Māori Rangatahi and Addictions
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Introduction

This review highlights substance use, abuse and dependence and related issues in regard to Māori (the indigenous people of Aotearoa/New Zealand) with a key focus on rangatahi (youth). It has been argued that the health status of every population group is influenced by a range of interacting factors, including the effects of colonisation, socioeconomic deprivation and age structure.

Common to many indigenous peoples are a shared experience of colonisation (Bals, Turi, Skre, & Kvernmo, 2010; Reid & Robson, 2007; Durie, 2003). It has been proposed that colonisation allowed for the removal of power and resources from indigenous peoples so that they have and currently experience historical, cultural and socioeconomic deprivation that impacts on the collective and individual wellbeing. Within this context, indigenous peoples have a distinct status and specific needs, with this factor needing to be considered separately from more generalised discussions regarding social disadvantage and inequities (Commission on Social Determinants of Health, 2008).

Policies to reduce outcome inequities for Māori in the domains of social development, education, justice, labour and health play a significant role in preventing and reducing the harms related to alcohol and other drug misuse (Baxter, 2008). However, it is important to be aware that socioeconomic explanations for inequities alone are inadequate, as they fail to account for and consider the factors that initially lead to the unequal distribution of socioeconomic resources by ethnicity (Harris, Tobias, Jeffreys, et al., 2006).

Although socioeconomic position has been associated with a range of poorer outcomes, it is unlikely that the differences between ethnic groups can be completely explained by socioeconomic status, with there being a clearly demonstrated independent effect of ethnicity; even when socio-economic position is taken into account, Māori still have poorer health outcomes including harm reduction caused by alcohol and other drug misuse (Ministry of Health, 2002b).

As a population with a relatively young age-structure, patterns of substance use, misuse and related problems for Māori differ from those of the total population (which reflects an older population structure). In 2013 Māori comprised 17.5% of the total population. Māori are a relatively young population;

- 22.7 years was the median age for Māori,
- 33.1% were under the age of 15 years.
- the average female Māori population was 25.4 years or under, and
- the average male Māori population was under 22.2 years (Statistics New Zealand, 2013).

The majority of Māori (86.0 percent) lived in the North Island.
- Just under one-quarter (23.8 percent) were in the Auckland region.
- The areas with the highest percentage of Māori, after Auckland, were the regions of Waikato (14.0 percent) Bay of Plenty (11.5 percent) and the Wellington (9.7 percent).

Addressing substance misuse-related harm for Māori as a relatively youthful population requires a targeted approach to addictions treatment.
Terms

There are a range of terms used to describe harmful alcohol and other drug use, for example substance misuse, substance abuse, substance dependence and addictive substance use. Other terms used include alcohol use, alcohol misuse, hazardous drinking, heavy drinking, binge drinking, abnormal drinking behaviour, illegal/non-medical drug use, harmful drug use, and dependent/habitual drug use (Slack, Nana, Webster, Stokes, & Wu, 2009). The harmful use of legal drugs, such as alcohol are termed misuse, whilst some authors also reserve the term abuse for illegal substances, with any illegal drug use assumed to be harmful (Slack, et al., 2009). Others use the term harmful or problematic drug use, instead of abuse, the rationale being that this term is less judgemental than abuse, as well as recognising the complicated relationships between substance use and its impacts (Slack, et al., 2009). Many of the above terms are used interchangeably. Depending on the study the terms abuse, dependence and disorder are most accurately used in relation to diagnostic criteria in the Diagnostic Service Manual V (American Psychiatric Association, 2013). Harm or problems denote wider impacts than just health related.

Alcohol

Substance use disorder is widespread in Aotearoa, but is much more common across some population groups, such as younger people, males and Māori (Wells, et al., 2007). Young Māori face particular issues with substance use disorders. Fergusson and Boden (2011a) reported that there is consistent evidence to suggest that a substantial proportion of Aotearoa young people engage in heavy drinking and hazardous drinking. It is estimated that over a third of young people engage in binge drinking or hazardous drinking and that by the age of 25, over 20% will have developed a significant alcohol-related problem (Fergusson & Boden, 2011a).

The Ministry of Health (2009) report that in 2007/08 the majority of Māori had started drinking alcohol when they were aged 15–17 years. However, compared with non-Māori, Māori were more likely to have first tried alcohol when aged 14 years or younger, and were also more likely to have first been drunk when 14 years or younger (Ministry of Health, 2009). Data from the Adults & Youth 2009-10 Drinking Behaviours Report (Alcohol Advisory Council, 2011) showed that 70% of the total population of young ‘drinkers’ reported having started drinking more than the occasional sip by the time they were 15 years. Key findings specific to Māori included that

- young Māori (12-24) were more likely to be ‘binge’ drinkers, than ‘moderate’ drinkers;
- young Māori women recorded a slightly higher percentage of ‘binge’ drinkers 40% as compared to 37% for young Māori men,
- of those who were ‘drinkers’, 5% were young Māori aged 12-14 years,
- 41% were aged 15-17 years, and
- 57% were aged 18-24 years were ‘binge’ drinkers.

