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The case for Re-framing Māori Suicide Prevention Research in Aotearoa/New Zealand: Applying Lessons from Indigenous Suicide Prevention Research

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Cover Page Footnote

1. Māori - the indigenous people of Aotearoa/New Zealand 2. Cultural sovereignty has been used here to refer to self-determination based on the positioning of Māori in a cultural frame which acknowledges ancestral descent lines and mana (authority) 3. Te Ika a Maui- the Maori name for the North Island of New Zealand, literally translates as the fish of Maui 4. Te Waipounamu - the Maori name for the South Island, literally translates as waters of greenstone 5. Tangata whenua - the original inhabitants of the land 6. classification of death as suicide - the role of the coroner 7. provisional count of all self-inflicted deaths referred to in the coronial system 8. an association between historical trauma and suicide was first proposed by Lawson-Te Aho in 1998 9. Daily micro-aggressions definition 10. Ngai Tahu is one of the main tribes in the South Island, named after eponymous ancestor Tahu Potiki 11. Tuhoe is the tribe centered in the North Island with a history of resistance to colonisation 12. The Waitangi tribunal is a New Zealand permanent commission of inquiry established under the Treaty of Waitangi Act, 1975 13. Ta moko or Maori tattoo is increasingly being used to map the therapeutic plans of Maori with mental illness into their skin 14. Tribal suicide prevention projects in the North Island using story-telling as hope building 15. There are a number of Maori youth cultural identity projects that might be considered as contributing to suicide prevention 16. <http://www.stuff.co.nz> suicide reporting rules under review 17. <http://www.stuff.co.nz/national/health/7200104/unravelling-youth-suicide> 18. Mauri ora is defined as complete wellbeing

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Abstract

The aim of this paper is to present a case for reframing Māori (the indigenous people of New Zealand) suicide prevention research away from a strong emphasis on clinical research towards research that is more self-determining and historically and culturally contextualised. Rising levels of indigenous suicide have produced an intensified global focus on suicide prevention in indigenous, migrant and LGBTIQ populations.

Suicide research in Aotearoa/New Zealand has largely disregarded the potential explanatory power of historical trauma and the inter-generational transfer of collective suffering on Māori, (the indigenous peoples of New Zealand) suicide levels. Similarly, the effects of regular exposure to racism, daily micro-aggressions and structural violence are often overlooked as explanatory of Māori suicide. Instead, Māori suicide is generally viewed through a pathological, agentic and individualistic lens and Māori suicide prevention efforts framed and informed by a risk factor discursive minimising the historical and contemporary outcomes of pervasive and pernicious histories under colonisation. This paper describes Māori suicide prevention research as a body of knowledge dominated by Western mono-cultural and a/historicised analysis. Such research has overwhelmingly informed Māori suicide prevention strategies and policies for thirty years. However, recent innovations in Māori suicide prevention research which take into account Māori imperatives for self-determination and re-claiming the healing potential of cultural sovereignty¹ are considered and the case for a new frame that enables a more comprehensive, accurate analysis of Māori suicide is proposed.

¹ Cultural sovereignty has been used here to refer to self-determination based on the positioning of Māori in a cultural frame which acknowledges ancestral descent lines and mana (authority)

Introduction

Originally from East Polynesia, Māori migrated to Aotearoa/New Zealand, establishing a new life in the 13th century (Wilson, n.d). Currently located on two main islands (North/Te Ika ā Maui² and South/Te Wai Pounamu³ and smaller surrounding islands that together, comprise Aotearoa/New Zealand Māori are recognised as tangata whenua⁴, the indigenous peoples of these lands. The first colonialists arrived in 1769, approximately 500 years after Māori. Colonising actions such as the introduction of infectious diseases, muskets and large scale acquisition of land by any means necessary (Keenan, 2007) set in motion a chain of events leading to colonial assertions about the imminent demise of Māori:

“The Maoris are dying out, and nothing can save them, our plain duty, as good, compassionate colonists, is to smooth down their dying pillow. Then history will have nothing to reproach us with.” (Featherstone, 1856, as cited in Koea, 2008, p.1).

