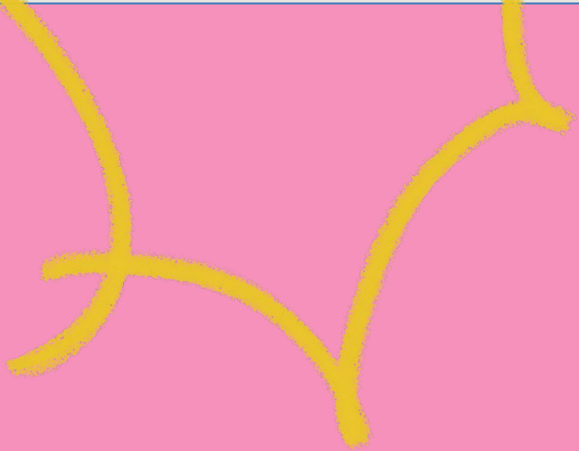

Identify Survey Findings for Young People with Oranga Tamariki Involvement: Health and Wellbeing Report.

ISBN: 978-0-473-71098-9

Inner cover - publication details
https://www.identifysurvey.nz
ISBN number: 978-0-473-71098-9
Recommended citation: Fenaughty, J., Cooper, G., Harrison, K., Padlie, K., Pasley, A., Mackie, K., Stewart, O., & Stonex, Z. (2024). Identify Survey Findings for Young People with Oranga Tamariki Involvement: Health and Wellbeing Report. Identify Survey: Auckland.

Acknowledgements

The depth of analysis and insights in this report would not have been possible without the matāuranga and expertise of the rangatahi co-authors, with care-experience, who have been involved throughout the project. As such, we especially acknowledge (in alphabetical order):

- Grayson Cooper
- Kat Padlie
- Karah Mackie
- Oliver Stuart

We also acknowledge VOYCE-Whakarongo Mai for their partnership and generosity in this work. VOYCE-Whakarongo Mai was instrumental in identifying young people to participate in the construction of these reports and co-facilitated the production of the analysis. We especially acknowledge the contributions of Kath Harrison who participated in every hui and was the lead at VOYCE-Whakarongo Mai on the project. We also acknowledge the contributions of Zoe Stonex and Tayla Taylor to the various parts of the project. We are grateful to Dr Lynda Bavin, who provided invaluable formatting and polishing support for this report.

We thank the Oranga Tamariki Evidence and Policy Team for peer-review comments that have helped to improve this report.

The *Identify* Survey on which these insights were generated from would not have been possible without the input and support of the following people and organisations:

- The community partner organisations, InsideOUT Kōaro and RainbowYOUTH, who helped ensure the survey was relevant to the needs of young people in Aotearoa New Zealand
- The *Identify* investigators: Dr Mohamed Alansari, Tabby Besley, Dr John Fenaughty (Principal Investigator), Dr And Pasley, Alex Ker, Dr Elizabeth Kerekere, Dr Peter Saxton, Pooja Subramanian, Dr Patrick Thomsen, and Dr Jaimie Veale
- We gratefully acknowledge Dr Elizabeth Kerekere's expertise and guidance as an investigator on the conceptualisation, collection, and interpretation of data for takatāpui/Māori participants, whānau and communities
- The community members, academics, organisations and young people who attended our community hui in Te Tai Tokerau, Tāmaki Makaurau, Te Whanganui-a-Tara and Ōtautahi, and those who gave feedback on our draft surveys
- The team at Curative for developing an appropriate brand, communication strategy, and visual language, to engage participants and stakeholders
- Frances Arnes who was involved in the initial phases of the research as a co-investigator while leading RainbowYOUTH
- Special thanks to Shaneel Lal, Tycho Vandenberg, Jack Byrne and Rachel Johnson for helping us develop specific questions

- We acknowledge Aych McArdle and Ricky Te Akau for their excellent support with participant engagement and recruitment
- Additional thanks to Alex Ker and Dr Kyle Tan for their support in preparing the data for analysis
- The University of Auckland Faculty of Education and Social Work and other funders (see below) for making this study possible
- Finally, but most importantly, the survey participants — your experiences matter and have made this report possible. Thank you for your trust and for taking the time to share your experiences with us.

Funding and Support

The four reports that focus on the experiences of young people with Oranga Tamariki involvement have been funded by Oranga Tamariki.

Identify was funded by The University of Auckland’s Faculty of Education and Social Work Faculty Research Development Fund (under grant agreement 3719526). The Rule Foundation (Grant PRF00056) and the University of Auckland Performance Based Research Fund Grants provided additional targeted funding to improve recruitment efforts. Additional in-kind support has been provided by host institutions of the investigators, including New Zealand Council for Educational Research, InsideOUT Kōaro, RainbowYOUTH, The University of Auckland and the University of Waikato.

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1 How to use this report

This report, along with the other reports in this series, builds on the initial Community and Advocacy Report from *Identify*. The Community and Advocacy report provides an overview of key areas of relevance for a range of takatāpui and rainbow young people in Aotearoa New Zealand. This report focuses on *some* of the current issues and priorities for takatāpui and rainbow young people that have had involvement with Oranga Tamariki or Child Youth and Family Service (CYFS) in relation to their experiences in secondary school.

We also recognise that reading and engaging with the findings in this report can be distressing. People reading the report, including whānau/family and friends and allies of takatāpui and rainbow young people, may need to access helpful supports and resources. We have provided a list of mental health supports and resources towards the end of this report.

The survey included additional items that are not included in this report (see Identify survey for researchers), and we invite other organisations or individuals interested in other analyses, including with sub-groups in the study, to contact us (identifysurvey@auckland.ac.nz).

The quotes in this report come from participants who shared their experiences in response to a range of specific open-text response questions throughout *Identify*. They are used to give more insight into some of the points made throughout the report, rather than representing the key themes across all participants' open-text responses. We have not edited these quotes, so the way they are represented here is how participants wrote them in the survey.

Definitions for the key terms, including some words that are *italicised*, are provided in the Glossary.

1.1 The words we use throughout this report

In this report, we use the terms takatāpui and rainbow collectively to include MVPFAFF+ and Rainbow Pacific identities and LGBTQIA+ people — that is, people whose genders, sexualities, and/or variations in sex characteristics exist beyond cisgender, heterosexual, and endosex norms. We recognise that everyone relates to the term rainbow differently, and that many of the words used, including rainbow, throughout the survey and this report are within a Pākehā framework of understanding gender, sexuality, and sex characteristics. Although we use rainbow inclusively in the report and the survey, care must be taken to recognise the diversity that can be obscured by this umbrella term. Where specific groups of young people within this umbrella term are discussed, we make this explicit in the text.

1.2 Explanation of statistical language and making sense of the stats

- The **mean (M)** is the average of a sample. It is found by dividing the sum of the values for a sample, by the number of cases in the sample
- **Standard deviation (SD)** measures how spread out the sample is in relation to the mean. That is, a larger standard deviation means that there is a greater difference between the mean and the upper and lower bounds of the sample, whereas a lower standard deviation means that the values in the sample are closer together
    - 68% of the values will fall within one standard deviation of the mean, and 95% of the values will fall within two standard deviations, assuming a normal distribution
- ***N*** refers to the total number of the *Identify* sample population. Sometimes, we also use *N* to show the total number of participants who answered a particular question, in cases where we also show the smaller percentages of that number (or ***n***)
- ***n*** refers to a subset of the *Identify* sample population. The *n* is used to show the number of participants who gave a certain response, out of those who were shown the question
- **Percentages** are based on the valid responses to each question. In *Identify*, not all participants were given the opportunity to answer every question, and participants may have skipped some questions
- A **proportion** is a part (usually a number) with a size that is relative to other parts
- Please note that integers are used for simplicity, so decimal places are rounded to 0, based on Swedish rounding
- **Statistical significance** refers to cases where the differences between groups are statistically meaningful (in most cases here, focused on whether it mattered if participants had been involved with Oranga Tamariki or not). Where differences are not significant, this means that the potential error of the measurement overlaps, so the values are practically equivalent.

2 Executive summary

The final report in this series focuses on health and wellbeing. The placement of this report at the end of this series of four reflects the need to consider these findings alongside the multiple disparities identified in the other reports. Although the analysis is cross-sectional and correlational, the disproportionate stressors and challenges reported by takatāpui and rainbow young people with involvement in Oranga Tamariki no doubt play a major role in the disparities identified here. To improve health and wellbeing outcomes requires improved access to unbiased and effective healthcare, as well as systematic improvement across all key domains of these young peoples' lives, including their homes, living situations, communities, peer groups, schools, sports teams, and places of worship.

This report is the outcome of a collaboration of care-experienced rangatahi, VOYCE - Whakarongo Mai kaimahi, and academic researchers, to identify and explore some key aspects of health and wellbeing outcomes for takatāpui and rainbow young people who have been involved with Oranga Tamariki. Given the well-established health disparities for takatāpui and rainbow young people in general, it is vital to understand whether takatāpui and rainbow young people who have had involvement in Oranga Tamariki also face disparities in this domain.

The *Identify* survey is the largest study focused on takatāpui and rainbow young people (aged 14-26) in Aotearoa New Zealand to date. This survey was live between February and August 2021. In total, 4784 rainbow and takatāpui young people were included in the analyses. As part of the Identify Survey, participants were asked "Have you ever been involved with Oranga Tamariki (OT) or Child, Youth and Family Services (CYFS) as a young person?", and those who responded yes are the focus in these series of reports.

This report draws on a diverse sample of rainbow and takatāpui young people who reported that they had been involved with Oranga Tamariki, including 186 (44.4%) who were currently in secondary education, 122 (29.1%) who were in post-secondary education, and 110 (26.3%) who were not in education but were either in paid or unpaid employment, or were unemployed. A detailed summary of participant demographics is provided in the first report in this series.

Ensuring that takatāpui and rainbow young people who have had some involvement with Oranga Tamariki can access effective and unbiased healthcare services is crucial for their overall well-being and development. For this group of young people, who may frequently face disruption and relocation, effective and affirming healthcare provision is especially important. Unbiased healthcare services can contribute to building trusting and positive relationships between young people and healthcare providers, supporting open discussions so they young people can receive appropriate medical advice and interventions.