These findings support earlier research from the Christchurch Health and Development Study (Horwood & Fergusson, 1998) which found substance use disorders were the most common mental health disorder
among young Māori, with 33.9% of young Māori between 16-18 years having a substance use disorder, with alcohol abuse or dependence being most common. Data also suggested that half of all Māori with a lifetime risk of developing a substance use disorder had the onset of their disorder in late adolescence or earlier (Baxter, 2008).

For some Māori youth, alcohol is increasingly being linked to their identity and what it means to be Māori (ALAC, 2009). Raggett and colleagues (2009) suggested the majority of Māori youth who drink believe that it is acceptable to get drunk in most situations. The 2012/13 New Zealand Health Behaviours study (MoH, 2013) found hazardous drinking levels have fallen among youths but the figures for Māori remain relatively unchanged.

**Other Drugs**

Other drug use for Māori appear to have their onset primarily in adolescence or young adulthood, with 24 years being the age of onset for drug disorders at the 90th percentile (Baxter, 2008). Supporting the high prevalence of cannabis disorder, the Christchurch Health and Development Study (Boden, Fergusson, & Horwood, 2006; Marie, Fergusson, & Boden, 2008) found cohort members who identified themselves as Māori were significantly more likely than non-Māori to report cannabis use, cannabis dependence, use of any illicit drugs, and dependence on any illicit drugs during adolescence and young adulthood.

Māori are almost twice as likely to have first used drugs when aged 14 years or younger, and significantly less likely to have first used drugs when aged 18 years or older (Ministry of Health, 2010a). There is growing evidence to support the notion of cannabis as a gateway drug. Research by the Christchurch Health and Development Study (Fergusson, Boden, & Horwood, 2006) found that the increasing use of cannabis was associated with the increasing use and problems related to other of illicit drugs. Fergusson & Boden (2011b) found the use of cannabis may increase the risks of using other illicit drugs, with this association being particularly marked for adolescent populations.

The national survey data on the use of new Psychoactive Substances in the New Zealand Drug Use Survey 2007/2008, showed lifetime and last year use of BZP (reported at 13.5% and at 5.6% respectively) was even higher than the use of amphetamines (7.2% and 2.1% respectively) or cocaine (3.6% and 0.6%). BZP users were significantly more likely to be male, aged between 18-34, and more likely to be Māori. More recently the Ministry of Health (2013c) indicated Māori were four times as likely to have used amphetamines in the past year as non-Māori, after adjusting for age and sex differences. Again young people between the age of 15 and 24 years are the most vulnerable.

**Comorbidity/Co-Existing Problems (CEP)**

Comorbidity within substance disorders was very common, with many Māori with a drug disorder (primarily cannabis dependence or abuse) also having an alcohol disorder (58.3%) (Baxter, 2008). Comorbidity with another disorder also exist among Māori with any disorder, 29.2% also have a substance disorder (Baxter, 2008). More specifically, among Māori with any anxiety disorders 17.6% also had a substance disorder;
and for those with a mood disorder, 20.6% also had a substance disorder. (Baxter, 2008). A 2011 Addiction Services: Workforce and Service Demand Survey (Matua Raḵi, 2011) reported that 56% of services reported seeing increased numbers of clients with co-existing problems. In the same survey people with co-existing problems made up approximately 48% of clients.

**Impacts**

Substance misuse-related harm occurs across the whole of New Zealand society, across the lifespan and includes personal, social and economic problems suffered by a person, their partner, whānau and wider community as a result of, or exacerbated by, substance misuse. There is a substantial evidence linking substance misuse to poorer physical and mental health, crime, violence, sexual violence, family violence, suicide, accidents, drowning, fire fatalities, dangerous driving, unsafe work practices, educational underachievement, loss of employment; financial instability, loss of housing and other assets, loss of cultural heritage, and loss of relationships and engagement with families and communities (Boden, Fergusson, & Horwood, 2013; Ministry of Health, 2010; Ministry of Health, 2009; SHORE & Whariki, 2006; Slack, et al, 2009). Addiction-related harm is a significant feature for rangatahi (youth), particularly in relation to dangerous driving, poorer mental health, and offending behaviour (The Werry Centre, 2009).