Resistance to colonisation was met with imprisonment, wide spread land confiscation and other punitive strategies (King, 2003). The population of Māori estimated to be around 240,000 at the time of first contact by Captain Cook in 1769, began to rapidly decline to 70,000 in 1840, 46,000 in 1896 (Pool, 2013), reaching the lowest point of 30,000 by 1918 (Sorrensen, 1956).

² Te Ika a Maui, the Māori name for the North Island – literally translates as the ‘fish of Maui’. Maui was a Demi-God who in Māori cultural narratives is credited with ‘fishing up’ the North Island.

³ Te Wai Pounamu, the Māori name for the South Island, literally translates as ‘the waters of greenstone’. The abundance of greenstone or New Zealand jade which was used for adzes and other tools and decorative pendants resulted in the name.

⁴ Tangata whenua refers to the original inhabitants of the land

Ellison-Loschmann and Pearce (2006) state

“In 1840 the Treaty of Waitangi, a formal agreement for British settlement and a guarantee of protection of Maori interests, was signed by representatives of the British crown and some of the Maori chiefs. It is estimated that Maoris numbered approximately 80000 at that time, along with a population of about 2000 settlers. The signing of the Waitangi treaty facilitated a large-scale influx of British migrants, and by 1858 a decline in the Maori population and an increase in the number of settlers saw the 2 groups both numbering approximately 59000. By 1901, the country’s demographics had drastically altered, with the population of 770313 settlers outnumbering the Maoris by 16.5:1.3” (p. 612).

Yet Māori did not die out as predicted, demonstrating extraordinary resilience in response to sustained efforts to exterminate Māori by dispossession, during the colonial period of New Zealand history.

