THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Adolescent Health Research Group

Te Ara Whakapiki Taitamariki

Māori Specific Findings of Youth2000 A National Secondary School Youth Health Survey

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Te Ara Whakapiki Taitamariki.
Māori specific findings of Youth2000: A National Secondary School Youth Health Survey

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HE MIHI

Ko tēnei rīpoata he whakarāpotopototanga mai i ngā whakaaro, i ngā kōrero i whakatakatoria tae noa ki tēnei rā, iho e ngā Āriki e ngā Tōhunga, e ngā Tūpuna o neherā. Nā rātou i tohu iho te ara, heoi tā mātou he whakapuawai ia rātou taonga ki te ao tūroa. He tohu whakamaharatanga.

Me ū, me mau ki ngā tikanga i whakaritea iho e o tātou tūpuna - he taonga tuku iho. Kei te mohio tātou, ko ēnei ngā kupu kōrero o ngā taitamariki i whakatipu.

Mā te pūmau ki ēnei taonga e tupu ai, e puta ai hoki tātou, ngā Iwi Māori, ki te whei ao, ki te ao mārama i roto i ngā rā, rua mano tau e heke iho nei.

Rawiri Wharemate
Kaumatua, Māori Advisory Group

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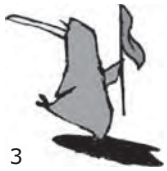

EXECUTIVE SUMMARY

This report, **Te Ara Whakapiki Taitamariki**, presents selected Māori findings from **Youth2000** a national secondary school youth health survey. **Youth2000** is the largest ever survey of the health and wellbeing of young Māori. It is long overdue. Te Ara Whakapiki Taitamariki is an important report that fills significant gaps in our understanding of the major health and wellbeing issues facing taitamariki. In addition these contemporary findings are now available for comparison with past and future New Zealand research.

Readers will likely know some taitamariki whose lives, experiences and issues are quite different to the profile of taitamariki health and wellbeing described in this report. In part this is because the report summarises all the questionnaire responses from more than 2,300 taitamariki who were at school on the day the survey was held at their school. Therefore:

- the report presents findings of the health and wellbeing of a population – not that of individuals and
- taitamariki have disproportionately low school retention rates – hence the report does not include information from all taitamariki, only those attending school, which we know from other research to be the healthiest individuals of this age group.

There are some concerning findings in this report. However Te Ara Whakapiki Taitamariki also contains many positive and reassuring findings. We hope that these go some way to dispelling the stereotype of all young Māori as "high risk" or "problem youth". In addition this report goes beyond listing problems to highlighting the positive connections that can promote taitamariki health and wellbeing aspects, such as whānau, school and wider community connections.

We hope the information in Te Ara Whakapiki Taitamariki guides policymakers, educators, health providers, communities and whānau working to advance the healthy development and positive futures for all taitamariki.

The major findings of this report are:

- Most taitamariki at secondary school are healthy, do not engage in multiple risky behaviours and report positive connections to whānau, schools and peers. Most taitamariki are proud of being Māori and Māori values are important to them.

- Taitamariki are more likely than other New Zealand youth to come from disadvantaged socioeconomic backgrounds. Lower socioeconomic status of taitamariki is a significant factor in the likelihood of taitamariki having serious physical or mental health issues, risky behaviours or difficulties in accessing healthcare. However other ethnic specific risk factors are likely to contribute to the generally lower health status of taitamariki.

- Whānau wellbeing plays a critical role in the healthy development of taitamariki. Most taitamariki report positive relationships with parents and their whānau. Interestingly many taitamariki want more time with parents. Of concern some taitamariki are growing up in whānau environments thatpresent significant potential risks to their wellbeing. For example, about a third of taitamariki smoke cigarettes with whānau and about a half obtain alcohol from whānau.

- School is a significant part of growing up in New Zealand. More than 80% of taitamariki report that being at school is important or very important to them. However compared to other students taitamariki report teachers expect less of them, teachers are more likely to be unfair and that they are less likely to stay on to complete secondary school.

- There are a significant number of taitamariki whose healthy development is at risk. Concerning numbers of taitamariki: misuse alcohol and drugs; experience serious emotional health problems; engage in risky sexual behaviours.

- Health services are not meeting the needs of all taitamariki. Taitamariki, although being generally healthy, have higher rates than other students of chronic illness and mental health concerns. Yet about half of surveyed taitamariki have not sought assistance from health services (even though they knew they needed to) due to a wide range of perceived barriers.

- Many taitamariki with health issues recognise these and consider getting assistance from friends, whānau, other adults and health services. Enhancing everybody's knowledge about what are the important health and wellbeing issues for taitamariki and what makes a difference in the lives of taitamariki are important steps forward.

INTRODUCTION

The health of taitamariki (young people) reflects the current health and wellbeing of our society and will determine the future health of our society. Some of New Zealand's current preventable adult morbidity and mortality can be attributed to behaviours that are initiated during adolescence, such as substance use, sexual behaviours, eating and exercise. Compared with many other countries New Zealand youth have high rates for a range of negative health outcomes, for example suicide and self-harm. Significant disparities between taitamariki and NZ European young people are known to exist for a number of outcomes such as smoking (Ministry of Health, 2003). While individual choice is an important component of decisions relating to health behaviours, a range of factors beyond the control of the individual also impact on health behaviour and health status independent of individual choice: socioeconomic status, of which education is a powerful determinant; the behaviour of peers and whānau; and the lack of appropriate and acceptable services for young people. These factors are usually beyond the influence of individual taitamariki but must be addressed if we are to make maximum use of the opportunities for taitamariki to realise their potential. Where possible we have presented the findings of the survey in the context of known information about some of these factors and have made recommendations to address them.

To address effectively those issues and challenges faced by taitamariki and provide them with an environment in which they can flourish, we need accurate and reliable information about a whole range of risk and resiliency factors that affect youth development, health behaviour and health status. While we have information on a number of risk factors (e.g. tobacco and alcohol) there is a lack of information on other areas (e.g. sensitive personal health areas, such as sexuality). There is also a comparative lack of population-based research on the protective and resiliency factors in the lives of taitamariki that promote health and wellbeing.

Some comparisons between taitamariki and NZ European students are included. These results, from analyses of the entire sample of young people who participated in **Youth2000**, take into account differences in student age, gender and socioeconomic characteristics. These comparisons are included because they illustrate disparities between taitamariki and NZ European.

Youth2000 is New Zealand's first national youth health and wellbeing survey. It is also the first survey undertaken that has sufficient taitamariki to allow Māori specific analyses to be undertaken for many of the areas investigated in the survey. The information and analyses in this survey will contribute to our knowledge about taitamariki. We anticipate the results of this survey will raise further questions about youth health and wellbeing, risk and resiliency factors and the role and influence played by taitamariki, their peers, whānau and social environments. We look forward to further research that increases our understanding and explores interventions to improve taitamariki health and wellbeing.

We hope the information contained in this report will be useful to whānau, communities, schools and Government as we strive to nurture vibrant, self-determining and healthy taitamariki.

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ABOUT THE SURVEY

The Beginnings

In 1997, researchers at The University of Auckland began reviewing the information available on the health and welfare of New Zealand's current generation of young people. It became apparent that much important information was not available because it had never been collected and that what information was available had many limitations. For example, many studies used inconsistent terms or definitions, were outdated, or were not applicable to New Zealand's current diverse population.

To overcome these shortcomings, the Adolescent Health Research Group (AHRG) was established with the aim of improving the health and wellbeing of New Zealand's young people. The AHRG's first goal was to develop, administer and analyse a health survey to provide current national data on youth health and well-being. In 1998, the Health Research Council of New Zealand granted preliminary funding for this work, which was used to gather more information on how to best develop such a survey. Youth, Māori and Pacific community leaders, health providers, youth health researchers, government agencies including Te Puni Kōkiri schools were consulted. This resulted in the development of a multimedia health and wellbeing survey to be administered using laptop computers.

The Questionnaire

Similar youth surveys conducted internationally were reviewed and their experiences were considered along with local feedback in developing the questionnaire. It became clear to the AHRG that the survey needed to:

- be broad rather than focus on a few specific issues,
- include ethnically and culturally specific questions to reflect New Zealand's diversity,
- focus on protective factors and resiliency as well as on risk factors and problems faced by youth and
- be anonymous and carried out in private.

The AHRG developed a range of topic domains for the survey. Each domain included questions that asked about a range of health risk behaviours, risk factors, health conditions and health-promoting/resiliency-enhancing factors.

Youth2000 Topics included:

Culture and Ethnicity
Home
School
Injuries and Violence
Health and Emotional Health
Food and Activities
Sexuality
Substance Use
Neighbourhood
Spirituality

M-CASI

Use of pen and paper questionnaires has been the traditional method for collecting self- report survey information from young people. With the advent of computer technology researchers have started to use computers to administer and collect this type of information. This new type of survey is called a Computer Assisted Self Interview (CASI). When compared with pen and paper questionnaires, CASI improves reporting of sensitive and illegal behaviours (e.g. drug use). CASI also reduces the time taken to answer a questionnaire and the time and cost of data analysis. With computer technology becoming more powerful and at the same time more affordable, CASI can be enhanced by multimedia graphics (M-CASI), allowing pictures, music and animation to accompany a CASI questionnaire.

The AHRG commissioned a team of designers and programmers to design a youth-orientated and 'user friendly' multimedia questionnaire. As students answered questions on different aspects of their life, they travelled around an island accompanied by a cartoon kiwi until they reached the top of a mountain at the end of the survey. Questions were read out over headphones as well as being displayed on the computer's screen. Answers did not require use of the keyboard, only the 'point and click' of the mouse. Students were able to choose not to answer questions at any point. Several on-screen reminders were given that involvement in the questionnaire was voluntary and that answers were confidential and anonymous. For the sensitive questions thought to be potentially upsetting for students, 'safety screens' provided advice and contact details of people to talk to.

Piloting the Survey

In 1999, the questionnaire was pilot tested using M-CASI (Watson et al., 2000). Taitamariki were included in the pilot testing and found M-CASI very acceptable. It took just under one hour for students in the pilot study to complete the questionnaire. All young people were able to use the computer with an initial brief instruction, even if they had never used a computer before. Young people reported that the laptop administered M-CASI questionnaire was acceptable and enjoyable and that the privacy and anonymity of the survey were important determinants of the honesty of their responses.

The survey questions and the M-CASI instrument were both refined following the pilot testing. The final **Youth2000** questionnaire has a possible 523 questions, but students typically only had to answer half of these. This was possible using a complex branching design in the questionnaire so that students only answered questions relevant to them. For example, all students were asked if they had ever smoked a cigarette. If they answered "yes" they would then be asked further questions about smoking cigarettes. If they answered "no" they would then be asked questions about a new topic.

The National Survey

Funding from a further Health Research Council grant enabled the AHRG to administer the large-scale national survey in 2001. The Starship Foundation, Portables Plus and the Alcohol Advisory Council of New Zealand (ALAC) also provided financial support. A project team was employed and surveying took place in schools between March and October 2001.

Ethical approval for this study was obtained from The University of Auckland Human Subjects Ethics Committee. Informed consent was obtained from all participating schools and all participating students. Information on the survey was sent to all families of students who were invited to participate in the survey.
The researchers have been advised and supported by a Māori advisory group comprising David Wharemate, Te Miringa Huriwai, Teorongonui Josie Keelan, Hine Martin, Megan Tunks, Suzanne Pitama and Christine Rimene. He mihi nui, he mihi aroha ki a koutou e tautoko ana mātou.

Schools

In 2001, New Zealand had 389 schools with more than 50 students enrolled in years 9 to 13 (ages 12 to 18 years). One third of these schools (133) were randomly selected and invited to participate in **Youth2000**. In total, 114 (86%) schools, from Kaitaia to Invercargill, took part in the survey.

Of the participating schools, 70% (80/114) were state funded, 24% (27/114) were state integrated (previously private, now receiving state funding to deliver New Zealand Curriculum) and 6% (7/114) were private. Almost one third of schools (32%) were situated in a rural setting. Overall, schools were enthusiastic about participating:

> *"Our school was pleased to be chosen to participate in this survey... it gives us specific information about the health of our students and helps us with curriculum planning"*;
>
> *"We were pleased with the organisation of the survey and minimal disruption to the school. The students were overwhelmingly positive about doing the health survey."*

Of the 19 non-participating schools, 79% (15/19) were in Auckland, Wellington or Christchurch and 53% (10/19) were private or state integrated secondary schools.

There was an uneven distribution of sampled students across the school deciles (Table 1). This is due in part to the small numbers of participating schools in each decile and to the random sampling methodology of the survey. Māori participants were over-represented in low and middle decile schools and under-represented in high decile schools. School decile is calculated taking into

account six factors: household income; occupation; household crowding; educational qualifications; income support; and ethnicity*. For the **Youth2000** survey, the Ministry of Education provided decile rankings for participating schools that had the ethnicity component removed.

Table 1: Participating taitamariki and NZ European students by school decile

Decile	1	2	3	4	5	6	7	8	9	10
Taitamariki (%)	7.1	10.8	9.5	13.2	13.1	10.3	11.7	10.3	8.6	5.3
NZ European (%)	0.5	2.3	3.4	8.8	12.8	12.0	14.9	17.0	14.1	14.4

* Decile components:

1. *household income* – percentage of households with equivalent income (i.e. adjusted for the number of adults and children in the household and the age of the children) in the lowest 20% nationally. Households with a member who is employed are usually not included in this group, nor are all households supported by a benefit (since more than 20% of families are dependent on a benefit).
2. *occupation* – percentage of employed parents in the lowest skilled occupational groups
3. *household crowding* – number of people in the household divided by the number of bedrooms.
4. *educational qualifications* – percentage of parents with no tertiary or school qualifications.
5. *income support* – percentage of parents who received a Domestic Purposes Benefit, Unemployment Benefit or Sickness and Invalid's Benefit.
6. *ethnicity* – percentage of Māori and Pacific students at school in the previous year.

Students

To be eligible to participate, students had to be New Zealand residents, have English language skills equivalent to Year 6 and be physically able to use a standard laptop computer. At each participating school, 15% of eligible Year 9 to 13 students were randomly selected from the school roll and invited to participate. On the day of the survey if selected students did not arrive at the school study venue, students on a randomly generated reserve list were invited to participate.

In total, 12 934 students were invited to participate in the survey. Three-quarters (9699) agreed to take part, which represents 4.0% of the total 2001 New Zealand secondary school student roll. Of the 9566 students in the final data set, 2325 (24.7%) identified as belonging to the Māori ethnic group. Table 2 shows the distribution of ethnic groups that were selected by participating students using the 1996 New Zealand Census prioritisation method.

Table 2: Ethnic Distribution of Students

	National Population		Surveyed Schools		Sampled Students	
Ethnicity	N	%	N	%	N	%
Māori	43767	17.5	11216	17.0	2325	24.7
Pacific	18096	7.2	5588	8.5	769	8.2
Asian	16923	6.8	4463	6.8	679	7.2
NZ European	167370	67.1	43647	66.3	5200	55.3
Other	3455	1.4	936	1.4	437	4.6

The age and gender distribution of students who participated in the survey (Table 3) was similar to that of the student population at the surveyed schools and of all secondary students nationwide. The surveyed schools had a higher proportion of female students; this is reflected in the higher proportion of female students in the sample. The surveyed schools have very similar percentages of students in each form/year compared to all schools nationwide. Less than expected numbers of students aged 17 and above (Year 13) participated. This was partly due to the inclusion of three schools whose year 13 students were unavailable to participate due to other commitments. There were fewer Māori participants in years 12 and 13, reflecting the smaller number of Māori who continue in school in these years.

It is not known why many of the 3235 non-participating students were absent on the day of the survey. Only 28% (908/3235) of these students were reported as being sick on the day of the survey. A small number of students (2.5%, 81/3235) told the survey or school staff they did not wish to participate.

Overall, the survey was received well by the participating students. In the final comments section of the survey many students wrote positively about participating in the survey:

Table 3: Age and gender of taitamariki

	Number	Percentage (%)
Age		
13 years or less	576	24.7
14 years	661	28.3
15 years	540	23.1
16 years	359	15.4
17 years or more	199	8.5
Gender		
Male	1237	52.9
Female	1103	47.1

NB Age missing for 5 participants

"It was cool how we could use laptops and I hope I will get chosen again for another survey. All the best for the future"

"This was a very great survey and I hope that every one likes and enjoys it as much as I did thank u for letting me do this survey"

"I think this survey was pretty cool. I answered the questions truthfully. I wasn't scared to because I know they won't know it was me."

