation from tribe, family, and homelands, exclusion from decision-making, assimilation, colonisation, and powerlessness in a society where indigenous people have been marginalised. Loss of language, culture, identity, self-management, and wellbeing have been the all-too frequent results in many indigenous communities.

Importantly, loss of land has not only had economic consequences but also the diminishment of personal and group standing and personal integrity. Māori tribes refer to their *mana whenua* (land based prestige) and describe themselves as *tangata whenua* (people of the land). If land is no longer part of the equation, collective and individual integrity is diminished. While those distant (and often ongoing) events cannot be seen as the triggers or conscious precursors to suicide, they create a wider context that contributes to a lack of self-confidence, dignity, pride, and sense of purpose.

The determinants of indigenous suicide can be linked to personal risk factors and collective risk factors. Personal factors include social

disadvantage (e.g. material hardship, physical and sexual abuse, unemployment, educational non-achievement, alcohol and drug use), family adversity (e.g. marital disharmony, foster care, diminished communication between generations and between parents), a mental health problem (e.g. substance abuse disorder, depression) and stress and adolescent adversity (e.g. breakdown of inter-personal relationships, bullying, fear of retaliation). In contrast to personal factors, collective factors reflect the journeys and realities of indigenous peoples over time. They include culture (e.g. loss of language, loss of access to culture), spirituality (e.g. disconnect between self and environment, aimlessness, and a languishing spirit), and colonisation (e.g. oppression, alienation from resources especially land, loss of autonomy). Collective factors provide a backdrop against which individual stamina is shaped (Durie, 2001).

Indigenous Responses to Suicide

The alarming loss of life and the associated life-years lost, have led indigenous peoples in many countries to develop suicide prevention strategies that are relevant to their own situations. Suicide in the Inuit regions for example is twenty-five times more frequent than for the rest of Canada. To address the problem the combined Inuit regions have developed a National Inuit Suicide Prevention Strategy. The Strategy has six priority areas for the prevention of suicide: creating social equity, creating cultural continuity, nurturing healthy Inuit children from birth, ensuring access to a continuum of mental wellness services for adults, healing unresolved trauma, mobilising Inuit knowledge for resilience (Inuit Tapiriit Kanatami, 2016).

Similarly, the higher incidence of suicide among Aboriginal peoples in Australia, has called for an Aboriginal sociology that is separate to the current mainstream suicidology, and which could have the potential to better inform the development and future direction of more effective and appropriate Australian Aboriginal suicide prevention initiatives (Elliott-Farrelly, 2004). It has also been argued that the appreciation of Australian Aboriginal history would contribute more to an understanding of suicide today than would psychological or medical theories about the victim (Tatz, 2005).

In 2009, the National Indian Health Board in the USA published the results of an initiative involving thirteen tribes working towards the prevention of suicide and other premature causes of death (National Indian Health Board, 2009). They identified key strategic elements that operated across all the participating tribes including partnerships and collaborations to produce a *preventive net*, maximise resources, and accomplish goals that could not otherwise be achieved by acting alone. Despite the seriousness of the topics, the use of humour was also important to engagement and commitment. Whole-of-community *buy-in* was an essential pre-requisite and was more likely to occur when there was a generational focus with opportunities for youth, elders and families to meet separately and together. Understanding the culture of youth was a challenge that needed to be overcome so that youth could be active participants in the process.

Māori and Mauri

For Māori in Aotearoa, New Zealand, the concept of *mauri* has been relevant to understanding suicide. The mauri is an inner human force that shapes the spirit, balances the mind, contextualises the body and is reflected in the ways individuals are perceived by themselves and others. Mauri is evident by the vitality, integrity, and energy within a person, and the establishment of positive relationships in the wider environment (Pohatu, 2003). It is sometimes referred to as a *life force*. The mauri is not located in a single organ, nor is it (yet) quantifiable. In short, it is the essence of a person's character and being and confers a degree of uniqueness that makes up *the whole person*.