The provision of effective healthcare for young people who have had involvement with Oranga Tamariki is particularly important given the findings in this report. For instance, general and mental health disparities are strongly evident, with a greater proportion of participants with Oranga Tamariki involvement reporting poor general well-being, non-suicidal self-injury (NSSI), thoughts of suicide, planning suicide, and suicide attempts in the past year. The higher levels of suicidality, NSSI, and serious injury post-suicide attempt suggest acute mental health needs, possibly linked to prejudice, intersectional experiences, and structural inequalities. Trauma, both prior to and during involvement with Oranga Tamariki, may be a significant factor contributing to these acute mental health issues.

Trans and non-binary participants with involvement face distinct challenges, reporting higher levels of NSSI, suicidal thoughts, and suicide attempts. Gender-affirming healthcare is highlighted as a crucial aspect, with a need for improved access, caregiver education, and responsive healthcare practices. Access to gender-affirming medication for trans and non-binary participants is examined, revealing both positive impacts and barriers such as a lack of information and non-supportive caregivers.

The report also returns to the mental health effects of sexual orientation and gender identity conversion efforts (SOGICE), emphasising the value of preventing and responding to such experiences. Access to healthcare is a prevalent concern, with a significant proportion reporting foregone healthcare and discrimination based on their rainbow identity. An intersectional approach is recommended to address healthcare discrimination, with a focus on school-based and post-secondary health services.

Despite relatively broad healthcare access, high levels of mental health needs persist, indicating the need to address structural factors. Structural issues play a significant role in exacerbating well-being challenges, with young people reporting a lack of support and increased abusive experiences across various contexts, including school, home, religion, housing, and healthcare. Intersectional analyses reveal that those with involvement are more likely to be Māori, trans and non-binary, and disabled, increasing the risk of racism, ableism, and transphobia, which undoubtedly impact these disparities.

Overall, the report underscores the value of comprehensive, intersectional, and trauma-informed approaches to address the diverse needs of takatāpui and rainbow young people who have had involvement with Oranga Tamariki. Healthcare settings can provide a critical opportunity for improving the wellbeing of young people with Oranga Tamariki involvement. The report concludes with insights that may help improve experiences for takatāpui and rainbow young people involved with Oranga Tamariki.

2.1 Key Findings

- Overall, the health and wellbeing outcomes for takatāpui and rainbow young people who have ever had involvement with Oranga Tamariki are noticeably worse than for young people in the study who had no Oranga Tamariki involvement.

- A smaller proportion of takatāpui and rainbow young people with Oranga Tamariki involvement reported “good” or better wellbeing compared to takatāpui and rainbow young people with no involvement

- Young people who had had involvement were more likely to have reported serious mental health outcomes at least once in the past 12 months compared to young people who had not had involvement, including higher proportions of:
    - non-suicidal self-injury
    - thoughts about suicide
    - planning a suicide attempt
    - having attempted suicide

- Trans and non-binary participants who had had involvement were more likely to report a suicide attempt in the past year compared to cisgender young people with involvement

- Young people with Oranga Tamariki involvement were more likely to report sexual orientation and gender-identity change efforts designed to make them heterosexual and/or cisgender, compared to young people with no involvement

- At least one in ten young people who reported involvement with Oranga Tamariki reported being treated unfairly by a healthcare practitioner on the basis of their rainbow identity
    - Māori participants, and those with Asian ethnicity, were more likely to report rainbow discrimination from health-care providers, and Pākehā/European participants least likely

- One third of trans or non-binary participants who had been involved with Oranga Tamariki had accessed at least one form of gender-affirming medication

- Almost one in five trans and non-binary young people who had Oranga Tamariki involvement wanted gender-affirming medication but were not able to access it. The most common reasons selected by participants’ to explain their unmet need for gender-affirming medication were not knowing where to find information or how to start the process, lack of parental or caregiver support, and the cost of treatment.

- The report concludes with detailed insights that may support the wellbeing of takatāpui and rainbow young people involved with Oranga Tamariki, for instance:
    - Practices and processes at Oranga Tamariki that prevent young people from building trusting relationships with caregivers or social workers hinder healing opportunities and negatively impact mental health and wellbeing. Addressing these issues through improved processes and procedures within Oranga Tamariki could lead to better outcomes for young people with involvement.
    - Many young people with involvement report difficulties in accessing unbiased healthcare, leading to foregone healthcare. Improving healthcare access, providing inclusive services, and addressing structural factors are likely to help address the mental health disparities identified in this report.
    - Young trans and non-binary individuals face additional stigma and discrimination, and they report increased mental health concerns. Targeted efforts to provide affordable and effective gender-affirming healthcare are an option to improve the health and wellbeing of some trans and non-binary young people with Oranga Tamariki involvement.
    - Young people with Oranga Tamariki involvement are at a higher risk of trauma, which may contribute to the observed acute mental health outcomes. Efforts to prevent trauma, provide NSSI- and suicide-prevention activities, and improve care practices within Oranga Tamariki may help reduce the acute mental health outcomes seen in this report.

3 Background

3.1 About Identify

Identify is an online survey for takatāpui, MVPFAFF+ and LGBTQIA+ (rainbow) young people and allies aged 14-26 years of age in Aotearoa New Zealand. The survey data was collected in 2021, from mid-February until the end of August. *Identify* asked about young people's experiences across a range of contexts, including education, employment, home, health, values and community. The survey included questions on factors that supported wellbeing as well as challenges in these contexts.

Identify is a collaboration between rainbow community researchers and organisations InsideOUT Kōaro and RainbowYOUTH, who work with rainbow young people in Aotearoa. Our team includes principal investigator Dr John Fenaughty and co-investigators Dr Jaimie Veale, Dr Elizabeth Kerekere, Dr Patrick Thomsen, Dr Peter Saxton, Dr Mohamed Alansari, Dr And Pasley, Alex Ker, Pooja Subramanian (RainbowYOUTH) and Tabby Besley (InsideOUT Kōaro).

4 Methods

The study received ethical approval from the New Zealand Health and Disability Ethics Committee (20/NTB/276).

4.1 Survey design

After developing the first draft of our survey questionnaire, the research team held community hui across Aotearoa New Zealand and invited feedback on the survey content, structure, branding and recruitment. The hui were attended by community members, rainbow organisation representatives, young people and academics, with the opportunity for people to give feedback via email if they were unable to attend. Nine hui were held in Te Tai Tokerau, Tāmaki Makaurau, Te Whanganui-a-Tara and Ōtautahi during January and February 2020.

Questions in the survey were either developed by the research team, often following community consultation, or were replicated or adapted from existing studies with rainbow communities (e.g., *Counting Ourselves*.[1]) or youth in general (e.g., the Youth'19 Survey.[2]); While many new questions were necessarily developed, replication or

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[1] Veale, J., Byrne, J., Tan, K. K., Guy, S., Yee, A., Nopera, T. M. L., & Bentham, R. (2019). Counting Ourselves: The health and wellbeing of trans and nonbinary people in Aotearoa New Zealand. Hamilton, NZ: Transgender Health Research Lab, University of Waikato. https://countingourselves.nz/wp-content/uploads/2022/09/Counting-Ourselves_Report-Dec-19-Online.pdf

[2] Fleming, T., Peiris-John, R., Crengle, S., Archer, D., Sutcliffe, K., Lewycka, S., & Clark, T. (2020). Youth19 Rangatahi Smart Survey Initial Findings: Introduction and Methods. The Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand. https://www.youth19.ac.nz/publications/category/Reports

adaptation of key measures was important for generating data that was comparable across studies.

The survey was assembled in Qualtrics and designed so that participants were only shown questions relevant to their previous answer (e.g., only participants who reported they were at secondary school were shown questions on secondary school). Early in the survey, participants were asked if they were rainbow young people or allies or friends of rainbow people. This question was used to branch to an 'allyship pathway' in the survey, whereby allies were asked a set of questions about being a rainbow ally, and a 'rainbow pathway'. Self-identified rainbow young people were asked questions relevant to their experiences as a rainbow person. These two survey branches were analysed as separate datasets. In this report, we present the initial findings from rainbow young people.

We conducted in-person recruitment at community events, including Pride festival events in the main centres, as well as nightclub events and community meetings. Posters were placed in prominent community venues, such as queer- and trans-friendly bars and cafes, schools and tertiary institutions, and in the libraries of two large cities. Online recruitment was conducted via advertisements and posts on Facebook, Instagram, TikTok, Twitter, YouTube, and Grindr. Word of mouth, including via social media, and preliminary data 'teasers' in mainstream media stories, also advertised the survey.

The survey contained various sections addressing different areas of participants' lives, including demographics; secondary, tertiary and post-secondary education; employment and work; health; family/whānau and friends; home and living environment; and community involvement.

As part of the Identify Survey, participants were asked "Have you ever been involved with Oranga Tamariki (OT) or Child, Youth and Family Services (CYFS) as a young person?". The Identity Survey questions are framed to capture the maximum number of young people who have engaged with Oranga Tamariki, including both Care and Protection and Youth Justice. They do not specify whether the young person has entered care or youth justice custody or is engaging with Oranga Tamariki in another way.

Participants' responses were recorded anonymously, meaning the research team could not tell whom a person was by looking at their responses.

After cleaning the data, the responses of 5218 participants were included in the dataset. Of these, 92% (*n* = 4784) self-identified as a rainbow person, and 8% (*n* = 434) reported they were allies of rainbow communities. This report focuses on the experiences of the 4784 rainbow, takatāpui and MVPFAFF+ participants.

Further description of the methods from Identify is provided in the Community and Advocacy Report[3].

If you would like to find out more about any of the data or you are interested in using the *Identify* data in your research, please feel free to contact us. We welcome collaborations on analysis and further studies that align with the values and aims of *Identify*.

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[3] Fenaughty, J., Ker, A., Alansari, M., Besley, T., Kerekere, E., Pasley, A., Saxton, P., Subramanian, P., Thomsen, P. & Veale, J. (2022). *Identify survey: Community and advocacy report.* Identify Survey Team. https://www.identifysurvey.nz/s/community_advocacy_report.pdf

5 Emotional wellbeing and healthcare

Initially we present a summary of the sample demographics before reporting on emotional wellbeing and health in three sections:

- Emotional wellbeing
- Access to general health care
- Access to gender-affirming health care

5.1 Summary Sample Demographics

A summary of participants' demographics, including key differences by Oranga Tamariki involvement is provided here. Participants used a diversity of terms to describe their gender and sexual identities, often using multiple identifiers. For a fuller demographic description please see the first report in this series. Participants who reported involvement with Oranga Tamariki were, on average, half a year younger ($\bar{x} = 18.7$ years old) than young people with no involvement ($\bar{x} = 19.2$). Young people who reported Oranga Tamariki involvement were more likely to be say they were trans and non-binary (64%; n = 266) compared to their young people with no involvement (51.5%; n = 1868) (X^2 (1, N = 4046) = 22.192, $p < 0.001$).