Are the Results Accurate?

The AHRG has taken a number of steps to increase the precision of the survey results. These include:

Sample Size: A large number of students from all over New Zealand were recruited and participated. In particular we recruited enough Māori students to ensure we could undertake accurate analyses specific to taitamariki.

Selection: Schools and students within the schools were randomly selected and invited to participate.

Confidentiality: Students were assured their participation was voluntary and their information was anonymous (they could never be identified).

Administration: A team of trained survey administrators using consistent guidelines administered the survey.

Analysis: The data have been analysed by a large multidisciplinary research team using appropriate statistical techniques. The research team is supported by broader advisory groups that include researchers, policymakers, youth health and development practitioners and young people.

There are a number of sources of potential errors (bias) in the results. These include:

Non-participants: Not all schools or students invited to participate did so. Non-participants could be very different from those who did participate. In addition, we know young people who are not in school are more likely to have greater health concerns (Denny et al., 2002; Dickson et al., 1993). Therefore, young people not in school may not be well represented by these findings.

Non-responses: Responses to some questions included the option: "I don't want to answer this question". A small number of students chose this option. The potential bias of students choosing not to answer specific questions is unknown but it is likely to be small. The number of respondents is identified in each table.

False responses: It is likely a small number of students were dishonest, either by over-reporting or by denying certain health behaviours. Previous studies, including our pilot testing, suggest this issue is small and unlikely to alter the results significantly. Students who answered a question with an impossible response (for example they said they had all 10 serious illnesses listed) were excluded from that analysis.

Computer problems: A small number of data files (1.4%, 133/9699) were unusable because of computer problems. The final study database, therefore, comprised 9566 files for analysis.

Interpreting the Data

Youth2000 is the largest health and wellbeing survey of New Zealand's young people to date and includes taitamariki from across the country. The data are of considerable importance for planning and programme development in our communities and schools. It is important to keep in mind that the survey is a profile of 12 to 18 year olds who attend school; therefore, the results may not reflect the experiences of all taitamariki.

The results include rates of health risk behaviours, protective factors and health status and service utilisation. The data will be used in this report to describe associations between these factors. As the survey was administered at one specific/discrete time, the data cannot be used to determine cause and effect relationships.

This report describes the findings for Māori youth. It includes comparisons between taitamariki of different ages and genders. The results contained in this report are NOT directly comparable

with the information obtained in the initial **Youth2000** reports published in 2003 as those results were for all young people who participated in the survey, including Māori (Adolescent Health Research Group, 2003a; Adolescent Health Research Group, 2003b).

In this report some comparisons between taitamariki and NZ European students are included because they illustrate disparities between Māori and NZ European youth. This is important information that highlights areas where we might increase our focus on health and wellbeing issues for taitamariki. These comparisons are from analyses of the entire dataset comparing the ethnic groups prioritised according to the 1966 Census. They take into account of differences in student age, gender and socioeconomic characteristics. The comparisons are presented as an odds ratio (OR) with the associated 95% confidence interval (95%CI). Odds ratios are estimates of the risk (odds) of taitamariki responding to a question in a particular way compared to NZ European. An odds ratio of 1.0 would mean the risk was equal, so odds ratio of less than 1.0 means the risk is reduced and an odds ratio of more than 1.0 means the risk is increased.

As we only collected data from a sample of students in New Zealand, percentages and measures such as odds ratios are estimates of the value we would have obtained if we had collected information from every student in the country. The confidence interval indicates the precision of our estimates by providing an interval in which we are relatively sure the true value lies. If a confidence interval includes 1.0 (e.g. OR 1.05; 95%CI 0.95–1.15) there is no indication of a difference at this particular level of significance between taitamariki and NZ European students. If the confidence interval does not include 1.0 (e.g. OR 2.13; 95%CI 1.84, 2.48 or OR 0.60 95% CI 0.48, 0.75) then this indicates that there is a difference in risk at this particular level of significance between taitamariki and NZ European students.

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The study findings are also available in tabulated form in the appendix.

TE AO MĀORI

Sue Crengle

Taitamariki who identified as Māori were asked a number of questions about their level of knowledge and participation in Te Ao Māori. This chapter describes these findings.

Knowledge of Iwi

The majority of taitamariki (60.3%) knew their iwi. A further 15.9% were not sure with which iwi they were affiliated. About one quarter (23.8%) of taitamariki reported they did not know their iwi. Most taitamariki (84.6%) stated Māori values were important to them.

Participation in Māori Community/Social Settings

Over one-third (39.7%) of taitamariki reported many family activities were based within Māori tikanga, with a further 30.9% reporting some of their families' activities were tikanga based. Many (73.9%) taitamariki had attended a tangi or unveiling. Taitamariki who had attended a tangi or unveiling were asked how much of the kawa/protocol they understood. The majority (60.7%) reported they understood half or more of the kawa, with a further 32.3% responding they understood some of the kawa.

While over two-thirds (69.4%) of taitamariki reported they felt comfortable or very comfortable in Māori surroundings, 5.2% stated they felt uncomfortable or very uncomfortable in Māori social surroundings. Some taitamariki (18.4%) reported feeling uncomfortable in Pākehā social situations.

The majority of taitamariki (70.9%) were proud to be Māori and very few (2.4%) reported that they were not proud to be Māori. Similar proportions (71.8%) of taitamariki reported it was important to them to be recognised as Māori. The majority (87.5%) of taitamariki felt accepted by other Māori. Very few (2.3%) did not feel accepted and 10.1% responded they did not know. While most (70.9%) taitamariki were satisfied with their knowledge of things Māori, some (29.1%) reported being dissatisfied with their level of knowledge about things Māori.

Te Reo Māori

Some taitamariki (13.7%) stated they were able to understand most or all te reo and a further 24.9% had 'average' understanding. The remainder stated they were only able to understand a few greetings and phrases (55.7%) or had no understanding of te reo (5.8%).
A few taitamariki (8.4%) reported they were fluent or could easily have a conversation in Māori. A further 22.0% were able to speak an "average" amount of te reo. The remaining taitamariki were able to use a few words or phrases (59.3%) or not able to converse using te reo at all (10.3%). These findings are consistent with findings in the 2001 census, published by Te Puni Kōkiri (Te Puni Kōkiri, 2003). For the purpose of the Te Puni Kōkiri report, language rate was defined as 'the percentage of the group (being discussed) that were classified as being able to converse about a lot of everyday things in the Māori language'. The Te Puni Kōkiri report identified language rates of 24.1% for 10 to14 year olds and 24.7% for 15 to 19 year olds.

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ENVIRONMENTS

Whānau, Communities and Schools

Margaret Kempton

Introduction

This section considers some of the features of the environments in which taitamariki are growing up. It focuses on issues of safety, care and connection in the contexts of whānau, schools and communities. This examination of contexts is important because any attempts to influence other health outcomes need to happen with an understanding of these contexts.

WHĀNAU

Background

Home and family are significant to the development of taitamariki. The influences and experiences they have at home are major determining factors of healthy development. While the health and wellbeing of taitamariki is described here, the importance of whānau wellbeing to any individual also needs to be recognised. Similarly, whānau wellbeing is enhanced by the individual wellness of its members. A large percentage of Māori children are part of whānau that struggle to meet their daily financial needs. Socioeconomic deprivation may prevent whānau from being able to function effectively both in meeting cultural expectations and in more mainstream goals such as financial stability (Cram, 1999).

Māori children are far more likely than NZ European children or those from other ethnic groups to live with only one parent. Two in five Māori children (41.2%) lived in a sole-parent family in 1996, up from 28.2% 1986 (Statistics New Zealand, 1999).

In 2001, 13.5% of Māori households were considered crowded (Statistics New Zealand, 2003). Households that contained a one-parent family and others were disproportionately represented in crowded households with 35.5% of these types of households being crowded. Privacy and personal space can be compromised in overcrowded houses and this can affect the educational achievement of children, as well as their physical and mental health (Howden-Chapman & Tobias, 2000).

Whānau Findings

Overcrowding

Most taitamariki (92.4%) reported they did not live in overcrowded houses, when a criterion of overcrowding was living in a place with 2 or more people per bedroom. However, more than 1 in 10 taitamariki (females 15.7%, males 10.5%) reported they did not have enough space to do their homework.

Socioeconomic environments of taitamariki

The taitamariki who participated in the study were much more likely to be from low decile (1 to 3) schools than NZ European students (Table 1). 27.4% of taitamariki attended decile 1 to 3 schools, compared with only 6.2% of NZ European students. In contrast, 24.2% of taitamariki attended decile 8 to 10 schools compared with 45.5% of NZ European students.

Youth2000 collected other indicators of socioeconomic status. Most taitamariki reported that in their household, they had a car that was working (93.9%), a telephone that was connected (91.1%) and at least one parent was in paid employment (90.6%).

Who do taitamariki live with?

Taitamariki came from a range of families with differing circumstances. Most taitamariki (over 98%) lived with members of their whānau (parents, grandparents, aunts, uncles, siblings, cousins). While most taitamariki (69%) lived in whānau with two parents (a biological parent or someone who acted as a parent) 31% lived in a single parent whānau.

Whānau Relationships

The majority of taitamariki felt that their parents care about them a lot (female 88.7%, males 90.8%). While some felt there were difficulties in their relationship with their parents, the majority were happy with their relationships with other whānau members (females 46.7%, males 60.3%). Most taitamariki (66.5%) said that they felt close to their parents all or most of the time.

Over half the taitamariki (female 52.5%, males 56.9%) felt they spent enough time with their parents. However, significantly fewer taitamariki (54.7%) felt they always got enough time with their parents when compared with NZ European students (65.2%), OR 0.68 (95% CI 0.60, 0.76). This may be related to taitamariki being more likely to be living with one parent and to the employment patterns of parents.

Parental Expectations and Aspirations

Youth2000 asked a number of questions about parental expectations and aspirations. Assumptions have been made that low achievement amongst taitamariki is related to the low aspirations and expectations of families and taitamariki. However, findings from the current study are similar to other research findings (Wylie et al., 2003; Bishop et al., 2003) that show that families of Māori students do hold high expectations for their educational achievement and work to support this.

In the current study few taitamariki reported their parents had little or no expectations of them (females 6.9%, males 8.1%). Most taitamariki (73.6%) always or usually received praise from their parents when they had done well. Few taitamariki (7.6%) hardly ever or never were praised when they had done well.

The majority of taitamariki (females 71.9%, males 73.0%) reported that it was very important to their parents that they attend school every day and nearly all taitamariki (females 92.1%, males 94.6%) talked to their families about how things are going at school at least some of the time.

SCHOOLS

Background

School influences and experiences are major determining factors of healthy development. While schools can be places where young people expand both their knowledge and their sense of self, for minority youth such as taitamariki, the mainstream setting of school can be distant from or oppressive to their ways of knowing and interacting (Dauite & Fine, 2003). Māori retention in secondary school is a well-recognised problem and many disaffected young Māori leave school by Year 11 at 16 years of age or younger (Ministry of Education, 2000). Retention rates for Māori at senior school level are significantly lower than non- Māori.

Disparities in Educational Achievement

Persisting disparities in educational attainment for Māori are well documented. The National Education Monitoring Project (NEMP) indicates Māori students performed less well than non-Māori students in most curriculum areas, with the exception of physical education; and with exceptions in physical education and art, taitamariki in low decile schools performed poorly (Flockton & Crooks, 1999). In 1999 only 18% of Māori school leavers received a seventh form qualification, which means taitamariki have limited options when entering tertiary education or the workforce. In contrast, compare with the non-Māori population: 44% of school leavers have a seventh form qualification and only 13% leave with no qualifications (Ministry of Education, 2000). Taitamariki are much more likely to be from low decile (1-3) schools. In Decile 1-3 schools in 1997, the percentage of those leaving with a 7th form qualification was 26%, while in Decile 8-10, that percentage was 59%. 28% of students in Decile 1-3 schools had no leaving qualifications, compared with 7% in Decile 8-10 schools (Ministry of Education, 1998). By definition, low decile schools serve children in communities and families with more limited financial resources, the majority being Māori and Pacific. Their achievement patterns mirror those found internationally of children from cultural and linguistic minority groups who live in school communities with limited access to the resources of mainstream communities. Children who live in these communities and attend these schools often achieve below the standards of other children (Phillips, McNaughton & MacDonald, 2001).

School Findings

Student Expectations and Aspirations

Most taitamariki (females 86.2%, males 84.1%) reported that it was important or very important for them to be at school every day. Taitamariki (91.3%) were less likely to report they would stay in school to at least year 12 compared with NZ European students (95.8%). After controlling for differences in age, gender and socioeconomic factors the difference remains significant (OR 0.60 95% CI 0.48, 0.75).

How do taitamariki feel about school?

Fewer taitamariki (31.4%) reported teachers were fair most of the time, compared to NZ European students (48.1%). Taitamariki were twice as likely as NZ European students to say teachers were hardly ever fair (OR 2.32, 95% CI 1.96, 2.75).

Teacher Expectations

Taitamariki (86.8%) were less likely to report that their teachers expected them to do well compared with NZ European students (89.3%). After controlling for differences in age, gender and socioeconomic factors, the difference remains significant (OR 0.76, 95% CI 0.63, 0.92). The finding that taitamariki were less likely to report they thought their teachers expected them to do well, coupled with findings about fairness, has potential significant negative educational implications.

Positive connections

Positive health and educational outcomes may result from positive relationships with adults and peers. While some responses from taitamariki about teacher expectations and fairness indicate problems, there is evidence of some positive connections with school. The majority of taitamariki said there was an adult at school they felt cared about them (females 87.2%, males 88.8%). However, less that half the students (females 48.1%, males 42.2%) said they usually got along well with their teachers. While it is not clear who exactly was providing this support, research suggested Māori teachers might help Māori educational achievement by acting as effective role models for Māori students. Māori teachers are in short supply, however, reducing the likelihood that Māori students will find effective role models. There were 14 961 teachers in secondary schools in 1998. Of these, only 946 were Māori (Te Puni Kākiri, 2003).

COMMUNITY

The majority of taitamariki (61.1%) reported they have an adult outside their family with whom they would feel happy talking if they were having a serious problem. The majority of taitamariki (82.6%) also reported they had a friend to whom they would feel happy talking if they had serious problem. The majority of taitamariki (84.1%) felt safe most of the time in their neighbourhood. For these results there were no differences between taitamariki and NZ European students.

Summary and Recommendations:

- Most relationships between whānau and taitamariki are caring and positive. A healthy whānau is essential for promoting security and identity in taitamariki, but without support for itself, whānau potential to nurture others is diminished. Many taitamariki want more time with their whānau. If this can be achieved it should show positive benefits in the lives of taitamariki.

- Despite deprivation, communities have some capacity to support young people. A narrow focus on disparities can mask the resources and opportunities available to young people (e.g. caring parents with educational aspirations, support of extended whānau). Support for families while children are young, related to easing the costs of housing, transport, nutrition, healthcare and early childhood education, may be one of the most effective ways to help children from low income homes (Wylie, 2003).

- Young people spend considerable time in educational settings. These are major settings in which young people develop relationships with peers and adults. It is recommended that schools be seen as "health promoting settings" (WHO, 1996). This means safe, supportive environments for all students including taitamariki.

- Some whānau do struggle economically and school practices can either additionally disadvantage taitamariki or mediate the effects of deprivation. In a recent analysis of what makes the difference for children from low income homes, Wylie (2003) argues for policy centred on enriching teaching practice and teacher development. Recent research with a strong professional development component has shown it is possible to bring the achievement levels of taitamariki in low decile schools up to the levels of their peers (Phillips, McNaughton & MacDonald, 2001). To achieve this,teachers need to have high expectations of taitamariki and taitamariki need to be aware of these expectations. It is not predetermined that poor educational outcomes will result for taitamariki from low decile schools.