There appear to be clear relationships between exposure to heavy drinkers and reduced personal wellbeing and poorer health status have been found in Aotearoa (Casswell, You, & Huckle, 2011). Issues with a known association with alcohol misuse include public disorder, crime, violence, assault, family and partner violence, dangerous driving, injury, accidents, drowning, fire fatalities, suicide, absenteeism, low work performance, unsafe work practices, and serious health and chronic diseases such as liver damage, cardiovascular disease, pancreatitis, hypertension, and cancer (Alcohol Advisory Council, 2011; Boden, Fergusson, & Horwood, 2013; Ministry of Health, 2008; World Health Organisation, 2007). Baxter (2008) found that the key impacts for Māori with an alcohol dependence disorder were regretting impulsive actions, their health being harmed, and their family hurt. In relation to young people specifically, the misuse of alcohol has been associated with increased risks of a number of adverse outcomes including: motor vehicle collisions, injuries and deaths; crime; violence; sexual assault, sexual risk taking; mental health problems; and victimisation (Fergusson & Boden, 2011a).

**Unmet Need**

Baxter (2007) emphasises that mental health service use data is not an accurate measure of mental disorders within a population, with levels of service use impacted upon not just by the prevalence of disorders but also by access to health services including primary care services and early detection services, and by the effectiveness of those services. An important point regarding statistical analyses of service use is that it is the unadjusted prevalence data which reflects the actual level of need for Māori, with the adjusted figures being a statistical adjustment not reflective of actual needs (Baxter, 2008). Research has consistently identified that overall, Māori children are generally more likely than other people to have experienced unmet need for health care. Overall, rates for unmet need for primary health care are approximately 1.5 times as high for
Māori children as the rates for non-Māori (Ministry of Health, 2012b). Unmet need for health care is also much more common in more deprived areas.

The 2007/08 New Zealand Alcohol and Drug Use Survey found that Māori past-year drinkers were 80% more likely to have wanted help to reduce their level of alcohol use in the past year, but not received it, compared with the total population (Ministry of Health, 2009). Similarly, in relation to drug use, Māori were significantly more likely to have wanted help to reduce their level of drug use in their lifetime but not received it (Ministry of Health, 2010a). Cost has been identified as a barrier to accessing services for substance use disorders (Wells, et al., 2007). Specifically in relation to drug use disorders, reasons for not accessing services included:

- Not knowing where to go;
- Service not being appropriate for specific drug use type;
- Fear of consequences if contact was made with the service;
- Being afraid of losing friends; and
- Social pressure to keep using drugs (Ministry of Health, 2010a).

The Ministry of Health (2009) reported that people living in the most deprived neighbourhoods were significantly more likely than people living in the least deprived neighbourhoods to have wanted help to reduce their level of alcohol use in the last year but to not have received help. However, although rates of disorder were higher among Māori, and there was a trend for greater severity, treatment for psychological problems was offered by GPs at similar rates for Māori and non-Māori, suggesting that there may be ethnic differences in the patient disclosure of symptoms or GP thresholds for offering treatment may be slightly higher for Māori than for non-Māori (Bushnell, 2005).

Analysis showed that Māori pepe (babies), tamariki (children) and rangatahi (youth) were accessing services more than any other ethnic group in 2009, however access rates had not increased at a rate that was comparable to need (Werry Centre, 2011). Possible reasons included the threshold for access to secondary mental health services as being

- Too high;
- Lack of services;
- Lack of inpatient units for children and youth;
- The need for preventative and early intervention services;
- The need for collaboration between services and sectors; and
- Workforce shortages (Mental Health Commission, 2011).
In response to workforce shortages an initiative is needed that contributes to encouraging rangatahi (youth) leadership developments in health. This should identify and foster leadership across the Māori health workforce including mental health. Specific priorities of the movement should include:

- Early identification of potential leaders;
- Creating opportunities for rangatahi to participate in Māori health leadership networks;
- Supporting rangatahi to access Māori leadership training and development opportunities; and
- Exposure to practical leadership models focused on developing both the clinical and cultural potential of rangatahi (Te Rau Matatini Ltd, 2012).

Of critical importance through this process is the development of meaningful relationships for rangatahi with each other, and with emerging and existing Māori health leaders. This process is expected to facilitate the ongoing development of leadership skills and knowledge that contributes to workforce, service delivery improvements and benefits for rangatahi.

**Conclusion**

It is clear from the evidence that the factors of addressing substance use, abuse and dependence issues for Māori requires an approach that acknowledges a relatively youthful population that requires a corresponding targeted approach to addictions treatment. Specific support must also be provided for rangatahi through the involvement of rangatahi in workforce initiatives and service delivery improvement that meets with their needs and expectations.
References