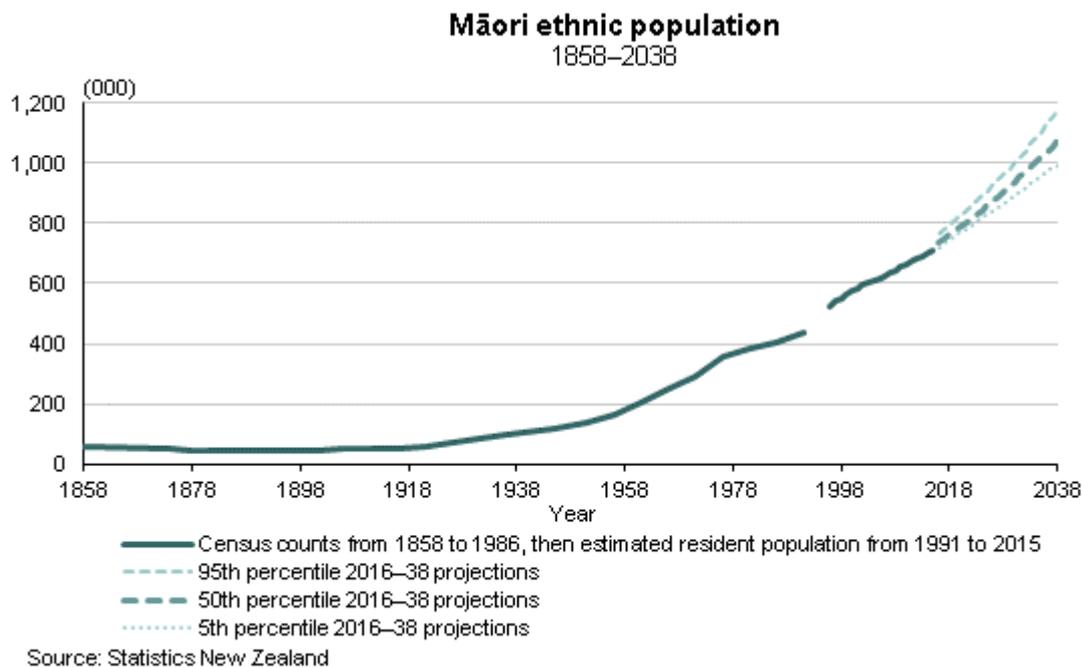


Figure One: Māori Population 1858-2038

Māori Suicide

Māori youth are 2.7 times more likely to die by suicide than non-Māori youth. The Office of the Chief Coroner⁵ [OCC, 2016a] reported that the Māori suicide total (130 deaths) and rate (21.74 per 100,000) is the highest since coronial provisional statistics were first recorded for the 2007/08 year. Māori males continue to be disproportionately represented in the provisional suicide statistics with 93 deaths recorded in 2014⁶. Finally, the age at time of suicide is decreasing. Two recent suicides of twelve year-old Māori children were also reported by Chief Coroner McLean. In one case, the failure of state funded child welfare to protect the child was given as the primary reason for suicide (OCC, 2016b). Furthermore, four cases of Māori teen suicide in one small rural community were ruled by the Chief Coroner McLean as the outcome of extensive family violence (OCC, 2016c).

Contesting Discourses in Māori suicide research

For Māori, as with other indigenous populations (Elias, Mignone, Hall, Hong, Hart & Sareen, 2012), suicide rates are often hypothesised as reflecting pervasive histories of cultural loss, disruption, suffering and oppression under colonisation. These alternative discourses are accepted by most Māori suicide prevention researchers as foundational to the story of Māori suicide using explanations that employ colonisation to underpin standard risk factor repertoires (Lawson-Te Aho & Liu, 2010). A colonisation/health outcomes association is increasingly supported as explanatory of contemporary Māori health inequities (Ellison-Loschman & Pearce, 2006; Reid & Robson, 2007). Yet there is a paucity of evidence associating historical trauma trajectories and the inter-generational transfer of such trauma on contemporary Māori suicide levels. While tribal and community sourced anecdotal evidence linking suicide with historical trauma⁷ is building in Aotearoa/New Zealand, there is a need to evidence associations between historical trauma and suicide in current generations as precisely and robustly as possible. That requires the building of an evidence base and upskilling of Māori suicide prevention researchers to be able to conduct this research and build the evidence base.

Clinical, Risk factor Biases in Māori Suicide Prevention Research

⁵ In New Zealand, a death is only classified as suicide by the coroner on completion of the coroner's inquiry. In some cases, an inquest may be heard several years after the death, particularly if there are factors relating to the death that need to be investigated first (for example, a death in custody). Consequently, a provisional suicide classification may be made before the coroner reaches a verdict.

⁶ Provisional count of all self-inflicted deaths referred into the coronial system, including active cases before a Coroner where intent is yet to be established by a Coroner

⁷ An association between historical trauma and Māori suicide was first proposed by Lawson-Te Aho in 1998.

Māori suicide prevention research has been weighted in favour of supporting clinical interventions and framing (Lawson-Te Aho & Liu, 2010) with emphasis given to clarifying measurable risk factors such as exposure to cyber and other forms of bullying (Kljakovic, Hunt & Jose, 2015), family violence (World Health Organisation, [WHO], 2014); disrupted intimate relationships (Clark, Robinson, Crengle, Fleming, Ameratunga, Denny, Bearinger, Sieving & Saewyc, 2011) exposure to multiple discriminations (Wells, McGee & Beautrais, 2011) as in the case with Māori LGBTIQ youth (Lawson-Te Aho, 2016a). Research that links historical trauma pathways directly to suicide outcomes in Māori youth is absent. However, there is mounting evidence implicating contemporary outcomes of historical processes including ongoing structural violence (Elias et al, 2012; Kirmayer, Gone & Moses, 2014; Lawson-Te Aho & Liu, 2010; Wexler, 2014; Wexler & Gone, 2012) racism (Priest, Paradies, Gunthorpe, Cairney & Sayers, 2011) and racialized micro-aggressions⁸ (O’Keefe et al, 2014) in Māori suicide outcomes (Lawson-Te Aho, 2014; 2016). Moreover, history provides valuable lessons for current theory-building. For example, the act of whakamōmori (suicide) in traditional times was a collectively sanctioned response to trauma in situations such as the loss of a spouse (Hirini & Collins, 2005). The difference is that contemporary Māori suicide, while still a response to group trauma, is not currently attributed to collective trauma histories that link everyday contemporary realities to complex trauma histories (Lawson-Te Aho, 2014).