When using the Education Counts (2021) ethnicity prioritisation framework[4], the participants with involvement were more likely to be Māori (26%, n = 107 vs. 14%, n = 488 with no involvement) (X^2 (1, N = 4054) = 44.011, $p < 0.001$), less likely to be Pākehā, NZ European or Other (65%, n = 271 vs. 74%, n = 2679 with no involvement) (X^2 (1, N = 4054) = 15.433, $p < 0.001$), and less likely to be Asian (7.4%, n = 31 vs. 10.6%, n = 385 with no involvement) (X^2 (1, N = 4054) = 4.159, $p < 0.05$). The number of Pacific participants was not significantly different by Oranga Tamariki status, however, this number (n = 9) was too low for robust statistical comparison and Pacific participants were under-represented in the whole sample (n =97).

5.2 Emotional wellbeing

We used the WHO-5 wellbeing index to measure participants' emotional wellbeing, which asked participants how they had been feeling in the past two weeks.[5] Based on their responses to these questions, nearly nine out of ten (85.0%; n = 346) participants who reported involvement with Oranga Tamariki were classed as having poor wellbeing.

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[4] Education Counts. (2021). Ethnic Codes. https://www.educationcounts.govt.nz/data-services/code-sets-and-classifications/ethnic_group_codes

[5] The original WHO-5 wellbeing index uses a 6-item scale. Due to a scale conflation in our survey, a 5-point scale was used, meaning that participants' scores (the sum of their responses to all 5 items) are not directly comparable to most other uses of the index. Participants' total scores were translated into a 100-point scale and used the cut-off of 50% or less to signal poor wellbeing, and 51% or above to indicate good wellbeing.

The proportion of young people reporting poor wellbeing was greater compared to young people who reported no involvement with Oranga Tamariki (74.4%, n = 2670; X^2 (1, N = 3994) = 22.114, $p < 0.001$).

5.2.1 Self-harm and suicide

If you need support or want to talk to someone, or know someone who needs support, you can reach out to these free confidential support lines:

- OutLine - 0800 688 5463 from 6pm - 9pm every night
- Free call or text 1737 to talk to a trained counsellor any time
- Lifeline - 0800 543 354 or text 4357.

Before asking questions about self-harm and suicide, we asked if participants were comfortable answering these questions. Almost all (94.7%; *n* = 397) OT-involved participants who were shown this question selected “I am comfortable with answering these questions”, though some (5.3%; *n* = 22) selected “I find this topic upsetting and would like to skip these questions”. Participants could also simply skip this question without selecting one of these responses and were then shown the next question in the survey and their response was noted as missing. Although not a direct indication of personal suicidality, an affirmative response to this question about finding this topic upsetting may indicate a history of suicidality. In comparison, 3.5% (n = 125) of those with no Oranga Tamariki involvement, opted to skip this section because they said they found the topic upsetting.

Of those who did say they were willing to answer these questions (n = 397), three-quarters (76.7%; *n* = 305) of participants with Oranga Tamariki involvement said they had hurt themselves on purpose once or twice (30.0%, n = 119), or three or more times (46.9%, n = 186) in the past 12 months (see Figure 1). In comparison, the rates for young people with no involvement were lower with just over half (54.1%; *n* = 1610/3508) reporting non-suicidal self-injury (NSSI) in the past 12 months X^2 (1, N = 3905) = 74.880, $p < 0.001$); a quarter of young people with no involvement reported having hurt themselves on purpose once or twice (26.1%, n = 917), and another quarter reported having hurt themselves three or more times, in the past 12 months.

Four out of five (82.6%; *n* = 328) participants with Oranga Tamariki involvement said they had thought about killing themselves in the past 12 months, which was a higher proportion compared to young people with no involvement (61.4%, n = 2148) (X^2 (1, N = 3895) = 69.278, $p < 0.001$) (see Figure 1). Two in five (43.6%; *n* = 173) of young people with involvement said they had made a plan about how they would kill themselves in the past 12 months, which was also noticeably larger proportion than those with no Oranga Tamariki involvement who reported this (26.9%, n = 942) (X^2 (1, N = 3895) = 48.359, $p < 0.001$). Concerningly, one in five (21.9%; *n* = 87) young people with involvement reported that they had tried to kill themselves (attempted suicide) in the past 12 months, and this proportion was also double that of young people with no involvement who reported this (8.5%, n = 296) (X^2 (1, N = 3895) = 72.772, $p < 0.001$). Among participants who had attempted suicide, two fifths (40%; *n* = 46) reported that these attempts resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse, and this proportion was also larger than young people with no involvement who reported requiring such treatment (15.5%, n = 92) (X^2 (1, N = 709) = 36.929, $p < 0.001$).

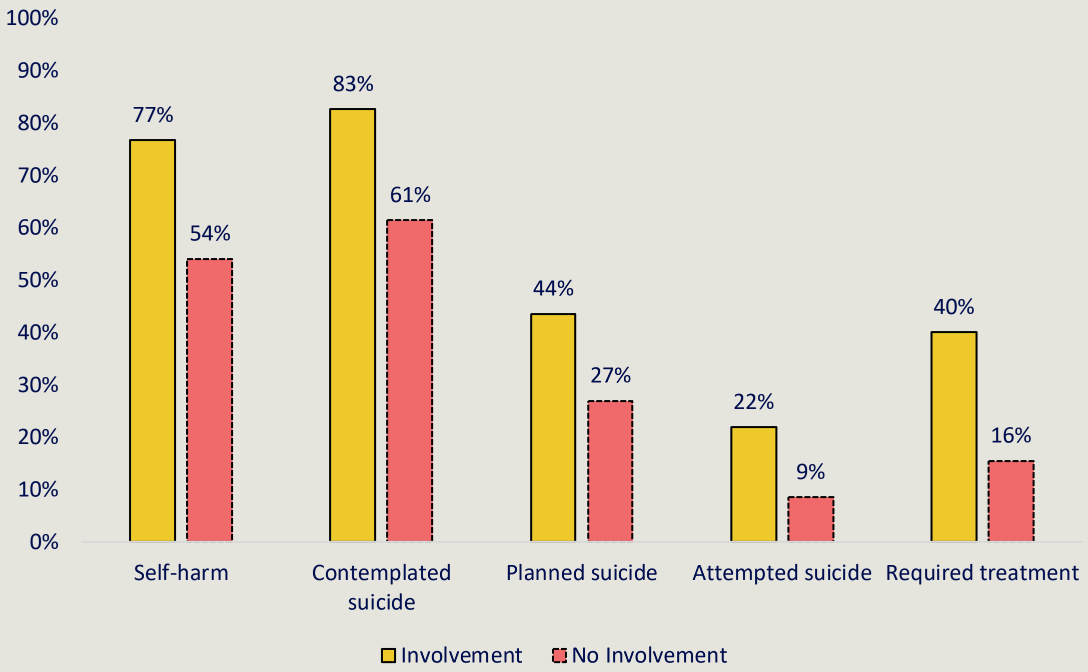

Figure 1. Proportion of participants with Oranga Tamariki involvement (N = 397) and with no involvement (N = 2498) who reported non-suicidal self-injury and various measures of suicidality, including whether treatment following a suicide attempt was required for young people with involvement (N = 115) and with no involvement (N = 594).

A further intersectional analysis identified higher rates of mental health harm for trans and non-binary participants with Oranga Tamariki involvement, compared to cisgender participants with involvement (see Figure 2). For instance, the rates of non-suicidal self-injury in the past 12 months were 83.3% (n = 210) for trans and non-binary young people with involvement vs 65.3% (n = 94) for cisgender young people with involvement (X^2 (1, N = 3897) = 16.75, $p < 0.001$). Disparities were also noted for reports of thoughts of killing themselves in the past 12 months for trans and non-binary participants with involvement (86.9%, n =219) compared to cisgender young people with involvement (75.0%, n = 108) X^2 (1, N = 3887) = 9.026, $p < 0.01$). Reports of making a plan for suicide in the past 12 months were also higher for trans and non-binary young people with involvement (48.8%, n = 122) compared to cisgender young people who were involved (37.1%, n = 20). Finally, nearly twice as many trans and non-binary young people with involvement reported a suicide attempt in the past 12 months (25.0%, n = 63) compared to cisgender young people who reported Oranga Tamariki involvement (13.1%, n = 23)(X^2 (1, N = 3887) = 4.393, $p < 0.05$). Of those who reported a suicide attempt, trans and non-binary participants with involvement seemed more likely to experience injury, poisoning, or overdose that had to be treated by a doctor or nurse as a result of their attempted suicide, compared to cisgender young people with involvement, however, the low sample size produced a non-significant result.

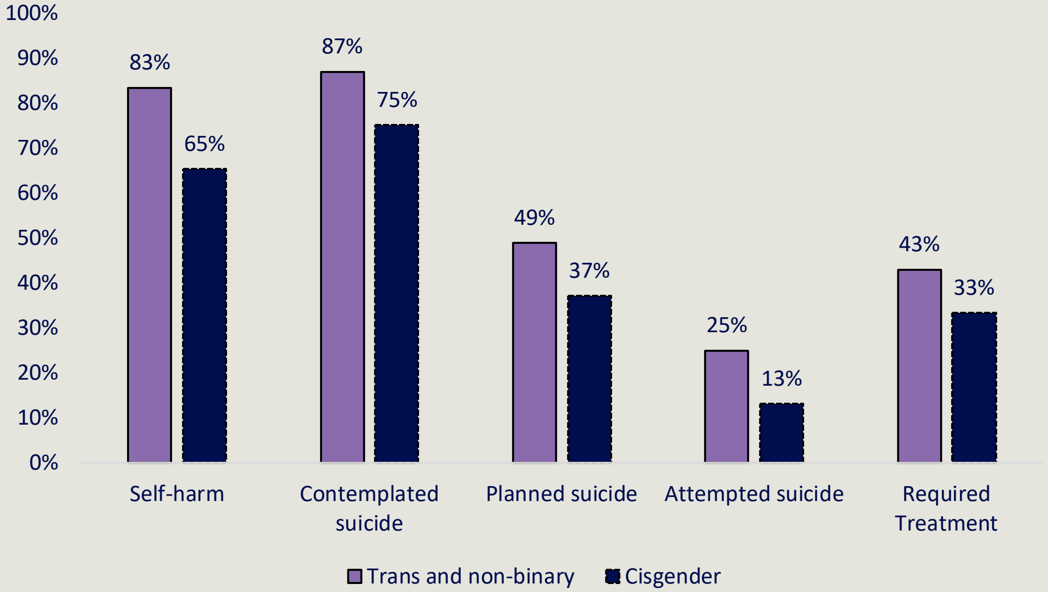

Figure 2. Non-suicidal self-injury and suicidality among young people with Oranga Tamariki involvement who were trans and nonbinary (N = 252) and cisgender (N = 144), including whether treatment following a suicide attempt was required for trans and non-binary (N = 84) and cisgender (N = 30) young people.

