Alcohol Healthwatch is an independent charitable trust which works to reduce alcohol-related harm. We are contracted by the Ministry of Health to provide a range of services regionally and nationally, including provision of research-based information on policy and practice, as well as coordination and public health expertise for inter-agency and community group's who work on alcohol issues.

We welcome the opportunity to provide comment on the Māori Affairs Select Committee Inquiry into the determinants of wellbeing for Māori children.

If you have any questions on the comments we have included in our submission, please contact:

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1. Introduction

New Zealand is one of the most poorly performing countries in the OECD in terms of outcomes for children (28th out of 30 countries). We also have one of the lowest rates of public investment in children in the OECD (less than half the average spend per child under the age of 6 years). The investment we do make ranks as one of the least effective.

How can we be proud of our country and of being 'Kiwi's' when we are doing such a poor job for our children?

When we are so concerned about the current economic environment and significant cuts are being made to public services how can we justify the costs of so many of our children, our future workforce, growing up in poverty which can lead to poorer health in adulthood, fewer education and vocational qualifications, getting into trouble with the law more often and dying younger? These outcomes tend to require greater public expenditure while contributing less to the economy.

We would like to emphasise the point that all children are vulnerable. The notion of 'Proportionate Universalism' introduced by Marmot (2010) says that "focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage". This is significant in light of what we all want as our end goal: that all children in New Zealand enjoy the same opportunities, access to services and positive health outcomes.

Under a public health model, priority is placed on having universal (primary prevention) interventions that are provided to those families that need additional assistance, with a focus on early intervention. Tertiary protection services are a last resort, and the least desirable option for families and governments. Universal services are protective and enable early intervention within existing relationships.

A number of international studies have found that national commitment and investment in public health strategies (that is, preventative health strategies rather than reactive health services) that are evidence-based can result in significant health care cost savings and overall economic cost savings (Robert Wood Johnson Foundation, 2011). For instance, in one particular study published in July 2011, researchers found that for each 10% increase in local public health spending, there were significant decreases in infant deaths (6.9% drop), deaths from cardiovascular disease (3.2% drop), deaths from diabetes (1.4% drop), and deaths from cancer (1.1% drop), (Robert Wood Johnson Foundation, 2011).

There are many underlying and contributing factors to the poor health and wellbeing of our children. The focus for our work at Alcohol Healthwatch is to decrease alcohol-related harm in New Zealand.

Alcohol is the most commonly used recreational drug in New Zealand and affects our children both directly and indirectly. Alcohol misuse results in increased mortality and morbidity, as well as considerable social harm to society. The burden that alcohol causes in New Zealand has been

conservatively estimated at $5.3 billion annually which equates to $14.5 million a day (Slack, Nana, & Webster, 2009). Economically speaking it does not make sense to continue to ignore evidence-based measures that we know are effective in decreasing alcohol-related harm. Alcohol-related harm is preventable.

Research shows that Māori experience a higher level of this burden from alcohol than non-Māori. This warrants a particular focus from a national policy perspective (Connor, Broad, Rehm, Vander Hoorn, & Jackson, 2005).

In the following section of our submission we will provide alcohol specific commentary under each of the terms of reference that have been supplied for this inquiry. Both Māori specific data and generic data are used to inform this submission, either because no Māori data is available, or the data is illustrating the impact on all children and young people regardless of ethnicity.

2. Terms of Reference

2.1 The historical and current health, education, and welfare profiles for Māori children

2.1.1 Māori and their relationship with alcohol – the historical context

The historical account of Māori and their relationship with alcohol provides a fascinating story, but also a concrete example of how colonisation has negatively impacted on Māori people's learned behaviours.

The relationship between Maori and alcohol has been described as being characterised by diversity and ambivalence (Durie, 1998 & Mancall & Robertson, 1999). Prior to contact with Pākehā, Māori lived in one of the few parts of the world that had never developed alcoholic beverages. There are many reports by European explorers and travelers of initial Māori aversion to alcohol. Until the mid - 1830s, missionaries found little to record regarding Māori drinking. As a result there were no cultural systems to regulate the use of alcohol before colonisation (Hutt, 2003).