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GENERAL HEALTH

Sue Crengle

GENERAL HEALTH AND HEALTH SERVICE USE

Background

As a population group, Māori at all stages of life have worse health status then their NZ European peers (Pōmare et al., 1995; Ajwani et al., 2003). Higher percentages of Māori are affected by a wide range of medical conditions (Pōmare et al., 1995). Lower socioeconomic status is associated with poorer health outcomes (Howden-Chapman & Tobias, 2000). Differences in socioeconomic status between the Māori and non-Māori populations account for some, but not all, differences in health status as analyses of health outcomes (such as life expectancy and mortality rates) that stratify by deprivation show Māori have worse outcomes compared with non- Māori peers in the same deprivation stratum (Reid et al., 2000).

Youth Health: A Guide to Action discusses the importance of Mason Durie's 5 principles associated with successful health outcomes. These include: choosing mainstream or kaupapa Māori options, ensuring services are relevant and culturally meaningful, ensuring that services are collaborative with other sectors and services, provide high quality care and are cost effective (Ministry of Health, 2002). However, there is little published information that focuses specifically on the health status and health service needs of taitamariki.

The NZ Health Survey (Ministry of Health, 1999) found Māori adults (defined as 15 years and over) rated their health lower than NZ European. The report Disability in New Zealand: An overview of the 1996/97 Surveys reports Māori disability rates of 197/1000 (about 2%) in the 5 to 14 year age group compared with a non-Māori rate of 118 per 1000 (Ministry of Health, 1998).

General Health Findings

In the **Youth2000** survey, the majority of taitamariki reported high levels of general health. Most (88.1%) female taitamariki described their health as good, very good or excellent and a similar number (85.3%) felt their health was the same or better than their peers. Similarly high numbers of male taitamariki (93.6%) described their health as good, very good or excellent and most (91.9%) reported they were of similar or better health than their peers.

In total, fewer taitamariki (90.6%) than NZ Europeans (93.4%) students reported they have good, very good or excellent health. This finding reflects the poorer health status experienced by Māori and is consistent with self-rated health findings from the 1996/97 NZ Health Survey (Ministry of Health, 1999). After adjusting for age, gender and socioeconomic factors, this finding remains significant (OR 0.74 95% CI 0.61, 0.90). This may be due to the survey's limited information on socioeconomic status resulting in socioeconomic status not being able to be accurately determined. However, other research has shown that within each deprivation decile Māori have worse health outcomes than NZ European, suggesting factors other than socioeconomic status play a role in

the disparity (Reid et al., 2000). These factors might include differential access to services, goods and resources in society or differences in access to health services.
Taitamariki were asked if they had a long-term health condition. More males (64.0%) than females (57.0%) reported they had a long-term health condition. Asthma (24.9%) was the commonest condition, followed by migraines (10.3%). A small number (2.1%) of taitamariki reported having a physical disability and 1.1% reported having diabetes.

Taitamariki who had a long-term health condition were asked if this caused them difficulties with everyday activities. While just on a half (50.7%) of male taitamariki reported their health condition hardly ever caused them problems many (41.9%) reported their health condition sometimes caused them problems and 7.4% reported it often caused them problems. Many (40.1%) female taitamariki reported their health condition hardly ever caused them problems. More female taitamariki reported their health condition sometimes (47.9%) or often (12.0%) caused them problems with every day activities.

After adjustment for age, gender and socioeconomic factors available in the study, more NZ Europeans (34.6%) (OR 1.19; 95%CI 1.06–1.35). This is likely to reflect a number of factors including incomplete adjustment for socioeconomic status, the impact of other factors that adversely affect health and are more common in the Māori community, reduced access to care and poorer management of long-term health issues.

The proportion of taitamariki in this survey reporting a disability (2.1%) is consistent with the finding of the earlier disability survey (Ministry of Health, 1998).

Health Service Use

In 1991, Māori in the 5 to 14 year and 15 to 24 year age groups in the Waikato had lower rates of contacting general practitioners than their non- Māori peers (Davis et al., 1997). The 1996/97 NZ health survey found that a similar percentage of Māori and NZ European adults had visited the general practitioner at least once in the year before the survey. The survey also found that Māori were more likely to report 'unmet need', i.e. the belief that was necessary to see a general practitioner but not doing so (Ministry of Health, 1999).

Access to Healthcare Findings

The majority of taitamariki (79.3%) reported they usually went to their family doctor for healthcare (Table 4). Taitamariki were no more or less likely than NZ European youth to report they did not go anywhere for healthcare (OR 1.3; 95% CI 0.99, 1.60).

Taitamariki were asked about barriers to accessing healthcare. Many taitamariki (females 44.9%, males 48.9%) reported they had no problems getting healthcare. However, taitamariki (48.1%) were more likely to report difficulties accessing healthcare than their NZ European peers (45.7%) (OR 1.38; 95%CI 1.21–1.58).

Table 4.
Reported sources of healthcare in 12 months prior to survey

	Taitamariki who usually get healthcare from this source (%)
Family doctor	79.3
School clinic	3.3
Hospital clinic	5.0
A&E or after hours clinic	2.4
Traditional healer, tohunga	0.6
Alternative therapist	0.5
Other	2.6
I don't go anywhere for healthcare	6.3

Those taitamariki who reported they had not accessed care when they thought they needed it had a range of reasons for not accessing healthcare (Table 5).

Table 5.
Reason for not accessing care when taitamariki thought they needed to access care

Reason	Females (%)	Males (%)
Don't know how to	9.1	11.8
Can't get in touch with the health professional	4.1	7.0
Can't get an appointment	7.6	6.0
Don't want to make a fuss	31.4	26.2
Couldn't be bothered	25.3	27.0
No transport to get there	9.5	6.3
Costs too much	18.4	15.3
Uncomfortable with the person	21.9	10.1
Too scared	20.1	9.2
Concerned it wouldn't be kept private	20.3	9.0
Other reason	4.6	6.6
No problem getting healthcare	44.9	48.9

Concerns about privacy, fear and discomfort with the person they would be seeing were important common reasons – particularly for young female taitamariki. Financial and structural barriers such as cost, not knowing how to or not being able to arrange an appointment and lack of transport were also reasonably common.

Recommendations

- Government policies to reduce socioeconomic disparities should continue.

  Health services with youth clientele should review their services, focusing particularly on reducing structural barriers (cost, appointment availability, transport). Health services should also ensure they provide appropriate and effective services for taitamariki. Further research with taitamariki on defining barriers to accessing care may help service providers address these barriers.
- The education and health sectors should ensure that taitamariki are provided with education and information on how to access services, their rights as consumers and how to access assistance if they feel their rights have been breached.
- Health services should ensure youth specific training for their providers and develop best practice in the provision of youth health services.
- Health services should provide very clear information about privacy and confidentiality for taitamariki.
- Service providers and taitamariki should work together to ensure that long-term health problems are effectively managed and the effect of these conditions on daily life is minimized.

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ACTIVITIES AND EXERCISE

Background

According to the Youth Health Status Report (Ministry of Health, 2002), 72% of youth in the 13 to 15 age group undertake 2½ hours of active leisure or sport per week. Higher percentages of males are active than females. Taitamariki were reported to be as active as NZ European youth. The Report further noted that increases in sedentary activities such as watching television, playing video and computer games is associated with increased risk of problems with weight and physical activity appears to have declined. In New Zealand, socioeconomic status has not been associated with levels of physical inactivity but education levels have been associated with physical inactivity (Ministry of Health, 2002).

Activities and Exercise Findings

Most taitamariki in **Youth2000** reported participating in regular exercise. Males (71.6%) were more likely than females (57.1%) to report having done 20 minutes of moderate or vigorous exercise 3 or more times in the previous week. There were no significant differences between taitamariki and NZ European students exercising for 20 minutes three or more times per week (OR 1.05; 95% CI 0.95–1.15).

Taitamariki were asked why they exercised. Having fun (87.3%), hanging out with friends (65.7%) and keeping fit (75.2%) were the three commonest reasons. (They were able to choose as many reasons as they thought applied to them so the total percentages add up to more than 100 percent).

Most taitamariki exercised in a team (40.1%) or with other people (37.2%), smaller numbers exercised on their own (22.7%).

Many taitamariki were involved in artistic activities, with about three-quarters (72.4%) of female students and half (53.9%) of male students spending some time every day involved with dance, music, crafts and other artistic pursuits.
Taitamariki were asked about their reading habits and 59.0% of female students and 47.0% of male students reported they spent some time reading for pleasure every day.

About two thirds of taitamariki (69.1% of male students and 65.6% of female students) used a computer or the Internet every day. Taitamariki were also asked how much time they spent playing computer games, Nintendo or Playstation each day. Male taitamariki (77.7%) were more likely to report they played computer games than female taitamariki (46.9%). About one-quarter of males (27.5%) and less than 10% (8.1%) of females played computer games for 1 hour or more per day. When asked about the amount of time spent watching television, 40.1% of taitamariki either did not watch TV or spent less than 1 hour per day watching TV. Slightly more male taitamariki (16.7%) spent more than 4 hours a day watching TV, compared with 14.3% of female taitamariki.

Recommendations

- Effective programmes that encourage taitamariki to exercise regularly and to maintain this exercise pattern as they become older need to continue to be enhanced and developed.
- Increased focus on encouraging female taitamariki to participate in physical activity could raise their participation in these activities.
- Reasons for exercise, such as having fun and being with friends, as well as preferring team or group participation in exercise activities should be incorporated into projects and programmes to engage taitamariki in on-going physical activity.

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NUTRITION AND WEIGHT

Background

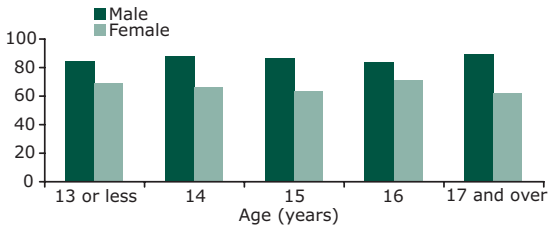
The Youth Health Status Report (Ministry of Health, 2002), notes that the prevalence of overweight and obesity in young people is increasing. The risk of obesity is associated with socioeconomic status – people from lower socioeconomic group have higher obesity rates. Information on the national prevalence of overweight and obesity in young people this age is limited to the National Nutrition Survey (Russell et al., 1999), which includes information for the 15 to 18 year age group. However, these data have limitations because adult definitions of overweight and obesity using Body Mass Index have been applied.

Taitamariki appear to have adopted a 'westernised' view of body image. Peer pressure and the increasing exposure to the ideals of a western culture throughout the media are major contributing factors (Moewaka & Borell, 2002). Females in particular are conscious of what they eat and how it is going to impact on their bodies. Many females will eat more or less of some foods in an effort "to be slim and not get fat" (Fuamatu et al., 1996). The perceptions of body size of some female taitamariki contribute to dissatisfaction with their own eating habits, irregular food consumption patterns and low self-esteem (Moewaka Barnes, 1997).

Nutrition and Weight Findings

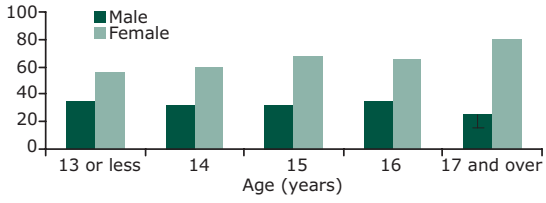
While most taitamariki eat breakfast, 31.6% of female taitamariki report never having breakfast. Most taitamariki are happy with their weight. However, while over 80% of male taitamariki reported they were happy with their weight in all age categories, about two-thirds of female taitamariki reported they were very happy, happy or OK with their weight. There are no significant differences across the age groups and there were no statistically significant differences in the proportions of taitamariki and NZ European students who reported they were happy with their weight.

Percentage of taitamariki who are happy with their weight



Although most taitamariki reported they were happy with their weight, many had tried to lose weight in the previous 12 months. The percentage of males who had tried to lose weight was similar across the age groups. The percentage of females who had tried to lose weight increased with age.

Percentage of taitamariki who have tried to lose weight in last 12 months by age



The higher proportion of females who reported being unhappy with their weight and attempting to lose weight compared with males is consistent with previously known data about female and male perceptions of body image, weight and weight control behaviour.

Recommendations

- Whānau and community-based approaches to healthy eating should be implemented.
- Specific female taitamariki health eating programmes should be developed.
- Schools should develop and implement health eating policies.

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CIGARETTES, ALCOHOL AND OTHER SUBSTANCES

Sue Crengle

This section describes the survey findings about alcohol, tobacco, marijuana and other drugs. The section is divided into four parts: cigarettes; alcohol; marijuana; and other drugs. Each part begins with a summary of current knowledge about use of these substances. This is followed by the specific findings from **Youth2000** relevant to taitamariki and recommendations for action.

Risk taking and experimental behaviour are a normal part of youth development. Not all substance use is necessarily a problem particularly from a young person's perspective. In addition, when considering risk-taking behaviour, we must be aware that other factors including social environments and the socioeconomic status of a young person and their whānau are additional important contributors to the behaviour and to the risk of being harmed as a result of behaviour.

CIGARETTE USE

Background

The Māori community did not use tobacco until it was introduced by the Pākehā in the late 19th century (Reid & Pouwhare, 1991). The penetration of tobacco into the Māori community was rapid. Unlike Pākehā women, wāhine Māori took up using tobacco products in a similar way to men and continue to have a high tobacco use (Reid & Pouwhare, 1991). Evidence documenting the harmful effects of tobacco emerged throughout the 1950s and 1960s. Health education and promotion about the harmful effects of tobacco resulted in reductions in smoking by Pākehā men and women. Reductions in Māori tobacco use have been much slower. Two factors are important here. First, health promotion messages were not effective for the Māori community and consequently failed to provoke changes in tobacco behaviour. Tobacco-related smoking cessation and prevention campaigns that target Māori have only been introduced since the late 1990s. Second, socioeconomic status or deprivation is strongly linked with smoking and smoking cessation behaviour (Jarvis & Wardle, 1999). The effects of low socioeconomic status on smoking prevalence rates, quit rates and the maintenance of non-smoking status in people who have quit, disproportionately affect Māori because they are over represented in low socioeconomic groups. Finally, the greatest risk factor for a young person taking up tobacco products is exposure to tobacco products in their environments, particularly having parents and friends who smoke (Ministry of Health, 2002a). Higher prevalence of smoking by Māori adults and exposure to smoking in family and social environments increases the likelihood that taitamariki will smoke.

The Tobacco Facts 2002 Report (Ministry of Health, 2002b) stated that 24% of Māori males and 42% of Māori females aged 14 to 15 years are at least weekly smokers. Māori start smoking at an earlier age than non-Māori, with around 30% starting before the age of 15 (compared with about 17% of NZ European) (Ministry of Health, 1999).

A number of Cochrane reviews* have examined specific components of prevention of tobacco uptake and smoking cessation in young people. A recent Cochrane review (Thomas, 2003) of school-based programmes to prevent starting smoking concluded:

* *Cochrane reviews examine a particular topic and provide high quality reviews of available scientific evidence on the topic. The findings are then summarised and published.*

1. there was a lack of rigorous studies about providing information,
2. studies that tested the impact of 'social influences interventions' were inconclusive (half the studies showed no effect and half showed some effect) and
3. there was a lack of high-quality evidence about effectiveness in several types of interventions including combinations of 'social influences and social competence intervention's and 'multi-modal programmes' that include community interventions.

Another Cochrane review (Sowden & Arblaster, 2003a) concluded there is some, but not strong, evidence that use of mass media can be effective in preventing the uptake of smoking in young people.

Stead and Lancaster (2003) reviewed the effects of interventions to reduce underage access to tobacco by deterring shopkeepers from making illegal sales. They concluded that, while interventions with retailers can result in reductions in the number of outlets selling tobacco to underage people, this effect is often not sustained over the longer term.

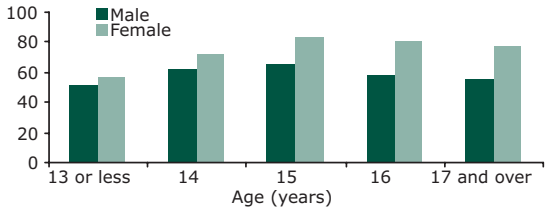
Evidence for the effectiveness of community interventions that use coordinated, widespread, multi-component programmes to prevent the uptake of smoking in young people is small but positive (Sowden & Arblaster, 2003b). Early trials of smoking cessation programmes for young people have been largely unsuccessful (Panday, 2003).