Legitimising Historical Trauma Research in Māori Suicide Prevention

A study of Māori suicide risk in one tribe examined three inter-related historical acts that contributed to the establishment of inter-generational patterns of incest over seven generations (Lawson-Te Aho, 2014). This began in the late 1820’s with a decision by the tribal leader to allow a brother and sister to marry and have children as a way of strengthening the prophetic (Matakite) ancestral line. This decision followed the deaths of one third of the tribe in an unpredicted attack by an enemy tribe believed to have been supported by the British Queen’s colonial representative. The decimation of the people was attributed to the failure of the prophetic ancestral line to forewarn of the impending deaths. As a result of the decision amid the enduring effects of colonisation, the boundaries around kinship relationships became suspended and incest normalised within the tribe over seven generations (Lawson-Te Aho, 2014; 2015a). This type of complex intergenerational trauma cannot be explained away simply

⁸ Daily micro aggressions are everyday experiences of subtle almost imperceptible discrimination that have a base in racism. They are associated with

by reference to unnamed acts of colonisation or isolated risk factor clusters for suicide. The specifics of tribal histories require closer examination to identify trauma trajectories resulting in Māori suicide outcomes through generations (Lawson-Te Aho, 2014).

Avoiding a one size fits all analysis in Māori suicide research

The specifics of historical trauma differ for indigenous populations. While there were commonly used strategies to colonise and subjugate indigenous populations, the colonisation of Māori does not share all the same features as the colonisation of the Lakota or Tiwi Islanders. The narratives are different, the colonising processes are unique, key players, people and outcomes are different. Within Aotearoa, colonisation took different pathways and tribal responses differed. For example, Ngāi Tahu⁹ embraced negotiation and intermarriage. Tūhoe¹⁰ pursued an isolationist stance that lasted over 100 years from the first colonial incursions (Binney, 2009). Tainui embraced sovereignty and self-determination strategies emulating aspects of the British monarchy (King, 1977). In short, a one size fits all analysis of Māori suicide does not align with Māori cultural and political systems, histories and structures and experiences of colonisation (Lawson-Te Aho, 2016).

Challenging the Research Frame in Māori Suicide Prevention Research

The contemporary effects of colonisation on Māori have been occasionally referenced in selective clinical research by suicide researchers (Collings & Beautrais, 2005). There is acceptance in principle of historical and collective impacts. Yet Māori suicide is persistently understood and interpreted through an individualised, agentic lens. This approach has directly informed suicide prevention research and research funding decisions situating them firmly within the normative assumptions of Western psychology and psychiatry (Lawson-Te Aho & Liu, 2010). Research on Māori suicide prevention has largely been conducted by non-Māori clinical researchers from a knowledge base securely grounded in Western psychiatry and psychology (Lawson-Te Aho & Mila, 2012). Such researchers operate from very powerful positions of privilege in which their mono-cultural discursive is given precedence, normalised as standard repertoires for understanding suicide, thereby undermining and marginalising alternative (read 'Māori') explanations (Smith, 1999). Individualised, clinically focused (Wexler & Gone, 2012) suicide prevention research diminishes by omission, the critical

⁹ Ngāi Tahu is the main tribe in the South Island of New Zealand named after ancestor Tahu Pōtiki

¹⁰ Tūhoe is the tribe situated in the central North Island with a history of resistance to colonisation

impacts of history and the potential of indigenous knowledge and worldviews which collectivise and historicise explanations for suicide thereby, potentially informing suicide prevention efforts from more appropriate frames (Hunter & Harvey, 2002; Marsella, 2009). Finally, the role of the colonised Māori collective in suicide and suicide prevention is significantly under researched.