The concept of mauri is important to understanding suicide (Durie, 2001). Suicide almost always reflects a weakened mauri with a loss of spirit and a loss of the will to live. An exception is with altruistic suicides where the mauri is strong and determined to die for a greater cause. While the human mauri is always present it is neither static nor unchanging. The mauri can have expressions of isolation, withdrawal, non-attendance, flux and non-participation (*mauri moe*). It can become suddenly

energized (*mauri oho*) and can become fully aware of the transformative possibilities in individual and group responsibilities and activities (*mauri ora*; Pohatu & Pohatu, 2003).

Often, but not always, the mauri is languishing when suicide is imminent. If suicide is to be prevented, the task is to ensure that the mauri can become strong and vibrant–mauri ora–despite adversities. Mauri ora has relevance to many situations, including but not confined to the prevention of suicide. It is important for health, wellness, the acquisition of knowledge, *whānau* (families) success, and effective leadership.

Mauri noho (or mauri moe–languishing) can be associated with cultural and spiritual alienation, negative emotions (anger, mistrust, sadness, guilt, gloom, and pessimism), insufficient knowledge, unrelenting pain, lack of mental and physical energy, isolation, and harmful relationships. When fear, grief, pain, despair, guilt, intimidation and humiliation become overwhelming there can be a risk of suicide.

In contrast mauri ora (flourishing) suggests robust spirituality, optimism, cultural engagement, emotional control, positive thinking, vitality and energy, rewarding relationships, and a readiness to engage with others.

There are no standard measures of mauri ora or mauri noho. Instead, the clue to a change in a person's mauri depends on the coming together of a range of qualities relevant to energy levels, emotional distress, optimism or pessimism, physical appearance, physical wellbeing, and relationships.

Risk and Protection

A number of risk factors associated with suicide have been identified by the World Health Organisation: Factors linked to health systems (e.g. barriers to health care), societal practices (such as inappropriate media reporting of suicide), community tensions including discrimination and stresses of acculturation, relationships (e.g. conflict, discord and loss), and individual factors (including previous suicide attempts, mental disorders, job loss, and family history; WHO, 2014b).

In contrast the three broad groupings of protective factors encompass strong personal relationships, religious or spiritual beliefs, and positive coping strategies and wellbeing (WHO, 2014b).

Building on the dual dimensions of risk and protection two main approaches to suicide prevention have been adopted. In the first, the focus is on supporting vulnerable individuals who already show mental distress that could lead to suicide. Access to effective services including specialist clinical services can prevent and reduce the risks known to be associated with suicide. The second broad approach is to bring about change within communities so that known risks can be ameliorated and opportunities for all people to be well can be increased. Apart from increasing the wellbeing of individuals, both risk aversion and protective strategies can also lead to greater community cohesion, safety, and equity. The aim is not confined to individual wellbeing but also to the wellbeing of a community as a whole.

Risks that lead to mauri noho and suicide include alcohol and drug use, cultural alienation, educational failure, poverty, family dysfunction, unemployment, violence, homelessness, unrewarding relationships, illness, and bereavement. Protective factors that guard against suicide incorporate a strong cultural identity, educational attainment, financial security, meaningful employment, quality parenting, self-determination, transport, access to health, social and civic services, social inclusion, sport, and recreation. In addition, to those general risk and protective factors, cultural distinctiveness has been seen as a major factor for Māori as well as inclusion in Māori societal structures such as whānau (families) and *hapū* (tribes) and the opportunity to participate in society as Māori (Ministry of Health, 2006).

Community Initiative

While clinical services and tailored advice will be important to help people who are clearly at risk for suicide, preventing suicide requires proactive approaches aimed at whole populations, or sub-populations. Several community initiatives have demonstrated approaches to suicide prevention that are attuned to building resilience. While

dealing with a crisis is critical, building resilience after the crisis has subsided is aimed at avoiding future crises. *Waka Hourua*, a Government initiative to reduce suicide rates for Māori and Pasifika populations, focuses on encouraging communities to reduce risks in their own communities and also to develop positive attitudes and lifestyles that offer protective advantages (Te Rau Matatini, 2014). The initiatives are built around approaches that resonate with Māori and Pasifika communities and recognise local leadership, communities shaped by shared cultures, beliefs, interests, and group action.