5.2.2 Sexual orientation and gender identity change efforts (SOGICE)

Before asking questions on conversion “therapy”,[6] we asked if participants were comfortable with answering these questions or if they preferred to skip this section if the topic was upsetting. Almost all participants who had been involved with Oranga Tamariki who answered this question said they were comfortable answering these questions (94.5%; *n* = 396), and some (5.5%; *n* = 23) selected the option to skip these questions because they found the topic upsetting. Participants could also simply skip this question without selecting one of these responses, and they were shown the next question in the survey and their response was noted as missing. Again, although not a direct indication of personal experience with Conversion therapy, an affirmative response to this question about finding this topic upsetting may indicate a history of exposure to sexual orientation and gender identity change efforts (SOGICE). Notably, the proportion of young people with involvement who opted to skip this section was twice that of the participants with no Oranga Tamariki involvement (2.6%, n = 93) (X^2 (1, N = 4050) = 11.576, p < 0.001). Of the participants who said they were comfortable

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[6] In the survey we defined conversion “therapy” as “a practice or treatment that tries to change a person’s sexual orientation or gender, or stop them from expressing their rainbow identity. It is sometimes known as reparative therapy, ex-gay therapy, and healing sexual brokenness. It can also happen in prayer sessions.”

answering these questions, one in twenty with involvement (5.1%; *n* = 20) said they had experienced conversion “therapy”, which was a higher than participants who had no Oranga Tamariki involvement (2.9%, n = 102) (X^2 (1, N = 3898) = 5.767, $p < 0.05$).

Figure 3 shows the categories of people who suggested conversion therapy to young people, highlighting the role of family and whānau (n = 16), as well as religious and spiritual leaders (n = 11) in suggesting sexual orientation and gender identity change efforts to young people with involvement.

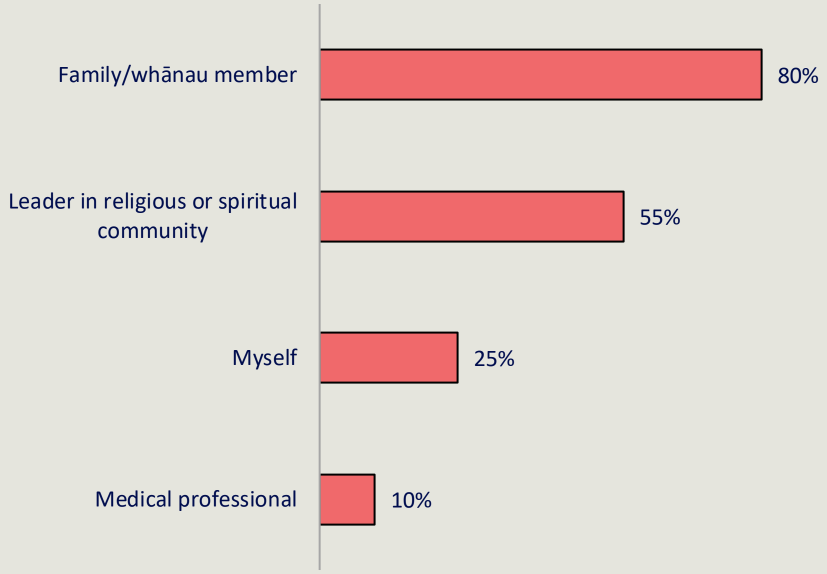

Figure 3. Categories of people who suggested “conversion therapy” to young people with Oranga Tamariki involvement (N = 20).

5.3 Access to general healthcare

In total, 419 participants with current or previous Oranga Tamariki involvement answered questions on accessing healthcare[7] in the past 12 months. Three quarters (75.0%; n = 313) of young people with involvement reported they had accessed healthcare, and fewer than one in ten (7.4%; n = 31) reported that they had not needed to access healthcare. Almost one in five (17.9%; n = 75) reported that they had not accessed healthcare, but had needed it (foregone healthcare). Rates of foregone healthcare were not significantly different by involvement with Oranga Tamariki.

Although no significant differences in foregone healthcare were reported by ethnicity and disability for participants who reported involvement with Oranga Tamariki, the sub-

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[7] We asked, “In the past 12 months, have you gone to a healthcare professional or expert because of a health issue? (This could be general, mental, sexual or spiritual health e.g., GP, counsellor, nurse, tohunga)”. This question is from the Youth2000 survey series, so that we could compare *Identify* responses to the general youth population.

sample sizes were very small and require caution when interpreting these findings (especially given that ethnicity and disability were associated with foregone healthcare for the broader sample of all young people). Those who reported foregone healthcare were asked to select from a list of reasons why they might not have seen a healthcare professional when they needed to. The reasons selected for foregone healthcare are presented below in Figure 4.

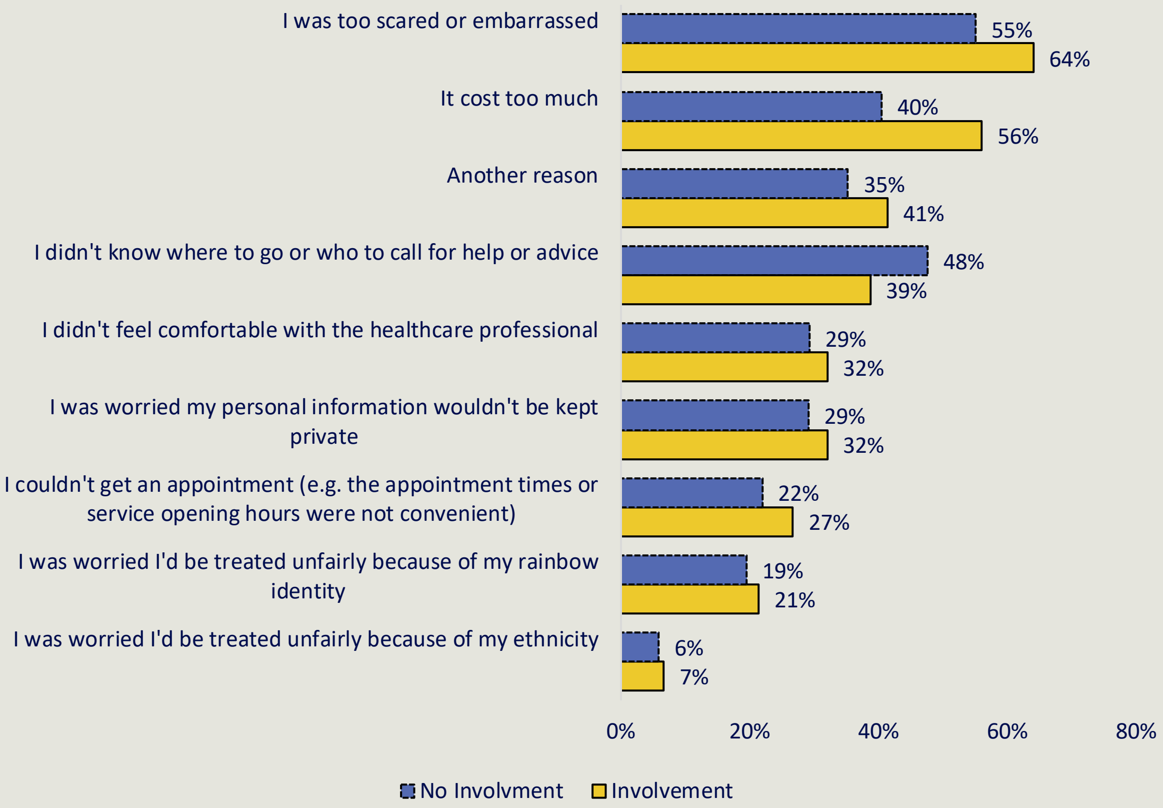

Figure 4. Reasons for not accessing needed healthcare in the past 12 months for young people with Oranga Tamariki involvement (n = 75), and with no involvement (n = 616).

Healthcare access is also often provided in education contexts. Young people with Oranga Tamariki involvement who were in secondary or tertiary education (*N* = 282) reported varying levels of comfort about talking to a health professional at their school or place of study, such as a nurse or school guidance counsellor, about issues related to their rainbow identity. In total, a third (35.1%, n = 99) reported they would feel either comfortable (23.4%, n = 66) or very comfortable (11.7%, n = 33) talking with a healthcare professional at their place of learning. Two in five (39.7%, n = 112) participants said they would feel uncomfortable (23.0%, n = 65) or very uncomfortable (16.7%, n = 47) doing so, and one quarter (23.0%, n = 65) said they felt neutral about this or that it does not apply (2.1%, n = 6). Rates of comfort or discomfort were not statistically different by Oranga Tamariki involvement status.

5.3.1 Discrimination in health care settings

Overall, almost one in eight (12.8%; *n* = 40) participants with Oranga Tamariki involvement said that they had been treated unfairly by a healthcare professional because of their rainbow identity, which was a higher proportion than the group of young people with no involvement (7.7%, n = 195) (X^2 (1, N = 2844) = 9.603, P < 0.01). We conducted intersectional analysis and found that the proportion of disabled participants with Oranga Tamariki involvement (15.1%, n = 28) who reported they were treated unfairly in healthcare encounters because of their rainbow identity was almost twice as large as the proportion of non-disabled participants with Oranga Tamariki involvement who reported this (8.3%, n = 10); however, the sample size was not large enough to find significance. However, the proportions of trans and non-binary participants (13.8%, n = 28) who reported being treated unfairly by healthcare professionals was not significantly different to cisgender participants with involvement (10.2%, n = 11). However, rates of discrimination by healthcare practitioners were higher among Māori (20%, n = 15) and Asian (25%, n < 10) participants, while rates for Pākehā and Europeans (9.4%, n = 20) with Oranga Tamariki involvement were lower (X^2 (1, N = 312) = 9.024, p < 0.05).