Alcohol was introduced initially into the Bay of Islands and other northern coastal communities and by 1840 it had become common enough to be mentioned in discussions before the signing of the Treaty of Waitangi (Hutt, 2003). Alcohol was generally not used as payment for settling disputes, as other commodities were, and it was also not evident at Māori ceremonial occasions in this period (Hutt, 2003).

By the 1850's, alcohol had become a tool of colonisation, with Māori landowners encouraged to run up bills at hotels, and their land taken to settle debts (Cullen, 1984). From around 1860, accounts start to mention Māori women drinking alcohol (Cullen, 1984).

Alcohol use by Māori seemed to increase significantly after the Land Wars, which were between 1860 to around 1872. Many Māori turned to alcohol as a response to dispossession, economic hardship, disease and the loss of social and cultural supporting structures. Banwell (1991, p 175) says that "under Pākehā control, alcohol was instrumental in alienating Māori from their land, their culture and their health".

Despite superseding legislation, iwi, hapū and marae continued efforts to enforce their own controls over alcohol, such as the aukati within the limits of the King Country, the codes at Parihaka which included forbidding drunkenness, or Māori councils making informal bylaws (Durie, 1998).

By the early 20th century, the government perceived a problem with Māori women drinking. In the 1910 Licensing Amendment Act "All North Island Māori women (except those married to Europeans) were barred from licensed premises and could not drink alcohol except on doctor's orders". Māori men were only allowed to drink alcohol on licensed premises and were often only allowed in certain bars by hoteliers. While the legal ban was lifted in 1948, informal bans remained for years (Cullen, 1984).

Early 20th century accounts by Māori doctors such as Te Rangihiroa (Peter Buck), described alcohol as a major social problem. Some Māori linked this to closer contact between Māori and Pākehā, as Māori were increasingly being employed in jobs such as forestry and freezing works, a trend that increased with Māori urbanisation. Urbanisation from the 1940s onwards also brought Māori women into cities, giving them both independent income and access to alcohol, as well as detaching them from traditional support structures (Hutt, 2003).

In the early 21st century, ambivalence and diversity remained. Durie (2001) cites as examples bans on alcohol at many marae, and high rates of abstinence from alcohol in Māori compared to non-Māori, at the same time noting that Māori have high rates of alcohol-related problems, including alcohol-related illness and death. The use of alcohol has also become wider for example; it is often given as a 'gift' as a gesture of appreciation and it plays a significant role in many ceremonial functions such as tangi, weddings and christenings.

2.1.2 The current context of Māori and their relationship with alcohol

Māori experience an excess burden of mortality and morbidity throughout life, starting with a higher infant mortality rate (mainly due to SIDS), higher rates of death and hospitalisation in infancy, childhood and youth (predominantly from injuries, asthma and respiratory infections), and higher mortality and hospitalisation rates in adulthood and older age (especially from injuries, cardiovascular disease, diabetes, respiratory disease and most cancers). Harmful alcohol use is a contributor to many of these illnesses and diseases, contributing as a risk factor of non-communicable diseases, and leading to injuries and premature loss of life in young people. Alcohol can also cause fetal alcohol spectrum disorder (FASD) which can occur when a women drinks during pregnancy. This is of particular concern for Māori women as they begin their childbearing earlier than non-Māori which may lead to an increased potential for an 'at risk pregnancy'. FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications for the individual, their family and the wider community. Data show that Māori women have distinctive alcohol consumption patterns, and combined with their fertility patterns, it means that they have a different picture of risk for the possibility of an alcohol-exposed pregnancy, compared to other groups in the population (Stuart, 2009).

The 2007/08 New Zealand Alcohol and Drug Use Survey presented findings about alcohol use in the New Zealand adult population (16 to 64 years of age). From 1996/97 to 2007/08 there was a significant increase in the prevalence of past-year alcohol consumption for both Māori men and Māori women, adjusted for age. Māori past-year drinkers generally consumed alcohol less frequently than non-Māori past-year drinkers; however Māori consumed a large amount of alcohol on a drinking occasion more frequently than non-Māori. One in four Māori past-year drinkers had consumed a large amount of alcohol at least weekly. Alcohol can directly cause aggression. A New Zealand study showed that more than half of all physical and sexual assaults that were reported were carried out by people who had been drinking and the chance of being a victim increased with increasing alcohol consumption as well (Connor, You & Casswell, 2009). This also translates to violence in the home and children are often witnesses to such acts of violence.