Cigarette Use Findings

Initiation of cigarette use

In this survey two thirds (66.6%) of taitamariki stated they had smoked at least one cigarette. The percentage that has tried smoking increases from 13 to 14 years and then levels out. Females are more likely at all ages to have tried smoking.

Percentage of taitamariki who have ever smoked a cigarette

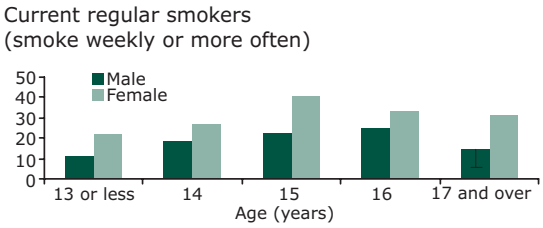


Taitamariki were asked where they got their first (whole) cigarette. Friends (58.5%) were the commonest source. Some taitamariki (15.2%) reported they stole their first cigarette. A few (8.3%) taitamariki reported a brother or sister gave them their first cigarette. A small number (4.0%) stated they had bought their first cigarette. Very few taitamariki were provided with their first cigarette by a parent (1.8%) or another adult (2.7%). Taitamariki who smoked were asked how much they currently smoked and what age they were when they started smoking this much (Table 6). The patterns of initiation of cigarette smoking are similar for each level of current smoking.

Table 6.
Age at beginning smoking by current smoking status

Age at starting smoking this much	Occasional smokers % (95% CI)	Smoke 1-2 times per month % (95% CI)	Smokes weekly or more % (95% CI)
12 years or less	**22.3** (17.3, 27.4)	**30.2** (17.0, 43.4)	**29.0** (25.5, 32.5)
13–15 years	**68.2** (62.6, 73.7)	**66.3** (52.5, 80.2)	61.6 (57.6, 65.6)
16 years or more	**9.5** (6.2, 12.8)	**3.5** (0, 8.3)	**9.4** (6.7, 11.9)

Regular cigarette use

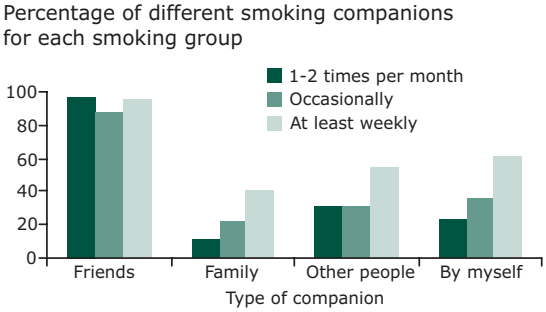


A total of 30.1% of female taitamariki and 18.4% of male taitamariki were regular (at least weekly) cigarette smokers. However, most taitamariki do not smoke cigarettes regularly (smoke cigarettes at least once a week). Female taitamariki (30.1%) are more likely than male taitamariki (18.4%) to smoke cigarettes regularly. A few taitamariki (16.6%) smoke cigarettes on a daily basis. Our findings show slightly less taitamariki smoke than reported in Tobacco Facts 2002 (Ministry of Health, 2002b). However in our study the confidence intervals are wide and the findings cannot be regarded as significantly different from those reported in Tobacco Facts.

Disparities in cigarette smoking between Taitamariki and NZ European students

After adjusting for age, gender and socioeconomic factors this study found that taitamariki are more likely to have smoked at least one cigarette compared with their NZ European peers (OR 1.92; 95%CI 1.69, 2.19). They are also more likely to be a regular (at least weekly) smoker (OR 2.13; 95%CI 1.84, 2.48). Factors that may contribute to these findings include: incomplete adjustment for socioeconomic status in the calculation of odds ratios; higher levels of social and environmental exposure to smoking; and limited access to appropriate, acceptable and effective smoking cessation and prevention programmes.

Who do taitamariki smoke with?



Current smokers were also asked with whom they smoked. Percentages do not add up to 100% as taitamariki were able to choose as many options as applied to them. Taitamariki most commonly smoke cigarettes with friends (93.1%), other people (not family or friends) (46.4%) or by themselves (50.9%). About one-third (32.6%) of taitamariki smoked cigarettes with family members. However, taitamariki who currently smoked different amounts differ in the patterns of their smoking companions. At all levels of current smoking the commonest smoking companions are friends. However, as smoking increased more taitamariki smoked with family, other people and by themselves.

How do taitamariki acquire cigarettes?

Overall friends are the commonest source of cigarettes (73.2%) for taitamariki smokers. Many taitamariki smokers (44%) reported they bought cigarettes themselves and similar numbers (41.6%) had someone else buy them on their behalf. A few taitamariki bought cigarettes from vending machines (8.0%). About a quarter of taitamariki acquired cigarettes from whānau. In total 27.8% of taitamariki reported getting cigarettes from siblings and 23.1% reported getting cigarettes from parents. Around 1 in 5 (21.1%) taitamariki reported stealing cigarettes.

Higher percentages of taitamariki who smoked occasionally (29.3%) or weekly (54.3%) bought cigarettes compared with those that smoked 1–2 times per month (18.5%); while more taitamariki

who smoked 1–2 times per month (90.3%) acquired cigarettes from friends than those who smoked occasionally (71.9%) or weekly (72.1%). As smoking levels increased, higher proportions of taitamariki acquired cigarettes from other sources including siblings, parents and other adults.

Do taitamariki worry about smoking cigarettes?

Regardless of how frequently they smoked, most taitamariki were worried to some extent about smoking. Of all taitamariki smokers, 32.3% worried a little, 22.4% had 'some' worry and 14.2% worried a lot about their smoking. About one-third of taitamariki smokers (31.0%) were not worried.

Most taitamariki (69.1%) who were current smokers had tried to stop or cut down their use of cigarettes.

Recommendations

- Programmes and projects to reduce socioeconomic disparities should continue
- Review government policy and programmes to reduce smoking-related disparities to ensure initiation prevention and smoking cessation programmes are appropriate, acceptable and effective for Taitamariki. Consider increasing Māori specific "why start" and cessation programmes as a part of a strategy to reduce smoking-related disparities.
- Police and regularly enforce legislation banning the sale of tobacco products to young people. This should be ongoing.
- Smoke-free spaces at all community venues – especially those where young people congregate such as marae, sports clubs, kapa haka groups, etc. – should be extended and further development of these spaces should be encouraged.
- Māori should be the major focus of all tobacco programmes and all such programmes should be appropriate and acceptable for use with taitamariki, their whānau and their community.
- Whānau, peer and community-based approaches, programmes and/or social marketing campaigns for smoking cessation and preventing initiation of tobacco products should be considered and implemented. These programmes should be rigorously evaluated as they are developed and implemented.
- As many taitamariki are influenced by adult smoking including acquiring cigarettes from adults' resources for adult smoking cessation programmes should be increased. Emphasis on maintaining quit status should be encouraged.
- Health providers should acquire knowledge and skills to enquire of taitamariki about their smoking status, worries about smoking, future intentions and then supported to reduce and quit cigarette smoking.
- Schools should view smoking as a health issue and not as an indicator of 'bad' behaviour with subsequent negative impacts for the individual.

ALCOHOL USE

Background

Alcohol is a pervasive social drug in New Zealand. The Ministry of Health (2002a) reported that around 79% of youth aged 14 to 17 drink alcohol, about 31% drinking every week and 44% drank 'heavily' (drinking five or more drinks on one occasion).

Information on trends in drinking patterns is available for the Auckland region (Casswell & Bhatta, 2001) and for New Zealand (Habgood et al., 2001). These studies found that amongst young people (aged 14–19) the quantity of alcohol consumed (by both males and females) on a typical drinking occasion increased primarily because of increases in the amount consumed by 14 to 17 year olds (Casswell & Bhatta, 2001; Habgood et al., 2001). In the 14 to 19 year old group the proportion drinking large quantities* increased, as did the proportion drinking enough to feel drunk (Casswell & Bhatta, 2001).

Alcohol use is associated with increased risk of alcohol related harm including vomiting, memory loss, falls, shame/embarrassment, violence and other effects. Risk of these adverse outcomes increases with increasing levels of consumption (Ministry of Health, 2002a).
Te Ao Waipiro (Whariki Research Group & Te Whānau o Waipareira Trust, 1997) documented alcohol-related experience of Māori aged 14 to 65 in 1995. Over 80% of males and females aged 14 to 29 had consumed alcohol in the previous 12 months. Males consumed higher qualities of alcohol and drank more frequently than females. About 52% of men and 31% of women had drunk a large quantity[3] on at least one occasion in the previous month. A smaller proportion of the Māori population drank than the general population. Māori also drank less frequently than the general population; however, Māori consumed more alcohol on each drinking occasion than the general population. More recent currently unpublished data on alcohol use and chronic disease risk, (Bramley et al., 2003) has similar findings: that Māori adults drink similar annual amounts to NZ European adults. However this amount is drunk over fewer drinking occasions, suggesting 'binge' drinking is a commoner drinking pattern for Māori. The Youth Health Status Report (Ministry of Health, 2002a) states that 43% of Māori aged 14-18 years reported they drank at least weekly. The Report also states that more Māori (44%) reported binge (> 5 drinks in a session) drinking in the two weeks before the survey than non- Māori (32%).
According to the Ministry of Health most young people (aged 14 to 17) acquire alcohol from their parents (62%) or friends (54%), with 7% stating they buy it themselves (Ministry of Health, 2002a). A 2002 study by the Alcohol and Public Health Research Unit found 61% of sales to 18-year-old 'pseudo-patrons' were made without identification (Woolgrove et al., 2002).
A number of factors are associated with higher risk of 'drinking heavily at 14 years', including having 'disadvantaged homes', being introduced to alcohol before the age of 5 years and having parents who drink heavily (Ministry of Health, 2002a).

Overseas literature suggests an association between alcohol availability (for example the number of outlets in defined geographical areas) and alcohol-related problems (Watts & Rabow, 1983; Alaniz, 2000; Gorman et al., 2001). Literature also shows alcohol availability can be disproportionately

** > 5 drinks for male students and > 3 drinks for female students*

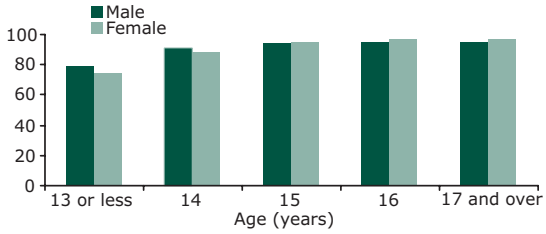
concentrated in communities with high concentrations of ethnic minorities (Alaniz, 1998) and alcohol advertising can be specifically targeted at ethnic groups (Alaniz & Wilkes, 1998). Little information on these issues is available for New Zealand.

Alcohol Findings

Use of alcohol at any time in the past

Overall, 89.5% of taitamariki had ever drunk alcohol (more than a few sips). The percentage of taitamariki that had ever tried alcohol at some time increased between 13 and 16 years. After adjusting for age, gender and socioeconomic factors more taitamariki (89.5%) than NZ European (84.9%) (OR 1.89; 95%CI 1.56, 2.28) have ever drunk alcohol.

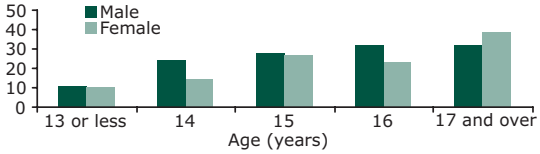
Percentage of students who have drunk alcohol



Current use of alcohol

There were no differences between the percentages of male and female taitamariki who drink alcohol regularly. This graph shows the percentage of male and female taitamariki who regularly use alcohol by age group.

Percentage of taitamariki who drink alcohol regularly(weekly or more often)



Those taitamariki who reported they had tried alcohol at some time before the survey were asked how frequently they drank in the 4 weeks before the survey. Most taitamariki (78.4%) reported they did not drink alcohol regularly (weekly or more often). The percentage of taitamariki who reported drinking alcohol regularly increased as taitamariki got older, particularly up to 15 years. After 15 years of age the graph suggests there is a small increase in the percentage of taitamariki drinking regularly. However, the actual number of taitamariki is relatively low and the 95% confidence intervals overlap. This means that apparent differences between these age groups are not significant.

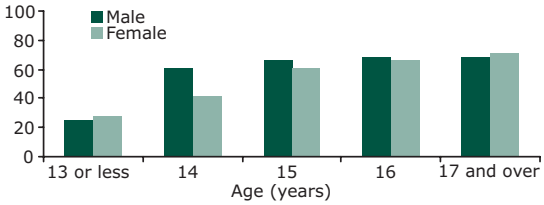
A higher percentage of taitamariki (21.6%) than NZ European students (17.5%) drank at least once per week. This difference remained significant after adjusting for age, gender and socioeconomic factors (OR 1.50 95%CI 1.28–1.76). It is difficult to interpret the significance of a difference between taitamariki and NZ European students when the behaviour being investigated (drinking at least once per week) is extremely common amongst both population groups. Furthermore some of this apparent difference may be due to incomplete adjustment for differences in socioeconomic status between taitamariki and NZ European students.

Consumption of large amounts of alcohol on a single occasion ('binge drinking')

Taitamariki were asked how many times they had drunk five or more alcoholic drinks within a 4-hour period over the preceding month, defined for the purpose of this report as binge drinking. Overall, about half (50.9%) of taitamariki reported at least one episode of binge drinking in the 4 weeks before the survey. As with ever drinking alcohol fewer younger taitamariki reported recent binge drinking. For youth aged 15 years and over about two thirds binge drank on at least one occasion in the 4 weeks before the survey.

After adjusting for age, gender and socioeconomic factors more taitamariki (50.9%) than NZ European (41.1%) students report binge drinking (1.82, 95%CI 1.61, 2.05). This is consistent with findings documented in Te Ao Waipiro (Whariki Research Group & Te Whānau o Waipareira Trust, 1997) and in the Youth Health Status Report (Ministry of Health, 2002a). Some of the disparity between Māori and NZ European may be due to incomplete adjustment for socioeconomic factors. Binge drinking, a common pattern among Māori adults, is a harmful pattern of drinking and associated with increased harmful physical and mental effects and one which may influence the drinking patterns of taitamariki. Efforts to reduce the frequency of binge drinking are required. Whānau and community-based approaches will be important.

Percentage of taitamariki that report at least 1 episode of binge drinking in the last 4 weeks



Sources of alcohol

Taitamariki who reported they drank alcohol were asked how they obtained it. Percentages add up to more than 100% as taitamariki were able to choose more than one source for alcohol. Over sixty percent (63.5%) of taitamariki reported they got alcohol from their friends. Nearly half reported they were provided with alcohol by their parents (49.6%) and about one-quarter reported they acquired alcohol from siblings (26.5%). One-third (33.5%) stated another (non-parental) adult provided them with alcohol. Buying alcohol themselves was reported by 16.0%. This is of concern as the legal age for buying alcohol is 18 years of age and nearly all taitamariki participants in the survey were aged 17 years or less.

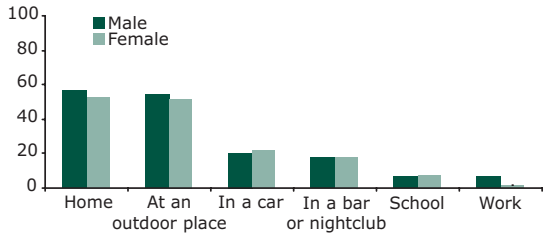
Taitamariki who reported they bought alcohol themselves were asked from where they bought it. The commonest places for purchasing alcohol were bottle stores (53.4%), supermarkets (8.3%) and pubs (6.3%).

Those taitamariki who bought alcohol themselves were also asked how often they were asked for identification. Over half (59.5%) taitamariki reported they were never or hardly ever asked for identification.

Taitamariki were asked where they drank and with whom they drank. Taitamariki most commonly drank with friends (females 94.4%, males 89.6%). Drinking with whānau (females 50.4%, males 54.9%) and other people (females 43.2%, males 40.8%) were also common. This provides us with useful opportunities to implement whānau and community-based approaches to alcohol harm minimisation. Few taitamariki drank by themselves (females 9.8%, males 11.1%). Females were significantly more likely to drink with friends than were the males. Otherwise, there were no significant differences between male and female taitamariki.