Mono-cultural Privilege in suicide prevention research is Epistemic Violence

Duran, Firehammer and Gonzalez (2008) call out the privileging of non-indigenous knowledge as ‘epistemic violence’. Clinical, individualised research has served to curtail the capacity of Māori/Indigenous researchers and practitioners, to address suicide from within the realities of Māori/Indigenous histories, communities, social and cultural contexts, environments and lives. While there is a growing literature that associates historical trauma as a key explanation for higher rates of indigenous suicide (Fast & Vezina, 2010; Kirmayer, Gone & Moses, 2014), evidence of an association between historical trauma and suicide has not been well researched in Aotearoa/New Zealand to date. Moreover, while research on suicide in indigenous populations recognises the explanatory potential of historical trauma and the intergenerational transmission of such trauma there remain gaps in the New Zealand research. However, while there is an extensive body of research (Treaty of Waitangi claims research reports)¹¹ recounting the detailed processes of colonisation through land confiscation and alienation, the evidence linking colonial trauma trajectories and Māori suicide is a work in progress. Furthermore, most of the Treaty based research has steered away from examining the collective trauma effects of colonial histories. The psychological effects of historical trauma have been more frequently included in recent claims for adjudication by the Waitangi Tribunal, (the Government agency, established to examine the validity of claims for recompense under the Treaty of Waitangi). However, the significance for contemporary historical trauma theory building in New Zealand that might better inform suicide prevention by tracking trauma trajectories is significantly under-developed

Localising Historical Trauma Theory in Māori suicide prevention research

Māori scholars who question and seek to provide evidence for an association between historical trauma and suicide are in the minority. Historical trauma research for suicide

¹¹ The Waitangi Tribunal (Māori: Te Rōpū Whakamana i te Tiriti) is a New Zealand permanent commission of inquiry established under the Treaty of Waitangi Act 1975. It is charged with investigating and making recommendations on claims brought by Māori relating to actions or omissions of the Crown, in the period largely since 1840, that breach the promises made in the Treaty of Waitangi.

prevention has not been funded signalling a lack of popularity in the general population suicide prevention research community (Lawson-Te Aho, 1998; Lawson-Te Aho, 2016). There are several potential explanations for this. First, revisiting trauma histories carries the risk of re-traumatisation (Lawson-Te Aho, 2014b). Second, the association between historical trauma and suicide needs to be established in cases of Māori suicide. To refocus Māori suicide prevention research calls for an in-depth examination of Māori tribal histories and processes of colonisation to demonstrate how one set of processes directly impacts on the other to drive up suicide rates through generations. This poses a number of very difficult challenges for Māori suicide prevention researchers. These challenges pertain to the ongoing non acceptance by western trained clinical researchers about the validity of historical trauma as a construct that explains current Māori suicide levels. A second challenge exists in terms of access to tribal histories combined with data about the preponderance of factors normally associated with suicide risk through generations. For example, the continuity of data recording processes such as rates of incarceration, poverty levels and other indicators of cultures in crisis, are methodologically imperfect. The poor quality of the data confuses the opportunity to construct the case for an association between historical trauma and Māori suicide but it does not completely negate it. Further challenges concern the extent to which complicity in suicide outcomes might be in some cases, attributed to trauma responses developed in individual Māori families without risk of blaming the victims. Moreover, there are major methodological challenges when linking suicide with specific tribal histories of colonisation.

Mainstream (non-Indigenous) suicide prevention research frames have so far not been able to reach beyond the measurement of the problem and clusters of known risk factors for Māori suicide, to definitively identify the associations between history and suicide which might better inform suicide prevention programmes. Therefore, prevention efforts, may be erroneously informing short term behavioural change interventions for which there is currently limited if any evidence of effectiveness. Examples include Māori targeted community first aid type approaches; education in Māori communities on the warning signs of suicide; after the fact support networks for Māori families with suicide histories; and other such adapted mainstream derived interventions for which there is limited evidence of effectiveness for Māori. There are a number of culturally specific suicide prevention programmes targeting Māori which focus on strengths building; re-indigenization through the reinvigorated uptake

of Māori cultural practices such as Māori tattoo¹² and other therapeutic art forms; genealogy based narratives and story-telling¹³ and, identity building programmes¹⁴. However, these are yet to be evaluated. Given the lack of evaluative data, it is easy to undermine such efforts and disqualify any real potential for Māori suicide prevention.