Among people who had ever consumed alcohol, Māori were significantly more likely than non-Māori to have started drinking alcohol when they were 14 years or younger. This risky pattern of drinking is significant due to this period being a crucial time for brain development in a young person. Adolescent binge drinking is a risk behaviour associated with significant later adversity and social exclusion. Binge drinking may also contribute to the development of health and social inequalities during the transition from adolescence to adulthood (Viner & Taylor, 2007).

Overall, 2.4% of Māori aged 16-64 years had received help to reduce their level of alcohol use in the past year, and a further 2.4% had wanted help to reduce their alcohol use in the last year but had not received it. Māori people generally have lower access rates to treatment services than non-Māori (MOH, 2011).

Māori, and particularly Māori women, were significantly more likely to have experienced harmful effects (e.g. on their friendships or social life, home life and/or financial position) from their own alcohol use in the last year compared with non-Māori. In particular, Māori women were almost four times more likely to have experienced assault (physical and/or sexual) in the past 12 months due to someone else's use of alcohol or drugs than non-Māori women, adjusted for age. For children, exposure to these types of experiences within their household can cause long-term psychological damage. The harm to others that alcohol use can cause is discussed further below.

The Youth 2007 survey presented findings from a large national survey of young people attending secondary schools in New Zealand; of which 1,702 students were of Māori descent. Findings on alcohol use among young people were included in this report.

Eighty-five percent of Māori students reported that they had ever used alcohol and 73% reported that they are current drinkers. 44% of Māori students thought it was okay for them to drink alcohol regularly. Most Māori students (78%) reported that their friends regularly drank alcohol and 66% reported that their parents drank alcohol regularly at home. Of the current drinkers, about half (51%) reported binge drinking (consuming 5 or more alcoholic drinks within one four hour period). When Māori students drink alcohol, they usually drink with their friends (90%), with whānau (60%), or with 'other' people (32%). These findings bring forth issues about parental supervision and role modelling, binge drinking effects on brain development and social influences on alcohol use.

The most common sources of alcohol for Māori students who were current drinkers were from parents (53%), friends (58%) or 'someone else' (44%). Sixteen percent reported that they bought alcohol themselves, most commonly from a bottle or liquor store (70%). Of those Māori students who had bought their own alcohol, almost half (47%) reported that they were 'hardly ever' asked for ID for proof of age. The most common types of alcohol consumed (in descending order) were Ready to Drinks (RTDs), beer, spirits and wine. Issues that arise from these findings include ease of access to alcohol by young people, the supply of alcohol to young people by others and the illegal supply of alcohol to young people under 18 years of age by licensed outlets.

The most common problems associated with drinking alcohol were; doing things that could have got them into serious trouble (reported by 28% of current drinkers) and getting injured after drinking alcohol (27%). Thirty-four percent of all Māori students reported that within the previous month they had been a passenger in a car with a driver who had been drinking alcohol. Of those Māori students who had driven on a public road, 15% reported that they had driven a car after consuming alcohol. These findings suggest that although the televised social marketing campaigns have contributed to the decline in drink driving statistics in New Zealand, there is obviously still work to be done in getting the drink driving message through to New Zealanders, including our young people.

According to the findings of the 2007/08 New Zealand Alcohol and Drug Use Survey (Ministry of Health 2009), almost 1 in 5 (18.8%) drinkers aged 16–17 years had experienced injuries in the past year due to their own alcohol use. Prevalence of having an injury was highest for both men and women aged 16–17 years (15.0%). Men (7.2%) were significantly more likely to have experienced an injury in the past year due to their own alcohol use than women (5.1%). In the last New Zealand youth survey (Ameratunga S 2011), 21.7% of current drinkers reported that the most common type of harm they incurred was being injured. Of those injured, the proportion was highest for Māori (27.1%) as compared to Pacific (23.5%), NZ European (21.1%), Other (19.4%) and Asian (10.1%) respectively. A little over 8% of current drinkers reported injuring someone else. The recent survey (Clark T C 2010) of students attending Alternative Education facilities found that 50% of students who currently drank had needed medical treatment for an alcohol-related injury and a further 79% reported that they had injured someone else while they were drinking. In another New Zealand survey (Kirkwood L 2009) of 972 participants, 30% said they had been injured as a result of drinking.