Māori and Pasifika community initiatives supported by Waka Hourua have demonstrated a capacity to promote wellness and at the same time to tackle the risks (Leadership Group, 2016):

- *Owning the problem* by public demonstrations that focus on community responsibility and a readiness to confront (rather than deny) the reality of suicide.
- Reducing poverty by increasing employment opportunities, improving standards of housing, investing in social welfare, and encouraging local leadership.
- *Outing the risks* such as alcohol outlets, legal and illegal drug trafficking, social media, unemployment, and discrimination.
- Building resilience by promoting entry into community based sport and exercise, fostering cultural festivals, facilitating summer camps for young people and their families, and encouraging schools as well as social services to engage with local Māori networks.
- Supporting families to recognise and respond to distress, to be more aware of *triggers* that could end in a suicidal attempt, to communicate in open non-judgmental ways, and to maintain supportive contact across wider family networks.
- Collective action by sectors, disciplines, and authorities so that efforts are coherent, coordinated and able to deliver greater impact than any single agency or service acting alone.

Turamarama ki te Ora

In 2016, a Māori tribal health service in Rotorua, New Zealand, hosted an international conference to discuss the prevention of indigenous suicide– *Turamarama ki te Ora* (bringing light to life). Ngāti Pikiao Health Services had hosted a successful national conference on suicide prevention in 2015 and the 2016 conference built on learnings from that year. Alongside the conference in an adjacent room, an indigenous youth summit was convened. The summit aimed to build indigenous youth champions who could return to their communities and lead positive changes from a youth's perspective.

Included among the 550 participants in the World Indigenous Suicide Prevention Conference and the Youth Summit were indigenous peoples from Canada, USA, Australia, the Pacific nations, and Māori from Aotearoa, New Zealand. They included leaders from indigenous communities, youth, elders, families bereaved by suicide, indigenous health and social service practitioners, and government organisations. The conference theme was *transforming indigenous communities* (Te Rūnanga o Ngāti Pikiao, 2016).

During the conference a presentation on Mauri Ora was delivered (Durie, 2016). It included comment on Māori cultural understandings of wellbeing (flourishing) and lack of wellbeing (languishing). The presentation concluded with a 14-point statement for suicide prevention and conference participants were invited to endorse it as a shared *Declaration* for the prevention of indigenous suicide. By the end of the Conference 450 delegates had endorsed the Declaration and 220 representatives has signed on behalf of their respective organisations.

The purpose of the Turamarama Declaration was to bring together the several threads and recommendations discussed at the conference and to create an opportunity for participants to demonstrate unity and collectivity. Moreover, it was worded to enable maximum accessibility for all participants, including those in the Youth Summit. The language in the Declaration purposely avoided technical, clinical, and sociological terminology; instead it was couched

in terms that were essentially humanistic, respectful, and comprehensible.

The Declaration contains fourteen articles (see Appendix 1 for the full text of *The Turamarama Declaration*). The first three articles recognise the anguish and perplexity that frequently accompany suicide and the impacts on families, and friends, as well as whole communities. A need to heal *our own wounds and the wounds of our lineage* is seen as an important message for the future. These opening three articles in the Declaration address a phase of suicide prevention often known as postvention. The task is to provide assistance to the *victims* of suicide so their mauri (spirit) can be rejuvenated and grief or perplexity overcome.

In the following three articles, expectations for wellness are expressed. High aspirations for indigenous peoples are advocated so they might enjoy long and fruitful lives supported by positive *safe and caring* communities that are enabling and inclusive. Being able to live well *as indigenous peoples and as citizens of the world* is presented as an overall aim. Fostering wellness is an approach to suicide prevention that focuses on whole populations including those for whom suicide would never be anything more than a remote possibility.

Attainment of wellness is further exemplified in articles 7-9. Indigenous cultures and languages are endorsed as key precursors to wellness, and families are highlighted as prime agents in their *key roles in strengthening the mauri*, transferring cultural values, cultural knowledge, and language between generations. Incorporating indigenous cultural values and protocols *to lift the spirit and strengthen our people* in schools, health and social services, as well as in community clubs, social media and urban environments is a key message in the Declaration.