Just over one third (35%, n < 10) of intersex participants reported that they had been made to see a healthcare professional, without their consent, because of their variations in sex characteristics.

5.3.2 Access to gender-affirming medication

We asked trans and non-binary participants with Oranga Tamariki involvement (*N* = 209) if they had ever taken hormones or puberty blockers to affirm their gender. Table 1 presents the data about use of, and desire for, gender-affirming hormones, puberty blockers, and medication to stop menstruation. Overall, almost one half (47%; *n* = 99) of trans or non-binary participants with involvement in Oranga Tamariki had accessed at least one type of gender-affirming medication listed in Table 1.

Table 1. Use of, and desire for, gender-affirming medications among trans and non-binary participants who were involved with Oranga Tamariki (N = 209).

Type of gender-affirming medication	Yes %, *n*	No, I want but cannot get this %, *n*	No, I want this in the future but not yet %, *n*	No, I don't want this %, *n*	Not sure %, *n*	Doesn't apply %, *n*
Gender-affirming hormones	20.6% 43	20.1% 42	14.4% 30	16.7% 35	19.1% 40	7% 19
Puberty blockers	10.5% 22	13.9% 29	4.3% <10	27.3% 57	11.0% 23	33.0% 69
Medication to stop menstrual cycle	34.0% 71	20.1% 42	8.6% 18	10.5% 22	8.6% 18	18.2% 38

We explored if there were any differences in accessing gender-affirming medications, as well as not being able to access gender-affirming mediations when medications were wanted, for young people with and with no Oranga Tamariki involvement. The proportions of young people with involvement who were able to access gender-affirming medication included 20.6% (n = 43) of those with involvement who were able to access gender-affirming hormones, compared to 18.7% (n = 258/1379); One in ten (10.5%, n = 22) of those with involvement reported that they were using puberty blockers, compared to 6.4% (n = 88/1373) of young people with no involvement (X^2 (1, N = 1582) = 4.752, $p < 0.05$); And a third (34.0%, n = 71) of those with involvement were using medication to stop a menstrual cycle, compared to 24.7% (n = 340/1377) of young people with no involvement (X^2 (1, N = 1586) = 8.139, $p < 0.01$). There were no significant differences in the proportions of young people with, or with no, Oranga Tamariki involvement who wanted gender-affirming medication but could not access these.

We asked participants with involvement in Oranga Tamariki who indicated that they wanted gender-affirming medication but could not access it (18.4%; *n* = 77) to select responses that explained why they were unable to access this healthcare. As shown in Figure 5, the most common reasons for participants' unmet need for gender-affirming medication were not knowing where to find information, and lack of parental or caregiver support, and the cost of treatment.

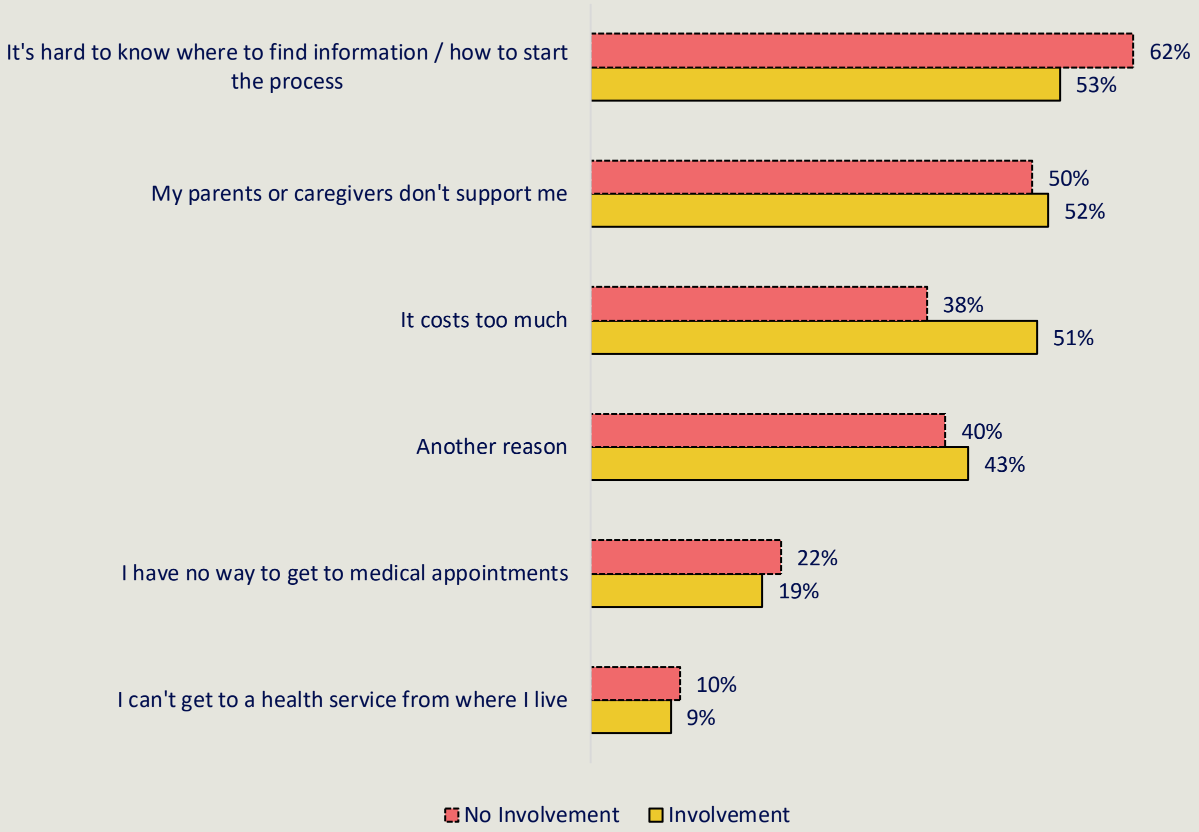

Figure 5. Reasons why young people said they could not access gender-affirming medication, for participants with Oranga Tamariki involvement (n = 77) and with no involvement (n = 375).

5.3.3 Impacts of gender-affirming medication

We asked participants who had accessed gender-affirming medication “what difference has gender-affirming medication made to your life? (*e.g., your mental health, how others treat you*)”. Selected quotes below highlight the positive impacts of such healthcare, including benefits to their mental health and wellbeing:

“it has made me happier and more secure” (NZ European/Pākehā, 15 years old)

“I have been on T for <6 months & effects aren't greatly noticeable to others, so I am still often misgendered by others, but I am confident in myself and my identity.” (Asian, NZ European/Pākehā, 25 years old)

“Makes me feel more like myself. Makes it easier to focus at school” (NZ European/Pākehā, 15 years old)

“I am mentally healthier, and feel free to live as me and love my life, my body, and the relationships I have with those around me” (Māori, NZ European/Pākehā, Pacific, Other European, 25 years old) “i tend to pass more easily, and i also generally feel more comfortable and at ease bc of T” (NZ European/Pākehā, 19 years old)

“It saved my life.” (NZ European/Pākehā, 18 years old)

“I have just started it, but it made me feel better since I now know the testosterone time bomb in my body won't detonate and make me into someone who wasn't me. But at the same time it left me feeling sad, as I really don't want to hurt my fertility. I simply have no choice, because otherwise my mental burden will kill me if I become a testosterone-filled man” (Asian, 20 years old)

“Dysphoria has been greatly dimished, I feel like me, and my mental health has vastly improved” (Other European, 20 years old)

“my mental health has gotten better because my body is running the way i finally want it to, however, anxiety has increased going out in public because i noticed a lot more people are staring at me. getting to greenlane hospital every 3 weeks requires a lot of bus money” (Asian, 20 years old)

“Insane improvement on mental health, sense of identity and personal relationships. Have been mostly overwhelmed by how positive the experiences I have had are but that was not universal and I am aware that I am very fortunate as to how I have been treated.” (Māori, NZ European/Pākehā, 24 years old)

“made a massive difference in my mental health, my comfort in my own body, and how others treat + gender me” (Māori, NZ European/Pākehā, 20 years old)

5.4 Summary and Insights

This report is the final of four that highlights a range of structural issues, challenges, and urgent needs facing young takatāpui and rainbow people with Oranga Tamariki involvement. Drawing from a range of health and wellbeing indicators, the report highlights significant health and wellbeing disparities for young people with involvement. Concerningly, despite these higher health and wellbeing needs, a noteworthy proportion of young people with involvement report difficulties in accessing unbiased healthcare. The following summary identifies key issues from the analysis, provides interpretation from some findings, and includes insights that may help guide practice and policy.

Across a range of contexts in these reports, higher proportions of young people with involvement report a lack of support, and more abusive experiences, in school, home, religion, housing and healthcare contexts. In addition, higher proportions of young people with involvement are Māori, trans, and disabled, increasing the chances of racism, ableism, and transphobia for these young people.

Reduced exposure to structural discrimination may prevent some of the disparities in wellbeing and mental health outcomes for young people with involvement.

Intersectional analyses and considerations are important to better understand the wellbeing and mental health experiences of young people with involvement.

A greater proportion of participants with involvement reported poor wellbeing compared to young people with no involvement. In addition, young people with involvement were more likely to report acute mental health outcomes, including non-suicidal self-injury (NSSI), thoughts of suicide, planning suicide, and a suicide attempt, in the past year, compared to those with no involvement. Young people with involvement who reported an attempted suicide were more likely to experience injury, poisoning, or an overdose that required medical attention. The higher levels of suicidality, NSSI and serious injury after a suicide attempt by young people with involvement indicate a higher level of acute mental health needs for this group compared to young people with no involvement.

- The reasons for the higher proportion of young people with Oranga Tamariki involvement reporting acute mental health outcomes may be due to the structural issues detailed in these reports, as well as a greater likelihood of trauma. For instance, we recognise that some young people may have experienced trauma before they became involved with Oranga Tamariki, which may be the reason or their involvement.