Perhaps the most alarming figures are the ones which tell us of the premature loss of life from a preventable cause, for example from the misuse of alcohol. The loss of a young person is both devastating for the family and friends involved, but also has negative ramifications for their country's economy in terms of lost productivity in the future. The recently published Child and Youth Mortality Review Committee's (2009, published in 2011) special report on the involvement of alcohol consumption in the deaths of children and young people from 2005-2007 suggests that an average 61 children and young adults aged between 4 weeks and 24 years and 364 days died because of their or someone else's drinking. The proportion of alcohol involvement deaths was highest for motor vehicle accidents (31%), closely followed by falls (30%), assaults (29.6%), poisoning (20.6%), drowning (15.7%) and suffocation (9.7%). In 32% of deaths, the death occurred due to someone else's drinking.

The harm that alcohol misuse causes to others is a worrying trend as mentioned above, and an area that is capturing the interest of researchers. Alcohol use by a parent, caregiver or supervisor has been recognised as an important contributing factor to the overall burden of child injuries (Bijur P E 1992).

There is also evidence gathered in a New Zealand literature review for the Families Commission suggesting that heavy alcohol use by a caregiver is associated with a range of negative child and adolescent outcomes including injuries, poisoning, child neglect and child abuse (Girling M 2006).

Another recent study on the relation of caregiver's (mothers and fathers) alcohol use to unintentional childhood injury by Damashek and colleagues (2009), who interviewed 170 mothers of toddlers about their children's injuries for the period of 6 months found that caregiver who reported alcohol use contributed to higher risk and severity of childhood injuries. Even small amounts of alcohol contributed to the risk of injuries and there was a direct correlation between the number of drinks and the severity of injuries. Caregivers who did not consume alcohol while supervising reported lower likelihood and severity of injuries.

A recent New Zealand study found that a large proportion of New Zealanders report that they experience physical, social, economic and psychological harms because of the drinking of others (Casswell, Harding, You, & Huckle, 2011). Eighty-four percent of these respondents indicated that they experienced adverse impacts from the drinking of the person who most affected them. Among younger respondents (12-29 years) over 95% of those who reported one person who most negatively affected their life reported at least one specific harm because of this person's drinking (Casswell et al, 2011). Seventeen percent of respondents with children in the household reported that their children experienced harm because of the drinking of someone else (Casswell et al, 2011). Eleven percent of those with children living in the household indicated that the child had been yelled at or verbally abused because of someone else's drinking. Furthermore, 7% children had witnessed violence in their home due to someone else's drinking and 2% reported that child protection services were called because of someone else's drinking The considerable impacts on children found in this study fit with previous research that indicates that heavy alcohol use in the family is a risk factor for child abuse (Walsh, MacMillan & Jamieson, 2003).

2.2 The extent of public investment in Māori children across the health, education, social services and justice sectors – and whether this investment is adequate and equitable

In the Youth 2007 survey, 16% of current drinkers reported that they were worried about their alcohol use, and 18% reported that they had tried to cut down their alcohol use. Māori students reported that if they were concerned about their alcohol or drug use they would seek help from friends (69%), parents (56%), school guidance counselor (43%), family doctor (34%), school nurse (21%), teachers (19%), 'other' (21%), and 31% would talk to a drug and alcohol service. Six percent of all Māori students reported having difficulty within the previous year accessing drug and alcohol services, and 23% reported having difficulty within the previous year accessing any type of health services when they needed one. In general, it appears that accessing support and services for alcohol concerns is difficult for young Māori, and these findings suggest that the public investment in appropriate and accessible alcohol and drug services for young Māori is inadequate. The Mental Health, Alcohol and Drug Sector Performance Monitoring and Improvement Report (MOH, 2011) showed that young Māori accessed alcohol and drug services less than non-Māori and waiting times to receive treatment were longer for young people than older people and also for Māori.