Parties, at home and at outdoor places were the most common places taitamariki stated they drink alcohol. Of particular concern is the high percentage of taitamariki who drink at outdoor places. This places them at higher risk of adverse outcomes such as injury on the way to or from outdoor venues. Male taitamariki were significantly more likely to drink at work than the female taitamariki. Otherwise, there were no significant differences between male and female taitamariki.

Sites of drinking by gender - (%)



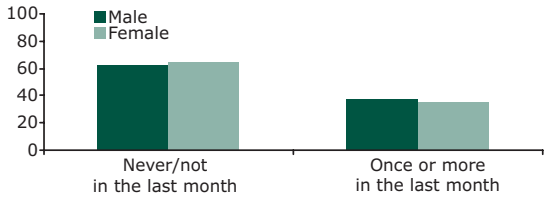
Concern about drinking

Many taitamariki (40.8%) reported they worried (a lot, some or a little) about their drinking. A few taitamariki (4.5%) reported they worried a lot and more (17.0%) reported they had 'some' worry about their drinking. About one in six taitamariki (17.2%) who used alcohol weekly or more often stated they had tried to cut down their drinking. A few taitamariki (6.4%) reported a parent, teacher or friend had told them they had a problem with drinking. Over 10% (11.1%) reported their friends had told them they should cut down their drinking. Taitamariki were more aware of and worried more about their own alcohol consumption than their families or other adults around them.

Risky behaviour associated with alcohol: Riding in car with a driver who had been drinking

Taitamariki were asked whether they had ridden in a car driven by a potentially drunk driver (someone who had drunk more than two glasses of alcohol in the 2 hours before driving). Most taitamariki (63.3%) had not been in this situation in the previous month. However, 35.5% of female and 37.4% of male taitamariki had been a passenger in a car driven by a potentially drunk driver at least once in the previous month. Taitamariki were not asked who the driver was. More information is required to enable the development and implementation of effective programmes to reduce this behaviour.

Percentage of taitamariki who rode in a car driven by a potentially drunk driver (someone who had drunk >2 glasses of alcohol in two hours before driving)



More taitamariki (36.7%) reported being in a car with a potentially drunk driver than did NZ European students (26.7%). After controlling for age, gender and socioeconomic factors this difference remained significant (OR 1.64, 95%CI 1.46, 1.84). These differences may be explained by incomplete controlling for factors, such as socioeconomic status, that influence the ability of taitamariki to make safe choices. They also highlight an area where more information is required to ensure that interventions to reduce potentially risky behaviours are effective. Such information includes the circumstances in which the choices were made and whether other options were available to taitamariki at the time.

Recommendations

- Policy and programmes to reduce alcohol-related disparities should be developed and implemented. Whānau and community-based approaches, programmes and/or social marketing campaigns for alcohol-related harm minimisation should be considered and implemented. They should be appropriate and acceptable to taitamariki and should be rigorously evaluated during development and implementation.
- Whānau, peer and community-based approaches to changing drinking patterns from more harmful 'binges' to less harmful patterns should be developed. They should also be appropriate and acceptable to Māori and should be rigorously evaluated during development and implementation.
- Harm minimisation programmes should incorporate a comprehensive approach to 'harm' including harm to health, personal safety and other issues associated with drinking behaviour and drinking environments e.g. getting into cars with potentially drunk drivers, alternative and safer methods of transport, facilities in neighbourhoods for taitamariki
- Consideration should be given to beginning harm minimisation programmes at younger ages than is currently carried out.
- As many taitamariki drink alcohol and acquire alcohol at home, resources for Māori adult alcohol related harm minimisation programmes should be increased.
- Communities should be encouraged to promote alcohol free spaces at all community venues, particularly those where young people congregate.
- Families and friends of taitamariki need to be aware of alcohol use by the taitamariki and be willing to have free and frank discussions about it.
- The Government should review the impact of lowering the drinking age on alcohol behaviour, access and alcohol-related outcomes for taitamariki under18 years of age.
- Legislation on the sale of alcohol to those under 18 years of age should be rigorously and proactively enforced.
- Providers need to acquire skills and knowledge to assess and intervene effectively with taitamariki who have hazardous drinking patterns

MARIJUANA USE

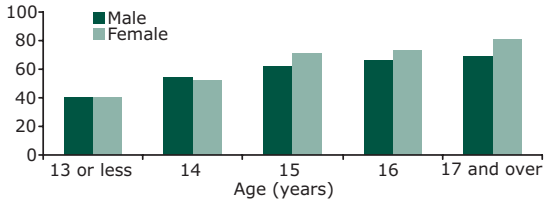
Background

In the 1998 National Drug Survey about 39% of Māori males aged 15 to 17 years and 29% of Māori females aged 15 to 17 years had tried marijuana in the previous 12 months (Ministry of Health, 2002a). The Christchurch Longitudinal study found young people who come from 'disadvantaged families', had greater exposure to 'childhood adversity' or had 'poor parental attachment' were more likely to be early onset users and/or heavy users of marijuana (Ministry of Health, 2002a). Frequent use of marijuana is associated with a number of adverse effects including loss of memory, loss of motivation, relationship problems and problems with parents (Ministry of Health, 2002a).

Marijuana Use Findings

Higher proportions of Māori (57.7%) than NZ European (34.0%) students reported they had ever tried marijuana. The percentage of taitamariki who said they had ever tried marijuana increased as their age increased. At age 17 years about 70% of male taitamariki and 80% of female taitamariki had tried marijuana at least once.

Percentage of taitamariki who had ever tried using marijuana

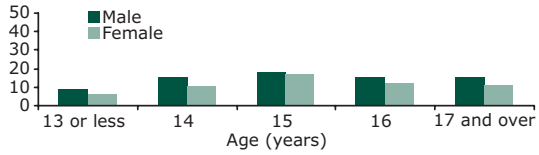


After controlling for age, gender and socioeconomic differences taitamariki were at higher risk of having used marijuana than their NZ European peers (OR 2.78, 95%CI 2.43, 3.17). These differences may reflect incomplete controlling for socioeconomic factors. Higher proportions of Māori students live in more deprived areas and face adverse social environments. These environments increase the risk of marijuana use (Ministry of Health, 2002a).

Regular use of marijuana

For the purposes of this survey, regular use of marijuana was defined as use at least once a week in the 4 weeks before the survey. A small proportion of taitamariki (12.9%) reported using marijuana regularly. The percentage of taitamariki using marijuana regularly peaked in the 15 year old age group and then appears to decline or remain at similar levels.

Percentage of taitamariki who use marijuana regularly (at least once a week)



Taitamariki (12.9%) were more likely to regularly use marijuana than their NZ European peers (4.7%). This difference remains significant after adjusting for age, gender and socioeconomic factors (OR 2.64, 95%CI 2.09, 3.35). Some of this difference may be due to incomplete adjustment for socioeconomic factors. However, this finding indicates marijuana use is an issue that must be addressed.

Reasons for using marijuana

Taitamariki were asked why they used marijuana. There were no differences between male and female taitamariki in the reasons for using marijuana. Percentages add up to more than 100% as taitamariki were able to choose more than one reason for smoking marijuana. The commonest reasons for smoking marijuana were to get 'high' (64.1%), have fun (63.9%), to relax (51.4%) and to have fun at parties (49.6%). Some taitamariki (22.1%) stated they had tried it once to see what it was like.

Taitamariki most commonly smoked marijuana with friends (96.6%) or with other (not friends or family) people (37.1%).

Sources of marijuana

Taitamariki were asked how they obtained marijuana. The most common source was friends (79.5%). Some (28.3%) reported buying marijuana themselves. Percentages add up to more than 100% as taitamariki were able to choose more than one source of marijuana.

Concerns about marijuana use

Just under half (48.1%) of taitamariki reported they worried (a lot, some or a little) about their use of marijuana, with 11.5% worrying a lot. Over forty percent (42.3%) of taitamariki who used marijuana reported they had tried to cut down or stop their use of this substance.

Recommendations

- Regular use of marijuana is undertaken by a small but significant percentage of taitamariki. This needs to be acknowledged and addressed by health and education services as well as by whānau and the community.
- Use of marijuana should be perceived as a health rather than behavioural issue by the education sector and managed by this sector as a health issue.
- Whānau, peer and community-based initiatives to reduce marijuana use and associated harmful effects should be developed and implemented.
- Government policies to reduce socioeconomic disparities should continue.
- There should be a commitment to local and central government to providing alternative activities and amenities for the enjoyment of taitamariki.
- Providers need to acquire skills and knowledge to assess and intervene effectively with taitamariki who use marijuana.

OTHER DRUG USE

Around 19% of taitamariki participating in the survey reported that they had tried other drugs on at least one occasion. Stimulants (including amphetamines) were reported as having ever been used by 6.1% of taitamariki. Similar small numbers reported using solvents (5.5%) and ecstasy (4.6%). In total 8.8% of taitamariki responded they had used any other types of drug (e.g., tranquillisers, narcotics, hallucinogens, cocaine, steroid pills or injections).

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MENTAL HEALTH AND EMOTIONAL WELLBEING

Terryann Clark

Background

Mental health and emotional wellbeing are a vital foundation for taitamariki if they are to participate fully in academic, social, whānau and community settings and reach their full potential. Whānau, schools and communities are all responsible for contributing toward the emotional and mental wellbeing of taitamariki.

There is very little known about the rates of mental health issues for taitamariki in New Zealand yet there are reasons for concern. Alarmingly, New Zealand has youth rates of suicide and self-harm that are among the highest in the western world (Ministry of Youth Affairs et al., 1998). For youth (all ethnic groups) aged 15–24 years, New Zealand has the second highest rates of suicide for males and fourth highest rates for females among selected OECD countries (Ministry of Health, 2001; Ministry of Health, 2004). Although in the last few years youth suicide deaths have decreased for both Māori and non-Māori there remain distinct disparities for taitamariki. In 2000, the Māori female rate was 7.4 per 100,000 while the non-Māori female rate was 5.4 per 100,000 and the Māori male rate was 43.5 per 100,000 while the non-Māori male rate was 26.4 per 100,000. (SPINZ, 2003).

There are no simple, single causes of mental illness among taitamariki and understanding about why some taitamariki are more resilient and others are more vulnerable, is an area that is still not well understood. It is well recognised that mental health disorders have multiple causes and that they interact in complex ways with adolescent development. There are some promising mental health promotion programmes for taitamariki which aim to prevent mental health problems. Māori youth development strategies, which aim to support the competence and opportunities of taitamariki and strengthen Māori communities, look toward prevention of mental illness. In addition, effective and early identification and treatment of mental health illness and symptoms are essential for taitamariki and their whānau.

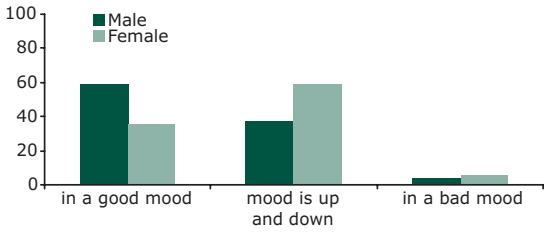
Youth2000 included a number of questions about the mental health and emotional wellbeing of taitamariki, including areas such as mood, depression, self-harm and suicidality. The findings from this study provide New Zealand's first representative taitamariki self-reported symptoms of mental health issues. These findings cannot confirm diagnoses of mental illness among taitamariki, rather they strongly signal taitamariki experiences of mental and emotional health issues. This chapter reports selected findings and includes some recommendations that may support the mental health and emotional wellbeing of taitamariki.

Mental Health and Emotional Wellbeing Findings

Mood

We asked taitamariki to report how they generally felt. Most male taitamariki (58.7%) were generally in a good mood, while most female taitamariki (59.2%) reported generally feeling up and down. About one-third of females (35.5%) reported they were generally in a good mood.

How taitamariki generally feel about their mood - (%)



Anxiety

In total, 5% of taitamariki (females 4.7%, males 5.8%) had a high level of anxiety symptoms. This is likely to impact on their ability to function well in their school, academic, family, community and social environments.

Attention and hyperactivity difficulties

About 5% of taitamariki (females 6.2%, males 4.8%) reported symptoms of inattention and about 7% (females 6.9%, males 6.5%) reported symptoms of hyperactivity; both are associated with Attention Deficit Hyperactivity Disorder (ADHD). These inattention symptoms are likely to have impacts both on the ability of taitamariki to learn effectively and on their relationships with their peers, school, whānau and communities.

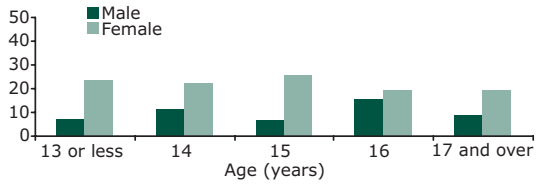
Depressive symptoms

Most taitamariki did not report significant symptoms of depression. The survey asked about symptoms of depression in several ways. Taitamariki were asked whether they had periods of feeling down most of the day, almost every day for periods of 2 weeks or more in the last 4 weeks, or for a period of 2 weeks or more within the last year. This level of depressive symptoms is considered to be a significant indicator of emotional distress and is likely to interrupt taitamariki' abilities to concentrate in the classroom and be well engaged in their schooling. In addition, it may affect their relationships with families, peers and other relationships.

Feeling down most of the day, almost every day, for 2 weeks or more and not feeling better if something good happens or is about to happen, is also considered a high level of emotional distress and potentially indicates clinical depression. Females were more likely to report periods of feeling down and not feeling better if something good happened (males 2.6%, females 6.1%).

Taitamariki also completed the Reynolds Adolescent Depression Scale (RADS), a validated self-report survey instrument that measures depressive symptoms (Reynolds, 1987 & Walker et al., 2004). Young people with a high level of symptoms on the RADS are likely to have clinically significant depression and require mental health assessment and intervention. Female taitamariki were about twice as likely as males to have significant depressive symptoms (females 22.7%, males 9.9%) as measured by the RADS.

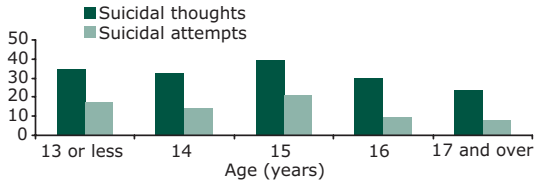
Percentage of taitamariki have significant symptoms of depression (RADS)



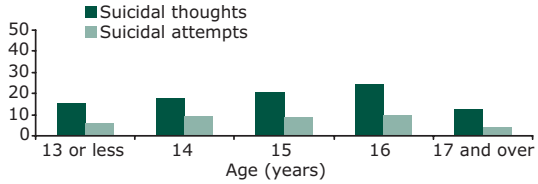
Suicide Behaviours

Previous research has reported it is not uncommon for young people in secondary schools to think about harming or killing themselves; however, most do not act on these thoughts. Of taitamariki who took part in **Youth2000**, 18.3% of males and 33.4% of females had thought about killing themselves in the last 12 months. Of particular concern, 8.7% of males and 15.7% of females reported they experienced suicidal thoughts in the 4 weeks before completing the survey. Some taitamariki (males 8.0%, females 15.3%) reported they had made a suicide attempt in the last 12 months. A smaller number of taitamariki (females 3.4%, males 1.8%) had made a serious attempt that required some kind of medical treatment or intervention.

Percentage of female taitamariki with suicidal behaviour in the last 12 months



Percentage of male taitamariki with suicidal behaviour in the last 12 months



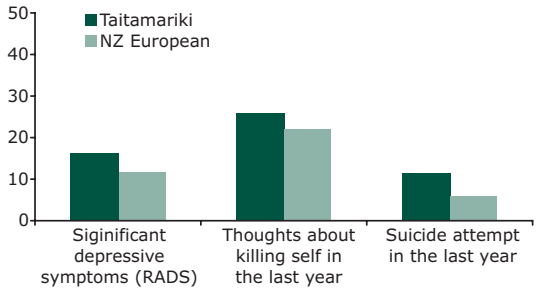
Disparities in emotional and mental health for taitamariki compared to NZ European students

Taitamariki (16.2%) were more likely to report significant depressive symptoms (using the RADS screening tool) compared to NZ European students (11.7%). After controlling for differences in age, gender and socioeconomic factors, the difference remains significant (OR 1.3, 95% CI 1.11-1.52).