The next three articles 10-12, are calls for action from *our own indigenous leaders, tribal authorities, and community champions*. All three groups have key roles in shaping the types of communities where indigenous peoples live. They can do so by ensuring access to indigenous cultures and heritage; access to build environments that are safe, nurturing and supportive; and legislation and policies that foster wellbeing and eliminate socio-economic disadvantage.

The final two articles in the Declaration introduce a global perspective. They urge the United Nations to highlight indigenous suicide as a worldwide phenomenon and invite indigenous peoples across the globe to join forces to turn the tide so that our combined energies can create a world where the mauri can flourish and all our peoples can live well, into old age.

Since the release of the Declaration, discussions about the implementation of the articles have commenced in a variety of forums. A Global Indigenous Network Advisory Group led by Ngāti Pikiao has been established to *give effect* to the Declaration and plan to discuss it with the World Federation of Public Health, and then with the World Health Organisation assembly. At local levels, the Declaration has also been shared with health promotion agencies, public health experts, men's health groups, and tribal leaders.

Although none of the underlying concerns were new, nor unfamiliar, the Declaration provided a timely reminder that a multi-dimensional approach is necessary if the multiple determinants of suicide are to be addressed. Moreover, they need to be shaped in a manner that affirms indigenous self-governance and management as well as indigenous cultures and world views. While many national suicide prevention programmes contain elements that are also identifiable in the Declaration, and although (in the case of New Zealand) an indigenous dimension may be included, the questions of ownership (*tino rangatiratanga*) and self-direction support indigenous peoples to assert their own wisdom and challenge local, national and global authorities to support their efforts.

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Appendix 1

THE TURAMARAMA DECLARATION

We, participants in Turamarama ki te Ora Indigenous Suicide Prevention Conference, held in Rotorua, New Zealand on 1-3 June 2016, are deeply concerned about the high rates of suicide among indigenous peoples.

1. ***We weep*** **for the increasing number of our people whose lives have been cut short by suicide;**
2. ***We respect*** **the courage and fortitude of families and friends who have endured unexpected and often inexplicable losses of dear ones;**
3. ***We commit*** **ourselves to healing our own wounds and the wounds of our lineage, and in so doing to exemplify the ways in which light can be brought into the world inhabited by our elders, our peers and our young people;**
4. ***We declare*** **that all our people should be able to 'live well', into old age;**
5. ***We believe*** **that the will to 'live well' is strong when the human mauri is strong; 'living well' means being able to live as Māori, as indigenous peoples, and as citizens of the world;**
6. ***We will strive*** **to build safe and nurturing communities that generate confidence, integrity, inclusion, equity, and goodwill;**
7. ***We recognise*** **the key roles that whānau and families play in strengthening the mauri by transferring knowledge, culture, language, values, and love to their children and grandchildren;**
8. ***We endorse*** **the benefits of tikanga, kawa, healing, and other cultural protocols to lift the spirit and strengthen our people in schools, health centres, sporting clubs, social media, the workplace, and the streets;**
9. ***We expect*** **health, education, and all social service providers to offer services that are accessible, timely and effective for indigenous peoples;**
10. ***We urge*** **our own indigenous leaders, tribal authorities, and community champions to create opportunities for our children, youth, women, men, and our older people so they can be part of te ao Māori and the indigenous world, and can be active participants in the communities where they live and work;**
11. ***We challenge*** **national and local authorities and city councils to adopt and enforce regulations to reduce the availability of alcohol and other harmful substances, to ensure that homes are warm, comfortable, and affordable, to insist that streets, workplaces, schools, and the internet are all safe places for our peoples, and to combat practices that diminish self-worth and hope;**
12. ***We call*** **on our elected leaders in Parliament, especially those who have responsibilities for education, social services, health, housing, employment, indigenous development, and the environment, to work together in order to create a society where equity of access, equitable outcomes, and extended opportunities can prevail;**
13. ***We recommend*** **that our people in the United Nations Permanent Forum on Indigenous Issues make all nation states aware of the extent of Indigenous suicide and ensure that suicide prevention is highlighted in the UN Millennium Goals;**
14. ***We pledge*** **ourselves to work collectively so that our combined energies can create a world where the mauri can flourish and all our peoples can live well, into old age.**

Declared at Rotorua, New Zealand

3rd June 2016

Signatories
(Here follows 220 signatures)