Maori suicide prevention in New Zealand

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Abstract

This paper reminds us that suicide is a major issue for Maori and suggests that the national suicide prevention strategy is somewhat limited in application to the Maori community. "In Our Hands" and "Kia Piki Te Ora O Te Taitamariki" are the two parts of the National Youth Suicide Prevention Strategy They have a set of broad goals and objectives, which together form a comprehensive but far too narrowly targeted approach to reducing suicide in Aotearoa/New Zealand. In order to identify trends in Maori suicide and the age structure of suicide epidemiology, New Zealand Health Information Service data from 1980 to 1998 were examined. The trend was for a gradual but significant increase in annual numbers of Maori suicides over this period. Overall, numbers of Maori suicides have trebled in the last two decades. Age structure of Maori suicide is different from non-Maori in that the age of peak incidence for Maori is more broadly based at 15-44 years of age than the 15-24 age of peak incidence for the non-Maori population. This should be reflected in the national suicide prevention strategy.

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Introduction

Approximately 540 New Zealanders kill themselves each year.[1] Suicide rates in Aotearoa/New Zealand are among the highest in OECD countries in the 15-24 age group and second in all other age groups.[2,3] Suicide is the leading cause of death for young people under the age of 25 years in Aotearoa/New Zealand and is a major public health problem.[2] There are disparities in Maori and non-Maori rates; in 1997 the Maori rate of suicide was 17.5/100,000 compared to non-Maori 13.1/100,000.

The National Youth Suicide Prevention Strategy provides a framework for understanding suicide prevention and signals the steps and range of government agencies; communities, services, hapu and iwi must take to reduce suicides in the 15-24 year old age group.[3] The National Strategy is made up of two parts: *In our Hands*, which is the mainstream population strategy and *Kia Piki te Ora O Te Taitamariki*, which focuses on specific Maori needs and approaches. Each has a set of broad goals and objectives, which together form the comprehensive approach to reducing the rate of suicide in Aotearoa/New Zealand.

This paper demonstrates that suicide is an important Maori health issue and that the national suicide prevention strategy is limited in its application to Maori.

Background

The two parts of the Strategy are not mutually exclusive and should be read together. The five goals of *In Our Hands* are: promoting the wellbeing of youth, early identification and help, crisis support and treatment, support for families after a suicide, and information and research. *In Our Hands* is aimed at the general population but notes that substantive efforts must be made to make services more appropriate and responsive to the culture and ethnicity of the people they serve.[4] For instance, the increasing numbers of young Pacific peoples and Asians in Aotearoa/New Zealand mean that health services need to develop ways to meet the needs of these populations.

The government also has a duty under the Treaty of Waitangi to ensure that policies and services are developed in consultation with Maori, that they are appropriate and effective for Maori, and that they reduce disparities in outcomes. *Kia Piki te Ora O Te Taitamariki* is the suicide

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prevention strategy developed for Maori that is firmly grounded in a Maori development approach.[5] It is inspired by a vision of a society where taitamariki Maori are valued, nurtured and strengthened and focuses more specifically on promoting resilience factors such as cultural identity and belonging.

The mission of *Kia Piki te Ora o te Taitamariki* is to reduce the rate of suicide and suicidal behaviour of taitamariki Maori by strengthening their participation in healthy Maori whanau and communities that provide safety, security and a uniquely Maori sense of identity. The five goals of *Kia Piki te Ora O Te Taitamariki* are strategies to achieve the above. They are strengthening whanau, hapu and iwi links and networks; strengthening the role of Maori youth in Maori development; increasing the role of cultural development; encouraging greater responsiveness of mainstream agencies to Maori and improving understanding of causes and incidence of suicide by young Maori.

Method

In order to identify trends in Maori suicide and the age structure of suicide epidemiology, New Zealand Health Information Service data from 1980 to 1997 were examined. Their sources of mortality information include: death certificates completed by doctors, post-mortem reports completed by pathologists and death registration forms completed by the funeral director and this information is collated to inform a mortality register in the NZHIS.