Talking about Māori suicide

Innovative Māori suicide prevention research has a community mobilisation, self-determination, cultural sovereignty emphasis rather than a limited risk factor focus leading to strategies such as improving access to clinical services for Māori youth (Lawson-Te Aho, 2016). Yet the considerable barriers to real stories of Māori suicide and therefore, a more accurate understanding of where suicide prevention efforts are best placed persist due to the public perception of the dangers of ‘talking about suicide’. This has been challenged by Māori and non-Māori in public discourse around suicide in New Zealand¹⁵. Yet the substantial need for education and support to empower the voices of Māori (and New Zealand) families who have experienced suicide, persist (OCC, 2014). In New Zealand, the public moratorium on ‘talking about suicide’ has grown out of the concern expressed by clinical researchers about the impacts of unregulated media reporting of suicide which has been asserted as amplifying the potential for a suicide contagion. This has generated a wide-spread fear response which has tended to shut down discussion on grounds that talking about suicide will lead to suicide. This approach has been contested by families who have discussed their experiences of suicide very publicly on social media and in the popular media (M. Milne, personal communication, May 15, 2016).

Māori Community Responses to Suicide

Where Māori voices have been empowered and community action taken, there is evidence of reductions in suicide in formerly high risk communities such as Kawerau¹⁶. However, again there is a paucity of evaluation data examining the processes by which these

¹² Māori tattoo or tā moko is increasingly being used to map the therapeutic plans of Māori onto their skin using traditional metaphors.

¹³ Tribal projects in the North Island – Ngātiwai (name of the tribal grouping) using story-telling as hope building.

¹⁴ There are a number of youth identity development programmes funded by various tribal organisations. These include language, genealogy and cultural development programmes. For example, Ngāi Tāhu (Southern tribe) language development programme called Kōtahi Māno Kaika

¹⁵ <http://www.stuff.co.nz/the-press/opinion/perspective/8909431/Suicide-reporting-rules-under-review>

¹⁶ <http://www.stuff.co.nz/national/health/7200104/Unravelling-youth-suicide>

communities were able to effect substantial changes in suicide levels and how such changes can inform sustainable Māori suicide prevention efforts. It is apparent that in the case of Kawerau community action, leadership and investment in community responses to the suicide issues made all the difference. However, suicide has started to climb again in Kawerau indicating the need for a more sustainable approach driven by families and communities and research about the methods used, differentiating between what worked and what did not work. The key lesson from Kawerau is that there is no more powerful advocate for Māori suicide prevention than family members who have buried their children from suicide supported by a connected, caring, committed community (M. Elliot, personal communication, 21 January 2016).

Innovation in Māori Suicide Prevention Research – Towards Mauriora and Aotearoa HOPE Projects

Two specific innovative Māori suicide prevention research projects warrant mention. The ‘Towards Mauri Ora’¹⁷ research project investigated potential links between Māori-centric entrepreneurship education programmes (known as Ahikaa programmes) and suicide prevention for ‘hard to reach’ Māori youth and families who participated in the programmes. The potential links were located in a range of suicide risk factors and protective factors which, it was proposed, were reduced or ameliorated (in the case of risk factors) and/or increased or strengthened (in the case of protective factors) for youth and families who completed the New Zealand Māori entrepreneurship education programmes. One key finding was that Māori youth and their families did not conceive of ‘risk’ and ‘protective’ factors, or the mechanisms by which these may be addressed in ways consistent with those presented in the bulk of suicide research. While numerous studies have generated lists of suicide risk and protective factors, as well as a considerable literature on resilience and interactions between these and other elements, much of the work on these types of factors may be characterised as post-mortem psycho-sociological autopsy based, and framed largely within Western narratives (Love, Lawson-Te Aho, Shariff & Love, 2016). Whilst acknowledging these bodies of work, the primary lenses through which this study viewed suicide prevention, protection, resilience and wellbeing for Māori was one of Mauri Ora. From this perspective, a range of inter-related dimensions were hypothesised as impacting on where individuals, whānau and communities were located on a continuum of:

¹⁷ Mauri Ora is defined as complete wellbeing

- i. Kahupō (spiritual blindness) – which places one in a state of separation from the spark of life and light, and firmly within the realm of vulnerability for suicide
- and;
- ii. Mauri Ora (complete wellbeing) – which connects one with the wairua (spirit) of creative potential, mana ake (elevation power, dignity and spiritual potential) and well-being.

The findings showed that the Ahi Kaa programmes provided one point of entry and one mechanism through which individuals, families and communities could move themselves further towards the mauriora end of the continuum, thereby demonstrating a measureable relationship between Ahi Kaa entrepreneurship education and the reduction of known risk factors for suicide.