- Equally, and perhaps more importantly, the reports in this series also highlight that inadequate policies and practices may produce trauma for young people during their involvement with Oranga Tamariki. If a young person's experience with Oranga Tamariki does not meet their needs or is oppressive and stigmatising, this may also produce or exacerbate trauma and contribute to the mental health disparities identified in this report. We are aware of involvement with Oranga Tamariki that has exposed takatāpui and rainbow young people to traumatising processes, including placement with inadequate caregivers who, at best, lack awareness, and at worse are prejudiced, discriminatory, spiteful and abusive. We also know situations where caregivers have not been adequately briefed about the young person's background and needs, reducing the chances of a responsive and harmonious placement. Ironically, we are also aware of situations where selective breaches of young people’s privacy about their gender and sexuality have occurred alongside the simultaneous withholding of other information about them that may have facilitated a better experience in the care of Oranga Tamariki.

- Poor management of their care can then result in unsuccessful care experiences, resulting in a greater likelihood of failed placement changes, that are often, poorly communicated. Regular failed placements can produce a sense of continual upheaval due to frequent changes in social workers, placements, and geographic locations. In turn, these outcomes of poor process increase the risk that these young people have repeated experiences of rejection and instability, experience a lack of exposure to healthy relationships, and develop exhaustion from continual advocacy for their basic needs. The normalisation of such trauma over time and repeated instances of the poor process and procedures listed above may result in a sense of hopelessness that such experiences are normal because they keep on happening. To the extent that young people, by the very nature of their experience with Oranga Tamariki, are exposed to such situations, the cumulative impact of these experiences may also explain some of the disparities observed in this report.

Approaches that address non-acute, as well as acute mental health and wellbeing issues will help improve the mental health and thriving of a broad range of takatāpui and rainbow young people with involvement.

In addition to addressing structural inequalities and stigma, interventions that address acute mental health issues are particularly important for takatāpui and rainbow young people with involvement.

NSSI- and suicide-prevention, monitoring, and treatment activities are likely to be very important for takatāpui and rainbow young people with involvement.

Addressing the conditions, including policies and procedures, as well as social worker training and capacity, within Oranga Tamariki, that are associated with trauma or distress, is highly likely to produce better outcomes for takatāpui and rainbow young people.

The disparities reflected in this report for mental health and wellbeing outcomes for young people with involvement, may not only reflect an increased risk of trauma, but may also reflect less resources to heal from such trauma.

- The very practices and processes that expose young people to inadequate caregivers, multiple caregivers and placements, including, at times, boarding schools and youth residences, may prevent young people from building trusting relationships with caregivers or social workers that can be used to provide support. Having limited support may reduce healing opportunities, and negatively impact their mental health and wellbeing compared to young people without involvement, therefore helping to produce the observed inequalities.

- Conversely, we are aware of young people with involvement who were badgered and pressured to share their traumatic experiences with caregivers, only to have such disclosures invalidated or weaponised against them. Such experiences may re-traumatise young people, invalidate their feelings, make it harder to regulate their behaviour, and discourage them from trusting others for support – all of which may contribute to the poorer mental health and wellbeing outcomes identified in this study
- We know of young people in care who have experienced gaslighting by being told they should be “grateful” for any care they receive, even inadequate and abusive care. Being told to be grateful for such care can normalise unhealthy relationships and substandard care for young people, and prevent them from establishing healthy relationship boundaries and reaching out for support, all of which may contribute to the poorer mental health and wellbeing findings observed here

In the context of increased likelihood of trauma and exposure to unhealthy relationships, placing young people with caregivers who can provide responsive, effective and consistent long-term care and support are an important opportunity to prevent and improve poor mental health and wellbeing outcomes for young people with involvement.

Young people with involvement may benefit from having their right to responsive, supportive and effective care regularly reiterated, assessed and monitored by Oranga Tamariki.

Specific training for caregivers on trauma-informed support, attachment theory, and healthy relationships and boundaries, may be useful for some young people with involvement.

In addition to a lack of effective support, the impacts of multiple placements may also contribute to the disparities in mental health and wellbeing seen in this study for young people with involvement.

- We know of some situations where placements broke down, where a young person has been told it is “their fault” despite the fact that their experiences of compounding trauma, structural disadvantage, and poor caregiver support were not recognised. In one situation, we know of a young person who was moved to an unpopular caregiver and told it was because no one else wanted them. Such experiences may increase feelings of worthlessness and produce additional trauma that may exacerbate poor mental health and wellbeing outcomes for young people with involvement
- Conversely, in the context of frequent placement breakdowns, and multiple instances of discrimination and poor practice from caregivers, we know of some young people who may blame themselves because they are the only constant factor in their care-journey, and therefore must be to blame. By taking the blame

for such experiences, such young people may foster a sense of control in an uncontrollable situation, however, this narrative may also contribute to feelings of worthlessness, shame and guilt, which may contribute to poorer mental health and wellbeing outcomes seen for some young people with involvement

- When young people have become distant from their whānau and family either prior to, or during their time in the care of Oranga Tamariki, some young people may become hypervigilant about the requirements needed to please caregivers, even if such requirements are unhealthy or abusive, to avoid being moved again. This is especially relevant if young people have developed some normality or continuity at school. Although adaptive in the short term, these practices and requirements may also contribute to current and future poorer mental health and wellbeing outcomes for young people with involvement
- Finally, in the context of inconsistent relationships, a strong desire for any attachment may develop, and while adaptive in the short-term, this may also produce situations where young people remain in unhealthy relationships, or join gangs, that meet their attachment needs but may also expose them to situations that may produce poorer mental health and wellbeing outcomes.

Particular attention to processes and policies that prevent placement breakdowns, and multiple placements for young people, is an important opportunity to improve mental health and wellbeing outcomes for young people with involvement.

Where a placement change is unavoidable, helping young people to understand and frame the transition as a complex situation with multiple antecedents may help to destigmatise the experience and reduce feelings of shame, worthlessness and/or guilt.

When placement changes occur the provision of adequate external support that is trauma-informed may be helpful to reduce and prevent trauma from an unavoidable transition.

As noted in the first report in this series, participants with involvement were more likely to have experienced sexual orientation and gender identity conversion efforts (SOGICE). Among those with involvement, perpetrators of SOGICE often included family members, caregivers or religious/spiritual leaders.

The first report in this series notes that the mental health effects of SOGICE could be avoided if young people with involvement are not exposed to family, caregivers, and faith communities that conduct or support SOGICE.

Mental health interventions and treatments that assess and respond to SOGICE will be an important component of an effective mental health response for young people with involvement.

Compared to their cisgender peers who were involved, higher proportions of trans and non-binary participants who were involved reported NSSI, suicidal thoughts, planning a suicide attempt, and attempting suicide. Additionally, our findings show that trans and non-binary young people face additional challenges accessing affordable gender-affirming healthcare, which may also impact their mental health and wellbeing. In total, a third of trans or non-binary participants had accessed at least one form of gender-affirming medication, However, almost one in five wanted access to gender-affirming medication but could not access it. The main reasons for the unmet need for gender-affirming medications were a lack of information and non-supportive parents or caregivers.

- The previous reports in this series highlight the additional stigma and discrimination faced by trans and non-binary young people, which likely explains the increased mental health distress identified for trans and non-binary young people in this report. Because some trans and non-binary young people will need gender-affirming healthcare, we recognise that the advocacy burden carried by them may be higher compared to cisgender young people with involvement. For some trans and non-binary young people, who are simply trying to cope with the challenges produced by Oranga Tamariki involvement, having the time and energy to access gender affirming healthcare can be insurmountable, and this may also reduce their mental health and wellbeing.

Acute and non-acute responses to addressing the mental health and wellbeing of young people with involvement will be more useful if they respond to the needs of trans and non-binary young people.

Provision of affordable (free) and effective gender-affirming healthcare is likely to significantly improve the overall health and wellbeing of takatāpui and rainbow young people who have involvement with Oranga Tamariki.

Improved access for gender-affirming medications to young people who want and need them will help address the health disparities for some young people with involvement.

Effective education and resourcing for caregivers on gender identity, and trans young people, will include material on gender-affirming medications.

Efforts to improve trans and non-binary young people's health and wellbeing will be most effective if they include information about gender-affirming medications, including where and how these can be accessed.

Other barriers to accessing gender-affirming medication exist and further work is required to explore solutions to these issues.

Three quarters of involved participants accessed healthcare in the last year. However, almost one in five had experienced foregone healthcare in the past year. A greater proportion of Māori and Asian participants with involvement reported healthcare discrimination experiences. In addition, involved participants were significantly more likely to report experiencing healthcare discrimination based on their rainbow identity. The context of high levels of mental health needs despite relatively broad healthcare access, suggests that current healthcare activity is insufficient and/or unable to address the structural conditions that may produce mental health challenges.

Exploring options to address foregone healthcare for this group may provide an important avenue to address some of the mental health needs for these young people.

School-based health services and post-secondary health services are key opportunities for health provision for this group if such services are responsive and inclusive for takatāpui and rainbow young people.

An intersectional approach to healthcare provision that accounts for racism, and other dimensions of discrimination, will be useful to improve healthcare access and practice for greater numbers of young people with involvement.

Improving healthcare access, as well as responsive and inclusive healthcare, will address some of the mental health disparities, however, to be most effective structural factors will also need to be addressed.

6 Appendices

6.1 Appendix A. Detailed methods

6.1.1 The survey, recruitment and ethical approval

A full methodology is described in the Identify Survey Community and Advocacy Report[8]. The survey focused on young people's experiences across various contexts, including education, employment, home, and the community. The survey included questions on protective aspects and challenges in these contexts. A section also collected health and wellbeing data, including measures of suicide ideation and attempts.

The survey was a collaboration between two national youth community organizations and researchers who represented a range of genders, sexualities, ethnicities, and ages. The survey content, structure, recruitment, and branding were informed by nine in-person regional community consultations in 2020. Questions in this study were either developed by the research team, often following community consultation, or were replicated from existing New Zealand studies with transgender and gender-diverse people[9] and a national youth behavioural surveillance study[10].

The survey was constructed in Qualtrics and supported smart logic, so that participants were only shown questions relevant to their previous answers. In-person recruitment was conducted at community events, including Pride festival events in main cities and existing nightclub events and community meetings. Posters were placed in prominent community venues (e.g., queer- and trans-friendly bars and cafes), schools and tertiary institutions, and in the libraries of two large cities. Online recruitment was conducted via advertisements and posts on Facebook, Instagram, TikTok, Twitter, YouTube, and Grindr. Word of mouth, including via social media and preliminary data "teasers" in mainstream media stories, also advertised the survey. The study received ethical approval from the New Zealand Health and Disability Ethics Committee (20/NTB/276).