Taitamariki (26.0%) were more likely to have thought about suicide in the last year compared with NZ European students (22.6%). After controlling for differences in age, gender and socioeconomic factors the difference remains significant (OR 1.18, 95% CI 1.03-1.36).

Taitamariki (11.5%) were more likely to report they had made a suicide attempt than NZ European students (5.7%). After controlling for differences in age, gender and socioeconomic factors the difference remains significant (OR 1.75, 95% CI 1.42-2.15).

Percentage of taitamariki and NZ European with selected mental health issues



Summary

Most taitamariki Māori in secondary schools throughout New Zealand do not report symptoms consistent with depression, anxiety disorders, inattention or suicidal behaviour. However there remains serious concern about the high rates of emotional and mental health distress for taitamariki. In addition, there are significant disparities for taitamariki compared to NZ European students. There are a number of background contexts that are important when interpreting these Māori specific statistics and information.

- Certain well known risk factors for mental illness and suicide are similar across all ethnic groups and are not isolated to taitamariki Māori. These include social and economic disadvantage, family breakdown, substance abuse, mental illness, exposure to suicide and suicide attempts, child abuse, imprisonment, low self-esteem, loss of romantic attachment and peer pressure (Commonwealth Department of Health and Aged Care, 2000).
- Socioeconomic factors may influence a person's ability to access information and healthcare. The **Youth2000** survey was unable to assess socioeconomic status in a comprehensive manner. For example, we could not ask taitamariki what was their total family income over the last year, as many taitamariki do not know.
- In addition, Kia Piki te Ora o te Taitamariki (Ministry of Youth Affairs et al., 1998) described the critical links between culture and behaviour and how these might impact on the mental and emotional health of taitamariki. Taitamariki might face additional risk factors such as cultural alienation, confusion over identity, the multiple impacts of colonisation, intergenerational modelling and behaviour transfer and institutional racism. It is important to understand these historical and contemporary contexts when interpreting these findings.

Strategies and Recommendations

While emotional distress and suicidal behaviours are not the norm for taitamariki they are distressingly high. Feelings and symptoms of sadness are common and they are often associated with patterns of depression. Suicidal ideation or thoughts are also common and should be assessed and addressed appropriately. Due to the interconnected nature of mental health, there are strategies at multiple levels that can be addressed by individuals, whānau, communities, health and allied professionals, schools and policy makers to make a difference for our taitamariki. The following strategies are likely to be helpful to support the emotional health of taitamariki:

1. Strengthening Māori Communities

Mason Durie (2001) identified 3 key principles to positive Māori development:

Integrated development: A Māori philosophical base and relevant framework centred on a Māori view. Māori policy should not be 'tacked' on to an existing policy or services; rather it should be constructed from a Māori base (p. 255).

Tikanga Māori: The promotion of Māori cultural norms, retention and revitalisation of te reo Māori, and Māori custom.

Māori self-determination: Māori autonomy and self-determination. For specific taitamariki mental health strategies this would include Māori ability to determine policies relating to mental health and maintain control over those things which affect them and doing so in a way that strengthens identity.

According to these principles, Māori communities must be supported and resourced to promote positive mental health and to respond to the mental health issues of taitamariki in their community. This includes improving Māori specific whānau development programmes and enhancing access to information and services.

Cultural development is an integral part of strengthening Māori communities, however it must be acknowledged that taitamariki express their cultural identity in many ways and cultural identity is fluid and evolves. This means that services must be acutely aware of taitamariki or youth specific issues and be careful not to alienate those taitamariki who may not feel comfortable with tikanga Māori (Borell, 2004). Competence in youth specific skills coupled with Māori clinicians and cultural competence in mental health are vital to successful programmes for taitamariki and strengthening Māori communities.

Economic development, policies and programmes to reduce socioeconomic disparities should continue and are a core component to strengthening Māori communities and reducing health and wellbeing inequalities.

2. Strengthening taitamariki through Māori youth development

More recently there has been an emphasis on positive youth development models and resilience, through supporting taitamariki to fulfil their potential and enhance their protective factors, rather than exclusively concentrating on risk (Ministry of Youth Affairs et al., 2002). This seems consistent with Māori philosophies of development and capacity building (Durie, 1995). The Youth Development Strategy Aotearoa (Ministry of Youth Affairs, 2002) identified 4 main goals in a healthy youth development strategy:

A strengths-based approach: Taitamariki bear a disproportionate burden of mental illness and distress compared with NZ European youth; however strengths of taitamariki and their whānau are often overlooked. A consistent strengths-based approach seeks to support these strengths and nurture a sense of contribution, value, choices and identity.

Developing skilled people to work with taitamariki: Those who work with taitamariki must address the specific learning competencies and skills required to work with them effectively. These skills are vital to provide safe and effective care for taitamariki and their whānau.

Creating opportunities for young people to actively participate and engage: Taitamariki and their whānau who are consumers of mental and emotional health services must have an active say in their treatment and rehabilitation. They should have access to appropriate adult mentors and whānau. Taitamariki should be encouraged to be active, energetic and innovative participants in their healthcare through activities such as consumer advocate groups and taitamariki activities.

Building knowledge on youth development through information and research: Whānau and communities must have access to appropriate and effective information to support their taitamariki. Health services must actively encourage research into the health and wellbeing of taitamariki and into effective treatment and outcomes for this group.

Consistent with these goals, taitamariki who have positive environments, perceive opportunities for development, have supportive and caring whānau and communities, attend schools where they feel included and safe and are exposed to high academic expectations are likely to have better health, educational and social outcomes.

3. Providing good mental health and wellbeing for all taitamariki

Taitamariki do better when they have access to adults who care about them, feel that teachers are fair and feel they belong and have a place in the school environment. As emotional distress is common, school staff, community members and families can help prevent it and address existing problems by helping young people manage issues like bullying and by ensuring they feel listened to and are able to participate in the school environment. Developing a school philosophy or style that values and includes young people, e.g. ensuring each young person has at least one area or activity in the school in which they can do well and having one staff member with whom they can communicate, has been shown to improve outcomes for young people who are vulnerable (Ministry of Youth Affairs, 2002). Implementation of the health and physical education curriculum or the use of school wide models such as Health Promoting Schools and Mentally Healthy schools may be helpful.

What is **NOT** recommended is raising awareness of youth suicide in health promotion programmes. It is tragic that some suicide awareness programmes may actually have been associated with increased rates of suicide among taitamariki (Beautrais et al., 1997; Beautrais, 1998). Programmes that train young people how to develop skills to avoid feeling suicidal appear to be more positive (Ministry of Youth Affairs, 2002; Te Puni Kōkiri, 2004; Ministry of Education & National Health Committee, 1997). These programmes are not likely to be called suicide awareness/prevention but focus on problem solving and how to deal with times when taitamariki are feeling down. This philosophy is also reflected throughout the health and physical education curriculum. In addition, there should be effective training, management and support for services that work with families and friends following suicide.

4. Recognising and treating mental health problems

The recognition and treatment of mental health problems is an important strategy for taitamariki. This report highlights that many taitamariki are distressed and have unmet mental health and emotional wellbeing needs. Taitamariki who appear sad and tired, or become withdrawn or unmotivated should be offered caring and supportive attention rather than being left to cope on their own. Symptoms should not be treated as behavioural issues but should be taken seriously and referred to school nurses and school or local counsellors. Talk with the local family doctor or mental health providers. Whānau must be able to access information and support about early signs of depression and other emotional distress.

Schools and services that see taitamariki should routinely complete comprehensive health assessments, which include screening for mental health problems (Goldenring & Cohen, 1988). Schools should ensure that school guidance, nursing and pastoral care staff are able to recognise and respond to these issues and get specialist mental health care when required. It is important to ensure there are adequate health and counselling staff at school that are well trained and have designated time to assess the emotional health of taitamariki. There must be training and skill development on suicide risk assessment and management for all those who work with taitamariki.

Schools should help facilitate good access to external health and welfare services in or near the school environment and provide transport when necessary. Health services must provide developmentally appropriate care for taitamariki and their whānau. There must be improved support and treatment of those who have already attempted suicide and their families and friends.

Safety Warning: *If parents, whānau members, friends, youth workers or clinicians are concerned that a young person may be suicidal, the person should ask the taitamariki directly whether they are thinking about or planning to harm themselves. This will NOT encourage them to think about suicide or make things worse. If they are thinking about or planning to harm themselves, help should be sort urgently from schools, mental health services and other experts in your community who work with mental health issues.*

5. Mainstream services

Most taitamariki attend mainstream schools, health and social services. Improvement of services that have contact with taitamariki who may be at risk of suicide (e.g., school guidance counsellors, primary health care, emergency services and government agencies such as Department of Corrections and Child, Youth and Family) should be trained to deliver safe care for taitamariki. Improved collaboration between mainstream and Māori services is important to ensure seamless transitions between services. Mental health services continue to be difficult to negotiate and navigate for taitamariki and their whānau. Years of institutional racism have ignored Māori methods of addressing the complex mental health needs of Māori whānau and their children. While many services are beginning to address these issues, innovative Māori specific methodologies, which are youth specific and are targeted to be responsive to the needs of taitamariki and their whānau are still needed and need further development.

6. Information and research

Further information is required about taitamariki mental health and those strategies most likely to be most effective for young Māori. This research provides an accurate picture of the rates or prevalence of emotional health issues for young people in secondary schools throughout New Zealand. However, we still need to explore the meanings of mental health issues for taitamariki.

Qualitative research to listen to the experiences and stories of young Māori in regard to mental health issues is an important next step.

Whānau, communities and service providers must have access to quality, up to date and relevant information about the mental health of taitamariki.

Whānau, schools and communities must be aware that emotional distress and mental health issues such as depression and suicidal thoughts are common amongst some taitamariki and there must be sufficient support, resources and services to respond to these concerns.

Workforce development remains a priority in the area of youth mental health and Māori mental health.

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SEXUAL AND REPRODUCTIVE HEALTH

Terryann Clark

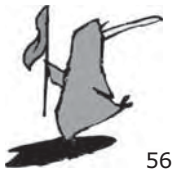
Background

Positive sexuality and healthy sexual and reproductive health are important for taitamariki, particularly as they learn about their changing bodies and relationships during adolescence. Previous research has highlighted the importance of sexuality education to support good relationships and decision-making skills (Hedgepeth & Helmich, 1996; Kirby, 1996, 2001; National Campaign to Prevent Teen Pregnancy, 2003). Contrary to popular belief, sexuality education does not hasten the onset of sexual activity; in fact comprehensive sexuality education can delay sexual activity and ensure that when taitamariki become sexually active, they are more likely to make use of contraception (Kirby, 1996, 2001; Kirby et al., 1997; National Campaign to Prevent Teen Pregnancy, 2003). Abstinence only programmes have been evaluated and have very little effect on sexual behaviour. Sexuality education which provides taitamariki with knowledge, understanding and skills to develop positive attitudes towards sexuality and decision-making skills (including abstinence), to take care of their sexual health, access sexual healthcare when needed are more likely to be effective (Jemmott et al., 1992). These skills are vital if we want to resource taitamariki with the skills needed to enhance their current and future interpersonal relationships (Ministry of Education, 1999).

New Zealand has one of the highest fertility rates for adolescents in the OECD (higher than Canada, Australia, Netherlands, Sweden but lower than Scotland and the United States). The birth rate for females aged 10-14 year each year is 0.2 or 0.3 live births per 1,000 and the birth rate for females aged 15-19 is 78 per 1,000 (all ethnic groups). Māori women are two to three times more likely to have a live birth than for the total population (0.6 live births per 1,000 females aged 10-14 years and 70 live births per 1,000 females aged 15-19 years per annum). It must be acknowledged that not all pregnancies for taitamariki are unplanned. However, many pregnancies are unintended and may result in broader emotional, social and economic negative consequences for taitamariki (Ministry of Health, 2001; Dickson et al., 2000).

Sexually transmitted infections can have serious physical and emotional affects for taitamariki. Sexually transmitted infections are relatively uncommon among those taitamariki under 15 years, but a disproportionate large number of sexually transmitted infections diagnosed are in their late teens or early twenties. Bacterial infections such as chlamydia and gonorrhoea are more common among taitamariki than viral diseases like herpes or warts. Bacterial infections can make it more difficult to get pregnant later in life, particularly where there are multiple and repeated infections, or pelvic inflammatory disease (Ministry of Health, 2002; ESR, 2001). There is still insufficient information about the true prevalence of sexually transmitted infections in adolescence due to these infections not being notifiable (numbers of diagnoses do not have to be reported). In addition, many taitamariki may not be aware that they have an infection, or delay seeking diagnoses and treatment due to inability to access to healthcare.

Those taitamariki who report that they have a history of sexual abuse, are particularly vulnerable to risky sexual behaviours. The Christchurch Health and Development Study (Broughton, et al, 2000) found that those youth who were sexually abused before the age of 16, were more likely to engage in risky sexual activity. In addition sexual abuse was closely correlated with social disadvantage and other adverse family factors.



Many sexual and reproductive health problems are preventable, yet taitamariki are a particularly vulnerable group. Previous research has identified taitamariki as being more likely to initiate sexual activity earlier than their NZ European peers (Lynskey & Fergusson, 1993; Tarrant & Scanlen, 1995; Lungley et al., 1993), less likely to use contraception (Lungley et al., 1993) more likely to be vulnerable to sexually transmitted diseases (ESR, 2001; New Zealand Public Health Report, 2001) and more likely to have a pregnancy during their teenage years (Dickson et al., 2000; Ministry of Health, 2002; New Zealand Public Health Report, 2001).

This chapter summarises the self-reported sexual and reproductive health of young Māori attending secondary school in New Zealand.

Sexual and Reproductive Health Findings

Sexual health information and education

Nearly all taitamariki (98.9%) report they get some form of sexuality education. The most common sources of information are: from school (90.2%), friends (64.0%), parents (59.6%) and TV (53.9%).

Sexual orientation and attraction

Most taitamariki (females 90.9%, males 90.1%) reported they are exclusively attracted to the opposite sex. A few taitamariki (3.3%) report that they are attracted to both genders and very few (0.8%) report they are exclusively same sex attracted. A small number of students reported that they were unsure of their attraction (2.7%), or weren't attracted to anyone (2.6%).

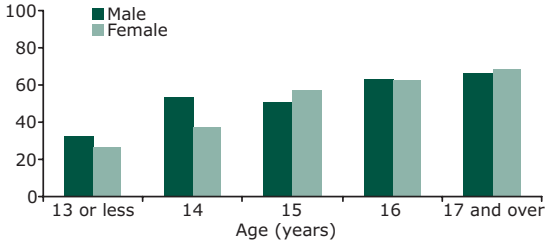
Reasons taitamariki have decided not to become sexually active

Taitamariki who have never had sexual intercourse were asked to identify reasons why they hadn't had sex. The most common reasons were; "wanting to wait until I'm older" (63.0%), "I haven't met anyone I want to do it with" (48.7%), "I don't want the risk of pregnancy" (46.4%), "I haven't had the opportunity to do it" (32.0%) and "I'm not emotionally ready" (25.9%).

Sexual activity

About a half of taitamariki (females 48.2%, males 53.5%) report they have had sexual intercourse. As would be expected, the older the taitamariki, the more likely they are to report ever having had sexual intercourse.

Percentage of taitamariki who have had sexual intercourse

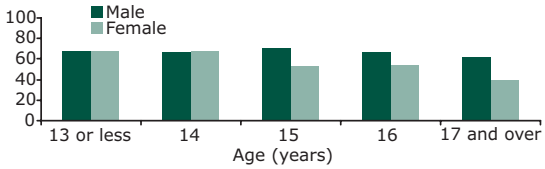


Of those taitamariki who reported they had had sexual intercourse, 76.5% of females and 68.9% of males reported they were currently sexually active (sex within the past 3 months).

Contraception use

Many taitamariki use contraception to prevent pregnancy. By the age of 17 years, 67.3% of males and 65.6% of females reported they always and mostly used contraception to prevent pregnancy. Condoms (82.2%) are the most common contraceptive used by taitamariki, followed by the oral contraceptive pill (35.4%) and the Emergency Contraceptive Pill (morning after pill) (13.6%). A high percentage of taitamariki report using condoms the last time they had sex. At 13 years old, 81.9% of males and 84.4% of females stated they used condoms the last time they had sex; however for female taitamariki the rate of condom use was lower in the older age groups. This may be due to these female taitamariki using other forms of contraception such as oral contraceptives. Taitamariki reported that the most common sources of contraceptive advice were from: friends (52.0%), parents (30.3%), a doctor (27.3%) or their school health service (24.5%).