The second research project, the Aotearoa Hope Project examined the constituents of hope in a group of Māori youth from five communities with concerning Māori youth suicide numbers. Three of the study communities mobilised their own responses to suicide and suicide rates have declined in two of the three (all rural) communities in the study, probably attributable to community action. The capacity to have and hold hope is untested in suicide prevention research generally (Lawson-Te Aho, 2016a) albeit that hopelessness is directly implicated in indigenous suicide. The Aotearoa Hope Project centred on Māori youth narratives about hope conveying these using digital stories, poetry, rap, Māori cultural dance and song and other expressive forms that resonated with Māori youth. The aim was to use the findings to empower the voices of Māori youth in suicide prevention design by transferring their ideas about the constituents of HOPE into a measure of HOPE. The measure has been developed to shape interventions based on the development of opportunities for experiences of HOPE.

These studies might be classified as hope-building projects that accentuate the privileging of Māori cultural practices, knowledge, worldviews and theory-building around the interaction between self-determination and suicide prevention against the backdrop of the enduring multi-generational effects of colonisation. While there is limited research about the precise role of hope in suicide prevention, there is substantial research about how hopelessness places a young person at risk of suicide (Lawson-Te Aho, 2016a). Hopelessness is linked to the enduring effects of colonisation (Walters, Beltran, Huh & Evans-Campbell, 2011). The

construct of hopelessness dominates studies on the identification of risk factors for suicide (Lawson-Te Aho & Liu, 2010). While there is value in some of these studies in terms of informing further research in this field, hopelessness in youth is often associated with disrupted life events such as traumatic stress and exposure to violence, loss of social connectedness and exposure to specific risk factors such as bullying for sexual and gender diverse Māori youth which are in turn associated with elevated risks of suicide (Lawson-Te Aho, 2016b).

Building a sense of community and belonging, reconnection and acceptance of life choices by families and communities might be identified as collectively based suicide prevention/protective factors (Lawson-Te Aho, 2014a). The building of a Māori evidence base that validates Māori Kaupapa (constructs) and Tikanga (processes) is long overdue (Lawson-Te Aho, 2014a). Researchers working with indigenous communities have identified the importance of factors such as connectedness and self-determining strategies for suicide prevention (Chandler & Lalonde, 2008; White, 2012; 2015a, 2015b). Reversing the logic of associating hopelessness with suicide might lead to an assertion that where hope presides, suicide does not. However, research such as the Aotearoa Hope Project has yet to precisely evidence this assertion. While it makes sense intuitively, conclusive evidence is still needed from the trial of the Māori Hope Scale

Changing the Landscape of Māori Suicide Prevention Research – Future Directions

New approaches to Māori suicide prevention research are being developed. Such approaches build onto cultural strengths while moving away from a clinically emphatic approach to suicide prevention research. Global directions in indigenous suicide prevention that emphasise local solutions, interventions and research grounded in the privileging of indigenous values, worldviews, traditional knowledge, political activism and resistance with the overall goal of achieving self-determination and local community embedded solutions are urgently needed (Wexler & Gone, 2012). While emotional, psychological, spiritual and relational ties are powerful motivators for change in the way research is conducted with rather than to Māori communities, community suicide prevention research led by and for Māori communities is relatively recent and requires substantial ongoing support. The need for Māori suicide prevention research with, alongside and in communities is critical for Māori suicide prevention. Finally, the promise of research such as Ahi Kaa and the Aotearoa Hope Study is predicated on the assumption that an intergenerational transformative potential resides regardless of the most devastating histories of colonisation. The seed potential to flourish in

the face of inter-generational historical trauma and daily adversity is ever present albeit often mired in the enduring effects of colonisation.

Suicide research should not preclude historically anchored explanations. Rather future directions need to embrace the transfer of knowledge, reclaiming, re-indigenization and emboldening of Māori responses to historical trauma and visions for the future on grounds that the direct descendants of ancestors who journeyed across the vast Pacific Ocean to Aotearoa in the 13th century, survived and endured against all the odds and predictions that the only course of action was to smooth the pillow of a dying race.

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