Currently, alcohol is not seen as a priority in public health funding and no 'targets' are in place. In addition, the health sector, like many others, is under constant pressure and scrutiny to cut costs. This is concerning in terms of both the long-term impact this will have on wellbeing and health outcomes for all New Zealanders, and the economic importance of investing in public health interventions, as explained earlier. For example, most recently there have been funding cuts for the CAYAD (Community Action on Youth Alcohol and Drugs) programmes and also the injury prevention sector, both of which work directly and indirectly to reduce inequalities in Māori health. The Alcohol Advisory Council and the Health Sponsorship Council have also been recently disestablished and it is unclear how effective the new Health Promotion Agency (HPA) will be in addressing Māori health outcomes, particularly as the legislation establishing the HPA fails to mention reduced inequalities as an intended outcome. Harmful alcohol use has had disastrous consequences for both our young and Māori people. These changes appear to be a short-term attempt at cost cutting rather than taking a long-term, multi-sectoral approach to the investment in preventable and evidence-based health interventions.

2.3 How public investment in the health, education, social services and justice can be used to ensure the wellbeing of Māori children

Evidence suggests that public investment to increase health and wellbeing and reduce inequalities should first focus on the determinants of health as discussed below (Marmot, 2011). Investment should also be made in culturally specific services to increase access for at risk populations and increase the effectiveness of the service for the Māori population. Any significant reduction in alcohol-related harm among Māori young people will require a multipronged approach and strategies aimed at preventing the early uptake of alcohol use, reducing the accessibility affordability of alcohol and banning marketing and advertising, particularly that which is targeted at young people. The evidence points to developing effective, culturally relevant and youth-appropriate services for Māori youth when they want to address their alcohol misuse (MOH, 2002).

As mentioned above, investment in evidence-based public health interventions is effective both at improving health and wellbeing outcomes for at-risk populations, and economically speaking.

Increased investment in health impact assessment approaches should also be undertaken. Good policy is robust policy and health impact assessments aid the development of good policy by allowing the policy-maker to enhance the positive and reduce the negative effects of the proposed policy. It has also been shown that health impact assessments improve health and reduce health inequalities, help policy-makers incorporate evidence into policy-making, promote a participatory, consultative approach to policy-making and help policy-makers address public health requirements in legislation and policy (MOH, 2007). Specific health impact assessments that would be useful for this inquiry are the Child Health Impact assessment and the Whānau Ora Health Impact Assessment tools.

2.4 The social determinants necessary for healthy growth and development for Māori children

Disparities in health between Māori and non-Māori have been evident for all of the colonial history of New Zealand. Explanations for these differences involve a complex mix of components associated with

socioeconomic and lifestyle factors, availability of health care, and discrimination (Ellison-Loschmann, & Pearce, 2006).

In order to improve population health status and reduce health inequalities, it is important to identify and understand the main factors that protect and promote good health - determinants of health. The social and economic factors that have been shown in a variety of settings to have the greatest influence on health are income and poverty, employment and occupation, education, housing, and culture and ethnicity. Social cohesion or social connectedness are of increasing interest and are also discussed. There is now good evidence that social, cultural and economic factors are the most important determinants of good health.

Māori children suffer disproportionately in low living standards. This has high social and economic costs, and reflects in the low well-being of many Māori and Pasifika children. Of the 200,000 children living below the poverty line in New Zealand, just 30% are Māori (University of Auckland, 2011). As a result Māori children experience significantly poorer health, educational, and social outcomes than other groups (Henare, Puckey& Nicholson, 2011).

One of a range of indicators of health status is life expectancy, which demonstrates an inequality in outcomes for Māori. There are marked ethnic differences in life expectancy. In 2005–2007, male life expectancy at birth was 79.0 years for non-Māori and 70.4 years for Māori, a difference of 8.6 years. Female life expectancy at birth was 83.0 years for non-Māori and 75.1 years for Māori, a difference of 7.9 years (MSD, 2010). In the report on Maori Child and Youth Mortality 2002/2003, overall the highest number of deaths due to specific causes were; death due to transport/vehicular injury (95 deaths or 19.9%), suicide (76 deaths or 15.9%), sudden unexpected death in infancy (SUDI) (68 deaths or 14.2%). Overall these three causes made up half of all Māori child and youth deaths. Unintentional injury deaths were almost one in three of all Māori child deaths. Vehicular related deaths were almost two-thirds of these deaths (95 of 154). Drowning, followed by poisoning were the next most common. Over 2002 and 2003 there were 23 deaths in Māori children and youth that were due to drowning (Child and Youth Mortality Review Committee, 2006). We believe that alcohol use is likely to be a significant factor in these deaths – either directly or indirectly.