Percentage of taitamariki that used a condom last time they had sex



Taitamariki reported a number of reasons for not using contraception, including: 'having sex was unexpected' (36.2%), "I don't think about it" (33.6%), "I don't think she/I will get pregnant" (19.3%) and "my partner didn't want to use contraception" (14.2%).

Pregnancy

Some taitamariki (8.7%) reported they (or a sexual partner) had been pregnant at some time.

Sexually transmitted infections

A few taitamariki reported that they had a sexually transmitted infection (males 2.9%, females 5.5%). This is likely to greatly underestimate the rates of infection due to the asymptomatic (many infections have no symptoms) nature of sexually transmitted infections and diseases.

Sexual abuse and coercion

Nearly one-quarter of taitamariki (24.6%) reported having had an experience(s) of sexual abuse or coercion. This was defined as the student reporting that they had been touched in a sexual way or made to do sexual things that they didn't want to do.

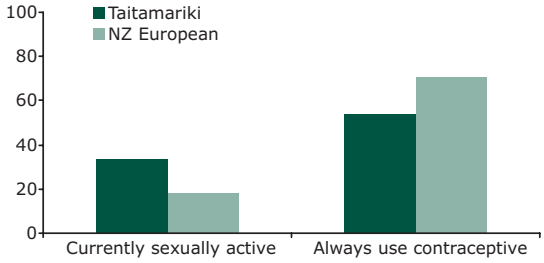
Disparities in sexual and reproductive health for taitamariki compared to NZ European students

Taitamariki (46.9%) were more likely to report ever having sex compared to NZ European students (26.5%). After controlling for differences in age, gender and socioeconomic factors the differences remain significant (OR 2.57, 95% CI 2.27,2.90).

Taitamariki (33.3%) were more likely to report being currently sexually active (sex within the past 3 months) compared to NZ European students (17.8%). After controlling for differences in age, gender and socioeconomic factors the difference remains significant (OR 2.4, 95% CI 2.11,2.73).

Taitamariki (53.8%) were less likely to report always using contraception when having sex compared to NZ European students (70.9%). After controlling for differences in age, gender and socioeconomic factors the difference remains significant (OR 0.6, 95% CI 0.48,0.74).

Percentage of taitamariki and NZ European with selected sexual health issues



Taitamariki (24.6%) were more likely to report sexual abuse and coercion compared with 17.6% of NZ European students. After controlling for differences in age, gender and socioeconomic factors this difference remains significant (OR 1.47, 95% CI 1.28, 1.69).

Summary and Recommendations

Contrary to common beliefs, most taitamariki who attend secondary school are not sexually active. More than half of young people who reported they engaged in sexual activity state they use some form of contraception to protect themselves from sexually transmitted infections, or unintended pregnancy.

Of concern are those taitamariki who report they rarely or never used any form of contraception, as they are very vulnerable to sexually transmitted infections and unintended pregnancies. In addition, a disturbing finding that nearly a quarter (24.6%) of taitamariki have been in sexually abusive or coercive situations is an area in need of urgent action.

Due to the interconnected nature of sexual and reproductive health, there are strategies at multiple levels that can be addressed by individuals, whānau, communities, health and allied professionals, schools and policy makers to make a difference for our taitamariki.

The following strategies are likely to be helpful to support the sexual and reproductive health of taitamariki:

1. Strengthening Māori communities

Māori communities are diverse and hold greatly varying views on sexuality and the ways that these are portrayed in our social, cultural and spiritual values. What Māori do have in common is our desire to protect our taitamariki and to protect and nurture our future generations. Families must be supported to talk to their children and taitamariki about relationships and sexuality in ways that are appropriate for their cultural and social beliefs. To address these personal health issues, whānau need to have increased access to appropriate, quality information, resources and parenting support. Through strengthening Māori communities and whānau with accurate information that is culturally acceptable and exploring societal values in regard to sexuality we will look toward an increased understanding and awareness of sexuality and sexual behaviour for all taitamariki. All community development must have a Māori philosophical base, with strong participation by taitamariki to enable them to find solutions, which are self-determining.
Strengthening Māori communities requires a commitment to economic development and policies and programmes to reduce socioeconomic disparities.

2. Strengthening taitamariki through Māori youth development

More recently there has been an emphasis on positive youth development models and resilience, through supporting taitamariki to fulfil their potential and enhance their protective factors, rather than exclusively concentrating on risk (Ministry of Youth Affairs, 2002). This seems more consistent with Māori philosophies of development and capacity building (Durie, 1995). The Youth Development Strategy Aotearoa (Ministry of Youth Affairs, 2002a) identified 4 main goals in a healthy youth development strategy:

A consistent ***strengths-based approach,*** which supports the skills, knowledge and talents of taitamariki.

Developing skilled people to work with taitamariki: Those who work with taitamariki must address the specific learning competencies and skills required to work with them effectively. These skills are vital to provide safe and effective care for taitamariki and their whānau.

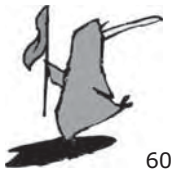
Creating opportunities for young people to actively participate and engage: Taitamariki and their whānau who are consumers of sexual and reproductive health services must have an active say and participation in their sexuality education and as consumers of sexual and reproductive health services. Taitamariki should have access to appropriate adult mentors and whānau. Finally taitamariki should be encouraged to be active, energetic and innovative participants in their healthcare thorough activities such as consumer advocate groups and programmes like peer education, peer mediation and support programmes.

Building knowledge on youth development through information and research: Taitamariki must have access to sexual health education, which includes strengthening social cohesion and providing supportive environments. Through health curricula schools must provide effective and safe information on sexual and reproductive health in a culturally appropriate manner. Whānau and communities must have access to appropriate and effective information to support their taitamariki. Health services must actively encourage research into the health and wellbeing of taitamariki and into effective prevention for this group.

Also consistent with these goals, taitamariki who have positive environments, perceive opportunities for development, have supportive and caring whānau and communities, attend schools where they feel included and safe and are exposed to high academic expectations are likely to have better health, educational and social outcomes.

3. Responsive, acceptable and accessible Health Services

Improved access to sexual and reproductive health services for taitamariki is an important strategy. Many taitamariki may not explicitly say they have sexual health concerns unless prompted. Being opportunistic and screening and educating all taitamariki when they access health services is an important strategy (Goldenring & Cohen, 1988). Sexual and reproductive education and services must be incorporated routinely into primary care and school-based health services. Sexual health and Family Planning services must incorporate taitamariki appropriate care, which is acceptable and accessible.



Taitamariki reported the most common reasons for not using contraception was that 'having sex was unexpected'. Condoms are the most common contraceptive used by taitamariki and they should be readily available. In addition access to emergency contraceptive pills is an important strategy to prevent unintended pregnancy. Schools should help facilitate good access to sexual health services in or near the school environment. There must be training and skill development on taitamariki appropriate sexual and reproductive care, which acknowledges cultural and developmental needs. In addition, counselling staff should be adequately trained to address the high rate of taitamariki who have been in sexually abusive situations.

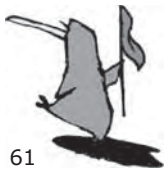
Sexual and reproductive health services continue to be difficult to negotiate and navigate for taitamariki and their whānau. While many services are beginning to address these issues, innovative Māori specific methodologies, which are youth specific and are targeted to be responsive to the needs of taitamariki and their whānau are still needed and need further development. Improved collaboration between mainstream and Māori services is important to ensure seamless transitions between services.

4. Providing good sexual and reproductive health for all taitamariki

While it is reassuring that most young people say they get some form of sexuality education from their school, the content of sexuality education varies greatly between schools. Sexuality education must teach knowledge and skill development that supports good relationships and decision-making skills and negotiation to ensure taitamariki have happy and fulfilling relationship now and in the future. It is important that schools provide effective, appropriate, comprehensive sexuality education within the health and physical education curriculum to all students. Schools also have a role in supporting and resourcing families/whānau to discuss sexuality in the home.

Those youth who have sexual identity issues may feel isolated due to societal prejudices and stereotypes. Efforts to create safe and accepting environments for youth who identify as gay, bisexual or transgender in our communities must continue if we want to create safe and accepting environments for all taitamariki. Sufficient support, resources and services need to be able to respond to diverse youth. Education for those who work with youth in regard to sexual identity issues also must continue.

The alarming number of taitamariki who have been in sexually abusive situations requires urgent action. Taitamariki are in a particularly vulnerable position in society and sexual abuse from peers and adults needs to stop. Sexuality education needs to teach peer appropriate behaviours, respect for boundaries to help reduce peer related sexual coercion and abuse. Taitamariki must be able to feel safe in their homes and communities and be able to access appropriate and accessible help if they make a disclosure of abuse.



Taitamariki do better when they have access to adults who care about them, feel that teachers are fair and feel they belong and have a place in the school environment. Developing a school philosophy or style that values and includes young people, e.g. ensuring each young person has at least one area or activity in the school in which they can do well and having one staff member with whom they can communicate, has been shown to improve outcomes for young people who are vulnerable (Ministry of Youth Affairs, 2002).

Implementation of the health and physical education curriculum or the use of school wide models such as Health Promoting Schools and Peer Sexuality may be helpful although to date there are no clear data that prove this. Further research into promising programmes and particularly those designed with Māori in mind should be supported.

5. Information and Research

Further information is required about taitamariki sexual and reproductive health and behaviour and those strategies most likely to be most effective for young Māori. This research provides an accurate picture of the rates or prevalence of sexual health issues for young people in secondary schools throughout New Zealand. However, we still need to explore the meanings of sexuality in the context of being Māori and youth. Qualitative research to listen to the experiences and stories of young Māori in regard to sexual and reproductive health issues is an important next step. In addition, behavioural strategies which seek to understand the complex decision-making behaviours of taitamariki in regard to sexual and reproductive health must continue to be developed if there are to be effective sexual and reproductive health strategies that are taitamariki specific.

Whānau, schools and communities must be aware that emotional distress and mental health issues, such as depression and suicidal thoughts, are frequently linked with sexuality and relationship issues.

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APPENDIX

Bold numbers refer to percentages of students, with 95% confidence intervals - below

ETHNICITY AND CULTURE

Do you know your iwi (tribe or tribes) ?

N = 2328

Yes	**60.3** 57.0, 63.5
No	**23.8** 21.1, 26.6
Not sure	**15.9** 14.3, 17.5

How many of the special activities or traditions your family celebrate (like holidays, special meals, religious activities, or trips) are based on Māori culture?

N= 2317

A lot	**11.0** 9.4, 12.5
Some	**28.7** 26.0, 31.3
Not many	**30.9** 28.8, 32.9
None	20.9 18.0, 23.7
Don't know	**8.6** 7.4, 9.9

Have you ever been to a tangi or unveiling?

N = 2335

Yes	**73.9** 69.8, 78.0
No	**17.6** 14.7, 20.6
Don't know	**8.5** 6.8, 10.2

How much of the kawa/protocol did you understand (how much of what was going on did you understand)?

N = 1718

All or most	**36.9** 33.8, 39.9
About half	**23.8** 21.9, 25.7
Some	**32.3** 29.5, 35.2
None	**7.0** 5.6, 8.3

How comfortable do you feel in Māori social surroundings?

N = 2321

Very uncomfortable	**11.1** 9.8, 12.4
Uncomfortable	**4.1** 3.2, 5.0
Slightly uncomfortable	**15.4** 13.5, 17.4
Comfortable	**43.4** 41.3, 45.5
Very comfortable	**26.0** 23.4, 28.6

How comfortable do you feel in Pākehā /NZ European social surroundings?

N = 2311

Very uncomfortable	**15.9** 14.5, 17.3
Uncomfortable	**2.5** 1.8, 3.2
Slightly uncomfortable	**7.9** 6.5, 9.2
Comfortable	**48.9** 46.4, 51.4
Very comfortable	**24.9** 22.9, 27.0

Are Māori values important to you (e.g., whānau and hui family gatherings), karakia (pray), wairua (spirituality) and whakapapa (family history)?

N = 2278

Not at all important	**15.4** 13.0, 17.7
Somewhat important	**39.3** 36.5, 42.2
Very important	**45.3** 41.2, 49.4

Which of the following statements best describes your ability in understanding Māori?

N = 2307

Understand no Māori at all	**5.8** 4.7, 6.8
Understand a few words of Māori and basic greetings	**55.7** 53.1, 58.2
Average understanding of Māori	**24.9** 22.9, 26.9
Understand most Māori conversations	**10.1** 8.8, 11.5
Full understanding of Māori language	**3.6** 2.3, 4.8

Which of the following statements best describes your ability in speaking Māori?

N = 2305

Speak no Māori at all	**10.3** 8.7, 12.0
Speak only a few words of Māori and basic greetings	**59.3** 56.4, 62.2
Speak an average amount of Māori	**22.0** 19.8, 24.0
Can easily have a conversation in Māori	**5.9** 4.8, 7.0
Fluent speaker of Māori	**2.5** 1.6, 3.4

How important is it to you to be recognised as a Māori person?

N = 2249

Not at all important	**28.2** 24.8, 31.7
Somewhat important	**38.3** 36.1, 40.5
Very important	**33.5** 29.8, 37.2

Do you feel accepted by other Māori people?

N = 2312

Not at all	**2.3** 1.7, 3.0
Some	**28.1** 26.1, 30.1
Quite a bit	**27.4** 25.7, 29.1
A lot	**32.0** 29.6, 34.5
Don't know	**10.1** 8.8, 11.5

How satisfied are you with your knowledge of things Māori?

N = 2257

Very satisfied	**11.8** 10.3, 13.4
Satisfied	**59.0** 57.1, 61.0
Unsatisfied	**24.2** 22.0, 26.4
Very unsatisfied	**4.9** 4.0, 5.9

ENVIRONMENTS

Overcrowding (More than 2 people per bedroom)

More than 2 people per bedroom (N = 2308)

yes	**7.6** 5.6, 9.5
no	**92.4** 90.5, 94.4

I don't have enough space of my own for doing homwork

(N = 2243)

Males	Females
10.5 8.5, 12.5	**15.7** 13.7, 17.8

Socioeconomic indicators

Mum or Dad (or someone who acts as your Mum or Dad) has a paid job, outside the home or works at home earning money (N=2279)	**90.6** 89.2, 92.0
There is a car that is working at home (N=2340)	**93.9** 92.7, 95.1
There is a telephone that is connected at home (N=2340)	**91.1** 89.5, 92.7

Family Relationships

	Males	Females
Mum and/or Dad (or someone who acts as your Mum or Dad) care about me a lot (N=2311)	**90.8** 88.8, 92.8	**88.7** 86.6, 90.8
Most weeks I get enough time to spend with Mum and/or Dad (or someone who acts as my Mum or Dad) (N=2289)	**56.9** 53.6, 60.3	**52.5** 49.4, 55.6
Most of the time I feel close to my Mum and/or Dad (or someone who acts as your Mum or Dad) (N=2340)	**68.2** 65.3,71.1	**63.5** 60.7,66.5

N= 2293	Males	Females
I'm happy with how we (my family) get on	**60.3** 57.6, 62.9	**46.7** 43.9, 49.4
My family relationships are neither good nor bad	**31.5** 29.1, 34.0	**38.4** 36.1, 40.7
Getting on with my family causes me problems	**8.2** 6.4, 10.0	**14.9** 12.7, 17.1

Family expectations and aspirations

	Males	Females
My family have little or no expectations of me (N=2306)	**8.1** 6.4, 9.8	**6.9** 5.2, 8.6
I always or usually receive praise from my family when I have done well (N=2329)	**73.2** 70.1, 76.2	**74.1** 71.4, 76.7
I hardly ever or never receive praise from my family when I have done well (N=2329)	**6.6** 5.3, 7.9	**8.4** 6.9, 10.0
I talk to my family about what is happening at school a lot or some of the time (N=2307)	**94.6** 93.2, 96.0	**92.1** 91.0, 93.5
It is very important to my parents/caregivers that I go to school every day (N=2310)	**73.0** 69.9,76.01	**71.9** 69.5,74.2

School

	Males	Females
There is an adult at school that cares (some or a lot) about me (N=2295)	**88.8** 86.9, 90.8	**87.2** 85.2, 89.2
I usually get along with my teachers (N=2315)	**42.2** 38.9, 45.5	**48.1** 44.9, 51.2
It is not important to me to be at school everyday (N=2311)	**15.9** 13.7, 18.1	**13.8** 11.1, 16.4
Teachers at my school hardly ever treat students fairly (N=2310)	**19.3** 16.4, 22.1	**16.0** 13.7, 18.4
People at school expect me to do well (N= 2276)	**85.1** 82.6,88.7	**88.0** 85.9,90.0
I think that I will stay at school until at least year 12 (N=2288)	**91.1** 89.4,93.1	**91.5** 89.3,93.7

Community

	Males	Females
There is an adult outside my family I would feel happy talking if I was having a serious problem (N=1974)	**58.2** 54.9, 61.6	**62.9** 60.2, 65.7
There is a friend I would feel happy talking if I was having a serious problem (N=2043)	**74.2** 71.4, 77.0	**89.8** 88.1, 91.6
I feel safe in my neighbourhood all or most of the time (N=1966)	**86.3** 84.0, 88.6	**81.0** 78.2, 84.0

FOOD, EXERCISE AND ACTIVITIES

Do you eat breakfast?