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[8] Fenaughty, J., Ker, A., Alansari, M., Besley, T., Kerekere, E., Pasley, A., Saxton, P., Subramanian, P., Thomsen, P. & Veale, J. (2022). https://www.identifysurvey.nz/s/community_advocacy_report.pdf Identify survey: Community and advocacy report. Identify Survey Team.

[9] Veale, J., Byrne, J., Tan, K. K., Guy, S., Yee, A., Nopera, T. M. L., & Bentham, R. (2019). Counting Ourselves: The health and wellbeing of trans and nonbinary people in Aotearoa New Zealand. Hamilton, NZ: Transgender Health Research Lab, University of Waikato. https://countingourselves.nz/wp-content/uploads/2022/09/Counting-Ourselves_Report-Dec-19-Online.pdf

[10] Fleming, T., Peiris-John, R., Crengle, S., Archer, D., Sutcliffe, K., Lewycka, S., & Clark, T. (2020). Youth19 Rangatahi Smart Survey Initial Findings: Introduction and Methods. The Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand. https://www.youth19.ac.nz/publications/category/Reports

6.1.2 Data preparation, participation rates and analysis

The survey received 6712 initial responses. After filtering responses that were flagged by Qualtrics as spam (n = 86) or that did not provide consent (n = 39), did not meet age requirements (n = 511), were not living in Aotearoa New Zealand (n = 33), were duplicates (n = 35), were illogical, including homophobic and transphobic responses (n = 19), or did not complete more than five questions after the branching question on current educational or employment status (n = 771), the sample consisted of 5218 valid responses.

Data was analysed using SPSS 27. Where the sub-sample was less than 10, and these data are reported, they are noted as <10 to help protect anonymity. When a participant did not respond to a question, actively declined to answer it (where applicable) or indicated that a question was not relevant (e.g., ‘this does not apply to me’), these participants were treated as missing for these questions and were not counted in the denominator that was used to calculate percentages for these items.

6.1.3 Strengths and limitations

The key strengths of the study were the high levels of participation from communities that can be difficult to identify and recruit. With sufficient numbers, we have produced large enough sub-sample sizes to facilitate intersectional analyses on a range of identity dimensions, including ethnicity, gender modality (including all of our prioritised gender categories), disability, Oranga Tamariki experience, homelessness experience, sexual orientation and gender identity change effort-experience, rural/urban-location and many regional experiences, alongside other sub-groups in each of the three exclusive education or employment sections of the report. As an anonymous and confidential online survey, participants are not required to disclose sensitive information to an interviewer or have their data attached to their name, which can reduce social desirability biases (where people prefer to not disclose difficult, negative, potentially shaming or distressing information), meaning the data may be more accurate than if they were not anonymous.

The main limitation in these data is the fact that the data were produced from a self-selected non-probability group from the population of interest. This means that we are unable to tell how the young people in this study compare to the overall population of rainbow young people in Aotearoa New Zealand. Factors that promoted some young people to participate, over those who did not, may therefore introduce bias into our results. For instance, our study required young people to have online access to participate, which means that it may over-represent young people who have access to online resources, and therefore online supports, who may be more supported and connected than rainbow young people who do not have this access and supports. This would mean that we may be oversampling a more connected and supported group of young people compared to the general population of rainbow young people in Aotearoa New Zealand.

Recruitment for the study relied on the internet and social media, as well as regional libraries, mass media stories, and posters in schools and tertiary education providers. The call to participate in the research was also widely shared through rainbow community networks and media. Young people connected to rainbow communities and media may therefore have been more likely to see the call to participate. Such young people may differ from those not connected to rainbow communities and media, as they may have more rainbow-friendly social connections and supports, which may operate as protective factors. The potentially greater concentration of more-connected participants in the study means the data may underestimate the effects of negative experiences because it cannot account for those who have fewer connections and, therefore, fewer supports, resulting in a potential underestimate of the challenges that may be operating.

In contrast, more young people with negative experiences may have been particularly motivated to participate in this research, so they could share their stories and experiences to help produce change. If this was the case, it would result in an over-estimation of challenges and negative outcomes relative to the general population of rainbow young people. However, widespread findings, based on representative samples in Aotearoa New Zealand[11] highlight acute levels of mental health challenges, including depression and suicidality, for sexuality[12] and gender[13] minority young people. It is more likely that the prevalence of these mental health outcomes recorded in the general population of rainbow young people will have prevented young people affected by these challenges from being able to participate in the study. In this situation, the study may under-estimate levels of challenge and negative experiences relative to the general population of rainbow young people in Aotearoa New Zealand.

Finally, a key limitation that we acknowledge is the under-representation of young people with Pacific, Māori and Asian ethnicities, and an over-representation of Pākehā and European young people compared to the general youth population in Aotearoa New Zealand. While a range of recruitment strategies were engaged to bolster recruitment from young people with these ethnicities, the under-representation of young people from these groups means that experiences and effects of racism will most likely be under-

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[11] Statistics New Zealand. (2022). LGBT+ population of Aotearoa: Year ended June 2021. https://www.stats.govt.nz/information-releases/lgbt-plus-populationof-aotearoa-year-ended-june-2021/

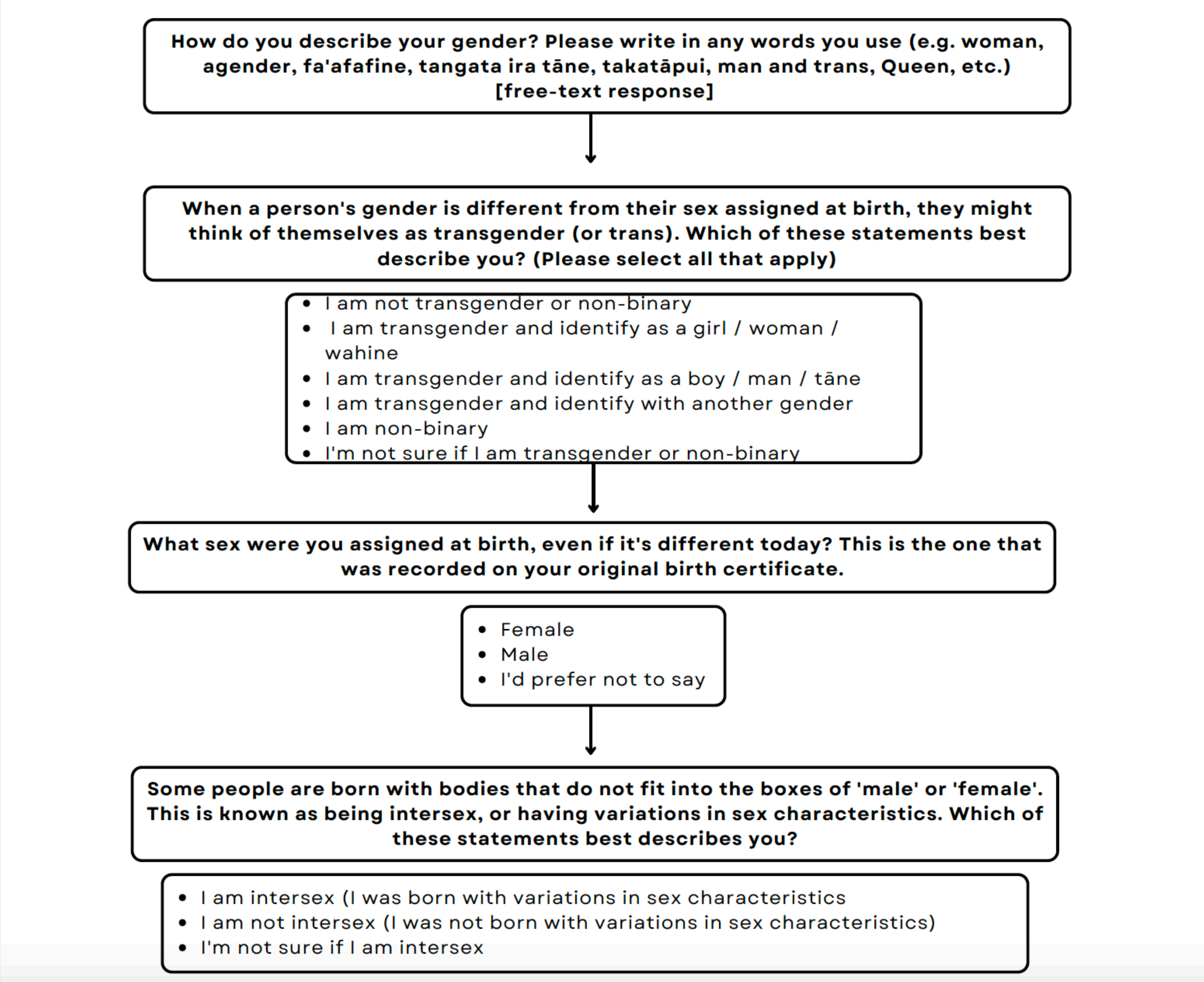
[12] Fenaughty, J., Clark, T., Choo, W.L., Lucassen, M., Greaves, L., Sutcliffe, K., Ball, J., Ker, A., & Fleming, T. (2022). Te āniwaniwa takatāpui whānui: Te aronga taera mō ngā rangatahi | Sexual attraction and young people's wellbeing in Youth19. Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand. https://www.youth19.ac.nz/publications/sexual-attraction-wellbeing

[13] Fenaughty, J., Fleming, T., Bavin, L., Choo, W.L., Ker, A., Lucassen, M., Ball, J., Greaves, L., Drayton, B., King-Finau, T., & Clark, T. (2023). Te āniwaniwa takatāpui whānui: te irawhiti me te ira huhua mō ngā rangatahi | Gender Identity and young people's wellbeing in Youth19. Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand. https://www.youth19.ac.nz/s/Youth19-Gender-Identity-and-young-peoples-wellbeing.pdf

estimated in our results, potentially painting a more positive picture of rainbow young people in general than is the reality.

6.1.4 Measuring gender, sex, and sex assigned at birth

We asked three questions to measure gender, sex, and sex assigned at birth, as shown in Figure 6 below.