2.4.1 Income and Poverty

Income is the single most important modifiable determinant of health and is strongly related to health and well-being (NHC, 1998). The link between poverty and ill health is clear; with few exceptions, the financially worst-off experience the highest rates of illness and premature death. Greater income inequality within society may also be associated with increased overall mortality. Both poverty and income inequalities have increased in New Zealand over the past decade (NHC, 1998).

The relationship between alcohol and poverty is complex in that it can act as both a protective and a risk factor, as can relative wealth. Alcohol use and poverty, when they occur together, intensify the damage done by the other (Samarasinghe, 2009). The obvious connection is the effect on health. A poor person who drinks heavily is much more likely to suffer damaging health consequences from alcohol than a wealthy person drinking equivalent amounts. The greater impact includes, for example, the loss of income from taking time off work which may mean poorer nutrition for the family, inability to access health services, and/or a reduced ability to meet their children's needs such as educational requirements. More subtle effects include the effect of alcohol on such things as how we relate to each

other. Samarasinghe (2009) argues that there is a link between greater damage caused by alcohol and living in overcrowded and open living conditions. Māori and Pasifika groups are more likely than other groups to live in (Henare et al, 2011).

New Zealand research shows that lower socio-economic groups have heavier alcohol consumption compared to those of higher socio-economic status. In addition they are more likely to experience more severe consequences of alcohol-related harm (Huckle, You & Casswell, 2010).

Research conducted in Manukau showed that liquor outlets were more numerous in communities with lower socio-economic status, the opening hours of premises were longer, and alcohol was cheaper (University of Waikato, 2012). These conditions are shown to increase harmful effects of alcohol such as the number of violent incidents and road crashes.

This clearly demonstrates firstly that the alcohol industry continues to abuse our vulnerable populations, and secondly that measures to reduce the accessibility of alcohol will benefit vulnerable members of our society. These communities must not be burdened with additional responsibilities of controlling and regulating the alcohol industry; it is the job of both local and national Governments to achieve this through good policy and the provision of best practice services, such as increased enforcement of the liquor laws.

2.4.2 Employment

The main factor determining adequate income is participation in paid employment, particularly full-time employment. Employment also enhances social status and improves self-esteem, provides social contact and a way of participating in community life, and enhances opportunities for regular activity, which all help to enhance individual health and well-being (NHC, 1998). Unemployment is detrimental to both physical and mental health and unemployed people in New Zealand report poorer health status than people who are employed (NHC, 1998). Māori, Pacific people and young adults have much higher rates of unemployment than the general population.

Patterns of harmful alcohol use can decrease an employee's productivity; for example if they are less productive or have a sick day due to a hangover or injury. It can also increase the chance of workplace injury, particularly in labour intensive jobs such as building and driving heavy machinery.

Early use of alcohol can also undermine educational achievement and then impact on future employment options.

2.4.3 Education

Education is critical in determining people's social and economic position and thus their health. A low level of education is associated with poor health status. In general, Māori educational outcomes lag behind those of other New Zealanders. Overall, academic achievement levels of Māori students are low, rates of suspension from school are three times higher for Māori students than non-Māori, Māori are over-represented in special education programmes for behavioural issues, Māori enroll in pre-school programmes in lower proportions, Māori leave school earlier with fewer qualifications and Māori enroll in tertiary institutions in lower proportions (Cunningham, 2011).

The harmful use of alcohol can negatively affect student's performance at school and university. Anecdotally, some high school teachers report that Monday's and Tuesday's are a waste of time as students are still hungover from the weekend and Thursdays and Fridays are unproductive also as students are busy organising their weekends instead of paying attention in class. Some overseas universities have trialed compulsory classes on Friday's to try and cut down student binge drinking (Wood, Sher & Rutledge, 2007).

Educational achievement and employment are equally important in the prevention of alcohol-related harm. Low levels of academic (school) qualifications and unemployment have been found to be associated with heavier drinking patterns. In young adults in New Zealand it has been found that educational attainment is one of the most significant predictors of heavy drinking (Casswell, Pledger & Hooper, 2003).

2.4.4 Housing

Overcrowding, damp and cold housing has direct detrimental effects on physical and mental health (Krieger& Higgins, 2002). High housing costs leave less money for other budget items essential to good health including nutritious food, education, and access to health services. Research also suggests that a co-occurring risk factor that is present in alcohol misuse is living in low socioeconomic areas (Huckle, You & Casswell, 2010).