N= 2300	Males	Females
Always	**47.9** 44.1, 51.8	**29.1** 25.9, 32.4
Sometimes	**37.4** 33.6, 41.2	**39.2** 36.1, 42.4
Hardly ever	**14.7** 12.5, 16.8	**31.6** 28.9, 34.4

Where do you usually get breakfast from?

N = 2290

Home	**85.2** 82.6, 87.8
School	**5.1** 3.2, 7.0
Shops or takeaways	**7.7** 5.7, 9.6
Other	**2.1** 1.5, 2.6

About how much time each day do you watch T.V?

N= 2249	Males	Females
I don't watch T.V	**2.5** 1.6, 3.4	**3.7** 2.5, 4.9
Less than 30 minutes	**37.6** 33.9, 41.3	**37.6** 34.1, 41.1
1-4 hours	**43.1** 39.8, 46.5	**44.4** 41.1, 47.6
More than 5 hours	**16.7** 14.0, 19.5	**14.3** 11.9, 16.8

About how much time each day do you use a computer or the internet (not playing games)?

N= 2220	Males	Females
I don't use a computer	**30.9** 27.8, 34.1	**34.4** 31.2, 37.7
Less than 30 minutes	**51.6** 48.3, 54.8	**50.3** 47.0, 53.7
1-4 hours	**13.3** 11.1, 15.4	**12.7** 10.9, 14.4
More than 5 hours	**4.2** 2.9, 5.6	**2.6** 1.6, 3.5

About how much time each day do you play computer games, Nintendo or playstation?

N= 2220	Males	Females
I don't play computer	**22.3** 19.6, 25.0	**53.2** 50.2, 56.1
Less than 30 mins	**50.2** 47.0, 53.3	**38.8** 36.0, 41.5
1-4 hours	**17.5** 15.0, 20.1	**5.6** 4.3, 6.8
More than 5 hours	**10.0** 7.8, 12.3	**2.5** 1.6, 3.5

About how much time each day would you spend reading for fun (not for school or work)?

N= 2222	Males	Females
I don't read for fun	**53.0** 49.7, 56.3	**41.0** 37.8, 44.1
Less than 30 mins	**40.4** 37.4, 43.3	**49.0** 45.5, 52.5
1-4 hours	**4.3** 3.0, 5.7	**8.0** 6.5, 9.6
More than 5 hours	**2.3** 1.3, 3.2	2.0 1.2, 2.8

About how much time each day would you spend doing arts (such as crafts music, drama, dance etc)?

N= 2222	Males	Females
I don't do any arts	**46.2** 42.2, 50.1	**27.6** 24.5, 30.7
Less than 30 mins	**40.7** 37.5, 43.9	**52.9** 49.9, 55.9
1-4 hours	**8.5** 6.5, 10.4	**14.1** 11.9, 16.2
More than 5 hours	**4.7** 3.4, 6.0	**5.4** 4.2, 6.7

GENERAL HEALTH

In general how would you say your health is?

N= 2320	Males	Females
Excellent	**29.5** 27.1, 32.0	**18.2** 15.7, 20.8
Very good	**40.6** 37.6, 43.6	**34.7** 32.2, 37.2
Good	**23.5** 21.0, 26.0	**35.2** 32.7, 37.7
Fair	**4.5** 3.5, 5.6	**9.1** 7.3, 10.8
Poor	**1.9** 1.1, 2.6	**2.8** 2.0, 3.6

How healthy do you think you are compared to other people your age?

N= 2311	Males	Females
Healthier than others	**37.0** 34.0, 40.1	**22.8** 20.1, 25.5
About the same	**54.9** 51.7, 58.2	**62.5** 59.8, 65.2
Not as healthy as others	**8.0** 6.4, 9.6	**14.7** 12.7, 16.8

Does this long-term health problem cause you difficulty with everyday activities?

N= 914	Males	Females
Hardly ever	**50.7** 46.1, 55.3	**40.1** 35.9, 44.4
Sometimes	**41.9** 37.2, 46.6	**47.9** 43.4, 52.3
Often	**7.4** 4.8, 9.9	**12.0** 9.2, 14.8

Sometimes people have a problem with their health but don't get any help. Here are some reasons people don't get healthcare even though they need to. Have any of these ever applied to you? (you can answer as many or few as you want)

N=2309	Males	Females
Don't know how to	**11.8** 9.5, 14.1	**9.1** 7.3, 10.8
Cant get in touch with the health professional	**7.0** 5.6, 8.3	**4.1** 2.8, 5.3
Cant get an appointment	**6.0** 4.4, 7.5	**7.6** 6.2, 9.0
Don't want to make a fuss	**26.2** 22.6, 29.8	**31.4** 28.4, 34.4
Couldn't be bothered	**27.0** 24.1, 30.0	**25.3** 22.4, 28.1
Have no transport to get there	**6.3** 4.5, 8.1	**9.5** 7.5, 11.4
Costs too much	**15.3** 12.9, 17.6	**18.4** 15.9, 21.0
Don't feel comfortable with the person	**10.1** 8.3, 11.9	**21.9** 19.2, 24.6
Too scared	**9.2** 7.4, 11.0	**20.1** 17.3, 23.0
Worried it wouldn't be kept private	**9.0** 7.2, 10.8	**20.3** 17.6, 23.1
Other	**6.6** 4.9, 8.3	**4.6** 3.4, 5.8
I've had no problems getting healthcare	**48.9** 45.2, 52.7	**44.9** 41.7, 48.2

SUBSTANCE USE

Cigarettes

Ever smoked a cigarette

N=2082	Males	Females
13	**51.9** 44.6, 59.1	**56.5** 50.4, 62.5
14	**62.3** 56.5, 68.1	**72.3** 67.6, 77.1
15	**65.1** 57.9, 72.3	**83.4** 78.6, 88.3
16	**58.1** 49.4, 66.8	**80.3** 75.1, 85.5
17	**54.9** 43.5, 66.4	**77.6** 68.8, 86.4

Weekly cigarette smoking

N=2068	Males	Females
13	**10.9** 6.1, 15.8	**22.0** 16.8, 27.2
14	**18.2** 13.8, 22.7	**26.6** 21.8, 31.3
15	**22.8** 17.4, 28.3	**40.1** 33.3, 46.9
16	**24.9** 17.6, 32.2	**33.1** 25.8, 40.4
17	**14.2** 5.3, 23.1	**31.5** 22.5, 40.6

Where did you get the cigarette from the first time you smoked a whole cigarette?

N = 1370	
Bought it myself	**4.0** 2.8, 5.1
Given by friends	**58.5** 55.6, 61.4
Given by brother or sister	**8.3** 6.7, 9.9
Given by parents	**1.8** 1.0, 2.5
Given by another adult I know	**2.7** 1.8, 3.7
Given by a stranger	**0.6** 0.2, 1.0
Stolen	**15.2** 13.7, 16.7
Other	**3.4** 2.4, 4.3
I don't remember	**5.6** 4.4, 6.8

Have you ever tried to cut down or give up smoking cigarettes?

N = 818

Yes	**69.1** 65.7, 72.5
No	**24.3** 21.2, 27.4
Not sure	**6.6** 4.6, 8.6

When did you start smoking this often?

N = 814

< 12 years	**27.0** 24.0, 30.1
13-15	**64.0** 61.0, 67.3
> 15	**9.0** 7.0, 11.0

Who do you smoke cigarettes with?

N = 818

Friends	**93.1** 91.1, 95.1
Family	**32.6** 29.1, 36.1
Other people	**46.4** 43.1, 49.8
By myself	**50.9** 47.6, 54.2

Where do you get cigarettes from?

N = 837

I buy myself	**44.0** 40.0, 47.9
From friends	**73.2** 70.4, 75.9
From brother or sister	**27.8** 24.4, 31.2
From parents	**23.1** 20.3, 25.9
From another adult I know	**26.8** 23.0, 30.6
I get someone else to buy them for me	**41.6** 38.5, 44.7
I steal them	**21.1** 18.0, 24.2
Tobacco vending machine	**8.0** 6.0, 10.0
Other	**5.6** 4.0, 7.2

Are you worried about smoking?

N = 820

A lot	**14.2** 11.7, 16.8
Some	**22.4** 19.1, 25.6
A little	**32.3** 28.9, 35.7
Not at all	**31.1** 27.3, 34.8

Alcohol

Ever drunk alcohol?

N=2080	Males	Females
13	**79.7** 74.3, 85.1	**74.4** 68.5, 80.4
14	**90.8** 86.9, 94.7	**87.9** 83.9, 91.8
15	**94.1** 90.8, 97.4	**95.5** 93.4, 97.7
16	**95.3** 91.3, 99.3	**97.2** 94.8, 99.7
17	**94.7** 90.0, 99.3	**96.9** 93.5, 100.

Weekly alcohol use

N=2068	Males	Females
13	**11.2** 6.4, 15.9	**9.8** 6.0, 13.6
14	**24.2** 19.3, 29.2	**14.5** 9.8, 19.2
15	**27.4** 20.1, 34.7	**26.7** 21.1, 32.3
16	**31.9** 24.2, 39.7	**23.2** 16.5, 30.0
17	**31.8** 20.8, 42.7	**38.5** 26.7, 50.3

Binge drinking

N=2012	Males	Females
13	**24.6** 18.8, 30.4	**28.5** 23.7, 33.3
14	**47.2** 40.9, 53.5	**42.1** 36.2, 48.1
15	**66.7** 59.4, 74.1	**60.7** 53.8, 67.7
16	**68.5** 60.5, 76.6	**66.1** 59.2, 73.1
17	**68.1** 58.0, 78.2	**71.3** 60.0, 82.5

Marijuana

Ever used marijuana?

N=1988	Males	Females
13	**40.2** 32.7, 47.7	**39.6** 33.2, 45.9
14	**53.6** 47.3, 59.9	**52.4** 46.6, 58.3
15	**62.5** 55.2, 69.8	**71.5** 64.7, 78.3
16	**66.0** 58.9, 73.0	**73.3** 66.3, 80.3
17	**68.6** 57.8, 79.3	**80.6** 73.0, 88.3

Weekly marijuana use

N=1979	Males	Females
13	**9.3** 4.8, 13.8	**6.4** 3.7, 9.1
14	**15.2** 10.9, 19.5	**10.5** 7.2, 13.8
15	**18.1** 12.9, 23.3	**17.2** 11.8, 22.6
16	**15.5** 9.2, 21.8	**12.3** 6.0, 18.7
17	**15.2** 6.8, 23.6	**11.5** 4.1, 18.9

Why do you smoke marijuana?

N=819

To relax	**51.4** 47.6, 55.2
To get high or wasted	**64.1** 59.8, 68.3
To feel better about myself	**23.8** 20.4, 27.2
To have fun	**63.9** 60.5, 67.4
To forget about things	**24.3** 20.6, 28.0
To try it once to see what its like	**22.1** 18.9, 25.3
My friends do	**21.9** 18.8, 24.9
To have fun at parties	**49.6** 45.6, 53.6
To make me feel more confident	**3.3** 2.2, 4.4
Because I'm bored	**27.7** 24.2, 31.3
None of these	**5.8** 4.1, 7.6

Who do you usually smoke with?

N=827	All
Friends	**96.6** 95.4, 97.8
Family	**16.9** 14.3, 19.4
Other people	**37.0** 33.6, 40.6
By myself	**20.0** 16.9, 23.1

How do you usually get it?

N=863	
Buy it myself	**28.3** 24.4, 32.2
From friends	**79.5** 76.7, 82.3
From brother or sister	**20.2** 17.2, 23.2
From parents	**7.1** 5.4, 8.9
From another adult I know	**17.8** 15.0, 20.7
Get someone else to buy it for me	**18.6** 16.1, 21.1
Stolen	**12.1** 9.3, 14.9
I grow marijuana	**7.1** 5.6, 8.7
None of these	**11.3** 9.0, 13.7

Are you worried about how much you smoke or use?

N= 834

A lot	**11.5** 9.5, 13.6
Some	**14.9** 12.6, 17.2
A little	**21.7** 18.8, 24.7
Not at all	**51.8** 48.3, 55.3

Have you ever tried to cut down?

N= 825

Yes	**42.3** 38.8, 45.9

Other Drugs

Ever used any other drug?

N = 1854

Yes	**19.0** 17.0, 21.0

What other drugs have you used?

N = 1854

Glue	**5.5** 4.4, 6.5
Ecstacy	**4.6** 3.6, 5.5
Stimulants	**6.1** 4.9, 7.3
Other drug	**8.8** 7.6, 10.1

EMOTIONAL AND MENTAL HEALTH

	Males	Females
In general you are in a good mood (N=2314)	**58.8** 56.3,61.3	**35.5** 32.8,38.1
Anxiety at a level considered consistent with an anxiety disorder (N=2185)	**5.8** 4.4,7.2	**4.7** 3.5,5.9
Symptoms of inattention associated with ADHD (N=2244)	**4.8** 3.5,6.1	**6.2** 4.7,7.8
Symptoms of hyperactivity associated with ADHD (N=2240)	**6.5** 5.1,8.0	**6.9** 5.6,8.3
Period of feeling down for at least 2 weeks within the last 4 weeks (N=2089)	**5.9** 4.4,7.3	**16.4** 14.1,18.7
Feeling down every day for 2 weeks and not feeling better if something good happened (N=2089)	**2.6** 1.7,3.6	**6.0** 4.5,7.6
Significant depressive symptoms (RADS>77) (N=2271)	**9.9** 8.1,11.7	**22.7** 20.4,25.0
Have thought about killing yourself in the last 12 months (N=2284)	**18.3** 15.8,20.8	**33.4** 30.4,36.4
Have thought about killing yourself in the last 4 weeks (N=2276)	**8.8** 6.8,10.7	**15.7** 13.6,17.8
Have ever tried to kill yourself in the last 12 months (N=2303)	**8.0** 6.1,10.0	**15.3** 12.7,17.9
Suicide attempt requiring medical intervention (N=2295)	**1.8** 1.0,2.6	**3.4** 2.2,4.6

SEXUAL HEALTH

	Males	Females
Ever had sexual intercourse (N=2201)	**49.7** 46.2,53.2	**45.8** 42.4,49.3
Currently sexually active (in the last 3 months) (N=2135)	**33.3** 30.4,36.2	**33.7** 30.7,36.8
Attracted exclusively to the opposite sex (N=2178)	**90.2** 88.3,92.0	**90.9** 89.0,92.8
Used a condom to protect against a STI, last time you had sex (N=933)	**66.9** 62.6,71.3	**57.1** 52.8,61.5
Always and mostly use contraception to prevent pregnancy (N=929)	**77.3** 72.8,81.7	**69.5** 64.5,74.5
Ever been or got your partner pregnant (N=914)	**11.1** 8.1,14.2	**18.6** 15.3,21.9
Ever had a sexually transmitted infection (N=955)	**3.0** 1.3,4.6	**5.5** 3.7,7.4
Ever been sexually abused (N=2175)	**14.8** 12.8,16.8	**26.3** 23.5,29.4