New Zealand adopted the ninth revision of the International Classification of Diseases in 1979 and in 1988, the ninth revision clinical modification. The deaths listed here have been classified according to the World Health Organisation custom.[6]

The data were examined to identify any trend in Maori suicides from 1980-1997 and to compare Maori and non-Maori age specific rates in 1997. Maori deaths from 1996 onward cannot be compared with these prior to and including 1995 because of the change in definition of Maori ethnicity that occurred in the New Zealand Health Information Service in 1995. Classification changed from a biological concept that included as Maori those with 50% or more Maori blood, to one of self-identification with the option of selecting multiple ethnicities.

Results

Five hundred and ninety Maori completed suicide between 1980 and 1997. There is a gradual but significant increase in annual suicides over this time from 15 in 1980 to 48 in 1994, a 320% escalation.

Annual Maori suicide numbers approximately double after the 1995 change of the Maori ethnicity definition. The definition is obviously more inclusive and for this reason there is a discontinuity in Figure 1.

Figure 2 shows the 1997 suicide figures and these are purposefully used as the most recent expression of age distribution in the Maori population that uses the more inclusive definition of Maori ethnicity. In 1997, the prevalence of Maori suicide demonstrated a typical bell-shaped curve across the age groups with a distinctively broad peak across the 15-24 and 25-44 year age groups. Each has a rate of 33.9/100,000. Non-Maori had lower rates in both these age categories at 24.3 and 20.1. The peak is in the 15-24 year group.

Maori suicide in the 10-14 year age group (6.6/100,000) equated to the older, 65+ age category (5.8/100,000) and 45-64 year olds (10.3/100,000) were marginally higher. Non-Maori had slightly elevated suicide rates compared to Maori over the age of 45 years.

Discussion

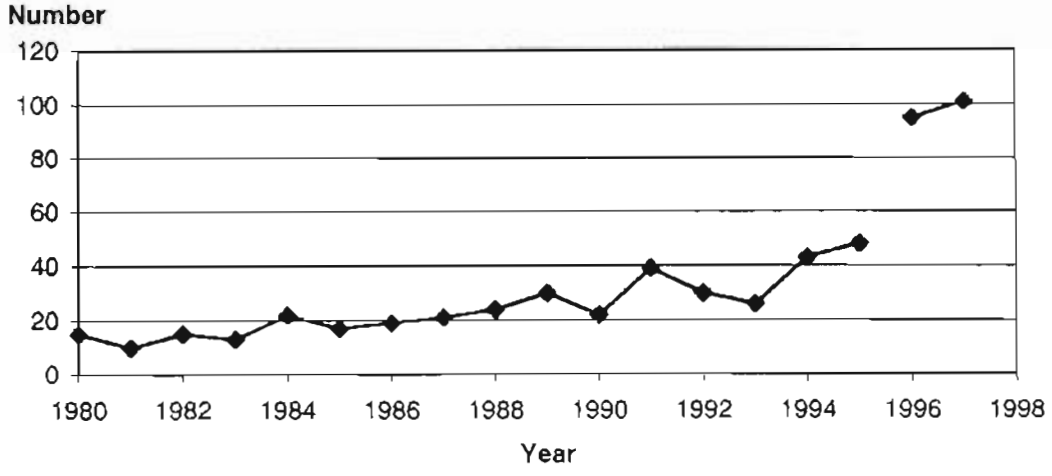
Making meaningful deductions from secondary data requires accuracy and consistency in the process by which that data was collected and analysed. There are some difficulties with both ethnicity and suicide classifications in New Zealand.

Even when Maori health and mental health both continue to be New Zealand government health gain priority areas. Maori rates of suicide remained higher than non-Maori rates in 1997.

The definition of Maori, prior to July 1995, was one of biological nature and ancestry. This meant that, to be recorded as Maori, you would have had 50% or more blood ancestry. After 1995, the change allowed for self-definition according to identification. Therefore, trend analysis by ethnicity before 1995 cannot be compared with that after 1995

The definition of suicide also has internal consistency problems. The coronial investigation may undercount the number of suicides through conscious mislabelling due to either historical, insurance and whanau sensitivity reasons. Historical mislabelling stems from New Zealand's colonial and Christian background, where suicide was a sin and the ruling was not made to spare the family.[7] Because life insurance is not paid out where there is any suspicion of suicide, a coroner may feel compelled to give a verdict of accidental death rather than suicide. The classic example is of motor vehicle accidents and young men – was it actually suicide I observed that, compared to non-Maori, Maori rarely wrote suicide notes. If there is no suicide note then it may be less complicated for the coroner to mislabel a suicide. Therefore, the number of Maori completed suicide is highly

Figure 1. Number of Maori suicide in Aotearoa/New Zealand, 1980-1997



likely to be underreported, due to the problems with the classification of both Maori ethnicity and suicide.