2.4.5 Health care services

Although Māori health is influenced by many factors outside the formal health sector, access to quality health services is none the less an important determinant of good health. Improving access to care is critical to addressing health disparities, and evidence suggests that Māori and non-Māori differ in terms of access to primary and secondary health care services, including alcohol treatment services (Ellison-Loschmann & Pearce, 2006).

2.4.6 Evaluation and Monitoring

A report prepared for Te Puni Kōkiri, Ministry of Māori Development titled 'Te Hoe Nuku Roa', highlighted the limitations of current models for measuring wellbeing, specifically in terms of Māori and Pasifika children and how such measurements are expressed in the country's GDP. The authors argue that GDP is a very poor way of measuring the 'good life and all its well-beings'. The emphasis has been on health and social wellbeing with a strong clinical approach to health and social service deliveries. These limited notions do not measure well-being against Māori or Pasifika holistic terms. The challenge is to identify culturally appropriate spiritual, environmental, extended family, and economic indicators of quality of life, especially for small children. To address this inadequacy, the authors argue that using a new political philosophy as espoused in the Capabilities Approach. This approach would be better able to systematically assess the four Māori-Pasifika well-beings and therefore measure poverty and wealth levels over time, and at any given time (University of Auckland, 2011).

There is also a lack of data overall on Māori child health and wellbeing.

2.5 The significance of Whānau for strengthening Māori children

A large amount of research suggests that the nature and quality of the family environment plays an important role in predisposing young people to the misuse of alcohol (Van Der Vorst, Engels, Meeus, Deković & Van Leeuwe, 2005). Factors associated with alcohol misuse by young people include: parental alcohol problems; early age of first drink; family dysfunction; childhood maltreatment and related conditions (Van Der Vorst et al, 2005).

Research shows that to effectively engage with young people, their parents are the best avenue to reach them with your messages (Drug Info Clearinghouse, 2008). Parents that we work with have told us that they are at a loss of how to handle alcohol and their teens. Internationally, investments in evidence-based interventions that provide parents with the tools and confidence to tackle this difficult issue have been useful. We also know that parents are important role models for their children and that the behaviour towards alcohol is important. This also translates to other adults that are visible in society, such as politicians, celebrities and sports people.

The overall aim of Whānau Ora is: Māori families supported to achieve their maximum health and wellbeing (MOH, 2007). Amongst the key themes included in the Whānau Ora framework is an emphasis of working directly with whānau, hapū, iwi and Māori communities. In short, it is important that these groups are involved in strengthening and determining the outcomes for Māori children.

2.6 Policy and legislative pathways to address the findings of this inquiry

Marmot (2011) says that to reduce health inequalities it will require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximize their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure health standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

Evidence based policy measures exist that could be used to reduce alcohol-related harm. Based on the findings of Connor et al (1995), the focus of these interventions in New Zealand should be on the reduction of alcohol-related injury, and the reduction of the disproportionate burden of alcohol on Māori. However, both of these objectives involve modifying drinking patterns, which are largely socially and culturally determined. Therefore, as well as targeted strategies, policy measures aimed at the modification of the wider drinking environment in New Zealand is required.

Specific alcohol-related policy measures and strategies that evidence shows to be effective in decreasing alcohol-related harm are as follows:

Although we do not know what the findings of this inquiry will be we do know what the evidence says will be effective in addressing this issue. We therefore recommend the following policy and legislative measures:

Alcohol specific recommendations

Policy measures

1. Strengthen the new alcohol legislation to include the three 'best buys' (in terms of cost and outcome effectiveness). These are: raise the taxes on alcohol, restrict the access to retailed alcohol and enforce bans on alcohol advertising. The recent disclosure of a public opinion survey on alcohol attitudes in New Zealand showed significant support for such measures (Peck, 2011). Currently, none of these measures are included in the new Alcohol Reform Bill. Evidence shows however, that these policies would have a significant impact on decreasing alcohol-related harm, particularly amongst at risk populations, such as young people and Māori (Babor et al, 2010).