How do you describe your gender? Please write in any words you use (e.g. woman, agender, fa'afafine, tangata ira tāne, takatāpui, man and trans, Queen, etc.) [free-text response]

When a person's gender is different from their sex assigned at birth, they might think of themselves as transgender (or trans). Which of these statements best describe you? (Please select all that apply)

- I am not transgender or non-binary
- I am transgender and identify as a girl / woman / wahine
- I am transgender and identify as a boy / man / tāne
- I am transgender and identify with another gender
- I am non-binary
- I'm not sure if I am transgender or non-binary

What sex were you assigned at birth, even if it's different today? This is the one that was recorded on your original birth certificate.

- Female
- Male
- I'd prefer not to say

Some people are born with bodies that do not fit into the boxes of 'male' or 'female'. This is known as being intersex, or having variations in sex characteristics. Which of these statements best describes you?

- I am intersex (I was born with variations in sex characteristics
- I am not intersex (I was not born with variations in sex characteristics)
- I'm not sure if I am intersex

Figure 6. Questions measuring gender, sex, and sex assigned at birth.

The total responses to the question on self-identifying as trans or non-binary are presented in Table 6 below. Participants who selected ‘Not transgender or non-binary’ were categorised as being cisgender, unless they stated elsewhere that they were not cisgender (i.e., in the free-text response, “How do you describe your gender?”, in which case they were recorded in line with their free-text response).

Table 2. When a person's gender is different from their sex assigned at birth, they might think of themselves as transgender (or trans). Which of these statements best describe you? (Please select all that apply) (N = 4772).

Response options	**%** ***n***
Not transgender or non-binary	48% 2275
Transgender girl / woman / whine	5% 220
Transgender boy / man / tāne	10% 475
Transgender and identify with another gender	11% 500
Non-binary	26% 1246
Unsure	13% 630

To facilitate comparisons between gender groups, we then used the responses from the three questions on gender and sex assigned at birth to code each participant’s gender. Some participants gave multiple responses and the responses of some did not match up (e.g., selected ‘transgender man’ and ‘assigned male at birth’).

We coded responses based on the following prioritisation:

- Transgender man OR transgender woman
- Non-binary
- Another gender
- Not transgender (i.e., cisgender)
- Unsure.

For the purposes of this report, we developed the following prioritised gender groups for our analysis:

- Trans boy/man/tāne
- Trans girl/woman/wahine
- Cis boy/man/tāne
- Cis girl/woman/wahine
- Non-binary or another gender
- Unsure or questioning gender.

6.2 Appendix B. Further resources and support

6.2.1 Community and mental health support

6.2.1.1 Helplines

OutLine
0800 688 5463
https://outline.org.nz

1737 - Need to talk?
Mental health helpline
https://1737.org.nz/

Lifeline
0800 543 354 or text 4357
https://www.lifeline.org.nz

6.2.1.2 Rainbow community organisations

InsideOUT Kōaro
https://insideout.org.nz/

RainbowYOUTH
https://ry.org.nz

Te Ngākau Kahukura
https://www.tengakaukahukura.nz

Gender Minorities Aotearoa
https://genderminorities.com

Intersex Youth Aotearoa
https://intersexyouthaotearoa.wordpress.com

6.2.1.3 Takatāpui/Māori

Tīwhanawhana

http://www.tiwhanawhana.com

Takatāpui: A resource hub
https://takatapui.nz

6.2.1.4 Pacific rainbow / MVPFAFF+

F'INE
https://finepasifika.org.nz

Manalagi Project
https://www.manalagi.org

6.3 Appendix C Glossary

This is a list of some of the words we have used throughout this report and their common definitions.

Ally: A person who actively supports or stands in solidarity with members of marginalised communities.

Cisgender: an adjective describing someone whose gender aligns with that associated with the sex they were assigned at birth.

Cisheteronormativity: The system of beliefs, practices and structures that construct heterosexual cisgender identities as the norm, and frame takatāpui, MVPFAFF+, LGBTQIA+ and rainbow identities as immoral, unnatural, and pathological.

Deadname: The name that trans or non-binary person was given at birth that they no longer use. Also used as a verb -- to deadname someone is to use the birth name that a trans or non-binary person no longer uses.

Gender-affirming health care: various forms of medical or health care that many, but not all, trans and non-binary people access to affirm their gender. This includes (but is not limited to) gender-affirming hormones, puberty blockers, laser hair removal, chest reconstruction (top) surgeries, genital reconstruction (bottom) surgeries, voice therapy, and psychosocial support.

Heterosexual: Describes someone who is exclusively attracted to a gender different from their own.

Intersex: Describes a person born with variations of sex characteristics such as chromosomes, reproductive anatomy, genitals, and hormones. People are sometimes born with these variations, or they may develop during puberty. There are up to 40 different intersex variations. Though the word intersex describes a range of natural body variations, many people will not identify with, or know, this term or related terms. In medical environments, variations in sex characteristics are known as 'differences in sex development' (DSD), though this terminology is widely critiqued by intersex activists for pathologising natural bodily development.

LGBTQIA+: An acronym that stands for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and more diverse sexualities, genders, and sex characteristics. It is used in a similar way to ‘rainbow’, but is often critiqued for centring Western understandings of gender, sex and sexuality.

MVPFAFF+: An acronym used to encompass the diverse gender and sexuality expressions and roles across Pacific cultures. The acronym stands for mahu, vakasalewa, palopa, faʻafafine, akavaiʻne, fakaleiti (leiti), fakafifine, and more. Their meanings are best understood within their cultural context and may mean something different to each person.

Non-binary: Both an umbrella term and identity used to describe people whose gender does not solely fit into a binary of boy/man or girl/woman. Note, non-binary people may or may not identify with the term transgender.

Queer: A reclaimed word that is often used as an umbrella term encompassing diverse sexualities and genders. It can also be used as an individual identity by someone who is either not cisgender or not heterosexual, and is often preferred by people who describe their gender or sexuality more fluidly.

Rainbow: An umbrella term, considered more inclusive than LGBTQIA+, describing people of diverse sexualities, genders, and variations of sex characteristics. It is most commonly used in an Aotearoa New Zealand context.

Takatāpui: A traditional Māori word that traditionally means 'intimate friend of the same sex'. It has since been embraced to encompass all Māori who identify with diverse genders, sexualities or variations of sex characteristics. Takatāpui denotes a spiritual and cultural connection to the past. It is best understood within its cultural context and may mean something different to each person.

Trans: Used as an umbrella term that includes people who are transgender and have any identity that is not cisgender.

Transgender: A term that describes people whose gender differs from that that they were presumed at birth; includes transwomen, transmen, non-binary, gender fluid, and agender people, as well as a range of other identities (see Gender Minorities Aotearoa.[14] for further detail).

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[14] Gender Minorities Aotearoa (nd.) *Trans 101: A glossary of trans words and how to use them.* https://genderminorities.com/glossary-transgender/

6.4 Appendix D: Variables and Survey Questions

Variable	**Survey Question**	**Variable Categories**
Oranga Tamariki Involvement	Have you ever been involved with Oranga Tamariki (OT) or Child, Youth and Family Services (CYFS) as a young person?	Yes; no
Age	How old are you	14-26
Ethnicity	Which ethnic group or groups do you belong to?	Prioritised categories: Māori; Pacific; Asian; NZ European and Other
Gender	How do you describe your gender? Please write in any words you use (e.g. woman, agender, fa'afafine, tangata ira tāne, takatāpui, man and trans, Queen, etc.)	Open text response
Trans and cisgender	When a person's gender is different from their sex assigned at birth, they might think of themselves as transgender (or trans). Which of these statements best describe you? (Please select all that apply)	I am **not** transgender or non-binary; I am transgender and identify as a girl / woman / wahine; I am transgender and identify as a boy / man / tāne; I am transgender and identify with another gender; I am non-binary; I'm not sure if I am transgender or non-binary
WHO-5 wellbeing index	In the last two weeks… - I have felt cheerful and in good spirits; I have felt calm and relaxed; I have felt active and vigorous; I woke up feeling fresh and rested; My daily life has been filled with things that interest me	All of the time, most of the time; about half of the time, some of the time, none of the time
Self-harm & Non-suicidal self-injury (NSSI)	In the past 12 months, have you hurt yourself on purpose, or done anything	Never; once or twice, three times or more

Variable	Survey Question	Variable Categories
	you knew might harm you (but not kill you)?	
Suicidal thoughts	In the past 12 months, which of the following have you done? (Please select all that apply) Thought about killing yourself	Yes; no
Planned suicide	In the past 12 months, which of the following have you done? (Please select all that apply) Made a plan about how you would kill yourself	Yes; no
Attempted suicide	In the past 12 months, which of the following have you done? (Please select all that apply) Tried to kill yourself	Yes; no
Post attempt care	Did this result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?	Yes; No; don't know
Sexual orientation and gender identity change efforts (SOGICE) (Conversion 'therapy')	Have you ever personally experienced "conversion therapy"?	Yes; no
SOGICE Perpetrator	Which of the following people suggested "conversion therapy" to you? (Please select all that apply)	A leader in my religious or spiritual community; A medical professional; A family / whānau member; Myself; Another person
Healthcare access	In the past 12 months, have you gone to a healthcare professional or expert because of a health issue? (This could be general, mental, sexual or spiritual health e.g., GP, counsellor, nurse, tohunga)	Yes; no, but I have needed to; no, but I have not needed to
Reasons for not accessing healthcare	There are many reasons why people don't go to see healthcare professionals. In the past 12 months, what are some of the reasons you have not seen a healthcare	Scared/embarrassed; Cost; Another; Didn't know where to go; Personal info; Uncomfortable;

Variable	Survey Question	Variable Categories
	professional when you needed to? (Please select all that apply)	No appointment; Worried unfair treatment (rainbow); Worried unfair treatment (ethnicity)
Healthcare comfort	Overall, how comfortable would you feel talking to a health professional at your school or place of study about your rainbow identity? (e.g. a school nurse, guidance counsellor)	Very comfortable, comfortable; neutral, uncomfortable, very uncomfortable
Healthcare discrimination	In the past 12 months, have you been treated unfairly by a healthcare professional because of your rainbow identity?	Yes; no
Gender affirming medication	Have you ever taken any of these types of medication to affirm your gender? Hormones? puberty blockers? other blockers? medication to stop the menstrual cycle?	Yes; No, I want it but can't get it; No, I want this in the future but not yet; No, I don't want this; I am not sure if I want this; Doesn't apply

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