There were five hundred and ninety reported Maori suicides between 1980 – 1997. Even when Maori health and mental health both continue to be New Zealand government health gain priority areas.[7] Maori rates of suicide remained higher than non-Maori rates in 1997.

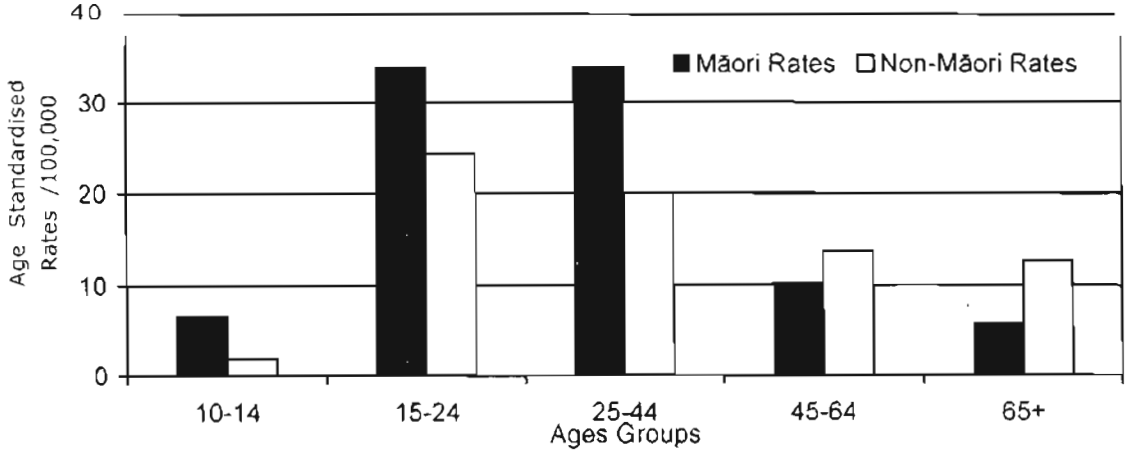
The most important difference in Maori and non-Maori suicide is the inclusion of the 25-44 year old age group with the younger 15-24 year old group as peak age of suicide incidence. This may occur because of the Maori population structure, which is youthful with relatively fewer Maori in the older age groups. Because 64% of Maori suicides occur outside the 15-24 years age cohort, it is therefore important that the National Suicide Prevention Strategy by extended to include Maori in the 25-44 years of age. Such narrow targeting is possibly a consequence of policies being determine according to total population data and since Maori are a minority within these data, the high rates in the 25-44 age group range become invisible. In other words particular characteristics of the demography of Maori suicide get subsumed within the total population demographics.

It is clear that Maori kill themselves too often and prevention strategies must target the appropriate audience through a myriad of mechanisms that incorporate a positive cultural framework. *Kia Piki Te Ora O Te Taitamariki*: The New Zealand Youth Suicide Prevention Strategy should be extended to include this age group.

The disparity between Maori and non-Maori suicide rates is also a macro-environment issue. It points to the need for the government policy to address issues around poverty, cultural alienation, colonisation, racism and to enhance social cohesion, ethnic identity and cultural identity. Without improvements in these key areas the disparity between Maori and non-Maori may continue to grow.

There is a need for evidence based research on Maori suicide in order that the development of culturally appropriate

Figure 2. Age Standardised Suicide Rates for Maori and Non-Maori, 1997



strategies for Maori suicide prevention from such research occurs. This will enable policy makers, health purchasers and providers to address the important Treaty of Waitangi implications of such disparities. The Treaty principles of partnership, participation and active protection are all being violated while the number of Maori who are completing suicide remains high.

References

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HE KUPU HOU

ka awhiowhio te mahunga	*dizzyness*
ka hiaruaki	*nausea*
he pakapaka	*blistered*