2. Decrease the legal blood alcohol content for adult drivers from 0.08 to 0.05 or below

3. Increase treatment options for alcohol dependency, in particular Māori specific treatment models

4. Raise the purchase age from 18 years to 20 years for both on and off licenses

5. Recognise that there are children in our society whose brain and genetic potential have been permanently compromised by prenatal alcohol exposure and that these children are particularly vulnerable.

6. Acknowledge that Fetal Alcohol Spectrum Disorder (FASD) is a disability and needs to be a funded policy priority across health and social services.

7. Ensure that the new Health Promotion Agency has a strong and autonomous alcohol-related function that uses evidence-based solutions to carry out their work.

8. Build capacity across sectors and communities for a stronger evidence-based response to alcohol-related harm.

9. Ensure GP's are assessing risks of harmful drinking by screening and are confident in responding to this by either using early and brief interventions, or referring to appropriate services.
10. Support parents to be well-equipped to act with confidence and communicate effectively with their children about alcohol and reduce the supply of alcohol to children/young people.

11. Investment in education and public service approaches to reduce alcohol-related harm should be redirected to more effective measures or aimed at support the uptake or compliance of more effective policies.

12. Adequately fund/increase investment into preventative interventions to address alcohol-related harm. Extra funding for community action and health promotion to prevent alcohol-related harm could come from an increase in tax on alcohol. The revenue from increased alcohol tax should be streamed back into prevention and treatment for alcohol-related issues. For example, the 'Sin Tax' that funds the Thai Health Fund.

Targeted strategies and interventions

The Australian Guidelines to reduce health risks from drinking alcohol recommends that for children and young people less than 18 years of age, not drinking alcohol is the safest option. Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important. For young people aged 15-17 years, the safest option is to delay the initiation of drinking for as long as possible.

For Māori youth, measures that restrict access to alcohol are important. Any significant reduction in alcohol-related harm among Māori young people will require a multi-pronged community approach that is culturally relevant and engages whānau, schools, the wider community and agencies. It is imperative however that these community approaches are underpinned by effective and supportive legislative and governmental strategies (as detailed above). The evidence points to developing effective, culturally relevant and youth-appropriate services for Māori youth that they can readily access when they want to address their alcohol misuse. Māori will need to be engaged in determining the most effective way to enable this.

Delivering these policy objectives will require action by central and local government, government ministries, NGOs, private sectors and community groups. National policies will only work with effective delivery systems focused on health equity in all policies.

General recommendations

13. Establish a political consensus that is based on an investment approach to improving child wellbeing. Currently, we rank as one of the best performing nations in the world in terms of aged poverty. This result can be attributed partly to the emergence of a cross-party accord in relation to national superannuation. Children's issues would be best served by a comparable cross-party accord.

14. Introduce child impact assessment of new policy and programmes. More investment should also be made to implement Whānau Ora Impact Assessments where appropriate.
15. A commitment to undertaking research on the effectiveness of specific early childhood interventions within specific communities, and resourcing those communities to identify and deliver solutions.
16. Improve the research/data collection/evaluation mechanisms for Maori children; including creating clear and measurable targets for child wellbeing and designing evidence-based interventions that reinforce positive development across their lifecycle. These should align with Māori models of health.
17. Enable multi-sectoral responses to child poverty and other family issues, coordinating central and local government efforts, and prioritising action for the youngest children and their families.
18. Invest in mental health and addiction services for children and youth. These are currently less well-developed than services for adults. Lower Māori child and youth access rates to these services also need to be addressed.
19. Māori people, including young Māori, need to be involved in the formulation, implementation and evaluation of policies in a meaningful way. The adoption of a political philosophy such as the Capabilities Approach (Nussbaum, 2011) may allow for more accurate assessment of well-being measures within the Maori-Pasifika worldview. It addresses human rights and social justice and offers better systems for Māori and Pasifika to evaluate the effectiveness of policies in terms of well-being for themselves.
20. An equal recognition of both economic and social goals is imperative.
21. A poverty removal strategy should sit alongside the wealth creation strategy to reduce the poverty experienced by too many of our Māori children and their whānau.
22. Support a multi-sectoral and preventative approach to improving the wider determinants of health and lifestyle patterns and decreasing inequalities.

In conclusion, it is important to ensure that Māori are engaged in determining the achievement and implementation of these policies to make certain they are effective for Māori and protect against unintended consequences.

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